BHW (Health Workforce)

Health Resources and Services Administration

Exploring Best Practices in the Use of Clinical Data for Evaluation

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Chat History

Amanda Gmyrek: Please enter any questions you may have for our presenters in the chat box.

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Q&A

Q/A Done Over the Phone

Transcript

Primary Care Training and Enhancement (PCTE) Program Evaluation Technical Assistance (TA) Webinar Series

Webinar Title: Exploring Best Practices in the Use of Clinical Data for Evaluation
Date: Tuesday, December 5, 2017 at 3:00pm ET – 4:30pm ET
Meeting Details:

- **URL:** https://hrsa.connectsolutions.com/exploring_best_practices/
- **Conference Number:** 1-800-593-9995
- **Participant passcode:** 7648580

[Please stand by for real-time captioning]

Welcome and thank you for standing by, you will be a listen only mode for the duration of the conference. Today's call is being recorded you may disconnect if you have objections, you may disconnect at this time. At the end of the presentation we will hold a question and answer session and if you would like to ask a question you may press star then one. I would now like to turn today's conference over to Mr. Craig Stevens.

Thank you, Karen and good afternoon, everyone. I am Craig Stevens from JSI and I am the Project Director for the HRSA Primary Care Training and Enhancement, or PCTE, evaluation technical assistance contract. The overarching purpose of HRSA's PCTE program is to strengthen the primary care workforce by supporting enhanced training for future primary care clinicians, teachers and researchers. The PCTE program focuses on supporting innovative training in three primary ways: one is to encourage high-quality primary care practice in underserved areas, another is to enhance diversity within the workforce, and the third is to produce clinicians who will practice and lead transforming health care delivery models.

Thank you for joining us today for the fifth in a series of six PCTE evaluation technical assistance webinars. We are very pleased to offer this webinar series designed to provide PCTE awardees with evaluation resources aimed at increasing your capacity to develop and conduct your

evaluations. These educational webinars will focus on the application of evaluation topic areas and concepts of relevance to PCTE awardees. I will now turn it over to my colleague, Amanda, a member of the JSI/JBS evaluation technical assistance team, who will provide some details about the webinar and logistics.

Thank you, Craig, and thank you again for joining today's webinar, my name is Amanda, I am with JBS International, I am part of the JSI/JBS evaluation technical assistance team. Before we begin, I have a couple of housekeeping items to address. First, at the end of today's presentations we will have a question and answer session; please hold all questions regarding the presentations until the end. When it is time for the Q&A we will have the operator give you instructions on how to ask questions. You can also type questions in the chat box. Second, today's meeting materials will be made available on the HRSA webpage, and we will notify you when they become available. Next, if you're having any difficulties with technical aspects of the webinar, please use the chat box for assistance. Please type in your question into the chat box and push send. I, or our IT support, will assist you as soon as possible. Finally, please note that there is a box on your screen titled contact information. If you did not provide your contact information when you entered the audio component of the webinar, please enter your contact information in this box. Please provide your name, discipline, your organization's name, and your email address. This box will remain open for the next five minutes or so, so please enter this information now. Thank you. Now I am going to turn this back over to Craig Stevens who will provide some context on the purpose and goals of this webinar and then introduce our speakers. Craig.

Thanks, Amanda, as I have spoken to folks in the past, the JSI/JBS team has done a number of site visits and interviews with PCTE awardees and there were a number of themes behind our focus on this particular topic today. So, I am going to provide a little bit of the context for the basis of the presentation. A number of PCTE awardees are collaborating with safety net organizations clearly to target at-risk and marginalized populations, as well as to provide trainees an opportunity to be exposed to primary care in underserved settings in the hopes of

recruiting them. Projects are focusing on interdisciplinary approaches and the partnerships of multi-service organizations are seen as very advantageous – and so there is a high focus among awardees in this particular area. And then, of course, health care reform, which has been very widespread and a number of PCTE awardees are very advanced in these areas. Having hands-on experience with healthcare transformation activities, as well as adopting healthcare reform measures as part of their evaluation approach.

Similarly, through our discussions and our review of proposals we've seen, there is a number of challenges to evaluating the triple or quadruple aim. One is collecting and analyzing date from partner organizations, particularly with multiple sites. Choosing measures, and which measures to choose related to access, quality, and cost. Those organizations that are interested in cross site evaluation and comparisons; and then organizational prioritization of data extraction and analysis. So, we have seen that time and resources, particularly of the parent organizations, are relatively restricted at times and make evaluation difficult. And lastly, baseline or historical data. So, with that, we've garnered a number of presenters that we hope by the end of this presentation will speak to the context as well as some of the feedback we have received from awardees.

