VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

Improving Cancer Preventative Services through Focused Quality Improvement Efforts

The Virginia Department of Health (VDH) is seeking medium to large health systems to develop, implement, and evaluate policies and/or system changes to improve the access and delivery of breast, cervical, colorectal and lung preventative cancer screening services. Health systems that include multiple primary care sites, centers, or clinics, that are owned or managed by the same entity and/or share a common data reporting system are eligible for this funding opportunity.

Interested health systems can choose one or more **evidence-based interventions** from the following list:

Provider Assessment and Feedback

Regularly evaluate provider performance in delivering preventive cancer screening to clients and reporting back to providers on their performance.

Provider Reminder or Recall Systems

Provided in different ways, such as in client charts or by e-mail. This can entail improving clinical decision support functions within a health system's EHR and clinic workflow.

Client Reminders

Client reminders are written (letter, postcard, email, patient portal) or telephone messages (including automated voice and text messages) advising people that they are due for screening.

Small Media

Develop and test videos and printed materials, such as letters, brochures, and newsletters that can be used to inform and motivate people to be screened for cancer.

Structural barriers

Address non-economic burdens or obstacles that make it difficult for people to access cancer screening, such as: 1)Reducing time or distance between service delivery settings and target populations; 2) Modifying hours of service to meet client needs; 3) Offering services in alternative or non-clinical settings ; 4) Eliminating or simplifying administrative procedures and other obstacles.

Benefit to the Health System

- Improved HEDIS measures related to breast, cervical and colorectal cancer screening
- Improved provider performance and patient health outcomes
- Optimized use of health systems EHR capabilities
- Increased provider adherence to current national preventive cancer screening guidelines

Data Collection and Reporting Requirements:

Baseline and six-month post project preventive cancer screening rates will be collected to demonstrate an improvement in preventive cancer screening rates. Aggregate measures will be shared with VDH for tracking, trending and analysis purposes.

Tuition

Health systems choosing a SYNC Capstone Project focused on preventive cancer screening and addressing one of the evidence-based interventions listed above will have tuition and travel costs covered by VDH.

If you are interested in participating in this funding opportunity, please contact Rachel Hunley at 804-864-7268 or Rachel.Hunley@vdh.virginia.gov.

Strategies

Initiating quality improvement activities using EHRs to improve care delivery and patient outcomes

Identifying current reporting capabilities and practices related to chronic diseases

Use EHR to develop patient registry to monitor and manage high risk populations (i.e., racial/ethnic minorities, low education attainment, low-income)

Use EHR to develop patient alerts for individuals with undiagnosed HTN (elevated reading at previous 3 visits)

Establish policy that includes the development of a self-management plan (may include BP self-monitoring, personalized wellness plan, maintaining medical appts.) and establish feedback loop for data sharing

Implement an AADE or ADA diabetes self-management education program (DSME) or a diabetes prevention program (DPP)

Develop referral systems to self-management programs for patients with diabetes (e.g., DSME)

Establish a referral policy for patients with prediabetes or at risk of developing type 2 diabetes to a DPP or lifestyle change program

Measures

% adult patients with high blood pressure and/or diabetes in adherence to medication regimen

% of patients with high blood pressure that have a self-management plan

# of patients with high blood pressure who enroll in an evidence-based lifestyle change program

# of patients with prediabetes or at high risk for type 2 diabetes who enroll in a CDC-recognized lifestyle change program

simple BP control (BP1) (NQF 18) -- Patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period

Diabetes: Hemoglobin A1c Poor Control (NQF 59) -- Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period