AMGA and AcademyHealth

Evidence-Driven Improvement Workshop Summary

Innovation, Quality & Leadership Conference   September 29, 2022

Contents

On September 29, 2022, AMGA partnered with AcademyHealth's Learning Health Systems Interest Group to convene the Evidence-Driven Improvement Workshop as part of the AMGA 2022 Innovation, Quality & Leadership Conference (IQL22) in Grapevine, TX. This annual event highlights thought leaders and case studies from organizations that have made impactful changes that are both sustainable and scalable for future success, as well as the disruptive factors sparking transformation in the healthcare industry.

The goal of this 90-minute workshop was to allow healthcare leaders and practitioners to learn from experts in health system-based research through examination of real-world problems.

Specifically, the workshop was intended to help attendees:

- Gain a deeper understanding of the benefits to organizations, clinicians, staff, and patients of engaging in evidence-driven improvement

- Explore the skills and strategies needed for healthcare delivery systems to begin evidence-driven improvement or engaging in health services research, including start-up resources such as staffing and costs

- Work with peers to exchange experiences and address current barriers

- Increase awareness of real-world challenges to evidence-driven improvement and research engagement and collaborate with experts and peers to formulate possible solutions

Workshop faculty were drawn from the AcademyHealth Learning Health Systems Interest Group, which is composed of a group of individuals from research, informatics, delivery systems, health plans, policy, and community-based organizations aligned for continuous improvement and innovation.

Overall, 20 participants attended the workshop, including health system executives, quality improvement specialists, and practicing clinicians. Prior to the workshop, participants were invited to submit specific challenges they perceive and/or experiences in using scientific evidence to improve equity, quality, outcomes, and/or costs, specifically with respect to

establishing buy-in, assessing readiness, and building capacity to engage in evidence-based improvement. A total of five (5) challenge cases were submitted, and four (4) were selected for discussion during the workshop.

Herein, we provide a summary of workshop proceedings and supporting materials. The workshop agenda, participant list, and submitted challenge cases may be found in the appendices.

Setting the Stage

Healthcare organizations in the United States are being challenged to address persistent health inequities while improving the quality and value of the care they deliver. From medical group practices to large, integrated delivery systems, organizations are functioning in an uncertain time, needing to rapidly adapt to changes in payment policies, organization of care delivery, and available treatments and technologies. Now more than ever, it is important to ensure that providers are acting on the best evidence available.

In particular, research tools can be powerful for healthcare organizations in addressing health disparities through three key phases:[1]

- **Detection**, which emphasizes clarifying the definition of a disparity and vulnerable populations as well as specifying the appropriate metrics for identifying where disparities exist

- **Understanding**, which elucidates why disparities exist by identifying factors that explain gaps in health and healthcare

- **Reduction**, which involves the development, implementation, and evaluation of interventions that reduce or eliminate health and healthcare disparities

In terms of understanding disparities, multiple factors are often cited involving multilevel social determinants of health (SDOH) disparities, including individual beliefs and preferences; effective patient-provider communication; and the organizational culture of the healthcare system.[1] Research can be used to uncover the unique interplay of these factors within a given healthcare organization and then evaluate interventions on their effectiveness.

Indeed, clinicians have indicated that rigorous research should provide the foundation for clinical practice guidelines and that research would improve the quality of patient care.[2] Research can be difficult to conduct within healthcare organizations, and collaborations can be difficult to establish. Moreover, research findings can be difficult to find and adopt. Results can be buried in academic publications, and findings can be challenging to adapt to different settings and circumstances.

Direct involvement of clinicians and healthcare organizations in the design and conduct of research is one important way to produce findings relevant and useful for healthcare decision-making. But how does a healthcare organization begin to engage in research? What does engagement look like, and what are strategies to obtain buy-in from organization leadership? What skills and resources are needed? How best can recommended approaches be adapted to the circumstances faced by a particular organization, especially when issues of diversity, equity, and inclusion vary so markedly across settings? Accordingly, the workshop aimed to address and overcome challenges, both those experienced and anticipated, by healthcare organizations considering engagement in health services research.

1. Kilbourne AM, Switzer G, Hyman K, Crowley-Matoka M, Fine MJ. Advancing Health Disparities Research Within the Health Care System: A Conceptual Framework. *Am J Public Health*. 2006; 96(12): 2113-2121. doi: 10.2105/AJPH.2005.077628

2. Keyhani S, Woodward M, Federman AD. Physician views on the use of comparative effectiveness research: a national survey. *Ann Intern Med.* 2010; 153(8): 551–552.

