

# Improving Health Outcomes: Strategic Data-Driven Interventions

Thursday, January 29, 2026  
3:00 - 4:00pm Eastern / 12:00 - 1:00pm Pacific

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## **MOSES/WEITZMAN** Health System

*Always groundbreaking. Always grounded.*

### **Community Health Center, Inc.**

A leading Federally Qualified Health Center based in Connecticut.

### **CeCN**

A national eConsult platform improving patient access to specialty care.

### **The Consortium for Advanced Practice Providers**

A membership, education, advocacy, and accreditation organization for APP postgraduate training.

### **National Institute for Medical Assistant Advancement**

An accredited educational institution that trains medical assistants for a career in team-based care environments.

### **The Weitzman Institute**

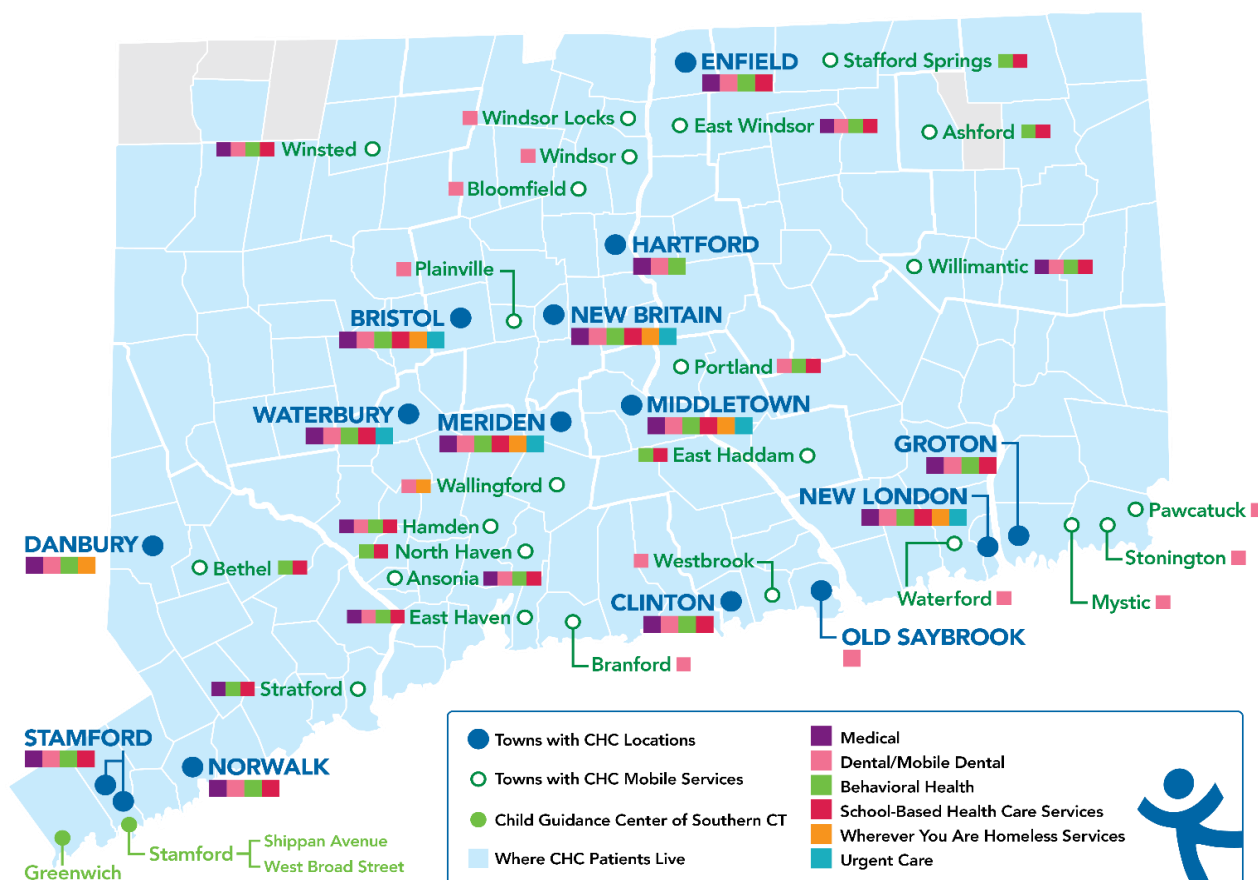
A center for innovative research, education, and policy.

