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USER CONFERENCE APR 30–MAY 2 | BOSTON, MA

Drivers and Dashboards

Visualizing Health Equity in DRVS

Ashley Brewer
Safety Compliance Manager
Community Health and Wellness
Partners of Logan County

Breanna Detrick
Family Nurse Practitioner
Community Health and Wellness
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Today's Presenters

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Ashley Brewer

Safety Compliance Manager

Community Health and Wellness Partners of Logan County

Breanna Detrick

Family Nurse Practitioner

Community Health and Wellness Partners of Logan County

WHOLE PERSON • WHOLE COMMUNITY

COMMUNITY HEALTH & WELLNESS PARTNERS

Care... To Live Life Fully

Agenda

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INTRODUCING CHWP

Overview of Community Health and Wellness Partners and our commitment to Health Equity.

HEALTH EQUITY PDSA

Review the inspiration behind our health equity PDSA, what it required, and the key goals for the project.

HEALTH EQUITY DASHBOARDS

Discuss the role dashboards are playing in demonstrating results from the health equity PDSA.

IMPACT OF EFFORTS

Highlight the impact of the PDSA efforts on screening rates, warm hand offs and referrals to social care, and staff engagement.

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Community Health & Wellness Partners

Goals for Achieving Health Equity

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Care... To Live Life Fully

Introducing CHWP | Mission & Vision

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Mission

Provide quality, whole-person, patient-centered medical care to anyone and everyone in our community.

Vision

To change lives within our community by eliminating barriers and providing a standard of healthcare that improves the well-being of the whole person.

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Commitment to Health Equity

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Utilized census data & insights from the Community Health Needs Assessment to develop an annual health equity plan.

Top SDOH Barriers:

Mental Health
Substance Use
Housing & Homelessness
Access to Healthcare
Limited Senior Services
Limited Reproductive Health Services
Limited Chronic Disease Management

Community Federal Poverty Level Breakdown:

Total Patients: 11,624

Over 200%: **27%**
151-200%: **11%**
101-150%: **13%**
100% & below: **14%**

Health Equity & SDOH

While CHWP historically collected SDOH data, it was not done in a consistent or standardized way.

CWHP secured buy-in to revamp SDOH screening efforts when the Joint Commission introduced the **National Patient Safety Goal**.

NPSG.16.01.01

Assess patient's health-related social needs and provide information about community resources and support services. Identify healthcare disparities in the patient population by stratifying quality and safety data using sociodemographic characteristics.

PDSA for Health Equity Plan

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Aim Statement:

Community Health and Wellness Partners (CHWP) recommends patients complete the **PRAPARE Tool** Social Determinants of Health Screening **annually** to meet the health center's HRSA and The Joint Commission standards by ensuring patients answer **all of the questions** and submit them through the electronic health record.

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2023 Health Equity PDSA

Revamping SDOH Screening Efforts

PRAPARE Alignment & Expansion

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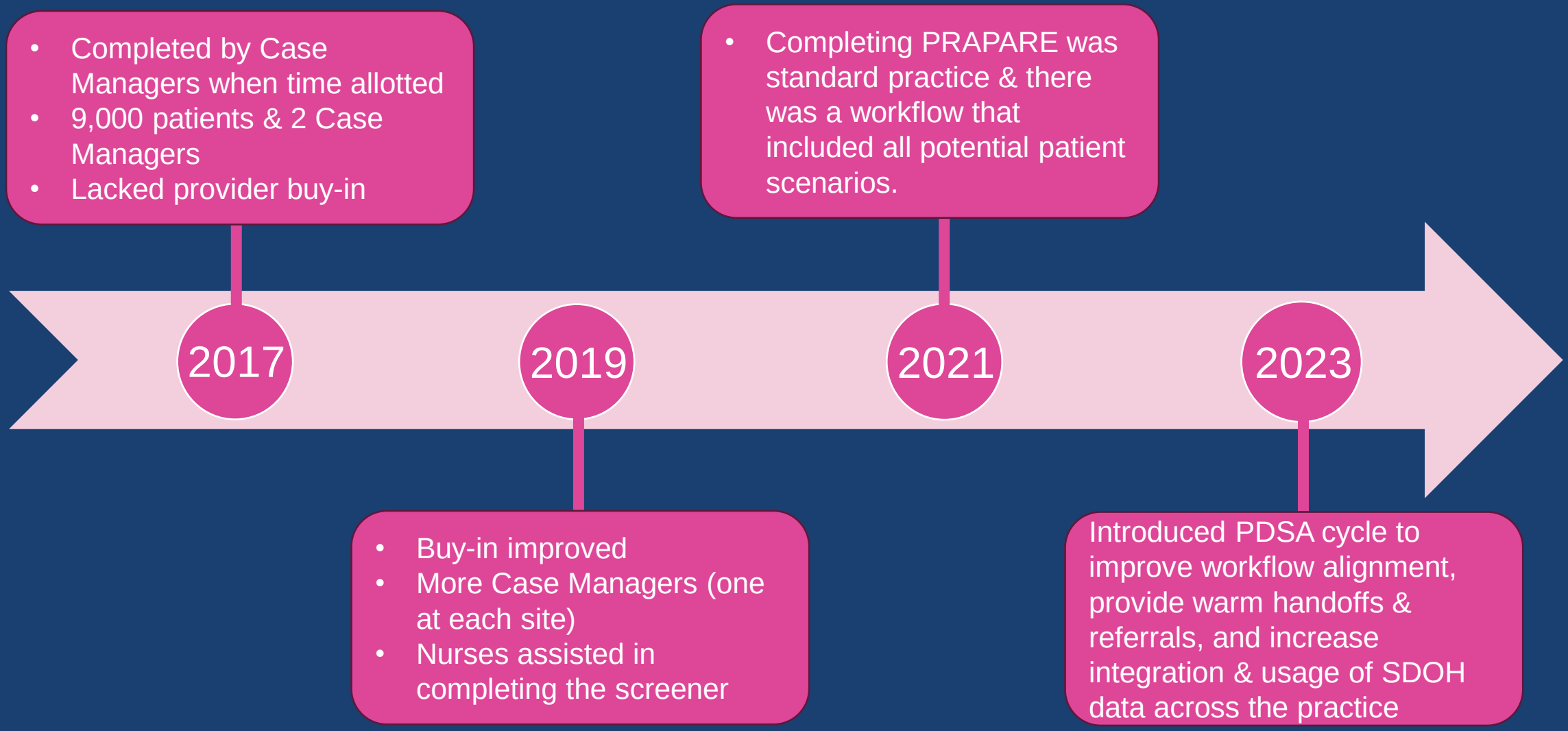

PDSA Key Goals & Steps

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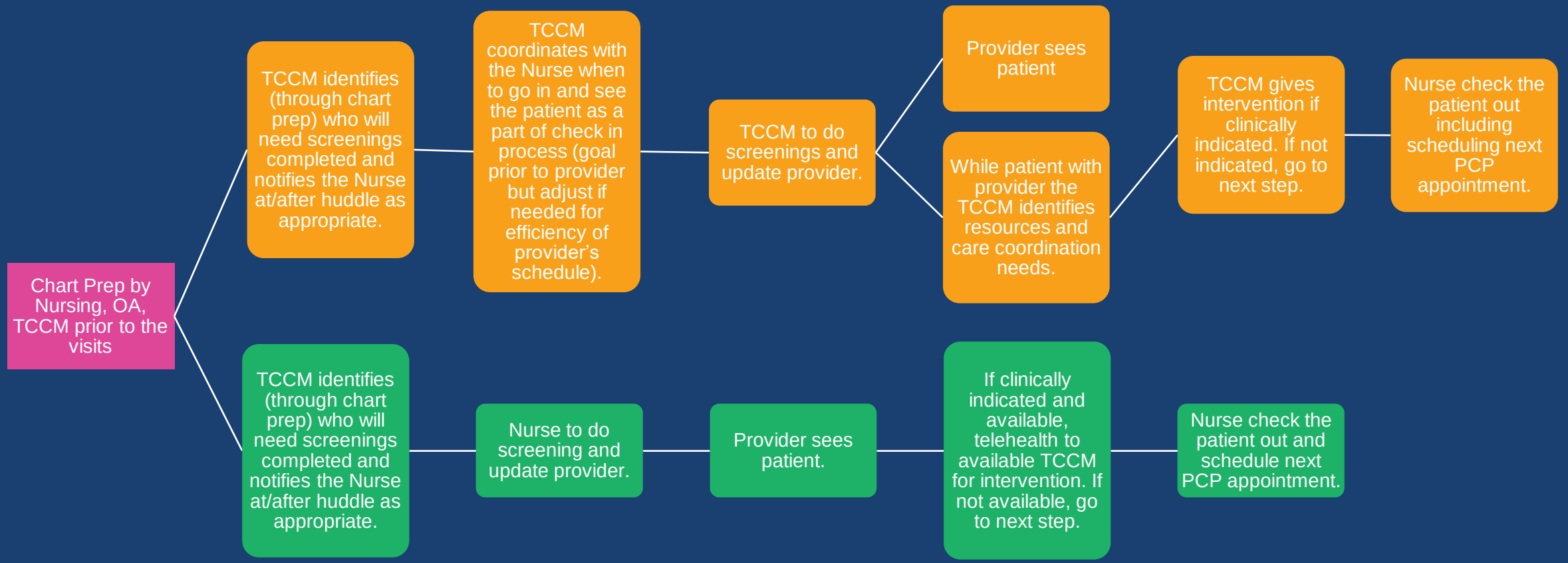
Standardize Workflows

