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
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

Health Centers
- ~1400 orgs
- 12,000 sites

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

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

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

HCCNs
- 80

PCAs
- 52
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.
“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
Value Transformation Framework

3 Domains

15 Change Areas

- Improvement Strategy
- Health Information Technology
- Policy
- Payment
- Cost
- Population Health Management
- Patient-Centered Medical Home
- Evidence-Based Care
- Care Management
- Social Determinants of Health
- Patients
- Care Teams
- Leadership
- Workforce
- Partnerships

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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
<table>
<thead>
<tr>
<th>ORGANIZATION</th>
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<tbody>
<tr>
<td><strong>National</strong></td>
<td>Centers for Disease Control and Prevention</td>
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<tr>
<td><strong>National</strong></td>
<td>National Association of Community Health Centers</td>
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<tr>
<td><strong>State</strong> (PCAs)</td>
<td>Georgia Primary Care Association</td>
</tr>
<tr>
<td><strong>Local</strong> (Health Centers)</td>
<td>Albany Area Primary Health Care Coastal Community Health Services Community Health Care Systems East Georgia Healthcare Center</td>
</tr>
</tbody>
</table>

*A CDC-funded project focused on colorectal and cervical cancer screening as part of a comprehensive transformation approach*
<table>
<thead>
<tr>
<th>Quadruple Aim</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improved Health Outcomes</strong></td>
<td>Colorectal cancer screening</td>
</tr>
<tr>
<td></td>
<td>Cervical cancer screening</td>
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<td></td>
<td>HTN control</td>
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<tr>
<td></td>
<td>Diabetes control (UDS = % uncontrolled)</td>
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<tr>
<td></td>
<td>Obesity screening/management</td>
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<tr>
<td></td>
<td>Depression screening/management</td>
</tr>
<tr>
<td><strong>Improved Patient Experience</strong></td>
<td>Patient experience</td>
</tr>
<tr>
<td><strong>Improved Staff Experience</strong></td>
<td>Staff experience</td>
</tr>
<tr>
<td><strong>Reduced Costs</strong></td>
<td>Cost</td>
</tr>
</tbody>
</table>
Impact: Quality Measures
Average Health Center Progress, 2017

Cancer Transformation Project Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>% Improvement</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cancer</td>
<td>6.5%</td>
<td>p=0.775</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>13.3%</td>
<td>p=0.039</td>
</tr>
<tr>
<td>Adult BMI</td>
<td>3.3%</td>
<td>p=0.929</td>
</tr>
<tr>
<td>Depression</td>
<td>12.5%</td>
<td>p=0.874</td>
</tr>
<tr>
<td>Hypertension</td>
<td>4.5%</td>
<td>p=0.149</td>
</tr>
<tr>
<td>Diabetes Control*</td>
<td>23.4%</td>
<td>p&lt;0.001</td>
</tr>
</tbody>
</table>

*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

*January – December 2017

<table>
<thead>
<tr>
<th>Question</th>
<th>Average Score Pre- (n=749)</th>
<th>Average Score Post- (n=706)</th>
<th>Significance (p)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of health center visits since January 1, 2017</td>
<td>3.3</td>
<td>5.2</td>
<td>-</td>
</tr>
<tr>
<td>The health center staff includes my opinion when making decisions about my care.</td>
<td>4.63</td>
<td>4.75</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>I receive a document (paper or electronic) which includes information about the decisions made at each visit.</td>
<td>4.59</td>
<td>4.61</td>
<td>0.226</td>
</tr>
<tr>
<td>Before today's visit, health center staff ask me to complete tests that screen for cancer?</td>
<td>2.46</td>
<td>2.53</td>
<td>0.202</td>
</tr>
</tbody>
</table>

*January – December 2017

1=never   2 = rarely   3=sometimes   4=often   5=always
## Impact*: Staff Experience

### Question

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

*January – December 2017

1=strongly agree 2 = somewhat agree 3=neither agree or disagree 4=somewhat disagree 5=strongly disagree
<table>
<thead>
<tr>
<th>Question</th>
<th>Average Score Pre- ($n=209$)</th>
<th>Average Score Post- ($n=203$)</th>
<th>Significance $p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>My health center has processes or protocols in place to support opportunities for <strong>patients to share in decision-making</strong>.</td>
<td>2.16</td>
<td>1.98</td>
<td>0.025</td>
</tr>
<tr>
<td>My health center has <strong>processes or protocols</strong> in place to support <strong>cancer screening</strong> for every patient, regardless of ability to pay.</td>
<td>1.69</td>
<td>1.55</td>
<td>0.025</td>
</tr>
<tr>
<td>At my health center, <strong>cancer screening is the responsibility of the entire care team</strong> and not just the medical providers.</td>
<td>1.80</td>
<td>1.68</td>
<td>0.042</td>
</tr>
<tr>
<td>At my health center, <strong>screening and management of chronic disease</strong> (depression, obesity, high blood pressure, diabetes) are the <strong>responsibility of the entire care team</strong> and not just the medical providers.</td>
<td>1.66</td>
<td>1.53</td>
<td>0.042</td>
</tr>
</tbody>
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*January – December 2017

Impact*: Staff Experience (continued)

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

- 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

- 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.
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

Train Teams

• Train in team-based approaches to care
  o Use expanded teams members (in addition to provider) to identify and offer cancer screening.
  o Incorporate cancer screening as part of pre-visit planning
  o Apply NACHC Quality Center’s Care Teams Action Guide
• **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](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
  o Create written workflows that include EHR screenshots showing staff how to document cancer screening and referrals
  o Engage IT staff and EHR vendor, as needed, to modify templates to fully capture screening and follow-up
Use Information Systems to Drive Improvement

<table>
<thead>
<tr>
<th></th>
<th>DM Poor Control</th>
<th>HTN Control</th>
<th>Childhd Immunz</th>
<th>Cerv Cancer</th>
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<th>BMI Adult</th>
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<th>CAD Lipid Rx</th>
<th>IV0 Asp</th>
<th>AntiT Rx</th>
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2018 UDS: 🟢 = Top 2 Sites or Sites at Goal, 🟢 = Sites near goal, ✴️ = Bottom 2 Sites

Number of UDS measures at goal:

5

6

7

8
Step 6: Engage Patients

Use Patient Decision Aids

Colorectal Cancer Screening: Which test is right for you?

Cervical Cancer Screening

Follow these guidelines based on your age, personal and family history, and how often you have a Pap test.

Screen for colorectal cancer when:

- You are 50 years old or older
- You are at average risk for colorectal cancer
- You have never had a colorectal screening test

Screening options:

- Fecal occult blood test (FOBT)
- Flexible sigmoidoscopy
- Colonoscopy


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

https://healthfinder.gov/HealthTopics/shared-decision-making/
Train Staff in Patient Engagement

- Use scripts, conversation cards, and motivational interviewing

Apply NACHC Quality Center’s Patient Engagement Action Guide

Part of the Value Transformation Framework:
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.

- **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
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Questions and Answers
Thank you!

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