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USER CONFERENCE
APRIL 13–15
BOSTON, MA
2026

Navigating The Shift: A Proven Framework for VBC Success

Today’s Presenters

Breann Streck, RN, BSN, CPC

Senior Practice Transformation Coach

Montana PCA

Montana Health Plus

Megan Duncan, RN BSN

Lead Care Manager

PureView Health Center

Today’s Agenda

Building a network of FQHCs

Network support for VBC success

FQHC Perspective: Supporting the Shift to VBC

Successes

Megan Duncan, RN, BSN Lead Care Manager

FQHC serving 9,400 unique patients (42,700+ visits annually)

Primary Care
Mental Health
Integrated Behavioral Health
LAC and Peer Support
Dentistry
Pharmacy
Case Management
Care Management
School Based Care
Mobile Clinic

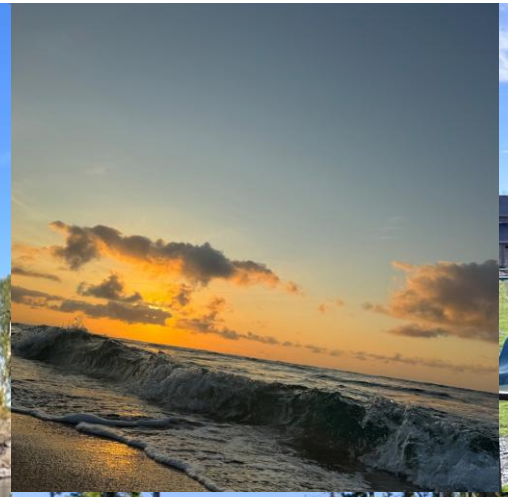
PureView Health Center

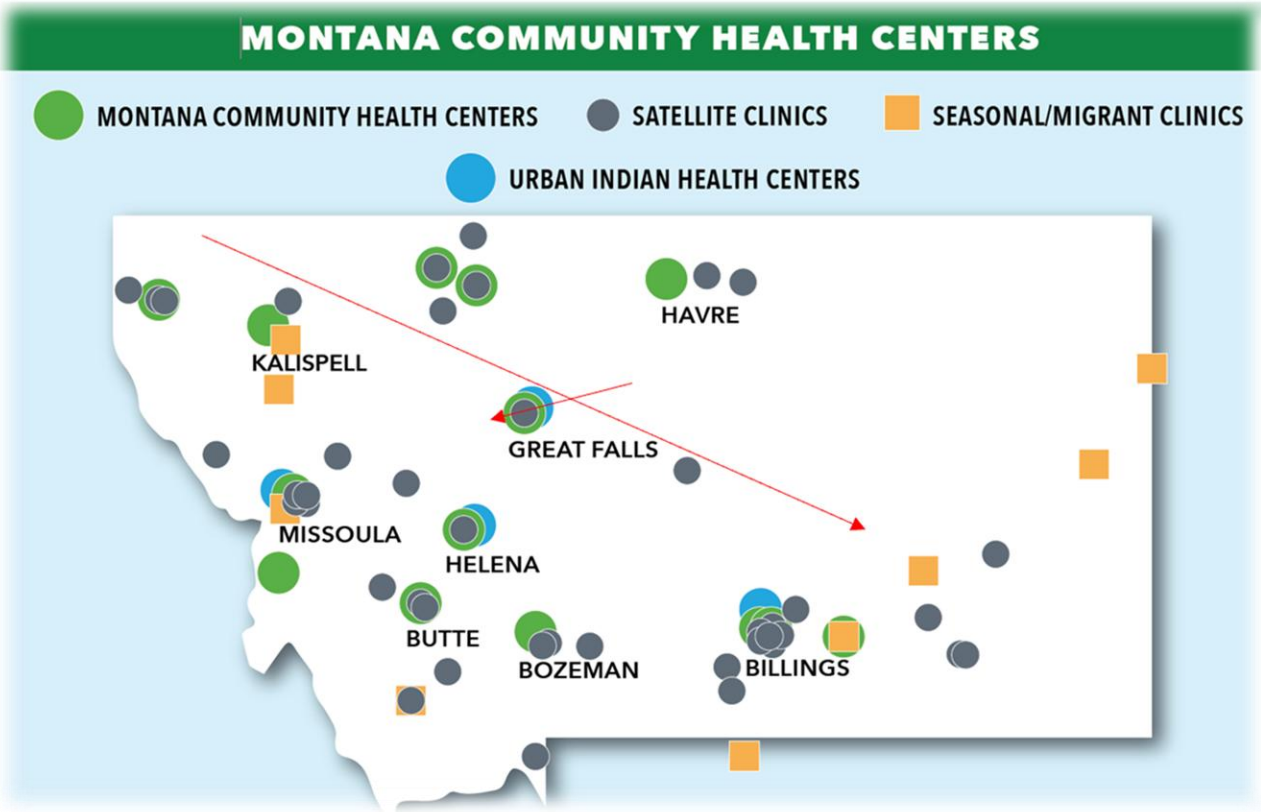

You Are
Loved


PUREVIEW
Health Center

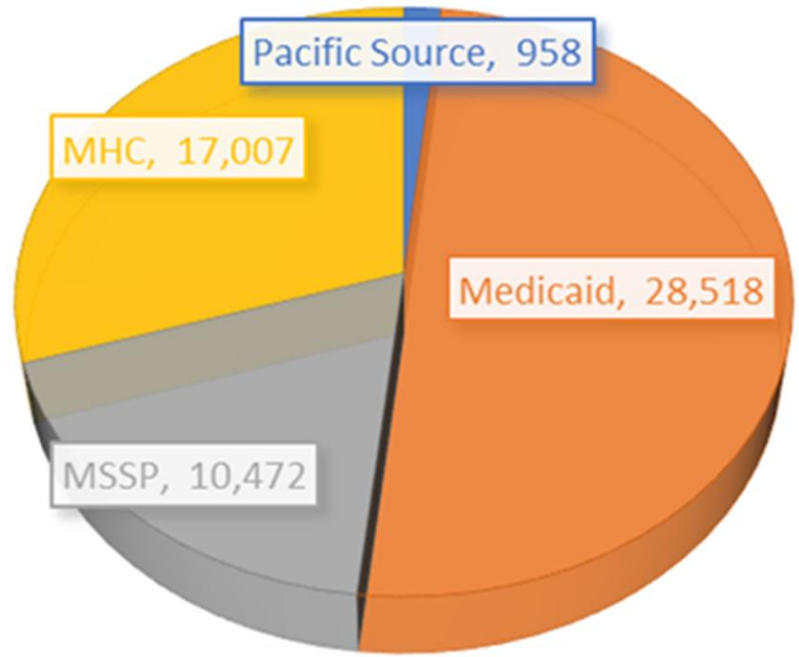

health+
MONTANA
HEALTH PLUS

Breann Streck, RN, BSN





NETWORK MEMBER ATTRIBUTION



Purpose of MT H+ Network: Improving population health, providing a formal statewide system of care, increasing optimal clinical outcomes and decreasing overall healthcare costs for people in Montana regardless of income or coverage status, by providing integrated, high-quality, patient-centered care in a network of community-based health centers to the citizens of the State of Montana and private and public payers.

The Landscape of VBC

CMS 2030 Goal

- **All** traditional Medicare beneficiaries are in an accountable care arrangement
- As of January 2025, **53.4%** of people with Traditional Medicare are in an accountable care relationship.*

FQHCs are critical in VBC:

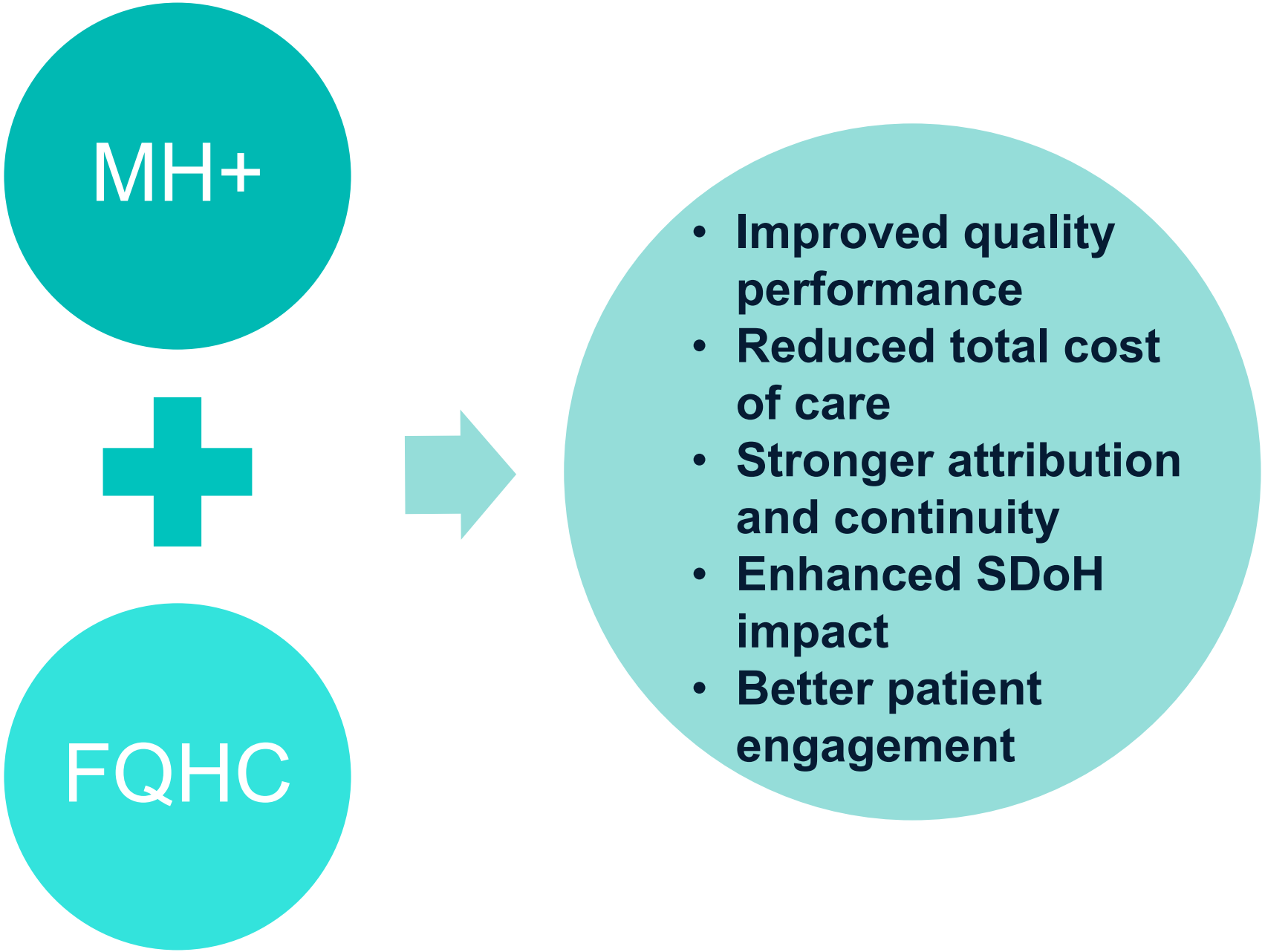
- Serve populations that VBC is designed to impact most
- Deliver Comprehensive, Team-Based Primary Care
- Prevention and Comprehensive Disease Management
- Reduce Total Cost of Care
- Positioned as a National Leader in VBC Transformation

* https://www.cms.gov/newsroom/fact-sheets/cms-moves-closer-accountable-care-goals-2025-aco-initiatives

