NATIONAL ASSOCIATION OF
Community Health Centers®

ELEVATE NATIONAL LEARNING FORUM

PCMH as the Foundation to Value-Based Care

October 10, 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.

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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: PCMH as the Foundation for Value-Based Care

- **Patient-Centered Medical Home *WHY, WHAT, HOW*?**
  - Transform the delivery of primary care into a comprehensive, patient-centered system focused on high quality, accessible, and coordinated care
- **Leverage PCMH recognition as a foundation to value-based care transformation**
  - The Value-Transformation Framework, Elevate, and PCMH
  - Finding Alignment: NCQA PCMH, NACHC VTF, Health Center Program Requirements
  - Voices from the health center field
- **Q&A**

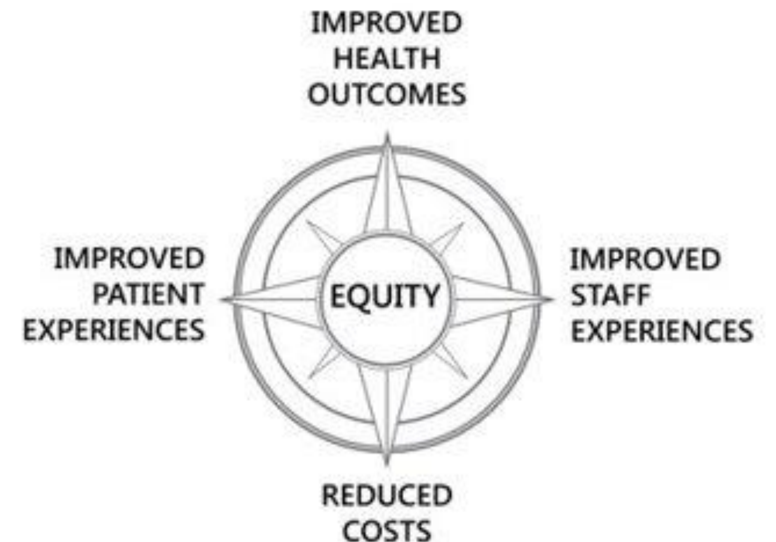
Patient-Centered Medical Home

WHY? WHAT? HOW?

WHY a Patient-Centered Medical Home (PCMH)?

- ✓ **Improved health outcomes** by improving care access and continuity and improved provision of prevention services.
- ✓ **Increased patient satisfaction** and patient **experience**.
- ✓ **Reduced costs** through improved coordination of care decreased hospitalizations and emergency department use.

Quintuple Aim Goals



Evidence of NCQA PCMH Effectiveness
American Academy of Pediatrics (AAP) Evidence Supporting the Medical Home

WHAT is the evolution of PCMH?

Patient Centered Medical Home (PCMH) Journey

1967

Medical Home
American Academy of Pediatrics (AAP) introduced medical home concept.

2007

Patient-Centered Medical Home
American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), American College of Physicians (ACP), and American Osteopathic Association developed a joint statement of seven principles of a PCMH.

2010

Patient Protection and Affordable Care Act
Signed into law, emphasizing the implementation and promotion of the medical home.

2023

HRSA Accreditation and PCMH Recognition Program
HRSA supports health centers in obtaining Ambulatory health care accreditation and/or PCMH recognition.

Leverage PCMH as a foundation to value-based care transformation

Early ‘Medical Home’

Patient Centered Medical Home (PCMH) Journey

1967

Value-Based Care

Medical Home
American Academy of Pediatrics (AAP) introduced the concept of a ‘medical home’ as an approach to comprehensive, high-quality care.

According to the AAP, a medical home should be:

- ✓ **Accessible**
- ✓ **Family-centered**
- ✓ **Continuous**
- ✓ **Comprehensive**
- ✓ **Coordinated**
- ✓ **Compassionate**
- ✓ **Culturally effective**

AAP Medical Home Definition

Shift to 'Patient-Centered'

Patient Centered Medical Home (PCMH) Journey

2007

Value-Based Care

Patient-Centered Medical Home
American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP), American College of Physicians (ACP), and American Osteopathic Association developed a joint statement of seven principles of a PCMH.

Joint Principles of the Patient-Centered Medical Home:

- ✓ **Personal physician**
- ✓ **Physician directed medical practice**
- ✓ **Whole person orientation**
- ✓ **Care is coordinated and/or integrated**
- ✓ **Quality and safety**
- ✓ **Enhanced access**
- ✓ **Payment** appropriately recognizes the added value of the PCMH

Joint Principles of the Patient-Centered Medical Home

Advancing PCMH

Patient Centered Medical Home (PCMH) Journey

The ACA promoted 'medical home' implementation.

Patient-Centered Medical Home
The Health Resources and Services Administration (HRSA) Accreditation and Patient-Centered Medical Home Recognition Initiative supports health centers in obtaining ambulatory health care accreditation and/or PCMH recognition through a contract with three organizations.

	NCQA	The Joint Commission (TJC)	Accreditation Association for Ambulatory Health Care (AAAHC)
PCMH	Recognition	Certification	Accredited
Scope	Site-level	Organization-level	Organization-level
Duration	Annual	3-year cycle	3-year cycle
On-site survey	No; online	Yes	Yes

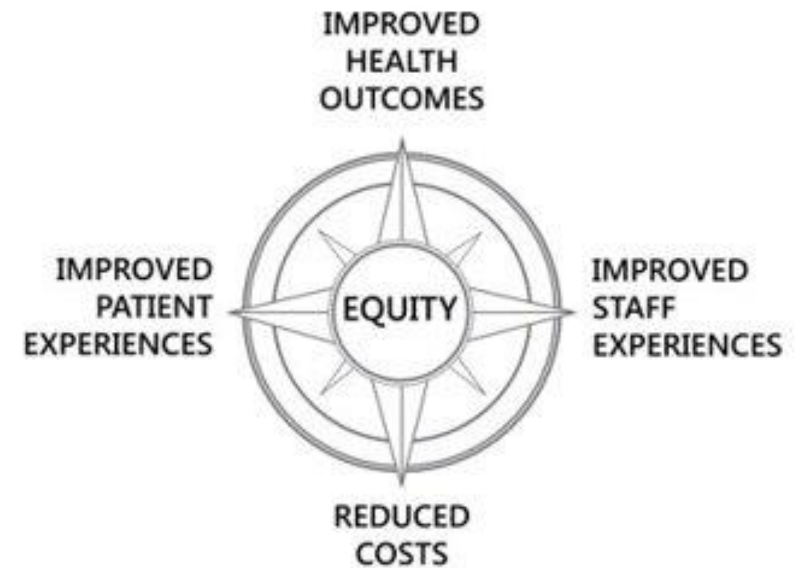
HRSA PCMH Comparison Chart

PCMH…the Next Frontier

Patient Centered Medical Home (PCMH) Journey

Value-Based Care

Leverage PCMH as a foundation to value-based care transformation.



