NATIONAL ASSOCIATION OF Community Health Centers®

Closing Care Gaps

A QI/Performance Improvement Workshop Focused on Cancer Screening

Today's Timeline

Time	Activity
8:30 am	Start
10:00 am	15-Minute Break
12:30 pm	Wrap-Up

NACHC & ACS Partnership

The **National Association of Community Health Centers (NACHC)** and the **American Cancer Society (ACS)** are collaborating to improve cancer screening and care in community health centers. This partnership involves providing training and resources to help these centers increase cancer screening rates and improve patient outcomes.

Coleman Associates brings over 30 years of expertise in operational redesign and performance improvement to support health centers in translating training into action. Their hands-on approach helps teams streamline workflows, engage staff, and close care gaps—making measurable gains in cancer screening and patient outcomes.

American Cancer Society®
Every cancer. Every life.

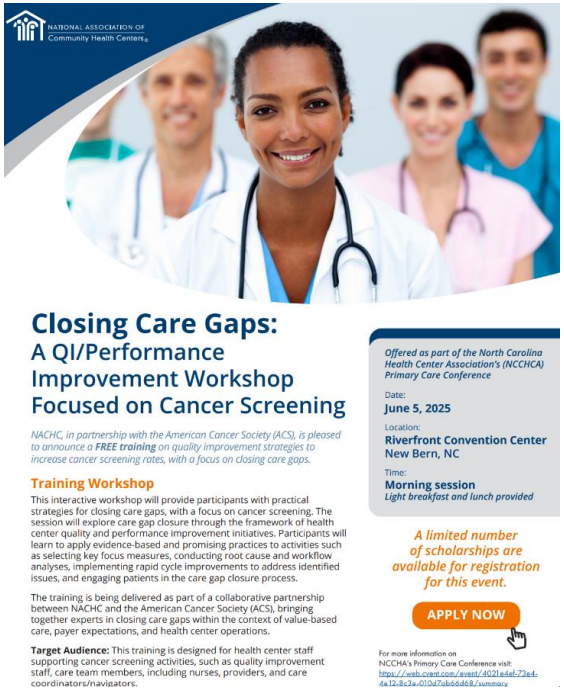
NATIONAL ASSOCIATION OF
Community Health Centers

COLEMAN
ASSOCIATES

Today's Session

This interactive workshop will provide participants with practical strategies for closing care gaps, with a focus on cancer screening.

The session will explore care gap closure through the framework of health center quality and performance improvement initiatives.



Funding Acknowledgment

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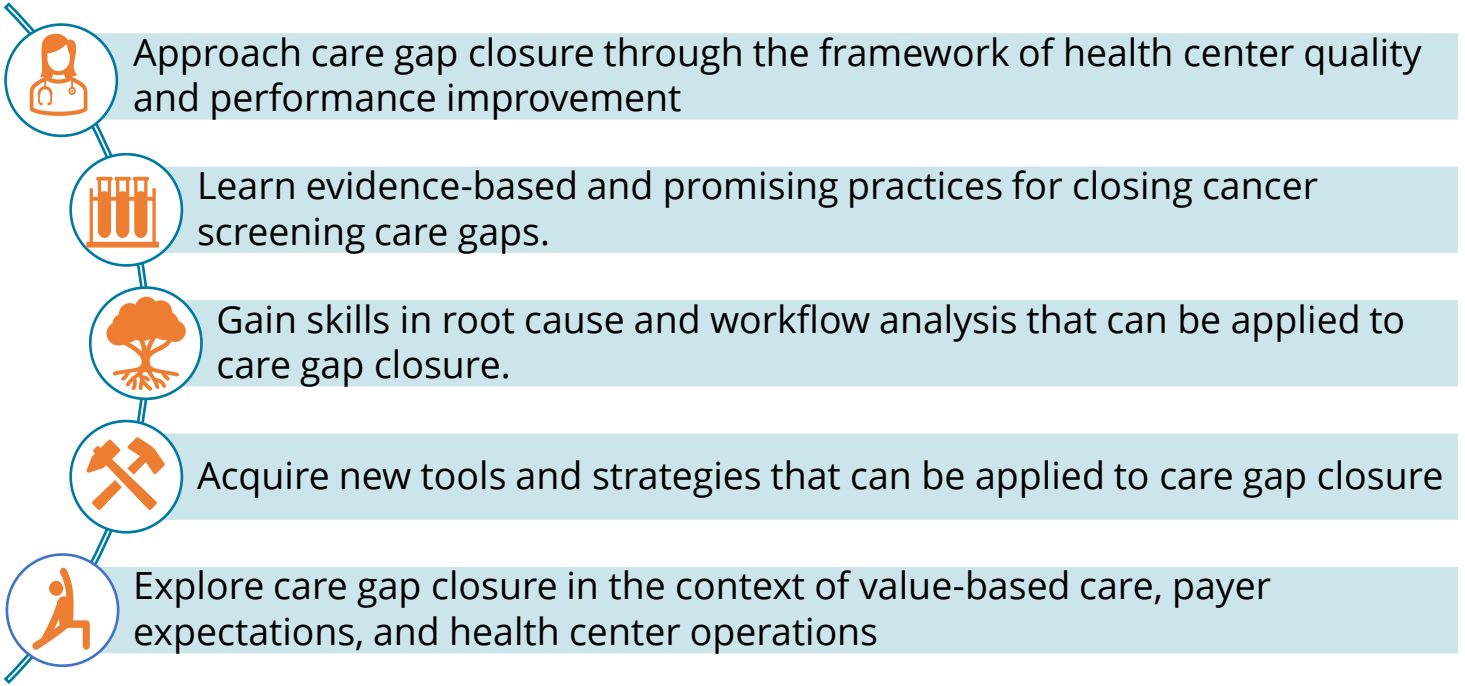
Agenda

- Welcome
- Setting the Stage
- Creating SMART Goals
- Root Cause Analysis: What's Getting in the Way?
- Evidence-Based Interventions for Cancer Screening
- Care Team/Provider Interventions
- Selecting and Testing Interventions
- Action Planning
- Wrap Up

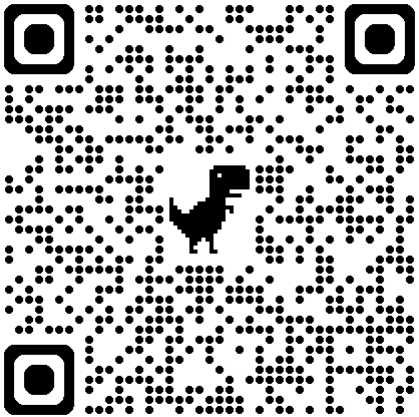
Learning Objectives

After completing this workshop, participants will be able to:



Pre-Test

Scan this QR Code to complete the Pre-Test



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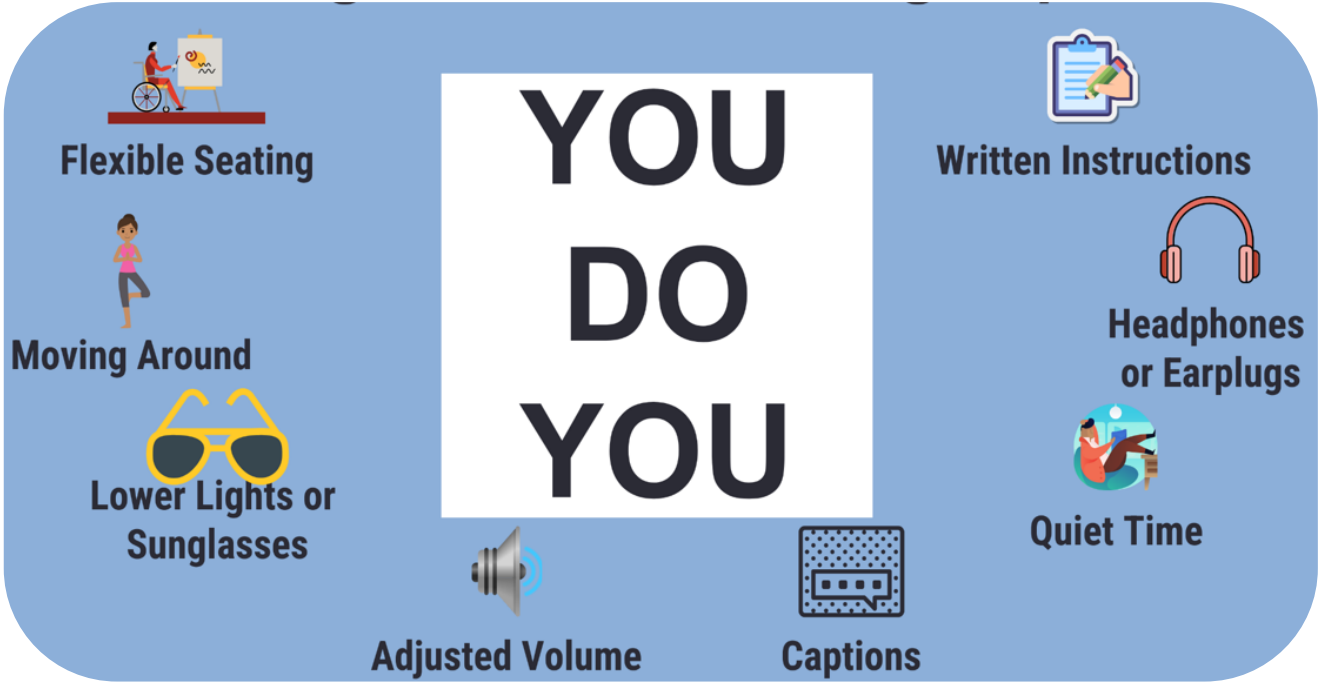
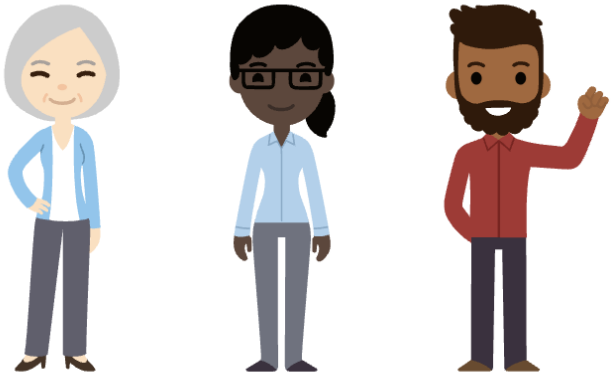
Your Learning Experience



Connect Before Content

Find 3 people to introduce yourself to and share:

- Your name
- Your role
- Your proudest small QI win



Setting the Stage

Understanding the Screening Gap

Breast Cancer Screening (UDS-CMS125v12)

Definition:
Percentage of women 50*–74 years of age who had a mammogram to screen for breast cancer in the 27 months prior to the end of the measurement period

Who:

Women 52–74 years old with a qualifying visit during the measurement period

(*use 52 as of December 31 as the initial age in assessment)

What Counts:

At least one mammogram within the 27 months prior to the end of the measurement year

(Screening only – NOT biopsy, ultrasound, or MRI)

Exclusions:

Bilateral mastectomy (or separate right & left)

Hospice or palliative care during the year

Women 66+ who are frail with advanced illness or in long-term care

Documentation Tip:

Include outside mammograms if date, clinician, and results are documented.

USPSTF Breast Cancer Screening

Target Population: Cisgender women and others assigned female at birth, age 40+, at average risk.

