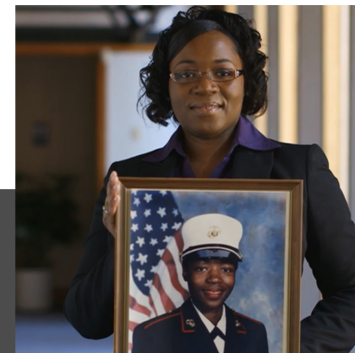




NATIONAL ASSOCIATION OF Community Health Centers



America's Voice for Community Health Care

Sustaining Health System Changes:

NACHC's Value Transformation Framework

As a Model for Sustaining Cancer Screening in Primary Care

June 7, 2019

Atlanta, GA

Enhancing Cancer Programs through Peer to Peer Learning: Shared Successes and Challenges in Health System Collaborations



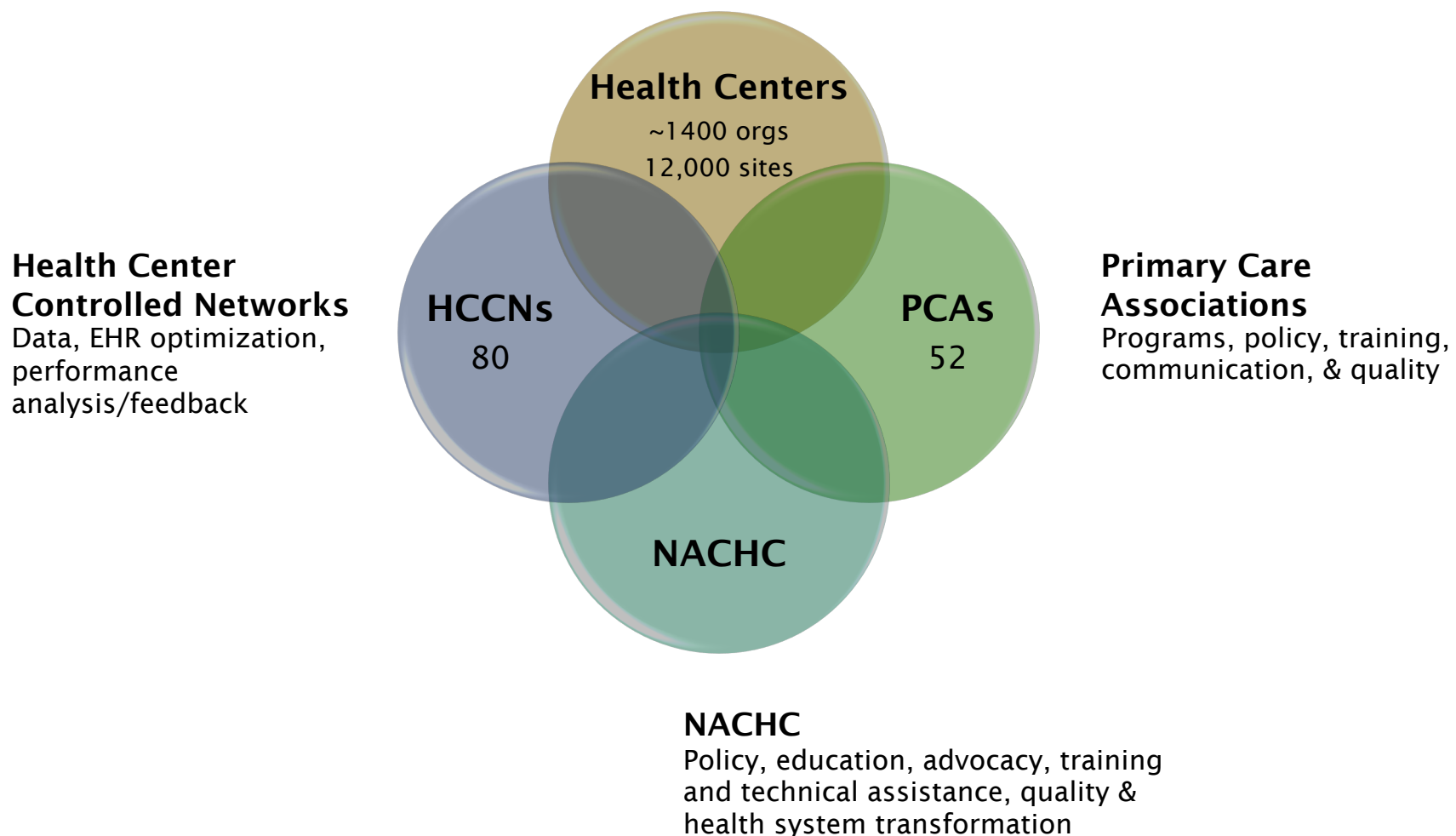
NATIONAL ASSOCIATION OF
Community Health Centers

America's Voice for Community Health Care

The NACHC Mission

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.

Health Center Program Partners



Value Transformation: A Sustainability Strategy



With the transition to value-based care...

...simultaneous focus on improving quality and outcomes while reducing costs is a *business imperative*.



To be sustainable...

...requires a business model that includes much *more than the delivery of effective clinical care*.



Value Transformation Framework Focus...

...enhancing *infrastructure, care delivery, and people systems* to provide better care to more patients at lower cost.

Advancing the Quadruple Aim

“Value” defined as the Quadruple Aim goals of:



Improved
health outcomes



Improved
staff experience



Improved
patient experience

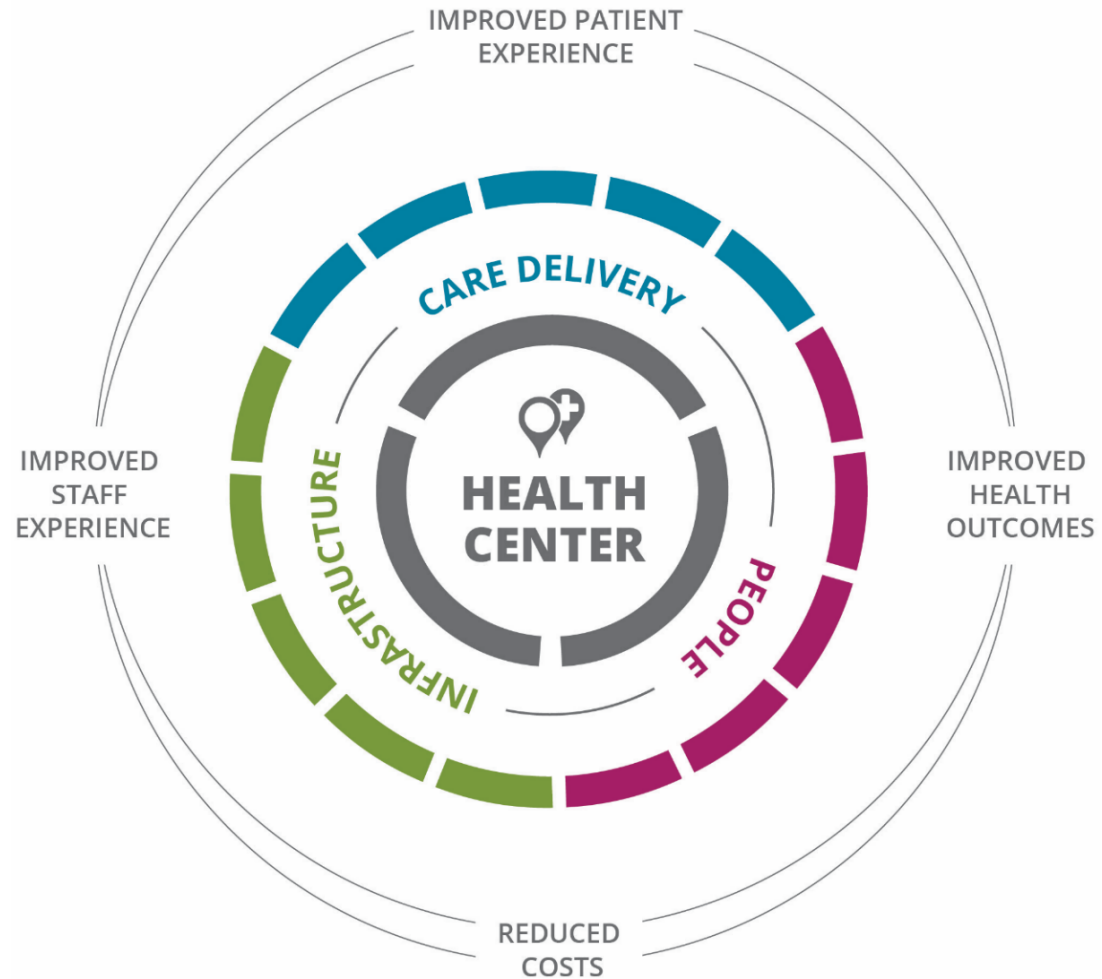


Reduced
costs

Packaging and implementing evidence-based transformational strategies for safety-net providers