HOW to Leverage PCMH as a Foundation to Value-Based Care Transformation?

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PCMH: A Foundation for Value-Based Care

The Value Transformation Framework

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

PCMH: Within the Transformation Journey

Leverage the Value Transformation Framework and Elevate:

Your transformation journey begins here!

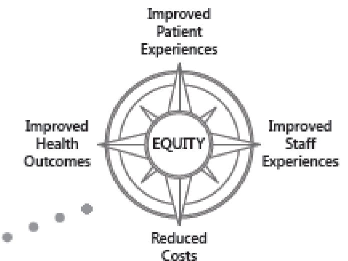
STEP 1 - ENGAGE
Register for Elevate and participate in the **FREE** health center learning community

STEP 2 – ASSESS
Measure transformation progress using the Value Transformation Framework (VTF) Assessment

STEP 3 – PLAN
Incorporate transformation efforts into your Improvement Strategy

STEP 4 – TRANSFORM
Apply the VTF and suite of **FREE** transformation tools and resources

STEP 5 – REASSESS
Measure transformation progress over time using the VTF Assessment; monitor, adjust, and improve



STEP 2: ASSESS

Value Transformation Framework Assessment

Change Area: Patient-Centered Medical Home

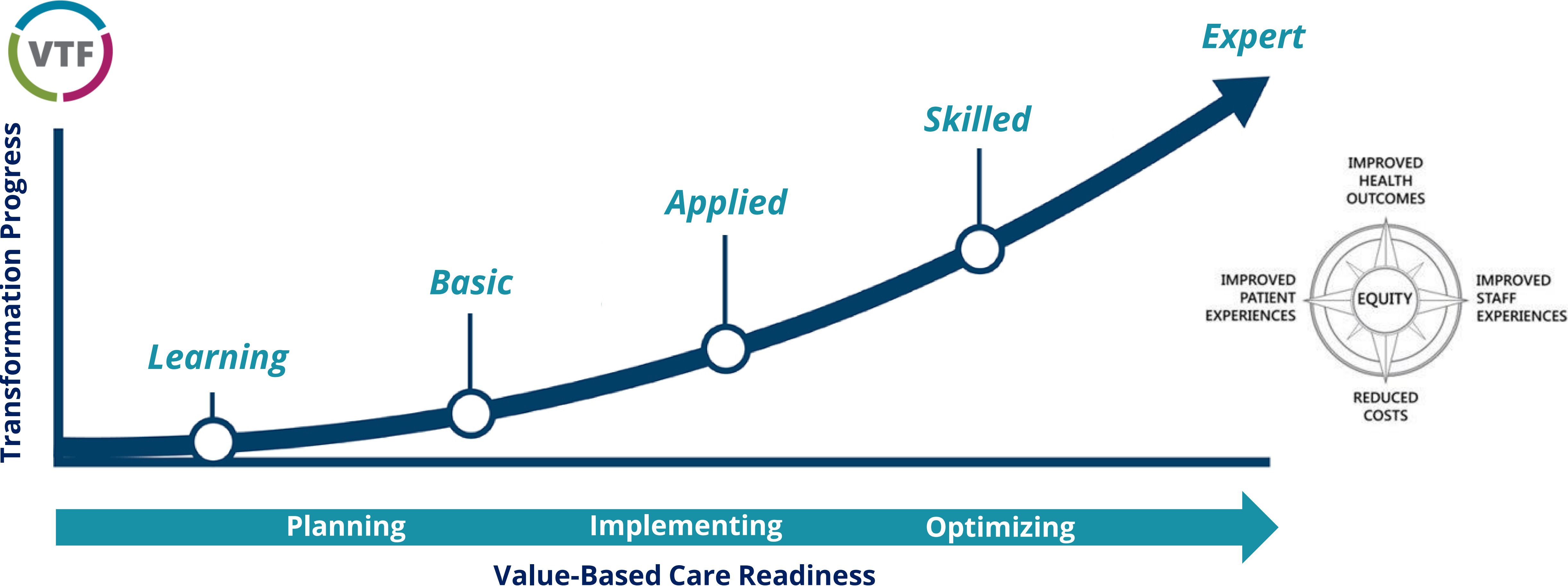
Employ a model of care that transforms the delivery of primary care into a comprehensive, patient-centered system focused on high quality, accessible, and coordinated care.

	1. Learning	2. Basic	3. Applied	4. Skilled	5. Expert
Application of PCMH Model	Health center leaders are aware of the Patient-Centered Medical Home (PCMH) model and the significance of obtaining PCMH recognition but have not applied for it from any of the HRSA-recognized organizations*.	Health center has assigned staff to be accountable for understanding the characteristics of the PCMH model (comprehensive, patient-centered, high quality, accessible, and coordinated care) and obtaining PCMH recognition from a HRSA-recognized organization*.	Health center has achieved PCMH recognition* for at least one site in the organization.	Health center has achieved PCMH recognition* for all sites within the organization.	Health center is actively applying the PCMH care model as a foundation for system-wide transformation efforts. Health center has expanded the PCMH care model to include innovative approaches to care, including virtual care, patient self-management, integrated care delivery models, and expanded care teams.

