

Charles B. Wang Community Health Center's High Performance

How the Value Transformation Framework Can Advance CDC's 6|18 Initiative

Since 1971, the Charles B. Wang Community Health Center has offered primary healthcare services to Asian/Chinese immigrant communities in New York City. It is a nonprofit and federally qualified health center, offering high quality, culturally relevant care. There are three sites in Lower Manhattan and two in Flushing, Queens; both serving more than 52,000 patients in 280,000 service visits.

The Charles B. Wang Community Health Center supports the belief that everyone should have the same opportunity to achieve their highest level of health. While large in size, the organization is a true grass-roots community health center, attentive to the social determinants of health affecting the patients they serve. The Charles B. Wang Community Health Center has created patient-centered prevention and control strategies to improve health and control healthcare costs, which aligns with the primary goals of the 6|18 Initiative, a strategic priority of the Centers for Disease Control and Prevention (CDC). Their success can be examined using the National Association of Community Health Centers' (NACHC) Value Transformation Framework.

BACKGROUND

When public health, primary care, purchasers, and payers collaborate, broader health system changes occur that can ultimately improve population health outcomes. To demonstrate this concept, the Centers for Disease Control and Prevention (CDC) developed and implemented the 6|18 Initiative. The name '6|18' comes from the initiative's focus on six common, costly, and preventable health conditions (tobacco use, high blood pressure, diabetes, asthma, unintended pregnancies, and healthcare-associated infections) and, approximately 18 evidence-based prevention and control interventions. These interventions can have a significant and positive impact on improving health and reducing costs.

As part of this initiative, the Centers for Disease Control and Prevention (CDC) is partnering with 15 state Medicaid programs and their counterpart state public health departments, as well as the District of Columbia Health Department and Los Angeles County Health Department, to improve and accelerate implementation of the 6|18 interventions to achieve better care, better health outcomes, and lower costs. The CDC is working with these organizations to understand best practices in implementing 6|18 interventions and to help disseminate best practices to other states.

The National Association of Community Health Centers, Inc. (NACHC) is working with the CDC in support of the 6|18 Initiative. Given the critical role health centers can play in improving population health, and their reach within communities across the nation, health centers are natural partners to work with the CDC. They can build and leverage collaborations with state Medicaid agencies, payers and other entities in an effort to better manage the common and costly health conditions that are the focus of the 6|18 Initiative.

**Charles B. Wang
Community Health Center**
www.cbwchc.org

Operating in Manhattan and
Queens, NY

 5 sites

 50,000 patients served

 275,000+ visits

Services

Adult Medicine, Pediatrics,
OB/GYN, Dental, Mental
Health, Nutrition,
Laboratory, Pharmacy

Patient Center

Medical Home

Level 3

Payer mix

Commercial health
insurance, Medicaid,
Medicare, sliding fees

Additional information

More information about the 6 | 18 Initiative, including evidence summaries, is available at www.cdc.gov/sixteen.

Information about state Medicaid and public health partnerships is available at www.chcs.org/medicaid-public-health-partnerships-untapped-potential-improve-health-care-reduce-costs

More information on NACHC Quality Center's Value Transformation Framework is available at <http://www.nachc.org/clinical-matters/clinical-quality/value-transformation-framework/>.

WHY STUDY THE CHARLES B. WANG COMMUNITY HEALTH CENTER?

A review of 2016 data in Health Center Program grantees in the nine aforementioned states that was reported to the Health Resources and Services Administration (HRSA) Uniform Data Systems (UDS), found that Charles B. Wang Community Health Center was one of four health centers that achieved $\geq 90\%$ performance rates for relevant 6|18 measures, and they ranked in the top quartile of health centers nationally for nearly all UDS measures.¹

