NATIONAL ASSOCIATION OF Community Health Centers®

ELEVATE NATIONAL LEARNING FORUM

elevate

Applying the Value Transformation Framework to Evidence-Based Care: **Cancer Screening**

June 13, 2023

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.

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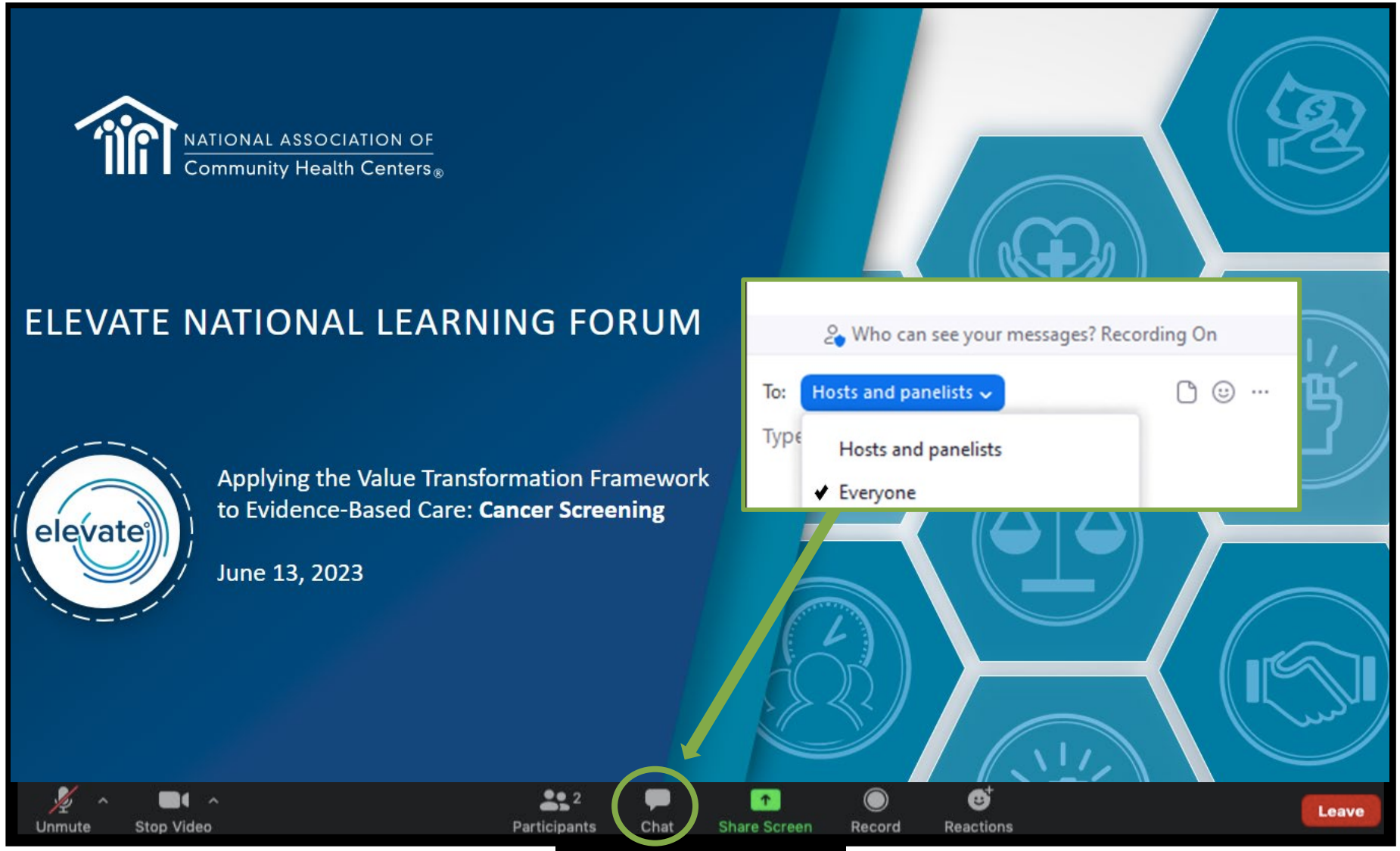


During today's session:

- **Questions:** Throughout the webinar, type your questions in the chat feature. Be sure to select "Everyone"! There will be Q&A and discussion at the end.
- **Resources:** If you have a tool or resource to share, let us know in the chat!

Agenda: Evidence-Based Care, Cancer Screening

- **Value Transformation Framework**
  - Organize Transformation Efforts Using the VTF
  - Continue Elevate Journey: Evidence-Based Care, Cancer Screening
- **Evidence-Based Care: Cancer Screening**
  - ‘What’, ‘Why’, ‘How’
  - Centers for Disease Control & Prevention: Cancer Screening Change Packages
  - Health Center perspective: Community Health of South Florida, Inc.
- **Q&A**
- **FREE Professional Development Opportunities**
  - QI staff, CHWs, CHW Supervisors, Care Managers, Care Manager Supervisors

Value Transformation Framework

The Value Transformation Framework (VTF) is ***an organizing framework*** to guide health center systems change

- ***Supports change*** in many parts of the health center simultaneously
- ***Organizes and distills evidence-based interventions*** for discrete parts of the systems called 'Change Areas'
- ***Incorporates evidence, knowledge, tools and resources*** relevant for action within different parts of the system, or Change Areas
- ***Links health center performance to the Quintuple Aim***

https://www.nachc.org/clinical-matters/value-transformation-framework/

Systems Approach: Elevate 2023

Supplemental Sessions

- Outreach and Enrollment Learning Collaborative
- National Diabetes Prevention Program – Basics for Health Centers
- Medicare Shared Savings Program Advance Investment Payment
- Brain Health Integration into Health Center Services

January

- Role of Leadership in Value-Based Transformation, with Attention to:
  - Cost
  - PCMH
  - Partnerships

February

- Population Health Management
  - Empanelment
  - Risk Stratification
  - Models of Care
- Role of Leadership in Population Health Strategy

March

- Optimizing Care Teams
- Extended Care Team: Enabling Services
- Providing Care Management
- Measuring Care Management Panel Data

April

- Optimizing Care Teams, with Attention to:
  - Improvement Strategy
  - Care Models
  - Workforce

May

- Improvement Strategy
- QI Case Study: Hypertension

June

- Evidence-Based Care: Cancer Screening

The Journey Continues:

Care Management

Payment & Value-Based Care

...and more!

Core Elevate Learning Forums

VTF: Evidence-Based Care

DOMAINS

INFRASTRUCTURE
- Improvement Strategy
- Health Information Technology (HIT)
- Policy
- Payment
- Cost

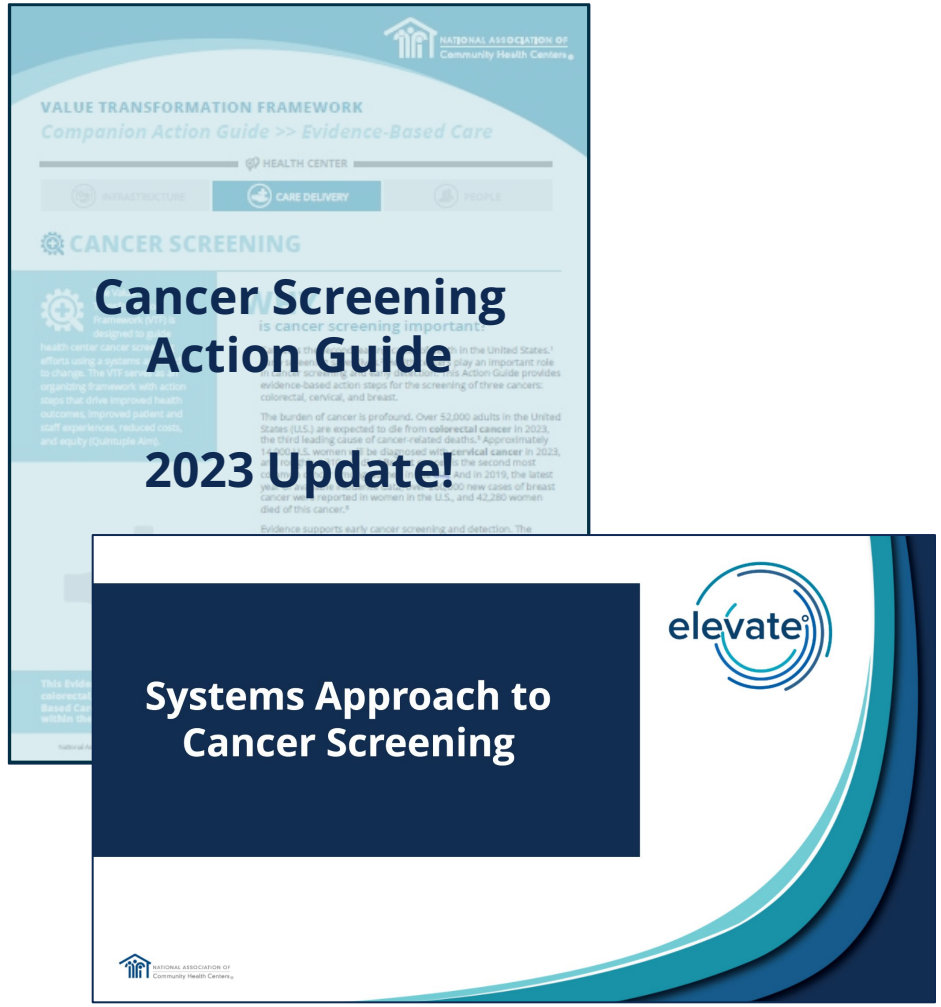
CARE DELIVERY
- Population Health Management
- Patient-Centered Medical Home
- Evidence-Based Care
- Care Coordination And Care Management
- Social Drivers Of Health

PEOPLE
- Patients
- Care Teams
- Governance And Leadership
- Workforce
- Partnerships

CHANGE AREAS

EVIDENCE-BASED CARE
Make patient care decisions using a process that integrates clinical expertise and best-practice research with patient values and self-care motivators.

RESOURCES



Systems Approach to Cancer Screening

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Systems Approach to Cancer Screening

WHAT?

WHY?

HOW?

WHAT is a systems approach to cancer screening?

Evidence-Based Care: Cancer Screening

Infrastructure

Care Delivery

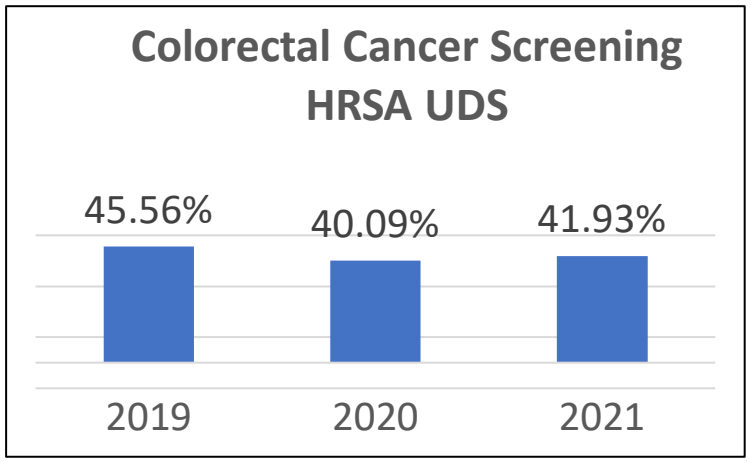
People

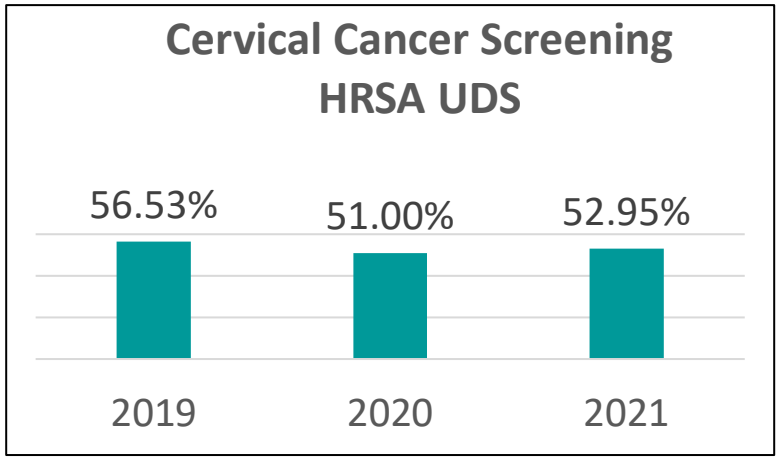
A systems approach to cancer screening requires attention to the **infrastructure**, **care delivery,** and **people** systems within the health center.

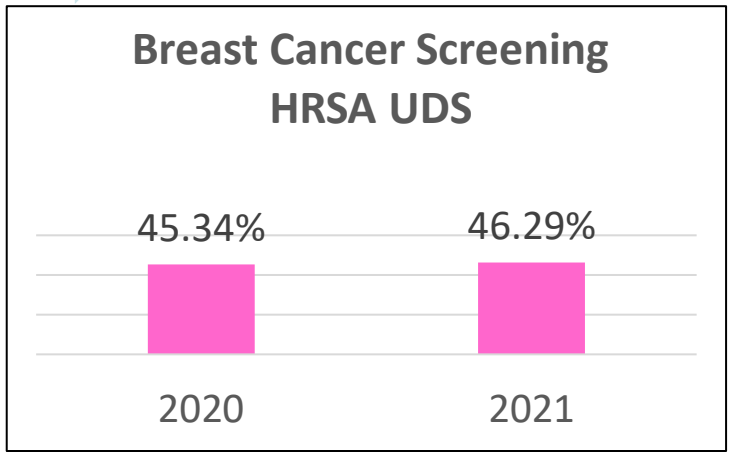
WHY a systems approach to cancer screening?

- Cancer burden is profound
- Screening and early detection saves lives
- Health centers play an important role in cancer screening and early detection

National screening rates have flatlined







https://data.hrsa.gov/tools/data-reporting/program-data/national

HOW to take a systems approach to cancer screening

A systems approach can also positively impact other performance areas:

- HTN control
- Diabetes control
- Weight management
- Depression
- ...and more!

