

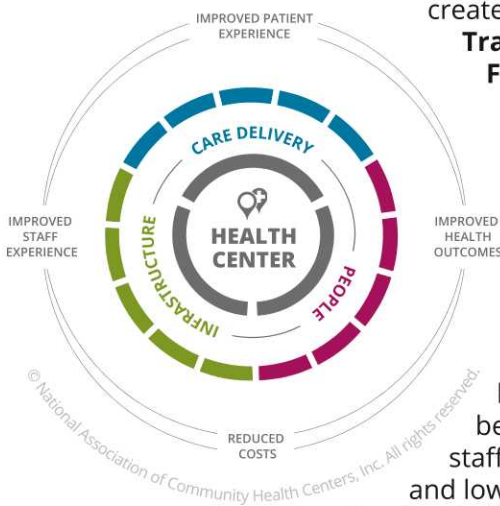
# HEALTH CENTER CASE STUDIES

## NACHC's Cancer Transformation Project

### Background

In response to pressures from skyrocketing health care costs, changing demographics, and disjointed technologies, the health care industry has mobilized around the notion of “value-based” care. Value-based care pays providers for positive patient health outcomes. This differs from the traditional fee-for-service approach. While many experts agree that this change will lead to better results at lower costs, there has been no clear organizing model for it.

The National Association of Community Health Centers (NACHC) created the **Value Transformation Framework (VTF)** as a systematic approach for health centers to move from volume-based to value-based care and, ideally, achieve better health outcomes, better patient and staff experiences, and lower costs: the **Quadruple Aim**. Based



on research and evidence-based practices, this framework helps organizations rethink how they deliver care and offers a clear path for positive change.

The Value Transformation Framework organizes health center operations into three “Domains”—people, infrastructure, and care delivery—and 15 “Change Areas”. NACHC’s Quality Center is leading the work of translating proven solutions and promising practices for health centers to advance value-based goals. Action Guides for each

Change Area describe well-defined, yet flexible, steps for improvement.

NACHC’s **Cancer Transformation Project**, funded by the Centers for Disease Control and Prevention (CDC), illustrates how colorectal cancer screening rates can be improved by applying the Value Transformation Framework. In this pilot, multi-disciplinary teams at eight health centers across Georgia and Iowa participated in a learning community during year one of the project (CY2017); six participated in year two (CY2018).

The project aimed to improve cancer screening rates by supporting health centers’ abilities to hire a care manager, make data-driven decisions, and apply evidenced-based interventions using the Value Transformation Framework. It was led by NACHC’s Quality Center in partnership with the Georgia and Iowa Primary Care Associations. Pilot sites engaged in monthly state-based and all-project calls, webinars for leaders and care managers, and received a variety of learning resources, reporting tools, and individualized coaching. Health centers received funding to support the hiring of a nurse care manager.

The case studies that follow describe the experiences of three pilot sites during their first two years of the project:

1. East Georgia Healthcare Center (Swainsboro, Georgia)
2. Community Health Centers of Southeastern Iowa (West Burlington, Iowa)
3. Coastal Community Health Services (Brunswick, Georgia)

*These case studies were developed with insights from six in-depth telephone interviews conducted in April 2019 with the Medical Director, Quality Improvement Lead, and Care Manager from each site.*

## 1

# CANCER TRANSFORMATION

*East Georgia Healthcare Center, Swainsboro, GA*

“

This project has really helped us change how we view and manage colorectal screenings...We have patients who would not have gotten screened, get screened. They found cancer early and got treated.”

## ABOUT EAST GEORGIA HEALTHCARE CENTER (EGHC)

[www.eghc.org](http://www.eghc.org)

EGHC began seeing patients in one clinic in 1994. By 2013, EGHC's Swainsboro site was recognized as a Level 3 Patient Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA). EGHC also received the Federally Qualified *Health Center of the Year* award from the Georgia Primary Care Association. They are dedicated to providing high quality, patient-centered health care that is mindful of costs.

During the first two years of the **Cancer Transformation Project**, EGHC experienced a tremendous period of growth and staff turn-over. They expanded from seven affiliate clinics in 2016 to 11 by 2018.



## INTEGRATING THE CANCER TRANSFORMATION PROJECT INTO PRACTICE

When the Cancer Transformation Project began, EGHC's Chief Medical Officer and Quality Manager invested a great deal of time into **risk stratification** as a **population health management** strategy to look at their patient trends. With this approach, they were able to more strategically identify people who needed more care, especially patients with chronic diseases. It became an opportunity for

EGHC to enhance their **care teams** by adding **care management** with a newly hired **care manager** for higher risk patients. The project helped them find new ways to introduce **cancer screening** to patients, and better ways to connect with them about cancer care. It also helped them **use data differently** to improve a range of **chronic disease management services** for their higher risk patients.

