2019

Health System Change Manual

Implementation of Evidence Based Interventions within clinics to increase preventive screening and community clinical linkages

Every Woman Matters
Nebraska Office of Women's Health

NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

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The Health Systems Change Manual can be found online:
http://dhhs.ne.gov/Pages/EWM-Health-Systems-Change.aspx

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Program Overview: Background and History of the NBCCEDP

Breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer death among women in the United States. Early detection and treatment of breast and cervical cancer through screening reduces mortality rates and greatly improves cancer patients' survival. However, there is a disproportionately low rate of screening among women of racial and ethnic minorities and among under or uninsured women, which creates a wide gap in health outcomes between these women and other women in the United States. To address this health disparity, Congress authorized the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) through the Breast and Cervical Cancer Mortality Prevention Act of 1990, directing the Centers for Disease Control and Prevention (CDC) to implement a national strategic effort for increasing access to breast and cervical cancer screening and diagnostic services for women in need.

The goal of the NBCCEDP is to decrease cancer incidence, morbidity, and mortality by focusing on underserved populations, who have increased cancer risk due to health disparities. CDC is pleased to offer this NBCCEDP Program Manual to grantees to provide an understanding of the NBCCEDP. The content is based on both current literature and the experience of those currently working in this program. This manual is intended to assist programs in meeting the requirements of the NBCCEDP as set forth in both the federal law and CDC guidance.

The NBCCEDP is administered by CDC's Division of Cancer Prevention and Control (DCPC) through cooperative agreements. Since 1991, the program has grown to include all 50 U.S. states, the District of Columbia, 6 U.S. territories, and 13 tribes or tribal organizations. Women diagnosed with cancer through the program are eligible for treatment through Medicaid coverage as authorized by the Breast and Cervical Cancer Treatment and Prevention Act passed by Congress in 2000. As of June 2016, the NBCCEDP has served more than 5.3 million women, provided more than 12.7 million breast and cervical cancer screening examinations, and diagnosed more than 63,293 invasive breast cancers, 20,349 premalignant breast lesions, 4,360 invasive cervical cancers, and 199,599 premalignant cervical lesions, of which 39% were high-grade.

Nebraska was one of the first 12 states to be awarded NBCCEDP funding in 1991. To date over 85,000 women have been enrolled in the program. 35% of clients are between the ages of 40-64 and 99% have less than a high school education. In the 2016-2017 fiscal year 1,934 enrolled for services. 486 mammograms were performed and 347 received Pap tests.

Target Populations

The EWM population is uninsured or underinsured women who are at or below 225% of the federal poverty level, aged 40 to 64 years for breast cancer services, and aged 21-64 years for cervical cancer services. The program is tasked with educating and motivating these women to seek screening; ensuring that services are convenient, accessible, and provided in a respectful, culturally competent manner; effectively communicating results; and recalling and assisting women who need additional services.

While all segments of society are affected by cancer, there are certain populations that are disproportionately burdened by the increased risk of cancer or by the lack of adequate healthcare options for prevention and/or treatment. Grantees should seek to achieve health equity by targeting efforts to populations disproportionately affected by cancer. Relevant data should be utilized to identify these populations and to select culturally appropriate and evidence-based interventions for implementation.

Disproportionately burdened populations may be defined by sex, race, ethnicity, disability, sexual orientation, gender identity, geographic location, or socioeconomic status. Among the populations that will benefit from this funding are those living in rural and frontier geographic areas; culturally isolated women; incarcerated or institutionalized women; medically underserved women; women from minorities defined by race, religion, ethnicity, or culture, including African Americans, Alaska Natives, American Indians, Asian Americans, Pacific Islanders and Hispanics; lesbian, gay, bisexual, or transgender individuals; and women with low literacy, non-English speaking language barriers, and disabilities.

Healthy People 2020 Objectives

In accordance with the Healthy People 2020 objectives for the nation, EWM will focus on strategies to address the national cancer burden. Measurable outcomes will be in alignment with the following performance objectives:

1. Reduce the female breast cancer death rate (Healthy People C-3)
2. Reduce the death rate from cancer of the uterine cervix (Healthy People C-4)
3. Reduce invasive uterine cervical cancer (Healthy People C-10)
4. Reduce late-stage female breast cancer (Healthy People C-11)
5. Increase age-appropriate screening prevalence for cervical and breast cancer (Healthy People C-15 and C-17)
6. Increase the proportion of women who were counseled by their providers about mammograms and Pap tests (Healthy People C-18.1 and C-18.2)

More information on Healthy People 2020 can be found here: www.healthypeople.gov/2020/topics-objectives/topic/cancer/objectives

NBCCEDP Focus

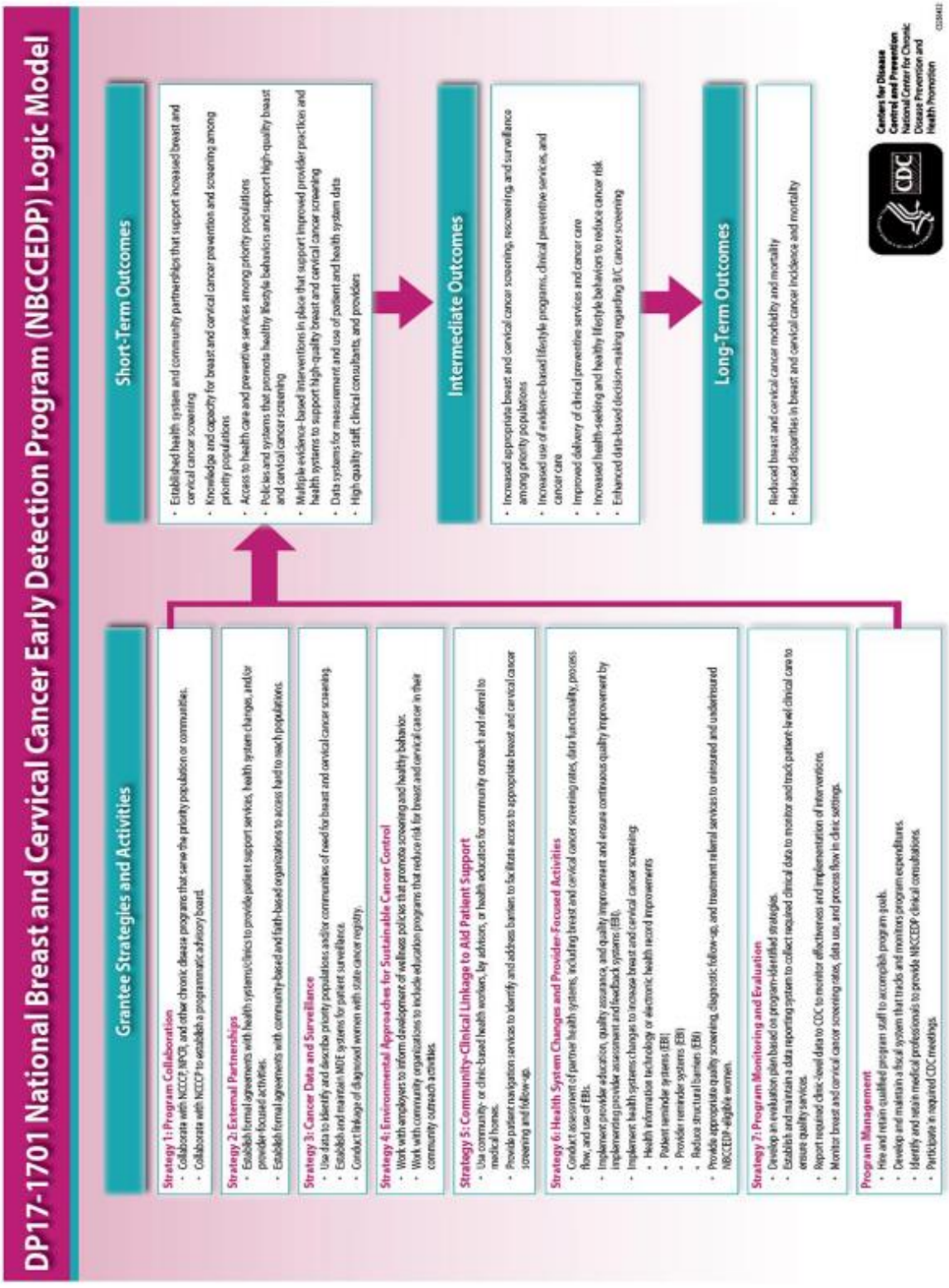
The main focus of EWM is to provide direct screening and diagnostic services for breast and cervical cancer to eligible women. Once a woman is enrolled in the EWM the grantee is responsible for the provision of rescreening mammograms and Pap tests at appropriate, recommended screening intervals, as well as cardiovascular screening and lifestyle programming and community linkages. Through the current five year funding cycle the program has expanded its activities to increase cancer screening and diagnostic services through population-based approaches focusing on health systems interventions, community approaches that link women to clinical services, and environmental approaches that increase access to screening, especially at worksites. This requires more defined work within health systems and communities. Furthermore, the use of a more aggressive outreach approach, versus passive in-reach, is emphasized.

