Davies Award Site Visit

El Rio Health
Tucson, Arizona

September 14, 2018
Mission & Values

Improving the health of our community through comprehensive, accessible, affordable, quality and compassionate care.

Step Up
I am accountable for making El Rio a world class health center.

I Matter
I make a difference by voicing my opinions and knowing I am heard.

Break Boundaries
I work with others to achieve success.

Value Health
I take time for my own health to promote yours.

Create Tomorrow
I embrace effective change and seek innovative solutions.

Honor Patients
I always put the patients first.
About Us

History

1970 - Opened in October
- Serving patients as El Rio Santa Cruz Neighborhood Health Center

1971 - A Federally Qualified Health Center
- Organization that receives a grant under section 330 of the Public Health Service.

1974 - A Non-for-Profit
- Managed by a Community Board of Directors – CEO/Executive Director and Senior Staff.

A Nationally Recognized Organization

2010 - Joint Commission
- El Rio was accredited for both Clinical and Diagnostic Laboratory Services

2010 - National Committee for Quality Assurance (NCQA)
- El Rio was granted a Level-3 Patient Centered Medical Home (PCMH)

2018 - Healthcare Equality Index (HEI)
- El Rio was recognized as leaders in LGBTQ Healthcare Equality Index
Our Practice

2017 UDS Data

- Total # of Patients Served: 101,563
- Total # of Patient Visits: 389,303
- # of Employees: 1,156
- # of Unique Clinic Sites: 14
- Number of Providers: 211
  - 140 Medical Providers
  - 31 Dental
  - 24 Behavioral Health
  - 16 Clinical Pharmacists

El Rio Patients by Race/Ethnicity

- Hispanic/Latino: 22%
- White: 7%
- African American: 4%
- American Indian: 4%
- Other: 4%

Patients by Payer Source

- Medicaid: 55%
- Private: 21%
- Uninsured: 12%
- Medicare: 11%

- 64% of patients live below the Federal Poverty Line
EL RIO HEALTH HAS MULTIPLE LOCATIONS IN TUCSON TO SERVE YOU AND YOUR FAMILY.

More than 95,000 people in Tucson come to El Rio Health for medical, dental, behavioral health & other health care services.

1. Birth & Women’s Health Center
   5979 E. Grant Road, #107
2. Broadway Health Center
   1101 E. Broadway Blvd.
3. Cherrybell Health Center
   1538 E. 22nd St.
4. Congress Health Center
   839 W. Congress Street
5. El Pueblo Health Center
   101 W. Irvington Rd, Bldg #100
6. HealthOn Broadway
   One West Broadway Blvd.
7. Northwest Health Center
   320 W. Prince Road
8. OB / GYN Associates
   225 W. Irvington Rd.
9. Pascua Yaqui Health Center
   7490 S. Camino de Oeste
10. Southeast Health Center
    6950 E. Golf Links
11. Southwest Health Center
    1500 W. Commerce Court
12. Special Immunology Associates
    1701 W. St. Mary’s Road, #160
2018 Key Results

WORLD CLASS EXPERIENCE FOR PATIENTS AND EMPLOYEES

- **Patient World Class Experience**
  - Overall satisfaction at patient appointment [Poor, Fair, Good, Excellent, NA].
  - Baseline = 90.6 Mean Score
    - 2018 Goal = 93 Mean Score
  - Length of time to get an appointment
  - Courtesy of person with whom you spoke
  - Courtesy and helpfulness of check-in staff
  - Length of time waiting to see the provider

- **Employee World Class Experience**
  - Increase employee quarterly survey response.
    - Baseline = 325
    - 2018 Goal = 500

HEALTHIER PATIENTS AND EMPLOYEES

- **Healthier Patients**
  - Decrease Emergency Room Visits
    - 2018 Goal = 600/1,000
  - Decrease Hospital Readmissions (w/in 30 days)
    - 2018 Goal = 8.9%
  - Increase Patient Portal Use (minimum 1 bidirectional interaction)
    - 2018 Goal = 30,000
  - Decrease overall patient “no-show” percentages across El Rio
    - 2018 Goal = 12%

