



California Federally Qualified Health Center Alternative Payment Model Implementation Guide

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About the Author

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About the Foundation

The [California Health Care Foundation \(CHCF\)](#) is an independent, nonprofit philanthropy that works to improve the health care system so that all Californians have the care they need. We focus especially on making sure the system works for Californians with low incomes and for communities who have traditionally faced the greatest barriers to care. We partner with leaders across the health care safety net to ensure they have the data and resources to make care more just and to drive improvement in a complex system.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

Important Note to Readers

The California Federally Qualified Health Center Alternative Payment Model (FQHC APM) is a proposed initiative of the California Department of Health Care Services (DHCS). At the date of publication, the program is subject to approval by the Centers for Medicare & Medicaid Services at the US Department of Health and Human Services. Information about the program contained in this guide reflects the most recently available details from DHCS and is subject to change. Official program guidelines are forthcoming from DHCS, and this guide will be updated as new information becomes available.

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SECTION 1.

Understanding the Federally Qualified Health Center Alternative Payment Model and How This Guide Can Help You

IN THIS SECTION

- ▶ Why Is California Moving Toward FQHC APM?
- ▶ Development of This Guide
- ▶ Road Map to This Guide
 - ▶ Is This Guide for You? How Can It Help?
 - ▶ Is FQHC APM Right for Your Health Center?
- ▶ California's Transition to FQHC APM
 - ▶ Development and Implementation Timeline of FQHC APM
- ▶ Defining FQHC APM
 - ▶ Who Participates?
 - ▶ Core Components

Why Is California Moving Toward FQHC APM?

The FQHC APM is designed to move away from the traditional fee-for-service (FFS) payment system, which rewards the volume of services provided, to a model that rewards high-quality and cost-effective care that is coordinated, team-based, convenient to access, and best meets patient needs.

“The APM has increased our ability to be flexible in order to be responsive to external challenges like the pandemic and wildfires.”

—FQHC CEO, Oregon

Under the traditional prospective payment system (PPS), FQHCs are paid for face-to-face encounters

with billable providers. Payment is based on volume of visits rather than value, which can discourage innovation and limits the ways in which providers and teams can care for their patients. Value-based payment (VBP) arrangements have the potential to remedy some of these issues in five meaningful ways by:¹

1. Giving health centers flexibility to provide care in the ways patients need and want
2. Allowing health centers to make critical infrastructure improvements
3. Helping improve patient outcomes
4. Helping deliver comprehensive, team-based, patient-centered care
5. Improving accountability by rewarding health centers that improve quality of care

Development of This Guide

To create this guide, the Center for Health Care Strategies (CHCS), with support from the California Health Care Foundation, drew upon its knowledge and experience working with FQHCs, VBP models, delivery systems, and Medicaid programs in California and around the country. CHCS conducted interviews with health centers and state primary care association leaders who have developed or participated in APMs for FQHCs to gather specific insights on implementation, best practices, lessons, and advice for success. To inform the topics and general approach to the guide, as well as review drafts, CHCS convened a group of advisors including staff working at California FQHCs in a variety of roles, a California Medi-Cal

managed care plan (MCP) leader, a health center CEO involved in Oregon's Alternative Payment and Advanced Care Payment Model, and representatives from the California Primary Care Association and the California Association of Public Hospital and Health Systems (see Appendix A for advisory group members).

Road Map to This Guide

Is This Guide for You? How Can It Help?

This guide is for leaders and staff in FQHCs that are considering or have committed to participating in the California FQHC APM, a voluntary VBP initiative offered by DHCS. The guide includes practical resources for reimagining and redesigning how your FQHC delivers care so it can be successful in the FQHC APM.

The guide will help you:

- ▶ Understand the impact of participating in FQHC APM for your FQHC's leaders, staff, and patients
- ▶ Identify key focus areas
- ▶ Set priorities
- ▶ Determine staffing needs
- ▶ Build and expand staff competencies

The guide is designed for all FQHC staff, including:

- ▶ **Leadership.** Chief executive officers, chief administrative officers, chief operations officers, chief financial officers, chief information officers, chief medical officers, chief behavioral health officers, chief strategy officers
- ▶ **Providers.** Physicians, physician assistants, nurse practitioners, certified nurse-midwives, therapists

- ▶ **Licensed and unlicensed clinical staff.** Nurses, social workers, medical assistants, counselors, pharmacists, care managers, care coordinators
- ▶ **Operations.** Administrative, information technology, and data analytics staff

Although staff can find useful information in all sections of the guide, certain sections will be more applicable based on their roles and responsibilities within the organization. Table 1 can help steer you to sections of interest to you (see next page).

Is FQHC APM Right for Your Health Center?

While this guide does not include a tool for deciding if your FQHC should participate in FQHC APM, it outlines factors that can contribute to your success under FQHC APM that can help inform your decision. As you explore the opportunities, challenges, and required investments of time and resources covered in the guide, you may wish to consider the following essential capabilities for success in APMs:

- ▶ **Leadership and staff buy-in.** Leadership, including boards of directors, understands the implications of FQHC APM for their FQHC and is able to articulate a vision for the FQHC as well as support providers and staff in the transition to FQHC APM. Staff may need to be trained to implement new quality-based payment models and understand how they are being held accountable. Your health center is able to engage patients and seek feedback on patients' experience.
- ▶ **A new financial model.** You and your team understand your current patient population and financial situation and can identify the financial risks and opportunities in FQHC APM, develop a new financial model, and set up new payment processes.
- ▶ **Practice transformation to support FQHC APM goals.** To improve on quality and cost

Table 1. Descriptions of This Guide’s Sections, and Their Targeted Staff

SECTION	DESCRIPTION	TARGETED STAFF
1. Understanding FQHC APM and How This Guide Can Help You	Why California is moving toward FQHC APM; development of the guide; road map to the guide; California’s transition to FQHC APM; defining FQHC APM.	All
2. An Overview of Financial Incentives in FQHC APM and What They Mean for Your Health Center	Adopting a new approach with new financial incentives; alternative touches; what populations are included; what financial success looks like under FQHC APM; additional financial considerations.	CEO, finance staff
3. Focusing on Patients, Not Visits	Transforming traditional care delivery; expanding how, where, and by whom care is delivered; facilitating team-based care; managing care in new ways.	Providers, clinical and support staff, administrative and operations staff, IT staff
4. Bringing Your Organization Along	Communicating change; redesigning care; understanding what this change mean for me; understanding that loss is part of making positive change; leading the change.	Leadership, providers, clinical and support staff, administrative and operations staff, IT staff
5. Data: Your Success Depends on It	The role of data; capturing and sharing data; ensuring your data are accurate; updating EHRs to support the work.	IT staff, finance, and operational staff
6. Partnering for Success	Collaborating with other FQHCs; working with MCPs and delegates; building external partnerships.	Leadership

Source: Author’s descriptions of the sections in the California Federally Qualified Health Centers Alternative Payment Model Implementation Guide, California Health Care Foundation, 2023.

metrics, your health center is able to incorporate clinical best practices into the workflow, if not already implemented. Roles and processes are defined and clear to providers and staff to ensure coordination and team-based care.

- ▶ **A robust IT infrastructure and data analytics capacity.** Your health center has, or is working toward updating, an electronic health record (EHR) that allows providers to capture and exchange data, support care coordination inside and outside the practice, and monitor and generate reports on targeted metrics. Staff are trained to populate the EHRs, use correct coding, and fully use EHR functionality. Your health center is able to analyze the data to determine the impact on quality and cost.

Your health center also has the infrastructure in place to share data between health plans, state agencies, and external providers. Being able to share and act on data in real time and across a wider range of providers is critical for effective care coordination, and it often requires sophisticated IT capacity and data analytic tools, as well as staff trained in these areas.

- ▶ **Robust care coordination efforts.** Having a care manager on-site increases connections with patients and the providers involved in their care. Your health center has the resources to hire and train staff for care management roles, and manage care transitions and link to external providers (e.g., specialists, hospitals, and community organizations).

California’s Transition to FQHC APM

California’s FQHC APM is one of four state-led FQHC APMs that converts FQHC Medicaid rates to a capitated per-member per-month (PMPM) payment. The three other models are profiled in Table 2.

Development and Implementation Timeline of California’s FQHC APM

Efforts to design an APM pilot for California’s FQHCs began in 2015 concurrent with the passage of Assembly Bill 147 and the convening of stakeholder workgroups to develop a model. These

Table 2. Examples of State-Led APMs

STATE	PAYMENT MODEL	QUALITY METRICS
Oregon Alternative Payment and Advanced Care Model	<ul style="list-style-type: none"> ▶ Health centers receive a base encounter payment from the health plan and an up-front supplemental capitated PMPM wrap payment from the state. ▶ Health centers submit reconciliation reports quarterly, with settlements paid annually. ▶ A portion of the payment is tied to meeting five quality benchmarks. 	<ul style="list-style-type: none"> ▶ FQHCs are accountable for five metrics that align with the coordinated care organization incentive measures: <ul style="list-style-type: none"> ▶ Colorectal cancer screening ▶ Depression screening ▶ Diabetes HbA1c >9% ▶ Weight assessment and counseling in children and adolescents ▶ Controlling high blood pressure
Washington Alternative Payment Methodology 4	<ul style="list-style-type: none"> ▶ Health centers receive an up-front PMPM payment from the health plan and a monthly “enhancement payment” from the state. ▶ The rate is then prospectively adjusted annually by the state to reflect the FQHC’s performance on five quality targets. ▶ FQHCs continue annual reconciliation to ensure PPS equivalency. ▶ In lieu of a settlement process, adjustments are made prospectively to future rates. 	<ul style="list-style-type: none"> ▶ Five process and outcome measures, which were selected from the state’s common measure set, are tracked: <ul style="list-style-type: none"> ▶ Antidepressant medication management ▶ Childhood immunization status ▶ Well-child visits ▶ Controlling high blood pressure ▶ Comprehensive diabetes care, including HbA1c >9%
Colorado Alternative Payment Methodology 2	<ul style="list-style-type: none"> ▶ APM 2 is a hybrid (partial population-based payment, partial FFS payment) primary care model that includes provisions for FQHC participation. ▶ FQHCs participating in the model will be paid a fully population-based payment, with rates based on historical spending and including an adjustment for quality performance. ▶ Payment to FQHCs will be reconciled annually to ensure PPS equivalency. In cases of underpayment, FQHCs will receive a onetime payment to make up the difference. In cases of overpayment, no action will be taken. 	<ul style="list-style-type: none"> ▶ Primary care providers report on 10 quality measures from the state’s APM Measure Set: three mandatory measures and seven measures selected by the provider. The Colorado Community Health Network coordinates measure selection for all FQHCs. ▶ Measures are categorized into the following types: structural measures, administrative measures, and electronic clinical quality measures.*

Source: Greg Howe, Rob Houston, and Tricia McGinnis, *How Health Centers Can Improve Patient Care Through Value-Based Payment Models*, California Health Care Foundation, June 2020.

* *Primary Care Alternative Payment Model Guidebook*, Colorado Dept. of Health Care Policy and Financing, November 2021.

efforts led to the development of a concept paper that DHCS submitted to the Centers for Medicare & Medicaid Services (CMS). DHCS, during discussions with CMS, and in consultation with other California stakeholders, decided not to pursue the pilot because of the complexity of waiving federal PPS equivalency requirements.

Stakeholder planning efforts for the pilot helped foster interest among health plans and FQHCs to build capacity for implementing new payment models, along with the disruption of the COVID-19 pandemic, which led to the creation of a new planning process launched by DHCS in April 2021. The new planning process included convening a workgroup of state stakeholders and engaging an actuarial firm to help with model design and rate setting. FQHC APM was informed by input from a broad array of other stakeholders, including:

- ▶ California Association of Public Hospitals and Health Systems
- ▶ California Primary Care Association
- ▶ California Hospital Association
- ▶ California Association of Health Plans
- ▶ Local Health Plans of California
- ▶ Several individual Medi-Cal MCPs and FQHCs

The process resulted in FQHC APM, a significant departure from the current PPS rates.

DHCS is planning to submit a State Plan Amendment to CMS in late 2023 to seek approval to implement FQHC APM, with a proposed implementation date of January 1, 2024. See Table 3 for a timeline of the FQHC APM rollout.

Table 3. Timeline for the FQHC APM Rollout

2023						2024
JAN./FEB.	MAR.	JUNE	AUG.	OCT.	NOV.	JAN.
Jan. 31: ▶ FQHCs submit applications to DHCS Mercer analyzes encounter data for applications submitted	Meeting with MCPs to discuss recommendations Mar. 31: ▶ FQHCs selected	Draft APM PMPMs released	Aug. 1: ▶ Interim scope change due (if applicable) ▶ Last date to withdraw from APM	Medicare Economic Index released	Final APM PMPM released	Go live!

Source: [Federally Qualified Health Center Alternative Payment Model \(FQHC APM\) Overview](#) (PDF), DHCS, September 30, 2022.

Guiding Principles of the FQHC APM

DHCS, in consultation with the workgroup (see description above), identified the following principles to guide the development and implementation of the FQHC APM.

Payment modernization should support:

- ▶ Patient-centered care allowing members to receive needed services conveniently
- ▶ Alignment of measures in CalAIM (California Advancing and Innovating Medi-Cal), Medi-Cal managed care, and pay-for-performance programs to ensure greatest impact in quality targets
- ▶ Data-informed innovation that encourages deeper health information exchange between MCPs and FQHCs
- ▶ Integrated whole-person care, including physical, behavioral, and oral health, and long-term services and supports
- ▶ Delivery reform focused on value, outcomes, and investing in early intervention and primary care resulting in per capita cost decreases to the larger Medi-Cal program
- ▶ Flexibility for FQHCs to reduce disparities and to address member needs, including social determinants of health (SDOH)
- ▶ Reduced administrative burden, consistent and timely payment, and a strong and resilient safety net in California

Source: [Federally Qualified Health Center Alternative Payment Model \(FQHC APM\) Overview](#) (PDF), DHCS, September 30, 2022.

Defining FQHC APM

Who Participates?

Participation in FQHC APM is voluntary for FQHCs, per federal regulations, and FQHCs with multiple sites with different PPS rates can choose which sites are included as long as all sites with the same PPS rate are included or excluded. FQHCs [apply](#) and are selected based on [DHCS criteria](#).² If a site is selected and there are intermittent sites affiliated with that site, then those intermittent locations must be included in the APM. While it is optional

for FQHCs to apply and participate if selected, Medi-Cal MCPs will be required to reimburse participating FQHCs under the FQHC APM payment provisions.

Core Components

The components of FQHC APM are described in detail throughout this guide. Table 4 provides an overview of the core components of the model (see next page).

Table 4. Overview of FQHC APM*

AREA	KEY PROVISIONS
Voluntary	<ul style="list-style-type: none"> ▶ FQHCs must apply and be accepted to participate in the APM. ▶ FQHCs may withdraw from the program both before and after contract start, subject to providing sufficient notice to DHCS.
Payment	<ul style="list-style-type: none"> ▶ The APM provides prospective, predictable payments. ▶ The APM allows flexible use of resources to enable and drive delivery system transformation. ▶ The APM PMPM will replace PPS, incorporating several payment streams that were previously separate: <ul style="list-style-type: none"> ▶ Health plan capitation or fee-for-service payments to the FQHC ▶ DHCS wrap-cap payments to the FQHC to cover the difference between health plan payments and PPS (and any reconciliation payments) ▶ DHCS PPS payments to the FQHC for visits from health plan members not assigned to the FQHC ▶ Payment to FQHCs must be at least equal to what would have been received under PPS.
Services/Payments	<ul style="list-style-type: none"> ▶ Includes primary care, non-specialty mental health services, specialty care (cardio, ophthalmology, dermatology) included in the PPS rate and paid by the MCP, podiatry, chiropractic (to the extent it's in MCP contract). ▶ Excludes dental, specialty mental health, Enhanced Care Management (ECM), and Community Supports. ▶ APM PMPM distinct from Medi-Cal MCP pay-for-performance programs; intended to complement rather than supplant.
Populations	<ul style="list-style-type: none"> ▶ The APM applies only to Medi-Cal managed care enrollees; FFS program remains unchanged. ▶ Dually eligible (full and partial) members excluded.
Data Reporting	<ul style="list-style-type: none"> ▶ All encounter data, including alternative care Current Procedural Terminology (CPT) codes, will be submitted to contracted health plans.
Quality and Access Expectations	<ul style="list-style-type: none"> ▶ FQHCs must maintain a floor of 70% PPS visits and alternative care services. ▶ FQHCs will be required to meet performance targets for two measures from six domains (12 metrics in total) that will be tied to payment. An additional domain, "Patient Experience of Access and Care," will have two metrics for reporting only. ▶ FQHCs will be subject to a corrective action plan, a 5% penalty, or removal from the program for not meeting quality measures.

* Table developed with information provided by Jill Yegian in the presentation to the CHCS FQHC APM Implementation Guide Advisory Group meeting, December 16, 2021, and later revised using [Federally Qualified Health Center Alternative Payment Model \(FQHC APM\): Overview](#) (PDF), DHCS, September 30, 2022.