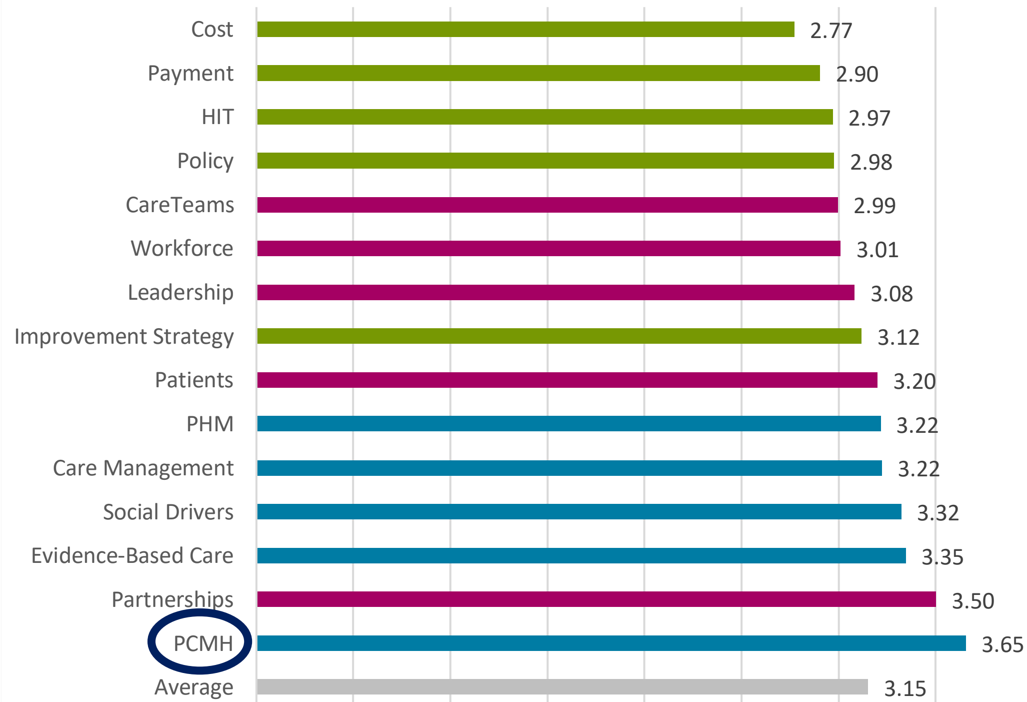
*HRSA contracts with three national organizations to provide technical assistance and training for their PCMH recognition processes:

- The Joint Commission for ambulatory health care accreditation and PCMH certification
- The Accreditation Association for Ambulatory Health Care for ambulatory health care and medical home accreditation
- The National Committee for Quality Assurance for PCMH recognition

Assess Readiness for Value-Based Care



PCMH: A Foundation to Value-Based Care



1578 Assessments conducted
445 Organizations
47 States & Territories represented
2-14% Average improvement over time period

268 Assessments conducted
139 Organizations
40 States & Territories represented

STEP 3: PLAN

NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK
Action Guide

HEALTH CENTER

INFRASTRUCTURE | CARE DELIVERY | PEOPLE

IMPROVEMENT STRATEGY

WHY is improvement strategy essential to health center performance?

An improvement strategy ensures health centers have clearly defined visions, goals, and action steps that drive transformation and improve performance. It guides health center performance by effectively and routinely measuring and communicating information about the quality, value, and outcomes of the health care experience. In an era of value-based care, this whole-systems approach supports health centers to:

- Function as "learning organizations" engaged in continuous quality improvement and applying evidence-based interventions and best practices.
- Implement organization-wide, system-level changes that are impactful, measurable and transformative.
- Drive improvements toward the Quintuple Aim goals – improved health outcomes, improved patient experiences, improved staff experiences, reduced costs, and equity.

IMPROVEMENT STRATEGY

The Value Transformation Framework addresses how an improvement strategy allows health centers to 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. It encompasses the systematic, continuous process of quality planning, improvement, control, and assurance. This Action Guide defines a concrete set of action steps health centers can take to develop an effective improvement strategy.

A health center's improvement strategy is most effective when aligned with the health center's overall strategic plan. This not only creates a solid foundation for health center improvement but integrates improvement and innovation activities within health center advancements in the infrastructure, care delivery, and people systems.

WHAT is a whole-systems improvement strategy?

An improvement strategy guides the advancement of healthcare quality. The Institute of Medicine's (IOM) 2001 landmark report, ***Crossing the Quality Chasm: A New Health System for the 21st Century***, outlined six aims for improvement in the health care system[1]. These includes care that is: safe, effective, patient-centered, timely, efficient, and equitable.

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Plan for transformation by outlining goals and incorporating transformation activities in your health center's Improvement Strategy.

- ✓ Use the VTF's organizing framework to support the connection of PCMH activities to larger value transformation efforts.
- ✓ Nest PCMH activities within larger VBC Strategy.

STEP 4: TRANSFORM

NEW Dedicated VBC Resources

Health Center Value-Based Care Business Analysis Tool

NACHC Quality Center, August 2025

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 (bundled 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 fol
# of covered lives a
# of providers partic
Annual salary+bene
median salary will be
Annual costs of non

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**

VALUE TRANSFORMATION FRAMEWORK
Action Brief
DEVELOPING YOUR HEALTH CENTER'S VALUE-BASED PAYMENT GOALS

VALUE TRANSFORMATION FRAMEWORK
Action Brief
ATTRIBUTION THRESHOLDS FOR VALUE-BASED CARE

VALUE TRANSFORMATION FRAMEWORK
Action Brief
ATTRIBUTION
WHAT
WHY

VALUE TRANSFORMATION FRAMEWORK
Action Brief
PAYOR DATA
WHY
WHAT

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

STEP 4: TRANSFORM

NEW Dedicated VBC Resources

WHAT are the opportunities?

	Medicare Shared Savings Program	Medicare Shared Savings Program-AIP	ACO REACH	Making Care Primary
Description:	The program is **run by Accountable Care Organizations (ACOs), which are groups of doctors, hospitals, and other health care providers.** ACOs meeting specific quality standards and achieving savings by spending less than targets evenly split the amount of savings with Medicare.	The ACO Investment Program (AIP) program **provides savings to MSSP ACOs in rural or underserved areas in an upfront infrastructure payment, and eight quarterly risk-factor based per beneficiary payments.** ACOs meeting specific quality standards and achieving savings by spending less than targets evenly split the amount of savings with Medicare.	Realizing Equity, Access, and Community Health) ACO REACH Model, **focuses on promoting health equity and addressing healthcare disparities for underserved communities**, continuing the momentum of provider-led organizations participating in risk-based models.	The Making Care Primary (MCP) Model is a **multi-state primary care initiative designed to enhance access and quality of care while addressing key community priorities. The MCP Model introduces an innovative payment structure to financially support the role of primary care** while improving patient outcomes and ensuring equitable healthcare delivery.
Pros:	• Most established Medicare VBC program • Centers for Medicare & Medicaid Services (CMS) is using the program as a "chassis" to develop and test new ACO models • Options to remain in one-sided risk arrangements longer	• Provides upfront investment with no downside financial risk to ACOs who participate. • Entry point for health centers seeking to broaden value-based care experience with infrastructure support. • Funds can be used to impact HRSN	• Heightened focus on health equity • Various payment arrangements to support value-based care • Option for primary care further along in VBC maturity to expand experience	• FQHC inclusive • Three progressive tracks each focusing on different aspects of care transformation and payment arrangements • Payment supports pathway to value-based care adoption
Cons:	• Managing total cost of care including specialty and inpatient costs is key to generating shared savings • Expected to eventually take on downside risk • Requires retooling of workflow and care delivery models for greatest impact	• Only available for new or low-revenue ACOs. • Five-year agreement period is required	• Pilot program and no longer receiving new entrants • For primary care practices experienced in value-based care delivery	• Single entry point • Limited to only 8 states: Colorado, Massachusetts, Minnesota, New Mexico, New Jersey, New York, North Carolina, and Washington • Unclear how will impact state PPS policy
LAN APM Category:	Category 3A – 3B	Category 3A	Category 4	Category 2A – 4A

Recorded webinars on health center VBP opportunities!

