# Transcription

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Megan: Hello everyone, and welcome to this ACHSI Expert webinar, "Data Integrity from a Healthy Start Perspective." I'm Megan Hiltner with the Healthy Start EPIC Center, and we have approximately 60 minutes set aside for this event. The webinar is being recorded, and the recording, along with the transcript and slides, will be posted to the EPIC Center's website following the webinar. We really want your participation today during the webinar. So at any point, if you have a question or a comment, please chat it into the chat box, and we will be getting to those questions after the presentation. We also want your feedback. So at any point...or, sorry, after the webinar, you will be prompted with a survey on your screen that will pop up right after, if you'll please take a moment and give us your feedback, we do appreciate that so we can continue to try and improve on these.

For this webinar, we've tried to get a little creative. We're presenting the content on data integrity through a scenario of a Healthy Start Case manager working with her project director and a local evaluator. Following this scenario, you're gonna hear a real-life Healthy Start example that you may be able to use from the Alameda Healthy Start team, Alameda County. And I wanna do a big thank you to our planning committee for this webinar, Miss Kristen Tharaldson from Minneapolis Healthy Start and Miss Misha Taherbhai from the Alameda County Healthy Start. Both have been really helpful in reminding us and helping us craft information that is relevant to what you all are experiencing on the ground. You'll hear more from Miss Taherbhai very soon.

So let's check out our agenda for today's webinar. First you're gonna hear some welcoming remarks from Miss Maria Benke. She's the Branch Chief with the division of Healthy Start and Perinatal Services. Then you'll hear the case example I spoke of a second ago on data integrity from the EPIC Center team. Then Miss Taherbhai from the Alameda County Healthy Start team will present. And then we will wrap up and open up to some questions and comments. So now I'd like to turn it over to Miss Maria Benke for some welcoming remarks. Maria.

Maria: Thanks so much, Megan, and good afternoon and good morning to those on the line. On behalf of the division of Healthy Start and Perinatal Services, thank you so very much for joining today's webinar on the topic of Data Integrity from a Healthy Start Perspective. I'd also like to thank the Healthy Start EPIC Center team for developing and coordinating this very important session, and, of course, to our speakers today for lending their time and expertise.

As you're aware, data is a very important element of the Healthy Start program. Data are used for quality improvement, performance monitoring, program monitoring, evaluation, and decision making. These data are used not only to inform our programs and what we do day-to-day, but also to tell our individual and collective stories and successes. And data integrity is important because good accurate data helps us to share our stories with confidence and also feel comfortable in the decisions that we make as a result of these data. So this is indeed a very important topic. And, again, I thank you for joining today, and for all that you do to ensure good quality Healthy Start data. I hope you enjoy today's presentation. And without further ado, I'll pass the ball back to Megan. Thank you.

Megan: Thank you so much, Maria, for those remarks. Before we get started, I do wanna do a quick pretest knowledge check. So if you'll take a moment and respond to this question that we've put here, we'll be visiting this content throughout the webinar and then revisiting the question again at the end. So the question is building a culture of data at your organization is the responsibility of, A, local evaluator, B, the project director, C, the staff entering the data, or D, all of the above. Click on the radio button. What you think is the most appropriate answer? It looks like you all are pros at this. The answers are coming in. And we're gonna close that poll. It looks like the majority of folks responded that they think it is D, all of the above. That's 87.5% of folks. So, like I said, we're gonna get to this information more throughout the presentation, and then we'll come back to it at the end.

The next question, which elements in this list are key to data quality? And please select all that you think apply. Is it that the element should be...or the lists should be...the key to data quality, sorry, everybody, is consistent, reliable, accurate, complete, valid? So with this one, you don't just have to pick one, you can pick all that apply. Or you can pick one. All right, let's skip to the results here. It looks like everyone thinks accuracy is key. And the majority of folks also think the other points are also key. So again, we will get back to this information and revisit that question at the end of the..."Oopsy," at the end of the webinar.

