NATIONAL ASSOCIATION OF Community Health Centers®

ELEVATE NATIONAL LEARNING FORUM

elevate

Patient Engagement

September 12, 2023

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®

NACHC Quality Center

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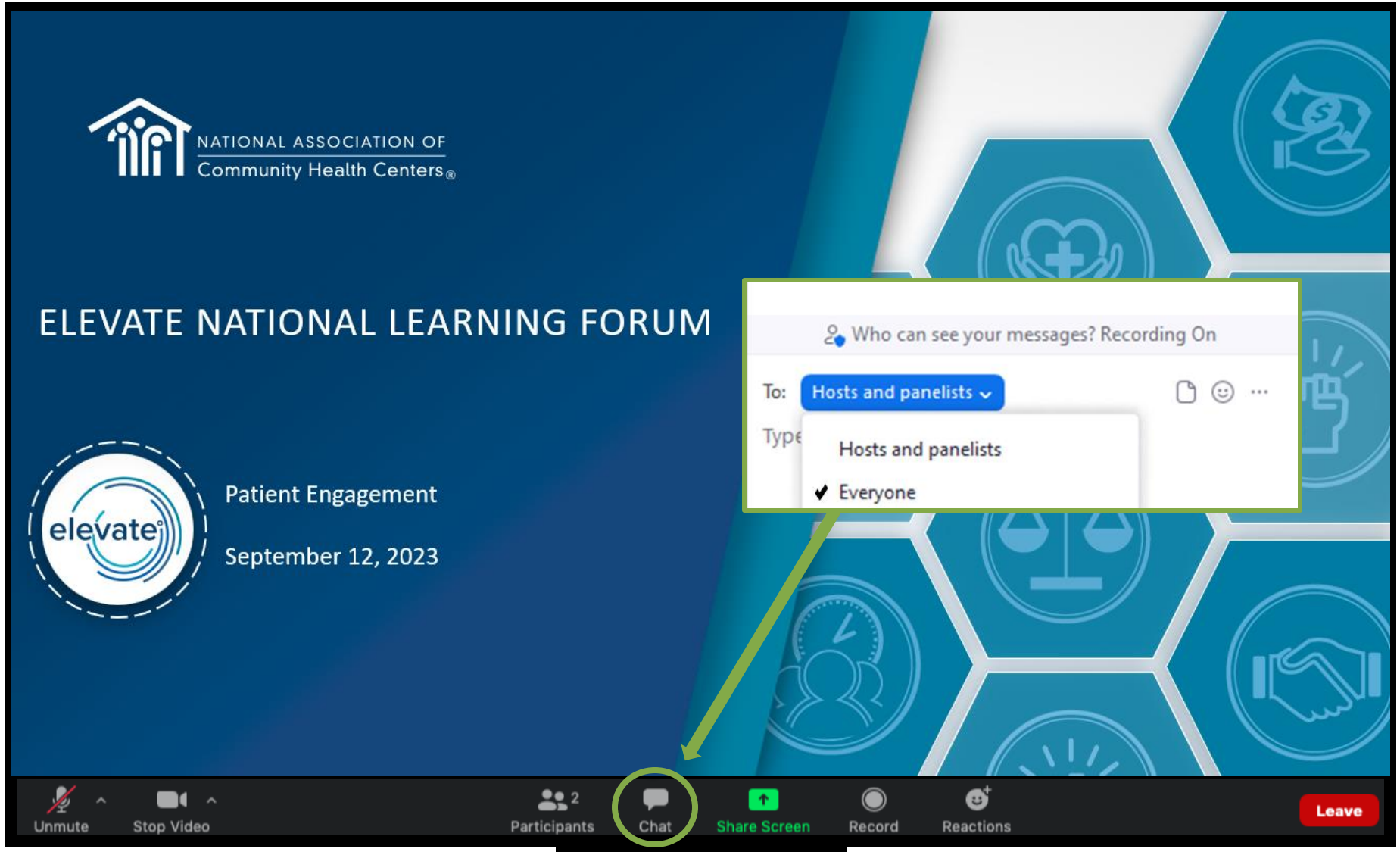


During today's session:

- **Questions:** Throughout the webinar, type your questions in the chat feature. Be sure to select "Everyone"! There will be Q&A and discussion at the end.
- **Resources:** If you have a tool or resource to share, let us know in the chat!

Agenda: Patient Engagement

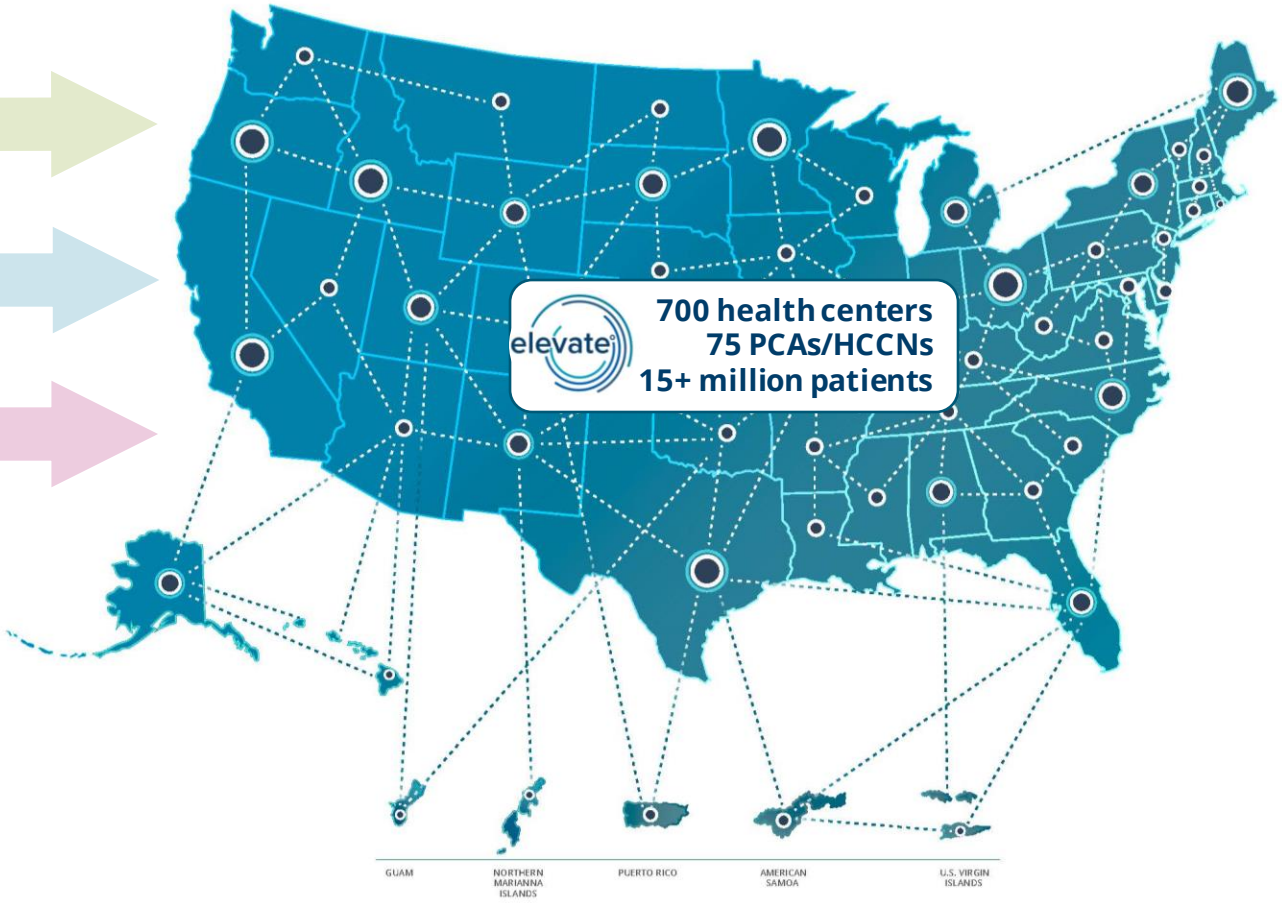
- **Value-Based Care**
  - The Value Transformation Framework, Elevate, and Patient Engagement
- **Patient Engagement *WHAT, WHY, HOW*?**
  - **Individual Care**
  - **Care System Design**
    - Featured Speakers:
      - Peter Chang, MD, MPH, CPE, FAAFP, CEO, Grace Health - **Patient self-rooming**
      - Joan Lingen, MD, Chief Medical Officer, Eastern Shore Rural Health - **Urgent care**
      - Nivedita Mohanty, MD, MS, Chief Health Impact Officer, AllianceChicago – **AI**
  - **Governance**
- **Q&A**
- **NEW Resources and Professional Development Opportunities**

Leading the Transition to Value-Based Care

Value Transformation Framework

- ✓ *Supports systems change*
- ✓ *Organizes and distills evidence-based interventions*
- ✓ *Incorporates evidence, knowledge, tools and resources*
- ✓ *Links health center performance to the Quintuple Aim*

Elevate National Learning Forum



Leading the Transition to Value-Based Care

Leverage the Value Transformation Framework and Elevate:

Action Brief: How to Use the VTF and Elevate

Action Brief: Assess Transformation Progress

Leading the Transition to Value-Based Care

2023 Supplemental Sessions

January
- Role of Leadership in Value-Based Transformation, with Attention to:
  - Cost
  - PCMH
  - Partnerships

February
- Population Health Management
  - Empanelment
  - Risk Stratification
  - Models of Care
- Role of Leadership in Population Health Strategy

March
- Optimizing Care Teams
- Extended Care Team: Enabling Services
- Providing Care Management
- Measuring Care Management Panel Data
- Outreach and Enrollment Learning Collaborative

April
- Optimizing Care Teams, with Attention to:
  - Improvement Strategy
  - Care Models
  - Workforce
- National Diabetes Prevention Program – Basics for Health Centers

May
- Improvement Strategy
- QI Case Study: Hypertension
- Medicare Shared Savings Program Advance Investment Payment
- Brain Health Integration into Health Center Services

June
- Evidence-Based Care: Cancer Screening

July
- Advancing Health Center Value-Based Care

September
- Patient Engagement
  - Individual care
  - Care system design
  - Governance

The Journey Continues

2023 Core Elevate Learning Forums

Leading the Transition to Value-Based Care

15 Change Areas organized by 3 Domains:

Infrastructure: the components, including health information systems, policies, and payment structures, that build the foundation for reliable, high-quality health care

Care Delivery: the processes and proven approaches used to provide care and services to individuals and target populations, such as evidence-based care and social drivers of health

People: the stakeholders who receive, provide, and lead care at the health center, as well as partners that support the goals of high-value care

Patient Engagement

Patient Engagement

WHAT?

WHY?

HOW?

WHAT can health centers do to improve patient engagement?

