



NATIONAL ASSOCIATION OF
Community Health Centers®

ELEVATE NATIONAL LEARNING FORUM



Year In Review

December 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.



ELEVATE NATIONAL LEARNING FORUM



Year In Review
December 12, 2023

Who can see your messages? Recording On

To: Hosts and panelists ▾

Type

- Hosts and panelists
- ✓ Everyone

Unmute Stop Video Participants **Chat** Share Screen Record Reactions Leave

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!

NACHC Quality Center



Cheryl Modica
Director,
Quality Center



Cassie Lindholm
Deputy Director,
Quality Center



Holly Nicholson
Deputy Director,
Learning & Development



Tristan Wind
Manager,
Quality Center



Rachel Barnes
Specialist,
Quality Center

Agenda: Year In Review



- **The Elevate Journey**
- **Year In Review: 2023 Learning Forums and Related Resources**
- **Elevate Wrapped**
- **Professional Development**
- **Elevate 2024**
- **Elevate Awards**

Elevate 2023: A Guided Path for Health Center Systems-Change



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](#)

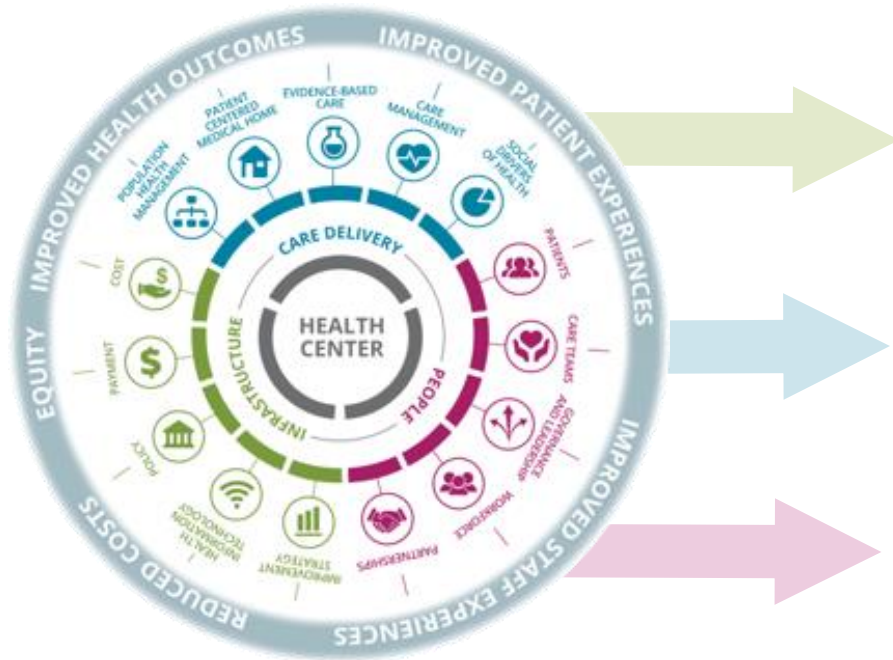


STEP 5 - REASSESS
Measure transformation progress over time using the VTF [Assessment](#); monitor, adjust, and improve



STEP 1: ENGAGE

elevate^o



Elevate provides guided application of the Value Transformation Framework

Elevate National Learning Community offerings available at *NO COST* to support VBC transformation:

- ✓ Monthly Learning Forums
- ✓ Supplemental Sessions
- ✓ Evidence-Based Action Guides
- ✓ Action Briefs
- ✓ Reimbursement Tip Sheets
- ✓ eLearning Modules
- ✓ Tools & Resources
- ✓ Professional Development Courses
- ✓ [Online Learning Platform](#)

STEP 2: ASSESS



VTF Assessment allows health center staff to self-assess organizational progress in activities important to value transformation.

- ✓ Self-assess progress in 15 Change Areas of the Value Transformation Framework
- ✓ Progress is measured along a continuum from '1' (learning) to '5' (expert)
- ✓ Designed to be completed by multiple staff across the organization, with sharing and discussion of scores
- ✓ Takes ~20-30 minutes to complete
- ✓ Complete at the beginning of a transformative initiative and repeat over time to measure improvement
- ✓ Results can be electronically shared with PCA/HCCN



reglantern.com/vtf

STEP 3: PLAN



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

Planning

- Strategic planning
- Set priorities, goals, and measures
- Select staff/team
- Identify champions
- Define current/future state
- Identify training needs
- Develop communication plan



[Improvement Strategy Action Guide](#)

STEP 4: TRANSFORM



Transform health center systems by leveraging VTF and Elevate resources to support practice changes and advance in value-based care.



Improvement

Improvement

Health Center Value-Based Care Glidepath Aligned with the Value Transformation Framework (VTF)

VALUE TRANSFORMATION FRAMEWORK Action Guide

CARE TEAMS

Transform Diabetes Prevention and Care

Developing Your Health Center's Value-Based Payment Goals

BRAIN HEALTH INTEGRATION INTO HEALTH CENTER SERVICES

POPULATION HEALTH MANAGEMENT EMPANELMENT

Finding Alignment - NCQA PCMH, HRSA Requirements, and the VTF

Reimbursement Tips: FQHC Requirements for Medicare Chronic Care Management Services

Risk Stratification



Year In Review:

2023 Learning Forums & Related Resources

January: Leadership



What we learned:

- ✓ Action steps leadership can take to drive transformation toward value-based care
- ✓ Governance's role in value-based care
- ✓ Understanding cost

WHY is Leadership Critical to Transformation?

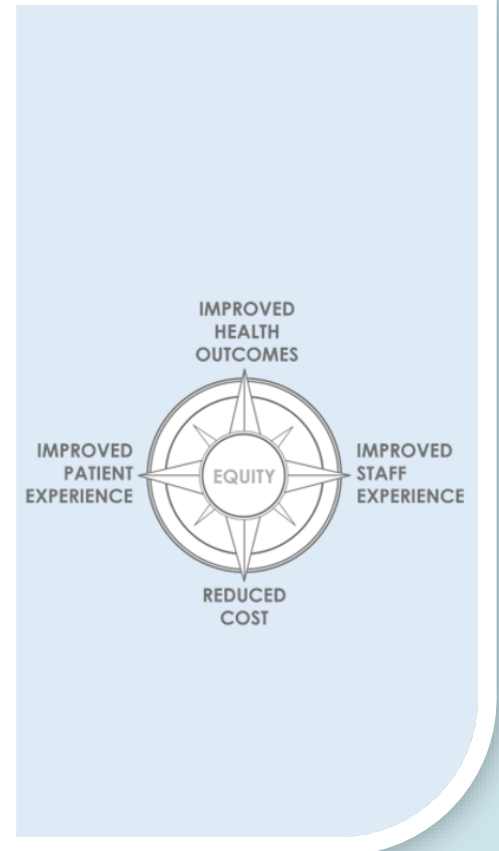


As healthcare moves from volume to value-based reimbursement, the business model and care model must connect and support one another.

Leaders can advance their organization's efforts to deliver better care with more efficiency, gaining a competitive advantage.

Leaders can take action to create the **environment, skills, and structure needed to support transformation.**

How a leader or governing body uses their position and knowledge to lead is essential to reaching improvements in the Quintuple Aim.



Resources: Leadership



 NATIONAL ASSOCIATION OF
Community Health Centers

Action Guide
LEADERSHIP

WHY
is Leadership Critical to Transformation?

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

WHAT
is Leadership's Role in Transformation?

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

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

LEADERSHIP
The Value Transformation Framework

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



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Leadership Action Guide



What we learned:

- ✓ How to empanel patients and utilize empanelment data
- ✓ How to risk stratify patients
- ✓ How to design care models based on risk
- ✓ How to leverage population health strategies to support value-based care at the *planning, implementing, and optimizing* levels

WHAT is population health management?



Empanelment → Risk Stratification → Models of Care

The process of matching every patient to a primary care provider and care team.



Segmenting patients into distinct groups of similar complexity and care needs to better target care and services.



