Addressing SDOH in Rural Kansas Communities

Kansas Healthcare Collaborative

kfmc Health Improvement Partners

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Welcome!

- What clinic or facility do you work for?
- What city are you located in?
- What is your role?
- If you are an RHC or FQHC, please let us know

Today's Webinar Agenda

- Welcome – 5 mins
- Content Presentation 45 mins
  - Emersen Frazier and Shelly McMaster, Stormont Vail Health – Regulatory Considerations and Data
  - Melissa Wimmer, Sterling Medical Center – Using CHWs to Address SDOH
  - Nicole Baum, Holton Community Hospital – Community Fund to Address SDOH
- Q&A 8-10 Mins
- Closing Comments 2 mins

SAVE THE DATE

KHC Summit on Quality
August 8th, 2024
Wichita, KS
Wichita State University
Rhatigan Student Center

Learn More

SAVE THE DATE

KFMC Health Equity Summit
October 30th, 2024
Wichita, KS
Wichita State University
Eugene M. Hughes Metropolitan Complex

Other Partners

- Blue Cross and Blue Shield of Kansas
- Community Care Network of Kansas
- Kansas Department of Health and Environment
- Kansas Health Information Network
- Kansas Health Institute
- Kansas Hospital Association
- Kansas Perinatal Quality Collaborative

SDOH Regulatory Considerations and Data Collection

Emersen Frazier, Stormont-Vail Health
Shelly McMaster, Stormont-Vail Health

ADDRESSING SDOH IN RURAL COMMUNITIES

Shelly McMaster, RN, BSN, MBA
Emersen Frazier, MPH

Stormont Vail Health *2022*

Working together to improve the health of our community.

STORMONT VAIL HEALTH

- Employed Physicians – 283
- Employed Advanced Practice Providers – 251
- Employees – 5,452
- Volunteer Hours – 25,349
- Community Benefit – $55,508,502*

Stormont Vail Topeka Hospital 	Licensed Beds	586
	Births	1,498
	Surgeries	17,646
	Inpatient Admissions	19,380
	Emergency Visits	53,405
	Outpatient Visits	156,726
Cotton O'Neil Clinics 	Primary Care & Specialty Clinics	30+
	Express Care Visits	86,392
	Clinic Visits	763,858
Unique Patients Served		209,429

- Flint Hills Campus became part of Stormont Vail in 2023, therefore is not included in the 2022 numbers -

CMS Regulatory Requirement

1. Expand the collection, reporting, and analysis of standardized data
2. Assess causes of disparities within our programs and address inequities in policies and operations to close gaps
3. Build capacity of health care organizations and the workforce to reduce health and health care disparities
4. Advance language access, health literacy, and the provision of culturally tailored services
5. Increase all forms of accessibility to health care services and coverage

Social Determinants of Health Collection

<u>Screening Requirements</u>:

- Admitted for Inpatient Hospital Stay
  - 18 years or older on date of admission
  - Domains:
    1. Food Insecurity
    2. Housing Instability
    3. Transportation Needs
    4. Utility Difficulties
    5. Interpersonal Safety
- CMS Screening Tool Flexibility

Social Determinants of Health:
Social Determinants of Health

Social Determinants Flowsheet

PHYSICAL ACTIVITY			How often do you get together with friends or relatives?	Once a week	04/15/24 1606
On average, how many days per week do you engage in moderate to strenuous exercise (like a brisk walk)?	0 days	04/15/24 1606	How often do you attend church or religious services?	Never	04/15/24 1606
On average, how many minutes do you engage in exercise at this level?	0 min	04/15/24 1606	Do you belong to any clubs or organizations such as church groups, unions, fraternal or athletic groups, or school groups?	No	04/15/24 1606
FINANCIAL RESOURCE STRAIN			How often do you attend meetings of the clubs or organizations	More than 4 times per year	04/15/24 1606

SDOH DATA COLLECTION JOURNEY

2017	2018	2019	2020	2021	2022	2023	2024
• Enhanced Risk Score (ERS) • Pilot PCMH model and process in ambulatory clinics • EPIC Health Planet Tools and Committee	• ERS, plus • 3 Target Questions • Roll process out to all Primary Care Clinics • My Chart Questionnaire • Develop Reporting	• SDOH on Strategic Plan • Roll SDOH out to Hospital • LINK Grant • Endo Food Pantry • Increase focus to SDOH EPIC Tool	• EPIC Enhancement - Document in Flowsheets • COVID Hits	• SDOH Strategic Plan – Increase Capture Rate • Evaluate and re-engineer process • Establish compliance metrics	• Community Engagement and Resource Focus • Director of Health Equity Position	• Focus on CMS Regulation and Gap Analysis • Stormont Vail obtains Flint Hills Hospital • Establish SDOH Culture and Process at Flint Hills • New SDOH questions for specialties (ACOG)	• SDOH and Population Health Management • Establish SDOH Committee focused on new evidence

Changing Culture

SDOH DATA COLLECTION PROCESS

Hospital	Inpatient	Outpatient or Observation	Emergency Department
Hospital Process	Initial Assessment on Admission (EPIC Navigator)	**If Available - Completed by Patient on MyChart Bedside	Completion by Case Management (Admission Assessment)
Ambulatory	Clinic Visits (All Visits, focus on AWV)	MyChart Questionnaire	
Ambulatory Process	Collected by MA/Nursing during Standard Rooming Process	Patient Completes on MyChart (pushed out prior to appointment)	