Intentionally and actively incorporate the patient perspective into

- ✓ **Individual care** → Patient self-management, care planning, shared decision making
- ✓ **Care system design** → Models of care, health center services, HIT
- ✓ **Governance** → 51% or more of health center Board members must be health center patients

Patient Engagement

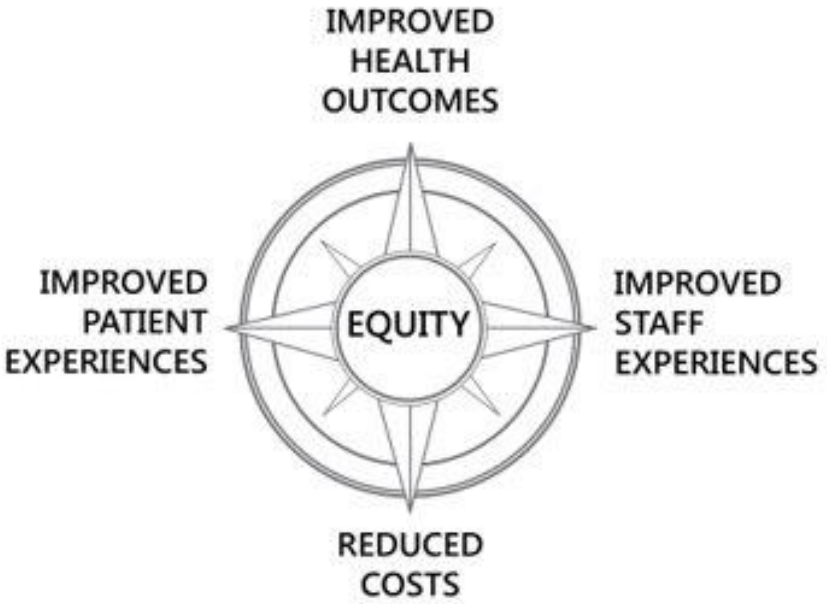
WHAT?

WHY?

HOW?

WHY engage patients in individual care, care system design, and governance?

Building a patient-centric health system requires actively engaging patients to achieve Quintuple Aim Goals:



Patient Engagement

WHAT?

WHY?

HOW?

HOW to engage patients in…

Individual care

Care system design

Governance

HOW to engage patients in individual care

Patient Satisfaction

The extent to which a patient's *expectations* about a health care encounter were met.[1]

Patient Experience

From the patient's perspective, whether something that *should* happen in a healthcare encounter happened or how often it happened.[1]

Patient Engagement

The desire and capability to actively choose to participate in care in a way uniquely appropriate to the individual, in cooperation with a healthcare provider, for the purposes of maximizing outcomes or improving experiences of care.[2]

1. What Is Patient Experience?. Content last reviewed August 2022. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html

2. Higgins T, Larson E, Schnall R. Unraveling the meaning of patient engagement: A concept analysis. Patient Educ Couns. 2017 Jan;100(1):30-36. doi: 10.1016/j.pec.2016.09.002. Epub 2016 Sep 3. PMID: 27665500.

HOW to engage patients in individual care

Two Key Patient Engagement Concepts:

Shared decision-making: Health care providers and patients (including family members and caregivers) work together to make a decision that is best for the patient, considering evidence-based information about available options, the provider's knowledge and experience, and the patient's values and preferences.[1]

Self-care support: Assistance provided to patients, especially those with chronic conditions, that enables them to manage their health on a day-to-day basis.[2]

1. Agency for Healthcare Research and Quality, Shared Decision Making Toolkit, SHARE Approach Curriculum Tools. https://www. ahrq.gov/professionals/education/ curriculum-tools/shareddecisionmaking/tools/index.html.

2. Agency for Healthcare Research and Quality, Programs, Improving Primary Care Practice, Self-Management Support. https://www.ahrq. gov/professionals/ prevention-chronic-care/improve/self-mgmt/self/index.html).

HOW to engage patients in individual care?

STEP 1 Identify a patient engagement lead

STEP 2 Establish patient engagement metrics; incorporate into *improvement strategy*

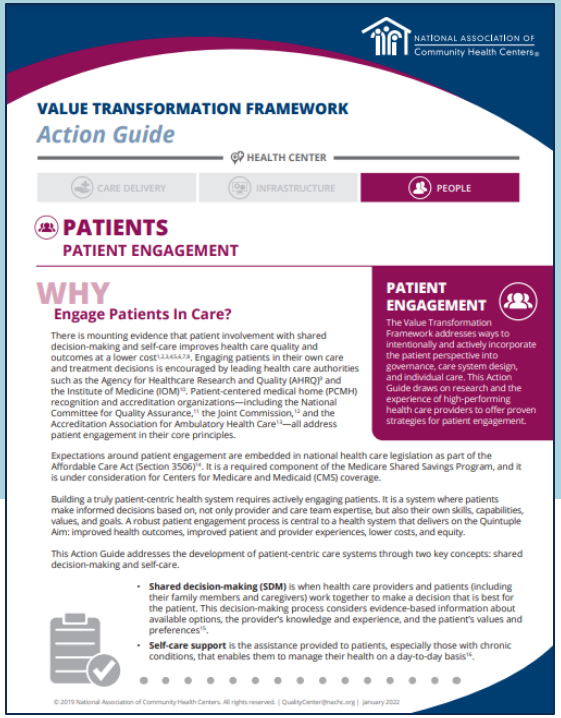
STEP 3 Train staff in patient engagement

STEP 4 Use daily huddles to plan for patient engagement needs

STEP 5 Communicate with patients effectively; use patient decision aids

STEP 6 Provide tools to support patient self-management

STEP 7 Provide a written care plan or summary


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].

Patient Engagement Action Guide

STEP 1:

IDENTIFY A PATIENT ENGAGEMENT LEAD

Designate and train a member of the staff whose role it is to maintain an organizational focus on patient engagement, including support for staff development in this area.

NATIONAL ASSOCIATION OF Community Health Centers®

STEP 2:

ESTABLISH PATIENT ENGAGEMENT METRICS; INCORPORATE INTO IMPROVEMENT STRATEGY

Health care organizations focused on the Quintuple Aim need to establish at least one performance metric for the 'patient experience' goal and incorporate into health center improvement strategy.

Patient satisfaction surveys are not enough! To measure the extent to which patients engage in their care, also consider:

- Patient experience surveys
- Appointment no show rates
- Preferred method of communication (e.g., phone, text, portal, email)
- Use of self-care tools (e.g., home blood pressure monitors)
- Patients self-reported values (e.g., blood pressure)

Improvement Strategy Action Guide

STEP 3:

TRAIN STAFF IN PATIENT ENGAGEMENT

Building a patient-centric model of care requires a culture of teamwork, open communication, and continuous learning.

Training should include:

- **Cultural humility** and an understanding of cultural health beliefs, prevention, and care.
- **Motivational interviewing** and how to communicate effectively to support patients with improving self-management skills.
- **Utilizing patient decision aids** and where to access credible online patient education tools or referral sources.

Patient engagement is everyone's responsibility!

See the Leadership Action Guide for details on Leadership's role in creating a culture of learning

STEP 4:

USE DAILY HUDDLES TO PLAN FOR PATIENT ENGAGEMENT NEEDS

Implement daily huddles that include pre-visit planning, which allows teams to anticipate care needs.

This planning period frees time during the visit for providers and staff to build a collaborative partnership with patients.


NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Action Guide

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].

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.

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.

"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]

See the Care Teams Action Guide for details on optimizing care teams to support patient care and engagement

STEP 5:

COMMUNICATE WITH PATIENTS EFFECTIVELY; USE PATIENT DECISION AIDS

Communicate with patients effectively and align care with patients' goals, priorities, and knowledge.

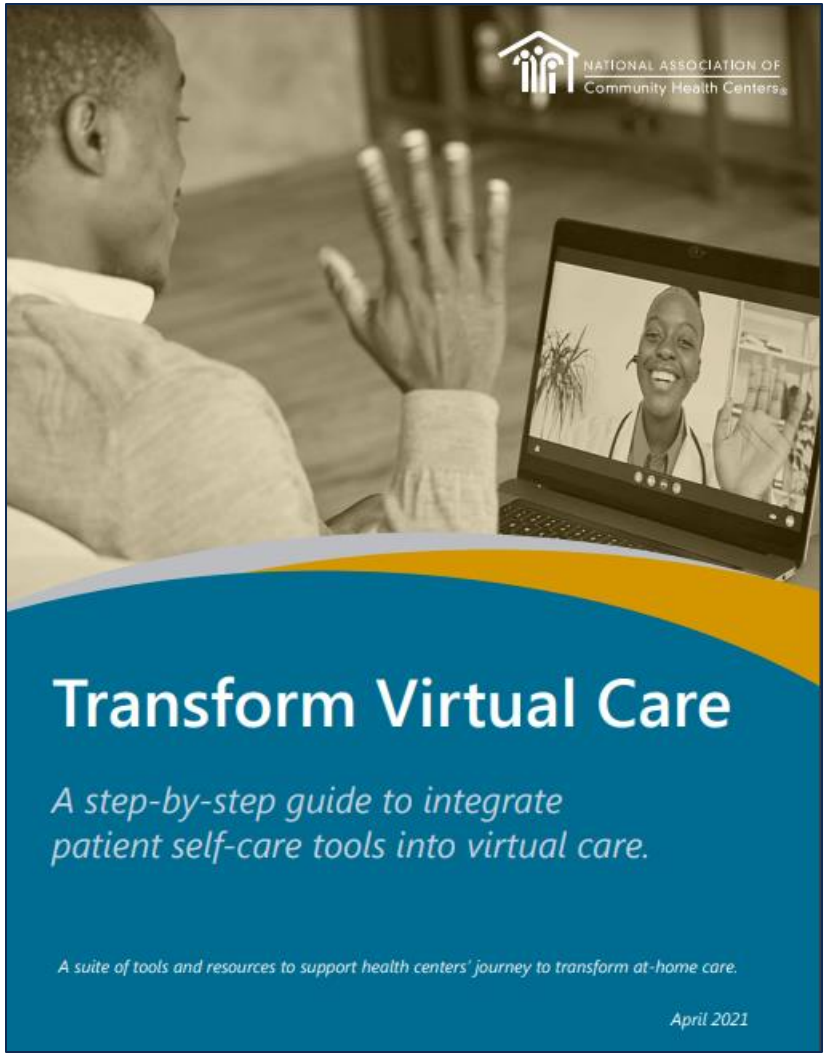
Strategies include:

- ✓ Providers set the norm that it is okay for patients to ask questions and offer suggestions to improve their own care
- ✓ Create a formal way to ask patients what they would like to accomplish at their visit
- ✓ Incorporate the Ask-Tell-Ask Method
- ✓ Incorporate Teach-Back
- ✓ Integrate Decision Aids
- ✓ Consider a patient's language and culture

STEP 6:

PROVIDE TOOLS TO SUPPORT PATIENT SELF-MANAGEMENT

Place self-care tools into the hands of patients to support patient engagement, building self-management skills, and improve patients' abilities to monitor chronic conditions from home.