Evidence-Driven Improvement Workshop

The workshop began in a plenary format with a brief didactic introduction to level-set and ensure the participants had a shared understanding of key concepts and terms. Faculty experts introduced the practice of health systems engaging in health services research, described key features and challenges, and discussed best practices for beginning to engage in this work at varying levels, from multispecialty group practices through fully integrated systems. In the second portion of the workshop, participants moved into four (4) small groups around tables, each with one of the experts and one of the challenge cases. Discussion of challenge cases then set the stage for participant reflection and consideration of challenges, as well as mitigation strategies for their home institutions.

Welcome

Presenter: Elizabeth L. Ciemins, PhD, MPH, MA (AMGA)

Description: Welcomed the participants, faculty, and guests. Explained the genesis of the workshop and goals and objectives. Thanked the two sponsors of the workshop, Pfizer Inc. and Janssen Pharmaceuticals.

Objectives: To introduce the participants to the workshop and faculty, provide background, and introduce the keynote speaker, Hal Luft.

Key Points: AMGA is addressing an identified challenge of AMGA member organizations in engaging in health services research and succeeding in evidence-driven improvement by hosting this workshop. AMGA partnered with AcademyHealth in order to bring national experts (Learning Health System Interest Group Faculty) together to address identified barriers to health services research participation by healthcare organizations through facilitated discussions with representatives from AMGA member organizations.

Brief Overview of Healthcare Embedded Evidence-Informed Improvement

Presenter: Hal S. Luft, PhD (UCSF; PAMFRI)

Description: Brief overview of what it means and what it takes to practice evidence-informed improvement within healthcare delivery systems.
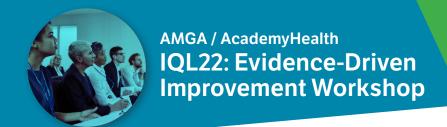
Objectives:

- Gain a deeper understanding of the benefits to organizations, clinicians, staff, and patients of engaging in evidence-driven improvement
- Explore the skills and strategies needed for healthcare delivery systems to begin evidence-driven improvement or engagement in health services research, including start-up resources such as staffing and costs

Key Points:

- The overarching goal of evidence-informed improvement is to bring some of the methods, skills, and/or data used by health services researchers to address important problems faced by health services operations. Doing this helps them to move toward becoming learning health systems (i.e., using evidence to improve care).
- LHS Terminology varies widely—some use the "S" (system) to mean a delivery system (e.g., Kaiser Permanente), whereas others use it to include outside community-based organizations. Still others expand the notion to mean the whole U.S. and beyond.

- The key is using one's own practice-based evidence to inform improvements to get the right care to the right person at the right time.

- Some delivery systems have a cadre of employed researchers. While those researchers may be part of the same organization, they often function quite independently (i.e., doing their own research) and do not typically collaborate with operations/quality improvement (QI), etc.

- Some speak of embedded researchers, but these are very rare. Rather, we should consider embedded research-tool users (i.e., people who use tools appropriately to get rigorous evidence to inform the operational decisions they need to make).

- The "toolbox" for health services research is huge (especially in comparison with what is "standard" in clinical trials). It ranges from careful observations and open-ended interviews to complex statistical analyses of electronic health record (EHR) and survey data.

- Some organizations may have people involved in QI (or elsewhere) who are familiar with such tools and how to use them, but many do not.

- One can sometimes find partners from other organizations. A key aspect to consider is whether the partnership has long-term potential and is not just a one-time engagement. The difference is that when the goal is a long-term relationship, the focus is on a partnership, not "hourly consulting."

- Building capacity first requires the identification of the "right" tool user(s), who:

  - Are willing to apply their toolbox to answer high-priority operational questions

  - Partner over a suitable time period

  - Have the necessary skills (qualitative, quantitative, both) or partner with those who do

  - Develop well-aligned partnering incentives (financial, data access, etc.)

  - Agree on what needs to be privileged vs. what can be used elsewhere (e.g., publications)

  - Identify the key decision makers in the organization

  - Determine the role of patients

  - Clarify the questions to be answered (critical, nice to know, bonus)

    - What evidence will be most convincing for the key decision makers?

    - What data will be needed? Patient reports/surveys, clinical, financial?

    - How to get these data?

    - What research design will be used to meet these goals and constraints?

    - What are the operational implications of this design?

    - Who needs to be on board to make the evaluation happen?

    - What is the timeline to get the data, analysis, etc.?

    - What will happen if there are delays on key milestones?

Introduction to the Challenge Cases

Presenter: Elizabeth L. Cope, PhD, MPH (AcademyHealth)

Description/Objectives: Common themes and the range of issues across the submitted challenge cases were reviewed to provide a foundation for the table discussions.

Key Points:

- Five (5) challenge cases were submitted:

  1. **Intermountain Healthcare:** Focus on setting evidence-based standards and managing the nuances of follow-up care in a resource-limited setting (using the example of PHQ-9 screening). This case highlights the importance of resourcefulness in seeking solutions to persistent challenges, including reaching out to peers, reviewing the literature, etc. Open questions remain as to the best way to keep momentum as well as scale in resource-limited settings.

