NATIONAL ASSOCIATION OF Community Health Centers®

ELEVATE NATIONAL LEARNING FORUM

elevate

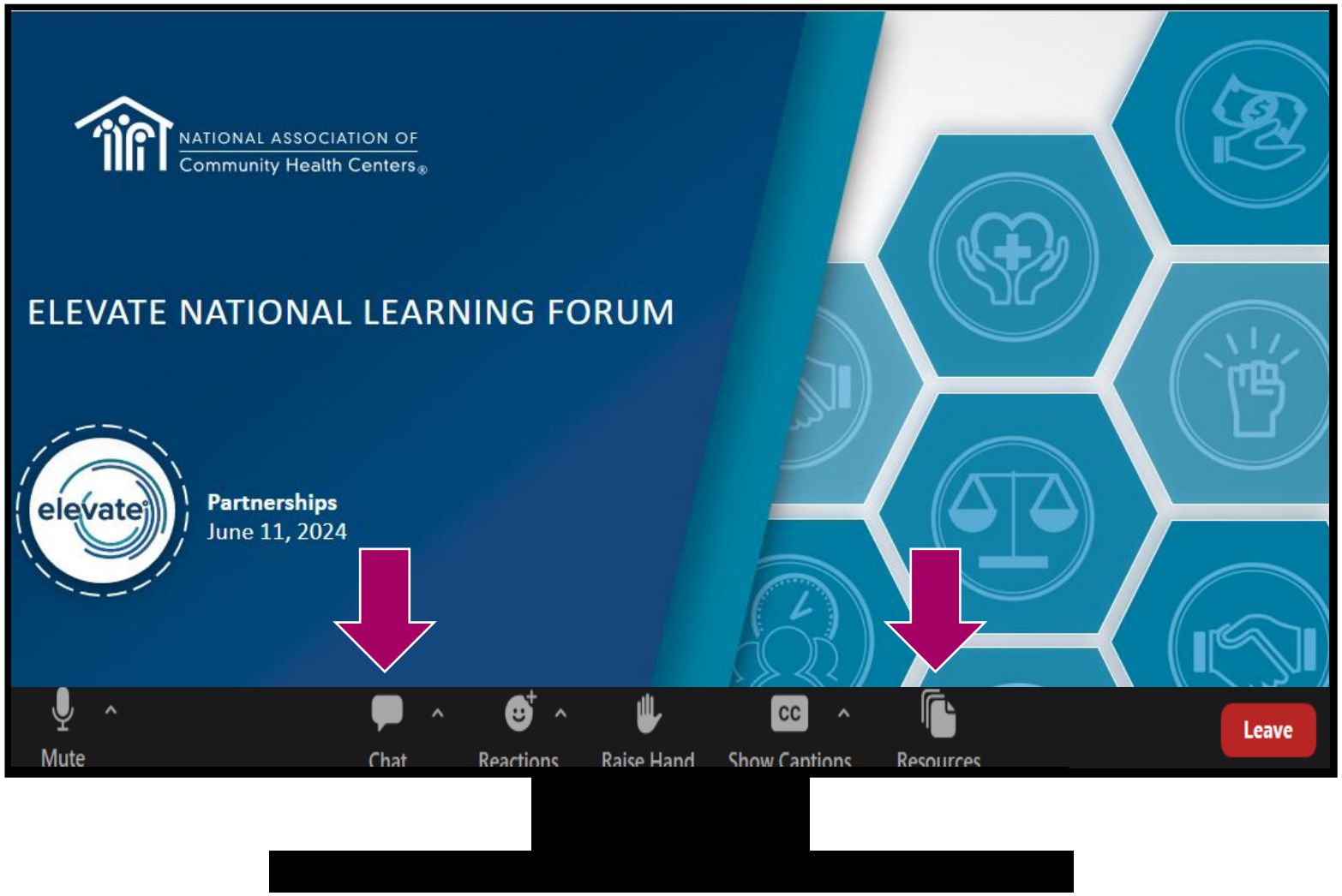
Partnerships
June 11, 2024

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**!

