HV-PM/CQI WEBINAR: STRATEGIES FOR IMPROVING DATA QUALITY AND ADDRESSING MISSING DATA

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>> All right. Welcome, everyone. Please continue to introduce yourself in the chat box. We have a lot to share with you today, so we're going to go ahead and get started. My name is Sara Voelker, and I'm the Associate Project Director for the PM/CQI Technical Assistance Center, and we're so happy that you all could join us today.

There are just a few things to keep in mind as you're participating in the webinar. Everyone is joining with your lines open so that you can ask questions and engage in dialogue. That being said, we do ask that you put yourself on mute and only unmute when you're speaking. You can also pose questions or comments through the Chat box. And if you do want to ask a question, in the upper left-hand corner of your screen, there's a little raise-your-hand button, and raise your hand and we'll call on you, and then you can unmute. If you're having any technical issues, there is a Tech Support box at the bottom of the screen where you can type in for help. A reminder that we are recording this webinar and you can find handouts, including the slides from today, in the File Share box.

With that, I'm pleased to introduce Kyle Peplinski, the Senior Data Analyst with HRSA's Maternal and Child Health Bureau Division of Home Visiting and Early Childhood Services. We're very excited to have him share some opening remarks today. Kyle.

>> Great, Sara. Thanks so much, and thank you all for joining us today for this webinar on improving data quality and reducing missing data. First of all, I just want to acknowledge that data quality, and in particular missing data in relation to MIECHV's benchmark performance measures, is a really tough issue, and it has multi-layered antecedence, causes, and solutions. But I do want to mention that we've seen marked improvement in data quality through the first couple of years of MIECHV's performance reporting on the new benchmark measures that were introduced in 2016. So, we think we're making great improvement here and are excited to offer the opportunity to share some more strategies and ideas about improving data quality and reducing missing data on today's webinar. I also just want to mention that we, HRSA, continues to think through additional ways that we can help you all in supporting high-quality performance data both for performance reporting, but more importantly for uses in your own programs to think through program performance, continuous quality improvement, and communicating about your own program.

Just one example of that is the inclusion of a missing data field on Form 2 starting with next year's annual performance reporting. And sort of another key strategy in those supports is this webinar today. So, again, thank you all for joining us today. We hope this is useful information, and I also want to thank the team at EDC on the PM/CQI TA contract for putting this content together. Thanks, Sara.

>> Great. Thanks so much, Kyle. Also joining us today are our presenters. So, we have Mallory, who is the

TA Specialist for Region VIII; Rachael, TA Specialist for Regions IV, VI, and X; and Susan, TA Specialist for Region II. We're excited to hear from all them today.

Our objectives for today are to describe the characteristics of quality data, review guidance for identifying missing data, share strategies that you can use to address data quality and missing data, and highlight some available TA resources to support you in this area. So, again, we encourage you to use the Chat box to engage with each other and pose questions as they come to mind, and we'll be pausing at a few spots to open up the lines and hear from as many of you as possible. With that, I will turn things over to Mallory.

>> Great, thanks so much, Sara. Hi, everyone. I'm Mallory Clark and I am the TA Specialist for Region VIII, and we're going to spend a little bit of time during the first part of our webinar this afternoon discussing data quality.

Quality data, consistently and accurately, indicates what's happening in your home visiting program. High-quality data gives you confidence in your findings and the impact of your program. Quality data are complete, which means all values are present. They're accessible, which means they're available when required or needed. They are relevant for answers to proposed questions. They're accurate or free from errors and reliable or consistent. It's important to use data to help identify CQI topics; however, before reviewing and interpreting those data, it's important to ensure that you are using quality data.

Module 2 of the CQI Toolkit released last year includes more details of quality data and has a handout to support you on using data to drive CQI and identify topics. A link to the module can be found in the File Share pod.