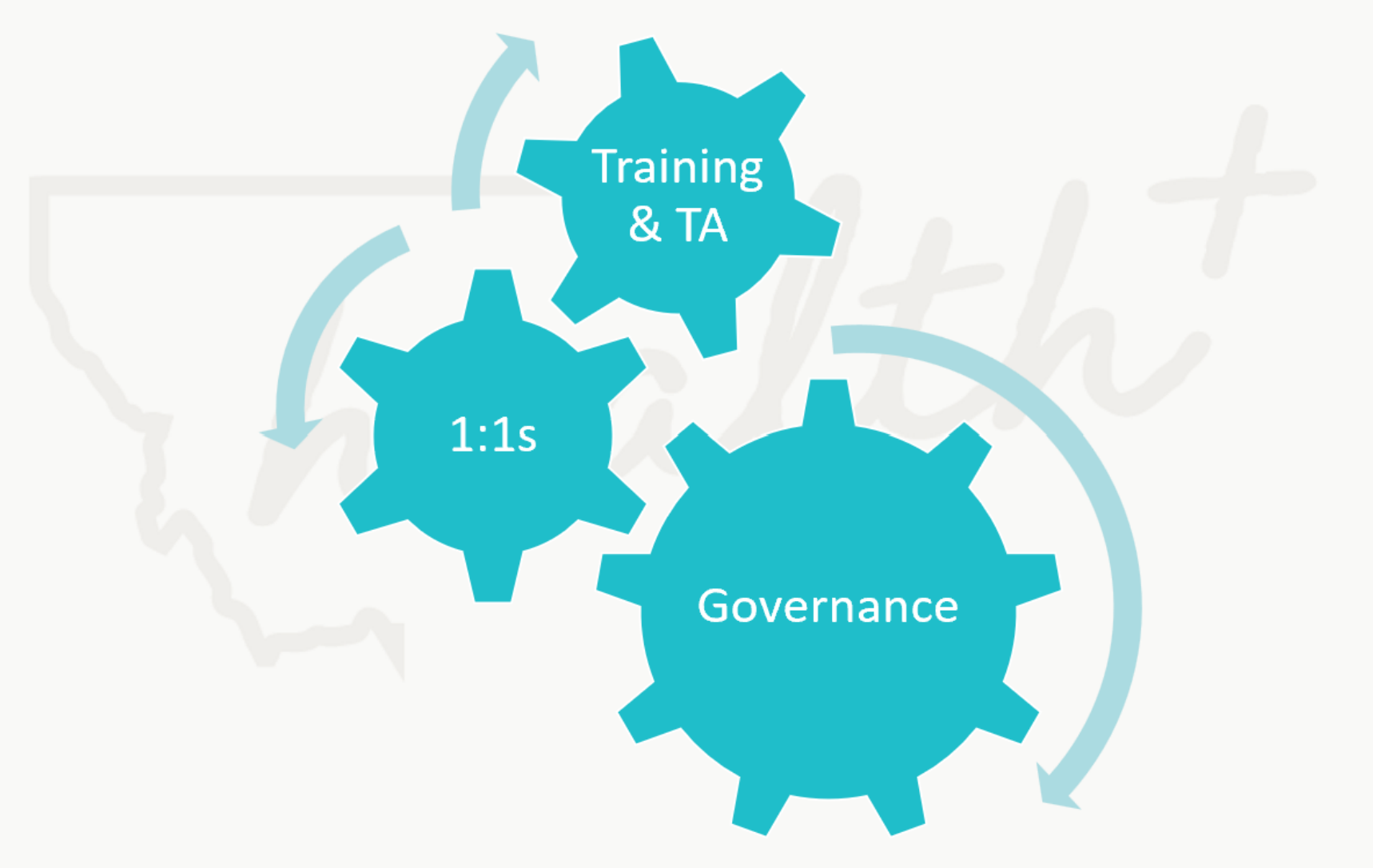
MSU: Project 2030

MH+ and FQHC Partnership for VBC

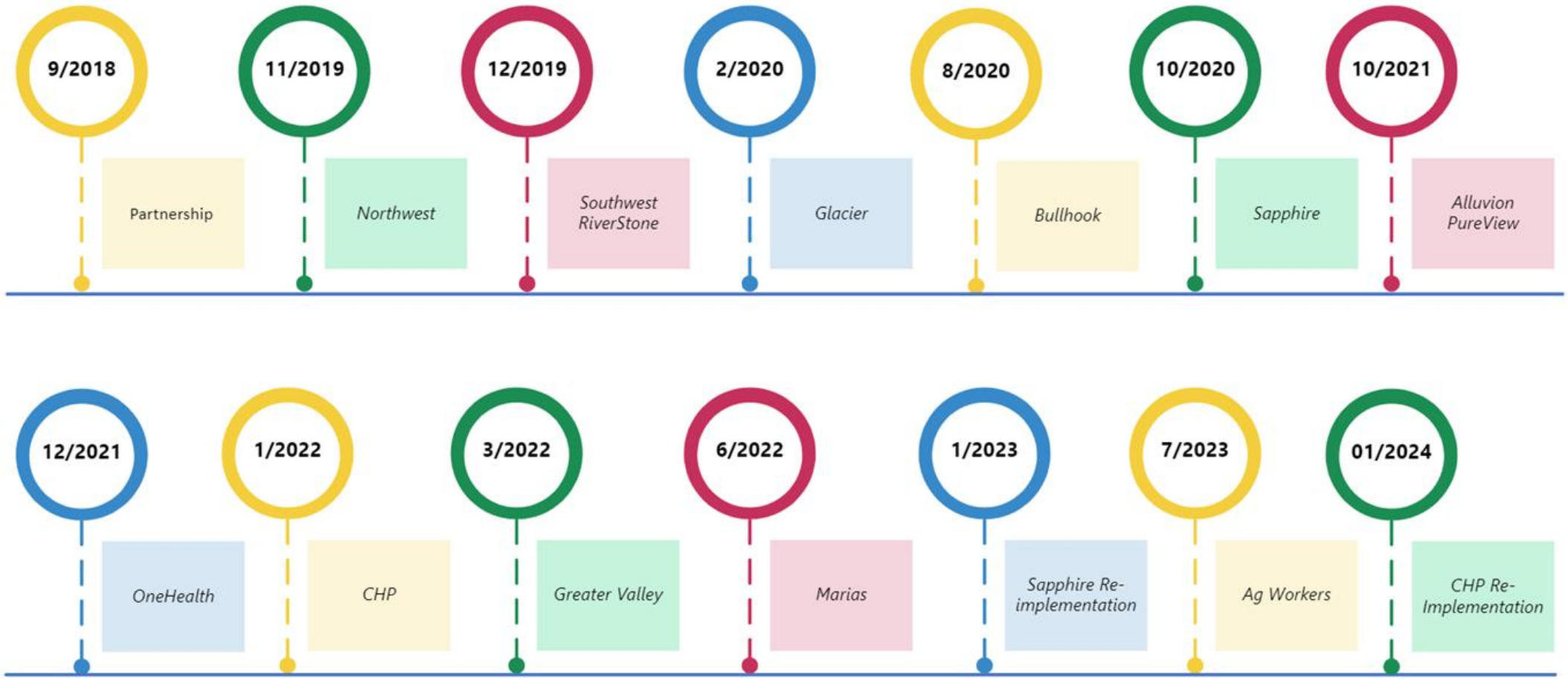
CIN/ACO Strengths	FQHC Strengths
Data and Analytics Population health platforms, risk stratification, quality dashboards	**Access** Trusted access to underserved, high risk populations, transitions of care
Contracting Expertise Payor negotiations, shared savings, risk model designs	**Integrated Primary Care** Medical, behavioral health, dental, pharmacy
Standardized Protocols Align quality measures, evidence-based guidelines Redefine roles...	**Social Drivers of Health** Screening, navigation and community partnerships
Education Care Management, clinic design, quality measures, coding, etc.	**Culturally Competent Care** Patient centered approaches that improve engagement


MH+
FQHC
• Improved quality performance
• Reduced total cost of care
• Stronger attribution and continuity
• Enhanced SDoH impact
• Better patient engagement

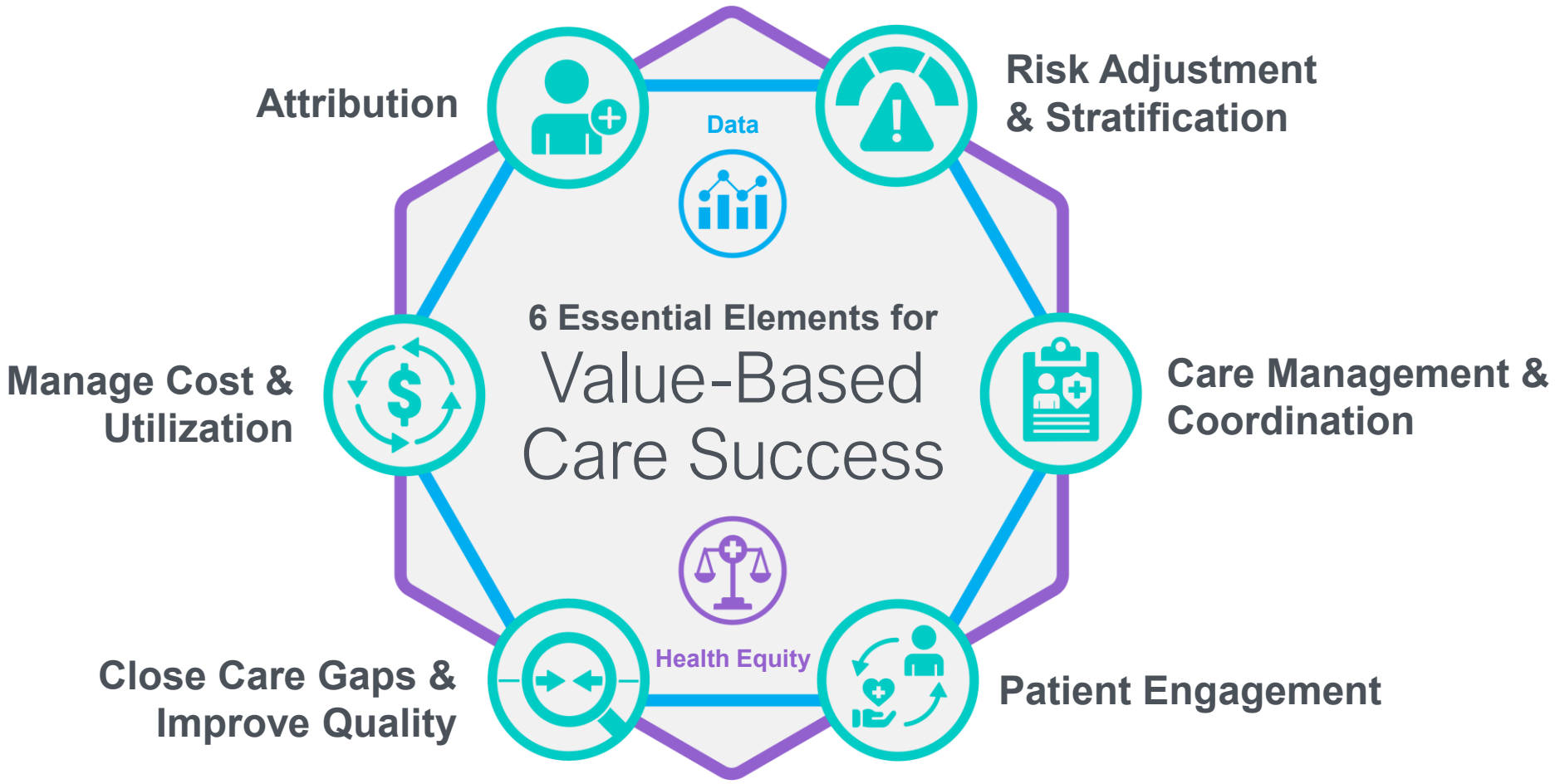
How We Work Together



The Data Strategy



Framework for FQHC Readiness to VBC model



"The Aha Moment" - Networking to Facilitate the Transition to VBC

Care Team – The Mindset Shift

Initial

We started with a dream, but no dedicated staff or workflow

- Invested in one Care Manager for the entire practice
- QI Leader and Medical Director and CEO were huge proponents for Value-Based Care
- Initial focus was on TOC/TCM
- Expanded into Population Health and targeted outreach for gaps/UDS
- Provided Care Coordination for the most complex patients
- Quickly saw the need and opportunity for a Chronic Care Management Program

Transition

Leadership support – From top down

- In addition, all teams were willing to participate – they saw the big picture
- Responsibilities were shifted – worked to higher licensure
- Shifted work **without** having to create more FTE to support over-all vision
- Eventually did begin expanding the team once billable revenue streams (TCM/CCM) were established to support ability to invest further

It Takes A Team
PureView - Value Based Care Team Design

Front Desk Staff
- Script for AWV
- Outreach as requested by CM team

Nursing Team
- PVP
- Use highest specificity code
- Promote Preventive Care
- Standing orders for screenings

Providers
- Improve coding specificity
- Improve code recapture
- Promote preventive care
- MH+ provided periodic training on coding tips

Care Management
- Provide TCM and CCM care
- Huddle/Warm-Handoffs
- Regular outreach to address gaps
- Promote preventive care
- Education and leadership

QI
- Identifies trends
- Assists in prioritizing outreach
- Assists with outreach strategy
- Reporting

Leadership
- Supports VBC vision
- Invests in staff and data/tech
- Invests in education
- Active involvement with ACO Board
- Participates in 1:1 meetings
- CMO Leadership

Coders/Billing
- Billing for TCM/CCM
- Validate documentation
- Coding tips/expertise

Data/Technology to Support the Shift

DRVS Tools:

- UDS Quality
- Transition of Care
- CMP/PVP
- Member Report
- Newly Assigned Members
- Medicare RAF Gaps
- Dashboards
- Risk Stratification
- ACC
- ACU

Transitions of Care (TOC)

Connection with BSCC (statewide HIE)

