Advancing Behavioral Health Equity in Primary Care

Building a Data-Informed Culture

August 31, 2022 | 12-1:30pm

While you are waiting…

************

Please rename yourself by adding your organization’s name.

How: Right-click on your name in the Participant list, and click, “Rename”
**Housekeeping**

**Mute**

*Minimize Interruptions*
Please make sure to mute yourself when you aren’t speaking.

**Chat**

*Go Ahead, Speak Up!*
Use the Zoom chat to ask questions and participate in activities.

**Naming**

*Where Are You From?*
Please rename yourself and add your organization’s name.

**Tech Issues**

*Here to Help*
Chat Brianna Harris privately if you are having issues and need tech assistance.
I Update Your Zoom Name

1. After launching the Zoom meeting, click on the "Participants" icon at the bottom of the window.

2. In the "Participants" list on the right side of the Zoom window, hover over your name and click on the "Rename" button.

3. Type in the display name you'd like to appear in the meeting and click on "OK".
Welcome!
Welcome ABHE Teams!
Instructions

1. Unmute yourselves, turn your cameras on and wave!
2. We will be taking three group photos.
3. We will take screen shots of everyone in gallery view.
Setting the Stage
## Agenda

1. Leveraging Your Data Sources
2. Best Practices: Using Data to Improve Outcomes
3. Breakouts: Reflecting on Today’s Lessons
4. Storyboards: Sharing Your ABHE Journey
5. Closing and Next Steps

### Invitation:

As you listen to our speakers, we encourage you to identify best practices that you can adopt at your clinic. You'll have an opportunity to share these during breakouts.
Today’s Objectives

By the end of our session today, you will ...

1. Strengthened their practice of aligning all ABHE data to drive learning and improvement
2. Identifying gaps in the relationships and processes that contribute to a data-driven culture
3. Established action steps to improve daily data practices to drive improvement
4. Gained clarity on the purpose and process for completing the final storyboard, and how it will be informed by current activities
Introductions
Joining us today…

Jerry Lassa
Metrics & Analytics Consultant
Data Matt3rs

Danielle King, PsyD
Director of Clinic and Community Collaborations
Cherokee Health Systems

Andy Rhea
Chief Information Officer
Cherokee Health Systems
Reviewing Team’s Progress
<table>
<thead>
<tr>
<th>Phase</th>
<th>2021</th>
<th>2022</th>
<th>2023</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>OCT-NOV</td>
<td>DEC-JAN</td>
<td>FEB-MAR</td>
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<tr>
<td>Events</td>
<td>Kick-off (11/3)</td>
<td>Learning Session 1 (12/2)</td>
<td>Topical Webinar 1 (3/3)</td>
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<tr>
<td>Deliverable (Data)</td>
<td>CAT Baseline</td>
<td>Data Abstraction</td>
<td>Patient Interviews</td>
</tr>
<tr>
<td></td>
<td>Patient Surveys</td>
<td>Project Roadmaps</td>
<td>Revise Roadmaps</td>
</tr>
<tr>
<td>Activities</td>
<td>• Test / Refine / Implement</td>
<td>• Collect Improvement Data</td>
<td>• Quarterly Progress Reports</td>
</tr>
</tbody>
</table>

**ABHE Program Timeline**
Advancing Behavioral Health Equity in Primary Care

Where We Are Focusing

- Senior Leadership & Organizational Commitment
- Data Driven Systems
- Access to Care
- Integrated Care Team & Care Delivery
- Patient Activation & Self-Management
- Community Partnerships

Health Equity

Patient & Family Engagement

Culture of Improvement
Strengthening Team's Use of Project Tools, Data and Measures
(1) Patient Interviews & CAT
What areas do we have the most opportunity to impact for our patients?
What aligns with our organization strategy? (e.g., pops of focus, site focus, clin/ops/fin goals)

(2) Universal Measure Set
Further refine focus: What measures do we have the most opportunity to impact?
How do these align with the CAT and our areas of focus?

(3) Dashboard / Measures
What process measures will help balance the universal measures?
What measures should we monitor routinely in a dashboard?

Identify opportunity, make change, monitor and improve.
Assessing Program Impact

- **Tools to guide team focus**

- PDSA cycles to test change and improve measure performance

- Patient Interviews & CAT
- Roadmap & Charter
- Universal Measure Set
- Dashboard / Measures of Focus
Putting the pieces together

What are we trying to achieve?

