Applying the VTF to Your Work

Care Teams & Care Management

March 14, 2023
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.
During today’s session:

• **Questions:** Throughout the webinar, type your questions in the chat feature. Be sure to select “Everyone”! There will be Q&A and discussion at the end.

• **Resources:** If you have a tool or resource to share, let us know in the chat!
Packaging and implementing evidence-based transformational strategies for safety-net providers

Bringing science, knowledge, and innovation to practice

Cheryl Modica  
Director, Quality Center

Cassie Lindholm  
Deputy Director, Quality Center

Holly Nicholson  
Manager, Instructional Design & Learning

Addison Gwinner  
Specialist, Quality Center
Agenda:

• Value Transformation Framework
  • Organize Transformation Efforts Using the VTF
  • Enhance Application of the VTF Through Elevate

• Elevate 2023
  • Elevate Year-At-A-Glance
  • Elevate ‘University’ Offerings and Tracks
  • Health Center Elevate Pathway
  • Use the VTF Assessment 2.0 to Drive Transformation
  • Elevate Online Platform

• Care Teams & Care Management
  • Optimizing Care Teams
  • Providing Care Management
  • Measuring Care Management Panel Data

• Next Steps
The Value Transformation Framework (VTF) is an organizing framework to guide health center systems change.

- **Supports change** in many parts of the health center simultaneously
- **Organizes and distills evidence-based interventions** for discrete parts of the systems called ‘Change Areas’
- **Incorporates evidence, knowledge, tools and resources** relevant for action within different parts of the system, or Change Areas
- **Links health center performance to the Quintuple Aim**
Enhance VTF Application Through Elevate

Register

Assess
Ideally 3+ staff
https://reglantern.com/vtf

Monthly Forum
2nd Tuesday 1-2pm ET
Invites are sent to registered participants

Online Resources
https://nachc.docebosaas.com/learn/signin

National Learning Forum:
Guided application of the VTF

Opportunity for a 6-month FREE trial to RegLantern continuous compliance tool!
Join us on 3/22 3-4pm ET for more info
The VTF’s systems approach weaves discussion of all 15 Change Areas continuously throughout the year.
Elevate ‘University’ Offerings

**Learning Forums**
- Education, training, and peer exchange in areas of health center systems change.

**Action Guides**
- Step-by-step, evidence-based instructions that break complex topics into manageable action steps.

**Reimbursement Tips**
- FQHC-specific guidance on billing and coding requirements for Medicare care management and other services.

**eLearning**
- Self-paced, online learning opportunities to enhance VTF applications, introduce new materials, and support existing practices.

**Microlearning**
- Concise (< 10 min) learning segments that offer focused learning materials for framework applications.
Elevate ‘University’ Tracks

Content tailored to health center transformation readiness

Planning  Implementing  Optimizing

Content tailored to health center roles

Care Management
Outreach & Enrollment
Community Health Workers
Leadership

www.nachc.org
Elevate 2023: Health Center Pathway

**January**

**Identify Transformation Team**
- Leadership support
- Interdisciplinary (QI, clinical, finance, HIT)
- Care team member engagement

**Register for Elevate**

**Complete the VTF Assessment 2.0**
- Assess progress on transformation continuum
- Identify areas for focused improvement

**Set Goals Based on VTF Assessment Results**
- Which Change Areas are most in need of improvement?
- Opportunities to leverage other health center initiatives?

**February**

**Leverage the VTF**
- Organize transformation efforts using VTF

**March**

**Access Elevate Resources**
- Attend monthly Elevate learning forums
- Apply evidence-based Action Guides
- Access eLearning modules & microlearnings
- Engage with peers nationally

**April**

**May**

**June**

**July**

**August**

**September**

**October**

**November**

**December**

**Continue Transformation**
- Measure transformation progress
- Identify areas for focused improvement

**Reassess; VTF Assessment 2.0**
VTF Assessment: Use To Drive Transformation

✓ Assess organizational progress in 15 areas of systems change important to value transformation.
✓ Recommended that 3 or more health center staff complete the assessment to get a balanced perspective of organizational progress in areas of systems change
Complete 3+ VTF Assessments:

✓ Health center receives 5 scholarships, each offering 45-day enrollment in the Institute for Healthcare Improvement (IHI) Open School

✓ Health center is eligible for a 6-month trial membership to an online document management platform to support health center OSV preparation and ongoing compliance.

