NATIONAL ASSOCIATION OF Community Health Centers®

ELEVATE NATIONAL LEARNING FORUM

elevate

Evidence-Based Care

July 9, 2024

THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NATIONAL ASSOCIATION OF Community Health Centers®

NACHC Quality Center

Cheryl Modica
Director,
Transformation and Innovation

Cassie Lindholm
Deputy Director,
Quality Center

Holly Nicholson
Deputy Director, Learning
and Development

Tristan Wind
Manager,
Quality Center

Agenda

Welcome

Elevate Journey

Evidence-Based Care

What, Why, How

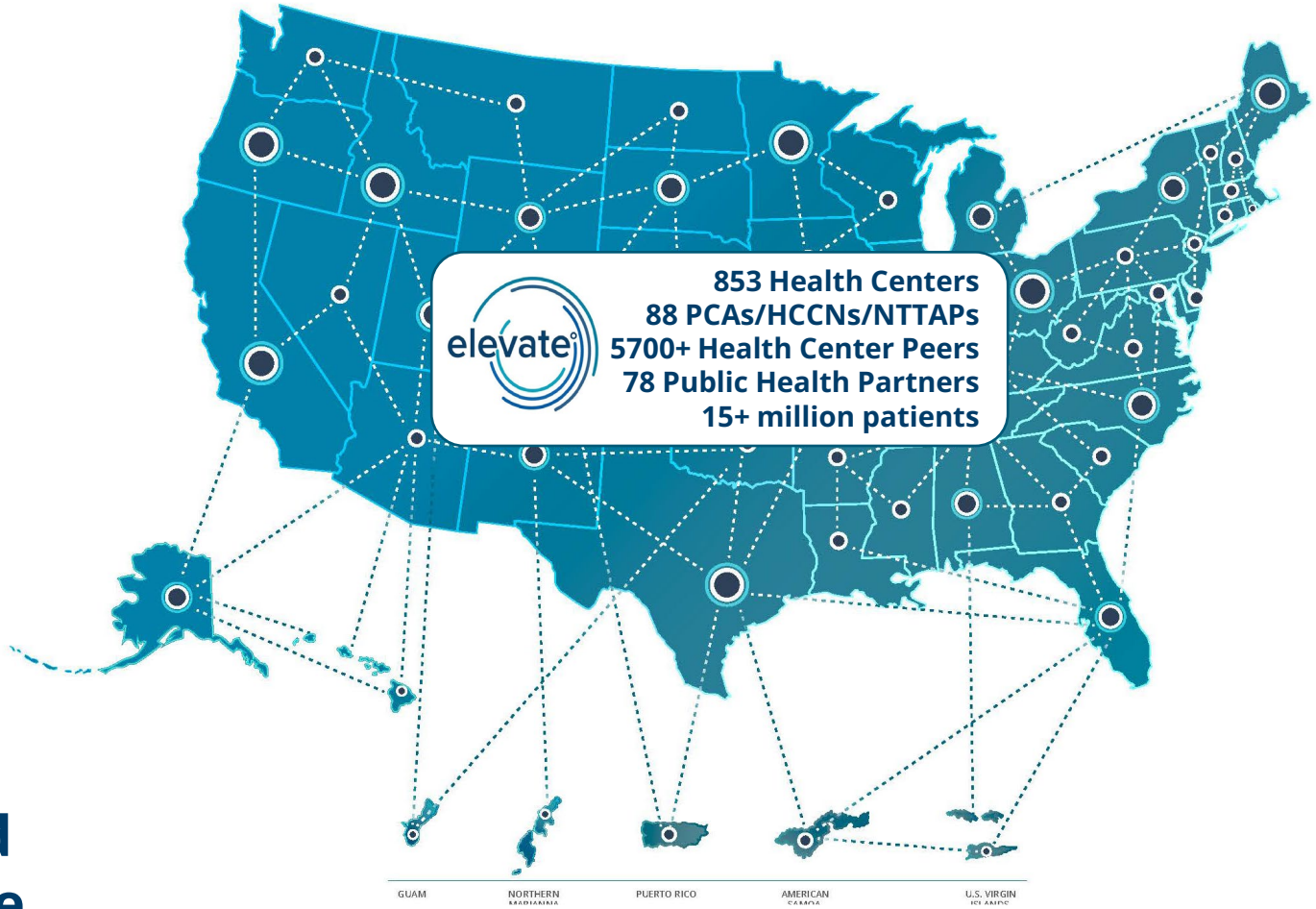
Featured Panelists:

- ***Jacqueline Miller, MD, FACS, Centers for Disease Control and Prevention***
- ***Sallyann Coleman King, MD, MSc, Centers for Disease Control and Prevention***
- ***Victoria Brenton, MPH, Iowa Department of Health and Human Services***
- ***Miriam Bell, MPH, Centers for Disease Control and Prevention***

Panel Discussion and Q&A

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 Payment Series – **LAST supplemental session July 25, 2024!**

*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 Assessment: Evidence-Based Care

VTF Change Area: Evidence-Based Care

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

	1 – Learning	2 – Basic	3 – Applied	4 – Skilled	5 – Expert
Evidence-Based Guidelines				*Health center applies evidence-based practices, demonstrating improved levels of clinical performance.*	
Care Gaps				*Health center analyzes care gap reports for targeted populations (e.g., patients who are on registries or defined as high-risk) and conducts outreach for clinical/preventive services to these groups.*	
Integrated Services				*In addition to offering fully integrated services for behavioral health, oral health and/or vision, the health center has assessed service area needs and incorporated additional integrated services (e.g., podiatry, alternative medicine, pharmacy).*	·

Evidence-Based Care

WHAT? WHY? HOW?

NATIONAL ASSOCIATION OF Community Health Centers®

WHAT is Evidence-Based Care?

Evidence-Based Care is making patient care decisions using a process that integrates:

WHAT is a '*Systems Approach*' to Evidence-Based Care?

In a *'systems approach'* to evidence-based care, health centers can combine treatments for specific conditions with broader interventions to have a bigger effect.

