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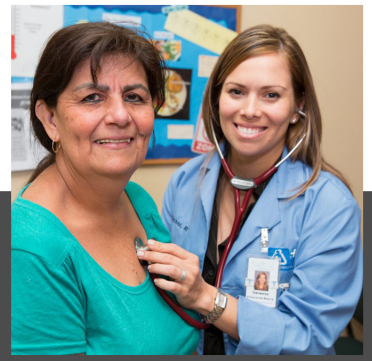

America's Voice for Community Health Care

NATIONAL ASSOCIATION OF Community Health Centers

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.

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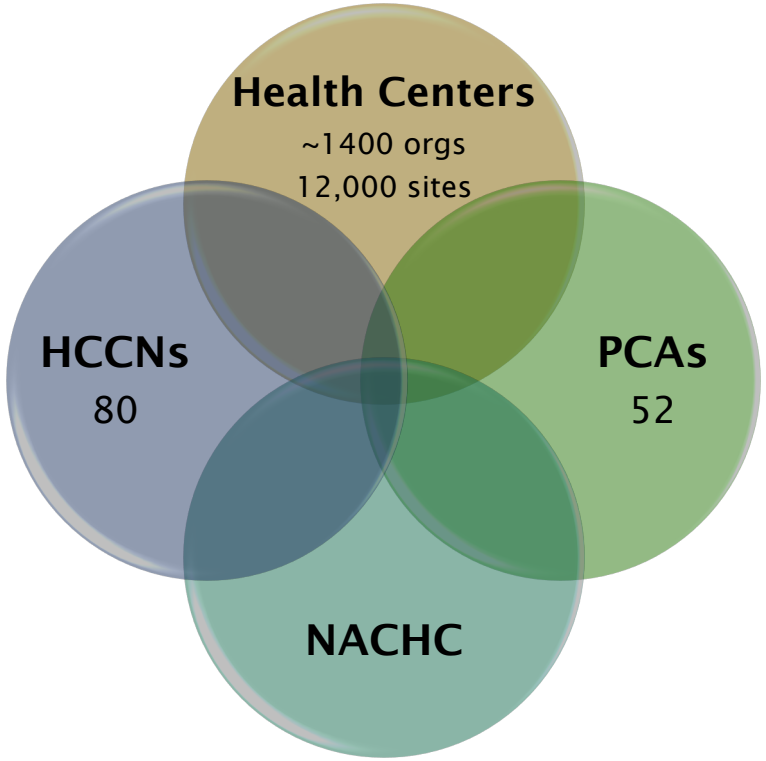
Health Center Program Partners

Health Center Controlled Networks
Data, EHR optimization, performance analysis/feedback



Primary Care Associations
Programs, policy, training, communication, & quality

NACHC
Policy, education, advocacy, training and technical assistance, quality & health system transformation

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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

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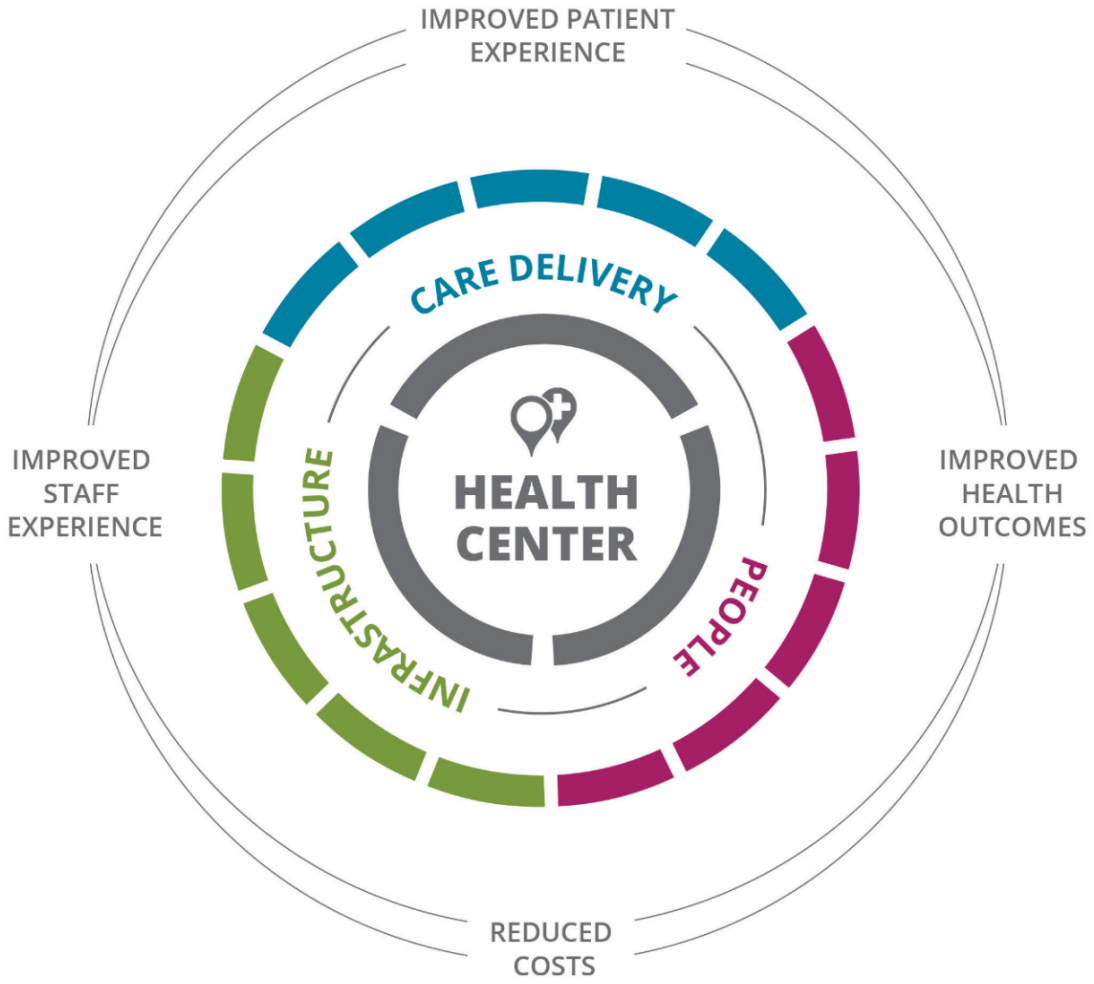
Value Transformation Framework