Key Definitions

- ▶ **Alternative touches.** Services not currently considered encounters under PPS but that are activities designed to increase patient engagement, improve patient outcomes, and generally allow better coordinated and integrated care.
- ▶ **Assigned patient.** A patient assigned to your health center by the MCP under FQHC APM.
- ▶ **Pay-for-transformation payment (or wedge).** The amount of PMPM payment in excess of the number of encounters. Calculate as the historic encounter utilization priced at the current PPS rate minus the current encounter utilization priced at the current PPS rate.
- ▶ **PMPM.** Per-member per-month payment for each assigned patient in your health center.
- ▶ **Quality metrics.** The set of 12 measures (at least two measures from each of six domains) that your health center will be required to report on to ensure that it is meeting the quality goals for FQHC APM. Performing well on quality metrics allows your health center to keep the pay-for-transformation payment (or wedge).
- ▶ **Risk stratification.** A technique for systematically categorizing patients based on their health status and other factors. It allows practices to manage patients based on their assigned risk level to make better use of limited resources, anticipate needs, and more proactively manage their patient population.*
- ▶ **Team-based care.** Patient care delivered by and coordinated among two or more members of the care team that addresses a patient's physical, behavioral, and social needs. The care team could include providers, and licensed and unlicensed staff.

* James Dom Dera, "[Risk Stratification: A Two-Step Process for Identifying Your Sickest Patients](#)," *Family Practice Management* 26, no. 3 (May/June 2019): 21–26.

SECTION 2.

An Overview of Financial Incentives in FQHC APM and What They Mean for Your Health Center

IN THIS SECTION

- ▶ FQHC APM: Adopting a New Approach with New Financial Incentives
- ▶ Counting Traditional Encounters Under FQHC APM
- ▶ Alternative Touches
- ▶ Populations Included in FQHC APM
- ▶ Financial Success Under FQHC APM
 - ▶ Overview of Assignment
 - ▶ Assignment and the Role of MCPs
 - ▶ PMPM Rates
 - ▶ Quality Adjustment
- ▶ The Bottom Line
- ▶ Additional Financial Considerations
 - ▶ Understanding Your Current Financial Situation
 - ▶ Payer Mix
 - ▶ Tracking and Managing Utilization

FQHC APM: Adopting a New Approach with New Financial Incentives

In FQHC APM, your health center will need to alter the way it conducts business to maximize its financial success. The fundamental change in the FQHC APM program will be the shift away from encounter-based billing practices under PPS toward one that manages care and utilization under an established PMPM budget. If your health center does not already receive a PMPM from MCPs, this shift will discourage increasing the number of traditional encounters your center has per patient, instead incentivizing your health center to provide comprehensive care using the methods (virtual, home) and

staff (nurses, medical assistants, community health workers) best suited to your patients' needs.

While some aspects of the FQHC APM financial model are still under development, the overall thrust is clear: The incentives in the model aim to provide patients with the right care at the right time, addressing patient care needs through flexible approaches and avoiding unnecessary and preventable visits. This section of the guide will focus on helping you understand the incentives in place under FQHC APM, which will enable your center to make the necessary care management transformations, build the data infrastructure, and ready your organization for the APM. More information on what financial success looks like under FQHC APM is included later on in this section.

Counting Traditional Encounters Under FQHC APM

Even though the PMPM payment structure represents a significant departure from the PPS structure, the PPS framework will still determine PMPM rates (more information below on how this will work). Therefore, your health center will still have to track and document traditional encounters to ensure that you are meeting program requirements and that you receive appropriate reimbursement even if the number of encounters falls.

While DHCS understands that FQHC APM could reduce the number of traditional encounters per patient for each health center due to the new financial incentives in place, it also wants to make sure that care will not be rationed or withheld. Therefore, under the proposed FQHC APM requirements, your health center must prove that it is providing at

Table 5. A Comparison of PPS and FQHC APM Payment Models

ITEM	PPS	FQHC APM
Profit motivation	Volume	Value
Revenue source	Payment for each encounter	PMPM payment for each assigned patient
How to increase revenue	Perform as many billable encounters as possible	Serve as many assigned patients as possible, improve efficiency and quality performance
Quality component	Optional, if agreed to by FQHC and MCP	Mandatory, offers financial incentive
Can the FQHC make less than PPS rate?	No	No
Potential perverse incentives	Performing encounters that deliver no value to the patient; having patients schedule multiple in-person or virtual visits so that more encounters are created	Withholding needed care from patients; receiving funding without transforming or improving care

Source: Author's comparison of PPS and FQHC APM payment models, California Federally Qualified Health Centers Alternative Payment Model Implementation Guide, California Health Care Foundation, 2023.

least 70% of the encounters it was before its entry into the FQHC APM. To do that, your FQHC will need to continue to count encounters. In addition to encounters, your health center must also document “alternative touches” that can count toward this 70% threshold (more information below on alternative touches). If the number of traditional encounters plus alternative touches drops below the threshold, the first step will be for DHCS and the FQHC to investigate why (e.g., data reporting anomalies, staffing issues, etc.) and to settle on a performance improvement plan and timeline. If access thresholds are not achieved after the performance improvement plan timeline, your FQHC may receive a financial penalty or be asked to leave the FQHC APM.³

Alternative Touches

Alternative touches are services not currently considered encounters under PPS but are activities designed to increase patient engagement, improve patient outcomes, and generally allow better coordinated and integrated care. There are five proposed domains of alternative touches: communication, education, case management, community supports, and care team support. Please note that these domains and alternative touches are proposed but not finalized. Section 3 addresses how your health center can deliver alternative touches.

Populations Included in FQHC APM

FQHC APM is focused on Medi-Cal patients, but it is important to note that your health center will not be reimbursed for all Medi-Cal patients who enter the health center under the FQHC APM framework. A subset of patients would continue to receive services under the traditional PPS reimbursement

model. Medi-Cal patients who would not be covered under the FQHC APM include:

- ▶ Medi-Cal FFS enrollees
- ▶ Individuals dually eligible for Medicare and Medi-Cal services
- ▶ Patients enrolled in a non-contracted MCP who visit the health center. In this circumstance, the health plan will pay the full PPS rate to the health center.

Ideally, care would be delivered to Medi-Cal patients who are not part of the FQHC APM reimbursement structure in a manner consistent with the patient-centered incentives in FQHC APM. Even without the financial incentives contained in FQHC APM, your health center can choose to optimize revenue for non-FQHC APM patients and serve them in a more patient-centered manner as described in this guide. This decision will likely happen on a center-by-center basis and be informed by the number of patients your health center serves from these populations, the overall financial health of the health center, the administrative systems in place to manage different financial incentives across the organization, and other factors. Before deciding to participate in FQHC APM, your health center may want to analyze the percentage of existing patients whose care will be covered under FQHC APM, which can help determine your health center's approach to implementing the model.

Financial Success Under FQHC APM

The FQHC APM payment model will create a different set of incentives to provide optimal care to the patients you serve. Instead of providing your health center with encounter-based payments, which incentivizes your FQHC to maximize the number of

traditional encounters, FQHC APM will provide a monthly PMPM payment for your center's assigned patients that provides a consistent and predictable revenue stream.

"We're now looking to get more Medicaid lives to cover, not chasing more encounters."

—FQHC chief administrative officer (CAO), Colorado

The way to maximize revenues under such a model is not to maximize encounters with patients, but instead to keep patients well so they do not need to go to your FQHC as often, thus freeing up availability to serve more patients and receive additional PMPM payments for newly assigned patients. Your health center will also be incentivized to provide high-quality care through a quality measurement and accountability structure. It will be important to engage assigned but not yet seen patients who may not have established relationships with your health center, particularly to meet quality measures that require preventive services. The structure of the payment model will allow greater flexibility for your center to provide necessary care to those patients you serve, which will be discussed in more detail later in this guide.

Under the currently proposed FQHC APM payment model, your FQHC's Medi-Cal revenue will depend on three primary factors:

1. Patient assignment.
2. PMPM rates.
3. A quality adjustment.

The relationship between these factors and revenue are shown in Figure 1. FQHC APM Revenue Formula and explained below (see next page).

Figure 1. FQHC APM Revenue Formula



Source: Author's visual representation of the FQHC APM revenue formula in the California Federally Qualified Health Centers Alternative Payment Model Implementation Guide, California Health Care Foundation, 2023.

Overview of Assignment

The cornerstone of your FQHC's revenue stream under FQHC APM will be its assignment of patients, which will determine **the number of PMPM payments your health center will receive**. Your contracted MCPs will assign patients to your health center and determine the factors and methodology under which to assign a patient to your FQHC. Thus, your center will have less control over day-to-day revenues under FQHC APM than it did under PPS. It is also important to note that under the proposed FQHC APM assignment methodology, your center will not receive a PMPM or separate PPS reimbursement for Medi-Cal managed care members enrolled in a contracted MCP who are not assigned to your center yet receive care at your center. Instead, care for these managed care members will be incorporated into your PMPM rate for those patients assigned to your health center over time.⁴

Assignment and the Role of MCPs

Because the MCP will have greater influence over your FQHC's revenue stream under FQHC APM, building a trusting and equitable relationship with the MCP will be crucial for the financial viability of your health center (see Section 6 for more information on building relationships with MCPs).

Since assignment will be so impactful for your center's revenue under FQHC APM, it is in your best interest to speak with the MCPs you work with as soon as possible to fully understand their

methodologies for assignment, including how patients are assigned and reassigned to providers. It is likely that many MCP members are already assigned to your FQHC in some way — such as via primary care provider selection, for quality measurement purposes, or other means — and there may even have been a small financial impact tied to this assignment such as a quality bonus or care management fee. If your center is already participating in such arrangements, it is likely, and possibly preferable, that assignment under FQHC APM would be similar to the existing arrangement. If no such assignment methodology currently exists with an MCP, it would be wise to prenegotiate the framework of such an arrangement ahead of time before signing a new FQHC APM contract. This way, your FQHC can ensure that a potential arrangement with the MCP(s) would be more favorable for your health center than the existing PPS structure.

Even though your MCP partners will have greater influence over your center's revenue, your FQHC does have significant leverage in negotiations with MCPs regarding assignment methodology. Some of these leverage points include:

- ▶ **Explicit program terms.** If your center is participating in FQHC APM, an MCP that chooses to contract with you must pay you in accordance with the program's terms.
- ▶ **More guidance will be coming.** Even though the assignment methodology is not currently

well-defined in state guidance, DHCS is planning to issue standardized contract language and an “All Plan Letter” providing guidance to MCPs outlining elements of the program (see Section 6 for more details on contracting with MCPs). The contract language and guidance may include relevant information for your FQHC when negotiating assignment with MCPs.

- ▶ **Your patients may have a say.** Many MCPs offer patients the opportunity to choose a primary care provider. If they select your center or a provider at your center, that could trigger assignment under such a methodology.
- ▶ **Your center is a valuable provider for your MCP’s network.** While MCPs have quite a bit of power to control how many patients you get paid for, they will likely want to send many patients to your center rather than higher-cost or lower-quality primary care providers, emergency departments, or urgent care practices. In addition, MCPs will be monitored for maintaining access to, and utilization of, primary care under the CalAIM Population Health Management initiative.⁵ The PMPM payment they offer you may also provide the MCP a desirable and predictable cost for primary care, care management, and sick visits.

PMPM Rates

While the assignment methodology is important for determining the number of patients for which your center will receive payment for serving under FQHC APM, the PMPM rate that your health center receives is the payment amount per assigned patient. The rates for your health center will be calculated by DHCS annually. These calculations will initially be based on historical utilization of assigned and unassigned members, trended forward as needed based on program changes, and priced at projected PPS rates. The proposed, though not final, formula for the APM PMPM is:

$$\frac{(\# \text{ of PPS Eligible Visits} - \text{Assigned Members} + \text{Number of PPS Eligible Visits} - \text{Unassigned Members}) \times (\text{current PPS for the FQHC})}{\text{MCP members assigned (member months) to the FQHC}}$$

Note that this proposed approach captures visits to the FQHC by both assigned and unassigned members in the numerator, but the denominator is restricted to plan members assigned to the FQHC APM site.⁶ If your FQHC has multiple PPS rates under the APM, each of those sites would have its own PMPM rate calculated by this formula.

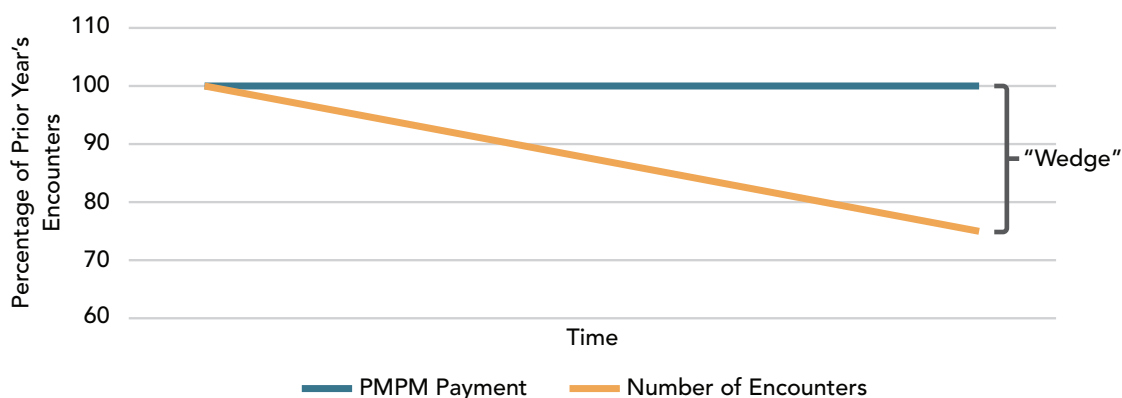
While the PMPM rates will be determined by DHCS, FQHCs cannot ultimately be paid under PPS rates, so if the total cost generated by encounters turns out to be above the projection, your center will be paid the difference annually. This process will likely be similar to current “wrap-cap” processes, as defined by the two-year payment requirement at 42 CFR § 447.45 and 45 CFR § 95, Subpart A.

Pay-for-transformation payments — “the wedge”

Due to the financial incentive to provide fewer encounters, encounters will likely decrease over time, which could lead to lower future PMPM calculations in some cases. To mitigate this possibility, the state has proposed that FQHCs participating in FQHC APM can keep the amount of PMPM payment in excess of the number of encounters as a “pay-for-transformation” payment, also colloquially referred to as “the wedge,” provided that the FQHC meets quality standards (see below for more information on quality incentives). The proposed calculation for pay-for-transformation payments is:

$$(\text{Total payments made through the APM PMPM}) - (\text{Program Period PPS eligible visits} * \text{Program Period PPS rate})$$

Figure 2. Pay-for Transformation Payments, a.k.a. “the Wedge”



Source: Author’s interpretation of the [Federally Qualified Health Center Alternative Payment Model \(FQHC APM\) Overview \(PDF\)](#), DHCS, September 30, 2022.

A graphic depicting the wedge is shown in Figure 2. Pay-for Transformation Payments, a.k.a. “the Wedge”.

It is important to note that pay-for-transformation payments, as currently conceived, are not actually additional dollars that will be paid to your center. You will continue to be paid using the same PMPM, provided that the FQHC meets quality benchmarks. However, if the number of encounters falls as a result of better, more efficient care, the FQHC can keep the wedge amount above PPS, which could represent a significant revenue improvement versus PPS. As a result, your FQHC can increase the size of the wedge by improving its efficiency while maintaining its quality and access to care.⁷ In addition, maximizing the size of the wedge frees up staff time and resources, thus creating virtual capacity that can be used to serve additional patients who, once assigned over time, could bring in greater revenues.

Quality Adjustment

The FQHC APM also holds health centers accountable for quality performance through the FQHC APM’s quality metrics. Your FQHC is probably familiar with pay-for-performance quality metrics, which reward or penalize your organization based on performance on process, outcome, or patient

experience metrics. Many of these metrics may be in your contracts with MCPs, or you may participate in one or more state or federal VBP programs, such as the Medicare Shared Savings Program. While the quality metrics in FQHC APM may not be exactly the same as the ones that you’ve already seen, they can likely be approached in a similar way and should not require extensive changes in the way the data are collected and reported.

“Pilot each component, and pilot everything at one place. Choose the most challenging site because you will be able to identify lots of problems this way.”