  2. **HealthPartners:** Focus on not compromising on quality during times of disruption. COVID-19 caused major disruptions and staffing demands/challenges. Under these conditions, teams can be very resistant to workflow change or anything that might increase burden on an already stretched system. This case highlights the importance of strategies that integrate research and QI and engage frontline staff in prioritization as a means of making progress on improvement without overtaxing staff who are working hard to respond to a number of internal/external stressors.

  3. **Summit Health:** Focus on confronting the landscape of data fragmentation and incompleteness coupled with a lack of standardized definitions and collection methods. If we want to improve and address disparities as part of this, we need to address the data limitations. This requires considered answers to questions such as: What is the definition of value and equity in healthcare? How do we define and subsequently measure performance and impact? What is context specific vs. scalable?

  4. **Sutter Health:** Focus on transforming organizations to have a culture of improvement and safety. This requires the capture and subsequent use of robust outcomes data paired with the alignment of organizational priorities with incentives at the clinical team and individual clinician level in a context of staff shortages and competing priorities.

  5. **SIMEDHealth:** Focus on changing providers' behavior to adopt more of a QI lens in their work. This type of behavior change is tricky in an environment that still defines productivity as a function of volume and service quantity at a time when clinician burden and burnout are increasingly pervasive.

- Key themes emerged across all cases related to establishing will, ensuring skill, navigating resource limitations, and adapting to both formal and informal workflows. The challenge cases should be used as a springboard to reflect on the work to be done upon returning home and how capacity can be built to carry out more evidence-driven improvement initiatives.

Challenge Case Workgroups

Faculty Facilitators: Elizabeth L. Ciemins, PhD, MPH, MA (AMGA); Elizabeth L. Cope, PhD, MPH (AcademyHealth); Hal S. Luft, PhD (UCSF; PAMFRI); Jill A. Marsteller, PhD, MPP (Johns Hopkins Bloomberg School of Public Health); Angela D. Thomas, DrPH, MPH, MBA (MedStar Health Research Institute)

Description: Participants met within their tables to discuss challenge case themes and how they manifest in their respective home institutions. Each table was co-led by the challenge case author and a related content expert. Each author provided a three-minute overview of their challenge case to set the stage for group discussion.

Objectives:

- Work with peers to exchange experiences and address current barriers
- Increase awareness of real-world challenges to evidence-driven improvement and research engagement and collaborate with experts and peers to formulate possible solutions

Instructions to Participants:

- The group was divided into their respective tables. Everyone received a note-taking worksheet (Appendix V) that could be used to reflect on any challenges individual participants may be experiencing, jot down any key points that emerge through discussion, and plan for steps that can be taken at home.
- For 40 minutes, participants talked with their respective tables.
  - Each table started with a round of introductions (name, institution, and a top-of-mind challenge related to evidence-driven improvement)
  - This was followed by orientation to the worksheet and a brief overview of the table's challenge case presented by its respective author.
  - Each person was asked to reflect on the challenge and start to fill out their worksheet, focusing on what they thought was the most pressing/important element of the presented challenge or their own challenge.
  - Finally, the whole table discussed what resonated with them, aha moments, etc.
- At the end of the 40 minutes, the group reconvened, and attendees at each table were invited to share key themes from their discussion and what steps they plan to take as a result of these conversations when they get home.

Report Out and Debrief

Facilitator: Elizabeth L. Ciemins, PhD, MPH, MA (AMGA)

Description/Objectives: Participants shared key points and aha moments from their small group discussions. This report-out session concluded the meeting.

Key Points:

- Challenges identified:
  - Aligning incentives with the needs of all stakeholders in the organization
  - SDOH screening, referrals—what, when, how, and how to evaluate
  - Culture of safety—how to create a culture of being psychologically safe to speak up
  - Convincing clinicians and administrators that the data do not lie and something needs to be changed

