PopHealth Analytics Reporting Suite User Guide

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CRISP DC powered by hMetrix

Table of Contents

Use Case Color-Coding		
🔴 - Targeted Patient Outreach & Care Gaps	🟠 - Performance Benchmarking & Quality Tracking	🟡 - Health Equity & Demographic Disparities
🟢 - Financial Management & Cost Driver Analysis	🔵 - Network, Facility & Provider Management	🟣 - Administrative Operations & Coordination Logistics

How Do I Use This Guide?

Welcome to the **PopHealth Analytics User Guide**. This document is structured to serve as both a comprehensive training manual for onboarding new team members and a quick-reference catalog for daily operational workflows.

To maximize the value of this platform and get the most out of this guide, we recommend adopting the following navigation and utilization approach:

1. Master the Foundational Core

Before diving into individual dashboards, ensure you completely understand the system-wide framework documented in the opening sections:

1. **The "Panel" Concept**: Review the Understanding Panels section to grasp how DC Medicaid beneficiaries are dynamically grouped backward in time based on treatment relationships and provider attribution.
2. **System Safeguards**: Familiarize yourself with the core layout components, universal filter controls, and safety features like the automatic five-minute warning for session timeouts.
3. **Data Nuances**: Carefully read the section on Claim Lag. Because clinical data processing can naturally take anywhere from several weeks to over three months, learning how to interpret "preliminary" data will prevent redundant patient outreach and ensure a better care experience.

2. Follow the Standardized Report Structure

Every report cataloged in the PopHealth Reports User Guide is meticulously broken down into six uniform sub-sections to make browsing seamless:

1. **Report Overview & Purpose**: A high-level explanation of what the dashboard measures and why it is critical to care quality or cost management.
2. **Available Filters & Interactivity**: A precise inventory of the dropdown menus, date sliders, and clickable chart elements available to scope your view.
3. **Key Metrics & KPIs**: Definitions of the exact performance indicators calculated on the screen (e.g., rates, ratios, patient counts, or expenditures).
4. **Visualizations & Data Tables**: A detailed breakdown of the trends, bar charts, maps, and summary grids displayed, including what each color or indicator symbol signifies.
5. **Functional Use Cases**: Actionable workflow examples that connect the technical data on your screen to your day-to-day healthcare management responsibilities.
6. **Screenshot**: A full visual preview of the live dashboard to assist with visual recognition during tool navigation.

3. Leverage the Dynamic Interactivity Matrix

The platform is designed to transition seamlessly from macro-level population tracking to micro-level patient intervention. Use this guide to learn how to actively interact with the data:

1. **The Tooltip Hover**: Move your mouse cursor over any line graph or bar chart element to instantly reveal context-specific information, such as precise counts, denominators, and quality benchmarks, without needing to click.
2. **The Drill-Through**: Click directly on a chart element or table row to seamlessly transport yourself to a Beneficiary Detail Table listing the specific line-level data making up that aggregate number.
3. **The Privacy Guardrail**: Remember that to comply with strict federal 42 CFR Part 2 privacy regulations, data drill-throughs are completely disabled on dashboards containing substance use disorder metrics
4. **The State-Preservation Rule**: When navigating away from a granular drill-through table, always click the dedicated in-report Blue Back Arrow in the top-left corner. Do not use your web browser's back button, or you will accidentally terminate your Tableau session and lose all your active filter choices.

4. Navigate by Your Staff Role & Use Case Color-Coding

If you are looking for immediate guidance tailored to your specific job responsibilities, flip directly to Part 4 of the Use Case Repository.

To make navigation simpler, the manual utilizes a universal **visual color-coding system** matching specific strategic use cases to the dashboard reports. You will notice corresponding colored circle indicators (🔴 🟠 🟡 🟢 🔵 🟣) embedded directly inside the headings of the *PopHealth Reports User Guide*. These visual keys map exactly to the strategic lens of your role:

1. **Targeted Patient Outreach & Care Gaps 🔴:** Focuses on operational care transitions, direct gap closure, high-utilizer outreach, and managing unmanaged patients. **Care Managers and Coordinators** should prioritize reports marked with a red indicator.
2. **Performance Benchmarking & Quality Tracking 🟠:** Focuses on tracking longitudinal HEDIS/CMS benchmarks and evaluating clinical or outreach initiatives over rolling time periods. **Quality Improvement and Clinical Leads** should prioritize reports marked with an orange indicator.
3. **Health Equity & Demographic Disparities 🟡:** Focuses on cross-filtering broad demographic trends, evaluating the Social Determinants of Health (SDOH), and slicing metrics by age, gender, race, or ethnicity. **Equity Officers and Analysts** should prioritize reports marked with a yellow indicator.
4. **Financial Management & Cost Driver Analysis 🟢:** Focuses on fiscal monitoring, evaluating expenditures, managing Per Member Per Month (PMPM) drivers, and investigating service line costs. **Finance and Network Administrators** should prioritize reports marked with a green indicator.

5. **Network, Facility & Provider Management** 🔵**:** Focuses on assessing facility-level utilization, verifying nursing partner quality, monitoring network performance, and tracking provider activity volumes. **Network Managers and Administrators** should prioritize reports marked with a blue indicator.
6. **Administrative Operations & Coordination Logistics** 🟣**:** Focuses on data feed quality (ADTs/CCDs), feed stability, prescriber trends, and coverage management logic. **IT Teams and System Administrators** should prioritize reports marked with a purple indicator.

By aligning the color of the indicator in a report's heading with the strategic color block in the use case repository, you can instantly determine if a dashboard contains the clinical or administrative functionality required for your daily operational workflows.

5. Understand Report Availability & Requesting Access

Access to specific dashboards within the PopHealth Analytics platform is configured dynamically based on your organization type (e.g., FQHC, Hospital, Managed Care Organization). Consequently, your PopHealth landing page may not display every report cataloged in this comprehensive manual.

If you identify a report in this guide that would bring strong operational or clinical value to your team, we encourage you to request a data review:

1. **Verify the Alignment**: Review how the dashboard's features map to your staff role or strategic color-coding.
2. **Contact the Team**: Reach out directly to the CRISP DC team to discuss your organizational needs and evaluate options for gaining access to the report.

Introduction to PopHealth Analytics

PopHealth Analytics is a robust, web-based platform designed to enable comprehensive population-level and panel-level health management by seamlessly combining clinical and administrative data.

The reports are powered by multiple data sources, heavily utilizing DC Medicaid Claims data and augmented by HIE data (including clinical labs), to track the healthcare journeys of **DC Medicaid beneficiaries**. By leveraging a beneficiary's unique identifier alongside their provider panel assignment, the platform accurately tracks healthcare utilization across various clinical settings.

This wealth of data empowers healthcare administrators, care coordinators, and population health analysts to:

1. Plan and develop targeted care coordination efforts for specific conditions and beneficiaries of interest.
2. Identify high-risk patient cohorts and close critical gaps in care.
3. Monitor quality improvement initiatives and track performance against benchmarks.

Currently, access to the PopHealth Analytics tool and its suite of reports is exclusively available through the secure HIE Portal.

Understanding Panels

To effectively navigate and filter data within PopHealth Analytics, it is important to understand how patient populations are grouped using Panels and Rosters.

What is a Panel?

A "Panel" serves as the primary dropdown selection used throughout the dashboards to identify a specific population. The individuals comprising a panel are DC Medicaid beneficiaries who are part of a clinical patient population based on a treatment relationship, or who are specifically attributed to a provider. Provider organizations maintain and submit these clinical patient panels to CRISP for processing. While a panel could potentially include non-DC Medicaid beneficiaries, the PopHealth platform's focus remains exclusively on the DC Medicaid population. Whenever you select a Panel from the top filter bar, the entire dashboard automatically updates to reflect data for that specific group.

It is important to understand the **Panel Nuance**: Panels are dynamic and reflect the current population looking backward. Since panels are regularly updated, members can be added or removed over time. Therefore, the reports will always display utilization and other metrics based on the current population included in the panel at the time of viewing.

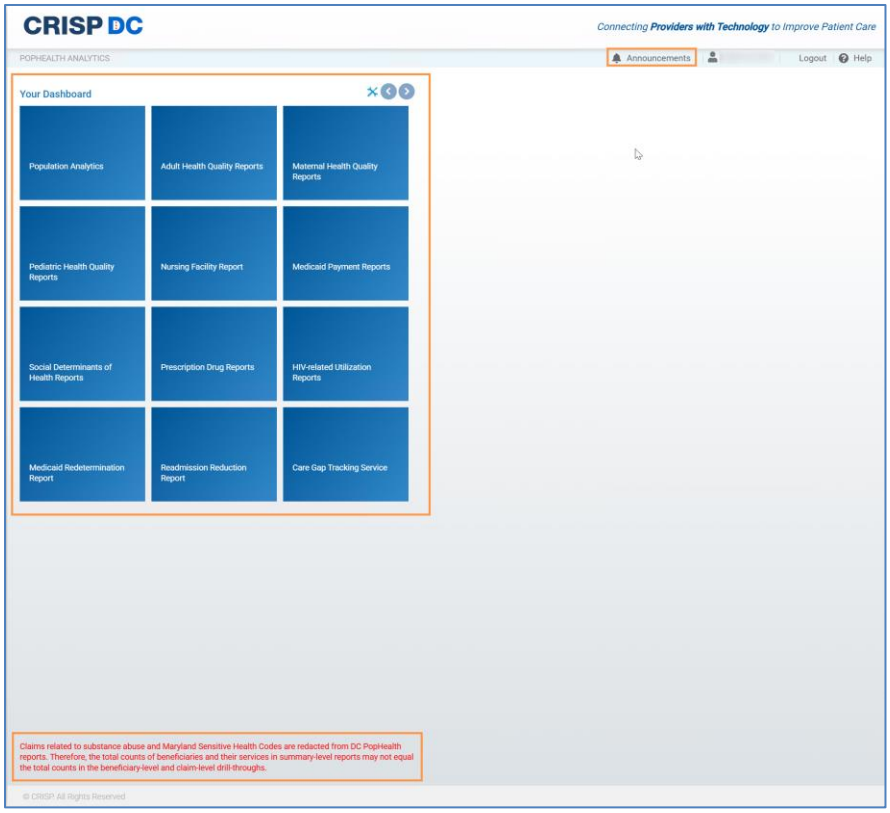
General Navigation & Common Features

This guide provides an overview of the universal navigation elements, interactive features, and data concepts you will encounter throughout the PopHealth report suite. Understanding these core functions will enable you to navigate the dashboards efficiently and interpret the data accurately.

1. Core Navigation & Interface Elements

The PopHealth suite is designed with a consistent and intuitive interface to ensure a seamless user experience across all reports.

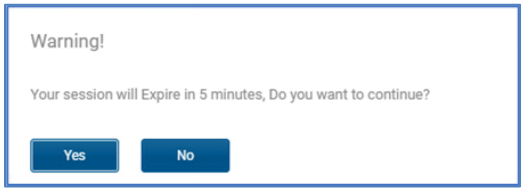
1. **Landing Page (Home)**: This is the PopHealth Analytics landing page you see upon logging into the application. This is where you can see all the report cards that you have access to. Clicking into these report cards shows you available reports.
    a. **Disclaimer**: Note the critical disclaimer displayed at the bottom of the landing page. Claims related to substance abuse and Maryland Sensitive Health Codes are strictly redacted from DC PopHealth reports. As a direct result, total counts of beneficiaries and their services in the summary-level reports may not equal the numbers found in beneficiary-level and claim-level drill-through views.
    b. **Announcement Section:** The top toolbar's Announcements section highlights system updates, scheduled maintenance, and administrative alerts shared by the CRISP DC team for the user community.
2. **Left Navigation Menu**: The primary method for navigating between reports is the vertical menu on the far left. Click a report name to load it. To maximize your viewing area, click the Collapse Menu icon at the top of the menu; click it again to expand.
3. **The "i" Info Button**: Located on many dashboards, this blue circular icon provides context:
    a. Hover: Displays a tooltip with a brief report description or technical specifications for quality measures.
    b. Click: Copies a direct, permanent link of the current report view to your clipboard for easy sharing.
4. **Session Timeout**: For security, the application includes an automatic logout. If the session is inactive for a set duration, a warning prompt will appear with five-minute remaining, allowing you to either continue the session or log out.



[Screenshot 1: Landing Page]

[Screenshot 2 and 3: Left navigation menu and the Collapse Menu button]

[Screenshot 4: 'i' Info Button]



[Screenshot 5: Session Timeout Warning prompt]

2. Universal Filters & Dashboard Controls

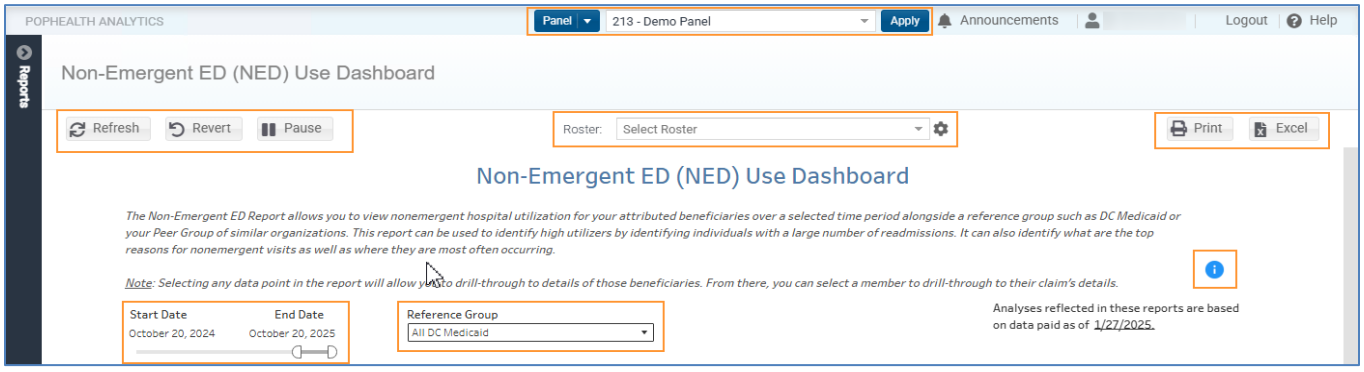
Filters and controls are located at the top of the screen to help you scope data to specific populations and time frames.

Population & Time Filters

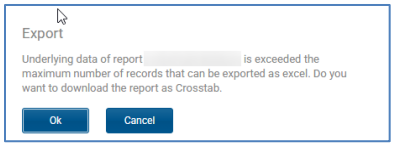
1. **Panel**: The primary dropdown used to select a specific practice, provider group, or attributed population. The entire dashboard updates based on this selection.
2. **Roster:** Allows for granular refinement within a Panel, such as selecting the "Attributed Roster" or custom-defined patient lists (e.g., "High-Risk Hypertensive Patients").
3. **Time Frame / Date Ranges**: Defines the reporting period. Use the timeline slider (drag the circular start/end indicators) or the "Measure Year" dropdown to select specific calendar or fiscal years.
4. **Reference Group**: Compares your Panel against a larger benchmark (e.g., "FQHC Peer Groups" or "All DC Medicaid"). Reference data typically appears alongside your panel data on charts for comparison.

Action Buttons

1. **Apply**: If present, click this blue button to refresh visualizations after changing filters. Some reports update automatically.
2. **Revert**: Discards all filter changes and drill-throughs, resetting the dashboard to its last saved or default state.
3. **Pause / Resume**: Temporarily freezes data updates. This is useful when making multiple filter changes at once to prevent the report from reloading after every individual selection.
4. **Print**: Opens the browser's print dialog to generate a PDF or physical copy of the current dashboard view exactly as it appears.
5. **Excel**: Exports the underlying summary data into a .csv or .xlsx file for offline analysis.
    a. **Excel Export Limitations:** When attempting to download large data sets directly as an Excel file, users will be blocked if the underlying volume exceeds standard system row limits. In these scenarios, a prompt will appear redirecting you to proceed with a Crosstab download, which seamlessly converts the entire unrestricted dataset into a flat .csv file format instead.



[Screenshot 6: Top filter bar and action buttons]



[Screenshot 7: Excel Export Limitation message]

3. Interacting with the Data (Hover & Drill-Through)

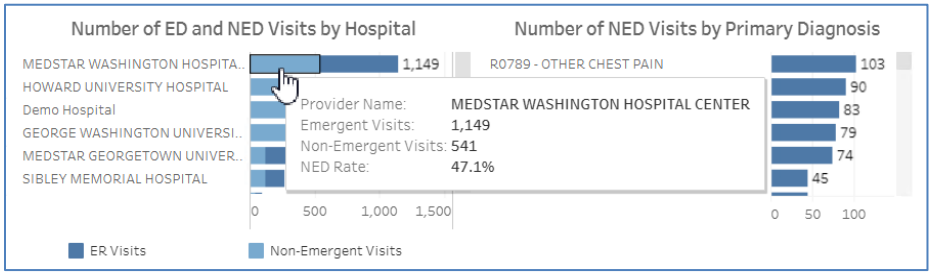
The dashboards are designed to be fully interactive, allowing you to move from high-level summaries to granular details seamlessly.

1. **Hover Over / Tooltips**: To see the precise values behind any visualization, simply move your mouse cursor and hover over a data point (e.g., a bar, a point on a line graph, or a map region). A small pop-up box, known as a tooltip, will automatically appear. This tooltip displays the exact metrics for that specific element, such as the member count, performance rate, denominator, and other relevant context, without requiring a click.
2. **Data Drill-Through**: This is the most powerful interactive feature. When you need to see the specific beneficiaries or claims that make up an aggregated number, you can click directly on the chart element.

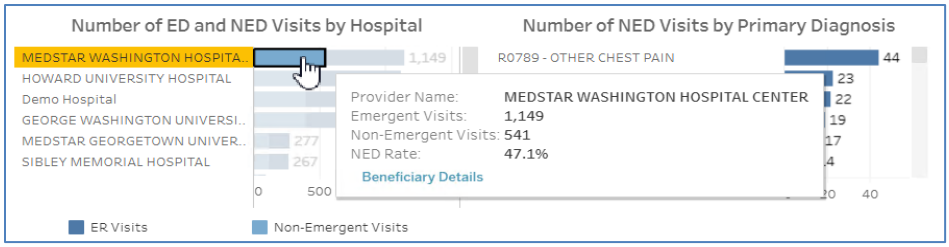
Click Path Example:

1. On a bar chart showing "Number of ED and NED Visits by Hospital," identify the bar you want to investigate.
2. Click directly on that bar.
3. The dashboard will automatically navigate you to a new view: a detailed, line-level table.
4. This table will list every individual beneficiary who meets the criteria of the bar you clicked, along with their relevant details.

IMPORTANT PRIVACY LIMITATION: To comply with strict privacy regulations (42 CFR Part 2), the drill-through functionality is disabled on reports covering substance use disorder subjects. This includes, but is not limited to, measures such as Follow-up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA), Follow-up After Hospitalization for Mental Illness (FUH), Initiation and Engagement of Treatment (IET), and Pharmacotherapy for Opioid Use Disorder (OUD).



[Screenshot 8: Hoverable chart element]



[Screenshot 9: Clickable chart element that leads to a Drill-Through view]

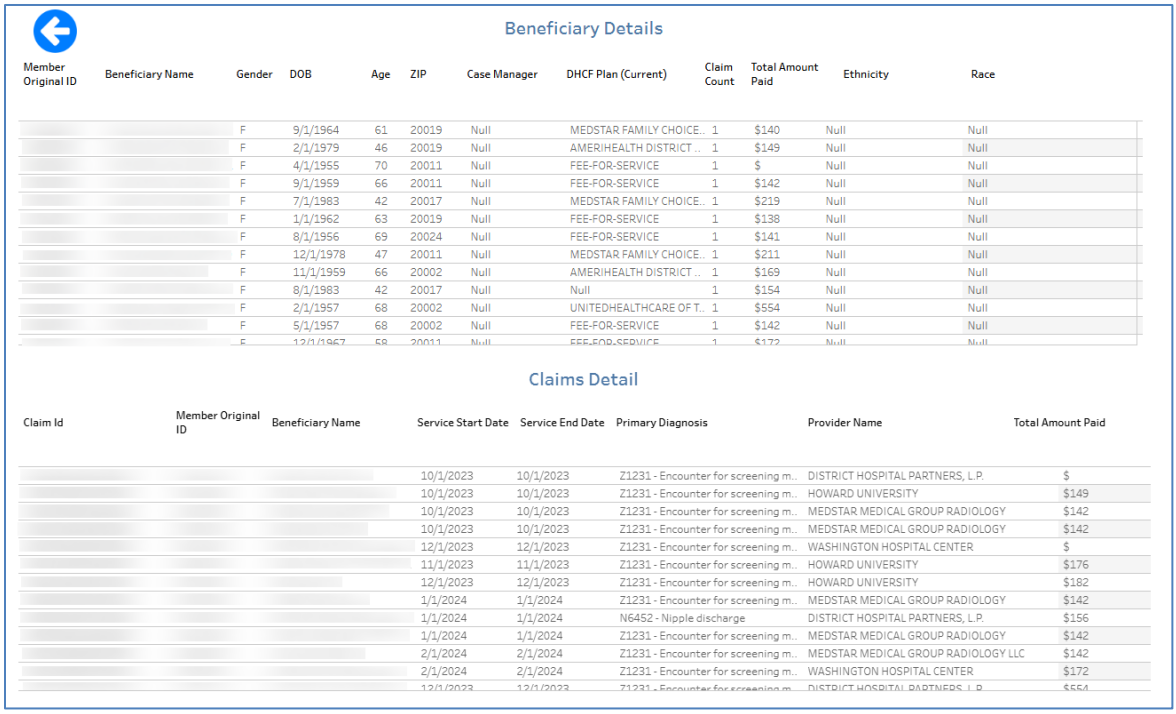
4. Navigating Beneficiary & Detail Tables

After using the drill-through feature, you will be presented with a Beneficiary Detail Table. These tables provide the line-level data behind the summary charts.

1. **Reading the Table:** Each row typically represents a unique beneficiary or claim, and columns provide specific details such as Member ID, Beneficiary Name, Diagnosis, Date of Service, and Cost. You can scroll horizontally and vertically to review all the available data.
2. **Returning to the Main Report (Blue Back Arrow):** To return to the main summary report from a detail table, use the dedicated **Blue Back Arrow** button. This button is typically located in the top-left of the screen on drill-through views.

How to Use:

1. After reviewing the detail table, locate the Blue Back Arrow.
2. Click the arrow.
3. You will be instantly and safely returned to the previous summary dashboard. Crucially, using this dedicated arrow **preserves the state of your previous session**.



[Screenshot 10: Beneficiary and Claim Details Table and the Blue Back Arrow]

5. Exporting Data & Reports

You can easily export the contents of any dashboard for offline use, presentations, or further analysis. Look for the export buttons, typically located in the top-right corner of the report.

Export to PDF: This option creates a static, printable version of the current dashboard view.

1. Click the **Print** button.
2. A new dialog or screen will appear. Click **Create PDF**.
3. Once the PDF is generated, click **Download** to save the file to your computer.

Export to Excel: This option exports the raw data underlying the dashboard's visualizations.

1. Click the **Excel** button.
2. An `.xlsx` file will be downloaded immediately to your computer.
3. This Excel workbook will contain multiple sheets: a separate worksheet for the data from each chart or table on the dashboard, plus an "About" sheet that provides metadata on the export, including the filters that were applied at the time of download.

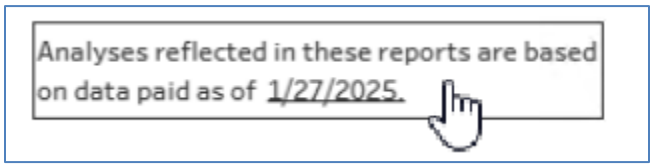
[Screenshot 11: Print and Excel buttons]

6. Understanding Data Nuances: Claim Lag & Care Gaps

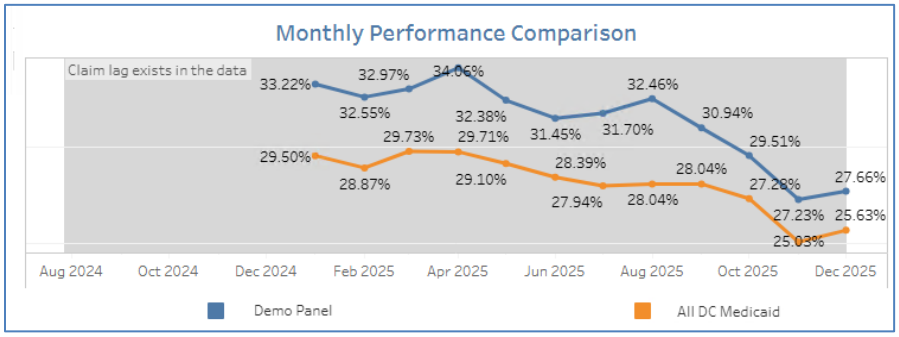
When interpreting the data, it is crucial to understand the concept of "claim lag". Many reports will display a disclaimer stating, **"Claim lag exists in the data shown."**

1. **What is Claim Lag?** Claim lag is the natural delay between when a healthcare service is provided to a patient and when the data for that service is fully processed and loaded into this platform. This process can take anywhere from several weeks to over three months. Consequently, data for the most recent 1-3 months is always considered preliminary and may be incomplete.
2. **DC Medicaid Claim Lag**: Over 80% of DC Medicaid claims are fully paid and finalized within 4 months of the service date.
3. **Impact on Care Gaps:** This data lag directly impacts the accuracy of care gap information. A report may indicate that a patient has an "open" care gap because the system has not yet received the claim for a screening that was actually performed last month.

Recommended Workflow: When using these reports for outreach, always factor in claim lag. If you identify a patient with a care gap, first consult your organization's EMR or internal billing records to confirm a service has not already been completed within the last 90 days. This prevents redundant outreach and ensures a better patient experience.



[Screenshot 12: Claim Lag disclaimer on a dashboard]

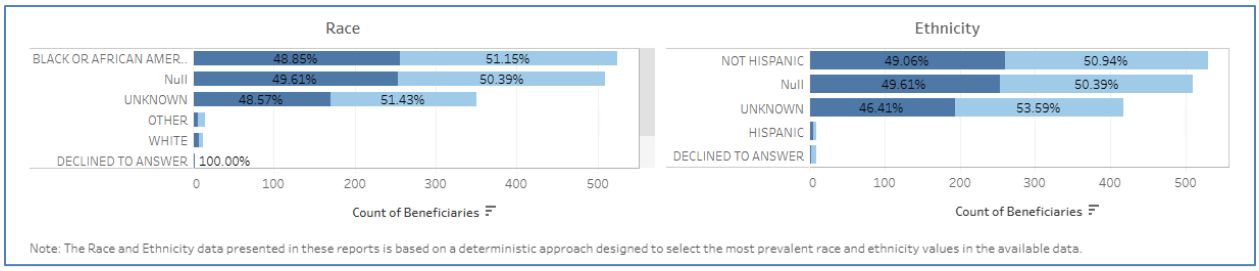


[Screenshot 13: Claim Lag highlight on a dashboard]

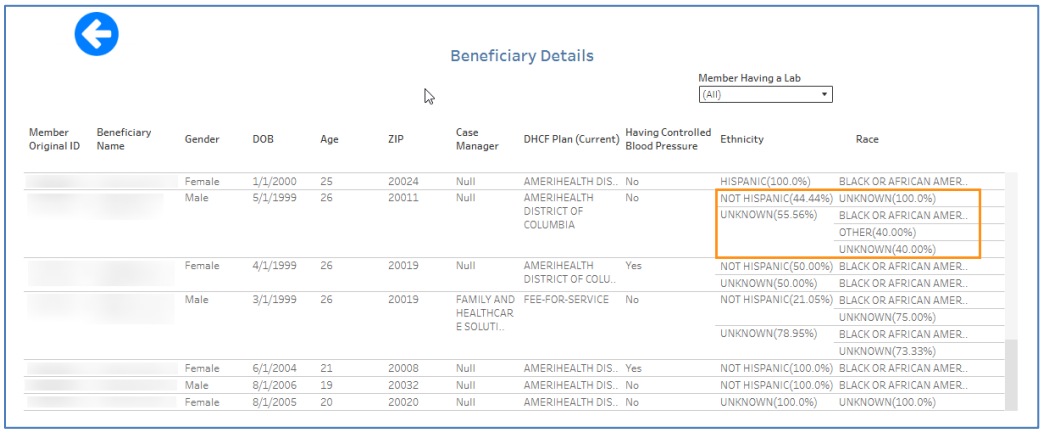
7. Understanding Race and Ethnicity

When interpreting race and ethnicity insights across the PopHealth platform, it is essential to understand how data logic shifts between high-level summaries and granular, patient-level views:

1. **Deterministic Summary Reporting**: The Race and Ethnicity bar charts presented in the main dashboard summary views utilize a deterministic logic model. This approach automatically calculates and displays only the most prevalent, primary race and ethnicity values captured across the available data history to ensure clean, actionable population benchmarking.
2. **Non-Deterministic Drill-Through Reporting**: Conversely, the **Beneficiary Details** drill-through tables adopt a non-deterministic approach designed to preserve complete clinical visibility. Instead of isolating a single metric, this view surfaced every historical race and ethnicity value recorded within the CRISP HIE framework for that specific beneficiary, often displaying a proportional percentage breakdown for individuals with multi-sourced or changing administrative records.



[Screenshot 14: Race and Ethnicity display in the main dashboard summary view]



[Screenshot 15: Race and Ethnicity display in Beneficiary Details drill-through view]

Population Navigator Tool User Guide

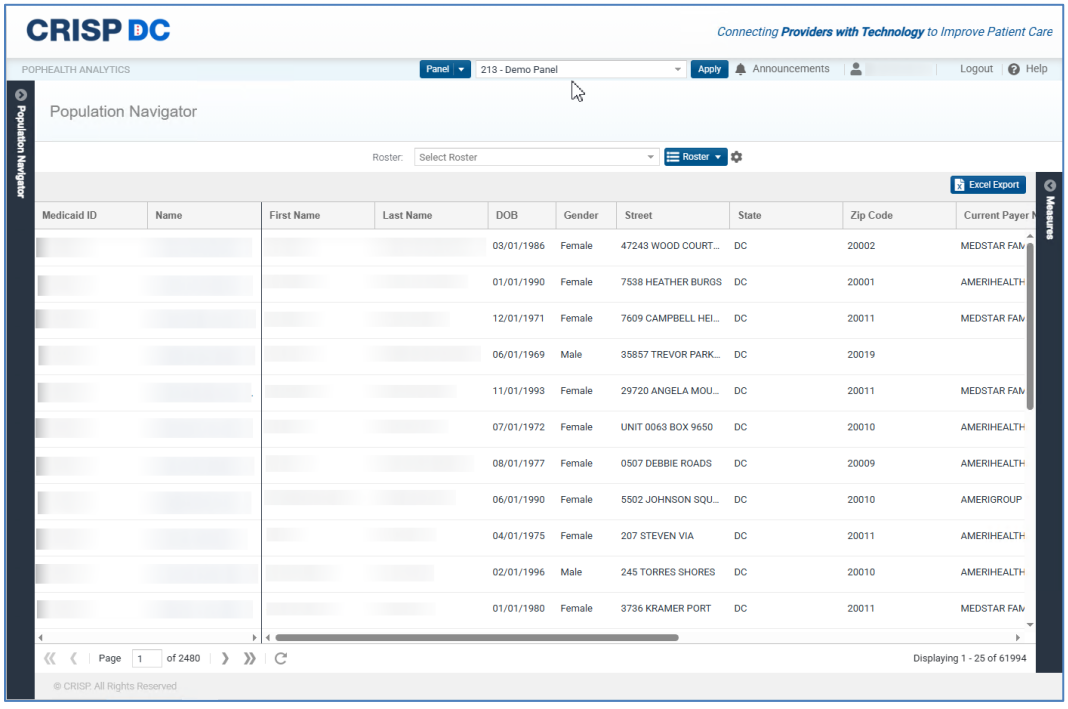
Overview & Purpose

The Population Navigator is a robust analytical tool designed for population health management. It allows users to view, segment, and manage comprehensive patient populations and provider panels. Through its advanced filtering capabilities, users can create targeted patient subsets, known as rosters, based on a wide range of criteria including demographics, chronic conditions, and social determinants of health. These custom rosters can then be saved and utilized as a powerful filtering mechanism across the entire suite of PopHealth reports, enabling precise and focused analysis.

Part 1: Landing Page, Columns, and Filters

1. Navigating the Patient List & Columns

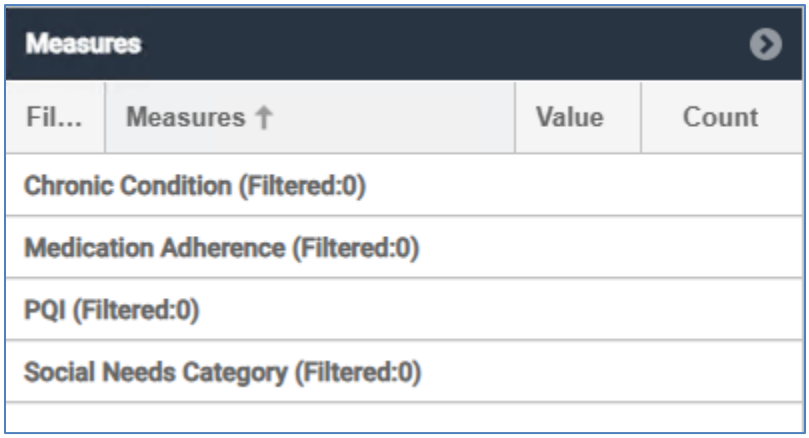
The main screen of the Population Navigator displays a detailed list of patients within your selected panel. The header bar contains key patient identifiers and clinical information. Standard columns include **Medicaid ID**, **Name**, **Zip Code**, **Current Payer Name**, **DHCF Program**, **Most Recent Type of Visit**, and **Most Recent Place of Visit**. Users can interact with this list by hovering over any column header and clicking to sort the data in ascending or descending order, which is indicated by an arrow icon, or use them as a mechanism to apply filters to the data.



[Screenshot 1: Main patient list columns]

2. The Measures Pane (Filtering)

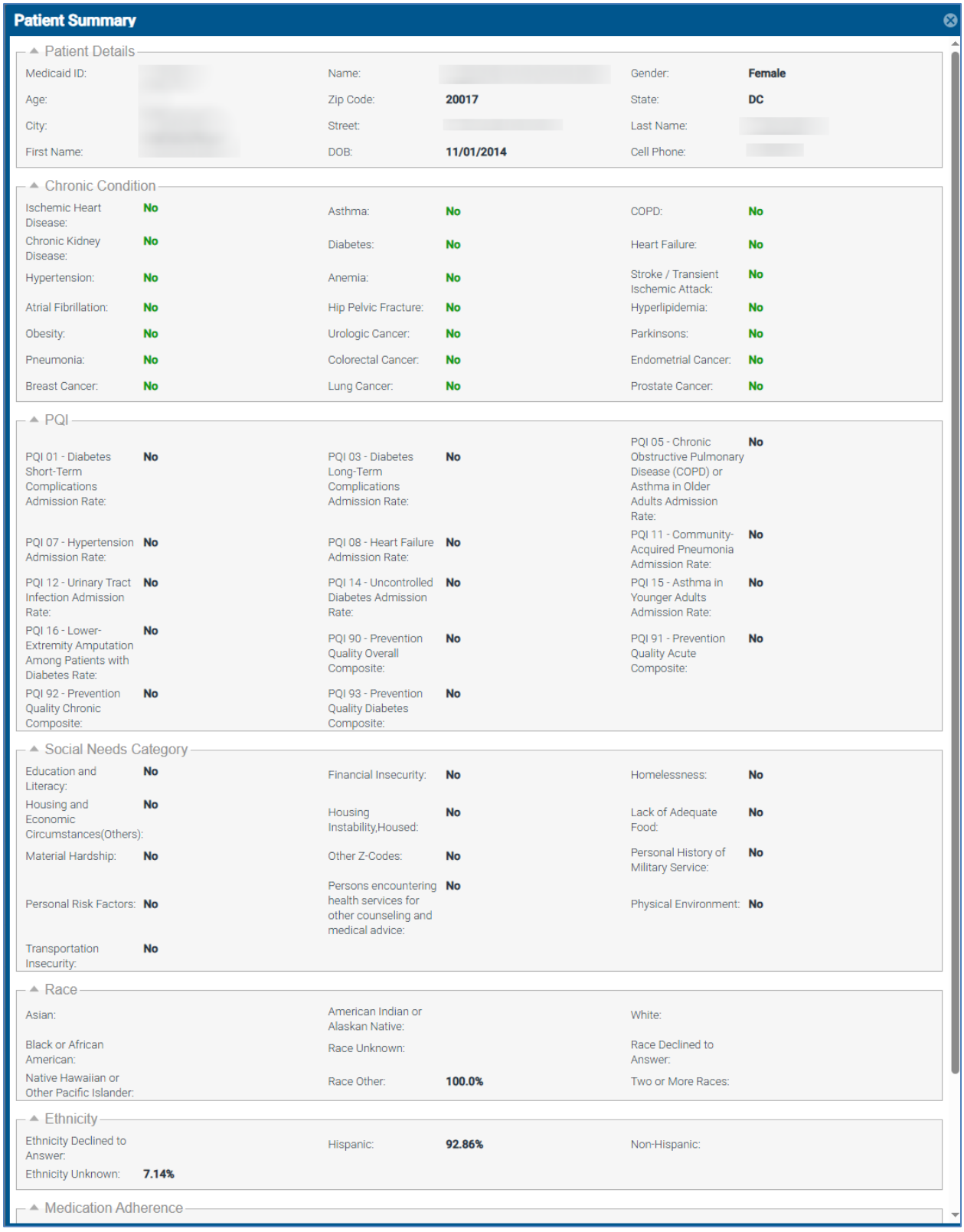
Located on the right side of the screen, the **Measures Pane** is the primary tool for filtering your patient population. This pane is organized into high-level categories such as **Chronic Conditions**, **Preventive Quality Indicators (PQI)**, and **Social Needs Categories**. To apply a filter, simply expand a category and check the box next to the desired measure (e.g., Diabetes). The 'Value' column indicates the filter criteria (e.g., "Yes" for a condition being present), and the 'Count' column displays the total number of beneficiaries in your current view who meet that specific criterion. Multiple filters can be applied simultaneously to create a highly specific patient cohort.



[Screenshot 2: Measures Pane on the right-side]

3. Patient Summary Cards

To gain a quick, high-level understanding of an individual patient, you can click on their hyperlinked name in the main patient list. This action opens a **Patient Summary** card. This pop-up window provides a snapshot of the patient's key information, including detailed demographics, a list of their chronic conditions marked as "Yes" or "No," and any identified social needs. This feature allows for rapid patient-level review without navigating away from the main population view.



Patient Summary

Patient Details

Medicaid ID:		Name:		Gender:	**Female**
Age:		Zip Code:	**20017**	State:	**DC**
City:		Street:		Last Name:	
First Name:		DOB:	**11/01/2014**	Cell Phone:	

Chronic Condition

Ischemic Heart Disease:	**No**	Asthma:	**No**	COPD:	**No**
Chronic Kidney Disease:	**No**	Diabetes:	**No**	Heart Failure:	**No**
Hypertension:	**No**	Anemia:	**No**	Stroke / Transient Ischemic Attack:	**No**
Atrial Fibrillation:	**No**	Hip Pelvic Fracture:	**No**	Hyperlipidemia:	**No**
Obesity:	**No**	Urologic Cancer:	**No**	Parkinsons:	**No**
Pneumonia:	**No**	Colorectal Cancer:	**No**	Endometrial Cancer:	**No**
Breast Cancer:	**No**	Lung Cancer:	**No**	Prostate Cancer:	**No**

PQI

PQI 01 - Diabetes Short-Term Complications Admission Rate:	**No**	PQI 03 - Diabetes Long-Term Complications Admission Rate:	**No**	PQI 05 - Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate:	**No**
PQI 07 - Hypertension Admission Rate:	**No**	PQI 08 - Heart Failure Admission Rate:	**No**	PQI 11 - Community-Acquired Pneumonia Admission Rate:	**No**
PQI 12 - Urinary Tract Infection Admission Rate:	**No**	PQI 14 - Uncontrolled Diabetes Admission Rate:	**No**	PQI 15 - Asthma in Younger Adults Admission Rate:	**No**
PQI 16 - Lower-Extremity Amputation Among Patients with Diabetes Rate:	**No**	PQI 90 - Prevention Quality Overall Composite:	**No**	PQI 91 - Prevention Quality Acute Composite:	**No**
PQI 92 - Prevention Quality Chronic Composite:	**No**	PQI 93 - Prevention Quality Diabetes Composite:	**No**		

Social Needs Category

Education and Literacy:	**No**	Financial Insecurity:	**No**	Homelessness:	**No**
Housing and Economic Circumstances(Others):	**No**	Housing Instability,Housed:	**No**	Lack of Adequate Food:	**No**
Material Hardship:	**No**	Other Z-Codes:	**No**	Personal History of Military Service:	**No**
Personal Risk Factors:	**No**	Persons encountering health services for other counseling and medical advice:	**No**	Physical Environment:	**No**
Transportation Insecurity:	**No**				

Race

Asian:		American Indian or Alaskan Native:		White:	
Black or African American:		Race Unknown:		Race Declined to Answer:	
Native Hawaiian or Other Pacific Islander:		Race Other:	**100.0%**	Two or More Races:	

Ethnicity

Ethnicity Declined to Answer:		Hispanic:	**92.86%**	Non-Hispanic:	
Ethnicity Unknown:	**7.14%**				

Medication Adherence

[Screenshot 3: Expanded Patient Summary Card]

4. Exporting Patient Lists

Once you have filtered the patient list to your desired cohort, you can export the data for offline analysis or use in other workflows.

Step-by-step instructions:

1. Click the **Excel Export** button located in the upper-right corner of the patient list.
2. A system prompt will appear, requiring you to attest that you understand the data contains Protected Health Information (PHI) and that you are responsible for its secure handling.
3. Click **Yes** to agree to the PHI attestation.
4. The download will begin automatically, generating an Excel file containing the data from your currently filtered view.

Part 2: Roster Functionality & Creation

1. Introduction to Rosters

Rosters are custom, saved subsets of patients that you create within the Population Navigator. Think of them as a saved "snapshot" of a filtered list. The primary power of rosters is their portability; once created, a roster can be selected from a drop-down menu in other PopHealth reports, instantly filtering those reports to show data for only the patients in your custom group. This is essential for tracking specific cohorts, managing intervention groups, and performing targeted quality improvement analysis.

2. How Panels Link to Rosters?

While a Panel represents your broader attributed patient population, a "Roster" allows for granular refinement within that specific Panel.

3. Creating a Roster from a Current View

This method is used to save a patient list that you have generated using the filters in the Measures Pane.

Step-by-step instructions:

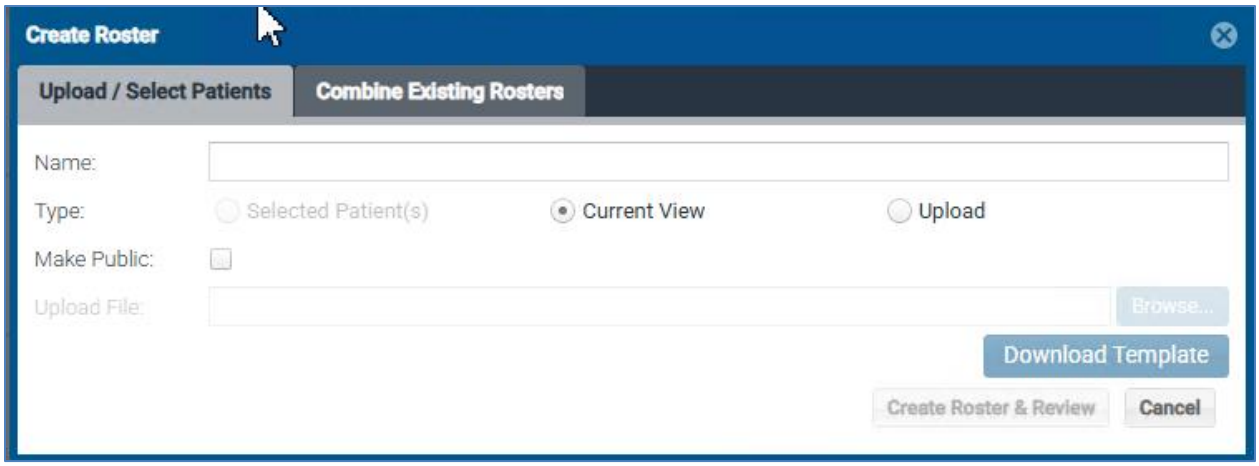
1. Apply one or more filters from the Measures Pane or Column Headers to segment the patient list as desired.
2. Click the blue **Roster** button above the patient list and select **Create** from the dropdown menu.
3. In the 'Create Roster' window, enter a descriptive **Name** for your roster.
4. Ensure the 'Type' is set to **Current View**.
5. Click **Create Roster & Review** to proceed. You will be shown a final list of patients for confirmation before saving.

Warning: The **Make Public** checkbox will make your roster visible to all users at your organization. Use this option with caution and only for rosters that are universally applicable.

4. Creating a Roster via Excel Upload

This method allows you to create a roster based on a list of patients from an external source.
Step-by-step instructions:

1. Click the **Roster** button and select **Create**.
2. Select the **Upload** option under 'Type'.
3. Click **Download Template** to get a pre-formatted Excel file.
4. Open the template and populate the MedicaidID column with the Medicaid IDs of the patients you wish to include. Save the file.
5. Return to the tool, click **Browse...**, and select your populated template file.
6. Click **Create Roster & Review** to upload the list and confirm the patient matches before saving.



[Screenshot 4: Roster creation menu and the Upload/Current View toggles]

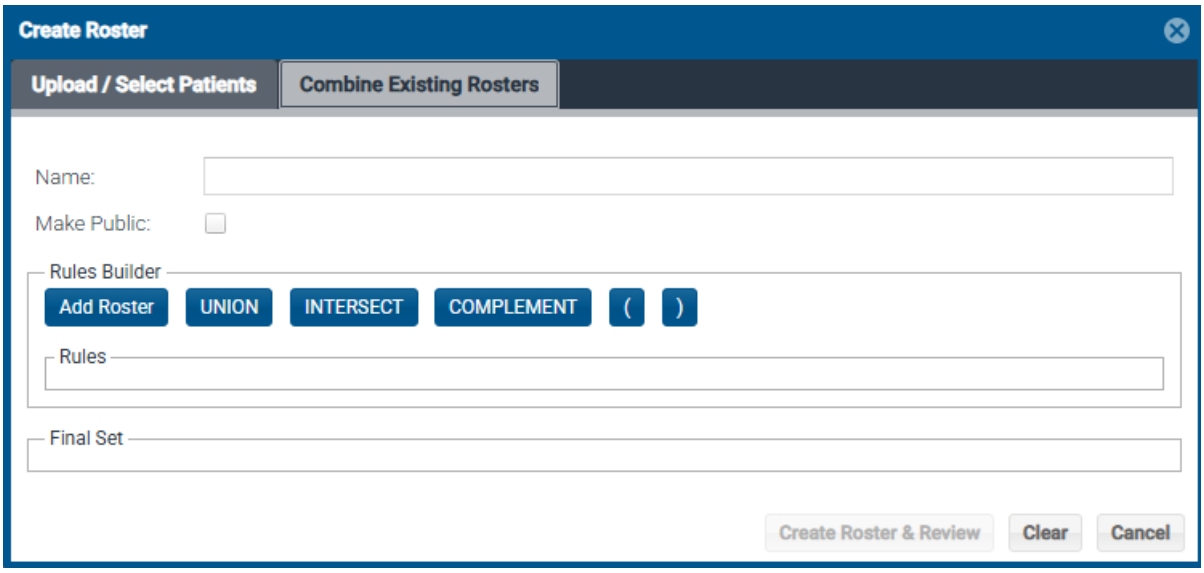
5. Combining Existing Rosters (Rules Builder)

The Rules Builder offers advanced functionality to create new rosters by logically combining up to two existing rosters.
Step-by-step instructions:

1. Click the **Roster** button, select **Create**, and navigate to the **Combine Existing Rosters** tab.
2. Enter a **Name** for your new combined roster.
3. Use the **Add Roster** button to select your first existing roster.
4. Select a logical operator:
    - **Union:** Combines all unique patients from both rosters. (Patients in Roster A **OR** Roster B).
    - **Intersect:** Creates a list of only the patients who appear in **BOTH** rosters. (Patients in Roster A **AND** Roster B).

- **Complement:** Creates a list of patients who are in the first roster but **NOT** in the second. (Patients in Roster A **but NOT** in Roster B).

5. Use the **Add Roster** button again to select your second roster.
6. Click **Create Roster & Review** to generate and save the new list.



[Screenshot 5: Rules Builder (Union, Intersect, Complement) interface]

Part 3: Roster and Panel Manager

1. Managing Visibility

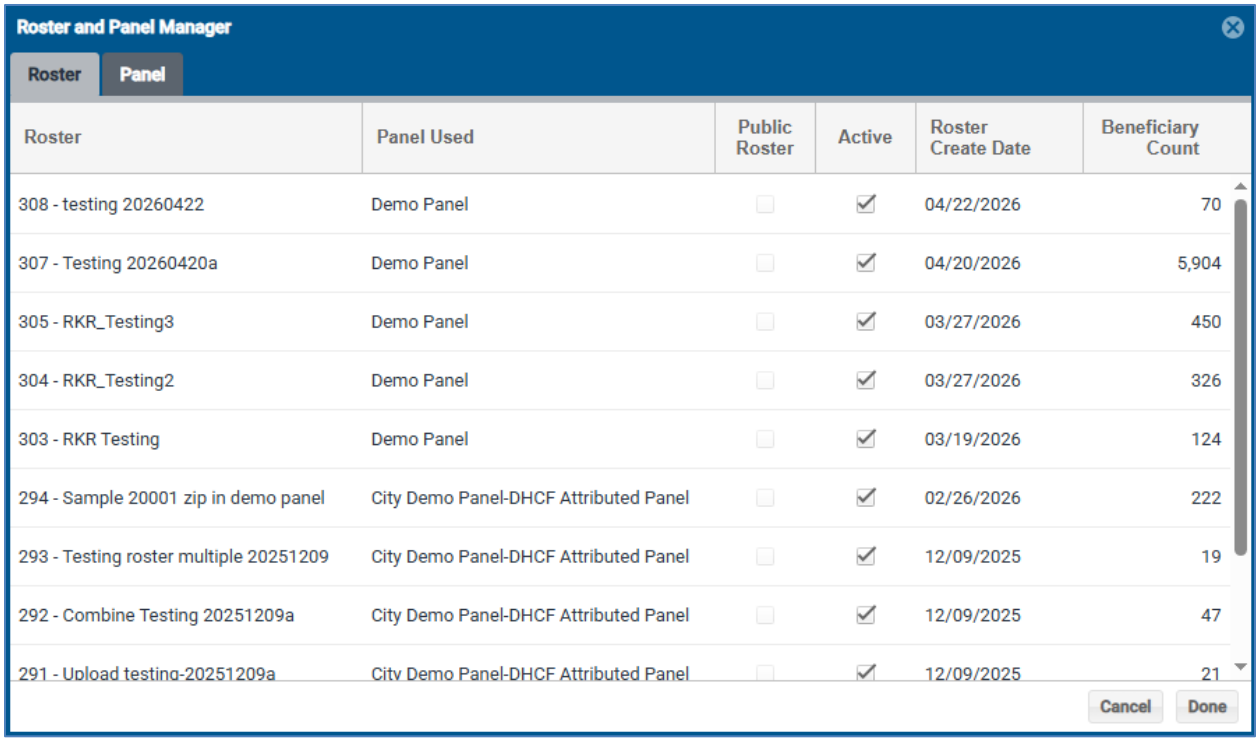
The **Roster and Panel Manager** is a personalization tool that allows you to control which rosters and provider panels are visible in the drop-down selection menus throughout the PopHealth reporting suite. By hiding rosters or panels that are not relevant to your daily workflow, you can de-clutter the interface and make it easier to find the specific populations you need to analyze.

2. How to Operate

Your selections in the Roster and Panel Manager are specific to your user account and do not affect what other users see.

Step-by-step instructions:

1. Click the **gear icon** located to the right of the Roster button.
2. The 'Roster and Panel Manager' window will open. You can toggle between the **Roster** and **Panel** tabs.
3. Review the list of available items. To hide an item from your dropdown menus, uncheck the box in the **Active** column next to its name. To make it visible again, check the box.
4. Click **Done** to save your preferences. The changes will be immediately reflected in the selection dropdowns.



[Screenshot 6: Roster and Panel Manager window with the Active checkboxes]

Part 4: Functional Use Cases

Managing a Chronic Condition Cohort

A Care Manager needs to identify and conduct outreach for all empaneled patients with uncontrolled Diabetes. They would use the Measures Pane to filter for 'Chronic Condition: Diabetes'. After reviewing the list, they would click 'Roster' -> 'Create', name it "Q3 Diabetes Outreach," and save it from the 'Current View'. Finally, they would use the 'Excel Export' function to download the list, which can be used to generate letters or as a call sheet for the care management team.

Tracking a Specific Community Program Cohort

A Population Health Analyst wants to track outcomes for a group of patients who attended a specific community health fair. The organization has a list of Medicaid IDs for the attendees. The analyst would navigate to 'Roster' -> 'Create', select the 'Upload' type, and download the template. After populating the template with the attendee IDs, they upload it to create a roster named "Community Health Fair Attendees - May 2024." This roster can now be applied to other PopHealth reports to monitor ED visits or primary care follow-up for this specific group.

Identifying Patients with Chronic Conditions and Health-related Social Needs

A Population Health Strategist aims to launch a pilot program for patients with both Diabetes and Housing Instability. First, they create a roster of all patients with Diabetes. Second, they create another roster of all patients with an identified 'Social Need: Housing Instability'. They then navigate to the 'Combine Existing Rosters' tool, use the 'Intersect' operator on these two rosters, and create a new, high-risk roster named "Diabetes + Housing Instability Pilot." This precisely targeted list becomes the foundation for the pilot program's enrollment and intervention efforts.

PopHealth Reports User Guide

1. Acute Care Setting Utilization Report - Inpatient

1. Report Overview & Purpose

This report provides a comprehensive overview of Inpatient (IP) and Emergency Room (ER) utilization for a selected patient population. It helps organizations analyze trends in admissions, readmissions, and associated costs, as well as identify avoidable hospitalizations and top diagnoses. The primary purpose is to support care management, quality improvement, and cost-containment initiatives by highlighting key drivers of acute care utilization.

2. Available Filters & Interactivity

1. **Panel**: Drop-down menu to select a specific panel or group of beneficiaries.
2. **Roster**: Drop-down menu to select a specific patient roster within a panel.
3. **Start Date**: Calendar selector to define the beginning of the reporting period.
4. **End Date**: Calendar selector to define the end of the reporting period.
5. **Utilization**: Drop-down menu to toggle the view between Inpatient (IP) and Emergency Department (ED) utilization data.
6. **Data Drill-Through**: Users can click on the bars within the "Avoidable vs. Unavoidable Inpatient Admissions by Hospital" and "Top Diagnosis by Number of Visits" charts to access a detailed list of the underlying beneficiaries. Users can also click on the rows in the "Utilization Summary by Patient" and "Utilization Summary by Hospital" tables to drill through to the beneficiary-level claims view.

3. Key Metrics & KPIs

1. **Total IP Admissions**: The total count of inpatient admissions during the selected time frame.
2. **Readmissions**: The total count of inpatient admissions that occur within 30 days of a previous inpatient discharge.
3. **Readmission Rate**: The percentage of total admissions that are classified as readmissions.
4. **Avg. LOS in Days**: The average length of stay, in days, for inpatient admissions.
5. **PQI (Prevention Quality Indicator) Admissions**: The count of inpatient admissions for conditions that are considered potentially avoidable through high-quality ambulatory care.
6. **Non-PQI Admissions**: The count of inpatient admissions that are not classified as potentially avoidable.

7. **Total Amount Paid**: The total dollar amount paid for services for the specified provider or patient group.
8. **Amount Paid Per Patient**: The average cost of care calculated on a per-patient basis.
9. **Amount Paid Per Visit**: The average cost of care calculated on a per-visit (admission) basis.
10. **Member Count**: The total number of unique members attributed to a provider or included in a summary.

4. Visualizations & Data Tables

1. **Monthly Trend of Total IP and Readmissions**: A line chart displaying the volume of total inpatient admissions (blue line) versus readmissions (orange line) over time, allowing for the identification of trends and seasonality.
2. **Monthly Trend of Average Inpatient Admissions and Readmissions Payments**: A line chart that tracks the average cost per admission and readmission over the selected period, helping to monitor cost trends.
3. **Avoidable vs. Unavoidable Inpatient Admissions by Hospital**: A stacked bar chart that breaks down admissions for each hospital into avoidable (PQI, light blue) and unavoidable (Non-PQI, dark blue) categories, highlighting opportunities for quality improvement.
4. **Top Diagnosis by Number of Visits**: A horizontal bar chart ranking the most common diagnoses leading to inpatient visits, providing insight into the clinical drivers of utilization.
5. **Utilization Summary by Patient**: A table detailing utilization metrics for individual patients, including their average length of stay, total admissions, readmissions, and readmission rate. This helps identify high-utilizing patients.
6. **Utilization Summary by Hospital**: A table that aggregates utilization and financial metrics by provider. It shows member count, total admissions, average length of stay, readmissions, readmission rate, and various cost metrics for each facility.

5. Functional Use Cases

1. **Understand Clinical Drivers of Cost**: A medical director can review the "Top Diagnosis by Number of Visits" chart to identify the most frequent conditions (e.g., Sepsis, Schizoaffective Disorder) driving hospitalizations and develop population health programs or clinical pathways to better manage these conditions in the community.
2. **Target Quality Improvement Initiatives**: A quality improvement director can analyze the "Avoidable vs. Unavoidable Inpatient Admissions by Hospital" chart to pinpoint facilities with a high proportion of PQI admissions and collaborate with them to improve outpatient care access and management for at-risk conditions.
3. **Monitor Utilization Trends Over Time**: A health plan administrator can use the "Monthly Trend" charts to track the overall volume and cost of inpatient admissions month-over-

month, assessing the impact of seasonal factors or new health plan interventions on utilization patterns.

4. **Identify High-Risk Patients for Care Management**: A care coordinator can sort the "Utilization Summary by Patient" table by "Readmission Rate" or "Total IP Admissions" to identify individuals with frequent hospitalizations who would benefit from intensive case management and care transition support.
5. **Evaluate Hospital Partner Performance**: A network manager can use the "Utilization Summary by Hospital" table to compare readmission rates and average costs across different facilities, informing value-based purchasing discussions and identifying high-performing partners.

6. Screenshot

Acute Care Setting Report

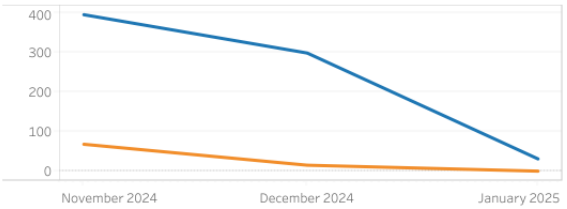
The Inpatient/ER utilization report allows you to view Inpatient and Emergency Room utilization of your beneficiaries over selected years. This report can help your organization identify specific visits that trigger Inpatient/ER based on APR DRG or patient demographic information.

Note: Selecting the Inpatient or Emergency Department Utilization filter toggles you between the Inpatient and Emergency Room utilization reports.

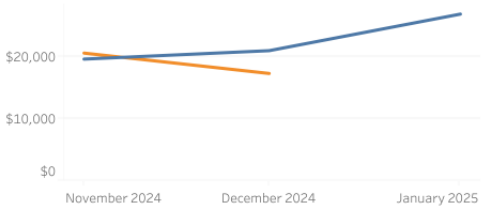
Start Date: October 20, 2024 | End Date: October 20, 2025 | Utilization: IP

Disclaimer: Claim lag exists in the data shown

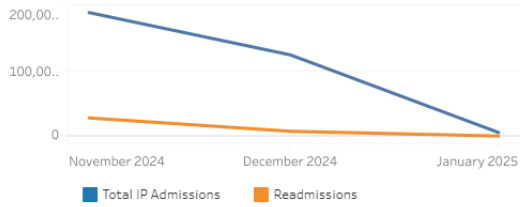
Monthly Trend of Total IP and Readmissions



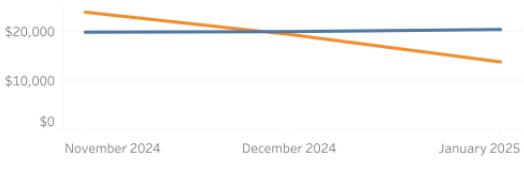
Monthly Trend of Average Inpatient Admissions and Readmissions Payments



Monthly Trend of Total IP and Readmissions for All DC Medicaid

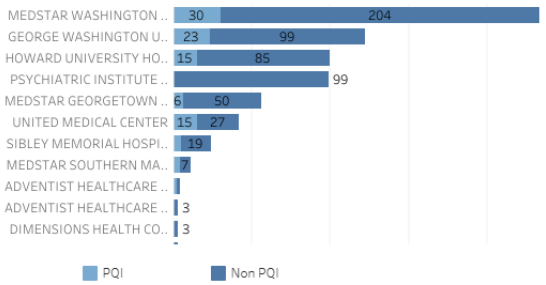


Monthly Trend of Average Inpatient Admissions and Readmissions Payments for All DC Medicaid

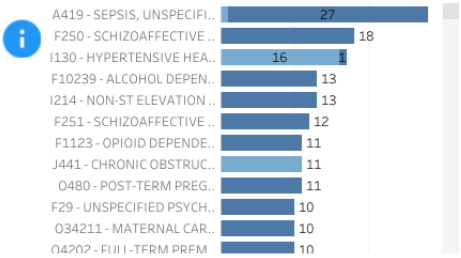


Total IP Admissions | Readmissions

Avoidable vs. Unavoidable Inpatient Admissions by Hospital



Top Diagnosis by Number of Visits



Utilization Summary by Patient

Member Original ID	Beneficiary Name	Avg. LOS in Days	Total IP Admissions	Readmissions	Readmission Rate
		1	4	3	75.0%
		11	3	2	66.7%
		11	3	2	66.7%
		22	3	2	66.7%
		11	3	2	66.7%
		1	3	2	66.7%

Utilization Summary by Hospital

Provider Name	Member Count	Total IP Admissions	Avg. LOS in Days	Readmissions	Readmission Rate	Total Amount Paid	Amount Paid Per Patient	Amount Paid Per Visit
MEDSTAR WA..	220	234	8	20	8.5%	$6,734,288	$30,610	$28,779
GEORGE WAS..	112	122	7	14	11.5%	$2,719,692	$24,283	$22,293
HOWARD UNI..	96	100	7	13	13.0%	$1,747,147	$18,199	$17,471
PSYCHIATRIC I..	90	99	8	14	14.1%	$736,105	$8,179	$7,435
MEDSTAR GEO..	51	56	9	7	12.5%	$1,192,942	$23,391	$21,303
UNITED MEDI..	39	42	8	6	14.3%	$467,957	$11,999	$11,142
SIBLEY MEMO..	23	24	5	2	8.3%	$355,732	$15,467	$14,822

2. Acute Care Setting Utilization Report - Emergency Room

1. Report Overview & Purpose

This report provides a comprehensive overview of Emergency Room (ER) utilization for a selected population. It is designed to help organizations analyze trends in ER visits and costs, identify top diagnoses driving ER use, and pinpoint specific beneficiaries and hospitals with high rates of non-emergent ER utilization. The goal is to support care management, cost control, and quality improvement initiatives by highlighting opportunities to divert non-emergent care to more appropriate settings.

2. Available Filters & Interactivity

1. **Start Date / End Date:** Allows the user to select a specific date range for the report's data.
2. **Utilization:** A dropdown menu to toggle the report's focus between different utilization types, currently set to 'ER' (Emergency Room).
3. **Roster:** A dropdown menu to filter the report for a specific, pre-defined list of beneficiaries.
4. **Data Drill-Through:** Users can click on charts or tables to navigate to a detailed view of the underlying claims or beneficiaries.

3. Key Metrics & KPIs

The report tracks the following performance indicators:

1. **Total ED Visits:** The total count of all emergency department visits within the filtered period.
2. **Non-Emergent Visits:** The count of ED visits classified as non-emergent, representing care that could have been delivered in a primary or urgent care setting.
3. **Total/Average ED Payments:** The total and average dollar amounts paid for ER services, shown for total and non-emergent visits.
4. **Total Claim Count:** The number of claims associated with a specific diagnosis code.
5. **Total Amount Paid:** The total amount for services aggregated by diagnosis, patient, or hospital.
6. **Non-Emergent Visit Rate:** The percentage of total ED visits classified as non-emergent (Non-Emergent Visits / Total ED Visits).
7. **Amount Paid Per Patient / Per Visit:** Cost metrics averaging the total amount paid across the number of patients or visits.

4. Visualizations & Data Tables

1. **Monthly Trend Charts:** Four dual-line charts tracking volume and average cost of total vs. non-emergent ER visits over time.

2. **Top ER Diagnosis:** A horizontal bar chart displaying top diagnoses ranked by total claims and amount paid.
3. **Visits by Hospital:** A bar chart comparing total and non-emergent ED visits across different hospitals.
4. **Utilization Summary by Patient:** A table detailing beneficiaries with the highest utilization, including visit counts and non-emergent rates.
5. **Utilization Summary by Hospital:** A detailed table aggregating utilization and cost metrics by hospital.

5. Functional Use Cases

1. **High-Risk Patient Identification:** Managers can use patient tables to enroll high utilizers in case management programs.
2. **Provider Network Collaboration:** Managers can identify facilities with high non-emergent rates to discuss alternative care pathways.
3. **Clinical Program Development:** Analyzing top diagnoses helps develop targeted outreach for specific conditions.
4. **Financial Planning & Budgeting:** Analysts use monthly trend charts to monitor expenditure and forecast future costs.
5. **Evaluating Payer-Specific Trends:** Comparing population trends with DC Medicaid helps inform tailored strategies for specific payers.

6. Screenshot

Acute Care Setting Report - All Population

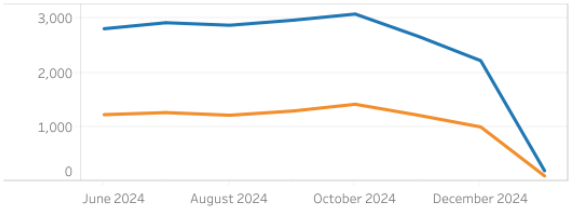
The Inpatient/ER utilization report allows you to view Inpatient and Emergency Room utilization of your beneficiaries over selected years. This report can help your organization identify specific visits that trigger Inpatient/ER based on APR DRG or patient demographic information.

Note: Selecting the Inpatient or Emergency Department Utilization filter toggles you between the Inpatient and Emergency Room utilization reports.

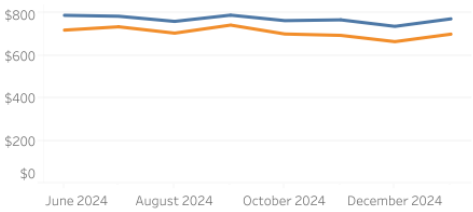
Start Date: May 19, 2024 | End Date: May 19, 2025 | Utilization: ER

Disclaimer: Claim lag exists in the data shown

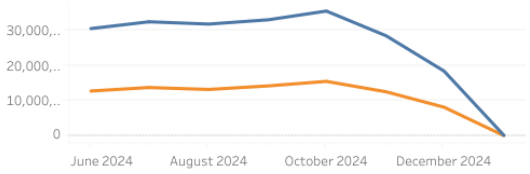
Monthly Trend of Total ER and Nonemergent ED Visits



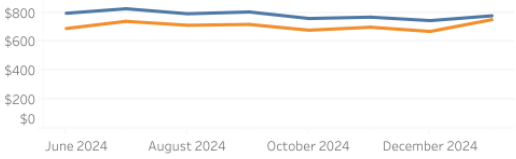
Monthly Trend of Average ER & Nonemergent ED Payments



Monthly Trend of Total ER and Nonemergent ED Visits for All DC Medicaid

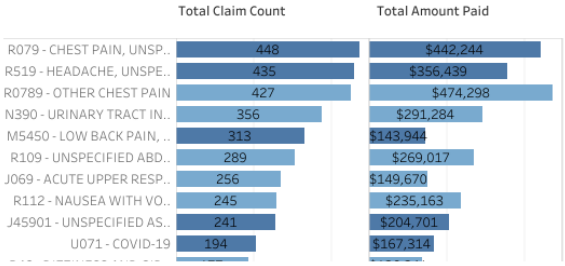


Monthly Trend of Average ER & Nonemergent ED Payments for All DC Medicaid

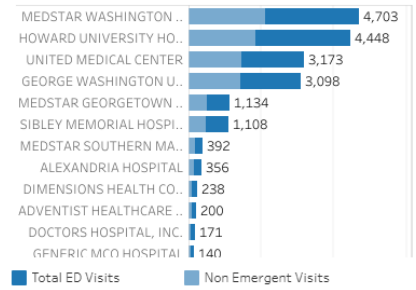


Total ED Visits | Non Emergent Visits

Top ER Diagnosis by Amount Paid & Visit Count



Number of ER vs Non Emergent Visits by Hospital



Total ED Visits | Non Emergent Visits

Utilization Summary by Patient

Member Original ID	Beneficiary Name	Total ED Visits	Non Emergent Visits	Non Emergent Visit Rate
[redacted]	[redacted]	83	66	79.5%
[redacted]	[redacted]	72	40	55.6%
[redacted]	[redacted]	53	27	50.9%
[redacted]	[redacted]	44	19	43.2%
[redacted]	[redacted]	42	20	47.6%
[redacted]	[redacted]	42	20	47.6%

Utilization Summary by Hospital

Provider Name	Member Count	Total ED Visits	Non-Emergent Visits	Non Emergent Visit Rate	Total Amount Paid	Amount Paid Per Patient	Amount Paid Per Visit
MEDSTAR WAS..	3,548	4,703	2,110	44.9%	$3,959,495	$1,116	$842
HOWARD UNIV..	2,981	4,448	1,844	41.5%	$2,860,235	$959	$643
UNITED MEDIC..	2,217	3,173	1,458	46.0%	$1,868,845	$843	$589
GEORGE WASHI..	2,027	3,098	1,415	45.7%	$2,689,677	$1,327	$868

3. ADT Completeness Report

1. Report Overview & Purpose

This report provides a comprehensive overview of the volume and data completeness of Admission, Discharge, and Transfer (ADT) messages received from participating hospitals. Its primary purpose is to allow data quality analysts and hospital administrators to monitor the consistency of data feeds and assess the completeness of key clinical fields (Admit, Diagnosis, Reason for Visit) within those messages. This ensures the data is reliable for downstream clinical and analytical use cases.

2. Available Filters & Interactivity

1. **Start Date**: Sets the beginning of the date range for the report's data.
2. **End Date**: Sets the end of the date range for the report's data.
3. **Hospital Name**: Filters the report to show data for one or more selected hospitals.
4. **Patient Class**: Filters data based on the patient's classification (e.g., Emergency, Inpatient, Observations).
5. **Event Type**: Filters the data by the specific type of ADT event (e.g., Discharge/end visit, Change an inpatient to an outpatient).
6. **Data Drill-Through**: Users can click on a hospital's bar in the "Percentage of ADTs" charts or a specific row in the detailed data table at the bottom to drill through to a detailed view of the underlying ADT messages that comprise the selected aggregate metric.

3. Key Metrics & KPIs

1. **Total ADTs Received**: The total count of ADT messages received from each hospital over the selected period.
2. **Percent of ADTs with Admit Populated**: The percentage of received ADT messages that contain a populated Admit field.
3. **Percent of ADTs with Diagnosis Populated**: The percentage of received ADT messages that contain a populated Diagnosis field.
4. **Percent of ADTs with Reason for Visit Populated**: The percentage of received ADT messages that contain a populated Reason for Visit field.
5. **Number of ADTs**: The total count of ADT messages, broken down by hospital, patient class, and event type in the detailed table.
6. **Admit/Diagnosis/Reason for Visit Count**: The raw count of ADTs with each respective field populated, shown in the detailed table.
7. **Admit/Diagnosis/Reason for Visit Percentage**: The percentage-based calculation of completeness for each field, broken down by hospital, patient class, and event type.

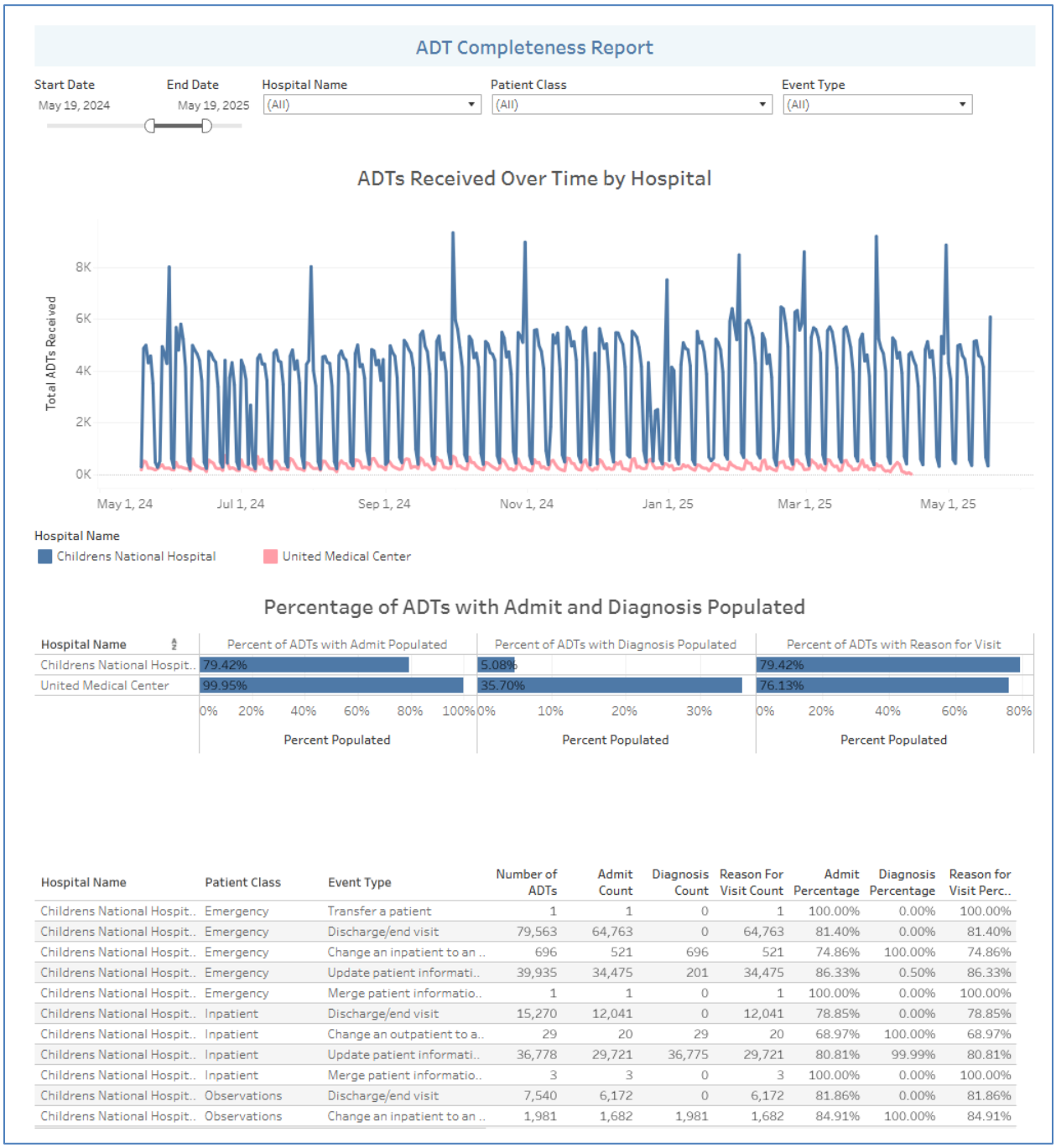
4. Visualizations & Data Tables

1. **ADTs Received Over Time by Hospital**: This line chart displays the daily volume of ADT messages, with separate-colored lines for each hospital (e.g., blue for Children's National Hospital, pink for United Medical Center). It is used to visualize data flow consistency, identify trends, and spot potential data feed interruptions.
2. **Percentage of ADTs with Admit and Diagnosis Populated**: This section contains three horizontal bar charts, each comparing hospitals on a key completeness metric: Admit Populated, Diagnosis Populated, and Reason for Visit Populated. These charts provide a quick, high-level comparison of data quality across facilities.
3. **Detailed Data Table**: This table provides a granular breakdown of ADT completeness metrics. It is organized by Hospital Name, Patient Class, and Event Type, and it displays both the raw counts and the percentage completeness for Admit, Diagnosis, and Reason for Visit fields, allowing for in-depth analysis of specific data quality issues.

5. Functional Use Cases

1. **Monitoring Data Feed Health**: An HIE (Health Information Exchange) operations manager can monitor the "ADTs Received Over Time" chart to ensure a consistent flow of data from partner hospitals. A sudden, sustained drop in volume from a specific hospital would trigger an investigation into a potential technical issue with their data interface.
2. **Comparing Data Quality Across Facilities**: A data governance lead can use the "Percentage of ADTs..." bar charts to benchmark the data quality of Children's National Hospital against United Medical Center. If one facility has a significantly lower percentage of populated diagnosis fields, it indicates a need for outreach and training with that facility's staff.
3. **Pinpointing Specific Problem Areas**: An analyst at Children's National Hospital can review the detailed data table and notice that "Update patient information" events for Inpatient admissions have a 99.99% diagnosis completion rate, while "Emergency" discharge events have a lower rate. This insight allows them to focus improvement efforts on the specific workflow in the emergency department.
4. **Validating Data After a System Change**: After United Medical Center updates its Electronic Health Record (EHR) system, a technical analyst can filter the report by that hospital and a recent date range to validate that ADT volume is stable and that data completeness percentages have not negatively changed.
5. **Evaluating the Impact of Training**: A hospital administrator, after implementing a new registration workflow to improve the capture of "Reason for Visit", can use this report to track the "Percent of ADTs with Reason for Visit Populated" over several months to measure the effectiveness of the new process.

6. Screenshot



Hospital Name	Patient Class	Event Type	Number of ADTs	Admit Count	Diagnosis Count	Reason For Visit Count	Admit Percentage	Diagnosis Percentage	Reason for Visit Perc..
Childrens National Hospit..	Emergency	Transfer a patient	1	1	0	1	100.00%	0.00%	100.00%
Childrens National Hospit..	Emergency	Discharge/end visit	79,563	64,763	0	64,763	81.40%	0.00%	81.40%
Childrens National Hospit..	Emergency	Change an inpatient to an ..	696	521	696	521	74.86%	100.00%	74.86%
Childrens National Hospit..	Emergency	Update patient informati..	39,935	34,475	201	34,475	86.33%	0.50%	86.33%
Childrens National Hospit..	Emergency	Merge patient informatio..	1	1	0	1	100.00%	0.00%	100.00%
Childrens National Hospit..	Inpatient	Discharge/end visit	15,270	12,041	0	12,041	78.85%	0.00%	78.85%
Childrens National Hospit..	Inpatient	Change an outpatient to a..	29	20	29	20	68.97%	100.00%	68.97%
Childrens National Hospit..	Inpatient	Update patient informati..	36,778	29,721	36,775	29,721	80.81%	99.99%	80.81%
Childrens National Hospit..	Inpatient	Merge patient informatio..	3	3	0	3	100.00%	0.00%	100.00%
Childrens National Hospit..	Observations	Discharge/end visit	7,540	6,172	0	6,172	81.86%	0.00%	81.86%
Childrens National Hospit..	Observations	Change an inpatient to an ..	1,981	1,682	1,981	1,682	84.91%	100.00%	84.91%

4. Adult Quality Measure Comparison Over Time Dashboard

1. Report Overview & Purpose

This report provides a longitudinal view of performance on adult quality measures. It allows users to compare performance across different time periods (month-over-month and year-over-year) and benchmark their selected panel against the "All DC Medicaid" peer group to identify trends and opportunities for quality improvement.

2. Available Filters & Interactivity

1. **Panel**: Allows the user to select the specific provider panel or group for which to view data.
2. **Roster**: Enables filtering the report for a specific, pre-defined patient roster.
3. **Selected Month**: Sets the primary month for the monthly quality indicator analysis.
4. **Comparison Month**: Sets the secondary month to compare against the "Selected Month" in the monthly analysis.
5. **Measure**: A drop-down menu to select the specific Adult Quality Measure to be analyzed in the report (e.g., PQI 90-Prevention Quality Overall Composite).
6. **Data Drill-Through**: Users can click on the aggregated numeric values within the "Quality Indicators - March 2025" and "Quality Indicators - Rolling Year" tables (e.g., the values '797' or '1,077') to access a detailed, beneficiary-level report.

3. Key Metrics & KPIs

1. **PQI 90-Prevention Quality Overall Composite**: The primary metric displayed, which is a composite score aggregating performance across multiple preventive care quality indicators.
2. **Mar 2025 / Feb 25 / Mar 2024**: These columns show the performance score or count for the selected metric during the specified time periods.
3. **Variance**: The percentage change in performance between the two comparison periods. A green down-arrow indicates a favorable variance (e.g., a decrease in an adverse event rate), while a red up-arrow would indicate an unfavorable change.
4. **All DC Medicaid**: This represents the benchmark or average performance for the entire DC Medicaid population, used for comparison in the trend chart.
5. **25, 75 Percentiles**: Displayed as dotted lines on the trend chart, these represent the 25th and 75th percentile of performance across the benchmark group, providing context for the user's performance.

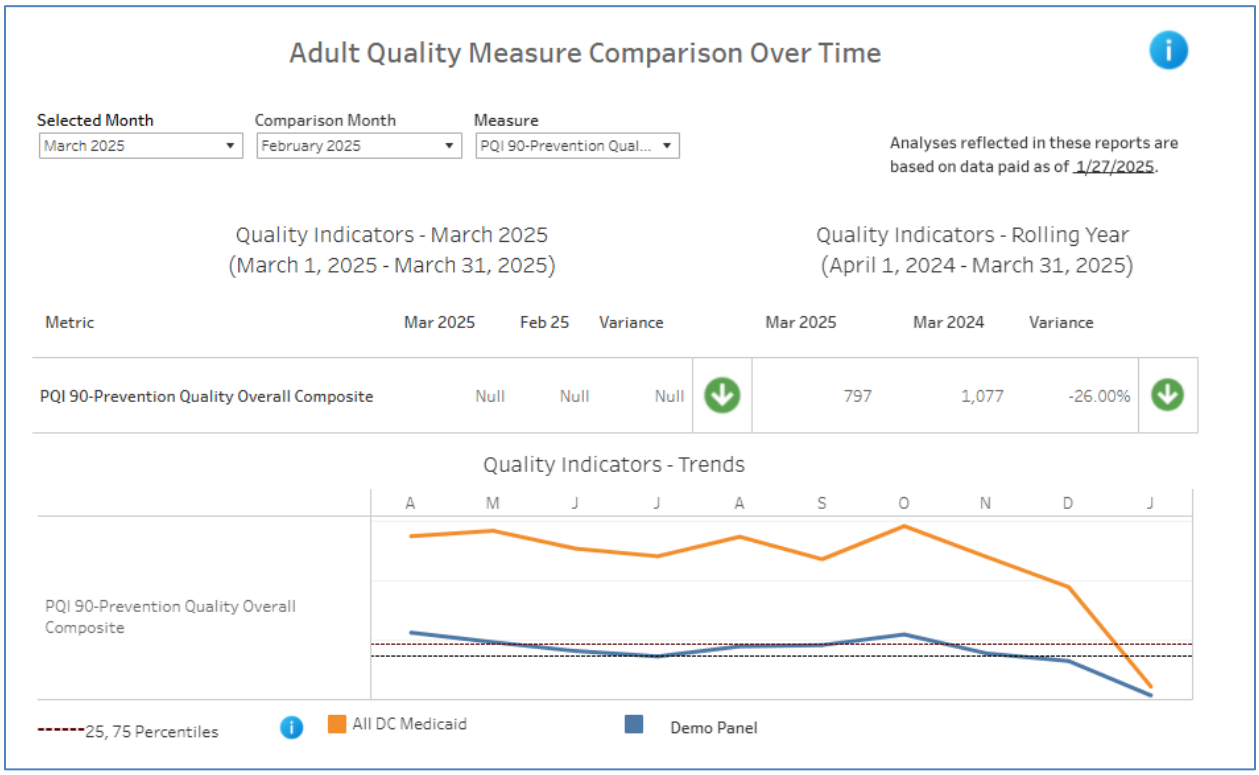
4. Visualizations & Data Tables

1. **Quality Indicators - March 2025**: This table presents a month-over-month comparison for the selected measure. It displays the metric, the scores for the "Selected Month" and "Comparison Month," and the calculated variance.
2. **Quality Indicators - Rolling Year**: This table displays performance for a 12-month rolling period. It compares the score for the period ending in the selected month (e.g., Mar 2025) against the score from the prior year (e.g., Mar 2024) and shows the year-over-year variance.
3. **Quality Indicators - Trends**: A line graph that plots the performance of the selected panel ("Demo Panel") and the benchmark ("All DC Medicaid") over the last several months. This visualization helps in identifying performance trends, seasonality, and gaps compared to the peer average.

5. Functional Use Cases

1. **Monthly Performance Monitoring**: A practice manager selects the most recent complete month (e.g., "March 2025") and compares it to the previous month ("February 2025") to track short-term progress on prevention quality initiatives.
2. **Annual Strategy Review**: A quality director reviews the "Quality Indicators - Rolling Year" table to assess year-over-year performance.
3. **Benchmarking Performance**: A care coordinator analyzes the "Quality Indicators - Trends" chart to see how their panel's performance (blue line) compares to the All DC Medicaid average (orange line), identifying months where they fell below the 25th percentile to guide improvement efforts.
4. **Identifying Gaps in Care**: After observing the rolling year score, a user drills through this number to get a list of specific beneficiaries who are impacting the score, allowing for targeted outreach to close care gaps.
5. **Measure-Specific Deep Dive**: A clinical lead uses the "Measure" filter to switch from the overall composite score to a more specific individual quality measure to investigate the root cause of a poor composite score.

6. Screenshot



5. Annual EPSDT Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive overview of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program performance. It is designed to help users assess the effectiveness of their panel in delivering recommended screening services to eligible beneficiaries, based on CMS-416 reporting guidelines. The report allows for performance comparison against a reference group and analysis across various demographics and time periods.

2. Available Filters & Interactivity

1. **Panel**: Drop-down menu to select a specific provider panel for analysis.
2. **Roster**: Drop-down menu to select a specific patient roster within the chosen panel.
3. **Federal Fiscal Year**: Drop-down menu to select the fiscal year for which to view the data.
4. **Reference Group**: Drop-down menu to select the comparison group for performance benchmarking (e.g., DC DHCF).
5. **Data Drill-Through**: Users can click on the bars within the "Number of Periodic Screenings by Beneficiaries," "Periodic Screening by Race," and "Periodic Screening by Ethnicity" charts to access a detailed list of the corresponding beneficiaries. Additionally, clicking on a provider name in the "Periodic Screening and Cost Distribution by Provider" table will drill down to the beneficiaries served by that provider. The blue information icons (i) in the overall performance table can be clicked to view the calculation methodology for the associated ratio.

3. Key Metrics & KPIs

1. **Eligible Beneficiaries (90-day enrollment)**: The total number of beneficiaries who were eligible for EPSDT services for at least 90 days within the selected period, broken down by age group.
2. **Screening Ratio**: The proportion of eligible beneficiaries who received the required number of periodic screenings for their age. Text is colored red if the panel's performance is lower than the Reference Group and blue if it is higher.
3. **Participant Ratio**: The proportion of eligible beneficiaries who received at least one initial or periodic screening service. This metric is also color-coded (red/blue) to indicate performance relative to the Reference Group.
4. **Median Gap Days between Visits**: The median number of days that elapsed between required screening visits for the beneficiary population.