I am very pleased to introduce our guest speakers for today, Ms. Natalie Truesdell from JSI and our speaker from Colorado Nursing Center, Ms. Deborah Center. Ms. Truesdell has ten years of experience working with health centers in the areas of needs assessment. She teaches planning, quality improvement, evaluation and the performance measurement. Ms. Truesdell has served as a uniformed data system, or UDS, editor, for 6 years, supporting review and editing of data for two states. In this role, she reviews the UDS data 457 health centers and supports grantees with improving data quality and reporting. Several of her projects have focused on primary care redesign, enhanced model of care coordination and integration of behavioral health and primary care, from both a planning and evaluation perspective. In addition, prior HRSA work in performance measurement includes being a project manager on two projects to test feasibility and approaches to using a set of core clinical performance

measures across HRSA programs through the center for quality. In the area of quality improvement, Ms. Truesdell has worked with primary care to develop a change package on best practices and hypertension and diabetes care from the state of Maine; and with behavioral health and primary care integration projects on performance measures that monitor primary care integration. Ms. Truesdell has a Master's in Business Administration and Master's in Public Health from Boston University.

Our second speaker is going to be Ms. Deborah Center, and she is an Education Program Director and lead coach, independent consultant and speaker focused on leadership development, establishing healthy work environments and cultivating civil cultures and healthcare teams. As the Education Program Director and lead coach at the Colorado Center for Nursing Excellence, she facilitates several federally funded initiatives related to leadership and interprofessional teams. Each program includes a three-prong approach involving training, coaching, and an integration capstone project focused on improving quality metrics. The 'Building Skills for Effective Teams: A Statewide Collaboration program' capstone projects, focus on improving outcomes within interprofessional teams within federally qualified health centers measured through UDS measures and patient satisfaction. Ms. Center has over 30 years of experience in healthcare and has held many positions from a staff level to executive leadership within both clinical practice settings, education, and workforce. She completed her bachelor's degree at Xavier University in Cincinnati, Ohio and her Master's of Science in Nursing with a clinical specialty in adult critical care at Wright State University in Dayton, Ohio. Miss Center is in the process of completing her dissertation for a PhD in organizational development and leadership psychology. Again, Natalie and Deborah, we are incredibly thankful that you are here and appreciate your time. And now I will turn it over to our first speaker, Natalie Truesdell.

Good afternoon everyone, this is Natalie Truesdell, and thank you, Craig, for a very nice introduction. So, one thing that Craig also mentioned perhaps is that I have also been part of the PCTE program team for the last few years. Prompting this particular session is the fact that, as Craig mentioned, we discovered as we were working with a lot of you all – grantees – that

there are a number of folks that are working with FQHC or community health center partners. That prompted us to think about the UDS data system as a potential data source for the PCTE evaluations. We thought it might be helpful to spend a little time orienting everyone to UDS and how it might useful for your evaluations. So, for some of you, this may be familiar, for others the UDS dataset may be new to you. I hope that for all that the presentation today will leave you with a better understanding of the UDS and give you some new ideas on how you can apply it to your particular evaluation program, if you do in fact have a health center partner. So, let me start here, I'm going to talk a little bit about who reports UDS data, to understand which of your partners might be collecting this data; I will go through some things to consider as you think about using UDS for your particular program as an evaluation tool. We will give you a better understanding of the scope of the report and what measures are included, and I will also be providing some other resources that may be helpful for you as you think about using UDS.

The uniform data system, or UDS, is a standard data set that is reported annually by all health centers and it provides consistent information about health centers. It has a corset of information that documents how health centers perform, and this includes patient demographics, services provided, clinical processes and results, patients use of services, cost and revenues. Related to PCTE goals, this dataset provides information to understand the impact that the health center program has on expanding access, addressing health disparities, and improving quality and reducing cost of care.

So, to orient all of you to who is reporting UDS data, those health centers that receive HRSA 330 funding, also known as federally qualified health centers or FQHC's are required to report this data, as is health centers that have a look-alike status, which means they conform to standards for the health center program but do not receive HRSA grant funds; as well as certain centers that are funded by the Bureau of Health Workforce also report this data. As I mentioned, it is reported on an annual basis, and calendar year 2017 data will be reported this coming February and our reports are due February 15. So, health centers are actively working to pull that data together for the 2017 calendar year over the coming weeks.

