Using Health Center Dental Dashboard© for Tracking, Measuring, and Improvement

June 6, 2017
Region IX Clinical Excellence Conference

Ice Breaker Activity

Review Dashboard: are you already collecting any measures?

Put a dot next to the ones you are already collecting

How are you using them?
NNOHA is a membership organization of safety-net oral health practitioners, programs and supporters. Member benefits include:

• Educational opportunities
• High quality resources
• Networking opportunities
• Active Listserv with daily topics relevant to your practice
• Technical assistance
• Mentoring
• Discounted Annual NNOHA Conference registration
• The advantage of belonging to the largest organization of people committed to the oral health of underserved populations

For more information, contact info@nnoha.org

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Learning Objectives

• Recognize the 15 measures that make up the Health Center Dental Dashboard©

• Understand how dental clinics can monitor and measure oral health data

• Observe how the Health Center Dental Dashboard© is being used to identify targeted areas for improvement and develop improvement strategies

• Identify ways you can use the Health Center Dental Dashboard© to implement and monitor improvement goals
What we hope you will take away today:

- Recognize some measures you may want to use for your quality improvement work in dental
- Think about how measures can impact your patient care
- Seek out resources so you can implement elements of the Health Center Dental Dashboard©

Grounding the Work

http://mountainparkhealth.org/free-dental-screenings-reduce-tooth-decay-rates/
## Session Overview

### Agenda

- History of the Project
- Measurement for Success: The 15 Dashboard Measures & Why
- The Dashboard in Action:
  Jennifer Hirota, DDS
  Dental Director
  Kokua Kalihi Valley Comprehensive Family Services
- Bringing it Home – what changes could you test that would result in improvement?

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### Measurement for Success:
The 15 Health Center Dental Dashboard© Measures
Quality Improvement And Data

• Health Centers are required to have an ongoing Quality Improvement/Quality Assurance (QI/QA) program that includes clinical services and management.

• Health Centers must now report data on the first oral health Clinical Quality Measure - the HRSA UDS sealants measure.

UDS 2015 Dental Sealants Measure

Percentage of children age 6-9 years of age at elevated caries risk, who received a dental sealant on a first permanent molar by state, UDS 2015
Why We Measure

- In order to manage a system, we are required to make predictions about its future performance
- A predictable (and thus manageable) process operates in a more or less consistent fashion over time

The Three Faces of Performance Measurement

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Improvement</th>
<th>Accountability</th>
<th>Research</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim</td>
<td>Improvement of care (efficiency &amp; effectiveness)</td>
<td>Comparison, choice, performance management</td>
<td>New knowledge (efficacy)</td>
</tr>
<tr>
<td>Methods:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Test Observability</td>
<td>Tests are observable</td>
<td>No test, evaluate current performance</td>
<td>Test blinded or controlled</td>
</tr>
<tr>
<td>- Bias</td>
<td>Accept consistent bias</td>
<td>Measure and adjust to reduce bias</td>
<td>Design to eliminate bias</td>
</tr>
<tr>
<td>- Sample Size</td>
<td>&quot;Just enough&quot; data, small sequential samples</td>
<td>Obtain 100% of available, relevant data</td>
<td>&quot;Just in case&quot; data</td>
</tr>
<tr>
<td>- Flexibility of Hypothesis</td>
<td>Flexible hypotheses, change as learning takes place</td>
<td>No hypothesis</td>
<td>Fixed hypothesis (null hypothesis)</td>
</tr>
<tr>
<td>- Testing Strategy</td>
<td>Sequential tests</td>
<td>No tests</td>
<td>One large test</td>
</tr>
<tr>
<td>- Determining if a change is an improvement</td>
<td>Run charts or Shewhart control charts (statistical process control)</td>
<td>No change focus (maybe compute a percent change or rank order)</td>
<td>Hypothesis, statistical tests (t-test, F-test, chi square, p-values)</td>
</tr>
<tr>
<td>- Confidentiality of the data</td>
<td>Data used only by those involved with improvement</td>
<td>Data available for public consumption and review</td>
<td>Research subjects' identities protected</td>
</tr>
</tbody>
</table>

Question 2 of the Model for Improvement

The most basic understanding of the 2nd question is this:

Measurement

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act Plan

Study Do

The Health Center Dental Dashboard©

Individual Dashboard Measures

The dashboard consists of 15 measures that are organized into three categories:

- Population Health
- Fiscal and operational sustainability
- Patient satisfaction

Population Health

Treatment Plan Completion

- % of newly referred patients who have Phase I treatment plan completed within six months.

