



# Community Health Center Association of Connecticut

*Innovations in Practice Transformation at CT Health Centers*

PRESENTED BY: RUSSELL DEXTER, CHIEF QUALITY OFFICER



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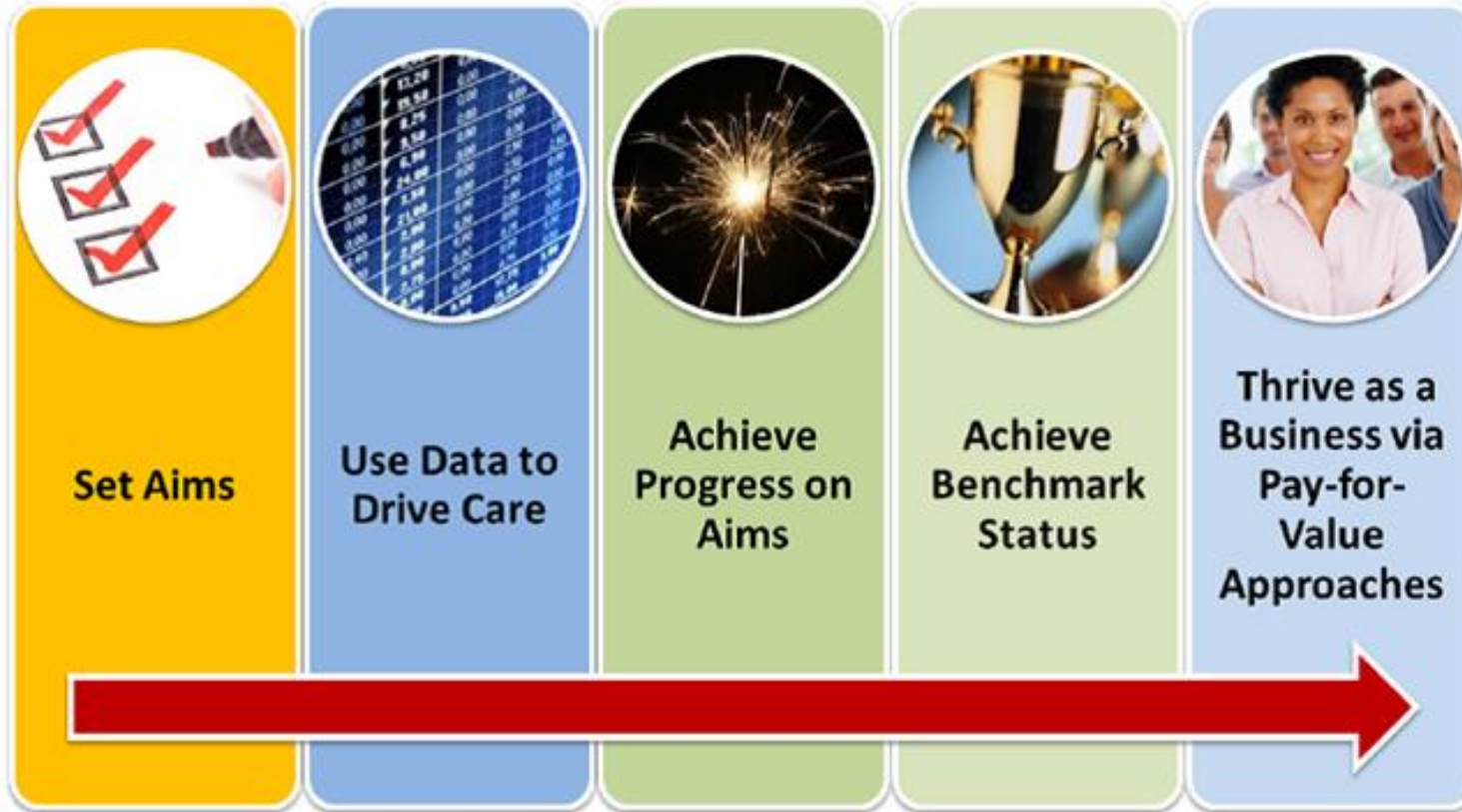
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- \$700 Million - Four-year initiative through CMS (9.29.15-9.28.19)
- Prepare primary care and specialty care practices to be successful under value-based payment models
- 31 Practice Transformation Networks - supporting over 140,000 providers nationally
- 16 Health Centers/1,000 providers/300k patients