Stormont Vail Health

SDOH Collection Barriers and Scripting

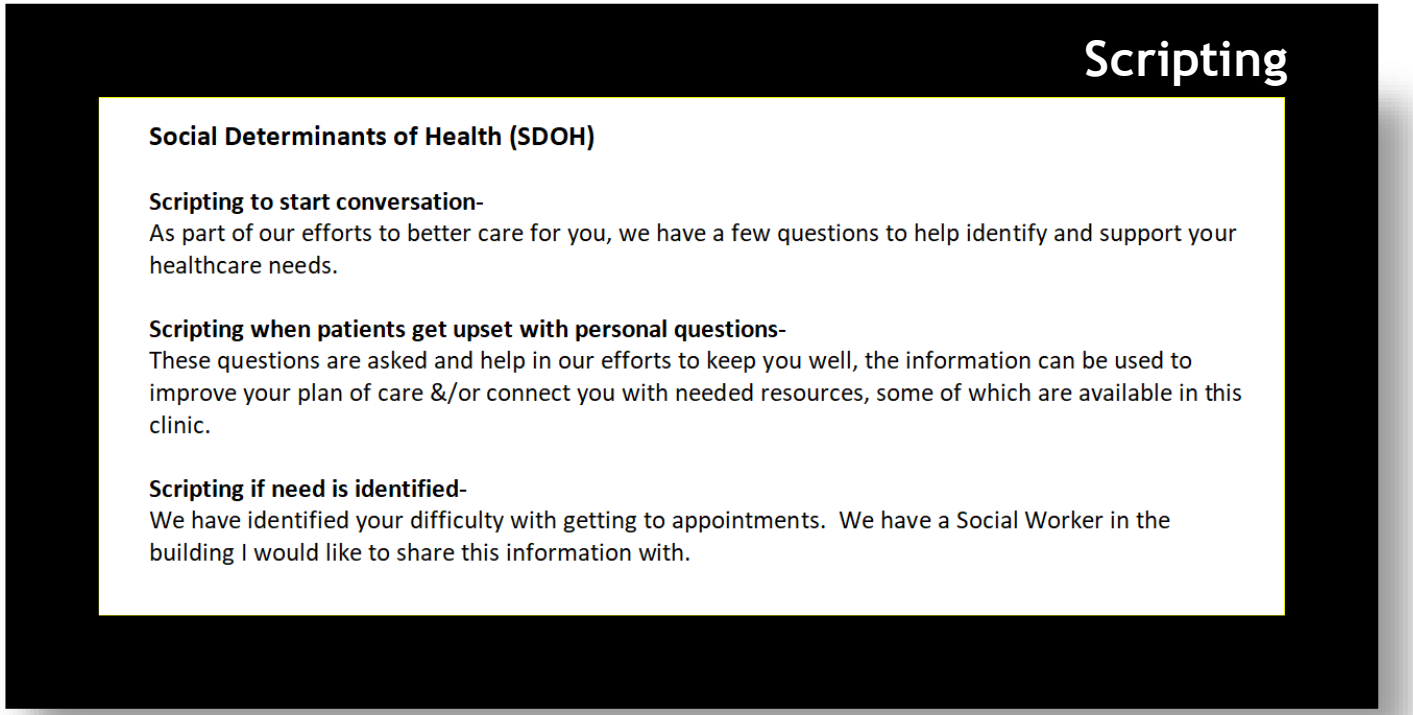
2017 – No one knew what SDOH was and why it was important

2018 – Staff felt awkward asking questions

2019 – Resistance to collecting during hospitalization

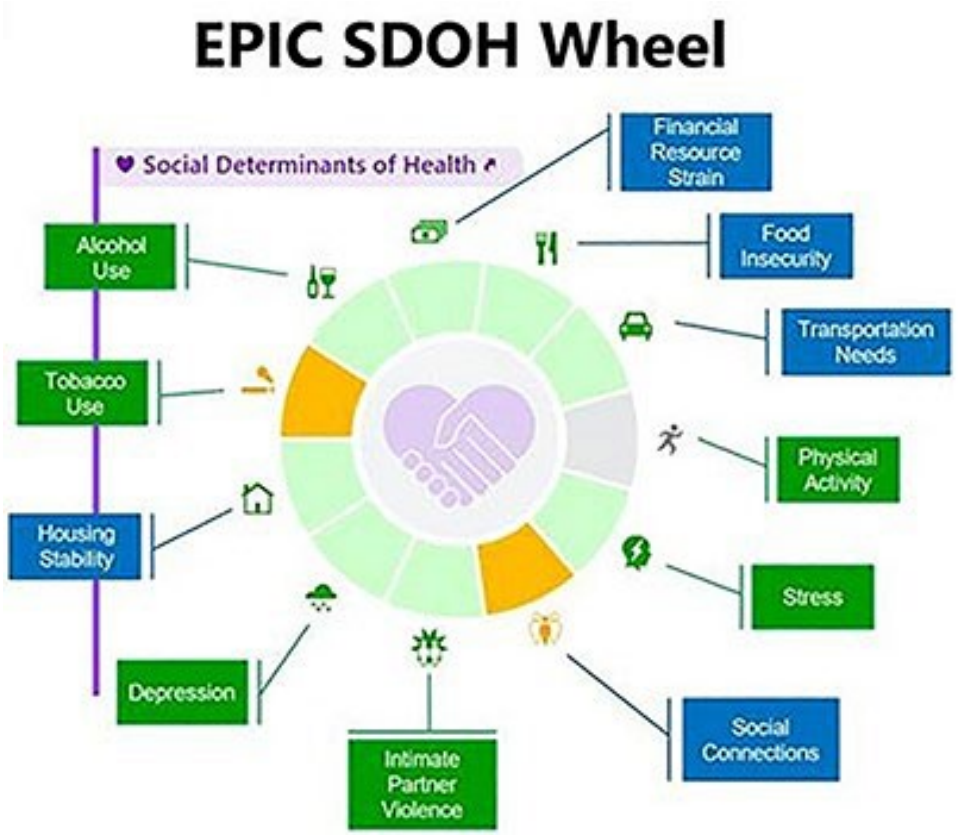
2020 – Covid slowed down progress

2023 – Specialty Practice use of SDOH



SDOH Questionnaire-

- ✓ SUBSTANCE USE
- ✓ DEPRESSION
- ✓ FINANCIAL RESOURCE STRAIN
- ✓ FOOD INSECURITY
- ✓ HOUSING STABILITY
- ✓ INTIMATE PARTNER VIOLENCE
- ✓ PHYSICAL ACTIVITY
- ✓ SOCIAL CONNECTIONS
- ✓ STRESS
- ✓ TRANSPORTATION NEEDS