Provide Warm Handoffs & Referrals

Increase Utilization of SDOH Data

CHWP PRAPARE Workflow

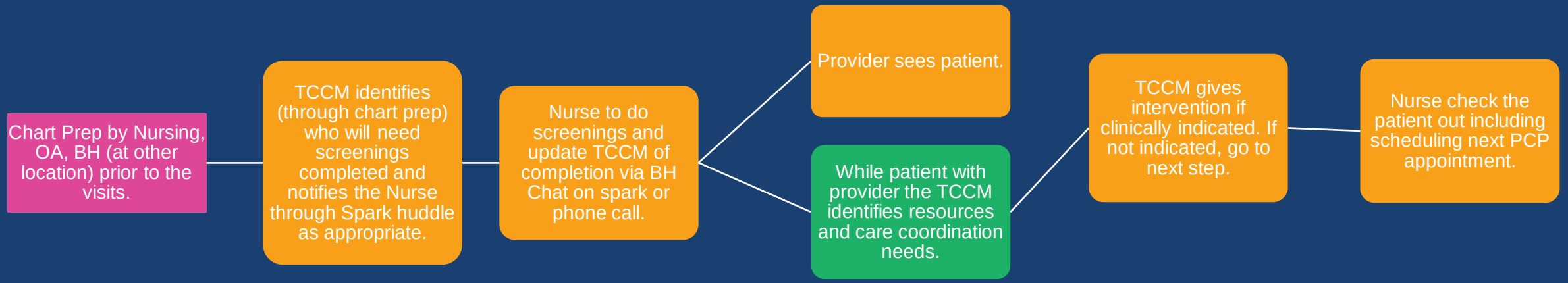
Plan A – Preferred Method



Plan B – TCCM with Another Patient

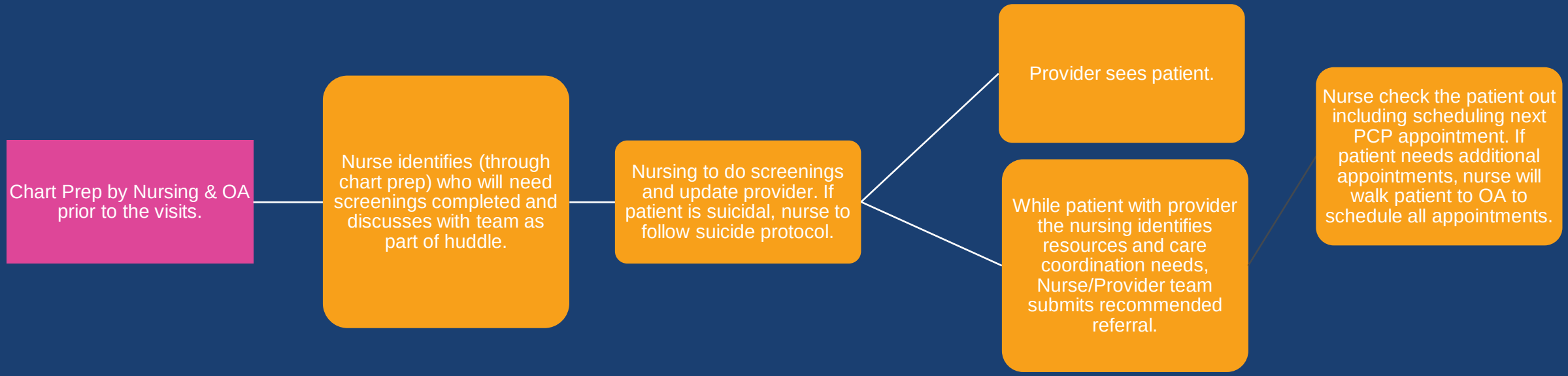
CHWP PRAPARE Workflow

Plan C – In-office TCCM not available, intervention via telehealth



CHWP PRAPARE Workflow

Plan D – No TCCM Available at any location (includes Saturday)



Individual Patient View Example

11:15 AM Wednesday, April 17, 2024 — **Visit Reason:** BHFUPhone BHFU-Televisit via Phone

MRN:
DOB:

Sex at Birth: F
GI: Female
SO: straight or heterosexual

Phone:
Lang: English
Risk: High (20)

Portal Access: N
Cohorts: CPC, Diabetes CGM Pilot Cohort, Diabetes/HTN Test, Hypertension Patients April 2023

PCP: Kiessling, Jodi
Payer: Buckeye Community Health PNM
CM: Unassigned

DIAGNOSES (10)

Anxiety	Asthma	CNMP
Depression	DM	HTN-E
HyLip	Pre-DM	PreDM First
SUD Depend		

RISK FACTORS (3)

ASCVD Intermediate (8.09)	BMI	SMI

SDOH (4)

EMPLOYMENT	INSURANCE	STRESS
TRANSPORT-MED		

RAF GAPS DIAGNOSIS CATEGORIES (0)

ALERT	MESSAGE	DATE	RESULT	OWNER
Colon CA 45+	Missing			
ClinPharm	Missing			PopHealth
Depression Remission	Out of Range	1/24/2024	9 - F/U Window 01/23/2023 - 05/23/2023	
PRAPARE	Overdue	7/13/2022		
Tobacco Scr	Will be non-compliant in next year	2/14/2024	N	
Flu - Seasonal	Overdue	10/12/2022		
PCV High-Risk	Missing			
Zoster Shingrix	Missing			
Eye	Overdue	7/5/2019	Negative	
Preventive Care Visit	Missing			
Well Visit 19+	Missing			
Ctrl Sub	Missing			
Anxiety Screen w/Dx	Missing			

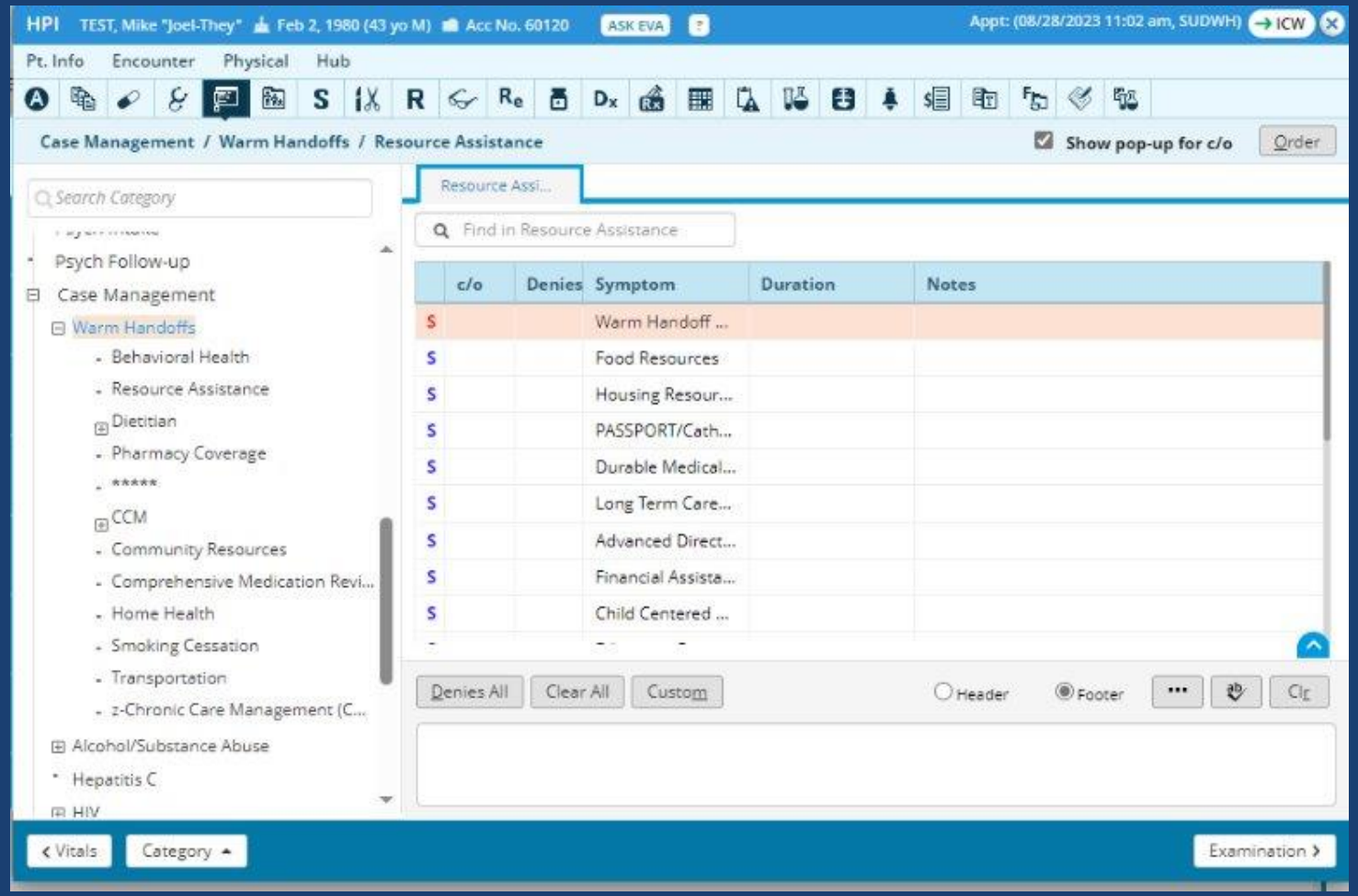
OPEN REFERRAL W/O RESULT	SPECIALIST/LOCATION	ORDERED DATE	APPT. DATE
Podiatry	Ohio Foot & Ankle Center, Ohio Foot & Ankle Center /	10/25/2023	

Does this patient have access to reliable transportation to attend appointment?

SDOH Warm Handoffs

Interventions may include **behavioral health** and **community resources** connected to the primary problem for their appointment.

Case Managers document their portion of the appointment within the PCP note utilizing structured fields.

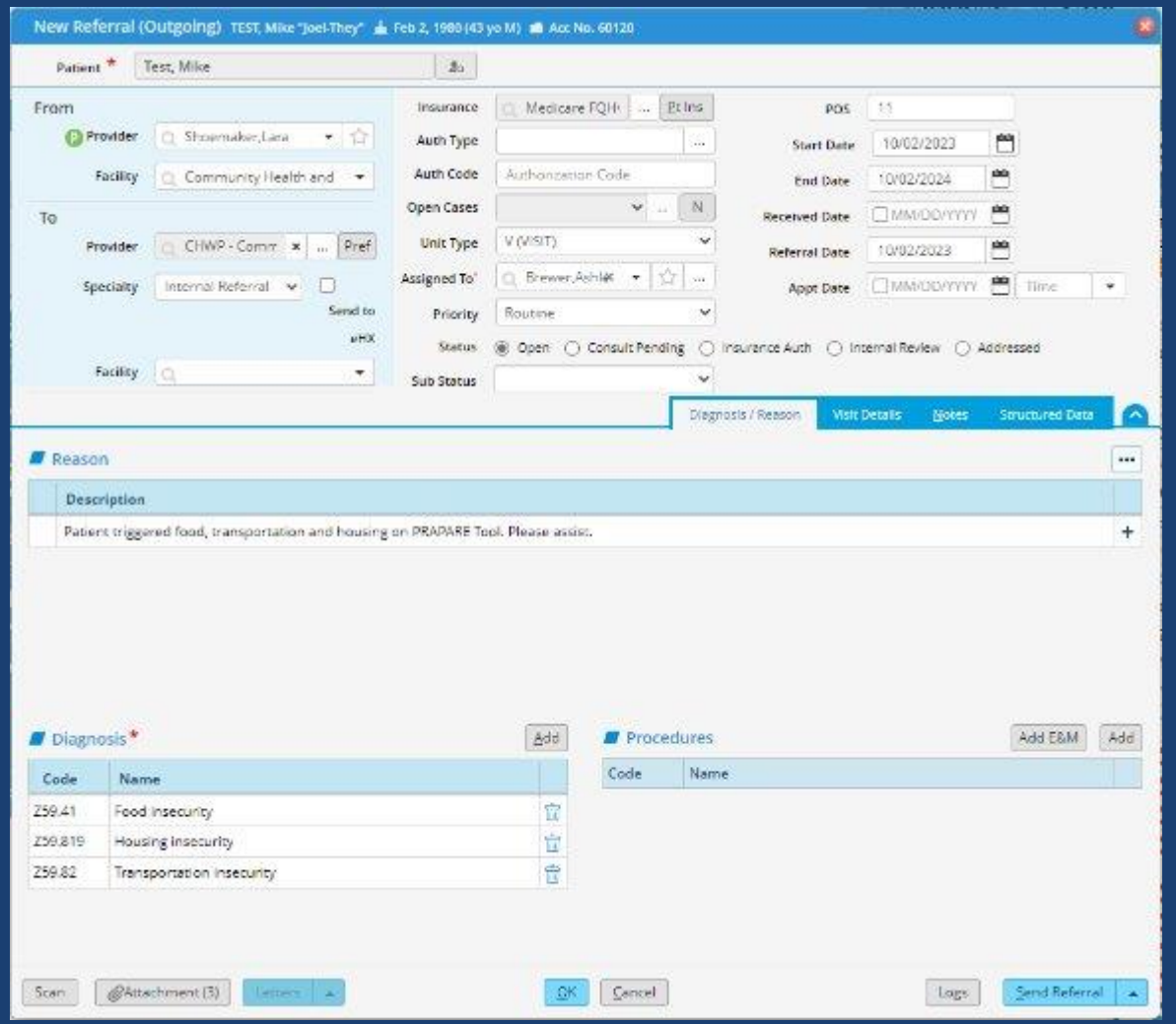


SDOH Referrals

Providers will specify areas that need addressing in the description and via diagnosis codes.