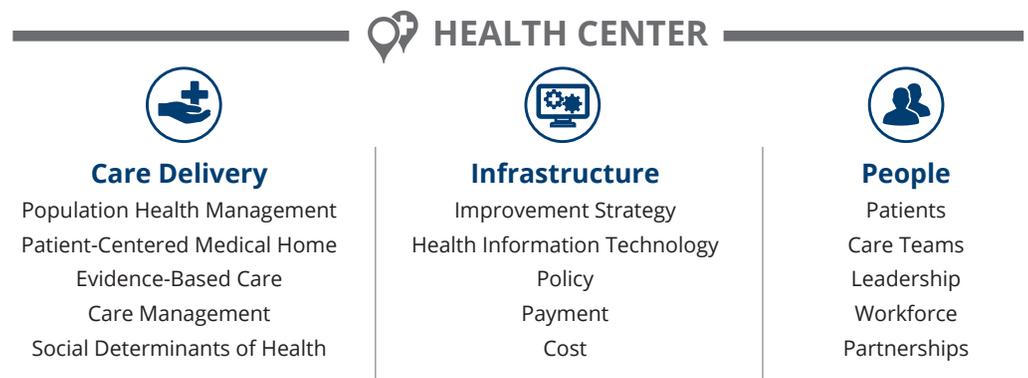
The high performance of Charles B. Wang Community Health Center in 6|18 measures can be considered in the context of the Value Transformation Framework developed by NACHC's Quality Center in order to distill lessons that may be applied by other health centers seeking to attain similar levels of performance. The Framework offers a way for health centers to organize efforts in support of transformation and improved health outcomes, improved patient and provider experience, and reduced costs (e.g., the Quadruple Aim). The Value Transformation Framework translates research and proven solutions in three domains (infrastructure, care delivery, and people/human capital) to support organizational improvement. This case study applies the Framework to a health center that performs high in not only 6|18 measures but across nearly all federally reported measures.

Through this case study, and a similar study of the Teche Action Clinic in southeastern Louisiana, we provide examples of how a health center's attention to care delivery, infrastructure and people (human capital) contributes to their success. Lessons gleaned from the experience of high performing centers such as Charles B. Wang Community Health Center and Teche Action Clinic can inform other health centers striving to improve health outcomes, quality, and costs through organizational change and application of evidence-based interventions.

THE NACHC QUALITY CENTER'S VALUE TRANSFORMATION FRAMEWORK

The Value Transformation Framework supports transformation toward value-driven care and the ability of health centers to achieve the Quadruple Aim goals. The Quadruple Aim goals are: improved health outcomes, improved patient experience, improved staff experience, and reduced costs. The Framework organizes action steps into three domains: care delivery, infrastructure, and people (human capital).

Value Transformation Framework



¹ 2016 Health Center Profile, Charles B. Wang Community Health Center, Inc. (Accessed February 15, 2018). Health Resources and Services Administration website. Retrieved from: <https://bphc.hrsa.gov/uds/datacenter.aspx?q=d&bid=021390&state=NY&year=2016>.

CDC's 6I18 INTERVENTIONS

NACHC is working with the CDC to support the 6I18 Initiative in order to accelerate the adoption of evidence-based interventions identified by the CDC, particularly among health center providers. For this case study, we'll review four of the 6I18 clinical conditions for which there is a related HRSA UDS measure: tobacco use, blood pressure, asthma, and diabetes.

CDC's 6I18 INITIATIVE



REDUCE TOBACCO USE

CDC 6|18 Evidence-Based Interventions for Tobacco Use:

- Increase access to evidence-based tobacco cessation treatments, including individual, group, and telephone counseling and Food and Drug Administration (FDA)-approved cessation medications (in accordance with the 2008 Public Health Service Clinical Practice Guidelines and the 2015 U.S. Preventive Services Task Force (USPSTF) recommendations).
- Remove barriers that impede access to covered cessation treatments, such as cost sharing and prior authorization.
- Promote increased use of covered treatment benefits by tobacco users

Charles B. Wang Community Health Center Actions to Reduce Tobacco Use:

- Implements clinical protocols and guidelines for reducing tobacco use in accordance with the 2008 Public Health Service Practice Guideline and 2015 U.S. Preventive Services Task Force tobacco cessation recommendation statement.
- Employs a smoking cessation counselor who provides tobacco cessation counseling and treatment support to patients.
- Engages in community anti-smoking campaigns.
- Refers patients for additional counseling and support from the NYC Quit Smoking Hotline and Asian Smokers' Quitline.
- Promotes increased use of covered treatment benefits by tobacco users.



CONTROL HIGH BLOOD PRESSURE

CDC 6|18 Evidence-Based Interventions for Controlling High Blood Pressure:

- Implement strategies that improve adherence to anti-hypertensive and lipid-lowering prescription medications via expanded access to:
 - low cost medication payments, fixed dose medication combinations, extended medication fills.
 - innovative pharmacy packaging.
 - improved care coordination using standardized protocols, primary care teams, medication therapy management programs and self-monitoring of blood pressure with clinical support.
- Provide home blood pressure monitors to patients with high blood pressure and reimburse for clinical support services required for self-measured blood pressure monitoring.

