COMMUNITY HEALTH CARE ASSOCIATION of New York State

CHCANYS NYS-HCCN presents

Data Governance & Quality Improvement in Action

Charting the Path Forward

March 25, 2025

For more information, please email Anita Li at ali@CHCANYS.org

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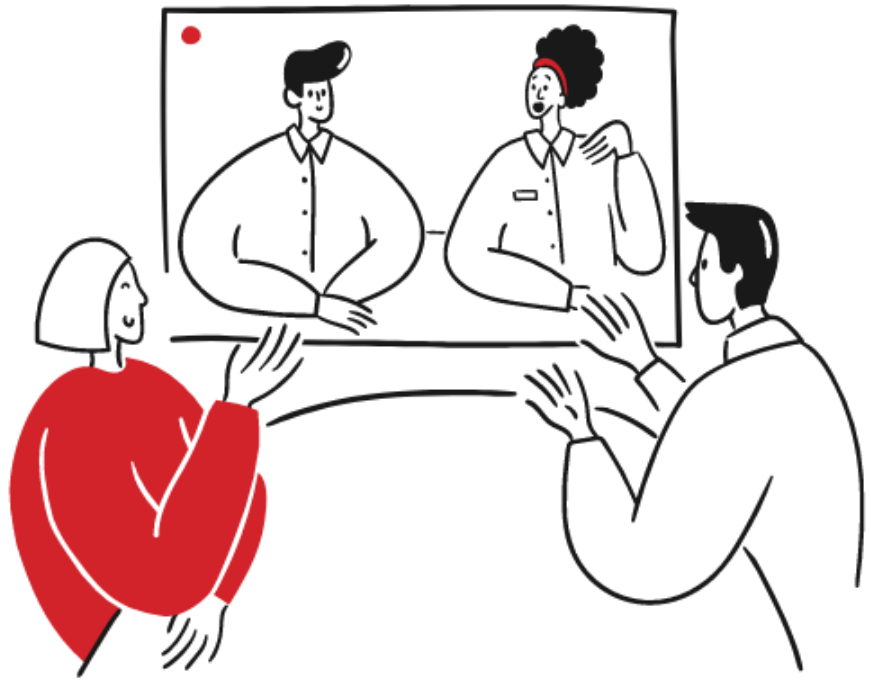
Agenda

1. Welcome & Introductions
2. Data Governance & Health Center Quality
    - Evergreen Health
3. Data Driven Quality Improvement
    - Charles B. Wang Community Health Center
4. Q&A
5. Closing and Evaluations

Housekeeping

- You have been muted upon entry. Please respect our presenters and stay on mute if you are not speaking.
- Please share your questions in the chat. CHCANYS staff will raise your questions to our speakers and follow up as needed if there are unanswered questions.
- The webinar is being recorded and will be shared after the session along with the slide deck.
- A webinar evaluation will be shared with participants



New York State HCCN Objectives

Project Period 2022-2025

1. **Clinical Quality**
2. **Patient-Centered Care**
3. **Provider and Staff Wellbeing**

2022-2025 Project Period

- Patient Engagement
- Patient Privacy & Cybersecurity
- Social Risk Factor Intervention
- Disaggregated Patient-level Data (UDS+)
- Interoperable Data Exchange & Integration
- Data Utilization
- Leveraging Digital Health Tools
- Health IT Usability & Adoption
- Improving Digital Health Tools- Closed Loop Referrals*

** - Applicant Choice Objective*
Bold- Objective Carried over into 2022-2025

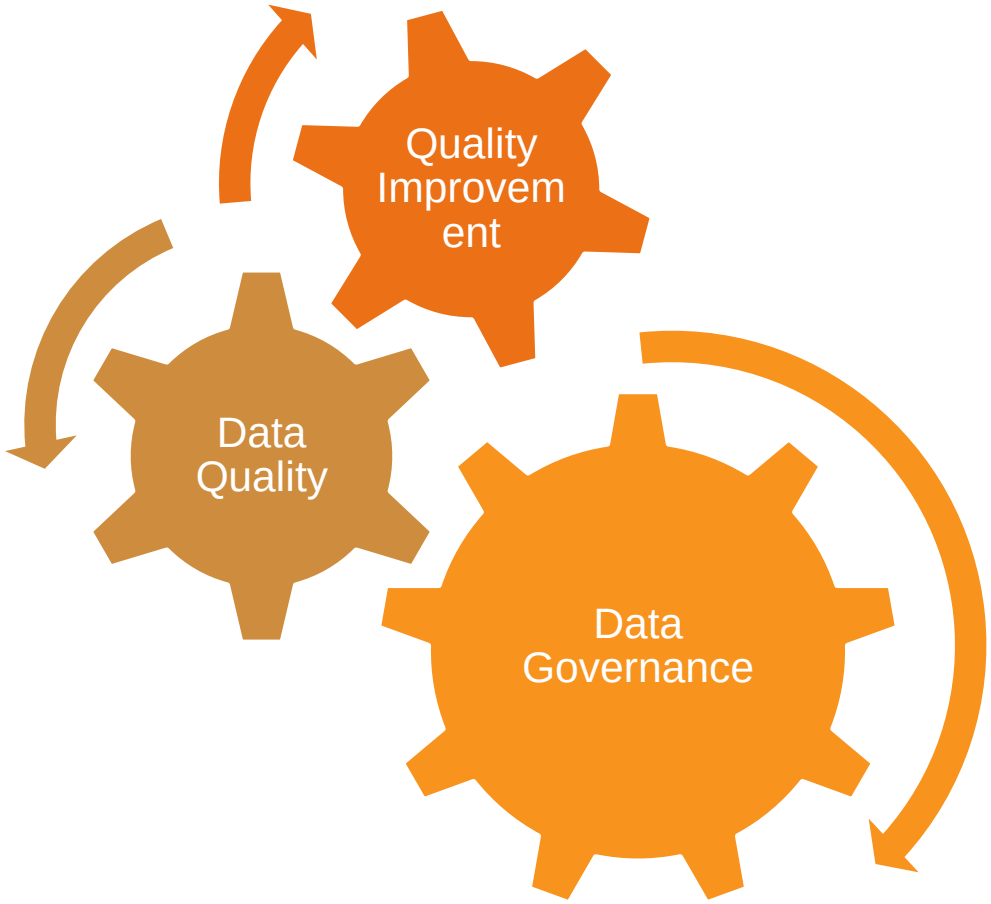
Data Governance & Quality Improvement

"Data governance includes the collection of processes, policies, roles, metrics, and standards that ensures an effective and efficient use of information. This also helps establish data management processes that keep your data secured, private, accurate, and usable throughout the data life cycle."

- Microsoft[1]

"Quality improvement (QI) is a systematic, formal approach to the analysis of practice performance and efforts to improve performance."

- American Academy of Family Physicians[2]



[1]What is Data Governance?
[2]Basics of Quality Improvement

Data Governance & Health Center Quality

Mistine Keis | Manager of Information Systems Optimization

Nicole Coonly | Data Trust & Enablement Manager

Neil Bhattarai | Director of Population Health & Value Based Initiatives

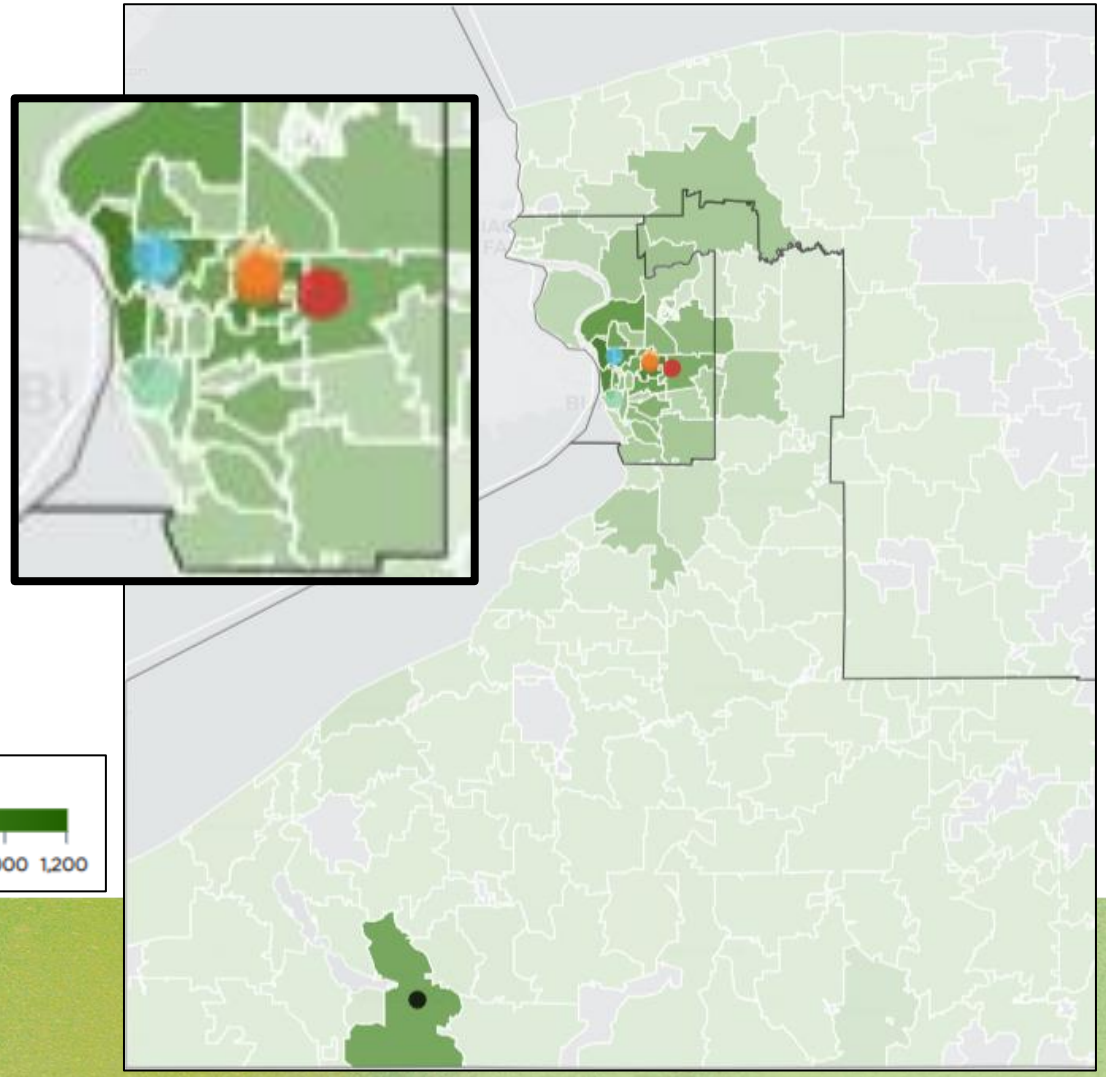
EvergreenHealth UNCONDITIONAL.