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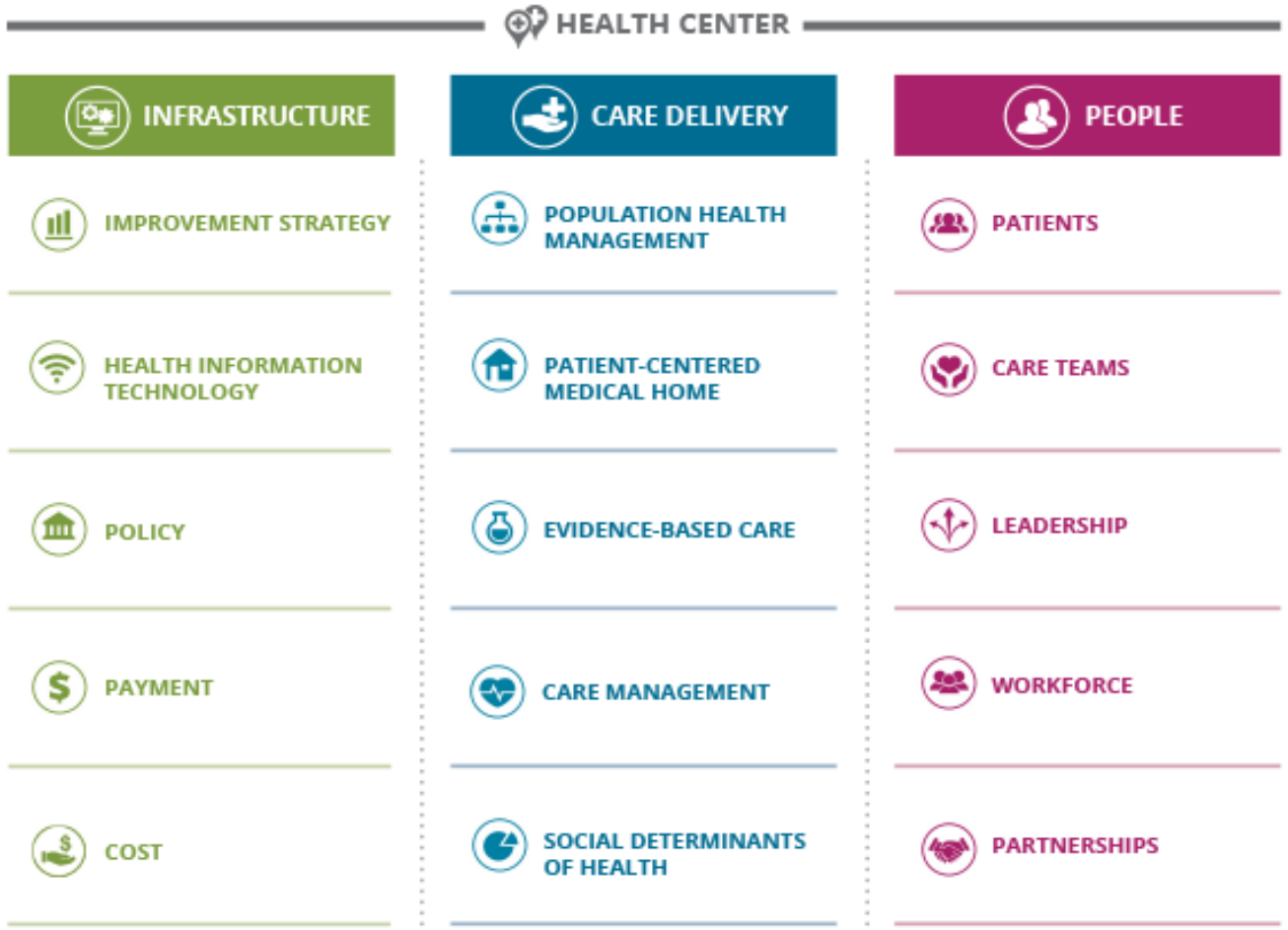
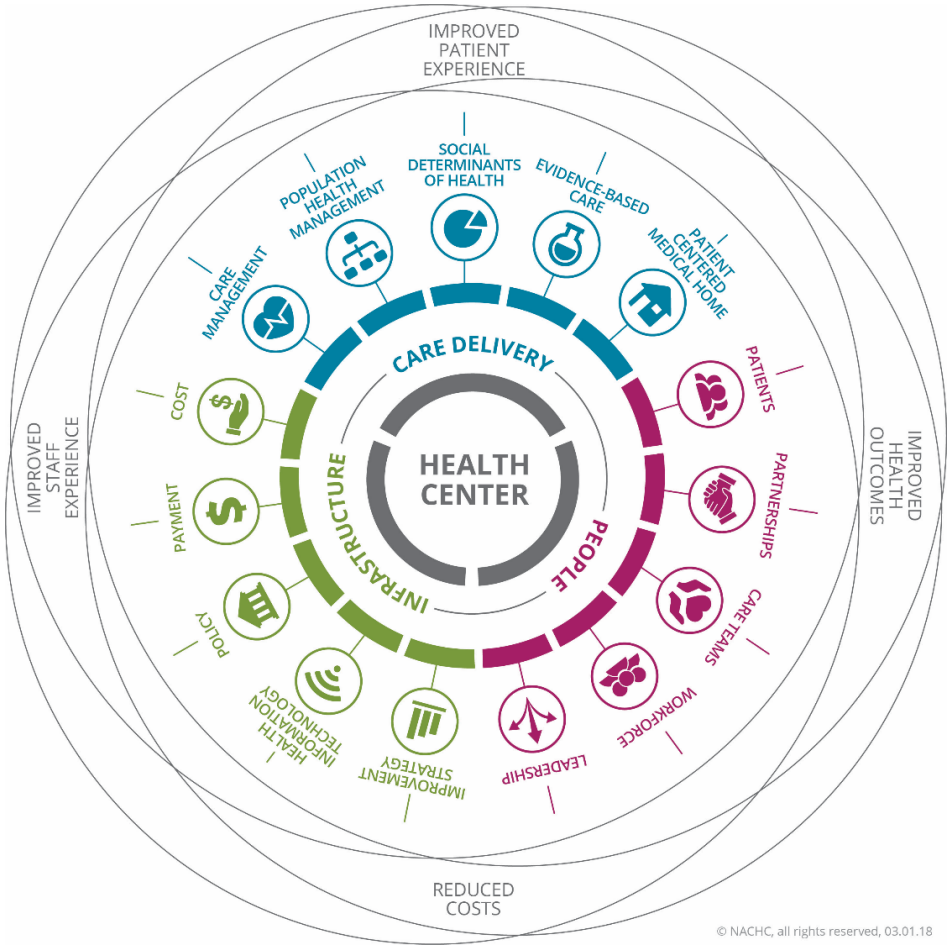
Value Transformation Framework

