Tableau in Action:
How Data Visualization Can Increase Literacy
Today’s Focus

12:00pm-12:05 Welcome and Overview (5 mins)

12:05-12:45 Dr. Jason Cunningham and Dana Valley from West County Health Centers (45 mins)

12:45-1:00pm Questions, Next Steps & Closing (15 mins)

Please remember to fill out the post webinar brief survey!!
Voices on the Webinar

Megan O’Brien, Value-Based Care Program Manager, Center for Care Innovations
mobrien@careinnovations.org

Dr. Jason Cunningham, Medical Director, West County Health Centers

Dana Valley, Associate Director of Quality Management, West County Health Centers

Angela Liu, SNAP-LA Program Coordinator, Center for Care Innovations
angela@datamatt3rs.com
Webinar Reminders

1. Everyone is **UNMUTED**.
   - Press *6 to mute; press *7 on your phone to unmute.

2. Remember to chat in questions!

3. Webinar is being recorded and will be posted and sent out via email.
SNAP-LA

CP3

Common need & timing alignment for data visualization tips & tools!
Webinar Participants

SNAP-LA

1. Eisner Pediatric & Family Medical Center
2. JWCH Institute, Inc.
3. KHEIR Center
4. Los Angeles LGBT Center
5. South Central Family Health Center
6. The Achievable Foundation
7. UMMA Community Clinic
8. Westside Family Health Center

CP3

1. Asian Health Services
2. Gardner Family HealthCare
3. Golden Valley Health Center
4. La Clinica de La Raza, Inc.
5. LifeLong Medical Care
6. Monterey County Clinics
7. Northeast Valley Health Corporation
8. Operation Samahan
9. Ravenswood Family Health Center
10. San Joaquin General Hospital
11. San Mateo Medical Center
12. Venice Family Clinic
13. Vista Community Clinic
Setting the Context

Does your organization currently use Tableau?

![Tableau Use Chart]

- Yes: 32%
- No: 68%
Setting the Context

**What questions do you have about using Tableau?**

1. Does it link to **EHR** systems (NextGen)?
2. How easy is it to **set up**?
3. What are its main **functions**?
4. What's the **cost/value & overall utility** for FQHCs?

1. To what degree to which you can **display granular data**?
2. How can Tableau assist with **population health management**?
3. How have you optimize Tableau to **increase engagement and buy-in**?
4. How quickly can it be **learned by all levels** of users (output vs input of information)?
5. What are **different staff roles** with use of Tableau?
6. What kind of **training** is necessary for end users?
7. What are the **expectations from providers** of what do with the data?
SNAP-LA Webinar #7
Data Visualization in Action
August 10, 2017
West County Health Center Sites:
- Primary Care - 4 sites (3-4 FTE Providers)
- Dental Clinic
- Teen Clinic
- Labor Center Outreach
- Wellness Center
- Healthcare for the Homeless

Patients
- 13,000 individuals
- 77,000 visits
- 80% under 200% of poverty level

2017 Budget
- $20 million
- 60% patient fees
- 40% grants, contracts, fundraising
Quality is kind of a big deal around here.
Any Questions?
Data as part of a conversation
Power to the “Content Expert” or “Citizen Scientist”

“It always happens when you give these little people power, it goes to their heads like strong drink.”
Liberation of Data

[Image: A compass and a flock of birds, symbolizing the liberation of data.]
### HTN % in Control-Care Team

**Goal:** >= 75%

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#### Site: SCHC

- # HTN In Control Patients (numerator): **74**
- # HTN Qualifying Patients (denominator): **81**
- % in Control: **91.4%**

**HTN in Control Definition:** Percentage of patients with Hypertension who had last blood pressure "in control". Patients must have had a primary care visit in the past 12 months and had a diagnosis of HTN in their problem list at least 6 months ago.