STEP 1 Engage Leadership

STEP 2 Apply Population Health Management Strategies

STEP 3 Design Models of Care that Incorporate Evidence-Based Cancer Screening

STEP 4 Create/Update Clinical Policies and Standing Orders

STEP 5 Deploy Care Teams in New Ways

STEP 6 Optimize Health Information Systems as Part of a Whole Systems Improvement Strategy

STEP 7 Monitor task performance in dashboards

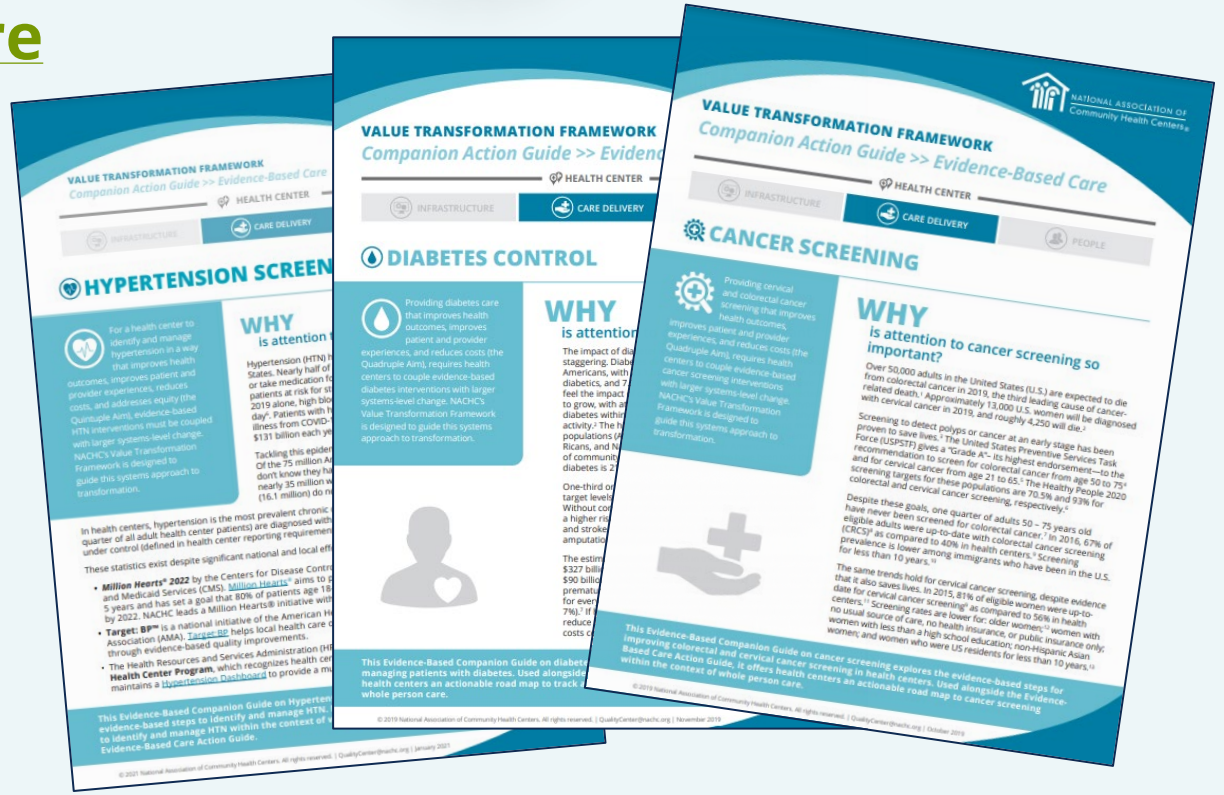
STEP 8 Engage Patients and Support Self-Management

STEP 9 Tailor Treatment for Social Context

STEP 10 Maximize Reimbursement

VTF Resource

Action Guide: Evidence-Based Care



Pair the Evidence-Based Care Action Guide with condition-specific companion guides to target specific clinical improvements within overall system improvements:

Cancer Screening Action Guide **Diabetes Control Action Guide**

HTN Screening & Control Action Guide

STEP 1

ENGAGE LEADERSHIP

Set cancer screening as a top **organizational priority**.

Leadership, in partnership with staff, should set short and long-term **targets for improvement**

Identify cancer screening **champion(s)**; consider a network of clinical champions (cancer screening, diabetes, hypertension, etc.) all working together to impact systems change

Establish a culture of quality. Provide **performance data and feedback** to staff as this has been shown to improve performance.

Join state, regional, or national initiatives (American Cancer Society's National Colorectal Roundtable Initiative's goal to achieve a CRCS rate of 80% or higher across the nation)

VTF Resource

NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

LEADERSHIP

WHY
is Leadership Critical to Transformation?

As healthcare moves from volume to value-based reimbursement, the business model and care model must connect and support one another. How a leader or governing body uses their position and knowledge to lead people, care delivery systems, and infrastructure is essential to reaching improvements in the Quintuple Aim: improved health outcomes, improved patient and staff experience, reduced costs, and improved equity. Leaders who embrace this shift early can advance their organization's efforts to deliver better care with more efficiency, gaining a competitive advantage. This Guide focuses on actions that leaders can take to create the environment, skills, and structure needed to support transformation.

LEADERSHIP

The Value Transformation Framework addresses how a health center leader or governing body uses their position, responsibility, and knowledge to lead people, care delivery processes and infrastructure to reach transformational goals. This Action Guide defines a discrete set of proven actions leaders can take to provide a foundation for organizational transformation.

WHAT
is Leadership's Role in Transformation?

Organizational transformation, and the shift to value-based care, requires health center leaders to develop organizational will, identify strategies and ideas to advance the organization, and take steps to execute change.[1] A key role in this process of Will-Ideas-Execution is providing the structure that allows for success[2]. Transformation requires leadership attention to the infrastructure, care delivery and people systems within the health center. While *leadership* encompasses such roles as administrators and the Board, this Action Guide is focused on steps that can be taken by the Chief Executive Officer in support of transformation. This begins with establishing a well communicated strategic vision for the organization and then translating that vision into an operational plan, with systems that can evolve as needed with bottom-up and top-down improvements. This requires a relentless focus on achieving the Quintuple Aim goals one step at a time. And while "leading" is critical to whole system change, one of the most important elements in this process of transformation is staff engagement and support[3,4].

Leaders can drive and inspire change by engaging the entire team and valuing ideas for improvement at all levels[5].

Action Guide: Leadership

STEP 2

APPLY POPULATION HEALTH MANAGEMENT STRATEGIES

Understand the impact of cancer in your community:

CDC's U.S. Cancer Statistics Data Visualizations Tool: compares cancer rates at the county level as well as at the congressional district, state, and national levels.

CDC's Quick Facts, CRCS: shows CRCS trends by year, state, race/ethnicity, insurance status, sex, and age.

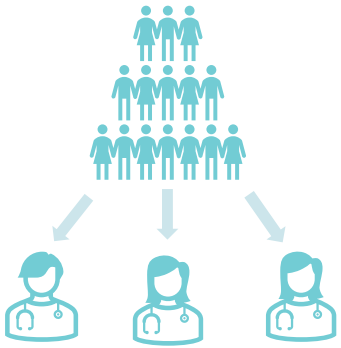
Agency for Healthcare Research and Quality (AHRQ)'s National Healthcare Quality and Disparities Reports: show each state's performance rates for a portfolio of measures, benchmarked against data from top-performing states.

STEP 2

APPLY POPULATION HEALTH MANAGEMENT STRATEGIES

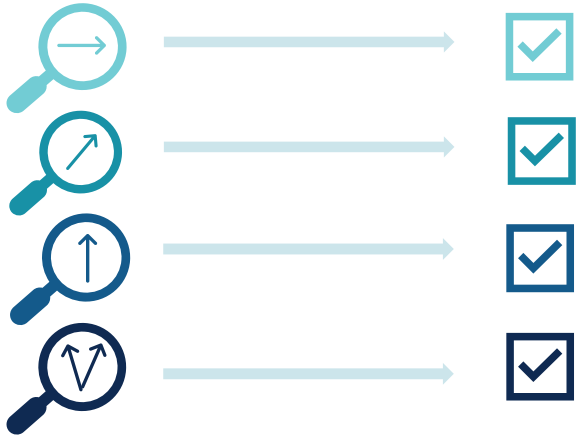
Empanelment

Matching every patient to a primary care provider and care team.



Risk Stratification

Segmenting patients into groups of similar complexity and care needs.

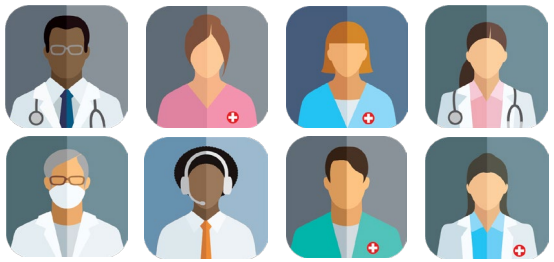


Models of Care

Care models based on risk for patients to be paired with more appropriate care team members and services.

Care Teams

Care teams and tasks are based on the needs of the patient population and the availability of personnel, services, and other resources.



Care Management

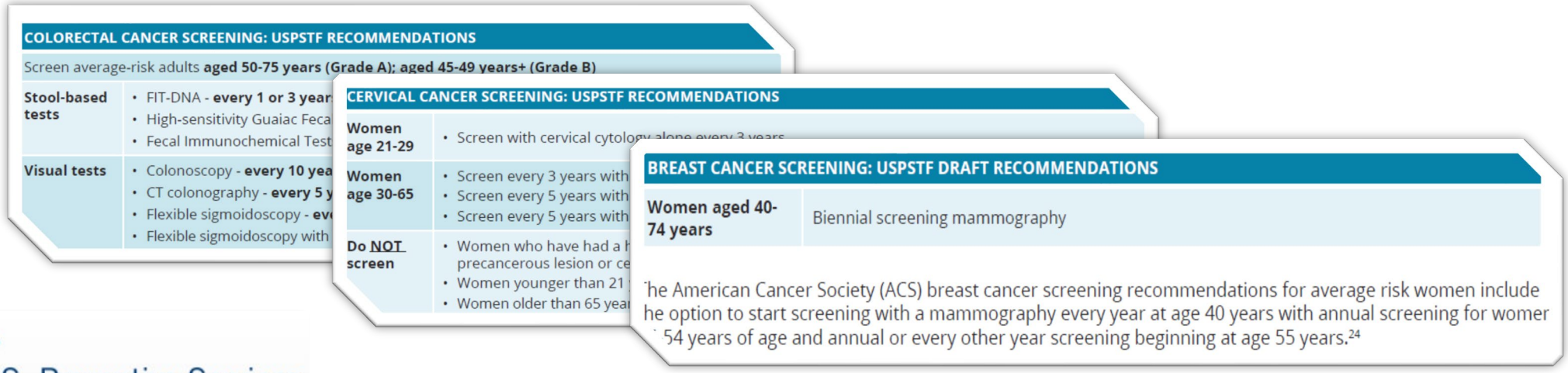
Intensive one-on-one services to individuals with complex health and social needs.

STEP 3

DESIGN CARE MODELS

LOW RISK | **RISING RISK** | **HIGH RISK** | **HIGHLY COMPLEX**

Use registries and care gap reports to identify and target patients for cancer screening within each risk group, and by age



COLORECTAL CANCER SCREENING: USPSTF RECOMMENDATIONS

Screen average-risk adults **aged 50-75 years (Grade A); aged 45-49 years+ (Grade B)**

Stool-based tests	• FIT-DNA - **every 1 or 3 year** • High-sensitivity Guaiac Feca • Fecal Immunochemical Test
Visual tests	• Colonoscopy - **every 10 yea** • CT colonography - **every 5 y** • Flexible sigmoidoscopy - **ev** • Flexible sigmoidoscopy with

CERVICAL CANCER SCREENING: USPSTF RECOMMENDATIONS

Women age 21-29	• Screen with cervical cytology alone every 3 years
Women age 30-65	• Screen every 3 years with • Screen every 5 years with • Screen every 5 years with
Do NOT screen	• Women who have had a h precancerous lesion or ce • Women younger than 21 • Women older than 65 yea

BREAST CANCER SCREENING: USPSTF DRAFT RECOMMENDATIONS

Women aged 40-74 years	Biennial screening mammography

'he American Cancer Society (ACS) breast cancer screening recommendations for average risk women include he option to start screening with a mammography every year at age 40 years with annual screening for womer 54 years of age and annual or every other year screening beginning at age 55 years.[24]

U.S. Preventive Services TASK FORCE

https://www.uspreventiveservicestaskforce.org/uspstf/

STEP 3

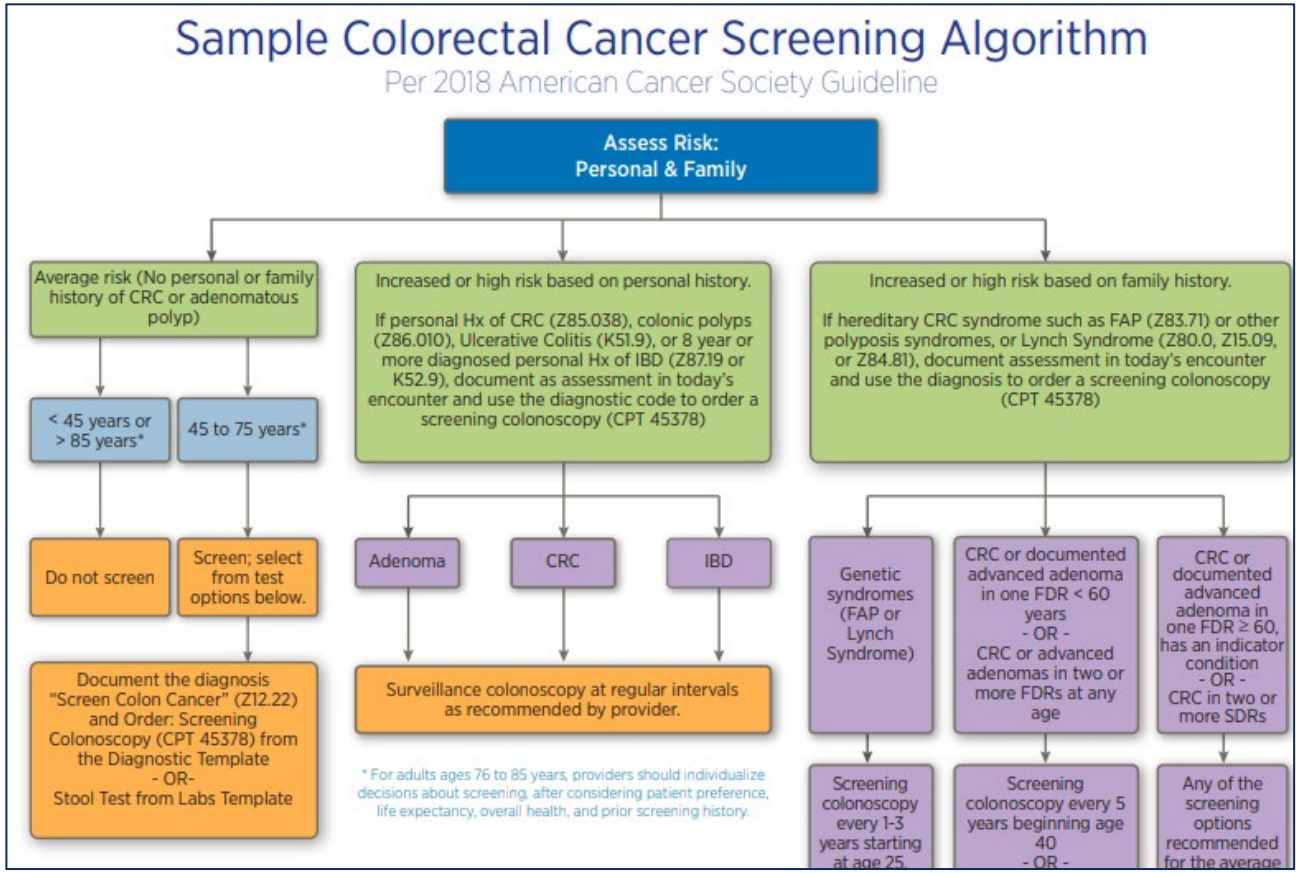
DESIGN CARE MODELS

Incorporate standardized workflows in care models:

Before the visit
- Empanelment
- Risk Stratification/Segmentation
- Registries & Gap Reports
- Health Information Exchange (HIE) Data

During the visit
- Care team roles
- Clinical protocols
- Standing orders
- Provider recommendation* (can be thru standing orders)
- Patient self-care guides/prevention checklists
- HIT/EHR clinical decision support; alerts

After the visit
- Referral and follow-up; closing the loop
- Documentation



https://nccrt.org/resource/sample-risk-assessment-screening-algorithm/

VTF Resource

Population Health Management Action Guides:

[Empanelment Action Guide](#) [Risk Stratification Action Guide](#)

[Models of Care Action Guide](#)

STEP 4

CREATE/UPDATE CLINICAL POLICIES AND STANDING ORDERS

Policies should:

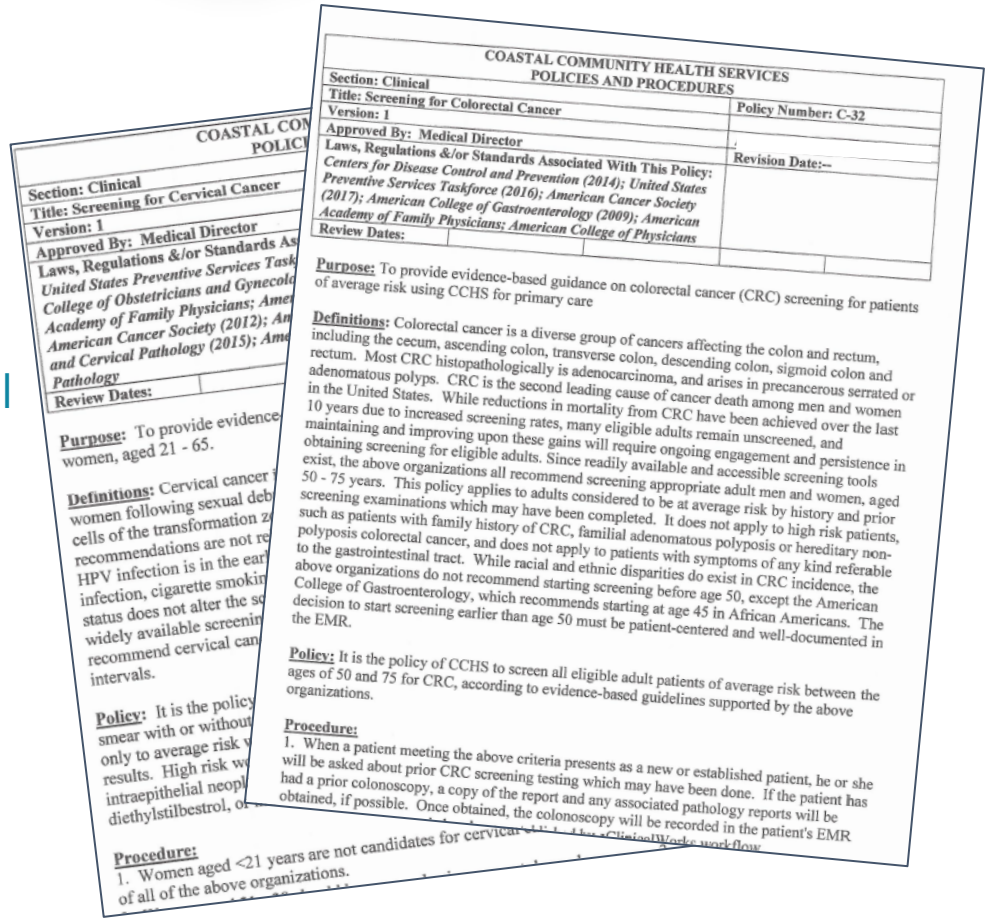
- ✓ Reflect current clinical guidelines
- ✓ Utilize evidence-based cancer screening tests
- ✓ Be constructed to address different risk levels

Standing orders can authorize certain staff to carry out medical orders (e.g., FIT test) per practice-approved protocols without a clinician's examination and can improve clinical measures.

Cancer Screening Guidelines include:

U.S. Preventive Services Task Force

American Cancer Society



COASTAL COMMUNITY HEALTH SERVICES
POLICIES AND PROCEDURES

Section: Clinical	
Title: Screening for Colorectal Cancer	Policy Number: C-32
Version: 1	
Approved By: Medical Director	
Laws, Regulations &/or Standards Associated With This Policy: *Centers for Disease Control and Prevention (2014); United States Preventive Services Taskforce (2016); American Cancer Society (2017); American College of Gastroenterology (2009); American Academy of Family Physicians; American College of Physicians*	Revision Date:--
Review Dates:	

Purpose: To provide evidence-based guidance on colorectal cancer (CRC) screening for patients of average risk using CCHS for primary care

Definitions: Colorectal cancer is a diverse group of cancers affecting the colon and rectum, including the cecum, ascending colon, transverse colon, descending colon, sigmoid colon and rectum. Most CRC histopathologically is adenocarcinoma, and arises in precancerous serrated or adenomatous polyps. CRC is the second leading cause of cancer death among men and women in the United States. While reductions in mortality from CRC have been achieved over the last 10 years due to increased screening rates, many eligible adults remain unscreened, and maintaining and improving upon these gains will require ongoing engagement and persistence in obtaining screening for eligible adults. Since readily available and accessible screening tools exist, the above organizations all recommend screening appropriate adult men and women, aged 50 - 75 years. This policy applies to adults considered to be at average risk by history and prior screening examinations which may have been completed. It does not apply to high risk patients, such as patients with family history of CRC, familial adenomatous polyposis or hereditary non-polyposis colorectal cancer, and does not apply to patients with symptoms of any kind referable to the gastrointestinal tract. While racial and ethnic disparities do exist in CRC incidence, the above organizations do not recommend starting screening before age 50, except the American College of Gastroenterology, which recommends starting at age 45 in African Americans. The decision to start screening earlier than age 50 must be patient-centered and well-documented in the EMR.

Policy: It is the policy of CCHS to screen all eligible adult patients of average risk between the ages of 50 and 75 for CRC, according to evidence-based guidelines supported by the above organizations.

Procedure:

1. When a patient meeting the above criteria presents as a new or established patient, he or she will be asked about prior CRC screening testing which may have been done. If the patient has had a prior colonoscopy, a copy of the report and any associated pathology reports will be obtained, if possible. Once obtained, the colonoscopy will be recorded in the patient's EMR

STEP 5:

DISTRIBUTE TASKS TO MEET CARE STANDARDS

Once a health center has agreed to a minimum set of care standards for each target group, **assign tasks** necessary to accomplish these standards to specific care team member roles. Create **proficiency checklists**.

Expand staff roles: include navigators, community health workers, care managers and others in team-based care

Create **exam room tools that summarize key care parameters** (e.g., recommended ages for all priority screenings, such as cancer, depression, blood pressure, etc.).

Use **daily huddles** that incorporate pre-visit planning (e.g., identifying care gaps in advance of patient visit, reminding patients of visit, etc.).

Implement **standing orders** to empower support staff to order or provide labs, referrals, and other services. Allow staff to **perform at the top of their licensure**.

Optimize HIT!

Consider which tasks can be delegated to technology. For example, use systems to send automated reminders and schedule services for care gaps so staff members can spend less time manually calling patients.

Determine which tasks can be completed remotely and which require staff to be at the health center in-person. Create policies and provide remote access for staff to connect to the EHR and work from home on designated tasks.

VTF Resource

Action Guide: Care Teams

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VALUE TRANSFORMATION FRAMEWORK

Action Guide

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. Developing an effective team-based model of care is at the heart of health center efforts to deliver on the Quintuple Aim: improved health outcomes, improved staff and provider experiences, lower costs, and improved equity.

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 in the context of a primary care visit, limits the quality of service delivered[3]. A reinvention of the care team model—with more responsibility given to supportive members of the care team—has proven to optimize the experience and outcomes of primary care for patients, providers, and staff[4]. In addition to improving service for chronic disease and preventive care, re-organizing care team roles can help address the widely-documented problem of primary care physician shortages[5,6,7].

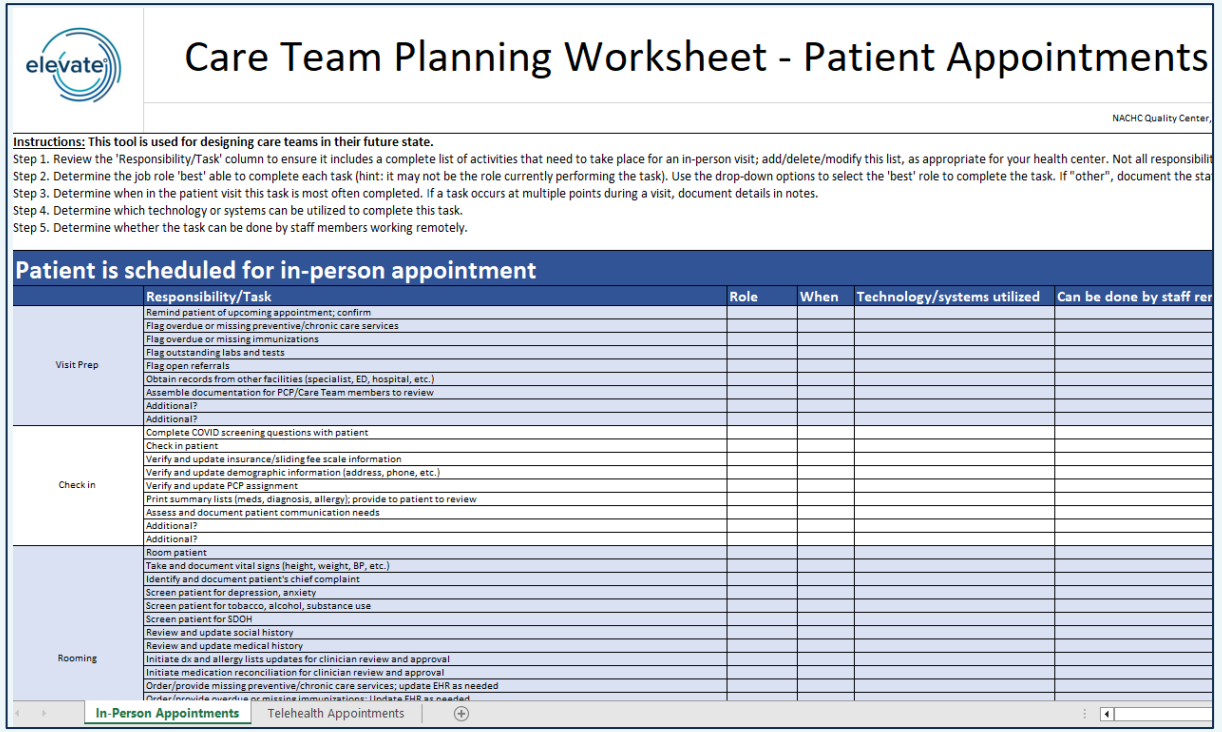
CARE TEAMS

The Value Transformation Framework addresses how health centers can 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 proven strategies to develop effective health center care teams.

Ultimately, patient care is a team sport. All members of the health center team are accountable for the delivery of high quality care to patients. Patient engagement, also crucial to care, is addressed in the Patient Engagement Action Guide.

While many health centers report using a team-based approach to care, these systems may not be functioning optimally to achieve desired outcomes. This Action Guide offers steps to more effectively distribute, or share, responsibility and accountability across health center care teams.

"Sharing the care involves both a paradigm shift and a concrete strategy for increasing capacity. The paradigm (culture) shift transforms the practice from an "I" to a "we" mindset. Unlike the lone-doctor-with-helpers model, in which the physician assumes all responsibility, makes all decisions, and delegates tasks to team members [but cannot increase capacity], the "we" paradigm uses a team comprising clinicians and non-clinicians to provide care to a patient panel, with a reallocation of responsibilities, not only tasks, so that all team members contribute meaningfully to the health of their patient panel."[8]



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Care Team Planning Worksheet - Patient Appointments

NACHC Quality Center,

Instructions: This tool is used for designing care teams in their future state.

Step 1. Review the 'Responsibility/Task' column to ensure it includes a complete list of activities that need to take place for an in-person visit; add/delete/modify this list, as appropriate for your health center. Not all responsibilit

Step 2. Determine the job role 'best' able to complete each task (hint: it may not be the role currently performing the task). Use the drop-down options to select the 'best' role to complete the task. If "other", document the sta

Step 3. Determine when in the patient visit this task is most often completed. If a task occurs at multiple points during a visit, document details in notes.

Step 4. Determine which technology or systems can be utilized to complete this task.

Step 5. Determine whether the task can be done by staff members working remotely.

Patient is scheduled for in-person appointment

	Responsibility/Task	Role	When	Technology/systems utilized	Can be done by staff rer
Visit Prep	Remind patient of upcoming appointment; confirm				
	Flag overdue or missing preventive/chronic care services				
	Flag overdue or missing immunizations				
	Flag outstanding labs and tests				
	Flag open referrals				
	Obtain records from other facilities (specialist, ED, hospital, etc.)				
	Assemble documentation for PCP/Care Team members to review				
	Additional?				
	Additional?				
Check in	Complete COVID screening questions with patient				
	Check in patient				
	Verify and update insurance/sliding fee scale information				
	Verify and update demographic information (address, phone, etc.)				
	Verify and update PCP assignment				
	Print summary lists (meds, diagnosis, allergy); provide to patient to review				
	Assess and document patient communication needs				
	Additional?				
	Additional?				
Rooming	Room patient				
	Take and document vital signs (height, weight, BP, etc.)				
	Identify and document patient's chief complaint				
	Screen patient for depression, anxiety				
	Screen patient for tobacco, alcohol, substance use				
	Screen patient for SDOH				
	Review and update social history				
	Review and update medical history				
	Initiate dx and allergy lists updates for clinician review and approval				
	Initiate medication reconciliation for clinician review and approval				
	Order/provide missing preventive/chronic care services; update EHR as needed				
	Order/provide overdue or missing immunizations; Update EHR as needed				

In-Person Appointments | Telehealth Appointments

Care Team Planning Worksheet: a tool to aid in the process of distributing tasks. Considers job role 'best' able to complete a task, technology, in-person vs remote and primary vs back-up.

STEP 6

OPTIMIZE HEALTH INFORMATION SYSTEMS AS PART OF IMPROVEMENT STRATEGY

Evidence-Based Care: Cancer Screening

- **Leadership**
- **Population Health Management**
- **Care Teams**
- **Workforce**
- **Improvement Strategy**

  Optimize Health Information Systems

A systems approach to cancer screening requires attention to the **infrastructure**, **care delivery,** and **people** systems within the health center.

STEP 6

OPTIMIZE HEALTH INFORMATION SYSTEMS AS PART OF IMPROVEMENT STRATEGY

Create guidance on how to document cancer (and other) screenings within **structured fields** in the EHR.

Documentation should include components for:

- ✓ Tests/screenings that were performed
- ✓ Referrals made
- ✓ Tracking test results and follow-up

If your EHR does not allow you to track test distribution and returns, set up a simple tracking log, and assign staff to regularly review and recall patients who have not completed a screening test.

Configure your EHR/PHM system to create Gap Reports – to identify needed preventive health screenings.

Implement automated reminders in the EHR to prompt the clinical team.