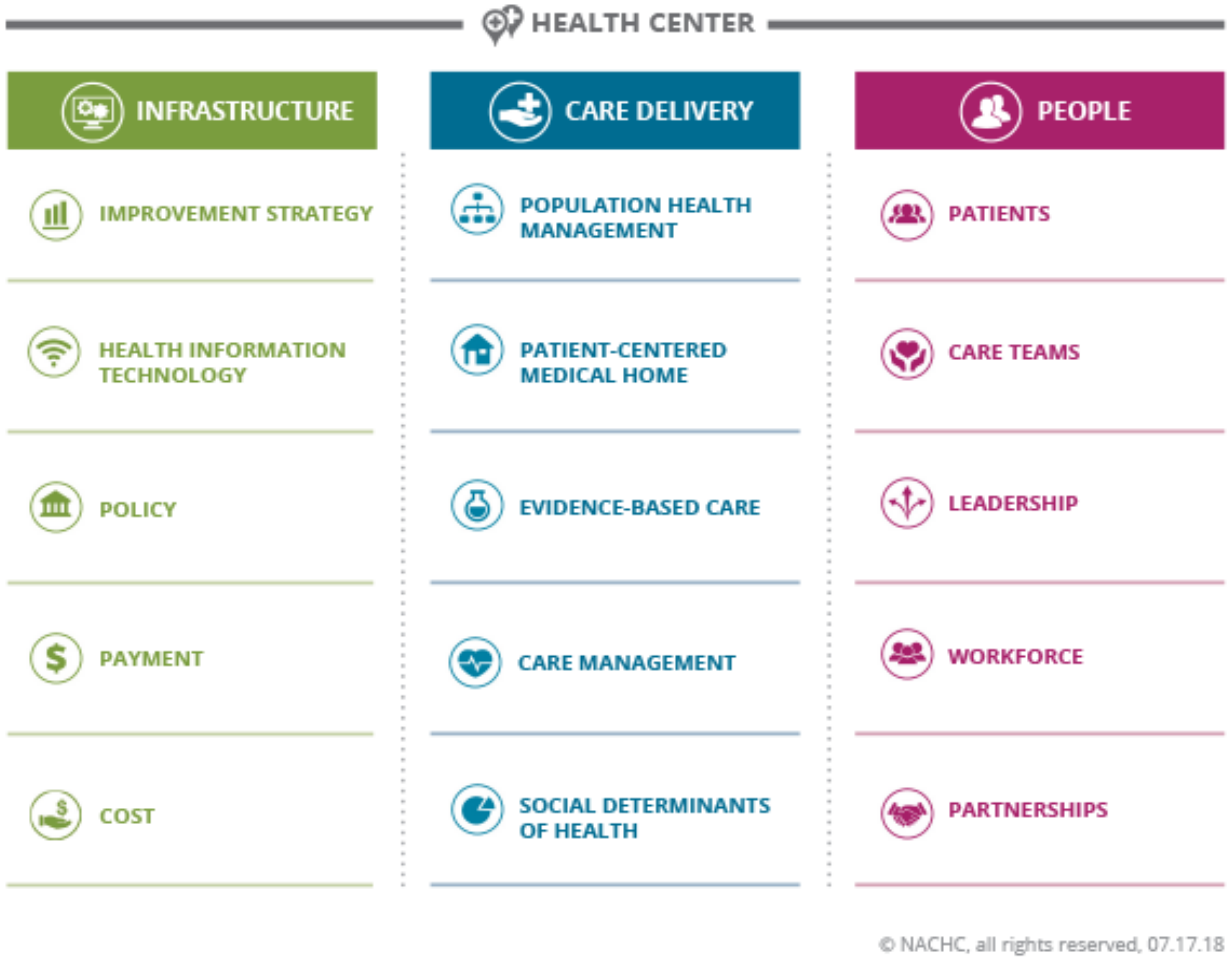
3 Domains

15 Change Areas



Systems Approach





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

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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***