## THE PATH TO VALUE-DRIVEN CARE

“

This effort [transformation] sounds like a lot of effort, and change is scary for a lot of the staff. But, in the grand scheme, it wasn't too time intensive. It was actually easier than we thought to lay this framework on top of our existing structure.”

### Applying Risk Stratification & Care Management

*“I think our Care Management program, overall, will be the most sustainable. We are at a point now where we're billing Medicare for those services.”*

The **risk stratification** process was new and challenging for EGHC, but it was also rewarding. Staff followed NACHC's recommended risk stratification steps to generate registry reports. (EGHC uses eClinicalWorks for its Electronic Medical Record.) By **looking at their data differently**, the Medical Director learned that some patients would go for years without getting screened. *“It was a gut-check to learn that we were only screening 20% of the patients we're supposed to screen.”* They also learned that the majority of their patients had three or four chronic conditions, and about 250 had six or seven. This group became their target group for **care management**.

The **Care Manager** at EGHC was new, and she began to personalize care. Higher-risk patients consulted with her either before or after their regular primary care appointment. **Humor** became her secret weapon for **patient engagement**. Providers made it a priority to work as a team with the Care Manager.

EGHC also had all staff conduct a personality assessment to **strengthen team-work** among **care team** members. Each person was assigned a color based on their personality type. They taught everyone how to use these colors for better communication and understanding. This helped reduce friction among staff. From the front office to the care teams, staff felt like they gained each other's support.

They now regularly use data to identify delivery improvements. They make step-by-step changes and periodically look at *“the percentage-change of patients that have been screened”*, among other data-points, to decide if the changes they are making work (or not).

### Building a Better Culture for Screening

*“We kept poop on everybody's mind. We had poop piggy banks, poop emoji pillows, poop awards, even poop-topped cupcakes!...Personal touches, like face-to-face meetings with care teams at all clinics and incentives helped everyone stay excited and on track with our goals.”*



In the past, individual providers at EGHC worked independently. Care teams were used, but not in the way suggested by the Value Transformation Framework. If a patient decided not to be screened for cancer, then no one pushed it. Providers would say, *“Patients don't want to do it”* or *“money is the problem.”*

To build a **better culture for screening**, the Care Manager and Quality Manager began to make monthly site visits to each of the 11 clinics in their system. Emails weren't enough. These short, but friendly, face-to-face visits reminded providers about CRC screenings. The Care Manager made it fun to talk about “poop”. She decorated the clinic and taught her co-workers to take the stress out of screening. As an extra step, she would call patients and remind them to bring in fecal samples for testing (patients would otherwise often forget or avoid this).

As an **incentive for providers**, EGHC implemented a competition to increase the percent of patients screened. Each month, the winning provider and care team would be awarded “The Golden Poop Trophy” and a luncheon celebration. Staff jumped at the chance to compete in this way, and they had fun with it. The entire team would be recognized.

EGHC found that patients became much more interested in getting screened as a result of this shift in culture. *“What made it easier was that our administration wanted to make the changes work. They bought incentives and wanted to work with us to find improvements.”*

## Addressing Costs & Access

*"A lot of patients are either under-insured or don't have insurance, so cost to the patient is a big factor. We work hard to make the costs come down."*

To tackle the problem of costly care for patients, EGHC began to develop more meaningful **partnerships**. They worked with

various gastroenterologists to lower the cost of colonoscopies and partnered with labs to get more screening done, including fecal immunochemical test (FIT) and Cologuard tests. They partnered with the American Cancer Society to develop a list of where patients could go for further evaluation. These had been roadblocks, but as a larger team, it became easier to improve screening rates.



## RESULTS TO DATE

*"We had a patient who resisted screening tests for years. After much persistence, we convinced her to get a colonoscopy. Some polyps were found. She had a CAT scan, was diagnosed with colon cancer, and was sent to surgery. Now, she is cancer free! ... It's rewarding when you finally get through to patients who have been resistant to screening, and then they get tested. You feel good when you're able to provide that service to them."*

Since the Cancer Transformation Project began, EGHC's has been able to improve their colorectal cancer (CRC) screening rate from 20% to 38%, and they continue to work toward greater improvement.

