NATIONAL ASSOCIATION OF
Community Health Centers®

# Together, our voices elevate all.

**March Learning Forum**

03.09.21

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QC Quality Center
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Attendee:

CS Camila Silva (NACHC)
Me

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# THE NACHC MISSION

## America’s Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

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

*Bringing science, knowledge, and innovation to practice*

**Cheryl Modica**

Director,
Quality Center

**Luke Ertle**

Manager,
Quality Center

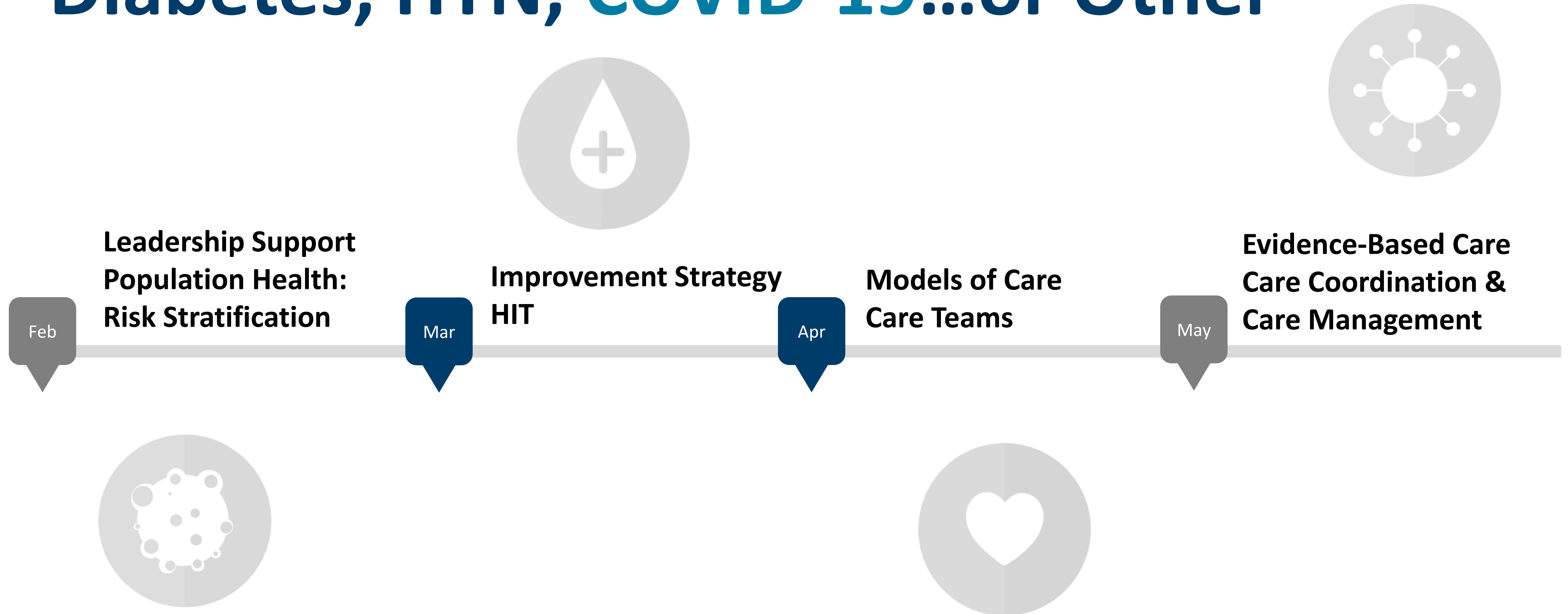
**Camila Silva**

Manager, Quality Center
Training & Curriculum

**Lizzie Utset**

Specialist, Health Science
Content

# Systems Approach…Cancer Screening, Diabetes, HTN, COVID-19…or Other



# FEBRUARY ACTION STEPS

## LEADERSHIP

- Leadership messaging around transformation & engagement in Elevate:
    - Share press release
    - Share video
    - Draft a business case
    - Present at a staff meeting

## POPULATION HEALTH MANAGEMENT

- Risk Stratification
    - If your health center already has a methodology: revisit to ensure process allows flexibility for segmentation, as needed (e.g., COVID vaccination, cancer screening, diabetes, etc.)
    - If your health center does not yet have a methodology: test evidence-based risk stratification steps outlined in NACHC Risk Stratification Action Guide.
    - Online self-paced module

## RISK STRATIFICATION STEPS:

Outlined below is a straightforward process to categorize patients' risk level by number of clinical conditions. Grouping patients by risk level allows a health center to direct care and resources to the needs of each subgroup.

**STEP 1** **Compile a List of Health Center Patients:** Create a complete list: include not only patients who come in for care, but also individuals who have been assigned to your health center.

**STEP 2** **Sort Patients by Condition:** Use the Uniform Data System (UDS) Table 6A measures or a list that's appropriate to your patient population.

**STEP 3** **Stratify Patients to Segment the Population into Target Groups:** Start by using the simple but effective method of "condition counts" (the number of conditions per patient).

**STEP 4** **Design Care Models and Target Interventions for Each Risk Group:** Each cohort (highly complex, high-risk, rising-risk, and low-risk) should be matched to a care model that meets their needs. (See Models of Care Action Guide.)

# Coastal Family Health Center

**Angel Greer, Chief Executive Officer**
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# *Reality along the Frontlines*

## Pre-Risk Stratification:

- COVID-19 vaccine arrived **before** list of eligible patients generated/contacted
- Media alerted – word spread
- Inundated with patient calls - outsourced to a Call Center
- **Outcome: many of those vaccinated not health center patients; only 8% African American when this group comprises 37% of patient population.**

## Risk Stratification, Step 1: **Generated a list of all adult patients**

# Step 2: Sorted adult patients by condition

| Patient | UDS High-Risk Conditions | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | Cancer | Heart Disease | Respiratory Disease | Asthma | Diabetes | HTN | Obesity | Depression | Mental Health |
| 1 | | | | | | | | | |
| 2 | | | | | | | | | |
| 3 | | | | | | | | | |
| 4 | | | | | | | | | |
| 5 | | | | | | | | | |
| Etc. | | | | | | | | | |

# Step 3: Stratified Patients

Stratified by age, race and condition count (using UDS parameters) to target specific segments of our patient population for COVID-19 vaccination.

| Age | Race | # of Conditions | Patients |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

# Step 4: Designed Intervention

Started with COVID them moving to cancer screening and other areas

**COVID-19 Vaccination**

1. Targeting patient population, particularly African Americans
2. Partnered with local African American churches to offer vaccines at time of worship
3. Partnered with MS Office of Minority health for additional initiatives to transcend racial/socioeconomic barriers

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GENERATIONS
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# Step 1: Generated a list of all adult* patients *assigned* to our health center

# Step 2: Sorted adult patients by condition: focused on diabetes

| Total GFHC Universe | Diabetes Population | % GFHC Universe |
|---|---|---|
| 20,796 | 2,405 | 11.56% |

| UDS | Indicator | PI or Req | Goal | Baseline Num/Den | Baseline Measure | 2019 Q1 Num | 2019 Q1 Den | 2019 Q1 % |
|---|---|---|---|---|---|---|---|---|
| UDS Table 7 Sec C | Improve Diab control >9 A1c | CRVFHP UDS | 25.00% | 8/22. | 36.00% | 6 | 19 | 31.58% |