We'd like to just take a second and, in the poll, please let us know if the data challenges you encounter are typically related to completeness, accessibility, relevance, accuracy, or reliability of data. All right. I'll give you just a few more seconds to finish up. It looks like for now we have an overwhelming majority of people say completeness is the most common error that you encounter, most common challenge that you encounter with your data quality. So, if anybody wants to expand on that a little bit more and tell me a little bit more about those challenges, feel free to unmute your line and share a little bit more. Okay. It turns out that nobody wants to share, but thank you so much for completing the poll, and I hope that through the rest of this webinar through the information that I provide and that Rachael provides will be able to help you better the completeness of your data.

So, to have quality data, good data collection techniques are necessary. Adopting the following four steps can help ensure collection of high-quality data that will inform your work. The first step is standardization, follow a consistent and standardized approach to collecting and inputting the data. This can be achieved by developing manuals or policies to document the process for collecting and inputting data.

Second step is appropriate tool selection. Choose tools, screenings, and assessments that are valid and reliable for the family being served. For example, the ASQ Questionnaire is considered a valid and reliable tool to screen for delays in child development for particular ages. Within the ASQ protocol, there are specific time frames that are considered reliable. For example, it's appropriate to use the nine-month ASQ from ages nine months and zero days to nine months and 30 days, but not 25 months, for example.

The next step is staff training. Ensure that all staff has initial and ongoing training and support to use in the standardized tools and data collection processes. For example, in the case of collecting data on attendance at the six-week postpartum visit, home visitors should be trained to know what occurs with the medical visit to identify the differences between a well-woman visit and a six-week postpartum visit.

The final step are data management processes. Ensure that data are stored and maintained in an appropriate manner so they can be reviewed and reported as needed. If data aren't reported, reports won't reflect that, so we really want to make sure that your work is counted.

Through our experience providing TA, we've identified several strategies awardees have used to identify data quality issues. Typically these can be categorized into two categories: measurement-based or programmatic-based strategies.

Awardees have used the following measurement-based strategies to address data quality. Many awardees support LIAs when identifying correcting data quality issues through specific reports. This can include running benchmark reports at the LIA level to help LIAs identify missing data and data quality issues. This should be done on a regular basis, but the frequency really depends on you as the awardee and LIAs capacity. It can be done twice a year, quarterly, monthly, or any other timeframe that you see fit.

Other awardees utilize model developers canned or built-in data quality reports that are in their data system to identify data quality issues. Awardees have also developed missing data reports specifically for Form 1 and Form 2. Awardees run these on a regular basis and discuss results with LIAs and, again, this can be done as frequently as you see fit.

Awardees have also developed new and improved data systems for either developing a new data system or improving their current data system to include data quality checks, which may be flags or reminders of required fields or logic to help in entering accurate data. For example, a data system that might validate ASQ score within an appropriate range or a data system can actually flag or remind the home visitor when it's time to administer the ASQ.

And, finally, many awardees dedicate staff time to addressing data quality and missing data issues in real time.

Programmatic-based strategies include developing policies, procedures, and protocols around administering and collecting data on specific performance measures or screening tools. For example, awardees may develop certain protocols on when to administer the ASQ that align with tool guidance and then make the [phonetic] performance measure guidance.

Capacity building can take on many forms. This can include targeting support to LIAs with specific data quality challenges. It may also include training on specific performance measures like training home visitors on cultural sensitivity for questions related to breast-feeding and bed sharing or providing information on community resources available for IPV referral. Supporting home visitors and understanding the importance of data and how they use it for program improvement or to tell the story of home visiting's impact on families is also an important part of capacity building.

Finally, CQI projects can help awardees and LIAs systematically address data quality issues. CQI allows teams to work together to identify and test strategies that work to address data quality challenges. A CQI project to address data quality may include testing different strategies in the way home visitors ask

families questions on specific performance measures to determine which works best for the family and for the home visitor.