Ultimately, a comprehensive public health approach is needed to increase access to high quality breast and cervical cancer screening and follow-up. This expanded focus will help to reduce disparities among vulnerable populations and missed screening opportunities for women who have health encounters. This approach is grounded in the National Center for Chronic Disease Prevention and Health Promotion's four Domains.

- Domain 1: Epidemiology and Surveillance
- Domain 2: Environmental Approaches
- Domain 3: Health Care System Interventions
- Domain 4: Community Programs Linked to Clinical Services

Logic Model

The DP17-1701 NBCCEDP Logic Model depicts the work of the strategies in achieving intended outcomes.



Health Systems Interventions and Provider Focused Activities Definition
A health system is any "system for delivering healthcare that may include, for example, hospitals, clinics, health maintenance organizations (HMOs), and community health centers." By working with a single health system to improve its breast and cervical cancer screening process, many individuals who need to be screened for breast and cervical cancer can be reached.

Strategies that are implemented across health systems that impact not only the individual patient, but the clinic community as a whole is a health system change intervention.

Patient Navigation
Sub recipients should establish patient navigation programs that provide individualized help to patients to overcome barriers and facilitate timely access to high-quality screening. Navigation under the Health System Changes subaward should include:

1. Provide patient navigation services to assist women eligible for NBCCEDP-paid clinical services in overcoming barriers to complete screening, diagnostic services, and initiation of cancer treatment.
2. Provide patient navigation services to support low-income women from priority populations but who have other payment sources (e.g., state funds, Medicaid) for screening in overcoming barriers to complete screening, diagnostics, and initiation of cancer treatment.

Women often face significant barriers to accessing and completing cancer screening and diagnostic services. Patient navigation is a strategy aimed to reduce disparities by helping women overcome those barriers. For purposes of this subaward, patient navigation is defined as individualized assistance offered to women to help overcome barriers and facilitate timely access to quality screening and diagnostic services, as well as initiation of timely treatment for those diagnosed with cancer. All EWM enrolled women with an abnormal screening result must be assessed for their need of patient navigation services and provided with such services accordingly.

Priority Populations for Patient Navigation Services
Navigation is an individualized intervention, intensive in nature, and potentially costly; therefore, priority should be given to navigate women who otherwise would not complete the screening and diagnostic process. Patient navigation services may be provided to clients enrolled in the EWM as well as those who have other resources (e.g., insurance) to pay for screening and diagnostic services. The target population of women who receive navigation paid for through the Women's and Men's Health Programs should be predominantly low-income women (≤250% FPL) and be of appropriate age per USPSTF screening guidelines. Reimbursement for navigation or navigated women must be supported by appropriate documentation.

Women screened through EWM who subsequently become insured may continue to receive patient navigation services to ensure the screening and diagnostic cycle is completed, and if cancer is diagnosed, that treatment is initiated. Navigators should assist in obtaining required patient-level clinical data.

Required Patient Navigation Activities
Although patient navigation services vary based on an individual's needs, at a minimum, patient navigation for women served through the WMHPs must include the following activities:

1. Assessment of individual patient barriers to cancer screening, diagnostic services, and initiation of cancer treatment
2. Patient education and support

3. Resolution of patient barriers (e.g., transportation, translation services)
4. Patient tracking and follow-up to monitor patient progress in completing screening, diagnostic testing, and initiating cancer treatment
5. A minimum of two, but preferably more, contacts with the patient, due to the centrality of the patient-navigator relationship.
6. Collection of data to evaluate the primary outcomes of patient navigation -- cancer screening and/or diagnostic testing, final diagnosis, and treatment initiation if needed.

Terminating Patient Navigation
Depending on screening and diagnostic outcomes, patient navigation services are terminated when a client (1) completes screening and has a normal result; (2) completes diagnostic testing and has normal results; (3) initiates cancer treatment; (4) refuses treatment; or (5) is no longer eligible for services.

Implementation of Evidence-based Interventions (EBIs)
The overall goal of the Health Systems Change Subaward is improving clinic-level breast and cervical cancer screening rates and strengthen the delivery of cancer screening services. To do this, subrecipients conduct a comprehensive assessment of their health care delivery system. The assessment should include breast and cervical cancer screening rates, data/electronic health record (EHR) functionality, patient/health system process flow, policies/standing orders for cancer screening, provider/health system adherence to clinical cancer screening guidelines, patient navigation/community health worker/support services, and use of EBIs or other strategies that support cancer screening. Final assessment of the health care system, should use these data to identify priority populations and to identify appropriate interventions for implementation.

The following table lists recommended EBIs to increase breast and cervical cancer screenings.

Approach	Intervention*	Breast	Cervical
Increasing Client Demand			
	Client Reminders	Recommended	Recommended
	Group Education	Recommended	Insufficient evidence
	One-On-One Education	Recommended	Recommended
	Small Media	Recommended	Recommended
Increasing Client Access			
	Reducing Structural Barriers	Recommended	Insufficient evidence
	Reducing Out-of-Pocket Costs	Recommended	Insufficient evidence
Increasing Provider Delivery			
	Provider Assessment and Feedback	Recommended	Recommended
	Provider Reminders	Recommended	Recommended

*If an intervention is recommended for one cancer but has insufficient evidence for the other cancer, CDC will allow the intervention to be implemented for both cancers.

*If an intervention is recommended for one cancer but has insufficient evidence for the other cancer, CDC will allow the intervention to be implemented for both cancers.

The Community Guide also recommends use of interventions from multiple approaches as an effective strategy to increase cancer screening. Research showed that combining EBIs from approaches that increase client demand with those that increase provider delivery or combining EBIs from all three approaches (increasing client demand, increasing client access, and increasing provider delivery) resulted in significant increases in screening among the community compared to the implementation of single EBIs.

Prior to implementing an EBI within clinic an implementation plan, which is a management tool for planning the implementation EBIs, must be completed for each partner health system. Additionally, subrecipients should work with program staff and contractors to strengthen the capability and use of health information technology systems, particularly the EHRs, to 1) monitor clinic-level screening rates, 2) identify populations who need to be screened, 3) implement EBIs, and 4) track completeness and timeliness of screening services.

Description of EBIs
The Community Guide serves as a resource to help select interventions to improve health and prevent disease in your state, community, community organization, business, healthcare organization, or school. The descriptions of EBIs recommended for increasing breast and/or cervical cancer screening are below and can be found at https://www.thecommunityguide.org/topic/cancer. CDC developed individual logic models for all EBIs, patient navigation, and community outreach. An additional 'meta-logic model' illustrates how these activities work together to achieve desired outcomes. Subrecipients are encouraged to use these logic models in designing their own evaluation plans. See page 6 for EBI Logic Model.

Client Reminders
Client reminders are written (letter, postcard, email) or telephone messages (including automated messages) advising people that they are due for screening. Client reminders may be enhanced by one or more of the following:

1. Follow-up printed or telephone reminders
2. Additional text or discussion with information about indications for, benefits of, and ways to overcome barriers to screening
3. Assistance in scheduling appointments

These interventions can address the overall target population or tailored with the intent to reach one specific person, based on characteristics unique to that person, related to the outcome of interest, and derived from an individual assessment.

Group Education
Group education conveys information on indications for, benefits of, and ways to overcome barriers to screening with the goal of informing, encouraging, and motivating participants to seek recommended screening. Group education is usually conducted by health professionals or by trained lay people who use presentations or other teaching aids in a lecture or interactive format, and often incorporate role modeling or other methods. Group education can be given to a variety of groups, in different settings, and by different types of educators with different backgrounds and styles.

One-On-One Education
One-on-one education delivers information to individuals about indications for, benefits of, and ways to overcome barriers to cancer screening with the goal of informing, encouraging, and motivating them to seek recommended screening. These messages are delivered by healthcare workers or

other health professionals, lay health advisors, or volunteers, and are conducted by telephone or in person in medical, community, worksite, or household settings.
These messages can be untailored to address the overall target population or tailored with the intent to reach one specific person, based on characteristics unique to that person, related to the outcome of interest, and derived from an individual assessment. One-on-one education is often accompanied by supporting materials delivered via small media (e.g., brochures), and may also involve client reminders.

Small Media
Small media include videos and printed materials such as letters, brochures, and newsletters. These materials can be used to inform and motivate people to be screened for cancer. They can provide information tailored to specific individuals or targeted to general audiences. Subrecipients should make effort to use existing materials such as Make It Your Own (MIYO) when implementing small media.