—FQHC CAO, Colorado

Proposed quality measures for the program have been aligned with the existing Managed Care Accountability Set. Under the current, proposed “gate and ladder” approach, your health center will be measured on 22 quality measures across six domains, which will be reported to DHCS on behalf of your health center. Three of these measures, as well as an additional “Aggregated Quality Factor Score” calculated from all reported measures, are “gate” measures, and your health center will need

to maintain a baseline score on these measures through its participation in the program. If your health center does not maintain these scores, it is subject to a corrective action plan, a 5% penalty, or removal from the program. Your center can choose 12 “ladder” measures from the list of 22, which will be tied to payment, though you must select at least 2 measures from each domain, except for measures in the Patient Experience of Access and Care domain, which will only be reported and not tied to payment. The proposed, but not finalized, list of 22 eligible measures, with the 3 gate measures indicated, are shown in Table 6 (see next page).⁸

The quality benchmarks FQHCs will need to achieve, and how they will be tied to payment, will change by program year. It is important to note that under the currently proposed structure, there is no additional financial bonus for quality that FQHCs will receive. Rather, performing well on selected quality metrics allows your FQHC to keep the wedge of the PMPM over PPS. If your center performs poorly on quality metrics, you may need to pay a percentage of the excess revenues created by the wedge back to the state. These penalties would not apply if there were no wedge created, and your center will not receive less than what it would have earned under PPS as a result of quality performance. The current proposed approach, which has not been finalized, is as follows:

- ▶ **Year 1.** Reporting only to establish baseline.
- ▶ **Year 2.** Greater than or equal to the 33rd percentile national or state-calculated benchmark (if national benchmarks not available) to retain 100% of the excess revenues above the PPS payments (up to 1% of excess revenues at risk, evenly distributed across all selected metrics).
- ▶ **Year 3.** Greater than or equal to the 50th percentile national or state benchmark to retain 100% of the excess revenues above the PPS payments (up to 3% of excess revenues at risk, evenly distributed across all selected metrics).
- ▶ **Year 4.** Greater than or equal to the 50th percentile national or state benchmark to retain 100% of the excess revenues above the PPS payments (up to 5% of excess revenues at risk, evenly distributed across all selected metrics).
- ▶ **Year 5 and beyond.** Maintaining the minimum previous performance levels in Year 4 with an ongoing continuous performance-improvement program based on gap methodology outlined. The FQHC has the potential to retain up to 100% of the excess revenues above the current PPS payments. The FQHC is at risk for an increasing 1% per year of excess revenues (not to exceed 10% of excess revenues). The potential risk will be evenly distributed across all selected metrics for that calendar year.

Meeting quality improvement targets will likely require your health center to create new interventions or initiatives. Fortunately, FQHC APM’s flexibility incentivizes your center to use strategies such as team huddles and cross-team collaborations that can improve quality performance but would take staff away from earning encounter-based revenues under PPS. In addition to DHCS’s external quality metrics, health centers can also use internal metrics to target staff’s individual performance and progress toward quality goals, efficiency metrics, or both, provided that data are collected at an individual staff level.

Table 6. Proposed FQHC APM Quality Measures

QUALITY CATEGORY	MEASURE NAME
Prevention — Adult	Cervical Cancer Screening
Prevention — Adult	Colorectal Cancer Screening
Prevention — Adult	Breast Cancer Screening
Prevention — Adult	Chlamydia Screening in Women
Access to Care	Child and Adolescent Well-Care Visits*
Access to Care	Well-Child Visits in the First 15 Months. For children who turned 15 months old during the measurement year, Six or More Well-Child Visits
Access to Care	Well-Child Visits for Age 15 Months–30 Months. For children who turned 30 months old during the measurement year: Two or More Well-Child Visits*
Access to Care	Adults’ Access to Preventive/Ambulatory Health Services*
Prevention — Peds	Childhood Immunization Status (CIS 10)
Prevention — Peds	Immunization for Adolescents
Prevention — Peds	Fluoride Varnish
BH Integration	Pharmacotherapy for Opioid Use Disorder
BH Integration	Depression Screening and Follow-Up for Adolescents and Adults
BH Integration	Depression Remission or Response for Adolescents and Adults
Chronic Care	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
Chronic Care	Controlling High Blood Pressure
Chronic Care	Asthma Medication Ratio
Maternity Care	Prenatal and Postpartum Care (Postpartum Care)
Maternity Care	Prenatal and Postpartum Care (Timeliness of Prenatal Care)
Maternity Care	Prenatal Depression Screening and Follow-Up
Maternity Care	Postpartum Depression Screening and Follow-Up
Patient Experience of Access and Care	CG-CAHPS (Consumer Assessment of Healthcare Providers and Systems): Getting Needed Care
Patient Experience of Access and Care	CG-CAHPS: Getting Care Quickly

* Gate measures

Source: [Federally Qualified Health Center Alternative Payment Model \(FQHC APM\): Overview](#) (PDF), DHCS, September 30, 2022.

The Bottom Line

Achieving financial success under FQHC APM will likely require your center to serve a greater number of patients through less or alternative touches or both, while maintaining or improving quality. Doing so would create a wedge that would allow your center to perform better financially than it would under PPS for the same number of encounters. However, it is also important to note that your center cannot perform worse financially under the proposed FQHC APM formula than under the PPS encounter-based model. As Table 7 shows, the only difference in revenues under APM versus PPS is that if the number of encounters decreases, the wedge will keep revenues steady.

Table 7. Effect on Revenue Under FQHC APM and PPS Payments and Utilization

PAYMENT METHOD	NUMBER OF PPS ENCOUNTERS	EFFECT ON REVENUE
PPS	Up	Up
PPS	Steady	Steady
PPS	Down	Down
FQHC APM	Up	Up
FQHC APM	Steady	Steady
FQHC APM	Down	Steady (Creates Wedge)

Source: Author-created table showing the effects of revenue under FQHC APM and PPS payments and utilization in the California Federally Qualified Health Centers Alternative Payment Model Implementation Guide, California Health Care Foundation, 2023.

In addition to creating the wedge, your FQHC could also maximize revenues by increasing the number of assigned patients in future years. This would be easiest to do in conjunction with the wedge, which would create the “virtual capacity” to care for additional patients.

Additional Financial Considerations

The shift from PPS payments to PMPM payments will require significant changes in how you manage your health center financially. Transitioning successfully to FQHC APM will likely require your FQHC to:

- ▶ Understand your current financial situation and how it will be affected by FQHC APM
- ▶ Understand your payer mix
- ▶ More closely track and manage utilization

Understanding Your Current Financial Situation

To develop effective financial strategies to succeed under FQHC APM, you must understand your health center’s current financial situation. This will likely include digging into some elements that your health center is already familiar with, such as your payer mix, as well as some elements that you currently track but may need to track differently to function well under FQHC APM, such as utilization. Your existing financial records should be examined both at a high level (revenue, expenses, profit and loss) as well as an operational level (payer mix, utilization, cost per patient visit, cost per patient) to understand how your center is performing. The more detail you can gain, the more you can understand your current financial structure and performance, which will position you better to succeed under FQHC APM.

Even though the PMPM rates under FQHC APM will be calculated for you, you will need to understand the true costs of providing care under this more predictable revenue stream. For example, it might be helpful to calculate the following:

- ▶ Cost of an average patient visit
- ▶ Average annual cost per patient served
- ▶ Cost of specific intervention or service

- ▶ Cost of alternative touches
- ▶ Percentage of currently served patients that will be included in FQHC APM versus PPS or other payment structures

These values could also be stratified by conditions, demographics, or other criteria to get a more detailed look. Once these values are known, they can be compared with PPS rates, PMPM rates, or other calculations to provide valuable data to help your center understand how it is performing in the new APM. Potential information that might be helpful to calculate include these:

- ▶ Cost of an average patient visit versus PPS rate
- ▶ PMPM rates versus average PPS revenue per patient per month
- ▶ PMPM rate versus (average visits per patient × cost of average patient visit)

These data can help identify high-value services or areas where costs could be streamlined due to greater efficiency, optimized staffing, and other means.

Payer Mix

Your health center's payer mix is an important consideration for participating successfully in the FQHC APM. Due to the nature of most FQHCs' patient populations, Medi-Cal patients who would be included in FQHC APM will likely represent a large proportion of many FQHC's assigned patients, thus providing impetus for organization-wide change of patient workflows, care models, staffing, and financial strategy. However, if your FQHC's Medi-Cal population has many Medi-Cal FFS patients, people dually eligible for Medicare and Medi-Cal, or Medicare, commercial, or uninsured patients who will still be under PPS, implementing such a dramatic organization-wide change for a relatively smaller population under FQHC APM could

be unnecessarily burdensome. Conversely, some FQHCs may consider it a low-risk opportunity to test the PMPM payment model with a small portion of the population.

While your health center's payer mix will likely not change significantly as a result of participation in FQHC APM, the size of your current population eligible under FQHC APM may influence your center's approach to the program. It will also inform your financial plan, as only a portion of your health center's revenue will be coming through the FQHC APM payment structure.

Tracking and Managing Utilization

The most fundamental shift under the FQHC APM payment structure will be how utilization is incentivized. Under PPS, your health center was financially incentivized to have as many encounters with patients as possible, which includes perverse incentives such as providing needed services separately over multiple visits to maximize revenue, which is not optimal, patient-centered care. Under FQHC APM's PMPM structure, the opposite is true. Your health center will be financially incentivized to see patients as little as possible because you will be paid the PMPM whether the patient needs services or not. However, this does not mean that patient access will be reduced under FQHC APM, as the quality metrics in place will help assure that patient care is being delivered efficiently and effectively, and if your assigned patients decide to seek care elsewhere, they may be assigned to other Medi-Cal providers in future years.

"Increase your timeline by a factor of two. It takes more time than you think to plan and implement."

—Oregon FQHC leader

While your health center probably tracks utilization in some way beyond encounters, the way it does so may need to change to reduce costs rather than maximize volume, which may also affect care management workflows. For example, internal policies and procedures may currently call for an in-person follow-up physician visit to discuss test results to generate another billable encounter, but under FQHC APM, your health center may consider providing a more cost-effective phone call from a registered nurse (RN) to follow up with the patient. Your center may also choose to provide preventive care in new ways, such as through group visits (which combine clinical care, health education, and peer support) or home visits. These visits are potentially beneficial, cost-effective, patient-centered services but would not be defined as PPS encounters. Since FQHC APM is not a total cost of care–based payment model that tracks patients’ utilization and costs outside the services provided by the FQHC, your health center will not have its payments adjusted

purely on utilization at other provider organizations (e.g., an inpatient hospital stay). However, because many quality metrics reward positive health outcomes and decreased utilization at high-cost or inappropriate care settings, tracking those activities may be worthwhile as well. See Section 6 for strategies for engaging MCPs and external providers to share data and coordinate care for your patients.

For these reasons, if the majority of your FQHC’s patients are assigned to the FQHC under FQHC APM, your FQHC may want to consider shifting to a cost-based budgeting strategy since revenue will likely be more stable and predictable. Such a strategy would allow your FQHC to optimize efficiency in operations and processes, right-size staffing, and allow staff to practice to the top of their licenses. Analyzing existing processes with this frame of reference may also uncover opportunities to add staff, such as community health workers, peer navigators, social workers, and others.

SECTION 3.

Focusing on Patients, Not Visits

IN THIS SECTION

- ▶ Overview of Care Delivery in FQHC APM
- ▶ Moving to APMs Means Transforming Traditional Care Delivery
 - Set Goals and Measure Your Progress Toward Them
- ▶ Expanding Who, How, and Where You Deliver Care to Best Meet Patient Needs
- ▶ Expanding Who Can Deliver Care
 - New Types of Visits
 - New(ish) Types of Staff
- ▶ Facilitating Team-Based Care Delivery
 - Empanelment
 - Standing Orders
 - EHR Permissions
- ▶ Expanding How Care Is Delivered
 - Phone Calls, Emails, Texts, and Patient Portals
 - Group Visits
- ▶ Expanding Where Care Is Delivered
 - Home Visits
 - Telehealth
- ▶ Managing Care in New Ways
 - Care Management
 - Trauma-Informed Care

Overview of Care Delivery in FQHC APM

Your care delivery model under an APM should be tailored to meet the needs of the individuals and families you care for. However, no organization moving to APMs should be starting from scratch in terms of transforming how care is delivered. If you are ready to move to the APM, you will have already engaged in a fair amount of practice transformation, whether you are a patient-centered medical home, or if over time you have made staffing changes and been engaged in workflow redesign to make care more person-centered and accessible.

Providers means physicians, nurse practitioners, certified nurse-midwives, and physician assistants or others, including some behavioral health professionals like therapists and psychiatrists licensed to diagnose and treat and provide medical or behavioral health care or both. In the traditional FFS/PPS payment model, these providers were the only staff who could bill.

However, you and your team will still want to think about how a change in the way your organization gets paid can help you go further with your care delivery model. For example, what types of care and services can now be delivered by staff other than a provider? What current staff could take on new roles? What kinds of training will they need? This is an opportunity to provide more comprehensive, integrated care for your patients through a team-based approach. Not only will this team-based approach improve access to a wider range of services and care for your patients, it may also ultimately reduce burnout and stress for your staff.

With the implementation of APM, your health center will focus on patients, not visits. Under APM your organization will receive a capitated (fixed) rate for each patient assigned to your health center whether you see them for a visit or not. You will no longer be paid by each visit a patient has with a provider (FFS PPS payments). In the APM, unlike the old FFS PPS model, your organization will benefit financially if your patients have better health outcomes.

The APM payment will be on a PMPM basis for each patient, and your organization will receive a payment adjustment for performance on quality

metrics. Since payment is no longer directly tied to in-person visits with providers, health care operations no longer need to revolve solely around them. Under FQHC APM, some health care patient service revenue will still be tied to visits, but not all of it as previously in the FFS model. This gives you and your team the opportunity to think expansively about what types of care and services will result in better outcomes for your patients. It also allows you to have all staff working at the top of their license for what they were trained to do.

Old Model: Volume-Based / Provider Schedule Driven

- ▶ FFS delivery model
- ▶ Encounter-based billing
- ▶ Hamster wheel
- ▶ Highly variable income



versus

New APM/Value-Based Population Health Approach

- ▶ Capitated model provides flexibility to traditional scheduling and supports team-based care model
- ▶ Can improve provider and staff satisfaction and retention
- ▶ Risk-stratified care model
- ▶ Upside/downside risk contract



Source: Adapted from "Value-Based Care Journey 2012–2022" (Mountain Family Health Centers presentation).

Any population health⁹ work your organization is engaged in will be an important foundation to build on. Staff involved in population health management should be key players in the APM redesign. Any team-based care approaches that you currently use will also be a critical part of your care delivery model and should grow and expand under FQHC APM. Understanding who your patients are, what illnesses they have, what behavioral health conditions they have, and what health-related social needs (HRSNs) they have will be important information to track. You will need data, and you will need to examine and discuss these data with providers and care team staff. Your care model and your staffing model, likely to be a team-based approach to care, should be in response to what you see in the data and should address the specific needs of your specific patients. Nurses, social workers, care managers, care coordinators, and other staff delivering care alongside providers often improves access to a wider range of care and services for your patients.

Moving to APMs Means Transforming Traditional Care Delivery

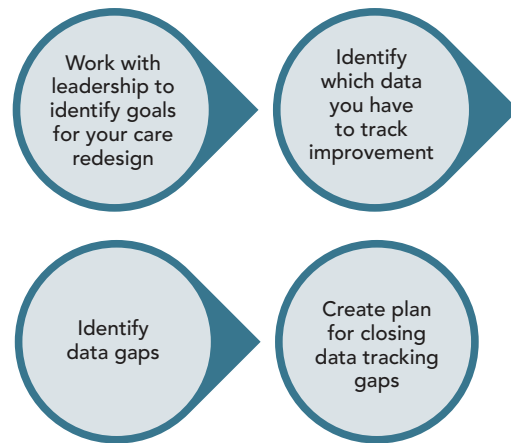
Changing how you deliver care to patients when you are used to doing things a certain way can be hard to imagine. Helping everyone else at your health center change how they have always done things can feel daunting. For tips on getting everyone on board and addressing people’s fear of change, see Section 4. Also, remember that best practice is that you and your colleagues do not change everything all at once. You are not going to do this overnight! Change takes time, and it is important to address this transformation methodically, one part at a time, so that no one feels overwhelmed.

“Take your time, take it slow.”

—FQHC CAO, Colorado

Set Goals and Measure Your Progress Toward Them

When you think about expanding your team-based care delivery model as you adapt APM, it is helpful to first set goals about what you want to accomplish. It is also important to think about how you will track progress toward your goals:



Following are some ideas about what data you might use to measure the success of your redesigned care delivery and staffing model:

- ▶ Quality and patient experience
- ▶ Patient access and care
- ▶ Financial sustainability
- ▶ SDOH / HRSN
- ▶ Health equity–related data including race, ethnicity, language, and disability (RELD)
- ▶ Health disparities
- ▶ Diversity of staff and congruence of race and ethnicity with patients
- ▶ Team composition
- ▶ Team functioning and communication
- ▶ Employee satisfaction including staff perceptions of well-being and burnout

If you choose any, or all, of these areas to focus on, work with your leadership and your team to identify specific goals within each area that you want to address. Make sure to identify how you will measure progress and identify if you already collect certain types of data that could help you track improvement. Try to build on what already exists at your organization. Also, for information on specific metrics that your organization will have to report on for FQHC APM, see Section 2.

One benefit of implementing APM is that it allows you to change staffing and care delivery processes to better meet the needs of families and patients. By expanding how you deliver care and by whom care is delivered, you can address some of the HRSNs of your patients. You also can better integrate behavioral health care services and employ staff with lived experience to connect with the patients and families you serve. These and other care transformation changes give you an opportunity to provide higher quality, comprehensive care that can reduce disparities you may see across your patient population.

It is possible your organization may already have enough data to understand where disparities in outcomes exist for the patients you care for. Using health equity as a focus and working toward meeting specific health equity metrics by collecting RELD data and reducing disparities for specific conditions can also help you and your team think about what types of care and support your patients might need more of. That in turn can help you think about new types of care and what staff might deliver it. Finally, you will need to be able to produce a broad range of internal and external reports that capture the meaningful patient services provided outside of a traditional visit.¹⁰

Expanding Who, How, and Where You Deliver Care to Best Meet Patient Needs

Health center staff who have already transitioned to an APM have underscored that an APM is all about moving to and fully embracing a team-based approach to care. To create high-functioning, interdisciplinary care teams, you and your team will want to think about expanding roles of current team members, establishing competencies for new roles, recruiting additional staff, and assessing training needs. It would also be valuable to think about career ladders and opportunities for staff such as medical assistants (see page 28) regarding Mosaic Medical's approach to MAs), community health workers, and any supervising changes or approaches that may be needed.