So, why might you want to use UDS as an evaluation tool? As I mentioned before we know that many programs have health center partners. So, it is a relevant data set that is available to many of the programs. It is a standard data set that your partners already have and, as Craig mentioned at the start of the webinar, we know that as in all evaluation projects there are constraints in terms of being able to do primary data collection. So, whenever you can, take advantage of data that already exists, there are benefits to that. The other benefit of UDS is that it does include clinical measures that span a wide range of areas including preventive services, screening and chronic disease; so, it gives you a pretty wide menu of clinical measures to choose from based on your program emphasis and focus. Another thing to mention is that the UDS clinical measures are aligned with the CMS electronic clinical quality measures, or e-CQMs. So, if you have clinical sites that are not health centers the impact may be collecting those same measures as their health center partners due to the fact that there has been work to align measures across reporting in recent years.

I just want to start off with just a few definitions in terms of understanding the UDS data set. One thing that I know varies often between organizations as how they define their patient panel or active patients. So, for UDS reporting, patients are defined as people that have had at least one reportable visit during the calendar year. This applies to anyone who has had a visit, not just a medical or dental visit, which prompts the question: “What is the definition of a visit for UDS?” A countable visit are those that are documented face-to-face encounters and contacts between a patient and a licensed or credentialed provider who exercises independent, professional judgment in providing those services. A provider is someone who assumes the primary responsibility for the patient and documents the services in the patient's record. All of this is provided in much more detail in the UDS reporting manual, which I will provide a reference to at the end of this session.

So, now that we have some understanding of who is included and who is reporting, this slide provides an overview of the type of information that is included in the UDS reports. It covers everything from patient demographics and patient characteristics to some operational data on

staffing, the clinical quality measures and financial data, all of which may be of interest as you are thinking about your PCTE evaluation. Because we are talking about workforce development, I do want to share the level of detail that is provided in the UDS about the staffing at a health center. So, Table 5, which references the particular table in the UDS report, provides a wealth of information on the staff at each health center. It includes the FTE by staff type, I know that is small print, but this is a high-level summary of the type of staff that FTE data is provided for. So, it includes information on physicians, nurse practitioners, physician assistants, certified nurse midwives as well as other types of staff at the health center including mental health providers, vision care, oral health, substance use services and enabling staff such as case managers. And for most of these, though not all, the number of visits provided by each provider type is part of the data sample. So, if you wanted to know how many mental health visits or case management visits a health center provided this information will be tracked by your health center partner as part of their UDS reporting.

So, to talk a little bit about the clinical quality measures that are available through UDS, this slide provides a list of the current UDS clinical quality measures. As you look at this list, you will see that there are opportunities to look at cancer screening, preventive measures, health behavior screening and counseling, measures that are focused on children and those that are focused on adults. There are also measures to focus on oral health and behavioral health. I am not going to go through the detailed definitions of each of these clinical measures on today's webinar. I am afraid we do not have time. Again, I will reference the UDS manual which provides the information on the numerator and denominator for each of these measures.

I will note that, again, these clinical measures and specifications are aligned with the e-CQMs, so if you're familiar with those, these definitions are in fact the same. I know many of the PCTE programs are thinking about how to address health disparities and the UDS data set is a resource as you consider measuring health disparities as well. Three of the clinical measures specifically in the UDS data set look at reporting out by race and ethnicity for the health center population. These include reporting the delivery and birth weight for all prenatal patients that

receive direct care or are referred to care from the health center. It includes a measure of control of high blood pressure and for patients with diabetes a measurement of HBA1c control. So, for these three measures, the data is reported directly by race and ethnicity. But if you consider looking at disparities and thinking about that in your program evaluation, you may want to consider talking with your health center to look at some of the other measures I referenced. Certainly, there are the required measures on race and ethnicity, but your health center may have the capability to report out by race and ethnicity for some of the cancer screening or other measures as well.

So I wanted to just go through a quick example of a particular situation and type of PCTE program where you might be using the UDS measures and what particular data you would look at. So, if a PCTE program is focusing on supporting a collaborative care model and the integration of behavioral health and primary care, there are several data points within the UDS that may be of help. There are the clinical quality measures, but there's also data within UDS that helps understand access and utilization of care, as well as cost. So, if you're interested in knowing to what degree screening is occurring at the health center, for those of you who might be familiar with the SBIRT model, Screening Brief Intervention and Referral to Treatment, this is actually captured as part of table 6a in the UDS report, which reports out CPT and codes for a select set of services and SBIRT is one of those. So, you could get a count in terms of the number of unique patient and unique visits that the SBIRT screening has been provided to.