The use of **Z-codes** helps with the ongoing tracking of CHWP patients' needs and notifies others working on the patient's teams of these needs.

Once assigned to the case manager, the case manager will contact the patient in accordance with our policy to close the loop.



Lessons Learned | Adjustments

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iPads are now utilized as mid-office kiosks for smart forms to prevent staff from having to take the time to input information.

Parents filling it out for kids (even newborns) can help identify failure to thrive needs.

Asking domestic violence questions to all genders.

Lessons Learned | Challenges

- Patients who come in for only same-day visits sometimes go unscreened due to limited time.
- If patients need resources and a case manager is not available, it can be hard to reach them after the visit to provide services.
- At the school, parents/guardians are often unavailable to complete the tool when the child is in the office.
- Some of the questions are less applicable to school-aged children.

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Increasing Utilization of SDOH Data

DRVS Dashboards

Integrating SDOH Data | Across the Practice

- Address barriers at point of care
- Factor barriers into care plans
- Identify gaps at population-level
- Improve tracking using Z Codes
- Provide data to CHNA committees

Integrating SDOH Data | School-Based Care

Identify **transportation needs** for rides home and/or pick up medications from the pharmacy

Collaborates with school staff to address needs to **increase school performance**

Reporting to ODH Grant, school boards, and community workgroups

Why Dashboards?

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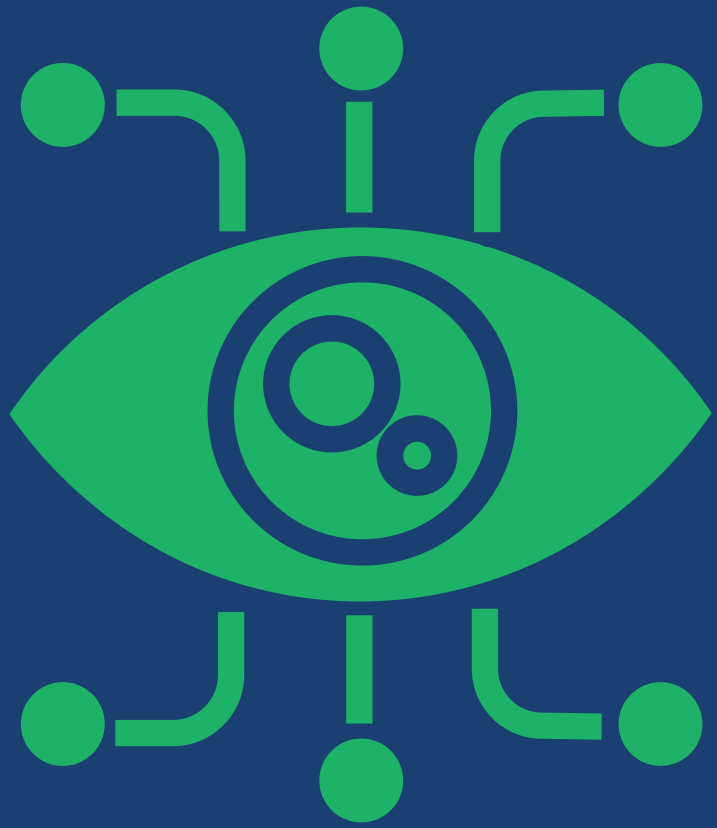
Cognitive burden associated with data and report comprehension is one of the **biggest barriers** to implementation of evidence-based practices.



Dashboards allow you to **visualize your data** and **tell a compelling story** about your health center's care delivery.

Dashboard Pre-Work

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Step 1

Identify key decision makers

Step 2

Set aside time to talk with stakeholder ONLY about quality goals

Step 3

Set your parameters for the dashboard

Step 4

Build your dashboards!

Step 5

Meet with stakeholders to iterate on dashboards

Step 6

Set up meeting annually to review next year's goals

Step 7

Update the dashboard as needed

Building Dashboards | Key Stakeholders / Audiences

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1. Health Equity Committee
2. Case Management / Community Resources
3. School-Based Health

Health Equity Committee | Dashboard Goals

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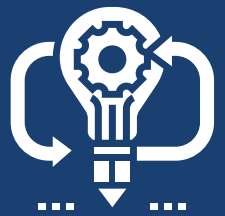
Responsible for analyzing & acting on disparities present in the data.

Dashboard is used to identify service gaps, barriers to care, and community needs.



Findings are used to make improvements to the PDSA.

Health Equity Committee

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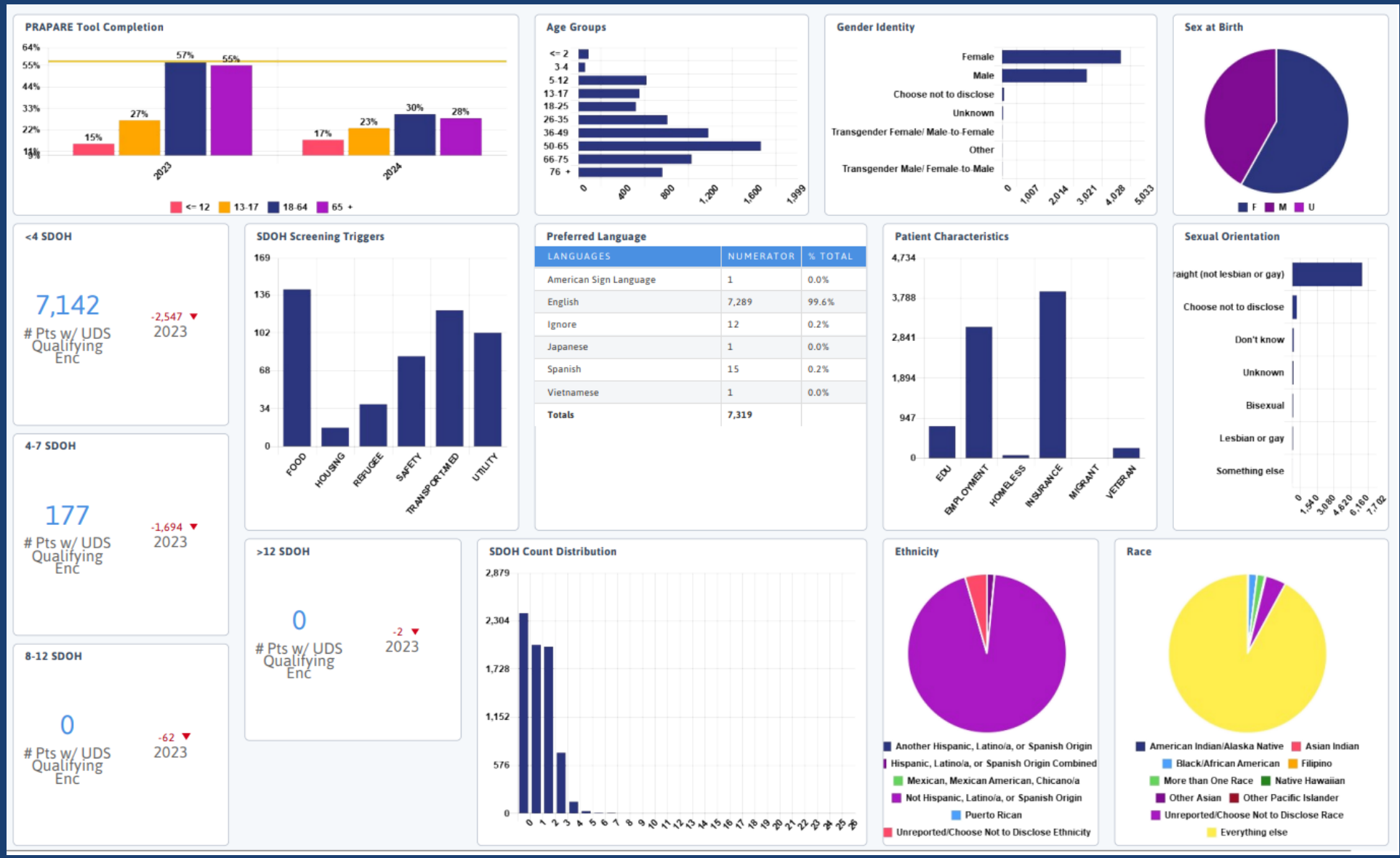

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Case Management / Community Resources | Dashboard Goals

Used to monitor the **improve use of the PRAPARE Screener** & identify greatest **community-level needs**.

Dashboard is emailed to the Case Management Supervisor, Chief Quality/Risk Officer, Safety/Compliance Manager, CEO, and CMO **monthly** for continued monitoring.

