NATIONAL ASSOCIATION OF Community Health Centers®

elevate

2022 Year-in-Review

Highlighting Key Evidence, Resources, Tools, and Action Guides to Support Your Transformation Journey

December 13, 2022

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

Cassie Lindholm

Deputy Director,
Quality Center

Addison Gwinner

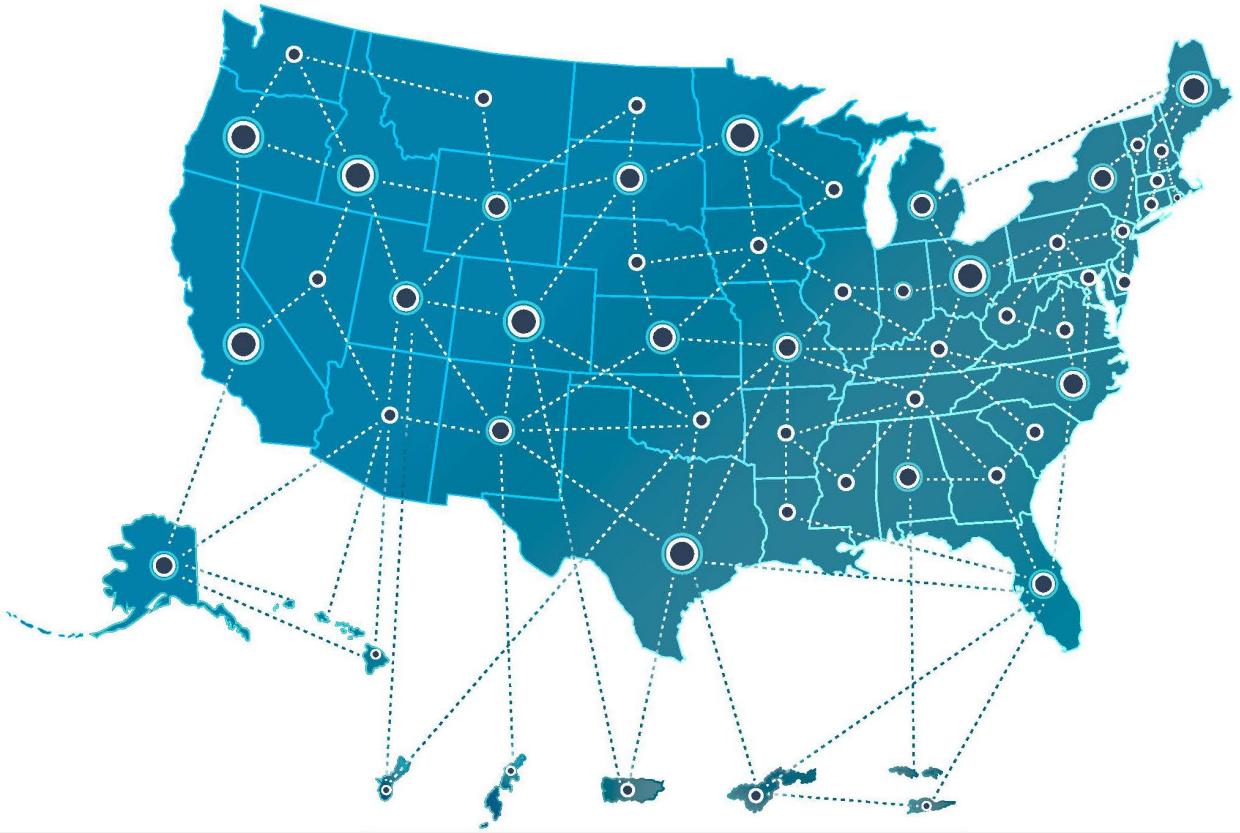
Specialist,
Quality Center

elevate

Together, our voices elevate all.

A national learning forum that supports health center systems change through application of the Value Transformation Framework

ELEVATE: A Growing Community



15% growth in 2022

All	668	77	37	6,000+	15 mil
States & Territories	Health Centers	PCAs/HCCNs/NTTAPs	CDC Grantees	Peers	Patients

Value Transformation Framework

INFRASTRUCTURE

IMPROVEMENT STRATEGY
Effectively and routinely measure and communicate information about the quality, value, and outcomes of the health care experience and use this information to drive improved performance.

HEALTH INFORMATION TECHNOLOGY
Leverage health information technology to track, improve, and manage health outcomes and costs.

POLICY
Pursue decisions, plans, and actions that help secure support and resources for health centers and expand access for under-served populations.

PAYMENT
Utilize value-based and sustainable payment methods and models to facilitate care transformation.

COST
Effectively address the direct and indirect expense of delivering comprehensive primary care to health center patients while considering the total cost of care for attributed patients.

CARE DELIVERY

POPULATION HEALTH MANAGEMENT
Use a systematic process for utilizing data on patient populations to target interventions for better health outcomes, with a better care experience, at a lower cost.

PATIENT-CENTERED MEDICAL HOME
Employ a model of care that transforms the delivery of primary care into a comprehensive, patient-centered system focused on high quality, accessible, and coordinated care.

EVIDENCE-BASED CARE
Make patient care decisions using a process that integrates clinical expertise and best-practice research with patient values and self-care motivators.

CARE COORDINATION AND CARE MANAGEMENT
Facilitate the delivery and coordination of care and manage high-risk and other subgroups of patients with more targeted services, when and how they need it.

SOCIAL DRIVERS OF HEALTH
Address the social and environmental circumstances that influence patients' health and the care they receive.

PEOPLE

PATIENTS
Intentionally and actively incorporate the patient perspective into governance, care system design, and individual care.

CARE TEAMS
Utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than a provider alone.

GOVERNANCE AND LEADERSHIP
Apply position, authority, and knowledge of leaders and governing bodies (Boards) to support and advance the center's people, care delivery processes, and infrastructure to reach transformational goals.

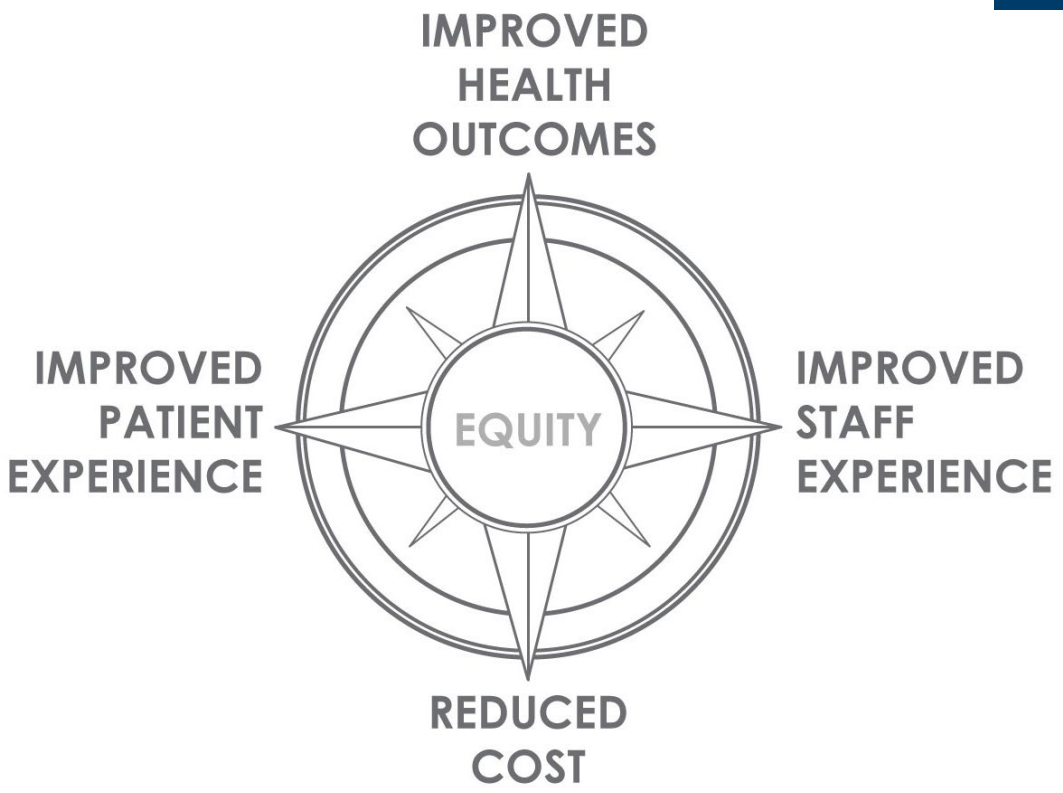
WORKFORCE
Leverage a trained and fully engaged staff to successfully address the health center's mission and goals, with optimal joy in work.

PARTNERSHIPS
Collaborate and partner with external stakeholders to pursue the Quintuple Aim.

The Value Transformation Framework **distills research and evidence-based** practices into **clear pathways for change,** known as Change Areas

nachc.org/clinical-matters/value-transformation-framework/

Our Goal



VALUE

Quintuple Aim Goals

Improved Performance through Systems Transformation

NATIONAL ASSOCIATION OF Community Health Centers®

VTF

THE 2022 JOURNEY

20+

Voices from the field

Representing diverse Health Centers, PCAs, and HCCNs

19

Learning Events

11 Learning Forums
8 Connect Sessions

6

Action Guides

2022 Updates to:
Payment
Risk Stratification
Empanelment
Patient Engagement
Care Teams
Leadership

8

Reimbursement Tips

2022 Updates to:
Behavioral Health Integration
Chronic, Complex Chronic, & Principal Care Management
Medicare Telehealth
Mental Health Telecommunication
Transitional Care Management
Psychiatric Collaborative Care
Virtual Communications Services

100+

Tools & Resources

Available on Docebo Online Learning Platform

WOW!

- **In 2022, the Quality Center awarded:**
  - **155 scholarships** to the Institute for Healthcare Improvement's (IHI) Open School (30+ QI related virtual courses)
  - **9 scholarships** to IHI's *Moving Quality Improvement from Theory to Action* course
  - **8 scholarships** to IHI's *Creating Joy in Work* course
- Stay tuned – more scholarship opportunities to come in 2023!

Other Elevate Support

Free 6-month trial subscription to RegLantern's Continuous Compliance Tool (health centers)

4-month Mentoring Program (PCA/HCCN staff)

Microlearnings - New in 2022!

10 MINUTES | MONTH, DAY, YEAR

NATIONAL ASSOCIATION OF Community Health Centers

THANK YOU! 2022 Featured Health Centers

Su Clínica

ESPERANZA health centers

Charles B. Wang Community Health Center
王嘉廉社區醫療中心

evara HEALTH

PARK DUVALLE COMMUNITY HEALTH CENTER

Mountain People's Health Councils Inc.