- In control is defined as:
  - Age 18-69 BP systolic <140 AND diastolic <90
  - Age over 60 BP systolic <150 AND diastolic <90
  - Age over 60 with Diabetes on the Problem List BP systolic <140 AND diastolic <90

This dashboard does not include patients with Graton Clinic listed as a Primary Facility.
Medical Assistant
Click on the boxes to be directed to files or folders on the docshare.
- Standing Orders Clinical Protocol
- Standing Order
- Population Management Expectations and Time Management
- Ordering a Referral for DM Eye Exam
- Charting a Depression Screen
- Charting a DM Foot Exam
- Ordering Labs/DI through and Order Set
- Perpetual LAB DI Tracking

Front Office
Click on the boxes to be directed to files or folders on the docshare.
- Creating an Open Access Alert/Dental Alerts
- SCHC - Open Access Recal List Management
- OAHC - Open Access Recall List Management
- CTFO - Open Access Management

Registered Nurse
Click on the boxes to be directed to files or folders on the docshare.
- Diabetes Care Plan Clinical Protocol

Referrals
Click on the boxes to be directed to files or folders on the docshare.
- Workflow for DM Eye Exam Referrals
## PHASE Nurse Population Management

This sheet displays active patients who have had a primary care visit in the past 12 months and eligible for the PHASE program. Excludes patients with Graton Clinic as Primary Facility.

Be sure to review the Office Visit Recall Tab to find PHASE patients who have not been seen in more than 12 months.

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<th>Last LDL Result</th>
<th>Last LDL Date</th>
<th>DM on Problem List</th>
<th>Last A1C Result</th>
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Visits at Teen Clinic

Number of Visits in April 2017

116

Number of Visits each Month in 2017

January: 134
February: 105
March: 113
April: 116

Cumulative Total Number of Visits in 2017

Number of Visits in April 2017 by Appointment Provider

Ramsey - Emily: 40
Kovner - Shari: 35
Elliott - Jerrold: 18
Ehrenreich - Kyla: 14
O'Brien - Kathleen: 9
eCW Maintenance

** MAINTENANCE MENU **

A. Provider Mapping
B. Duplicate Patients by Name / DOB
C. Duplicate Patients by SSN
D. Active Staff eCW Users
E. Active eCW Visit Types
F. Feed The Donkey A Carrot
<table>
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<tr>
<th>User ID</th>
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<th>User Name</th>
<th>Primary Service Location Name</th>
<th>Type</th>
<th>Last Host Login Time</th>
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Patients that display on this Dashboard are defined as having any one of the following:

- At least one question from Social History indicating homelessness
- Dx code of x42 HCH on the Problem List
- Dx code of Z69.0 Homelessness on the PL
- Dx code of Z69.1 Inadequate housing on the PL
Total Healthcare for the Homeless Referrals

Number of total HCH Team referrals created in the past 12 months by referring provider and referral name

HCH Program

- Homeless Services, Program
- Thibault, Sarah

Total Referrals to HCH in the past 12 months

127
Advanced Care Directive
When each site reaches 300 Advanced Care Directives, it will receive a BREAKFAST of CHAMPIONS.
For every 10 Advanced Care Directives, every member of the Care Team will receive a RAFFLE TICKET.
Percentage of active patients aged 13 and older, with a primary care visit within the past month who have tobacco use status documented as "current, former or never" in the last 12 months. This dashboard does not include patients with Groton Clinic listed as a Primary Facility.
Quality is kind of a big deal around here.
Drop in to Tableau Tuesdays!
Tuesdays from Nine to Noon
Innovation Hub: 652 Petaluma Ave, Sebastopol
August 29 ON LOCATION at RRHC!
Questions: dvalley@wchealth.org
2017 Areas of Focus for West County

- Annual Depression Screenings on all patients aged 18 and over
- Tobacco Screening and Cessation Counseling
- Diabetic Care Plans
- PHASE
- Cervical Cancer Screening
- Well Child Exams
- Colorectal Cancer Screening
- HTN Blood Pressure Control

May is National Stroke Awareness and National High Blood Pressure Awareness Month

High blood pressure equals high risk of stroke.

80% of strokes can be prevented.

Nearly 1 in 6 American adults with high blood pressure DON’T KNOW.

Most people who have a first STROKE have HIGH BLOOD PRESSURE.

Source: American Heart Association

Hiding in Plain Sight: Identifying Potential Hypertension Patients

This info is available on the HTN Dashboard in the Hiding In Plain Sight Tab.

Data Team Trivia

Which Data Donkey doesn’t like...