Save the Date: Thursday, March 22, 2023, 3-4 pm ET
RegLantern Orientation Call for Health Center Compliance Tool trial subscription
Register Here

RegLantern Continuous Compliance Tool
• Cloud-based platform that helps health centers move toward continuous HRSA compliance
• Allows health centers to compile and organize all documents demonstrating compliance in one place
• Embedded with checklists, alerts, and reminders
• Allows a health center to share documents with on-site reviewers during Operational Site Visit (OSV)
• Access to exclusive discounts for health centers interested in continuing subscription after trial period.
Access NACHC's Learning Hub at https://nachc.docebosaas.com/learn/signin
VTF & Elevate Resources

DOMAINS

INFRASTRUCTURE
- Improvement Strategy
- Health Information Technology (HIT)
- Policy
- Payment
- Cost

CARE DELIVERY
- Population Health Management
- Patient-Centered Medical Home
- Evidence-Based Care
- Care Coordination And Care Management
- Social Drivers Of Health

PEOPLE
- Patients
- Care Teams
- Governance And Leadership
- Workforce
- Partnerships

RESOURCES

CHANGE AREAS

CARE TEAMS
Utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than a provider alone.
Care Teams & Care Management
Care Teams & Care Management

WHAT?

WHY?

HOW?
The process of matching every patient to a primary care provider and care team.

Segmenting patients into distinct groups of similar complexity and care needs to better target care and services.

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

- **Low Risk**: Focus is keeping patients engaged in the health care system without use of unnecessary services.
- **Rising Risk**: Focus is on managing risk factors more than disease conditions.
- **High Risk**: Requires structured care management and one-on-one support.
- **Highly Complex**: Requires intensive, pro-active care management.

**WHAT role do care teams have in population health management?**
WHAT role do care teams have in population health management?

Care Teams

Care teams and the tasks that team members are assigned are developed, based on the needs of the patient population (care models) and the availability of personnel, services, and other resources.

Care Management

A component of care models for high risk and highly complex patients. Care team members provide intensive, one-on-one services to individuals with complex health and social needs.
Strategies for optimizing care teams and providing care management services can be utilized by health centers at any level – **Planning, Implementing, Optimizing** – with consideration to available resources and attention to staffing challenges.
Care Teams & Care Management

WHAT?  WHY?  HOW?
WHY should health centers optimize care teams and provide care management?

Transitioning to value-based care requires a shift in the way care is delivered:

➢ Increase capacity for the number of patients served
➢ ‘Share the Care’ - provide care as a team with varying staff roles providing care to a panel of patients together
➢ Reallocate tasks and responsibilities so all team members contribute meaningfully and to full capacity
➢ Leverage opportunities to capture revenue outside of PPS

... All while balancing staffing challenges and limited resources!

Optimizing care teams has been demonstrated to improve the experience and outcomes of primary care for patients, providers, and staff.

Care Teams & Care Management

WHAT?

WHY?

HOW?
Care Teams & Care Management

NACHC Care Teams Action Guide

NACHC Care Management Action Guide

NACHC CCM Reimbursement Tip Sheet
HOW to optimize care teams?

**STEP 1** Define care standards

**STEP 2** Distribute tasks to meet standards and document workflow

**STEP 3** Update job descriptions

**STEP 4** Train staff

**STEP 5** Monitor task performance in dashboards

**STEP 6** Hardwire accountability into personnel systems and performance reviews

**STEP 7** Educate patients on redesigned care team
KEY STEP: DEFINE CARE STANDARDS

Identify the minimum set of care and services to be provided to patients by age and risk group.

For example, which clinical guidelines will your health center consider:

- U.S. Preventive Services Task Force (USPSTF)?
- Healthcare Effective Data and Information Set (HEDIS)?
- Uniform Data Systems (UDS)?

Essentially, how is a 'care gap' defined by your health center?
**KEY STEP:** DEFINE CARE STANDARDS

**LOW RISK**
- Care gap closure
- Open referral and outstanding lab follow up
- ED and hospitalization follow up

**RISING RISK**

**HIGH RISK**
- SDOH support
- Prescriptions/refills
- Triage

**HIGHERLY COMPLEX**
- Care management support

---

**Frequency and Intensity of Support**
Once a health center has agreed to a minimum set of care standards for each target group, the tasks necessary to accomplish these standards can be assigned to specific care team member roles.

Ensure staff members are tasked with work that enables them to perform at the top of their licensure.

Implement standing orders to empower support staff to order or provide labs, referrals, and other services.

**Optimize HIT!**

Consider which tasks can be delegated to technology. For example, use systems to send automated reminders and schedule services for care gaps so staff members can spend less time manually calling patients.

Determine which tasks can be completed remotely and which require staff to be at the health center in-person. Create policies and provide remote access for staff to connect to the EHR and work from home on designated tasks.
Distribute Tasks

Consider using or creating a tool to aid in the process of distributing tasks.