Cervical cancer screenings hover at around 50%, without much change. Though they tried to create a

superhero uterus (a "Wonder Womb") to encourage more cervical cancer screening, it didn't take off as well as the "poop emoji" tactic. *"We aren't giving up."*

During the risk stratification process, EGHC also learned that about 98% of their high-risk patients were obese. With care management, the care teams have been able to address this problem as well, leading to improvements in diabetes control.

EGHC also found that the **number of patient complaints dropped** from 2016 to 2017, dropping even more in 2018. Now patients feel more listened-to and that their doctors take more time with them. Patient satisfaction scores are up to 98%. *"I believe this type of framework [the Value Transformation Framework] helped lead to better patient satisfaction."*

## THE LEARNING COMMUNITY

*"The intervention reports and reporting processes [in the learning community] gave us time to reflect every month on what we were doing, and see what was, or was not, working."*

When the project began, EGHC's Chief Medical Officer and Quality Manager found that initial one-on-one meetings, phone calls and coaching with NACHC helped them understand the project and its goals, and led them to define their own plan of action. Population Health Management techniques helped them **use data differently** and keep regular records of their strategies and screening

rates. This helped the health center identify places where they could **change their operations** and **structure a logical path** for screening improvements.

The Quality Manager, and later the Care Manager (hired in the first year of the project), appreciated the ability to share their experiences during monthly project calls and learn from the other seven participating health centers. When they struggled, the learning community model allowed staff across health centers to discuss their challenges and share ideas and possible solutions.

## CHALLENGES WITH IMPLEMENTATION

*“One of the hardest parts of our job is tracking medical records or not being able to access them. If there was a way to have someone’s entire medical record available when they come into the office, I think that would make health care, in general, a lot better.”*

If EGHC staff could wish for any one thing to help with their care delivery, it would be more **effective systems for Electronic Medical Records (EMRs)**. *“We need EMRs that talk to each other. If we could share information from the various networks, and transcribe information into one shared system so you don’t have to fax information from one clinic or hospital to another, (and if a million hands weren’t involved), then things would be much easier!”*

Expensive care for the health center’s low-income patients, and the migratory nature of many of their patients, makes follow-up care very difficult. Staff turnover during a period of organizational growth also posed a big challenge for EGHC. Even though the number of auxiliary staff increased during the project, the number of provider staff did not. *“We have a shortage of providers right now, and we have*

*a lot more patients than providers. So staff burnout is a problem. We have to balance that out.”* This void has been difficult for them. Expanding partnerships has been a helpful way to tackle some of this problem.

## LESSONS LEARNED

*“Try to be open to change and creativity. If you can find the ‘fun’ in your work, you will find that changes are sustainable. There are no bad ideas. If you can make changes fun, then you can remove the taboo from otherwise hard topics, like colorectal cancer.”*

EGHC believes that the strategies it employed through the Cancer Transformation Project are **sustainable** and important. Because the Value Transformation Framework focuses on systems change, the Chief Medical Officer described the project work as “second nature.” The changes they made have become ingrained in their processes, unlike a set of add-on tasks. The Care Manager is now a trusted and critical part of the care team, enhancing many aspects of standard care and cancer screening.

*“Be patient, just continue with it, and be resilient. You will find success.”*

## KEY LEARNINGS FROM EAST GEORGIA HEALTHCARE CENTER

- ✓ **Risk Stratification** may not be easy, but it sheds light on health risks and is essential for shaping **care management**.
- ✓ Hiring a **Care Manager** helps to improve health outcomes for high-risk and complex patients.
- ✓ Understanding **staff motivation** and personal traits can encourage better communication within **care teams**.
- ✓ **Monthly face-to-face** visits by the QI leads at all clinics can keep the **culture of screening** alive.
- ✓ **Using data differently** and regularly helps to shape **policies** for care delivery, improve **EHR documentation**, adjust **workflows**, and target staff **trainings**.
- ✓ Humor can be used to remove the “taboo” around screening and increases **patient engagement** (use décor, posters, and competitions).
- ✓ **Staff incentives & clinic spirit** can help change the culture around screening. Things like the “Golden Poop Trophy” and monthly care team winners can increase staff engagement.
- ✓ Working with **external partners**, including labs and colonoscopists, helps to **reduce the costs** of cancer screening and follow-up care for patients.