Examples of specific conditions:

- Cancer
- Diabetes
- HIV
- Hypertension
- Obesity

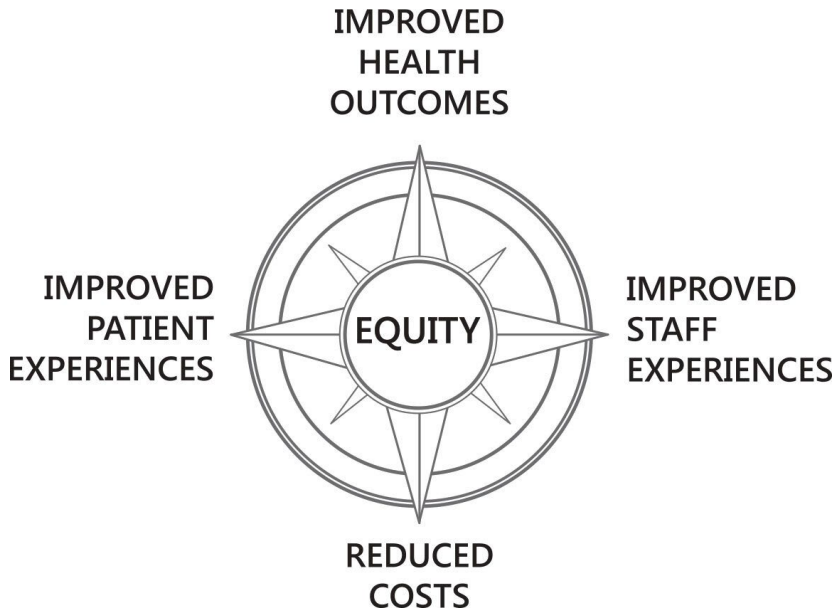
Examples of broad interventions:

- Population health management strategies, including:
  - Empanelment, risk stratification, care model design
  - Social drivers of health
- Team-based care and care management
- Leveraging HIT
- Patient engagement

WHY use a Systems Approach to Evidence-Based Care?

When evidence is the foundation for care decisions and interventions - rather than opinion, common practice, or expediency - better outcomes can be achieved.

When broader interventions become the foundation for care delivery, health centers are better positioned to advance toward the **Quintuple Aim Goals**.



WHY use a Systems Approach to Evidence-Based Care?

Population health management strategies, broad interventions as the foundation of care delivery:

Social Drivers of Health: The social, economic, and environmental circumstances that influence patients' health and the care they receive.

SDOH Interventions

Empanelment

Matching every patient to a primary care provider and care team.

SDOH Assessment

Risk Stratification

Segmenting patients into groups of similar complexity and care needs.

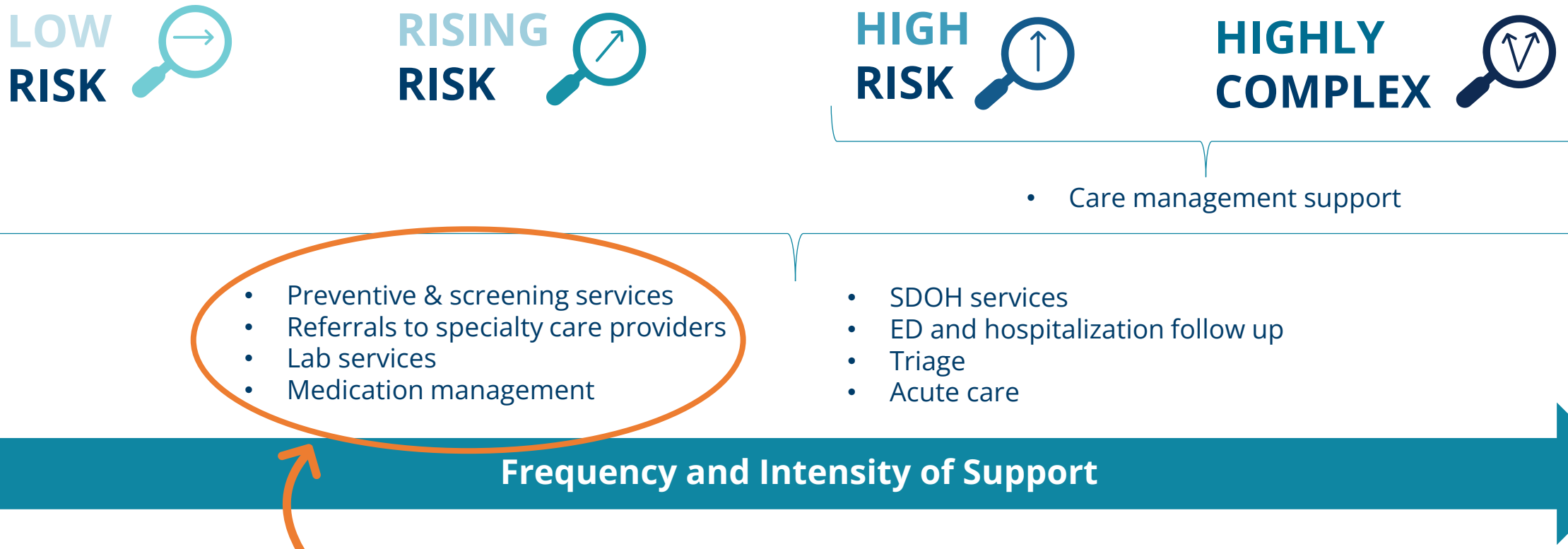
Models of Care

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

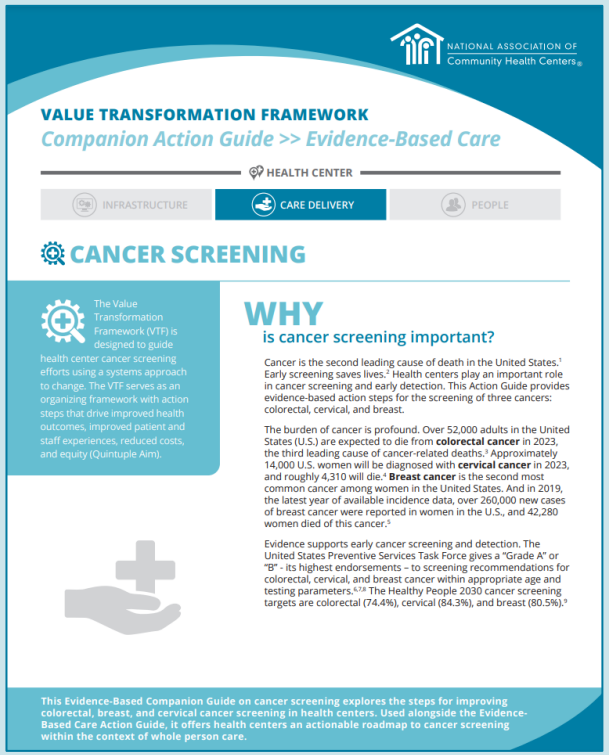
Incorporate condition-specific, evidence-based interventions!