Okay. So, as I said right at the beginning, we're gonna be reviewing data integrity from the perspective of a Healthy Start case manager. So I'd love to introduce to you all Mimi. She's just come on board with her Healthy Start program and is quickly getting up to speed on her responsibilities as a case manager. Next I would like to introduce to you Cindy. She's the project director of the Healthy Start program where

Mimi works, and Cindy is doing her best to onboard Mimi. After a few months of being on the job, let's hear how it's going with Mimi through a routine conversation that she has with Cindy. Mimi.

Mimi: It seems like we're asking a lot of questions of these women. Can I just ask the woman what she needs and respond based on that.

Cindy: Well, Mimi, it's important that we get an understanding and the bigger picture, because our hope is to work with women over time to ensure health outcomes. So it's important that we understand which services participants can receive and what they may still need. Only by gathering comprehensive information are we able to know this about all participants. So, for example, only if we know how many participants have received depression screenings, intimate partner violence screenings, and others, and how many scored positively can we know exactly how we should move forward with referrals and services. So, for example, do our participants generally have insurance but do not have access to behavioral healthcare, or do they have prenatal and postpartum care but breastfeeding seems to be a real challenge? If the former is true, then we may devote fewer resources towards insurance navigators and more towards building referral partners or providing transportation to those services. There may be other reasons, too, but these are really key.

And so what we really want is to want it to meet embody these keys to quality data. So we really want our data to be consistent, reliable, accurate, complete, relevant, and valid, so that when we're looking at it, we can really feel secure that it's telling us what we need it to tell us about any one participant and about all of our participants as a whole.

Mimi: Okay, I understand what you're saying about the importance, but I'm still not sure how to ask patients about their private lives. I feel like it's none of my business.

Cindy: I totally understand that feeling. It's important to remember that we do not want to force anyone to do anything they're uncomfortable with. Your best plan of approach is to just ask the relevant questions, stopping to explain things when necessary, and always acknowledging the participant's feelings and concerns. And if she or whomever doesn't wanna answer, she doesn't have to. We just want to be able to best connect her with the support or services she needs, not only today, but moving forward. Feel free to acknowledge to the client that some things we ask may seem strange, but they help us do this. And I feel like as

long as they understand why we're asking the questions, they'll feel more comfortable answering them.

Megan: So the case managers come together for a meeting. Mimi and Sharon and Kim, some of the case managers come together and they talk and discuss how they collect all this data, but never see or hear anything more. So Mimi decides to go back to Cindy, the Project Director, with these concerns. Let's listen in to more of that conversation.

Mimi: Sharon, Kim, and I were talking more about the data question you and I were talking about, and we all mentioned that we don't really know what comes of the data that we collect.

Cindy: Oh, well, that data is actually all around. For example, when you started, there were charts for all the participants that helps you know what to expect when you met with families. That was data collected in the past. We also report out to the staff, like you've seen at meetings, and to partners, funders, and so on. Also, perhaps more importantly, we interpret the data and use it in a number of ways.

So here are a couple of specific examples of all those questions we asked for a.k.a. Data and action. Lately we've noticed that lots of pregnant women have not had prenatal visits. We could assume that they may be...providers don't take Medicaid, lack of care available in her native language, or no transportation. But complete and accurate data allows us to find patterns. Here in the upper right-hand corner and some analysis we did around who has had a prenatal visit, based on this, we see that 80% of uninsured women have not had a prenatal visit, and only 4% of uninsured women have completed a prenatal visit. Alternatively, among those women who have private insurance, 40% have completed prenatal visits. That's based on what we have asked our women and suggest that maybe we should consider stepping up our efforts to connect women with navigators who could connect them with exchange health plan.

Another example when we talk to...the results of all the questions you've asked, we see here that we are successfully screening most of our women for depression, but a notable drop in referrals over the course of the year. Now that we see this, we need to figure out why this happens.

Here's another example, you know how earlier today in the team meeting we were talking about building better referral processes. That's

because in looking at the data we have, we saw that 91% of our participants have been screened for depression this year, which means that you all have asked the vast majority of our participants if they are feeling down hopeless, etc. You remember those questions on the screening tools.

Mimi: Oh, yeah, sure, I do.