Roadmap & Charter

AIM Statement

CSC aims to provide equitable care for Asian American patients seeking primary care and behavioral health services by May 2023, as measured by:

1. An increase in the annual number of referrals from the medical department to the behavioral health department by 50% (from 210 referrals in 2021 to 315 referrals)
2. An increase in patients in screened for depression from 74% to 90%
Where can we improve capabilities to better serve our patients?

Driving our efforts...

Listening to the voice of all patients.

The health center staff wants to improve BHE, but patient and client input to improve BHE care is obtained indirectly (e.g., through patient comments and surveys). A more focused and structured approach is being considered.

Patients and clients are authentically engaged in understanding of their life experiences, how to improve access to care and information, and how to improve communication and collaboration with the care team. Staff members meet regularly with patients and clients to better understand community strengths, challenges, and historical disinvestment so they can effectively provide BHE care.

Patients and clients that reflect the community makeup (language, race, ethnicity and SOGI) are engaged in regular meetings using mixed modes (in-person, email, smartphone, etc.) to inform equitable care practices. Staff actively build relationships with the community and community partners to understand BHE needs and provide equitable care.

Patient and clients representing the communities served systematically inform (e.g., via patient and family advisory councils or boards, focus groups, peer navigators) and drive strategic efforts to improve BHE in meeting their whole care needs.
### Data Element ID Description and Response Options

<table>
<thead>
<tr>
<th>Data Element ID</th>
<th>Description and Response Options</th>
<th>Denominator</th>
<th>Numerator</th>
</tr>
</thead>
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<td>ABHE_4</td>
<td>Depression Utilization of the PHQ-9 Tool (NQF 0712e)</td>
<td>Number of patients 18 years of age and older with an office visit and a diagnosis of major depression or dysthymia.</td>
<td>Number of patients 18 years of age and older with a diagnosis of major depression or dysthymia who also completed the PHQ-9.</td>
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<td>67</td>
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<tr>
<td>ABHE_4_2</td>
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<td>67</td>
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<tr>
<td>ABHE_4_4</td>
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<td>45</td>
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<td>ABHE_4_5</td>
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<td>9</td>
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<td>1</td>
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<td>ABHE_4_14</td>
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</table>

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**Putting the pieces together**

*Which UMS measure(s) will help us assess improvement?*

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**Universal Measure Set**

May also monitor related UDS measures.
Putting the pieces together

How can we track periodic progress of our efforts?

BH Services & Screening Tool Use

<table>
<thead>
<tr>
<th>BH Services &amp; Screening Tool Use</th>
<th>BH SERVICES OFFERED</th>
<th>Comments / clarification</th>
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</thead>
<tbody>
<tr>
<td>BH SERVICES OFFERED</td>
<td>Substance Use Disorder Treatment</td>
<td>Yes</td>
</tr>
<tr>
<td>Substance Use Disorder Treatment</td>
<td>Behavioral medicine techniques (e.g., relaxation training, sleep promotion)</td>
<td>Yes</td>
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<tr>
<td>Behavioral medicine techniques (e.g., relaxation training, sleep promotion)</td>
<td>Motivational interviewing</td>
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</tr>
<tr>
<td>Motivational interviewing</td>
<td>Stages of change model</td>
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</tr>
<tr>
<td>Stages of change model</td>
<td>Health behavior change interventions related to smoking, alcohol abuse, and obesity</td>
<td>Yes</td>
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<tr>
<td>Health behavior change interventions related to smoking, alcohol abuse, and obesity</td>
<td>Group interventions</td>
<td>Yes</td>
</tr>
<tr>
<td>Group interventions</td>
<td>Chronic disease management</td>
<td>Yes</td>
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<tr>
<td>Chronic disease management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Dashboard / Measures of Focus

ABHE Improvement Dashboard Chinatown Services Center
Reporting Period: Q2 2022

CAT DRIVERS OF FOCUS

Measures of Focus

CAT Drivers

UMS, SDOH, Internal measures
Putting the pieces together

CSC Change Ideas
Area of Focus: Clear roles and develop integration workflow
Prioritize Changes:
1. **Utilize interdepartmental meetings**/mutual patient consultations to clearly introduce and identify roles and capacity of each department/provider
2. **Develop clear and concise workflows** on how to conduct internal referrals and train all staff to understand the workflow (including triggers on when it is appropriate to make the referrals, i.e. mild to moderate emotional distress)
3. Discuss and develop means to track referrals and how to follow up with both provider and patient

What change ideas can we test to improve our capabilities and impact measures of focus?