### **Center for Key Populations**

A health program with international reach, focused on the most vulnerable among us.



# Locations & Service Sites



## THREE FOUNDATIONAL PILLARS

<b>1</b> Clinical Excellence	<b>2</b> Research and Development	<b>3</b> Training the Next Generation
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## Overview

- Founded: May 1, 1972
- Staff: 1,400
- Active Patients: 150,000
- Patients CY: 107,225
- SBHCs across CT: 152

Year	2022	2023	2024
Patients Seen	102,275	104,917	107,225

# National Training and Technical Assistance Partners (NTTAP) Clinical Workforce Development

Provides **free** training and technical assistance to federally funded health centers and look-alikes across the nation through webinars, activity sessions, communities of practice, trainings, publications, and more!

To learn more, please visit <https://www.weitzmaninstitute.org/nca>.

# Speakers

- Karoline Oliveira, Ed. D, Chief of Clinical Excellence, Moses/Weitzman Health System
- Tierney Giannotti, MPA, Director, Population Health; Community Health Center, Inc.

# Learning Objectives

1. Describe the significance of collecting demographic data for community member health and access to care
2. Understand how CHCI's data is reflected based on patient data reporting
3. Understand how patient demographic data is used to support health outcomes



# Patient Demographic Data

Race

Ethnicity

Language

Housing  
Status

Household  
Income

# Improving Health Outcomes Requires:

- ✓ Develop strategies to improve health outcomes across our patient populations
- ✓ Screen for and address health related needs that contribute to improving health outcomes
- ✓ Collect demographic data in order to understand who our patients are for the purpose of developing appropriate practices and interventions

# How is demographic data used to improve health outcomes?

Ensuring access to  
care members of  
our surrounding  
community

Ensuring health of  
our individual  
community  
members

# Ensuring Access to Care

Document important differences in access between patient groups

Supports targeted efforts to promote access to care within communities that seek primary care at a lower rate

# Ensuring Health for Community Members

Identifying the prevalence of various health conditions and related risk factors within specific groups

Understanding risks at the individual or community level

Allocation of resources for the development of targeted health interventions



## Note...

- It is important to understand, however, the practice of collecting demographic data or describing health related needs, alone, do not lead to better health outcomes or clinical experiences for patients
- Demographic data must be incorporated into the development and implementation of policies and practices in order to effectively address health related needs
- AND...the data must be complete, reliable and robust

# Reporting Race of CHC Patients

**Denominator:** Patients who DO report race

**Finding:** 25% of our patients are Black/African American

Patients By Race & Ethnicity (as reported to UDS for 2024)	%
Racial and/or Ethnic Minority Patients	78.33%
Black/African American Patients	27.74%
Hispanic/Latino Patients	58.23%
Non-Hispanic White Patients	39.37%
Asian Patients	6.05%
Native Hawaiian/Other Pacific Islander Patients	0.58%
American Indian/Alaska Native Patients	1.01%
More than one race Patients	1.79%

**Denominator:** ALL of our patients regardless of whether we have data on their race

**Finding:** 12% of our patients are Black/African American

Patients By Race & Ethnicity (where denominator includes patients of unknown ethnicity or race)	%
Racial and/or Ethnic Minority Patients	67.58%
Black/African American Patients	13.18%
Hispanic/Latino Patients	53.67%
Non-Hispanic White Patients	18.70%
Asian Patients	2.88%
Native Hawaiian/Other Pacific Islander Patients	0.28%
American Indian/Alaska Native Patients	0.48%
More than one race Patients	0.85%

# Patient Feedback

Patients have questions about what we use the data for

## Trust:

Patients are more likely to share if they trust the relationship

## Timing:

Patients may feel more comfortable after seeing the clinical provider rather than at the time of registration