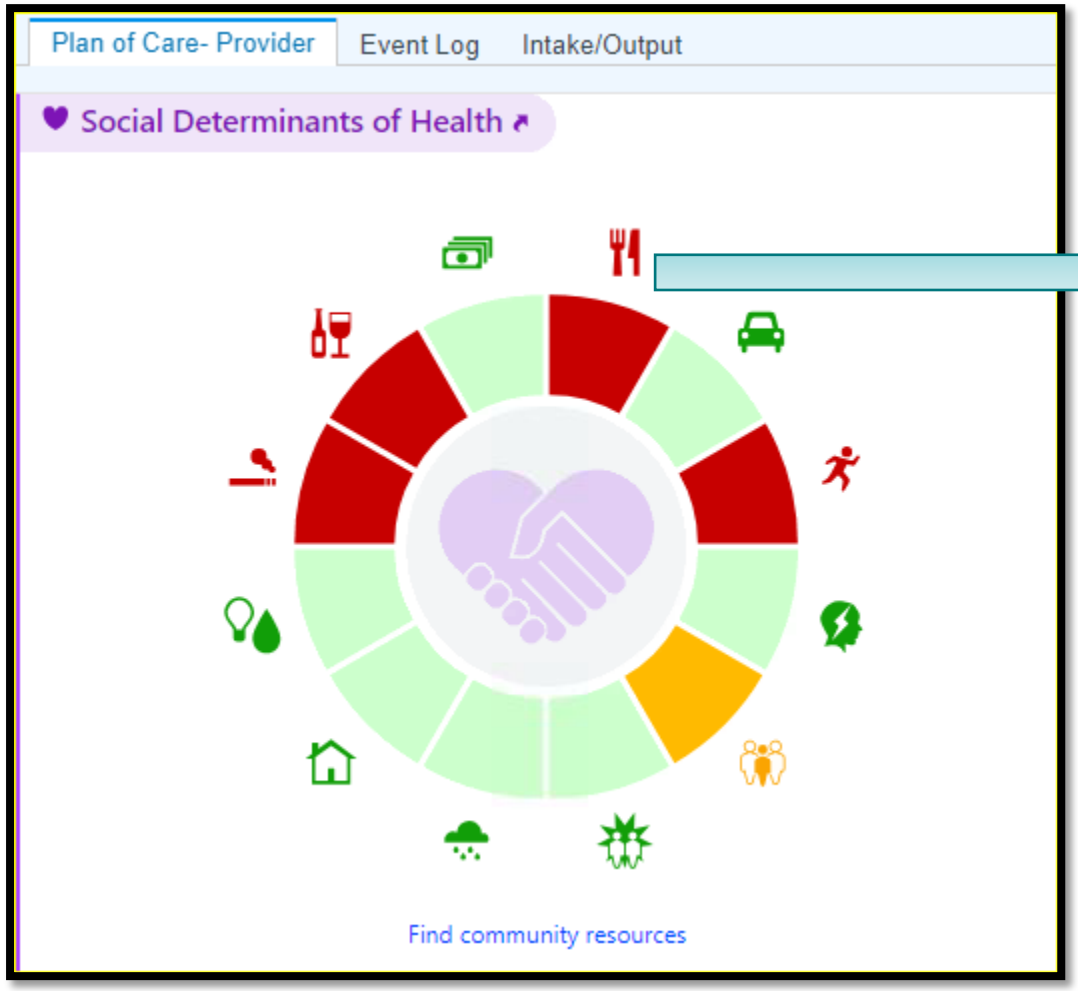
- Social Risk Factors
- Behavioral Health Risk Factors

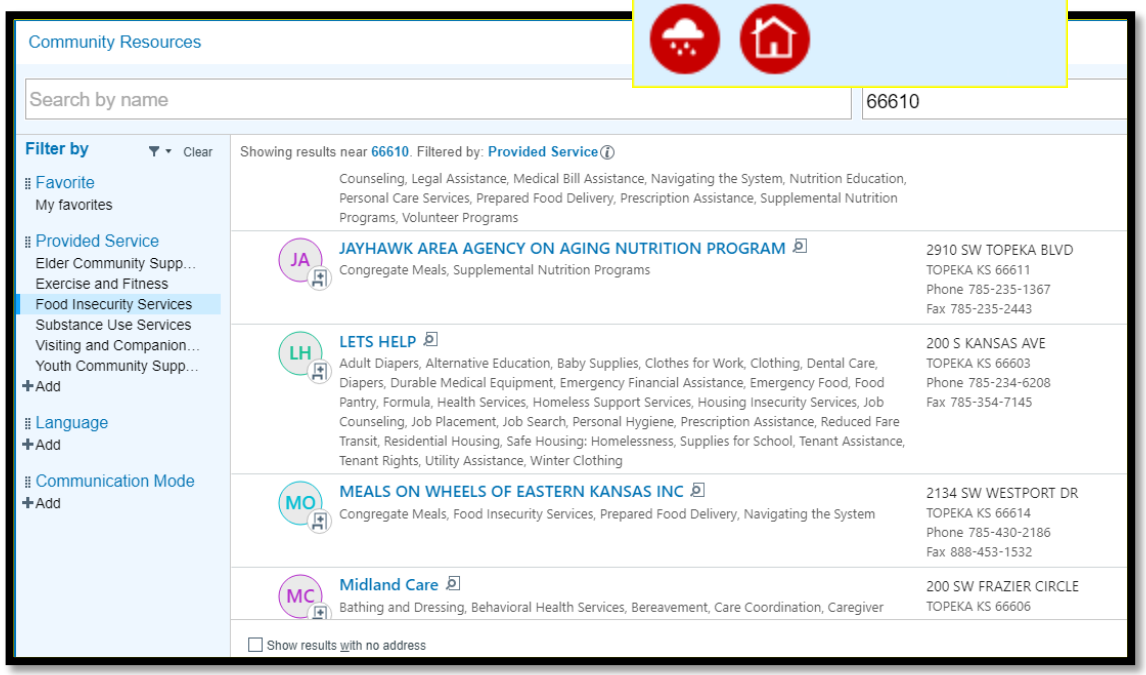
As social factors are documented, the SDOH Wheel will update:

- Green....no to low risk
- Yellow...moderate risk
- Red.....high risk
- Gray.....no data *(patient refused or not screened)*

ThedaCare.