PDSA cycles to test change and improve measure performance
Monitor progress and refine as needed

- Assessments at baseline, midpoint, endpoint, post program
- Selected measures quarterly in Improvement Dashboard

PDSA cycles to test change and improve measure performance
Improving Behavioral Health Equitable Care In Our Organization

The opportunity and why it’s important to the patients we serve

How we assessed where to improve

The ways we tested changes

The measurable impact we made

Center for Care Innovations
How well is your team leveraging data and information to inform your improvement journey?

Instructions

• Take a moment to reflect on the poll question.
• Respond to the question.
Tips on data and measures hygiene

- Periodically revisit your AIM statement, drivers and sub-goals that contribute to AIM achievement, and measures of focus, to ensure they are all aligned.

- Give your team permission to de-prioritize activities or measures if there are too many.

- Identify measure “two-fers” where team efforts improve both.

  For example:
  - CAT driver “MH screening workflows and R&R” & “UMS depression screening”
  - CAT driver “MH/PC team integration” & “UMS HTN BP control improvement”

  If these correlations are not occurring, assess why.

- Ensure PDSA cycles are in support of AIM statement and other measures of focus.

- Change and improvement takes time. Consider staggering expectations.

  For example:
  - Measure 1 improvement in Q1-Q2. Measure 2 improvement in Q3-Q4.
Using Data to Improve Outcomes: A Team-Based Approach
Using Data to Improve Outcomes

• Building the Team
• Using Data to Improve Outcomes
• Using Health Equity Data to Improve Outcomes for All
• The Next Chapter...
Building the Team

• IT and Clinical Teams Integration
  • Living in Two Different Worlds
  • Speaking Two Different Languages
• IT and Clinical Collaboration
• HIT Toolkit Development
Using Data To Improve Outcomes
The Importance of Data Collection
CHS Data Warehouse

**Data Sources**
- Biometric Patient Data
- EHR Data
- Claims Data
- Pharmacy Data
- HIE Data
- Payor Data
  - Risk Scores
  - Rosters
  - Cost

**Data Warehouse**

**Business Intelligence**
- Data Mining
- Reporting
- Analytics
CHS Data Warehouse

- Provides interactive on-demand reporting
  - Quality metrics (UDS, PCMH, THL)
  - Outreach reports for non-compliant patients
- Patient Dashboard
- Predictive modeling
- Executive summary dashboard reports
- Population Management and Care Coordination
Population Management & Care Coordination

Daily automated integrated treatment opportunities reports
# Cherokee Health Systems Point of Care Report

## Appointment Info:
- **Date:** 05/24/2021 12:00PM
- **Time:** 05/24/2021 12:00PM
- **Name:** Thomas, PNP, Anna M
- **Visit:** Nurse Visit
- **DOB:** 09/09/2000
- **Age:** 22
- **Sex:** F

## Allergies
- **Penicillin's**
- **Sulfa (Sulfonamide Antibiotics)**

## Primary Care Diagnoses
- J44.9: Chronic obstructive pulmonary disease, unspecified
- O47.00: Insomnia, unspecified
- M29.051: Pain in right hip
- E00.9: Hypothyroidism
- I10: Hypertension
- I35.0: Aortic valve stenosis, unspecified etiology
- N81.0: Osteoporosis
- J44.9: Chronic obstructive pulmonary disease, unspecified
- I10: Hypertension
- J44.9: COPD

## Behavioral Diagnoses
- F11.20: Opioid dependence, uncomplicated
- F10.20: Sedative, hypnotic or anxiolytic dependence, uncomplicated
- F14.10: Cocaine abuse, uncomplicated
- F32.9: Major depressive disorder - single episode, unspecified
- F11.21: Opioid use disorder, moderate, in early remission, on

## Problems
- **Chronic**
  - Right hip pain
  - Acne keratosis
  - Acute cystitis with hematuria
  - Aortic valve insufficiency, etiology of cardiac valve disease unspecified
  - Aortic valve stenosis, unspecified etiology
  - Calculus of gallbladder with acute cholecystitis without obstruct

