NATIONAL ASSOCIATION OF Community Health Centers®

ELEVATE NATIONAL LEARNING FORUM

elevate

Population Health

Attribution & Empanelment

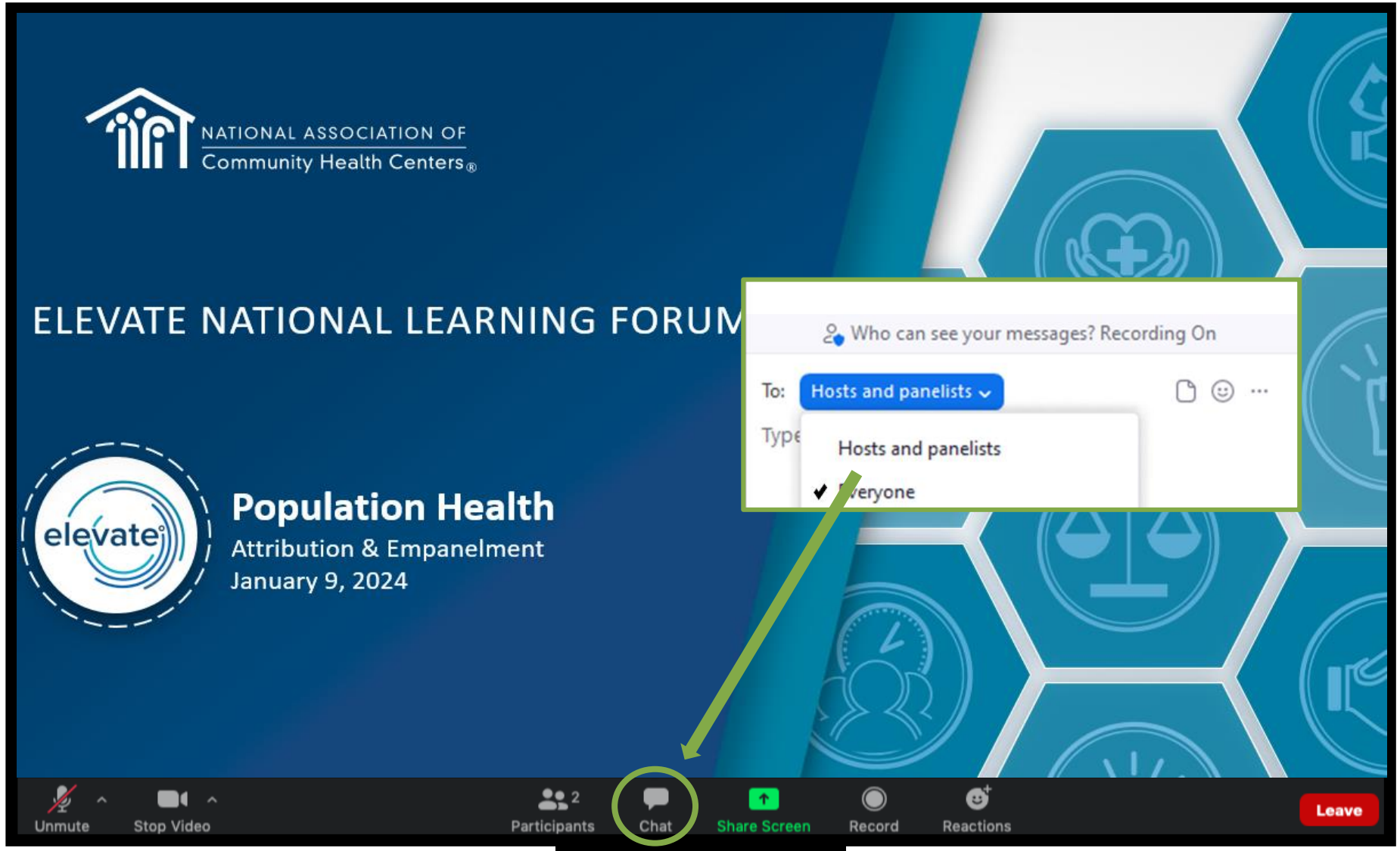
January 9, 2024

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,
Quality Center

Holly Nicholson
Deputy Director, Learning
and Development

Tristan Wind
Manager,
Quality Center

Rachel Barnes
Specialist,
Quality Center

Elevate 2024 Launch

Welcome to the Elevate 2024 Launch!

Elevate is a national learning forum of community health centers and partners coming together to transform systems and enhance value.

Through Elevate, you are part of a community of 724 CHCs, 75 PCAs/HCCNs, and 52 public health partners.

Advancing health center transformation together!

Elevate Journey

Your transformation journey begins here!

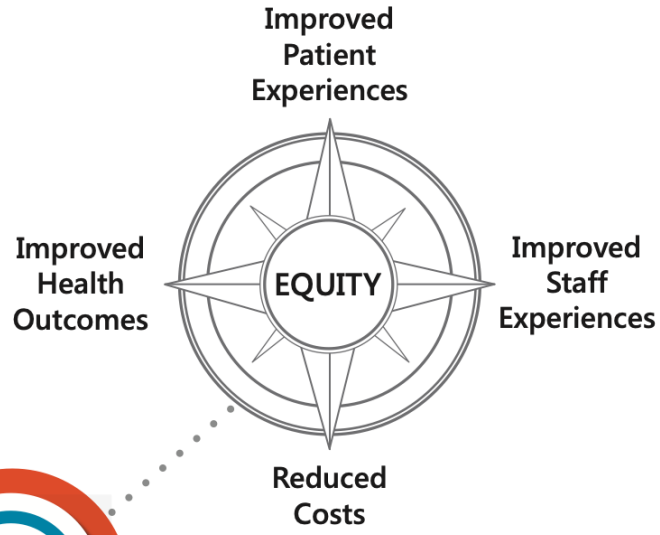
STEP 1 - ENGAGE
Register for Elevate and participate in the **FREE** health center learning community. Invite others

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 transformation tools and resources

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



The Value Transformation Framework (VTF)

INFRASTRUCTURE

IMPROVEMENT STRATEGY
Define vision, goals, and action steps that drive transformation and improved performance.

HEALTH INFORMATION TECHNOLOGY
Leverage health information technology to track, improve, and manage the Quintuple Aim.

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

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

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

CARE DELIVERY

POPULATION HEALTH MANAGEMENT
Use data on patient populations to target interventions that advance the Quintuple Aim.

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

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

CARE COORDINATION AND CARE MANAGEMENT
Facilitate the delivery and coordination of care for high-risk and other patient segments through targeted services, provided when and how needed.

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

PEOPLE

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

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

GOVERNANCE AND LEADERSHIP
Apply position, authority, and knowledge of governing bodies (boards) and leaders to support and advance the center's transformation goals.

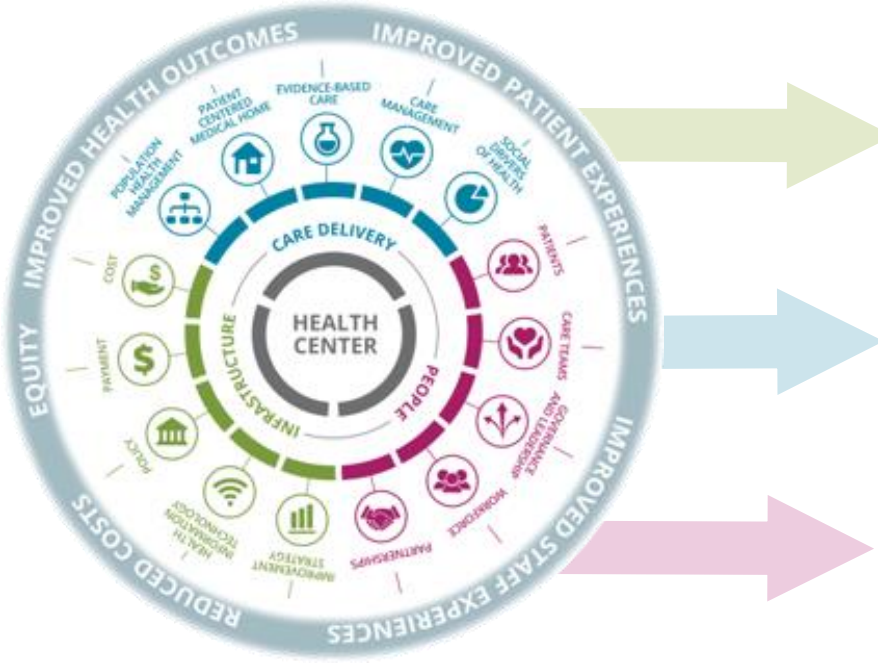
WORKFORCE
Leverage a trained and fully engaged staff to successfully address the health center's mission and goals, with optimal joy in work.