Expanding Who Can Deliver Care

In states where FQHCs are already being paid under APMs, a core part of FQHC care transformation has been the expansion of the types of care being delivered by an interdisciplinary care team. You will want to clearly identify new roles and responsibilities for nonprovider staff who may now be asked to do things they did not do previously or that they provided before only as part of a visit with a provider. While you want to try to have everyone working to the top of their license, you'll also want to make sure you are not asking anyone to conduct duties that they are not licensed to perform.

To think more about this, here is an example that the Institute for Health Care Improvement uses in "[Team-Based Care: Optimizing Primary Care for Patients and Providers](#)"¹¹ to illustrate how work can be shared by different members of a team:

Let's consider the example of a diabetic patient. Does a physician need to do their foot exam? No, a nurse can do the initial assessment. Does

a physician need to be the one to discuss their dietary requirements and restrictions? No, in fact, a dietitian — given the specialization of their training — might be a more effective educator. By reassigning these responsibilities to other care team members, the physician can then spend more time focusing on what matters most to patients, such as communicating with patients, collaboratively setting goals, or using their expertise for more serious conditions.

Make sure that what you are asking staff to do is congruent with what they are licensed or regulated to do. If you do not have these already, you may want to develop competencies for each clinical role in your organization. Staff can then be trained and/or assessed on these competencies. This may be something you want in your onboarding process with new staff as well. Even staff licensed to provide certain types of care or to perform certain tasks may need additional training or a refresher if they are going to handle different responsibilities than they had previously. Do not run the risk of assuming staff can make this transition just because you ask them to.

Without support and training you may find staff blocking your efforts because they are fearful or not feeling confident about what they are being asked to do. It is also good to know that different staff may have different concerns. For example, providers may need time before they fully trust that some tasks they may have done are now being done by other clinical and support staff. And nurses and medical assistants, for example, may worry that this change means they will be asked to take on even more work than they already do. Take the time to talk to staff about their concerns and to observe how changes are impacting workflow and workload. But remember, staff taking on new tasks and roles may also be a very positive opportunity for them to grow and attain skills. Many clinics report that this increase in responsibilities has frequently

improved staff satisfaction and reduced turnover at their organization.

Here are some additional ideas about staff that you may want to consider adding to your interdisciplinary care teams to provide higher quality, person-centered care that can meet your population health goals. Key roles include:

- ▶ Behavioral health staff: therapists, social workers, peer counselors
- ▶ Pharmacists/PharmDs
- ▶ Nutritionists, educators
- ▶ Care managers
- ▶ Care coordinators
- ▶ Community health workers

See the upcoming section *New(ish) Types of Staff* for more information.

Finally, if your organization is unionized, you may want to check in with union representatives as applicable before these changes start. It is important to ensure that the union supports any transitions for staff in terms of their roles or tasks.

New Types of Visits

Nurse encounters

LVNs and RNs can play a significant and important role in team-based primary care, taking over substantial amounts of care and services that may have previously been unnecessarily handled by providers.¹² Having nurses take on tasks and care they can handle can free up providers to manage care for patients with more serious or complicated medical issues.

RN Visits at Mountain Family Health Center (Colorado) Under APMs

- ▶ Goal: 30% of visits seen by RNs
- ▶ 11–12 visits a day
- ▶ Call center screens patients to determine if they need to see a provider or can be seen by a nurse
- ▶ A nurse facilitator reviews the nurse panel/schedule each day
- ▶ Maintains separate RN and medical assistant (MA) schedules

To get ideas about what expanded roles LVNs and RNs might play in your clinic, the following are examples of roles of RNs in exemplary primary care practices:¹³

- ▶ Complex care management
- ▶ Facilitating prescription renewals
- ▶ Patient education
- ▶ Care coordination, including transitions of care support when patients are moving between acute care settings such as hospitals into primary care and to home
- ▶ Chronic disease management
- ▶ Planning and coordinating care with the clinical team

Medical assistant encounters

Medical assistants (MAs) are key staff in a team-based primary care model, and using them to their full capabilities can benefit both patients and MAs. Organizations who expand roles for MAs have reported improved patient satisfaction measures, and MAs who have played an increased role in the delivery of team-based primary care, although reporting higher workloads, state that they have greater job satisfaction.¹⁴ Moving to APMs also

presents an opportunity to create a career ladder for MAs, which can help reduce turnover and further increase job satisfaction.¹⁵

Resources: Expanding Medical Assistant Roles

- ▶ [New Roles for Medical Assistants in Innovative Primary Care Practices¹⁶](#)
- ▶ [An Expanded Role for the Medical Assistant in Primary Care: Evaluating a Training Pilot¹⁷](#)
- ▶ [How to Train Medical Assistants for Expanded Roles: AHRQ Webinar¹⁸](#)

Medical assistants are unlicensed personnel, and in California their scope of practice includes the following:¹⁹

- ▶ Administering medication only by intradermal, subcutaneous, or intramuscular injections (including flu and pneumonia shots)
- ▶ Administering medication orally, sublingually, topically, vaginally, or rectally, or by providing a single dose to a patient for immediate self-administration
- ▶ Administering by inhalation if medications are patient-specific and have been or will be routinely and repetitively administered by patient
- ▶ Performing venipuncture or skin puncture (including “finger sticks”) for the purpose of withdrawing blood
- ▶ Performing skin tests
- ▶ Measuring and describing skin test reaction and making a record in the patient’s chart
- ▶ Performing electrocardiograms

- ▶ Applying and removing bandages and dressings
- ▶ Taking blood pressure and glucose monitoring readings
- ▶ Performing pregnancy and HIV testing

Oregon’s Mosaic Medicals’ Investment in Medical Assistants

Mosaic Medical developed a systemic, tiered program to provide opportunities and career growth for MAs after APM was implemented. Before doing so, MA advancement was not standardized and was not well-resourced. Mosaic Medical noticed the critical value that MAs have in team-based care and invested in them by developing MA training, competencies, and opportunities for MAs systemically (rather than by clinic). They also created an MA supervisor role to support MAs and to manage the program.

Interviews with other organizations that have implemented the APM at their FQHC stressed the importance of developing a standardized, tiered program for different levels of MA roles. Additionally, investments in training, competencies, and clear articulation of how MAs can advance in their roles was viewed as particularly important for successfully implementing different levels of roles for MAs.²⁰

New(ish) Types of Staff Community health workers

The American Public Health Association defines a community health worker (CHW) as a frontline public health worker who is a trusted member of a community or someone with a thorough understanding of the community being served.²¹

Resources: Incorporating CHWs in FQHCs

- ▶ [Including Community Health Workers \(CHWs\) in Health Care Settings \(PDF\)](#)²²
- ▶ [Community Health Worker Core Consensus Project: CHW Assessment Toolkit \(PDF\)](#)²³
- ▶ [Community Health Worker Core Consensus Project](#)
- ▶ [Strategies to Improve the Integration of Community Health Workers into Health Care Teams: “A Little Fish in a Big Pond”](#)²⁴
- ▶ [Integrating Community Health Workers into Primary Care to Support Behavioral Health Service Delivery: A Pilot Study](#)²⁵
- ▶ [Integrating Community Health Workers on Clinical Care Teams and in the Community](#)²⁶

CHW is a broad term that includes *promotores de salud*, health advocates, peer health advisors, and health navigators.²⁷ One of the most important things that CHWs bring to a care team in addition to their interactions with patients and families is their lived experience (behavioral health, justice-involved, etc.) and perspective. If you do not already use CHWs at your organization, you may want to consider doing so under the APM. You can hire them into your organization, or you can partner with a local CHW organization to provide this type of support. CHWs can be an excellent way to address patients’ health-related social needs, and to build and maintain trust with the people you care for — critically important if you are trying to reduce health disparities and drive more equitable care.

But bringing on new staff, particularly unlicensed staff, to work with patients and to be part of an interdisciplinary care team can be challenging if you do not have a clearly thought-out plan beforehand. You will want to have a strong grasp of what needs

to be in place before CHWs join your care teams. Questions regarding the role of CHWs should be discussed at both the leadership and the care delivery level.

Following are some best practices.

How to help CHWs integrate successfully into primary care teams

- ▶ Provide clarity around the role of the CHWs and other members of the health care team to avoid confusion and service duplication, avoid the tendency of providers to “dump” tasks on the CHW,²⁸ and help avoid bias from other care team members, especially for CHWs with lived experience (e.g., behavioral health, justice involvement, etc.).
- ▶ Ensure opportunities for CHWs to share with the team their unique perspectives and understanding of the community and the value of community linkages.²⁹
- ▶ Allow CHWs to access and contribute to care team notes in electronic health records.³⁰
- ▶ Engage leadership champions to educate staff about the role of the CHW before and throughout CHW program implementation.³¹
- ▶ Set up a standard way to assess CHWs’ skills.
- ▶ Offer individual caseloads for CHWs instead of shared patients/clients to avoid duplicating the work of other care team members.
- ▶ Provide training and structured supervision for CHWs and include them in team meetings.³²

Determining Core Roles and Core Skills of CHWs

Since clarity around the role of CHWs is a best practice for successful integration and acceptance onto a care team, you will want to clearly identify what

the CHWs will do and what their core skills are to them and to care team staff. The Community Health Worker Core Consensus Project identified 10 core roles and 11 core skills for CHWs.³³

Core Roles

1. Cultural mediation among individuals, communities, and health and social service systems
2. Providing culturally appropriate health education and information
3. Care coordination, case management, and system navigation
4. Providing coaching and social support
5. Advocating for individuals and communities
6. Building individual and community capacity
7. Providing direct service
8. Implementing individual and community assessments
9. Conducting outreach
10. Participating in evaluation and research

Core Skills

1. Communication
2. Interpersonal and relationship building
3. Service coordination and navigation
4. Capacity building
5. Advocacy
6. Education and facilitation
7. Individual and community assessment
8. Outreach
9. Professional and conduct
10. Evaluation and research
11. Knowledge base

Your CHW program is more likely to succeed if the perspectives of CHWs, who know their own roles and unique challenges within the target populations and the community, are considered.³⁴ Periodically, sharing the success of CHWs with CHC leadership and the entire care team gives value and credibility to the CHW profession. Demonstrating the results of their work fosters respect within the care team and supports the sustainability of these positions.³⁵

Pharmacists and Pharmacy Technicians

Many FQHCs use, or are starting to use, pharmacists and/or pharmacy technicians (pharm techs) as key members of the interprofessional primary care team. These clinical staff can play an important role in the care of those with chronic and acute conditions. Some of the results that FQHCs have seen with the use of pharmacists and pharm techs included improved medical outcomes, achievement of clinical metrics, helping clinics reach national standards, and increased patient access to care and medication.³⁶ Pharmacists and pharm techs may be especially useful in providing medication therapy management (MTM), a multifaceted approach of reviewing medications, identifying and remedying medication-related problems, providing disease state management and self-management education, addressing medication adherence issues, and considering preventive health strategies to optimize medication-related health.³⁷ The use of pharm techs as part of primary care teams has also been noted to reduce total cost of care by reducing acute care utilization costs.³⁸

If you use pharmacists and/or pharm techs, you will want to think about how you can best support their success in your FQHC and as members of your care teams. Some tips for thinking about approaching this include securing physician and provider leadership commitment to this staffing model, identifying high risk populations for interventions, and working closely with clinic staff to integrate pharmacists and/or pharm techs into clinic workflow.³⁹

If you use pharmacists, you will want to think about how you can best support their success in your FQHC and as members of your care teams.

Resources: Incorporating Pharmacists in FQHCs

- ▶ [Pharmacist Care in Federally Qualified Health Centers: A Narrative Review⁴⁰](#)
- ▶ [Pharmacists in Federally Qualified Health Centers: Models of Care to Improve Chronic Disease⁴¹](#)
- ▶ [Integration of Pharmacy Teams into Primary Care](#)

What helps pharmacists integrate successfully into primary care teams?

- ▶ Clinicians directly referring patients to pharmacists
- ▶ Patient visits with pharmacists separate from dispensing functions
- ▶ Availability of private rooms for pharmacist and patient meetings
- ▶ Clinicians' prior experience collaborating with pharmacists on patient care, and pharmacists with experience providing comprehensive MTM
- ▶ Educating nonclinicians and other clinic staff on MTM (what it entails, what its benefits are)
- ▶ Educating patients and clinicians on the role of pharmacists to improve understanding and participation⁴²

Facilitating Team-Based Care Delivery

Empanelment

Empanelment is the act of assigning patients to certain primary care providers (PCPs) and care teams, with sensitivity to patient and family preference. Under APM it also can apply to RNs, LVNs, and MAs, who also may have a group of patients who like to see them when those patients need their services. Patients can reliably visit or have an appointment with their same provider or staff person any time they need care. Empanelment is the basis for population health management, and it prioritizes the relationship that patients have with clinical staff as a critical part of high-quality care. The goal of focusing on a population of patients is to ensure that every established patient receives optimal care, whether or not they regularly come in for visits. Accepting responsibility for a finite number of patients, instead of the universe of patients seeking care in the practice, allows the provider and care team to focus more directly on the needs of each patient.⁴³

Resources on Empanelment

- ▶ [Empanelment: How to Form Patient Panels in Primary Care](#)⁴⁴
- ▶ [Safety Net Initiative, Empanelment: Establishing Patient-Provider Relationships \(PDF\)](#)⁴⁵

Standing Orders

Standing orders authorize nurses, pharmacists, and other appropriately trained health care personnel, where allowed by state law, to assess a patient's immunization status and to administer vaccinations according to a protocol approved by a medical director in a health care setting, a physician, or another authorized practitioner. Standing orders work by enabling assessment and vaccination of the patient without the need for clinician examination

or direct order from the attending provider at the time of the interaction.⁴⁶ Many organizations have set up standing orders to help streamline the delivery of care. Some examples of how this can work include standing orders for:

- ▶ Immunizations, flu and COVID vaccines
- ▶ Lab testing
- ▶ Routine screenings such as mammograms and fecal immunochemical testing for colorectal cancer
- ▶ Pregnancy testing
- ▶ HIV testing

EHR Permissions

Depending on how your EHR permissions were set up before APM, you may need to update them so that non-provider staff can document in the appropriate places in your EHR. See Section 5 for more information about EHRs.

Expanding How Care Is Delivered

Phone Calls, Emails, Texts, and Patient Portals

Communicating with patients outside of office visits might have been discouraged under the old PPS payment model. With the APM there is no reason to not communicate with patients by phone, email, patient portal, or text (assuming it can be done securely), especially if it may help them with their health issues.

Telehealth Visits and Phone Calls Can Help Relieve Stress for Providers

One FQHC in Oregon set up blocks of telephonic visits for each provider so that they got a break from seeing patients with complex health needs all day long.

Billing and payment are not connected to in-person visits under APM; improving health for your patients is. If it is clinically indicated, patients should be brought into the office. However, if care or advice or a consultation can just as easily be delivered by phone, telehealth, or through secure messaging, it should be provided that way. Patients who call the clinic can be offered the option of a telehealth visit or phone call rather than being required to make an appointment for an office visit.

Group Visits

Group medical visits are a clinic-based intervention that aims to improve patient health by combining clinical care, health education, and peer support. Research shows that group visits can provide a way for patients and providers to interact that can positively impact health care inequalities.⁴⁷ Group visits, in addition to providing medical care, can provide the added benefit of community and support. This peer support may have lasting benefits for people's health and help those managing a chronic condition to be able to engage in better self-care.

Resources: Group Visits

- ▶ [Group Medical Visits as Participatory Care in Community Health Centers⁴⁸](#)
- ▶ [Integrated Center for Group Medical Visits](#)
- ▶ [Comparing Two Approaches to Group Medical Visits for Patients with Diabetes⁴⁹](#)
- ▶ [Example of Diabetes Group Visits Curriculum from Serve the People Health Center \(PDF\)⁵⁰](#)
- ▶ [Centering Pregnancy Care⁵¹](#)
- ▶ [SAMHSA Resources on Group Therapy for Substance Abuse⁵²](#)
- ▶ [Guide for Clinicians Leading Substance Abuse Group Therapy⁵³](#)

Group therapy visits can also be helpful for those with behavioral health diagnoses, and research shows that group therapy is just as effective — if not more so — than individual therapy.⁵⁴ There are two predominant kinds of group psychotherapy. In a heterogeneous group, people with different symptoms and diagnoses come together and explore their interpersonal relationships via the social microcosm of the group; for example, a Black women's group that focuses on single parenting, or a men's group that focuses on substance use. In homogeneous groups, currently the most popular group therapy format, people come together to explore their shared problem or diagnosis.⁵⁵

Some examples of common conditions that group visits can focus on include:

- ▶ Substance use disorder
- ▶ PTSD
- ▶ Grief
- ▶ Dealing with specific physical illnesses
- ▶ Anxiety
- ▶ Depression
- ▶ Bipolar disorder
- ▶ Caregiving
- ▶ Eating disorders

Resources: Home-Based Services

- ▶ [ACOs Use Home Visits to Improve Care Management, Identify Needs, and Reduce Hospital Use⁵⁶](#)
- ▶ [The Team Approach to Home-Based Primary Care: Restructuring Care to Meet Patient, Program, and System Needs⁵⁷](#)
- ▶ [Four Tips for Adding House Calls to Your Practice⁵⁸](#)

If you have previously done group visits, you know that these visits have always required that the provider signs off on every patient so that all the patients can be billed for. You will no longer need to do this. But when considering implementing group visits at your center, think about what makes the most sense given the types of patients you care for and examine your clinic data if you need help thinking about what kind of group visits or sessions might help your patients specifically.

