A team-based care approach for improving colorectal cancer screening rates

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Chief Operations Officer
Esperanza Health Centers

- Pediatrics
- Adult Medicine
- Women’s Health
- Behavioral Health & Psych
- Care Coordination
- Wellness Programs

Annually:
- Patients: 22K
- Encounters: 85K
- 60% Medicaid
- 25% uninsured
- 70% prefer Spanish language
Colorectal Cancer Screening:

- Colorectal cancer (CRC) in US:
  - 3rd most common cause of cancer
  - 2nd leading cause of cancer-related deaths

- CRC screening rates in 2015:
  - non-Hispanic whites: 62%
  - Latinos: 47%
  - Uninsured Latinos: 19.5%

- 2015 FQHCs nationwide: 38%

- Esperanza Health Centers:
  - 2015 screening rate = 43%
  - Uninsured (ages 50-75): 34%
  - Latino 91%
  - Difficult to obtain colonoscopy for uninsured >> primarily FIT testing
2016 & 2017 Strategies and Initiatives

1) Added care coordinators to clinical teams
2) Performance dashboards
   • Monthly data dashboards
3) Set ambitious but achievable goal of 60%
4) Changed EHRs to Athena w reporting and population health tool
5) Performance Coaching/ Sharing Best Practices
Strategy #1 Care Coordinators

Before

Provider

Patient

MA

After

Provider

Patient

Care Coordinator

MA

Care Coordinator- taught patients how to perform FIT tests, reminder calls to bring in FIT tests, mailed FIT tests to some patients.
Strategy #2 Sample Dashboard

Colorectal Cancer Screening (Jan - May 2017)

<table>
<thead>
<tr>
<th>Name</th>
<th>Patients</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bender</td>
<td>16/29</td>
<td>55%</td>
</tr>
<tr>
<td>Chico</td>
<td>73/119</td>
<td>61%</td>
</tr>
<tr>
<td>Connolly</td>
<td>107/171</td>
<td>63%</td>
</tr>
<tr>
<td>Doubek</td>
<td>50/91</td>
<td>55%</td>
</tr>
<tr>
<td>Hoque</td>
<td>27/61</td>
<td>44%</td>
</tr>
<tr>
<td>Kindleberger</td>
<td>63/112</td>
<td>56%</td>
</tr>
<tr>
<td>Liu</td>
<td>31/59</td>
<td>53%</td>
</tr>
<tr>
<td>Luna</td>
<td>268/449</td>
<td>60%</td>
</tr>
<tr>
<td>Peña</td>
<td>168/315</td>
<td>53%</td>
</tr>
<tr>
<td>Shokunbi</td>
<td>184/278</td>
<td>66%</td>
</tr>
<tr>
<td>Silva</td>
<td>296/456</td>
<td>65%</td>
</tr>
<tr>
<td>Simon-Price</td>
<td>28/62</td>
<td>45%</td>
</tr>
<tr>
<td>Tanner</td>
<td>17/31</td>
<td>55%</td>
</tr>
<tr>
<td>Van Wieren</td>
<td>164/213</td>
<td>77%</td>
</tr>
<tr>
<td>Villegas</td>
<td>9/15</td>
<td>60%</td>
</tr>
<tr>
<td>Yacht</td>
<td>78/168</td>
<td>46%</td>
</tr>
<tr>
<td>Clinic Total</td>
<td>1313/2209</td>
<td>59%</td>
</tr>
</tbody>
</table>
Strategy #3: Set ambitious but achievable goal of 60%

• Team-based bonus if met goal
  • 1/10 measures
    • Worth $333 for providers
    • Worth $100 for MA
    • Worth $100 for Care Coordinator

• Care team competitions (small incentives)
  • $100 gift card per team member
  • Lunch for department
Strategy #4 Switched EMR - Quality Priority

- Available monthly dashboards
- Point of Care reminders
- Accurate & Live population health tool for care coordinators
Strategy # 5 Performance Coaching

• Investing in department and team meetings to set culture and share best practices
Clinic Trend - Strategy Points & New Goal

2014: 46%
2015: 43%
2016: 69%
2017: 80%
2018: 83%
Tips for replicating at other FQHCs

• Get buy-in and resources from leadership
• Set culture
• Set ambitious but realistic goals—consider incentives
• Invest in dashboards and teams

• Make sure EHR has population health tool
• If high % uninsured, focus on FIT tests vs colonoscopy
• No magic bullet—multipronged approach

2018 Celebrating CRC awareness month!
The future of quality at Esperanza:

- Continue aggressive goals: 83% by 2018
- Formalized team performance coaching
- Predictive Analytics for performance
- Monitor all diagnostic follow up
- Social Media Buzz
Questions?
Thank you!

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