COLLABORATIVE VENTURES NETWORK

COVID-19 and The Great Data Chase

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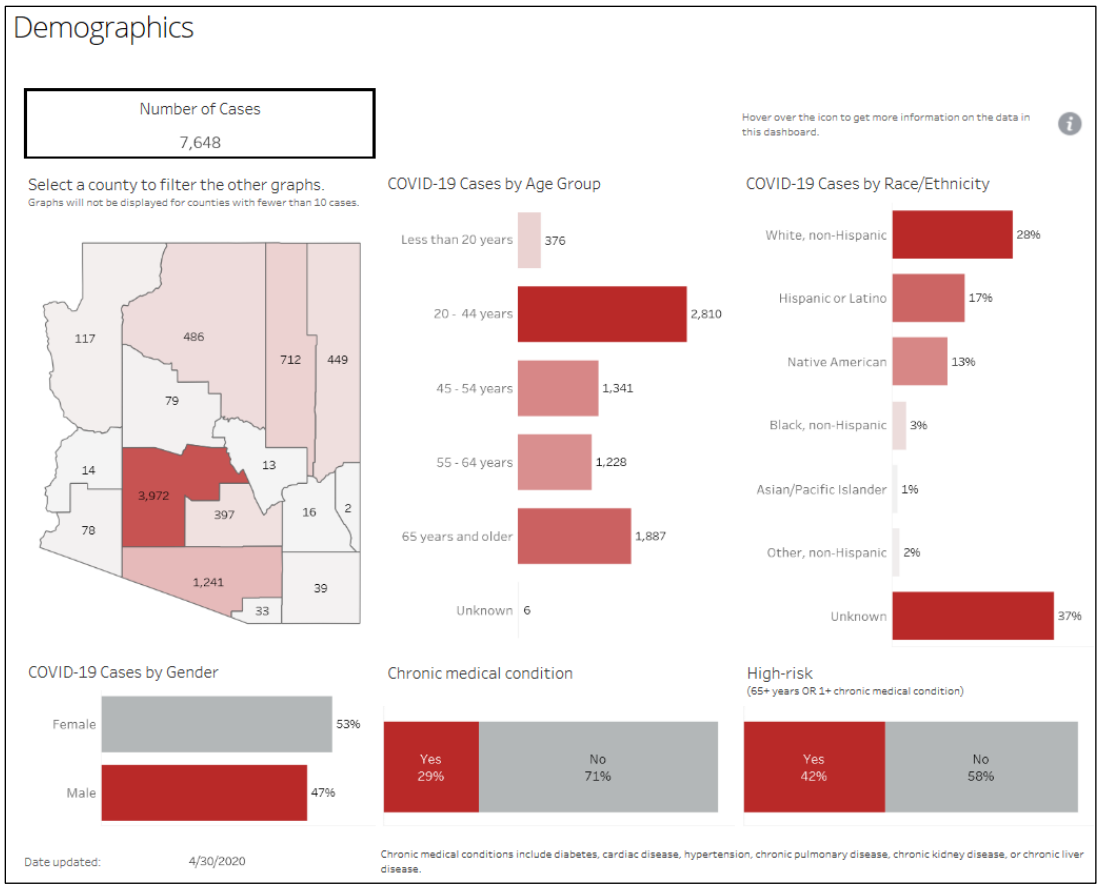
When talking about data in a public health pandemic, there are several avenues one could address: the size of the pandemic, the size of the response, the impact of either, et cetera. The HRSA Health Center COVID-19 Survey, for example, shows that 78% and 75% of health centers in Arizona and Nevada, respectively, responded with data updated as of April 17, 2020. At that time, ninety-four percent (94%) of those who responded in Arizona can test at their health centers and 44% have walk up or drive-in testing for COVID-19 available. These data are slightly better that the national results wherein 85% of the total responding health centers,74% can test for COVID-19 and 48% have walk-up or drive-in testing. Nineteen, or about 8% of health center sites, have been closed in Arizona and the PPE adequacy (respondents stating that they have an adequate supply of surgical masks, N95/PPR masks, gowns, gloves, and face masks/goggles) rates range between 89% to 94% depending on the type of equipment. For Nevada, 75% of health centers responded that they had 75% testing capabilities that were also walk-up & drive-in eligible. Eight, or almost 15% of health center sites have been closed in the state and the reported rates of PPE adequacy were at 75% for all types of equipment that was being inquired about.

But this survey answers only the question of COVID-19 capability and preparedness for testing and access to care, i.e. the size of the response of Arizona and Nevada health centers. This doesn't answer the question of COVID-19 prevalence at health centers. For that, one would have to look at multiple data sources including the states' HIEs, DRVS or the health center population health tool, and others. Health centers that are connected to Health Current, Arizona's statewide HIE, receive daily COVID-19 testing data and historical reporting, including Dynamic Alerts & Batch Alerts via SFTP. Azara has developed multiple dashboards and measures to identify both testing and telehealth capacity among health centers on its tool. And there's a myriad of state, national and international options to choose from when trying to obtain some understanding of the size of the public health pandemic.

Even with the myriad of data sources available currently regarding COVID-19, most are limited by several factors: lack of broad national COVID-19 testing; lack of interoperable data systems; or delayed reporting of what was deemed non-essential data such as race and ethnicity. For example, below is the most recent graph of Arizona's demographics for Arizona COVID-19 cases, where it shows that the largest category of race and ethnicity for Arizona COVID-19 cases is "unknown". There has been evidence to show that some minorities are at higher risk particularly- Native American, Hispanic & African American- due to higher percentages of chronic diseases that are impacted negatively by COVID-19 and potentially higher likelihood of being considered an essential worker according to Dr. Jay Butler, Associate Director of Infectious Disease at CDC.

Demographics of Arizona COVID-19 Cases, ADHS 4/30/2020



Thereby it's even more critical that health centers capture as much detail about patients and the organization's own experience during this crisis as possible. With primary care providers on "the front lines" of this pandemic; more likely to serve communities that have higher rates of chronic diseases associated with COVID-19-related deaths; and potentially more community members, including health center staff, who are essential workers, it will be vital to have the data to learn what was useful and what wasn't. For example, at Providence Health & Services- the first healthcare organization to see a COVID-19 patient in January of this year- they tried out remote patient monitoring similar to what had been done in China, but patients decompensated (meaning, they either didn't recover as well or didn't recover at all) in an environment completely devoid of human contact. When they changed their method to patients being provided iPads in the ICU for their stay to maintain connection with family and friends, as well as medical personnel coming in and monitoring them regularly, the patients recovered much quicker. With data and the ability to perform lean six sigma, PDSA cycles, or whatever method of rapid evaluation-retooling your organization is most adept with, it will be effortless to have evidence to show how, specifically, this pandemic impacted your health center, and ultimately, your community.