# Strategies for Data Collection

- Conduct focus groups
- Recorded videos in patient waiting areas
- Live trainings for appropriate staff
- Text messaging to patients
- Grand Rounds to front line clinical teams

# Alicia Video



## Key Take-A-Ways...

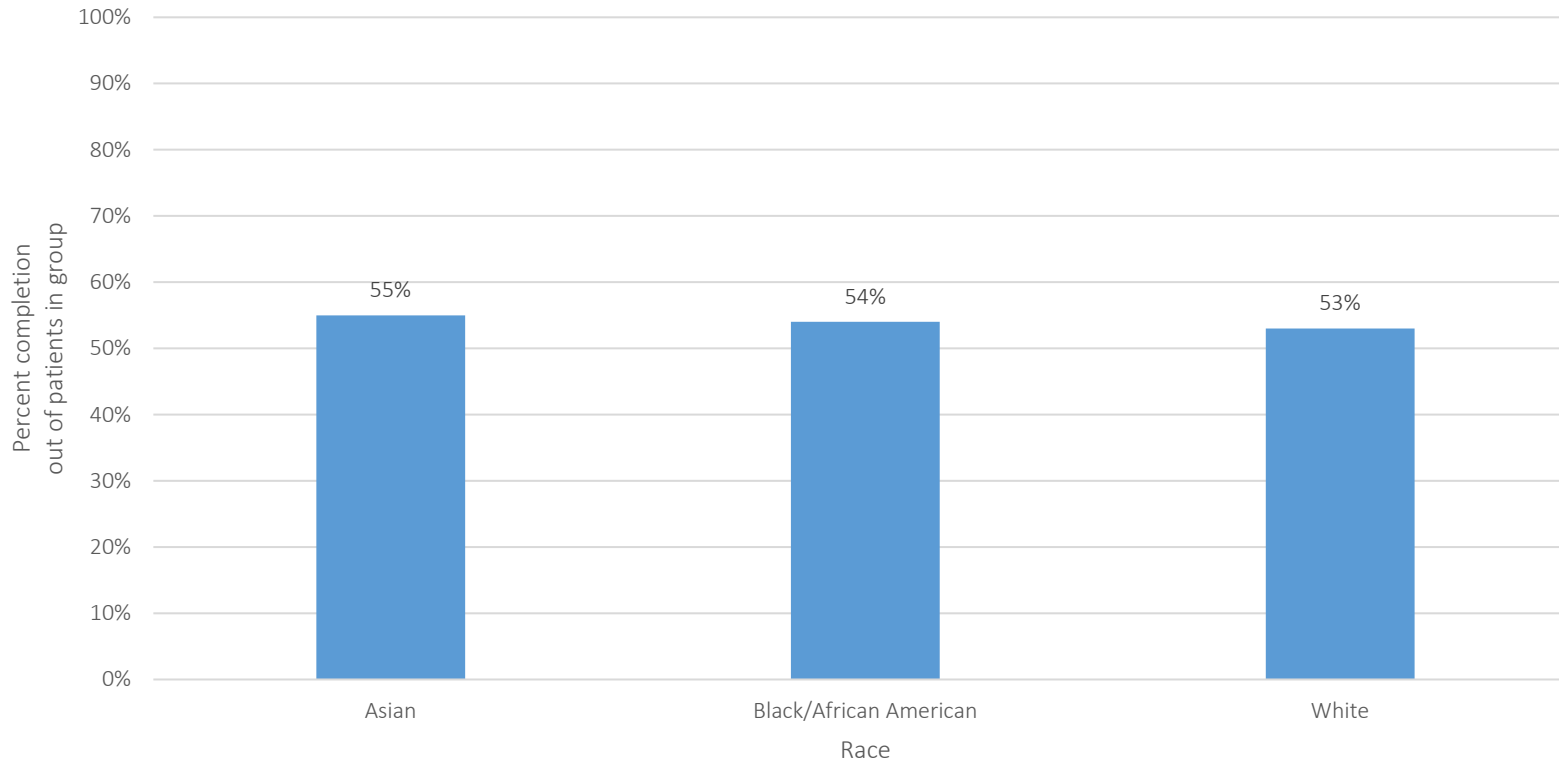
1. Collecting demographic data is part of the pursuit of improving health outcomes
2. Collecting demographic data is fundamental to
  - Ensuring health of our community members
  - Ensuring access to care
3. We all contribute to the collection of patient demographic data