4. Visualizations & Data Tables

1. **EPSDT Overall Performance Table**: A summary grid that displays the key metrics (Eligible Beneficiaries, Screening Ratio, Participant Ratio, Median Gap Days) broken down by distinct age groups (<1 to 19-20) and a grand total.
2. **Performance over Time - Screening/Participant Ratio**: Two line charts that trend the Screening Ratio and Participant Ratio from 2019 to 2025, comparing the selected panel's performance against the chosen reference group.
3. **Beneficiaries Receiving Recommended Periodic Screening**: A line chart that displays the percentage of beneficiaries who received all recommended screenings, categorized by age group and compared against the reference group.
4. **Number of Periodic Screenings by Beneficiaries**: A bar chart illustrating the distribution of beneficiaries based on the count of periodic screenings they received (from "No Visits" to 14+), with bars segmented by gender.
5. **Beneficiaries Receiving At Least One Periodic Screening**: A line chart showing the performance of the panel in ensuring beneficiaries receive at least one screening during the year, broken down by age.
6. **Periodic Screening by Race/Ethnicity**: Two horizontal bar charts that show the total number of beneficiaries who received periodic screenings, stratified by their self-reported Race and Ethnicity.
7. **Periodic Screening and Cost Distribution by Provider**: A table that lists individual providers, the number of periodic screenings they have conducted, and the total amount paid for those services.

5. Functional Use Cases

1. **Identify Age-Specific Care Gaps**: A practice manager can review the "EPSDT Overall Performance" table to pinpoint which age group (e.g., Age 6-9) has the lowest Screening Ratio, indicating a need for targeted outreach and appointment scheduling for that cohort.
2. **Monitor Program Improvement Over Time**: A quality improvement lead can use the "Performance over Time" line charts to track the impact of a new patient engagement initiative launched in a specific year, looking for a sustained increase in both the Screening and Participant Ratios.
3. **Address Health Equity Concerns**: A population health analyst can examine the "Periodic Screening by Race" and "Periodic Screening by Ethnicity" charts to identify potential disparities. If one group shows significantly lower numbers, they can drill through to the beneficiary list to initiate culturally competent outreach.
4. **Analyze Provider Network Performance**: A network manager can use the "Periodic Screening and Cost Distribution by Provider" table to identify high-performing providers for best practice sharing, as well as providers with low screening volumes who may require additional support or education.

5. **Target Non-Engaged Beneficiaries**: A care coordinator can click on the "No Visits" bar in the "Number of Periodic Screenings by Beneficiaries" chart to generate a list of all eligible children who have not had a single screening, enabling direct follow-up to address barriers to care.

6. Screenshot

Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Dashboard

The Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Dashboard allows you to view the performance of your panel of beneficiaries receiving the recommended services. The dashboard is based on the CMS-416 reporting guidelines that is used to assess the effectiveness of state Medicaid programs in reaching EPSDT eligible children. More details regarding the EPSDT program can be found here: *https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html*

Federal Fiscal Year: 2023

Reference Group: DC DHCF (Medicaid Alli...

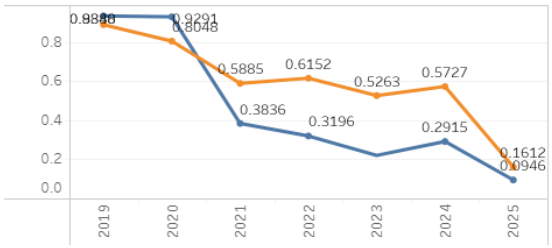
Red colored text in the Screening and Participant Ratio means that Panel's performance is lower than the Reference Group's for that age group. Blue colored text in the Screening and Participant Ratio means that Panel's performance is higher than the Reference Group's for that age group. Click on the info button to get the calculation for the Screening and Participant Ratio

EPSDT Overall Performance

	Age <1	Age 1-2	Age 3-5	Age 6-9	Age 10-14	Age 15-18	Age 19-20	Grand Total
Eligible Beneficiaries (90-day enrollment)	608	1,366	2,420	3,113	4,085	3,316	1,182	16,085
Screening Ratio	0.478	0.216	0.193	0.137	0.160	0.195	0.164	
Participant Ratio	0.729	0.231	0.138	0.105	0.129	0.155	0.130	
Median Gap Days between Visits	42	99	140	98	174	133	83	

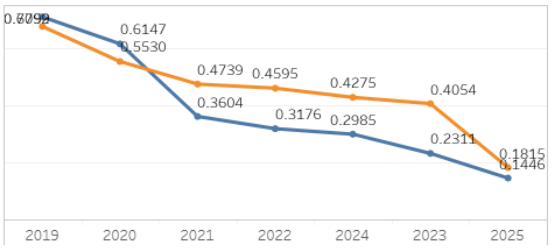
Performance over Time - Screening Ratio

Performance of EPSDT eligibles receiving required number of services



Performance over Time - Participant Ratio

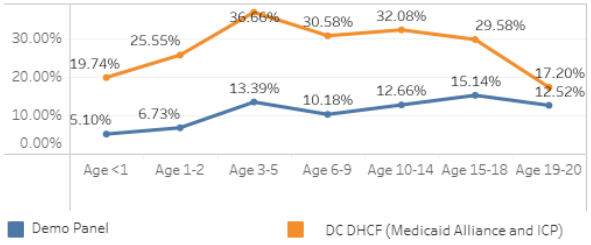
Performance of EPSDT eligibles receiving any initial or periodic services



EPSDT Service Performance

Beneficiaries Receiving Recommended Periodic Screening

Performance of EPSDT eligibles receiving recommended services by age category

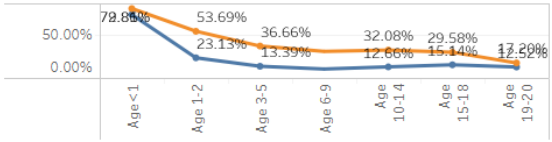


Number of Periodic Screenings by Beneficiaries

View details of EPSDT eligibles beneficiaries receiving indicated number of services

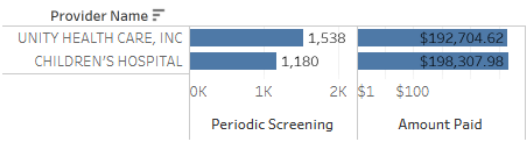
Beneficiaries Receiving At Least One Periodic Screening

Performance of EPSDT eligibles receiving at least one periodic screening in the year



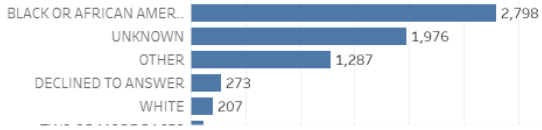
Periodic Screening and Cost Distribution by Provider

View details for EPSDT eligibles who received services with a specific provider



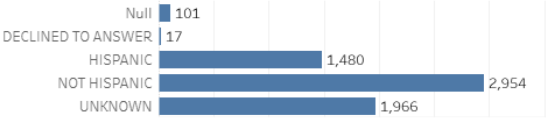
Periodic Screening by Race

View details for EPSDT eligibles who received services by Race



Periodic Screening by Ethnicity

View details for EPSDT eligibles who received services by Ethnicity



Note: The Race and Ethnicity data presented in these reports is based on a deterministic approach designed to select the most prevalent race and ethnicity values in the available data.

6. Annual Retention in Care Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of patient retention in HIV medical care. It allows users to monitor the percentage of patients with an HIV diagnosis who have had at least two medical encounters at least 90 days apart within the selected 12-month measurement year. The primary purpose is to identify and address gaps in care continuity and track performance against care retention goals.

2. Available Filters & Interactivity

1. **Roster**: Allows the user to filter the dashboard data for a specific, pre-defined list of patients.
2. **Measure Year**: Selects the 12-month period for which the retention metrics are calculated.
3. **Chronic Condition**: Filters the patient population by a specific chronic condition; in this context, it defaults to HIV patients.
4. **Suppression Flag**: Filters the patient cohort based on their viral suppression status (e.g., All, Suppressed, Not Suppressed).
5. **Data Drill-Through**: Users can click on the numerical values in the main KPI boxes (HIV Patients, HIV Patients having at least two... encounters, Retention Rate) or on the individual bars within any of the charts to navigate to a detailed, patient-level list.

3. Key Metrics & KPIs

1. **HIV Patients**: The total number of unique HIV patients in the selected population and measurement year.
2. **HIV Patients having at least two HIV medical care encounters**： The total number of patients from the denominator who meet the retention criteria (at least two encounters, ≥90 days apart).
3. **Retention Rate**: The primary KPI of the dashboard, calculated as the percentage of total HIV patients who met the criteria for being retained in care.

4. Visualizations & Data Tables

1. **Retention in HIV Medical Care of HIV Patients by Age Category and Gender**: A dual-axis combination chart that displays the total number of HIV patients (blue bars) and the corresponding retention rate (green line) for various age groups, segmented by "Female" and "Male". This helps identify disparities in care retention based on age and gender.
2. **Distribution of Medical Care Encounters for HIV Patients**: A bar chart illustrating the number of patients grouped by the quantity of medical encounters they had during the

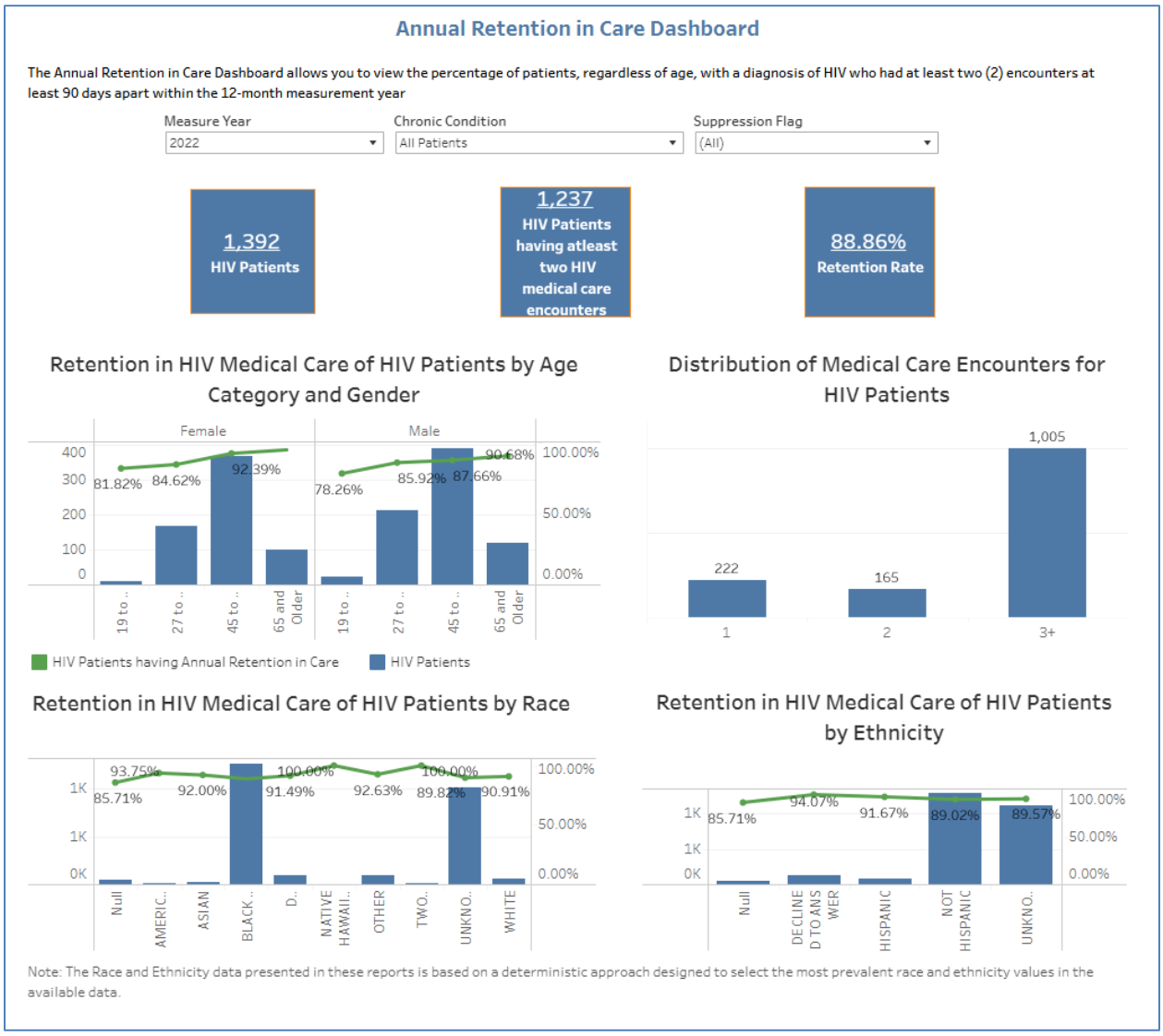
year (1, 2, or 3+). This visualization highlights the volume of patients who did not meet the two-encounter minimum for retention.

3. **Retention in HIV Medical Care of HIV Patients by Race**: A dual-axis chart showing the total number of HIV patients (blue bars) and the retention rate (green line) across different racial categories. This is used to assess equity in care retention across racial demographics.
4. **Retention in HIV Medical Care of HIV Patients by Ethnicity**: A dual-axis chart that breaks down the total number of HIV patients (blue bars) and the retention rate (green line) by ethnicity (e.g., Hispanic, Not Hispanic). This allows for the identification of potential disparities in care continuity based on ethnicity.

5. Functional Use Cases

1. **Monitor Overall Program Health**: A program director can view the topline "Retention Rate" KPI (88.86%) to quickly assess the overall performance of their HIV care program against annual targets or benchmarks.
2. **Identify Demographic Disparities**: A care coordinator can use the "Retention by Race" and "Retention by Ethnicity" charts to identify specific populations with lower-than-average retention rates, prompting targeted outreach and culturally competent engagement strategies.
3. **Target Age-Specific Interventions**: A clinician can analyze the "Retention by Age and Gender" chart to find that, for example, younger male patients have a lower retention rate than older patients and then develop youth-focused engagement initiatives to improve their adherence to care.
4. **Manage Patient Panels**: A case manager can select their specific "Roster" and then drill through on the "1" encounter bar in the "Distribution of Medical Care Encounters" chart to get a list of their specific patients who are not retained in care and require immediate follow-up.
5. **Evaluate Care Gaps for a Specific Year**: A quality improvement specialist can use the "Measure Year" filter to compare retention rates year-over-year, identifying trends and evaluating the effectiveness of past interventions aimed at improving patient engagement.

6. Screenshot



7. Blood Pressure Control for Patients with Diabetes (BPD) Dashboard

1. Report Overview & Purpose

This dashboard monitors the percentage of members aged 18-75 with Type 1 or Type 2 diabetes who have achieved adequate blood pressure control. The primary purpose is to track performance against the quality measure definition of a blood pressure reading of less than 140/90 mmHg. It provides insights into performance trends, facility-level data, and the demographic breakdown of the patient population.

2. Available Filters & Interactivity

1. **Measure Year**: Allows the user to select the specific measurement year for the report data.
2. **Reference Group**: Enables comparison of the selected panel's performance against a benchmark group, such as "All DC Medicaid".
3. **Data Drill-Through**: Users can click on data points within any of the charts, including the lines in the "Monthly Performance Comparison," the bars in the "Annual Performance Trend," "Number of Visits by Facility," "Measure Performance Status," and the segments within all "Beneficiary Distribution" charts, to cross-filter the dashboard and drill through to a detailed list of beneficiaries and their claim-level details.

3. Key Metrics & KPIs

1. **Blood Pressure Control Performance Rate**: The primary KPI, representing the percentage of diabetic patients whose most recent blood pressure reading was below 140/90 mmHg. This is displayed in the monthly and annual trend charts.
2. **Count of Beneficiaries (Controlled vs. Uncontrolled)**: The absolute number of patients who are either meeting the blood pressure target (<140/90 mmHg) or not meeting the target (>140/90 mmHg).
3. **Number of Visits by Facility**: The total count of patients seen at each facility, segmented by their blood pressure control status.

4. Visualizations & Data Tables

1. **Monthly Performance Comparison**: A line graph that tracks the blood pressure control performance rate month-over-month, comparing the selected panel against the chosen reference group. This helps identify seasonal trends or the immediate impact of interventions.
2. **Annual Performance Trend**: A bar chart that displays the overall performance rate for the selected year and previous years, providing a high-level view of year-over-year improvement or decline.

3. **Number of Visits by Facility**: A horizontal bar chart ranking facilities by the number of patients in the measure. Each bar is segmented to show the proportion of patients with adequately versus inadequately controlled blood pressure, highlighting facilities with potential care gaps.
4. **Measure Performance Status**: A simple bar chart showing the total count of beneficiaries in the measure, split into two categories: "Blood Pressure Not Adequately controlled" and "Blood Pressure Adequately controlled."
5. **Beneficiary Distribution by Categories**: A collection of bar charts that break down the patient population by Social Needs, Gender, Age Category, Chronic Conditions, Race, and Ethnicity. Each bar shows the proportion of controlled vs. uncontrolled patients within that specific demographic or clinical segment.

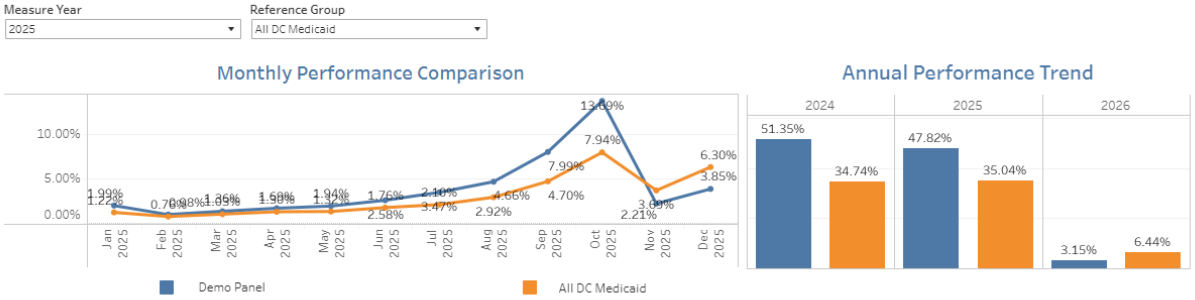
5. Functional Use Cases

1. **Assess Long-Term Progress**: A quality improvement manager can use the "Annual Performance Trend" chart to assess overall year-over-year performance and report progress to leadership.
2. **Target Facility-Level Resource Allocation**: A care coordinator can analyze the "Number of Visits by Facility" chart to identify clinics with a large number of patients with uncontrolled blood pressure and drill through to create a patient list for targeted outreach.
3. **Analyze Comorbid Compliance Risks**: A population health analyst can select the "Blood Pressure Not Adequately controlled" segment in the "Measure Performance Status" chart to cross-filter the entire dashboard, then review the "Chronic Conditions" chart to see which comorbidities are most common among non-compliant patients.
4. **Evaluate Intervention Effectiveness**: A clinical director can monitor the "Monthly Performance Comparison" chart to evaluate the effectiveness of a new hypertension management program launched in a specific quarter.
5. **Investigate Demographic Health Disparities**: A health equity officer can use the "Race" and "Ethnicity" charts to identify potential disparities in blood pressure control among different demographic groups and drill down to investigate the underlying causes.

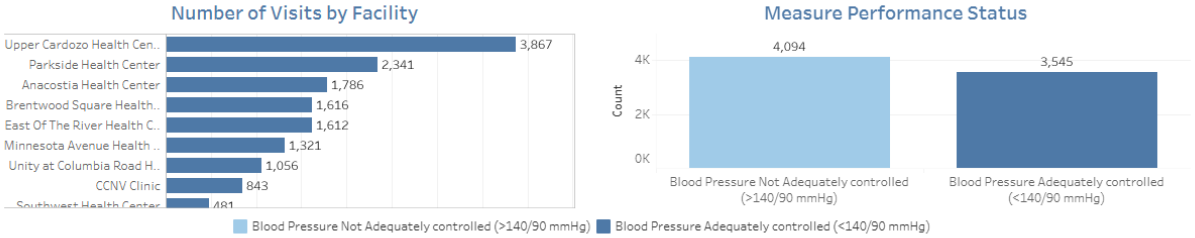
6. Screenshot

Blood Pressure Control for Patients With Diabetes (BPD) Dashboard

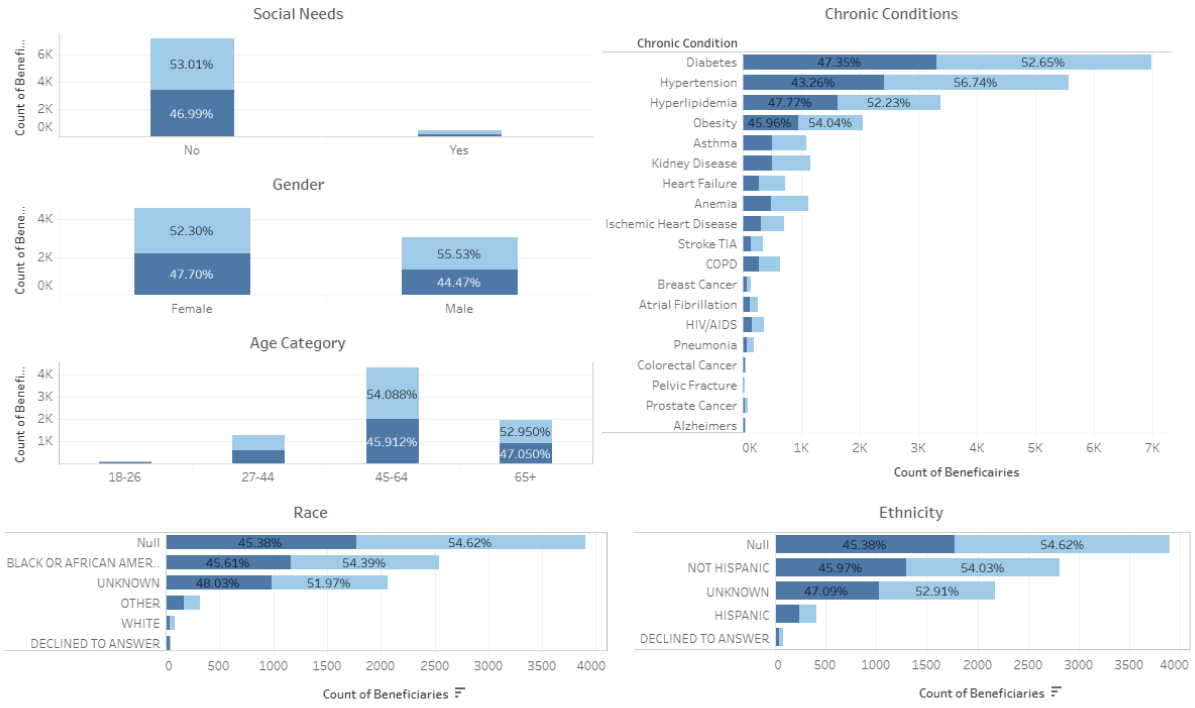
The Blood Pressure Control for Patients With Diabetes Dashboard monitors the percentage of members aged 18–75 with Type 1 or Type 2 diabetes who achieved adequate blood pressure control, defined as a reading of less than 140/90 mmHg, during the measurement year. The performance numerator is determined using the most recent blood pressure recording on file for the period; to meet the compliance threshold, both the representative Systolic BP must be below 140 mmHg and the representative Diastolic BP must be below 90 mmHg.



Note: Selecting a data point below within the dashboard allows you to cross-filter and drill-through to the beneficiary and claim-level details.



Beneficiary Distribution by Categories



Note: The Race and Ethnicity data presented in these reports is based on a deterministic approach designed to select the most prevalent race and ethnicity values in the available data.

8. Breast Cancer Screening (BCS) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of the Breast Cancer Screening measure. It allows users to track the percentage of female members, ages 50-74, who are compliant with recommended routine breast cancer screening, specifically having received a mammogram within the measurement period. The report is designed to help identify care gaps, monitor performance against benchmarks, and analyze disparities across different patient populations.

2. Available Filters & Interactivity

1. **Measure Year**: A dropdown menu to select the specific year for which to view the performance data.
2. **Reference Group**: A dropdown menu to select a comparison group (e.g., All DC Medicaid) to benchmark performance against.
3. **Roster**: A dropdown menu to select and filter the report for a specific patient roster or panel.
4. **Data Drill-Through**: Users can click on the numerical values within the KPI boxes (e.g., Number of Beneficiaries who haven't received the Screening), the bars in the *Annual Performance Trend*, *Number of Visits by Facility*, *Social Needs*, *Age Category*, *Race*, and *Ethnicity* charts, and the patient counts within the *Chronic Conditions* table to navigate to a detailed list of the underlying beneficiaries.

3. Key Metrics & KPIs

1. **Number of Eligible Beneficiaries**: The total count of members who meet the denominator criteria for the breast cancer screening measure for the selected period.
2. **Number of Beneficiaries who received Screening**: The total count of eligible beneficiaries who were compliant and received a mammogram.
3. **Number of Beneficiaries who haven't received the Screening**: The total count of eligible beneficiaries who have a care gap and did not receive a mammogram.
4. **Screening Rate**: The primary performance metric, calculated as the percentage of eligible beneficiaries who received the screening.

4. Visualizations & Data Tables

1. **Monthly Performance Comparison**: A line chart that tracks the screening rate of the selected panel against the chosen reference group on a month-by-month basis, allowing for trend analysis throughout the year.
2. **Annual Performance Trend**: A bar chart comparing the screening rate for the current year with the rates from the previous two years, showing year-over-year performance trends.

3. **Number of Visits by Facility**: A horizontal bar chart that ranks clinical facilities by the volume of visits, helping to identify key providers.
4. **Beneficiary Distribution by Categories**:
    a. **Social Needs**: A bar chart that segments the beneficiary population by the presence or absence of documented social needs, showing the screening compliance rate for each group.
    b. **Age Category**: A bar chart that breaks down the population into different age groups (50-64 and 65-74) and displays the screening compliance within each segment.
    c. **Race & Ethnicity**: Two separate bar charts that illustrate the distribution and screening rates across different racial and ethnic groups, highlighting potential disparities.
    d. **Chronic Conditions**: A table that lists common chronic conditions and compares the screening rates between beneficiaries who have a specific condition and those who do not.

5. Functional Use Cases

1. **Close Care Gaps**: A care coordinator can click on the "Number of Beneficiaries who haven't received the Screening" KPI to drill down to a patient list and initiate targeted outreach efforts.
2. **Analyze Health Equity**: A population health manager can review the "Race" and "Ethnicity" charts to identify disparities in screening rates.
3. **Monitor Performance Trends**: A practice manager can use the "Monthly Performance Comparison" line chart to see if a recent quality improvement initiative has increased their screening rate.
4. **Target High-Risk Populations**: A clinician can use the "Chronic Conditions" table to identify comorbid groups who are lagging and may need prioritized engagement.
5. **Evaluate Provider Performance**: A network analyst can use the "Number of Visits by Facility" chart to identify which facilities are seeing the most patients for this measure.

6. Screenshot

9. CCD Completeness Report

1. Report Overview & Purpose

This report provides a comprehensive overview of the submission of Continuity of Care Documents (CCDs) from participating hospitals. It is designed to help users monitor the volume and timeliness of CCD receipts, ensuring that patient health information is being exchanged efficiently after a discharge event.

2. Available Filters & Interactivity

1. **Start Date / End Date**: Allows the user to select a specific date range for the report's data using a calendar picker or the associated date slider.
2. **Hospital Name**: A dropdown menu to select a specific hospital to view their CCD submission data.

3. Key Metrics & KPIs

1. **CCD Count**: The total number of Continuity of Care Documents received on a given day from the selected hospital. This metric helps track the volume and consistency of data submission.
2. **Median Days**: The median number of days between a patient's ADT (Admission, Discharge, Transfer) discharge event and the receipt of their corresponding CCD. This metric indicates the typical timeliness of document submission.
3. **Average Days**: The average number of days between a patient's ADT discharge event and the receipt of their corresponding CCD. This provides a mean measure of submission timeliness, which can be influenced by outlier delays.

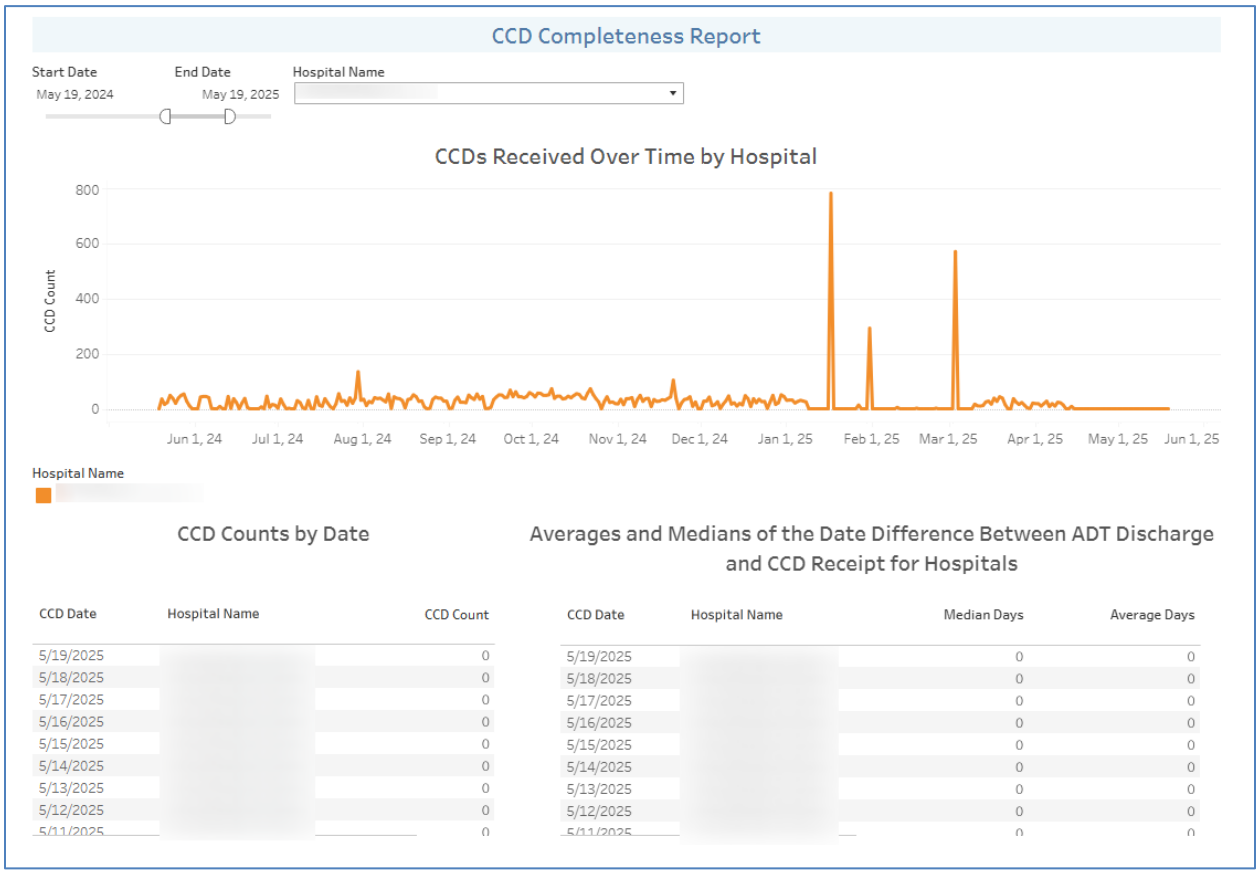
4. Visualizations & Data Tables

1. **CCDs Received Over Time by Hospital**: This line chart visualizes the daily volume of CCDs received from the selected hospital over the chosen time period. It is useful for quickly identifying trends, gaps, or significant spikes in data submission.
2. **CCD Counts by Date**: A detailed table listing the specific CCD count for each day within the reporting period for the selected hospital.
3. **Averages and Medians of the Date Difference Between ADT Discharge and CCD Receipt for Hospitals**: This table presents the daily median and average time lag (in days) for receiving CCDs after a patient discharge, allowing for a detailed analysis of submission timeliness.

5. Functional Use Cases

1. **Monitor Data Feed Health**: An HIE administrator reviews the "CCDs Received Over Time" chart daily to ensure a consistent flow of documents from a partner hospital, quickly identifying potential transmission failures if counts drop to zero for an extended period.
2. **Assess SLA Compliance**: A hospital liaison officer uses the "Averages and Medians" table to verify if a hospital is meeting its contractual obligations for timely CCD submission post-patient discharge.
3. **Investigate Data Anomalies**: A data quality analyst notices an unusually large spike in the line chart and drills into the data for that day to determine if it was a result of a backlog being processed or a potential data duplication issue.
4. **Identify Performance Trends**: A hospital performance manager filters for their facility and reviews the line chart over a multi-month period to identify trends or seasonality in CCD submission volumes.
5. **Troubleshoot Submission Gaps**: When the "CCD Counts by Date" table shows zero submissions for several consecutive days, an integration specialist can use this information to initiate an investigation with the hospital's IT department to check for system outages or interface errors.

6. Screenshot



10. Cervical Cancer Screening (CCS-E) Dashboard

1. Report Overview & Purpose

The Cervical Cancer Screening Dashboard provides a comprehensive view of member compliance with recommended screening guidelines. It allows users to track screening rates over time, compare performance against a reference group, and analyze disparities across various demographic, clinical, and social categories to identify opportunities for targeted intervention.

2. Available Filters & Interactivity

1. **Panel**: Selects the specific group or panel of beneficiaries to analyze.
2. **Roster**: Narrows the analysis to a specific roster of beneficiaries within the selected panel.
3. **Measure Year**: Filters the report data to a specific measurement year.
4. **Reference Group**: Selects a benchmark population (e.g., All DC Medicaid) for comparison in trend charts.
5. **Data Drill-Through**: Users can click on the aggregated numbers in the KPI cards (Number of Eligible Beneficiaries, Number of Beneficiaries who received Screening, etc.) or the individual bars within the *Annual Performance Trend*, *Number of Visits by Facility*, *Social Needs*, *Age Category*, *Race*, and *Ethnicity* charts to navigate to a detailed list of the underlying beneficiaries.

3. Key Metrics & KPIs

1. **Number of Eligible Beneficiaries**: The total count of female members who meet the age and continuous enrollment criteria for the cervical cancer screening measure during the measurement year.
2. **Number of Beneficiaries who received Screening**: The count of eligible beneficiaries who were compliant with the screening measure (e.g., had a cytology or HPV test within the specified timeframe).
3. **Number of Beneficiaries who haven't received the Screening**: The count of eligible beneficiaries who were not compliant with the screening measure.
4. **Screening Rate**: The primary KPI, calculated as the percentage of eligible beneficiaries who received the recommended screening.

4. Visualizations & Data Tables

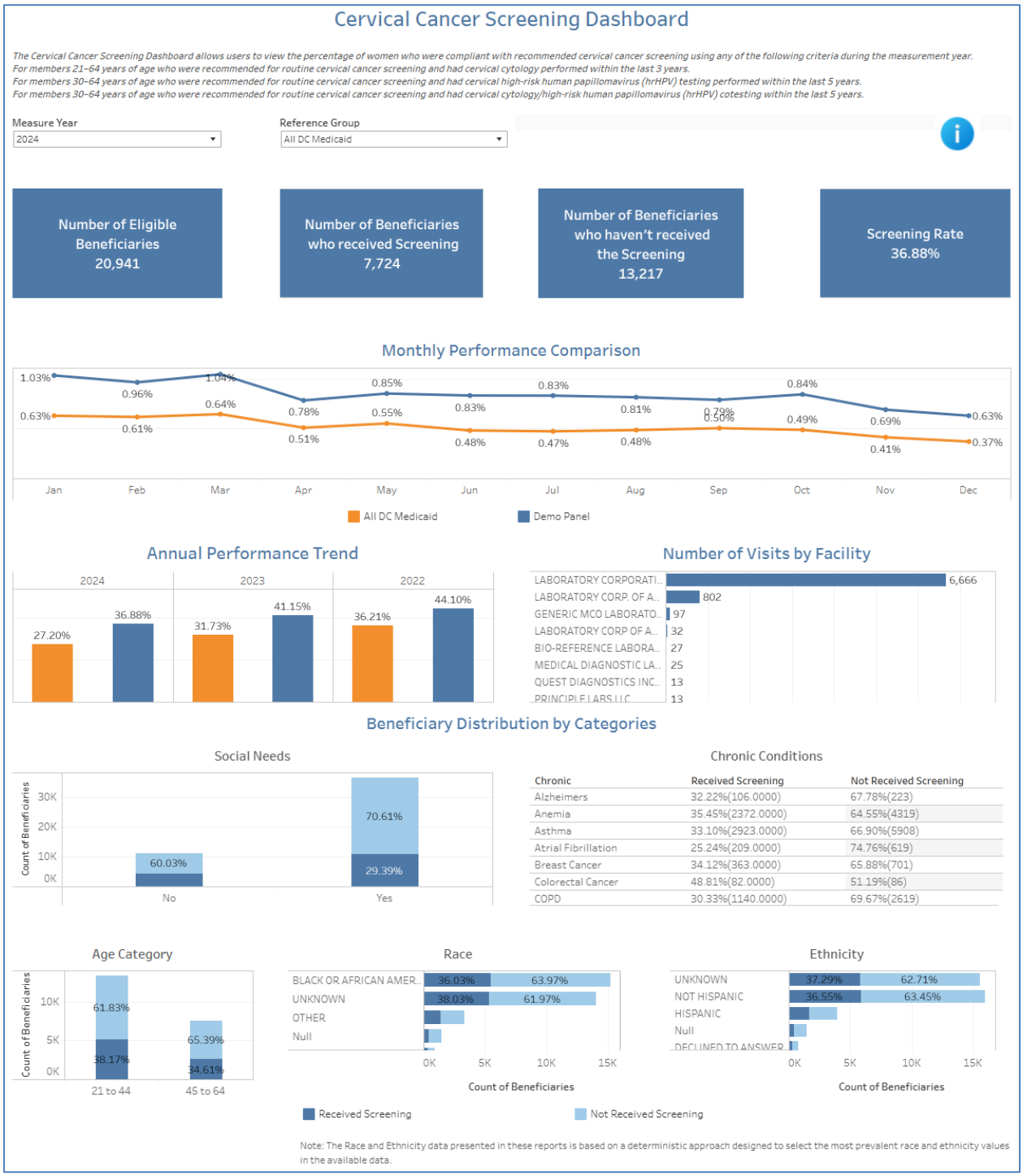
1. **Monthly Performance Comparison**: A dual-axis line chart that tracks the screening rate month-over-month for the selected panel against the chosen reference group, allowing for timely monitoring of performance trends.

2. **Annual Performance Trend**: A bar chart comparing the year-end screening rates for the selected panel and the reference group over the last three years.
3. **Number of Visits by Facility**: A horizontal bar chart that ranks clinical facilities by the total number of screening-related visits, identifying key service providers.
4. **Beneficiary Distribution by Categories**:
    a. **Social Needs**: A stacked bar chart showing the screening compliance for beneficiaries with and without identified social needs.
    b. **Chronic Conditions**: A table detailing the screening rates (both percentage and raw count) for beneficiaries with specific chronic conditions, such as Anemia, Asthma, and Breast Cancer.
    c. **Age Category**: A stacked bar chart comparing screening compliance between different age groups (e.g., 21 to 44 vs. 45 to 64).
    d. **Race**: A stacked bar chart illustrating screening compliance across different racial groups.
    e. **Ethnicity**: A stacked bar chart showing screening compliance across different ethnic groups.

5. Functional Use Cases

1. **Monitor Overall Program Performance**: A Quality Improvement Manager can view the *Screening Rate* KPI to get an immediate snapshot of their panel's current compliance and use the *Annual Performance Trend* to see if this rate is an improvement over previous years.
2. **Identify Disparities in Care**: A Care Coordinator can analyze the *Race* and *Ethnicity* charts to identify specific demographic groups with lower screening rates and initiate culturally competent outreach programs to close these care gaps.
3. **Target High-Risk Clinical Populations**: A Case Manager can use the *Chronic Conditions* table to identify patient cohorts (e.g., those with COPD, 69.67% not screened) who are not receiving screenings and coordinate with their primary care providers to address the gap during visits for their chronic illness.
4. **Evaluate Outreach Campaign Effectiveness**: After launching an outreach initiative in April, a user can monitor the *Monthly Performance Comparison* chart to see if there is a subsequent increase in the screening rate for their panel compared to the reference group.
5. **Address Social Determinants of Health**: An analyst can review the *Social Needs* chart to determine if there is a correlation between identified social needs and lower screening rates, informing strategies that integrate social support services with clinical outreach.

6. Screenshot



11. Childhood Immunization Status (CIS-E) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of the Childhood Immunization Status (CIS-E) quality measure. It is designed to help users track the percentage of children who are up to date on key immunizations by their second birthday, compare performance against benchmarks, and identify specific patients and vaccine series that require intervention.

2. Available Filters & Interactivity

1. **Panel:** Allows the user to select a specific provider panel or group to analyze.
2. **Measure Year:** Filters the report data to a specific measurement year.
3. **Reference Group:** Selects a benchmark population (e.g., All DC Medicaid) for comparison in performance charts.
4. **Roster:** Allows the user to select a specific patient roster for analysis.
5. **Last One Year / Full Range:** Toggles the time frame displayed in the "Monthly Performance Comparison" line chart.
6. **Data Drill-Through:** Users can click on the bars or data points within the **Number of Visits by Facility**, **Measure Performance Status**, **Vaccination Status Across Different Combination 3 Vaccine Categories**, and **Beneficiary Distribution by Categories** charts to drill down to a detailed, patient-level view.

3. Key Metrics & KPIs

1. **Monthly Performance Comparison:** The percentage of children in the selected panel who have completed the required combination of immunizations, tracked monthly and compared against a reference group.
2. **Annual Performance Trend:** The overall immunization compliance percentage for the selected panel across the last several years, compared to a reference group.
3. **Completed Combination 3 Vaccination:** The total count and proportion of children who have received the required combination of immunizations for the measure.
4. **Not Completed Combination 3 Vaccination:** The total count and proportion of children who are missing one or more required immunizations.
5. **Vaccination Status Counts:** The number of children who have received a specific quantity (e.g., 0, 1, 2, 3, 4+) of doses for each individual vaccine series (e.g., DTaP, MMR, IPV).
6. **Beneficiary Demographics:** The distribution of the patient population by gender, race, and ethnicity, shown in both counts and percentages.

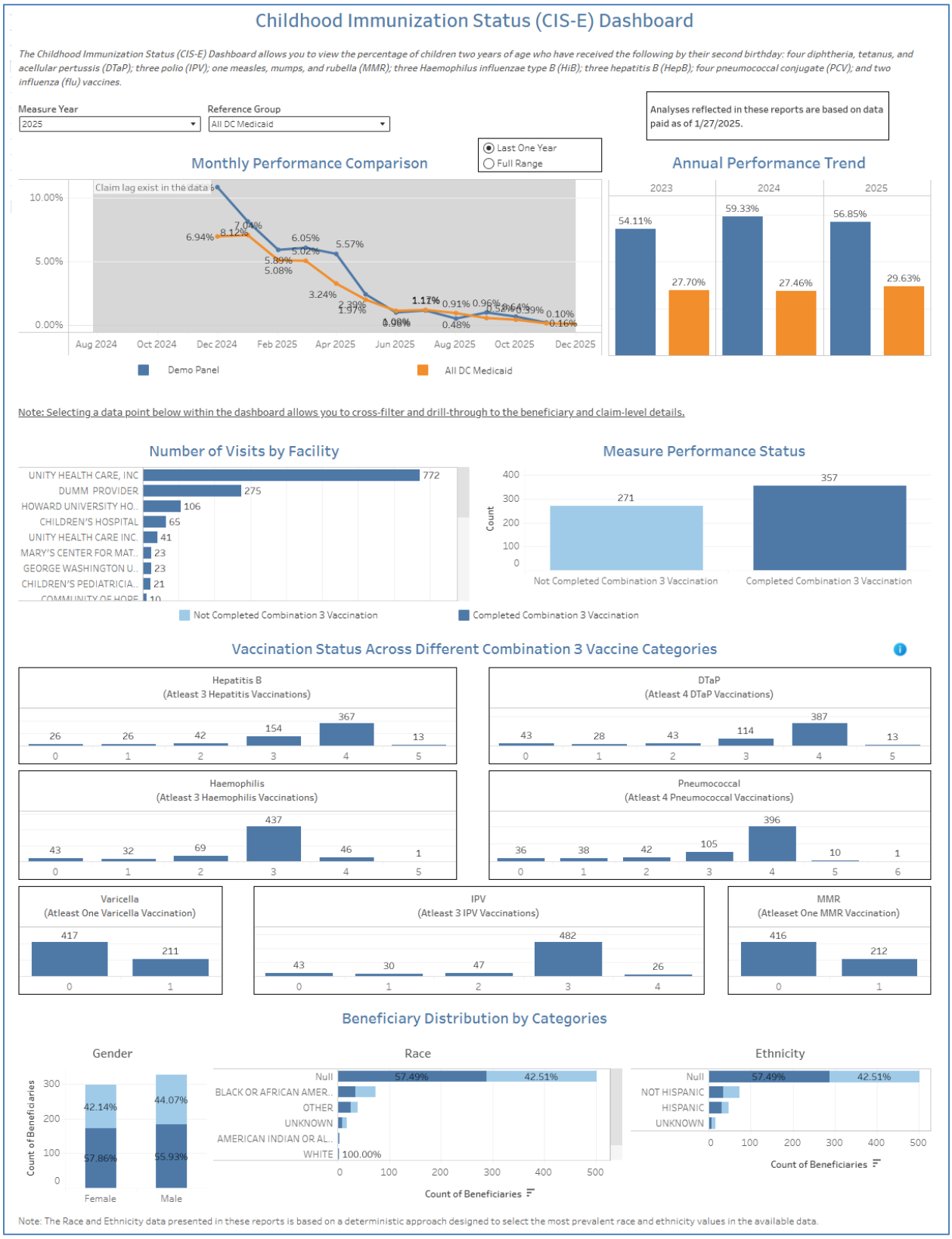
4. Visualizations & Data Tables

1. **Monthly Performance Comparison:** A dual-line chart illustrating the trend of immunization compliance rates over time for the selected panel versus the reference group.
2. **Annual Performance Trend:** A clustered bar chart that compares year-over-year immunization compliance rates between the selected panel and the reference group.
3. **Number of Visits by Facility:** A horizontal bar chart that ranks facilities by the number of patients in the measure, color-coded to distinguish between patients who have and have not completed the required vaccinations.
4. **Measure Performance Status:** A simple bar chart comparing the total count of patients who are compliant ("Completed") versus non-compliant ("Not Completed") with the immunization measure.
5. **Vaccination Status Across Different Combination 3 Vaccine Categories:** A series of charts detailing the dose completion status for each individual vaccine required for the measure (e.g., Hepatitis B, DTaP, MMR), showing how many children have received 0, 1, 2, 3, or more doses.
6. **Beneficiary Distribution by Categories:** A set of bar charts breaking down the patient population by Gender, Race, and Ethnicity to provide demographic context.

5. Functional Use Cases

1. **Track Progress Toward Quality Goals**: A quality improvement manager can monitor the "Monthly Performance Comparison" chart to track their panel's progress towards immunization goals throughout the year and compare it to the overall Medicaid performance.
2. **Target Provider Support and Outreach**: A care coordinator can use the "Number of Visits by Facility" chart to identify practices with a large number of children who have not completed their vaccinations, allowing for targeted provider outreach and support.
3. **Isolate Specific Vaccine Gaps**: A clinical lead can analyze the "Vaccination Status" charts to identify specific vaccine gaps, such as discovering that many children are missing only their 4th DTaP shot, to initiate a reminder campaign focused on that specific dose.
4. **Design Culturally Competent Health Equity Initiatives**: A population health strategist can review the "Beneficiary Distribution" charts for Race and Ethnicity to determine if disparities in immunization rates exist, informing the development of culturally competent health equity initiatives.
5. **Generate High-Priority Outreach Lists**: A nurse case manager can click on the "Not Completed Combination 3 Vaccination" bar in the "Measure Performance Status" chart to drill down to a list of non-compliant children and begin direct outreach to their families to schedule appointments.

6. Screenshot



12. Colorectal Cancer Screening (COL-E) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive overview of Colorectal Cancer Screening compliance for members aged 45-75. It is designed to help providers and care managers monitor screening rates, identify patient care gaps, and analyze performance trends against a reference group. The report tracks compliance based on several recommended screening methods, including FOBT, colonoscopy, and sigmoidoscopy, within specified timeframes.

2. Available Filters & Interactivity

1. **Panel:** Allows users to select a specific provider panel or group to view its performance data.
2. **Roster:** Enables the selection of a specific patient roster within the chosen panel.
3. **Measure Year:** Filters the entire dashboard to display data for the selected measurement year.
4. **Reference Group:** Sets the comparison group (e.g., All DC Medicaid) for performance benchmarking in the trend charts.
5. **Data Drill-Through:** Users can click on the numerical values in the KPI cards (e.g., "Number of Beneficiaries who haven't received the screening"), the individual bars in any bar chart (e.g., "Annual Performance Trend," "Age Category by Gender," "Race," "Ethnicity"), or the data cells within the "Chronic Conditions" table to navigate to a detailed, beneficiary-level report of the selected population.

3. Key Metrics & KPIs

1. **Number of Eligible Beneficiaries:** The total count of members who meet the age and enrollment criteria for the colorectal cancer screening measure in the selected year.
2. **Number of Beneficiaries who received Screening:** The total count of eligible beneficiaries who have completed a recommended colorectal cancer screening.
3. **Number of Beneficiaries who haven't received the screening:** The total count of eligible beneficiaries who are not yet compliant with the screening measure.
4. **Screening Rate:** The primary performance metric, calculated as the percentage of eligible beneficiaries who received the recommended screening.

4. Visualizations & Data Tables

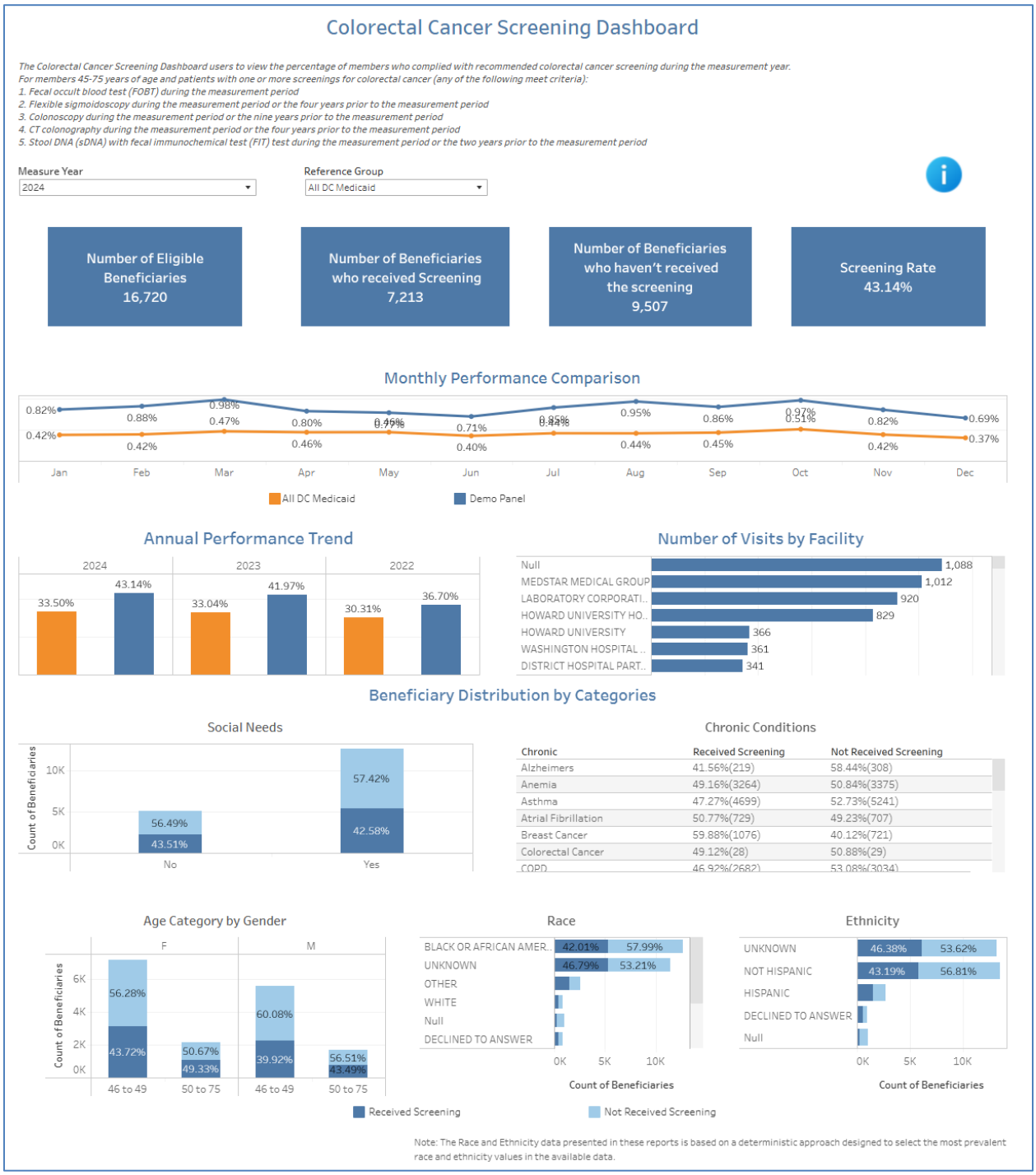
1. **KPI Cards:** Four large tiles at the top of the dashboard that display the key metrics: Number of Eligible Beneficiaries, Number who received Screening, Number who haven't received the screening, and the overall Screening Rate.

2. **Monthly Performance Comparison:** A dual-axis line chart that tracks the screening rate month-over-month for the selected panel (Demo Panel) compared to the selected reference group (All DC Medicaid).
3. **Annual Performance Trend:** A bar chart comparing the panel's year-end screening performance against the reference group over the past three years.
4. **Number of Visits by Facility:** A horizontal bar chart ranking facilities by the number of patient visits, helping to identify key service locations.
5. **Beneficiary Distribution by Categories:** A section containing multiple visualizations to break down the beneficiary population:
    a. **Social Needs:** A stacked bar chart showing the screening compliance status (Received vs. Not Received) for beneficiaries with and without identified social needs.
    b. **Chronic Conditions:** A table detailing screening rates for beneficiaries with specific chronic conditions, showing both percentages and raw counts for compliant and non-compliant members.
    c. **Age Category by Gender:** Bar charts that segment the population by gender and age groups (46-49, 50-75) to compare screening compliance.
    d. **Race & Ethnicity:** Horizontal bar charts illustrating the distribution of screening compliance across different racial and ethnic groups.

5. Functional Use Cases

1. **Evaluate Core Population Compliance Rates**: A practice manager can select their specific panel and the current "Measure Year" to quickly assess their overall "Screening Rate" and identify the exact number of patients needing outreach for screening.
2. **Track Progress of Care Gap Closures**: A quality improvement coordinator can analyze the "Annual Performance Trend" chart to track progress year-over-year and determine if care gap closure initiatives have been successful.
3. **Prioritize High-Risk Clinical Interventions**: A care coordinator can use the "Chronic Conditions" table to identify high-risk patients (e.g., those with Alzheimer's showing a low screening rate) and drill through to generate a patient list for targeted intervention.
4. **Identify Disparities to Inform Outreach**: A health equity analyst can review the "Race," "Ethnicity," and "Social Needs" charts to identify disparities in screening rates and inform the development of culturally competent outreach programs.
5. **Tailor Preventive Point-of-Care Conversations**: A provider can use the "Age Category by Gender" chart to observe which specific cohorts have lower screening rates than their counterparts and can tailor patient conversations to address potential barriers.

6. Screenshot



13. Contraceptive Care for All Women (CCW) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive analysis of the Contraceptive Care for All Women (CCW) quality measure. It is designed to help users track performance over time, compare their panel against the 'All DC Medicaid' reference group, and identify disparities in care across various demographic segments. The report visualizes utilization rates for different contraceptive methods to support quality improvement and population health management initiatives.

2. Available Filters & Interactivity

1. **Measure Year**: Allows the user to select the reporting year for the displayed data.
2. **Reference Group**: Enables comparison of the selected panel/roster against a broader population, such as 'All DC Medicaid'.
3. **Roster**: Allows users to filter the dashboard to view data for a specific provider roster or patient panel.
4. **Select Measure**: Filters the monthly trend, performance comparison, and demographic charts to focus on a specific component of the CCW measure, such as 'Contraceptive Care Most Effective Method (Aged 21-44)'.
5. **Data Drill-Through**: Users can click on the bars, lines, or data points within any of the visualizations (Summary of Contraceptive Care, Monthly Trend, Performance Comparison, and all demographic charts) to navigate to a detailed, beneficiary-level report.

3. Key Metrics & KPIs

1. **Contraceptive Care Rate**: The primary metric, representing the percentage of women aged 15-44 at risk of unintended pregnancy who were provided a most effective or moderately effective method of contraception.
2. **Rate per 1000**: Used in the monthly trend chart to show the number of members meeting the measure criteria for every 1000 eligible members in the population.
3. **Percentile of FQHC Peer Group Performance**: A comparative metric that benchmarks the user's panel performance against other peers.

4. Visualizations & Data Tables

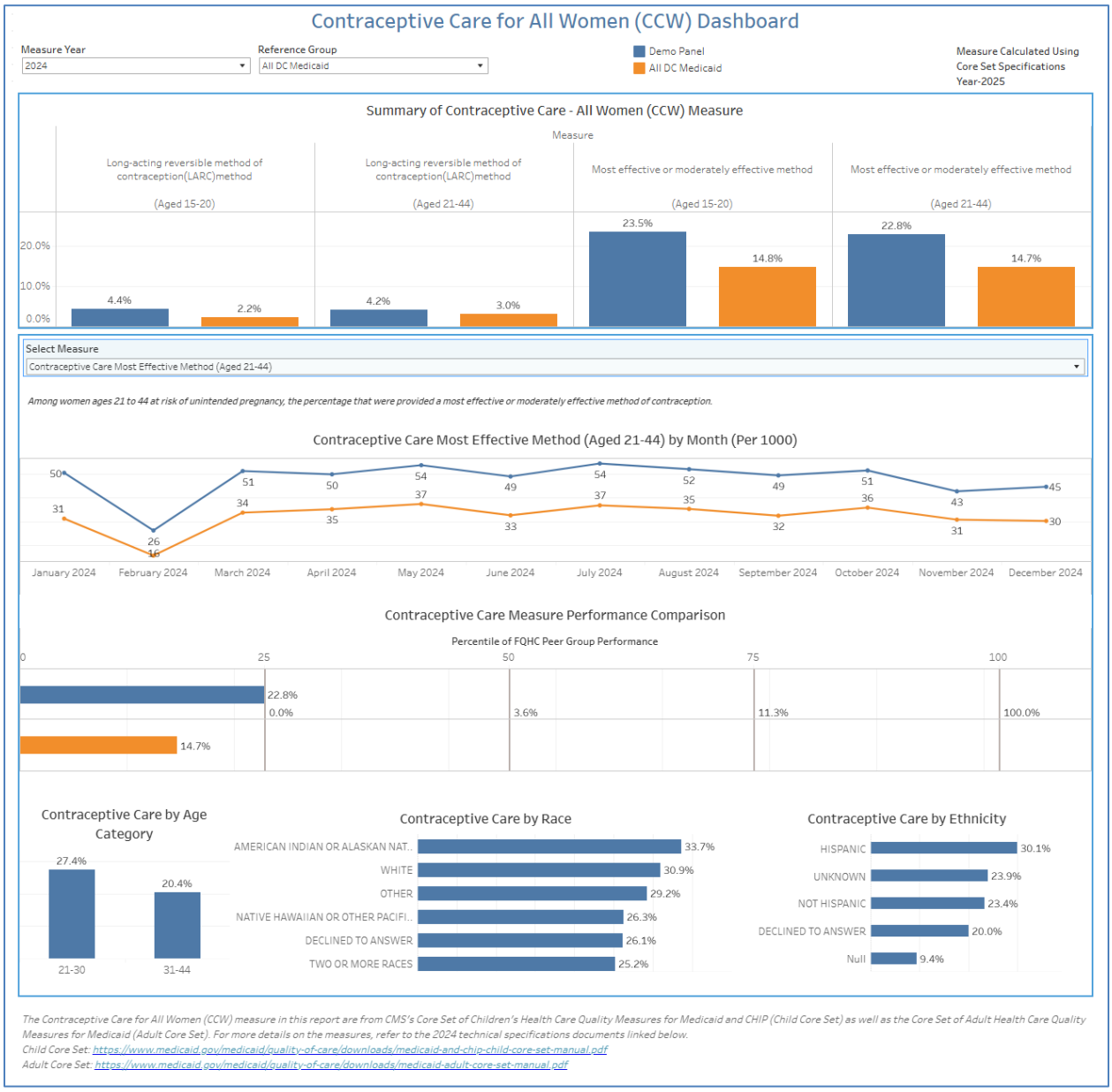
1. **Summary of Contraceptive Care - All Women (CCW) Measure**: A bar chart comparing the performance of the selected 'Demo Panel' (blue) against the 'All DC Medicaid' reference group (orange). The comparison is shown across four categories: LARC methods and most/moderately effective methods, each broken down by age groups (15-20 and 21-44).

2. **Contraceptive Care Most Effective Method (Aged 21-44) by Month (Per 1000)**: A line chart that trends the selected CCW measure's rate (per 1000 members) over the months of the selected year. It provides a visual comparison of the monthly performance between the Demo Panel and the reference group.
3. **Contraceptive Care Measure Performance Comparison**: A horizontal bar chart that displays the Demo Panel's performance percentile relative to an FQHC peer group. This visualization helps users understand their standing compared to similar organizations.
4. **Contraceptive Care by Age Category**: A vertical bar chart that breaks down the contraceptive care rate by different age brackets (e.g., 21-30, 31-44), highlighting which age groups have higher or lower rates of care.
5. **Contraceptive Care by Race & by Ethnicity**: Two horizontal bar charts that display the measure performance across different racial and ethnic groups. These charts are crucial for identifying and addressing potential health disparities in contraceptive care.

5. Functional Use Cases

1. **Benchmark Core Measure Performance Relative to Peers**: A quality improvement manager can use the "Summary of Contraceptive Care" chart to compare their panel's performance in providing 'Most effective or moderately effective methods' for women aged 21-44 against the DC Medicaid average to identify areas of success.
2. **Investigate Prescription Disparities and Health Equity Gaps**: A clinical director can analyze the "Contraceptive Care by Race" chart to investigate potential disparities, such as the difference in care rates between different racial and ethnic groups, and develop targeted outreach programs.
3. **Monitor Localized Clinical and Educational Campaign Trajectories**: A practice administrator can monitor the "Contraceptive Care... by Month" line chart to assess the impact of a new patient education campaign, looking for an upward trend in the measure rate in the months following the campaign's launch.
4. **Formulate Tailored Interventions for Specific Age Brackets**: A population health analyst can use the "Contraceptive Care by Age Category" view to discover which specific age brackets have a lower rate of care and recommend tailored interventions for that older cohort.

6. Screenshot



The Contraceptive Care for All Women (CCW) measure in this report are from CMS's Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) as well as the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set). For more details on the measures, refer to the 2024 technical specifications documents linked below.
Child Core Set: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf
Adult Core Set: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf

14. Controlling High Blood Pressure (CBP) Dashboard

1. Report Overview & Purpose

This dashboard tracks the percentage of members aged 18-85 with a hypertension diagnosis whose blood pressure is adequately controlled. The primary purpose is to monitor performance on the CBP measure, identify care gaps, and analyze patient populations with uncontrolled hypertension to guide quality improvement interventions. Adequate control is defined as a blood pressure reading of less than 140/90 mmHg.

2. Available Filters & Interactivity

1. **Panel**: Allows the user to select a specific provider panel or group to view its performance.
2. **Measure Year**: Filters the dashboard data to a specific measurement year.
3. **Reference Group**: Selects a benchmark group (e.g., "All DC Medicaid") to compare the selected panel's performance against.
4. **Roster**: Filters the report for a specific, pre-defined list of patients.
5. **Data Drill-Through**: Users can click on the data points within the *Monthly Performance Comparison* line chart, the bars in the *Annual Performance Trend*, *Number of Visits by Facility*, *Measure Performance Status*, and any of the *Beneficiary Distribution* charts to drill through to a detailed, patient-level list.

3. Key Metrics & KPIs

1. **Blood Pressure Control Rate**: The primary KPI, representing the percentage of eligible members whose most recent blood pressure reading was less than 140/90 mmHg.
2. **Count of Beneficiaries**: The total number of members within a given segment (e.g., by facility, by control status, by demographic).
3. **Number of Visits**: The total volume of patient visits, segmented by facility and whether the patient's blood pressure was adequately controlled or not.

4. Visualizations & Data Tables

1. **Monthly Performance Comparison**: A line chart that plots the selected panel's monthly blood pressure control rate against the selected reference group's rate throughout the measure year. This helps visualize performance trends and identify months with significant changes.
2. **Annual Performance Trend**: A bar chart comparing the year-over-year blood pressure control rates for the selected panel and the reference group. This provides a high-level view of long-term performance improvement or decline.
3. **Number of Visits by Facility**: A horizontal bar chart ranking facilities by the total number of visits.

4. **Measure Performance Status**: A simple bar chart displaying the total count of beneficiaries in the population who have adequately controlled vs. not adequately controlled blood pressure.
5. **Beneficiary Distribution by Categories**: A set of horizontal bar charts that stratify the beneficiary population by Social Needs, Gender, Age Category, Race, Ethnicity, and Chronic Conditions. Each bar shows the breakdown of controlled vs. uncontrolled members, helping to identify disparities and high-risk cohorts.

5. Functional Use Cases

1. **Track Monthly Performance:** A quality manager can select their panel and the current year to monitor the "Monthly Performance Comparison" chart, identifying if their interventions are improving control rates month-over-month compared to the DC Medicaid average.
2. **Target Facility-Level Outreach:** A practice manager can use the "Number of Visits by Facility" chart to identify a clinic with a high volume of patients with uncontrolled blood pressure. They can then drill through on that segment to generate a patient list for targeted outreach and follow-up appointments.
3. **Identify High-Risk Co-morbidities:** A care coordinator can analyze the "Chronic Conditions" chart to see which co-morbidities (e.g., Diabetes, Kidney Disease) are most associated with uncontrolled hypertension, allowing them to prioritize care management resources for these high-risk members.
4. **Investigate Health Disparities:** A health equity analyst can review the "Race" and "Ethnicity" charts to determine if specific demographic groups have lower rates of blood pressure control, prompting further investigation into potential barriers to care.
5. **Set Annual Improvement Goals:** A leadership team can review the "Annual Performance Trend" to understand historical performance and set a data-driven, realistic improvement target for the upcoming measurement year.

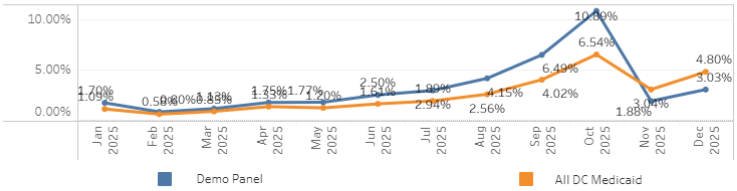
6. Screenshot

Controlling High Blood Pressure (CBP) Dashboard

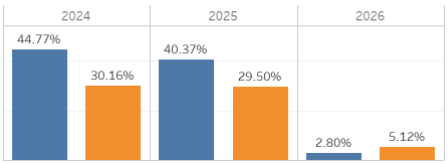
The Controlling High Blood Pressure Dashboard tracks the percentage of members aged 18–85 with a hypertension diagnosis whose blood pressure was successfully managed during the measurement year. To meet the numerator criteria for adequate control, a member's most recent blood pressure reading—recorded on or after their second diagnosis of hypertension—must demonstrate a representative systolic value of less than 140 mmHg and a representative diastolic value of less than 90 mmHg.

Measure Year: 2025 | Reference Group: All DC Medicaid

Monthly Performance Comparison

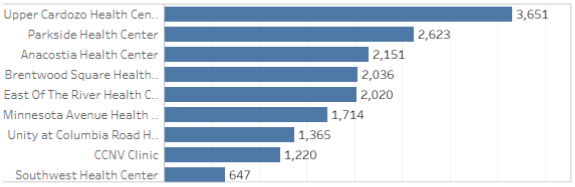


Annual Performance Trend

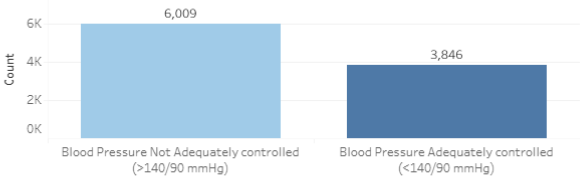


Note: Selecting a data point below within the dashboard allows you to cross-filter and drill-through to the beneficiary and claim-level details.

Number of Visits by Facility



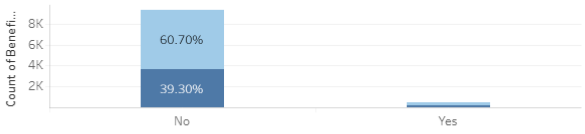
Measure Performance Status



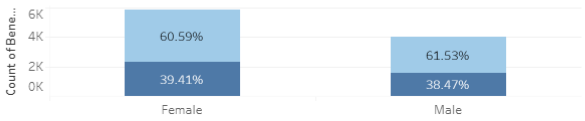
Blood Pressure Not Adequately controlled (>140/90 mmHg) | Blood Pressure Adequately controlled (<140/90 mmHg)

Beneficiary Distribution by Categories

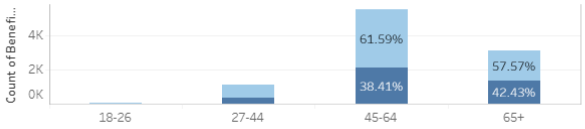
Social Needs



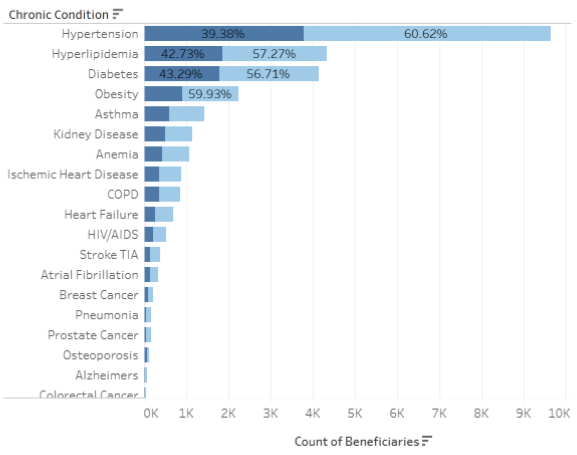
Gender



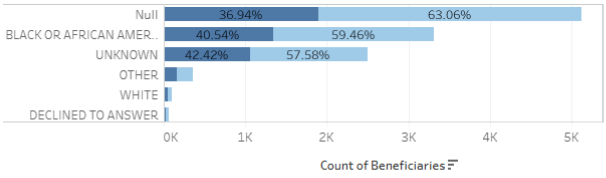
Age Category



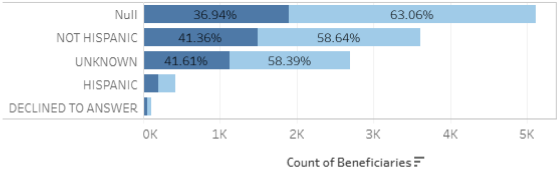
Chronic Conditions



Race



Ethnicity



Note: The Race and Ethnicity data presented in these reports is based on a deterministic approach designed to select the most prevalent race and ethnicity values in the available data.

15. Cost by Service Type Report

1. Report Overview & Purpose

This report provides a comprehensive breakdown of healthcare costs and member utilization by service (claim) type. It is designed to help users identify the primary drivers of medical expenditure, analyze cost trends over time, and understand how different services contribute to the overall Per Member Per Month (PMPM) cost.

2. Available Filters & Interactivity

1. **Start Date / End Date**: Allows the user to select a specific time frame for the report's data.
2. **CCW Chronic Condition Flag**: Filters the patient population based on specific chronic conditions.
3. **DHCF Plan**: Filters the report data by a specific health plan.
4. **Gender**: Filters the patient population by gender.
5. **Age Category**: Filters the patient population by pre-defined age groupings.
6. **Roster**: Allows the user to select a specific patient roster.
7. **Data Drill-Through**: Users can click on the rows within the "Payment by Claim Type" table or the colored segments within the "Payment by Claim Type Over Time" chart to navigate to a detailed view of the underlying claims or beneficiaries.

3. Key Metrics & KPIs

1. **Member Count**: The total number of unique members who have had at least one claim of a specific type within the selected period.
2. **% of Total Member Count**: The proportion of the entire member population that utilized a given service type.
3. **Claim Payment Amount**: The total dollar amount paid for all claims associated with a specific service type.
4. **% of Total Claim Payment Amount**: The proportion of the total healthcare spend attributed to a specific service type.
5. **PMPM (Per Member Per Month)**: The average cost of care for a given service type, normalized on a per-member, per-month basis. It is calculated as (Total Claim Payment Amount / Total Member Months).

4. Visualizations & Data Tables

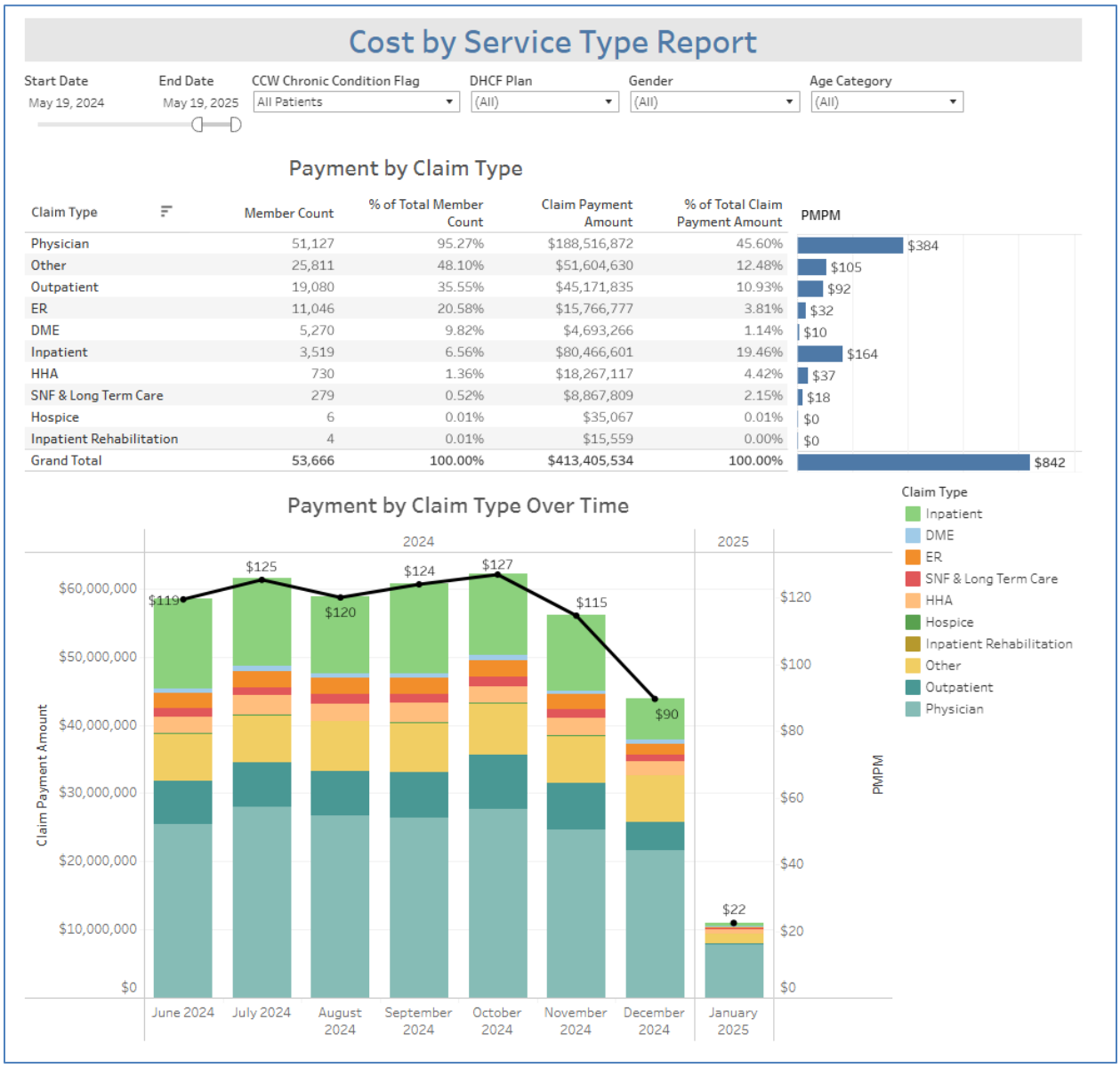
1. **Payment by Claim Type**: A detailed table that aggregates key metrics by each claim type (e.g., Physician, Outpatient, Inpatient). It is paired with a horizontal bar chart that visually represents the PMPM for each service type, making it easy to compare the relative cost intensity of different services.

2. **Payment by Claim Type Over Time**: A combination chart displaying monthly trends. The stacked bar chart shows the total claim payment amount each month, with colored segments representing the contribution of each service type. An overlaid line graph plots the total PMPM over time, allowing users to track the overall cost trend for the population.

5. Functional Use Cases

1. **Identify Top Cost Drivers**: A financial analyst can sort the "Payment by Claim Type" table by "Claim Payment Amount" to quickly identify the highest areas of expenditure.
2. **Analyze High-Cost Service Utilization**: A care manager can observe that while Inpatient services only involve 6.56% of the members, they account for 19.46% of the total cost, highlighting the high cost of hospitalizations.
3. **Monitor Monthly Spending Trends**: A practice manager can use the "Payment by Claim Type Over Time" chart to see that total costs peaked in October 2024 (with a PMPM of $127) and investigate the drivers of that monthly spike.
4. **Evaluate Cost-Effectiveness of Care Settings**: By comparing the PMPM for different services, a strategist can see that Outpatient care has a PMPM of $92, while Inpatient care has a much higher PMPM of $164, informing initiatives to shift care to lower-cost settings where appropriate.
5. **Target a Specific Population for Intervention**: A medical director can filter the report using the "CCW Chronic Condition Flag" for 'Diabetes' to understand the specific service utilization patterns and costs for that high-risk population.

6. Screenshot



16. Dental Services Utilization Dashboard

1. Report Overview & Purpose

This report provides a comprehensive overview of dental care utilization and associated costs for enrolled children under the age of 21. It allows users to analyze trends in dental services, costs, provider activity, and beneficiary demographics to support population health management and network oversight.

2. Available Filters & Interactivity

1. **Panel:** Drop-down filter to select a specific provider panel or group.
2. **Roster:** Drop-down filter to select a predefined list of beneficiaries.
3. **Start Date / End Date:** Slider to define a specific time period for the analysis.
4. **Claims Type:** Drop-down filter to view the data by "Total Claims" or other available claim types.
5. **Cost Measure:** Drop-down filter to change the cost metric, such as "Total Cost".
6. **Data Drill-Through:** Users can click on the segments of the donut charts ("Claim Counts by Dental Service Category", "Cost by Dental Service Category"), or the bars within the bar charts ("Age Category and Gender", "Race", "Ethnicity", "Number of Dental Visits by Provider Name", "Top 20 Procedure Codes") to navigate to a detailed, line-level report of the underlying beneficiaries or claims.

3. Key Metrics & KPIs

1. **Claim Counts:** The total number of dental claims, categorized by service type (e.g., Diagnostic, Preventive, Restorative, Endodontics).
2. **Total Cost:** The total monetary value associated with dental claims, also categorized by service type.
3. **Beneficiary Demographics:** The count and percentage of beneficiaries receiving dental services, broken down by age, gender, race, and ethnicity.
4. **Visits by Provider:** The total number and percentage of dental visits attributed to each provider, highlighting the most frequently visited facilities.
5. **Procedure Code Utilization:** The frequency and percentage of the top 20 most common dental procedure codes billed during the selected period.

4. Visualizations & Data Tables

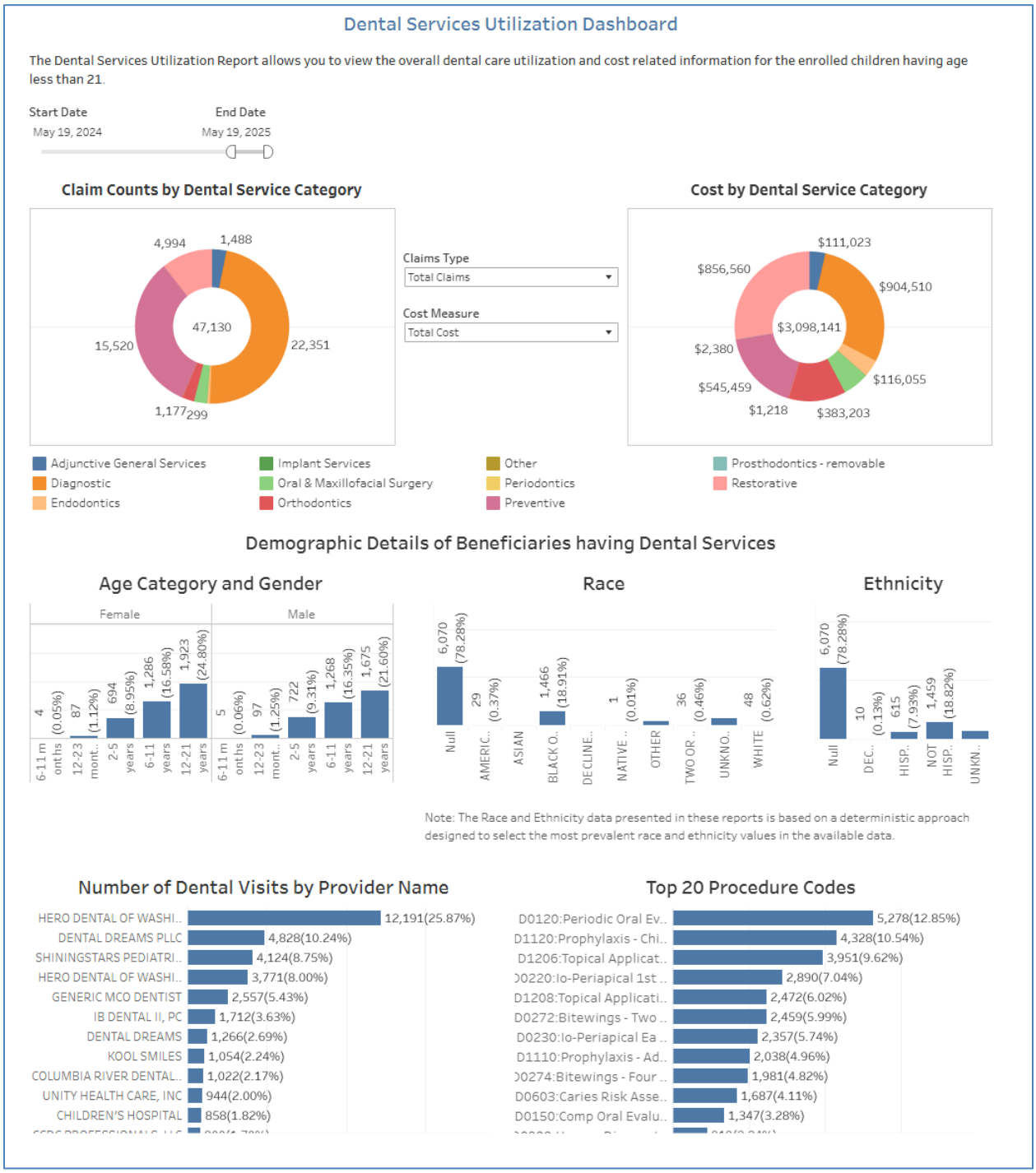
1. **Claim Counts by Dental Service Category:** A donut chart illustrating the volume distribution of claims across different dental service categories, such as Diagnostic, Preventive, and Restorative.

2. **Cost by Dental Service Category:** A donut chart showing the financial distribution of costs across the same dental service categories, highlighting the most expensive types of care.
3. **Demographic Details of Beneficiaries having Dental Services:** A series of bar charts that break down the patient population by age group and gender, race, and ethnicity, providing insights into which demographic segments are utilizing dental services.
4. **Number of Dental Visits by Provider Name:** A horizontal bar chart that ranks the top dental providers by the total number of patient visits, showing their share of the total volume.
5. **Top 20 Procedure Codes:** A horizontal bar chart that lists and ranks the most frequently billed dental procedure codes, indicating common treatments and services.

5. Functional Use Cases

1. **Analyze Cost Drivers:** A financial analyst can use the "Cost by Dental Service Category" chart to identify that "Restorative" services account for the largest portion of spending and drill through to investigate the specific claims and providers driving these costs.
2. **Monitor Preventive Care:** A quality improvement manager can review the "Top 20 Procedure Codes" to track the utilization of preventive services like "Prophylaxis - Child" (D1120) and "Topical Application of Fluoride" to ensure adherence to pediatric dental guidelines.
3. **Evaluate Provider Network:** A network manager can use the "Number of Dental Visits by Provider Name" chart to identify high-volume providers for potential partnerships or to assess if patient distribution across the network is equitable.
4. **Target Outreach Programs:** A care coordinator can analyze the "Age Category and Gender" chart to identify age groups with lower-than-expected utilization of diagnostic or preventive services, prompting targeted outreach campaigns.
5. **Assess Service Trends Over Time:** By adjusting the date range slider, a user can compare claim counts and costs for a specific service category (e.g., "Orthodontics") between different periods to identify emerging trends or the impact of policy changes.

6. Screenshot



17. Expenditure Per Member Per Month (PMPM) Dashboard

1. Report Overview & Purpose

This report provides a comprehensive overview of expenditure on a Per Member Per Month (PMPM) basis. It is designed to help users gain insight into the overall spending for their beneficiaries, identify key cost drivers by service category and demographic, and compare their panel's spending trends against a broader reference group.

2. Available Filters & Interactivity

1. **Panel:** Dropdown menu to select the specific panel of beneficiaries to analyze.
2. **Roster:** Dropdown menu to select a specific provider roster within the selected panel.
3. **Start Date / End Date:** Date range slider to define the time period for the analysis.
4. **Reference Group:** Dropdown menu to select the comparison group for benchmarking purposes (e.g., All DC Medicaid).
5. **Data Drill-Through:** Users can click on the bars within the "PMPM by Claim Category," "PMPM by DHCF Plan," and "PMPM by Demographics" (Age, Gender, Race, Ethnicity) charts to filter the report and drill down into more specific data. The "Top Providers by Payment Amount" table also allows for drill-through to a beneficiary-level view.

3. Key Metrics & KPIs

1. **PMPM (Per Member Per Month):** The core metric of the report, representing the average cost of services per member for each month in the selected period. It is used across all visualizations to compare spending.
2. **Claim Count:** The total number of claims filed for the specified provider and time period.
3. **Beneficiary Count:** The total number of unique beneficiaries who received services from the provider.
4. **Amount Paid:** The total dollar amount paid on all claims within the filtered criteria.
5. **Average Amount Paid:** The total amount paid divided by the claim count, representing the average cost per claim.

4. Visualizations & Data Tables

1. **PMPM by Claim Category:** A stacked bar chart comparing the PMPM of the selected "Demo Panel" (blue bars) against the "All DC Medicaid" reference group (orange bars) across various service categories like Inpatient, Physician, HHA, etc. This helps identify which services are driving costs.
2. **PMPM by DHCF Plan:** A stacked bar chart that breaks down PMPM by different Managed Care Organizations (MCOs) or DHCF plans, allowing for comparison of costs across different health plans.