Caries at Recall

- % of patients with caries diagnosed during a periodontal exam.

Risk Assessment of All Dental Patients

- % of all dental patients who have had an oral health risk assessment.

Oral Evaluation and/or Risk Assessment of All Primary Care Patients

- % of all levels of care patients who have had an oral health risk assessment performed by an accessible provider.

Topical Fluoride

- % of 0-5 year old children identified as needing fluorides who receive this service in a timely manner.

Fiscal & Operational Sustainability

Gross Charges (Production) per Encounter

Encounters per Hour

No Shows

Direct Cost per Visit

Recall Rates

Patient Satisfaction

Recommendation to Family and Friends

% of patients who would recommend health center services to family and friends.
“If I had to reduce my message for management to just a few words, I’d say it all had to with reducing variation.”
- W. Edwards Deming
Attributes of a Leader Who Understands Variation

- Leaders understand the different ways that variation is viewed.
- They explain changes in terms of random and non-random variation. They can tell when a change has lead to improvement.
- They use dynamic displays of data and related methods to learn about the variation that lives in the data and expect others to also consider variation in their decisions and actions.
- They understand the concept of stable and unstable processes and the potential losses due to tampering. They enjoy doing nada!
- Capability of a process is understood before change is attempted.

Source: Dr. Robert Lloyd IHI
Why Use A Dashboard

- Dashboards give a quick status update for key measures.
- They are a snapshot, not an in-depth analysis.
- Regularly seeing the data makes it much easier to respond quickly to areas of concern, or to change courses of action.
- Dashboards can be used to facilitate communication between departments, highlight successful strategies, maintain momentum in QI activities, and identify operational deficiencies.
- They are a tool to take action!
The Health Center Dental Dashboard© in Action

• Understand how Health Centers can monitor and measure oral health data

• Assess possible roadblocks with gathering and using data

• Determine measures that they can apply in their own organizations

Why did we join the NNOHA Collaborative?

• Help us create/alter our current processes to improve the quality of care we are providing.

• Implement positive/evidence based results for sustainability

-DO WE KNOW HOW?
Collaborative Rationale

- Based on the concept that there are Best Practices to manage chronic health conditions
- Gap between science and practice
  - Current practice deviates from best available scientific knowledge/evidence.
- The Best Practices are not being used in a given population because of
  - Lack of Knowledge
  - Resistance to Change
  - Non-supportive systems

Building Belief

Tests increase in scope and scale. Learning from data.

System changes that will result in improvement

Change ideas, suggestions, intuition

Change
PDSA

Attempt to implement small cycles of change to help reach our goal for each measure.

Specifically, we are currently working on the Sealant Measure which is needed for UDS reporting for children aged 6-9.

- Denominator: children 6-9 of age who had a dental visit in the measurement period who had an oral assessment or comp/periodic oral evaluation visit (D0120, 0150, 0145) and are at moderate (D0602) to high risk for caries (D0603) in the measurement period.

- Numerator: Children who received a sealant on a permanent first molar tooth during the measurement period.

Measurement & QI

Kokua Kalihi Valley

Series median: dashed line; Goal: solid line.
Sealant Measure

- EDR is Dentrix Enterprise
- Last year, 2016 we reported 61% Sealants for 6-9 year olds (good- but pattern/line graph is ??)
  - Line graph or Line chart displayed our monthly information with a series of data points to our providers/Staff- (what? why? wow?)
- Notice that the pattern follows the school's schedule due to the mobile van services.
- We are constantly working at PDSA cycles to improve our numbers and also achieving a more stable result.

