

# YOUR CLINIC'S DASHBOARD



**Mobile  
Health Map**

**DATA TO CREATE YOUR DASHBOARD**

## **NOTES:**

- Use this worksheet to compile your data.
- If your clinic does not provide or have data on a screening/demographic data point, please enter "0".
- To learn more about a specific screening, learn more at the links provide for each screening.

Once you have this information, simply [login](#) and create your dashboard to help you evaluate your clinic's impact. And don't forget to update your data each year to track your impact!

## **Demographics (Add Percentages)**

### **Gender**

Men	
Women	
Transgender/Nonbinary	

## Ages

0-17	
18-44	
45-64	
65+	

## Race/Ethnicity

American Indian and Alaska Native	
Asian	
Black/African American	
Hispanic/Latino	
Native Hawaiian and other Pacific Islander	
White	
Multiracial	
Unknown	

## Insurance Status/Type

Private	
Medicaid/CHIP	
Medicare	
Multiple	
Uninsured	

## Patient/Visit Counts (Totals)

<b>Visits</b> Number of contacts/encounters between a patient and a provider. If some patients visit the clinic more than once, this number will be greater than the number of patients.	
<b>Patients</b> Number of people who had at least one visit. If the patient has more than one visit, they will still be counted only one time.	

# Number of People Screened/Counseled (Totals)

## COVID-19

<a href="#">COVID-19 vaccinations</a>	
<b>COVID-19 tests</b> Number of COVID-19 tests provided including those you administered and home test kits you distributed.	

## Children's Health

<a href="#">Immunizations</a>	
<a href="#">Vision Screening</a>	
<a href="#">Injury Prevention Counseling</a>	

## Women's Health

<a href="#">Cervical Cancer</a>	
<a href="#">Breast Cancer</a>	
<a href="#">Chlamydia</a>	
<a href="#">Osteoporosis</a>	
<a href="#">Folic Acid</a>	
<a href="#">Calcium*</a>	

## All Adults

<a href="#">Colorectal Cancer Screening</a>	
<a href="#">Hypertension</a>	
<a href="#">Cholesterol</a>	
<a href="#">Obesity</a>	
<a href="#">Depression</a>	
<a href="#">Diabetes</a>	
<a href="#">Syphilis</a>	
<a href="#">HIV</a>	
<a href="#">Tobacco Use</a>	
<a href="#">Alcohol Misuse</a>	
<a href="#">Unhealthy Drug Use</a>	
<a href="#">Flu Shots</a>	
<a href="#">Diet Counseling</a>	
<a href="#">Tetanus diphtheria boosters</a>	
<a href="#">Social Determinants of Health</a>	

## Older Adults

<a href="#">Vision</a>	
<a href="#">Pneumococcal Vaccine</a>	
<a href="#">Hearing Screening</a>	

## Costs

Yearly clinic operating costs	
-------------------------------	--

# Public Health Quality Questions

## NOTES:

For each prompt, users must choose one of the following options:

- Use strategy now
- Use more next year
- Don't use and don't plan to implement within next year

## Equitable

- Services will be affordable for those who are uninsured, underinsured or low-income?
- Written information will be easy to understand for those with low-literacy or language barriers?
- Locations will be convenient?
- The staff will speak the 2 most common languages?
- The staff will reflect the diversity of the target population?

## Health-promoting

- Offer counseling and education?
- Use clinical interventions?
- Implement long-lasting clinical interventions such as vaccinations?
- Change the context to people's health, e.g by offering healthy food in schools?
- Address the social determinants of health including poverty and discrimination ?

## Proactive

- Analyze community health reports and community data?
- Get feedback from people you serve on a regular basis?
- Review program data for emerging needs among your target population?
- Adjust services to address emerging needs?
- Train personnel in emergency response?

## Transparent

- Operational data?
- Equity data?
- Outcomes data?
- Governance data?
- Financial data?

## Effective and Efficient

- Use evidence-based interventions (programs proven to be effective and efficient)?
- Measure changes in knowledge, behavior, or health after intervention?
- Measure differences in a group's health when compared to another group that haven't received your program?
- Track expenses per individual served?
- Track return on investment?

## **Need personalized assistance?**

**Reach out to our team via [MobileHealthMap@hms.harvard.edu](mailto:MobileHealthMap@hms.harvard.edu), and we'll guide you through the process!**



# Providers Use Our Map to Demonstrate Impact

<b>FUNDING REQUESTS AND GRANT WRITING</b>	Many clinics have used data from the map to support expansion grants and requests for private funding.
<b>PRESENTATIONS TO SENIOR LEADERSHIP TEAMS</b>	Mobile clinic managers use the map's data to show health systems administrators the value of the services, including how many emergency room visits the clinic helped to prevent.
<b>CONVERSATIONS WITH POLICY-MAKERS</b>	Mobile clinic directors have compiled data from the map to inform their conversations with those driving policies in support of health care access and health care equity.
<b>TESTIMONY TO LOCAL GOVERNMENT OFFICIALS</b>	Mobile health providers have used map data to lobby government officials for public funding to support post-COVID community health initiatives.
<b>TALKING POINTS FOR INTERVIEWS WITH MEDIA</b>	Clinic spokespeople have used map data to create messages and talking points for press conferences and interviews with journalists.