- Carrots, when crunchy
- Eggplant, when anonymous
- Broccoli, when present

Donkey Egg: a hidden message or feature created by the Data Donkeys for the fine people of WCCHC. Legend tells that when discovered, the Donkey Egg may benefit the discoverer considerably.

Tableau Tuesdays!

Tuesdays from Nine to Noon
First Tuesday of the month for new staff

Innovation Hub:
652 Petaluma Ave, Sebastopol
Questions: dvalley@wchealth.org
Annual Depression Screenings on all patients aged 18 and over
Tobacco Screening and Cessation Counseling
Diabetic Care Plans
PHASE
Cervical Cancer Screening
Well Child Exams
Colorectal Cancer Screening
HTN Blood Pressure Control
Donkey Egg Scavenger Hunt

First question:
Who discovered and developed the first polio vaccine?

The answer to the first question is hidden within a dashboard that you’d use to find lists of patients for recall! There, you will find the second question and a hint for where to find the answer to the next question. The first person to email us (dvalley@wchealth.org) with ALL FOUR correct answers will get a PRIZE!

Donkey Egg (n.): a hidden message or feature created by the Data Donkeys for the fine people of WCHC. Legend tells that when discovered, the Donkey Egg may benefit the discoverer considerably.
### SITE MANAGEMENT QUALITY SUMMARY

#### APRIL 2017

### 2017 Clinical Areas of Focus

#### PHASE on ASA
- Percent of PHASE eligible patients, seen in the last 12 months who have either a contraindication, an exclusion to ASA or have ASA in their current medication list.
- **High Performer:** Wendy - 90%
- **Low Performer:** n/a - 69%
- **Goal:** 75%
- **Agency Result:** 83%
- **Result month prior:**
- **Result:** 77%

#### Diabetic Care Plans
- Diabetic patients with last A1C test in the last 12 months with a result of >9 or above with a Care Plan in the last 12 months.
- **High Performer:** Kirkconnell - 90%
- **Low Performer:** n/a - 50%
- **Goal:** 90%
- **Agency Result:** 67%
- **Result month prior:** 76%
- **Result:** 90%

#### Cessation Counseling
- Percentage of "current" smokers, seen in the last 12 months who have documentation of cessation counseling in the last 12 months.
- **High Performer:** Kirkconnell - 40%
- **Low Performer:** n/a - 15%
- **Goal:** 75%
- **Agency Result:** 35%
- **Result month prior:** n/a
- **Result:** 25%

#### Tobacco Screening
- Percentage of patients aged 13 and older, seen in the last 12 months, who have been screened for tobacco use in the last 12 months.
- **High Performer:** Jameson - 71%
- **Low Performer:** n/a - 28%
- **Goal:** 75%
- **Agency Result:** 59%
- **Result month prior:** n/a
- **Result:** 60%
**Optimizing Funding**

OAHC QIP Results as of 05/01/2017
QIP Measurement Year ends 06/30/2017.

![Graph showing QIP counts across various measures](image)

**Operationalizing Data**

How will you share this info with your staff?
Which staff members still need Tableau/data support?
What is the status of Population Management at your site?

**Quality Concerns**

- There are 61 patients seen in the last 12 months with a blank default facility (Provider Reassign, Dash, Null Tab)
- 25% of DM patients are up to date on eye exams

**Site Management Action Goals**

What will your team focus on this month?
QUALITY WATCH

KEEPING OUR GOALS IN SIGHT
## Diabetes dashboard

**Patients aged 16 and up with DM on problem list. All measures are on DM patients with a primary care appointment in the last 12 months.**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Tab</th>
<th>Filters to apply</th>
<th>Goal</th>
<th>My result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Diabetic patients</strong> (assigned to my care team who have been seen in the last 12 months)</td>
<td># of Diabetic patients</td>
<td>My rendering provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of DM patients with A1C complete</strong></td>
<td>DM Lab Outreach</td>
<td>My rendering provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of DM patients with LDL complete</strong></td>
<td>DM Lab Outreach</td>
<td>My rendering provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of DM patients with a Depression Screen complete</strong></td>
<td>DM Office Procedure Outreach</td>
<td>My rendering provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of DM patients with a Foot Exam complete</strong></td>
<td>DM Office Procedure Outreach</td>
<td>My rendering provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of DM patients with an Eye Exam complete</strong></td>
<td>DM Office Procedure Outreach</td>
<td>My rendering provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Number of active DM patients last seen over 12 months</strong></td>
<td>Office Visit Recall List</td>
<td>My rendering provider</td>
<td>Last Office Visits ‘null’ and ‘greater than 12 months’</td>
<td></td>
</tr>
</tbody>
</table>

