Understanding Community Health Centers and Opportunities for Research and Data Partnerships

February 8, 2023

INTRODUCTIONS

CHAD
Community HealthCare Association of the Dakotas

Shannon Bacon

Becky Wahl

GREAT PLAINS
HEALTH DATA NETWORK

WHAT IS A COMMUNITY HEALTH CENTER

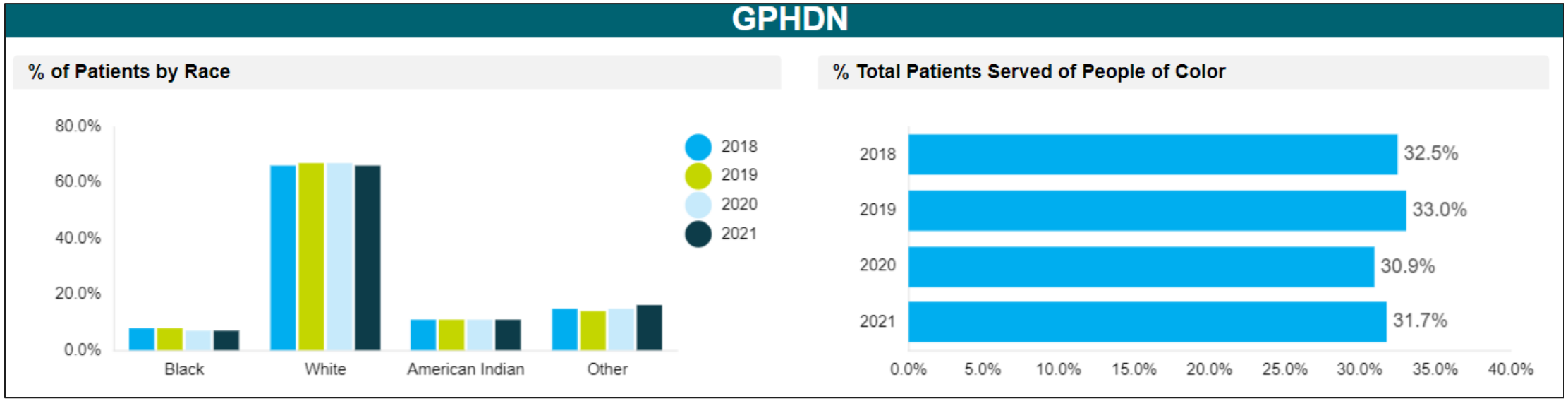
- Non-profit, community-driven clinics;
- Provide high-quality primary and preventative care to all individuals, regardless of their insurance status or ability to pay;
- Located in underserved and low-income urban and rural areas; and,
- Patients receive services that promote health, diagnose and treat disease, and manage chronic conditions and disabilities.
  - Dental, medical, behavioral, insurance enrollment specialists, vision care, translation/interpretation, and pharmacy.

WHO IS CHAD?

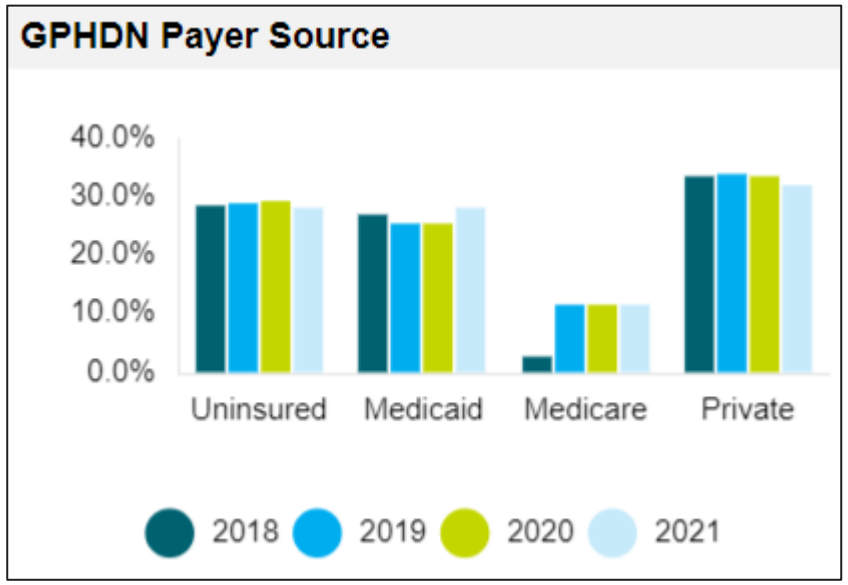
- Federally funded Primary Care Association
- Our board of directors = CHC leadership
- CHAD supports CHCs in their mission to provide access to health care for all Dakotans regardless of insurance status or ability to pay. This can look like:
  - Training
  - Peer networking
  - Coordinated implementation of an initiative
  - Coaching and technical assistance