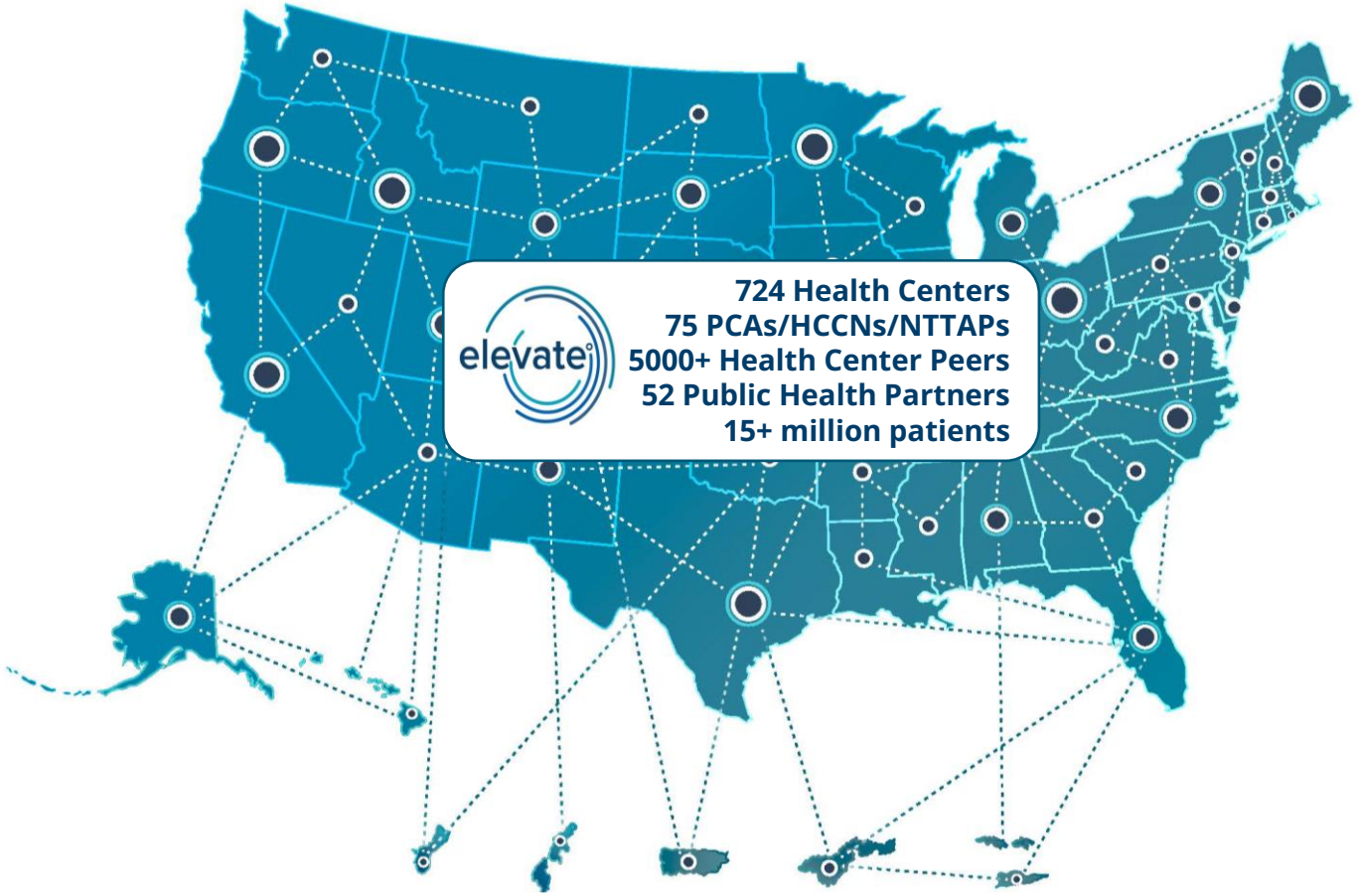
PARTNERSHIPS
Collaborate and partner with external stakeholders to pursue the Quintuple Aim.

Organizing framework to guide health center systems change and value transformation

15 Change Areas organized by 3 Domains
Infrastructure Care Delivery People

Step 1: Engage





Elevate **provides guided application of the Value Transformation Framework**

National learning forum and peer exchange

Collaborate * Learn * Share * Create * Innovate

Step 2: Assess

VTF Assessment allows health center staff to self-assess organizational progress in activities important to value transformation (the 15 Change Areas)

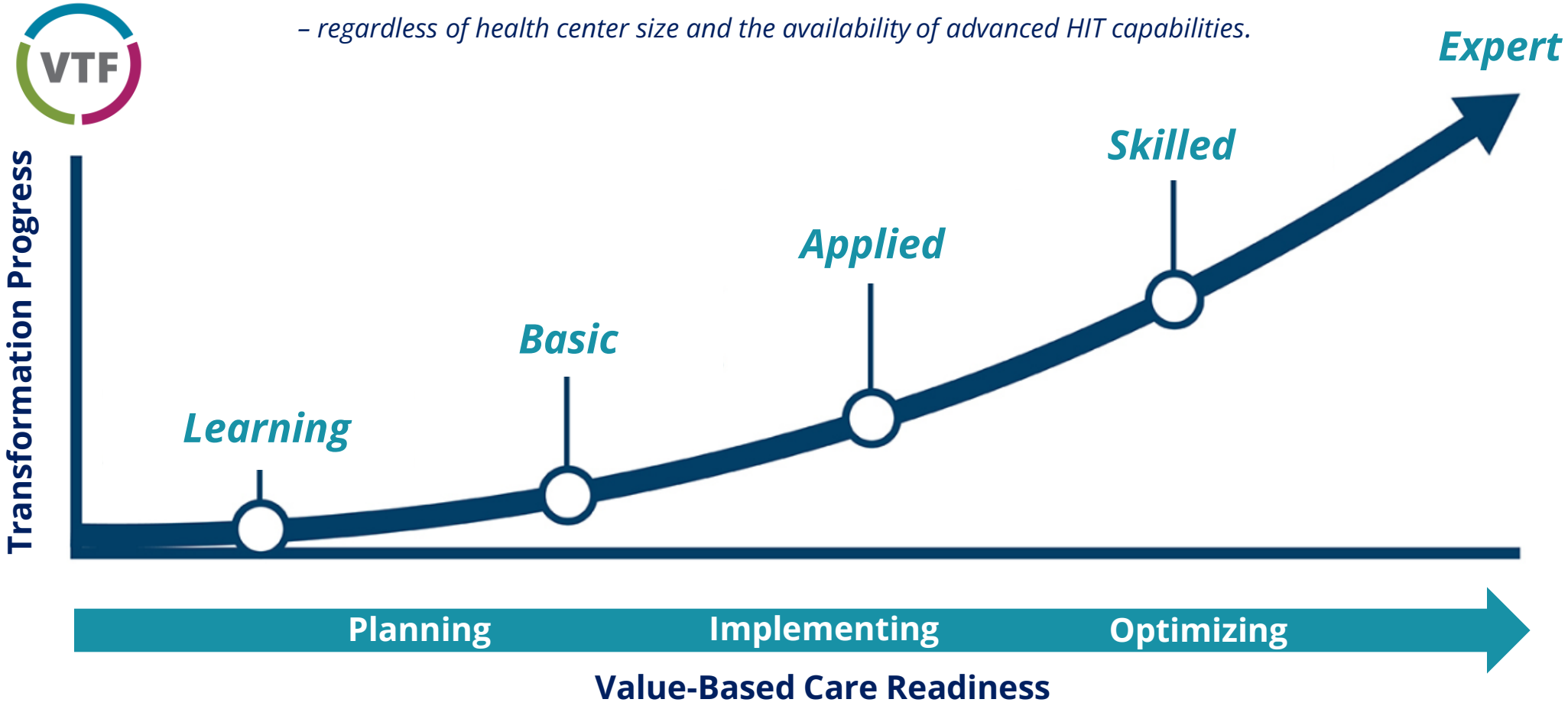
- ✓ Complete at the beginning of a transformative initiative and repeat over time to measure improvement
- ✓ Designed to be completed by multiple staff across the organization, with sharing and discussion of scores
- ✓ Takes ~20-30 minutes
- ✓ Results can be electronically shared with PCA/HCCN