Ages 40–74: Biennial mammography recommended (Grade B – Moderate net benefit)

Age 75+: Insufficient evidence to recommend for or against screening (Grade I)

Women with dense breasts: Insufficient evidence on benefits of supplemental screening (e.g., ultrasound or MRI) (Grade I)

Key Notes:

- Applies to average-risk individuals (excludes those with BRCA mutations, high-risk lesions, or prior breast cancer)
- Both 2D mammography and 3D digital breast tomosynthesis are effective
- Timely follow-up and treatment are critical to reducing disparities in outcomes
- New in 2024: Screening now starts at age 40 (vs. individualized decision in prior guidelines)

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/breast-cancer-screening#bcei-recommendation-title-area

Healthy People 2023: Breast Cancer (C-05)

Goal: Increase the proportion of females who are screened for breast cancer

Current Status (2023): 79.8%

Target: 80.3%

Baseline (2019): 76.2% of females aged 50-74 years received a breast cancer screening

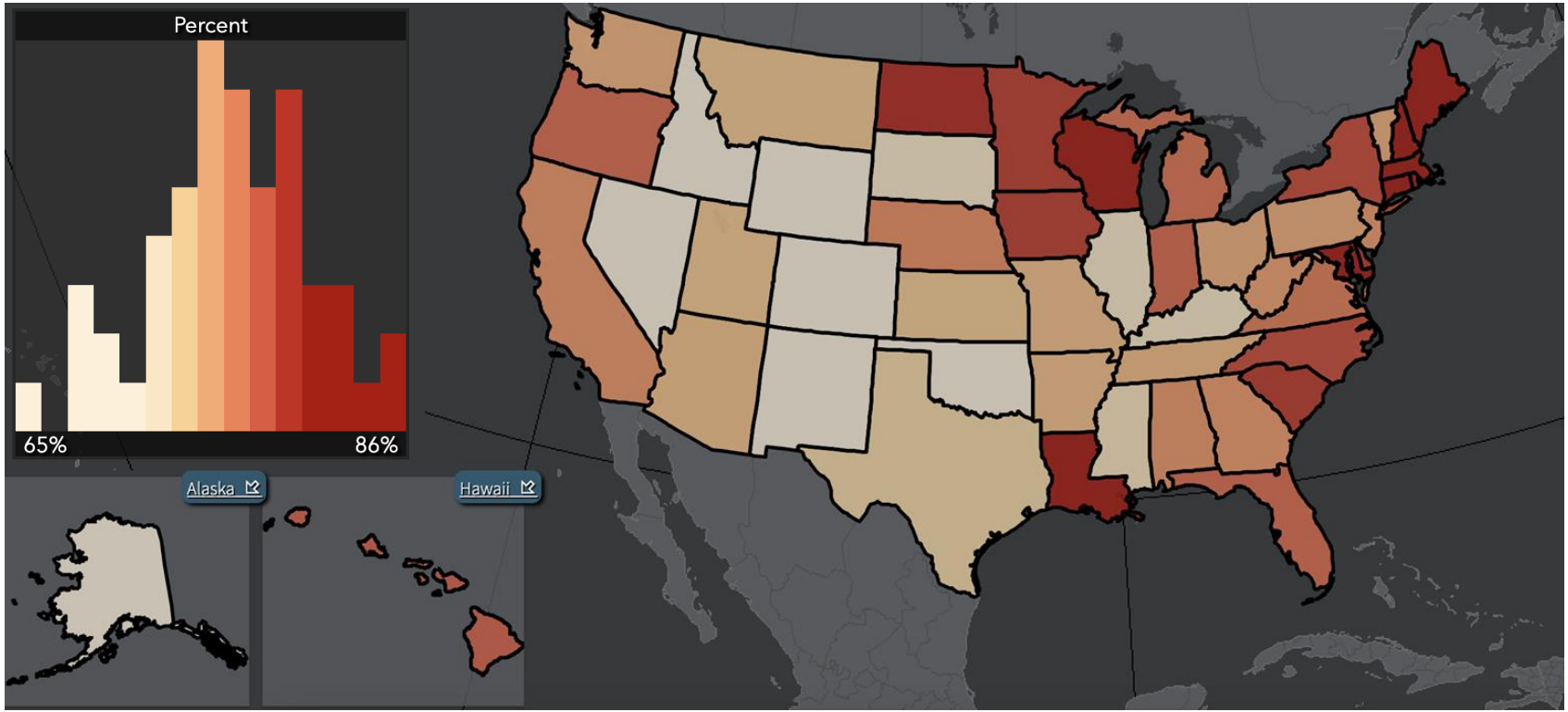
Trend: Improving

Key Strategies:

- Increase breast cancer screening
- Expand access to personalized treatments
- Strengthen community-based cancer control efforts
- Address racial/ethnic disparities in mortality

https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/cancer/increase-proportion-females-who-get-screened-breast-cancer-c-05

Screening for Breast Cancer in 2022



NCI Cancer Atlas: https://gis.cancer.gov/canceratlas/app/

Cervical Cancer Screening (UDS-CMS124v12)

Definition:

Percentage of women 21*-64 years of age who were screened for cervical cancer.

- Women age 21*–64 who had cervical cytology performed within the last 3 years
- Women age 30–64 who had human papillomavirus (HPV) testing performed within the last 5 years

Who:

Women 24–64 years old with a qualifying visit during the measurement period

(*use 24 as of December 31 as the initial age in assessment)

What Counts:

Pap test (cervical cytology) in the last 3 years

HPV test in the last 5 years (for women 30–64)

Exclusions:

Hysterectomy with no cervix

Congenital absence of cervix

Hospice or palliative care during the year

Reminder:

Start at age 24 (not 21) for UDS report

USPSTF Cervical Cancer Screening 2018

Target Population: Individuals with a cervix, ages 21–65, at average risk.

Ages 21–29: Cytology (Pap test) every 3 years (Grade A)

Ages 30–65: (Grade A) Choose one of the following:

- Cytology every 3 years
- High-risk HPV (hrHPV) testing every 5 years
- Cotesting (Cytology + hrHPV) every 5 years

Do Not Screen: Under 21 years, Over 65 years (with adequate prior screening), Post-hysterectomy (with cervix removed, no history of high-grade lesion or cancer)

Key Notes:

- Applies regardless of sexual history or HPV vaccination status
- Does not apply to high-risk individuals (e.g., HIV+, DES exposure, immunocompromised, prior CIN2+ or cervical cancer)
- Focus on adequate screening, follow-up, and treatment regardless of screening method
- Update to this recommendation is currently in progress

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening

Healthy People 2023: Cervical Cancer (C-09)

Goal: Increase the proportion of females who get screened for cervical cancer screening

Current Status (2021): 73.9% of females aged 21–65 screened

Target: 79.2%

Baseline (2019): 75.0% screened

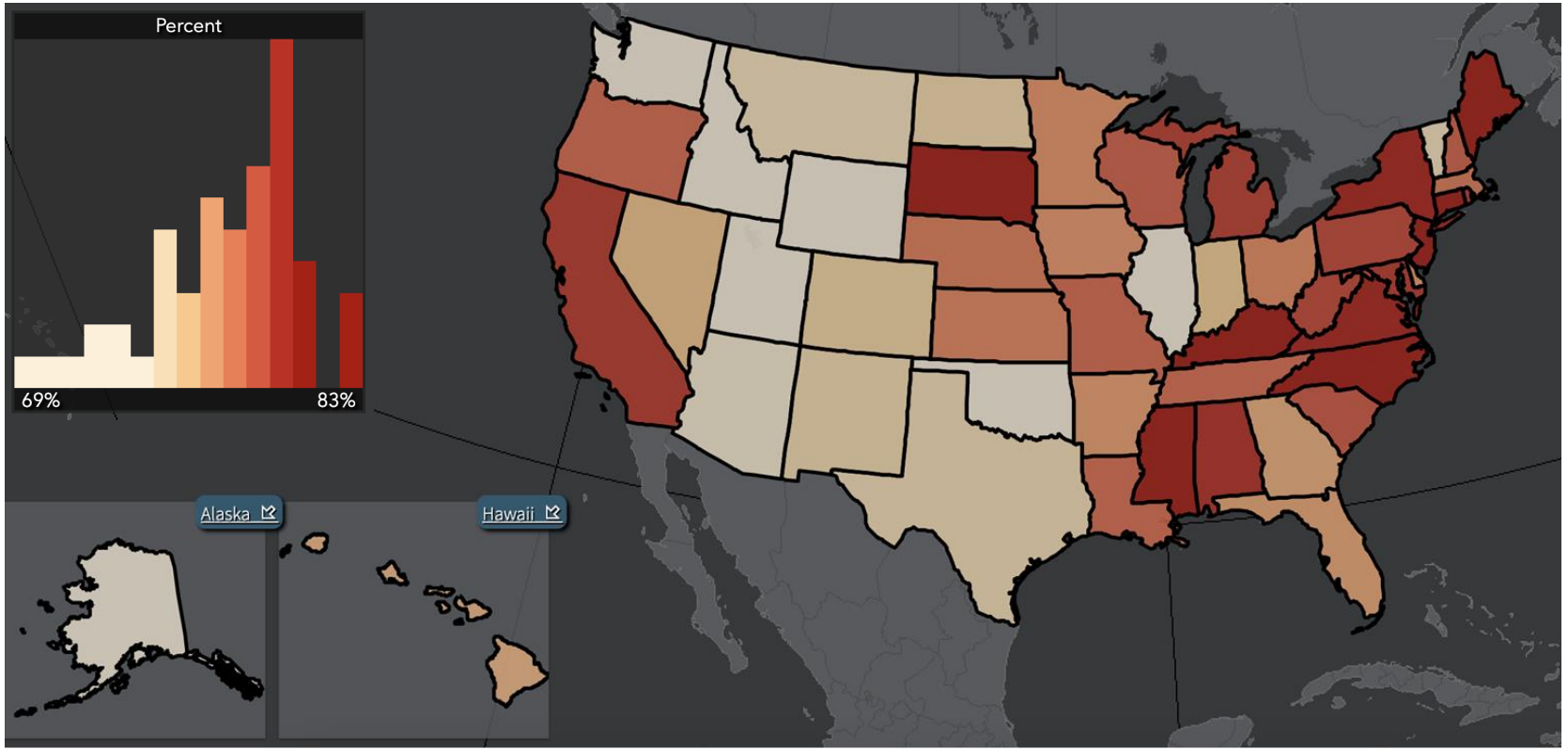
Trend: Little or no detectable change — Screening rates have declined slightly since baseline

Key Strategies:

- Remind and educate patients using personalized outreach and community-based support.
- Support providers with screening prompts and performance feedback.
- Remove barriers like cost, transportation, and limited clinic hours.

https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/cancer/increase-proportion-females-who-get-screened-cervical-cancer-c-09

Screening for Cervical Cancer in 2020



NCI Cancer Atlas: https://gis.cancer.gov/canceratlas/app/

Colorectal Cancer Screening (UDS-CMS130v12)

Definition:

Percentage of adults 45*-75 years of age who had appropriate screening for colorectal cancer.

Who:
Adults 46-75 years old with a qualifying visit in the reporting year

(*use 46 as of December 31 as the initial age in assessment)

What Counts:
FOBT or FIT during the measurement year
sDNA with FIT (e.g., Cologuard) within past 3 years
Sigmoidoscopy or CT colonography within past 5 yrs
Colonoscopy within past 10 years

Exclusions:
Colorectal cancer diagnosis or total colectomy
Hospice or palliative care
Adults 66+ with frailty & advanced illness or living in long-term care

Reminder:

Outside screenings count only with documentation of date, clinician, and result—no self-reports or digital rectal exam-based tests.

USPSTF Colorectal Cancer Screening

Target Population: Adults aged 45–85 at average risk (no personal/family history, polyps, or IBD)

Ages 50–75: Screen all adults for colorectal cancer (Grade A)

Ages 45–49: Begin routine screening (Grade B)

Ages 76–85: Selective screening based on health status and screening history (Grade C)

Key Notes: Applies only to those without symptoms or high-risk conditions (e.g., Lynch syndrome, familial adenomatous polyposis). Emphasizes shared decision-making in older adults (76–85). New in 2021: Expanded screening to begin at age 45 (was 50).