Virtual Care Action Guide

STEP 7:

PROVIDE A WRITTEN CARE PLAN OR SUMMARY

Provide each patient with a written care plan or visit summary after each visit.

- Review existing care plan templates and visit summaries to determine if/where enhancements may be needed.
- Design patient visit processes to include patient goal setting and, where appropriate, the development of an action plan.

Patients should consider themselves members of their care team!

HOW to engage patients in…

✓ **Individual care**

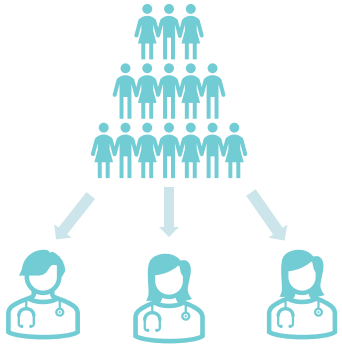
Care system design

Governance

HOW to engage patients in care system design?

Empanelment

Matching every patient to a primary care provider and care team.

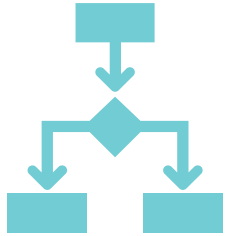


Risk Stratification

Segmenting patients into groups of similar complexity and care needs.

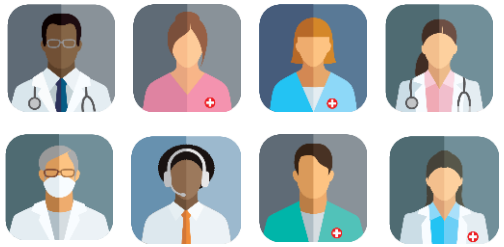
Models of Care

Care models based on risk for patients to be paired with more appropriate care team members and services.



Care Teams

Care teams and tasks are based on the needs of the patient population and the availability of personnel, services, and other resources.



Care Management

Intensive one-on-one services to individuals with complex health and social needs.

Leverage population health data to identify patient needs & engage patients in care system design!

- ✓ Models of care
- ✓ Health center services
- ✓ HIT

Featured Speaker

Peter Chang, MD, MPH, CPE, FAAFP
President/CEO
Grace Health

- Joined Grace Health in 1994 as a Family Practice Physician
- Appointed as Grace Health President/CEO in July 2017
- Doctorate of Medicine from University of Kansas School of Medicine
- Masters of Public Health in Executive Masters Program in Health Management and Policy from University of Michigan
- Certified Physician Executive from Certifying Commission in Medical Management

WHY? Patient Self-Rooming

- ✓ Patient and Staff Safety
- ✓ Improve the Patient Experience
- ✓ Enhance Communication
- ✓ Optimize Staff Experience

HOW? Patient Self-Rooming

- ✓ **Infrastructure Changes**
- ✓ **Welcome Message**
- ✓ **Self Check-In**
- ✓ Display Outside of Patient Room
- ✓ Location Display in Clinical Space
- ✓ Real Time Location System (RTLS) – Staff and Equipment

Reception Area

HOW? Patient Self-Rooming

- ✓ Infrastructure Changes
- ✓ Welcome Message
- ✓ Self Check-In
- ✓ **Display Outside of Patient Room**
- ✓ Location Display in Clinical Space
- ✓ Real Time Location System (RTLS) – Staff and Equipment

Hallway / Patient Room Entrance

HOW? Patient Self-Rooming

- ✓ Infrastructure Changes
- ✓ Welcome Message
- ✓ Self Check-In
- ✓ Display Outside of Patient Room
- ✓ **Location Display in Clinical Space**
- ✓ **Real Time Location System (RTLS) – Staff and Equipment**

Provider Area & Exam Room

HOW? Patient Self-Rooming

- ✓ Infrastructure Changes
- ✓ Welcome Message
- ✓ Self Check-In
- ✓ Display Outside of Patient Room
- ✓ Location Display in Clinical Space
- ✓ Real Time Location System (RTLS) – Staff and Equipment

WHAT? Patient Self-Rooming

- ✓ Utilization of SyncTimes
- ✓ Workflow Changes
- ✓ Efficiency Using Analytics

Decrease Cycle Time

Exam Room Utilization

Staff Utilization

- ✓ Integrate Behavioral Health
- ✓ Patient Survey
- ✓ Emergencies

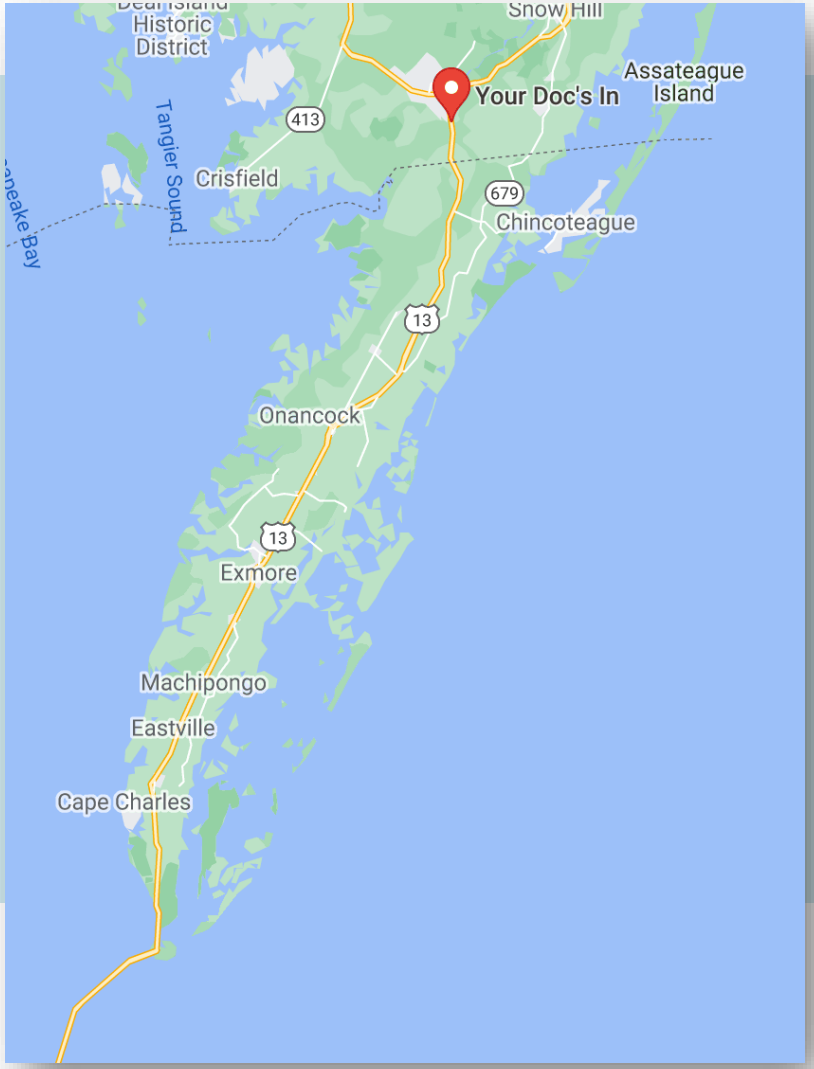
Featured Speaker

Joan K. Lingen, MD, FACOG
Chief Medical Officer
Eastern Shore Rural Health System, Inc.

Dr Lingen is a 1989 graduate of The Chicago Medical School (now renamed The Rosalind Franklin University of Medicine and Science) which she attended as a U.S. Navy Health Professions Scholar. As a commissioned U.S. Navy Medical Corps officer, she completed her OB/GYN internship and residency at the Naval Hospital in San Diego, CA. After completing military assignments at the U.S. Naval Hospital in Yokosuka, Japan and at the National Naval Medical Center in Bethesda, MD, she worked with the Mid-Atlantic Permanente Medical Group (Kaiser) in suburban Washington, DC and then at an urgent care/ occupational medical group in Virginia Beach, VA. She provided women's primary care services and served as a Clinical Director for the Eastern Shore Rural Health System, Inc. (ESRHS), on the Eastern Shore of Virginia for 16 years before being promoted to Chief Medical Officer in August of 2021.

WHY? Urgent Care Within a Health Center System

- 70 miles long, 5-15 miles wide
- Population 45K
- March 2022 Community Needs Survey identified lack of urgent care as a major concern
- Single Level 1 community hospital ER



WHY? Urgent Care Within a Health Center System

Eastern Shore Rural Health System, Inc.
Community Health Center Locations

A **Chincoteague Island Community Health Center**
4049 Main Street
Chincoteague Island, VA 23336

B **Atlantic Community Health Center *(with Dental)***
5219 Lankford Highway
New Church, VA 23415

C **Atlantic Community Pharmacy**
7001 Lankford Highway
Oak Hall, VA 23416

D **Metompkin Elementary School Dental***
24501 Parksley Road
Parksley, VA 23421

E **Corporate Office**
20280 Market Street
Onancock VA 23417

F **Onley Community Health Center**
(with Behavioral Health;
Pharmacy opens late 2023)
20206 Badger Lane
Onley, VA 23418

G **Eastern Shore Rural Health**
Express Care
Four Corner Plaza
25228 Lankford Highway
Onley, VA 23418

H **Nandua Middle School Dental***
20330 Warrior Drive
Onley, VA 23418

I **Pungoteague Elementary**
School Dental*
28480 Bobtown Road
Melfa, VA 23410

J **Occohannock Elementary**
School Dental*
4208 Seaside Road
Exmore VA, 23350
This site is served by the travel dental program.

K **Franktown Dental**
9159 Franktown Road
Franktown, VA 23354

L **Eastville Community Health Center**
(with Behavioral Health, Dental
& Independent Pharmacy)
17068 Lankford Highway
Eastville, VA 23347

M **Kiptopeke Elementary**
School Dental*
24023 Fairview Road
Cape Charles, VA 23310

Support services including health education, pharmacy assistance and insurance enrollment counseling is available at all locations.

www.esrh.org

* *In partnership with Accomack County Public Schools.*
* *In partnership with Northampton County Public Schools.*

Updated 4/21/23

HOW? To Develop an Urgent Care Center

By doing what FQHCs often do → NETWORK!

HOW? To Develop an Urgent Care Center

- The Urgent Care Association (UCA) is the trade association for Urgent Care, with a membership of more than 4,000 Urgent Care centers representing clinical and business professionals from the United States and abroad.
- The UCA Accreditation program advances an Urgent Care organization to the highest level of distinction in patient care through safety, quality & scope of services. UCA Accreditation also helps Urgent Care centers stay in-network with select payers.
- Annual meeting in April – Accreditation Survey Preparation workshop, networking.