The other measure, which would be available, is a clinical quality measure on depression screening. This measure looks at the number of patients that are screened positive that also have a documented follow-up plan. This looks at this measure for all patients age 12 and older with one medical visit in the calendar year. So, there are two ready quality measures to look at and consider. And then in terms of access, as I mentioned, on the staffing table there is a report on the number of mental health visit. You could look at the number of mental health visits per patient based on the number of unique patients in the UDS. Then, to get a sense of cost, there is a comprehensive table on health center costs related to staffing and full program cost for

mental health. So, that's on table 8. You could use that combined with the total mental health visits to get an average cost per visit for the mental health services at the health center. So, this is just one example of some of the points of data that you could pull out of UDS for an evaluation purpose, but there are many others. I just wanted to pull this out to give you a flavor of how the UDS data set could be used.

So, a few things to know as you think about using UDS data. As I mentioned, it is reported on an annual basis. So, health centers should have historical data for as long as they have been a HRSA grantee. For a program that is looking for some historical data or baseline data the UDS data is fairly reliable for that purpose. Although, I will put the caveat, there is always a caveat, that some of the clinical measure definitions have changed slightly over the years. Once you choose which clinical measure you're looking at, you'll want to consider and talk to the health center about whether the definition for that particular measure has changed over time as you benchmark data and trend it across years. The other thing to think about is health centers have been moving from reporting a sample of patients. Historically, health centers have been reporting a sample of 70 patients as part of their UDS report, and now with electronic health records becoming more robust, health centers are now reporting a full universe of the total patient population – and that can have some impact in terms of the actual results on the UDS measure. It is something to consider.

So, as you're thinking about using the UDS data set as part of your evaluation and talking to your health center partners, there's a few things that you may want to discuss with them. One of those is to have that conversation about how they are currently using UDS data at the organizational level for their own quality improvement process. You might want to know whether they are looking at the data at the provider level and providing provider feedback reports that would be important to developing your evaluation plan. You'd also want to think about how often they are pulling their UDS data measures and at what frequency. Health centers may be looking at a subset of the clinical measures aligned with their quality program on a more frequent basis than the full sets; and may be looking at some of it quarterly, some

monthly and some on an annual basis. Talking through that with them might be helpful to know what data is easy to access. You can jointly decide what frequency of data would be useful to look at for your program evaluation.

The other thing to discuss with them is their data validation process. As anyone that looks at data a lot knows that can be a time-consuming process and, as a partner, that might be a place where you can support your health center partner in reviewing data, asking questions and being part of the data validation process.

So, I want to provide a few resources that will give you a more detailed understanding that I can today on these UDS measures. So, the UDS comes out with a reporting manual each year, which has the full data definitions. Here on the screen you can see the 2017 reporting manual and a link to that. The other resource to be aware of is the HRSA-funded HITEQ center, and HITEQ stands for Health Information Technology Evaluation Quality. This center collaborates with HRSA partners to support health centers in full optimization and use of their EHR and health IT systems primarily for quality improvement and better use of data. This center has a website, www.hiteqcenter.org, that has a wealth of resources. In particular, what might be of interest to this audience is that there are some tools related to data validation and data dashboards.

So, this is just a quick screenshot to give you a preview of what you'll be looking for in the hiteqcenter.org. This is referencing the health center data validation tool, which is an Excel-based tool that's designed to support data validation of EHR reporting. The one shown here is for the adult BMI clinical measure. It allows you to compare results from your EHR to results from chart reviews to examine any problems with the underlying data in your EHR report. This is identifying whether there are any problems with your EHR report logic that might be affecting your ultimate result or compliance rate that you are getting from the EHR as it relates to any particular measure. It also allows you to drill down and see if there's any other workflow or other issues related to data capture.

The other resource that's really hot off the press, this is again, through the HITEQ center, is a new UDS data dashboard tool. This provides an opportunity to look at historical data for UDS through the Tableau platform. It provides data for individual health centers and can provide trend data for the clinical measures, which I showed you for the timeframe from 2011 through 2016. It also has opportunities for comparison of performance between various groups. You can summarize data at a state level, at a national level and compare this to an individual health center. This is a free resource that is available to health centers that might be useful to you as well. I know that the detail on these charts is not visible on the screen here, but I will share at the end of this a link to a presentation to understand this resource in more detail. But I think for the PCTE grantees this might be very helpful in terms of having that trend data that people are interested in looking at.

You may be asking how you would access this. This system just went live last month. Each health center director received an email with instructions on how to log in using a unique user ID and password through the HITEQ center website. So, if you have interest in accessing it, the first step would be to reach out to your health center partner and see if they have received and logged into the system. The other place to go is to send an email out to the HITEQ center webpage as well, for questions on access. This here is just a link to a more detailed presentation on that data dashboard if you want to explore that further.