Cindy: Well, you all have done such a great job screening people and capturing data about that screening, and so now we have seen a real increase in participants to have been identified as potentially struggling with depression. And as you know, mental health support services are a little sparse in this community. So we have been working with folks at ABC Health Center as well as the Health Department to identify more resources.

Megan: So Mimi looks at some of the data that Cindy has shared. She can't make sense of some of it. And given what she has seen and heard from clients, she and Cindy connect with their local evaluator to understand more. So now let's listen in to that conversation.

Mimi: I just wanted to let you know that this information that you shared with me is not at all consistent with what I've seen and heard from participants, especially the depression screening and referral measures. Among those I've spoken to, more than half already have a referral to a mental health provider for depression, but it shows here that only 20% have referrals.

Cindy: Thanks for letting us know. Given that we have seven sites, it's hard to say what you see at this one site is indicative or the same as all others. Why don't we sit down and take a look at how we get at those numbers. I think that may help us see how we got to the numbers we have.

Mimi: Generally, when we look at these measures and say 20% received the appropriate referral, what that means is that 80% of the participants who were screened positive for depression didn't get the appropriate referral. But sometimes that's not actually the case. It's set for 80% of the participants, we don't have enough evidence to know that they received the appropriate referral. So our goal is to make sure that we have accurate representation of all of those that we know received the appropriate referral. So while it's true that perhaps the number is not as high as it actually is because we don't have that evidence, it also may

be, as Cindy said, that one site is very different from all the others, so we need to look at this sort of from both sides, and we're digging deeper. We need to make sure we're looking at the right group of women. Are we looking at just those who screened positive, not all women? For example we wouldn't expect all women to need a referral, just those who screened positive. Are we accurately capturing those who need to measure? So capturing not only those for whom a certain checkbox is checked or a certain field is complete, but everyone who needs to in sort of the variety of ways that might be possible in our program.

And sort of, as I just got to, we got to remember that data is only as good as what is entered. Is data being entered into the system as needed on a timely basis, regularly by everyone, etc? So we can always dig deeper, but these are the things that we look at.

Cindy: There are also much bigger picture keys to data integrity. When we were initially creating our processes, we looked at our data, our database design and variable definitions. This means we take care to train everyone and ensure that everyone is interpreting all questions and answers the same way. For example, we want to be sure that all case managers are reporting all aspects of safe sleep in the same way. Sometimes there could be a lack of appropriate business rules because we have to report and share some of this information monthly. We need to be sure we are ready for that. So that's why we have the rule that there cannot be more than 10 days between when the screening is done and when it is entered into the system.

There's also input errors that could impact the data down the line like we just discussed. When we run checks to be sure that no women are entered as being born in 1883 because we are pretty sure that we do not have any 134 year-old mom. That's an input error.

The database requires ongoing management as well. So maintaining mapping, ensuring that reports continue to run appropriately, and no line breaks at all parts of that. And those things must be done regularly, otherwise it can be too much to go back and find where the issue originated. So exactly what you were doing, Mimi, is exactly what we need to be doing at all times.

Lastly, data integration. As you know, we get data from the health department, the site on Lace Avenue, and here. All of those need to be integrated successfully into a single database, otherwise, when we run

our queries or reports, it won't include everyone.

Mimi: And not only did we do these things initially we still have to focus on these things every day to be sure that we maintain good processes. One thing that we can all do together, though, is bring some data checks that should be used before any data is shared widely and, at worse, considered accurate. So some things that we may do just to sort of maintain integrity or avoid anomalies or things like that is ensure that all denominators that are defined the same are reported the same. So for example, if we're looking at total clients for a number of different things, is the total clients that we're looking at the same across those? And if not, why not?

Our year-to-date number is larger than the month before. So for example, if we're looking at year-to-date numbers for March and year-to-date numbers for August, August should always be larger than March. Is there any unreasonable data, as Cindy just mentioned? Are there any moms who their birth year is inadvertently entered as 1883 instead of 1983, or birth dates that are in the future, you know? This mom had the baby in January 3rd of 2019, anything like that. So building in those data checks ensures that those anomalies don't occur, and that we're working from some more accurate data, and we can then dig down into what's actually going on from a reasonableness perspective.