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

Focus is keeping patients engaged in the health care system without use of unnecessary services.

Focus is on managing risk factors more than disease conditions.

Requires structured care management and one-on-one support.

Requires intensive, pro-active care management.

Resources: Population Health Management



Empanelment Action Guide

Risk Stratification Action Guide

Models of Care Action Guide

Empanelment

This microlearning course will help you to use empanelment data to drive health center decision-making.

VTF CHANGE AREAS	ACTION STEPS
	<ol style="list-style-type: none">1. DEFINE and document patient-provider assignment process2. MEASURE patient-provider assignment process3. DETERMINE each PCP's "right" panel size4. ADJUST patient-provider assignment process

You will learn what empanelment is, why it is

Empanelment Microlearning

Risk Stratification

This microlearning course will help you to understand how to use risk stratification to segment your target population while considering the social drivers of health and other criteria.

Risk Stratification Microlearning



What we learned:

- ✓ The role of care teams in population health management
- ✓ How to provide care management services to meet Medicare CCM requirements
- ✓ How to measure care management panel data
- ✓ How to leverage care teams and care management to support value-based care at the *planning*, *implementing*, and *optimizing* levels

WHAT role do care teams have in population health management?



Care teams and the tasks that team members are assigned are developed, based on the needs of the patient population (care models) and the availability of personnel, services, and other resources.



A component of care models for high risk and highly complex patients. Care team members provide intensive, one-on-one services to individuals with complex health and social needs.



Resources: Care Management



NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK Action Guide

HEALTH CENTER

CARE DELIVERY INFRASTRUCTURE PEOPLE

CARE MANAGEMENT

WHY
Use Care Management with High-Risk Patients?

Value-based care requires health care organizations to better control the clinical and financial risks associated with high-risk patients. A systematic process for managing the care of high-risk patients, using proven interventions in a supportive one-on-one environment, has been shown to improve health outcomes^{1,2}. High-risk patients, by definition, have multiple health needs often compounded by complex social and other issues. These patients are at risk for poor health outcomes, inadequate quality of care, and increased costs^{4,5,6}. The Centers for Medicare and Medicaid Services (CMS) recognizes care management as a critical tool to achieve the Quadruple Aim: improved health outcomes, improved patient and staff experiences, lower costs, and improved equity⁷.

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

WHAT
Does a High-Risk Care Management Model Look Like?

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

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

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TCM Microlearning

Transitional Care Management (TCM)

This microlearning course will help you to understand how transitional care management (TCM) supports the transition of patients from an inpatient setting to their primary care providers.

AWV Microlearning

Annual Wellness Visits (AWV)

This microlearning course will help you to gain knowledge about Annual Well Visits (AWV), why these visits are important, and the action steps to build AWV processes into your health center workflows.

Care Management Action Guide

VTF CHANGE AREAS	ACTION STEPS
POPULATION HEALTH MANAGEMENT	<ol style="list-style-type: none"> 1 COMPILE a list of patients eligible for an AWV 2 OUTREACH to schedule AWV 3 MANAGE care team roles
CARE COORDINATION & CARE MANAGEMENT	

You will learn what Medicare Annual Wellness Visits

Resources: Care Management



PAYMENT

Reimbursement Tips:

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

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

The Chronic Care Management (CCM) model of care refers to personalized and supportive services for individuals with multiple (two or more) non-complex chronic conditions to coordinate care and develop a care plan to achieve health goals.

Complex Chronic Care Management (CCCM) is for patients who require moderate or high medical decision making (MDM) and additional time to furnish complex chronic care management services.

Principal Care Management (PCM) is for individuals with a single, complex chronic high-risk condition. Patients require moderate or high medical decision making.

Program Requirements

CMS will separately reimburse health centers for Chronic Care Management (CCM), Complex Chronic Care Management (CCCM), and Principal Care Management (PCM). These care management programs refer to a comprehensive set of services administered to help a patient coordinate and manage chronic conditions. CCM, CCCM, and PCM services are typically provided outside of face-to-face visits and include:

- Comprehensive assessment
- Comprehensive care plan
- Medication management
- Preventive care
- Care transition management (see related Reimbursement Tips)
- Continuity of care
- 24/7 access
- Resources
- Electronic communication options
- Electronic health record documentation
- Social drivers of health

Patient Eligibility & Consent

CCM. Patients who have multiple (two or more) chronic conditions or episodic conditions expected to last at least 12 months or until the patient dies, or that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

CCCM. Patient must be at moderate or high complexity medical decision making (MDM) and require a longer threshold of time than for CCM patients (see Coding & Billing below).

BILLING REQUIREMENTS	CCM	CCCM	PCM
Initiating Visit required prior to start.	X	X	X
2 or more chronic conditions lasting at least 12 months or until patient death.	X	X	
1 complex chronic disease lasting at least 3 months.			X
Patient at risk of death, acute exacerbation/decompensation, or functional decline.	X	X	X
Patient at significant risk of hospitalization.			X
Comprehensive Care plan developed, implemented, revised or monitored. Address, as needed, all medical conditions, psychological needs, ADLs.	X	X	X
Moderate or high complexity MDM		X	X
Frequent adjustments to medication regimen and/or care management.			X
Ongoing communication and care coordination with other care providers.			X

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CCM Reimbursement Tips

PAYMENT

Reimbursement Tips:

FQHC Requirements for Medicare Transitional Care Management (TCM)

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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TCM Reimbursement Tips

PAYMENT

Reimbursement Tips:

FQHC Requirements for Medicare Wellness Visits: Initial Preventive Physical Exam (IPPE) & Annual Wellness Visits (AWV)

Medicare Wellness Visits include the Initial Preventive Physician Exam (IPPE) and Annual Wellness Visits (AWV) which are reimbursable according to Medicare Part B Program requirements. IPPE and AWV encounters also qualify as initiating visits for Centers for Medicaid and Medicare Services (CMS) care management services if conducted within 1 year of the start of care management services.

Program Requirements

While encouraged as part of high-quality care, Medicare Wellness Visits are not required to be furnished to Medicare beneficiaries. Medicare Wellness Visit requirements are based upon the beneficiary's enrollment date with Medicare Part B. It's important to have a mechanism in place to capture the Medicare Part B enrollment date for both new and established patients to assist eligibility determination for a Medicare Wellness Visit.

PHE Exception. With the waiver of geographic and originating sites during the COVID-19 PHE, patients may receive AWV telehealth services in their homes. Patients may self-report vital signs (i.e., weight and blood pressure) to the provider during a visit if they have access to the necessary medical equipment. For patients unable to self-report, it is acceptable to document that body mass index and blood pressure were not able to be obtained. All other visit requirements must still be met. The PHE telehealth flexibilities for AWV will continue through December 31, 2024 after the PHE expires on May 11, 2023.

Patient Eligibility & Consent

Individuals who are enrolled in Medicare Part B are eligible to receive Medicare Wellness Visits. Medicare Advantage Organizations are required to cover these services and follow the associated CMS coverage requirements and guidelines. Patient consent for a Medicare Wellness Visit must be documented in the medical record.

Timeframe & Services

Medicare Wellness Visits include the IPPE and AWV. A beneficiary's enrollment date with Medicare Part B is associated with the Medicare Wellness Visit services that are furnished. A patient must first be enrolled with Medicare Part B before a visit can be furnished.

	IPPE	AWV (Initial)	AWV (Subsequent)
When does the patient visit occur?	Within 12 months of first Part B enrollment date	12 months after IPPE OR >12 months after Part B enrollment and IPPE never performed*	12 months after the initial AWV*
What is the frequency of the visit?	One lifetime benefit. "Use it or lose it"	One lifetime benefit	One subsequent AWV per year
What is the cost to the patient?	No coinsurance	No coinsurance	No coinsurance

* To determine if a patient has previously received a Medicare Wellness Visit, check with your MAC or the 2023 Eligibility Determination System (EDS).