Case Management / Community Resources

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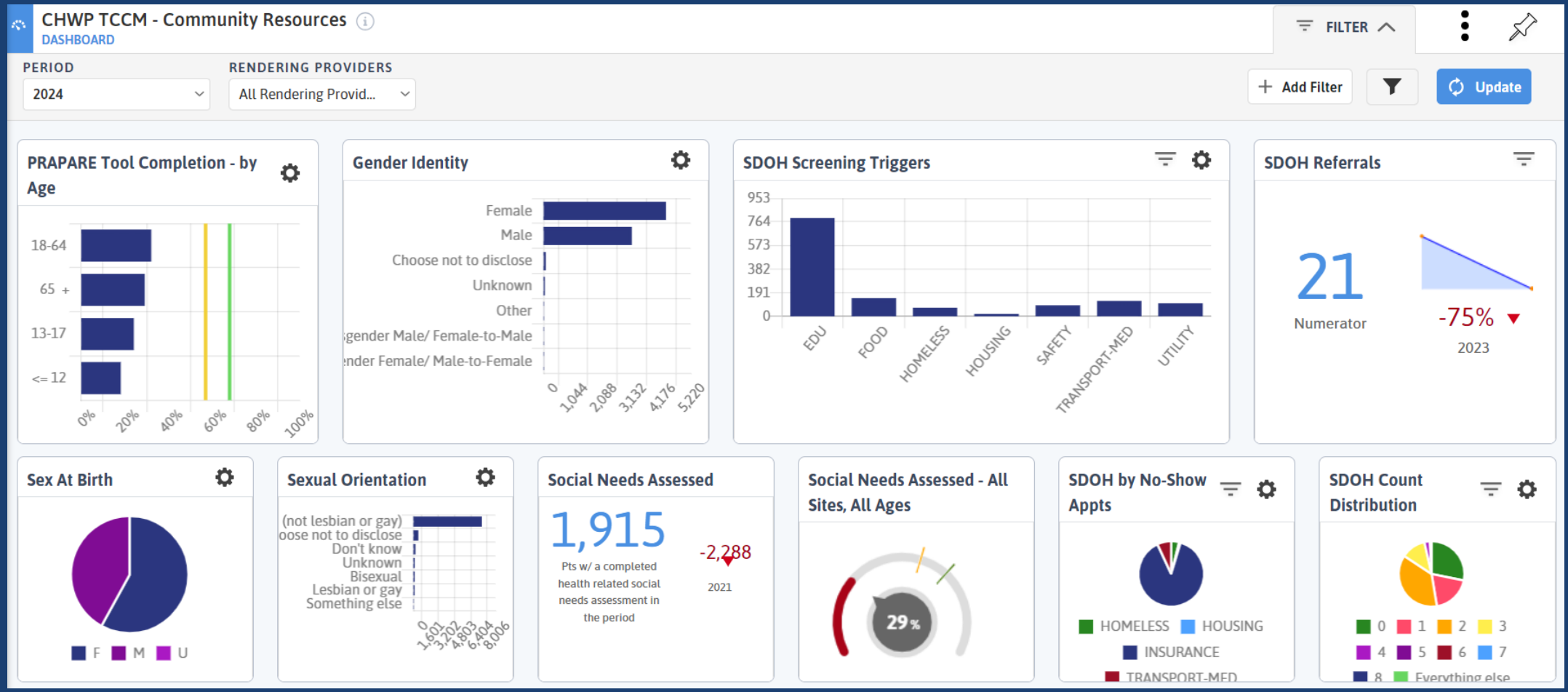

Case Management / Community Resources

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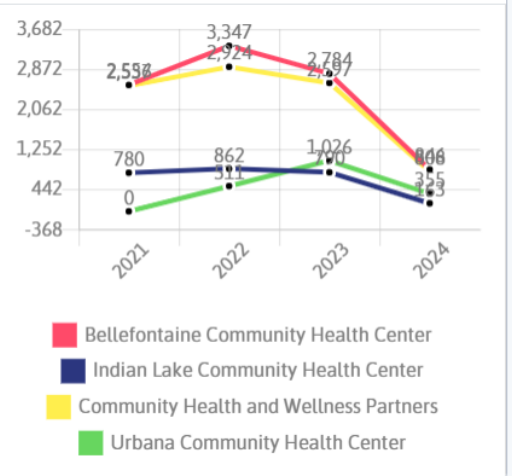
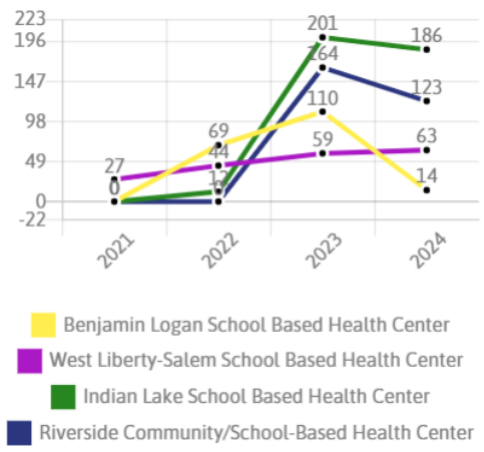
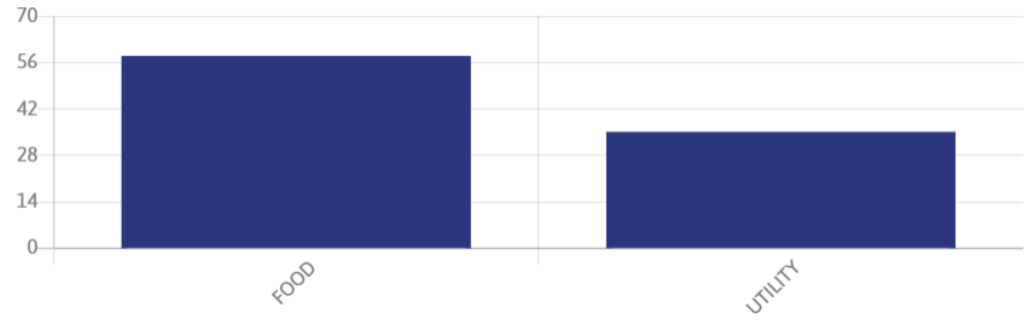
PRAPARE Tool Completion (All Ages)



PRAPARE Tool - Schools (All Ages)



Material Security



UDS 2023-Patients Positive for at Least One SDOH

MEASURE	RESULT	NUM	DENOM	EXCL
Childhood Immunization Status (CMS117v11)	8.0%	2	25	0
Child Weight Assessment (CMS155v11)	85.8%	545	635	0
BMI Screen & Follow-Up 18+ (CMS69v11)	82.5%	3,193	3,868	16
Depression Remission at Twelve Months (CMS159v11)	5.8%	32	556	255
Depression Screening & Follow-Up (CMS2v12)	41.6%	1,056	2,536	2,046
Tobacco Use: Screening & Cessation (CMS138v11)	78.5%	1,682	2,143	0
Colorectal Cancer Screening (CMS130v11)	51.5%	1,091	2,120	48
Cervical Cancer Screening	29.7%	279	939	276

SDOH Referral Types

SDOH	RESULT
TRANSPORT-MED	10%
FOOD	9%
VIOLENCE	6%
UTILITY	3%
INSURANCE	2%
EDU	2%
EMPLOYMENT	1%
HOMELESS	0%
HOUSING	0%
VETERAN	0%

Case Management / Community Resources

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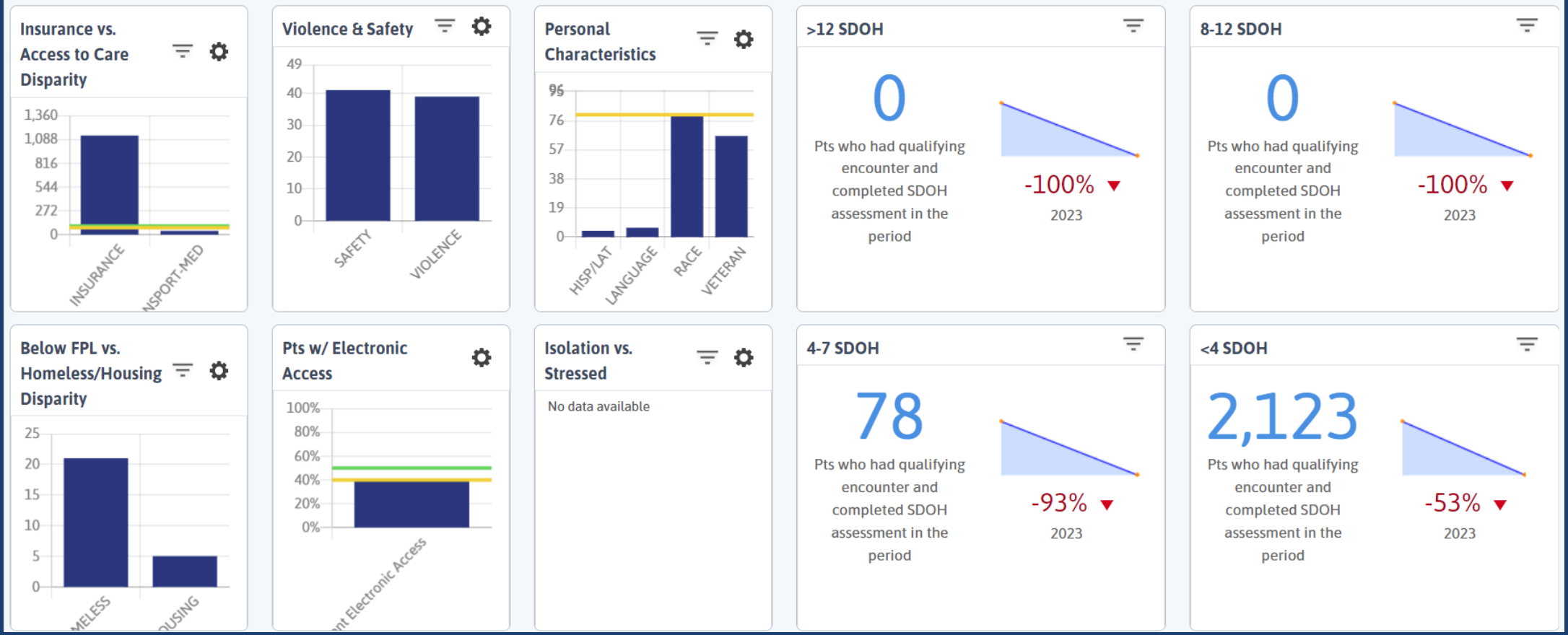

School-Based Health | Dashboard Goals

Focus on select quality measures and implementing the PRAPARE Tool for all students.

Dashboard is emailed to the Assistant CMO, Case Manager Supervisor, Integrated Health Manager, Nursing Manager, Chief Quality/Risk Officer, Safety/Compliance Manager, CEO, Chief BH Officer, and CMO monthly for continued monitoring.