- Identify ED Visits
- Identify Inpatient Admissions/Discharges

Patient Outreach

- Care coordination
- Medication reconciliation
- Patient education

TCM

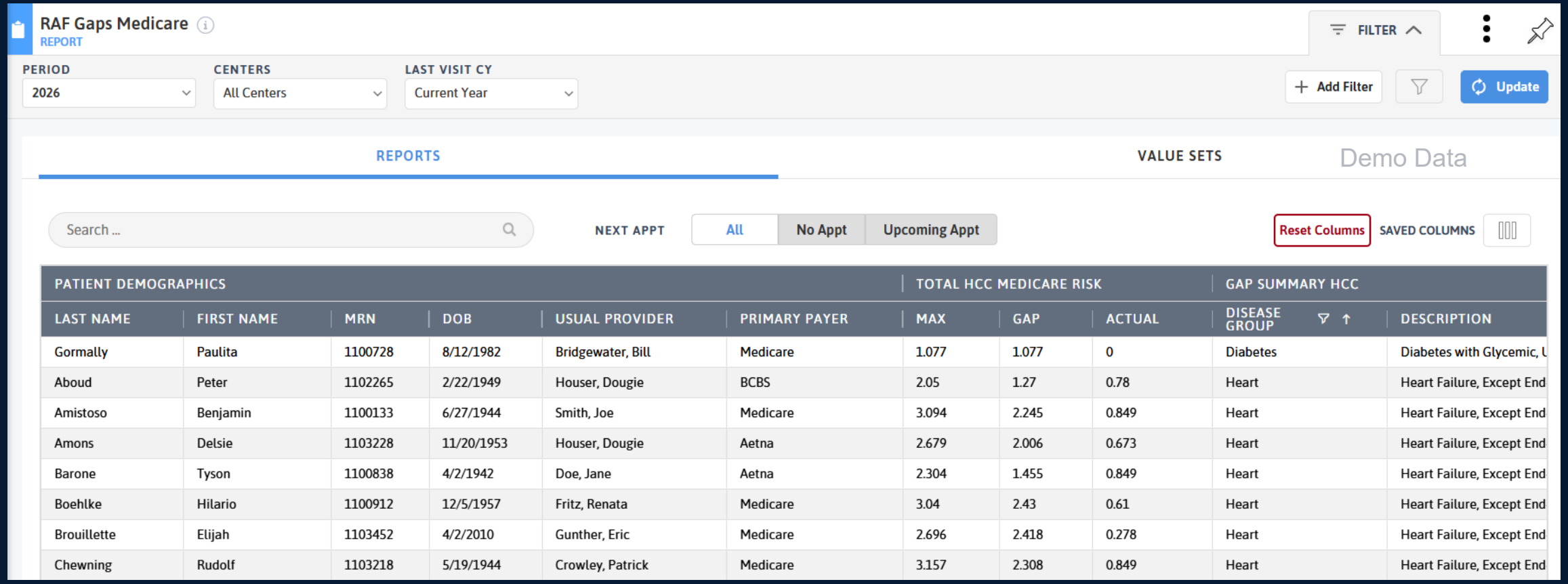
- Transitional care management (TCM) is a billable revenue stream
- Compliance with documentation requirements
- TOC services within specified time-frame to qualify

RAF (Risk Adjustment Factor) Gaps

1. Prep for visit utilizing the Medicare Raf Gap Report

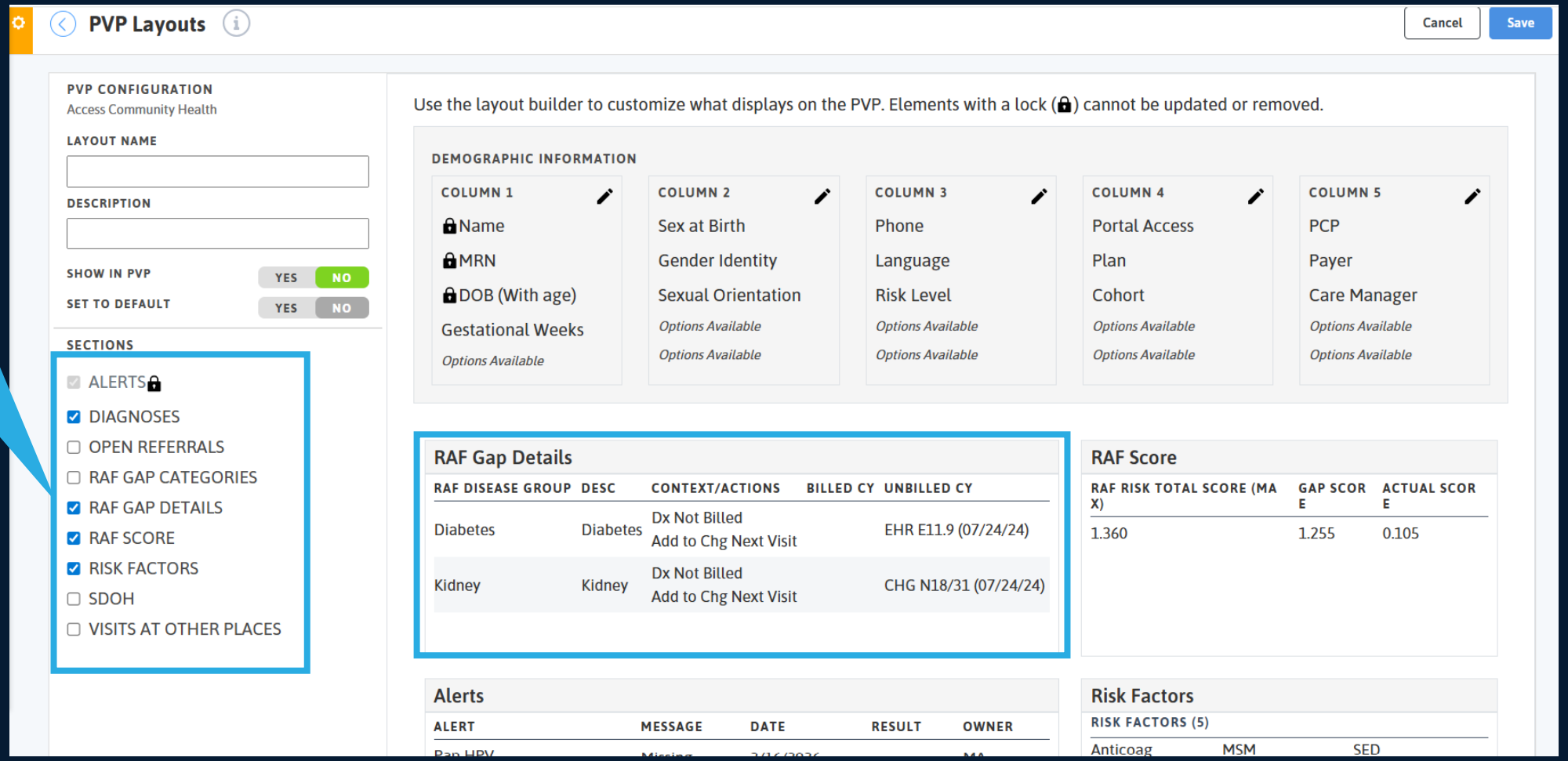
2. Upgrades in DRVS – PVP/CMP

Medicare RAF Report



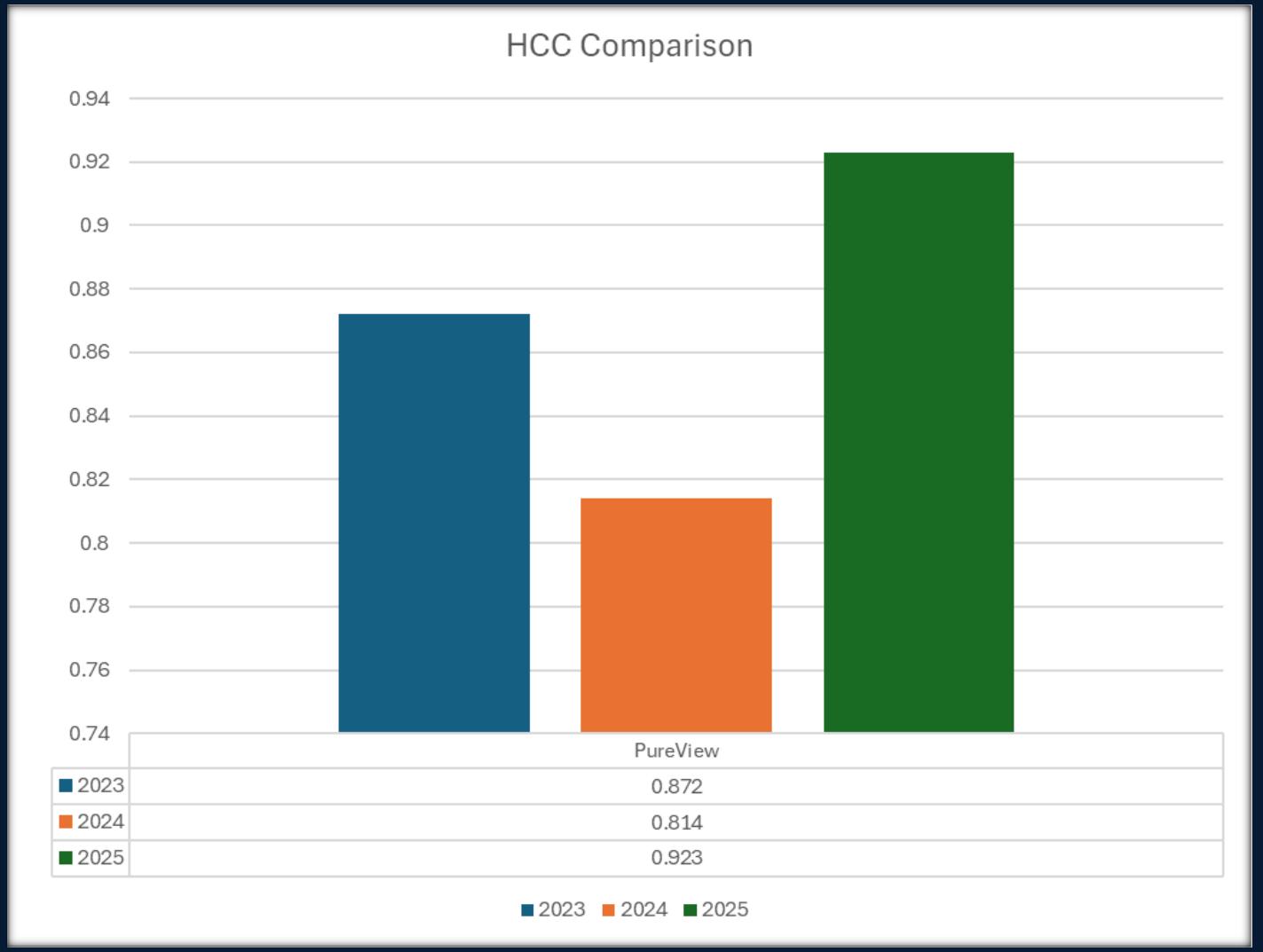
RAF Details via PVP Configuration

Create new PVP template and add “RAF GAP Details” to the PVP in the Patient Visit Planning Admin.