Reducing Structural Barriers
Structural barriers are non-economic burdens or obstacles that make it difficult for people to access cancer screening. Interventions designed to reduce these barriers may facilitate access to cancer screening services by:

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 (e.g., mobile mammography vans at worksites or in residential communities)
4. Eliminating or simplifying administrative procedures and other obstacles (e.g., scheduling assistance, patient navigators, transportation, dependent care, translation services, limiting the number of clinic visits)

Such interventions often include one or more secondary supporting measures, such as:

1. Printed or telephone reminders and education about cancer screening
2. Information about screening availability (e.g., group education, pamphlets, or brochures)

Measures to reduce out-of-pocket costs to the client (though interventions principally designed to reduce client costs are considered to be a separate class of approaches)

Reducing Out-of-Pocket Costs
Interventions to reduce client out-of-pocket costs attempt to minimize or remove economic barriers that make it difficult for clients to access cancer screening services. Costs can be reduced through a variety of approaches, including vouchers, reimbursements, reduction in co-pays, or adjustments in federal or state insurance coverage. Efforts to reduce client costs may be combined with measures to provide client education, information about program availability, or measures to reduce structural barriers.

Provider Assessment and Feedback
Provider assessment and feedback interventions both evaluate provider performance in delivering or offering screening to clients (assessment) and present providers with information about their performance in providing screening services (feedback). Feedback may describe the performance of a group of providers (e.g., mean performance for a practice) or an individual provider and may be compared with a goal or standard.

Provider Reminders
Reminders inform health care providers it is time for a client's cancer screening test (called a "reminder") or that the client is overdue for screening (called a "recall"). The reminders can be provided in different ways, such as in client charts or by e-mail.

Community-Clinical Linkages to Aid Patient Support Definition
Coordination of services among health systems, communities, and public health using community-based and/or clinic-based health workers can increase access to clinical care and promote health behaviors. Subrecipients use community-based and/or clinic-based health workers/lay advisors, native language speakers, or health educators for community outreach to identify women for screening, provide patient education about risk factors and preventive health behaviors, and address barriers to care.

The goal of the activity is to link women to community resources, medical homes, or health care systems/clinics for cancer screening, diagnostic, genomics, and/or treatment resources. The best way to achieve this is often by working with community and national affiliate partners to reach disparate populations and use culturally appropriate interventions that are tailored for the communities for which they are intended to reach. These health workers may also refer women to health insurance enrollment.

Required Activities Connecting Women in the Community to Clinical Services
Subrecipients are required to develop processes to link women to health systems within the community where they live and work. The first steps are to use available data to identify priority disparate populations and/or communities of need and the available resources for that community. Use of community-based workers (lay or professional) can help link women to health systems by providing outreach, education, and/or navigation services.

Subrecipients should identify and collaborate with key community-based organizations and other community partners that can help reach these disparate populations using culturally appropriate communications and interventions. The organizations may be able to integrate screening messages into their existing outreach, serve as access ports to reach priority women, and assist with referring or navigating women to screening sites. A Memorandum of Understanding (MOU) with these organizations should be developed that clearly defines the activities, roles, and expected outcomes.

The goals of these activities are to:
1. Inform women about the program
2. Educate women about breast and cervical cancer screening
3. Link women to health systems to get needed clinical services

A monitoring and evaluation plan should be in place to ensure priority women are identified, linked or navigated to screening, and screened. Potential tools for monitoring and tracking include:
1. Community Health Worker Encounter Registry
2. Referral form or screening vouchers
3. Bundled payment and de-identified patient level clinic documentation
4. Memorandum of Understanding among partners

Environmental Approaches for Sustainable Cancer Control Definition
Environmental approaches promote health and support healthy behaviors in states, communities, and smaller settings such as work sites and businesses. Environmental approaches can involve one

group or a group of organizations making changes in policies and physical surroundings that makes healthy choices easy, convenient, and affordable for all.

Required Activities

Inform policies that increase access to cancer screening where women live and work. Subrecipients and partners should use behavior risk factor data, cancer surveillance data, and other available data sources to identify priority communities. This will require engaging community partners such as cancer coalitions and community champions. The focus is to educate and inform employers and community-based organizations in priority communities about ways to help increase breast and cervical cancer screening rates among low-income women by making screening services accessible and facilitating healthy lifestyles that reduce cancer risk.

The goal is to have employer and organizational policies in place that increase access to screening and improve health behaviors. Outcomes to be tracked would include policies developed and outcomes of having these policies in place.

Health Systems Change Subawards: Scope of Work for 2018-2019

1. Participate with DHHS Contractor, Partnership for a Healthy Lincoln (PHL), to assess current clinic processes and procedures for identifying:
   a. Women at risk for breast cancer with an emphasis on women 40-75;
   b. Women at risk for cervical cancer 21-65 with an emphasis on women over 40;
   c. Women at risk for uncontrolled hypertension 18 and up with an emphasis on women 40-75;
   d. Men and women 50-75 at risk for colon cancer.

2. Participate with PHL to utilize electronic medical records to assess screening rates for breast, cervical, and colon cancer and assess clinic rate of uncontrolled hypertension;

3. Develop and initiate process improvement plans to increase screening rates and decrease uncontrolled hypertension within clinic population;

4. Participate with DHHS to assess, develop, and implement health systems change implementing proven evidence based clinic interventions (EBI) to increase breast, cervical, and colon cancer screening rates, and navigating to diagnostics and treatment if needed for those individuals having abnormal screening results;

5. Participate with DHHS to assess, develop, and implement health systems change utilizing proven evidence based clinic strategies to increase adherence to medication regiment and lifestyle modification for those women found to have uncontrolled hypertension;

6. Select at least 3 of 5 NQF (National Quality Forum) based quality measures using a collaborative process including FQHC's, DHHS, and potentially MCO's (Managed Care Organization/Medicaid). Minimally must select breast cancer and cervical cancer screening and hypertension control. Measures include breast, cervical, colon cancer screening, HPV vaccine uptake, and hypertension control;

7. Work collaboratively with local health department or other community partners to explore and implement utilization of community supports/bidirectional referrals for navigation to specialty care or screening access to mammography, colonoscopy, diagnostic and treatment services, Target BP and Check.Change.Control.® from American Heart Association (AHA), National Diabetes Prevention Programs, and Living Well;

8. Provide appropriate documentation as required in Attachment 2 to document work done to increase preventive screening rates, identification of women with hypertension, initiate quality improvement processes and implement health systems changes, inclusive of team-based care for hypertension control;

9. Participate in monthly teleconference calls with assigned DHHS nurse technical assistance to review progress, challenges, and address training needs;

10. Participate in quarterly webinars facilitated by PHL regarding clinic based EBIs, team-based care for blood pressure control; and,

11. Assist in development of resources and tools for dissemination of best practices and utilization of effective EBIs.

Screening Guidelines

Every Woman Matters (EWM) screening guidelines include:

- Screening clients who are 40-74 years of age for breast and cervical cancer screening
- screening women who are 40-64 years of age for cardiovascular/diabetes screening
- providing diagnostic breast and cervical cancer screening to women with prior abnormals who are 21 years of age and older

Nebraska Colon Cancer Screening Program (NCP) screening guidelines include:

- screening women and men who are 50-74 years of age for colon cancer screening

PLEASE NOTE:

- When EWM/NCP says 40-74, 40-64, 50-74, etc. it means that if a client is 64 or 74 they are still eligible for services, but once they turn 75 years of age they are no longer eligible.

- For the purposes of the Health Systems Change project the subaward scope was written based upon U.S. Preventive Services Task Force (USPSTF) guidelines. The USPSTF guidelines say until the age of 75.

- You'll find that this manual says 40-64 and 40-74 on various pages and it also says 40-75 and 50-75, which does also mean "until the age of 75."

BLOOD PRESSURE SCREENING USPSTF RECOMMENDATION/GUIDELINES:

Recommendation Summary		
Population	**Recommendation**	**Grade**
Adults aged 18 years or older	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment (see the Clinical Considerations section of the USPSTF).	A

COLON CANCER SCREENING USPSTF RECOMMENDATION/GUIDELINES:

Recommendation Summary		
Population	**Recommendation**	**Grade**
Adults aged 50 to 75 years	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years. The risks and benefits of different screening methods vary. See the Clinical Considerations section and the Table for details about screening strategies.	A
Adults aged 76 to 85 years	The decision to screen for colorectal in adults aged 76 to 85 years should be an individual one, taking into account the patient's overall health and prior screening history. - Adults in this age group who have never been screened for colorectal cancer are more likely to benefit. - Screening would be most appropriate among adults who 1) are healthy enough to undergo treatment if colorectal cancer is detected and 2) do not have comorbid conditions that would significantly limit their life expectancy.	C

BREAST CANCER SCREENING USPSTF RECOMMENDATION/GUIDELINES:

Recommendation Summary		
Population	**Recommendation**	**Grade**
Women aged 50 to 74 years	The USPSTF recommends biennial screening mammography for women aged 50 to 74 years	B
Women aged 40 to 49 years	The decision to start screening mammography in women prior to age 50 years should be an individual one. Women who place a higher value on the potential benefit than the potential harms may choose to begin biennial screening between the ages of 40 and 49 years. - For women who are at average risk for breast cancer, most of the benefit of mammography results from biennial screening during ages 50 to 74 years. Or all of the age groups, women aged 60 to 69 years are most likely to avoid breast cancer death through mammography screening. While screening mammography in women aged 40 to 49 years may reduce the risk for breast cancer death, the number of deaths averted is smaller than that in older women and the number of false-positive results and unnecessary biopsies is larger. The balance of benefits and harms is likely to improve as women move from their early to late 40s. - In addition to false-positive results and unnecessary biopsies, all women undergoing regular screening mammography are at risk for the diagnosis and treatment of noninvasive and invasive breast cancer that would otherwise not have become a threat to their health, or even apparent, during their lifetime (known as "overdiagnosis"). Beginning mammography screening at a younger age and screening more frequently may increase the risk for overdiagnosis and subsequent overtreatment. - Women with a parent, sibling, or child with breast cancer are at higher risk for breast cancer and thus may benefit more than average-risk women from beginning screening in their 40s. Go to the Clinical Considerations section for information on implementation of the C recommendation.	C
Women aged 75 years or older	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women aged 75 years or older	I
All women	The USPSTF concludes that the current evidence is insufficient to assess the benefits and harms of digital breast tomosynthesis (DBT) as a primary screening method for breast cancer	I
Women with dense breasts	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the adjunctive screening for breast cancer using breast ultrasonography, magnetic resonance imaging, DBT, or other methods in women identified to have dense breasts on an otherwise negative screening mammogram	I

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small.	Offer or provider this service for selected patients depending on individual circumstances.
D	The USPSTF recommends against this service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

Activities, Payment Rates, and Required Documentation Table

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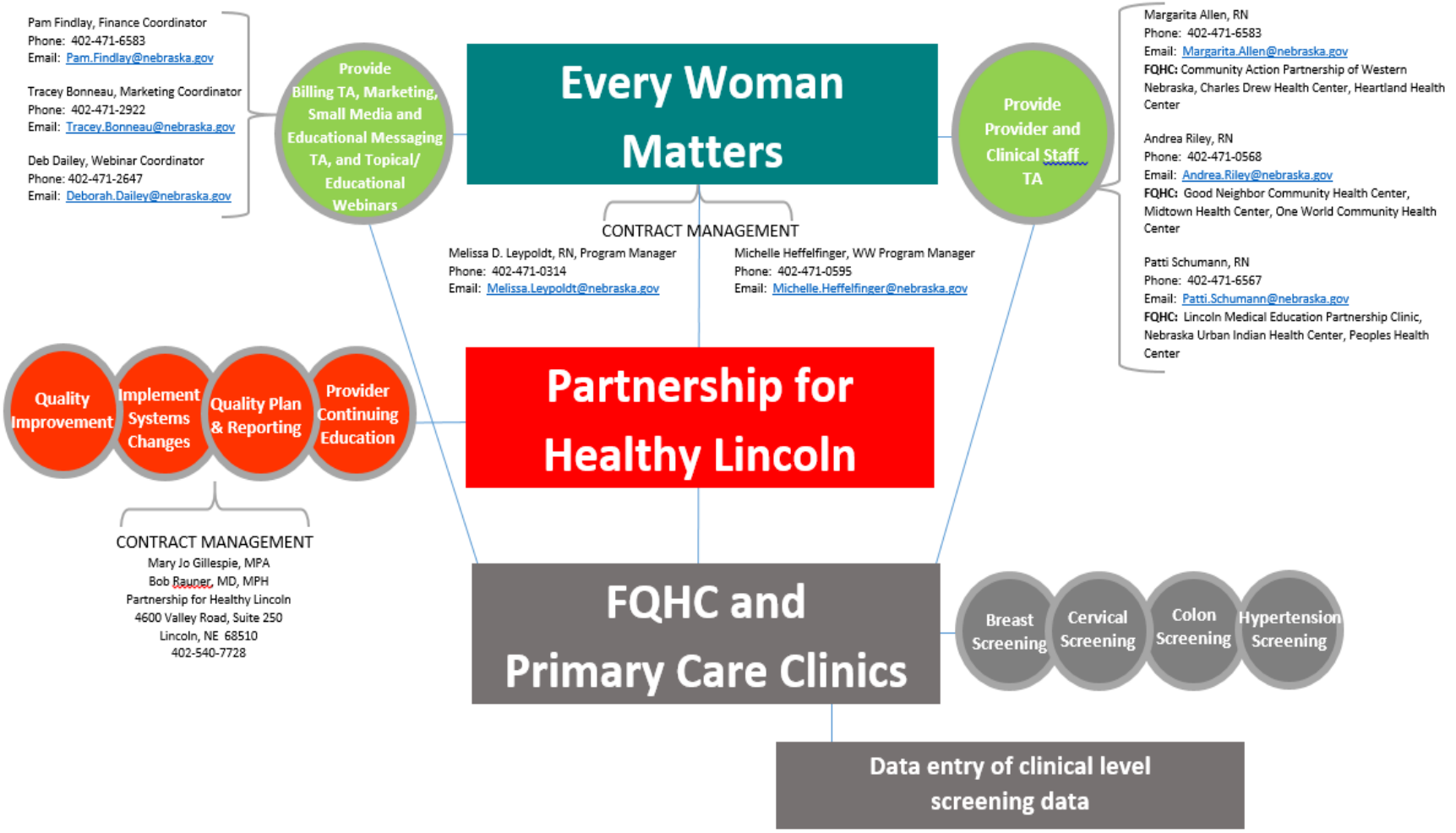
Reimbursement Table FY19:

Activity	Payment Rate	**Performance Pay**	Quality Measures	Required Documentation	Program Audit
Annual Clinic Assessment And Quality Improvement Plan Milestone Completion of the Quality Plan and Clinic Assessment	$5,000	0	Quality measures identified, screening goals set. CDC clinic assessment complete and comprehensive	Quality Improvement Plan	PHL Summary Report
Milestone Data Extraction/ Screening Rate Screening Rates Captured from EHR (4 data extractions per contract period – dates to be determined)	$2,000 per data extraction for Screening rates based on calendar year. $5000 per data extraction for Screening rates based on rolling 24 month calculation. Progress report complete and comprehensive	0	Screening rates Progress report complete and comprehensive	Updated Quality Improvement Plan	PHL Summary Report
Milestones for Planning and Implementing Evidence Based Interventions for Health Systems Change.					
Evidence Based Interventions for Health Systems Change to Increase Breast and Cervical Cancer Screening Selection, planning and implementation of EBIs for systems change to increase breast and cervical cancer preventive screening	$4,000	0	Copies of end products (provider feedback reports, client reminder cards, provider reminders, clinic team minutes) Workflow Process Map required	Evidence-Based Health Systems Change Intervention Plan	Clinic observation
Evidence Based Interventions for Health Systems Change to Increase Women with Controlled Hypertension Selection, planning and implementation of EBIs for systems change to increase identification and referral of women 40-64 with hypertension/ inclusive of team based care for control of HTN	$4,500	0	Copies of end products (provider feedback reports, client reminder cards, provider reminders, clinic team minutes)	Evidence-Based Health Systems Change Intervention Plan	Clinic observation

Activity	Payment Rate	Performance Pay	Quality Measures	Required Documentation	Program Audit
Breast and Cervical Cancer Screening and Navigation Milestone	**Max $25,000**				
Cancer Screening					
Breast Cancer Screening Rate Increase	$5000 for an absolute increase of at least 15%. $10,000 for an absolute increase of at least 25%.			Base line screening rates and 4th screening rates as noted in final Quality Improvement Plan	PHL Summary Report
Breast and Cervical Cancer navigation	$208 per patient	30%	Age/gender requirements Definitive Diagnosis and Treatment completion rates	Data String- De-identified clinic record	Completeness of data string De-identified clinic record
Supports for Structural Barrier Reduction to increase breast and cervical cancer screening.	Limited up to $100/client based on need.	0	Actual costs- based on receipts approved by Nursing TA	Number of women needing structural reductions as noted on navigation data string.	Comparison of assessment of barriers and purchase of structural barrier reduction supports.
Colon Cancer Navigation Milestone	**Max $700**				
Colon Cancer barrier reduction	$50 per patient	15%	Age/gender requirements Definitive Diagnosis and Treatment completion rates	Data String- De-identified clinic record	Completeness of data string De-identified clinic record
Community Clinical Linkages-Collaborative Impact for Breast Navigation	$5000 (Lancaster and Douglas County ineligible this year)	0	Number of women screened, appropriately followed up, and referred to treatment resources as needed.	Completed Community Clinical Linkages Template	MedIt and CHW data entry and summary
EBI Impact Participation	$5000	0	Participation in best practices project/webinar;	Webinar/video completed, Tools developed, Meeting attendance	PHL Summary Collaborative Impact Report Progress Reports

Health Systems Change

Project Objectives: Increase breast, cervical and colorectal cancer screening rates within partner health system clinics that serve priority populations by implementing evidence-based interventions in partnership with health system clinics to increase screening rates. Baseline and annual data for every participating clinic must be reported to CDC. Data must include clinic-level screening data.