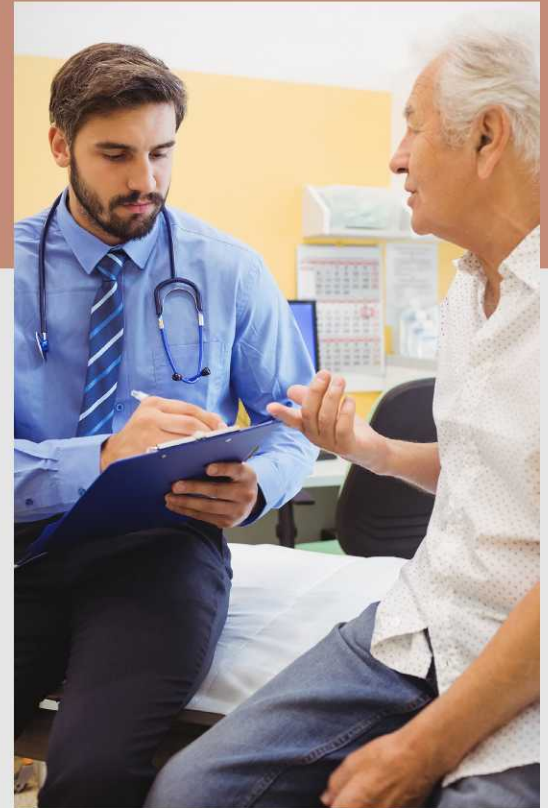
## 2

## CANCER TRANSFORMATION

*Community Health Centers of Southeastern Iowa,  
West Burlington, IA*

“

Changing the way our clinic functions to focus on Population Health Management has been a big change; an important and helpful one.”



### ABOUT COMMUNITY HEALTH CENTERS OF SOUTHEASTERN IOWA (CHC/SEIA)

[www.chcseia.com](http://www.chcseia.com)

CHC/SEIA is a nonprofit network of community health clinics guided by its mission to provide access to affordable, compassionate, high quality health care for all. CHC/SEIA offers 24-hour medical services, dental care, behavioral health services, lab services, and 340B pharmacy services. They operate as a certified Patient-Centered Medical Home and received the Health Center Quality Leader award in 2016 and 2017.

One of its four clinics participated in the **Cancer Transformation Project**.



## INTEGRATING THE CANCER TRANSFORMATION PROJECT INTO PRACTICE

Through the Cancer Transformation Project, CHC/SEIA was able to expand their **Population Health Management** efforts. They had been using **care management** in their clinics, but the project grant helped improve these services by enabling them to focus on cancer screening rates and chronic disease data points with **streamlined workflows**. To stay on track with their goals, the Medical Director and staff regularly **revisit UDS metrics** with a

**huddle board**. CHC/SEIA leadership knows that transformation takes time and is dependent upon reimbursement opportunities, but they believe that the improvements they've seen in **health outcomes** can be expanded and sustained. They are currently enhancing their focus on the **social determinants of health** to better serve their higher risk patients, and recently hired a Population Health Manager to coordinate care managers for this type of care.

## THE PATH TO VALUE-DRIVEN CARE

“

I think this project helped us map out processes better, and in more areas.”

While the Cancer Transformation Project started as a way for CHC/SEIA to improve **cancer screenings**, they **expanded** this initiative to look at several key metrics. Now, they regularly focus on data for the **top six chronic conditions** facing their patient populations (cancer screening, hypertension, depression, diabetes, obesity/BMI, asthma). By strengthening their systems and instituting **better workflows for care management**, the clinical leadership team was able to focus on **process improvements** for all of these health targets.

### Focusing on Data & the Plan-Do-Study-Act Approach

*“Everyone now pays attention to our metrics and processes to make improvements. It’s an ongoing learning process with constant monitoring.”*



CHC/SEIA uses a **huddle board** so everyone can see their metrics daily. They identify improvements, and determine if changes are working, by applying the **“plan-do-study-act”** approach. As a result, they feel that they can **map out processes better**, and the clinical staff

can make changes when they notice something isn’t working. *“It’s been interesting to pullout UDS measures specifically for each clinic”* and make clinic-based improvements.

The Medical Director feels that while cancer is costly for the health care system, chronic disease states like hypertension and diabetes burden their patients the most. So in addition to targeting regular screening, they focus a lot more time now on **patient empowerment** and education. *“We find we have to educate, educate, educate – about screening, follow-up care, and prevention.”*

### Billing for Care Management

**Case management** and **care managers** have been in place for a while at CHC/SEIA. They have chronic care managers, who provide case management, and patient navigators who help identify and support higher risk patients. Their Electronic Medical Record (EMR) system doesn’t automatically rank patients by risk to link them to care management services (it requires manual notes), so EMR-driven **risk stratification** has been difficult for CHC/SEIA. For this reason, they use their entire team to identify higher-risk patients, rather than just focus on EMR data.