PATIENTS WE SERVE

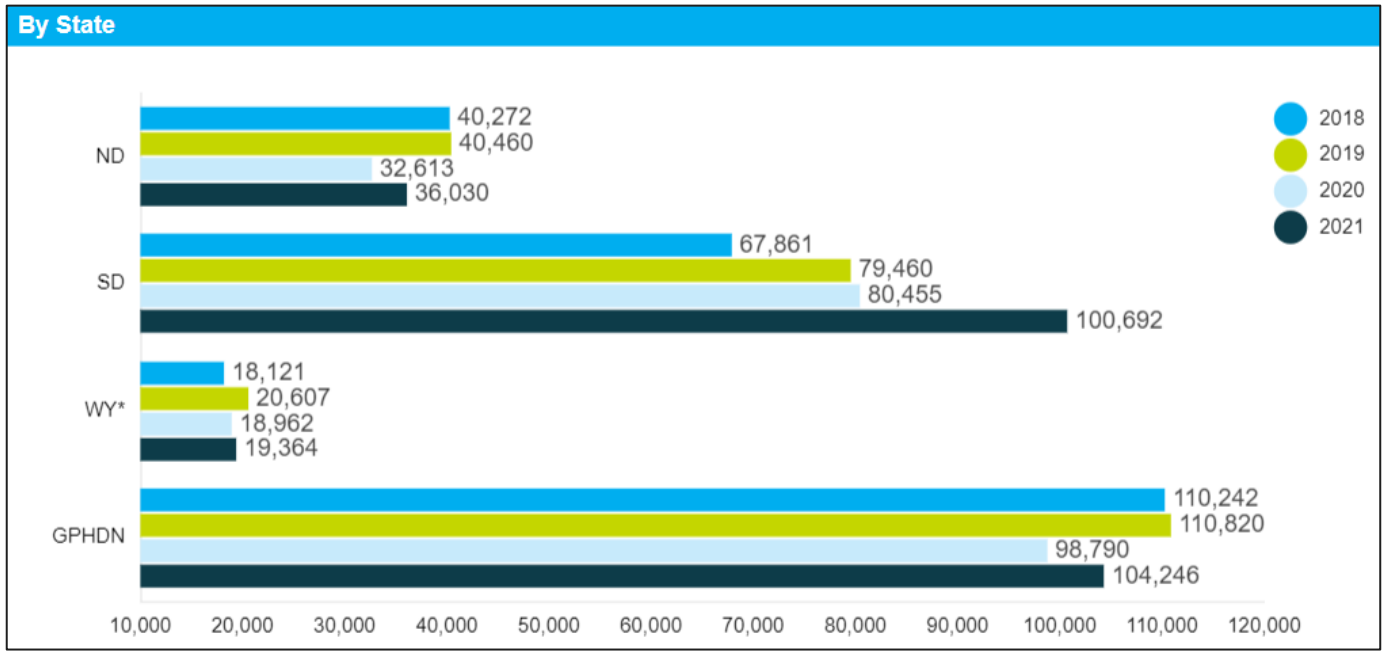
Health Centers serve all populations with limited access to health care, including rural and frontier areas, veterans, limited English proficiency, uninsured, Medicare and Medicaid, and low-income.