URGENT CARE ASSOCIATION®

HOW? To Develop an Urgent Care Center

In 2022, 103,000 encounters at Denver Health urgent care centers:

- ✓ Adult Urgent Care Clinic
- ✓ Downtown Urgent Care
- ✓ Pediatric Urgent Care
- ✓ Pena Urgent Care
- ✓ Virtual Urgent Care

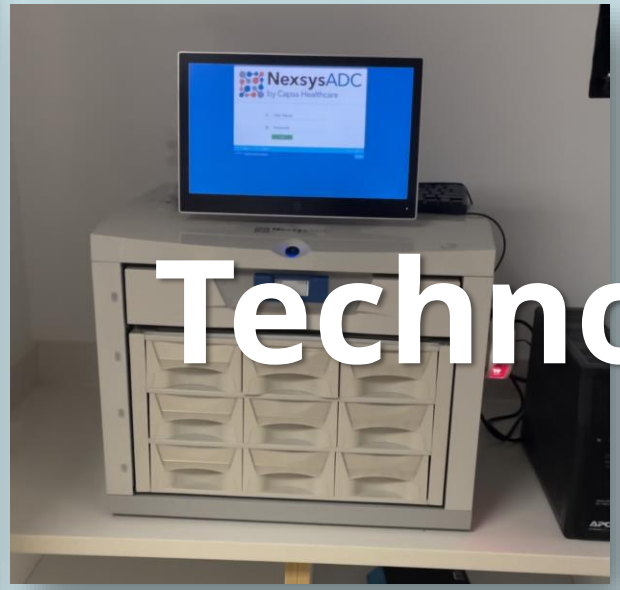
In Aug. 2022 ESRHS CMO, CNO, and COO traveled to Denver to tour and learn from our Denver Health Colleagues.

Lindsey Fish, MD
Medical Director at Peña Urgent Care Clinic
Denver Health and Hospital System

DENVER HEALTH
est. 1860
FOR LIFE'S JOURNEY

WHAT? Does an Urgent Care Center Look Like

WHAT? Does an Urgent Care Center Look Like



Technology

WHAT? Does an Urgent Care Center Look Like

Staffing

Hours of operation/providers:

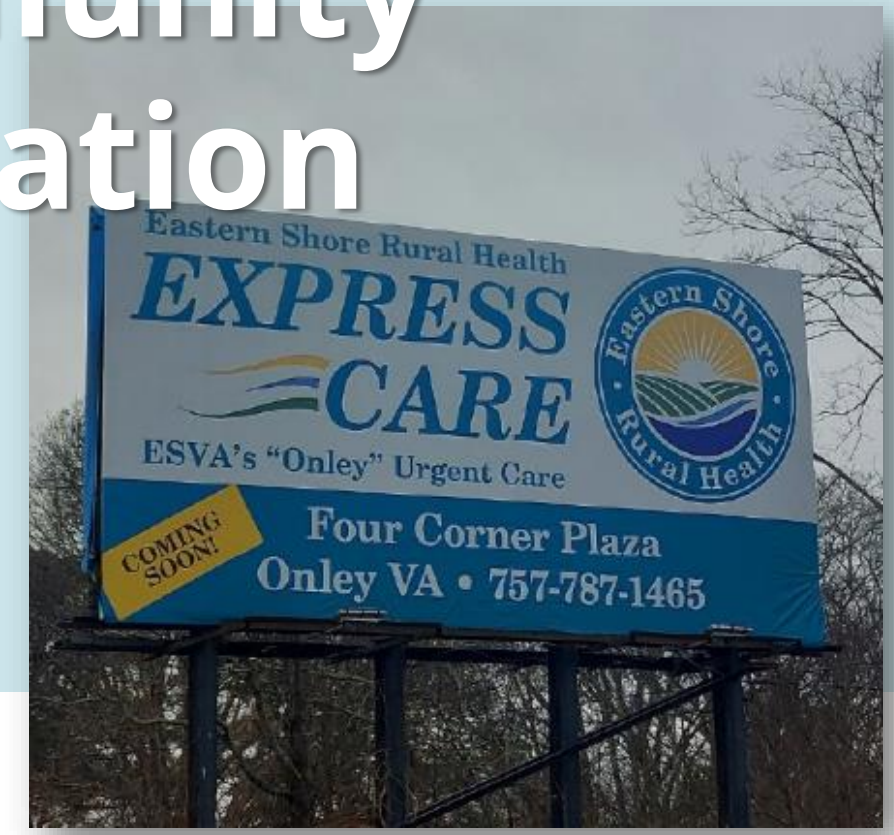
M-F = 12:00-8:00 pm/2 providers
S/S/Holidays = 8:00-4:00 pm/1.5 providers

2 Clinical Support Staff per medical provider
1 X-ray tech
3 Front desk staff

Leadership = Center Manager, Center Nurse Manager, Clinical Director

WHAT? Does an Urgent Care Center Look Like

Community Education



WALK-IN ACUTE CARE FOR AGES 2+

Eastern Shore Rural Health

EXPRESS CARE

expresscare.esrh.org

Weekdays: 12pm-8pm
Weekends: 8am-4pm

Four Corner Plaza, Onley VA 23418

WHAT WE TREAT

- Minor sprains, burns, cuts, wounds, or rashes
- Suspected broken bone, not shifted or out of place
- Earaches, toothaches/mouth injuries & sinus infections
- Urinary Tract Infections (UTI)
- Sexually Transmitted Disease (STD)
- Mild allergic reactions
- Animal or insect bite
- Minor infections such as fever, flu, cold, cough & sore throat
- Nausea, vomiting, & diarrhea
- Pain or discomfort
- Eye infection or irritation
- Sore throat
- Mild to moderate asthma symptoms
- Occupational injuries & illness

Plus:

- DOT physicals
- Some additional occupational medical services

WHAT? Does an Urgent Care Center Look Like

Community Education

WHERE SHOULD YOU GO?

Primary Care

Call or see your Primary Care Provider (PCP) for your **routine** or **acute** medical needs. Your provider's office is the best place to go for routine care and is available to call 24/7. Make an appointment for ...

Routine care:

- Check-ups, physicals & Well Child Checks
- Vaccines
- DOT exams
- Routine disease management
- Medication refills

Acute medical needs:

- Minor sprains, burns, cuts, wounds, or rashes
- Suspected broken bone, not shifted or out of place
- Earache, toothache & sinus infections
- Urinary Tract Infections (UTI)
- Mild allergic reactions
- Animal or insect bite
- Minor infections such as fever, flu, cold, cough & sore throat
- Nausea, vomiting & diarrhea
- Pain or discomfort
- Referral to a specialist
- Eye infection or irritation
- Sore throat
- Mild to moderate asthma symptoms

Express Care

Go to Urgent Care for common things that need to be treated soon, but your Primary Care Provider (PCP) is **not** available.

Urgent care is a good option when your PCP is not available, and your condition requires immediate care but is **not** life threatening. No appointment is needed. Extended and weekend hours available.

Acute medical needs:

- Minor sprains, burns, cuts, wounds, or rashes
- Suspected broken bone, not shifted or out of place
- Earache, toothache & sinus infections
- Urinary Tract Infections (UTI)
- Mild allergic reactions
- Animal or insect bite
- Minor infections such as fever, flu, cold, cough & sore throat
- Nausea, vomiting & diarrhea
- Pain or discomfort
- Eye infection or irritation
- Sore throat
- Mild to moderate asthma symptoms

Emergency Room

Go to the Emergency Room (ER) for serious life threatening conditions.

The ER is not the place to go for minor illnesses or injuries. If you experience any of the symptoms below, go to the closest ER or call 911 ...

Life threatening symptoms:

- Sudden chest pain
- Stroke symptoms - weakness/numbness on one side of the face or body, trouble with vision or speech, sudden confusion
- Seizures
- Shortness of breath
- Sudden severe headache
- Severe abdominal pain
- Severe burns & deep wounds
- Broken bones
- Severe allergic reaction
- Less than 4 weeks old with temperature higher than 100.4˚F
- Coughing or vomiting blood
- Sudden loss of consciousness
- Drug overdose or poisoning
- Head or eye injury
- Thoughts of suicide or self-harm
- Uncontrolled bleeding

WHAT? Does an Urgent Care Center Look Like

Community Education

WHAT? Does an Urgent Care Center Look Like

First Three Months

Patient volume:

- Monthly average = 1,100
- M-F = 50-60
- Sat = 30-40
- Sun = 20-30

Featured Speaker

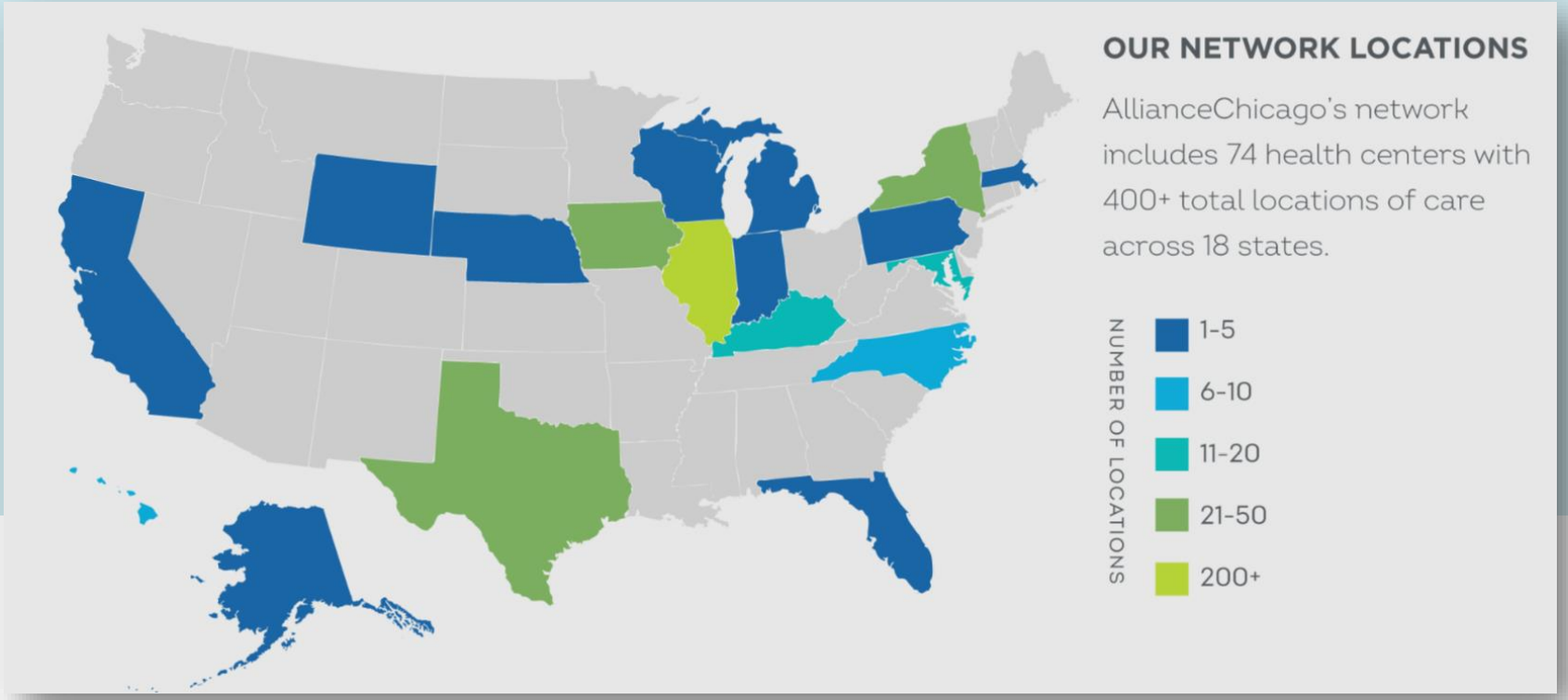
Dr. Nivedita Mohanty, MD, MS
Chief Health Impact Officer
AllianceChicago