The project enabled CHC/SEIA to streamline the way their care managers work. They now use **flow sheets**, which helps them track and document care management services. In turn, this helps with their UDS measures. With more structure in place, they can expand services to their Medicare population and add **more screening and prevention services** for them. Over the past two years, they’ve enhanced their ability to catalogue care managers’ work and **charge for care management services**. They also receive some reimbursement for care management services through the Iowa Medicaid Health Home Program. They plan to apply this approach to bill for behavioral health care in the future.

During the pilot project, a Medicaid Managed Care Organization drastically reduced paying for chronic disease care management for their Medicaid members. As a result, the health center had to review the roles of their RN Patient Care Managers and the services they provide. CHC/SEIA feels confident that the changes they’re making will help sustain them.



### Expanding Care Teams & the Role of Care Managers

CHC/SEIA is in the process of developing a new and integrative model, where they'll call their care team an "Impact Team". The Impact Team will have expanded roles, with a bit more focus on the **Social Determinants of Health (SDOH)**. For example, the behavioral health team would not only treat patients' anxiety and depression, but would work with the Impact Team to change patient habits. *"We had one patient who had an 'edge' to her. Turns out she couldn't read. Once I got to know her, I could give her extra attention and low-level education. Her HbA1c [blood sugar] has improved."*

CHC/SEIA's **Population Health Manager** supervises all case management activities and is placing greater focus on services to address SDOH. Their Health Center Controlled Network is determining a way to use the **PRAPARE tool for SDOH (NACHC's social risk assessment tool) within their electronic health record**. Additionally, the health center is continuing to work on standardizing all aspects of care management within their EMR. This is a new approach to help all care managers deliver a similar level of care and standardization of services to be able to bill for them. They are excited about this change.



### RESULTS TO DATE

*"We try to set smart goals. We have to make sure that we can measure what we're doing to show improvement."*

The clinics involved with transformation have seen significant improvements over the past two years. With care management, more FIT tests are given out and returned. Cervical cancer screening rates are up by 20%. Hypertension measures have increased to 80% (up by approximately 10 percentage points). Diabetic measures show patients getting their blood sugar levels down. Depression screening rates have increased, as have BMI checks. *"Success trickles into all areas."*

Nurses and care managers now spend a lot **more time with patients** who have one of the top six chronic conditions, with more attention and closer follow-up care. Patients appreciate this extra attention. Success stories include people who were screened and able to treat a precancerous polyp before anything worse happened.

During this process, and through another

initiative with a Managed Care Organization, the health center identified about 50 patients who over-use medical services. They aim to work more closely with nearby emergency rooms to help follow these patients and better manage their care needs.

The Medical Director believes that the improvements they've seen are mainly due to new processes they've put in place for care management. In turn, providers better target their care to meet UDS goals. As a team, they focus on a different UDS measure each month to slowly make improvements. *"We never get lackadaisical when rates drop."* Providers seem to appreciate the streamlining of processes around cervical and colorectal cancer screening.

The entire organization is committed to doing more and *"we appreciate learning best practices from others."* Still, they want to do more. *"It's a constant battle to get in front of the patient and help them know that these things are important."*

### THE LEARNING COMMUNITY

*"What I found really beneficial was hearing other centers talk about what they've done. We don't have to recreate the wheel. We like when we can work off of something that somebody else started."*

To help implement the Value Transformation Framework Model, the Director of Quality and the newly hired RN Care Manager appreciated being

able to talk one-on-one with NACHC staff to learn the steps needed for change and ask questions. They also appreciated the learning community approach to sharing ideas. Hearing from other pilot sites was invaluable. They benefited from learning about other sites' workflows, policies, and successful strategies that could be adopted. They felt that monthly calls kept them focused, motivated, and on track.



## CHALLENGES WITH IMPLEMENTATION

*"It's hard to transition [to value-based care], when not everyone's doing it. A hospital across the street still functions with the fee-for-service model. When different components of the local healthcare system are at different stages of transformation it makes it very difficult to implement some of our desired changes."*

It was hard for CHC/SEIA to follow the full path of the pilot project because of competing priorities at the center. Some of the main components of this project, such as risk stratification or streamlining care management, are *"works in progress"*. They wish they could hire more care managers. They wish they could hire a diabetic educator on site and/or a dietician/nutritionist. They wish they could have real-time, actionable data for each patient. In an ideal world, they would want to use an EMR that automatically stratifies patients into groups and defines their care needs. *"We need true interoperability with electronic health records, and portability."* They hope to implement a more robust data analytic software in the future through initiatives with their PCA and HCCN.

