North Carolina Community Health Center Association

Site Visit Presentation

June 24, 2026

Introduction

Chris Shank, President & CEO

Presentation Outline

1. NCCHCA Background and Structure
2. State Landscape
3. PCA Learning and Technical Assistance Strategy and Approach
4. Activity Successes and Promising Practices
5. PCA Partnerships

Four Key Takeaways

1. NCCHCA Has a Statewide Reach Through a Networked Support System

a. NCCHCA acts as the HRSA-funded **Primary Care Association (PCA)** anchoring this network, with sister entities — the **Health Center Controlled Network (HCCN)** and **Carolina Medical Home Network (CMHN, a clinically integrated network/ACO)** — handling IT, value-based care, and Medicare/Medicaid contracting.

b. The model emphasizes **shared roles**: PCA drives policy and TA, HCCN drives data/IT optimization, and CMHN drives payer alignment — together creating a unified front for federally qualified centers.

Four Key Takeaways

2. Strategic Response to a Volatile Policy and Payer Landscape

a. NC FQHCs are navigating major shifts in the policy and health care environments.

b. NCCHCA employs **data-driven approach** to learning and TA to target and refine TA in response to needs.

c. NCCHCA's response emphasizes **targeted technical assistance** with focus on multiple levers that can be pulled to support CHC success in the landscape.

d. Strong partnerships allow NCCHCA to bring additional resources to CHCs.

Four Key Takeaways

3. Measurable Clinical and Operational Progress

a. NCCHCA is on track to **meet all objective targets by 2027**.

b. Data shows progress: NC CHCs are serving more people with more varied services: **Patients served grew steadily since 2018**.

c. Significant **behavioral health growth** is underway, with CHCs expanding integrated behavioral services as a strategic priority alongside emergency preparedness investments tested during the **2024 Hurricane Helene response**.

Four Key Takeaways

4. Next Chapter Will Emphasize

a. Alternative Payment Methodology adoption

b. Behavioral health integration

c. Workforce pipeline development

NCCHCA Background and Structure

Chris Shank, President & CEO
Chris Bishop, Chief of Staff
Sanga Krupakar, VP of Network & Analytics
LyTonya Alexander, VP of Care Management & Provider Services / SVP of Value-Based and Managed Care Services
Jeff McKissack, Director of Finance
Tim Gallagher, Head of Growth & Managed Services
Katherine Jackson, VP of Human Resources

Mission and Vision

Our **mission** is to promote and support patient-governed community health care organizations and the populations they serve.

Our **vision** is that every North Carolina community will have access to a patient-centered, patient-governed, culturally competent health care home that integrates high quality medical, pharmacy, dental, vision, behavioral health, and enabling services without regard to a person's ability to pay.

Organization History

Established in 1978 as the North Carolina Primary Care Association, NCCHCA is the HRSA funded state Primary Care Association (PCA). We provide education and technical assistance to our members in the following areas:

1. Clinical
2. Operations
3. Financial
4. Administrative
5. Governance

NCCHCA's Extensive Reach: Associated Entities

1. State partnerships to elevate NC FQHCs
2. Federal partnerships to enhance NC FQHC efficiencies and services
3. Part owner / managed services provider in a clinically integrated network
4. A research arm to explore further engagement in clinical research
5. MSSP Accountable Care Organization (ACO)

Slide 11

1 From Alice: For CS_-- how much do we want to emphasize THIS NC?
BJ Rudell (NCCHCA), 2026-06-08T17:21:44.500

2 From Bishop: [@Mel Goodwin-Hurley (NCCHCA)] do we need to retitle this to PCA instead of NCCHCA?
BJ Rudell (NCCHCA), 2026-06-08T17:22:29.078

3 Recommended re-write:

1. Develops state-level partnerships with state agencies, funders, and national organizations to help elevate FQHCs

2. Holds a Health Center Controlled Network (HCCN) cooperative agreement with HRSA since 2013 to _[achieve what]_____

3. Part owner in, and managed services provider for, Carolina Medica Home Network, LLC (CMHN)--a clinically integrated network of 25 FQHCs

4. Launched Translational Health Institute of the Safety Net in NC (THIS-NC), a research arm in partnership with North Carolina Central University to explore further engagement in clinical research in service to North Carolina's FQHCs

5. Recently established an MSSP Accountable Care Organization (ACO) to serve 12 FQHCs to address the impact of the end of Making Care Primary.
BJ Rudell (NCCHCA), 2026-06-08T17:23:43.224

Associated Entities

NCCHCA

CMHN CIN = Carolina Medical Home Network, Clinically Integrated Network

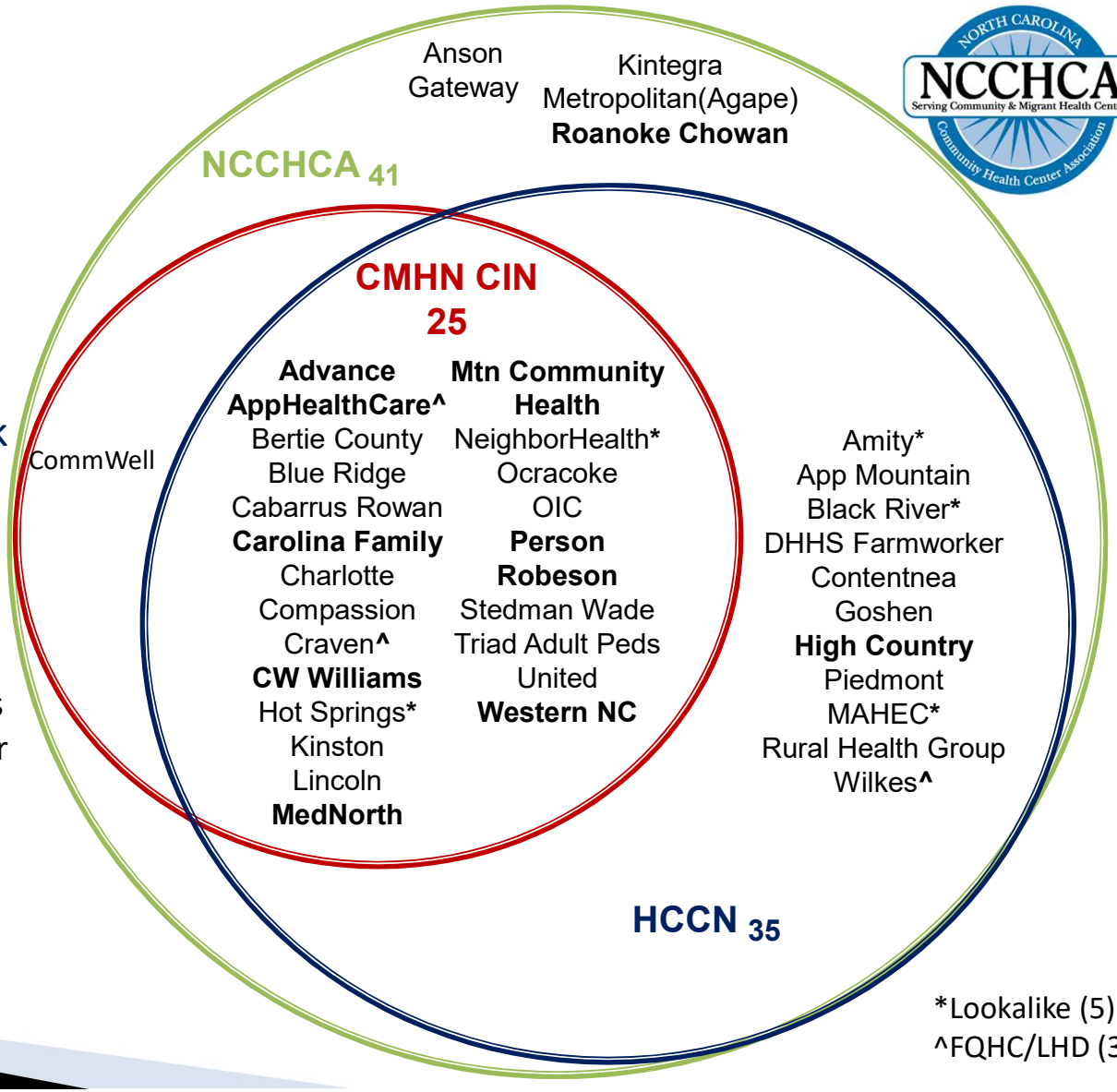
HCCN = Health Center Controlled Network

Medicare ACO participants **bolded in black**.

* NCCHCA is a member of the CMHN CIN.

*B&D Integrated Health Services was designated as FQHC-LAL in April 2026 and is currently applying for membership in NCCHCA.

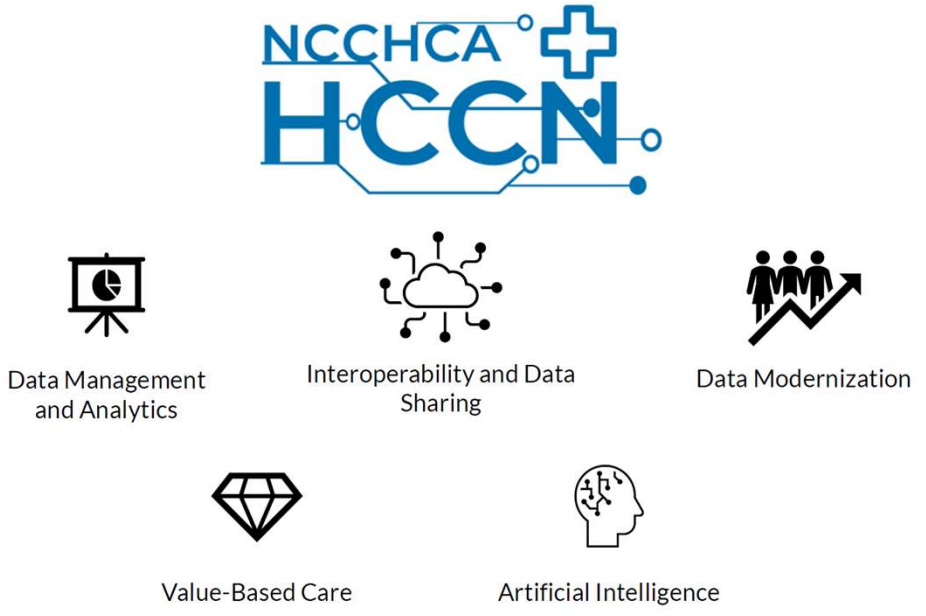
*First Choice CHC lost their FQHC status in 2026, but remains a member of the Medicare ACO.



*Lookalike (5)
^FQHC/LHD (3)

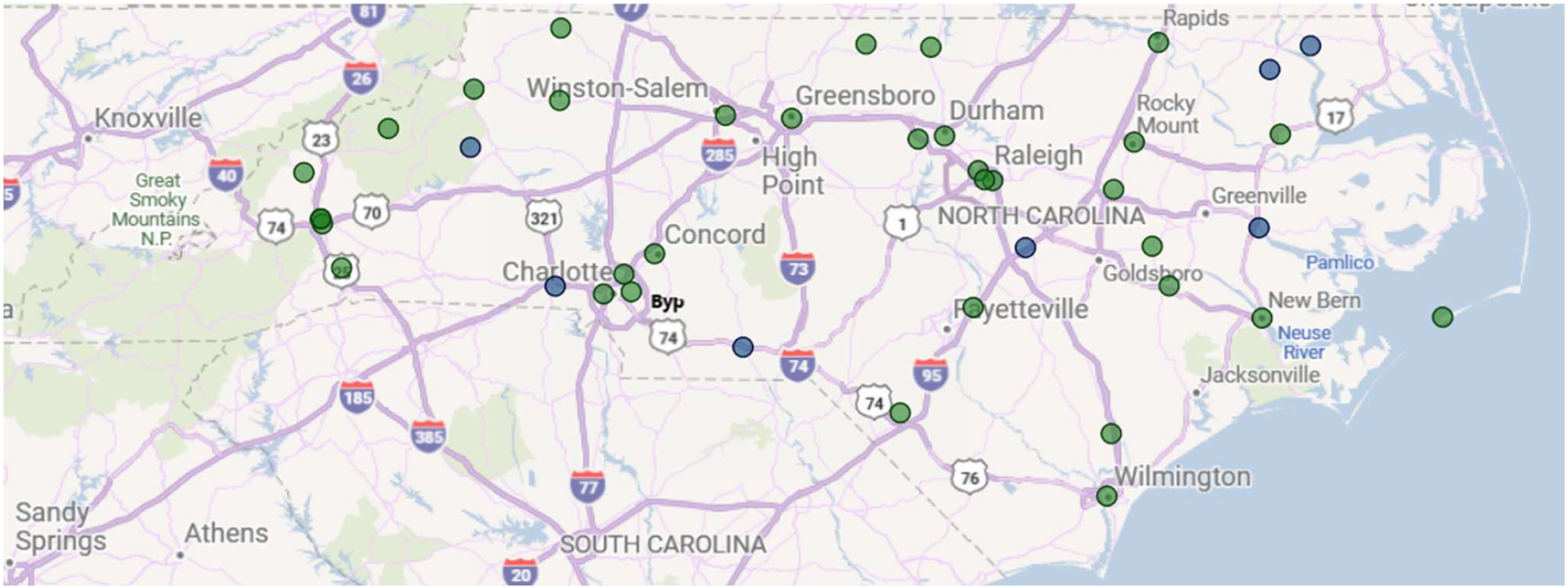
Health Center Controlled Network (HCCN) Overview

1. Founded in 2013, the NCCHCA HCCN is currently participating in the fifth HRSA funding opportunity (FY25-28).
2. The goal of the current cooperative agreement is to help PHCs use health IT and data effectively.
    a. This includes data management and analytics, interoperability and data sharing, and leveraging data to enhance care, health outcomes, and overall efficiency.



The Network: 35 Participating Health Centers

618,789 Patients Served in 2024 (798,826 for the PCA)



PCA and HCCN Member

PCA Member, Not currently in HCCN

Source: 2024 UDS

Distinct Roles, Shared Purpose

PCA

- Member engagement
- Education and technical assistance
- Policy alignment and advocacy
- Convening and shared priorities

HCCN

- Health IT and EHR optimization
- Data, analytics, and reporting
- Interoperability and data sharing
- Technology support

Together

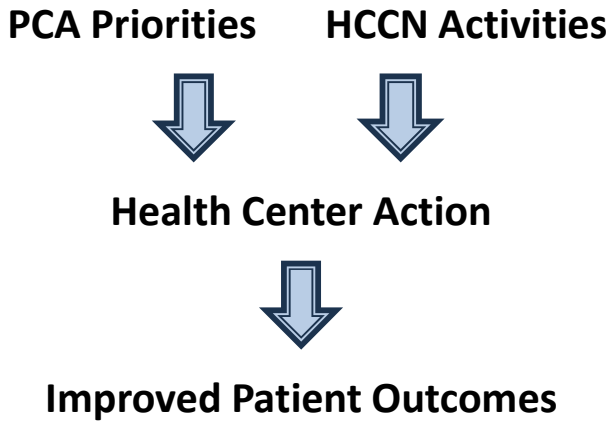
- The PCA identifies and aligns the needs of health centers.
- The HCCN translates these needs into practical tools, workflows, training, and technical assistance.