So, I will close here. I believe we will hold for questions until the very end, so I will pass it back to Amanda for our next speaker.

Great, thank you so much, Natalie, for that interesting presentation on using UDS for PCTE program evaluation and for the resources contained within; very helpful. I am now going to turn the webinar over to Deborah Center, representing PCTE awardee, Colorado Nursing Center. Deborah will be presenting on using clinical and team metrics to engage and measure team effectiveness in federally qualified health centers in Colorado. Deborah?

Thank you, good afternoon everyone and I really appreciate the opportunity to provide some highlights of our program. Our program actually has built on three other grants prior to this with a multi-organizational collaboration around interprofessional teams. My role is, as one of the program directors, and I lead many of the elements of the grant. So, our hope is that this demonstrates how we apply the UDS. As Natalie says, to take advantage of data that already exists that are important to the FQHC's that we work with. As a brief overview to our program, our grant actually has four main objectives. The first one is around the building skills for effective teams – and that is the largest element of our grant. That really focuses on building teams with an impact – teams of federally qualified health centers in Colorado. That is where we focus on the UDS measures as part of their measuring of the outcomes for that element. The other elements of the grants are important too in a professional team training. Both B and C focus on interprofessional students that are at the provider level from multiple organizations. One being related to developing team skills and the other is on leadership skills for these students. There is no clinical component for those two elements of the grant, and so we really don't focus on the UDS measures to evaluate those components. The students come from multiple schools across the state representing medicine, osteopathy, dentistry, advance practice nursing, pharmacy, physician assistants and social work. Then, the last element of the grant is focused on increasing interprofessional clinical experiences through a preceptor development program.

Our partners in this grant come from all across the state, from both practice and education. We have our clinical partner is the Colorado community health network that represents the 22 different federally qualified health centers across the state. In the map you can see that Colorado is a very square-shaped state, our population pretty much goes down the center of the state along the I-25 corridor, which actually allows us to have some geographic challenges between the mountains and the plains that add to our beauty, but creates some difficulties related to providing resources to our population. The clinics don't all reside along the middle of the state, where the majority of the population is. Those that are along the outside edges often

represent clinics that are very, very small – some only with one provider and have limited resources, often with no dental or behavioral health services. So, we have to figure out ways to link those together. On the map there, you can see that all the red and the blue squares represent where the clinics are, with the red ones being those that are affiliated with a medical center. Then the pink circle is in the center there, where the Colorado Center for Nursing Excellence is located; and the yellow stars represent all of our academic partners that bring students to our interprofessional trainings. To date, we have had—out of the 22 clinics—we have had seven different federally qualified health centers participate that represent 16 different locations across the state, with ten of them rural and six of them being from metro or urban locations.

To set the tone for how we use metrics in this program, really it is trying to be as holistic as possible. Our program builds upon the previous grant, the HRSA-funded grant, where we had some lessons learned. One big lesson was that many of these clinics are involved with multiple other projects that focus on quality, behavioral health integration and building teams. Then our goal was to ensure that the strategies that we applied avoided duplication or splintering of their resources and efforts, so that they really truly could improve the quality and the outcomes over time. So, our focus is starting out with some baseline measurement of metrics and helping the clinics and the teams see what that data means, in order to institute a change program through their capstone project; and then doing some follow-up measures at the conclusion of their effort to really look at the difference. Along the way, trying to incorporate some strategies that can help them do some ongoing process improvement and sustainability of their efforts once they identify some strategies that work. So, we start with looking at team metrics before we get to the clinical measures. Our philosophy is that to create the lasting sustainable improvements on those clinical metrics that we really need to look at creating a foundation with how the culture within the clinic works, and so that is really where we spend a little bit of our energy up front. We do some foundational measurements of teams to really identify some root causes

and barriers that could impact the clinical metrics along the way in order to improve that as we go forward.

The first one is to use the team excellence assessment, which was developed by Dr. Larson and LaFasto in their research on when teams work best. This is a survey of the teams that they actually complete that looks at those eight principles of effective teams that could potentially sabotage the teams' efforts. Once they receive their results, the results are debriefed with Dr. Larson and the team coaches from the center, in order for the teams to identify where they should focus in order to improve their culture and their climate that could impact their quality measures. They receive the results as an individual team. They also see it in comparison to the other clinics that are part of their cohort, as well as Dr. Larson's database of over 6,000 different teams. So, it really gives them some rich data to begin.