Performance Measures

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

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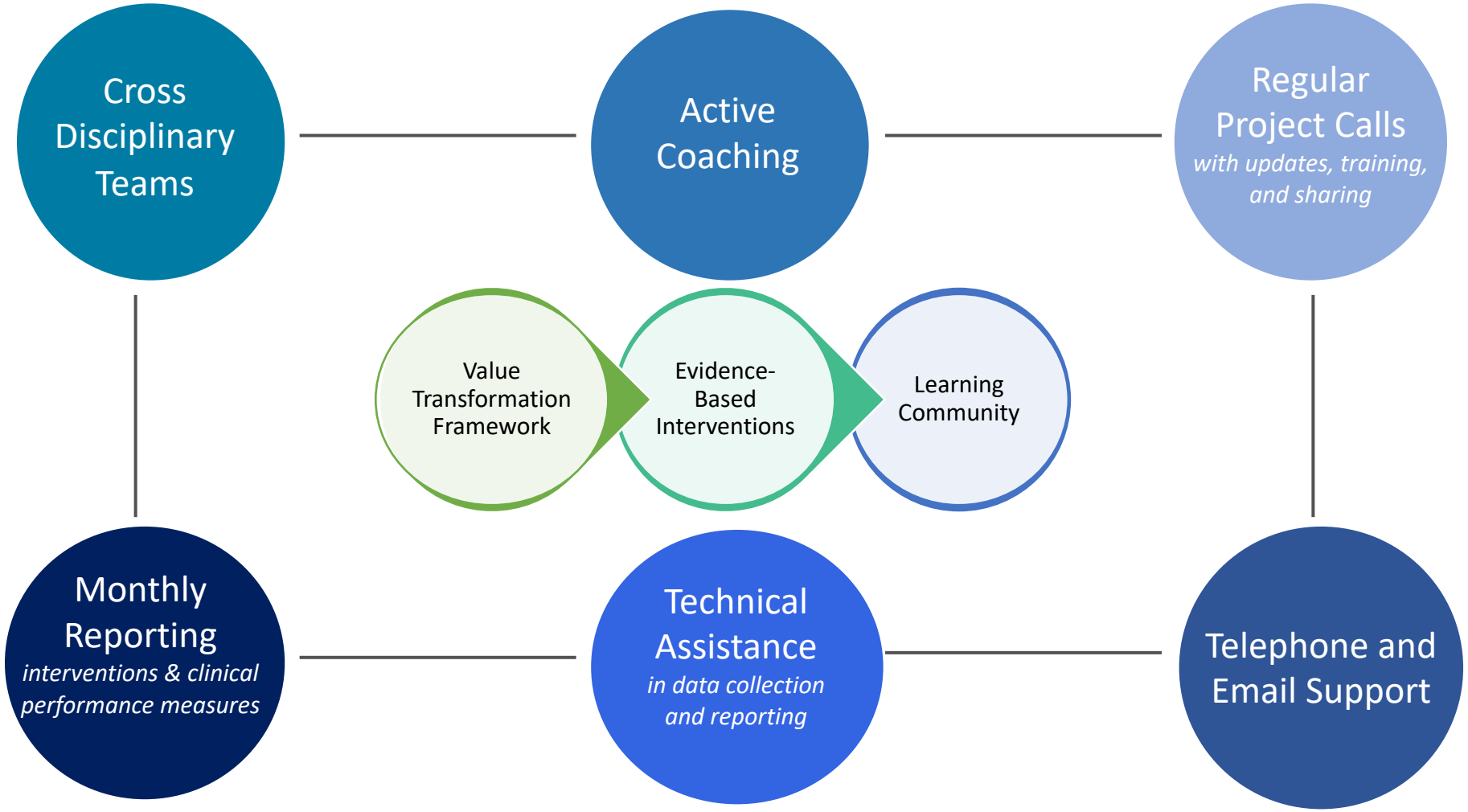
Enhanced Learning Community Model



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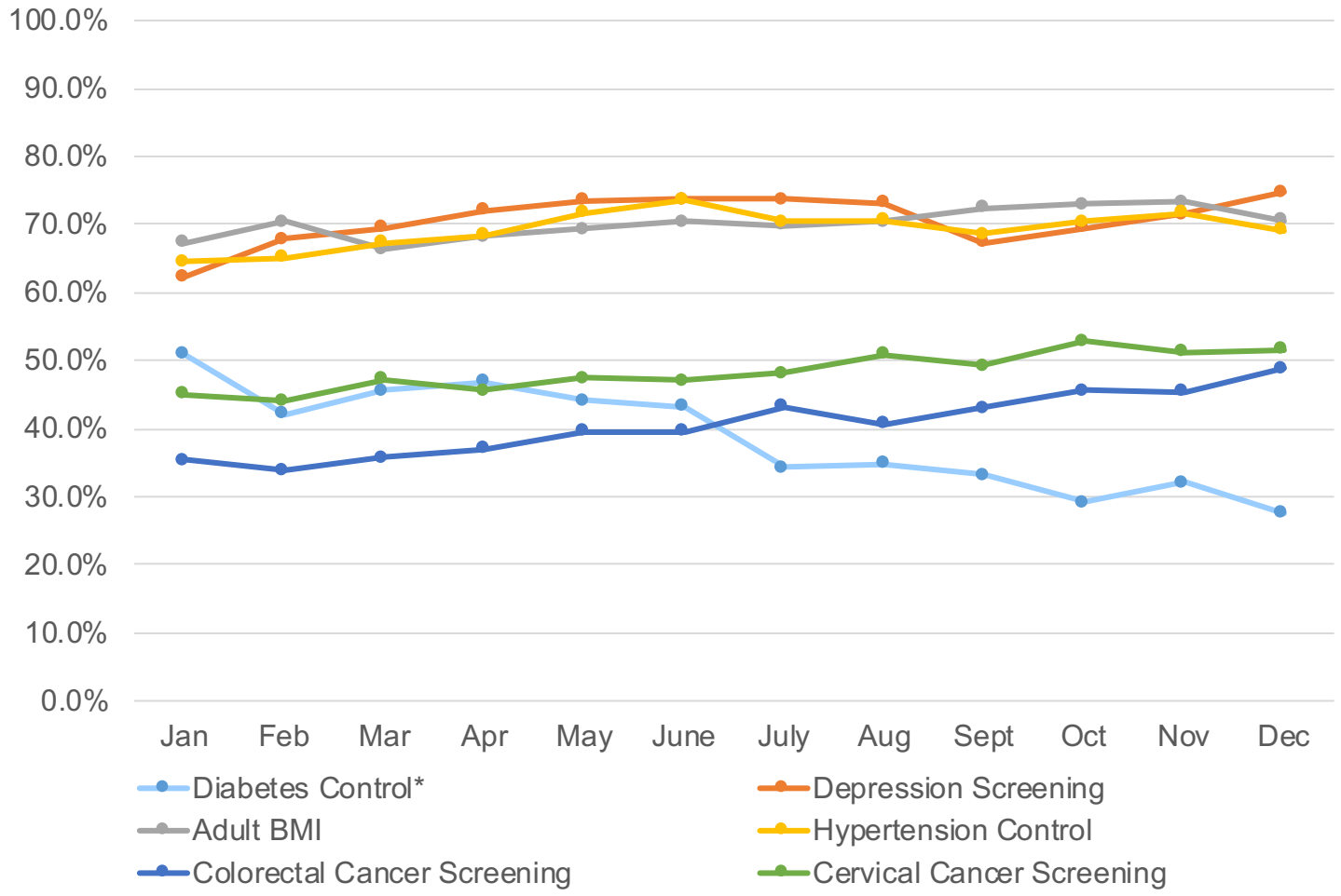
Impact: Quality Measures