From PCA to Health Center Action

1. **Alignment with PCA Priorities**: Connect HCCN activities to shared goals around quality improvement, data utilization, population health, and value-based care.

2. **Improving Technical and Data Capacity**: Provide focused support in EHR optimization, analytics, interoperability, reporting, platform implementation, and workflow improvement.

3. **Strategy to Practice:** Helps health centers turn priorities into practical tools, trainings, dashboards, workflows, and effective implementation support.



Carolina Medical Home Network (CMHN)

1. CMHN is a clinically integrated network (CIN), or a collective of health care providers with aligned interests who work collaboratively to improve quality, reduce costs, and improve patient experience, and who also have shared financial interests and governance
   a. 25 CHCs in NC are participating in the CMHN CIN Medicaid contracts
2. Newly launched Medicare Shared Savings Program Accountable Care Organization (ACO)
   a. 12 CHCs in NC are participating in the CMHN Medicare ACO
3. Support for success in Advanced Medical Home Care Management, Tailored Care Management, and value-based care

Slide 17

1 Do these need to be capitalized (are they proper names)? Or can they be lowercased?
BJ Rudell (NCCHCA), 2026-06-08T17:50:53.005

L(1 0 Proper names thanks!
LyTonya Alexander (NCCHCA), 2026-06-11T12:25:02.801

CMHN Mission, Vision, and Values

1. **Mission**: To promote high-value care through the personalized, coordinated delivery of data-driven healthcare services.
2. **Vision**: A leading healthcare network creating value to all stakeholders through collaborative, person-centered, community healthcare.
3. **Values**: Offering care that is:
    a. Compassionate
    b. Affordable
    c. Evidence-based
    d. Patient-focused
    e. Timely
4. Across a network that is:
    a. Transparent
    b. Outcomes-driven
    c. Has integrity

CMHN Background

2014

- NCCHCA + 33 FQHCs formed Carolina Medical Home Network, LLC.
- Not financially or clinically integrated. Messenger model

2015-2020

- CMHN + 8 FQHCs participated in Track 1 MSSP ACO (upside only)
- CMHN's first value-based contracting experience
- Low-risk VBC learning opportunity. Preparing for managed care.

2020

- Transitioned to Clinically Integrated Network (CIN) models, with single signature authority. New Participation Agreements with FQHCs moving forward under CIN.
- NC Medicaid Managed Care launched July 1st, 2021

2026

- Over 140,000 total Medicaid lives assigned to CMHN participating health centers
- Earned Medicaid shared savings
- Considered a high performer by State and managed care plans
- Year 1 - MSSP ACO (Enhanced track)

CMHN: Medicaid Preferred Payer Arrangements (PPA)

Key Milestones

1. RFP released to Medicaid payers in Q1 2025
2. RFP response evaluators met Sept-Oct 2025
3. CMHN Board of Managers decision based on evaluators' recommendation: Oct 30, 2025
4. CMHN payer negotiations: Nov-Dec 2025

1. Significant **variation in PHP contracting requirements** and processes required CMHN & FQHCs to expend limited resources on administrative activities that don't add patient care value.

2. The **burden of these inconsistencies was so high** that CMHN prepared to contract only with PHPs that were responsive to the terms of this we were seeking, which will allow CMHN and its members to better allocate resources to directly benefit patients and increase their providers' capacity to serve them and their communities.

3. Through the Preferred Payer Arrangements, CMHN successfully completed negotiations to achieve **standardized quality measures** across all PHPs aligned with UDS and HEDIS.

Slide 20

L(1 [@BJ Rudell (NCCHCA)] I added a third bullet here based on feedback to explain what resulted from the PPA and a bit more about the overall outcome.
LyTonya Alexander (NCCHCA), 2026-06-11T12:28:48.927

1 0 Fantastic. My aspiration is for no slides to look "squished." This one borders on squished, with the 3-bulleted content brushing up against the title. I'll tweak it if that's okay, without undercutting the messaging.
BJ Rudell (NCCHCA), 2026-06-11T13:28:02.634

1 1 Copying/pasting this slide and revising for your review.
BJ Rudell (NCCHCA), 2026-06-11T13:29:09.202

CMHN: Medicaid PPA Focus Areas & Achievements

1. Shared Savings: new 5-year contracts including glidepath to downside risk, accessible to centers of all sizes
2. Risk Adjustments
3. Quality Measures Alignment (more standard measure set and targets, equal weighting)
4. Quality Incentive Programs (independent of shared savings program)
5. Data Transparency (more timely and complete data sharing)
6. Delegated Care Management (reduced annual audit burden)
7. Infrastructure & Admin Funding (Per Member Per Month)
8. Medicaid Enrollment, Assignment & Attribution (improve accuracy)

Slide 21

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1 From Lauren: Option 2: abbreviated, without descriptions for each PPA focus area.
BJ Rudell (NCCHCA), 2026-06-08T18:15:02.767

2 Does this need to be spelled out?
BJ Rudell (NCCHCA), 2026-06-08T18:15:35.075

L(2 0 Yes happy to spell out "pmpm" here for clarity
LyTonya Alexander (NCCHCA), 2026-06-11T12:25:54.523

AP1

Funding Streams

efile Public Visual Render | ObjectId: 202511119349301366 - Submission: 2025-04-21 | TIN: 56-1240332

Form **990** — Department of the Treasury, Internal Revenue Service

Return of Organization Exempt From Income Tax

Under section 501(c), 527, or 4947(a)(1) of the Internal Revenue Code (except private foundations)

Do not enter social security numbers on this form as it may be made public.

Go to www.irs.gov/Form990 for instructions and the latest information.

OMB No. 1545-0047

2023

Open to Public Inspection

Part I Summary

Activities & Governance

1 Briefly describe the organization's m
To promote community based prima

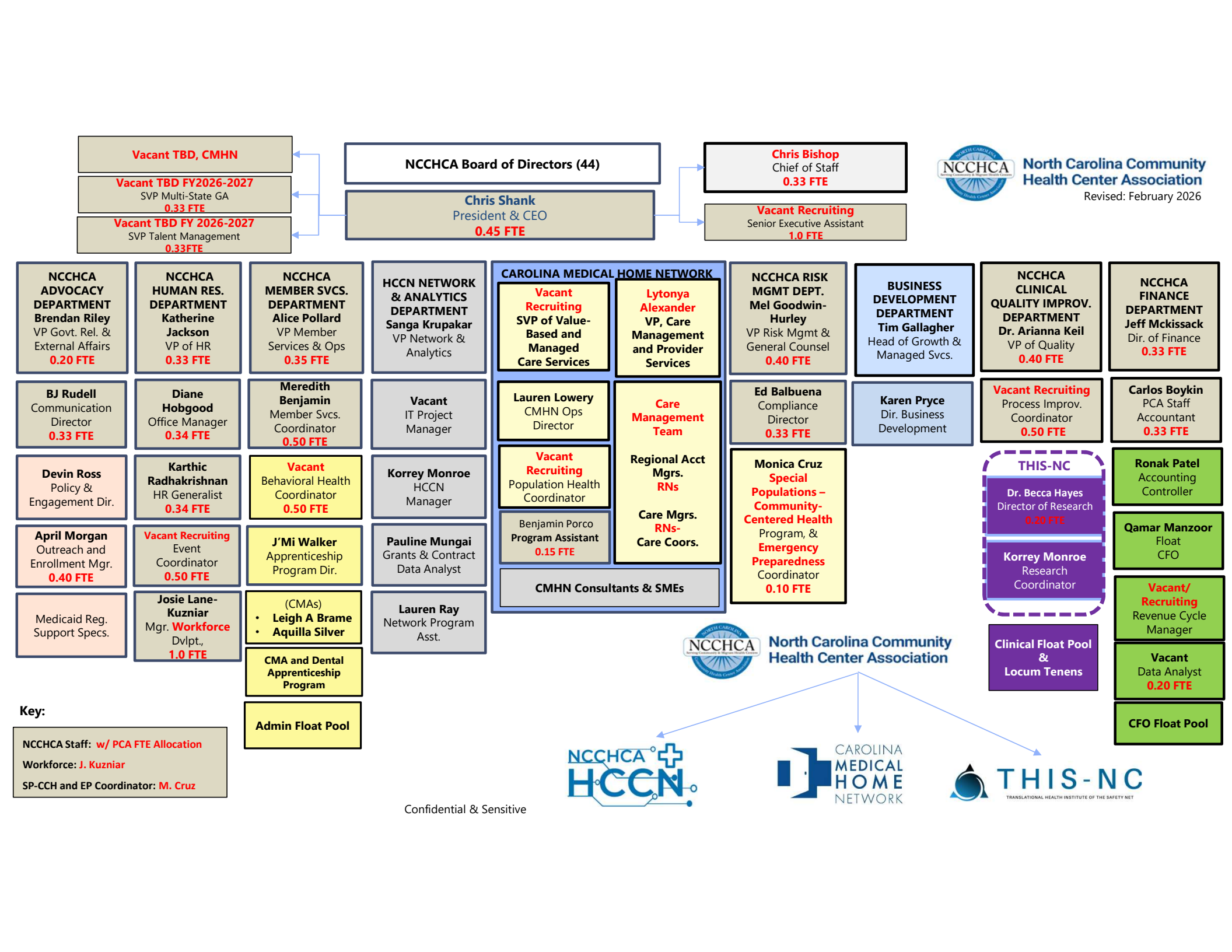
2 Check this box ☐

3	Number of voting members of the governing body (Part VI, line 1a)	3	46
4	Number of independent voting members of the governing body (Part VI, line 1b)	4	45
5	Total number of individuals employed in calendar year 2023 (Part V, line 2a)	5	69
6	Total number of volunteers (estimate if necessary)	6	
7a	Total unrelated business revenue from Part VIII, column (C), line 12	7a	0
b	Net unrelated business taxable income from Form 990-T, Part I, line 11	7b	0

		Prior Year	Current Year
Revenue	8 Contributions and grants (Part VIII, line 1h)	15,633,178	12,069,713
	9 Program service revenue (Part VIII, line 2g)	5,316,618	4,890,369
	10 Investment income (Part VIII, column (A), lines 3, 4, and 7d)	6,689	5,465
	11 Other revenue (Part VIII, column (A), lines 5, 6d, 8c, 9c, 10c, and 11e)	62,855	97,068
	12 Total revenue—add lines 8 through 11 (must equal Part VIII, column (A), line 12)	21,019,340	17,062,615
Expenses	13 Grants and similar amounts paid (Part IX, column (A), lines 1–3)	21,019	0
	14 Benefits paid to or for members (Part IX, column (A), line 4)		0
	15 Salaries, other compensation, employee benefits (Part IX, column (A), lines 5–10)		7,234,413
	16a Professional fundraising fees (Part IX, column (A), line 11e)	6,126,753	0
	b Total fundraising expenses (Part IX, column (D), line 25) 0		
	17 Other expenses (Part IX, column (A), lines 11a–11d, 11f–24e)		7,553,569
	18 Total expenses. Add lines 13–17 (must equal Part IX, column (A), line 25)	6,147,772	14,787,982
	19 Revenue less expenses. Subtract line 18 from line 12	14,871,568	2,274,633
or ices		Beginning of Current Year	End of Year

Slide 22

AP1 The 990 is a placeholder and this slide will be revised.
Alice Pollard (NCCHCA), 2026-06-11T20:23:30.840



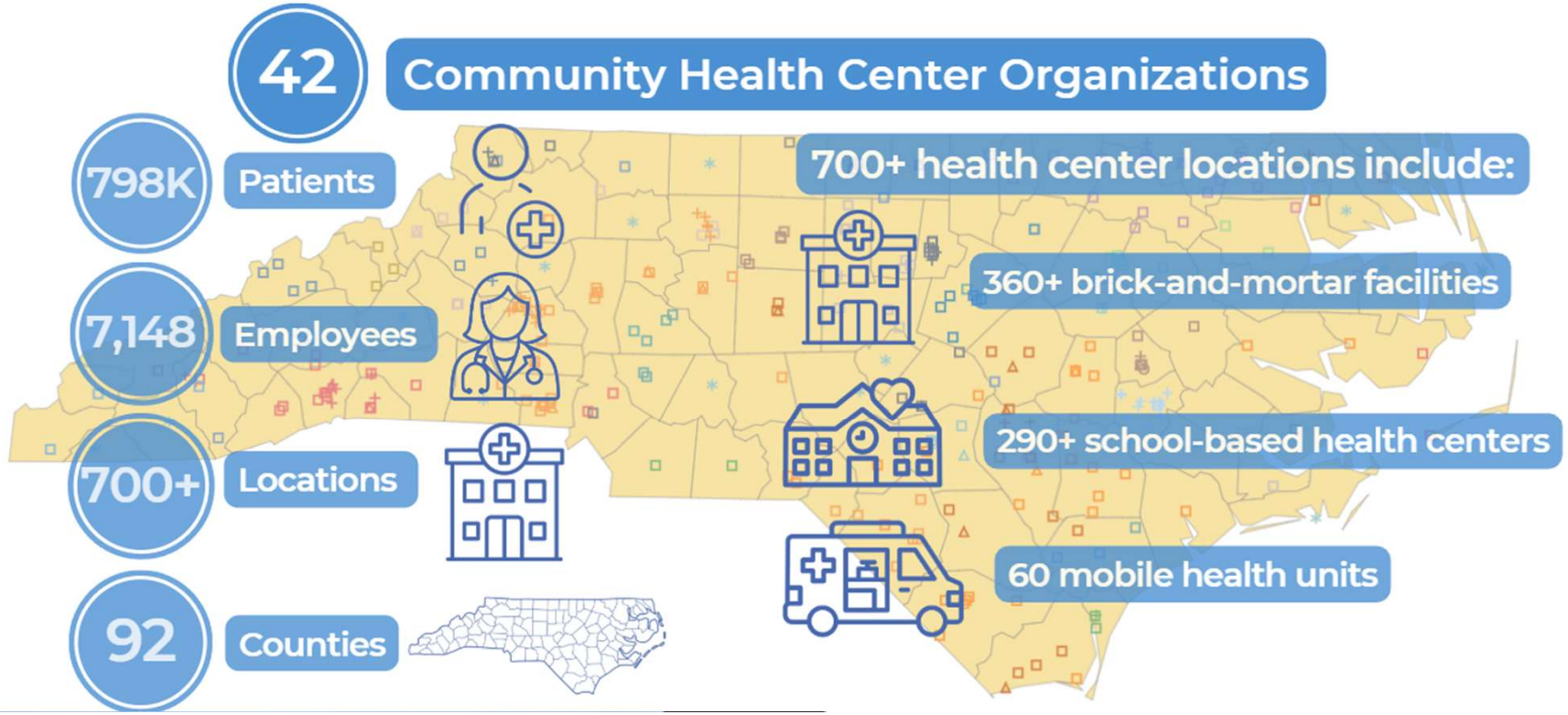
Confidential & Sensitive

State Landscape

Alice Pollard, VP of Member Services & Operations
Brendan Riley, VP of Government Relations & External Affairs

By the Numbers: NC's Community Health Centers

Federally Qualified Health Centers (FQHCs) - aka Community Health Centers (CHCs) - are patient-governed nonprofits that provide patient-centered, comprehensive primary care for rural and underserved patients regardless of insurance status or ability to pay.



