NATIONAL ASSOCIATION OF Community Health Centers®

OPTIMIZING VALUE-BASED PAYMENT STRATEGIES WHILE MITIGATING FINANCIAL RISK

elevate

Session 4 in a 4-Part Series
June 27, 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.

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NACHC Speakers

Cheryl Modica, PhD, MPH, BSN
Director, Transformation & Innovation

E. Benjamin Money, Jr., MPH
Senior Vice President, Population Health

Optimizing Value-Based Payment Strategies

Learning Objectives:

- ✓ Outline contracting strategies to mitigate financial risk and enhance the prospect of success in risk arrangements.
- ✓ Discuss strategies for developing a FQHC primary care capitated alternative payment methodology for Medicaid.

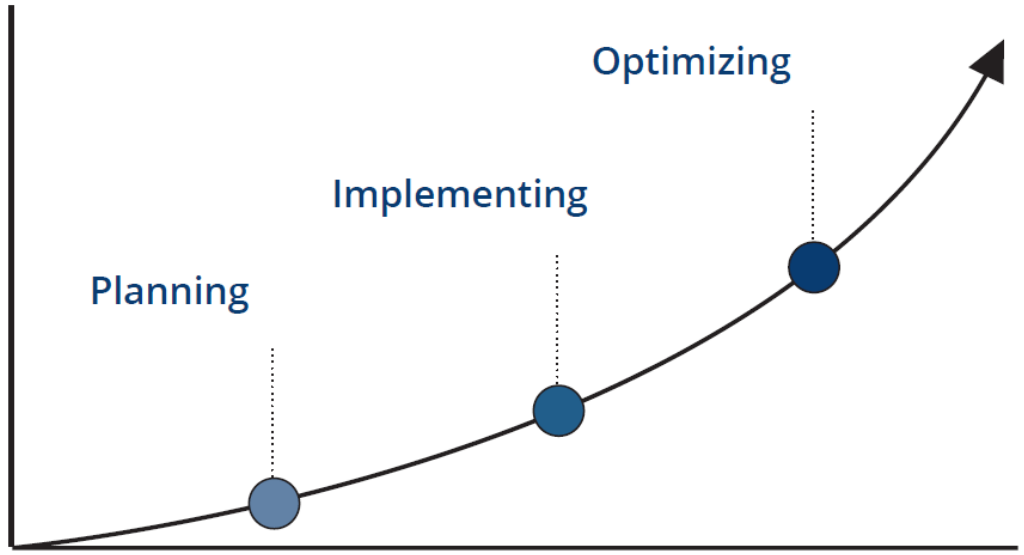
Q&A

Value-Based Payment Readiness

Planning: Health centers in the *Planning* stage are aware of the importance of value-based care and working to increase knowledge in this area and prepare for value-based payment arrangements. Reliant on prospective payment system (PPS) with little or no participation in pay-for-performance (LAN2).

Implementing: Health centers in the *Implementing* stage are reliant on PPS payments though may participate in one or more alternative payment models, such as pay for performance (LAN 2) or an upside shared savings model (LAN 3a). Developing capability and legal structures to allow clinical and financial integration with external partners. Exploring or moving toward risk arrangements.

Optimizing: Health centers in the *Optimizing* stage are in upside and downside risk arrangements (LAN 3a-4). Includes strategies to transform care and services and working to deliver on the Quintuple Aim and value-based care metrics important to payers.



Learning Objective: Mitigating Financial Risk

Outline contracting strategies to mitigate financial risk and enhance the prospect of success in risk arrangements.