Primary Drivers	Secondary Drivers
Patient and Family Centered Care Design	<ul style="list-style-type: none"> <li>1.1 Patient &amp; family engagement</li> <li>1.2 Team-based relationships</li> <li>1.3 Population management</li> <li>1.4 Practice as a community partner</li> <li>1.5 Coordinated care delivery</li> <li>1.6 Organized, evidenced based care</li> <li>1.7 Enhanced Access</li> </ul>
Continuous, Data-Driven Quality Improvement	<ul style="list-style-type: none"> <li>2.1 Engaged and committed leadership</li> <li>2.2 Quality improvement strategy supporting a culture of quality and safety</li> <li>2.3 Transparent measurement and monitoring</li> <li>2.4 Optimal use of HIT</li> </ul>
Sustainable Business Operations	<ul style="list-style-type: none"> <li>3.1 Strategic use of practice revenue</li> <li>3.2 Staff vitality and joy in work</li> <li>3.3 Capability to analyze and document value</li> <li>3.4 Efficiency of operation</li> </ul>

# TCPi Transformation Roadmap



# Five Phases of Transformation

# CHCACT Models of Support



## Coaching & Guidance

CT-PTN offers a high-touch approach with regular coaching sessions to guide transformation based on individual health center needs.



## Learning Collaborative

Structured learning opportunities to drive transformation.



## CMS Resources

Opportunities to learn from CMS Faculty & SANs.



## Peer Network

Shared learning & experiences from other FQHCs across CT.

# The Power of Health Centers

CMS AIM or PTN Measure	Commitment (by Sept 2019)	Cumulative Results (through June 2019)
Improved Clinical Outcomes – # of Patients meeting Diabetes Care Composite: (A1c<8, BP<140/90, LDL>100)	1,493	2,497
Improved Clinical Outcomes – # of Patients Meeting Asthma Care Measure	770	3,050
Reduction in Unnecessary Testing – Antibiotic RX's for URIs	68	388
Reduction in Unnecessary Hospitalizations (Combination of ED & Inpatient visits)	3,024	28,483
Cost Savings	\$38 Million	\$108 Million

# Segmenting Health Centers to Target Technical Assistance

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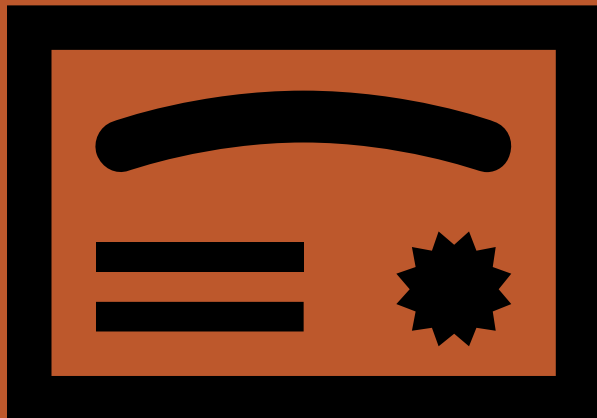
## Highest Performing: Exemplary Practices

- Charter Oak Health Center
- Fair Haven Community Health Care
- First Choice Health Centers
- Generations Family Health Center
- Norwalk Community Health Center
- StayWell Health Center

## Other Health Centers: Targeted Technical Assistance

- Population Health Management Cohort
- Care Teams Cohort
- Diabetes Clinical Outcomes Cohort

# Health Center Exposure & Recognition



## **April 2017 CMS Grand Rounds Event**

## **August 2018 National Expert Panel Event**

- Generations
- StayWell

## **February 2019 CMS Quality Conference**

- Charter Oak
- Fair Haven

## **June 2019**

- Generations recognized by CMS for commitment to PFE

## **August 2019 National Expert Panel**

- Charter Oak

## **August 2019 NACHC CHI**

- Family Centers

## **September 2019 – Recognition Certificates from CMS**



CMS NQIIC

Large-scale Clinical  
Quality  
Improvement  
Initiative

Collaboration  
between CHCACT,  
NACHC, and 16  
Peer PCAs

Elevate forum is  
foundation for  
Group Technical  
Assistance

Next Steps for  
Practice  
Transformation

Questions?