GENERATIONS FAMILY HEALTH CENTER

# Step 3: Stratified Patients by Race

| Patient Study based on patients seen 4/1/2018 to 3/31/2019: Date Run on 6/11/2019 from PA Procedure Codes, Labs and lastly Charge Details folders | Total Spec Pop | % of GFHC Universe | Diabetics Count | Diabetics % of Spec Pop | Makes up % of Total GFHC DM Pop | Diabetic Count with A1c>9 | Spec Pop % with A1c>9 | Makes up % of all DM > A1c |
|---|---|---|---|---|---|---|---|---|
| | Special Population Breakdowns | | | | | | | |
| **Special Population** | DM Pop | | | | | | | |
| **Total GFHC Universe = 20796** | 2405 | 11.56% | **Total GFHC DM Pop >9** | | **26.49%** | | | |
| Non-Hispanic | 14313 | 7.77% | 1616 | 11.29% | 67.19% | 366 | 22.65% | 57.46% |
| Unreported/Refused to Report | 410 | 0.16% | 34 | 8.29% | 1.41% | 11 | 32.35% | 1.73% |
| **Race** | | | | | | | | |
| American Indian/Alaskan Native | 496 | 0.46% | 96 | 19.35% | 3.99% | 21 | 21.88% | 3.30% |
| Native Hawaiian | 21 | 0.02% | 4 | 19.05% | 0.17% | 1 | 25.00% | 0.16% |
| Other Pacific Islander | 46 | 0.04% | 8 | 17.39% | 0.33% | 4 | 50.00% | 0.63% |
| Black/African American | 1608 | 1.13% | 234 | 14.55% | 9.73% | 63 | 26.92% | 9.89% |
| Asian | 504 | 0.29% | 60 | 11.90% | 2.49% | 9 | 15.00% | 1.41% |
| White | 14871 | 8.10% | 1685 | 11.33% | 70.06% | 427 | 25.34% | 67.03% |
| Unreported/Refused to report | 3241 | 1.53% | 318 | 9.81% | 13.22% | 112 | 35.22% | 17.58% |

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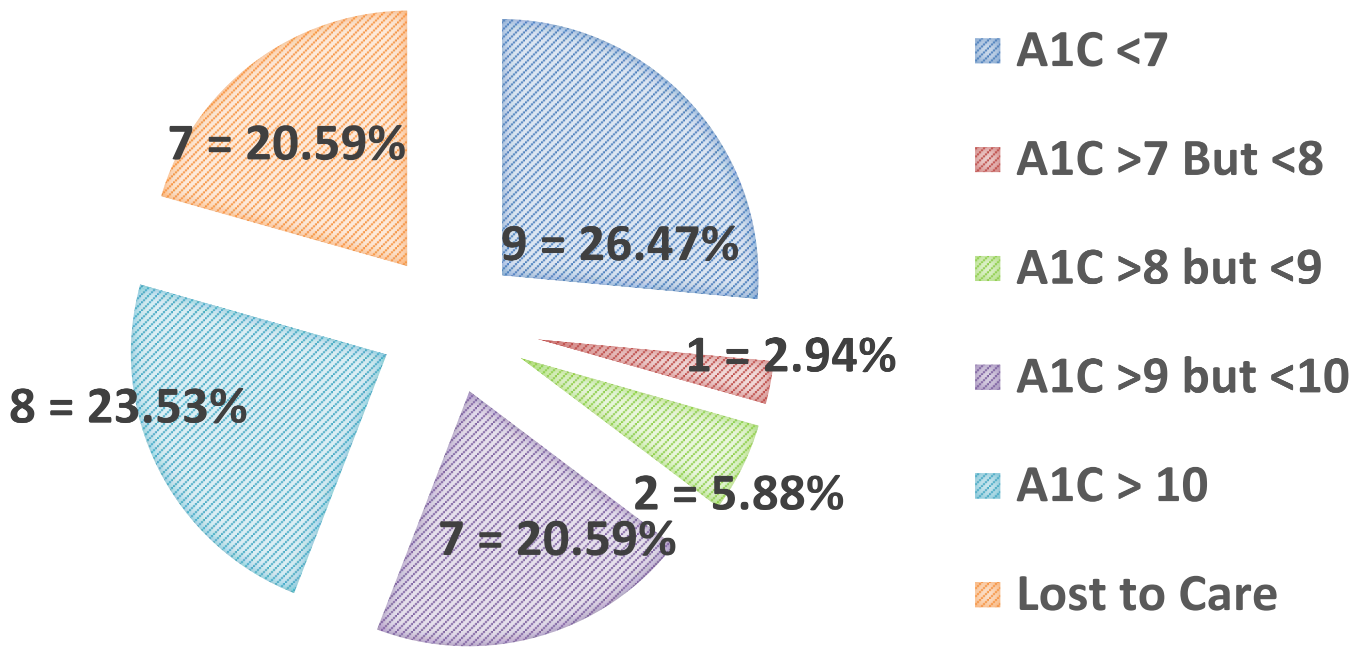
# Step 4: Designed Intervention across Risk Groups

## Root Cause Analysis for Diabetes

1. What proof do I have that the cause exists?
2. What proof do I have that the cause will lead to the stated effect?
3. What proof do I have that this cause actually contributed to the problem I'm looking at?
4. Is anything else needed, along with this cause, for the stated effect to occur? (Is it self-sufficient? Is something needed to help it along?)
5. Can anything else, besides this cause, lead to the stated effect? (Are there alternative explanations that fit better? What other risks are there?)

## Risk Stratification

| SDOH Complete | 14 | 34 | 41.18% |
|---|---|---|---|
| Lives Improved | 12 | 34 | 35.29% |
| Lost to Care | 7 | 34 | 20.59% |




| UDS | Indicator | PI or Req | Goal | Baseline Num/Den | Baseline Measure 2018 | 2019 Q1 Num | 2019 Q1 Den | 2019 Q1 % | 4Q Num | 4Q Den | 4Q % |
|---|---|---|---|---|---|---|---|---|---|---|---|
| UDS Table 7 Sec C | Improve Diab control >9 A1c | CRVF HP UDS | 25.00% | 8/22. | 36.00% | 6 | 19 | 31.58% | 17 | 112 | 15.18% |

GENERATIONS
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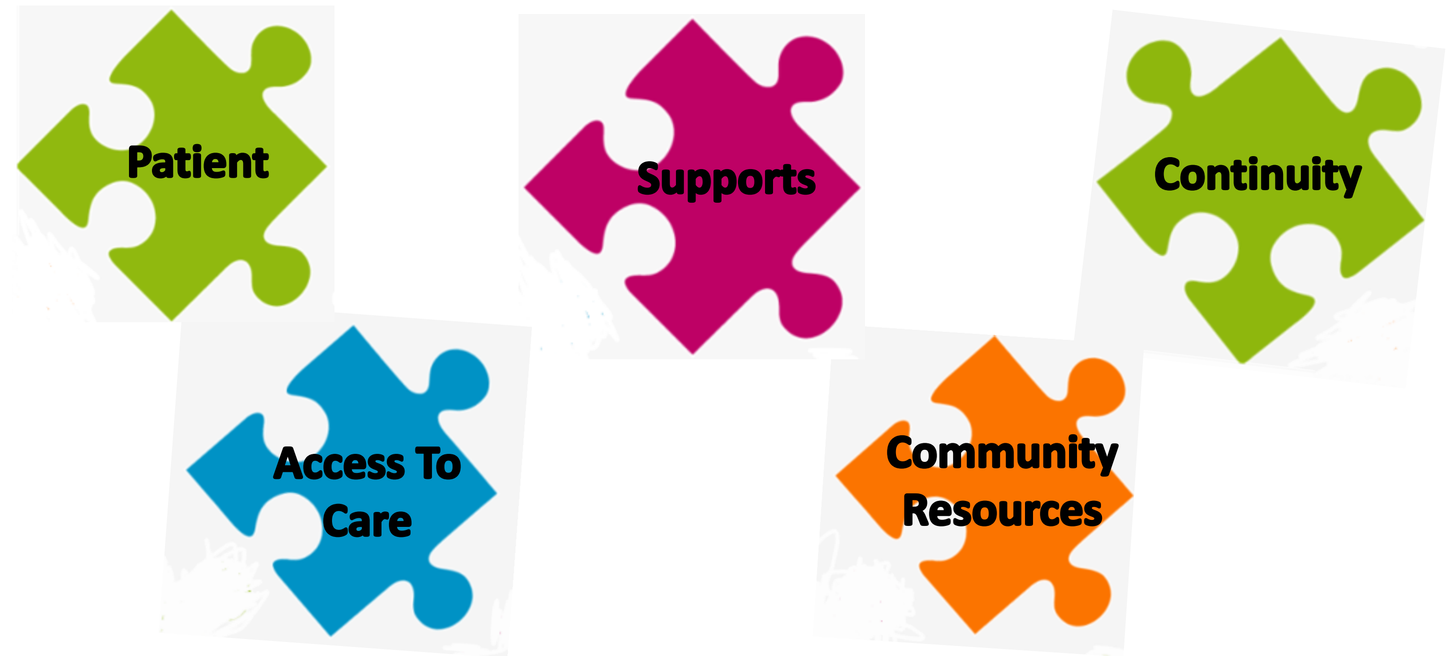
# Risk Stratification




| UDS | Indicator | eCQM Code | Report Engine | Num | Den | 2020 |
|---|---|---|---|---|---|---|
| CRVFHP UDS Table 7C | Improve Diab control >9 A1c | CMS12 2v8 | PA | 9 | 81 | 11.11% |