PATIENTS WE SERVE



TOTAL PATIENTS

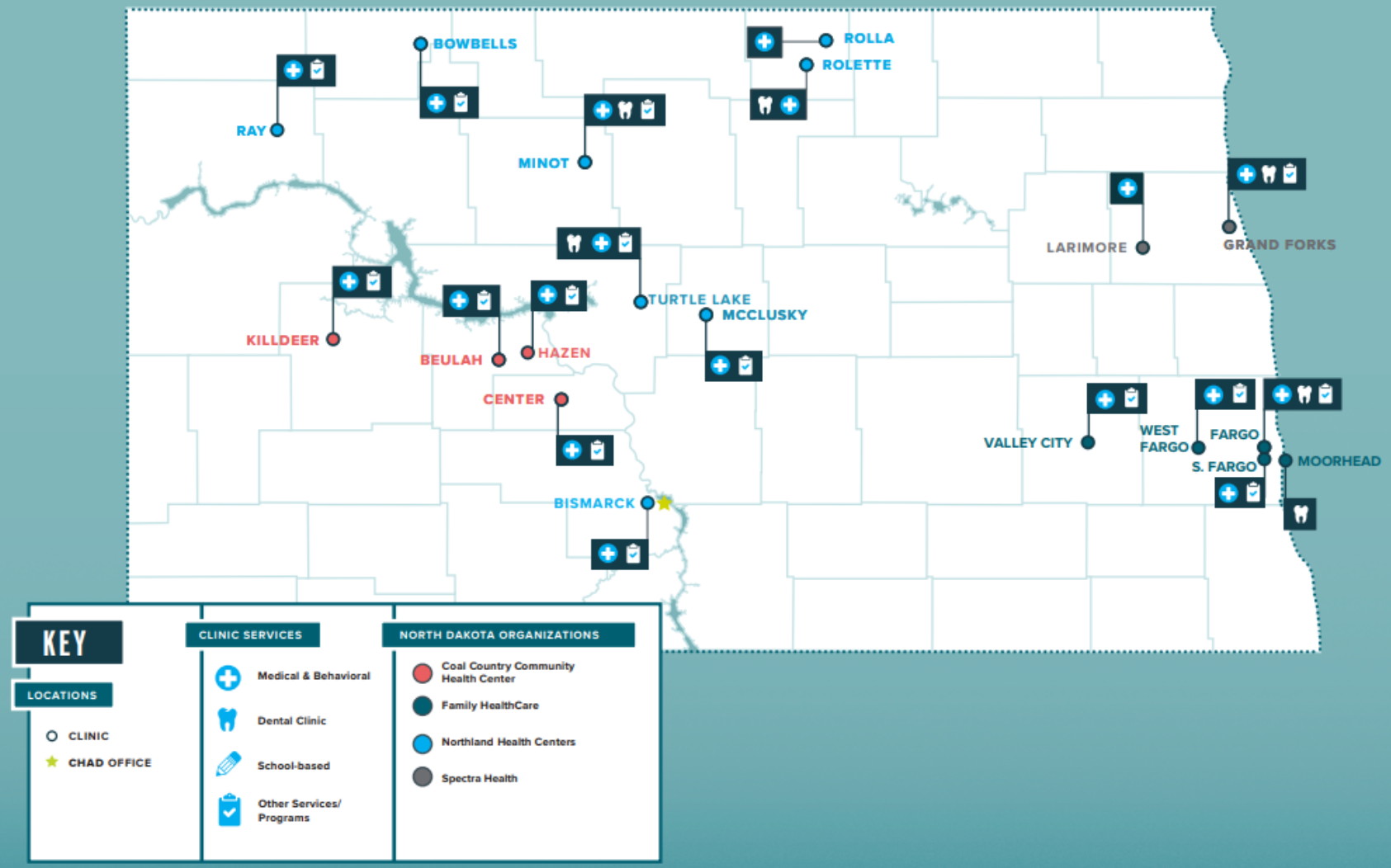


ABOUT GPHDN

- Affiliate of CHAD
- Partnership between CHAD and WYPCA
- Comprised of 11 Community Health Centers (CHCs) - 4 in ND, 3 in SD, 4 in WY
- GPHDN has combined land mass of nearly 246,000 miles with only a little over 2.2 million residents.
- Consists of 76 sites
- Range of small PHCs
  - Smallest PHC serves 362 patients
  - Largest PHC serves nearly 28,000 patients
- Serves nearly 105,000 patients across ND, SD, and WY