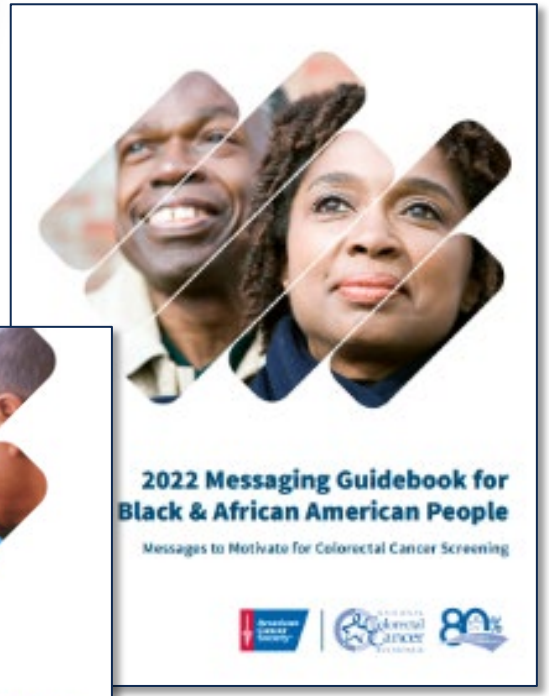
Helpful Resources:

1. Colorectal Cancer Screening and Risk Assessment Workflow: Documentation Guide for Health Center NextGen Users developed by NACHC
2. EHR Best Practice Workflow And Documentation Guide To Support Colorectal Cancer Screening Improvement With EClinicalWorks developed by the Health Center Network of New York with support from NACHC, ACS, and the National Association of Chronic Disease Directors

STEP 7

ENGAGE PATIENTS AND SUPPORT SELF-MANAGEMENT

- ✓ Engage and educate patients about the importance of regular cancer screening.
- ✓ Offer patient education materials in multiple languages, at appropriate literary levels, with translators available, as needed.
- ✓ Provide materials that use pictures and visuals, rather than words, is also important.
- ✓ For CRCS, consider creating a mock stool test demonstration that can be used to instruct patients and for patients to demonstrate the technique via teach-back.
- ✓ Use telephone and text messaging systems to emphasize provider recommendations and remind patients



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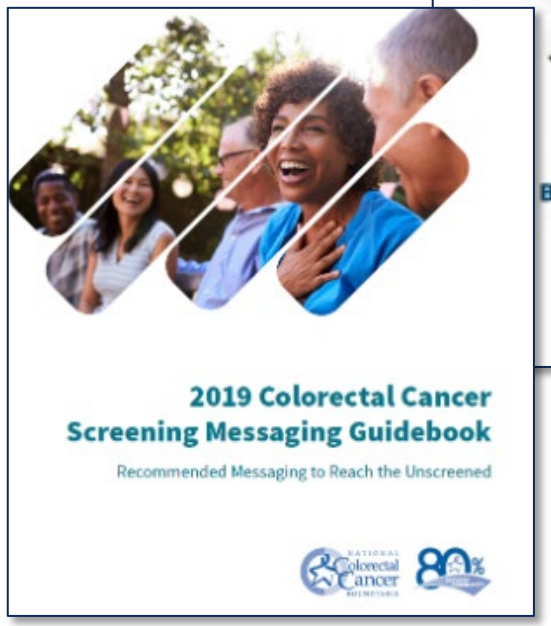
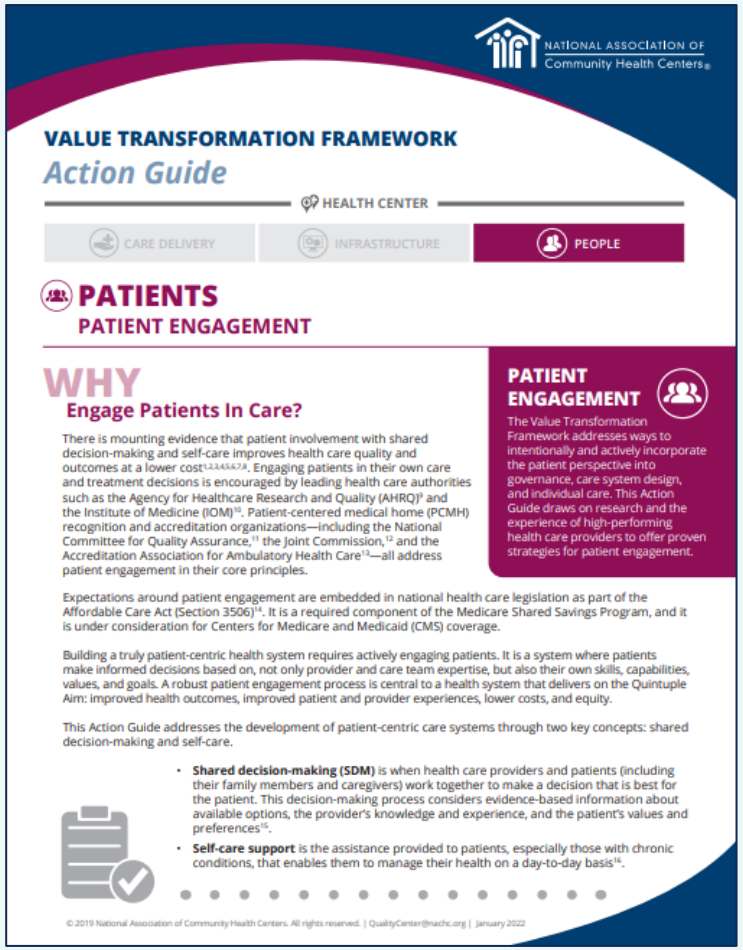


Download here

susan g. komen® PATIENT NAVIGATION TRAINING PROGRAM

Navigation training link

VTF Resource



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VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

PATIENTS

PATIENT ENGAGEMENT

WHY

Engage Patients In Care?

There is mounting evidence that patient involvement with shared decision-making and self-care improves health care quality and outcomes at a lower cost[1,2,3,4,5,6,7,8]. Engaging patients in their own care and treatment decisions is encouraged by leading health care authorities such as the Agency for Healthcare Research and Quality (AHRQ)[9] and the Institute of Medicine (IOM)[10]. Patient-centered medical home (PCMH) recognition and accreditation organizations—including the National Committee for Quality Assurance,[11] the Joint Commission,[12] and the Accreditation Association for Ambulatory Health Care[13]—all address patient engagement in their core principles.

PATIENT ENGAGEMENT

The Value Transformation Framework addresses ways to intentionally and actively incorporate the patient perspective into governance, care system design, and individual care. This Action Guide draws on research and the experience of high-performing health care providers to offer proven strategies for patient engagement.

Expectations around patient engagement are embedded in national health care legislation as part of the Affordable Care Act (Section 3506)[14]. It is a required component of the Medicare Shared Savings Program, and it is under consideration for Centers for Medicare and Medicaid (CMS) coverage.

Building a truly patient-centric health system requires actively engaging patients. It is a system where patients make informed decisions based on, not only provider and care team expertise, but also their own skills, capabilities, values, and goals. A robust patient engagement process is central to a health system that delivers on the Quintuple Aim: improved health outcomes, improved patient and provider experiences, lower costs, and equity.

This Action Guide addresses the development of patient-centric care systems through two key concepts: shared decision-making and self-care.

- **Shared decision-making (SDM)** is when health care providers and patients (including their family members and caregivers) work together to make a decision that is best for the patient. This decision-making process considers evidence-based information about available options, the provider's knowledge and experience, and the patient's values and preferences[15].
- **Self-care support** is the assistance provided to patients, especially those with chronic conditions, that enables them to manage their health on a day-to-day basis[16].

Action Guide: Patient Engagement

STEP 7

ENGAGE PATIENTS AND SUPPORT SELF-MANAGEMENT

Patient:_____ Date: _____

IMPORTANT

As a ***woman aged 50-75 years of age***, your doctor wants you to receive the following screenings based upon the *BEST MEDICAL information. Be sure to ask your doctor, nurse practitioner or physician assistant at today's visit to check if you need the tests which can ***save your life*** ☺.

ROUTINE CARE:

- Blood Pressure
- Depression screening
- Weight screening and counseling for better weight control
- Screening for use of aspirin or a cholesterol lowering medication to prevent heart disease

CANCER SCREENINGS:

- Breast cancer (mammogram every 1-2 years)
- Cervical cancer (Pap test every 3 years for women aged 21-65 years or every 5 years for women aged 30-65 who get an HPV test alone or HPV test in combination with Pap test).
- Colon cancer (women aged 45-75 years; FIT test annually or other screening/ diagnostic tests and frequencies depending on risk. 75+ depending on provider recommendation and provider preference).

BLOOD TESTS:

- HbA1c for diabetes
- Hepatitis C screening
- HIV
- Diseases transmitted through sexual activity

LIFESTYLE:

- Tobacco use
- Alcohol use
- Relationship violence

*BEST MEDICAL INFORMATION/RESEARCH: US Preventive Services Task Force (USPSTF):

- Aspirin Use in some adults 50-59 years can lower your risk for heart attack, stroke and colorectal cancer. Drugs that lower cholesterol may be used in some adults 40-75 years of age with risk factors to prevent cardiovascular disease. Check with your doctor before taking aspirin or any medication
- Cervical Cancer screening recommended through age 65 years.
- Blood glucose monitoring recommended in overweight adults 40-70 years of age.
- Hepatitis C one-time monitoring or additional screening as needed.
- HIV Screening through 65 years of age.

STEP 8

DEVELOP/ENHANCE COMMUNITY PARTNERSHIPS

Use Formal Referral Arrangements to create colonoscopy referral network:

Calculate the health center's need for colonoscopy

- American Cancer Society Steps for Increasing Colorectal Cancer Screening Rates: A Manual for Community Health Centers, page 17 provides calculation assistance

Identify area endoscopists

Reach out to area endoscopists; request partnerships

- Consider direct referral agreements

Formalize endoscopist partnership agreements and expectations

- Standardized Colonoscopy Reporting and Data System (CO-RADS) Recommendations: pre-, intra-, and post-procedure elements to be documented in colonoscopy report.
- Evidence-based colonoscopy follow-up: results and any implications, next steps/treatments, timing of next screening based upon results.
- Monitor colonoscopy procedure quality: adenoma detection rate (≥30% male screening; ≥20% female screening), cecal intubation rate, quality of bowel prep, use of appropriate intervals for screening and surveillance.

STEP 8

DEVELOP/ENHANCE COMMUNITY PARTNERSHIPS

HRSA Form 5A **outlines service requirements for various types of partnerships in support of cancer screening and other services.**

Requirements include **screening for breast, cervix, and colorectal cancers (e.g., mammography, Pap testing, fecal occult blood testing, sigmoidoscopy, colonoscopy)**.

Health centers utilize one or more of the following three delivery methods to provide a service:

1. **Direct (Health Center Pays):** Services provided directly by the health center and for which the health center pays and bills.

2. **Formal Written Contract/Agreement (Health Center Pays):** Services provided on behalf of the health center by another entity via a formal written contract/agreement, where the health center is accountable for paying and/or billing for the direct care provided via the agreement.

3. **Formal Written Referral Arrangement (Health Center Does NOT Pay):** Services provided by an entity other than the health center, with which the health center has a formal written referral arrangement (e.g., MOU, MOA, or other formal written arrangement). The actual service is provided and paid/billed for by the other entity (the referral provider).

https://bphc.hrsa.gov/compliance/compliance-manual/chapter4

STEP 9

TAILOR TREATMENT FOR SOCIAL CONTEXT

- ✓ Assess patients' potential food insecurity, housing instability, financial and other social drivers of health (SDOH)
- ✓ Apply information to treatment decisions
- ✓ Link to more targeted services, such as care coordination, care management or other follow-up services
- ✓ Refer patients to community resources, as appropriate.
- ✓ For patients diagnosed with cancer, develop an inventory of community resources that may provide assistance during treatment such as familyreach.org, which serves patients facing hardship after a cancer diagnosis.

VTF Resource

NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

INFRASTRUCTURE | CARE DELIVERY | PEOPLE

SOCIAL DRIVERS OF HEALTH

WHY
consider the Social Drivers of Health?

Health centers, by virtue of their mission and model, play a pivotal role in addressing Social Drivers of Health (SDOH) among medically underserved patients nationwide. Signed into law in 1964 as part of President Lyndon B. Johnson's 'war on poverty', health centers serve patients and communities at greater risk of preventable chronic and other diseases[1-3].

Social drivers of health are the conditions in which people are born, grow, work, live, and age. SDOH are non-medical conditions that include social, economic, physical, or other factors present in people's lives. These factors have been found to directly influence health, functioning, and quality of life outcomes and risks[4-12].

Research shows that social drivers, also called social risks, may have a greater influence on health and health equity than lifestyle choices or health care, with some studies suggesting that SDOH may account for 30-55% of health outcomes[13].

The movement of health systems toward value-based care provides significant opportunities to address SDOH while improving value and quality of care[14]. Value-based care is a potentially important financing mechanism for SDOH services with opportunities for long-term sustainability and population health improvements[14].

SOCIAL DRIVERS OF HEALTH

The Value Transformation Framework addresses how health centers can use a systematic process to address the social, economic, and environmental circumstances that influence patients' health and the care they receive. This Action Guide offers a set of action steps health centers can take to integrate social risk assessment and interventions as part of organizational transformation.

WHAT
can health centers do to address social risk?

SDOH include such factors as income, education, employment, food, housing, and social inclusion and non-discrimination. Healthy People 2030 groups SDOH into 5 domains[4]:

- Economic stability
- Education access and quality
- Health care access and quality
- Neighborhood and built environment
- Social and community context

Action Guide: Social Drivers of Health

STEP 10

MAXIMIZE REIMBURSMENET

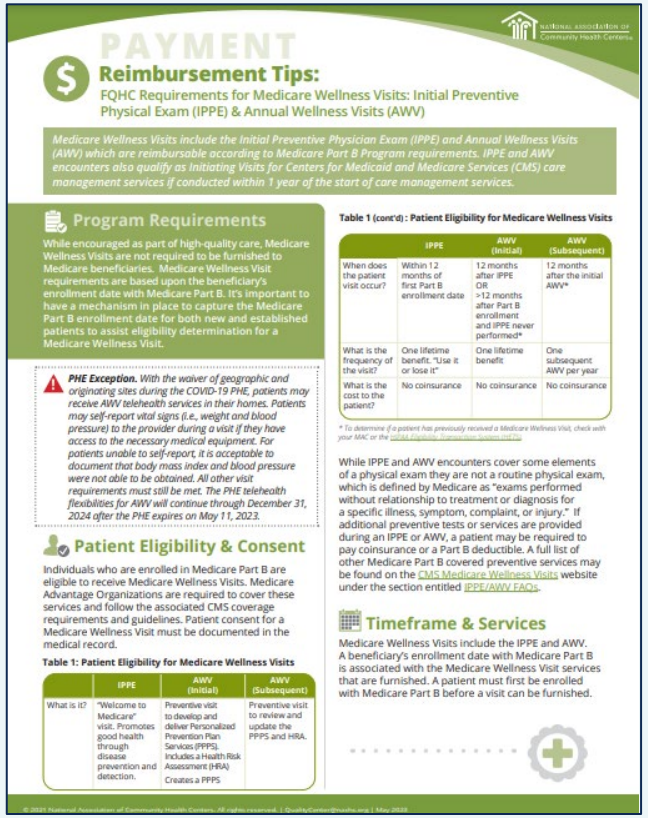
Reimbursement opportunities exist outside of the prospective-payment system (PPS), including:

Medicare Care Management Services

Additional reimbursement may also be available in your state from Medicaid, health home initiatives, or other payers.

VTF Resource

Reimbursement Tip Sheets



PAYMENT

Reimbursement Tips:

FQHC Requirements for Medicare Wellness Visits: Initial Preventive Physical Exam (IPPE) & Annual Wellness Visits (AWV)

Medicare Wellness Visits include the Initial Preventive Physician Exam (IPPE) and Annual Wellness Visits (AWV) which are reimbursable according to Medicare Part B Program requirements. IPPE and AWV encounters also qualify as Initiating Visits for Centers for Medicaid and Medicare Services (CMS) care management services if conducted within 1 year of the start of care management services.

Program Requirements

While encouraged as part of high-quality care, Medicare Wellness Visits are not required to be furnished to Medicare beneficiaries. Medicare Wellness Visit requirements are based upon the beneficiary's enrollment date with Medicare Part B. It's important to have a mechanism in place to capture the Medicare Part B enrollment date for both new and established patients to assist eligibility determination for a Medicare Wellness Visit.