- **Healthier Employees**
  - Decrease Emergency Room Visits
    - 2018 Goal = 290
  - Increase Employee Patient Portal Use (minimum 1 bidirectional interaction)
    - 2018 Goal = 500

POSITIVE FINANCIAL RESULTS

- **Operating Margin**: Achieve an Operating Margin of 4.5%. Stretch goal 5.5% for 2018.
# Integrated Cascading Dashboard

<table>
<thead>
<tr>
<th>Measure</th>
<th>Below Threshold</th>
<th>Meets or Exceeds Threshold</th>
<th>Meets or Exceeds Target</th>
<th>Meets or Exceeds Stretch Goal</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality</strong></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Affordable Care Act (ACA) (11-15)</td>
<td>Increase the percentage of patients aged &lt;65 who have one or more comprehensive wellness visits during the measurement year</td>
<td>56.6%</td>
<td>64.7%</td>
<td>69.4%</td>
<td>69.5%</td>
</tr>
<tr>
<td>Asthma Pharmacotheraphy (15-21)</td>
<td>Increase the percentage of asthma patients who were prescribed an asthma medication therapy during the measurement year</td>
<td>67.6%</td>
<td>85.8%</td>
<td>81.1%</td>
<td>85.1%</td>
</tr>
<tr>
<td>Breast Cancer Screening (20-49)</td>
<td>Increase the percentage of female patients aged 50-74 who received a mammogram in the previous two years</td>
<td>73.6%</td>
<td>73.2%</td>
<td>71.0%</td>
<td>74.3%</td>
</tr>
<tr>
<td>Cervical Cancer Screening (12-64)</td>
<td>Increase the percentage of female patients aged 21-65 who received a pap test in the previous year (and accompanied by an HPV test, if required) from the previous two years</td>
<td>72.3%</td>
<td>72.6%</td>
<td>72.6%</td>
<td>72.6%</td>
</tr>
<tr>
<td>Colon Cancer Screening (70-75)</td>
<td>Increase the percentage of patients aged 70-75 who received an appropriate screening for colorectal cancer in the corresponding time frame</td>
<td>52.8%</td>
<td>55.6%</td>
<td>55.6%</td>
<td>55.6%</td>
</tr>
<tr>
<td>Chronic Home Telemonitoring (by Age 75)</td>
<td>Increase the percentage of patients who received all of the required chronic home telemonitoring by their 75th birthday</td>
<td>23.1%</td>
<td>24.6%</td>
<td>24.6%</td>
<td>24.6%</td>
</tr>
<tr>
<td>Coronary Artery Disease (CAD) Lipid Therapy (15-21)</td>
<td>Increase the percentage of patients with CAD aged &lt;65 who were prescribed a lipid-lowering therapy during the measurement year</td>
<td>9.1%</td>
<td>21.9%</td>
<td>21.9%</td>
<td>21.9%</td>
</tr>
<tr>
<td>Depression Screening and Follow up (15-21)</td>
<td>Increase the percentage of patients aged &lt;65 who were screened for depression during the measurement year</td>
<td>69.2%</td>
<td>76.0%</td>
<td>81.0%</td>
<td>76.0%</td>
</tr>
<tr>
<td>Diabetes Eye Exam (18-75)</td>
<td>Increase the percentage of diabetic patients aged 18-75 who received an eye exam during the measurement year</td>
<td>28.6%</td>
<td>61.9%</td>
<td>61.9%</td>
<td>61.9%</td>
</tr>
<tr>
<td>Diabetes Eye Care (18-75)</td>
<td>Increase the percentage of diabetic patients aged 18-75 whose most recent HbA1c result was &lt;9%</td>
<td>54.6%</td>
<td>61.7%</td>
<td>61.7%</td>
<td>61.7%</td>
</tr>
<tr>
<td>Flu Vaccination (15-64)</td>
<td>Increase the percentage of patients aged 16-64 who received a flu vaccine during the measurement year’s flu season (September 1 – March 31)</td>
<td>41.3%</td>
<td>43.4%</td>
<td>43.4%</td>
<td>43.4%</td>
</tr>
<tr>
<td>Flu Vaccination + Influenza A + Influenza B (15-64)</td>
<td>Increase the percentage of patients aged 16-64 who received the flu vaccine during the measurement year’s flu season (September 1 – March 31)</td>
<td>38.2%</td>
<td>40.0%</td>
<td>40.0%</td>
<td>40.0%</td>
</tr>
<tr>
<td>High Blood Pressure Control (18-75)</td>
<td>Increase the percentage of hypertensive patients aged 18-75 whose most recent blood pressure measurement was &lt;140/90</td>
<td>44.8%</td>
<td>61.0%</td>
<td>61.0%</td>
<td>61.0%</td>
</tr>
<tr>
<td>Hypertensive Vascular Disease (HVD) Therapy (15-21)</td>
<td>Increase the percentage of patients aged 15-21 who were discharged for AHA/CASPIA who were prescribed an antihypertensive therapy during the measurement year</td>
<td>88.9%</td>
<td>90.0%</td>
<td>90.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Medications Filled (15-21)</td>
<td>Increase the percentage of “medicated” patients aged 5-65 who received a prescription for a medication that had been prescribed at least once during the measurement year</td>
<td>87.7%</td>
<td>91.8%</td>
<td>91.8%</td>
<td>91.8%</td>
</tr>
<tr>
<td>Preventive Vascular Care (15-85)</td>
<td>Increase the percentage of patients aged &lt;85 who have received absolute vascular care</td>
<td>34.0%</td>
<td>36.6%</td>
<td>36.6%</td>
<td>36.6%</td>
</tr>
<tr>
<td>Tobacco Use Enabling and Cessation Counseling (15-85)</td>
<td>Tobacco use within 2 years of their most recent HEDIS 2014 HEDIS Medically Managed (MM) mean; Stretch Goal = 2010 Stretch Goal</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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**Threshold** = 90% of Target except where noted.