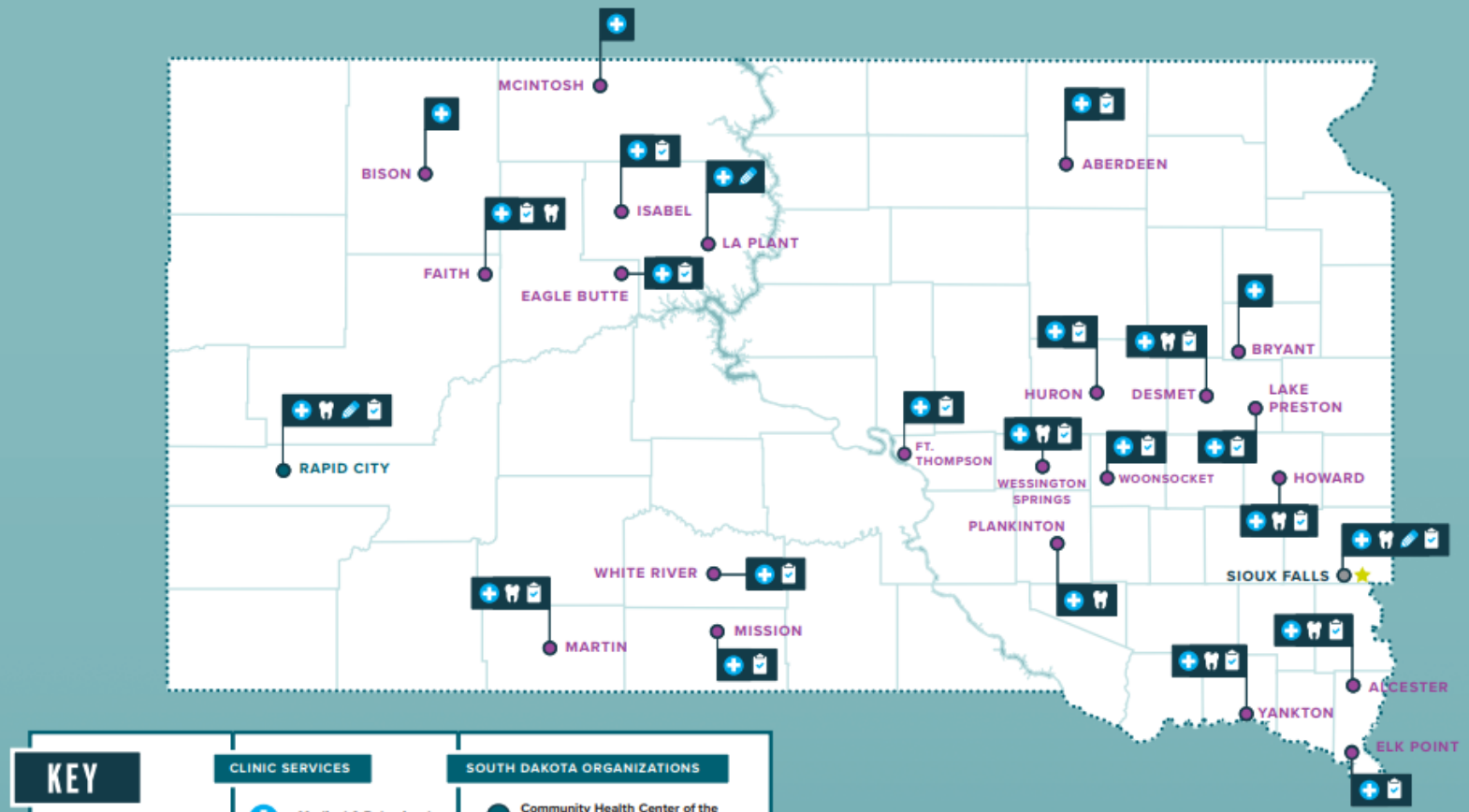
GREAT PLAINS HEALTH DATA NETWORK

NORTH DAKOTA COMMUNITY HEALTH CENTERS



GREAT PLAINS HEALTH DATA NETWORK

SOUTH DAKOTA COMMUNITY HEALTH CENTERS



KEY

LOCATIONS

- CLINIC
- CHAD OFFICE

CLINIC SERVICES

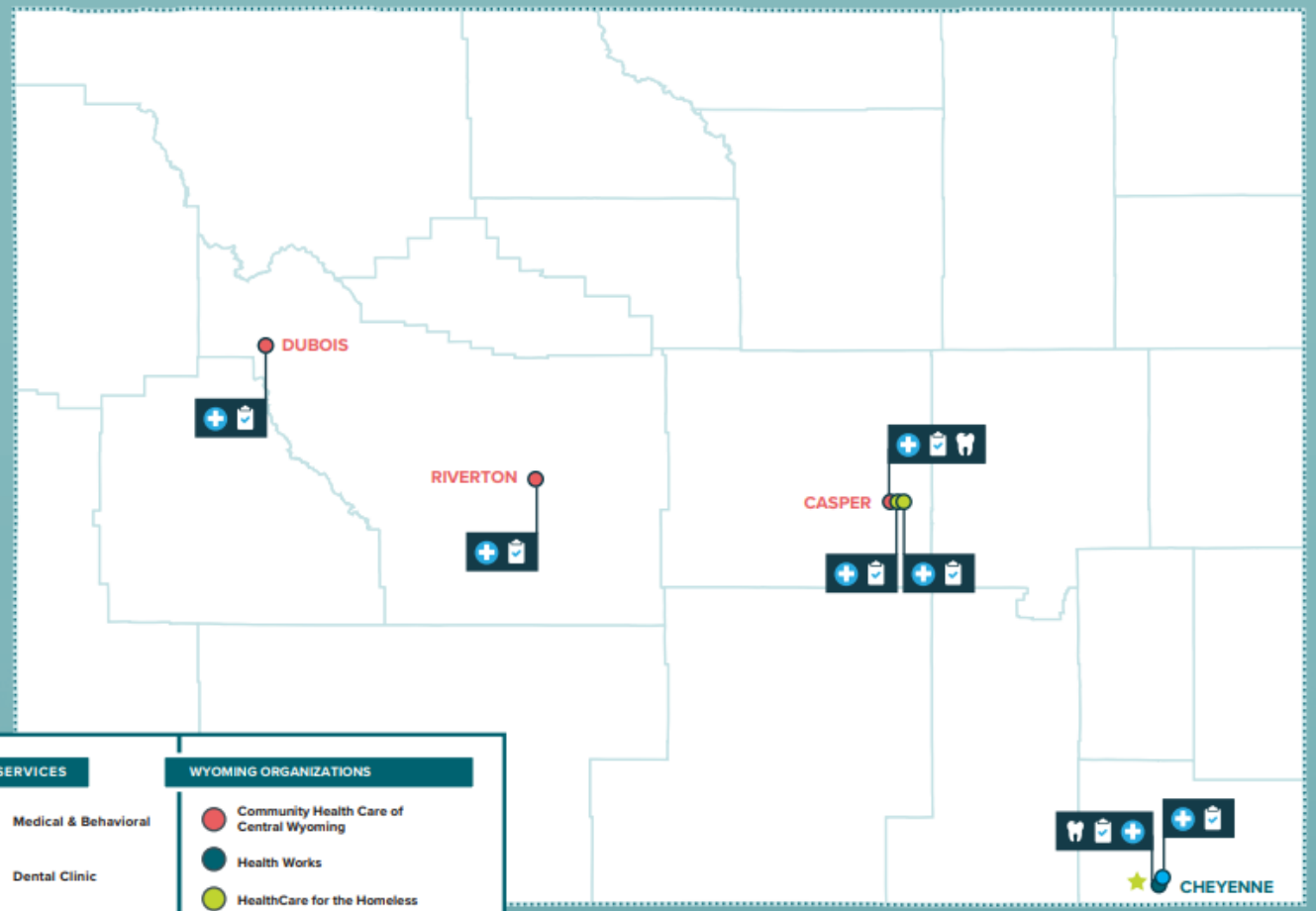
- Medical & Behavioral
- Dental Clinic
- School-based
- Other Services/ Programs

