NATIONAL ASSOCIATION OF Community Health Centers®

ELEVATE NATIONAL LEARNING FORUM

elevate

Year In Review

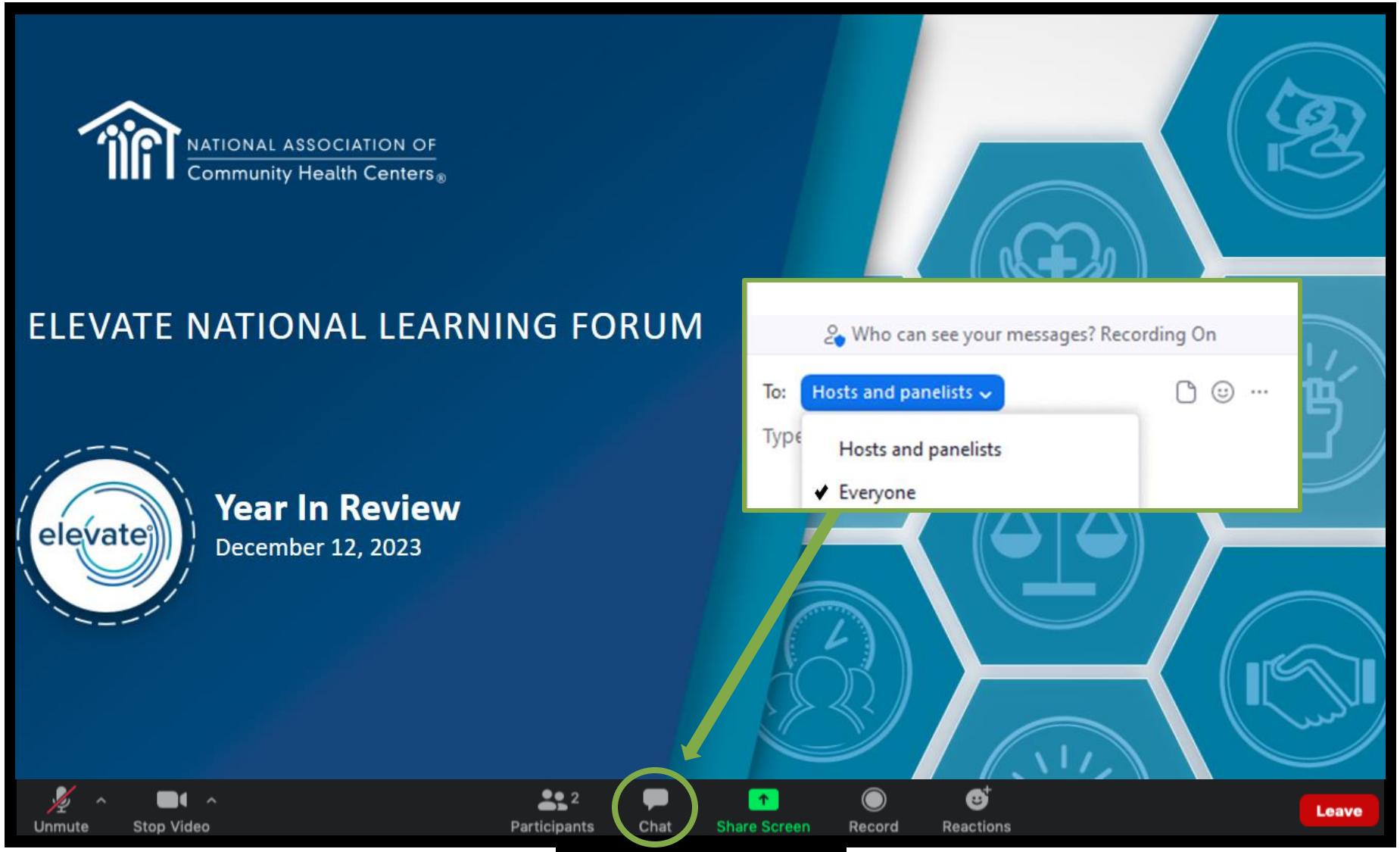
December 12, 2023

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.

NATIONAL ASSOCIATION OF Community Health Centers®



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,
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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 **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

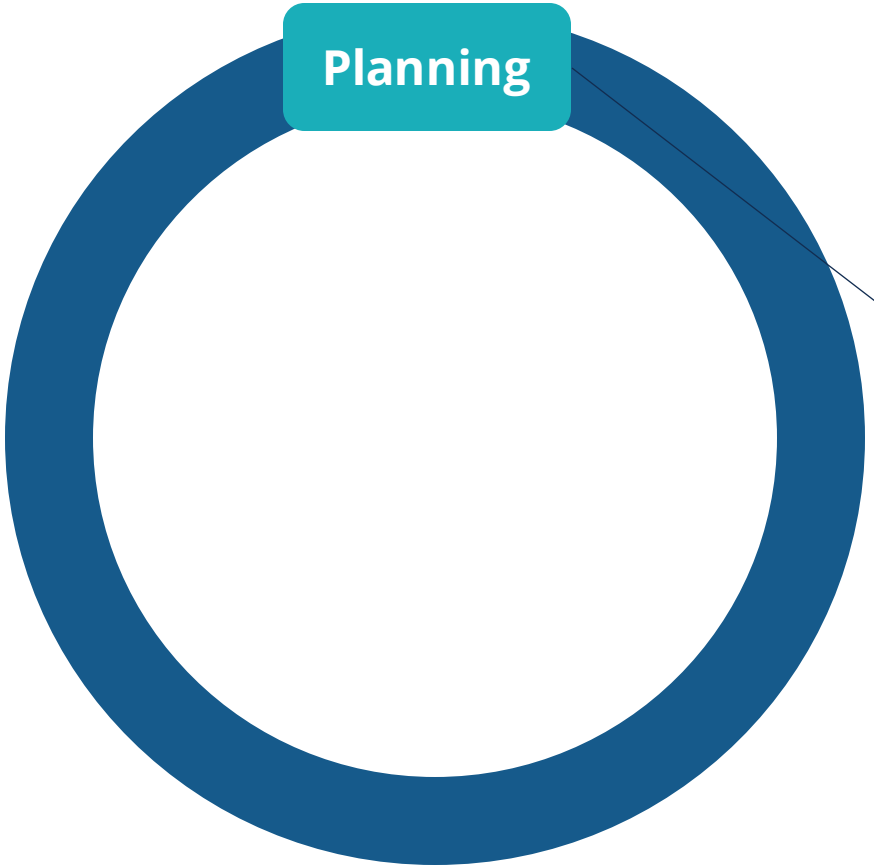
STEP 2: ASSESS

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

STEP 3: PLAN

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



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

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.

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.

WHAT

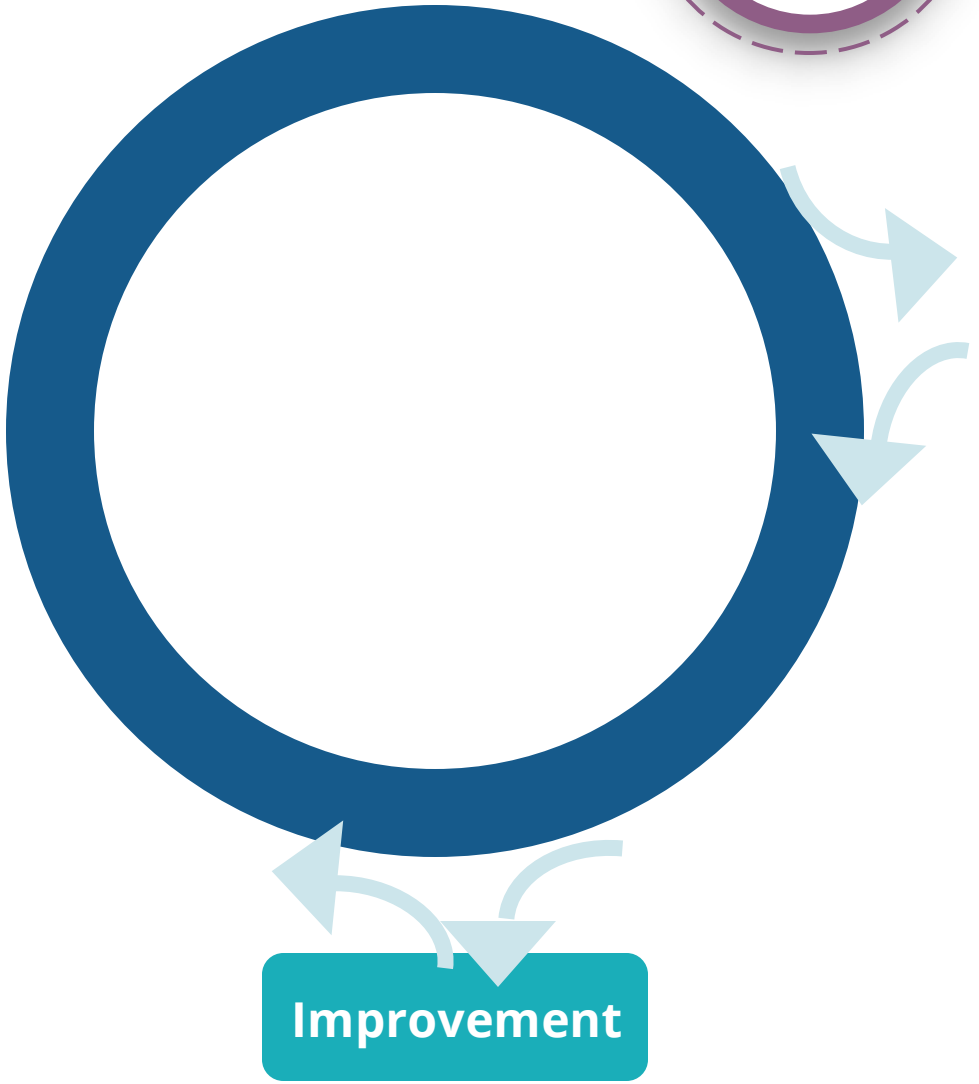
is a whole-systems improvement strategy?

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.

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.



Year In Review:

2023 Learning Forums & Related Resources

NATIONAL ASSOCIATION OF Community Health Centers®

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

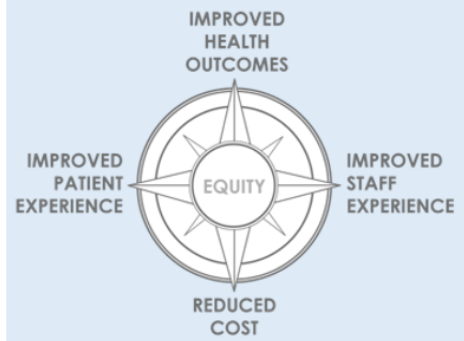
WHY is Leadership Critical to Transformation?

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.