## Issues and Opportunities:
FO QA dashboard

This dashboard shows all patients who have had a primary care appointment in a given period.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Tab</th>
<th>Filters to apply</th>
<th>Goal</th>
<th>My result</th>
<th>Care Team High Performer</th>
<th>Care Team Low Performer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients seen last month with a registration form with a scan date in the last 12 months</td>
<td>Monthly Reg</td>
<td>My rendering provider</td>
<td>75%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients seen last month with social history complete</td>
<td>Monthly Reg</td>
<td>My rendering provider</td>
<td>75%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients seen last month with income documented</td>
<td>Monthly Income</td>
<td>My rendering provider</td>
<td>75%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Plan of action for managing results to include celebrating wins, learning best practices and providing support for teams with lower outcomes.
BEHIND THE SCENES

NUTS and BOLTS
Cost

• Beginning
  – 60-day free trial
  – $1500 one-time Desktop license, $300 annual maintenance (x how many builders you will have)
  – Free Tableau Reader

• When you are hooked
  – Server

• Business Intelligence space is getting more crowded
  – Consider PowerBI or other data visualization software
Fluency

• Basic Fluency
  – 30-60 days – online tutorials, Tableau Community

• Conversational Tableau Fluency
  – 6 months

• Advanced Learner
  – 1 year with focused learning or in-person certification
Penny Wilson
Report Systems Assistant
pwilson@wchealth.org

Dana Valley
Associate Director of Quality Management
dvalley@wchealth.org

Mike Heinle
Report Systems Manager
mheinle@wchealth.org

This could be you!
Data Assistant
Any Questions?
Thanks!

dvalley@wchealth.org

Jcunningham@wchealth.org
Upcoming Events

SNAP-LA

- **August 24**: Attend upcoming webinar focused on Health Information Exchange in LA.

- **September 18**: Save the Date for our last in-person session! And register once we send out the EventBrite.

CP3

- **August 17**: Attend webinar focused on “From Data to Action: Key Steps and Strategies for Using Data to Improve Care.”
Upcoming CCI Webinar & Workshop

**Effective Communication Strategies for Strengthening Patient-Clinician Relationships**

**Webinar:** August 29, 11:00 am – 12:00 pm  
**Workshop:** September 7, 9:30 am – 4:00 pm

**Objective:** Learn and apply techniques to discover and identify patient vulnerabilities and resilience through eliciting patient narratives and developing shared care plans

**Open To:** Clinicians and members of their care team. Participants should plan to attend both the webinar and workshop.

Limited 40 spots available  
Register separately ASAP:

**Webinar:** Register [here](#)  
**Workshop:** Register [here](#)
Cedars-Sinai Community Clinic Initiative: Managing to Leading Program

Healthforce Center at UCSF is now accepting applications for the second cohort of Managing to Leading. **Applications due August 30.**

Managing to Leading is a transformative leadership development program that equips leaders with the knowledge, skills, and confidence to effectively lead change and improve health care in today’s complex and uncertain environment.

**PROGRAM DATES:** September 2017 - April 2018  
**APPLICATION DEADLINE:** August 30

**APPLY**  
https://healthforce.ucsf.edu/CedarsSinai

**QUESTIONS?**  
alleysha.mullen@ucsf.edu  
415-476-1859

**DESIGNED FOR:** Individual mid-level clinicians, administrators, and other non-clinical staff who are:  
• managing or supervising others;  
• transitioning from doing to leading;  
• planning and overseeing the work of others; or  
• increasingly tasked with complex projects or initiatives that involve multiple people or departments
Thank You!

For questions, please contact:

Megan O’Brien
Value-Based Care Program Manager
mobrien@careinnovations.org

Please remember to fill out the post webinar brief survey!!