Sealant PDSA/Measurement

- Tracking more accurately now exams/sealants= % month
  - Following the child- exam and sealant within the same month. Poor outcome because space/opening further out than 4 weeks.
  - Measuring child exam and sealant within 3 month.
- PDSA Sealants column every 30 minutes
- PDSA same day sealants
QI Impact

• The Positives:
  • Providers/Staff are:
    • Improving Quality Assurance with PDSA cycles
    • Open to change and open to learning
    • Getting involved

• The Negatives:
  • Is everyone on-board for the change?
  • Is everyone doing it consistently?

PDSAs

• PDSAs inform the system – think strategically about what you need to achieve and the key elements you need to get there

• Scientific method that we use

• Discipline to complete the full cycle, helps us to understand our systems
PDSA Exercise

• Using the PDSA form, plan a small test of change in your health center.

• Share: what are you trying to accomplish?

Sharing… complete this sentence:

The first step I will take to begin, or improve my measurement capacity in dental is…
Next Steps

• The Health Center Dental Dashboard© is free to use, but users will need to sign up to receive the Excel template

• Access to the Health Center Dental Dashboard© and the User’s Guide is posted on NNOHA’s website: http://www.nnoha.org

• Measures continue to be refined through NNOHA’s Dashboard Learning Collaborative

Contact Information

• **Colleen Lampron, MPH**
  NNOHA Dashboard Consultant & Collaborative Director
  coleenlampron@afl-enterprises.com

• **Irene Hilton, DDS, MPH**
  NNOHA Dental Consultant & Collaborative Chair
  Irene@nnoha.org

• **Jennifer Hirota, DDS**
  Co-Dental Director, Kokua Kalihi Valley CFS
  jhirota-tulikihihifo@kkv.net
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• Irene Hilton, DDS, MPH
  NNOHA Dental Consultant & Collaborative Chair
  Irene@nnoha.org

• Jennifer Hirota, DDS

Tools for Data Driven Decision Making

Vija Sehgal, MD- Chief Quality Officer
Marie Hassel, CPHQ- Director of Quality
Contributor: Heather Budd, VP of Clinical Transformation Azara Healthcare
Waianae Coast Comprehensive Health Center

- Serving the community since 1972 – celebrating 45th anniversary this year
- Largest of 14 community health centers in the State of Hawai`i
- In 2016, served 36,019 patients through 206,873 encounters
- 68% of patients are Native Hawaiian/Pacific Islander/Asian
- 53% of patients are at 100% of the poverty level and below
- 58% of patients are covered under Medicaid and 9% are uninsured
- Primary care provided through 8 clinic sites covering West Oahu on the island of O`ahu
Why A Population Management Program

- Leadership commitment to improve clinical measures
  - Strategic goal to improve important clinical measures
  - Struggling to meet PCMH reporting requirements
- Current system was reactive and burdensome
  - Improvement had been slow over the years
- Decrease missed opportunities
- Several programs were evaluated for ease of use, reporting capabilities, available improvement tools and cost
  - Evaluation team: clinical leaders, providers, medical assistants, quality improvement staff, data analysts, IT staff and EMR staff
Several programs were evaluated. Evaluation team: clinical leaders, providers, medical assistants, quality improvement staff, data analysts, IT staff and EMR staff

AZARA Benefits

- Interface with Nextgen
- Quality Improvement Tools
- Robust Training and Support
- Reporting Capabilities
- Ability to Drill Down
- Dashboards/Scorecards
- End user ease of use