## Measures and Calculations
- **BMI:** 20.67 (12.00)
- **BP:** 179/78
- **BP:** 179/78
- **BP:** 179/78
- **BMI:** 22.68 (14.00)
- **BP:** 101/72

## Lab Results
- **Cholesterol:** 214 03/12/2019
- **GFR:** 74 03/12/2019
- **Glucose:** 80 03/12/2019
- **HbA1C:** 5.2 03/12/2019
- **HDL:** 63 03/12/2019
- **INR:** 1.1 06/04/2014
- **LDL:** 110 03/12/2019
- **Triglycerides:** 180 03/12/2019
- **TSH:** 74.24 03/12/2019

## Medications
- **Albuterol sulfate HFA 90 mcg/actuation aerosol inhaler 10 mg tablet**
- **Levodopa 150 mcg tablet**
- **Lisinopril 20 mg tablet**
- **Mucormycin nasal spray 10 mg tablet extended release 24 hr**
- **Finasteride 5 mg tablet**
- **Vitamin D 100 mcg capsule**
- **Flaxseed 8 mg sublingual film**

## Care Team
- **PCP:** Health FNP, Lindsey Jean
- **TRT:** Christian, King MD, Darius House
### Care Team

<table>
<thead>
<tr>
<th>Type</th>
<th>Provider Name</th>
<th>Event</th>
<th>Time</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>PCP</td>
<td>Wallace MD, Febe</td>
<td>BH 45 Therapy</td>
<td>01:50 PM</td>
<td>06/16/2016</td>
</tr>
<tr>
<td>TX</td>
<td>Freeman MD, Dennis</td>
<td>DT Extraction/Procedure</td>
<td>02:10 PM</td>
<td>06/16/2016</td>
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<tr>
<td>PC</td>
<td>Perry MD, Gregory</td>
<td>BH Hgt Pay 15</td>
<td>11:30 AM</td>
<td>06/16/2016</td>
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</table>

### Future Appointments

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<th>Event</th>
<th>Time</th>
<th>Date</th>
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<tbody>
<tr>
<td>Freeman MD, Dennis</td>
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<tr>
<td>Perry MD, Gregory</td>
<td>BH Hgt Pay 15</td>
<td>11:30 AM</td>
<td>06/16/2016</td>
</tr>
</tbody>
</table>

### Self Management

- **Goal**: Become more human.
- **Status**: In Progress.

### Diagnoses

#### Cardiac Conditions

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
<th>Start Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>250.00</td>
<td>DM, uncomplicated, type II</td>
<td>In Progress</td>
<td>06/17/2019</td>
</tr>
<tr>
<td>272.4</td>
<td>Hyperlipidemia NCD/ACOS</td>
<td>In Progress</td>
<td>06/17/2019</td>
</tr>
<tr>
<td>401.1</td>
<td>Hypertension, benign essential</td>
<td>In Progress</td>
<td>06/17/2019</td>
</tr>
</tbody>
</table>

#### Behavioral

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Axis</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>F41.1</td>
<td>GAD (generalized anxiety disorder)</td>
<td>In Progress</td>
<td>06/17/2019</td>
</tr>
<tr>
<td>F06.30</td>
<td>Mood disorder due to a general medical condition</td>
<td>In Progress</td>
<td>06/17/2019</td>
</tr>
</tbody>
</table>

### Treatment Opportunities

<table>
<thead>
<tr>
<th>Opportunity</th>
<th>Last Date</th>
<th>Last Result</th>
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</thead>
<tbody>
<tr>
<td>Diabetes Cases A1C Poor Control (3 or higher)</td>
<td>03/22/2019</td>
<td>9.2</td>
</tr>
<tr>
<td>Diabetes Cases Retinal Eye Exam</td>
<td>09/10/2017</td>
<td>CG</td>
</tr>
<tr>
<td>ER / Inpatient Alerts - 2 or more in the last 30 days (3)</td>
<td>N/A</td>
<td>N/A</td>
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</table>