School-Based Health

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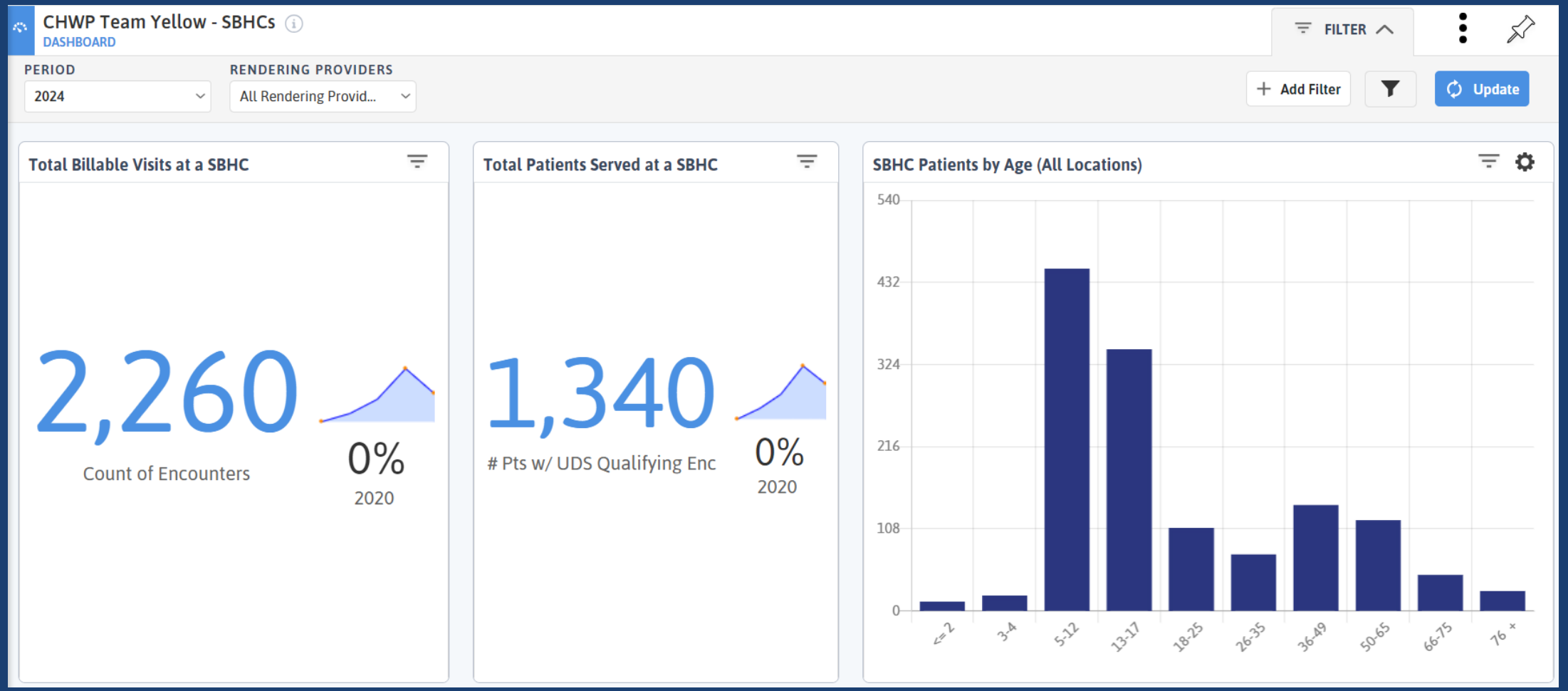

School-Based Health

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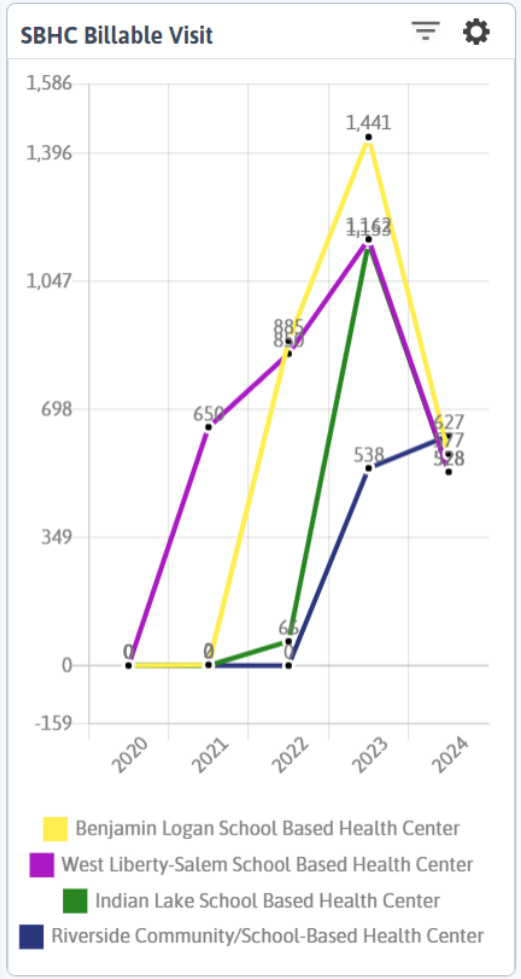

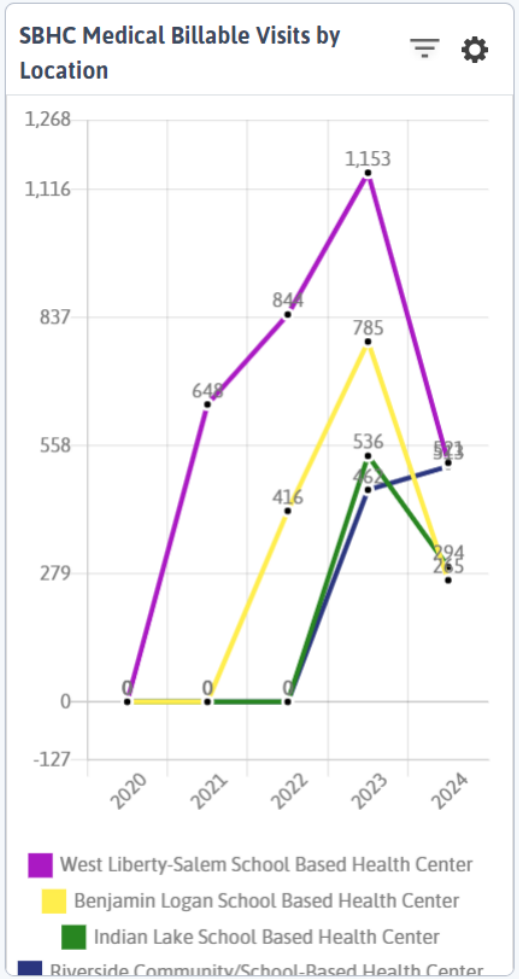

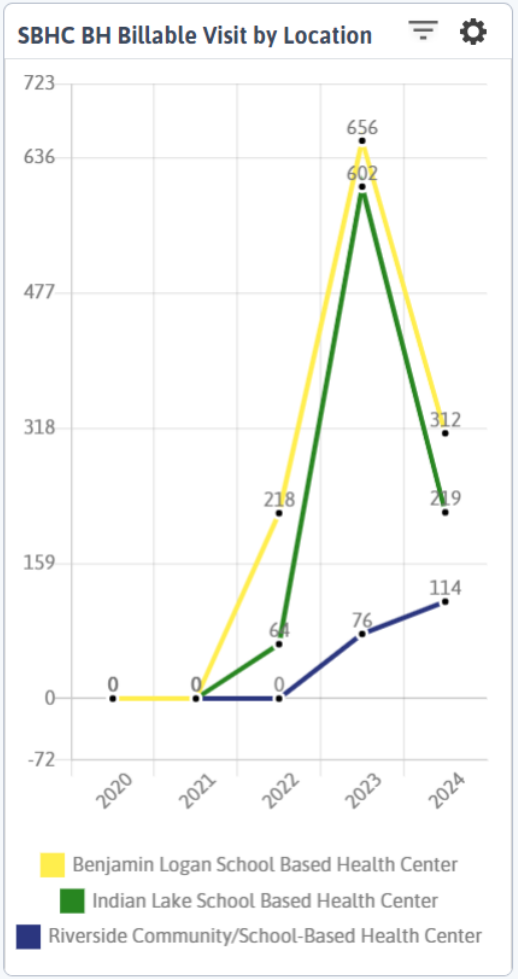

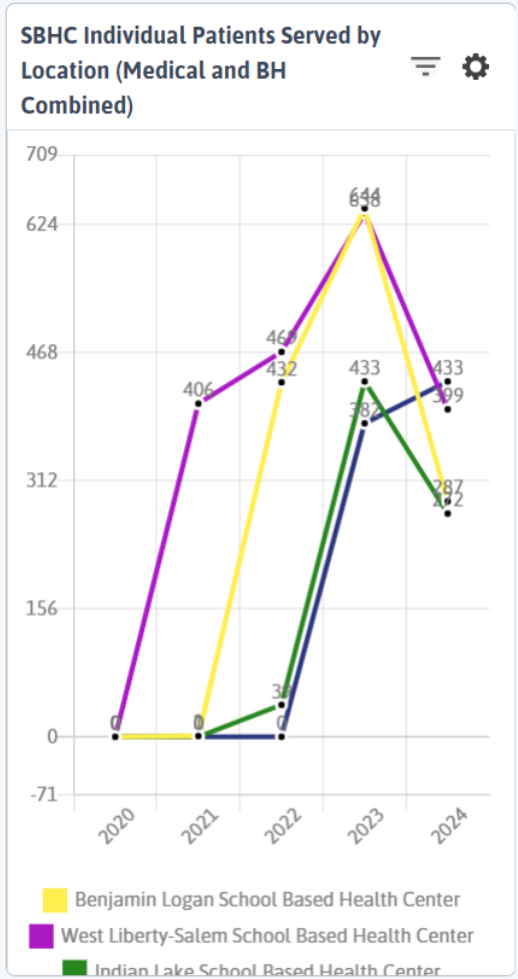

School-Based Health

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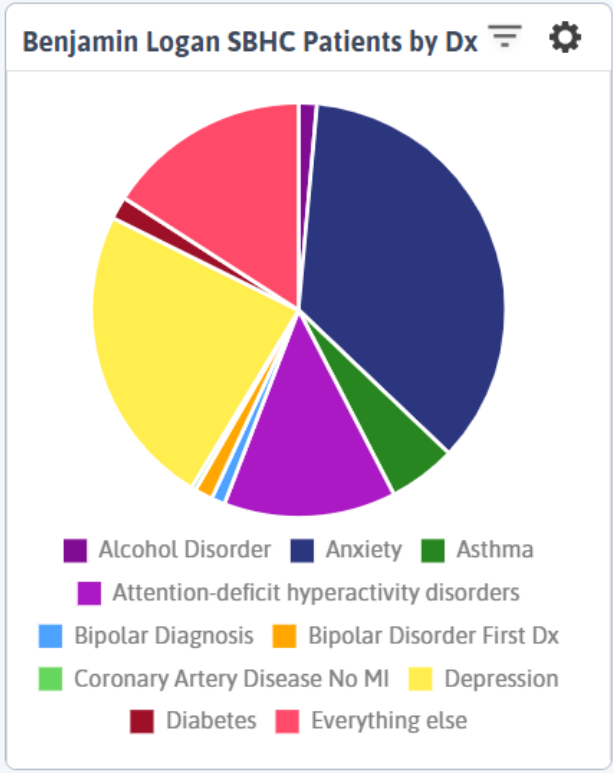