Wide NC Reach and Organization Transitions

42* Community Health Center Organizations Located in 92 of 100 NC Counties

36 Health Center Grantees, Including:

- 11 Migrant Health Centers
- 1 Migrant Voucher Program
- 11 Health Care for the Homeless Grantees
- 3 Public Housing Primary Care Grantees
- 3 Public Health Department/FQHC Dual Entities
- 11 CHCs With Ryan White Funding

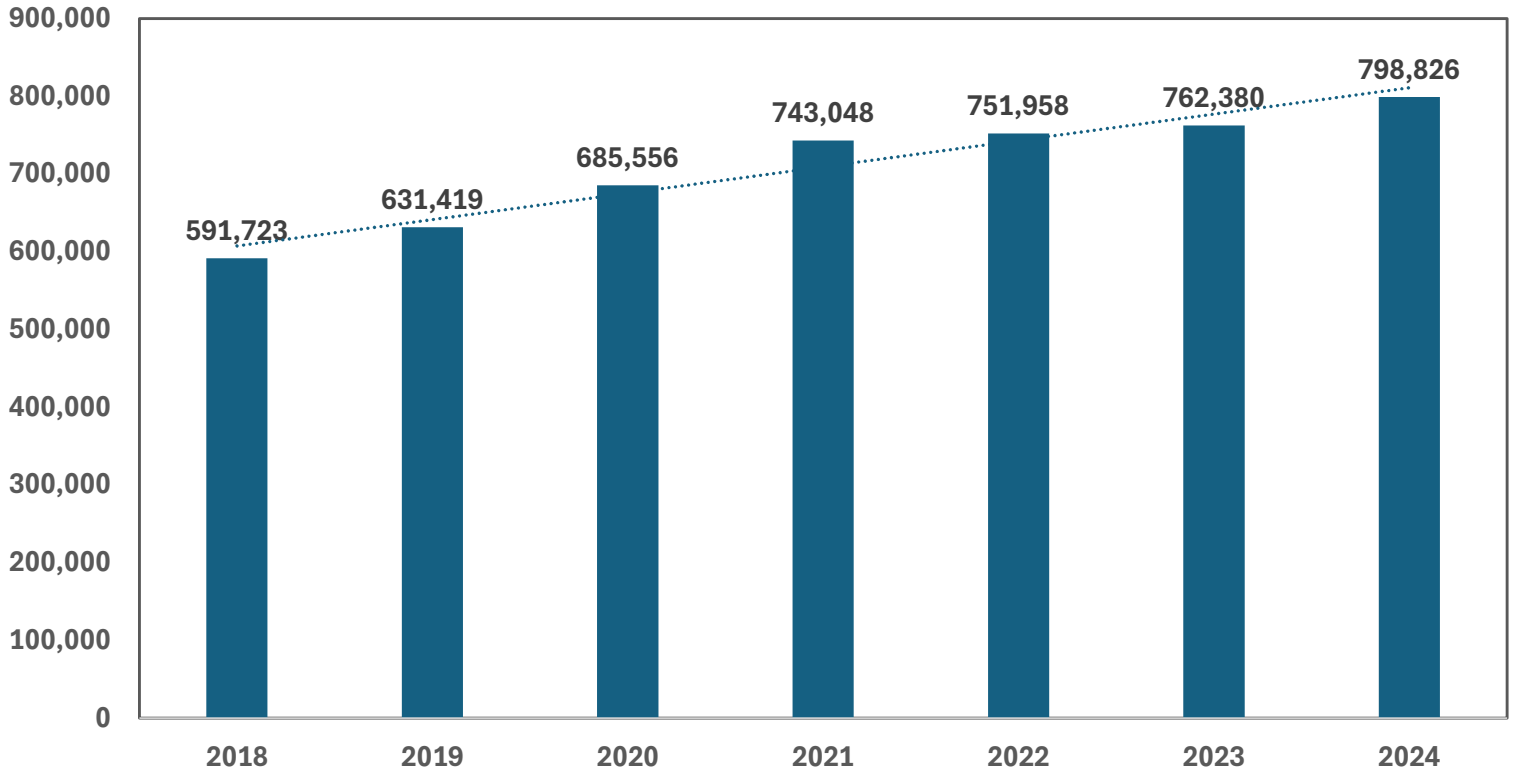
6 Health Center Look-alikes:

- The country's oldest look-alike health center
- 3 LAL organizations recognized since 2022
  - Including one recognized in April 2026 that is applying for NCCHCA membership*
- 1 Area Health Education Center (AHEC)

Organization Transitions

- 3 New look alike organizations recognized since 2022
- 2 FQHC grantees have merged with another FQHC grantee since 2022
- 1 FQHC grantee lost designation in Service Area Competition to another FQHC grantee

NC Health Centers: Expanding Patient Reach



UDS, 2018-2024

1

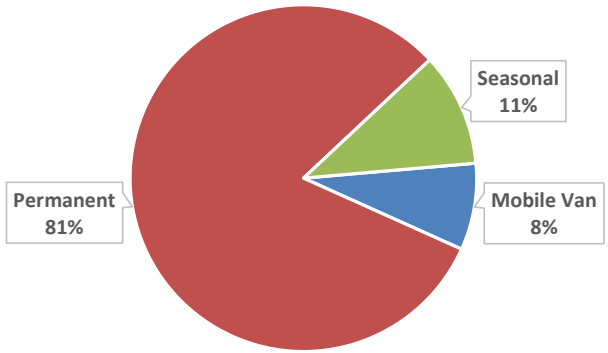
NC Health Centers: Growth

700+

Total Number of CHC Sites

The number and type of sites operated by CHC entities has grown and diversified.
TA needs have shifted with more emphasis on supporting uniformity between CHC sites.

CHC Sites by Location Type

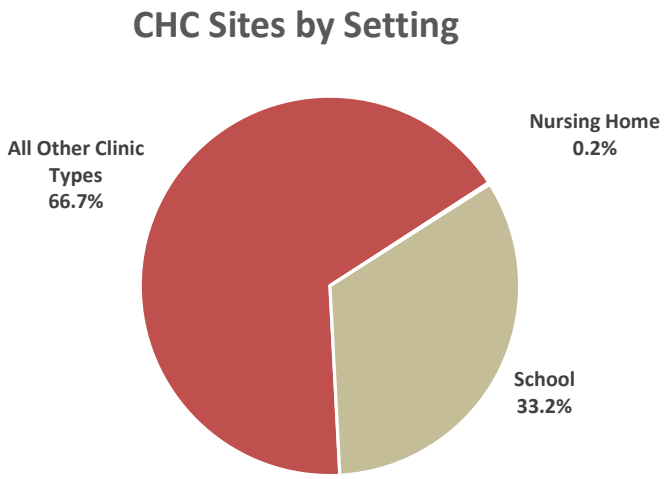


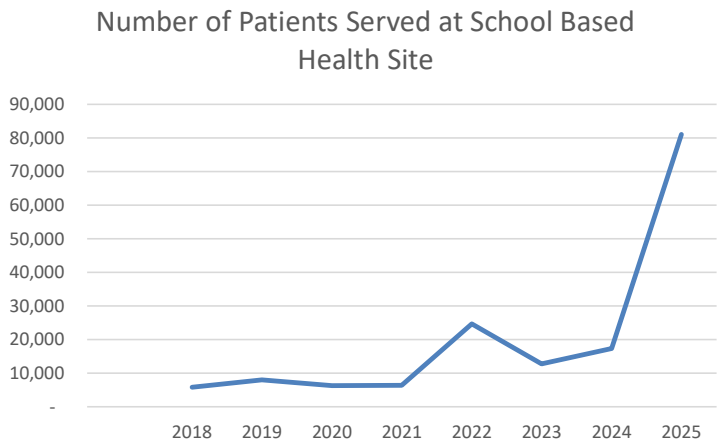
Increase in mobile units.
NCCHCA has formed new partnerships with vendors, as well as invested in TA related to effective mobile operations.

Slide 28

1 From Alice: Change these slides.
From Bishop: Or focus on one data point with multiple slides. Key question: what is the data we want to emphasize and the story we want to tell?
BJ Rudell (NCCHCA), 2026-06-08T18:39:19.601

NC Health Centers: Growth in School Based Health





NCCHCA has invested in additional TA for school-based health center sites in response to growth

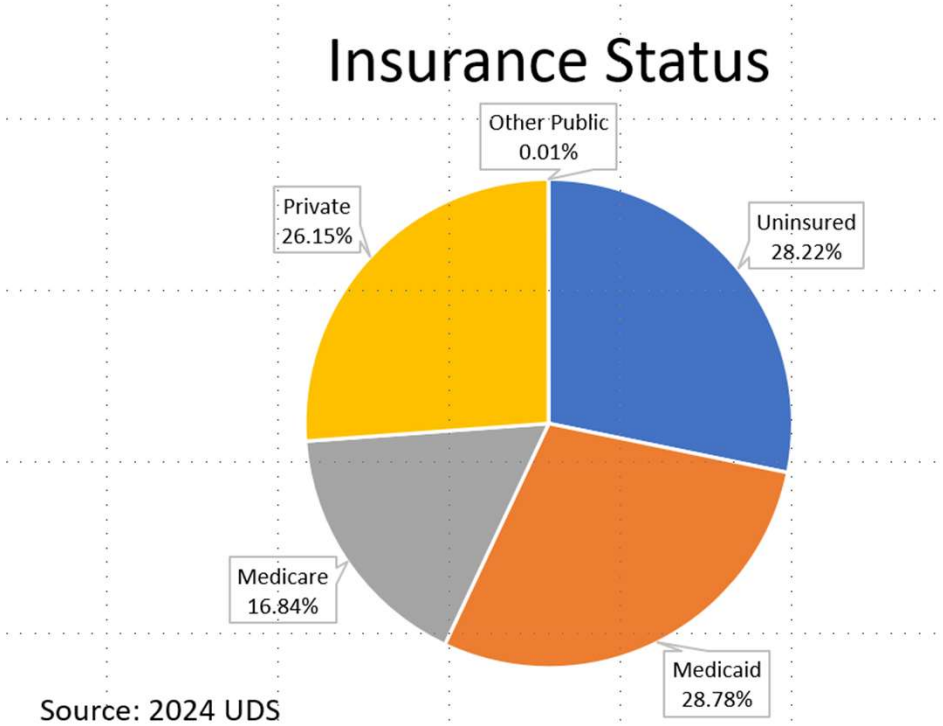
NC Health Centers: Underserved Populations

798,826

Total Patients Served

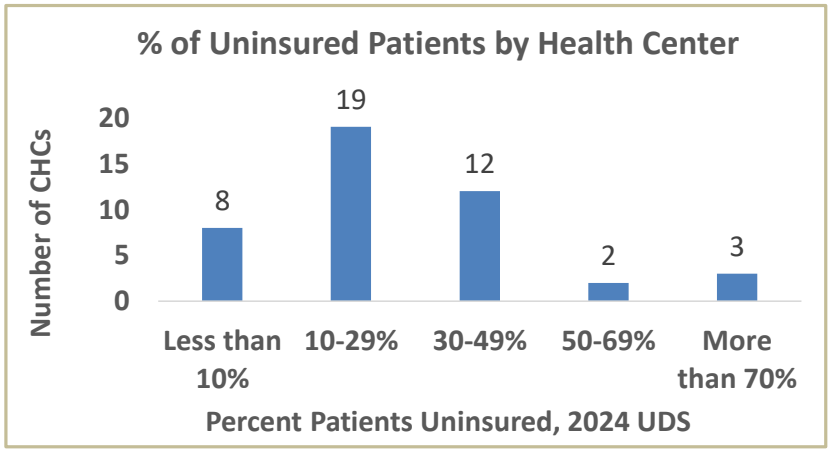
24.0%

Patients Best Served in Language Other Than English



Source: 2024 UDS

NC Health Centers: Underserved Populations



Significant variation in payer mix among CHCs.

FQHC Payer Mix	U.S.	N.C.
Medicaid	48.6%	28.78%
Medicare	11.2%	16.84%
Uninsured	18.1%	28.22%

2024 Data (HRSA UDS)

NC CHCs payer mix reflects lower proportion of patients with Medicaid and higher proportion of patients who are uninsured compared with CHCs nationwide.

State Landscape Overview

- 2021: Transitioned to commercial Medicaid managed care
- 2023: Enacted Medicaid expansion
- 2024: Enacted Medicaid Alternative Payment Methodology (APM) for FQHCs and Rural Health Clinics
- 2024: Hurricane Helene hits Western North Carolina
- 2025: N.C. enacts, then rescinds, Medicaid provider rate reductions due to state funding shortfall
- 2025: N.C. awarded $213 million for Rural Health Transformation Program

Slide 32

1 From Brendan: I added these based on the prompt in the agenda. Are there other aspects of the policy and health care landscape that folks want me to highlight?
BJ Rudell (NCCHCA), 2026-06-08T19:07:29.147

2 From Alice: Adding this slide further up of the stage and then using the health center data slides to demonstrate changes.
BJ Rudell (NCCHCA), 2026-06-08T19:07:55.563

3 From Alice: Chris S- Ask about how to address LAL proliferation.
BJ Rudell (NCCHCA), 2026-06-08T19:08:20.807

External Landscape: Dynamic and Volatile

2021

State transitions 1.6 million Medicaid beneficiaries to commercial **Medicaid managed care** via enrollment in Standard Plans (April 2026 enrollment: 2.2m)

State enacts **Medicaid expansion**, covering over 725,000 individuals as of April 2026

2022

State enacts **Medicaid Alternative Payment Methodology** (APM), changing the way NC Medicaid reimburses Federally Qualified Health Centers and Rural Health Clinics

2023

Hurricane Helene hits Western North Carolina, causing $59.6 billion in damage, incl. $20m in estimated facility costs and >$24m in economic losses for Community Health Centers (source)

State transitions Medicaid beneficiaries with serious mental illness, severe substance use disorders, intellectual or developmental disabilities, or traumatic brain injury to a specialty managed care plan: **Behavioral Health and I/DD Tailored Plans** (April 2026 enrollment: 271k)

2024

State launches **Children and Families Specialty Plan** for children and families in foster care system (April 2026 enrollment: <32k)

2025

State enacts, then rescinds, **Medicaid provider rate reductions** due to state funding shortfall

N.C. awarded $213m for **Rural Health Transformation Program**

Slide 33

1 From Brendan: This is a revised slide for timeline impact. I welcome visual edits and any suggestions to reduce volume of text

BJ Rudell (NCCHCA), 2026-06-08T19:10:29.531

1

NCCHCA Support for FQHCs

- Educated policymakers about the potential impacts of Medicaid expansion on FQHCs' finances, services, and patients
- Bolstered FQHCs' outreach & enrollment efforts for implementing Medicaid expansion, including through technical assistance and through hiring of Regional Support Specialist staff
- Convened rapid response team to support FQHCs affected by Hurricane Helene & connect them to emergency resources
- Developed, implemented, and taught FQHCs about a new Medicaid Alternative Payment Methodology to improve financial sustainability
- Leveraged clinical integrated network and other tools to improve partnerships with payors under Medicaid managed care