### Labs

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td>Cholesterol</td>
<td>241</td>
<td>03/13/2015</td>
</tr>
<tr>
<td>HRAIC</td>
<td>5.6</td>
<td>03/15/2015</td>
</tr>
<tr>
<td>HCT</td>
<td>41</td>
<td>03/13/2015</td>
</tr>
<tr>
<td>INR</td>
<td>0.6</td>
<td>03/13/2015</td>
</tr>
<tr>
<td>LDL</td>
<td>168</td>
<td>03/13/2015</td>
</tr>
<tr>
<td>Triglycerides</td>
<td>185</td>
<td>03/13/2015</td>
</tr>
<tr>
<td>TSH</td>
<td>2.692</td>
<td>03/13/2015</td>
</tr>
</tbody>
</table>

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**Note:** The information is extracted from a screenshot of a patient dashboard from Cherokee Health Systems. The highlighted sections indicate specific entries and dates relevant to patient care and appointments.
Communication
HIE & Payor Data Integration with EHR

- Automated tasks created for admissions, discharges and transfers
- Appears on Patient Dashboard
## Quality Measure Focus

### TN PCMH Measure Focus

<table>
<thead>
<tr>
<th>Measure</th>
<th>MCO</th>
<th>Benchmark</th>
<th>CHS Current Benchmark</th>
<th>NUM</th>
<th>DEN</th>
<th>Gap Closures Needed to Unlock Star</th>
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<tbody>
<tr>
<td>Adolescent Immunizations</td>
<td>AGP</td>
<td>≥225%</td>
<td>24.51%</td>
<td>75</td>
<td>306</td>
<td>5</td>
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<tr>
<td>Diabetic Eye Exam</td>
<td>AGP</td>
<td>≥51%</td>
<td>22.02%</td>
<td>48</td>
<td>218</td>
<td>64</td>
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<tr>
<td>Diabetic Eye Exam</td>
<td>UHC</td>
<td>≥51%</td>
<td>36.72%</td>
<td>112</td>
<td>305</td>
<td>44</td>
</tr>
</tbody>
</table>

**Strategy Plan**
- **Adolescent Immunizations**
  - Targeted Outreach – Payer Specific
- **Diabetic Eye Exam**
  - Targeted Outreach – Payer Specific
  - Maximize RetinaVue scheduling until year-end

### UDS Measure Focus

<table>
<thead>
<tr>
<th>Measure</th>
<th>Benchmark</th>
<th>CHS Current Benchmark</th>
<th>NUM</th>
<th>DEN</th>
<th>Gap Closures Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic Vascular Disease</td>
<td>≥90%</td>
<td>86.80%</td>
<td>1,577</td>
<td>1,820</td>
<td>61</td>
</tr>
<tr>
<td>Statin Rx for CVD</td>
<td>≥80%</td>
<td>75.10%</td>
<td>4,152</td>
<td>5,532</td>
<td>274</td>
</tr>
</tbody>
</table>

**Strategy Plan**
- **Ischemic Vascular Disease**
  - Targeted Outreach
  - Need Rx (e.g., aspirin) if clinically appropriate
- **Statin Rx for CVD**
  - Targeted Outreach
  - Need Rx for statin if clinically appropriate

**Goal** - Promote targeted focus on performance measure progress and opportunities
## Executive Summary UDS Dashboard

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
<th>Measures at or above target: 7 of 18</th>
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</thead>
<tbody>
<tr>
<td>Adult Weight Screening (Line 13)</td>
<td>94%</td>
<td>89%</td>
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<tr>
<td>Breast Cancer Screening</td>
<td>40%</td>
<td>44%</td>
</tr>
<tr>
<td>Cervical Cancer Screening (Line 11)</td>
<td>53%</td>
<td>47%</td>
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<tr>
<td>Childhood Immunization (Line 16)</td>
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<td>53.9%</td>
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<td>Colorectal Cancer Screening (Line 19)</td>
<td>38%</td>
<td>31.0%</td>
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<tr>
<td>Dental Sealants</td>
<td>80%</td>
<td>90.9%</td>
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<tr>
<td>Depression Remission at Twelve Months</td>
<td>50%</td>
<td>21.5%</td>
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<tr>
<td>Early Entry Into Prenatal Care</td>
<td>64%</td>
<td>66.0%</td>
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<tr>
<td>HIV Screening</td>
<td>50%</td>
<td>30.4%</td>
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<td>Ischemic Vascular Disease (Line 18)</td>
<td>90%</td>
<td>85.7%</td>
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<td>Location</td>
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<td>BCS</td>
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<tr>
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<td>30%</td>
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## Provider Interactive Dashboard

### Provider Summary

#### Coffey FNP-BC, Carla Renee

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<th>Target %</th>
<th>Coffey FNP-BC, Carla Renee %</th>
<th>CHS 5th Street %</th>
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<td>UDS</td>
<td>Adult Weight Screening</td>
<td>93%</td>
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<td>UDS</td>
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Showing 1 to 11 of 11 entries (filtered from 38 total entries)
What Has Worked For Us?

