Leveraging Health Information Technology (HIT) Through Practice Facilitation to Increase Cancer Screening Rates in Federally Qualified Health Centers (FQHCs)

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Defining the Problem: the Cancer Burden in New York State, 2017

Cancer Type	Number of New Cases	Number of Deaths
Breast	16,310	2,410
Cervical	810	790
Colorectal	8,490	2,870

Source: The American Cancer Society

THE CANCER SCREENING DEMONSTRATION PROJECT OVERVIEW

In collaboration with the New York State Department of Health (NYSDOH) and the Island Peer Review Organization (IPRO), CHCANYS piloted a 5-year, innovative grant-funded project beginning in 2012 to establish a clinical information system, the Centers for Primary Care Informatics (CPCI), to promote preventive cancer screening among NY FQHCs.

Project Aim:

To increase breast, cervical, and colorectal cancer screening rates across NYS FQHCs connected to the CPCI by 10% over baseline by June 2017

Project timeline & delivery method:

Cohort 1 ran January 2014– December 2014, learning collaborative approach, 14 practice settings

Cohort 2 ran January 2015– December 2015, learning collaborative approach, 15 practice settings

Cohort 3 ran April 2016– March 2017, practice facilitation approach, 12 practice settings

A PRACTICE FACILITATION APPROACH TO DRIVE IMPROVEMENT

Practice facilitation is an approach to supporting improvement in primary care practices that focuses on building organizational capacity for continuous improvement (1).

Practice facilitators are specially trained individuals who work with primary care practices to make meaningful changes designed to improve patients' outcomes. They help physicians and quality improvement teams develop the skills they need to adapt clinical evidence to the specific circumstance of their practice environment (2).

Making the case for practice facilitation:

· Proven effective at increasing primary care prevention services & adopting evidence-based clinical guidelines (3)

· Proven sustainable (4)

· Improves patient health outcomes while being cost-effective (5)

Sources:
(1) Knox, 2010; (2) DeWalt, et al., 2010; (3) Nagykaldi, Mold, and Aspy, 2005; Baskerville, Liddy, and Hogg, 2012; (4) Parchman, et al., 2013; Baskerville, Liddy, and Hogg, 2012; (5) Hogg, Baskerville, and Lemelin, 2005

Figure 1. The Center for Primary Care Informatics Data Warehouse
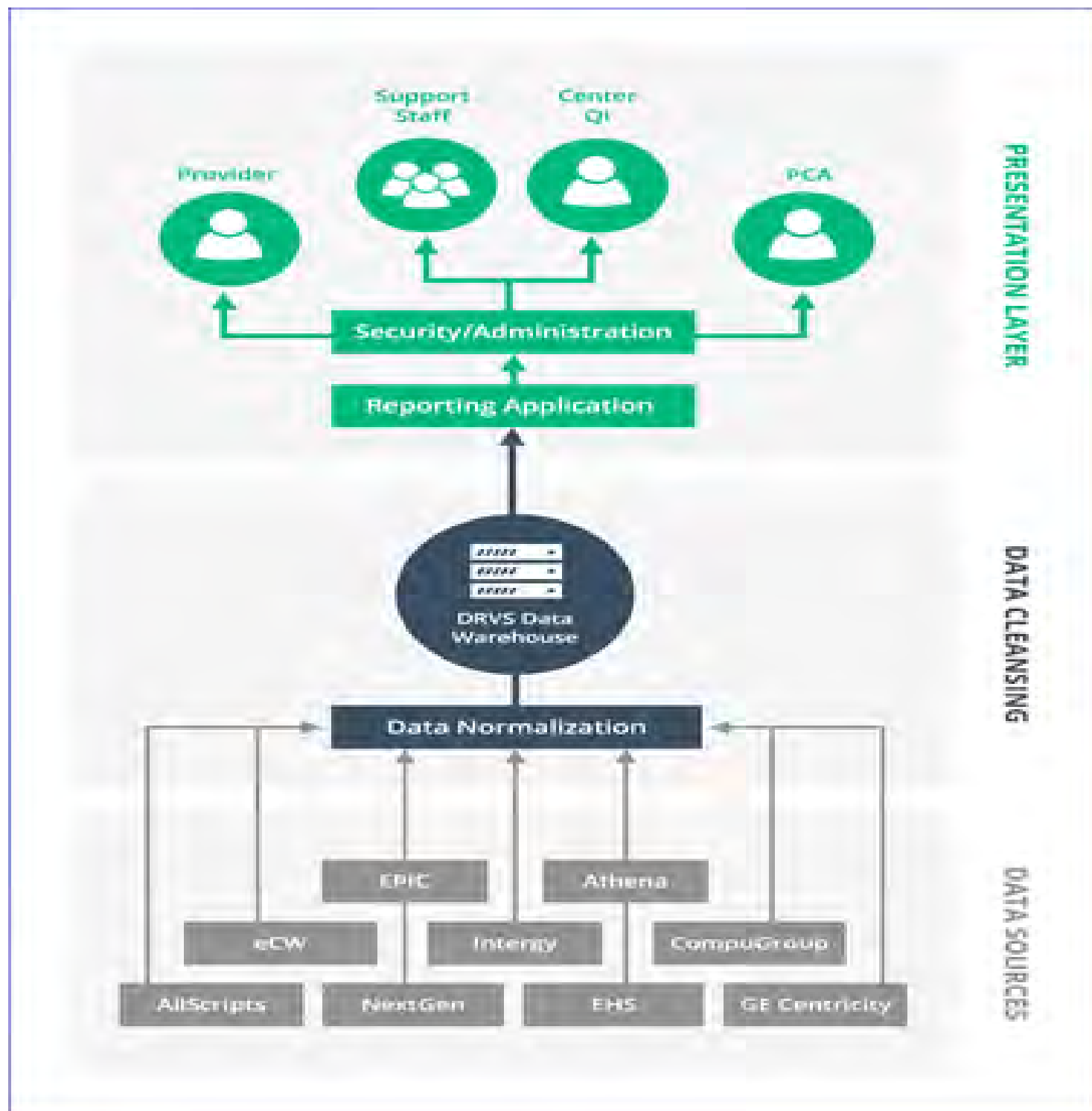
The CPCI:

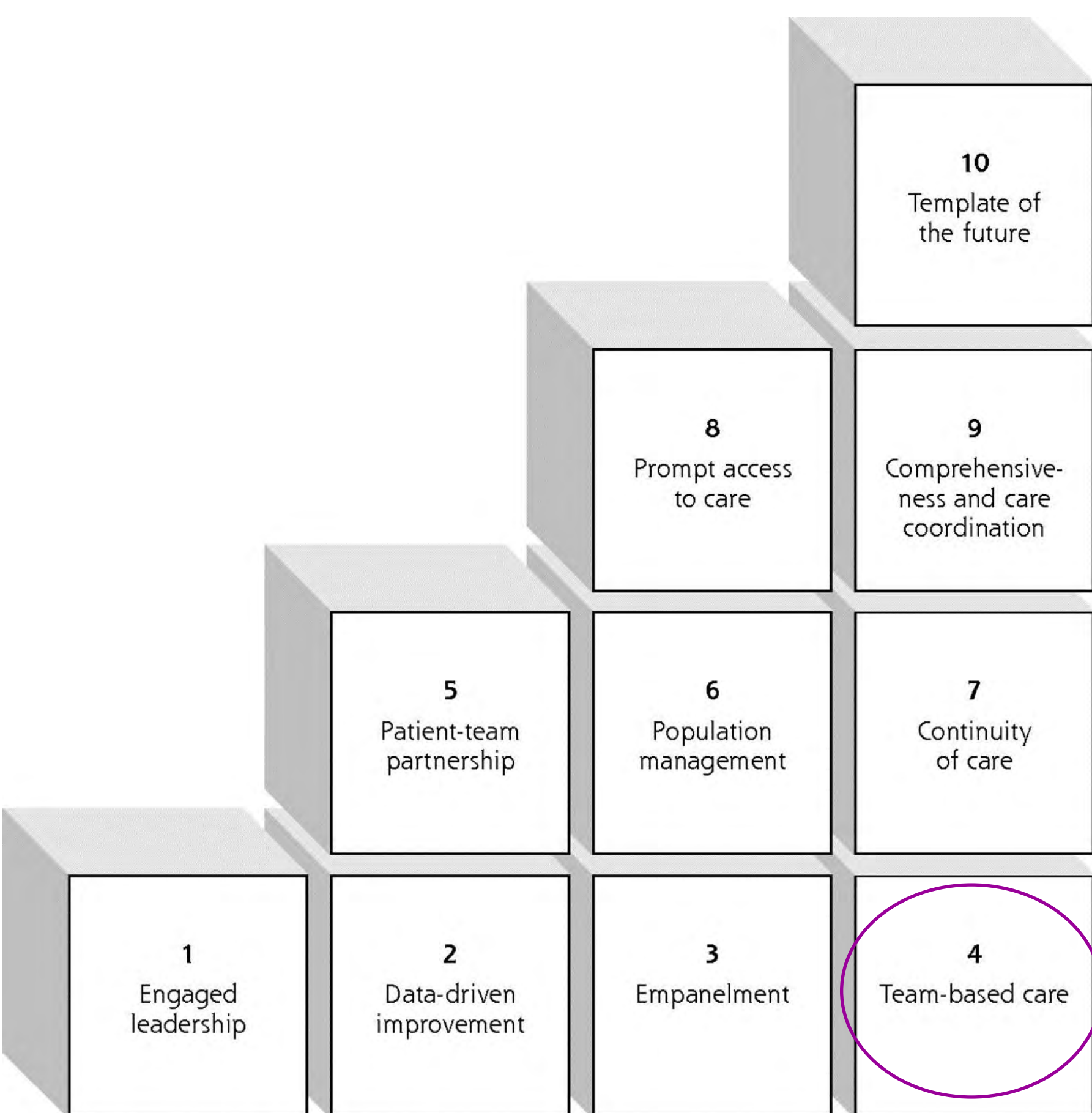A cloud-based data warehouse platform, created by Azara Healthcare, which