NEW HEALTH
North End • Charlestown

Fish River Rural Health

Keystone Rural Health Consortia, Inc.
One Team Working Together For Better Community Health Care

ZUFALL HEALTH COMMUNITY HEALTH CENTERS

In the top 20 health centers nationally when looking at composite performance across measures for prevention and/or control of six high-cost, high burden conditions (2019 UDS): colorectal cancer, cervical cancer, HTN, diabetes, depression, & obesity

Population Example: Adults 50-75 Years of Age

- **Provides a shared experience** for peer-to-peer exchange & learning
- **Allows for more focused discussion** of the VTF's 15 Change Areas
- **Focuses on a population likely to have multiple chronic conditions** & benefit from care management services, an essential function of value-based care models
- **Centers our discussion around six high-cost, high-burden measures** of clinical prevention and care: colorectal & cervical cancer screening, diabetes, hypertension, obesity, & depression.
- **Provides additional revenue opportunity** & a proving ground for value-based care models (For health centers who further target the Medicare segment)

ELEVATE 2022 JOURNEY

- Leadership
- Cost
- Population Health
- Care Teams
- Workforce
- Care Management
- Payment
- Policy
- Evidence-Based Care
- Improvement Strategy
- Patient-Centered Medical Home
- Social Drivers of Health (SDOH)
- Health Information Technology
- Patients
- Partnerships

- Leadership
- Cost
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- Patients
- Partnerships

January '22

LEADERSHIP & COST

VTF

The Value Imperative

January '22

Health center field examples by:

Keystone Rural Health Consortia

Fish River Rural Health

The value imperative for health centers:

- What is the value proposition to health centers to participate in value-based payment models?
- Are there certain health center value-based care or payment model design features that account for the uniqueness of health centers and the populations they serve?
- What are strategies for funding the transition from volume to value-based payment models?

Resources & Tools

LEADERSHIP & COST

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.

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].

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.

Evidence-Based Actions

Business Case for Transformation
Create a compelling, brief statement about the imperative for transformation to create understanding and buy-in among staff and the Board (see sample in Leadership Action Guide)

Support factors that contribute to successful teams of high achievers:

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

Resources

Leadership Action Guide

January Learning Forum Recording

Build a Psychologically Safe Workplace
Amy Edmondson | TEDxHGSE

Cultivating Great Teams: What Health Care Can Learn from Google
Wisdom, J. (February 21, 2017)

Reimbursement Tip Sheets


NATIONAL ASSOCIATION OF Community Health Centers

PAYMENT

Reimbursement Tips:

Payment Reimbursement Tips: FQHC Requirements for Medicare Chronic Care Management Services:

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)
- Principal Care Management (PCM)

- Leadership
- Cost
- Population Health
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- Partnerships

January '22

Population Health

VTF

Empanelment

January '22

Health center field example by:

NEW HEALTH North End • Charlestown

Northend Waterfront Health

Microlearning: What, Why, How?

STEP 1 Document your patient-provider assignment policies and procedures

STEP 2 Check effectiveness of patient-provider assignment process

STEP 3 Determine each PCP's 'right' panel size

STEP 4 Adjust 'actual' panel size toward 'right' panel size

STEP 5 Use the 4-cut methodology to suggest PCP assignments

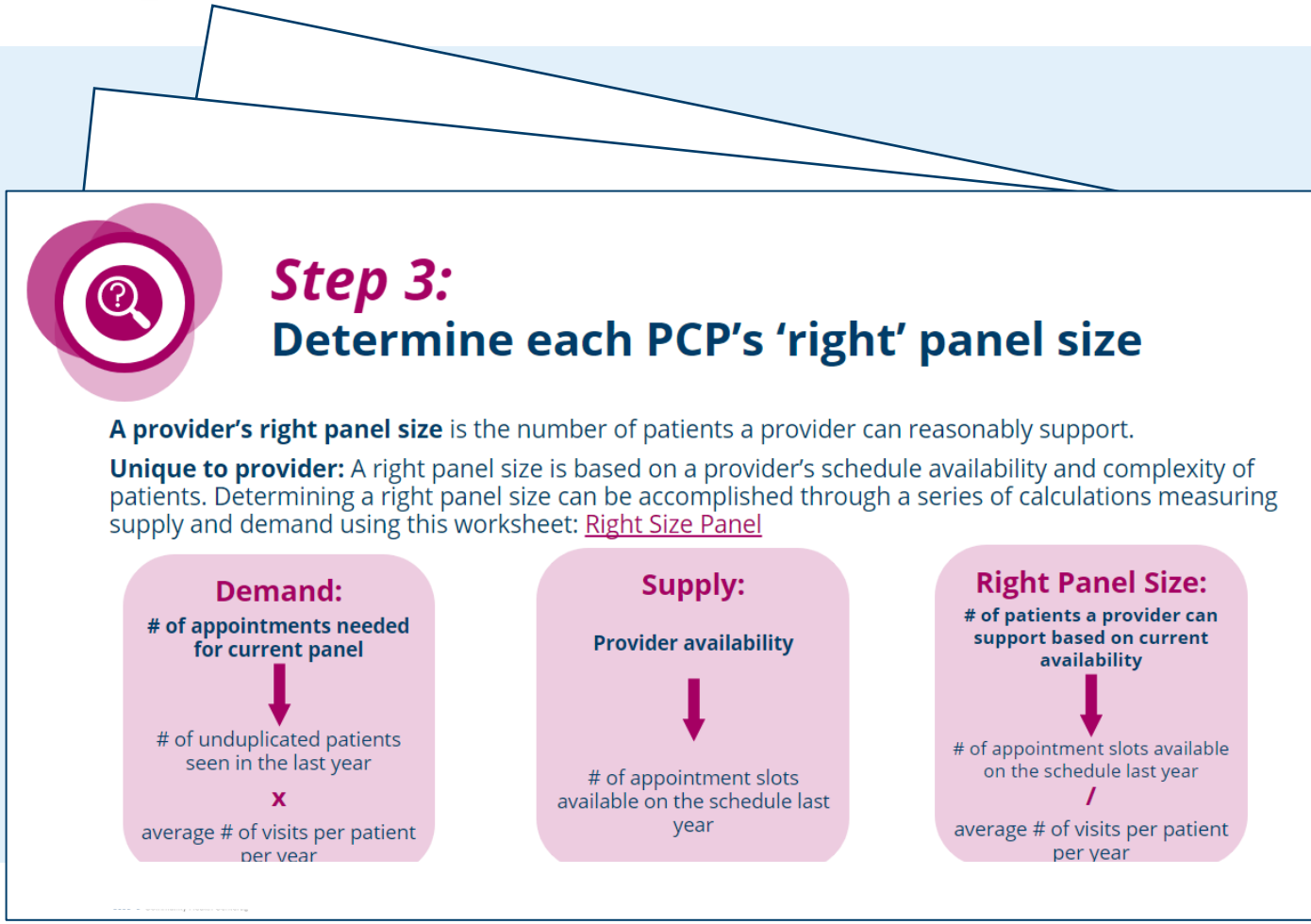
STEP 6 Review Panels by PCP, Seek PCP and Care Team Input

STEP 7 Use risk stratification to segment and manage patient panel

STEP 8 Optimize care team roles for effective panel management

STEP 9 Use empanelment data to improve patient access

STEP 10 Incorporate payer attribution data



Resources & Tools

Empanelment

Action Guide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VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

POPULATION HEALTH MANAGEMENT

EMPANELMENT

WHY

Empanelment?

Empanelment builds the patient-provider relationship that is at the center of patient-driven primary care. It is a fundamental population health management activity that matches every health center patient with a primary care provider (PCP) and care team who assumes responsibility for their care.

Empanelment supports continuity of care and offers stability and predictability to a practice, allowing it to focus proactively on managing the health of a population of patients. The provider-patient consistency that results from empanelment allows for improved communication, better identification of medical problems, more consistent treatment approaches, and improved clinical outcomes[1].

Empanelment also allows health center leaders to evaluate provider workload, distribution, and staffing models. It assists frontline staff in essential tasks such as scheduling patient appointments with the correct provider and team. In addition, empanelment provides essential information about patient access to care within the health center and continuity of care that allows leaders to make data-driven decisions supporting practice management and growth[1].

Empanelment is a vital foundational step toward health care systems change and the Quintuple Aim goals of improved health outcomes, improved patient experience, improved staff experience, reduced costs, and improved equity.

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 health outcomes, with a better care experience, at a lower cost, and improved equity. This Action Guide focuses on one foundational component of population health management: empanelment.

WHAT

is Empanelment?

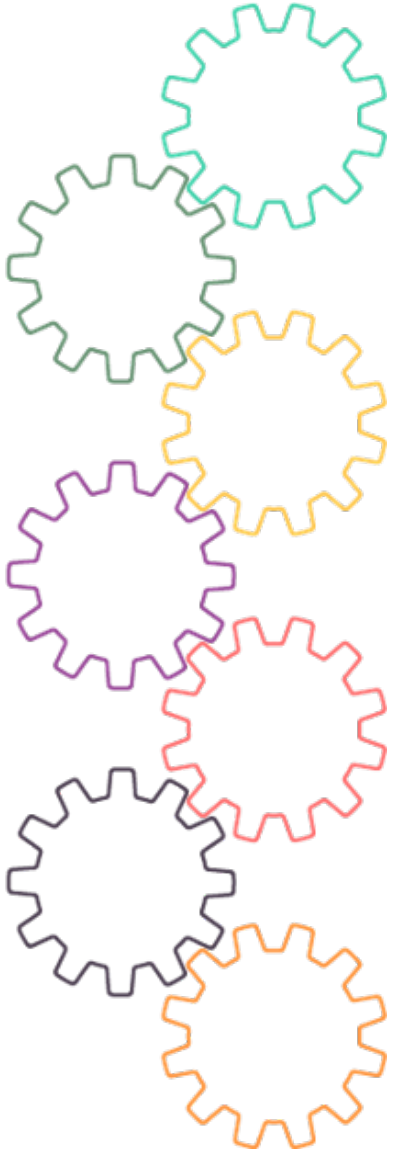
Empanelment is the process of matching every patient with a PCP and care team, taking patient and family preference into consideration. It identifies the population of patients a provider and care team are responsible for.

Resources

[Empanelment Action Guide]

[January Session Recording]

[Panel Size Worksheet]



Risk Stratification

February '22

Health center field example by:

ZUFALL HEALTH COMMUNITY HEALTH CENTERS

Zufall Community Health Centers

Microlearning: What, Why, How?