WHY use a Systems Approach to Evidence-Based Care?

Care model design:



HOW to use a Systems Approach to Evidence-Based Care?



NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Companion Action Guide >> Evidence-Based Care

HEALTH CENTER

INFRASTRUCTURE | CARE DELIVERY | PEOPLE

CANCER SCREENING

The Value Transformation Framework (VTF) is designed to guide health center cancer screening efforts using a systems approach to change. The VTF serves as an organizing framework with action steps that drive improved health outcomes, improved patient and staff experiences, reduced costs, and equity (Quintuple Aim).

WHY

is cancer screening important?

Cancer is the second leading cause of death in the United States.[1] Early screening saves lives.[2] Health centers play an important role in cancer screening and early detection. This Action Guide provides evidence-based action steps for the screening of three cancers: colorectal, cervical, and breast.

The burden of cancer is profound. Over 52,000 adults in the United States (U.S.) are expected to die from **colorectal cancer** in 2023, the third leading cause of cancer-related deaths.[3] Approximately 14,000 U.S. women will be diagnosed with **cervical cancer** in 2023, and roughly 4,310 will die.[4] **Breast cancer** is the second most common cancer among women in the United States. And in 2019, the latest year of available incidence data, over 260,000 new cases of breast cancer were reported in women in the U.S., and 42,280 women died of this cancer.[5]

Evidence supports early cancer screening and detection. The United States Preventive Services Task Force gives a "Grade A" or "B" - its highest endorsements – to screening recommendations for colorectal, cervical, and breast cancer within appropriate age and testing parameters.[6,7,8] The Healthy People 2030 cancer screening targets are colorectal (74.4%), cervical (84.3%), and breast (80.5%).[9]

This Evidence-Based Companion Guide on cancer screening explores the steps for improving colorectal, breast, and cervical cancer screening in health centers. Used alongside the Evidence-Based Care Action Guide, it offers health centers an actionable roadmap to cancer screening within the context of whole person care.

STEP 1 Engage leadership

STEP 2 Apply population health strategies

STEP 3 Design models of care that incorporate evidence-based interventions

STEP 4 Create/update clinical policies and standing orders

STEP 5 Deploy Care Teams in New Ways

STEP 6 Optimize Health Information Systems

STEP 7 Engage patients and support self-management

STEP 8 Develop/enhance community partnerships

STEP 9 Tailor treatment for social context

STEP 10 Maximize reimbursement

See condition specific action guides:

✓ ***Cancer Screening***
✓ ***HIV Prevention***
✓ ***Diabetes***
✓ ***Hypertension***

Systems Approach to Evidence-Based Care

Old Approach

Patient reason for visit: Hypertension management

Services patient receives:

- Blood pressure check (MA)
- Prescription for refill on hypertension medication (Provider)

Systems Approach

Patient reason for visit: Hypertension management

Care gap alerts in the EHR indicate the patient is also due for CRC screening, HgA1c, and has never been screened for SDOH

Services patient receives (via *team-based care*):

- Blood pressure check (MA)
- HgA1c (RN via *standing orders*)
- Prescription for refill on hypertension medication (Provider)
- Discussion of CRC screening options (Provider)
- FIT *education* (Patient Navigator)
- SDOH screening (Patient Navigator)
    - Identified need for transportation to pick up HTN medication from the pharmacy. Patient is connected to community resources.

Evidence-Based Care Guidelines, Recommendations, and Measures

U.S. Preventive Services Task Force Recommendations

- Breast cancer screening
- Cervical cancer screening
- Colorectal cancer screening
- Hypertension screening
- Statin Use for Prevention of Cardiovascular Disease
- Prediabetes screening
- Depression screening
- Weight loss to prevent obesity
- Falls prevention
- …others

American Diabetes Association: Standards of Care in Diabetes

- Improving Care and Promoting Health in Populations
- Diagnosis and Classification of Diabetes
- Prevention or Delay of Diabetes and Associated Comorbidities
- Comprehensive Medical Evaluation and Assessment of Comorbidities
- Facilitating Positive Health Behaviors and Well-being to Improve Health Outcomes
- …others

2017 ACC / AHA / AAPA / ABC / ACPM / AGS / APhA / ASH / ASPC / NMA / PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines

American Cancer Society Prevention and Early Detection Guidelines

- Breast cancer
- Cervical cancer
- Colorectal cancer
- Nutrition and physical activity guidelines
- Vaccine guidelines
- …others

…and MORE!

Evidence-Based Care Guidelines, Recommendations, and Measures

HEDIS® includes more than 90 measures across 6 domains of care:

- Effectiveness of Care.
- Access/Availability of Care.
- Experience of Care.
- Utilization and Risk Adjusted Utilization.
- Health Plan Descriptive Information.
- Measures Reported Using Electronic Clinical Data Systems

CMS eCQMs measure many aspects of patient care, including:

- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population/Public Health
- Efficient Use of Healthcare Resources
- Clinical Process/Effectiveness

Healthy People 2030: Data-driven national objectives to improve health and well-being over the next decade

What can health centers do?