- Embedding researchers in the team
- Healthcare is dynamic and the data used today for one effort may change in the middle
- How is "research" different from pan-do-study-act (PDSA)?
- How can a (large) organization bring together efforts not just from QI and research, but also marketing (patient outreach), operations, etc.?
- The loss of institutional memory due to retirements, departures, etc., is very problematic.
- Convincing frontline staff of the value proposition of applying evidence-generation (research) tools to problem-solving practices. Key disconnects:
  - Time it takes to investigate problems and identify effective solutions
  - Perceived need for "pristine" data (efficacy) vs. "good enough" data to signal efficiency/effectiveness
  - Need for clinicians to add tasks/steps when they are already stretched beyond capacity
  - Building a culture of evidence-driven improvement
  - Managing internal/external pressures related to incentives for quality improvement in tandem with incentives for productivity
  - Restarting proactive mentality and improvement initiatives after a few years characterized by disruption, reactive mentality, and "all hands-on deck" adaptability
  - Adding even "just one more thing" in the current climate of burnout and staff shortages
  - Will evidence generation/use lead to clinician empowerment and the ability to improve care/patients' lives or will it just increase burden and fatigue?
- Solutions Suggested:
  - Strengths-based strategies for identifying priorities (what are we good at that we want to be the best at and known for?)
  - Push-pull strategies that identify champions who can, in turn, motivate others to join them in the beginning and then use peer pressure to bring along the stragglers
  - Focus on small improvements that can illustrate quick wins with limited impact on workload (or demonstrate temporary workload investment followed by conditions that are better than the starting point)
  - Alignment of involvement in evidence generation and use with personal passions, career goals, etc.
  - Deliberate communications strategies tailored to the target audience (demonstrate salience, credibility, legitimacy)
  - Find opportunities to automate as much as possible
  - Use pilots—introduces another challenge of how to implement what worked in one area to other areas that may be different
  - Leveraging the expertise of implementation scientists and change management specialists
  - Acknowledge the complexity and "dirtiness" of real-world care delivery—statisticians can help adjust and account for imperfections where they can, and where they cannot, they can acknowledge the shortcomings and keep moving
  - Use high reliability healthcare organization (HRO) and Just Culture/Just Medicine principles to create a culture where it's safe to speak up

- Embed researchers as part of the team with a mutual desire for synergy—operations to inform research and research to inform operations
- Also consider the ethical dilemmas around screening for SDOH. Do you have resources to support patients (internal or referral) who screen positive? If no, should you still ask? Consider how asking patients about the same issues that are real for them over and over could potentially mean they are reliving the trauma of their situation. Communication across providers about SDOH internally and externally can mitigate, but that's a whole separate challenge.

Participant Feedback

In follow-up to the workshop, participants were invited to provide feedback and share what they learned, what could have been better, and what (if anything) they planned to try after returning home. We received responses from four (4) participants. The responses are provided below.

1. What is one thing you learned or enjoyed?

- The very important concept of research as a tool in driving operational and clinical improvements.
- Learning that my clinic is not alone in facing specific problems—that all clinics struggle with health equity issues, incentives, working toward value, struggling for change despite having solid evidence-based data, etc.
- Learned to be thoughtful and cautious about SDOHs—asking patients can trigger traumatic memories and feelings; recent research showed that asking these questions is detrimental to many clinicians' well-being as well.
- What others are doing.

2. What is one thing that could have been improved?

- Future round table sessions with examples from AMGA groups leveraging research toward greater success.
- I wished there were more specifics in terms of the examples. If there were incentives, how much? How were they determined? What was the specific intervention and what was the outcome? How long did it take? Details would be amazing. It would provide a roadmap of sorts, and then we can share notes on our own personal journeys of applying what the other clinics had tried.
- A little tight on space for the number of participants plus the food in the room.
- The introduction from the speaker could have been shorter.

3. What is one thing you plan to try when you get back to work?

- Continued focus on measuring ROI to promote and advance research efforts.
- I will be mindful of moral injury regarding SDOH. As a clinic, I want us to be mindful of the patient's traumas and burden on my colleagues. If we mandate SDOH be asked, we must have readily available resources to provide. How morally and emotionally taxing for all parties involved if, for example, I learn a patient has no access to food and then I have no way of providing help. I want to make sure our clinic has a list of resources to provide and are ready to act on the answers, not merely jot them down for the record.
- Talk with our team working on SDOHs about possible detrimental issues.
- No changes in current plan.

Appendix I: Workshop Agenda

2022 AMGA IQL Evidence-Driven Improvement Workshop

Grapevine, TX | Thursday, September 29, 2022] | 6:30 – 8:00 am CT

Session Description: This AMGA AcademyHealth Learning Health Systems Interest Group Workshop aims to address and overcome challenges, both those experienced and anticipated, by healthcare organizations building the capacity to engage in health services research. Participants will have the opportunity to submit and discuss specific challenges they see in engaging in research to improve equity, quality, outcomes, and/or costs, specifically with respect to developing commitment, assessing readiness, and building capacity. An expert panel will discuss best practices in these areas, tailoring the discussion based on the "challenge cases" submitted by attendees at the time of registration. Together, workshop attendees will discuss lessons learned in a diversity of health systems settings.
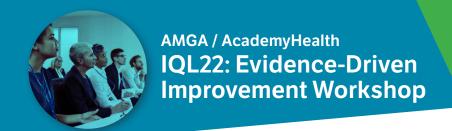
Audience: This workshop will be useful to anyone interested in working to engage their home delivery system setting in health services research.