PHE Exception. *With the waiver of geographic and originating sites during the COVID-19 PHE, patients may receive AWV telehealth services in their homes. Patients may self-report vital signs (i.e., weight and blood pressure) to the provider during a visit if they have access to the necessary medical equipment. For patients unable to self-report, it is acceptable to document that body mass index and blood pressure were not able to be obtained. All other visit requirements must still be met. The PHE telehealth flexibilities for AWV will continue through December 31, 2024 after the PHE expires on May 11, 2023.*

Patient Eligibility & Consent

Individuals who are enrolled in Medicare Part B are eligible to receive Medicare Wellness Visits. Medicare Advantage Organizations are required to cover these services and follow the associated CMS coverage requirements and guidelines. Patient consent for a Medicare Wellness Visit must be documented in the medical record.

Table 1: Patient Eligibility for Medicare Wellness Visits

	IPPE	AWV (Initial)	AWV (Subsequent)
What is it?	"Welcome to Medicare" visit. Promotes good health through disease prevention and detection.	Preventive visit to develop and deliver Personalized Prevention Plan Services (PPPS). Includes a Health Risk Assessment (HRA) Creates a PPPS	Preventive visit to review and update the PPPS and HRA.

Table 1 (cont'd) : Patient Eligibility for Medicare Wellness Visits

	IPPE	AWV (Initial)	AWV (Subsequent)
When does the patient visit occur?	Within 12 months of first Part B enrollment date	12 months after IPPE OR >12 months after Part B enrollment and IPPE never performed*	12 months after the initial AWV*
What is the frequency of the visit?	One lifetime benefit. "Use it or lose it"	One lifetime benefit	One subsequent AWV per year
What is the cost to the patient?	No coinsurance	No coinsurance	No coinsurance

* To determine if a patient has previously received a Medicare Wellness Visit, check with your MAC or the eMDA Eligibility Transaction System (EligTx).

While IPPE and AWV encounters cover some elements of a physical exam they are not a routine physical exam, which is defined by Medicare as "exams performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury." If additional preventive tests or services are provided during an IPPE or AWV, a patient may be required to pay coinsurance or a Part B deductible. A full list of other Medicare Part B covered preventive services may be found on the CMS Medicare Wellness Visits website under the section entitled IPPE/AWV FAQs.

Timeframe & Services

Medicare Wellness Visits include the IPPE and AWV. A beneficiary's enrollment date with Medicare Part B is associated with the Medicare Wellness Visit services that are furnished. A patient must first be enrolled with Medicare Part B before a visit can be furnished.

Care Management Action Guide

NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

CARE MANAGEMENT

WHY

Use Care Management with High-Risk Patients?

Value-based care requires health care organizations to better control the clinical and financial risks associated with high-risk patients. A systematic process for managing the care of high-risk patients, using proven interventions in a supportive one-on-one environment, has been shown to improve health outcomes[1,2,3]. High-risk patients, by definition, have multiple health needs often compounded by complex social and other issues. These patients are at risk for poor health outcomes, inadequate quality of care, and increased costs [4,5,6]. The Centers for Medicare and Medicaid Services (CMS) recognizes care management as a critical tool to achieve the Quadruple Aim: improved health outcomes, improved patient and staff experiences, lower costs, and improved equity[7].

This Action Guide provides the steps to start a health center care management program for high-risk patients. The outlined recommendations meet the requirements of Chronic Care Management (CCM) services defined by CMS and, therefore, are eligible for reimbursement.

CARE MANAGEMENT

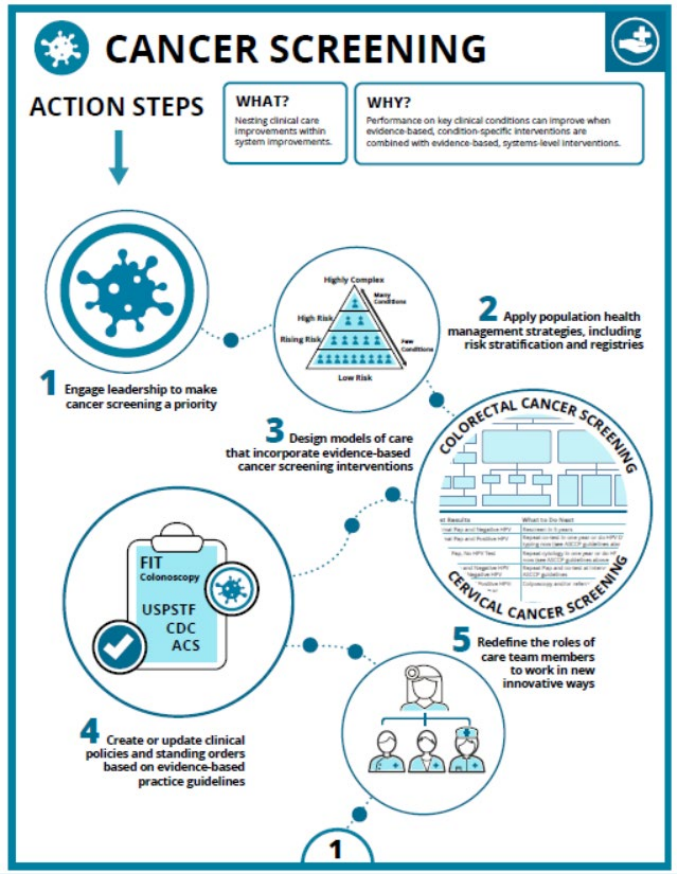
The Value Transformation Framework addresses how health centers can effectively deliver and coordinate care and manage high-risk and other subgroups of patients with more targeted services. This Action Guide outlines steps health centers can take to develop a comprehensive care management program for high-risk patients that meets the requirements for reimbursement from the Centers for Medicare and Medicaid Services (CMS).

WHAT

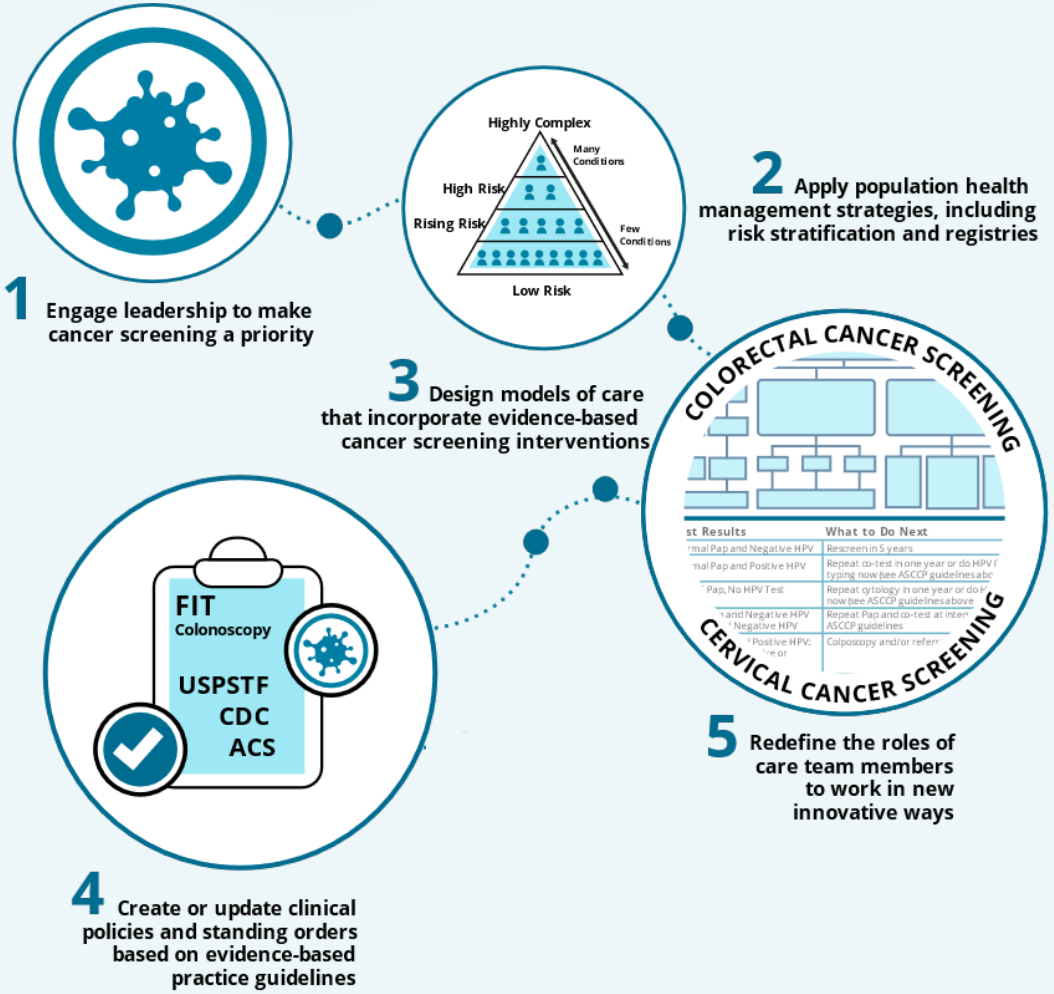
Does a High-Risk Care Management Model Look Like?

High-risk care management involves intensive, one-on-one services, provided by a nurse or other health worker, to individuals with complex health and social needs. The formal design of a health center care management program can ensure a standardized approach to managing high-risk patients by a care manager. The model discussed in this Action Guide is based on a nurse in the role of care manager. Other staffing models can be employed with some modification. Key components of care management include: identifying and engaging high-risk individuals, providing a comprehensive assessment, creating an individual care plan, engaging in patient education, monitoring clinical conditions, and coordinating needed services[8,9,10].

VTF Resource



https://bit.ly/VTF_EBC_Cancer-graph



Featured Speaker

Stephanie Melillo, MPH
Health Scientist
Division of Cancer Prevention and Control
Centers for Disease Control & Prevention

Stephanie Melillo joined the Division of Cancer Prevention and Control at the Centers for Disease Control and Prevention as a Health Scientist in 2011. She is a member of the evaluation team, translating research findings into practical resources for CDC's screening program award recipients and other public health professionals. She has worked with the Community Preventive Services Task Force in various capacities since 2004 and draws on this experience to inform the way CDC thinks about the implementation of evidence-based recommendations.

Cancer Prevention Works

Cancer Screening Change Packages

Taking Action. Saving Lives.

Stephanie Melillo, MPH

NACHC Elevate Learning webinar
June 13, 2023

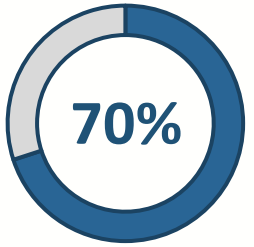
Federally Qualified Health Centers (FQHCs) Vital to Population Health

NATIONAL ASSOCIATION OF Community Health Centers®

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

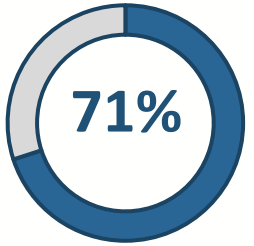
Federally Qualified Health Centers Partnered with CDC*

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)



= 472 clinics

Colorectal Caner Control Program (CRCCP)

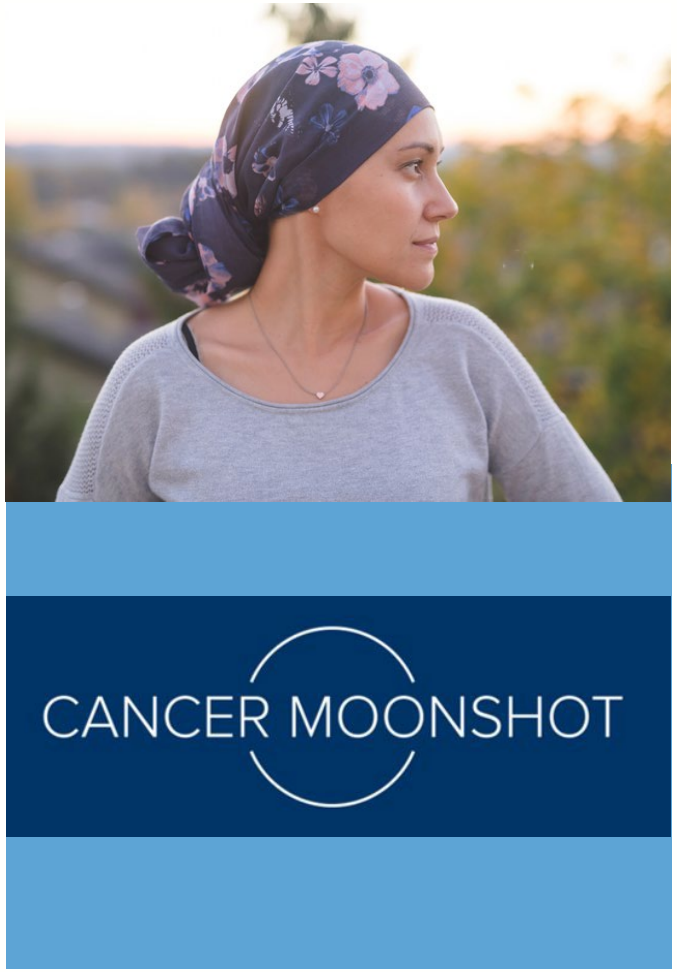


= 594 clinics

Source: Clinic data submission, March 2021

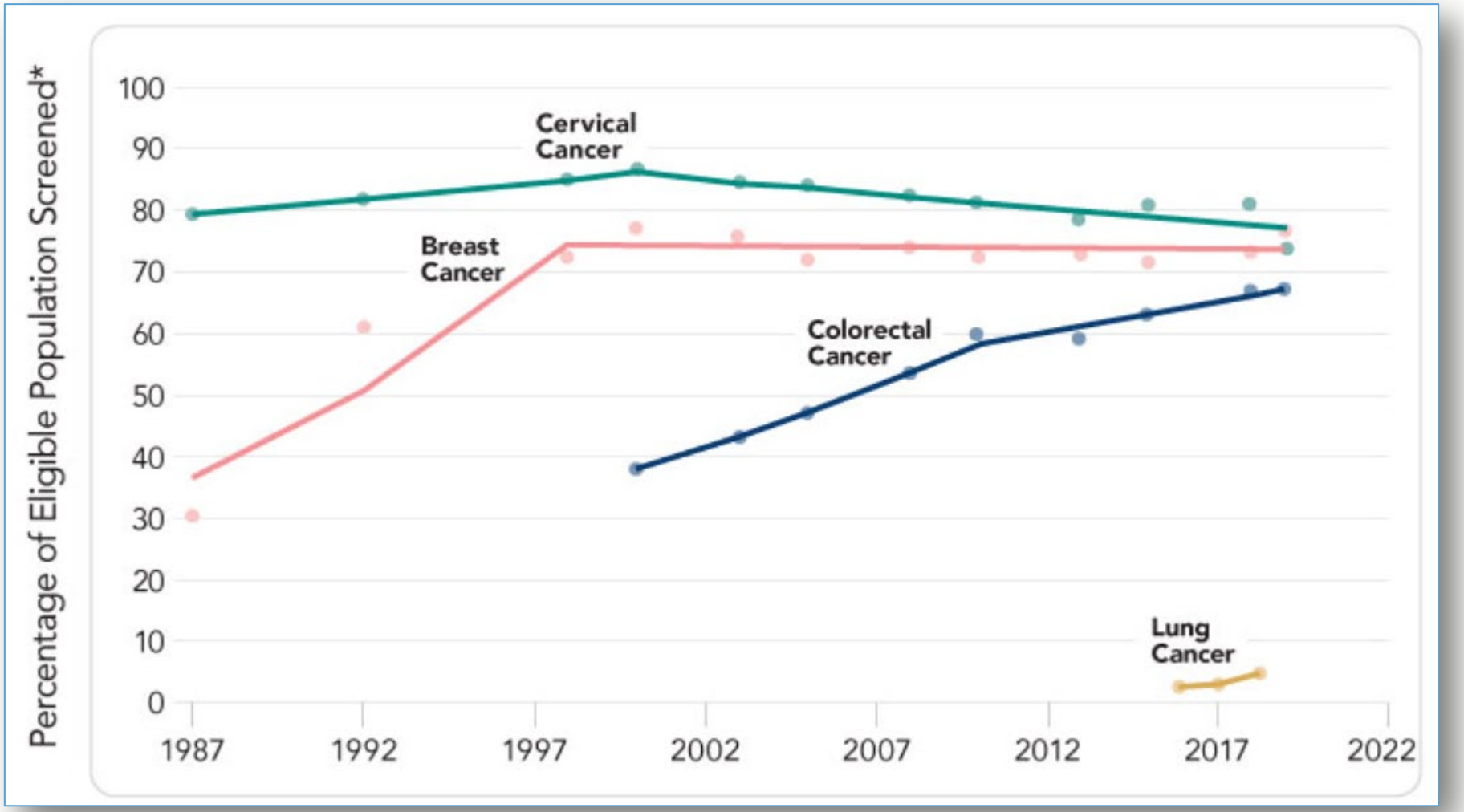
Cancer Moonshot 2.0 Priorities

- Close the screening gap
- Understand and address environmental and toxic exposures
- Decrease the impact of preventable cancers
- Bring cutting edge research through the pipeline to patients
- Improve the experiences for patients and caregivers