- Start by identifying the responsibility or task that needs to be completed.
- Determine the job role 'best' able to complete that task.
- Also consider:
  - Technology
  - In-person vs remote
  - Primary vs back-up

NACHC Care Team Planning Worksheet - Patient Appointments
HOW to optimize care teams?

Planning
• Begin by assessing your current state:
  • What are the tasks that are being completed?
  • Who is completing each task?
• Start with just one provider & care team rather than organization-wide.

Implementing
• Redistribute tasks to more appropriate roles, enabling staff to work to the top of their skill level.
• Leverage HIT systems already in place.
• Expand to additional providers & care teams as staff begins to feel comfortable with the process.

Optimizing
• Incorporate new, innovative HIT and staff roles to further optimize care team processes and patient care:
  • Integrated services
  • Remote patient monitoring
  • Telehealth
HOW to provide care management?

STEP 1 Identify or hire a care manager
STEP 2 Identify high risk patients
STEP 3 Define care manager-care team interface
STEP 4 Define services provided as part of care management
STEP 5 Enroll patients in care management
STEP 6 Create individualized care plans
STEP 7 Enhance and expand partnerships
STEP 8 Document and bill for chronic care management
STEP 9 Graduate patients from care management
STEP 10 Measure outcomes
Identify or hire a care manager

Identify staff to provide one-on-one services to high risk and highly complex patients.

An RN often serves in this role, but other members of the care team (MA, CHW, etc.) can perform many care management services within state/license requirements.

Use **empanelment data** to help determine which care teams to add care managers to, and **risk stratification data** to help determine the number of care managers needed to meet the needs of the patient population.

If your health center does not have the staffing or resources to hire/identify full-time care managers, consider formalizing care management responsibilities within current care team members’ roles to provide services to a smaller number of patients.

**Tools & Resources:** Sample Care Manager Job Description
KEY STEP: IDENTIFY HIGH RISK PATIENTS

Identify high risk patients based on:
- Risk stratification data
- CCM eligibility criteria

The target caseload for a full-time care manager varies depending on several factors and is likely to be in the range of 50-150 patients. Factors affecting caseload size include:

- Health center procedures and resources
- The care manager’s experience
- The clinical and social complexity of patients
- Available social supports
- Target care management outcomes

Evaluate caseload size and manageability on an ongoing basis.
DEFINE SERVICES PROVIDED AS PART OF CARE MANAGEMENT

Ensure comprehensive care plans support chronic disease and prevention needs, as well as mental, social, and environmental factors.

CCM services include:

- Comprehensive assessment of medical, functional, and psychosocial needs
- Preventive care
- Medication management
- Comprehensive care plan
- Continuity of care
- Coordination with home-health and community-based providers
- 24/7 access to providers or clinical staff

Also consider incorporating Transitional Care Management (TCM) services.

Tools & Resources:
- Care Management Protocol for High-Risk Patients
- NACHC TCM Reimbursement Tip Sheet
Consider enrolling eligible patients through:

- Warm handoffs from the primary care provider (or other designated care team member) to the care manager.
- The care manager can call, email, or mail a letter indicating that their provider has recommended them for care management.
- Discuss with patients after a change in health status such as a new diagnosis, transition in care, etc.

- For CCM, provider must have a discussion with patient about CCM prior to enrollment (must be documented!).
- Obtain and document patient consent.
- Track enrolled patients and their assigned care manager in the EHR where other care team members can view.

Tools & Resources:
Sample Consent Form
Sample Internal Referral to CM Form
FQHC Reimbursement Tip Sheets for CMS/Medicare Care Management Services are available free of charge on NACHC’s Elevate platform.
Planning
• Start small! If your health center is not able to hire full-time care managers, formalize care management responsibilities within current care team members’ roles to provide services to a smaller number of patients.

Implementing
• Enroll patients and build care management patient panels. This takes time!

Optimizing
• Incorporate care management services and goals into value-based care contracts and optimize reimbursement opportunities.
• Leverage care management data and outcomes to expand services to a larger portion of the patient population.
Use care management panel data to scale your care management program, to meet the needs of your patient population while balancing staffing needs and care team responsibilities.

How? ...
Measuring Care Management Panel Data

➢ Measure the number of patients in each care manager's panel to help assess workload and balance with other care team responsibilities.

➢ Measure each care manager's panel size over time to view ‘net’ changes.

Keep in mind when setting goals or calculating potential revenue for care management, it takes time to build a patient panel.
If you have more than one care management program, measure panel size by program (or by payor if you have multiple value-based contracts).