So, we'd like to take a few minutes to reflect on what we just talked about around data quality and the strategies there. So, in the chat box, if you could please answer the following questions: What experiences have you had using these strategies to address data quality challenges? How do you plan on using one or more of these strategies to address data quality challenges? Or what other strategies have used to address those challenges? So, if you would like to text them in the chat box, we recommend that. You can also unmute your lines and share the strategies out loud.

>> [Indiscernible]

>> I'm sorry. Does somebody want to share?

So, Jeremy mentioned that they've made quarterly review of Form 1 and Form 2 reporting more formal and using a video conference to make it more interactive. That's a great idea.

Looks like a few more people are still entering in some responses, so I'm just going to wait a little bit longer.

>> And Tracy, did you want to share over the phone line? I saw you had your hand raised.

>> Okay. While we're waiting for Tracy, I'm just going to go through some of the other things that have brought up. Andrea used a CQI project related to referral documentation and transfers in developing a new data system with business rules. I think that's a great idea.

Katie mentioned that they used data check files from the data system to check for missing and inaccurate data. Sounds like that's in some of your programs but not all of them yet.

Mack mentioned using monthly CQI meetings with an LIA. Great.

I'm specifically looking at specific performance measures. That's a great idea.

Reminders for when things are due, missing reports, like before the reporting period ends, quarterly data reports and review of outcomes with each LIA in the performance measure workshop annually. That's a great idea to get everybody together and discuss challenges, successes, and strategies.

Quarterly benchmark reviews, presenting members by LIAs. That's a great idea.

In-person review missing data and data quality issues. Great.

It sounds like these are really great ideas. Just for the purpose of the time, if nobody wants to share out loud, Rachael, I think I will pass it over to you.

>> Okay. Thanks so much, Mallory. And feel free to enter keep entering great ideas that you guys have in the chat box. Please do that. Well, good afternoon, everyone. My name is Rachael Glisson and I'm the TA specialist working with Regions IV, VI, and X. And since we've heard a bit about quality data; next, we're going to cover some specific issues regarding missing data. So, first we're going to talk about what is missing data; next, we'll discuss common reasons awardees have missing data and how to handle it in reporting. We have a few examples from Form 1, but we will mostly be focused on Form 2. And you'll

have many opportunities to test your knowledge throughout the section of the webinar with poll questions, so get ready. Lastly, we'll leave you with some strategies you can use to address missing data throughout the year.

All right. What do we mean by "missing data "? Missing data is an extremely important topic when talking about quality data. These two really go hand in hand. When values are missing that are needed for measurement calculations, awardees are only able to show a partial or incomplete picture of the work they're doing on the ground. It affects accuracy and completeness of data in reporting. For Form 1, data are considered missing if one or more data elements needed are unknown. The example given is if information was not collected for a child's insurance status. The value is unknown and should be reported as missing data for Table 18.

In Form 2, data are considered missing if one or more data elements needed to determine inclusion in the numerator or denominator are unknown. And we're going to cover several examples over the next few slides.

So, each performance measure has a specific missing -- has specific missing data guidance, and you can find it in the Form 2 Toolkit in the Guidance on Identifying Missing Data Documents in the File Share pod.

It's important to understand the reasons for missing data because the strategies for addressing it could be different. Some common reasons for missing data are, the data collection schedule doesn't exactly match up to the performance measurements. For example, in, say, sleep: any child one year or younger without safe sleep information should be reported as missing data. This would include children who did not have safe sleep information because they did not reach their first data collection of, say, two months old. They should be reported as missing data.

Also, missed visits. When families miss visits, especially around data collection time points, it's very possible that the result will be missing data. So, for example, if you're working to reengage a family around six months, you might miss the breast-feeding status. You might not have that information to report due to families missing visits.

Another reason could be need for additional staff support. So much of data reporting relies on staff feeling confident and comfortable with screening tools, data collection schedules, data systems, and entry. All of these pieces can be challenging, so when that staff support isn't available, missing data could occur.