- ✓ Follow the evidence! Review NACHC Evidence-Based Care Action Guides for synthesis of guidelines in *Cancer Screening*, *Diabetes*, *HIV Prevention*, and *Hypertension*
- ✓ Understand reporting requirements (UDS, PCMH, etc.)
- ✓ Understand payor goals and value-based payment contract requirements

UDS Measures

Breast Cancer Screening

Percentage of women 50–74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period

Cervical Cancer Screening

Percentage of women who were screened for cervical cancer using either of the following criteria:

- Women age 21–64 who had cervical cytology performed within the last 3 years
- Women age 30–64 who had human papillomavirus (HPV) testing performed within the last 5 years

Colorectal Cancer Screening

Percentage of adults 45–75 years of age who had appropriate screening for colorectal cancer:

- Fecal occult blood test (FOBT) during the measurement period
- Stool deoxyribonucleic acid (DNA) (sDNA) with fecal immunochemical test (FIT) during the measurement period or the 2 years prior to the measurement period
- Flexible sigmoidoscopy during the measurement period or the 4 years prior to the measurement period
- Computerized tomography (CT) colonography during the measurement period or the 4 years prior to the measurement period
- Colonoscopy during the measurement period or the 9 years prior to the measurement period

UDS Measures

Controlling High Blood Pressure

Percentage of patients 18–85 years of age who had a diagnosis of essential hypertension starting before and continuing into, or starting during the first six months of the measurement period, and whose most recent blood pressure (BP) was adequately controlled (less than 140/90 mmHg) during the measurement period

Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Percentage of the following patients—all considered at high risk of cardiovascular events—who were prescribed or were on statin therapy during the measurement period:

- All patients who were previously diagnosed with or currently have a diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD) or have ever had an ASCVD procedure
- Patients 20 through 75 years of age who have ever had a low-density lipoprotein cholesterol (LDL-C) laboratory result level greater than or equal to 190 mg/dL or were previously diagnosed with or currently have an active diagnosis of familial hypercholesterolemia
- Patients 40 through 75 years of age with a diagnosis of diabetes
- Patients 40 through 75 years of age with a 10-year ASCVD risk score greater than or equal to 20 percent

Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9.0 percent)

Percentage of patients 18–75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period

Evidence-Based Care Featured Panelists

Breast & Cervical Cancer Screening

Jacqueline Miller, MD, FACS

CAPT, USPHS, Medical Director, National Breast and Cervical Cancer Early Detection Program, CDC

Colorectal Cancer Screening

Sallyann Coleman King, MD, MSc

CAPT., USPHS, Medical Director, Colorectal Cancer Control Program, CDC

Colorectal Cancer Screening

Victoria Brenton, MPH

Colorectal Reporting & Coordinating Manager Iowa Department of Health and Human Services

Diabetes Prevention

Miriam Bell, MPH

Team Lead, National Diabetes Prevention Program, Division of Diabetes Translation, CDC

Hypertension Management

Hilary K. Wall, MPH

Senior Scientist in the Division for Heart Disease and Stroke Prevention, CDC

Systems Approach

YOU!

Raise your hand to share your experience providing evidence-based care from a systems approach

Featured Panelists

Jacqueline Miller, MD, FACS
CAPT, USPHS, Medical Director, National Breast and Cervical Cancer Early Detection Program, CDC

Jacqueline Miller, MD, FACS, is a Captain with the U.S. Public Health Service and a board-certified general surgeon. She is the Medical Director for CDC's National Breast and Cervical Cancer Early Detection Program which provides free breast and cervical cancer screening and diagnostic services to women who are uninsured and have low incomes and works with health systems to implement evidence-based interventions to increase cancer screening. Dr. Miller oversees the program's clinical guidance and provides technical assistance to funded program recipients and providers. She also provides patient care in an outpatient clinic setting.

Sallyann Coleman King, MD, MSc
CAPT, USPHS, Medical Director,
Colorectal Cancer Control Program, CDC

Sallyann Coleman King, MD, MSc serves as the Medical Director of the Colorectal Cancer Control Program. Dr. Coleman King did her undergraduate training at Emory University in Atlanta, Georgia and her master's degree in a program jointly taught at the London School of Hygiene and Tropical Medicine and the University College London in London, England. She completed her medical degree and residency at Emory University School of Medicine in internal medicine and preventive medicine and then went on to complete a fellowship in Outcomes Research and a Clinical Trials fellowship. Dr. Coleman King then completed a fellowship in the Epidemic Intelligence Service at the CDC. She is a Commander in the U.S. Public Health Service and supports emergency response needs of the country.

Evidence-Based Interventions: Cancer Screening

Multicomponent interventions had greatest impact:

- Combining interventions from each of the three approaches
- Two or more interventions to reduce structural barriers

Approach	Intervention	Breast	Cervical	Colorectal
Increasing Client Demand	**Client Reminders**	Recommended	Recommended	Recommended
	Group Education	Recommended	Insufficient evidence	Insufficient evidence
	One-On-One Education	Recommended	Recommended	Recommended
	Small Media	Recommended	Recommended	
Increasing Client Access	**Reducing Structural Barriers**	Recommended	Insufficient evidence	Recommended
	Reducing Out-of-Pocket Costs	Recommended	Insufficient evidence	Insufficient evidence
Increasing Provider Delivery	**Provider Assessment and Feedback**	Recommended	Recommended	Recommended
	Provider Reminders	Recommended	Recommended	Recommended
Engage Community Health Workers		Recommended	Recommended	Recommended
Patient Navigation Services		Recommended	Recommended	Recommended