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

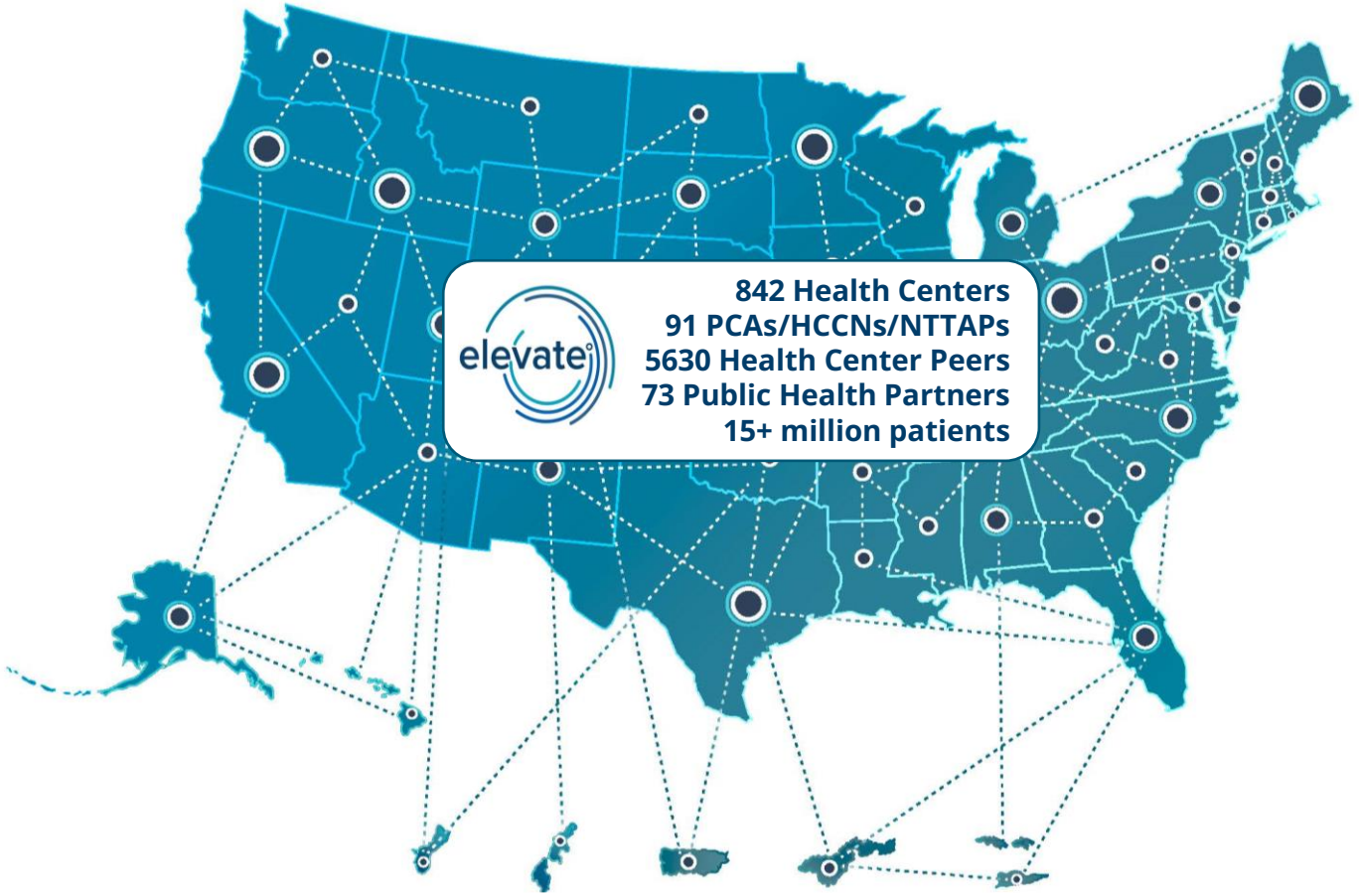
Partnerships

- ***What, Why, How***
  - ***Jason Patnosh from NACHC***
- ***Case Studies:***
  - ***Michelle Reed from Heartland Health Services, featured health center***
  - ***Jane McElroy from University of Missouri, featured public health partner***
- ***New Partnership Opportunity!***
  - ***Gervean Williams from NACHC***

Q&A and Discussion

Closing

Welcome!



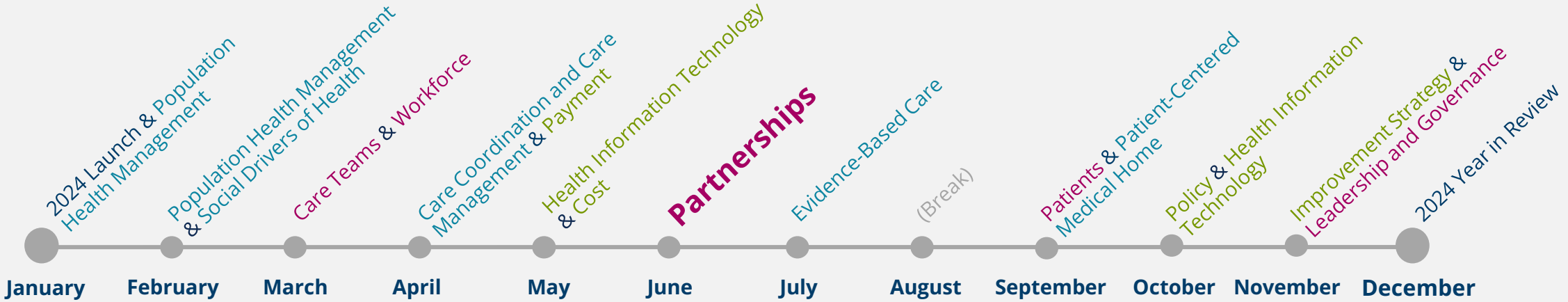
Elevate **provides guided application of the Value Transformation Framework**

National learning forum and peer exchange

Collaborate * Learn * Share * Create * Innovate

Elevate 2024

Monthly Learning Forums:



Supplemental Sessions:

- Value-Based Care Series – Next session June 13, 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

VTF: Partnerships

The Value Transformation Framework

15 Change Areas organized by 3 Domains:

Infrastructure

Care Delivery

People: the stakeholders who receive, provide, and lead care at the health center, as well as partners that support the goals of high-value care

- Stakeholders include patients, care teams, governance and leadership, workforce, and external ***PARTNERSHIPS***

VTF Assessment: Partnerships

VTF Change Area: Partnerships

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

	1 – Learning	2 – Basic	3 – Applied	4 – Skilled	5 – Expert
External Partners				*Health center staff routinely engage with key external partners to enhance/expand programs and services, refer patients, and secure funding. Health center identifies and engages with partners that advance transformation and value-based care objectives.*	
Health Center Program Partners				*Health center actively engages with one or more key Health Center Program partners, including participation in a partner sponsored learning community or project.*	
Payor Partnerships				*Health center engages with key payers and receives clinical and performance data from them.*	

Partnerships

WHAT? WHY? HOW?

NATIONAL ASSOCIATION OF Community Health Centers®

WHAT Partnerships are Important to Health Centers?

Partnerships are the collaborative relationships that health centers have with external stakeholders.

External Partners

- **Healthcare providers:** specialists, hospitals, mental/behavioral, substance abuse, care management, care coordination, etc.
- **Social services:** housing, food, transportation etc.
- **Public entities:** schools, criminal justice, departments of public health, etc.
- **Government:** local, regional, and state

Health Center Program Partners

- **Health Resources and Services Administration** (HRSA)
- **National Association of Community Health Centers** (NACHC)
- **National Training and Technical Assistance Partners** (NTTAPs)
- **Primary Care Associations** (PCAs)
- **Health Center Controlled Networks** (HCCNs)