Recapture Rate Improvement

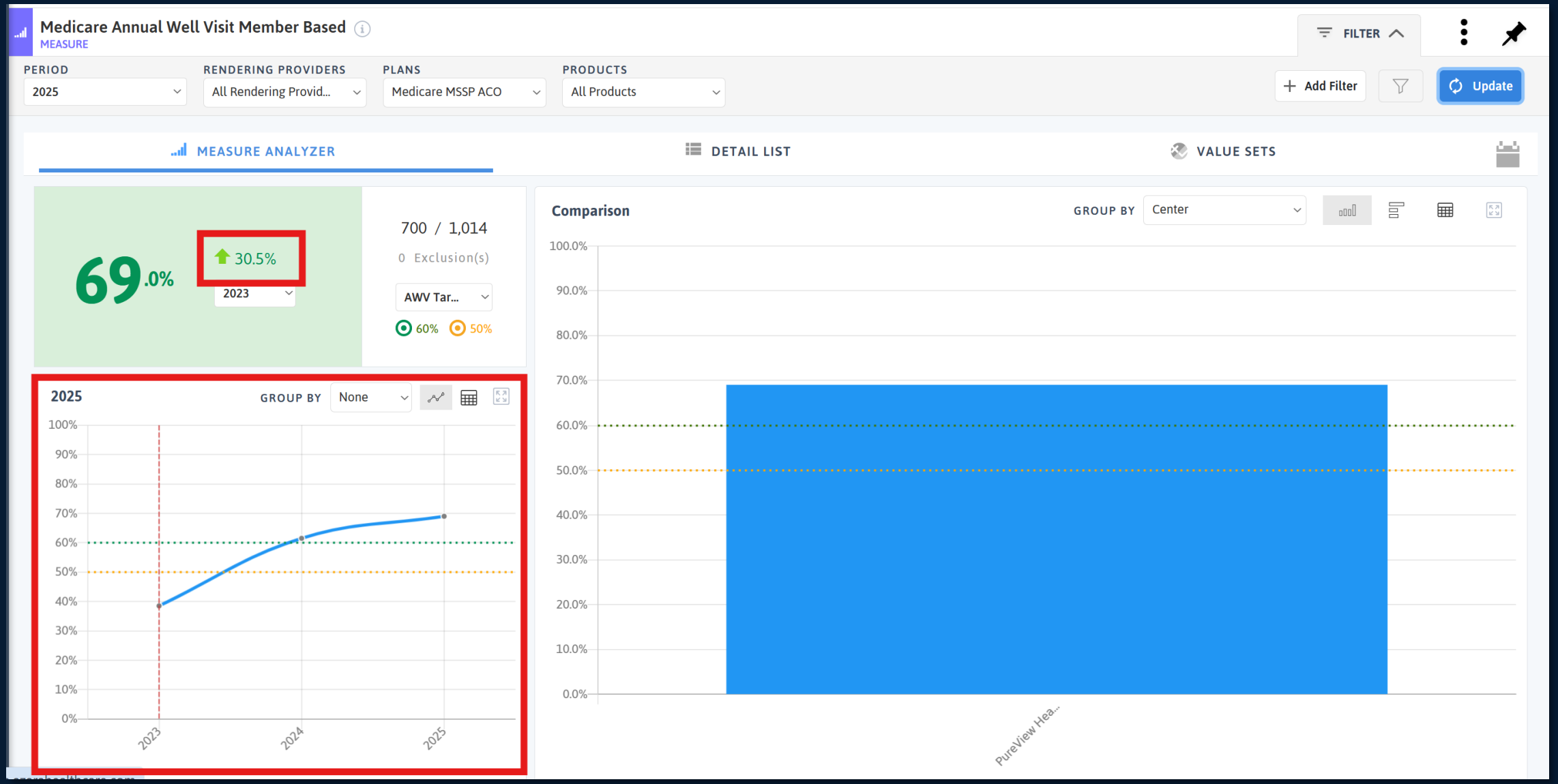
HCC Improvement



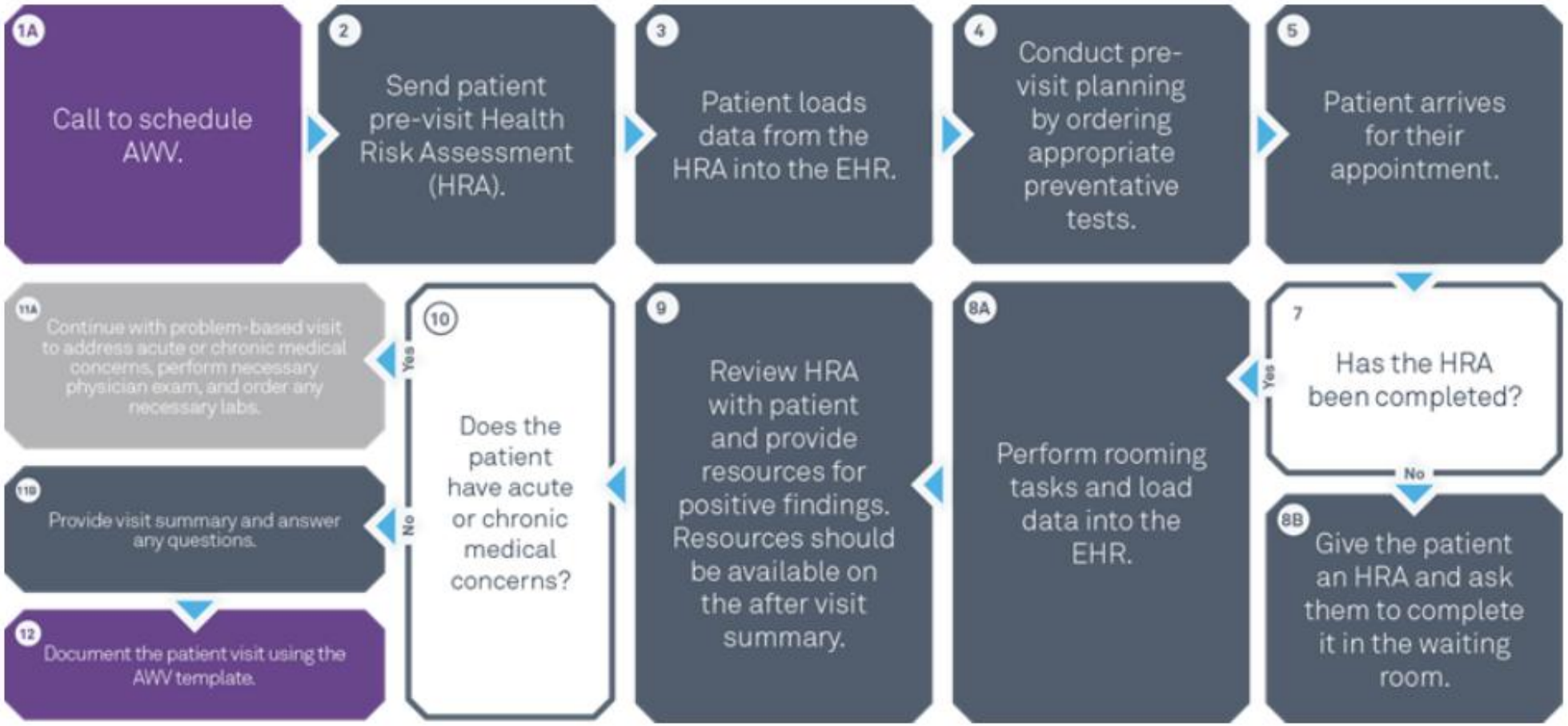
Patient Spend Data Comparison - Pureview

	2025	2024
Estimated CMS Financial Benchmark	$12,144.22	$10,815.69
YTD Average Per Patient Spend	$11,461.65	$10,253.55

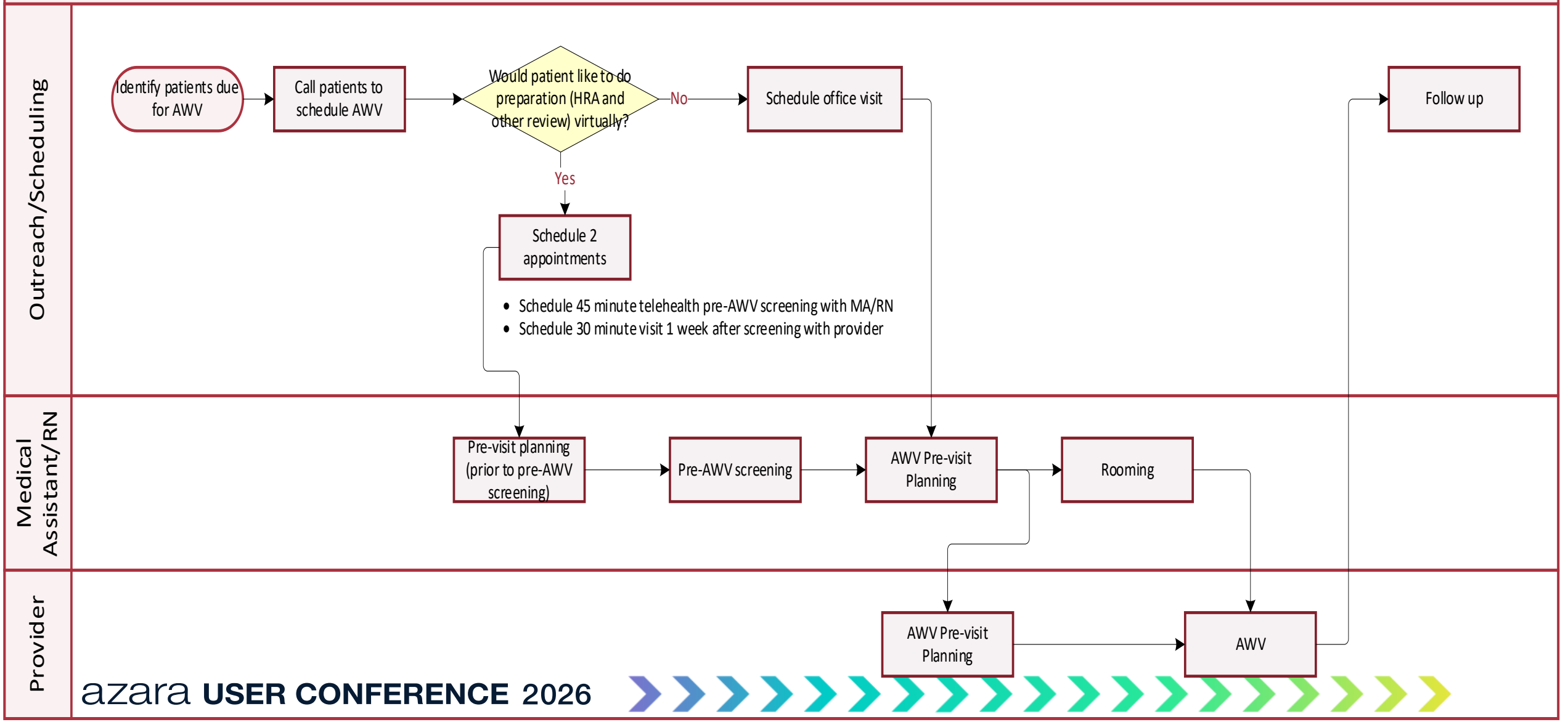
Medicare Wellness Visit (MWV)



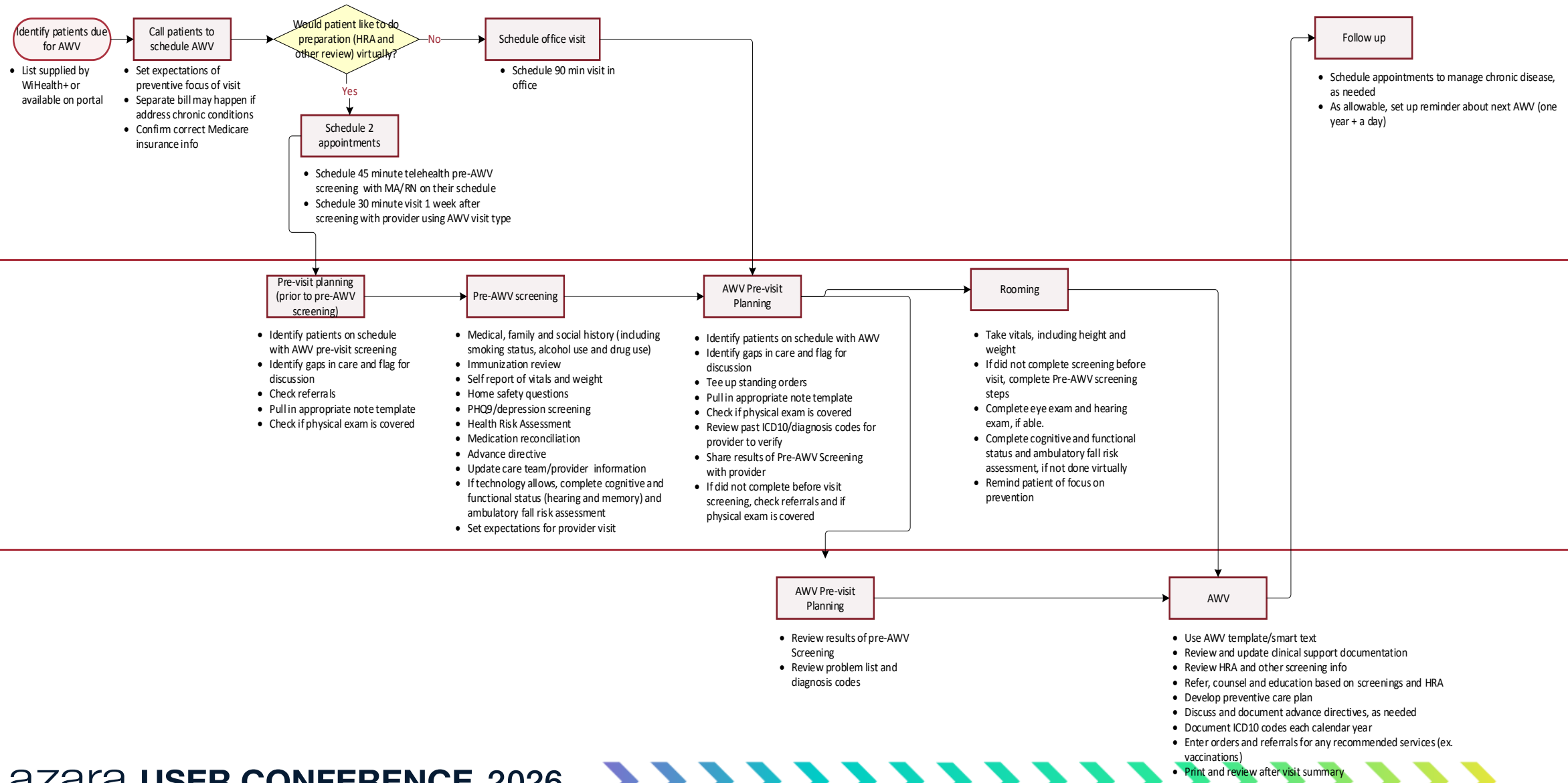
Examples of MWV Workflows


1A
Call to schedule AWV.
2
Send patient pre-visit Health Risk Assessment (HRA).
3
Patient loads data from the HRA into the EHR.
4
Conduct pre-visit planning by ordering appropriate preventative tests.
5
Patient arrives for their appointment.
7
Has the HRA been completed?
Yes
No
8A
Perform rooming tasks and load data into the EHR.
8B
Give the patient an HRA and ask them to complete it in the waiting room.
9
Review HRA with patient and provide resources for positive findings. Resources should be available on the after visit summary.
10
Does the patient have acute or chronic medical concerns?
Yes
No
11A
Continue with problem-based visit to address acute or chronic medical concerns, perform necessary physician exam, and order any necessary labs.
11B
Provide visit summary and answer any questions.
12
Document the patient visit using the AWV template.