Screening Options:

- Annual: FIT or high-sensitivity gFOBT
- Every 1–3 yrs: Stool DNA-FIT
- Every 5 yrs: CT colonography or sigmoidoscopy
- Every 10 yrs: Colonoscopy
- Combo: Sigmoidoscopy (10 yrs) + FIT (annual)

https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/colorectal-cancer-screening

Healthy People 2023: Colorectal Cancer (C-07)

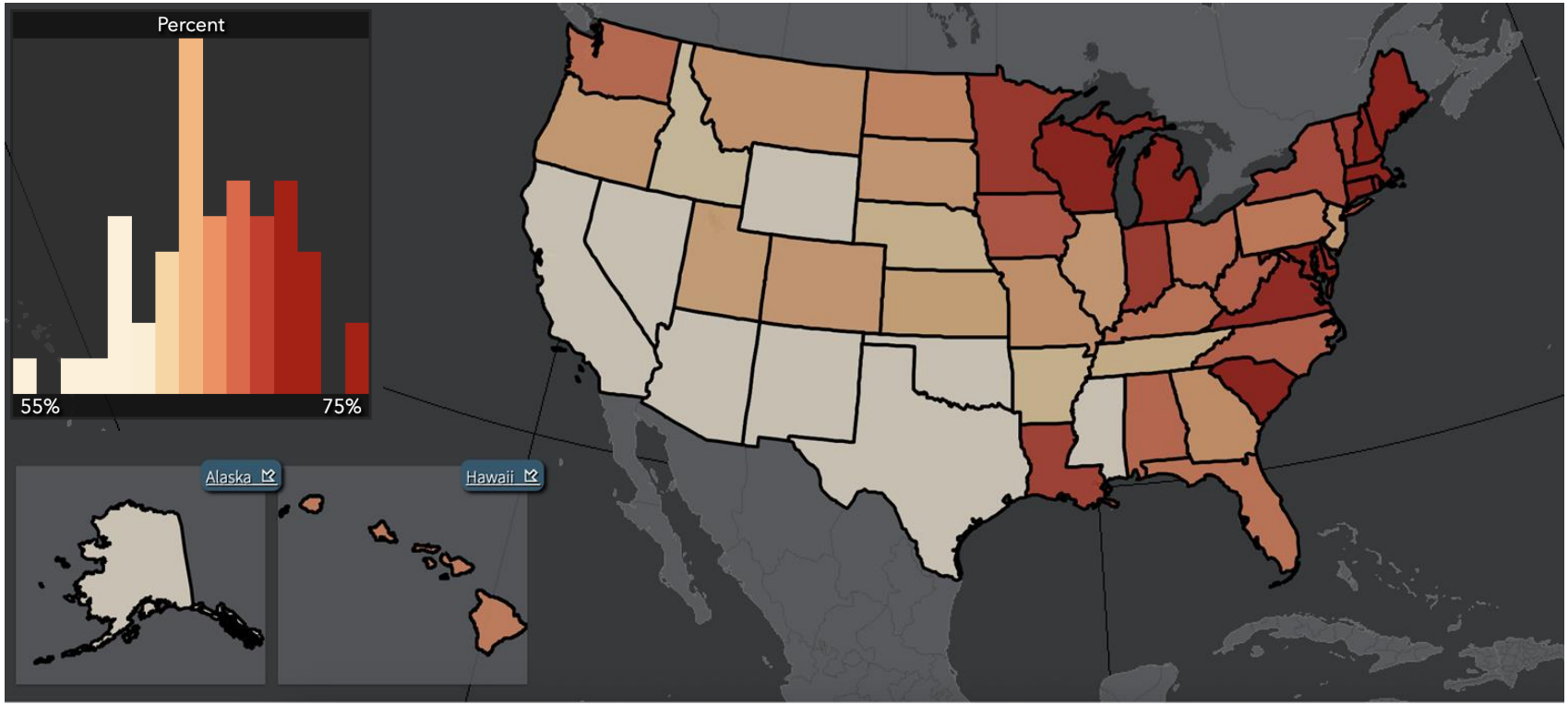
- **Goal:** Increase the proportion of adults who get screened for colorectal cancer
- **Current Status (2023):** 63.5%
- **Target:** 72.8%
- **Baseline (2023):** 63.5% of adults 45 to 75 years of age received a colorectal cancer screening based on recent guidelines
- **Trend:** Baseline

Key Strategies:

- Strengthen clinician and patient-targeted interventions
- Expand access to preventive care, especially for underserved groups
- Improve education about current screening guidelines
- Address disparities in screening uptake by race, income, and insurance status

https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/cancer/increase-proportion-adults-who-get-screened-colorectal-cancer-c-07

Screening for Colorectal Cancer in 2022

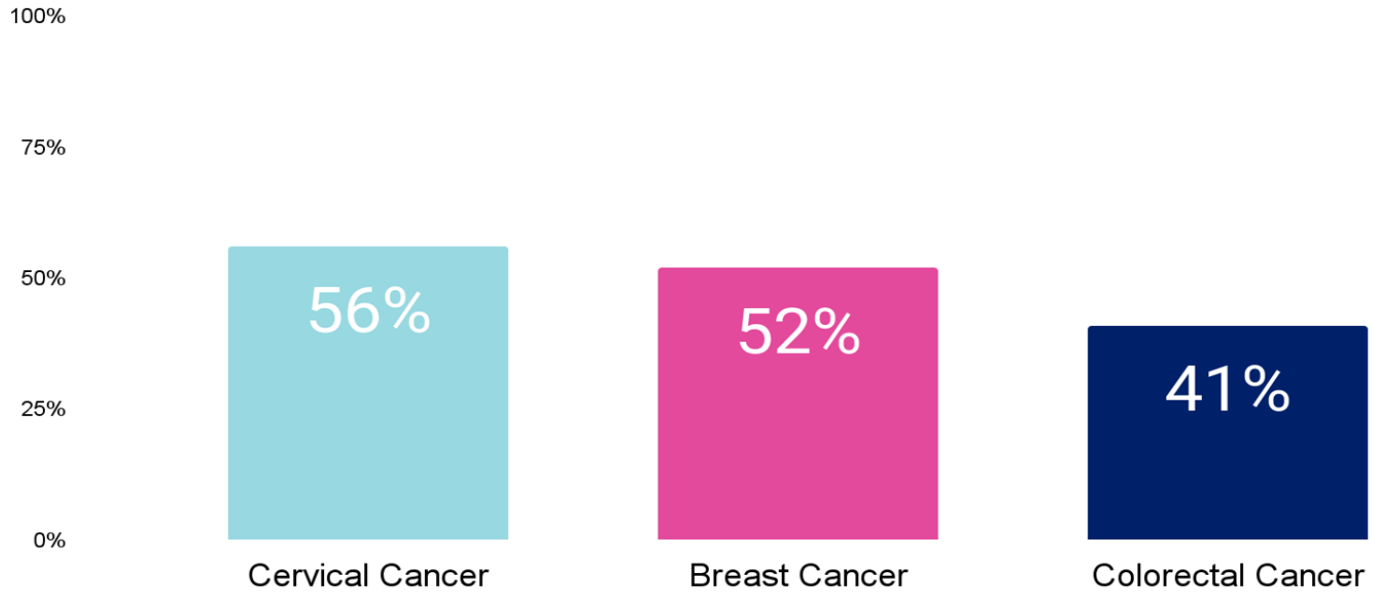


NCI Cancer Atlas: https://gis.cancer.gov/canceratlas/app/

Let’s See Where We’re Starting

2023 UDS Cancer Screening Data for Cervical, Breast, and Colorectal Cancer in Health Center Patients

2023 UDS Cancer Screening (in FQHCs)



HRSA. (2024). *Table 6B: Quality of Care Measures*. data.hrsa.gov. https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=6B&year=2023

Why Cancer Screening Matters

Cancer screening reduces mortality by detecting cancer early and, for cervical and colorectal cancers, preventing cancer through treatment of precancerous lesions

Understanding the Screening Gap

Cancer Screening Disparities

- Early detection saves lives—screening reduces mortality for breast, cervical, colorectal, and lung cancers.
- Access to screening is not equitable across populations.
- Disparities lead to later-stage diagnoses, higher mortality, and unnecessary suffering.

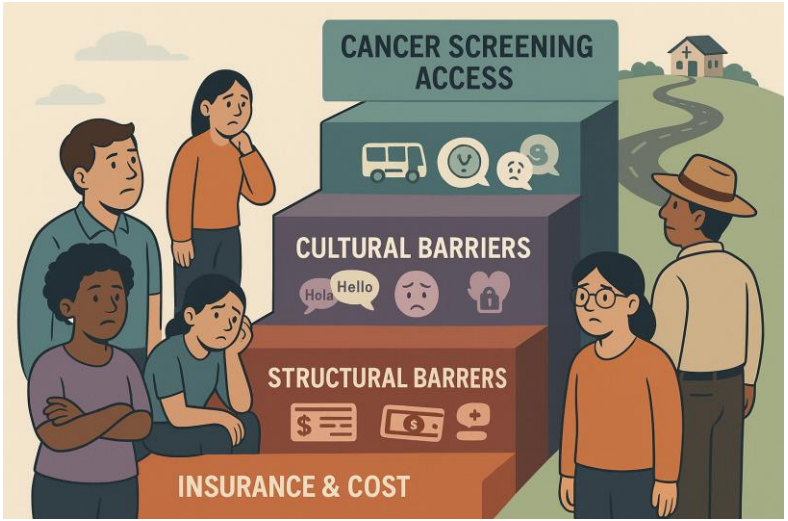
Who is Most Affected?

- Non-Hispanic Black and Alaska Native people have the highest colorectal cancer mortality.
- Black, Hispanic, American Indian, and Alaska Native women have the highest cervical cancer death rates.
- Black individuals are more likely to be diagnosed at later stages for breast, cervical, and colorectal cancers.
- People in non-expansion Medicaid states are less likely to be diagnosed early.

https://www.fightcancer.org/sites/default/files/Disparities%20in%20Cancer%20Screening%20and%20Early%20Detection.pdf

Root Causes of Screening Disparities

- **Insurance & Cost**: Lack of coverage and out-of-pocket expenses deter screenings
- **Structural Barriers**: Transportation, childcare, lack of clinician referrals
- **Cultural Barriers**: Language access, fear, distrust of healthcare systems, stigma
- **Geographic Barriers**: Rural communities face limited access to screening services



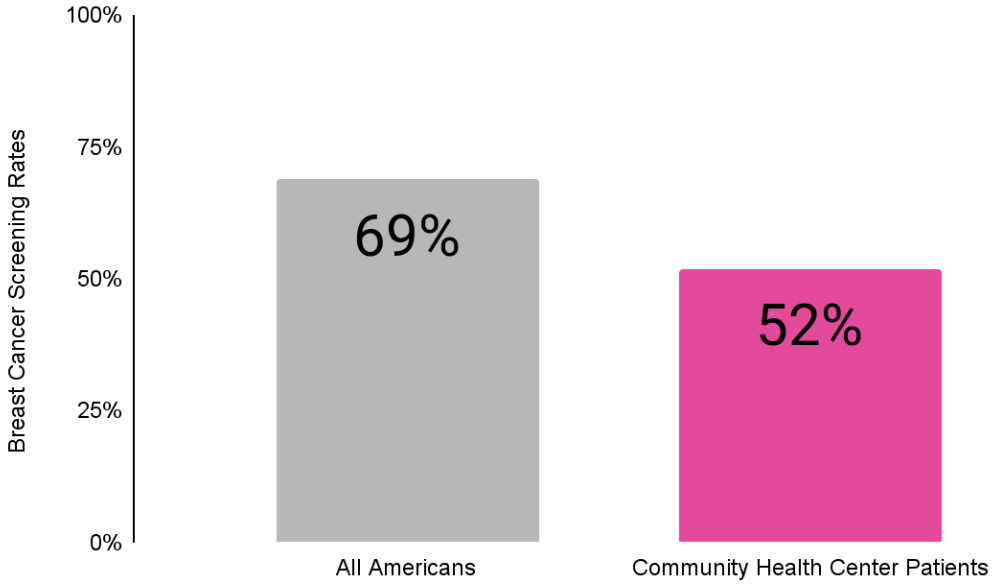
https://www.fightcancer.org/sites/default/files/Disparities%20in%20Cancer%20Screening%20and%20Early%20Detection.pdf