Source: White House, Fact Sheet: President Biden Reignites Cancer Moonshot to End Cancer as We Know It

Despite Gains, Progress Still to Be Made

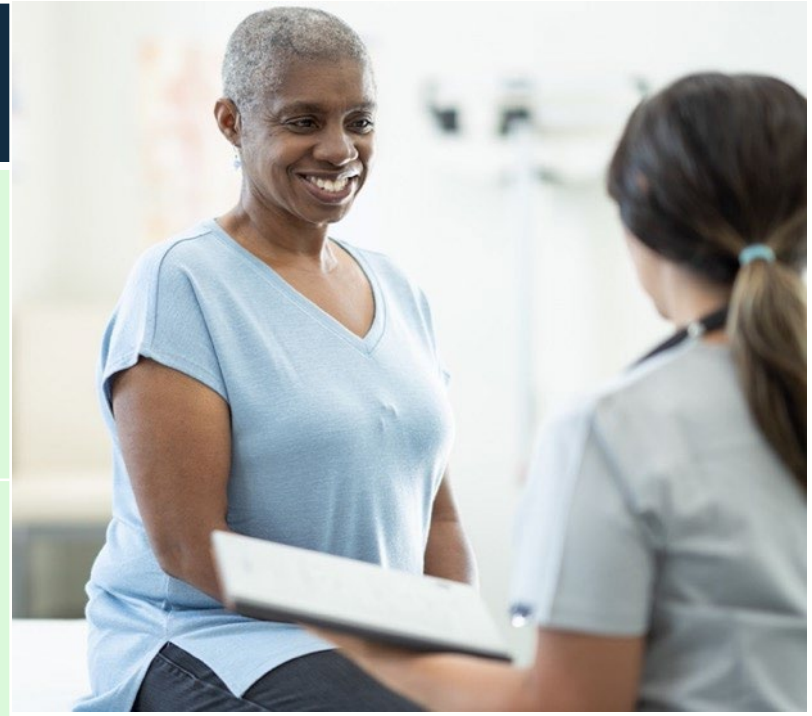


Source: President's Cancer Panel, Cancer Screening in the United States: Challenges and Opportunities

Cancer Screening Tests

U.S. Preventive Services TASK FORCE

Grade	Definition	Recommendation
A	High certainty that the net benefit is substantial	Offer or provide this service
B	High certainty that the net benefit is moderate or moderate certainty that net benefit is moderate to substantial	Offer or provide service



Source: uspreventiveservicestaskforce.org/Page/Name/grade-definitions

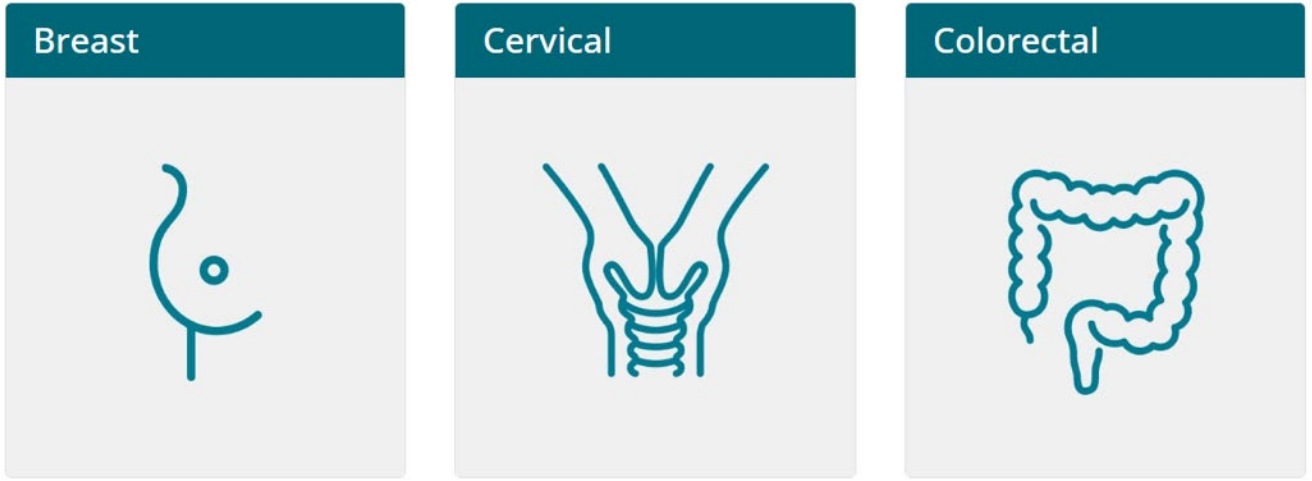
CDC Cancer Screening Change Packages

Taking Action. Saving Lives.

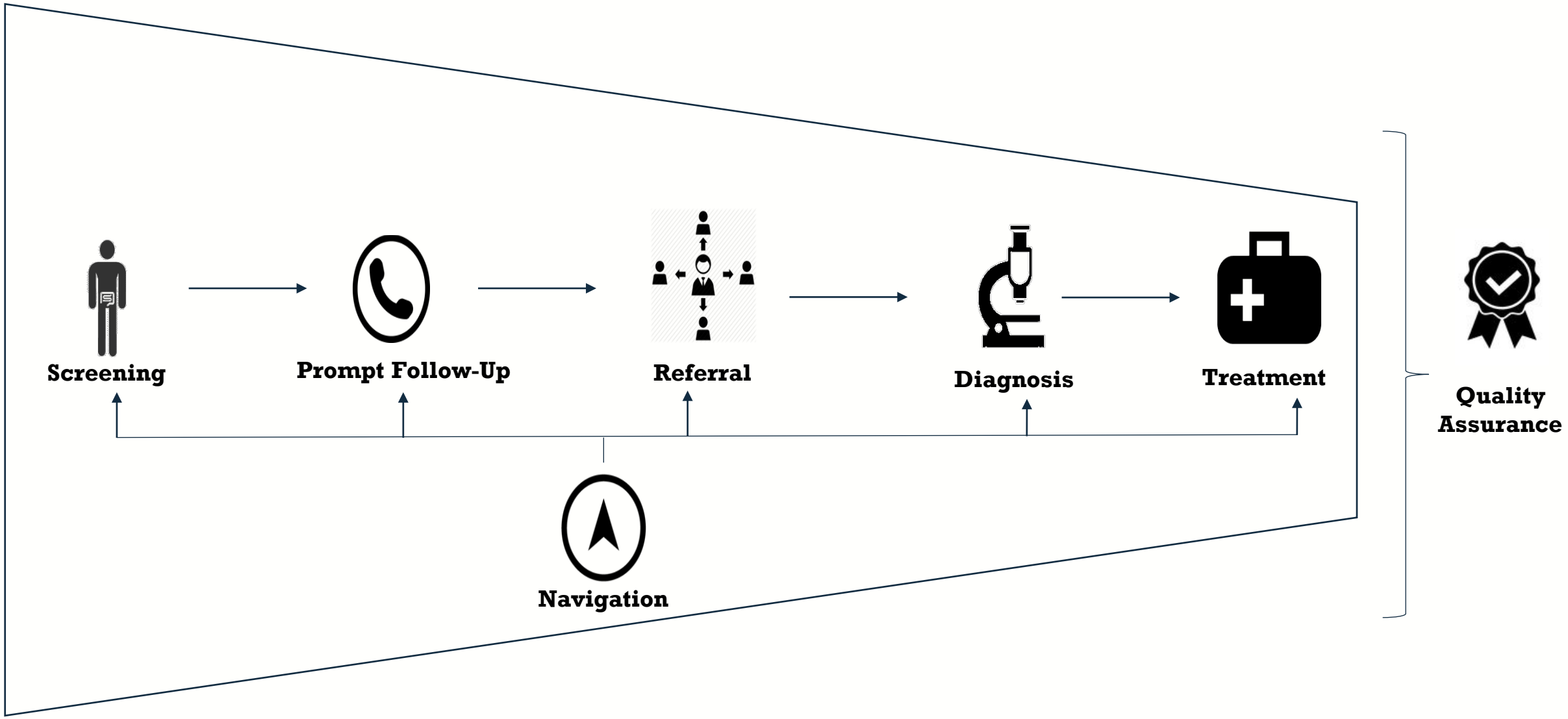
Strategies, tools and resources to improve:

- Awareness
- Access
- Equity
- Use

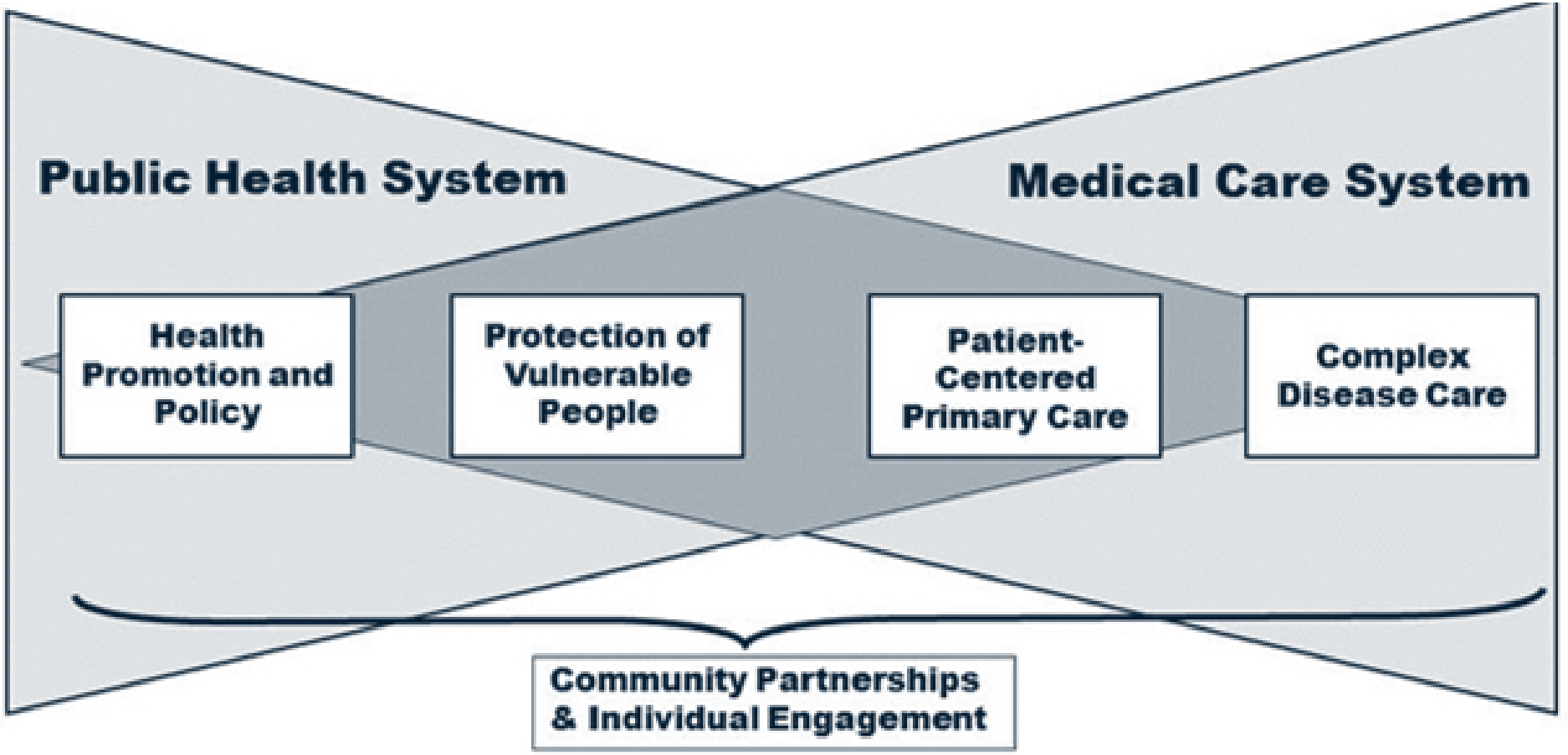
Nearly 300 adoptable or adaptable tools and resources



Cancer Screening is Not a Test, But a Process



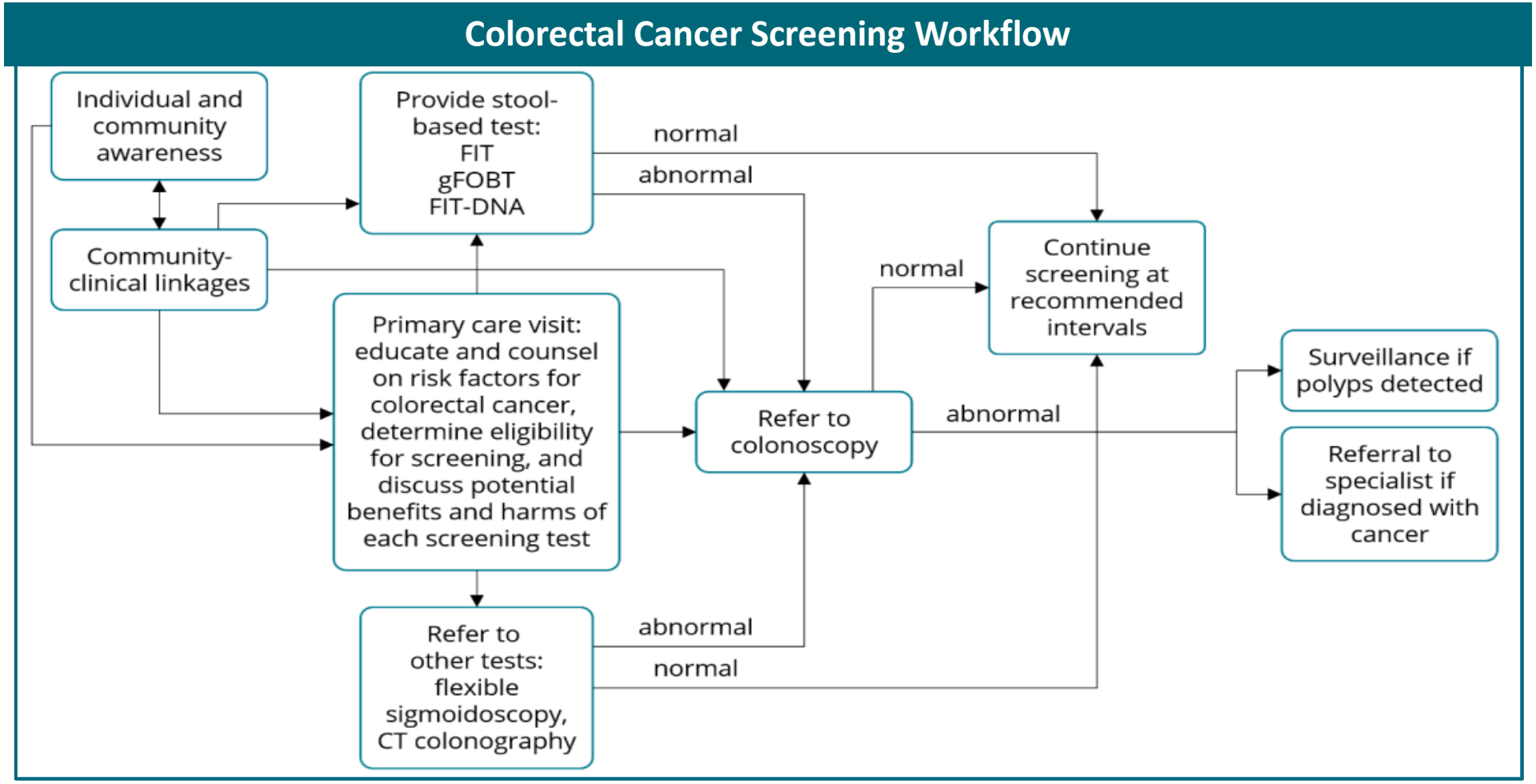
Working Together to Keep Communities Healthy



*Adapted from Centers for Disease Control and Prevention, "A Health System: Health Protection for Life!", 2007.