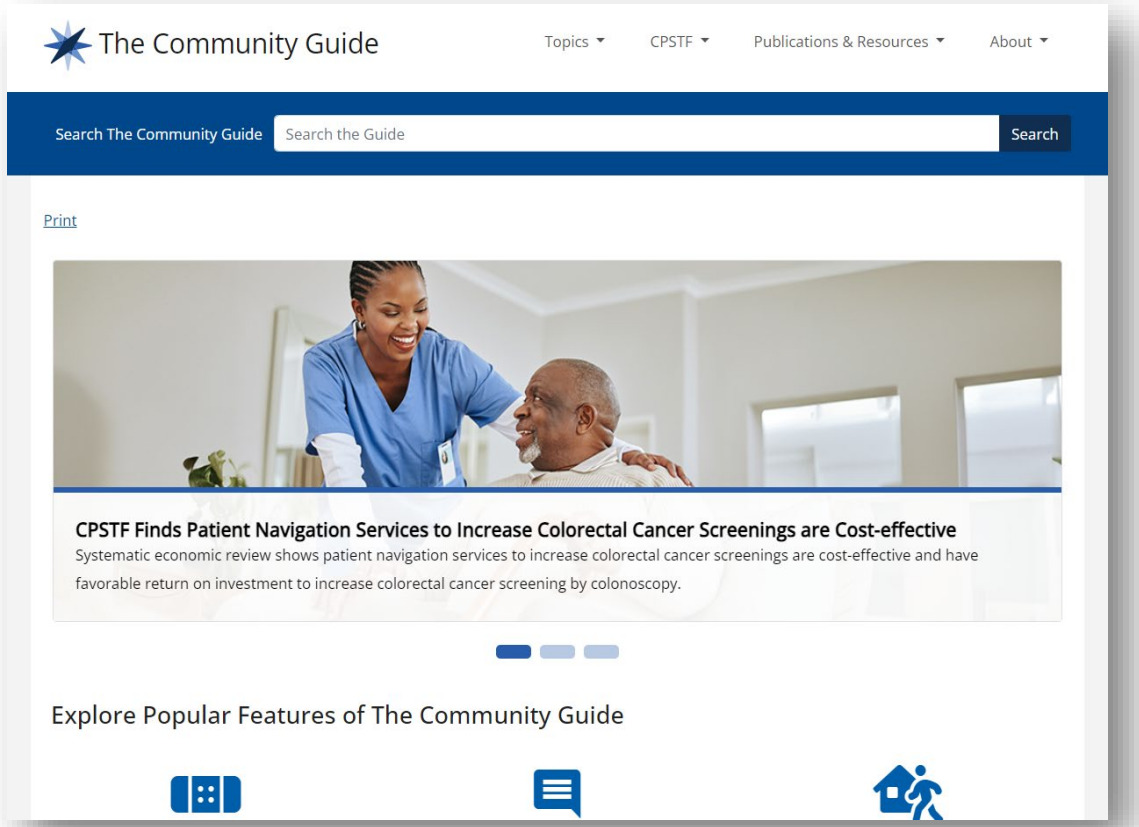
Breast: Women 40 to 74 years, biennial screening mammography

Cervical: Women 21 to 29, every 3 years with cytology alone; 30-65 years, every 3 to 5 years depending on test (Grade A)

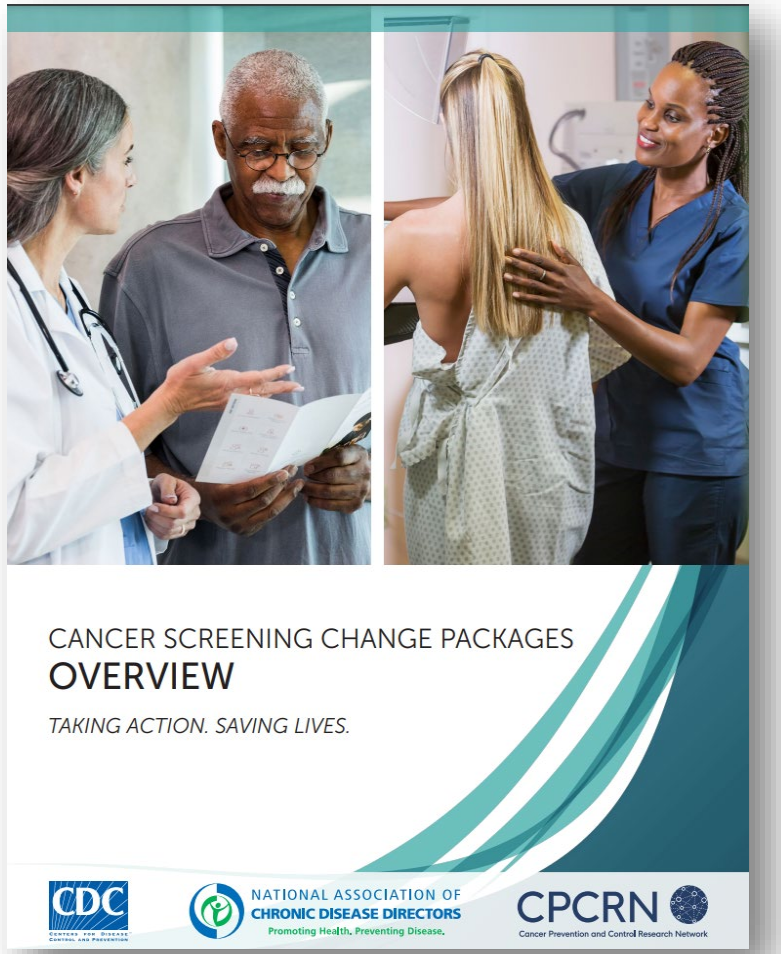
Colorectal: People 45 to 49 years of age (Grade B); People 50 to 75 years of age (Grade A)

U.S. Preventive Services Task Force Recommendations

Evidence-Based Interventions: Cancer Screening



[The Guide to Community Preventive Services (The Community Guide)]



[Cancer Screening Change Packages Toolkit]
Covers clinical settings for breast, cervical, and colorectal

Featured Panelist

Victoria Brenton, MPH
Colorectal Reporting & Coordinating Manager
Iowa Get Screened: Colorectal Cancer Program
Iowa Department of Health and Human Services