The Call to Action

- No one should die from a cancer that could have been prevented or caught early.
- Eliminating screening disparities is essential to:
  - Saving lives
  - Reducing suffering
  - Advancing health equity

https://www.fightcancer.org/sites/default/files/Disparities%20in%20Cancer%20Screening%20and%20Early%20Detection.pdf

Breast Cancer Screening



American Cancer Society. (2025). Cancer Prevention & Early Detection Facts & Figures 2025-2026. https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-prevention-and-early-detection-facts-and-figures/2025-cped-files/cped-cff-2025-2026.pdf

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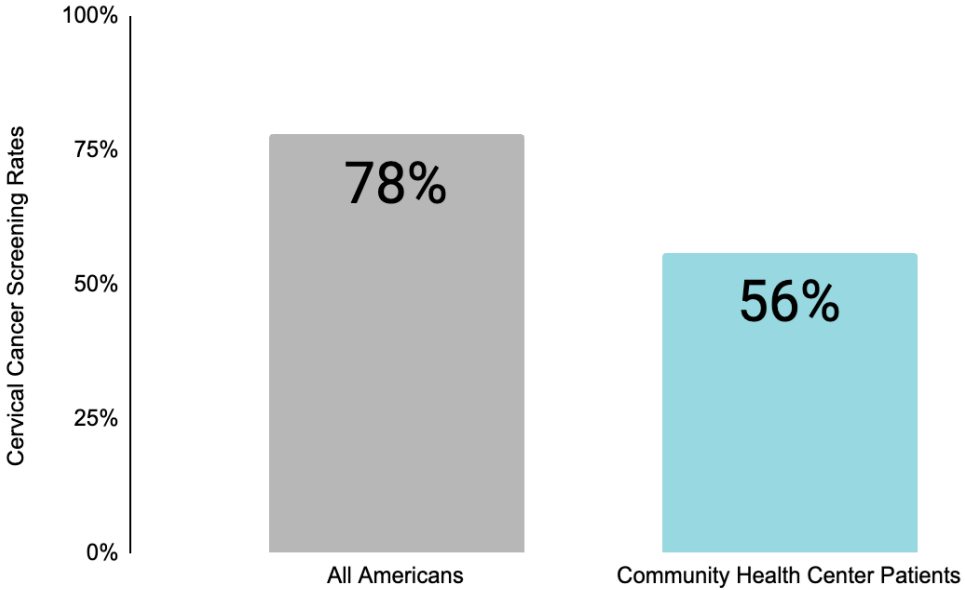
Cervical Cancer Screening



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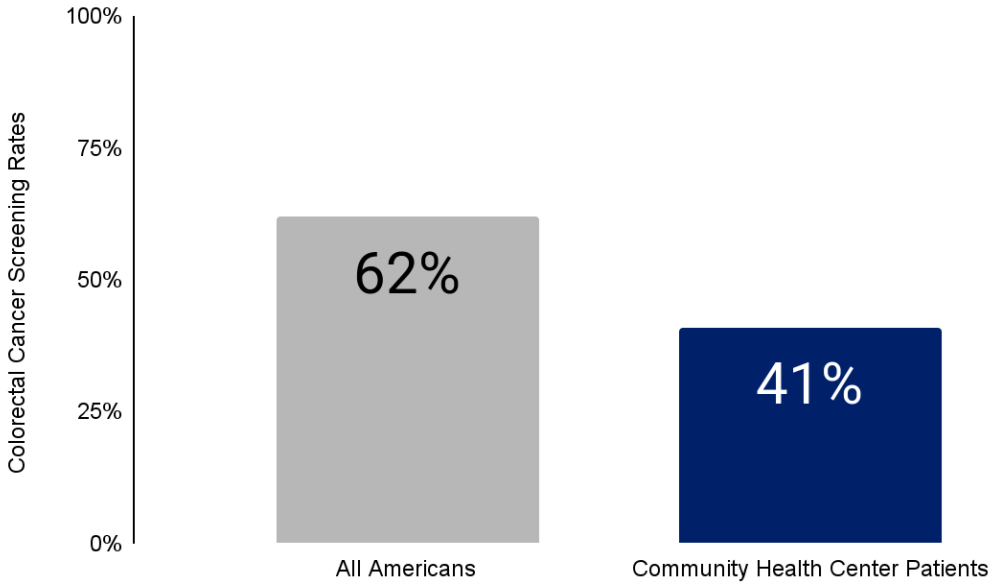
Colorectal Cancer Screening



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HRSA. (2024). Table 6B: Quality of Care Measures. https://data.hrsa.gov/tools/data-reporting/program-data/national/table?tableName=6B&year=2023

What is Your Clinic's Data?

Look Up Your Data Here If You Don't Know It

Problem Statement: Screening Gaps

- Cancer screening rates in health centers lag behind national benchmarks
- Health centers serve groups with historically lower screening rates and higher mortality: uninsured, low-income, people of color
- Many health center patients face non-health related challenges that hinder screening: transportation, childcare, time off from work, language
- Fear and mistrust of the health care system

Closing these gaps is critical to advancing equity and saving lives.

https://www.fightcancer.org/sites/default/files/Disparities%20in%20Cancer%20Screening%20and%20Early%20Detection.pdf

How Care Gaps Connect to VBP*

- Missed services lower quality scores (e.g., HEDIS, UDS measures)
- Lower scores reduce shared savings or performance payments
- Persistent care gaps may trigger penalties or reduced capitation rates
- Poor performance can hurt payer negotiations and contract renewals

*VBP = value-based payment

SMART Goals

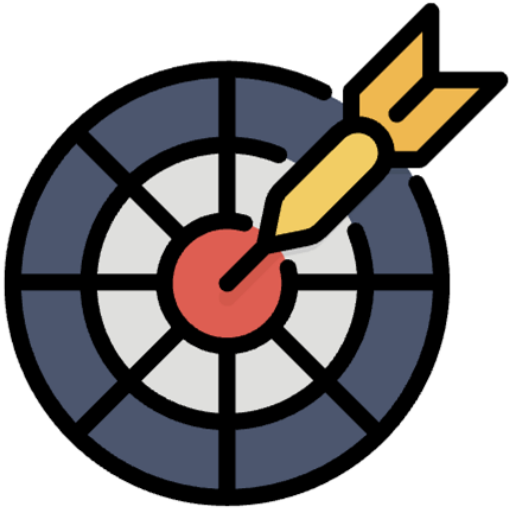
Making an Impact

SMART Goals:

- Align the team
- Drives Accountability
- Tracks Progress on Quality Measures

What is a SMART Goal?

- **S**pecific
- **M**easurable
- **A**chievable
- **R**elevant
- **T**ime-bound



SMART goals decrease ambiguity and increase the chances of success

Example: SMART Goal

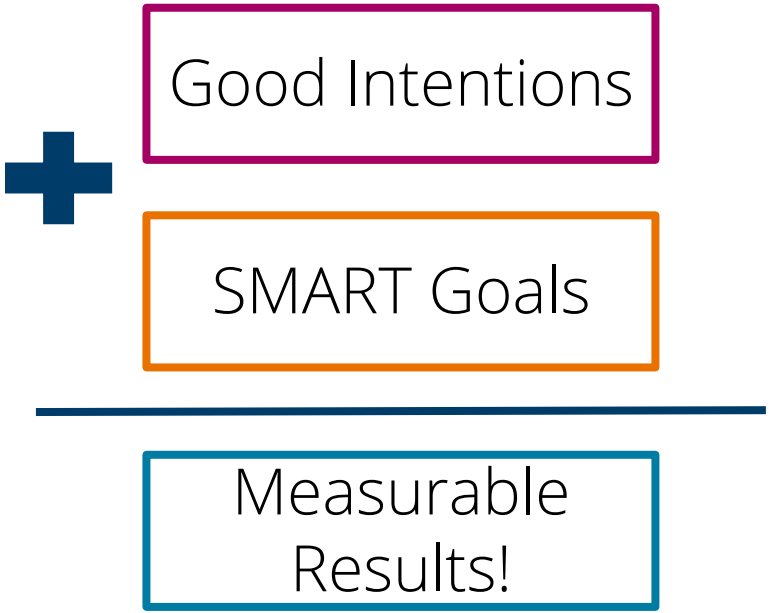
Non-SMART Goal	SMART Goal
“Improve cancer screenings.”	“Increase cervical cancer screening documentation in structured EHR fields for Dr. Smith’s panel from 45% to 75% by June 30, 2025.”

SMART Example: Cervical Cancer

- **S**pecific: focus on cervical cancer screenings in structured fields
- **M**easurable: from 45% to 75%
- **A**chievable: target one provider's panel
- **R**elevant: aligns with HRSA, UDS, and value-based care measures
- **T**ime-bound: complete by June 30, 2025

Key Takeaway

- SMART goals help turn good intentions into measurable results
- Use SMART goals to close care gaps and improve performance on contracts
- Start small: one panel, one team, one screening



Quick Practice

Rewrite the vague goals as SMART Goals:

Value Goal 1:

“Improve breast cancer screening rates at our clinic.”

Vague Goal 2:

“Do better at getting patients in for colorectal cancer screening.”

Process Mapping

What is Process Mapping?

"You don't learn to process map, you process map to learn!"
– Shared wisdom from the field

Process Mapping

A visual tool that helps teams understand how work really gets done: step-by-step, from start to finish.

It allows us to:

- Make the invisible visible
- Identify redundancies, bottlenecks, and confusion
- Create a shared understanding across roles
- Highlight opportunities for improvement and redesign

Current State Process Map

Purpose:
To understand how cervical cancer screening currently happens (or fails to happen) in our health center. This process map is based on real workflows and highlights the moments where breakdowns are common

Why this Matters:
Cervical cancer screening is a UDS measure, tied to value-based payments, and key to women's health. But patients still fall through the cracks due to gaps in documentation, workflows, and communication

Common Breakdowns: Current State

Step	Common Breakdown
Scheduling	No screening check during booking
Visit Prep	Incomplete chart reviews & poor documentation
Huddle	No ownership or mention of screening
Visit	Screenings skipped due to acute priorities
Documentation	Scanned records or free-text don’t count
Follow-Up	Abnormal results not tracked to resolution
Outreach	Limited follow-up for patients not on schedule

STEP 1 *Patient is Due or Schedules Visit*

What Usually Happens:

- Patients call to schedule for various reasons (acute care, chronic management, checkups).
- Front desk staff do not check if the patient is due for cervical cancer screening.
- Outreach staff sometimes call overdue patients—but only if they have access to reports and appointments available.

Gaps in Reality:

- No system prompt to check screening status at scheduling.
- Outreach team doesn't consistently run care gap reports or may not follow up due to lack of appointment availability.

STEP 2 *Visit Prep (If Any)*

What Usually Happens:

- Medical Assistants sometimes review charts, but it's not standardized process.
- External Pap/HPV results may be scanned into the chart but not entered in structured EHR fields.

Gaps in Reality:

- Visit prep checklists don't include screening reviews.
- Visit Prep doesn't happen consistently
- Lack of training on structured data entry for screenings.
- Screening info from external OB/GYNs is often lost in scanned PDFs.

STEP 3 *Morning Huddle (If It Happens)*

What Usually Happens:

- Huddles focus on logistics, no-show risks, and urgent issues.
- Cervical cancer screening is not consistently mentioned or prioritized.
- Team members assume someone else will handle it.

Gaps in Reality:

- Screening status is not a standard huddle topic.
- Role confusion—MA thinks clinician will bring it up; clinician thinks MA will.

STEP 4 *During the Visit*

What Usually Happens:

- If the visit is acute or focused on another issue, preventive services are skipped.
- Providers often don't have time to discuss or perform Pap/HPV tests.
- If the patient declines, no clear plan is set for follow-up.

Gaps in Reality:

- No time built into visits for preventive care.
- No standard script or support materials to help patients overcome fears or misconceptions.