Bringing science, knowledge, and innovation to practice

Value Transformation Framework

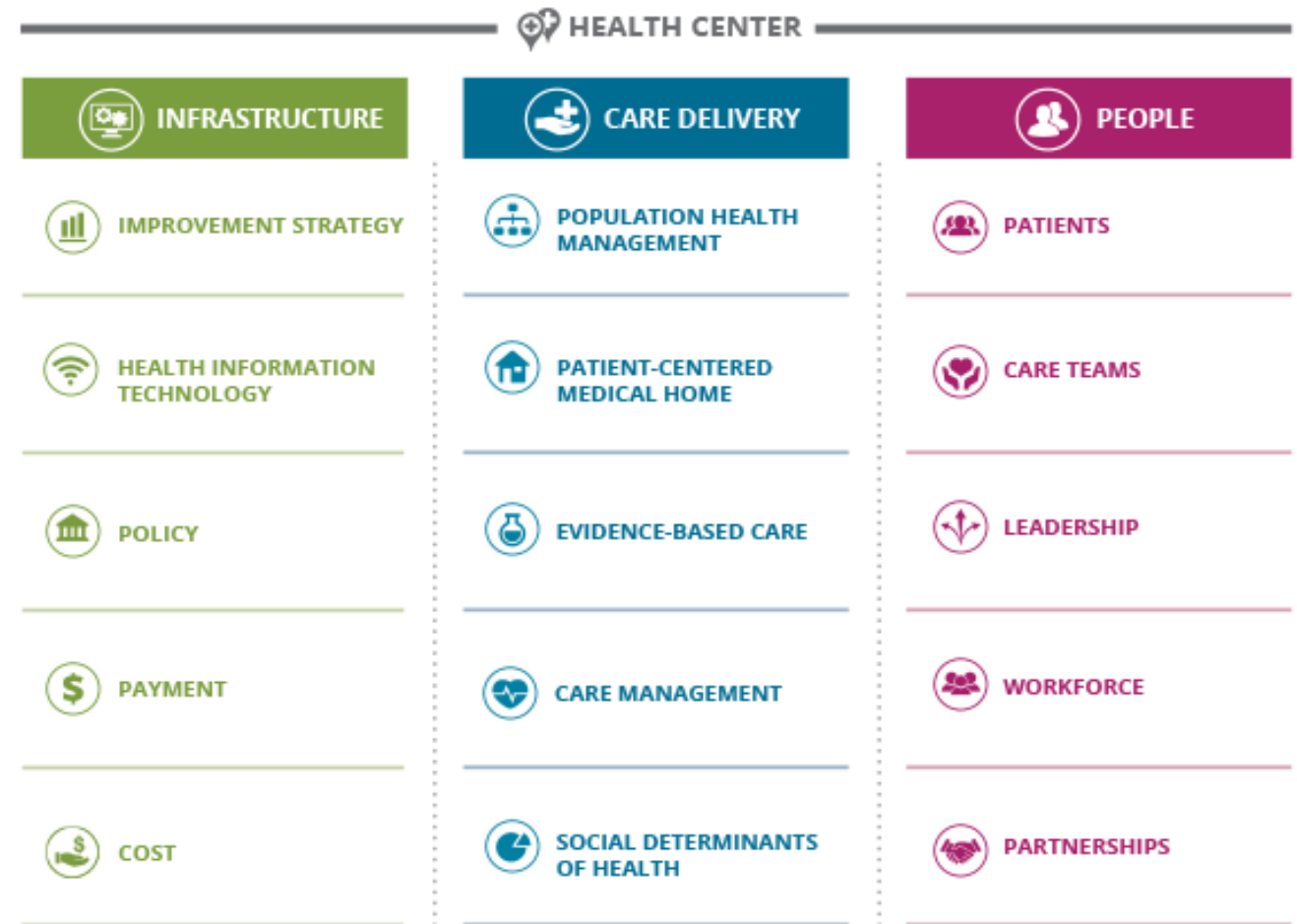


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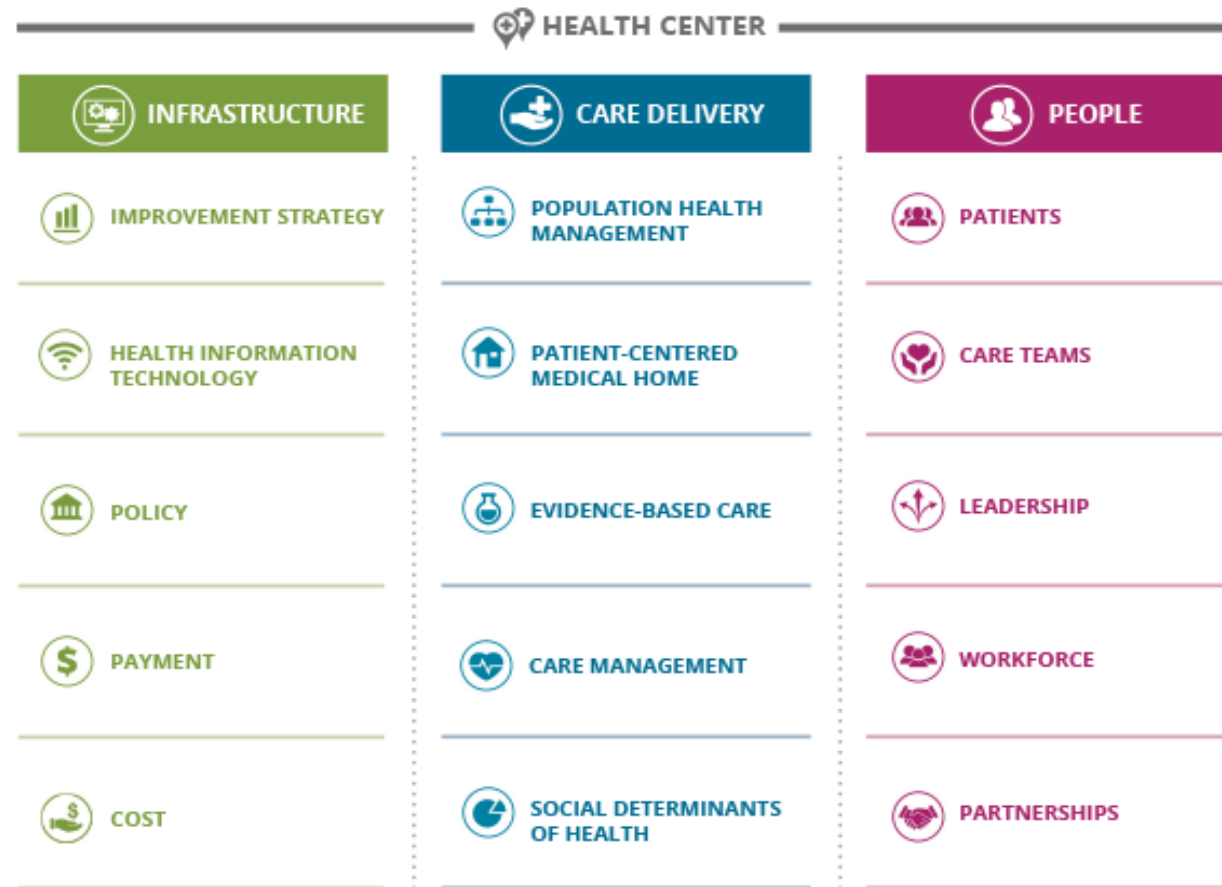
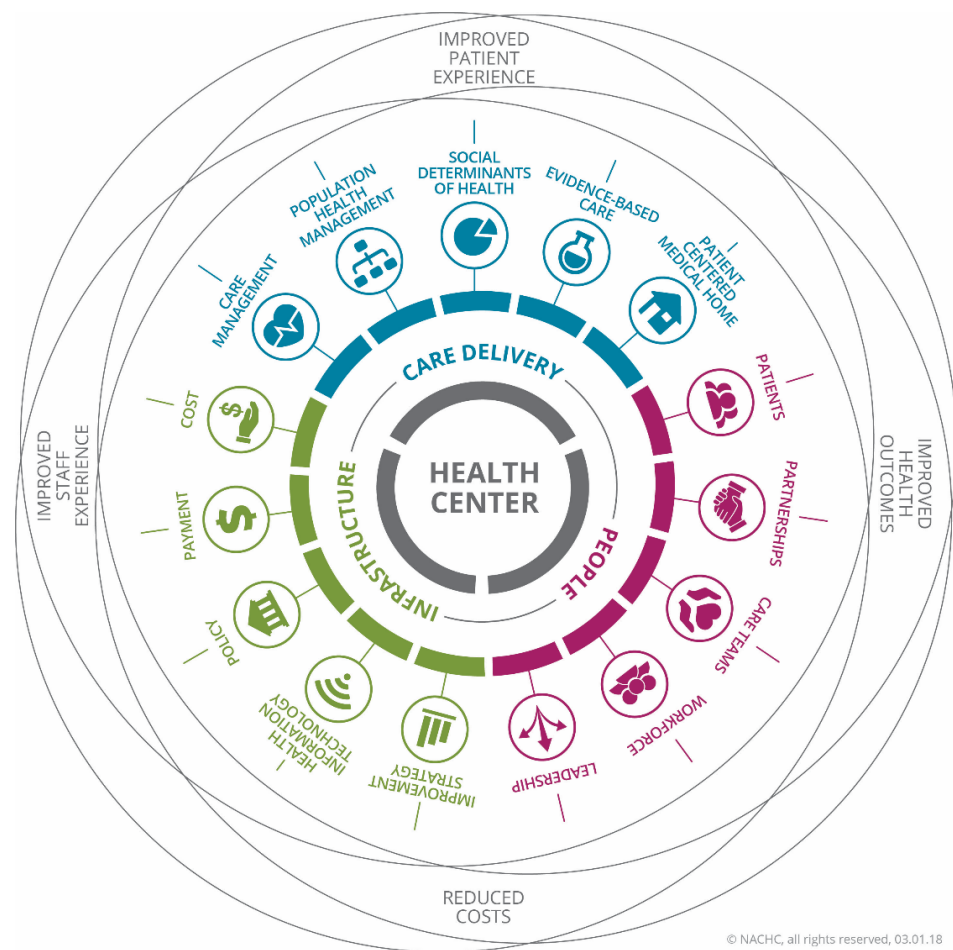
Value Transformation Framework

3 Domains

15 Change Areas



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Value Transformation Framework

Cancer Transformation Project


Embeds the work of cancer prevention and screening within a systems transformation approach.