Dr. Mohanty is a practicing physician with over 16 years of experience in community health, clinical research, quality improvement, academic medicine, and international volunteerism. In addition to medical training, she holds a Master's in Healthcare Quality and Patient Safety. Dr. Mohanty works closely with health centers to leverage HIT, strategic partnerships, and best practices to benefit patients and the workforce that serves them.

WHY? Use Chatbots in Community Health

Strength in Partnership

A Multiorganizational, Multidisciplinary Team:
Health Center Controlled Network, FQHCs, and Technology Platform



WHY? Use Chatbots in Community Health

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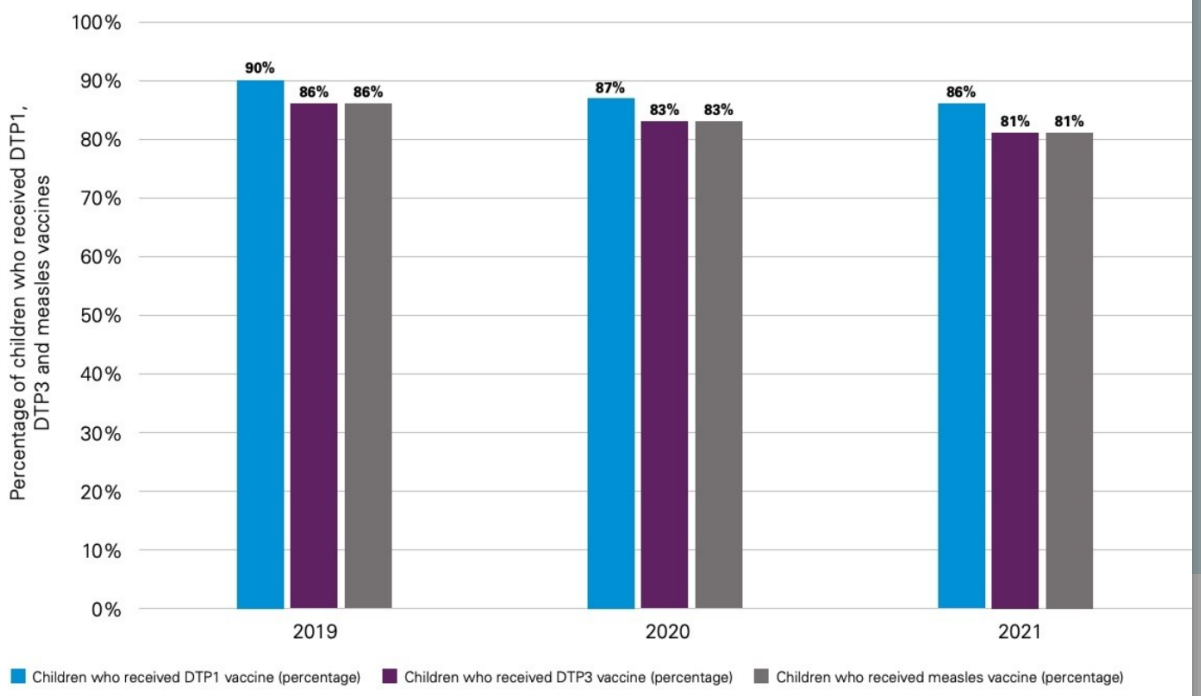
CHEC-UP: Child Health Engagement and Coaching Using Patient-Centered Innovation

Figure 1.3. The COVID-19 pandemic brought a drop in vaccination coverage
Percentages of children globally who received DTP1, DTP3 and measles vaccines



Source: World Health Organization and United Nations Children's Fund, 'Estimates of National Immunization Coverage (WUENIC), 2021 revision', July 2022.

WHY? Use Chatbots in Community Health

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CHEC-UP

Child **H**ealth **E**ngagement and **C**oaching **U**sing **P**atient-centered Innovation

Project Goals

To reduce disparities in well-child care and immunization completion in vulnerable communities through bi-directional, patient-centered communication with patients using customized Artificial Intelligence chatbots to:

- Remind parents of upcoming well child visits and immunizations
- Proactively engage and educate families prior to their visit through age-based recommendations from the CDC Developmental Milestones and Positive Parenting Handouts
- Facilitate easy appointment scheduling

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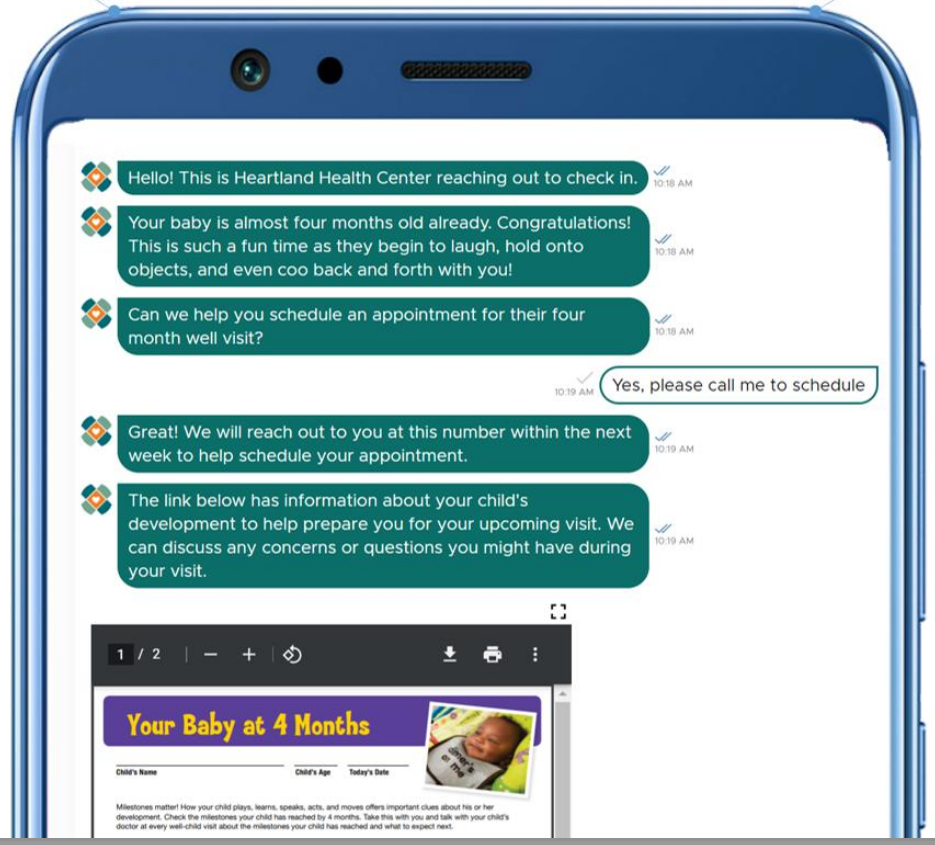
HOW? Use Chatbots in Community Health

Patient Centered- Intervention

Research has shown high levels of smartphone usage in community health



PERSONALIZED

Families receive a chatbot via text and email in their preferred language before a visit is due.

FLEXIBLE

Families can request a call for scheduling or self-schedule.

EMPOWERING

Families receive Anticipatory Guidance handouts **before** the visit to enrich dialogue.

HEARTLAND HEALTH CENTERS
HEALTHCARE FROM THE HEART

Patient Families

qliqSOFT

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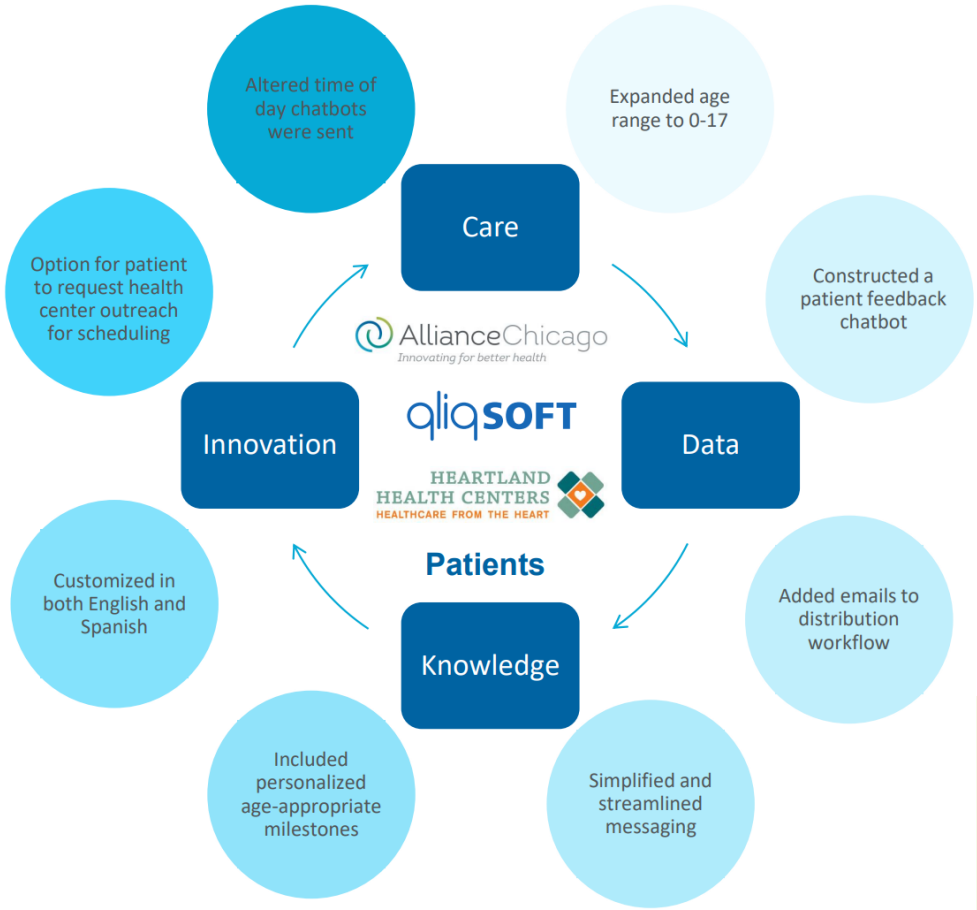
HOW? Use Chatbots in Community Health



Learning Health Systems Framework

Frequent collaboration, data analysis, and feedback all resulted in continuous improvements to the project.