# Putting Data to Use

# Using Demographic Data

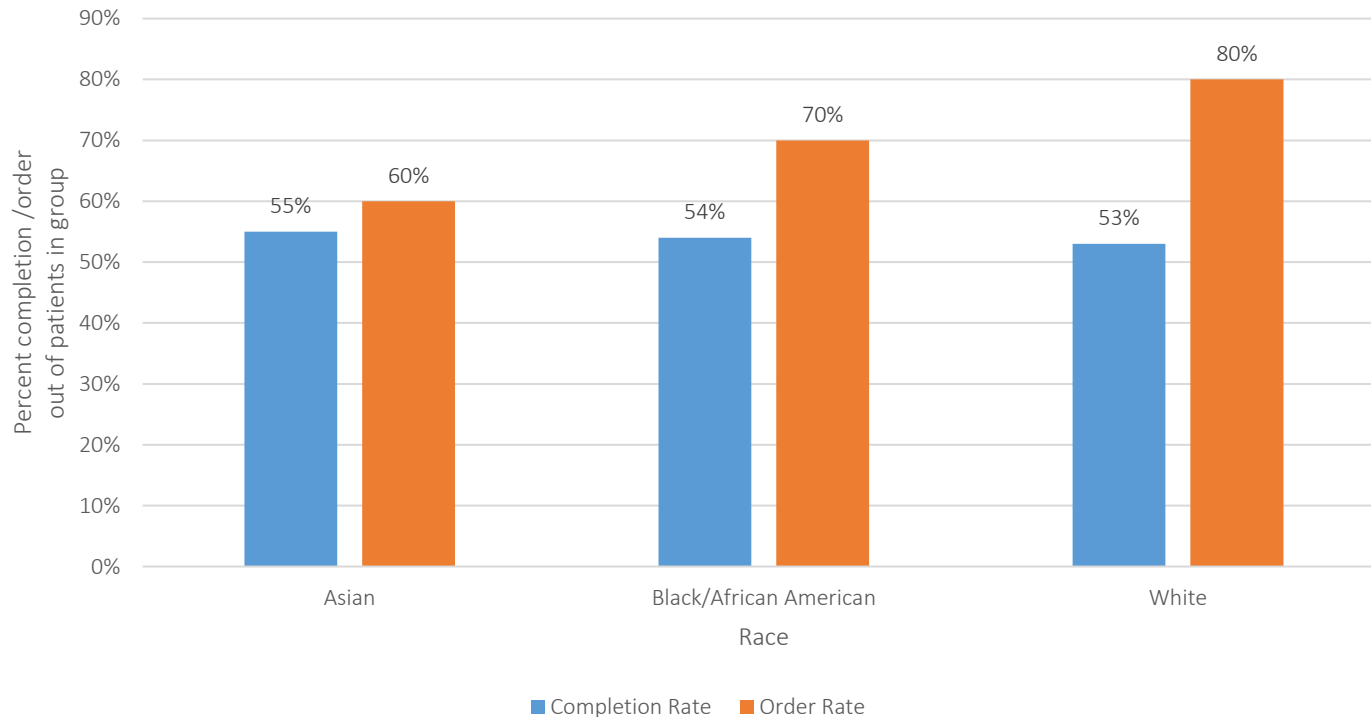
- Analyze the population of patients seen at the health center and in the communities where the site is located
  - Example: Identify the make up of the city where your site is located and then look at the population of patients you serve. If 13% of the city is Black/African American, you want 13% of your patients to be Black/ African American
- Analyze quality measure rates by key demographic variables. Disaggregate the measures to identify differences
  - Example: UDS cancer screening rates – look at rate of orders and completion by race, ethnicity, preferred language

# Patients up to date with Colorectal Cancer Screening



Preliminary Analysis: There is no difference in colorectal cancer screening by race