	IPPE	AWV (Initial)	AWV (Subsequent)
What is it?	"Welcome to Medicare" visit. Promotes good health through disease prevention and detection.	Preventive visit to develop and deliver Personalized Preventive Services (PPPS). Includes a health risk Assessment/Risk Assessment and creates a PPPS	Preventive visit to review and update the PPPS and HRA.

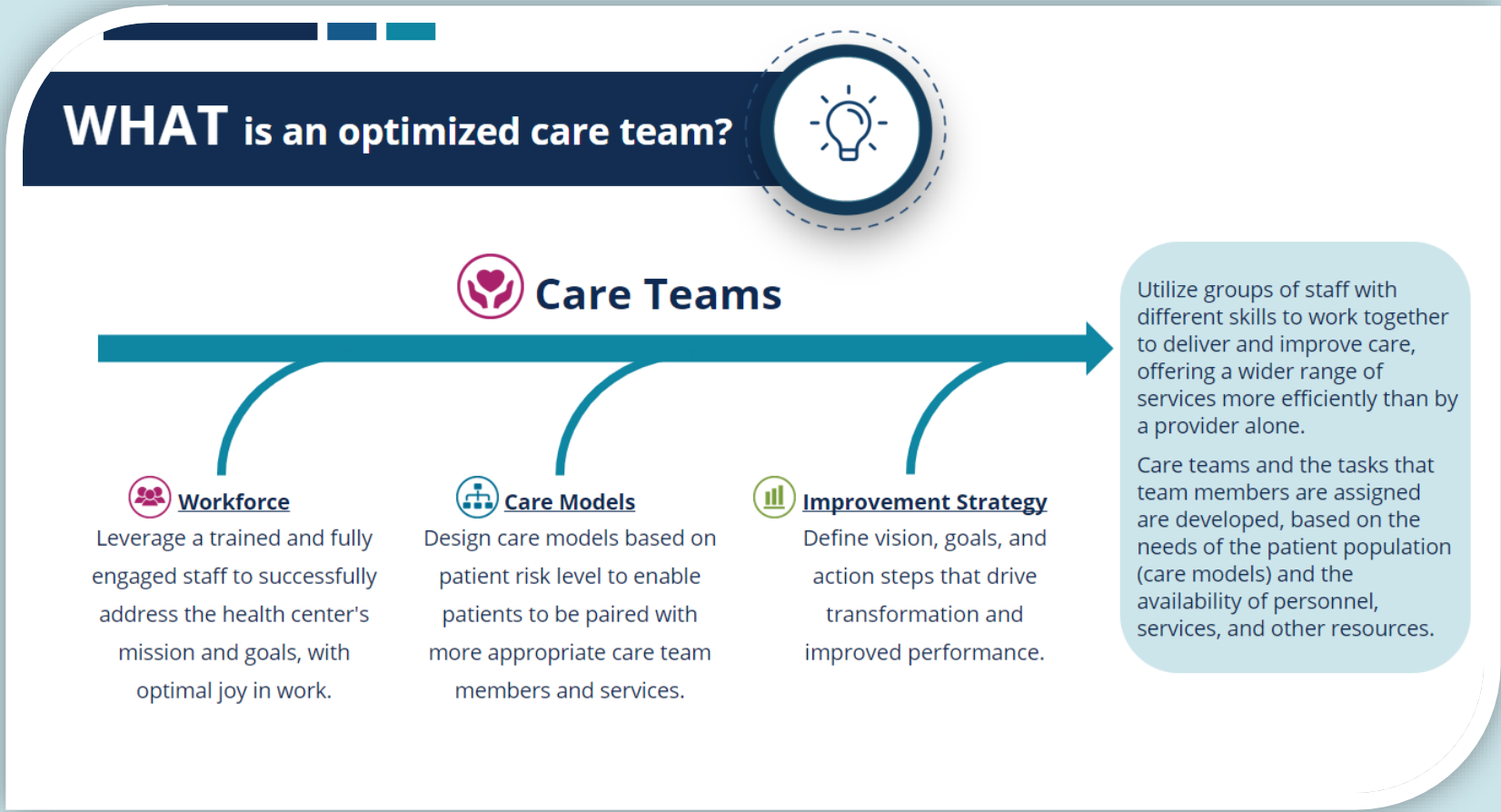
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AWV Reimbursement Tips



What we learned:

- ✓ How to optimize care teams
- ✓ A case study from Community Health Center Association of Connecticut on *A Systematic Approach to Optimizing Care Team Roles & Responsibilities*



Resources: Care Teams



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 patients¹. It is, therefore, not surprising that physicians face burnout and adults in the U.S. receive only 55% of recommended services². 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 delivered³. 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 staff⁴. 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^{5,6}.

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."

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Expanded Care Teams

This microlearning course will help you to gain an understanding about the meaning of expanded care teams, why expanded care teams are important, and how to build expanded care team processes.

VTF CHANGE AREA

CARE TEAMS

1. DEFINE Care Model
2. DISTRIBUTE task workflow
3. UPDATE job descriptions
4. TRAIN staff

You will learn **what** Expanded Care Teams are, **why** they are important, and **7** action steps that

Care Teams Microlearning

Care Team Planning Worksheet - Patient Appointments

NACHC Quality Center

Instructions: This tool is used for designing care teams in their future state.

- Step 1. Review the "Responsibility/Task" column to ensure it includes a complete list of activities that need to take place for an in-person visit; add/delete/modify this list, as appropriate for your health center. Not all responsibilities are required.
- Step 2. Determine the job role "best" able to complete each task (hint: it may not be the role currently performing the task). Use the drop-down options to select the "best" role to complete the task. If "other", document the staff member's name.
- Step 3. Determine when in the patient visit this task is most often completed. If a task occurs at multiple points during a visit, document details in notes.
- Step 4. Determine which technology or systems can be utilized to complete this task.
- Step 5. Determine whether the task can be done by staff members working remotely.

Visit Type	Responsibility/Task	Role	When	Technology/systems utilized	Can be done by staff
Visit Prep	Remind patient of upcoming appointment; confirm				
	Flag overdue or missing preventive/chronic care services				
	Flag overdue or missing immunizations				
	Flag outstanding labs and tests				
	Flag open referrals				
Check in	Obtain records from other facilities (specialists, ED, hospital, etc.)				
	Assemble documentation for PCP/Care Team members to review				
	Additional?				
	Complete COVID screening questions with patient				
	Check in patient				
	Verify and update insurance/billing fee scale information				
	Verify and update demographic information (address, phone, etc.)				
	Verify and update PCP assignment				
	Print summary lists (meds, diagnosis, allergy); provide to patient to review				
	Assess and document patient communication needs				
Rooming	Additional?				
	Room patient				
	Take and document vital signs (height, weight, BP, etc.)				
	Identify and document patient's chief complaint				
	Screen patient for depression, anxiety				
	Screen patient for tobacco, alcohol, substance use				
	Screen patient for SDOH				
	Review and update social history				
	Review and update medical history				
	Initiate dx and allergy lists updates for clinician review and approval				