Visit Planning Improvement Project
GOAL: Improve 6 Clinical Measures

Configuring Visit Planning (for DRVS Admins)
- Focus early on measures with potential to show improvement quickly – process measures.
- Include measures with longer term improvement potential.
- Tie the measure selection to existing staff and provider bonus program and 330 grant.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline April 2015</th>
<th>Interim Target</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Cancer Screening (NQF/UDS)</td>
<td>59%</td>
<td>65%</td>
<td>70%</td>
</tr>
<tr>
<td>Asthma Appropriate Use of Medications (NQF/UDS)</td>
<td>&lt;1%</td>
<td>50%</td>
<td>70%</td>
</tr>
<tr>
<td>Hypertension BP Control 140/90 (NQF/UDS)</td>
<td>55%</td>
<td>60%</td>
<td>70%</td>
</tr>
<tr>
<td>Pedi Weight Screening and Nutrition/Physical Activity Counseling (UDS)</td>
<td>16%</td>
<td>35%</td>
<td>50%</td>
</tr>
<tr>
<td>Depression Screening and Follow-Up (NQF/UDS)</td>
<td>&lt;1%</td>
<td>10%</td>
<td>30%</td>
</tr>
<tr>
<td>Adult Weight Screening and Follow-Up (NQF/UDS)</td>
<td>51%</td>
<td>65%</td>
<td>75%</td>
</tr>
</tbody>
</table>

What Is A Visit Planning Tool
Facilitates more efficient pre-visit planning sessions by allowing care teams to review alerts for patients with upcoming appointments
- Electronic chart prep, does the work MAs/ LPNs/RN’s already doing manually, using EHR data to identify gaps in care.
- Displays only relevant and actionable items to help teams prepare for visits
- Displays active diagnoses and relevant risk factors
- Shows all patients with appointments and alerts in one single list ideal for huddling
- Uses configurable clinically relevant alerts, not just based on quality populations
**Visit Planning Benefits**

1. Improve Measure Performance: Identify and close gaps at point of care.
2. Optimize Treatment for Patients: by having data available at time of visit.
3. Emphasize time for relationship: provider can engage patient in care.
4. Increase Staff Satisfaction - MA and Provider days are smoother.

**Select A Leadership Team**

- **Team member recommendations:**
  - CMO or Medical Director
  - COO or Director of Operations
  - Director of Nursing
  - Practice or Site Managers
  - Quality Director or Manager
  - Azara Administrator
  - EHR Specialist/ IT

- **Establish a project schedule and weekly meeting time.**

- **Select pilot team members (Pediatrics Main Clinic and Waipahu Clinic):**
  - Choose motivated change agents who will be project ambassadors.
  - Pilot team members do not need to be in the weekly meeting.
## Sample Standing Orders

<table>
<thead>
<tr>
<th>All Adults</th>
<th>Population</th>
<th>Frequency</th>
<th>Dx Code</th>
<th>MA/LPN Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL</td>
<td>All &gt;17</td>
<td>every 5 years</td>
<td>V77.91</td>
<td>Remind Provider</td>
</tr>
<tr>
<td>Colon Cancer Screen</td>
<td>FIT</td>
<td>&gt;49, w/o colonoscopy past 10 yrs</td>
<td>yearly</td>
<td>V76.51</td>
</tr>
<tr>
<td>Tobacco Usage/ Advice to Quit</td>
<td>&gt;12</td>
<td>yearly</td>
<td>NA</td>
<td>Perform</td>
</tr>
<tr>
<td>Flu</td>
<td>All patients</td>
<td>yearly</td>
<td>V04.81</td>
<td>Perform</td>
</tr>
<tr>
<td>Pneumovax</td>
<td>&gt; 65, if last was &gt; 5 years ago</td>
<td>repeat once</td>
<td>V03.82</td>
<td>Perform</td>
</tr>
<tr>
<td>Depression Screening</td>
<td>All patients &gt;12</td>
<td>yearly</td>
<td>NA</td>
<td>Perform</td>
</tr>
<tr>
<td>Weight Screening and Follow-Up</td>
<td>All patients, BMI &gt;24 or &lt;18.5</td>
<td>yearly</td>
<td>NA</td>
<td>Remind Provider</td>
</tr>
</tbody>
</table>

## Standardize Documentation

### Configuring Visit Planning (for DRVS Admins)

- Map all your evaluation measures.