3. **PMPM Monthly Trend (Demo Panel & All DC Medicaid):** Two parallel area/line charts that display the PMPM trend over time. Each chart is broken down by claim category, allowing users to track spending patterns and identify anomalies for both their specific panel and the overall Medicaid population.
4. **PMPM by Demographics:** A set of four bar charts that visualizes PMPM across different Age Categories, Genders, Races, and Ethnicities. This is used to identify spending variations among different demographic groups.
5. **Top Providers by Payment Amount:** A data table listing the top providers, ranked by the total amount paid. It includes their associated Claim Count, Beneficiary Count, and Average Amount Paid.

5. Functional Use Cases

1. **Identify High-Cost Service Categories:** A care manager can use the "PMPM by Claim Category" chart to see that "Physician" services have a PMPM of $384 for their panel, significantly higher than other categories, prompting a deeper dive into specialist utilization.
2. **Benchmark Against Peers:** An administrator can compare their panel's overall PMPM trends in the "PMPM Monthly Trend" chart against the "All DC Medicaid" trend to assess if their cost management initiatives are effective relative to the broader system.
3. **Analyze Demographic Spending:** A health equity officer can examine the "PMPM by Demographics" charts to find that spending for the "65 and Older" age group is the highest ($1,194), leading them to investigate the specific healthcare needs and costs associated with this population.
4. **Evaluate MCO Performance:** A health plan analyst can review the "PMPM by DHCF Plan" chart to compare the cost structures of different plans, informing network and contract negotiations.
5. **Monitor High-Volume Providers:** A network manager can use the "Top Providers by Payment Amount" table to identify that highest "Amount Paid" provider, and can drill down to understand the services driving these costs.

6. Screenshot

Provider Name	Claim Count	Beneficiary Count	Amount Paid	Average Amount Paid
MEDSTAR WASHINGTON HOSPITAL CENTER	27,900	10,210	$48,068,813	$1,723
GEORGE WASHINGTON UNIVERSITY HOSPITAL	8,837	4,554	$23,899,597	$2,704
GUARDIANTRAC, LLC	14,777	532	$22,523,549	$1,524
HOWARD UNIVERSITY HOSPITAL	9,292	5,394	$17,172,070	$1,848
MEDSTAR GEORGETOWN UNIVERSITY HOSPITAL	4,013	1,920	$12,240,854	$3,050
UNITY HEALTH CARE, INC	53,124	22,390	$12,088,514	$228

18. Follow-Up After Emergency Department Visit for Mental Illness (FUM) Dashboard

1. Report Overview & Purpose

This dashboard measures the percentage of beneficiaries (age 6 and older) who received a follow-up visit for mental illness within 7 or 30 days of an Emergency Department (ED) visit for a mental illness or intentional self-harm. The report is designed to help quality improvement teams and care managers monitor performance on the FUM (Follow-Up after Mental Illness) quality measure, identify care gaps, and track trends against a benchmark.

2. Available Filters & Interactivity

1. **Panel**: Drop-down menu to select a specific provider panel or organization for analysis.
2. **Roster**: Drop-down menu to filter the report for a pre-defined list of beneficiaries.
3. **Start Date / End Date**: Date selectors that define the measurement period for the report.
4. **Reference Group**: Drop-down menu to select a population to use as a performance benchmark (e.g., All DC Medicaid).
5. **FUM Rate**: Drop-down menu to select the follow-up window for the measure, currently set to "30 Day Follow-Up".
6. **Data Drill-Through:** Users can click on the bars or segments within the "Beneficiary Distribution by Follow-Up Days," "Beneficiary Distribution by Primary Diagnosis," "Number of Visits by Providers," and the demographic charts (Age, Gender, Race, Ethnicity) to navigate to a detailed, beneficiary-level report.

3. Key Metrics & KPIs

1. **7 or 30 Day Follow-Up Rate**: The core metric of the report, representing the percentage of patients with an eligible ED visit who received a follow-up for mental illness within 7 or 30 days.
2. **Beneficiary Count by Follow-Up Days**: The total number of beneficiaries who completed a follow-up, categorized by the timeliness of the visit (0-7 Days, 7-15 Days, 15-30 Days).
3. **Follow-Up Rate by Diagnosis**: The performance on the FUM measure broken down by the patient's primary mental health diagnosis.
4. **Follow-Up Rate by Demographics**: The FUM rate calculated for specific demographic subgroups, including age, gender, race, and ethnicity.

4. Visualizations & Data Tables

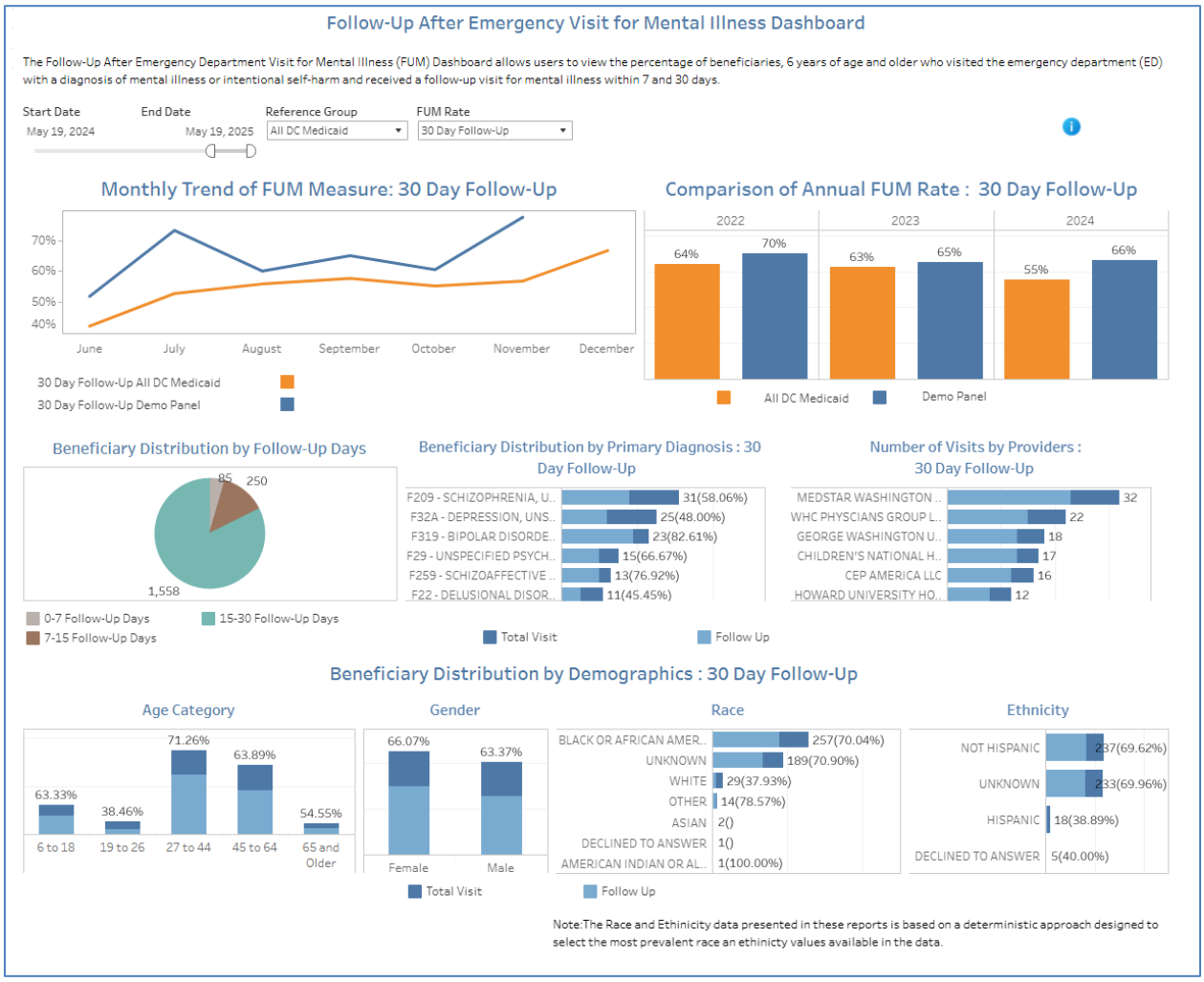
1. **Monthly Trend of FUM Measure**: A line graph that tracks the 7 or 30-day follow-up rate over several months, comparing the selected panel's performance (orange line) to the reference group (blue line).

2. **Comparison of Annual FUM Rate**: A bar chart comparing the overall annual FUM rate for the selected panel against the reference group for the past three years.
3. **Beneficiary Distribution by Follow-Up Days**: A pie chart that visualizes the proportion of completed follow-up visits that occurred within 0-7, 7-15, and 15-30 days of the initial ED visit.
4. **Beneficiary Distribution by Primary Diagnosis**: A horizontal bar chart displaying the follow-up rate and total patient volume for the most common primary diagnoses, allowing for identification of conditions with low follow-up adherence.
5. **Number of Visits by Providers**: A horizontal bar chart ranking providers or provider groups by the total number of follow-up visits they have conducted, highlighting key contributors to follow-up care.
6. **Beneficiary Distribution by Demographics**: A series of bar charts that segment the FUM rate by Age Category, Gender, Race, and Ethnicity to identify potential disparities in care.

5. Functional Use Cases

1. **Performance Monitoring**: A Quality Director can select their panel and review the "Comparison of Annual FUM Rate" and "Monthly Trend" charts to assess year-over-year and month-over-month performance against the "All DC Medicaid" benchmark.
2. **Identify At-Risk Populations**: A care manager can analyze the "Beneficiary Distribution by Demographics" charts to find populations with low follow-up rates (e.g., patients aged 19 to 26 at 38.46%) and drill through to the patient list to prioritize outreach.
3. **Target Clinical Interventions**: A clinical lead can examine the "Beneficiary Distribution by Primary Diagnosis" chart to see if patients with specific conditions, like Bipolar Disorder, have lower follow-up rates, and then develop targeted engagement strategies for that group.
4. **Evaluate Access to Care**: An administrator can use the "Beneficiary Distribution by Follow-Up Days" pie chart to determine if patients are getting timely appointments. A large proportion in the "15-30 Follow-Up Days" category may indicate a need to improve scheduling processes.
5. **Provider Network Management**: A network manager can use the "Number of Visits by Providers" chart to identify top-performing providers for follow-up care and potentially leverage them to share best practices across the network.

6. Screenshot



19. Follow Up Post-Acute Setting Discharge Report - Inpatient

1. Report Overview & Purpose

This report is designed to track and analyze patient follow-up rates after discharge from an inpatient setting. It provides insights into which patient populations and facilities have higher or lower rates of follow-up care within 7-14 days, helping care managers identify gaps in care transitions and opportunities for intervention to improve outcomes.

2. Available Filters & Interactivity

1. **Panel**: Selects the specific care management panel or patient group to analyze.
2. **Roster**: Allows for the selection of a specific patient roster within the chosen panel.
3. **Start Date / End Date**: A date range slider to define the time period for the discharge data.
4. **Utilization**: Specifies the type of acute care setting discharge to be analyzed (e.g., Inpatient).
5. **Reference Group**: Selects a benchmark population (e.g., All DC Medicaid) to compare against the selected panel's performance.
6. **Data Drill-Through**: Users can click on the bars within the "Number of Inpatient Discharges," "Top Diagnoses," "Comparison of Follow Up," and the demographic distribution charts (Gender, Race, Ethnicity) to navigate to a detailed list of the underlying beneficiaries.

3. Key Metrics & KPIs

1. **Follow Up Rate**: The percentage of patients who received a follow-up visit within the specified timeframe (7-14 days) after an inpatient discharge. This is trended monthly.
2. **Number of Discharges with Follow Up**: The total count of patients who were discharged and subsequently had a follow-up visit.
3. **Number of Discharges with No Follow Up**: The total count of patients who were discharged but did not have a follow-up visit within the specified timeframe.
4. **Counts by Demographics**: The number of beneficiaries with and without follow-up, segmented by gender, age group, race, and ethnicity.
5. **Counts by Diagnosis**: The number of beneficiaries with and without follow-up, categorized by their primary discharge diagnosis.

4. Visualizations & Data Tables

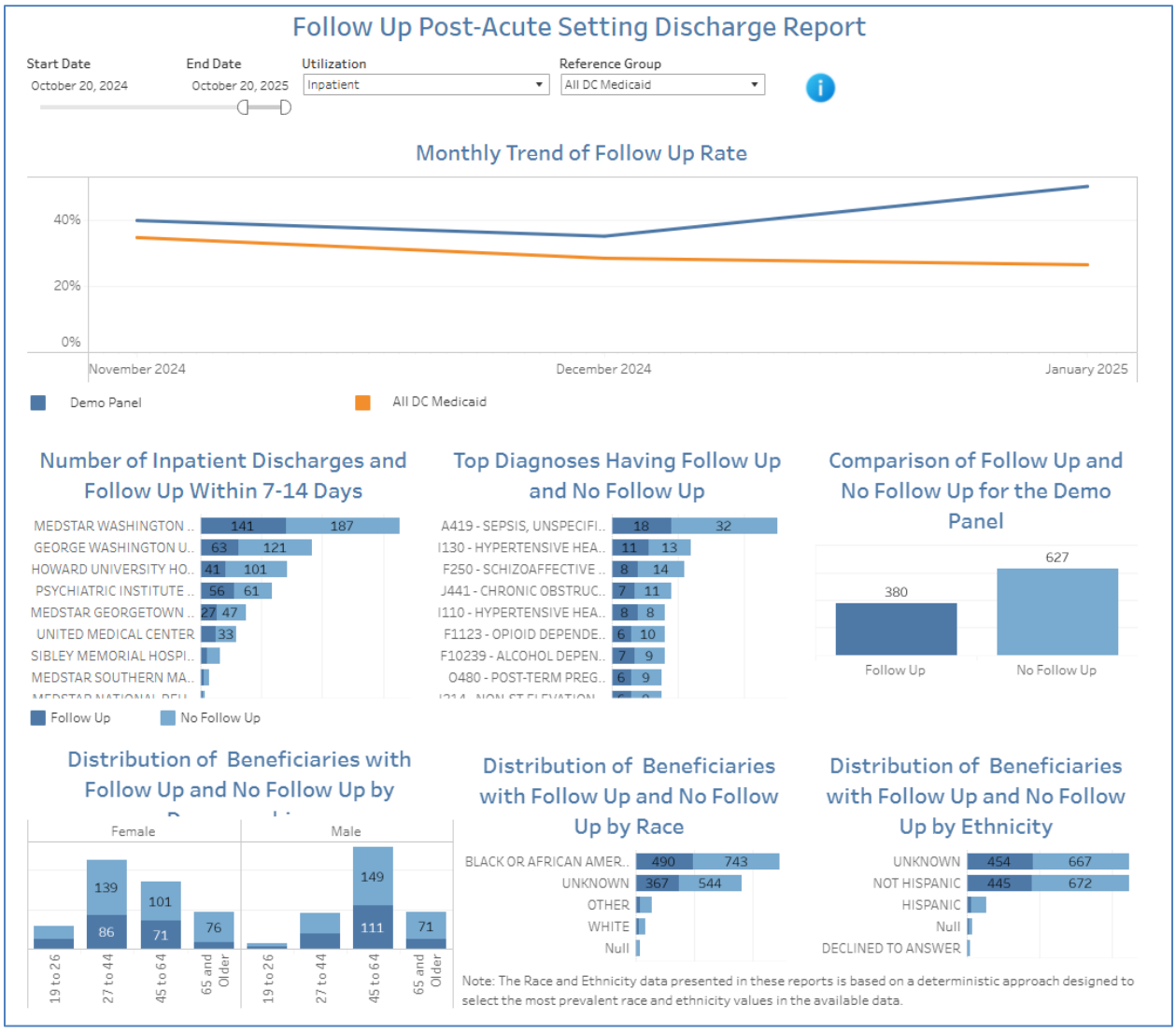
1. **Monthly Trend of Follow Up Rate**: A line graph comparing the follow-up rate of the selected "Demo Panel" (blue line) against the "All DC Medicaid" reference group (orange line) over time. This helps visualize performance trends and benchmark against a broader population.

2. **Number of Inpatient Discharges and Follow Up Within 7-14 Days**: A horizontal bar chart that breaks down the number of follow-ups (blue) and no follow-ups (light blue) by discharging facility. This highlights which hospitals have better or worse follow-up adherence for their discharged patients.
3. **Top Diagnoses Having Follow Up and No Follow Up**: A horizontal bar chart showing the top diagnoses associated with discharges. Each bar is segmented to show the count of patients with that diagnosis who did and did not receive a follow-up, identifying conditions where follow-up care may be lacking.
4. **Comparison of Follow Up and No Follow Up for the Demo Panel**: A simple bar chart providing a high-level, aggregate view of the total number of patients in the panel who received a follow-up versus those who did not.
5. **Distribution of Beneficiaries with Follow Up and No Follow Up (by Gender, Race, Ethnicity)**: A series of bar charts that segment the follow-up and no follow-up populations by key demographics. These charts are crucial for identifying potential disparities in care transitions among different patient groups.

5. Functional Use Cases

1. **Identify High-Risk Facilities**: A care manager can use the "Number of Inpatient Discharges" chart to identify hospitals which have a high number of patients with no follow-up, and then target outreach efforts to those specific facilities.
2. **Analyze Diagnosis-Specific Gaps**: A clinical director can review the "Top Diagnoses" chart to see that patients with Sepsis have a high rate of no follow-up and can initiate a quality improvement project to improve post-discharge care for this specific condition.
3. **Monitor Program Effectiveness**: A program manager can track the "Monthly Trend of Follow Up Rate" line chart over several months to determine if a new care transition intervention is successfully increasing the panel's follow-up rate compared to the DC Medicaid average.
4. **Investigate Health Equity**: A health equity officer can analyze the Race and Ethnicity distribution charts to identify disparities. For instance, they could see if the "Black or African American" population has a disproportionately higher number of "No Follow Up" cases and drill down to investigate the root causes.
5. **Target Age-Specific Interventions**: A case manager can look at the "Distribution by Gender" chart, which also includes age buckets, to see that the 27-44 age group has the highest volume of both follow-ups and no follow-ups, prompting them to tailor post-discharge support for that specific demographic.

6. Screenshot



20. Follow Up Post-Acute Setting Discharge Report - Emergency Room

1. Report Overview & Purpose

This report tracks the rate at which beneficiaries receive a follow-up visit after being discharged from a post-acute care setting, such as an Emergency Room. Its primary purpose is to help care managers, quality improvement teams, and administrators monitor care coordination, identify gaps in post-discharge care, and analyze trends and disparities across different providers and patient populations.

2. Available Filters & Interactivity

1. **Start Date / End Date**: Selects the measurement period for the discharge events included in the report.
2. **Utilization**: Filters the report to show discharges from a specific post-acute setting (e.g., Emergency Room, Inpatient).
3. **Reference Group**: Selects a comparison group (e.g., All DC Medicaid) to benchmark the Demo Panel's performance against.
4. **Data Drill-Through**: Users can click on the numerical values or colored segments within any of the bar charts (e.g., "Number of Emergency Room Discharges," "Top Diagnoses," "Comparison," and all "Distribution" charts) to navigate to a detailed, beneficiary-level view of the underlying patient and claims data.

3. Key Metrics & KPIs

1. **Follow Up Rate**: The primary KPI, calculated as the percentage of beneficiaries who had a qualifying follow-up visit within the specified timeframe (e.g., 7-14 days) after a discharge.
2. **Number of Follow Ups**: The total count of beneficiaries who received a follow-up visit after a qualifying discharge event.
3. **Number of No Follow Ups**: The total count of beneficiaries who did not receive a follow-up visit after a qualifying discharge event.

4. Visualizations & Data Tables

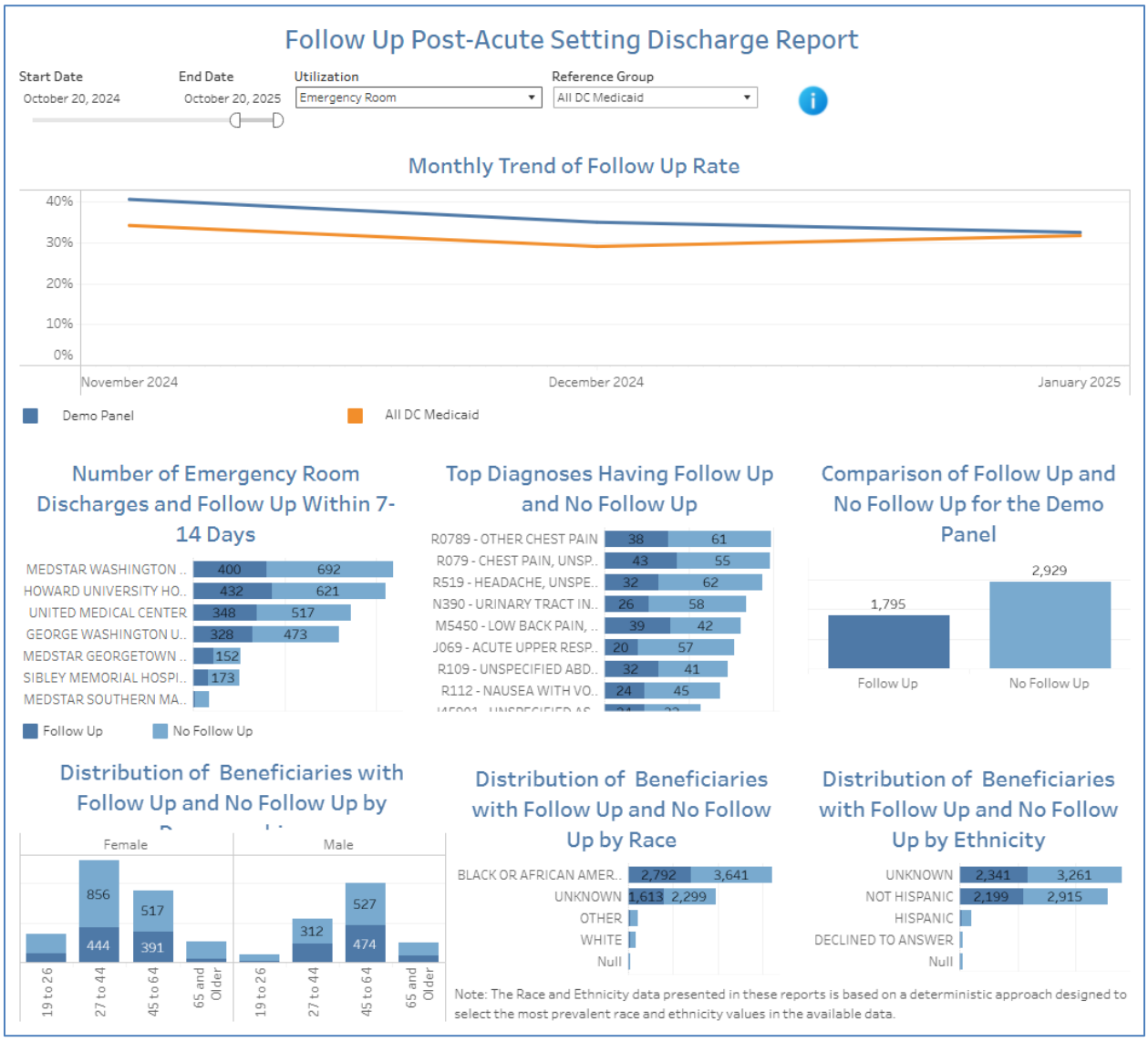
1. **Monthly Trend of Follow Up Rate**: A line graph comparing the follow-up rate of the selected "Demo Panel" against the "Reference Group" over time. This helps visualize performance trends and benchmark against a larger population.
2. **Number of Emergency Room Discharges and Follow Up Within 7-14 Days**: A horizontal bar chart that breaks down the number of beneficiaries with and without a follow-up for major discharging hospitals. It is used to identify which facilities have higher or lower rates of successful follow-up.

3. **Top Diagnoses Having Follow Up and No Follow Up**: This horizontal bar chart shows the follow-up status for beneficiaries based on their primary discharge diagnosis. It helps pinpoint specific conditions where post-discharge care may be lacking.
4. **Comparison of Follow Up and No Follow Up for the Demo Panel**: A simple bar chart providing a high-level, aggregate view of the total count of beneficiaries with and without a follow-up for the selected panel.
5. **Distribution of Beneficiaries by Gender and Age**: These bar charts segment the follow-up and no follow-up counts by gender and then by specific age brackets. They are used to identify demographic patterns in follow-up care adherence.
6. **Distribution of Beneficiaries by Race / by Ethnicity**: These horizontal bar charts display the breakdown of follow-up and no follow-up counts across different racial and ethnic groups, highlighting potential health equity disparities.

5. Functional Use Cases

1. **Monitor Operational Progress and Trends**: A quality improvement manager uses the "Monthly Trend" chart to track their panel's follow-up rate against the "All DC Medicaid" average, reporting on progress toward organizational goals.
2. **Review Clinical Care Transition Protocols**: A care coordinator at a hospital filters the report to their facility and uses the "Top Diagnoses" chart to see which specific discharge diagnosis codes have low follow-up rates, prompting a review of their discharge instructions for this group.
3. **Address Health Equity Care Gaps**: A health equity analyst reviews the "Distribution by Race" and "Distribution by Ethnicity" charts to identify disparities and drills through to the beneficiary list for a group with "No Follow Up" to initiate targeted outreach.
4. **Deploy Targeted Reminder Campaigns**: A program director analyzes the "Distribution by Gender and Age" charts to pinpoint specific demographics with a high proportion of "No Follow Up," leading to the development of tailored message campaigns for that demographic.
5. **Identify and Leverage System Best Practices**: A network manager compares performance across different facilities in the "Number of Emergency Room Discharges" chart to identify best practices at high-performing hospitals that could be shared with lower-performing ones.

6. Screenshot



21. Gap in HIV Medical Visits Dashboard

1. Report Overview & Purpose

This report identifies the percentage of patients with an HIV diagnosis who have not had a medical visit within the last six months of the selected measurement year. It is designed to help care teams and administrators monitor patient engagement, identify care gaps, and target outreach efforts to improve health outcomes for the HIV patient population.

2. Available Filters & Interactivity

1. **Roster:** Allows users to select a specific patient panel or group.
2. **Measure Year:** Filters the report data to a specific calendar year.
3. **Chronic Condition:** Narrows the patient population based on a selected chronic condition; defaults to "All Patients".
4. **Suppressed Viral Load:** Filters patients based on their viral load status (e.g., Suppressed, Not Suppressed, All).
5. **Data Drill-Through:** Users can click on the KPI cards ("HIV Patients", "Patients having Gap in Medical Visits", "Percentage of Patients having Gap in Medical Visit") or the individual bars within the "Age Category and Gender," "Race," and "Ethnicity" charts to navigate to a detailed, patient-level list.

3. Key Metrics & KPIs

1. **HIV Patients:** The total number of patients with an HIV diagnosis within the filtered population.
2. **Patients having Gap in Medical Visits:** The total count of HIV patients who have not had a medical visit in the last six months.
3. **Percentage of Patients having Gap in Medical Visit:** The percentage of the total HIV patient population that has a gap in medical visits.

4. Visualizations & Data Tables

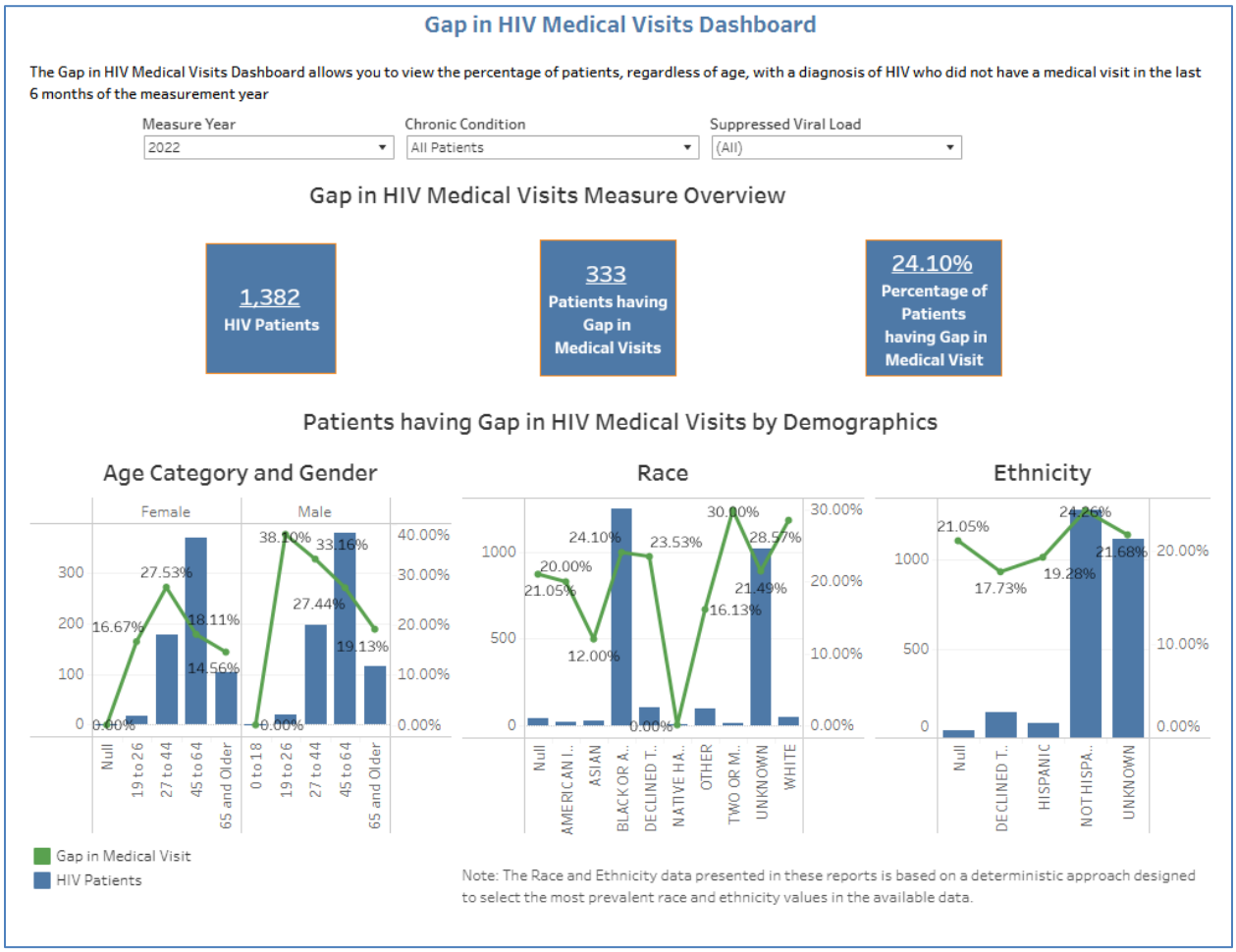
1. **Gap in HIV Medical Visits Measure Overview:** This section contains three key performance indicator (KPI) cards that provide a high-level summary of the total HIV patient count, the number of patients with a care gap, and the overall gap percentage.
2. **Age Category and Gender:** A dual-axis combination chart displaying the total number of HIV patients (blue bars) and the corresponding care gap percentage (green line) for various age groups, segmented by Female and Male. This allows for easy comparison of gap rates across different age and gender cohorts.
3. **Race:** A dual-axis combination chart showing the total number of HIV patients (blue bars) and the care gap percentage (green line) broken down by patient race.

4. **Ethnicity:** A dual-axis combination chart that presents the total number of HIV patients (blue bars) and the care gap percentage (green line) categorized by patient ethnicity.

5. Functional Use Cases

1. **Track Performance Against Quality Targets**: A practice manager can select their specific provider roster to view the overall care gap percentage and track performance against internal quality improvement targets.
2. **Isolate Disengaged Beneficiaries for Care Gaps**: A care coordinator can analyze the "Age Category and Gender" chart to identify specific cohorts with the highest gap rates and drill through on that specific bar to generate a patient list for targeted outreach.
3. **Investigate Systemic Health Disparities**: A population health strategist can use the "Race" and "Ethnicity" charts to identify potential health disparities, such as higher gap rates among specific racial categories, prompting further investigation.
4. **Evaluate Long-Term Engagement Program Impact**: A quality improvement team can use the "Measure Year" filter to compare current care gap data with previous years, assessing the long-term impact of patient engagement initiatives.
5. **Prioritize Resource Allocation for Vulnerable Beneficiaries**: A clinic director can filter for patients with a "Not Suppressed" viral load and then examine the demographic charts to prioritize outreach to the most vulnerable, high-risk patient segments who are not engaged in care.

6. Screenshot



22. Health Home Measures Dashboard

1. Report Overview & Purpose

This report provides a comparative analysis of key quality and utilization metrics from the CMS Core Set for Medicaid Health Home programs. It is designed to help users evaluate their panel's performance on measures related to behavioral health follow-up, substance use treatment, and healthcare utilization against a broader reference group, such as the entire DC Medicaid population.

2. Available Filters & Interactivity

1. **Panel**: Select the specific provider group or panel to analyze.
2. **Roster**: Choose a specific patient roster or cohort within the selected panel.
3. **Start Date/End Date**: Define the reporting period for the measures.
4. **Reference Group**: Select the benchmark population for comparison (e.g., All DC Medicaid).
5. **Panel Type**: Filter the patient population by their enrollment status or program type (e.g., MHGPS Enrolled Patients).
6. **Data Drill-Through**: Users can click on the individual bars to access the measure-specific dashboards.

3. Key Metrics & KPIs

The report is divided into two categories of metrics:

1. **Rate Based Measures**: These are performance rates shown as percentages.
    a. **30 Day Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-HH)**: The percentage of ED visits for alcohol or other drug (AOD) dependence where the member received a follow-up visit within 30 days.
    b. **30 Day Follow-Up After Hospitalization for Mental Illness (FUH-HH)**: The percentage of hospital discharges for mental illness where the member received a follow-up visit within 30 days.
    c. **Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)**: The percentage of members with a new episode of AOD abuse or dependence who initiated treatment through two or more services within 34 days.
    d. **Plan All-Cause Readmissions (PCR-HH)**: The percentage of hospital discharges that result in an unplanned readmission for any cause within 30 days.
    e. **Controlling High Blood Pressure (CBP)**: The percentage of members with a diagnosis of hypertension whose blood pressure is adequately controlled.
    f. **Use of Pharmacotherapy for Opioid Use Disorder (OUD)**: The percentage of members with an OUD diagnosis who receive pharmacotherapy.

   g. **Colorectal Cancer Screening (COL)**: The percentage of eligible members who are up-to-date on colorectal cancer screenings.
2. **Count Based Measures**: These are raw counts of specific utilization events.
   a. **Admission to an Institution from the Community (AIF-HH)**: The total number of inpatient or skilled nursing facility admissions that originated from a community setting.
   b. **Ambulatory Care - Emergency Department (ED) Visits (AMB-HH)**: The total number of ED visits.
   c. **Inpatient Utilization (IU-HH)**: The total number of inpatient hospital stays.
   d. **Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite**: The total count of hospital admissions that may have been preventable with better outpatient care.

4. Visualizations & Data Tables

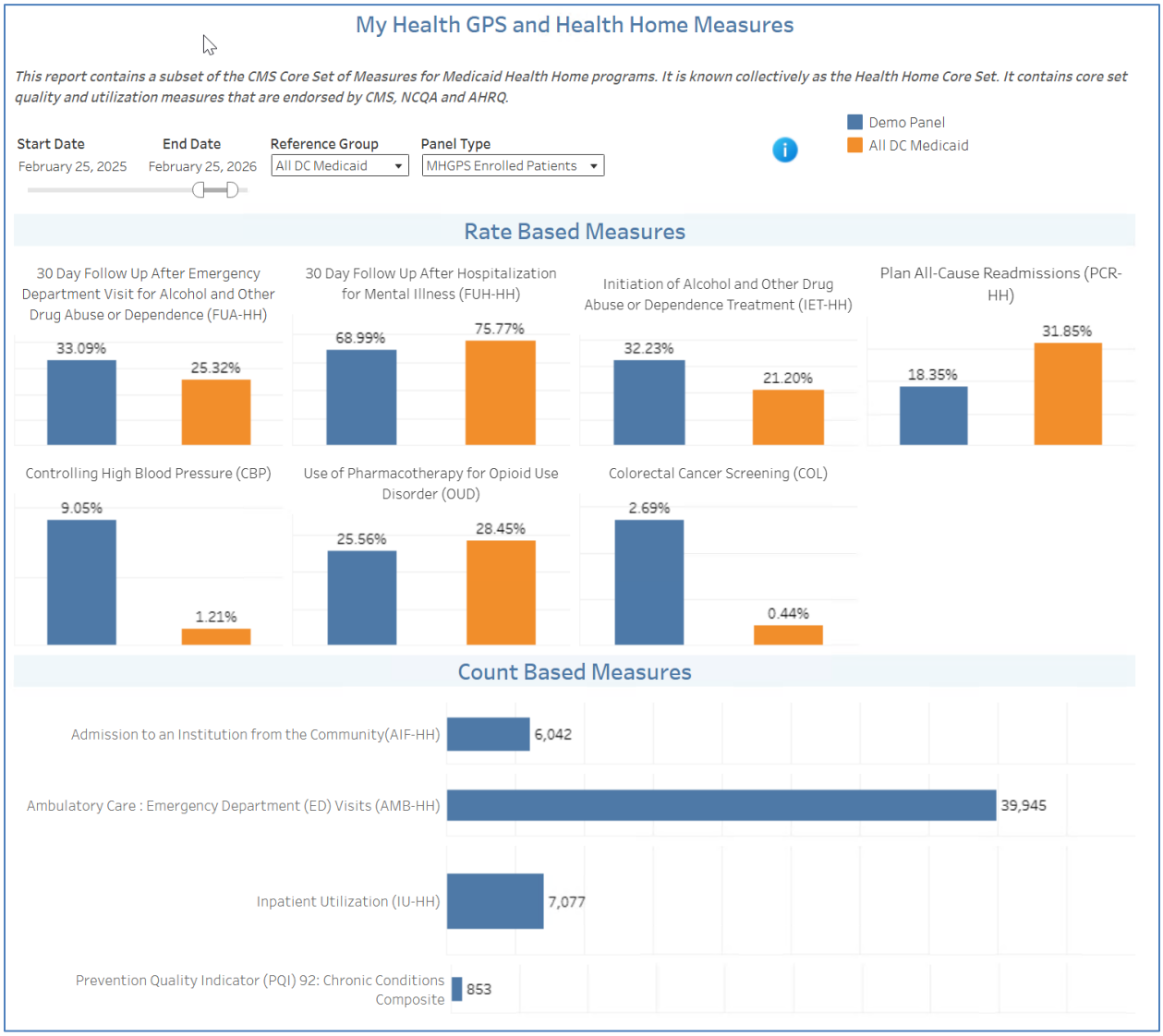
1. **Rate Based Measures Bar Chart**: This grouped bar chart provides a direct comparison of the selected panel's performance (blue bars) against the chosen reference group (orange bars) for the four rate-based measures. This visualization helps quickly identify areas of strong performance or opportunities for improvement relative to the benchmark.
2. **Count Based Measures Horizontal Bar Chart**: This chart displays the total volume for four key utilization metrics for the selected panel. It provides a straightforward view of the scale of inpatient admissions, ED visits, and potentially preventable hospitalizations within the patient population.

5. Functional Use Cases

1. **Evaluate Post-Discharge Care Effectiveness**: A care manager can review the "30 Day Follow-Up After Hospitalization for Mental Illness (FUH-HH)" rate to assess the success of their team's transition-of-care protocols and patient engagement efforts for members with mental health conditions.
2. **Identify Opportunities to Reduce Readmissions**: A quality improvement lead can compare their panel's "Plan All-Cause Readmissions (PCR-HH)" rate to the "All DC Medicaid" benchmark to determine if a new initiative is needed to improve discharge planning and post-acute care coordination.
3. **Monitor Substance Use Treatment Engagement**: A behavioral health director can track the “Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH)” metric over time to measure the impact of programs designed to connect patients with timely substance use disorder care.
4. **Assess Emergency Department Utilization**: A practice manager can analyze the "Ambulatory Care - ED Visits (AMB-HH)" count to understand the volume of ED use among their patients, prompting an investigation into access to primary care or urgent care alternatives.

5. **Target Preventable Hospitalizations**: A population health analyst can use the "Prevention Quality Indicator (PQI) 92" count to identify if there is a high volume of admissions for chronic conditions, indicating a need for enhanced chronic disease management programs for their population.

6. Screenshot



23. Health Home Measures: Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-HH) Dashboard

1. Report Overview & Purpose

This report measures the percentage of emergency department (ED) visits for beneficiaries aged 18 and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence who had a follow-up visit for AOD within 7 or 30 days. The dashboard is designed to help care managers and quality improvement teams track performance, identify care gaps, and compare their patient panel's follow-up rates against the overall DC Medicaid population.

2. Available Filters & Interactivity

1. **Panel:** Allows the user to select a specific patient panel or cohort for analysis.
2. **Roster:** Enables filtering for a sub-population or specific roster of patients within the selected panel.
3. **Start Date / End Date:** Defines the measurement period for the data displayed in the report.
4. **Reference Group:** Allows the user to select the comparison group for the trend and performance charts (e.g., All DC Medicaid).
5. **FUA Rate:** Specifies the follow-up timeframe being measured (7 Day Follow Up, 30 Day Follow Up).
6. **Panel Type:** Filters the panel's patient population by a specific characteristic, such as enrollment type.

3. Key Metrics & KPIs

1. **7 Day Follow-Up Rate:** The primary performance metric, calculated as the percentage of ED visits for AOD that received a follow-up visit for AOD within 7 days of the initial ED visit.
2. **30 Day Follow-Up Rate:** The primary performance metric, calculated as the percentage of ED visits for AOD that received a follow-up visit for AOD within 30 days of the initial ED visit.
3. **Number of Visits:** The total count of qualifying ED visits for AOD by primary diagnosis.

4. Visualizations & Data Tables

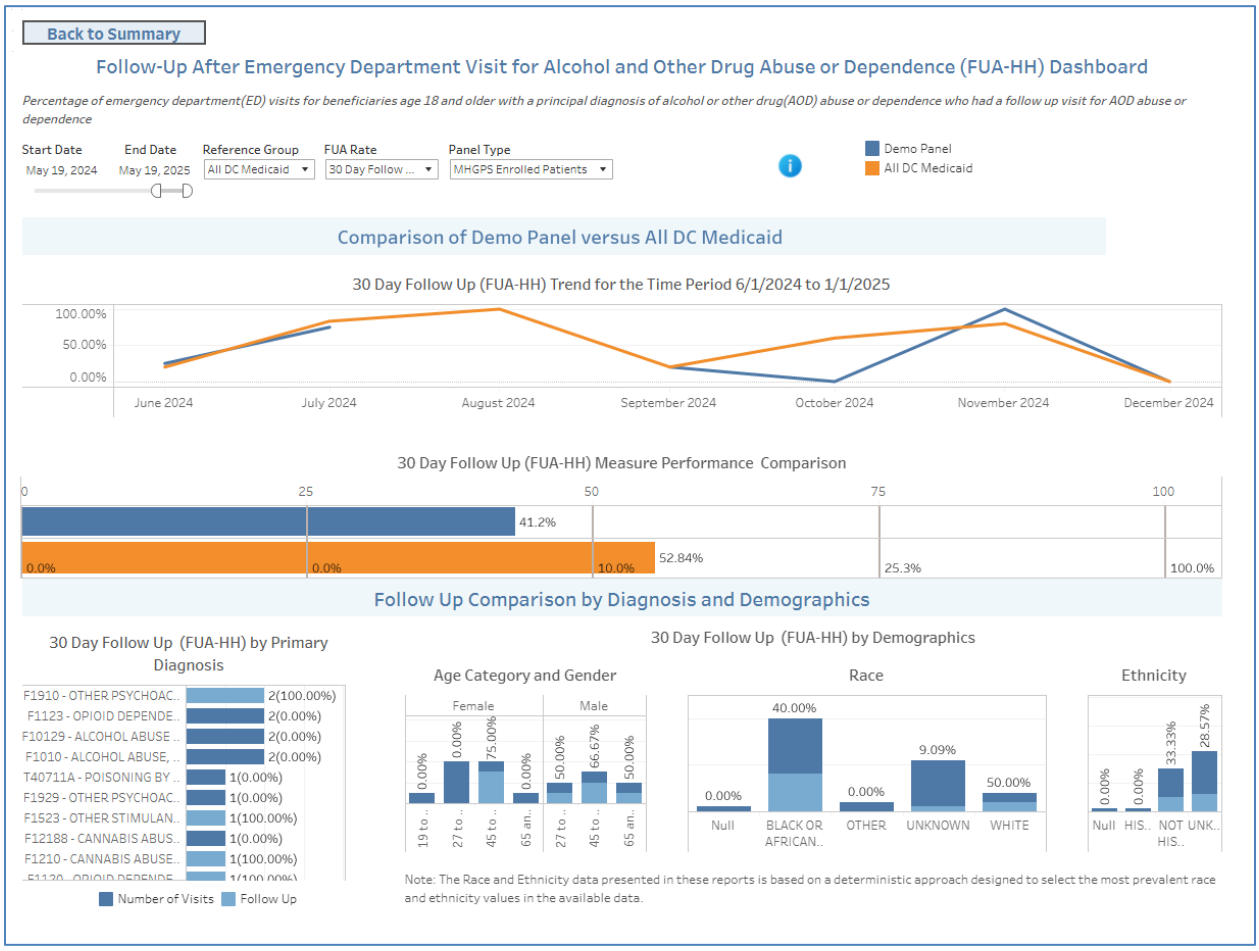
1. **Comparison of Demo Panel versus All DC Medicaid:** This section contains two visualizations:
    a. **7 or 30 Day Follow Up (FUA-HH) Trend:** A line chart that plots the follow-up rate over time, comparing the selected panel (blue line) against the reference group (orange line).

   b. **Measure Performance Comparison:** A horizontal bar chart that provides a summary comparison of the overall follow-up rates for the selected panel and the reference group for the entire period.
2. **Follow Up Comparison by Diagnosis and Demographics:** This section breaks down the follow-up performance into more granular detail:
   a. **7 or 30 Day Follow Up (FUA-HH) by Primary Diagnosis:** A horizontal bar chart displaying the total number of visits and the corresponding follow-up rate for specific AOD-related diagnosis codes.
   b. **Age Category and Gender:** A set of bar charts that break down follow-up rates by age group, separated for female and male beneficiaries.
   c. **Race & Ethnicity:** Two separate bar charts that illustrate the follow-up performance across different racial and ethnic groups, helping to identify potential disparities in care.

5. Functional Use Cases

1. **Track Cohort Performance:** A Care Manager can select their specific "Panel" and "Roster" to monitor their patients' 7 or 30-day follow-up rate and compare it against the "All DC Medicaid" benchmark to assess performance.
2. **Identify High-Risk Diagnoses:** A Quality Improvement Director can use the "Primary Diagnosis" chart to pinpoint which substance use disorders (e.g., Opioid Dependence vs. Alcohol Abuse) have the lowest follow-up rates, enabling targeted intervention strategies.
3. **Analyze Demographic Gaps:** An outreach coordinator can examine the "Race," "Ethnicity," and "Age Category and Gender" charts to identify any demographic groups with significantly lower follow-up rates, in order to design culturally and age-appropriate engagement campaigns.
4. **Inform Resource Allocation:** A program manager can use insights from the dashboard to allocate clinical resources and staff time to the specific patient populations and diagnosis groups that are least likely to receive timely follow-up care.
5. **Evaluate Program Efficacy:** A user can set the date filters to a period after implementing a new patient outreach initiative to measure its impact on the FUA-HH rate compared to a prior period.

6. Screenshot



24. Health Home Measures: Follow-Up After Hospitalization for Mental Illness (FUH-HH) Dashboard

1. Report Overview & Purpose

This report measures the percentage of health plan enrollees (age 6 and older) who received a follow-up visit with a mental health practitioner within seven days of being discharged from a hospitalization for mental illness or intentional self-harm. The primary purpose is to monitor and improve the timeliness of follow-up care for this vulnerable population, comparing a selected provider panel's performance against a broader reference group like All DC Medicaid.

2. Available Filters & Interactivity

1. **Panel**: Drop-down menu to select the specific provider panel or group to analyze.
2. **Start Date / End Date**: Calendar controls to define the measurement period for the report.
3. **Reference Group**: Drop-down menu to select the population to use as a benchmark for comparison (e.g., All DC Medicaid).
4. **FUH Rate**: Drop-down to select the follow-up window (e.g., 7 Day Follow Up).
5. **Roster**: Drop-down menu to select a specific patient roster within the chosen panel.

3. Key Metrics & KPIs

1. **7 Day Follow Up (FUH-HH) Rate**: The core metric of the report, calculated as the percentage of eligible hospital discharges for mental illness that were followed by an outpatient mental health visit within seven days.
2. **Total Visits**: The total number of hospitalizations for the selected diagnoses within the filtered population and time frame.
3. **Follow Up**: The total number of hospitalizations that had a qualifying follow-up visit, used as the numerator for the FUH-HH rate.
4. **Panel vs. Reference Group Comparison**: The report directly compares the FUH-HH rate of the selected "Demo Panel" against the "All DC Medicaid" reference group to benchmark performance.

4. Visualizations & Data Tables

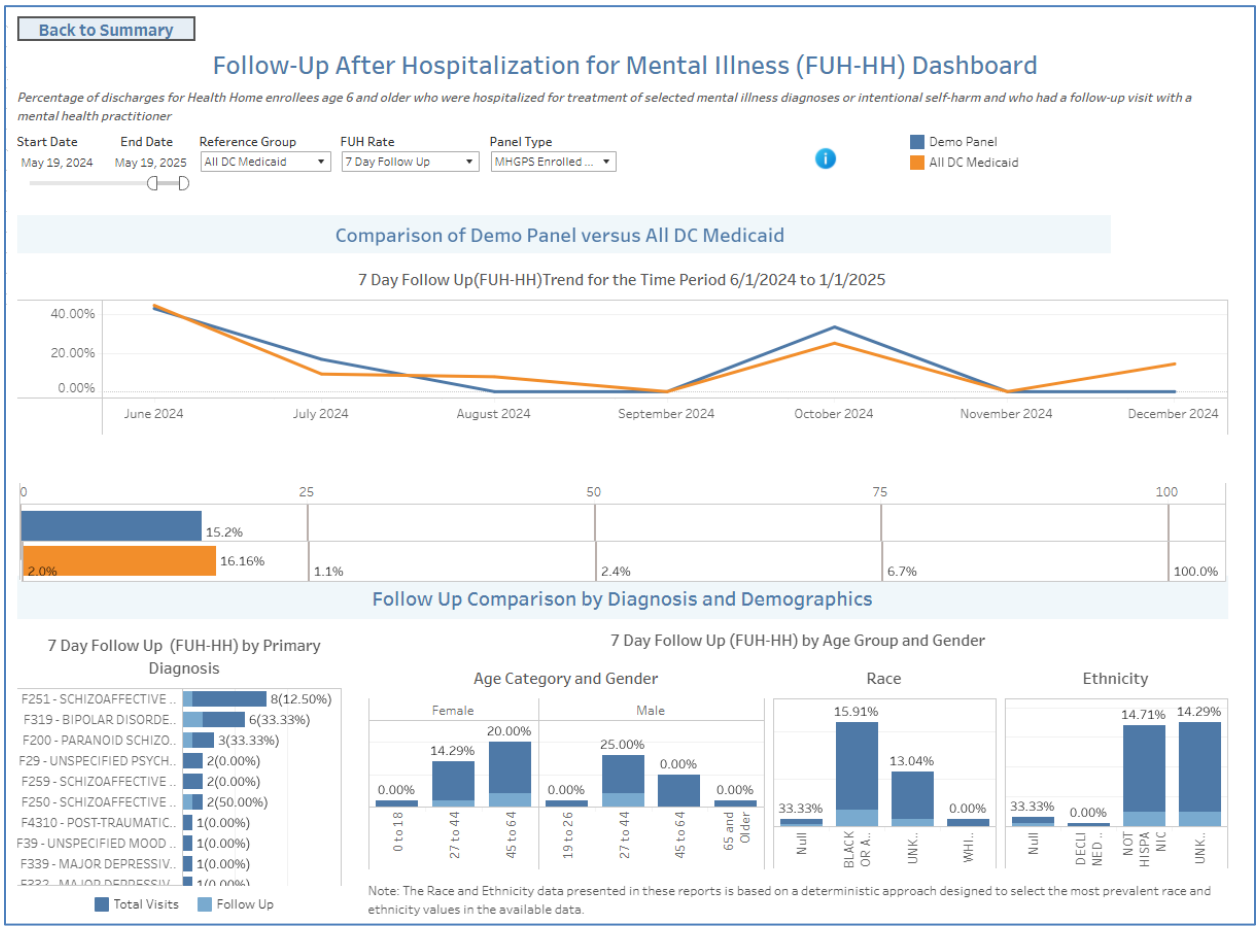
1. **7 Day Follow Up(FUH-HH)Trend for the Time Period**: A line graph that plots the FUH-HH rate over time, showing separate trend lines for the selected panel (blue) and the reference group (orange) to visualize performance trends and gaps.
2. **Follow Up Comparison by Diagnosis and Demographics**: A high-level summary view using horizontal data bars to show the overall FUH-HH rate for the selected panel versus the reference group.

3. **7 Day Follow Up (FUH-HH) by Primary Diagnosis**: A horizontal bar chart that breaks down performance by the patient's primary diagnosis. It displays the total number of visits and the corresponding follow-up rate for each condition, helping to identify which patient populations may require more targeted post-discharge support.
4. **7 Day Follow Up (FUH-HH) by Age Group and Gender, Race, and Ethnicity**: A series of bar charts that segment the FUH-HH rate by key demographic factors. These visualizations are crucial for identifying potential disparities in care among different patient populations.

5. Functional Use Cases

1. **Monitor Performance Against Benchmarks**: A practice manager can select their "Demo Panel" and compare its 7-day follow-up trend against the "All DC Medicaid" average to assess whether their performance is above or below the regional standard.
2. **Identify High-Risk Diagnostic Groups**: A clinical quality lead can review the "by Primary Diagnosis" chart to find that patients with "F315 - BIPOLAR DISORDER" have a 20.00% follow-up rate, prompting an investigation into the specific post-discharge care coordination for this group.
3. **Investigate Demographic Disparities**: A health equity analyst can use the "Age Category and Gender" chart to identify that males in the 45-64 age group have a 0.00% follow-up rate, indicating a critical gap in care that requires immediate attention and targeted outreach.
4. **Evaluate Outreach Initiatives**: After implementing a new automated appointment reminder system, a care coordinator can track the "7 Day Follow Up (FUH-HH) Trend" chart over several months to determine if the initiative led to a sustained increase in the panel's follow-up rate.
5. **Allocate Care Management Resources**: A care management director can use the diagnosis and demographic charts to identify the largest patient cohorts with the lowest follow-up rates (e.g., patients with Schizoaffective Disorder), thereby prioritizing these groups for intensive case management resources.

6. Screenshot



25. Health Home Measures: Admission to an Institution from the Community (AIF-HH) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive overview of institutional admissions for Health Home enrollees aged 18 and older who have been residing in the community for at least one month. The report is designed to help care managers, program directors, and analysts monitor admission trends, identify high-risk members and high-volume providers, and understand the primary diagnoses driving institutional stays. The goal is to leverage these insights to reduce preventable institutionalizations and improve care coordination.

2. Available Filters & Interactivity

1. **Panel**: A drop-down menu to select a specific provider panel or group (e.g., "213 - Demo Panel").
2. **Start Date / End Date**: Date selectors that allow the user to define a specific time frame for the analysis.
3. **Panel Type**: A drop-down menu to filter for a specific type of enrolled patient population (e.g., "MHGPS Enrolled Patients").
4. **Roster**: A drop-down menu to select a specific patient roster within the chosen panel.
5. **Data Drill-Through**: Users can click on the bars or rows within the following charts and tables to navigate to a detailed, beneficiary-level view:
    a. Number of Visits and Average LOS by Provider
    b. Top Diagnosis by Number of Visits
    c. Number of Institution Visits by Length of Stay
    d. Utilization Summary by Patient
    e. Age Category and Gender
    f. Race
    g. Ethnicity

3. Key Metrics & KPIs

1. **Number of Institution Visits**: The total count of admissions to an institution for the selected patient population and time frame.
2. **Average Length of Stay (Avg. LOS in Days)**: The average duration, in days, of an institutional stay. This is displayed by the provider and by the individual patient.
3. **Total Amount Paid**: The total healthcare expenditure associated with institutional stays, shown by diagnosis and by individual patients.
4. **Institutional Admissions**: The count of admissions for a specific patient.
5. **Patient Demographics**: A breakdown of the admitted population by age, gender, race, and ethnicity.

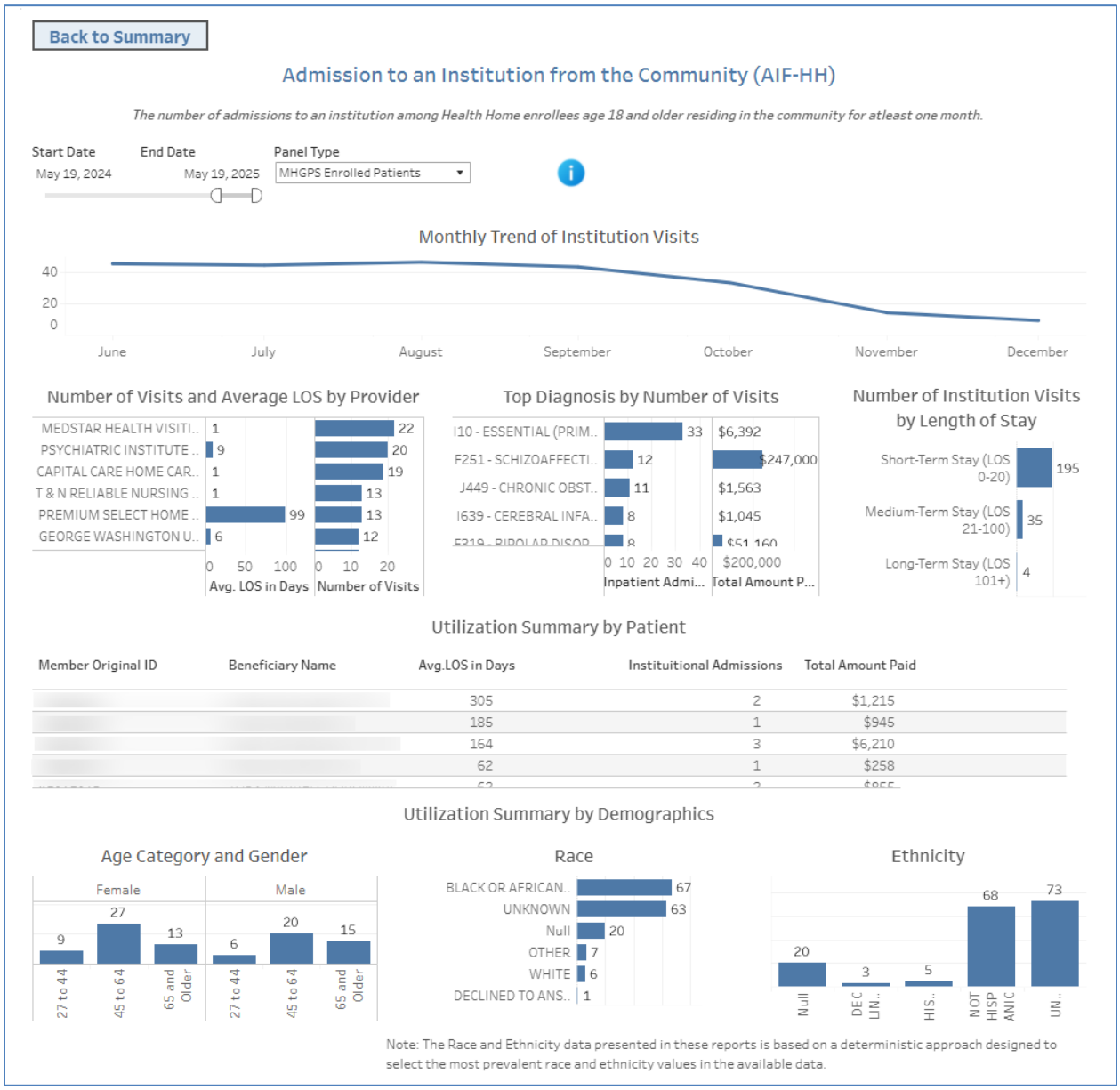
4. Visualizations & Data Tables

1. **Monthly Trend of Institution Visits**: A line graph that plots the number of institutional admissions over time, allowing users to track trends and seasonality.
2. **Number of Visits and Average LOS by Provider**: A chart that lists providers, showing the total number of visits they received (as a bar chart) and the corresponding average length of stay (in days). This helps identify providers with high admission volumes or unusually long stays.
3. **Top Diagnosis by Number of Visits**: A horizontal bar chart displaying the top diagnoses leading to admissions, ranked by the number of inpatient admissions. A secondary bar chart shows the total amount paid for visits associated with each diagnosis, highlighting high-cost conditions.
4. **Number of Institution Visits by Length of Stay**: A bar chart that categorizes all institutional visits into three groups based on duration: Short-Term (0-20 days), Medium-Term (21-100 days), and Long-Term (101+ days).
5. **Utilization Summary by Patient**: A detailed table listing individual patients, their average length of stay, total number of institutional admissions, and the total amount paid for their care during the selected period.
6. **Utilization Summary by Demographics**: A set of three bar charts that provide a demographic profile of the admitted population, broken down by Age and Gender, Race, and Ethnicity.

5. Functional Use Cases

1. **Monitor Admission Trends**: A care manager uses the "Monthly Trend of Institution Visits" line chart to see if a new community support program implemented in August corresponds with a decrease in admissions in the following months.
2. **Identify High-Cost Conditions**: A program director analyzes the "Top Diagnosis" chart to see that Schizoaffective Disorders account for a disproportionately high total cost ($247,000) and can allocate resources to enhance outpatient support for members with this condition.
3. **Evaluate Provider Utilization**: A network manager reviews the "Number of Visits... by Provider" chart to identify that "PREMIUM SELECT HOME" has a very high average length of stay (99 days) and initiates a review to understand the patient complexity or care model at that facility.
4. **Target High-Risk Members for Intervention**: A Health Home supervisor uses the "Utilization Summary by Patient" table to identify the member with an average LOS of 305 days, flagging them for an intensive case conference to develop a more robust community-based care plan.
5. **Assess Health Equity**: A population health analyst examines the "Race" and "Ethnicity" charts to determine if certain demographic groups are overrepresented in institutional admissions, which could inform the development of culturally competent outreach initiatives.

6. Screenshot



26. Health Home Measures: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-HH) Dashboard

1. Report Overview & Purpose

This dashboard measures the percentage of Health Home enrollees (age 13+) with a new episode of alcohol or other drug (AOD) abuse or dependence who receive timely initiation and engagement of AOD treatment. The report is designed to help care managers and program administrators monitor treatment engagement rates, compare their panel's performance against a reference group, and identify demographic or diagnostic-specific disparities in care.

2. Available Filters & Interactivity

1. **Start Date / End Date**: Sets the measurement period for the report.
2. **Reference Group**: Selects the comparison population for the key metrics (e.g., All DC Medicaid).
3. **IET Rate**: Toggles the report view between "Initiation" and "Engagement" rates.
4. **Panel Type**: Filters the patient population based on their enrollment status or program type.
5. **Roster**: Allows selection of a specific patient roster or panel.
6. **Panel Dropdown**: Toggles between different panels or groups available to the user.

3. Key Metrics & KPIs

1. **Engagement (IET-HH) Rate**: The primary KPI, representing the percentage of patients with a new AOD episode who engaged in treatment within a specified timeframe.
2. **Comparison Rate**: The IET-HH rate for the selected Reference Group (e.g., All DC Medicaid), used as a benchmark.
3. **Total Claims**: The number of claims associated with specific primary diagnoses for patients within the AOD episode cohort.

4. Visualizations & Data Tables

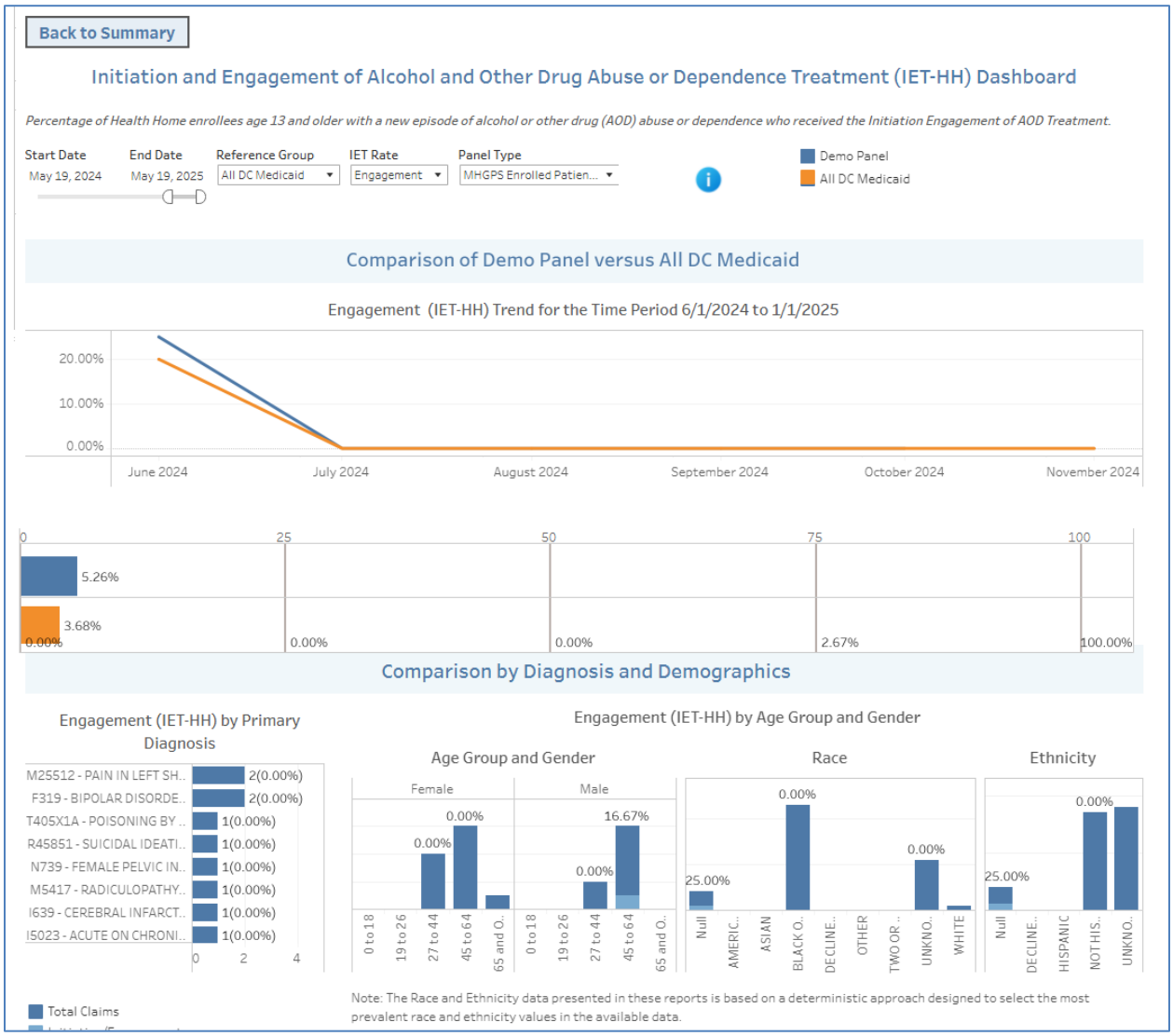
1. **Engagement (IET-HH) Trend**: A line graph that plots the engagement rate over time for the selected panel (Demo Panel) and the reference group (All DC Medicaid), allowing for trend analysis and performance comparison.
2. **Comparison of Demo Panel versus All DC Medicaid**: A horizontal bar chart providing a snapshot comparison of the current overall engagement rates between the user's panel and the reference group.
3. **Engagement (IET-HH) by Primary Diagnosis**: A horizontal bar chart that displays the total number of claims for the most common primary diagnoses among the patient cohort.

4. **Engagement (IET-HH) by Age Group and Gender**: A bar chart that breaks down the engagement rate by various age brackets, segmented by gender, to identify demographic-specific care gaps.
5. **Engagement (IET-HH) by Race / Ethnicity**: Two separate bar charts that display the engagement rates across different racial and ethnic groups, highlighting potential disparities in treatment access or follow-up.

5. Functional Use Cases

1. **Monitor Program Performance**: A program manager can compare their panel's overall engagement rate to the All DC Medicaid rate to evaluate the effectiveness of their AOD treatment programs.
2. **Identify Demographic Disparities**: A care coordinator can review the "Age Group and Gender" chart to see that males aged 45-64 have a 16.67% engagement rate while other groups have 0%, prompting targeted outreach to under-engaged demographics.
3. **Analyze Co-occurring Conditions**: A clinical supervisor can use the "Primary Diagnosis" chart to identify common co-morbidities within the AOD population and ensure integrated treatment plans are in place.
4. **Track Trends Over Time**: An analyst can monitor the "Engagement (IET-HH) Trend" line chart to determine if a new outreach initiative launched in a specific month corresponds with an increase in engagement rates.
5. **Support Quality Improvement Initiatives**: A quality improvement specialist can use the dashboard to establish a baseline engagement rate and track progress towards a specific goal, such as increasing the rate for patients of a specific race identified as having low engagement.

6. Screenshot



27. Health Home Measures: Ambulatory Care: Emergency Department (ED) Visits (AMB-HH) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive overview of Emergency Department (ED) utilization for Health Home enrollees. It is designed to help care managers, analysts, and administrators identify trends, high-cost diagnoses, high-utilizing patients, and demographic patterns related to ED visits, enabling targeted interventions to reduce avoidable utilization and manage costs.

2. Available Filters & Interactivity

1. **Panel:** Filters the report data to a specific provider panel or group.
2. **Roster:** Filters the report to a specific, user-defined list of patients.
3. **Start Date / End Date:** A date range slider to define the reporting period for the ED visits.
4. **Panel Type:** A drop-down menu to select a specific enrolled patient population (e.g., MHGPS Enrolled Patients).
5. **Data Drill-Through:** Users can click on the bars within the *Top ER Diagnosis*, *Number of Emergent Visits by Hospital*, *Age Category and Gender*, *Race*, and *Ethnicity* charts, or on the rows in the *Utilization Summary by Patient* table to navigate to a detailed view of the underlying beneficiaries and their claims.

3. Key Metrics & KPIs

1. **ED Visits:** The total count of emergency department visits within the selected time frame.
2. **Total Amount Paid:** The total dollar amount paid for claims associated with the ED visits.
3. **Number of Emergent Visits by Hospital:** The volume of ED visits attributed to specific hospital facilities.
4. **ER Visit (per patient):** The number of ED visits for an individual patient, used to identify high utilizers.
5. **Demographic Counts:** The number of patients within specific age, gender, race, and ethnicity categories who have had an ED visit.

4. Visualizations & Data Tables

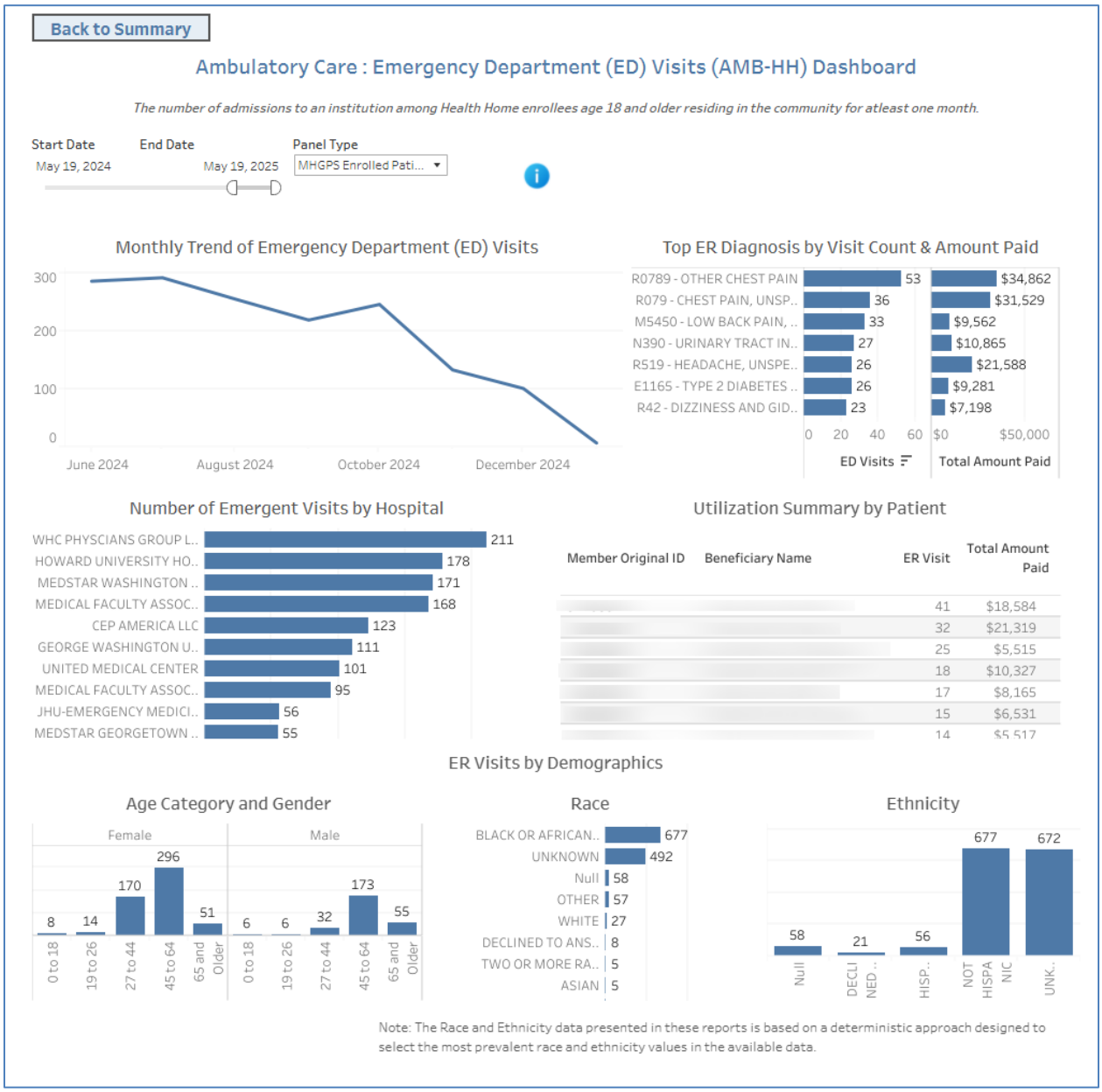
1. **Monthly Trend of Emergency Department (ED) Visits:** A line chart displaying the number of ED visits over time, allowing users to track utilization trends and seasonality.
2. **Top ER Diagnosis by Visit Count & Amount Paid:** A horizontal bar chart that ranks the most common ED diagnoses. It visualizes both the frequency of visits and the total cost for each diagnosis, helping to identify high-volume and/or high-cost conditions.

3. **Number of Emergent Visits by Hospital:** A horizontal bar chart that ranks hospitals based on the volume of ED visits from the filtered patient population, highlighting key facilities where patients seek emergency care.
4. **Utilization Summary by Patient:** A table listing the patients with the highest number of ED visits. It includes their Member ID, Name, total ER Visit count, and the Total Amount Paid for their visits.
5. **ER Visits by Demographics:** A series of bar charts that break down the ED visit population by *Age Category and Gender*, *Race*, and *Ethnicity*. This helps in understanding the demographic profile of patients utilizing the ED.

5. Functional Use Cases

1. **High-Utilizer Intervention:** A care manager can use the "Utilization Summary by Patient" table to identify individuals with the most frequent ED visits and enroll them in a care coordination program to address underlying issues and prevent future visits.
2. **Cost-Driver Analysis:** An analyst can examine the "Top ER Diagnosis" chart to see that "Other Chest Pain" has the highest visit count (53) and the highest cost ($34,862), prompting an investigation into whether these visits could be managed in a lower-cost primary or urgent care setting.
3. **Network Management:** A practice manager can review the "Number of Emergent Visits by Hospital" chart to understand patient flow and establish better communication or care transition protocols with the most frequently visited hospitals.
4. **Program Effectiveness Monitoring:** A program director can use the "Monthly Trend of ED Visits" chart to monitor the impact of a newly implemented patient education initiative, expecting to see a downward trend in visits over several months.
5. **Health Equity Assessment:** A health equity officer can analyze the "ER Visits by Demographics" charts to determine if specific populations, such as Black or African American patients aged 45-64, are disproportionately represented in ED visits, guiding targeted community outreach and resource allocation.

6. Screenshot



28. Health Home Measures: Inpatient Utilization (IU-HH) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive overview of acute inpatient utilization and associated costs for Health Home enrollees. It is designed to help care managers, analysts, and program coordinators identify trends, high-utilizing hospitals, prevalent diagnoses, and specific patient populations driving inpatient care. The report visualizes data on services including total, maternity, mental and behavioral health, surgery, and medicine to support care management and resource allocation.

2. Available Filters & Interactivity

1. **Panel**: Drop-down menu to select a specific provider panel.
2. **Roster**: Drop-down menu to select a specific patient roster within the chosen panel.
3. **Start Date / End Date**: Date-range selectors to define the reporting period for the dashboard data.
4. **Panel Type**: Drop-down menu to filter the report by the type of enrolled panel.
5. **Data Drill-Through**: Users can click on the bars within the "Number of IP Visits by Hospital," "Total IP Diagnosis by Visit Count," and "IP Visits by Demographics" charts, as well as the individual rows in the "Utilization Summary by Patients" table, to navigate to a detailed view of the underlying beneficiaries and their claims.

3. Key Metrics & KPIs

1. **Inpatient (IP) Visits**: The total count of inpatient hospital admissions within the selected timeframe.
2. **Inpatient Admissions**: The volume of inpatient stays, often segmented by diagnosis, hospital, or demographic group.
3. **Total Amount Paid**: The total cost of claims associated with inpatient admissions, shown by diagnosis or for individual beneficiaries.
4. **Avg. LOS in Days**: The average length of stay (in days) for a beneficiary's inpatient admissions.
5. **IP Visits by Demographics**: The count of inpatient visits stratified by patient age, gender, race, and ethnicity.

4. Visualizations & Data Tables

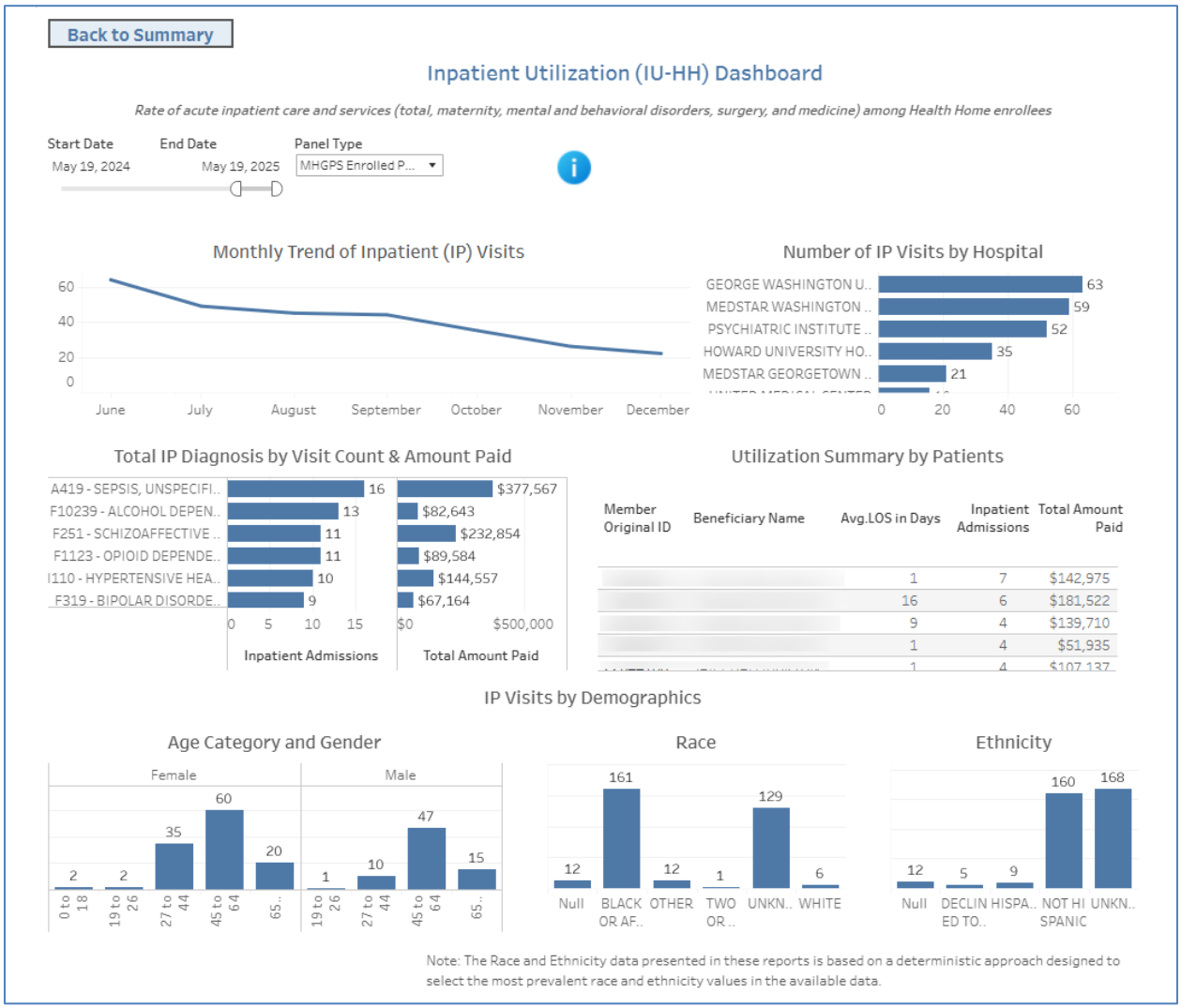
1. **Monthly Trend of Inpatient (IP) Visits**: A line chart that displays the total number of inpatient visits over time, allowing users to identify seasonal patterns, trends, or the impact of interventions.

2. **Number of IP Visits by Hospital**: A horizontal bar chart that ranks hospitals based on the volume of inpatient visits they receive, highlighting the most frequently used facilities.
3. **Total IP Diagnosis by Visit Count & Amount Paid**: A set of horizontal bar charts that list the top inpatient diagnoses. It visualizes both the frequency (Inpatient Admissions) and financial impact (Total Amount Paid) of each diagnosis.
4. **Utilization Summary by Patients**: A detailed table that lists high-utilizing beneficiaries, providing their Member ID, name, average length of stay, total number of admissions, and the total amount paid for their care.
5. **IP Visits by Demographics**: A series of bar charts breaking down inpatient visits by Age Category and Gender, Race, and Ethnicity.

5. Functional Use Cases

1. **High-Risk Patient Identification**: A care manager reviews the "Utilization Summary by Patients" table to identify individuals with a high number of admissions and total costs. They can then prioritize this patient for intensive case management to prevent future hospitalizations.
2. **Targeted Clinical Program Development**: An analyst observes in the "Total IP Diagnosis" chart that Sepsis and Schizoaffective Disorder are driving significant costs and admissions. This insight can be used to justify the development of targeted preventative care programs for at-risk populations.
3. **Evaluating Hospital Network Performance**: A network manager uses the "Number of IP Visits by Hospital" chart to see that a particular hospital has the highest volume of visits. They can drill down to analyze the types of admissions to better understand referral patterns and opportunities for care coordination with that specific facility.
4. **Assessing Health Equity**: A public health coordinator examines the "IP Visits by Demographics" charts and notes a high concentration of visits among Black or African American patients and Not Hispanic patients. This data can inform investigations into potential health disparities and guide the allocation of culturally competent resources.
5. **Monitoring Utilization Trends**: A program director monitors the "Monthly Trend of Inpatient (IP) Visits" chart to track the effectiveness of a new community health initiative launched in July. A decline in visits in the subsequent months could indicate a positive program impact.

6. Screenshot



29. HealthCheck Dashboard for Recommended Dental Procedures

1. Report Overview & Purpose

This dashboard provides a comprehensive view of dental procedure performance for a selected panel of beneficiaries, benchmarked against a chosen reference group. It allows users to analyze adherence to the DC Medicaid HealthCheck Dental Periodicity Schedule by age group, identifying gaps in care and areas for targeted quality improvement.

2. Available Filters & Interactivity

1. **Panel:** Select the specific panel (e.g., provider, practice) to view its performance data.
2. **Measure Year:** Choose the calendar year for which to display the data.
3. **Reference Group:** Select a population to compare the selected panel against (e.g., All DC Medicaid).
4. **Roster:** Select a specific roster of beneficiaries within the chosen panel.
5. **Age Category:** Filters the donut charts and maps to a specific age group or all ages.
6. **Data Drill-Through:** Users can click on the procedure group names (e.g., "Caries-Risk Assessment", "Clinical Oral Examination") or any of the percentage values within the main "HealthCheck Dashboard for Recommended Dental Procedures" table to drill down to the dental procedure group dashboards.

3. Key Metrics & KPIs

1. **Number of Beneficiaries:** The total count of eligible beneficiaries within each specified age group.
2. **Avg. No. of Services Received:** The average number of recommended dental services received per beneficiary in each age group.
3. **Procedure Performance (%):** The percentage of beneficiaries in each age group who have completed a specific recommended dental service. Services measured include Caries-Risk Assessment, Clinical Oral Examination, Counseling, Oral Prophylaxis, Topical Fluoride, Radiographic Assessment, and Sealants.
4. **Performance Indicator:** Performance scores highlighted in red text indicate that the selected panel's performance is lower than the reference group's performance for that specific age group and procedure.

4. Visualizations & Data Tables

1. **HealthCheck Dashboard for Recommended Dental Procedures Table:** This central table breaks down key dental procedure performance metrics by age group (from 6-11 months to 12-21 years). It provides beneficiary counts, average services received, and completion percentages for seven distinct dental procedures, with a grand total column for overall performance.

2. **Comparison of Completed Recommended Services (Donut Charts):** This section features two donut charts that visualize the distribution of beneficiaries based on the percentage of recommended services they have completed (e.g., 0-20%, 20-40%). One chart represents the "Selected Panel" and the other represents the "All DC Medicaid" (or chosen reference group), allowing for a direct comparison of overall population health management.
3. **Completed Visits by Ward for Selected Panel (Map):** This is a map of the District of Columbia. It displays the rate of completed dental visits by geographic ward for the selected panel, using a color gradient to indicate performance levels and help identify geographic disparities in care.

5. Functional Use Cases

1. **Launch Targeted Screening Outreach Campaigns**: A practice manager can identify age-specific care gaps by reviewing the main table to find which cohort has the lowest compliance rates for a specific procedure and launch an outreach campaign.
2. **Benchmark Overall Population Management Compliance**: A quality improvement analyst can benchmark their organization's performance by comparing the "Selected Panel" donut chart to the "All DC Medicaid" chart to see if their patient population's service completion distribution is better or worse than the state average.
3. **Investigate Underperformance and Schedule Appointments**: A care coordinator can investigate underperformance by clicking on an individual red-colored metric to drill down to a list of specific children who are due for that preventive service and schedule appointments.
4. **Allocate Geographic and Mobile Health Resources**: A public health official can use the "Completed Visits by Ward" map to identify neighborhoods with low dental service completion rates, informing decisions on where to allocate community health resources or mobile dental clinics.
5. **Evaluate Year-over-Year Quality Initiatives**: A provider can use the "Measure Year" filter to track year-over-year performance changes for key procedures, evaluating the effectiveness of previously implemented quality improvement initiatives.

