Cancer Prevention and Early Detection Program Manual

Section 4: Clinic Quality Improvement Strategy

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Types of Organizations Eligible for this Strategy

- Health systems and network organizations.
- Community-based organizations are not eligible for this strategy.

Only organizations who apply and are funded for the Clinic Quality Improvement strategy will implement these activities. Organizations funded for this strategy will be referred to only as "organizations" throughout this section.

Overview

The Clinic Quality Improvement (CQI) strategy is an organizational-level approach that funds changes in administrative and clinical processes, policies, and protocols; utilizes health information technology to improve cancer prevention and early detection; and increases capacity of health systems to monitor performance and implement evidence-based interventions (EBI). As compared to other Cancer Prevention and Early Detection (CPED) strategies, the CQI strategy is less prescriptive, as multiple activities and intervention options are available. Appropriate selection of interventions is based on organizational structure, staff capacity, existing activities, etc.

The primary goals of the Clinic Quality Improvement strategy are to strengthen organization capacity and infrastructure and implement evidence-based interventions using a quality improvement lens.

The Clinic Quality Improvement strategy can be used to implement EBIs to improve breast and cervical and/or colorectal cancer screening rates. Organizations must have CDPHE approval for the EBIs and cancers that will be addressed through their Cancer Prevention and Early Detection (CPED) contract.

Why is the CQI Strategy Important?

The Colorado Department of Public Health and Environment (CDPHE) receives funding to implement health systems change from the Centers for Disease Control and Prevention (CDC). The CDC has found that most cancer screening in the United States is opportunistic, with patients typically being offered a screening test when they are in the office for a different reason. A high quality cancer screening system would include the following characteristics:

- An explicit policy with specified age categories, method, and interval for screening
- A defined priority population
- A management team responsible for implementation
- A healthcare team for decisions and care
- A quality assurance structure

- A method for identifying cancer occurrence in the population

Organized screening places emphasis on ensuring the entire eligible population is screened and up-to-date with their surveillance intervals, including follow-through and completion of the entire screening process for those who require additional follow-up or rescreening. It also emphasizes continuous quality improvement. The use of various evidence-based interventions (EBIs) can strengthen and improve the capacity for the organization to promote screening across the entire eligible population.[1] Systematic changes are needed to coordinate all aspects of client care and increase access to services for clients at greatest risk.

CQI Transition

In an effort to bring more expertise to CQI through practice transformation, the University of Colorado Practice Innovation Program is contracting with CDPHE to deliver the CQI program for colorectal, breast and cervical cancer. This new model will also make data reporting less cumbersome for clinics with a shift to automated eCQM data pulls through Azara with support from CCMCN. Additionally, practice facilitation will be provided by CCHN to provide technical assistance and support for the implementation of selected EBI. Clinic contracts for CQI will end December 31, 2022 and will begin contracting with the University of Colorado Practice Innovation Program to continue implementing the same EBI beginning January 1, 2023

More information on the process for this transition will be communicated with clinics as it becomes available. For questions regarding this transition please contact your CDPHE Organization Lead and CQI Strategy Lead.

Step 1: Continuing Application

The final Continuing Application process for the 5 year contract term was completed early in 2022. The information below reflects the process that was followed each year.

In the first year of each organization's contract, each organization participated in an assessment and planning process to garner information about cancer prevention and early detection efforts in the population served by and living within the organization's service area. Each year, organizations submit a Continuing Application to add, continue, or remove strategies based on current capacity and goals. Organizations may be asked to update relevant information during the annual Continuing Application process. This will be the foundation for understanding the needs of the organization, and the organization's patient population and community. For more information, see Section 1: Grant Management of the Program Manual.

[1] Centers for Disease Control and Prevention (CDC). 2017. *Colorectal Cancer Control Program: Organized Approaches to Increase Colorectal Cancer Screening.*

The assessment and planning tool, the Readiness Assessment, and continuing application processes serve to:

- Identify gaps in organized approaches to cancer screening services and/or gaps in primary care referrals within non-primary care clinics.
- Propose specific interventions for implementation through the CQI strategy.
- Improve the organization's ability to support cancer screening among their patient population or improve referrals to primary care sites to manage preventive services, including cancer screening.

Step 2: Readiness Assessment

With guidance from a Technical Assistance provider, organizations will conduct a Readiness Assessment one time to assess an organization's capacity and interest in implementing one or more of the following EBIs: Provider Assessment & Feedback, Provider Reminders, Patient Reminders, Reducing Client Out-of-Pocket Costs, Group Patient Education, One-on-One Education, Reducing Structural Barriers, and Small Media. Only organizations who are new to CQI, or that have selected a new cancer screening EBI to focus on, will need to complete a Readiness Assessment.