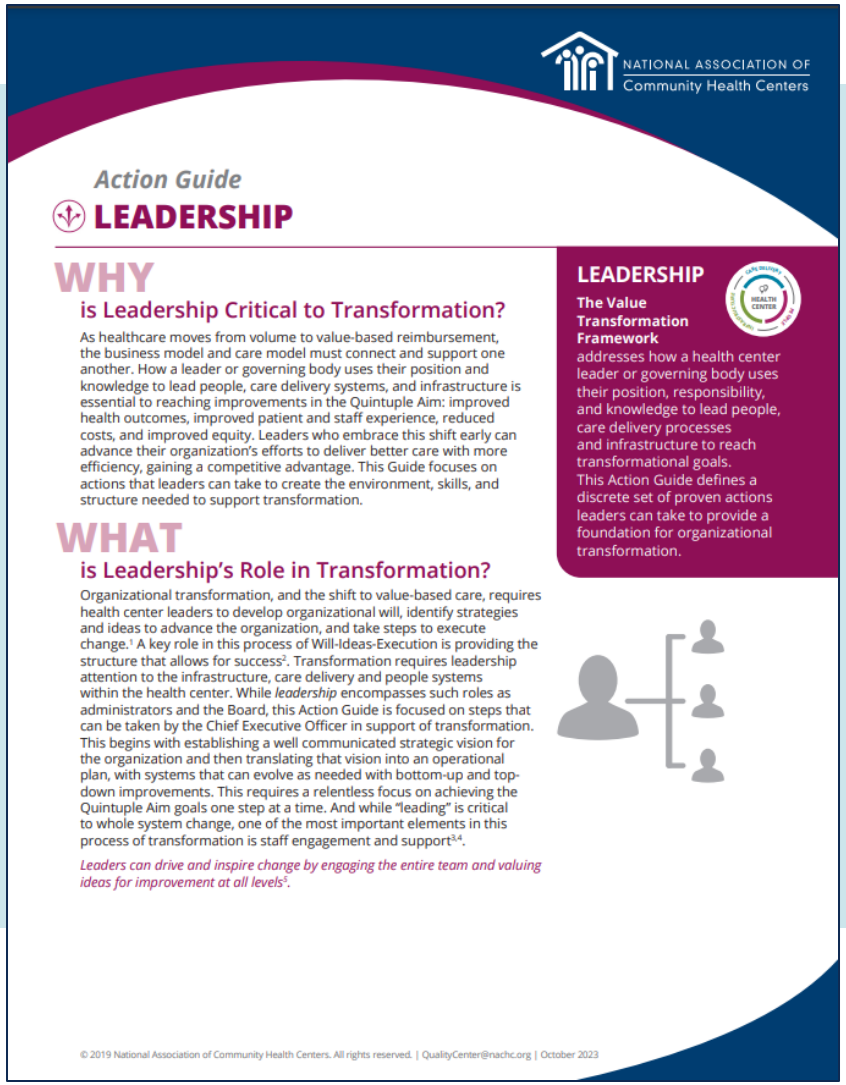
Leaders can take action to create the **environment, skills, and structure needed to support transformation.**

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



January Learning Forum Recording

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.

Leadership Action Guide

February: Population Health Management

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.

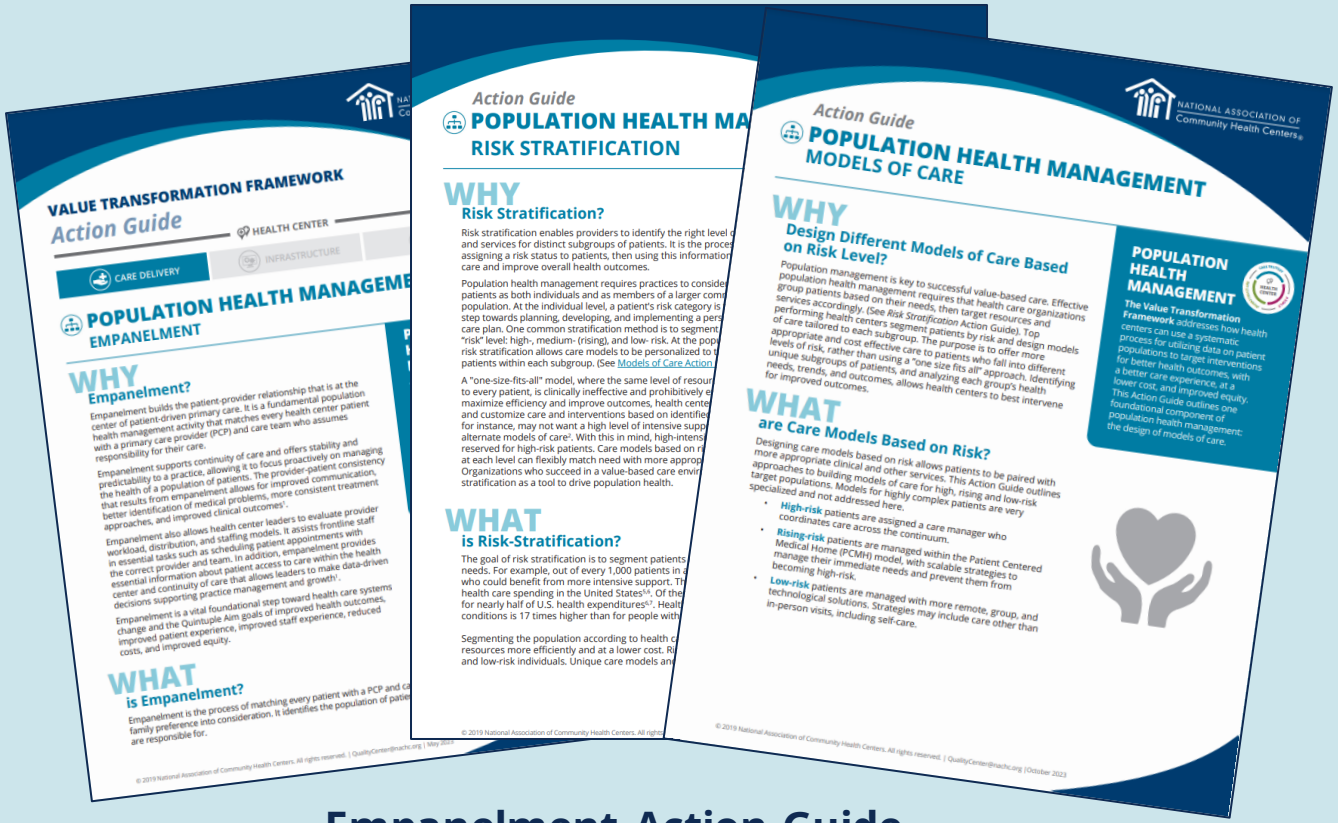
Segmenting patients into distinct groups of similar complexity and care needs to better target care and services.

Low Risk	*Focus is keeping patients engaged in the health care system without use of unnecessary services.*
Rising Risk	*Focus is on managing risk factors more than disease conditions.*
High Risk	*Requires structured care management and one-on-one support.*
Highly Complex	*Requires intensive, pro-active care management.*

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

February Learning Forum Recording

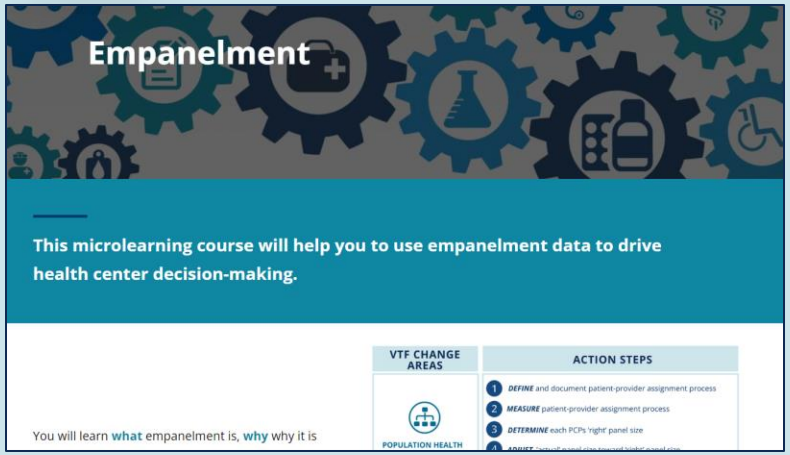
Resources: Population Health Management



[Empanelment Action Guide]

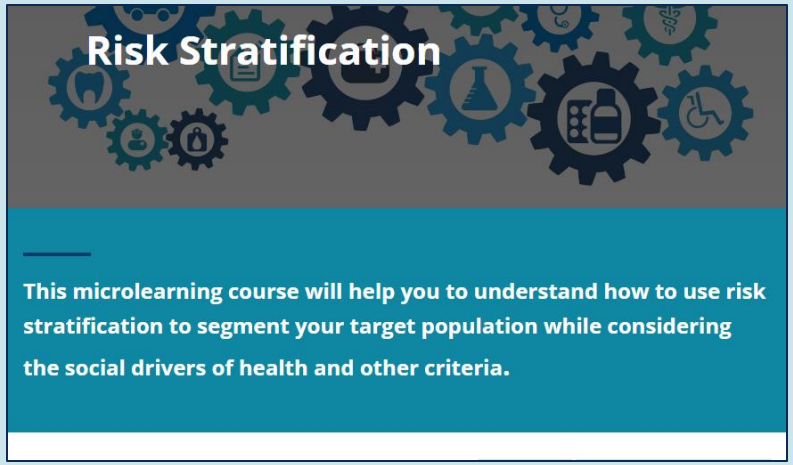
[Risk Stratification Action Guide]

[Models of Care Action Guide]



[Empanelment Microlearning]

[Risk Stratification Microlearning]



March: Care Teams & Care Management

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

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.

Care Management

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.

[March Learning Forum Recording]

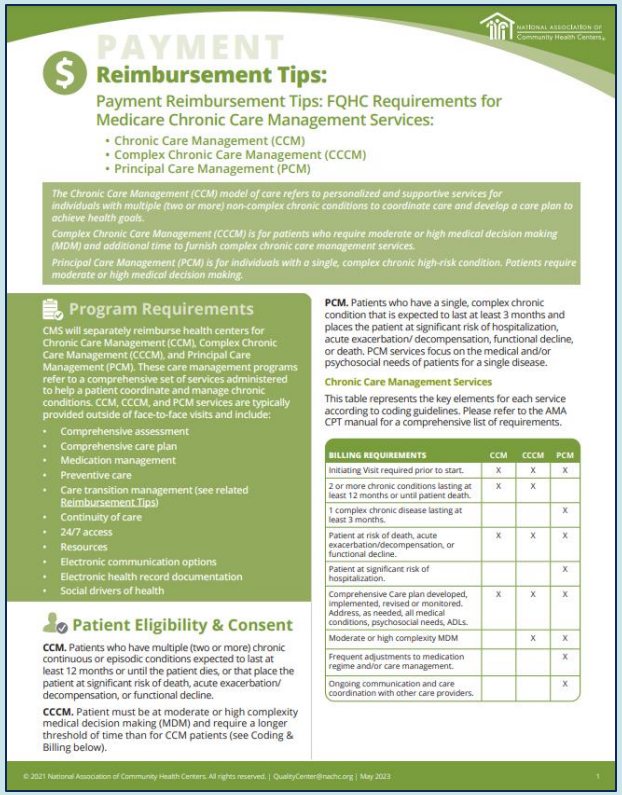
Resources: Care Management

[Care Management Action Guide]

[TCM Microlearning]

[AWV Microlearning]

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 continuous 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).