EPIC Screening & Referrals





SDOH Tools and Transparency

Social Determinants of Health

Macros: (1) Patient Declined (2) Patient Unable t...

Physical Activity

On average, how many days per week do you engage in moderate to strenuous exercise (like a br

0 days | 1 day | 2 days | 3 days | 4 days | **5 days** | 6 days | 7 days | Patient unable to answer | Patient declined

On average, how many minutes do you engage in exercise at this level?

0 min | 10 min | 20 min | **30 min** | 40 min | 50 min | 60 min | 70 min | 80 min | 90 min | 100 min | 110 min | 120 min | 130 min | 140 min | 150+ min | Patient unable to answer | Patient declined

Financial Resource Strain

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

Very hard | Hard | Somewhat hard | Not very hard | **Not hard at all** | Patient unable to answer | Patient decl

Housing Stability

In the last 12 months, was there a time when you were not able to pay the mortgage or rent on tim

Yes | **No** | Patient unable to answer | Patient declined

In the past 12 months, how many times have you moved where you were living?

3

At any time in the past 12 months, were you homeless or living in a shelter (including now)?

Yes | **No** | Patient unable to answer | Patient declined

Chart Review

Encounters | Labs | Imaging | Procedures | ECG | Other Orders | Medications | Episodes | Letters | Notes | Misc Reports | Wounds

Plan of Care

Care Coordination Notes

Updated 6 years ago - Eliza Jenkins, RN

The patient has multiple medical issues. Followed by case management since 2010. Intermittent medication non-compliance. Always confirm whether patient is taking medications and whether she understands doses and timing.

Allergies

Penicillins

No severity specified - Hives

Problems

Noted

Cardiovascular and Mediastinum

Essential Hypertension 22 years ago

Local chart

Patient admits to poor compliance with med regimen in past-- doing

Social Determinants of Health

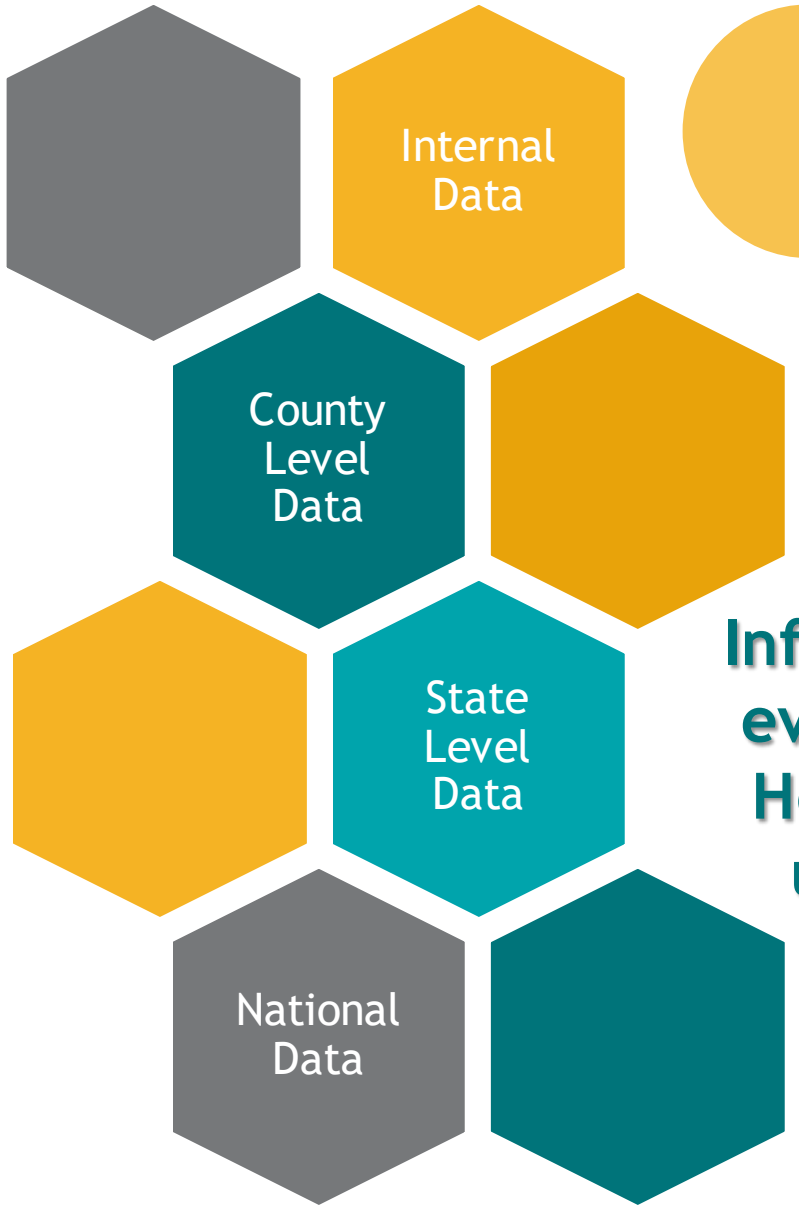
Find community resources

Electronic health record system, patient surveys, CAHPS, payer mix data, etc.

County Health Rankings, CHNAs, CHIPs, health department, zip code level data, etc.

Kansas Health Institute, KDADS, KDHE, Kansas Health Matters, Kanas Hospital Association, etc.

CDC, NIH, OMB, AHRQ, HRSA, Census Track data, academic research centers, etc.



Information is everywhere. How can we utilize it?