The Readiness Assessment will document clinics' current breast, cervical, and/or colorectal cancer screening processes, electronic health record (EHR) screening data quality, available clinic resources (e.g. staffing, IT infrastructure) to guide the selection of priority EBIs, and identify gaps in capacity or infrastructure that could hinder the implementation of EBIs. The Assessment will serve as baseline data collection for the CQI strategy. Included in the Readiness Assessment is a Workflow Mapping exercise. Using Lean Quality Improvement methodology, the workflow mapping will highlight how:

1. The clinic identifies clients due, or overdue, for screening;
2. Clients are notified that they are due for screening;
3. Screening tests are ordered (and by whom);
4. Clients receive a screening, test kit or order;
5. Clients are referred for mammography, biopsy, colposcopy or colonoscopy;
6. The clinic tracks completion of ordered or referred tests; and
7. The clinic ensures abnormal test results receive appropriate follow-up.

The Technical Assistance providers and CDPHE will review each clinics' Readiness Assessment results and prioritize EBI implementation. For EBIs not prioritized, a capacity building plan may be created to advance clinic capacity and readiness to implement EBIs in the future.

Step 3: Intervention Selection

Once organizations have submitted a Continuing Application, participated in the Readiness Assessment, and are approved to receive funding for implementing the CQI strategy, organizations should complete the CQI Start-up Checklist. The intention of this document is to identify steps needed to plan for successful implementation.

CQI Portfolio Alignment Checklist

- ❏ Based on each organization's responses in the Readiness Assessment, the Technical Assistance providers and CDPHE CQI Strategy Lead will work with the organization to provide recommendations on which specific activities and evidence-based interventions align with the organization's goals, challenges, barriers, successes, and ideal future state.
- ❏ Review the CQI Portfolio. This is the collection of evidence-based interventions, best and promising practices, used to guide and support an organization to prevent and manage cancer and chronic disease. Examples with an "*" indicate recommended activities for all organizations.

Capacity & Infrastructure Building Activities		
Activity	*Yes/No*	*Examples*
Assessments	□	*Assessment and Planning Tool and Continuing Application**
	□	*Readiness Assessment**
	□	*Workflow Mapping*
	□	*Primary Care Team Guide Assessment (PCTGA)*
	□	*Health Information Technology Assessment (HIT)*
Quality Improvement Culture	□	*QI Methodology* (Lean, PDSA, etc.)*
	□	*Engage Leadership*
	□	*Data-driven Improvement*
	□	*Patient-team Partnership*
Health Equity	□	*Standards for Data Collection*

	□	*Staff Training on Equity*
	□	*Quality and Equity*
Health Information Technology	□	*Data Input, Export, and Sharing*
	□	*Population Management*
	□	*Telehealth*
Standard Policy & Workflow	□	*Empanelment & Continuity of Care*
	□	*Prompt Access to Care via Health Navigation*
	□	*Team-based Care*
	□	*Workflow Optimization*

Evidence-based Interventions			
Intervention	*Breast*	*Cervical*	*Colorectal*
Patient Reminders	□	□	□
Group Education	□		
One-On-One Education	□	□	□
*Small Media***	□	□	□
Reducing Structural Barriers	□		□
Reducing Out-of-Pocket Costs	□		
Provider Assessment & Feedback	□	□	□
Provider Reminder & Recall Systems	□	□	□

**Indicates a supporting activity which must be implemented with another EBI

Step 4: Implementation

After selecting interventions, organizations will work with their *CDPHE Organization Lead and/or CQI Strategy Lead* to complete their Implementation Plan. This CQI tool is used to document steps necessary to implement EBIs over the course of a fiscal year. The

implementation plan is created by the organization and the CDPHE CQI Strategy Lead and is finalized within the first 30 days of contract execution.

For organizations interested in funds to support follow-up colonoscopies, including eligibility, clinical requirements, reimbursement, and other data requirements, please see the CQI Sub-Section on Follow-Up Colonoscopy Services of the Program Manual.

Data Collection and Reporting Requirements

Continuous quality improvement methodologies will be used to systematically implement, monitor, assess, and improve selected interventions. Examples of quality improvement methodologies may include the Institute for Healthcare Improvement's (IHI) Model for Improvement, continuous Plan-Do-Study-Act (PDSA) cycles, LEAN methodology, and other related tools for process and quality improvement.