## LESSONS LEARNED

*"I would tell another health center to stick with it. It's not a quick transformation. It takes a real cultural shift and it has to start from the top. Everyone has to be involved. Though it may take a year or two to do it, it's worth it, and the changes are absolutely sustainable."*

CHC/SEIA appreciates how the Cancer Transformation Project changed the way they think about care delivery. It started with improvements focused only on cancer screening, and expanded to hypertension, diabetes, obesity prevention, and more. They appreciate the value of care managers within their care teams. The Value Transformation Framework helped them focus on where they want to go and how to get there. *"We have interventions that fall under each area of the framework that we're working on. It keeps us focused on the value of patient care and the bigger picture."*

*"Now that we're getting paid for some of our care management services, our leadership is more invested in these changes."*



## KEY LEARNINGS FROM CHC/SEIA

- ✓ Focusing on **population health management** can lead to significant improvements with health outcomes and screening rates.
- ✓ Use a care team **huddle board to drive improvements based on data**. Shared dashboards help care teams pay attention to UDS metrics every day, and work together towards systematic goals.
- ✓ The **"plan-do-study-act"** approach helps care teams identify improvements that work, and helps the Quality Improvement leadership **streamline workflows**.
- ✓ The **Learning Community** makes it easier to implement best practices. Patience is key.
- ✓ **Flow sheets** direct care managers to focus on the six most common **chronic conditions**, as well as **preventive screenings** for their higher risk patients – and **helps with billing** for related services.
- ✓ **Care management services** should be standardized within the EMR.
- ✓ Data points for some **social determinants of health** can be included in the EMR to help more patients stay on track with their care, and miss fewer appointments.
- ✓ Before starting **risk stratification**, compare models and talk to a few different facilities that are doing it. Take a step-by-step approach.

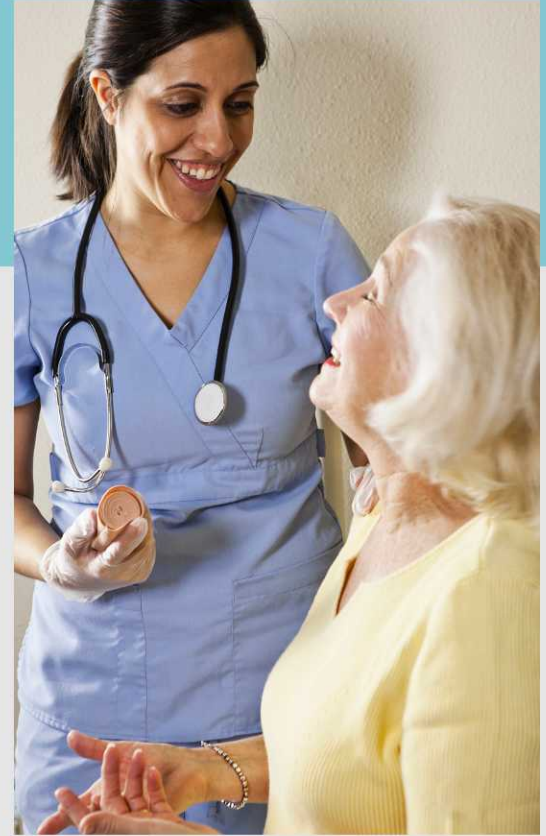
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# CANCER TRANSFORMATION

Coastal Community Health Services, Brunswick, GA



This looked to me like an opportunity to make care management easier.... The model [Value Transformation Framework] isn't terribly confusing: it's an overall holistic approach, which was great."



## ABOUT COASTAL COMMUNITY HEALTH SERVICES ("COASTAL")

[www.coastalchs.org](http://www.coastalchs.org)

Coastal Community Health Services embraces their community by seeking to meet the primary and preventive health care needs of local medically underserved residents. They provide quality, affordable and accessible health and support services as a Patient-Centered Medical Home (PCMH). They became designated as a Federally Qualified Health center in November 2013. Coastal aims to empower local leaders who value a healthy community.

As a fairly new and growing center, staff turnover was a difficult challenge during the first two years of the **Cancer Transformation Project**. They aim to get great people in place.