STEP 1 ***COMPILE:*** a list of health center patients

STEP 2 ***SORT:*** identify stratification criteria; weight

STEP 3 ***STRATIFY:*** patients to segment into target groups

STEP 4 ***DESIGN:*** care models and target interventions for each risk group

Step 3:
STRATIFY: Assign patients into target groups

Arrange patients from highest risk score to lowest risk score.

This can be done for the overall population or provider panel, depending on size of your health center.

Risk Level	Total Risk Score *(Example)*	Estimated % patient population
Highly complex	>20	5-10%
High Risk	11-20	20-30%
Rising Risk	2-10	40-50%
Low Risk	0-1	10-20%

Patient Name	Risk Score	
Patient A	22	Highly complex
Patient B	18	
Patient C	16	High risk
Patient D	12	
Patient E	10	
Patient F	9	
Patient G	5	
Patient H	5	Rising risk
Patient I	4	
Patient J	3	
Patient K	3	
Patient L	2	
Patient M	1	
Patient N	0	Low risk
Patient O	0	

Remember: *Risk groups are a tool for targeting services, they are not a clinical diagnosis.*

Resources & Tools

Risk Stratification

Action Guide

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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 stratification method is to segment patients 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.)

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 health outcomes, with a better care experience, at a lower cost, and improved equity. This Action Guide focuses on one foundational component of population health management: risk stratification.

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]. Organizations who succeed in a value-based care environment utilize risk stratification as a tool to drive population health.

WHAT

is Risk-Stratification?

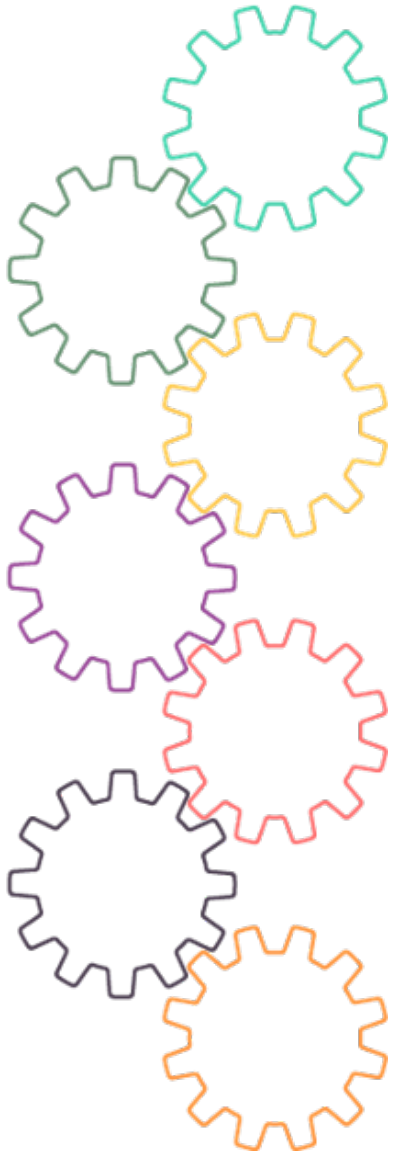
The goal of risk stratification is to segment patients into distinct groups of similar complexity and care needs. For example, out of every 1,000 patients in a panel, there will likely be close to 200 patients (20%) who could benefit from more intensive support. This 20% of the population accounts for 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].

Resources

[Risk Stratification Action Guide]

[Getting Started with Risk Stratification Video]

[Models of Care Action Guide]



Keystone Rural Health Consortia

Kristie Bennardi
Chief Executive Officer
& Chief Financial Officer

Health Center Perspective

Emporium, PA

Rural

Founded 1976

7,838
Patients

- Leadership
- Cost
- Population Health
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- Partnerships

March '22

Care Teams & Workforce

VTF

Annual Wellness Visits

March '22

Health center field examples by:

Keystone Rural Health Consortia

Evara Health

Microlearning: What, Why, How?

STEP 1 Compile a List of Patients Eligible for an AWV

STEP 2 Outreach to Schedule AWV

STEP 3 Manage Care Team Roles & Schedule AWV

STEP 4 Conduct AWV

STEP 5 Document, Code, and Bill for AWV

Billing and coding guidance by:

Messina Consulting

Achieve Revenue Management

Step 4: Conduct AWV

Meets AWV requirements for:

- ✓ Perform Health Risk Assessment
- ✓ Review patient's potential depression risk factors
- ✓ Review patient's functional level of safety
- ✓ Screen for potential SUDs

Patient completes screening questions, including:

- Patient self-assessment *(how does the patient rate their health)*
- Tobacco use screening
- Alcohol use screening
- Substance use screening
- Depression screening
- SDOH screening (PRAPARE)
- Activities of daily living (ADLs)
- Home safety

Optimize Technology and Care Team Roles!

Can be completed by MA, nurse, CHW, or other care extender

Complete prior to the visit via phone/video to reduce staff time needed during the visit

Use electronic forms for patients to self-complete

Care Teams

April '22

Health center field examples by:

ESPERANZA health centers — **Esperanza Health Centers**

Microlearning: What, Why, How?

STEP 1 Define Care Standards

STEP 2 Distribute Tasks to Meet Standards and Document Workflow

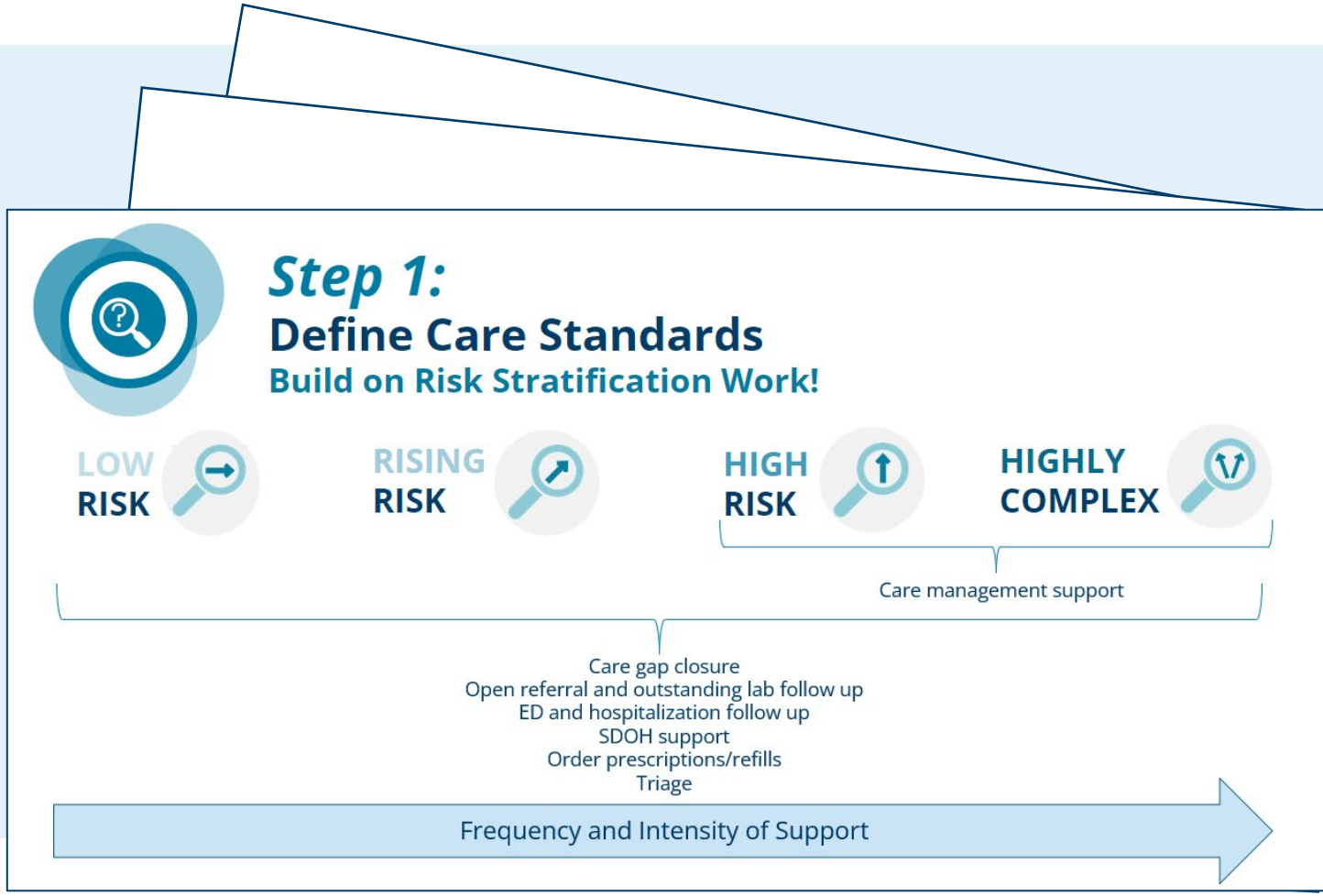
STEP 3 Update Job Descriptions

STEP 4 Train Staff

STEP 5 Monitor Task Performance in Dashboards

STEP 6 Hardwire Accountability into Personnel Systems and Performance Reviews

STEP 7 Educate Patients on Redesigned Care Team



Resources & Tools

Care Teams

Action Guide

NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK

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HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

CARE TEAMS

WHY

Focus on Care Teams?

Much has been written about the success of the "care team model" in delivering high-quality, low-cost, impactful health care. Developing an effective team-based model of care is at the heart of health center efforts to deliver on the Quintuple Aim: improved health outcomes, improved staff and provider experiences, lower costs, and improved equity.

Transitioning to value-based care requires a significant shift in the way care delivery, infrastructure, and people are engaged and deployed in the health care system. In the volume-based system, a primary care physician would need to spend an estimated 21.7 hours per day to provide all recommended acute, chronic, and preventive care to a panel of 2500 patients[1]. It is, therefore, not surprising that physicians face burnout and adults in the U.S. receive only 55% of recommended services[2]. The volume-driven model of care coupled with the complexity of preventive, acute, and chronic care needs in the context of a primary care visit, limits the quality of service delivered[3]. 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[4]. In addition to improving service for chronic disease and preventive care, re-organizing care team roles can help address the widely-documented problem of primary care physician shortages[4,5,7].

Ultimately, patient care is a team sport. All members of the health center team are accountable for the delivery of high quality care to patients. Patient engagement, also crucial to care, is addressed in the Patient Engagement Action Guide.

While many health centers report using a team-based approach to care, these systems may not be functioning optimally to achieve desired outcomes. This Action Guide offers steps to more effectively distribute, or share, responsibility and accountability across health center care teams.