SOUTH DAKOTA ORGANIZATIONS

- Community Health Center of the Black Hills
- Falls Community Health
- Horizon Health Care

GREAT PLAINS HEALTH DATA NETWORK

WYOMING COMMUNITY HEALTH CENTERS



KEY

LOCATIONS

- CLINIC
- WYPCA OFFICE

CLINIC SERVICES

- Medical & Behavioral
- Dental Clinic
- School-based
- Other Services/ Programs

WYOMING ORGANIZATIONS

- Community Health Care of Central Wyoming
- Health Works
- HealthCare for the Homeless
- Crossroads

PARTICIPATING HEALTH CENTERS

FAMILY HealthCare

Coal Country Community Health Center

Falls Community health

Spectra Health

Community Health Center of the Black Hills

Northland Health Centers

HealthWorks Where health happens

CROSSROADS Healthcare Clinic

Community Health Centers

HORIZON Health Care Keeping communities well

Health Care for the Homeless

GPHDN FOCUS AREAS

- **Data Security**
- **Data Strategy**
  - Individual and network approach to using data
  - Identifying priorities for Azara
- Virtual Care
  - Telehealth
  - **Patient Engagement –** online scheduling/registration, two-way texting
- Data Aggregation and Analytic System (DAAS)/**Azara**
  - Implementation
  - Sustainability

DATA AGGREGATION AND ANALYTIC SYSTEM (DAAS)/AZARA

- DAAS is a population health management tool called Azara will data that is aggregated at the network and individual health center level.
- Connects to the health center electronic health record (EHR) and extracts the information into one data system called Azara.
- Currently have four health centers connected and three near completion of implementation. The remaining four should be implemented in the next 3-6 months.

AVAILABLE DATA

- Health Center Program Uniform Data System (UDS) data
  - Data on patient characteristics;
  - Services provided;
  - Clinical processes and health outcomes;
  - Patient's use of services;
  - Staffing;
  - Costs; and
  - Revenues.
- Patient's social risk factor data/risk stratification

AVAILABLE DATA

- Clinical data examples
  - Childhood immunization status
  - Child weight assessment
  - BMI screening and follow-up
  - Depression
  - Tobacco screening
  - Colorectal cancer screening
  - Cervical cancer screening
  - Breast cancer screening
  - Controlled substance data
  - Hypertension controlling high blood pressure
  - Diabetes A1c>9 or untested
  - Statin therapy for prevention and treatment of cardiovascular disease
  - IVD aspirin use
  - HIV screening
  - COVID-19 data
  - Dental
  - OB/Pregnancy data

POTENTIAL RESEARCH IDEAS

- Utilize patient engagement tool to test effectiveness of tailored messaging (reminder/recall notifications, or disease management education messages) and impacts on clinical quality measures or social determinants of health measures:
  - **Clinical Quality Examples:** Tobacco cessation; cancer screenings; hypertension; diabetes management; immunization; depression screening
  - **SDOH example:** Test out text messages with transportation assistance offer pre-visit for diabetic (or another cohort) patients who've screened positive on transportation need previously. What is the effect on diabetic management?

POTENTIAL RESEARCH IDEAS

- Analyze social determinant of health data correlation to clinical quality measures and identify/test potential interventions.
  - Example: What is the top social need for patients with uncontrolled blood pressure? Test out intervention on the top social need to identify whether there is improvement in blood pressure control.
- What are the health outcome impacts of onsite food pantries in medical settings? What implementation factors contribute to success?

TOBACCO SCREENING

Tobacco Screening
DASHBOARD

FILTER

PERIOD: TY January 2023
CENTERS: All Centers
RENDERING PROVIDERS: All Rendering Provid...

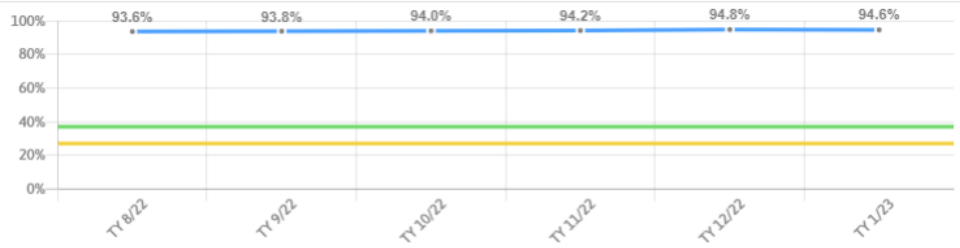
Add Filter | Update

Screening & Cessation (UDS)