- **Advancing Health Center Value-Based Care**
- **MSSP AIP 2-Part Webinar Series**

STEP 4: TRANSFORM

NEWLY Released

- ✓ Action Brief: How to Use the VTF and Elevate
- ✓ Action Brief: Assess Transformation Progress
- ✓ Improvement Strategy Action Guide
- ✓ QI/QA Plan Template
- ✓ Medicare Reimbursement Tip Sheets (13 new/updated)

Access even more NACHC tools & resources to support health center VBC transformation at: https://nachc.docebosaas.com/learn/signin

VALUE TRANSFORMATION FRAMEWORK
Action Guide
IMPROVEMENT STRATEGY

Health Center QI/QA Plan Template

Instructions for Use: This QI/QA Plan Template is designed to support health centers in meeting HRSA Health Center Program Requirements. Health centers may customize this Plan by editing all red text to meet individual health center needs. For the greatest impact, implement this Plan as a component of your health center Improvement Strategy.

This instructional cover page may be removed by the health center.

Created by the NACHC Quality Center in partnership with RegLantern. July 2023.

Finding Alignment

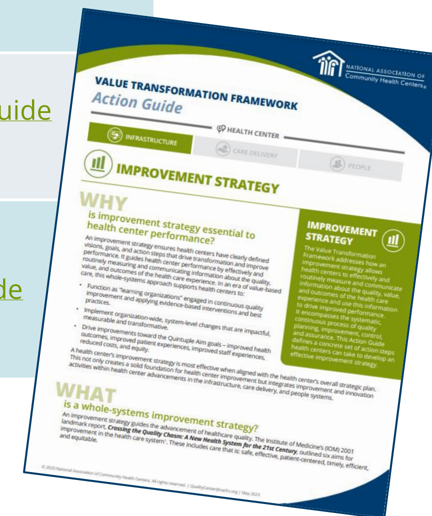
- ✓ NACHC VTF
- ✓ NCQA PCMH
- ✓ HRSA Health Center Program Requirements

Finding Alignment: NACHC VTF, NCQA PCMH, HRSA Health Center Program Requirements

Team-Based Care and Practice Organization (TC)

NCQA PCMH Core Criteria+	NACHC VTF Change Area	HRSA Health Center Program Requirement	NACHC Elevate Resources
TC 01 PCMH Transformation Leads: Designates a clinician lead of the medical home and a staff person to manage the transformation and ongoing patient-centered care.	**Governance & Leadership** **PCMH** (VTF Assessment level: Basic)	**Site Visit Protocol*** Quality Improvement/Assurance Element B: Designee to Oversee QI/QA Program	Leadership Action Guide Improvement Strategy Action Guide QI/QA Plan Template
TC 02 Structure and Staff Responsibilities: Defines the practice's organizational structure and staff responsibilities/skills to support key practice functions.	**Improvement Strategy** (VTF Assessment level: Basic)	**Site Visit Protocol*** Quality Improvement/Assurance Element C: QI/QA Procedures or Processes	Improvement Strategy Action Guide QI/QA Plan Template
TC 06 Individual Patient Care Meetings/Communication: Has regular patient care-team meetings or a structured communication process focused on individual patient care.	**Care Teams** (VTF Assessment level: Basic)	N/A	Care Teams Action Guide
TC 07 Staff Involvement in Quality Improvement: Involves care team staff in the practice's performance evaluation and quality improvement activities.	**Improvement Strategy** (VTF Assessment level: Basic - Applied)	**Site Visit Protocol*** Quality Improvement/Assurance Element C: QI/QA Procedures or Processes	Improvement Strategy Action Guide QI/QA Plan Template
TC 09 Medical Home Information: Has a process for informing patients/families/caregivers about the role of the medical home and provides patients/families/caregivers materials that contain the information.	**Patients** (VTF Assessment level: Basic)	N/A	Patient Engagement Action Guide

+"NCQA PCMH Standards and Guidelines." National Committee for Quality Assurance. 2023. https://store.ncqa.org/pcmh-standards-and-guidelines.html
*https://bphc.hrsa.gov/compliance/site-visits/site-visit-protocol


VALUE TRANSFORMATION FRAMEWORK
Action Guide
IMPROVEMENT STRATEGY
WHY is improvement strategy essential to health center performance?
WHAT is a whole-systems improvement strategy?

Finding Alignment: NACHC VTF, NCQA PCMH, HRSA Health Center Program Requirements

Knowing and Managing Your Patients (KM)

NCQA PCMH Core Criteria+	NACHC VTF Change Area	HRSA Health Center Program Requirement	NACHC Elevate Resources
KM 01 Problem Lists: Documents an up-to-date problem list for each patient with current and active diagnoses.	**Population Health Management** **Evidence-Based Care**	N/A	
KM 02 Comprehensive Health Assessment: Comprehensive health assessment includes: • Medical history of patient and family • Mental health/substance use history of patient and family • Family/social/cultural characteristics • Communication needs • Behaviors affecting health • Social functioning • Social determinants of health • Developmental screening using a standardized tool • Advance care planning	**Population Health Management** (VTF Assessment level: Learning) **SDOH** (VTF Assessment level: Learning)	**UDS*** Table 3B, 4, 6A	NACHC SDOH Action Guide NACHC Reimbursement Tips - Advance Care Planning
KM 03 Depression Screening: Conducts depression screenings for adults and adolescents using a standardized tool.	**Evidence-Based Care** (VTF Assessment level: Basic)	**UDS*** Table 6B	
KM 09 Diversity: Assesses the diversity of its population • Race • Ethnicity • Gender identity • Sexual orientation • One other aspect of diversity	**Population Health Management** (VTF Assessment level: Learning) **SDOH** (VTF Assessment level: Learning)	**UDS*** Table 3B	NACHC SDOH Action Guide

VALUE TRANSFORMATION FRAMEWORK
Action Guide
SOCIAL DRIVERS OF HEALTH
WHY consider the Social Drivers of Health?
SOCIAL DRIVERS OF HEALTH
WHAT can health centers do to address social risk?