In keeping with the Value Transformation Framework...

supports transformation toward value-driven care and the Quadruple Aim

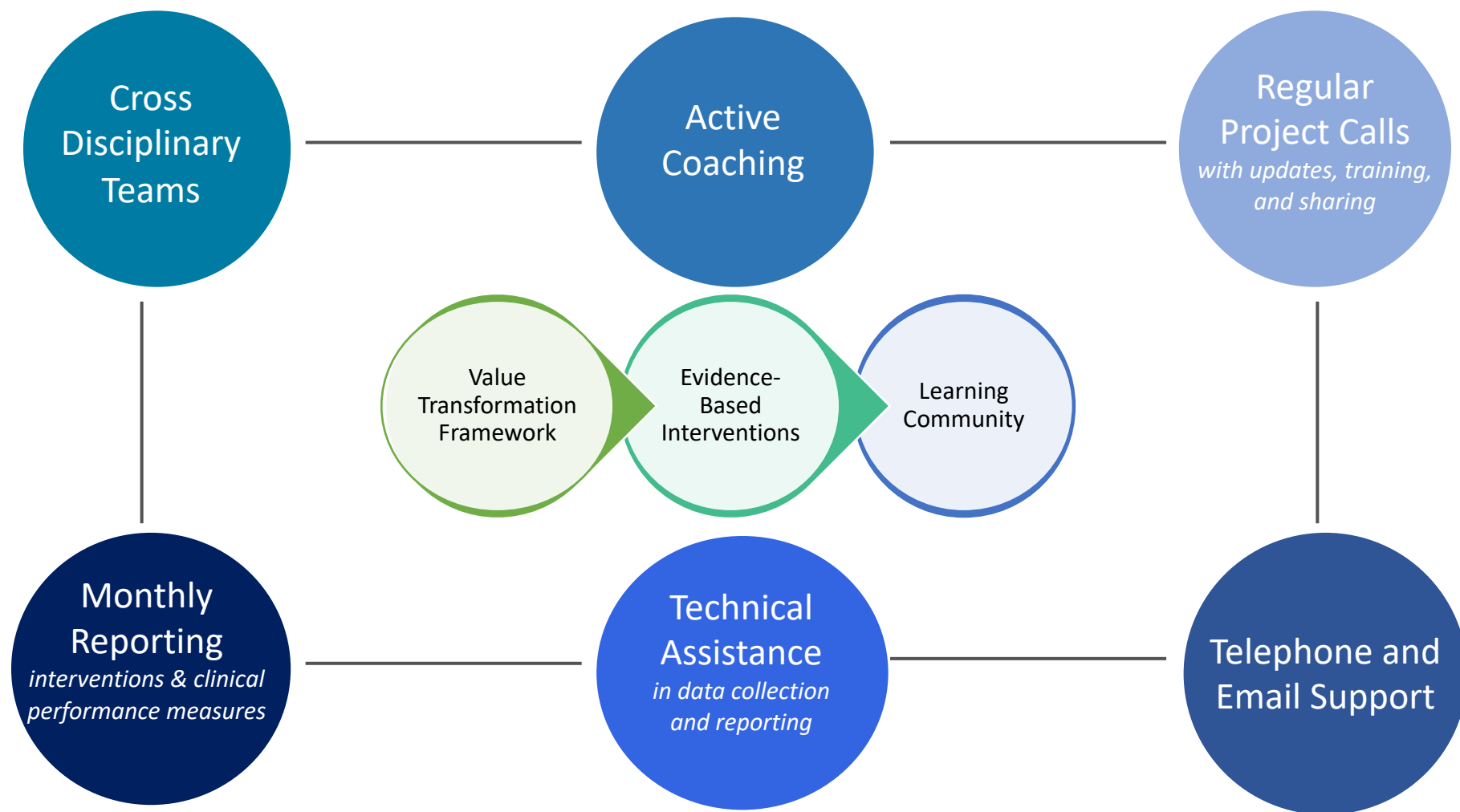
NACHC Cancer Transformation Project

	ORGANIZATION	
National	Centers for Disease Control and Prevention	
National	National Association of Community Health Centers	
State (PCAs)	Georgia Primary Care Association	Iowa Primary Care Association
Local (Health Centers)	Albany Area Primary Health Care Coastal Community Health Services Community Health Care Systems East Georgia Healthcare Center	CHCs of Southeastern Iowa CHCs of Southern Iowa Eastern Iowa Health Center Primary Health Care

A CDC-funded project focused on colorectal and cervical cancer screening as part of a [comprehensive transformation approach](#)

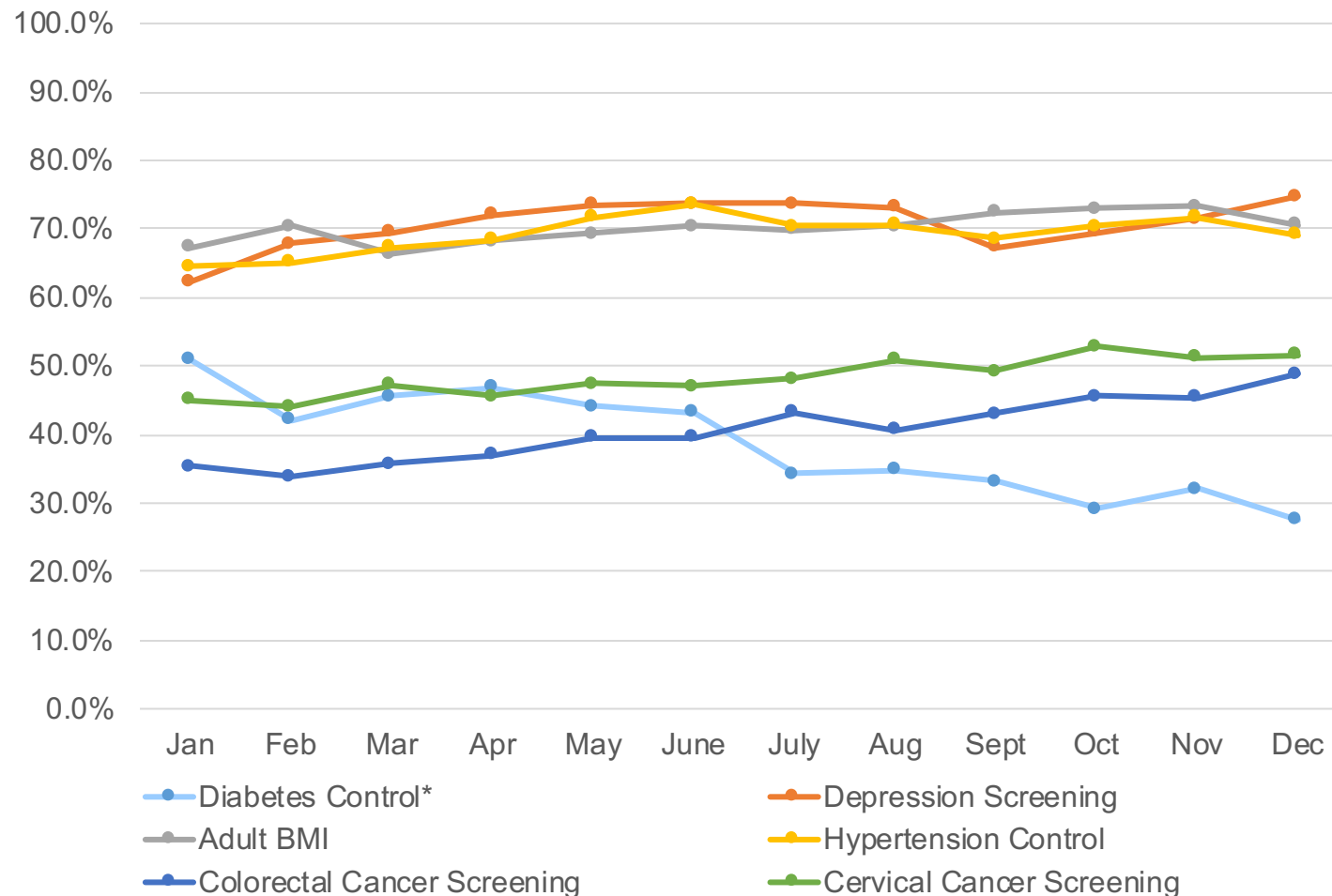
Quadruple Aim	Measure
Improved Health Outcomes	Colorectal cancer screening
	Cervical cancer screening
	HTN control
	Diabetes control (UDS = % uncontrolled)
	Obesity screening/management
	Depression screening/management
Improved Patient Experience	Patient experience
Improved Staff Experience	Staff experience
Reduced Costs	Cost