STEP 5 *Documentation*

What Usually Happens:

- If screening is completed in-house, results may be documented correctly—or may not.
- External results are scanned but not entered in structured EHR fields, so they don't count.
- Providers are unaware their documentation doesn't meet reporting requirements.

Gaps in Reality:

- Free-text entries and scanned documents are invisible to quality reports.
- Providers and MAs lack training on documentation that counts.

STEP 6 *Results and Follow-up*

What Usually Happens:

- Normal results are reviewed but not always communicated to patients.
- Abnormal results trigger a referral, but follow-up is often not tracked to resolution.
- Some patients fall through the cracks entirely after an abnormal result.

Gaps in Reality:

- No closed-loop tracking system.
- Limited coordination between PCP and OB/GYN follow-up care.

STEP 7 *Ongoing Patient Engagement*

What Usually Happens:

- Patients who decline or miss screening are not re-contacted.
- Outreach team may not follow up due to appointment limitations or lack of workflows.
- Wellness visits are limited; few are booked each day due to staffing or time constraints.

Gaps in Reality:

- No follow-up plan for patients who decline.
- Not enough appointments for screenings.
- Low comfort level among staff for offering Pap/HPV routinely.

Future State Process Map

Purpose:
This map represents the optimized cervical cancer screening workflow after known care gaps are addressed. It reflects improved coordination, documentation, and proactive care—designed to maximize quality, patient outcomes, and team clarity.

Why this Matters:
By redesigning this process, we reduce missed opportunities, improve health outcomes, and hit key UDS and Value-Based Payment goals.

STEP 1 *Patient is Due or Schedules Visit*

What Happens Now:

- Patients are flagged as due during scheduling via EHR alerts or a care gap dashboard visible to front desk staff.
- Outreach team runs weekly care gap reports and proactively schedules overdue patients.
- Open screening slots are reserved for outreach follow-up appointments.

Improvements in Place:

- Screening needs are visible during scheduling.
- Outreach aligned with scheduling capacity.
- More patients scheduled specifically to address preventive needs.

STEP 2 *Visit Prep (If Any)*

What Happens Now:

- MAs use a structured visit prep checklist that includes cervical cancer screening status.
- External results are entered into structured fields in the EHR, so they count toward metrics.
- Prep notes include due dates, patient history, and past deferrals.

Improvements in Place:

- Visit prep workflow standardized across all teams.
- MAs trained on structured data entry.
- Every overdue screening is flagged before the patient is roomed.

STEP 3 *Morning Huddle (If It Happens)*

What Happens Now:

- Overdue screenings are discussed in daily huddles.
- Teams agree on who will introduce and complete the screening.
- Huddle tools include preventive care flags and standing order protocols.

Improvements in Place:

- Shared accountability and role clarity.
- Standing orders allow MAs to start the process.
- Focused team planning before the visit starts.

STEP 4 *During the Visit*

What Happens Now:

- Provider or MA introduces screening using patient-friendly education materials.
- Pap/HPV is offered as part of regular visits (not just wellness exams).
- If patient declines, it's noted with a plan to re-offer next visit or refer.

Improvements in Place:

- Screening normalized as routine care.
- Scripted language and materials available in multiple languages.
- Flexibility to complete screening without extra appointments.

STEP 5 *Documentation*

What Happens Now:

- All Pap and HPV screenings are entered in structured fields that map to UDS and CQM logic.
- Outside records are reviewed during chart prep and updated accordingly.
- Providers and MAs know exactly where and how to document screenings.

Improvements in Place:

- Structured data = accurate reports.
- Documentation workflows trained and standardized.
- Dashboards now reflect real-time progress.

STEP 6 *Results and Follow-up*

What Happens Now:

- Normal results are shared with patients promptly (via portal, text, or phone).
- Abnormal results are tracked using a follow-up log or EHR task system.
- Care managers monitor referrals until follow-up is complete.

Improvements in Place:

- Closed-loop follow-up is the norm.
- No result is lost or uncommunicated.
- Patients feel informed and supported throughout.

STEP 7 *Ongoing Patient Engagement*

What Happens Now:

- Patients who defer are auto-added to future outreach lists with personalized notes.
- Monthly performance data shows which teams are increasing screenings.
- Wellness visits and embedded screenings are widely available across providers.

Improvements in Place:

- Consistent patient follow-up.
- Real-time team dashboards.
- Recognition and incentives for high-performing teams.

New State: What's Different?

Step	Future State Enhancement
Scheduling	Flags due screenings and enables direct scheduling
Visit Prep	Structured checklist and EHR-based tracking
Huddle	Ownership of screening discussed in daily workflow
Visit	Screening is part of every visit type
Documentation	Structured fields ensure quality compliance
Follow-Up	Abnormal results tracked to resolution
Outreach	Proactive and coordinated with open appointment slots

Root Cause Analysis

What's Getting in the Way?

What Are Care Gaps?

- Missed or delayed recommended services (e.g screenings, follow-ups)
- Examples: overdue Pap test, missed colonoscopy, mammogram done but not documented
- These are symptoms of a system issue—not just individual oversights.

Why Systems Thinking?

- Systems thinking is understanding how different parts of a system interact and affect one another over time.
- Care gaps occur not in isolation, but across intersecting workflows, teams, and processes
- Closing care gaps means fixing the system, not blaming individuals.

Patient's Journey Through the System

- Learns about the health center
- Schedules an appointment
- Interacts with front desk, MA, clinician, and possibly nurse
- Receives (or misses) education and services during the visit
- Gets results, follow-up care, or referrals

Each step is a point of opportunity or breakdown

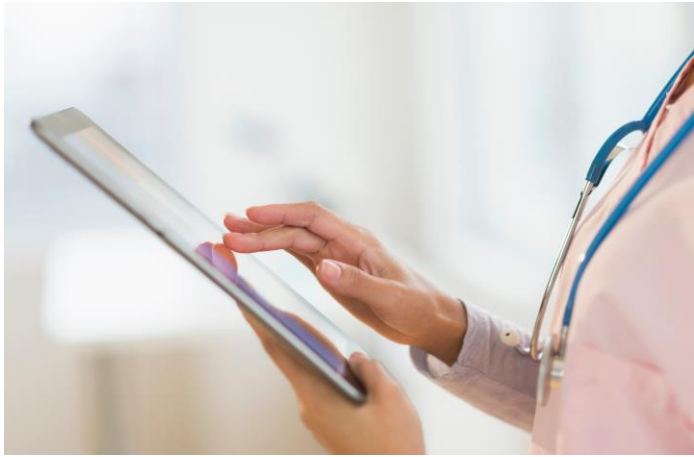
Where the System Can Breakdown

- **Scheduling**: Appointments not available or not prioritized for screenings
- **Documentation**: Screenings done elsewhere but not captured in structured data
- **Staff Roles**: Unclear who does what (prep, education, referrals)
- Patient Education: Not timely, not in the right language or literacy level
- **Follow-Up**: No system to track if screening was completed or results returned

Where else can the system break down?

Cervical Cancer Screening Example

- Screening done at OB/GYN but only scanned into chart.
- Patient comes in for unrelated issue, and the team reviews the documents from the OB/GYN.
- MA didn't know it had to be entered into structured fields.



Problem wasn't effort—it was the system

Every Team Member Plays a Role!

- Front desk: Flags overdue screenings when scheduling
- MAs: Prep charts, ask about outside care, start patient education
- Providers: Offer service or referrals
- Outreach team: Call those not on the schedule

System design supports or hinders all of these roles

Use Systems Thinking to Close Gaps

Ask:

- Where do our processes break down?
- What part of the system is creating friction?
- How can we make it easy for staff to do the right thing every time?

From Fragmented to Integrated Systems

Fragmented Tasks

“That’s not my job”

“I don’t know”

OLD MINDSET

NEW MINDSET

Integrated Systems

Let’s design a system where everyone knows their role and gaps are visible

Key Takeaways

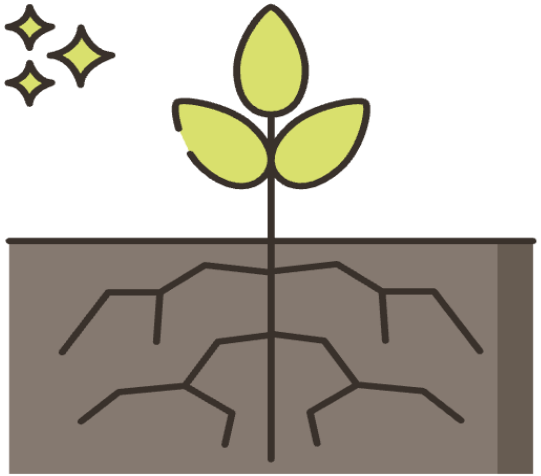
- Closing care gaps = fixing systems, not just working harder
- Look at the full journey—from outreach to follow-up
- Build workflows that make it easy to close the loop
- Use systems thinking to improve equity, quality, and financial performance.

Tools for Finding & Addressing Gaps

- Patient Visit Tracking Toolkit
- Mystery Shopper Exercise
- NACHC Care Gaps Action Guide
- NACHC Root Cause Analysis Worksheet

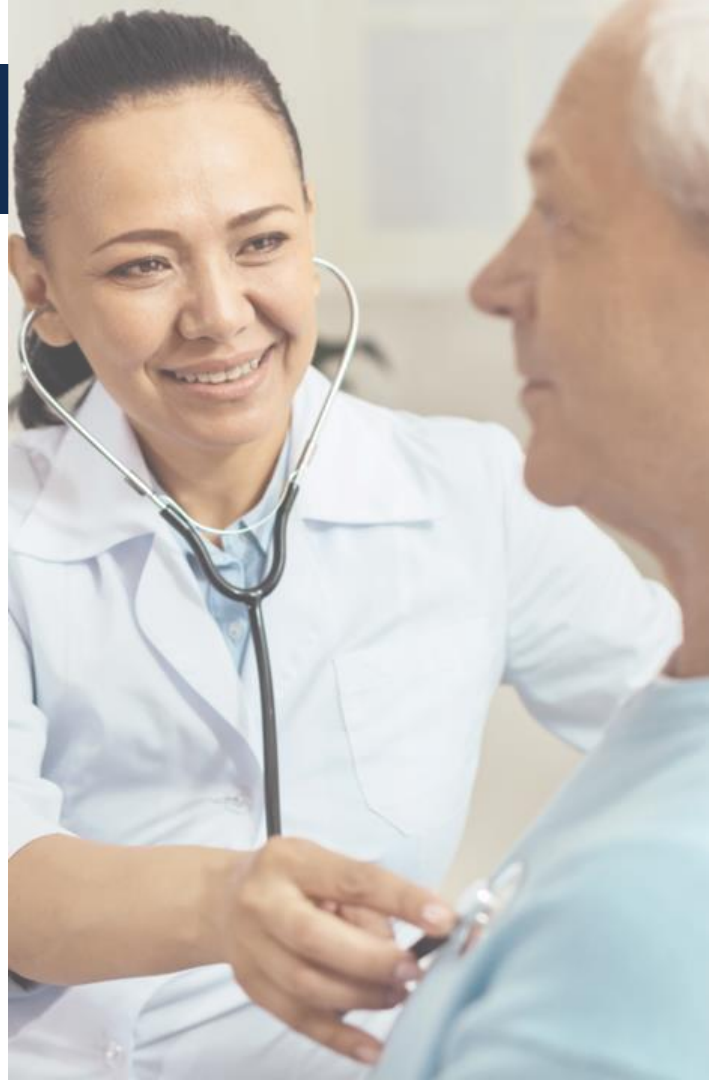
Why Root Cause Analysis?

