INTEGRATING SCREENING FOR SOCIAL DETERMINANTS OF HEALTH INTO CLINICAL PRACTICE AS AN INTEGRAL PART OF QUALITY IMPROVEMENT

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RYAN M. BUCHHOLZ, MD, FAAP
LEARNING OBJECTIVES

• Increase awareness about the PRAPARE tool and implementation plan for screening social determinants of health
• Increase understanding of framework for addressing SDH
• Increase comprehension of how SDH can be integrated into quality improvement
DISCLOSURES

• Neither we nor our immediate family members have had a beneficial financial relationship/arrangement or affiliation (activities for which remuneration is received or expected) with one or more commercial organizations that could be perceived as a real or apparent conflict of interest.

• A commercial interest is defined as a proprietary entity producing health care goods and services, with the exception of non-profit or government organizations.
Level of Diabetes Control

7/2011: Ryan meets Mr. Thomas for the first time
7/2011: Ryan meets Mr. Thomas for the first time.
Founded in 1985 as Health Care for the Homeless Project
Became a Federally Qualified Health Center in 1996
Began providing health care in the DC Jail in 2006
Currently operate over 25 sites throughout the District
promoting healthier communities through compassion and comprehensive health and human services

UNITY SITES

• 10 Community Health Centers
• 10 Medical Sites in Homeless Shelters
• 4 School-Based Health Centers
• 1 Mobile Van
• Health Services in DC Jail
• Homeless Outreach
HOMELESS SERVICES
OUTREACH AND MEDICAL RESPITE

• Serve 10 homeless sites, including emergency shelters
• Two medical respite programs: Christ House, a free standing 34-bed facility for men, and Pat Handy, a shelter based program with 12 medical respite beds for women
• Mobile van and walking outreach bring health care to those living on the streets
WHO WE SERVE
2016

- Total of 106,853 patients served; 532,202 visits
  - 10,443 patients experiencing homelessness
  - 8,033 patients who are incarcerated
- 69% are African American
- 18% are Hispanic
- 68% of patients have income below the federal poverty level

promoting healthier communities through compassion and comprehensive health and human services
WHO WE SERVE
2014 INSURANCE COVERAGE

- 61% of our patients have Medicaid
- Unity has Enrollment Specialists at various sites to help individuals sign-up for health insurance through DC Health Link

promoting healthier communities
through compassion and comprehensive health and human services
7/2011: Ryan meets Mr. Thomas for the first time
Level of Diabetes Control

7/2016:
Ryan meets Mr. Thomas for the first time
7/2011: Ryan meets Mr. Thomas for the first time.

7/2016: Mr. Thomas loses his home and refrigerator, his stability.

Level of Diabetes Control

A1c %

Date

Level of Diabetes Control

7/2016: Mr. Thomas loses his home and refrigerator, his stability.

7/2011: Ryan meets Mr. Thomas for the first time.
Social determinants of health account for 90% of an individual’s health status, but our current healthcare system only address the remaining 10% (McGinnis, et. al, 2002). Despite strong evidence linking patients’ social circumstances to their health, little guidance exists for health care practitioners and institutions on addressing social needs in clinical settings.
WHO Framework for Tackling SDH Inequities

Key dimensions and directions for policy

Intersectoral Action

- Policies on **stratification** to reduce inequalities, mitigate effects of stratification
- Policies to reduce **exposures** of disadvantaged people to health-damaging factors
- Policies to reduce **vulnerabilities** of disadvantaged people
- Policies to reduce **unequal consequences** of illness in social, economic and health terms

Social Participation and Empowerment

- Monitoring and follow-up of health equity and SDH
- Evidence on interventions to tackle social determinants of health across government
- Include health equity as a goal in health policy and other social policies
PROVIDERS NEED TOOLS TO CAPTURE AND STRATIFY PATIENTS BY SDH

How well do we know our patients?

Are services addressing SDH sustainable?

Are community partnerships adequate and integrated?