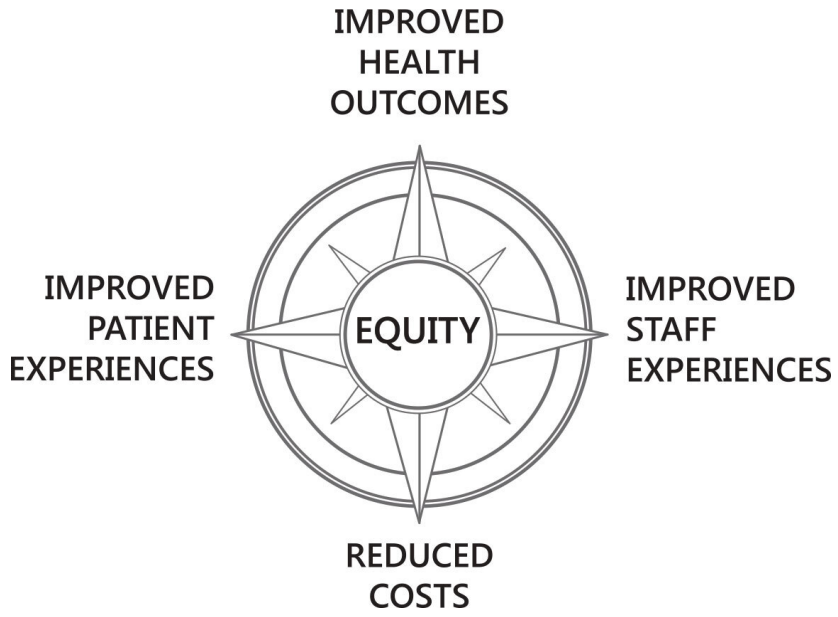
Payors & Value-Based Payment

- **Medicaid, Medicare, Commercial plans**
- **Clinically Integrated Networks**
- **Accountable Care Organizations**

WHY Engage in Partnerships?

When health centers connect with partners, together they can focus on accomplishing one or more shared goals, enhancing transformation efforts and impact.

By engaging in meaningful partnerships, health centers are better positioned to advance toward the **Quintuple Aim Goals**.



HOW to Build Successful Partnerships

STEP 1 Understand your patients and community

STEP 2 Define your care model

STEP 3 Identify gaps that partners can fill

STEP 4 Build and align partnerships

STEP 5 Connect back to the *people*

STEP 1

UNDERSTAND YOUR PATIENTS AND COMMUNITY

- ✓ Consider both **empaneled** and **attributed** patients
- ✓ Know your local **community**
- ✓ Understand **social drivers of health**

Use data to drive partnership decisions!

- ➢ *UDS data*
- ➢ *Needs assessment findings*
- ➢ *Patient experience data*

STEP 2

DEFINE YOUR CARE MODEL

Care models are methods of delivering targeted, appropriate, and cost-effective care according to patients' risk level, rather than following a "one size fits all" approach.

LOW RISK

Few or no risk factors. Stable or healthy.

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

Goals: maintain connection; support health

RISING RISK

One or several risk factors or conditions; moves in and out of stability.

Focus is on managing risk factors more than disease conditions.

Goals: identify and manage risk factors

HIGH RISK

Multiple risk factors or conditions.

Requires structured care management and one-on-one support

Goals: chronic care management and preventive services

HIGHLY COMPLEX

Multiple complex conditions; could include psychological condition(s).

Requires intensive, pro-active care management

Goals: prevent high-cost emergency or acute care services

What services do you have the resources and staffing to provide internally? What services could a partner organization provide?

STEP 3

IDENTIFY GAPS THAT PARTNERS CAN FILL

Identify Gaps Partners Can Fill

- Patient Care and Services
- Social Drivers of Health
- Infrastructure
- Capital
- Culture
- Data
- Other

STEP 4 *BUILD AND ALIGN PARTNERSHIPS*

The Science and Art of Partnerships

- Culture and mission alignment
- Shared values
- Quality program and measures alignment
- Capital and resources
- Roles and responsibilities
- Sharing of technology and data

STEP 5

CONNECT BACK TO THE PEOPLE

Determine the impact the partnership has on the *People* of your health center

- Patients
- Care Teams
- Governance and Leadership
- Workforce

Helpful Resource

Partnership Assessment Tool for Health

Welcome to the Partnership Assessment Tool for Health (PATH). This resource is intended for community-based organizations (CBOs) that provide human services and healthcare organizations currently engaged in a partnership. For the purposes of this tool, we define partnership as **a structured arrangement between a healthcare organization** (e.g. health system, hospital, provider, insurer, state or local public health department) **and nonprofit or for-profit community-based organization** (e.g. housing organization, workforce development agency, food bank, early childhood education provider) **to provide services to low-income and/or vulnerable populations**.

The objective of the PATH is to help partnering organizations **work together more effectively to maximize the impact of the partnership**. As your partnership continues serving the community, open and honest dialogue around strengths, gaps, challenges, and opportunities is essential for partners to stay aligned, focus communications, prioritize changes, leverage opportunities, identify needs, and more. These types of conversations require dedicated time and can be challenging. The tool provides an approachable format to understand progress toward benchmarks characteristic of effective partnerships, to identify areas for further development, and guide strategic conversation between partners.

Developed by **Partnership for Healthy Outcomes**

Bridging Community-Based Human Services and Healthcare

A collaboration of

The **Partnership Assessment Tool for Health (PATH)** provides a template to:

1. Understand progress toward benchmarks characteristic of effective partnerships
2. Identify areas for further development
3. Guide strategic conversations

The objective of the tool is to help partnering organizations work together more effectively to maximize the impact of the partnership.

Featured NACHC Speaker

Jason Patnosh
Associate Vice President, Partnership, Development, and Innovation
National Association of Community Health Centers

Jason joined NACHC in 1999 as an intern and continued to grow in his responsibilities and roles with NACHC's AmeriCorps project, then transitioned to development and fundraising, where he helped to navigate successful funding from foundations, federal agencies, and corporate partners. For more than 20 years, Jason served as NACHC's lead liaison for the field and partners responding to natural disasters across the country, helping to strengthen partnerships for NACHC and health centers with national relief organizations like Americares and Direct Relief. Since the emergence of COVID-19, he was worked to enhance resources for health centers fighting the pandemic. Additionally, he was appointed to serve on NACHC's Organizational Development team, an internal workgroup to advance NACHC's operations and improve performance for the entire organization. Finally, Jason was instrumental in the launch and sustainability of NACHC's new Center for Community Health Innovation.

NACHC STRATEGY via Science, Education, Practice, and Policy (SEPP)

Partnership and Development

- **Expand current investment from BPHC and CDC**, identify new resources from other HHS agencies, and new non-HHS federal partners (emphasize agencies that address SDOH, climate change, Black maternal mortality, and workforce development).

- **Aligned missions = aligned partners**. Non-profit and academic partnerships can help to leverage investments for our shared work.

- **Increase private engagement and investment to support NACHC and the movement**. Increase resources to support **s**cience/research, training/ **e**ducation, **p**ractice (centers of excellence), and determine when success can lead to **p**olicy/payment improvements for long-term sustainability.