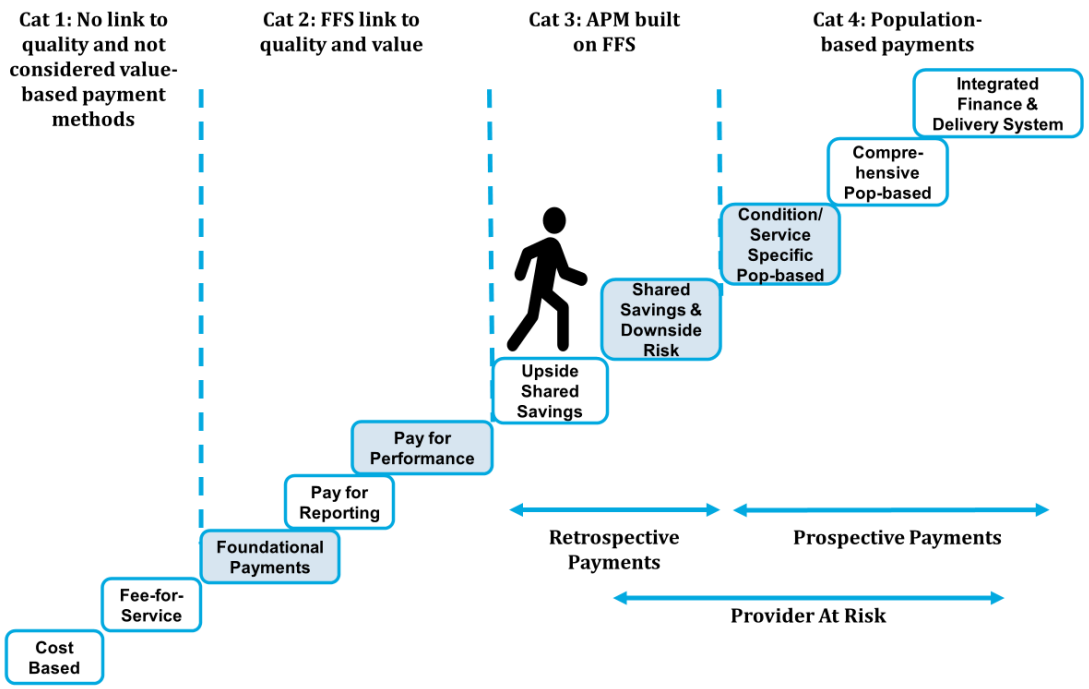
Featured Speaker

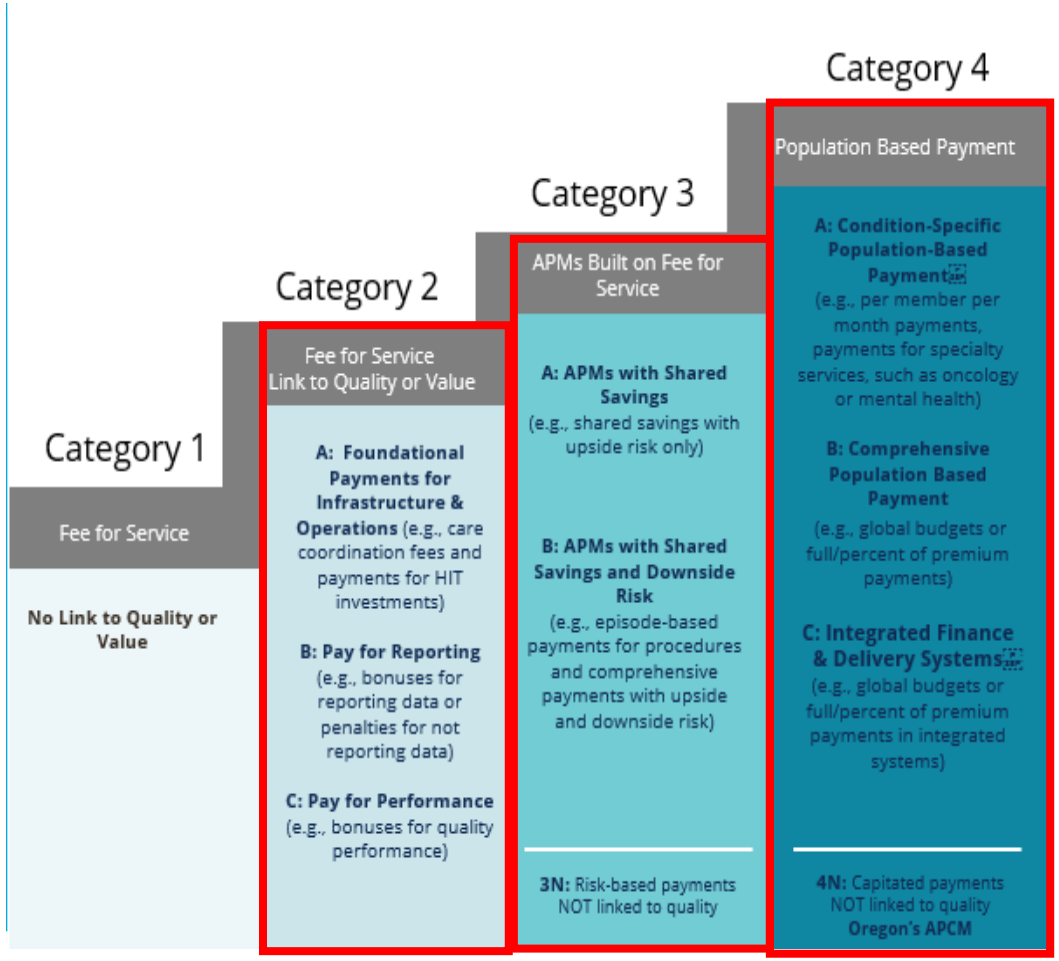
Art Jones, MD
Chief Clinical Officer, Medical Home Network
Principal, Health Management Associates

Art Jones, M.D. has 27 years of experience as a primary care physician and CEO at a Chicago area community health center that has adopted advanced alternative payment models since 1987. He was one of the founders and continues to serve as the Chief Clinical Officer for Medical Home Network (MHN) and MHN Accountable Care Organization (ACO) comprised of thirteen FQHCs and three health systems serving 180,000 Chicago area Medicaid recipients. MHN is completely delegated for care management and successfully operates under a global risk arrangement on total cost of care. MHN supports 64 FQHCs in ACO REACH or MSSP.

Dr. Jones is also a principal at Health Management Associates where he focuses on helping FQHCs and their clinically integrated networks succeed in advanced alternative payment models.

Alternative Payment Models: Health Care Learning Action Network Categories





[Health Care Learning Action Network (HCPLAN) Alternative Payment Model (APM) Framework]

MEDICAL HOME NETWORK

Why Would a Provider Agree to a LAN 3B or 4 APM?