6. Screenshot

HealthCheck Dashboard for Recommended Dental Procedures

The HealthCheck Dashboard for Recommended Dental Procedures dashboard allows you to view the recommended dental procedure performance by age group.

Click each procedure group to access the procedure-specific dashboard. Click on the performance score to view the beneficiary and claim-level details for the specific procedure groups. Procedure groups are based on the DC Medicaid HealthCheck Dental Periodicity Schedule that can be found here: https://www.dchealthcheck.net/documents/DC_Medicaid_HealthCheck_DENTAL_Periodicity-10-20.pdf.

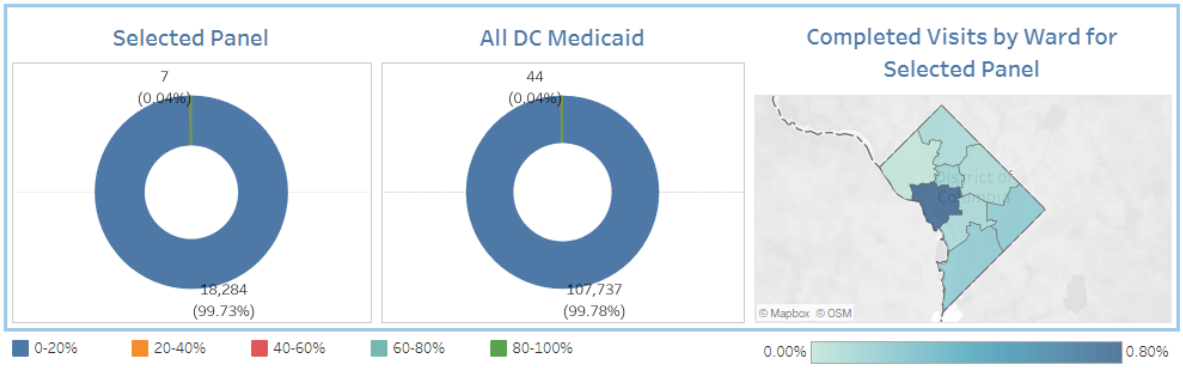
Measure Year: 2025 | Reference Group: All DC Medicaid

Red colored text means that Panel's performance is lower than the Reference Group's for that age group.

	6-11 months	12-23 months	2-5 years	6-11 years	12-21 years	Grand Total
Number of Beneficiaries	3	565	3,055	5,524	9,186	18,333
Avg.No.of Services Received	0.00	0.01	0.01	0.01	0.01	0.01
Caries-Risk Assessment	0.00%	0.18%	0.03%	0.07%	0.07%	0.07%
Clinical Oral Examination	0.00%	0.35%	0.23%	0.24%	0.30%	0.27%
Counseling	0.00%	0.18%	0.00%	0.05%	0.04%	0.04%
Oral Prophylaxis	0.00%	0.18%	0.23%	0.16%	0.26%	0.22%
Topical Fluoride	0.00%	0.35%	0.23%	0.18%	0.24%	0.22%
Radiographic Assessment	0.00%	0.00%	0.00%	0.20%	0.30%	0.21%
Sealants			0.00%	0.00%	0.03%	0.02%

Comparison of Completed Recommended Services for Selected Panel and Reference Group Population

Age Category: (All)



30. HealthCheck Dashboard: Caries-Risk Assessment

1. Report Overview & Purpose

This dashboard provides a comprehensive view of the percentage of enrolled children under the age of 21 who received a caries-risk assessment visit within the selected measurement year. It is designed to help care managers, quality improvement teams, and dental program managers monitor performance trends, identify disparities in care across different demographic groups, and understand the risk profile of the assessed population. The report visualizes performance over time, breaks down visits by risk level, and details performance across various demographic segments.

2. Available Filters & Interactivity

1. **Panel**: Allows the user to select a specific panel or program (e.g., "213 - Demo Panel").
2. **Roster**: Filters the dashboard to display data for a specific provider roster or group.
3. **Age Category**: Filters the visualizations to show data for a selected age group.
4. **Measure Year**: Selects the specific year for which performance data is displayed.
5. **Measure Performance Timeframe**: Adjusts the timeframe for the performance measurement, likely allowing for views by month, quarter, or year.
6. **Data Drill-Through**: Users can click on the data points in the Performance Over Time line chart, the bar in the Number of Risk Assessment Visits by Beneficiaries chart, the segments of the Caries-Risk Assessment Visits by Service Type donut chart, and the bars within the Performance by Demographics charts to drill down into a detailed, beneficiary-level list of members.

3. Key Metrics & KPIs

1. **Risk Assessment Performance Rate**: The primary KPI, representing the percentage of eligible children who received a caries-risk assessment visit. This is trended over time in the "Performance Over Time" chart.
2. **Number of Risk Assessment Visits**: A total count of beneficiaries who have received a risk assessment visit within the specified timeframe.
3. **High/Low Risk Assessment Ratio**: The proportion of assessment visits that were categorized as "High-Risk" versus "Low-Risk," indicating the overall dental health risk of the population.

4. Visualizations & Data Tables

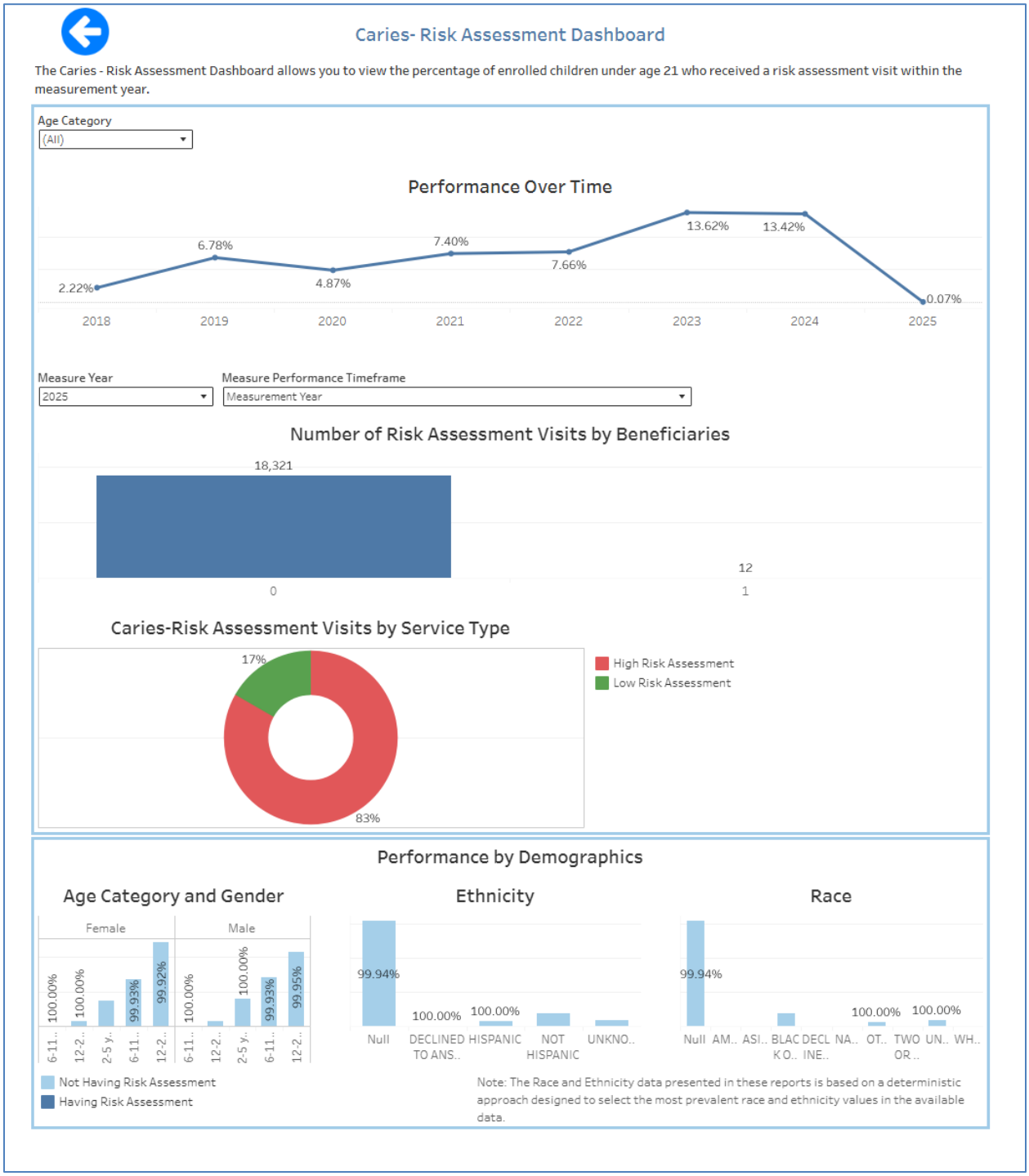
1. **Performance Over Time**: A line chart that trends the percentage of children receiving a risk assessment from 2018 to 2025. This visual helps identify long-term trends and the impact of interventions over multiple years.

2. **Number of Risk Assessment Visits by Beneficiaries**: A single bar chart displaying the total volume of beneficiaries (18,321) who received a risk assessment visit, providing a clear count for the selected period.
3. **Caries-Risk Assessment Visits by Service Type**: A donut chart that segments the completed assessments into "High Risk Assessment" (17%) and "Low Risk Assessment" (83%). This helps in understanding the overall risk stratification of the assessed patient population.
4. **Performance by Demographics**: A set of four bar charts that break down the percentage of members "Having Risk Assessment" vs. "Not Having Risk Assessment" across different demographic categories:
    a. **Age Category and Gender**: Compares performance rates between males and females across various age bands (e.g., 6-11, 12-21).
    b. **Ethnicity**: Shows performance rates for different ethnic groups (e.g., Hispanic, Not Hispanic, Unknown).
    c. **Race**: Displays performance rates across various racial categories (e.g., American Indian, Asian, Black).

5. Functional Use Cases

1. **Monitor Annual Performance Trends**: A quality improvement manager can use the Performance Over Time line chart to track year-over-year changes in risk assessment rates to evaluate the effectiveness of dental health campaigns.
2. **Identify Demographic Disparities**: A public health analyst can review the Performance by Demographics charts for Race and Ethnicity to identify if specific populations have lower rates of risk assessments and may require targeted outreach.
3. **Stratify Population Risk**: A dental program director can analyze the Caries-Risk Assessment Visits by Service Type donut chart to understand the proportion of high-risk children, informing resource allocation for preventive care and follow-up.
4. **Evaluate Provider Roster Performance**: A network manager can use the Roster filter to isolate a specific provider group's performance, comparing their assessment rates to the overall network average to identify high-performing or underperforming practices.
5. **Generate a Patient Outreach List**: A care coordinator can identify a low-performing group, such as the 2-5 year old male cohort, in the Age Category and Gender chart, and then click on the "Not Having Risk Assessment" bar for that group to drill through to a specific list of children who need to be scheduled for an appointment.

6. Screenshot:



31. HealthCheck Dashboard: Clinical Oral Examination Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of oral examination rates for enrolled children under the age of 21. It is designed to help care managers, quality improvement teams, and administrators monitor performance over time, identify disparities in care among demographic groups, and understand the types of oral evaluation services being provided.

2. Available Filters & Interactivity

1. **Panel**: Dropdown menu to select the specific data panel or program being viewed.
2. **Roster**: Dropdown menu to filter the dashboard for a specific roster of beneficiaries.
3. **Age Category**: Dropdown menu to filter the report data for a specific patient age group.
4. **Measure Year**: Dropdown menu to select the specific measurement year for performance reporting.
5. **Measure Performance Timeframe**: Dropdown menu to define the time period for the performance metrics (e.g., Measurement Year).
6. **Data Drill-Through**: Users can click on the data points in the "Performance Over Time" line chart, the bars in the "Number of Oral Evaluation Visits by Beneficiary Count" and "Performance by Demographics" charts, and the segments of the "Oral Evaluation Services by Service Type" donut chart to navigate to a detailed list of the underlying beneficiaries.

3. Key Metrics & KPIs

1. **Performance Over Time**: The primary KPI, representing the percentage of enrolled children under age 21 who received a comprehensive or periodic oral evaluation within the selected measurement year.
2. **Number of Oral Evaluation Visits by Beneficiary Count**: A count of beneficiaries based on the number of oral evaluation visits they received during the period (e.g., how many beneficiaries had one visit, two visits, etc.).
3. **Oral Evaluation Services by Service Type**: A percentage breakdown of the different types of oral evaluation services provided, including Comprehensive, Consultation, Counseling, Limited, and Periodic.
4. **Performance by Demographics**: The percentage of beneficiaries who received an oral evaluation, segmented by key demographic categories such as Age, Gender, Race, and Ethnicity.

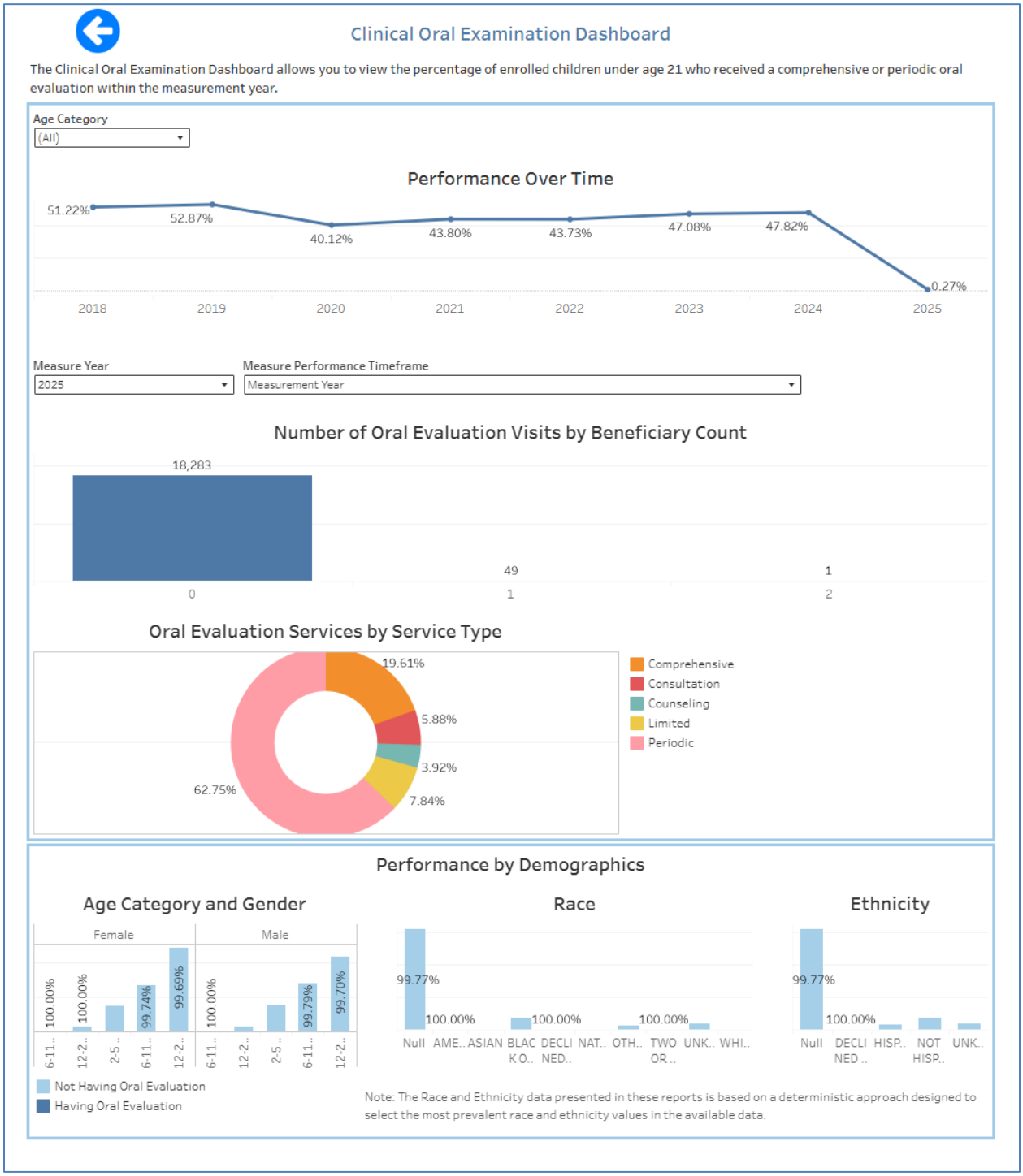
4. Visualizations & Data Tables

1. **Performance Over Time**: A line chart that tracks the trend of the oral evaluation completion rate across multiple years, allowing for easy identification of improvement or decline in performance. In the current view, it shows a significant drop in 2025.
2. **Number of Oral Evaluation Visits by Beneficiary Count**: A horizontal bar chart that visualizes the distribution of visit frequency. The chart indicates that the vast majority of beneficiaries (18,283) had one oral evaluation.
3. **Oral Evaluation Services by Service Type**: A donut chart that shows the proportional mix of different oral evaluation services. The largest segment is Periodic (62.75%), followed by Comprehensive (19.61%).
4. **Performance by Demographics**: A series of bar charts that compare the oral evaluation rates across different groups. This allows users to quickly spot potential disparities in care among different age categories, genders, races, and ethnicities.

5. Functional Use Cases

1. **Track Annual Performance Goals**: A quality improvement manager can review the "Performance Over Time" chart at the end of a measurement year to determine if the organization met its target for pediatric dental examinations.
2. **Identify Health Disparities**: An outreach coordinator can use the "Performance by Demographics" charts to identify if specific racial or ethnic groups have lower rates of oral evaluations, prompting the design of targeted outreach campaigns.
3. **Analyze Service Mix**: A clinical director can examine the "Oral Evaluation Services by Service Type" donut chart to understand if the mix of comprehensive versus periodic exams aligns with preventive care guidelines.
4. **Focus on Specific Age Cohorts**: A pediatric practice manager can use the "Age Category" filter to isolate the 6-11 year-old population and assess their specific oral evaluation rates to prepare for a back-to-school dental health initiative.
5. **Investigate Care Gaps for a Specific Provider Group**: A network manager can select a specific provider group from the "Roster" dropdown to evaluate their specific performance and compare it to the overall network average, identifying opportunities for provider education.

6. Screenshot:



32. HealthCheck Dashboard: Counseling Services Dashboard

1. Report Overview & Purpose

This report provides a comprehensive view of counseling service utilization for enrolled children under the age of 21. Its primary purpose is to track performance over time, identify disparities in care across different demographic groups, and monitor the total number of beneficiaries receiving these services within a given measurement year.

2. Available Filters & Interactivity

1. **Panel**: Allows the user to select a specific panel or group for analysis.
2. **Roster**: Filters the dashboard to display data for a selected patient roster.
3. **Age Category**: Narrows the results to a specific age group within the under-21 population.
4. **Measure Year**: Selects the specific measurement year for which to display performance data.
5. **Measure Performance Timeframe**: Defines the time period used for the performance measurement (e.g., Measurement Year).
6. **Data Drill-Through**: Users can click on the data points in the "Performance Over Time" line chart, the bar in the "Number of Counseling Services" chart, or any of the bars within the "Performance by Demographics" charts to navigate to a detailed, beneficiary-level report.

3. Key Metrics & KPIs

1. **Performance Rate**: The primary KPI, representing the percentage of enrolled children under age 21 who received a counseling service within the measurement year. This is trended over time and broken down by demographics.
2. **Beneficiary Count**: The total number of unique beneficiaries who have received counseling services.
3. **Compliance by Demographics**: The percentage of patients within specific age, gender, race, and ethnicity categories who have ("Have Received Counselling") or have not ("Haven't Received Counselling") received the service.

4. Visualizations & Data Tables

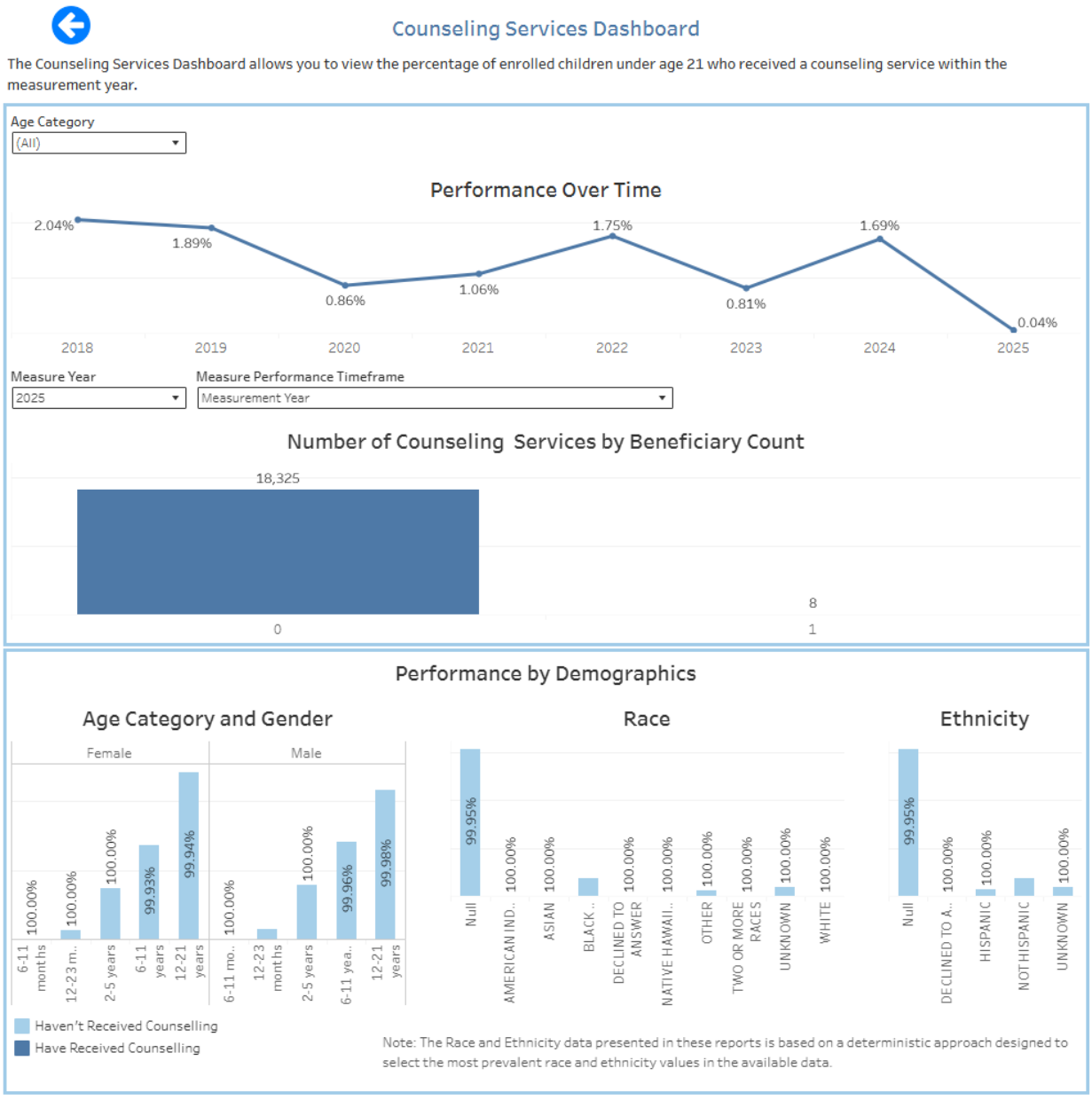
1. **Performance Over Time**: A line chart that trends the percentage of children receiving counseling services annually from 2018 to 2025. This visualization helps identify long-term trends, improvements, or declines in service utilization.
2. **Number of Counseling Services by Beneficiary Count**: A horizontal bar chart that displays the total count of beneficiaries (18,325) who received counseling services for the selected timeframe.

3. **Performance by Demographics**: A series of bar charts that break down counseling service compliance rates. These charts categorize the population by Age Category and Gender (Female/Male), Race, and Ethnicity, allowing for the identification of disparities in care among different subgroups.

5. Functional Use Cases

1. **Evaluate Behavioral Health Program Effectiveness**: A quality improvement manager can analyze the "Performance Over Time" chart to evaluate the effectiveness of an outreach program, noting if the percentage of children receiving counseling increased after the program's implementation.
2. **Address Demographic-Specific Care Gaps**: A care coordinator can use the "Performance by Demographics" charts to identify a specific age or gender group that has a lower-than-average counseling rate and requires targeted intervention.
3. **Establish Baseline and Internal Panel Benchmarks**: A practice manager can use the "Roster" filter to isolate their specific patient panel's performance, comparing it to the overall organizational average to set internal goals.
4. **Investigate Clinical Health Equity Access Gaps**: A public health analyst can filter by "Measure Year" and examine the "Race" and "Ethnicity" charts to investigate potential health equity gaps in access to counseling services.
5. **Extract Direct Patient Outreach and Care Worklists**: A care manager, after identifying a low-performing demographic, can click on the corresponding bar in the demographic chart to drill through to a patient list for direct outreach and appointment scheduling.

6. Screenshot:



33. HealthCheck Dashboard: Oral Prophylaxis Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of oral prophylaxis service utilization among enrolled children under the age of 21. Its primary purpose is to monitor performance rates over time, identify beneficiaries with gaps in care, and analyze demographic disparities in the receipt of preventive dental services. The report helps stakeholders track adherence to recommended dental procedures and target outreach efforts effectively.

2. Available Filters & Interactivity

1. **Roster:** Allows users to filter the dashboard data for a specific patient population or provider group.
2. **Age Category:** Filters the report to show data for specific age groups of beneficiaries (e.g., 6-11, 12-21).
3. **Measure Year:** Selects the primary 12-month period for which performance metrics are calculated and displayed.
4. **Measure Performance Timeframe:** Defines the specific time window used for the performance calculation, such as 'Measurement Year'.
5. **Data Drill-Through:** Users can click on the numerical values or visual elements within the following charts to navigate to a detailed, beneficiary-level report:
    a. Number of Oral Prophylaxis Services by Beneficiary Count (the horizontal bar)
    b. Oral Prophylaxis Services by Service Type (the segments of the donut chart)
    c. Performance by Demographics (the individual bars for Age/Gender, Race, and Ethnicity)

3. Key Metrics & KPIs

1. **Performance Rate:** The primary KPI, displayed as a percentage in the "Performance Over Time" line chart. It represents the proportion of eligible children who have received an oral prophylaxis service within the selected measurement year.
2. **Beneficiary Count by Service Number:** A count of beneficiaries based on the number of oral prophylaxis services they have received. In the screenshot, this prominently displays the number of children who have received zero services (18,292), indicating a gap in care.
3. **Service Type Distribution:** The percentage breakdown of oral prophylaxis services delivered, categorized by service type (e.g., Prophylaxis - Adult vs. Prophylaxis - Child).
4. **Demographic Performance:** The percentage of beneficiaries who have received the service, segmented by age, gender, race, and ethnicity. This is used to measure and compare service uptake across different population subgroups.

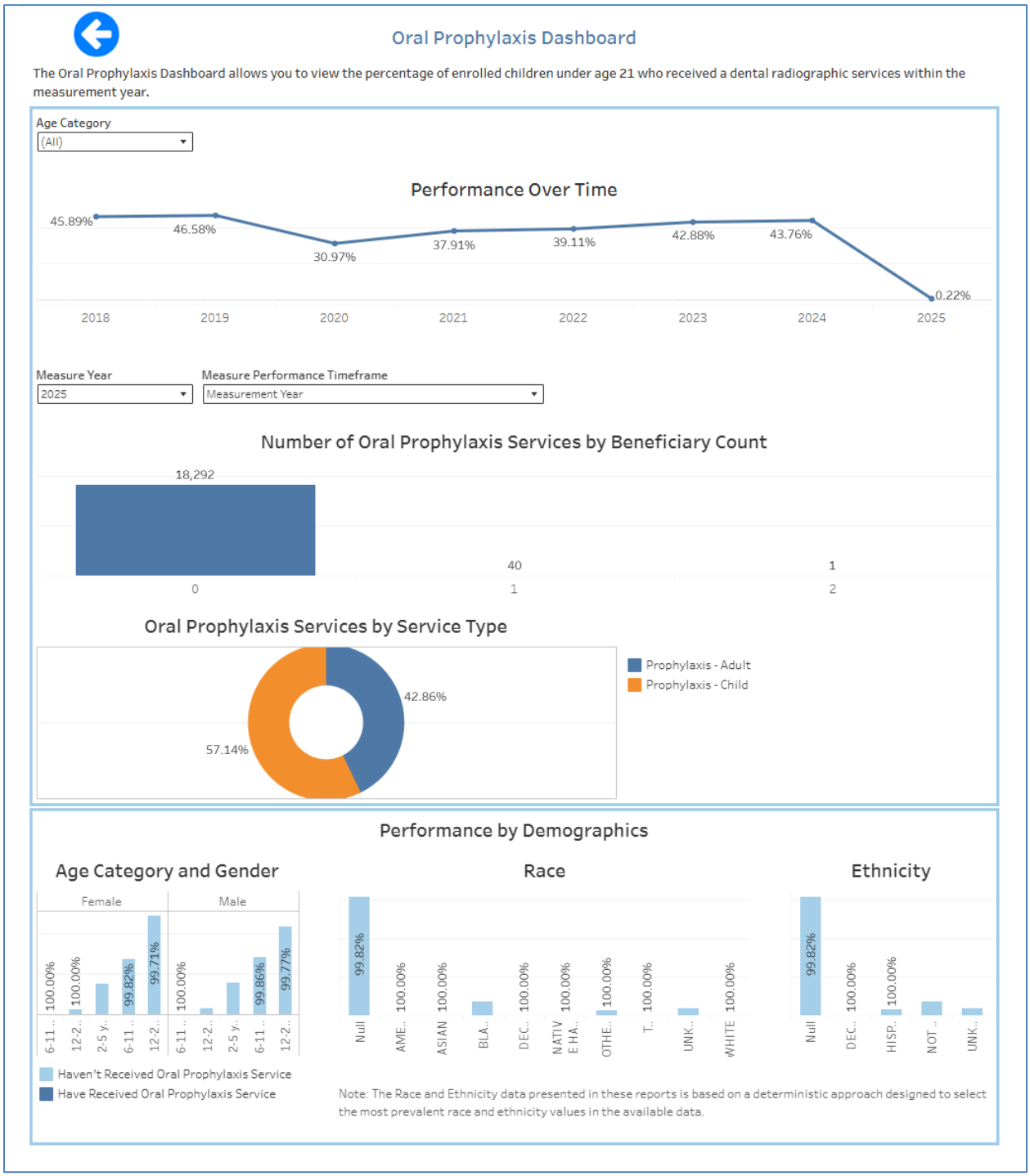
4. Visualizations & Data Tables

1. **Performance Over Time:** A line chart that plots the oral prophylaxis performance rate annually from 2018 to 2025. This visualization makes it easy to spot trends, improvements, or declines in service delivery over multiple years.
2. **Number of Oral Prophylaxis Services by Beneficiary Count:** A horizontal bar chart that visualizes the number of beneficiaries grouped by the count of services received. The largest bar typically highlights the cohort with zero services, representing the target population for intervention.
3. **Oral Prophylaxis Services by Service Type:** A donut chart that shows the proportional split of different types of prophylaxis services administered. In the example, it breaks down services into "Prophylaxis - Adult" (57.14%) and "Prophylaxis - Child" (42.86%).
4. **Performance by Demographics:** A series of vertical bar charts that compare the percentage of beneficiaries who have and have not received oral prophylaxis services across different demographic categories: Age Category and Gender, Race, and Ethnicity.

5. Functional Use Cases

1. **Track Annual Quality Goals:** A Quality Improvement manager can use the "Performance Over Time" chart to compare the current "Measure Year" performance rate against historical data and established annual targets.
2. **Generate Outreach Lists for Gaps in Care:** A care coordinator can click the bar in the "Number of Oral Prophylaxis Services by Beneficiary Count" chart for "0" services to drill down to a list of all children who are due for their preventive dental cleaning.
3. **Investigate Health Equity Concerns:** A health plan administrator can analyze the "Performance by Demographics" charts to identify if specific racial or ethnic groups show significantly lower rates of service, prompting further investigation into potential barriers to care.
4. **Tailor Interventions for Specific Age Groups:** A program manager can filter by "Age Category" (e.g., 6-11 years) to assess performance for that specific group and drill into the demographic data to design age-appropriate outreach materials.
5. **Evaluate Provider Roster Performance:** A network manager can use the "Roster" filter to isolate a specific clinic or provider group, review their overall performance, and identify which of their empaneled children require follow-up for dental services.

6. Screenshot:



34. HealthCheck Dashboard: Radiographic Assessment Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of dental radiographic assessment performance for enrolled children under the age of 21. It tracks the percentage of this population that has received at least one dental radiographic service within the selected measurement year. The primary purpose is to help users monitor compliance with recommended dental procedures, identify trends over time, and pinpoint demographic groups with potential care gaps.

2. Available Filters & Interactivity

1. **Panel:** Allows the user to select a specific provider panel for analysis.
2. **Roster:** Enables filtering the dashboard to a pre-defined list or roster of beneficiaries.
3. **Age Category:** Filters the entire dashboard to a specific age group of beneficiaries.
4. **Measure Year:** Selects the primary year for which performance is being measured.
5. **Measure Performance Timeframe:** Adjusts the reporting period, such as by Measurement Year or a different timeframe.
6. **Data Drill-Through:** Users can click on the bars or segments within the "Number of Radiographic Assessment Visits by Beneficiary Count," "Radiographic Assessment by Service Type," and "Performance by Demographics" (Age Category and Gender, Race, Ethnicity) charts to drill down to a detailed, beneficiary-level list of patients who meet that specific criterion.

3. Key Metrics & KPIs

1. **Performance Percentage:** The core metric of the report, representing the percentage of eligible children who received a dental radiographic service in the measurement year.
2. **Beneficiary Count by Visit Number:** A count of beneficiaries grouped by the number of radiographic assessment visits they have had (e.g., 0, 1, 2, 3, 4+ visits).
3. **Assessment Rate by Service Type:** The proportional breakdown of different radiographic services performed, such as Bitewings, Intra-Oral, Panoramic, and Other Images.
4. **Demographic Performance Rate:** The performance percentage broken down by specific demographic categories, including age, gender, race, and ethnicity.

4. Visualizations & Data Tables

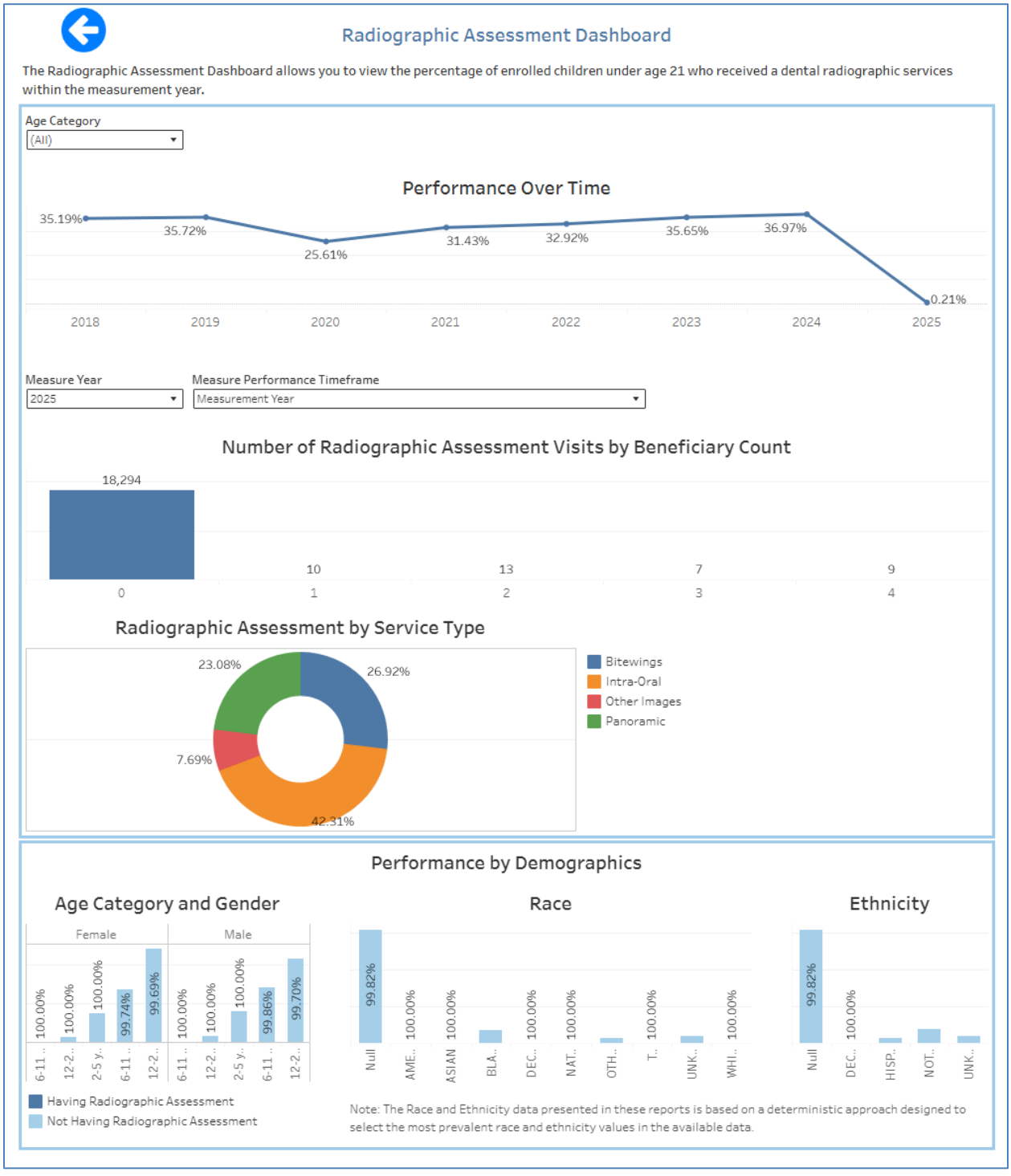
1. **Performance Over Time:** A line chart that tracks the trend of the radiographic assessment performance percentage from 2018 to 2025, allowing for year-over-year comparison and trend analysis.

2. **Number of Radiographic Assessment Visits by Beneficiary Count:** A horizontal bar chart illustrating the distribution of visit frequency. This helps identify how many beneficiaries have had one, two, or multiple assessments versus those with none.
3. **Radiographic Assessment by Service Type:** A donut chart that shows the percentage breakdown of the different types of radiographic services provided, highlighting the most frequently used procedures.
4. **Performance by Demographics:** A series of vertical bar charts that compare the assessment performance rates across different groups based on Age Category and Gender, Race, and Ethnicity. This visual is key for identifying disparities in care.

5. Functional Use Cases

1. **Monitor Quality Improvement:** A Quality Director can use the "Performance Over Time" chart to track the success of a new dental outreach program by observing if the performance percentage has increased since its implementation.
2. **Identify Health Disparities:** A Care Manager can analyze the "Performance by Demographics" charts to identify specific racial or ethnic groups with lower-than-average assessment rates and then drill through to get a list of those beneficiaries for targeted outreach.
3. **Analyze Service Utilization:** A Practice Administrator can review the "Radiographic Assessment by Service Type" donut chart to understand which imaging services are most commonly performed versus those that are underutilized.
4. **Target Specific Age Groups:** A public health analyst can use the "Age Category" filter to isolate adolescent populations (e.g., 12-17) and assess their specific radiographic assessment rates compared to younger children.
5. **Investigate High Utilizers:** A Clinical Reviewer can click on the bar for "4" visits in the "Number of Radiographic Assessment Visits" chart to generate a list of beneficiaries who have received an unusually high number of assessments for case review.

6. Screenshot:



35. HealthCheck Dashboard: Sealant Services Dashboard

1. Report Overview & Purpose

This dashboard provides a detailed analysis of sealant application rates for enrolled children between the ages of 6 and 14, targeting the most critical years for preventive sealant care. It helps identify children with gaps in care and monitors performance trends over time to ensure that high-risk dental surfaces are protected according to clinical guidelines.

2. Available Filters & Interactivity

1. **Panel:** Dropdown to select the specific data panel or program.
2. **Roster:** Filter for specific beneficiary rosters within a panel.
3. **Age Category:** Filters the data for specific patient age groups (e.g., 6-9, 10-14).
4. **Measure Year:** Selects the specific measurement year for reporting.
5. **Data Drill-Through:** Clickable charts allow users to drill down into patient lists for direct care coordination.

3. Key Metrics & KPIs

1. **Sealant Performance Rate:** Percentage of children in the 6-14 age range who received at least one sealant during the measurement year.
2. **Sealant Gap Count:** Number of eligible children who have not received any sealant services.
3. **Demographic Performance:** Service completion rates segmented by age, gender, race, and ethnicity.

4. Visualizations & Data Tables

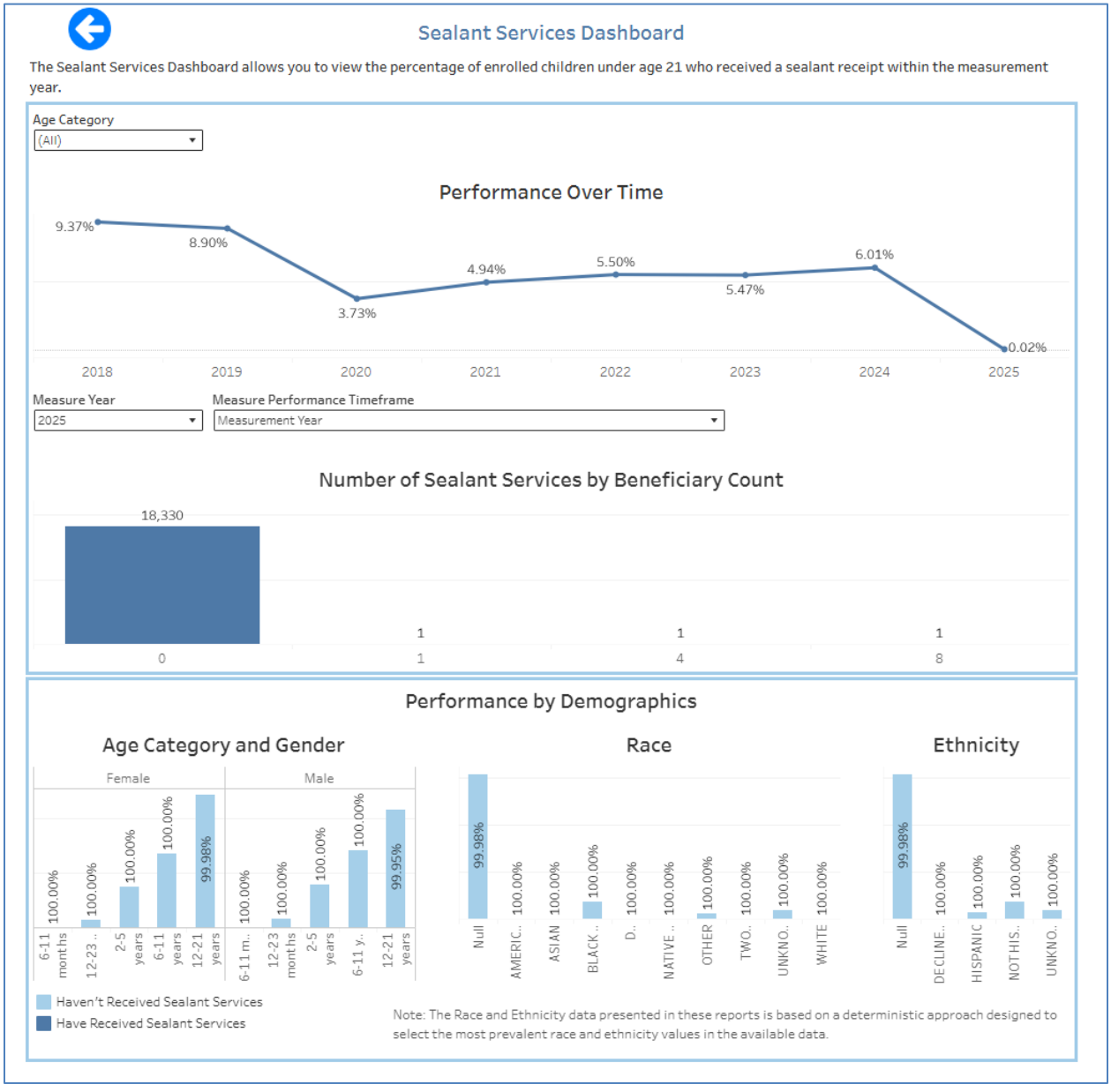
1. **Performance Over Time:** Line chart tracking sealant rates annually.
2. **Number of Sealant Services by Beneficiary Count:** Bar chart showing the distribution of services across the population.
3. **Performance by Demographics:** Comparison charts to identify disparities in preventive care uptake.

5. Functional Use Cases

1. **Pinpoint Health Disparities Across Demographics**: A health equity officer can identify health disparities in preventive care uptake by reviewing the stratified racial and ethnic performance data.
2. **Generate Targeted Outreach and Enrollment Worklists**: A care coordinator can generate actionable outreach lists for children in the 614 age group who are missing essential sealant services by drilling into the care gap data.

3. **Evaluate Public and School-Based Clinical Interventions**: A population health analyst can evaluate the impact of community or school-based sealant programs on overall performance rates by tracking metrics across custom rosters and time ranges.

6. Screenshot:



36. HealthCheck Dashboard: Topical Fluoride Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of topical fluoride application rates for enrolled children under the age of 21. It is designed to help care managers, quality improvement teams, and administrators monitor performance over time, identify disparities in care among demographic groups, and understand the utilization of preventive dental services.

2. Available Filters & Interactivity

1. **Panel**: Dropdown menu to select the specific data panel or program being viewed.
2. **Roster**: Dropdown menu to filter the dashboard for a specific roster of beneficiaries.
3. **Age Category**: Dropdown menu to filter the report data for a specific patient age group.
4. **Measure Year**: Dropdown menu to select the specific measurement year for performance reporting.
5. **Measure Performance Timeframe**: Dropdown menu to define the time period for the performance metrics.
6. **Data Drill-Through**: Users can click on data points in the trend charts or demographic bars to navigate to a detailed list of underlying beneficiaries.

3. Key Metrics & KPIs

1. **Performance Rate**: The primary KPI, representing the percentage of enrolled children under age 21 who received a topical fluoride application within the selected measurement year.
2. **Beneficiary Count**: A count of beneficiaries based on the number of fluoride treatments they received during the period.
3. **Performance by Demographics**: The percentage of beneficiaries who received fluoride, segmented by key demographic categories such as Age, Gender, Race, and Ethnicity.

4. Visualizations & Data Tables

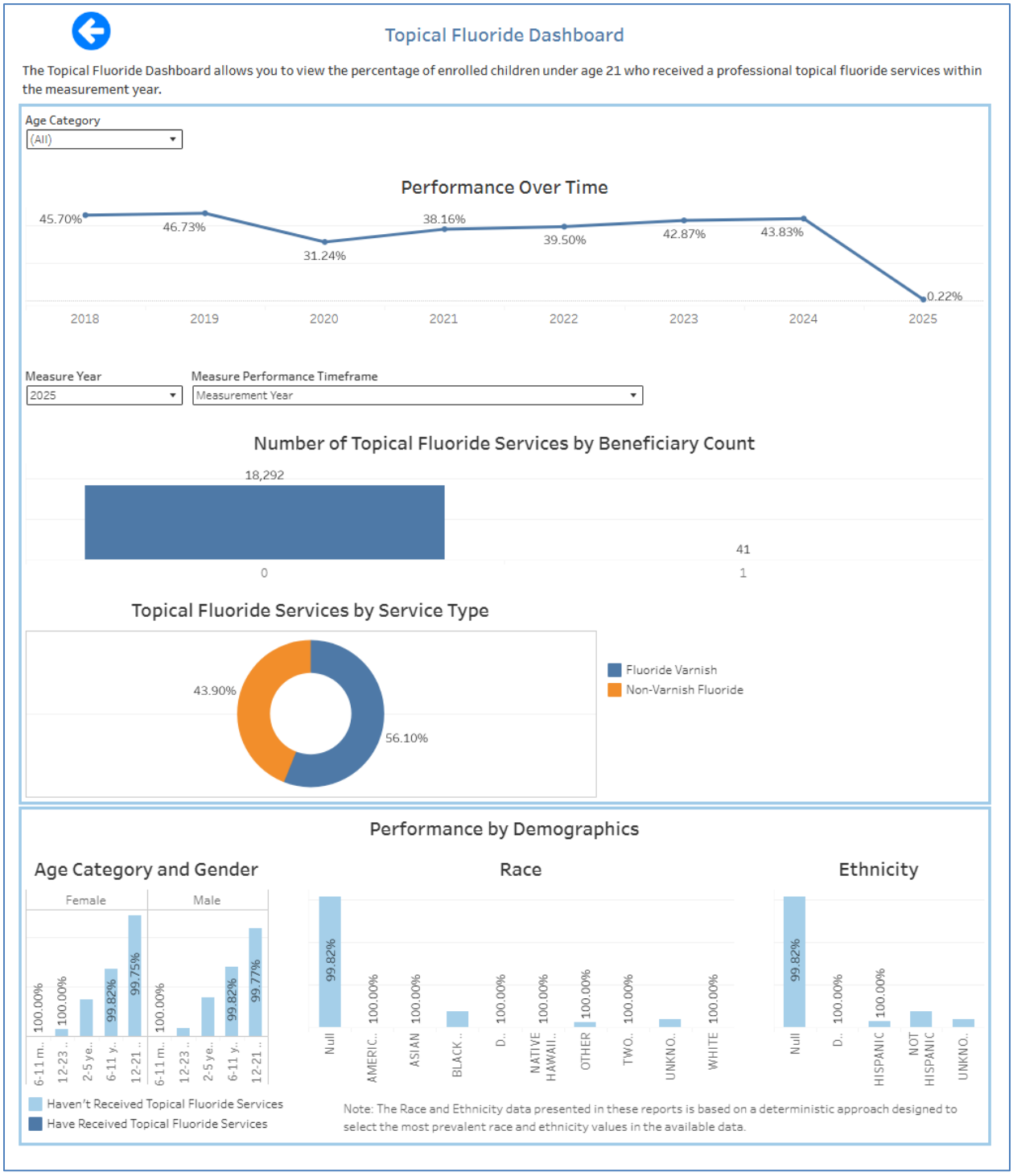
1. **Performance Over Time**: A line chart that tracks the trend of fluoride application completion rates across multiple years.
2. **Number of Topical Fluoride Services by Beneficiary Count**: A bar chart visualizing the distribution of treatment frequency among the population.
3. **Performance by Demographics**: Bar charts comparing rates across groups to spot potential disparities in care.

5. Functional Use Cases

1. **Track Annual Performance Goals**: Quality managers can review annual trends to see if targets for preventive services were met.

2. **Identify Health Disparities**: Outreach coordinators can identify subgroups with lower rates for targeted intervention.
3. **Generate Outreach Lists**: Users can drill down into care gaps to identify specific beneficiaries due for fluoride application.

6. Screenshot:



37. HEDIS MY 2024 Adults Access to Preventive/Ambulatory Health Services (AAP) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of the HEDIS measure for Adults' Access to Preventive/Ambulatory Health Services (AAP). Its purpose is to track the percentage of beneficiaries aged 20 and older who have had at least one ambulatory or preventive care visit during the measurement year. This enables healthcare organizations to monitor performance, identify gaps in care, and analyze disparities across different patient populations to improve access to essential health services.

2. Available Filters & Interactivity

1. **Panel:** Allows users to switch between different high-level views or dashboards.
2. **Roster:** Enables filtering the report data to a specific list or group of beneficiaries, such as those assigned to a particular practice or care manager.
3. **Measure Year:** Allows the user to select the HEDIS measurement year for which to view the data.
4. **Reference Group:** Allows the user to select a benchmark or comparison group for the performance trends. Currently set to "All DC Medicaid".
5. **Data Drill-Through:** Users can click on the numerical values in the KPI cards (e.g., "Number of Beneficiaries who did not have an Ambulatory or Preventive Care Visit"), the bars within the "Ambulatory Visits by Provider" chart, the segments of the "Beneficiary Distribution" charts (Social Needs, Age, Gender, Race, Ethnicity), and the rows within the "Chronic Condition Distribution" table to navigate to a detailed list of the corresponding beneficiaries.

3. Key Metrics & KPIs

1. **Number of Eligible Beneficiaries:** The total count of beneficiaries included in the denominator for this HEDIS measure for the selected roster and year.
2. **Number of Beneficiaries who had an Ambulatory or Preventive Care Visit:** The count of eligible beneficiaries who met the numerator criteria by having at least one qualifying visit.
3. **Number of Beneficiaries who did not have an Ambulatory or Preventive Care Visit:** The count of eligible beneficiaries who represent a gap in care, having had no qualifying visit during the measurement period.
4. **Measure Rate:** The primary performance metric, calculated as the percentage of eligible beneficiaries who had a qualifying visit.

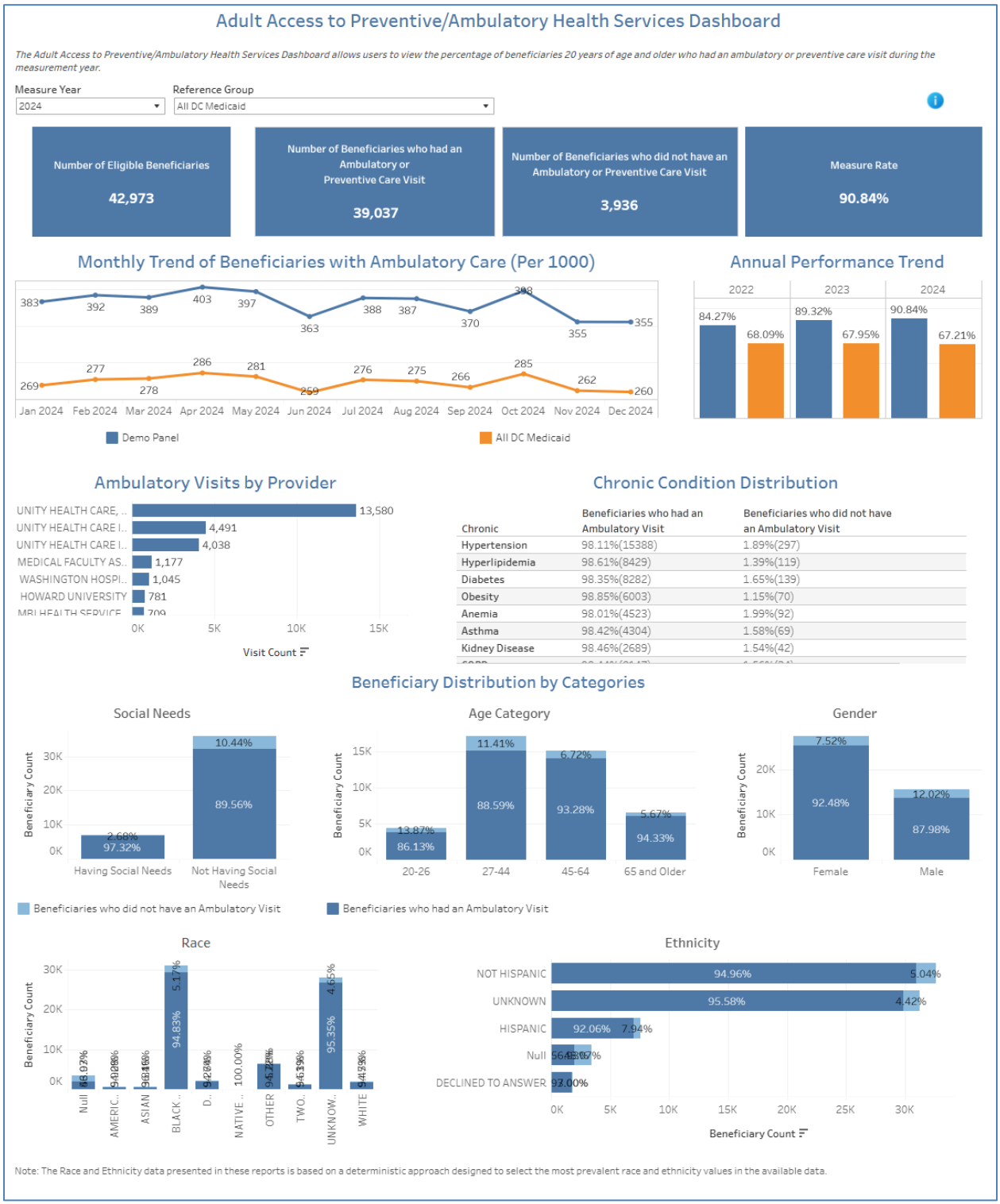
4. Visualizations & Data Tables

1. **KPI Cards:** Four large boxes at the top of the dashboard displaying the core metrics: Number of Eligible Beneficiaries, Numerator Count, Gap Count, and the overall Measure Rate.
2. **Monthly Trend of Beneficiaries with Ambulatory Care (Per 1000):** A line chart tracking the rate of beneficiaries with visits per 1000 members on a month-by-month basis throughout the year. It compares the selected panel ("Demo Panel") against the "All DC Medicaid" reference group.
3. **Annual Performance Trend:** A bar chart comparing the overall Measure Rate for the selected roster against the reference group for the past three years.
4. **Ambulatory Visits by Provider:** A horizontal bar chart that ranks providers by the total number of ambulatory visits, helping to identify the highest volume providers.
5. **Chronic Condition Distribution:** A table that breaks down the population by common chronic conditions. It shows the percentage and count of beneficiaries with each condition who either had or did not have an ambulatory visit.
6. **Beneficiary Distribution by Categories:** A series of bar charts that segment the beneficiary population to show performance across different demographics. It provides breakdowns by Social Needs (Having vs. Not Having), Age Category, Gender, Race, and Ethnicity, highlighting the percentage within each segment that did not have a visit.

5. Functional Use Cases

1. **Closing Care Gaps:** A care manager can click the "Number of Beneficiaries who did not have an Ambulatory or Preventive Care Visit" KPI to instantly generate a patient worklist for targeted outreach and appointment scheduling.
2. **Addressing Health Disparities:** A health equity officer can analyze the "Race" and "Ethnicity" distribution charts. If they observe a higher percentage of "did not have a visit" for a specific group, they can drill through to that patient list to understand potential barriers and implement culturally competent interventions.
3. **Managing High-Risk Populations:** A population health analyst can review the "Chronic Condition Distribution" table. They can identify the number of beneficiaries with Diabetes who have not had a visit, and drill down to that specific cohort to prioritize them for follow-up, preventing potential complications.
4. **Evaluating Provider Engagement:** A network manager can use the "Ambulatory Visits by Provider" chart to identify practices with low visit counts relative to their panel size, signaling a need for further engagement, training, or support.
5. **Monitoring Annual Performance:** A quality improvement director can use the "Annual Performance Trend" chart to track year-over-year progress on the AAP measure, comparing their organization's performance to the "All DC Medicaid" benchmark to set future goals.

6. Screenshot



38. HEDIS MY 2024 Eye Exam for Patients with Diabetes (EED) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of the HEDIS Eye Exam for Patients with Diabetes (EED) measure. It tracks the percentage of beneficiaries aged 18 to 75 with Diabetes (Type 1 or Type 2) who had a retinal eye exam during the measurement year. The report is designed to monitor performance, compare against a reference group, and identify disparities in care across different providers and demographic groups.

2. Available Filters & Interactivity

1. **Measure Year**: A dropdown menu to select the specific HEDIS measurement year for the report data.
2. **Reference group**: A dropdown menu to select the comparison group for the performance trend line chart.
3. **Roster**: A dropdown menu to select and filter the report for a specific provider roster.
4. **Data Drill-Through**: As noted on the dashboard, clicking on data points within the visualizations (such as the line chart, provider bars, procedure code bars, or the demographic performance charts) allows the user to drill through to a detailed list of the underlying beneficiaries or claims.

3. Key Metrics & KPIs

1. **Performance Rate**: The percentage of eligible beneficiaries who received the recommended retinal eye exam. This is the primary measure tracked in the performance comparison line chart and the demographic breakdown charts.
2. **Claim Count**: The total number of eye exam-related claims, used to measure visit volume by provider and procedure code.
3. **Amount Paid**: The total dollar amount paid on claims for eye exam services, shown per provider.
4. **Beneficiary Count**: The absolute number of beneficiaries who are compliant ("Receiving One or More Retinal Eye Exam") versus non-compliant ("Not Receiving the Recommended Retinal Eye Exam").

4. Visualizations & Data Tables

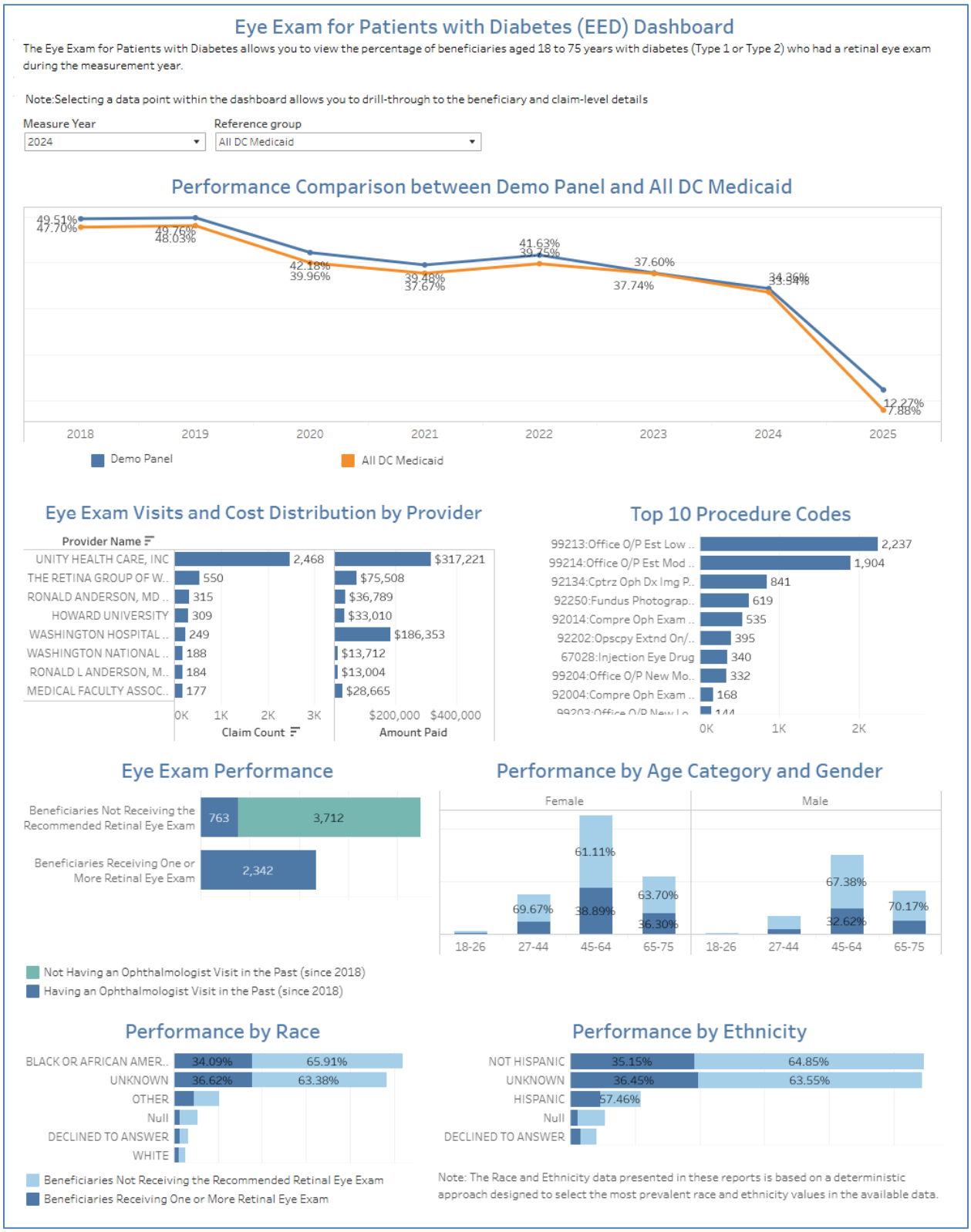
1. **Performance Comparison between Demo Panel and All DC Medicaid**: A time-series line chart that compares the EED performance rate of the selected "Demo Panel" against the "All DC Medicaid" average from 2018 to 2025.

2. **Eye Exam Visits and Cost Distribution by Provider**: A dual-axis bar chart that displays providers ranked by claim volume. It shows both the total number of eye exam claims (Claim Count) and the total costs (Amount Paid) for each provider.
3. **Top 10 Procedure Codes**: A horizontal bar chart that lists the 10 most frequently used procedure codes for eye exams, ranked by the number of associated claims.
4. **Eye Exam Performance**: A bar chart that quantifies the total number of beneficiaries who have received the recommended eye exam versus those who have not.
5. **Performance by Age Category and Gender**: A grouped bar chart that shows the compliance rate for the EED measure, broken down by gender (Female, Male) and specific age brackets (18-26, 27-44, 45-64, 65-75).
6. **Performance by Race**: A stacked horizontal bar chart illustrating the percentage of beneficiaries within different racial groups who have had an ophthalmologist visit versus those who have not.
7. **Performance by Ethnicity**: A stacked horizontal bar chart illustrating the percentage of beneficiaries within different ethnic groups (e.g., Hispanic, Not Hispanic) who have had an ophthalmologist visit versus those who have not.

5. Functional Use Cases

1. **Monitor Quality Improvement Initiatives**: A practice manager can use the "Performance Comparison" line chart to track their panel's EED compliance rate month-over-month to evaluate the effectiveness of a new patient outreach program.
2. **Identify Health Disparities**: A population health analyst can review the "Performance by Race" and "Performance by Ethnicity" charts to identify specific demographic groups with low compliance rates and allocate resources for culturally-competent engagement.
3. **Optimize Referral Networks**: A network manager can analyze the "Eye Exam Visits and Cost Distribution by Provider" chart to identify high-performing, cost-effective ophthalmology providers to prioritize in their referral network.
4. **Generate Patient Outreach Lists**: A care coordinator can click on the "Beneficiaries Not Receiving the Recommended Retinal Eye Exam" segment in the "Eye Exam Performance" chart to drill down to a patient-level list for targeted reminders and appointment scheduling assistance.
5. **Inform Targeted Interventions**: A clinical leader can examine the "Performance by Age Category and Gender" chart to discover that, for example, young adult males (18-26) have the lowest compliance, and then design an intervention campaign specifically for that cohort.

6. Screenshot



39. HEDIS MY 2024 Glycemic Status Assessment for Patients with Diabetes (GSD) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive assessment of the Glycemic Status quality measure for patients aged 18-75 with diabetes (types 1 and 2). It is designed to help users track performance against HEDIS benchmarks, analyze trends over time, and identify specific patient populations with poor glycemic control (HbA1c > 9.0%) or controlled status (HbA1c < 8.0%). The report breaks down beneficiary data by various demographic and clinical categories to highlight disparities and inform targeted interventions.

2. Available Filters & Interactivity

1. **Panel**: Selects the specific panel or provider group for which to view data.
2. **Measure Year**: Selects the HEDIS measurement year for the report's data.
3. **Reference Group**: Allows users to select a comparison group for benchmarking, such as "All DC Medicaid".
4. **Most Recent Glycemic Status**: Filters the dashboard to show beneficiaries based on their most recent glycemic status level (e.g., <8.0%, >9.0%).
5. **Roster**: Allows a user to select a specific provider roster to view data for their attributed patient panel.
6. **Data Drill-Through**: Users can click on the KPI boxes (e.g., "Number of Eligible Beneficiaries"), the bars within the various distribution charts (Age, Gender, Race, etc.), and the rows in the "Chronic Condition Distribution" table to drill down to a detailed, beneficiary-level report.

3. Key Metrics & KPIs

1. **Number of Eligible Beneficiaries**: The total count of patients in the selected population who meet the criteria for the GSD measure (denominator).
2. **Number of Beneficiaries with most recent Glycemic Status <8%**: The count of eligible beneficiaries whose most recent glycemic status test result was less than 8.0% (numerator).
3. **Number of Beneficiaries not having most recent Glycemic Status <8%**: The count of eligible beneficiaries whose glycemic status is not controlled (<8.0%), representing the care gap.
4. **Measure Rate**: The overall performance rate, calculated as the percentage of eligible beneficiaries with a glycemic status of less than 8.0% or greater than 9.0%.

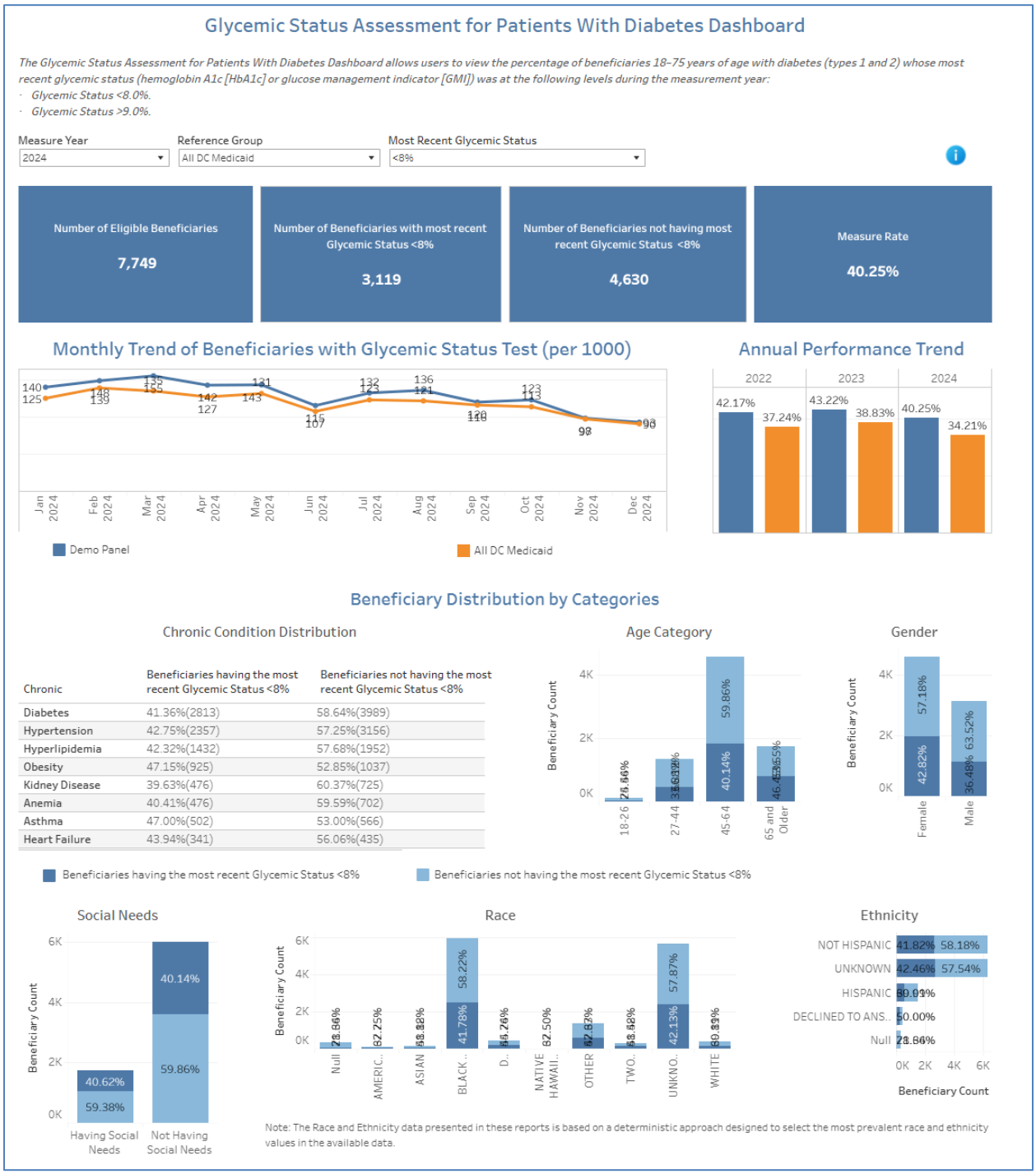
4. Visualizations & Data Tables

1. **Monthly Trend of Beneficiaries with Glycemic Status Test (per 1000)**: A line chart that tracks the monthly rate of glycemic status testing for the selected panel compared to the chosen reference group (e.g., All DC Medicaid) throughout the measurement year.
2. **Annual Performance Trend**: A bar chart comparing the measure rate performance over the past three years for the selected panel against the reference group.
3. **Chronic Condition Distribution**: A data table that breaks down the percentage of beneficiaries with and without the most recent glycemic status <8% across a list of common chronic conditions, such as Hypertension, Kidney Disease, and Heart Failure.
4. **Beneficiary Distribution by Categories**: A series of stacked bar charts that segment the beneficiary population by Age Category, Gender, Social Needs, Race, and Ethnicity. Each bar shows the proportional breakdown of beneficiaries who have a recent glycemic status <8% versus those who do not, allowing for quick identification of disparities.

5. Functional Use Cases

1. **Monitor Year-over-Year Progress and Strategic Reporting**: A quality improvement manager can use the "Annual Performance Trend" chart to monitor year-over-year progress on the GSD measure and report performance to leadership.
2. **Analyze High-Risk Clinical Cohorts and Comorbidities**: A care coordinator can filter the "Most Recent Glycemic Status" to show only poorly controlled patients (>9.0%) to identify that cohort, then review the "Chronic Condition Distribution" to see which comorbidities are most common in this high-risk group.
3. **Coordinate Culturally Competent Support Resource Allocation**: A population health analyst can examine the "Race," "Ethnicity," and "Social Needs" charts to identify demographic groups with lower rates of glycemic control, informing the strategy for culturally competent outreach and allocation of social support resources.
4. **Extract Roster-Specific Follow-Up and Action Lists**: A practice manager can select a specific Roster to see how their target population's measure rate compares to the overall performance, then drill through on the "Number of Beneficiaries not having the most recent Glycemic Status <8%" to generate a patient list for follow-up.
5. **Prioritize Point-of-Care Patient Education Delivery**: A physician can use the "Age Category" chart to see which age bracket has the highest number of beneficiaries and use this insight to prioritize patient education materials or group visits for that specific population.

6. Screenshot



40. HEDIS MY 2024 Kidney Health Evaluation for Patients with Diabetes (KED) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of the HEDIS Kidney Health Evaluation for Patients with Diabetes (KED) measure. It allows users to track the percentage of beneficiaries aged 18-85 with diabetes who have received a timely kidney health evaluation, identify care gaps, and analyze performance across different demographic and clinical categories. The primary purpose is to support quality improvement efforts by highlighting patient populations that require targeted outreach to ensure they receive necessary kidney screenings.

2. Available Filters & Interactivity

1. **Panel**: Selects the specific provider panel or group to analyze.
2. **Measure Year**: Filters the report data for a specific HEDIS measurement year.
3. **Reference Group**: Selects a benchmark group (e.g., All DC Medicaid) to compare the selected panel's performance against.
4. **Roster**: Narrows the analysis to a specific patient roster within the selected panel or group.
5. **Data Drill-Through**: Users can click on the numerical values in the main KPI cards (e.g., "Number of Beneficiaries who haven't received a Kidney Health Evaluation"), the bars within the various distribution charts (Age, Gender, Social Needs, Race, Ethnicity), or the rows in the "Chronic Condition Distribution" table to navigate to a detailed list of the corresponding beneficiaries.

3. Key Metrics & KPIs

1. **Number of Eligible Beneficiaries**: The total number of patients aged 18-85 with diabetes (type 1 or type 2) who are included in the denominator for this measure.
2. **Number of Beneficiaries who have received a Kidney Health Evaluation**: The total number of eligible beneficiaries who received both an eGFR and a uACR test during the measurement year (the measure numerator).
3. **Number of Beneficiaries who haven't received a Kidney Health Evaluation**: The total number of eligible beneficiaries who are missing one or both required tests, representing the care gap.
4. **Measure Rate**: The percentage of eligible beneficiaries who have received the required kidney health evaluation (Numerator / Denominator).

4. Visualizations & Data Tables

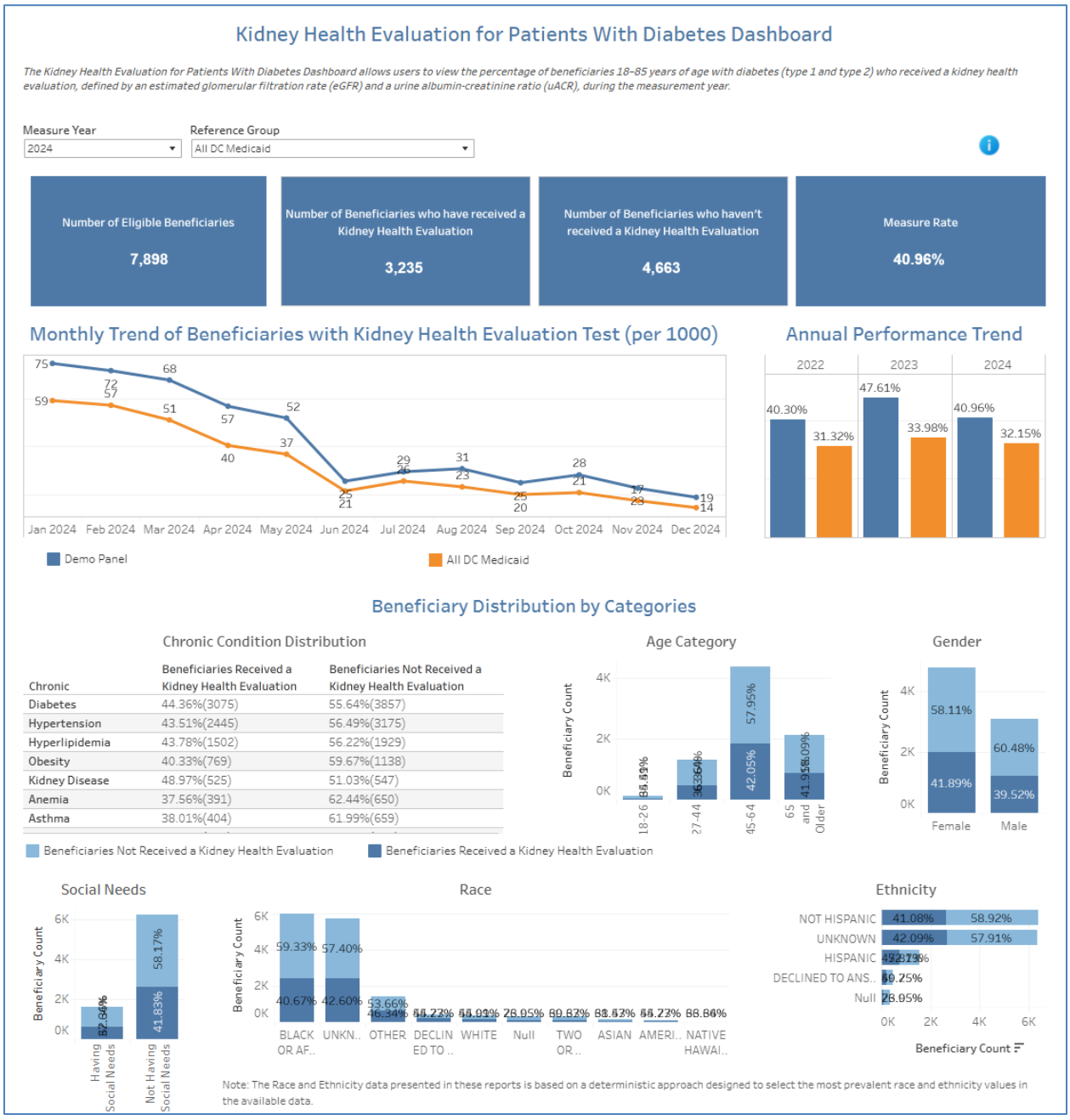
1. **Monthly Trend of Beneficiaries with Kidney Health Evaluation Test (per 1000)**: A line chart that plots the measure rate trend throughout the selected year. It compares the

performance of the selected panel (blue line) against the chosen reference group (orange line), helping to identify performance changes over time.
2. **Annual Performance Trend**: A bar chart comparing the measure rate year-over-year for the selected panel and the reference group. This visualization provides a high-level view of long-term performance trends.
3. **Beneficiary Distribution by Categories**: A collection of tables and charts that stratify the beneficiary population to reveal performance insights.

5. Functional Use Cases

1. **Monitor Overall Compliance**: A quality improvement manager reviews the "Measure Rate" KPI, and the "Annual Performance Trend" chart to assess the organization's current and historical performance on the KED measure against the "All DC Medicaid" benchmark.
2. **Identify and Close Care Gaps**: A care coordinator clicks on the "Number of Beneficiaries who haven't received a Kidney Health Evaluation" KPI to drill through to a patient list, which can be used to initiate targeted outreach campaigns via phone calls or patient portal messages.
3. **Analyze Clinical Sub-Populations**: A clinician observes in the "Chronic Condition Distribution" table that patients with existing "Kidney Disease" have a compliance rate of only 48.97%. They can drill into this specific cohort to ensure these high-risk patients are scheduled for their necessary evaluations.
4. **Address Disparities in Care**: A population health analyst examines the "Social Needs" chart and finds that patients "Having Social Needs" have a lower completion rate. This insight prompts them to collaborate with social workers to address barriers to care, such as transportation or appointment scheduling difficulties.
5. **Tailor Interventions for Specific Demographics**: A practice manager uses the "Age Category" chart to see that the "18-26" age group has the lowest compliance rate. They can use this information to develop a targeted educational campaign for younger diabetic patients about the importance of early and regular kidney health screening.

6. Screenshot



41. HEDIS MY 2024 Statin Therapy for Patients with Cardiovascular Disease (SPC) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of the HEDIS measure for Statin Therapy for Patients with Cardiovascular Disease (SPC). Its purpose is to allow users to monitor the percentage of their beneficiaries, aged 21-75 with Clinical Atherosclerotic Cardiovascular Disease (ASCVD), who were dispensed at least one high- or moderate-intensity statin medication. The report helps track performance over time, identify adherence risks, and analyze demographic and comorbidity trends to improve quality scores and patient outcomes.

2. Available Filters & Interactivity

1. **Panel**: Select the specific provider panel or group to view.
2. **Roster**: Choose a custom patient list or roster to apply to the dashboard.
3. **Measure Year**: Select the HEDIS Measurement Year to analyze.
4. **Reference Group**: Choose a benchmark group (e.g., All DC Medicaid) to compare your panel's performance against.
5. **Chronic Condition**: Filter the dashboard population to view only patients with a specific co-occurring chronic condition.
6. **Data Drill-Through**: Users can click on the data points within the line charts, the segments of the donut chart ("Distribution of Patients by MAP Risk Score Category"), the rows in the tables ("Top Statin Medication," "Chronic Condition Distribution"), and the bars in the demographic charts to navigate to a detailed, patient-level list.

3. Key Metrics & KPIs

1. **SPC Measure Performance**: The primary HEDIS metric, calculated as the percentage of eligible beneficiaries who were dispensed at least one statin medication prescription during the measurement year.
2. **Statin Medication Adherence (PDC)**: Measures the Proportion of Days Covered (PDC) for statin prescriptions. The line chart specifically tracks the percentage of the population with a PDC of at least 80%, a common threshold for medication adherence.
3. **Medication Adherence Prediction (MAP) Model Risk Score Category**: A predictive score that categorizes patients into four groups based on their likelihood of medication non-adherence: Likely Adherent, Medium Likelihood Non-Adherent, Low Likelihood Non-Adherent, and High Likelihood Non-Adherent.
4. **Statin Utilization & Cost**: Metrics including member count, pharmacy claims, total days covered, and amount paid for the most frequently prescribed statin medications.
5. **Statin Therapy Reception by Chronic Condition**: The count and percentage of patients with specific chronic diseases (e.g., Hypertension, Diabetes) who have or have not received statin therapy.

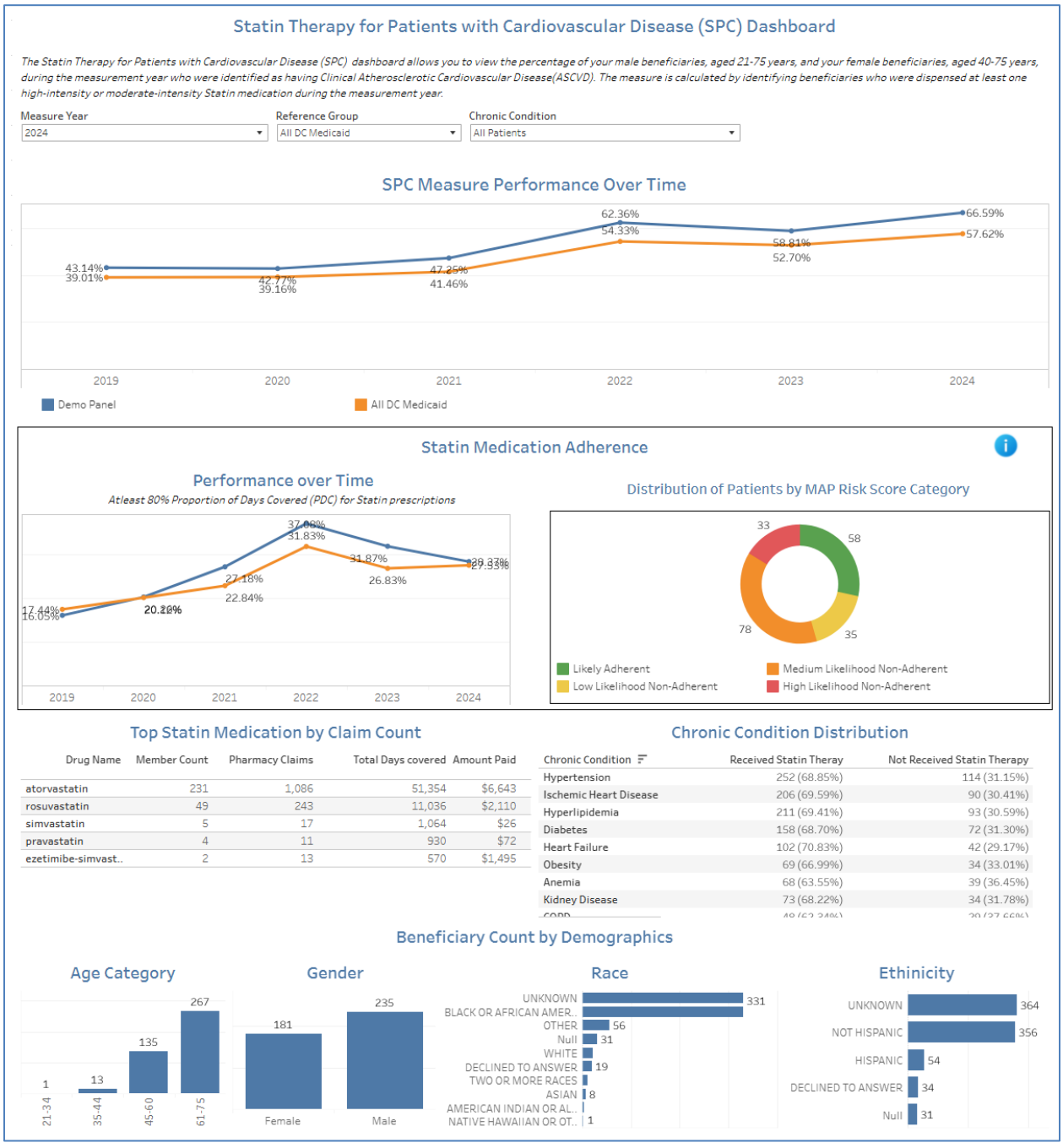
4. Visualizations & Data Tables

1. **SPC Measure Performance Over Time**: A line graph comparing the selected panel's statin therapy performance rate against the chosen reference group from 2019 to 2024. This visual helps track progress and identify performance gaps.
2. **Statin Medication Adherence (Performance over Time)** : A line chart illustrating the trend in medication adherence (PDC ≥ 80%) for the panel versus the reference group over several years.
3. **Distribution of Patients by MAP Risk Score Category**: A donut chart that segments the patient population by their predicted medication adherence risk, allowing for quick identification of high-risk cohorts.
4. **Top Statin Medication by Claim Count**: A table that details the most common statin drugs prescribed, including the number of members, claims, days covered, and total cost associated with each.
5. **Chronic Condition Distribution**: A summary table listing common chronic conditions and breaking down the number and percentage of patients within each group who did or did not receive the indicated statin therapy.
6. **Beneficiary Count by Demographics**: A series of four bar charts that provide a demographic breakdown of the patient population by Age Category, Gender, Race, and Ethnicity.