· Extracts data from EHRs to calculate performance on metrics, including breast, cervical, & colorectal cancer screening

· Aggregates data into reports that support data-driven clinical care & mandated & regulatory reporting (UDS, eHIVQAL, Meaningful Use, etc.)

· Offers clinical decision support tools, including:

  - Pre-visit planning report

  - Customized clinical registries & dashboards

  - Care management module

CHCANYS' PRACTICE FACILITATION MODEL

· Based on Thomas Bodenheimer's 10 building blocks of high-performing primary care practices & adapted from the Agency for Healthcare Quality & Research's (AHRQ's) Practice Facilitation handbook

· Monthly onsite and remote training sessions

· Curriculum tailored to each health center's needs

· Builds foundations in data quality, team-based care, and population health management competancies for practice transformation
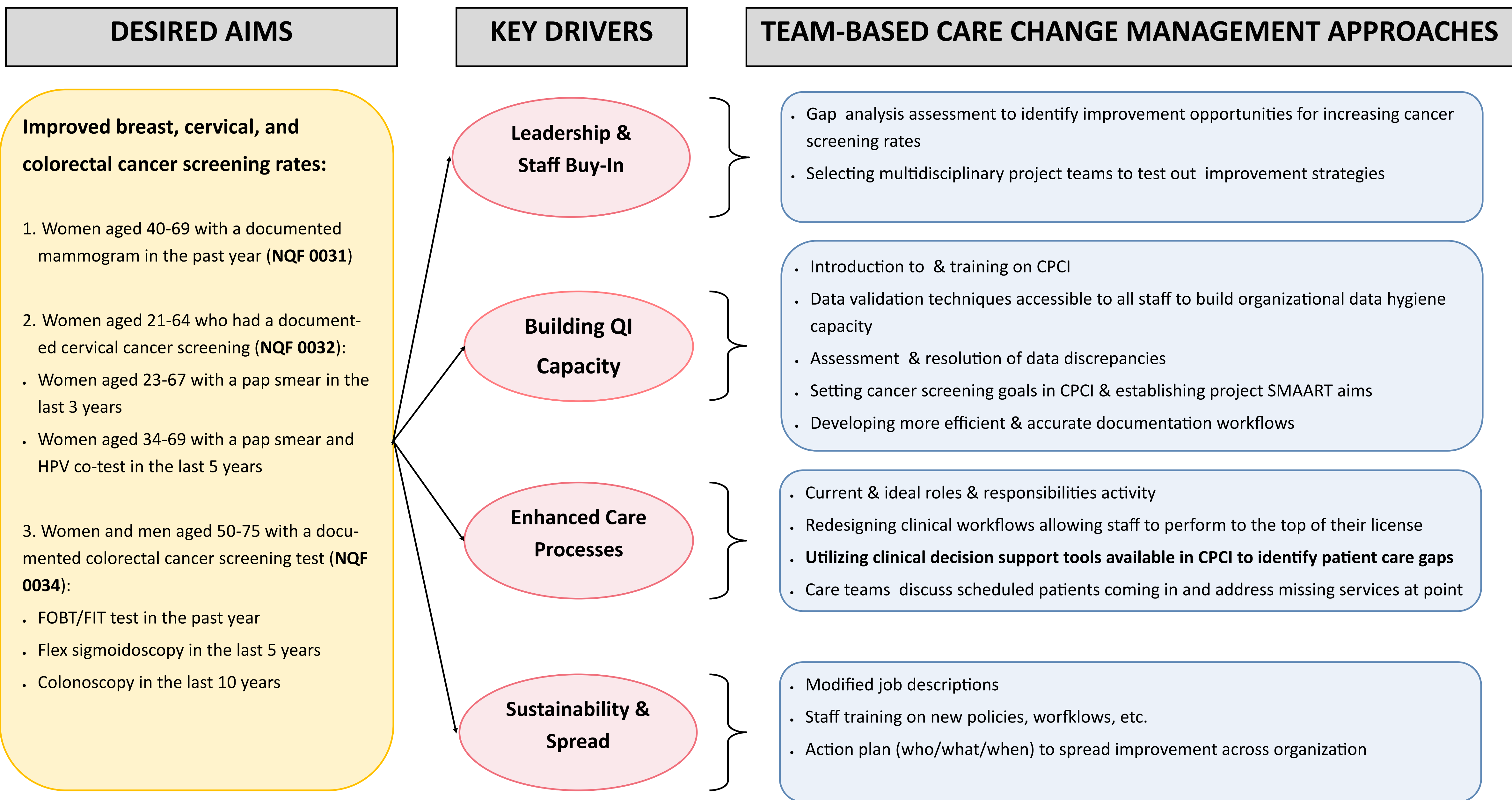
Source: Bodenheimer, et. al, 2011, AHRQ Practice Facilitation Handbook