# Quality Incentive Analysis

**Overview for NACHC Elevate 2021**

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February 25, 2021

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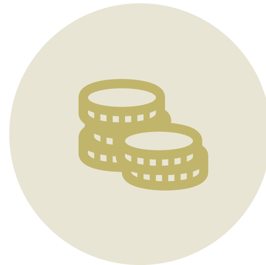
# Lance Luttrell

- 10 years at an FQHC in Tennessee
- Operations Analyst, Dental Administrator, and COO (6 years)
- Industrial Engineer
- Continuous Compliance Lead for RegLantern
- I love where problem solving intersects with process improvement and people

# What is the Quality Incentive Analysis?

ALIGNING TEAM MEMBER RESOURCES



FINANCIAL OPPORTUNITY

POPULATION HEALTH

COMPLIANCE

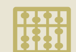
# HRSA QIA Awards

- In August of 2020, HRSA Awarded $117M to Health Centers for their performance on the UDS data for 2019
- UDS 2020 data was submitted on February 15, 2021 and will be reviewed for awards in August of 2021
- While engaging a range of health center staff in improvement efforts across multiple areas of the health Center (systems approach), there is also the  opportunity to focus on specific areas (VTF Change Areas) and corresponding quality measures that will payoff to help build quality initiatives in the future

# Why focus on UDS measures?

UDS measures are for **all** patients – insured and uninsured alike

UDS measures easier because they are based on **your data**, not the Insurance Company's data



UDS measures **overlap** with other quality programs

UDS measures **cross departments** and involve the whole team

The QIA Awards offer **meaningful financial incentives** for those who meet the measures

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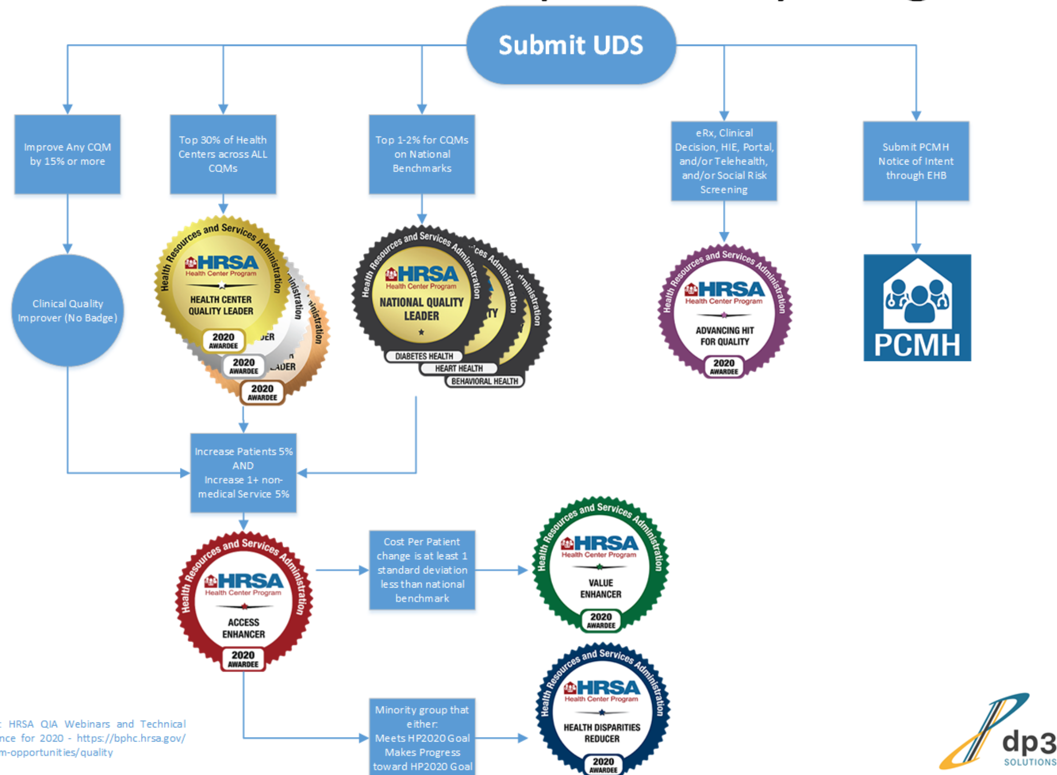
# How are Quality Improvement Awards Awarded?

HRSA QIA Award Dependency Diagram




Source: HRSA QIA Webinars and Technical Assistance for 2020 - https://bphc.hrsa.gov/program-opportunities/quality

- Quality Measures can be earned by:
  - Improving any measure by 15% or more ($3K)
  - Having the overall score in the top 30% ($17K - $28K)
  - Being in the top 1-2% for Diabetes, Heart, or Behavioral Health ($28K)
  - These have base payouts + **$1 PER PATIENT SERVED**
- Access, Disparities Reducer, and Value all depend on at least 1 Quality Measure
- **NOTE**: PCMH and HIT Awards are earned separately

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# Quality Incentive Analysis

- Quality Incentive Analysis prioritizes quality improvement efforts to maximize expected payments.
- Get paid for doing the right thing.
- Risk stratification is *exactly* what the health center should do. Quality Incentive Analysis is what the quality improvement team should do.
- <u>All measures are important</u>. This helps set target goals that have financial rewards tied to them.

# QIA Objectives

- Make the Goal Clear
  - Using financial rewards to set targets can be helpful in motivating the team
  - Remember: HRSA pays for 15% improvement, Top 30% Overall, Top 1-2% for Behavioral Health, Diabetes, or Heart Health
- Prioritize which measures to address by financial reward
- Provide senior leaders with information to decide among various priorities
  - The initial solution often “chooses” the easiest solutions without considerations for public health or strategic value
  - Leaders still have to weigh the value of different initiatives, but this provides a way to think about the *time* investment for staff and systematic solutions

# Developing Solutions

- As we identify areas for improvement, we should ask these key questions:

***<u>VTF CHANGE AREAS:</u>***

***IMPROVEMENT STRATEGY****: Are my reports pulling in our document activity?*

***HIT****: Is there an EMR rule or alert that can help our care teams close these gaps systematically?*

***CARE TEAMS****: Would a standing order allow other team members to address these areas?*

***IMPROVEMENT STRATEGY****: Are there opportunities for a chart review to validate our systematic process or manually close gaps?*

# All are Important. All are not the Same.

| Perinatal | Preventive Health Screening | Chronic Disease Management |
|---|---|---|
| Early Entry to Prenatal Care | Cervical Cancer Screening | Statin Therapy for CVD |
| % Low / Very Low Birth Weight | Breast Cancer Screening* | Aspirin for IVD |
| | Weight Assessment and Counseling for Children | Controlling High Blood Pressure |
| | BMI Screening and Follow-Up | Diabetes: A1c Poor Control |
| | Tobacco Use Screening and Cessation Counseling | HIV Linkage to Care |
| | Colorectal Cancer Screening | HIV Screening* |
| | Childhood Immunization | |
| | Screening for Depression and Follow-Up | |
| | Dental Sealants | |