Annual Wellness Visit Workflow – Proposed 5.25.22

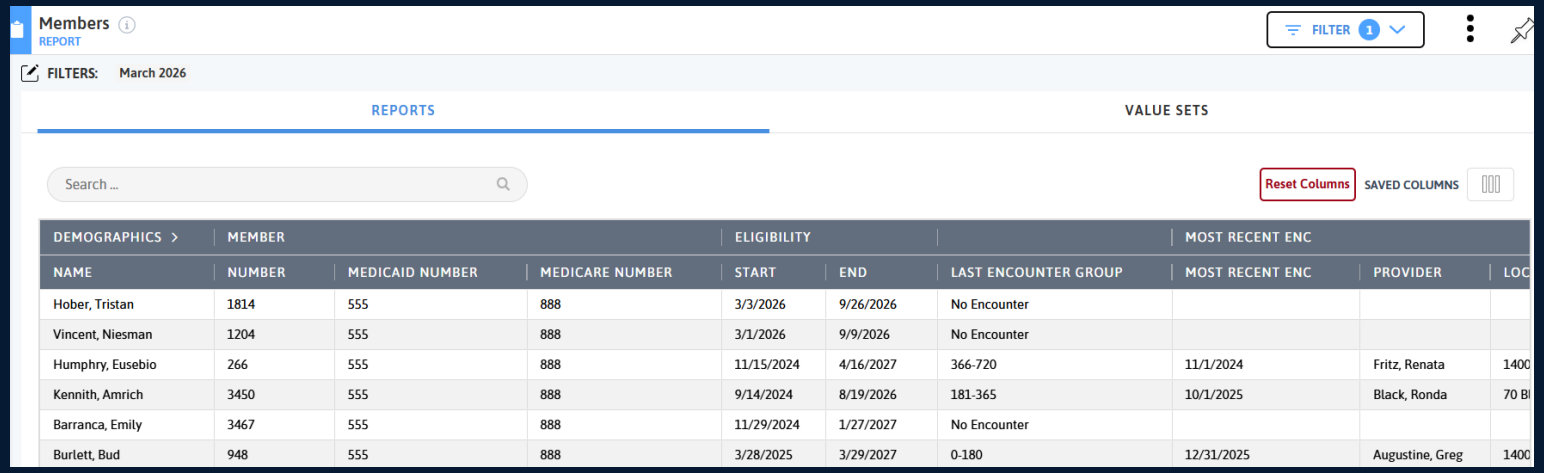


Annual Wellness Visit Workflow – Proposed 5.25.22



Member Report

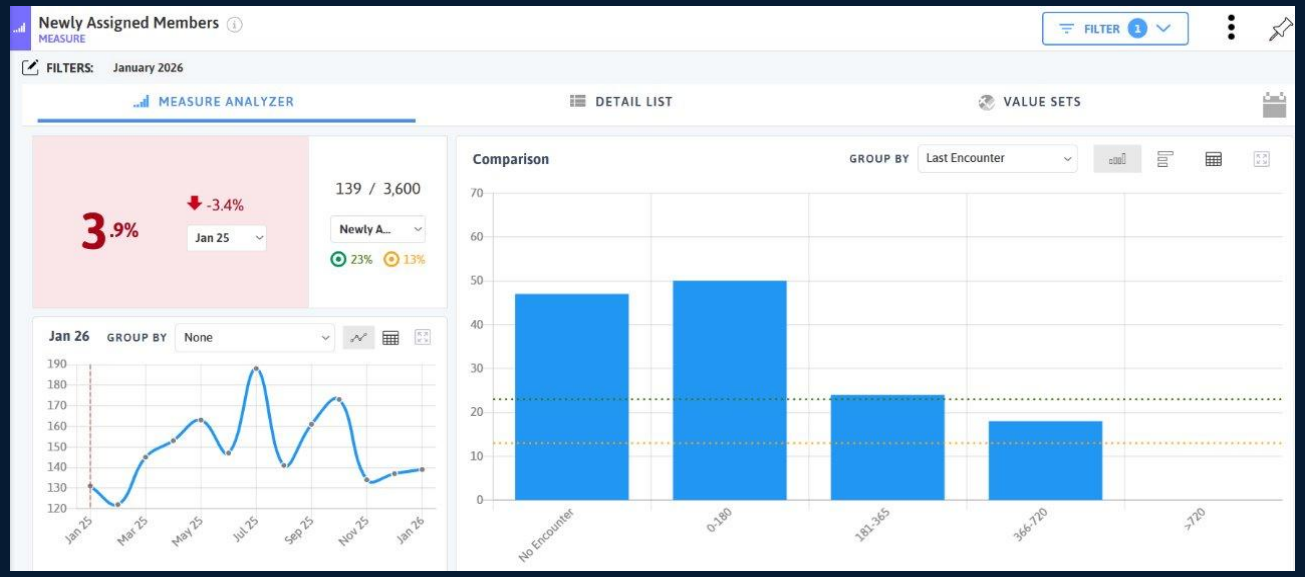
- **Identify patients who haven't been seen**
- Stratify by cost
- Ensure that patient is seen for annual preventative care appointment



DEMOGRAPHICS	MEMBER			ELIGIBILITY			MOST RECENT ENC		
NAME	NUMBER	MEDICAID NUMBER	MEDICARE NUMBER	START	END	LAST ENCOUNTER GROUP	MOST RECENT ENC	PROVIDER	LOC
Hober, Tristan	1814	555	888	3/3/2026	9/26/2026	No Encounter			
Vincent, Niesman	1204	555	888	3/1/2026	9/9/2026	No Encounter			
Humphry, Eusebio	266	555	888	11/15/2024	4/16/2027	366-720	11/1/2024	Fritz, Renata	1400
Kennith, Amrich	3450	555	888	9/14/2024	8/19/2026	181-365	10/1/2025	Black, Ronda	70 Bl
Barranca, Emily	3467	555	888	11/29/2024	1/27/2027	No Encounter			
Burlett, Bud	948	555	888	3/28/2025	3/29/2027	0-180	12/31/2025	Augustine, Greg	1400

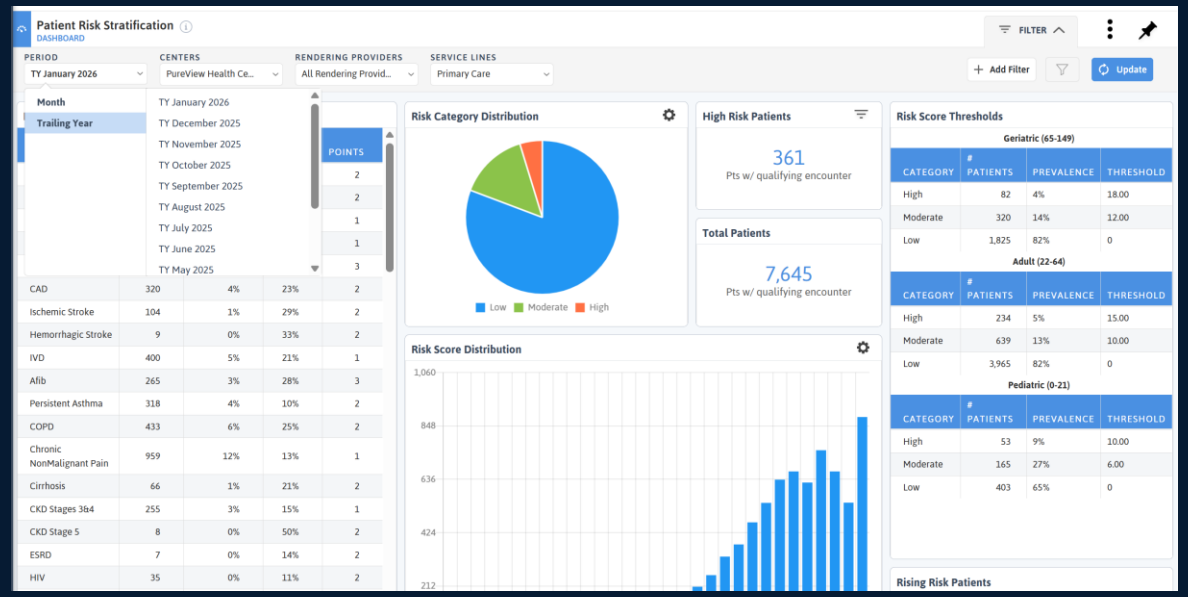
Newly Assigned Member Measure

- Outreach to newly assigned members
- Offer to establish with a primary care provider
- Coordinate integrated care services
- PureView is the preferred provider
- Focus on prevention to decrease downstream healthcare costs