Slide 34

1 From Brendan: New slide – designed as a teaser for highlighted work that we have done as it relates to the dynamic landscape in preceding slide.
BJ Rudell (NCCHCA), 2026-06-08T19:23:32.397

PCA TA Strategy and Approach to Project Objectives and Measures

Meredith Benjamin, Member Services Coordinator
Mel Goodwin-Hurley, VP of Risk Management & General Counsel
Dr. Arianna Keil, VP of Quality
Alice Pollard, VP of Member Services & Operations

Needs Assessment:
Evaluation Process and Respondent Profile

- Formal evaluation — widely distributed to NC community health centers
- Electronic distribution — shared with all health center CEOs, workgroups, Connected Communities, and Focal Point newsletter
- Three-week response window — evaluation was open for responses in 2025
- Annual cadence — this evaluation will be shared on a recurring basis
- 80 unique responses received — from 34 health centers, representing 81% of community health centers in the state
- Multi-region coverage — Multiple health centers represented in each Medicaid region
- 14+ role categories — participation from multiple types of employees at health centers

Needs Assessment:
Clinical Services and Patient Care

Category	Top Finding	Count
Top Health Concerns	Chronic Disease and Mental Health (tied)	51
Services to Expand	Behavioral Health Services	27
Behavioral Health Focus	School-Based Behavioral Health Services	24
NCCHCA Support	Seek funding support for new or expanded services	37

Needs Assessment: Workforce and Staffing

Category	Top Finding	Count
Top Workforce Challenges	Recruitment challenges and shortage of qualified candidates (tied)	34
Hardest Positions to Fill	Medical Providers and Medical Assistants/Clinical Support (tied)	34
Technical Assistance Priority	Customer service learning for front line staff	33
NCCHCA Support	Sharing best practices from other health centers	41

Needs Assessment: Infrastructure and Operations

Category	Top Finding	Count
Meeting Patient Demand	Mostly able with some challenges in specific services and locations	33
Top Operational Challenge	Staff/provider shortages and heavy workloads	32
Technical Assistance Priority	Patient access and scheduling best practices	26
NCCHCA Support	Sharing best practices from other health centers	39

Needs Assessment: Key Takeaways

1. **Workforce crisis is the binding constraint** — staffing emerges as the top challenge or root cause across all three domains.
2. **Learning from colleagues is the top-demanded intervention** — structured network learning is NCCHCA's highest-leverage investment.
3. **Clinical needs outpace workforce capacity** — closing this gap requires parallel investment in staffing, management, and operations.
4. **Centers favor collaborative over individual solutions** — pointing to a network-level strategy, not clinic by clinic intervention.
5. **Shared services show early promise** — cooperative infrastructure (call centers, staffing pools, group purchasing) can address constraints no single center can solve.

NCCHCA Service Strategy

Central Question for NCCHCA: What do community health centers need to improve their performance and impact?

Domains of Performance

- Governance, leadership, and management
- Workforce
- Financial sustainability
- Community health and health-related needs
- Quality, patient care, and safety
- Patient experience
- Access and affordability

From BPHC Health Center Performance Improvement Toolkit

Needs Identified by:

- Formal Assessment (annual survey, topic specific assessments)
- Quarterly Meetings with CHC CEO
- Feedback from Workgroups, Task Force Meetings, Member questions
- Analyzing trends from UDS and other data sources
- Understanding health landscape trends affecting CHCs
- And more…

NCCHCA Strategies for Meeting Needs Through PCA

- Workgroups
- Conferences
- Individual technical assistance
- Group technical assistance
  - Synchronous
  - Asynchronous
- Connected Community platform

Learning Strategy

Learning Sessions

1. Organized process for equipping CHC staff or Board with knowledge, skills, and abilities to meet specific goals.
2. NCCHCA's learning sessions are designed to be provided to multiple people, either from different organizations or the same organization.

NCCHCA Process

1. Needs Analysis and Goal Setting
2. Design and Development
3. Implementation and Delivery
4. Evaluation and Improvement

Learning and Group TA Methodologies

Workgroups

1. By health center role (e.g., practice managers) or topic area (e.g., emergency preparedness)
2. This year, NCCHCA hosted 14 workgroups for NC CHCs
3. Workgroups offer in depth opportunities for professional networking, group technical assistance, and sharing best practices live

Conferences

1. NCCHCA hosts three annual conferences
    a. Primary Care Conference: 350 safety net leaders and partners; focused on C-Suite Executives
    b. Clinical Conference: 266 medical and behavioral health providers and health center administrators
    c. MOUD Symposium: 131 health center staff involved in the treatment of patients with opioid use disorder

Individual Technical Assistance

Learning and Group TA Methodologies

Group Technical Assistance

1. Live – in person or virtual (Zoom, Microsoft Teams)
2. Pre-recorded (Relias Academy, Connected Community, social media)
3. Hybrid – live in person and simultaneously on a virtual platform

Member Platform

1. Connected Community

NCCHCA Technical Assistance Strategy

Technical Assistance:

Providing **targeted, specialized** support to **one** organization or individuals at that organization to help them solve a problem, build capacity, or improve operations

Proactive TA:

NCCHCA anticipates current or future need and engages health center

Reactive TA:

Health center identifies need and communicates with NCCHCA

1. INDIVIDUAL TECHNICAL ASSISTANCE

TA is provided to an individual or organization to address a specific challenge or goal.

2. CAPTURE INSIGHTS

Information from each TA engagement is documented, including:

- Challenges
- Questions
- Topics of interest
- Resource needs
- Context and outcomes

3. IDENTIFY TRENDS AND NEEDS

Insights from multiple TA engagements are aggregated and analyzed to look for patterns.

- Common challenges
- Recurring questions
- Emerging topics
- Resource gaps
- Populations most affected

4. INFORM ACTION

Trends and needs inform decisions and actions, such as:

- Developing resources
- Planning trainings
- Shaping TA priorities
- Informing policy/ program improvements

5. CONTINUOUS FEEDBACK LOOP

What we learn from trends and needs improves future TA and helps us better support individuals and organizations.

Individual TA provides the **insight**. Analyzing those insights reveals the **bigger picture**. Together, they drive more responsive and **impactful support**.

NCCHCA Technical Assistance Strategy

NCCHCA supports health centers with challenges on a spectrum from technical to adaptive

Technical

- Easy to identify issue
- Quick and easy solutions
- Can be solved by expert or authority
- Solutions can be implemented quickly

Adaptive

- May require change in values and approaches to work
- Can require changes across many boundaries
- No quick fixes, requires experimentation

NCCHCA Technical Assistance Strategy

Example:
"What are the in-person visit requirements for Medicare-covered tele-behavioral health services?"

Example:
"We have a 25% vacancy in our MA role."

Example:
"We want to start Collaborative Care Management Services–help!"

Example:
"We have been operating in the red."

NCCHCA Technical Assistance Strategy

Technical ⟷ ***Adaptive***

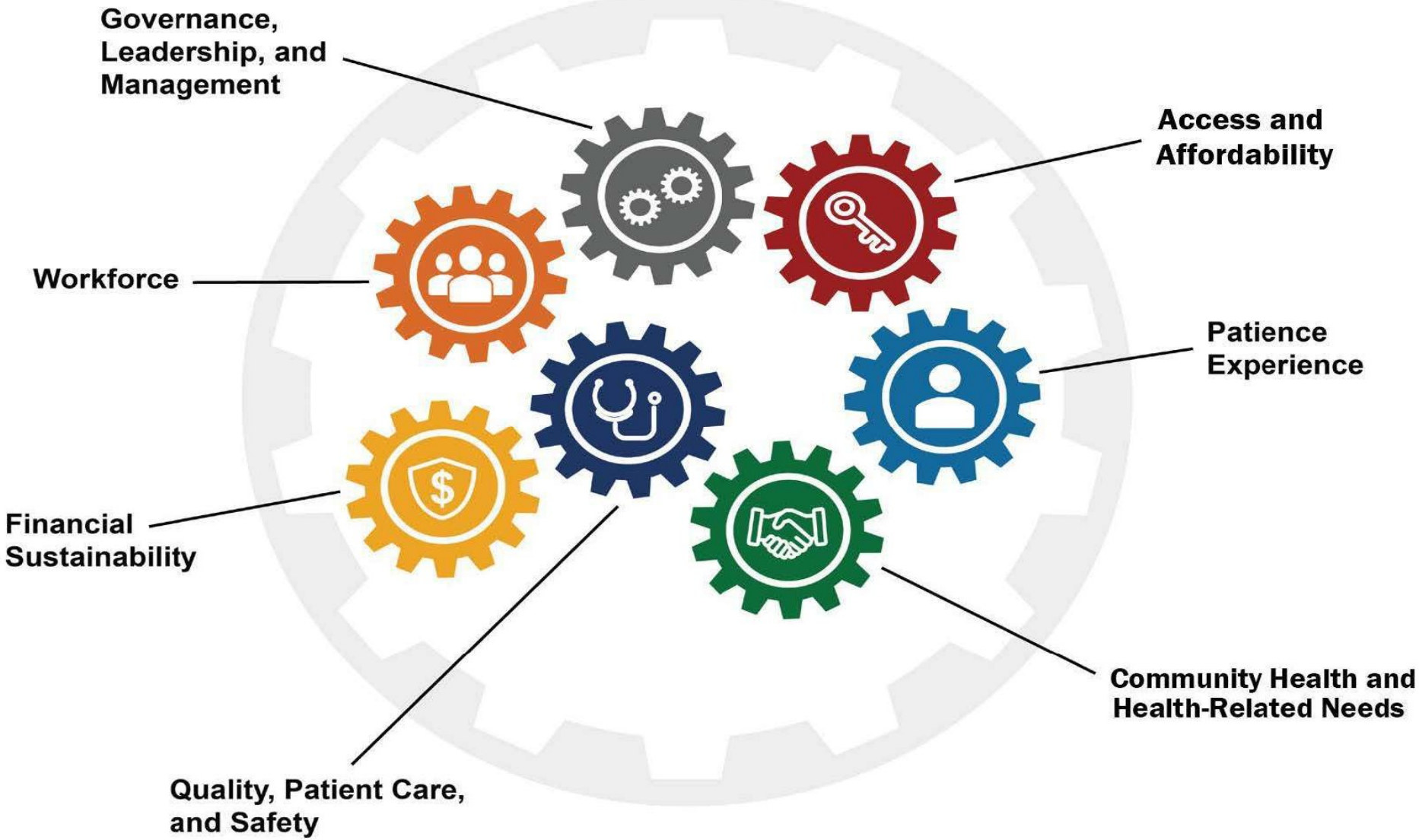
Requires a Broad Toolbox of Support

- Toolkits, manuals, and case studies
- Webinars and workshops
- FAQs and fact sheets
- Consulting and coaching
- Peer-to-peer networking
- Site visits and hands-on support
- Implementation support
- Data-based capacity building
- Identifying and harnessing outside resources
- Elevating issues in need of policy solution

NCCHCA Goals for Group/Individual Learning and Technical Assistance

1. Align strategies and topics with the Health Center Performance Improvement Toolkit
   a. Aligning needs assessment with toolkit
   b. Using toolkit to identify areas of need for individual and collective CHCs
   c. Building annual training plan with goal of addressing each domain
   d. Using toolkit domains and resources to measure impact of NCCHCA services

2. Proactively identify TA needs and engage CHCs to address potential challenges
   a. Using data to understand which CHCs may be at risk for challenges or able to implement solutions
   b. Using data to identify community needs and working with CHC to address them
   c. Designing workplans for each CHC to outline their areas of focus


Governance, Leadership, and Management
Access and Affordability
Workforce
Patience Experience
Financial Sustainability
Community Health and Health-Related Needs
Quality, Patient Care, and Safety

PCA Evaluation Tools

1. NCCHCA Standard Evaluation tools

2. NCCHCA CEO calls with health center CEOs (monthly or quarterly)

PCA Workplan Tracking Tool

Current state: Shared Excel spreadsheet

OBJECTIVE NUMBER & NAME	ACTIVITY NAME	ACTIVITY DESCRIPTION -A description of the activity that details how it is tailored to the needs of the health centers. -The modality, frequency, length, and training purpose/objectives for T/TA offerings -The name of partner organization(s), and how they will support the development and delivery of this activity, if applicable -A description of how the Advancing Health Center Excellence Framework performance domain(s) aligns with the activity	RESPONSIBLE PARTY (Full names and titles; lead person responsible in red)	EXPECTED OUTCOME
#1 Access to Care				
	Activity 1: Training and Technical Assistance – Strengthen Health Center Marketplace Outreach and Enrollment to Increase Access to Coverage for Health Center Patients	Activity Overview: In partnership with Care Share Health Alliance and the NC Navigator Consortium, the O&E Manager will host a Marketplace Open Enrollment Conference (in-person and/or virtual) in October 2025. The Conference will offer an opportunity for health centers to receive updates about changes to the Marketplace included in the 2025 Marketplace Integrity and Affordability Final Rule and the OBBBA, as well as T/TA to support patient access to health insurance outreach and enrollment and primary care services. Modality, Frequency, Length, Training Purpose/Objectives: The annual conference will be offered in-person and/or online. The annual Marketplace Open Enrollment Conference will offer an opportunity for health centers to receive T/TA to provide and enhance patient access to comprehensive, high-quality health insurance outreach and enrollment and increase patient access to primary health care services. The Conference will also highlight changes/updates to Marketplace coverage and discuss how health insurance enrollment assisters can best support consumers with these changes. Partners: NCCHCA will partner with Care Share Health Alliance and the NC Navigator Consortium to plan, host, and develop agenda items and content for the Conference. Supporting AHCE Domains: This activity supports the Access and Affordability domain by strengthening health center capacity to a) assist patients in determining eligibility for coverage and financial assistance available through the Marketplace, b)	April Morgan, Outreach and Enrollment Manager; Brendan Riley, Vice President, Government Relations and External Affairs	Expected Outcome: Observe a 20% increase in health center attendance from 2024 Open Enrollment Conference such that at least 52 health center staff, representing at least 17 health centers, participate in the 2025 Marketplace Open Enrollment Conference. The average participant usefulness score will be at least 4.5 (out of 5).
	Activity 2: Training and Technical Assistance – Strengthen Health Center Outreach and Enrollment to Increase Access to Medicaid Coverage for Health Center Patients	Activity Overview: NCCHCA will offer six (6) in-person and/or online training opportunities to strengthen health center capacity to a) support utilization of Medicaid coverage among health center patients, b) help health center patients maintain their Medicaid coverage, and c) navigate changes to Medicaid included in the OBBBA. Modality, Frequency, Length, Training Purpose/Objectives: NCCHCA will offer six (6) in-person and/or	April Morgan, Outreach and Enrollment Manager; Brendan Riley, Vice President, Government Relations and External Affairs	Observe a 10% increase in health center attendance from FY24-25 Medicaid technical assistance sessions such that staff from at least 26 health centers participate in Medicaid technical assistance opportunities during FY25-26. The average participant usefulness score