MEDICAL HOME NETWORK

- To secure a greater share of savings generated.
- To increase organizational attention on the pursuit of value-based care.
- In response to payer requirements to stay in a value-based care arrangement.
- To support a model of care that improves member access to care, enhances member experience, improves performance on quality metrics, and reduces low-value services and total cost of care.

Risk Mitigation Strategies

MEDICAL HOME NETWORK

1. Create a separate legal structure that holds the financial risk but offers me equity.

2. Include potentially preventable emergency department visits, hospitalizations and rehospitalizations as metrics when you are only in a pay-for-quality program.

3. Demonstrate ability to generate shared savings before progressing to shared risk.

4. Assure panel size is adequate to minimize the impact of statistical variation in performance.

5. Negotiate a risk-adjusted medical loss ratio (MLR) that reflects your historical experience and fix it for at least the next three years.

6. Assure individual member stop loss charges against the savings pool are actuarily sound.

Risk Mitigation Strategies (cont'd)

MEDICAL HOME NETWORK

7. Use the quality component of the deal to mitigate downside risk comparable to its impact on limiting earned savings.

8. Consider clinical and financial integration with health care partners who complement your service area and/or service offerings but only if they can be trusted to be accountable for their performance and outcomes.

9. Only take risk for services you can reasonably impact (medical risk vs. Insurance risk).

10. Build an adequate reserve pool and negotiate a cap on losses limited to that pool.

11. Take a uniform multi-payer approach in negotiations.

12. Act as if you were already taking downside risk even before you do.

Individual Member Stop Loss

MEDICAL HOME NETWORK

- Reinsurance for catastrophic cases that are usually beyond what the health care provider can influence.
- Built on actuarial experience of a health plan's membership in a specific product line.
- Charged as an expense when calculating surplus or deficit in a provider's pool.
- The expense varies by probability that it will be used, the attachment point, and the percentage of expense insured once the attachment point is reached.

Stop Loss Premium (illustrative purposes only)

MEDICAL HOME NETWORK

	Reinsurance Premium (PMPM)		
Reinsurance Attachment Point	**$250,000**	**$500,000**	**$1,000,000**
Medicaid Eligibility Category			
TANF/CHIP	$14.00	$6.52	$3.14
Medicaid Expansion	$15.45	$6.79	$2.78
Special Needs Children	$26.81	$12.09	$5.27
Aged, Blind, Disabled	$92.47	$44.15	$20.64

- Lower attachment point reduces risk but at a greater cost to the savings pool.
- Stop loss costs rise as the risk and cost of the population increases.

Using Your Quality Performance to Mitigate Risk

MEDICAL HOME NETWORK

Shared Risk Deal: 50:50 split with the health plan

Example	Savings Generated $200,000		Losses Generated $200,000	
Provider Initial Split		$100,000		($100,000)
Composite Quality Score	**Percent of Provider Portion of Savings Retained**	**Savings Earned**	**Percent of Provider Responsibility for Percent of Losses**	**Provider Payback**
100%	110%	$110,000	50%	($50,000)
95%	105%	$105,000	50%	($50,000)
90%	100%	$100,000	50%	($50,000)
85%	85%	$85,000	55%	($55,000)
80%	80%	$80,000	60%	($60,000)
75%	75%	$75,000	65%	($65,000)
70%	70%	$70,000	70%	($70,000)
65%	65%	$65,000	75%	($75,000)
60%	60%	$60,000	80%	($80,000)
55%	55%	$55,000	85%	($85,000)
50%	50%	$50,000	90%	($90,000)
<50%	0%	$0	100%	($100,000)

Better scores on quality metrics should reduce potential downside risk payments.

Plan to Progress from Shared Savings to Shared Risk

MEDICAL HOME NETWORK

- Agree with the payer on a vision to progress to downside risk with a defined timeline.
- Let the payer make an initial offer for shared savings progressing to shared risk.
- Negotiate the same upside portion in the shared savings contract that will be in the shared risk agreement in the future.
- Reserve the difference between the portion of savings that the payer initially offered, and this enhanced amount to build your risk reserve pool.
- As you assume downside risk, cap your risk at the amount in the reserve pool.
- Stop funding the reserve pool once you reach the level the payer initially required in the initial shared risk arrangement.

Learning Objective: Capitated APM for Medicaid

Discuss strategies for developing a FQHC primary care capitated alternative payment methodology (APM) for Medicaid.

Featured Speaker

HOSTETLER GROUP

Craig Hostetler
Owner and Principal
Hostetler Group

Craig Hostetler is a consultant focused on aligning payment reform with practice transformation, particularly for vulnerable populations. He is nationally recognized as a pioneer in evolving FQHC payment to support holistic, team-based care. In his previous job, he was the executive director of the Oregon Primary Care Association (OPCA) for 15 years. Under his leadership, OPCA designed a Medicaid capitated Alternative Payment Methodology (APM) for FQHCs, removing the incentive to produce billable visits. Craig has been a consultant for over 6 years, working with FQHCs, PCAs, NACHC, and other organizations supporting health centers on understanding VBC and capabilities FQHCs need to be successful, developing VBC strategies that takes the current environment into account, developing and implementing FQHC capitated APMs for Medicaid, understanding and addressing SDoH barriers, and facilitating staff/board member strategic planning retreats.