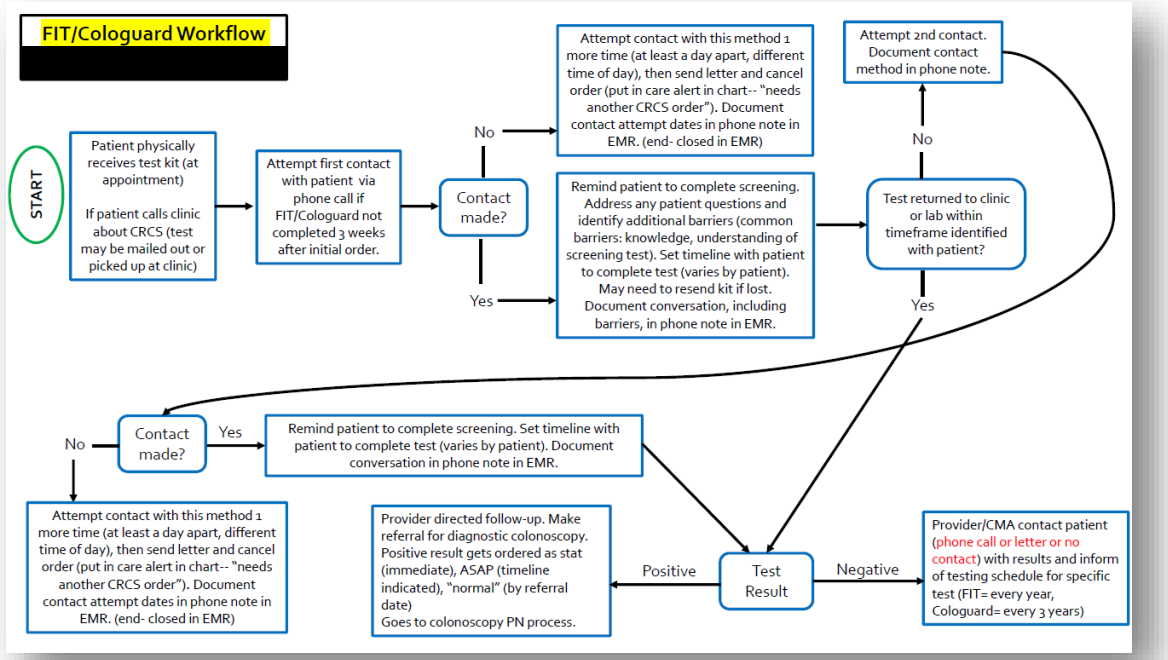
Victoria Brenton is the Colorectal Cancer Program Reporting and Coordinating Manager. She has been with the Iowa Department of Health & Human Services since 2010, where she started as the Program Manager of the Iowa Comprehensive Cancer Control Program. She earned an MPH from Des Moines University in 2020. Victoria loves all things health related and geeking out over the latest research articles. When she's not talking to others about getting screened for colorectal cancer, she stays busy with her 9-year-olds twins, her spouse and goldendoodle, Frida.

Systems Approach to Cancer Screening

IOWA Health and Human Services

Health Agency Collaborates with Trusted Partner: Iowa Primary Care Association (PCA)

- ✓ Builds partnership with the Iowa PCA and health centers into their CDC grant
- ✓ Supports development of health center workflows for cancer screening, specific to the electronic health record
- ✓ Takes a systems approach; requests a team-based approach, ideally QI Director, Patient Navigator and Data person



Featured Panelist

Hilary K. Wall, MPH
Senior Scientist, Division for Heart Disease and Stroke Prevention
Centers for Disease Control and Prevention (CDC)

Ms. Wall serves as the Science Lead for Million Hearts®, a national initiative with the goal of preventing one million heart attacks and strokes by 2027. In this role, she provides scientific leadership and expertise to a portfolio of work related to cardiovascular disease prevention, health care systems change, and related public policy. With a career spanning 20+ years, Ms. Wall has contributed significantly to the field, authoring publications and developing evidence-based tools, resources, and technical assistance for clinicians and public health professionals to support cardiovascular disease prevention.

Evidence-Based Interventions: Prevention Hypertension Screening

Systematic use of these evidence-based interventions…

- Accurate BP measurement
- "Hiding in plain sight" – finding potentially undiagnosed hypertension
- Antihypertensive medications including fixed dose combinations
- Self-measured blood pressure monitoring
- Lifestyle modifications
- Social drivers of health

…Using these types of implementation strategies

- Identification of a clinical champion
- Standardized treatment protocols
- Patient registries
- Clinician audit and feedback reports
- EHR reminders
- Clinician education and training
- Patient education
- Task sharing/team-based care

Clinical Guidelines: 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. **https://www.ahajournals.org/doi/10.1161/HYP.0000000000000065**
U.S. Preventive Services Task Force Recommendations: Hypertension: Screen adults 18 years of age and older with office blood pressure (BP) measurement; recommends BP measurement outside of the clinical setting for diagnostic confirmation before starting treatment (Grade A).
U.S. Preventive Services Task Force Recommendations.

Evidence-Based Interventions: Management Cholesterol Management

Systematic use of these evidence-based interventions…

- Cholesterol screening including non-fasting tests
- ‘Hiding in plain sight’ – finding high-risk untreated patients
- Statin and non-statin therapies
- Identifying familial hypercholesterolemia (FH)
- Shared decision-making
- Social drivers of health

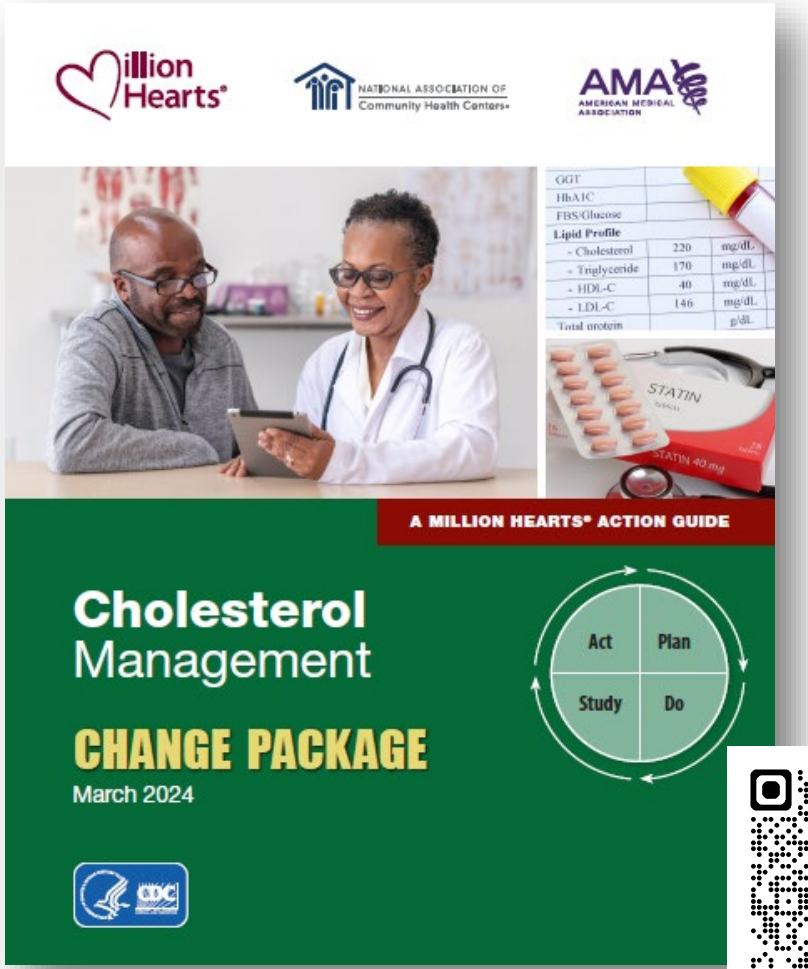
…Using these types of implementation strategies