# All are Important. All are not the Same

EMR RULES / STANDING ORDERS

CARE COORDINATION

CARE MANAGEMENT

| Perinatal | Preventive Health Screening | Chronic Disease Management |
|---|---|---|
| Early Entry to Prenatal Care | Cervical Cancer Screening | Statin Therapy for CVD |
| % Low / Very Low Birth Weight | Breast Cancer Screening* | Aspirin for IVD |
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| | Tobacco Use Screening and Cessation Counseling | HIV Linkage to Care |
| | Colorectal Cancer Screening | HIV Screening* |
| | Childhood Immunization | |
| | Screening for Depression and Follow-Up | |
| | Dental Sealants | |

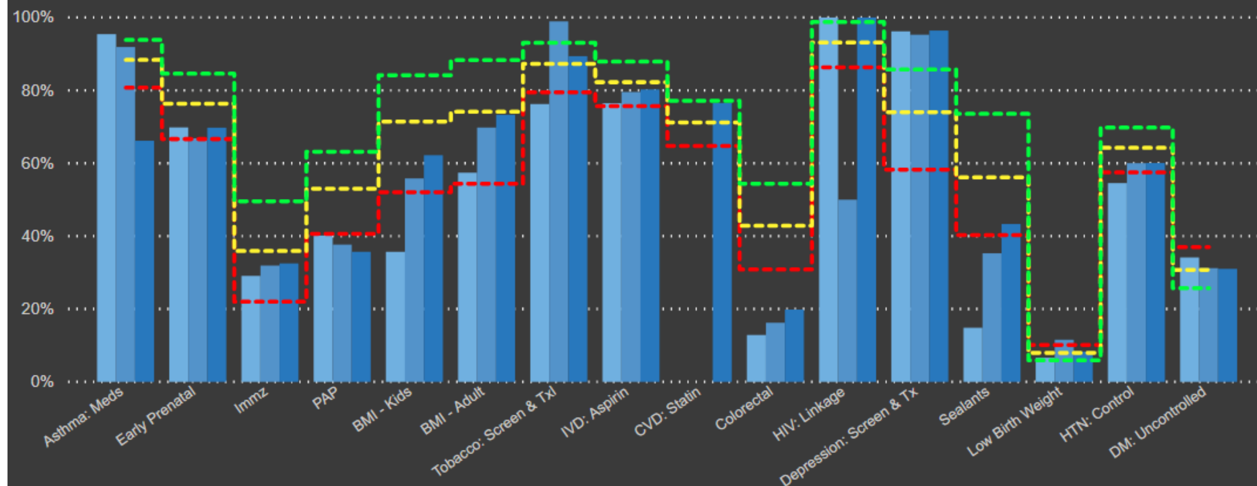
# Coastal Family Health Center (MS)

## Coastal Family Health Center, Inc. (MS)

H80CS00188 | Coastal Family Health Center, Inc. (MS)

### UDS Comparison to National Benchmarks

2017 2018 2019 25th Percentile (Worst) 50th Percentile (Middle) 75th Percentile (Best)




### Total Patients in Most Recent UDS

**35,640**

### Patients to Improve 15%

| Measure | Patient Gap | Current Pct |
|---|---|---|
| Asthma: Meds | 42 | 66% |
| Early Prenatal | 99 | 70% |
| Immz | 68 | 33% |
| PAP | 1,475 | 36% |
| BMI - Kids | 1,035 | 62% |
| BMI - Adult | 3,183 | 73% |
| IVD: Aspirin | 96 | 80% |
| CVD: Statin | 587 | 77% |
| Colorectal | 1,389 | 20% |
| Sealants | 14 | 43% |
| Low Birth Weight | -21 | 8% |
| HTN: Control | 1,402 | 60% |
| DM: Uncontrolled | -632 | 31% |

### Patients to Meet Next Quartile

| Measure | Patient Gap | Qrtl Rank |
|---|---|---|
| Asthma: Meds | 41 | 4 |
| Early Prenatal | 44 | 3 |
| Immz | 16 | 3 |
| PAP | 486 | 4 |
| BMI - Kids | 636 | 3 |
| BMI - Adult | 172 | 3 |
| Tobacco: Screen & Txl | 554 | 2 |
| IVD: Aspirin | 13 | 3 |
| CVD: Statin | 24 | 2 |
| Colorectal | 1,019 | 4 |
| Sealants | 12 | 3 |
| Low Birth Weight | 0 | 3 |
| HTN: Control | 389 | 3 |
| DM: Uncontrolled | -11 | 2 |

# Quality Incentive Analysis - Assumptions

- There are roughly 2 FTE focused on Quality Improvement efforts
- Each measure is given a rank for the work it takes to implement systematic solutions as well as individual care gap closure.
- Scenario 1
  - A initial solution that picks measures based solely on financial incentive
- Scenario 2
  - The Health Center's Board identifies a Cancer Screening measure as a priority
  - Then, they use any additional time, to address other measures

# Scenario 1 – Initial Solution

| | | | | | | | | Hours by Step | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Order** | **Measure** | **Hours** | **Patients** | **Old** | **New** | **Old** | **New** | **1** | **2** | **3** | **4** | |
| 1 | Patients - Substance Use Disorder MY | **90** | **15** | 0% | 0% | | | 90 | | | | |
| 4 | Asthma: Medication | **50** | **45** | 66% | 82% | 4 | 3 | | | | 50 | |
| | Early Prenatal Care | **0** | **0** | 70% | 70% | 3 | 3 | | | | | |
| | Childhood Immunizations | **0** | **0** | 33% | 32% | 3 | 3 | | | | | |
| | Cervical Cancer Screening | **0** | **0** | 36% | 36% | 4 | 4 | | | | | |
| | Breast Cancer Screening | **0** | **0** | 0% | | | | | | | | |
| 2 | Weight Assessment and Nutrition - Children | **300** | **700** | 62% | 72% | 3 | 2 | | 300 | | | |
| | BMI - Adult | **0** | **0** | 73% | 73% | 3 | 3 | | | | | |
| | Tobacco Use: Screening and Cessation | **0** | **0** | 89% | 89% | 2 | 2 | | | | | |
| | IVD: Use of Aspirin | **0** | **0** | 80% | 80% | 3 | 3 | | | | | |
| | CVD: Statin | **0** | **0** | 77% | 77% | 2 | 2 | | | | | |
| | Colorectal Cancer Screening | **0** | **0** | 20% | 20% | 4 | 4 | | | | | |
| | HIV: Linkage to Care | **0** | **0** | 100% | 100% | | | | | | | |
| | HIV: Screening | **0** | **0** | 0% | | | | | | | | |
| | Depression: Screening and Follow-Up | **0** | **0** | 96% | 96% | 1 | 1 | | | | | |
| | Depression Remission at 12 Months | **0** | **0** | 0% | | | | | | | | |
| 3 | Dental Sealants | **20** | **15** | 43% | 59% | 3 | 2 | | | 20 | | |
| | Low and Very Low Birth Weight | **0** | **0** | 8% | 8% | 3 | 3 | | | | | |
| | Hypertension: Control | **0** | **0** | 60% | 60% | 3 | 3 | | | | | |
| 2 | Diabetes: Uncontrolled | **3440** | **666** | 31% | 15% | 2 | 1 | | 3440 | | | |
| | **Total Time** | 3900 | | | | | **Time** | 90 | 3740 | 20 | 50 | |
| | **Remaining Hours Other Award Areas** | 20 | | | | | **Award** | $ 64,390.00 | $ 103,192.50 | $ 3,162.50 | $ 3,162.50 | $ 173,907.50 |

# Scenario 1 - Interpretation

- How to allocate staff
  - 90 hours for MAT patient tracking
  - 300 hours on BMI systematic solutions
  - 3,440 hours on Diabetes Care Coordination
  - 20 hours on Dental Sealants
  - 50 hours on Asthma Medications
- Financial Potential:
  - >$173,000 – National Quality Leader in BH and Diabetes. Improvement Awards for Diabetes, Sealants and Asthma

# Scenario 1 – Systematic Solutions

- Strategies for systematic solutions:
  - What will it take to add MAT services to be eligible for BH services?
  - For the BMI and Sealant Measure:
    - **IMPROVEMENT STRATEGY:** Are my reports pulling in our document activity?
    - **HIT:** Is there an EMR rule or alert that can help our care teams close these gaps?
    - **CARE TEAMS:** Would a standing order allow other team members to address these areas?
    - **IMPROVEMENT STRATEGY:** Are there opportunities for a chart review to validate our systematic process or manually close gaps?
  - For Dental Sealants particularly, the need to review the report and review policies of same-day sealants can make a *huge* difference.