+"NCQA PCMH Standards and Guidelines." National Committee for Quality Assurance. 2023. https://store.ncqa.org/pcmh-standards-and-guidelines.htm
*https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2023-uds-manual.pdf

Finding Alignment: NACHC VTF, NCQA PCMH, HRSA Health Center Program Requirements

Knowing and Managing Your Patients (KM)

NCQA PCMH Core Criteria+	NACHC VTF Change Area	HRSA Health Center Program Requirement	NACHC Elevate Resources
KM 10 Language: Assesses the language needs of its population.	**Patients** (VTF Assessment level: Learning)	**UDS*** Table 3B	
KM 12 Proactive Outreach: Proactively and routinely identifies populations of patients and reminds them or their families/caregivers about needed services: • Preventive care services • Immunizations • Chronic or acute care services • Patients not recently seen by the practice	**Evidence-Based Care** (VTF Assessment level: Basic)	**UDS*** Table 68, 7	NACHC Cancer Screening Action Guide NACHC Diabetes Action Guide NACHC Hypertension Action Guide
KM 14 Medication Reconciliation: Reviews and reconciles medications for more than 80% of patients received from care transitions.	**Care Coordination/ Management** (VTF Assessment level: Basic)	N/A	
KM 15 Medication Lists: Maintains an up-to-date list of medications for more than 80% of patients.	**Evidence-Based Care**	N/A	

+"NCQA PCMH Standards and Guidelines." National Committee for Quality Assurance. 2023. https://store.ncqa.org/pcmh-standards-and-guidelines.html
*https://bphc.hrsa.gov/sites/default/files/bphc/data-reporting/2023-uds-manual.pdf

Finding Alignment: NACHC VTF, NCQA PCMH, HRSA Health Center Program Requirements

Knowing and Managing Your Patients (KM)

NCQA PCMH Core Criteria+	NACHC VTF Change Area	HRSA Health Center Program Requirement	NACHC Elevate Resources
KM 20 Clinical Decision Support: Implements clinical decision support following evidence-based guidelines for care of: • A mental health condition • A substance use disorder • A chronic medical condition • An acute condition • A condition related to unhealthy behaviors • Well-child or adult care • Overuse/appropriateness issues	**Population Health Management** (VTF Assessment level: Learning) **Evidence-Based Care** (VTF Assessment level: Basic)	N/A	NACHC Cancer Screening Action Guide NACHC Diabetes Action Guide NACHC Hypertension Action Guide
KM 21 Community Resource Needs: Uses information on the population served by the practice to prioritize needed community resources.	**Care Coordination/ Management** (VTF Assessment level: Applied) **SDOH** (VTF Assessment level: Basic)	**Site Visit Protocol*** Required and Additional Health Center Services Element C: Providing Culturally Appropriate Care	NACHC SDOH Action Guide

VALUE TRANSFORMATION FRAMEWORK
Action Guide
SOCIAL DRIVERS OF HEALTH
WHY
consider the Social Drivers of Health?
SOCIAL DRIVERS OF HEALTH
WHAT
can health centers do to address social risk?

+"NCQA PCMH Standards and Guidelines." National Committee for Quality Assurance. 2023. https://store.ncqa.org/pcmh-standards-and-guidelines.html
*https://bphc.hrsa.gov/compliance/site-visits/site-visit-protocol

Finding Alignment: NACHC VTF, NCQA PCMH, HRSA Health Center Program Requirements

Patient-Centered Access and Continuity (AC)

NCQA PCMH Core Criteria+	NACHC VTF Change Area	HRSA Health Center Program Requirement	NACHC Elevate Resources
AC 01 Access Needs and Preferences: Assesses the access needs and preferences of the patient population.	**Care Coordination/ Management** (VTF Assessment level: Basic)	**Site Visit Protocol*** Accessible Locations and Hours of Operation Element B: Accessible Hours of Operation	NACHC Empanelment Action Guide
AC 02 Same-Day Appointments: Provides same-day appointments for routine and urgent care to meet identified patient needs.	**Care Coordination/ Management** (VTF Assessment level: Basic)		
AC 03 Appointments Outside Business Hours: Provides routine and urgent appointments outside regular business hours to meet identified patient needs.	**Care Coordination/ Management** (VTF Assessment level: Basic)		
AC 04 Timely Clinical Advice by Telephone: Provides timely clinical advice by telephone.	**Care Coordination/ Management**		
AC 05 Clinical Advice Documentation: Documents clinical advice in patient records and confirms clinical advice and care provided after hours does not conflict with the patient's medical record.	**Care Coordination/ Management**		
AC 10 Personal Clinician Selection: Helps patients/families/caregivers select or change a personal clinician.	**Population Health Management** (VTF Assessment level: Basic)	N/A	
AC 11 Patient Visits With Clinician/Team: Sets goals and monitors the percentage of patient visits with the selected clinician or team.	**Population Health Management** (VTF Assessment level: Applied)	**Site Visit Protocol*** Quality Improvement/Assurance Element C: QI/QA Procedures or Processes	

NATIONAL ASSOCIATION OF Community Health Centers
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.

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+"NCQA PCMH Standards and Guidelines." National Committee for Quality Assurance. 2023. https://store.ncqa.org/pcmh-standards-and-guidelines.html
*https://bphc.hrsa.gov/compliance/site-visits/site-visit-protocol

Finding Alignment: NACHC VTF, NCQA PCMH, HRSA Health Center Program Requirements

Care Management and Support (CM)

NCQA PCMH Core Criteria+	NACHC VTF Change Area	HRSA Health Center Program Requirement	NACHC Elevate Resources
CM 01 Identifying Patients for Care Management: Considers the following when establishing a systematic process and criteria for identifying patients who may benefit from care management: • Behavioral health conditions • High cost/high utilization • Poorly controlled or complex conditions • Social determinants of health • Referrals by outside organizations (e.g., insurers, health system, ACO), practice staff, patient/family/caregiver	**Care Coordination/ Management** **Population Health Management** (VTF Assessment level: Expert)	N/A	NACHC Care Management Action Guide NACHC Risk Stratification Action Guide NACHC Reimbursement Tips - Chronic Care Management
CM 02 Monitoring Patients for Care Management: Monitors the percentage of the total patient population identified through its process and criteria.	**Care Coordination/ Management**	N/A	
CM 04 Person-Centered Care Plans: Establishes a person-centered care plan for at least 75% of patients identified for care management.	**Care Coordination/ Management**	N/A	
CM 05 Written Care Plans: Provides a written care plan to the patient/family/caregiver for at least 75% of patients identified for care management.	**Care Coordination/ Management**	N/A	