![Sample Flowchart]

1. **Patient Arrives for Visit**
   - Front Desk Checks in Patient.
   - MA/LPN Performs vital signs and places order via standing orders.
2. **Pap today?**
   - No: Provider sees patient and performs pap.
3. **Provider sees patient and performs pap.**
   - Schedule future pap w/o copay, or refer to grant program for uninsured.
4. **Lab Performs diagnostics.**
   - Result returns electronically from lab.
5. **Result received by medical records, gets scanned and documented that it was received.**
   - Paper Pap Result Arrives.
6. **Results are forwarded to the Women’s Health LPN.**
   - Care Coordinator arranges future visit.
7. **Provider reviews and signs off on result and follow-up plan.**
   - MA/LPN Prepares for procedure.
**Validate the Patient Visit Planning Report**

**Visit Planning (for DRVS Admins)**

- Accurate data is critical to a successful roll-out.
- The Basics:
  - Are the correct patients listed?
  - Are the patients shown under the scheduled provider?
- The Details:
  - Review 5-10 patients demographic data, visit reason, PCP, Diagnoses, Risk Factors, and Alerts.
**Clarify Roles and Responsibilities**

### Configuring Visit Planning (for DRVS Admins)

**MA/LPN**

1. Run Azara PVP for scheduled patients daily. Print copies for notes.
2. Identify missing data for diagnostic or lab tests. Look for scanned only results in Documents (especially Mammogram, Pap, Colonoscopy, A1c).
3. Screen, educate, order labs and diagnostics as supported by standing orders, and enter Provider specific reminders in the HPI field in the EHR during patient intake.

**Care Manager/ BH/ Pharmacist/ Health Educators**

1. On the fly check-in with MA to determine high risk patients who need to be seen face-to-face or receive additional education.
2. Share any special patient circumstances with the team.

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### Configuring Visit Planning (for DRVS Admins)

**Provider**

1. Delegate standing order tasks to appropriate support team members. Visit Planning Report provides technology foundation for trust.
2. Ensure huddles are happening. May take many forms but at the very least there should be some conversation with your MA/LPN about the plan for patients- a quick team meeting.

**All**

1. Data Hygiene: Report data errors so they can be addressed and fixed. Workflows and inputs change over time. Azara will find root cause and update.
Configuring Visit Planning (for DRVS Admins)

1. Have a consistent time and stand for meeting. Any team member can initiate.

2. Must Discuss:
   a. Patients with special intervention needs
   b. Patients with risk factors
      | DRVS Risk Factor | Risk Factor Description                  |
      |------------------|-----------------------------------------|
      | Pregnancy        | Currently pregnant.                    |
      | OBS              | BMI indicates obesity                   |
      | TOB              | Current tobacco user                    |
      | SMI              | Active Dx of Severe Mental illness and/or Psychosis. |
      | ASD              | Active Dx of Substance Abuse and/or Dependency |
      | SOC              | Other Social Determinants               |
   c. Any scheduling bottlenecks anticipated, and plans to workaround

3. Organize for extra services if needed:
   a. Behavioral Health, Pharmacy, Enabling Services
   b. Diabetes, Asthma, Nutrition Education

---

Pilot Results

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Target</th>
<th>Pilot Site (March 2015)</th>
<th>Pilot Sites May 2015</th>
<th>(one month after kick-off)</th>
<th>All Teams at WCCHC April 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>UDS Adult Weight Assessment and Follow-up</td>
<td>75%</td>
<td>51%</td>
<td>71%</td>
<td>65.2%</td>
<td></td>
</tr>
<tr>
<td>UDS Asthma Pharmacological Treatment</td>
<td>70%</td>
<td>&lt;1%</td>
<td>83%</td>
<td>85.7%</td>
<td></td>
</tr>
<tr>
<td>UDS Weight Assessment and Counseling for Children and Adolescents</td>
<td>50%</td>
<td>16%</td>
<td>27%</td>
<td>61.0%</td>
<td></td>
</tr>
<tr>
<td>UDS Cervical Cancer Screening</td>
<td>70%</td>
<td>59%</td>
<td>77%</td>
<td>75.1%</td>
<td></td>
</tr>
<tr>
<td>UDS Hypertension BP &lt;140/90</td>
<td>70%</td>
<td>55%</td>
<td>50%</td>
<td>59.9%</td>
<td></td>
</tr>
<tr>
<td>UDS Depression Screening and Follow-up</td>
<td>30%</td>
<td>&lt;1%</td>
<td>15%</td>
<td>56.6%</td>
<td></td>
</tr>
</tbody>
</table>
Pilot Results

