Menti Placeholder

- Icebreaker health center trivia: Approximately how many health centers are there in the US?
- A: 1400

NATIONAL ASSOCIATION OF Community Health Centers®

ELEVATE NATIONAL LEARNING FORUM

elevate

Health Information Technology (HIT) & Cost

May 14, 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:

- **Engage with us!** Throughout the webinar, type questions and comments in the chat feature. Be sure to send them to "Everyone"! There will be Q&A and discussion at the end.
- **Access resources!** Select to access related NACHC resources, tools, **and the slides for this webinar**!

Menti Placeholder

- Location on US map
- Type of organization

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

Agenda

Welcome

Elevate Journey

Health Information Technology (HIT)

Applied Example: Transitional Care Management

- NACHC
- HealthEfficient

Cost

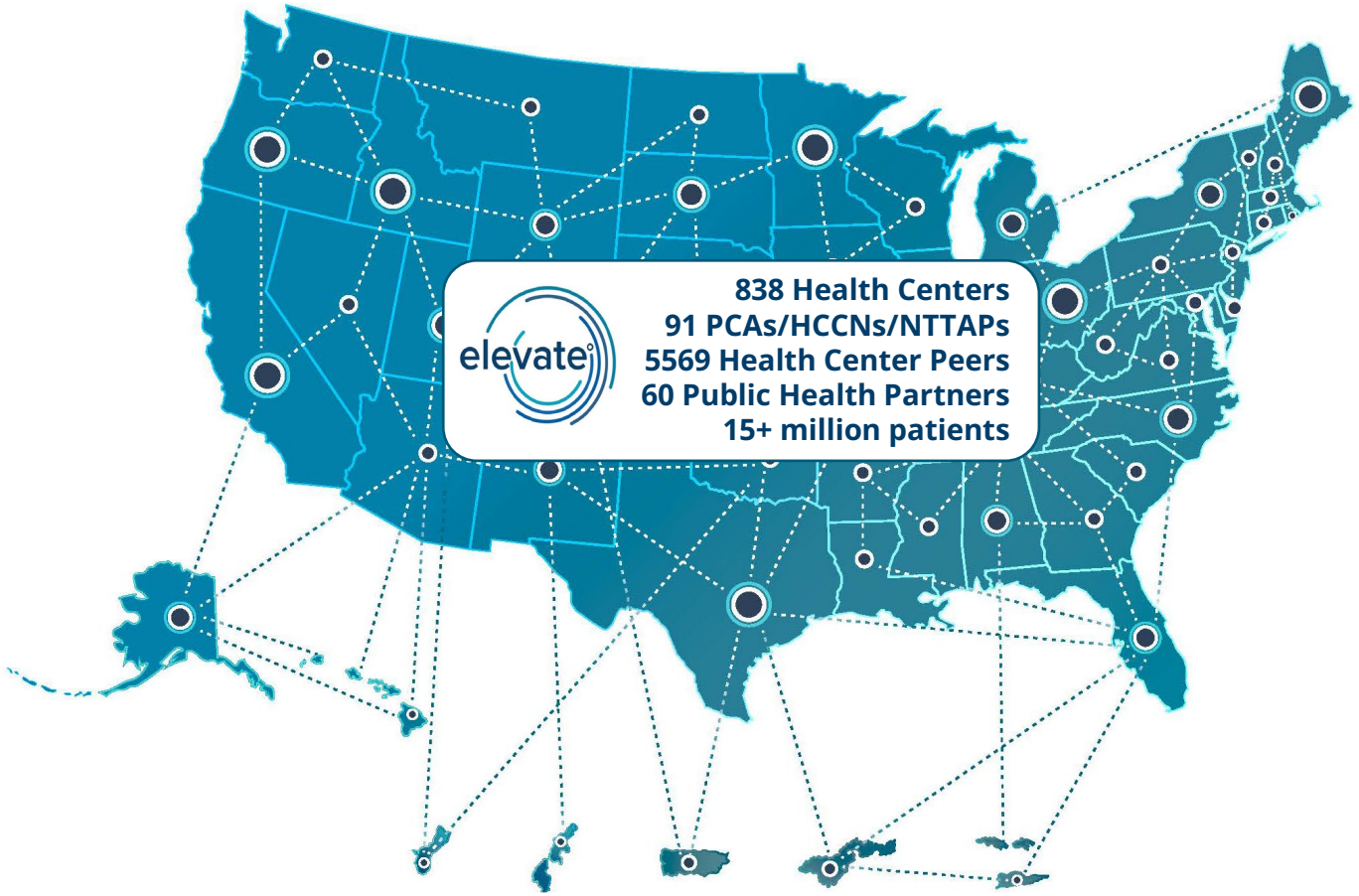
Applied Example: Hierarchical Condition Categories (HCC) Coding

- Facktor
- StayWell Health Center

Q&A and Discussion

Closing

Welcome!



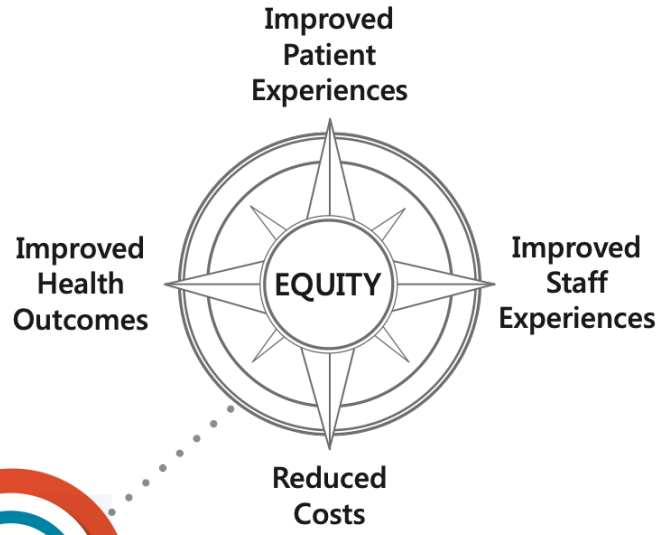
Elevate **provides guided application of the Value Transformation Framework**

National learning forum and peer exchange

Collaborate * Learn * Share * Create * Innovate

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

Data Dashboard

VTF Assessments (2019-current)
507 Health Centers
1823 Assessments

Average VTF Assessment Scores by Change Area

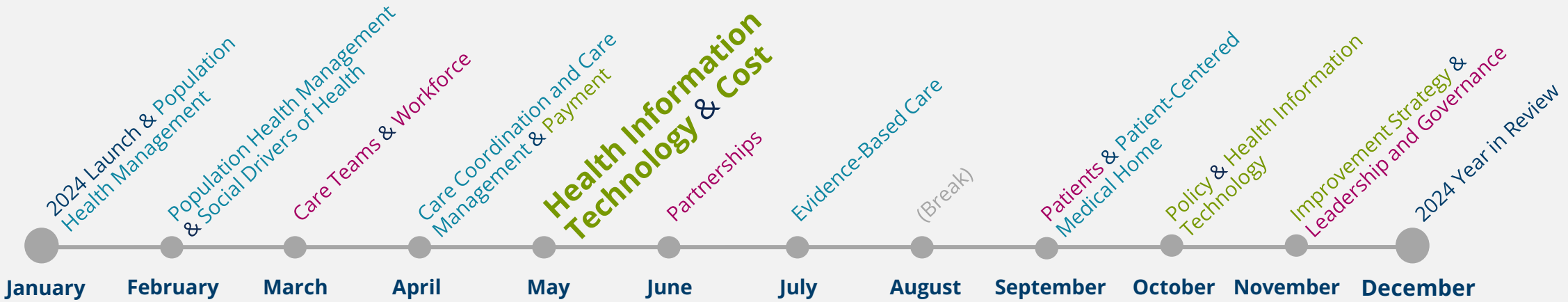
Improvement Strategy 3.12	Health Information Technology 2.90	Policy 2.97	Payment 2.83	Cost 2.75
Population Health Management 3.08	Patient-Centered Medical Home 3.59	Evidence-Based Care 3.29	Care Coordination and Care Management 3.19	Social Drivers of Health 3.10
Patients 3.14	Care Teams 2.99	Governance and Leadership 3.01	Workforce 2.86	Partnerships 3.42

Leverage data to drive improvement!