CDC's 6|18 INITIATIVE *(continued)*

Charles B. Wang Community Health Center Actions to Control High Blood Pressure:

- Uses the electronic health record to track patients with hypertension and schedules follow-up and recall as needed.
- Promotes the use of covered treatment benefits for patients with hypertension.
- Provides patients with educational materials and self-management guidance to improve adherence to blood pressure and lipid-lowering medications.



CONTROL ASTHMA

CDC 6|18 Evidence-Based Interventions for Controlling Asthma:

- Use the 2007 National Asthma Education and Prevention Program (NAEPP Guidelines) as clinical practice guidelines.
- Promote strategies that improve access and adherence to asthma medications and devices.
- Expand access to intensive self-management education by licensed professionals or qualified lay health workers for patients whose asthma is not well-controlled with medical management.
- Expand access to home visits by licensed professionals or qualified lay health workers to provide intensive self management education and reduce home asthma triggers for patients whose asthma is not well-controlled with medical management and self-management education.

Charles B. Wang Community Health Center Actions to Control Asthma:

- Uses guidelines in accordance with the updated 2007 National Asthma Education and Prevention Program guidelines as part of evidence-based clinical practice and medical management guidelines.
- Provides education and guidance to patients around strategies for adhering to asthma medication
- Conducts integrated patient education and outreach efforts. For example, outreach to the parents of children with asthma in local schools, with language/ culturally appropriate educational materials.



PREVENT DIABETES

CDC 6|18 Evidence-Based Intervention to Prevent Diabetes:

- Expand access to the National Diabetes Prevention Program (the National DPP), a lifestyle change program for preventing type 2 diabetes.

Charles B. Wang Community Health Center Actions to Control/Prevent Diabetes:

- Schedules regular follow-up visits for patients with diabetes to ensure the delivery of preventive care, education, and treatment.
- Promotes lifestyle changes in a way that is culturally/linguistically appropriate.
- Provides targeted and individualized preventive services to high-risk patients through their on-site Care Coordinator.

“ A large part of our success has to do with the culture we set at the center. It is pretty rigorous in terms of patient care and follow-up and not leaving loose ends...staff know that we look at the data and they take pride in using that data as a proxy for the quality of patient care. ”

ORGANIZATIONAL APPROACHES THAT SUPPORT HIGH PERFORMANCE IN 6|18 CONDITIONS

The Charles B. Wang Community Health Center implements 6|18 evidence-based interventions as part of comprehensive system attentive to care delivery, infrastructure and people – domains outlined in NACHC’s Value Transformation Framework. Their high level of performance in 6|18 and other clinical conditions goes beyond the implementation of evidence-based interventions and is tied back to the larger system and how they deliver care, the design of their infrastructure, and the expectations and support they provide to staff, patients, and partners. Charles B. Wang Community Health Center’s systems approach enables this health center to achieve high levels of performance across 6|18 conditions that are sustained over time. They are able to sustain this performance across multiple, autonomous sites by focusing attention around the same top level goals (better health outcomes, better patient and provider experiences, and lower delivery costs). While employees are encouraged to carefully collect data, ask questions, and provide input to foster innovation across sites, they are organized around a central core set of goals and priorities.

“ We highly value patient care and follow up. We don’t let patients disappear until their next visit. Our care coordination team tries hard to fill the gaps we see, and they stay in touch with patients between visits. Patients know this and they appreciate this level of quality. ”



Care Delivery

Organizational systems of care delivery at the Charles B. Wang Community Health Center support standardized work-flow processes. Care delivery expectations – whether for asthma, tobacco cessation, diabetes or another condition - are clearly articulated and followed by staff. This begins with excellent training, ongoing communication, and leadership commitment to excellence within a culture of caring. Care Coordinators offer continued outreach between visits including follow-up on patient referrals, appointment reminders, reporting of abnormal results, and follow-up with patients after hospitalizations. Leadership at the health center has worked hard to create a culture that tracks and supports patients from the time they walk in the door, to delivery and coordination of care and follow-up. The health center has carefully determined which questions should be embedded within the electronic health record (EHR) to document their work in a way that is logical and supported by providers. Staff are extensively trained in workflows and documentation. Health center leadership regularly reports performance standards and outcomes to the Quality Assurance Committee and Board of Directors.

“ We value the rules and follow them: this is communicated for all to follow. ”



Infrastructure

It is clear that staff at the Charles B. Wang Community Health Center are immersed in the language of quality. They enter into improvement efforts with measures in mind first.

