# Year In Review:

## 2024 Learning Forums & Related Resources

NATIONAL ASSOCIATION OF Community Health Centers®

# January: Empanelment & Attribution

## What we learned:

- ✓ The difference between empanelment and attribution
- ✓ How to empanel patients and leverage empanelment and attribution data
- ✓ Case examples from:
  - FQHC Urban Healthcare Network
  - Southside Community Health Center

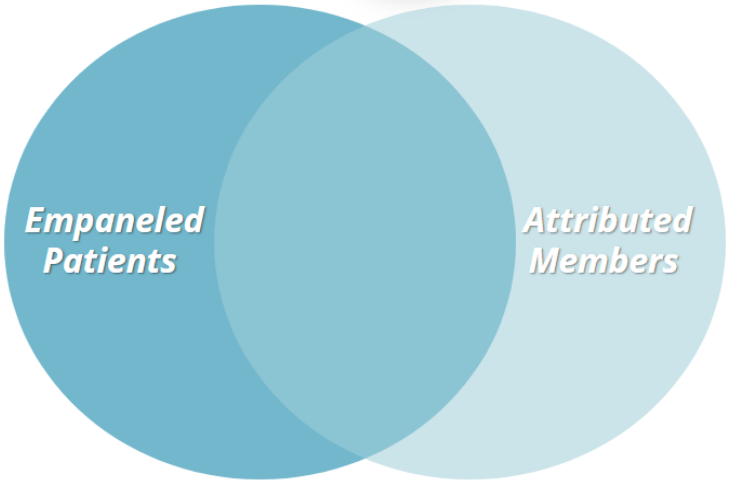
### WHAT is the difference between empanelment and attribution?

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

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

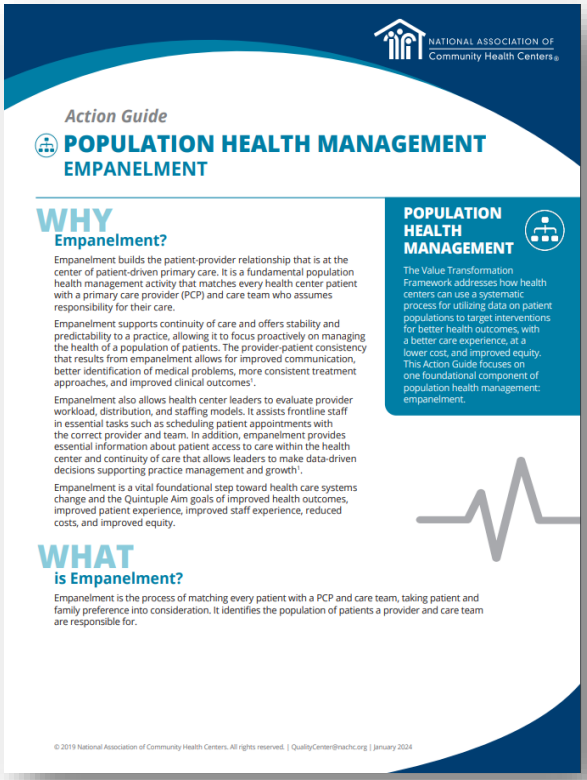
*A 'payor' refers to a Medicaid, Medicare, or commercial insurance plan.*

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




**January Learning Forum Recording**

# Resources: Empanelment & Attribution



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*Action Guide*

**POPULATION HEALTH MANAGEMENT**
**EMPANELMENT**

## WHY
### Empanelment?

Empanelment builds the patient-provider relationship that is at the center of patient-driven primary care. It is a fundamental population health management activity that matches every health center patient with a primary care provider (PCP) and care team who assumes responsibility for their care.

Empanelment supports continuity of care and offers stability and predictability to a practice, allowing it to focus proactively on managing the health of a population of patients. The provider-patient consistency that results from empanelment allows for improved communication, better identification of medical problems, more consistent treatment approaches, and improved clinical outcomes[1].

Empanelment also allows health center leaders to evaluate provider workload, distribution, and staffing models. It assists frontline staff in essential tasks such as scheduling patient appointments with the correct provider and team. In addition, empanelment provides essential information about patient access to care within the health center and continuity of care that allows leaders to make data-driven decisions supporting practice management and growth[1].

Empanelment is a vital foundational step toward health care systems change and the Quintuple Aim goals of improved health outcomes, improved patient experience, improved staff experience, reduced costs, and improved equity.

**POPULATION HEALTH MANAGEMENT**

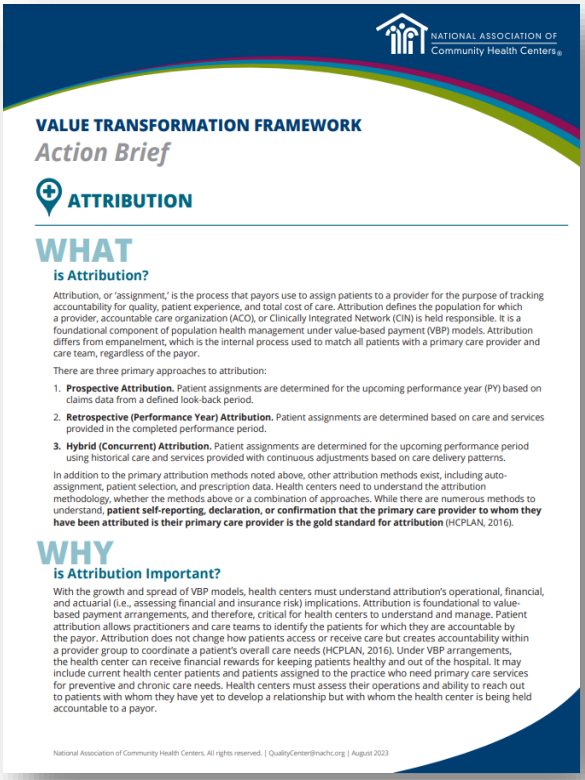
The Value Transformation Framework addresses how health centers can use a systematic process for utilizing data on patient populations to target interventions for better health outcomes, with a better care experience, at a lower cost, and improved equity. This Action Guide focuses on one foundational component of population health management: empanelment.

## WHAT
### is Empanelment?

Empanelment is the process of matching every patient with a PCP and care team, taking patient and family preference into consideration. It identifies the population of patients a provider and care team are responsible for.



[Empanelment Action Guide]



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**VALUE TRANSFORMATION FRAMEWORK**

*Action Brief*

**ATTRIBUTION**

## WHAT
### is Attribution?

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

There are three primary approaches to attribution:

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

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

## WHY
### is Attribution Important?

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



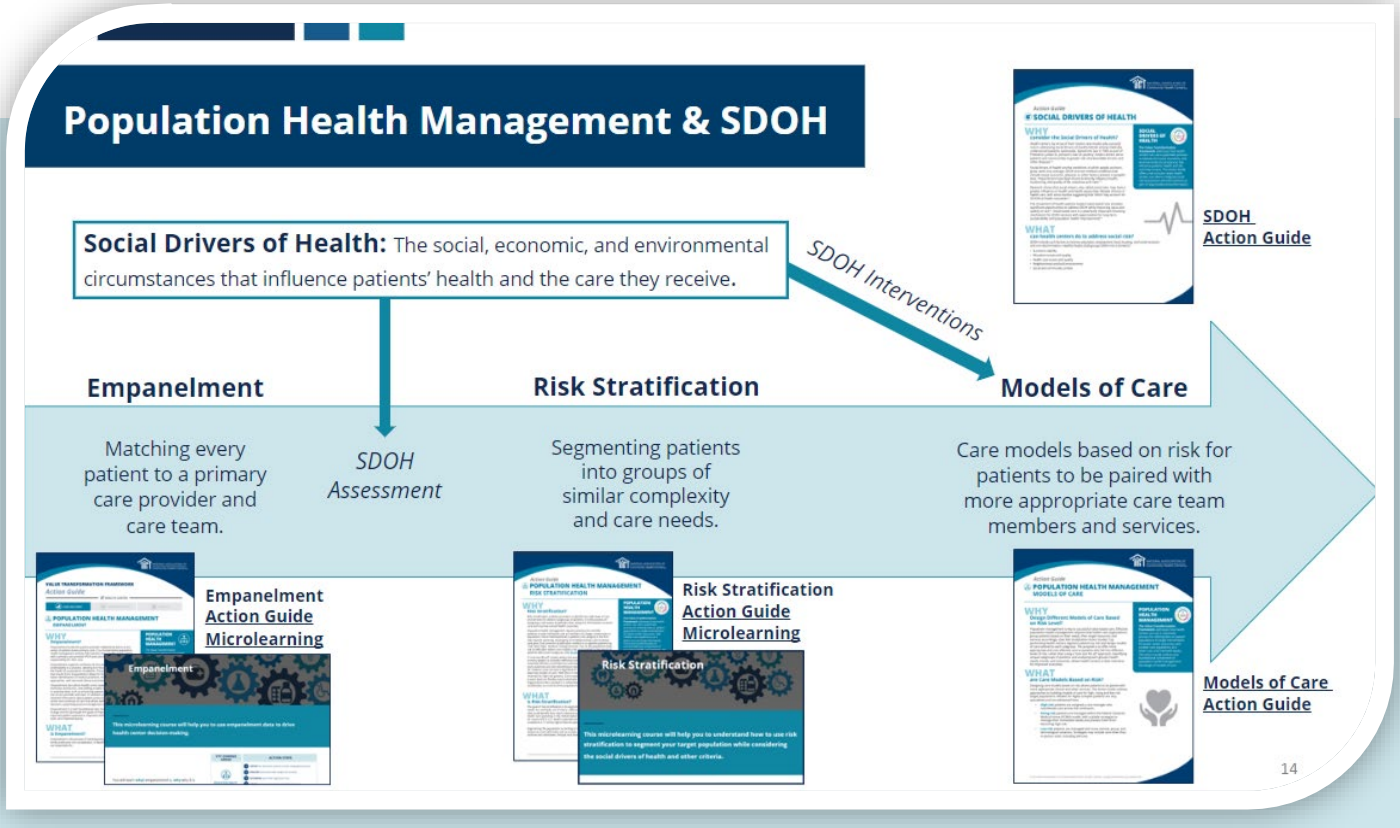
[Attribution Action Brief]


[Empanelment Learning Course]

# February: SDOH & Risk Stratification

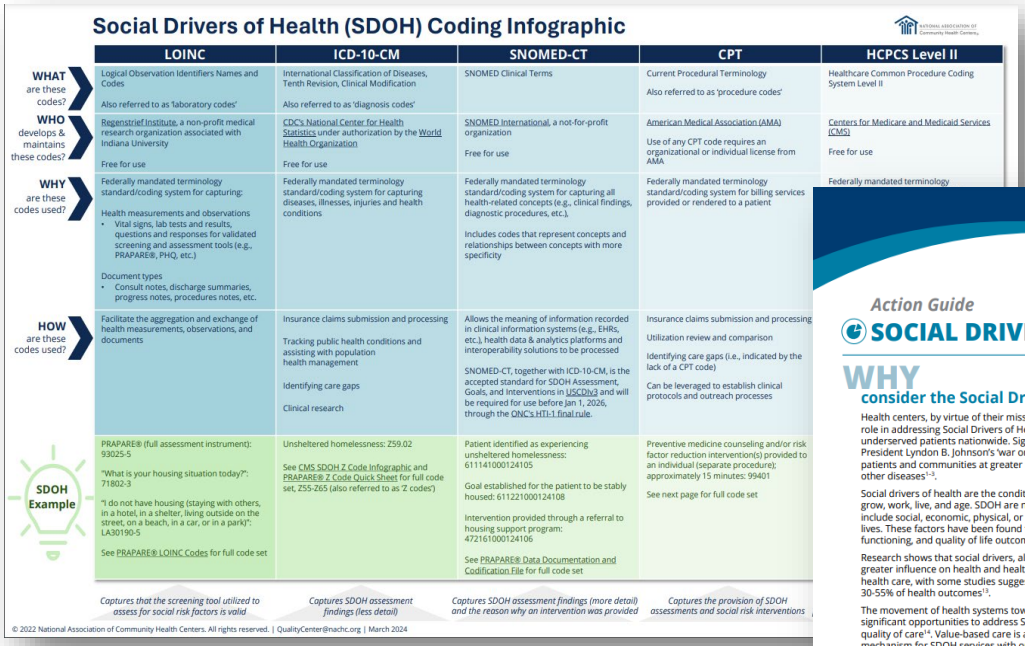
## What we learned:

- ✓ How to assess for and respond to social risk factors
- ✓ SDOH case example from HealthLinc
- ✓ How to risk stratify patients
- ✓ How to design care models based on risk




**February Learning Forum Recording**

# Resources: SDOH

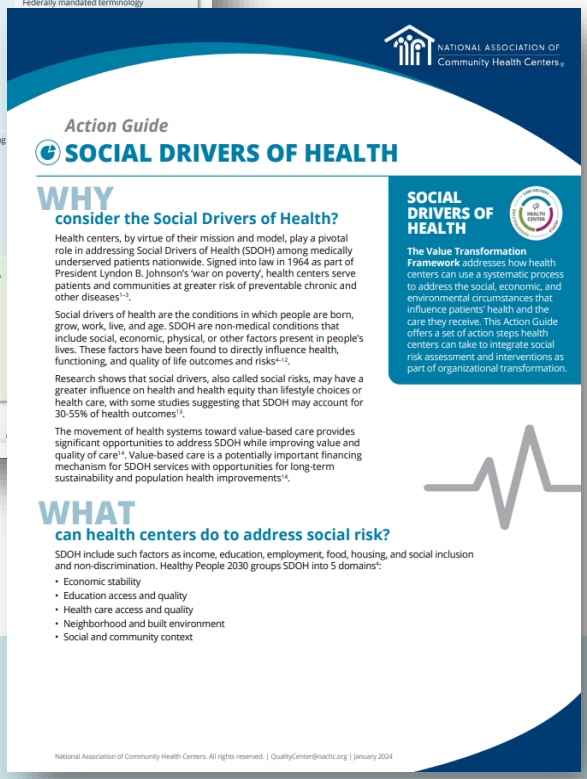


## Social Drivers of Health (SDOH) Coding Infographic

| | LOINC | ICD-10-CM | SNOMED-CT | CPT | HCPCS Level II |
|---|---|---|---|---|---|
| **WHAT** are these codes? | Logical Observation Identifiers Names and Codes<br><br>Also referred to as 'laboratory codes' | International Classification of Diseases, Tenth Revision, Clinical Modification<br><br>Also referred to as 'diagnosis codes' | SNOMED Clinical Terms | Current Procedural Terminology<br><br>Also referred to as 'procedure codes' | Healthcare Common Procedure Coding System Level II |
| **WHO** develops & maintains these codes? | Regenstrief Institute, a non-profit medical research organization associated with Indiana University<br><br>Free for use | CDC's National Center for Health Statistics under authorization by the World Health Organization<br><br>Free for use | SNOMED International, a not-for-profit organization<br><br>Free for use | American Medical Association (AMA)<br><br>Use of any CPT code requires an organizational or individual license from AMA | Centers for Medicare and Medicaid Services (CMS)<br><br>Free for use |
| **WHY** are these codes used? | Federally mandated terminology standard/coding system for capturing:<br><br>Health measurements and observations<br>• Vital signs, lab tests and results, questions and responses for validated screening and assessment tools (e.g., PRAPARE®, PHQ, etc.)<br><br>Document types<br>• Consult notes, discharge summaries, progress notes, procedures notes, etc. | Federally mandated terminology standard/coding system for capturing diseases, illnesses, injuries and health conditions | Federally mandated terminology standard/coding system for capturing all health-related concepts (e.g., clinical findings, diagnostic procedures, etc.).<br><br>Includes codes that represent concepts and relationships between concepts with more specificity | Federally mandated terminology standard/coding system for billing services provided or rendered to a patient | Federally mandated terminology |
| **HOW** are these codes used? | Facilitate the aggregation and exchange of health measurements, observations, and documents | Insurance claims submission and processing<br><br>Tracking public health conditions and assisting with population health management<br><br>Identifying care gaps<br><br>Clinical research | Allows the meaning of information recorded in clinical information systems (e.g., EHRs, etc.), health data & analytics platforms and interoperability solutions to be processed<br><br>SNOMED-CT, together with ICD-10-CM, is the accepted standard for SDOH Assessment, Goals, and Interventions in USCDIv3 and will be required for use before Jan 1, 2026, through the ONC's HTI-1 final rule. | Insurance claims submission and processing<br><br>Utilization review and comparison<br><br>Identifying care gaps (i.e., indicated by the lack of a CPT code)<br><br>Can be leveraged to establish clinical protocols and outreach processes | |
| **SDOH Example** | PRAPARE® (full assessment instrument): 93025-5<br><br>"What is your housing situation today?": 71802-3<br><br>"I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)": LA30190-5<br><br>See PRAPARE® LOINC Codes for full code set | Unsheltered homelessness: Z59.02<br><br>See CMS SDOH Z Code Infographic and PRAPARE® Z Code Quick Sheet for full code set, Z55-Z65 (also referred to as 'Z codes') | Patient identified as experiencing unsheltered homelessness: 611141000124105<br><br>Goal established for the patient to be stably housed: 611221000124108<br><br>Intervention provided through a referral to housing support program: 472161000124106<br><br>See PRAPARE® Data Documentation and Codification File for full code set | Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes: 99401<br><br>See next page for full code set | |
| | *Captures that the screening tool utilized to assess for social risk factors is valid* | *Captures SDOH assessment findings (less detail)* | *Captures SDOH assessment findings (more detail) and the reason why an intervention was provided* | *Captures the provision of SDOH assessments and social risk interventions* | |



[SDOH Coding Infographic]



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*Action Guide*

## SOCIAL DRIVERS OF HEALTH

### WHY
**consider the Social Drivers of Health?**

Health centers, by virtue of their mission and model, play a pivotal role in addressing Social Drivers of Health (SDOH) among medically underserved patients nationwide. Signed into law in 1964 as part of President Lyndon B. Johnson's 'war on poverty', health centers serve patients and communities at greater risk of preventable chronic and other diseases[1-3].

Social drivers of health are the conditions in which people are born, grow, work, live, and age. SDOH are non-medical conditions that include social, economic, physical, or other factors present in people's lives. These factors have been found to directly influence health, functioning, and quality of life outcomes and risks[4-12].

Research shows that social drivers, also called social risks, may have a greater influence on health and health equity than lifestyle choices or health care, with some studies suggesting that SDOH may account for 30-55% of health outcomes[13].

The movement of health systems toward value-based care provides significant opportunities to address SDOH while improving value and quality of care[14]. Value-based care is a potentially important financing mechanism for SDOH services with opportunities for long-term sustainability and population health improvements[14].

**SOCIAL DRIVERS OF HEALTH**

**The Value Transformation Framework** addresses how health centers can use a systematic process to address the social, economic, and environmental circumstances that influence patients' health and the care they receive. This Action Guide offers a set of action steps health centers can take to integrate social risk assessment and interventions as part of organizational transformation.

### WHAT
**can health centers do to address social risk?**

SDOH include such factors as income, education, employment, food, housing, and social inclusion and non-discrimination. Healthy People 2030 groups SDOH into 5 domains[4]:

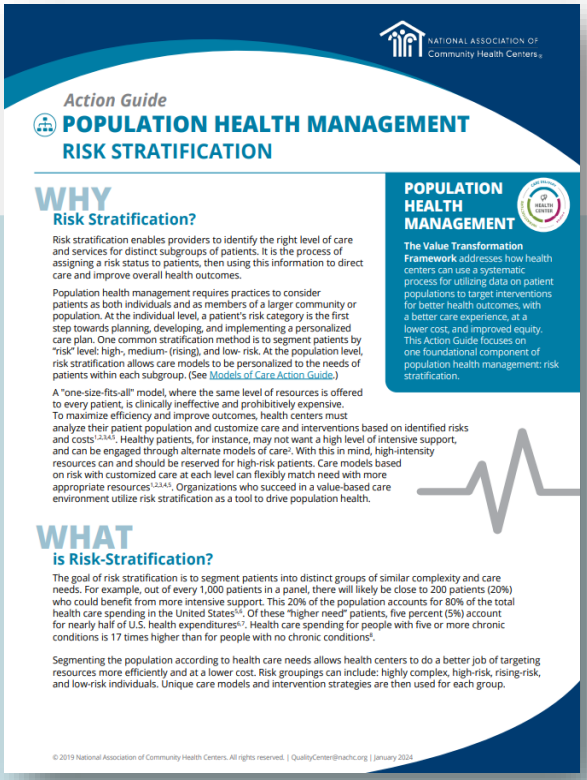
- Economic stability
- Education access and quality
- Health care access and quality
- Neighborhood and built environment
- Social and community context



[SDOH Action Guide]


[SDOH Microlearning]

# Resources: Risk Stratification



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**POPULATION HEALTH MANAGEMENT**
**RISK STRATIFICATION**

## WHY
### Risk Stratification?

Risk stratification enables providers to identify the right level of care and services for distinct subgroups of patients. It is the process of assigning a risk status to patients, then using this information to direct care and improve overall health outcomes.

Population health management requires practices to consider patients as both individuals and as members of a larger community or population. At the individual level, a patient's risk category is the first step towards planning, developing, and implementing a personalized care plan. One common stratification method is to segment patients by "risk" level: high-, medium- (rising), and low- risk. At the population level, risk stratification allows care models to be personalized to the needs of patients within each subgroup. (See Models of Care Action Guide.)

A "one-size-fits-all" model, where the same level of resources is offered to every patient, is clinically ineffective and prohibitively expensive. To maximize efficiency and improve outcomes, health centers must analyze their patient population and customize care and interventions based on identified risks and costs[1,2,3,4,5]. Healthy patients, for instance, may not want a high level of intensive support, and can be engaged through alternate models of care[2]. With this in mind, high-intensity resources can and should be reserved for high-risk patients. Care models based on risk with customized care at each level can flexibly match need with more appropriate resources[1,2,3,4,5]. Organizations who succeed in a value-based care environment utilize risk stratification as a tool to drive population health.

**POPULATION HEALTH MANAGEMENT**

**The Value Transformation Framework** addresses how health centers can use a systematic process for utilizing data on patient populations to target interventions for better health outcomes, with a better care experience, at a lower cost, and improved equity. This Action Guide focuses on one foundational component of population health management: risk stratification.