WHEN PRIORITIZING LOCAL DATA IS HELPUL

- **Small amount of internal resourcing to collect data**
- **Hold a large share hold of patient care in your area (>70%)**
- **Have access to community level data that is updated on a regular basis**
  - Ideally every 6 months to a year
- **Have information on methodology of how data is collected and interpreted**
  - When more resources are available, can use statistician to replicate using internal data.
  - Vital to understand what leading and lagging indicators your organization has the power to impact

WHAT CAN A DASHBOARD DO?

"The dashboard is able to **capture progress** made in certain areas as well as **identify areas of focus**. The dashboard also serves to **identify patient populations** that may be at increased risk for adverse outcomes. Discussing these dashboards in regularly scheduled quality meetings allows leadership to **continuously address gaps in care** and work to eliminate disparities."

- The American Hospital Association in partnership with Health Research & Educational Trust

Capture Progress

Will be able to easily acquire data that shows how SVH compares to other systems or public health data

Help Understand Populations

High level overview of patient population and which groups are underserved in our community

Identify Trends in Risk

See how various outcomes trend over time to track overall effectiveness of care

Drive Policy Change

Have ready data that supports new or innovative policy recommendations

EXAMPLE DASHBOARD

County Health Ranking Measures

- Takes data from Shawnee County from 2013-2019 to come up with %
- Defines LBW % as babies born <2500 grams or about 5.51 lbs.
- No distinction between LBW and VLBW, or cause of LBW
- Baby race based on mother no ethnicity data reported

Stormont Vail Mini Dashboard Measures

- All patients from Shawnee County 2013-2019
- Used same categories for LBW %
- Used % unit instead of rate
- Raw numbers = total cases NOT %

What the County Health Ranking Reports:

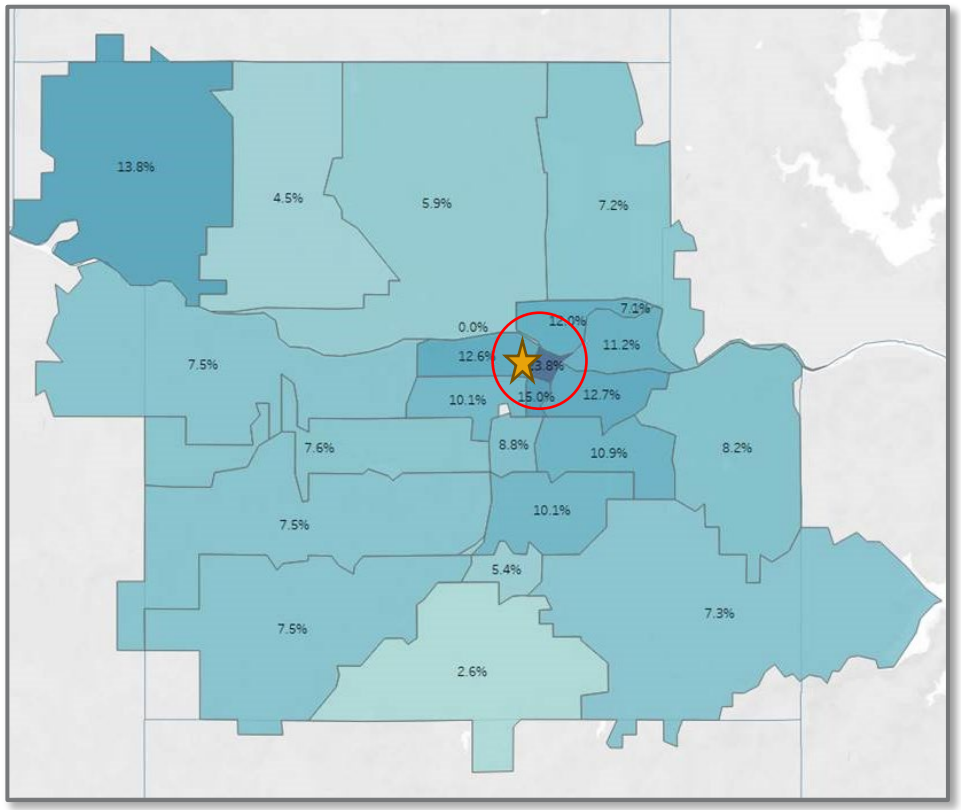
	Shawnee (SN) County	Trend	Error Margin	Top U.S. Performers	Kansas
Low birthweight	7%		7-7%	6%	7%

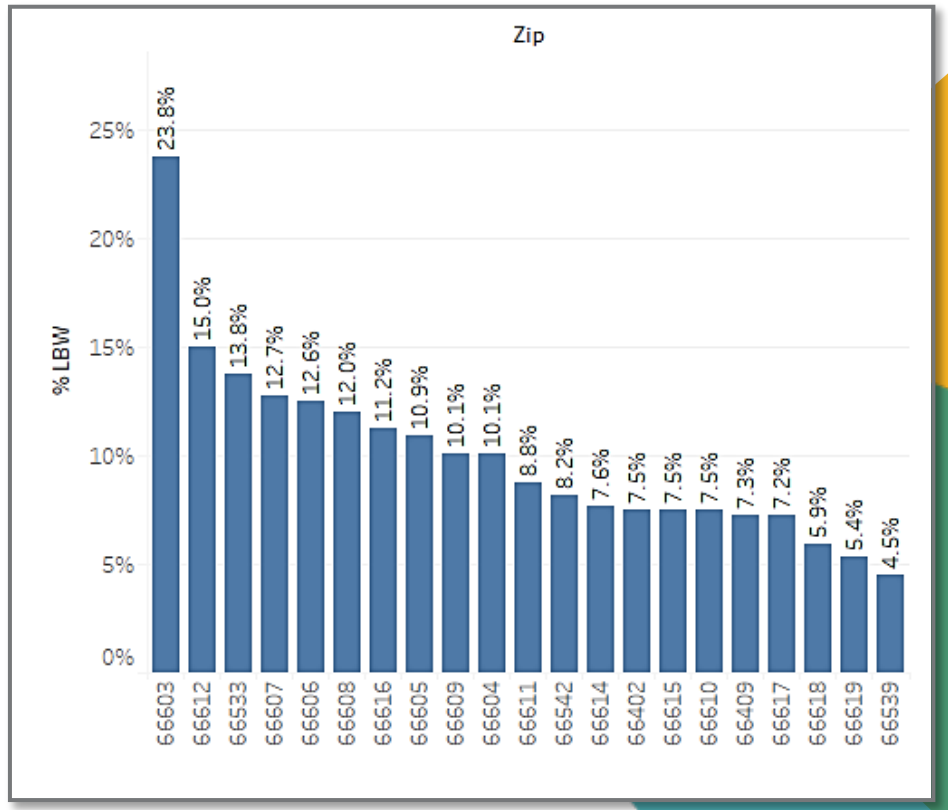
	Value	Error Margin	x
% LBW	7%	7-7%	
American Indian & Alaska Native	6%	2-10%	
Asian	7%	4-10%	
Black	12%	10-13%	
Hispanic	7%	6-8%	
White	6%	6-7%	