Enhanced Learning Community Model



Impact: Quality Measures

Average Health Center Progress, 2017



Cancer Transformation Project Measures

	% Improvement	p-value
Cervical Cancer	6.5%	p=0.775
Colorectal Cancer	13.3%	p=0.039
Adult BMI	3.3%	p=0.929
Depression	12.5%	p=0.874
Hypertension	4.5%	p=0.149
Diabetes Control*	23.4%	p<0.001

*Diabetes Control = decrease in adults with an A1c of >9% or who have not been screened in 12 months.

Included 8 participating health centers in Georgia and Iowa.

Impact*: Patient Experience

Question	Average Score Pre- (n=749)	Average Score Post- (n=706)	Significance <i>p</i>
Number of health center visits since January 1, 2017	3.3	5.2	-
The health center staff includes my opinion when making decisions about my care.	4.63	4.75	<.001
I receive a document (paper or electronic) which includes information about the decisions made at each visit.	4.59	4.61	0.226
Before today's visit, health center staff ask me to complete tests that screen for cancer?	2.46	2.53	0.202
*January – December 2017 1=never 2 = rarely 3=sometimes 4=often 5=always			

Impact*: Staff Experience

Question	Average Score Pre- (n=209)	Average Score Post- (n=203)	Significance <i>p</i>
I have been provided sufficient training to help me fulfill my specific role(s) as a member of my larger health center team.	2.06	1.82	0.001
I feel I am an important contributing member of my health care team .	1.62	1.46	0.030
If I have ideas about how to improve systems or processes , I feel others will listen to me .	2.24	2.09	0.045
My job allows me to fully use my skills and abilities .	1.87	1.72	0.070

*January – December 2017

1=strongly agree 2 = somewhat agree 3=neither agree or disagree 4=somewhat disagree 5=strongly disagree

Impact*: Staff Experience (continued)

Question	Average Score Pre- (n=209)	Average Score Post- (n=203)	Significance <i>p</i>
My health center has processes or protocols in place to support opportunities for patients to share in decision-making .	2.16	1.98	0.025
My health center has processes or protocols in place to support cancer screening for every patient, regardless of ability to pay.	1.69	1.55	0.025
At my health center, cancer screening is the responsibility of the entire care team and not just the medical providers.	1.80	1.68	0.042
At my health center, screening and management of chronic disease (depression, obesity, high blood pressure, diabetes) are the responsibility of the entire care team and not just the medical providers.	1.66	1.53	0.042

*January – December 2017

1=strongly agree 2 = somewhat agree 3=neither agree or disagree 4=somewhat disagree 5=strongly disagree

System Transformation in Motion



Advancing on the Quadruple Aim



- 115 health centers
- 17 PCAs/HCCNs
- 19 states

Action Steps: Improving and Sustaining Cancer Screening

- Step 1: Secure Leadership Commitment
- Step 2: Apply Population Health Management/Risk Stratification
- Step 3: Design Care Models with Cancer Screening EBIs
- Step 4: Deploy Team-Based Approaches
- Step 5: Optimize Health Information Systems
- Step 6: Engage Patients and Partners
- Step 7: Build/Enhance Partnerships

Step 1: Secure Leadership Commitment

- **Leadership Commitment to Cancer Screening**

- Set cancer screening as a top organizational priority
- Call out cancer screening improvement in verbal/written messages
- Allocate staff time/resources

- **Clinical Champion**

- Focuses efforts on cancer screening
- Calculates baseline rates; communicates baseline performance and target goals
- Holds leadership and staff accountable to progress; communicates progress
- Sustains focus through organizational meetings and agendas

Step 2: Apply Population Health Management / Risk Stratification



CARE DELIVERY



INFRASTRUCTURE



PEOPLE



POPULATION HEALTH MANAGEMENT RISK STRATIFICATION

WHY

Risk Stratification?

Risk stratification enables providers to identify the right level of care and services for distinct subgroups of patients. It is the process of assigning a risk status to patients, then using this information to direct care and improve overall health outcomes.

Population health management requires practices to consider patients as both individuals and as members of a larger community or population. At the individual level, a patient's risk category is the first step towards planning, developing, and implementing a personalized care plan. One common method of segmenting patients is by "risk" level: high-, medium- (rising), and low- risk. At the population level, risk stratification allows care models to be personalized to the needs of patients within each subgroup. (See [Models of Care Action Guide](#).)

A "one-size-fits-all" model, where the same level of resources is offered to every patient, is clinically ineffective and prohibitively expensive. To



POPULATION HEALTH MANAGEMENT

The Value Transformation Framework addresses how health centers can use a systematic process for utilizing data on patient populations to target interventions for better outcomes, with a better care experience, at a lower cost. This Action Guide

<http://www.nachc.org/wp-content/uploads/2019/03/Risk-Stratification-Action-Guide-Mar-2019.pdf>

- **Segment Patient Population**
Complete risk stratification for overall patient population

Segment Patient Population



Highly complex. Require intensive, pro-active care management.



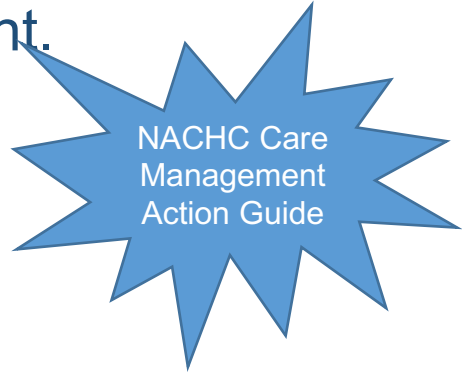
High-risk. Engage in care management to provide one-on-one support for medical, social and care coordination needs.