Expanding Where Care Is Delivered

Under FQHC APM, you will have more options in how and where care is delivered. For example, certain types of care or services can now be delivered in the home. This approach can improve patient and family engagement and can significantly improve outcomes for those patients who may have trouble coming to the office.

Home Visits

APMs allow you to deliver care outside of the walls of the clinic. You and your team will want to think about what care and services can be delivered only in the clinic and what might be better delivered in the home, or at least provided as an option to be delivered at home. Home visits can also be useful for providing care management and transition of care support to those who have recently come

home from the hospital or other acute or long-term care facilities.

Primary care provided in the home can increase access and reduce risks for certain high-risk populations who have complex health or social needs or both. In particular, homebound, and functionally limited patients, may have significant challenges accessing office-based primary care.⁵⁹ According to a Home-Based Primary Care Interventions Systematic Review by AHRQ, home-based primary care can better address the needs, values, and preferences of chronically ill, frail, and disabled patients who have difficulty accessing traditional office-based care.⁶⁰ The potential benefits of home-based primary care include:

- ▶ Increased access to care for people who have difficulty traveling to outpatient medical offices or for whom going to a medical office is contraindicated
- ▶ Better understanding of patients' environments, needs, and constraints that can improve care and outcomes
- ▶ Decreased hospitalizations and urgent care use when acute incidents are prevented or addressed in the home
- ▶ Potential for prevention or slowing of functional and cognitive decline
- ▶ Better support for and reduced burden on family caregivers
- ▶ Increased satisfaction of patients and providers⁶¹

According to the American Academy of Family Physicians, the best candidates for home visits are patients with complex or high-risk conditions who have difficulty getting to the office, including:

- ▶ Frail older adults with multiple (often five or more) chronic conditions and deficiencies in activities of daily living

- ▶ Younger homebound patients, usually with one principal neuromuscular condition such as multiple sclerosis, amyotrophic lateral sclerosis, or cervical spine injuries (some on ventilators)
- ▶ Patients with high-risk diagnoses like congestive heart failure and chronic obstructive pulmonary disease
- ▶ Patients with high hospital and emergency department (ED) utilization in the past 6 to 12 months
- ▶ Patients with [hierarchical condition category \(HCC\) scores](#)⁶² greater than 2.0
- ▶ Postacute transitional care management patients who would benefit from a short course of home-based primary care that reduces complications and readmissions⁶³

Telehealth

Although the California legislature approved parity of phone and video visits with in-person visits⁶⁴ so these visits were reimbursable as PPS visits, moving to the APM can be an opportunity to move to or expand your telehealth program as part of the larger redesign of care delivery at your FQHC.

The use of telehealth can improve access to care for patients and can advance health equity by increasing access to care for marginalized and underserved communities. Telehealth is easier to provide under APM. You do not have to use the complex coding needed for providing telehealth under the FFS model. Also, providers have more freedom to deliver care that patients need in the most appropriate, effective, and accessible form (e.g., video visit, phone call, or in person) without worrying about what is and is not covered. Lower expenditures for providers and lower costs for patients may also come with the provision of telehealth, eliminating expenses such as transportation and childcare that patients might otherwise incur if they had to visit

the clinic. It may also be a way to manage burnout and improve quality of life for clinical staff, providing them time to work remotely, which can improve retention rates.

Resources: Telehealth

- ▶ [California Telehealth Resource Center](#)
- ▶ [A Practical Guide to Expanding Home-Based Primary Care with Telehealth](#)⁶⁵
- ▶ [FQHCS and Telehealth](#)⁶⁶
- ▶ [How FQHCs are Conquering the Digital Divide in Telehealth, Remote Monitoring](#)⁶⁷
- ▶ [FQHC Telehealth Consortium Focuses on Addressing Health Disparities in Phase II Work](#)⁶⁸
- ▶ [Payment Reimbursement Tips: Mental Health Telecommunications Services](#)⁶⁹
- ▶ [Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders \(PDF\)](#)⁷⁰

Telehealth can also be a way to improve access to behavioral health services for your patients. Although the delivery of behavioral health through telehealth is not right for everyone, it can make this care accessible for populations who might not be able to, or who do not feel comfortable, accessing care in the office. It can also be a person-centered option for patients who prefer to engage in care through telehealth. Patients should always have the choice of receiving services in person but ideally can also choose a hybrid delivery of services (e.g., receiving services in person some of the time and via telecommunications technology at other times).⁷¹ Many behavioral health practices have seen that when they offer behavioral health service through telehealth, no-show rates for patients decrease.⁷²

Finally, telehealth may also increase your ability to get care to people in rural areas, and it may improve

access for those in urban areas where there may be longer waits for appointments.

Some questions to consider in expanding or beginning telehealth visits as part of your move to APMs:

- ▶ What will be the workforce implications of moving some proportion of visits to telehealth?
- ▶ What staff will you need more or less of?
- ▶ Are there some types of visits or patients that you will want to primarily move to telehealth?

You and your team will want to have a clearly thought-out strategy for when you will provide in-person, telehealth, and hybrid options for care and for what service and by what staff based on the needs of your patient population and your staffing model and care model goals.

Managing Care in New Ways

Care Management

Borrowing from the Center for Health Care Strategies, AHRQ defines care management as a “promising, team-based, patient-centered approach ‘designed to assist patients and their support systems in managing medical conditions and chronic illness more effectively.’”⁷³

Providing care management for patients who are high risk, or at risk of becoming high risk — whether due to medical, behavioral, or social needs — can be another intervention in your value-based care strategy under the APM.

Care management usually involves intensive, one-on-one services provided by a nurse or other health worker (sometimes a social worker or even unlicensed supervised staff) for those with complex

health and social needs. Sometimes payers or Medicaid managed care organizations are also providing care management to members they consider high risk. It is worth exploring at the organizational level whether this is the case and for which patients and which plans so that services are not being duplicated, patients are not confused about which care manager is their primary care manager, and multiple care managers can coordinate with each other.

Key components of care management include:

- ▶ Identifying and engaging high-risk or at-risk patients
- ▶ Providing a comprehensive assessment of their needs
- ▶ Creating an individual care plan
- ▶ Engaging in patient education
- ▶ Monitoring clinical conditions
- ▶ Coordinating needed services⁷⁴

You and your team will also want to think about who will be offered care management and how you group patients according to risk.

Identifying patients for care management

Risk stratification is a technique for systematically categorizing patients based on their health status and other factors.⁷⁵ It allows practices to manage patients based on their assigned risk level to make better use of limited resources, anticipate needs, and more proactively manage their patient population.⁷⁶

The following risk groupings and descriptions of each group are from the Value Transformation Framework Action Guide by the National Association of Community Health Centers.⁷⁷ While there are other approaches to risk groupings, this list may help you consider how to think about

assigning your patients a risk level and where to focus your care management services.

However please note that DHCS will be establishing a standardized risk stratification, segmentation, and tiering process for all Medi-Cal members via the PHM Program and PHM Service (see more in the DHCS [CalAIM: Population Health Management Policy Guide](#)).

Risk groupings

- ▶ **Highly complex.** This is a small group of patients with the greatest care needs. This group, likely less than 5% of the population, has multiple complex illnesses, often including psychosocial concerns or barriers. Care models for this population require intensive, proactive care management. The goal for this group is to use lower-cost care management services to achieve better health outcomes while preventing high-cost emergency or unnecessary acute care services. It is important to remember that in California, some patients who fall into this group may also qualify for ECM. The ECM provider will likely be the patient's health home but not always. If the FQHC is providing care management and the patient is also receiving care management services elsewhere, coordination between the various care managers and coordinators is essential. It is also best practice to discuss with the patient how multiple care managers will work together to provide care for them.
- ▶ **High risk.** The next tier includes patients with multiple risk factors that, if left unmanaged, would result in them transitioning into the highly complex group. It typically describes about 20% of the patient population. This cohort of patients is appropriately engaged in a structured care management program that provides one-on-one support in managing medical, social, and care coordination needs.

A care manager works with patients to ensure that they receive appropriate chronic disease management and preventive services.

- ▶ **Rising risk.** This tier includes patients who often have one or several chronic conditions or risk factors, and who move in and out of stability with their conditions. One analysis showed that extending care management to this population reduced the number of patients who moved to the high-risk group by 12%, with a 10% decrease in overall costs.⁷⁸ With rising-risk patients, successful models of care focus on managing risk factors more than disease states. Common risk factors for this population include obesity, smoking, blood pressure, and cholesterol levels. Identifying these risks enables staff to target the root causes of multiple conditions.
- ▶ **Low risk.** This group includes stable or healthy patients. These patients have minor conditions that can be easily managed. The care model for this group aims to keep them healthy and engaged in the health care system, without the use of unnecessary services.

The American Academy of Family Physicians (AAFP) suggests using a combination of objective data and subjective input to better assess a patient's risk level.

Here is an example combining objective data and subjective input to arrive at a more accurate risk score for a particular patient:

A patient with diabetes whose A1C is 9.2 could be categorized as high risk. However, consider that the patient had an A1C of 12 earlier in the year but has since begun exercising, lost 30 pounds, and started taking his or her medication as prescribed. This subjective data leads us to assign the patient a lower risk level.⁷⁹

The AAFP has also endorsed a two-step process for identifying the sickest patients.⁸⁰ They advise approaching risk stratification in the following way:

Step 1. Sort patients into one of three groups (high, medium, and low) based on objective data you take from your EHR. Think about risk based on the presence or absence of factors such as:

- ▶ Chronic conditions
- ▶ Advanced age
- ▶ Multiple comorbidities
- ▶ Physical limitations
- ▶ Substance disorder
- ▶ Lack of insurance
- ▶ Low health literacy
- ▶ Frequent hospitalizations
- ▶ ED visits
- ▶ Recent major surgery or brain trauma
- ▶ Polypharmacy
- ▶ Difficulty following a treatment plan

Step 2. Assign each patient to a risk level based on how your providers and staff answer the following questions:

- ▶ Is the patient healthy with no medical problems? If so, are the patient's biometrics in or out of range?
- ▶ Does the patient have chronic conditions but is doing well?
- ▶ Does the patient have chronic conditions that are out of control but without complications?

- ▶ Does the patient have complications of chronic disease or high-risk social determinants of health?
- ▶ Is the patient potentially in danger of dying or being institutionalized within the next year?⁸¹

The AAFP states that "whatever method you use, risk stratification should be seen as a dynamic process. You should reevaluate risk scores regularly and as you become aware of changes in the patient's status."⁸²

Best practices in care management

The authors of *Implementation of Care Management: An Analysis of Recent AHRQ Research* reviewed and analyzed findings from 12 AHRQ projects and summarized best practices in care management.⁸³ Here are a few things they highlighted that may be helpful to keep in mind for your care management program.

Resources: Care Management and Risk Stratification

- ▶ [NAHC Value Transformation Framework Action Guide](#)⁸⁴
- ▶ [Two-Step Process for Identifying Your Sickest Patients](#)⁸⁵
- ▶ [AAFP risk stratification algorithm](#)⁸⁶
- ▶ [Care Management: Implications for Medical Practice, Health Policy, and Health Services Research](#)⁸⁷
- ▶ [Care Management: An Implementation Guide for Primary Care Practices](#)⁸⁸
- ▶ [The Medical Home: Care Management](#)⁸⁹

Best practices included:

- ▶ Care managers performing the following functions:

- ▶ **Self-management support** — goal setting, care plan development, motivational interviewing, behavior change counseling, health education, self-care skills building
- ▶ **Strengthening linkages and relationships** — ongoing outreach and follow-up services, transmission of clinical information during transitions across the care continuum, linking to community resources, building a continuous relationship with patient and caregiver
- ▶ **Clinical care** — medication reconciliation, assessment of adherence to treatment recommendations, treatment intensification, monitoring for adverse events
- ▶ **Administration** — participating in quality improvement activities and care team meetings
- ▶ Care managers having a broad focus on issues not often addressed by primary care providers — that is, looking at the patient’s overall resources and ability to follow through on the PCP’s recommendations.
- ▶ Care managers having their own high-risk patient panels and meeting with providers regularly to discuss and coordinate the care of these patients.⁹⁰

Trauma-Informed Care

People who come from marginalized communities and who have experienced poverty, likely a large portion of your patients, are more apt to have trauma, and to have more difficulty recovering from it.⁹¹ Trauma can have a profound negative impact on people’s mental and physical health, on their ability to form trusting relationships, and on their ability to care for themselves or family members.

The Substance Abuse and Mental Health Services Administration states that “individual trauma results from an event, series of events, or set of

circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”⁹²

Examples of trauma include:

- ▶ Experiencing or observing physical, sexual, and emotional abuse
- ▶ Childhood neglect
- ▶ Having a family member with a mental health or substance use disorder
- ▶ Experiencing or witnessing violence in the community or while serving in the military
- ▶ Poverty, exposure to racism, and systemic discrimination⁹³

Using a trauma-informed care approach at your clinic can help to create an environment where patients who may feel distrustful or have had negative experiences with the health care system can feel safe and where patients who may sometimes feel unseen or unheard can feel welcome, seen, and listened to. Trauma-informed care can be a powerful method for reducing health disparities, providing more equitable care, and helping higher-risk patients engage in their care.

What is trauma-informed care?

Trauma-informed care seeks to:

- ▶ Realize the widespread impact of trauma and understand paths for recovery
- ▶ Recognize the signs and symptoms of trauma in patients, families, and staff
- ▶ Integrate knowledge about trauma into policies, procedures, and practices
- ▶ Actively avoid re-traumatization⁹⁴

Resources to Support Trauma-Informed Care

- ▶ [Trauma-Informed Care Implementation Resource Center](#)⁹⁵
- ▶ [Key Ingredients for Successful Trauma-Informed Care Implementation](#)⁹⁶
- ▶ [Guide to Trauma-Informed Organizational Development](#)⁹⁷

Best practices and practical steps for implementing trauma-informed care include:

- ▶ Identifying a person or group of people who want to help the organization become trauma-informed
- ▶ Announcing to all staff the organization's commitment to becoming trauma-informed and initiating a continuous quality improvement or performance improvement plan
- ▶ Providing training from consultants/trainers with expertise in trauma-informed systems change⁹⁸

SECTION 4.

Bringing Your Organization Along

IN THIS SECTION

- ▶ Communicating Change
- ▶ Redesigning Care
 - ▶ Create a Guiding Committee
 - ▶ Coordinate with Operations, IT, Data, Quality, and Finance Teams
 - ▶ Create a Sense of Urgency
- ▶ What This Change Means for You
 - ▶ Clinical Staff
 - ▶ Leadership
 - ▶ Operations and Finance
 - ▶ The Board
 - ▶ Payers and Funders
 - ▶ Unions (as Applicable)
 - ▶ Patients
- ▶ Understanding Loss Is Part of Making Positive Change
- ▶ Leading the Change
 - ▶ Using Strategies from Implementation Science to Help Guide Practice Transformation

Communicating Change

Managing and leading the transition to FQHC APM requires a strategy and preparation for how you will communicate with staff, colleagues, leadership, and your board. It requires listening to staff and stakeholders at all levels of the organization. It means communicating different messages at different phases of the work. It means relying on deputies and champions to help get the message out and ensuring that questions or concerns are coming back to you and your team.

When you implement the APM, you may have the inclination to share only parts of the bigger picture transformation, or you may think that sharing information with clinical staff on a “need to know” basis will be sufficient. Experiences from FQHCs in other states who have implemented an APM stress the importance of being transparent with all staff. In fact, most FQHC interviewees who have been through this advised that erring on the side of sharing more information, rather than less, is the best approach.

Change management experts advise that when change is happening, you want to share why change is happening, you want to do so multiple times, and you want to get the message out through multiple channels and messengers. You also want to make yourself and leadership available to hear and answer the questions that people have.

As one FQHC staff member in the workgroup stated, “If you don’t share information about why and how a change will take place, staff will simply make up ideas about what is not shared with them.”

Redesigning Care

Create a Guiding Committee

As you begin your care redesign process, you will want to pull together a committee or group of internal advisors who work at your FQHC to provide input and guidance around needed changes and to receive feedback on how things are going as implementation progresses.

You want to get multiple perspectives on the patient experience, as well as the experience of delivering care and the entire workflow in the current setup so that improvements can be identified. For example, you may want to include:

- ▶ Front desk staff
- ▶ Medical assistants and lab techs
- ▶ Community health workers, peer counselors, HIV counselors
- ▶ Referral coordinators
- ▶ Care coordinators, care managers, and referral coordinators
- ▶ Nurses, social workers, and behaviorists
- ▶ Providers and the medical director
- ▶ Any other staff who work with patients or has a window into patient and staff experience

At this point in the brainstorming process you want to strive to let everyone have a say, to allow everyone's voice to be heard. This approach also sets the tone for the more team-based model you will be moving toward. These meetings need a leader or a facilitator, but part of their role is to draw out diverse opinions to get the best ideas on the table about how care can be improved.