Example

Change Area				
Definition				
1- Learning	2- Basic	3- Applied	4- Skilled	5- Expert
Health center is working toward implementing a QI plan….	HRSA has a QI/QA Plan that meets HRSA standards….	Health center engages in quality planning and improvement, including regular use of QI tools…	Health center maintains formal quality planning structures and processes, employs a formal Model for Improvement…	Health center maintains formal planning, improvement, control, and assurance activities. Health center functions as a 'learning organization'…

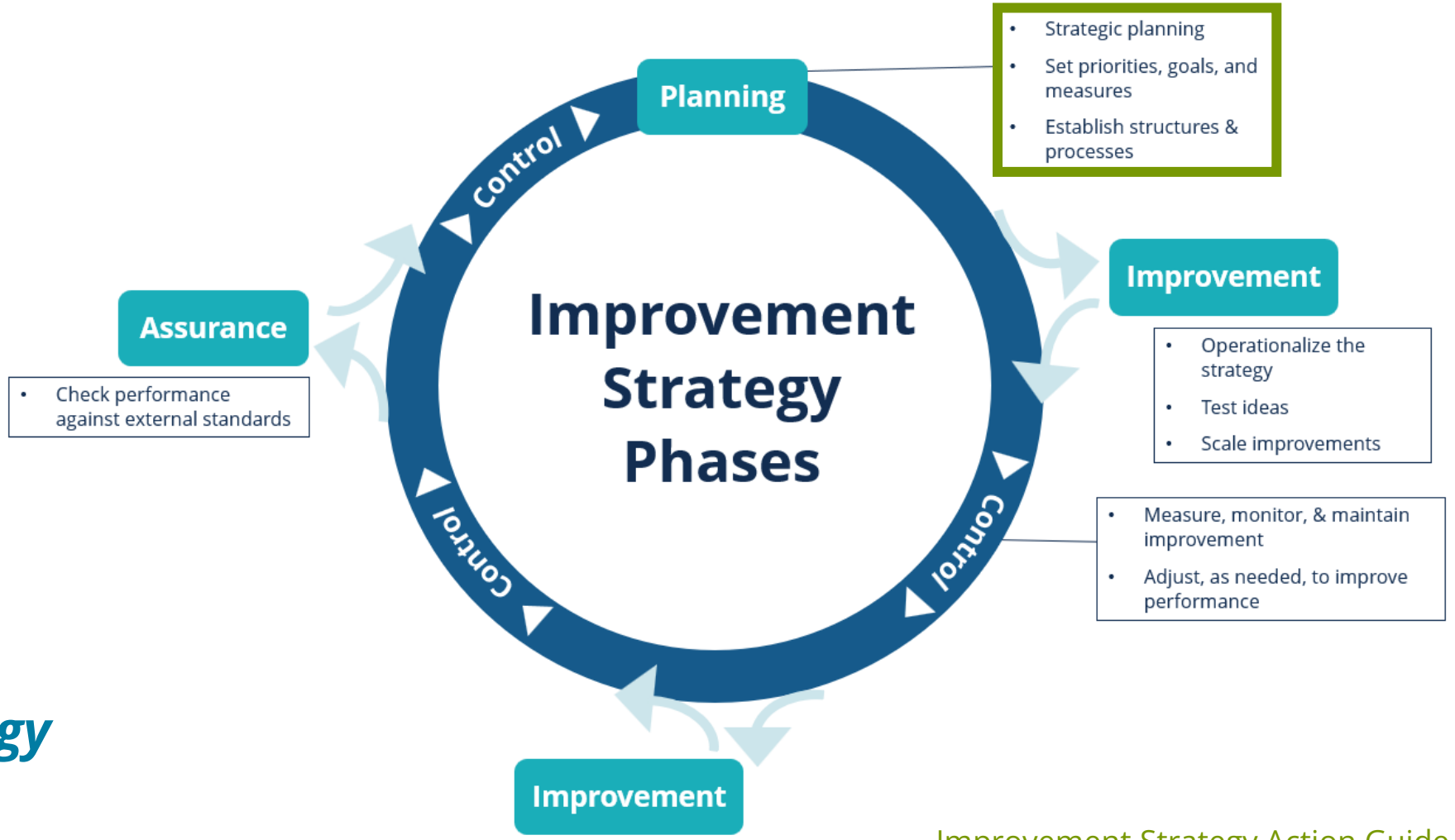
Step 2: Assess

The VTF Assessment can be used to assess readiness for value-based care. Strategies presented through Elevate can be utilized by health centers at any level – ***Planning, Implementing, Optimizing*** *– regardless of health center size and the availability of advanced HIT capabilities.*



Step 3: Plan

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

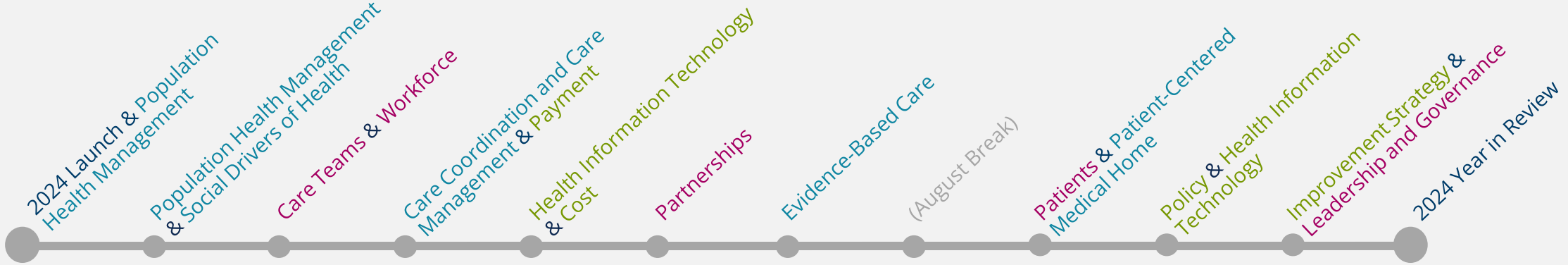


Improvement Strategy Action Guide

STEP 4: TRANSFORM

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

Transform Together Through Monthly Learning Forums*



- ✓ Invite additional staff from your organization to register for Elevate.
- ✓ Block calendar for monthly learning forums (2nd Tuesday, 1-2 pm ET). Registration emails will be sent out one month prior.

- ✓ Complete **VTF Assessment** and share results with PCA/HCCN.

- ✓ Plan transformation efforts; incorporate into your health center improvement strategy.

- ✓ Attend monthly learning forums.
- ✓ Log in to NACHC Learning Hub to access free Elevate resources.
- ✓ Initiate and continue transformation efforts!

- ✓ Reassess; Share **VTF Assessment** results with PCA/HCCN.

*Schedule of Monthly Learning Forum Topics may be adjusted by the Quality Center as needed.

NEW Format: Monthly Learning Forums

- Welcome & Logistics
- VTF Change Area(s) of the Month
- Health Center Sharing
- PCA/HCCN Sharing
- Peer-to-Peer Sharing/Discussion
- Summary and Closing

Joined by 2023 Health Center Quality Leaders!

Elevate Learning Forums throughout 2024 will feature speakers from Health Centers who have earned HRSA's Health Center Quality Leader badge in 2023.

Health centers who have earned this badge had the best overall (top 10%) UDS Clinical Quality Measure (CQM) performance.

Population Health

Empanelment & Attribution

NATIONAL ASSOCIATION OF Community Health Centers®

WHAT is population health management?

Using data on patient populations to target interventions that result in improved health outcomes, improved patient experiences, improved staff experiences, reduced costs, and equity.