Operations within individual units, comprised of internal medicine, pediatrics, obstetrics and gynecology, dental, and mental health, are based on quality assurance (QA) goals established by the unit chiefs and by the clinical leadership. Progress is reported to the QA Committee, clinical leadership, and the Board of Directors. The team shares aggregate and individual-level clinical data with providers and care teams. They use the data for quality improvement efforts and to reach goals, such as those outlined in the 6|18 Initiative.

Health center leadership note that while they provide staff with data to make decisions and encourage a quality improvement process (including the Plan-Do-Study-Act (PDSA) cycle), they are very flexible in their approach to meet the needs of a situation.

“ We are very practical. We try things out. Sometimes we are top-down, sometimes we are bottom-up, sometimes we use PDSAs and sometimes other approaches. We adapt to what works. ”

“ We know that if we don't have the report in hand, we don't get credit, so, we are very good bean counters. ”

The health center has invested heavily in informatics. The clinical informatics team is staffed by 4-5 individuals with a clinical, quality and IT background. Over the past dozen years, this team has focused on building systems to capture discrete bits of information in their electronic health record to effectively count the work they do. Templates and forms created by the team are specifically designed to help with workflow. The informatics team works very closely with providers, and the entire care team, to design templates that capture data as a natural part of daily work. Every unit has an EHR Improvement Committee that includes providers and nursing staff.

The clinical informatics team modifies software and templates based on input from the provider and nursing staff to ensure efficiency and capture data. During the development process for new templates, the team asks such questions as: “Where can we put the form so it will be most readily used by staff?”, “How will a template be used?”, “Who will use it?”, and “Why?”, “Do we capture all reimbursable work?”. The goal is to best capture and report data in order get full credit (and funding) for the work they do.



People

Health center staff are fluent in Mandarin, Cantonese, Taishanese, Shanghainese, Fujianese, Vietnamese, and Korean to specifically serve their patient base. The center supports patients in linguistically and culturally appropriate ways by integrating patient care into patient education and outreach efforts. For example, their flu shot program is linked to their asthma and asthma education program.

The Charles B. Wang Community Health Center embraces a very family-oriented, comprehensive approach to care. The team recognizes that many of the patients they serve have special needs or risks. Staff are attentive to not just the patient and their social determinants of health, but also their circle of care. Patients' families are important and included in patient care teams and self-management strategies. These standards - high quality expectations and personalized care - contribute to the health center's high level of performance.

Patient care teams at Charles B. Wang Community Health Center have evolved over time. The current care teams, under the patient-centered medical home (PCMH) model, include a provider, one RN for every 2-4 clinicians, a medical assistant (MA), and back office staff to track and follow-up care. The health center has more recently established a new role within the organization, that of a Care Coordinator. They see this role as pivotal to providing the personalized care and follow-up needed to achieve 6 | 18 and other clinical goals with high-risk patients. While a nurse initially filled this position, the center has moved to using highly trained medical assistants. The team reports that they can provide more targeted services to high-risk patients when there is an on-site Care Coordinator who responds to the individual needs of patients.

CHALLENGES AND OPPORTUNITIES

Despite all of the successes of Charles B. Wang Community Health Center, they face challenges as they strive to maintain a high level of excellence. After nearly a dozen years using EHRs, and a heavy investment in clinical informatics, the leadership recognizes the burden of data reporting on the care team.

There is a critical need to balance the time it takes to capture and report on data with the time it takes to deliver personalized care. They would like to have more time for care delivery. They also acknowledge the difficulty in linking some of the 'softer' components of care, such as their culture of caring, to outcomes.

While they report great success with their new Care Coordinator role, the limitation is that the efforts of this position have centered on 'high-risk' patients as defined by payers. The center recognizes these definitions do not include patients who have special needs (other than acute needs) that would benefit from care coordination. Some of the special needs they plan to acknowledge when considering 'risk' include language, culture, literacy, stress and family barriers. They hope to expand services to these patient groups, and be reimbursed for the provision of services, to a larger groups of patients.

KEY LESSONS

This case study highlights a number of key actions Charles B. Wang Community Health Center implemented within its care delivery, infrastructure and people systems, including:

- **Evidence-Based Care** – implementing 6I18 interventions
- **Improvement Strategy** – creating a culture of quality
- **Health Information Technology** – data driven decisions
- **Patients** – a culture of caring
- **Care Teams** – standardized work processes within an environment of trust

When Charles B. Wang Community Health Center's high levels of performance in 6I18 measures, and nearly all measures reported in the UDS, are considered against NACHC's Value Transformation Framework, key lessons emerge for other health centers regarding actions that can be taken within care delivery, infrastructure and people systems to improve performance and advance toward the Quadruple Aim.