Relationship Building
- Clinician on EHR team
- Communicate often

Understanding Different Worlds
- Clinicians understand IT’s parameters and goals
- IT understands clinical flow and goals
Improving Outcomes: Quality Measures

- Depression Remission
- CHS Baseline: 6.6%
- CHS Current: 18/8%
- National: 13.8%
Improving Outcomes: Quality Measures

What we did:

• Staff Trainings
  • → Check the numbers

• Creating Alerts
  • → Check the numbers

• Standard Screening Protocols
  • → Check the numbers

• Staff Meeting Updates
  • → Check the numbers

• Opportunity Report
  • → Check the numbers
The Next Step: Developing a Health Equity Lens

- The Turning Point
- Health Equity Committee
- Data Collection
  - Clinic Processes – SOGI
  - State of Health Equity Report
  - Weekly Health Equity Summary Report
## UDS Health Equity Summary - Birth Sex

**Summary for reporting period ending August, 08 2022 - Report Group: All CHS**

<table>
<thead>
<tr>
<th>Target</th>
<th>BMI Acut</th>
<th>BCS</th>
<th>Pap</th>
<th>IMI</th>
<th>CDKNLX</th>
<th>Serlfnt</th>
<th>Dp Fndltion</th>
<th>Trnslqtr</th>
<th>HIV Sclen</th>
<th>MD</th>
<th>Dgg Sclen</th>
<th>Sttln Tx</th>
<th>Dlltss</th>
<th>Hynprsn</th>
<th>Brfhwrght</th>
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</tr>
</tbody>
</table>

*Primary Behavioral Health INTEGRATED CARE Training Academy*
## UDS Health Equity Summary - Ethnicity

Summary for reporting period ending August, 08-2022 - Report Group: All CHS

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<thead>
<tr>
<th>Target</th>
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<th>StIats</th>
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<th>HIV Screen</th>
<th>IVD</th>
<th>Deep Screen</th>
<th>StIats Tr</th>
<th>Diabetes</th>
<th>Hypertension</th>
<th>Birthweight</th>
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## UDS Health Equity Summary - Gender Identity

Summary for reporting period ending August, 08 2022 - Report Group: All CHS

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<th>Syphilis</th>
<th>HPV/Ev</th>
<th>Trimestr</th>
<th>HIV/Screen</th>
<th>HCV/Screen</th>
<th>IVD</th>
<th>Chlamydia</th>
<th>Diabetes</th>
<th>Hypertension</th>
<th>BMI Weight</th>
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# UDS Health Equity Summary - Sexual Orientation

Summary for reporting period ending August, 08 2022 - Report Group: All CHS

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*Summary for reporting period ending August, 08 2022 - Report Group: All CHS.*
Improving Outcomes: Health Equity

- Weekly review of health equity report
- Disparity identified - Low birth weight in 79% of Black/African American OB patients
- Reached out to local leaders to collaborate and established informal birth coalition
- The story continues...
QUESTIONS
Let’s Reflect!
Prompts

1. Based on what you’ve heard, what are the bright spots that you can build on?

2. What are some of the best practices that your team can adopt?

Instructions

• Prompt 1: (12-minutes)
  • Each person has 2-min to share their reflections.
  • Each person has 2-min to add to what’s been shared.

• Prompt 2: (3-minutes)
  • Each person has 1-min to share a best practice.

• Reconvene Teams
  • Volunteers to share reflections with cohort.
Best Practices

• Align your aim statements & data sources
• Spread out your change ideas across the program
• Develop PDSAs that support your project goals
• Strengthen relationships between departments
• Develop your data warehouse processes
• Review data charts to identify opportunity areas
• Commit to debriefing data reports with your team

Reminder:
Small, incremental, progress leads to long-lasting change!
What are some of the best practices that your team can adopt?