# Scenario 1 - Limitations

- This is a **BIG** jump to address Diabetes in such a dramatic way
- MAT services may be too big of a jump for the organization
- The Asthma Measure has been discontinued in 2021
- What about Cancers and things that are really affecting our patients?
- Again, all measures are important! It depends on the unique needs of each community and the strategic goals of the Health Center's leadership.

# Scenario 2 – Cancer Screening First

| | | | | | | | | Hours by Step | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Order** | **Measure** | **Hours** | **Patients** | **Old** | **New** | **Old** | **New** | **1** | **2** | **3** | **4** | |
| | Patients - Substance Use Disorder MY | 0 | 0 | 0% | 0% | | | | | | | |
| | Asthma: Medication | 0 | 0 | 66% | 66% | 4 | 4 | | | | | |
| | Early Prenatal Care | 0 | 0 | 70% | 70% | 3 | 3 | | | | | |
| | Childhood Immunizations | 0 | 0 | 33% | 32% | 3 | 3 | | | | | |
| 1 | Cervical Cancer Screening | 3150 | 1572 | 36% | 52% | 4 | 3 | 3150 | | | | |
| | Breast Cancer Screening | 0 | 0 | 0% | | | | | | | | |
| | Weight Assessment and Nutrition - Children | 0 | 0 | 62% | 62% | 3 | 3 | | | | | |
| | BMI - Adult | 0 | 0 | 73% | 73% | 3 | 3 | | | | | |
| | Tobacco Use: Screening and Cessation | 0 | 0 | 89% | 89% | 2 | 2 | | | | | |
| | IVD: Use of Aspirin | 0 | 0 | 80% | 80% | 3 | 3 | | | | | |
| | CVD: Statin | 0 | 0 | 77% | 77% | 2 | 2 | | | | | |
| | Colorectal Cancer Screening | 0 | 0 | 20% | 20% | 4 | 4 | | | | | |
| | HIV: Linkage to Care | 0 | 0 | 100% | 100% | | | | | | | |
| | HIV: Screening | 0 | 0 | 0% | | | | | | | | |
| | Depression: Screening and Follow-Up | 0 | 0 | 96% | 96% | 1 | 1 | | | | | |
| | Depression Remission at 12 Months | 0 | 0 | 0% | | | | | | | | |
| | Dental Sealants | 0 | 0 | 43% | 43% | 3 | 3 | | | | | |
| | Low and Very Low Birth Weight | 0 | 0 | 8% | 8% | 3 | 3 | | | | | |
| | Hypertension: Control | 0 | 0 | 60% | 60% | 3 | 3 | | | | | |
| | Diabetes: Uncontrolled | 0 | 0 | 31% | 31% | 2 | 3 | | | | | |
| | | | | | | | | | | | | |
| | **Total Time** | 3150 | | | | | **Time** | 3150 | 0 | 0 | 0 | |
| | **Remaining Hours Other Award Areas** | 770 | | | | | **Award** | $ 38,802.50 | | | | $ 38,802.50 |

# Scenario 2 – Cancer Screening First (Cont.)

| | | | | | | | | Hours by Step | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Order** | **Measure** | **Hours** | **Patients** | **Old** | **New** | **Old** | **New** | **1** | **2** | **3** | **4** | |
| 1 | Patients - Substance Use Disorder MY | **90** | **15** | 0% | 0% | | | 90 | | | | |
| 2 | Asthma: Medication | **80** | **80** | 66% | 95% | 4 | 1 | | 80 | | | |
| | Early Prenatal Care | **0** | **0** | 70% | 70% | 3 | 3 | | | | | |
| 2 | Childhood Immunizations | **130** | **20** | 33% | 37% | 3 | 2 | | 130 | | | |
| | Cervical Cancer Screening | **0** | **0** | 36% | 36% | 4 | 4 | | | | | |
| | Breast Cancer Screening | **0** | **0** | 0% | | | | | | | | |
| | Weight Assessment and Nutrition - Children | **0** | **0** | 62% | 62% | 3 | 3 | | | | | |
| 2 | BMI - Adult | **290** | **400** | 73% | 75% | 3 | 2 | | 290 | | | |
| | Tobacco Use: Screening and Cessation | **0** | **0** | 89% | 89% | 2 | 2 | | | | | |
| 2 | IVD: Use of Aspirin | **60** | **56** | 80% | 89% | 3 | 1 | | 60 | | | |
| 2 | CVD: Statin | **70** | **64** | 77% | 78% | 2 | 1 | | 70 | | | |
| | Colorectal Cancer Screening | **0** | **0** | 20% | 20% | 4 | 4 | | | | | |
| | HIV: Linkage to Care | **0** | **0** | 100% | 100% | | | | | | | |
| | HIV: Screening | **0** | **0** | 0% | | | | | | | | |
| | Depression: Screening and Follow-Up | **0** | **0** | 96% | 96% | 1 | 1 | | | | | |
| | Depression Remission at 12 Months | **0** | **0** | 0% | | | | | | | | |
| 2 | Dental Sealants | **30** | **29** | 43% | 75% | 3 | 1 | | 30 | | | |
| | Low and Very Low Birth Weight | **0** | **0** | 8% | 8% | 3 | 3 | | | | | |
| | Hypertension: Control | **0** | **0** | 60% | 60% | 3 | 3 | | | | | |
| | Diabetes: Uncontrolled | **0** | **0** | 31% | 31% | 2 | 3 | | | | | |
| | **Total Time** | 750 | | | | **Time** | | 90 | 660 | 0 | 0 | |
| | **Remaining Hours Other Award Areas** | 20 | | | | **Award** | | $ 64,390.00 | $ 94,855.00 | | | $ 159,245.00 |

*NOTE: This amount will not fully add to the previous slide b/c of overlapping awards*

# Scenario 2 - Interpretation

- How to allocate staff
  - 3,150 hours for Cervical Cancer Screening
  - 90 hours on MAT services
  - Remaining hours on Asthma, Immunizations, BMI, Statins, Aspirins, and Dental Sealants
- Financial Potential:
  - >$165,000* – National Quality Leader in BH. Improvement Awards for Cervical Cancer, Sealants and Asthma. And a Bronze Health Center Leader Award.

# Scenario 2 – Systematic Solutions

- Strategies for systematic solutions:
  - How will we address Cervical Cancer Screenings?