- Care gaps are symptoms – Root Cause Analysis (RCA) finds the true problem
- Without understanding the cause, interventions fail or backfire
- RCA helps us fix the system, not just the surface



Three Types of Care Gaps

- **Data Gaps**: Issues with documentation or reporting (EHR setup, codes, mapping)
- **Service Delivery Gaps**: Workflow, training, or staffing issues
- **Service Engagement Gaps**: Barriers to patient access, trust, or prioritization



Step-by-Step RCA: Worksheet

- Pick a CQM and a patient list with gaps
- Start with Question 1 and move through each in order
  - If the answer is "No", use the Five Whys Tool
  - If the answer is "Yes", move to the next question
- Don’t skip questions—each one builds on the last

Example: Cervical Cancer Screening

Problem: Many patients overdue for cervical cancer screening

Structured investigation:

- Q1: Structured fields available? ✅
- Q2: Included in reports? ✅
- Q3: Documented correctly? ❌ (scanned notes only)

Five Whys Tool

- Start with the first "Why?" (e.g., Why is screening not documented?)
- Keep asking "Why?" until you uncover a system-level issue
- Don’t stop at blaming people—dig until you find a process gap

Root Cause Identifier Worksheet

Data Gaps:

Q1–Q3
documentation and reporting

Service Delivery Gaps:

Q4–Q7
team roles and visit workflows

Service Engagement Gaps:

Q8–Q12
education, access, outreach

Root Cause Analysis Example: Why Cervical Cancer Screenings Are Missed

Identifying systemic issues that lead to missed or misreported screenings

What's the Problem?

A significant number of eligible patients are overdue for cervical cancer screening.

This gap affects:

- Patient safety and early detection
- HRSA UDS performance
- Value-Based Payment outcomes

We set out to investigate: Why are screenings missed or not counted, even when performed?

Step-by-Step Root Cause Investigation

Question	Answer
Q1: Are structured EHR fields available?	✅ Yes
Q2: Are structured fields included in reports?	✅ Yes
Q3: Is the service documented correctly?	⛔ No

We have the tools. But the process **breaks at the point of documentation.**

Why Isn’t Screening Documented Correctly?

Root Cause:

Providers and staff don’t enter external screening results in structured fields.

Why?

- Results scanned or added to notes
- Staff unaware these don’t count
- No training on CQM data entry
- Onboarding doesn’t include quality documentation
- Quality and clinical education are siloed

How to Fix It?

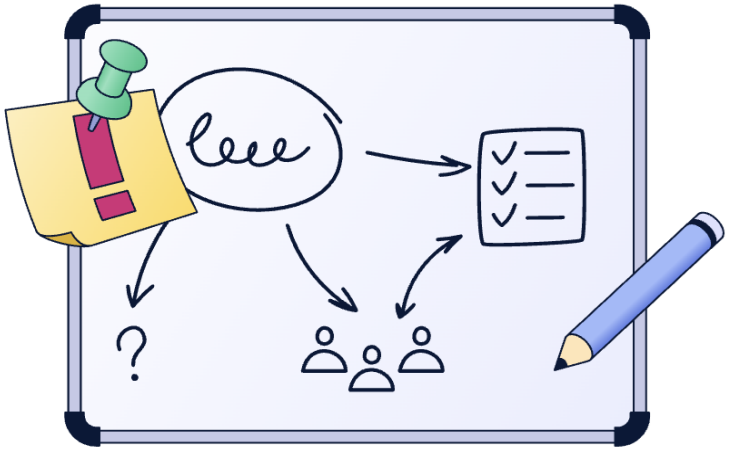
- Train staff on structured EHR data entry
- Add to onboarding and continuing education
- Standardize process for scanned external records
- Include checks during chart prep and huddles

Common Pitfalls

- Stopping after one “Why?”
- Jumping to a solution without understanding the system
- Blaming individuals instead of examining workflows
- Skipping data verification (e.g., assuming reports are correct)

Trips for Facilitating RCA

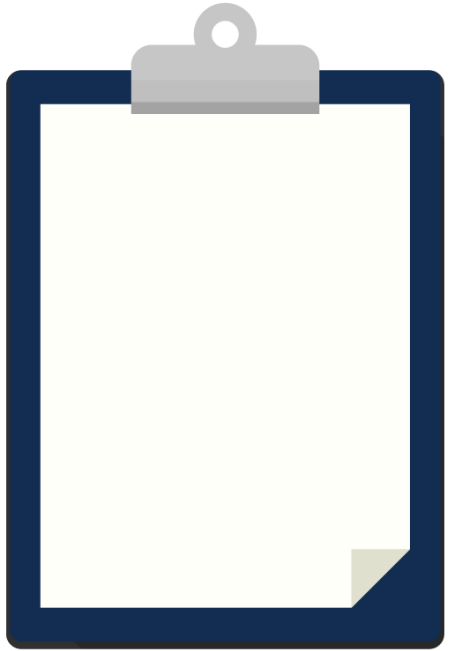
- Use a real CQM and patient list
- Walk through the worksheet live with your team
- Use a whiteboard or digital tracker to visualize steps
- Assign someone to take notes and document findings



Let's Practice!

- Identify one of your own quality gaps from your health center.
- Use NACHC's Root Cause Identifier Worksheet and the Five Whys Tool to determine the root cause.

Be prepared to share



What Happens Next?

Once a root cause and intervention are identified:

- Go to Step 4: Try a Small Change (PDSA Cycle) – We'll talk more about this soon!
- Track results and adapt
- Share outcomes and lessons learned

Key Takeaways

- RCA helps you identify why a care gap exists—not just what it is
- The worksheet provides a structured, team-friendly approach
- Closing gaps effectively requires a systems lens and team engagement


BREAK
TIME !!

Agenda

- Welcome
- Setting the Stage
- Creating SMART Goals
- Root Cause Analysis: What's Getting in the Way?
- Evidence-Based Interventions for Cancer Screening
- Care Team/Provider Interventions
- Selecting and Testing Interventions
- Action Planning
- Wrap Up

Evidence-Based Interventions for Cancer Screening

Evidence-Based Interventions

Evidence-based interventions are approaches to prevention or treatment that are peer-reviewed, documented empirical evidence of effectiveness by research and evaluation.

What is ‘Strong Evidence’ in Cancer Screening?

Strong evidence means the intervention is supported by multiple high-quality studies demonstrating effectiveness, ideally across settings and populations.

According to The Community Guide and USPSTF:

- ✳️ Systematic reviews confirm effectiveness
- ✳️ Results are consistent across different groups
- ✳️ Outcomes include increased screening rates and reduced late-stage diagnoses

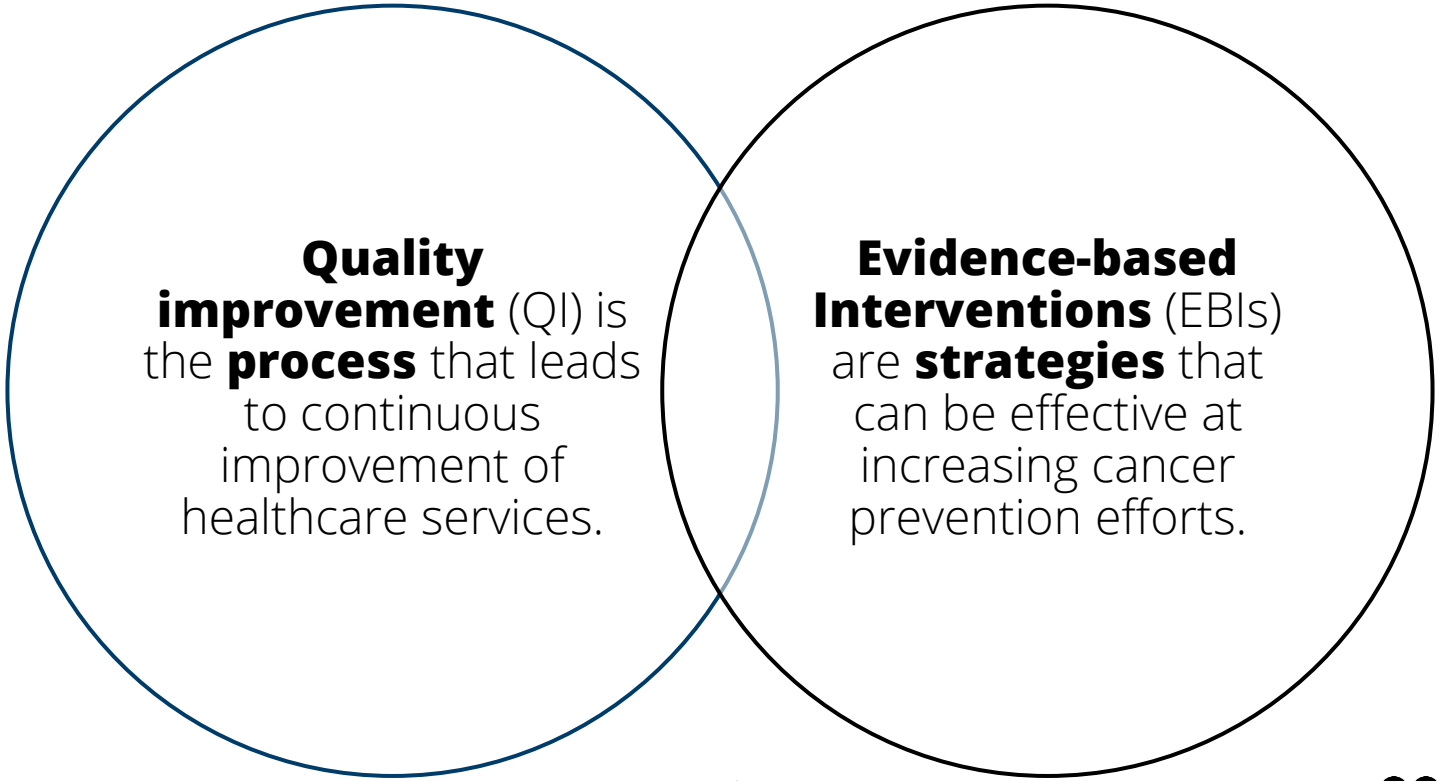
Sources:

The Community Guide to Preventive Services: www.thecommunityguide.org
U.S. Preventive Services Task Force (USPSTF): www.uspreventiveservicestaskforce.org

Why Evidence-Based Interventions (EBIs)

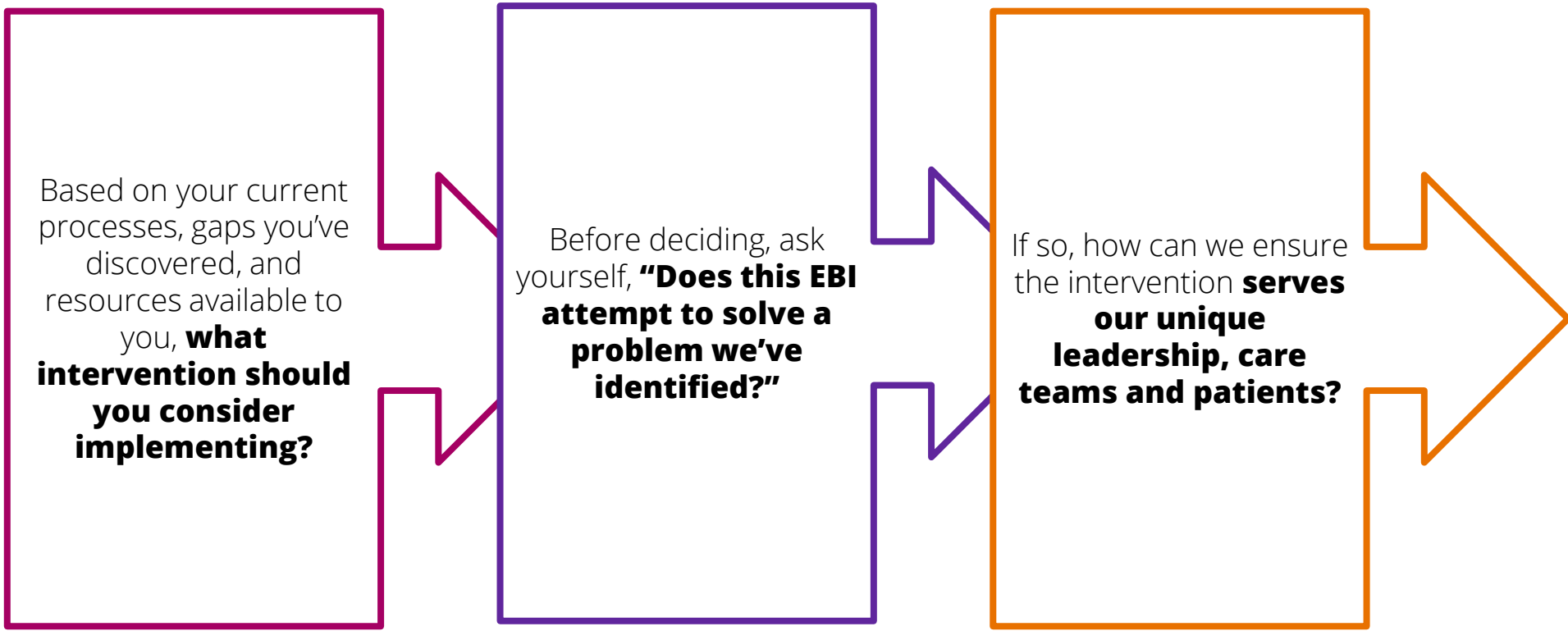
- Care gaps in screening persist across populations
- EBIs are proven strategies to address systemic barriers
- Increases likelihood of a successful initiative
- Increase cost benefit by saving time and resources
- Adds value and evidence when describing your program and sharing your plan with various stakeholders
- Defines what to evaluate and measuring impact