And then remember, all of this takes time. If a data collection system has only been in place for a relatively short period of time, it will take time to get everyone bought in. As you all know, it will take time to build the queries and reports appropriately to sort of get all the bugs out of that, and ensure that everything is included appropriately, and for all participants to be assessed. If we are starting at a particular period of time, we're not gonna see everybody immediately. So it will take time to build up that information or the data set about those participants or clients. So be sure to allow time for that, and allow the opportunity for people to ask the questions and get the understanding that they need. Because it does take time.

Megan: Well, so folks, this is Megan again. And I just wanna say thanks to my colleagues who went through that scenario. We hope you found it helpful in really understanding that data integrity is a real team approach. It really is something that everyone on a Healthy Start team can contribute to. And so that's what we were aiming to reflect in that scenario.

But we now have the privilege of hearing from Miss Misha Taherbhai, who is the Data Management Analyst with the Alameda County Healthy Start Initiative. She provides data management and analysis for the Alameda County Public Health Department's Maternal, Paternal, and Child Health Home Visiting program. She has some valuable examples to share from their perspective as a Healthy Start grantee. And we will be sharing…she has some tools that she'll be referencing in her presentation. And we will both be posting those to our website. She's kindly offered to share them with you all, but we'll also be emailing them out to everyone following this presentation. So, Misha, I'm gonna turn it over to you now for your portion of the presentation.

Misha: Thanks, Megan. Good afternoon, everyone. I'm Misha Taherbhai with Alameda County Healthy Start Initiative or ACHSI in San Leandro, California. And today, I'm gonna talk about three ways in which we strive to improve data quality around the Healthy Start screening tools.

So first, a little information about us. We are a level 3 grantee and part of the County Public Health Department. We serve African-American women living in 10 target ZIP codes with the highest infant mortality rates. We serve the greater parts of Oakland, Ashland, and Cherryland neighborhoods. ACHSI clients are permeated throughout our home visiting system of care, which comprise of 11 programs including internal County home visiting programs as well as three community-based programs with whom we contract.

So the first way we improve data quality and integrity is through building a data culture throughout our programs. We did this by creating a data and evaluation team devoted to planning the rollout of the screening tools and all the processes and trainings for our staff. This team comprised of a few program managers, myself, the data analyst, and the director. And in the summer of 2017, we began conducting our trainings. Our training is focused on things that really impact data quality, such as providing users with the context and the use of the data, training them on how to collect the data, where the data is going, and why the data is important. We provided staff with documents on required questions, required for XML upload as well as questions needed for benchmark calculations. Also, we provided staff with data definitions on criteria of a Healthy Start client. For example, for us, a client who has…our client who has…or as person who has consented to services and had at least one face-to-face visit. We also train staff on the definitions of the common Healthy Start terminology, such as the postpartum phase, interconception phase, and preconception phase.

We share tip sheets on systemizing time per week for the data entry and timelines on when to enter the data into the database. For example, one of our rules is that the screening tools initiated in a given month on paper need to be started to be entered into the database by the 10th of the following month so that we can generate the XML file to upload to HSMED. And as we all know, that standardization around data entry is so important for data quality.

Finally, one of my roles here at ACHSI is to provide on-call data support for our staff and managers. And I think that this on-call data support has really improved our manager buy-in regarding the value of data collection.

Here is the screenshot, excuse me, of the tip sheet that I mentioned. Some of the tips that...and this was actually created by one of our program managers for her own staff but we found it to be helpful so we've disseminated to all of our ACHSI staff. Some of the tips are that they can pre-fill the demographics and pregnancy history screening tools with information that they already have and start putting it to the system before they do their first home visit. And then, of course, they have to administer only one screening tool per visit to prevent fatigue for themselves as well as the clients. Of course, they're not allowed to give the tool to the client. They have to do it themselves. And finding that time and organizing themselves per week or bi-weekly to do the data entry for the data that they have collected on paper.

