Health Center Mission

*Improve the health of the Nation’s underserved communities and vulnerable populations by assuring access to comprehensive, culturally competent, quality primary health care services*
What is a “Community Health Center”? 

Local, non-profit, community-owned health care providers serving low income and medically underserved communities. 

Characteristics of federally funded centers: 
• Funded through grants from the Health Resources and Services Administration (HRSA) 
• Located in medically underserved area or serve a medically underserved population 
• Governed by a community board 
• Provide comprehensive primary health care 
  – Primary & Preventive Care 
  – Culturally and linguistically competent care 
  – Enabling Services (translation, transportation,...) 
• Provide services available to all with fees adjusted based on ability to pay (“sliding scale”).
What is a “Community Health Center”?

Health Center characteristics (continued):
• Meet other performance and accountability requirements regarding administrative, clinical, and financial operations
• Often provide on-site dental, pharmaceutical, and mental health and substance abuse services
• Report quality data to HRSA annually using measures defined in the Uniform Data System (UDS)
• Synonyms: Federally Qualified Health Center (FQHC), Community Health Center (CHC), Section 330 Health Center
Health Center Statistics

In 2017:

• 1,373 program grantees
• >10,000 sites
  – every U.S. state, the District of Columbia, Puerto Rico, the Virgin Islands, and the Pacific Basin
• More than 27 million patients served
  – 1 in 12 people nationwide rely on a health center for their preventive and primary health care needs
  – 1 in 9 children
  – 1 in 5 people in rural areas
  – 1 in 3 people living in poverty
• 75% of health centers are recognized as Patient Centered Medical Homes (PCMH)
Challenges faced by many CHC patients

Patient-related:
- Financial barriers (esp. lack of insurance)
- Access issues – lack of transportation, ability to take time off work
- Poor health literacy
- Fear/Distrust of medical system
- Cultural issues
- Language barriers
- High no-show rate for appointments, tests
Challenges faced by many CHC patients

Systems-related:

• Costs along the entire care spectrum (e.g. fees for imaging, pathology, anesthesia, hospital/facilities, ...)

• Cost of follow-up treatment if needed

• Indirect costs of screening (time off work, post-treatment care, etc.)

• Lack of structures and processes in specialty practices and referral facilities to address patient barriers
CRC “Steps” Manual

- Step-by-step instructions to help primary care practices implement team-based, systematic processes to increase CRC screening.
- Developed with input from NACHC, HRSA, CDC and CHC clinicians and staff
- Most information relevant to wide range of primary care practices (not just CHCs), and to screening and follow-up of other cancer types

http://nccrt.org/about/provider-education/manual-for-community-health-centers-2/
Step #1: Baseline Data

Guidance on how to determine accurate baseline screening rate
Cancer-related Health Center Data

What about UDS Quality Measures?

- Childhood Immunization Status
- Cervical Cancer Screening
- Tobacco Use Screening and Cessation Intervention
- Use of Appropriate Asthma Medications
- Screening for Clinical Depression and Follow-up
- Controlling High Blood Pressure
- Early Entry to Prenatal Care
- Diabetes: HbA1c ≥ 9%
- Weight Assessment and Counseling for Children and Adolescents
- Low Birth Weight
- Body Mass Index Screening and Follow-up Plan for Adults
- Ischemic Vascular Disease: Use of ASA or Another Antiplatelet
- Colorectal Cancer Screening
- Dental Sealants for children aged 6-9
- HIV Linkage to Care
- CAD and Lipid Therapy
Determining Screening Rates

- Identify correct patient populations required to calculate a colorectal cancer screening rate

- Identify the numerator and denominator for your baseline screening rate using Health Resources and Services Administration (HRSA) Recommendations
  
  **Denominator**
  - Patients 50-75 years of age with a visit during the measurement period
  
  **Numerator**
  - Patients with one or more screenings for CRC, defined by any one of the following:
    - Fecal occult blood test (FOBT) during the measurement period (MP)
    - Flexible sigmoidoscopy during MP or the four years prior
    - Colonoscopy during MP or the nine years prior
    - FIT-DNA during MP or the two years prior
    - CT Colonography during MP or the four years prior
FQHC Screening Rates Are Rising

CRC Screening Rate

_ALL FQHCs-UDS_

More than 300,000 additional FQHC patients screened!
Step #2: Create a Team

- Engage staff at multiple levels with focus on quality and process improvement
- Identify champions who can ingrain new processes into practice
- Integrate screening navigation
Patient Navigation

Navigator models may include:

- Outreach
- Assistance with scheduling lung CT
- Appointment reminders
- Track screening completion
- Ensure that screening results reach PCP and are entered into medical record
- Monitor follow up of abnormal findings
Step #3: Get Patients Screened

- Ensure high-quality screening, as well as diligent tracking of test completion and follow-up
- Develop and implement measurement and feedback to PCPs and other team members
Standing Orders

- Standing orders that allow nursing staff, medical assistants or navigators to discuss cancer screening and submit referrals for screening have been demonstrated to increase screening rates.

