Case Study

NATIONAL ASSOCIATION OF Community Health Centers

Teche Action Clinic's High Performance

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

Teche Action Clinic
www.tabhealth.org

Operating in southeastern Louisiana

13 sites

25,000 patients served

Mobile clinic

Services
Adult Medicine, Pediatrics, OB/GYN, Dental, Mental Health, Nutrition, Laboratory, Pharmacy, Patient Assistance Center, Mobile Unit, School-based clinics

Patient Center Medical Home
Certification

Payer mix
Commercial health insurance, Medicaid, Medicare, sliding fees

Teche Action Clinic is a private, not-for-profit federally qualified health center providing comprehensive, safe, quality health care at thirteen locations and a mobile clinic for residents in southeastern Louisiana. Teche Action Clinic was the first community health center in Louisiana to receive accreditation by The Joint Commission (1999) and was certified in 2011 as a Primary Care Medical Home (PCMH).

This clinic's philosophy is to serve as a caring, culturally competent, community responsive institution where all who seek health services may come. They have proven their success in creating a patient-centered, prevention-focused care delivery system focused on improving quality, improving health outcomes, and reducing costs. Their success can be examined using the National Association of Community Health Center's (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, initially, 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. Initial efforts focused on interventions for tobacco use, asthma, and unintended pregnancy, conditions particularly prevalent among Medicaid beneficiaries.

The National Association of Community Health Centers, Inc. (NACHC) is collaborating 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.

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Additional information

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

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 TECHE ACTION CLINIC?

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 Teche Action Clinic was one of four health centers that achieved ≥ 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 Teche Action Clinic 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 Charles B. Wang Community Health Center in New York City, 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 Teche Action Clinic and Charles B. Wang Community Health Center 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

HEALTH CENTER

Care Delivery	Infrastructure	People
Population Health Management	Improvement Strategy	Patients
Patient-Centered Medical Home	Health Information Technology	Care Teams
Evidence-Based Care	Policy	Leadership
Care Management	Payment	Workforce
Social Determinants of Health	Cost	Partnerships

[1] 2016 Health Center Profile, Teche Action Board, Inc. (Accessed February 15, 2018). Health Resources and Services Administration website. Retrieved from: https://bphc.hrsa.gov/uds/datacenter.aspx?q=d&bid=060180&state=LA&year=2016.

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CDC's 6|18 INTERVENTIONS

The NACHC-CDC partnership for the 6|18 Initiative is an effort 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 6|18 clinical conditions for which there is a related HRSA UDS measure: tobacco use, blood pressure, asthma, and diabetes.

> "We have to be very aggressive in helping people to quit."

CDC's 6|18 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 Practice Guideline and the 2015 U.S. Preventive Services Task Force (USPSTF) tobacco cessation recommendation statement.
- 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.

Teche Actions to Reduce Tobacco Use:

- Incorporates questions about smoking status as part of vital signs taken at each visit. Patients coming in for a medical or dental visit are asked about smoking status alongside the other vital signs of height, weight, and blood pressure.
- Uses 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.
- Connects patients to partner cessation programs such as the Louisiana Department of Health's 24 hour 1-800 quit hotline (http://www.quitwithusla.org/).
- Provides patients with educational materials and other tools to help quit. The center is developing a booklet with targeted messages for their patient population aimed to help cessation efforts.
- Working to have staff become certified by the State as "Smoking Cessation Professionals."
- Promotes the use of covered treatment benefits for tobacco users, including patches and medication treatment.
- Plans to work with the Department of Health using funds available through a settlement with Louisiana tobacco companies to offer additional free tobacco cessation treatment options.

> "We try to help manage psycho-social aspects of a child's condition – like if there is tobacco exposure at home, or trouble with medication, or sleep apnea – we do the best we can to support the family in making changes that help the child."

CONTROL HIGH BLOOD PRESSURE

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

- Implement strategies that improve adherence to blood pressure, lipid-lowering and smoking cessation medications (with sample actions suggested).
- Provide hypertensive patients with blood pressure monitors and reimburse for clinical support services required for self-measured blood pressure monitoring.

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

Teche Actions to Control High Blood Pressure:

- Takes a personalized approach to patients' adherence to blood pressure and lipid-lowering medications, meeting patients where they are in terms of language, education, culture, and other social factors.
- Uses a care team approach to improve blood pressure control and overall cardiovascular care.

CONTROL ASTHMA

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

- Use the 2007 National Asthma Education and Prevention Program (NAEPP Guidelines) as part of evidence-based clinical practice and medical management guidelines.
- Implement 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 the medical management approach outlined in the 2007 NAEPP Guidelines.
- Expand access to home visits by licensed professionals or qualified lay health workers to provide both targeted, intensive self-management education and the reduction of home asthma triggers for patients whose asthma is not well-controlled through use of both 2007 NAEPP Guidelines' medical management and asthma self-management education.