This is another tool that we've provided our case managers, which is, basically a document with the recommended questions that we recommend the case manager ask at their first visit. That way they can prioritize and organize the questions so that they can manage their time in the most efficient way when administering the screening tools.

The second way we have improved data quality is by building the database infrastructure. As the data and management analyst, I am the designated in-house database administrator for Healthy Soft, which is the system that we use for screening tools data collection. And I maintain regular communication with our developer. One of the things we talk about is creating business logics in our system to improve user experience. For example, I work with a developer to configure workflows into the system. Each user has a designated role with particular views and rights that allow them to use the database according to the role in their program. For example, the supervisor role allows supervisors to

reassign screening tools to different case managers or delete a screening tool if it has been incorrectly entered or entered as a duplicate. I work with the development team to constantly enhance the database by pre-filling certain fields to reduce data entry burdens or modify questions or menu options so that they are clear to the user to understand. And a lot of these suggestions come from the user level. So liaising between the users and the developers is an important part of my job. Because as you mentioned, the data that we get out of the system is only good as the data that we put in. So if the database is easier to understand for the user, the quality of the data will eventually improve.

Secondly, we let the technology do the dirty work. We create reports and dashboards for supervisors so they can track screening tool completion by case manager and other variables. And a really neat feature of our database, which is new and we are really excited to roll out, is the auditing feature, which is great for data quality. It's a notification-based data cleaning tool which essentially self-cleans the database and identifies data errors. For example, if you have an illogical birth date or a gestational age that is out of parameter, the system will notify the user to fix it. Also the system warns users of missing data and required fields. As evaluators and data analysts, we know how problematic missing data can be so this really helps with that. Also, it warns case managers on screening tools that need to be initiated in the future. For example, based on the estimated due date of the prenatal tool, it will alert case managers to initiate the postpartum two weeks before they have to.

And most importantly, the Audit feature is easy to understand for both program managers and staff because it's formatted basically as a to-do list for the user. So here is a screenshot of the audit list in Healthy Soft. So this is available to the user as well as the program managers so the program manager can have tabs on the objections that their program is facing. So the user just goes into this list and it takes them directly to the record that they need to fix. And every 24 hours, it's refreshed based on which objections were resolved and which are still pending.

Finally, ACHSI is building a data learning community around the screening tools. And we have created a listserv where staff and managers ask questions about the screening tools or the database in an open forum format. And this allows to essentially create, like, a virtual FAQ or encyclopedia on the screening tools. It sheds light on possible training needs, whether it's a challenging question or using the system in a more efficient way, or informing me on new audit objections that need

to be programmed into the system.

In general, we approach data quality with the Plan, Do, Study, Act framework if you will. For instance, planning the business logic to be implemented, whether it be a new audit objection or a custom created field. Then we study the task by writing the logic and specifications. The developers do by coding the logic and the software. And finally we act and implement the new feature with staff.

Also, towards the end of 2017, our home visiting system of care program started using the results-based accountability framework to report service delivery and change, which has also helped build a culture of accountability within our programs. And we can use this for program improvement. And I think this framework really falls in line with the goal of the screening tools, which is, in the short-term, measure how much and how well we provide our services, and then in the long term, figure out if anyone is better off. Thank you. Back to you, Megan.

Megan: Well, thank you so, so much, Misha, and the team, your team at Alameda County Healthy Start for sharing all of those useful tools and relevant examples. Now let's go back and revisit the next steps for Mimi and Cindy. Some of the things that they've learned and they heard from Misha or two, create a tip sheet for their staff to reference. Possibly identify someone from their team who could be the phone-a-friend person if they're having a data-related challenge. Maybe build a number of common-sense checks into their database system. Those are some doable things that they realize they can begin now implementing in their program to improve data quality. So, with that, we'd love to hear from all of you. What are some tips that you could give either Mimi or Cindy or their team, or do you have questions about what Misha shared about what Alameda County is doing at their program? Please chat your questions or comments into the chat box right now.

And Misha, we do have a question in the chat box right now. "Can you describe a bit more about the results-based accountability framework that you're using?"