Data Governance & Health Center Quality

March 2025

About Evergreen Health

- **AIDS Community Services**
- Founded in 1983 by a group of volunteers
- **Evergreen Health (2011)**
- Multi-service healthcare organization
- Almost 600 employees/contractors
- 6 service delivery locations
- 11 buildings
- 28,000 people served
- **5 FQHC LAL Sites (2020)**
- Urban, Suburban, and Rural



What We Do

- **Medical Services**
- Primary Care
- Gynecology
- Podiatry
- HIV Pre Exposure Prophylaxis (PrEP)
- HIV Care
- Hepatitis C Care
- Dental

- **The Pharmacy at Evergreen**
- Filled 200,817 rx in 2022
- Provide:
  - Free consultations with Pharmacists
  - Free medication screenings for interactions and allergies
  - 24-hour emergency access to pharmacist
  - Free home/same-day delivery

What We Do

- **Mental Health Counseling**
- Individual and group counseling
- Psychiatry
- Medication management

- **Substance Use Counseling**
- Individual substance use counseling and support groups
- Medication Assisted Treatment
- Peer services

What We Do

- **Harm Reduction Program**
- Syringe Exchange Program
- Narcan training
- Supportive counseling
- Vein and skin care
- Low threshold medication and assisted treatment

- **Care Coordination**
- Provide assistance with:
  - Finding a doctor or specialist
  - Advocating for patients
  - Helping patients understand and remember confusing information
  - Linkage to additional resources and programs
  - Scheduling appointments, tests and more

What we do

- **Supportive Services**
- Housing
- Transportation
- Food Pantry
- THRIVE Wellness
  - Art therapy, Nutrition, and more
- Rapid Testing

- **Southern Tier**
  - Care Coordination
  - HIV Specific Services
  - HIV and Hep C Testing
  - Syringe Exchange Program

EvergreenHealth UNCONDITIONAL.

History of Data Governance at Evergreen & Affiliates

History of Building Data Governance

- 2014 Began Data Governance Discussion (COO & Kevin Bidtah, CIO)
  - Specialty HIV practice on EMDs
  - All other services on “Penelope”
  - Kevin “How do we tell our story better”
- 2015/2016 – Medent implementation
- Continued discussions around Data Governance
- 2018 – Data Governance at Evergreen Huddle

Cont.

- Kevin promoted “Data Life Cycle” – where is our data from beginning to end?
- Main components:
  - Data Privacy & Security
  - Data Definitions
  - Data Management: Recovery, Backups, Warehouse, etc.
  - Data Roles: ex. Stewards and Owners

Key Takeaway

- One person was the main driver and champion in promoting; worked with other executives/chiefs to setup this structure
- Campaigned on:
  - Risks
  - Return on Investment
  - Information Governance & Security (also Cybersecurity)

EvergreenHealth
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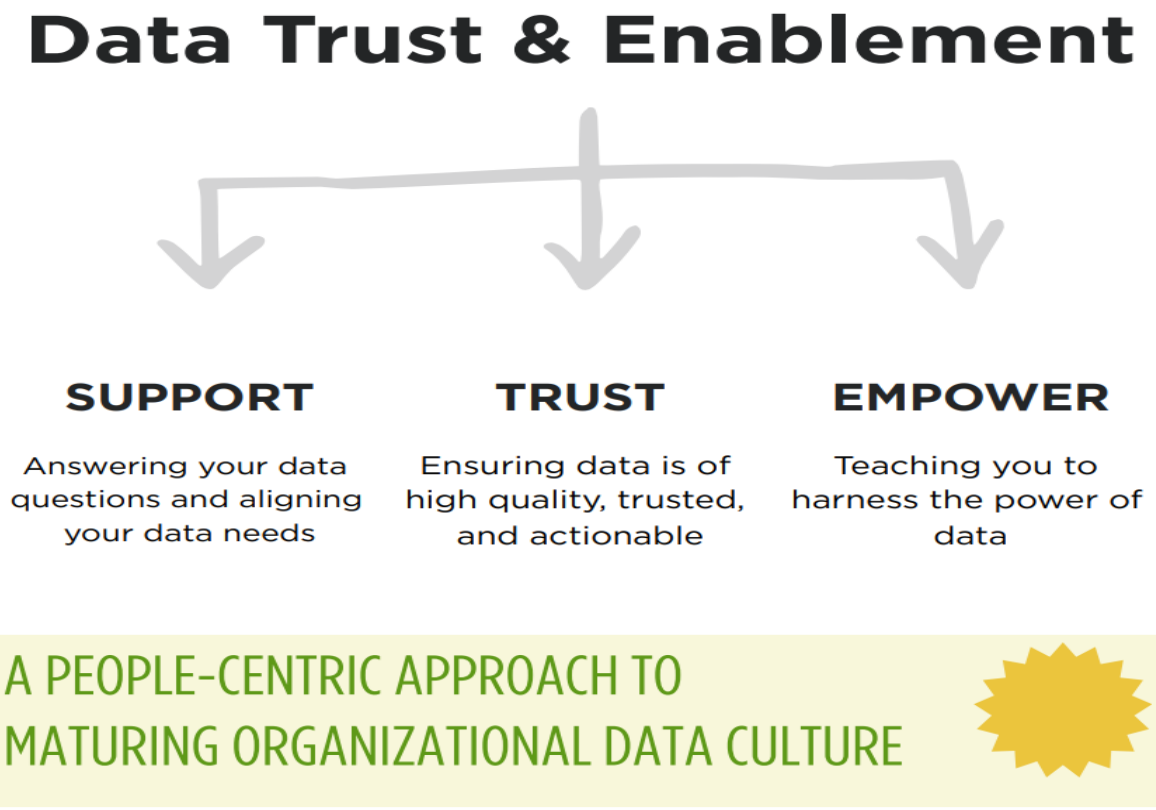
Data Governance at Evergreen & Affiliates

Nicole Coonly

DTE as a Data Governance Initiative



Data Trust & Enablement

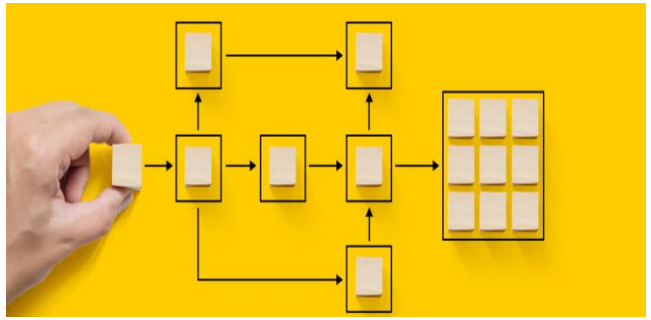
- Reach out to the Centers to schedule DTE “Around the World” meetings with the Data Owners & Stewards. This is a non-invasive approach to Data Governance & meeting teams where they are in their data journey.
  - Created a 5-question survey to evaluate their needs
- Schedule the meeting, send the survey, and send a list of the reports they receive for review
- Meeting is individualized to that teams’ needs identified in the survey results.

Committees for Information Governance & Security

Information Governance: IGS Committee – comprised of IT/IS/Compliance	• Policies are created and reviewed here (AI Use, Acceptable Use, CURES Act) • New Systems/software, workflows, and data sources/exports brought here to review. • Data & Security best practices information articles are written to share with staff
Medent Change Committee	• Contains staff from the different Centers • Where changes in the EHR are brought to ensure everyone approves and is aware of the changes, as these changes may impact other Centers

Continued Data Governance efforts

- Data Strategy Group
  - Working towards data governance internally in the Information Systems Dept – making sure we share information with the right people
  - The purpose is to define how data will be collected, governed, utilized, and safeguarded to advance the mission of Evergreen, enhance decision-making, and improve patient outcomes. To promote data literacy and engagement, establish common objectives and goals across projects and teams, improve data quality and break down data silos.