Featured Health Center

Michelle Reed RN BSN
Director of Clinical Education and Digital Support
Heartland Health Services

- Grew up in Peoria Illinois attending Methodist College of Nursing and Grand Canyon University
- Has been a Nurse for 28 years with 24 years in a community Hospital and 4 years with Heartland holding multiple leadership positions over the years
- Currently oversee the Medicaid Innovation Collaborative, Clinical Education, Chronic Care Management, Infection Control and Employee Health
- In my free time I help care for my parents and spend time with my husband and 15-year-old daughter along with our 2 rescue dogs. When time allows, we like to golf, camp, boat or relax by the pool

Featured Health Center

HEARTLAND HEALTH SERVICES

- Located in Peoria, Illinois and Pekin, Illinois
- We have 8 sites, 21,859 patients (UDS), 69,187 visits (UDS)
- HHS was established 32 years ago, and it started out as a free clinic with only one employed staff member. Community members came together to meet a need and they have been doing so ever since.
- HHS is a FQHC and is recognized as a Patient Centered Medical Home and has multiple HRSA badges.

Featured Health Center

HEARTLAND HEALTH SERVICES

Medicaid Innovation Collaborative (MIC)

- Who are the partners?
- What are the services provided?

MIC MEDICAID INNOVATION COLLABORATIVE

AUNT MARTHA'S HEALTH & WELLNESS · CHESTNUT HEALTH SYSTEMS · Eagle View Community Health System · HEARTLAND HEALTH SERVICES · OSF HEALTHCARE

HTC An HFS Initiative Healthcare Transformation Collaboratives

Funds for the Medical Innovation Collaborative (MIC) come from the Illinois Deptartment of Health and Family Services/Healthcare Transformation Collaborative.

OSF OnCall Programs

Community Health Workers

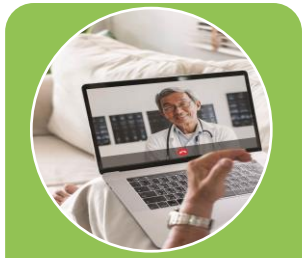
Digital CHWs located in OSF communities and neighborhoods.

Maternal & Child Health

Remote patient monitoring for pregnant and postpartum women

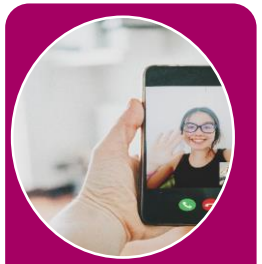
Health & Wellness

Wellness applications and education cover smoking cessation, diet, exercise, & weight management



Chronic Disease Management RPM

Remote patient monitoring for chronic conditions such as hypertension, diabetes, COPD, etc.



Advanced Care RPM

Remote patient monitoring for patients with multiple chronic conditions

Heartland Health Services Homeless Shelter Program

Eagle View Transport Van

Chestnut Programs

Chestnut Family Dental

FOOD FARMACY SHOPPING PASS

Name_____ Date_____

This voucher will allow you to shop at Bread for Life Co-op at Home Sweet Home. Please present this voucher upon entrance. This voucher is good for two trips. Voucher is good for 14 days from above date.

Bread for Life Co-op at Home Sweet Home
301 E. Oakland Avenue
Bloomington, IL 61701

Monday: 3-5 p.m.
Wednesday and Friday: 2-4 p.m.
Thursday: 6-8 p.m.

MIC MEDICAID INNOVATION COLLABORATIVE

VISIT ONE · VISIT TWO

CHESTNUT HEALTH SYSTEMS chestnut.org

This voucher in non-transferable and can only be redeemed by the person named above.

Featured Health Center

HEARTLAND HEALTH SERVICES

MIC Governance Structure

MIC Governance Council
Meets Quarterly.
Focus: Provide oversight & receives finance & subcommittee updates. Includes patient board member representatives.

Executive Operations Committee
Meets Monthly (non-MIC GC months)
Focus: Strategy and driving execution

Subcommittees
Meets Monthly
Focus: Collaboration, intersections, achievements & next steps

Operations/ Community Health Workers

Marketing & Communications

Data & Reporting Committee

People

- **Initially, the OSF OnCall senior leaders and government relations team met with CEOs of FQHCs in OSF's markets, inviting them to join the Medicaid Transformation journey. Four FQHCs ultimately joined the collaboration. HHS looked at the community needs, our time-frame, resources, safety and the expected benefits for patients.**
- **Members from all 5 organizations participate in monthly or quarterly committee meetings to promote transparency and collaboration. We also distribute a quarterly communication toolkit to ensure all employees stay connected to our collective efforts.**

Featured Health Center

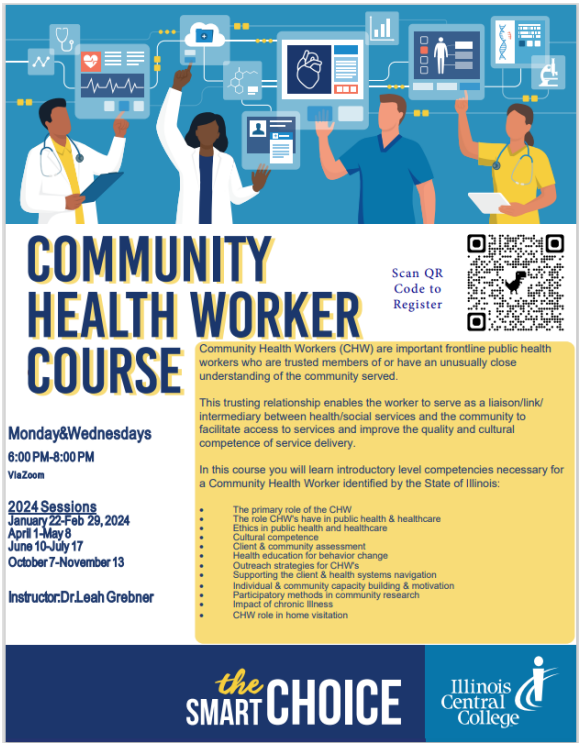
HEARTLAND HEALTH SERVICES

Infrastructure

- Population data was used to estimate the volume of patients we could expect to serve with our digital programs over the 5-year contract.
- The Collaborative is an Organized Health Care Arrangement (OHCA). This allows multiple covered entities to share protected health information about patients.
- Each organization established operational infrastructure to support care delivery as outlined in the contract. OSF has dedicated time from program management, finance, data delivery, data analytics to ensure successful program delivery and state-required reporting in Illinois.