## INTEGRATING THE CANCER TRANSFORMATION PROJECT INTO PRACTICE

While Coastal had seen many delivery models, the structure presented in the **Value Transformation Framework (VTF)** was new to the Medical Director and team. The Cancer Transformation Project showed them the value of many elements within the model, like focusing on **evidence-based interventions**, creating **written policies for key**

**conditions**, and strengthening **teamwork** and **patient engagement** to achieve goals.

*"As a clinician... I didn't think about a policy for hypertension, I just thought about treating it. This project helped me understand the importance of structure for better outcomes."*

## THE PATH TO VALUE-DRIVEN CARE



Doing risk stratification, studying to write new policies, getting the policies written, getting them in place through the QI committee, reporting this to the board and educating board members on the clinical processes that we're planning to implement.... all of those things were very important for me to learn in my job as medical director at an FQHC....There was definitely some gratification as we saw rates for most of these conditions improve."

### Using Data

"Reviewing our data each month made me constantly look for things that could improve the metrics. We could bring this back to the staff and clinicians and say, 'This is where we are, and this is why what you're doing makes a difference.'"

Using data more deliberately helped Coastal with improvement projects as well as care management.

Over a period of months they tried to conduct **risk stratification** for all patients. They found that it was better to use the ICD10 codes for just two common conditions (hypertension and diabetes) rather than 6 or 8 conditions to identify a target group of about 120-150 people for **care management**.

Their Electronic Medical Record (EMR) posed challenges, so the process took about 6 months to refine. "The challenge was with understanding how our EMR spits out the data we needed for the risk stratification." Coastal divides patients among three levels of care: care assist, care coordination, and complex case management. When it comes to cancer screening, they simply stratify by age to follow cancer screening protocols.

### Teamwork

"Team-based [care] is so important. One of my patients has no health insurance, hypertension, and obesity (just like everybody else) and she was having post-menopausal bleeding. She came in to see our part-time gynecologist. For \$20 she was also able to get a colonoscopy and an endometrial biopsy. Cancer was found. This was very emotional for her, but the entire staff from nursing to front office, were attentive to her needs, gave her hugs and managed her referrals to cancer surgery. Kindness and compassion flowed from the entire team; the patient needed the support and appreciated it."

The project reinforced **teamwork** at Coastal. Previously, the nurses and the clinical staff did what they could, but the new "**care team**" approach gave each team member a more participatory role. "Everybody owns trying to make sure the patient gets a FIT test if they're due, or a pap smear, or whatever the measure might be. Before it was more the clinician's role to make sure these things got done. I think the project reinforced that it requires a team of people to get things done."



### Shifting to Focus on Care Management & Patient-Engagement

At Coastal, it took time for staff to recognize the extensive value of **care management** to help patients and physicians achieve their goals. In the past, many of the clinicians focused only on care coordination. The initiative made them shift their focus to education. "Health plans, leadership, and non-clinical staff [may not understand] the strength of care management and the value it can bring to an organization... It took a while just to integrate [care management] into the process."

The **care manager** now plays an essential role within the care team by working with different individuals to help patients stay on target with their personal goals. At Coastal, the team pursues **patient engagement** strategies, with consideration for their unique patient population, including language needs. The Medical Director also spends time educating providers on the importance of patient empowerment. "It's been a critical task to keep everyone focused."





## RESULTS TO DATE

*“We help patients set goals, keep talking about those goals, talk about patient flow and how clinicians could help achieve goals, then make sure we record what we’re doing in the charts. We see results.”*

As a team, the staff at Coastal set clinic-wide goals by looking at Healthy People 2020 and at national community health center screening averages. They agreed on challenging but achievable goals. They are reaching some of their goals (like with colorectal cancer (CRC) screening), and still striving to reach others (like cervical cancer screening).

When Coastal began gathering data, they found that 15% of their patients were getting screened for CRC. Now, they screen closer to 50%. They attribute much of their success to the fact that all of their clinicians

are now data-driven. *“We made it a group effort, so I think that was part of our success.”*

It has taken time, but for two years in a row, Coastal received **quality awards** from HRSA based on their improvements. They did as well as many of the large centers in Georgia. Coastal is worried these changes will be difficult to sustain without resources for additional staffing.

Through **Population Health Management**, they’ve also learned how many uninsured patients fall through the cracks when their FIT tests are positive. The Medical Director was able to acquire a small fund to help pay for initial consults with patients who test positive and need a colonoscopy, but it’s been difficult. Funding is always a challenge.