Instructions

• Take 30-seconds to reflect on the prompt
• Type your response in the chat box.
• Don't click "send" yet!
• Wait for Juan Carlos to say "click send"
Sharing Your Journey through the Storyboard
Part 1: Introducing Your Organization and Team
Part 2: Defining Your Project Goals and Measures

Our Case for Change

Opportunity for change:
- Current context and data that supports your “why”
  - Description of your community including region, city, population, and behavioral health needs.
  - Description of the current state of your organization including current behavioral health services and team members.

What we learned from our patients:
- List lessons learned from patient interviews including:
  - What opportunity areas did they identify?
  - What surprised you?

Centering equity in our work:
- Describe how your team plans to integrate equity as it relates to SH Integration.

What We Set Out to Accomplish

Outline: the problem you are trying to solve:
- Summarize your rehab from the “Our Case for Change” to describe why this matters for your patients, clinic staff, and organization.

 Aim Statement:
- Pull “aim statements” directly from project roadmap (e.g., what will you improve? For whom? By when? By how much?):
  - Example: By May 2023, [insert organization name] will improve [outcome measure] for [population of focus] as measured by:
    - [Process measure 1] from [baseline data] to [target data]
    - [Process measure 2] from [baseline data] to [target data]
    - [Process measure 3] from [baseline data] to [target data]

What We Tested

<table>
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<tr>
<th>Change concept</th>
<th>Objective of test</th>
<th>Why did you do it?</th>
<th>What question did you want to answer with this test?</th>
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<td>3</td>
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Part 3: Sharing Lessons from Your Data & Patient Stories

Measure of Focus #

What We Heard

Barriers We Faced

What We Accomplished

What We Learned
Part 4: Sharing Your Plan to Continue the Work

Our Sustainability Plan

<table>
<thead>
<tr>
<th>Actions (What)</th>
<th>Measure (Data)</th>
<th>Leads (Who)</th>
<th>Operationalize (How)</th>
<th>Comments</th>
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</thead>
<tbody>
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<td>Action 1</td>
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<td>Action 2</td>
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<td>Action 3</td>
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<td>Action 4</td>
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</tbody>
</table>

Additional Supports

1. Insert text here....
2. Insert text here....
3. Insert text here....
Closing & Next Steps
## Poll Questions

1. Please select the number that best represents your experience with today’s session.
   - 5 – Excellent
   - 4 – Very Good
   - 3 – Good
   - 2 – Fair
   - 1 – Poor

2. Please select the number that best represents your response to the statement: Today's session was a valuable use of my time.
   - 5 – Strongly Agree
   - 4 – Agree
   - 3 – Neutral
   - 2 – Disagree
   - 1 – Strongly Disagree

3. Please select the number that best represents your response to the statement: "Today’s session presented information in a way that was accessible to me”
   - 5 – Strongly Agree
   - 4 – Agree
   - 3 – Neutral
   - 2 – Disagree
   - 1 – Strongly Disagree

4. Please select the number that best represents your response to the statement: "I know what is expected of my team over the next few months."
   - 5 – Strongly Agree
   - 4 – Agree
   - 3 – Neutral
   - 2 – Disagree
   - 1 – Strongly Disagree
1. 9/2: Midpoint CAT due
2. 9/19-9/20: Site Visit at Cherokee Health Systems
3. 10/26: Register for learning session 3
4. 10/26: Q3 Improvement dashboard due
5. 10/26: Q3 Quarterly reflection due
Site Visit Sneak Peek

We’re Coming Together In-Person!

**When & Where**
Two-day site visit at CHS in Knoxville, TN from 9/19 - 9/20

**Topics**
- Leveraging Community Partnerships & Patient Voices as Data
- Integrated Care Planning and Implementation
- Using Data to Inform Improvement
- Integrated Care Clinical Model
- Clinical Roles Differentiation
- Equity in Health Care

**Activities**
- Tour of the Facility
- Panel Discussions
- Group Workshops
- Patient Testimonials
- Wine & Cheese Reception (Meet Your Peers)
- Dinner with the CCI Team (Meet the CCI Team)
Stay Connected

Email
- Reach out to the CCI team if you have questions about upcoming events, activities, or program components.

Program Club
- Log in to access public forums and get updates about program announcements, assignments, and resources.

Newsletters & Bi-monthly Buzz
- Learn about upcoming events, activities, and resources.

Meetings with Coaches
- Meet with your coach to thought partner and troubleshoot program challenges.
Questions

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Thank you!