Readiness Assessment

Baseline data will be collected using the Readiness Assessment. The Readiness Assessment will be executed once upon contract execution. For more details about the Readiness Assessment, please see Step 2 above.

Clinical Quality Measures

Clinical Quality Measures (eCQMs) are electronic health record (EHR)-reported screening and control rates that include breast, cervical, and colorectal cancer screening rates, and are key outcome measures for the CQI evaluation. All organizations are required to submit clinic-level eCQMs to CDPHE on an annual basis. eCQMs are used by CDPHE to meet the CDC Colorectal Cancer Control Program (CRCCP) and National Breast and Cervical Cancer Early Detection Program (NBCCEDP) reporting requirements. Organizations will fall into one of two tracks (fiscal or calendar year) based on what was submitted on their Assessment and Planning Tool, and rates will be requested by CQI staff following the timeline below:

- Fiscal year track: Covers the period 7/1 to 6/30, due in July
- Calendar year track: Covers the period 1/1 to 12/31, due in February *(This reporting timeframe is only an option under extenuating circumstances and will need to be approved by CDPHE in advance)*

Each of the following data elements must be reported for breast, cervical, and colorectal cancer screening at both the individual clinic/site-level and at the health system/organization level:

1. Numerator used to calculate the screening rate
2. Denominator used to calculate the screening rate
3. Screening rate

4. Measure type (Healthcare Effectiveness Data and Information Set (HEDIS), National Quality Forum (NQF), or Other), including measure number and version, where applicable
5. EHR-rate reporting source (HCCN data warehouse, Clinic EHR, Health System EHR, EHR Vendor, Other)
6. Confidence in EHR-reported screening rate

Organizations must be *consistent* in the methodology they use to calculate cancer screening rates. CDPHE encourages organizations to use the measure most frequently used by the organization. If there is a choice in measures, CDPHE encourages organizations to use the following National Quality Forum (NQF) endorsed measures:

- Breast cancer screening (NQF 2372): Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer
- Cervical cancer screening (NQF 0032): Percentage of women 21-64 years of age who were screened for cervical cancer using either of the following criteria:
    - Women 21-64 years of age who had cervical cytology (Pap test) performed within the past 3 years
    - Women 30-64 years of age who had cervical cytology (Pap test)/Human Papillomavirus (HPV) co-testing performed within the past 5 years
- Colorectal cancer screening (NQF 0034): Percentage of patients 50-75 years of age who had appropriate screening for colorectal cancer; any of the following meet criteria:
    - Fecal occult blood test (FOBT) in the past year
    - Flexible sigmoidoscopy performed in the past 5 years
    - Colonoscopy performed in the past 10 years
    - Computed tomography (CT) colonography performed in the past 5 years
    - Fecal immunochemical DNA test (FIT-DNA) performed in the past 3 years

Additional measures are requested from all clinics participating in CQI and include Diabetes Poor Control (NQF 0059), Hypertension Control (NQF 0018), Tobacco Use Assessment & Intervention (NQF 0028), and Statin Therapy (CMS 347).

EBI Implementation Data (formerly Quarterly Metrics)

In addition to eCQMs, all organizations participating in CQI will be required to submit EBI Implementation Data annually by July 31. These intervention specific metrics cover EBI implementation from the previous year (July 1st - June 30th), and will be collected using an online survey link. They are used to understand successes and make course corrections to each organization's implementation of evidence based interventions.

Annual Evaluation

All organizations will be responsible for completing an annual evaluation survey, which will be made available on July 15 and will be due on August 15 of each year. The purpose of the annual evaluation survey is to understand each organization's progress in improving capacity

and infrastructure as well as to give context to the CQMs and other metrics each organization provides. This electronic survey will be combined with the CPED Progress Report to reduce the reporting burden on organizations.

Contract Monitoring and Quality Assurance

Contractor Performance Evaluations

Organizations must meet additional requirements as part of contractor performance for the CQI strategy. Additional information on Contractor Performance Evaluations can be found in Section 1: Grant Management of the Program Manual.

- Quality of Service.
    - To receive a standard rating organizations must also meet the following strategy specific measures:
        - Participation in 80% of monthly phone calls.
        - Completion of data collection tools (or data narrative if no data is available).
        - All deliverables listed in implementation plans have been received.
- Timeliness of Service.
    - To receive a standard rating organizations must also meet strategy specific measures:
        - Completion of data collection tools (or narrative) by due date.
        - All deliverables listed in implementation plans have been received by associated due dates.