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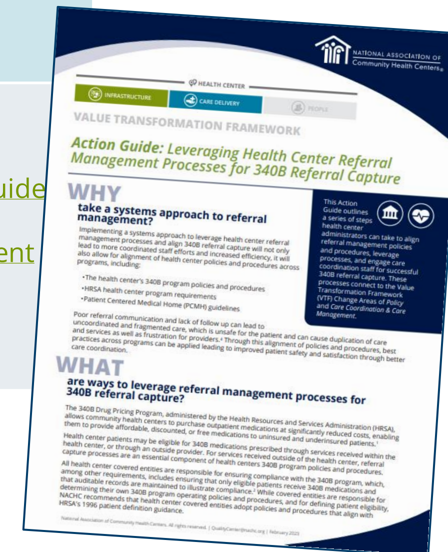
*https://bphc.hrsa.gov/compliance/site-visits/site-visit-protocol

Finding Alignment: NACHC VTF, NCQA PCMH, HRSA Health Center Program Requirements

Care Coordination and Care Transitions (CC)

NCQA PCMH Core Criteria+	NACHC VTF Change Area	HRSA Health Center Program Requirement	NACHC Elevate Resources
CC 01 Lab and Imaging Test Management: The practice systematically manages lab and imaging tests by: • Tracking lab tests until results are available, flagging and following up on overdue results • Tracking imaging tests until results are available, flagging and following up on overdue results • Flagging abnormal lab results, bringing them to the attention of the clinician • Flagging abnormal imaging results, bringing them to the attention of the clinician • Notifying patients/families/caregivers of normal lab and imaging test results • Notifying patients/families/caregivers of abnormal lab and imaging test results.	**Care Coordination/ Management**	**Site Visit Protocol*** Quality Improvement/Assurance Element C: QI/QA Procedures or Processes	NACHC Models of Care Action Guide
CC 04 Referral Management: The practice systematically manages referrals by • Giving the consultant or specialist the clinical question, the required timing and the type of referral • Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan • Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports	**Care Coordination/ Management** (VTF Assessment level: Basic - Applied)	**Site Visit Protocol*** Quality Improvement/Assurance Element C: QI/QA Procedures or Processes	NACHC Models of Care Action Guide NACHC 340B Referral Management Action Guide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HEALTH CENTER

INFRASTRUCTURE | CARE DELIVERY | PEOPLE

VALUE TRANSFORMATION FRAMEWORK

Action Guide: Leveraging Health Center Referral Management Processes for 340B Referral Capture

WHY take a systems approach to referral management?

Implementing a systems approach to leverage health center referral management processes and align 340B referral capture will not only lead to more coordinated staff efforts and increased efficiency, it will also allow for alignment of health center policies and procedures across programs, including:

- The health center's 340B program policies and procedures
- HRSA health center program requirements
- Patient Centered Medical Home (PCMH) guidelines

Poor referral communication and lack of follow up can lead to uncoordinated and fragmented care, which is unsafe for the patient and can cause duplication of care and services as well as frustration for providers.[4] Through this alignment of policies and procedures, best practices across programs can be applied leading to improved patient safety and satisfaction through better care coordination.

This Action Guide outlines a series of steps health center administrators can take to align referral management policies and procedures, leverage processes, and engage care coordination staff for successful 340B referral capture. These processes connect to the Value Transformation Framework (VTF) Change Areas of *Policy* and *Care Coordination & Care Management*.

WHAT are ways to leverage referral management processes for 340B referral capture?

The 340B Drug Pricing Program, administered by the Health Resources and Services Administration (HRSA), allows community health centers to purchase outpatient medications at significantly reduced costs, enabling them to provide affordable, discounted, or free medications to uninsured and underinsured patients.[1]

Health center patients may be eligible for 340B medications prescribed through services received within the health center, or through an outside provider. For services received outside of the health center, referral capture processes are an essential component of health centers 340B program policies and procedures.

All health center covered entities are responsible for ensuring compliance with the 340B program, which, among other requirements, includes ensuring that only eligible patients receive 340B medications and that auditable records are maintained to illustrate compliance.[2] While covered entities are responsible for determining their own 340B program operating policies and procedures, and for defining patient eligibility, NACHC recommends that health center covered entities adopt policies and procedures that align with HRSA's 1996 patient definition guidance.

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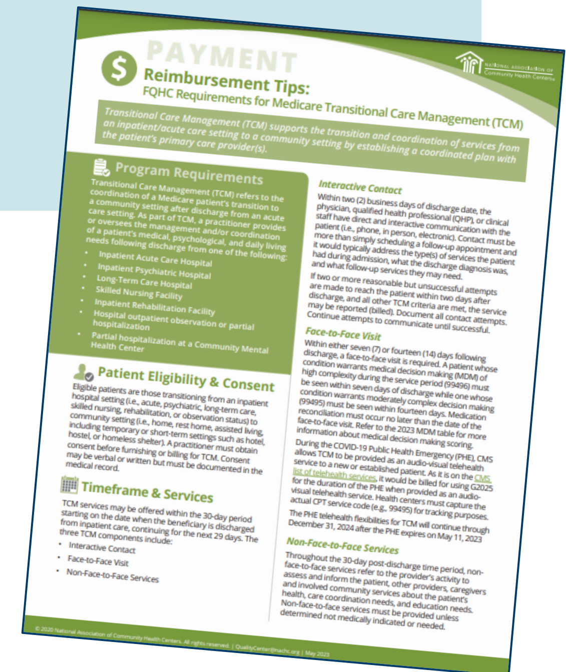
Finding Alignment: NACHC VTF, NCQA PCMH, HRSA Health Center Program Requirements

Care Coordination and Care Transitions (CC)

NCQA PCMH Core Criteria+	NACHC VTF Change Area	HRSA Health Center Program Requirement	NACHC Elevate Resources
CC 14 Identifying Unplanned Hospital and ED Visits: Systematically identifies patients with unplanned hospital admissions and emergency department visits.	**Care Coordination/ Management** (VTF Assessment level: Basic)	**Site Visit Protocol*** Continuity of Care and Hospital Admitting	NACHC Care Management Action Guide NACHC Reimbursement Tips - Transitional Care Management
CC 15 Sharing Clinical Information: Shares clinical information with admitting hospitals and emergency departments.	**Care Coordination/ Management**		
CC 16 Post-Hospital/ED Visit Follow-Up: Contacts patients/families/caregivers for follow-up care, if needed, within an appropriate period following a hospital admission or emergency department visit.	**Care Coordination/ Management** (VTF Assessment level: Basic)		


PAYMENT

Reimbursement Tips:

FQHC Requirements for Medicare Transitional Care Management (TCM)

National Association of Community Health Centers

Transitional Care Management (TCM) supports the transition and coordination of services from an inpatient/acute care setting to a community setting by establishing a coordinated plan with the patient's primary care provider(s).