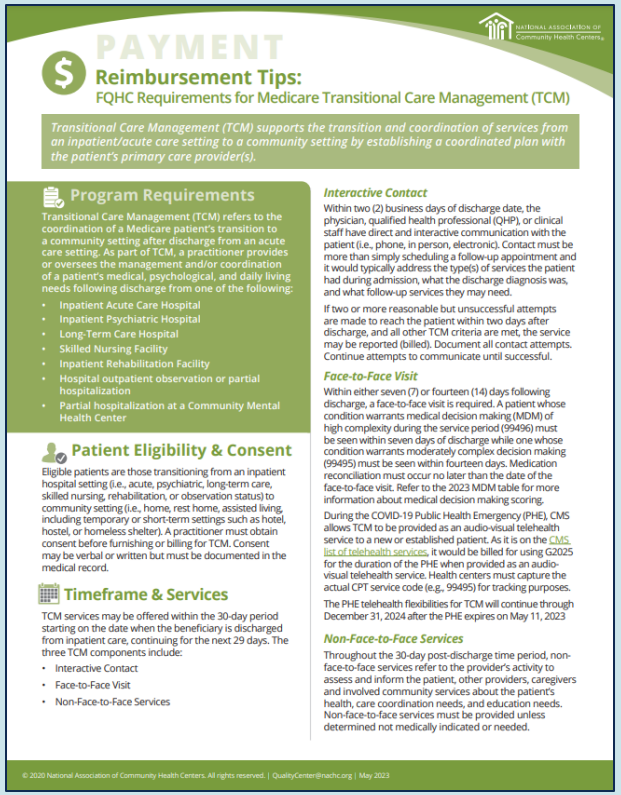
PCM. Patients who have a single, complex chronic condition that is expected to last at least 3 months and places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death. PCM services focus on the medical and/or psychosocial needs of patients for a single disease.

Chronic Care Management Services

This table represents the key elements for each service according to coding guidelines. Please refer to the AMA CPT manual for a comprehensive list of requirements.

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, psychosocial needs, ADLs.	X	X	X
Moderate or high complexity MDM		X	X
Frequent adjustments to medication regime and/or care management.			X
Ongoing communication and care coordination with other care providers.			X

[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.

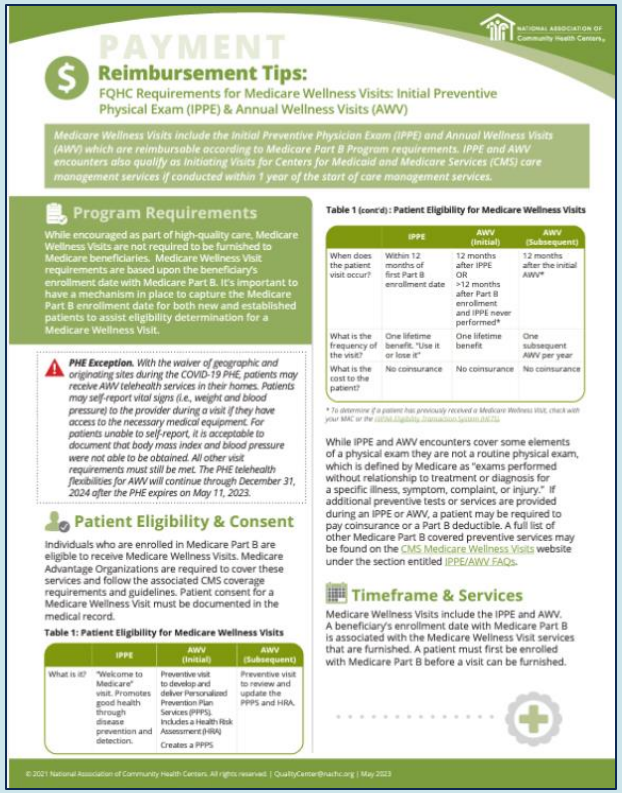
During the COVID-19 Public Health Emergency (PHE), CMS allows TCM to be provided as an audio-visual telehealth service to a new or established patient. As it is on the CMS list of telehealth services, it would be billed for using G2025 for the duration of the PHE when provided as an audio-visual telehealth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

[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.

Table 1 (cont'd): Patient Eligibility for Medicare Wellness Visits

	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 IntNet Eligibility Transaction System (NETS).*

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.

Table 1: Patient Eligibility for Medicare Wellness Visits

	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 Prevention Plan Services (PPPS). Includes a Health Risk Assessment (HRA). Creates a PPPS	Preventive visit to review and update the PPPS and HRA.

While IPPE and AWV encounters cover some elements of a physical exam they are not a routine physical exam, which is defined by Medicare as "exams performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury." If additional preventive tests or services are provided during an IPPE or AWV, a patient may be required to pay coinsurance or a Part B deductible. A full list of other Medicare Part B covered preventive services may be found on the CMS Medicare Wellness Visits website under the section entitled IPPE/AWV FAQs.

Timeframe & Services

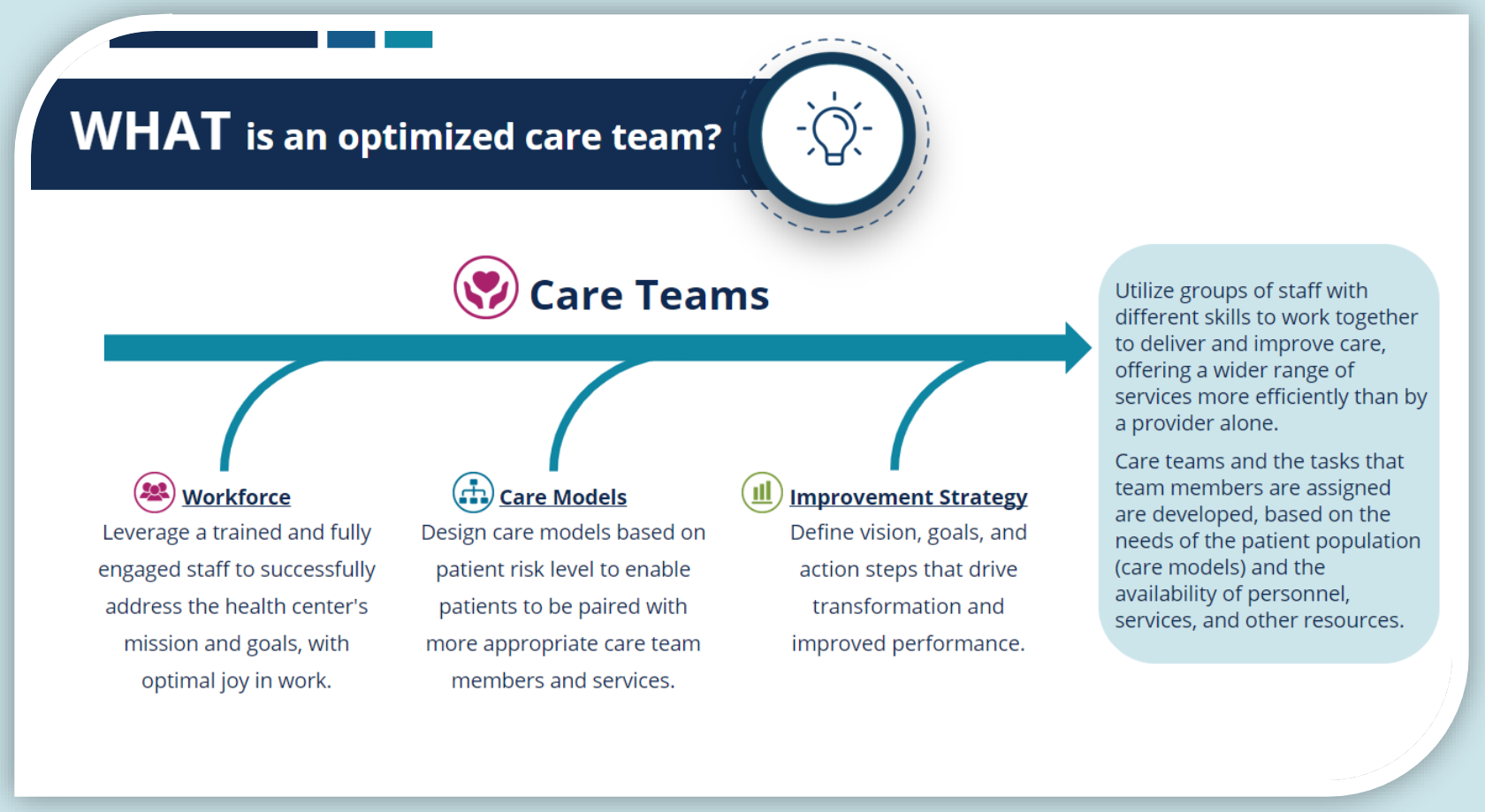
Medicare Wellness Visits include the IPPE and AWV. A beneficiary's enrollment date with Medicare Part B is associated with the Medicare Wellness Visit services that are furnished. A patient must first be enrolled with Medicare Part B before a visit can be furnished.

[AWV Reimbursement Tips]

April: Optimizing Care Teams

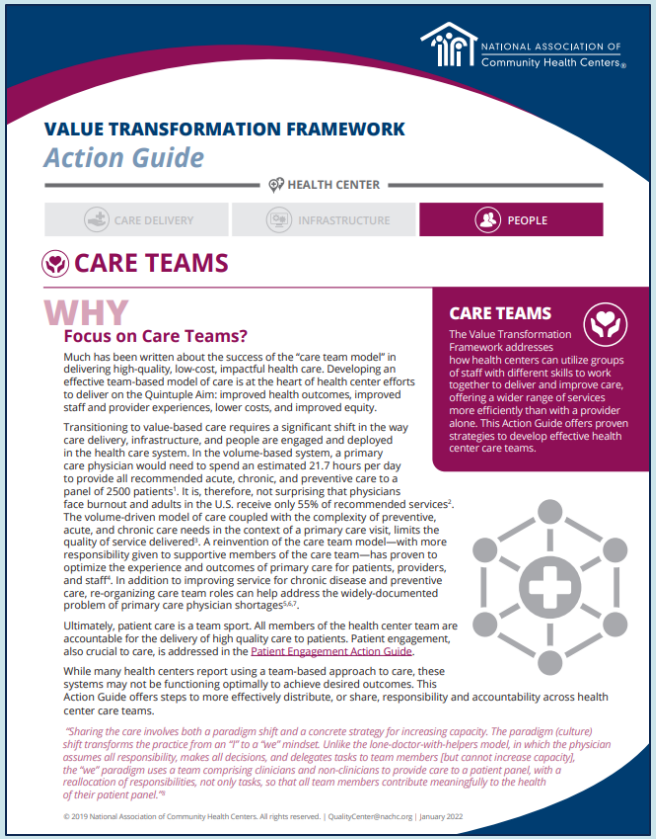
What we learned:

- ✓ 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*



April Learning Forum Recording

Resources: Care Teams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VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

CARE TEAMS

WHY

Focus on Care Teams?

