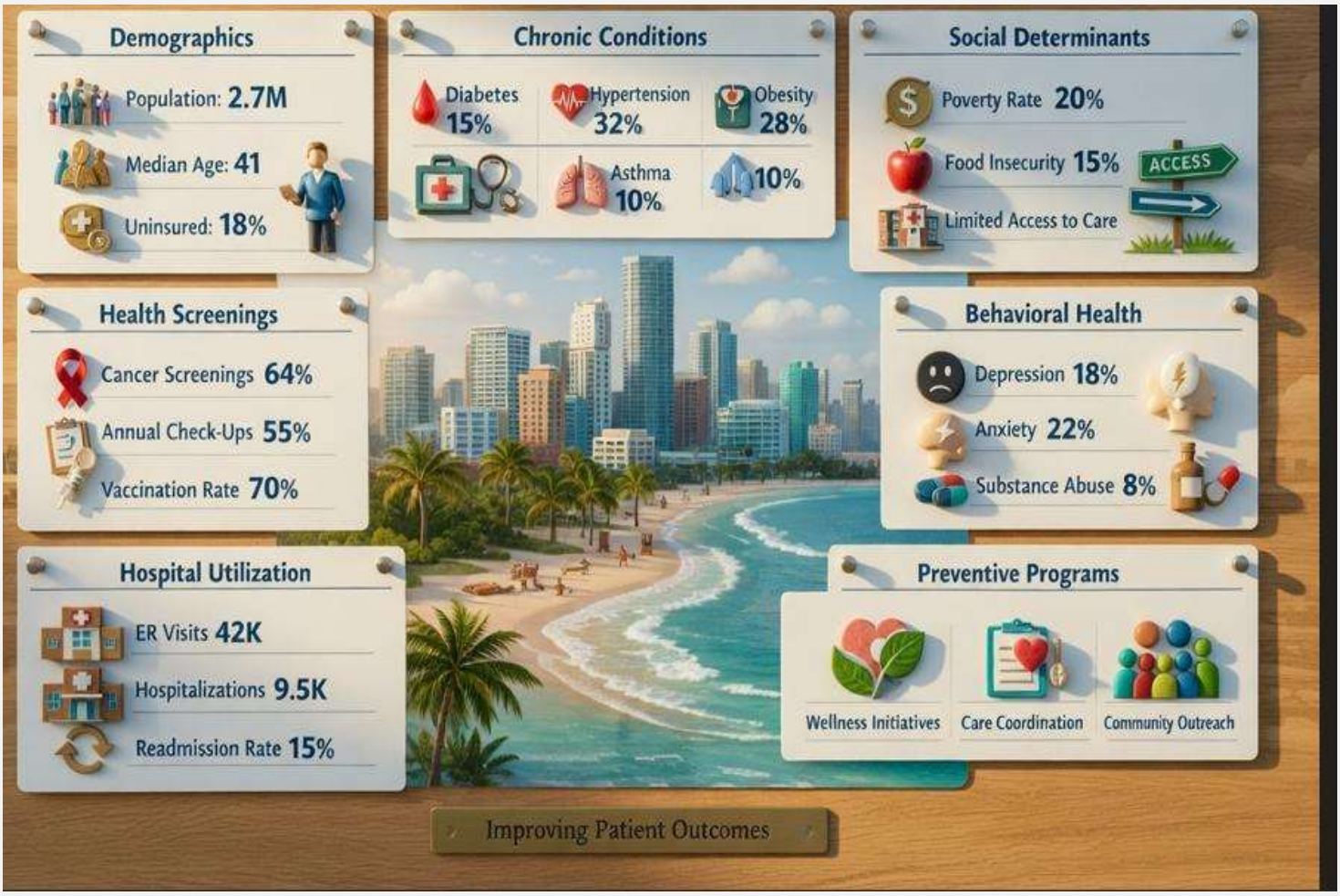
Population Health Management Dashboard: Miami-Dade County, Florida



Key Health Needs and PHM Infrastructure

The following table summarizes the prioritized health needs, required data sources, datasets, and measurable KPIs. This structure supports data-driven decision-making and program evaluation.

Health Need	Data Source	Data Set	KPI
Diabetes and chronic disease management	Electronic health records, Florida Department of Health reports, payer claims, admission-discharge-transfer feeds, U.S. Census data	ICD-10 diabetes diagnoses, hemoglobin A1c values, blood pressure, BMI, medication adherence, hospitalization history, emergency department visits, age, race/ethnicity, preferred language, insurance status, zip code	Percentage of patients with A1c below 8%; diabetes-related emergency department visits; diabetes-related hospitalizations; percentage of high-risk patients enrolled in care management

Mental health and psychosocial stressors	Behavioral health records, primary care screening records, community surveys, referral tracking systems, community partner reports	Depression screening results, anxiety screening scores, missed appointments, referral completion, insurance coverage, language needs, transportation barriers, social risk screening results	Percentage of patients screened for depression/anxiety; behavioral health follow-up rate; referral completion rate; missed appointment rate
Maternal and child health	Florida Department of Health maternal-child data sets, hospital obstetric records, prenatal clinic records, community health center reports	Birth weight, prenatal visit completion, maternal age, tobacco use, insurance type, infant mortality indicators, gestational diabetes, hypertension in pregnancy	Prenatal care completion rate; low birth weight rate; infant mortality rate; postpartum follow-up rate
Access, equity, and community outreach	U.S. Census Bureau, EHR utilization records, payer data, community-based organization reports, care coordination databases	Uninsured status, transportation barriers, no-show rates, preferred language, housing instability, food insecurity, community health worker participation, telehealth use	Uninsured rate; no-show rate; percentage screened for social needs; referral closure rate; community health worker engagement rate

This dashboard gives the Board of Directors a brief overview of the big population health issues in Miami-Dade County and the data infrastructure needed to sustain a PHM program. The suggested actions focus on measurable performance indicators, which could be followed over time to determine quality, access, and equity. Moreover, the incorporation of social and behavioral determinants and clinical measurements helps provide a more comprehensive view of care planning and intervention design (American Diabetes Association Professional Practice Committee, 2024). Since engagement of community health workers, screening of social needs, and chronic disease surveillance have all been linked to better outcomes, this dashboard establishes a feasible model of immediate benefits in patient care and long-term population health enhancement (Arroyave Caicedo et al., 2024; Evans et al., 2025).

References

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