- Identification of a clinical champion
- Standardized treatment protocols
- Patient registries
- Clinician audit and feedback reports
- EHR reminders
- Clinician education and training
- Patient education
- Task sharing/team-based care

Clinical Guidelines: Grundy SM, et al. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Circulation. 2019 Jun 18;139(25):e1082-e1143. **https://www.ahajournals.org/doi/10.1161/CIR.0000000000000625**

U.S. Preventive Services Task Force Recommendations: Statin Use to Prevent Cardiovascular Disease: Statin therapy for adults 40 to 75 years of age with 1 or more cardiovascular risks and estimated 10-year risk of CVD event of 10% or greater (Grade B). **link**

CDC Resources



Featured Panelist

Miriam Bell, MPH
Team Lead, National Diabetes Prevention Program,
Division of Diabetes Translation, CDC

Miriam T. Bell, MPH is the Team Lead, National Diabetes Prevention Program where she provides guidance and strategic direction to a team of talented public health professionals to achieve the National DPP programmatic goals, which are to ensure the program's success through increased coverage & reimbursement, programmatic quality, participant demand and clinical referral. Prior to joining the CDC, Miriam served as the Director, Center for Care Partnership for Kaiser Permanente – Georgia Region (KPGA) for seven years. In that role she was instrumental in setting Kaiser Permanente's population health strategy, by conceptualizing and implementing an end-to-end diabetes prevention strategy, which included offering an in-person National Diabetes Prevention Program for KPGA members. In addition to setting the strategy for diabetes prevention, she also managed the following teams: Nutrition Service, Health Education and Elder Care (which included oversight of the region's Special Needs Plan). Miriam has also served as the Deputy Director, Public Health Programs & Services for the State of Georgia, Division of Public Health and various roles at Moffitt Cancer Center in Tampa, FL. Miriam earned a Bachelor of Art degree from Emory University and a Master of Public Health from the University of South Florida.

EVIDENCE-BASED INTERVENTIONS FOR DIABETES PREVENTION & MANAGEMENT

Miriam Bell, MPH

Team Lead, National Diabetes Prevention Program

Diabetes Prevention Recognition Program

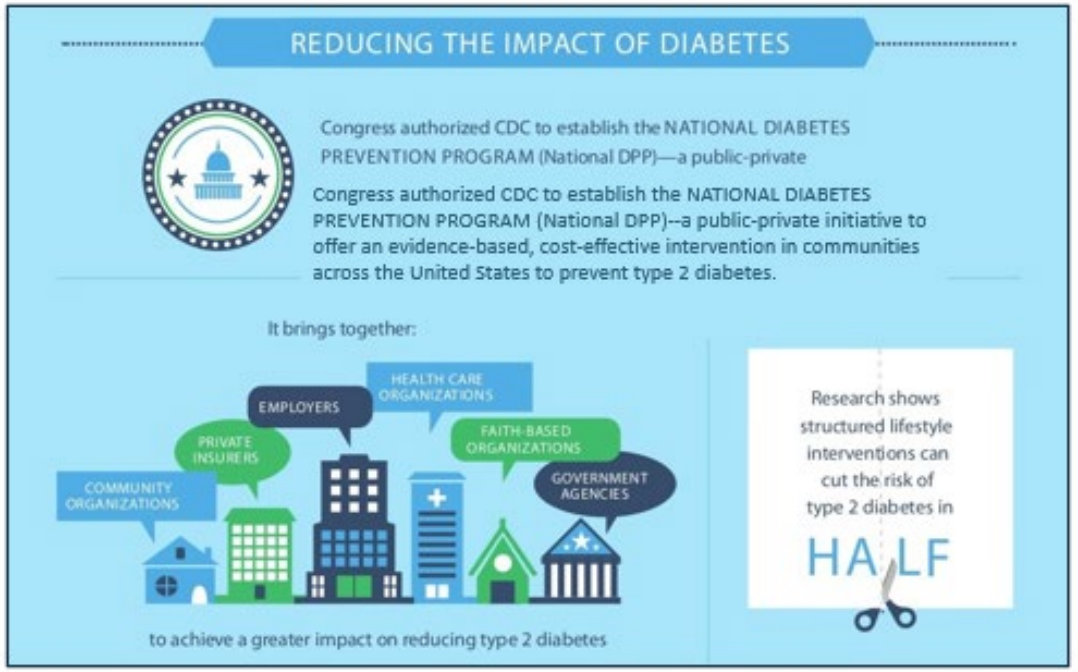
NATIONAL DIABETES PREVENTION PROGRAM

Evidence-Based Interventions: Prevention Diabetes

U.S. Preventive Services Task Force Recommendations
Screening for prediabetes and type 2 diabetes in adults aged 35 to 70 years who are overweight. Clinicians should offer or refer patients with prediabetes to effective intervention programs (Grade B).