QI & EBIs Go Hand in Hand



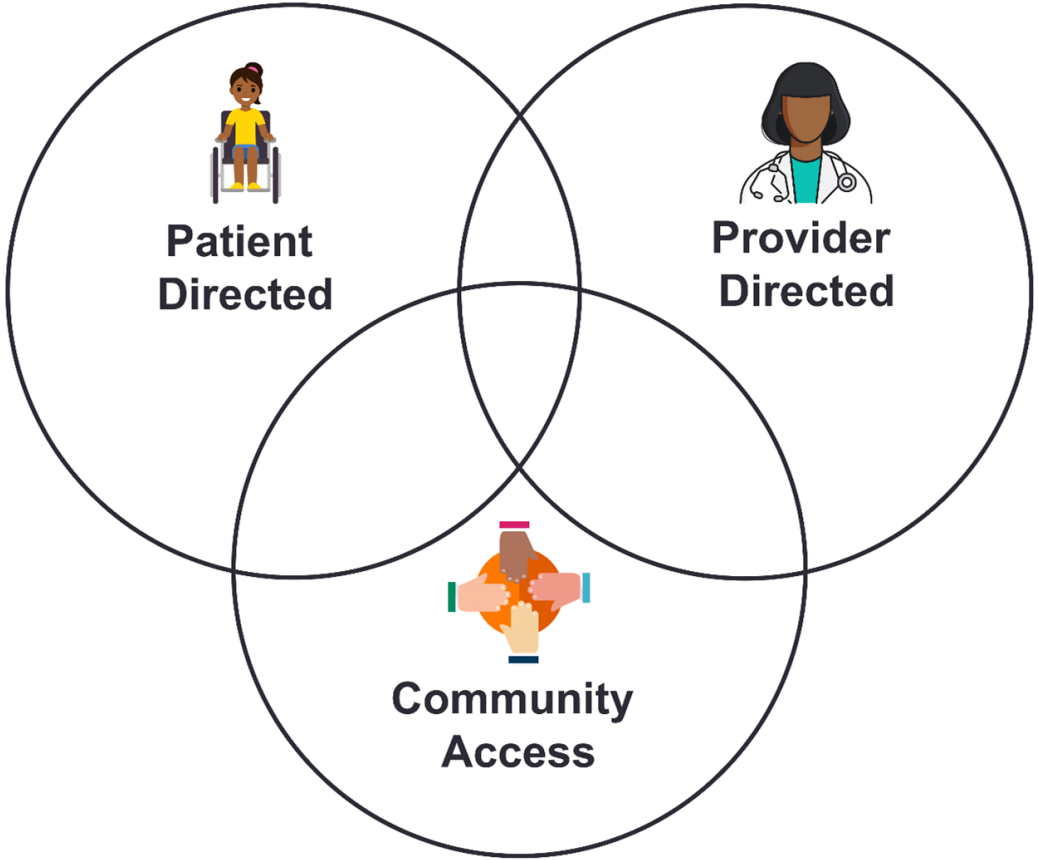
Intervention Design

Selecting an EBI through QI



Evidence-Based Interventions

The Community Preventive Services Task Force (CPSTF) recommends multicomponent interventions for increasing screening for cervical, breast, and colorectal cancer.



Source:
The Community Guide, ACS Screening Intervention Slide Decks

Cancer Screening EBIs

Multicomponent interventions had greatest impact:

- Combining interventions from each of the three approaches
- Two or more interventions to reduce structural barriers

Approach	Intervention	Breast	Cervical	Colorectal
Patient-Directed	Client Reminders	Recommended	Recommended	Recommended
	Group Education	Recommended	Insufficient evidence	Insufficient evidence
	One-On-One Education	Recommended	Recommended	Recommended
	Small Media	Recommended	Recommended	Recommended
Provider-Directed	Provider Assessment and Feedback	Recommended	Recommended	Recommended
	Provider Reminders	Recommended	Recommended	Recommended
	EHR Enhancements	Recommended	Recommended	Recommended
	Professional Education	Recommended	Recommended	Recommended
	Standing Orders	Recommended	Recommended	Recommended
Increasing Community Access	Reducing Structural Barriers	Recommended	Insufficient evidence	Recommended
	Reducing Out-of-Pocket Costs	Recommended	Insufficient evidence	Insufficient evidence
	Engage Community Health Workers	Recommended	Recommended	Recommended
	Patient Navigation Services	Recommended	Recommended	Recommended

Source: The Community Guide, ACS Evidence Based Interventions Guide

Tips for Patient-Directed Strategies

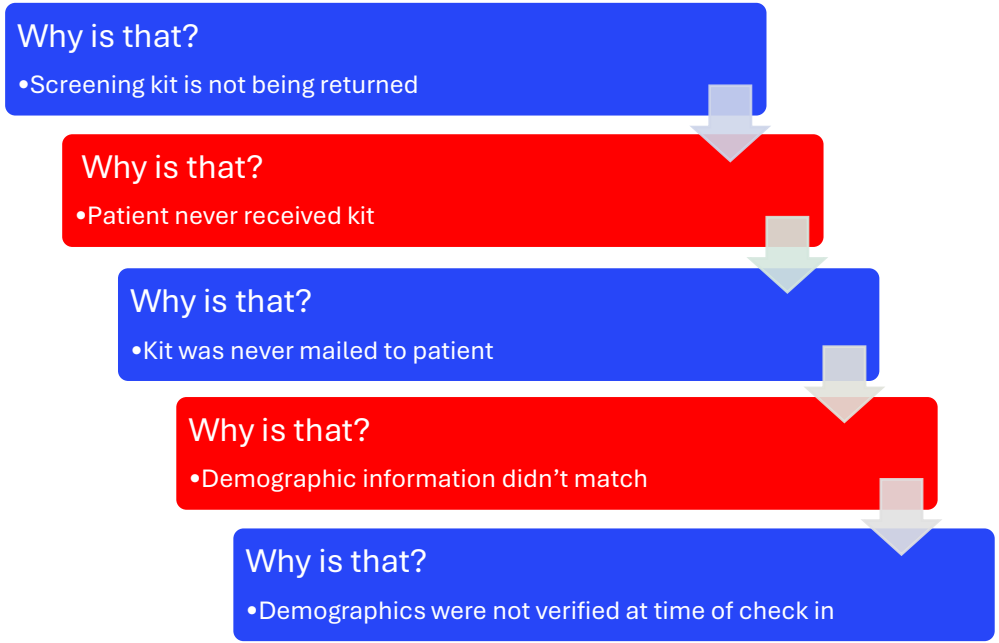
- Tailor content to literacy/language
- Use motivational interviewing
- Leverage patient portals and text reminders
- Embed education into touchpoints: intake, scheduling, outreach

Tips for Systems-Level Success

- Automate reminders in EHR
- Provide feedback that's visible (dashboards, whiteboards)
- Use incentives (internal recognition, not always monetary)
- Engage champions in driving culture change

Health Center Example: 5 Why's for CRCS

Problem: Colorectal Cancer Screening (CRCS) not being completed, in particular FIT Tests



Action:
Ensure patient demographics including phone number, address, and insurance are updated at time of check-in for patient visit. Ensure address is one that can be shipped to. If unable to mail to patient, offer for patient to pick one up at clinic.

EBIs:
-Provider education
-Reduction of structural barriers

Cost Effectiveness & Equity Impact

Community Preventive Services Task Force Findings:

Multicomponent interventions are cost-effective

They improve outcomes, especially in underserved populations.

Equity-Driven Impact:

Address language, access, and follow-up barriers

Use community-based delivery sites

Partner with navigators and CHWs

Key Takeaways

- Use multicomponent strategies for biggest impact
- Match the intervention to the root cause
- Keep equity front and center—tailor for your population

Matching Interventions to Your Gap

Use your root cause analysis (RCA) findings to guide intervention selection:

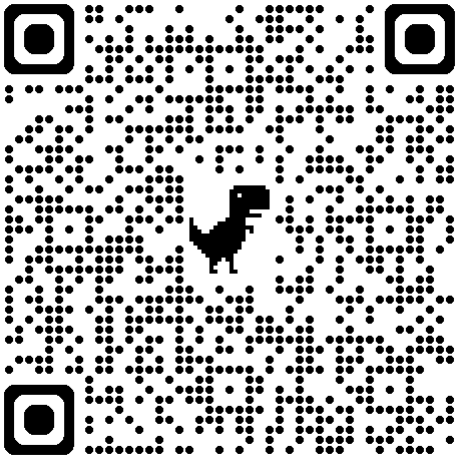
Type of Gap	Best EBI Categories
Data Gap	EHR Enhancements, Standing Orders
Service Delivery Gap	Professional Education, Reminders, Feedback
Service Engagement Gap	Patient Navigation, Education, Reducing Barriers

Let's Practice

Using your root cause analysis from earlier today, what evidence-based intervention(s) could you try to address it?

Be prepared to share.

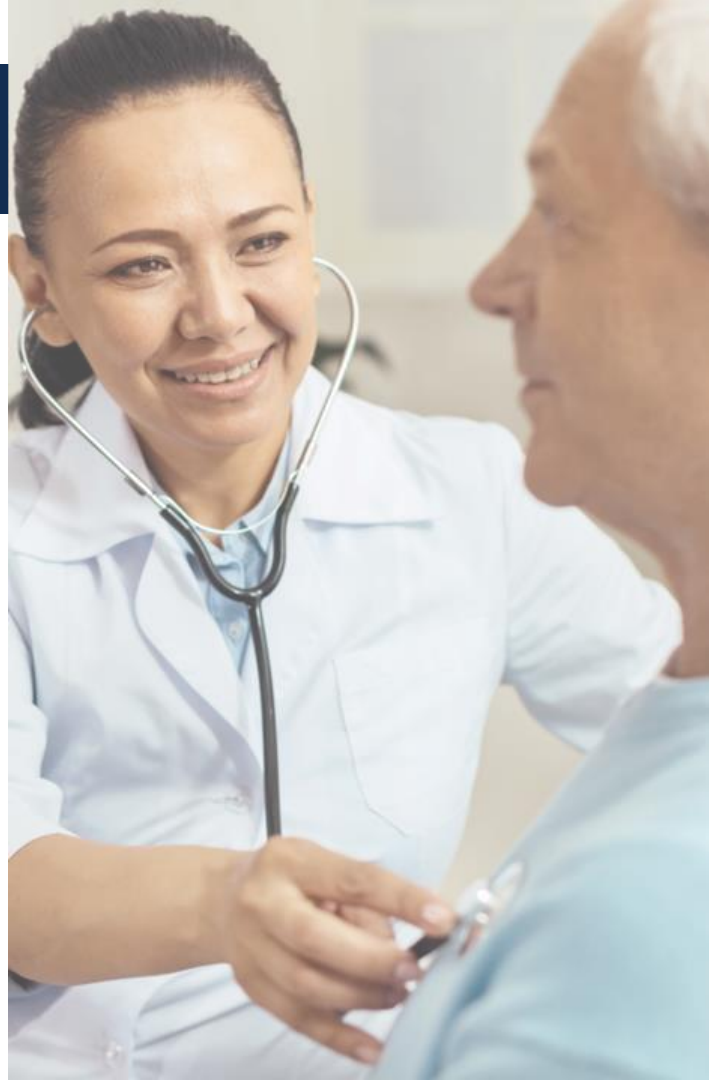
Scan for ACS EBI Guide



Care Team/Provider Interventions

Why A Whole-Person Approach?