**Notes**
- Targets and Stretch Goals are based on organizational goals and/or external benchmarks (when available).
- The Integrated Cascading Dashboard is designed to help organizations track their performance against national benchmarks and set meaningful stretch goals.
- The dashboard includes key performance indicators (KPIs) related to quality of care, patient safety, and patient experience.
- Each measure is categorized by whether it meets or exceeds the threshold, target, or stretch goal.

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**Organizational Identity**
- **EL RIO HEALTH**
- **NCQA LEADER**
- **LGBTQ+ HEALTH**
Relevant Cascading Dashboard (HbA1c)
**Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life: 3Q15 - 2Q18**

<table>
<thead>
<tr>
<th>Goal</th>
<th>Increase the percentage of patients aged 3-6 years who had 1 or more well-child visits during the measurement year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benchmark</strong></td>
<td>76.8% (2016 HEDIS Commercial HMO Mean)</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>5,455 patients aged 3-6 years who had one or more well-child visits during the measurement year</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>7,025 patients who turned 3, 4, 5, or 6 years old during the measurement year</td>
</tr>
<tr>
<td><strong>Quarter</strong></td>
<td>2nd Quarter (April – June 2018)</td>
</tr>
</tbody>
</table>

**Interpretation**
The data demonstrates no significant trend while consistently maintaining compliance rates above 70%.

**Action Plan**
Continue to utilize provider specific missed opportunity reports as well as disseminate best practices from SW clinic QI project to other pediatric sites.