# PRAPARE IMPLEMENTATION AND ACTION TOOLKIT

www.nachc.org/prapare

## Chapter 1: Understand the PRAPARE Project

## Chapter 2: Engage Key Stakeholders

## Chapter 3: Strategize the Implementation Process

- Chapter 4: Technical Implementation with EHR Templates
- Chapter 5: Develop Workflow Models
- Chapter 6: Develop a Data Strategy
- Chapter 7: Understand and Evaluate Your Data

- Chapter 8: Build Capacity to Respond to SDH Data
- Chapter 9: Respond to SDH Data with Interventions
- Chapter 10: Track Enabling Services
GOALS & OBJECTIVES

EHR integration
- Work with IT department integrating the PRAPARE tool into ECW
- Develop smart form which automatically tabulates the responses
- Ensure the data can be extracted and reportable

Work flow development
- Run a pilot for 4 weeks to evaluate work flow options
- Work with multidisciplinary team to finalize clinic work flow

Staff education
- Develop webinar with the multidisciplinary QI team
- Present live webinar in a team based training

Screening
- Go live the day after the webinar with screening and addressing SDH
- Have data team provide monthly reports which include screening tool responses and number of patients being screened
Outcomes & Measurement

Integration of the screening tool into ECW
- Integrate the PRAPARE tool into social history part of the clinical note
- Utilize smart form for automatic tabulation of the tool
- Test the tool in ECW for structured data and ability to create reports from the responses to the tool

Develop work flow
- Pilot the screening tool at two sites to develop a final work flow
- The pilot will run for 4 weeks and then based off of all staff input a final work flow will be developed explaining exactly how, when, by whom, and where a patient will be screened for SDH

Provide SDH education intervention to all clinical staff
- A webinar training about SDH, healthcare disparities, and the PRAPARE tool will be provided live to all 500 clinical staff. Staff will watch the webinar with their PCMH team.
- The webinar will be based on adult learning theory and a post-test will be administered following the webinar and again 4 weeks later

Screen patients for SDH
- Social workers and providers will begin to screen patients for SDH using the PRAPARE smart form in ECW
- A report will be run monthly to evaluate how many patients were screened and how many were referred for additional services.
A post-education survey via survey monkey was sent out to all clinical staff after the webinar evaluating the presentation and if we met the education objectives.

Four weeks after the webinar, another survey monkey was sent out evaluating knowledge, attitudes, and perceptions of the training and the PRAPARE tool.

Reports will be prepared by the data team monthly on an excel spreadsheet by extraction of the PRAPARE tool responses using the clinical information systems from the EHR E-Clinical Works. The report will be de-identified of patient data, but will include provider names.
PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences

• Unity Healthcare cares about you as a whole person. Your health is just one part of who you are and the other parts include the social determinants of health. This includes where you work, play, and live. These are called the social determinants of health.

• To better meet your needs we are asking a series of questions to evaluate your social determinants of health. If you need assistance completing this form or have questions, please don’t hesitate to let a medical assistant know. Thank you for taking the time to complete this survey.
### Personal Characteristics

1. Are you Hispanic or Latino?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>I choose not to answer this question</th>
</tr>
</thead>
</table>

2. Which race(s) are you? Check all that apply.

<table>
<thead>
<tr>
<th>Asian</th>
<th>Native Hawaiian</th>
<th>Black/African American</th>
<th>Other (please write)</th>
<th>I choose not to answer this question</th>
</tr>
</thead>
</table>

3. At any point in the past 2 years, has season or migrant farm work been your or your family’s main source of income?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>I choose not to answer this question</th>
</tr>
</thead>
</table>

4. Have you been discharged from the armed forces of the United States?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>I choose not to answer this question</th>
</tr>
</thead>
</table>

5. What language are you most comfortable speaking?

<table>
<thead>
<tr>
<th>English</th>
<th>Language other than English (please write)</th>
<th>I choose not to answer this question</th>
</tr>
</thead>
</table>