Risking-risk. Manage within PCMH model; support in managing risk factors (e.g., obesity, smoking, blood pressure, cholesterol).



Low-risk. Manage using more remote, group, and technological solutions; focus on keeping patients healthy and engaged.



NACHC Care
Management
Action Guide

Step 3: Design Care Models: with Cancer Screening EBIs

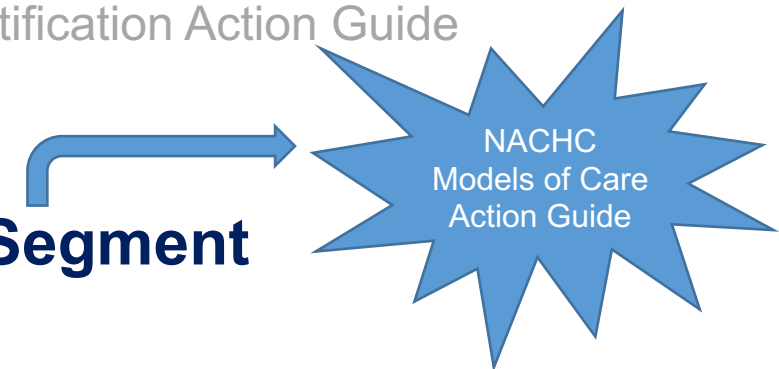
- **Segment Patient Population**

- **Complete risk stratification for overall patient population**
 - Use existing risk stratification process, if one in place
 - Adopt risk stratification process outlined in NACHC's Risk Stratification Action Guide
 - Deploy other risk stratification methodology

- **Design Distinct Care Models for each Population Segment**

- **Identify Need for Cancer Screening within Target Segments**

- **Use EHR Registries or Population Health tool to identify patients within target segment(s)**



Incorporate Cancer Screening EBIs in Models of Care

- **Clinical Policies / Standing Orders**
- **Clinical Champion(s)**
- **Sharing Performance Data**
- **Patient Reminders/Recall**
- **Care Team Huddles**
- **Patient Incentives**
- **Staff Incentives**

Step 4: Deploy Team-Based Approaches

HEALTH CENTER



CARE DELIVERY



INFRASTRUCTURE



PEOPLE



CARE TEAMS

WHY

Focus on Care Teams?

Much has been written about the success of the “care team model” in delivering high-quality, low-cost, impactful health care (the Quadruple Aim). Developing an effective team-based model of care is at the heart of health center efforts to deliver on the Quadruple Aim: improved health outcomes, improved staff and provider experiences, and lower costs.

Transitioning to value-based care requires a significant shift in the way care delivery, infrastructure, and people are engaged and deployed in the health care system. In the volume-based system, a primary care physician would need to spend an estimated 21.7 hours per day to provide all recommended acute, chronic and preventive care to a panel of 2500 patients¹. It is, therefore, not surprising that physicians face burnout and adults in the U.S. receive only 55% of recommended services². The volume-driven model of care coupled with the complexity of preventive, acute and chronic care needs



CARE TEAMS

The Value
Transformation

Framework addresses how to utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than with a provider alone. This Action Guide offers steps for health centers seeking proven strategies to develop effective care teams.

<http://www.nachc.org/wp-content/uploads/2019/03/Care-Teams-Action-Guide-Mar-2019.pdf>

- **Train in team-based approaches to care**
 - **Use expanded teams members (in addition to provider) to identify and offer cancer screening.**
 - **Incorporate cancer screening as part of pre-visit planning**
 - **Apply NACHC Quality Center's *Care Teams* Action Guide**
 - Part of the Value Transformation Framework:
<http://www.nachc.org/wp-content/uploads/2019/02/Care-Teams-Action-Guide.pdf>.

- **Train in cancer screening tests and process**

- **Train staff in health center's selected screening test(s)**
- **Train staff to communicate with patients around need for, and completion of, test**
- **Train staff in techniques for high-quality test processing**

CDC Screening for Colorectal Cancer Optimizing Quality (CME) course for primary care providers, nurses and other health care professionals:

<https://www.cdc.gov/cancer/colorectal/quality/#pc>.

This 3-part course provides 2.25 CME, 2.0 CNE, or 0.2 CEU.