Before coming to Oregon, Craig has worked in Washington, DC and overseas in London, England and Sydney, Australia as a health care manager.

WHAT is a FQHC Capitated APM for Medicaid?

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- Federal law allows states to implement an alternative to FQHC PPS rates (Social Security Act 1902(bb)(6)).
- Converts an FQHC's PPS rate and utilization to a capitated per member per month payment.
- Reimbursement has to be at least as much as what an FQHC would have received under PPS.
- CMS has to approve a State Plan Amendment (SPA).
- Each participating FQHC has to agree to implement a capitated APM (i.e., it's voluntary).
- It's not that the payment is innovative

With the majority of patient service revenue off the visit, you can get innovative with the care model.

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FQHC Capitated APMs

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Should be unique to an individual FQHC's rate and utilization.

- Why? It has to be reconciled to PPS.

Rates should reasonably reflect costs.

- Otherwise, you're memorializing a negative operating margin.

- Make sure the capitated APM is trended forward by Medicare Economic Index (MEI) or other market basket indicator & can account for increases in FQHC costs from changes in the intensity, duration, amount, and types of services offered in future years.

- Utilization of services included in developing the initial capitated rate should be stable (e.g., consider excluding mental health services in the beginning if FQHCs plan to significantly expand the breadth of these services).

FQHC Capitated APM is Different than other Primary Care Capitation

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- Based on individual FQHC Medicaid rates and utilization.
- Can work with individual health center care model strategies, addressing the unique needs of populations they serve.
- It can work in rural and urban areas if the underlying FQHC rate reasonably reflects FQHC costs.
- Health centers have to receive at least as much as they would have received under PPS.

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WHY Develop a FQHC Capitated APM?

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Fee-for-service has its flaws:

- Rewards volume without accountability to quality or cost
- Focuses work on the billable provider instead of the work of the team
- Doesn't reward continuity between the patient and provider
- Doesn't incentivize proactively managing patients
- Doesn't incentivize provider organizations to work together
- Doesn't incentivize efficiencies in the health care system
- Hasn't sufficiently supported primary care and behavioral health integration
- Didn't work during COVID: billable visits decreased significantly and less flexibility to pivot the care model

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Common Purposes of FQHC Capitated APM?

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- **It's about the care model**
  - Remove the incentive to produce billable visits
  - Provide flexibility to implement robust team-based care, including SDoH interventions
  - Increase focus on care coordination
  - Support integration of services
  - Improve health equity
- **Use the capitated APM as a recruitment and retention tool**
- **Predictable cash flow – state, FQHCs**
- **Control destiny on state VBP efforts**

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Accountability Plan: Can Demonstrate FQHC Value

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Purpose of an accountability plan

- Demonstrate value as billable encounters decrease.
- Measure improvement in cost, quality, patient experience, and health equity.
- Show innovation efforts / how the care model can change.
- Gain stakeholder commitment to the APM.
- Align APM with state payment reform.
- Should evolve over time as VBP and care transformation evolve.

Care Transformation Examples *(Under Capitated APM)*

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- Building **care teams and workflows** that are a reflection of the patients medical, behavioral, dental and social drivers of health needs.
- Reducing emergency room visits and unnecessary hospitalizations through implementing **trauma informed approaches** and **care management for complex care needs**.
- Documenting patients' social drivers of health needs through motivational interviewing, leading to the **co-creation of treatment plans with the patient**.
- Providing **alternative forms of access** (e.g., e-visits, telehealth, increase access to non-billable clinic staff, group visits).
- Focus data collection efforts for capitated APM clinics on **cost, quality and patient experience metrics** to show value as the health center generates revenue not connected to billable encounters.

Steps for Developing & Implementing a Capitated APM

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- Moves away from volume-based pay
- State can get wide range of data under an accountability plan as clinics move off the visit: billable and non-billable access, cost, quality metrics, and even innovation work (e.g., testing SDoH interventions)
- Predictable cash flow
- A bridge to VBP that works with FQHC payment

MCO Benefits *(under Capitated APM)*

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Helps align FQHC payment with MCO VBP initiatives.

FQHCs have more flexibility to help MCOs meet VBP goals that are in their contracts with the State.

Can work with a group of clinics on moving common metrics under the accountability plan.

Tip: *If Managed Care Organizations (MCOs) are paying FQHC capitated rates, the cost of PMPM payments to FQHCs, not PPS equivalency, should be used when states set next year's MCO rates*

Capitated APM Increasing Popularity

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- Started in Oregon (first statewide), then WA, then CO, then MA
- NACHC APM Academy (2018-19): IA, LA, MT, TN, NY
- NACHC APM Academy (2019-20): AK, DC, FL, IN, ME
- Several other states are actively pursuing capitated APM implementation (e.g., CA, IL, MI)

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State Medicaid Benefits *(under Capitated APM)*

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- Initial Steps/Clarify Your Purpose
- Align Stakeholders/Payment Models
- Assess FQHC Readiness
- Discuss Key Decision Points
- Model Financial Scenarios
- Finalize Capitated APM model
- State Plan Amendment (SPA) Approval
- Build Capacity: PCA & FQHCs
- Operationalize the Capitated APM