Our team included patients as vital members of the learning team. We collected ongoing feedback from patients via surveys and interviews to strengthen our intervention.

> A visit can be so busy and overwhelming to families, that the idea of giving them anticipatory guidance ahead of time may help them take in the information when they have the time to focus…[and] come up with questions to ask during the visit."
>
> *-Lead Pediatrician*

WHAT? Can Chatbot Use Accomplish

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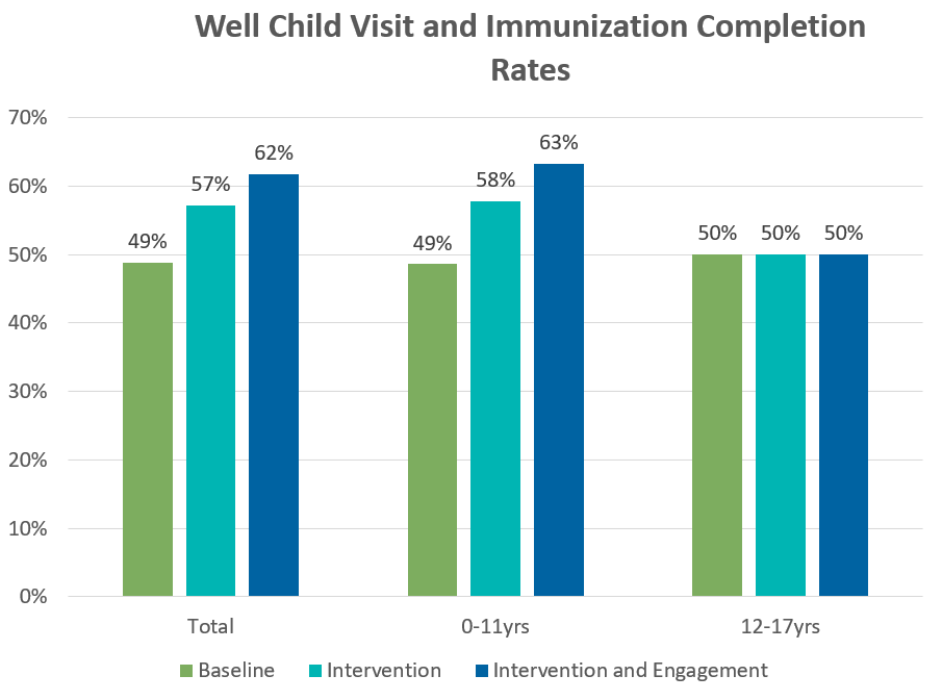
CHEC-UP Results



The intervention group that engaged with the chatbot demonstrated a 27% relative increase in well child visit and immunizations compared to baseline.

- Patients in the **Intervention** group receiving the chatbot saw an **8%** increase in well child visit and immunization completion.
- Patients in the **intervention** group that **engaged** with the chatbot saw a **13%** increase in well child visit and immunization completion.

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WHY? Use Chatbots in Community Health

The REACH Project: **RE**-Imagining Primary Care Using **A**rtificial Intelligence and **CH**atbots

- ✓ Improve adherence of care providers and patients to recommendations
- ✓ Improve the patient experience
- ✓ Advance population health and incorporate recognition of contributing social drivers
- ✓ Improve access to education while averting costly visit and care team time
- ✓ Alleviate care team burden
- ✓ Offer a cost-effective, scalable alternative
- ✓ Allow the flexibility for local providers to tailor messages to their communities and populations.

HOW? Use Chatbots in Community Health

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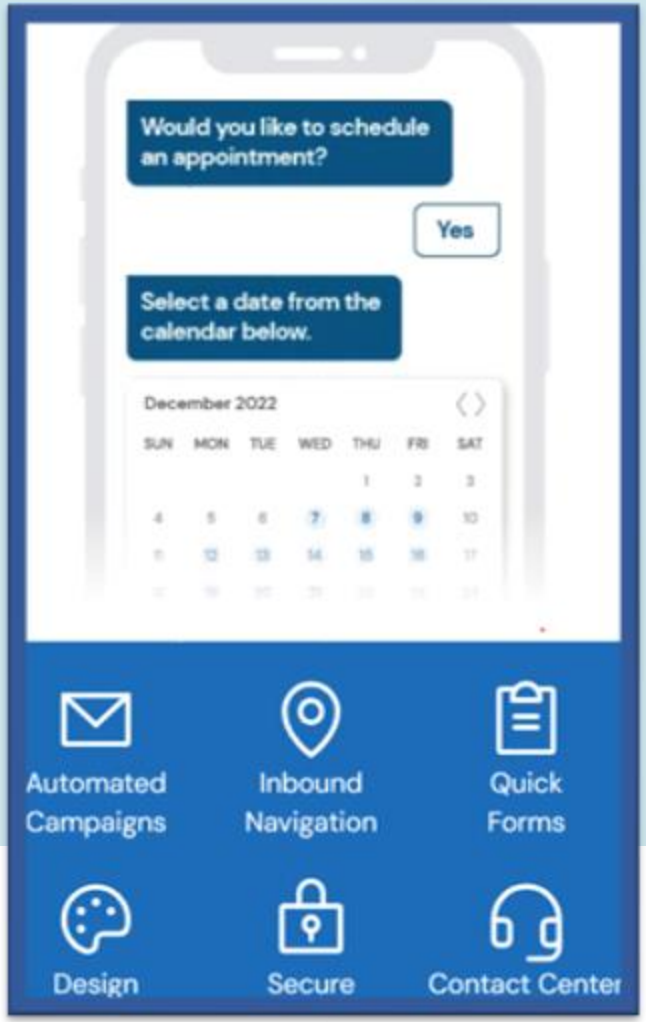
The REACH Approach

- ✓ Breast CA Screening
- ✓ Colon CA Screening
- ✓ Immunizations
- ✓ Patients w/ HTN

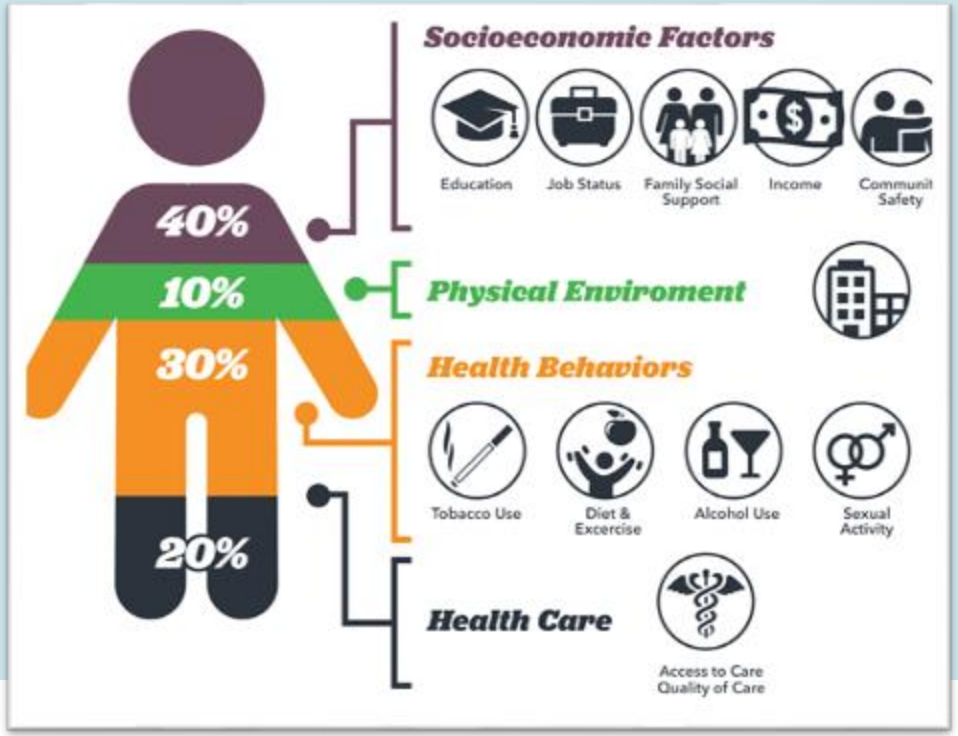


Chatbots:

- ✓ Alleviate care team burden
- ✓ Improve patient access to information
- ✓ Screen for SDOH

HOW? Use Chatbots in Community Health

The REACH Approach to SDOH



- ✓ Respects patient privacy
- ✓ Streamlines workflow
- ✓ Reduces staffing constraints
- ✓ Aligns screening questions with available resources

WHAT? Can Chatbot Use Accomplish

Patient Outreach

- ✓ **1630** patients
- ✓ Age range: 2 months to 70 years
- ✓ **24-29%** Engagement Rate Across all Chatbots
- ✓ **36%** Requested Care Coordination Assistance
- ✓ Peak patient engagement time period **11am-2pm**

Social Drivers of Health

- ✓ **58%** of Respondents to SDOH screening identified needs (in prior published work 27% identified needs*)
- ✓ Food was the most requested **(54%)**
- ✓ Insurance was the second most requested **(31%)**
- ✓ Transportation was the least requested **(15%)**

*Tuzzio, L., Wellman, R. D., De Marchis, E. H., Gottlieb, L. M., Walsh-Bailey, C., Jones, S. M., ... & Lewis, C. C. (2022). Social risk factors and desire for assistance among patients receiving subsidized health care insurance in a US-based integrated delivery system. *The Annals of Family Medicine*, *20*(2)

WHAT? Can Chatbot Use Accomplish

Breast Cancer Screening:

Baseline: **0%** of patients receiving outreach had completed or scheduled a mammogram

After engaging with the bot: **46%** completed their mammogram, and *additional* **36%** have a referral in progress

Blood Pressure Monitoring:

46% of patients engaging with the chatbot wish to enroll in remote monitoring

96% increase in enrollment from baseline enrollment (33 patients at baseline compared with 65 post chatbot)

Patient and Workforce Experience

Overall Experience: **4.86**
Communication Mode: **5**
Educational Materials: **4.85**
Respect for Privacy: **5**
SDOH Domains offered: **4.71**

% Desiring more chatbot communication: **88%**

% Preferring chatbots to phone outreach: **75%**

"It [feels like you are] showing more concern [about] the patient and with everything happening in the world with COVID I'm happy [you]'re showing concern."
- Patient Survey Respondent

"I can confidently say we have sparked innovation amongst Settlement Health staff. My colleagues are now messaging me on teams or stopping me in the hall to see if we can create chatbots to help them within their role to reach their targeted population. I look forward to creating more outreach scripts." - Population Health Manager

HOW to engage patients in…

- ✓ **Individual care**
- ✓ **Care system design**

Governance

HOW to engage patients in governance?

