Health Center Field Example

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Director of Operations

PARK DUVALLE
COMMUNITY HEALTH CENTER

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Since 1968, Park DuValle Community Health Center has been serving the needs of Louisville, KY and surrounding areas.

Total Patients Served: 23,342

UDS Measure	National	Park DuValle
Colorectal	42%	81%
Cervical	53%	66%
HTN	60%	73%
BMI	61%	63%
Depression	67%	76%
Diabetes	32%	13%

Health Resources and Services Administration HRSA Health Center Program HEALTH CENTER QUALITY LEADER 2022 Awardee

Health Resources and Services Administration HRSA Health Center Program ACCESS ENHANCER 2022 Awardee

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PCMH

POPULATION HEALTH MANAGEMENT INTERVENTIONS

- ✓ The quality team generates open care gap reports (internal population health management tool) for all scheduled patients
- ✓ Care gap reports are created daily; reviewed by the provider and care team during morning huddle
- ✓ Appointment Agendas are provided by Wellcare; document diseases/conditions that have been on the patient's past claims and require a follow up for the current measurement year to determine whether that condition is still active or have been resolved
- ✓ Quality Improvement Committee meets with leadership monthly to discuss quality measures and ways to improve

CARE MODEL

Colorectal Screening

The quality team routinely runs reports for all patients with an ordered colorectal cancer screening (CRCS).

FIT

- Tests are provided in-house
- The quality team follows up with patients who do not return the FIT.

Cologuard

- The quality team registers the patient into Exact Science to have the Cologuard test mailed to the patient.
- Exact Science follows up for return of the Kit.
- The quality team retrieves results from Exact Science and inputs results in the electronic medical record.

PARTNERSHIPS

Security to Health Food Program

- Targets patients who are either food insecure and/or have COPD, DM and/or HTN
- Staffed by the Chronic Disease Manager and 2 case managers
  - 6-month program
  - Participants receive $75/month, free access to plant-based healthy cooking, yoga, and dance fitness classes
  - Pre- and post- measures of weight, A1C, and blood pressure
  - Patients provided resources to community and healthcare needs

Collaboration with Managed Care Organizations (MCOs)

- Monthly or quarterly meetings of the Chronic Disease Manger, Quality Team, COO, and DOO with the MCOs to learn of quality successes and opportunities for improvement.
- The Chronic Disease Manager uses the 'opportunities for improvement' to educate providers on what steps can be completed to improve that targeted measure (i.e., coding education).