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

Transitioning to value-based care requires a significant shift in the way care delivery, infrastructure, and people are engaged and deployed in the health care system. In the volume-based system, a primary care physician would need to spend an estimated 21.7 hours per day to provide all recommended acute, chronic, and preventive care to a panel of 2500 patients[1]. It is, therefore, not surprising that physicians face burnout and adults in the U.S. receive only 55% of recommended services[2]. The volume-driven model of care coupled with the complexity of preventive, acute, and chronic care needs in the context of a primary care visit, limits the quality of service delivered[3]. A reinvention of the care team model—with more responsibility given to supportive members of the care team—has proven to optimize the experience and outcomes of primary care for patients, providers, and staff[4]. In addition to improving service for chronic disease and preventive care, re-organizing care team roles can help address the widely-documented problem of primary care physician shortages[5,6,7].

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

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

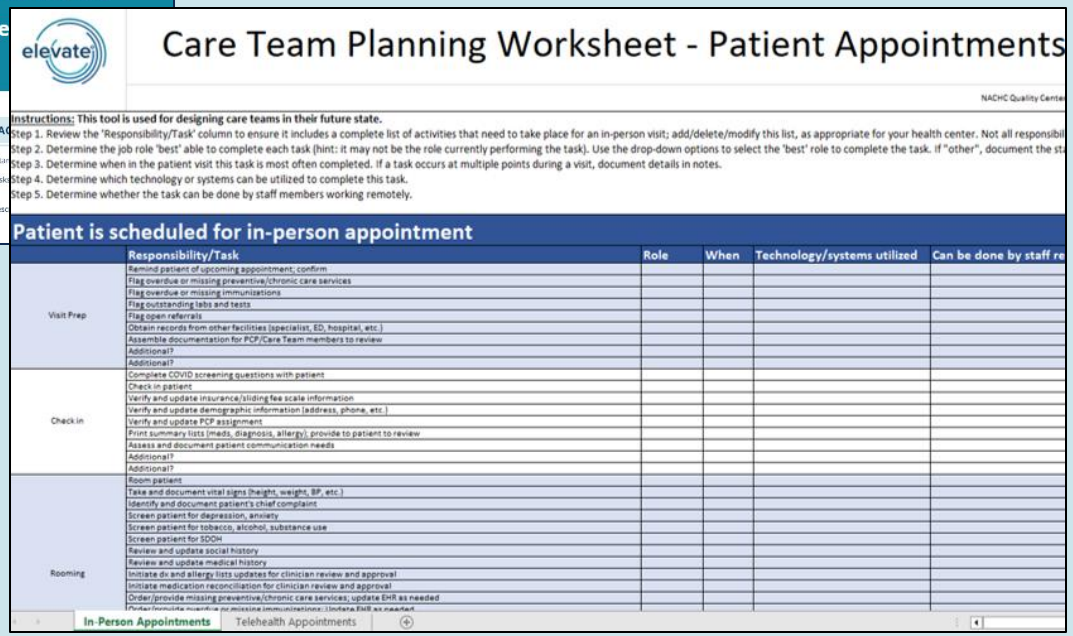
CARE TEAMS

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

"Sharing the care involves both a paradigm shift and a concrete strategy for increasing capacity. The paradigm (culture) shift transforms the practice from an "I" to a "we" mindset. Unlike the lone-doctor-with-helpers model, in which the physician assumes all responsibility, makes all decisions, and delegates tasks to team members [but cannot increase capacity], the "we" paradigm uses a team comprising clinicians and non-clinicians to provide care to a patient panel, with a reallocation of responsibilities, not only tasks, so that all team members contribute meaningfully to the health of their patient panel."[8]

[Care Teams Action Guide]

[Care Teams Microlearning]

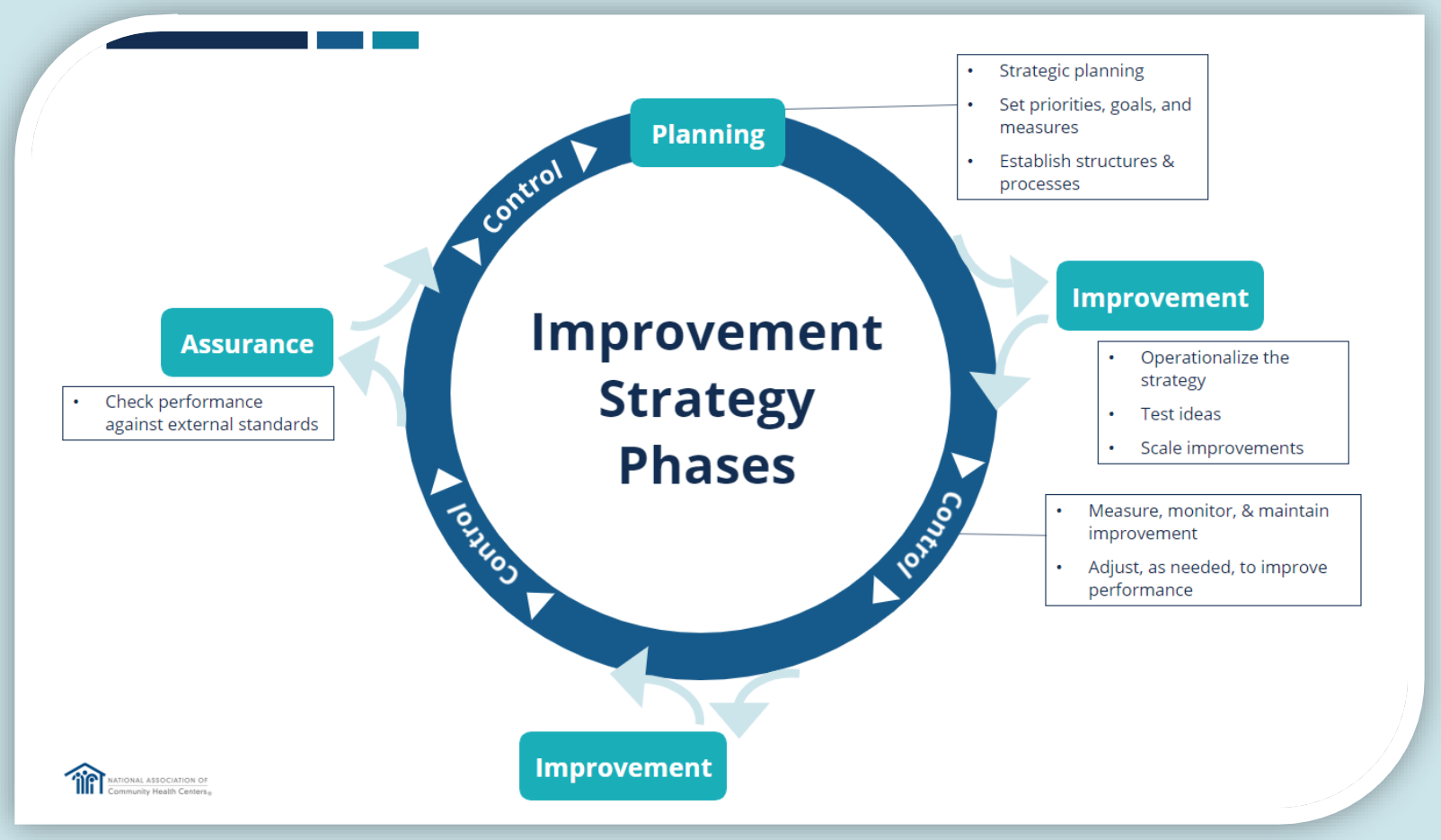


[Care Team Planning Worksheet]

May: Improvement Strategy

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



May Learning Forum Recording

Resources: Improvement Strategy

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IMPROVEMENT STRATEGY

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- Function as "learning organizations" engaged in continuous quality improvement and applying evidence-based interventions and best practices.
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- Drive improvements toward the Quintuple Aim goals – improved health outcomes, improved patient experiences, improved staff experiences, reduced costs, and equity.

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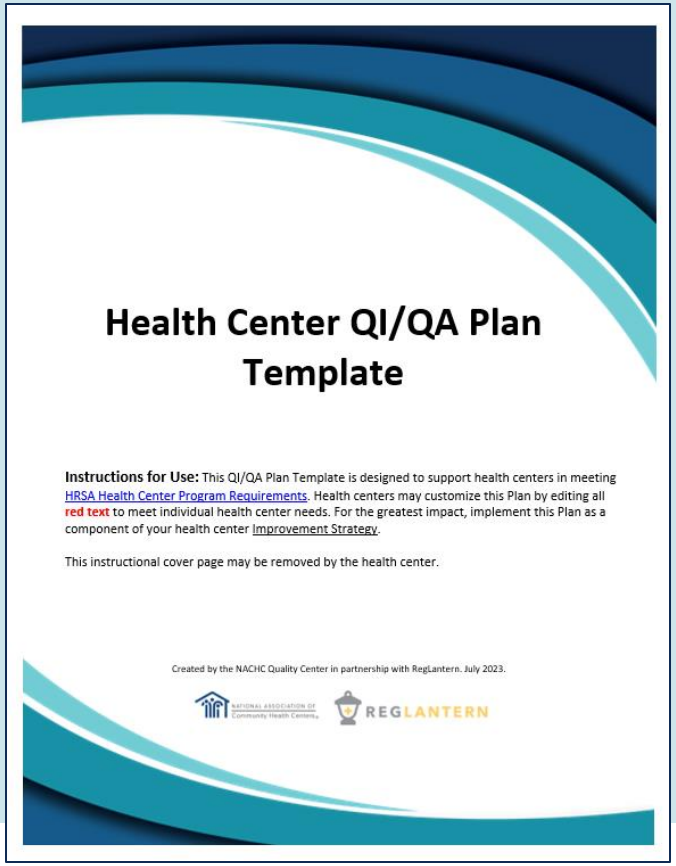
A health center's improvement strategy is most effective when aligned with the health center's overall strategic plan. This not only creates a solid foundation for health center improvement but integrates improvement and innovation activities within health center advancements in the infrastructure, care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

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[1] – much like NACHC's approach to health center systems change using the Value Transformation Framework.

[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.