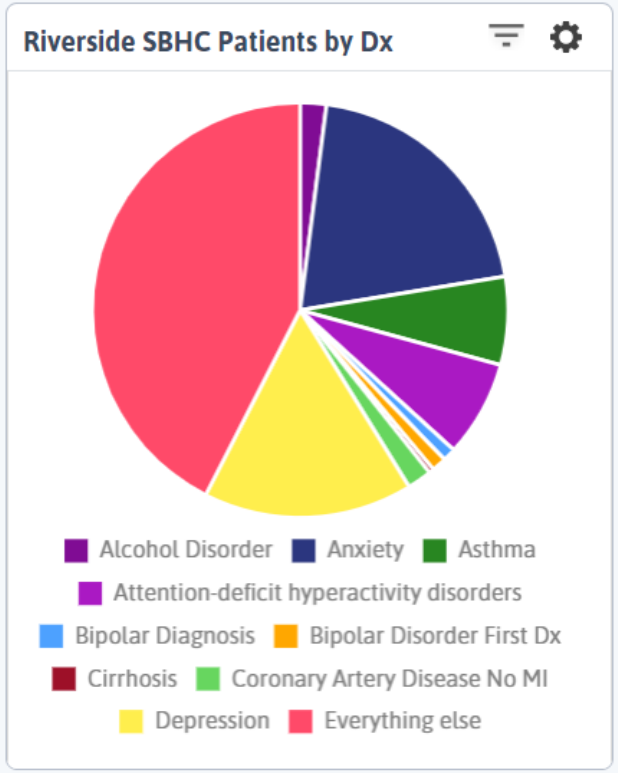

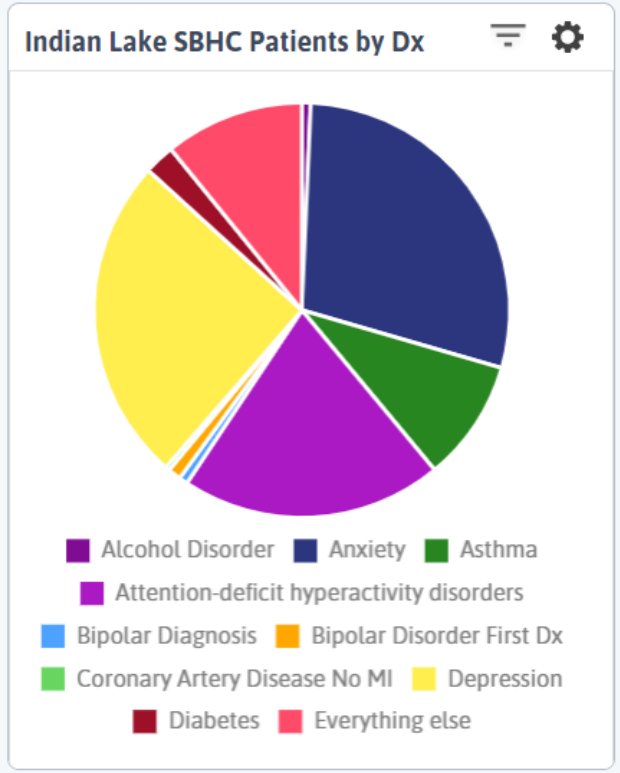

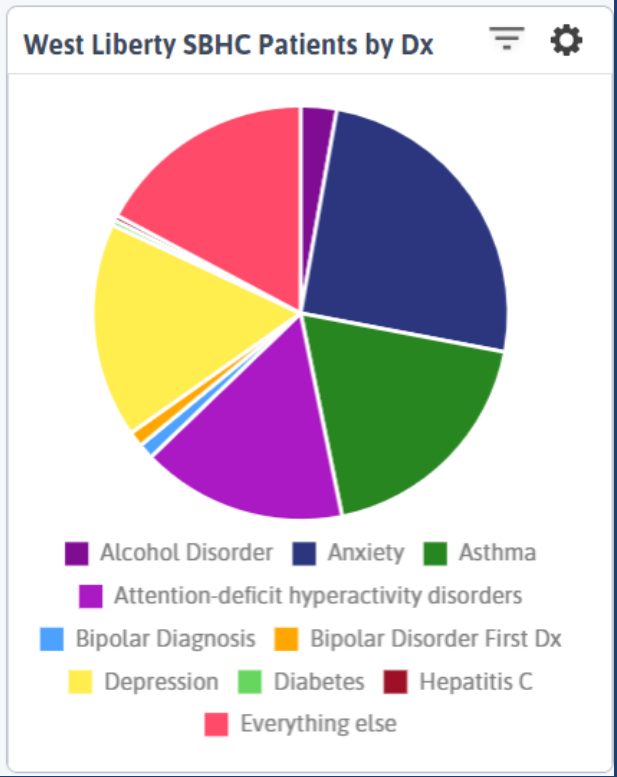

School-Based Health

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Benjamin Logan SBHC Metrics

MEASURE	RESULT	NUM	DENOM	EXC
Well-Child Care Visits (3-21 Yrs)	13.4%	23	172	
Child Weight Assessment (CMS155v11)	94.0%	156	166	
Depression Screening & Follow-Up (CMS2v12)	72.3%	73	101	
Depression Screening & Follow-Up 12-17	80.4%	45	56	
Chlamydia Screening (CMS 153v12)	0.0%	0	6	
Asthma Self-Mgmt Plan	0.0%	0	5	
Tobacco Use: Screening & Cessation (CMS138v11)	71.4%	20	28	
Tobacco User - 13+	4.3%	6	139	
Tobacco Users	3.6%	1	28	
Adolescent Immunizations - HPV	0.0%	0	19	

Riverside SBHC Metrics

MEASURE	RESULT	NUM	DENOM	EXC
Well-Child Care Visits (3-21 Yrs)	18.5%	29	157	
Child Weight Assessment (CMS155v11)	97.0%	130	134	
Depression Screening & Follow-Up (CMS2v12)	60.5%	127	210	
Depression Screening & Follow-Up 12-17	57.7%	30	52	
Chlamydia Screening (CMS 153v12)	6.7%	1	15	
Asthma Self-Mgmt Plan	0.0%	0	9	
Tobacco Use: Screening & Cessation (CMS138v11)	95.2%	157	165	
Tobacco User - 13+	21.9%	73	334	
Tobacco Users	29.1%	48	165	
Adolescent Immunizations - HPV	0.0%	0	6	

Indian Lake SBHC Metrics

MEASURE	RESULT	NUM	DENOM	EXC
Well-Child Care Visits (3-21 Yrs)	19.3%	32	166	
Child Weight Assessment (CMS155v11)	94.3%	149	158	
Depression Screening & Follow-Up (CMS2v12)	84.0%	68	81	
Depression Screening & Follow-Up 12-17	77.8%	42	54	
Chlamydia Screening (CMS 153v12)	0.0%	0	12	
Asthma Self-Mgmt Plan	0.0%	0	11	
Tobacco Use: Screening & Cessation (CMS138v11)	82.4%	14	17	
Tobacco User - 13+	7.8%	9	116	
Tobacco Users	17.6%	3	17	
Adolescent Immunizations - HPV	14.3%	3	21	

West Liberty SBHC Metrics

MEASURE	RESULT	NUM	DENOM	EXC
Well-Child Care Visits (3-21 Yrs)	11.5%	36	314	
Child Weight Assessment (CMS155v11)	98.2%	275	280	
Depression Screening & Follow-Up (CMS2v12)	67.6%	121	179	
Depression Screening & Follow-Up 12-17	65.1%	71	109	
Chlamydia Screening (CMS 153v12)	0.0%	0	11	
Asthma Self-Mgmt Plan	0.0%	0	7	
Tobacco Use: Screening & Cessation (CMS138v11)	100.0%	40	40	
Tobacco User - 13+	3.4%	7	205	
Tobacco Users	5.0%	2	40	
Adolescent Immunizations - HPV	0.0%	0	19	

School-Based Health

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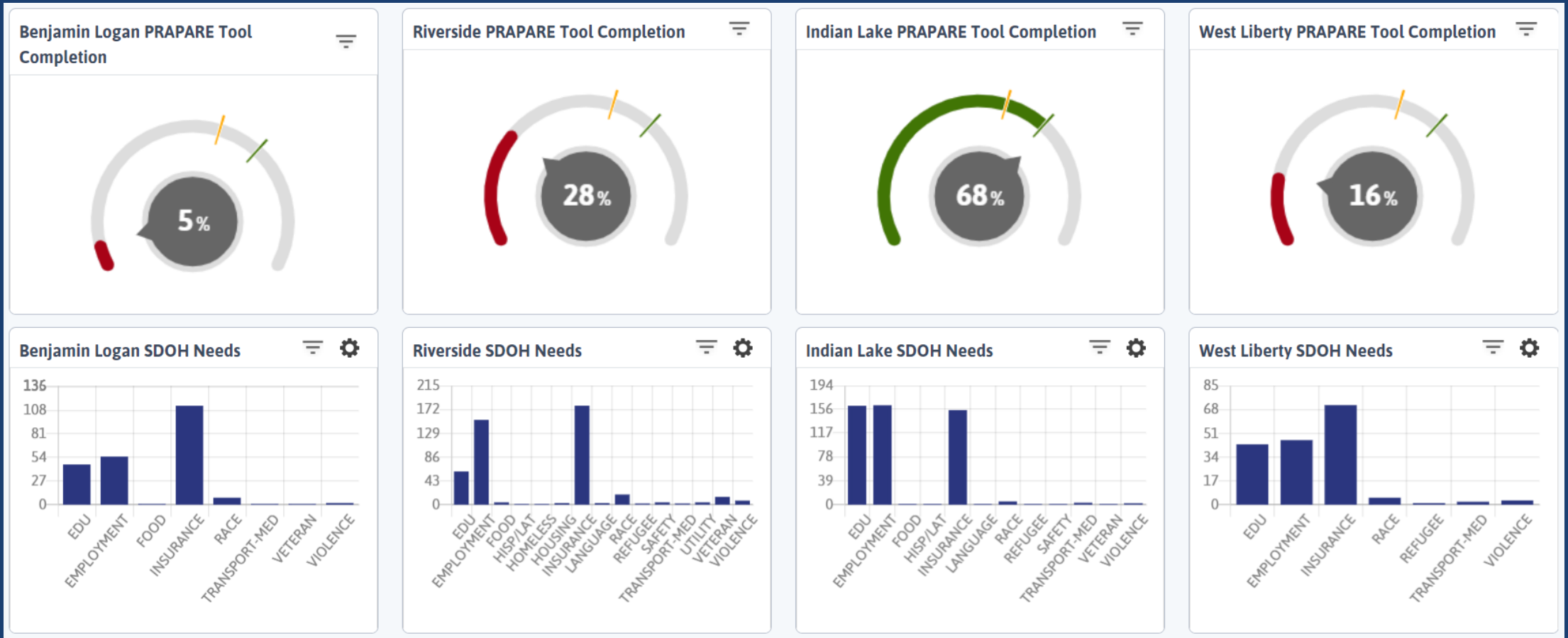
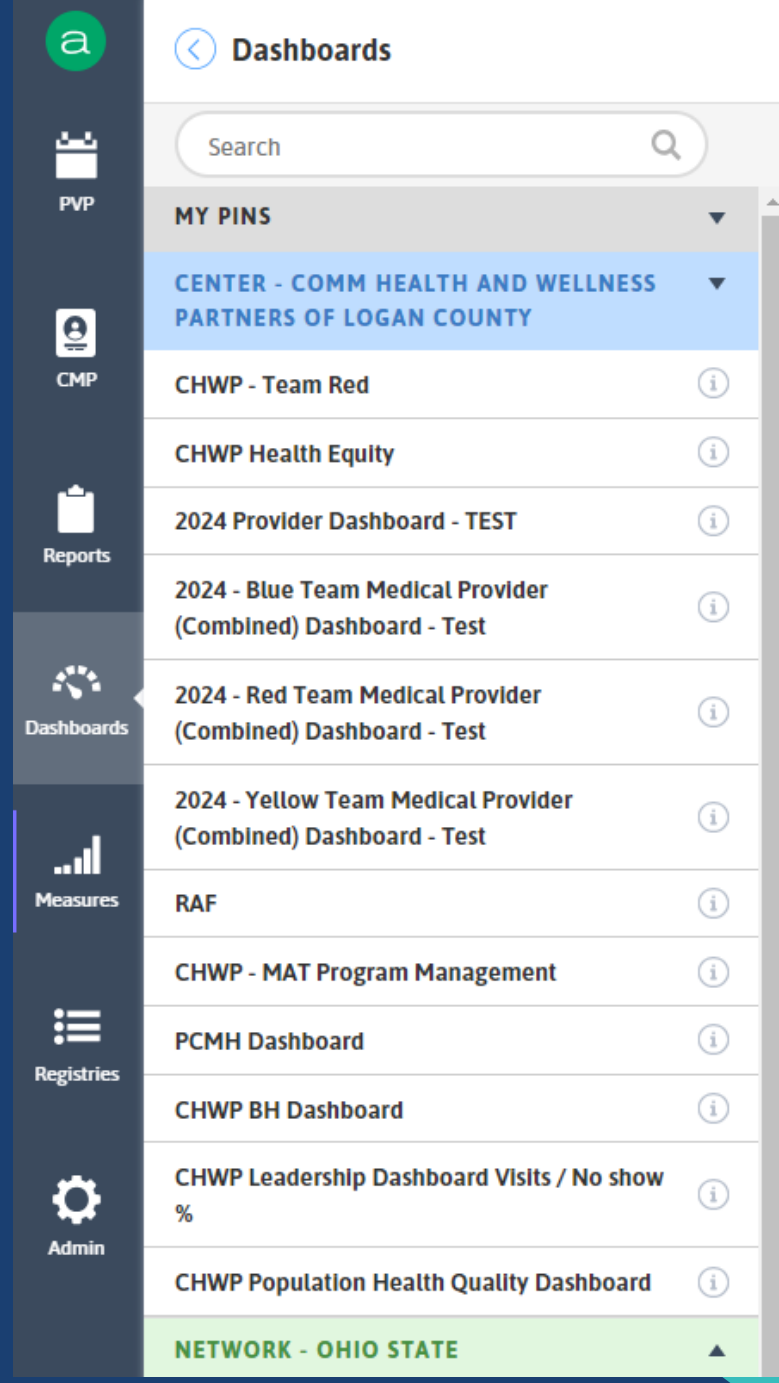