Objectives: Attendees participating in this workshop will:

- Learn the benefits of engaging in health services research as a healthcare organization
- Understand the skills and strategies needed to engage in health services research
- Work with peers to exchange experiences and analyze current situations
- Increase awareness of real-world challenges and collaborate with experts and peers to formulate possible solutions.

Agenda

7:00 – 7:05 **Welcome (Elizabeth Ciemins)**

7:05 – 7:25 **Brief Overview of Healthcare Embedded Evidence-Informed Improvement (Hal Luft)**
Brief overview of what it means and what it takes to practice evidence-informed improvement within healthcare delivery systems.

7:25 – 7:30 **Introduction to the Challenge Cases (Elizabeth Cope)**
Common themes and the range of issues across the submitted challenge cases will be reviewed to provide a foundation for the table discussions.

7:30 – 8:10 **Challenge Case Workgroups (All Participants)**
Participants will meet within their tables to discuss challenge case themes and how they manifest in their home institutions. Each table will be co-led by the challenge case author and a related content expert. Each author will provide a three-minute overview of their challenge case to set the stage for group discussion.

8:10 – 8:30 **Report Out and Debrief (All Participants; five minutes per table)**
Participants share key points and aha moments from their small group discussions.

Appendix II: Workshop Participants

Name	Affiliation
Faculty	
Elizabeth L. Ciemins, PhD, MPH, MA	American Medical Group Association
Elizabeth L. Cope, PhD, MPH	AcademyHealth
Hal S. Luft, PhD	University of California, San Francisco and Director Emeritus at the Palo Alto Medical Foundation Research Institute (PAMFRI)
Jill A. Marsteller, PhD, MPP	Johns Hopkins Bloomberg School of Public Health
Angela D. Thomas, DrPH, MPH, MBA	MedStar Health Research Institute
Participants	
Marina Palushaj	Alliance Health Professionals, PLLC
Richard Bone, MD	Advocate Aurora Medical Group
Kevin McCune, MD	AMGA (formerly Advocate Aurora Medical Group)
Kim Pierce, MD	Butler Health System
Beth Averbeck, MD	HealthPartners
Jason Maxwell-Wiggins, MD	HealthPartners
Rae Ann Williams, MD, FACP	HealthPartners
Austin Lepper	McFarland Clinic, PC
Bonnie Basler, MD	North Mississippi Medical Clinics, Inc.
Jeanne Robinson, MD	Northwest Permanente P.C. Physicians and Surgeons
Muninder Dhaliwal	One Community Health
C. Todd Staub, MD, FACP	OptumCare
Jennifer Obenrader, Pharm D	Premier Medical Associates, P.C.
Robert Crossey, DO, FAAFP	Premier Medical Associates, P.C.
Francis Colangelo, MD, FACP, MS-HQS	Premier Medical Associates, P.C.
Scott Barlow, MBA	Revere Health
Elizabeth Buisker, DO	SCL Health Medical Group (part of Intermountain)
Daniel Duncanson, MD, CPE	SIMEDHealth
Michael Conroy, MD	Sutter Medical Foundation
Annie Mervis, MSW	University of Utah Community Clinics

Appendix III: Faculty Bios

Elizabeth Ciemins, PhD, MPH, MA, is a health services research scientist and vice president of research and analytics at AMGA. In her role, she focuses on data-driven population health improvement through comparative and predictive clinical analytics. Prior to AMGA, she served for eight years as director of the Center for Clinical Translational Research at Billings Clinic, where her research focused on the use of telemedicine to provide care across a large, geographically dispersed service area in the areas of diabetes, hypertension, palliative care, and health IT. Dr. Ciemins' areas of research interest include chronic disease management, health information technology, palliative care, childhood and adult obesity, care transitions, rural health, mental health, and complexity science approaches to behavior change in healthcare.

Elizabeth Cope, PhD, MPH, is senior director at AcademyHealth and oversees the Health Systems Improvement and Public and Population Health program areas. For nearly 15 years, Dr. Cope has been committed to creating a research-to-practice bridge that centers the well-being of communities and resilience of health systems, with a particular focus on safety net and pediatric settings. With expertise in implementation, improvement, and engagement sciences, she oversees learning collaboratives, multilevel measurement strategies, and coalition-building focused on the translation of community-centered research into health systems improvement.

Harold S. Luft, PhD, is the Caldwell B. Esselstyn Professor Emeritus of Health Policy and Health Economics at the Philip R. Lee Institute for Health Policy Studies at the University of California, San Francisco and director emeritus at the Palo Alto Medical Foundation Research Institute (PAMFRI). His work has covered medical care utilization, health maintenance organizations, hospital market competition, quality and outcomes of hospital care, risk assessment and risk adjustment, primary care delivery, care for patients with advanced cancer, and healthcare reform. A core theme linking this work is how better information and improved incentives can lead to increased value in healthcare delivery. His current work focuses on building a virtual community for people using research methods to address operational and organizational issues within learning health systems.