EvergreenHealth
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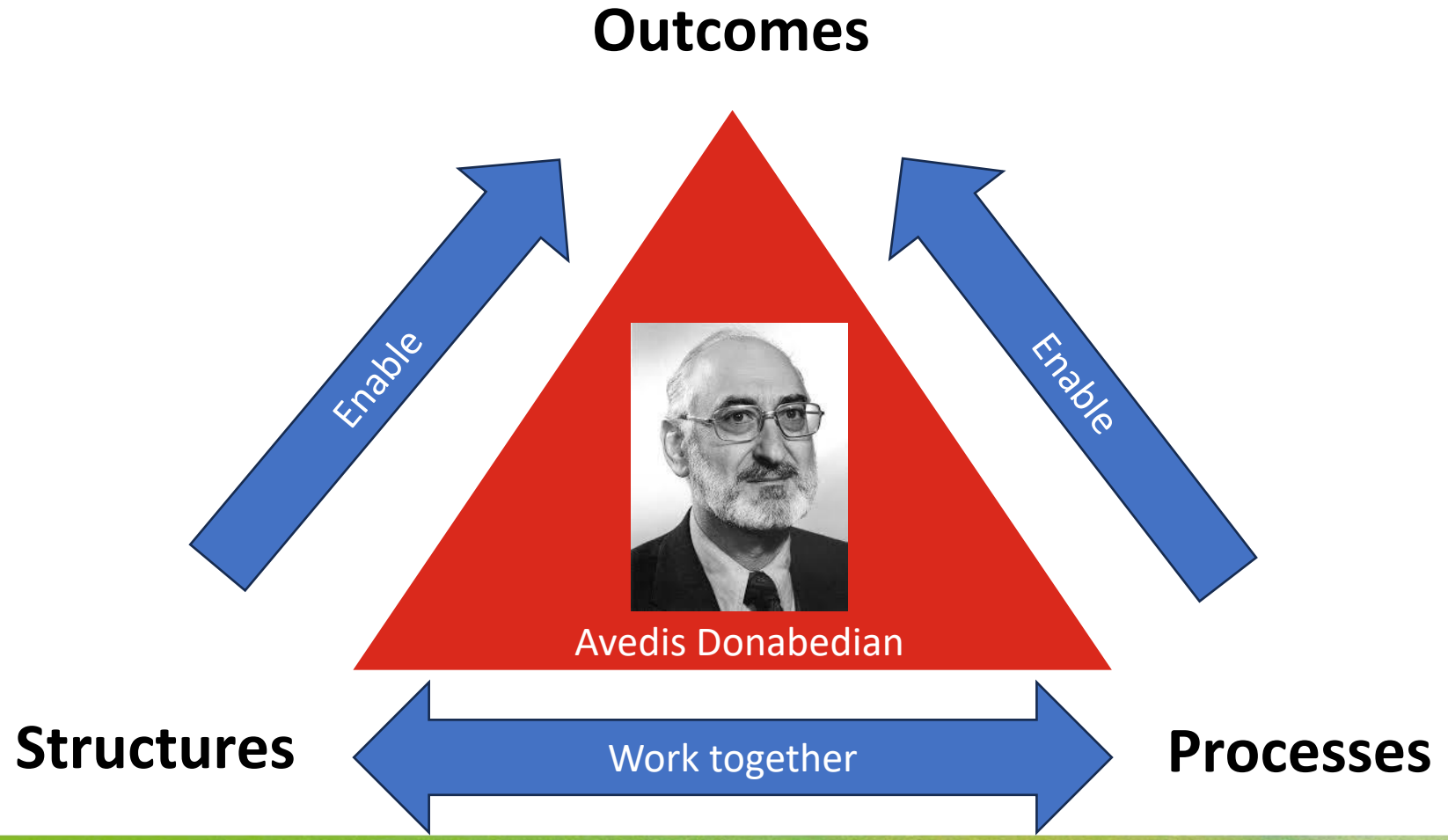
Health Center Quality

Neil Bhattarai

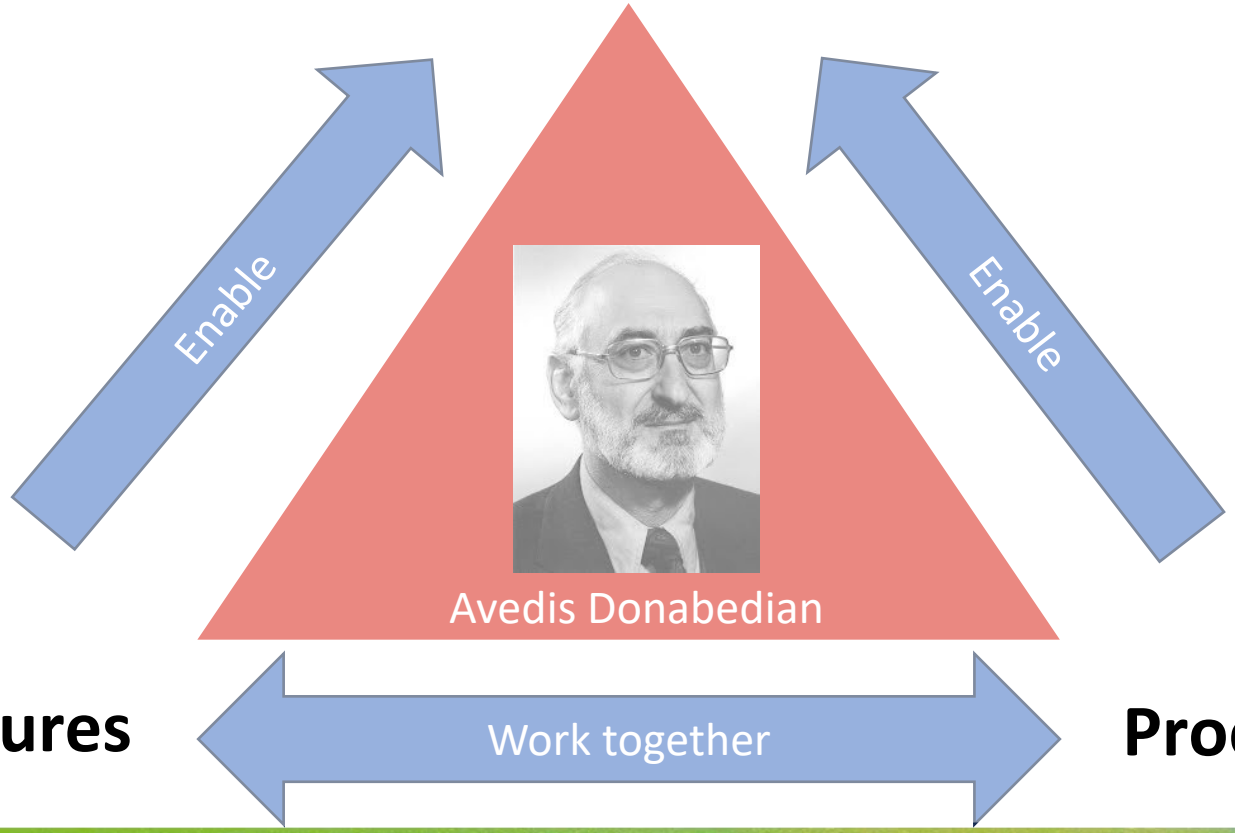
- Population health oversight
- Relationship to Quality and Data Validation
  - Which has led to trust
- How it effects QI efforts
- P&SC – practice notice workflow

Donabedian Model



Donabedian Model

Outcomes Quality metrics



Data infrastructure group
Roles, stewards

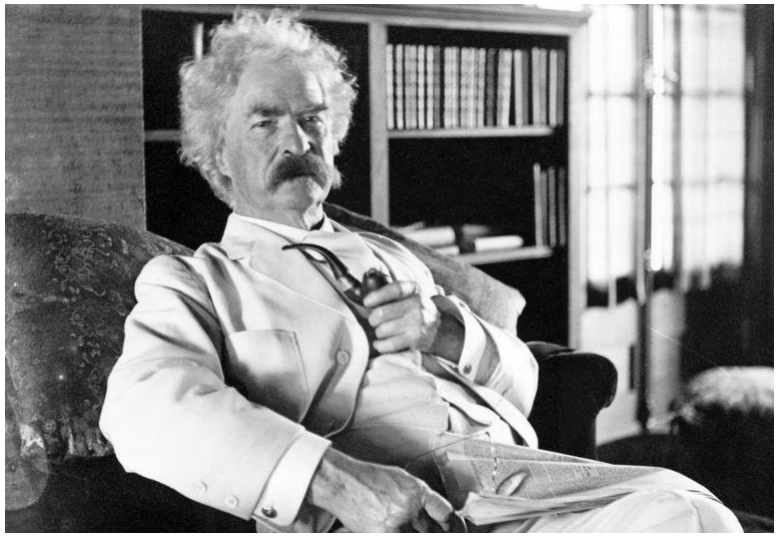
Structures

Processes

Data Privacy & Security
Data Definitions
Data Management: Recovery, Backups, Warehouse etc.
Data governance

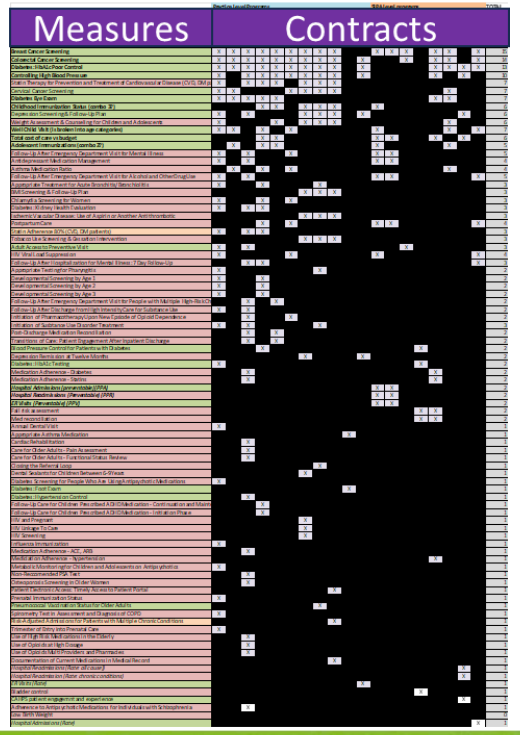
“Data is like garbage. You’d better know what you are going to do with it before you collect it.”