- Quality measures are met (or missed) at many points in the patient journey
- Everyone on the care team contributes—not just the clinician
- Consistency across all touchpoints closes gaps and improves outcomes



Before the Visit

Make It Easy to Get in the Door

Reduce Structural Barriers:

Mobile screening units (breast)

Mailed FIT kits + return instructions (CRC)

Language, transportation, and childcare support

Evening/weekend or walk-in appointments

Improve Scheduling Access

Shorten phone hold times

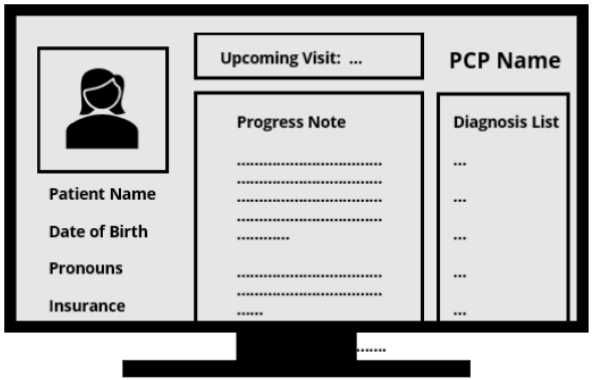
Offer online or text-to-schedule options

Address no-show rates and TNAA (Third Next Available Appointment)

Align productivity targets and empanelment with access goals

Prepare for the Day Ahead

- **Visit Prep Checklists**: Clinical and financial readiness
- **Standing Orders**: Empower MAs to close gaps proactively
- **EHR Reminders**: Highlight overdue quality measures
- **Robust Confirmation Calls**: Prep patients for services due
- **Morning Huddles**:
    - Review patients due for screenings
    - Strategize as a team for flow and follow-through



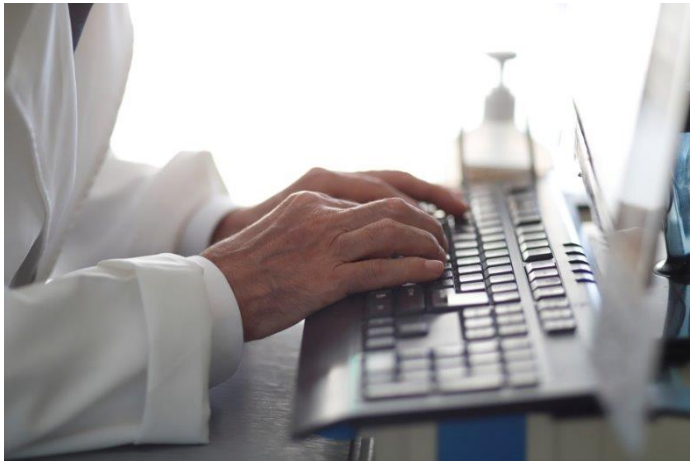
During the Visit

Teamwork in Action!

- QuickStart Approach: MA and clinician start with the first patient together
- Keep Supplies Ready: Avoid delays during screenings(Set-up Pap trays, have FIT tests available, etc.)
- Frequent Team Communication: Flag issues, reroute as needed

Document for Impact

- Prioritize real-time charting
  - Better documentation
  - Get home on time
- Use EHR templates to ensure screening are:
  - Properly captured
  - Counted toward CQMs (avoid free-text pitfalls)



After the Visit

Close the Loop

- Follow-up Reminders:
- Use tickler systems or task lists
- Track external screenings
- Improve automation of incoming results
- Ensure they are entered in structured fields

Re-Engage & Appreciate

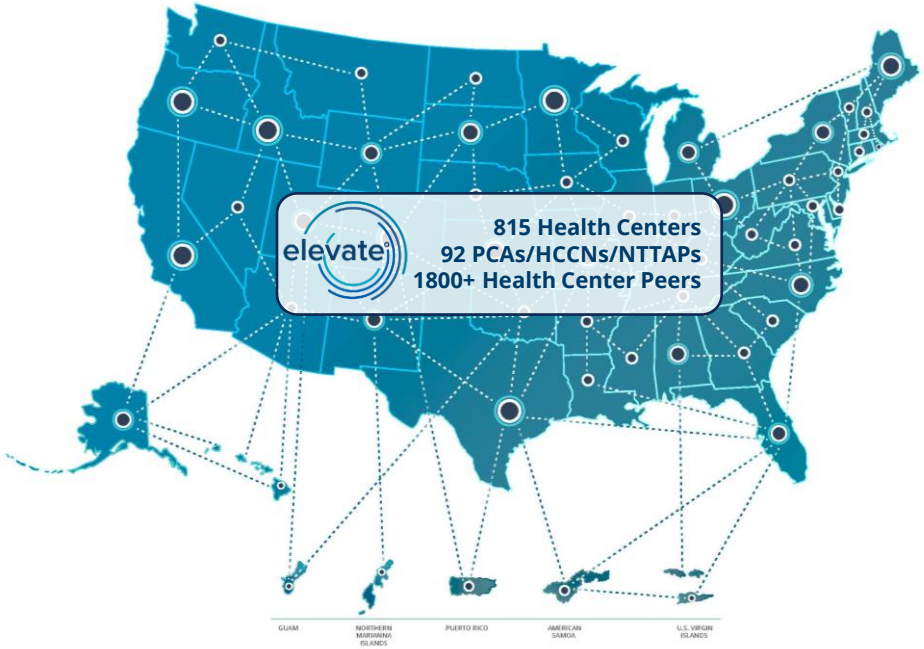
- Follow-up with patients who missed or declined screening
- Make it easy to reschedule
- Thank patients who completed their screening (text, call, or in person)

The Power of a Full-Visit Workflow

The most effective screening programs:

- Involve the full team
- Are consistent before, during, and after the visit
- Every care team member can help move the mark on quality
- Encourage ongoing improvement.
- Embed QI in team huddles and staff meetings
- Use data for accountability and motivation
- Leverage NACHC and ACS technical assistance
- Join national collaboratives (e.g., ECHO series, roundtables, grant programs, cohort studies, Elevate)

Join Elevate 2025!



Share Elevate 2025 with others!

Elevate **is NACHC's national learning forum supporting health centers and partners to transform systems and enhance value**

Want to Learn More About Elevate?

1. Elevate informational video (1 min)

Also visit NACHC's Elevate webpage

2. Value Transformation Framework (VTF) video (1 min)

Also visit NACHC's VTF webpage

Next Steps & Discussion

Which step in the visit process is your team's biggest opportunity?

Meet with your team and choose one tool to pilot when you are back at your health center.

How to Test Your Ideas

Selecting & Testing Interventions

Why Small Changes Matter

- Big changes take time
- Small changes help you
- Test ideas safely
- Learn what works
- Build momentum

You don’t need perfection—just progress

PDSA Cycle At-A-Glance

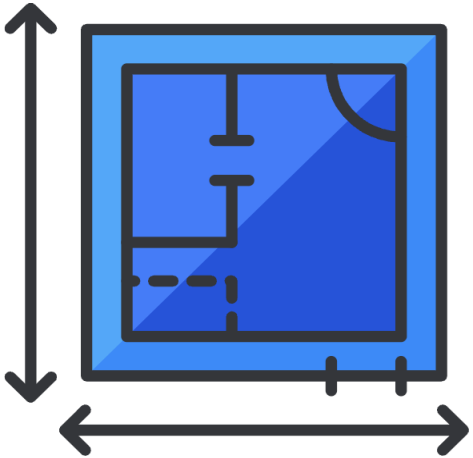
- Plan: Pick a small change
- Do: Try it out
- Study: Check what happened
- Act: Decide what's next

Plan: Pick One Small Change

Choose a change tied to a known root cause

Keep it focused:

- One team
- One clinician
- One day



Example: “Let’s try having the MA ask about outside cervical screenings during intake tomorrow.”

DO: Just Try It!

- Run the test as soon as possible
- Assign someone to observe or take notes
- No need for a perfect script or training—just start
- Reminder: You're not launching. You're learning.

STUDY: See What Happened

- What went well? What was clunky?
- Did the change solve the problem?
- Gather quick data:
  - How many patients got screened?
  - How did the team feel?
  - Any surprises?

ACT: Decide What's Next

- Adopt: It worked! Let's keep it.
- Adapt: Tweak it and try again.
- Abandon: Didn't work—what else could we try?

Don’t Wait for Perfection

- PDSA is about speed over polish
- Don’t get stuck in planning
- If it’s not a little messy, you’re probably not moving fast enough
- “Failing forward” is part of the process

Example: Small Change in Action

- **Problem**: Screenings done elsewhere not counted in reports
- **Small Change**: One MA starts asking patients about outside mammograms and enters them in structured fields
- **Results**: 5 screenings captured in 1 day
- **Decision**: Tweak language and test with the full team next week

Tips for PDSA Success

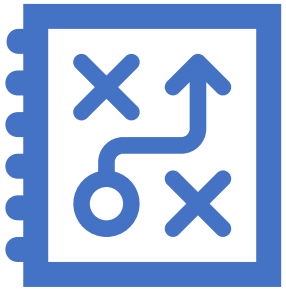
- Start small
- Test fast
- Involve the people doing the work
- Learn, adapt, repeat

Challenge for You

What's **one small change** you can test this week to close a care gap?

Who needs to be involved?

When will you try it?



NATIONAL ASSOCIATION OF Community Health Centers®

Action Planning:

Making It Right At Your Site

Guided Planning Session

Use your worksheet

to plan your test to improve a cancer screening measure at your site

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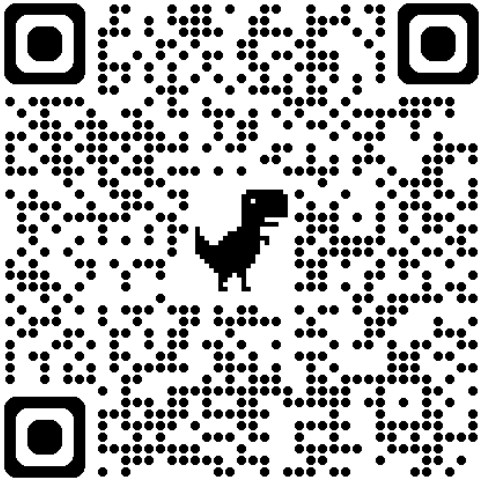
Wrap Up

Post-Assessment

Scan this QR Code to complete the Post-Test



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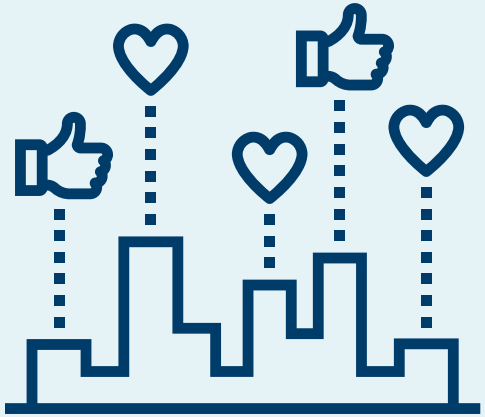

Provide Us Feedback

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Thank you!!!