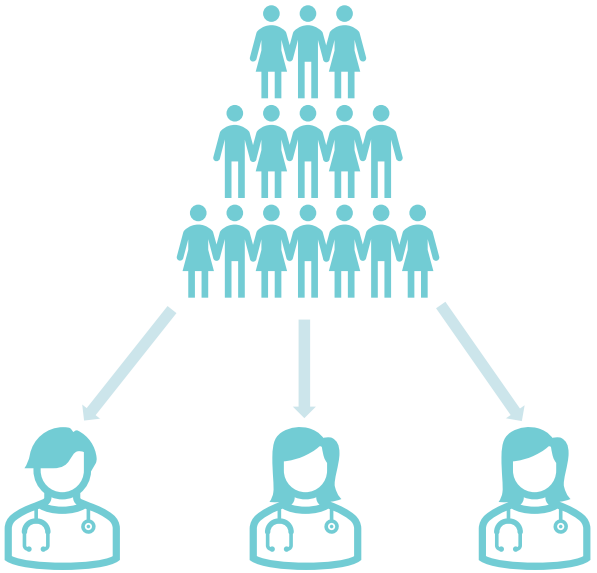
Population health management strategies include:

- ✓ Empanelment & Attribution
- ✓ Risk Stratification
- ✓ Models of Care

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.

WHAT is population health management?

Health Center Processes:

Include all health center patients.

Empanelment → **Risk Stratification** → **Models of Care**

Attribution lists may be shared with health centers; used to inform empanelment.

Member risk scores may be shared with health centers; used to inform models of care.

Payor Processes:

Include members of that payor.

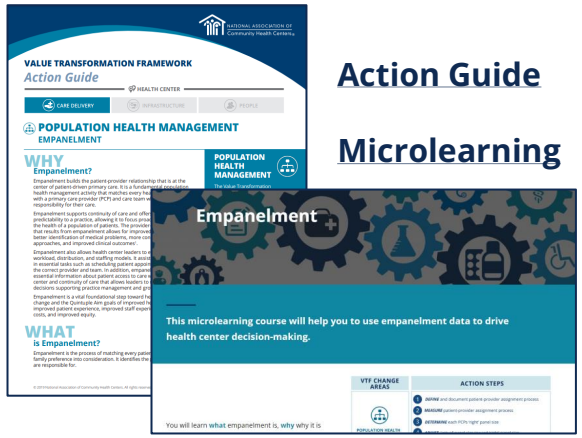
Attribution → **Risk Stratification**

A payor's process of assigning members to a provider.

A payor may have their own algorithm for risk stratifying members, for example, based on diagnosis codes or total cost of care.

Step-by-Step Resources for Each Process

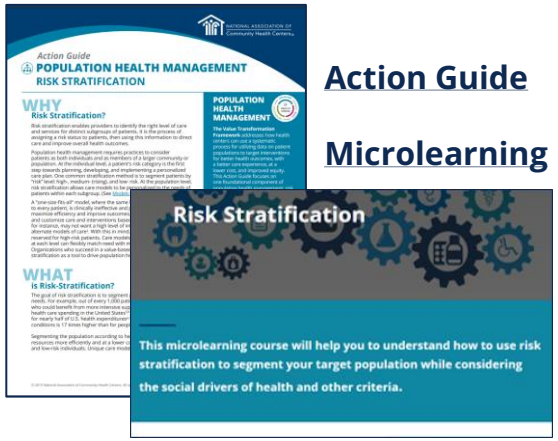
Health Center
Processes:



[Action Guide]

[Microlearning]

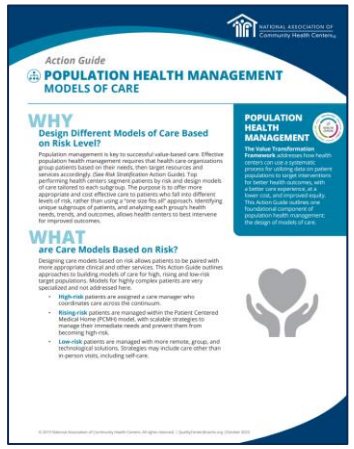
Empanelment →



[Action Guide]

[Microlearning]

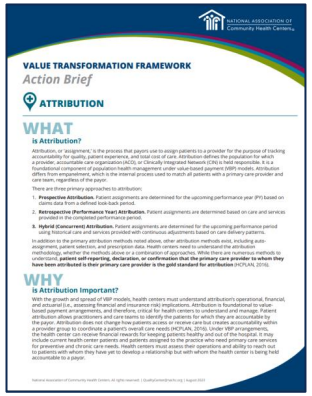
Risk Stratification →



[Action Guide]

Models of Care

Payor
Processes:



[Action Brief]
Leverage attribution lists to inform empanelment

Attribution → **Risk Stratification**

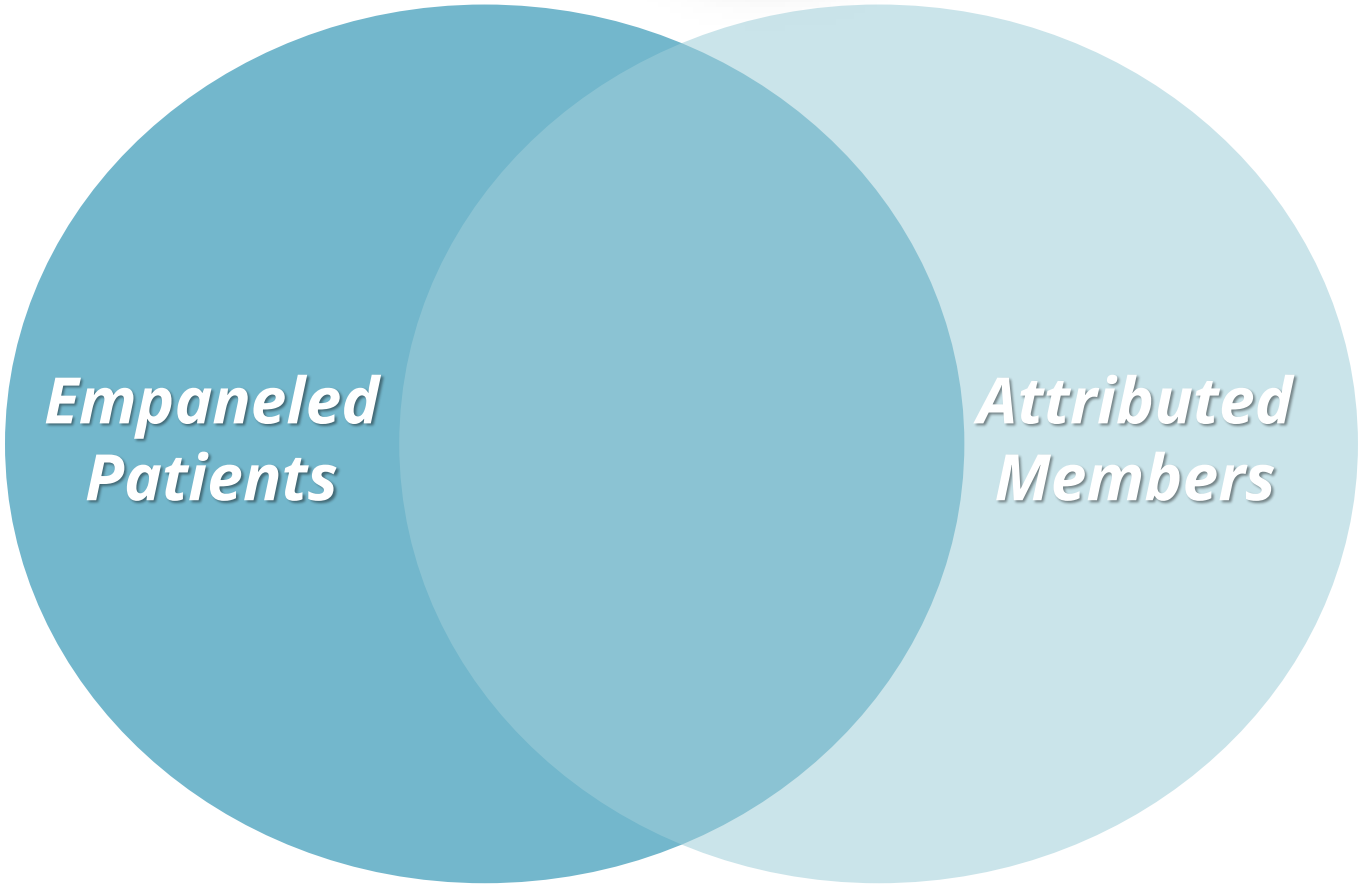
WHAT is the difference between empanelment and attribution?