Jill A. Marsteller, PhD, MPP, is currently a professor of health policy and management at the Johns Hopkins Bloomberg School of Public Health. She is an expert in implementation, organizational learning, and evaluation, with much of her work focusing on research questions surrounding how to provide best-evidence care in a range of healthcare delivery settings. She specializes in organizational behavior and theory, specifically in estimating the influence of organizational variables and contextual measures on performance improvement activities, and in the use of implementation science models and methods to understand and test questions around real-world application of evidence in learning health systems.

Angela D. Thomas, DrPH, MPH, MBA, is vice president of Health care Delivery Research at MedStar Health, where she leads a team of experts to apply rigorous scientific methods to enable next-generation healthcare delivery through quality, safety, innovation, health economics, payment reform, outcomes, health services research, data science, and health equity. This team of healthcare delivery experts leads, implements, and evaluates data-driven solutions that support policies and programs that improve healthcare in a manner that integrates science with the clinical and operational expertise required to meet patient and community needs.

Appendix IV: Challenge Cases Received

How can my health system engage in evidence-driven improvement for better care value and equity?

2022 AMGA & AcademyHealth LHS IG Workshop

Thursday, September 29, 2022 | 6:30 am – 8:00 am CT | Grapevine, TX

"Learning is experience. Everything else is just information." - Albert Einstein

Thank you for registering for the 2022 Evidence-Driven Improvement workshop! Our workshop aims to assist healthcare organizations in breaking down barriers and overcoming challenges when trying to implement evidence-based solutions to address real-world problems.

Engagement in evidence-driven improvement includes focused efforts to improve quality, equity, outcomes, or costs within your organization through formal (e.g., in collaboration with AMGA Research and Analytics) or informal (e.g., a rigorous quality improvement project within your system, projects, or studies).

To enrich our discussion and ensure its relevancy, we're asking participants to select a high-priority area in which your organization has been challenged (or successful) in using evidence to improve patient care or health equity. Your contribution will help us ensure all workshop participants leave with a stronger understanding of how to successfully engage in evidence-driven improvement and health services research to implement solutions to improve patient care.

This is your opportunity to ask questions and learn from an esteemed panel of health system leaders, health services researchers, and clinical experts. Or, to share your experiences and successes to benefit the audience. Please describe your challenges below.

Examples of submissions to the workshop might include:

- How to begin using evidence to drive improvement in your organization
- Challenges faced when considering a rigorous quality improvement (QI) or health services research project
- How to increase organizational readiness for rigorous QI or health services research
- Experience of participating in an internal, external, or AMGA health services research project

Learning Objectives:

- Finding alignment between organizational priorities and health services research opportunities to implement evidence into practice
- Gaining senior leadership support for evidence-driven improvement or health services research
- Dealing with differing timelines for improvement activities and operational decision-making
- Calculating the return on investment for rigorous QI or formal health services research
- Reducing the costs of engaging in health services research (e.g., appropriate research staff)
- Adding health services research approaches when clinical research is the model

Your name: Elizabeth Buisker, DO, MBA	
Title: Vice President and CMO, Medical Group - Western Colorado	**Organization:** Intermountain Healthcare

Describe your organization's quality improvement/research experience and research infrastructure:

- Strong acute care site QI program; less robust research experience and infrastructure. Driven mostly by Oncology and Neurology; challenges in contracting, patient volumes, and support staff to support research

Briefly describe a challenge (or success) in using evidence to drive improvement or participate in health services research:

- Challenged in setting standards for PHQ-9 screening in our primary and specialty care clinics; managing the nuances of screening, follow-up after diagnosis, use during treatment, what to do when there are no resources and a positive screen; wide spectrum of knowledge/comfort in treating the findings among clinicians

What steps have you taken to address this challenge or how did you achieve success?

- Narrowed to standard screening; otherwise, we have not overcome this challenge

What worked well?	**What didn't work or remains a challenge?**
- Enthusiasm for the importance of the work	- Lack of knowledge/resources and prioritization have stalled the work

What evidence-based approach(es), if any, did you use or try to use?

- Using literature search, society best practices, used previous practice models, started pilot programs

With which specific challenges do you need help from workshop faculty and participants or would like us to address?

- Innovative solutions when resources are scarce; how to take a pilot and implement it broadly

Your name: Jason Maxwell-Higgins, MD, and Beth Averbeck, MD	
Title: Maxwell: Chair, Dept of Pediatrics Averbeck: Medical Director, Primary Care	**Organization:** HealthPartners (Minnesota/Wisconsin)

Describe your organization's quality improvement/research experience and research infrastructure:

We have a Quality Improvement team that tracks health measures and metrics for numerous disease processes for all our patients, clinicians, and care teams. The team includes directors and teams from System Quality Improvement, Care Delivery, Experience, Quality and Data, Analytics, and individual service lines.