5. Functional Use Cases

1. **Monitor HEDIS Performance**: A Quality Improvement Manager reviews the "SPC Measure Performance Over Time" chart quarterly to track their panel's progress towards the year-end HEDIS goal, comparing it directly to the "All DC Medicaid" benchmark.
2. **Prioritize High-Risk Patients for Outreach**: A Care Coordinator clicks on the "High Likelihood Non-Adherent" segment of the "Distribution of Patients by MAP Risk Score Category" donut chart to drill through to a patient list for targeted medication counseling and adherence support.
3. **Analyze Pharmacy Costs**: A practice administrator examines the "Top Statin Medication by Claim Count" table to understand which medications, such as atorvastatin, contribute most to pharmacy expenditures and to inform formulary discussions.
4. **Identify Gaps in Care for Co-Morbid Patients**: A physician lead uses the "Chronic Condition Distribution" table to find that a significant percentage of patients with Diabetes are not on statin therapy, prompting a review of care protocols for this patient group.
5. **Assess Health Equity**: A Population Health Analyst reviews the "Race" and "Ethnicity" charts to identify any disparities in prescribing patterns and develops culturally competent outreach materials to address potential gaps in care for specific demographic groups.

6. Screenshot



42. HEDIS MY 2024 Statin Therapy for Patients with Diabetes (SPD) Dashboard

1. Report Overview & Purpose

This dashboard displays the HEDIS measure for Statin Therapy for Patients with Diabetes (SPD), which tracks the percentage of beneficiaries aged 40-75 with diabetes who were dispensed a statin medication. The report is designed to help providers and care managers monitor performance on this quality measure, analyze medication adherence, and identify patient populations for targeted intervention.

2. Available Filters & Interactivity

1. **Measure Year**: Allows the user to select the HEDIS measurement year for the report data.
2. **Reference Group**: Enables comparison of the selected Roster's performance against a broader population, such as "All DC Medicaid".
3. **Chronic Condition**: Filters the entire dashboard to show data for patients with a specific co-occurring chronic condition.
4. **Roster**: Allows the user to select a specific patient group for analysis.
5. **Data Drill-Through**: Users can click on the numbers, bars, or segments within the "Top Statin Medication by Claim Count" table, the "Chronic Condition Distribution" table, the "Distribution of Patients by MAP Risk Score Category" donut chart, and the demographic bar charts (Age, Gender, Race, Ethnicity) to navigate to a detailed, beneficiary-level view.

3. Key Metrics & KPIs

1. **SPD Measure Performance**: The primary metric, representing the percentage of diabetic patients (ages 40-75) who received at least one high or moderate-intensity statin medication during the measurement year.
2. **Statin Medication Adherence (PDC)**: Measures the percentage of patients who have a Proportion of Days Covered (PDC) of at least 80% for their statin prescriptions, a key indicator of medication adherence.
3. **MAP Risk Score Category**: A predictive score that categorizes patients into different levels of likelihood for non-adherence (Likely Adherent, Low/Medium/High Likelihood Non-Adherent).
4. **Beneficiary & Claim Counts**: Raw counts of members, pharmacy claims, and total days covered for specific statin medications.
5. **Amount Paid**: The total cost associated with claims for specific statin medications.

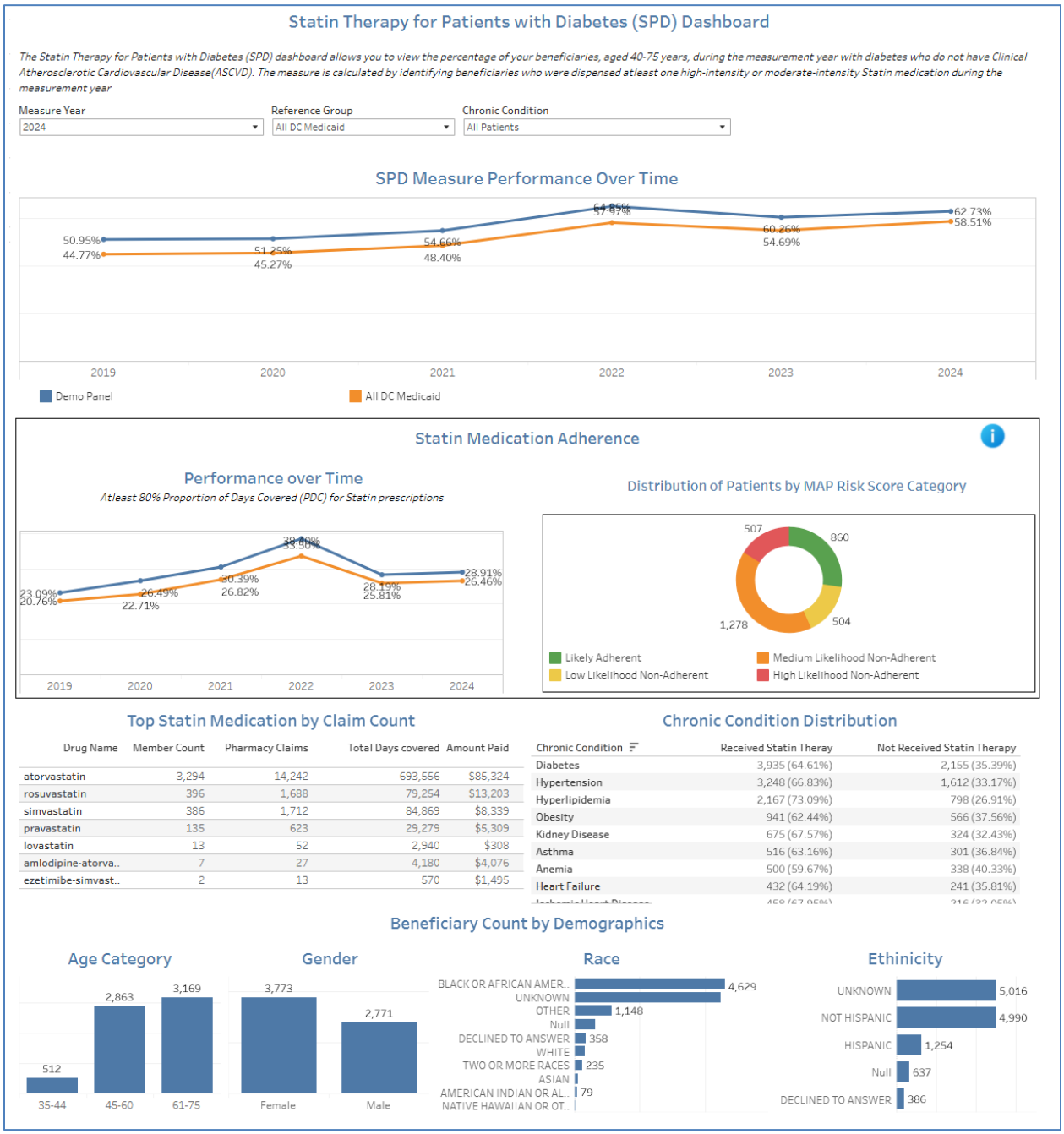
4. Visualizations & Data Tables

1. **SPD Measure Performance Over Time**: A line graph comparing the selected roster's performance on the SPD measure against the chosen reference group over a multi-year period.
2. **Statin Medication Adherence - Performance over Time**: A line graph that tracks the PDC rate (adherence) for the selected roster and the reference group over time.
3. **Distribution of Patients by MAP Risk Score Category**: A donut chart that segments the patient population by their predicted medication adherence risk, providing a quick view of at-risk cohorts.
4. **Top Statin Medication by Claim Count**: A table that ranks statin drugs by claim volume, detailing the number of members, claims, days covered, and total amount paid for each.
5. **Chronic Condition Distribution**: A table listing common chronic conditions and showing the count and percentage of patients within each condition who have or have not received statin therapy.
6. **Beneficiary Count by Demographics**: A series of bar charts that display the breakdown of the patient population by Age Category, Gender, Race, and Ethnicity.

5. Functional Use Cases

1. **Monitor Quality Measure Performance**: A Quality Improvement Manager can use the "SPD Measure Performance Over Time" chart to track their organization's performance against the "All DC Medicaid" benchmark and identify trends.
2. **Target High-Risk Patients for Intervention**: A Care Coordinator can click on the "High Likelihood Non-Adherent" segment of the donut chart to drill down to a patient list and initiate outreach to address barriers to medication adherence.
3. **Analyze Co-morbidity Care Gaps**: A Population Health Analyst can review the "Chronic Condition Distribution" table to see if patients with both Diabetes and Hyperlipidemia are receiving statins at an appropriate rate, identifying potential gaps in care.
4. **Assess Health Equity**: A Health Equity Officer can use the "Race" and "Ethnicity" charts to identify any disparities in statin therapy rates among different demographic groups and develop targeted community outreach programs.
5. **Review Prescribing Patterns**: A Pharmacy Director can use the "Top Statin Medication by Claim Count" table to understand which statins are most commonly prescribed (e.g., atorvastatin) and analyze associated utilization and costs for formulary management.

6. Screenshot



43. High Risk Medications Report

1. Report Overview & Purpose

This report identifies members who have been prescribed medications considered high-risk, based on the Beers Criteria for Potentially Inappropriate Medication Use. The primary purpose is to enable care managers, pharmacists, and prescribers to review these specific prescriptions to mitigate the risk of adverse drug events and ensure patient safety. The report provides a detailed list of these medication claims and a trend analysis of their volume over time.

2. Available Filters & Interactivity

1. **Roster**: Filters the report for a specific, pre-defined list of members (e.g., a provider's patient panel).
2. **Member Name**: Filters the report data for a single, selected member.
3. **Prescriber Name**: Filters to show only high-risk medications written by a specific prescriber.
4. **Pharmacy Name**: Filters to show only high-risk medications dispensed by a specific pharmacy.
5. **Drug**: Filters the report for a specific high-risk medication.
6. **Data Drill-Through**: Users can click on a data point (i.e., a specific month) within the "Trend of Rolling 12 Months-All" line chart to filter the detailed medication table above, showing only the claims from that selected month.

3. Key Metrics & KPIs

1. **Number of High Risk Claims**: The total count of prescription claims for medications on the high-risk list. This is the primary metric tracked in the trend chart.
2. **Member Details**: Identifiers for the patient receiving the medication (Member ID, Member Name).
3. **Prescriber Details**: Identifiers for the prescribing clinician (Prescriber NPI, Prescriber Name).
4. **Claim Details**: Specifics of the prescription fill, including the Pharmacy Name, Date Filled, Quantity, Days Supply, and Cost.
5. **Medication Details**: Specifics of the drug prescribed, including Drug name, BRAND/generic classification, and Strength Description.

4. Visualizations & Data Tables

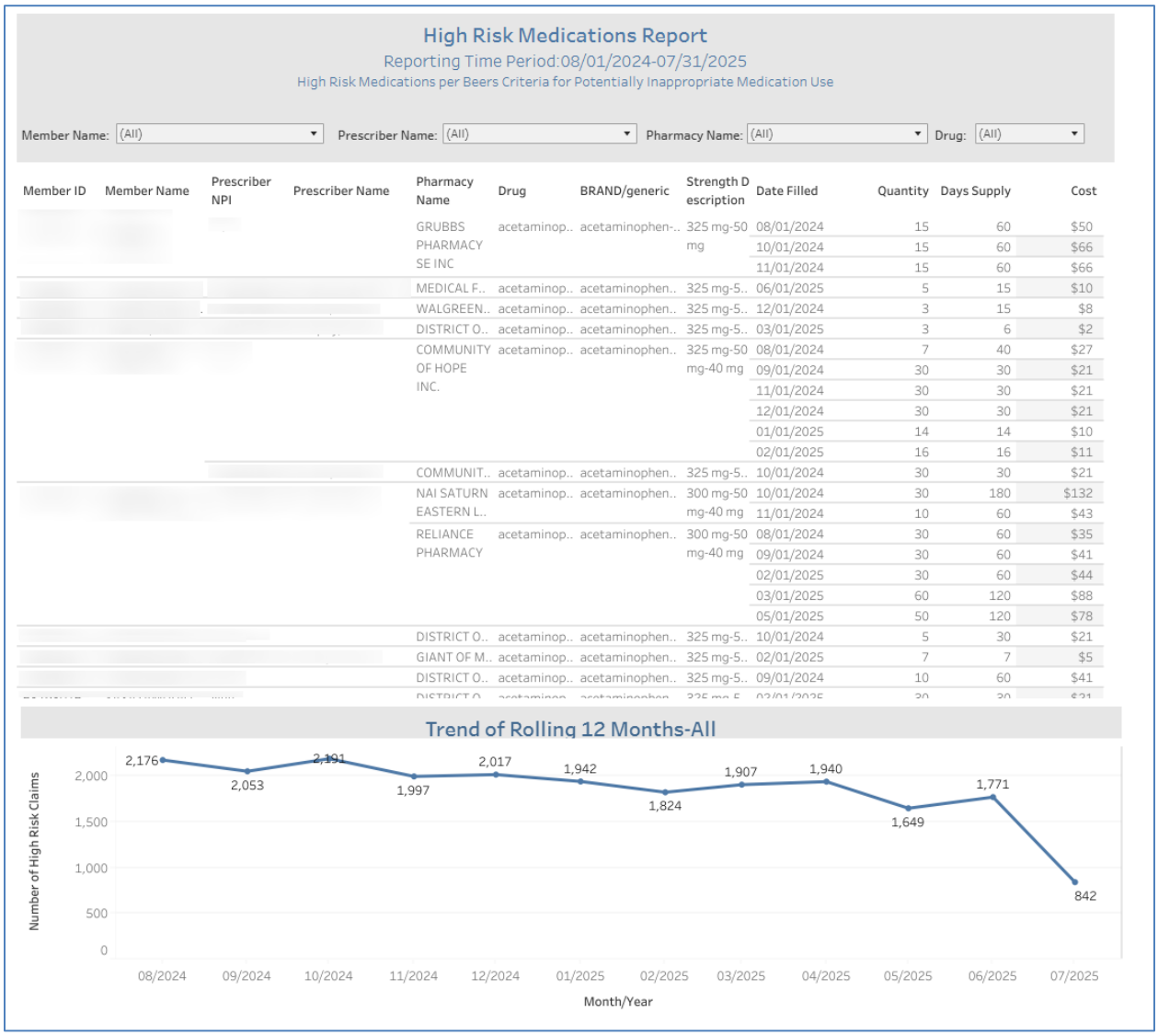
1. **High Risk Medications Detail Table**: A comprehensive table listing each individual high-risk medication claim within the selected time period. It provides granular details including member, prescriber, pharmacy, drug specifics, strength, fill date, quantity, days supply, and cost, allowing for a thorough review of each case.

2. **Trend of Rolling 12 Months-All**: A line chart that visualizes the total number of high-risk medication claims for each month over the past year. This chart helps users identify patterns, seasonality, or the impact of interventions on prescribing habits over time.

5. Functional Use Cases

1. **Targeted Patient Intervention**: A care manager filters the report by their assigned Roster to identify all their patients on high-risk medications. They can then prioritize outreach to the patients with the highest-risk prescriptions (e.g., based on drug type or day's supply) to coordinate a medication review with their provider.
2. **Prescriber Education**: A clinical pharmacist reviews the report and filters by Prescriber Name to identify clinicians with a high volume of high-risk prescriptions. They can use this specific data to initiate a peer-to-peer conversation about safer alternative therapies.
3. **Monitoring Quality Initiatives**: A health plan's Quality Improvement director monitors the "Trend of Rolling 12 Months" chart on a monthly basis. They can use this visualization to track the effectiveness of a new pharmacist-led medication therapy management program, expecting to see a downward trend in claims over time.
4. **Pre-Appointment Planning**: A primary care physician filters the report by a specific Member Name before an upcoming annual wellness visit. This allows them to quickly identify a potentially inappropriate prescription for acetaminophen and address it directly with the patient during their appointment.
5. **Pharmacy Network Analysis**: A pharmacy network manager filters by Pharmacy Name to identify pharmacies that may be dispensing a high volume of these medications. This could highlight a need for enhanced clinical decision support alerts or pharmacist education at specific locations.

6. Screenshot



44. High Risk Medications Report: Prescriber Summary

1. Report Overview & Purpose

This report summarizes high-risk medications prescribed to a patient population, based on the Beers Criteria for Potentially Inappropriate Medication Use. Its primary purpose is to identify and rank prescribers by the volume of these medications, enabling clinical leaders to track prescribing patterns and identify opportunities for provider outreach and education.

2. Available Filters & Interactivity

1. **Panel**: Selects the primary provider panel or patient population for the report.
2. **Roster**: Narrows the analysis to a specific patient roster within the selected panel.

3. Key Metrics & KPIs

1. **Claim Count**: The total number of prescription claims for a specific drug, strength, and prescriber within the reporting period.
2. **Rank**: A numerical ranking of the prescriber/drug combination, typically based on the highest claim count.
3. **% Change from Previous 12 Months**: The percentage increase or decrease in claim volume for that specific drug and prescriber compared to the preceding 12-month period.

4. Visualizations & Data Tables

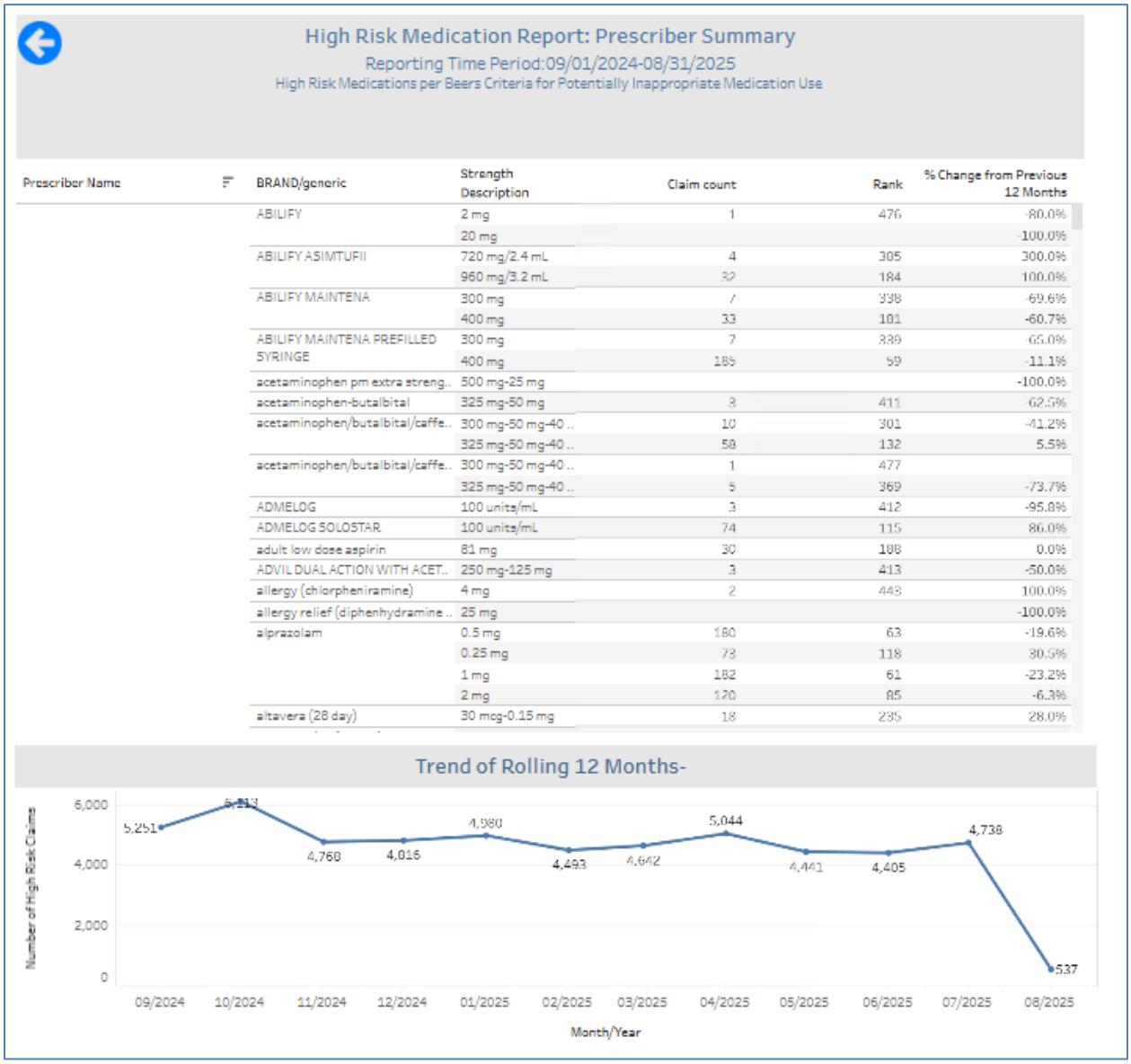
1. **Prescriber Summary Table**: This is the main table, which aggregates data by prescriber, drug name (brand/generic), and strength. It serves to identify which prescribers are ordering the highest volume of specific high-risk medications and to show recent trends in their prescribing patterns.
2. **Trend of Rolling 12 Months**: This line chart displays the total number of high-risk medication claims for the entire selected population over the past year. It provides a high-level view of whether the overall use of these medications is increasing, decreasing, or remaining stable over time.

5. Functional Use Cases

1. **Prioritize High-Risk Clinician Educational Outreach**: A medical director can sort the main summary table by "Claim count" in descending order to identify providers with the highest rates of high-risk prescribing for targeted educational outreach.
2. **Assess Impact of Pharmacy Clinical Protocols**: A quality improvement manager can monitor the "Trend of Rolling 12 Months" chart month-over-month to see if the total number of high-risk claims is decreasing, allowing them to assess the impact of a recent intervention.

3. **Prepare for Scheduled Provider Academic Detailing Meetings**: A provider relations specialist can use the report to review a specific prescriber's summary data and identify any high-volume or significantly increasing high-risk drugs when preparing for a meeting with that physician.

6. Screenshot



High Risk Medication Report: Prescriber Summary

Reporting Time Period:09/01/2024-08/31/2025

High Risk Medications per Beers Criteria for Potentially Inappropriate Medication Use

Prescriber Name	BRAND/generic	Strength Description	Claim count	Rank	% Change from Previous 12 Months
	ABILIFY	2 mg	1	476	-80.0%
		20 mg			-100.0%
	ABILIFY ASIMTUFII	720 mg/2.4 mL	4	305	300.0%
		960 mg/3.2 mL	32	184	100.0%
	ABILIFY MAINTENA	300 mg	7	338	-69.6%
		400 mg	33	101	-60.7%
	ABILIFY MAINTENA PREFILLED SYRINGE	300 mg	7	339	-65.0%
		400 mg	185	59	-11.1%
	acetaminophen pm extra streng..	500 mg-25 mg			-100.0%
	acetaminophen-butalbital	325 mg-50 mg	8	411	-62.5%
	acetaminophen/butalbital/caffe..	300 mg-50 mg-40 ..	10	301	-41.2%
		325 mg-50 mg-40 ..	58	132	5.5%
	acetaminophen/butalbital/caffe..	300 mg-50 mg-40 ..	1	477	
		325 mg-50 mg-40 ..	5	369	-73.7%
	ADMELOG	100 units/mL	3	412	-95.8%
	ADMELOG SOLOSTAR	100 units/mL	74	115	86.0%
	adult low dose aspirin	81 mg	30	188	0.0%
	ADVIL DUAL ACTION WITH ACET..	250 mg-125 mg	3	413	-50.0%
	allergy (chlorpheniramine)	4 mg	2	443	100.0%
	allergy relief (diphenhydramine ..	25 mg			-100.0%
	alprazolam	0.5 mg	180	63	-19.6%
		0.25 mg	73	118	30.5%
		1 mg	182	61	-23.2%
		2 mg	120	85	-6.3%
	altavera (28 day)	30 mcg-0.15 mg	18	235	28.0%

Trend of Rolling 12 Months-

45. HIV Medical Visit Frequency Dashboard

1. Report Overview & Purpose

This dashboard allows users to monitor the percentage of patients with an HIV diagnosis who have had at least one medical visit in each 6-month period of a 24-month measurement window. The report's primary purpose is to track patient engagement and adherence to recommended care protocols, enabling the identification of care gaps and demographic disparities. It helps ensure that patients are consistently receiving the care necessary to manage their condition effectively.

2. Available Filters & Interactivity

1. **Measure Year**: Allows the user to select the 24-month measurement period ending in the chosen year.
2. **Chronic Condition**: Enables filtering for patients with specific co-occurring chronic conditions.
3. **Suppression Flag**: Allows users to include or exclude patients based on their viral suppression status.
4. **Roster**: Filters the dashboard to display data for a specific patient roster or panel.
5. **Data Drill-Through**: Users can click on the KPI tiles (HIV Patients, Patients With Recommended Visits, Visit Percentage) or on the individual bars within any of the charts (e.g., a specific age group bar in the 'Age Category and Gender' chart) to navigate to a detailed, patient-level report.

3. Key Metrics & KPIs

1. **HIV Patients**: The total number of unique patients with a diagnosis of HIV within the filtered population.
2. **Patients With Recommended Visits**: The total count of HIV patients who met the measure's criteria, which requires at least one medical visit in each 6-month period of the 24-month measurement window.
3. **Visit Percentage**: The percentage of total HIV patients who met the criteria for recommended visits. This is the primary compliance KPI for the report.

4. Visualizations & Data Tables

1. **KPI Tiles**: Three large summary tiles at the top of the dashboard display the core metrics: total HIV Patients, the number of Patients with Recommended Visits, and the overall Visit Percentage.
2. **Percentage of Patients Receiving Recommended Visits by Months**: This section contains four separate 100% stacked bar charts, one for each 6-month interval (0-6, 7-12,

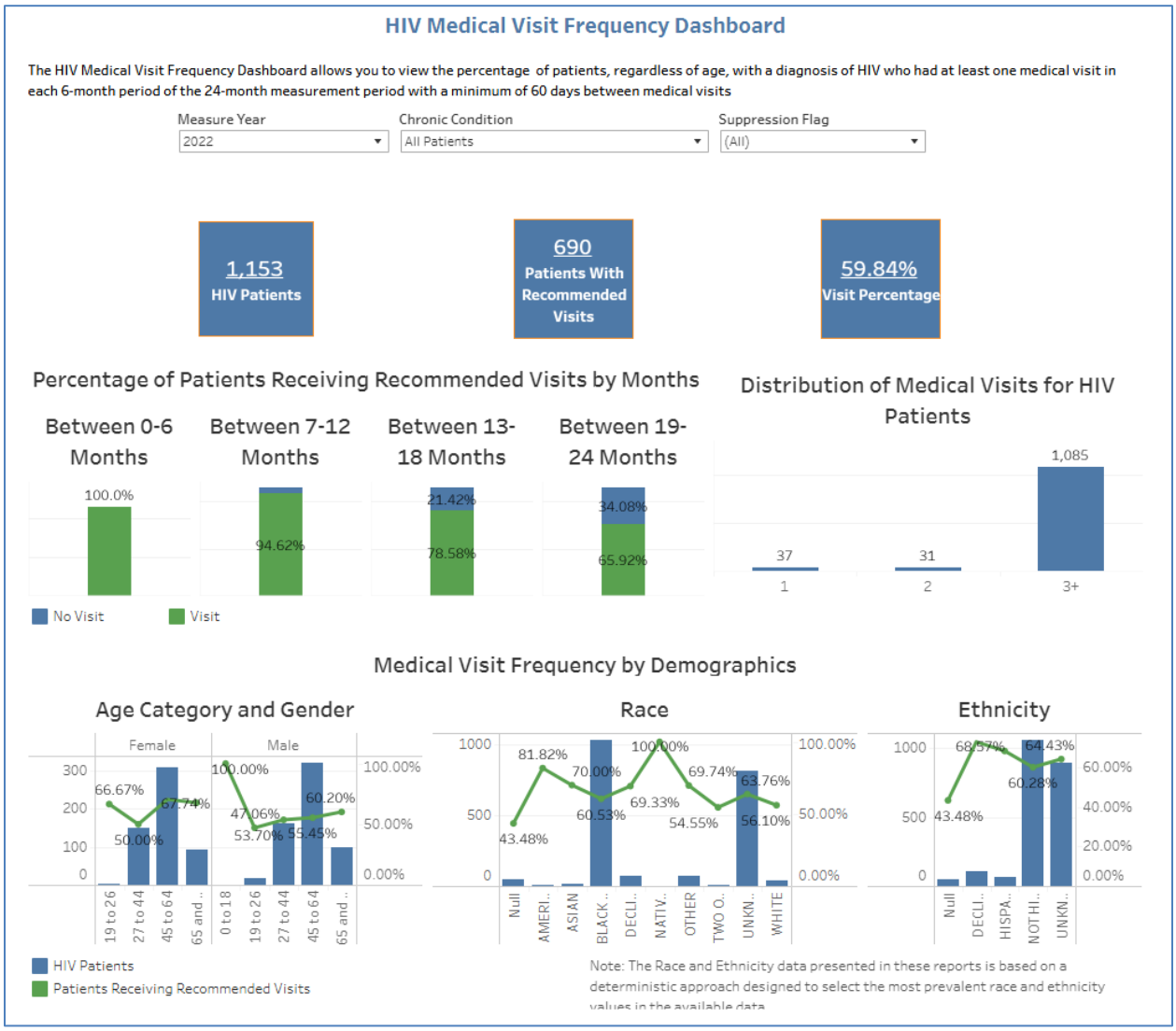
13-18, 19-24 Months). Each chart shows the percentage of the patient population that had a visit (green) versus no visit (blue) during that specific time frame.

3. **Distribution of Medical Visits for HIV Patients**: A bar chart that categorizes the patient population by the total number of medical visits they had over the measurement period (1, 2, or 3+).
4. **Medical Visit Frequency by Demographics**: A series of three combination charts that break down performance by different demographic factors. Each chart displays the total number of HIV patients as bars and the corresponding Visit Percentage as a line graph.

5. Functional Use Cases

1. **Monitor Overall Program Performance**: A public health official can use the main KPI tiles to quickly assess the overall "Visit Percentage" (59.84%) for the entire HIV patient population in the selected year to track progress against organizational goals.
2. **Identify Demographic Disparities**: A health equity coordinator can analyze the "Medical Visit Frequency by Demographics" charts to find populations with lower-than-average adherence, such as males in the '27 to 44' age group, to develop targeted outreach programs.
3. **Track Patient Engagement Over Time**: A care manager can review the "Percentage of Patients Receiving Recommended Visits by Months" charts to see if patient visit adherence declines over the 24-month period, helping to identify when patients may be falling out of care.
4. **Prioritize High-Risk Patients**: A clinic manager can use the "Distribution of Medical Visits" chart to see that a large number of patients (1,085) have 3+ visits, but a smaller cohort has only 1 or 2. They can then drill down on the '1' or '2' visit bars to generate a list of patients who may need more intensive follow-up.
5. **Evaluate Roster-Specific Adherence**: A primary care provider can select their specific panel from the "Roster" filter to evaluate their own patients' compliance with recommended visit frequency and compare it to the organizational baseline.

6. Screenshot



46. HIV Viral Load Suppression (HVL-AD) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive overview of HIV viral load suppression rates within a specified patient population. It allows users to track the prevalence of HIV cases and monitor the effectiveness of treatment over time, as defined by a viral load of less than 200 copies/mL. The report is designed to help identify trends and disparities across different demographic groups to support targeted public health interventions and care management.

2. Available Filters & Interactivity

1. **Measure Year**: Allows the user to select the specific year for which to view the viral load suppression data.
2. **Chronic Condition**: Filters the patient population based on co-occurring chronic conditions.
3. **ART Medication**: Filters the patient population based on their prescribed Antiretroviral Therapy (ART) medication.
4. **Roster**: Narrows the report to a specific, pre-defined list or panel of patients.
5. **Data Drill-Through**: Users can click on the aggregate numbers in the overview boxes, the bars within the demographic charts (Age/Gender, Race, Ethnicity), or the rows in the "Over Measure Years" table to navigate to a detailed, patient-level report.

3. Key Metrics & KPIs

1. **HIV Patients**: The total number of HIV-positive patients in the selected population for the measure year.
2. **HIV Patients with Suppressed Viral Load**: The count of patients whose last viral load test in the measurement year was less than 200 copies/mL.
3. **Viral Load Suppression Rate**: The percentage of HIV patients with a suppressed viral load, calculated as (HIV Patients with Suppressed Viral Load / Total HIV Patients).
4. **Comparison with Previous Year**: A visual indicator (up arrow, down arrow) showing whether the suppression rate has improved or declined compared to the prior year.

4. Visualizations & Data Tables

1. **Viral Load Suppression Overview**: A set of three key performance indicator (KPI) cards at the top of the dashboard displaying the total number of HIV patients, the number of patients with suppressed viral load, and the overall suppression rate for the selected Measure Year.
2. **Viral Load Suppression Over Measure Years**: A summary table that tracks key metrics (Total Patients, Suppressed Patients, Suppression Rate) annually. It includes trend indicators to quickly show year-over-year performance changes.

3. **Viral Load Suppression by Age Category and Gender**: A grouped bar chart that displays the total number of HIV patients (blue bars) and the corresponding viral load suppression rate (green line) across different age brackets, separated by gender.
4. **Viral Load Suppression by Race**: A bar chart visualizing the total number of HIV patients and the suppression rate for various racial groups.
5. **Viral Load Suppression by Ethnicity**: A bar chart that breaks down the total number of HIV patients and the suppression rate by ethnicity (e.g., Hispanic, Not Hispanic).

5. Functional Use Cases

1. **Evaluate Long-Term Public Health Program Interventions**: A public health program manager reviews the "Viral Load Suppression Over Measure Years" table to assess the long-term impact of a region-wide health initiative on suppression rates.
2. **Execute Target Outreach for Clinical Care Gaps**: A care coordinator uses the "Age Category and Gender" chart to identify specific demographics with lower suppression rates and drills through to the patient list to initiate targeted outreach.
3. **Extract Historical Benchmarks for Financial Grant Applications**: A population health analyst filters by a historical "Measure Year" to generate a snapshot report on the regional state of viral load suppression for an annual grant application.
4. **Mitigate Clinical Gaps and Address Treatment Disparities**: A quality improvement director examines the "Race" and "Ethnicity" charts to identify disparities in care outcomes and allocate resources for culturally competent patient education programs.
5. **Monitor Assigned Panel Care and Adherence Metrics**: A case manager selects their specific panel from the "Roster" dropdown to monitor the viral load suppression status of their assigned patients and follow up with those who are not suppressed.

6. Screenshot

HIV Viral Load Suppression Dashboard

The NASTAD HIV Viral Load Suppression Dashboard allows you to view the prevalence of HIV cases and the viral load suppression among the HIV population by measurement year. Viral Load Suppression is identified by HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.

Measure Year: 2023 | Chronic Condition: All Patients | ART Medication: (All)

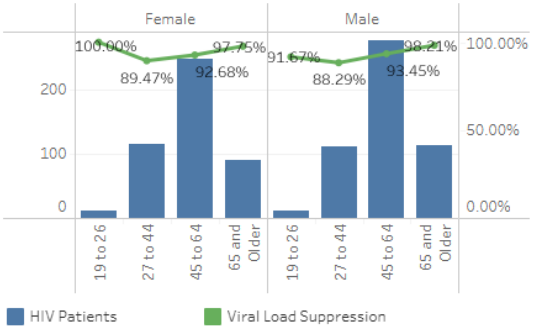
Viral Load Suppression (< 200 Copies/mL) Overview for the Measure Year- 2023

970 HIV Patients

904 HIV Patients with Suppressed Viral Load

93.20% Viral Load Suppression Rate

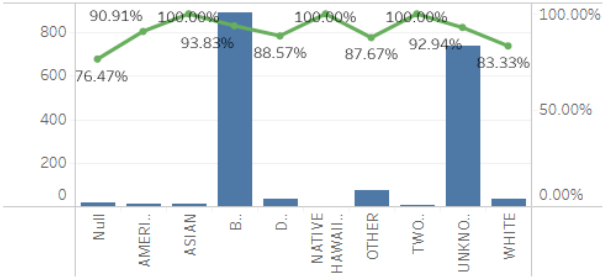
Viral Load Suppression by Age Category and Gender



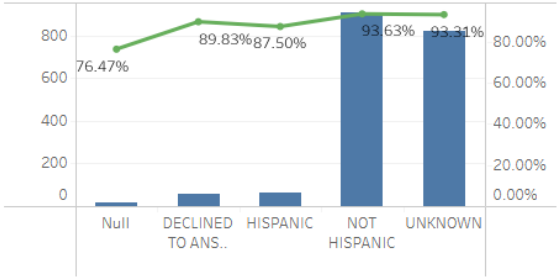
Viral Load Suppression Over Measure Years

Measure Year	HIV Patients	HIV Patients with Suppressed Viral Load	Suppression Rate	Comparison with Previous ..
2019	698	605	86.68%	○
2020	1,033	961	93.03%	↑
2021	918	851	92.70%	↓
2022	1,055	970	91.94%	↓
2023	970	904	93.20%	↑
2024	1,084	977	90.13%	↓
2025	90	82	91.11%	↑

Viral Load Suppression by Race



Viral Load Suppression by Ethnicity



Note: The Race and Ethnicity data presented in these reports is based on a deterministic approach designed to select the most prevalent race and ethnicity values in the available data.

47. Hypertension Medication (RAS Antagonists) Adherence Report

1. Report Overview & Purpose

This report identifies patients who are prescribed Renin-Angiotensin System (RAS) antagonist medications for hypertension and assesses their adherence over the prior year. The primary purpose is to flag individuals with a high likelihood of non-adherence, enabling care managers and providers to conduct timely outreach and interventions to improve medication compliance and health outcomes.

2. Available Filters & Interactivity

1. **Non-Adherence Risk Category**: Filters the patient list based on the calculated likelihood of non-adherence (e.g., High, Medium, Low).
2. **Care Program/MCO**: Filters for patients enrolled in a specific Managed Care Organization (MCO) or care program.
3. **Has Hypertension**: Filters for patients with a confirmed diagnosis of hypertension (Yes/No).
4. **Has Heart Failure**: Filters for patients with a co-morbid diagnosis of heart failure (Yes/No).
5. **Roster**: Allows users to select a specific patient panel or roster to narrow the results.
6. **Data Drill-Through**: Users can click on any patient row in the main data table to navigate to a more detailed beneficiary-level view.

3. Key Metrics & KPIs

1. **Hypertension Medication (RAS) PDC (Prior 1 Year)**: This is the Proportion of Days Covered, a standard adherence metric calculated as the percentage of days in the last year that the patient had the prescribed medication available. A higher PDC indicates better adherence.
2. **Likelihood of Hypertension Medications (RAS) Non-Adherence**: This is the primary risk score, presented as a percentage. It is color-coded to indicate risk level:
    a. Red (High Likelihood Non-Adherence, 52.63% to 100%)
    b. Orange (Medium Likelihood Non-Adherence, 44.23% to 52.62%)
    c. Yellow (Low Likelihood Non-Adherence, 32.74% to 44.22%)
    d. Green (Likely Adherent, 0% to 32.73%).

4. Visualizations & Data Tables

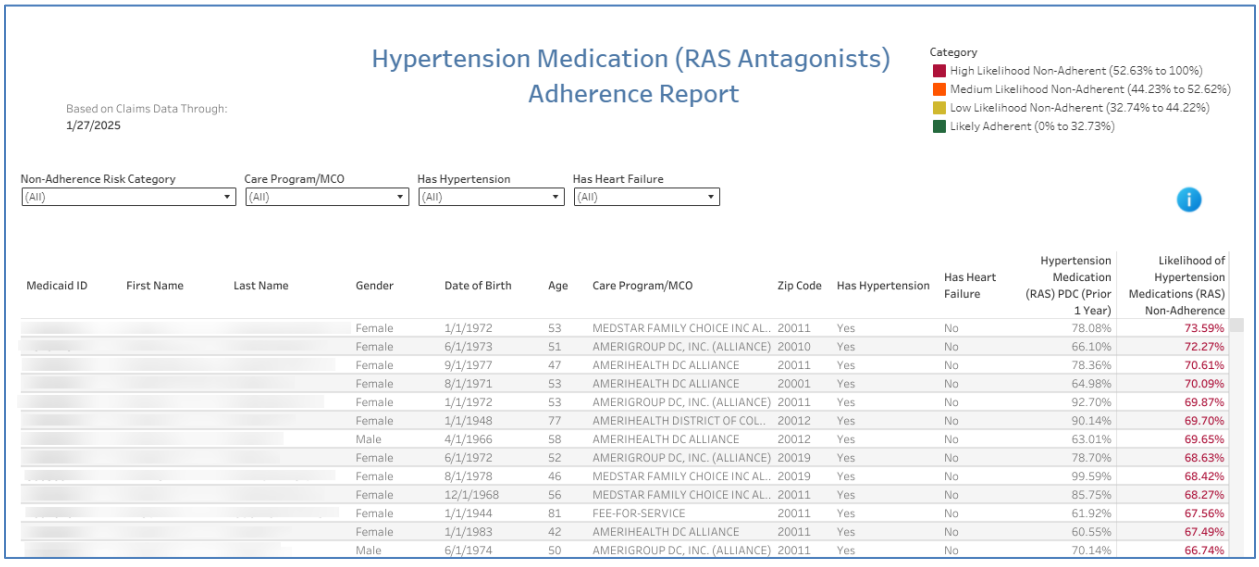
1. **Patient Adherence List**: The core of the report is a detailed table that lists individual patients. Each row contains patient demographics (Medicaid ID, Name, Gender, DOB, Age), their assigned health plan (Care Program/MCO), diagnostic flags (Has Hypertension, Has Heart Failure), and the key adherence metrics (PDC and Likelihood of

Non-Adherence). The list is sorted by the "Likelihood of Non-Adherence" column, bringing the highest-risk patients to the top for easy identification.

5. Functional Use Cases

1. **Prioritize Care Management Outreach:** A care manager sorts the report by "Likelihood of Non-Adherence" to generate a prioritized worklist of patients (e.g., those in the red "High Likelihood" category) for immediate telephonic outreach to discuss barriers to taking their medication.
2. **Manage a Specific Patient Panel:** A primary care physician uses the "Roster" filter to view only patients on their panel, allowing for focused pre-visit planning to address medication adherence during upcoming appointments.
3. **Analyze MCO Performance:** A health plan administrator uses the "Care Program/MCO" filter to isolate and analyze the adherence rates for their members, comparing performance against benchmarks and identifying opportunities for targeted member engagement programs.
4. **Focus on High-Risk Co-morbid Patients:** A population health analyst filters for patients where "Has Hypertension" is 'Yes' and "Has Heart Failure" is 'Yes' to identify a clinically complex cohort where medication adherence is especially critical for preventing hospitalizations.
5. **Track Intervention Effectiveness:** A user exports the patient list via the "Excel" button at the beginning of a quarter to establish a baseline. After implementing an adherence intervention, they export the list again at the end of the quarter to compare PDC and risk scores for the same population to measure the program's impact.

6. Screenshot



Medicaid ID	First Name	Last Name	Gender	Date of Birth	Age	Care Program/MCO	Zip Code	Has Hypertension	Has Heart Failure	Hypertension Medication (RAS) PDC (Prior 1 Year)	Likelihood of Hypertension Medications (RAS) Non-Adherence
			Female	1/1/1972	53	MEDSTAR FAMILY CHOICE INC AL..	20011	Yes	No	78.08%	73.59%
			Female	6/1/1973	51	AMERIGROUP DC, INC. (ALLIANCE)	20010	Yes	No	66.10%	72.27%
			Female	9/1/1977	47	AMERIHEALTH DC ALLIANCE	20011	Yes	No	78.36%	70.61%
			Female	8/1/1971	53	AMERIHEALTH DC ALLIANCE	20001	Yes	No	64.98%	70.09%
			Female	1/1/1972	53	AMERIGROUP DC, INC. (ALLIANCE)	20011	Yes	No	92.70%	69.87%
			Female	1/1/1948	77	AMERIHEALTH DISTRICT OF COL..	20012	Yes	No	90.14%	69.70%
			Male	4/1/1966	58	AMERIHEALTH DC ALLIANCE	20012	Yes	No	63.01%	69.65%
			Female	6/1/1972	52	AMERIGROUP DC, INC. (ALLIANCE)	20019	Yes	No	78.70%	68.63%
			Female	8/1/1978	46	MEDSTAR FAMILY CHOICE INC AL..	20019	Yes	No	99.59%	68.42%
			Female	12/1/1968	56	MEDSTAR FAMILY CHOICE INC AL..	20011	Yes	No	85.75%	68.27%
			Female	1/1/1944	81	FEE-FOR-SERVICE	20011	Yes	No	61.92%	67.56%
			Female	1/1/1983	42	AMERIHEALTH DC ALLIANCE	20011	Yes	No	60.55%	67.49%
			Male	6/1/1974	50	AMERIGROUP DC, INC. (ALLIANCE)	20011	Yes	No	70.14%	66.74%

48. Immunizations For Adolescents (IMA-CH) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of immunization rates for adolescent beneficiaries up to age 13, focusing on the Meningococcal, Tdap, and HPV vaccines. It is designed to help providers and organizations track their performance against reference groups over time, identify care gaps, and analyze vaccination trends across different demographics and providers. The report highlights completion rates for individual vaccines as well as for specific combinations required for quality measures.

2. Available Filters & Interactivity

1. **Panel**: Selects the specific provider panel or group to view performance data for.
2. **Roster**: Filters the report for a specific, pre-defined list of beneficiaries.
3. **Measure Year**: Selects the primary year for which performance is being measured and displayed in certain charts.
4. **Reference Group**: Chooses the comparison group (e.g., "All DC Medicaid") to benchmark the selected panel's performance against.
5. **Measure**: Toggles the view between different measure types, such as "Actual Measure."
6. **Vaccine**: Allows for the selection of one or more specific vaccines or combinations to filter the dashboard visuals.
7. **Data Drill-Through**: The user can likely click on the aggregated numbers within the Immunization Performance in 2025 and Beneficiary Count and Payment by Provider charts to navigate to a detailed, beneficiary-level report.

3. Key Metrics & KPIs

1. **Meningococcal**: The percentage of beneficiaries who have received one dose of the meningococcal vaccine by their 13th birthday.
2. **TDAP**: The percentage of beneficiaries who have received one dose of the Tetanus, Diphtheria, Pertussis (Tdap) vaccine by their 13th birthday.
3. **HPV**: The percentage of beneficiaries who have completed the Human Papillomavirus (HPV) vaccine series by their 13th birthday.
4. **Combination 1**: The percentage of beneficiaries who are compliant for both the Meningococcal and Tdap vaccines.
5. **Combination 2**: The percentage of beneficiaries who are compliant for the Meningococcal, Tdap, and HPV vaccines.
6. **Beneficiary Count**: The total number of beneficiaries categorized by their vaccination status (fully vaccinated, partially vaccinated, unvaccinated).
7. **Amount Paid**: The total payment amount associated with immunization services, aggregated by provider.

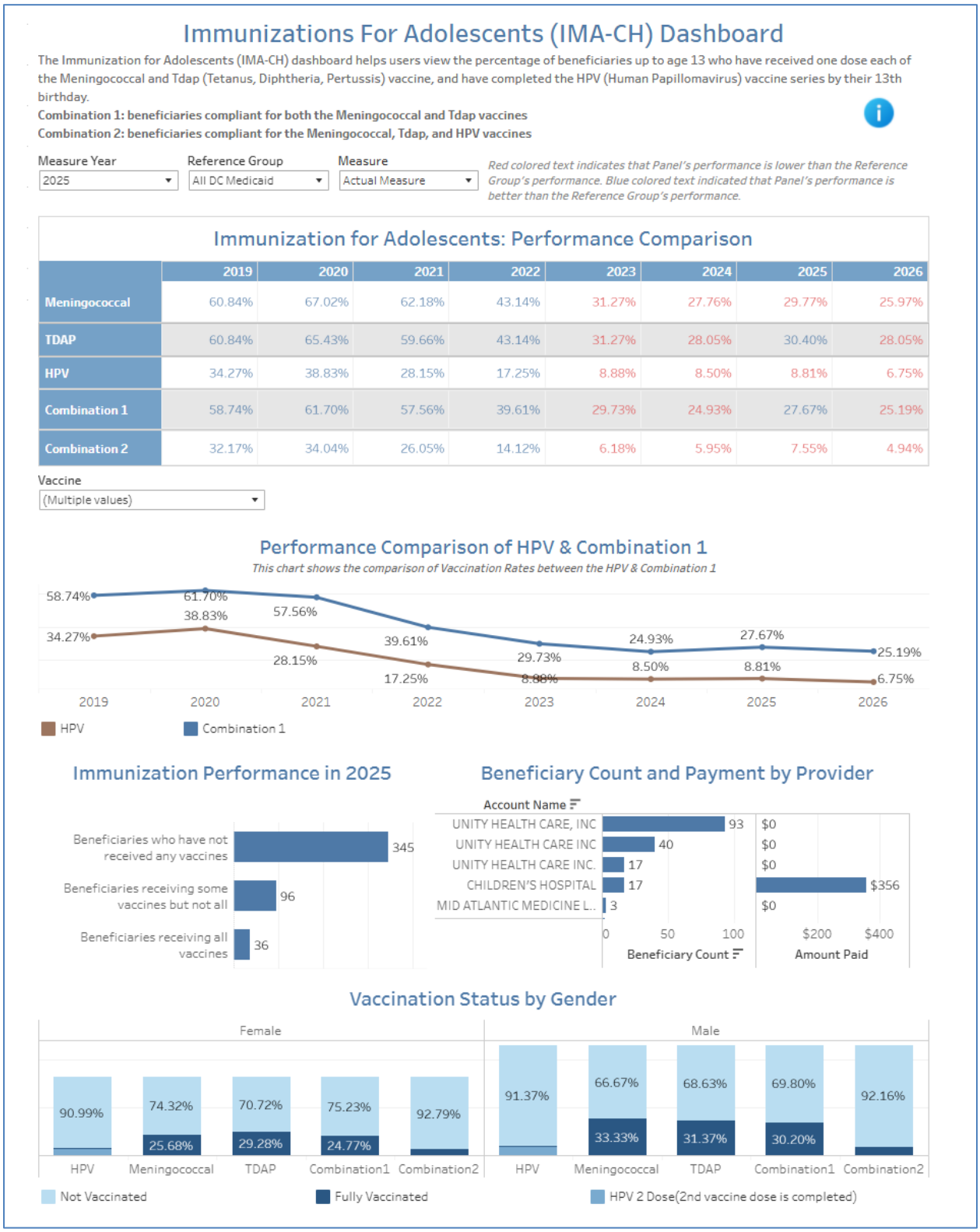
4. Visualizations & Data Tables

1. **Immunization for Adolescents: Performance Comparison**: A table displaying the panel's vaccination rates for each key metric from 2019 to 2026. Performance is color-coded (blue for better, red for worse) to indicate how the panel's rate compares to the selected Reference Group.
2. **Performance Comparison of HPV & Combination 1**: A line chart that tracks and compares the performance trends of the HPV and Combination 1 vaccination rates from 2019 to 2026, allowing for easy visualization of progress or decline over time.
3. **Immunization Performance in 2025**: A horizontal bar chart that segments the beneficiary population into three groups: those who have not received any vaccines, those receiving some but not all, and those receiving all vaccines. This helps quantify the scale of different care gap categories for the selected measure year.
4. **Beneficiary Count and Payment by Provider**: A dual-axis chart that shows the number of beneficiaries served and the total payment received by each provider account. This visual helps identify key providers by volume and financial impact.
5. **Vaccination Status by Gender**: A set of stacked bar charts, separated for Female and Male beneficiaries, illustrating the percentage of patients who are "Fully Vaccinated" versus "Not Vaccinated" for each of the five key metrics. This highlights any potential disparities in vaccination rates between genders.

5. Functional Use Cases

1. **Track Quality Improvement**: A care manager can use the "Performance Comparison" table to monitor their panel's year-over-year performance for the "Combination 2" metric to assess the effectiveness of their outreach initiatives.
2. **Identify Gender-Specific Gaps**: A public health analyst can review the "Vaccination Status by Gender" chart to determine if there is a significant difference in HPV vaccination rates between male and female adolescents, informing targeted educational campaigns.
3. **Prioritize Patient Outreach**: A clinical lead can drill through the "Beneficiaries who have not received any vaccines" bar in the "Immunization Performance" chart to generate a list of completely unvaccinated adolescents for immediate outreach and scheduling.
4. **Analyze Provider Performance**: An administrator can use the "Beneficiary Count and Payment by Provider" chart to identify providers with high beneficiary counts but low vaccination rates (by cross-referencing with other charts), indicating a need for provider education or support.
5. **Set Performance Benchmarks**: A practice manager can compare their panel's 2025 TDAP vaccination rate against the "All DC Medicaid" reference group to set a realistic and data-driven performance target for the upcoming year.

6. Screenshot



49. Lead Screening in Children (LSC-E) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of the Lead Screening in Children quality measure. It allows users to track the percentage of children who are two years of age and have received at least one capillary or venous lead blood test for lead poisoning by their second birthday. The report is designed to help organizations monitor performance, identify care gaps, and analyze trends against benchmarks.

2. Available Filters & Interactivity

1. **Measure Year**: Allows the user to select the specific year for which to view the performance data.
2. **Reference Group**: Enables the user to select a benchmark group (e.g., "All DC Medicaid") to compare their performance against.
3. **Roster**: Allows the user to filter the dashboard to a specific, pre-defined list or panel of beneficiaries.
4. **Data Drill-Through**: Users can click on the aggregated numbers within the KPI cards or on the segments within the bar charts to navigate to a detailed list of the specific beneficiaries that make up that number.

3. Key Metrics & KPIs

1. **Number of Eligible Beneficiaries**: The total number of children in the selected population who are eligible for the measure (denominator).
2. **Number of Beneficiaries who have received a Lead blood test**: The count of eligible children who have received the required screening (numerator).
3. **Number of Beneficiaries who haven't received a Lead blood test**: The count of eligible children who are missing the required screening, representing the care gap.
4. **Measure Rate**: The overall performance percentage, calculated by dividing the number of screened beneficiaries by the total number of eligible beneficiaries.

4. Visualizations & Data Tables

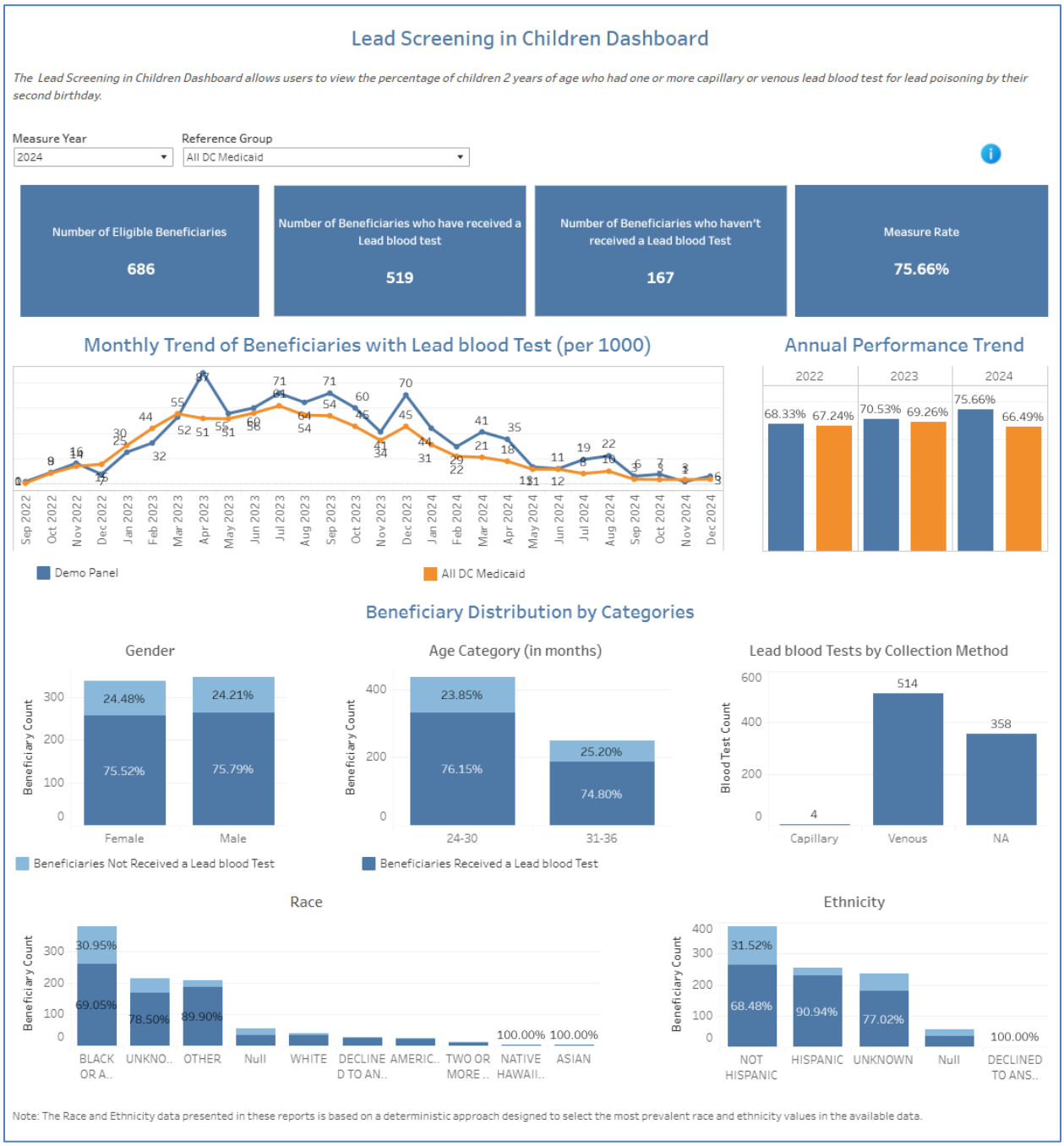
1. **Monthly Trend of Beneficiaries with Lead blood Test (per 1000)**: A line chart that tracks the monthly performance trend of the selected panel (Demo Panel) against the selected reference group (All DC Medicaid). This helps identify seasonal variations or the impact of interventions over time.
2. **Annual Performance Trend**: A bar chart comparing the annual screening rate for the selected panel against the reference group. This provides a high-level, year-over-year performance comparison.

3. **Beneficiary Distribution by Categories**: A set of stacked bar charts that break down the beneficiary population by Gender, Age Category (in months), Race, and Ethnicity. Each bar shows the proportion of beneficiaries who have received a lead test versus those who have not, helping to identify potential disparities in care among different demographic groups.
4. **Lead blood Tests by Collection Method**: A bar chart that displays the total count of lead blood tests categorized by the collection method used: Capillary, Venous, or NA (Not Applicable/Unknown). This provides insight into the types of tests being administered.

5. Functional Use Cases

1. **Monitor Overall Compliance**: A quality improvement manager can use the main "Measure Rate" KPI and the "Annual Performance Trend" chart to quickly assess the organization's current and historical compliance with the lead screening HEDIS measure.
2. **Identify Disparities in Care**: A public health analyst can examine the "Race" and "Ethnicity" charts to identify demographic groups with lower-than-average screening rates and allocate targeted outreach resources accordingly.
3. **Generate Patient Outreach Lists**: A care coordinator can click on the "Number of Beneficiaries who haven't received a Lead blood test" KPI card to drill down to a specific list of children who are due for screening, enabling direct patient outreach.
4. **Benchmark Performance**: A practice administrator can use the "Monthly Trend" line chart to compare their panel's performance (blue line) against the "All DC Medicaid" average (orange line) to see if their practice is performing above or below the regional benchmark.
5. **Analyze Testing Methods**: A lab services coordinator can review the "Lead blood Tests by Collection Method" chart to understand the distribution of test types (e.g., mostly Venous) and ensure adequate supplies and training are available for the most common methods.

6. Screenshot



50. Maternal and Perinatal Health - Pediatric Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive overview of key quality measures related to maternal and perinatal health. It is designed to help providers and health plans monitor performance, compare their results against a benchmark (All DC Medicaid), and identify opportunities for improving patient care in areas such as postpartum visits, contraceptive care, and prenatal care. The report allows for detailed analysis by breaking down a selected measure across various dimensions like time, provider, and patient demographics.

2. Available Filters & Interactivity

1. **Panel:** Allows the user to select the specific provider panel or group to view performance for.
2. **Start Date / End Date:** Defines the measurement period for the data displayed in the report.
3. **Reference Group:** Sets the comparison group for the performance metrics; "All DC Medicaid" is selected by default.
4. **Roster:** Enables the user to select a specific patient roster for analysis.
5. **Select Measure:** A dropdown that filters the lower half of the dashboard to display detailed trend, performance, and demographic data for a specific maternal health measure (e.g., "Postpartum Care Visit Between 7 and 84 Days").
6. **Data Drill-Through:** Users can click on the bars within the "Summary of All Maternal and Perinatal Health Measures," "Postpartum Care Measure Performance Comparison," "Postpartum Care by Age Group," "Postpartum Care by Race," and "Postpartum Care by Ethnicity" charts, as well as the individual rows in the "Postpartum Care by Place of Birth" table, to access a detailed list of the underlying beneficiaries.

3. Key Metrics & KPIs

1. **Contraceptive Care Within 3/90 Days (LARC/Most Effective Method):** Measures the percentage of patients (aged 15-20) who received Long-Acting Reversible Contraception (LARC) or another most-effective contraceptive method within 3 and 90 days of delivery.
2. **Postpartum Care Visit Between 7 and 84 Days (PPC-CH):** The percentage of live birth deliveries that had a postpartum visit on or between 7 and 84 days after delivery. This is the primary measure detailed in the lower half of the report.
3. **Timeliness of Prenatal Care:** Measures the percentage of patients who received timely prenatal care according to established guidelines.

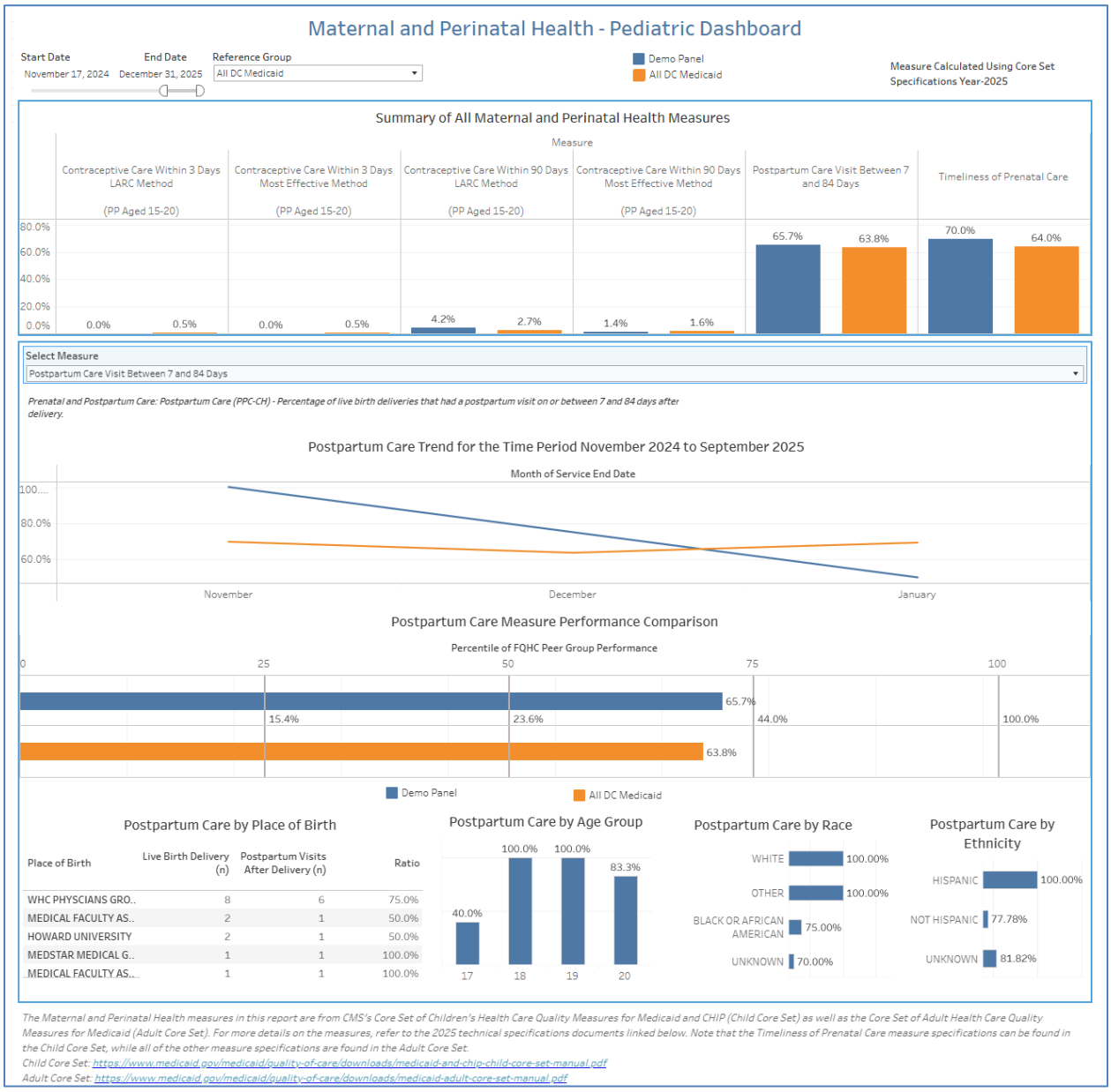
4. Visualizations & Data Tables

1. **Summary of All Maternal and Perinatal Health Measures:** A bar chart that provides a high-level comparison of the selected panel's performance (blue bars) against the reference group (orange bars) across all six key maternal health metrics.
2. **Postpartum Care Trend:** A line chart that tracks the performance of the selected measure over the specified time period, comparing the panel's trend line against the reference group's trend.
3. **Postpartum Care Measure Performance Comparison:** A horizontal bar chart that benchmarks the panel's performance on the selected measure against the reference group and displays its percentile ranking relative to the FQHC Peer Group.
4. **Postpartum Care by Place of Birth:** A table that breaks down performance on the selected measure by the facility where the birth occurred, showing the number of deliveries, number of postpartum visits, and the resulting performance ratio.
5. **Postpartum Care by Age Group / Race / Ethnicity:** A series of bar charts that stratify the selected measure's performance across different patient demographic categories, allowing for the identification of potential disparities in care.

5. Functional Use Cases

1. **Monitor Overall Performance:** A practice manager reviews the "Summary" chart to quickly assess their panel's performance against the DC Medicaid average, identifying "Contraceptive Care Within 90 Days" as an area needing improvement.
2. **Identify Care Disparities:** A quality improvement director uses the "Select Measure" filter for "Postpartum Care Visit" and examines the "by Race" and "by Ethnicity" charts to see if certain demographic groups have lower follow-up rates, informing targeted outreach strategies.
3. **Analyze Referral Partner Performance:** A clinical lead analyzes the "Postpartum Care by Place of Birth" table to determine if postpartum visit rates are lower for patients delivering at a specific hospital, prompting a conversation about care coordination with that facility.
4. **Evaluate Quality Initiative Impact:** A user can monitor the "Postpartum Care Trend" chart over several months to track whether a new patient reminder program is successfully improving the postpartum visit rate for their panel compared to the benchmark.
5. **Target Age-Specific Interventions:** A care coordinator notices in the "Postpartum Care by Age Group" chart that the youngest patients have the lowest visit rates. They can then drill through that specific age group's bar to get a patient list for direct follow-up and scheduling assistance.

6. Screenshot



51. Maternal and Perinatal Health Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive overview of key maternal and perinatal health quality measures. It allows users to compare the performance of a selected panel against the "All DC Medicaid" reference group, track trends over time, and analyze performance across various demographic and facility-level breakdowns to identify areas for quality improvement and address health disparities.

2. Available Filters & Interactivity

1. **Panel:** Drop-down menu to select the specific provider panel or group to analyze. The current selection is "213 - Demo Panel".
2. **Start Date / End Date:** Calendar controls to define the reporting period for the analysis.
3. **Reference Group:** Drop-down menu to select the comparison group for benchmarking. The current selection is "All DC Medicaid".
4. **Roster:** Drop-down menu to select a specific patient roster.
5. **Select Measure:** Drop-down menu that controls the data displayed in the lower half of the dashboard, allowing users to focus on a specific maternal health measure. The current selection is "Contraceptive Care Within 90 Days LARC Method (PP Aged 21-44)".
6. **Data Drill-Through:** Users can click on the bars in the "Summary of All Maternal and Perinatal Health Measures," "Contraceptive Care by Age Group," "Contraceptive Care by Race," and "Contraceptive Care by Ethnicity" charts, as well as the rows in the "Contraceptive Care by Place of Birth" table, to access a detailed, beneficiary-level view of the underlying data.

3. Key Metrics & KPIs

1. **Timeliness of Prenatal Care:** The percentage of pregnant women who received a prenatal care visit in the first trimester or within 42 days of enrollment.
2. **Postpartum Care Visit Between 7 and 84 Days:** The percentage of women who had a postpartum visit on or between 7 and 84 days after delivery.
3. **Contraceptive Care (LARC Method / Most Effective Method):** The percentage of women aged 21-44 who had a live birth and were provided a long-acting reversible method (LARC) or most effective method of contraception within 3 or 90 days of delivery.
4. **Contraceptive Care Measure Performance Comparison:** The selected panel's performance ranked as a percentile against the FQHC (Federally Qualified Health Center) peer group.
5. **Contraception Ratio by Demographics:** The rate of contraceptive care provided, broken down by place of birth, age group, race, and ethnicity.
6. **Live Birth Delivery (n):** The total number of live birth deliveries for a given place of birth.

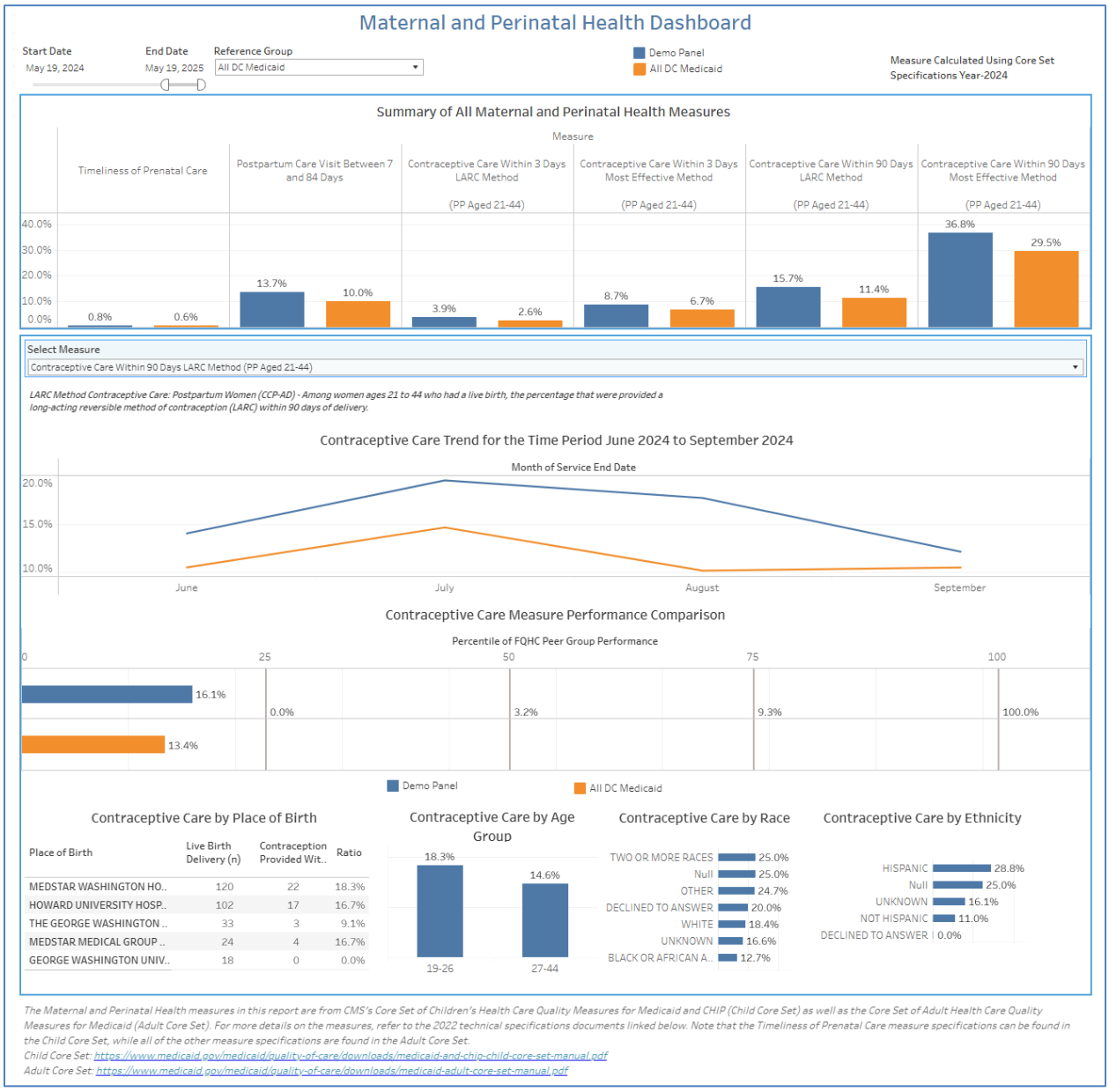
4. Visualizations & Data Tables

1. **Summary of All Maternal and Perinatal Health Measures:** A grouped bar chart that provides a high-level comparison of the selected "Demo Panel" (blue) against the "All DC Medicaid" average (orange) across six different maternal and perinatal health measures.
2. **Contraceptive Care Trend for the Time Period:** A line chart that visualizes the performance trend of the measure selected in the dropdown (e.g., "Contraceptive Care Within 90 Days LARC Method") over a four-month period for both the Demo Panel and All DC Medicaid.
3. **Contraceptive Care Measure Performance Comparison:** A horizontal bar chart that benchmarks the Demo Panel's performance for the selected measure against a peer group, showing its percentile ranking.
4. **Contraceptive Care by Place of Birth:** A data table that breaks down the selected contraceptive care measure by hospital/facility. It lists the number of live births, the number of patients who received contraception, and the resulting performance ratio.
5. **Contraceptive Care by Age, Race, and Ethnicity:** A series of three vertical bar charts that display the performance rate for the selected measure, stratified by patient age group, race, and ethnicity to highlight potential disparities.

5. Functional Use Cases

1. **Identify Performance Gaps:** A Quality Improvement director can review the "Summary of All Maternal and Perinatal Health Measures" chart to quickly identify that their panel is underperforming in "Postpartum Care Visit Between 7 and 84 Days" compared to the DC Medicaid average, prompting an internal review of postpartum outreach protocols.
2. **Analyze Health Equity:** A care manager can use the "Contraceptive Care by Race" and "by Ethnicity" charts to determine if certain racial or ethnic groups have lower rates of receiving LARC methods post-delivery, in order to develop culturally competent patient education materials.
3. **Evaluate Facility-Level Performance:** A hospital administrator can use the "Contraceptive Care by Place of Birth" table to benchmark their facility's postpartum contraceptive care rates against other local hospitals, identifying opportunities for best-practice sharing or process improvement.
4. **Monitor Program Effectiveness:** After implementing a new patient counseling program in July, a clinical lead can monitor the "Contraceptive Care Trend" line chart to assess whether the initiative led to an increase in the desired contraceptive care measure in August and September.
5. **Focus on Specific Age Groups:** A program manager can use the "Contraceptive Care by Age Group" chart to see that the 19-26 age group has a higher rate of contraceptive care than the 27-44 group, leading them to investigate potential barriers for the older cohort.

6. Screenshot



52. Maternal Quality Measure Comparison Over Time Dashboard

1. Report Overview & Purpose

This report provides a comparative analysis of key maternal health quality measures over specified timeframes. It is designed to help clinical and administrative leaders monitor performance, identify trends, and compare their panel's results against benchmarks like the overall DC Medicaid population. The report visualizes both short-term (month-over-month) and long-term (rolling year) performance to support quality improvement initiatives in maternal care.

2. Available Filters & Interactivity

1. **Panel:** Allows the user to select the specific provider panel or group to analyze.
2. **Roster:** Enables filtering the report for a specific patient roster or sub-population.
3. **Selected Month:** A drop-down menu to choose the primary month for analysis (e.g., March 2025).
4. **Comparison Month:** A drop-down menu to select the month to compare against the "Selected Month" (e.g., February 2025).
5. **Measure:** Filters the entire report to display data for a single selected quality measure or all measures.
6. **Data Drill-Through:** Users can click on the numeric values within the "Quality Indicators - March 2025" and "Quality Indicators - Rolling Year" tables, or on the data points within the "Quality Indicators - Trends" line chart, to navigate to a detailed list of the specific beneficiaries included in that metric's calculation.

3. Key Metrics & KPIs

1. **Postpartum Care Visit Between 7 and 84 Days:** Measures the percentage of women who delivered a live birth and had a postpartum visit on or between 7 and 84 days after delivery.
2. **Timeliness of Prenatal Care:** Measures the percentage of women who delivered a live birth and received a prenatal care visit in the first trimester or within 42 days of enrollment in the organization.
3. **Variance:** The percentage point difference between the two compared periods (e.g., Selected Month vs. Comparison Month, or Current Rolling Year vs. Previous Rolling Year). A red downward arrow indicates a decline in performance.

4. Visualizations & Data Tables

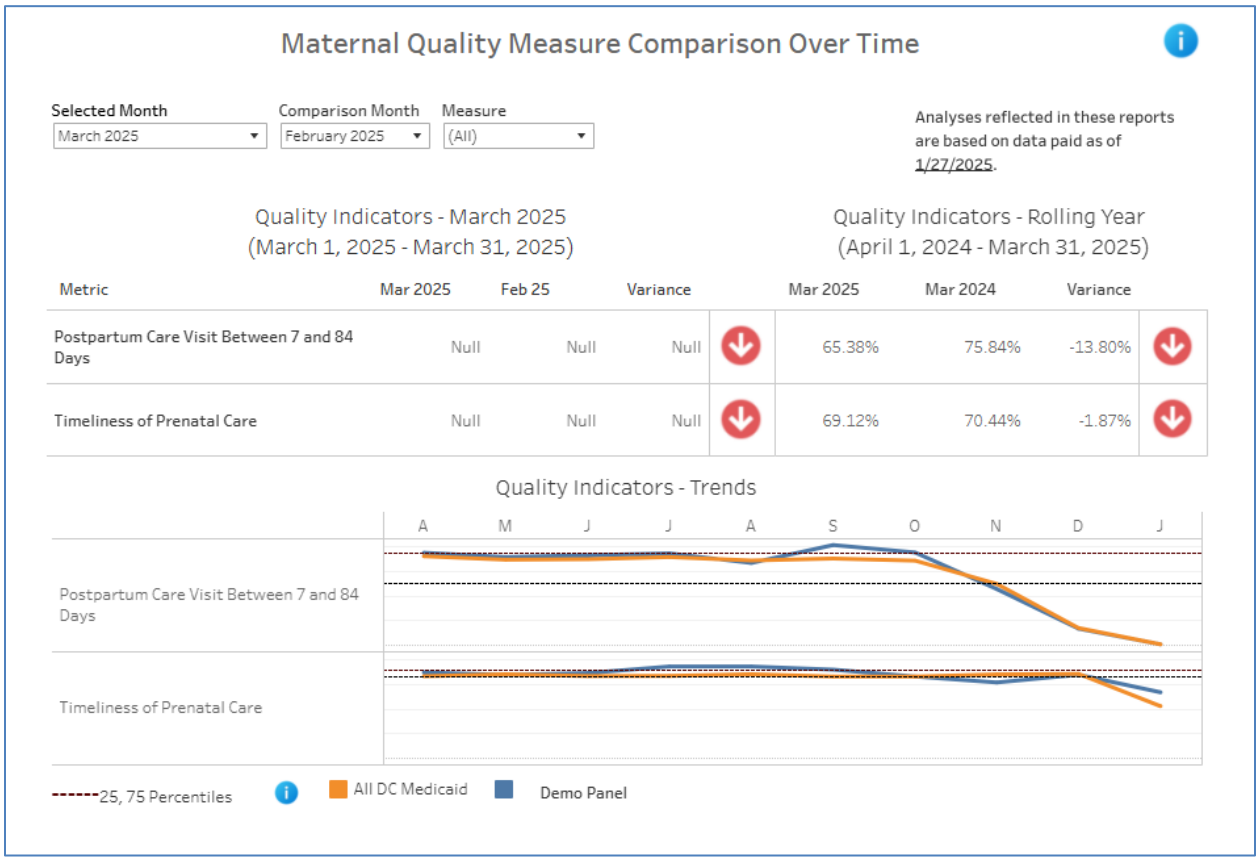
1. **Quality Indicators - March 2025:** A summary table comparing performance for the selected month against the comparison month. It displays the metric name, the performance rate for each month, and the variance between them. In the screenshot, this table shows "Null" values, indicating no data for the selected periods.

2. **Quality Indicators - Rolling Year (April 1, 2024 - March 31, 2025):** This table provides a year-over-year comparison for a 12-month rolling period. It shows the performance rate for the current year (e.g., Mar 2025) versus the prior year (e.g., Mar 2024) and the resulting variance.
3. **Quality Indicators - Trends:** A multi-line chart that plots the performance of the selected metrics over time (monthly). It allows for visual comparison of the selected panel's trend (blue line) against the "All DC Medicaid" benchmark (orange line). Dotted lines represent the 25th and 75th percentiles, providing context for performance distribution.

5. Functional Use Cases

1. **Annual Performance Assessment:** A practice manager reviews the "Quality Indicators - Rolling Year" table to evaluate the year-over-year change in postpartum care visit rates to report on annual quality goals.
2. **Benchmarking Performance:** A clinical director uses the "Quality Indicators - Trends" chart to see how their panel's "Timeliness of Prenatal Care" performance compares to the overall DC Medicaid average throughout the year.
3. **Investigating Performance Dips:** A quality improvement specialist notices a significant negative variance (-13.80%) for the rolling year postpartum care metric. They click on the 65.38% value to drill down to the patient list and identify beneficiaries who may need follow-up.
4. **Monitoring Recent Initiatives:** A care coordination team leader uses the "Quality Indicators - March 2025" table to track immediate, month-over-month changes after implementing a new patient outreach program for prenatal visits.
5. **Identifying Areas for Improvement:** A physician lead observes in the trend chart that their panel's performance on a key metric consistently falls below the 75th percentile benchmark, signaling an opportunity for a targeted quality improvement project.

6. Screenshot



53. Measure Comparison by Time Period Dashboard

1. Report Overview & Purpose

This report provides a comprehensive performance overview for a selected provider panel, comparing key metrics over time. It allows users to analyze utilization, per capita costs, and quality indicators for a specific month and year-to-date (YTD), comparing current performance to the previous year and benchmarking against peer groups and the overall DC Medicaid population.

2. Available Filters & Interactivity

1. **Panel:** A drop-down menu to select the specific provider panel for which to view data.
2. **Month:** A drop-down menu to select the primary month for the analysis (e.g., "October 2023").
3. **Comparison Groups (Checkboxes):** Toggles used to display corresponding trend lines on the graphs.
    a. **All DC Medicaid:** Displays the performance trend for the entire DC Medicaid population.
    b. **Peer Group:** Displays the performance trend for the selected panel's designated peer group.
    c. **Subscriber:** Displays the performance trend for the selected panel.
4. **Data Drill-Through:** Users can click on the numeric values within the "Demo Panel Utilization," "Facility Per Capita Utilization," and "Demo Panel Quality Indicators" tables to navigate to a detailed view of the beneficiaries or claims that constitute the selected metric.

3. Key Metrics & KPIs

1. **Facility Utilization:**
    a. **Total Facility Charges:** The total dollar amount charged by facilities for services.
    b. **Total Inpatient Charges:** The total dollar amount charged for inpatient hospital stays.
    c. **Total Inpatient Discharges:** The total count of patients discharged from an inpatient setting.
    d. **Total ED Visits:** The total count of emergency department visits.
2. **Facility Per Capita Utilization:**
    a. **Expenditure Per Member Per Month (PMPM):** The average cost of care for each enrolled member for the month.
    b. **Facility Discharges per 1000:** The rate of inpatient discharges normalized per 1,000 members.
    c. **NED Visits per 1000:** The rate of non-emergent ED visits normalized per 1,000 members.

3. **Quality Indicators:**
    a. **NED Visits Rate:** The percentage of all ED visits that were classified as non-emergent.
    b. **PCR Rate:** Potentially preventable complication rate.
    c. **PQI 92 - Prevention Quality Chronic Composite Count:** A count of hospital admissions for specific chronic conditions that evidence suggests could have been avoided through better ambulatory care.

4. Visualizations & Data Tables

1. **Metric Comparison Tables:** The report contains three sets of summary tables (Utilization, Per Capita Utilization, and Quality). Each set has two tables: one for the selected month (e.g., October 2023 vs. October 2022) and one for the Year-to-Date period. These tables display the metric value for the current and prior year, along with the percentage variance, indicated by a red (increase) or green (decrease) arrow.
2. **Trends Line Charts:** Below each set of tables is a corresponding line chart that plots the monthly trend of each metric over the past year. These charts visualize the performance of the selected panel ("Subscriber") in comparison to its "Peer Group" and the "All DC Medicaid" population, allowing for easy identification of performance gaps or trends over time.

5. Functional Use Cases

1. **Monitor ED Utilization:** A practice manager notices the "Total ED Visits" for October 2023 has a negative variance (-1.2%), but the YTD variance is a positive 9.8%. They can use the "Total ED Visits" trend chart to see if the monthly decrease is a new trend or an anomaly, helping to evaluate the effectiveness of recent care management initiatives.
2. **Analyze Inpatient Costs and Volume:** A clinical director observes a significant year-over-year increase in "Total Inpatient Charges" (24.2%). They can drill through on the "Total Inpatient Discharges" number to identify the specific patient population and diagnoses driving the higher admission rates.
3. **Benchmark Per Capita Spending:** An administrator reviews the "Expenditure Per Member Per Month (PMPM)" and sees their panel's PMPM is higher than the Peer Group on the trend chart. This prompts a deeper dive into utilization metrics to identify the primary cost drivers.
4. **Evaluate Ambulatory Care Quality:** A quality improvement lead examines the "PQI 92" count, which has increased by 20.6% in October and 24.4% YTD. This indicates a potential issue in managing chronic conditions in the outpatient setting, prompting a review of care plans for high-risk chronic patients.
5. **Prepare for Performance Reviews:** A network manager uses the YTD tables to assess overall annual performance against the prior year's benchmarks. They can quickly identify areas of success (e.g., decreased NED Visits Rate) and areas needing improvement (e.g., increased Facility Discharges per 1000) to set strategic goals.

6. Screenshot

Measure Comparison by Time Period

Month: October 2023

All DC Medicaid ☑ Peer Group ☑ Subscriber ☑

25, 75 Percentiles — Zero

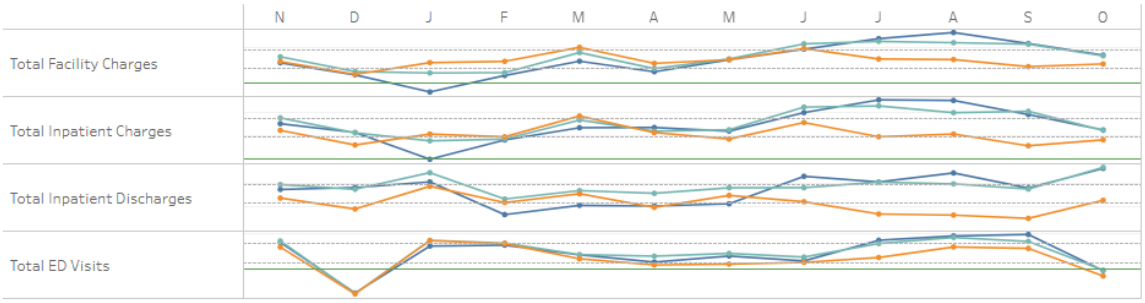
Analyses reflected in these reports are based on data paid as of 1/27/2025.