National Diabetes Prevention Program

NATIONAL DIABETES PREVENTION PROGRAM



Evidence-Based Interventions: Management Diabetes

Guiding Principles for the Care of People with or at Risk for Diabetes

Diabetes Self-Management Education and Support Toolkit

National Diabetes Prevention Program

DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT

A COMPREHENSIVE RESOURCE FOR ACHIEVING SUCCESS IN DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT

Evidence-Based Care Featured Panelists

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Hypertension Management

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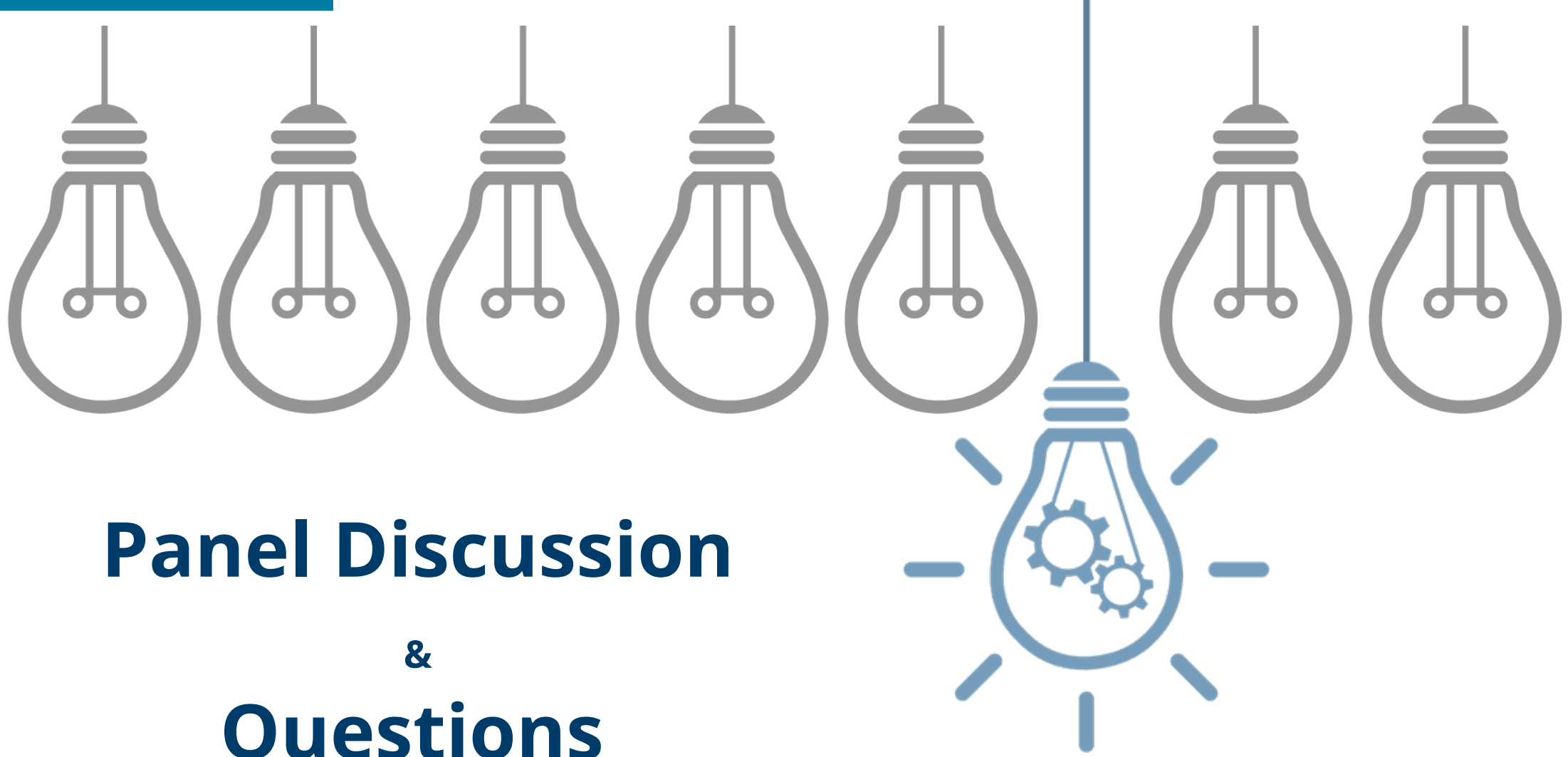
Systems Approach

YOU!

Raise your hand to share your experience providing evidence-based care from a systems approach.



Panel Discussion

&

Questions

Systems Approach to Evidence-Based Care

Old Approach

Patient reason for visit: Hypertension management

Services patient receives:

- Blood pressure check (MA)
- Prescription for refill on hypertension medication (Provider)

Systems Approach

Patient reason for visit: Hypertension management

Care gap alerts in the EHR indicate the patient is also due for CRC screening, HgA1c, and has never been screened for SDOH

Services patient receives (via *team-based care*):

- Blood pressure check (MA)
- HgA1c (RN via *standing orders*)
- Prescription for refill on hypertension medication (Provider)
- Discussion of CRC screening options (Provider)
- FIT *education* (Patient Navigator)
- SDOH screening (Patient Navigator)
    - Identified need for transportation to pick up HTN medication from the pharmacy. Patient is connected to community resources.

Evidence-Based Care: Hypertension

NACHC SMBP Toolkit

NACHC Million Hearts® Resources: Impactful Strategies for HTN Control

Increase/optimize **medication therapy** (treatment intensification)

Increase **patient contact** (touchpoints)

Promote consistent **medication use** (adherence)

Increase uptake of self-measured blood pressure monitoring (SMBP)

NACHC Million Hearts Resources

Million Hearts®

LEARNING LAB

A bi-monthly mixed methods learning series focused on cardiovascular disease prevention and management topics.

CE Credits pending for Physicians, Physician Assistants, Nurses, Certified Health Education Specialists, Pharmacists, Certified Public Health Professionals, and Other Health Care Professionals.

NATIONAL ASSOCIATION OF Community Health Centers®

07/11/2024 | 1:00 - 1:45 pm ET

Hypertension in Pregnancy: Impactful Strategies and Tools

More sessions to come! Details coming soon.

REGISTER TODAY!

Access required session resources and learn more about the Million Hearts® Learning Lab

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!

Elevate goes on summer break!

No August Learning Forum

Next Monthly Learning Forum:

Patients & PCMH

elevate

September 10, 2024
1:00 – 2:00 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

elevate°

Together, our voices elevate° all.

The Quality Center Team

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