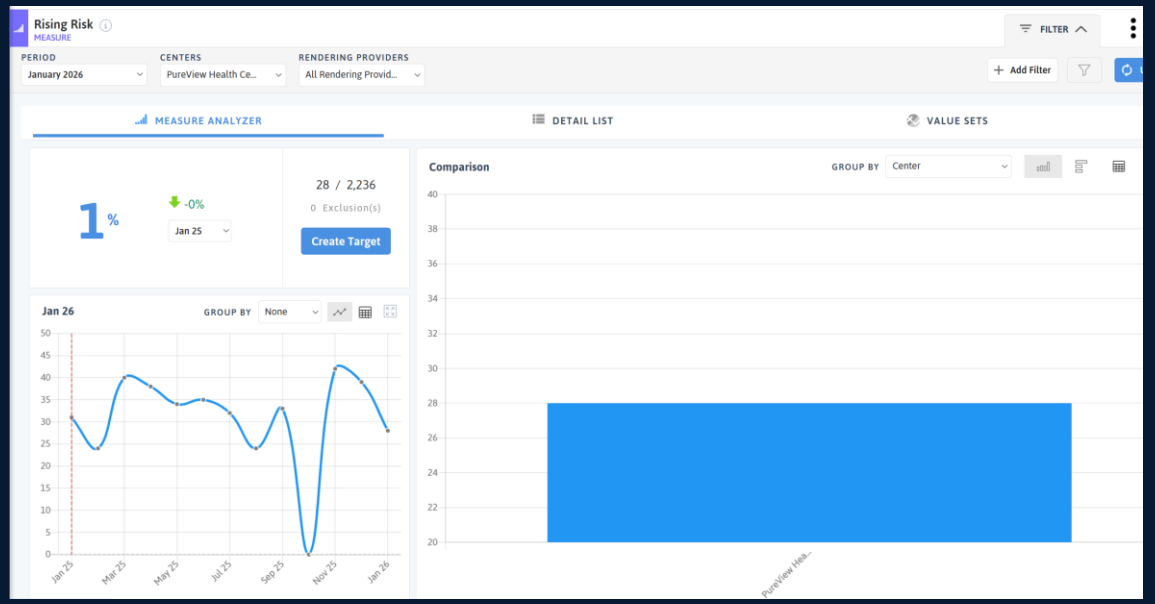


Risk Stratification

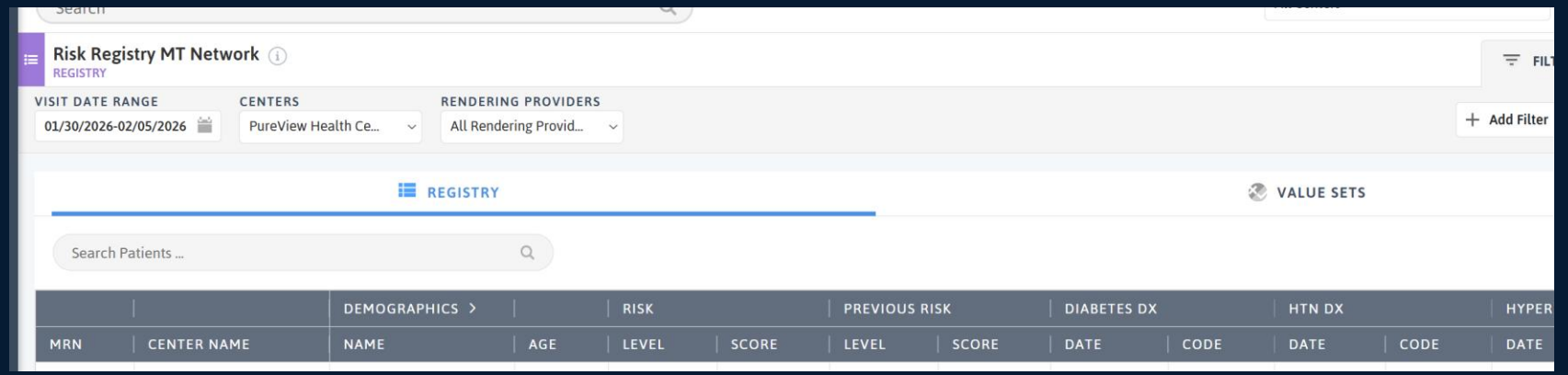
Patient Risk Dashboard



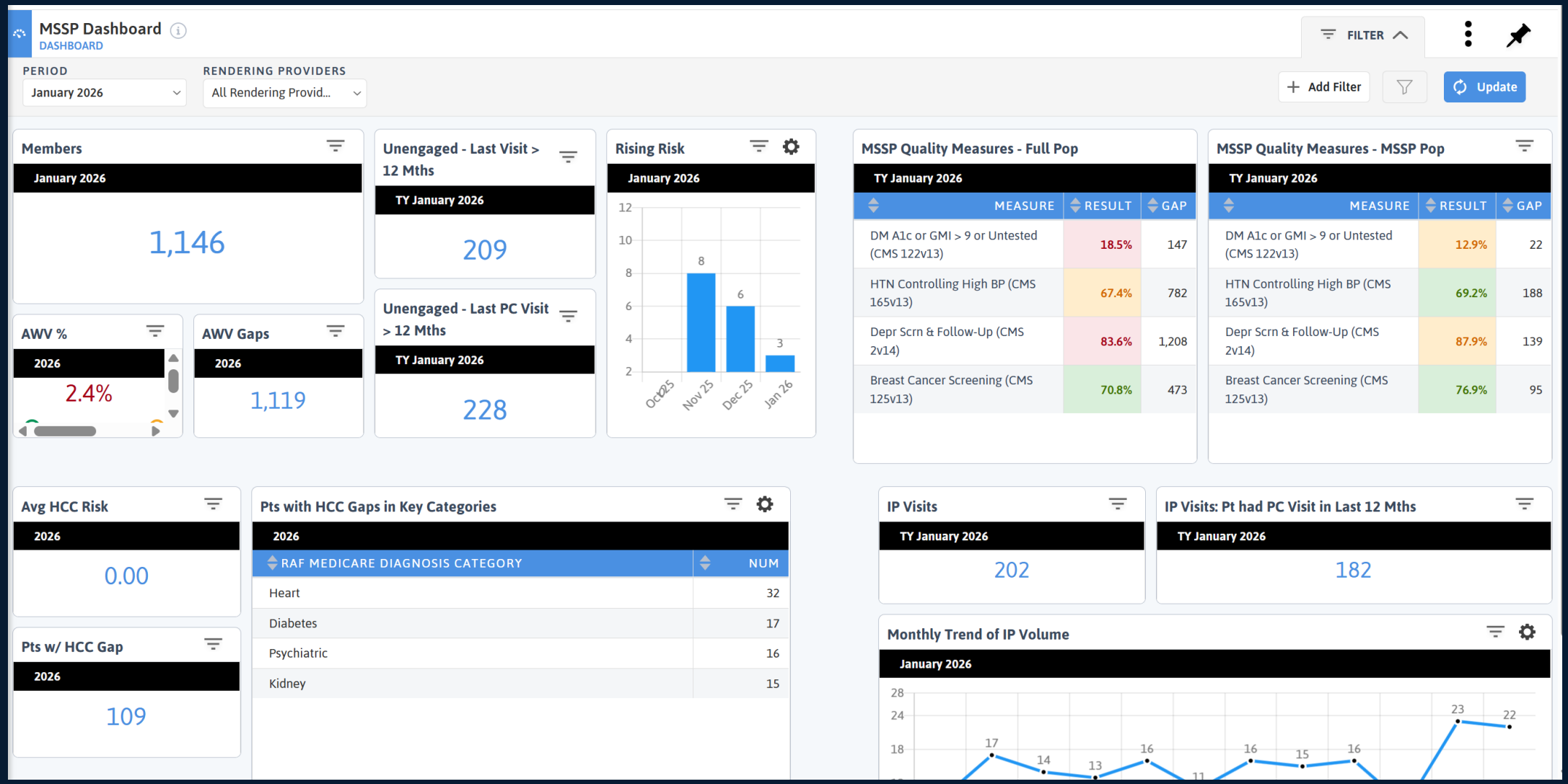
Rising Risk



Custom Registry: Identify Patients for Care Management

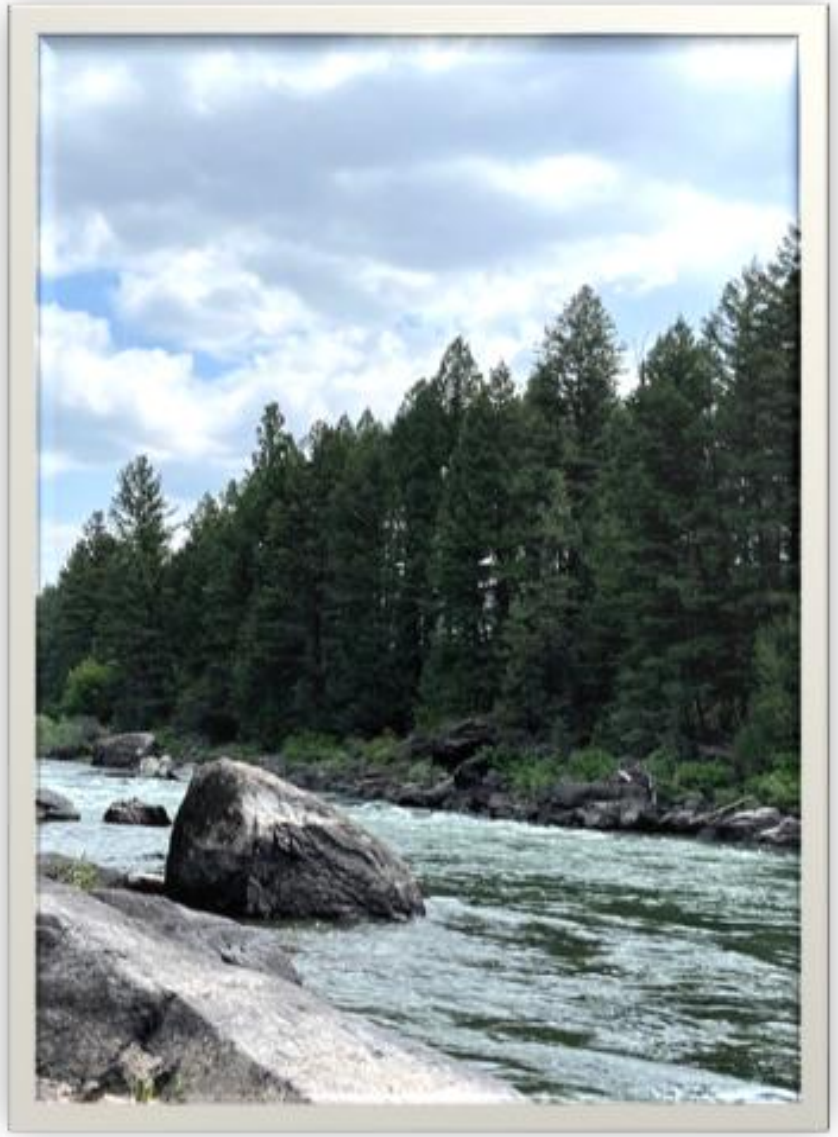


MSSP Dashboard

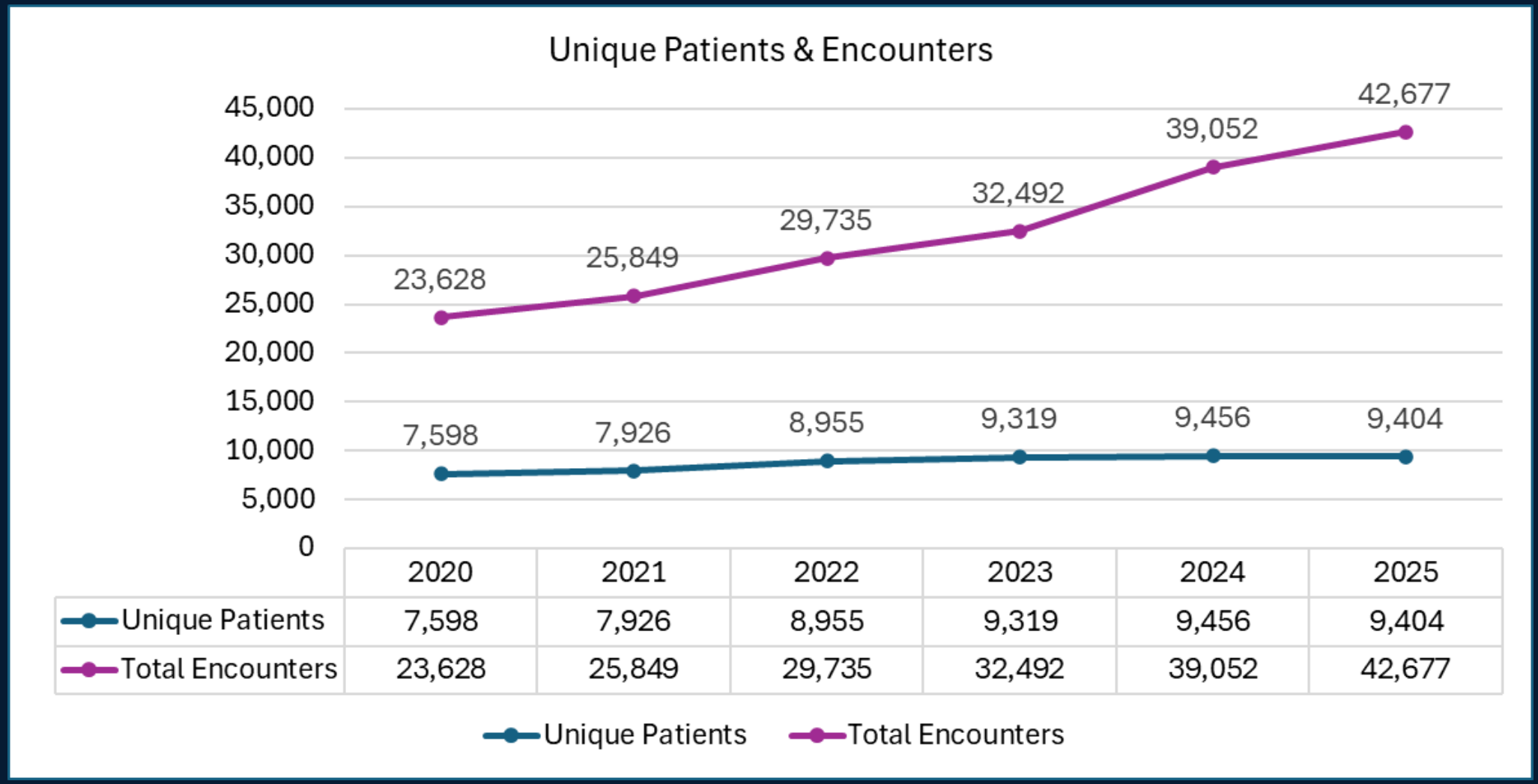


Making the Data Meaningful

- **Numbers represent <u>real</u> people**
- Filter reports to make outreach individualized, not just cold calls
- Celebrate those small wins!
- Share the success with whole team
- Re-center, re-prioritize, re-educate



Improved Patient Engagement



	2020	2021	2022	2023	2024	2025
Unique Patients	7,598	7,926	8,955	9,319	9,456	9,404
Total Encounters	23,628	25,849	29,735	32,492	39,052	42,677

Quality Data Initiative

- [x] Network Level Support
- [x] Monthly Reporting and Data Stratification of Key Quality Metrics
- [x] Monthly Learning Calls

Hypertension Controlling High Blood Pressure (CMS165v13)

MEASURE

PERIOD: 2025

RENDERING PROVIDERS: All Rendering Provid...