Measure each care manager’s panel size by program over time to view ‘net’ changes.

For CCM, this data can be used to set goals and predict potential program revenue.
Measuring Care Management Panel Data

- Measure patient enrollments and disenrollments by month.
- Measure patient disenrollments by reason.

This perspective gives a higher level of insight into how a care manager is building and retaining their panel.
Measuring Care Management Panel Data

- Measure the number of high-risk patients enrolled in care management.

<table>
<thead>
<tr>
<th>Month</th>
<th>Enrolled</th>
<th>High Risk</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td>0</td>
<td>549</td>
<td>0.00%</td>
</tr>
<tr>
<td>May</td>
<td>19</td>
<td>547</td>
<td>3.47%</td>
</tr>
<tr>
<td>Jun</td>
<td>56</td>
<td>549</td>
<td>10.20%</td>
</tr>
<tr>
<td>Jul</td>
<td>68</td>
<td>550</td>
<td>12.36%</td>
</tr>
<tr>
<td>Aug</td>
<td>73</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sep</td>
<td>99</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct</td>
<td>111</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nov</td>
<td>134</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar</td>
<td>17</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Measure the number of CCM eligible patients enrolled in care management.

<table>
<thead>
<tr>
<th>Month</th>
<th>Enrolled</th>
<th>Eligible</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td>0</td>
<td>380</td>
<td>0.00%</td>
</tr>
<tr>
<td>May</td>
<td>5</td>
<td>382</td>
<td>1.31%</td>
</tr>
<tr>
<td>Jun</td>
<td>8</td>
<td>390</td>
<td>2.05%</td>
</tr>
<tr>
<td>Jul</td>
<td>11</td>
<td>394</td>
<td>2.79%</td>
</tr>
<tr>
<td>Aug</td>
<td>14</td>
<td>398</td>
<td>3.69%</td>
</tr>
<tr>
<td>Sep</td>
<td>18</td>
<td>401</td>
<td></td>
</tr>
<tr>
<td>Oct</td>
<td>21</td>
<td>401</td>
<td></td>
</tr>
<tr>
<td>Nov</td>
<td>22</td>
<td>399</td>
<td></td>
</tr>
<tr>
<td>Dec</td>
<td>19</td>
<td>403</td>
<td></td>
</tr>
<tr>
<td>Jan</td>
<td>29</td>
<td>404</td>
<td></td>
</tr>
<tr>
<td>Feb</td>
<td>32</td>
<td>400</td>
<td></td>
</tr>
<tr>
<td>Mar</td>
<td>36</td>
<td>407</td>
<td></td>
</tr>
</tbody>
</table>

This data can be used to figure out how many care managers are needed to care for a patient population.
Measuring Care Management Panel Data

➢ Measure the number of completed Care Management encounters.

<table>
<thead>
<tr>
<th>Month</th>
<th>Panel Size</th>
<th>CM Encounters</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>May</td>
<td>2</td>
<td>2</td>
<td>100.00%</td>
</tr>
<tr>
<td>Jun</td>
<td>8</td>
<td>7</td>
<td>87.50%</td>
</tr>
<tr>
<td>Jul</td>
<td>9</td>
<td>9</td>
<td>100.00%</td>
</tr>
<tr>
<td>Aug</td>
<td>12</td>
<td>12</td>
<td>100.00%</td>
</tr>
<tr>
<td>Sep</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nov</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan</td>
<td>41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb</td>
<td>52</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar</td>
<td>57</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

➢ Measure the number of billed CCM encounters.

<table>
<thead>
<tr>
<th>Month</th>
<th>Enrolled CCM Patients</th>
<th>Billed G0511</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>May</td>
<td>0</td>
<td>0</td>
<td>0.00%</td>
</tr>
<tr>
<td>Jun</td>
<td>1</td>
<td>1</td>
<td>100.00%</td>
</tr>
<tr>
<td>Jul</td>
<td>3</td>
<td>3</td>
<td>100.00%</td>
</tr>
<tr>
<td>Aug</td>
<td>4</td>
<td>4</td>
<td>100.00%</td>
</tr>
<tr>
<td>Sep</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nov</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar</td>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This data can be used to ensure care managers have enough 'protected' time to complete care management responsibilities. (Patient engagement is also a factor.)
Measuring Care Management Panel Data

- Measure the impact on quality measures.