- **National level:** Guides NACHC in program and resource development.
- **State level:** Guides PCAs & HCCNs in training and technical assistance offerings.
- **Health center level:** Guides health centers in transformation & QI opportunities.

Elevate 2024

Monthly Learning Forums:



Supplemental Sessions:

- Value-Based Care Series – Starts June 6, 2024!

Professional Development Courses:

- **Clinical Staff & Health Coaches:** Lifestyle Coaching for the CDC's National Diabetes Prevention Program (Cohort in progress)
- **Clinical Staff & Health Coaches:** Person-Centered Care for Individuals with Higher Weight (Cohort in progress)

*Schedule may be adjusted by the Quality Center as needed.

Elevate Featured Health Centers: 2023 Health Center Quality Leaders!

ESPERANZA health centers

mainlinehealth systems, inc.

SOUTHSIDE Your Community Health Services

VCC

MVHC

St. Croix Regional Family Health Center

care resource
Your Community's Source for Healthcare

NORTHWEST MICHIGAN HEALTH SERVICES INC

HealthLinc
YOUR COMMUNITY HEALTH CENTER®

RHG
RURAL HEALTH GROUP
healthcare that fits your family

CAMILLUS HEALTH CONCERN

StayWell Health Center
Growing a healthier community one person at a time.

HEARTLAND HEALTH SERVICES

WAIMĀNALO HEALTH CENTER

URBAN HEALTH PLAN
Providing Care for Healthier Lives

Valley Professionals Community Health Center
CARING PROFESSIONALS IN YOUR COMMUNITY.

AudubonArea
Community Care Clinic, Inc.

CHARLES B. WANG COMMUNITY HEALTH CENTER

GPW Health Center
Dedicated to Your Health

OneWorld
Community Health Centers, Inc.

SFCHC
SAN FERNANDO COMMUNITY HEALTH CENTER

FIRSTMED
Health + Wellness
Your Healthcare Home

UMC
UNCOMPAHGRE MEDICAL CENTER

sunrise
COMMUNITY HEALTH

LAMPREY HEALTH CARE
SINCE 1971

Leveraging HIT to Manage Total Cost of Care

Track Admit, Discharge, and Transfer (ADT) alerts for patients moving through care transitions. Exchange data in real-time using a Health Information Exchange (HIE).

Integrate HIT efforts into the care delivery model

- Provide Transitional Care Management Services to prevent readmissions
- Provide Chronic Care Management Services to manage chronic conditions

Manage total cost of care, improve performance in value-based payment contracts

Review Hierarchical Condition Categories (HCC) coding for patients.

HCC coding uses categories of clinically similar diagnosis codes arranged in a hierarchy by severity and used to calculate a patient risk score. Often used by payors in value-based payment arrangements.

→ Correct any gaps in diagnosis coding & specificity to improve accuracy of HCC coding and better predict cost of care.

Health Information Technology (HIT)

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VTF Assessment: HIT

VTF Change Area: Health Information Technology

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

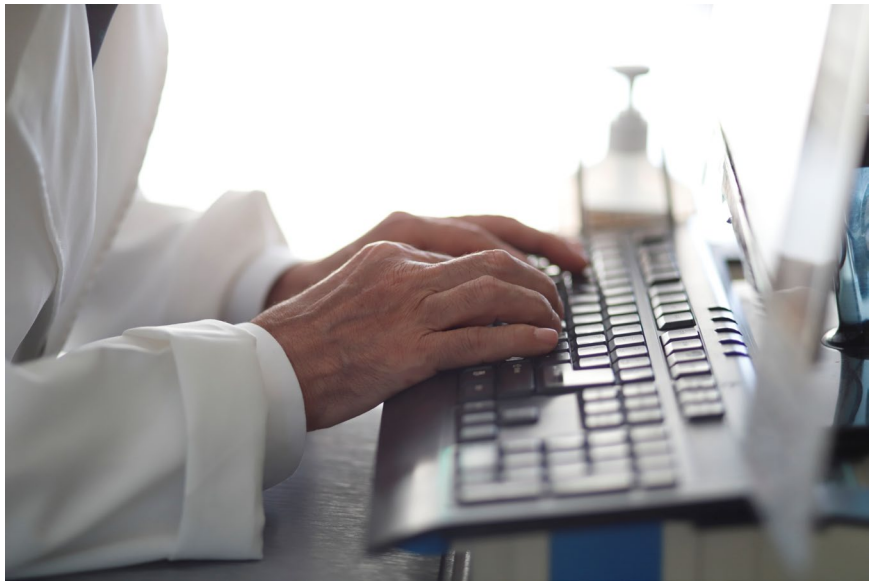
	1 – Learning	2 – Basic	3 – Applied	4 – Skilled	5 – Expert
HIT & Data Governance Workplan & Strategy				*Health center's HIT work plan and strategy explicitly align with specific organizational, improvement and transformation goals....*	
HIT to Enhance Care Delivery				*HIT efforts focus on clinical and cost data to measure, improve, and manage outcomes...*	
HIT Staffing				*Health center supports advanced training and development for HIT staff; assigns provider champions to HIT projects or steering committees.*	
Privacy and Security				*Health center identifies gaps in IT infrastructure. Uses data from analysis of privacy and security risks to formulate mitigation strategies.*	
Hospitalization and Claims Data				*Health center has agreements with outside partners to exchange patient data through manual or request-based processes...*	

WHAT is Health Information Technology?

Health information technology (HIT) involves the processing, storage, and exchange of health information in an electronic environment.*

Widespread use of HIT within the health care industry will improve the quality of health care, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork, and expand access to affordable health care. *

It is imperative that the privacy and security of electronic health information be ensured as this information is maintained and transmitted electronically.*

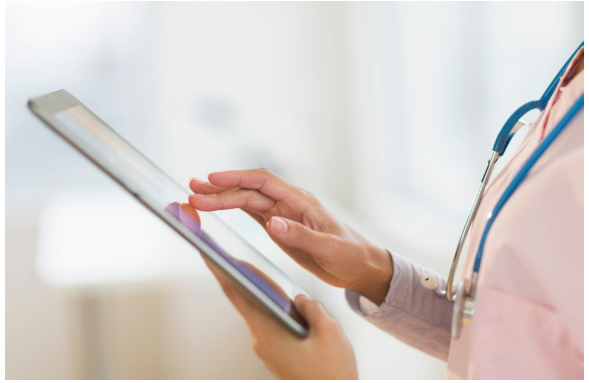


*https://www.hhs.gov/hipaa/for-professionals/special-topics/health-information-technology/index.html

WHAT can health centers do to leverage HIT?

Implement an HIT & Data Governance Workplan & Strategy:

- ✓ Technology for staff (clinical point of care, data analytics)
- ✓ Technology for patients (home monitoring, texting, telehealth)
- ✓ HIT best practices, including the use of data from external sources (e.g., data warehouse, health information exchanges)
- ✓ Data governance policies and procedures



Enhance Care Delivery:

- ✓ Integrate HIT efforts into the care delivery model
- ✓ Optimize HIT to enhance access to care
- ✓ Using advanced analytics (e.g., advanced population health tools; artificial intelligence)
- ✓ In addition to clinical and cost data, capture social risk and non-traditional 'touches' (e.g., phone, text, email) and enabling services

WHAT can health centers do to leverage HIT?