MEASURE ANALYZER

68.4%

6.0%

2023

1,640 / 2,398

95 Exclusion(s)

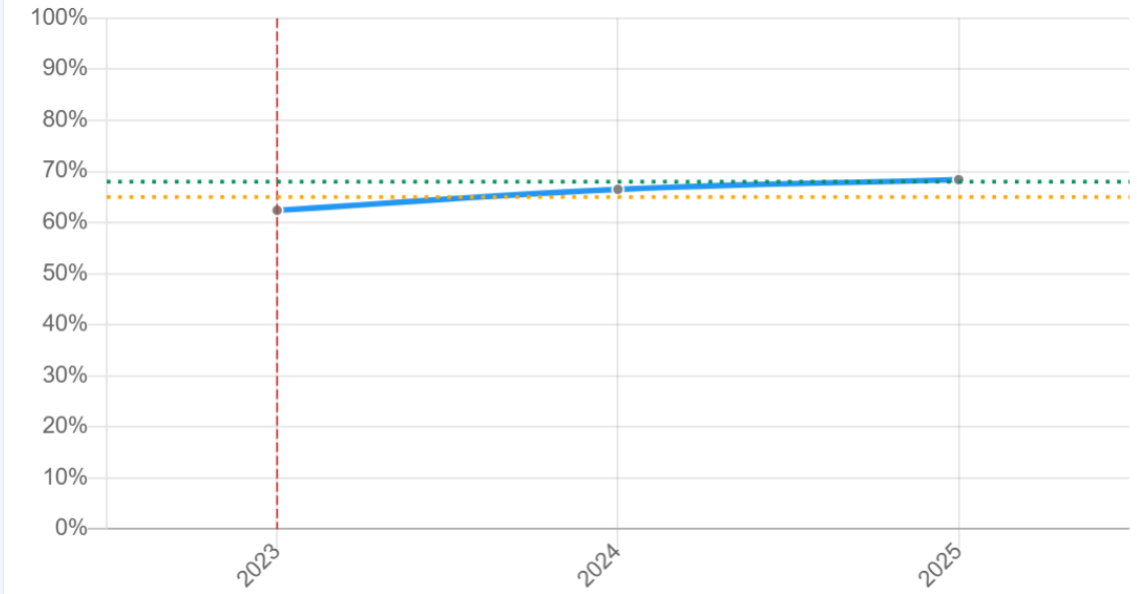
758 Gaps **0** To Target

Controlling ...

68% 65%

SELECTED	68.4%
Center Avg	68.4%
Network Avg	62.2%
Best Center	75.2%

2025 YTD PROGRESSION GROUP BY None



Hypertension Controlling High Blood Pressure (CMS165v13)

MEASURE

PERIOD: 2025

RENDERING PROVIDERS: All Rendering Provid...

PLANS: Medicare MSSP ACO

MEASURE ANALYZER

70.5%

9.5%

2023

328 / 465

35 Exclusion(s)

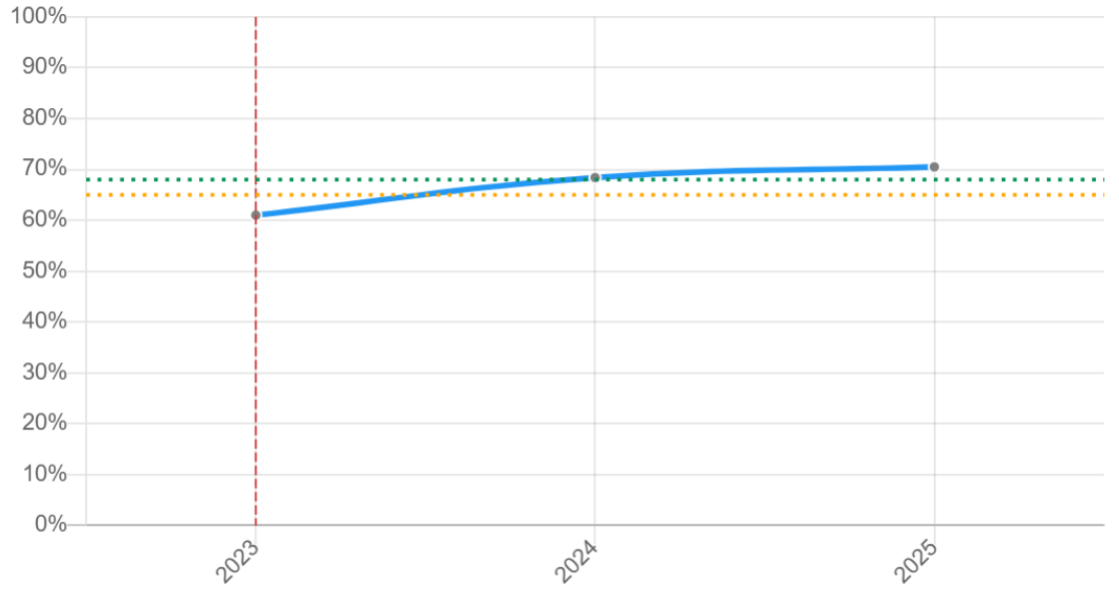
137 Gaps **0** To Target

Controlling ...

68% 65%

SELECTED	70.5%
Center Avg	68.4%
Network Avg	62.2%
Best Center	75.2%

2025 YTD PROGRESSION GROUP BY None



Breast Cancer Screening Ages 50-74 (CMS 125v13)

MEASURE

PERIOD: 2025

RENDERING PROVIDERS: All Rendering Provid...

MEASURE ANALYZER

71.1%

9.0%

2023

1,157 / 1,628

38 Exclusion(s)

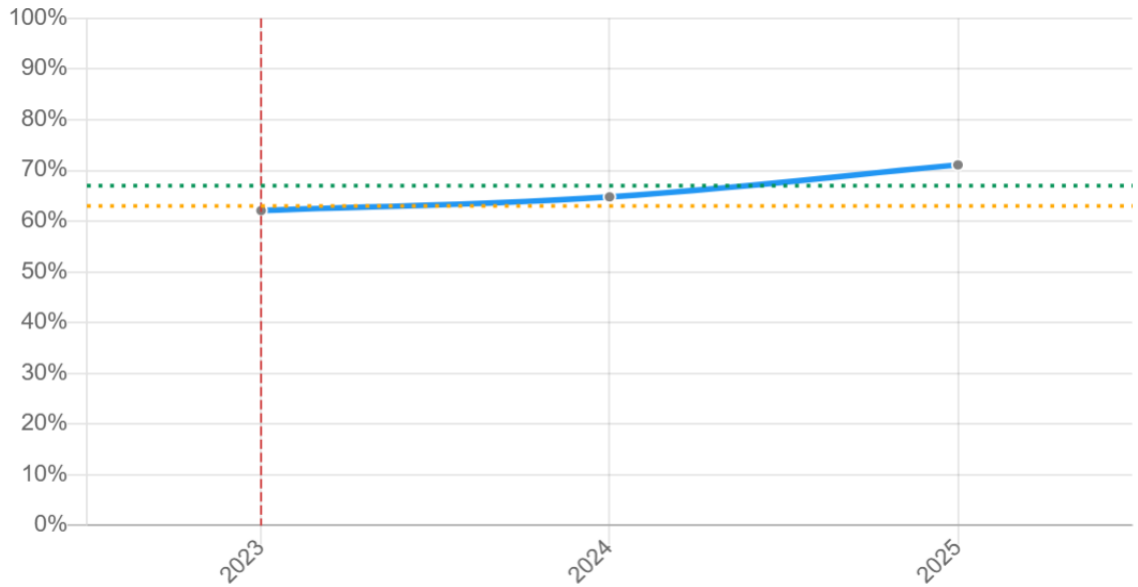
471 Gaps 0 To Target

Breast Canc...

67% 63%

SELECTED	71.1%
Center Avg	71.1%
Network Avg	52.4%
Best Center	72.8%

2025 YTD PROGRESSION GROUP BY None



Breast Cancer Screening Ages 50-74 (CMS 125v13)

MEASURE

PERIOD: 2025

RENDERING PROVIDERS: All Rendering Provid...

PLANS: Medicare MSSP ACO

MEASURE ANALYZER

81.9%

3.9%

2023

245 / 299

11 Exclusion(s)

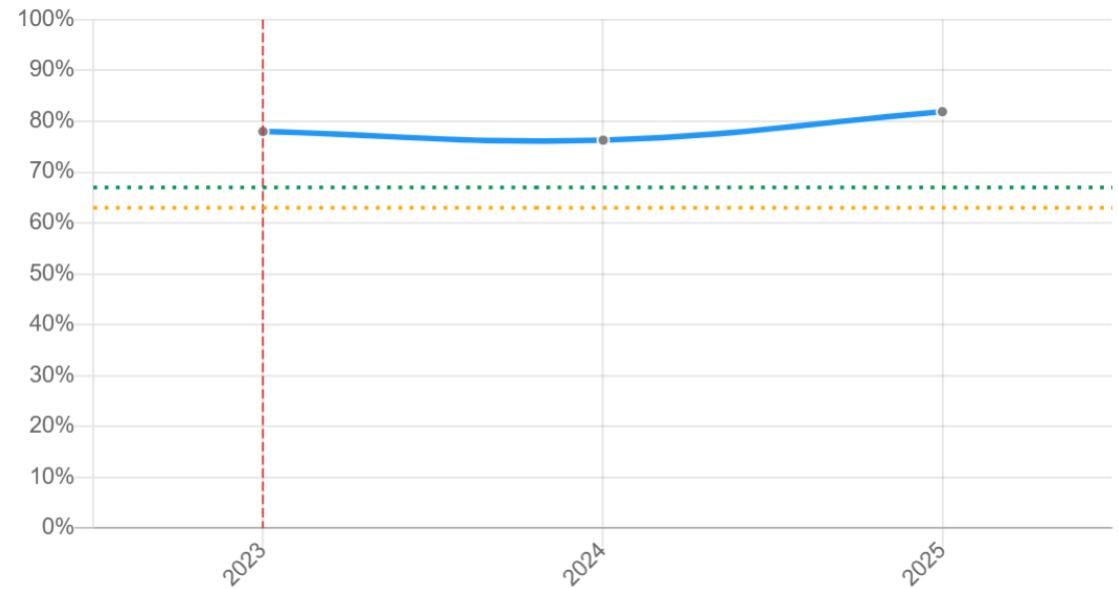
54 Gaps 0 To Target

Breast Canc...

67% 63%

SELECTED	81.9%
Center Avg	71.1%
Network Avg	52.4%
Best Center	72.8%

2025 YTD PROGRESSION GROUP BY None



Colorectal Cancer Screening (CMS 130v13)

MEASURE

PERIOD: 2025

RENDERING PROVIDERS: All Rendering Provid...

MEASURE ANALYZER

58.7%

9.5%

2023

2,237 / 3,810

77 Exclusion(s)

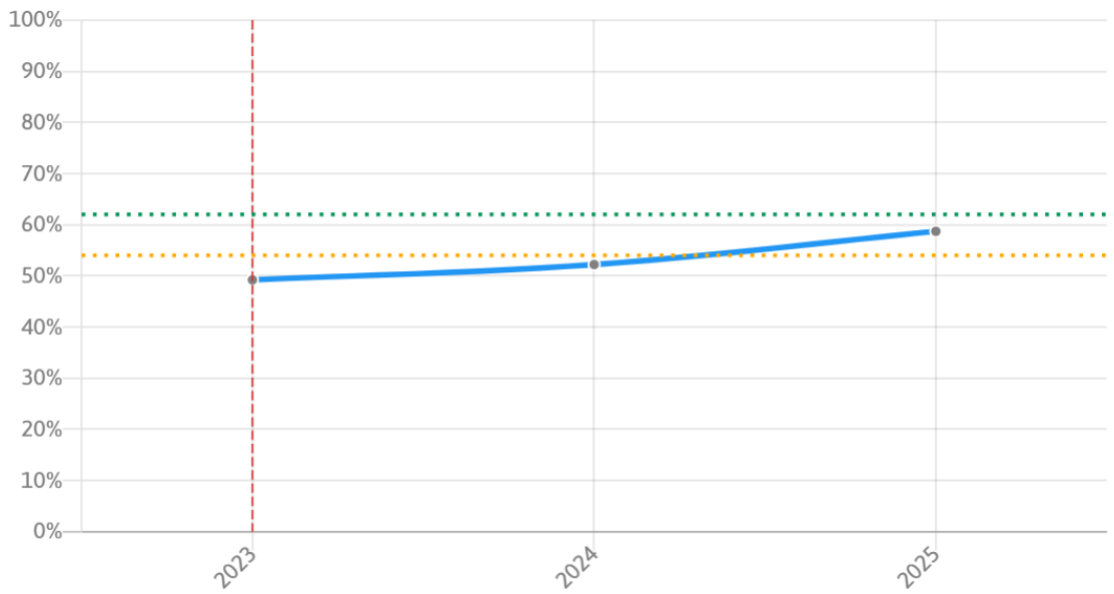
1,573 Gaps 126 To Target

Colorectal ...

62% 54%

SELECTED	58.7%
Center Avg	58.7%
Network Avg	44.9%
Best Center	62.8%

2025 YTD PROGRESSION GROUP BY None



Colorectal Cancer Screening (CMS 130v13)

MEASURE

PERIOD: 2025

RENDERING PROVIDERS: All Rendering Provid...