We also look at provider satisfaction by using an intent-to-leave, a three-question survey that was developed by Dr. Janet Hauser, that allows them to look at their satisfaction within the clinic. Our first cohort ended in September and out of that cohort we actually had two providers that at baseline had a high risk for leaving their clinic. Both of them were from very rural settings and at the end of the year-long program they had no desire to leave. So, while we can't fully take credit for that, any time that you can keep a provider in a rural setting, it is pretty fantastic, so we're pretty excited about those results.

Then the last part of the team metrics is around an interprofessional collaborative competency attainment survey, which is a 20-question survey that looks at six domains for collaborative practice. We do that at baseline and at follow-up to see if there is any shift in their learning and their ability to function as a group together.

For our first cohort, we did see statistically significant change in all six of the domains there from the beginning to the end. The training program that they take along the way does really focus a lot on the soft skills, improving communication and collaboration. So, it was great that

we could see, at the end of their year, that that had definitely been impacted, so we are pretty excited about that as well.

So, the clinical measures that we do then go to the UDS measures. We have done this now for a couple grants and honestly, by adding these clinical measures into this training program it gives a legitimate focus and purpose for all our team to begin and actually submit participants for this and be able to obligate this amount of time. Each team has a capstone project that they work on and it's really about nine months out of the year that they are working on this element, where they pick two UDS measures and one patient satisfaction metric that they want to work on. Our goal is that they connect them together, so it really is more of a cohesive type of capstone. Every clinic has a little bit of a different process that they use. So, we work in collaboration with their Quality Directors and, for some of them, their business innovation personnel to make sure that we're being really strategic about which measures that particular clinic needs to develop over time – and that we are asking for the documentation and the strategies that support what their clinic is already doing, so that again we are not splintering or going off what they need to do.

So, we then we help them, support them, through the training to do a rapid-cycle process improvement on those UDS measures. All of the soft skills that we teach them in class hopefully help them improve those measures. The first place that we start is to really help them understand what their measure is and where they get the data. As Natalie said, some of the clinics can pull the data from different locations and so helping them understand what their data means, how frequently they can pull it, where it's even coming from, from their EHR, is really significant. In each of our teams we have a couple of providers and some of them really do question the data and the credibility of the data. So, by slowing them down and actually letting them look at where that's coming from, some of them actually do some auditing of their electronic health record, to really get clear and make sure that the data is as appropriate to what they're trying to do as possible.

Then, each team actually creates what they call a strategic inclusion process, where they look at which UDS measures they're doing and who needs to be involved. Which members of their team really need to be a part of that? Once they have done that, then they do a process where they look at their workflow and map out all of the elements that impact that UDS measure, so that they can make sure that they know exactly what that means and where the work is coming from. They then create a strategic goal and then part of our grant, we hope that they do an improvement of those UDS measures by about five percent in the time of our grant. However, some of their clinics have different goals that they want them to accomplish, and so we want to work with them related to that. They, then, have to develop a process for tracking and conducting their PDSA along the way and creating a pilot for that to be able to do that. We do, part of our training, is to include a process where we teach them about PDSA. As someone who has been doing this work for a long time, that's something that I would have thought many of the clinics already knew and it was going to be language they already understood. But it is amazing how many of them are still in their infancy stages with this. So, we use what is called a Mr. Potato Head PDSA exercise, just to get all the players on the right page with the same language; and it's amazing how that engages them differently after they've done that. We also help them look at how they are going to communicate this with the rest of the clinic and provide clinic feedback, whether through their huddles, whether it's through a visual management board, how they are going to do that. And then what will be their plan to disseminate as they go further to the rest of their clinic, beyond the one location that they might be coming to us from?

In September, we had our first cohort complete their program and report out on their capstone projects. We had eight teams in our first cohort that actually identified 17 different UDS measures to work on. One of the teams was a high achiever and did three instead of what we requested as two. Out of them, 53% of them had a greater than 5% increase in their quality measure after nine months of working on this with their teams.

Some of the teams picked UDS measures that were easier to make some improvements on than others. Others were pretty challenging. We had a couple of clinics from rural settings that represent resort or mountain area locations that sometimes will have patients that are just there for vacation. Like Natalie said, in relation to a visit, they count in their measures. But they're there for –maybe, they got the flu while they were skiing. And, so it's impossible to get them to do a mammogram and colonoscopy and everything while they're there; it's just not realistic for them to do all of that. But they still are something that they have to work on.

Out of our eight teams, six of them saw a minimum increase in their quality measures in at least one or both of their quality measures. For the two teams that did not show an increase, they spent the bulk of their time identifying processes and the barriers to those process changes, doing training for their team, set up to where, I believe, that over the next few months they should be able to meet those goals even though they didn't within the timeframe of measurement for our grant.