Teche Actions to Control Asthma:

- Uses the updated 2007 National Asthma Education & Prevention Program guidelines for asthma control initiatives.
- Diagnoses severity of asthma at initial visit as part of developing a personalized care plan.
- Instructs patients 4 years of age and older on the use of spirometry.
- Implements strategies that improve access and adherence to asthma medications and devices. For example: after patients understand the severity of their symptoms, a personalized action plan is created for each patient that includes self-management strategies and a schedule of follow-up appointments.
- Includes measurement of uncontrolled asthmatics on their performance dashboard.
- Utilizes an Asthma Care Handbook created for patients and schools and provides parents and caregivers other educational information, including CDC's "Help Your Child Get Control Over Asthma".

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

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.

Teche Actions to Control/Prevent Diabetes:

- Offers patients internal and external referrals to registered dieticians and certified diabetic educators for group education classes on lifestyle changes, dietary changes, and self-management goals.
- Refers patients to behavioral health providers to address identified barriers. The center partners with Pennington BioMedical Research Center in the PROPEL (Promoting Successful Weight Loss in Primary Care in Louisiana) program for intensive one-on-one coaching on lifestyle changes in support of sustained weight loss.
- Provides diabetic patients with a simple report card of their HbA1c score with a grade from A-F. This creative "report card" is easily understood by patients, and motivates them to improve.

> "When patients come in, no matter what their educational level is, our goal is to make sure that people understand what they should be doing to help improve their own health outcomes."

ORGANIZATIONAL APPROACHES THAT SUPPORT HIGH PERFORMANCE

Teche Action Clinic's systems approach is attentive to care delivery, infrastructure and people – domains outlined within NACHC's Value Transformation Framework. This multi-pronged approach enables them to achieve high levels of performance across the 6|18 conditions that are sustained over time. Like many of Teche Action Clinic's approaches to health prevention and chronic disease improvement, they take a broad, community and organizational perspective in their efforts to achieve goals. They intentionally work as part of a larger medical neighborhood, including collaborations with public housing and the business community. The health center's Chief Executive Officer, Dr. Wiltz, is a physician who understands how the clinical and business models apply to health center operations.

Applying the Value Transformation Framework to Advance 6|18 Initiatives

Care Delivery

Despite serving communities with high rates of poverty and compounding social risks, including some of the highest illiteracy rates in the country, Teche Action Clinic has been able to achieve outstanding levels of clinical performance, including measures that align with CDC 6|18 conditions. Ninety-nine percent (99%) of Teche Action Clinic patients are at or below 200% of poverty.[1] Their focus on the empowerment of individuals, while having a population health perspective, has been a contributing factor in their success.

Dr. Wiltz's early and active support for the Patient-Centered Medical Home (PCMH) care delivery model was behind the decision to seek PCMH certification. Similarly, his leadership has moved the center toward a value-based model of care. Teche standardizes work processes and has hardwired the capture of key clinical data into standardized processes. This has resulted in improved clinical intervention completion rates, data capture, and tracking. For example, the health center now includes questions about tobacco status as a standard part of the patient visit intake process, along with height, weight, blood pressure and other vitals. Data fields for tobacco status have been built into the electronic health record (EHR) to capture this information.

Teche Action Clinic is engaged in a broad range of collaborative efforts. They are partnering with the State Department of Health to create a new "Chambers of Health" initiative. This initiative is modelled after the Practical Playbook which advances collaboration between public health and primary care to improve population health.[2]

> "If they [staff] understand the expectations and what it is they need to do, they will perform."

Infrastructure

Dr. Wiltz is a strong advocate on the value that was played by the HRSA sponsored Health Disparities Collaboratives that aimed to use improvement methodologies and team approaches to improve diabetic, cardiovascular, and asthma care.[3] He is also highly supportive of the Chronic Care Model which identifies the essential elements of a health care system that support high quality chronic disease care.[4] He recognizes how these models have influenced the health center's QI efforts and inspired his clinical staff to become highly collaborative achievers.

Teche Action Clinic has modified the Plan-Do-Study-Act (PDSA) improvement model[5] to Plan-Train-Study-Act (PTSA) to reflect their heavy emphasis on training. Staff receive extensive training in work processes and electronic health record documentation. They share an EHR tip sheet (internally created and updated) with every provider and nurse. Training on how to record diagnostic codes for payment from Medicaid and managed care plans, including codes for evidence-based prevention services listed in the 6|18 Initiative, is now standard practice. Training on UDS definitions, measurement, and data capture (including screen shots on how to accurately capture data in the clinic's EMR) helps Tech Action Clinic track their work, earn reimbursement for their full range of patient care, and expand their ability to deliver and track evidence-based care.

> "We are working with the larger community... It aligns perfectly with 6|18."

To create a broader environment of change, Teche Action Clinic participates in collaborative activities that support wellness initiatives throughout the community. For example, they are part of "Well-Ahead Louisiana", an initiative started by the Louisiana Department of Health to improve the health and wellness of Louisiana citizens. This partnership promotes community-wide healthy choices such as establishing tobacco-free zones among other wellness initiatives. Teche Action Clinic is now a designated 'WellSpot', because it strives to "make it easier for Louisiana citizens to live well". On site, the health center's security guard issues 'citations' to people who smoke on the property – the citation being a 'ticket' to call the 24 hour 1-800 quit hotline (http://www.quitwithusla.org/). The center has plans to expand the 'smoke-free' zone around the center by requesting that the City Council donate the surrounding sidewalks.