Partnership for Healthy Lincoln Roles and Responsibilities:

Annual Clinic Assessment and Quality Improvement: Contract Signing/Initial Setup of FQHC's; Includes intro YouTube video and/or webinar on Quality Improvement; Overview of quality improvement project with FQHCs; Review specific quality improvement measures; Set-up in data base and CME provider system; Quality Plan Completion; Round 1 site visits to 7 FQHCs and 2 primary care clinics in Lincoln, NE; Site-specific selection of at least 4 of 6 NQF (National Quality Forum)-based quality measures (Collaborative process including FQHC's, DHHS and potentially MCO's (Managed Care Organization/Medicaid); Determine reporting parameters and timelines; Completion of CDC required clinic health systems assessment; Documentation: Initial Summary Report

Data Extraction/Screening Rates: Completion of data pull for all 7 FQHCs and 2 primary care clinics in Lincoln, NE; baseline report to DHHS; ongoing clinic technical assistance; follow-up with FQHC; Documentation: Project Progress Report

Data Extraction/Screening Rates: Completion of data pull for all 7 FQHCs and 2 primary care clinics in Lincoln, NE; baseline report to DHHS; ongoing clinic technical assistance; follow-up with FQHC; YouTube video with project status update; Documentation: Progress Report

Data Extraction/Screening Rates: Completion of 2nd round site visits; review of NQF (National Quality Forum) based quality data; staffing for Quality Improvement presentation; Documentation: Site Visit Progress Reports

Data Extraction/Screening Rates: Completion of data pull for all 7 FQHCs and 2 primary care clinics in Lincoln, NE; final report to DHHS; Project presentation to DHHS; YouTube video or webinar wrap up presentation to FQHC's; listing of published or potential journal articles, papers or presentations; CME processing and upload.

Screening Navigation Strings: Provision of Continuing Education for providers

Evidence Based Interventions for Health Systems Change: Development and implementation of "Community-Clinical Collaborative Impact Project" to increase preventive screen, community linkages to healthy supports, and access to care in priority populations

FQHC / Primary Care Clinics Roles and Responsibilities:

Annual Clinic Assessment and Quality Improvement: Contract Signing/Initial Setup of Health System with Partnership for a Health Lincoln (PHL); Quality Plan Completion Inclusive of CDC Clinic Assessment; Site-specific selection of at least 3 of 5 NQF (National Quality Forum)-based quality measures (Collaborative process including FCHC's, DHHS and potentially MCO's (Managed Care Organization / Medicaid); Minimally must select breast cancer screening and hypertension control

Data Extraction/Screening Rates: Completion of data pulls; Review specific quality improvement measures; Documentation: Project Progress Report

Screening Navigation Strings: Performance and completion measures paged on patient data; breast cancer screening rate improvement; submission of data string

Evidence Based Interventions for Health Systems Change: Selection and implementation of Evidence Based Interventions for Health Systems Intervention to increase cancer screening rates

Every Woman Matters Role and Responsibilities:

Provide a primary contact person for duration of the subaward; provide technical assistance, as needed, to provide resources and support; review assessment tools and provide feedback; provide e-learning space for linkage of educational resources and tools; review and approve summary reports; provide payment according to payment structure; provide resource manual inclusive of required templates.

Annual Clinic Assessment and Quality Improvement Plan

- Contract Signing / Initial Setup of Health System with Partnership for a Healthy Lincoln (PHL)
- Quality Plan completion inclusive of CDC Clinic Assessment
- Site-specific selection of at least 3 of 5 National Quality Forum (NQF) based quality measures (collaborative process including FQHC's, DHHS, and potentially Managed Care Organization/Medicaid (MCO's) – minimally must select breast cancer screening and hypertension control

Pay for Performance:	• None
Tool Collects:	• Clinic Assessment • Clinic Staffing and contact information identified
Quality Measures:	• Quality measures identified, screening goals set • CDC clinic assessment complete and comprehensive
Required Documentation:	• Quality Improvement Plan
Program Audit:	• Partnership for Healthy Lincoln (PHL) Summary Report
DHHS Staff Responsibilities:	• Nurse provides Technical Assistance • Observation of clinic process, deeper dive • Interview of Care Coordination staff • Recommendations for EBI resources and tool
PHL Responsibilities:	• Work with clinical and IT staff to develop plan and assist for EHR, Electronic Health Record, utilization and data extraction • Training and needs assessment around quality improvement processes • Provision of CEUs • Data Analysis of EHR data extractions • Recommendation for quality/data improvement
Clinic Responsibilities:	• Completion of Clinic Assessment • Work with EHR vendor to extract quality data set • Team processes for clinic assessment, screening goals, CEUs • Identification of Evidence Based Interventions to increase screening rates

Required documentation for Annual Clinic Assessment and Quality Improvement Plan can be found at: http://dhhs.ne.gov/Pages/EWM-Health-Systems-Change.aspx

- **Select:** Health Systems Change Templates tab
- **Select:** Health Systems Annual Clinic Assessment – Quality Improvement Plan

Data Extraction / Screening Rates

- Data extraction for screening rates based on calendar year
- Data extraction for screening rates based on rolling 24 month calculation
- Progress report complete and comprehensive

Pay for Performance:	• Increased payment for meeting Standard Screening Rate calculation based on rolling 24 months.
Tool Collects:	• Current screening rate captured from EHR (4 data extractions per contract period) • Identification of challenges and successes in meeting screening goals • Implementation of EBIs • Quality Improvement processes
Quality Measures:	• Screening rates • Progress report complete and comprehensive
Required Documentation:	• Updated Quality Improvement Plan
Program Audit:	• Partnership for Healthy Lincoln (PHL) Summary Report
DHHS Staff Responsibilities:	• Nurse provides Technical Assistance on monthly basis • Continue collection of qualitative data around implementation of selected EBI
PHL Responsibilities:	• Continue to work with clinic providers to extract quality data from EHRs • Identify challenges and successes making recommendations for changes • Calculation of screening rates and progress to meet screening goals • Summary of aggregate data from all clinics
Clinic Responsibilities:	• Team process for addressing quality improvement steps to increase screening • Address challenges to meet needs of clients • Meet screening goals

Required documentation for Annual Clinic Assessment and Quality Improvement Plan can be found at: http://dhhs.ne.gov/Pages/EWM-Health-Systems-Change.aspx

- **Select:** Health Systems Change Templates tab
- **Select:** Health Systems Data Extraction and Screening Rates

Breast, Cervical, and/or Colon Cancer Screening Navigation Strings

- Performance and Completion Measures based on patient data
- Breast and Cervical Cancer Screening Rate Improvement
- Submission of Data String

Pay for Performance:	• Breast Cancer Screening Rate Increase ---absolute increase of at least 15% ---absolute increase of at least 25% • Breast and Cervical Cancer Navigation – $208/per client; 30% • Colon Cancer Navigation – $50/per client; 15%
Tool Collects:	• De-identified data string collets patient level data • Demographics • Screening results • Follow Up • Patient engagement • Navigation/Structural barrier reduction provided • Final diagnosis
Quality Measures:	• Age/gender requirements • Definitive diagnosis and treatment completion rates • Actual costs – based on approved by Nursing TA
Required Documentation:	• Baseline screening rates and 4th quarter screening rates as notes in final Quality Improvement Plan • Data String – de-identified clinic record • Number clients needing structural reductions as noted on data string
Program Audit:	• Partnership for Healthy Lincoln (PHL) Summary Report • Completeness of data string – de-identified clinic record • Comparison of assessment of barriers and purchase of structural barrier reduction supports
DHHS Staff Responsibilities:	• Nurse provides Technical Assistance by reviewing data string and providing feedback on completeness of data string • Identifies potential resources: health literacy, patient engagement tools, etc.
PHL Responsibilities:	• Calculation of absolute increase in screening rate from baseline
Clinic Responsibilities:	• Identification of women eligible for navigation and in need of structural barrier reduction • Data entry into de-identified data spreadsheet for submission

Required documentation for Breast, Cervical, and/or Colon Cancer Screening Navigation Strings can be found at: http://dhhs.ne.gov/Pages/EWM-Health-Systems-Change.aspx

- **Select:** Health Systems Change Templates tab
- **Select:** Breast Navigation; Cervical Navigation; and/or Colon Navigation

Activities and Payment

How and When to use the Navigation String Spreadsheets

Purpose of Spreadsheets: These spreadsheets are to be used to identify individuals at high risk for breast, cervical or colon cancer, and provision of patient centered navigation to increase healthy outcomes.

When to Complete: Annual Clinic Assessment and Quality Improvement Plan and the Data Extraction/Screening Rate must be complete along with patient pathways for identification of high risk individuals, prior to submission of Navigation String spreadsheets. Each spreadsheet has a drop down box to make it easier to complete (see required data tables below).

Requirements:

Cancer Diagnostic and Treatment Navigation Spreadsheet

- Age restrictions:
  - Women 21-65 for breast and cervical cancer navigation
  - Women and Men 50-75 for colon cancer navigation after positive FOBT/FIT
- Navigation record must be complete
- Documentation of at least two contacts to client

About patient navigation:

Sub recipients should establish patient navigation programs that provide individualized help to patients to overcome barriers and facilitate timely access to high-quality screening. Navigation under the Health System Changes subaward should include:

1. Provide patient navigation services to assist women eligible for NBCCEDP-paid clinical services in overcoming barriers to complete screening, diagnostic services, and initiation of cancer treatment.
2. Provide patient navigation services to support low-income women from priority populations but who have other payment sources (e.g., state funds, Medicaid) for screening in overcoming barriers to complete screening, diagnostics, and initiation of cancer treatment.