In-Person Appointments | Telehealth Appointments

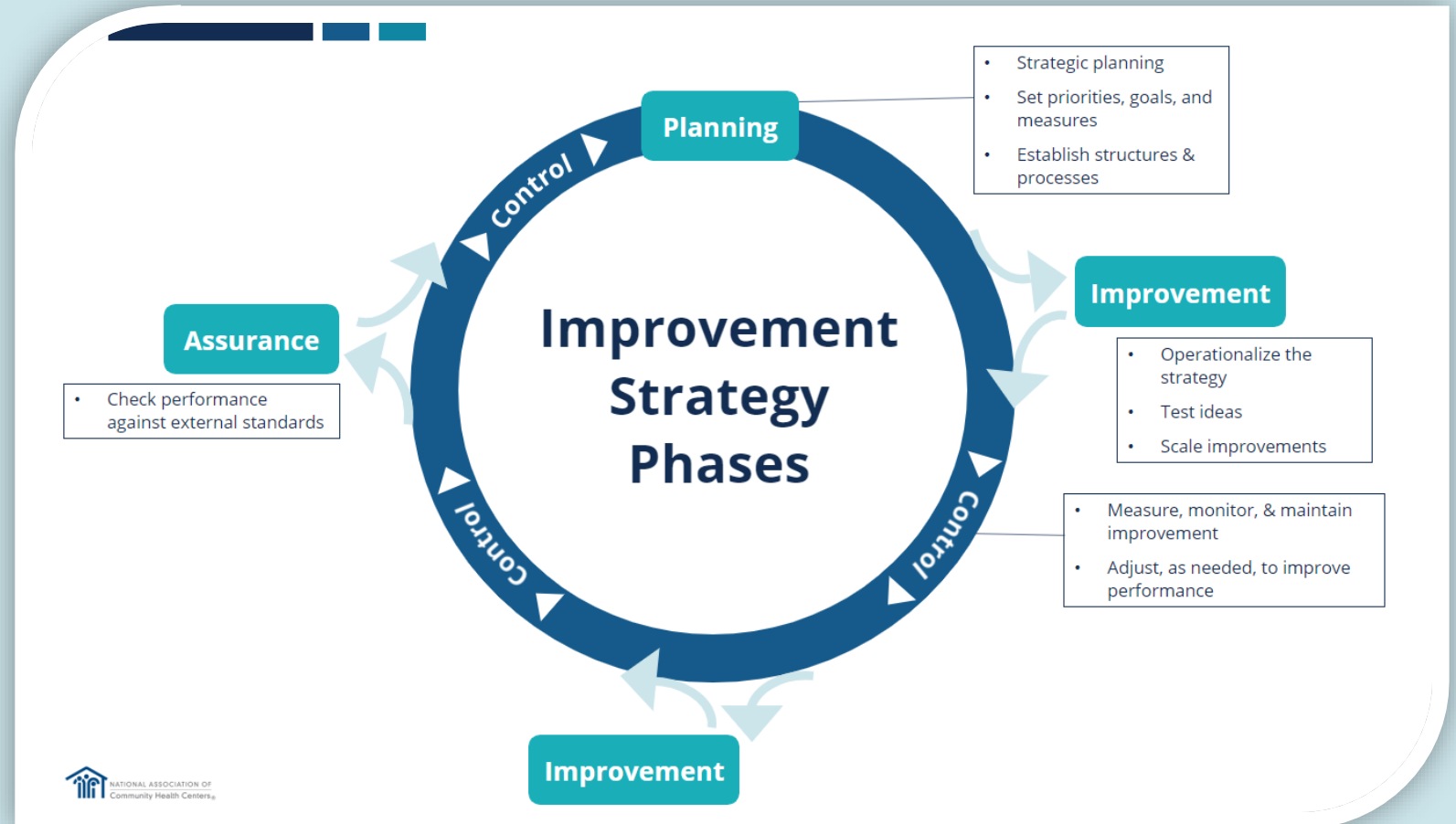
Care Team Planning Worksheet

Care Teams Action Guide



What we learned:

- ✓ How to implement an improvement strategy
- ✓ What HRSA requires in health center QI/QA plans
- ✓ How the VTF and Elevate support health center improvement strategies



Resources: Improvement Strategy



NATIONAL ASSOCIATION OF Community Health Centers

Action Guide
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.

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 system¹. These include care that is: safe, effective, patient-centered, timely, efficient, and equitable.

Organizations and health care systems worldwide have adopted these aims to define quality of care^{2,3}. *Crossing the Quality Chasm* made an urgent call for fundamental changes in the health care system to close the quality gap and advocated for a systems approach to implementing change – much like NACHC’s approach to health center systems change using the Value Transformation Framework.

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Improvement Strategy Action Guide

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.

QI/QA Plan Template



What we learned:

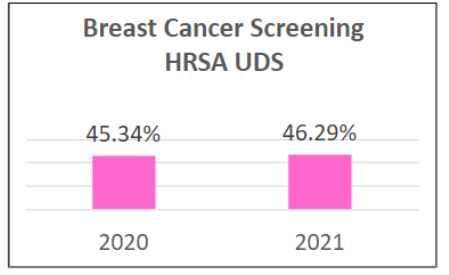
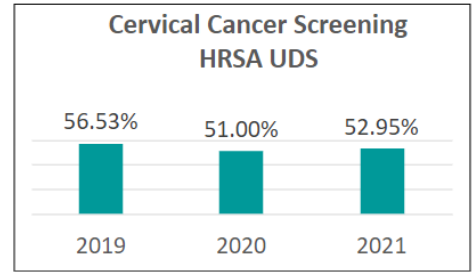
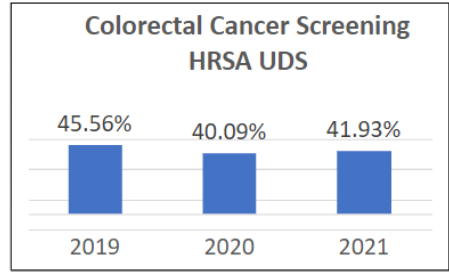
- ✓ How to apply evidence-based care strategies to cancer screening
- ✓ How to apply **CDC's Cancer Screening Change Package**
- ✓ Community Health of South Florida, Inc. health center case study

WHY a systems approach to cancer screening?



- Cancer burden is profound
- Screening and early detection saves lives
- Health centers play an important role in cancer screening and early detection

National screening rates have flatlined



<https://data.hrsa.gov/tools/data-reporting/program-data/national>

Resources: Evidence-Based Care



Action Guide
HIV PREVENTION: PRE-EXPOSURE PROPHYLAXIS (PREP)

NATIONAL ASSOCIATION OF Community Health Centers

The Value Transformation Framework (VTF) is designed to guide health center systems change and can be applied to evidence-based HIV prevention and care. The VTF serves as an organizing framework with action steps that drive improved health outcomes, improved patient and staff experiences, reduced costs, and equity (Quintuple Aim).

WHY is attention to PrEP and nPEP adherence and retention so important?

Pre-exposure prophylaxis (PrEP) and non-occupational post-exposure prophylaxis (nPEP) are medications used to prevent human immunodeficiency virus (HIV) acquisition. PrEP is a daily antiretroviral medication that prevents up to 99% of HIV infections for at-risk populations when taken as directed, and nPEP is indicated in emergent cases 572 hours following a possible or known exposure to HIV outside work settings^{1,2}.

HIV remains a significant public health crisis in the United States (U.S.), especially for traditionally marginalized populations, including men who have sex with men (MSM), transgender women (TGW), people who inject drugs (PWID), and people of color. Approximately 1.2 million Americans are currently living with HIV^{3,4}, though the Centers for Disease Control and Prevention (CDC) reports that the annual number and rate of diagnoses of HIV infection decreased 7% and 8%, respectively, in 2021 compared with 2017.

Decreases in HIV infection were noted in individuals 13-24 years of age and individuals 45 years of age and older⁵. Though promising, the numbers remain far lower than the projected goals of the *End of the Epidemic by 2030 Framework*, highlighting the need for increased uptake in prevention strategies. Screening programs were disrupted by the COVID-19 pandemic, contributing to a decrease in HIV diagnoses in the U.S. and worldwide, underscoring the need to reevaluate HIV prevention efforts^{6,7}.

In 2021, MSM accounted for 67% of new HIV infections⁸. African American and Latinx MSM represent the two highest-risk sub-populations, with 8,883 and 8,000 new HIV infections, respectively, accounting for roughly 57% of HIV infections among MSM⁹. African American MSM have a 50 percent lifetime chance of acquiring HIV¹⁰. Latinx MSM have a 25 percent chance of contracting HIV¹¹.

This Evidence-Based Companion Guide on Pre-exposure Prophylaxis (PrEP) and Non-occupational Post-Exposure Prophylaxis (nPEP) explores the steps to prevent the acquisition of HIV in at-risk populations and support and monitor medication adherence. Used alongside the Evidence-Based Care Action Guide, it offers health centers an actionable roadmap for HIV prevention within the context of whole-person care.