[2] The Practical Playbook. (Accessed February 15, 2018). https://www.practicalplaybook.org/.

[3] Chin, M. Quality Improvement Implementation and Disparities: The Case of the Health Disparities Collaboratives. Med Care. 2010 Aug;48(8):668-75.

[4] MacColl Center for Health Care Innovation. The Chronic Care Model. (Accessed February 15, 2018). http://www.improvingchroniccare.org/.

[5] Institute for Healthcare Improvement. How To Improve. (Accessed February 15, 2018). http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx.

People

Teche Action Clinic's philosophy begins with caring for the individual, 'meeting them where they are', and includes extensive partnerships that are leveraged to support each individual patient. When a patient comes in for care at Teche Action Clinic, staff guide and educate them in a language, and at a level, the patient can understand. Their Board, staff, and providers follow the mantra: "EMPOWERS: Effectively Managing Patient Outcomes with Environmental Resources Systematically". Dr. Wiltz tells his patients "I'm your primary care provider, but you're your primary care provider too, because you're with yourself 24 hours a day".

Teche Action Clinic recognizes that patients are cared for beyond the four walls of the health center. They have created strategic partnerships with external organizations to improve health outcomes, including areas like cancer screening, obesity prevention, and smoking cessation. For example, Teche partners with Louisiana State University's Science Center in colorectal cancer screening efforts and has leveraged the quality improvement skills of an American Cancer Society (ACS) field representative, serving as an ad hoc member of the QI Committee, to train staff in performance improvements. The Chambers of Health initiative the health center is leading with the Department of Health is building stronger partnerships to advance the health of populations.

Another key factor in their success is that they not only monitor the performance of providers, but also monitor the performance of nursing at the individual level. Nurses are audited for their performance on select UDS measures. The center reports that when they began tracking and reporting on UDS measures at the individual – as well as team - level (e.g., the number of patients who had a pap smear, offered colorectal cancer screening, or referred to smoking cessation programs), results went up. Nursing, provider and care team performance results are shared at Quality Improvement meetings. There is an annual nursing boot camp to help nurses achieve goals and celebrate their successes.

In addition to empowering patients and providers with education and training, the health center gives providers and staff control over data and information that can be used to drive change. The health center allows providers to run their own UDS reports within a standardized reporting tool. This simple process of ownership and flexibility has resulted in significant improvements. Practitioners don't have to wait for the vendor to generate reports. Instead, the vendor built a UDS report within their EHR that providers can manipulate, make changes to, and observe where improvements are needed within specific areas of care, locations, or services.

CHALLENGES AND OPPORTUNITIES

Along with many successes, Teche Action Clinic has experienced some challenges. Key among these has been maintaining high levels of standardization, training, and data capture while increasing the number of clinics and size of the staff.

This growth in volume has also stressed the organization's ability to keep pace with training needs and patient referrals. The center's growth creates a volume of information that can be difficult to track within the EHR. In an effort to manage the volume of referrals now taking place, the health center is creating a Referral Department that will be staffed by a team of individuals dedicated to closing referral gaps.

Another significant challenge facing the health center, and larger community, are the complex social risks faced by many of the patients, including poverty, language barriers, poor nutrition, housing and transportation needs. They are tackling this, in part, through community partnerships and helping build local solutions driven by the community. Teche Action Clinic believes that solutions can't be crafted from Federal or State governments, but must be driven "bottom-up" by the community. They are currently seeking solutions for local social risk factors through the Chambers of Health initiative. This model is based on the belief that when communities are given tools to improve, they do. Interventions with the Chambers of Health center on active collaboration among a wide range of public and private entities. Teche Action Clinic values the fact that joint efforts between the Health Department (with their public health focus) and the health center (with their primary care foundation) can achieve profound results. The health center is also working with the schools to develop school-based clinics in every community, and leading initiatives through WIC and public housing programs to create medical-neighborhoods – where medical and social supports come together to enhance the health of populations.

KEY LESSONS

This case study highlights a number of key actions Teche Action Clinic implemented within its care delivery, infrastructure and people systems, including:

- **Evidence-Based Care** – implementing guidelines for 6l18 conditions
- **Improvement Strategy** – creating a culture of quality
- **Health Information Technology** – data driven decisions
- **Patients** – a culture of caring
- **Care Teams** – standardized work processes accompanied by training and accountability
- **Partnerships** – building collaborations and actions with many across the community

When Teche Action Clinic's high levels of performance in 6l18 measures, and most measures reported in the UDS, are considered against NACHC's Value Transformation Framework, key lessons emerge regarding actions that other health centers may choose to take within care delivery, infrastructure and people systems in order to improve performance and advance toward the Quadruple Aim.

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