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.

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Impact*: Patient Experience

Question	Average Score Pre- (*n=749*)	Average Score Post- (*n=706*)	Significance *p*
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

1=never 2 = rarely 3=sometimes 4=often 5=always

**January – December 2017*

Impact*: Staff Experience

Question	Average Score Pre- (*n=209*)	Average Score Post- (*n=203*)	Significance *p*
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

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Impact*: Staff Experience (continued)

Question	Average Score Pre- (*n=209*)	Average Score Post- (*n=203*)	Significance *p*
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

Elevate Learning Forum

elevate

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

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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

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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

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

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

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.

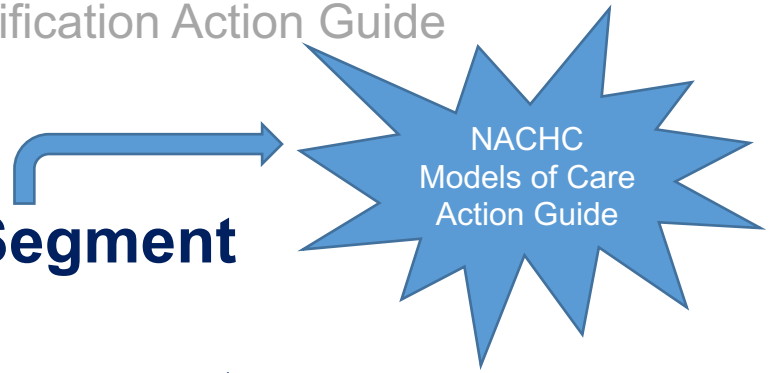
NACHC Care Management Action Guide

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.

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)**

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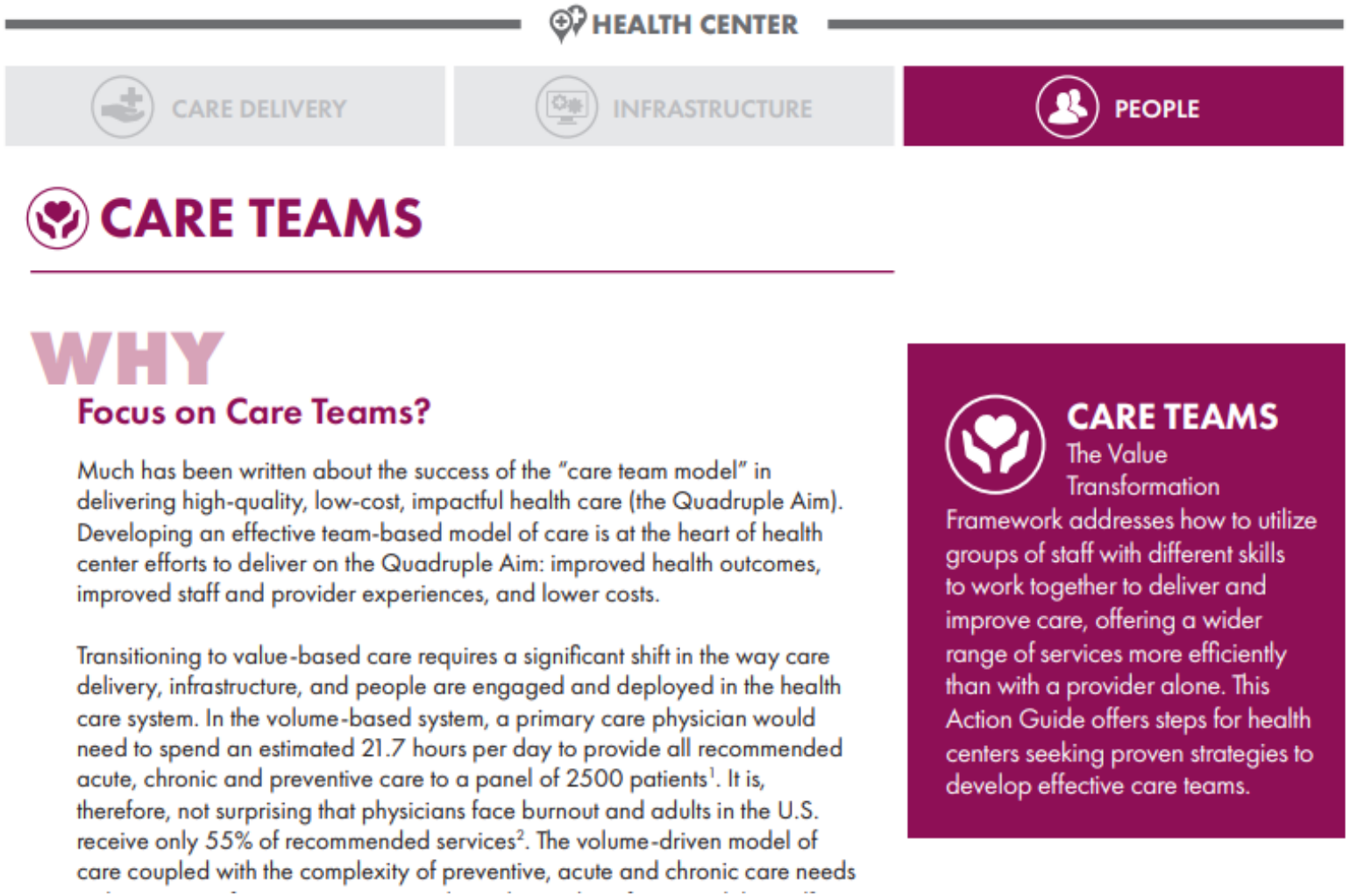
Incorporate Cancer Screening EBIs in Models of Care