### Money & Resources

7. What is your housing situation today?

<table>
<thead>
<tr>
<th>I have housing</th>
<th>I do not have housing (staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, or in a park)</th>
<th>I choose not to answer this question</th>
</tr>
</thead>
</table>

8. Are you worried about losing your housing?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>I choose not to answer this question</th>
</tr>
</thead>
</table>

9. What address do you live at?

<table>
<thead>
<tr>
<th>Street:</th>
<th>City, State, Zipcode:</th>
</tr>
</thead>
</table>

### Family & Home

10. What is the highest level of school that you have finished?

<table>
<thead>
<tr>
<th>Less than high school degree</th>
<th>High school diploma or GED</th>
<th>More than high school</th>
<th>I choose not to answer this question</th>
</tr>
</thead>
</table>

11. What is your current work situation?

<table>
<thead>
<tr>
<th>Unemployed</th>
<th>Part-time or temporary work</th>
<th>Full-time work</th>
<th>I choose not to answer this question</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Otherwise unemployed but not seeking work (e.g., student, retired, disabled, unpaid primary care giver) Please write:</th>
<th>I choose not to answer this question</th>
</tr>
</thead>
</table>

12. What is your main insurance?

<table>
<thead>
<tr>
<th>None/uninsured</th>
<th>Medicaid</th>
<th>CHIP Medicaid</th>
<th>Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other public insurance (not CHIP)</td>
<td>Other Public Insurance (CHIP)</td>
<td>Private Insurance</td>
<td></td>
</tr>
</tbody>
</table>
13. During the past year, what was the total combined income for you and the family members you live with? This information will help us determine if you are eligible for any benefits.

I choose not to answer this question

14. In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Utilities</td>
<td>Child Care</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Phone</td>
<td>Other (please write):</td>
</tr>
</tbody>
</table>

I choose not to answer this question

Optional Additional Questions

17. In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

I choose not to answer this question

18. Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply.

| Yes, it has kept me from medical appointments or from getting my medications |
| Yes, it has kept me from non-medical meetings, appointments, work, or from getting things that I need |
| No |

I choose not to answer this question

19. Are you a refugee?

| Yes | No |

I choose not to answer this question

20. What country are you from?

| United States | Country other than the United States (please write): |

16. Stress is when someone feels tense, nervous, anxious, or can’t sleep at night because their mind is troubled. How stressed are you?

| Not at all | A little bit |
| Somewhat | Quite a bit |
| Very much | I choose not to answer this question |

21. Do you feel physically and emotionally safe where you currently live?

| Yes | Unsure | No |

I choose not to answer this question

22. In the past year, have you been afraid of your partner or ex-partner?

| Yes | Unsure | No |
| I have not had a partner in the past year |

I choose not to answer this question

For more information about this tool, please contact Michelle Jester at mjester@nachc.org or visit the "Social Determinants of Health Resources" folder at http://www.healthcarecommunities.org/ResourceCenter.aspx
WORK FLOW: NURSE VISITS & Case Manager Visits

Pt arrives for nurse visit and registers with PRC
NCM reads script to the patient
NCM reads through questions with the patient
Enters responses into ECW
Develops care plan that matches the Pt’s resources

Pt arrives for case management visit and registers with PRC
CM reads script to the patient
CM reads through questions with the patient
Enters responses into ECW
Identifies SDH priorities to address
Patient presents to clinic for a visit with a primary care provider

- Staff identifies a patient who...
  1. Is 18 year old or older
  2. Has not completed the PRAPARE tool within the last 12 months
  3. Has an appointment with their primary care provider

- MA performs intake

  - MA reads the PRAPARE script to the patient and assesses if the patient is able to complete independently.
  - Is the patient able to read in English or Spanish?

  - **YES**
    - Hand the PRAPARE tool to the patient. The patient will complete the tool independently while waiting for the provider
  
  - **NO**
    - The MA will read the questions to the patient directly and assist the patient in completing the screening tool

- The MA will input the information in the PRAPARE smart form in ECW for the provider to review.