Low birthweight (LBW) represents infant current and future **morbidity**, premature **mortality** risk, and **maternal exposure** to health risks. LBW children have greater **developmental and growth problems**, are at higher risk of **cardiovascular disease**, **respiratory conditions**, and cognitive problems such as **cerebral palsy**, and visual, auditory, and intellectual **impairments** (County Health Rankings and Roadmaps).

EXAMPLE DASHBOARD

This mini dashboard was created in collaboration with the strategy team to use patient data in Epic compared to data from the Shawnee County Health Ranking. This information plus SDOH needs context can lead to a comprehensive health equity intervention.





★ = SVH approx. location

Stormont Vail Health

Stay in Touch with Us!

Shelly McMaster

Administrative Director, Clinical Integration

Email: SMcMaste@stormontvail.org

Emersen Frazier, MPH

Director, Health Equity & Policy

Email: Emersen.Frazier@stormontvail.org

THANK YOU

Best Practices for Using CHWs to Address SDOH in Rural Communities

Melissa Wimmer, Sterling Medical Center

Community Health Workers Program

STERLING MEDICAL CENTER-LYONS MEDICAL CENTER

RICE COUNTY DISTRICT HOSPITAL

CHW TEAM

-Melissa Wimmer RN, BSN

Program Director/Home Health RN

-Lisa Stout, Patient Navigator, CHW-C

-Jessica Inguanza, CHW-C

-Julissa Reyes, CHW-C

Rice County Health CHW

Bridging the gap between resources and wellness

- Chronic Health Issues
  - PreDiabetes
  - Hypertension
  - COPD
- Health Education
- Prenatal/Postnatal Support
- Disability Advocacy/Application
- Food Disparity
- Housing Instability

RCH CHW cont..

- Medical Appointment Transportation Facilitation
- Mental Health Advocacy
- Insurance Education
  - Presumptive Eligibility

Who and how are we serving?

- PreDiabetics/Diabetics
- Hypertensives
- COPD
- Pre/Postnatal Patients
- Newborns

- Patients over 60
- Disabled
- Families caring for grandchildren in foster care or kinship

How do we get patient referrals?

Relationships and Trust

- Clinic Provider Referrals
- ER/Hospital Discharge Provider Referrals
- EMS
- Community Events
- School Staff
- Council on Aging Staff
- Community Members

Rice County Overview

Small Town Strength

- Alden (122)
- Bushton (203)
- Chase (399)
- Frederick (9)
- Geneseo (89)
- Little River (472)
- Lyons (3,556)
- Sterling (2,507)

- Total County Population 9,150

Each Communities Needs
and Resources

- Serve in each community
  - Pt home visits in each town
  - Know resources specific to where they are located
  - Find the community advocates
  - Be the voice between the patient and provider

Health and wellness can be a long journey when there has been no previous roadmap.

- Walk along side patients through lifestyle changes
- Offer simple education and goals
- Make the process enjoyable
- Provide resources in conversation, then reinforce by providing contact information or making contact calls with patient

Reaching the Community….

- At the local coffee stops
  - Farmers BP Check/Mental Health
- Local Hispanic Business
  - BP/BS Check Saturday Morning
- High School Mental Health Day
  - CHW Staff Provided Support
- Local Craft Fair
  - Health Trivia and Education
- Thrift Store Support
  - Referral/Donate Time

Education, Activity, Support

- Hypertension
- Mobility issues
- Pre Diabetes
- Helped qualify for Disability

- Meal Planning
- Exercise Support
- Mental Health Championing
- Medication Advocacy

Since the start of our CHW program….

- Over 130 patients seen for home visits
  - No Patient Charge
  - Scheduled by patients need level
  - SDOH assessment, resource search, and referral collaboration
- Integral Partner with County Health Collaborative
- Outreach through Community Events
  - Created access to health education, tools, and resources
  - More than 300 people reached and multiple populations
  - Increased access to affordable fresh fruits and vegetables

Challenges are everywhere…

- Lack of Understanding of CHW team goals and expectations
- Resource limitations
- Sustainability/CMS/Medicaid Funding
- Unite Us Barrier
  - Small entities not using computer system to connect
  - Referral process limited
- Patient Transportation limitations

The Future is Exciting!

- Increased Community Knowledge of Program
- New Centralized and Visual Location in County
- Foundational Healthcare Community Support
- Continued Partnership Growth
  - K-State Extension
  - Rice County Health Department

Community Health Workers choose everyday to..