Program Requirements

Transitional Care Management (TCM) refers to the coordination of a Medicare patient's transition to a community setting after discharge from an acute care setting. As part of TCM, a practitioner provides or oversees the management and/or coordination of a patient's medical, psychological, and daily living needs following discharge from one of the following:

- Inpatient Acute Care Hospital
- Inpatient Psychiatric Hospital
- Long-Term Care Hospital
- Skilled Nursing Facility
- Inpatient Rehabilitation Facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a Community Mental Health Center

Patient Eligibility & Consent

Eligible patients are those transitioning from an inpatient hospital setting (i.e., acute, psychiatric, long-term care, skilled nursing, rehabilitation, or observation status) to community setting (i.e., home, rest home, assisted living, including temporary or short-term settings such as hotel, hostel, or homeless shelter). A practitioner must obtain consent before furnishing or billing for TCM. Consent may be verbal or written but must be documented in the medical record.

Timeframe & Services

TCM services may be offered within the 30-day period starting on the date when the beneficiary is discharged from inpatient care, continuing for the next 29 days. The three TCM components include:

- Interactive Contact
- Face-to-Face Visit
- Non-Face-to-Face Services

Interactive Contact

Within two (2) business days of discharge date, the physician, qualified health professional (QHP), or clinical staff have direct and interactive communication with the patient (i.e., phone, in person, electronic). Contact must be more than simply scheduling a follow-up appointment and it would typically address the type(s) of services the patient had during admission, what the discharge diagnosis was, and what follow-up services they may need.

If two or more reasonable but unsuccessful attempts are made to reach the patient within two days after discharge, and all other TCM criteria are met, the service may be reported (billed). Document all contact attempts. Continue attempts to communicate until successful.

Face-to-Face Visit

Within either seven (7) or fourteen (14) days following discharge, a face-to-face visit is required. A patient whose condition warrants medical decision making (MDM) of high complexity during the service period (99496) must be seen within seven days of discharge while one whose condition warrants moderately complex decision making (99495) must be seen within fourteen days. Medication reconciliation must occur no later than the date of the face-to-face visit. Refer to the 2023 MDM table for more information about medical decision making scoring.

During the COVID-19 Public Health Emergency (PHE), CMS allows TCM to be provided as an audio-visual telehealth service to a new or established patient. As it is on the CMS list of telehealth services, it would be billed for using G2025 for the duration of the PHE when provided as an audio-visual telehealth service. Health centers must capture the actual CPT service code (e.g., 99495) for tracking purposes.

The PHE telehealth flexibilities for TCM will continue through December 31, 2024 after the PHE expires on May 11, 2023

Non-Face-to-Face Services

Throughout the 30-day post-discharge time period, non-face-to-face services refer to the provider's activity to assess and inform the patient, other providers, caregivers and involved community services about the patient's health, care coordination needs, and education needs. Non-face-to-face services must be provided unless determined not medically indicated or needed.

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Finding Alignment: NACHC VTF, NCQA PCMH, HRSA Health Center Program Requirements

Performance Measurement and Quality Improvement (QI)

NCQA PCMH Core Criteria+	NACHC VTF Change Area	HRSA Health Center Program Requirement	NACHC Elevate Resources
QI 01 Clinical Quality Measures: Monitors at least five clinical quality measures across the four categories: • Immunization measures • Other preventive care measures • Chronic or acute care clinical measures • Behavioral health measures	**Improvement Strategy** (VTF Assessment level: Basic) **Evidence-Based Care**	**Site Visit Protocol*** Quality Improvement/Assurance Element C: QI/QA Procedures or Processes **UDS**** Table 6B, 7	Improvement Strategy Action Guide QI/QA Plan Template NACHC Cancer Screening Action Guide NACHC Diabetes Action Guide NACHC Hypertension Action Guide
QI 02 Resource Stewardship Measures: Monitors at least two measures of resource stewardship: • Measures related to care coordination • Measures affecting health care costs	**Improvement Strategy** (VTF Assessment level: Basic)	**Site Visit Protocol*** Quality Improvement/Assurance Element C: QI/QA Procedures or Processes	Improvement Strategy Action Guide QI/QA Plan Template

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Finding Alignment: NACHC VTF, NCQA PCMH, HRSA Health Center Program Requirements

Performance Measurement and Quality Improvement (QI)

NCQA PCMH Core Criteria+	NACHC VTF Change Area	HRSA Health Center Program Requirement	NACHC Elevate Resources
QI 03 Appointment Availability Assessment: Assesses performance on availability of major appointment types to meet patient needs and preferences for access.	**Improvement Strategy** (VTF Assessment level: Basic) **Care Coordination/ Management** (VTF Assessment level: Basic)	**Site Visit Protocol*** Quality Improvement/Assurance Element C: QI/QA Procedures or Processes	Improvement Strategy Action Guide QI/QA Plan Template NACHC Empanelment Action Guide

QI 04 Patient Experience Feedback: Monitors patient experience through:
• Quantitative data. Conducts a survey to evaluate patient/family/ caregiver experiences across at least three dimensions, such as:
  • Access
  • Communication
  • Coordination
  • Whole-person care, self-management support and comprehensiveness
• Qualitative data. Obtains feedback from patients/families/caregivers through qualitative means
	Improvement Strategy
	(VTF Assessment level: Basic)
	
	Patients
	(VTF Assessment level: Basic)
		Site Visit Protocol*
		Quality Improvement/Assurance Element C: QI/QA Procedures or Processes
			Improvement Strategy Action Guide
			QI/QA Plan Template

VALUE TRANSFORMATION FRAMEWORK
Action Guide
IMPROVEMENT STRATEGY
WHY is improvement strategy essential to health center performance?
WHAT is a whole-systems improvement strategy?