Women often face significant barriers to accessing and completing cancer screening and diagnostic services. Patient navigation is a strategy aimed to reduce disparities by helping women overcome those barriers.

For purposes of this subaward, patient navigation is defined as individualized assistance offered to women to help overcome barriers and facilitate timely access to quality screening and diagnostic services, as well as initiation of timely treatment for those diagnosed with cancer.

Patient Navigation Activities should include:

1. Assessment of individual patient barriers to cancer screening, diagnostic services, and initiation of cancer treatment
2. Patient education and support
3. Resolution of patient barriers (e.g., transportation, translation services)
4. Patient tracking and follow-up to monitor patient progress in completing screening, diagnostic testing, and initiating cancer treatment
5. A minimum of two, but preferably more, contacts with the patient, due to the centrality of the patient-navigator relationship.
6. Collection of data to evaluate the primary outcomes of patient navigation -- cancer screening and/or diagnostic testing, final diagnosis, and treatment initiation if needed.

Performance Benchmark Calculation- Calculation to be done and verified by Partnership for a Healthy Lincoln

Purpose: To evaluate Health Systems Change work done within the facility and the combined impact of quality improvement measures.

Requirements: Completion of Annual Clinic Assessment and Quality Improvement Plan and the Data Extraction/Screening Rate

Navigation Data:

DHHS Cancer Screening Navigation Data **Excel document can be found on the Health Systems Change webpage at:** **http://dhhs.ne.gov/page/EWM-Health-Systems-Change.aspx**	
Column Heading	**Description of Heading**
Patient ID	Patient ID – ID given to client at clinic site
County of Residence	County of Residence in Nebraska
Gender	Male or Female – what is the gender of Patient
Race	Race of Patient
Hispanic	Yes or No - is the Patient Hispanic
Insurance Status	Type of insurance coverage of Patient
DOB	Patient Date of Birth (00/00/0000)
Screening Test	Type of Screening Test (dropdown of breast, cervical and colon screening tests)
Date of 1st Contact	Date (00/00/0000)
Date of 2nd Contact	Date (00/00/0000)
Structural Barrier Identified	List barrier identified (dropdown of barriers)
Structural Barrier Reduction Provided	What was provided to the client (dropdown of barrier reductions)
Screening Results	Results of Screening Test (dropdown of breast, cervical and colon screening results)
Screening Date	Date of Screening (00/00/0000)
Diagnostic Test	What diagnostic test was performed (dropdown of breast, cervical and colon diagnostic tests)
Diagnostics Complete	Yes or No
Workup Complete Date	Date of when workup was completed (00/00/0000)
Treatment Initiated	Yes or No
Final Diagnosis	Final Diagnosis (dropdown of breast, cervical and colon final diagnosis)
Community Support Provided	Yes or No
Name of Community Support Provided	What support was patient linked to

Note:
Men and Women 50-74: Navigation for Abnormal Colorectal Cancer Screening

If a patient receives more than one screening, she would be entered on the form for each screening.

Evidence Based Interventions for Health Systems Change

- Selection, plan and implementation of Evidence Based Interventions for systems change to increase breast and cervical cancer preventive screening.

Pay for Performance:	• None
Tool Collects:	• Captures selection of EBI, core components, detailed description of implementation and resources needed
Quality Measures:	• Copies of end products (provider feedback reports, client reminder cards, provider reminders, clinic team meeting minutes) • Workflow Process Map required
Required Documentation:	• Evidence-Based Health Systems Change Intervention Plan
Program Audit:	• Clinic observation
DHHS Staff Responsibilities:	• Nurse provides Technical Assistance by reviewing EBI template, recommendations related to educational resources regarding EBI, assistance with EBI process flow • Assists as needed in target population resources
Partnership for Health Lincoln Responsibilities:	• Data comparison and data analysis of screening rates in comparison to EBI chosen
Clinic Responsibilities:	• Implementation of EBI • Works on Quality Improvement processes to increase number of women engaged in EBIs • Works on provider recall and tickler systems as needed

Required documentation for Evidence Based Interventions for Health Systems Change can be found at: http://dhhs.ne.gov/Pages/EWM-Health-Systems-Change.aspx

- **Select:** Health Systems Change Templates tab
- **Select:** FQHC Template: Evidence Based Interventions for Health Systems Change

Activities and Payment

How and When to use the 2018-2019 Evidence Based Interventions for Health Systems Change Template

Purpose of Template: This template is to assist in identifying, planning and monitoring major activities in implementing a collaborative impact project around increase breast cancer screening rates, and/or increasing cervical cancer screening rates, and/or decreasing the number of women with uncontrolled hypertension. Use this tool for oversight of the project and to help guide implementation. Entries must be meaningful and concise.

See Health Systems Change Manual pages 8-10 for acceptable EBIs.

When to Complete: Annual Clinic Assessment and Quality Improvement Plan and the Data Extraction/Screening Rate must be complete prior to submission of the Evidence Based Interventions for Health Systems Change template.

Requirements: The evidence based intervention selected for implementation must match one of the EBIs identified from the Annual Clinic Assessment and Quality Improvement Plan. The evidence based intervention selected by the clinic to implement should be one from the Health Systems Change Manual section titled Health Systems Change Interventions and Provider Focused Activities located on pages 8-10.

The chosen EBIs selected for implementation and submission to DHHS must represent available funding. Priority Funding for 2018-2019 include Breast and Cervical Cancer initiatives and WISEWOMAN initiatives.

Resources: Assigned TA will assist with completion of the Evidence Based Intervention for Health Systems Change template and identification of potential resources. You may add additional information that you feel enhances your project. Please keep in mind that the Evidence Based Intervention for Health Systems Change template will be submitted to CDC as part of the grant requirements.

Community Clinical Linkages

- Completion of Community Clinical Linkages Replication of Lancaster Impact Project template

Max Overhead:	• None
Tool Collects:	• Identifies, plans and monitors major activities in implementing a collaborative process within the community while partnering with clinics and community organizations • Increase in screening rates with populations experiencing disparate health outcomes
Quality Measures:	• Number of women screened, appropriately followed up, and referred to treatment resources as needed
Required Documentation:	• Community Clinical Linkages Replication of Lancaster Impact Project template
Program Audit:	• MedIt and CHW data entry • Summary Report
DHHS Staff Responsibilities:	• Nurse provides Technical Assistance by reviewing Community Clinical Linkages Replication of Lancaster Impact Project template, staff participates as appropriate in process • Ensures patient pathways and data capture meets requirements of CDC funder and community. • Assists as needed in target population resources
Partnership for Health Lincoln Responsibilities:	• Facilitation and coordination of Community Clinical Linkages Replication of Lancaster Impact Project. Lead for strategic planning, documentation and submission of all work products and meeting minutes.
Clinic Responsibilities:	• Implementation of Community Clinical Linkages Replication of Lancaster Impact Project • Works on Quality Improvement processes to increase number of women engaged and recruited • Build community partnerships with other organizations • Identify barriers for patients and what structural barrier reductions can be provided • Write a narrative report on the project including lessons learned, sustainability, partnerships

Required documentation for Community Clinical Linkages can be found at:
http://dhhs.ne.gov/Pages/EWM-Health-Systems-Change.aspx