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HIV Prevention Action Guide

VALUE TRANSFORMATION FRAMEWORK
Companion Action Guide >> Evidence-Based Care

NATIONAL ASSOCIATION OF Community Health Centers

HEALTH CENTER

INFRASTRUCTURE CARE DELIVERY PEOPLE

DIABETES CONTROL

Providing diabetes care that improves health outcomes, improves patient and provider experiences, and reduces costs (the Quadruple Aim), requires health centers to couple evidence-based diabetes interventions with larger systems-level change. NACHC's Value Transformation Framework is designed to guide this systems approach to transformation.

WHY is attention to diabetes so important?

The impact of diabetes within the United States population is staggering. Diabetes directly impacts an estimated 114.4 million Americans, with 23.1 million people diagnosed, 84.1 million pre-diabetic, and 7.2 million undiagnosed diabetics. Many more feel the impact of diabetes indirectly. This problem is expected to grow, with at least 15-30% of pre-diabetics developing type 2 diabetes within 5 years without weight loss or moderate physical activity.¹ The highest rates of diabetes are found among minority populations (African Americans, Mexican Americans, Puerto Ricans, and Native Americans) and older Americans.² The percent of community health center patients who have been told they have diabetes is 21% versus 11% in the general population.³

One-third or more patients with diabetes do not meet healthy target levels for blood sugar, blood pressure, or cholesterol.⁴ Without control for these targets, patients with diabetes have a higher risk of serious health complications like heart disease and stroke. Diabetes can lead to kidney failure, lower limb amputations, and adult-onset blindness.⁵

The estimated cost of diabetes in the United States in 2017 was \$327 billion, including \$237 billion for direct medical costs and \$90 billion in indirect costs for disability, time lost from work, and premature death.⁶ The cost of medical care increases significantly for every 1% increase in a patient's glycemic level (for HbA1c above 7%).⁷ If health center patients with uncontrolled diabetes could reduce their HbA1c by just 1.25%, the potential savings in medical costs could exceed \$3.44 billion over three years.⁸

This Evidence-Based Companion Guide on diabetes care explores the evidence-based steps for health centers an actionable road map to track and control diabetes within the context of whole person care.

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Diabetes Control Action Guide

VALUE TRANSFORMATION FRAMEWORK
Companion Action Guide >> Evidence-Based Care

NATIONAL ASSOCIATION OF Community Health Centers

HEALTH CENTER

INFRASTRUCTURE CARE DELIVERY PEOPLE

CANCER SCREENING

Providing cervical and colorectal cancer screening that improves health outcomes, improves patient and provider experiences, and reduces costs (the Quadruple Aim), requires health centers to couple evidence-based cancer screening interventions with larger systems-level change. NACHC's Value Transformation Framework is designed to guide this systems approach to transformation.

WHY is attention to cancer screening so important?

Over 50,000 adults in the United States (U.S.) are expected to die from colorectal cancer in 2019, the third leading cause of cancer-related death.¹ Approximately 13,000 U.S. women will be diagnosed with cervical cancer in 2019, and roughly 4,250 will die.²

Screening to detect polyps or cancer at an early stage has been proven to save lives.³ The United States Preventive Services Task Force (USPSTF) gives a "Grade A"- its highest endorsement—to the recommendation to screen for colorectal cancer from age 50 to 75⁴ and for cervical cancer from age 21 to 65.⁵ The Healthy People 2020 and screening targets for these populations are 70.5% and 93% for colorectal and cervical cancer screening, respectively.⁶

Despite these goals, one quarter of adults 50 – 75 years old have never been screened for colorectal cancer.⁷ In 2016, 67% of eligible adults were up-to-date with colorectal cancer screening (CRCs) as compared to 40% in health centers.⁸ Screening prevalence is lower among immigrants who have been in the U.S. for less than 10 years.⁹

The same trends hold for cervical cancer screening, despite evidence that it also saves lives. In 2015, 81% of eligible women were up-to-date for cervical cancer screening¹⁰ as compared to 56% in health centers.¹¹ Screening rates are lower for older women¹² women with no usual source of care, no health insurance, or public insurance¹³ women with less than a high school education; non-Hispanic Asian women; and women who were US residents for less than 10 years¹⁴

This Evidence-Based Companion Guide on cancer screening explores the evidence-based steps for improving colorectal and cervical cancer screening in health centers. Used alongside the Evidence-Based Care Action Guide, it offers health centers an actionable road map to cancer screening within the context of whole person care.

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Cancer Screening Action Guide

VALUE TRANSFORMATION FRAMEWORK
Companion Action Guide >> Evidence-Based Care

NATIONAL ASSOCIATION OF Community Health Centers

HEALTH CENTER

INFRASTRUCTURE CARE DELIVERY PEOPLE

HYPERTENSION SCREENING & CONTROL

For a health center to identify and manage hypertension in a way that improves health outcomes, improves patient and provider experiences, reduces costs, and addresses equity (the Quintuple Aim), evidence-based HTN interventions must be coupled with larger systems-level change. NACHC's Value Transformation Framework is designed to guide this systems approach to transformation.

WHY is attention to hypertension so important?

Hypertension (HTN) has reached epidemic proportions in the United States. Nearly half of all adults in the U.S. (45%) are diagnosed with HTN or take medication for HTN¹. Sustained, elevated blood pressure puts 2019 alone, high blood pressure contributed to over 1,300 deaths each day.² Patients with hypertension may also be at greater risk of severe illness from COVID-19³. Costs linked to high blood pressure equal about \$131 billion each year in the United States⁴.

Tackling this epidemic requires identification and control of hypertension. Of the 75 million Americans with this condition, approximately 11 million don't know they have it so they are not receiving treatment⁵. Among the nearly 35 million who know about their diagnosis, slightly more than half (16.1 million) do not have it under control⁶.

In health centers, hypertension is the most prevalent chronic condition. Close to 5 million patients (nearly one quarter of all adult health center patients) are diagnosed with high blood pressure, yet 37% of them don't have it under control (defined in health center reporting requirements as <140/90 mm Hg)⁷.

These statistics exist despite significant national and local efforts to reduce and control HTN, including:

- **Million Hearts[®] 2022** by the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS). **Million Hearts[®]** aims to prevent 1 million heart attacks and strokes within 5 years and has set a goal that 80% of patients age 18-85 with high blood pressure will have it under control by 2022. NACHC leads a Million Hearts[®] initiative with health centers across the country.
- **Target: BP[™]** is a national initiative of the American Heart Association (AHA) and the American Medical Association (AMA). **Target:BP[™]** helps local health care organizations improve blood pressure control rates through evidence-based quality improvements.
- The Health Resources and Services Administration (HRSA) promotes blood pressure control through its **Health Center Program**, which recognizes health centers that have achieved the Million Hearts[®] goal. HRSA maintains a **Hypertension Dashboard** to provide a multilevel view of HTN control in health centers.

This Evidence-Based Companion Guide on Hypertension (HTN) screening and control offers evidence-based steps to identify and manage HTN. It serves as a road map for health centers Evidence-Based Care Action Guide.

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Hypertension Action Guide

Resources: Evidence-Based Care



The graphic features a dark blue background on the left with white text and logos. On the right, a pattern of light blue hexagons contains various white icons: a heart with a cross, a hand holding a brain, a hand holding a dollar sign, a hand holding a lightbulb, a hand holding a scale, a hand holding a handshake, a hand holding a clock, and a hand holding a sun. The text on the left includes the National Association of Community Health Centers logo, the title 'BRAIN HEALTH INTEGRATION INTO HEALTH CENTER SERVICES', the 'elevate' logo, and the webinar details: 'Webinar 1: Early Detection of Dementia & Reducing Risk Factors' and 'Wednesday, May 3rd 1-2pm ET'.

NATIONAL ASSOCIATION OF
Community Health Centers®

**BRAIN HEALTH INTEGRATION
INTO HEALTH CENTER SERVICES**

**Webinar 1: Early Detection of Dementia &
Reducing Risk Factors**

Wednesday, May 3rd 1-2pm ET

3-Part Brain Health Webinar Series

1. Early Detection of Dementia & Reducing Risk Factors
2. Care Management for Patients with and at-risk for Dementia & Leveraging Reimbursement Opportunities
3. Health Center Partnerships & Community Linkages to Care for Patients with and at-risk for Dementia

Resources: Evidence-Based Care



Increase the impact of **diabetes prevention and management** at health centers.