Some examples of some improvements – that they did, one team was looking at cervical cancer screening and they shifted from a 71.6% baseline to 78%. We had a couple teams that looked at putting sealants on patients age 6 to 9. One team going from 67.4 to 74.4; and another team starting with a baseline of 9.52 going up to 20.25. So, they were pretty excited about that. A couple of teams worked on colorectal screenings, which I think seems to be one of the most challenging ones for them to really make dramatic increase on over time. One team went from 26 to 35. Another team started out with 11.92 and went up to 56.85 at the completion of their capstone. Because they worked very, very hard on trying to identify the right people to give out the FIT test, to actually do the follow-up calls, and to get the patients to return those FIT tests – and spent a lot of time and energy on getting documentation of completed colonoscopies that were done in locations outside of their health center. So, really, looking beyond their walls in relation to improving that.

The last one to talk about briefly is one done with depression screening. One of our teams had a baseline value of 31% compliance at the beginning. Their clinic established their goal at 40%. At the end of their year their outcome was up to 76%, because they were able to engage the right people. They went through a process of scrubbing their data prior to visits every day. So, in their morning huddles they would know which patients that had come to the clinic that morning that needed to be screened and then to be able to follow through with it as they went through their day. A couple of the clinics told stories in their capstone presentations about how these related to real patients, telling a story specifically about a homeless patient in one of the clinics that had come in for a specific symptom-related process. Because this team was working on their depression screen, they actually triggered them to do that screening while that patient was there, which they might not have done on a regular day. Because they did that, they triggered seeing evidence of the behavioral risk that was able to get that patient seen by a behavioral health provider during the same visit. That patient is now engaged in care related to his depression, smoking cessation and two other health symptoms that they would have not maybe picked up on that one visit, had they not been working on this. So, because they are able to tell those stories to their team and to their staff, it really has made the UDS measure and the use of the UDS data more real to all members of the staff. It is not just a number on their visual management board that they're either doing or not doing. It's really made it come alive.

Over time, we're working with our external evaluator to look at these measures longitudinally, like Natalie suggested, maybe looking at it over time. For our grant, it's a little challenging when you have clinics coming from multiple locations. But I would strongly encourage any of you that are working in one clinic to really do that, because it is a really meaningful data point to those clinics.

We also look at patient satisfaction. Part of our goal is around increasing the clinic's patient engagement over time. The data is challenging, though, for us to get because many of the clinics only measure that annually or twice a year. So, the data doesn't always correlate with the program that they're implementing. So, I really don't feel like the data that's on the screen

there is really relevant to their particular projects, because at baseline it maybe [the data] was maybe six months old and really didn't look at what they had been doing over the last six months. So, we are working with them to figure out ways to measure that more accurately as we go forward. Then we also ask them in their capstones to work on team building and measure some type of baseline and follow-up results – so far, the teams have done really well in that category.

So, how do you engage these clinic metrics with the team? How do they really get focused? I would say that for FQHC, if you're working in that population at all and that type of setting, the staff that are in those settings are mission driven. They are very focused on the population that they serve, so doing anything that improves patient outcomes for this population is a significant motivator for them. Really making it real and helps them focus and see a purpose on that. It really was something that engaged many of our teams in the beginning of the process of the team building to really be on track with what we are doing. And then, hopefully, it creates something that's sustainable within the clinic, because it has positive outcomes that allow the clinic to see longer than in the time period than just in their training. Then, it also lets them measure against national standards. For many of our teams, though, they gave us feedback at the end that the clinical metrics is what got them to the table. It's what helped them see that this was an important topic. But, in reality, for their clinics, it was about the content that was taught to them around relationships, improving communication, building teams, dealing with conflicts, that will help them improve their quality and their measures more long-term. So, keep that in mind in relationship to these measures.

Then, how do you overcome the challenges? I mean, anytime you're doing any kind of change process or quality improvement, there are definitely going to be challenges along the way. The first, like Natalie said, is really understanding the metrics and what they mean. Many of our clinics have been able to drill down the numbers to where they can pull it by team, by pod, by provider; and many of them pulled it on a monthly basis in order to allow the teams to look at what they're doing and how they are improving. So, really understanding what that means is

significant. Then, looking at how the EHR impacts the credibility of the data. We've had a couple of the clinics that have shifted their electronic medical records along the way – and as a result, doesn't always pull all the data from the places that they are documenting. So, they have to do some processes where they've audited to make sure that the data is actually being pulled from the appropriate places. Then, making sure that you have the right players at the table and including the people from the business development and quality that are really going to help you understand where that data comes from and how to use that data and how frequently you can even obtain that data is really key. The other challenge, which I think was overwhelming to some of our team members, there is so much change happening every day that they just assume that change is something that happens quickly. What they learned through this process is that real change, quality change, change that really impacts these UDS numbers and really makes a difference really is a slow, strategic process, and takes time. Then, lastly, trying to figure out how to use these metrics in a sustainable way that become a routine, that's not just something that they're doing because they have a grant or because they are doing a specific process, or is something that they can deal with when there's turnover in their location that doesn't make the numbers drop off. So, how do they include it into their huddles routinely? How do they embed it in their orientation programs, so that it doesn't die as soon as they're done with a specific project as they go through this process?