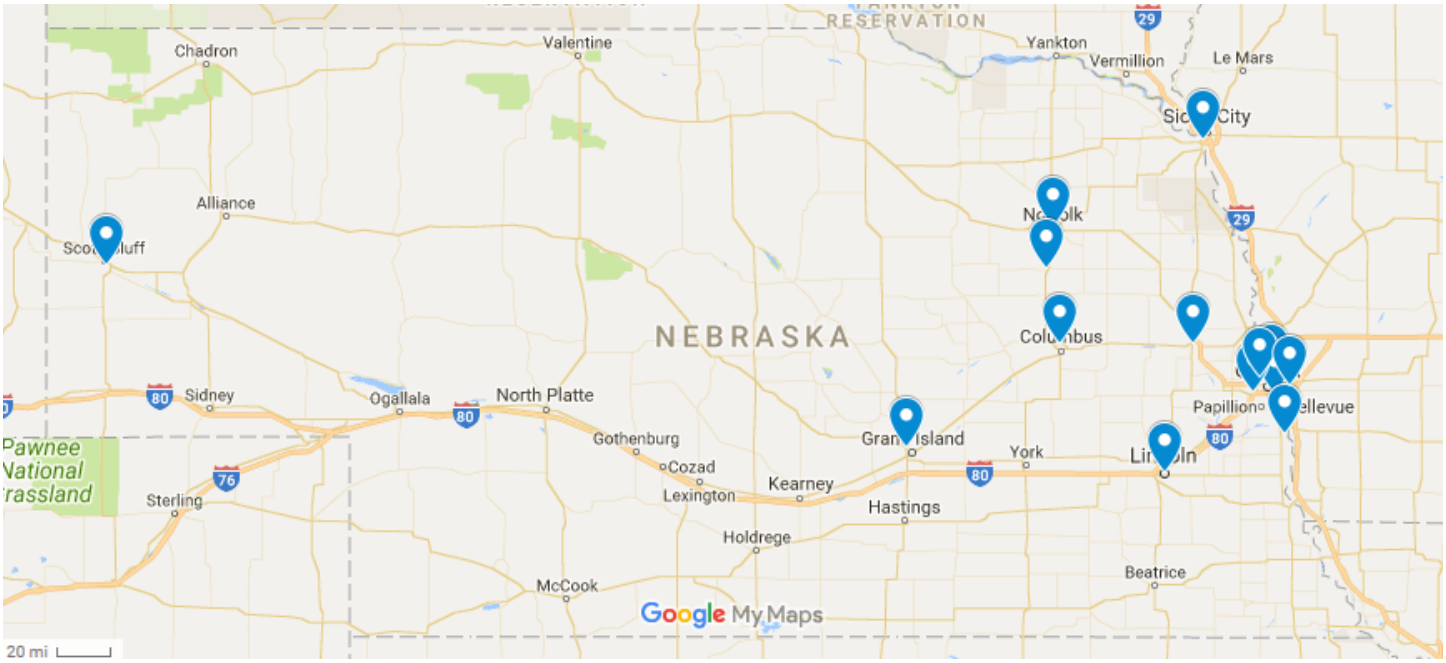
- **Select:** Health Systems Change Templates tab
- **Select:** FQHC Template: Replication of Lancaster Impact Project

Health Systems Change Resources

There is a Health Systems Change website that has many different evidence based interventions, tools, and resources for you to utilize. Please familiarize yourself with the page and the many resources that are listed:

http://dhhs.ne.gov/Pages/EWM-Health-Systems-Change.aspx

FQHC Locations/Map



Federally Qualified Health Centers

Charles Drew Health Center
2915 Grant Street
Omaha, NE 68111
Ph. 402-451-3553 || Fax: 402-453-1970
Website: www.charlesdrew.com

Community Action Partnership of Western Nebraska Health Center
975 Crescent Drive
Gering, NE 69341
Ph. 308-632-2540 || Fax: 308-632-2752
Website: www.capwn.org

Good Neighbor Community Health Center
4321 41st Avenue, PO Box 1028
Columbus, NE 68602
Ph. 402-562-7500 || Fax: 402-564-0611
Website: www.ecdhd.ne.gov

Satellite Clinic: Good Neighbor Fremont Clinic
2400 N. Lincoln Avenue || Fremont, NE 68025
Ph. 402-721-0951

Heartland Health Center
3307 West Capital Avenue
Grand Island, NE 68803
Ph. 308-382-4297 || FAX: 308-382-4376
website: www.heartlandhealthcenter.org

Midtown Health Center
302 West Phillip Avenue
Norfolk, NE 68701
Ph. 402-371-8000 || Fax: 402-371-0971
Website: www.midtownhealthne.org

Satellite Clinic: Madison Medical Clinic
222 Main Street || Madison, NE 68748
Phone: 402-454-3304

OneWorld Community Health Centers, Inc.
4920 South 30th Street
Omaha, NE 68107
Ph. 402-734-4110 || Fax: 402-991-5642
Administration: 402-502-8845
Website: www.oneworldomaha.org

Satellite Clinic:

Cass Family Medical
409 Main Street
Plattsmouth, NE 68048
Ph. 402-296-2345

West Omaha
4101 S. 120th Street
Omaha, NE 68137
Ph. 402-505-3907

Northwest Omaha
4229 N. 90th Street
Omaha, NE 68134
Ph. 402-401-6000

Teen & Young Adult Health Center
4310 South 24th St.
Omaha, NE 68107
Ph. 402-502-8940

Bellevue
2207 Georgia Avenue
Bellevue, NE 68005
Ph. 402-502-8855

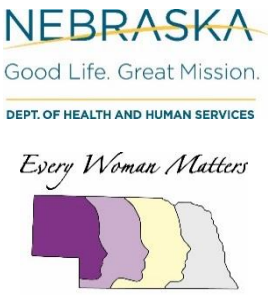
Bluestem Health 1021 North 27th Street Lincoln, NE 68503 Ph. 402-476-1455 ext. 1007 Fax: 402-476-1655 Website: www.phclincoln.org			
	Satellite Clinic:	Health 360 Clinic 2301 O Street Lincoln, NE 68510 Ph. 402-441-6642	People's Quick Care 2246 O Street Lincoln, NE 68510 Ph. 402-476-1455

Community Health Hub Contact Information

Community Health Hub	County Coverage:
Central District Health Department 1137 South Locust Grand Island, NE 68801 Phone: 308-385-5175 Toll Free: 877-216-9092 Website: www.cdhd.ne.gov	Hall, Merrick, Hamilton
East Central District Health Department 4321 41st Avenue Columbus, NE 68602 Phone: 402-562-7500 Website: www.ecdhd.ne.gov	Boone, Nance, Platte, Colfax
Elkhorn Logan Valley Health Department 2104 21st Circle Wisner, NE 68791 Phone: 402-529-2233 Website: www.elvphd.org	Madison, Stanton, Cuming, Burt
Lincoln-Lancaster Health Department 3140 N Street Lincoln, NE 68510 Phone: 402-441-8000 Website: www.lincoln.ne.gov	Lancaster
North Central Health Department 422 E. Douglas Street O'Neill, NE 68763 Phone: 877-336-2406 Website: www.ncdhd.ne.gov	Cherry, Keya Paha, Brown, Rock, Holt, Boyd, Knox, Antelope, Pierce
Northeast NE Health Department 215 North Pearl Street P.O. Box 68 Wayne, NE 68787 Phone: 402-375-2200 Website: www.nnphd.org	Cedar, Dixon, Thurston, Wayne
Panhandle Public Health Department 808 Box Butte Avenue P.O. Box 337 Hemingford, NE 69348 Phone: 308-487-3600 Website: www.pphd.org	Banner, Box Butte, Cheyenne, Dawes, Deuel, Garden, Grant, Kimball, Morrill, Scotts Bluff, Sheridan, Sioux

Public Health Solutions 995 E. Hwy 33, Suite 1 Crete, NE 68333 Phone: 402-826-3880 Web: www.phsneb.org		Fillmore, Gage, Jefferson, Saline, Thayer
Sarpy/Cass Health Department 701 Olson Drive, Suite 101 Papillion, NE 68046 Phone: 402-339-4334 Web:www.sarpycasshealthdepartment.org		Sarpy, Cass
South Heartland Health Department 606 N. Minnesota Avenue, Suite 2 Hastings, NE 68901 Phone: 402-462-6211 Web: www.southheartlandhealth.org		Adams, Clay, Webster, Nuckolls
Southeast District Health Department 2511 Schneider Avenue Auburn, NE 68305 Phone: 402-274-3993 Web: www.sedhd.org		Johnson, Nemaha, Otoe, Pawnee, Richardson
Southwest District Health Department 404 West 10th Street P.O. Box 1235 McCook, NE 69001 Phone: 308-345-4223 Website: www.swhealth.ne.gov		Chase, Dundy, Frontier, Furnas, Hayes, Hitchcock, Keith, Perkins, Red Willow
Three Rivers Public Health Department 2400 North Lincoln Avenue Fremont, NE 68025 Phone: 402-727-5396 Web:www.threeriverspublichealth.org		Dodge, Saunders, Washington
Two Rivers Public Health Department 701 4th Avenue, Suite 1 Holdrege, NE 68949 Phone: 888-669-7154 Web: www.trphd.org		Buffalo, Dawson, Franklin, Gosper, Harlan, Kearney, Phelps

DHHS Women's & Men's Health Program Contacts



Nebraska Department of Health & Human Services
Women's & Men's Health Programs - Every Woman Matters
301 Centennial Mall South || P.O. Box 94817 || Lincoln, NE 68509-4817
Phone: 402.471.0929 or 800.532.2227 || **Fax:** 402.471.0913
Email: dhhs.ewm@nebraska.gov or dhhs.nccsp@nebraska.gov
Web: www.dhhs.ne.gov/EWM

Program Management:

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Michelle Heffelfinger, WW Program Manager
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Email: Michelle.Heffelfinger@nebraska.gov

Health Systems Change Technical Assistance:

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FQHC: Community Action Partnership of Western Nebraska, Charles Drew Health Center, Heartland Health Center

Andrea Riley, RN
Phone: 402-471-0561
Email: Andrea.Riley@nebraska.gov

FQHC: Good Neighbor Community Health Center, Midtown Health Center, OneWorld Community Health Center

Patti Schumann, RN
Phone: 402-471-8691
Email: Patti.Schumann@nebraska.gov

FQHC: Lincoln Medical Education Partnership, Nebraska Urban Indian Health Center, Bluestem Health Center

Billing/Invoicing:

Pam Findlay, Finance Coordinator
Phone: 402-471-6583
Email: Pam.Findlay@nebraska.gov

Data Entry:

Jill Crane, Data Manager
Phone: 402-471-6007
Email: Jill.Crane@nebraska.gov

Media/Marketing:

Tracey Bonneau, Marketing Coordinator
Phone: 402-471-2922
Email: Tracey.Bonneau@nebraska.gov

Glossary/Definitions

Below is a listing of common terms or definitions that are frequently used throughout the Health Systems Change Manual.