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Oregon APM Strategy

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- **Built up the PPS rates.**
  - Developed a strategy to increase PPS rates to be closer to allowable costs for HCs.
- **Converted individual health center PPS rates and utilization to a capitated APM and made it budget neutral (based on PMPM, not PPS rate).**
  - In today's environment, consider negotiating additional investments to support health equity (e.g., CMS models that increase investment in primary care for FQHCs).
- **Strengthened the relationship with the State through building the APM and including them in the APCM Learning Community.**
- **Developed an accountability plan as a bridge to VBP and to show health center value to the State and MCOs.**

How VBP and Capitated APMs Work Together

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- Capitated APMs can still be considered separate from FQHC value-based pay (VBP) arrangements (i.e., VBP payments are in addition to APMs, similar to PPS).
- Or, you could directly link it to VBP as long as FQHCs receive at least as much as they would have under PPS.
- Metrics that are captured within the capitated APM program can be aligned with current and future VBP efforts.
- Capitated APMs offer flexibility to produce better health outcomes and to prepare for increasing levels of risk in VBP.
- The capitated APM financial model can be at the health center level, while VBP can take place at the network level.

Why Would a Health Center Implement a Capitated APM?

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- Implement team-based care that supports the holistic needs of patients (medical, behavioral health, dental, SDOH).
- Reduce the focus on producing billable visits.
- Prepare for value-based pay.
- Improve care coordination.
- Use the APM as a recruitment and retention tool.
- Improve focus on data and data analytics for VBP metrics captured in the accountability plan.

Health Center Capabilities Needed in a Capitated APM?

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- Patient-centered, team-based care is fundamental
- Finance – Medicaid payor mix & finance department capabilities
- Population health approaches to care delivery, whole person care
- Integration of medical and behavioral health services
- Open access
- Evidence-based & innovation (e.g., testing SDoH interventions)
- Care coordination/care management, particularly for high-risk patients
- Tracking and moving cost, quality and access metrics
- Data & analytics capability, including SDoH data
- Culture of quality

WHY Should Your Health Center Implement a Capitated APM?

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Does it align with HC goals?

- Overall mission
- Better care, health equity
- VBP strategy

Does the HC have capacity?

- Financial stability
- Capacity to run PPS and capitated APM methodologies
- Data reporting and data analytics capability
- Care transformation competencies (e.g., population health capabilities)

Does your FQHC Medicaid rate reasonably represent your allowable costs?

Can it address some of your health center pain points (e.g., recruitment/retention, financial)?

Craig Hostetler
Owner and Principal
Hostetler Group

Art Jones, MD
Chief Clinical Officer, Medical Home Network
Principal, Health Management Associates

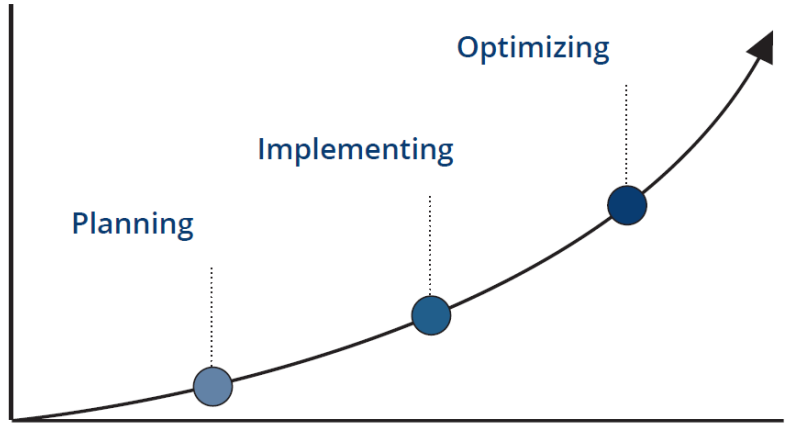
Heidy Robertson-Cooper, MPA
President
Health Care Advisors

Questions & Discussion

Value-Based Payment: Next Steps

- Assess where you are.
- Know your costs, and patient spend throughout the system.
- Know your value.
- Start small.
- Find partners.
- Re-invest earned shared savings.
- Leverage the Health Center model of care to improve the patient and care team experience.
- Think long-term.
- The risk of standing still.
- Get in the water and start swimming!