Incorporate HIT Staffing:

- ✓ Train/hire staff with medical informatics and clinical decision support expertise
- ✓ Staff regularly engage in aligning data priorities as they relate to QI and strategic goals

Ensure Privacy and Security:

- ✓ Implement tests and strategies to address gaps in IT infrastructure
- ✓ Use assessment information to track success and mitigate privacy and security risks

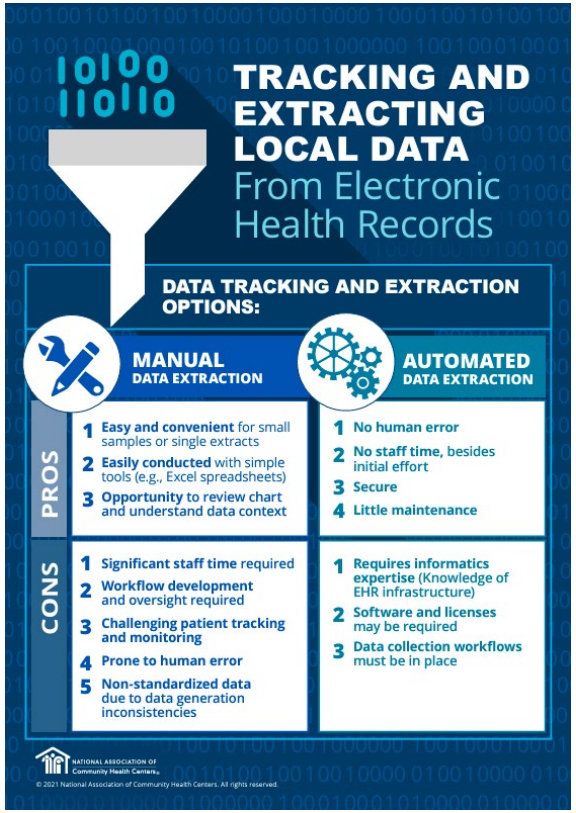
Track Hospitalization and Claims Data:

- ✓ Exchange data in real-time using a Health Information Exchange (HIE)
- ✓ Obtain and analyze cost and utilization data from external partners

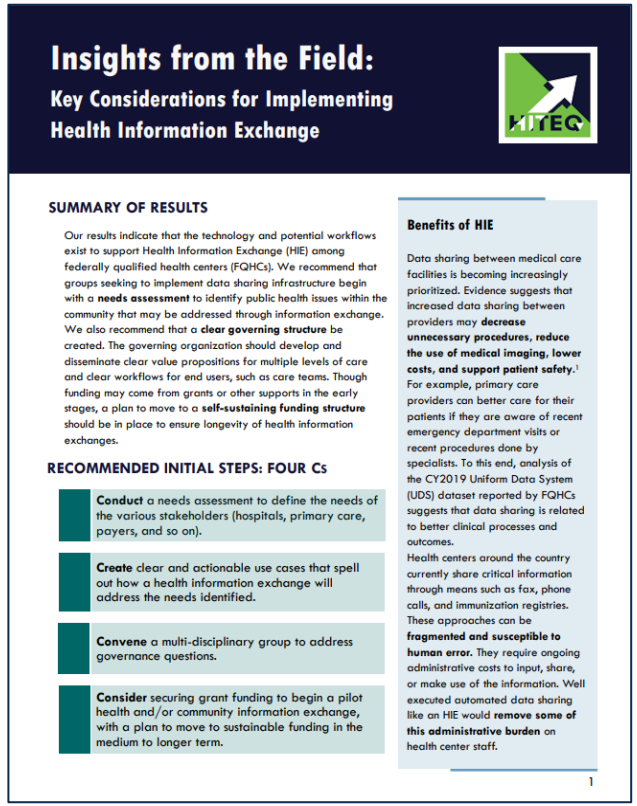
WHAT HIT resources are available?

[Visit NACHC Informatics Resources]

[HITEQ Center]



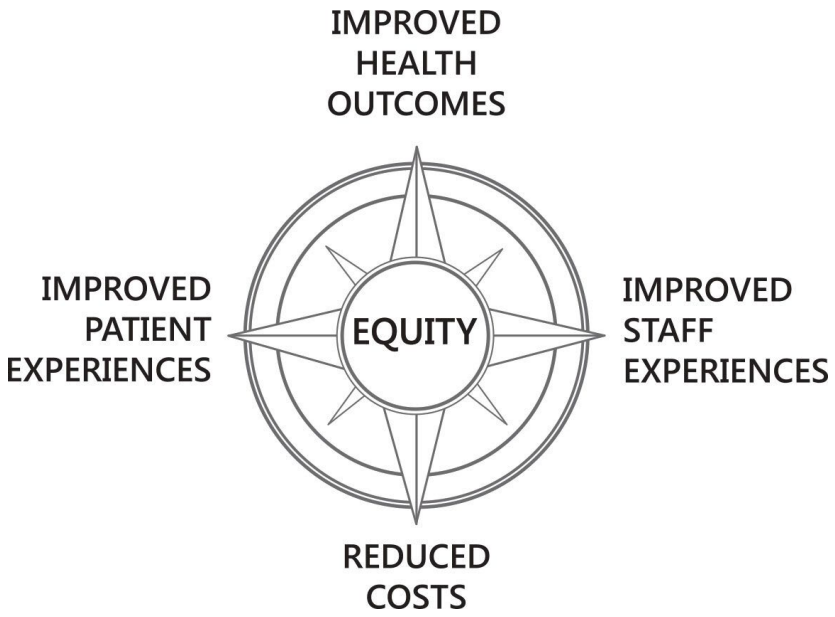
[Tracking and Extracting Local Data from EHRs]



[Key Considerations for Implementing HIE]

WHY leverage HIT?

Quintuple Aim Goals:



Improve health outcomes

- Point of care support
- Data analytics for QI

Improve patient experience

- Enhanced access to care
- Home monitoring, texting, telehealth

Improve staff experience

- Efficient workflows

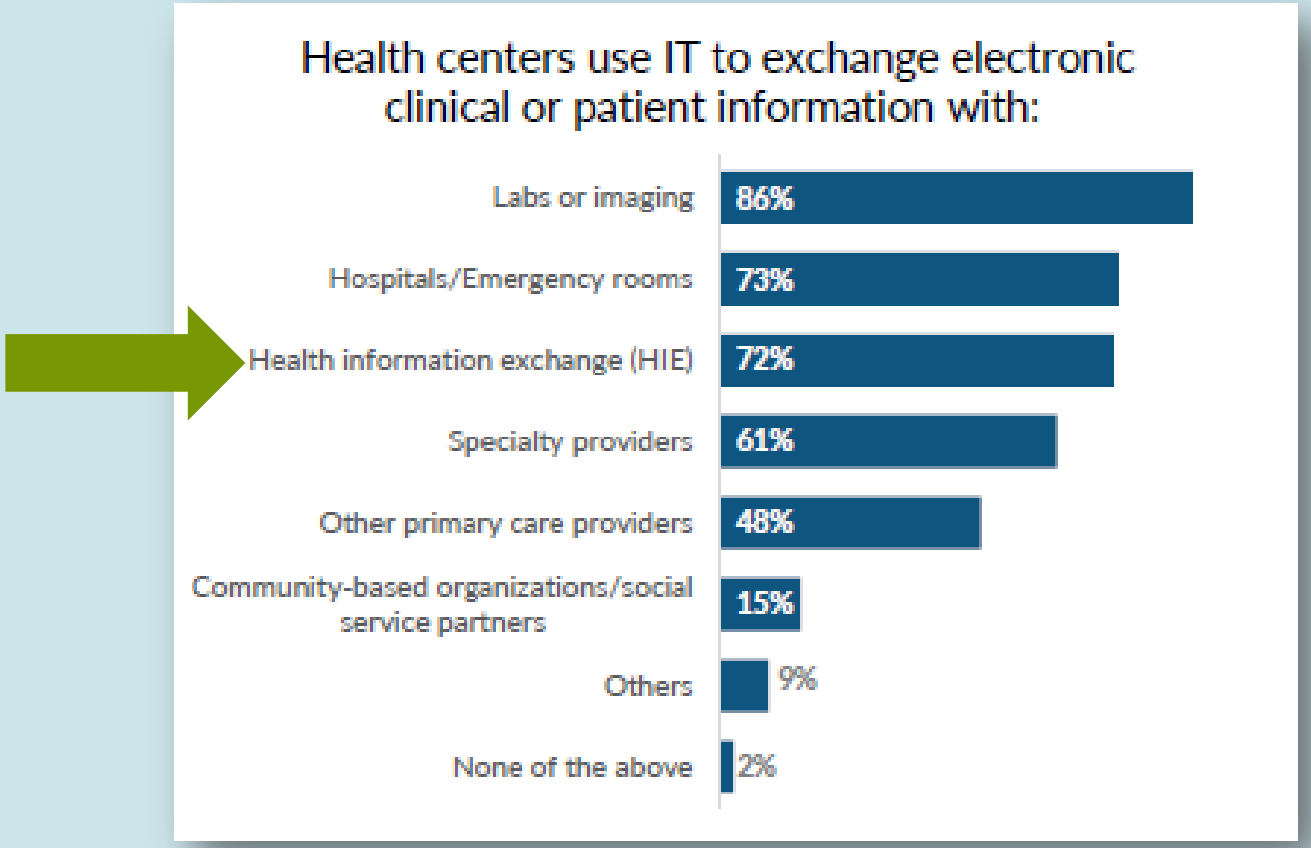
Reduce cost

- Enhanced care coordination

Advance equity

- Identification of population level disparities

Health Center use of HIT



Source: National Association of Community Health Centers. Community Health Center Chartbook. March 2023.

Menti Placeholder

How are you receiving notifications about patients being discharged from hospitalizations?

- We are not receiving hospital discharge information and have **no current plans to work towards this**
- We are not receiving hospital discharge information, but are **actively working towards this**
- Electronic faxes, phone calls, or other **manual exchange**
- Health Information Exchange **(HIE) not integrated** with the EHR/Population Health Management system
- Health Information Exchange **(HIE) that is integrated** with the EHR/Population Health Management system
- N/A

Featured HCCN

Stephanie Rose, MBA, CCE
Senior Director of Operations
HealthEfficient

Stephanie Rose oversees many of HealthEfficient's programs supporting community health centers. She develops and manages initiatives related to population health, clinical quality improvement, Electronic Health Record installation and improvement, Patient-Centered Medical Home transformation, UDS and UDS+ Reporting, Social Drivers of Health (SDoH), and more.

Featured HCCN

HealthEfficient is a not-for-profit, mission-driven organization that supports community health centers and other safety-net providers in improving clinical and operational performance, through the effective use of Health Information Technology and data analytics.

Along with our regional partners, we operate a federally-funded Health Center Controlled Network (HCCN) of 50+ community health centers across the country -- and now worldwide.

Featured HCCN

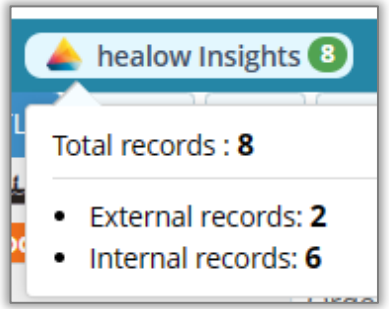
Health Information Exchange

- Securely Access and Share Patient Information
- Reduces silos
- Enhances Care Coordination
- Reduces Medical Errors
- Closes care gaps
- Improves Population Health Management
- Saves time for providers, staff, and patients

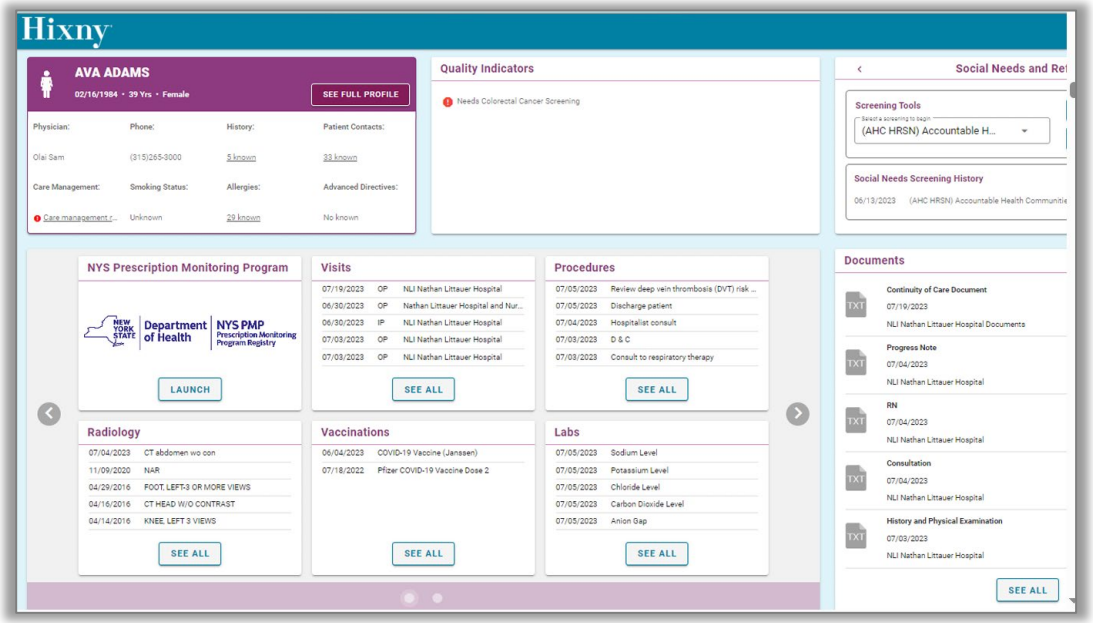
HealthIT.Gov Health Information Exchange Basics

Featured HCCN

How to Take Advantage of HIE Data



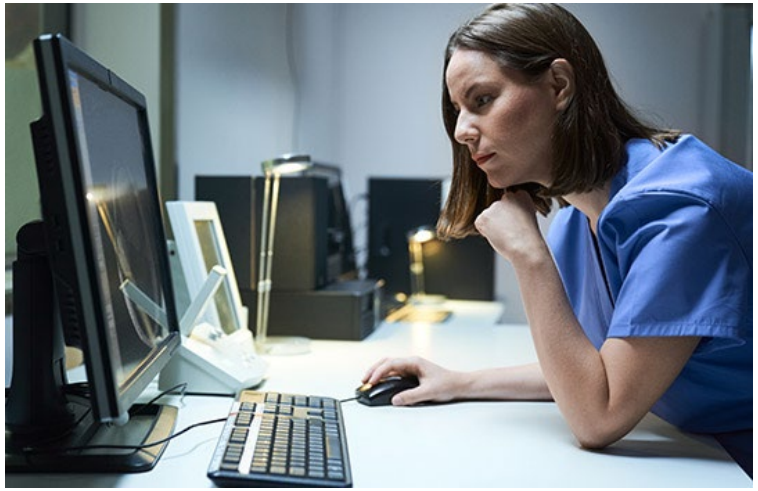
- Direct EHR Integration
- HIE Portals
- FHIR Apps
- Nationwide Networks – CareQuality/CommonWell
- Integrated EHR Alerts and Notifications
- Document Import/Export



Featured HCCN

Supporting Clinical Care with HIE

- Previsit planning
- Close Care Gaps
- Obtain Test Results
- Population Health Management
- Identify inpatient hospitalization and ER visits for follow-up
- Coordinate Care with other providers
- Enhanced Features vary by HIE