Demo Panel Utilization - October 2023

YTD Facility Utilization

Metric	Oct 23	Oct 22	Variance		Oct 23	Oct 22	Variance	
Total Facility Charges	$26,018,579	$22,531,599	15.5%	↑	$241,443,445	$212,439,921	13.7%	↑
Total Inpatient Charges	$12,583,733	$10,135,426	24.2%	↑	$117,848,689	$91,950,952	28.2%	↑
Total Inpatient Discharges	820	652	25.8%	↑	7,116	6,085	16.9%	↑
Total ED Visits	2,913	2,947	-1.2%	↓	29,778	27,118	9.8%	↑

Demo Panel Utilization - Trends

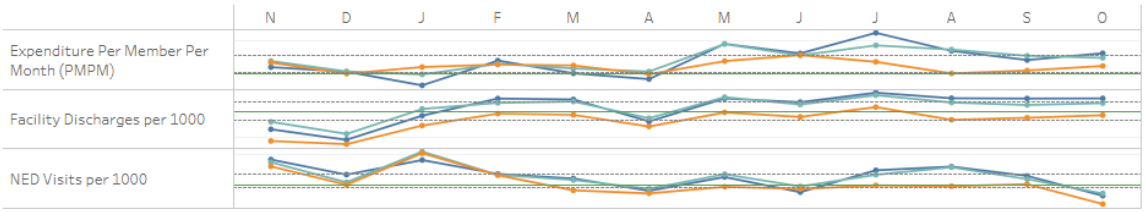


Facility Per Capita Utilization - October 2023

YTD Facility Per Capita Utilization

Metric	Oct 23	Oct 22	Variance		Oct 23	Oct 22	Variance	
Expenditure Per Member Per Month (PMPM)	$446	$399	11.8%	↑	$404.83	$375.44	7.8%	↑
Facility Discharges per 1000	329	314	4.7%	↑	310.4	301.0	3.1%	↑
NED Visits per 1000	21	23	-7.7%	↓	21.8	21.1	3.5%	↑

Facility Per Capita Utilization - Trends

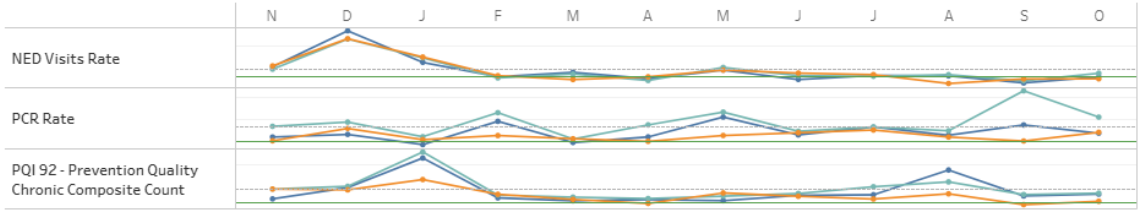


Demo Panel Quality Indicators - October 2023

YTD Quality Indicators

Metric	Oct 23	Oct 22	Variance		Oct 23	Oct 22	Variance	
NED Visits Rate	43.6%	43.8%	-0.5%	↓	43.9%	43.7%	0.5%	↑
PCR Rate	15.5%	13.2%	17.6%	↑	16.9%	14.3%	18.1%	↑
PQI 92 - Prevention Quality Chronic Composite Count	82	68	20.6%	↑	703	565	24.4%	↑

Demo Panel Quality Indicators - Trends



54. Medicaid Redetermination Report

1. Report Overview & Purpose

This report is designed to help users identify and monitor upcoming Medicaid Redetermination dates for their beneficiary population. Its primary purpose is to enable proactive outreach to patients to avoid gaps in their healthcare coverage. The report uses color-coding and a "Days Left for Redetermination" metric to highlight individuals who are within or past the 90-day recertification window.

2. Available Filters & Interactivity

1. **Roster:** Allows users to select a specific patient roster or panel to view.
2. **Days Left for Redetermination:** Filters the beneficiary list based on the timeframe until their redetermination date (e.g., <0 Days, 0-30 Days).
3. **Current Payer Name:** Filters the report to show beneficiaries associated with a specific insurance payer.
4. **DHCF Program:** Narrows the results to beneficiaries enrolled in a specific Department of Health Care Finance (DHCF) program.
5. **Program Code:** Filters the list by the specific code associated with the beneficiary's health program.
6. **Data Drill-Through:** This report is a beneficiary-level detail table. No further drill-through functionality is available from the tables shown.

3. Key Metrics & KPIs

1. **Days Left for Redetermination:** A calculated metric indicating the number of days remaining until the beneficiary's Medicaid redetermination deadline. A negative number signifies that the deadline has passed. The report visually codes this metric:
    a. **Red:** <0 Days
    b. **Orange:** 0-30 Days
    c. **Yellow:** 31-60 Days
    d. **Light Yellow:** 61-90 Days
2. **Medicaid Redetermination Date:** The specific date by which the beneficiary must complete their Medicaid recertification process.
3. **# Case Manager:** A count of case managers assigned to the beneficiary. A value of '0' indicates the beneficiary is not currently assigned a case manager.

4. Visualizations & Data Tables

1. **DC Medicaid Redetermination Report Table:** This is the main component of the report, presenting a detailed list of beneficiaries. It includes demographic information (Name, DOB, Gender, Address), payer details, and the key redetermination metrics. Each row is

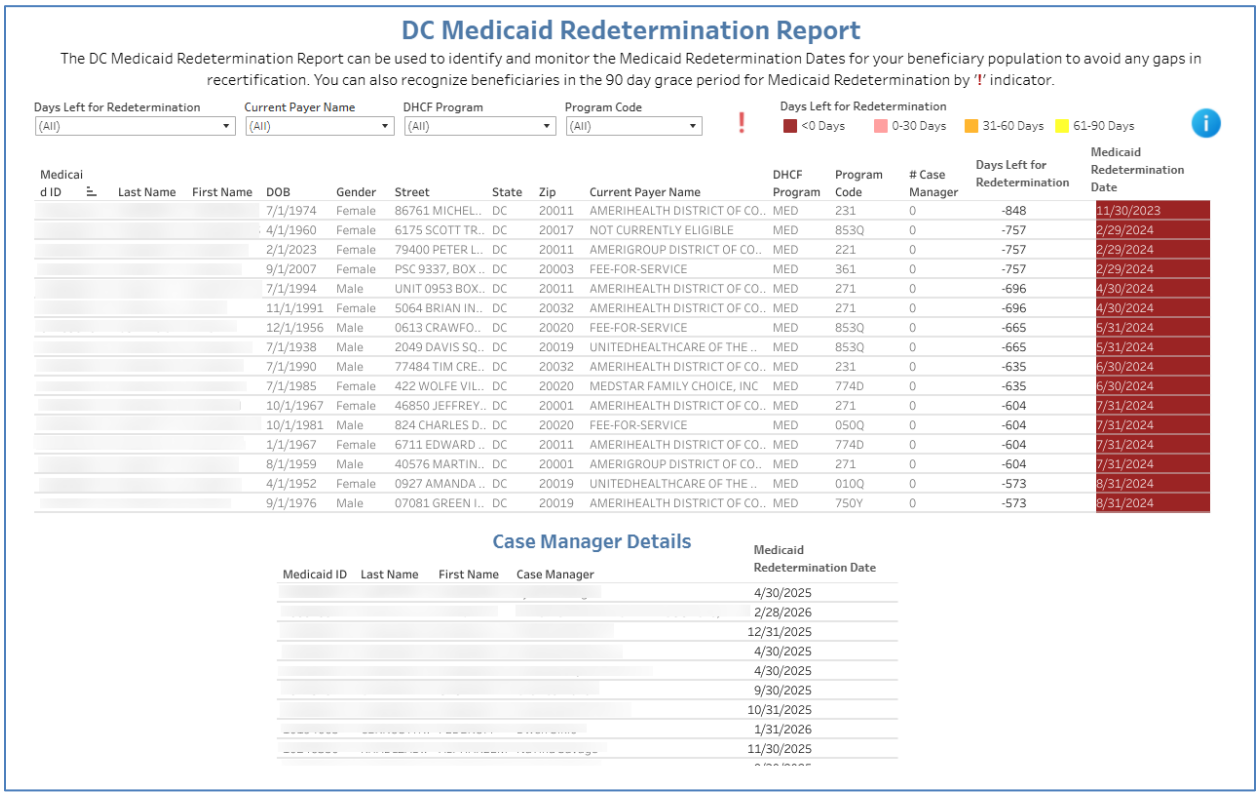
color-coded based on the urgency of the upcoming redetermination date, allowing for quick visual identification of at-risk patients.

2. **Case Manager Details Table:** A secondary table that lists beneficiaries along with their assigned Case Manager and redetermination date. This provides a quick reference for identifying which staff member is responsible for a particular patient's care coordination.

5. Functional Use Cases

1. **Prioritize Urgent Outreach:** A care coordinator filters the "Days Left for Redetermination" to "0-30 Days" to generate a high-priority worklist of patients who need immediate assistance with their recertification paperwork.
2. **Manage Gaps in Coverage:** A practice manager filters for "Days Left for Redetermination" of "<0 Days" to identify patients who may have already lost coverage, enabling targeted follow-up to help them reapply and restore their benefits.
3. **Forecast Staffing Needs:** A population health director reviews the report without date filters, sorting by "Medicaid Redetermination Date" to understand the volume of redeterminations due in upcoming months and plan staff allocation accordingly.
4. **Coordinate with Health Plans:** A provider relations specialist filters by a specific "Current Payer Name" to generate a list of at-risk members for a particular health plan, facilitating collaborative outreach efforts.
5. **Assign Unmanaged Patients:** A clinical supervisor reviews the list for patients with upcoming redetermination dates where "# Case Manager" is 0, in order to assign them to a case manager for support through the recertification process.

6. Screenshot



55. Medication Synchronization Opportunity Summary

1. Report Overview & Purpose

This report provides a summary of medication synchronization opportunities across various pharmacies. It is designed to help care managers and pharmacy liaisons identify and prioritize pharmacies with a high number of patients whose medication refills are not aligned, presenting a key opportunity to improve medication adherence and patient outcomes through targeted synchronization programs.

2. Available Filters & Interactivity

1. **Panel:** Allows the user to select the specific provider panel or group to view.
2. **Roster:** Enables filtering the report to a specific patient roster or population list.
3. **Data Drill-Through:** Users can click on a specific pharmacy row within the main data table to view the underlying patient-level details for that pharmacy. Clicking on a data point in the monthly trend chart will also likely filter to the specific patients from that month.

3. Key Metrics & KPIs

1. **Number of Patients:** The total count of unique patients associated with each pharmacy within the selected roster.
2. **Number of Out of Sync Patients:** The total number of patients at a given pharmacy whose medication fill dates are not synchronized.
3. **% Out of Sync Patients:** The percentage of a pharmacy's patients who are out of sync, calculated as (Number of Out of Sync Patients / Number of Patients). This is the primary KPI for identifying high-opportunity pharmacies.
4. **Average Days Supply:** The average number of days for which medications are prescribed for patients at each pharmacy.

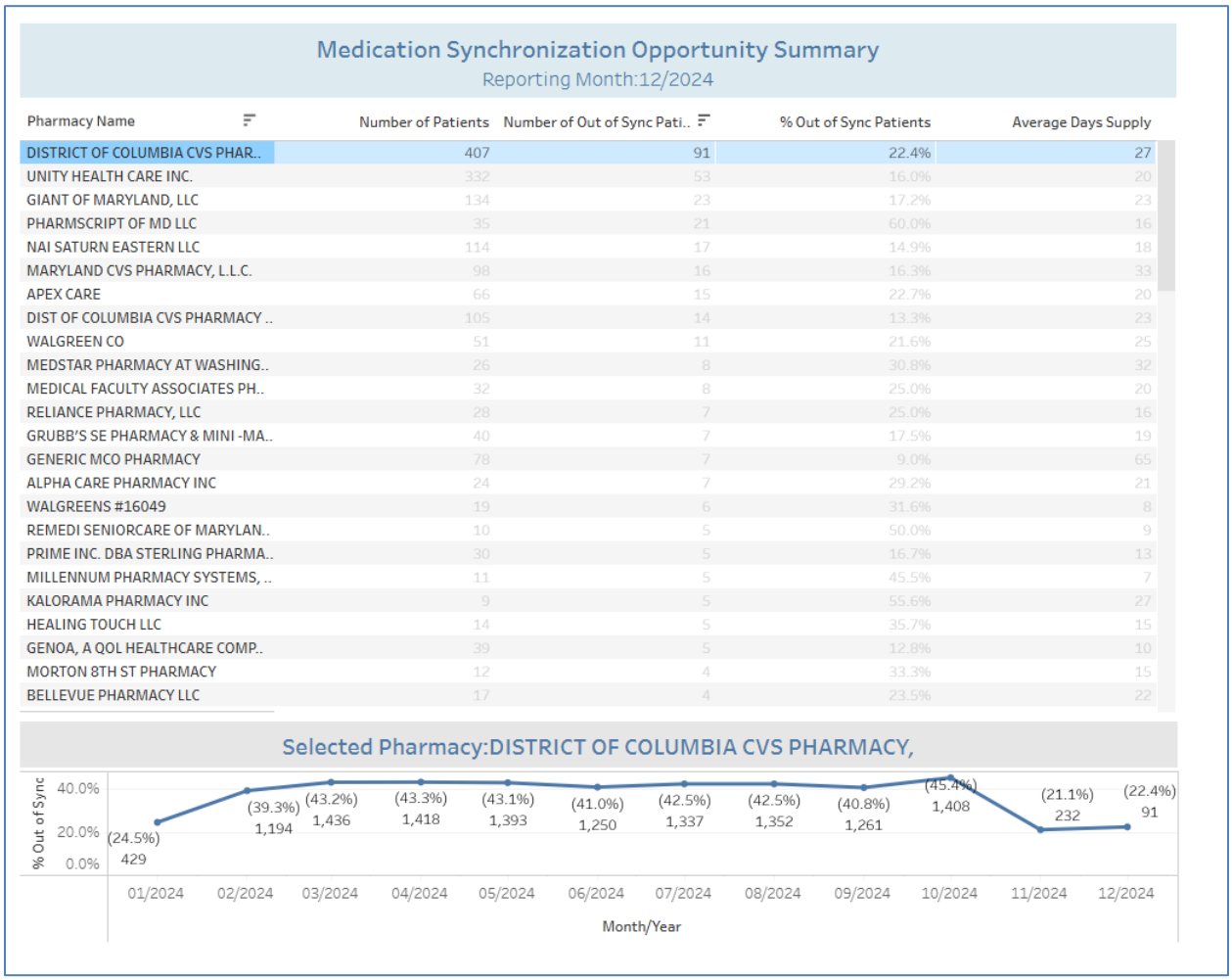
4. Visualizations & Data Tables

1. **Medication Synchronization Opportunity Table**: This is the primary data grid in the report. It lists all relevant pharmacies and ranks them based on the key metrics. The table can be sorted by any column, allowing users to prioritize pharmacies by name, total patient count, or synchronization opportunity (% or number). The currently selected pharmacy is highlighted.
2. **Selected Pharmacy Trend Chart**: A line graph at the bottom of the report that displays the historical trend of synchronization for the pharmacy selected in the table above. It plots the "% Out of Sync" and the raw "Number of Out of Sync Patients" on a month-by-month basis for the current reporting year, allowing for performance monitoring over time.

5. Functional Use Cases

1. **Prioritize High-Impact Outreach:** A care manager sorts the table by "Number of Out of Sync Patients" in descending order to identify the pharmacies with the largest volume of patients who could benefit from a med-sync program, allowing them to focus outreach efforts for maximum impact.
2. **Identify At-Risk Pharmacies:** A clinical leader sorts the table by "% Out of Sync Patients" to pinpoint pharmacies where synchronization is a systemic issue, even if the total patient count is low, in order to initiate quality improvement discussions.
3. **Monitor Program Effectiveness:** A user selects a pharmacy that recently implemented a new synchronization initiative to view its performance trend in the line chart, assessing whether the "% Out of Sync" has decreased over the past few months.
4. **Analyze Prescribing Patterns:** A pharmacy benefits manager reviews the "Average Days Supply" column to identify pharmacies with consistently low averages (e.g., less than 30 days), indicating a potential opportunity to educate providers on the benefits of 90-day fills.
5. **Generate a Targeted Campaign List:** An outreach coordinator filters the report to their specific patient roster, then uses the "Excel" button to export the data. They can then use this list to create a targeted mail or phone campaign for the top 10 pharmacies with the highest synchronization opportunity.

6. Screenshot



Pharmacy Name	Number of Patients	Number of Out of Sync Pati..	% Out of Sync Patients	Average Days Supply
DISTRICT OF COLUMBIA CVS PHAR..	407	91	22.4%	27
UNITY HEALTH CARE INC.	332	53	16.0%	20
GIANT OF MARYLAND, LLC	134	23	17.2%	23
PHARMSCRIPT OF MD LLC	35	21	60.0%	16
NAI SATURN EASTERN LLC	114	17	14.9%	18
MARYLAND CVS PHARMACY, L.L.C.	98	16	16.3%	33
APEX CARE	66	15	22.7%	20
DIST OF COLUMBIA CVS PHARMACY ..	105	14	13.3%	23
WALGREEN CO	51	11	21.6%	25
MEDSTAR PHARMACY AT WASHING..	26	8	30.8%	32
MEDICAL FACULTY ASSOCIATES PH..	32	8	25.0%	20
RELIANCE PHARMACY, LLC	28	7	25.0%	16
GRUBB'S SE PHARMACY & MINI -MA..	40	7	17.5%	19
GENERIC MCO PHARMACY	78	7	9.0%	65
ALPHA CARE PHARMACY INC	24	7	29.2%	21
WALGREENS #16049	19	6	31.6%	8
REMEDI SENIORCARE OF MARYLAN..	10	5	50.0%	9
PRIME INC. DBA STERLING PHARMA..	30	5	16.7%	13
MILLENNUM PHARMACY SYSTEMS, ..	11	5	45.5%	7
KALORAMA PHARMACY INC	9	5	55.6%	27
HEALING TOUCH LLC	14	5	35.7%	15
GENOA, A QOL HEALTHCARE COMP..	39	5	12.8%	10
MORTON 8TH ST PHARMACY	12	4	33.3%	15
BELLEVUE PHARMACY LLC	17	4	23.5%	22

56. Non-Emergent ED (NED) Use Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of non-emergent emergency department (NED) utilization for an attributed panel of beneficiaries. It is designed to help users identify high-utilizing individuals, understand the primary reasons for these visits, and benchmark performance against a selected reference group like the overall DC Medicaid population. The insights gained can be used to develop targeted interventions aimed at reducing avoidable ED visits and guiding patients to more appropriate care settings.

2. Available Filters & Interactivity

1. **Panel**: Select the specific provider panel to analyze.
2. **Roster**: Select a specific roster within the chosen panel.
3. **Start Date / End Date**: A date-range slider to define the reporting period for the analysis.
4. **Reference Group**: Select a population to compare the selected panel against (e.g., All DC Medicaid).
5. **Data Drill-Through**: As noted on the report, selecting any data point (e.g., a bar on a chart, a point on a line graph) will drill through to a detailed list of the underlying beneficiaries.

3. Key Metrics & KPIs

1. **NED Rate**: The percentage of total Emergency Department (ED) visits that were classified as non-emergent. This is the primary measure for tracking trends and comparing performance.
2. **Number of NED Visits**: The total count of non-emergent ED visits within the specified timeframe.
3. **Number of ED Visits**: The total count of all ED visits (emergent and non-emergent), used for context and rate calculation.
4. **Beneficiaries**: The number of unique individuals contributing to the NED visit counts.

4. Visualizations & Data Tables

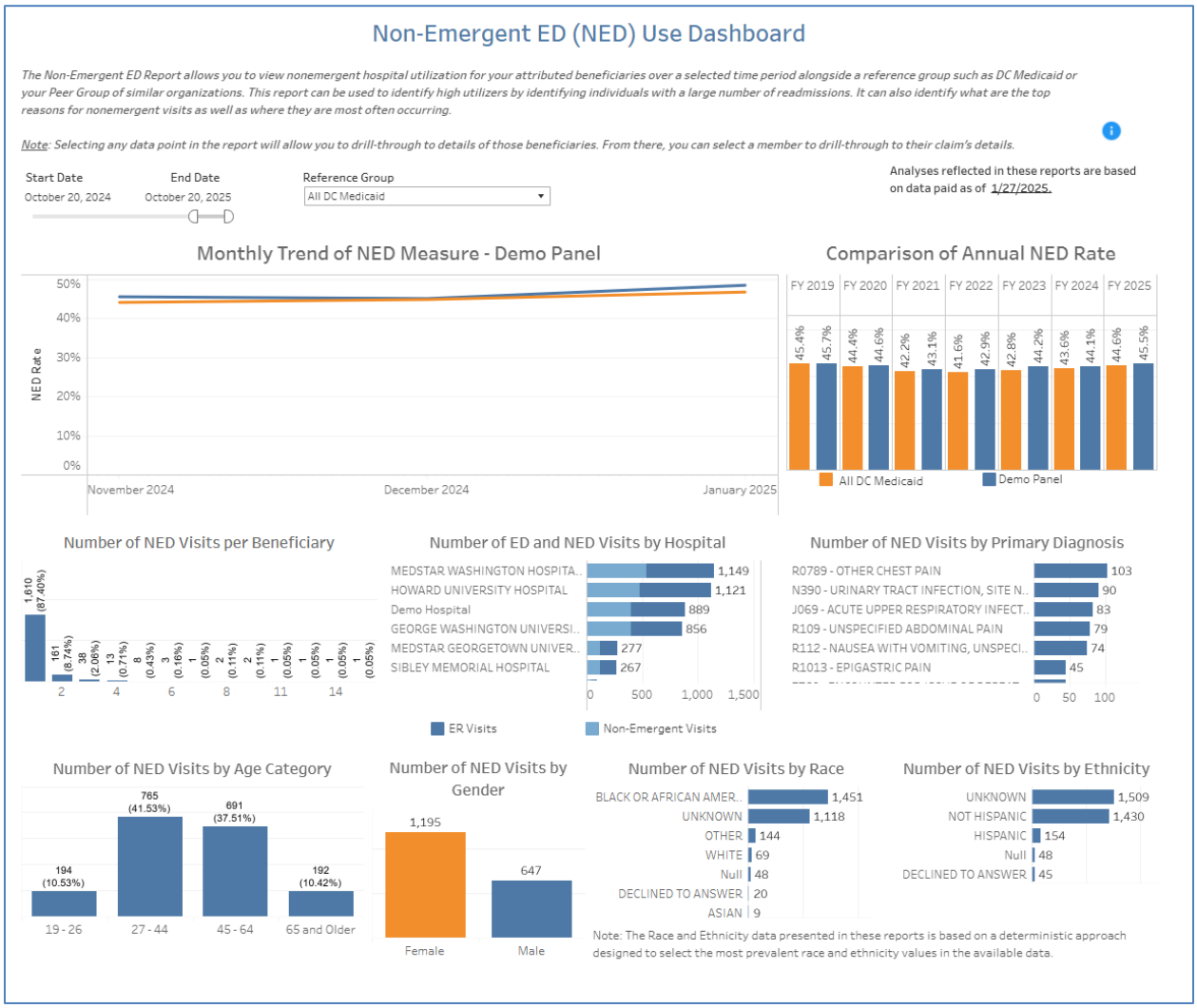
1. **Monthly Trend of NED Measure**: A line graph that tracks the NED Rate over time for both the selected panel and the reference group, allowing for trend analysis and ongoing performance monitoring.
2. **Comparison of Annual NED Rate**: A bar chart comparing the fiscal year NED Rate for the selected panel against the reference group, providing a high-level, year-over-year performance benchmark.
3. **Number of NED Visits per Beneficiary**: A bar chart that stratifies the patient population by the number of NED visits they have had, making it easy to identify frequent utilizers.

4. **Number of ED and NED Visits by Hospital**: A horizontal bar chart that displays the volume of both total ED and non-emergent ED visits at different hospitals, highlighting key locations where members seek care.
5. **Number of NED Visits by Primary Diagnosis**: A horizontal bar chart ranking the most common primary diagnoses associated with NED visits, revealing clinical drivers of utilization.
6. **Number of NED Visits by Age Category, Gender, Race, and Ethnicity**: A series of bar charts that break down the total number of NED visits by key demographic factors, helping to identify trends within specific populations.

5. Functional Use Cases

1. **Identify High-Utilizing Patients**: A care manager can click on the bars in the "Number of NED Visits per Beneficiary" chart for patients with 8, 11, or more visits to drill down to a list of these individuals for targeted case management and outreach.
2. **Benchmark Performance**: A practice administrator can use the "Comparison of Annual NED Rate" chart to see if their panel's rate (e.g., 44.1% in FY 2024) is higher or lower than the "All DC Medicaid" benchmark (43.6% in FY 2024) to assess performance.
3. **Develop Clinical Interventions**: A clinical director can review the "Number of NED Visits by Primary Diagnosis" chart, note that "Other Chest Pain" and "Urinary Tract Infection" are top reasons, and then launch initiatives to educate patients on seeking care at urgent care or their PCP for these conditions.
4. **Analyze Demographic Disparities**: A population health analyst can examine the "Number of NED Visits by Age Category" and "Race" charts to determine if specific groups, such as the 27-44 age bracket or Black or African American beneficiaries, have disproportionately high NED use, informing the need for culturally competent outreach programs.
5. **Evaluate Hospital Partnership Opportunities**: A network manager can use the "Number of ED and NED Visits by Hospital" chart to identify that Medstar Washington Hospital has the highest volume of NED visits and initiate discussions with the hospital to collaborate on ED diversion or care coordination programs.

6. Screenshot



57. Oral Evaluation for Adults (OEV) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of the Oral Evaluation for Adults (OEV) quality measure. It allows users to track the percentage of adults who received an oral evaluation over time and analyze performance across various demographics, chronic conditions, and service types to identify trends and care gaps.

2. Available Filters & Interactivity

1. **Measure Year**: Allows the user to select the specific measurement year for the report's data.
2. **Reference Group**: Enables the user to select a benchmark population (e.g., All DC Medicaid) for comparison against their selected roster.
3. **Roster**: Allows the user to select a specific patient panel or group to analyze.
4. **Data Drill-Through**: Users can click on most chart elements to navigate to a detailed, beneficiary-level view. This includes the data points on the "Oral Evaluation Performance over Time" line chart, segments of the "Oral Evaluation by Service Type" pie chart, and the bars within the "Dental Procedures," "Beneficiary Count and Cost Distribution by Provider," "Performance by Age Category and Gender," "Performance by Race," and "Performance by Ethnicity" charts. Users can also click on the values in the "Chronic Condition Distribution" table.

3. Key Metrics & KPIs

1. **Oral Evaluation Rate**: The primary metric, calculated as the percentage of adults in the selected population who received at least one oral evaluation during the measurement year.
2. **Performance by Chronic Condition**: The percentage and raw count of members with specific chronic conditions (e.g., Diabetes, Heart Failure) who have or have not received an oral evaluation.
3. **Service Type Distribution**: A breakdown of the types of oral evaluations performed, categorized as Periodic, Comprehensive, or Limited.
4. **Procedure Volume**: The total count of specific dental evaluation procedure codes rendered.
5. **Beneficiary Count by Provider**: The number of unique beneficiaries who received services from a specific dental provider.
6. **Amount Paid by Provider**: The total amount paid to a specific dental provider for services rendered to the selected population.

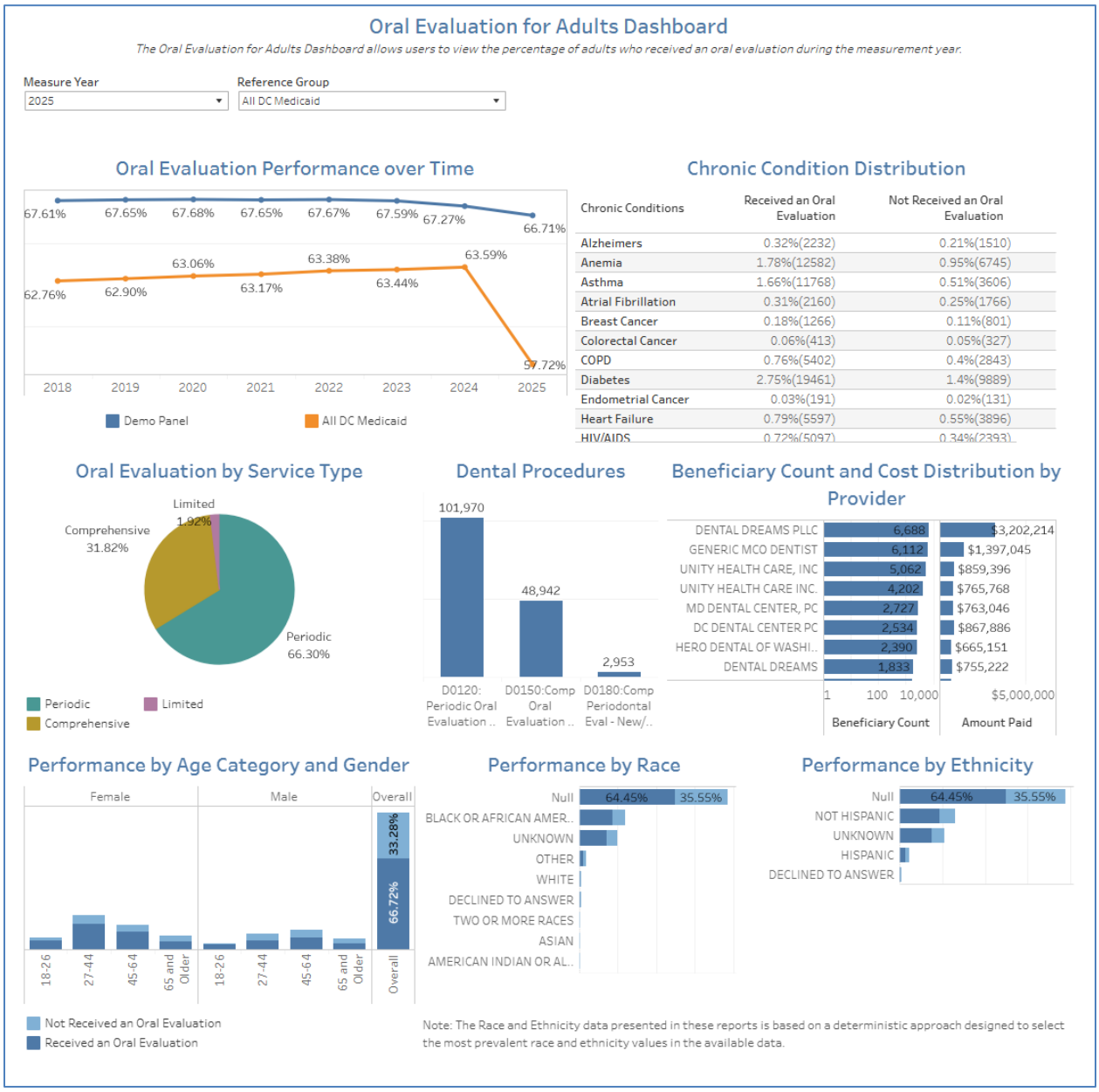
4. Visualizations & Data Tables

1. **Oral Evaluation Performance over Time**: A line chart that tracks and compares the oral evaluation rate for the selected panel against a reference group over several years.
2. **Chronic Condition Distribution**: A data table that stratifies the population by chronic condition, showing the percentage and count of members who did and did not receive an oral evaluation. This helps identify potential correlations between systemic health and dental care access.
3. **Oral Evaluation by Service Type**: A pie chart illustrating the proportion of different evaluation types, highlighting the mix of preventive (Periodic, Comprehensive) versus problem-focused (Limited) visits.
4. **Dental Procedures**: A vertical bar chart showing the volume of the most common oral evaluation procedure codes, such as D0120 (Periodic Oral Evaluation) and D0150 (Comprehensive Oral Evaluation).
5. **Beneficiary Count and Cost Distribution by Provider**: A horizontal bar chart that ranks dental providers by the number of beneficiaries they served and the corresponding total amount paid.
6. **Performance by Age Category and Gender**: A grouped bar chart comparing the rates of oral evaluation between different age groups, split by female and male beneficiaries.
7. **Performance by Race / Ethnicity**: Stacked horizontal bar charts that display the percentage of members within different racial and ethnic groups who have received an oral evaluation, helping to identify potential health disparities.

5. Functional Use Cases

1. **Track Quality Improvement**: A quality manager can monitor the "Oral Evaluation Performance over Time" chart monthly to assess the impact of a new dental health outreach campaign on their panel's performance compared to the "All DC Medicaid" average.
2. **Target High-Risk Members**: A care coordinator can use the "Chronic Condition Distribution" table to identify diabetic patients with a low rate of oral evaluations and initiate targeted outreach to schedule dental appointments, promoting integrated care.
3. **Analyze Network Adequacy**: A network manager can review the "Beneficiary Count and Cost Distribution by Provider" chart to identify the highest-volume dental providers and assess if network capacity is sufficient to meet member needs.
4. **Investigate Health Disparities**: A health equity officer can analyze the "Performance by Race" and "Performance by Ethnicity" charts to pinpoint specific demographic groups with lower-than-average oral evaluation rates and develop culturally-tailored interventions.
5. **Evaluate Service Utilization Patterns**: A clinical director can examine the "Oral Evaluation by Service Type" pie chart to determine if the majority of evaluations are for routine preventive care (Periodic) or for specific problems (Limited), informing strategies to encourage preventive visits.

6. Screenshot



58. Oral Evaluation During Pregnancy: Ages 15-20 (OEVP-CH) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of the Oral Evaluation During Pregnancy (OEVP-CH) measure for enrolled individuals aged 15-20. It allows users to track the percentage of this population with live-birth deliveries who received a timely oral evaluation. The report is designed to monitor performance against benchmarks, identify disparities in care, and understand beneficiary demographics and provider utilization.

2. Available Filters & Interactivity

1. **Panel**: Selects the specific provider panel or group to analyze.
2. **Measure Year**: Filters the report data to a specific measurement year.
3. **Reference Group**: Selects a comparison group (e.g., All DC Medicaid) to benchmark performance against.
4. **Roster**: Allows for the selection of a specific patient roster within the chosen panel.
5. **Last One Year / Full Range**: Toggles the time frame displayed in the "Monthly Performance Comparison" chart.
6. **Data Drill-Through**: Users can click on the bars or data points within any of the following charts to access a detailed, beneficiary-level view:
    a. Number of Visits by Facility
    b. Measure Performance Status
    c. Beneficiary Distribution by Categories (Social Needs, Age, Race, Ethnicity, Chronic Conditions)

3. Key Metrics & KPIs

1. **Performance Rate**: The primary metric, calculated as the percentage of eligible members (ages 15-20 with a live birth) who received a comprehensive or periodic oral evaluation during their pregnancy. This is displayed monthly and annually.
2. **Count of Beneficiaries**: The total number of beneficiaries who have and have not met the measure's criteria ("Having Oral Evaluation" vs. "Not Having Oral Evaluation").
3. **Number of Visits**: The total count of oral evaluation visits attributed to specific dental facilities.
4. **Beneficiary Demographics**: Population counts and percentages broken down by age, race, ethnicity, social needs, and chronic conditions.

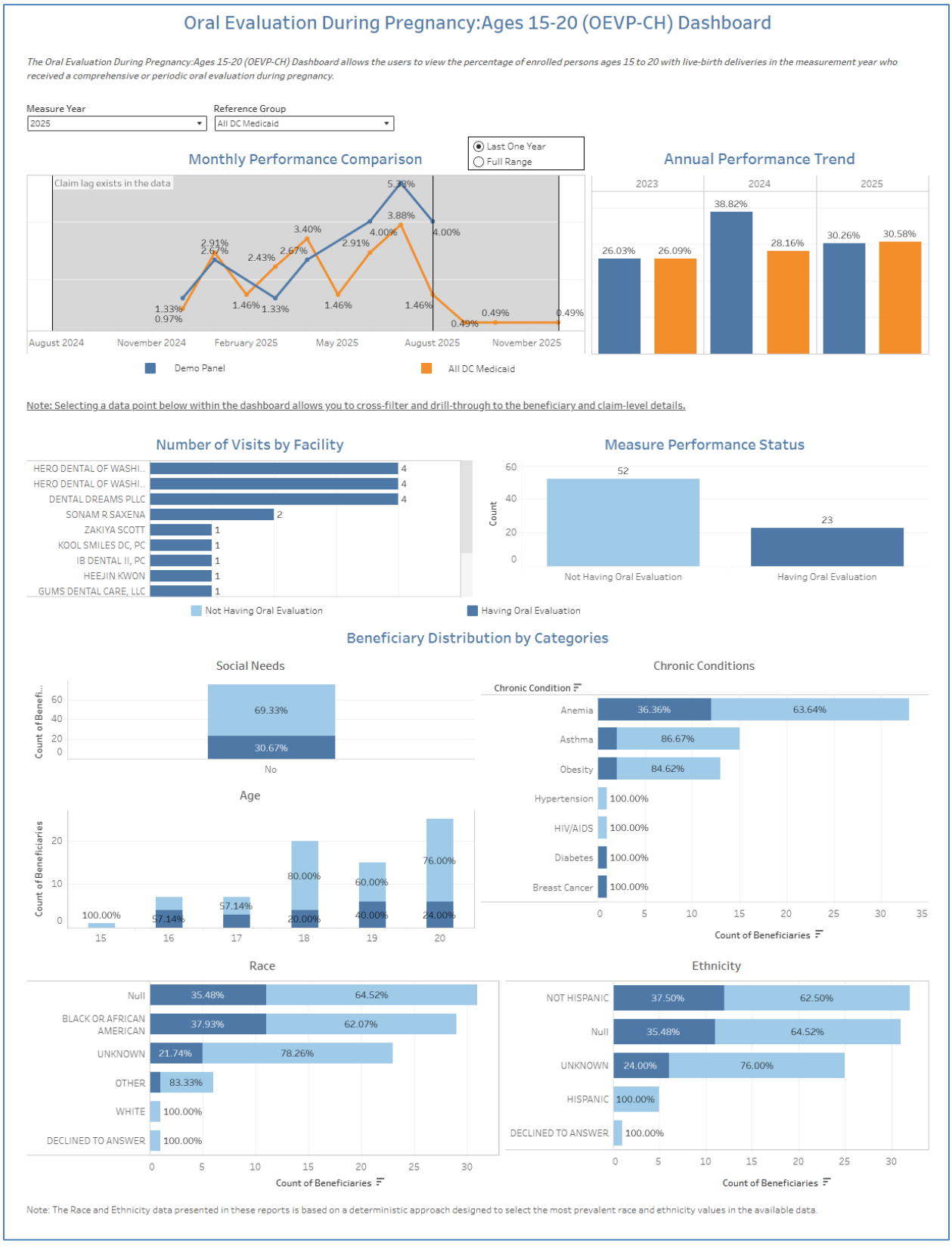
4. Visualizations & Data Tables

1. **Monthly Performance Comparison**: A line chart that tracks the panel's performance rate month-over-month and compares it to the selected Reference Group. It indicates periods where a claim lag may affect the most recent data.
2. **Annual Performance Trend**: A bar chart comparing the performance rate across multiple years (e.g., 2023, 2024, 2025) for both the selected panel and the reference group, highlighting long-term trends.
3. **Number of Visits by Facility**: A horizontal bar chart that ranks dental facilities by the volume of oral evaluation visits, identifying the most utilized providers for this service.
4. **Measure Performance Status**: A bar chart showing the total count of beneficiaries who are compliant (Having Oral Evaluation) versus non-compliant (Not Having Oral Evaluation) with the measure.
5. **Beneficiary Distribution by Categories**: A series of stacked horizontal bar charts that break down the beneficiary population by Social Needs, Chronic Conditions, Age, Race, and Ethnicity. Each bar shows the proportion of members within that category who have or have not had an oral evaluation, helping to identify potential disparities in care.

5. Functional Use Cases

1. **Monitor Monthly Performance**: A quality improvement manager can use the "Monthly Performance Comparison" chart to track their panel's progress toward OEVP-CH goals, comparing their performance to the "All DC Medicaid" average to identify any significant deviations.
2. **Identify High-Performing Providers**: A network manager can review the "Number of Visits by Facility" chart to identify dental providers who are seeing the most patients for this measure, potentially to understand best practices or strengthen referral partnerships.
3. **Target Gaps in Care by Age**: A care coordinator can analyze the "Age" distribution chart to see if a particular age group, such as 15-year-olds, has a lower rate of receiving oral evaluations and can develop targeted outreach campaigns for that specific demographic.
4. **Investigate Health Equity Concerns**: A health equity analyst can drill through the "Race" and "Ethnicity" charts to see if there are significant differences in oral evaluation rates among different groups, informing culturally competent intervention strategies.
5. **Develop Integrated Care Plans**: A case manager can use the "Chronic Conditions" chart to identify beneficiaries with conditions like Diabetes or Asthma who have not had an oral evaluation, facilitating integrated care outreach that addresses both their chronic and dental health needs.

6. Screenshot



59. Panel Demographics Report

1. Report Overview & Purpose

This report provides a comprehensive demographic, clinical, and financial overview of a selected patient panel. It is designed to help users understand the composition of their patient population, identify key trends in chronic conditions and diagnoses, and pinpoint high-risk, high-cost, and high-comorbidity members for targeted interventions.

2. Available Filters & Interactivity

1. **Start Date/End Date**: Defines the reporting period for the data displayed.
2. **DHCF Plan**: Filters the panel to show only members enrolled in a specific DHCF Plan.
3. **Gender**: Filters the panel by member gender (Male, Female, All).
4. **Age Category**: Narrows the view to a specific age group (e.g., 0 to 19, 20 to 44).
5. **Social Needs Category**: Filters members based on documented social needs categories.
6. **APR DRG**: Filters the panel for members with a specific All Patient Refined Diagnosis Related Group.
7. **Chronic Condition #1, #2, #3**: Filters for members who have up to three specific chronic conditions.
8. **CC Operator**: Sets the logical relationship between the Chronic Condition filters (e.g., OR, AND).
9. **Roster**: Allows the user to select a specific, pre-defined list of patients.
10. **Data Drill-Through**: Users can click on the bars within the "Distribution of Patients by DHCF Plan," "Age Category and Gender," "Race," and "Ethnicity" charts to view the underlying list of members. Additionally, clicking on any row within the "Chronic Conditions Distribution," "High Cost Member List," "Top 10 Diagnosis," and "High Comorbidity Member List" tables will navigate to a detailed list of the corresponding members.

3. Key Metrics & KPIs

1. **Member Count**: The total number of unique patients included in a specific category, diagnosis, or demographic group.
2. **Percentage**: The proportion of the total panel that a specific subgroup represents (e.g., the percentage of members with Hypertension).
3. **Total Claim Count**: The total number of claims submitted for a specific member within the reporting period.
4. **IP/ER/NED Visits**: Counts of Inpatient, Emergency Room, and Non-Emergent ED visits, used to measure acute care utilization.
5. **PQI Visits**: Count of Prevention Quality Indicator-related visits, which indicate visits that were avoidable with proper outpatient care.

6. **Total Amount Paid**: The sum of all paid amounts on claims for a member or a group of members, indicating the total cost of care.
7. **Total IP Admissions**: The total number of inpatient admissions for a cohort, typically grouped by primary diagnosis.
8. **PMPM**: Per Member Per Month; the average paid amount for a member cohort, normalized on a monthly basis.
9. **Chronic Condition Count**: The total number of distinct chronic conditions diagnosed for a member.

4. Visualizations & Data Tables

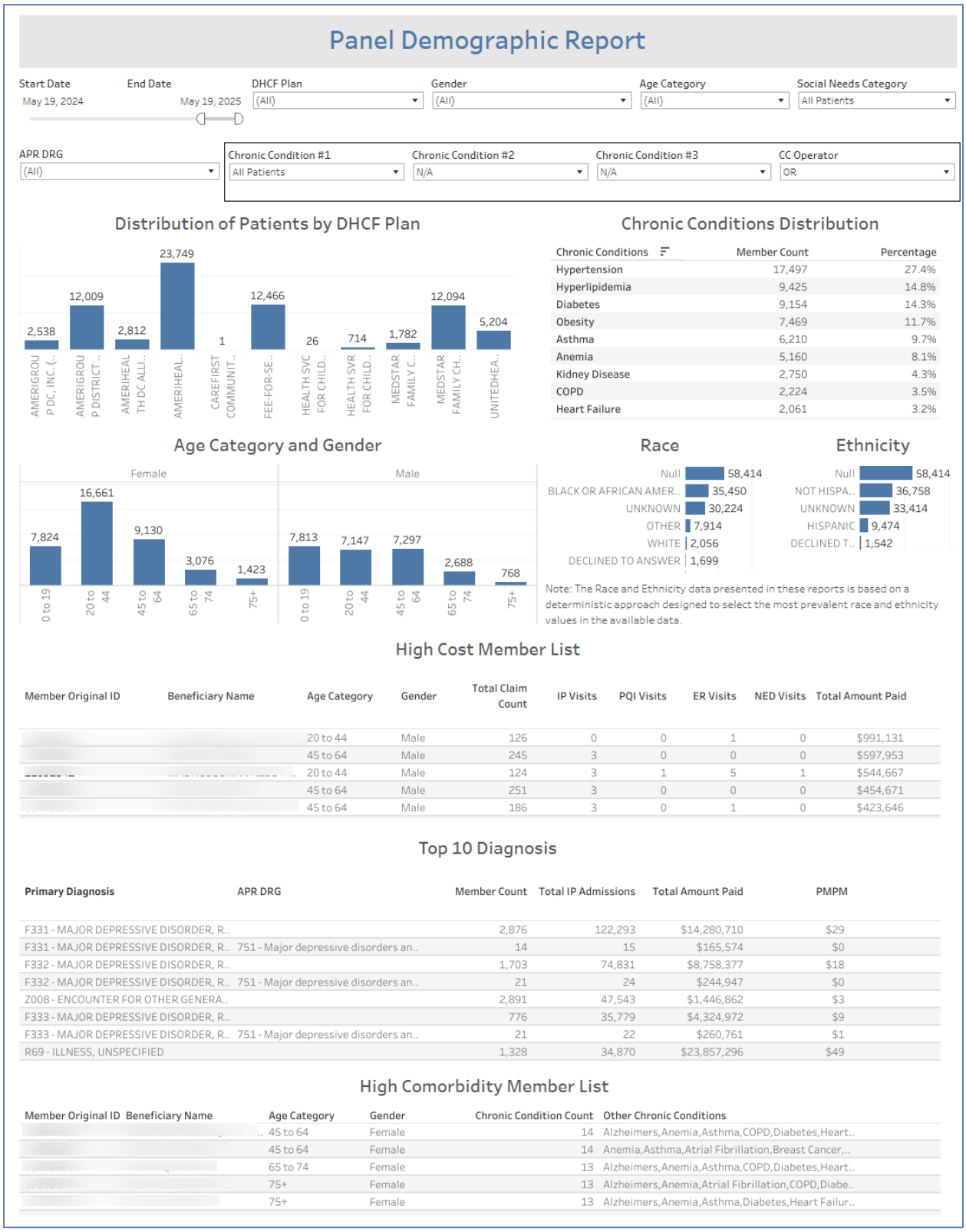
1. **Distribution of Patients by DHCF Plan**: A bar chart that displays the total number of members enrolled in each health plan, allowing for quick comparison of panel size across different payers.
2. **Chronic Conditions Distribution**: A table listing the most prevalent chronic conditions within the panel, ranked by member count, and showing the percentage of the total panel affected by each.
3. **Age Category and Gender**: A set of bar charts breaking down the panel population by age group and gender, highlighting the demographic composition of the panel.
4. **Race and Ethnicity**: Two bar charts that illustrate the racial and ethnic distribution of the patient panel.
5. **High Cost Member List**: A table identifying the top members by total healthcare spending. It includes member details, utilization metrics (IP, ER visits), and the total paid amount.
6. **Top 10 Diagnosis**: A summary table listing the most common primary diagnoses, ranked by member count. It includes associated metrics like total IP admissions, total cost, and PMPM for each diagnosis group.
7. **High Comorbidity Member List**: A table that lists members with the highest number of chronic conditions, providing their name, age, gender, and a list of their conditions.

5. Functional Use Cases

1. **Care Management Prioritization**: A care manager can use the "High Cost Member List" and "High Comorbidity Member List" to identify patients with complex needs and high spending, allowing them to prioritize these individuals for outreach and intensive case management.
2. **Population Health Program Development**: A public health analyst can review the "Chronic Conditions Distribution" and "Top 10 Diagnosis" tables to identify prevalent conditions like Hypertension and Major Depressive Disorder, justifying the need for targeted disease management programs.
3. **Assessing Health Equity**: A user can analyze the "Race" and "Ethnicity" charts in combination with the chronic condition filters to investigate potential disparities in disease prevalence across different demographic groups.

4. **Resource Planning**: A clinic administrator can view the "Age Category and Gender" distribution to understand the primary demographics of their panel, helping to ensure that staffing and services (e.g., pediatrics, geriatrics) are appropriately aligned with patient needs.
5. **Contracting and Payer Analysis**: An analyst can filter by a specific "DHCF Plan" to understand the unique risk profile and disease burden of that sub-population, which can inform conversations and contract negotiations with that health plan.

6. Screenshot



60. Pediatric Non-Emergent ED (NED) Use Dashboard

1. Report Overview & Purpose

This dashboard provides insights into non-emergent hospital utilization of the Emergency Department (ED) for an attributed pediatric beneficiary population. Its primary purpose is to help users identify high-utilizing beneficiaries, understand the primary reasons for these visits, and benchmark performance against a selected reference group like DC Medicaid. The report helps track trends and patterns to inform strategies aimed at reducing unnecessary ED use and directing patients to more appropriate care settings.

2. Available Filters & Interactivity

1. **Panel**: Drop-down menu to select the primary panel or organization whose data is being analyzed.
2. **Roster**: Drop-down menu to select a specific patient roster within the chosen panel.
3. **Start Date / End Date**: Date range slider to define the reporting period for the analysis.
4. **Reference Group**: Drop-down menu to select a comparison group for benchmarking, such as "All DC Medicaid."
5. **Data Drill-Through**: As noted on the dashboard, clicking on the bars or data points within any of the charts (e.g., "Number of NED Visits per Beneficiary", "Number of NED Visits by Primary Diagnosis", "Number of NED Visits by Age Category") will allow you to drill through to a detailed list of the underlying beneficiaries.

3. Key Metrics & KPIs

1. **NED Rate**: The percentage of total ED visits that are classified as non-emergent. This is the primary KPI for tracking the appropriateness of ED utilization.
2. **Number of NED Visits**: The total count of non-emergent ED visits within the selected time frame and population.
3. **Number of ED Visits**: The total count of all ED visits (emergent and non-emergent) for the selected population.
4. **Visits per Beneficiary**: A count of how many beneficiaries have had one, two, three, or more non-emergent ED visits, used to identify frequent utilizers.

4. Visualizations & Data Tables

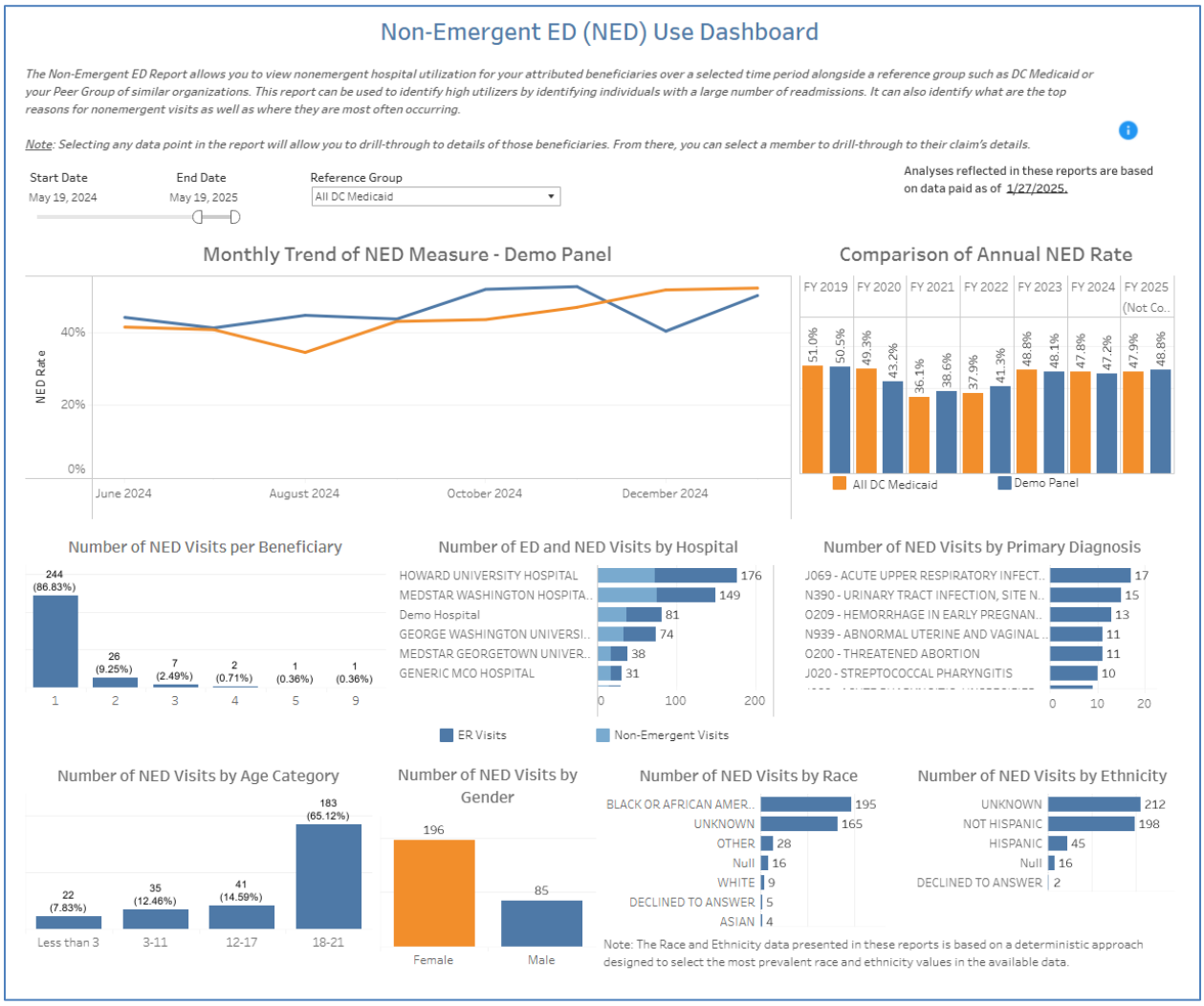
1. **Monthly Trend of NED Measure**: A line graph that tracks the NED Rate on a monthly basis, comparing the selected panel's trend (blue line) against the reference group's trend (orange line).
2. **Comparison of Annual NED Rate**: A bar chart that provides a year-over-year comparison of the annual NED Rate from FY 2019 to FY 2025, benchmarking the Demo Panel (blue bars) against the All DC Medicaid group (orange bars).

3. **Number of NED Visits per Beneficiary**: A bar chart that shows the distribution of beneficiaries by the number of NED visits they have had, highlighting the volume of single-visit vs. repeat-visit patients.
4. **Number of ED and NED Visits by Hospital**: A horizontal bar chart that lists top hospitals and displays the total volume of both ED visits and non-emergent ED visits attributed to the panel's beneficiaries at each facility.
5. **Number of NED Visits by Primary Diagnosis**: A horizontal bar chart ranking the most common primary diagnoses (e.g., Acute Upper Respiratory Infections, Urinary Tract Infection) for non-emergent ED visits.
6. **Number of NED Visits by Age Category**: A bar chart illustrating the volume of NED visits across different pediatric age groups (Less than 3, 3-11, 12-17, 18-21).
7. **Number of NED Visits by Gender**: A bar chart breaking down the total number of NED visits by gender.
8. **Number of NED Visits by Race & Ethnicity**: Two separate horizontal bar charts that display the distribution of NED visits across different racial and ethnic groups.

5. Functional Use Cases

1. **Identify and Manage High-Utilizers**: A care manager can use the "Number of NED Visits per Beneficiary" chart to click on the bar for members with "3" or more visits, drill down to the patient list, and initiate outreach to connect them with a primary care provider.
2. **Benchmark and Track Performance**: An administrator can review the "Comparison of Annual NED Rate" chart to see if their panel's rate is higher or lower than the "All DC Medicaid" average and use the "Monthly Trend" to monitor the impact of a new patient education initiative in near-real-time.
3. **Develop Targeted Clinical Interventions**: A clinical director can analyze the "Number of NED Visits by Primary Diagnosis" chart to identify that "Acute Upper Respiratory Infections" is the top reason for NED visits and launch a campaign to educate parents on managing cold symptoms at home or at an urgent care clinic.
4. **Optimize Network and Hospital Relations**: A provider network manager can use the "Number of ED and NED Visits by Hospital" chart to identify that a specific hospital has a disproportionately high volume of their panel's NED visits, prompting a collaborative discussion with that hospital about patient diversion protocols.
5. **Inform Health Equity Initiatives**: A population health analyst can examine the "Number of NED Visits by Age Category" and "by Race" charts to identify if a specific demographic (e.g., children under 3, a particular racial group) is overrepresented in NED visits, indicating a potential gap in access to primary care that needs to be addressed.

6. Screenshot



61. Pediatric Quality Measure Comparison Over Time Dashboard

1. Report Overview & Purpose

This report provides a longitudinal analysis of key pediatric quality measures. It is designed to help clinical and administrative staff track performance over time, compare current results against historical data and benchmarks, and identify trends in pediatric well-care delivery.

2. Available Filters & Interactivity

1. **Panel**: Filters the report to show data for a specific provider panel or group.
2. **Roster**: Narrows the data to a specific, pre-defined list of patients.
3. **Selected Month**: Sets the primary month for analysis in the monthly comparison table.
4. **Comparison Month**: Sets the secondary month to compare against the "Selected Month".
5. **Measure**: Filters the entire report to focus on a single pediatric quality measure.
6. **Data Drill-Through**: Users can click on the metric names or aggregated values within the "Quality Indicators" tables to navigate to a detailed, patient-level report for that specific measure and time period.

3. Key Metrics & KPIs

1. **Child and Adolescent Well Care Visits**: Tracks the rate of well-care visits for children and adolescents.
2. **Well Child Visits for Age 15 Months to 30 Months**: Measures the percentage of children in this age range who received the recommended number of well-child visits.
3. **Well Child Visits in the First 15 Months**: Measures the percentage of children who received the recommended number of well-child visits within their first 15 months of life.
4. **PDI 90-Pediatric Quality Overall Composite**: A composite score that aggregates performance across multiple pediatric quality indicators to provide an overall quality rating.
5. **Variance**: The percentage change in performance between two time periods (either month-over-month or rolling year-over-year).

4. Visualizations & Data Tables

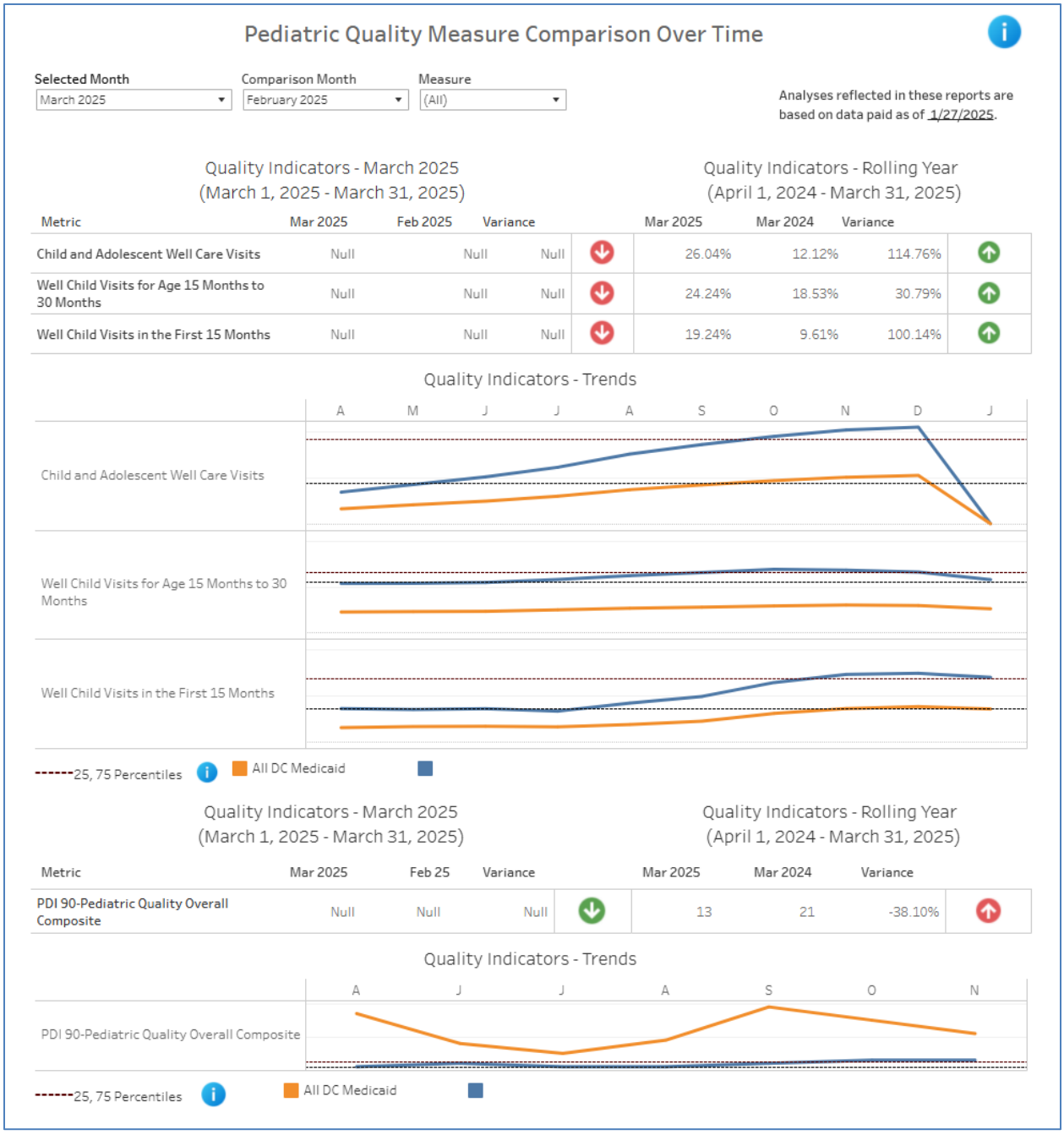
1. **Quality Indicators - March 2025**: A table comparing performance for a selected month against a comparison month. It displays the metric, the performance value for each month, and the variance.
2. **Quality Indicators - Rolling Year**: A table comparing performance for the most recent 12-month period against the prior 12-month period. It includes performance values, the calculated variance, and a red (down) or green (up) trend arrow.

3. **Quality Indicators - Trends**: A series of line charts that plots the performance of each metric over time. These charts visualize the user's selected panel/roster performance (blue line) against the "All DC Medicaid" benchmark (orange line) and the 25th and 75th percentile performance bands (dotted lines).

5. Functional Use Cases

1. **Monthly Performance Monitoring**: A practice manager selects the most recent completed month and the prior month to quickly assess short-term changes in well-child visit rates and identify any sudden performance drops.
2. **Annual Quality Review**: A quality improvement director reviews the "Rolling Year" table to evaluate year-over-year performance for the "PDI 90-Pediatric Quality Overall Composite" to report on annual quality goals.
3. **Benchmarking against Peers**: A pediatrician uses the "Trends" chart to visually compare their panel's performance on "Child and Adolescent Well Care Visits" against the "All DC Medicaid" average to understand their standing within the network.
4. **Identifying Patient Care Gaps**: A care coordinator observes a low performance rate in the "Well Child Visits in the First 15 Months" metric, clicks on the value in the table to drill through, and generates a list of non-compliant infants for outreach.
5. **Targeting Improvement Efforts**: A clinical lead analyzes all metrics and notes that "Well Child Visits for Age 15 Months to 30 Months" has the largest negative variance. They use this specific data point to prioritize and launch a recall campaign for that age group.

6. Screenshot


Pediatric Quality Measure Comparison Over Time
Selected Month
March 2025
Comparison Month
February 2025
Measure
(All)
Analyses reflected in these reports are based on data paid as of 1/27/2025.
Quality Indicators - March 2025
(March 1, 2025 - March 31, 2025)
Quality Indicators - Rolling Year
(April 1, 2024 - March 31, 2025)
Metric
Mar 2025
Feb 2025
Variance
Mar 2025
Mar 2024
Variance
Child and Adolescent Well Care Visits
Null
Null
Null
26.04%
12.12%
114.76%
Well Child Visits for Age 15 Months to 30 Months
Null
Null
Null
24.24%
18.53%
30.79%
Well Child Visits in the First 15 Months
Null
Null
Null
19.24%
9.61%
100.14%
Quality Indicators - Trends
A M J J A S O N D J
Child and Adolescent Well Care Visits
Well Child Visits for Age 15 Months to 30 Months
Well Child Visits in the First 15 Months
25, 75 Percentiles
All DC Medicaid
Quality Indicators - March 2025
(March 1, 2025 - March 31, 2025)
Quality Indicators - Rolling Year
(April 1, 2024 - March 31, 2025)
Metric
Mar 2025
Feb 25
Variance
Mar 2025
Mar 2024
Variance
PDI 90-Pediatric Quality Overall Composite
Null
Null
Null
13
21
-38.10%
Quality Indicators - Trends
A J J A S O N
PDI 90-Pediatric Quality Overall Composite
25, 75 Percentiles
All DC Medicaid

62. Pharmacy Report - Medication Adherence

1. Report Overview & Purpose

This report provides a detailed analysis of medication adherence for individuals who have received more than a 90-day supply of medication in the last six months. It utilizes the Proportion of Days Covered (PDC) metric to categorize patient adherence, with a primary threshold of 80%. The report's purpose is to help care teams identify non-adherent patients, understand demographic trends in adherence, and review medication-specific data to support targeted interventions.

2. Available Filters & Interactivity

1. **Roster**: A dropdown menu to select and view data for a specific patient roster.
2. **Chronic Condition**: A dropdown menu to filter the entire report for patients diagnosed with a specific chronic condition.
3. **Data Drill-Through**: Users can click on the segments of the Distribution of Patients by Medication Adherence donut chart or the bars within the Distribution of Patients by Age and Distribution of Patients by Gender charts to filter the High Comorbidity Member List at the bottom of the report.

3. Key Metrics & KPIs

1. **Proportion of Days Covered (PDC)**: The primary metric used to measure medication adherence. It is expressed as a percentage, and the report groups patients into several ranges (e.g., 50-60%, 80-90%) and also uses a binary classification of "PDC Less than 80%" vs. "PDC Greater than 80%".
2. **Patient/Member Count**: The total number of patients or members within a specific category, such as an adherence range, demographic group, or prescribed a particular medication.
3. **Pharmacy Claims**: The total number of pharmacy claims for a specific medication.
4. **Amount Paid**: The total dollar amount paid for claims associated with a specific medication.
5. **Avg. Days of Supply**: The average number of days a single prescription for a given medication is intended to last.
6. **Chronic Condition Count**: The number of chronic conditions diagnosed for an individual patient.

4. Visualizations & Data Tables

1. **Distribution of Patients by Medication Adherence**: A donut chart that visualizes the breakdown of the patient population into different PDC percentage categories, showing both the patient count and percentage for each segment.

2. **Distribution of Patients by Age, Gender, Race, and Ethnicity**: A series of bar charts that segment the patient population by key demographics. The Age and Gender charts are stacked to show the proportion of patients with PDC less than 80% versus greater than 80% within each group.
3. **Top 20 Medications by Claim Count**: A table that lists the 20 most frequently claimed medications. It includes data on the total Amount Paid, the number of unique Member Count on the drug, and the Avg. Days of Supply.
4. **High Comorbidity Member List with Medications Adherence**: A detailed, patient-level table that lists individuals, their Member ID, age, gender, PDC category and specific percentage, and their diagnosed chronic conditions. This table updates dynamically based on interactions with the charts above.

5. Functional Use Cases

1. **Prioritize High-Risk, Non-Adherent Patients**: A care manager clicks on the "70-80%" and "60-70%" segments of the adherence donut chart to filter the "High Comorbidity Member List" for patients with suboptimal adherence, then sorts that list by "Chronic Condition Count" to focus outreach on the most complex cases first.
2. **Analyze Demographic Adherence Gaps**: A population health analyst reviews the "Distribution of Patients by Age" chart and observes that the 45-64 age group has a significant number of patients with PDC less than 80%. This insight can be used to develop age-specific educational materials or intervention strategies.
3. **Evaluate High-Cost Medication Adherence**: A pharmacy benefits manager identifies "semaglutide" in the "Top 20 Medications" table as having a very high "Amount Paid". They can then filter the report by patients with diabetes to investigate adherence patterns for this specific high-cost drug.
4. **Prepare for Disease-Specific Program Reviews**: Before a meeting on diabetes management, a program director filters the entire report by the "Diabetes" chronic condition. This provides a focused view of adherence rates, top medications, and at-risk members within that specific population.
5. **Identify Specific Patients for Medication Reconciliation**: A clinical pharmacist uses the report to identify a patient with a high number of chronic conditions and a low PDC score (e.g., 81.14%). They can use this information to schedule a comprehensive medication review with the patient to address potential barriers to adherence.

6. Screenshot

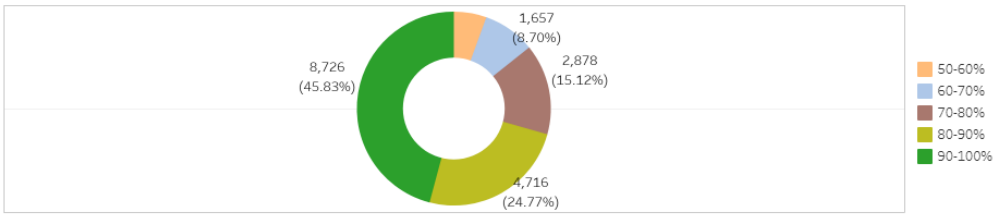
Pharmacy Report- Medication Adherence

The Pharmacy Report: Medication Adherence details medication adherence for individuals who received more than a 90-day supply of medication in the last six months. The report categorizes patients based on whether they achieved an 80% Proportion of Days Covered (PDC) threshold for their medication adherence across all relevant Multum medication categories.

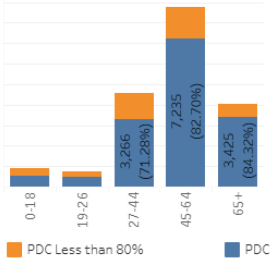
Chronic Condition: All Patients

Note: The data in this report may include medications prescribed for long-term use that do not align with current clinical guidelines.

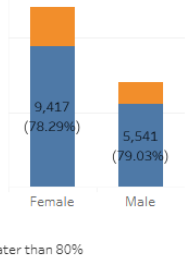
Distribution of Patients by Medication Adherence



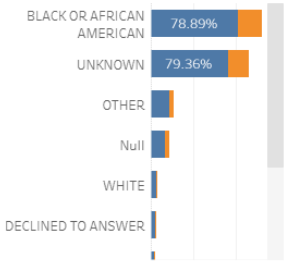
Distribution of Patients by Age



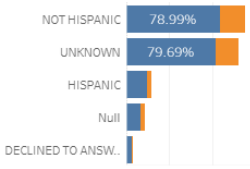
Distribution of Patients by Gender



Distribution of Patients by Race



Distribution of Patients by Ethnicity



PDC Less than 80% PDC Greater than 80%

Top 20 Medications by Claim Count

Drug Name	Category	Sub Category	Pharmacy Claims	Amount Paid	Member Count	Avg. Days of Supply
atorvastatin	Null	Null	13,915	$92,635	4,891	53
amLODIPine	Null	Null	11,862	$49,148	3,863	49
metFORMIN	Null	Null	9,690	$44,137	3,158	46
albuterol	Null	Null	8,939	$224,281	2,284	28
lisinopril	Null	Null	6,309	$31,852	2,143	52
losartan	Null	Null	6,235	$41,860	2,107	50
hydroCHLOROthia..	Null	Null	5,556	$10,248	1,827	48
gabapentin	Null	Null	5,358	$163,212	1,521	33
aspirin	Null	Null	4,842	$11,419	1,908	57
semaglutide	Null	Null	4,672	$4,707,009	1,168	30
fluticasone nasal	Null	Null	4,437	$31,636	1,560	43
cetirizine	Null	Null	4,316	$20,518	1,459	42
traZODone	Null	Null	4,256	$20,937	1,096	34
QUEtiapine	Null	Null	4,208	$34,505	854	31
sertraline	Null	Null	3,918	$22,885	988	34
metoprolol	Null	Null	3,747	$21,260	1,133	44
insulin glargine	Null	Null	3,514	$386,219	1,260	44
ergocalciferol	Null	Null	3,363	$6,680	821	32
omeprazole	Null	Null	2,988	$18,064	944	44
ibuprofen	Null	Null	2,816	$12,483	1,406	19

High Comorbidity Member List with Medications Adherence

Member Id	Beneficiary Name	Age Category	PDC Category	PDC	Gender	Chronic Condition Count	Chronic Conditions
[redacted]	[redacted]	45-64	90-100%	93.88%	Female	12	Anemia,Asthma,Atrial Fibrillation,COPD,Diab..
[redacted]	[redacted]	45-64	90-100%	98.38%	Female	12	Anemia,Asthma,Breast Cancer,COPD,Diabete..
[redacted]	[redacted]	45-64	90-100%	90.50%	Female	11	Anemia,Asthma,COPD,Diabetes,Heart Failure..
[redacted]	[redacted]	45-64	90-100%	94.00%	Female	11	Anemia,Asthma,COPD,Diabetes,Heart Failure..
[redacted]	[redacted]	45-64	90-100%	92.20%	Female	10	Anemia,Atrial Fibrillation,COPD,Diabetes,Hea..
[redacted]	[redacted]	45-64	80-90%	83.43%	Female	10	Anemia,COPD,Diabetes,Heart Failure,Hyperli..
[redacted]	[redacted]	45-64	90-100%	99.13%	Male	9	Asthma,COPD,Diabetes,Heart Failure,HIV/AID..
[redacted]	[redacted]	45-64	90-100%	93.00%	Female	8	Anemia,Asthma,COPD,Heart Failure,HIV/AIDS..
[redacted]	[redacted]	45-64	90-100%	91.67%	Male	8	Alzheimers,Anemia,Diabetes,Heart Failure,H..
[redacted]	[redacted]	45-64	80-90%	81.14%	Male	8	Anemia,COPD,Heart Failure,HIV/AIDS,Hyperli..

63. Plan All-Cause Readmissions (PCR) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of all-cause readmissions for an attributed beneficiary panel. It is designed to help users track readmission rates over time, compare performance against a reference group (like All DC Medicaid), and identify the key drivers of readmissions, including specific hospitals, APR DRGs, and patient demographics.

2. Available Filters & Interactivity

1. **Panel**: Selects the primary organization or panel for which to view data.
2. **Start Date / End Date**: Defines the reporting period for the analysis.
3. **Reference Group**: Selects a comparison group, such as "All DC Medicaid," to benchmark the panel's performance against.
4. **Panel Type**: Specifies the type of panel or attribution model being analyzed.
5. **Roster**: Narrows the analysis to a specific, pre-defined list of beneficiaries.
6. **Data Drill-Through**: Users can click on the bars within the "Beneficiary Count by Readmission", "Number of Index Visits by Hospital", "Number of Index Visits by APR DRG", and the "Beneficiary Count by Demographics" (Age, Gender, Race, Ethnicity) charts to navigate to a detailed list of the specific beneficiaries that make up those counts.

3. Key Metrics & KPIs

1. **PCR Measure / Rate**: The primary metric, representing the rate of all-cause readmissions. It is displayed as a monthly trend and as an annual comparison, calculated for the selected panel and the reference group.
2. **Beneficiary Count by Readmission**: The number and percentage of unique beneficiaries, categorized by how many times they have been readmitted (e.g., 1, 2, 3 times) within the selected period.
3. **Number of Index Visits**: The total count of initial hospitalizations (index events) that resulted in a subsequent readmission, broken down by the hospital where the index visit occurred and by the patient's APR DRG.
4. **Beneficiary Count by Demographics**: The total number of unique beneficiaries with a readmission, segmented by age, gender, race, and ethnicity.

4. Visualizations & Data Tables

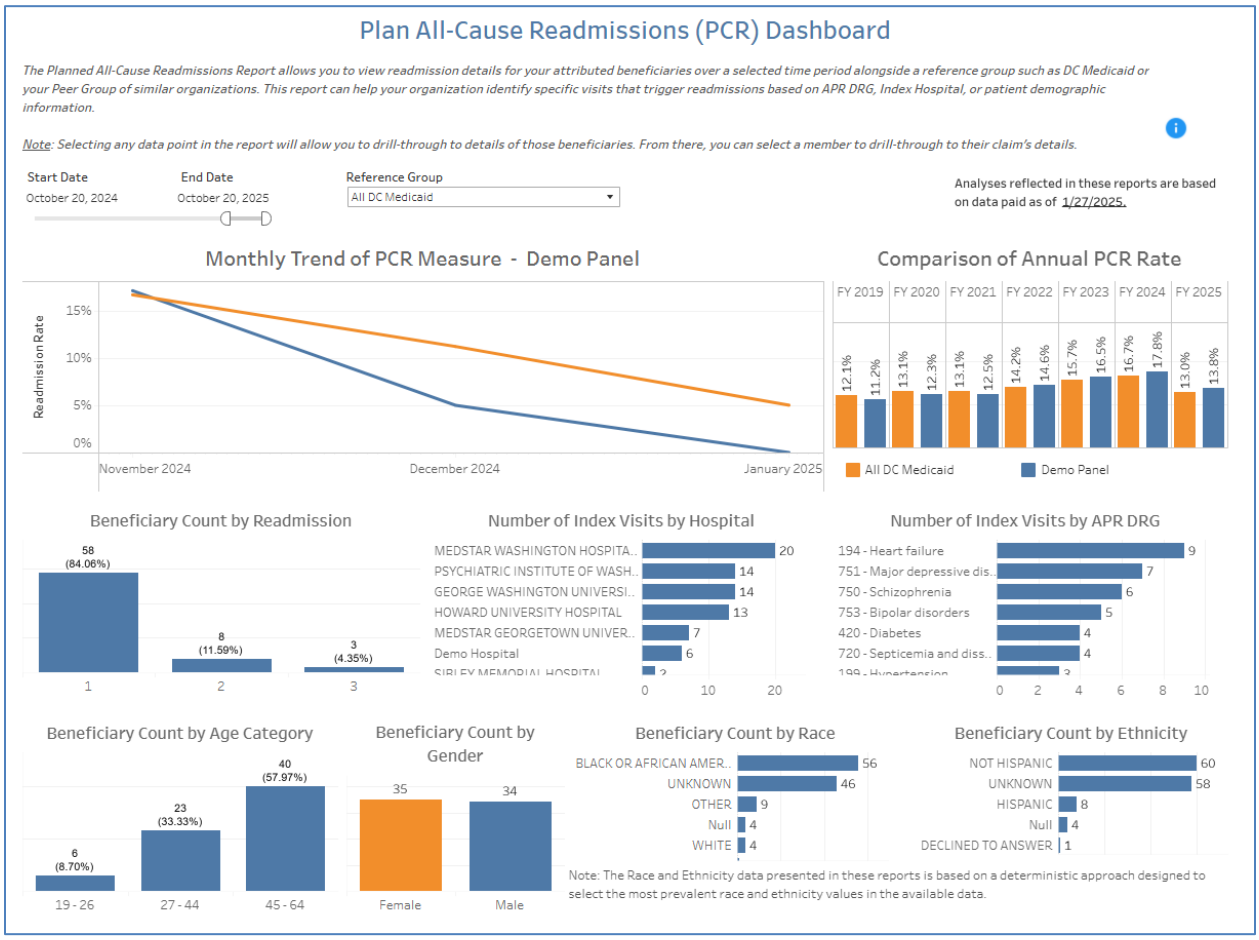
1. **Monthly Trend of PCR Measure**: A line graph that tracks the plan's readmission rate (blue line) against the selected reference group's rate (orange line) on a monthly basis, allowing for trend analysis.
2. **Comparison of Annual PCR Rate**: A bar chart that compares the plan's fiscal year-end readmission rate against the reference group's rate for the past three years.

3. **Beneficiary Count by Readmission**: A bar chart illustrating the distribution of readmissions among the beneficiary population, highlighting how many patients have had one or multiple readmissions.
4. **Number of Index Visits by Hospital**: A horizontal bar chart that ranks the hospitals where the initial (index) admission occurred, identifying facilities with the highest volume of visits leading to readmission.
5. **Number of Index Visits by APR DRG**: A horizontal bar chart that ranks the clinical conditions (APR DRGs) associated with the index admission, pinpointing the top diagnoses that precede a readmission.
6. **Beneficiary Count by Demographics**: A set of four bar charts that provide a demographic breakdown of the readmitted patient population by Age Category, Gender, Race, and Ethnicity.

5. Functional Use Cases

1. **Performance Benchmarking**: A quality director can use the "Comparison of Annual PCR Rate" chart to assess their panel's performance against the "All DC Medicaid" benchmark over the last three years to identify long-term trends and report on quality goals.
2. **Targeting High-Risk Patients**: A care manager can examine the "Beneficiary Count by Readmission" chart and drill through on beneficiaries with 2 or more readmissions to create a high-risk list for intensive case management and intervention.
3. **Informing Hospital Partnerships**: An administrator can use the "Number of Index Visits by Hospital" chart to identify that a particular hospital is a major source of index stays leading to readmissions and initiate a collaboration to improve care transition protocols.
4. **Developing Clinical Programs**: A clinical lead can analyze the "Number of Index Visits by APR DRG" chart to see that "Schizophrenia" is the leading cause for readmissions, providing data-driven evidence to support a new behavioral health post-discharge program.
5. **Health Equity Analysis**: A population health analyst can review the "Beneficiary Count by Demographics" charts to determine if readmissions are disproportionately affecting specific age, race, or ethnic groups, guiding the development of targeted and culturally appropriate outreach initiatives.

6. Screenshot



64. Plan All-Cause Readmissions (PCR) Dashboard - Hospital Users

1. Report Overview & Purpose

This dashboard provides a comprehensive view of all-cause readmissions for a selected hospital and time period. It allows users to track readmission rate trends, benchmark performance against the DC Medicaid average, and identify key drivers of readmissions, including patient demographics, primary diagnoses (APR DRG), and index hospital locations. The primary purpose is to support quality improvement initiatives aimed at reducing preventable readmissions.

2. Available Filters & Interactivity

1. **Start Date / End Date**: A date range selector that allows the user to define the reporting period for the analysis.
2. **Index Hospital Name**: A drop-down menu to select the specific hospital for which to view readmission data.
3. **Data Drill-Through**: Users can click on the data points within any of the following charts to navigate to a detailed, beneficiary-level view of the underlying patient and claims data:
    a. Monthly Trend of PCR Measure
    b. Comparison of Annual PCR Rate
    c. Beneficiary Count by Readmission
    d. Number of Index Visits by Readmitting Hospital
    e. Number of Index Visits by APR DRG
    f. Beneficiary Count by Age Category
    g. Beneficiary Count by Gender
    h. Beneficiary Count by Race
    i. Beneficiary Count by Ethnicity

3. Key Metrics & KPIs

1. **Readmission Rate**: The percentage of index hospitalizations that are followed by a subsequent inpatient admission within a defined period. This is the central performance measure, tracked monthly and annually.
2. **Beneficiary Count**: The total number of unique beneficiaries who have had one or more readmissions within the selected timeframe, often broken down by demographic or clinical categories.
3. **Number of Index Visits**: The total count of initial hospital stays (index events) that resulted in a readmission. This metric helps quantify the volume of events driving the readmission rate.

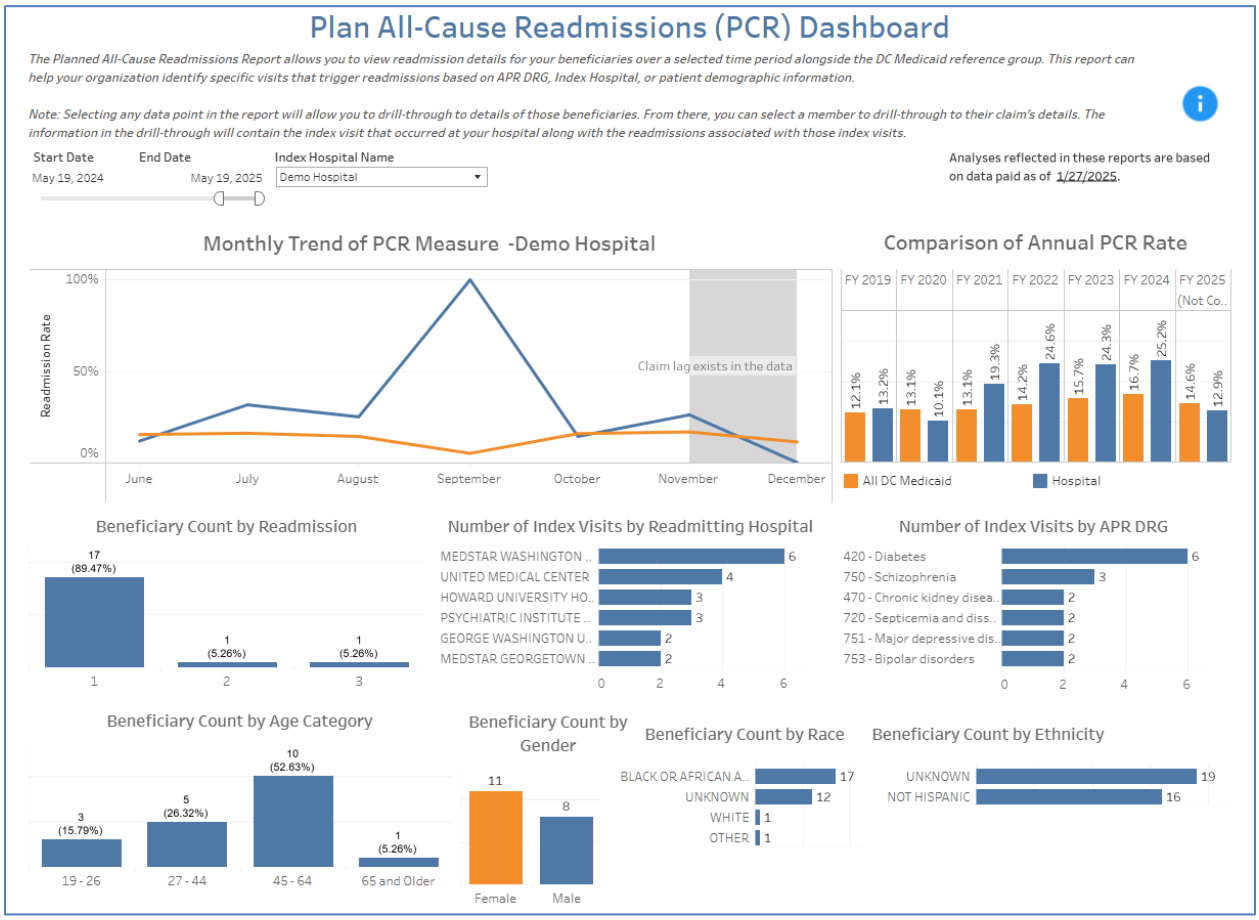
4. Visualizations & Data Tables

1. **Monthly Trend of PCR Measure**: A line chart that plots the hospital's readmission rate against the All DC Medicaid benchmark on a month-by-month basis, enabling the identification of trends, seasonality, or sudden spikes.
2. **Comparison of Annual PCR Rate**: A grouped bar chart comparing the hospital's annual readmission rate to the All DC Medicaid average for multiple fiscal years, providing a high-level performance benchmark over time.
3. **Beneficiary Count by Readmission**: A bar chart that segments the readmitted patient population by the number of times they were readmitted (e.g., 1, 2, 3 times), highlighting frequent utilizers.
4. **Number of Index Visits by Readmitting Hospital**: A horizontal bar chart that ranks the hospitals where the index (initial) admission occurred for readmitted patients.
5. **Number of Index Visits by APR DRG**: A horizontal bar chart that identifies the top All Patient Refined Diagnosis Related Groups (APR DRGs) from the index admission, revealing the clinical conditions most frequently leading to readmission.
6. **Demographic Breakdowns**: A series of bar charts that display the distribution of readmitted beneficiaries by **Age Category**, **Gender**, **Race**, and **Ethnicity**, helping to identify at-risk populations.