- **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 patients[1]. It is, therefore, not surprising that physicians face burnout and adults in the U.S. receive only 55% of recommended services[2]. 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 Teams

- **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 Teams

- **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**

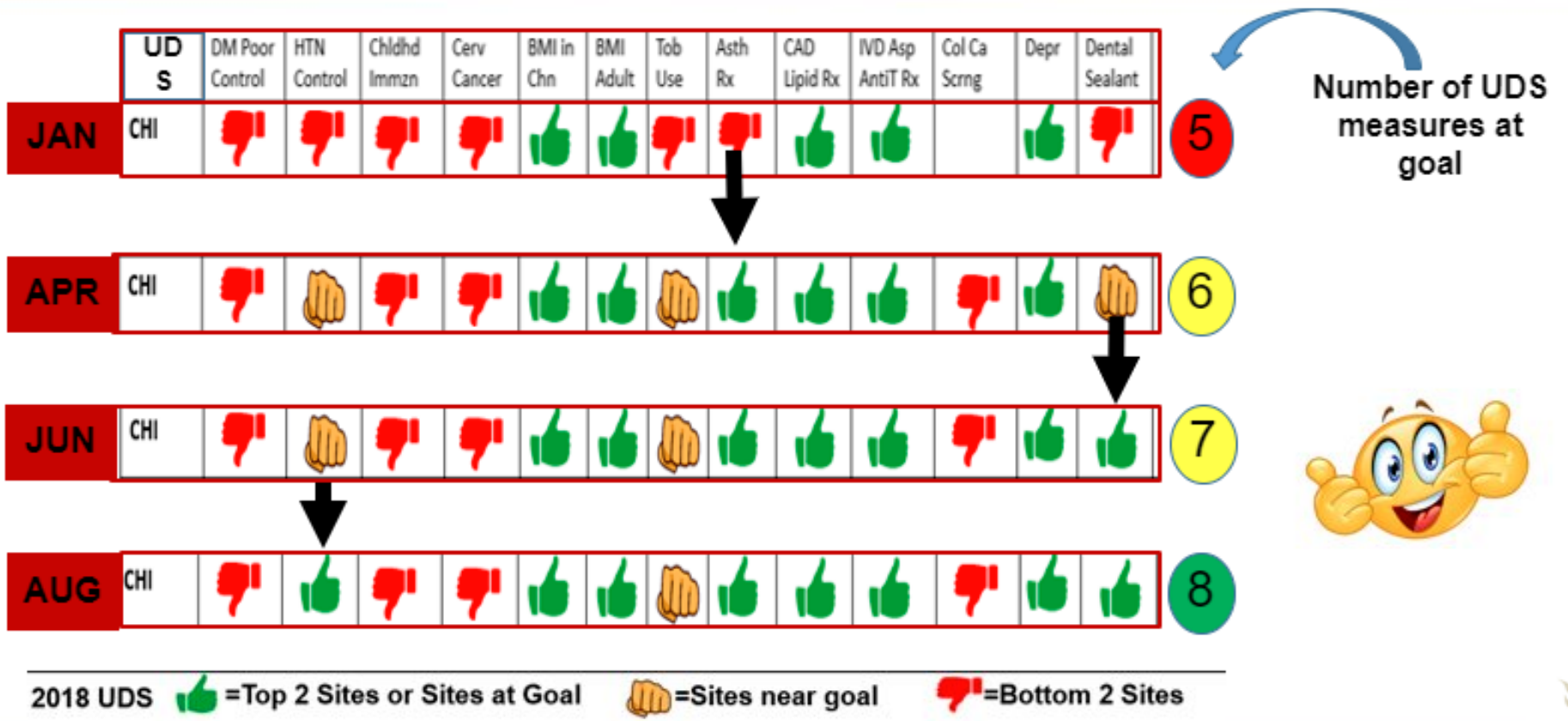
CDC Screening for Colorectal Cancer Optimizing Quality (CME) course for primary care providers, nurses and other health care professionals: https://www.cdc.gov/cancer/colorectal/quality/#pc.