- The provider reviews the completed tool, chooses enabling services, provides a treatment plan correlating with identified resources or barriers, and refers for additional services as needed.
CLOSING THE LOOP

Enabling Services:
- Once tool has been completed, choose an enabling service
- This will allow us to track how providers are addressing SDH
ORDER SET

To improve provider comfort addressing SDH, handouts addressing each determinant have been developed. They will be placed in an order set, in addition to helpful websites, and referrals.

**Resource guides** → Housing, domestic violence, mental health, addiction, LGBTQ, education, and employment

**Website Link** → Interfaith network resource guide website

**Referrals** → case manager & mental health clinician
The screening tool is a validated tool that was developed by the National Association for Community Health Centers (NACHC).

Utilizing the PRAPARE tool will allow the organization to compare the results nationally to other FQHCs.
SURVEY DATA

Staff Quotes
- “The PRAPARE tool was very helpful in addressing our patient’s needs”
- “It is now quick and easy”
- “The tool highlights issues that would not have come up during regular patient visits”
- “The tool has better helped us reach out to patient’s who are in need”
INITIAL SCREENING RESULTS

60 Patients screened
8.2 Average number of SDH identified
It is possible to move a mountain stone by stone (Chinese Proverb)
And that is what community medicine is all about!
6/2017: "I take real good pride in my health now."

7/2016: Mr. Thomas loses his home and refrigerator, his stability.

7/2011: Ryan meets Mr. Thomas for the first time.
QUALITY IMPROVEMENT
AT UNITY HEALTH CARE

promoting healthier communities
through compassion and comprehensive
health and human services
ALIGNING GOALS AND OBJECTIVES

**Goal**

- Unity is a great health care organization

**Critical Success Factors**

- We provide high quality care
- Patients have great care experiences
- Our staff are great
- We are financially healthy

**Necessary Conditions**

- No measures in the 4th Quartile
- Staff are courteous & helpful
- We recruit & retain capable staff
- We are stable & sustainable

**Necessary Conditions**

- Better quality on DM, PNC, LBW, CVD
- Customer serv. culture maintained
- Staff are supported
- We maintain + margins monthly
PATIENT CENTERED MEDICAL HOMES
(NCQA LEVEL III: 14 SITES)

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UNIFORM DATA SYSTEM

- **Diabetes Control**: The percentage of adults, age 18 to 75, with diabetes who have their blood sugar under control, defined as a HbA1c under 9 percent.
- **Timely Prenatal Care**: The percentage of pregnant women receiving prenatal care in the first trimester.
- **Hypertension Control**: The percentage of adults, age 18 to 85, with hypertension who have their blood pressure under control, defined as under 140/90.
- **Low Birth Weight**: The percentage of babies born with birth weight below 2,500 grams.
- **Childhood Immunization**: The percentage of children who receive 10 federally recommended vaccines by 2 years of age.
- **Cervical Cancer Screening**: The percentage of women, age 24 to 64, with at least one Pap test prior three years.
- **Asthma Therapy**: The percentage of patients age 5 to 40 who have persistent asthma who receive asthma drugs.

*Low Birth Weight is the only measure for which a lower number is better.

**Downloadable Data**: Full .CSV Spreadsheet Of All Data

Source: U.S. Health Resources and Services Administration

http://www.kaiserhealthnews.org/Stories/2012/April/18/community-health-centers-under-pressure.aspx

http://www.kaiserhealthnews.org/Stories/2012/April/18/community-health-center-chart.aspx
QI MEASURES

Access
- Trimester of Entry into Prenatal Care
- Access to care for patients with newly diagnosed HIV infection

Preventive Care
- Colon Cancer Screening
- Cervical Cancer Screening
- Depression Screening
- Pediatric immunizations
- Dental sealants for high-risk pediatric patients

Chronic Disease Care
- Aspirin therapy in patients with ischemic vascular disease
- Lipid medication in patients with heart disease