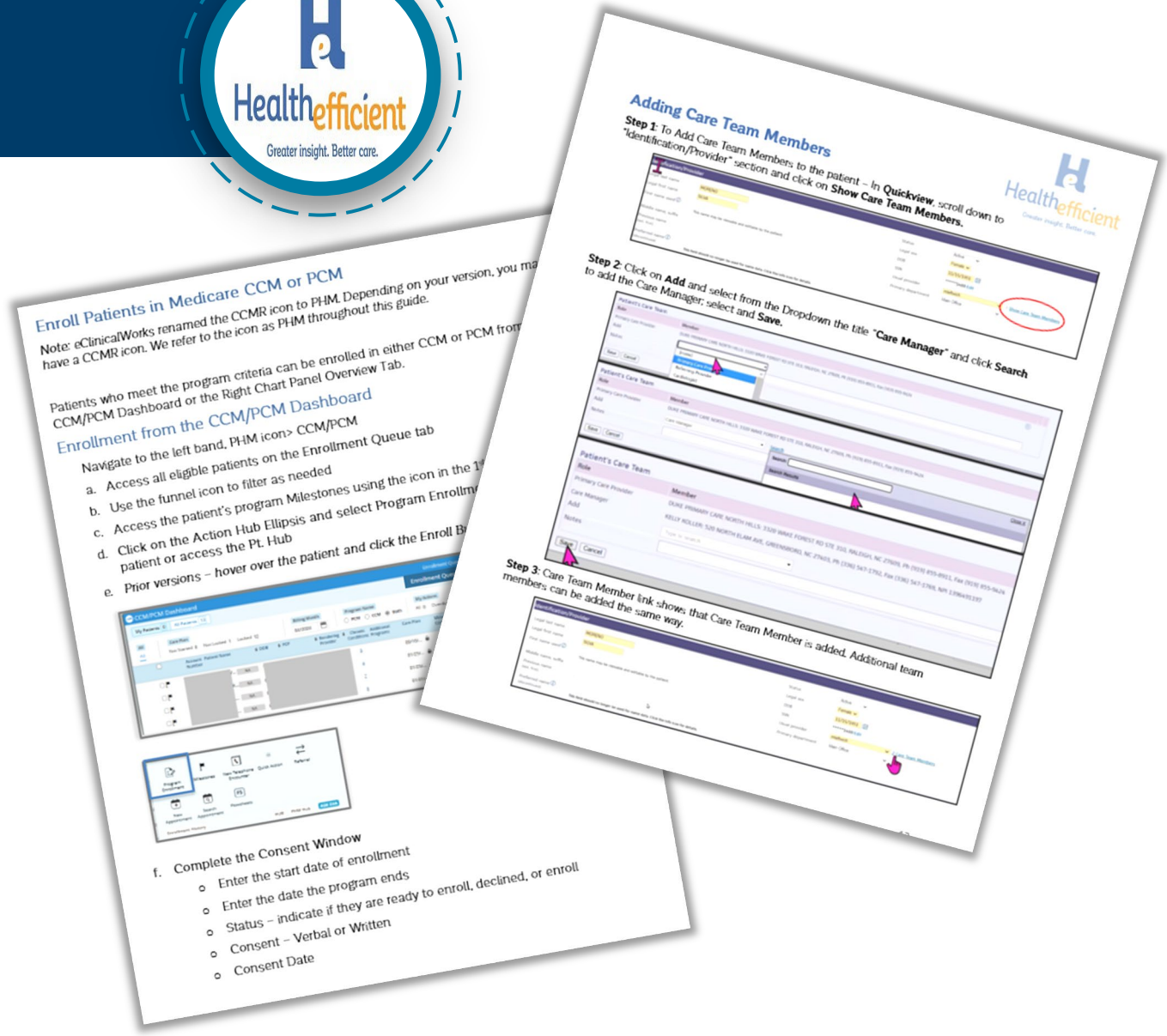


Featured HCCN

Coming Soon!

athenaOne, eClinicalWorks, and NextGen Best Practice Documentation Guides for:

- Chronic Care Management (CCM/PCM)
- Transition of Care Management (TCM)
- PRAPARE Screening



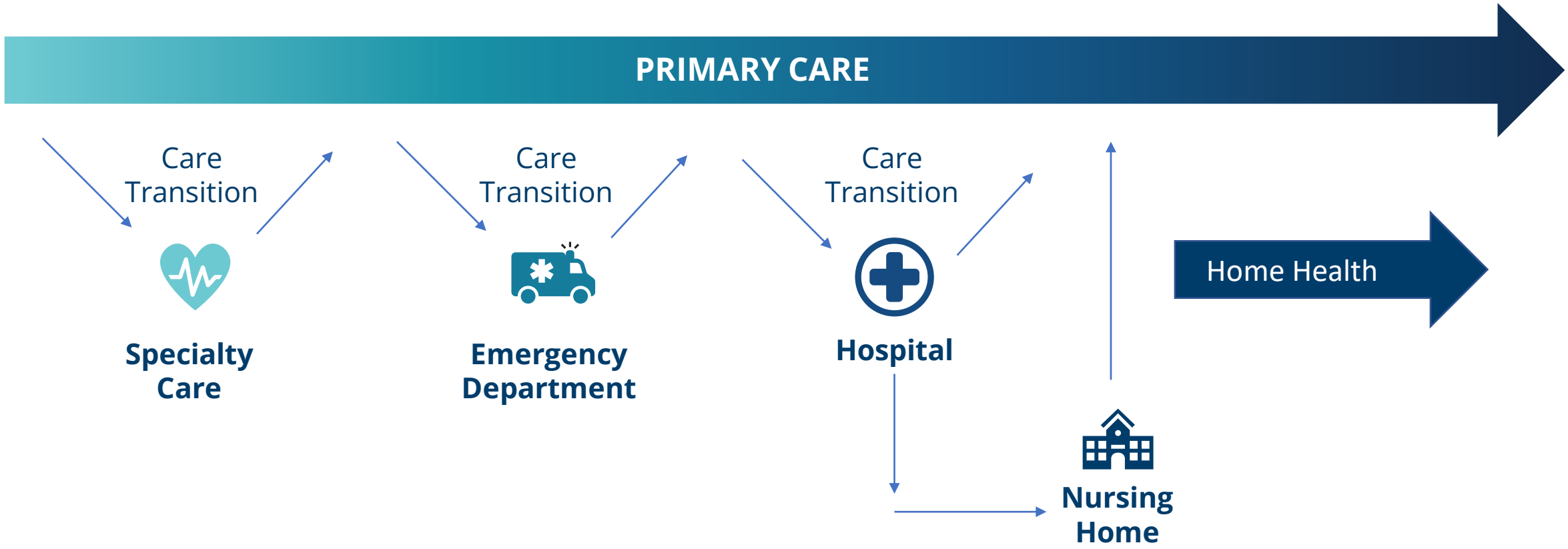
HIT Applied Example:
Transitional Care Management

WHAT is TCM?

Transitional Care Management (TCM) supports the transition and coordination of services from an **inpatient setting** to a **community setting** by establishing a coordinated plan with the patient's Primary Care Provider (PCP).

WHAT is TCM?

Examples of Care Transitions Along the Patient Continuum of Care:



WHY provide TCM services?

Transitions increase the risk of adverse events due to the potential for miscommunication as responsibility is given to new parties.*

Hospital discharge is a complex process representing a time of significant vulnerability for patients.*

Safe and effective transfer of responsibility for a patient's medical care relies on effective provider communication with patient comprehension of discharge instructions.*

Improve Patient Experience

Increase Revenue

Improve Health Outcomes

Demonstrate HRSA OSV Compliance: Continuity of Care and Hospital Admitting

Health center procedures address the following areas for patients who are hospitalized as inpatients or who visit a hospital's emergency department:

- ✓ Receipt and recording of medical information related to the hospital or ED visit, such as discharge follow-up instructions and laboratory, radiology, or other results; and
- ✓ Follow-up actions by health center staff, when appropriate.