Care Delivery

- Each organization presented funding proposals, with digital/community health workers as a central focus due to their vital role in engaging Medicaid patients locally.
- The MIC is based on digital and virtual methods for connecting with patients and communities. It also challenges member organizations to collaborate in patient care, pushing us beyond traditional approaches.



*Community Health Worker training offered through the local college

Featured Health Center

Outcomes & Metrics

HHS Shelter		Completed visits 2023
Dream Center	start 3/20	91
Salvation Army	start 5/2	99
Peoria Rescue Ministries	start 2/17	189
Esther House	start 3/29	152
Veterans Haven	start 12/15	2
Total		533

- Engagement rate for OB: 94%
- Patient Satisfaction for OB: 80 (NPS)
- 7pt reduction in average systolic and 5pt reduction in diastolic BP readings for high-risk patients
- Saw significant drops in Hb A1C with the biggest drop in patients over 10 decreasing by 2.31 points

Patient Stories

A woman initially reluctant to engage, was staying at a shelter for women. She avoided disclosing her name and was standoffish. She gained a sense of familiarity from seeing a caregiver on site regularly and asked to have her blood pressure taken. Finding that her blood pressure was high, she was encouraged to seek medical attention. It was discovered that this patient had a history of trauma and had been off her medications for eight months. With support, she eventually agreed to visit the emergency room and began treatment. Gradually, she opened up, received medication refills and established care with healthcare providers. Despite reluctance, she attended in-person appointments and received referrals for mental health and dermatology. She later sent a card expressing her appreciation and the difference the team made for her. She shared that, over time, she had transitioned to her own housing, began working, and enrolled in college. This demonstrates significant progress and resilience. - Heartland Health Services Homeless Shelter Program

Featured Health Center

Lessons Learned

- Patient input is valuable - Ask!
- Patients need care beyond traditional business hours. 24/7/365 access to dedicated care team is key!
- Personalized Technology
- Innovate: Patients need access to care where they are, when they need it.
- Relationship & Trust Building: Don't underestimate the power of relationships (Patients & Partners).
- Data and Technology are complicated. It takes longer than you think.
- Be adaptable and comfortable in the grey space.
- The virtual care landscape and policies are constantly changing.
- Stories are powerful - Share them!
- Learn as much as you can about your partners services before development.
- Include as many people as able during development.
- Understand that each entity has a different primary focus, however the betterment of the patient is everyone's desire.

Featured Health Center

HEARTLAND HEALTH SERVICES

Additional Patient Stories

Pregnancy & Postpartum Program – Stories of Impact

Baby at almost 16% weight loss on day 15 of life. No gain ever with 34 wet diapers in 24 hours and three stools in TWO WEEKS. Pediatrician's office had been doing weight checks but mom reported no advice on what to do other than return for another weight check. Weight check with the Peds nurse showing further weight loss and instructions to follow up at baby's next appointment in 9 days. They may have been advising her in person to supplement but mom reported they did not. No additional education or recommendations documented in EMR.

OSF OnCall Connect team recommended to start supplementing with formula immediately, q 2 hours, 2 ounces, limit breastfeeding to 10 minutes to conserve calories, and start pumping. Instructed mom to call the Peds office the following day. (Provider suspected the baby may need to be admitted for failure to thrive). Provider contacted pediatric office the following day to provide warm handoff. Connect team also referred mom to WIC for vouchers.

Sara S. triaged a patient yesterday who only spoke Spanish. She was having high BPs and signs of pre-eclampsia with decreased fetal movement over the past 2 weeks. The patient wanted to wait to be seen until her next OB appointment but Sara strongly encouraged her to go in immediately. The patient went in to labor and delivery triage and the ultrasound showed that she had no visible amniotic fluid, absent fetal movement and absent fetal tone. They performed a c-section immediately and the baby was also breech as well. Had she not gone in as recommended by Sara, it would have most likely resulted in a fetal demise.

We got this message a few days later from RN in the hospital: I just wanted to let you know that I talked with the Spanish speaking patient you sent in for quite some time today. She wanted to make sure I let you know how grateful she is to have gotten your advice. She said if you wouldn't have sent her in, the baby or her would have passed. Her situation sounds heartbreaking - she is here alone with the baby and all family is in Guatemala. She was so grateful for your support.

Featured Public Health Partner

Jane McElroy, PhD
Professor
University of Missouri

Epidemiologist and Professor in Family and Community Medicine Department at University of Missouri