CARE TEAMS

The Value Transformation Framework addresses how health centers can utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than with a provider alone. This Action Guide offers proven strategies to develop effective health center care teams.

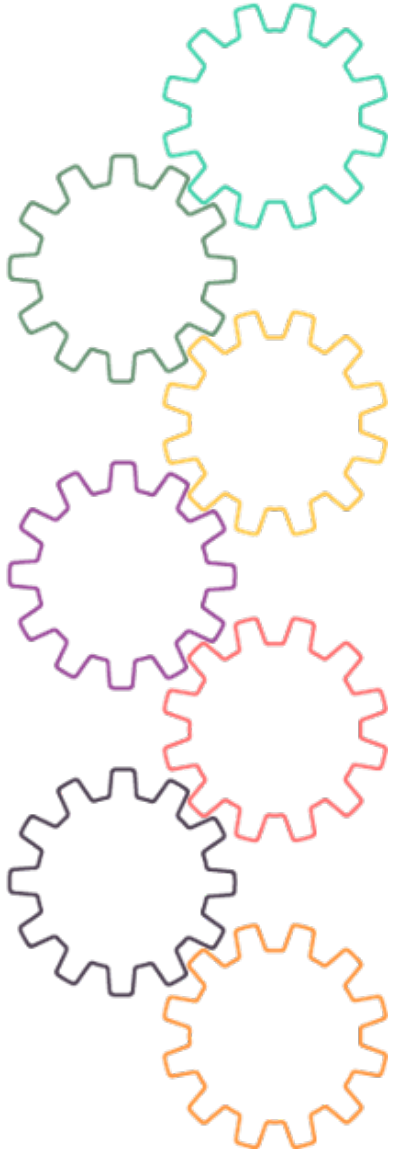
"Sharing the care involves both a paradigm shift and a concrete strategy for increasing capacity. The paradigm (culture) shift transforms the practice from an "I" to a "we" mindset. Unlike the lone-doctor-with-helpers model, in which the physician assumes all responsibility, makes all decisions, and delegates tasks to team members (but cannot increase capacity), the "we" paradigm uses a team comprising clinicians and non-clinicians to provide care to a patient panel, with a reallocation of responsibilities, not only tasks, so that all team members contribute meaningfully to the health of their patient panel."[6]

Resources

'Share the Care' Model
Ghorob, A. Bodenheimer, T. (2012). Sharing the Care to Improve Access to Primary Care. New England Journal of Medicine. 366, 1955-1957.

Team Based Worksheet
http://www.safetynetmedicalhome.org/sites/default/files/Team-Planning.xls

Workflow Mapping Tips
https://www.ahrq.gov/ncepcr/tools/pf-handbook/mod5.html



- Leadership
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May '22

Care Management

VTF

Transitional Care Management

May '22

Health center field example by:

Keystone Rural Health Consortia

Microlearning: What, Why, How?

STEP 1 Identify/Hire Care Coordination/Care Management Staff

STEP 2 Identify Patients For Care Coordination/Care Management

STEP 3 Define Care Manager-Care Team Interface

STEP 4 Define Services Provided as Part of Care Management

STEP 5 Enroll Patients in Care Management

STEP 6 Create Individualized Care Plans

STEP 7 Enhance and Expand Partnerships

STEP 8 Document and Bill for Care Management

STEP 9 Graduate (Transition) Patients from Care Management

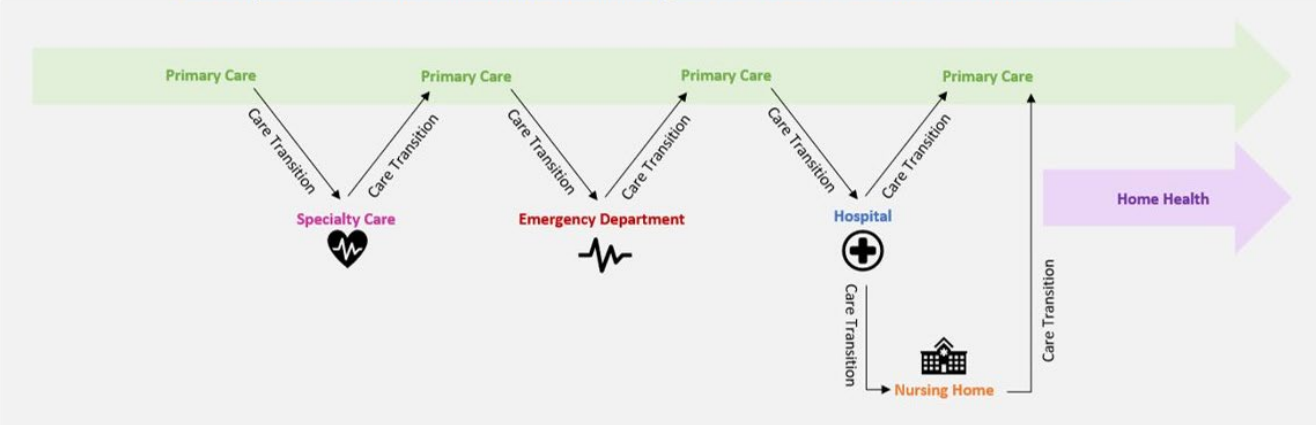
STEP 10 Measure Outcomes

Billing and coding guidance by:

Messina Consulting

WHAT
Is Transitional Care Management (TCM)

Examples of Care Transitions Along the Patient Continuum of Care



Chronic Care Management

June '22

Health center field example by:

Su Clínica

Microlearning: What, Why, How?

STEP 1 Identify or Hire a Care Manager
STEP 2 Identify High-Risk Patients
STEP 3 Define Care Manager – Care Team Interface
STEP 4 Define the Services Provided as Part of Care Management
STEP 5 Enroll Patients in Care Management
STEP 6 Create Individualized Care Plans
STEP 7 Enhance and Expand Partnerships
STEP 8 Document and Bill for Chronic Care Management
STEP 9 Graduate Patients from Care Management
STEP 10 Measure Outcomes

Step 2:
Identify High Risk Patients

For Chronic Care Management Programs, consider eligibility criteria:

CCM

Multiple **(two or more) chronic conditions** expected to last at least 12 months or until the patient dies, or places the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.

CCCM

Multiple **(two or more) complex chronic conditions** expected to last at least 12 months or until the patient dies, or places the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. **Complex CCM patient is at a moderate or high medical decision making.**

PCM

A qualifying condition that is expected to last at least 3 months and places the patient at **significant risk of hospitalization**, acute exacerbation/ decompensation, functional decline or death. **PCM patient is at a moderate or high medical decision making.**

DSMES

June '22

Diabetes Self-Management and Education Support

DSMES expertise by:

Association of Diabetes Care & Education Specialists

ADCES Association of Diabetes Care & Education Specialists

DSMT Medicare Benefit

ADCES DEAP DIABETES EDUCATION ACCREDITATION PROGRAM

Requires specific referral from qualified professional (MD, DO, NP, APRN, PA) overseeing patient's diabetes

- 10 hours initial training: once per beneficiary's life and to be used within 12 consecutive months
  - ➢Hours do not roll over
- 2 hours of follow-up available every year starting year two

DSMT is approved for telehealth: audio only and audio/video (PHE)


MEDICARE HEALTH INSURANCE

Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a — Coverage starts/Cobertura empieza
HOSPITAL (PART A) 03-01-2016
MEDICAL (PART B) 03-01-2016

ORDER FORM — Diabetes Self-Management Education & Support/Training & Medical Nutrition Therapy Services

Diabeteseducator.org/referdsmes

Resources & Tools

Care Management

Action Guide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VALUE TRANSFORMATION FRAMEWORK

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HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

CARE MANAGEMENT

WHY

Use Care Management with High-Risk Patients?

Value-based care requires health care organizations to better control the clinical and financial risks associated with high-risk patients. A systematic process for managing the care of high-risk patients, using proven interventions in a supportive one-on-one environment, has been shown to improve health outcomes[1,2,3]. High-risk patients, by definition, have multiple health needs often compounded by complex social and other issues. These patients are at risk for poor health outcomes, inadequate quality of care, and increased costs [4,5,6]. The Centers for Medicare and Medicaid Services (CMS) recognizes care management as a critical tool to achieve the Quadruple Aim: improved health outcomes, improved patient and staff experiences, lower costs, and improved equity[7].

This Action Guide provides the steps to start a health center care management program for high-risk patients. The outlined recommendations meet the requirements of Chronic Care Management (CCM) services defined by CMS and, therefore, are eligible for reimbursement.

CARE MANAGEMENT

The Value Transformation Framework addresses how health centers can effectively deliver and coordinate care and manage high-risk and other subgroups of patients with more targeted services. This Action Guide outlines steps health centers can take to develop a comprehensive care management program for high-risk patients that meets the requirements for reimbursement from the Centers for Medicare and Medicaid Services (CMS).

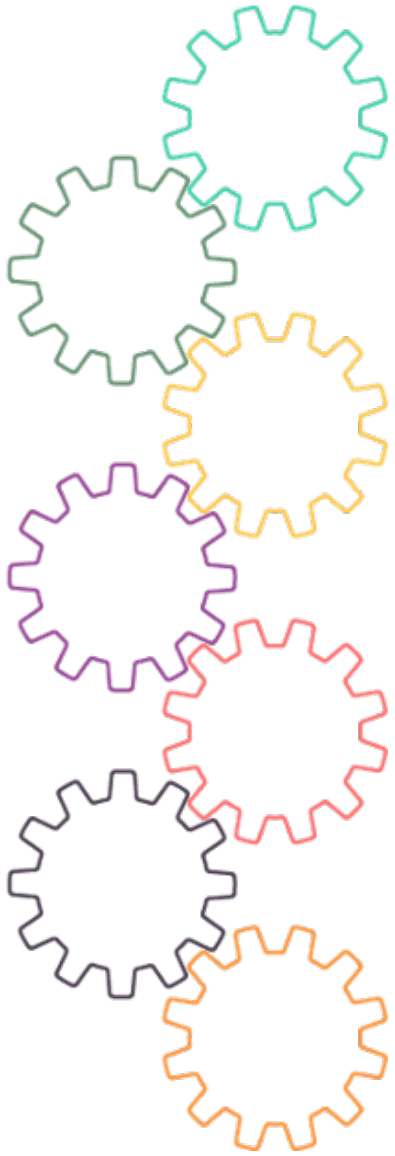
WHAT

Does a High-Risk Care Management Model Look Like?