    ***Are our PAPs and HPV values pulling into our report correctly for the past 3 to 5 years?***

    **Can we create a rule in the EMR for our schedulers and nursing staff to make patients aware they are due for this screening?**

    **Do we have a standing order in place to enable nursing staff to initiate adding this procedure to a visit?**

    **When can we set aside time to do a quarterly review of open gaps to see if some patients have received the service?**

# Scenario 2 – Take-Aways

- Even with such an analytical approach, there are ways for strategic priorities to be upheld
- A systematic approach needs to be built into a regular process to establish the measure and review throughout the year
- By limiting the number of measures, there may be some trade off of financial incentives

# Conclusion

- Quality Incentive Analysis can help set goals for your team
- Take into account the work that will be required to achieve different goals
- Systematic solutions can impact a lot of patients for the same amount of work
- There is ***real*** money to be made by doing what you're already doing
- Providing focus for stretched teams can help give them a sense of accomplishment and success

# Interested in a Deeper Dive?

Elevate Elective Series: Quality Improvement Analysis

March 24th 1-2 pm ET

For questions or for requests to review your health center's opportunities, contact us at:

lance@reglantern.com

Reglantern.com

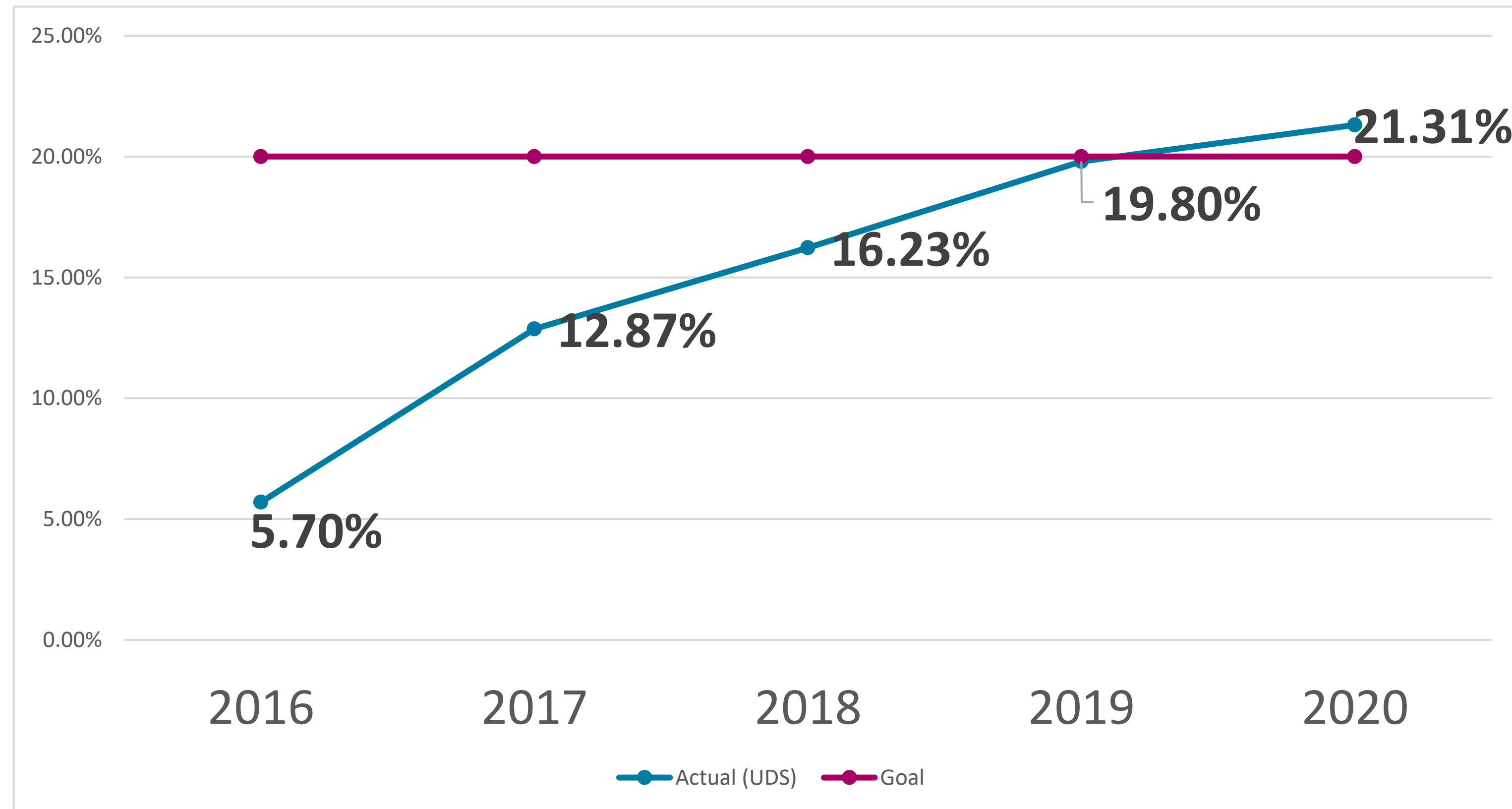
1-833-REGLANTERN (734-5268)

# Strategies to Drive Improvement:
## Applying methods to cancer screening

**Colorectal Cancer Screening (CRCS):**
Patients 50-75 years of age from each risk group; target CRCS

CARING BEGINS AT
COASTAL FAMILY
HEALTH CENTER

# Colorectal Cancer Screening Rate Trend 2016-2020

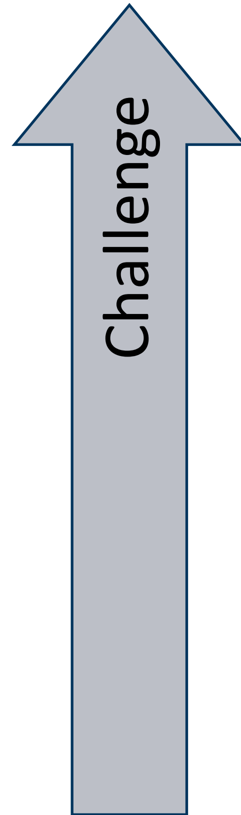


# CRC: Improvement Journey

| | |
|---|---|
| HIT | • Developed **standing order** protocol for **FIT/FOBT** |
| Evidence-Based Care | • FIT FOBT Testing standardized as a new protocol<br>• Updated **standing order** protocols to include the **FIT FOBT**<br>• Implemented the use of **Care Guidelines** as a form of CDS alerts |
| Care Teams | • Enhanced training: **FIT/FOBT** and **GI referrals and documentation** |
| Care Management & Coordination | • Utilized BH staff/**care management** to discuss screenings/care gaps<br>• Utilized 3rd party to generate **patient recalls** lists for care management |
| Partnerships | • Worked with Exact Sciences to promote **Cologuard** as an option |
| Population Health | • Implemented **Azara** and the **Visit Planning Report** as a tool for huddles |

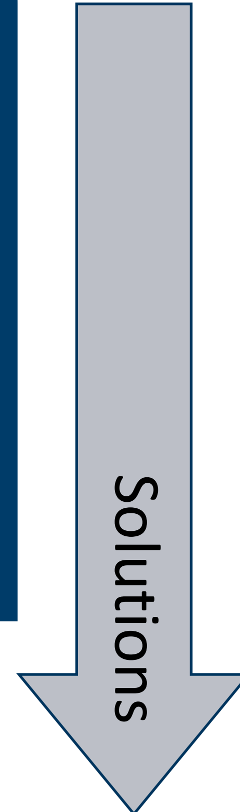
Improvement Strategy

# CRC: 2020 Pandemic




Pandemic constraints made it difficult to screen patients for colorectal cancer

1. Augmented use of Cologuard orders during telehealth visits
2. Payer use of home FIT FOBT kits
3. Usability improvements in Care Guidelines with upgrade
4. Continued use of Azara Visit Planning report
5. Continued data validations and monitoring ensured proper documentation for reporting