Empanelment: The **health center's process** of assigning every patient to a primary care provider (PCP) and care team, with consideration to patient/family preference.

Attribution: A **payor's process** of assigning members to a provider for the purpose of tracking accountability for quality, patient experience, and total cost of care in value-based payment contracts.

A 'payor' refers to a Medicaid, Medicare, or commercial insurance plan.

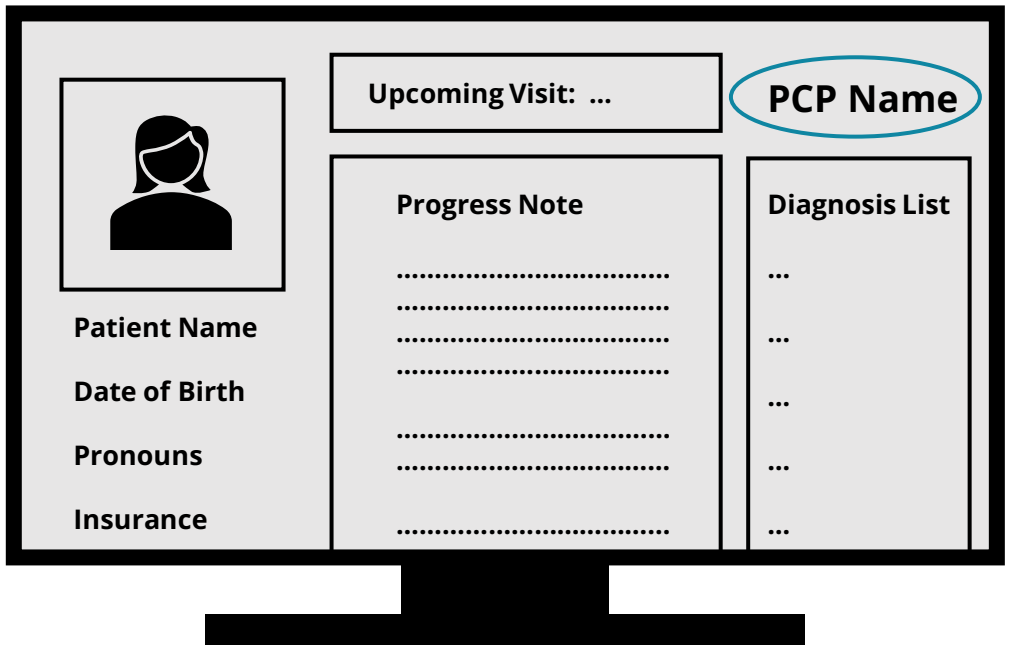
A 'member' refers to a person who has healthcare coverage through that payor.



WHAT are the data sources for empanelment and attribution?

Empaneled Provider

- ✓ Captured in the EHR within each patient's individual chart.
- ✓ EHR reports listing PCPs for multiple patients.
  (may use a population health management system if applicable)



Attributed Provider

It depends on the payor. Attribution lists may be shared with the health center through:

- Provider portals
- Secure fax/email
- Clinically Integrated Network (CIN) distribution
- Other methods

WHAT if the empaneled and attributed provider are different?

- **There are varying methodologies payors may use to attribute patients.**
- **The empaneled provider may not match the attributed provider!**
- What is most important is that a health center PCP and care team assumes responsibility for the patient. Always take patient/family preference of PCP into account.
- Attribution may inform empanelment if the patient has not yet been seen at the health center or if the empaneled provider is incorrect/outdated *(e.g., empaneled provider no longer works there)*.
- Some payors may work with you to update attribution assignments, some may not.

WHY are empanelment & attribution important?

Empanelment

Patients benefit from continuity of care

Improved communication, better identification of medical problems, more consistent treatment approaches, and improved clinical outcomes

Ease scheduling & access to care challenges

Scheduling stability and predictability allows leaders to make data-driven decisions supporting practice management and growth

Evaluate provider and care team workload

Leverage data to evaluate workload and staffing models needed to best support the patient panel (combine with strategies for risk stratification and models of care)

Attribution

Improve performance under value-based payment contracts

Provide care to members assigned to the health center

Contributes to financial expectations under value-based payment contracts

Understand financial risks and incentives

HOW can we act on empanelment & attribution data?

Engage patients in care!

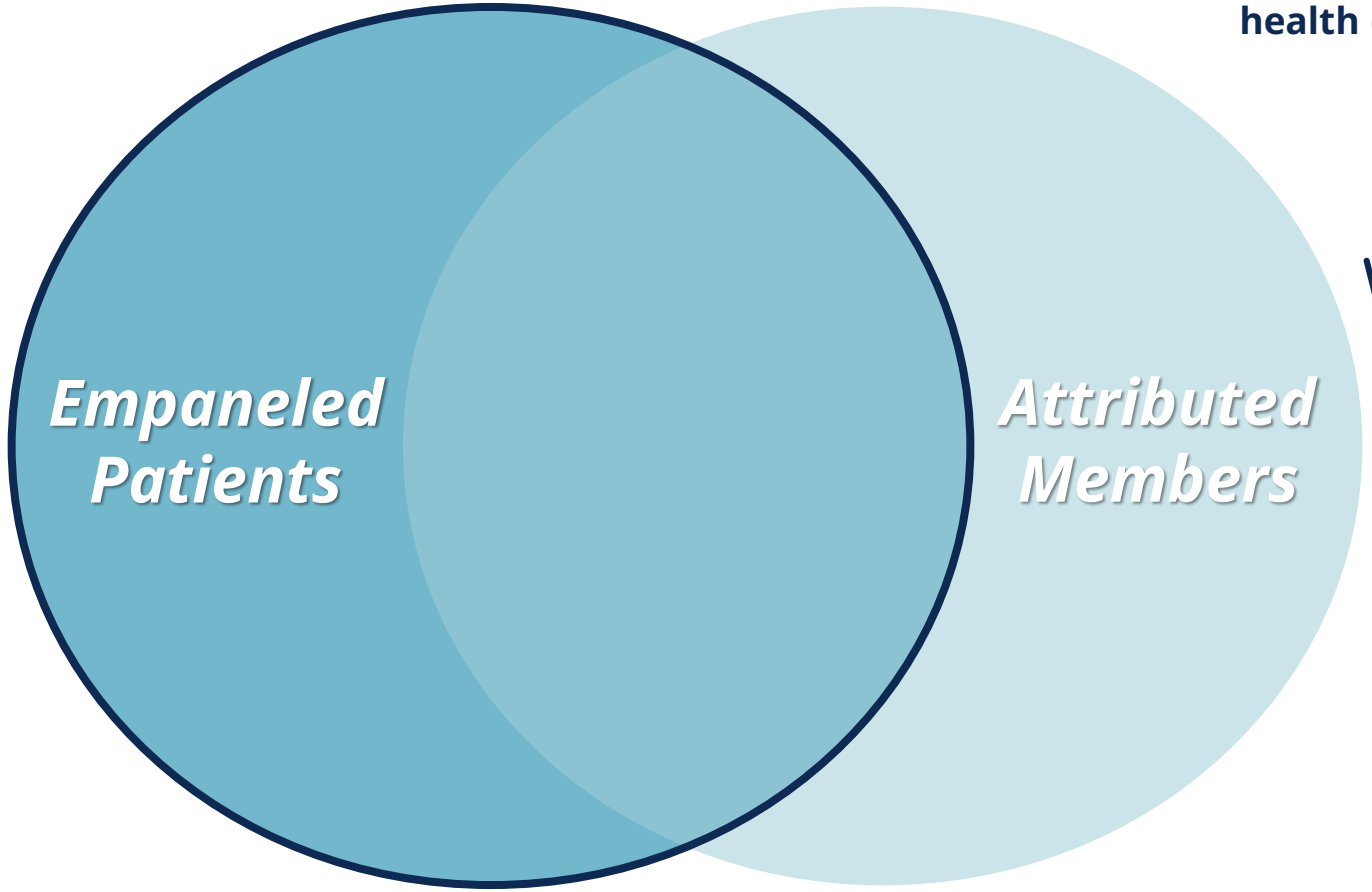
Outreach strategies may include:

- Calling patients on the phone
- Text message campaigns
- Email campaigns
- Letter campaigns

Are all these patients engaged in care?