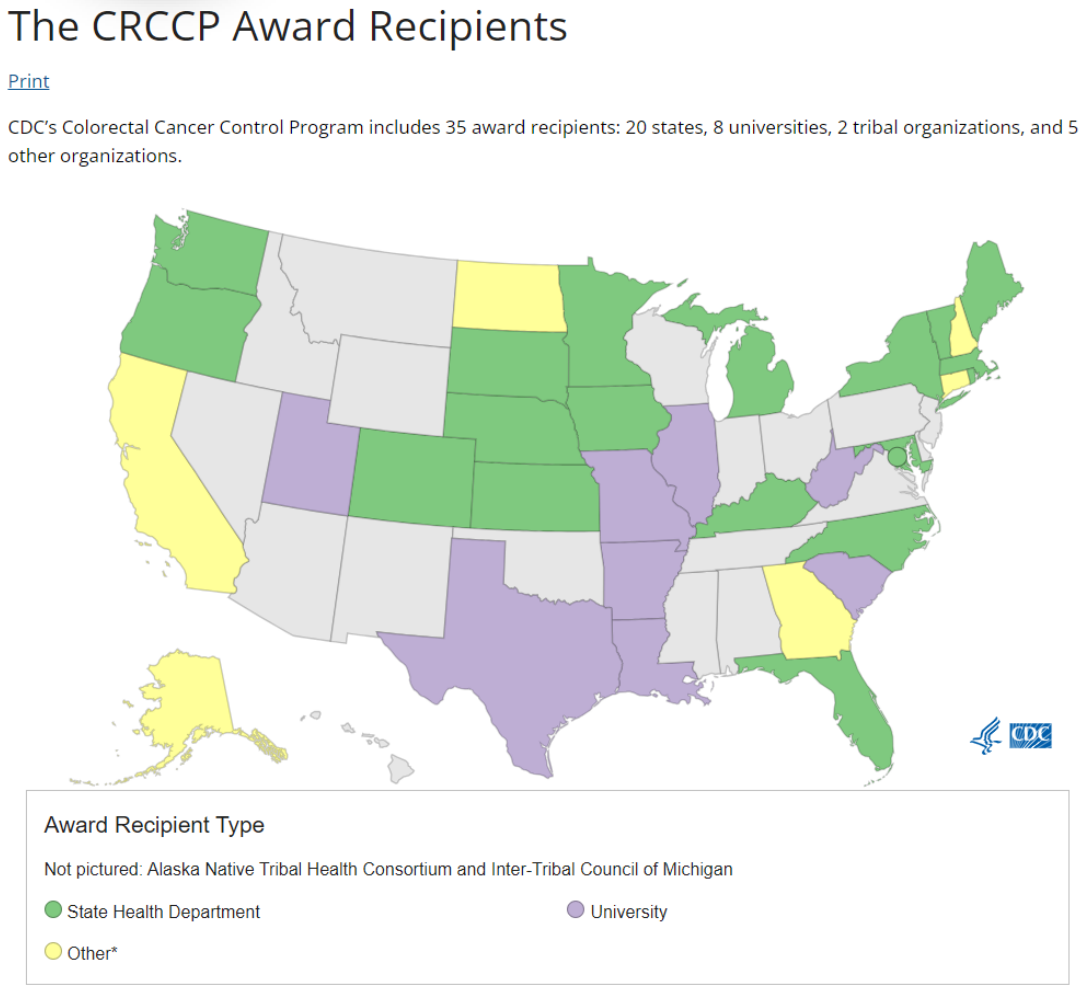
Co-director of Colorectal Cancer Control Program (partnership with community clinics to improve CRC screening rates)--MPICCS

Co-director of the Rural Health Research Center with mission to improve health of Missouri through hearing the voices of rural Missourians

Featured Public Health Partner

- Colorectal Cancer Control Program
- 5-year grant cycle
- Started in Missouri in 2020

- Evidence-Based Interventions (EBIs)
  - Provider Reminders
  - Patient Reminders
  - Provider Assessment and Feedback
  - Reducing Structural Barriers
    - Patient Navigation
    - Patient education
    - Assistance in finance and transportation



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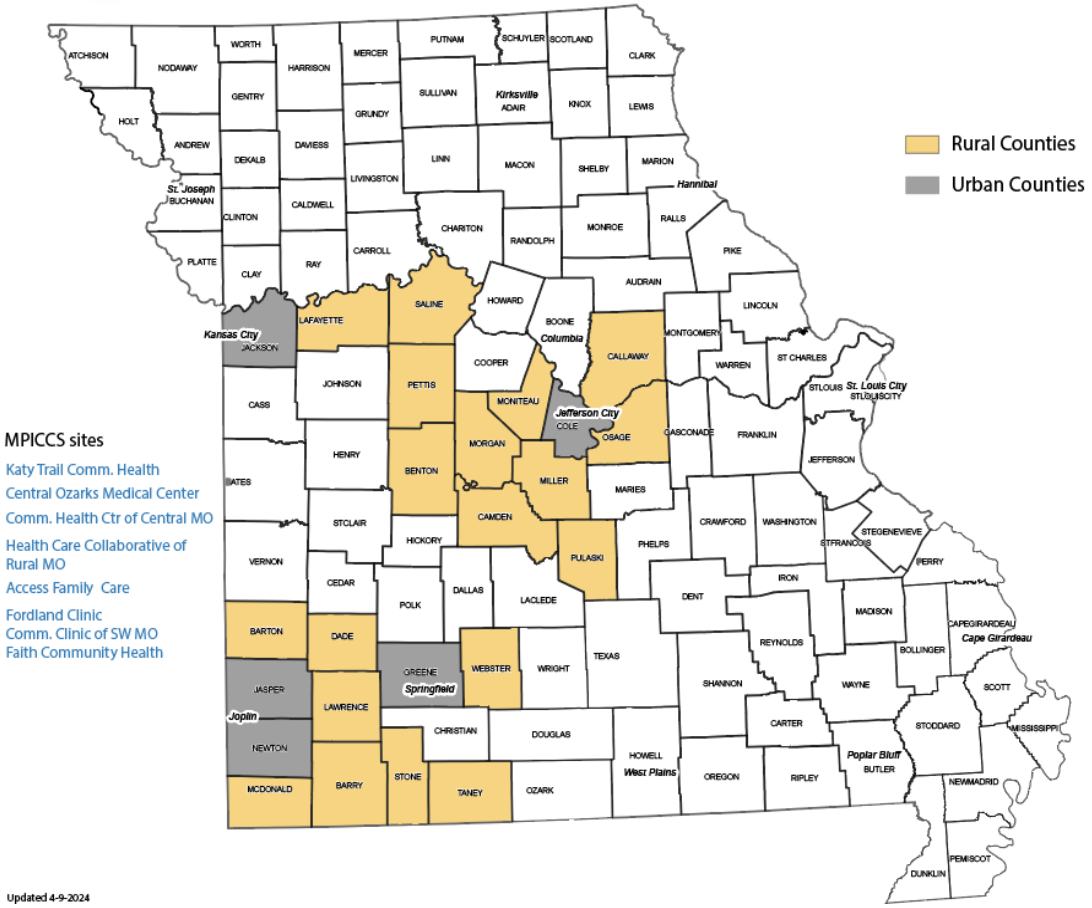
MPICCS
MISSOURI PARTNERSHIP TO INCREASE COLORECTAL CANCER SCREENING

MPICCS
School of Medicine
University of Missouri

- Facts
- MO overall CRC screening rate is 64%
- 99 (34% of MO population) out of 115 Missouri counties are rural

- The University of Missouri partners with health systems under MPICCS

  - 9 Health systems (**7 FQHCs**, 2 Free Community Clinic)
  - Total of 33 Clinics (22 are in Rural Counties)
  - Patient demographics:
    - 84% White; 4 % Black; 6 % Hispanic
    - 28% Uninsured
    - 7% Non-English Speakers



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MPICCS School of Medicine University of Missouri