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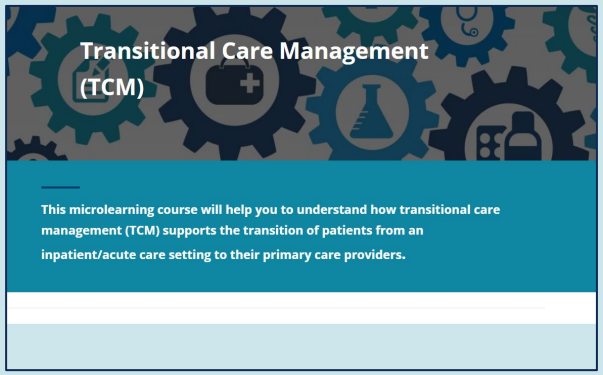
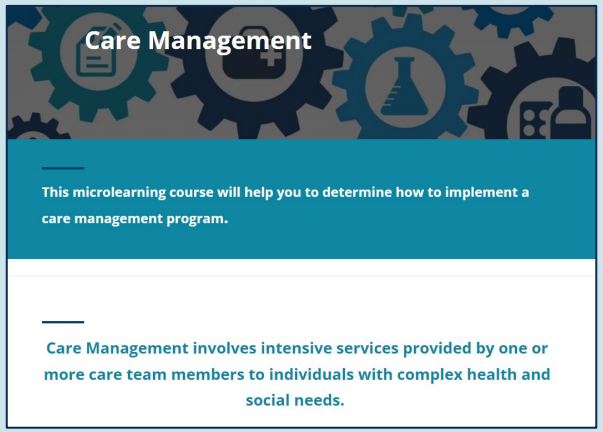
* https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/carecoordination/measure1.html

HOW to implement a TCM program

NEW!



TCM Microlearning



Care Management Microlearning

STEP 1 Ensure leadership support of initiative

STEP 2 Define care management services to be provided

STEP 3 Identify or hire a care manager

STEP 4 Announce initiative to all health center staff

STEP 5 Identify eligible patients through data

STEP 6 Provide training specific to job role

STEP 7 Design workflow and prepare HIT systems to support program

STEP 8 Enroll patients

STEP 9 Provide and document care management services

STEP 10 Ensure regular communication with provider, care team

STEP 11 Code and bill for services

STEP 12 Monitor program outcomes as part of health center quality improvement plan

STEP 5 *Identify Eligible Patients Through Data*

Patients eligible for TCM services are those who need moderate decision-making during transitions in care from an inpatient/acute care setting to their community setting.

- 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

To identify eligible patients:

- Utilize state or local Health Information Exchanges (HIEs) to review Admit, Discharge, Transfer (ADT) data.
- Strengthen relationships with local care systems (hospitals, EDs, nursing homes, etc.) to manually exchange transition of care information for shared patients.

STEP 9

Provide and Document Care Management Services

Three components in 30-day period starting on the date the patient is discharged:

1. Interactive Contact
2. Face-to-Face Visit
3. Non-Face-to-Face Services

All three components are required to bill Medicare for TCM services. Program requirements for Medicare TCM can be applied for ***all patients*** moving through transitions of care, though reimbursement may vary by state or payer.

STEP 9

Provide and Document Care Management Services

1 Interactive Contact

Within 2 business days of the discharge date, the billing provider or qualified auxiliary personnel (under the supervision of the billing provider) initiates direct and interactive communication with the patient or caregiver (phone, in-person, electronic).

Contact should address:

- ✓ Type of services the patient had during admission
- ✓ The discharge diagnosis
- ✓ Follow-up services that may be needed
- ✓ Scheduling a face-to-face follow-up appointment with the provider (PCP)

It may also be beneficial (though not required) to address:

- ✓ Medication reconciliation (required on or before the date of the face-to-face visit)
- ✓ Social Drivers of Health (SDOH)
- ✓ ADLs (Activities of Daily Living)

STEP 9

Provide and Document Care Management Services

2 Face-to-Face Visit

Following discharge, and after the interactive contact, a face-to-face visit with a provider (PCP) is required.

- A patient whose condition warrants medical decision making of **high complexity (99496)** must be seen within **7** days of discharge.
- A patient whose condition warrants medical decision making of **moderate complexity (99495)** must be seen within **14** days of discharge.
- The face-to-face visit cannot take place on the date of discharge.

Telehealth Visits

During the COVID-19 Public Health Emergency (PHE) and until 12/31/2024, CMS allows TCM to be provided as an audio-visual telehealth service. As it is on the CMS list of telehealth services, the current guidance is that it would be billed for using G2025 for the duration of the PHE when provided as an audiovisual telehealth service. Health centers must capture the actual CPT service code (e.g., 99495) for tracking purposes.

STEP 9

Provide and Document Care Management Services

2 Face-to-Face Visit

The face-to-face visit allows the authorized billing provider to assess the patient and develop a plan to aid the patient's return to their community setting. Clinical notes may include:

- ✓ Medication reconciliation (required on or before the date of the face-to-face visit)
- ✓ Referrals made to other providers
- ✓ Identification of community resources available to the patient
- ✓ Any contacts made with other providers to coordinate care
- ✓ Continuing care instructions for family members who may be present
- ✓ Patient education materials given to the patient
- ✓ Labs and/or diagnostic tests performed
- ✓ DME ordered or discontinued

STEP 9

Provide and Document Care Management Services

3 Non-Face-to-Face Services

Throughout the 30-day post-discharge time period, additional care coordination services may be needed by the patient. These "Non-Face-to-Face Services" by the ***Provider*** may include:

- ✓ Obtaining and reviewing the discharge information
- ✓ Reviewing the need for, or following up on, pending diagnostic tests and treatments
- ✓ Interacting with other qualified health care professionals who will assume or reassume care of the patient's system-specific problems
- ✓ Educating patient, family, guardian, and/or caregiver(s)
- ✓ Establishing or reestablishing referrals and arranging for needed community resources
- ✓ Assisting with the scheduling of follow-up with community providers and services

STEP 9

Provide and Document Care Management Services

3 Non-Face-to-Face Services

Throughout the 30-day post-discharge time period, additional care coordination services may be needed by the patient. These "Non-Face-to-Face Services" by the ***Care Manager*** or other care team members may include:

- ✓ Identify and facilitate access to, and communication with, community and health resources, including home health agencies, available to support patient and/or family service needs
- ✓ Provide assessment to support adherence and management of medication treatment regimen
- ✓ Educate patient and/or family/caretaker to support self-management, independent living, and ADLs
- ✓ Communicate aspects of care with the patient and any individuals involved in the care or decision-making process

STEP 9

Provide and Document Care Management Services

Provide care management services to high-risk patients on a routine basis to prevent readmissions and support management of chronic conditions.

The face-to-face visit component of TCM qualifies as an initiating visit for Medicare care management services.

The care management visit must occur within 12 months of the initiating visit.

Summary of Medicare Care Management Services

*Billed Using G0511**

See NACHC resource: ***CMS Billing Lingo, Defined!*** for definitions of terms used throughout this document.

	Chronic Care Management (CCM)	Complex Chronic Care Management (CCCM)	Principal Care Management (PCM)	Chronic Pain Management (CPM)	Behavioral Health Integration (BHI)	Community Health Integration (CHI)	Principal Illness Navigation (PIN)	Remote Physiologic Monitoring (RPM)	Remote Therapeutic Monitoring (RTM)
Description	Personalized and supportive services provided to patients with multiple chronic conditions to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with multiple chronic conditions, who require moderate or high medical decision making, to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with a single complex chronic condition to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with chronic pain to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with behavioral health needs to coordinate care and develop a care plan to achieve health goals.	Personalized and supportive services provided to patients with unmet social drivers of health (SDOH) needs that interfere with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions.	Personalized and supportive services provided to patients with a high-risk condition and healthcare navigation needs.	A patient's use of devices to remotely assess and record physiologic data (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate) outside of the clinical setting, usually in the home.	A patient's use of devices to remotely monitor adherence and response to therapeutic treatment (e.g., respiratory, musculoskeletal) using non-physiologic data outside of the clinical setting, usually in the home.