Ensuring That Providers Feel Supported and Are On Board with the Care Changes of the FQHC APM

At one FQHC organization, the chief medical officer (CMO) set up one-hour meetings with every provider in the organization to talk with them about what this change meant for them and to answer their questions. While these interviews were time-intensive, the CMO reported they were extremely effective. They also allowed the CMO to learn about any concerns the providers had so they could be addressed ahead of time.

It is helpful to share agendas before meetings so that staff who struggle to talk in groups, especially in front of those who traditionally hold the most

authority and power (e.g., providers), feel like they can prepare some ideas and get ready to participate in brainstorming. Agendas also help busier people to understand what will be discussed and why they should attend. Make sure that calendars are blocked if these meetings are taking place when patients are normally seen so that clinical staff can attend and you have leadership buy-in for the meetings. Remember to discuss care models that you will base the work on and which metrics you will focus on.

Ask the team to think about how they would describe the patients you care for. If how you delivered care could be changed to better meet your patients' needs, what would it look like? You want to make it clear at this stage that the mandate for the group is to think expansively and creatively and truly brainstorm about new ways of delivering care.

Following are sample questions to spur discussions with staff:

- ▶ Do our patients need more access to services like behavioral health or case/care management?
- ▶ What types of care or services could be delivered by a registered nurse or a licensed vocational nurse? What types by a medical assistant or licensed practical nurse?
- ▶ What types of visits must be conducted by a provider?
- ▶ Are there patients who might benefit or prefer a home visit or telehealth visit instead of an in-person visit?
- ▶ What is the current state of our telehealth visits? What would it look like if nurses, social workers, care managers, or peer counselors could deliver care through telehealth if they are not already?

- ▶ What kind of care might be improved through group visits?
- ▶ What kind of data would be helpful (e.g., population health, quality improvement, demographics) to help you understand who your patients are and what common issues they may have?

Coordinate with Operations, IT, Data, Quality, and Finance Teams

While redesign discussions are happening, it is important to coordinate with any operations, IT, data, quality, or finance teams. Keep them in the loop and make sure that parallel discussions are happening with them, as well as having them attend some meetings where they can hear the discussions the clinical redesign team are having. For any process improvements or care redesign to succeed, you will need to coordinate closely with these other teams.

Lessons from Leadership at Community Care Cooperative in Massachusetts

FQHC leaders across the country have used different strategies to improve communication about change. Community Care Cooperative (C3) is a nonprofit accountable care organization governed by 18 FQHCs in Massachusetts. At C3, the CEO, CMO, and chief financial officer (CFO) wrote letters to each other regarding their movement toward APM. Their letters openly addressed what they needed to be successful in their own role and what they needed from their colleagues. This strategy aimed to facilitate communication, work through challenges, and develop alignment.

Create a Sense of Urgency

Change management experts and those who have already done this work stress that you want to create a sense of urgency. Even if people seem excited to make changes when new concepts are introduced, they may begin to doubt that now is the right time to make changes. Others may doubt right from the start that a change will be positive.

Lessons from the Executive Team at Virginia Garcia Health and Other FQHCs in Oregon

At Virginia Garcia Health Center in Oregon, the executive team dispersed across clinics and had ongoing discussions at staff meetings about their short- and long-term goals.

At another clinic in Oregon, the CMO set aside an hour in each provider's schedule to meet with them. While this took time, it was valuable in aligning the providers and the health center as a whole.

Your first task is to demonstrate why now? What are the benefits of doing this now, and what are the risks of not doing this now? Some reasons you might share include:

- ▶ **Providing more flexibility.** The APM provides flexibility for FQHCs to offer more comprehensive care to patients while allowing clinical staff to offer enhanced care sustainably.
- ▶ **Reducing staff burnout.** The team-based care model can help reduce burnout and turnover because it spreads accountability across the team and allows all staff to take on more responsibility.
- ▶ **Addressing care gaps.** Implementing the APM allows the organization the flexibility to deliver care that can address previously noted gaps (for example, through nurse visits, complex care management, or mental health services).

► **Reducing that “hamster wheel” feeling.**

Improving and transforming the care delivery and staffing model can reduce the “hamster wheel” feeling that providers often have seeing patients in short visits back-to-back all day. However, it may increase certain kinds of work for other clinical staff.

► **Working at the “top of license.”** To get everyone working at the top of their license, your organization will need to invest in and build adaptive reserves and the capacity of those staff who will be taking on tasks or roles they may not have occupied previously.

What This Change Means for You Clinical Staff

Those who have been through this process stress the importance of talking to staff about their changing roles and what the impact of that looks like on a day-to-day basis. Best practice is to try to stand in their shoes and listen to their preferences, concerns, and opinions on an ongoing basis.

Also, it is good to remember that the communication and messaging you develop to gain support internally for APM can be used to recruit providers and other clinical staff to work at your FQHC. There are many clinicians who want to work in an environment where the focus of the day is purely and truly on improving the health outcomes of patients without the stress of meeting productivity metrics and worrying about how many billable visits a day are taking place.

Leadership

Key takeaways from those who have been through this process include the importance of buy-in from leadership and solid agreement across all levels of staff and departments on why the organization was moving to the APM and what that meant for care and staffing redesign.

“Don’t jump. Use phases. Develop an on-ramp. Make the process incremental.”

—FQHC CEO, Oregon

Interviewees stressed the importance of developing “strategic pathways toward value” and having leadership understand the importance of growing the organization’s data and analytics capacity. Leadership’s commitment to the necessary culture change required for the APM must take place for the care delivery improvement and redesign to be successful.

Operations and Finance

It is critical that operations and finance staff have an understanding and are on board for the APM implementation. As one interviewee stated, “You need to get the CEO, CMO, and CFO on the same page or nothing is going to work.”

Other best practices include making sure to communicate clearly to operations and finance staff that the organization will have a foot in both the FFS world and the APM world. There will be both capitated payment for services under FQHC APM, and FFS for services not included in FQHC APM (e.g., Medicaid dental, Medicare, commercial insurance, etc.). This is a substantial change!

The Board

Similarly, interviewees stressed the importance of buy-in from the board before embarking on the APM journey. You, your team, and leadership will want to know how much the board understands about how your FQHC gets paid. As one interviewee stated, “Not all FQHC board members have a deep background in finance and accounting. If the board is confused, they will not make good decisions.” Most board members prefer receiving information at a high level and may not need to know all the details of the payment model, for example.

“Get buy-in from your board. Bringing them in early will help keep things moving.”

—FQHC CEO, Oregon

Training for the board on the APM and how it fits in with the visions of care may also be helpful. It will be important for the board to understand that the reports they are used to reviewing will start to look different.

“Leadership was not brought in at the beginning, and that slowed us down.”

—FQHC CEO, Oregon

Here are some points you may want to review with your board before and during the transition to APM:

- ▶ What is FQHC APM? What will it mean for our health center?
- ▶ How does the APM work with VBP models?
- ▶ What are financial indicators (e.g., dashboards) for APM?
- ▶ What services will still be FFS?
- ▶ What are samples of financial reports (from Oregon health centers in APM)?
- ▶ What are care model changes that will be implemented?

Payers and Funders

Medi-Cal payers in California are compelled to participate in APM, so they likely understand the “why” behind this change. Still, many interviewees cautioned to not forget about payers and funders during this transition. For funders and donors in particular, workgroup participants shared that emphasizing “enhancements” over “change” is the best way to communicate what is taking place. Demonstrating how the APM will improve the effectiveness and

efficiency of care for those who are higher risk and higher cost may also help funders understand the benefits of the transition.

Unions (as Applicable)

For leaders of organizations with unionized staff, it will be key to partner with union leadership so both union and management see the importance and value in pursuing APM. This may take some time to develop. One helpful model to look at is the [Kaiser Labor Management Partnership](#).⁹⁹

You will want to have early conversations with the union regarding how the roles of unionized staff may need to change under APM. It is also important to review what is not changing. Specifically, you may want to discuss and highlight with the union and union staff that under APM, staff will be working to their full scope. If broadening the scope of certain staff is relevant, it is also something to raise with the union in the beginning of this process to gauge interest and to see if it could be of value to their membership.

Patients

It is important to have a dedicated time and a strategy to hear from and communicate directly with patients about how this change will and will not affect them. Two-way communication about the APM and expected change is important to have with your patients if you want patients to continue to seek care at your clinic.

“With patients it was surprisingly the hardest. Patients were afraid they would be blocked from care. We made flyers with pictures of the care team members connected with the primary care doctor and provided ways to reach them all.”

—FQHC staff in OR

Some ideas for supporting two-way communication with patients are to:

- ▶ Establish patient advisory groups.
- ▶ Solicit input from patients about what this change means for them.
- ▶ Develop clear messaging about what will and will not be changing for patients. For example, depending on your plan you might tell patients that this change will not affect access to the doctors and clinical staff they are used to seeing. But you also might tell them that this change will make it easier to get an appointment or to reach clinical staff by phone, receive care at home or by a telehealth appointment, etc. Try to stand in their shoes and think about what their concerns might be. Do not just imagine what their fears are, ask them.

Understanding That Loss Is Part of Making Positive Change

When an organization or group of people is asked to undertake change — even when it is seen as a positive and welcome change — some, if not all, members involved will feel a sense of loss.¹⁰⁰ Ignoring this feeling that your employees may experience, failing to validate or discuss it, can create roadblocks for your organization as staff resist going along with change.

As leaders at your organization, you may have already had time to work through any feelings of loss or anxiety you have about the coming change, but you must allow space for others to do this as well and recognize these kinds of reactions as normal parts of the change management process. What is often below that feeling of loss is not a fear of change but a fear of not being successful in a new way.¹⁰¹

Leading the Change

Interviewees with FQHCs in other states with multiple sites that have gone through this transition had this advice: “Focus on one clinic first, possibly the one that has the most challenges. Once things are running smoothly there, you can test out and spread these processes to another clinic, and then to all of them.”

Using Strategies from Implementation Science to Help Guide Practice Transformation

You and your colleagues are likely already familiar with Plan-Do-Study-Act cycles and the Model for Improvement,¹⁰² and this approach may help you evaluate and refine the changes you are implementing as part of your care model redesign under APM. It is important to make sure that you are not implementing changes that have not been thoroughly assessed before you spread and scale them more broadly. Here are tips for how to think about this process:

Take a modular approach to change:

- ▶ Go one clinic at a time, or even one “team” at a time within a clinic.
- ▶ Test out the proposed changes with one team or clinic first.
- ▶ Use the results of tests of change to decide if the test was successful.
- ▶ Identify and address challenges before adopting further changes.

Resources: Scaling and Spreading Changes

- ▶ [Spreading and Scaling up Innovation and Improvement](#)¹⁰³
- ▶ [Scaling and Spreading Innovation in Health Care Delivery](#)¹⁰⁴

Scale changes more broadly once you are confident that a change is working and that staff are on board with the change:

- ▶ What works at one site may also work at another or may need to be evaluated individually at each site and adjusted based on the needs of that location, staff, and patients.
- ▶ Continue to use data and metrics to measure how the change is going both at individual sites and across the organization as a whole.

SECTION 5.

Data: Your Success Depends on It

IN THIS SECTION

- ▶ The Importance of Data in FQHC APM
- ▶ What Data Do You Need to Collect?
 - ▶ Quality
 - ▶ Alternative Touches
 - ▶ Patient Care and Engagement
 - ▶ Risk Stratification
 - ▶ Utilization and Financial Monitoring
 - ▶ Patient and Provider Experience and Satisfaction
 - ▶ Health Equity
- ▶ How Do You Ensure Your Data Are Accurate?
 - ▶ Defining “Good Data”
 - ▶ Ensuring Accurate and Comprehensive Coding and Data Entry
 - ▶ Correcting Data
- ▶ What Changes Do You Need to Make to Your Current Data Infrastructure?
 - ▶ Creating a Data Governance Plan
 - ▶ Considering Staffing Needs
 - ▶ Identifying EHR Changes and Optimization

The Importance of Data in FQHC APM

Data are critical to your success in FQHC APM. Patient-level data are important for engaging patients, managing care, tracking care transitions, addressing health-related social needs, stratifying risk, and providing insights on population health. Financial data, including utilization and revenue, will help you determine if your health center is performing well financially. Clinical and process data

are essential for quality improvement and for meeting required benchmarks.

Sharing data is also critical to demonstrating your accomplishments and highlighting any gaps. Your health center needs to have an EHR that allows providers to capture and exchange data, support care coordination inside and outside the practice, and monitor and generate reports on targeted metrics (that require EHR data). You will want to make sure that staff have access to any new training — provided by your health center or offered through outside organizations — they may need to input specific data or notes, use correct coding, and fully utilize EHR functionality. Your health center must also have the infrastructure to share data between health plans, state agencies, and external providers. Being able to share and act on data in real time and across a wide range of providers is helpful for effective care coordination. Data are also important for future rate setting that impacts your revenue.

“Someone cares about the work I do because someone is tracking the work I do.”

—FQHC CMO, Oregon

This section highlights key data considerations and how they relate to the various topics described in this guide. For greater detail about how to use data in those specific topics (e.g., caring for patients), please refer to those sections.

What Data Do You Need to Collect?

The following section describes the kinds of data you will need to collect and how they will be used in FQHC APM. Appendix B provides an overview of data elements and data sharing requirements under FQHC APM.

Quality

As described in Section 2, your FQHC will be required to track a set of quality measures, that will be reported to DHCS by the MCPs, to ensure you are meeting the initiative's quality goals. The list of quality metrics can be found in Table 6. Many of these metrics are likely in your contracts with MCPs, or you may participate in one or more state or federal VBP programs. While the quality metrics in FQHC APM may not be the same as the ones you have already seen, they can likely be approached in a similar way and not require extensive changes in the way the data are collected and reported.

Alternative Touches

As described in Section 3, alternative touches are services currently not considered encounters under PPS but that are designed to increase patient engagement, improve patient outcomes, and generally allow better coordinated and integrated care. There are five domains of alternative touches: communication, education, case management, community supports, and care team supports. Alternative touches will be tracked via CPT codes. Leveraging EHR templates and smart sets to set-up or flag these codes in the EHR can help with CPT coding accuracy.

Patient Care and Engagement

Except for capturing alternative encounters, most of the data you currently collect for providing good patient care and the way you use them will not change in the new FQHC APM. However, because you will have greater flexibility to provide a broader range of services under the new model, one area that may require additional data is health-related social needs (HRSNs). You may need to implement new processes for identifying HRSNs through assessments and screening tools (see Section 3). You may also want to consider how you could leverage your EHR to support providers in screening for and documenting HRSNs, coordinating the delivery of services by your health center, and referring

to community supports when necessary. To track HRSN under FQHC APM, DHCS is directing health centers to use only the 18 Z codes outlined for In Lieu of Services.

Additionally, under a new model of delivering care, you will want to consider ways to enhance data sharing and communication between patients and their providers. Patients will need to be able to access their own health information (test results, visit summaries), make requests of providers and staff (appointment scheduling, prescription refills), and be connected to health resources (health education, community supports). Your health center will need to have a reliable electronic platform for computer or smartphone access to that information and services, and for patient and provider communication through text, telephone, videoconferencing, and remote monitoring.

Risk Stratification

Risk stratification is a technique for systematically categorizing patients based on their health status and other factors. It allows practices to manage patients based on their assigned risk level to make better use of limited resources, anticipate needs, and more proactively manage their patient population.¹⁰⁵ See Section 3 for determining patient risk levels and how to focus care accordingly.

Utilization and Financial Monitoring

As described in Section 2, your health center will need to continue to track and document encounters to ensure that you are meeting program requirements and that MCPs will reimburse you fairly for your activities. You will also want the ability to track and analyze how alternative services are being utilized, to better understand the needs of your patients and how these services impact your health center financially. You may also want to analyze how some providers use their time, and some EHRs have the capability to do this. While you are not required to track patient utilization and costs outside the

services provided by the FQHC (e.g., an inpatient stay at a hospital), your health center may want to track those activities, as there may be opportunities for your health center to be rewarded for helping improve health outcomes and decrease utilization at high-cost or inappropriate care settings.

Patient and Provider Experience and Satisfaction

Two measures of patient experience (Patient Experience of Access and Care domain) are included in the quality metrics and are collected through the CAHPS Clinician & Group Survey: Getting Needed Care and Getting Care Quickly (see Section 2, Table 6). You may want to collect additional data to understand the impact of the new model on patients and providers. For patients, you could design and conduct surveys that capture patient experience and satisfaction in key areas you are targeting in the new model. Likewise, you could survey your staff to determine their experience and satisfaction in working in the new model, and ask for suggestions for improvements, as well as insights on what is working and best practices.