Local Public Health Department and Community Clinic Partnership

FQHC or Community Clinic ⟷ MO Local Public Health Agency

Nonprofit health centers or clinics—outpatient

Serve medically underserved areas and populations

Provide primary care services regardless of ability to pay

Services are provided on a sliding scale fee

Are community-based and patient-centered

Qualifies for specific reimbursement under Medicare and Medicaid

Fiscal support from property tax, or city and county general revenue. Work directly with MO DHSS thru contracts (i.e., CDC, state revenue, other fed agencies)

None have full service clinical care but *some* nursing services such as immunization shots, infection testing, blood draws, BP, glucose checks, WIC, and/or breast and gyn screening

Inexpensive place for preventive health care

Some LPHA and FQHC are co-located (next door)

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MPICCS School of Medicine University of Missouri

LPHA and FQHC Project

WHY:

Both groups work with underserved and under-represented populations

Both groups have a focus on health care though often at different levels

WHAT: Provide educational material to LPHA and Fit-kits to eligible patients

a) either established patient at the FQHC
b) no established care anywhere but will become patient at FQHC

FQHC is the clinical site to 'read' the fit results and contact patients for follow-up care

HOW: Provide a plan to the LPHA and FQHC to support coordination of work

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MPICCS School of Medicine University of Missouri

Key take aways

- Great opportunity to connect 2 organizations/institutions
- Relationship building was key
- Greater reach for screening between 2 groups
- Very low cost and minimal effort by program staff
- LPHA often easier to get preventive care done
- Captures those who don't use/have an established primary care
- Important to have the protocol template that could be adapted to reduce burden

Patient Navigator Program School of Nursing Students

Why:

- To reduce no-shows to colonoscopy appointments
- Provide patients with necessary information to successfully complete colonoscopies
- No state funding available for PN and limited resources available by FQHC

What:

- Adapted from the South Carolina patient navigator model
- Partnered with the University of Missouri Sinclair School of Nursing
- Piloted with one health system (5 clinics)

Featured Public Health Partner

The Navigation Process

Step 1

- Student nurses receive an excel from partner health system that have open referrals for colonoscopies

Appointment Provider Name	Patient Acct No + Name	Order Encounter Date	Referral Location
Dr. Smith	MRN + Name	2/27/2024	WMMC
Dr. Smith	MRN + Name	2/23/2024	SSS
Dr. Smith	MRN + Name	2/5/2024	JCMG

Step 2

- Student review the patient's chart to confirm the procedure center the patients were referred to

Step 3

- Students call the procedure center to confirm or determine the colonoscopy appointment date

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MPICCS School of Medicine University of Missouri

Step 4

Patients are assigned a student nurse to start the navigation process which includes: (they make the calls)

- Understanding the importance procedure
- Review the prep and the medication to withhold
- If barriers are discovered hand the patient off to a CHW to assist

Featured Public Health Partner

MPICCS School of Medicine University of Missouri

Step 5

- Tracking all navigation calls on excel sheets
  - Appointment dates
  - Conversations with patients

- Documenting in patients' chart

Step 6

- Follow-up with patient about results
- Ensure receipt of colonoscopy/pathology report to clinic

Featured Public Health Partner

Key take aways

- Required time investment (buy-in) by the FQHC—active involvement
  - Getting data to us in timely manner
  - Setting up system whereby students could access the patient's chart
  - Having a CHW able to address SDOH/barriers faced by patient
  - Assigned nurse for medical oversight
- Significant effort needed by staff to train and supervise the students
    - Frequent repeated instructions needed
- Professional development was critical and time consuming
- Patient navigator system allowed for successful colonoscopy completion at virtually no cost to the FQHC
- Supported a good relationship with procedural center
- Nurses 'discovered' barriers that were addressed so colonoscopy happened
- Excellent 'real' field experience for emerging nurses

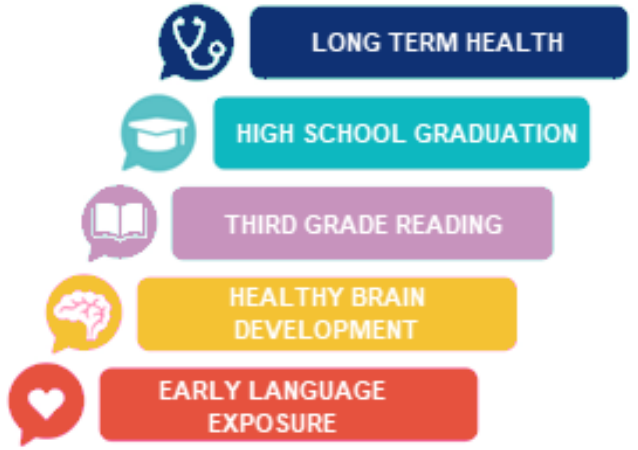
Talk With Me Baby

A New Blueprint for Health Equity & Literacy

How Does Literacy Impact Health Equity?

Only 33% of United States students read at the proficient level or above by the end of 3rd grade

- Proficient level reading at end of 3rd grade is strongly correlated with high school graduation.
- High school graduation and post-graduation education/training are strongly correlated with gainful employment, better health and longer lives.
- In 2022, only 33% of the nation's children were reading on a proficient level or above by the end of the 3rd grade.
- For students from poor households the results are even more sobering: only 19% read on the proficient level. *
  - Up to 81% of U.S. children struggle with learning and achievement in school from the 4th grade on.
- As a result, too many will drop out of or underachieve in school.



THE EDUCATION – HEALTH CONNECTION

4 YEARS OR MORE OF COLLEGE AFTER HIGH SCHOOL IS CORRELATED WITH…

5-7 years Longer Life 12% less risk for Smoking	5% less risk for Obesity 2.2% less risk for Heart Disease	1.3% less risk for Diabetes

We can do better!

*The Nation's Report Card: https://www.nationsreportcard.gov/reading/nation/achievement/?grade=4

What is Talk With Me Baby?

Talk With Me Baby for healthcare is a collaboration of Grady Health System and the Rollins Center for Language and Literacy at the Atlanta Speech School in Atlanta, GA. The initiative, designed to combat illiteracy and generational poverty was developed with grant support from the James M. Cox Foundation and United Way of Greater Atlanta/Woodruff Foundation.

TALK WITH ME BABY

Talk With Me Baby is a research-based intervention that helps children build healthy neural and social foundations for learning, literacy, and school achievement starting with the last trimester of pregnancy to the age of 3 when brain growth is at its peak.