- Health centers are governed by a board of directors
- Health center boards are unique because 51% of members must be patients of the center
- The patient-majority, community-based board model helps ensure heath centers are responsive to patient and community needs

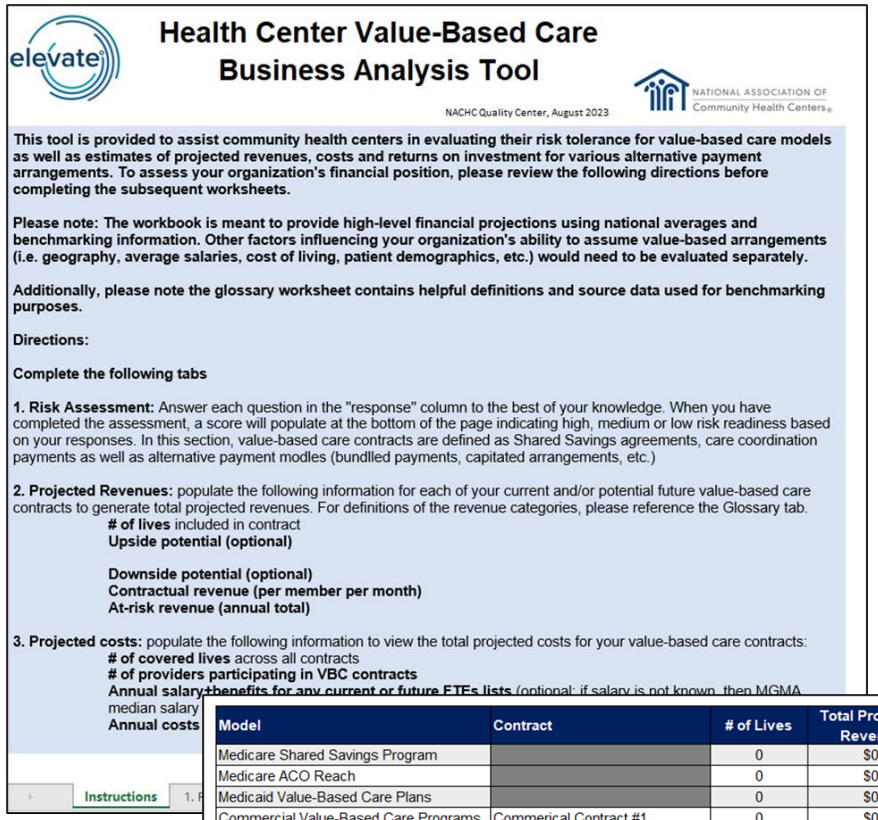
Learn More About the Patient-Driven Governance Model

Health Center Board Roles Video
9-minute overview of health center board roles

Health Center Board: Benefits to Health Centers
Outlines the benefits of the model

Dedicated Value-Based Care Resources

NEW!



elevate

Health Center Value-Based Care Business Analysis Tool

NACHC Quality Center, August 2023

NATIONAL ASSOCIATION OF Community Health Centers

This tool is provided to assist community health centers in evaluating their risk tolerance for value-based care models as well as estimates of projected revenues, costs and returns on investment for various alternative payment arrangements. To assess your organization's financial position, please review the following directions before completing the subsequent worksheets.

Please note: The workbook is meant to provide high-level financial projections using national averages and benchmarking information. Other factors influencing your organization's ability to assume value-based arrangements (i.e. geography, average salaries, cost of living, patient demographics, etc.) would need to be evaluated separately.

Additionally, please note the glossary worksheet contains helpful definitions and source data used for benchmarking purposes.

Directions:

Complete the following tabs

1. Risk Assessment: Answer each question in the "response" column to the best of your knowledge. When you have completed the assessment, a score will populate at the bottom of the page indicating high, medium or low risk readiness based on your responses. In this section, value-based care contracts are defined as Shared Savings agreements, care coordination payments as well as alternative payment modles (bundlled payments, capitated arrangements, etc.)

2. Projected Revenues: populate the following information for each of your current and/or potential future value-based care contracts to generate total projected revenues. For definitions of the revenue categories, please reference the Glossary tab.

# of lives included in contract
Upside potential (optional)

Downside potential (optional)
Contractual revenue (per member per month)
At-risk revenue (annual total)

3. Projected costs: populate the following information to view the total projected costs for your value-based care contracts:

# of covered lives across all contracts
# of providers participating in VBC contracts
Annual salary/benefits for any current or future FTEs lists (optional: if salary is not known, then MGMA median salary
Annual costs

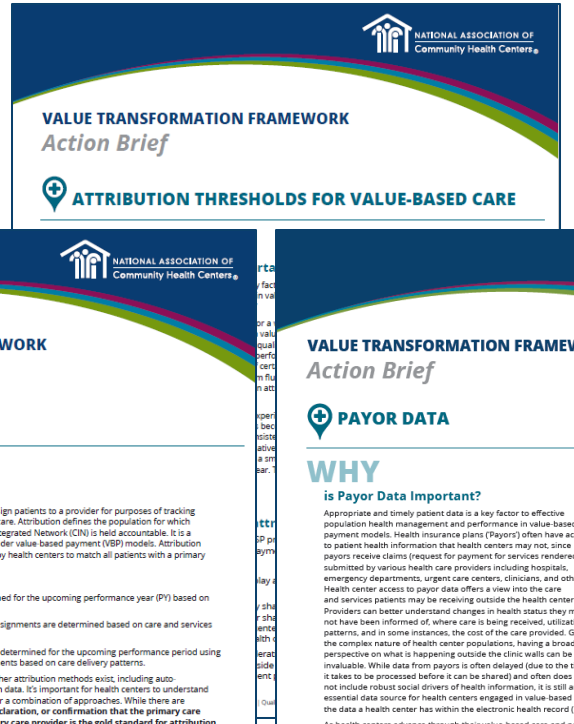
Instructions | 1. F

Model	Contract	# of Lives	Total Projected Revenue	Total Projected Cost	Total Net Operating Income
Medicare Shared Savings Program		0	$0	$0	$0
Medicare ACO Reach		0	$0	$0	$0
Medicaid Value-Based Care Plans		0	$0	$0	$0
Commercial Value-Based Care Programs	Commerical Contract #1	0	$0	$0	$0
Commercial Value-Based Care Programs	Commerical Contract #2	0	$0	$0	$0
Commercial Value-Based Care Programs	Commercial Contract #3	0	$0	$0	$0
Medicare Advantage Plans	Medicare Advantage Contract #1	0	$0	$0	$0
Medicare Advantage Plans	Medicare Advantage Contract #2	0	$0	$0	$0
Medicare Advantage Plans	Medicare Advantage Contract #3	0	$0	$0	$0
Total		**0**	**$0**	**$0**	**$0**

NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK
Action Brief

DEVELOPING YOUR HEALTH CENTER'S VALUE-BASED PAYMENT GOALS



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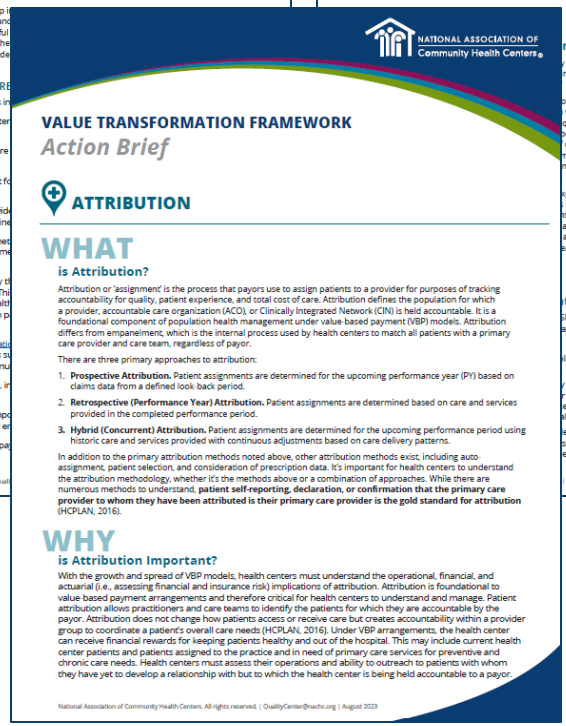
VALUE TRANSFORMATION FRAMEWORK
Action Brief

ATTRIBUTION THRESHOLDS FOR VALUE-BASED CARE



NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK
Action Brief

ATTRIBUTION

WHAT
is Attribution?

Attribution or 'assignment' is the process that payors use to assign patients to a provider for purposes of tracking accountability for quality, patient experience, and total cost of care. Attribution defines the population for which a provider, accountable care organization (ACO), or Clinically Integrated Network (CIN) is held accountable. It is a foundational component of population health management under value-based payment (VBP) models. Attribution differs from empanelment, which is the internal process used by health centers to match all patients with a primary care provider and care team, regardless of payor.

There are three primary approaches to attribution:

1. **Prospective Attribution.** Patient assignments are determined for the upcoming performance year (PY) based on claims data from a defined look-back period.
2. **Retrospective (Performance Year) Attribution.** Patient assignments are determined based on care and services provided in the completed performance period.
3. **Hybrid (Concurrent) Attribution.** Patient assignments are determined for the upcoming performance period using historic care and services provided with continuous adjustments based on care delivery patterns.

In addition to the primary attribution methods noted above, other attribution methods exist, including auto-assignment, patient selection, and consideration of prescription data. It's important for health centers to understand the attribution methodology, whether it's the methods above or a combination of approaches. While there are numerous methods to understand, **patient self-reporting, declaration, or confirmation that the primary care provider to whom they have been attributed is their primary care provider is the gold standard for attribution** (HCPLAN, 2016).

WHY
is Attribution Important?

With the growth and spread of VBP models, health centers must understand the operational, financial, and actuarial (i.e., assessing financial and insurance risk) implications of attribution. Attribution is foundational to value-based payment arrangements and therefore critical for health centers to understand and manage. Patient attribution allows practitioners and care teams to identify the patients for which they are accountable by the payor. Attribution does not change how patients access or receive care but creates accountability within a provider group to coordinate a patient's overall care needs (HCPLAN, 2016). Under VBP arrangements, the health center can receive financial rewards for keeping patients healthy and out of the hospital. This may include current health center patients and patients assigned to the practice and in need of primary care services for preventive and chronic care needs. Health centers must assess their operations and ability to outreach to patients with whom they have yet to develop a relationship with but to which the health center is being held accountable to a payor.