Using Data to Measure Health Equity

For a deeper understanding of the impact on patients, and to drive more equitable care, you will want to have a strategy for using data to drive

health equity. Beyond identifying race, ethnicity, language, and disability data elements which are a critical first step towards identifying and tracking health disparities, you will want to think about what process and outcome measures you might want to track for subpopulations and specific conditions that impact patients who come to your health center and who live in your community. These data will allow you to conduct a deeper analysis of gaps and to develop actionable strategies to reduce disparities in care. CMS created the Disability Impact Statement, a tool to address health disparities in practices by identifying health disparities and priority populations, defining goals, establishing a health equity strategy, determining organizational needs to implement a strategy, and monitoring and evaluating progress.¹⁰⁶ Having a data strategy that supports your overall health equity strategy will be critical to tracking and measuring your success.

Additional resources:

- ▶ [A Typology for Health Equity Measures](#)
- ▶ [Achieving Health Equity: A Guide for Health Care Organizations](#)

How Do You Ensure Your Data Are Accurate?

Defining “Good Data”

Because of the importance of encounter data, DHCS will continue to engage all stakeholders to improve encounter data by defining clear standards on data quality with a goal of establishing a single source of truth. For all types of data, the American Health Information Management Association offers the following characteristics of data quality:¹⁰⁷

- ▶ **Accuracy.** The data should be free of errors.
- ▶ **Accessibility.** Proper safeguards have been established to ensure data are available when needed.
- ▶ **Comprehensiveness.** The data contain all required elements.
- ▶ **Consistency.** The data are accurate and the same across the entire patient encounter.
- ▶ **Currency.** Data are up-to-date.
- ▶ **Definition.** All data elements are clearly defined.
- ▶ **Granularity.** The data are at the appropriate level of detail.
- ▶ **Precision.** The data are precise and collected in their exact form.
- ▶ **Relevancy.** Data are relevant to the purpose they were collected for.
- ▶ **Timeliness.** Documentation is entered promptly, is up-to-date, and is available within specified and required time frames.

Ensuring Accurate and Comprehensive Coding and Data Entry

While your staff likely already know the importance of entering diagnoses and notes into a patient’s EHR for documentation and to inform their care plan and future visits, coding takes on a new importance under a FQHC APM. Coding properly will

contribute to patient care planning, population health, and stratification. As a result, your staff will likely need additional training on coding, and internal processes will need to emphasize the importance of coding. Larger FQHCs may consider hiring dedicated staff for coding and documentation, and FQHCs of any size may want to work closely with their MCPs to identify best practice strategies to accurately document patient diagnoses and characteristics. External consulting firms also provide support for accurate coding and billing infrastructure.

In addition to coding, the importance of capturing accurate data in all areas will need to be bolstered. Your health center may also want to explore additional training and to create standardized processes for writing notes, making assignments for seeing patients, and updating patient contact information.

Correcting Data

MCPs and FQHCs will need to work together to ensure encounter data and membership data are accurate for quality reporting (see Section 6 on working with MCPs). In the absence of explicit DHCS requirements about correcting data discrepancies, your health center will need to work with the MCP to develop processes to ensure accurate data. If your health center is in a delegated arrangement that includes independent practice associations or clinically integrated networks, you will also need to consider how these entities interact with your data.

What Changes Do You Need to Make to Your Current Data Infrastructure?

Creating a Data Governance Plan

While your health center may already have policies and a data infrastructure in place, it will be helpful for leadership to map out a data strategy for FQHC APM based on the new financial, patient care, and quality reporting requirements (see Appendix B).

Lessons from Community Care Cooperative: Risk Adjustment and Billing Infrastructure Support for FQHCs

C3 is a nonprofit accountable care organization (ACO) governed by 18 FQHCs in Massachusetts. To support successful participation in the ACO, C3 offers participating health centers access to experts in ICD-10, HCPCS, and CPT coding for a limited fee and for varying amounts of time. Certified Risk and Professional Coders provide the following services to health centers:

- ▶ **Post-encounter coding.** Using a certified coder to determine the accuracy of codes documented by providers, and providing recommendations for alterations of the specific encounter before claims submission.
- ▶ **Retrospective record review.** Reviewing past medical history, pharmacy, and labs to identify diagnosis trends and opportunities.
- ▶ **Individual or group provider education.** Training from a clinical coding expert to drive improvement efforts in provider documentation.
- ▶ **Prospective chart review.** Reviewing past medical history, pharmacy, and labs to identify coding opportunities before a planned visit occurs.

This support is one component of C3's larger efforts to support health centers in moving toward VBP. C3 also assigns a cross-functional Health Center Performance Management Team (HCPM) that partners with each health center's leadership team to support, monitor, and promote performance across the various programs and state deliverables. HCPMs have subject matter expertise in the full scope of C3's business operations, including care management, risk adjustment, quality, practice transformation, telehealth, EHR optimization, and population health platform technology optimization.

HCPMs meet with health centers monthly to review performance metrics and progress, and meet as needed with quality, risk adjustment, and care management leads to provide assistance, offer guidance, and receive updates on targeted quality improvement initiatives. C3 has found this level of support to be critical to each health center's success in the ACO model.

Source: [Provider Manual](#) (PDF), Community Care Cooperative, September 2021.

Typically, the chief information officer (CIO) is responsible for leading this process and would seek out input from staff throughout the organization, either individually or by creating a team of operational and clinical staff that would work together to develop a strategy.

The American Health Information Management Association identified the following best practices for data governance in health care organizations.¹⁰⁸ While these practices are foundational for any health center, they are even more important for your health center in FQHC APM:

- ▶ **Establish program priorities.** One way is to prioritize critical data elements for the organization. It is important to consider where these critical data elements are used, how they are defined, and how they are used during the entire data lifecycle (i.e., data creation, collection, use, and destruction).
- ▶ **Ensure accountability.** It is critical to have clearly defined roles and responsibilities (e.g., sponsors, data stewards, domain owners, technical leads), outlining who is responsible for what and when. Having a governance structure in place allows the organization to address questions and issues

as they arise as well as work toward the required goals.

- ▶ **Demonstrate value by defining key metrics.** Consider measuring the results of your data governance work by tying key metrics to program goals. For example, key metrics may be tied to data quality (e.g., data accuracy, data completeness), risk or cost reduction (e.g., reduction in rework), or process improvement (e.g., data issues corrected). There can also be value in tracking data literacy across the organization (e.g., knowledge of data management principles; adherence to data management standards, policies, and procedures; published data definitions; attendance at trainings).
- ▶ **Support collaboration.** Those in data governance roles should have opportunities to collaborate, discuss challenges, and share best practices throughout the organization.

Considering Staffing Needs

As described in the data coding section, staff at all levels of the organization will need to understand changes to data collection and use under FQHC APM. This effort will require training by internal data staff or external experts, reassigning roles and responsibilities among staff, and in some cases

hiring additional staff to meet data and infrastructure needs. Table 8 outlines key data responsibilities and competencies required under FQHC APM (see next page).

Identifying EHR Changes and Optimization

Your health center needs to have an EHR that allows providers to capture and exchange data, support care coordination inside and outside the practice, and monitor and generate reports on targeted metrics. An efficient EHR frees time for providers to focus on care delivery.

Your health center could consider making the following changes to optimize your existing EHR, keeping in mind the type and current capacity of your EHR, your data goals, and your budget to make changes:

- ▶ Configure your EHR to capture and generate reports on alternative encounters
- ▶ Include screening tools for health-related social needs and links to internal and external resources
- ▶ Ensure the EHR captures data required for risk stratification
- ▶ Link the EHR with real-time data from health plans and outside entities to facilitate care transitions and follow-up care

Table 8. Data Considerations and Desired Outcomes for Key Staff

STAFF	CONSIDERATIONS	DESIRED OUTCOMES
<p>Leadership CEOs, CAOs, CFOs, CIOs, CMOs, Chief behavioral health officers</p>	<ul style="list-style-type: none"> ▶ Is there a data governance plan in place? ▶ Can the IT infrastructure and EHR meet our needs? ▶ Is there adequate staffing for coding, IT support, and data analysis? ▶ Are staff fully trained to take on new responsibilities? ▶ Do staff roles need to be adjusted? ▶ Is data collection and use reflected in the workflows? ▶ Will existing financial reports capture financial performance under FQHC APM? ▶ Do you need to invest in additional analytical or acuity tools? ▶ Can you review financial metrics in real time? ▶ What changes will you need to make to collect data? ▶ Are MCPs sharing data and participating in improvement activities? 	<ul style="list-style-type: none"> ▶ Quality data are accurate and timely. ▶ Assignment is correct. ▶ Alternative touches are counted accurately. ▶ Risk is stratified and accurately reflects clinical and social needs. ▶ Clinical data are actionable, and staff are using them to provide better care. ▶ Health center payments reflect the services being provided. ▶ Internal reports show the financial impact of FQHC APM. ▶ MCPs are engaged in ensuring good data.
<p>Providers Physicians, physician assistants, nurse practitioners, certified nurse-midwives, behavioral health providers</p>	<ul style="list-style-type: none"> ▶ Do clinicians understand new processes for entering clinical and SDOH data in EHRs? ▶ How are data being used to improve quality, particularly on APM metrics? 	<ul style="list-style-type: none"> ▶ Clinical staff are entering encounter data accurately and are incorporating such data entry into their workflow. ▶ Clinical staff are engaged in risk stratification activities. ▶ Clinical staff are capturing and using SDOH data to provide better care and to make appropriate referrals. ▶ Staff have access to data to inform quality improvement activities.
<p>Licensed and unlicensed clinical staff Nurses, social workers, medical assistants, counselors, pharmacists, care managers, care coordinators</p>	<ul style="list-style-type: none"> ▶ Do staff understand new processes for entering and accessing data in EHRs? ▶ Are the data available so that staff can act on them and provide better care? 	<ul style="list-style-type: none"> ▶ Staff are responsive to clinical and social needs. ▶ Data allow staff to coordinate care with providers and licensed and unlicensed staff.
<p>Administrative, operations, and IT staff</p>	<ul style="list-style-type: none"> ▶ Do coders understand changes, particularly for tracking alternative touches? ▶ Do IT staff understand new reporting requirements, processes, and EHR updates to support clinical staff? 	<ul style="list-style-type: none"> ▶ Coding is accurate. ▶ Alternative touches are captured. ▶ Process is in place for participating in, and making changes to, data governance plan.

Source: Authors analysis based on key informant interviews and review of DHCS APM Overview, September 2022: [FQHC APM September 2022 Overview \(PDF\)](#).

SECTION 6.

Partnering for Success

IN THIS SECTION

- ▶ Collaborating with Other Health Centers
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 - ▶ Knowing Your Value
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 - ▶ MCP Responsibilities Under FQHC APM
 - ▶ Contracting with MCPs for FQHC APM
- ▶ Building External Partnerships

Your success in FQHC APM will be greatly enhanced through collaboration with external partners. Health centers in other states participating in APMs have affirmed the value of strong relationships with other health centers implementing similar initiatives, health plans, specialists, hospitals, and state agencies. This section provides an overview of opportunities and considerations for partnerships.

Collaborating with Other Health Centers

Collaborating and learning from other FQHCs can be worthwhile, with the caveat that one health center is one health center. Capacities of health centers differ based on their geographic location (e.g., rural vs. urban) and size. Because of these differing capacities, health centers have varying capabilities to address issues that arise as well as differing abilities to work with external partners, such as negotiating with MCPs. Staff from all areas of your health center (care delivery, finance, operations) would benefit from making connections with staff in similar roles at other health centers. Health centers will benefit from sharing takeaways about new

processes, progress on quality metrics, and financial best practices.

Regional and statewide organizations can provide opportunities for problem solving, technical assistance, and collaboration. Your health center may already be part of a regional network of health centers. Statewide, the [California Primary Care Association](#) and the [California Association of Public Hospitals and Health Systems](#) support health centers in FQHC APM in a number of ways regularly updated on their websites. DHCS will establish a learning and improvement community for health centers participating in FQHC APM.

Learning from Other FQHCs: Statewide Learning Collaboratives

Massachusetts. C3, along with MassLeague, the state's primary care association, convened the [Community Health Center Readiness Program](#), a learning collaborative to help FQHCs be successful in VBP and accountable care.

The collaborative covers topics such as change management, care coordination, transition of care, and quality measures.

Oregon. Oregon's Primary Care Association led various learning collaboratives that covered the shift in the care model that brought in experts and provided training. For example, one training led by leaders from the MacColl Institute focused on the 10 building blocks of high-performing primary care.

Working with MCPs

Collaborating with the MCPs is critical to your success in just about every area of FQHC APM and will include ensuring that patients are assigned accurately, your health center is receiving its full PMPM, receiving and sharing information about patient care and care transitions, coordinating care management efforts, providing reports and receiving feedback on meeting quality goals, and aligning current pay-for-performance efforts with FQHC APM. This section can help you prepare for discussions with your MCPs about contracting and changes related to FQHC APM.

Knowing Your Value

As you enter discussions with the MCPs, it will be helpful for you to understand the value that your health center brings to the MCP by being prepared to answer the following questions:

- ▶ What is your health center's mission and purpose, and how do they align with FQHC APM?
- ▶ Whom do you serve and what services do you provide?
- ▶ Who are your biggest competitors?
- ▶ What makes you better or at least different than your competitors?

Building Relationships with MCPs

Beyond reaching an agreement on the initial contractual provisions, your health center will benefit from having a good ongoing working relationship with MCPs. Based on interviews with people who had worked for both an MCP and an FQHC, JSI Research and Training Institute published *“What I Wish I Had Known About Health Plans When I Worked at a Health Center . . .”*: *Insights for Strategically Engaging with Public Medi-Cal Health Plans*.¹⁰⁹ This resource includes the following insights about building partnerships with MCPs, which you can apply to your work on FQHC APM:

- ▶ Identify champions within the health plan and build a positive relationship with them. Suggestions include medical directors, directors in quality and access, and directors of provider relations departments. Forge relationships between those in similar roles (e.g., CEO to CEO, CMO to CMO).
- ▶ Get to know the history and mission of local plans.
- ▶ Be able to explicitly articulate your vision for improving the health of your community.
- ▶ Ask plan leaders about their priorities and pain points. Be ready to clearly articulate yours.
- ▶ Begin initial discussions by putting forward ideas (areas or goals you want to pursue together with the plan) rather than starting conversations about specific proposals.
- ▶ Find opportunities to work together outside of your contracted relationship.

The report also includes recommendations for making requests for financial support:

- ▶ **Meet face-to-face with health plan leaders.** This can help you understand and align priorities before creating finalized plans or asks. Understanding priorities before fully developing an idea can allow a plan to provide helpful input, and it generates buy-in.
- ▶ **Align with the plan's major areas of focus.** Even if your current priorities don't align with the plan's, consider whether supporting the plan's priority could be beneficial in building a relationship.
- ▶ **Recognize that health plan financial performance is cyclical.** These cycles can be tracked by reviewing comments of the CEO

or publicly available board meeting minutes. In up cycles, a plan may have more appetite to invest strategically in initiatives that have longer-term returns. In down cycles, quicker return becomes a more important criterion for investment.

- ▶ **Create a well-thought-out financial business case.** Health plan boards will require it. The added value of any ask is not captured solely in the business case but on how a proposal contributes to the health plan’s mission, goals, and quality improvement efforts as a whole. Health plans aim to generate the most overall — not just financial — value for the dollars they oversee and invest in the community.
- ▶ **Ask for what you need.** Onetime investments (e.g., for more efficient and effective information systems, management practices, and infrastructure that will improve quality outcomes) may be easier to gain approval for than requests for ongoing support.

MCP Responsibilities Under FQHC APM

DHCS requires MCPs under FQHC APM to:

- ▶ Ensure that FQHCs are paid the full state-established APM PMPM (equal to projected PPS) for assigned members
- ▶ Share complete FQHC encounter data with DHCS
- ▶ Conduct dispute resolution with FQHCs
- ▶ Review and reconcile quality data issues with FQHCs

Contracting with MCPs for FQHC APM

If your center is participating in FQHC APM, the MCP will need to modify the contract with you under the FQHC APM terms. DHCS will issue guidance to MCPs via an “All Plan Letter” that will include suggested practice for MCP efforts to modify their contracts with participating FQHCs. Possible

elements that may be included in modified contract language are shown in the “Possible Elements of Contract Modifications” box. Many of the contractual provisions relate to finance, and Section 2 of this report includes recommendations for negotiating aspects of these provisions of the contract with MCPs, particularly around assignment.

Possible Elements of Contract Modifications

- ▶ Contract revision implementation timeline
- ▶ APM PMPM must be paid to FQHCs for each assigned member
- ▶ Medi-Cal populations covered and not covered by the APM payment methodology
- ▶ Scope of services included in the APM
- ▶ Timing of DHCS notification to the plans of the capitation rate and the clinic-specific APM PMPMs
- ▶ Member assignment
- ▶ FQHC payment requirements
- ▶ Detailed reporting and data sharing requirements
- ▶ Reconciliation process
- ▶ Procedures for collecting and reporting accurate encounter data
- ▶ Aligning the new payment methodology with existing health plan incentive programs for providers
- ▶ Process for resolving disputes between health plans and health centers, including when the health plan does not have a relationship with the health center

Other items you will want to consider include these:

- ▶ How will you and the MCP work together on improving quality?

- ▶ What will communication look like between your health center leaders and the MCP? How often will you meet to discuss roadblocks and address problems, and who will be part of those meetings?
- ▶ With regard to data sharing, who will be the main points of contact between your health center and the MCP, and what will be the process for resolving problems?
- ▶ How can the MCP support your health center's care management efforts? What are the expectations around care transitions?