***Even with the challenge of the pandemic, we surpassed our goal during the 2020 reporting year.***

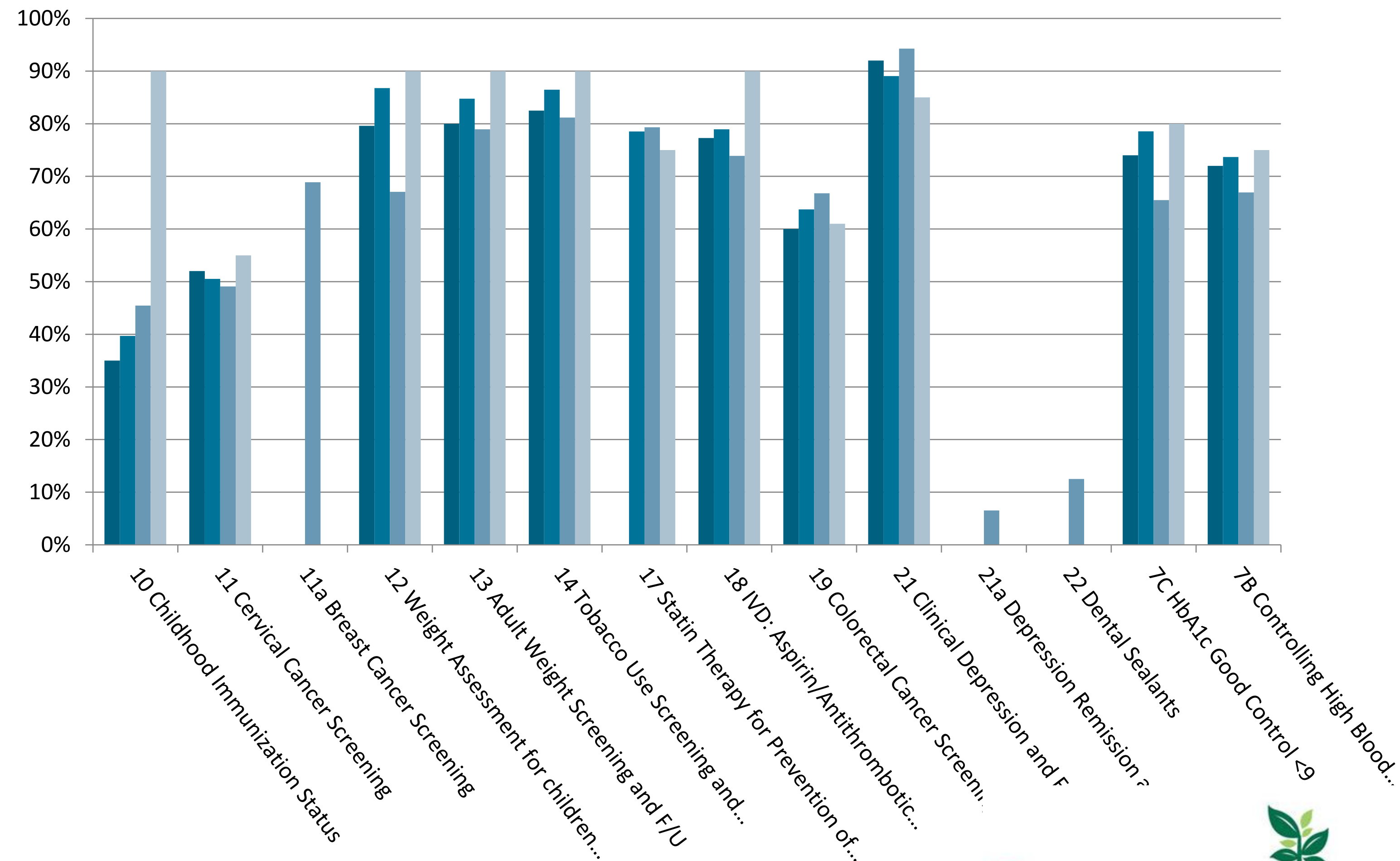
NATIONAL ASSOCIATION OF Community Health Centers®

Coastal Family Health Center

# Strategies To Drive Performance Improvement

# Improvement Strategy

- Set goals
- Define workflow
- Define timeline
- Continuously measure
- Celebrate improvement




GENERATIONS FAMILY HEALTH CENTER

# MARCH ACTION STEPS

## IMPROVEMENT STRATEGY

- Set **goals** for your improvement efforts, and create a plan on how to tackle each goal.
    - *Remember, break large goals into small action steps that can have timelines attached to them*

## HEALTH INFORMATION TECHNOLOGY

- Using the goals that you have stablished, take an inventory of your HIT systems and workflows.
    - *Look for areas that are working optimally and for areas that need to be improved in order to help you achieve those goals.*

# UPCOMING EVENTS

## March 2021

| SUN | MON | TUE | WED | THU | FRI | SAT |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 |
| 7 | 8 | 9 | 10 | 11 | 12 | 13 |
| 14 | 15 | 16 | 17 | 18 | 19 | 20 |
| 21 | 22 | 23 | 24 | 25 | 26 | 27 |
| 28 | 29 | 30 | 31 | | | |

**09. March Elevate Core Webinar**

*Don't forget to register to the online platform: nachc.docebosaas.com*

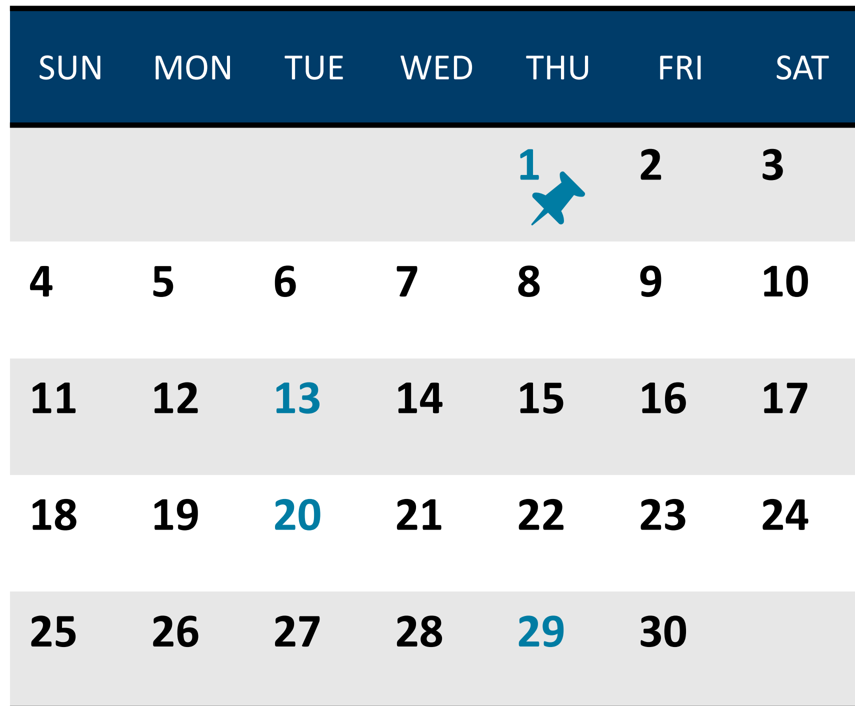
**19. Due Date for VTF Assessment** (https://reglantern.com/vtf)

**22. RegLantern Demonstration/Orientation***

**24. Quality Improvement Analysis – Deeper Dive Into HRSA Quality Improvement Awards*** *(Elective Call)*

*Open to health centers that have completed 3+ VTF Assessments and PCAs/HCCNs/NTTAPs with 1+ staff who have completed a VTF. RegLantern Trial begins April 1st.