Misha: Sure. The results-based accountability framework is something that basically provides...it's a reporting framework. For example, we use this framework with each of our home visiting programs. They describe performance measures that fall in each one of those quadrants. And then they report on them quarterly. For example…yes, that's the slide that I'm looking for. There we go. So each program is responsible for

reporting on the first two quadrants. So how much did they do, what exactly did they do? For example, the screenings that they provided, how well did they do it, did they provide it within a specific time frame or within six months of the case being served, etc. So how well they did it. And then in the future, we want to put all of that data together, and we can create a story of is anyone better off. It's actually a countywide initiative. All departments in the county are using the RBA framework to build accountability for each of their departments.

Megan: And Misha, that was one of my questions. Is this something that you all were trained on, has it been rolled out to your whole staff? So that was helpful in...

Misha: It's actually, we were trained on it by the office of the director of the county, and then each department has a person that also does individual trainings with each team in the department, on [crosstalk 00:33:53].

Megan: Thank you for sharing. Got it. And so, folks, chat in any other ideas or examples or questions you might have. We did get an example here that someone shared public posting of performance, public meeting internal to the Healthy Start program, not to the larger community. But public posting of performance helps alert staff when performance is dropping that more focus needs to be placed on collecting and reporting data. So that was one example that someone shared. Any other ideas or questions from the group?
And someone has asked if they can get a copy of the presentation slides. And, yes, we will be sending those out not only with the tools that Misha shared, but we'll send the slides and we will also share any key takeaways from the webinar. They'll also be posted on the website, healthystartepic.org.

Okay, well, I'm gonna just go check in on some of these key takeaways right now that we've pulled together. But we do have some time set aside here for more questions and comments, so feel free to share those. But some of the key takeaways we've pulled here are…and also, Jillian, Yvonne, Michelle, Misha, anyone that has other reflections to share, please chime in. But data is just another way to say information about your participants. Data are people. Keep that in mind as you're thinking about data integrity.

Another key takeaway is to use training and reference material tip sheets that were shared to support everyone's shared understanding of

the data needs and requirements. Another is to be sure to consider the role of people, process, and technology in data and that all are very important. Another key takeaway is using data every day. Both increases data integrity by identifying potential issues sooner and buy-in, or by creating data-driven culture. And lastly, that data and quality is everyone's job.

We did get another chat, another comment in here shared, that this group limits the number of people with access to data entry and permission to change information to ensure that data is entered in a consistent manner. So that's one way that they're managing that.

Here's a question. And this person shares that they're new to all of this. They've shared that they actually have three Healthy Start databases. And this person needs to pull them all together. One of them is for performance stat. So what staff are actually doing things and how many home visits or office visits, that sort of thing. Another, the databases is for their Healthy Start benchmarks or performance measures. And then the third database is the Healthy Start database on the low birth weight. And this person is asking how important is it that all of these three data sources live with each other?

Misha: Jive with each other.

Megan: Oh, I'm sorry, live...jive with each other. Sorry about that. So I'd love to ask any of the experts on the call. What do you think? Do you think that merging these three databases would support this person who's new to this?

Misha: This is Misha. I can share a similar story with...

Megan: And Misha can you speak up just a little bit? You kind of cut out a little there.

Misha: Oh, okay. Can you hear me now? Is that better...

Megan: Yes, that's better. Thanks.

Misha: Okay. So we actually have a similar setup where our programs have multiple databases. However, I think that it is really important for data quality, to use one database. So if you can integrate the databases, that would be the best scenario, but that might not always be possible. So having a document that maps the fields from one database to

another also helps. For example, what I did for our team is I mapped some of the questions on the screening tool to the questions that we were already collecting in another database, so that everybody is on the same page as to what that field is in one database corresponds to the other one.

Megan: And when you say, Misha, "That you map that," is that as straightforward as putting that into, say a Word document and just…or a table of some sort and mapping it that way. Is that the kind of a format that you used?