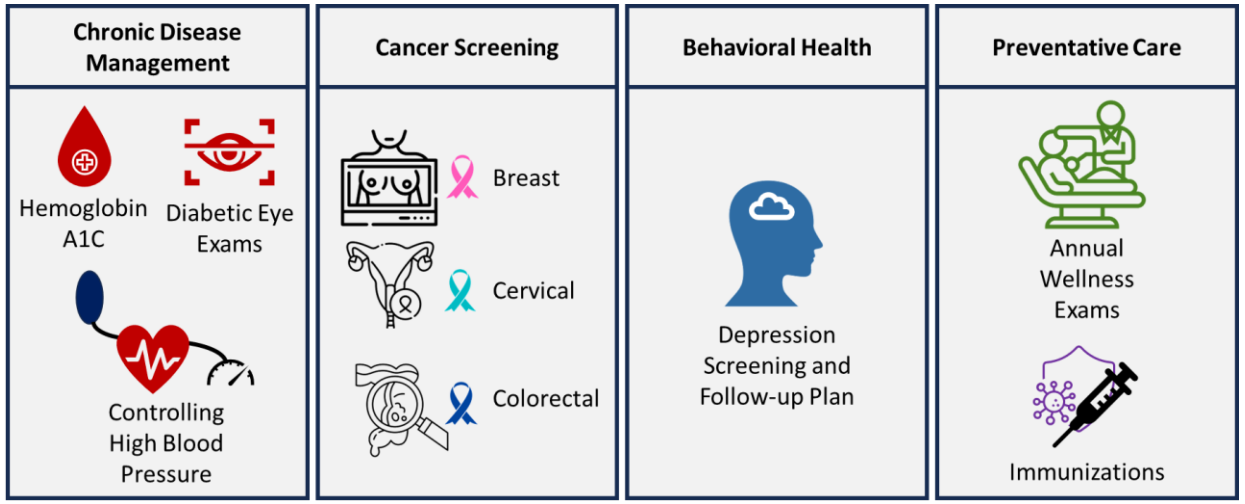
– Mark Twain



Knowing what to do with data…

- Going from vital many to Critical Few

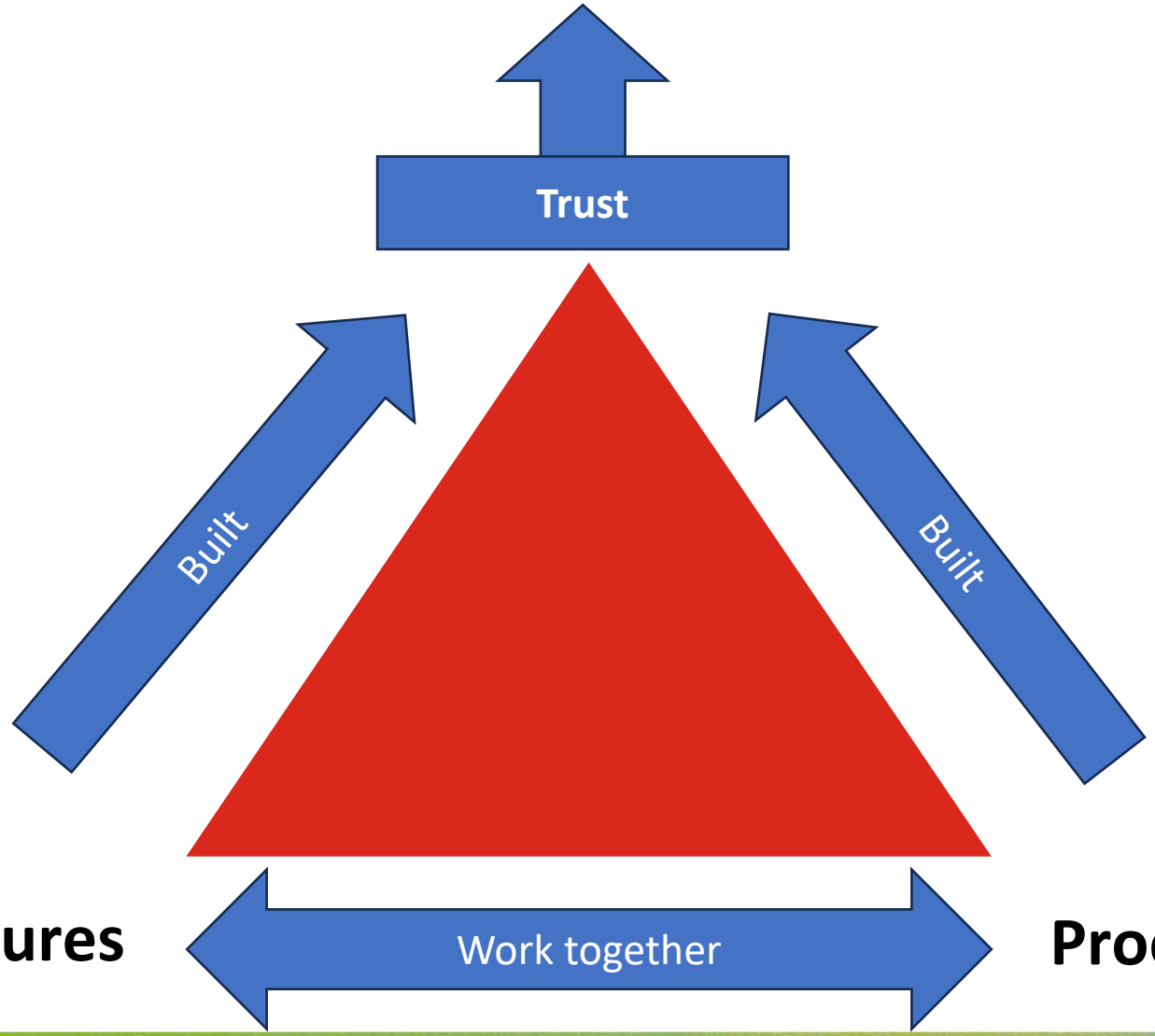




How does strong foundation of data help build a quality culture?

"It is a capital mistake to theorize before one has data."
– Sherlock Holmes in *A Study in Scarlet* by Arthur Conan Doyle

Outcomes Quality metrics



Data infrastructure group
Roles, stewards

Structures

Data Privacy & Security
Data Definitions
Data Management: Recovery, Backups, Warehouse etc.
Data governance

Processes

Data Trust Example - PVP

- **Problem**: Azara Patient Visit Planning (PVP) was inaccurately showing appointments leading to providers not wanting to utilize PVP.
- **Approach**: Methodical data validation, provider partnership in understanding measures
- **Result**
  - PVP accuracy at 96% (+/- 3%)
  - PVP utilization – 90% daily printouts across practice sites

Data Trust Examples – CQM Audits

- CQM data validations help enable providers to get credit where they're due
- Monthly monitoring by leadership teams

Data Trust Example – Quarterly Provider Scorecards

- Quarterly Provider Review
- UDS scope =/= practice
- Ability to select providers and cohorts helps with improving data trust
- Answer specific questions from the Providers and their specific patient data
- Increases provider’s participation in Quality & Population Health

Mark Twain Quote:

THE APOCRYPHAL TWAIN: "DATA IS LIKE GARBAGE. YOU'D BETTER KNOW WHAT YOU'RE GOING TO DO WITH IT BEFORE YOU COLLECT IT."

Posted on March 6, 2025 by Matt Seybold

There is perhaps no greater testament to Twain's lasting reputation than the habitual misattribution of miscellaneous wit and wisdom to his name. The circulation of such apocryphal aphorisms was common enough in the 20th century. It has only increased with the popularization of social media. The most common question addressed to the Center for Mark Twain Studies is some variety of "Did he really say that?" Whenever possible, we track down the original source, as well as attempt to trace how their words came to be imagined in Twain's mouth.

Data Driven Quality Improvement

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Dr. Ady Oster, MD, MBA

Chief of Population Health

Dr. Hyoseong Nuna Kim

Executive Vice President &
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Introduction: Who are we?

Located in New York City, the Chinatown Health Clinic opened in 1971, initially staffed by volunteer doctors, nurses, social workers, community health workers, and students. It has grown to provide bilingual and bicultural health care services to underserved communities in Manhattan and Queens.

We received FQHC Designation in 1976. Re-named the Charles B. Wang Community Health Center 1999 to recognize large donation.