- **Believe in the basics of creating trust and support in the home. This choice sets a foundation for navigating communication and stability to achieve a healthier future physically and mentally for every person they come in contact with.**

Addressing SDOH with a Community Fund

Nicole Baum, Holton Community Hospital

HOLTON COMMUNITY HOSPITAL FOUNDATION

HOMETOWN HEART FUND

AGENDA

- Introduction of myself
- Foundation Mission/HHF Policy
- The Community Tie
- Sustaining Funds
- Patient Stories
- Final Takeaways

INTRODUCTIONS

- Nicole Baum, RN, BSN
- Program Director for Senior Life Solutions
- Foundation Director
- Born and raised in Holton, KS- returning to my established roots

THE HOMETOWN HEART FUND

Foundation mission: *The Holton Community Hospital Foundation supports the hospital in achieving its goals of compassion, professionalism and excellence in healthcare through philanthropic giving. Operating in accordance with the mission of Holton Community Hospital, the foundation builds lifelong relationships with contributors, raises funds and dedicates its resources to further advance the needs of the Hospital and those it serves.*

- Creation of the Hometown Heart Fund:

  - Created in 2021

  - Purpose: to assist Holton Community Hospital or physician's clinic patients with expenses for basic needs items, durable medical equipment, pharmaceuticals and travel expenses. Assistance can also be granted for physical, occupational, and cardiovascular service patients due to lack of insurance or for those who are underinsured

  -Special account within this fund for No-Cost Mammograms

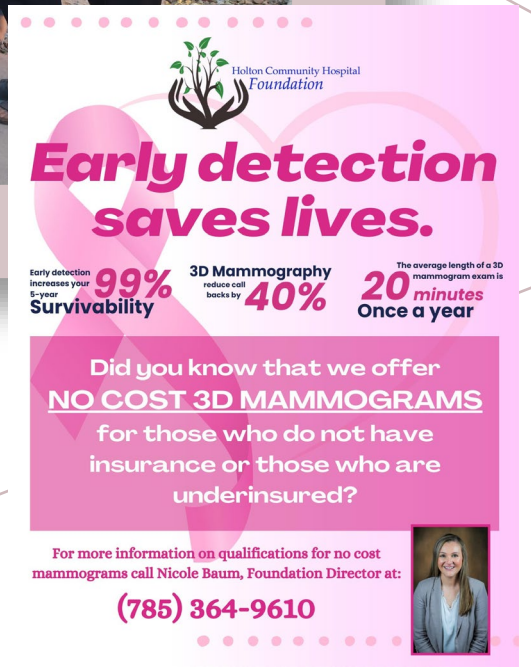
HOMETOWN HEART FUND POLICY BREAKDOWN

- Funds will not be paid directly to patients but rather on behalf of the patients.
- This fund covers:
  - $200 yearly for basic needs and transportation services
    - Jackson County EMS and our local transport directly bill the Foundation
    - Secured Transports
  - $500 annually for assistance with DME (oxygen equipment, wheelchairs, crutches, etc.), Pharmacy, Therapy, and Cardiovascular Services
  - No cost mammograms cover $200 per mammogram which covers the screening process
- Exceptions for the total yearly amount paid on behalf of any one patient or category of items eligible will only be approved under extenuating circumstances and if all other applicable funding sources have been exhausted.

NO COST MAMMOGRAMS

-Funds provided cover the screening/reading process for our patients covering $200 per mammogram

-Patient story- "*In December I went in for my mammogram and they told me to come back for a different one. I did. Then it was "you need to have a biopsy." I was in shock! I did mammograms every year! My chemo doctor told me that I have the pten gene. During my chemo, the breast I was having removed got infected and I got a 102 temp. I had to run to Lawrence for emergency surgery. He said if I would have waited the cancer would have went in my chest wall. So he took it out and I told the surgeon no more and to take the other breast too. I got prosthetics and can say- I am a survivor." - Tracey Shumaker*



Early detection increases your 5-year **Survivability** **99%**

3D Mammography reduce call backs by **40%**

The average length of a 3D mammogram exam is **20** ***minutes***

Once a year

Did you know that we offer NO COST 3D MAMMOGRAMS for those who do not have insurance or those who are underinsured?

THE COMMUNITY TIES

Holton Community Hospital Foundation Board

- Currently composed of 10 members
- Board consists of members throughout the community: Banks, local businesses, etc.
- Part of composing the Hometown Heart Fund or any changes made upon yearly review
- Vote upon exemptions under extenuating circumstances

Our community truly supports this Hospital and Foundation:

- Supports through monetary donation, volunteering, estate, memorials etc.
- Funds that come through the Foundation get poured directly back into the hospital and the HHF to give back to our patients.

"Keeping Our Patients Care Close To Home"

SUSTAINING FUNDS

Two main factors that help to keep our funds with the Hometown Heart Fund sustained/growing:

- Gracious donors
    - Designations within a will/Property-Vehicle/Real Estate
    - Specified Donations
    - Memorials or Tributes
- Events:
    - Color Run 2023
    - Breast Cancer Awareness Events

The HCH Foundation received an amazing donation in the amount of $4,000.00 in memory of Jane Aeschliman-Evans in support of the recent purchase of breast biopsy equipment for our radiology and surgery departments.
This equipment allows our general surgeon, Dr. Denis Jimenez, to provide surgical intervention for patients that have been diagnosed with breast cancer.


For Those We Love
In Memory Of:
Sharon Eshelman
Penni Britt
In Honor Of:
Naoma Foltz
Lynn Smith


GIANT COMMUNICATIONS
September 22, 2023
DATE
Pay to the Order of Holton Hospital Foundation
$ 10,000
ten thousand and no/100
DOLLARS
MEMO We Are Stronger Together Initiative
Giant Communications