Misha: Yes, it was basically a spreadsheet to help case managers match the different fields from one database to the next. Because sometimes the integration on the back-end would require a development team to do that integration. So this is how you can map it on the front-end so that one case manager, when they're pulling data from another database, they know exactly where it needs to go into the other database that they need to put it into.

Megan: Thank You, Misha. And, you know, another person chatted in that they are a smaller Healthy Start site, and they also have three separate databases. One is around program data, one is the benchmark data, and one is the CVS access for their monthly submission, and they all can be linked with ID numbers. So they do have that linkage. But for their site, these three, this method seems to be working. So I feel like having both perspectives. It's probably trying to figure out what is the best, what is gonna work best for you.

Jillian: And I think if I can build on what that person said, I think having that way that they can be connected through a unique ID or some other patient identifier or participant identifier can be one of the keys, because that allows you to sort of go into all of them and be able to connect that information if needed. So while they can live separately, having that unique ID that works across all of them, may be one of the keys to success.

Megan: Thanks, Jillian. Any other? We do have a bit more time so feel free to chat in questions or comments that you might have. One person did just share that they're just reminding us that we have to be careful about how you deliver the question to the participant to ensure that you get accurate information. That is a very important reminder. Thank you for that.

A question for you, Misha. "Can we get some examples of dashboards or reports or audit lists that you're using?"

Misha: Sure, yes, I can definitely send that over. I can send it to the EPIC Center and then EPIC Center can blast them out.

Megan: That'd be great. That would be great if you can do that, Misha. Would be happy to share that with everybody. And I was gonna share this, this is kind of for at the end, but I will share this out. If folks are thinking about, if you do need some support on this, technical assistance is available, and the division wanted us to remind grantees of this as well. If you do want some one-on-one support with topics such as data integrity and that sort of thing, you can request technical assistance either through your project officers, or you may have been introduced to your technical assistance coordinator. That person would be a representative on the EPIC Center team. And we're just trying to help support as an extension of the division, help support you and coordinate this. So just know that's free and it is available to you to request technical assistance. But we would be thrilled to share some of these tools you created, Misha.

Misha: Okay, sure.

Megan: Somebody else did share also a key takeaway here, and I'm gonna go…I'm gonna share that here too, that data gives you a tool or a way to describe things that someone in your program might already know but others or people outside your program might not. So keep that in mind.

And here's a question, and I'll just pose this to the group. "Are there any tips or information sheets on how to get an overview of data for Healthy Start for case managers who haven't had any data experience?" Anybody know of any great resources on that? I guess, Misha, how have you trained some of your case managers on this topic?

Misha: So I think it's important to definitely start with a training on how to use a system, whether it is a database or if it's as simple as starting, maybe even starting with basic technology training if you have staff that are not very familiar with technology. Then after they get comfortable with that, then they will be comfortable with actually interfacing with a database. So for the screening tools, for example, we do a lot of trainings on the database, and trainings on the different fields of the database, how you collect it on paper, and then how you enter it into the

system. So I think those types of trainings start getting people familiar with the data and familiar with the meaning of data and the importance of data.

Megan: Well, and I did wanna let everybody know in addition to those types of training examples Misha shared, the Community Health Worker course in the Phase 2 of the rollout of the course. There is gonna be content on this topic. So I wanted to alert everybody to that piece. And, you know, I think you bring up a really good point too. These are opportunities for us to learn and think through opportunities to support you all and your staff too so we could explore training opportunities on the EPIC Center's end to support you all with this as well.

Somebody just shared that they have a frequent case management meeting where managers can ask the data coordinators any data clarifications that they need. So that's a good strategy as well, to have those case management meetings with those data folks present.

All right. Here's a question. I'm guessing it might be for you Misha, but, "Do you rely more on objective data or subjective data? For example, if asked, 'Do you smoke?' And the participant says, 'No,' however a record may show otherwise?" When you're doing your...

Misha: So I think, just in general, it's better to rely on objective data because you have evidence for the objective data. And I think we talked about this in the prior slides where the data that you pull is the data that you've entered in. And, of course, that you may not get the whole picture with just anecdotal accounts or just, you know, objectively just asking case managers...sorry, subjectively asking case managers information about the clients. So I think this is where the definitions really help, and data entry really helps so you're getting an objective picture of what's going on with the participants.