Workplan 2025-26 | Workplan 2026-27 | Objective Measures (2) | Objective Progress Graphs | CHCs Participation in Obj (2) | Example Repor

Future state: Salesforce

1

NCCHCA: Meeting All Objective Targets by 2027

1. NCCHCA is on track to meet all objective targets by June 30, 2027

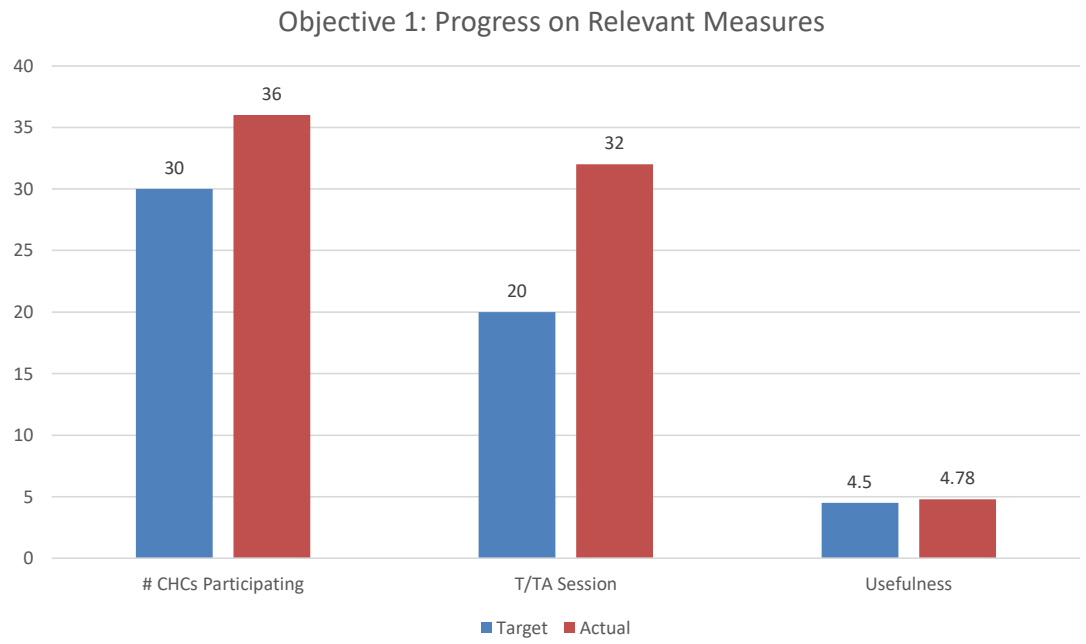
2. In Year 3, NCCHCA will be targeting CHCs who have not yet engaged in TA related to each objective to promote engagement

3. NCCHCA has refined strategy and redoubled efforts to ensure all applicable education sessions include an evaluation

Slide 54

1 Add verbiage as a lead-in to the three charts?
BJ Rudell (NCCHCA), 2026-06-09T15:13:39.438

Example of Progress Tracking on Objective Measures



Early Success on UDS Objectives

- CHCs Reporting Engaging in HPET on UDS
  - No reports in baseline; 32 reporting engaging in HPET in 2024
  - **Exceeding Target**
- Cervical Cancer Screening
  - 48.2% Baseline; 51.73% on 2024 UDS
  - **On Track to Meet or Exceed Target**
- Depression Screening & Follow Up
  - 58.9% Baseline; 67.83 % on 2024 UDS
  - **Exceeding Target**
- Patients With A1C Greater than 9%
  - 28% Baseline; 27.12% on 2024 UDS
  - **On Track to Meet or Exceed Target**

Activity Successes and Promising Practices

Increasing Access to Primary Care

Activity Successes and Promising Practices

April Morgan, Outreach & Enrollment Manager
Brendan Riley, VP of Government Relations & External Affairs

Outreach and Enrollment

1. NCCHCA, in collaboration with Care Share Health Alliance and the NC Navigator Consortium, received funding from philanthropic organizations and health insurers to conduct Medicaid and Marketplace outreach, education, and enrollment.
2. As part of the collaboration, NCCHCA leveraged resources (e.g., lodging, free registration) to offer valuable technical assistance to health centers:
   a. Two-day Open Enrollment Conference (October 2025) reached 112 attendees, including **56 health center staff** representing **20 health centers**.
   b. Four Medicaid technical assistance sessions were offered in February and March 2026 (3 in-person regional, 1 virtual), reaching 232 individuals, including staff from **25 health centers**.

Outreach and Enrollment

1. With the launch of Medicaid Expansion in December 2023, NCCHCA hired a team of Regional Support Specialists (RSS) to support health center capacity around Medicaid outreach, education, and enrollment.
2. In 2025, NCCHCA's Regional Support Specialist Team connected:
   a. 271 individuals to Medicaid
   b. 113 individuals to Marketplace coverage

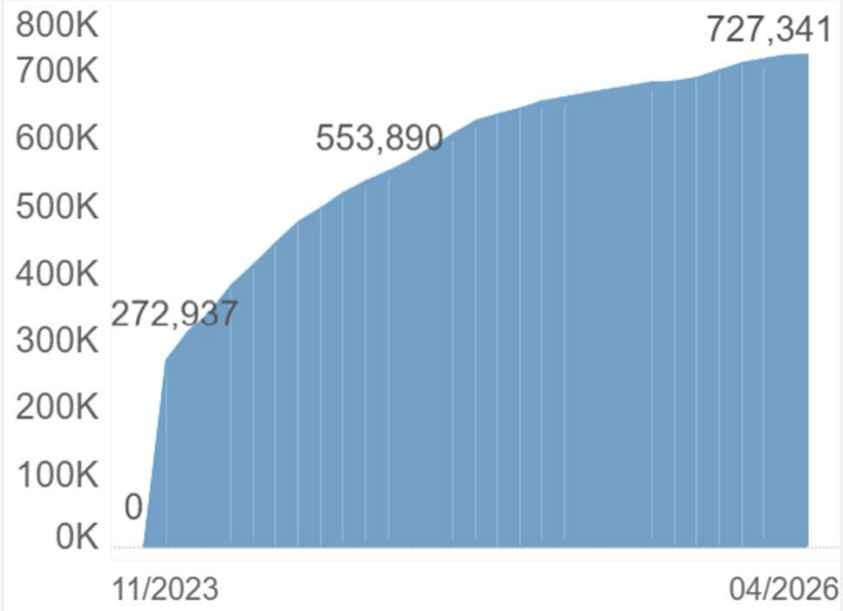
NC Medicaid Expansion Enrollment as of May 1, 2026: **727,341**

Note: Enrollments processed after this date are not reflected in this dashboard.

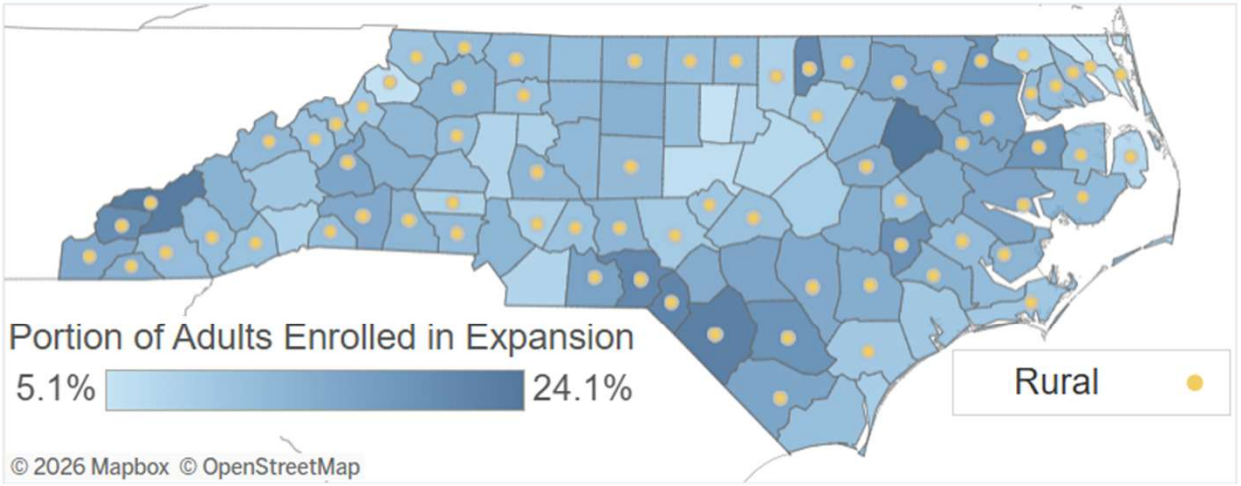
This dashboard shows the number of people enrolled in NC Medicaid only through expansion coverage.
The charts, excluding the map, can be viewed by health plan, demographics, and/or county by using the filters below.
Note: Enrollment counts are pulled at the beginning of the month except for January 2024 which was pulled on the twelfth of the month. For privacy reasons, categories and/or charts with counts less than 11 will not display.

Health Plan	Age Group	Sex	Ethnicity	Race	Rurality	County
(All)	(All)	(All)	(All)	(All)	(All)	(All)

NC Medicaid Expansion Enrollment Trend



Portion of Adults (19-64) by County Enrolled in NC Medicaid Expansion

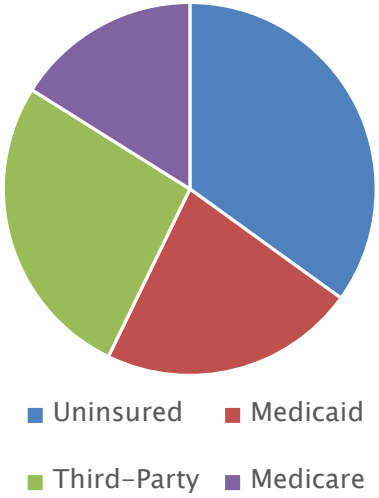


The statewide average portion of adults (19-64) enrolled in Medicaid Expansion is 10.6%.
Note: In the June 2024 update, the rural/urban county designation was modified to reflect the NC Office of Rural Health's definition which classifies 71 counties as rural and 29 as urban.
https://www.census.gov/programs-surveys/metro-micro/about.html

Outcome: Increase in Coverage Among CHC Patients

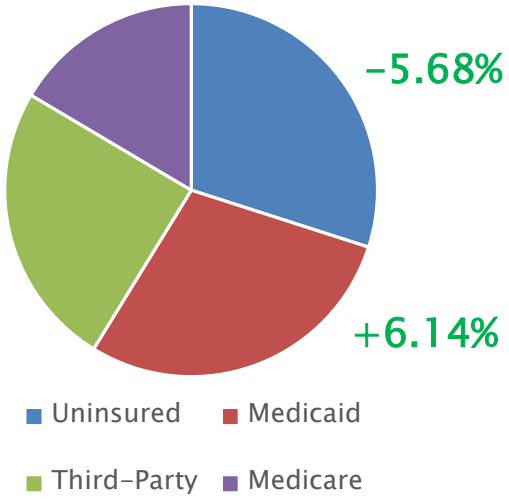
2022

Payer Mix



2024

Payer Mix



Source: HRSA UDS

Alternative Payment Methodology

The Milbank Memorial Fund & National Academy for State Health Policy highlighted this model as an example of how states can make it easier for people to access primary care in the 2025 Issue Brief, Implementing High-Quality Primary Care: A Policy Menu for States

1. As the state was preparing its transition to Medicaid managed care in 2021, we initiated state partnerships to overhaul the FQHC reimbursement methodology.
2. We sought to modernize rate methodologies to keep pace with costs; improve cash flow; reduce administrative burden; and eliminate incentives for managed care plans to view FQHCs as high-cost providers (avoiding steerage concerns and facilitating a level playing field for FQHCs in Medicaid value-based arrangements focused on Total Cost of Care).
3. Implemented in 2024, the APM:
   a. Includes a triennial rate rebasing process
   b. Requires real-time managed care wraparound payments
   c. Rationalizes pharmacy reimbursement by removing payment for pharmacy goods and services from the FQHC cost-per-visit
   d. Establishes an accelerated supplemental payment process for dental services; and more
4. Next triennial rate rebasing process under the APM: effective July 1, 2026.
5. Key outcome: **N.C. FQHCs' per-Medicaid patient-revenue increased by 26% from 2023 to 2024** (compared to only a 7.7% increase from 2022-2023), per analysis of UDS data.

Slide 63

1 From Brendan: I welcome any feedback on suggested framing differences, or if it would be helpful to hear more about what we did to train and prepare FQHCs.
BJ Rudell (NCCHCA), 2026-06-10T13:18:50.671

2 From Brendan: I have duplicated this slide to make streamlined edits per conversation on 5/18 but am preserving this for posterity in the interim.
BJ Rudell (NCCHCA), 2026-06-10T13:19:10.617

Fostering a Health Center Workforce

Activity Successes and Promising Practices

Josie Lane-Kuzniar, Workforce Development Manager
J'Mi Walker, Apprenticeship Program Director
Dr. Arianna Keil, VP of Quality
Chris Shank, President & CEO

NCCHCA Services to Support Workforce Recruitment, Retention, and Development

NCCHCA has several service lines, in progress or planned, to meet workforce needs at CHCs:

Education and Technical Assistance

- Understanding needs
- Comprehensive Workforce Development Planning
- Health Professions Education and Training Planning
- Human Resource Workgroup
- Workforce Workgroup
- Salary & Benefits Survey
- Trainings for CHC Staff on Recruitment, Retention, Workforce Wellbeing and Related Issues
- CHC Human Resources Assessment

Apprenticeships / Workforce Development

- Medical Assistant Apprenticeship Initiative
- Dental Assistant Recruitment & Certification
- Behavioral Health MA Training Certificate
- Dental Hygienist Partnership
- LPN Apprenticeship
- Pharmacy Tech Apprenticeship

Temporary Staffing

- Float Pools for Non-Credentialed Staff (e.g. CFO)
- Locum Tenens Services for Credentialed Provider Staff – both Medical Leaders & Primary Care Physicians

Active programs

In-development programs

Workforce: Listening and Planning

- Conducted and analyzed the 2025 Workforce Needs Assessment to inform workforce priorities, resources, and technical assistance planning
- Conducted 2026 Workforce Needs Assessment; analysis in progress
- Conducted, analyzed, and distributed deidentified results for the 2025–2026 Salary & Benefits Survey
- Applied workforce assessment findings to guide resource development and support strategies

Workforce: Support and Technical Assistance

1. Offered individualized workforce support opportunities to NC community health centers
   a. Recruitment, retention, onboarding, HR guidance, communication support
2. Provided technical assistance to CHCs at varying stages of Comprehensive Workforce Plan (CWP) development and implementation
3. Developed and shared CWP planning tools:
   a. CWP Prioritization & Progress Map
   b. Readiness Self-Assessment Matrix
4. Maintained the NCCHCA Workforce Resource Library
5. Developed and shared relevant workforce resources and technical assistance opportunities with CHCs

Workforce: Engagement and Shared Learning

1. Hosted two-part Onboarding for Retention interactive technical assistance series
2. Offered five-session supervisor and manager development series:
   a. Beyond Core Competencies for Health Center Managers and Supervisors
3. Facilitated recurring statewide workforce convenings:
   a. Workforce Workgroup, six meetings annually
   b. HR Workgroup, quarterly
4. Supported technical assistance and facilitated discussion around:
   a. Recruitment and retention
   b. Employee engagement
   c. HR policy updates
   d. Compensation promising practices
5. Supported asynchronous member exchange through Connected Community

Workforce: Educational Partnerships and Pathways

Completed the Residency/Training Partnership Resource in collaboration with NC AHEC partners.