Focusing Your Cancer Screening Improvement Efforts

Where is change most needed or likely to have the greatest impact?



Organizing Framework

Cancer screening services can be improved through implementing:

Change Concept

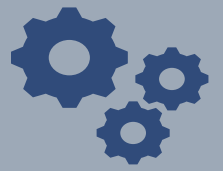
General notions that are useful for developing more specific strategies for changing a process

Change Idea

Actionable, specific ideas or strategies for changing a process.

Tools & Resources

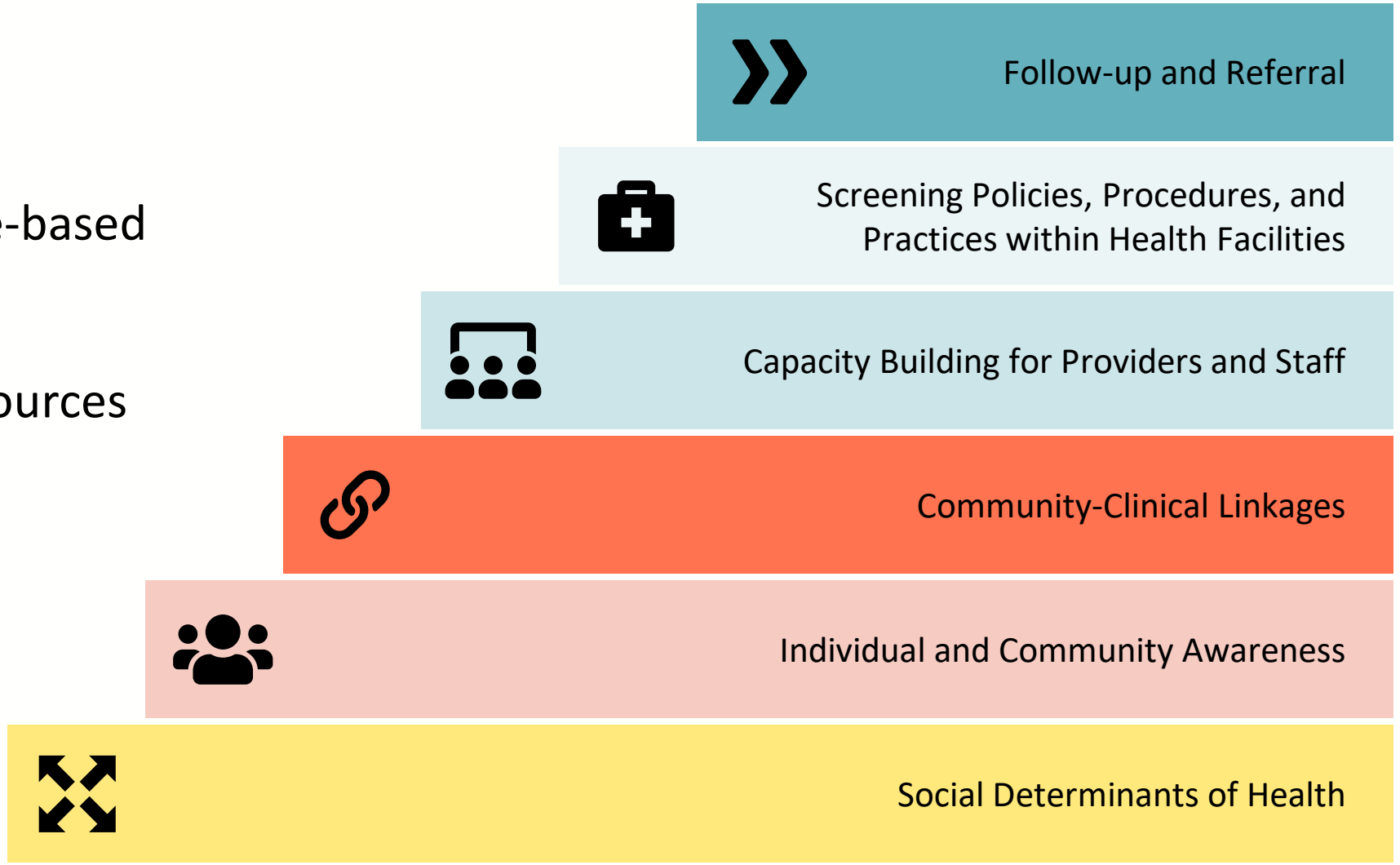
Can be adapted or adopted to support implementation of the Cancer screening improvement strategy



Taking Action. Saving Lives.

Six Focus Areas

- Evidence and practice-based strategies
- Related tools and resources vetted by experts

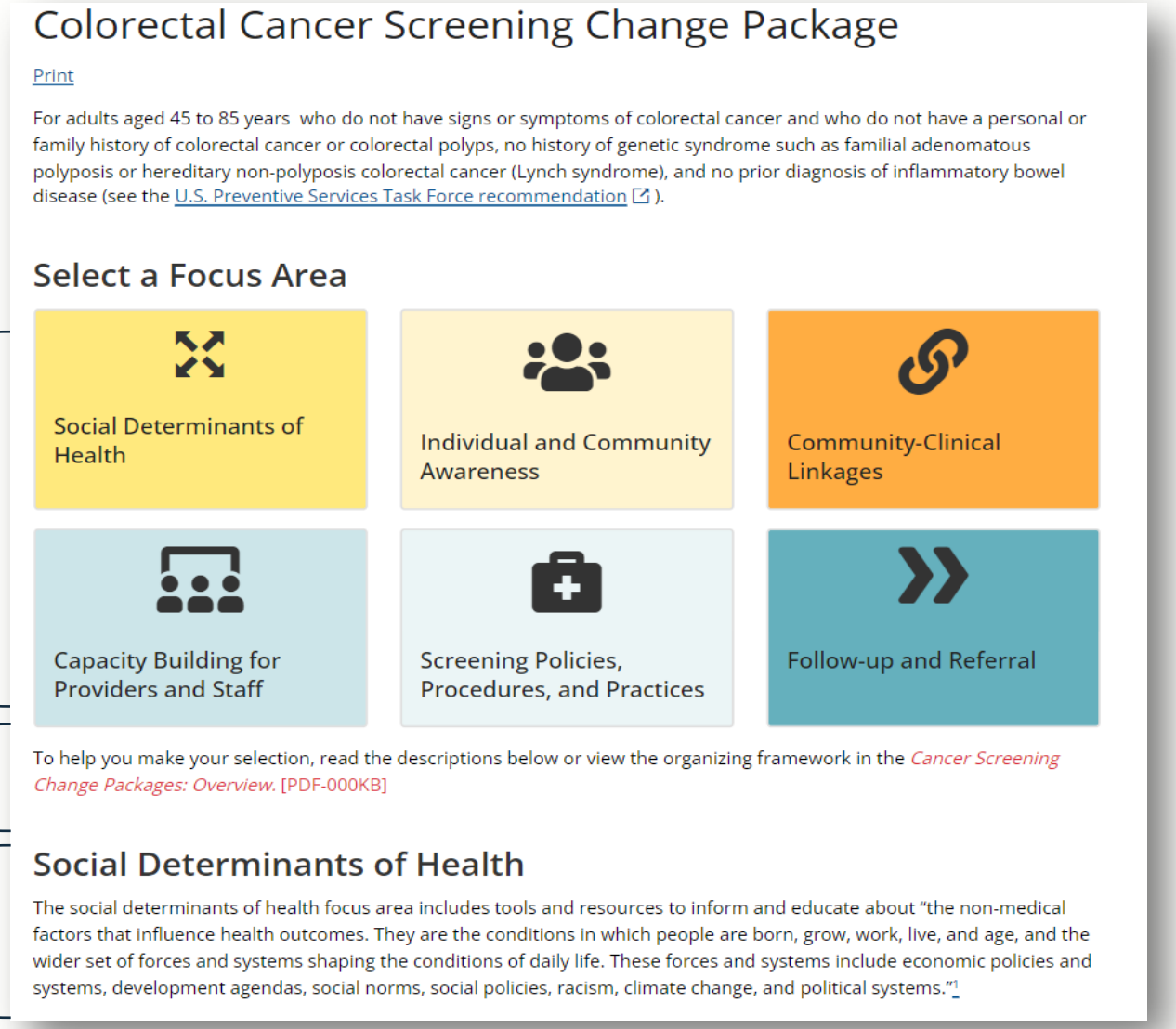


Focus Area Selection

Focus Area

Organizing Framework PDF

Focus Area Definition



Four Cancer Screening Change Packages

Supporting the delivery of cancer screening services that received A or B recommendations from United States Preventive Services Task Force

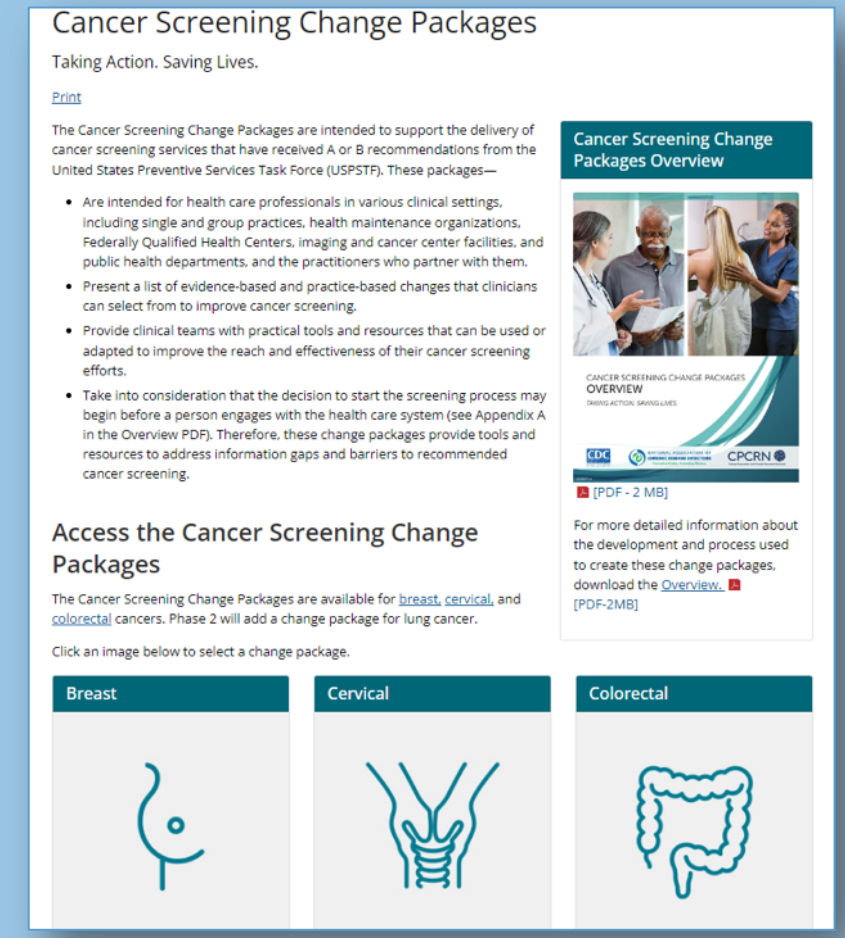
- **Breast cancer**
- **Cervical cancer**
- **Colorectal cancer**

Launched February 2023

- **Lung cancer**

2024

Questions? Demonstration?



Visit:

cdc.gov/cancer/dcpc/resources/change-packages/

Contact: dcpccommunications@cdc.gov

Thank you!

Go to the official federal source of cancer prevention information:

www.cdc.gov/cancer

Division of Cancer Prevention and Control

Reliable. Trusted. Scientific.

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

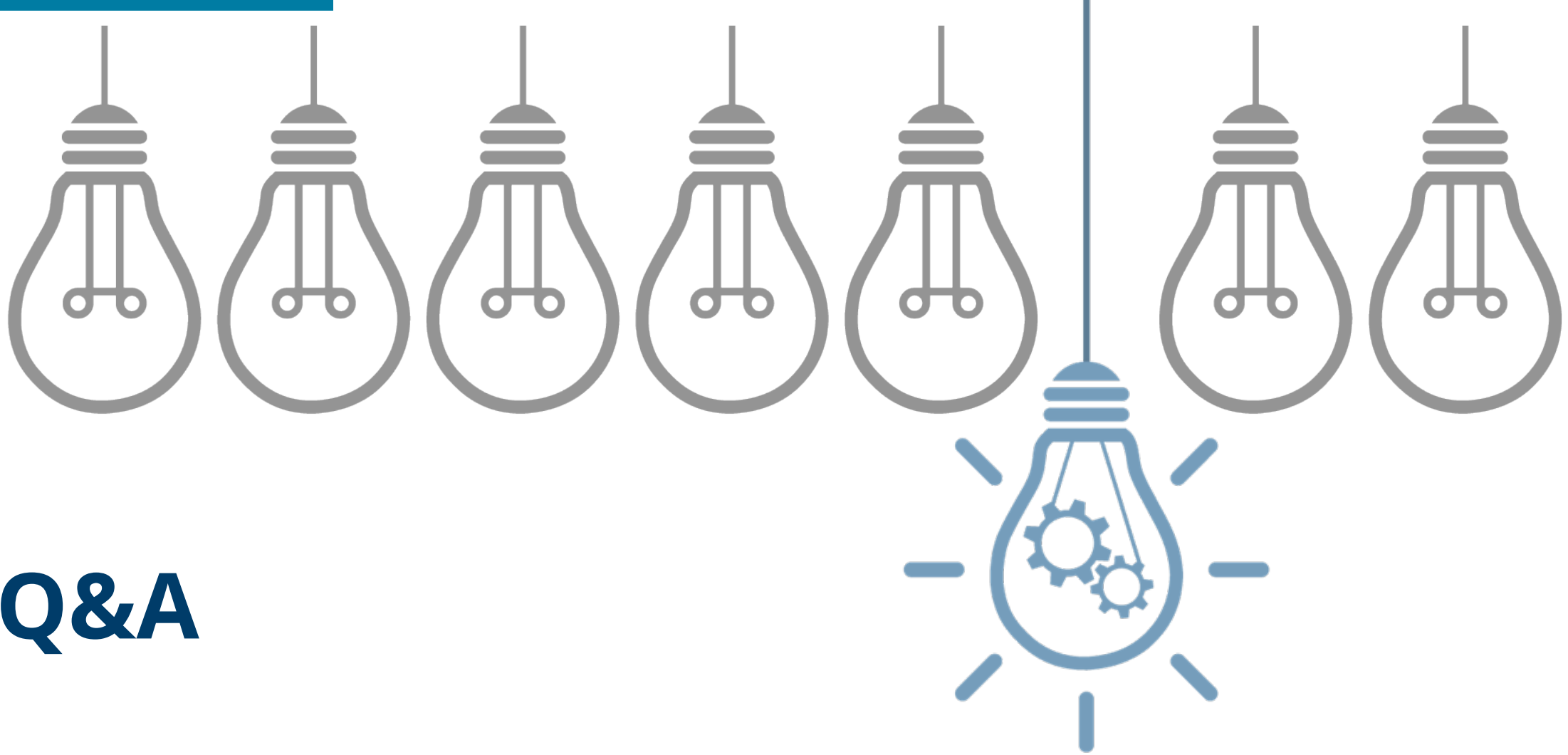
Health Center Perspective

Allison Madden
Assistant Vice President, Performance Improvement/Quality

Allison has 40 years of healthcare experience and has served at Community Health of South Florida, Inc. (CHI) for the past 20 years. She has been involved in just about every aspect of CHI since beginning her journey there in 2003, starting as a billing liaison, then creating a HEDIS department when Value Based Care became a focus of health plans. This grew to become the Care Management Department which includes a focus on HEDIS measures, Care Management, and referrals. Allison currently serves as Assistant VP of Performance Improvement/Quality. She is also a certified professional coder and has a Masters degree in Integrated Healthcare Management.