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Finding Alignment: NACHC VTF, NCQA PCMH, HRSA Health Center Program Requirements

Performance Measurement and Quality Improvement (QI)

NCQA PCMH Core Criteria+	NACHC VTF Change Area	HRSA Health Center Program Requirement	NACHC Elevate Resources
QI 08 Goals and Actions to Improve Clinical Quality Measures: Sets goals and acts to improve upon at least three measures across at least three of the four categories: • Immunization measures • Other preventive care measures • Chronic or acute care clinical measures • Behavioral health measures	**Improvement Strategy** (VTF Assessment level: Basic) **Evidence-Based Care**	**Site Visit Protocol*** Quality Improvement/Assurance Element C: QI/QA Procedures or Processes **UDS**** Table 6B, 7	Improvement Strategy Action Guide QI/QA Plan Template NACHC Cancer Screening Action Guide NACHC Diabetes Action Guide NACHC Hypertension Action Guide
QI 09 Goals and Actions to Improve Resource Stewardship Measures: Sets goals and acts to improve performance on at least one measure of resource stewardship: • Measures related to care coordination • Measures affecting health care costs	**Improvement Strategy** (VTF Assessment level: Basic)	**Site Visit Protocol*** Quality Improvement/Assurance Element C: QI/QA Procedures or Processes	Improvement Strategy Action Guide QI/QA Plan Template

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Performance Measurement and Quality Improvement (QI)

NCQA PCMH Core Criteria+	NACHC VTF Change Area	HRSA Health Center Program Requirement	NACHC Elevate Resources
QI 10 Goals and Actions to Improve Appointment Availability: Sets goals and acts to improve on availability of major appointment types to meet patient needs and preferences.	**Improvement Strategy** (VTF Assessment level: Basic) **Care Coordination/ Management** (VTF Assessment level: Basic)	**Site Visit Protocol*** Quality Improvement/Assurance Element C: QI/QA Procedures or Processes	Improvement Strategy Action Guide QI/QA Plan Template NACHC Empanelment Action Guide
QI 11 Goals and Actions to Improve Patient Experience: Sets goals and acts to improve performance on at least one patient experience measure.	**Improvement Strategy** (VTF Assessment level: Basic) **Patients** (VTF Assessment level: Basic)	**Site Visit Protocol*** Quality Improvement/Assurance Element C: QI/QA Procedures or Processes	Improvement Strategy Action Guide QI/QA Plan Template
QI 15 Reporting Performance Within the Practice: Shares clinician-level or practice-level performance results with clinicians and staff for measures it reports.	**Improvement Strategy** (VTF Assessment level: Basic)	**Site Visit Protocol*** Quality Improvement/Assurance Element C: QI/QA Procedures or Processes	Improvement Strategy Action Guide QI/QA Plan Template

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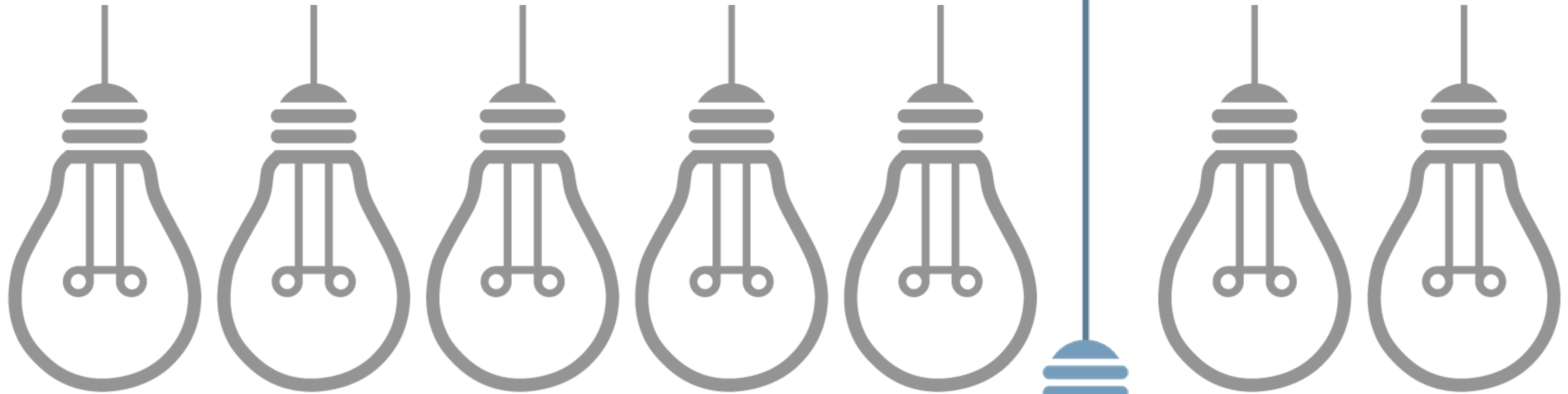
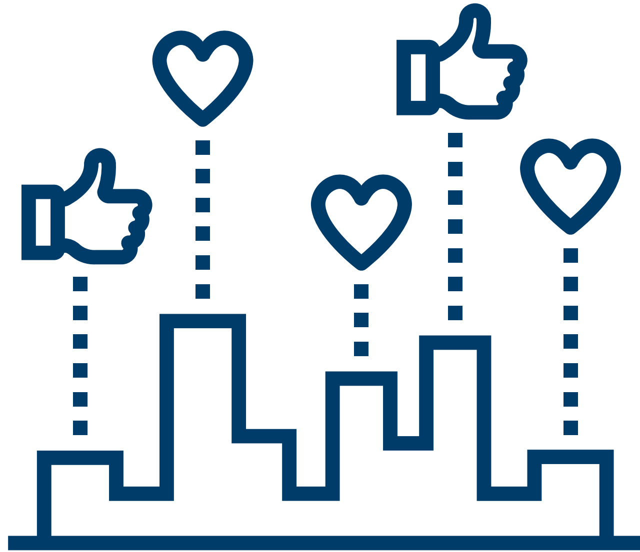


Voices from the field

We invite you to raise your hand to share how you are using PCMH as a foundation for value-based care transformation.



Provide Us Feedback

2023-2024 QI Advisory Board Members:

Applications are now being accepted for members to serve on NACHC's QI Advisory Board for the term of Jan 1, 2024 - Dec 31, 2025

Deadline: December 1, 2023

Apply here!

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!

ELEVATE PULSE

Be on the lookout for the **Elevate Pulse** from the **Quality Center**.

- Slides and recordings
- Tools
- Upcoming Opportunities

Sent the 2nd Friday of each month!

NATIONAL ASSOCIATION OF Community Health Centers®

Leading the Transition to Value-Based Care

FOR MORE INFORMATION CONTACT:

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Next Monthly Forum Call:

November 14, 2023
1:00 – 2:00 pm ET

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

700 CHCs | 75 PCAs/HCCNs | >15 Million Patients

- ✓ Monthly Webinars
- ✓ Supplemental Sessions
- ✓ Evidence-Based Action Guides
- ✓ Action Briefs
- ✓ eLearning Modules
- ✓ Tools & Resources
- ✓ Professional Development Courses
- ✓ Online Learning Platform

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Together, our voices elevate all.

The Quality Center Team

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