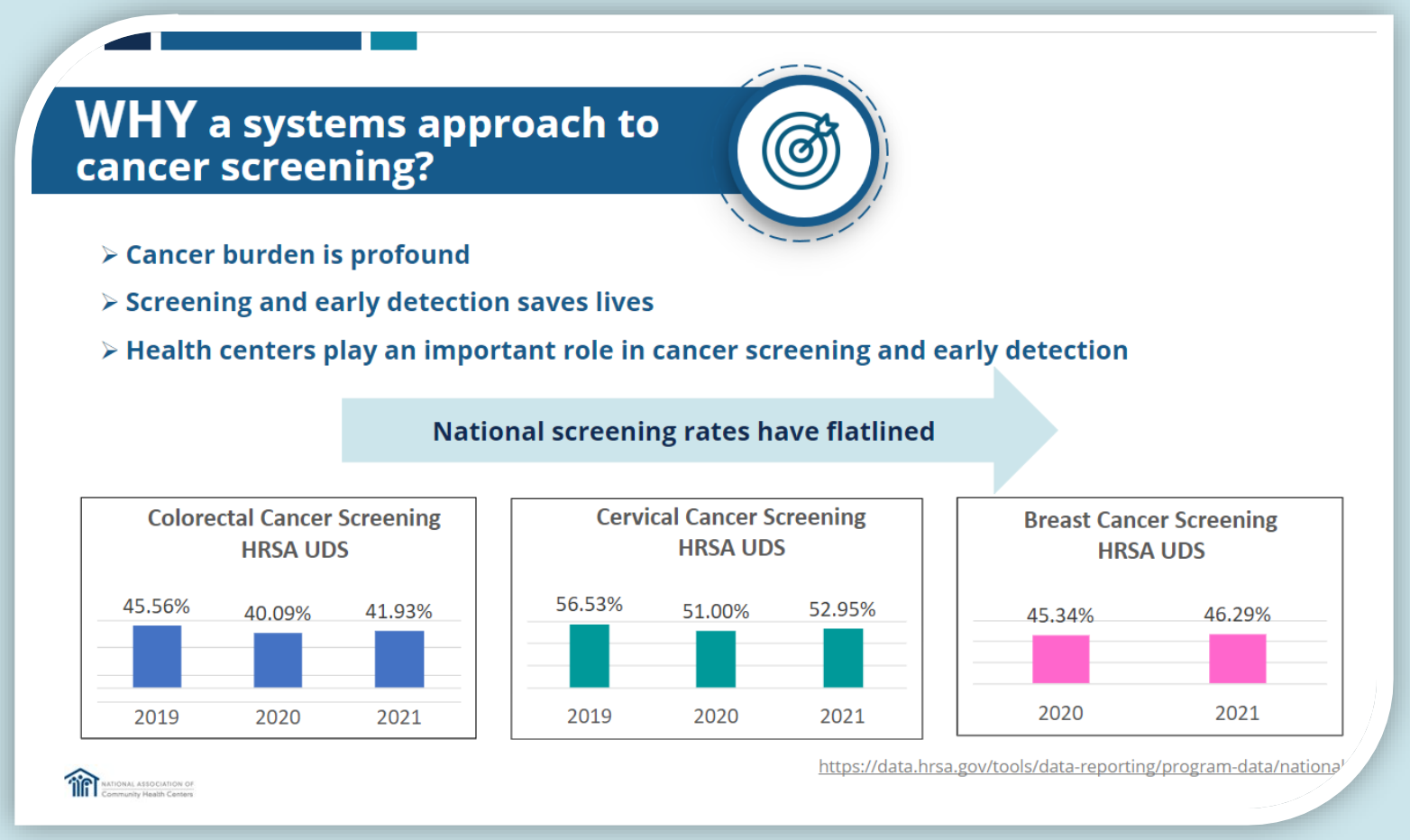
NATIONAL ASSOCIATION OF Community Health Centers® REGLANTERN

[QI/QA Plan Template]

June: Evidence-Based Care

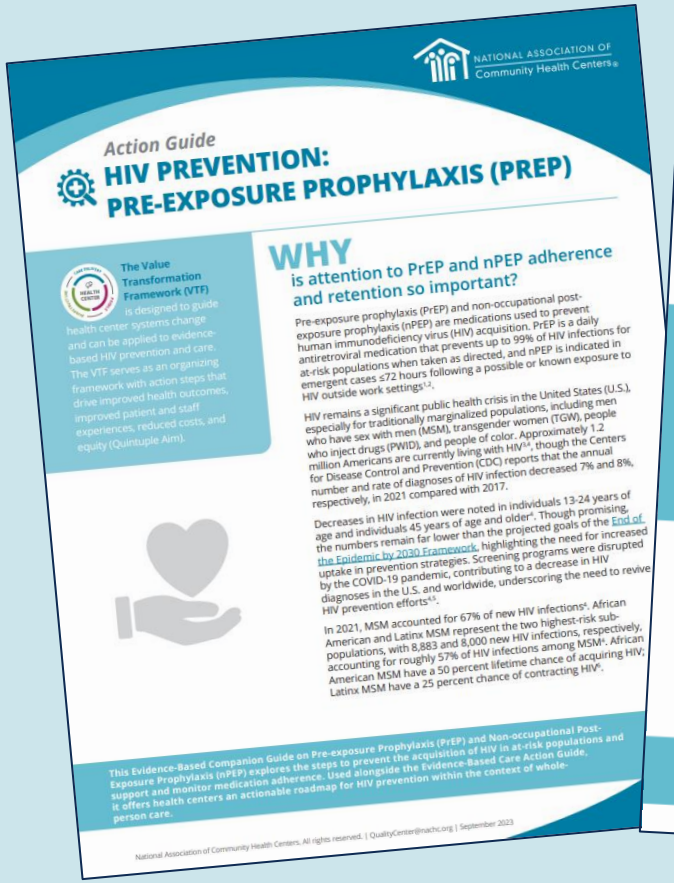
What we learned:

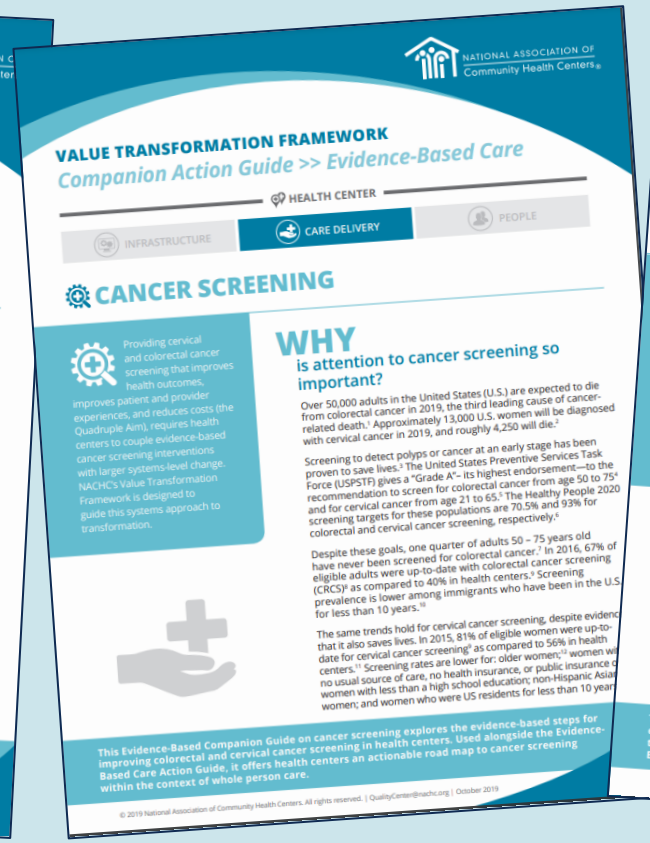
- ✓ How to apply evidence-based care strategies to cancer screening
- ✓ How to apply **CDC's Cancer Screening Change Package**
- ✓ Community Health of South Florida, Inc. health center case study

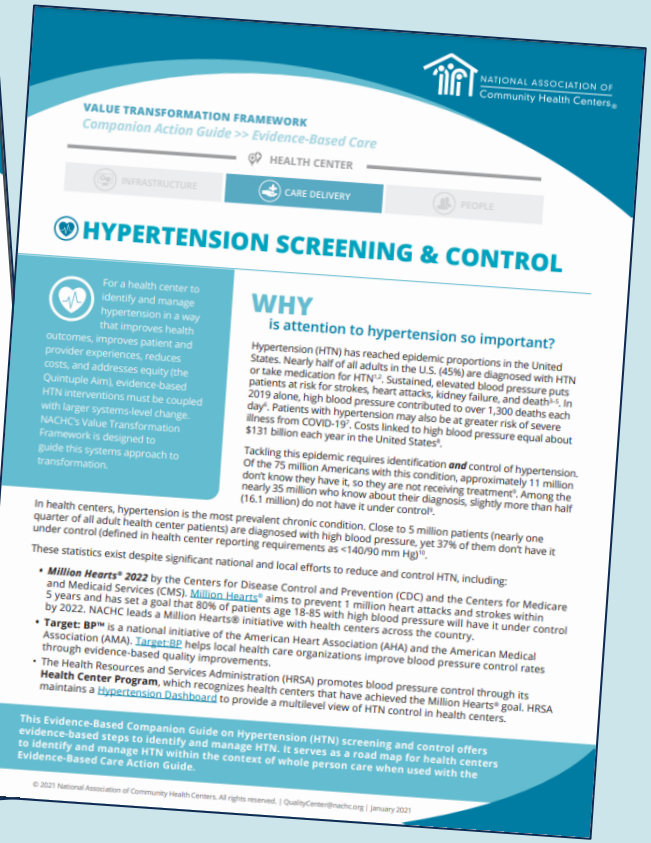


June Learning Forum Recording

Resources: Evidence-Based Care







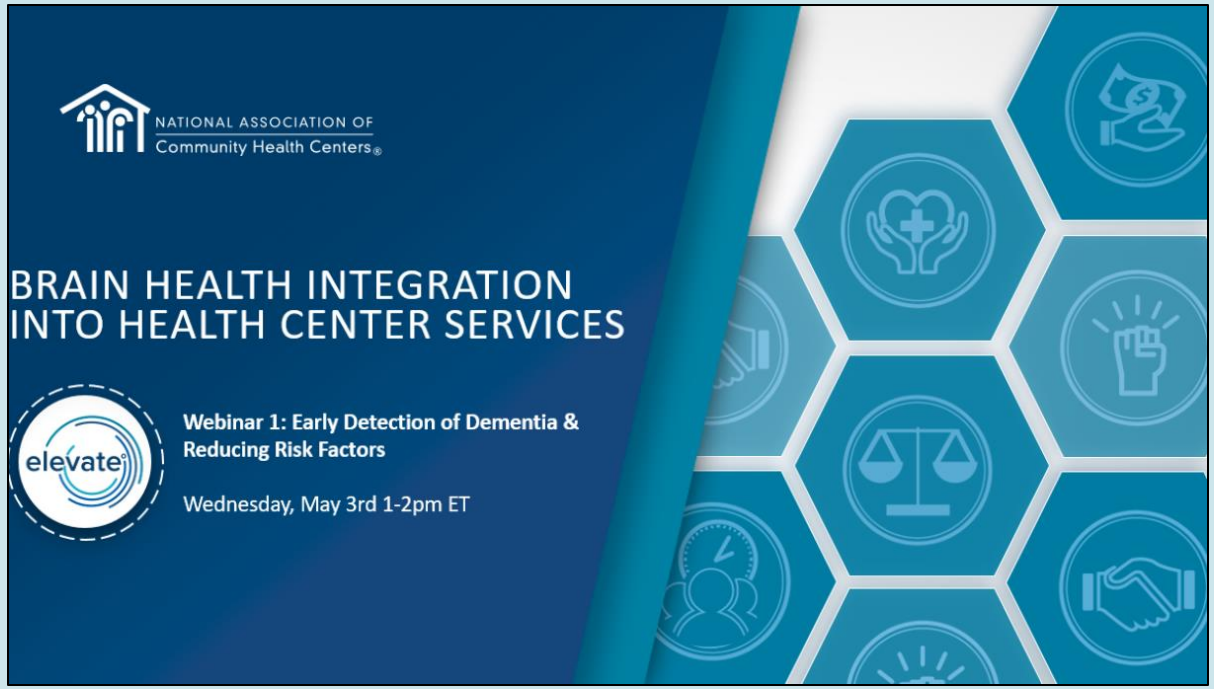
[HIV Prevention Action Guide]