Accessing Dashboards

Dashboards are distributed through **monthly email subscriptions** to all “Chiefs”, Department Managers, and the Quality team.

Data is reviewed at **team meetings**.

Staff can log onto Azara & see their **dashboards pinned**.



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PDSA Impact

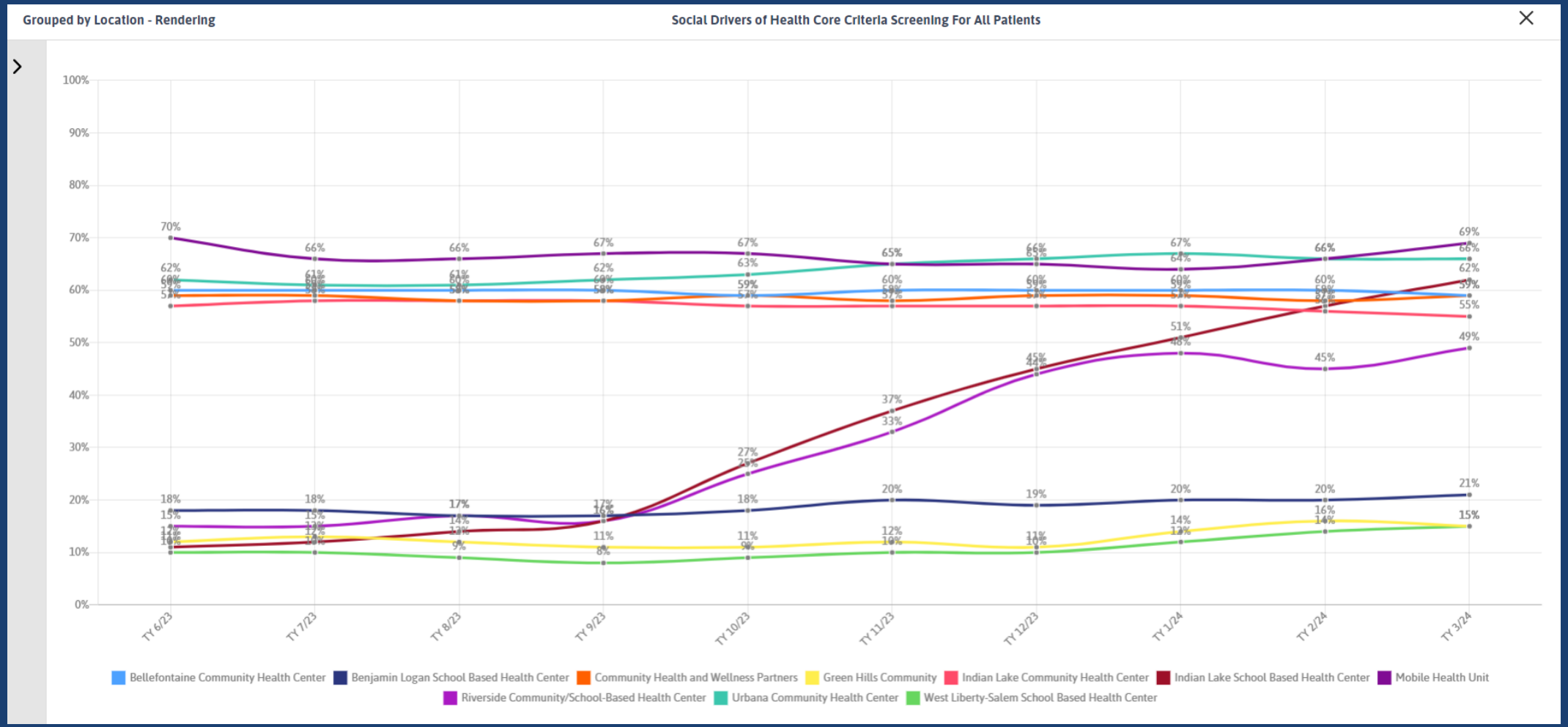
Screening Rates and Social Care Supports Provided

PDSA for Health Equity | Study

Study the compliance and document trends monthly at a minimum. Document any improvement.

Quarter	18+ Completion	17 & Younger Completion	All Ages Combined
Quarter 2	46%	9%	58%
Quarter 3	54%	13%	47%
Quarter 4	60%	29%	54%
2023	56%	20%	49%

Screening Rates



Warm Handoffs Growth

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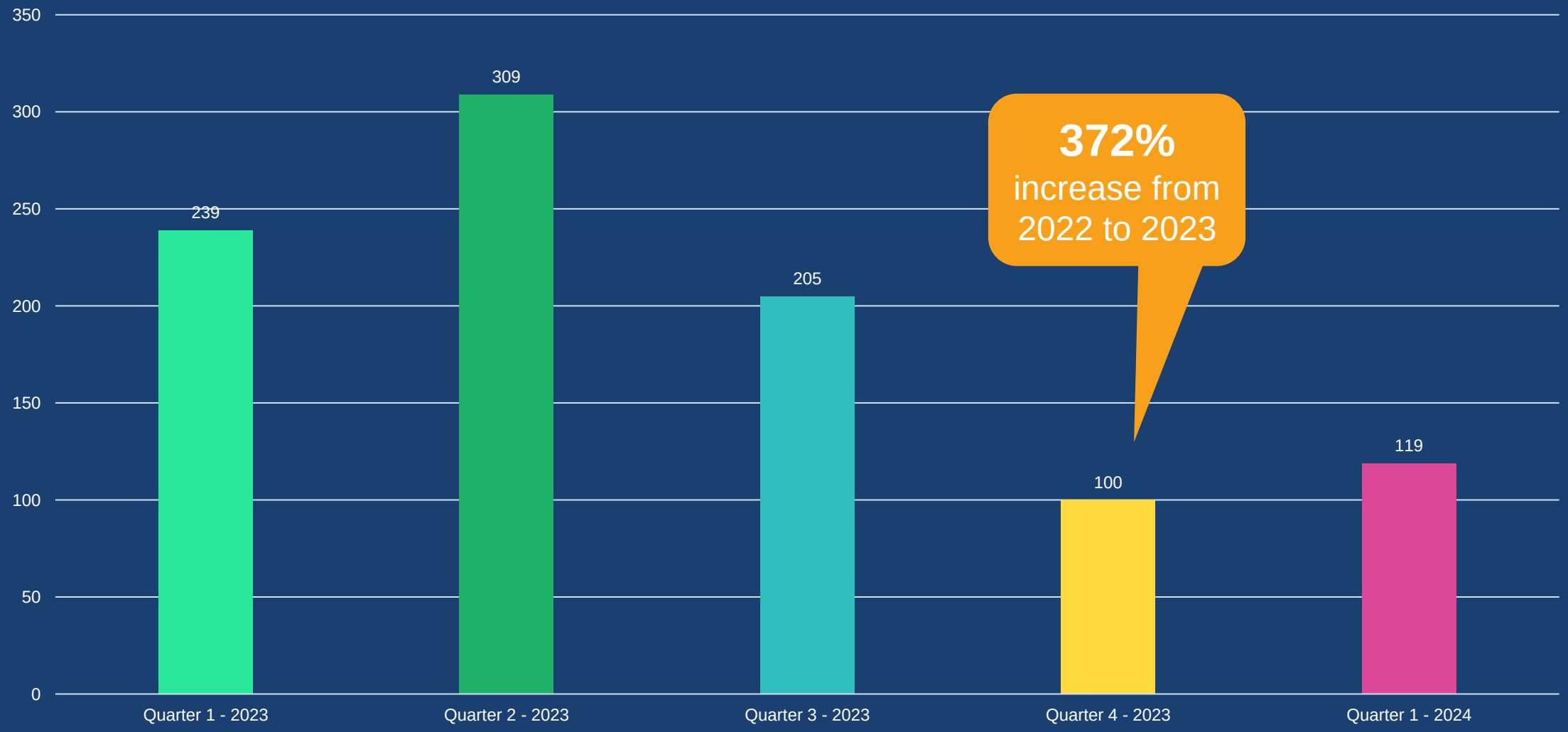