A

A1c: a blood test used to measure average blood sugar over the previous two to three months and a crucial step in monitoring how well blood sugar is being controlled in diabetics. The A1c test is also referred to as the HbA1c test, the glycated hemoglobin test or the glychohemoglobin test.

age criteria: Every Woman Matters is 40-74; Nebraska Colon Cancer Screening Program is 50-74. This is interpreted as the starting age for receiving services is age 40 or 50 years old. They are not eligible to receive screening services once they turn age 75.

B

barriers: any problem or obstacle that could potentially prevent a client from obtaining necessary screening or treatment (e.g., no transportation, no child care, language barriers that may require an interpreter, etc.)

blood glucose: the main sugar that the body makes from the three elements of food – proteins, fats, and carbohydrates.

blood pressure: the force that the circulating blood exerts on the walls of the arteries.

body composition: the relative amounts of muscle, fat, bone, and other anatomical components that contribute to a person's total body weight.

Body Mass Index (BMI): a measurement of body mass that is correlated with skinfold thickness and body density.

BSE: acronym for Breast Self-Exam.

breast biopsy: the removal and examination, usually microscopically, of breast tissue.

breast ultrasound: a test that uses ultrasonic waves to scan the breast.

C

CDC: acronym for Centers for Disease Control and Prevention.

cervical biopsy: the removal and examination, usually microscopically, of cervical tissue

cholesterol: a waxy, fat-like substance present in every cell in the body and in many foods.

Clinical Breast Exam (CBE): an exam of the breast by a clinician.

Colonoscopy: a procedure that allows a doctor to see inside the large intestine to find polyps or cancer. During this procedure, the doctor can remove polyps and some very early stage colon cancers.

Community Health Hub (CHH): framework of where public health resources are passed down to community utilizing collaborative synergy and activities in a systemic way that improves access to high-quality preventive screening services, enhances community linkages and strengthens data collection and utilization that impacts quality of life and health outcomes for Nebraska residents.

CVD: acronym for Cardiovascular Disease.

D

diabetes: diabetes mellitus is a chronic syndrome of impaired carbohydrate, protein, and fat metabolism due to insufficient secretion of insulin or to target tissue insulin resistance.

diagnostic mammogram: Breast x-rays, which generally include four views of the breasts. Performed when any or all of the following reasons/conditions are present: palpable mass, pain, discharge, and/or breast implants. Also performed as a follow-up exam for suspicious findings obtained during physical examinations or screening mammograms.

diagnostic referral: a client who has a positive finding and referred to a diagnostic specialist for further testing

diagnostic services: services rendered to a client who needs follow up after a screening visit that resulted in an abnormal finding.

diastolic: The diastolic reading, or the bottom number, is the pressure in the arteries when the heart rests between beats. This is the time when the heart fills with blood and gets oxygen. A normal diastolic blood pressure is lower than 80.

E

Encounter Registry: A real time web based application. A repository for statewide and local resources related to improving health outcomes. A system to match health resources with individuals based on their specific health status and needs. Provides a picture of health knowledge, needs and status of communities served.

Every Woman Matters Screening Guidelines: The screening program follows USPSTF Guidelines however, the program's eligibility for participation has strict age requirements.

EWM: acronym for Every Woman Matters.

F

fasting: abstaining from food and drink as director by provider.

Fecal Occult Blood Test (FOBT): a test for hidden blood in the stool. Hemoccult Sensa II test kits will be used for the Nebraska Program.

Federally Qualified Health Center (FQHC): local, non-profit community-owned health care providers serving low income Nebraskans and medically underserved communities. The centers provide quality, affordable, integrated primary care and preventative services including medical, dental, and behavioral health services.

H

HDL: acronym for High-Density Lipoproteins which carry cholesterol in the blood stream.

health coaching: also referred to as wellness coaching, is a process that facilitates healthy, sustainable behavior change by challenging a client to develop their inner wisdom, identify their values, and transform their goals into action. **Health coaching** draws on the principles from positive psychology and appreciative inquiry, and the practices of motivational interviewing and goal setting.

health navigation: also known as peer navigation and patient navigation, and can share similar approaches to some care coordination and case management interventions. There is no standard definition of navigation because each navigation program targets the specific needs of clients in the local context.

Health Navigation to Screening: Assistance provided by Health Coach/Navigator to help a EWM/WW client complete her mammogram or population based clients complete their mammogram or Pap. This could be in the form of linking her to care, scheduling her appointment and removing barriers to screen (i.e., transportation, interpretation, etc.)

Health Navigation to Diagnosis & Treatment: Assistance provided by Health Coach/Navigator to help those population based clients screened where a diagnostic issue is detected. It is facilitating those next steps of care. Again, this could be in the form of linking her to a provider and/or specialist, scheduling her biopsy, etc., and removing barriers to getting to appointments surrounding diagnosis and treatment.

Health Systems Change: A change in organizational or legislative policies or in environmental supports that encourages and channels improvement(s) in systems, community, and individual-level health outcomes.

Healthy Lifestyle Questionnaire (HLQ): a behavior and health assessment that is completed by the client at the screening visit that aids the clinician in determining the need for lifestyle interventions to reduce the risk of CVD and diabetes.

Healthy Behavior Support Systems: local supports in the form of nutrition, physical activity (Walk & Talk Toolkit), Check.Change.Control.® for blood pressure control and the National Diabetes Prevention Program. Supports vary by local health department and/or area of the state. Local supports are identified and put into place by the Health Coach and to help clients address behavior change and improve health outcomes.

hypertension: persistently high arterial blood pressure.

L

LDL: acronym for Low-Density Lipoproteins, which are a combination of a fat and a protein which acts as a carrier for cholesterol and fats in the bloodstream.

lifestyle intervention: a conscious change in patterns of eating, exercise or unhealthy habits (e.g., smoking, alcohol intake) to produce a positive change in a person's overall health.

lipid panel: a group of blood tests that determines risk of coronary heart disease; includes total cholesterol, HDL, LDL, and triglycerides.

M

mammogram: a breast screening process/ x-ray of the breast.

MedIT: Online **MED**ical **I**nformation **T**racking system developed by OxBow Data Management System, LLC.

N

National Diabetes Prevention Program (NDPP): a partnership of public and private organizations working to prevent or delay type 2 diabetes. The partners work to make it easier for people with pre-diabetes to participate in evidence-based, affordable, and high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve their overall health.

nutritional assessment: the process of assessing an individuals' nutritional status by evaluating dietary intake for a period of time.

O

obese: Having a body mass index (BMI) of 30 or above.

P

Pap test (Papanicolaou Smear): a screening test of the cells of the cervix used to detect early cervical abnormalities.

pelvic exam: an internal physical examination used to detect a variety of gynecological disorders. Includes a visual inspection of the vagina and cervix as well as palpation of the uterus and ovaries.

polyp: a growth, usually benign, protruding from a mucous membrane.

pre-diabetes: a condition characterized by slightly elevated blood glucose levels, regarded as indicative that a person is at risk of progressing to Type 2 diabetes.

priority population: demographic factors such as age, gender, race/ethnicity, income level, education attainment or grade level, marital status, or health care coverage status; geography such as a region of a state or a specific community; or a location in which the priority population may be reached such as a workplace, school or church.

Q

quality assurance: necessary to determine how well needs and expectations are met within available resources, involving all staff members to develop various approaches to implement actions to improve services.

S

screening cycle: a screening cycle begins when a client has a breast or cervical screening exam along with a cardiovascular screening exam on the EWM Program and ends with one of the following:

- normal screening results
- definitive diagnosis of not cancer
- initiation of treatment if client diagnosed with cancer or pre-cancer
- completion of a lifestyle intervention if referred

Screening Guidelines for Every Woman Matters: The screening program follows USPSTF Guidelines however, the program's eligibility for participation has strict age requirements.

success story: a story that is a compilation of anecdotes that are heard, a norm change that is observed, a policy that is passed after substantial work, significant earned media that is garnered on a topic. A success story help defend your work and is an opportunity to share successes and innovations with others, providing inspiration, tools and other resources to strengthen cancer prevention and control efforts.

sustainability: the ability to maintain or support an activity or process over the long term.

systolic: When your heart beats, it squeezes and pushes blood through your arteries to the rest of your body. This force creates pressure on those blood vessels, and that's your systolic blood pressure. A normal systolic pressure is below 120. A reading of 140 or more is high blood pressure (also called hypertension)

T

total blood glucose: the main sugar that the body makes from the three elements of food – proteins, fats, and carbohydrates.

triglycerides: a neutral fat synthesized from carbohydrates for storage in animal fat cells.