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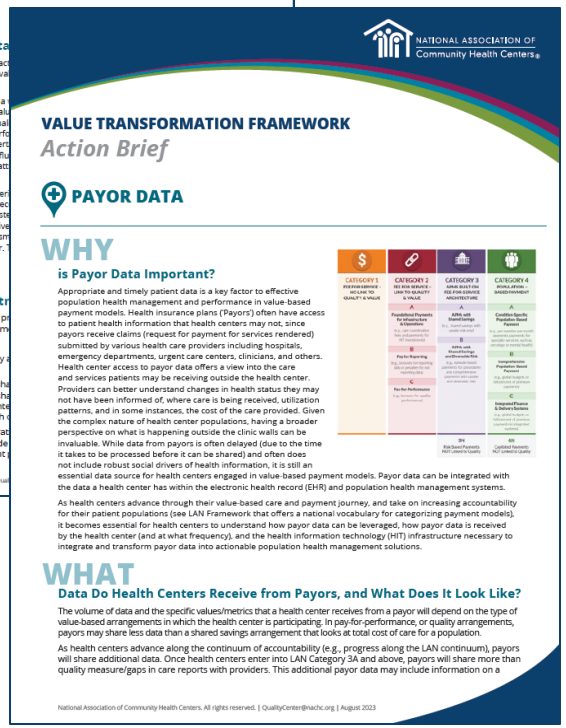

NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK
Action Brief

PAYOR DATA

WHY
is Payor Data Important?

Appropriate and timely patient data is a key factor to effective population health management and performance in value-based payment models. Health insurance plans ("payors") often have access to patient health information that health centers may not, since payors receive claims (request for payment for services rendered) submitted by various health care providers including hospitals, emergency departments, urgent care centers, clinicians, and others. Health center access to payor data offers a view into the care and services patients may be receiving outside the health center. Providers can better understand changes in health status they may not have been informed of, where care is being received, utilization patterns, and in some instances, the cost of the care provided. Given the complex nature of health center populations, having a broader perspective on what is happening outside the clinic walls can be invaluable. While data from payors is often delayed (due to the time it takes to be processed before it can be shared) and often does not include robust social drivers of health information, it is still an essential data source for health centers engaged in value-based payment models. Payor data can be integrated with the data a health center has within the electronic health record (EHR) and population health management systems.

As health centers advance through their value-based care and payment journey, and take on increasing accountability for their patient populations (see LAN Framework that offers a national vocabulary for categorizing payment models), it becomes essential for health centers to understand how payor data can be leveraged, how payor data is received by the health center (and at what frequency), and the health information technology (HIT) infrastructure necessary to integrate and transform payor data into actionable population health management solutions.

WHAT
Data Do Health Centers Receive from Payors, and What Does It Look Like?

The volume of data and the specific values/metrics that a health center receives from a payor will depend on the type of value-based arrangements in which the health center is participating. In pay-for-performance, or quality arrangements, payors may share less data than a shared savings arrangement that looks at total cost of care for a population.

As health centers advance along the continuum of accountability (e.g., progress along the LAN continuum), payors will share additional data. Once health centers enter into LAN Category 3A and above, payors will share more than quality measure/gaps in care reports with providers. This additional payor data may include information on a

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Business Analysis Tool to assist health centers in making financial projections regarding VBP engagement

Suite of Value-Based Payment Action Briefs

Developing VBP Goals, Attribution, Attribution Thresholds, Payor Data

Professional Development for CHC Workforce

Care Manager
Professional Development Opportunity

Essentials *training for health center care managers with 0-2 years experience*

Care Manager
Professional Development Opportunity

Intermediate *training for health center care managers with over 2 years experience*

Care Manager Supervisor
Professional Development Opportunity

Leading *training for health center staff who supervise care managers*

CHWs
Professional Development Opportunity

Training for new health center CHWs

CHW Supervisors
Professional Development Opportunity

Training for health center staff who supervise CHWs

QI Staff
Professional Development Opportunity

Training for health center staff in QI roles

Courses In-Progress

550+ applicants
210 awards

Trainings
Sept – Dec 2023

Professional Development for CHC Workforce

NEW!

Announcing the expansion of the recently launched Health Center Professional Development program to include 3 NEW course offerings:

Lifestyle Coach Training: Gain the knowledge, skills, and experience to deliver a successful Diabetes Prevention Program at your site.

Person-Centered Care for Individuals who have Higher Weight: Gain knowledge on best practices to support individuals with higher weight bodies to build a workforce equipped to care for adults with elevated body mass index.

Health Center Nursing Professionals: A learning community of health center nurses focused on the role of nursing in value-transformation.

Offerings begin in October

Applications due September 22nd!

Lifestyle Coaching & Higher Weight Application

Nursing Application

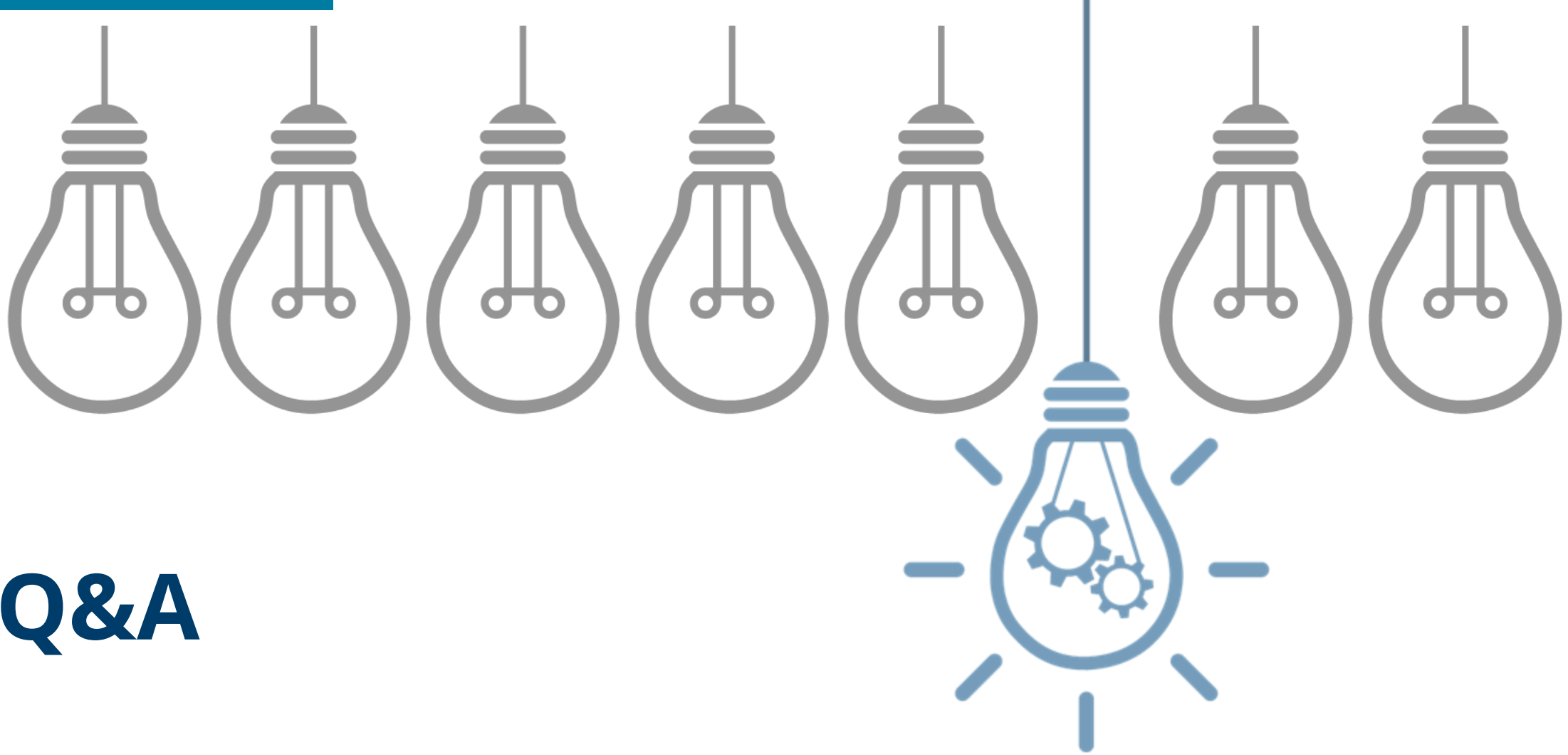
InnovationEX
HOSTED BY NACHC

InnovationEx 2023: Operationalizing and Sustaining Innovation for the Future

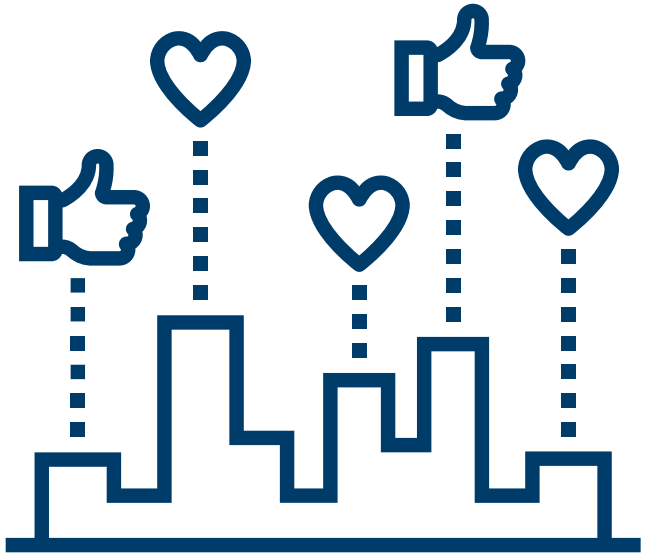
Join us **Monday, October 23, 2023** for NACHC's **inaugural Innovation Experience event!**

- ✓ Assist health centers in taking innovation to the next level – operationalize and sustain for the future
- ✓ Build/expand the community of health center innovators
- ✓ Spread sustainable innovations throughout the health center ecosystem
- ✓ Convene a forum for health center innovators to network and share best and promising practices, and strategies

Hosted by NACHC's Center for Community Health Innovation.
This is a **limited-space, in-person only,** pre-conference event to FOM/IT, **register here today!**



Q&A



Provide Us Feedback

FOR MORE INFORMATION CONTACT:

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Next Monthly Forum Call:

October 10, 2023
1:00 – 2:00 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

elevate°

Together, our voices elevate° all.

The Quality Center Team

Cheryl Modica, Cassie Lindholm, Holly Nicholson, LeeAnn White, Tristan Wind, Rachel Barnes

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