<table>
<thead>
<tr>
<th>UDS Measure</th>
<th>All Health Center Patients</th>
<th>Care Management Patients (&gt;1yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorectal Cancer Screening</td>
<td>71%</td>
<td>81%</td>
</tr>
<tr>
<td>Diabetes A1C Control</td>
<td>32%</td>
<td>21%</td>
</tr>
<tr>
<td>Hypertension Control</td>
<td>68%</td>
<td>77%</td>
</tr>
</tbody>
</table>

Filter to include care management patients who have been enrolled in care management for >6 months or >1 year, and patients who have graduated from a care management program.
Consider building structured data fields into documentation workflows, for the ability to measure progress on patient care management goals.

Measure the impact of different care plans and interventions.
Measuring Care Management Panel Data

Planning
- Determine the structured data fields you will build into your care management workflows.
  - How will the care manager be identified within the patient's chart?
  - How will encounters be documented?
  - How will goals/progress toward goals be documented?

Implementing
- Determine which panel data measures you will review and how often you will review them.
  - Consider starting with panel size, enrollments & disenrollments, and completed encounters.

Optimizing
- Expand to review additional panel data measures.
- Focus on outcomes of the care management program.
  - Care management goals
  - Clinical quality measures
The PCA Experience: Optimizing Care Team Roles & Responsibilities

Heather Adams
Director of Training & Education

Colleen Rankine
VP, Operations
CHCACT & The PCA Experience

- Investment in the process
  - Leadership
  - Time
  - Commitment to improvement
- Understanding
  - Current state/process
  - Future state/process

Optimize
Swimlane Process Map

- Approach to systematic change
- Owned by the participants
- Empowering the opportunity to change
- Involving participants doing the work in making the changes
Discussion
Extended Care Team: Enabling Services

Ted Henson
Director, Health Center Growth & Development
Training & Technical Assistance
National Association of Community Health Centers
Enabling Services: Vital Workforce

Described in Section 330(b)(1)(A)(iv) of the Public Health Service Act as “non-clinical services that aim to increase access to healthcare, and to improve health outcomes.”

- 25,000+ strong!
  - Case Managers (11,327)
  - Eligibility Workers (4,347)
  - Outreach Workers (2,774)
  - Patient Specialists (2,579)
  - Community Health Workers (1,900)
  - Interpretation (1,213)
  - Transportation
  - Other.

- Potential return on investment (ROI) for enabling services
Sample Workflow: Enrollment Assistance

Patient at MCHC

- See a Provider
- Makes an appointment
- Speaks to a kynector
- Calls about a bill

Checks to see if they have insurance

- No
- Yes

Enrolls in kynect

Educate, and verify eligibility through screening

Join NACHC and experts from the Association of Diabetes Care & Education Specialists (ADCES) for the opportunity to learn how health centers can implement the CDC-recognized lifestyle change program, focused on healthy eating and physical activity, that has been shown to reduce participants’ risk of developing type 2 diabetes.

This webinar will also highlight findings from NACHC’s Healthy Together project which optimizes technology and takes a whole-person approach, including use of self-care tools, for individuals at risk for diabetes as well as living with diabetes.

Thursday, April 6th 12-1pm ET

Registration is required! Register here.
Upcoming Learning Opportunity:
Brain Health 3-Part Webinar Series

Join NACHC and experts from the field for this 3-part series focused on leveraging health center workflows to care for patients at risk for or diagnosed with dementia.

**Wednesday, May 3rd 1-2pm ET**
Early Detection of Dementia & Reducing Risk Factors

**Wednesday, May 17th 1-2pm ET**
Care Management for Patients with Dementia & Leveraging Reimbursement Opportunities

**Wednesday, May 31st 1-2pm ET**
Health Center Partnerships & Community Linkages to care for Patients with Dementia

Registration is required! Register [here](#)
COMPLETE the VTF Assessment

- Assess organizational progress in 15 areas of systems change important to value transformation.
- Recommended that 3 or more health center staff complete the assessment to get a balanced perspective of organizational progress in areas of systems change.
2023 Elevate Calls

Monthly Forums: 2nd Tuesday of the month, 1-2 pm ET

January 10th
February 14th
March 14th
April 11th
May 9th
June 13th
July 11th
August: Summer break, no Elevate call this month
September 12th
October 10th
November 14th
December 12th: Year in Review

Supplemental Sessions

Online Compliance Tool Trial Offer
March 22nd 3-4 pm ET. Register here

Outreach & Enrollment Learning Community
6-part series, March – June (filled)

National Diabetes Prevention Program & NACHC’s Healthy Together Project
April 6th, 12-1 pm ET. Register here.

Brain Health
3- part series: May 3rd, 17th, 31st, 1-2 pm ET. Register here
Provide Us Feedback
Together, our voices elevate all.

The Quality Center Team
Cheryl Modica, Cassie Lindholm, Holly Nicholson, & Addison Gwinner
qualitycenter@nachc.org