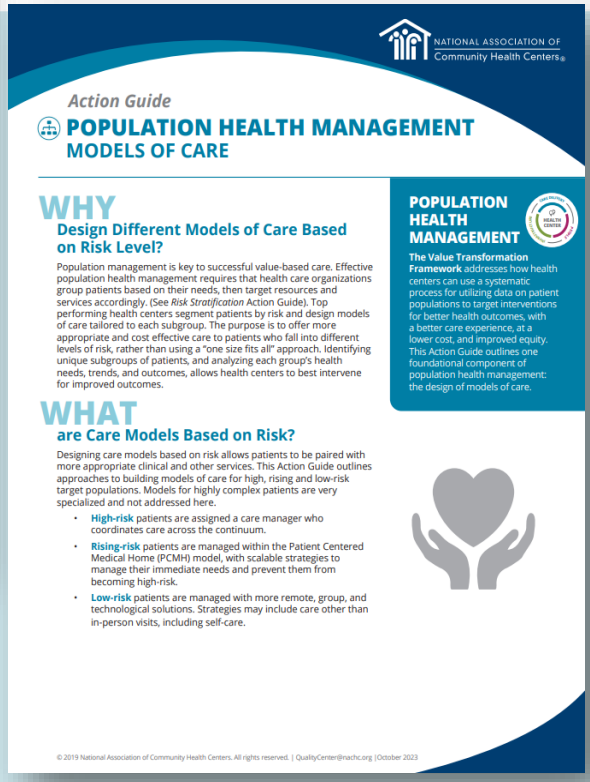
## WHAT
### is Risk-Stratification?

The goal of risk stratification is to segment patients into distinct groups of similar complexity and care needs. For example, out of every 1,000 patients in a panel, there will likely be close to 200 patients (20%) who could benefit from more intensive support. This 20% of the population accounts for 80% of the total health care spending in the United States[5,6]. Of these "higher need" patients, five percent (5%) account for nearly half of U.S. health expenditures[5,7]. Health care spending for people with five or more chronic conditions is 17 times higher than for people with no chronic conditions[8].

Segmenting the population according to health care needs allows health centers to do a better job of targeting resources more efficiently and at a lower cost. Risk groupings can include: highly complex, high-risk, rising-risk, and low-risk individuals. Unique care models and intervention strategies are then used for each group.



[Risk Stratification Action Guide]



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**POPULATION HEALTH MANAGEMENT**
**MODELS OF CARE**

## WHY
### Design Different Models of Care Based on Risk Level?

Population management is key to successful value-based care. Effective population health management requires that health care organizations group patients based on their needs, then target resources and services accordingly. (See *Risk Stratification* Action Guide). Top performing health centers segment patients by risk and design models of care tailored to each subgroup. The purpose is to offer more appropriate and cost effective care to patients who fall into different levels of risk, rather than using a "one size fits all" approach. Identifying unique subgroups of patients, and analyzing each group's health needs, trends, and outcomes, allows health centers to best intervene for improved outcomes.

**POPULATION HEALTH MANAGEMENT**

**The Value Transformation Framework** addresses how health centers can use a systematic process for utilizing data on patient populations to target interventions for better health outcomes, with a better care experience, at a lower cost, and improved equity. This Action Guide outlines one foundational component of population health management: the design of models of care.

## WHAT
### are Care Models Based on Risk?

Designing care models based on risk allows patients to be paired with more appropriate clinical and other services. This Action Guide outlines approaches to building models of care for high, rising and low-risk target populations. Models for highly complex patients are very specialized and not addressed here.

- **High-risk** patients are assigned a care manager who coordinates care across the continuum.
- **Rising-risk** patients are managed within the Patient Centered Medical Home (PCMH) model, with scalable strategies to manage their immediate needs and prevent them from becoming high-risk.
- **Low-risk** patients are managed with more remote, group, and technological solutions. Strategies may include care other than in-person visits, including self-care.



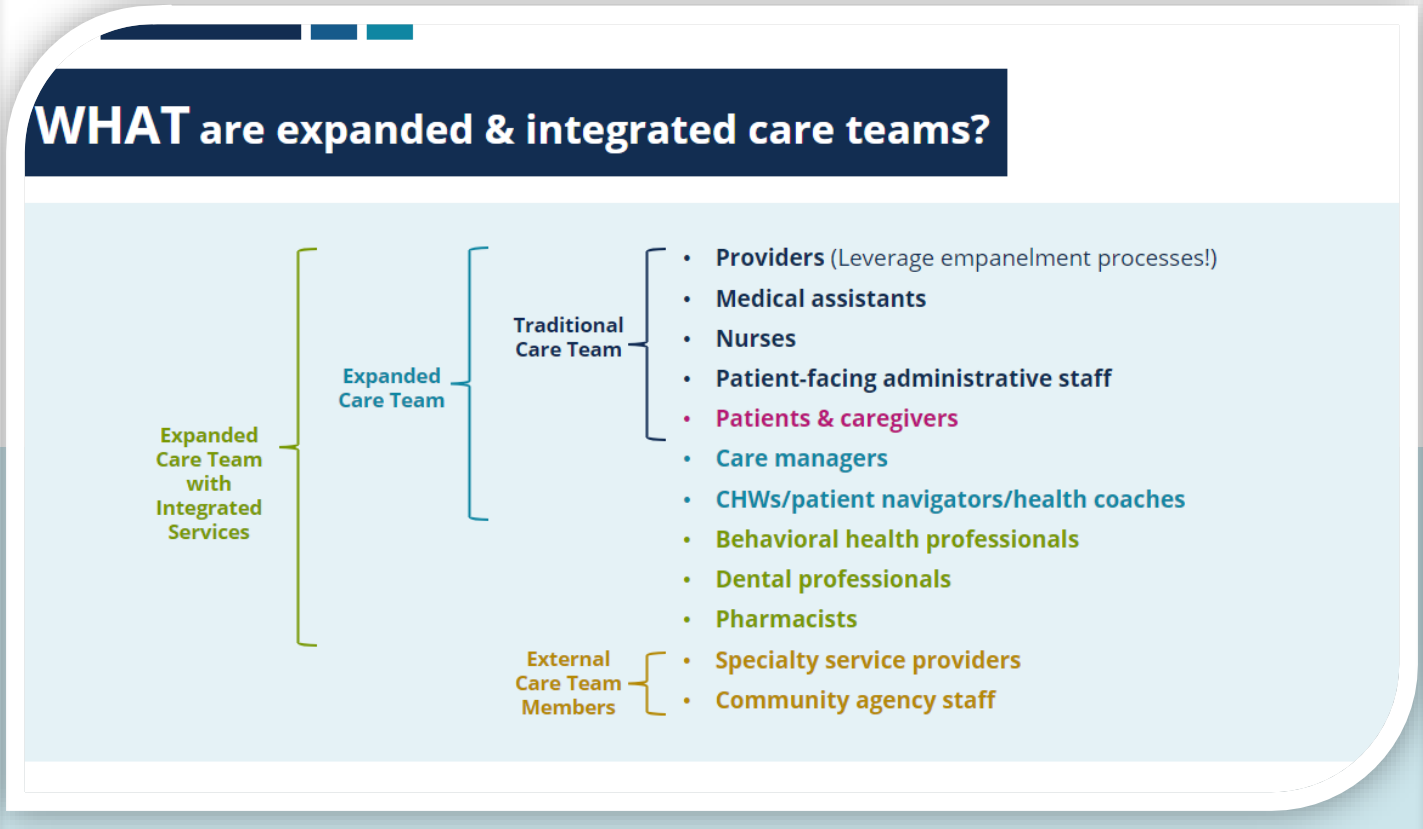
[Models of Care Action Guide]


[Risk Stratification Microlearning]

# March: Care Teams & Workforce

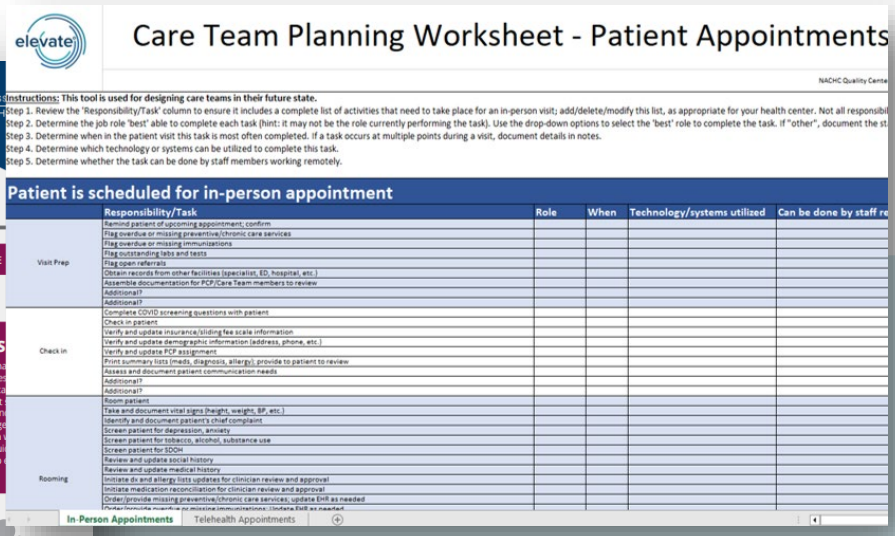
## What we learned:

- ✓ What are expanded and integrated care teams
- ✓ How to optimize care teams
- ✓ How to leverage standing orders, presented by Georgia PCA
- ✓ How to address workforce wellness, presented by ACU




[March Learning Forum Recording]

# Resources: Care Teams


Care Team Planning Worksheet - Patient Appointments

Instructions: This tool is used for designing care teams in their future state.
Step 1. Review the 'Responsibility/Task' column to ensure it includes a complete list of activities that need to take place for an in-person visit; add/delete/modify this list, as appropriate for your health center. Not all responsibil
Step 2. Determine the job role 'best' able to complete each task (hint: it may not be the role currently performing the task). Use the drop-down options to select the 'best' role to complete the task. If "other", document the st
Step 3. Determine when in the patient visit this task is most often completed. If a task occurs at multiple points during a visit, document details in notes.
Step 4. Determine which technology or systems can be utilized to complete this task.
Step 5. Determine whether the task can be done by staff members working remotely.

Patient is scheduled for in-person appointment

| | Responsibility/Task | Role | When | Technology/systems utilized | Can be done by staff re |
|---|---|---|---|---|---|
| Visit Prep | Remind patient of upcoming appointment; confirm | | | | |
| | Flag overdue or missing preventive/chronic care services | | | | |
| | Flag overdue or missing immunizations | | | | |
| | Flag outstanding labs and tests | | | | |
| | Flag open referrals | | | | |
| | Obtain records from other facilities (specialist, ED, hospital, etc.) | | | | |
| | Assemble documentation for PCP/Care Team members to review | | | | |
| | Additional? | | | | |
| | Additional? | | | | |
| Check in | Complete COVID screening questions with patient | | | | |
| | Check in patient | | | | |
| | Verify and update insurance/sliding fee scale information | | | | |
| | Verify and update demographic information (address, phone, etc.) | | | | |
| | Verify and update PCP assignment | | | | |
| | Print summary lists (meds, diagnosis, allergy); provide to patient to review | | | | |
| | Assess and document patient communication needs | | | | |
| | Additional? | | | | |
| | Additional? | | | | |
| Rooming | Room patient | | | | |
| | Take and document vital signs (height, weight, BP, etc.) | | | | |
| | Identify and document patient's chief complaint | | | | |
| | Screen patient for depression, anxiety | | | | |
| | Screen patient for tobacco, alcohol, substance use | | | | |
| | Screen patient for SDOH | | | | |
| | Review and update social history | | | | |
| | Review and update medical history | | | | |
| | Initiate dx and allergy lists updates for clinician review and approval | | | | |
| | Initiate medication reconciliation for clinician review and approval | | | | |
| | Order/provide missing preventive/chronic care services; update EHR as needed | | | | |
| | Order/provide overdue or missing immunizations; Update EHR as needed | | | | |

In-Person Appointments | Telehealth Appointments

## Care Team Planning Worksheet


NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK
*Action Guide*

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

CARE TEAMS

WHY
Focus on Care Teams?