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

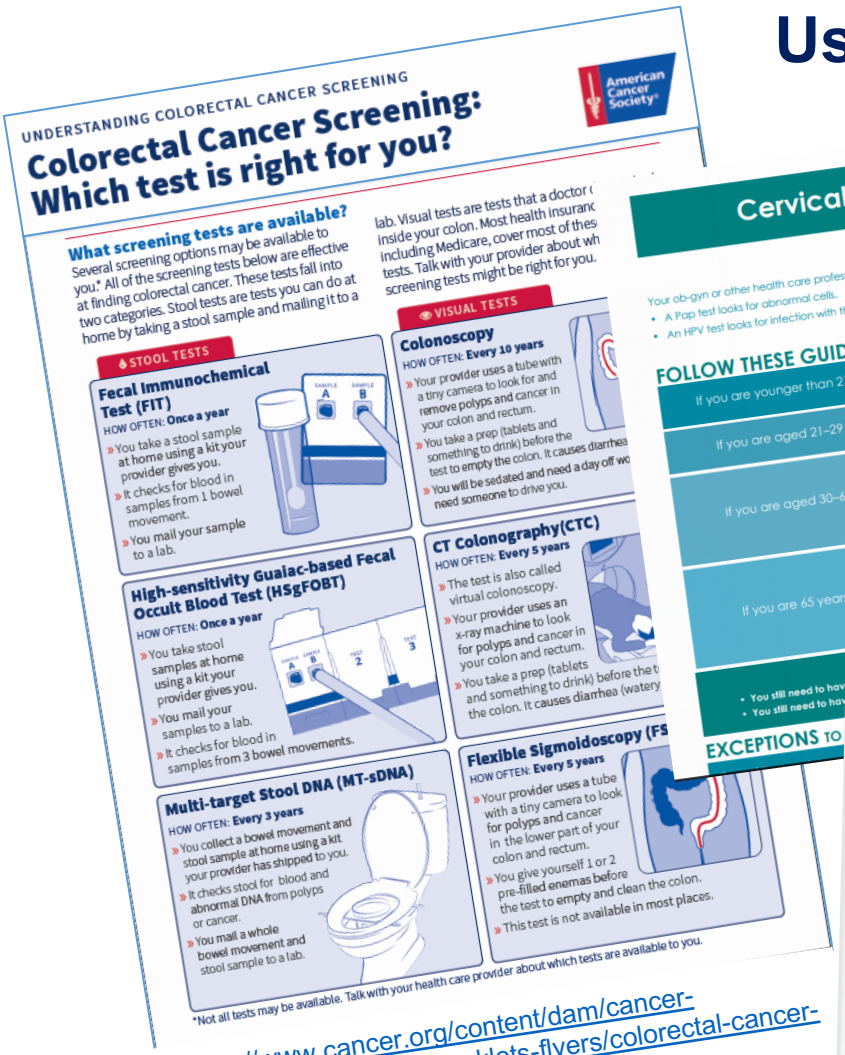


CHI
Community Health of South Florida, Inc.
"Patient Care Comes First"

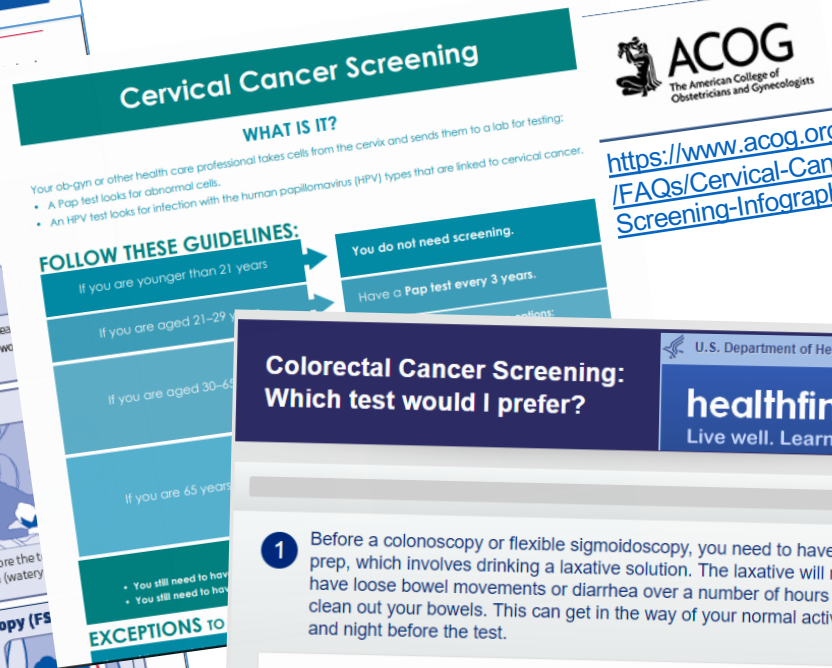
NATIONAL ASSOCIATION OF Community Health Centers

Step 6: Engage Patients

Use Patient Decision Aids

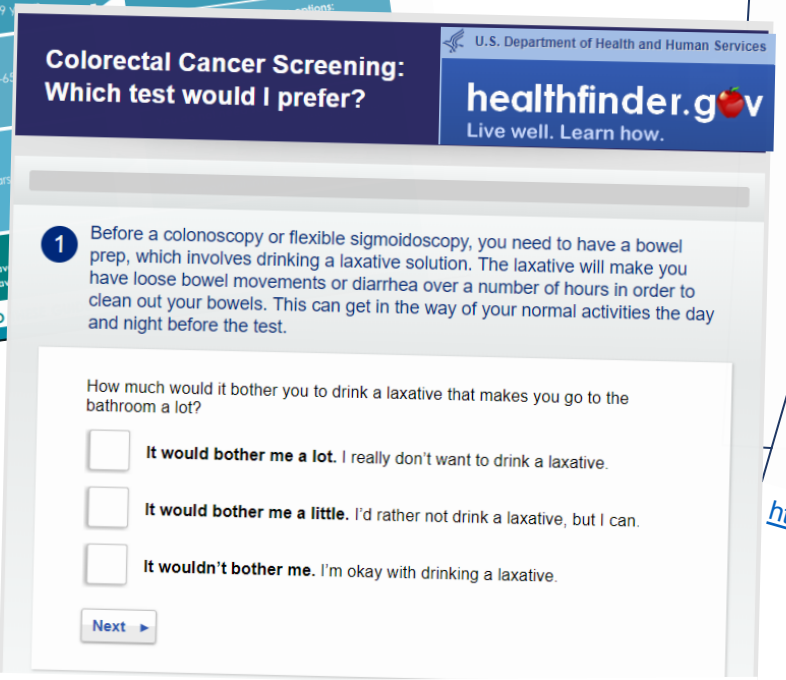


https://www.cancer.org/content/dam/cancer-org/cancer-control/en/booklets-flyers/colorectal-cancer-screening-which-test-is-right-for-you.pdf