(Scheduling annual visits, managing chronic conditions, etc.)

If not, re-engage!



Engage members in care at the health center

HOW can we empanel patients and leverage empanelment data?

STEP 1 Define and document patient-provider assignment process

STEP 2 Measure patient-provider assignment process

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

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

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

STEP 6 Review panels using PCP and care team input

STEP 7 Use risk stratification to segment and manage patient panels

STEP 8 Optimize care team roles for effective panel management

STEP 9 Use empanelment data to improve patient access

STEP 10 Incorporate payer attribution data

[Action Guide]

[Microlearning]

KEY STEP: *DETERMINE EACH PCPs 'RIGHT' PANEL SIZE*

A provider's right panel size is the number of patients a provider can reasonably support.

Unique to provider: A right panel size is based on a provider's schedule availability and complexity of patients. Determining a right panel size can be accomplished through a series of calculations measuring supply and demand using this Right Panel Size Worksheet

DEMAND	**Appointment needs of current population**	=	**# of unduplicated patients seen in the last year**	X	**average # of visits per patient per year**
SUPPLY	**Provider availability**	=	**# of appointment slots available on the schedule last year**		
RIGHT PANEL SIZE	**The # of patients the provider can support based on current availability**	=	**# of appointment slots available on the schedule last year**	÷	**average # of visits per patient per year**

KEY STEP:

ADJUST 'ACTUAL' PANEL SIZE TO 'RIGHT' PANEL SIZE

> OVER-EMPANELED

If actual panel size is larger than right panel size, consider:

- 'Closing' the panel
- Expanding the provider's schedule
- Re-empaneling some of their assigned patients to other providers (use 4-cut methodology!)
- Forming a 'provider team' (e.g., partner an MD/DO with a PA/NP to care for a panel together)
- Increasing care team support

If actual panel size is less than right panel size, consider:

- Assigning new health center patients to this provider
- Re-empaneling patients from over-empaneled providers to this provider
- Forming a 'provider team' with an over-empaneled provider

UNDER-EMPANELED <

HOW can we leverage attribution data to inform empanelment and improve VBC performance?

STEP 1 Develop an accurate up-to-date list of all providers eligible for attribution

STEP 2 Understand the attribution methodology of payors

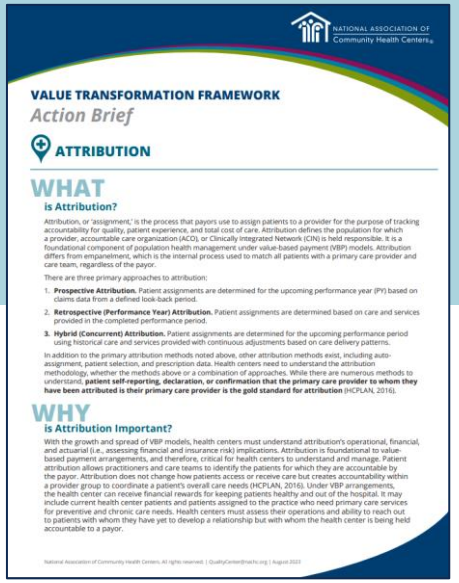
STEP 3 Develop processes for the intake of attribution lists

STEP 4 Leverage attribution lists to inform empanelment

STEP 5 Identify a process for patients who are not attributed but receive care from your health center

STEP 4 Use attribution information to drive patient engagement and care needs

Action Brief



NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Action Brief

ATTRIBUTION

WHAT

is Attribution?

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

There are three primary approaches to attribution:

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

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

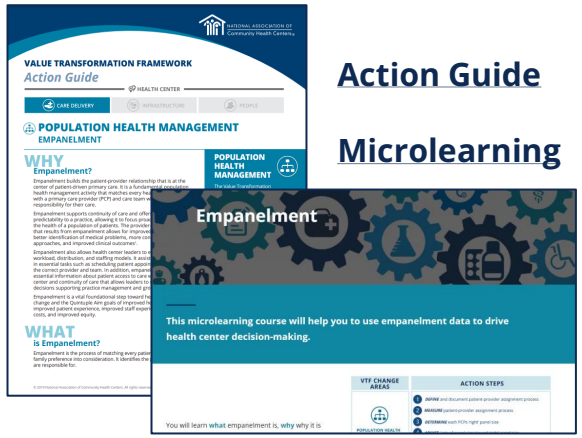
WHY

is Attribution Important?

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

Step-by-Step Resources for Each Process

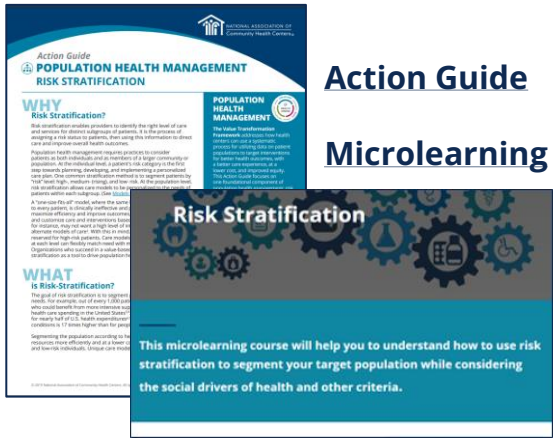
Health Center
Processes:



[Action Guide]

[Microlearning]

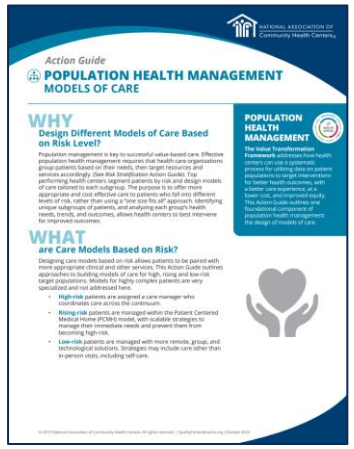
Empanelment →



[Action Guide]

[Microlearning]

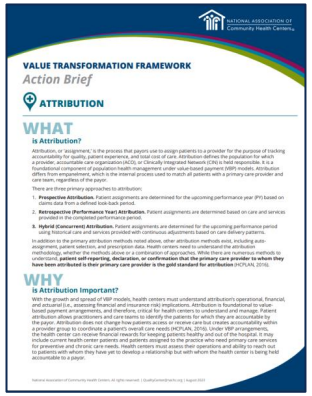
Risk Stratification →



[Action Guide]

Models of Care

Payor
Processes:



[Action Brief]
Leverage attribution lists to inform empanelment

Attribution → **Risk Stratification**

February Learning Forum

***Health Center* Processes:**

Include all health center patients.

***Payor* Processes:**

Include members of that payor.

Attribution → Risk Stratification

Examples from the Field

Featured Speaker

Mark Sonneborn, MS
Consultant
FQHC Urban Healthcare Network

- *Joined FUHN in early 2022, first as a volunteer, now staff*
  - *Prior to this, nearly 3 decades leading data and analytics initiatives for state hospital associations*
- *Leads FUHN's data analytics and technology efforts*
  - *Provides analyses on operational, financial, and clinical performance metrics*
  - *Informs strategic discussions on payer strategies*
  - *Liaison for current and potential research partners*
- *Coordinates FUHN efforts to achieve HCCN objectives*

FQHC Urban Healthcare Network

FQHC Urban Healthcare Network (FUHN) is comprised of 11 clinics in the Twin Cities and Mankato.

- FUHN has participated in the Medicaid Accountable Care Organization (ACO) program since its inception 12 years ago.
- In Minnesota, a Medicaid ACO is called an Integrated Healthcare Partnership (IHP).
- The state agency that administers Medicaid is the Department of Human Services (DHS).