Healthy Together is a lifestyle change program that blends:

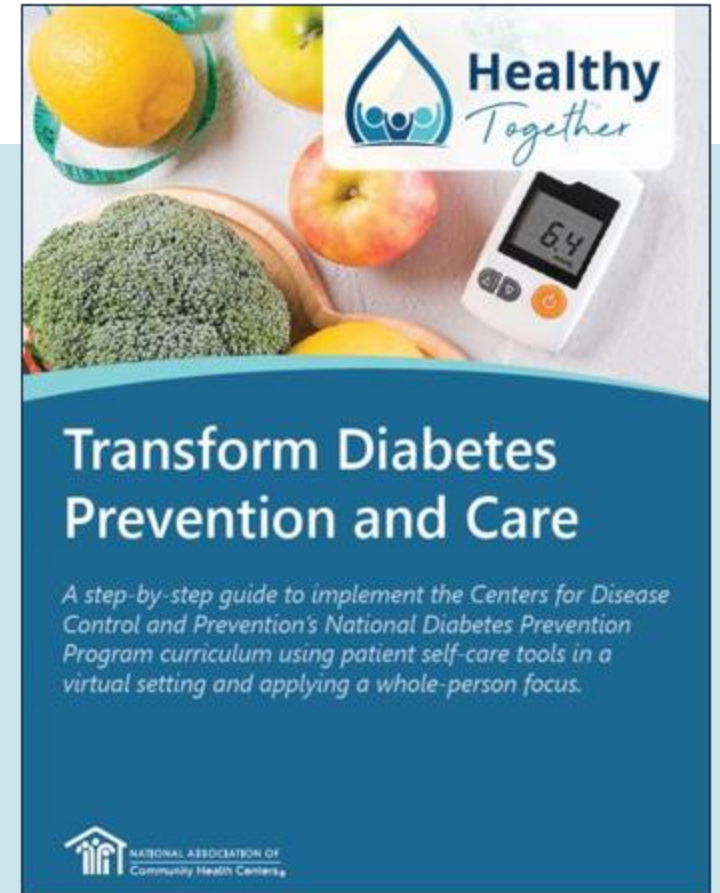
- ✓ Virtual care
- ✓ Self-care tools
- ✓ Lifestyle coaching following the CDC's National Diabetes Prevention Program curriculum

Recorded Webinar: National Diabetes Prevention Program - Basics for Health Centers

Coming Soon: National Diabetes Prevention Program (National DPP) Curriculum Module Recording Library



Healthy Together Project Summary



Healthy Together Action Guide

July: Value-Based Care



What we learned:

- ✓ What value-based care is
- ✓ What some of the available value-based care payment programs are
- ✓ How to get started with value-based care
- ✓ How the VTF and Elevate support value-based care transformation

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:	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • 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:	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • Only available for new or low-revenue ACOs. • Five-year agreement period is required 	<ul style="list-style-type: none"> • Pilot program and no longer receiving new entrants • For primary care practices experienced in value-based care delivery 	<ul style="list-style-type: none"> • 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

Resources: Value-Based Care



Suite of Value-Based Payment

Action Briefs

[Developing VBP Goals](#)

[Attribution](#)

[Attribution Thresholds](#)

[Payor Data](#)

Resources: Value-Based Care



Health Center Value-Based Care Business Analysis Tool

This tool is designed to assist community health centers in evaluating value-based payment options. It provides a process for estimating 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

- 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)
- 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 will be used)
 - Annual costs of non-FTE related expenses

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	Commercial Contract #1	0	\$0	\$0	\$0
Commercial Value-Based Care Programs	Commercial 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

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

Health Center Value-Based Care Glidepath Aligned with the Value Transformation Framework (VTF)

This tool is designed to provide a glidepath or roadmap for a health center's transition to value-based care. It outlines key actions for consideration during three critical phases of transition: planning, implementing, and optimizing. While it recognizes there is no 'right' way or singular path, it offers guidance on crucial steps for consideration at key phases in the journey.

Use this guide as a checklist or reference tool to support organizational conversations and planning for value-based care and achievement of the Quintuple Aim goals: improved health outcomes, improved patient experiences, improved staff experience, reduced costs, and equity.

Feedback and comments are welcome at qualitycenter@nachc.org and will help us improve the tool.

CARE DELIVERY	VTF Change Area	VTF Assessment Tool Question Set	<input checked="" type="checkbox"/>	Task	Planning	Implementing	Optimizing
	Population Health Management	Data sources			Analyze existing value-based care models for model effectiveness, risk level, and eligibility		
Risk Stratification; Empanelment				Develop a strategy for risk stratification and supporting stratified care management and coordination			
				Use risk stratification to identify and manage high-risk individuals			
				Support multiple levels of analysis (population, provider, patient)			
Patient-Centered Medical Home	Application of PCMH model			Evaluate current methods to track patient engagement and identify key areas for improvement			
				Train staff in patient experience/engagement			
Evidence-Based Care	Evidence-Based Guidelines			Using best-practice research, develop a specific strategy to support highly complex patients			
	Care Gaps			Develop defined care pathways specific to patient's diagnosis and risk level; strategies to address gaps in care			
				Integrate behavioral health into primary care			
Care Coordination/Management	Care Coordination & Referrals			Assess care coordination/care management capabilities			
				Assess the care continuum network in your community, including clinical outcomes and efficiency of specialists and health systems; develop a process for referrals and coordination of care			
	Transitions of Care			Develop care transition protocols to reduce avoidable emergency room visits and hospital admissions			
				Based on assessment findings, develop or expand care management capabilities			
Social Drivers of Health	SDOH Assessment			Explore value-add and/or revenue generating opportunities through care coordination/care management services			
				Identify social drivers that impact individuals in your community			
	SDOH Interventions; Healthy Equity			Select social drivers of health screening tool, if not already done			
			Develop a process to leverage resources across the health care and social service spectrum to meet patient population needs and enhance equity.				

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VBC Glidepath for health centers to begin Value-Based Care

August





What we learned:

- ✓ How health centers can incorporate the patient perspective into
 - Individual care
 - Care system design
 - Governance
- ✓ Case studies from
 - Grace Health
 - Eastern Shore Rural Health
 - AllianceChicago

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

Resources: Patient Engagement



The image shows the cover of a report titled 'VALUE TRANSFORMATION FRAMEWORK Action Guide' for 'HEALTH CENTER'. The cover features a dark blue header with the National Association of Community Health Centers logo. Below the title, there are three navigation buttons: 'CARE DELIVERY', 'INFRASTRUCTURE', and 'PEOPLE', with 'PEOPLE' being the active selection. The main content area is divided into two columns. The left column is titled 'PATIENTS PATIENT ENGAGEMENT' and 'WHY Engage Patients In Care?'. The right column is titled 'PATIENT ENGAGEMENT'. The bottom of the cover features a list of bullet points and a small icon of a clipboard with a checkmark.

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 Care¹³—all address patient engagement in their core principles.

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 preferences¹⁵.
- **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 basis¹⁶.

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Patient Engagement Action Guide



What we learned:

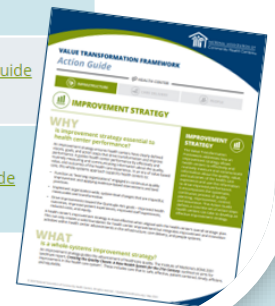
- ✓ How to leverage PCMH as the foundation to value-based care transformation
- ✓ Alignment between NCQA PCMH, HRSA Health Center Program Requirements, and NACHC VTF
- ✓ Voices from the field: how health centers are leveraging PCMH

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>





Finding Alignment - NCQA PCMH, HRSA Requirements, and the VTF

It may feel daunting to keep up with the many requirements of all the programs in which health centers participate! Thankfully, there is often alignment or areas of similarity across these programs.