Provided individualized HPET support:

1. Educational partnerships
2. Preceptor capacity
3. Educational program and rotation structures

Supported CHCs exploring workforce pathway and educational partnership opportunities

Medical Assistant Apprenticeship Initiative (MAAI)

12-Month Apprenticeship | 2,000 Clinical Hours | 200 Didactic Hours

Full-Time Employment | Earn While You Learn

Program Model

- Registered apprenticeship designed for CHCs
- Apprentices hired as full-time employees
- Blended training approach:
  - On-the-job clinical training (2,000 hours)
  - Structured didactic learning (200 hours)
- Monthly foundational training sessions (in-person/virtual)

Training and Support Structure

- Preceptor-led model for daily skill development
- Standardized skills checklist + competency validation
- Supervision Assist for tracking hours and progress
- Ongoing support from NCCHCA Clinical Instructor

Why It Works

- Leads to Certified Clinical Medical Assistant (CCMA) designation, via the National Healthcareer Association
- Removes barriers to entry (no upfront education cost)
- Aligns training with real clinical workflows
- Builds a sustainable, internal workforce pipeline

MAAI Outcomes and Impact

13 CHCs | 5 Cohorts | 100% CCMA Pass Rate (Cohort 3)

Program Reach

- Apprentices placed across 13 CHCs
- Representation across NC
- Continued expansion into new pilot sites and regions

Apprentice Placements by Cohort

- Cohort 2 (Summer 2024)
  - Rural Health Group (1) | OIC Family Medical Center (1) | Cabarrus Rowan (1) | Triad Adult & Pediatric Medicine (2) | United Health Centers (2) | Compassion Health (1)
- Cohort 3 (Winter 2025)
  - Commwell (2) | Cabarrus Rowan (1) | Amity (2)
- Cohort 4 (Summer 2025)
  - Lincoln CHC (1) | MedNorth (2) | Piedmont (5) | Cabarrus Rowan (1) | Appalachian Mountain Health (3) | Metropolitan CHC – Agape (1)
- Cohort 5 (Winter 2026)
  - Cabarrus Rowan (2) | Amity (1) | MedNorth (2) | OIC Family Medical Center (4) | Metropolitan CHC – Agape (2) | Triad Adult & Pediatric Medicine (2) | Compassion Health (1) | Commwell (3)

Graduation and Certification Outcomes

- Cohort 2 (Sept 2025) -- 8 Graduates | 7 Certified | 1 Retesting (2026)
- Cohort 3 (April 2026) -- 5 Graduates | 100% Certified (5/5 CCMA Pass Rate)

Float Pools for Non-Credentialed Staff

1. Solution for health centers with vacancies in Chief Financial Officer (CFO) role
   a. CFO is critical role requires specialized FQHC knowledge
   b. Having qualified professional to support temporarily eases the burden on incoming CFO, helps establish or maintain processes, and identify potential solutions
2. Since 2022, NCCHCA has provided CFO float services at XXX CHCs

Slide 72

1 Number?

BJ Rudell (NCCHCA), 2026-06-10T13:05:26.736

Locum Tenens Services for Credentialed Provider Staff

1. Advisory Group assembled and monthly meetings held
2. Tiered medical leader and tiered primary care physician positions drafted and shared with HR
3. Intake form drafted (to be completed by interested health centers) to guide appropriate resourcing
4. Potential contracting structure identified
5. Currently exploring payer and provider credentialing options

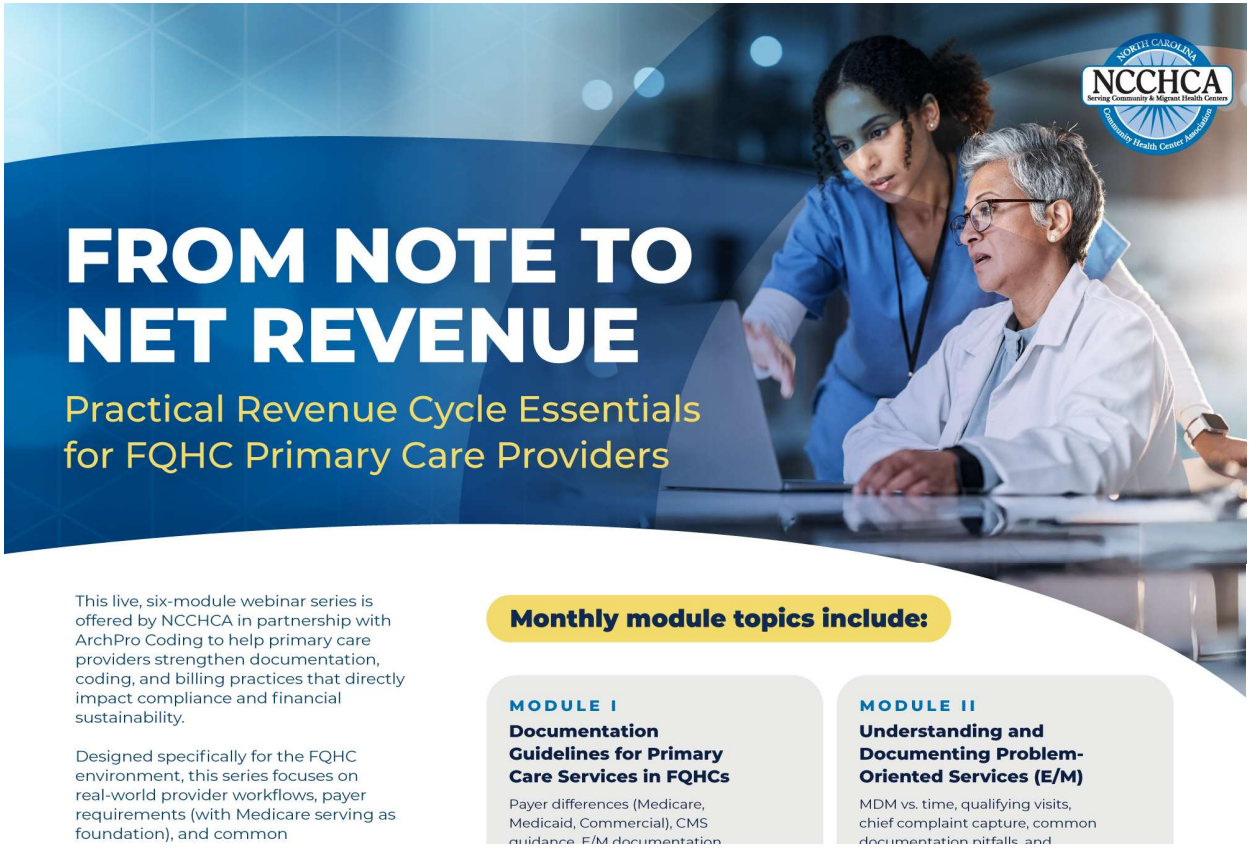
Fast Tracking Value Based Care Delivery

Activity Successes and Promising Practices

LyTonya Alexander, VP of Care Management & Provider Services/SVP of Value Based and Managed Care Services

Value-Based Care

- In partnership with ArchPro Coding, offering six-module series with two live monthly webinars
  - Target audience: primary care clinicians
  - 10 FQHCs registered, 21 participants per session
  - Average satisfaction rating: 4.4/5 (modules 1-4)
- CMHN has also partnered with consultants and subject matter experts to support our FQHCs' success in value-based care models.



Enhancing Emergency Preparedness and Response

Activity Successes and Promising Practices

Mel Goodwin-Hurley, VP of Risk Management & General Counsel

Emergency Preparedness

1. NCCHCA monitors adverse weather events and actively communicates with health centers in areas experiencing severe impacts, working to troubleshoot issues and communicate CHC operational status with HRSA.
2. Continuing the Emergency Preparedness and Severe Weather Impacts on Health Centers learning series, NCCHCA, in partnership with Direct Relief, will present on Hazard Vulnerability and Risk Assessments (HVA) for CHCs.
3. Expanding on the 2024–2025 case study initiative focused on Emergency Preparedness communication methods, NCCHCA is highlighting strategies used by CHCs during the 2024 Helene response. Western health centers are sharing best practices and lessons learned from this unprecedented event.

Partnerships to Support PCA Objectives

"AMH was impacted by the recent hurricane resulting in the closure of all sites for a period of 3 days. Following the initial three days, AMH was able to open 3 (50%) of 6 sites and the remaining sites within one and ½ weeks. Without the mental (encouragement, coordinating regional FQHC check in meetings to share barriers, best practices and needs), physical (showing up onsite with supplies and equipment to support our team) and monetary (access to disaster relief grants, stabilization payments from the various payers and grants via community partners) support- our success would not have been as smooth and efficient. Ms. Shank and her team remain a dependable resource to our health center as we continue to transition to life as normal post Helene."

Shantelle Simpson, Appalachian Mountain Community Health Centers

Emergency Preparedness

1. Partners: NCCHCA collaborated with several organizations in response to the impacts of Hurricane Helene in Western North Carolina, including Direct Relief, International Medical Corps (IMC), Americares, and Project Hope.
2. Outcomes:
   a. Fast and consistent deployment of resources to CHCs impacted by Hurricane Helene
   b. Training for CHCs: Emergency Preparedness and Severe Weather Impacts on Health Centers training that was led in collaboration with IMC.

Advancing Clinical Quality and Performance

Activity Successes and Promising Practices

Alice Pollard, VP of Member Services and Operations
Dr. Arianna Keil, VP of Quality

Partnerships to Support PCA Objectives

Behavioral Health

1. Partners: JBS International (HRSA's Contracted TA Provider for BH Integration), Collaborative Family Health Care Association, and NC Central U.
2. Outcomes:
   a. 3 session training series on Integrated Behavioral Health open to all FQHCs and FQHC-LALs
   b. Free technical assistance from CFHA, leader in integrated BH
   c. One-day conference on Medications for Opioid Use Disorder, providing expert training to NC FQHCs and FQHC-LALs

Maternal Health

1. Partners: Nurture NC (statewide coalition to improve maternal health), NC Division of Public Health Women's Health Branch (Title V agency), and NC MATTERS (provider consultation for maternal mental health issues)
2. Outcomes:
   a. NCCHCA hosted Maternal Health Convening providing insight into services for CHC providers and patients
   b. Application to NC Philanthropy for $3 million project to integrate Shared Maternity Care at NC FQHCs

Partnerships to Support PCA Objectives

Intimate Partner Violence

1. Partners: North Carolina Coalition Against Domestic Violence, NC Stop Human Trafficking, and the UNC School of Social Work
2. Outcomes:
   a. Training Series for CHCs: Strengthening CHC Response to Human Trafficking and Intimate Partner Violence.
   b. Development of a template MOU for CHCs to use when entering their own partnerships with local IPV agencies.

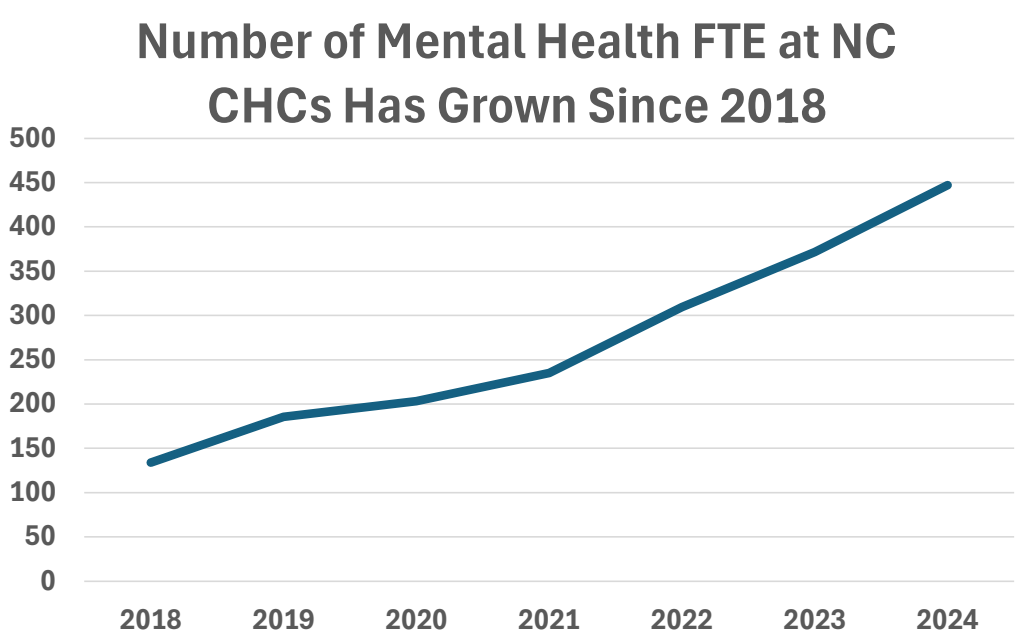
Diabetes

1. Partners: NC Division of Public Health's Community and Clinical Connections for Prevention and Health Branch
2. Outcomes:
   a. Individual technical assistance for four FQHCs funded by NCDPH
   b. More than $10,000 for each of the four FQHCs to implement practice changes to support quality improvement for patients with diabetes

Supporting Growth of CHC Behavioral Health Services

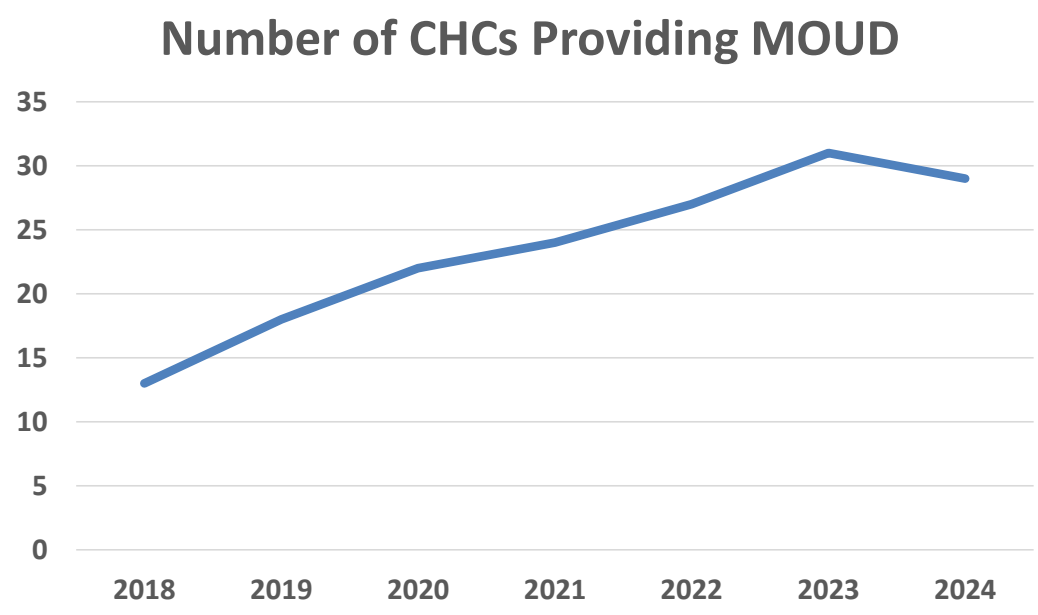
1. Sustained PCA work toward goals
   a. More health centers offering behavioral health services
   b. Increased # of services offered
   c. More health centers offering medications for opioid use disorder treatment (gold standard)
2. Multi-pronged approach to support goals
   a. Advancing needed policy changes (e.g. same day behavioral health/medical billing, coverage for Associates-level professionals, Collaborative Care Model Reimbursement)
   b. Group Learning and Peer Learning, especially related to opioid use treatment to help address perceived barriers
   c. Multiple educational tools that address clinical best practices, operations, and billing
   d. Partnerships with other TA providers
   e. Identifying funding resources for CHCs to establish or grow programs
3. Up next . . .
   a. Identifying CHCs with little to no BH integration for targeted learning group and funding support