Much has been written about the success of the "care team model" in delivering high-quality, low-cost, impactful health care. Developing an effective team-based model of care is at the heart of health center efforts to deliver on the Quintuple Aim: improved health outcomes, improved staff and provider experiences, lower costs, and improved equity.

Transitioning to value-based care requires a significant shift in the way care delivery, infrastructure, and people are engaged and deployed in the health care system. In the volume-based system, a primary care physician would need to spend an estimated 21.7 hours per day to provide all recommended acute, chronic, and preventive care to a panel of 2500 patients[1]. It is, therefore, not surprising that physicians face burnout and adults in the U.S. receive only 55% of recommended services[2]. The volume-driven model of care coupled with the complexity of preventive, acute, and chronic care needs in the context of a primary care visit, limits the quality of service delivered[3]. A reinvention of the care team model—with more responsibility given to supportive members of the care team—has proven to optimize the experience and outcomes of primary care for patients, providers, and staff[4]. In addition to improving service for chronic disease and preventive care, re-organizing care team roles can help address the widely-documented problem of primary care physician shortages[5,6,7].

CARE TEAMS
The Value Transforma
Framework addresses
how health centers ca
of staff with different
together to deliver an
offering a wider range
more efficiently than
alone. This Action Gui
strategies to develop
center care teams.

Ultimately, patient care is a team sport. All members of the health center team are accountable for the delivery of high quality care to patients. Patient engagement, also crucial to care, is addressed in the Patient Engagement Action Guide.

While many health centers report using a team-based approach to care, these systems may not be functioning optimally to achieve desired outcomes. This Action Guide offers steps to more effectively distribute, or share, responsibility and accountability across health center care teams.

*"Sharing the care involves both a paradigm shift and a concrete strategy for increasing capacity. The paradigm (culture) shift transforms the practice from an "I" to a "we" mindset. Unlike the lone-doctor-with-helpers model, in which the physician assumes all responsibility, makes all decisions, and delegates tasks to team members [but cannot increase capacity], the "we" paradigm uses a team comprising clinicians and non-clinicians to provide care to a patient panel, with a reallocation of responsibilities, not only tasks, so that all team members contribute meaningfully to the health of their patient panel."*[8]

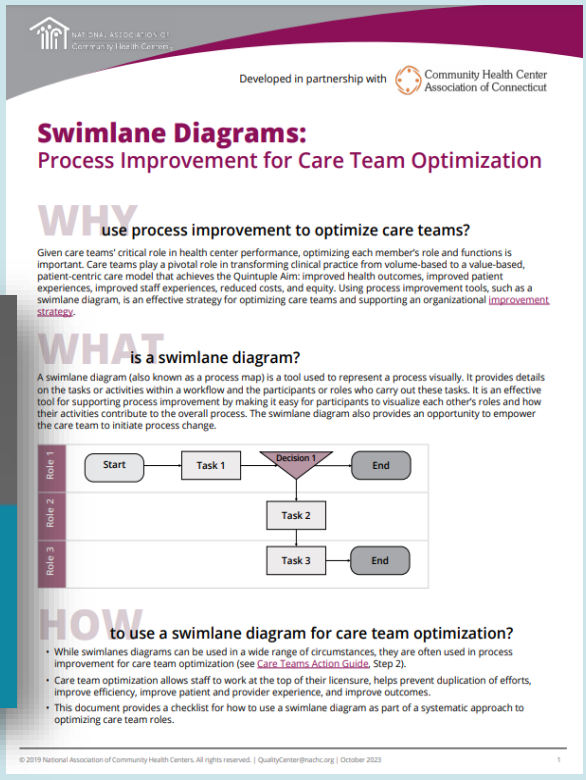


## Care Teams Action Guide


Expanded Care Teams

This microlearning course will help you to gain an understanding about the meaning of expanded care teams, why expanded care teams are important, and how to build expanded care team processes..

## Care Teams Microlearning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Developed in partnership with Community Health Center Association of Connecticut

**Swimlane Diagrams:**
Process Improvement for Care Team Optimization

WHY
use process improvement to optimize care teams?

Given care teams' critical role in health center performance, optimizing each member's role and functions is important. Care teams play a pivotal role in transforming clinical practice from volume-based to a value-based, patient-centric care model that achieves the Quintuple Aim: improved health outcomes, improved patient experiences, improved staff experiences, reduced costs, and equity. Using process improvement tools, such as a swimlane diagram, is an effective strategy for optimizing care teams and supporting an organizational improvement strategy.

WHAT
is a swimlane diagram?

A swimlane diagram (also known as a process map) is a tool used to represent a process visually. It provides details on the tasks or activities within a workflow and the participants or roles who carry out these tasks. It is an effective tool for supporting process improvement by making it easy for participants to visualize each other's roles and how their activities contribute to the overall process. The swimlane diagram also provides an opportunity to empower the care team to initiate process change.




HOW
to use a swimlane diagram for care team optimization?

- While swimlanes diagrams can be used in a wide range of circumstances, they are often used in process improvement for care team optimization (see Care Teams Action Guide, Step 2).
- Care team optimization allows staff to work at the top of their licensure, helps prevent duplication of efforts, improve efficiency, improve patient and provider experience, and improve outcomes.
- This document provides a checklist for how to use a swimlane diagram as part of a systematic approach to optimizing care team roles.



## Care Team Optimization with Swimlanes

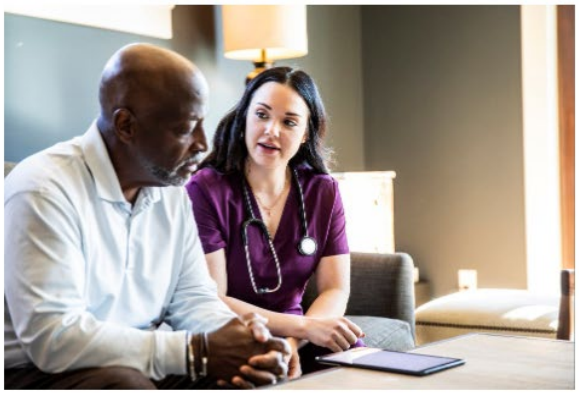
# April: Care Management & Payment

## What we learned:

- ✓ Key components of a chronic care management program
- ✓ How to implement a care management program
- ✓ Case example from OneWorld Community Health Centers, Inc.
- ✓ Medicare reimbursement opportunities for care management

**WHAT services does a care management program provide?**

**Key components of Chronic Care Management include:**



- Identifying and engaging high-risk individuals
- Conducting a comprehensive assessment
- Creating an individual care plan
- Providing patient education
- Monitoring clinical conditions
- Coordinating needed services

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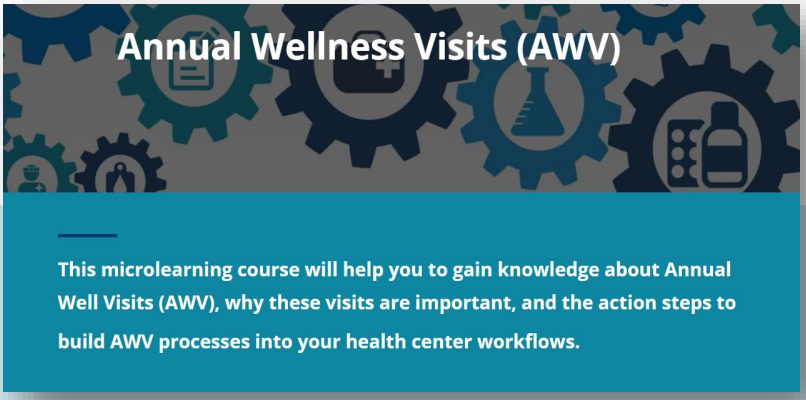
[April Learning Forum Recording]

# Resources: Care Management




## AWV Microlearning


## Care Management Action Guide


## Care Management Microlearning

# Resources: Care Management

## Summary of Medicare G0511 Care Management Services:

- ✓ Chronic Care Management
- ✓ Complex Chronic Care Management
- ✓ Principal Care Management
- ✓ Chronic Pain Management
- ✓ Behavioral Health Integration
- ✓ Community Health Integration
- ✓ Principal Illness Navigation
- ✓ Remote Physiologic Monitoring
- ✓ Remote Therapeutic Monitoring

### Summary Includes:

- ✓ Description
- ✓ Initiating visit requirements
- ✓ Eligible patients
- ✓ Authorized billing providers
- ✓ Examples of auxiliary personnel
- ✓ Service elements
- ✓ CPT & HCPCS codes
- ✓ Examples of co-occurring services

## Summary of Medicare Care Management Services

*Billed Using G0511**

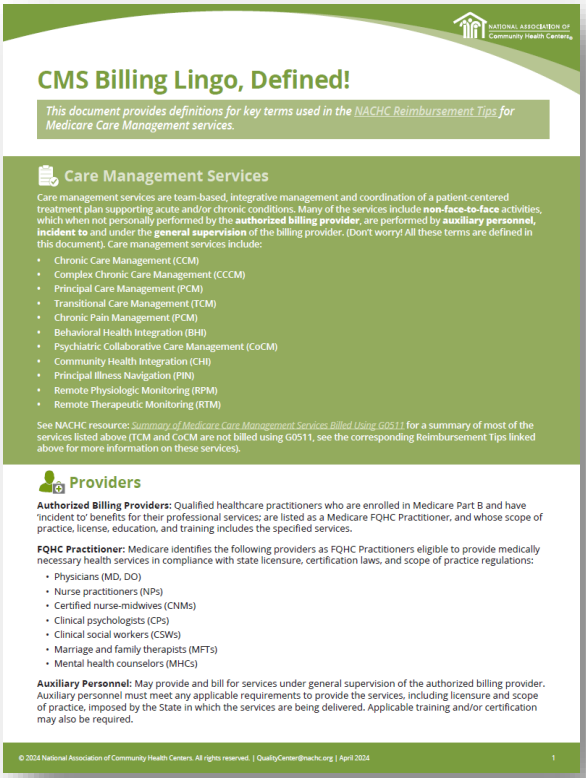
See NACHC resource: ***CMS Billing Lingo, Defined!*** for definitions of terms used throughout this document.