ACOG The American College of Obstetricians and Gynecologists

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



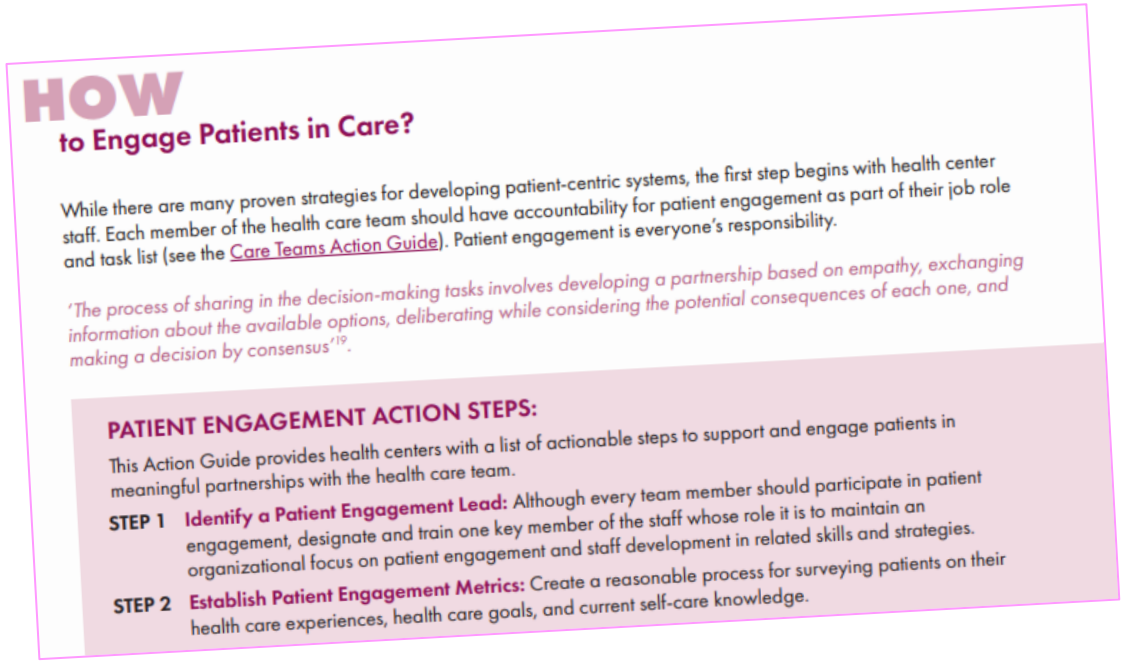
https://healthfinder.gov/HealthTopics/shared-decision-making/

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

Engage Patients, *cont'd*

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.

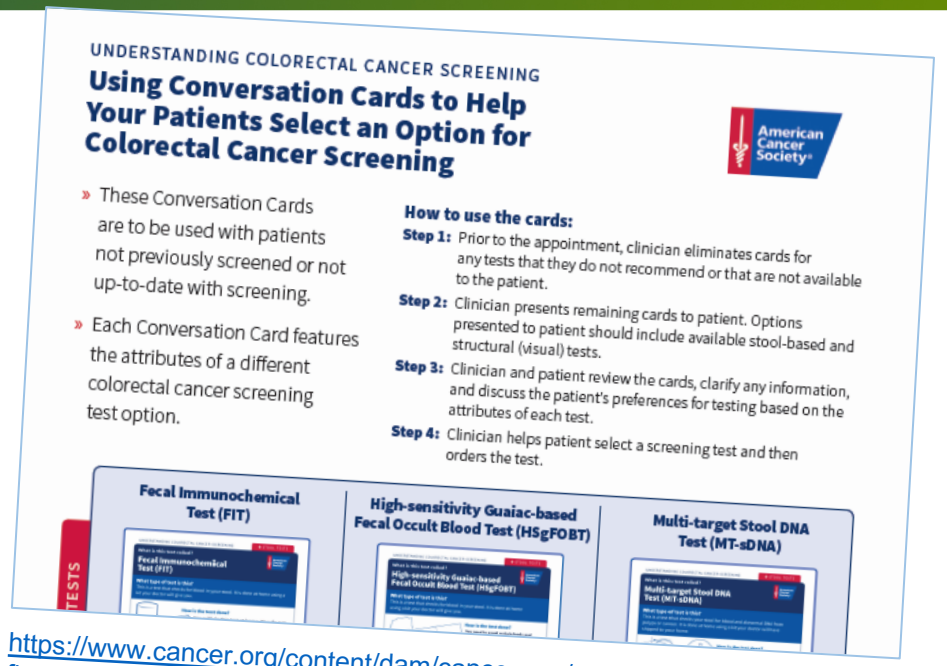
'The process of sharing in the decision-making tasks involves developing a partnership based on empathy, exchanging information about the available options, deliberating while considering the potential consequences of each one, and making a decision by consensus'[19].

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

American Cancer Society

- These Conversation Cards are to be used with patients not previously screened or not up-to-date with screening.
- Each Conversation Card features the attributes of a different colorectal cancer screening test option.

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**

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Systems Approach to Improving and Sustaining Cancer Screening

Step 1: Secure Leadership Commitment

Step 2: Apply Population Health Management/Risk Stratification

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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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