Value-Based Payment Series



FQHC Capitated APM for Medicaid

Mitigate Financial Risk

CMMI VPB Models

New Models of Care

Current State of Primary Care

SDOH and Health Equity

Upside (LAN 3A) & Downside Risk (LAN 3B)

Attribution Fundamentals

Population Health Critical to VBP Success

Leveraging NACHC's Elevate Program

Developing a VBP Roadmap

Role of Clinically Integrated Networks & Partners

Medicaid PPS as a foundation for VBP

Current VBP Landscape

NACHC's Value-Based Payment Learning Series

Link to recorded module (10 mins)

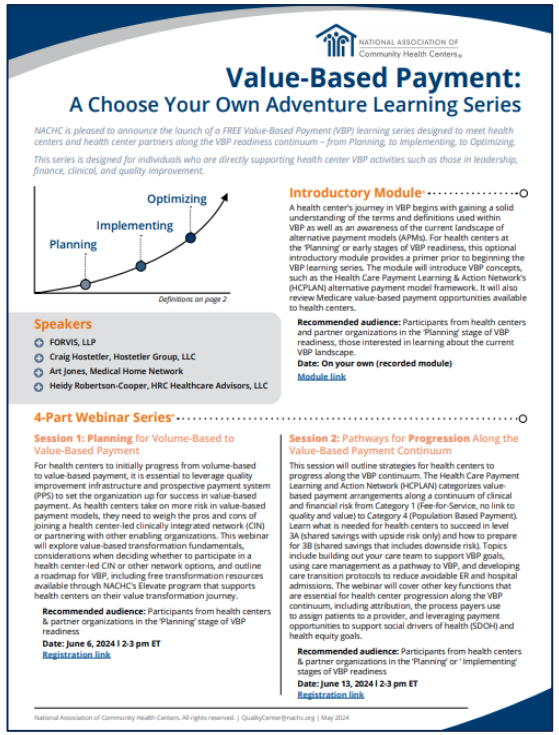
Session 1: Planning for Volume-Based to Value-Based Payment

Session 2: Pathways for Progressing Along the VBP Continuum

Session 3: Implementing High-Quality Primary Care within VBP Models

Session 4: Optimizing VBP Strategies while Mitigating Financial Risk

Registration Link: 4-Part Series



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Value-Based Payment:
A Choose Your Own Adventure Learning 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 along the VBP readiness continuum – from Planning, to Implementing, to Optimizing.

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

Optimizing
Implementing
Planning

Definitions on page 2

Speakers

- FORVIS, LLP
- Craig Hostetler, Hostetler Group, LLC
- Art Jones, Medical Home Network
- Heidy Robertson-Cooper, HRC Healthcare Advisors, LLC

Introductory Module

A health center's journey in VBP begins with gaining a solid understanding of the terms and definitions used within VBP as well as an awareness of the current landscape of alternative payment models (APMs). For health centers at the 'Planning' or early stages of VBP readiness, this optional introductory module provides a primer prior to beginning the VBP learning series. The module will introduce VBP concepts, such as the Health Care Payment Learning & Action Network's (HCPLAN) alternative payment model framework. It will also review Medicare value-based payment opportunities available to health centers.

Recommended audience: Participants from health centers and partner organizations in the 'Planning' stage of VBP readiness, those interested in learning about the current VBP landscape.

Date: On your own (recorded module)

Module link

4-Part Webinar Series

Session 1: Planning for Volume-Based to Value-Based Payment

For health centers to initially progress from volume-based to value-based payment, it is essential to leverage quality improvement infrastructure and prospective payment system (PPS) to set the organization up for success in value-based payment. As health centers take on more risk in value-based payment models, they need to weigh the pros and cons of joining a health center-led clinically integrated network (CIN) or partnering with other enabling organizations. This webinar will explore value-based transformation fundamentals, considerations when deciding whether to participate in a health center-led CIN or other network options, and outline a roadmap for VBP, including free transformation resources available through NACHC's Elevate program that supports health centers on their value transformation journey.

Recommended audience: Participants from health centers & partner organizations in the 'Planning' stage of VBP readiness

Date: June 6, 2024 | 2-3 pm ET

Registration link

Session 2: Pathways for Progression Along the Value-Based Payment Continuum

This session will outline strategies for health centers to progress along the VBP continuum. The Health Care Payment Learning and Action Network (HCPLAN) categorizes value-based payment arrangements along a continuum of clinical and financial risk from Category 1 (Fee-for-Service, no link to quality and value) to Category 4 (Population Based Payment). Learn what is needed for health centers to succeed in level 3A (shared savings with upside risk only) and how to prepare for 3B (shared savings that includes downside risk). Topics include building out your care team to support VBP goals, using care management as a pathway to VBP, and developing care transition protocols to reduce avoidable ER and hospital admissions. The webinar will cover other key functions that are essential for health center progression along the VBP continuum, including attribution, the process payers use to assign patients to a provider, and leveraging payment opportunities to support social drivers of health (SDOH) and health equity goals.

Recommended audience: Participants from health centers & partner organizations in the 'Planning' or ' Implementing' stages of VBP readiness