Resources Provided in 2023

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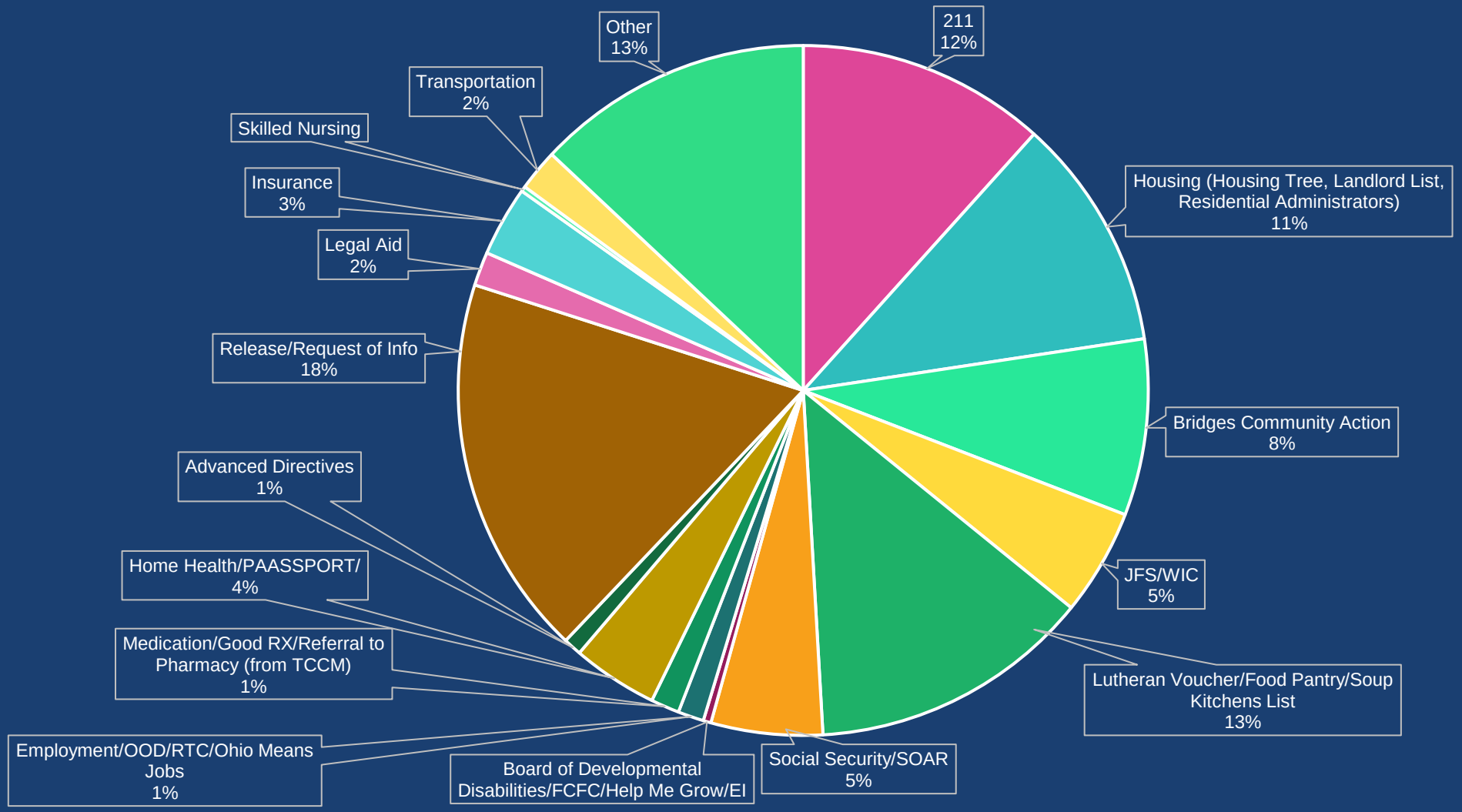

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Lessons Learned

Building Successful Dashboards

Building Successful Dashboards

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- Treat your dashboards as a **living document**
- Cultivate engagement through **regular review** at stakeholder meetings
- **Update dashboards annually** to align with UDS changes and evolving quality goals
- **Empower staff at all levels** to access dashboards to track trends

Looking Ahead | 2024 Quality Goals

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Continued improvements in PRAPRE screening rates.

57%

Adults

57%

Children

49%

All Ages, Combined

Looking Ahead

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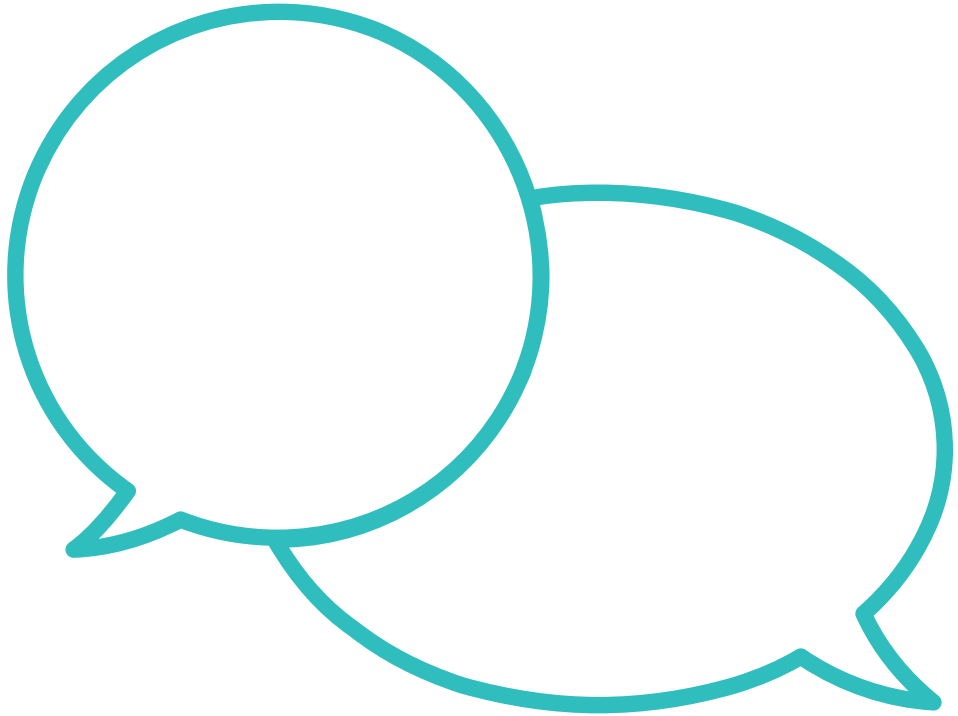
Encourage **workflow consistency** across care teams

Increase use of **Z codes** at point of care

Improve **health literacy** and utilize data to **adapt patient care plan**

Promote **utilization of SDOH information** at all levels of care

Questions?



Azara healthcare

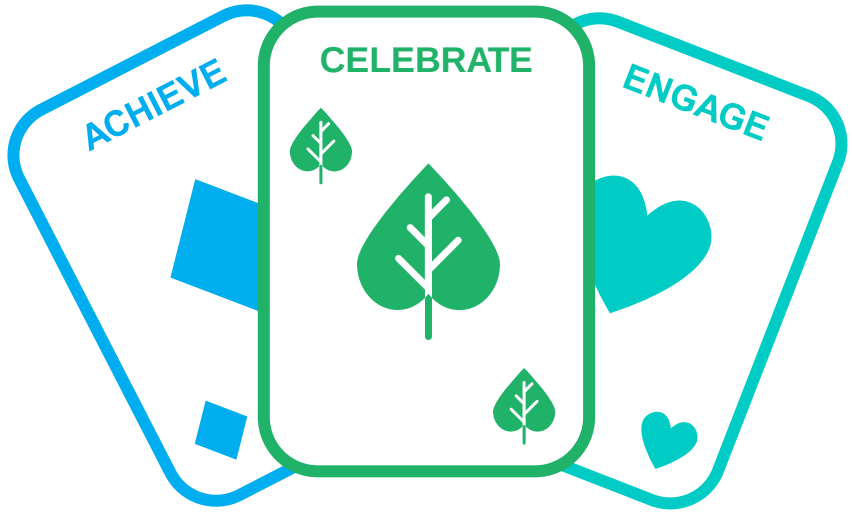
@AzaraDRVS

Achieve, Celebrate, Engage!

ACE'd it? Share your DRVS success story and become an Azara ACE!

Show your organization has used DRVS to **A**chieve measurable results, **C**elebrate improvement in patient health outcomes, and effectively **E**ngage care teams and/or patients. Stories should showcase how DRVS helped your organization overcome a challenge, the tools and solutions used to drive improvement and details of the successes that resulted from your initiatives. ACEs should be able to provide examples that quantify quality improvement, cost savings, operational efficiency or patient health improvement.

azara
ACE Program



Benefits:

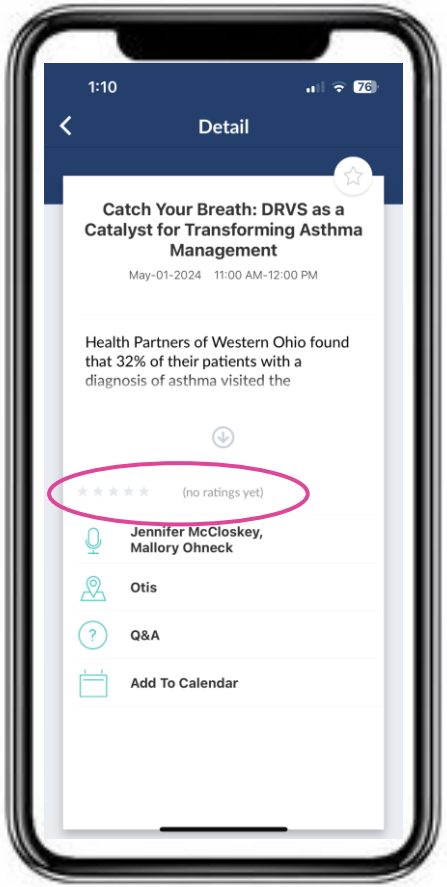
- Azara will help tell your story and provide a client-branded version for your use
- Potential to create a 2-4 minute video or hour-long Azara-hosted webinar
- Win Azara swag!

Submit your success story by completing the form at this link or scan our QR code:

See this year's ACE posters in the Ballroom Foyer!

We Want to Hear From You!

Click on the session from your agenda in the conference app.
Click the stars in the center of your screen to rate and provide feedback.



Quick and Easy

Provide brief feedback or ideas

Rate the session and the speaker(s)

Help us continue to improve

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Thanks for attending!