Outcomes
- Blood Pressure in patients with hypertension
- Low Birth Weight
- Hemoglobin A1c level in patients with diabetes
**Diabetes Control Improvement Plan**

**Leader:** Bob Holman

- **Strategic Focus:** Quality of Care and Services
- **Aspiration:** We provide high quality care and services

**Goals/Metrics:**
- Percent of UDS Measures in top 3 Quartiles at the end of 2014: 67% (current)
- Percent of UDS Measures in top 3 Quartiles by the end of 2016: 100% (goal)

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**9) Key Performance Indicator:** **Diabetes Control** - How Success is Measured: **Proportion of adult patients aged 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes (DM), whose most recent hemoglobin A1c (HbA1c) during the measurement year was greater than 9%, or was missing a result, or if an HbA1c test was not done during the measurement year.**

**Leaders:** Bob Holman, James Huang

**Benchmark (Source):** 68.8% is the national average among FQHCs, from [http://bphc.hrsa.gov/uds/datacenter.aspx](http://bphc.hrsa.gov/uds/datacenter.aspx).

**Unity Baseline:**
- 2012: 58.9% → 2013: 60.0% (3rd quartile) → 2014: 56.1% (4th quartile) → Q1 to Q3 2015: 54.1%

**Tactics to Improve**

1) Improve Data Capture among patients with diabetes (DM) and dissemination to teams:
   - a) Data team and QI team to generate quarterly lists (by provider and by health center) of patients with HbA1c > 9% (plus patients with missing HbA1c values) for care teams

2) Improve work flows and team-based care for patients with diabetes:
   - a) Point of care HbA1c testing at health centers, following a protocol developed by DM work group
   - b) Team-based outreach to patients with HbA1c>9% and patients with no HbA1c in calendar year
   - c) Adopt and spread a standardized treatment algorithm for patients with HbA1c>9% to care teams
   - d) Expand team-based approach by providing nurse DM visits for assessment, education, and self-management of diabetes to occur within 30 days of treatment

3) Develop a registry for outreach and in-reach among diabetes patients with...
Key Drivers

Project Name: Improving blood pressure control at Unity among adults with hypertension
Project Leaders: Andy Robie, Sarah Price, Cathy Anderton, Ryan Buchholz

Revision Date: 5 Jan. 2016

SMART AIM

To increase the % of Unity patients with high blood pressure who have well-controlled blood pressure from 64% to 70% by December 2016.

GLOBAL AIM

To prevent death and sickness from heart attacks and strokes among Unity patients.

KEY DRIVERS

- Unity teams care for patients with high blood pressure based on best evidence
- Hypertension is on the problem list for patients with high blood pressure
- Patients with hypertension are aware of their diagnosis
- Nursing staff are well-trained and equipped to measure BP accurately
- Reliable, site-specific blood pressure data available to staff at health centers and sites regularly
- Patient-centered registry helps Unity teams actively care for patients with uncontrolled BP
- Unity data analytics team helps to identify Unity patients with undiagnosed high BP

INTERVENTIONS / PDSA Cycles

- Evidence-based protocol for high blood pressure is adopted, distributed, and accessible to Unity teams
- Unity adopts an evidence-based guideline (JNC8) for blood pressure control (March 2014)
- Team-based training for better blood pressure control (May/June 2014)
- Unity health centers and other Unity sites have appropriate equipment for reliable BP measurement
- Provider-ordered Nurse BP Check visits for improved blood pressure control
- Key
  - Dotted box = Placeholder for future additions
  - Green shaded = what we’re working on right now
# QI MEASURES - DRVS