Total Patients Served: 58,835, accounting for 290,000 visits in 5 clinical sites

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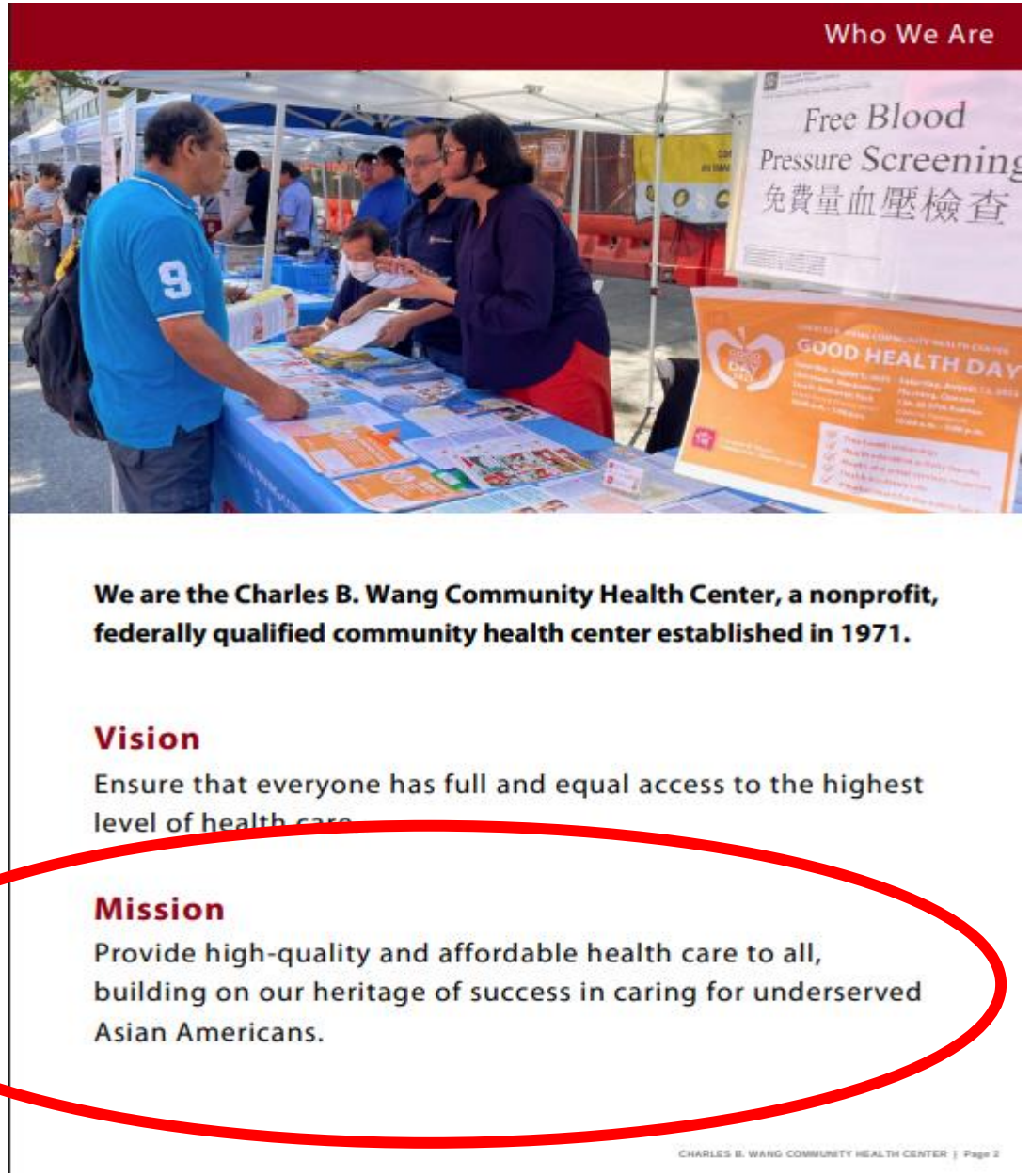
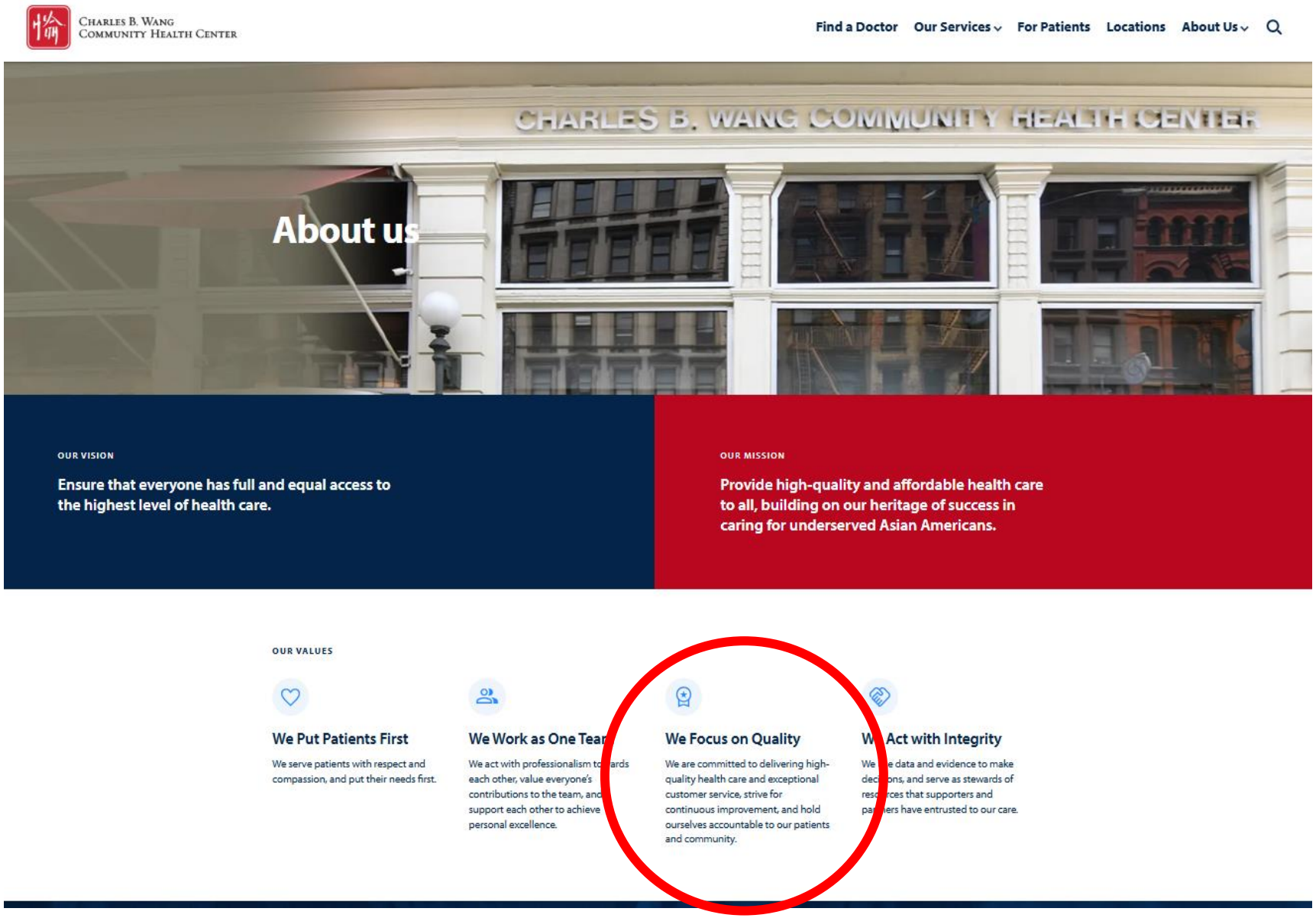
Quality of Care – An Organizational Priority



Quality of Care – An Organizational Priority



Quality of Care – An Organizational Priority

Quality of Care – An Organizational Priority

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CBWCHC 2023-2024 UDS Clinical Metrics

	Measure	2024	2023	2024 Goal
1	Entry Prenatal	91.5%	95.4%	90.0%
2	Childhood Immunization	77.4%	75.0%	82.0%
3	Cervical Cancer	81.4%	83.7%	82.5%
4	Breast Cancer	76.5%	77.5%	82.5%
5	Weight Asses/ Counsel Child/Adolescent	97.7%	97.3%	95.0%
6	BMI and Follow-Up	93.3%	92.6%	88.0%
7	Tobacco Screening and Cessation	94.3%	92.3%	97.5%
8	Statin	82.7%	83.4%	72.0%
9	IVD Antiplatelet	77.6%	87.1%	95.0%
10	CRC Screening	65.1%	62.7%	70.0%
11	HIV Linkage	N/A	N/A	N/A
12	HIV Screening	61.0%	60.5%	N/A
13	Depression Screening and Follow-Up	90.5%	89.1%	92.5%
14	Depression Remission	7.2%	11.2%	15.0%
15	Dental Sealants	87.0%	71.8%	80.0%
16	Birth Weight of	8.3%	8.2%	5.0%
17	High Blood Pressure	82.5%	79.2%	80.0%
18	Diabetes: Poor Control	11.0%	10.9%	8.0%

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Quality of Care – An Organizational Priority

We Maintain a Quality Improvement (QI) Culture Amidst Competing Demands

- Quality is a strategic goal
- Investment in resources & staff:
  - Clinical leaders drive QI with support
  - All care team staff have accountability and awareness
  - Onsite informatics staff build reports to support clinical goals

Historical Development

Data Driven QI: How did we get here?

- Diabetes and Hepatitis B grants developed capacity
  - Clinical staff trained in QI
  - Informatics staff with SQL knowledge developed reports
  - Developed disease registries
  - Supported implementation of team-based care

- UDS Mandated clinical quality goals solidified process
  - Initially just DM, cancer screening
    - UDS Reporting became integral part of work

Historical Development

Data Driven QI: How did we get here?

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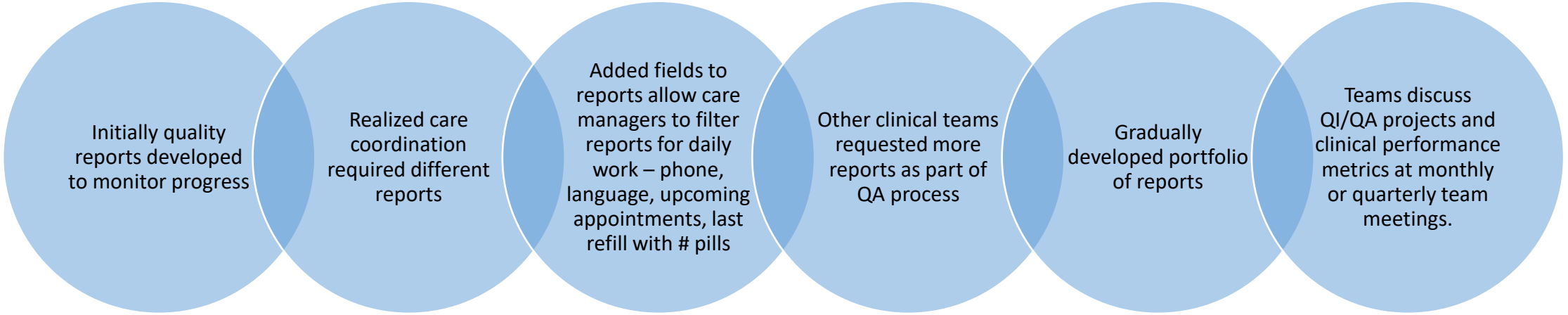
Data and Reporting Development – Iterative and Clinically Driven



Historical Development

Data Driven QI: How did we get here?

Building Momentum

Early adopter of team-based care

- Clinical champions supported by CMO focused on DM care
- CMO and Board accepted need for protected time for staff

DM-specific expertise adopted by other programs/departments

- Clinical champions developed expertise in chronic disease management and team-based care
- Protocols disseminated/adapted to other departments – asthma, HBV, HTN, special needs

Federal/National quality metrics provide further structure and financial motivation

- UDS metrics and PCMH provided further impetus for center-wide adoption of team-based care

Success feeds success

- Board takes pride in accomplishments, used in fundraising
- Quality now integral part of strategic plan
- Improves staff retention and facilitates hiring

Historical Development

Data Driven QI: How did we get here?

Sample DM Control Quarterly Report

Uncontrolled DIABETES (IM)

Performance Measure: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c (HbA1c) greater than 9.0 percent during the measurement period.
Exclusion: Patients aged 66 and older by the end of the measurement period with an indication of frailty for any part of the measurement period who also meet any of the following advanced illness criteria: advanced illness with one inpatient visit or two outpatient visits or taking dementia medications during the measurement period or the year prior.

Numerator: Patients whose most recent hemoglobin A1c level during the measurement year is greater than 9.0 percent or who had no test conducted during the measurement period.