[Diabetes Control Action Guide]

[Cancer Screening Action Guide]

[Hypertension Action Guide]

Resources: Evidence-Based Care



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

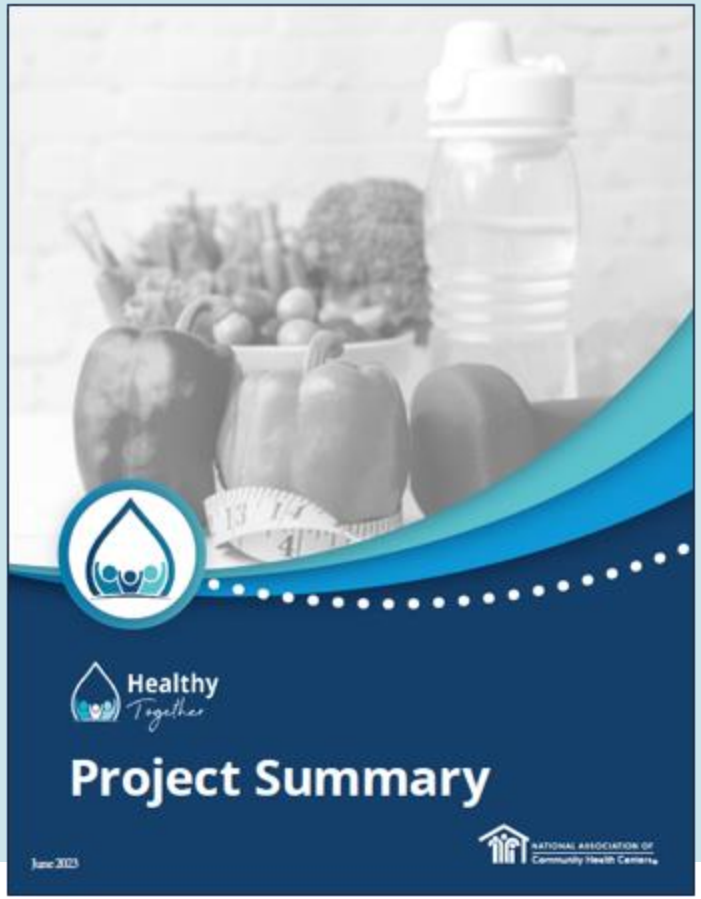
Increase the impact of **diabetes prevention and management** at health centers.

Healthy Together is a lifestyle change program that blends:

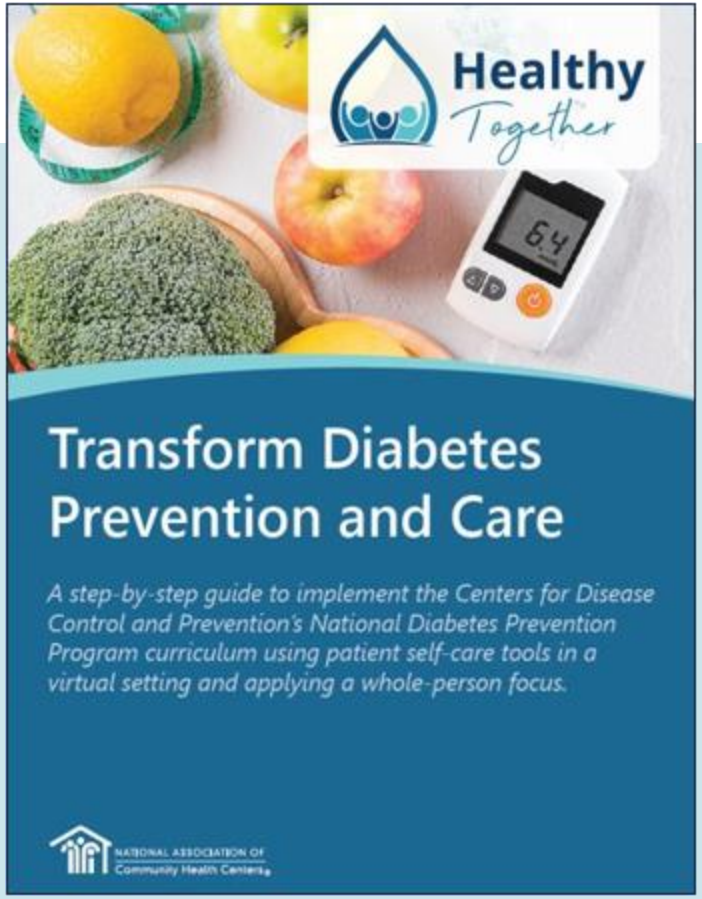
- ✓ Virtual care
- ✓ Self-care tools
- ✓ Lifestyle coaching following the CDC's National Diabetes Prevention Program curriculum

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:	• 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

July Learning Forum Recording

Resources: Value-Based Care

Suite of Value-Based Payment Action Briefs

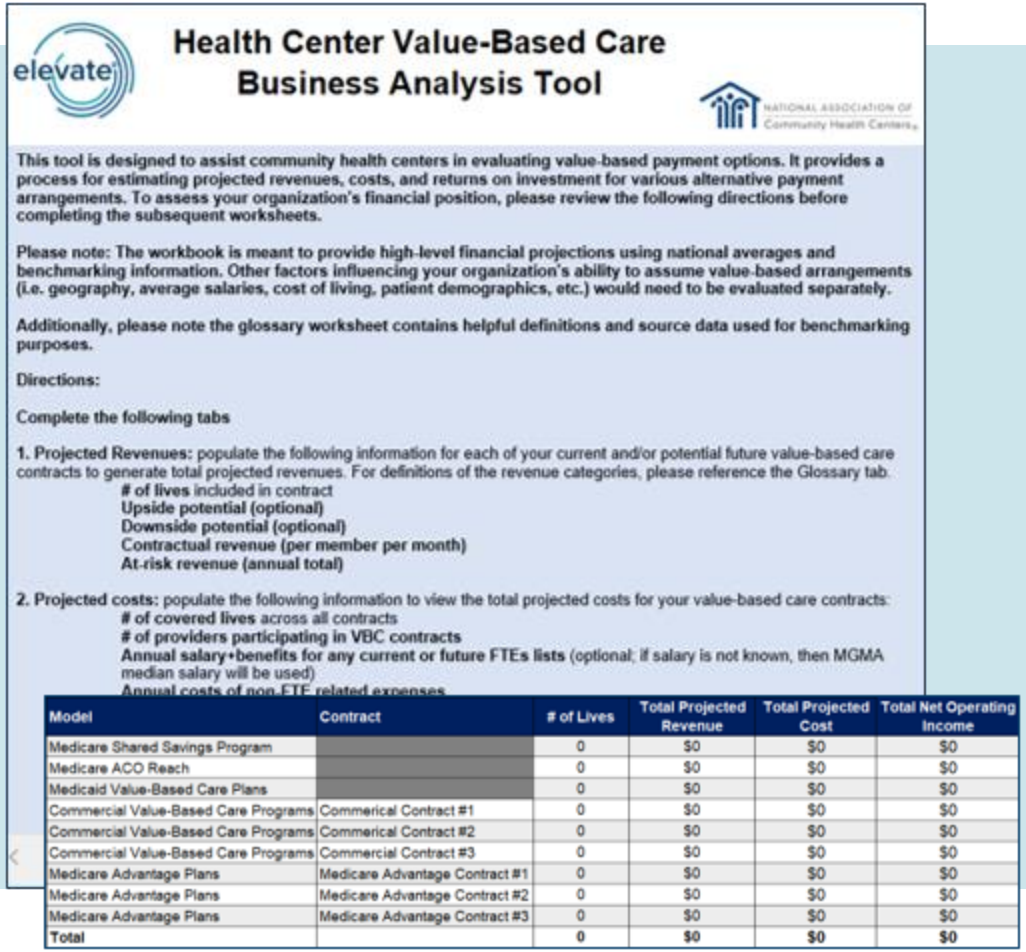
Developing VBP Goals

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

1. 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.

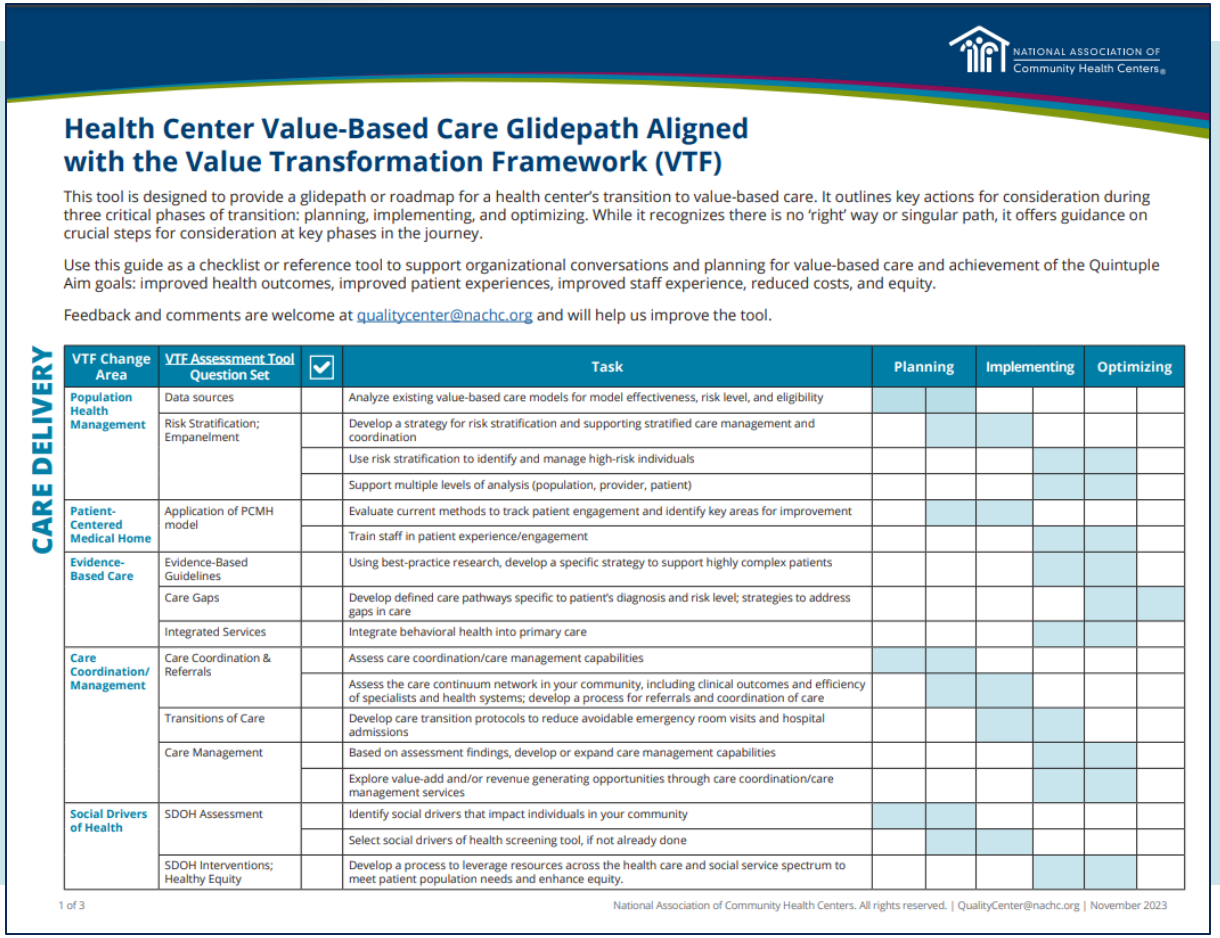
- **# of lives** included in contract
- **Upside potential (optional)**
- **Downside potential (optional)**
- **Contractual revenue (per member per month)**
- **At-risk revenue (annual total)**

2. 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	Commerical Contract #1	0	$0	$0	$0
Commercial Value-Based Care Programs	Commerical Contract #2	0	$0	$0	$0
Commercial Value-Based Care Programs	Commerical 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	☑	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						
	Integrated Services		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						
	Care Management		Based on assessment findings, develop or expand care management capabilities						
			Explore value-add and/or revenue generating opportunities through care coordination/care management services						
Social Drivers of Health	SDOH Assessment		Identify social drivers that impact individuals in your community						
			Select social drivers of health screening tool, if not already done						
	SDOH Interventions; Healthy Equity		Develop a process to leverage resources across the health care and social service spectrum to meet patient population needs and enhance equity.						