Step 5: Optimize Health Information Systems

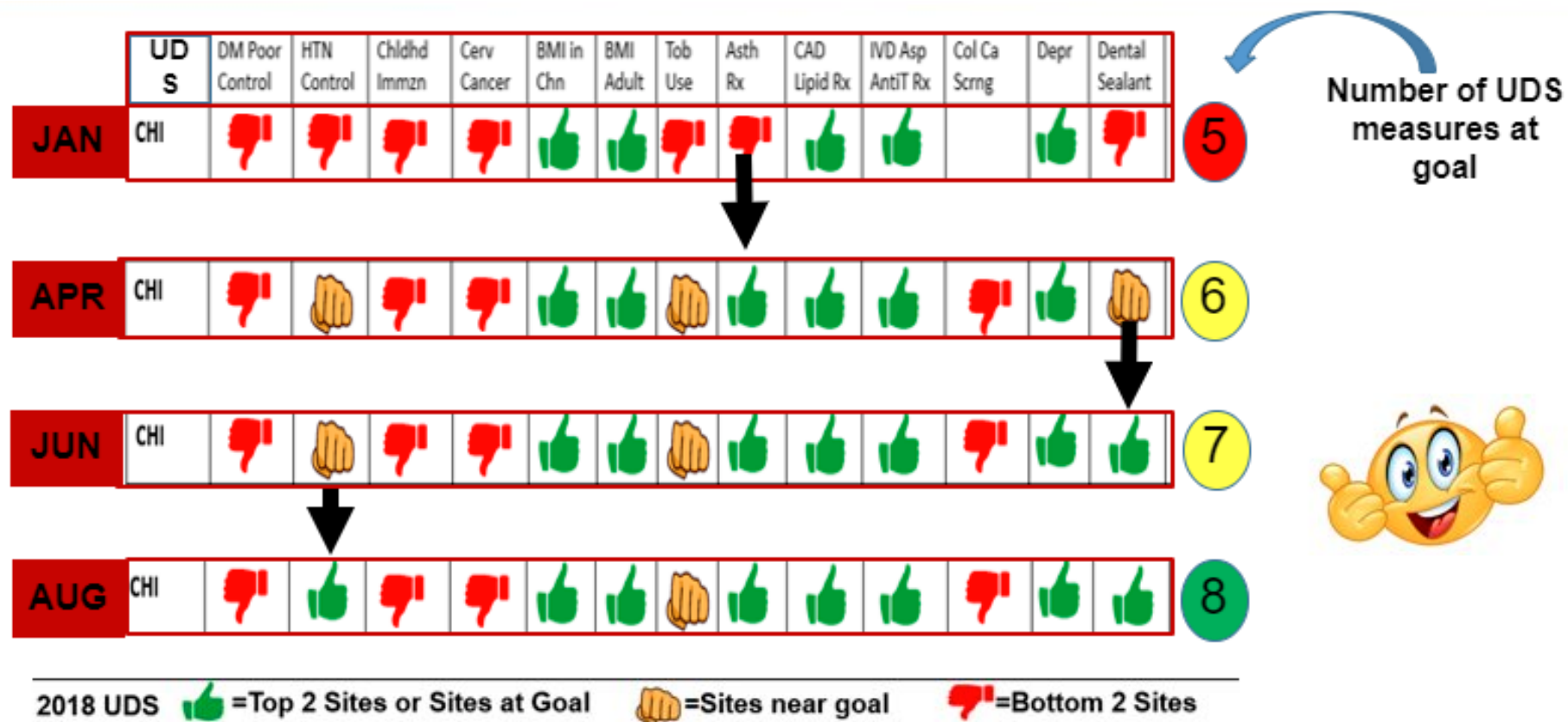
- Use point-of-care reminders

- Capture screening

- Create **written workflows that include EHR screenshots** showing staff how to document cancer screening and referrals
- Engage IT staff and EHR vendor, as needed, to **modify templates** to fully capture screening and follow-up



Use Information Systems to Drive Improvement



Step 6: Engage Patients

Use Patient Decision Aids

UNDERSTANDING COLORECTAL CANCER SCREENING

Colorectal Cancer Screening: Which test is right for you?

What screening tests are available?
Several screening options may be available to you. All of the screening tests below are effective at finding colorectal cancer. These tests fall into two categories. Stool tests are tests you can do at home by taking a stool sample and mailing it to a lab. Visual tests are tests that a doctor or nurse performs inside your colon. Most health insurance plans, including Medicare, cover most of these tests. Talk with your provider about which screening tests might be right for you.

STOOL TESTS

Fecal Immunochemical Test (FIT)
HOW OFTEN: Once a year
You take a stool sample at home using a kit your provider gives you.
It checks for blood in samples from 1 bowel movement.
You mail your sample to a lab.

High-sensitivity Guaiac-based Fecal Occult Blood Test (Hs-gFOBT)
HOW OFTEN: Once a year
You take stool samples at home using a kit your provider gives you.
You mail your samples to a lab.
It checks for blood in samples from 3 bowel movements.

Multi-target Stool DNA (MT-sDNA)
HOW OFTEN: Every 3 years
You collect a bowel movement and stool sample at home using a kit your provider has shipped to you.
It checks stool for blood and abnormal DNA from polyps or cancer.
You mail a whole bowel movement and stool sample to a lab.

VISUAL TESTS

Colonoscopy
HOW OFTEN: Every 10 years
Your provider uses a tube with a tiny camera to look for and remove polyps and cancer in your colon and rectum.
You take a prep (tablets and something to drink) before the test to empty the colon. It causes diarrhea.
You will be sedated and need a day off work.

CT Colonography (CTC)
HOW OFTEN: Every 5 years
The test is also called virtual colonoscopy.
Your provider uses an x-ray machine to look for polyps and cancer in your colon and rectum.
You take a prep (tablets and something to drink) before the test. It causes diarrhea (watery stool).

Flexible Sigmoidoscopy (FS)
HOW OFTEN: Every 5 years
Your provider uses a tube with a tiny camera to look for polyps and cancer in the lower part of your colon and rectum.
You give yourself 1 or 2 pre-filled enemas before the test to empty and clean the colon.
This test is not available in most places.

*Not all tests may be available. Talk with your health care provider about which tests are available to you.

Cervical Cancer Screening

WHAT IS IT?
Your ob-gyn or other health care professional takes cells from the cervix and sends them to a lab for testing:
• A Pap test looks for abnormal cells.
• An HPV test looks for infection with the human papillomavirus (HPV) types that are linked to cervical cancer.

FOLLOW THESE GUIDELINES:

- If you are younger than 21 years: You do not need screening.
- If you are aged 21–29: Have a Pap test every 3 years.
- If you are aged 30–65: Have a Pap test every 3 years.
- If you are 65 years and older: You do not need screening.

EXCEPTIONS TO GUIDELINES

- You still need to have a Pap test if you have ever had cervical cancer.
- You still need to have a Pap test if you are currently taking hormone therapy.

ACOG
The American College of Obstetricians and Gynecologists

<https://www.acog.org/Patients/FAQs/Cervical-Cancer-Screening-Infographic>

Colorectal Cancer Screening: Which test would I prefer?

U.S. Department of Health and Human Services
healthfinder.gov
Live well. Learn how.

1 Before a colonoscopy or flexible sigmoidoscopy, you need to have a bowel prep, which involves drinking a laxative solution. The laxative will make you have loose bowel movements or diarrhea over a number of hours in order to clean out your bowels. This can get in the way of your normal activities the day and night before the test.

How much would it bother you to drink a laxative that makes you go to the bathroom a lot?

☐ It would bother me a lot. I really don't want to drink a laxative.

☐ It would bother me a little. I'd rather not drink a laxative, but I can.

☐ It wouldn't bother me. I'm okay with drinking a laxative.

Next

COLORECTAL CANCER

Screen for life
National Colorectal Cancer Action Campaign

What Is Colorectal Cancer?
Colorectal cancer is cancer that starts in the large intestine or rectum. Sometimes it is called colon cancer or rectal cancer. It is the large intestine or large rectum. It is the large intestine or large rectum. It is the large intestine or large rectum.

Screening Saves Lives
Colorectal cancer is the second leading cause of cancer death in the United States, but it can be prevented. Screening tests can find polyps in the colon or rectum before they turn into cancer. Screening tests can also find colorectal cancer early, when it can be removed. Screening tests can also find colorectal cancer early, when it can be removed.

NOTAS

PREGUNTAS PARA HACERLE A SU MÉDICO

INFÓRMESE ANTES DE VISITAR A SU MÉDICO
Las pruebas de detección del cáncer colorectal se recomiendan para hombres y mujeres a partir de los 50 años. Las pautas nacionales para la detección del cáncer colorectal incluyen varias opciones de pruebas de detección.