## DRVS Home

<table>
<thead>
<tr>
<th>UDS CQM's</th>
<th>Full Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period: TY January 2017</td>
<td></td>
</tr>
<tr>
<td>CAD Lipid Therapy</td>
<td>92%</td>
</tr>
<tr>
<td>New HIV Cases With Timely Follow Up</td>
<td>99%</td>
</tr>
<tr>
<td>Hypertension Controlling High Blood Pressure (NQF 0018)</td>
<td>63%</td>
</tr>
<tr>
<td>Child Weight Screening / BMI / Nutritional / Physical Activity Counseling (NQF 0024 modified)</td>
<td>17%</td>
</tr>
<tr>
<td>Tobacco Use: Screening and Cessation (NQF 0028)</td>
<td>94%</td>
</tr>
<tr>
<td>Cervical Cancer Screening - Pap Only (NQF 0032 – CMS124v4)</td>
<td>54%</td>
</tr>
<tr>
<td>Colorectal Cancer Screening (NQF 0034)</td>
<td>38%</td>
</tr>
<tr>
<td>Use of Appropriate Medications for Asthma (NQF 0036)</td>
<td>96%</td>
</tr>
<tr>
<td>Childhood Immunization Status (NQF 0038)</td>
<td>37%</td>
</tr>
<tr>
<td>Diabetes A1c &lt; 8 (NQF 0059 modified)</td>
<td>53%</td>
</tr>
<tr>
<td>Diabetes A1c &gt; 9 or Untested (NQF 0059)</td>
<td>36%</td>
</tr>
<tr>
<td>IVD Aspirin Use (NQF 0068)</td>
<td>88%</td>
</tr>
<tr>
<td>Screening for Clinical Depression and Follow-Up Plan (NQF 0418)</td>
<td>45%</td>
</tr>
<tr>
<td>BMI Screening and Follow-Up 18+ Years – 2 BMI Ranges (NQF 0421 – CMS69v4)</td>
<td>47%</td>
</tr>
</tbody>
</table>

promoting healthier communities through compassion and comprehensive health and human services
### Visit Planning

**Buchholz, Ryan**

#### 8:00 AM | Thursday, February 9, 2017

- **Diagnoses**
  - HTN
  - PREDIABETES
- **Risk Factors**

<table>
<thead>
<tr>
<th>Alert</th>
<th>Message</th>
<th>Most Recent Date</th>
<th>Most Recent Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Visit</td>
<td>Overdue</td>
<td>2/26/2014</td>
<td>48</td>
</tr>
<tr>
<td>LDL</td>
<td>Overdue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCV</td>
<td>Overdue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Weight Screening</td>
<td>Missing Follow-up</td>
<td>12/16/2016</td>
<td>29.01</td>
</tr>
<tr>
<td>HIV Screen</td>
<td>Overdue</td>
<td>7/21/2014</td>
<td>Non Reactive</td>
</tr>
<tr>
<td>Fall Risk Screening</td>
<td>Overdue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence Screening</td>
<td>Overdue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gonorrhea Screening</td>
<td>Overdue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>Missing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 8:15 AM | Thursday, February 9, 2017

- **Diagnoses**
  - Flu - Seasonal
- **Risk Factors**

#### 8:30 AM | Thursday, February 9, 2017

- **Diagnoses**
  - ASM
- **Risk Factors**

<table>
<thead>
<tr>
<th>Alert</th>
<th>Message</th>
<th>Most Recent Date</th>
<th>Most Recent Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu</td>
<td>Overdue</td>
<td>10/29/2015</td>
<td>J45.20</td>
</tr>
<tr>
<td>Asthma Severity</td>
<td>Overdue</td>
<td>10/29/2015</td>
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<tr>
<td>Dental Visit</td>
<td>Overdue</td>
<td></td>
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</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Overdue</td>
<td></td>
<td></td>
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<tr>
<td>Annual Well Child Check</td>
<td>Overdue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lead Screening</td>
<td>Overdue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu - Seasonal</td>
<td>Missing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Violence Screening</td>
<td>Overdue</td>
<td></td>
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</tr>
</tbody>
</table>
promoting healthier communities through compassion and comprehensive health and human services
QI MEASURES - COLORECTAL CANCER SCREENING

promoting healthier communities through compassion and comprehensive health and human services
QI MEASURES - HYPERTENSION

Heart of Gold Winners
Columbia Road and Walker Jones

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