Date: June 13, 2024 | 2-3 pm ET

Registration link

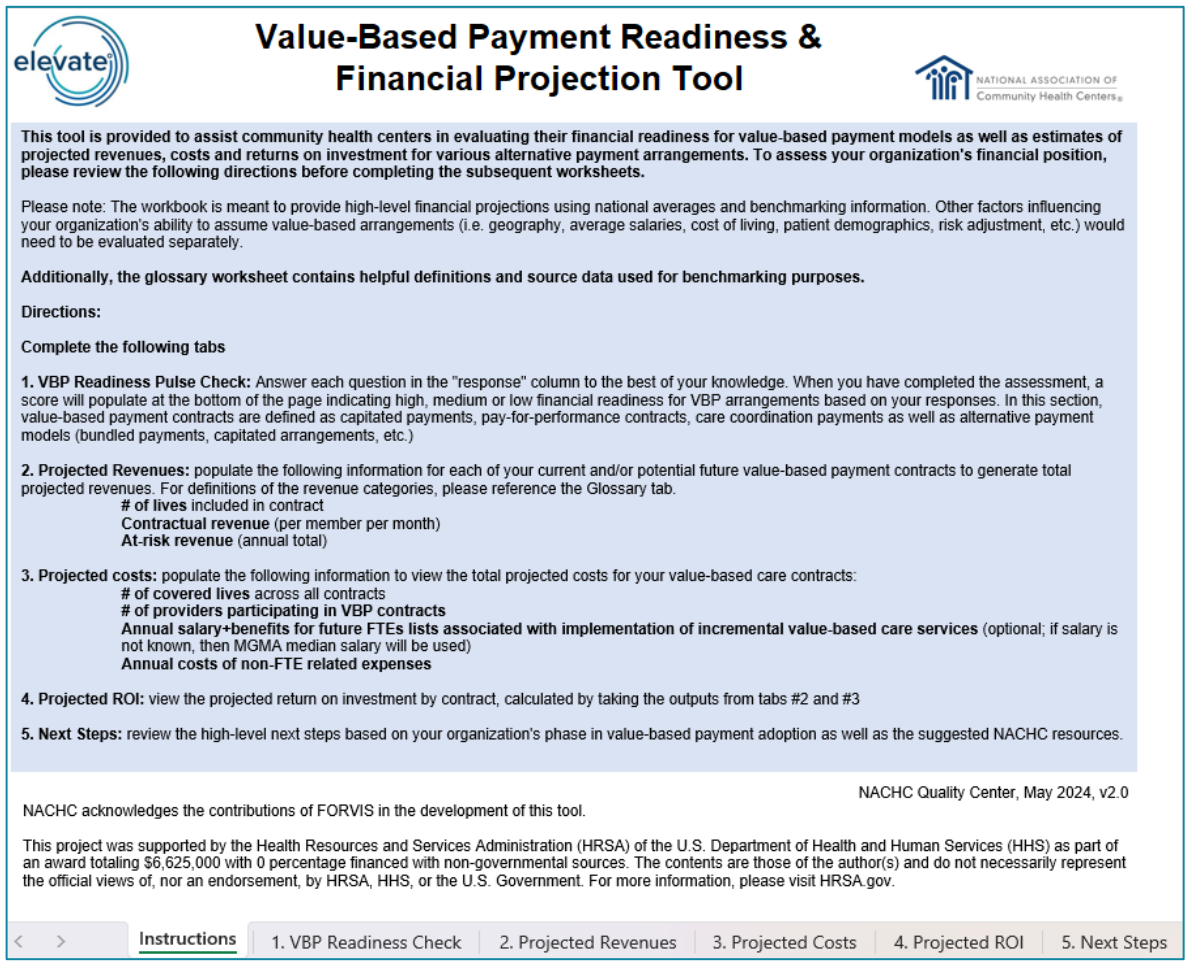
Supplemental Sessions!

1. FQHC VBP Financial Projection Tool
2. Total Cost of Care

7/25

Registration Link: Supplemental Sessions

NACHC: Value-Based Payment Resources



elevate

Value-Based Payment Readiness & Financial Projection Tool

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This tool is provided to assist community health centers in evaluating their financial readiness for value-based payment models as well as estimates of projected revenues, costs and returns on investment for various alternative payment arrangements. To assess your organization's financial position, please review the following directions before completing the subsequent worksheets.

Please note: The workbook is meant to provide high-level financial projections using national averages and benchmarking information. Other factors influencing your organization's ability to assume value-based arrangements (i.e. geography, average salaries, cost of living, patient demographics, risk adjustment, etc.) would need to be evaluated separately.

Additionally, the glossary worksheet contains helpful definitions and source data used for benchmarking purposes.

Directions:

Complete the following tabs

1. VBP Readiness Pulse Check: Answer each question in the "response" column to the best of your knowledge. When you have completed the assessment, a score will populate at the bottom of the page indicating high, medium or low financial readiness for VBP arrangements based on your responses. In this section, value-based payment contracts are defined as capitated payments, pay-for-performance contracts, care coordination payments as well as alternative payment models (bundled payments, capitated arrangements, etc.)

2. Projected Revenues: populate the following information for each of your current and/or potential future value-based payment contracts to generate total projected revenues. For definitions of the revenue categories, please reference the Glossary tab.
- **# of lives** included in contract
- **Contractual revenue** (per member per month)
- **At-risk revenue** (annual total)

3. 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 VBP contracts**
- **Annual salary+benefits for future FTEs lists associated with implementation of incremental value-based care services** (optional; if salary is not known, then MGMA median salary will be used)
- **Annual costs of non-FTE related expenses**

4. Projected ROI: view the projected return on investment by contract, calculated by taking the outputs from tabs #2 and #3

5. Next Steps: review the high-level next steps based on your organization's phase in value-based payment adoption as well as the suggested NACHC resources.

NACHC Quality Center, May 2024, v2.0

NACHC acknowledges the contributions of FORVIS in the development of this tool.