| | Chronic Care Management (CCM) | Complex Chronic Care Management (CCCM) | Principal Care Management (PCM) | Chronic Pain Management (CPM) | Behavioral Health Integration (BHI) | Community Health Integration (CHI) | Principal Illness Navigation (PIN) | Remote Physiologic Monitoring (RPM) | Remote Therapeutic Monitoring (RTM) |
|---|---|---|---|---|---|---|---|---|---|
| **Description** | Personalized and supportive services provided to patients with multiple chronic conditions to coordinate care and develop a care plan to achieve health goals. | Personalized and supportive services provided to patients with multiple chronic conditions, who require moderate or high medical decision making, to coordinate care and develop a care plan to achieve health goals. | Personalized and supportive services provided to patients with a single complex chronic condition to coordinate care and develop a care plan to achieve health goals. | Personalized and supportive services provided to patients with chronic pain to coordinate care and develop a care plan to achieve health goals. | Personalized and supportive services provided to patients with behavioral health needs to coordinate care and develop a care plan to achieve health goals. | Personalized and supportive services provided to patients with unmet social drivers of health (SDOH) needs that interfere with, or present a barrier to, the diagnosis, treatment, and self-management of illnesses, diseases, or conditions. | Personalized and supportive services provided to patients with a high-risk condition and healthcare navigation needs. | A patient's use of devices to remotely assess and record physiologic data (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate) outside of the clinical setting, usually in the home. | A patient's use of devices to remotely monitor adherence and response to therapeutic treatment (e.g., respiratory, musculoskeletal) using non-physiologic data outside of the clinical setting, usually in the home. |
| **Initiating Visit Requirements** *Not part of care management services; billed separately.* | Any one of the following:<br>• E/M visit (CPT 99212-99215)<br>• Initial Preventive Physical Exam (IPPE) (CPT G0402)<br>• Annual Wellness Visit (AWV) (CPT G0438, G0439)<br>• Transitional Care Management (TCM) (CPT 99495-99496) | | | A face-to-face visit of at least 30 minutes in the clinical setting. | Any one of the following:<br>• E/M visit (CPT 99212-99215)<br>• Initial Preventive Physical Exam (IPPE) (CPT G0402)<br>• Annual Wellness Visit (AWV) (CPT G0438, G0439)<br>• Transitional Care Management (TCM) (CPT 99495-99496)<br>• Psychiatric diagnostic evaluation (CPT 90791) performed by Clinical Psychologist | Any one of the following:<br>• E/M visit (CPT 99212-99215)<br>• Annual Wellness Visit (AWV) (CPT G0438, G0439)<br>• Transitional Care Management (TCM) (CPT 99495-99496)<br>*Note: IPPE is NOT an accepted initiating visit for CHI services* | Any one of the following:<br>• E/M visit (CPT 99212-99215)<br>• Annual Wellness Visit (AWV) (CPT G0438, G0439)<br>• Transitional Care Management (TCM) (CPT 99495-99496)<br>• Psychiatric diagnostic evaluation (CPT 90791) performed by Clinical Psychologist<br>*Note: IPPE is NOT an accepted initiating visit for PIN services*<br>*Note: Initiating visit must be repeated annually for PIN services to continue.* | No initiating visit required | |



**Summary of Medicare Care Management Services Billed Using G0511**

# Resources: Payment



## CMS Billing Lingo, Defined!

*This document provides definitions for key terms used in the NACHC Reimbursement Tips for Medicare Care Management services.*

### Care Management Services

Care management services are team-based, integrative management and coordination of a patient-centered treatment plan supporting acute and/or chronic conditions. Many of the services include **non-face-to-face** activities, which when not personally performed by the **authorized billing provider**, are performed by **auxiliary personnel, incident to** and under the **general supervision** of the billing provider. (Don't worry! All these terms are defined in this document). Care management services include:

- Chronic Care Management (CCM)
- Complex Chronic Care Management (CCCM)
- Principal Care Management (PCM)
- Transitional Care Management (TCM)
- Chronic Pain Management (PCM)
- Behavioral Health Integration (BHI)
- Psychiatric Collaborative Care Management (CoCM)
- Community Health Integration (CHI)
- Principal Illness Navigation (PIN)
- Remote Physiologic Monitoring (RPM)
- Remote Therapeutic Monitoring (RTM)

See NACHC resource: *Summary of Medicare Care Management Services Billed Using G0511* for a summary of most of the services listed above (TCM and CoCM are not billed using G0511, see the corresponding Reimbursement Tips linked above for more information on these services).

### Providers

**Authorized Billing Providers:** Qualified healthcare practitioners who are enrolled in Medicare Part B and have 'incident to' benefits for their professional services; are listed as a Medicare FQHC Practitioner, and whose scope of practice, license, education, and training includes the specified services.

**FQHC Practitioner:** Medicare identifies the following providers as FQHC Practitioners eligible to provide medically necessary health services in compliance with state licensure, certification laws, and scope of practice regulations:

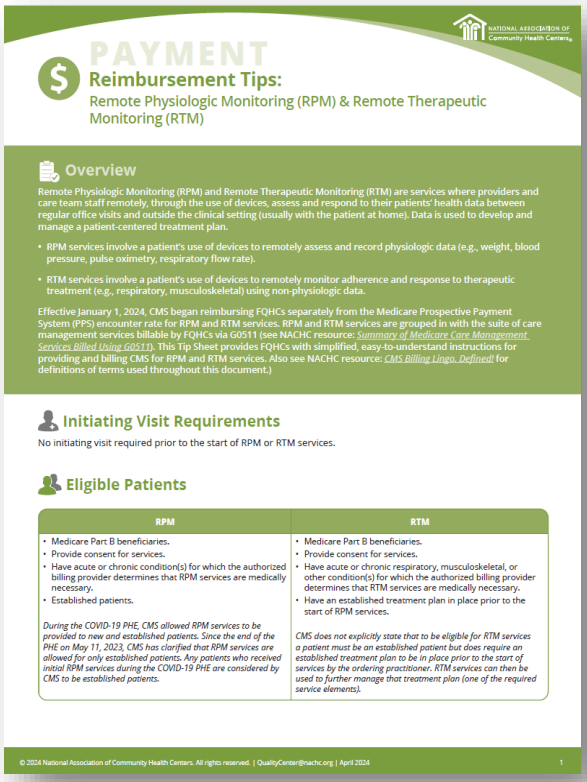
- Physicians (MD, DO)
- Nurse practitioners (NPs)
- Certified nurse-midwives (CNMs)
- Clinical psychologists (CPs)
- Clinical social workers (CSWs)
- Marriage and family therapists (MFTs)
- Mental health counselors (MHCs)

**Auxiliary Personnel:** May provide and bill for services under general supervision of the authorized billing provider. Auxiliary personnel must meet any applicable requirements to provide the services, including licensure and scope of practice, imposed by the State in which the services are being delivered. Applicable training and/or certification may also be required.





**CMS Billing Lingo, Defined!**



PAYMENT

## Reimbursement Tips:

Remote Physiologic Monitoring (RPM) & Remote Therapeutic Monitoring (RTM)

### Overview

Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) are services where providers and care team staff remotely, through the use of devices, assess and respond to their patients' health data between regular office visits and outside the clinical setting (usually with the patient at home). Data is used to develop and manage a patient-centered treatment plan.

- RPM services involve a patient's use of devices to remotely assess and record physiologic data (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate).
- RTM services involve a patient's use of devices to remotely monitor adherence and response to therapeutic treatment (e.g., respiratory, musculoskeletal) using non-physiologic data.

Effective January 1, 2024, CMS began reimbursing FQHCs separately from the Medicare Prospective Payment System (PPS) encounter rate for RPM and RTM services. RPM and RTM services are grouped in with the suite of care management services billable by FQHCs via G0511 (see NACHC resource: *Summary of Medicare Care Management Services Billed Using G0511*). This Tip Sheet provides FQHCs with simplified, easy-to-understand instructions for providing and billing CMS for RPM and RTM services. Also see NACHC resource: *CMS Billing Lingo, Defined!* for definitions of terms used throughout this document.)

### Initiating Visit Requirements

No initiating visit required prior to the start of RPM or RTM services.

### Eligible Patients

| RPM | RTM |
|---|---|
| • Medicare Part B beneficiaries.<br>• Provide consent for services.<br>• Have acute or chronic condition(s) for which the authorized billing provider determines that RPM services are medically necessary.<br>• Established patients.<br><br>*During the COVID-19 PHE, CMS allowed RPM services to be provided to new and established patients. Since the end of the PHE on May 11, 2023, CMS has clarified that RPM services are allowed for only established patients. Any patients who received initial RPM services during the COVID-19 PHE are considered by CMS to be established patients.* | • Medicare Part B beneficiaries.<br>• Provide consent for services.<br>• Have acute or chronic respiratory, musculoskeletal, or other condition(s) for which the authorized billing provider determines that RTM services are medically necessary.<br>• Have an established treatment plan in place prior to the start of RPM services.<br><br>*CMS does not explicitly state that to be eligible for RTM services a patient must be an established patient but does require an established treatment plan to be in place prior to the start of services by the ordering practitioner. RTM services can then be used to further manage that treatment plan (one of the required service elements).* |





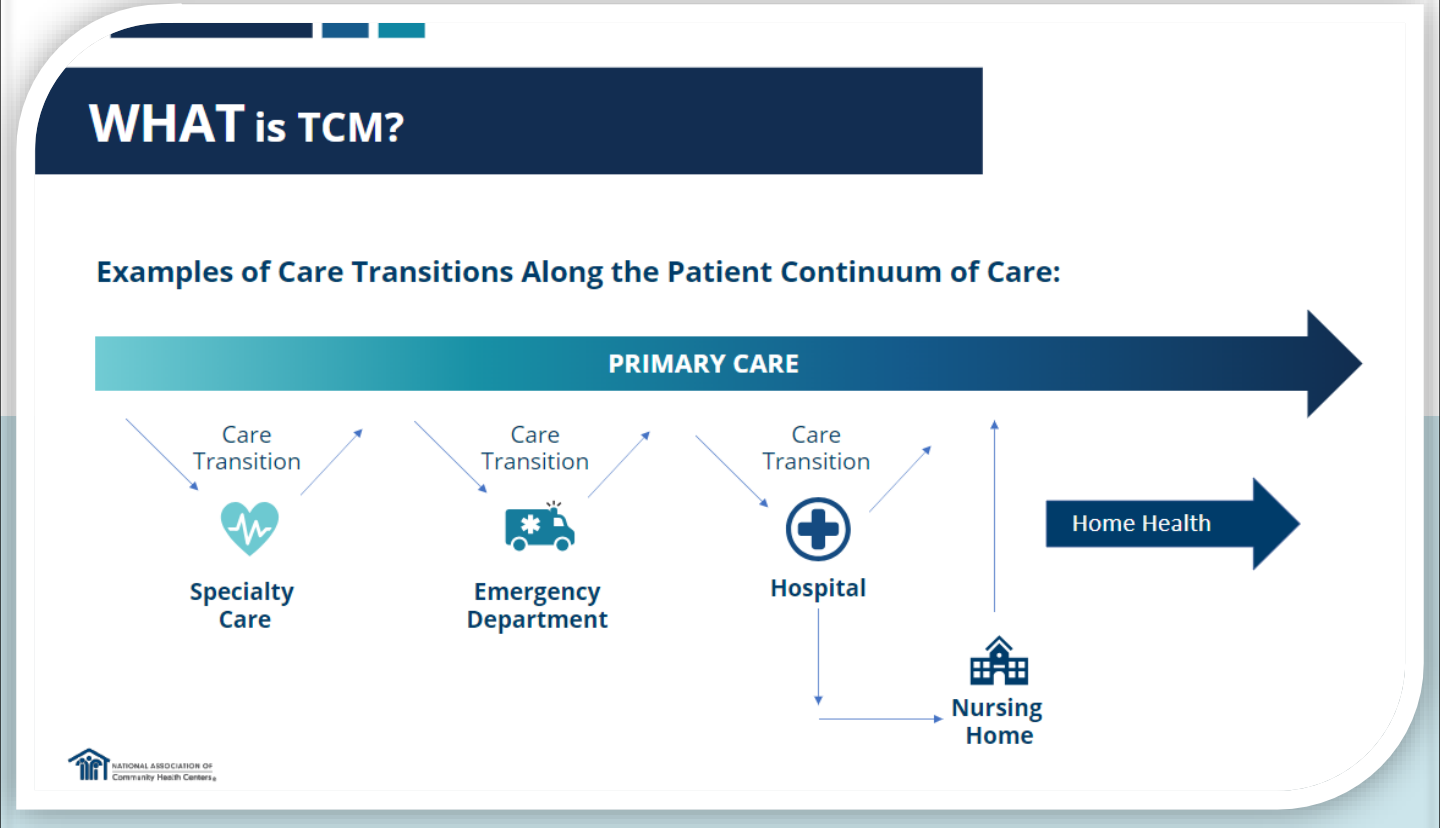
## Reimbursement Tip Sheets:

- ✓ Remote Physiologic Monitoring & Remote Therapeutic Monitoring **(New)**
- ✓ Community Health Integration **(New)**
- ✓ Principal Illness Navigation **(New)**
- ✓ Chronic Care Management, Complex Chronic Care Management & Principal Care Management
- ✓ Transitional Care Management
- ✓ Initial Preventive Physical Exam & Annual Wellness Visits
- ✓ Behavioral Health Integration
- ✓ Chronic Pain Management
- ✓ Psychiatric Collaborative Care Management

# May: Health Information Technology & Cost

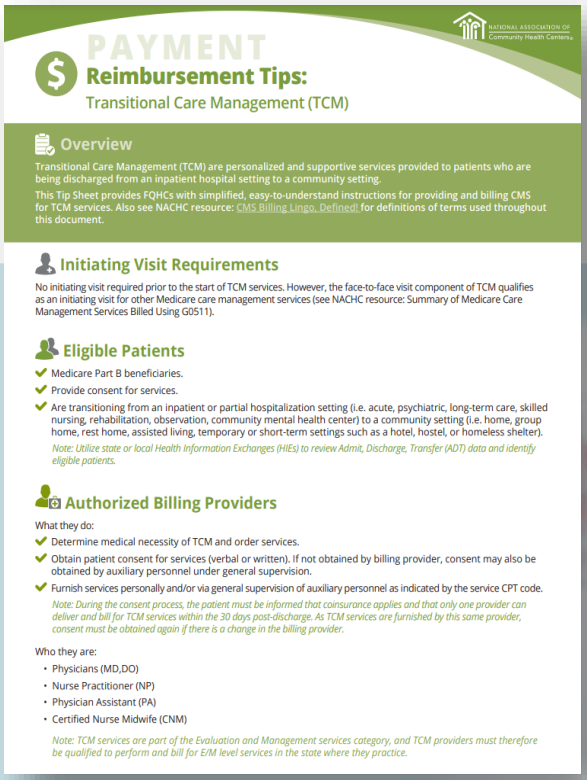
## What we learned:

- ✓ How to leverage HIT to manage total cost of care
- ✓ How to support clinical care with Health Information Exchange (HIE) data, presented by HealthEfficient
- ✓ How to implement a transitional care management program
- ✓ Why HCC coding is important to managing total cost of care, with a case example from StayWell Health Center




[May Learning Forum Recording]

# Resources: Health Information Technology & Cost



PAYMENT

## Reimbursement Tips:

Transitional Care Management (TCM)

### Overview

Transitional Care Management (TCM) are personalized and supportive services provided to patients who are being discharged from an inpatient hospital setting to a community setting.

This Tip Sheet provides FQHCs with simplified, easy-to-understand instructions for providing and billing CMS for TCM services. Also see NACHC resource: CMS Billing Lingo, Defined! for definitions of terms used throughout this document.

### Initiating Visit Requirements

No initiating visit required prior to the start of TCM services. However, the face-to-face visit component of TCM qualifies as an initiating visit for other Medicare care management services (see NACHC resource: Summary of Medicare Care Management Services Billed Using G0511).

### Eligible Patients

- Medicare Part B beneficiaries.
- Provide consent for services.
- Are transitioning from an inpatient or partial hospitalization setting (i.e. acute, psychiatric, long-term care, skilled nursing, rehabilitation, observation, community mental health center) to a community setting (i.e. home, group home, rest home, assisted living, temporary or short-term settings such as a hotel, hostel, or homeless shelter).

*Note: Utilize state or local Health Information Exchanges (HIEs) to review Admit, Discharge, Transfer (ADT) data and identify eligible patients.*

### Authorized Billing Providers

What they do:

- Determine medical necessity of TCM and order services.
- Obtain patient consent for services (verbal or written). If not obtained by billing provider, consent may also be obtained by auxiliary personnel under general supervision.
- Furnish services personally and/or via general supervision of auxiliary personnel as indicated by the service CPT code.

*Note: During the consent process, the patient must be informed that coinsurance applies and that only one provider can deliver and bill for TCM services within the 30 days post-discharge. As TCM services are furnished by this same provider, consent must be obtained again if there is a change in the billing provider.*

Who they are:

- Physicians (MD,DO)
- Nurse Practitioner (NP)
- Physician Assistant (PA)
- Certified Nurse Midwife (CNM)

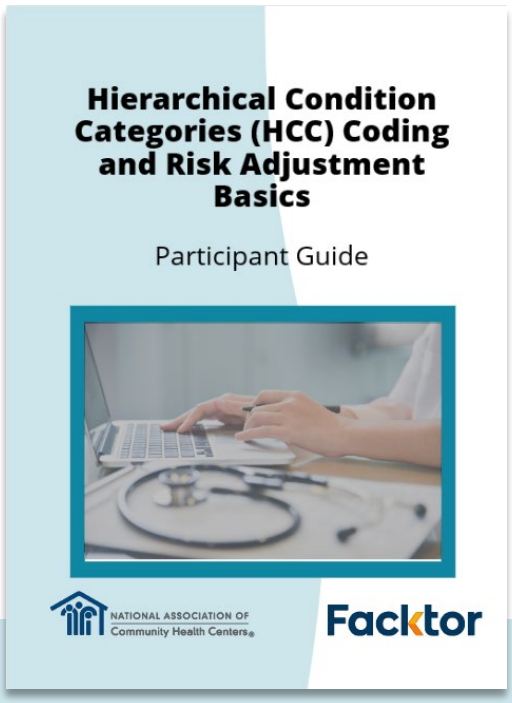
*Note: TCM services are part of the Evaluation and Management services category, and TCM providers must therefore be qualified to perform and bill for E/M level services in the state where they practice.*

**TCM Reimbursement Tip Sheet**


**TCM Microlearning**

# Resources: Hierarchical Condition Category Coding

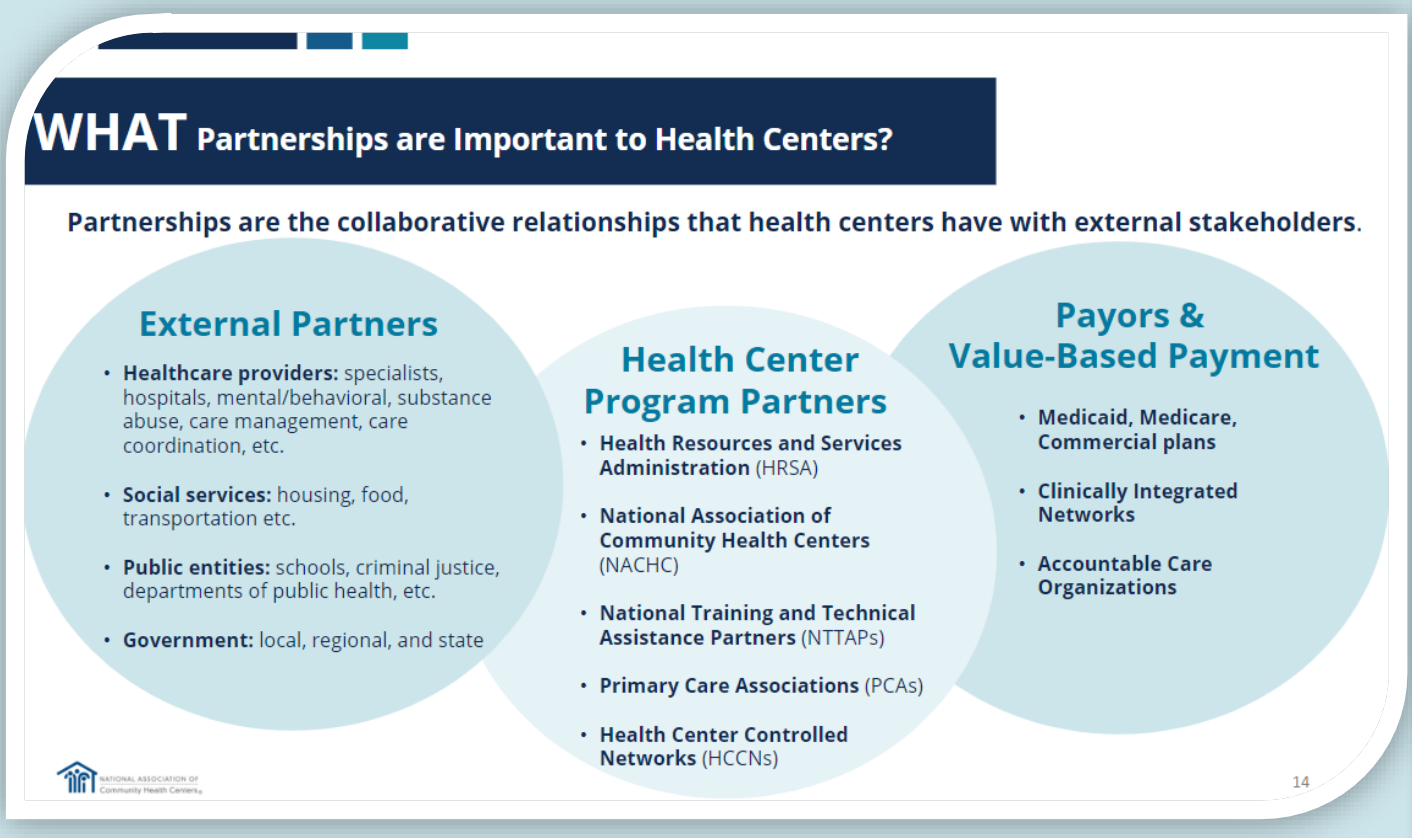

## HCC Coding eLearning Course



# June: Partnerships

## What we learned:

- ✓ What partnerships are important to health centers
- ✓ Examples of successful partnerships from:
  - Heartland Health Services
  - Missouri Partnership to Increase Colorectal Cancer Screening
- ✓ NACHC partnership strategy and opportunities




[June Learning Forum Recording]

# July: Evidence-Based Care

## What we learned:

- ✓ What is a systems approach evidence-based care
- ✓ Evidence-based interventions panel discussion, featuring representatives from:
  - CDC National Breast and Cervical Cancer Early Detection Program
  - CDC Colorectal Cancer Control Program
  - CDC National Diabetes Prevention Program
  - CDC Heart Disease and Stroke Prevention division
  - Iowa department of health and human services

### 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.

**July Learning Forum Recording**

# Resources: Evidence-Based Care


[Cancer Screening Action Guide]

[Diabetes Action Guide]