## THE LEARNING COMMUNITY

*“My assumption was that I wasn’t really doing the [monthly] reports for me, but to my surprise, we found the reports showed strategies that were resulting in a better return of the FIT test. It was helpful to document and track.”*

When the project began, the monthly project-wide calls, webinars, and tracking tools built into the Cancer Transition Project didn’t seem valuable. In retrospect, Coastal now values the help and comradery they received from the other health centers involved in the project. Over time, the monthly calls and shared resources became important sources of information on evidence-based practices with real-life experiences from fellow health centers. *“We could learn from each other in the learning community, and that was great.”* This step in the project helped Coastal and the other health centers appreciate the significant changes they were making to their operational systems, and helped them see the how these changes helped them advance toward their Quadruple Aim goals of delivering better care and better experiences with more cost controls.

The Medical Director contributed to the learning community by researching and sharing many of the policies and standing orders he wrote for Coastal. The care manager and quality improvement lead contributed (and still contribute) to training others in care management strategies.

## CHALLENGES WITH IMPLEMENTATION

*“Our nurses get layers and layers and layers of work, and they become overwhelmed because they are so patient-dedicated. If they cannot do something they need to, it produces a lot of dissatisfaction in their job role. ...The focus on patient volume puts so much pressure on us all of the time. We think ‘well, I need to see more and more patients so I’ll just leave-off these other things since there’s no time...”*

Coastal recognizes that a systems approach is effective, but requires a minimum base of staffing and support. *“It’s a big disappointment to go through the work we did for this project, get great results, and then not be able to continue it in the same way because we just don’t have the resources or staff to do it.”* In the same vein, Coastal is aware that their referral system is *“in shambles”*, again because they don’t have staff to handle the work.

While the “care team” approach helped everyone become more engaged in whole-patient-care, it may add to the stress team members feel. If a clinician is overwhelmed, it’s easy for them to pass over screening.

*“Sometimes we just don’t have time for screenings because the blood sugar is 500 and the blood pressure is 200 systolic – I don’t want my staff to feel like they’ll be punished if they miss a thing or two [when there are more acute problems].”*

When team members are stressed, it contributes to staff turn-over. The Medical Director hopes to find better ways to encourage a “safe work environment” for his staff. He feels like his first priority must be to hire a full-slate of staff, and only then can he consider performance markers.

Encouraging patients to come in for cancer screening has been hard. Their patient population is under-educated, low-income, and under-insured. They often don't speak English. The care manager sends text messages, physician reminders, and phone calls in an effort to reach people. It's time consuming. Some patients respond better than others to the outreach. Incentives, like \$25 gift cards, proved successful but not affordable to sustain. Still, this extra outreach has led to more people completing their FIT test.

The team at Coastal appreciates learning improved ways to do risk stratification. They recognize the value of this step for better care delivery, but find it hard. *“When you have an EMR that fights you every step of the way, it's extremely frustrating. If EMR vendors were responsive to clinician needs, it would be a miracle and a huge benefit for everything we're trying to accomplish in terms of patient care. EMRs aren't set-up to accurately reflect populations who need screening because of the*

*way their calendar functions are set. The data are often unreliable through these systems.”*

Coastal also deals with environmental barriers like no public transit system for people who must bring a 24 hour FIT test back to the clinic and can't afford gas. This hampers their efforts but makes small successes seem more valuable. When a patient finally gets screened, and cancer is found, they think, *“my goodness, we really helped somebody today.”*

## LESSONS LEARNED

*“Good people on your clinical team who understand population health and are on board with trying new best practices are essential for organizational success, and your leadership has to be invested.”*

The staff at Coastal worked extremely hard, and they're proud of their accomplishments. They strongly believe that everyone on staff should be on the same page, and taught the same evidence-based best practices, before success can be achieved. They warn that team leaders can't just add more tasks for nurses to complete during a short office visit, rather, it is about redesigning how work is done. There needs to be good work processes, training, and buy-in from ALL staff.

## KEY LEARNINGS FROM COASTAL COMMUNITY HEALTH SERVICES

- ✓ Use research supporting **evidence-based practices** to help get **leaders** on-board with organizational change and **population health management**.
- ✓ Use **risk stratification** to shape **care management** for chronic disease.
- ✓ **Teamwork** leads to better results when **care teams** incorporate care management, set **feasible goals** together, and **look at data** together.
- ✓ Don't create **incentive programs** that you can't **sustain**.
- ✓ Sometimes, completely **new patient engagement strategies** must be created for specific patient populations. Learn about your patient populations and their needs/ motivators.
- ✓ **Tracking data regularly** helps to shape **policies** and **standing orders**, improve **EMR documentation**, adjust **workflows**, and target staff **trainings**.
- ✓ **Share the data with everyone**, including patients (such as via newsletters). Congratulate sites for achieving goals and consistently **thank everyone** for their continued efforts.