Health care professionals are trained to utilize a family-centered education & coaching approach during the provision of routine care that results in lasting impacts.

Backed by an independent study completed by Brazelton Touchpoints Center and Harvard Medical School faculty.

What is Talk With Me Baby?

For expectant families and families with children aged 0-3

Utilizes the sciences of early brain development, language acquisition, and reading

Based on research showing strong correlations between literacy and engagement in preventive health practices, being equipped to comprehend health information, navigating healthcare systems, and making informed decisions

Utilizes a strengths-based, family-centered, coaching approach to equip families to support their child's brain, language and social-emotional development critical for all future learning achievement

Aims to strengthen learning and literacy for ALL families while interrupting cycles of generational economic immobility caused by illiteracy for others

Research completed by faculty from the Harvard School of Medicine in 2024 indicates TWMB is embraced by health professionals and has lasting positive impacts on family behaviors and children's language development

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The NACHC and Sesame Workshop Talk With Me Baby Collaboration

NATIONAL ASSOCIATION OF Community Health Centers®

SESAME WORKSHOP

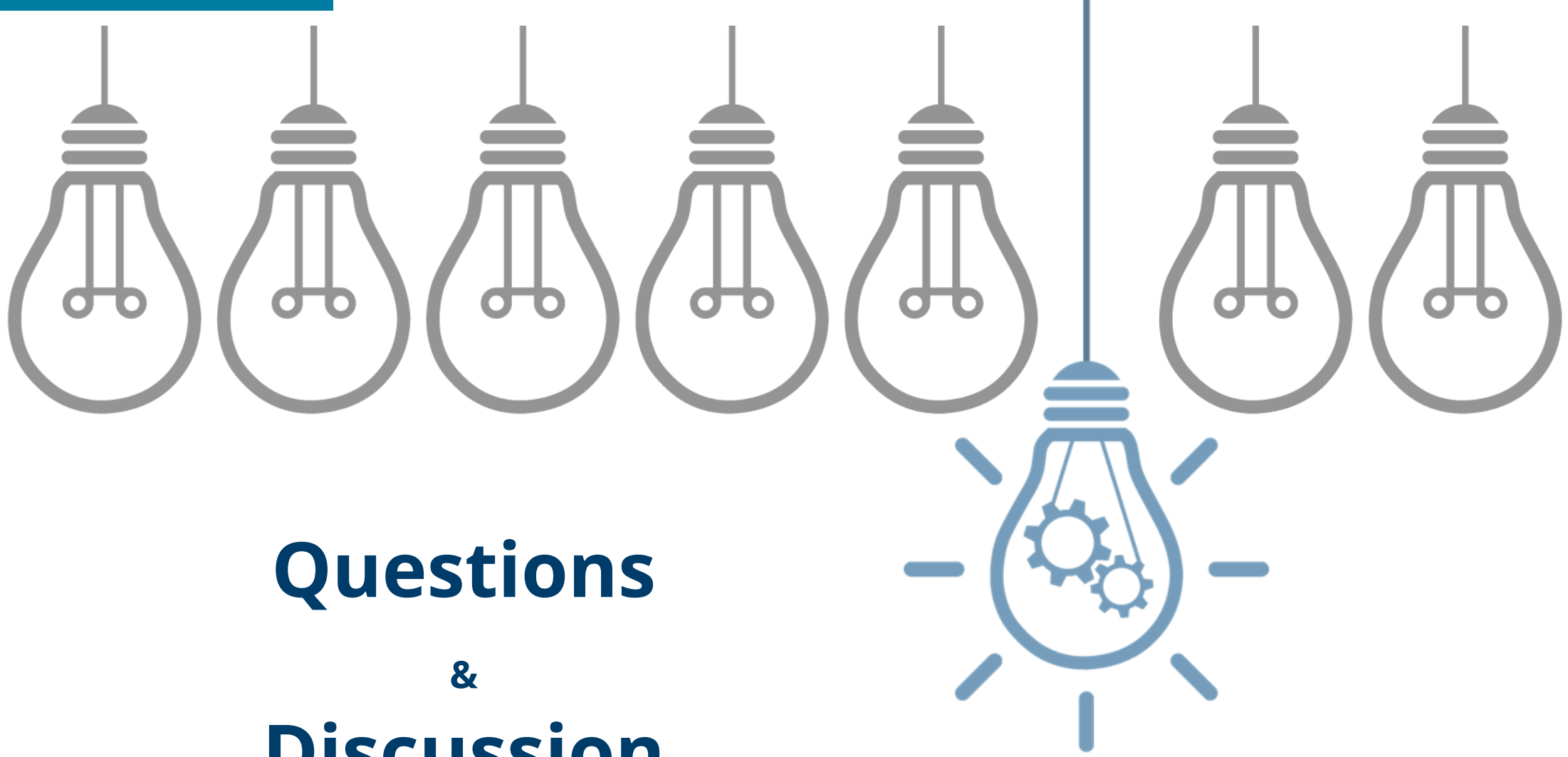
PHASE 1

- Implementation Guide for Health Center Leaders
- Resources for Staff
- Resources for Families

PHASE 2

- Informational and Implementation Webinars for Health Center Leaders
- CBT Training for Staff

Use the QR Code to tell us about your health center and get more information.
Available soon on the NACHC website.
Questions? Contact Gervean Williams, Director, Finance and Center Operations: gwilliams@nachc.org



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!

PRAPARE® Tiger Team

PRAPARE™
Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences

What is the PRAPARE® Tiger Team?

The PRAPARE® Tiger Team, established in 2020, serves as an open forum for PRAPARE® stakeholders, including users, vendors, payers, and developers. This forum is dedicated to discussions on PRAPARE® functionalities and utilization within electronic health record (EHR) systems, workflows, implementation, and data collection. The PRAPARE® Tiger Team meets every 3 weeks on Mondays from 2:00pm-3:00pm Eastern via teleconference (zoom).

- Visit PRAPARE® Tiger Team webpage for current information on events.
- View our YouTube Playlist for recordings of previous sessions.
- For more information or support, please email prapare@nachc.org.

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!

FOR MORE INFORMATION CONTACT

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301.310.2250

Next Monthly Learning Forum:

Evidence-Based Care

elevate

July 9, 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

qualitycenter@nachc.org