5. Functional Use Cases

1. **Benchmark Performance**: A Quality Improvement director can view the "Comparison of Annual PCR Rate" chart to assess their hospital's FY 2024 readmission rate (25.2%) against the DC Medicaid average (14.6%) to set performance improvement goals for the upcoming year.
2. **Identify High-Risk Conditions**: A Care Management leader can analyze the "Number of Index Visits by APR DRG" chart to discover that Diabetes (420) and Schizophrenia (750) are top drivers of readmissions, prompting the development of specialized post-discharge follow-up programs for these patient cohorts.
3. **Analyze Monthly Fluctuations**: A hospital administrator can use the "Monthly Trend of PCR Measure" chart to investigate the cause of a sharp spike in readmissions during September by drilling through on that data point to review the specific patient cases.
4. **Target Population Health Interventions**: A population health manager can observe in the "Beneficiary Count by Age Category" chart that the 45-64 age group has the highest volume of readmissions (10 beneficiaries), and use this insight to tailor transition-of-care support for that demographic.
5. **Address Readmission Frequency**: A discharge planning supervisor can use the "Beneficiary Count by Readmission" chart to identify the small cohort of patients with 2 or 3 readmissions and drill through to conduct a detailed case review to prevent future events.

6. Screenshot



65. Postpartum Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive overview of postpartum care utilization, costs, and adherence to recommended follow-up schedules. It is designed to help care managers, quality improvement teams, and administrators monitor the timeliness of postpartum visits, analyze the financial aspects of postpartum services, and identify gaps in patient care following delivery.

2. Available Filters & Interactivity

1. **Panel**: Allows the user to select a specific provider panel or group.
2. **Start Date / End Date**: A date range slider to filter the report's data for a specific time period.
3. **Chronic Condition**: A dropdown menu to filter the patient population by specific chronic conditions.
4. **Roster**: Enables selection of a specific patient roster for analysis.
5. **Cost Measure**: A dropdown menu within the "Cost Distribution" chart to change the cost metric being displayed (e.g., Total Cost).
6. **Data Drill-Through**: Users can click on the bars in the "Distribution of First Postpartum Visits" chart, the segments of the "Cost Distribution for Postpartum Services" donut chart, and the sections of the "Percent of Patients Receiving Recommended Postpartum Care" stacked bar charts to navigate to a detailed list of beneficiaries or claims.

3. Key Metrics & KPIs

1. **Number of First Postpartum Visits**: The total count of initial postpartum visits, categorized by the number of weeks that have passed since delivery.
2. **Cost of Postpartum Services**: The total expenditure on postpartum care, broken down by service category. The report displays both the dollar amount and the percentage contribution of each category (e.g., Physician Visits, Procedures, Drugs).
3. **Percentage of Patients with Postpartum Visits**: This metric measures patient adherence to recommended postpartum care. It is displayed for the overall patient population, as well as for specific timeframes critical for patient health (within 2 weeks and within 6 weeks of delivery).

4. Visualizations & Data Tables

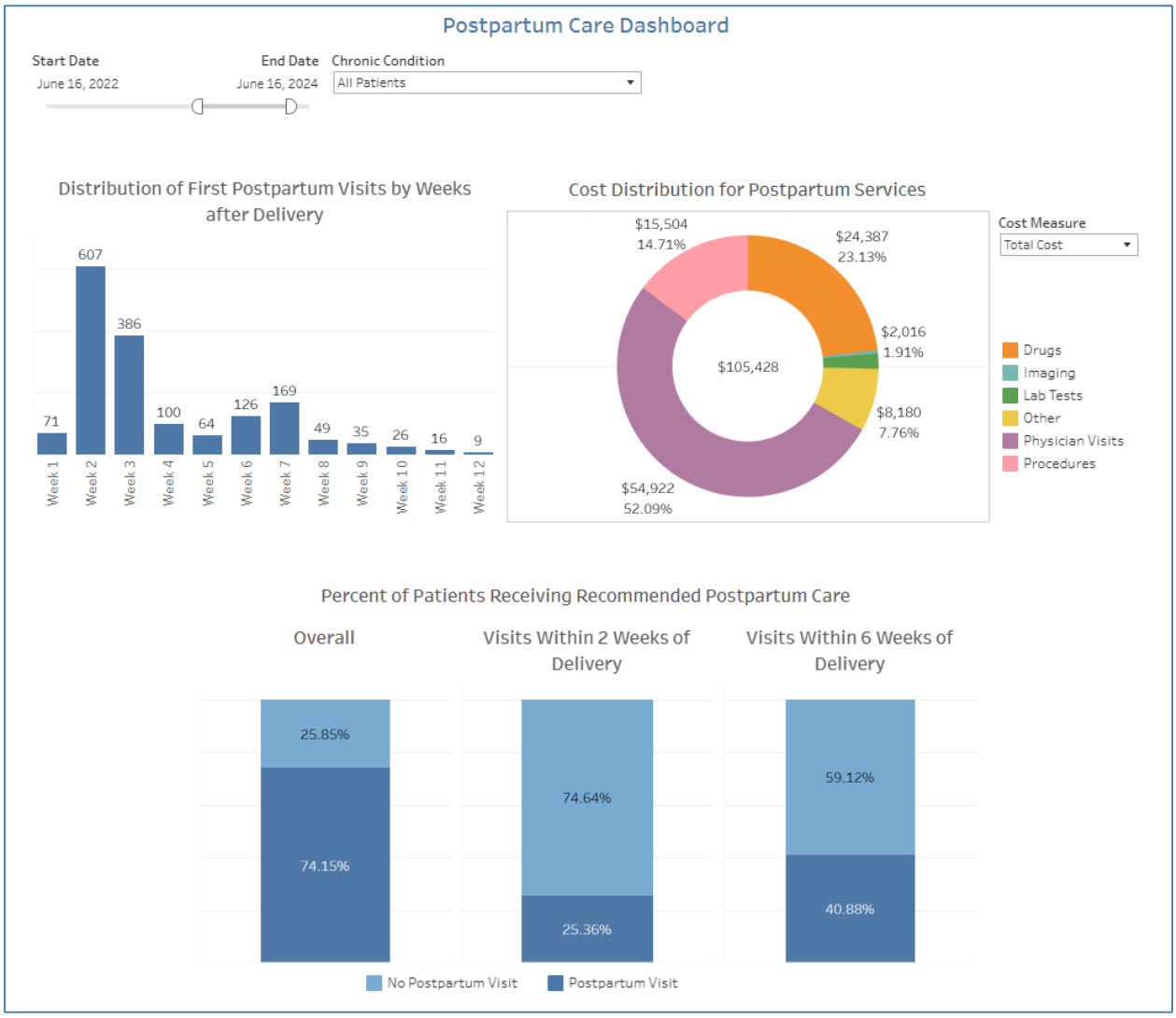
1. **Distribution of First Postpartum Visits by Weeks after Delivery**: This bar chart illustrates the volume of initial postpartum visits occurring each week for the first 12 weeks after delivery. It helps identify peak times for follow-up care and potential delays in patient visits.

2. **Cost Distribution for Postpartum Services**: A donut chart that breaks down the total cost of postpartum care into distinct service categories: Physician Visits, Procedures, Drugs, Imaging, Lab Tests, and Other. Each segment shows the total cost and its corresponding percentage of the overall expenditure.
3. **Percent of Patients Receiving Recommended Postpartum Care**: This section contains three stacked bar charts that visualize patient adherence. The charts compare the percentage of patients who received a postpartum visit versus those who did not for three distinct cohorts: "Overall," "Visits Within 2 Weeks of Delivery," and "Visits Within 6 Weeks of Delivery."

5. Functional Use Cases

1. **Monitor Timeliness of Care**: A care manager can use the "Distribution of First Postpartum Visits" chart to track whether patients are receiving their initial check-up within the clinically recommended window (e.g., by week 3).
2. **Analyze Cost Drivers**: A practice administrator can review the "Cost Distribution" donut chart to understand which services, such as "Physician Visits" or "Procedures," contribute most to postpartum care costs and identify opportunities for cost management.
3. **Track Quality Measure Performance**: A quality improvement specialist can use the "Visits Within 6 Weeks of Delivery" chart to monitor performance on HEDIS measures related to postpartum care and identify the need for interventions to improve follow-up rates.
4. **Identify Gaps in Care**: A population health manager can filter by a specific roster and analyze the "Overall" chart (showing 25.85% with No Postpartum Visit) to quantify the care gap and target specific patient groups for outreach.
5. **Evaluate Program Effectiveness**: After launching a patient reminder campaign, a user can filter the dashboard to the post-campaign date range to see if there is an increase in the "Percent of Patients Receiving Recommended Postpartum Care" within 2 and 6 weeks, thereby measuring the campaign's impact.

6. Screenshot



66. Pregnancy Dashboard: Delivery Outcomes

1. Report Overview & Purpose

This dashboard provides a comprehensive overview of pregnancy delivery outcomes for a selected patient population. It is designed to help clinical and administrative users analyze trends related to delivery types, associated costs, gestational age, and hospital-level performance. The report enables the monitoring of key maternal health metrics to support quality improvement and cost management initiatives.

2. Available Filters & Interactivity

1. **Roster:** Allows the user to select a specific patient cohort or panel for analysis.
2. **Start Date/End Date:** A date range slider to define the time period for the delivery data included in the report.
3. **Chronic Condition:** Filters the patient population to include only those with a specific diagnosed chronic condition.
4. **Cost Measure:** A drop-down menu (shown with "Total Cost" selected) that changes the financial metric displayed in the "Cost by Delivery Type" visualization.
5. **Data Drill-Through:** Users can click on the segments of the donut charts (Number of Deliveries, Cost by Delivery Type) or the bars/bar segments within the charts (Gestational Age, Number of Babies, Number of Deliveries by Hospital Name) to navigate to a detailed, beneficiary-level report.

3. Key Metrics & KPIs

1. **Number of Deliveries by Delivery Type:** The total count of deliveries, segmented into Cesarean and Vaginal births.
2. **Cost by Delivery Type:** The total cost associated with deliveries, broken down by Cesarean and Vaginal births. The specific cost metric can be adjusted using the "Cost Measure" filter.
3. **Gestational Age at Time of Delivery:** The distribution of deliveries across different weeks of gestation, highlighting the volume of preterm, term, and post-term births.
4. **Number of Babies by Outcome:** A count of babies categorized by outcome (Live Birth, Non-Live Birth) and by birth type (Single, Twins, Triplets).
5. **Deliveries by Hospital:** A comparative metric showing the volume of deliveries performed at different hospitals, segmented by delivery type.

4. Visualizations & Data Tables

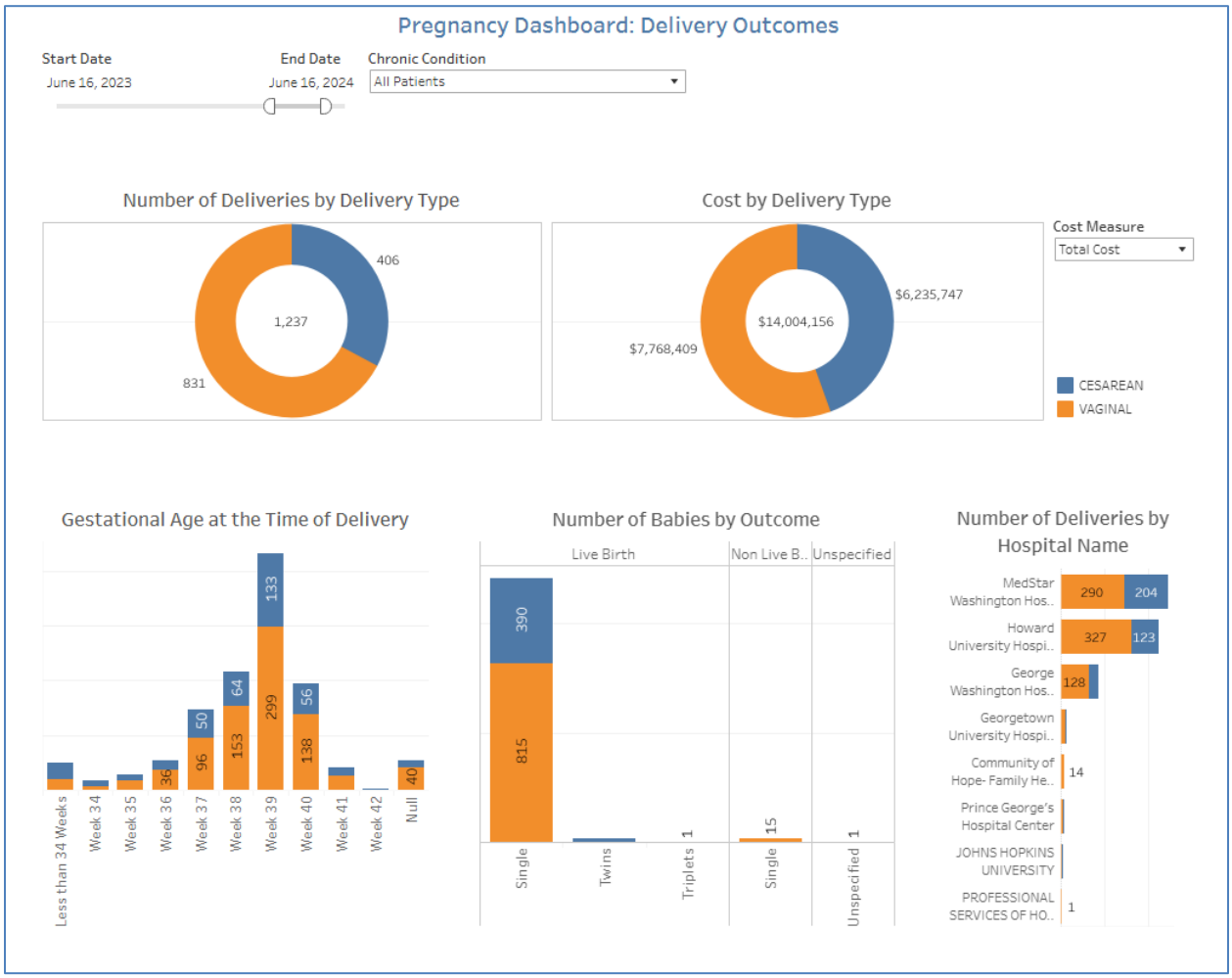
1. **Number of Deliveries by Delivery Type:** A donut chart visualizing the proportion and count of Vaginal versus Cesarean deliveries within the selected population.

2. **Cost by Delivery Type:** A donut chart that displays the financial impact of different delivery methods, showing the total cost for Vaginal and Cesarean procedures.
3. **Gestational Age at the Time of Delivery:** A stacked bar chart illustrating the number of deliveries that occurred at each week of gestation, from less than 34 weeks to 42 weeks. Each bar is segmented by delivery type, allowing for analysis of C-section rates at different gestational ages.
4. **Number of Babies by Outcome:** A stacked bar chart that categorizes births by outcome (e.g., Live Birth) and type (e.g., Single, Twins), with bars segmented by delivery method.
5. **Number of Deliveries by Hospital Name:** A horizontal stacked bar chart that ranks hospitals by the total number of deliveries. Each hospital's bar is color-coded to show the breakdown between Vaginal and Cesarean deliveries, facilitating inter-facility comparisons.

5. Functional Use Cases

1. **Monitor Cesarean Rates:** A quality improvement manager can use the "Number of Deliveries by Hospital Name" chart to identify hospitals with a disproportionately high rate of Cesarean births compared to vaginal births for further review and intervention.
2. **Analyze Preterm Birth Trends:** A perinatal care coordinator can filter by a specific date range and use the "Gestational Age at the Time of Delivery" chart to track the volume of births occurring before 37 weeks to assess the effectiveness of preterm birth prevention programs.
3. **Evaluate Maternity Care Costs:** A financial analyst can use the "Cost by Delivery Type" chart in conjunction with the "Cost Measure" filter to compare the total costs, average costs, or other financial metrics between Cesarean and Vaginal deliveries to inform payer negotiations.
4. **Assess Outcomes for High-Risk Populations:** A population health strategist can use the "Chronic Condition" filter to select a cohort (e.g., patients with hypertension) and analyze all dashboard metrics to understand delivery patterns and outcomes for that specific high-risk group.
5. **Inform Patient Referral Patterns:** A care manager can review the "Number of Deliveries by Hospital Name" chart to understand delivery volumes and types at various facilities, helping to guide patient referrals based on hospital experience with specific types of deliveries.

6. Screenshot



67. Pregnancy Dashboard: Maternal Demographics

1. Report Overview & Purpose

This report provides a demographic and clinical overview of a pregnant beneficiary population. It is designed to help care managers, clinicians, and public health officials identify key characteristics of expectant mothers, including age, race, ethnicity, geographic location, and prevalent chronic conditions. The dashboard supports population health initiatives by highlighting potential high-risk groups and informing resource allocation for maternal health programs.

2. Available Filters & Interactivity

1. **Roster:** Allows the user to select a specific patient panel or group.
2. **Start Date / End Date:** Filters the report to include data for beneficiaries within the specified time frame.
3. **Chronic Condition:** Narrows the view to display only beneficiaries diagnosed with a selected chronic condition.
4. **Prenatal Visits:** Filters the population based on the status of their prenatal care or pregnancy (e.g., Completed Pregnancies).
5. **Data Drill-Through:** Users can click on the bars within the 'Maternal Age Distribution', 'Beneficiary by Race', and 'Beneficiary by Ethnicity' charts, or on the rows in the 'Maternal Chronic Condition Distribution' table, to navigate to a detailed list of the beneficiaries that comprise that specific segment. The shaded areas on the 'Number of Pregnant Women by Neighborhood' map may also support drill-through to a patient list for that geographic area.

3. Key Metrics & KPIs

1. **Maternal Age Distribution:** The total count of pregnant women segmented into specific age brackets (e.g., 0-19, 20-32, 33-44, 45-64).
2. **Maternal Chronic Condition Distribution:** The count and percentage of pregnant women diagnosed with specific chronic health conditions, such as Obesity, Anemia, or Hypertension.
3. **Beneficiary Count by Race:** The total number of pregnant women categorized by their self-identified race.
4. **Beneficiary Count by Ethnicity:** The total number of pregnant women categorized by their self-identified ethnicity.
5. **Number of Pregnant Women by Neighborhood:** A geographic count indicating the concentration of pregnant beneficiaries in different neighborhoods.

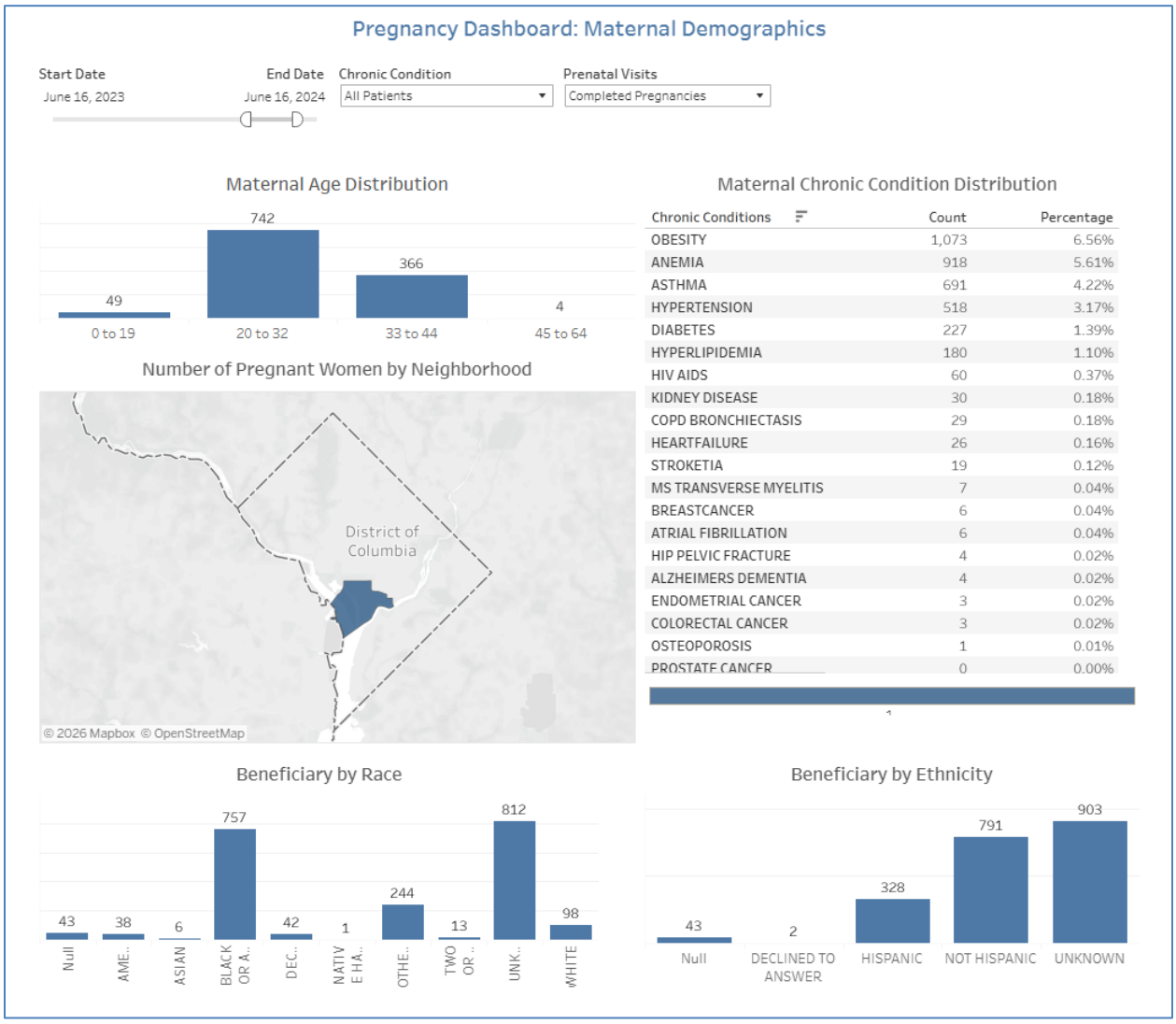
4. Visualizations & Data Tables

1. **Maternal Age Distribution:** A bar chart that visualizes the age breakdown of the pregnant population. In the provided view, the 20-32 age group represents the largest cohort.
2. **Number of Pregnant Women by Neighborhood:** A map of the District of Columbia where shading intensity corresponds to the volume of pregnant women, allowing for quick identification of high-density areas.
3. **Maternal Chronic Condition Distribution:** A table that ranks chronic conditions by prevalence within the cohort. It lists the condition, the absolute count of affected individuals, and the corresponding percentage of the total population.
4. **Beneficiary by Race:** A bar chart illustrating the racial composition of the patient panel.
5. **Beneficiary by Ethnicity:** A bar chart displaying the ethnic makeup of the patient panel, with categories including Hispanic, Not Hispanic, and Unknown.

5. Functional Use Cases

1. **Identify High-Risk Pregnancies:** A care manager can use the 'Maternal Age Distribution' chart to identify the number of adolescent (0-19) or advanced maternal age (33+) patients who may require more intensive monitoring or specialized care.
2. **Plan Targeted Interventions:** A public health planner can analyze the 'Maternal Chronic Condition Distribution' table to find the most common comorbidities (e.g., Obesity, Anemia, Hypertension) and design targeted wellness and disease management programs for pregnant women.
3. **Optimize Community Outreach:** A community health organization can use the 'Number of Pregnant Women by Neighborhood' map to pinpoint areas with high concentrations of expectant mothers to strategically deploy resources like mobile health vans or local educational workshops.
4. **Investigate Health Disparities:** A health equity analyst can use the 'Beneficiary by Race' and 'Beneficiary by Ethnicity' charts in conjunction with the Chronic Condition filter to explore the prevalence of certain conditions among different demographic groups and identify potential inequities in care or outcomes.
5. **Track Cohort Demographics Over Time:** A program manager can use the date filters to monitor changes in the demographic and clinical profile of their pregnant population on a quarterly or yearly basis to assess the impact of their programs.

6. Screenshot



68. Prenatal Care Dashboard

1. Report Overview & Purpose

This report provides a comprehensive overview of prenatal care activities for a selected patient population. It focuses on the timing of the initial prenatal visit, the cost distribution of services, and patient adherence to recommended visit schedules throughout pregnancy. The primary purpose is to help care managers and providers identify gaps in care, monitor costs, and improve maternal health outcomes by ensuring timely and consistent prenatal engagement.

2. Available Filters & Interactivity

1. **Panel:** Selects the specific data panel or organizational view.
2. **Roster:** Filters the dashboard to a specific list of patients or a provider's panel.
3. **Start Date / End Date:** Defines the time period for the analysis using a date range slider.
4. **Chronic Condition:** Filters the patient population based on the presence of a specific chronic condition.
5. **Prenatal Visits:** Filters the data to show metrics for different pregnancy statuses, such as "Completed Pregnancies".
6. **Cost Measure:** Toggles the cost distribution chart between different financial metrics, such as "Total Cost".
7. **Data Drill-Through:** Users can click on the bars within the "Gestational Age for the First Prenatal Visit" chart, the segments of the "Cost Distribution for Prenatal Services" donut chart, and the segments of the "Percent of Patients Receiving Recommended Prenatal Visits" stacked bar charts to navigate to a detailed list of the patients comprising that specific metric.

3. Key Metrics & KPIs

1. **Gestational Age at First Prenatal Visit:** This metric counts the number of patients initiating prenatal care, categorized by the gestational week of their first visit. It helps track how early in their pregnancy patients are engaging with the healthcare system.
2. **Cost Distribution for Prenatal Services:** This KPI breaks down the total cost of prenatal care into categories, such as "Non-ED Visits" and "Procedures". It provides insight into the primary drivers of prenatal care expenses.
3. **Recommended Prenatal Visit Compliance:** This metric measures the percentage of patients who attended a recommended prenatal visit versus those who did not within specific gestational week ranges (<28, 28-31, 31-34, 34-37, >37). It is a key indicator of care adherence throughout the pregnancy.

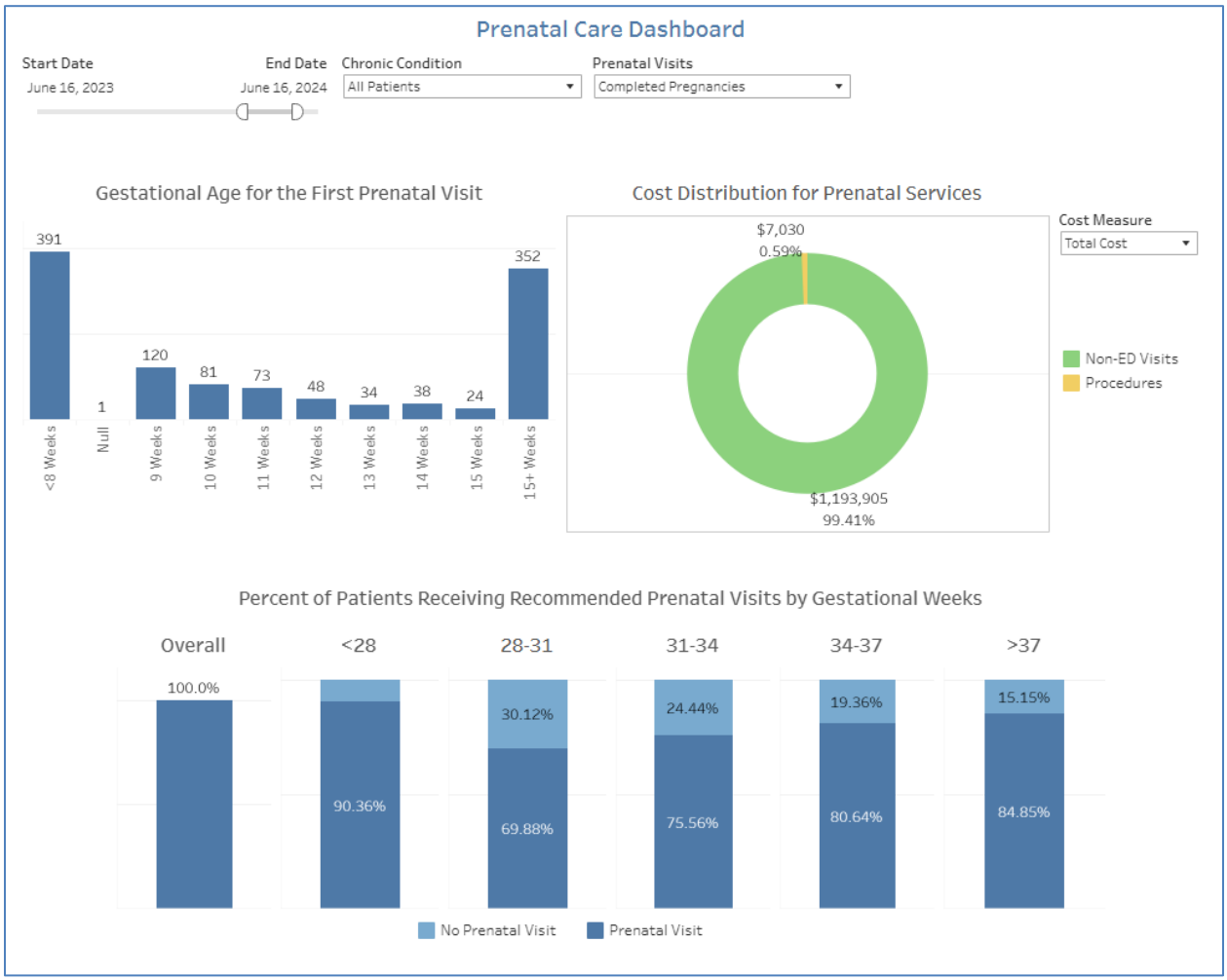
4. Visualizations & Data Tables

1. **Gestational Age for the First Prenatal Visit:** A bar chart that displays the number of patients based on when they had their first prenatal visit. The chart highlights that the largest groups initiated care either very early (<8 Weeks) or late (15+ Weeks).
2. **Cost Distribution for Prenatal Services:** A donut chart illustrating the financial breakdown of prenatal services. It shows the total dollar amount and percentage for "Non-ED Visits" versus "Procedures," indicating that routine visits constitute the vast majority of the total cost.
3. **Percent of Patients Receiving Recommended Prenatal Visits by Gestational Weeks:** A series of stacked bar charts that visualize patient compliance with recommended visits across different stages of pregnancy. The visualization shows that while compliance is high in the <28 weeks period, the percentage of patients with "No Prenatal Visit" (the lighter blue segment) increases as the pregnancy progresses.

5. Functional Use Cases

1. **Identify Late Entry to Care:** A care coordinator can review the "Gestational Age for the First Prenatal Visit" chart to identify the number of patients starting care after the first trimester (e.g., 13+ weeks) and drill through to that patient list to initiate targeted outreach.
2. **Analyze High-Risk Population Adherence:** A population health manager can use the "Chronic Condition" filter to select for "Hypertension" or "Diabetes" and then analyze the "Percent of Patients Receiving Recommended Prenatal Visits" to ensure this high-risk group is adhering to their visit schedule.
3. **Monitor Provider Roster Performance:** A practice manager can select their specific clinic from the "Roster" filter to assess how their providers are performing on key metrics, such as getting patients in for an initial visit before 8 weeks, compared to the overall organizational average.
4. **Investigate Cost Drivers:** A financial analyst can use the "Cost Distribution" chart to understand the primary expenses in the prenatal care bundle. If "Procedures" costs were unexpectedly high, they could drill down to review the specific claims driving that expense.
5. **Target Care Gaps in Late Pregnancy:** A quality improvement lead can observe the trend in the "Percent of Patients Receiving Recommended Prenatal Visits" chart, notice the compliance drop-off in the ">37" weeks category, and drill down to see which patients are missing these crucial late-term visits to implement a reminder campaign.

6. Screenshot



69. Prenatal Immunization Status (PRS) Dashboard

1. Report Overview & Purpose

The Prenatal Immunization Status (PRS) Dashboard tracks the percentage of deliveries in the measurement period in which members had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations. The report allows users to compare performance over time and against a reference group, and to analyze beneficiary demographics to identify care gaps.

2. Available Filters & Interactivity

1. **Measure Year**: A drop-down menu to select the year for which to view the performance data.
2. **Reference Group**: A drop-down menu to select a comparison group for the performance metrics (e.g., All DC Medicaid).
3. **Roster**: A drop-down menu to select a specific provider roster to filter the dashboard data.
4. **Time Range Toggle**: Radio buttons to select the time frame for the "Monthly Performance Comparison" chart, either "Last One Year" or "Full Range".
5. **Data Drill-Through**: Users can click on the data points within the **Monthly Performance Comparison** line chart, the bars in the **Annual Performance Trend**, **Number of Visits by Facility**, **Measure Performance Status**, and the various **Beneficiary Distribution** charts to drill through to a detailed, beneficiary-level view.

3. Key Metrics & KPIs

1. **Prenatal Immunization Rate**: The primary KPI, calculated as the percentage of deliveries where the member received both influenza and Tdap vaccinations during the specified period. This is displayed in the monthly and annual trend charts.
2. **Count of Visits by Facility**: The total number of patient visits associated with this measure, categorized by the healthcare facility.
3. **Measure Performance Status**: The total count of beneficiaries who received the required vaccinations versus those who did not.
4. **Beneficiary Demographics**: A breakdown of the patient population by social needs, age, race, ethnicity, and chronic conditions, showing the vaccination status for each subgroup.

4. Visualizations & Data Tables

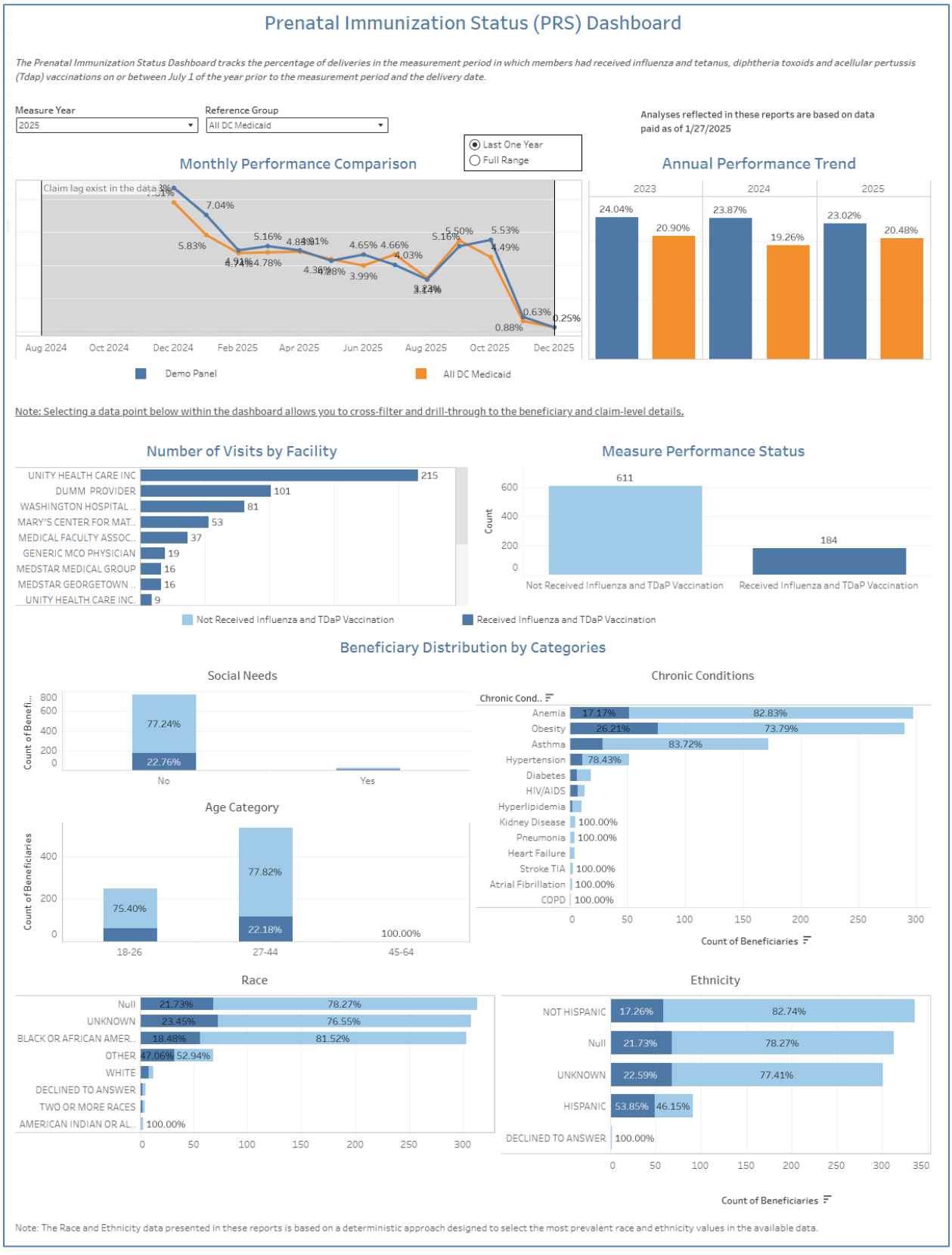
1. **Monthly Performance Comparison**: A line graph that trends the prenatal immunization rate on a monthly basis, comparing the selected panel's performance (blue line) against the reference group (orange line).

2. **Annual Performance Trend**: A bar chart comparing the immunization rates for the selected panel (blue bars) and the reference group (orange bars) across the last three years.
3. **Number of Visits by Facility**: A horizontal bar chart that ranks facilities by the total number of visits. Each bar is stacked to show the proportion of patients who received the vaccination versus those who did not.
4. **Measure Performance Status**: A bar chart showing the total count of beneficiaries in two categories: "Not Received Influenza and Tdap Vaccination" and "Received Influenza and Tdap Vaccination".
5. **Beneficiary Distribution by Categories**: A series of horizontal stacked bar charts that segment the beneficiary population by Social Needs, Age, Race, Ethnicity, and Chronic Conditions. Each chart visualizes the count and percentage of beneficiaries within each category who have or have not received the required immunizations.

5. Functional Use Cases

1. **Monitor Monthly Performance**: A practice manager can use the "Monthly Performance Comparison" line chart to track their panel's vaccination rate month-over-month against the "All DC Medicaid" benchmark to assess the impact of recent quality improvement initiatives.
2. **Identify High-Need Patient Groups**: A care coordinator can analyze the "Beneficiary Distribution" charts (e.g., Age Category, Race, Ethnicity) to identify specific demographic groups with lower-than-average vaccination rates and drill through to create a targeted outreach list.
3. **Evaluate Facility-Level Performance**: A quality improvement director can review the "Number of Visits by Facility" chart to identify which clinics have the highest volume and success rates for prenatal immunizations, in order to share best practices across the network.
4. **Analyze Gaps for Patients with Chronic Conditions**: A clinician can examine the "Chronic Conditions" chart to see if pregnant patients with conditions like Asthma or Diabetes have different immunization rates, helping to inform integrated care protocols.
5. **Conduct Annual Performance Review**: A leadership team can use the "Annual Performance Trend" bar chart to review year-over-year performance, set future goals, and demonstrate long-term improvement in prenatal care quality.

6. Screenshot



70. Prescription of HIV Antiretroviral Therapy (ART) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of Antiretroviral Therapy (ART) utilization among patients diagnosed with HIV. It is designed to help clinical and administrative users monitor the percentage of HIV patients who are prescribed ART, track performance over time, and identify potential disparities in care across different demographic groups.

2. Available Filters & Interactivity

1. **Measure Year:** Allows the user to select the specific measurement year for which to view the data.
2. **Chronic Condition:** Filters the patient population based on co-occurring chronic conditions.
3. **Suppressed Viral Load:** Filters patients based on their viral load status (e.g., suppressed, not suppressed, or all).
4. **Roster:** Allows users to filter the report to a specific list or panel of patients (e.g., by provider or care manager).
5. **Data Drill-Through:** Users can click on the KPI boxes (HIV Patients, HIV Patients taking ART Medications), the numbers within the "Performance...over Measure Years" table, and the individual bars within the "Age Category and Gender," "Race," "Ethnicity," and "Percentage of HIV Patients taking ART Medications" charts to navigate to a detailed, patient-level report.

3. Key Metrics & KPIs

1. **HIV Patients:** The total count of active patients with a diagnosis of HIV within the selected measure year.
2. **HIV Patients taking ART Medications:** The total number of patients from the "HIV Patients" cohort who have been prescribed ART medications.
3. **ART Drug Utilization Rate:** The primary performance metric, calculated as the percentage of total HIV patients who are taking ART medications.
4. **Comparison with Previous Year:** A trend indicator (up arrow for increase, down arrow for decrease, circle for no change) that shows how the current ART Drug Utilization Rate compares to the rate from the prior year.

4. Visualizations & Data Tables

1. **ART Utilization of HIV Patients for the Measure Year:** A set of three large KPI tiles at the top of the report that prominently display the core metrics (total HIV Patients, number of patients on ART, and the overall Utilization Rate) for the selected year.

2. **Performance of Prescription of HIV Antiretroviral Therapy Measure over Measure Years:** This table provides a longitudinal view of the key metrics, showing the number of HIV patients, patients on ART, and the utilization percentage for each year from 2018 to 2025. It includes a "Comparison with Previous Year" column with trend icons.
3. **Percentage of HIV Patients taking ART Medications:** A horizontal bar chart that breaks down the most commonly prescribed ART medications. It shows the percentage of the patient population taking each specific drug.
4. **ART Utilization of HIV Patients by Demographics:** This section contains three combination bar-and-line charts to visualize utilization rates across different demographics: Age Category and Gender, Race, and Ethnicity.

5. Functional Use Cases

1. **Track Annual Performance Goals:** A program manager can review the "Performance...over Measure Years" table to monitor the year-over-year ART utilization rate.
2. **Identify Disparities in Care:** A quality improvement director can analyze the "ART Utilization of HIV Patients by Demographics" charts to identify specific populations with lower-than-average treatment rates.
3. **Analyze Medication Prescribing Patterns:** A pharmacy director can use the "Percentage of HIV Patients taking ART Medications" chart to understand which drugs are most frequently prescribed.
4. **Conduct Targeted Patient Outreach:** A care manager can use the "Roster" filter to view their specific patient panel and drill through to specific segments.
5. **Investigate Low-Performing Segments:** A clinical lead can focus their investigation by examining demographic charts for specific years.

6. Screenshot

Prescription of HIV Antiretroviral Therapy (ART) Dashboard

The Prescription of HIV Antiretroviral Therapy (ART) Dashboard allows you to view the percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year.
HIV antiretroviral therapy is described as the prescription of atleast one U.S. Food and Drug Administration approve HIV antiretroviral medication. The list of ART Medications for calculating the measure is available at https://hivinfo.nih.gov/understanding-hiv/fact-sheets/fda-approved-hiv-medicines

Measure Year: 2021 | Chronic Condition: All Patients | Suppressed Viral Load: (All)

ART Utilization of HIV Patients for the Measure Year-2021

1,298 HIV Patients

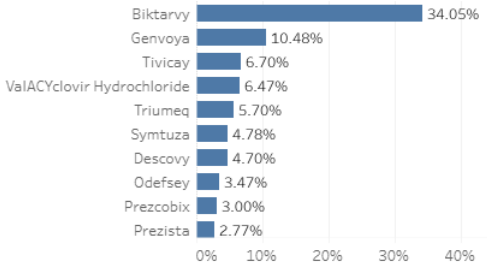
891 HIV Patients taking ART Medications

68.64% ART Drug Utilization Rate

Performance of Prescription of HIV Antiretroviral Therapy Measure over Measure Years

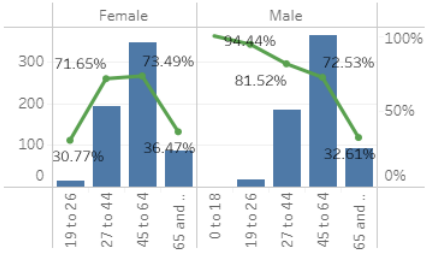
Measure Year	HIV Patients	HIV Patients Taking ART Medication	Percentage	Comparison with Previous Year
2018	1,010	775	76.73%	
2019	1,390	1,020	73.38%	↓
2020	1,470	1,060	72.11%	↓
2021	1,298	891	68.64%	↓
2022	1,433	1,031	71.95%	↑
2023	1,307	867	66.34%	↓
2024	1,544	1,085	70.27%	↑
2025	607	330	54.37%	↓

Percentage of HIV Patients taking ART Medications

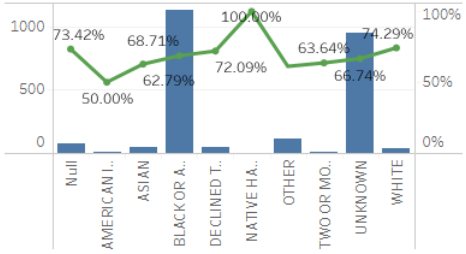


ART Utilization of HIV Patients by Demographics

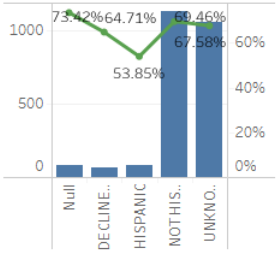
Age Category and Gender



Race



Ethnicity



HIV Patients
HIV Patients taking ART Medications

Note: The Race and Ethnicity data presented in these reports is based on a deterministic approach designed to select the most prevalent race and ethnicity values in the available data.

71. Prevention Quality Indicators (PQI) Dashboard

1. Report Overview & Purpose

The Prevention Quality Indicators (PQI) Dashboard identifies inpatient hospital admissions that could have been potentially avoided with higher quality and more accessible outpatient care. This report helps users pinpoint gaps in care by analyzing admissions for care-sensitive conditions. The primary goal is to reduce avoidable hospitalizations and improve chronic disease management.

2. Available Filters & Interactivity

1. **Panel:** A drop-down menu to select a specific provider panel or patient population for analysis.
2. **Roster:** A drop-down menu to select a specific patient roster within the chosen panel.
3. **Start Date / End Date:** Date selectors that allow the user to define a custom time period for the analysis.
4. **PQI Selection:** A drop-down menu to choose the specific Prevention Quality Indicator to be analyzed.
5. **Data Drill-Through:** Users can click on the bars within various charts to navigate to a detailed, beneficiary-level report.

3. Key Metrics & KPIs

1. **Count of PQI:** The primary metric representing the total number of potentially avoidable hospital admissions.
2. **Count of PQI per Beneficiary:** Measures the frequency of avoidable admissions for individual beneficiaries.

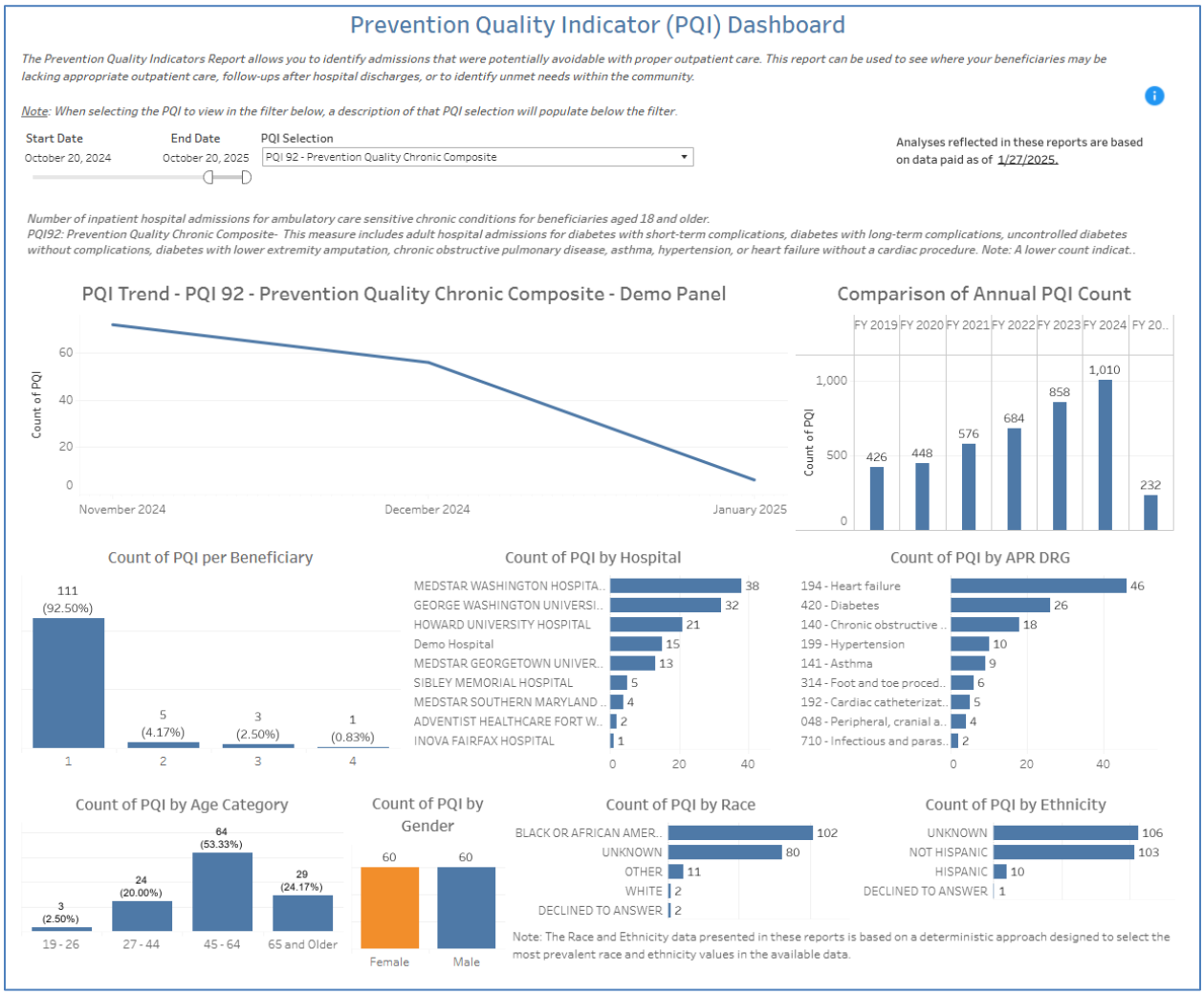
4. Visualizations & Data Tables

1. **PQI Trend:** A line chart displaying the count of PQI events over the selected time period.
2. **Comparison of Annual PQI Count:** A vertical bar chart that compares the total PQI count across multiple fiscal years.
3. **Count of PQI per Beneficiary:** A bar chart categorizing the number of beneficiaries by how many PQI events they experienced.
4. **Count of PQI by Hospital:** A horizontal bar chart ranking hospitals by the volume of PQI events.
5. **Count of PQI by APR DRG:** A horizontal bar chart breaking down the PQI events by the primary diagnosis.
6. **Count of PQI by Age Category, Gender, Race, and Ethnicity:** A series of bar charts that segment the PQI count by key demographic factors.

5. Functional Use Cases

1. **Identify High-Risk Patients for Intervention:** A care manager can use the charts to identify individuals for intensive case management.
2. **Target Quality Improvement with Partner Hospitals:** Administrators can identify facilities with high PQI volumes to collaborate on discharge planning.
3. **Develop Condition-Specific Clinical Programs:** Directors can launch targeted outpatient clinics based on leading causes of avoidable admissions.
4. **Monitor Health Equity Initiatives:** Analysts can track community health programs' success in reducing care access disparities.
5. **Evaluate Program Effectiveness Over Time:** Managers can measure long-term impact by looking for sustained reductions in avoidable admissions.

6. Screenshot



72. Preventive Pediatric Healthcare Utilization Dashboard

1. Report Overview & Purpose

This report provides a comprehensive overview of preventive pediatric healthcare service utilization for a selected patient panel. It shows the percentage of beneficiaries who have received recommended screenings and procedures, broken down by specific age categories. The primary purpose is to help providers and care managers identify and close gaps in preventive care by comparing their panel's performance against a broader reference group, such as the entire DC Medicaid population.

2. Available Filters & Interactivity

1. **Panel**: Dropdown menu to select the specific provider panel for analysis.
2. **Roster**: Dropdown menu to select a specific patient roster within the chosen panel.
3. **Measure Year**: Dropdown to select the calendar year for which the data is displayed.
4. **Reference Group**: Dropdown to select the benchmark population for comparison (e.g., All DC Medicaid).
5. **Age Category**: Dropdown menu that filters the "Comparison of Completed Recommended Services" charts by a specific age group.
6. **Data Drill-Through**: Users can click on any of the percentage values within the main "Preventive Pediatric Healthcare Utilization Dashboard" data table to navigate to a detailed list of beneficiaries who are included in that specific metric.

3. Key Metrics & KPIs

1. **Number of Beneficiaries**: The total count of unique beneficiaries within each defined age category (Infancy, Early Childhood, Middle Childhood, Adolescence) and the grand total for the selected panel.
2. **Service Utilization Rate (%)**: The central metric of the report, this shows the percentage of beneficiaries in an age group who received a specific recommended preventive service (e.g., Anemia, Behavioral, Developmental screening).
3. **Performance Indicator (Red Text)**: Percentages highlighted in red indicate that the panel's performance for that specific service and age group is lower than the selected Reference Group's performance.
4. **Percentage of Recommended Services Completed**: Displayed in the donut charts, this metric categorizes the patient population into brackets based on the overall percentage of their total recommended services that they have completed (e.g., 0-20%, 80-100%).

4. Visualizations & Data Tables

1. **Preventive Pediatric Healthcare Utilization Dashboard (Table)**: This is the primary data grid that details the utilization rates for various preventive services. Rows represent the

specific services (Anemia, Behavioral, etc.), and columns represent the pediatric age groups. The cells contain the performance percentages, with underperformance relative to the benchmark highlighted in red.

2. **Comparison of Completed Recommended Services (Donut Charts)**: This section features two side-by-side donut charts comparing the selected "Demo Panel" against the "All DC Medicaid Population." Each chart visualizes the distribution of beneficiaries based on the proportion of their required preventive services they have completed, allowing for a high-level comparison of overall care completion between the two groups.

5. Functional Use Cases

1. **Identify Care Gaps for a Specific Service**: A care coordinator can scan the main table for red percentages to quickly pinpoint services where their panel is underperforming. For example, they can see that "Anemia" screening for the "Early Childhood" group (16.38%) is a key area for improvement.
2. **Target Outreach by Age Group**: A clinic manager can analyze the columns to determine which age group requires the most attention. Observing low utilization for "Developmental" screenings in the "Middle Childhood" (0.39%) and "Adolescence" (0.06%) cohorts, they can initiate targeted outreach campaigns for those specific age ranges.
3. **Benchmark Panel Performance**: A population health analyst can use the donut charts to assess the overall preventive health of their panel compared to the broader Medicaid population. This helps in understanding if their patient population is generally more or less compliant with recommended care schedules.
4. **Generate Actionable Patient Lists**: After identifying a low performance metric, such as the 5.21% for "Behavioral" services in "Early Childhood," a user can click on that percentage to drill through to a list of specific children who have not yet received this service, enabling direct follow-up.
5. **Monitor Quality Improvement Initiatives**: A quality director can filter the report by "Measure Year" to track progress on pediatric quality measures over time. This allows them to evaluate the effectiveness of interventions aimed at improving specific screening rates, such as Dyslipidemia screenings for adolescents.

6. Screenshot

Preventive Pediatric Healthcare Utilization Dashboard

The Preventive Pediatric Healthcare Utilization Dashboard shows the percentage of beneficiaries who received the recommended preventive screenings and procedures by age category in the measure year.

Click on the performance score to view the beneficiary and claim-level details for the specific servicess. Services are based on the Periodicity Schedule found here: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf

Measure Year: 2023 | Reference Group: All DC Medicaid

Analyses reflected in these reports are based on data paid as of 1/27/2025

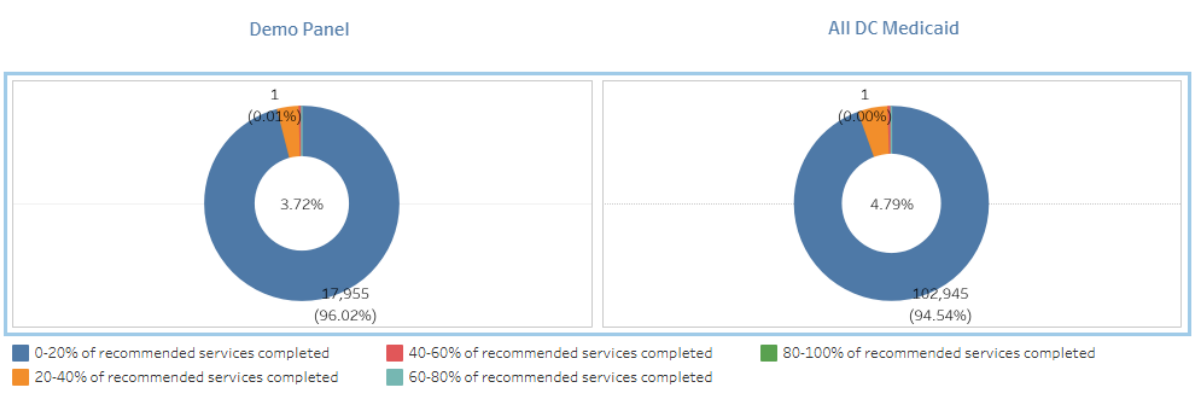
Red colored text means that Panel's performance is lower than the Reference Group's for that age group.

	Infancy	Early Childhood	Middle Childhood	Adolescence	Grand Total
Number of Beneficiaries	618	3,322	4,639	10,120	18,699
Anemia	1.78%	16.38%	2.00%	1.50%	4.28%
Behavioral	14.72%	5.21%	6.47%	6.70%	6.64%
Developmental	21.52%	12.04%	0.39%	0.06%	2.98%
Dyslipidemia	0.00%	0.87%	3.49%	10.16%	6.52%
Hepatitis B	0.49%	0.30%	0.28%	1.17%	0.77%
Tuberculosis	0.16%	0.63%	0.43%	1.70%	1.14%

Infancy : <=9 Months
Early Childhood: 10 Months through 5th birthday
Middle Childhood: 5 Years through 11th birthday
Adolescence: 11 Years through 22nd birthday

Comparison of Completed Recommended Services for Demo Panel and All DC Medicaid Population

Age Category: (All)



73. Service Line Readmission Analysis

1. Report Overview & Purpose

This report provides a detailed analysis of hospital readmissions, segmented by clinical service line and specific patient diagnoses (APR-DRGs). It is designed to help hospital administrators and clinical quality leaders identify which service lines and patient populations have the highest rates of readmission. The report facilitates performance comparison by contrasting a selected hospital's data against statewide benchmarks, highlighting opportunities to improve care transitions and reduce preventable readmissions.

2. Available Filters & Interactivity

1. **Index Hospital Name**: Allows the user to select a specific hospital for analysis from a drop-down list.
2. **Discharge Date**: Enables the user to filter the report data to a specific year.

3. Key Metrics & KPIs

1. **Eligible Discharges**: The total number of patient discharges that meet the criteria to be included in the readmission analysis for a given period.
2. **Readmissions**: The total count of eligible patients who were readmitted to any hospital within a specified timeframe (typically 30 days) following their initial discharge.
3. **Percent Readmissions**: The percentage of eligible discharges that resulted in a readmission (Readmissions / Eligible Discharges).
4. **Intra Readmissions**: The count of readmissions where the patient returned to the *same* hospital as the initial (index) admission.
5. **Intra Readmission Rate**: The percentage of eligible discharges that resulted in an intra-hospital readmission.
6. **Inter Readmissions**: The count of readmissions where the patient was admitted to a *different* hospital than the initial admission.
7. **Inter Readmission Rate**: The percentage of eligible discharges that resulted in an inter-hospital readmission.
8. **Readmission Ratio (O/E)**: The ratio of Observed-to-Expected readmissions. A value greater than 1.0 indicates more readmissions occurred than were statistically expected after risk adjustment, while a value less than 1.0 indicates better-than-expected performance.

4. Visualizations & Data Tables

1. **Service Line Readmission Analysis Table**: This primary table provides an aggregated summary of readmission metrics broken down by clinical service line (e.g., General

Medicine, Mental Health, Cardiology). It offers a high-level view of which departments are the largest contributors to the hospital's overall readmission rate.

2. **Index Visit Service Line: All (Demo Hospital) Table**: This table details the top diagnosis-related groups (APR-DRGs) driving readmissions for the selected hospital. It identifies the specific conditions of patients who are most frequently readmitted.
3. **Index Visit Service Line: All (Statewide) Table**: This table presents the same DRG-level breakdown but uses statewide data. It serves as a benchmark, allowing the selected hospital to compare its high-volume or high-risk DRGs against statewide trends.
4. **Index Visits Tables**: Located to the right of the DRG tables, these provide a further breakdown of readmission diagnoses. For a selected index DRG, this table shows the most common DRGs that patients were diagnosed with upon readmission, offering insight into clinical pathways leading to re-hospitalization.

5. Functional Use Cases

1. **Benchmark Service Line Performance**: A Quality Director at the "Demo Hospital" can compare their Mental Health service line's 24.0% readmission rate and 1.345 O/E Ratio to identify it as an area performing worse than expected, prompting a targeted quality review.
2. **Identify High-Risk Patient Cohorts**: A Cardiology department manager can use the "Index Visit Service Line" table to see that "Heart Failure" (DRG 194) is a significant driver of readmissions and can initiate a review of discharge planning and patient education for this specific cohort.
3. **Analyze Readmission Patterns**: A case manager reviewing the high readmissions for Schizophrenia (DRG 750) can use the corresponding "Index Visits" table to see that patients are often readmitted for Diabetes (Readmit DRG 420). This insight can lead to creating new post-discharge protocols that better manage co-morbidities for behavioral health patients.
4. **Investigate Patient Leakage**: An administrator notices the Vascular Surgery service line has a high "Inter Readmission Rate" (33.3%). They can use this data to investigate why patients are seeking follow-up care at other facilities, which could inform network development or patient navigation strategies.
5. **Prioritize Improvement Efforts**: A clinical analyst can sort the main service line table by the "Readmission Ratio (O/E)" to distinguish between service lines with a high volume of readmissions versus those performing poorly relative to their expected, risk-adjusted rate. For example, they might prioritize Neurology (O/E of 1.401) over General Medicine (O/E of 0.945) for immediate intervention.

6. Screenshot

Service Line Readmission Analysis

Index Hospital Name: Demo Hospital

Discharge Date: 2024

Index APR DRG ServiceLine	Eligible Discharges	Readmissions	Percent Readmissions	Intra Readmissions	Intra Readmission Rate	Inter Readmissions	Inter Readmission Rate	Readmission Ratio(O/E)
Grand Total	281	65	23.1%	16	5.7%	49	17.4%	1.005
General Medicine	133	31	23.3%	9	6.8%	22	16.5%	0.945
Mental Health and S..	100	24	24.0%	4	4.0%	20	20.0%	1.345
Cardiology	20	3	15.0%	1	5.0%	2	10.0%	0.429
Vascular Surgery	3	2	66.7%	1	33.3%	1	33.3%	1.075
Ungroupable	4	2	50.0%	0	0.0%	2	50.0%	1.845
Neurology	2	1	50.0%	0	0.0%	1	50.0%	1.401
General Surgery	4	1	25.0%	1	25.0%	0	0.0%	0.837
Orthopedics	3	0	0.0%	0	0.0%	0	0.0%	0.000
Ophthalmology	1	0	0.0%	0	0.0%	0	0.0%	0.000
Dermatology	1	0	0.0%	0	0.0%	0	0.0%	0.000
Cardiothoracic Surg..	1	0	0.0%	0	0.0%	0	0.0%	0.000

Index Visit Service Line:All(Demo Hospital)

Index APR DRG Code	Index APR DRG Description	Eligible Discharges	Readmissions	Percent Readmissions	Intra Readmissions	Intra Readmissio..	Inter Readmissions	Inter Readmissio..	Readmission Ratio(O/E)
750	Schizophrenia	45	9	20.0%	1	2.2%	8	17.8%	0.894
420	Diabetes	32	14	43.8%	5	15.6%	9	28.1%	1.164
753	Bipolar disord..	29	10	34.5%	2	6.9%	8	27.6%	2.387
751	Major depress..	19	5	26.3%	1	5.3%	4	21.1%	1.734
194	Heart failure	16	3	18.8%	1	6.3%	2	12.5%	0.489

Index Visits:

Readmit APR DRG..	Readmit APR DRG Descript..	Index APR DRG Code - ..	Readmissions	Intra Readmissions	Inter Readmissions
420	Diabetes	750 - Schizo..	15	6	9
750	Schizophrenia	892 - HIV wi..	12	2	10
753	Bipolar disor..	753 - Bipola..	7	1	6
720	Septicemia a..	956 - Ungro..	4	0	4
199	Hypertension	199 - Hyper..	3	1	2

Index Visit Service Line: All(Statewide)

Index APR DRG Code	Index APR DRG Description	Eligible Discharges	Readmissions	Percent Readmissions	Intra Readmissions	Intra Readmission Rate	Inter Readmissions	Inter Readmission Rate	Readmission Ratio(O/E)
560	Vaginal delive..	1,090	14	1.3%	11	1.0%	3	0.3%	0.202
750	Schizophrenia	1,037	256	24.7%	100	9.6%	156	15.0%	1.063
720	Septicemia an..	553	78	14.1%	30	5.4%	48	8.7%	0.766
540	Cesarean secti..	539	19	3.5%	13	2.4%	6	1.1%	0.536
753	Bipolar disord..	494	107	21.7%	35	7.1%	72	14.6%	1.344

Index Visits :

Readmit APR DRG Code	Readmit APR DRG Description	Index APR DRG Code - Description	Readmissions	Intra Readmissions	Inter Readmissions
750	Schizophre..	956 - Ungro..	277	99	178
662	Sickle cell a..	950 - Exten..	145	89	56
194	Heart failure	956 - Ungro..	123	40	83
753	Bipolar diso..	956 - Ungro..	119	42	77
751	Major depr..	844 - Partia..	83	34	49

All APR DRGs in this report are assigned the Service Line and descriptions corresponding to APR DRG version 41.

74. Severe Obstetric Complications (SOC) Dashboard

1. Report Overview & Purpose

This dashboard tracks the percentage of inpatient deliveries where members experienced severe maternal morbidity, such as eclampsia, sepsis, or a blood transfusion, during the delivery hospitalization. It is designed to monitor performance, identify trends, and analyze the characteristics of the affected beneficiary population. The report provides both an overall complication rate and a secondary rate that excludes cases where a blood transfusion was the only complication.

2. Available Filters & Interactivity

1. **Measure Year:** A dropdown menu to select the specific year for which to view the performance data.
2. **Reference Group:** A dropdown menu to select the comparison group for performance benchmarking (e.g., All DC Medicaid).
3. **Numerator Rate:** A dropdown menu to toggle the complication rate calculation between "All Severe Obstetric Complications (SOC)" and a rate that excludes blood transfusions.
4. **Data Drill-Through:** Users can click on the data points, bars, or segments within any of the following charts to cross-filter the dashboard and drill through to a detailed, beneficiary-level view:
    a. Number of Visits by Facility
    b. Measure Performance Status
    c. Beneficiary Distribution charts (Social Needs, Age Category, Race, Ethnicity, Chronic Conditions).

3. Key Metrics & KPIs

1. **Severe Obstetric Complications (SOC) Rate:** The primary metric, calculated as the percentage of inpatient deliveries with a severe obstetric complication. This rate is displayed monthly and annually, comparing the selected panel against a reference group.
2. **Count of Patients with/without SOC:** The absolute number of unique beneficiaries who experienced a severe obstetric complication compared to those who did not within the measurement period.
3. **Number of Visits by Facility:** The total count of hospital visits associated with SOC, broken down by individual medical facilities.
4. **Count of Beneficiaries:** The total number of unique beneficiaries, categorized by various demographic (age, race, ethnicity), social, and clinical (chronic conditions) factors.

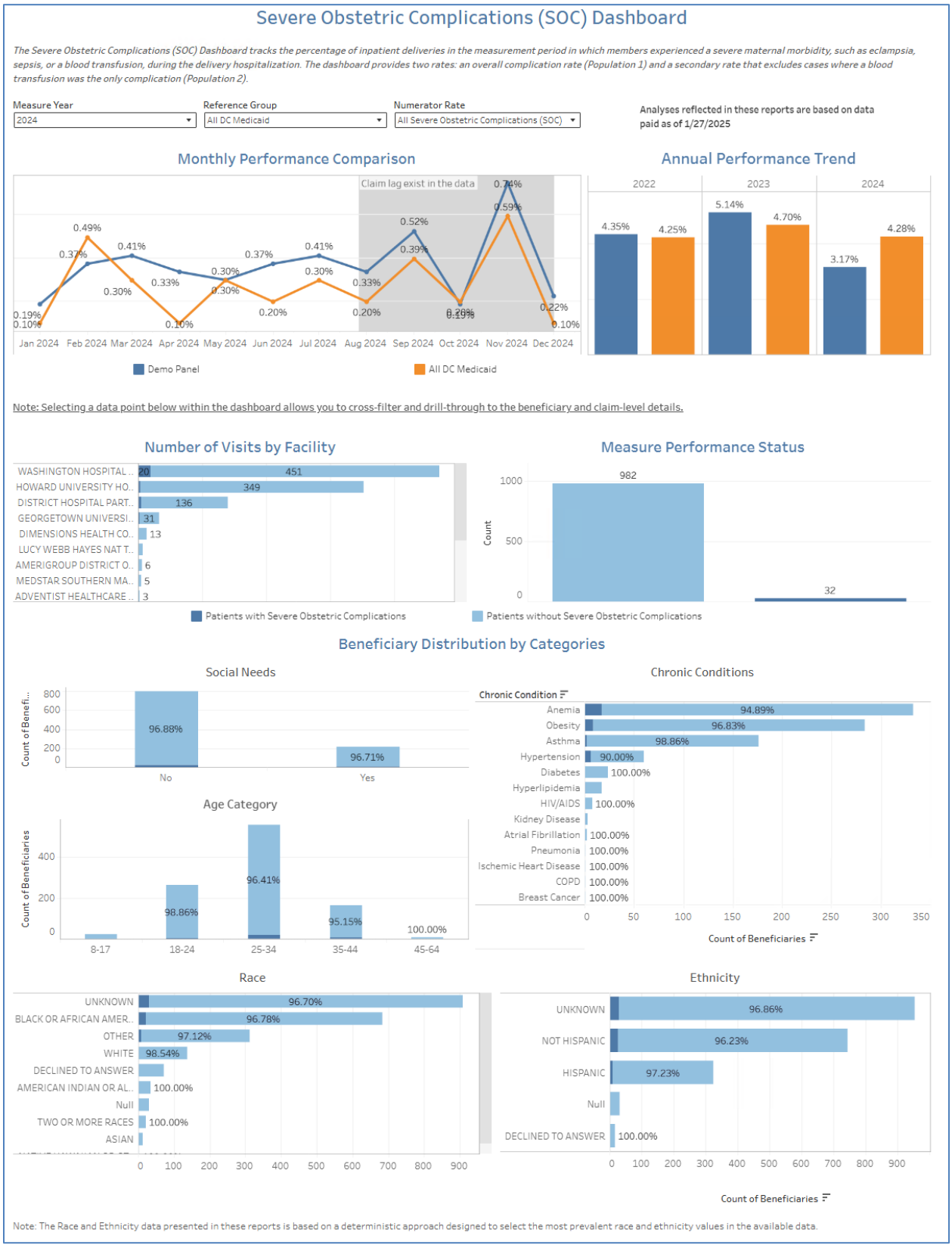
4. Visualizations & Data Tables

1. **Monthly Performance Comparison:** A dual-line chart that trends the monthly SOC rate for the selected panel (Demo Panel) against the reference group (All DC Medicaid). This allows for month-over-month performance monitoring and identification of spikes or dips in the complication rate. A shaded area indicates a period where claim lag may affect the data's completeness.
2. **Annual Performance Trend:** A grouped bar chart comparing the annual SOC rates for the selected panel and the reference group over the past three years. This provides a high-level view of long-term performance trends.
3. **Number of Visits by Facility:** A horizontal bar chart that ranks medical facilities by the number of patients who experienced SOC. This helps identify facilities with the highest volume of complex obstetric cases.
4. **Measure Performance Status:** A bar chart that provide a direct comparison of the total count of patients without SOC versus those with SOC.
5. **Beneficiary Distribution by Categories:** A series of bar charts that profile the population with SOC across multiple dimensions:
    a. **Social Needs:** Compares counts of beneficiaries with and without identified social needs.
    b. **Age Category:** Shows the distribution of SOC cases across different age brackets.
    c. **Race & Ethnicity:** Displays the breakdown of SOC cases by beneficiary race and ethnicity.
    d. **Chronic Conditions:** A horizontal bar chart detailing the prevalence of various co-occurring chronic conditions among the SOC population.

5. Functional Use Cases

1. **Monitor Monthly Performance:** A Quality Improvement Manager can use the "Monthly Performance Comparison" chart to track the plan's SOC rate against the DC Medicaid average, identifying months where the rate significantly exceeded the reference group's rate to trigger an investigation.
2. **Identify High-Volume Facilities:** A Provider Network Manager can review the "Number of Visits by Facility" chart to identify that facilities that have the highest counts of SOC cases, prioritizing them for targeted quality improvement outreach and support.
3. **Analyze Health Disparities:** A Population Health strategist can use the "Race" and "Ethnicity" charts to identify potential disparities.
4. **Assess Comorbidity Impact:** A Clinical Director can analyze the "Chronic Conditions" chart to see conditions that are highly prevalent in the SOC population, informing care management protocols for high-risk pregnant members with these comorbidities.
5. **Evaluate Long-Term Strategy:** An executive can use the "Annual Performance Trend" chart to assess the effectiveness of multi-year maternal health initiatives by comparing the SOC rate year-over-year.

6. Screenshot



75. Skilled Nursing Facility (SNF) Utilization Report

1. Report Overview & Purpose

This report provides a comprehensive overview of Skilled Nursing Facility (SNF) utilization for a selected patient population. It helps users analyze admission patterns, costs, and patient demographics to identify key trends, manage network performance, and understand the primary drivers of post-acute care stays. The report summarizes which facilities are most utilized, the top diagnoses leading to SNF stays, and the demographic breakdown of beneficiaries.

2. Available Filters & Interactivity

1. **Panel**: Filters the report to display data for a specific group or panel of beneficiaries.
2. **Start Date/End Date**: Allows the user to define a specific time period for the analysis of SNF utilization.
3. **Roster**: Filters the report to a user-defined list of beneficiaries.
4. **Data Drill-Through**: Users can click on the bars or values within the `SNF Utilization Overview` table, `Top Diagnosis of SNF Stays` chart, `Count of Beneficiaries Across SNF by Demographics` charts, `Count of Beneficiaries Across SNF by Race` chart, and `Count of Beneficiaries Across SNF by Ethnicity` chart to navigate to a detailed, beneficiary-level view.

3. Key Metrics & KPIs

1. **Number of Patients with SNF Visits**: The total count of unique patients who had at least one stay at the specified SNF during the selected period.
2. **Number of SNF Stays**: The total count of admissions to the SNF. This may be higher than the patient count if individuals have multiple stays.
3. **Avg LOS (Average Length of Stay)**: The average number of days a beneficiary spent in the SNF per admission.
4. **Avg SNF Paid per Month**: The average monthly payment made to the SNF for the attributed beneficiaries within the selected timeframe.
5. **Count of Beneficiaries**: The total number of unique individuals segmented by demographic categories such as age, gender, race, and ethnicity.

4. Visualizations & Data Tables

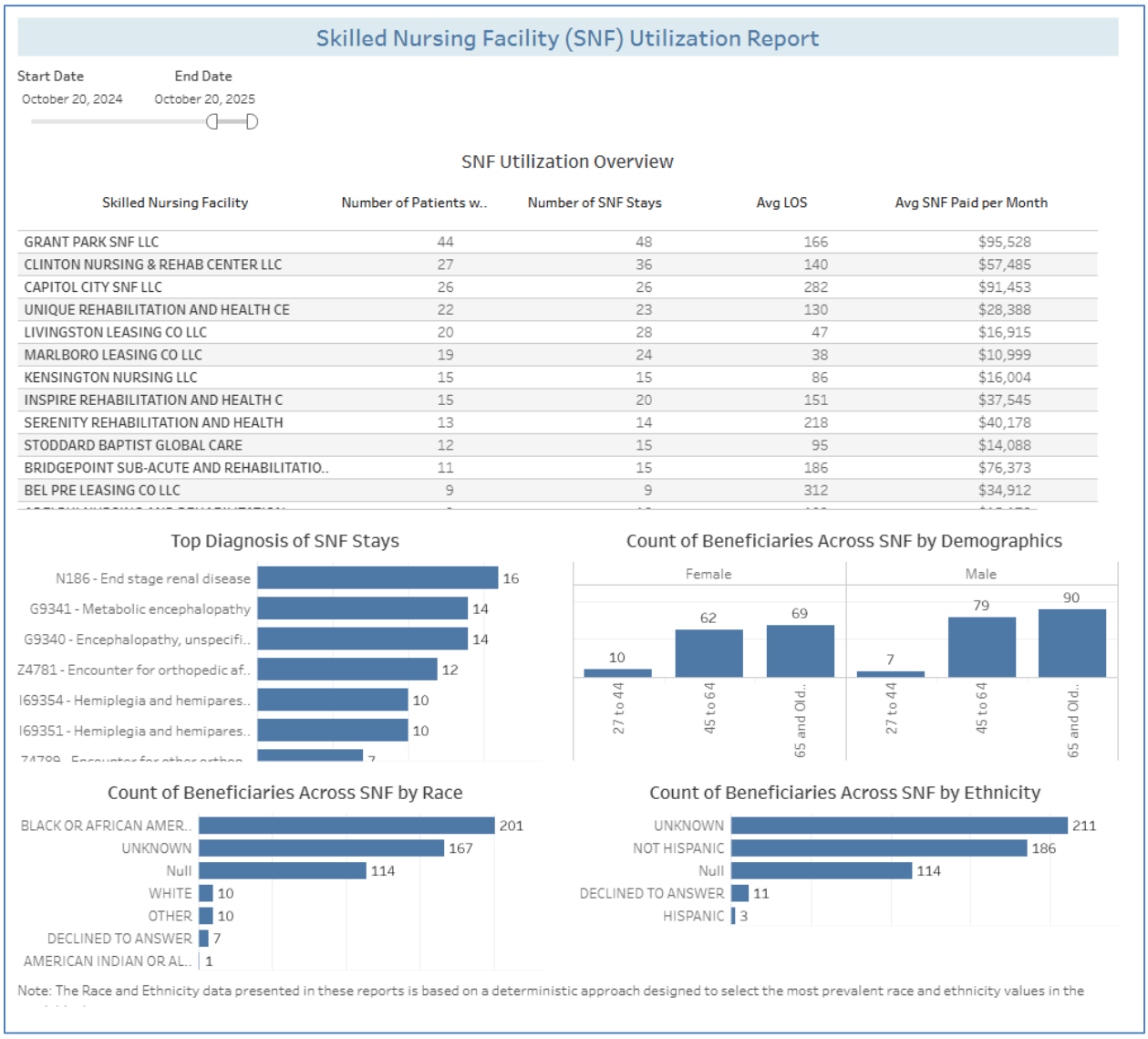
1. **SNF Utilization Overview**: A summary table that lists SNFs and ranks them by patient volume. It provides key metrics for each facility, including the number of patients, number of stays, average length of stay, and average monthly cost.
2. **Top Diagnosis of SNF Stays**: A horizontal bar chart that displays the most common diagnoses (by ICD-10 code and description) associated with SNF admissions, allowing users to quickly identify the primary clinical reasons for stays.

3. **Count of Beneficiaries Across SNF by Demographics**: A pair of vertical bar charts that break down the SNF beneficiary population by gender (Female, Male) and age group (e.g., 27 to 44, 45 to 64, 65 and Old.).
4. **Count of Beneficiaries Across SNF by Race**: A horizontal bar chart illustrating the racial distribution of beneficiaries who have had an SNF stay.
5. **Count of Beneficiaries Across SNF by Ethnicity**: A horizontal bar chart showing the ethnic breakdown of the SNF beneficiary population.

5. Functional Use Cases

1. **Network Management Strategy**: A network manager can review the `SNF Utilization Overview` table to identify the most utilized and highest-cost facilities, informing strategies for value-based purchasing or contract negotiations.
2. **Targeted Care Transition Programs**: A care manager can analyze the `Top Diagnosis of SNF Stays` chart to understand prevalent conditions like "End stage renal disease" and "Metabolic encephalopathy," enabling the development of targeted care transition programs.
3. **Investigate Health Disparities**: A population health analyst can use the `Count of Beneficiaries Across SNF by Race` and `Ethnicity` charts to investigate potential disparities in post-acute care access or outcomes for different demographic groups.
4. **Justify Resource Allocation**: A clinical director can observe the demographic data showing a high volume of patients aged 65 and older to justify resource allocation for geriatric-specific programs or staff training.
5. **Set Realistic Expectations**: A discharge planner can use the `Avg LOS` column to set realistic expectations with patients and families regarding their potential length of stay for post-hospital rehabilitation.

6. Screenshot



76. Hospital Readmission Report (SNF)

1. Report Overview & Purpose

This report provides a detailed analysis of hospital readmissions originating from patients discharged to Skilled Nursing Facilities (SNFs). Its primary purpose is to help hospitals and health systems identify which SNF partners have the highest readmission rates, associated costs, and longest lengths of stay for readmitted patients. This information is critical for managing post-acute care networks, improving care coordination, and reducing costly readmissions.

2. Available Filters & Interactivity

1. **Index Hospital Name:** Allows the user to select the initial hospital from which patients were discharged to an SNF.
2. **Index Admission Time Period:** Filters the report data based on the time frame of the patient's initial hospital stay.
3. **Index Admission APR DRG:** Narrows the analysis to patients with a specific All Patient Refined Diagnosis Related Group (APR DRG) during their index hospital admission.
4. **Data Drill-Through:** Users can click on the individual bars within the "Avg. SNF LOS," "Avg. Readmissions Payment," and "Percentage of Discharges" charts, or on the rows within the summary table, to drill down into a detailed list of the underlying beneficiaries or claims that constitute the selected metric.

3. Key Metrics & KPIs

1. **Avg. SNF LOS:** The average number of days a patient stayed at the SNF before being readmitted to the hospital.
2. **Avg. Readmissions Payment:** The average cost of the hospital readmission for patients coming from a specific SNF.
3. **Percentage of Discharges with Readmissions:** The percentage of patients sent to a specific SNF who were subsequently readmitted to the hospital. This is the primary readmission rate KPI.
4. **Eligible Discharges:** The total count of patients discharged from the index hospital to the nursing facility, serving as the denominator for the readmission rate calculation.
5. **Avg. Amount Paid:** The average payment amount made to the nursing facility for the patient's stay.
6. **PCR Ratio along Nursing Facility:** The Post-Acute Care Readmission (PCR) ratio, representing the readmission rate for each specific nursing facility.

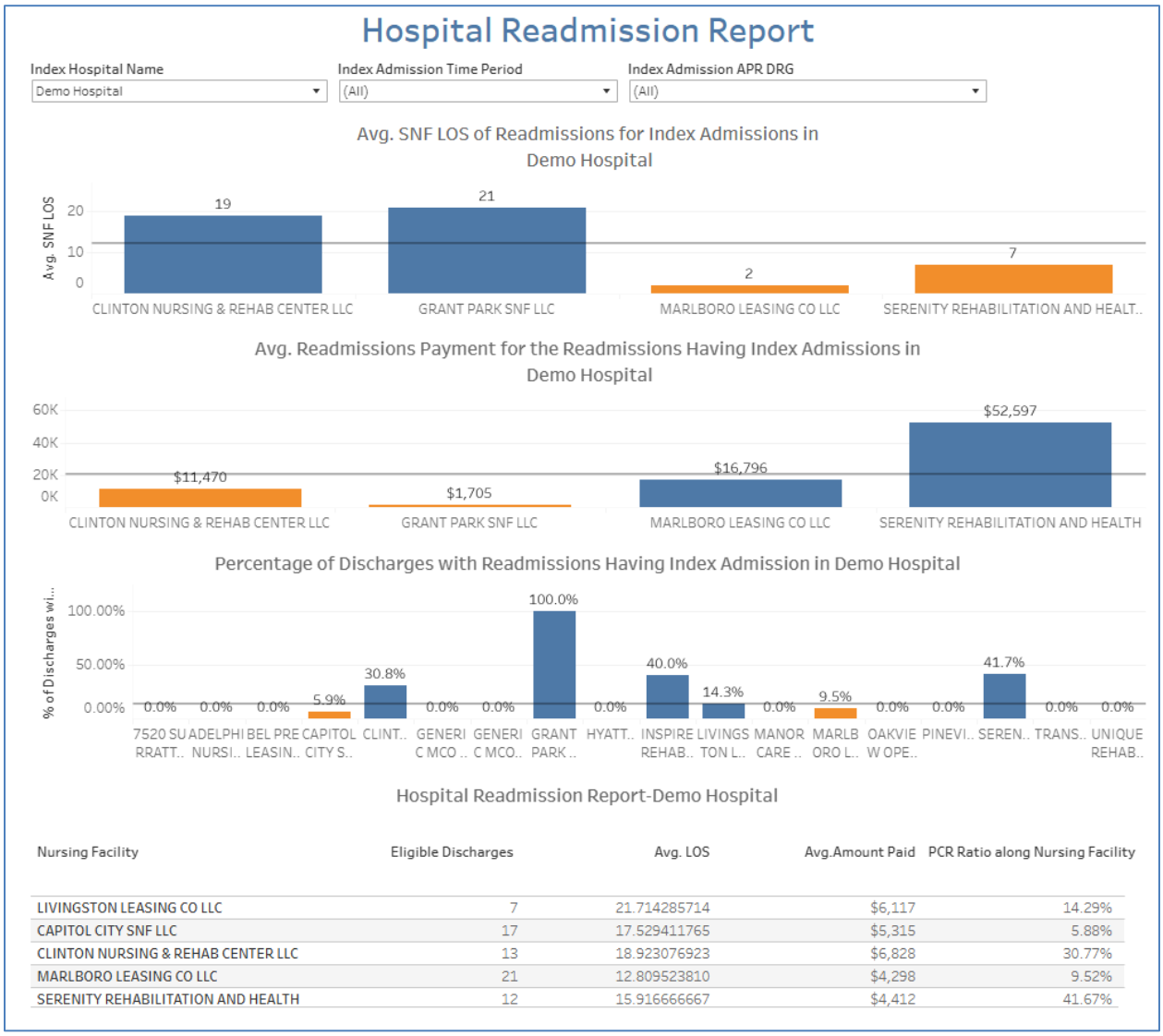
4. Visualizations & Data Tables

1. **Avg. SNF LOS of Readmissions for Index Admissions in Index Hospital:** A bar chart comparing the average length of stay at different SNFs for patients who were eventually readmitted. This helps identify if LOS correlates with readmission risk.
2. **Avg. Readmissions Payment for the Readmissions Having Index Admissions in Index Hospital:** A bar chart that visualizes the average cost of a readmission, broken down by the SNF the patient was discharged to. This highlights the financial impact of readmissions from specific partners.
3. **Percentage of Discharges with Readmissions Having Index Admission in Index Hospital:** This bar chart displays the readmission rate for each SNF, making it easy to identify high-performing and low-performing facilities in preventing readmissions.
4. **Hospital Readmission Report-Index Hospital:** A summary table that provides a detailed, sortable view of performance for each nursing facility. It consolidates key metrics including Eligible Discharges, Average LOS, Average Amount Paid, and the PCR (Readmission) Ratio, allowing for direct comparison across facilities.