We have a Research Institute that conducts hundreds of peer-reviewed health services research studies each year, many of which are published in peer-reviewed journals. Other studies are used internally to improve QI within our organization. The Research Institute is composed of an interdisciplinary team made up of investigators, research associates, biostatisticians, and clinicians.

Our Quality and Research Institute teams work collaboratively together and both report our Chief Quality Officer, who reports to the COO. In addition, oversight occurs through the Quality Council of the Board of Directors.

Furthermore, the Quality and Research Institute teams work collaboratively with clinicians and administrators throughout Primary Care, Specialty Care, and Hospital Services.

Lastly, being an Integrated Medical System, it allows our care delivery system to partner with our insurance plan to improve patient well-being and lower total cost of care.

Briefly describe a challenge (or success) in using evidence to drive improvement or participate in health services research:

A recent success: We are fortunate to be a single-separate employer with several different medical groups (including inpatient and outpatient), each with similar patient demographics, under one umbrella. This allows us to do research using one entity as a control and another entity as the test group. Recent example: Administering Flumist to patients with asthma. We were able to administer Flumist to asthmatic patients on one half of our organization, while administering injectable influenza to the other half of our organization; and then look at outcomes. This allowed us to publish data supporting the use of Flumist in mild and moderate asthmatics, as efficacy was similar to injectable and there was no higher rate of ER visits or hospitalization.

Challenges: Doing QI during COVID. Patient demand and staffing challenges have left us understaffed with team members who are overburdened. This leads to resistance against change in general, but specifically any change in workflow, which hinders all research and QI initiatives.

We needed to redirect resources for general QI to help with COVID testing, immunizations, and treatment, and we needed to hold clinician access for acute needs, thereby delaying preventive care and well-managed chronic care. For example, we extended refills for patients for up to 18 months, instead of 12.

What steps have you taken to address this challenge or how did you achieve success?

Success: I believe much of the success was a result of reorganizing our enterprise as elucidated above, with QI and Research working together under the umbrella of QI and reporting to the COO.

We have standardized workflows with specific responsibilities.

Our central QI team helps with direct outreach to patients to support clinics.

Challenge: We are still working through this. Prioritize opportunities given staffing and capacity challenges

- Select initiatives wisely
- Select initiatives that are staff/clinician friendly (e.g., reduce clinician/staff responsibilities, time spent working)
- Select initiatives with the biggest potential to improve patient outcomes

What worked well?	What didn't work or remains a challenge?
Our overall organizational and governance structure works very well to improve QI and pursue research initiatives.	Staffing Finances (grants, etc.)

What evidence-based approach(es), if any, did you use or try to use?

We used Evidence-Based Quality Improvement approaches such as:

- Total quality management (TQM) and continuous quality improvement (CQI) ("PDSA cycles").
- We avoid simplified "Before/After" assessment of our QI process instead opting for Time Series Design using our extensive measurement data (both vendor and bespoke).
- We can do controlled Before/After assessments using one of our systems as a control and the other as the action arm.

With which specific challenges do you need help from workshop faculty and participants or would like us to address?

Capacity management when opportunities exceed existing capacity

Your name: Ashish D. Parikh, MD	

Title: Chief Quality Officer	**Organization:** Summit Health

Describe your organization's quality improvement/research experience and research infrastructure:

- Clinical and Quality Departments work to disseminate best practices, reduce variations in care, drive better high-value care, and improve outcomes
- Quality Department that uses PDSA cycle to implement QI projects
- Research Department and committee that oversees all clinical and non-clinical research

Briefly describe a challenge (or success) in using evidence to drive improvement or participate in health services research:

- It is essential to have complete and accurate data set in order to study it and determine areas of opportunity and improvement.
- In the clinical world, no data set is fully accurate or complete, whether it is EHR data, claims data, other data, or a combination of all of these.
- For example, we have begun the journey of evaluating our patient outcomes based on race/ethnicity. This has uncovered the incompleteness of the data (we do not have this information on 30% of patients), lack of standardization of definitions (race/ethnicity categories not standard across various data sources), and varying collection methods may impact results (self-reported on an app vs. reported to PSR at time of check-in).
- Before data can be analyzed, we need to improve our collection methodology.

What steps have you taken to address this challenge or how did you achieve success?

- Narrowed to standard screening; otherwise, we have not overcome this challenge

What worked well?	**What didn't work or remains a challenge?**
- Standardizing clinical workflows	- Optimizing and syncing our various technology platforms and data sets

What evidence-based approach(es), if any, did you use or try to use?