Depression Screening & Follow-up

Pilot Location

- Non-PVP Pilot
- PVP Pilot


Pilot Results

Depression Screening & Follow-up

Pilot Location

- Non-PVP Pilot
- PVP Pilot

January, 2015
Visit Planning Results Explained

• Improved Data Capture
  • Standardized Workflows
  • Updated Mappings
  • Daily Opportunity for Ongoing Data Hygiene

• Improved Processes
  • Delegation of Appropriate Tasks to Team via Standing Actions
  • More Complete and Efficient List of Patients and Care Needs
  • Daily Huddles for Logistics and Incorporation of Care Management and Other Resources for Patient Care and Education

Lessons Learned and Wins
# Full Implementation

- Full implementation or non pilot provider data

---

## Provider Data

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Alert</th>
<th>Message</th>
<th>West Revenue Date</th>
<th>West Revenue Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td>122149</td>
</tr>
<tr>
<td>BP</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td>398</td>
</tr>
<tr>
<td>Dental Visit</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>Depression Screening</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>A1C</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td>8.9</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>Ultrasound Screening</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>LTL</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>Adult Weight Screening</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>HIV C Screening</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>Lipstick Lumina Therapy</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>Aspire</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>Stabilization Therapy</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>P-6 Screening</td>
<td>Missing</td>
<td></td>
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<tr>
<td>Visional Screening</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>Geriatric Screening</td>
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<td>2018</td>
<td>8.9</td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>Ultrasound Screening</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>LTL</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>Adult Weight Screening</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>HIV C Screening</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>Lipstick Lumina Therapy</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>Aspire</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
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</tr>
<tr>
<td>Stabilization Therapy</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
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</tr>
<tr>
<td>P-6 Screening</td>
<td>Missing</td>
<td></td>
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<tr>
<td>Visional Screening</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
<tr>
<td>Geriatric Screening</td>
<td>Overdue</td>
<td>1Y222/19</td>
<td>2018</td>
<td></td>
</tr>
</tbody>
</table>
Sample Scorecard

Custom Scorecards - Visit Planning Evaluation

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Result</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension: Controlling High Blood Pressure (NQF 0018)</td>
<td>01.9%</td>
<td>01.9%</td>
<td>838</td>
<td>1,428</td>
<td>74</td>
</tr>
<tr>
<td>Child Weight Smoking / BMI / Nutritional / Physical Activity Counseling (NQF 0024 modified)</td>
<td>58.8%</td>
<td>68.8%</td>
<td>767</td>
<td>1,113</td>
<td>12</td>
</tr>
<tr>
<td>Tobacco Use: Screening and Cessation (NQF 0026)</td>
<td>09.6%</td>
<td>09.4%</td>
<td>3,188</td>
<td>3,791</td>
<td>0</td>
</tr>
<tr>
<td>Dental Cancer Screening (NQF 0032)</td>
<td>70.0%</td>
<td>73.0%</td>
<td>1,350</td>
<td>2,051</td>
<td>123</td>
</tr>
<tr>
<td>Use of Appropriate Medications for Asthma (NQF 0036)</td>
<td>70.0%</td>
<td>70.0%</td>
<td>152</td>
<td>508</td>
<td>186</td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-Up Plan (NQF 0418)</td>
<td>30.0%</td>
<td>39.3%</td>
<td>2,115</td>
<td>4,613</td>
<td>1,439</td>
</tr>
<tr>
<td>BMI Screening and Follow-Up 10+ Years (NQF 0421)</td>
<td>75.0%</td>
<td>67.4%</td>
<td>2,442</td>
<td>4,187</td>
<td>585</td>
</tr>
</tbody>
</table>

Data Driven Decisions

- Focus improvement efforts
- Align staff and provider quality bonus program
- Identify proactive peer review topics
- Dashboards and scorecards allow for individual and site level communications