1 of 3

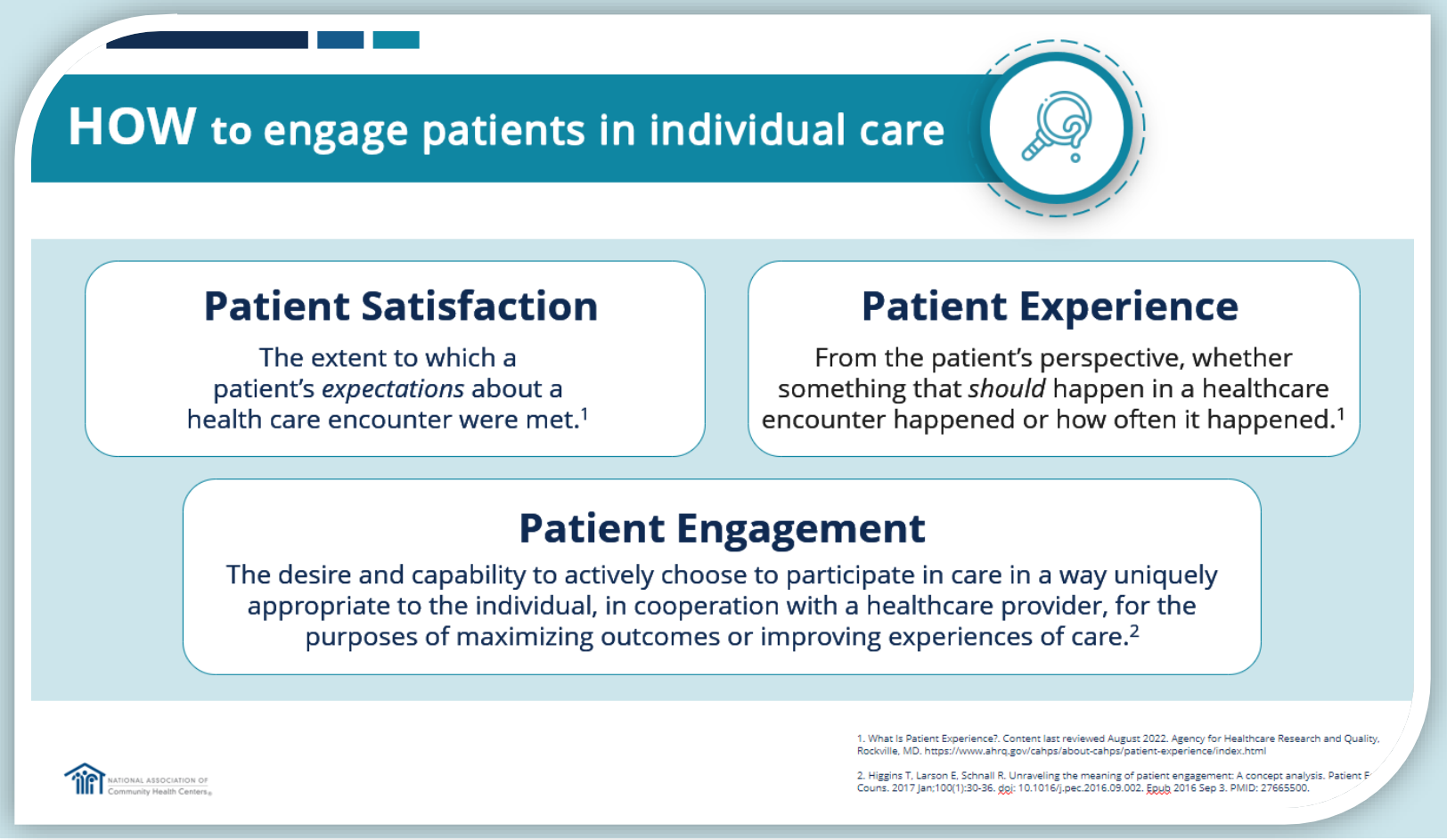
VBC Glidepath for health centers to begin Value-Based Care

August

September: Patient Engagement

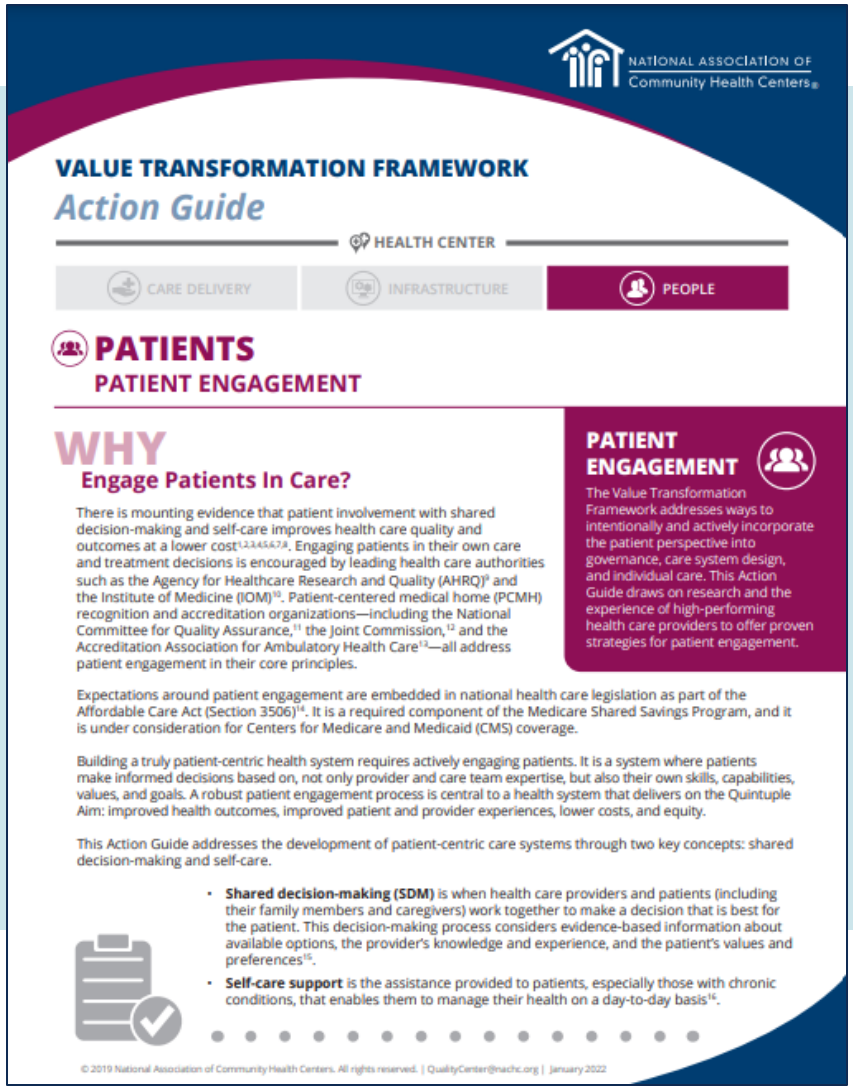
What we learned:

- ✓ 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



September Learning Forum Recording

Resources: Patient Engagement



NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

PATIENTS

PATIENT ENGAGEMENT

WHY

Engage Patients In Care?

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

PATIENT ENGAGEMENT

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

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

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

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

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

Patient Engagement Action Guide

October: PCMH as the Foundation to VBC

What we learned:

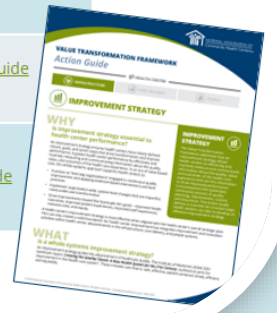
- ✓ How to leverage PCMH as the foundation to value-based care transformation
- ✓ Alignment between NCQA PCMH, HRSA Health Center Program Requirements, and NACHC VTF
- ✓ Voices from the field: how health centers are leveraging PCMH

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

Team-Based Care and Practice Organization (TC)

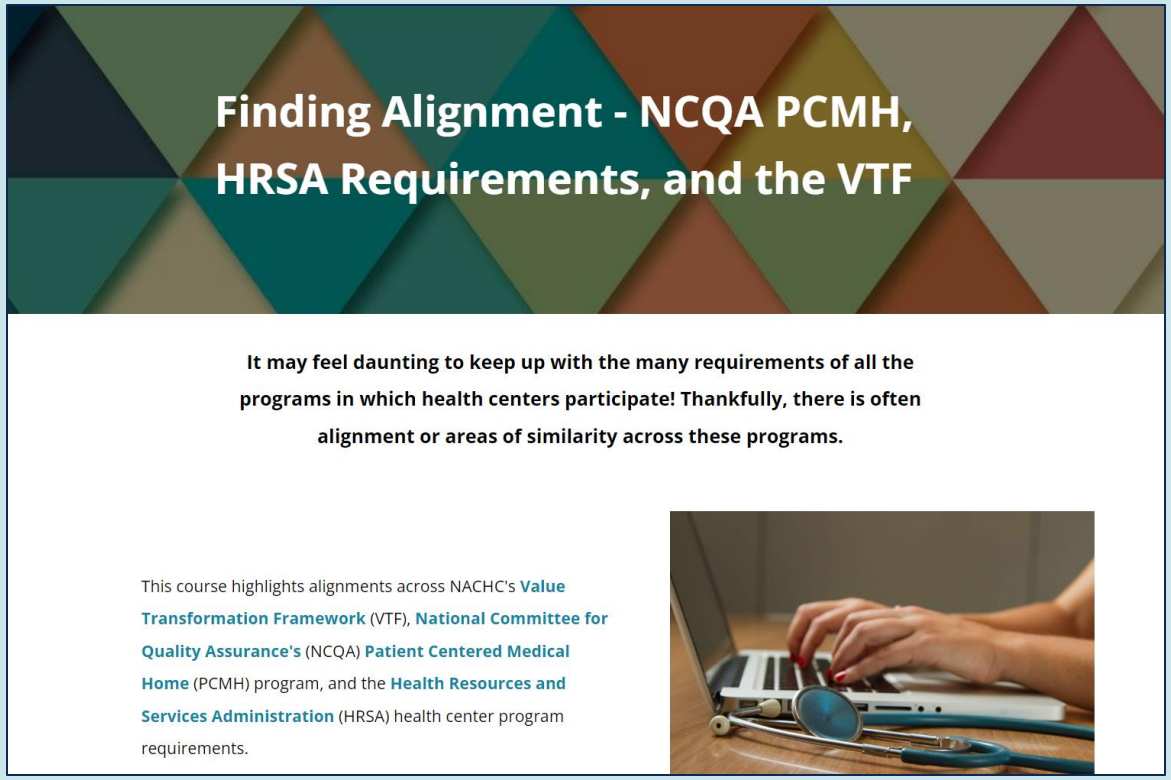
NCQA PCMH Core Criteria+	NACHC VTF Change Area	HRSA Health Center Program Requirement	NACHC Elevate Resources
TC 01 PCMH Transformation Leads: Designates a clinician lead of the medical home and a staff person to manage the transformation and ongoing patient-centered care.	**Governance & Leadership** **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