Next steps for our program is to help them make this more meaningful long-term. We are working with the Colorado Community Health Network in the Colorado Department of Public Health and Environment to create more resource tools and a dashboard that is relevant to them, that includes their UDS measures, so that they can see which other clinics across the state have made some improvements in certain areas, so that they can network and share that information across locations. We are helping them share their capstone reports and their clinic reports across the state as well, to be able to share best practices and build upon that as they go forward. And working hard at linking between cohorts, the teams between cohorts, so that

they can build on the momentum of the previous group as they go forward and not start over from scratch and really make some positive outcomes for their clinics as they go forward.

So, I think that is a quick overview of how we have been applying this in Colorado. It is our hope that with our second cohort, that will end in about six months, that our data is only better with each team, each group that goes forward. So, we look forward to being able to share some of our future results with you in the future. If you have any questions I look forward to hearing them when we get to that component. So, I will turn it back to Amanda for questions.

Great! Thank you so much, Deb for that really interesting and impressive presentation on hearing about changes in terms of what teams were able to make. It was really impressive. So, I'm going to turn it over to our operator, Karen, who will provide attendees with some instructions about asking questions via the telephone. Also, if you are on the Adobe Connect only, you can enter your questions into the chat box and I will ready those for our presenters. Karen?

At this time, if you'd like to ask a question please press star then 1 and record your first and last name clearly when prompted. Again, if you would like to ask a question over the phone line at this time, please press star and then 1. One moment for your first question.

There are no questions on the phone lines at this time.

We also have no chat questions at the moment either. Maybe we'll give folks a few minutes to type or ask any questions they may have. Otherwise, we'll wrap up.

So, I have a quick question – this is Craig – for Natalie. One of the things that we did notice is that a number of awardees weren't really clear whether or not their organizations that they were working with are federally qualified health centers. I am wondering if there is a location where the FQHCs can be listed so that they actually can find out. Or, if they are planning ahead, or if other folks are thinking about doing this work and listening to this webinar. The second part would be timing. It sounds like from your presentation that folks are going to be

submitting their UDS data and are thinking about it now, and now would be the time to actually start having these conversations, if indeed health centers are looking at their data, working on it and putting some effort into it.

Hi, Craig. This is Natalie, thanks for your question. In terms of knowing whether your Health Center partner is reporting, I think there are a few ways to know that. HRSA's website does have a list of all the federally qualified health centers. I don't have that link handy, but I think that is something that we could share out to participants, if that's of assistance. Most Health Centers on their website will recognize if they are federally qualified. It is a badge of honor for most health centers, so it is usually prominent on their website. And then of course talking to your partners, they will definitely be able to tell you if they are a part of the Health Center program and are reporting UDS. Then, remind me of your second question, Craig?

If folks are interested in knowing what can be done with UDS if they have partners. It sounds like now is the time to engage folks and have those conversations, anticipating that reporting will be complete. So, if they are doing any analysis that might be beneficial to awardees, that analysis is essentially done and submitted by February 15, so to start those conversations now.

Yes, definitely. So, the health centers are putting those reports together. They are due on February 15. As I mentioned, they are doing their annual report now, so will be able to give you that 2017 data in February, if that's important for your evaluation purposes. But many health centers are looking at this data more frequently than their required reporting timelines. So, depending on your partner, they may have data sooner than that if you're looking at pulling reports on a quarterly or monthly basis.

And I would add – this is Deb. I think all of them are always looking at ongoing process improvement. So, I don't know if they would need to wait till when they're reporting. I think that any time, if they just know they're a federally qualified health center and ask them what are their priority UDS measures that they want to work on. I think they would potentially engage in that.

Thanks Natalie and Deb.

Great, thanks. Karen, any questions from the phone line?

Currently no questions.

Great. Well, thank you so much again, Natalie and Deb, for your presentations., It is really interesting and informative. If there are no further questions then I think we will close today's webinar. Thank you all.

Thank you.

Thank you, this concludes today's conference, you may disconnect at the time–at this time.

[Event Concluded]