5. Functional Use Cases

1. **Identify High-Risk SNF Partners:** A hospital discharge planner can use the "Percentage of Discharges with Readmissions" chart to quickly identify SNFs with the highest readmission rates and initiate partnership reviews or care coordination improvements.
2. **Analyze Financial Impact of Readmissions:** A financial analyst can use the "Avg. Readmissions Payment" chart to determine which SNFs are associated with the most expensive readmissions, helping to quantify the financial risk in the post-acute network.
3. **Evaluate Care Pathways for Specific Conditions:** A care manager can filter the report by a specific "Index Admission APR DRG" to compare which SNFs are most effective at managing those specific patient cohorts and preventing their readmission.
4. **Assess Length of Stay against Outcomes:** A network manager can compare the "Avg. SNF LOS" chart with the readmission rate chart to investigate whether a shorter or longer stay at a particular SNF has a discernible impact on patient readmission outcomes.
5. **Build a Preferred SNF Network:** A health system executive can use the comprehensive summary table to rank SNFs across multiple performance indicators (cost, LOS, readmission rate) to make data-driven decisions about which facilities to include in a preferred partner network.

6. Screenshot



77. Social Determinants of Health Map

1. Report Overview & Purpose

This report provides a geographical visualization of Social Determinants of Health (SDOH) within a selected population. It allows users to identify specific areas, such as wards, neighborhoods, or census tracts, that have the highest concentration of members with documented social needs, facilitating targeted interventions and resource allocation.

2. Available Filters & Interactivity

5. **Panel:** Allows the user to select the specific provider panel or population group for analysis.
6. **Roster:** Enables filtering the report to a specific, pre-defined list of patients.
7. **Start Date / End Date:** A date range slider that filters the data to include only members with documented needs within the selected time frame.
8. **Geography:** A dropdown to change the geographic boundary level for the map, such as Ward, census tract, or neighborhood.
9. **Social Needs Category:** Allows filtering the map to display data for a specific social need (e.g., housing insecurity, food insecurity) or for all categories combined.
10. **Data Drill-Through:** Users can click on any of the colored geographic regions (e.g., a specific ward) on the map to drill through to a detailed list of members within that selected area who have a documented social need.

3. Key Metrics & KPIs

5. **Percent of Members with a documented Social Need:** This is the core metric of the report. It is calculated as the number of members in a specific geographic area with at least one documented social need, divided by the total number of members in that same area, for the selected time period.

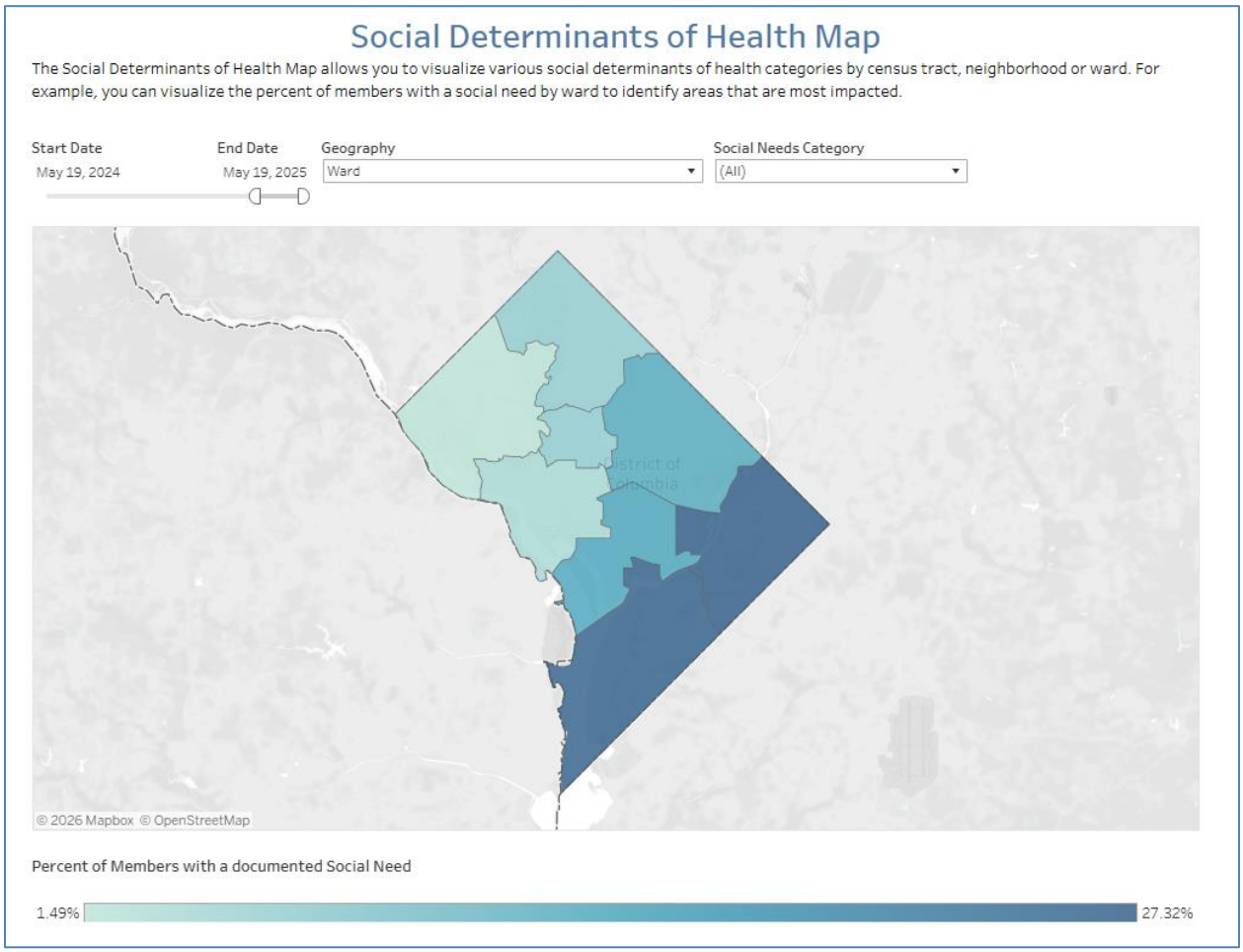
4. Visualizations & Data Tables

6. **Social Determinants of Health Map:** A map where different geographic regions are color-coded based on the "Percent of Members with a documented Social Need." Darker shades represent a higher percentage of members with social needs, while lighter shades indicate a lower percentage.
7. **Percentage Legend:** A color gradient bar located below the map that provides a key for the map's color scale. It displays the minimum (1.49%) and maximum (27.32%) values for the "Percent of Members with a documented Social Need" currently displayed on the map.

5. Functional Use Cases

6. **Deploy Targeted Geographic Community Resource Referrals**: A care coordinator can use the map to identify the wards with the highest percentage of patients with housing instability to proactively connect them with local housing assistance programs.
7. **Optimize Clinical Field Staff and Unit Deployment**: A health system administrator can analyze the map by census tract to strategically deploy mobile health units or community health workers to areas with the greatest overall social needs.
8. **Formulate Condition-Specific Community Partnerships**: A public health analyst can filter by a specific social need category (e.g., Food Insecurity) to pinpoint specific neighborhoods that would benefit most from a new targeted community partnership.
9. **Tailor Practice-Level Support to Match Panel Risk Profiles**: A practice manager can select their specific roster and review the map to understand the geographic distribution of their own patient panel's social needs and tailor practice-level resources accordingly.
10. **Measure Regional Social Need Identification Trajectories**: An outreach team can use the date filters to track the change in documented social needs in a target area over time, helping to measure the impact of a recently launched community-based intervention.

6. Screenshot



78. Social Determinants of Health Report 🔴 🟡

1. Report Overview & Purpose

This report provides a comprehensive analysis of Social Determinants of Health (SDoH) within a specified patient population, based on the presence of Z-codes. It visualizes utilization patterns, prevalence of social needs, and demographic breakdowns of affected members. The primary purpose is to help care teams and administrators identify members with social needs, understand the impact of these needs on healthcare utilization, and allocate resources effectively to address barriers to care.

2. Available Filters & Interactivity

1. **Roster:** Allows selection of a specific patient panel for analysis.
2. **Start Date:** Sets the beginning of the date range for the report data.
3. **End Date:** Sets the end of the date range for the report data.
4. **Chronic Condition:** Filters the patient panel to include only those with a specific chronic condition.
5. **DHCF Plan:** Filters the report to show data for members enrolled in a specific DHCF (Department of Health Care Finance) Plan.
6. **Social Needs Category:** Filters the entire report to focus on a single, specific social need category.
7. **Data Drill-Through:** Users can click on the numerical values within the Utilization KPIs (e.g., "4,975 Members with a Social Need") or on the bars within the various charts (e.g., Age Category and Gender, Race, Ethnicity, Social Needs Category, Social Needs Subcategory) to navigate to a detailed, beneficiary-level list.

3. Key Metrics & KPIs

The report is divided into two main utilization panels:

1. **Total Panel**: Metrics reflecting the entire selected population.
    a. **Members with Claims and/or Social Needs:** The total count of members in the filtered panel.
    b. **Inpatient Admissions:** The total number of inpatient admissions for this panel.
    c. **Avoidable IP Admission:** The total number of potentially preventable inpatient admissions.
    d. **Non Emergent ED Rate:** The percentage of all ED visits that were for non-emergent conditions.
2. **Panel of Members with a Social Need**: Metrics focused only on members with an identified social need.
    a. **Members with a Social Need:** The total count of members with at least one SDoH Z-code.

b. **Inpatient Admissions:** The total number of inpatient admissions for this subgroup.
c. **Avoidable IP Admission:** The total number of potentially preventable inpatient admissions for this subgroup.
d. **Non Emergent ED Rate:** The percentage of ED visits by this subgroup that were non-emergent.

4. Visualizations & Data Tables

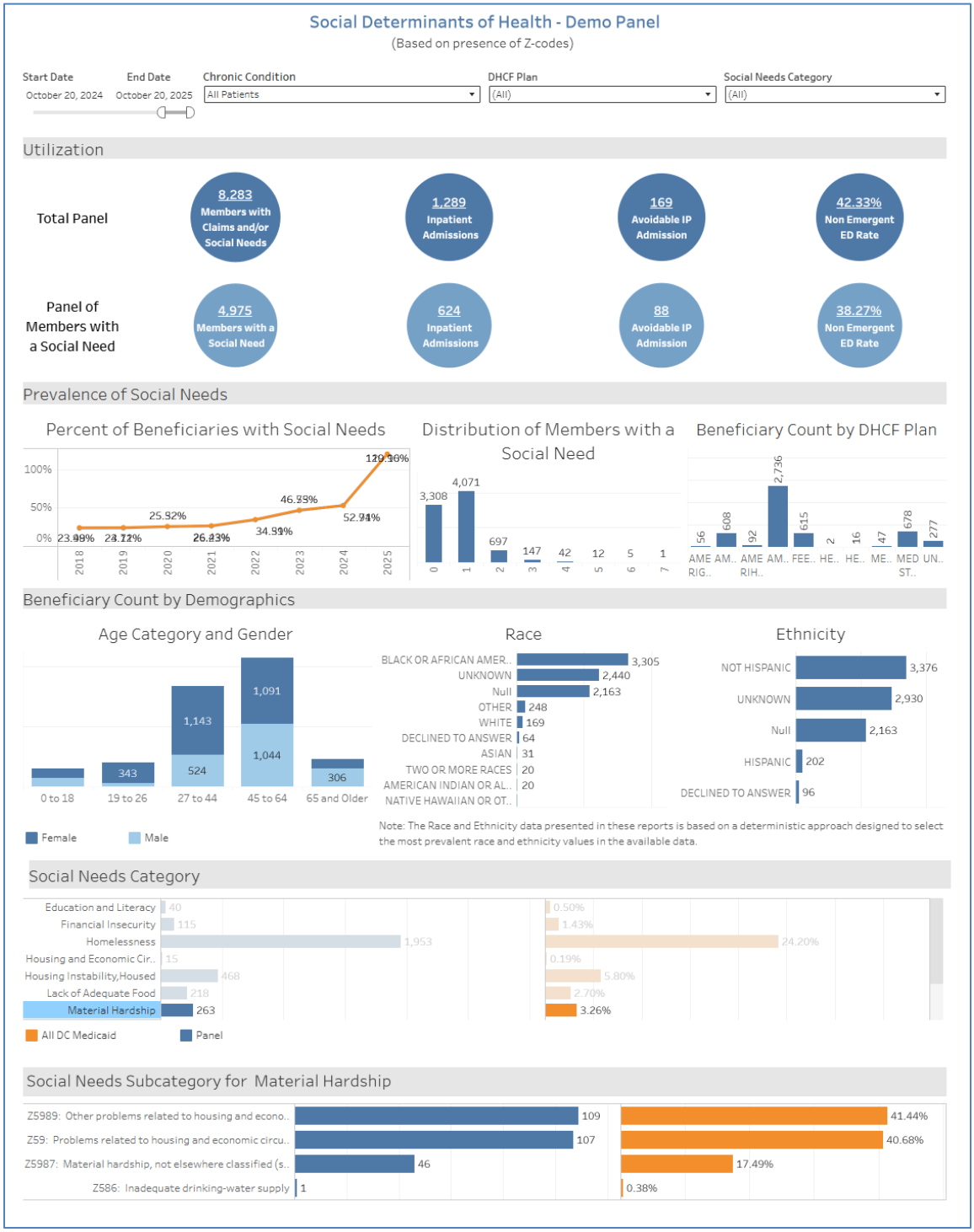
1. **Prevalence of Social Needs**:
    a. **Percent of Beneficiaries with Social Needs:** A line graph tracking the percentage of the panel with identified social needs over time, showing a trend.
    b. **Distribution of Members with a Social Need:** A bar chart illustrating how many members have 1, 2, 3, etc., distinct social needs.
    c. **Beneficiary Count by DHCF Plan:** A bar chart that breaks down the number of members with social needs by their specific health plan.
2. **Beneficiary Count by Demographics**:
    a. **Age Category and Gender:** A bar chart showing the distribution of members with social needs across different age groups, with bars segmented by gender.
    b. **Race & Ethnicity:** Two separate horizontal bar charts displaying the racial and ethnic composition of the panel with social needs.
3. **Social Needs Category**: A horizontal bar chart that ranks the different types of social needs (e.g., Homelessness, Financial Insecurity, Material Hardship) by the number of affected members.
4. **Social Needs Subcategory**: A detailed horizontal bar chart providing a breakdown of a selected parent category into more specific Z-codes and their corresponding member counts.

5. Functional Use Cases

1. **Targeted Outreach**: A care manager can view the "Social Needs Category" chart to identify "Homelessness" as the most prevalent need and then click on that bar to drill through to a patient list for targeted outreach and connection to housing resources.
2. **Health Equity Assessment**: A health equity officer can analyze the "Race" and "Ethnicity" charts to identify potential disparities in the prevalence of social needs among different demographic groups, informing strategic initiatives.
3. **Impact Analysis**: A hospital administrator can compare the "Inpatient Admissions" and "Avoidable IP Admission" metrics between the "Total Panel" and the "Panel of Members with a Social Need" to quantify the impact of SDoH on hospitalizations and justify investments in community health programs.
4. **Program Planning**: A population health strategist can filter the report by a specific "DHCF Plan" and review the demographic and social needs data to tailor care management programs and partnerships to the unique needs of that plan's members.

5. **Monitoring Trends**: A leadership team can monitor the "Percent of Beneficiaries with Social Needs" line chart quarterly to assess whether new screening protocols or community interventions are impacting the identification and prevalence of social needs over time.

6. Screenshot



79. Statin Medication Adherence Report

1. Report Overview & Purpose

This report identifies patients at risk of not adhering to their prescribed statin medications. It provides a patient-level list, sorted by the predicted likelihood of non-adherence, to help care managers and providers prioritize outreach and intervention efforts for cardiovascular health management. The analysis is based on claims data and includes key patient demographics and comorbidity information.

2. Available Filters & Interactivity

1. **Roster**: Filters the patient list to a specific provider's or care manager's assigned panel.
2. **Non-Adherence Risk Category**: Filters the list to show only patients who fall within a selected risk level (e.g., High Likelihood, Medium Likelihood).
3. **Care Program/MCO**: Narrows the patient list to a specific Managed Care Organization (MCO) or health plan.
4. **Has Diabetes**: Filters the list to show patients with or without a diabetes diagnosis.
5. **Has Heart Failure**: Filters the list to show patients with or without a heart failure diagnosis.
6. **Data Drill-Through**: Clicking on a patient's row in the main data table will navigate to a detailed view of that specific beneficiary's profile and claims history.

3. Key Metrics & KPIs

1. **Statin PDC (Prior 1 Year)**: Proportion of Days Covered (PDC) is a standard adherence measure that calculates the percentage of days a patient had their statin medication available over the last year. A lower PDC indicates poorer adherence.
2. **Likelihood of Statin Non-Adherence**: A predictive score, expressed as a percentage, that estimates the probability of a patient being non-adherent to their statin therapy. The report is sorted by this metric to surface the highest-risk individuals first.
3. **Category**: A color-coded risk stratification based on the "Likelihood of Statin Non-Adherence" score:
    a. **Likely Adherent**: 0% to 55.89%
    b. **Low Likelihood Non-Adherent**: 55.90% to 65.64%
    c. **Medium Likelihood Non-Adherent**: 65.65% to 83.83%
    d. **High Likelihood Non-Adherent**: 83.84% to 100%

4. Visualizations & Data Tables

1. **Patient Detail Table**: The core of the report is a detailed table listing individual patients. It includes columns for Medicaid ID, patient name, demographic information (Gender, DOB, Age), Care Program/MCO, Zip Code, key comorbidity flags (Diabetes, Heart

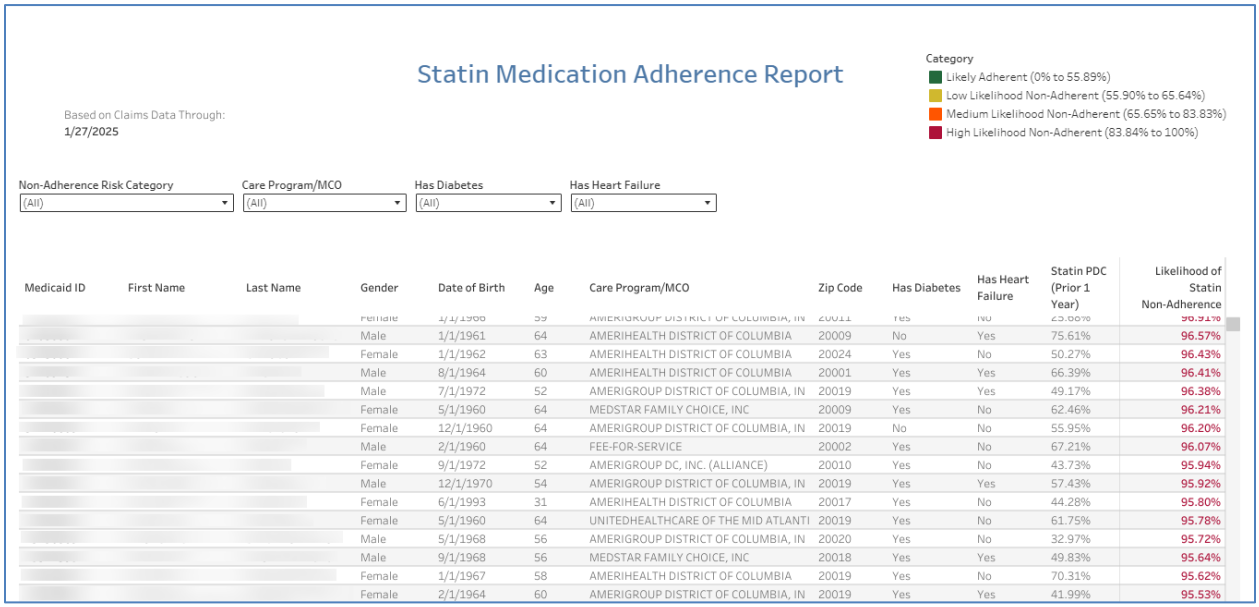
Failure), and the core adherence metrics (Statin PDC, Likelihood of Statin Non-Adherence).

2. **Category Legend**: A color-coded legend is displayed on the right side of the report. It defines the different categories of non-adherence likelihood, corresponding to the risk stratification applied to the patient list.

5. Functional Use Cases

1. **Prioritize High-Risk Outreach**: A care coordinator can view the default, sorted list to immediately identify the top 10-20 patients with the highest likelihood of non-adherence for proactive outreach and intervention.
2. **Manage Comorbid Populations**: A population health manager can filter for patients with "Has Diabetes: Yes" and "Has Heart Failure: Yes" to create a focused list of highly vulnerable patients who require intensive medication management support.
3. **Evaluate MCO Performance**: An administrator at a specific MCO can filter by their "Care Program/MCO" to assess the overall statin adherence risk profile of their members and identify opportunities for targeted quality improvement initiatives.
4. **Inform Pre-Visit Planning**: A primary care physician can filter the report by their specific "Roster" to review their patients' adherence scores before appointments, enabling a more informed discussion about medication barriers.
5. **Identify Geographic Needs**: A user can export the data to Excel and pivot by "Zip Code" to identify geographic hot spots with a high concentration of non-adherent patients, potentially signaling a need for community-level pharmacy or transportation resources.

6. Screenshot



80. Top 200 Drugs

1. Report Overview & Purpose

This report provides a comprehensive overview of the top 200 most frequently prescribed and highest-cost drugs for a selected population over a specific time period. The primary purpose is to help users identify key drivers of pharmaceutical utilization and expenditure, enabling targeted interventions for cost management and quality improvement. The report allows for a high-level summary view and a detailed drill-down into specific drug strengths.

2. Available Filters & Interactivity

1. Panel: Allows the user to select the specific panel or population group for which to view drug utilization data.
2. Roster: Enables filtering the report to a specific sub-population or patient list within the selected panel.
3. Drug Name: Filters the "Top 200 Drugs" table to display data for a single, selected drug.
4. Data Drill-Through: Users can click on any drug name in the "Top 200 Drugs" table to populate the "Cost and Utilization Details" table below, which breaks down the selected drug's metrics by specific strength.

3. Key Metrics & KPIs

1. **Claim Count:** The total number of pharmacy claims for the drug during the reporting period.
2. **Claim Count %:** The percentage of total claims that are attributed to this specific drug.
3. **Cost:** The total dollar amount spent on the drug.
4. **Avg Cost Per Fill:** The average cost for a single prescription fill of the drug (Total Cost / Claim Count).
5. **Rank by Claim Count:** The drug's rank from 1 to 200 based on its total number of claims.
6. **Rank by Cost:** The drug's rank from 1 to 200 based on its total cost.
7. **Cost %:** The percentage of total drug spending that is attributed to this specific drug.
8. **Avg Days Supply:** The average number of days a single prescription for the drug is intended to last.

4. Visualizations & Data Tables

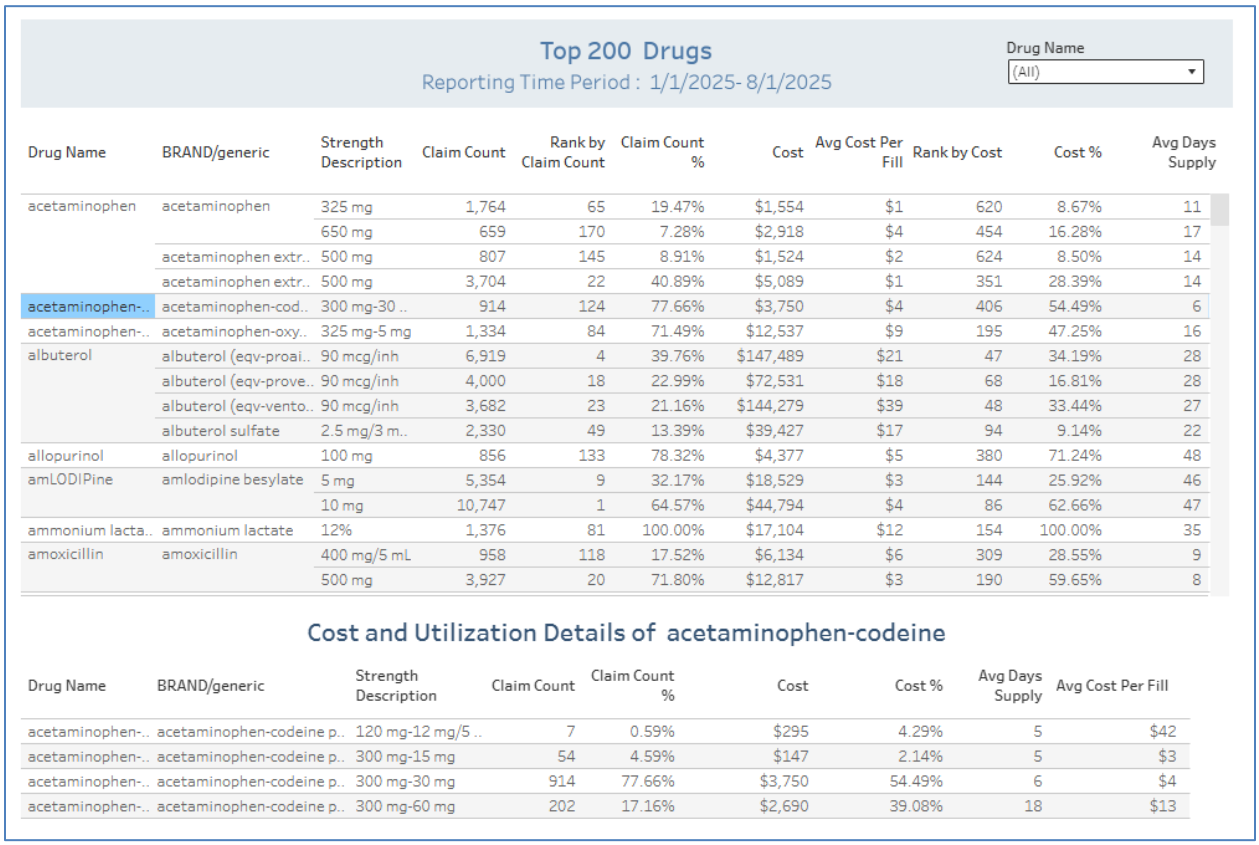
1. **Top 200 Drugs Table:** This is the main table in the report. It lists drugs alphabetically and provides a summary of key utilization and cost metrics for each. This allows for quick identification and comparison of high-volume and high-cost medications.
2. **Cost and Utilization Details of [Drug Name] Table:** This is a secondary, detailed table that populates when a user clicks on a drug in the main table. It breaks down the selected drug by its various strengths, showing the claim count, cost, and supply metrics

for each formulation. This view is crucial for understanding which specific strengths are driving the overall utilization and cost of a drug.

5. Functional Use Cases

1. **Identify Formulary Opportunities for Generic Substitution**: A pharmacy director can sort the "Top 200 Drugs" table by "Cost" to identify the most expensive medications and investigate opportunities for generic substitution or therapeutic alternatives to reduce spending.
2. **Assess Condition Prevalence to Guide Quality Care**: A clinical quality manager can analyze the "Claim Count" for medications like albuterol to assess the prevalence of conditions like asthma and ensure alignment with evidence-based care guidelines.
3. **Evaluate Cost-Effectiveness of Disparate Strength Formulations**: A care manager can click on a specific high-cost drug, like a brand-name medication, to view the "Cost and Utilization Details" and determine if lower-cost generic versions of the same strength are available but underutilized.
4. **Spot General Patterns of Patient Non-Adherence**: A population health analyst can use the "Avg Days Supply" metric for chronic disease medications (e.g., for hypertension or diabetes) to identify potential patterns of non-adherence across the roster.
5. **Analyze Roster-Specific Provider Prescribing Behavior**: A practice manager can filter by their specific "Roster" to understand the top prescribed drugs for their patient panel, helping to inform provider education and prescribing behavior analysis.

6. Screenshot



Top 200 Drugs

Reporting Time Period : 1/1/2025- 8/1/2025

Drug Name: (All)

Drug Name	BRAND/generic	Strength Description	Claim Count	Rank by Claim Count	Claim Count %	Cost	Avg Cost Per Fill	Rank by Cost	Cost %	Avg Days Supply
acetaminophen	acetaminophen	325 mg	1,764	65	19.47%	$1,554	$1	620	8.67%	11
		650 mg	659	170	7.28%	$2,918	$4	454	16.28%	17
	acetaminophen extr..	500 mg	807	145	8.91%	$1,524	$2	624	8.50%	14
	acetaminophen extr..	500 mg	3,704	22	40.89%	$5,089	$1	351	28.39%	14
acetaminophen-..	acetaminophen-cod..	300 mg-30 ..	914	124	77.66%	$3,750	$4	406	54.49%	6
acetaminophen-..	acetaminophen-oxy..	325 mg-5 mg	1,334	84	71.49%	$12,537	$9	195	47.25%	16
albuterol	albuterol (eqv-proai..	90 mcg/inh	6,919	4	39.76%	$147,489	$21	47	34.19%	28
	albuterol (eqv-prove..	90 mcg/inh	4,000	18	22.99%	$72,531	$18	68	16.81%	28
	albuterol (eqv-vento..	90 mcg/inh	3,682	23	21.16%	$144,279	$39	48	33.44%	27
	albuterol sulfate	2.5 mg/3 m..	2,330	49	13.39%	$39,427	$17	94	9.14%	22
allopurinol	allopurinol	100 mg	856	133	78.32%	$4,377	$5	380	71.24%	48
amLODIPine	amlodipine besylate	5 mg	5,354	9	32.17%	$18,529	$3	144	25.92%	46
		10 mg	10,747	1	64.57%	$44,794	$4	86	62.66%	47
ammonium lacta..	ammonium lactate	12%	1,376	81	100.00%	$17,104	$12	154	100.00%	35
amoxicillin	amoxicillin	400 mg/5 mL	958	118	17.52%	$6,134	$6	309	28.55%	9
		500 mg	3,927	20	71.80%	$12,817	$3	190	59.65%	8

Cost and Utilization Details of acetaminophen-codeine

Drug Name	BRAND/generic	Strength Description	Claim Count	Claim Count %	Cost	Cost %	Avg Days Supply	Avg Cost Per Fill
acetaminophen-..	acetaminophen-codeine p..	120 mg-12 mg/5 ..	7	0.59%	$295	4.29%	5	$42
acetaminophen-..	acetaminophen-codeine p..	300 mg-15 mg	54	4.59%	$147	2.14%	5	$3
acetaminophen-..	acetaminophen-codeine p..	300 mg-30 mg	914	77.66%	$3,750	54.49%	6	$4
acetaminophen-..	acetaminophen-codeine p..	300 mg-60 mg	202	17.16%	$2,690	39.08%	18	$13

81. Top 200 Drugs: Medication Details

1. Report Overview & Purpose

This report provides a detailed, line-item view of prescription drug claims. Its primary purpose is to allow users to review and analyze specific prescription details, including the prescriber, pharmacy, member, and cost, to support utilization management, cost analysis, and case review activities.

2. Available Filters & Interactivity

1. **Roster:** Filters the report for a specific, pre-defined list of members or providers.
2. **Prescriber Name:** Filters the data to show prescriptions written by a selected healthcare provider.
3. **Pharmacy Name:** Filters the data to show prescriptions filled by a selected pharmacy.
4. **Beneficiary Name:** Filters the data to show all prescriptions for a selected beneficiary.
5. **Data Drill-Through:** This report is a detailed data table and represents the lowest level of data granularity. It does not support further drill-through functionality.

3. Key Metrics & KPIs

1. **Drug Quantity:** The total quantity of the medication dispensed in a single claim (e.g., number of tablets, milliliters).
2. **Days Supply:** The number of days the dispensed medication is expected to last for the patient.
3. **Cost:** The total cost of the prescription drug claim.

4. Visualizations & Data Tables

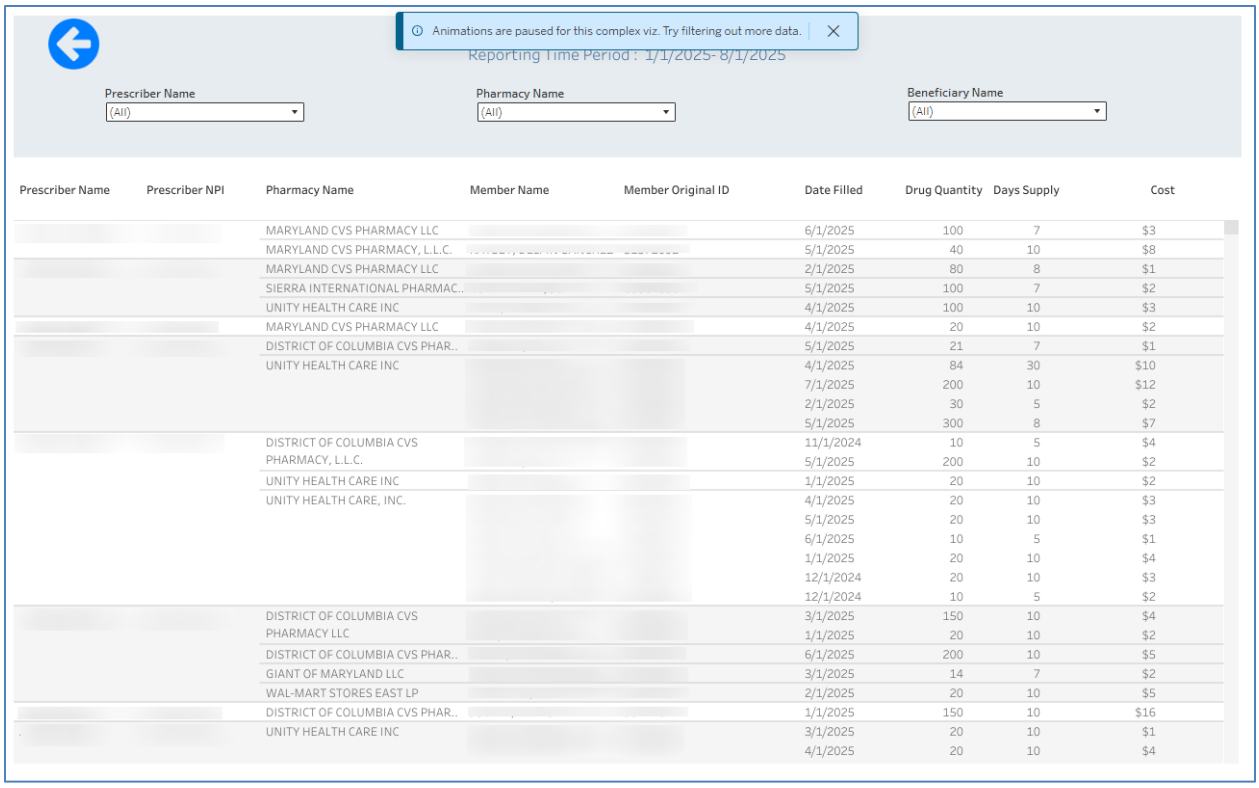
1. **Prescription Detail Table:** This is a comprehensive table that lists individual prescription drug claims. Each row contains detailed information about a single transaction, including:
    a. Prescriber Name and Prescriber NPI
    b. Pharmacy Name
    c. Member Name and Member Original ID
    d. Date Filled
    e. Drug Quantity, Days Supply, and Cost

5. Functional Use Cases

1. **Review Prescriber Patterns**: A clinical director can filter by a specific `Prescriber Name` to analyze their prescribing volume, common pharmacies used, and the cost of drugs prescribed over the reporting period.

2. **Analyze High-Cost Claims**: A financial analyst can sort the `Cost` column in descending order to quickly identify the most expensive prescriptions and investigate them for appropriateness or potential cost-saving alternatives.
3. **Conduct Patient Medication Reconciliation**: A care manager can use the `Beneficiary Name` filter to view a patient's complete prescription fill history, helping to identify potential drug interactions, polypharmacy, or adherence issues.
4. **Investigate Specific Claims**: A claims auditor can use a combination of filters, such as `Beneficiary Name`, `Prescriber Name`, and `Date Filled`, to locate and verify the details of a specific claim to resolve a payment or authorization inquiry.
5. **Assess Pharmacy Dispensing Activity**: A network manager can filter by `Pharmacy Name` to review the volume and cost of prescriptions filled by a specific pharmacy in their network.

6. Screenshot



82. Use of Pharmacotherapy for Opioid Use Disorder (OUD) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of medication-assisted treatment for beneficiaries diagnosed with Opioid Use Disorder (OUD). It measures the percentage of members aged 18 and older with an OUD diagnosis who have received an FDA-approved medication, such as Buprenorphine, Naltrexone, or Methadone. The report is designed to help providers and administrators monitor treatment rates, identify disparities in care, and compare performance against broader benchmarks.

2. Available Filters & Interactivity

1. **Measure Year:** Allows the user to select the specific calendar year for which to view the performance data.
2. **Reference Group:** Enables comparison of the selected panel's performance against a larger population, such as "All DC Medicaid".
3. **Roster:** Allows the user to select a specific patient panel or roster to analyze.

3. Key Metrics & KPIs

1. **Pharmacotherapy Treatment Rate:** The primary KPI, representing the percentage of beneficiaries with an OUD diagnosis who received at least one FDA-approved medication for OUD during the measurement period. This is displayed monthly and annually.
2. **Count of Beneficiaries:** The total number of beneficiaries who either received or did not receive an FDA-approved medication for OUD.
3. **OUD Medication Dispensing Events:** The total count of medication dispensing events, aggregated by the dispensing facility.

4. Visualizations & Data Tables

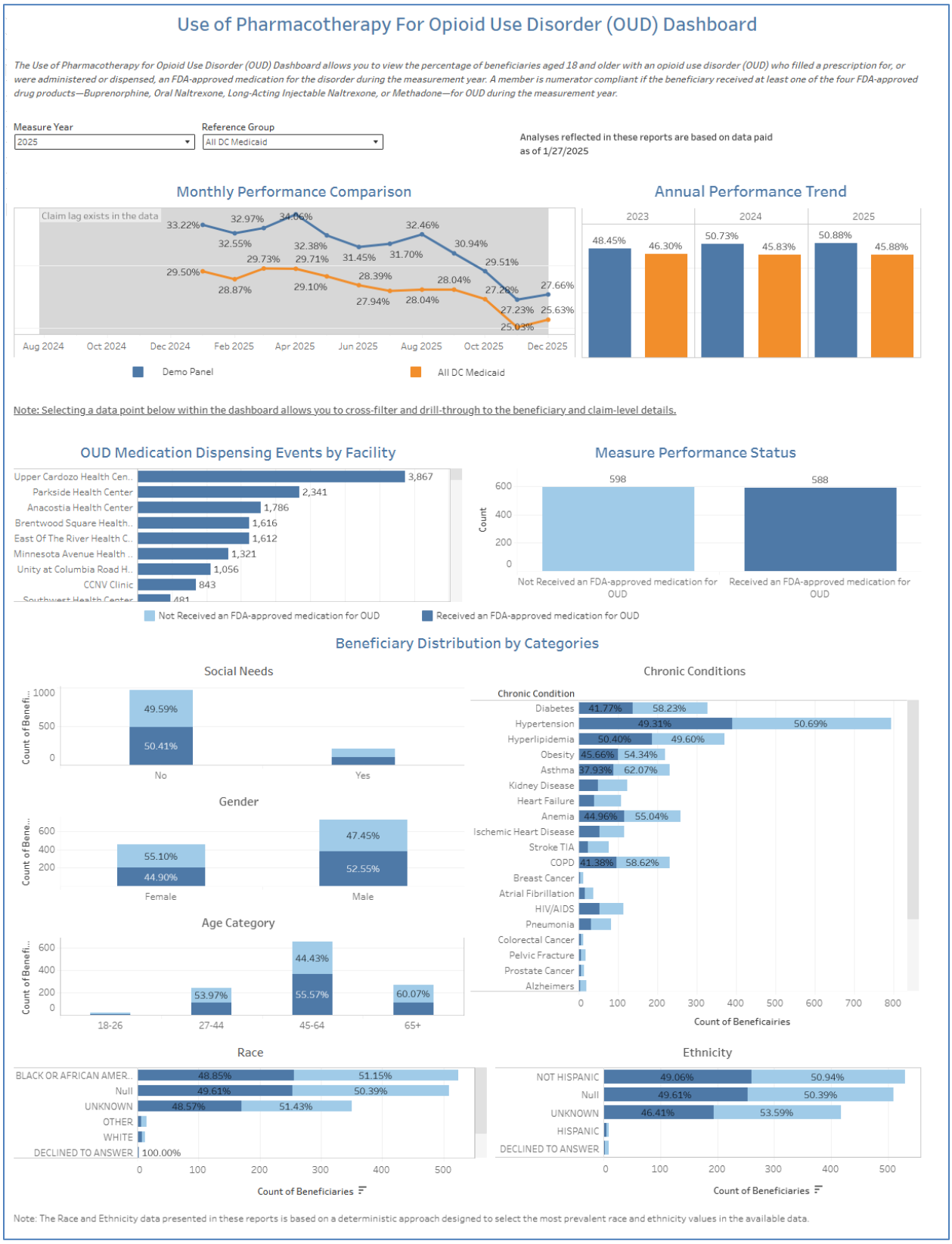
1. **Monthly Performance Comparison:** A dual-axis line chart that trends the monthly pharmacotherapy treatment rate for the selected panel against the chosen reference group (e.g., All DC Medicaid).
2. **Annual Performance Trend:** A bar chart comparing the overall annual treatment rate for the selected panel and the reference group across the last three years.
3. **OUD Medication Dispensing Events by Facility:** A horizontal bar chart ranking clinical facilities by the total number of OUD medication dispensing events, helping to identify key treatment centers.
4. **Measure Performance Status:** A simple bar chart that shows the total count of beneficiaries who received an FDA-approved medication versus those who did not.

5. **Beneficiary Distribution by Categories:** A collection of horizontal bar charts that break down the OUD population by various demographic and clinical factors. These charts show the distribution (in percentages) of those who received medication vs. those who did not across categories including Social Needs, Gender, Age, Race, Ethnicity, and a list of Chronic Conditions.

5. Functional Use Cases

1. **Monitor Program Performance**: A care manager can use the "Annual Performance Trend" and "Monthly Performance Comparison" charts to track their panel's OUD treatment rates over time and see how they compare to the "All DC Medicaid" average.
2. **Identify Disparities in Care**: A public health analyst can examine the "Beneficiary Distribution" charts for Race, Ethnicity, and Age Category to identify specific demographic groups that may have lower rates of receiving pharmacotherapy, flagging areas for targeted outreach.
3. **Assess Co-morbidity Impact**: A clinician can use the "Chronic Conditions" chart to understand if beneficiaries with certain co-occurring conditions (e.g., Diabetes, Hypertension) are more or less likely to receive medication for OUD, informing integrated care strategies.
4. **Evaluate Facility-Level Activity**: An administrator can review the "OUD Medication Dispensing Events by Facility" chart to identify high-volume treatment centers and facilities with lower-than-expected dispensing activity, which may warrant further investigation or support.
5. **Inform Quality Improvement Initiatives**: A quality improvement team can select a specific "Measure Year" to establish a baseline performance and then track the impact of new intervention programs by monitoring changes in the monthly treatment rates.

6. Screenshot



83. Well-Child Visits (WCV) Dashboard

1. Report Overview & Purpose

This dashboard provides a comprehensive view of adherence to recommended well-child visit guidelines for a selected panel of beneficiaries. It tracks performance over time, benchmarks against the broader DC Medicaid population, and analyzes visit distribution by beneficiary demographics and provider. The primary purpose is to help providers and care managers monitor and improve the rate at which children and adolescents receive essential well child visits.

2. Available Filters & Interactivity

1. **Panel:** Select the specific provider panel or group to analyze.
2. **Roster:** Select a specific list of patients within the chosen panel.
3. **Measure Year:** Select the specific measurement year for the report's data.
4. **Measure:** Select the specific well-child visit measure to display (e.g., Child and Adolescent Well Care Visits).
5. **Reference Group:** Choose the population to use as a benchmark for comparison (e.g., All DC Medicaid).
6. **Gender:** Filter the entire dashboard's data to a specific gender.
7. **Data Drill-Through:** Users can click on the bars or data points within the following charts to navigate to a detailed, beneficiary-level report: "Child and Adolescent Well Care Visits," "Beneficiary Age during their First Well-Care Visit," "Well-Care Visits and Cost Distribution by Provider," and the "Gender," "Race," and "Ethnicity" demographic charts.

3. Key Metrics & KPIs

1. **Performance Rate:** The percentage of eligible beneficiaries in the panel who received the recommended number of well-child visits within the measurement year.
2. **Beneficiary Count:** The total number of beneficiaries included in a specific measure, segment, or visualization.
3. **Number of Visits:** The count of well-child visits a beneficiary has received, categorized to show distribution (e.g., No Visit, 1, 2, etc.).
4. **Claim Count:** The total number of claims submitted for well-child visits by a specific provider.
5. **Amount Paid:** The total dollar amount paid to providers for well-child visit claims.

4. Visualizations & Data Tables

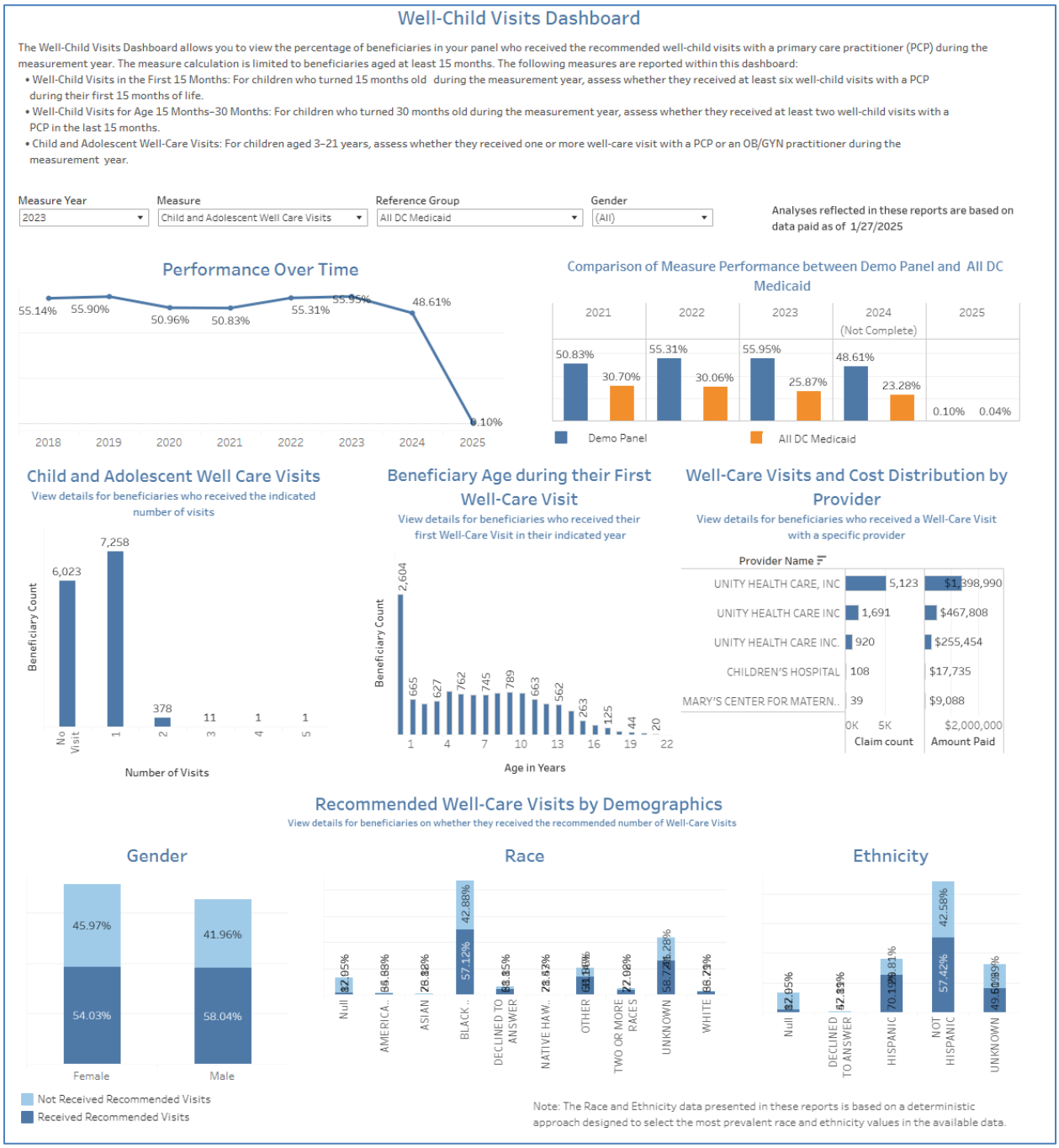
1. **Performance Over Time:** A line chart that trends the panel's well-child visit performance rate from 2018 to 2025, allowing for historical performance analysis.

2. **Comparison of Measure Performance between Demo Panel and All DC Medicaid:** A grouped bar chart that compares the performance rate of the selected panel (blue bars) against the chosen reference group (orange bars) for recent years. This provides a direct benchmark of performance.
3. **Child and Adolescent Well Care Visits:** A bar chart illustrating the distribution of beneficiaries based on the number of well-care visits they received during the period, highlighting the number of patients with zero visits.
4. **Beneficiary Age during their First Well-Care Visit:** A bar chart that displays the count of beneficiaries grouped by their age when they had their first well-care visit.
5. **Well-Care Visits and Cost Distribution by Provider:** A table that ranks providers by claim count and total amount paid, identifying the top contributing providers for well-child services.
6. **Recommended Well-Care Visits by Demographics:** A set of stacked bar charts breaking down the percentage of beneficiaries who received (dark blue) versus did not receive (light blue) recommended visits, segmented by Gender, Race, and Ethnicity.

5. Functional Use Cases

1. **Monitor Annual Performance:** A practice manager can use the "Performance Over Time" chart to track their clinic's year-over-year performance in delivering well-child visits and identify any significant dips that require investigation.
2. **Benchmark Against Peers:** A quality improvement lead can view the "Comparison of Measure Performance" chart to see how their panel's 2023 rate compares to the All DC Medicaid average to set realistic improvement goals.
3. **Identify and Engage Non-Compliant Patients:** A care coordinator can analyze the "Child and Adolescent Well Care Visits" chart, see that 6,023 beneficiaries had "No Visit," and click on that bar to drill down to a patient list for targeted outreach.
4. **Analyze Health Equity Gaps:** An administrator can review the "Race" and "Ethnicity" charts to identify disparities. For example, they can compare the rate of received visits for "BLACK" (57.12%) versus "WHITE" (66.21%) beneficiaries to inform culturally competent outreach strategies.
5. **Understand Provider Contribution:** A network manager can use the "Well-Care Visits and Cost Distribution by Provider" table to identify key providers who handle a high volume of well-child visits, to partner with them on quality initiatives.

6. Screenshot



84. Well-Child Visits Historical Prevalence Dashboard

1. Report Overview & Purpose

This dashboard provides a historical view of well-child visit prevalence, tracking the percentage of beneficiaries who have met the recommended number of visits with a primary care practitioner (PCP). The report's purpose is to help users monitor and improve adherence to well-child visit guidelines across three critical developmental phases: Less than 15 months, 15-30 months, and 3-21 years.

2. Available Filters & Interactivity

1. **Roster:** Allows the user to select a specific panel or roster of beneficiaries for analysis.
2. **Age Category:** Filters the view to analyze the historical prevalence for a specific age group. For example, selecting "3-21 years" shows data for children in that age range who were previously in the younger age categories.
3. **Reference Group:** Allows the user to select a comparison group, such as "All DC Medicaid," to benchmark the selected roster's performance.
4. **Data Drill-Through:** Users can click on the aggregated counts in the **"Number of Beneficiaries Who Completed Recommended Visits"** row within the main data table to navigate to a detailed list of those specific beneficiaries.

3. Key Metrics & KPIs

1. **Number of Beneficiaries:** The total count of unique beneficiaries within the selected panel and the reference group.
2. **Recommended Visit Count:** The specific number of well-child visits recommended for each age group, as per healthcare guidelines.
    a. **Less than 15 Months:** At least 6 Well-Child Visits.
    b. **15-30 Months:** At least 2 Well-Child Visits.
    c. **3-21 Years:** At least 1 Well-Child Visit (per year).
3. **Number of Beneficiaries Who Completed Recommended Visits:** The raw count of beneficiaries who met the visit threshold for their respective age category.
4. **Percentage of Beneficiaries Who Completed Recommended Visits:** The primary KPI, calculated as the (Number of Beneficiaries Who Completed Recommended Visits) / (Total Number of Beneficiaries). This percentage measures the adherence rate for each age group.

4. Visualizations & Data Tables

1. **Key Findings:** A dynamic text summary at the top of the dashboard that highlights the performance percentages for the selected panel across all three age-based measures.

2. **Prevalence Data Table:** A comprehensive table that compares the selected panel (e.g., "Demo Panel") against the chosen reference group (e.g., "All DC Medicaid"). The table is structured with columns for each of the three age categories ("Less than 15 Months," "15-30 Months," and "3-21 Years") and rows for each key metric, allowing for direct side-by-side performance comparison.

5. Functional Use Cases

1. **Benchmark Provider Performance:** A practice administrator can select their provider roster and compare their well-child visit completion rates for the "15-30 Months" category against the "All DC Medicaid" average to assess their performance relative to the network.
2. **Support Quality Improvement Initiatives:** A quality improvement coordinator can use the dashboard to track the impact of a new patient reminder system by monitoring changes in the "Percentage of Beneficiaries Who Completed Recommended Visits" for the "3-21 Years" group over time.
3. **Prioritize High-Risk Populations:** A population health analyst can focus on the "Less than 15 Months" category, which requires the most frequent visits, and drill through to the non-adherent list to ensure these infants receive critical early developmental screenings.
4. **Evaluate Age-Specific Interventions:** A program manager can use the "Age Category" filter to analyze the effectiveness of an intervention aimed at toddlers by isolating the "15-30 Months" group and comparing its performance before and after the program's implementation.

6. Screenshot

Well-Child Visits Historical Prevalence Dashboard

The Well-Child Visits Historical Prevalence Dashboard allows you to view the historical look back into counts and percentage of beneficiaries in your panel who received the recommended number of well-child visits with a primary care practitioner (PCP) during the following 3 phases:

1. Less than 15 months
2. 15-30 months
3. 3-21 years

You can select an age group and review the prevalence of the well-child visits across the prior age groups regardless of the measure year. The data is available from Jan 2018 to Jan 2024 to populate this dashboard.

Selecting an age group specifies the current age range of your beneficiary population. For example, choosing the 3-21 years age category means you are examining the historical prevalence of well-child visits among your current population aged 3-21 years when they were under 15 months old, between 15 and 30 months old, or currently within the 3-21 years age range. Similarly, selecting the 15-30 months age category allows you to review the historical well-child visit prevalence for your current population aged 15-30 months when they were under 15 months old or are currently between 15-30 months of age. If you opt for the Less than 15 months category, you will be analyzing well-child visit prevalence among your current population aged less than 15 months.

Age Category: 3-21 Years

Reference Group: All DC Medicaid

Analyses reflected in these reports are based on data paid as of 1/27/2025

Key Findings:

- For the 19,150 Demo Panel beneficiaries,
  - ★ 10.67% beneficiaries have received at least 1 well-child visit every year since they turned 3 years old
  - ★ 12.40% of the beneficiaries received at least 2 well-child visits when they were in between 15 to 30 month old
  - ★ 7.23% of the beneficiaries received atleast 6 well-child visits when they were less than 15 months old

	Demo Panel			All DC Medicaid		
Number of Beneficiaries	19,150			104,483		
Recommended Visit Count	Less than 15 Months At least 6 Well-Child Visits	15-30 Months At least 2 Well-Child Visits	3-21 Years At least 1 Well-Child Visits	Less than 15 Months At least 6 Well-Child Visits	15-30 Months At least 2 Well-Child Visits	3-21 Years At least 1 Well-Child Visits
Number of Beneficiaries Who Completed Recommended Visits	1,385	2,374	2,044	4,291	6,908	5,362
Percentage of Beneficiaries Who Completed Recommended Visits	7.23%	12.40%	10.67%	4.11%	6.61%	5.13%

Guide to Drill-Through Views

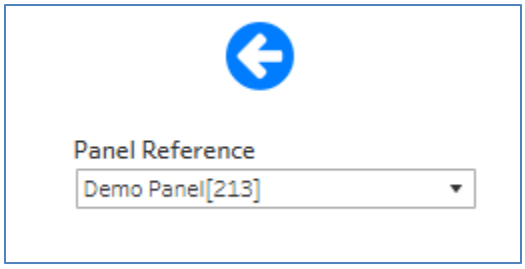
1. Overview & Purpose

Drill-through views are the most granular level of reporting available in the population health suite. When you click on a metric, bar, or data point in a main dashboard, you are transported to a drill-through screen that provides the underlying, row-level data. These views are designed to give users direct access to the specific patient, claim, or clinical details that constitute the aggregated summaries. While the core layout featuring a blue back arrow and export functions remains consistent, the specific data tables and columns presented are dynamic. They intelligently adapt to the context of the parent report, displaying relevant fields for the specific clinical or financial domain being analyzed, from maternity care details to lab results for chronic conditions.

2. Universal Navigation & Controls

Navigating into and out of these detailed views is straightforward. The most critical control is the large **"Blue Back Arrow"** button located in the top-left corner of the view. Clicking this button will safely return you to the main report you were just viewing, preserving all the filters and selections you had previously applied.

CRITICAL: Do NOT use your web browser's back button. Using the browser's navigation will exit the Tableau session and will not preserve your state, forcing you to start over. Always use the in-report "Blue Back Arrow." Across many drill-through views, you may also see common filters that allow for further refinement of the detail data. A frequent example is the **Panel Reference** drop-down, which allows you to isolate patients associated with a specific provider panel or cohort.



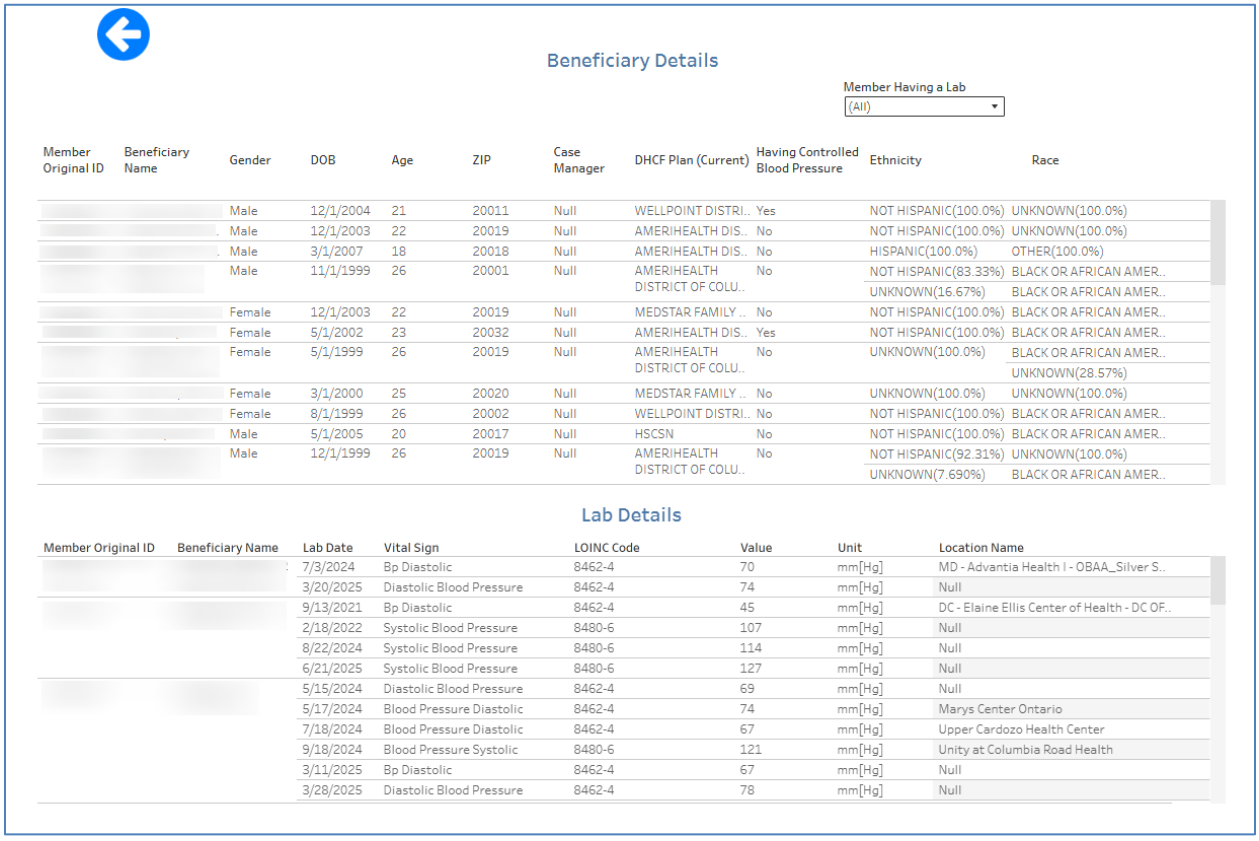
[Screenshot1: Blue Back Arrow and Panel Reference drop-down]

3. Common Data Tables & Unique Field Variations

The structure of drill-through views is designed for consistency and intuitive analysis. Nearly all views begin with a standard **"Beneficiary Details"** table, which provides fundamental demographic information for the patients included in the metric. This is typically followed by

one or more context-specific tables, such as a **"Claim Details"** table. However, the power of these views lies in their ability to adapt. The specific columns and even the entire tables will change based on the report's focus. This ensures the most relevant data is always at the forefront. Notable variations observed include:

- **Social Determinants of Health (SDoH) Reporting:** The standard tables are preceded by a unique "Social Needs Details" table, which includes binary flags for risk factors like `Homelessness Indicator`, `Food Insecurity`, and `Financial Insecurity`.
- **Chronic Condition Management (Hypertension):** Instead of a claims table, the view may feature a "Lab Details" table containing specific clinical data points such as `Vital Sign` (e.g., Systolic Blood Pressure), `Value`, and `Unit`.
- **Maternal & Pediatric Health:** The "Beneficiary Details" table is augmented with highly specific fields critical to perinatal care, such as `Delivery Date`, `Place of Birth`, and `Postpartum Visits After Delivery`.
- **Immunizations:** The view includes a "Vaccination Details" table that explicitly lists the status of each required vaccine for a series, providing immediate insight into which specific immunizations are missing.



Beneficiary Details

Member Having a Lab: (All)

Member Original ID	Beneficiary Name	Gender	DOB	Age	ZIP	Case Manager	DHCF Plan (Current)	Having Controlled Blood Pressure	Ethnicity	Race
		Male	12/1/2004	21	20011	Null	WELLPOINT DISTRI..	Yes	NOT HISPANIC(100.0%)	UNKNOWN(100.0%)
		Male	12/1/2003	22	20019	Null	AMERIHEALTH DIS..	No	NOT HISPANIC(100.0%)	UNKNOWN(100.0%)
		Male	3/1/2007	18	20018	Null	AMERIHEALTH DIS..	No	HISPANIC(100.0%)	OTHER(100.0%)
		Male	11/1/1999	26	20001	Null	AMERIHEALTH DISTRICT OF COLU..	No	NOT HISPANIC(83.33%)	BLACK OR AFRICAN AMER..
									UNKNOWN(16.67%)	BLACK OR AFRICAN AMER..
		Female	12/1/2003	22	20019	Null	MEDSTAR FAMILY ..	No	NOT HISPANIC(100.0%)	BLACK OR AFRICAN AMER..
		Female	5/1/2002	23	20032	Null	AMERIHEALTH DIS..	Yes	NOT HISPANIC(100.0%)	BLACK OR AFRICAN AMER..
		Female	5/1/1999	26	20019	Null	AMERIHEALTH DISTRICT OF COLU..	No	UNKNOWN(100.0%)	BLACK OR AFRICAN AMER..
										UNKNOWN(28.57%)
		Female	3/1/2000	25	20020	Null	MEDSTAR FAMILY ..	No	UNKNOWN(100.0%)	UNKNOWN(100.0%)
		Female	8/1/1999	26	20002	Null	WELLPOINT DISTRI..	No	NOT HISPANIC(100.0%)	BLACK OR AFRICAN AMER..
		Male	5/1/2005	20	20017	Null	HSCSN	No	NOT HISPANIC(100.0%)	BLACK OR AFRICAN AMER..
		Male	12/1/1999	26	20019	Null	AMERIHEALTH DISTRICT OF COLU..	No	NOT HISPANIC(92.31%)	UNKNOWN(100.0%)
									UNKNOWN(7.690%)	BLACK OR AFRICAN AMER..

Lab Details

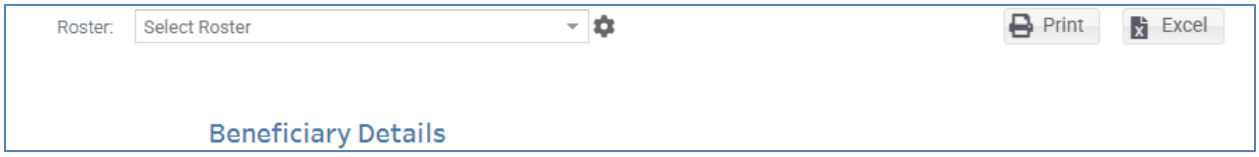
Member Original ID	Beneficiary Name	Lab Date	Vital Sign	LOINC Code	Value	Unit	Location Name
		7/3/2024	Bp Diastolic	8462-4	70	mm[Hg]	MD - Advantia Health I - OBAA_Silver S..
		3/20/2025	Diastolic Blood Pressure	8462-4	74	mm[Hg]	Null
		9/13/2021	Bp Diastolic	8462-4	45	mm[Hg]	DC - Elaine Ellis Center of Health - DC OF..
		2/18/2022	Systolic Blood Pressure	8480-6	107	mm[Hg]	Null
		8/22/2024	Systolic Blood Pressure	8480-6	114	mm[Hg]	Null
		6/21/2025	Systolic Blood Pressure	8480-6	127	mm[Hg]	Null
		5/15/2024	Diastolic Blood Pressure	8462-4	69	mm[Hg]	Null
		5/17/2024	Blood Pressure Diastolic	8462-4	74	mm[Hg]	Marys Center Ontario
		7/18/2024	Blood Pressure Diastolic	8462-4	67	mm[Hg]	Upper Cardozo Health Center
		9/18/2024	Blood Pressure Systolic	8480-6	121	mm[Hg]	Unity at Columbia Road Health
		3/11/2025	Bp Diastolic	8462-4	67	mm[Hg]	Null
		3/28/2025	Diastolic Blood Pressure	8462-4	78	mm[Hg]	Null

[Screenshot 2: Standard Beneficiary Details table, and a unique table for Lab Details]

4. Exporting Patient Lists

For users who need to perform offline analysis, create targeted outreach lists for care management, or integrate patient data into an Electronic Health Record (EHR) or care

coordination platform, these detailed views provide a direct export function. By clicking the **"Excel"** button in the top-right corner of the screen, you can download the complete, row-level dataset currently displayed on the screen into a CSV or Excel file. This includes all beneficiaries and their associated details, respecting any filters you have applied within the dashboard.



[Screenshot 3: Excel export button on a drill-through screen]

5. Feature-Specific Functional Use Cases for Detail Data

- **Social Needs Details (Homelessness, Food Insecurity, etc.)**: A Community Health Worker drills into a list of patients with high ER utilization. By reviewing the "Social Needs Details" table, they can identify individuals flagged for `Homelessness` or `Food Insecurity`, allowing them to proactively connect these patients with community-based housing and nutrition programs to address the root-cause social barriers that are impacting their health.
- **Having Controlled Blood Pressure**: A Population Health Nurse analyzing the hypertension dashboard filters the drill-through list to patients with "No" in the "Having Controlled Blood Pressure" column. They then use the associated "Lab Details" to stratify this list by the most recent systolic reading, creating a prioritized outreach list to engage patients with dangerously high blood pressure for medication management and follow-up appointments.
- **Postpartum Visits After Delivery**: A Maternal Care Coordinator for a health plan uses the pediatric dashboard to monitor newborn health. They drill into the beneficiary list and filter for infants whose mothers have '0' in the `Postpartum Visits After Delivery` column. This generates a specific list of mothers who have missed this critical follow-up, enabling targeted outreach to schedule the appointment and screen for postpartum complications.
- **Combination 3 Vaccination Status**: A Pediatric Clinic Manager drills into the Childhood Immunization Status (CIS) measure to see children marked as "Incomplete." The detailed vaccination table shows exactly which vaccines are missing for each child. The manager provides this list to the front-desk staff to add alerts to these patients' charts, prompting the clinical team to address the care gap opportunistically during the child's next visit for any reason.
- **MAP Risk Category**: A Clinical Pharmacist supporting a diabetes management program drills through the Statin Therapy (SPD) dashboard. They filter for patients in the "High" `MAP Risk Category` who, according to the claims Gantt chart, show inconsistent statin fills. This allows for a targeted intervention to discuss medication adherence barriers, such as cost or side effects, with the patients most at risk for an adverse cardiovascular event.

- **Primary Diagnosis / APR DRG**: A Utilization Analyst for an Accountable Care Organization (ACO) investigates a spike in preventable hospitalizations. By drilling into the patient list, they examine the `Primary Diagnosis` and `APR DRG` columns. They identify a pattern of admissions for Ambulatory Care Sensitive Conditions like asthma or dehydration, providing the data needed to launch a targeted outpatient disease management program to better manage these conditions and prevent future inpatient stays.

Use Case Repository

Part 1: Core Strategic Use Cases

These high-level use cases focus on the primary goals of the PopHealth program, moving from patient-level action to system-wide analysis.

1. Targeted Patient Outreach & Closing Care Gaps 🔴

Objective: Identify high-risk, high-utilizing, or non-compliant patients to generate actionable lists for direct intervention, care management, and scheduling.

1. **Specific Focus**: Identifying high-risk patients, targeting non-engaged beneficiaries, generating outreach lists, managing "unmanaged" patients, and age-specific interventions.
2. **Associated Reports**:
    a. Acute Care Setting Utilization Report (Inpatient & ER)
    b. Admission to an Institution from the Community (AIF-HH)
    c. Ambulatory Care: Emergency Department (ED) Visits
    d. Annual EPSDT Dashboard
    e. Breast Cancer, Cervical Cancer, and Colorectal Cancer Screening Dashboards
    f. Childhood Immunization Status (CIS-E) Dashboard
    g. Follow Up Post-Acute Setting Discharge Report (Inpatient & ER)
    h. Gap in HIV Medical Visits & HIV Medical Visit Frequency Dashboards
    i. HealthCheck Dashboard for Recommended Dental Procedures
    j. HEDIS MY 2024 Dashboards (AAP, EED, GSD, KED, SPC, SPD)
    k. High Risk Medications Report & Pharmacy Report - Medication Adherence
    l. Medicaid Redetermination Report
    m. Medication Synchronization Opportunity Summary Report
    n. Non-Emergent ED (NED) Use Dashboard (Adult & Pediatric)
    o. Oral Evaluation during Pregnancy: Ages 15-20 (OEVP-CH) Dashboard
    p. Panel Demographics Report
    q. Pediatric Quality Measure Comparison Over Time Dashboard
    r. Plan All-Cause Readmissions (PCR) Dashboard (Standard & Hospital Users)
    s. Pregnancy Dashboards (Maternal Demographics, Prenatal Care)
    t. Prenatal Immunization Status (PRS) Dashboard
    u. Prescription of HIV Antiretroviral Therapy (ART) Dashboard
    v. Prevention Quality Indicators (PQI) Dashboard
    w. Preventive Pediatric Healthcare Utilization Dashboard
    x. Severe Obstetric Complications (SOC) Dashboard
    y. Social Determinants of Health Map & Report
    z. Statin & Hypertension Medication Adherence Reports

aa. Well-Child Visits Dashboard

2. Performance Benchmarking & Quality Improvement Tracking

Objective: Tracking metrics over time (MoM or rolling years), setting annual goals, and comparing panel performance against peer groups or the "All DC Medicaid" benchmark.

1. **Specific Focus**: Monitor program improvement, track monthly/annual performance, evaluate outreach campaign effectiveness, and track quality improvement (QI) initiatives.
2. **Associated Reports**:
    a. Adult & Pediatric Quality Measure Comparison Over Time Dashboards
    b. Annual Retention in Care Dashboard
    c. Blood Pressure Control for Patients with Diabetes (BPD) & Controlling High Blood Pressure (CBP) Dashboards
    d. Breast Cancer, Cervical Cancer, and Colorectal Cancer Screening Dashboards
    e. Childhood Immunization Status (CIS-E) Dashboard
    f. Contraceptive Care for All Women (CCW)
    g. Follow-Up After ED Visit (AOD Dependence & Mental Illness)
    h. Health Home Measures Dashboard
    i. HEDIS MY 2024 Dashboards (AAP, EED, GSD, KED, SPC, SPD)
    j. HIV Viral Load Suppression Dashboard
    k. Immunizations For Adolescents (IMA-CH)
    l. Initiation and Engagement of AOD Treatment (IET-HH)
    m. Lead Screening in Children (LSC-E) Dashboard
    n. Maternal & Perinatal Health Dashboards (Standard & Pediatric, Quality Measure Comparison)
    o. Measure Comparison by Time Period Dashboard
    p. Non-Emergent ED (NED) Use Dashboard (Adult & Pediatric)
    q. Oral Evaluation for Adults (OEV)
    r. Oral Evaluation during Pregnancy: Ages 15-20 (OEVP-CH) Dashboard
    s. Plan All-Cause Readmissions (PCR) Dashboard (Standard & Hospital Users)
    t. Postpartum Dashboard
    u. Prenatal Immunization Status (PRS) Dashboard
    v. Preventive Pediatric Healthcare Utilization Dashboard
    w. Severe Obstetric Complications (SOC) Dashboard
    x. Use of Pharmacotherapy for Opioid Use Disorder (OUD) Dashboard
    y. Well-Child Visits Dashboards (Standard & Historical Prevalence)

3. Health Equity & Demographic Disparity Analysis

Objective: Slicing data by age, gender, race, ethnicity, and SDOH to identify inequities and design culturally competent, targeted interventions.

1. **Specific Focus**: Assess health equity, analyze demographic disparities, address social determinants of health, and optimize community outreach.
2. **Associated Reports**:
    a. Admission to an Institution from the Community (AIF-HH)
    b. Ambulatory Care: Emergency Department (ED) Visits
    c. Annual EPSDT Dashboard & Annual Retention in Care Dashboard
    d. Breast Cancer, Cervical Cancer, and Colorectal Cancer Screening Dashboards
    e. Childhood Immunization Status (CIS-E) Dashboard
    f. Contraceptive Care for All Women (CCW)
    g. Follow-Up After ED Visit (AOD Dependence & Mental Illness)
    h. Follow Up Post-Acute Setting Discharge Report (Inpatient & ER)
    i. Gap in HIV Medical Visits & HIV Medical Visit Frequency Dashboards
    j. HEDIS MY 2024 Dashboards (AAP, EED, GSD, KED, SPC, SPD)
    k. HIV Viral Load Suppression Dashboard & Prescription of HIV ART Dashboard
    l. Immunizations For Adolescents (IMA-CH)
    m. Initiation and Engagement of AOD Treatment (IET-HH)
    n. Inpatient Utilization (IU-HH)
    o. Lead Screening in Children (LSC-E) Dashboard
    p. Maternal & Perinatal Health Dashboards (Standard & Pediatric)
    q. Non-Emergent ED (NED) Use Dashboard (Adult & Pediatric)
    r. Oral Evaluation for Adults (OEV) Dashboard
    s. Oral Evaluation during Pregnancy: Ages 15-20 (OEVP-CH) Dashboard
    t. Panel Demographics Report
    u. Pharmacy Report - Medication Adherence
    v. Plan All-Cause Readmissions (PCR) Dashboard (Standard & Hospital Users)
    w. Pregnancy Dashboard: Maternal Demographics
    x. Prenatal Immunization Status (PRS) Dashboard
    y. Severe Obstetric Complications (SOC) Dashboard
    z. Skilled Nursing Facility (SNF) Utilization Report
    aa. Social Determinants of Health Map & Report
    bb. Use of Pharmacotherapy for Opioid Use Disorder (OUD) Dashboard
    cc. Well-Child Visits Dashboard

4. Financial Management & Cost Driver Analysis

Objective: Analyzing expenditures (PMPM), investigating high-cost services, and promoting cost-effectiveness (generic substitutions, shift to outpatient care).

1. **Specific Focus**: Identify top cost drivers, financial planning and budgeting, evaluate cost-effectiveness of care settings, and investigate adherence for high-cost medications.
2. **Associated Reports**:
    a. Acute Care Setting Utilization Report (Inpatient & ER)
    b. Admission to an Institution from the Community (AIF-HH)
    c. Ambulatory Care: Emergency Department (ED) Visits

d. Cost by Service Type Report
e. Dental Services Utilization Dashboard
f. Expenditure Per Member Per Month Dashboard
g. Inpatient Utilization (IU-HH)
h. Measure Comparison by Time Period Dashboard
i. Panel Demographics Report
j. Postpartum Dashboard
k. Pregnancy Dashboard: Delivery Outcomes
l. Prenatal Care Dashboard
m. Skilled Nursing Facility (SNF) Utilization & Hospital Readmission Report (SNF)
n. Top 200 Drugs

5. Network, Facility & Provider Management 🔵

Objective: Evaluating hospital relationships, analyzing referral networks, assessing SNF partner quality, and monitoring provider prescribing patterns.

1. **Specific Focus:** Evaluate hospital partner performance, benchmark service line performance, optimize referral networks, and monitor impact of clinical programs at specific facilities.
2. **Associated Reports**:
    a. Acute Care Setting Utilization Report (Inpatient & ER)
    b. Admission to an Institution from the Community (AIF-HH)
    c. Annual EPSDT Dashboard
    d. Breast Cancer Screening Dashboard
    e. Childhood Immunization Status (CIS-E) Dashboard
    f. Dental Services Utilization Dashboard
    g. Expenditure Per Member Per Month Dashboard
    h. Follow-Up After ED Visit for Mental Illness
    i. Follow Up Post-Acute Setting Discharge Report (Inpatient & ER)
    j. Health Home Measures Dashboard
    k. HEDIS MY 2024 Eye Exam (EED) & Statin Therapy (SPC, SPD)
    l. Immunizations For Adolescents (IMA-CH)
    m. Inpatient Utilization (IU-HH)
    n. Maternal & Perinatal Health Dashboard
    o. Medication Synchronization Opportunity Summary Report
    p. Non-Emergent ED (NED) Use Dashboard (Adult & Pediatric)
    q. Oral Evaluation for Adults (OEV)
    r. Oral Evaluation during Pregnancy: Ages 15-20 (OEVP-CH) Dashboard
    s. Plan All-Cause Readmissions (PCR) Dashboard (Standard & Hospital Users)
    t. Pregnancy Dashboard: Delivery Outcomes
    u. Prenatal Immunization Status (PRS) Dashboard
    v. Prevention Quality Indicators (PQI) Dashboard
    w. Service Line Readmission Analysis

x. Severe Obstetric Complications (SOC) Dashboard
y. Skilled Nursing Facility (SNF) Utilization & Hospital Readmission Report (SNF)
z. Use of Pharmacotherapy for Opioid Use Disorder (OUD) Dashboard
aa. Well-Child Visits Dashboard

6. Administrative Operations & Care Coordination Logistics

Objective: Day-to-day management of patient panels, staffing forecasts, monitoring data feeds (ADTs/CCDs), and ensuring patients maintain Medicaid coverage.

1. **Specific Focus**: Monitoring data feed health, validating data after system changes, verifying panel membership, forecasting staffing needs, and prescriber education.
2. **Associated Reports**:
    a. ADT Completeness Report
    b. CCD Completeness Report
    c. High Risk Medications Report
    d. Medicaid Redetermination Report
    e. Panel Demographics Report
    f. Top 200 Drugs

Part 2: Specialized Use Case Groupings

These sections help users find reports based on specific disease states, life stages, or technical functionalities.

1. Grouping by Clinical Domain & Disease State

Cardiometabolic Management

1. **Focus**: Diabetes, Hypertension, Heart Disease.
2. **Reports**: BPD, CBP, HEDIS EED, HEDIS GSD, HEDIS KED, HEDIS SPC/SPD, Hypertension & Statin Medication Adherence.

Infectious Disease (HIV)

1. **Focus**: Retention in care and viral suppression.
2. **Reports**: Annual Retention in Care, Gap in HIV Medical Visits, HIV Medical Visit Frequency, HIV Viral Load Suppression, Prescription of HIV ART.

Behavioral Health & Substance Use

1. **Focus**: Post-ED follow-up and treatment engagement.

2. **Reports**: Follow-Up After ED (AOD & Mental Illness), Initiation and Engagement of AOD Treatment (IET-HH), Health Home Measures, Use of Pharmacotherapy for Opioid Use Disorder (OUD).

Oncology & Screenings

1. **Reports**: Breast Cancer, Cervical Cancer, and Colorectal Cancer Screening Dashboards.

Dental & Oral Health

1. **Reports**: Dental Services Utilization, HealthCheck Recommended Dental Procedures, Oral Evaluation for Adults, Oral Evaluation during Pregnancy: Ages 15-20 (OEVP-CH)

2. Grouping by Patient Life Stage & Demographic Cohort

Maternal & Perinatal Care

1. **Reports**: CCW, Maternal & Perinatal Health Dashboards, Maternal Quality Measure Comparison, Postpartum, Pregnancy Delivery Outcomes, Maternal Demographics, Prenatal Care, Oral Evaluation during Pregnancy: Ages 15-20 (OEVP-CH), Prenatal Immunization Status (PRS), Severe Obstetric Complication (SOC) Dashboard

Pediatric & Adolescent Care

1. **Reports**: Annual EPSDT, Immunizations (IMA-CH), Lead Screening, Pediatric NED Use, Pediatric Quality Measure Comparison, Preventive Pediatric Utilization, Well-Child Visits, Childhood Immunization Status (CIS-E)

3. Grouping by Setting of Care

1. **Acute Care & ED**: Inpatient, ER, Ambulatory Care ED Visits, Non-Emergent ED (NED), PQI, Severe Obstetric Complications (SOC) Dashboard.
2. **Post-Acute & Institutional**: AIF-HH, Follow Up Post-Acute, SNF Utilization, SNF Hospital Readmission.
3. **Pharmacy & Medication**: High Risk Medications, Medication Sync, Pharmacy Adherence, Top 200 Drugs.

Part 3: Functional Methodology (How to Use the Dashboards)

This section defines the "Unified Actions" that can be taken across the report suite.

Methodology	Unified Action

Generating Outreach Lists	Clicking on charts/KPIs to generate actionable, line-level patient lists for direct contact and scheduling.
Tracking Intervention Impact	Monitoring time-series charts (MoM/Rolling Years) to visually track if an intervention is moving the needle.
Demographic Disparity Analysis	Reviewing standardized demographic charts to find groups with disproportionately low compliance or high utilization.
Network Optimization	Analyzing ranking charts to identify top-performing partners or underperforming partners for QI meetings.
Clinical Causality Analysis	Pairing diagnostic codes (APR DRGs) or service types with "Amount Paid" or PMPM to pinpoint spending.
Data Troubleshooting	Monitoring daily volume line charts for administrative messages to spot interface drops or spikes.

Part 4: Targeted User Personas

A quick reference for different staff members to find their primary tools.

1. **Care Managers/Coordinators**: Focus on direct intervention, care transitions, and late pregnancy gaps. (Key: Acute Care, AIF-HH, HEDIS Dashboards, Medicaid Redetermination, Well-Child.)
2. **Quality Improvement & Clinical Leads**: Focus on benchmarking against HEDIS/CMS and evaluating clinical initiatives. (Key: Comparison Over Time Dashboards, BPD/CBP, Health Home Measures, PQI.)
3. **PopHealth Analysts & Equity Officers**: Focus on broad demographic trends and SDOH to allocate community resources. (Key: Annual EPSDT, SDOH Map, Oral Evaluation, Maternal Demographics.)
4. **Finance & Network Administrators**: Focus on operational health, partner performance, and PMPM benchmarking. (Key: Cost by Service Type, Expenditure PMPM, SNF Utilization, Service Line Readmission.)
5. **Pharmacy Management**: Focus on adherence, prescribing patterns, and formulary costs. (Key: High Risk Meds, Medication Sync, Statin Adherence, Top 200 Drugs.)
6. **IT & System Administrators**: Focus on data quality, feed health, and SLA compliance. (Key: ADT/CCD Completeness.)

Part 5: Advanced "Deep Dive" & Singleton Scenarios

1. **Evaluating Payer-Specific Trends**: Comparing specific population trends against the Medicaid benchmark via the Acute Care Utilization Report.
2. **SLA Compliance**: Verifying if partner hospitals meet contractual obligations for data submission via the CCD Completeness Report.
3. **Geographic Resource Allocation**: Using map visualizations in HealthCheck Dental or Maternal Demographics to perform outreach to specific wards.
4. **Prescriber Education**: Identifying clinicians with high volumes of high-risk prescriptions via the High Risk Medications Report.
5. **Pre-Appointment Planning**: Looking up specific patients before a visit to identify inappropriate prescriptions.
6. **Medicaid Coverage Management**: Identifying patients who lost coverage and sorting upcoming redetermination dates via the Medicaid Redetermination Report.
7. **Investigating Patient Leakage**: Analyzing "Inter Readmission Rates" in Service Line Readmission Analysis to see why patients go to competing facilities.
8. **Generic Drug Promotion**: Comparing average cost per fill of brand-name vs. generic equivalents via the Top 200 Drugs report.
9. **Cesarean & Preterm Trends**: Tracking birth outcomes and preventing preterm births via the Pregnancy Delivery Outcomes Dashboard.

Part 6: Reporting Metadata & Operational Boundaries

1. Data Granularity Tags

- **Aggregate/Strategic**: (Benchmarking, PMPM, Trend Lines) - e.g., Adult Quality Measure Comparison, Cost by Service Type.
- **Line-Level/Tactical**: (Patient Lists, Drill-Throughs) - e.g., High Risk Medications, Medicaid Redetermination.

2. Privacy & Compliance (42 CFR Part 2)

STRICT RULE: Drill-through to patient lists is disabled for the following reports to comply with federal substance use disorder privacy laws:

1. Follow-up After ED for Alcohol/Drug Abuse (FUA)
2. Follow-up After Hospitalization for Mental Illness (FUH)
3. Initiation and Engagement of AOD Treatment (IET)
4. Pharmacotherapy for Opioid Use Disorder (OUD)

3. Advanced Interactivity

The following dashboards feature dynamic cross-filtering:

1. Blood Pressure Control for Patients with Diabetes (BPD)

2. Controlling High Blood Pressure (CBP)
3. Use of Pharmacotherapy for Opioid Use Disorder (OUD) Dashboard
4. Oral Evaluation during Pregnancy: Ages 15-20 (OEVP-CH) Dashboard
5. Prenatal Immunization Status (PRS) Dashboard
6. Childhood Immunization Status (CIS-E) Dashboard
7. Severe Obstetric Complications (SOC) Dashboard