Building External Partnerships

Most of the work you will do to prepare for and implement FQHC APM will be within your own health center, or in partnership with other sites within your FQHC. In addition to working with MCPs, you may wish to explore expanding or creating new partnerships with other external entities to support and advance your efforts to care for your patients, meet the quality metrics, and succeed financially. Partnerships can also position your health center to participate in current or future VBP opportunities outside FQHC APM that could provide additional resources or flexibility.

Using the available data and expertise of your health center, and ideally in partnership with the MCPs, the

following questions can guide your health center in exploring partnership opportunities:

- ▶ Where are your patients getting clinical care outside of your health center? Which hospitals, behavioral health providers, specialists see your patients?
- ▶ What links do you currently have with these facilities and providers?
- ▶ How can you work together to manage care transitions and to develop shared care management plans?
- ▶ Are there opportunities to share data in real time, such as through participation in local health information exchanges or other data exchange framework? Can data be linked directly to your EHR to provide accurate and timely care?
- ▶ What organizations in your community are addressing health-related social needs? How can you work together to identify health and social needs and make referrals?
- ▶ What facilities provide after-hours care? How can you receive data about the care provided to your patients in these facilities, and what data can you share to allow for better after-hours care?

Working Together for Better Patient Care: Lessons from Rocky Mountain Health Plans and Mountain Family Health Centers

Mountain Family Health Centers, an FQHC with four sites in Colorado, and Rocky Mountain Health Plans have been working together since 2014 as contractual partners under various state VBP and APM programs for their Medicaid patients.

Through this partnership, they identified the following key lessons:

- ▶ It's not who you are, it's what you do.
- ▶ Follow "first principles": transparency, responsibility for community, inclusion, performance.
- ▶ Regular meetings (at least quarterly) between the plan and health center provided the opportunity for the plan to discuss areas of common concern and address emerging issues.
- ▶ Focusing on common goals helped forge a strong partnership. Goals and shared activities include:
 - ▶ Moving away from an FFS mentality
 - ▶ Engaging in rigorous, transparent, and objectively measured practice transformation
 - ▶ Creating a durable program founded on local leadership
 - ▶ Sharing data for transparent analysis and goal setting
 - ▶ Sharing the burdens and benefits, equitably and timely
 - ▶ Working to improve community capacity and health trends
- ▶ Health plan support was critical to success. The health plan provided a practice transformation team that served as "boots on the ground" and engaged in practice transformation, quality improvement, and developing data-use competencies. The plan also deployed community care teams, sometimes led by the FQHC.
- ▶ Making sure that risk adjustment was working, payments were accurate, and reporting for monitoring financial outcomes took a culture change and a commitment operationally for both partners.
- ▶ Both entities leaned into new activities to address health-related social needs, such as promoting social risk factor screening and awareness, developing incentives and supports for screening, and curating a network of human and community service providers.
- ▶ The health plan supported efforts to build a broader network of community partners and develop mutually beneficial relationships with them. The plan also rolled out a social information exchange to support alerts, task and record sharing, and consent management to allow health care providers, human services, and community agencies to share information.

Sources: Greg Howe, "Health Plan Leaders Find Success Working with FQHCs Through Value-Based Payment Arrangements," Center for Health Care Strategies (CHCS), January 24, 2020; P. Gordon and A. Fernandez, "Advanced Payment Models FQHC & CMHC Engagement" (CHCS meeting, Sacramento, California, May 9, 2019); and Interview with Art Fernandez, Mountain Family Health Centers, April 12, 2022.

APPENDICES

Appendix A. Advisory Group Members

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Appendix B. Overview of Data Elements and Sharing Requirements Under FQHC APM

EXAMPLE DATA	PERSON RESPONSIBLE FOR COLLECTING	STAFF RESPONSIBLE FOR REPORTING/ USING	HOW/WHEN IS IT CAPTURED?	WITH WHOM IS IT SHARED?	HOW IS IT USED?	WHAT'S CHANGING
QUALITY						
ICD-10 codes CG-CAHPS survey	<ul style="list-style-type: none"> ▶ Clinician ▶ Medical assistant ▶ Lab technician 	<ul style="list-style-type: none"> ▶ Clinical staff ▶ QI staff ▶ Operations staff ▶ Finance staff 	<ul style="list-style-type: none"> ▶ Patient visit ▶ Lab tests 	<ul style="list-style-type: none"> ▶ Health center staff ▶ MCPs ▶ DHCS 	<ul style="list-style-type: none"> ▶ Ensure your health center is delivering quality care ▶ Determine quality adjustment and ongoing participation in FQHC APM 	<p>Your health center will need to report on 22 quality measures. 12 of those measures will be tied to payment. Many of these metrics are likely in your contracts with MCPs, or you may participate in one or more state or federal VBP programs. Some metrics in FQHC APM may be new to your health center, but can likely be approached in a similar way and not require extensive changes in the way the data are collected and reported.</p>
ALTERNATIVE TOUCHES						
CPT codes (with assigned relative value units)	<ul style="list-style-type: none"> ▶ Clinician ▶ Medical assistant ▶ Dietician ▶ Care manager ▶ Health coach ▶ CHW 	<ul style="list-style-type: none"> ▶ Clinical staff ▶ Nonprovider care team ▶ Finance staff 	<ul style="list-style-type: none"> ▶ Patient visit ▶ Nurse advice line ▶ CHW visit ▶ Pharmacy visit ▶ Wellness activity ▶ Meeting with care manager 	<ul style="list-style-type: none"> ▶ Health center staff ▶ MCPs ▶ DHCS 	<ul style="list-style-type: none"> ▶ Deliver comprehensive and coordinated care ▶ Track utilization and what care is being delivered ▶ Set future rates 	<p>Alternative touches are services currently not billable under PPS but that are designed to increase patient engagement, improve patient outcomes, and generally allow better coordinated and integrated care. They fall under five domains: communication, education, case management, community supports, and care team support.</p>
PATIENT CARE AND ENGAGEMENT						
18 ICD-10-CM Z codes designated for In Lieu of Services by DHCS	<ul style="list-style-type: none"> ▶ Clinician ▶ Care manager ▶ Medical assistant ▶ CHW 	<ul style="list-style-type: none"> ▶ Clinical staff ▶ Nonprovider care team ▶ Finance staff 	<ul style="list-style-type: none"> ▶ Patient visit ▶ Nurse advice line ▶ CHW visit ▶ Meeting with care manager 	<ul style="list-style-type: none"> ▶ Health center staff ▶ MCPs 	<ul style="list-style-type: none"> ▶ Address HRSNs using health center services or referring to community services 	<p>You will now have greater flexibility to provide a broader range of services to address health-related social needs, which may require additional data. You may need to implement new processes for identifying HRSNs through assessments and screening tools, documenting HRSNs, coordinating the delivery of services by your health center, and referring to community supports when necessary.</p>
UTILIZATION AND FINANCIAL MONITORING						
Encounter data: PPS billable visits vs. patients engaged ICD-10 codes HCPS codes CPT codes	<ul style="list-style-type: none"> ▶ Clinician ▶ Medical assistant 	<ul style="list-style-type: none"> ▶ Finance staff 	<ul style="list-style-type: none"> ▶ Patient visit/ encounter 	<ul style="list-style-type: none"> ▶ Health center staff ▶ MCPs ▶ DHCS 	<ul style="list-style-type: none"> ▶ Ensure you are meeting program requirements ▶ Ensure MCPs will reimburse you fairly ▶ Understand how providing new services impacts your health center financially 	<p>All encounter data from your health center will go through the MCP to DHCS. Encounter data from your health center are critical for quality reporting, rate setting, care management, and all aspects of the FQHC APM. You may want to analyze how some providers use and bill their time. To take advantage of future opportunities for your health center to be rewarded for impacting positive health outcomes and decreased utilization at high-cost or inappropriate care settings, you may want to track patient utilization and costs outside the services provided by the FQHC (e.g., an inpatient stay at a hospital).</p>

Appendix B. Overview of Data Elements and Sharing Requirements Under FQHC APM (continued)

EXAMPLE DATA	PERSON RESPONSIBLE FOR COLLECTING	STAFF RESPONSIBLE FOR REPORTING/ USING	HOW/WHEN IS IT CAPTURED?	WITH WHOM IS IT SHARED?	HOW IS IT USED?	WHAT'S CHANGING
RATE SETTING						
Historic health plan payments to FQHCs; Historic PPS Wrap payments to FQHCs	<ul style="list-style-type: none"> ▶ Finance staff 	<ul style="list-style-type: none"> ▶ Finance staff 	<ul style="list-style-type: none"> ▶ Patient visit/ encounter 	<ul style="list-style-type: none"> ▶ MCPs ▶ DHCS 	<ul style="list-style-type: none"> ▶ Set rates 	DHCS will use historic utilization data to set rates for FQHC APM.
RISK STRATIFICATION						
ICD-10-CM, including Z codes CPT codes	<ul style="list-style-type: none"> ▶ Clinician ▶ Care manager 	<ul style="list-style-type: none"> ▶ Care manager ▶ Operations staff ▶ Clinician ▶ Finance staff ▶ Clinical leadership 	<ul style="list-style-type: none"> ▶ New patient visit ▶ Visit with new chronic condition diagnosis ▶ Transition of care ▶ Chart review 	<ul style="list-style-type: none"> ▶ Health center staff 	<ul style="list-style-type: none"> ▶ Systematically categorize patients based on their health status and other factors ▶ Help to make better use of limited resources, anticipate needs, and more proactively manage your patient population 	Your health center may develop and implement a risk stratification process to better target the care you deliver. This process would take into account a patient's health-related social needs, behavioral health, and chronic health conditions.
PATIENT AND PROVIDER EXPERIENCE AND SATISFACTION						
CG-CAHPS Your own surveys	<ul style="list-style-type: none"> ▶ Patient (self-reported) ▶ Providers 	<ul style="list-style-type: none"> ▶ QI staff ▶ Clinicians ▶ Clinical leaders ▶ Operations staff 	<ul style="list-style-type: none"> ▶ Surveys: mail or in person after visit 	<ul style="list-style-type: none"> ▶ Health center staff ▶ MCPs ▶ DHCS 	<ul style="list-style-type: none"> ▶ Understand the impact of the new model on patients and providers 	Three measures of patient experience are included in the quality metrics requirements: provider rating, timeliness of receipt of requested appointment, and if the patient would recommend this provider. You may want to collect additional data by conducting surveys of both patients and providers.
HEALTH EQUITY						
Race, Ethnicity, Language, and Disability (RELD) data	<ul style="list-style-type: none"> ▶ Clinician ▶ Medical assistant 	<ul style="list-style-type: none"> ▶ Clinical staff ▶ Nonprovider care team ▶ Finance staff 	<ul style="list-style-type: none"> ▶ New patient visit, intake ▶ Patient visit ▶ Surveys 	<ul style="list-style-type: none"> ▶ Health center staff ▶ MCPs ▶ DHCS 	<ul style="list-style-type: none"> ▶ Measure and track disparities ▶ Conduct a deeper analysis of gaps in care ▶ Develop actionable strategies to reduce disparities in care 	For a deeper understanding of the impact on patients, and to drive more equitable care, you will want to identify and ensure that you are collecting RELD data elements. With these data, your health center may want to conduct an analysis of disparities, identify gaps in care, and create a strategy for reducing health disparities.

Appendix C. Additional Resources

Expanding Medical Assistant Roles

- ▶ [New Roles for Medical Assistants in Innovative Primary Care Practices](#)
- ▶ [An Expanded Role for the Medical Assistant in Primary Care: Evaluating a Training Pilot](#)
- ▶ [How to Train Medical Assistants for Expanded Roles: AHRQ Webinar](#)

Incorporating CHWs in FQHCs

- ▶ [Including Community Health Workers \(CHWs\) in Health Care Settings \(PDF\)](#)
- ▶ [The Community Health Worker Core Consensus Project: CHW Assessment Toolkit](#)
- ▶ [Community Health Worker Core Consensus Project](#)
- ▶ [Strategies to Improve the Integration of Community Health Workers into Health Care Teams: “A Little Fish in a Big Pond”](#)
- ▶ [Integrating Community Health Workers into Primary Care to Support Behavioral Health Service Delivery: A Pilot Study](#)

Incorporating Pharmacists in FQHCs

- ▶ [Pharmacist Care in Federally Qualified Health Centers: A Narrative Review](#)
- ▶ [Pharmacists in Federally Qualified Health Centers: Models of Care to Improve Chronic Disease](#)

Empanelment

- ▶ [Empanelment: How to Form Patient Panels in Primary Care](#)
- ▶ [Safety-Net Initiative, Empanelment: Establishing Patient-Provider Relationships](#)

Group Visits

- ▶ [Group Medical Visits in Community Health Centers](#)
- ▶ [Integrated Center for Group Medical Visits](#)
- ▶ [Comparing Two Approaches to Group Medical Visits for Patients with Diabetes](#)
- ▶ [Example of Diabetes Group Visit Curriculum from Serve the People Health Center in CA](#)
- ▶ [Centering Pregnancy Care](#)
- ▶ [SAMHSA Resources on Group Therapy for Substance Abuse](#)
- ▶ [Guide for Clinicians Leading Substance Abuse Group Therapy](#)

Home-Based Services

- ▶ [ACOs Use Home Visits to Improve Care Management, Identify Needs, And Reduce Hospital Use](#)

- ▶ [The Team Approach to Home-Based Primary Care: Restructuring Care to Meet Patient, Program, and System Needs](#)
- ▶ [Four Tips for Adding House Calls to Your Practice](#)

Telehealth

- ▶ [California Telehealth Resource Center](#)
- ▶ [A Practical Guide to Expanding Home-Based Primary Care with Telehealth](#)
- ▶ [FQHCS and Telehealth](#)
- ▶ [How FQHCs are Conquering the Digital Divide in Telehealth, Remote Monitoring](#)
- ▶ [FQHC Telehealth Consortium Focuses on Addressing Health Disparities in Phase II Work](#)
- ▶ [Payment Reimbursement Tips: Mental Health Telecommunications Services](#)
- ▶ [Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders](#)

Care Management and Risk Stratification

- ▶ [NAHC Value Transformation Framework Action Guide](#)
- ▶ [Two-Step Process for Identifying Your Sickest Patients](#)
- ▶ [AAFP risk stratification algorithm](#)
- ▶ [Care Management: Implications for Medical Practice, Health Policy, and Health Services Research](#)
- ▶ [Care Management: An Implementation Guide for Primary Care Practices](#)
- ▶ [The Medical Home: Care Management](#)

Supporting Trauma-Informed Care

- ▶ [Trauma-Informed Care Implementation Resource Center](#)
- ▶ [Key Ingredients for Successful Trauma-Informed Care Implementation](#)
- ▶ [Guide to Trauma-Informed Organizational Development](#)

Scaling and Spreading Changes

- ▶ [Spreading and Scaling up Innovation and Improvement](#)
- ▶ [Scaling and Spreading Innovation in Health Care Delivery](#)

Patient-Centered Medical Home

- ▶ [PCMH certification](#)
- ▶ [AHRQ on the PCMH](#)
- ▶ [AHRQ's Tools for Implementing the PCMH](#)

Building Blocks of Primary Care

- ▶ [The 10 Building Blocks of High-Performing Primary Care](#)
- ▶ [The Ten Building Blocks of High Performing Primary Care: A Framework for Achieving the Patient Centered Medical Home](#)

Health Equity

- ▶ [Creating a Disparities Impact Statement](#)
- ▶ [A Typology for Health Equity Measures](#)
- ▶ [Achieving Health Equity: A Guide for Health Care Organizations](#)

Data

- ▶ [Health Care Data Governance](#)

Managed Care

- ▶ [Engaging with Medi-Cal MCPs](#)

Appendix D. Ideas for Care Models That Can Help Guide Your FQHC APM Work

The suggested models below have been used by various FQHCs that have made the transition to APMs. They are listed here as options to help provide a template or road map to guide FQHCs' work in transitioning to APMs.

Patient-Centered Medical Home

The patient-centered medical home¹¹⁰ is an approach to delivering high-quality, cost-effective primary care. Using a patient-centered, culturally appropriate, and team-based approach, the PCMH model coordinates patient care across the health system. The model has been associated with effective chronic disease management, increased patient and provider satisfaction, cost savings, improved quality of care, and increased preventive care.¹¹¹

The Building Blocks of Primary Care

Through their studies of "exemplary primary care practices" and their work helping other practices become more person-centered, Dr. Thomas Bodenheimer and his colleagues formulated the "essential elements of primary care," also known as the 10 building blocks of high-performing primary care.¹¹² They noted that high-performing primary care practices vary in size, resources, staffing, and populations served, yet they exhibit surprising similarity in how they provide high-quality, accessible, and patient-centered health care. Those similarities were identified as the building blocks of high-performing primary care.¹¹³

These building blocks have four foundational elements:

- ▶ Engaged leadership
- ▶ Data-driven improvement
- ▶ Empanelment
- ▶ Team-based care

In turn, these four foundational elements assist the implementation of the other six building blocks:

- ▶ Patient-team partnerships
- ▶ Population management
- ▶ Continuity of care
- ▶ Prompt access to care
- ▶ Comprehensiveness and care coordination
- ▶ Template of the future

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