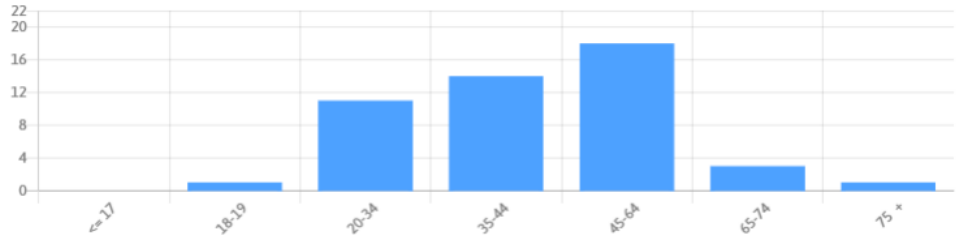
Bad Request

% of Pts As Tobacco User

Tobacco User, Cessation Provided



Tobacco User: No Cessation By Age



Details

		DEMOGRAPHICS >				
CENTER NAME	MRN	PATIENTID	NAME	SEX AT BIRTH	DATE OF BIRTH	MED
Access Community Health	1100261	277	Hassen, Lynetta	M	1/14/2004	8348
Family Health Center	1104106	2547	Leadbeater, Ryann	F	4/19/1987	5948
Neighborhood Health Center	1104080	1709	Sieger, Lesley	M	2/16/1986	6053
Family Health Center	1102811	1504	Polikoff, Modesto	M	10/10/1997	3561
Access Community Health	1104290	3547	Dumond, Aurelio	M	1/27/1986	7421
Access Community Health	1101913	3298	Kluemper, Curt	M	2/14/1977	5576
Neighborhood Health Center	1104323	3580	Gionta, Jeffrey	M	8/1/2001	4092
Access Community Health	1102079	4132	Stirman, Easter	M	12/28/2001	7655
Access Community Health	1102797	1490	Deruiter, Jamaal	M	9/10/1980	3857
Neighborhood Health Center	1103088	3409	Landman, Carrol	M	7/22/1965	1645
Access Community Health	1101804	2373	Miniuk, Marcela	F	1/11/1990	5735
Access Community Health	1102871	1564	Eagin, Simonne	F	3/16/1955	3843
Neighborhood Health Center	1104003	1632	Gantvoort, Jen	F	11/4/1973	8770
Access Community Health	1100645	3095	Gagan, Shaniqua	F	9/30/1978	4965
Neighborhood Health Center	1100938	4661	Kozak, Owen	M	11/6/1985	6792
Family Health Center	1101019	4742	Lessey, Elvera	F	6/11/2000	5322
Family Health Center	1101889	3274	Mullineaux, Gale	M	2/6/1942	7834

1 to 17 of 48 | Page 1 of 3

DIABETES AND TRANSPORTATION

Diabetes Prevalence
MEASURE

FILTER

PERIOD: TY January 2023 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid... | SDOH: TRANSPORT-MED

Add Filter | Update

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

Search Patients ...

All | Gaps | Num | Excl

Measure Investigation Tool | Reset Columns | SAVED COLUMNS

		DEMOGRAPHICS >							NEXT APPOINTMENT			
CENTER NAME	MRN	NAME	SEX AT BIRTH	DATE OF BIRTH	MEDICAID-NUMBER	USUAL PROVIDER	INACTIVE	DECEASED	DATE ↓	PROVIDER	LOCATION	APPOINTMENT TYPE
Access Community Health	1102204	Riffee, Gayle	M	11/14/1971	5460009	Smith, Joe	N	N	7/13/23 9:53 am	Black, Ronda	ACH - Needs Update	Annual Visit
Access Community Health	1102282	Shen, Marlen	F	1/17/1966	5171723	Decelles, Larry	N	N	6/26/23 8:38 am	Gunther, Eric	ACH - Needs Update	High BP
Access Community Health	1104285	Pinnix, Cammie	F	8/22/1965	5059010	Gunther, Eric	N	N	6/10/23 6:53 am	Smith, Joe	ACH - Needs Update	Physical
Access Community Health	1100789	Koretsky, Elvis	M	6/21/1994	1092922	Crowley, Patrick	N	N	5/28/23 8:23 am	Augustine, Greg	ACH - Needs Update	High BP
Access Community Health	1101567	Jaster, Esteban	M	9/5/1972	1968342	Crowley, Patrick	N	N	5/27/23 9:08 am	Winslow, Francine	ACH - Needs Update	Annual Visit
Neighborhood Health Center	1102032	Papps, Domonique	M	9/21/1975	9209787	Crane, Vince	N	N	5/5/23 6:38 am	Bar, Samuel	NHC - Needs Update	Injury
Access Community Health	1104751	Rousselle, Dario	M	9/7/1983	6288669	Crowley, Patrick	N	N	5/2/23 2:23 am	Black, Ronda	ACH - Needs Update	Mental Health and Counseling
Access Community Health	1101016	Dreibelbis, Kris	F	6/3/1981	9823585	Decelles, Larry	N	N	4/29/23 7:08 am	Augustine, Greg	ACH - Needs Update	Annual Visit
Neighborhood Health Center	1102776	Carmell, Frankie	M	5/30/1965	8457963	Pane, Janet	N	N	4/22/23 8:23 am	Green, Leslie	NHC - Needs Update	Office visit
Access Community Health	1102953	Delpit, Eddie	M	3/25/1965	2505235	Fritz, Renata	N	N	4/21/23 3:08 am	Crowley, Patrick	ACH - Needs Update	High BP
Family Health Center	1101303	Kalin, Laci	F	9/19/1977	6483567	Weixel, Evan	N	N	4/19/23 10:08 am	Rigoli, Brian	FHC - Needs Update	Mental Health and Counseling
Access Community Health	1100445	Mallegni, Joseph	M	8/26/1999	5853998	Smith, Joe	N	N	4/18/23 3:53 am	Smith, Joe	ACH - Needs Update	Annual Visit
Family Health Center	1100262	Heckaman, Shaun	M	12/14/1952	3154423	Houser, Dougie	N	N	4/17/23 9:38 am	Cote, David	FHC - Needs Update	Injury
Family Health Center	1102717	Luangrath, Mike	M	9/10/1994	5652703	Plant, Robert	N	N	4/17/23 3:53 am	Mejido, Daniel	FHC - Needs Update	Annual Visit
Family Health Center	1103067	Palin, Isobel	F	3/13/2001	7674667	Cote, David	N	N	4/16/23 5:23 am	Branchburg, Tom	FHC - Needs Update	Office visit
Access Community Health	1104007	Aronica, Zachariah	M	5/28/1982	2865879	Black, Ronda	N	N	4/13/23 7:53 am	Winslow, Francine	ACH - Needs Update	Injury
Family Health Center	1100157	Fanton, Mari	F	7/3/1996	1999319	Rigoli, Brian	N	N	4/11/23 4:38 am	Mejido, Daniel	FHC - Needs Update	Injury
Access Community Health	1102842	Schul, Nella	F	11/23/1972	2036500	Doe, Jane	N	N	4/10/23 6:08 am	Smith, Joe	ACH - Needs Update	Physical
Access Community Health	1101345	Kolodziej, Preston	F	5/29/1966	8323920	Gunther, Eric	N	N	4/8/23 6:23 am	Winslow, Francine	ACH - Needs Update	Office visit