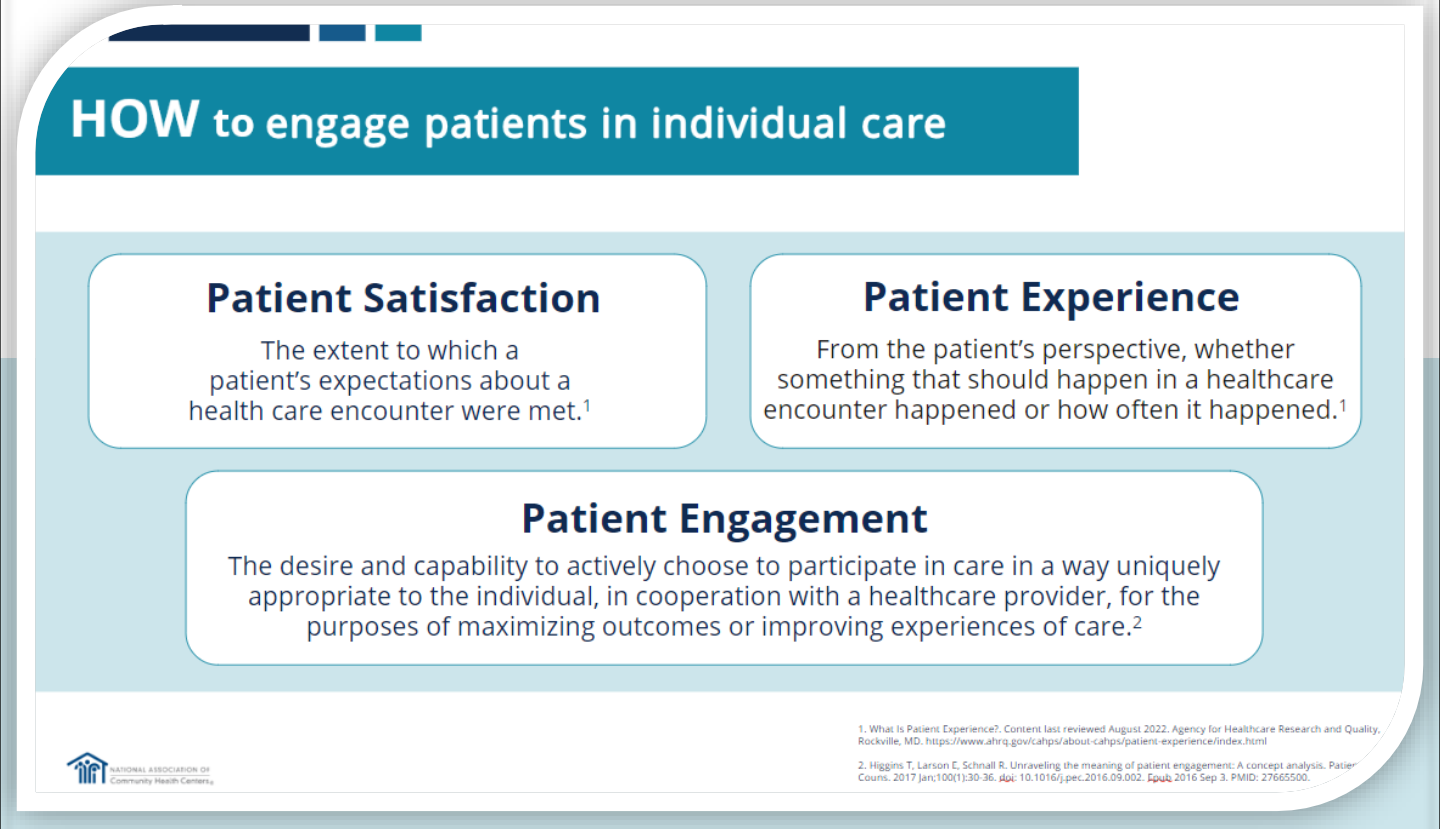
[HIV Prevention Action Guide]

[Hypertension Action Guide]

# September: Patients & PCMH

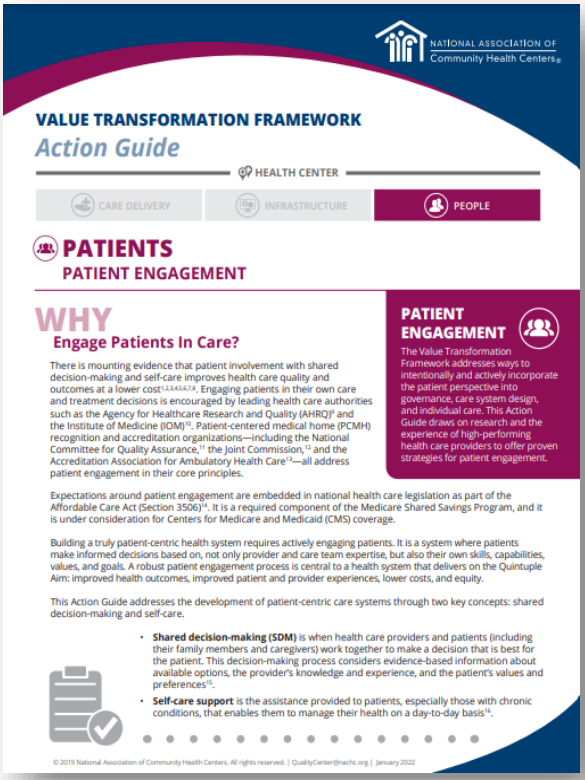
## What we learned:

- ✓ Why a patient-centric health system
- ✓ How health centers can incorporate the patient perspective into
  - Individual care
  - Care system design
  - Governance
- ✓ Case examples from:
  - Eastern Shore Rural Health System
  - National Health Council




**September Learning Forum Recording**

# Resources: Patient Engagement



NATIONAL ASSOCIATION OF Community Health Centers®

**VALUE TRANSFORMATION FRAMEWORK**

*Action Guide*

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

**PATIENTS**

**PATIENT ENGAGEMENT**

**WHY**

**Engage Patients In Care?**

There is mounting evidence that patient involvement with shared decision-making and self-care improves health care quality and outcomes at a lower cost[1,2,3,4,5,6,7,8]. Engaging patients in their own care and treatment decisions is encouraged by leading health care authorities such as the Agency for Healthcare Research and Quality (AHRQ)[9] and the Institute of Medicine (IOM)[10]. Patient-centered medical home (PCMH) recognition and accreditation organizations—including the National Committee for Quality Assurance,[11] the Joint Commission,[12] and the Accreditation Association for Ambulatory Health Care[13]—all address patient engagement in their core principles.

**PATIENT ENGAGEMENT**

The Value Transformation Framework addresses ways to intentionally and actively incorporate the patient perspective into governance, care system design, and individual care. This Action Guide draws on research and the experience of high-performing health care providers to offer proven strategies for patient engagement.

Expectations around patient engagement are embedded in national health care legislation as part of the Affordable Care Act (Section 3506)[14]. It is a required component of the Medicare Shared Savings Program, and it is under consideration for Centers for Medicare and Medicaid (CMS) coverage.

Building a truly patient-centric health system requires actively engaging patients. It is a system where patients make informed decisions based on, not only provider and care team expertise, but also their own skills, capabilities, values, and goals. A robust patient engagement process is central to a health system that delivers on the Quintuple Aim: improved health outcomes, improved patient and provider experiences, lower costs, and equity.

This Action Guide addresses the development of patient-centric care systems through two key concepts: shared decision-making and self-care.

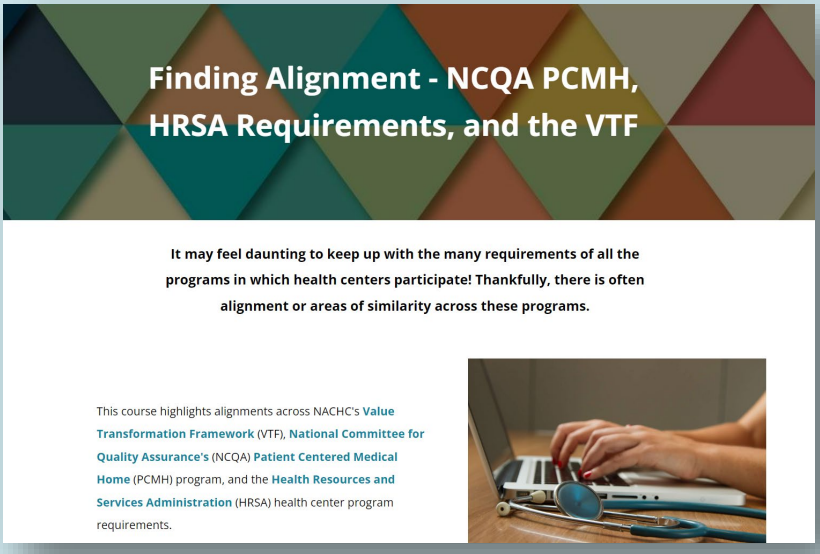
- **Shared decision-making (SDM)** is when health care providers and patients (including their family members and caregivers) work together to make a decision that is best for the patient. This decision-making process considers evidence-based information about available options, the provider's knowledge and experience, and the patient's values and preferences[15].
- **Self-care support** is the assistance provided to patients, especially those with chronic conditions, that enables them to manage their health on a day-to-day basis[16].



**Patient Engagement Action Guide**

# Resources: PCMH

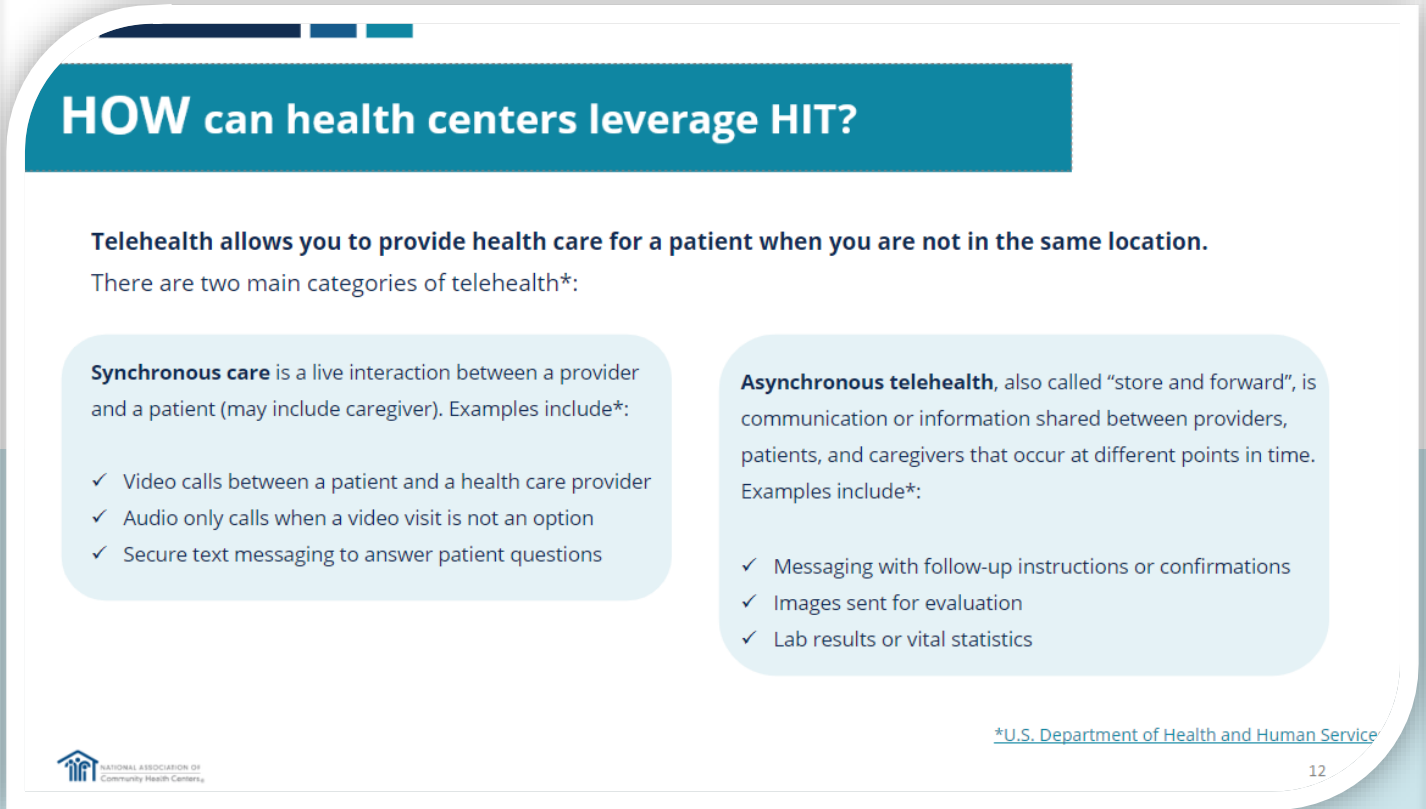
**Finding Alignment: NCQA PCMH, HRSA Requirements, and the VTF Microlearning**