October Learning Forum Recording

Resources: PCMH



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

November Learning Forum Recording

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

elevate

NATIONAL ASSOCIATION OF Community Health Centers®

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

elevate

NATIONAL ASSOCIATION OF Community Health Centers®

Health Center Next Steps

Your 2024 transformation Journey begins here!

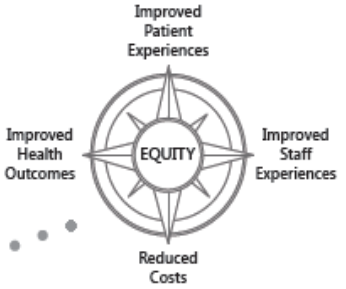
STEP 1 - ENGAGE
Invite others to Register for Elevate

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

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

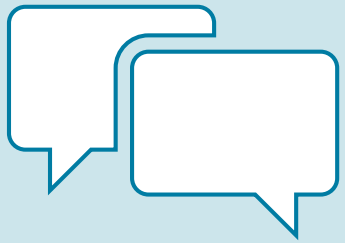
STEP 4 – TRANSFORM
Engage in Elevate to access transformation tools and resources

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

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.

Elevate Awards

Most PCA/HCCN VTF Assessments completed in 2023

Congratulations

ASPPR
ASOCIACIÓN DE SALUD PRIMARIA DE PUERTO RICO, INC.

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

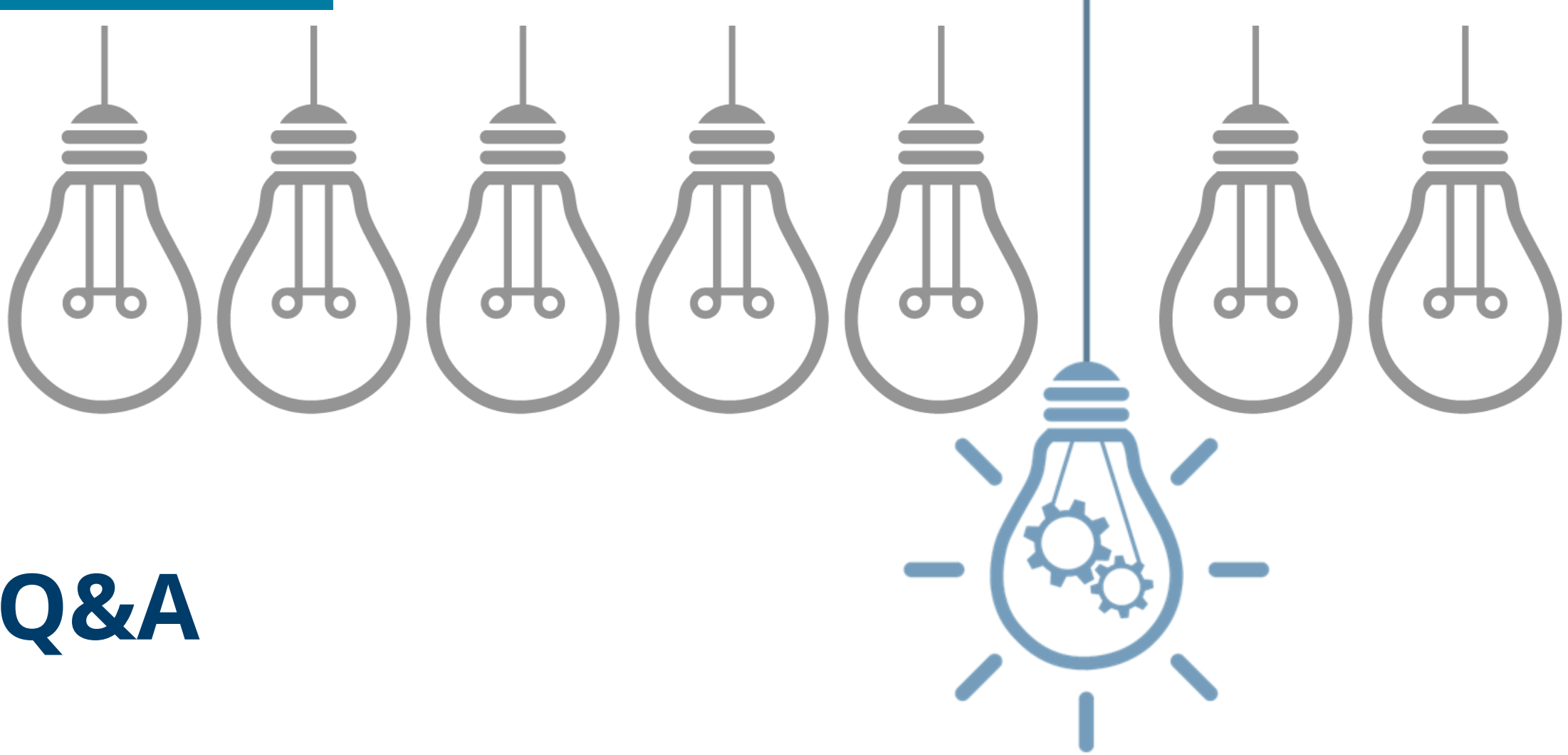
Elevate Awards

Most Elevate Registrants

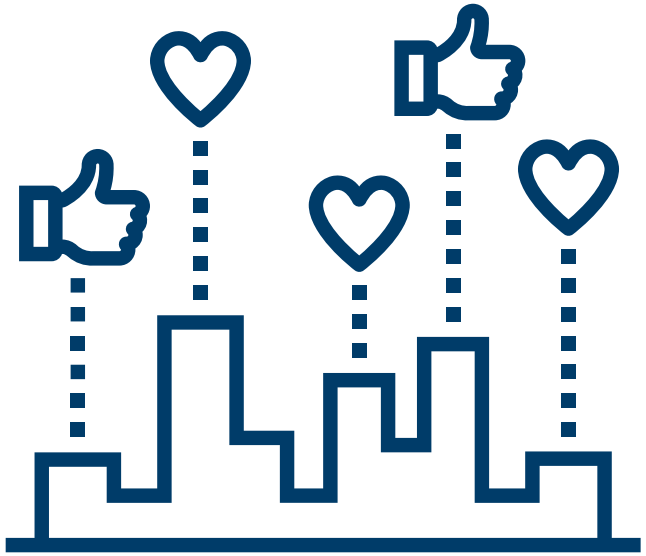
Congratulations

ICHS International Community HEALTH SERVICES

International Community Health Services
(Washington)
with 41 Registrants!



Q&A



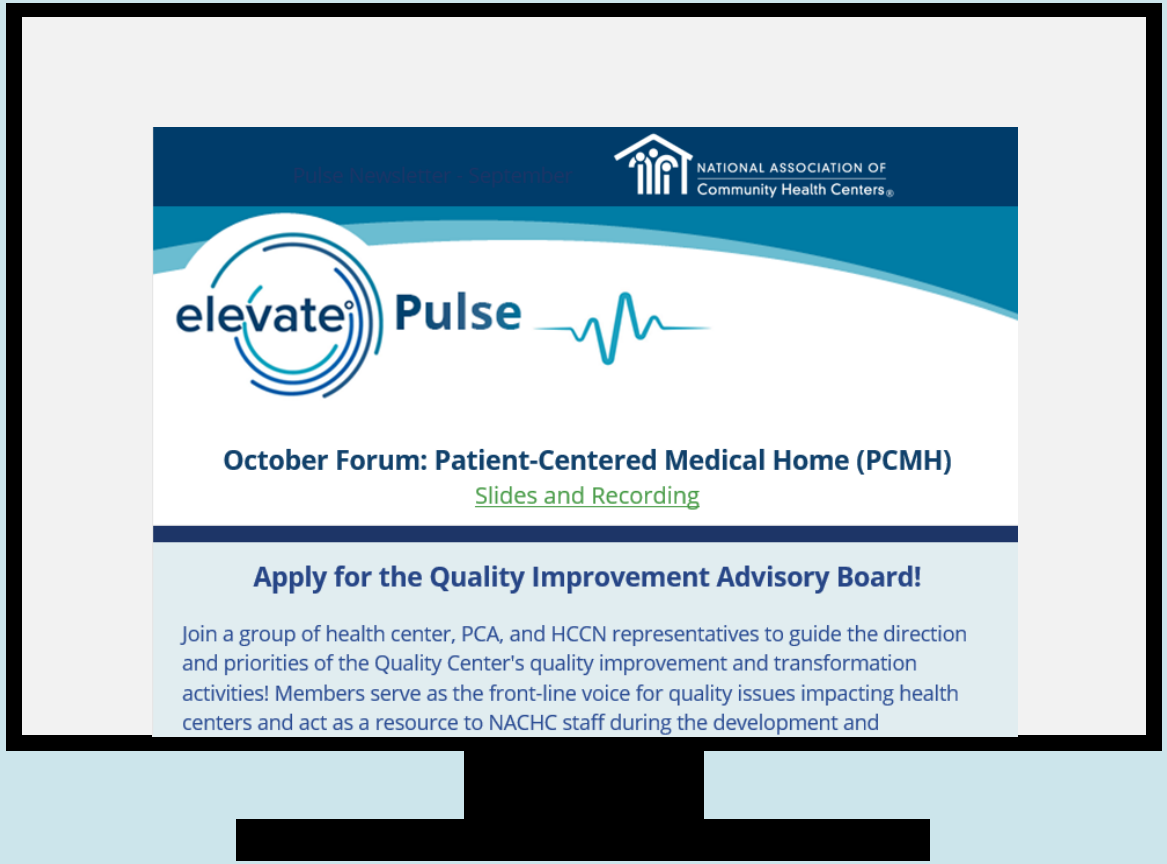
Provide Us Feedback

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:

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

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NATIONAL ASSOCIATION OF Community Health Centers®

elevate°

Together, our voices elevate° all.

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