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**Control Rules (Special Cause Variation)**

- One point outside the upper or lower control limits (3 SD)
- Two out of three successive points more than 2 SD from the mean on the same side of the center line
- Four out of five successive points more than 1 SD from the mean on the same side of the center line
- Eight successive points on the same side of center line
- Six successive points increasing or decreasing (a trend)
- Obvious cyclic behavior (14 in a row alternating)

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**Control Chart: Well Child Visits [3-6]**

<table>
<thead>
<tr>
<th>Month</th>
<th>Violation</th>
</tr>
</thead>
<tbody>
<tr>
<td>3Q15</td>
<td>2 points out of the last 3 below −2 sigma</td>
</tr>
</tbody>
</table>

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**Well Child Visits [3-6]**

- UCL = 79.692
- Average = 74.108
- LCL = 68.525

Rule violation

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

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**EL RIO HEALTH**

- NCQA Recognized Practice
- LGBTQ Healthcare Equality Leader

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**COMMUNITY HEALTH CENTER**

- Healthcare Equality Index
Create Tomorrow Quality Improvement Governance

Clinical Advisory Council

- Specialty QA Committees
  - BWHC QA Committee
  - SIA QA Committee

Patient Safety & Therapeutics Committee

- Clinical Credentialing & Competency Committee
  - Patient Care Review Committee
  - Serious Safety Events Committee

Joint Commission Committee

- Protocol / Policy Committee
  - Environment of Care Committee
  - Tracer Committee
  - 14 Chapter Groups (as outlined in Quality Plan)

Performance Improvement Committee

- Front Line Performance Improvement Teams
  - Create Tomorrow CQI
Create Tomorrow Quality Improvement Projects

- Abnormal lab and results Tracking
- Human DX/IPE NACHC Collaborative
- At-Risk Teen Project
- National Collaborative for Transforming Primary Care for LGBTQ People
- Team-Based Care Learning Collaborative
- STI Screening in Teens
- HIV/HEP-C Screening Opt Out Program
- Six Sigma Projects:
  - Diabetic HbA1c >9 Control
  - Provider Capacity
  - Eligibility & Coding Error Denials
El Rio IT Department- Quick Facts

• All IT functions are in-house – close to 50 employees
• Host our own data center
• NextGen EHR system for 10 years
  – Medical
  – Dental
• IT Leadership team
  – Deep knowledge of FQHC’s
  – Health IT
  – Data analytics
• Knowledge resource for other agencies
• Clinical and operational leadership work collaboratively with IT on QI
Other Innovative Healthcare IT Projects

- Telehealth/Virtual visits
- Collection of SDOH and other clinical data on a tablet - entered by patient
- Patient self check-in through Kiosks
- Online scheduling, form completion, and check-in
- HIE and other interoperability partnerships (API’s) – care coordination, continuity of care, closing gaps in care, and is linked to increased value based payments
Case Study: 24 Month Old Autism Screening
As of 2018, 1 in 59 children has been identified with Autism Spectrum Disorder (ASD)
Research has shown that autism can be reasonably detected by age 2
Average age of diagnosis of ASD is 4-6 years old
Early detection and treatment are key to improved outcomes
AAP recommends universal screening at 18 and 24 months old with a standardized tool
Barriers to Screening

Waiting for patients to schedule their well visit without timely outreach

Inconsistency in provider adherence to AAP autism screening timelines

Provider does not regularly remember to administer screening

Data is not readily available or reviewed regularly resulting in less than optimal quality numbers
Local Problem

- Need to review AAP guideline adherence for 24 month well baby screenings
- Providers moderately effective in meeting the recommended screenings (50-60% range for SW Pediatrics)
  - Anemia
  - Lead
  - Autism
- Rate of completion higher at SW Peds than other sites

**Goal:** Significantly increase screening rates at SW Peds and subsequently provide a best practice model for the organization
Baseline Data September 2016

SW Pediatrics
Anemia: [Bar Value]
Lead: [Bar Value]
Autism: [Bar Value]

All Other Clinics
Anemia: [Bar Value]
Lead: [Bar Value]
Autism: [Bar Value]
Using Data to Increase Well Checks