PLANS: Medicare MSSP ACO

MEASURE ANALYZER

75.4%

8.8%

2023

457 / 606

17 Exclusion(s)

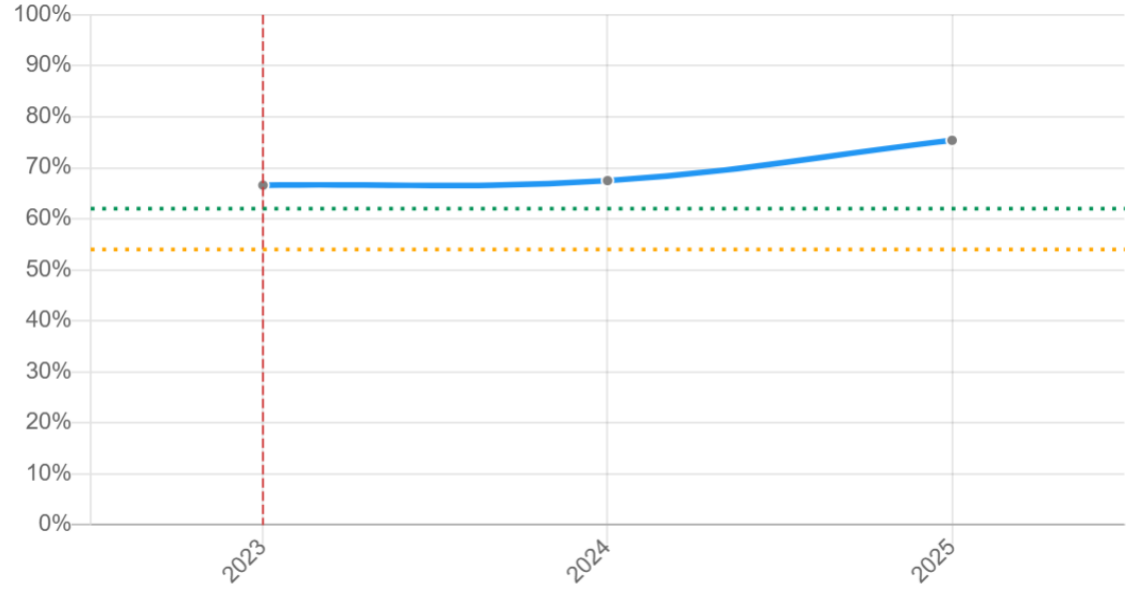
149 Gaps 0 To Target

Colorectal ...

62% 54%

SELECTED	75.4%
Center Avg	58.7%
Network Avg	44.9%
Best Center	62.8%

2025 YTD PROGRESSION GROUP BY None



The Next Frontier

ACC: Our Journey Getting Started

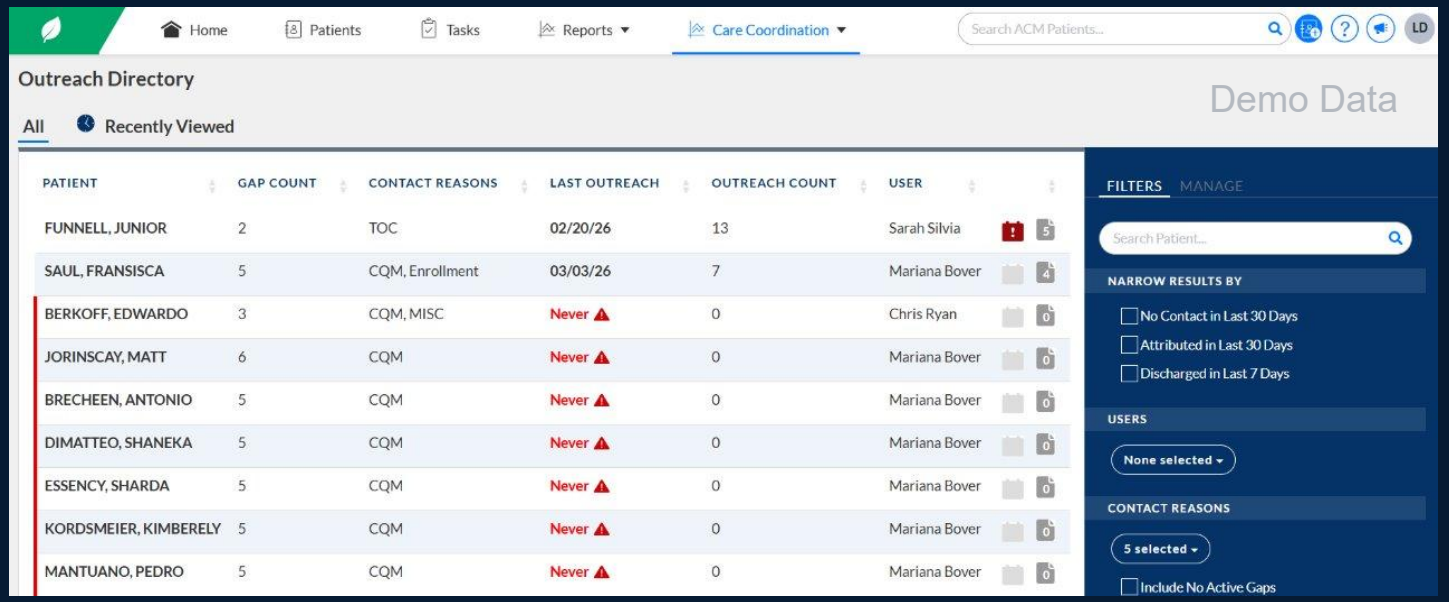
As our Care Management and Population Health processes evolved, we saw the need for an **interactive dashboard for more comprehensive panel management.**

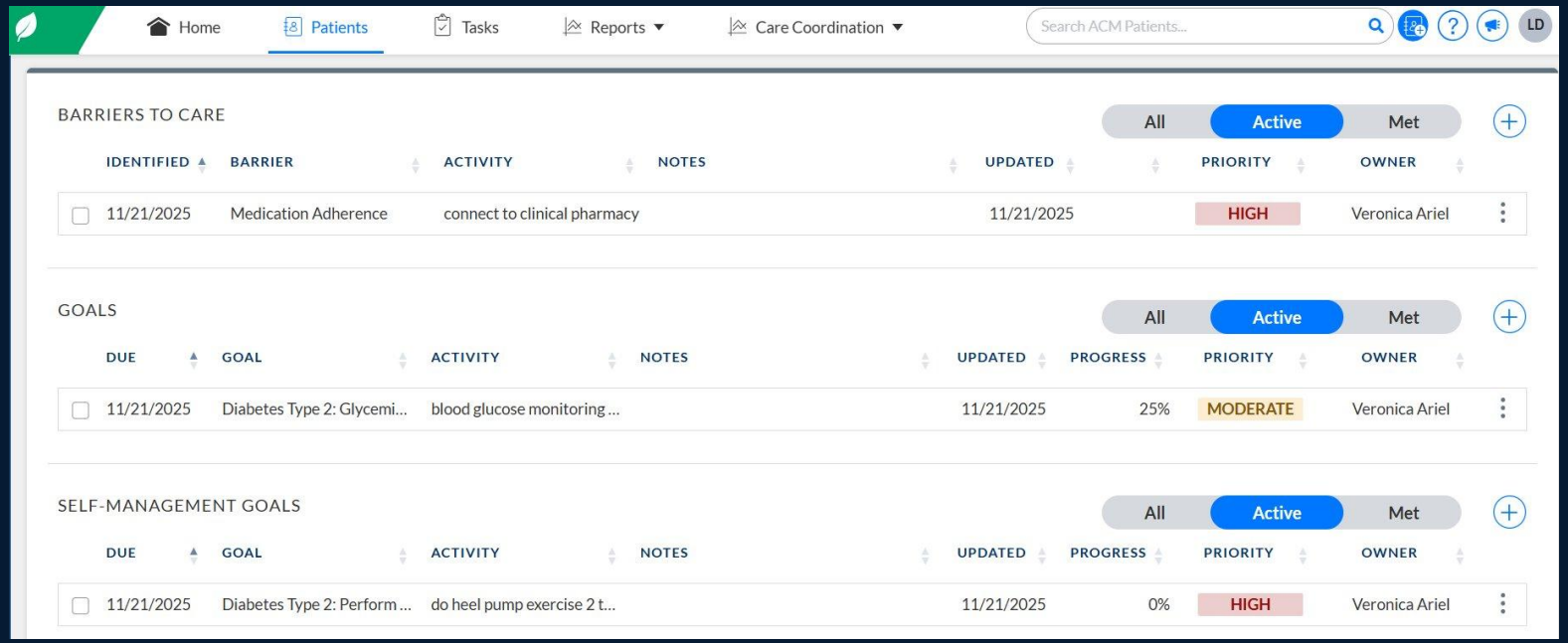
We wanted to ensure that our outreach processes were **streamlined for efficiency.**

And that our outreach was **tailored, custom, and meaningful** to individual patients.

ACC Tool

- [x] Population Health
- [x] Chronic Care Management
- [x] Transition of Care



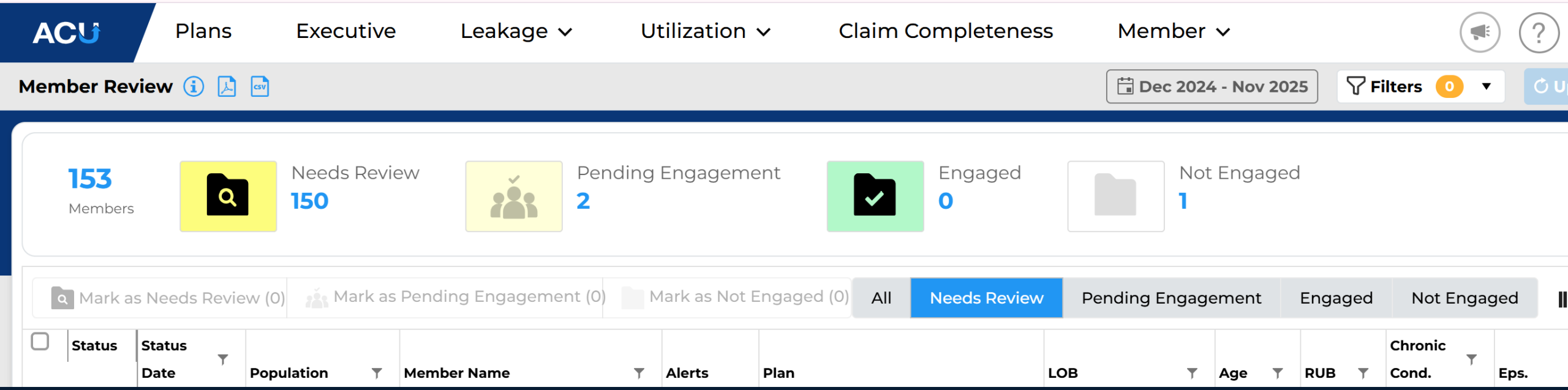


Azara Cost & Utilization (ACU)

15

Partnership between Network and Practice

Starting w/ Member Review



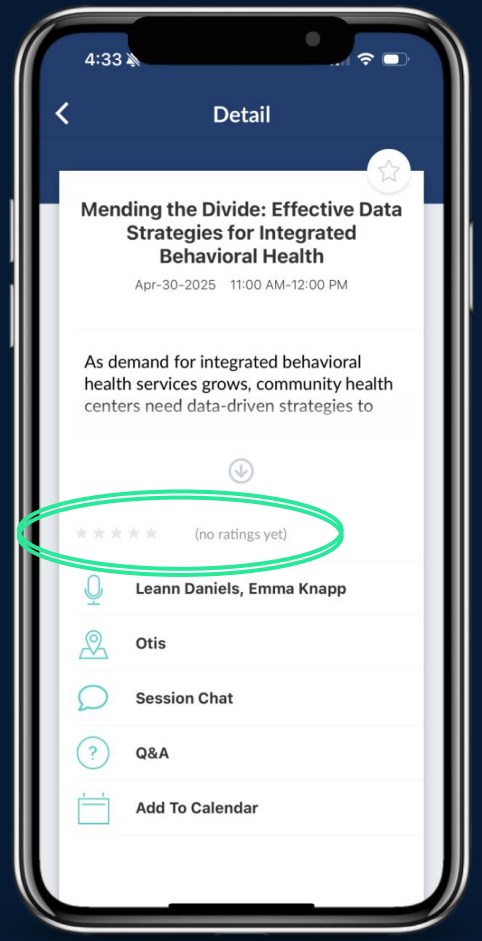
The Partnership Intersect – MH+ and our FQHCs

- Continuing to work together between network and FQHC
- Spreading best practices throughout the Network
- Repeat, Repeat, Repeat Education
- Keeping teams engaged
- Keeping patients engaged

Questions?

We want to hear from you!

Click on the session from your agenda in the conference app.
Click the stars in the center of your screen to rate and provide feedback.



Quick and Easy

Provide brief feedback or ideas

Rate the session and the speaker(s)

Help us continue to improve

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Thanks for attending!