- Established clinical guidelines and published evidence
- Evaluation of local factors and applicability of best practices and evidence
- Using PDSA cycle to evaluate the impact of any new strategies

With which specific challenges do you need help from workshop faculty and participants or would like us to address?

- What is the definition of "value and equity" in healthcare?
- What are the goals?
- What are the measures of success?
- What data do we need to identify current performance, opportunities, and impact?
- How do we identify strategies that are impactful, scalable, and sustainable?

Your name: Michael Conroy, MD	
Title: Chief Medical Officer	**Organization:** Sutter Medical Group

Describe your organization's quality improvement/research experience and research infrastructure:

Sutter Health has years of experience with central patient outreach and education, coaching clinical teams, providing actionable reports to the team and clinician level, and aligning departmental incentives with system goals related to quality.

Sutter has an Institute for the Advancement of Health Equity (IAHE), which is developing community programs, doing research, and influencing the approach to outreach by our Quality teams. Sutter has a separate Institute for Medical Research that interacts with IAHE.

Our Integrated Quality Services department does the patient outreach and education on cancer screening and other preventive measures, as well as chronic disease management needs.

We work to ensure a Foundation leader is paired with a Medical Group physician leader for each area of work that touches patient care (California model!) and focus on building and strengthening those relationships.

Briefly describe a challenge (or success) in using evidence to drive improvement or participate in health services research:

Challenge: We have very little, if any, access to outcomes data (for example, reduction in vascular events over time with a BP-management initiative).

Significant staff cuts, on top of high LOA rates, make normal outreach and patient care difficult.

Specific to initiatives around hypertension, national expert groups have made frequent changes to guidelines over the past 4-5 years, causing confusion with clinicians and patients.

A challenge is accurately recording race/ethnicity and SDOH measures. Another is aligning organizational priorities with incentives down to the clinical team and individual level.

What steps have you taken to address this challenge or how did you achieve success?

We use external data or expert opinion on messaging and setting goals and targets. Quality Medical Director working to educate frontline clinicians on the why and how of addressing quality gaps. Working with staff and clinicians on the culture of safety, to make it easier to speak up around quality and safety concerns.

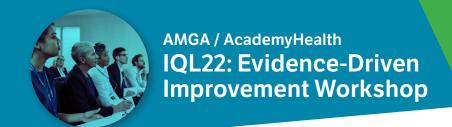| **What worked well?**	**What didn't work or remains a challenge?**
We've been particularly successful in utilizing a tiered checking system with visual boards and coaching at each level (exec to frontline leader).	Outcomes data is a challenge.
Seeing success with reported quality concerns.	Struggling to identify efficient, cost-effective way to capture SDOH information with our 850,000 patients without disrupting operations.
Creating standard work expectations for staff and clinicians very useful for improving BP control and documentation of medication reconciliation rates.	

What evidence-based approach(es), if any, did you use or try to use?

Not sure how to answer this question.

With which specific challenges do you need help from workshop faculty and participants or would like us to address?

Would appreciate what others can share about research and data related to capturing SDOH data, applying specific actions to improve screening rates, or improving the culture of safety in their organizations.

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Your name: Dan Duncanson, MD, CPE	
Title: CEO	**Organization:** SIMEDHealth

Describe your organization's quality improvement/research experience and research infrastructure:

Been working on quality since 2012, baby steps initially, then moving toward full transparency with performance report cards. No significant research toward quality or disparity, other than learning from our own experiences.

Briefly describe a challenge (or success) in using evidence to drive improvement or participate in health services research:

Biggest challenge is changing providers' behavior. Long-established practice patterns, motivated toward efficiently moving patients through the system. With productivity continuing to be the main driver of practice revenue, we don't want to disrupt their efficiency too much while adding additional quality thinking and documentation into their routines.

What steps have you taken to address this challenge or how did you achieve success?

Repeating the message and emphasizing the importance.

Transparency with the income being brought in by quality and cost-of-care performance.

Transparent performance reports down to the primary care physician level.

What worked well?	**What didn't work or remains a challenge?**
All of the above	All of the above (depends on the physician)

What evidence-based approach(es), if any, did you use or try to use?

Information obtained from others; comparative data.

With which specific challenges do you need help from workshop faculty and participants or would like us to address?

Not sure.

Appendix V: Participant Notetaking Guide

A challenge I am facing is:

Today I learned:

Will (motivation & buy-in):

Skill (knowledge & proficiency):

Resources (data, infrastructure, staff, time):

Organizational structure & governance (policies, processes, culture):

Actions I will take over the next 3-6 months:

What I will do:

What I will try:

What I will plan for:

Mission:

AMGA advances multispecialty medical groups and integrated systems of care as the preeminent model to deliver high performance healthcare.

Vision:

We are leading the transformation that results in healthier people.

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