• First increase the number of patients who come for well visits
• Utilize Relevant analytic tool
  ▶ IT department created reports of children with gaps in care
• Provider teams use Relevant reports for directed outreach

**Desired Outcome:** More children come to clinic for well checks and screenings
<table>
<thead>
<tr>
<th>Measure</th>
<th>Start Date</th>
<th>End Date</th>
<th>Patient Name</th>
<th>MRN</th>
<th>Risk Score</th>
<th>DOB</th>
<th>Provider Name</th>
<th>Location</th>
<th>MSmt Value</th>
<th>Numerator</th>
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</thead>
<tbody>
<tr>
<td>Well-Child Visits in the 1st 15 Months of Life</td>
<td>09/01/2017</td>
<td>08/31/2018</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Modak, Rajiv</td>
<td>Southwest</td>
<td>N</td>
<td></td>
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<td>08/31/2018</td>
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<td></td>
<td></td>
<td>Samoy, Sarah</td>
<td>Southwest</td>
<td>N</td>
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<td>09/01/2017</td>
<td>08/31/2018</td>
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<td>Strempe, Patricia</td>
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<td></td>
<td></td>
<td>Samoy, Sarah</td>
<td>Southwest</td>
<td>N</td>
<td></td>
</tr>
</tbody>
</table>
Gaps in Care Workflow

Outreach

- MA team generates list
- Post cards sent to call for WCC
- Generate new list each month

Opportunity

- *Daily
- MA team reviews schedule during morning huddle
- Gaps in care noted
- Appointment changed from sick to well visit
Design and Implementation

- Bring together a multidisciplinary QI team
  - Physician
  - Medical assistant (MA)
  - Nurse (LPN)
  - IT
- Discuss baseline data, current barriers, proposed workflow changes and stakeholder analysis
- Test of change was incorporated into Plan-Do-Study-Act (PDSA)
- Data analyst reported progress weekly
- Data sharing for positive reinforcement
El Rio Workflow Utilized

- Identify problem
- Review data
- Set improvement goal

- Propose intervention

- Identify barriers
- Discuss easiest barriers to overcome

- Provider Engagement and feedback

- Staff Engagement and feedback

- Address costs – financial and other

- Data analysis – can we monitor progress?

Create new workflow

El Rio Health
Change From Provider Driven Screening to Medical Assistant Driven Screening

- Screening protocol included in MA workflow checklist
- MA orders lab tests (CBC, lead) in EMR
- MA administers MCHAT survey and enters into EMR
Medical Assistant Pre Visit Protocol for 24 Month Well Check

• Open intake for well visit (6 point check)
• Verify vaccines and utilize standing orders
• Vital patient (weight, length, head circumference, temperature, pulse, respirations, and vision screening)
• Provide MCHAT to parent and review purpose of screening
• Enter vitals into EMR
• Complete other tasks and place on exam room door
  • CBC and lead labs
  • Anticipatory guidance/growth charts
  • ROAR book
Parent Questionnaire

Child’s Name: __________________________ Date of Birth: ____________ Date of Screening: ____________

Please complete this form before today’s visit with your child’s physician. Answers should indicate how your child usually behaves. Please try to answer every question. If the behavior is rare (i.e., you’ve seen it once or twice), please answer as if the child does not engage in the noted behavior. To indicate “No” or “No,” completely, fill in appropriate squares with pencil or pen.