Estas son las pruebas de detección recomendadas:

- Colonoscopia (una vez cada 10 años)
- La prueba gFOBT de alta sensibilidad también conocida como análisis de sangre oculta en materia fecal (una vez al año)
- Sigmoidoscopia flexible (una vez cada 5 años)

Los beneficios y riesgos de estas pruebas de detección varían. Pregúntele a su médico cuál es la prueba más adecuada para usted. Y consulte con su proveedor de seguros para averiguar cuáles son las pruebas cubiertas por su plan y cuánto tendrá que pagar.

¡Las pruebas de detección de cáncer colorectal salvan vidas!

RECURSOS
Para obtener más información:
Visite www.cdc.gov/spanish/cancer/colorectal/sfl
O llame al 1-800-CDC-INFO (1-800-232-4636 — oprima 2 para español). Los usuarios de teléfonos (TTY) pueden llamar al 1-888-232-6348.

Screen for life
Campaña Nacional contra el Cáncer Colorectal

CDC
Departamento de Salud y Servicios Humanos de los EE.UU.
Centros para el Control y la Prevención de Enfermedades (CDC)

CDC Publicación #2006-00, revisada en febrero de 2017

https://www.cdc.gov/cancer/colorectal/sfl/print_materials.htm

<https://www.cancer.org/content/dam/cancer-org/cancer-control/en/booklets-flyers/colorectal-cancer-screening-which-test-is-right-for-you.pdf>

<https://healthfinder.gov/HealthTopics/shared-decision-making/>

Train Staff in Patient Engagement

- Use scripts, conversation cards, and motivational interviewing

HOW to Engage Patients in Care?

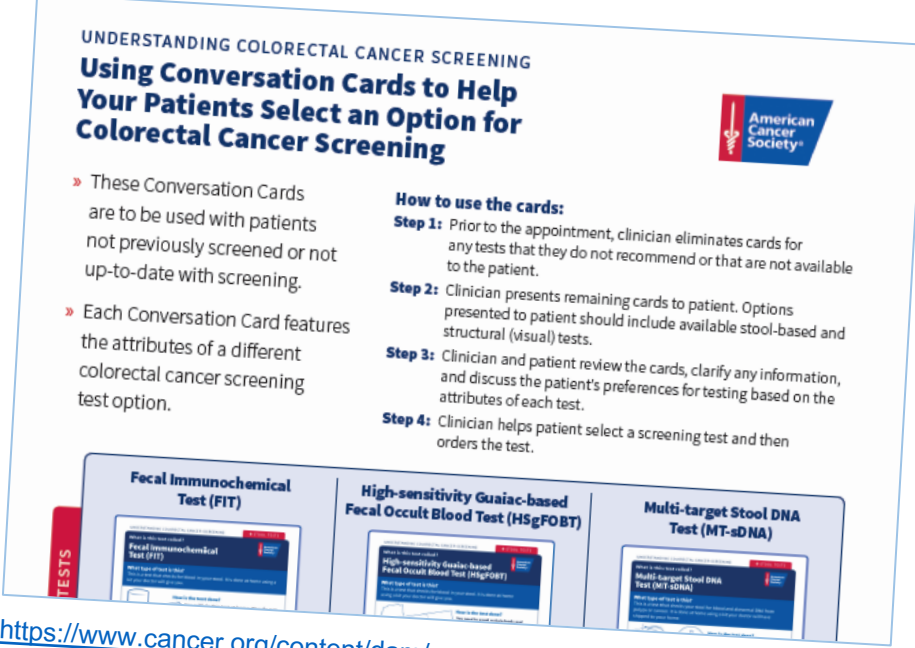
While there are many proven strategies for developing patient-centric systems, the first step begins with health center staff. Each member of the health care team should have accountability for patient engagement as part of their job role and task list (see the [Care Teams Action Guide](#)). Patient engagement is everyone's responsibility.

*'The process of sharing in the decision-making tasks involves developing a partnership based on empathy, exchanging information about the available options, deliberating while considering the potential consequences of each one, and making a decision by consensus.'*¹⁹

PATIENT ENGAGEMENT ACTION STEPS:

This Action Guide provides health centers with a list of actionable steps to support and engage patients in meaningful partnerships with the health care team.

- STEP 1 Identify a Patient Engagement Lead:** Although every team member should participate in patient engagement, designate and train one key member of the staff whose role it is to maintain an organizational focus on patient engagement and staff development in related skills and strategies.
- STEP 2 Establish Patient Engagement Metrics:** Create a reasonable process for surveying patients on their health care experiences, health care goals, and current self-care knowledge.



UNDERSTANDING COLORECTAL CANCER SCREENING
Using Conversation Cards to Help Your Patients Select an Option for Colorectal Cancer Screening

How to use the cards:

- Step 1:** Prior to the appointment, clinician eliminates cards for any tests that they do not recommend or that are not available to the patient.
- Step 2:** Clinician presents remaining cards to patient. Options presented to patient should include available stool-based and structural (visual) tests.
- Step 3:** Clinician and patient review the cards, clarify any information, and discuss the patient's preferences for testing based on the attributes of each test.
- Step 4:** Clinician helps patient select a screening test and then orders the test.

TESTS

- Fecal Immunochemical Test (FIT)**
- High-sensitivity Guaiac-based Fecal Occult Blood Test (HsgFOBT)**
- Multi-target Stool DNA Test (MT-sDNA)**

<https://www.cancer.org/content/dam/cancer-org/cancer-control/en/booklets-flyers/conversation-cards-colorectal-cancer-screening.pdf>

- Apply NACHC Quality Center's *Patient Engagement Action Guide*

Part of the Value Transformation Framework:

<http://www.nachc.org/wp-content/uploads/2019/02/Patient-Engagement-Action-Guide.pdf>.

Step 7: Build/Enhance Partnerships

Create Colonoscopy Referral Network

- **Calculate the health center's need for colonoscopy***
 - Overall stool test positivity rate in a population is generally 5-10%; positive results require a colonoscopy
 - Approximately 15% of the population over age 40 is high risk and will require a colonoscopy.
 - *American Cancer Society *Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers*, p. 17 provides calculation assistance: http://nccrt.org/wp-content/uploads/0305.60-Colorectal-Cancer-Manual_FULFILL.pdf.
- **Identify area endoscopists**
- **Reach out to area endoscopists; request partnerships**
 - Consider direct referral agreements
- **Formalize endoscopist partnership agreements and expectations**

Systems Approach to Improving and Sustaining Cancer Screening

- Step 1: Secure Leadership Commitment
- Step 2: Apply Population Health Management/Risk Stratification
- Step 3: Design Care Models with Cancer Screening EBIs
- Step 4: Deploy Team-Based Approaches
- Step 5: Optimize Health Information Systems
- Step 6: Engage Patients and Partners
- Step 7: Build/Enhance Partnerships





Questions and Answers

Thank you!

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