Denominator: Patients 18-75 years of age with a medical visit during the measurement period.

2024 Q4		
Denominator	numerator	%
3367	372	11.0%

2023		
Denominator	Numerator	%
3039	331	10.9%

GOAL
8%

Site - Dept	Denominat	Numerat	%
Canal - IM	1621	144	8.9%
HV - IM	1343	125	9.3%
F45 - IM	311	32	10.3%
Canal - WH	53	51	96.2%
HV - WH	30	16	53.3%
Flushing - PED	4	1	25.0%
Flushing - WH	3	3	100.0%
Walker - PED	2	0	0.0%

Data reports developed in collaboration with Clinical and Clinical informatics team - shared with all teams to monitor progress on UDS or other metrics

Historical Development

Data Driven QI: How did we get here?

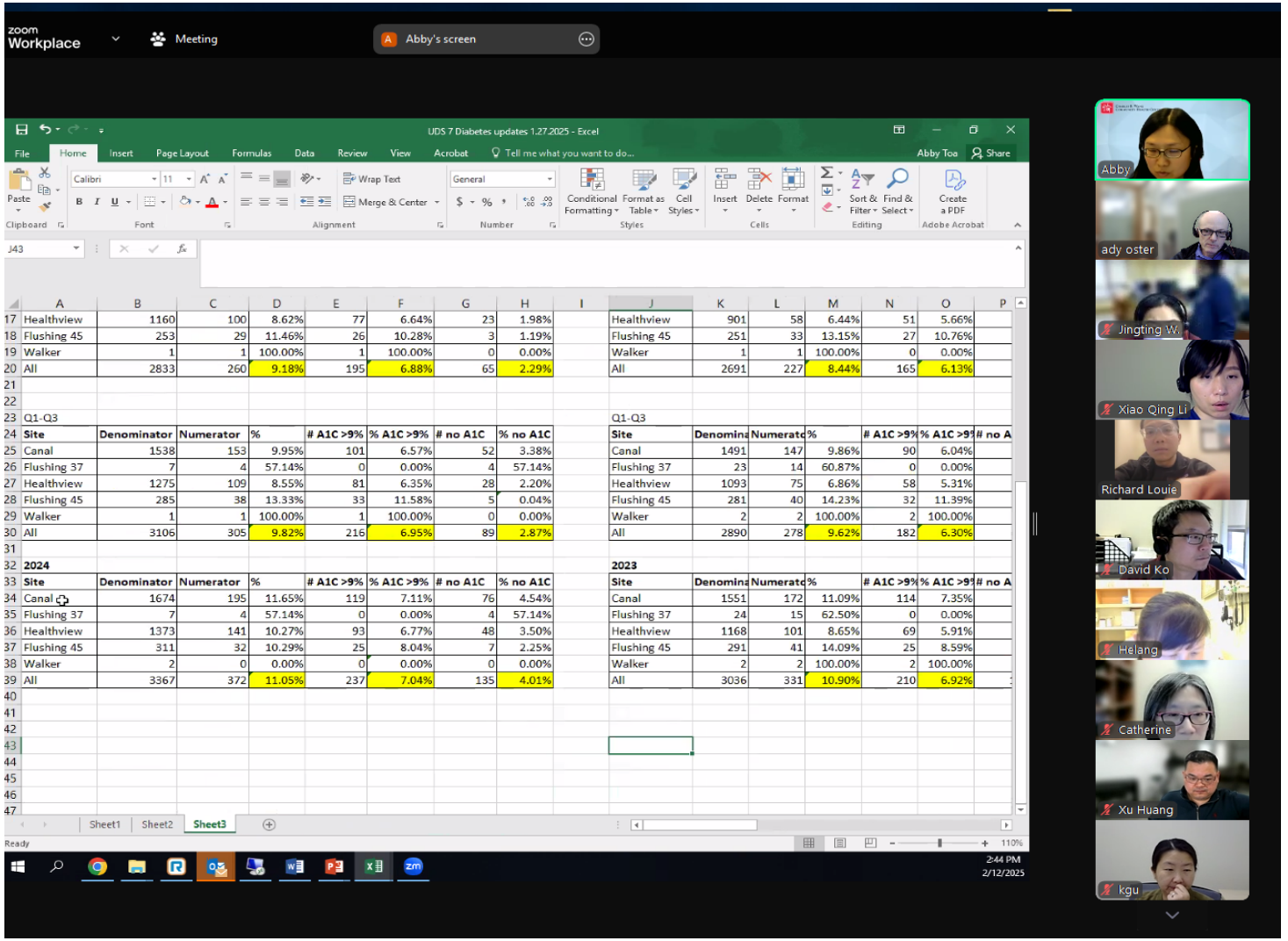
Reporting Structure - 2 teams, developed organically

- **Clinical Informatics –** report to CMO - EMR support and reporting
- **Business Analytics –** report to CFO - Financial/operational reporting
    - Some overlap
    - Frequent collaboration
    - New requests assigned based on expertise and availability

Data Driven Quality Improvement at CBWCHC:

Integration of Reports into Clinical Work

Monthly QA/QI Meetings: Team Meetings where data reports are shared and discussed



	A	B	C	D	E	F	G	H
17	Healthview	1160	100	8.62%	77	6.64%	23	1.98%
18	Flushing 45	253	29	11.46%	26	10.28%	3	1.19%
19	Walker	1	1	100.00%	1	100.00%	0	0.00%
20	All	2833	260	9.18%	195	6.88%	65	2.29%
21								
22								
23	Q1-Q3							
24	**Site**	**Denominator**	**Numerator**	**%**	**# A1C >9%**	**% A1C >9%**	**# no A1C**	**% no A1C**
25	Canal	1538	153	9.95%	101	6.57%	52	3.38%
26	Flushing 37	7	4	57.14%	0	0.00%	4	57.14%
27	Healthview	1275	109	8.55%	81	6.35%	28	2.20%
28	Flushing 45	285	38	13.33%	33	11.58%	5	0.04%
29	Walker	1	1	100.00%	1	100.00%	0	0.00%
30	All	3106	305	9.82%	216	6.95%	89	2.87%
31								
32	**2024**							
33	**Site**	**Denominator**	**Numerator**	**%**	**# A1C >9%**	**% A1C >9%**	**# no A1C**	**% no A1C**
34	Canal	1674	195	11.65%	119	7.11%	76	4.54%
35	Flushing 37	7	4	57.14%	0	0.00%	4	57.14%
36	Healthview	1373	141	10.27%	93	6.77%	48	3.50%
37	Flushing 45	311	32	10.29%	25	8.04%	7	2.25%
38	Walker	2	0	0.00%	0	0.00%	0	0.00%
39	All	3367	372	11.05%	237	7.04%	135	4.01%
40								
41								
42								
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46								
47								

	J	K	L	M	N	O	P
	Healthview	901	58	6.44%	51	5.66%	
	Flushing 45	251	33	13.15%	27	10.76%	
	Walker	1	1	100.00%	0	0.00%	
	All	2691	227	8.44%	165	6.13%	
	Q1-Q3						
	Site	**Denomina**	**Numerato**	**%**	**# A1C >9%**	**% A1C >9%**	**# no A**
	Canal	1491	147	9.86%	90	6.04%	
	Flushing 37	23	14	60.87%	0	0.00%	
	Healthview	1093	75	6.86%	58	5.31%	
	Flushing 45	281	40	14.23%	32	11.39%	
	Walker	2	2	100.00%	2	100.00%	
	All	2890	278	9.62%	182	6.30%	
	2023						
	Site	**Denomina**	**Numerato**	**%**	**# A1C >9%**	**% A1C >9%**	**# no A**
	Canal	1551	172	11.09%	114	7.35%	
	Flushing 37	24	15	62.50%	0	0.00%	
	Healthview	1168	101	8.65%	69	5.91%	
	Flushing 45	291	41	14.09%	25	8.59%	
	Walker	2	2	100.00%	2	100.00%	
	All	3036	331	10.90%	210	6.92%	

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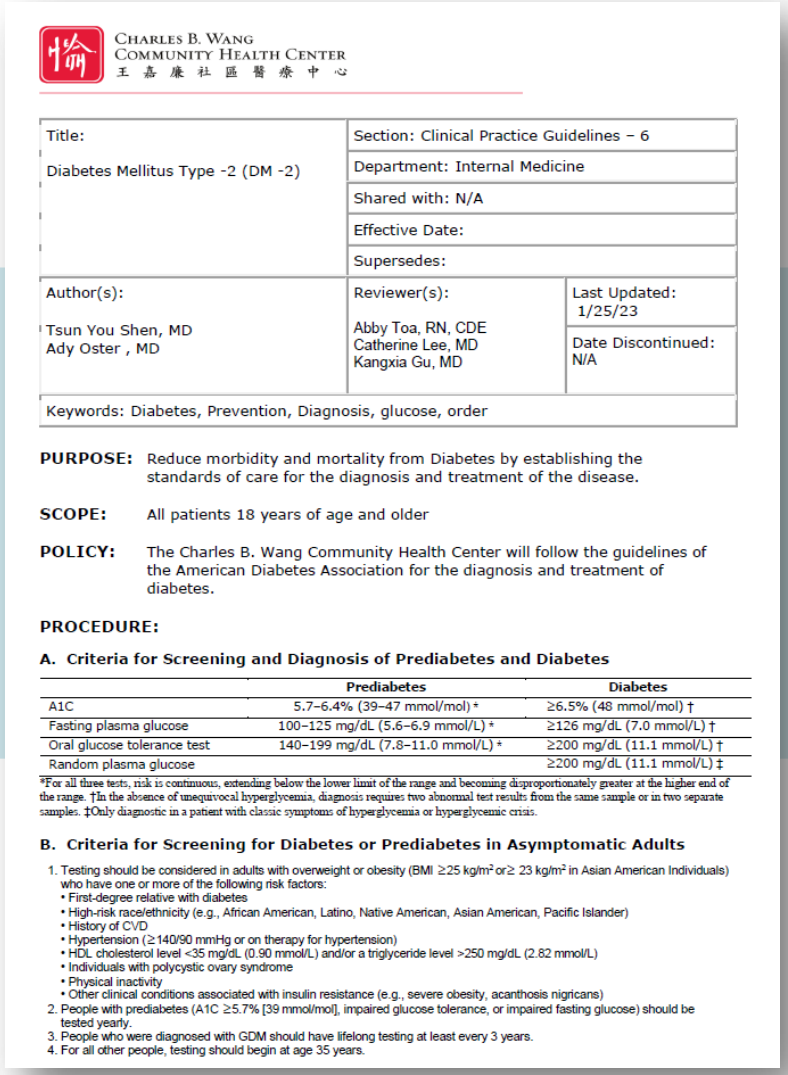
Clinical Protocols Developed



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Title: Diabetes Mellitus Type -2 (DM -2)	Section: Clinical Practice Guidelines – 6	
	Department: Internal Medicine	
	Shared with: N/A	
	Effective Date:	
	Supersedes:	
Author(s): Tsun You Shen, MD Ady Oster , MD	Reviewer(s): Abby Toa, RN, CDE Catherine Lee, MD Kangxia Gu, MD	Last Updated: 1/25/23 Date Discontinued: N/A
Keywords: Diabetes, Prevention, Diagnosis, glucose, order		

PURPOSE: Reduce morbidity and mortality from Diabetes by establishing the standards of care for the diagnosis and treatment of the disease.