This course highlights alignments across NACHC's [Value Transformation Framework](#) (VTF), [National Committee for Quality Assurance's](#) (NCQA) [Patient Centered Medical Home](#) (PCMH) program, and the [Health Resources and Services Administration](#) (HRSA) health center program requirements.



Finding Alignment: NCQA PCMH, HRSA Requirements, and the VTF Microlearning

November: Partnerships



What we learned:

- ✓ A message on Partnerships from NACHC's President & CEO, Dr. Kyu Rhee
- ✓ How to build successful partnerships
- ✓ Health center case studies from
 - LaMaestra Community Health Centers
 - Valley Health Partners

A Message on *Partnerships* from NACHC's President & CEO



Providers



Payers



Purchasers



Policymakers



Producers



Pioneers



Patients

Elevate 2023



2023 Supplemental Sessions

Launch of Health Center Staff Professional Development Courses



2023 Core Elevate Learning Forums

The Journey Continues in 2024!



Professional Development

Enhancing skills to support health center transformation

Professional Development



8 Professional Development Offerings to Health Center Staff!



- Care Managers (essentials)
- Care Managers (intermediate)
- Care Management Supervisors
- Community Health Workers (CHWs)
- CHW Supervisors
- Diabetes Care Professionals
- Elevated BMI Care Professionals
- Quality Improvement (QI) Staff



640+ applicants
249 participants

Trainings
Sept - Dec 2023



The Journey Continues in 2024

Health Center Next Steps



Your 2024 transformation Journey begins here!



STEP 1 - ENGAGE
Invite others to Register for Elevate



STEP 2 - ASSESS
Complete VTF Assessment at the beginning of 2024 (assess/reassess)



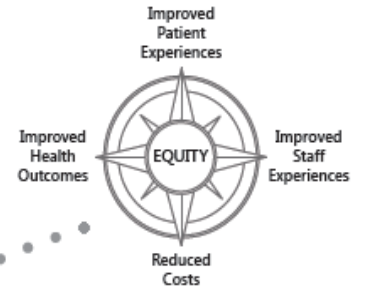
STEP 3 - PLAN
Select target areas/measures for your Improvement Strategy



STEP 4 - TRANSFORM
Engage in Elevate to access transformation tools and resources

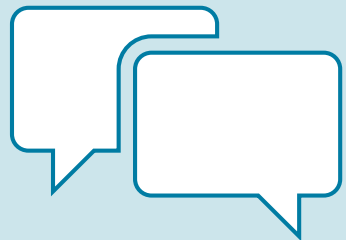


STEP 5 - REASSESS
Reassess using the VTF Assessment



We've Heard From You!

- ✓ *Reconsider the name 'Elevate' as it is sometimes confused with other programs with same name*
- ✓ *Connect more closely with other NACHC work*
- ✓ *Showcase field examples of what's working and 'best' practices*
- ✓ *Provide additional opportunities for peer exchange*
- ✓ *Link the transformation journey to health center's ongoing QI efforts and health center and PCA/HCCN workplans*



Monthly Forums: New Format

- ✓ **Short evidence-based content (<10 mins) that focuses on Change Area/s for the month**
 - With additional, robust asynchronous learning opportunities outside of monthly forums
- ✓ **Health Center Field Example (<10 mins)**
- ✓ **PCA/HCCN Sharing (<10 mins)**
- ✓ **Breakout Rooms (by health center roles)**
 - Leadership, clinician, care management, operations, finance, etc.
- ✓ **Field input into learning community content and curriculum**



Other New Features

- ✓ **Supplementary Trainings: Care Management, Quality Improvement, etc.**
- ✓ **Innovation Opportunities**
- ✓ **Professional Development**
- ✓ **New Learning Formats (short videos, eLearning, podcasts, etc.)**



Elevate Presenters & Faculty

- ✓ **Health Center 2022 HRSA Gold Quality Badge Awardees**
- ✓ **PCA/HCCN partners**
- ✓ **Interested health centers**
- ✓ **NACHC subject matter experts**
- ✓ **Consultants, as needed/appropriate**



Your Input on a 2024 Name is Needed!!

We need your vote! Do you think we should...

- ✓ **Keep the name 'Elevate'**
- ✓ **Change to a new name**
- ✓ **If you selected to 'change to a new name', do any of these options resonate?**
 - Transformation Collaborative
 - Transformation Learning Hub
 - TransforNATION
 - Valued Care Collaborative
 - Other: specify _____

How Would You Describe the Work?

For YOU and other staff in your health center (or health centers you work with), which phrase best describes the work of value transformation and systems change?

- ✓ Ignite Change; Transform Lives
- ✓ Smarter Together
- ✓ Change Makers
- ✓ Committed to Excellence in Care
- ✓ Building Better Health, One Change at a Time
- ✓ Part of Something Bigger
- ✓ Other: specify _____

Elevate Awards





Most VTF Assessments completed in 2023

congratulations



One Health/Bighorn Valley Health Center
(Montana)
with 15 Assessments!

Elevate Awards



The VTF is the framework for our 2024 Quality and Risk Plan. We had board members, senior leadership, and directors take the VTF Assessment. We chose the three areas where we scored the lowest – Population Health, Care Coordination and Management, and Workforce to focus our efforts on next year. Each area has a committee comprised of staff from all departments and disciplines who will be working on goals to help us move to the next level in the VTF survey.

We've found such great resources and support from NACHC's VTF and would highly recommend that other CHC's check out the assessment process to aid in developing transformation goals for their health centers! Thank you for this recognition.





Most PCA/HCCN VTF Assessments completed in 2023

congratulations



Asociación de Salud Primaria de Puerto Rico, Inc.
with 4 Assessments!