High-risk care management involves intensive, one-on-one services, provided by a nurse or other health worker, to individuals with complex health and social needs. The formal design of a health center care management program can ensure a standardized approach to managing high-risk patients by a care manager. The model discussed in this Action Guide is based on a nurse in the role of care manager. Other staffing models can be employed with some modification. Key components of care management include: identifying and engaging high-risk individuals, providing a comprehensive assessment, creating an individual care plan, engaging in patient education, monitoring clinical conditions, and coordinating needed services[8,9,10].

Resources

- Scheduling Virtual Care Management Services
- Scheduling Virtual Communication Services
- Website/Email Message
- Sample Care Manager Job Description
- Care Management Protocol for High-Risk Patients
- Checklist of FQHC Requirements to Bill CMS for Care Management
- Checklist, Integrated Care Management
- Sample Referral Form
- Sample Informed Consent
- Sample Closeout Form
- Tracking Form
- Patient Waiver of Fees Application
- Keystone Care Manager job description
- Keystone Nurse Care Manager TCM script



- Leadership
- Cost
- Population Health
- Care Teams
- Workforce
- Care Management
- Payment
- Policy
- Evidence-Based Care
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- Health Information Technology
- Patients
- Partnerships

July '22

Payment & Policy

VTF

Care Management Coding and Billing

July '22

Billing and coding guidance by:

Messina Consulting

NACHC Health Center Finance Training Team

Important CMS Guidance Update!

An initiating visit is required prior to the start of care management services during which **the practitioner must discuss care management services with the patient.**

Qualifying initiating visits:

- ✓ Initial Preventive Physical Examination (IPPE)
- ✓ Annual Wellness Visit (AWV)
- ✓ Evaluation and Management service (E/M)
- ✓ The face-to-face visit included in Transitional Care Management (TCM)

What are the services that encompass care management in an FQHC?

CCM	CCCM	PCM	BHI	CoCM	TCM
Chronic Care Management	**Complex Chronic Care Management**	**Principal Care Management**	**Behavioral Health Integration**	**Psychiatric Collaborative Care Model**	**Transitional Care Management**
Multiple **(two or more) chronic conditions** expected to last at least 12 months or until the patient dies, or places the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline.	Multiple **(two or more) complex chronic conditions** expected to last at least 12 months or until the patient dies, or places the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline. **Complex CCM patient is at a moderate or high MDM.**	**A qualifying condition** that is expected to last at least 3 months and places the patient at **significant risk of hospitalization**, acute exacerbation/ decompensation, functional decline or death. PCM patient is at a moderate or high MDM.	Integrated behavioral health and primary care services that does not require, but may use, services of psychiatric consultation or designated behavioral health manager.	Integrated behavioral health and primary care services but with two additional service components beyond general BHI: **a dedicated care manager and psychiatric consult**.	Supports the transition and coordination of services from an inpatient/acute care setting to a community care setting by establishing a coordinated plan with the patient's PCP. **TCM patient is at a moderate of high MDM.**

Resources & Tools

Payment

Action Guide

NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

INFRASTRUCTURE | CARE DELIVERY | PEOPLE

PAYMENT

CARE MANAGEMENT & VIRTUAL COMMUNICATION SERVICES

WHY

structure care management services to meet CMS* reimbursement requirements?

Care management services are an essential population health activity under value-based care. Health centers are in a position to offer care management services to a wide range of people who have higher risks for some of the most common chronic conditions. Many of these patients clinically qualify for, and would benefit from, care management (See the Value Transformation Framework's Care Management Action Guide).

Health centers have the opportunity to obtain revenue above and beyond their federally-qualified all-inclusive flat rate when they offer, document, and bill for allowable care management services. This additional revenue can help fund systems transformation as well as be an important part of a health center's value-based care model.

CMS allows Federally Qualified Health Centers (FQHCs) to separately bill for care management services and virtual communication services (not a care management service), including:

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)
- Principal Care Management (PCM)
- Transitional Care Management (TCM)
- General Behavioral Health Integration (BHI)
- Psychiatric Collaborative Care Model (CoCM)
- Virtual Communication Services (VCS)

To obtain revenue for care management services that benefit high risk patients, health center staff must establish systems to identify those in need of care management services, and establish processes to provide, document, and bill for these services. This action guide, and companion set of *Reimbursement Tips*, is designed to support health centers in this process of establishing and obtaining reimbursement for care management and virtual communication services.

**Centers for Medicare and Medicaid Services (CMS)*

Resources

Reimbursement Tip Sheets (11 in total)

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PAYMENT

Reimbursement Tips:

FQHC Requirements for Medicare Telehealth Services.

Telehealth refers to delivery of patient services via interactive audio and video telecommunication services to patients in remote sites, including their homes.

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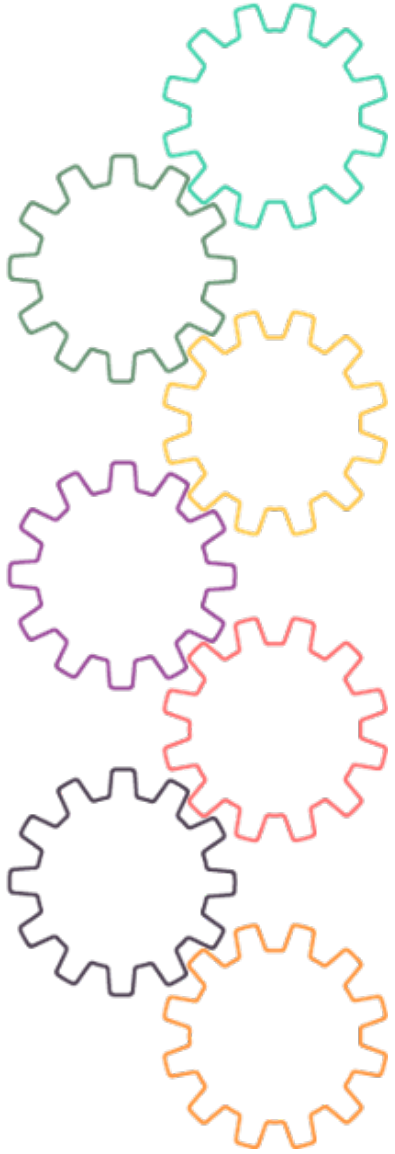
PAYMENT

Reimbursement Tips:

Payment Reimbursement Tips: FQHC Requirements for Medicare Chronic Care Management Services:

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)
- Principal Care Management (PCM)



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September'22

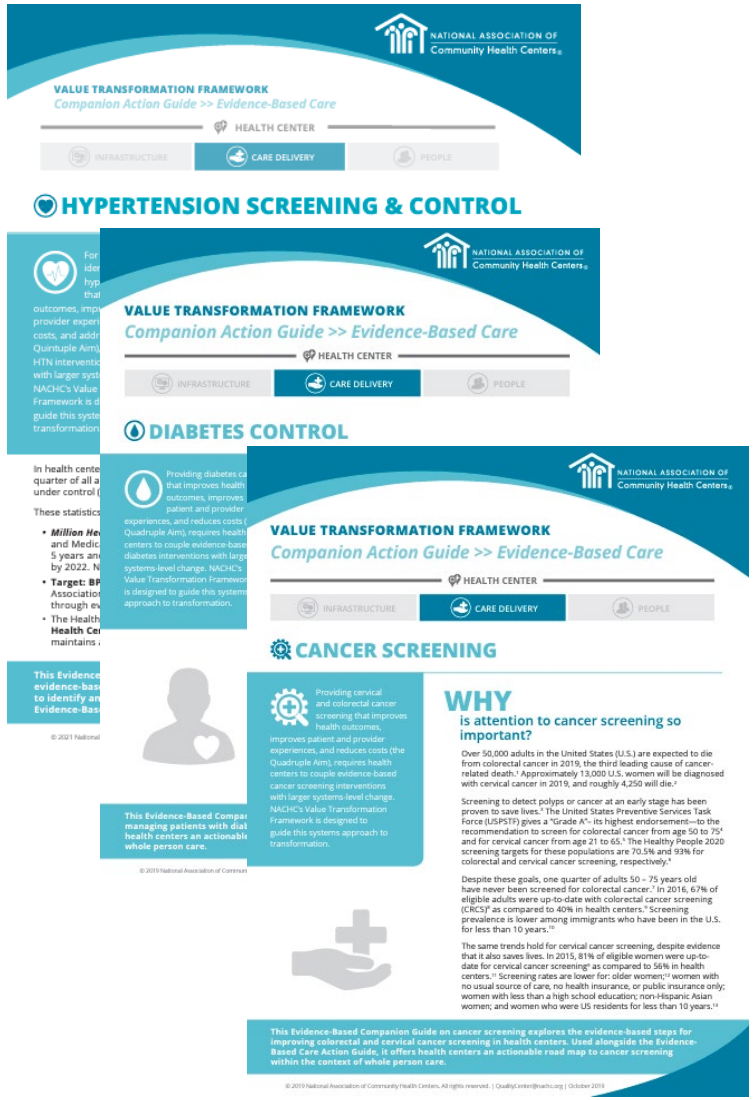
Evidence Based Care

VTF

Resources & Tools

EVIDENCE-BASED CARE

Action Guide



Resources

https://www.uspreventiveservicestaskforce.org/uspstf/

Medicare Services Checklist

Evidence-Based Care Action Guide

Cancer Screening Action Guide

Diabetes Control Action Guide

Hypertension Screening & Control Guide

Care Delivery Infographics

cancer.org/get-screened

2022 Messaging Guidebook For Black & African American People: Messages To Motivate For Colorectal Cancer Screening

UPDATED: Steps Guide for Increasing Colorectal Cancer Screening Rates

https://learning.nccrt.org/colonoscopy-calculator-form/

Cancer Screening

September '22

Health center field examples by:

Mountain People's Health Councils, Inc.

Park Duvalle Community Health Center

Microlearning: What, Why, How?