DATA EXAMPLES – HYPERTENSION BY SOCIAL NEEDS

Social Needs Assessed
DASHBOARD

FILTER

PERIOD: TY January 2023 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid... | PATIENT DIAGNOSES: Hypertension

Add Filter | Update

Social Needs Assessed

88%

Needs Assessed Trend

2,480
1,984
1,488
992
496
0
TY 8/22 TY 9/22 TY 10/22 TY 11/22 TY 12/22 TY 1/23

Core +1 Assessed

31%

Housing & Income

1,344
1,076
807
538
269
0
FPL<200 HOMELESS HOUSING

Personal Characteristics

1,885
1,508
1,131
754
377
0
HISP/LAT LANGUAGE RACE

>12 SDOH

534
Pts who had qualifying encounter and completed SDOH assessment in the period
TY 8/22

SDOH Count Distribution

2 3 4 5 6 7 8 9 10 11

Material Security

1,778
1,424
1,068
712
356
0
FOOD MATERIAL SECURITY MED/CARE PHONE RENT/MORTGAGE UTILITY

Violence & Stress

1,313
1,052
789
526
263
0
SAFETY STRESS VIOLENCE

Migrant-Incarc-Refugee (Situational)

1,673
1,340
1,005
670
335
0
MIGRANT

8-12 SDOH

1,316
Pts who had qualifying encounter and completed SDOH assessment in the period
TY 8/22

Transportation & Isolation

1,339
1,072
804
536
268
0
ISOLATION TRANSPORT-MED TRANSPORT-NONMED

Education & Employment

1,950
1,560
1,170
780
390
0
EDU EMPLOYMENT

Insurance

No data available

4-7 SDOH

221
Pts who had qualifying encounter and completed SDOH assessment in the period
TY 8/22

<4 SDOH

7
Pts who had qualifying encounter and completed SDOH assessment in the period
TY 8/22

BUILDING COHORT - HYPERTENSION

Hypertension Controlling High Blood Pressure (CMS 165v10)
MEASURE

FILTER

PERIOD: TY January 2023 | CENTERS: All Centers | RENDERING PROVIDERS: All Rendering Provid... | SERVICE LINES: Primary Care | SDOH: FOOD

Add Filter | Update

MEASURE ANALYZER | DETAIL LIST | VALUE SETS

Search Patients ...