# Colorectal Cancer Screening: Completed and Order Rate for Patients Not Up to Date



Add in the rate of ordering screening for patients who are not up to date: There is a difference in the ORDERING OF colorectal cancer screening by race



# Analysis of Means (ANOM)

- Similar to analysis of variance (ANOVA)
- Created by engineers to provide a visual display of results
- Provides multiple comparisons and corrects for the number of comparisons
- Comparison is to the overall average
- Do not compare individual results to one another

# ANOM: Template

## Analysis of Means (ANOM) Template for Percent Data for 2 groups

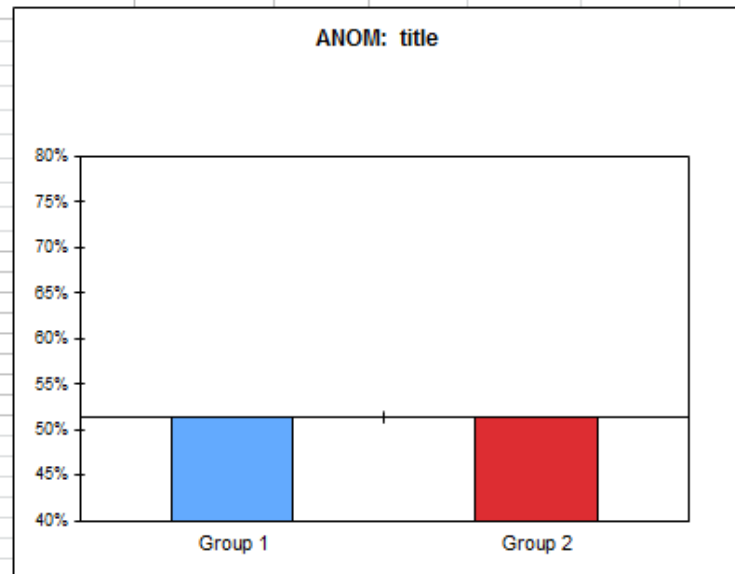
### Follow the steps for an ANOM that has 2 groups:

- 1) Type or paste your numerator and denominator into the formulas section below (columns B & C).
- 2) Type the Group names into this same section to the left (column A)
- 3) If you to sort the percent data (ascending or descending then select the groups to lower limits cells, go to Data pull-down menu and select Sort by percent.
- 4) Adjust where x-axis crosses the y-axis. Go to the chart - Double click on y-axis - go to scales tab. Change x-axis crosses at to the overall percent.

### formulas section

Groups	Numerator	Denominator	percent	upper limit	lower limit
Group 1			#DIV/0!	#DIV/0!	#DIV/0!
Group 2			#DIV/0!	#DIV/0!	#DIV/0!
overall	0	0	#DIV/0!	overall percent	

\*\*\*\*\* don't forget the x-axis crosses the y-axis at the overall percent (instruction 4)