Figure 2. Thomas Bodenheimer's 10 Building Blocks to High-Performing Primary Care

Source: Bodenheimer, et. al, 2011

Why TBC?

· Improves patient outcomes

· Maximizes efficiency

· Builds better staff relationships

· Increases job satisfaction

What does team-based care look like?

· Clinical support staff working with the same provider every day

· Care teamlet huddles (Provider-MA/LPN) to identify patients with missing services coming in for appointments

· Coordination of additional services to meet patient care needs

Figure 3. A Care Teamlet Huddling with the CPCI's PVP Report

Source: Pre-Visit Planning training video

Figure 4. CHCANYS Cancer Screening Key Driver Model

DESIRED AIMS	KEY DRIVERS	TEAM-BASED CARE CHANGE MANAGEMENT APPROACHES

Improved breast, cervical, and colorectal cancer screening rates:

1. Women aged 40-69 with a documented mammogram in the past year (NQF 0031)

2. Women aged 21-64 who had a documented cervical cancer screening (NQF 0032):
· Women aged 23-67 with a pap smear in the last 3 years
· Women aged 34-69 with a pap smear and HPV co-test in the last 5 years

3. Women and men aged 50-75 with a documented colorectal cancer screening test (NQF 0034):
· FOBT/FIT test in the past year
· Flex sigmoidoscopy in the last 5 years
· Colonoscopy in the last 10 years

Leadership & Staff Buy-In
· Gap analysis assessment to identify improvement opportunities for increasing cancer screening rates
· Selecting multidisciplinary project teams to test out improvement strategies

Building QI Capacity
· Introduction to & training on CPCI
· Data validation techniques accessible to all staff to build organizational data hygiene capacity
· Assessment & resolution of data discrepancies
· Setting cancer screening goals in CPCI & establishing project SMAART aims
· Developing more efficient & accurate documentation workflows

Enhanced Care Processes
· Current & ideal roles & responsibilities activity
· Redesigning clinical workflows allowing staff to perform to the top of their license
· Utilizing clinical decision support tools available in CPCI to identify patient care gaps
· Care teams discuss scheduled patients coming in and address missing services at point

Sustainability & Spread
· Modified job descriptions
· Staff training on new policies, workflows, etc.
· Action plan (who/what/when) to spread improvement across organization

Source: AHRQ Practice Facilitation Handbook

Figure 5. The Pre-Visit Planning (PVP) Report in the CPCI

Table 1. Impact of Practice Facilitation on Breast, Cervical, & Colorectal Cancer Screening Rates Over an 18 Month Period

Aggregate Cancer Screening Rates per Month				
	March 2016 (baseline)	**March 2017** (project end)	**Relative Change** (March 2016-March 2017)	**Sustained Improvement** (September 2017)
Breast**	35.1%	42.4%	**20.8%**	42.6%
Cervical	42.0%	42.5%	**1.2%**	46.4%
Colorectal	36.9%	45.2%	**22.5%**	45.7%

*1 health care setting removed from evaluation due to unreliable data

**Data presented does not reflect the change to breast cancer screening recommendation for women 50-74 (NQF 2372)

Table 2. PVP Report Utilization Over an 18 Month Period

HIT Adoption based on CPCI Utilization– Number of PVP Reports Run per Month				
	March 2016 (baseline)	**March 2017** (project end)	**Relative Change** (March 2016-March 2017)	**Sustained Improvement** (September 2017)
Total Monthly Reports Run	507	1065	**110.1%**	720