All | Gaps | Num | Excl

Measure Investigation Tool | SAVED COLUMNS

		DEMOGRAPHICS >							MOST RECENT ENCOUNTER			NEXT APPOINTMENT	
CENTER NAME	MRN	NAME	SEX AT BIRTH	DATE OF BIRTH	MEDICAID-NUMBER	USUAL PROVIDER	INACTIVE	DECEASED	DATE	PROVIDER	LOCATION	DATE	PROVIDE
Family Health Center	1100314	Zitzloff, Creola	F	12/3/2002	1896463	Rigoli, Brian	N	N	12/25/2022	Houser, Dougie	Lakeview Adult Medicine	2/17/23 4:08 am	Houser, D
Access Community Health	1100324	Simonetty, Linnie	F	9/6/1969	6740469	Gunther, Eric	N	N	12/25/2022	Gunther, Eric	Main St. Office		
Access Community Health	1100328	Pillion, Waylon	M	9/9/1940	4519606	Fritz, Renata	N	N	12/12/2022	Bridgewater, Bill	Main St. Office		
Access Community Health	1100332	Fowle, Kelly	M	4/5/1984	8556909	Black, Ronda	N	N	10/7/2022	Black, Ronda	Main St. Office	2/9/23 4:38 am	Bridgewa
Neighborhood Health Center	1100389	Sumruld, Alexis	M	6/7/1995	8979625	Lynes, Lori	N	N	12/25/2022	Bar, Samuel	Main Office	3/15/23 9:08 am	Pane, Jan
Family Health Center	1100423	Ricardi, Adalberto	M	2/19/1964	5110572	Houser, Dougie	N	N	12/25/2022	Jones, James	Florence Ave. Center	3/3/23 9:23 am	Ryan, Fra
Access Community Health	1100441	Wittman, Eden	F	5/11/1972	7134018	Decelles, Larry	N	N	1/6/2023	Winslow, Francine	70 Blanchard Rd.		
Neighborhood Health Center	1101541	Duvel, Kermit	M	4/26/2001	3135472	Paul, Jessica	N	N	5/6/2022	Parker, Philip	Adult Health	3/18/23 7:08 am	Lynes, Lor
Access Community Health	1101566	Gertz, Stanley	F	6/13/1980	7060516	Decelles, Larry	N	N	6/16/2022	Augustine, Greg	Main St. Office		
Access Community Health	1101567	Jaster, Esteban	M	9/5/1972	1968342	Crowley, Patrick	N	N	12/25/2022	Crowley, Patrick	1400 Cambridge St.	5/27/23 9:08 am	Winslow,
Access Community Health	1101590	Rellihan, Julie	F	11/15/1952	3267347	Winslow, Francine	N	N	11/23/2022	Smith, Joe	Main St. Office		
Access Community Health	1101601	Trantham, Kathleen	F	11/16/1983	3400430	Augustine, Greg	N	N	11/24/2022	Doe, Jane	Main St. Office		
Neighborhood Health Center	1101625	Stubler, Claud	M	6/1/1975	8216005	Pane, Janet	N	N	1/16/2023	Crane, Vince	Main Office	3/5/23 3:38 am	Green, Le
Access Community Health	1101642	Appelbaum, Augustine	M	4/8/1979	8975051	Doe, Jane	N	N	5/29/2022	Bridgewater, Bill	70 Blanchard Rd.	3/20/23 3:38 am	Black, Ro
Neighborhood Health Center	1101647	Yellock, Taina	F	11/14/2003	3179437	Lynes, Lori	N	N	12/3/2022	Green, Leslie	Neighborhood Medical Ce...	2/17/23 4:38 am	Crane, Vir
Access Community Health	1102754	Sheirich, Winnie	F	12/30/1980	7096931	Decelles, Larry	N	N	1/8/2023	Augustine, Greg	1400 Cambridge St.	3/26/23 6:53 am	Black, Ro
Neighborhood Health Center	1102761	Jaquet, Lincoln	M	11/7/1975	6041667	Pane, Janet	N	N	10/25/2022	Parker, Philip	Neighborhood Medical Ce...	4/14/23 8:23 am	Lynes, Lor
Access Community Health	1102816	Whisenton, Darius	M	8/14/1969	6989089	Winslow, Francine	N	N	2/16/2022	Augustine, Greg	Main St. Office		
Access Community Health	1102842	Schul, Nella	F	11/23/1972	2036500	Doe, Jane	N	N	9/23/2022	Augustine, Greg	Main St. Office	4/10/23 6:08 am	Smith, Joe

DATA EXAMPLES – DIABETES BY DEMOGRAPHICS

Section C: Diabetes: Hemoglobin A1c Poor Control

LINE	RACE AND ETHNICITY	TOTAL PATIENTS 18 THROUGH 74 YEARS OF AGE WITH DIABETES (3A)	PATIENTS WITH HBA1C > 9% OR NO TEST DURING YEAR (3F)
Hispanic or Latino/a			
1a	Asian	32	22
1b1	Native Hawaiian	20	11
1b2	Other Pacific Islander	33	22
1c	Black/African American	25	15
1d	American Indian/Alaska Native	25	16
1e	White	29	17
1f	More than One Race	23	14
1g	Unreported/Chose Not to Disclose Race	33	21
	Subtotal Hispanic or Latino/a	**220**	**138**
	Unmapped	0	0
	Ignore	0	0
Non-Hispanic or Latino/a			
2a	Asian	59	38
2b1	Native Hawaiian	66	34
2b2	Other Pacific Islander	58	34
2c	Black/African American	52	30
2d	American Indian/Alaska Native	64	40
2e	White	45	28
2f	More than One Race	58	35
2g	Unreported/Chose Not to Disclose Race	28	19
	Subtotal Non-Hispanic or Latino/a	**430**	**258**

FUTURE DATA

- Admissions, Discharge, and Transfer (ADT) data;
- Claims data;
- Referral data;
- Patient engagement data;
- Health information exchange (HIE) data;
- Prescription fill data; and,
- Other possibilities available

HOW TO REQUEST DATA

- Researchers would determine which CHCs they would like to have part of their study.
- Researchers identify which data is needed.
- Contact Becky Wahl or Shannon Bacon at GPHDN to request data.
- GPHDN will reach out to CHCs to share study information and develop participation agreement.
- GPHDN will determine data use cost depending on data needs– subscription costs range from $18,500 to $35,500/health center annually
- Data use agreements will be executed upon agreement.

Contact Information:

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DaCCoTA/CHAD Liaison
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