STEP 1 ***ENGAGE*** leadership
STEP 2 ***APPLY*** population health management strategies
STEP 3 ***DESIGN*** models of care
STEP 4 ***CREATE/UPDATE*** clinical policies and standing orders
STEP 5 ***DEPLOY*** care teams in new ways
STEP 6 ***OPTIMIZE*** health information systems
STEP 7 ***ENGAGE*** patients and support self-management
STEP 8 ***DEVELOP/ENHANCE*** community partnerships
STEP 9 ***TAILOR*** treatment for social context
STEP 10 ***MAXIMIZE*** reimbursement

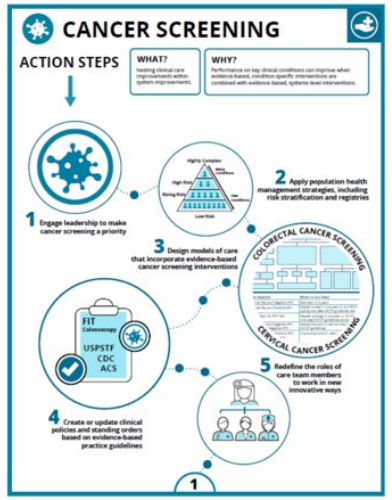
Additional expertise by:

Division of Cancer Prevention and Control, CDC

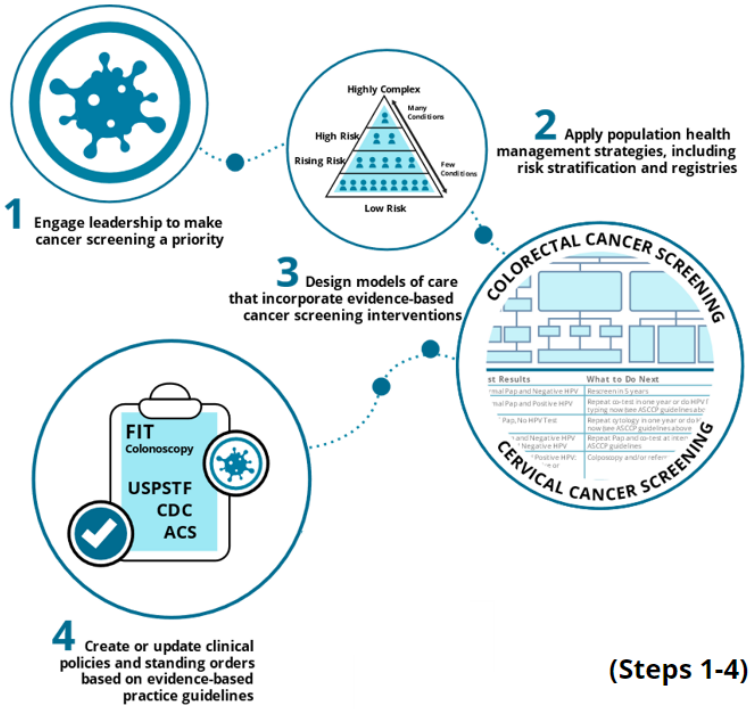
American Cancer Society

10 Action Steps for Cancer Screening

NACHC Infographic



https://bit.ly/VTF_EBC_Cancer-graph



(Steps 1-4)

Keystone Rural Health Consortia

Kristie Bennardi
Chief Executive Officer
& Chief Financial Officer

Health Center Perspective

Emporium, PA

Rural

Founded 1976

7,838
Patients

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October '22

Improvement Strategy & PCMH

VTF

Resources & Tools

Improvement Strategy

Action Guide

COMING SOON!

Resources

HRSA Quality Improvement/Assurance

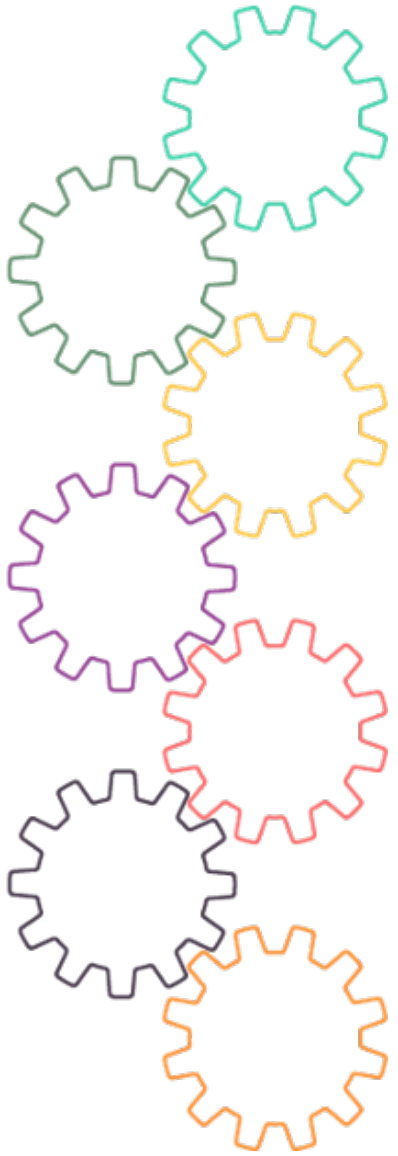
Board Oversight of Quality During COVID-19

CDC Develop SMART Objectives

PDSA

FMEA

RCA



Improvement Strategy

October '22

Health center field example by:

Charles B. Wang Community Health Center

Charles B. Wang Community Health Center 王嘉廉社區醫療中心

Microlearning: What, Why, How?

STEP 1 ***ENSURE*** policies and procedures are in place
STEP 2 ***DETERMINE*** priorities
STEP 3 ***DESIGN*** models of care
STEP 4 ***SELECT*** measures
STEP 5 ***DETERMINE*** measures for active improvement
STEP 6 ***SET*** S.M.A.R.T. goals
STEP 7 ***UTILIZE*** data dashboards
STEP 8 ***ASSIGN*** staff leads
STEP 9 ***INITIATE*** improvement activities
STEP 10 ***ENSURE*** timely progress
STEP 11 ***MEET GOALS*** and repeat steps

Additional expertise by:

RegLantern

- Leadership
- Cost
- Population Health
- Care Teams
- Workforce
- Care Management
- Payment
- Policy
- Evidence-Based Care
- Improvement Strategy
- Patient-Centered Medical Home
- Social Drivers of Health (SDOH)
- Health Information Technology
- Patients
- Partnerships

November '22

SDOH, HIT, Patients & Partnerships

VTF

Social Drivers of Health

November '22

Additional expertise by:

- NACHC Social Drivers of Health Team
- NACHC Informatics Team

Microlearning: What, Why, How?

STEP 1 ***PRIORITIZE*** SDOH and engage leadership

STEP 2 ***UNDERSTAND*** risk factors in your community

STEP 3 ***IDENTIFY*** community resources

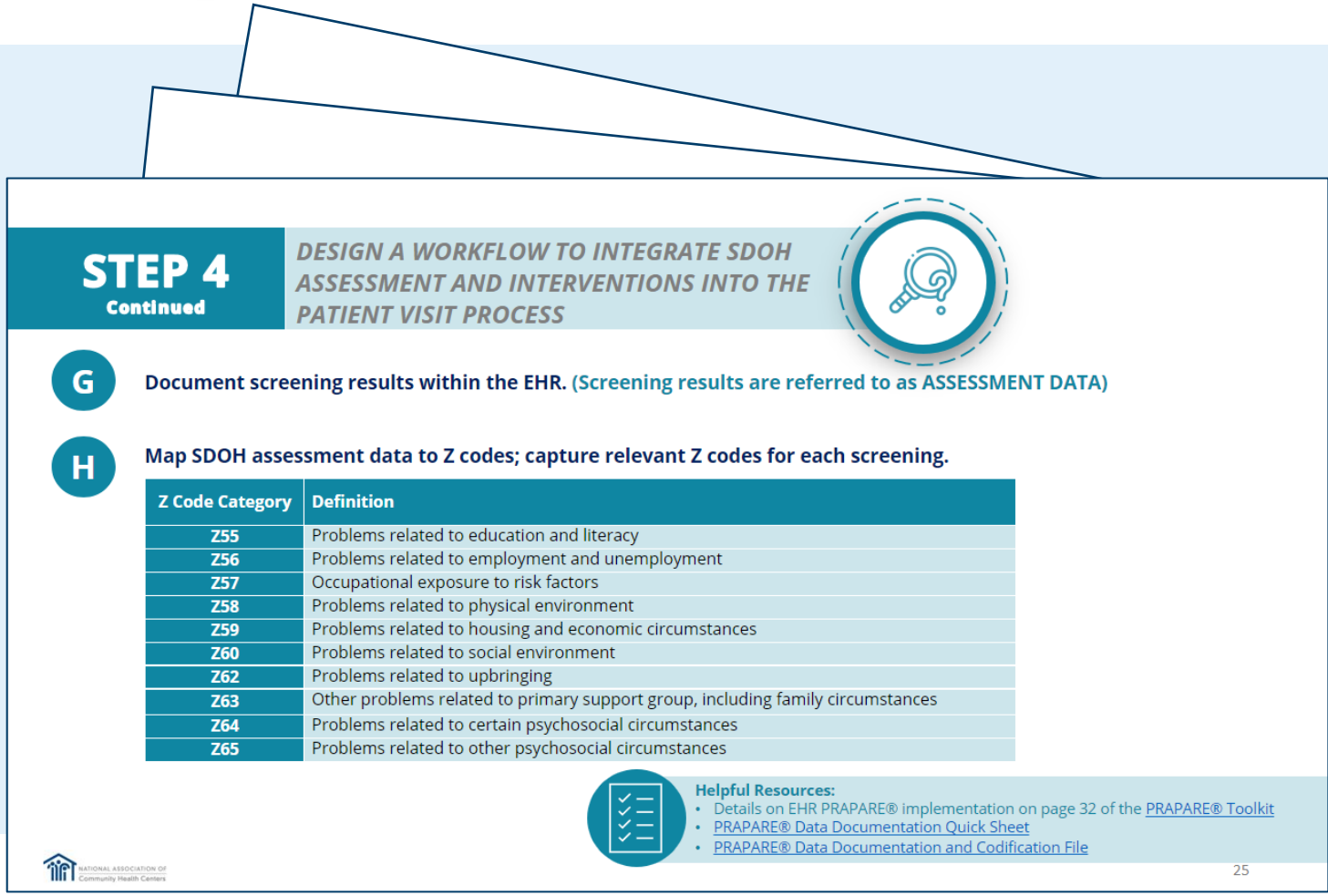
STEP 4 ***DESIGN*** a workflow

STEP 5 ***TRAIN*** health center staff

STEP 6 ***IMPLEMENT*** workflow, monitor results, improve process

STEP 7 ***COLLECT*** data; use data to drive change

STEP 8 ***LEVERAGE*** data to drive Value Based Care



STEP 4
Continued

DESIGN A WORKFLOW TO INTEGRATE SDOH ASSESSMENT AND INTERVENTIONS INTO THE PATIENT VISIT PROCESS

G **Document screening results within the EHR.** (Screening results are referred to as ASSESSMENT DATA)

H **Map SDOH assessment data to Z codes; capture relevant Z codes for each screening.**

Z Code Category	Definition
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z58	Problems related to physical environment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

Helpful Resources:
- Details on EHR PRAPARE® implementation on page 32 of the PRAPARE® Toolkit
- PRAPARE® Data Documentation Quick Sheet
- PRAPARE® Data Documentation and Codification File

Resources & Tools

SDOH & Patients

Action Guide


NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

PATIENTS

PATIENT ENGAGEMENT

WHY

Engage Patients In Care?