Tools & Resources:

- Summary of Medicare G0511 Care Management Services

STEP 11 *Code and Bill for Services*

WHAT PROVIDER CODES	Services	What FQHC bills to CMS	What CMS pays (Physician Fee Schedule)
99495	Face-to-face visit within 14 days of discharge, moderate complexity	G0467 G2025 (telehealth)	$195.99 $95.27 (telehealth)
99496	Face-to-face visit within 7 days of discharge, high complexity		

TCM Documentation Requirements

- ✓ Date the beneficiary was discharged
- ✓ Date of interactive contact with the beneficiary and/or caregiver
- ✓ Date of the face-to-face visit
- ✓ Complexity of medical decision making (moderate to high)
- ✓ Services provided during face-to-face visit and non-face-to-face components

Tools & Resources:
- TCM Reimbursement Tip Sheet

STEP 12

Monitor Program Outcomes as Part of Health Center Quality Improvement Plan

Assess the impact of your TCM program by measuring:

- Billed TCM encounters
- Hospital readmission rates
- Avoidable ED visits
- Enrollments in CCM
- Total cost of care data
- Patient experience surveys

It is beneficial to work with accountable care organizations, Clinically Integrated Networks, payers, or local healthcare systems to improve processes and track outcomes together.

Cost

VTF Assessment: Cost

VTF Change Area: Cost

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

	1 – Learning	2 – Basic	3 – Applied	4 – Skilled	5 – Expert
Cost Strategy				*Health center aligns strategy to address total cost of care with organizational, improvement, and transformation goals. Health center has assessed, and is pursuing, the financial requirements to support transition to value-based care models, including capital planning.*	
Cost Analysis				*Health center has identified health center per-member-per-month costs for the full scope of services offered. Health center can analyze costs by service area (e.g., behavioral health, enabling services, vision, and pharmacy). Health center leaders share cost metrics relative to quality performance with providers.*	

WHAT can health centers do to address cost of care?

Develop a Cost Strategy:

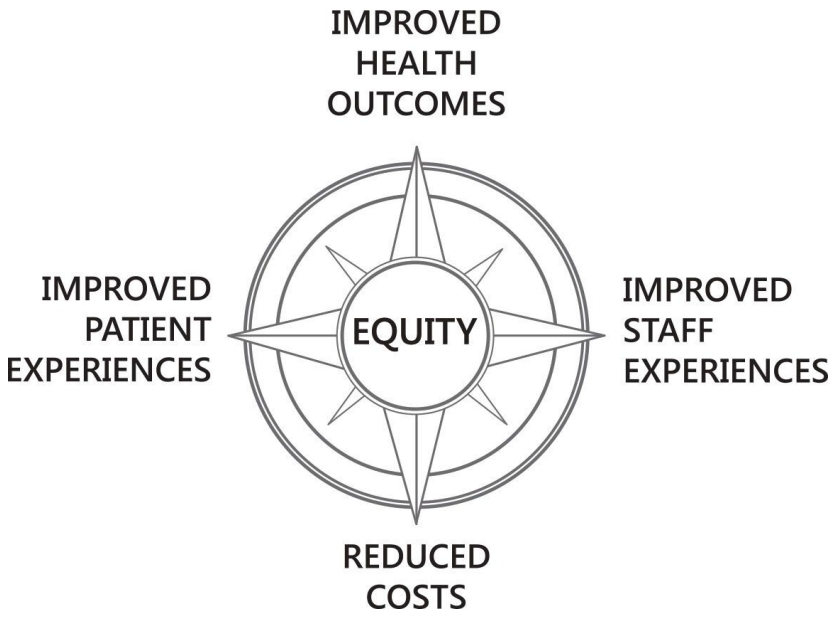
- ✓Address total cost of care to Quintuple Aim results and secure additional revenue sources and/or capital to support advancement of value-based care

Perform Routine Cost Analysis:

- ✓Analyze and monitor health center per-member-per-month costs
- ✓Monitor return on investment
- ✓Health center leaders share individual-level cost data with providers and use the data to develop performance incentives

WHY address cost of care?

Quintuple Aim Goals:



Improve health outcomes

- Better prevent and manage chronic conditions

Improve patient experience

- Reduced hospital and unnecessary ED visits
- Coordinated care

Improve staff experience

- Better coordination with hospital/specialty providers

Reduce cost

- ☺

Advance equity

- Identify/address disparities associated with cost

Cost Applied Example: HCC Coding

Featured Subject Matter Expert

elevate

Facktor

Excellence & Innovation In Healthcare Consulting Since 2001

About

- Facktor is a national professional healthcare consulting firm now working across 36 states and representing over 250+ clients nationally.
- Committed to revolutionizing community health, Facktor has an extensive history working with Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes (LALs).
- Our team-based approach mirrors the health center C-suite, leveraging subject matter expertise to deliver high-quality project-based and interim staffing services.

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Hierarchical Condition Category (HCC) Coding:

- **What is it?** A classification system used to risk-adjust patients based on their diagnoses and health conditions.
- **Why is it used?** HCC codes specify the severity of chronic disease, comorbidities, and associated complications. It is a central component of risk-adjustment (RA), a methodology used by payers and health plans to compare the health risk of individuals and populations, and to predict future healthcare costs.
- **Why is it important to managing total cost of care?** Medicare Advantage, Medicaid Managed Care, and other capitated or prospective payment models rely on HCC and RA to direct premium funds, care management resources, and community supports towards high and rising risk patients. Accurate HCC code capture and annual reconfirmation is key to ensuring appropriate reimbursement in risk-based payment models.

Featured Subject Matter Expert

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Stay Tuned for Upcoming HCC Training Content from Facktor & NACHC:

HCC Coding for Non-Coders: Building the case for risk adjustment at your health center
New to risk adjustment (RA) and hierarchical condition category (HCC) coding? This session will introduce non-coders to key HCC concepts, compliance, strategies, and important considerations for health center leaders building a case for implementing HCC and clinical documentation improvement (CDI) initiatives.

Featured Health Center

Dr. Tess Kryspin Lombard, MD
Chief Medical Officer
StayWell Health Center

- *Tess Kryspin Lombard, MD is the Chief Medical Officer at StayWell Health Center in Waterbury CT.*
- *After graduating from New York Medical College and completing a residency in Internal Medicine at St Vincent's Medical Center in Connecticut, Dr Lombard worked in private practice, Medical Education, Inpatient Hospital Medicine and several Community Health Centers.*
- *With an MBA, Dr Lombard works in both Clinical and Administrative Medicine.*
- *Dr Lombard is a Fellow of the American College of Physicians, a Fellow of the American Association of Physician Leaders, a Fellow in the American Board of Quality Assurance and Utilization Review physicians and a Certified Physician Executive.*
- *In 2019, Dr Lombard was the recipient of the CHCQM Diplomate Achievement Award for her work in risk adjustment and use of data to ensure excellent care.*

Featured Health Center

- **Waterbury, Connecticut**
- **Seven sites, serving 23,000 patients, 100,000 visits**

- **AHA Target BP Gold, AHA Check Change Control Cholesterol Gold**
- **Part of REACH value-based care program**
- **Celebrating our 50th Anniversary**

Featured Health Center

How to best manage total cost of care through Hierarchical Condition Categories coding?