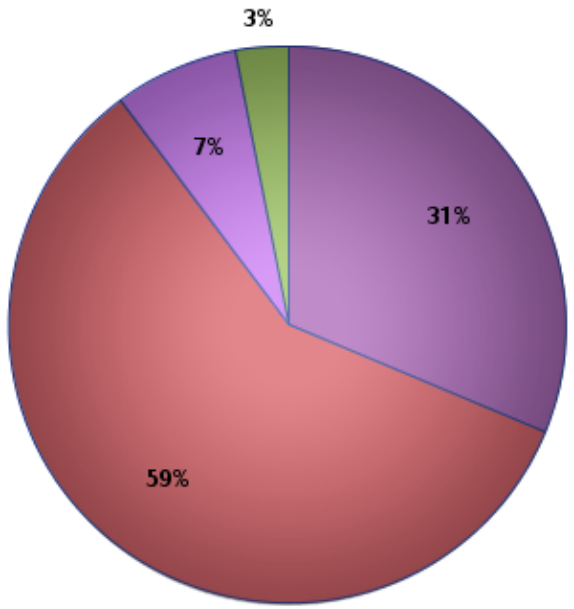
- DHS provides FUHN-attributed patient data.
- Includes claims data for patients wherever they are seen – not just when they are seen by FUHN clinics

FQHC Urban Healthcare Network

IHP Organization: FQHC Urban Health Network (FUHN)

Run Month: SEP2023

Attributed Members



Attribution Step Description	Attributed Members
PCP-One IHP	10,573
PCP-Most IHP	5,644
Ties-Latest IHP	1,293
HCH-One IHP	332
SPE-One IHP	100
Ties-wSPE Most IHP	52
SPE-Most IHP	34
Ties-wSPE Latest IHP	32
HCH-Most IHP	1

FQHC Urban Healthcare Network

Support member health centers' attribution process: provide spreadsheets to health centers on a secure SharePoint site, specific to each clinic, including:

- **Monthly list of attributed patients:** name and demographic information, attributed PCP, utilization category, how much they've incurred in medical cost, and more.
    - MN Medicaid uses a retrospective methodology to assign patients based upon the provider seen in previous year.
- **Care gap report:** shows whether each attributed patient is meeting specific quality measures (e.g., well child visit).
- **Utilization report**: shows high utilizers of ED.

Support deeper dives into clinical and HIT workflows to identify opportunities for improvement in meeting quality metrics.

Host an HCCN Clinical Quality Improvement Committee comprised of staff from member health centers; meets monthly to review data across the network and identify opportunities for improvement in closing gaps and reducing total cost of care.

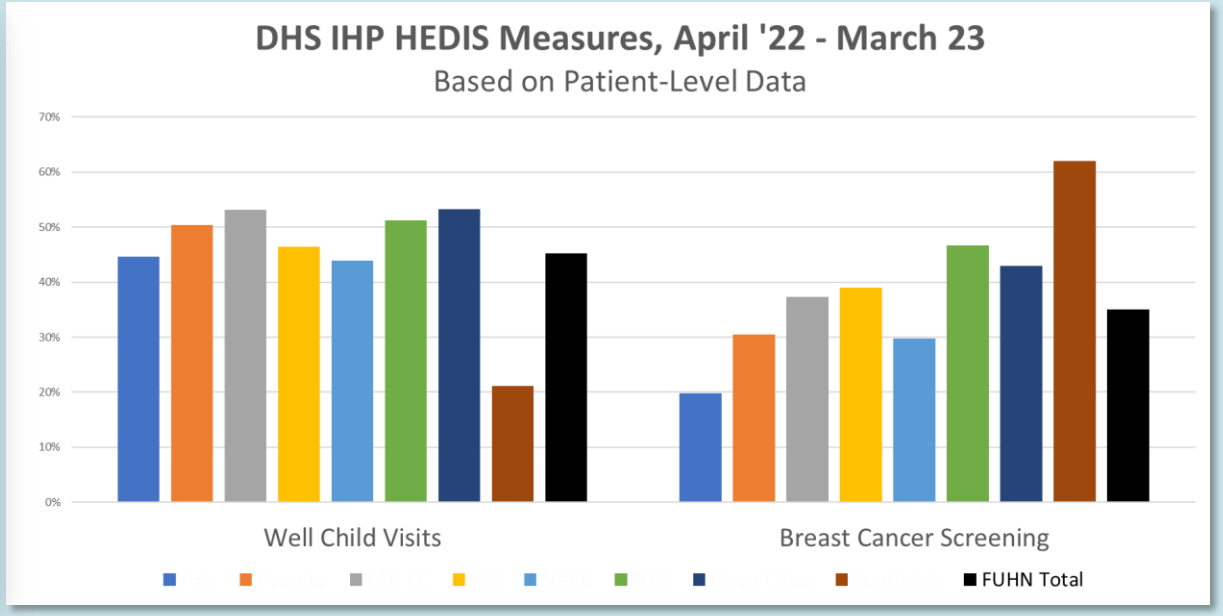
FQHC Urban Healthcare Network

Health Centers leverage attribution data to close gaps in care.

From DHS Gap Report, July '22 – June '23

Child and Adolescent Well-Care Visits

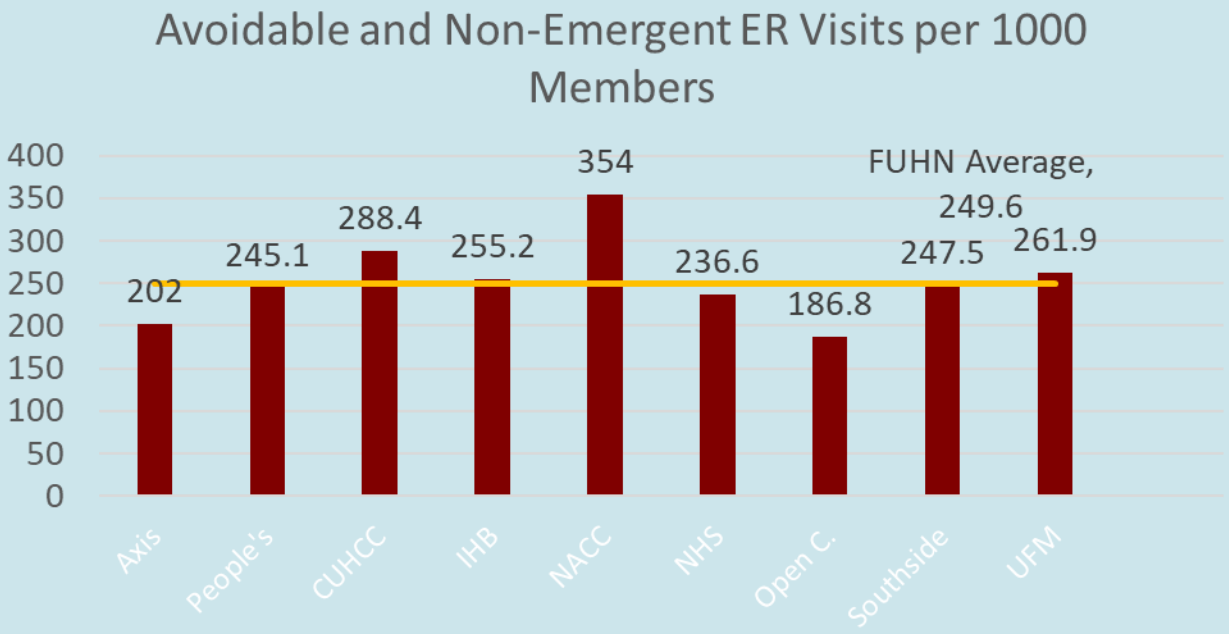
Clinic	Met	Not Met	Total	% Met
	588	832	1,420	41%
	444	374	818	54%
	523	524	1,047	50%
	271	311	582	47%
	196	248	444	44%
	492	469	961	51%
	168	166	334	50%
	193	641	834	23%
	270	673	943	29%
Grand Total	**3,145**	**4,238**	**7,383**	**43%**



FQHC Urban Healthcare Network

Health Centers leverage attribution data to inform care models for high risk and high-cost individuals.