Growth in Behavioral Health Capacity



- Pre-2018: Work with NC Medicaid to ensure same day medical/behavioral health billing
- 2018: NCCHCA dedicates 1.0 FTE to focus on behavioral health and enabling services learning & TA. Initial areas of focus are on integrated models of care and reimbursement
- 2019: Dedicated resources to support CHCs to recruit and retain behavioral health providers
- 2019-2021: Integration assessments for CHCs with current Behavioral Health; readiness assessments for CHCs without Behavioral Health
- 2022: NCCHCA secures appropriated funding to expand Medications for Opioid Use Disorder, allowing additional Behavioral Health FTE
- 2023: NCCHCA creates School Based Behavioral Health Workgroup to support CHCs expanding this service line

MOUD Growth



- Pre-Pre-2018: Creation of Medication Assisted Treatment Workgroup for Medical and Behavioral Health Providers
- 2018-2020: Significant Learning Investment
  - Partnership with UNC Health Care & Mountain Area Health Education Center to bring no cost individualized learning sessions to FQHCs launching MOUD programs
  - Partnership with UNC Health Care to bring Addiction Medicine Fellows to train at CHCs
  - Significant 1:1 outreach to CHC medical & behavioral health leadership to encourage MOUD and address barriers to engagement
- 2022: NCCHCA secures appropriated funding to expand Medications for Opioid Use Disorder, allowing additional Behavioral Health FTE
- 2023: NCCHCA co-hosts first MOUD Conference

PCA Partnerships

Sanga Krupakar, VP of Network & Analytics

NCCHCA Collaboration Framework

NCCHCA partners with several organizations and individuals to advance our mission. The goals of partnerships vary and examples of the goals of collaboration include:

1. Amplifying messages about FQHCs' impact and needs
2. Advancing shared or related policy goals (e.g., Medicaid expansion)
3. Bringing quality, no- or low-cost, and FQHC-specific training/TA to health center organizations
4. Bringing quality, no- or low-cost, and FQHC-specific services to health center organizations
5. Joint funding opportunities to increase success in grant applications

How the HCCN Meets Health Center Needs

Connecting health center priorities to practical support and stronger performance

Health Center Priorities

- Surveys & assessments
- Outreach & conversations
- User groups
- Support requests
- Emerging needs

1. Hear the Need

Gather input from across the network.

2. Prioritize

Review shared needs and focus on high-impact opportunities.

3. Build Support

Develop learning sessions, tools, templates, and technical assistance.

4. Deliver Support

Provide assistance with EHR optimization, analytics, interoperability, reporting, and workflows.

5. Support in Practice

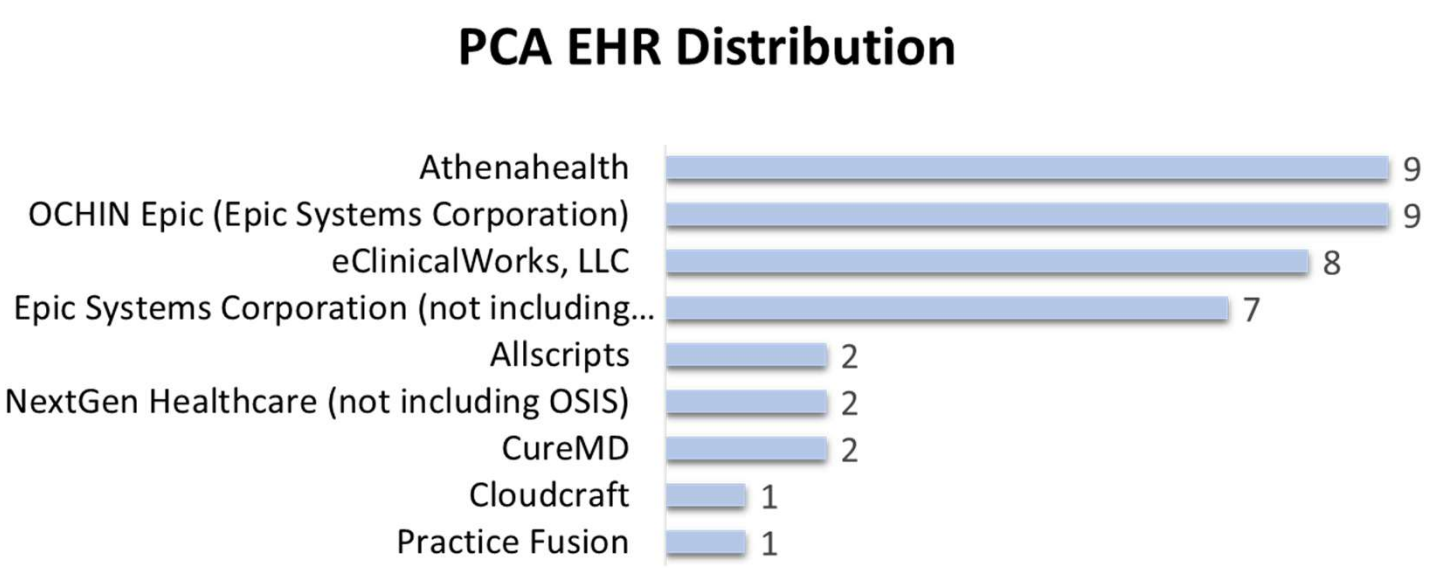
Health centers apply support to strengthen capacity and performance.

Impact in CHCs

- Stronger HIT capacity
- More effective use of data
- Improved workflows and operations
- Readiness for implementation

Aligned with PCA priorities

Advancing Care Quality: EHR Enablement



"EHR user groups have been really important for MedNorth. It brings together a workgroup to solve problems and make improvements in how we use Epic. One great example: when we talked with other organizations, we learned about two tools in Epic that we weren't using yet—the Financial Assistance and ROI (release of information) tools. Once we knew about them, we decided to set them up at MedNorth…All this matters as we expand our facility and grow our services. The user groups make sure our technology helps us take better care of patients. With the explosion of AI products, this user group will help guide us into the future."

Sarah "Beth" Royal, RHIA
Director of HIM/QI/Data Management
MedNorth Health Center

Advancing Care Quality: Data Aggregation

Program Context

1. The North Carolina Department of Health and Human Services (NC DHHS) delivers a statewide farmworker health initiative through FQHCs and clinic partners in collaboration with the Office of Rural Health (ORH).
2. Requires coordinated data collection across multiple care delivery sites.

HCCN Contribution

1. Enable aggregation of encounter-level data using Azara DRVS.
2. Support tracking of program activity and performance in real time.
3. Facilitate reporting to NC DHHS, ORH, and HRSA
4. Help identify trends, gaps, and quality improvement opportunities.

"NC DHHS has implemented Azara DRVS to support monitoring and reporting for our Farmworker Health Program. Azara allows us to aggregate data from our seven partner organizations' EHRs and our legacy data system. This reduces the need for duplicate data entry and provides more timely access to data at our central office. The user-friendly reporting features have also allowed us to support quality improvement initiatives with more sophisticated data. All of this contributes to enhanced care for patients."

Kate Furgurson, MPH
NC Farmworker Health Program,
Data & Quality Specialist
Office of Rural Health
NC Department of Health & Human Services

Shared Value-Based Care Infrastructure: Arcadia

130,000+ Patients | **200+ Arcadia Users** | **67,000 CM Encounters (last 90 days)**

One HCCN supporting both Standard and Tailored Plan Care Management across NC FQHCs with shared Arcadia infrastructure, standardized protocols, and a single analytics layer.

Shared Value-Based Care Infrastructure: Arcadia

Value Delivered to Health Centers

Centralized Reporting

Standardized dashboards eliminating duplicative data pulls across health centers

Shared Savings Support

Attribution tracking and care management support reducing total cost of care while improving quality outcomes

Actionable Insights

Patient-level care gap alerts and risk scores delivered to frontline staff

Reduced Admin Burden

Automated workflows replace manual processes; single platform across all payers

Standardized Protocols

Consistent CM workflows and documentation across member FQHCs

Regulatory Alignment

HEDIS reporting support built into platform infrastructure

Shared Value-Based Care Infrastructure: Arcadia

	Standard Plan Care Management Medicaid Managed Care	Tailored Plan Care Management BH / IDD / TBI
Patient Population	• Medicaid enrollees w/chronic conditions • High utilization • Rising-risk identified via risk stratification	• Members with SMI • Intellectual/developmental disabilities • Traumatic brain injury (TBI)
Arcadia Integration	• Risk scores • Care gaps • Task management • Outreach tracking	• Specialized workflows for BH encounters • IDD service plans • TBI tracking
Outcome Focus	• Reduced ED utilization • Improved HEDIS quality scores • Shared savings performance metrics	• Reduced psychiatric hospitalizations • Improved community tenure • Crisis diversion • Care plan adherence

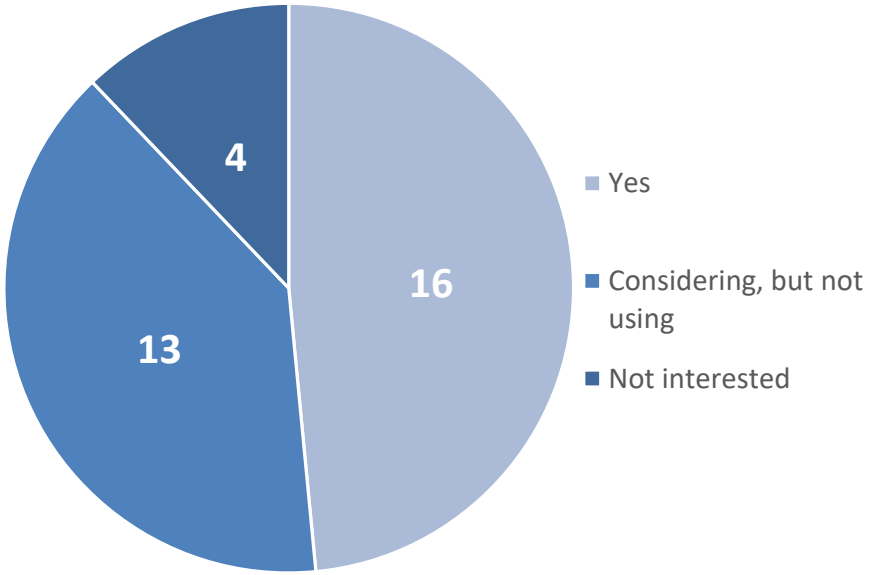
Advancing Health Centers: Artificial Intelligence Readiness

HCCN Support to Date

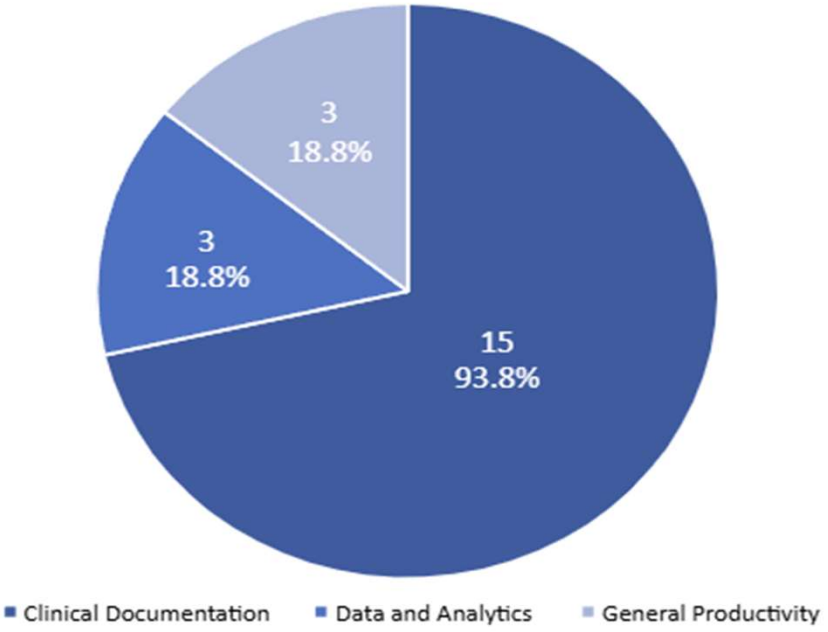
1. Delivered an AI in Healthcare series to establish foundational knowledge and showcase real-world applications.
2. Shared practical tools and templates for AI implementation.
3. Facilitated discussions on use cases, risk management, governance, workflow integration, and vendor assessment.

Advancing Health Centers: Artificial Intelligence Readiness

AI Usage Across the HCCN (n=33)



Categorized AI Usage in the HCCN



Slide 94

1 Suggest revising the left chart so there's no space between "Yes" and the responses below it, and to enlarge the text there and in the right chart.
BJ Rudell (NCCHCA), 2026-06-10T13:09:51.535

AP1 0 [@Sanga Krupakar (NCCHCA)] are you or someone from your team able to make the change that BJ suggests?
Alice Pollard (NCCHCA), 2026-06-11T20:16:04.817

S(1 1 [@Korrey Monroe (NCCHCA)] can you help with this?
Sanga Krupakar (NCCHCA), 2026-06-11T20:24:50.912

Safety Net Partnerships

Primary Care Advisory Committee (PCAC)

1. Composition
   a. NCCHCA
   b. North Carolina Office of Rural Health
   c. North Carolina Association of Local Health Departments
   d. North Carolina Association of Free and Charitable Clinics
   e. North Carolina School-Based Health Alliance
   f. Organizations representing other eligible grant recipients within the Community Health Grant Program
2. Provides guidance to the NC Community Health Grant Program, which provides funding for nonprofit primary care safety net organizations to increase access to primary medical & preventive care.