- **Education and awareness of the Physicians, APRNs, PAs of the existence and importance of HCC**
  - Focus on updating the problem list with the most accurate and detailed codes on an ongoing basis including removing inaccurate codes
  - As a member of the Value Based REACH program, this concept is reinforced with every patient appointment
  - Training new staff to the incentives to the organization of Value Based Care
    - Timing of AWVs for high-risk patients, schedule based on insurance coverage

Featured Health Center

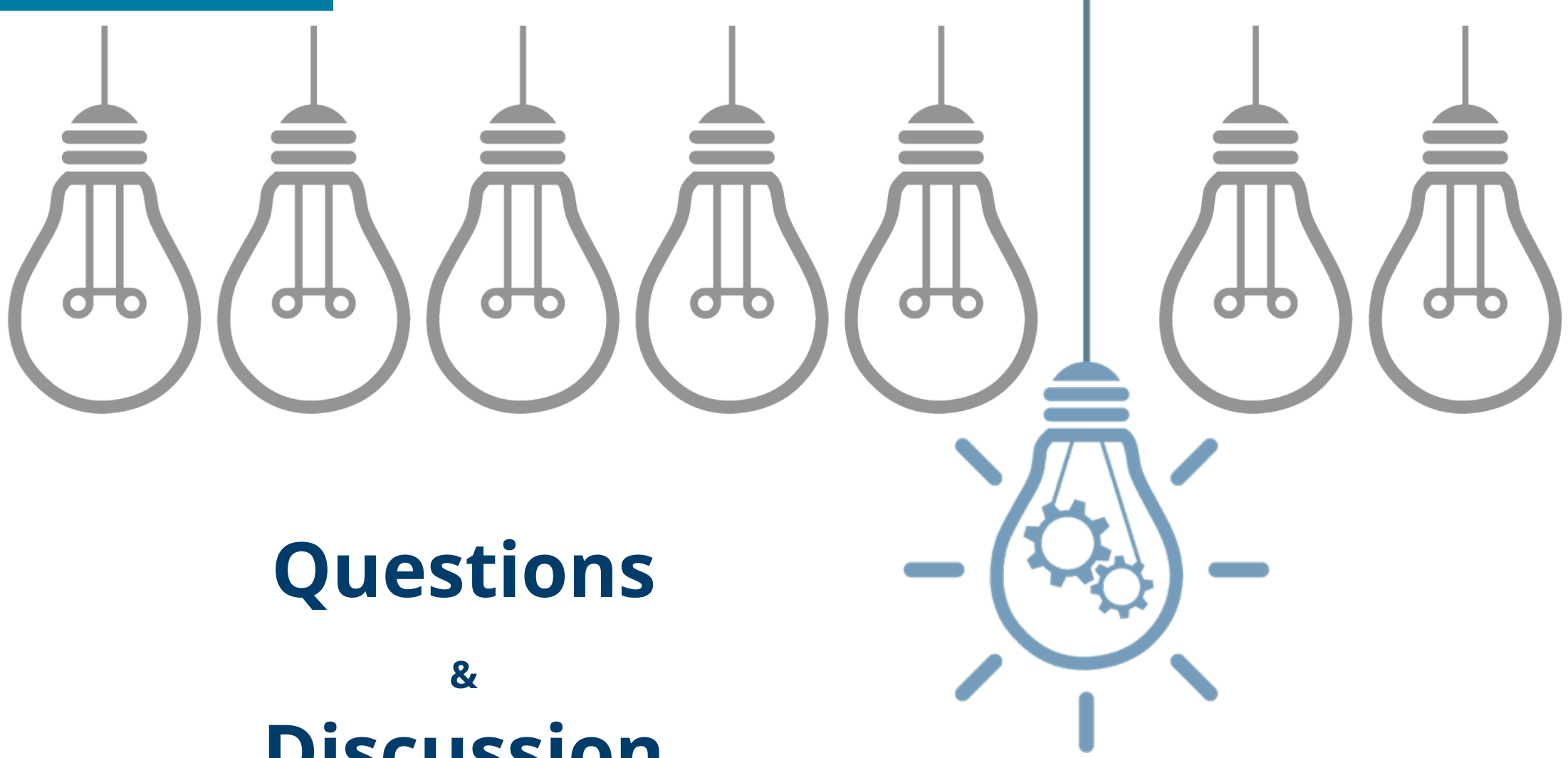
How to best manage total cost of care through Hierarchical Condition Categories coding?

- **Infrastructure:**
  - Use tools such as CareScreen, HCCs are captured at the time of the appointment
  - As important to confirm, or not confirm, a diagnosis
  - Utilize 2 screens in order to be able to easily maneuver between programs
- **Care Delivery:**
  - Goal is to accurately capture the patient's clinical picture
  - For Medicare patients who receive CCM, there is a demonstrated adherence to UDS quality metrics

Featured Health Center

Lessons Learned/Challenges

- Understand the Medicare process for the “Healing” of the New Year - Code for amputations, cancers, every year
- Accurate coding of BH diagnoses - Drug abuse, uncomplicated F19.10 vs drug dependence F19.20
- Work backwards – run the list of patients on insulin, GFRs or BMI (morbid obesity) and then update Problem List
- Incentives - Bonus to the Center- Star Levels +Diagnosis review vs Bonus to the staff – dollars may differ in Private Practice
- Primarily the Adult Medical Physicians/PAs/APRNs that are driving income generation through CCM and value-based care programs (HCC documentation) - acknowledge this responsibility and how it contributes to workloads/burnout



Questions

&

Discussion

Value-Based Payment Series

NACHC is pleased to announce the launch of a **FREE Value-Based Payment (VBP) learning series** designed to meet health centers, and health center partners, at any point along the VBP readiness continuum – from Planning, to Implementing, to Optimizing (see flyer for definitions).

This series is designed for individuals who are directly supporting health center VBP activities, such as leadership, finance, clinical, and quality improvement.

Series begins June 6th, 2024 2-3pm ET

Register here!

Elevate Pulse

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

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

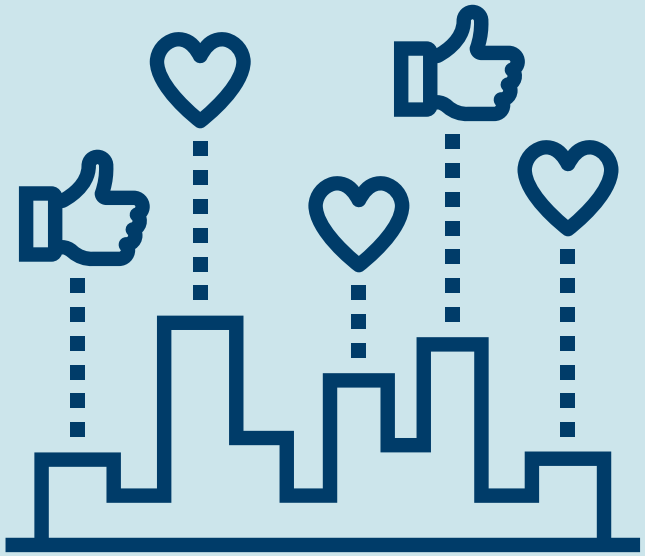
NACHC's Learning Hub

***FREE* on-demand learning sessions, microlearning courses, and printable resources, developed by NACHC exclusively for health centers and partners!**

- ✓The Aging Population and Dementia
- ✓Patient Engagement
- ✓Care Management
- ✓Value-Based Care
- ✓Optimizing Care Teams
- ✓Elevate Session Recordings and Slides

Access the NACHC Learning Hub here!

Need help signing in?
Click here for instructions!



Provide Us Feedback

FOR MORE INFORMATION CONTACT

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Next Monthly Learning Forum:

Partnerships

elevate

June 11, 2024
1:00 – 2:00 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

elevate°

Together, our voices elevate° all.

The Quality Center Team

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

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