- Staff training on risk assessment, components of the screening discussion, ... is essential for a successful program.

- Know your state – rules vary regarding use of standing orders.

J Am Board Fam Med 2009
Outreach

- Addresses individuals who may not have frequent visits to the health center, or may not have received information on screening during recent visits

- Multiple modalities available
  - Telephone
  - Text
  - Email
  - Snail mail
Regular Reporting of Screening Performance

![Graph showing percentage of patient 50–75yo who have received appropriate colorectal cancer screening]

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<th>CHA</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
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<td>15.54%</td>
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<td>Colorectal Cancer Screening</td>
<td>Percentage of adults 50-80 years of age who had an appropriate screening for colorectal cancer</td>
<td>Patients in the denominator who received one or more screenings for colorectal cancer</td>
<td>All patients 51 to 80 years of age during the measurement year</td>
<td>NCQA/NQF PQRS/PCPI</td>
<td>National Committee for Quality Assurance</td>
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Step #4: Coordinate Care

Suggestions on **creation of a medical neighborhood** to coordinate the care of patients beyond the walls of the health center

Includes the hospital, radiology, anesthesia, pathology, surgery and oncology
IMPROVING LINKS TO CARE IN THE DELIVERY OF COLORECTAL CANCER SCREENING AND FOLLOW UP

A funding opportunity through the American Cancer Society’s CHANGE Program
Issue: Limited Access to Specialty Care

Accessing specialty care, including screening and follow up colonoscopy, is a major challenge for many FQHC patients.

- Appropriate screening not available for patients at increased risk
- Follow up colonoscopy not available for patients with positive FIT or guaiac test results
  - Delay or failure to obtain follow up colonoscopy is associated with increased risk of CRC and late-stage dx
  - Studies from safety net settings find follow up rates < 50%
- Lack of access makes some clinicians reluctant to recommend screening
Links of Care Pilot Project

Grant funding to FQHCs and local partners to stimulate collaboration and support development of the long-term structures and relationships needed to improve access to specialists in the community in the delivery of cancer screening and follow up, using CRC as the model.

Pilot FQHCs:
- West Side Community Health Services, Saint Paul, MN
- Beaufort-Jasper-Hampton Comprehensive Health Services, Port Royal, SC
- Fair Haven Community Health Center New Haven, CT
The Goals

Primary goal:
• Increase timely access to specialists for FQHC patients after a positive colorectal cancer screening result.

Secondary goals:
• Advance evidence-based strategies to increase colorectal cancer screening rates within primary care systems.
• Develop processes, tools and templates to promote replication of this work in other communities and for other types of cancer screening and follow-up.
Lessons Learned

• **Effective patient navigation is essential**
  – Proactively addresses anticipated barriers
  – Increases adherence with screening
  – Protects good relationship with hospital and specialists by effectively addressing concerns about no shows, follow up of abnormal screens, other challenges.

• **Agreement on expectations**
  – Defined number of screenings per month
  – Clear role delineation re: f/u of abnormals, annual reminders

• **Ensure program efficiency**
  – Use consistent protocols that reduce the burden on health center and screening center staff while ensuring that all needed medical information is transmitted (e.g. standardized referral forms).
  – Agreement on billing procedures, management of inaccurate billing,...
Lessons Learned

• **Form and leverage the right partnerships**
  – Regular communication between health center staff and the screening site at multiple levels regarding what is working and what needs to be improved

• **When things go wrong (and they will):**
  – Joint problem-solving
  – Accept the blame (no finger pointing)
  – ...but share the credit
Model for Addressing Other Cancer Issues

Steps for Increasing HPV Vaccination in Practice
An Action Guide to Implement Evidence-based Strategies for Clinicians

Includes pediatricians, family physicians, general internists, obstetrician-gynecologists, nurse practitioners, physician assistants, nurses, medical assistants, and their office managers.

HPV VACs
Vaccine Adolescents against Cancers

Lung Cancer Screening
IMPLEMENTATION GUIDE

2016