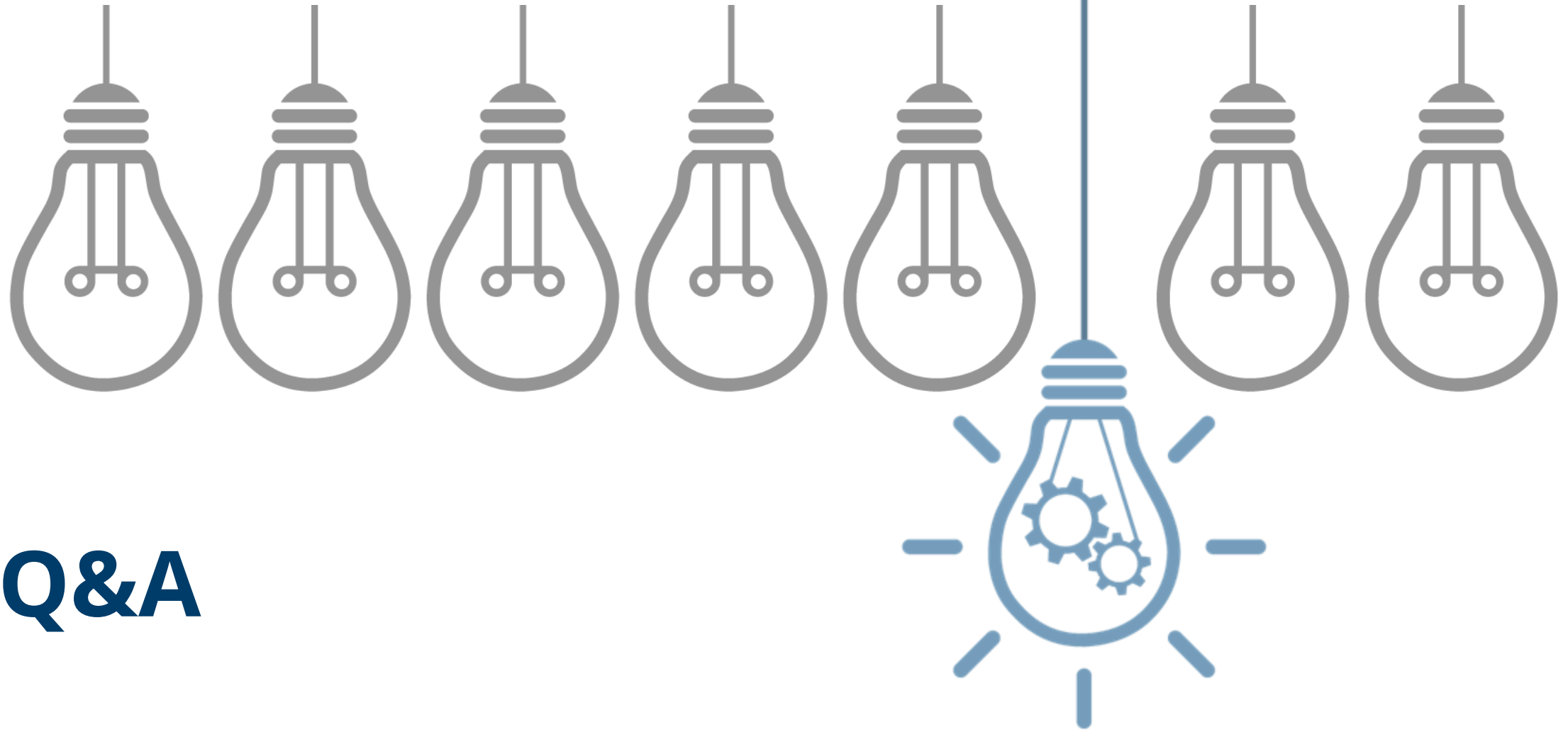


Most Elevate Registrants

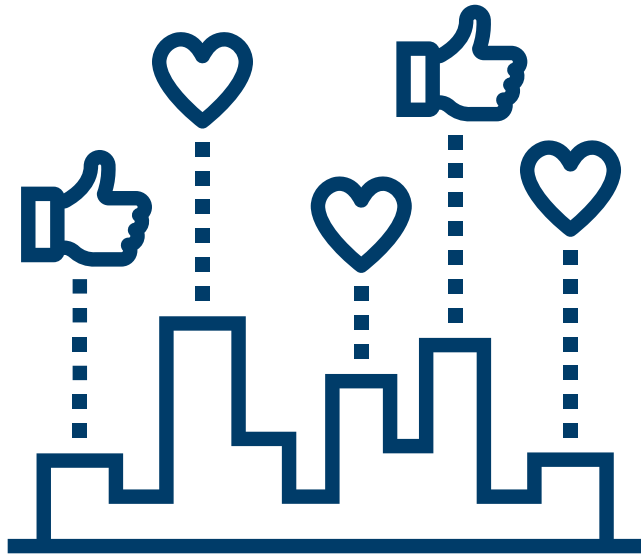
congratulations



International Community Health Services
(Washington)
with 41 Registrants!



Q&A



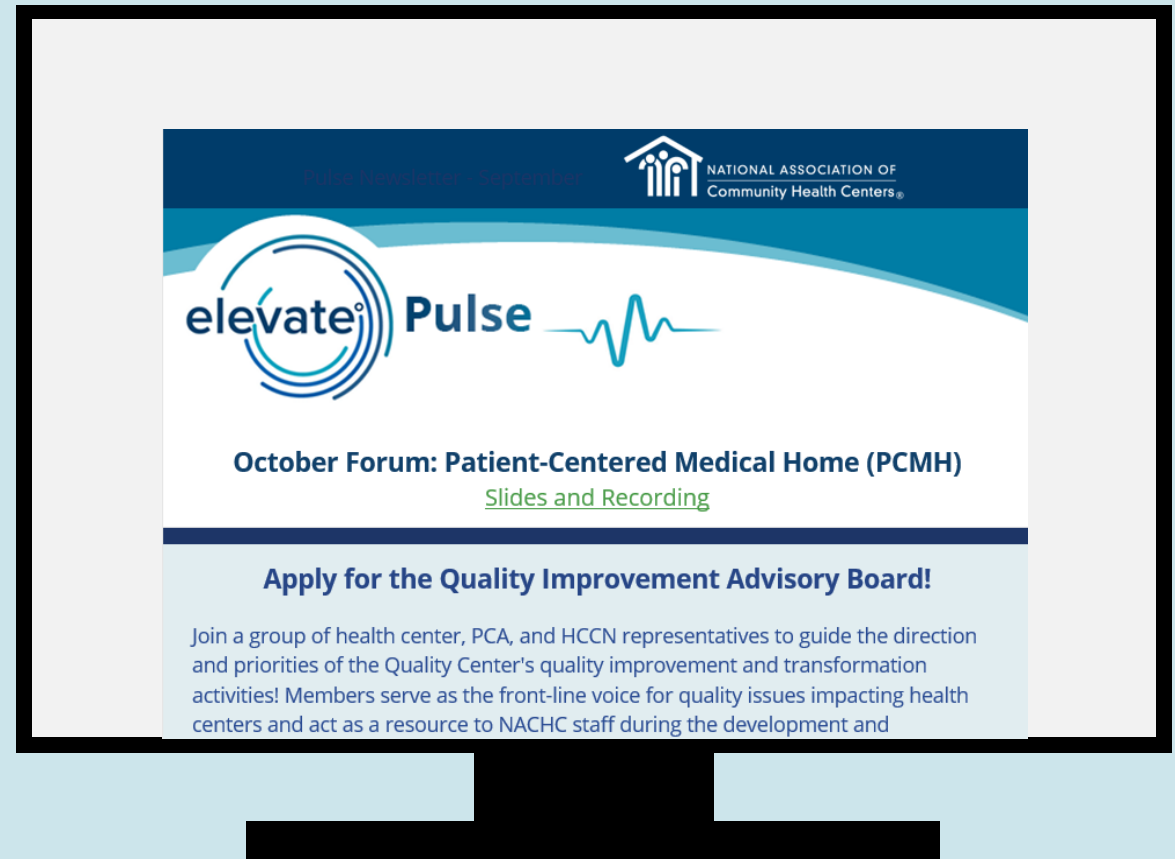
Provide Us Feedback

Elevate Pulse

Be on the lookout for the **Elevate Pulse** from the **NACHC Quality Center**:

- ✓ Slides & recordings
- ✓ Tools & resources
- ✓ Upcoming opportunities

Sent the 2nd Friday of each month!



CONTROLLING HYPERTENSION LEARNING SERIES:



NATIONAL ASSOCIATION OF
Community Health Centers®



The 4 Most Impactful Strategies & Tools to Achieving Success

Learn from American Medical Association experts about the four most impactful strategies to improve blood pressure control, and how high-performing health centers have implemented these strategies with great success!



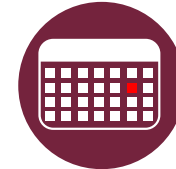
TREATMENT INTENSIFICATION

01/10/2024
3:00 - 4:00 pm ET



MEDICATION ADHERENCE

01/17/2024
3:00 - 4:00 pm ET



RAPID FOLLOW-UP

02/21/2024
3:00 - 4:00 pm ET



SMBP

02/28/2024
3:00 - 4:00 pm ET

REGISTER TODAY!



FOR MORE INFORMATION CONTACT
qualitycenter@nachc.org

Cheryl Modica
Director, Quality Center
National Association of Community Health Centers
cmodica@nachc.org
301.310.2250

2024 Kick-off Session!!!

January 9, 2024
1:00 – 2:00 pm ET

***Coming in 2024: Streamlined
process to register each month for
Elevate Learning Forums!***

*Registration links will be shared in the Elevate
Pulse Newsletter*

*Recommendation: Add a reoccurring placeholder
to your calendar to block the time (2nd Tuesday
of each month, 1-2pm ET)*

NACHC Quality Center



Cheryl Modica
Director,
Quality Center



Cassie Lindholm
Deputy Director,
Quality Center



Holly Nicholson
Deputy Director,
Learning & Development



Tristan Wind
Manager,
Quality Center



Rachel Barnes
Specialist,
Quality Center



elevate°

**Together, our
voices elevate° all.**

The Quality Center Team

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

qualitycenter@nachc.org