SCOPE: All patients 18 years of age and older

POLICY: The Charles B. Wang Community Health Center will follow the guidelines of the American Diabetes Association for the diagnosis and treatment of diabetes.

PROCEDURE:

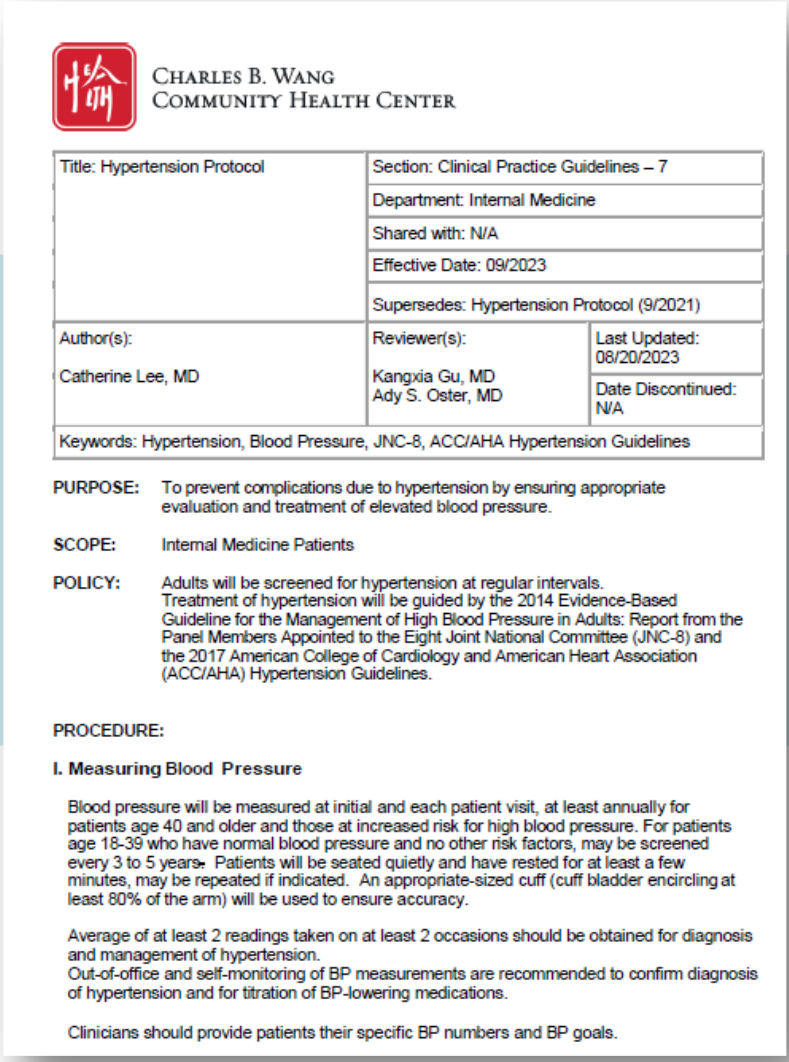
A. Criteria for Screening and Diagnosis of Prediabetes and Diabetes

	Prediabetes	Diabetes
A1C	5.7–6.4% (39–47 mmol/mol) *	≥6.5% (48 mmol/mol) †
Fasting plasma glucose	100–125 mg/dL (5.6–6.9 mmol/L) *	≥126 mg/dL (7.0 mmol/L) †
Oral glucose tolerance test	140–199 mg/dL (7.8–11.0 mmol/L) *	≥200 mg/dL (11.1 mmol/L) †
Random plasma glucose		≥200 mg/dL (11.1 mmol/L) ‡

*For all three tests, risk is continuous, extending below the lower limit of the range and becoming disproportionately greater at the higher end of the range. †In the absence of unequivocal hyperglycemia, diagnosis requires two abnormal test results from the same sample or in two separate samples. ‡Only diagnostic in a patient with classic symptoms of hyperglycemia or hyperglycemic crisis.

B. Criteria for Screening for Diabetes or Prediabetes in Asymptomatic Adults

1. Testing should be considered in adults with overweight or obesity (BMI ≥25 kg/m^2 or≥ 23 kg/m^2 in Asian American Individuals) who have one or more of the following risk factors:
   - First-degree relative with diabetes
   - High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
   - History of CVD
   - Hypertension (≥140/90 mmHg or on therapy for hypertension)
   - HDL cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)
   - Individuals with polycystic ovary syndrome
   - Physical inactivity
   - Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
2. People with prediabetes (A1C ≥5.7% [39 mmol/mol], impaired glucose tolerance, or impaired fasting glucose) should be tested yearly.
3. People who were diagnosed with GDM should have lifelong testing at least every 3 years.
4. For all other people, testing should begin at age 35 years.



CHARLES B. WANG
COMMUNITY HEALTH CENTER

Title: Hypertension Protocol	Section: Clinical Practice Guidelines – 7	
	Department: Internal Medicine	
	Shared with: N/A	
	Effective Date: 09/2023	
	Supersedes: Hypertension Protocol (9/2021)	
Author(s): Catherine Lee, MD	Reviewer(s): Kangxia Gu, MD Ady S. Oster, MD	Last Updated: 08/20/2023 Date Discontinued: N/A
Keywords: Hypertension, Blood Pressure, JNC-8, ACC/AHA Hypertension Guidelines		

PURPOSE: To prevent complications due to hypertension by ensuring appropriate evaluation and treatment of elevated blood pressure.

SCOPE: Internal Medicine Patients

POLICY: Adults will be screened for hypertension at regular intervals.
Treatment of hypertension will be guided by the 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults: Report from the Panel Members Appointed to the Eight Joint National Committee (JNC-8) and the 2017 American College of Cardiology and American Heart Association (ACC/AHA) Hypertension Guidelines.

PROCEDURE:

I. Measuring Blood Pressure

Blood pressure will be measured at initial and each patient visit, at least annually for patients age 40 and older and those at increased risk for high blood pressure. For patients age 18-39 who have normal blood pressure and no other risk factors, may be screened every 3 to 5 years. Patients will be seated quietly and have rested for at least a few minutes, may be repeated if indicated. An appropriate-sized cuff (cuff bladder encircling at least 80% of the arm) will be used to ensure accuracy.

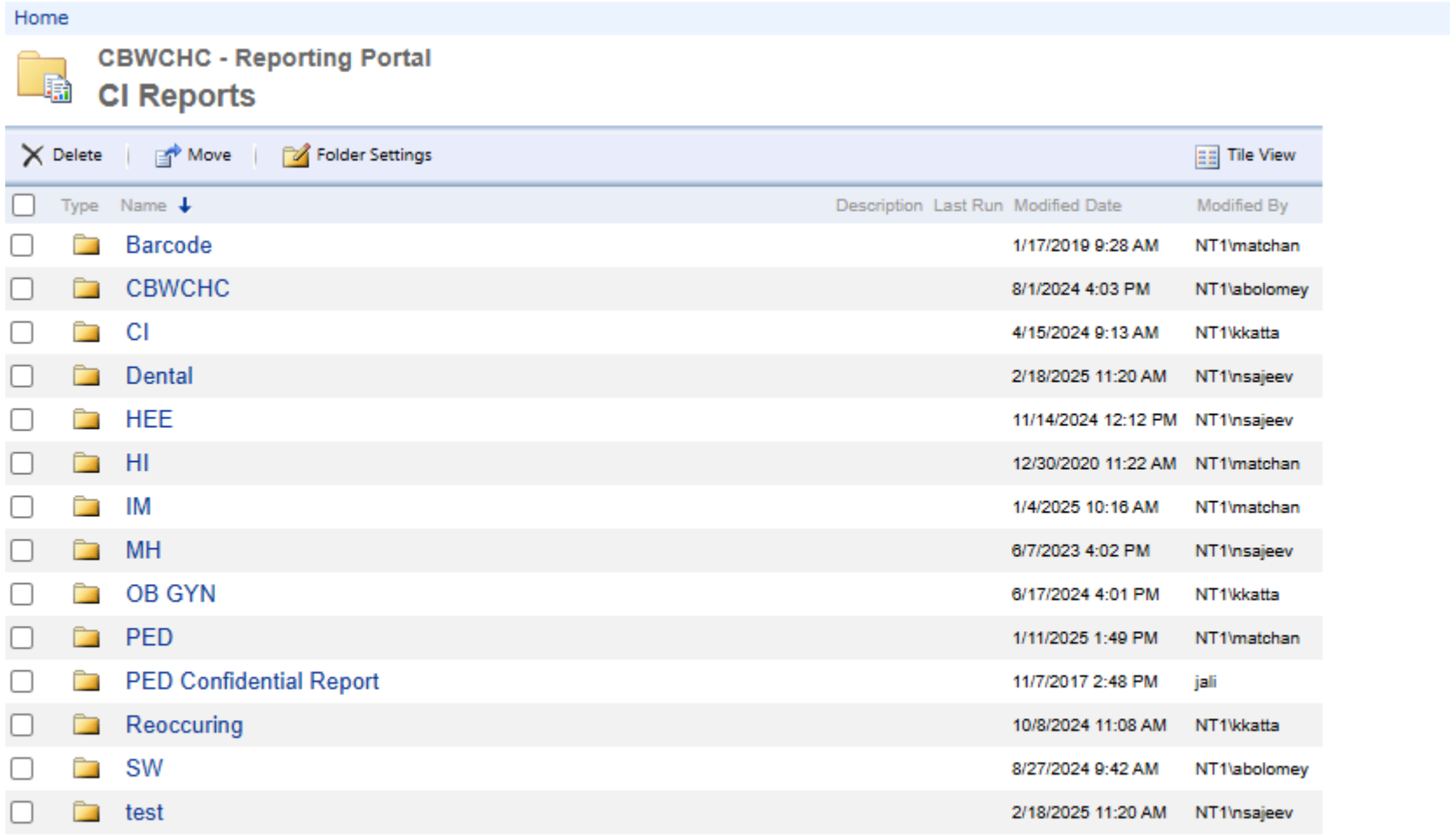
Average of at least 2 readings taken on at least 2 occasions should be obtained for diagnosis and management of hypertension.
Out-of-office and self-monitoring of BP measurements are recommended to confirm diagnosis of hypertension and for titration of BP-lowering medications.