Slide 95

1 Is this accurately worded?
BJ Rudell (NCCHCA), 2026-06-10T17:21:57.094

AP1 0 I have updated this slide slight to make it more accurate, but I think it’s good to go now!
Alice Pollard (NCCHCA), 2026-06-11T20:19:49.908

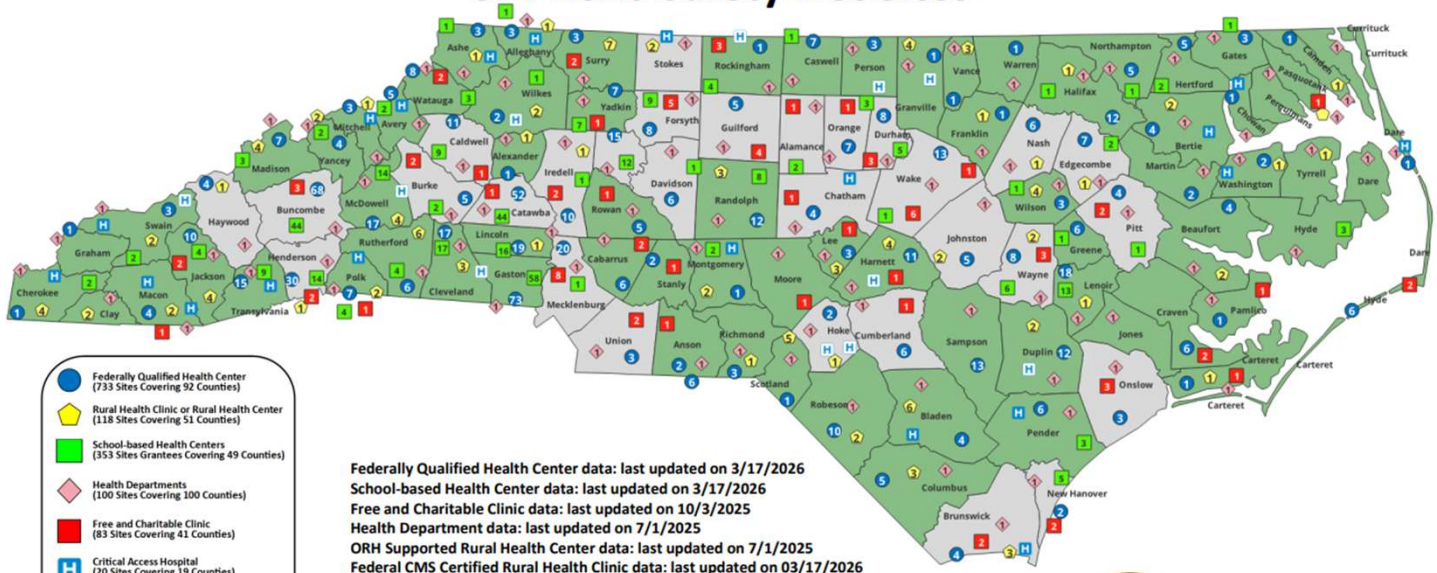
Safety Net Partnerships

Translational Health In the Safety Net (THIS–NC)

1. NCCHCA worked with local funders to include other safety net provider data within our analytics platform specifically for the potential research benefits from such an infrastructure.
2. The only PCA in the nation to have ingested patient data from free clinics and local health departments to augment what we are collecting from North Carolina community health centers.
3. Will support future research opportunities.

Safety Net Partnerships

North Carolina Office of Rural Health
SFY 2026 Safety Net Sites



Federally Qualified Health Center data: last updated on 3/17/2026
School-based Health Center data: last updated on 3/17/2026
Free and Charitable Clinic data: last updated on 10/3/2025
Health Department data: last updated on 7/1/2025
ORH Supported Rural Health Center data: last updated on 7/1/2025
Federal CMS Certified Rural Health Clinic data: last updated on 03/17/2026
Critical Access Hospital data: last updated on 7/1/2025
Small Rural Hospital data: last updated on 7/1/2025
*To reflect sites' comprehensive service models, some sites may be listed under multiple designations (A School-based Health Centers could also be designated as a Federally Qualified Health Center).

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of Rural Health

Slide 97

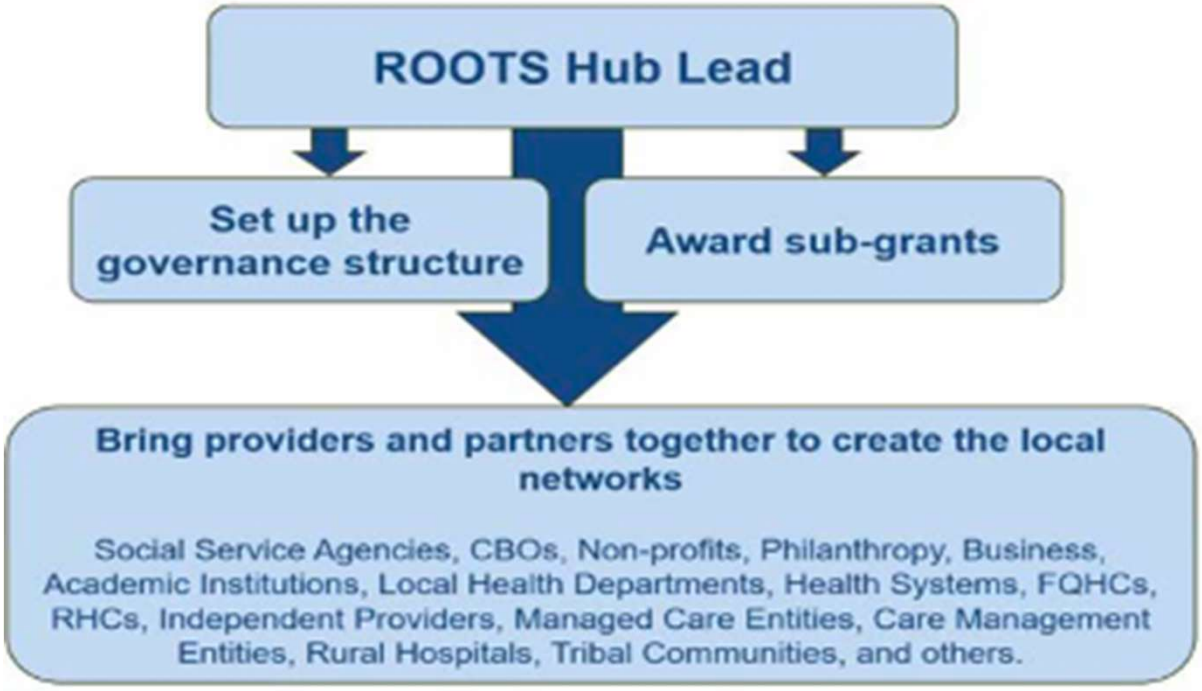
1 Is there a clearer version of this graphic?
BJ Rudell (NCCHCA), 2026-06-10T17:28:31.984

AP1 0 I’ve added this one here, which is a different source, but I think a clearer picture and more up to date. Happy to change back if desired.
Alice Pollard (NCCHCA), 2026-06-11T20:15:13.184

Rural Health Transformational Program (RHTP)

1. North Carolina awarded $218M in December 2025
2. NC Department of Health and Human Services (NC DHHS) projects regions will each receive approximately $93M through 10/2030
3. NC DHHS announced the selection of organizations to serve as leads for the North Carolina Rural Organizations Orchestrating Transformation for Sustainability (ROOTS) Hub for the state's Rural Health Transformation Program (NCRHTP).
4. These organizations will work as regional networks connecting medical, behavioral health, and social supports as North Carolina increases access to care for rural communities across all 100 counties.

Rural Health Transformational Program (RHTP)



Rural Health Transformational Program (RHTP)

1. While the composition of each Hub Network may vary based on the Hub Action Plan, it must include rural safety net providers, such as rural hospitals, LHDs, FQHCs, RHCs, independent practitioners, providers, care management entities, and Medicaid managed care organizations
2. Additional partners include, but are not limited to, community partners that have deep knowledge of the issues affecting the community and that can support the Hub, such as CBOs, social service agencies, CHWs, philanthropic organizations, local businesses, and community members.
3. NCCHCA is developing and implementing a strategy to assist our members as they engage under this program.

Thank you!

1

Improving Sustainability by Modernizing FQHC Medicaid Payment

The Milbank Memorial Fund & National Academy for State Health Policy highlighted this model as an example of how states can make it easier for people to access primary care in the 2025 Issue Brief, Implementing High-Quality Primary Care: A Policy Menu for States

Background

- As the state was preparing its transition to Medicaid managed care in 2021, NCCHCA initiated state partnerships to overhaul the FQHC reimbursement methodology to keep pace with FQHCs' costs, improve cash flow, reduce admin burden, and facilitate FQHC success in value-based arrangements.

Process

- NCCHCA facilitated a health center-driven process of policy development through a Board-appointed ad hoc Payment Reform Committee that researched other states' payment models, made recommendations, and advised NCCHCA staff on negotiations with the state from 2021 to 2022.
- NCCHCA partnered with the state and health centers on developing language for a State Medicaid Plan Amendment, educating health plan partners, and securing state appropriations to enact the APM, which was fully implemented in 2024.
- Currently, N.C. is in the final stages of the next triennial rate rebasing process under the APM, with new rates effective July 1, 2026.

Highlighted Outcome

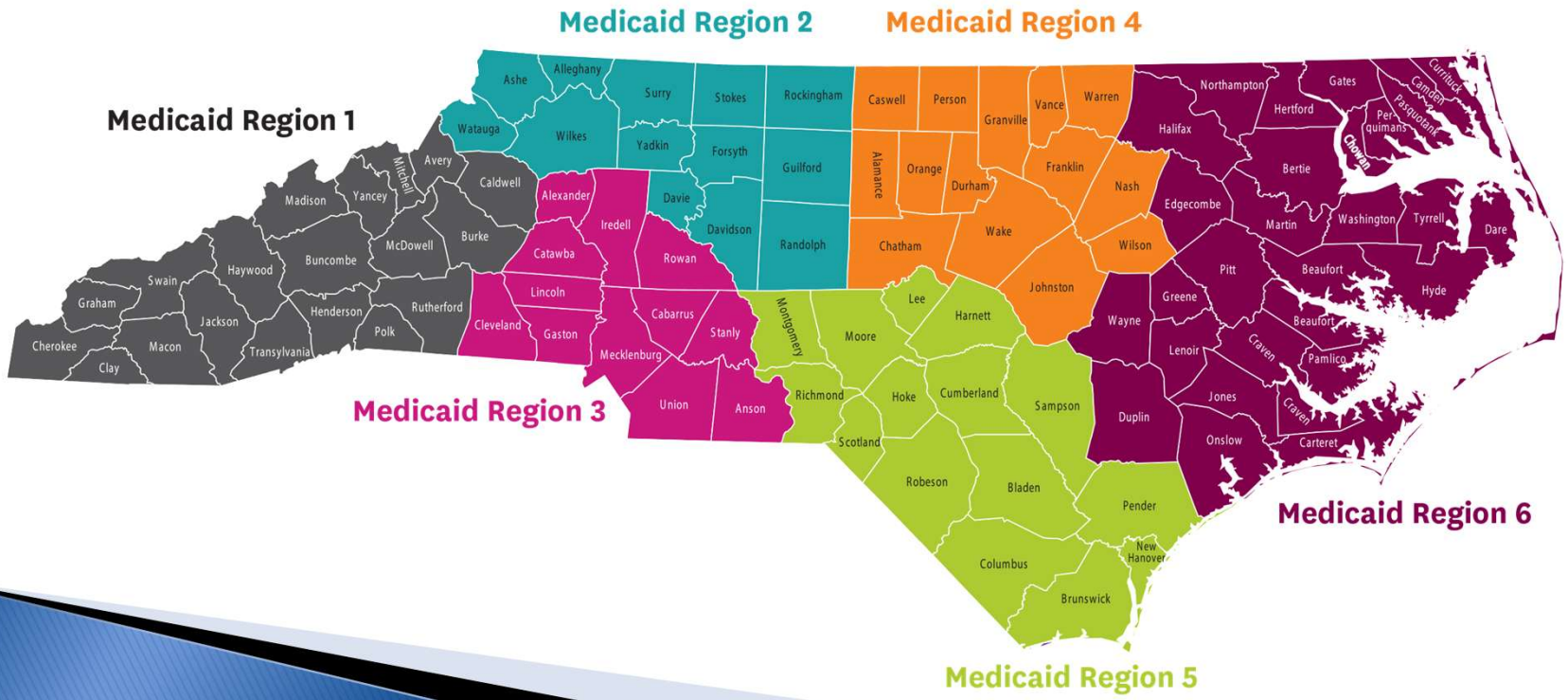
- **N.C. FQHCs' per-Medicaid patient-revenue increased by 26% from 2023 to 2024** (compared to only a 7.7% increase from 2022-2023) per analysis of UDS data.

Slide 102

1 From Brendan: This is a revised version of the APM slide.
BJ Rudell (NCCHCA), 2026-06-10T13:25:52.477

Regional Groups to Address Access to Care

- Geographic organizing improves access to care
- Six regions organized around NC Medicaid regions
- CHC CEO meetings to discuss goals and challenges
- NC Rural Health Transformation Program ROOTS Hubs



NCCHCA's Extensive Reach: Associated Entities

1. Develops partnerships with state agencies, funders, and national organizations to help elevate FQHCs in North Carolina
2. Holds a Health Center Controlled Network (HCCN) cooperative agreement with HRSA since 2013 to leverage health information technology (IT) and data analytics to optimize clinical and operational practices
3. Part owner in, and managed services provider for, Carolina Medical Home Network (CMHN), a clinically integrated network of 25 FQHCs known as Carolina Medical Home Network, LLC (CMHN)
4. Launched Translational Health Institute of the Safety Net in NC (THIS-NC), a research arm in partnership with North Carolina Central University, in 2024 to explore further engagement in clinical research in service to FQHCs in North Carolina
5. Recently established an MSSP Accountable Care Organization (ACO) to serve 12 FQHCs in North Carolina

Slide 104

1 From Alice: For CS_-- how much do we want to emphasize THIS NC?
BJ Rudell (NCCHCA), 2026-06-08T17:21:44.500

2 From Bishop: [@Mel Goodwin-Hurley (NCCHCA)] do we need to retitle this to PCA instead of NCCHCA?
BJ Rudell (NCCHCA), 2026-06-08T17:22:29.078

AP2 0 [@Mel Goodwin-Hurley (NCCHCA)] , do you think the title of this slide needs to be updated to PCA?
Alice Pollard (NCCHCA), 2026-06-11T20:22:36.549

2 1 Hello! I think this should remain "NCCHCA"
Mel Goodwin-Hurley (NCCHCA), 2026-06-11T20:38:34.527

3 Recommended re-write:

1. Develops state-level partnerships with state agencies, funders, and national organizations to help elevate FQHCs

2. Holds a Health Center Controlled Network (HCCN) cooperative agreement with HRSA since 2013 to _[achieve what]_____

3. Part owner in, and managed services provider for, Carolina Medica Home Network, LLC (CMHN)--a clinically integrated network of 25 FQHCs

4. Launched Translational Health Institute of the Safety Net in NC (THIS-NC), a research arm in partnership with North Carolina Central University to explore further engagement in clinical research in service to North Carolina's FQHCs

5. Recently established an MSSP Accountable Care Organization (ACO) to serve 12 FQHCs to address the impact of the end of Making Care Primary.
BJ Rudell (NCCHCA), 2026-06-08T17:23:43.224