There is mounting evidence that patient involvement with shared decision-making and self-care improves health care quality and outcomes at a lower cost[1,2,3,4,5,6,7,8]. Engaging patients in their own care and treatment decisions is encouraged by leading health care authorities such as the Agency for Healthcare Research and Quality (AHRQ)[9] and the Institute of Medicine (IOM)[10]. Patient-centered medical home (PCMH) recognition and accreditation organizations—including the National Committee for Quality Assurance,[11] the Joint Commission,[12] and the Accreditation Association for Ambulatory Health Care[13]—all address patient engagement in their core principles.

PATIENT ENGAGEMENT

The Value Transformation Framework addresses ways to intentionally and actively incorporate the patient perspective into governance, care system design, and individual care. This Action Guide draws on research and the experience of high-performing health care providers to offer proven strategies for patient engagement.

Expectations around patient engagement are embedded in national health care legislation as part of the Affordable Care Act (Section 3506)[14]. It is a required component of the Medicare Shared Savings Program, and it is under consideration for Centers for Medicare and Medicaid (CMS) coverage.

Building a truly patient-centric health system requires actively engaging patients. It is a system where patients make informed decisions based on, not only provider and care team expertise, but also their own skills, capabilities, values, and goals. A robust patient engagement process is central to a health system that delivers on the Quintuple Aim: improved health outcomes, improved patient and provider experiences, lower costs, and equity.

This Action Guide addresses the development of patient-centric care systems through two key concepts: shared decision-making and self-care.

- **Shared decision-making (SDM)** is when health care providers and patients (including their family members and caregivers) work together to make a decision that is best for the patient. This decision-making process considers evidence-based information about available options, the provider's knowledge and experience, and the patient's values and preferences[15].
- **Self-care support** is the assistance provided to patients, especially those with chronic conditions, that enables them to manage their health on a day-to-day basis[16].

Resources

[Patient Engagement Action Guide]

[PRAPARE® Implementation and Action Toolkit]

[PRAPARE® Implementation and Action Toolkit (Spanish)]

[AAPCHO Enabling Services Implementation Guide]

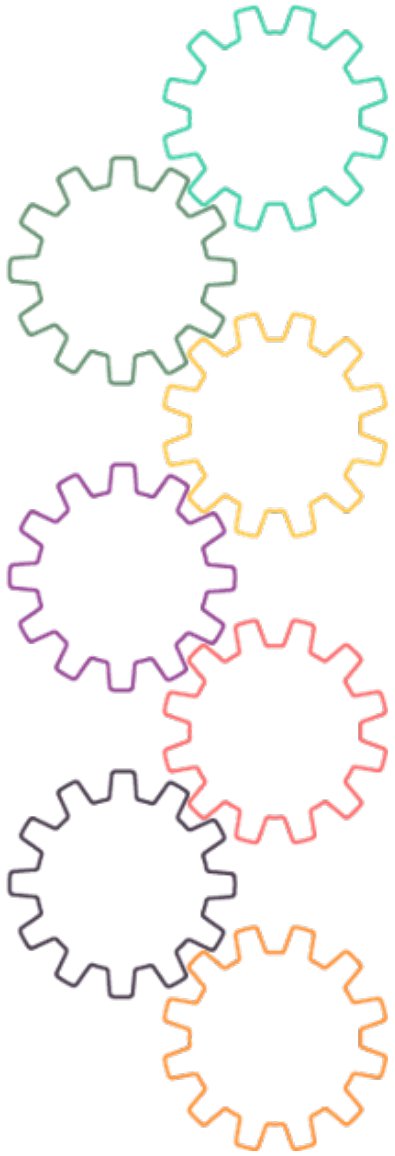
[CDC SDOH Tools]

[HRSA Compliance Manual: Needs Assessment]

[County Health Rankings]

[findhelp.org]

[211.org]



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Elevate 2022 Offerings

Action Guide

Step-by-step instructions for breaking complex value-based care topics into manageable action steps.

- ✓ Empanelment
- ✓ Risk Stratification
- ✓ Models of Care
- ✓ Cancer Screening
- ✓ Diabetes
- ✓ Hypertension
- ✓ Care Management
- ✓ Patients
- ✓ Care Teams
- ✓ Leadership

Microlearning

~10-minute recorded webinars that break down complex value-based care topics into manageable action steps.

- ✓ Empanelment
- ✓ Risk Stratification
- ✓ Models of Care
- ✓ Cancer Screening
- ✓ Annual Wellness Visits
- ✓ Transitional Care Management
- ✓ Care Management Billing and Coding
- ✓ Care Teams
- ✓ Improvement Strategy
- ✓ Social Drivers of Health

PAYMENT Reimbursement Tips

FQHC-specific guidance on billing and coding requirements for Medicare care management and other services

- ✓ Behavioral Health Integration
- ✓ Chronic Care Management
- ✓ Annual Wellness Visits
- ✓ Medicare Telehealth Services
- ✓ Psychiatric Collaborative Care Model
- ✓ RPM & Self-Measured Blood Pressure
- ✓ Tobacco Cessation Counseling
- ✓ Transitional Care Management
- ✓ Virtual Communication Services
- ✓ Mental Health Telecommunication Services
- ✓ Sliding Coinsurance for Care Management Services

Value Transformation Framework Self-Assessment

https://reglantern.com/vtf

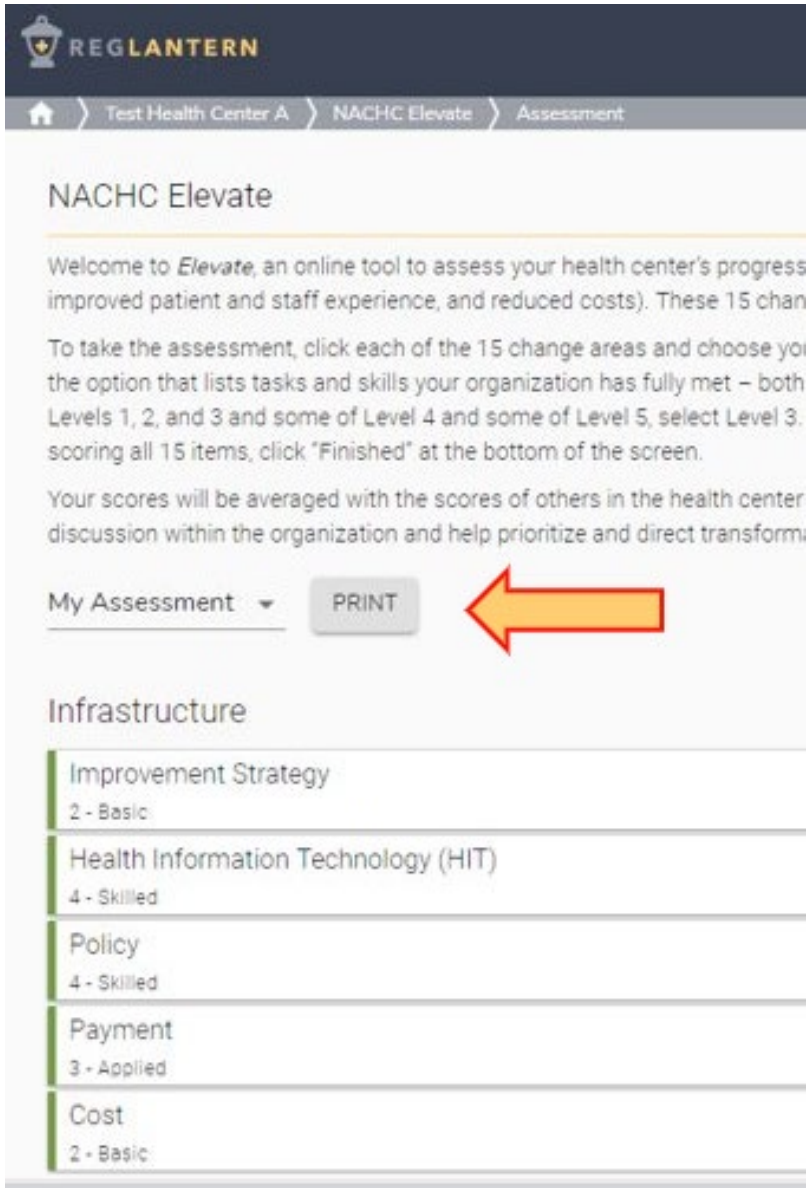
Built around the **Value Transformation Framework**

3 domains

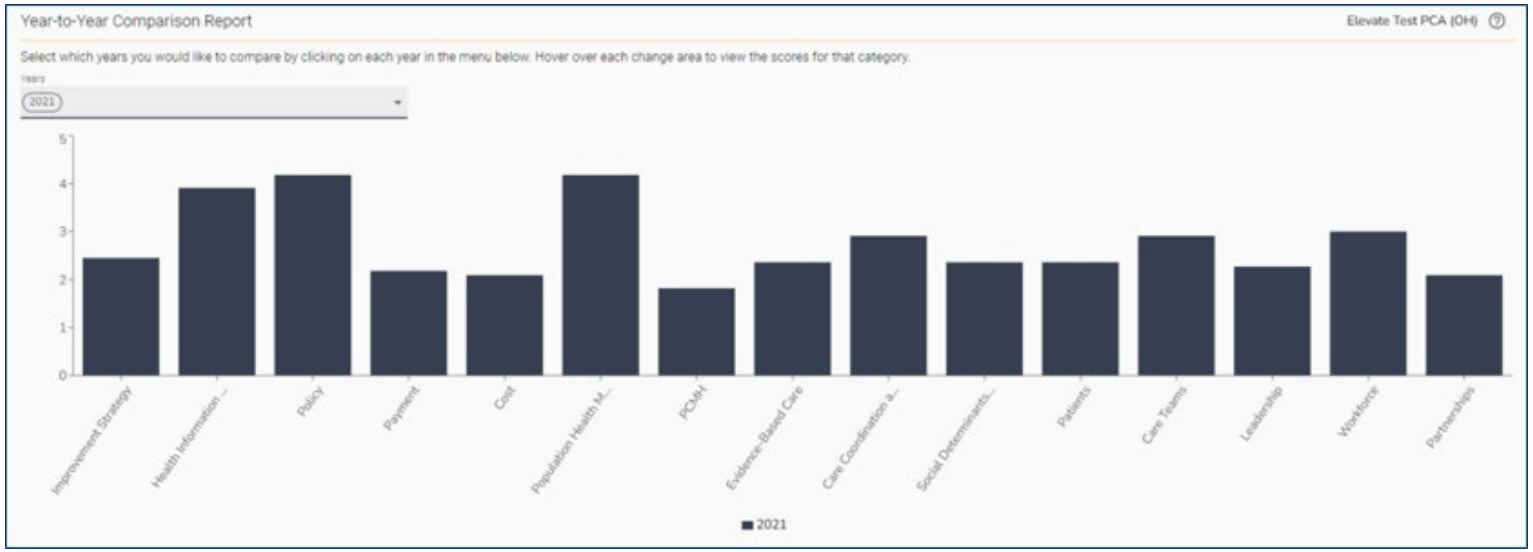
15 change areas

Value Transformation Framework Assessment Tool

Allows health centers, PCAs, and HCCNs to measure readiness for value-based care and monitor progress as they improve across Change Areas.