Risk Band	% of Attributed Patients	% of Cost	Avg Cost
1	19.2%	2.4%	$ 1,312
2	21.2%	5.2%	$ 2,574
3	41.9%	36.3%	$ 9,163
4	13.5%	32.2%	$ 25,284
5	4.2%	23.9%	$ 60,233



Featured Speaker

Ranelle Kirchner, MS, RD, LDN, CDES
Chronic Conditions Care Manager
Southside Community Health Services

Ranelle Kirchner is a Licensed Registered Dietitian, Certified Diabetic Care & Education Specialist, and Le Cordon Bleu culinary graduate with a passion for health and wellness. She is also the author of two diabetes cookbooks and is currently working as the chronic condition care manager and DSME quality coordinator at Southside community health services.

Southside Community Health Services

- Located in South Minneapolis, Minnesota - 4 blocks from George Floyd Square
- 2 sites: Medical/BH and Dental/Vision; 9,925 patients (UDS 2022); 31,645 visits (UDS 2022)
- EHR is OCHIN Epic
- Earned and sustained gold health center quality leader badge for 5 consecutive years

Southside Community Health Services

Empanelment

- Patients assigned to the first medical provider they see at the health center.
- Patients can choose to see another provider at future visits if this best meets their schedule/needs.
- QI Director and Care Managers regularly assess UDS reports to identify care gaps and patients needing follow-up for chronic conditions. Review monthly clinical quality measure reports to identify opportunities for improvement.
- Created standardized workflows to address chronic conditions in high-risk patients (e.g., HTN, diabetes, etc.).

Attribution

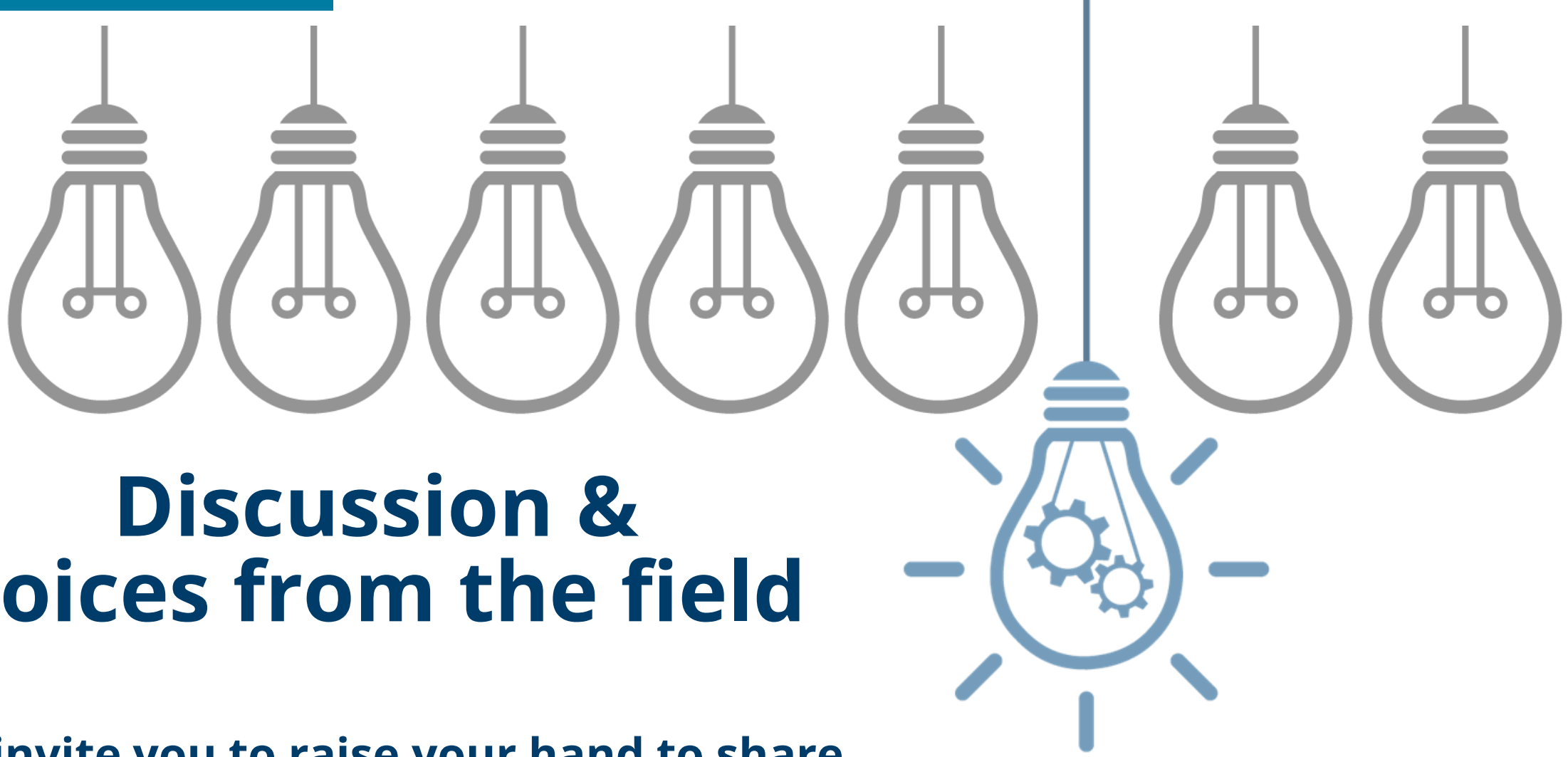
- Use Medicaid attribution lists provided by HCCN to supplement UDS reports and internal data and inform outreach efforts to high-ED and high-risk patients.
- Use attribution data to help inform care models for high-risk patients (includes regular touchpoints with a provider, PharmD, Chronic Condition Care Manager, and screening for SDOH).

Southside Community Health Services

Empanelment & Attribution serve as the foundation of patient care.

We have learned that our patients have the most success when:

- They have frequent touch-points (can be in-person or telehealth with anyone from the care team)
- Their care plans are individualized based on their unique life circumstances
- They build self-management skills: “Teach a person to fish and then fish with them until they catch their own fish” approach



Discussion & Voices from the field

We invite you to raise your hand to share how you have implemented population health workflows.

Leverage Population Health Strategies to Control Hypertension and Other Chronic Conditions

Health Center

Processes: **Empanelment** → **Risk Stratification** → **Models of Care**

Payor

Processes: **Attribution** → **Risk Stratification**

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.

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!

Elevate Pulse

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

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

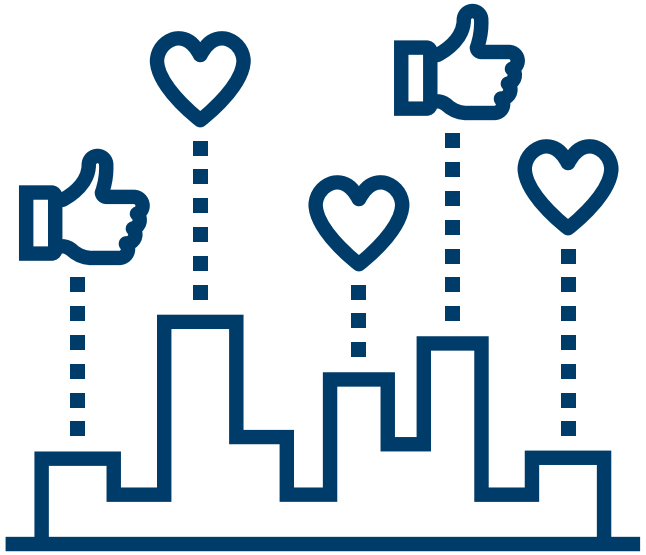
Sent the 2nd Friday of each month!

Elevate on the NACHC Learning Hub

Access dozens of

FREE resources!

Elevate on the NACHC Learning Hub



Provide Us Feedback

FOR MORE INFORMATION CONTACT

qualitycenter@nachc.org

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

NATIONAL ASSOCIATION OF Community Health Centers®

Next Monthly Forum:

Population Health Management, Risk Stratification & Social Drivers of Health

February 13, 2024
1:00 – 2:00 pm ET

Scan and register below!

NATIONAL ASSOCIATION OF Community Health Centers®

elevate°

Together, our voices elevate° all.

The Quality Center Team

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

qualitycenter@nachc.org