Clinicians should provide patients their specific BP numbers and BP goals.

Data Driven Quality Improvement at CBWCHC

Integration of Reports into Clinical Work

Create and maintain a portfolio of department-specific recurring reports



Data Driven Quality Improvement at CBWCHC

Integration of Reports into Clinical Work

NEW REPORTS – Request Template Guides Users

Instructions: All fields under General Information are required. Fill in all other fields as necessary.

General Information

Requestor:	PED Requestor
Extension:	PED Extension
Deadline:	04/30/16
Recurring?	Yes, quarterly
Purpose of the report:	To identify patients with active diagnosis of neurologic and developmental disorders.

Population

Numerator:	Pediatric patients at Walker site who had at least one medical visit during reporting period who is defined as special needs by ICD 10
Denominator:	Pediatric patients at Walker site who had at least one medical visit during reporting period.
Exclusion:	Patients who have not had any visit during reporting period or without ICD 10 code listed.
Report Time Frame:	01/01/14 - 03/31/16
Appointment/Encounter Type:	All PED Encounter Types
Patient Age:	0 - 21 years
Patient Sex:	All
Patient Visit/Home Location:	Visit Location - W_PED
Other:	

Fields to Include

Patient Information	PCP/Provider Information
PID	PCP Name
Name	
Date of Birth	
Last DOV	

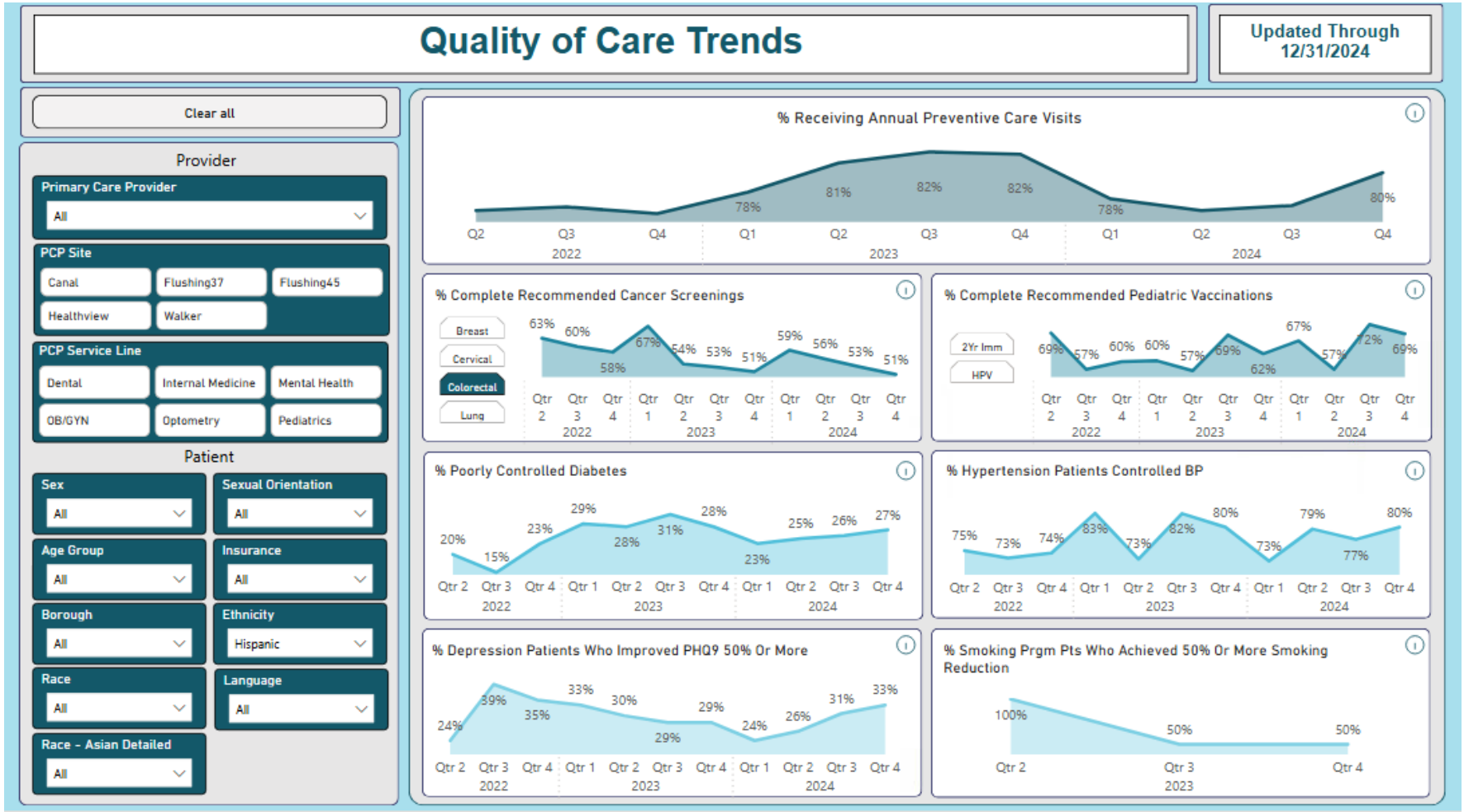
Obsterm Name	All/First/Last Obsvalue	Specific Obsvalue	Within Time Frame	Comment
SPEC NDSPT	All	Add/Added/Remove	Yes	
HIGH RSK PT	All	Add/Added/Remove	Yes	
HRSK ACUITY LVL	All	Add/Added/Remove	Yes	

Order	CPT Code	Test/Service/Referr	All/First/Last Order	Status	Within Time Frame	Comment

Data Driven Quality Improvement at CBWCHC

Integration of Reports into Clinical Work

Transitioning to Power BI Reporting:



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王嘉廉社區醫療中心

Data Driven Quality Improvement at CBWCHC
Integration of Reports into Clinical Work

Engage everyone in our QI work + opportunity to use the data/reporting

Daily work

- Care teams implement the PDSAs and measure success.

Monthly/quarterly meetings

- Site teams review progress on metrics regularly and discuss with other sites

Quarterly progress reports:

- Includes peer review, QI project reports, UDS and other indicators.
- Clinical director in advisory role

Results summarized with data and presented **to our Board and MDAC***

*Medical and Dental Advisory Committee: standing subcommittee of external clinicians advising the governing board.

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Key Takeaways

Invest in the program:
Communicate importance of QI/QA, designate resources, provide training and protected time, ensure participation at all levels.

Have and follow a process:
Establish goals, monitor progress, create reporting, set schedules, provide feedback to all staff
– provide support (knowledge and administrative)!

Regularly share lessons learned:
Every clinical service presents at QA committee meeting annually - share PDSAs, findings, and lessons learned!

Charles B. Wang Community Health Center
王嘉廉社區醫療中心

Dr. Ady Oster, MD, MBA
Chief of Population Health

Ady Oster is Chief of Population Health at Charles B. Wang Community Health Center and is an Internal Medicine-trained primary care physician. He has been at the health center for over 15 years and was part of the team which implemented the Team-Based Care Model, developed disease registries, and the center's original Patient Centered Medical Home certification. He completed a research fellowship centered on health services research.

Dr. Hyoseong Nuna Kim
Executive Vice President and Chief Medical Officer

Dr. Hyoseong Nuna Kim is an Executive Vice President and Chief Medical Officer at the Charles B. Wang Community Health Center. She graduated from Brown University and received her medical degree from the Brown University School of Medicine. Dr. Kim completed her residency training at Mount Sinai Medical Center and served as a board-certified pediatrician at the Fort Defiance Indian Hospital prior to joining the Health Center where she has continued to provide exceptional care for children in need.

Questions?

Resources

- **Data Governance Series**

https://www.chcanys.org/chc-resources/clinical-technology-resources/health-it/data-management-analytics

- **Center for Care Innovations | Data Governance Handbook: Implementing Data Management Practices in Health Centers**

https://www.careinnovations.org/resources/data-governance-handbook-implementing-data-management-practices-in-health-c/

- **HITEQ | Learning to Love Your Data: Data Governance and Literacy**

https://hiteqcenter.org/Resources/HITEQ-Resources/learning-to-love-your-data-health-center-data-for-everyone-session-3-data-governance-and-literacy

- **National Library of Medicine**

https://pmc.ncbi.nlm.nih.gov/articles/PMC2965885/

- **ASTP/ONC**

https://www.healthit.gov/playbook/ambulatory-guide/data-governance/

Please fill out our survey!

Please share your feedback using the survey link in the chat, the QR code, or the link in the follow up email!

Completing the survey helps us to provide relevant and helpful information. Thank you in advance!