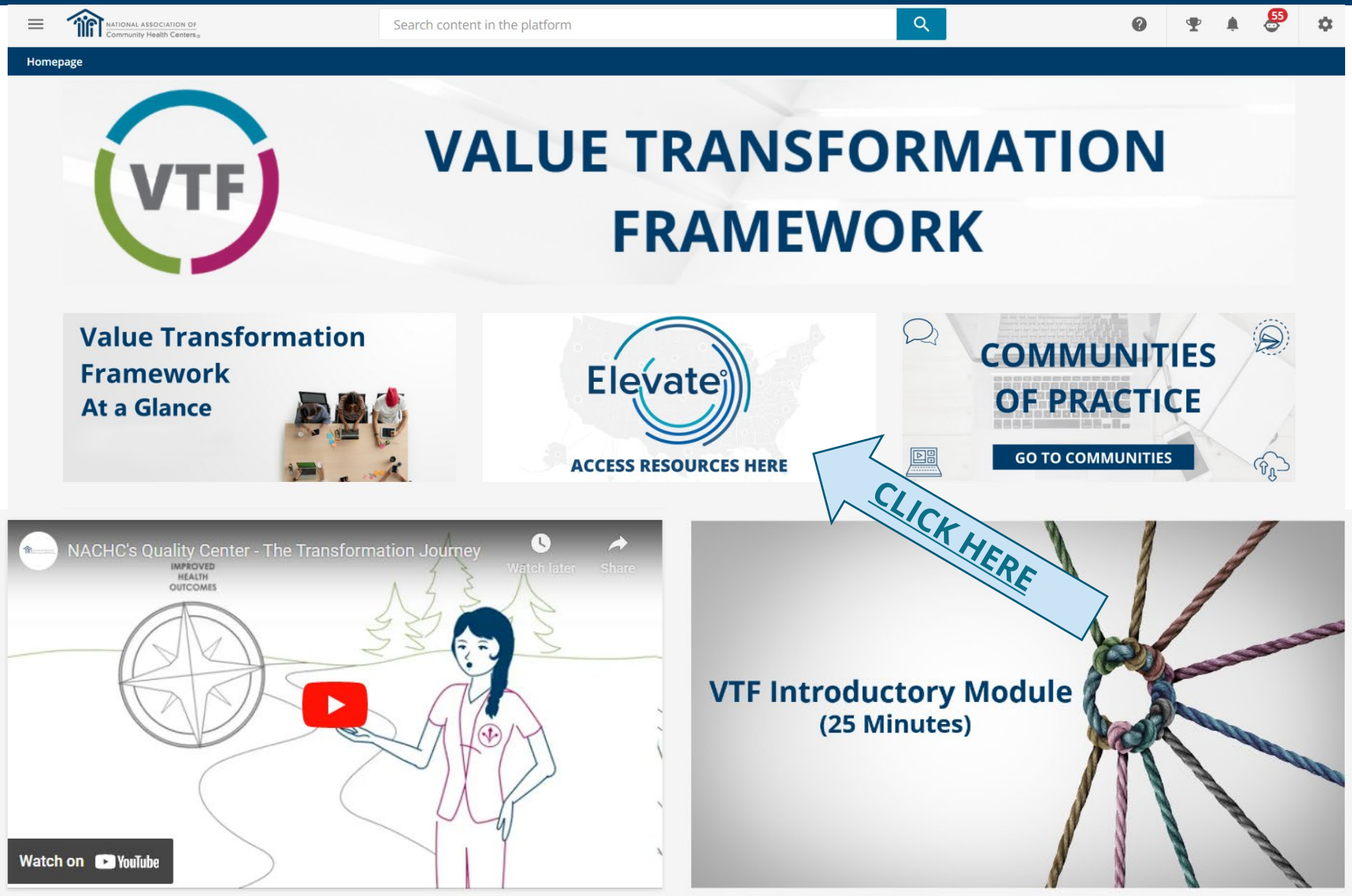
VTF Assessment Tool:
Expanded Functionality



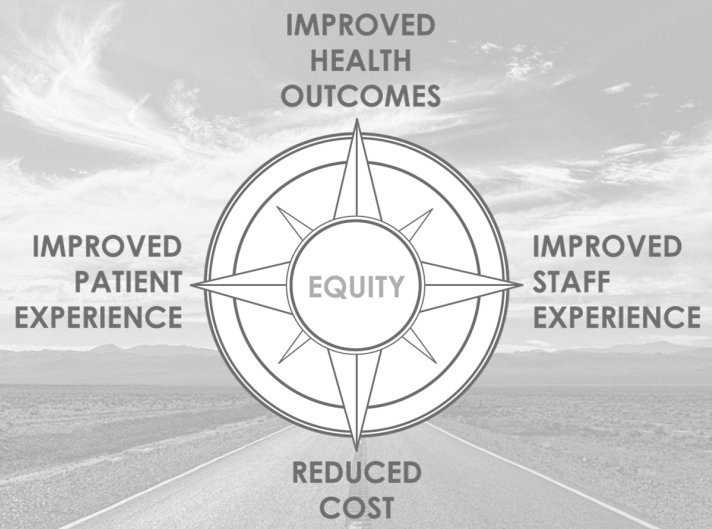
In 2022, enhancements were made to the reporting features of the tool that allow PCAs and HCCNs to:

- view health center members' assessment results, with permission
- send notifications for assessment reminders
- view dashboard reports comparing member health center performance across change areas and timeframes

Elevate Online Platform



Coming Soon
ELEVATE 2023



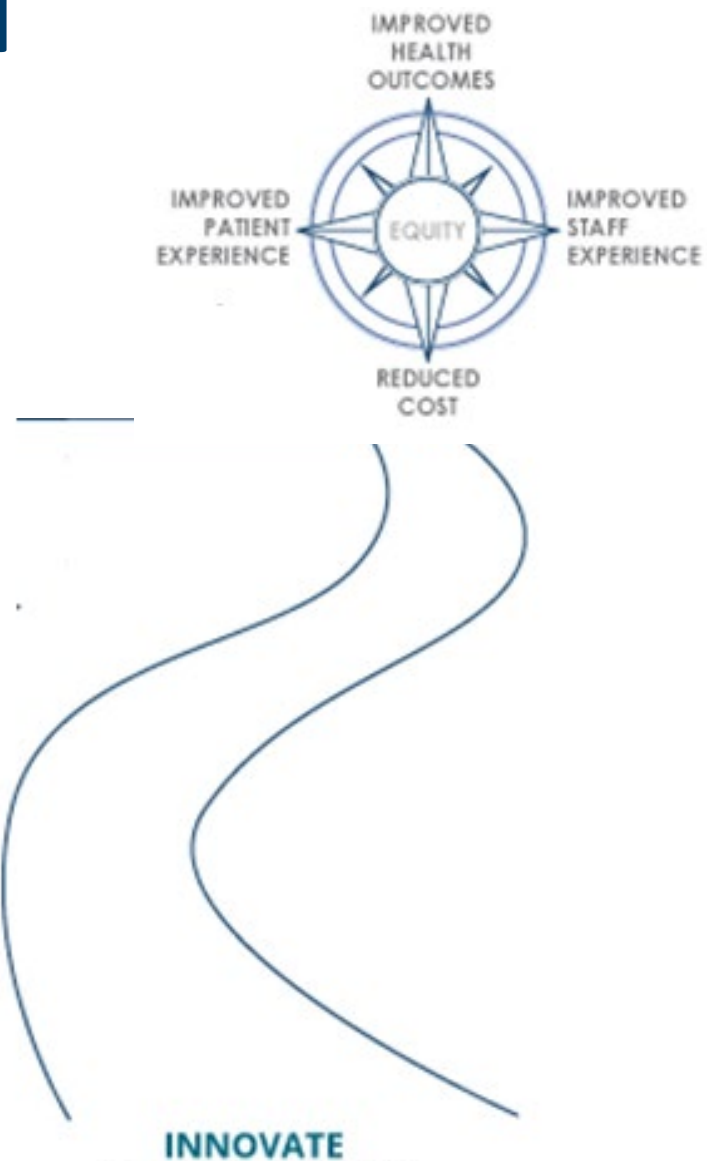
Elevate University

A curriculum co-designed with PCAs & HCCNs from across the country to support the advancement of health center value-based care models.

Reimagine in 2023 and Beyond

Strategic Opportunities:

- Virtual Visits as a Core Delivery Modality
- Patient as the Primary Place of Care
- Systems Approach to Workforce Resiliency
- Expand Services to Support Whole-Person Care
- Distributed and Collaborative Model of Care
- Workflows that Maximize Revenue Opportunities
- Support for Broadband/Fiber Optic Networks as a Utility
- Use of Data and AI to Inform Care Decisions



Elevate National Learning Forum

Ways to Engage in 2023

Self-paced

VTF Assessment

Online Tool

15 Questions

Assess progress in each VTF Change Area

We want your feedback!

Elevate Learning Forum

Learning Forum

Evidence-based action steps for 15 VTF Change Areas

Supplemental Sessions

Elevate Connect

Elevate *Connect*

Variable format:
Topic or role-specific
Stand-alone or learning series
Share & exchange tools
Peer discussion

Self-paced

Online Platform

Online Platform

Library of Microlearnings

Self-paced learning modules

Repository of tools & resources

CALL FOR APPLICATIONS

2023-25 QI Advisory Board Members:

Applications are now being accepted for members to serve on NACHC's QI Advisory Board for the term of Jan 2023 - Dec 2025

Deadline: January 9, 2023

Apply at this link!

FOR MORE INFORMATION CONTACT:

qualitycenter@nachc.org

Cheryl Modica
Director, Quality Center
National Association of Community Health Centers
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301.310.2250

SHARE YOUR FEEDBACK

Don't forget! Let us know what you thought about today's session.

Next Monthly Forum Call:

January 10, 2023
1:00 – 1:45 pm ET

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