WE ARE Stronger TOGETHER
DAN HARRIS REAL ESTATE AND AUCTION, LLC
HOLTON WALMART
AESCHLIMAN CONSTRUCTION
BAUM CONTRACTING, LLC
HOT SPOT
GREGG AND THERESA WATKINS
HHS DRUM LINE
BENEVOLENCE
FARMERS STATE BANK
CHEAPER THAN THERAPY
CECIL K'S
ROBINSON PHOTOBOOTH
THE COCKEYED PIG
RUSS AND HEATHER BACON
HHS SPIRIT SQUAD
NETAWAKA FITNESS CENTER
PRAIRIE BAND, LLC
BEVERLEY BROWN BOUTIQUE
HOLTON FIRE DEPARTMENT
BROWNS
WHITE LAW OFFICE
PENNYS COFFEE SHOP
HEART TO HOME
CHASE, JAYCI, AND BANKS WILSON
TEAM BLAKE
BURGER BUS
RHINO FITNESS
ROUSH & SONS TOWING AND RECOVERY LLC
JOSTENS
AIS
MELLIES FARM
CAFE CO-OP GIFTS
DAMONS PURPOSE
HALFLETE FITNESS CENTER
CAFE CATERING BY CINDY
TRAILS CAFE
TWIST MY BALLOON
JHETTS
BAUM MOTORS
VICTORIA LAMBERSON PHOTOGRAPHY
HOLTON LIVESTOCK EXCHANGE
KNZA
GIANT COMMUNICATIONS
TO THOSE WHO HAVE FOUGHT AND ARE CURRENTLY FIGHTING THE BATTLE - MIKE AND SHIRLEY COYLE, CHRIS HEINEKEN, CAROL BRAUM, NAOMA FOLTZ, LYNN SMITH, DIANA FATE, CORY SHIELDS, DAMON GUIGLEY, JANIE AESCHLIMAN/EVANS, SHIRLEY GOODEN AND DEB HENRY, SARA HOMAN, DUNNE THOMSEN, RAY WRIGHT, SANDY ROUSH-WILLIAMS, SHARON ESHELMAN, PENNI BRITT, KATHERINE CAVINESS, KATIE PITTAWAY, SHARON STAVROPOULOS, RAY HOLCOMB, GINNY "MAMAW" ROBINSON, CARL FARLEY, BOBBY PRINE, CATHLEEN REED, LISA (SCHUMANN) CHAPMAN, ELIZABETH KENNEDY, JUNE REED, DAVID BAUM, BUNNY AND RITA DARVEAUX, TOBY BECKER, AND MALETA GEISS.
WILLCOFF BREWING
HH
Oktoberfest
Eliza
MARQUEE
BREWS FOR BOOBS

EXAMPLES OF PATIENTS WE HELP

- Patient unable to afford a medication (Short term coverage)
- Patient needing a ramp to be able to safety enter and exit home
- Patient life flighted to Kansas City. Family member could not afford gas to make it to the hospital.
- Patient needing to leave hospital on Lovenox. Pharmaceutical coverage while social work is completing patient assistance.

While the Hometown Heart Fund is used as more of a short term/immediate solution- I work directly with our social work/case management team to meet the needs of the patient moving forward.

- Applying for Medicaid
- Referring on to the Health Department for basic needs
- Etc.

THANK YOU!

Nicole Baum

Phone: 785-364-9610

Fax: 785-362-7777

Nicole.baum@rhrjc.org

www.hchfoundation.net

"We care about the future of our rural health care and how it impacts our community, schools, churches, civic organizations, and our patients."

Questions?

Resources

- Health Equity Resource Hub
- KHC Health Equity Education Archive
- KHA/KHC: Regulatory Requirements Related to Health Equity & Social Determinants of Health
- KMAP Bulletin: Community Health Worker Services
- CMS Health Equity Services in the 2024 Physician Fee Schedule Final Rule
- Kansas Health Matters

Health Equity Resource Hub

Dismantle Health Disparities & Foster Equitable Healthcare Solutions

KFMC and our partners believe that everyone deserves the opportunity to lead a healthy life, regardless of their background, identity, or socioeconomic status. Our Health Equity Resource Hub was created to help healthcare professionals, organizations, and communities make informed decisions, raise awareness, and take action.

kfmc
Health Improvement Partners

Visit **www.kfmc.org/health-equity-resource-hub** or scan the QR code to access the Health Equity Resource Hub. The Hub will be updated regularly, so be sure to check back as we expand upon the current offering.

Upcoming Education and Important Dates

- 5/9 Navigating Rural Health Resources Series – HPSAs
- 5/22 KHC Office Hours - Applying High Reliability Concepts in Critical Access Hospitals
- 6/19 IHC Annual Forum - Altoona, IA
- 6/21 Resiliance Learning Action Series
- 6/26 KHC Office Hours - Advanced Directives are for the Living - Improving Workflows in Your Organization
- **July 31, 2024: Next Health Equity Webinar (Transportation)**
- 8/8 KHC Summit on Quality
- October 30, 2024: Kansas Health Equity Summit

Contact Information

- Jill Daughhetee, JDaughhetee@khconline.org
- Tammy Elliott, telliott@kfmc.org
- Emersen Frazier, emersen.frazier@stormontvail.org
- Shelly McMaster, SMcMaste@stormontvail.org
- Melissa Wimmer, mwimmer@rch-lyons.com
- Nicole Baum, nicole.baum@rhrjc.org

Kansas Healthcare COLLABORATIVE

Connect with us on:

KHCqi

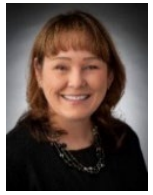
@KHCqi

Kansas Healthcare Collaborative

→ *Find contact info and more at:*
www.KHConline.org/staff

Malea Hartvickson
Executive Director

Mandy Johnson
Senior Director, Programs

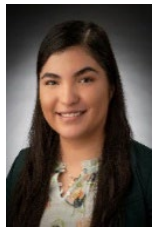


Treva Borcher
Director of Operations

Eric Cook-Wiens
Data & Measurement Director

Liz Warman
Quality Improvement Advisor

Jill Daughhetee
Director of Education and Communications

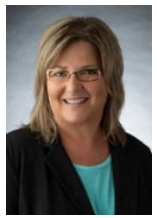


Azucena Gonzalez
Health Care Quality Data Analyst

Erin McGuire
Quality Improvement Advisor

Jenni Peters
Quality Improvement Advisor

Julia Pyle
Quality Improvement Advisor



Patty Thomsen
Quality Improvement Advisor

Rebecca Wagner
Project Specialist


KHC
underserved
evidence
opioid
workflow
measure
overdose
policy
smbp
grants
interventions
innovation
training
doctors
improvement
suicide
reporting
funding
diabetes
hqin
rural
data
prevention
overdose
clinical
projects
hospitals
advocacy
quality
change
coalitions
fqhc
policy
physicians
procedures
measure
macra
toolkit
cancer
creativity
improvement