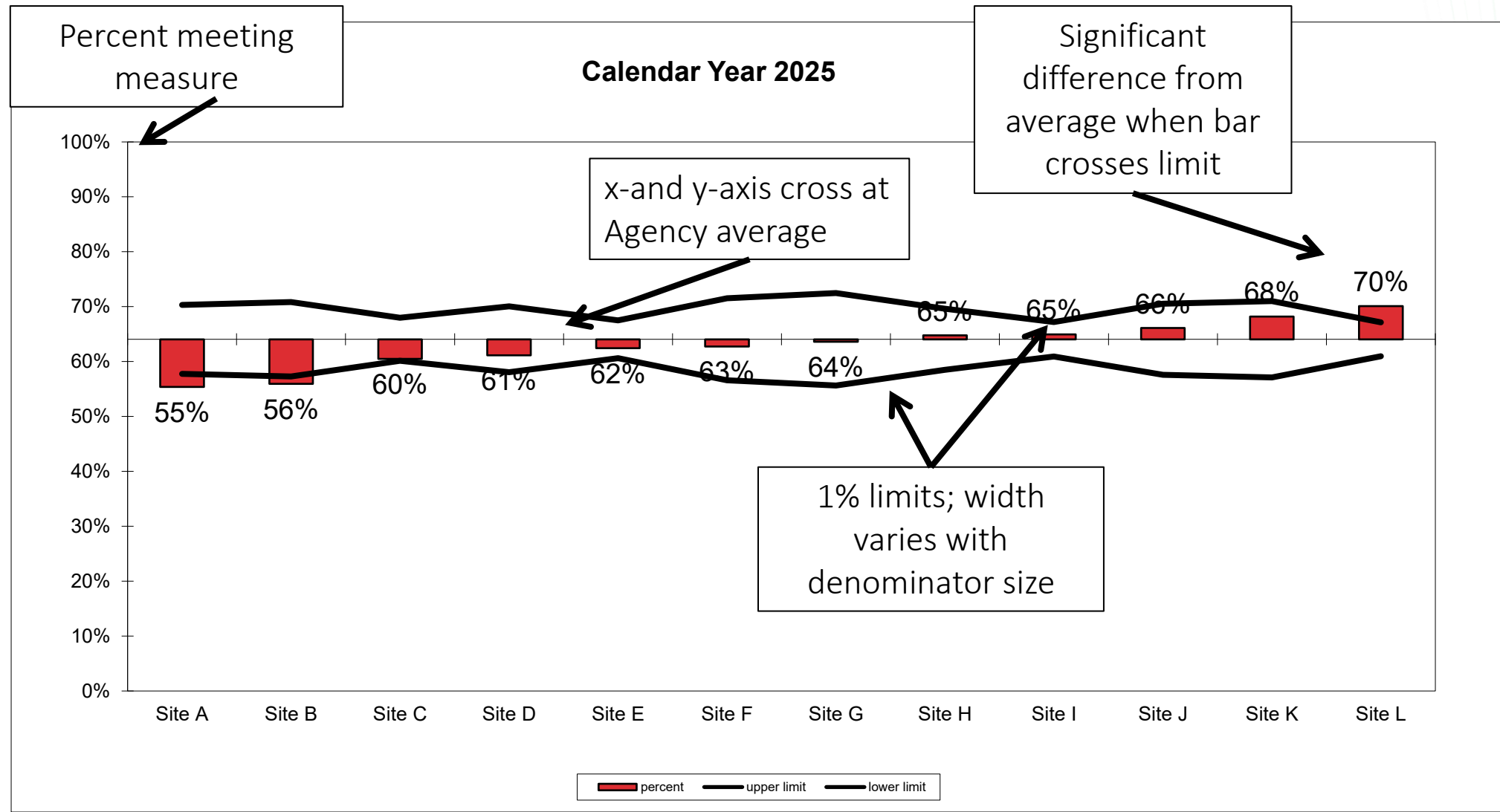


### Table of Factors for Percent Data ANOM

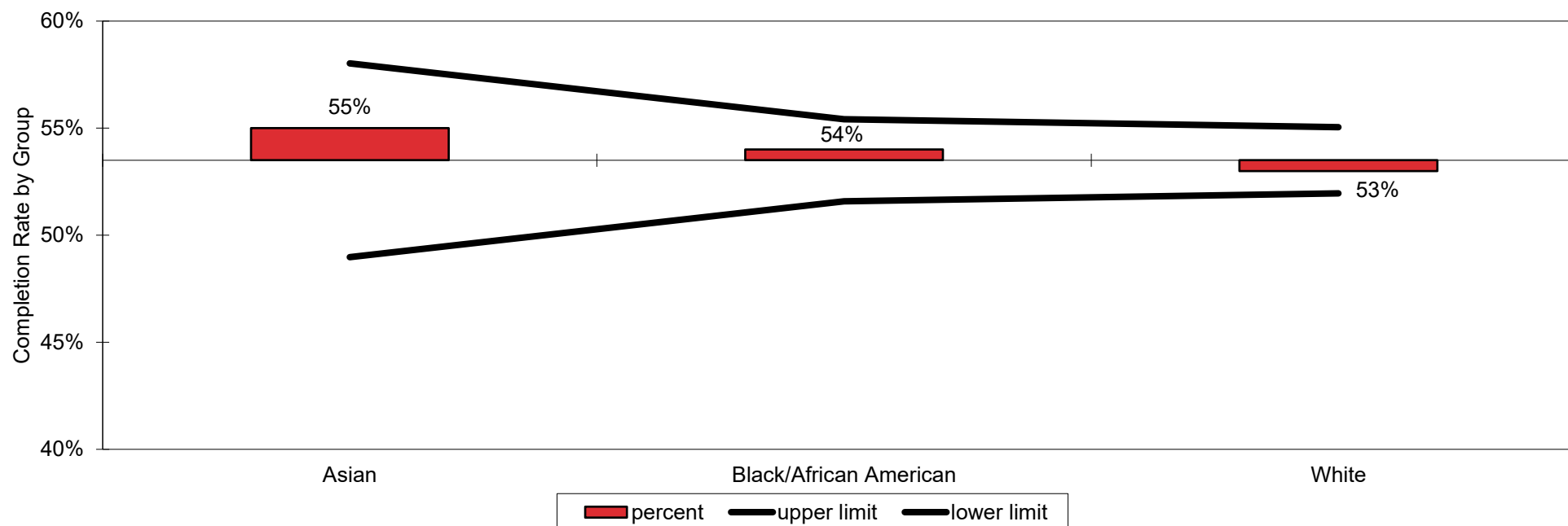
Number of Groups being compared	Risk		
	10%	5%	1%
2	1.16	1.39	1.82
3	1.73	1.95	2.4
4	1.93	2.16	2.62
5	2.07	2.3	2.76
6	2.18	2.41	2.87
7	2.26	2.49	2.95
8	2.33	2.55	3.02
9	2.39	2.61	3.07
10	2.44	2.66	3.12
15	2.61	2.83	3.29
20	2.73	2.94	3.39
30	2.88	3.09	3.53
40	2.98	3.18	3.62
50	3.05	3.25	3.68
60	3.11	3.31	3.73