Health Center Perspective

- **Capture Structured Data**
  - Work with your HCCN, if relevant (we are a member of Health Choice Network)
  - Create reports/forms to capture data in structured fields
  - Leverage resources of your EHR (e.g., smart phrases)
- **Close Care Gaps**
  - Patients on the schedule (pre-visit planning)
  - Patients not yet scheduled for appointments (care gap reports)
- **Train Staff**
  - Providers – key to data capture
    - 30-min trainings 1x/week on EPIC features (schedule optimization, 'smart phrases')
    - Instructional on creating notes that include 'smart phrases'
  - Care team



Q&A

FREE Professional Development Training Opportunities

NACHC is covering the cost for a limited number of health center staff to participate in professional development training opportunities tailored specifically to health center roles:

Care Management

- ***Essentials*** *training for health center care managers with 0-2 years of experience*
- ***Intermediate*** *training for health center care management with over 2 years of experience*
- ***Leading*** *training for health center staff who supervise care mangers (may or may not be care managers themselves)*

Community Health Workers

- *Course for new health center CHWs*
- *Course for health center CHW supervisors (may or may not be CHWs themselves)*

Quality Improvement

- *Course for health center QI staff*



Trainings will begin in September

Application available soon, due July 19th!



VTF Health Center Assessment

Allows health center staff to self-assess organizational progress in activities important to value transformation.

- Can be completed at the beginning of a transformation initiative to set a baseline and then repeated over time to measure improvement.
- Recommended that 3 or more health center staff complete the assessment to get a balanced perspective of organizational progress in areas of systems change.
- Health centers can electronically share their averaged score with their PCA/HCCN to help drive value transformation efforts at the state/regional level.

Opportunities to Expand Care Team Skills

Register
https://bit.ly/2023Elevate

Assess https://reglantern.com/vtf
Ideally 3+ staff complete the VTF Assessment

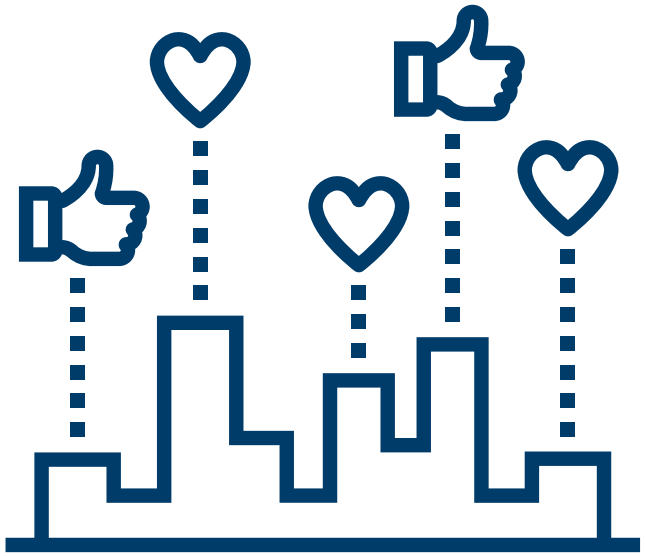
Unlock Workforce Upskill Opportunities!

Engage: Monthly Forum & Supplemental Sessions
registered participants

Access: Online Resources
https://nachc.docebosaas.com/learn/signin

National Learning Forum: Guided application of the VTF

NATIONAL ASSOCIATION OF Community Health Centers®



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

SHARE YOUR FEEDBACK

Don't forget! Let us know what you thought about today's session.

Next Monthly Forum Call:

July 11, 2023
1:00 – 2:00 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

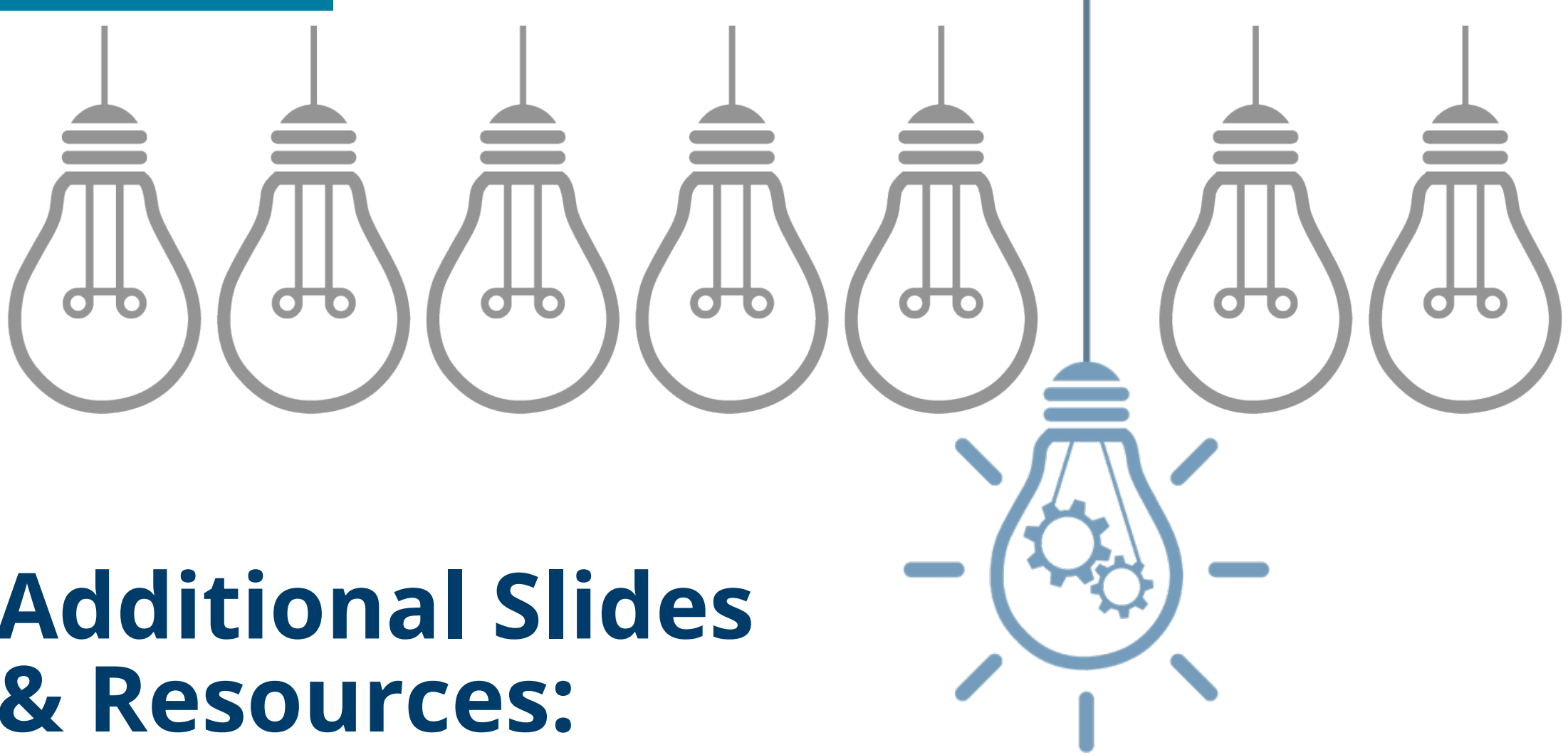
elevate°

Together, our voices elevate° all.

The Quality Center Team

Cheryl Modica, Cassie Lindholm, Holly Nicholson, & Addison Gwinner

qualitycenter@nachc.org



Additional Slides & Resources:

How the VTF and Elevate Support Health Center Systems Change

Begin Transformation Journey

- **Identify Transformation Team**
- **Register for Elevate**
  - *Leadership support*
  - *Interdisciplinary (QI, clinical, finance, HIT, operations)*
  - *Care team member engagement*
- **Complete the VTF Assessment**
  - *Assess progress on transformation continuum*
  - *Identify areas for focused improvement*
  - *Unlock professional development opportunities*
- **Set Goals Based on VTF Assessment Results Incorporate into Health Center QI Plan**
  - *Which Change Areas are most in need of improvement?*
  - *Opportunities to leverage other health center initiatives?*

Transformation Journey Continues

- **Leverage the VTF**
  - *Organize transformation efforts using VTF and VTF Assessment results*
- **Access Elevate Resources**
  - *Attend monthly Elevate learning forums*
  - *Apply steps from evidence-based Action Guides, reimbursement tip sheets, and other resources*
  - *Access eLearning modules & microlearnings*
  - *Engage with peers nationally*
- **Reassess; VTF Assessment**
  - *Measure transformation progress*
  - *Identify areas for focused improvement*

WHAT are the clinical guidelines for colorectal cancer screening?

Clinical guidelines recommend screening men and women at average risk for colorectal cancer aged 45-75 years

Average risk individuals have no:

- ✓ Personal or family history of adenomatous polyps or colorectal cancer.
- ✓ Personal history of inflammatory bowel disease such as Crohn's disease or ulcerative colitis.
- ✓ Genetic syndrome such as familial adenomatous polyposis or hereditary non-polyposis colorectal cancer.

Adults 76-85 years of age may be screened depending on their overall health and personal preferences.

US Preventive Services Task Force (USPSTF)
American Cancer Society

WHAT are CRCS testing options?

Stool-based tests

- Fecal Immunochemical Tests (FIT) - **every year**
- High-sensitivity Guaiac Fecal Occult Blood Tests (gFOBT) - **every year**
- FIT-DNA - **every 1 or 3 years**

For average risk adults

Visual tests

- Colonoscopy - **every 10 years**
- CT colonography - **every 5 years**
- Flexible sigmoidoscopy - **every 5 years**
- Flexible sigmoidoscopy with FIT - **Flexible sigmoidoscopy every 10 years plus FIT every year**

Annual, high-quality stool-based screening is comparable to a high-quality colonoscopy-based screening program when positive stool tests are followed by colonoscopy (see NACHC Cancer Screening Action Guide for relevant references).

Achieving high CRCS rates requires use of **both** stool-based and visual tests to balance logistics, patient preference, staffing, and availability of providers who can perform colonoscopies.

WHAT are 3 types of stool-based tests?

Type	Brand	Manufacturer	Sensitivity*	Specificity*	# Stool Samples
FIT *(CLIA-waived)*	OC Light iFOB Test	Polymedco	78.6%-97.0%	88.0-92.8%	1
	QuickVue iFOB	Quidel	91.9%	74.9%	1
	Hemosure One-Step iFOB	Hemosure, Inc.	54.5%	90.5%	1 or 2
	Insure FIT	Clinical Genomics	75%	96.6%	2
	Hemoccult-ICT	Beckman Coulter	23.2%-81.8%		2 or 3
HSgFOBTs+	Hemoccult II SENSA	Beckman Coulter	61.5%-79.4%	86.7%-96.4%	3
mt-sDNA	Cologuard	Exact Sciences	92.3%	89.8%	1

http://nccrt.org/wp-content/uploads/dlm_uploads/IssueBrief_FOBT_CliniciansRef-09282019.pdf
*Direct comparison between tests is not possible; consult original studies for additional information.
+High-sensitive guaiac-based FOBT; Hemoccult II and generic guaiac-based tests should not be used.

WHAT are the clinical guidelines for cervical cancer screening?

USPSTF Recommendations

Age 21-29

- Screen with cervical cytology alone every 3 years

Age 30-65

- Screen every 3 years with cervical cytology alone, OR
- Screen every 5 years with high-risk human papillomavirus (hrHPV) testing alone, OR
- Screen every 5 years with hrHPV testing in combination with cytology (co-testing)

Do Not Screen

- Patients who have had a hysterectomy with removal of the cervix and no history of a high-grade precancerous lesion or cervical cancer
- Patients with a cervix younger than 21 years
- Patients with a cervix older than 65 years with adequate screening history and not otherwise at risk for cervical cancer

U.S. Preventive Services Task Force Final Recommendation Statement, Cervical Cancer Screening

WHAT are the clinical guidelines for cervical cancer screening?

ACS Recommendations

Age 25-65

- Primary HPV test every 5 years
  - If primary HPV testing not available:
    - HPV + Pap test every 5 years OR
    - Pap test alone every 3 years

Do Not Screen

- Patients who have had regular screening in the past 10 years with normal results and no history of cervical intraepithelial neoplasia grade (CIN-2) or more serious diagnosis within the past 25 years.

The American Cancer Society Guidelines for the Prevention and Early Detection of Cervical Cancer

FDA Approved 'Primary' HPV Tests

WHAT are the clinical guidelines for colorectal cancer screening?

Screen average-risk adults aged **50-75 years (Grade A); aged 45-49 years+ (Grade B)**

Stool-Based Tests

- FIT-DNA – **every 1 or 3 years**
- High-sensitivity Guaiac Fecal Occult Blood Test (gFOBT) **- every year**
- Fecal Immunochemical Tests (FIT) **- every year**

Visual Tests

- Colonoscopy – **every 10 years**
- CT colonography – **every 5 years**
- Flexible sigmoidoscopy – **every 5 years**
- Flexible sigmoidoscopy with FIT – **Flexible sigmoidoscopy every 10 years plus FIT every year**

U.S. Preventive Services Task Force Final Recommendation Statement, Colorectal Cancer Screening

The American Cancer Society recommends screening for all individuals begin at age 45

WHAT are the clinical guidelines for breast cancer screening?

USPSTF Recommendations

Age 40-74

- Biennial screening mammography

U.S. Preventive Services Task Force Final Recommendation Statement, Breast Cancer Screening

WHAT are the clinical guidelines for breast cancer screening?

ACS Recommendations

Age 40-44

- Option to start screening with annual mammography

Age 45-54

- Annual mammogram

Age 55+

- Yearly mammogram or switch to mammogram every other year; continue screening as long as patient is in good health and life expectancy is at least 10 years

American Cancer Society Recommendations for the Early Detection of Breast Cancer