# October: HIT & Policy – Telehealth & RPM

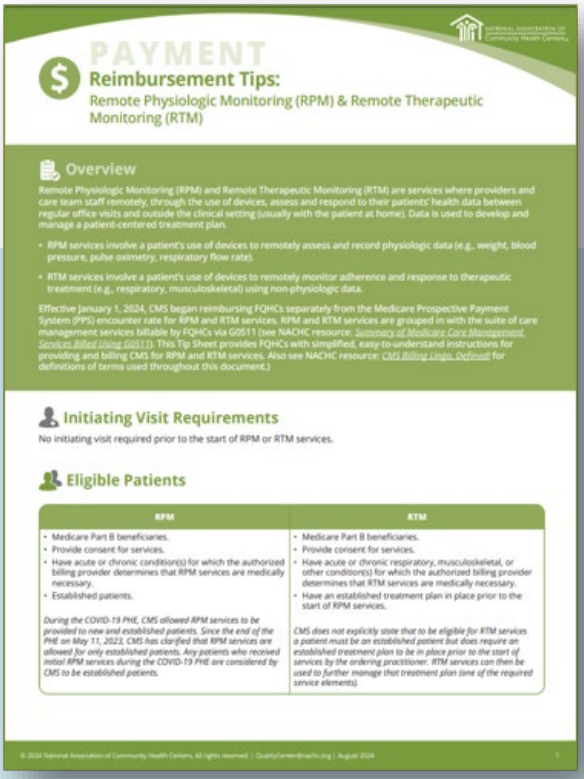
## What we learned:

- ✓ How to leverage telehealth and RPM to modernize the care model, presented by Mid-Atlantic Telehealth Resource Center
- ✓ Case example from San Fernando Community Health Center
- ✓ Policy implications for Telehealth and RPM




[October Learning Forum Recording]

# Resources: HIT



PAYMENT

**Reimbursement Tips:**

Remote Physiologic Monitoring (RPM) & Remote Therapeutic Monitoring (RTM)

**Overview**

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**Initiating Visit Requirements**

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**Eligible Patients**

| RPM | RTM |
|---|---|
| • Medicare Part B beneficiaries.<br>• Provide consent for services.<br>• Have acute or chronic condition(s) for which the authorized billing provider determines that RPM services are medically necessary.<br>• Established patients.<br>*During the COVID-19 PHE, CMS allowed RPM services to be provided to new and established patients. Since the end of the PHE on May 11, 2023, CMS has clarified that RPM services are allowed for only established patients. Any patients who received initial RPM services during the COVID-19 PHE are considered by CMS to be established patients.* | • Medicare Part B beneficiaries.<br>• Provide consent for services.<br>• Have acute or chronic respiratory, musculoskeletal, or other condition(s) for which the authorized billing provider determines that RTM services are medically necessary.<br>• Have an established treatment plan in place prior to the start of RPM services.<br>*CMS does not explicitly state that to be eligible for RTM services a patient must be an established patient but does require an established treatment plan to be in place prior to the start of services by the ordering practitioner. RTM services can then be used to further manage that treatment plan (one of the required service elements).* |



[RPM/RTM Reimbursement Tips]


[Virtual Care Action Guide]

## Coming Soon:

- ✓ **Artificial Intelligence (AI) Action Guide**
- ✓ **AI Learning Module**

  *Created in partnership with Waianae Coast Comprehensive Health Center*

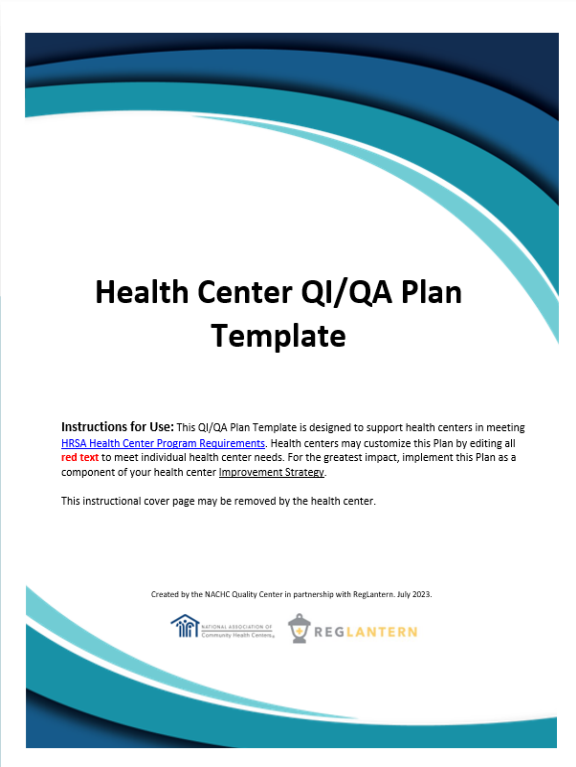
# November: Improvement Strategy & Leadership

## What we learned:

- ✓ How to implement a health center improvement strategy
- ✓ QI/QA Plan essentials by RegLantern
- ✓ Case example from Charles B. Wang Community Health Center


[November Learning Forum Recording]

# Resources: Improvement Strategy



Health Center QI/QA Plan Template

**Instructions for Use:** This QI/QA Plan Template is designed to support health centers in meeting HRSA Health Center Program Requirements. Health centers may customize this Plan by editing all red text to meet individual health center needs. For the greatest impact, implement this Plan as a component of your health center Improvement Strategy.

This instructional cover page may be removed by the health center.

Created by the NACHC Quality Center in partnership with RegLantern. July 2023.

NATIONAL ASSOCIATION OF Community Health Centers® REGLANTERN

## Template QI/QA Plan

NATIONAL ASSOCIATION OF Community Health Centers®

*Action Guide*

IMPROVEMENT STRATEGY

WHY

is improvement strategy essential to health center performance?

An improvement strategy ensures health centers have clearly defined visions, goals, and action steps that drive transformation and improve performance. It guides health center performance by effectively and routinely measuring and communicating information about the quality, value, and outcomes of the health care experience. In an era of value-based care, this whole-systems approach supports health centers to:

- Function as "learning organizations" engaged in continuous quality improvement and applying evidence-based interventions and best practices.
- Implement organization-wide, system-level changes that are impactful, measurable and transformative.
- Drive improvements toward the Quintuple Aim goals – improved health outcomes, improved patient experiences, improved staff experiences, reduced costs, and equity.

A health center's improvement strategy is most effective when aligned with the health center's overall strategic plan. This not only creates a solid foundation for health center improvement but integrates improvement and innovation activities within health center advancements in the infrastructure, care delivery, and people systems.

IMPROVEMENT STRATEGY

**The Value Transformation Framework** addresses how an improvement strategy allows health centers to effectively and routinely measure and communicate information about the quality, value, and outcomes of the health care experience and use this information to drive improved performance. It encompasses the systematic, continuous process of quality planning, improvement, control, and assurance. This Action Guide defines a concrete set of action steps health centers can take to develop an effective improvement strategy.

WHAT

is a whole-systems improvement strategy?

An improvement strategy guides the advancement of healthcare quality. The Institute of Medicine's (IOM) 2001 landmark report, ***Crossing the Quality Chasm: A New Health System for the 21st Century***, outlined six aims for improvement in the health care system[1]. These includes care that is: safe, effective, patient-centered, timely, efficient, and equitable.

Organizations and health care systems worldwide have adopted these aims to define quality of care[2,3]. ***Crossing the Quality Chasm*** made an urgent call for fundamental changes in the health care system to close the quality gap and advocated for a systems approach to implementing change[1] – much like NACHC's approach to health center systems change using the Value Transformation Framework.

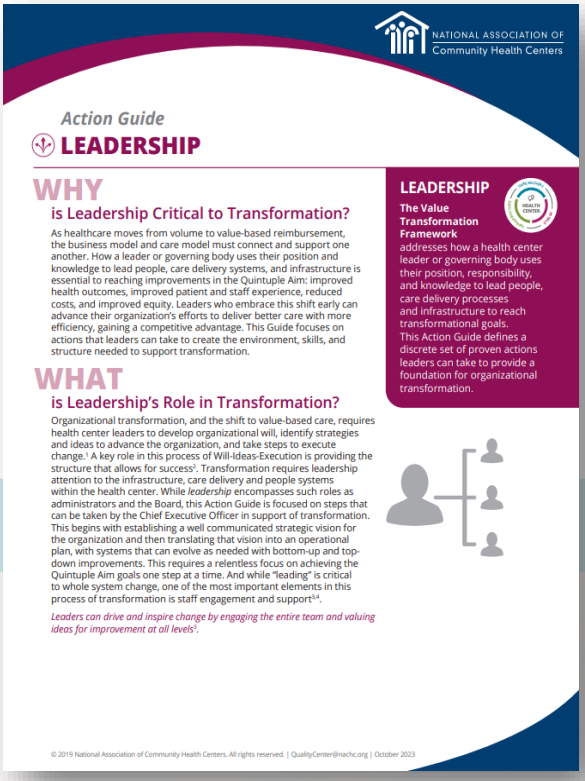


## NACHC Improvement Strategy Action Guide

## Coming Soon!

- ✓ Clinical Quality Measure Action Guide
- ✓ CQM Care Gaps Root Cause Identifier Worksheet

# Resources: Leadership



NATIONAL ASSOCIATION OF Community Health Centers

*Action Guide*

**LEADERSHIP**

## WHY
### is Leadership Critical to Transformation?

As healthcare moves from volume to value-based reimbursement, the business model and care model must connect and support one another. How a leader or governing body uses their position and knowledge to lead people, care delivery systems, and infrastructure is essential to reaching improvements in the Quintuple Aim: improved health outcomes, improved patient and staff experience, reduced costs, and improved equity. Leaders who embrace this shift early can advance their organization's efforts to deliver better care with more efficiency, gaining a competitive advantage. This Guide focuses on actions that leaders can take to create the environment, skills, and structure needed to support transformation.

**LEADERSHIP**

**The Value Transformation Framework** addresses how a health center leader or governing body uses their position, responsibility, and knowledge to lead people, care delivery processes and infrastructure to reach transformational goals. This Action Guide defines a discrete set of proven actions leaders can take to provide a foundation for organizational transformation.

## WHAT
### is Leadership's Role in Transformation?

Organizational transformation, and the shift to value-based care, requires health center leaders to develop organizational will, identify strategies and ideas to advance the organization, and take steps to execute change.[1] A key role in this process of Will-Ideas-Execution is providing the structure that allows for success[2]. Transformation requires leadership attention to the infrastructure, care delivery and people systems within the health center. While *leadership* encompasses such roles as administrators and the Board, this Action Guide is focused on steps that can be taken by the Chief Executive Officer in support of transformation. This begins with establishing a well communicated strategic vision for the organization and then translating that vision into an operational plan, with systems that can evolve as needed with bottom-up and top-down improvements. This requires a relentless focus on achieving the Quintuple Aim goals one step at a time. And while "leading" is critical to whole system change, one of the most important elements in this process of transformation is staff engagement and support[3,4].

*Leaders can drive and inspire change by engaging the entire team and valuing ideas for improvement at all levels[5].*



## Leadership Action Guide


# Resource provided by the Quality Center Team

*Cheryl Modica, Cassie Lindholm, Holly Nicholson, Tristan Wind*

qualitycenter@nachc.org