# UPCOMING EVENTS



**01. RegLantern Trial Starts**

**13. April Elevate Core Webinar**

**20. Models of Care: Virtual Care & Patient Self-Care Tools** *(Elective Call)*

**29. Business Continuity** *(3-Part Elective Call)*

- *Part 2, May 13*
- *Part 3, May 27*

# CHC's with 3+ Assessments (74)

***As of March 8th, 2021***

- Coastal Family Health Center, Inc.
- Neighborhood Health Center
- Shawnee Health Services
- Care SC Inc
- Chiricahua Community Health Centers, Inc.
- East GA Healthcare Center, Inc.
- Elica Health Centers
- Healthlinc, Inc.
- Lone Star Circle of Care
- Marias Healthcare Services, Inc.
- North Country Family Health Center
- OIC Family Medical Center
- Primary Health Center
- Southeast Community Health Systems
- Southwest Care
- United Community and Family Services
- Will County Community Health Center
- 1st Choice Healthcare, Inc.
- Aaron E. Henry Community Health Services Center
- Access Family Care
- Ajo Community Health Center
- Brighter Beginnings CHC
- Chase Brexton Health Care
- Cherry Health
- Community First Health Centers
- Community Health Center of the North Country
- Community Health of South Florida, Inc.
- Compass Health Network
- Denver Health's Community Health Services
- East Jordan Family Health Center
- Family Centers Health Care
- Family Health Centers
- Family HealthCare Network
- Fenway Community Health Center
- GPW Health Center
- Grace Community Health Center
- Health Help Inc. dba White House Clinics
- HealthCore Clinic Inc
- Heart City Health Center, Inc.
- Heartland Health Services
- Hometown Health Center
- Hyndman Area Health Center, Inc.
- Kaniksu Health Services
- Kinston Community Health Center
- Kintegra
- Langley Medical Services
- Lee County Cooperative Clinic
- Lower Lights Christian Health Center
- Mariposa Community Health Center
- Migrants Health Center Inc.
- Muskingum Valley Health Centers
- North Orange County Regional Health Foundation
- OH North East Health Systems, Inc.
- OneWorld Community Health Centers, Inc.
- Open Door Family Medical Center, Inc.
- Optimus Health Care
- Outside In
- Raphael Health Center, Inc.
- Robeson Health Care Corporation
- Rural Health Group
- Rural Health Medical Program, Inc.
- Ryan, William F Community Health Center Inc
- Shingletown Medical Center
- Sonoma Valley Community Health Center
- St. Francis House NWA Inc. dba Community Clinic
- St. Vincent de Paul Village, Inc.
- Sunset Community Health Center
- TX Tech University Health Sciences Center
- Valley Professionals Community Health Center Inc.
- Valleywise Health
- Vista Community Clinic
- Western North Carolina Community Health Services
- Whitman Walker Health Center
- Zufall Health Center

# CHC's with 2 Assessments (24)

*As of March 8th, 2021*

- Advance Community Health/Wake Health Services Inc
- Alliance Community Healthcare
- Appalachian Mountain Community Health Centers
- Charter Oak Health Center
- Christian Community Health Center
- Community Health & Wellness Center
- Community Health Care, Inc.
- Compass Community Health
- Concilio de Salud de Loiza
- Cross Road Health Ministries, Inc.
- CT Institute for Communities, Inc.
- El Centro De Corazon
- El Dorado County Community Health Center
- Family Health Ctr of Southern Oklahoma
- Greater Baden Medical Services, Inc.
- Hidalgo Medical Services
- Lake Superior Community Health Center
- North Central Family Medical Center
- Northeast Florida Health Services Dba: Family Heal
- Northeast Valley Health Corporation
- Southbridge Medical Advisory Council Inc
- Suncoast Community Health Center
- The Achievable Foundation
- The Chautauqua Center, Inc.

# CHC's with 1 Assessment (88)

***As of March 8th, 2021***

- Accordia Health
- Alliance Medical Center
- Ammonoosuc Community Health Services, Inc.
- Angel Harvey Family Health Center
- Asian American Health Coalition: dba Hope Clinic
- Asian Americans for Commu Involvement
- Bee Busy Wellness Center
- Benewah Medical Center
- Berks Community Health Center
- Betances Health Center, Inc.
- Cabun Rural Health Services, Inc.
- Capital Area Health Network
- Capitol City Family Health Center Dba: Care South
- Capstone Rural Health Center
- Care Resource
- Caring Hands Healthcare Centers, Inc.
- Central Counties Health Centers, Inc.
- Central Florida Health Care, Inc.
- Central VA Health Services, Inc.
- Centro de Salud de Lares
- Chambers Community Health Center
- Cherokee Health Systems
- Community Health Center of Southeastern IA
- Community Health Centers of Greater Dayton
- Community Health Systems, Inc.
- Community Hlth Ctrs of the Central Coast
- Community Medical Centers, Inc.,
- CommWell Health
- Duffy Health Center
- East Bay Community Action Program
- El Rio Santa Cruz Neighborhood Health Center, Inc.
- Erie Family Health Center, Inc.
- Flint Hills Community Health Center, Inc.
- Fordland Clinic, Inc
- Friend Family Health Center, Inc.
- Gardner Family Health Network, Inc.
- Generations Family Health Center, Inc.
- Genesee Community Health Center
- Greater Portland Health
- Health Ministries Clinic, Inc.
- Honor Health
- Howard Brown Health Center
- International Community Health Services
- Johnson Health Center
- Jordan Health
- Kansas City Care Clinic
- Katahdin Valley Health Center
- Kodiak Community Health Center
- La Casa De Salud, Inc.
- La Clinica de los Campesinos, Inc
- La Clinica Del Valle Family Health Care Center
- La Comunidad Hispana
- Lake County Health Department CHC
- Lamprey Health Care
- Lorain County Health & Dentistry
- Manatee County Rural Health Services, Inc.
- Mary's Center For Maternal And Child Care, Inc.
- Mat-Su Community Health Services
- MedNorth Health Center
- Mercy Health Services, Inc.
- Mid-Delta Health Systems, Inc.
- Molokai Community Health Center
- Native American Health Center, Inc
- Neighborhood Family Practice
- NEPA Community Health Care
- New Orleans AIDS Taskforce
- North Olympic Healthcare Network PC
- Northwest MI Health Services, Inc.
- Oak Orchard Health Center
- Partnership Health Center
- Peak Vista Community Health Centers
- PrimeCare Community Health, Inc
- PryMed
- Sadler Health Center Corporation
- San Fernando Community Hospital
- School Health Clinics of Santa Clara County
- Share Our Selves
- Shasta Community Health Center
- South of Market Health Center
- Southwest Community Health Center, Inc.
- Tandem Health
- TCA Health Inc, NFP
- The Health and Hospital Corporation
- The Wright Center for Community Health
- Union Community Health Center, Inc
- VIP Community Services
- West Cecil Health Center, Inc
- Whitney Young Health Center

# Health Center Toolkits

## April 20th

Join us for a special series that will walk-through this new resource. During it we will talk about an existing health center pilot program and how your health center can transform its virtual care.

# Quality Center Supports Health Center, PCA, & HCCN QI Professional Development

*through the Institute for Healthcare Improvement (IHI)*

100 scholarships to Open School:

- Year-long access to a catalog of online courses including 35 continuing education credits for nurses, physicians, and pharmacists.
- Can earn a **Basic Certificate in Quality and Safety**.

20 scholarships to *Psychology of Change* course:

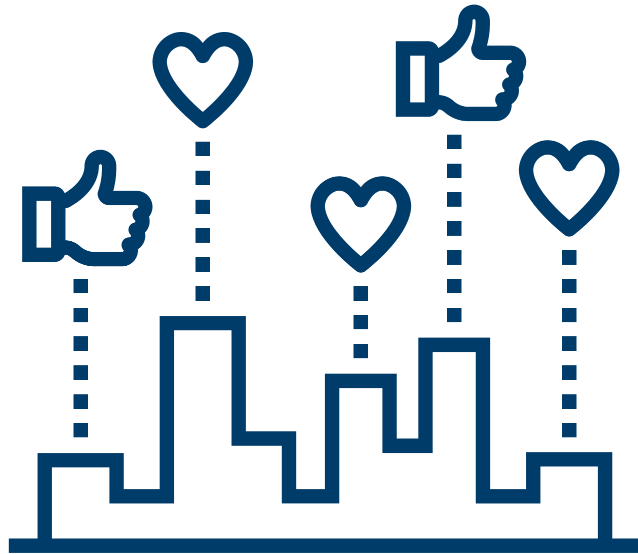
- 9-week virtual course
- Gain the adaptive leadership skills and tools you need to address the human side of change.

*Open to health centers that have completed 3+ VTF Assessments and PCAs/HCCNs/NTTAPs with 1+ staff who have completed a VTF.

# Our Contributors… Calling the Nation

Come Share!

bit.ly/Elevate2021Partnership



# Provide Us Feedback

## FOR MORE INFORMATION CONTACT:

qualitycenter@nachc.org

**Cheryl Modica**
**Director, Quality Center**
National Association of Community Health Centers
cmodica@nachc.org
301.310.2250

# Next Monthly Forum Call:

April 13th, 2021
1 -2 pm ET