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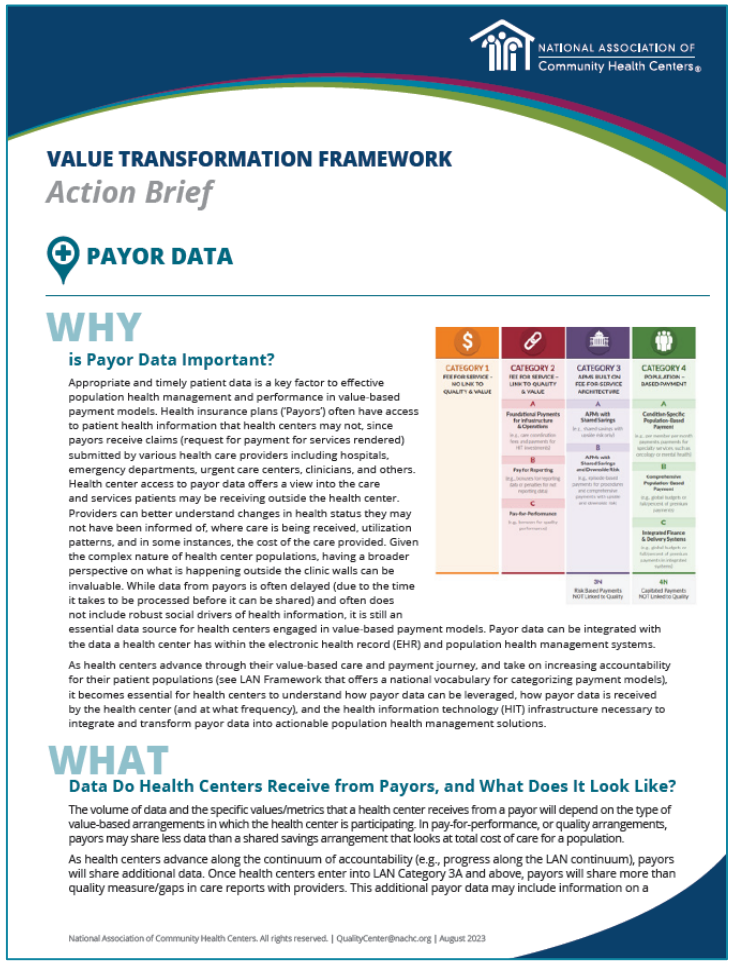
Instructions | 1. VBP Readiness Check | 2. Projected Revenues | 3. Projected Costs | 4. Projected ROI | 5. Next Steps

Value-Based Payment Readiness & Financial Project Tool (2024 update)



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VALUE TRANSFORMATION FRAMEWORK

Action Brief

PAYOR DATA

WHY

is Payor Data Important?

Appropriate and timely patient data is a key factor to effective population health management and performance in value-based payment models. Health insurance plans ('Payors') often have access to patient health information that health centers may not, since payors receive claims (request for payment for services rendered) submitted by various health care providers including hospitals, emergency departments, urgent care centers, clinicians, and others. Health center access to payor data offers a view into the care and services patients may be receiving outside the health center. Providers can better understand changes in health status they may not have been informed of, where care is being received, utilization patterns, and in some instances, the cost of the care provided. Given the complex nature of health center populations, having a broader perspective on what is happening outside the clinic walls can be invaluable. While data from payors is often delayed (due to the time it takes to be processed before it can be shared) and often does not include robust social drivers of health information, it is still an essential data source for health centers engaged in value-based payment models. Payor data can be integrated with the data a health center has within the electronic health record (EHR) and population health management systems.

As health centers advance through their value-based care and payment journey, and take on increasing accountability for their patient populations (see LAN Framework that offers a national vocabulary for categorizing payment models), it becomes essential for health centers to understand how payor data can be leveraged, how payor data is received by the health center (and at what frequency), and the health information technology (HIT) infrastructure necessary to integrate and transform payor data into actionable population health management solutions.

WHAT

Data Do Health Centers Receive from Payors, and What Does It Look Like?

The volume of data and the specific values/metrics that a health center receives from a payor will depend on the type of value-based arrangements in which the health center is participating. In pay-for-performance, or quality arrangements, payors may share less data than a shared savings arrangement that looks at total cost of care for a population.

As health centers advance along the continuum of accountability (e.g., progress along the LAN continuum), payors will share additional data. Once health centers enter into LAN Category 3A and above, payors will share more than quality measure/gaps in care reports with providers. This additional payor data may include information on a

Suite of Value-Based Payment Action Briefs:

Developing VBP Goals

Attribution

Attribution Thresholds

Payor Data

COMING SOON...Business Case for Value-Based Payment

A Systems Approach to Transformation

Value Transformation Framework

- ✓ *Supports systems change*
- ✓ *Organizes and distills evidence-based interventions*
- ✓ *Incorporates evidence, knowledge, tools and resources*
- ✓ *Links health center performance to the Quintuple Aim*
- ✓ *Assess health center transformation progress*

Step-by-Step

Guided Application

Trainings & Resources

elevate

National Learning Forum

848 CHCs | 90 PCAs/HCCNs/NTTAPS | >15 Million Patients

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

Register for free HERE

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