1. Does your child enjoy being swung, bounced on your knee, etc.? Yes No
2. Does your child take an interest in other children? Yes No
3. Does your child like climbing on things, such as up stairs? Yes No
4. Does your child enjoy playing peek-a-boo, hide-and-seek? Yes No
5. Does your child ever pretend, for example, to talk on the phone or take care of dolls, pretend other things? Yes No
6. Does your child ever use his/her index finger to point, to ask for something? Yes No
7. Does your child ever use his/her index finger to point, to indicate interest in something? Yes No
8. Can your child play properly with small toys (e.g., cars or bricks) without just mouthing, fiddling, or dropping them? Yes No
9. Does your child ever bring objects over to you (parent) to show you something? Yes No
10. Does your child look you in the eye for more than a second or two? Yes No
11. Does your child ever seem oversensitive to noise? (e.g., plugging ears) Yes No
12. Does your child smile in response to your face or smile? Yes No
13. Does your child initiate you? (e.g., you make a face – will your child initiate it?) Yes No
14. Does your child respond to his/her name when you call? Yes No
15. If you point at a toy across the room, does your child look at it? Yes No
16. Does your child walk? Yes No
17. Does your child look at things you are looking at? Yes No
18. Does your child make unusual finger movements near his/her face? Yes No
19. Does your child try to attract your attention to his/her own activity? Yes No
20. Have you ever wondered if your child is deaf? Yes No
21. Does your child understand what people say? Yes No
22. Does your child sometimes stare at nothing or wander with no purpose? Yes No
23. Does your child look at your face to check your reaction when faced with something unfamiliar? Yes No

Responses in red

Responses in both red and blue
Medical Assistant Documentation
• Teams can access independently
• Allowed monitoring of progress in real time
• Demonstration of quality improvement was critical in engaging both providers and staff
SW Pediatrics Autism Screening

Control Chart: SW Peds Autism Screening (MCHAT)

- UCL = 98.526
- Average = 78.143
- LCL = 57.760

Rule violation:
- No
- Yes

QI Project Planning

QI Project Implementation
Formal Process For Spread of Autism Screening

- Presentation to El Rio Board of Directors
- Reviewed by Clinical Advisory Committee (CAC)
  - reviews all policy/procedure changes
  - comprised of various stakeholders in leadership
    - Nursing
    - Medical
    - Dental
    - Pharmacy
    - Lab
    - IT
    - Compliance

Both recommended spread to all clinic sites
El Rio Autism Screening

Control Chart: El Rio Peds Autism Screening (MCHAT)

- UCL = 79.197
- Average = 60.143
- LCL = 41.089

Rule violation:
- No
- Yes

QI Project Implemented
How IT Was Critical to Success

• Creation of reports in Relevant
  ❖ individual teams able to access their own data
  ❖ identified gaps in care
  ❖ allow outreach to bring patients in for interventions

• Relevant reports with autism screening rates
  ❖ presented real time data for discussion
  ❖ facilitated planning at monthly meetings

• Data used to engage teams and celebrate success
  ❖ facilitated healthy competition among teams
How IT Was Critical to Success

- Increased staff satisfaction as data demonstrated their power in improving quality of care for patients.
- Decreased provider workload as MA drives screening process.
- High autism screening rates resulted in positive outcomes:
  - chosen to be part of a grant funded project
  - all children who failed autism screening would have expedited evaluation by a behavioral/developmental specialist
  - prior to this, children would have to wait over a year to see a pediatric autism specialist
Developmental Referral Process

Provider referral into EHR for tracking

MA faxes referral to Pediatric Developmental team (Intermountain BH)

Developmental team contacts family to set up appointment

Email sent to team notifying them of appointment status (updated weekly)
Jan 2017-June 2018
Total patients screened
N = 842

- Negative Screening
  N = 730

- Positive Screening
  N = 112

- Completed Evaluation
  N = 84

- Declined Evaluation
  N = 28

- Diagnosed ASD
  Treatment Implemented
  N = 22

- Evaluation non-confirmatory
  ASD
  N = 66
Future State to Refine Process

- Creation in NextGen HER of automatic alerts for gaps in care like autism screening
- MCHAT entry into EHR via tablet
- Provider incentive tied to quality measures in Relevant
- Staff incentive tied to teams quality measures in Relevant.
Arizona Alliance of Community Health Centers
Health Care Heroes Innovation Award 2018