Chapter 8, p. 159 from Davis Ballestracci text

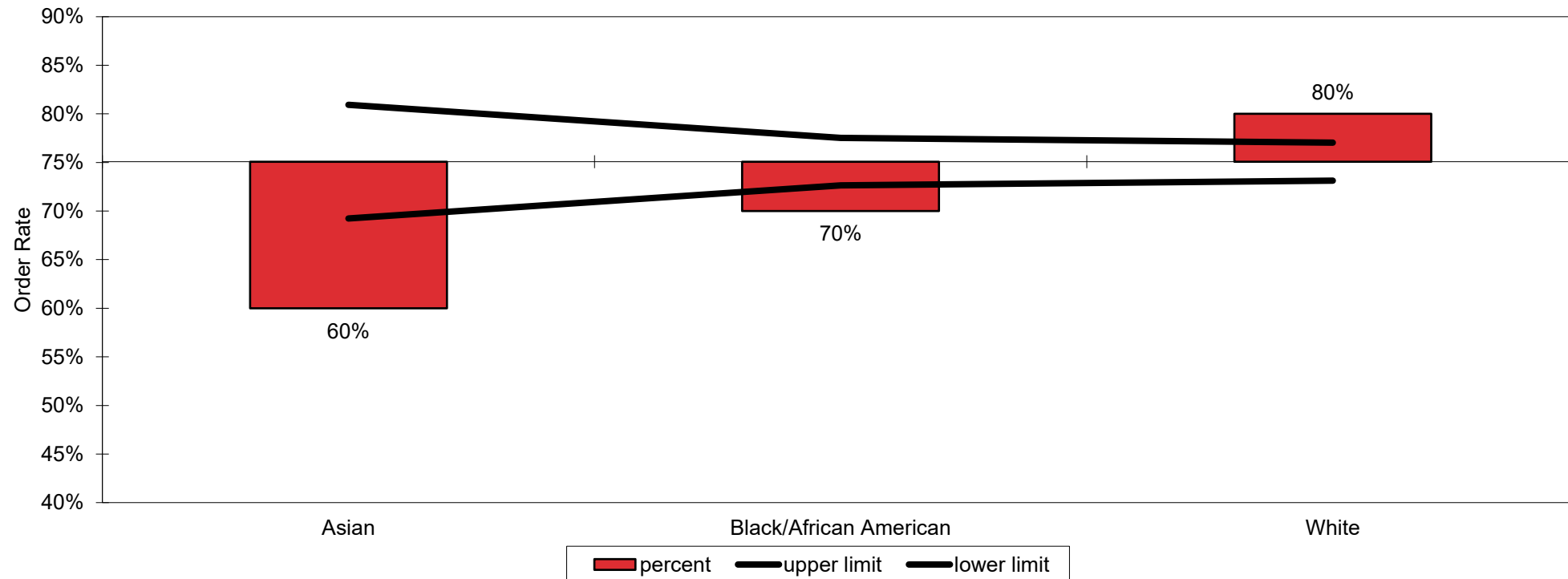
# Analysis of Means



# Colorectal Cancer Screening Rate by Race



# Patients not Up to Date with Colorectal Cancer Screening: Rate of Orders





## Key Points

Using analysis of means may be helpful for identifying variation at a disaggregated level when it appears that rates may be stagnant

This example also shows the importance of digging deeper and understanding the workflow behind the data

# References

- Data Display
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  - ✓ Tufte ER. The Visual Display of Quantitative Information. Cheshire, CT: Graphics Press, 1983. Introduction and Chapter 1, pp 9-53.
- Control Charts
  - ✓ Amin SG. Control charts 101: a guide to health care applications. *Quality Management in Health Care*. 2001; 9:1-28.
  - ✓ Benneyan JC, Lloyd RC, Plsek PE. Statistical process control as a tool for research and healthcare improvement. *Qual Saf Health Care*. 2003; 12:458-464.
- Analysis of Means
  - ✓ Balestracci D, Barlow JL. Statistical stratification: analysis of means. In Quality Improvement: Practical Applications for Medical Group Practice (2<sup>nd</sup> Ed). Center for Research in Ambul Health Care Administration: Englewood, CO, 1996; pp. 151-189.
  - ✓ Homa K. Analysis of means used to compare providers' referral patterns. *Qual Manag Health Care*. 2007;16(3):256-64.

# Questions?

# Wrap-Up

## Activity Session - Improving Health Outcomes: Strategic Data-Driven Interventions

- Join subject matter experts from Community Health Center, Inc. (CHCI) for an interactive 60-minute activity session on designing meaningful community health interventions. Through hands-on case studies and collaborative discussions, this session will explore the importance of data, connect their individual mission to broader healthcare goals, and develop practical strategies for robust data collection, impactful patient outreach, and transformative care delivery.
- **When:** Thursday, February 12<sup>th</sup>, 2026
- **Time:** 3:00 - 4:00pm Eastern / 12:00 - 1:00pm Pacific
- <https://education.weitzmaninstitute.org/content/activity-session-improving-health-outcomes-strategic-data-driven-interventions>



# Explore more resources!

## National Learning Library: Resources for Clinical Workforce Development



CHC has curated a series of resources, including webinars to support your health center through education, assistance and training.

[Learn More](#)

### **CLINICAL WORKFORCE DEVELOPMENT** Transforming Teams, Training the Next Generation

The National Training and Technical Assistance Cooperative Agreements (NCAs) provide free training and technical assistance that is data driven, cutting edge and focused on quality and operational improvement to support health centers and look-alikes. Community Health Center, Inc. (CHC, Inc.) and its Weitzman Institute specialize in providing education and training to interested health centers in Transforming Teams and Training the Next Generation through;

**National Webinars** on advancing team based care, implementing post-graduate residency training programs, and health professions student training in FQHCs.

**Invited participation in Learning Collaboratives** to advance team based care or implement a post-graduate residency training program at your health center.

Please keep watching this space for information on future sessions. To request technical assistance from our NCA, please email [NCA@chc1.com](mailto:NCA@chc1.com) for more information.

<https://www.weitzmaninstitute.org/ncaresources>

## Health Center Resource Clearinghouse



<https://www.healthcenterinfo.org/>



# Contact Information

For information on future webinars, activity sessions, and communities of practice: please reach out to [nca@chc1.com](mailto:nca@chc1.com) or visit <https://www.chc1.com/nca>

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