Megan: Great.

Jillian: And there may be instances where they are...

Megan: And a couple more other... Oh, go ahead. Jillian, were you sharing something?

Jillian: Yeah, I was just gonna say there may be instances where information is not consistent across data sources. So, for example, a couple folks shared that they're using more than one system, and so

there may be inconsistencies across those data sources, and that is best to have a protocol for how to handle that because that will happen. So whether…you know, so maybe getting together with your team and deciding how you're gonna handle that. Will you call the person and follow up on that question or you ask next time you see them? Again, having sort of a data integrity protocol around that is a really good way to do it.

Megan: And then somebody also shares that they enter what the client says unless they have information from a doctor or other provider or source that says otherwise. That's their protocol.

Misha: Good call.

Megan: And I think the person that asked this question just points out that it's challenging because every healthy start may not have a medical home to access records for accuracy like postpartum visits or Well Woman Care or other preventive services. So they're just adding a little bit more to the complexity of this, but...

So, with that, let's…you know, we've sort of a little bit more time, but I'm gonna go ahead and go back to the post-knowledge check here. Remember we did this little pretest at the beginning. So if you'll take a moment and respond to these two questions, then we can revisit if anybody has any last-minute questions or comments they wanna ask. So building a culture of data at your organization is the responsibility of, is it the evaluator, the project director, the staff entering the data, or all of the above? And, well, everyone that responded is saying that it's all of the above. And that is true.

So the next question is around the elements. Which of these elements in this list are key to data quality? And you can select all that apply. Is it consistent, reliable, accurate, complete, valid? And we'll take another moment here. Okay. And, again, everyone does feel strongly that accuracy is key, and the others listed here are also very important. And the answer is that all are key elements to data quality listed here. So, consistent, reliable, accurate, complete, and valid. We try to touch on those points throughout both the scenario, and also Misha did give some examples of that in her presentation, too.

I did wanna give a few wrap-up reminders here. And I'll leave these up on the screen real quick, but I do wanna get to…somebody asked a quick question here, and I wanna get to their questions. This person has

shared that, for a lot of questions that clients may not wanna answer, they store, this group stores two options. And that may be difficult to capture and connect responses. So for example, in the case manager's view, in the home... Oh, is the home safe? From the participant's view, is the home safe? So they're just giving two different options for that. So they're just sharing their example there.

And another person shared that there are very few providers in our area and we have relationships with most offices. We mail letters to other providers, doctors specifically, on health risk factors such as smoking and drug use and many others. And so that does help, I guess they're sharing that just to talk about how they're trying to connect with partners, and share, and also provide support on education and that sort of thing. So thank you for sharing those examples from your fight.

We have a couple of webinars coming up in February. On February the 15th, there's a conversations with the division webinar. That's from 1:00 to 2:30 Eastern Time. And then on February the 20th, we have a webinar from 3:00 to 4:30 p.m. Eastern Time, and that is on program P, Engaging Men in Fatherhood and Care Through Gender Transformative Programming. That webinar will be presented by Promundo, and they're gonna share an example of a fatherhood program that they've been rolling out and studied.

All of our webinars are recorded, and transcripts and slides, they're all posted to the EPIC Center website. And following this webinar, we will be sending out an email to not only all of you that are registered or on the webinar, but all those who've registered. They'll get the email with the key takeaways, the slides, the tools, examples that Misha shared, those will be included in that email as well. So we wanna try and get information out and engage you as much as possible.

And I guess I'll just open it up since we have a minute or two, presenters, any other closing remarks that you'd like to share before we wrap up?

Misha: Thanks for everybody for sharing what you all shared in the chat. It was great.

Megan: Great, well, a huge thank you again to you, Misha, for sharing your wealth of knowledge, and to Kristen Tharaldson for advising us on the contents of this webinar. We do appreciate everyone's time. Thank you all for carving out time in your busy schedules to participate. That

concludes our webinar for today. We hope you have a good rest of your day.