And the last one, respondent refusal or non-response. Sometimes participants decline to answer a question or participate in a screening. It's part of data collection and happens but could result in missing data.

So now that we know what we mean by "missing data" and some common reasons that missing data occur, how do we handle it in reporting? HRSA states that awardees should include the number of missing data even if it's under 10%. In Form 1, it is included in the tables; in Form 2, it should be included in the comment section. And if missing data exceeds 10% for Form 1 or Form 2, awardees should describe reasons for missing data and possibly include plans to reduce missing data over the next reporting period.

You have some great tools available to help you understand missing data, so please always reference the Guidance on Identifying Missing Data in the Form 1/Form 2 Toolkits. Also please reach out with any

questions to your TA Specialist.

So, now we're going to jump in with some examples. Let's take a look at household income from Form 1. Household income refers to the annual gross income for the household, and it's recorded at enrollment and annually thereafter. To determine household income in relation to the federal poverty guidelines, the awardee will need to know the household income and the number of household members reported in the household, both home visiting enrollees and non-enrollees. If either the household income or the total number of household members is not recorded, then the household should be recorded as "unknown" or "did not report." And that's in that second to last row in Table 14.

So let's jump to some Form 2 examples starting with postpartum care. To refresh your memory, this measure looks at the percent of the mothers enrolled in home visiting prenatally or within 30 days after delivery who received a postpartum visit with a healthcare provider within eight weeks (56 days) of delivery. The logic statements from the Form 2 Toolkit walk you through the different scenarios of data collection and reporting. The statements give you next steps and are there to help narrow down the numerator and denominator for each measure.

In the postpartum care logic statements, we start with: For each mother enrolled in your program at any point during the reporting point period, was she enrolled prenatally or within 30 days after delivery? Yes, continue on; no, she's not included in the measure; or, information missing. Let's get really concrete and talk through an example.

In our program, we had 80 mothers enrolled at any point during the reporting period that were enrolled prenatally or within 30 days after delivery. That's coming from this first logic statement. Out of the 80 mothers that we identified for step one, 60 of those reached eight weeks post-delivery within the reporting period. The second logic question helps us identify those 60 mothers. The final question is if a mother completed a postpartum visit on or before eight weeks (56 days) after delivery. In our example, 40 mothers completed the visit within eight weeks of delivery. Ten completed it, but after eight weeks, and ten mothers did not have any information recorded about a postpartum care visit.

Now that we've talked through the beginning of one example, let's test our knowledge about how to handle certain cases with two poll questions.

So, I'm going to read both poll questions and then give you some time to answer them. But the first one is: We have a mother who enrolled prenatally but did not reach eight weeks postpartum in the reporting period. Do we include her in the denominator? Report her as missing? Exclude her from the measure? Or, I don't know?

On the second question is: A mother enrolled prenatally reached eight weeks postpartum in the reporting period but has no information about if she completed her postpartum doctor's visit recorded. Do you include her in the denominator? Report her as missing? Exclude from the measure? Or, I don't know? All right. I'll give you about ten more seconds to answer both of these questions. Great. This is looking really good.

So, for our first poll question, you guys are correct. The answer is to exclude her from the measure. She didn't reach that eight weeks postpartum in the reporting period, so she's not going to be included in the measure. And for the second poll question, you all are correct again. The answer is to report her as missing data. She has no information about if she completed that postpartum visit but reached all of the other criteria, so we're going to report her as missing. Great job.

So, we'll go ahead and finish up our example for postpartum care. So, we had 60 mothers that reached the eight-week post-delivery time point in the reporting period, but ten of them did not have any information about a postpartum visit recorded. These ten mothers should be excluded from the denominator and recorded as missing data. So, our numerator would be 40, our denominator 50, and missing data is ten, or about 17%. So, a note including the reasons for missing data would be expected for this measure, for this example.

I'm just going to continue on because I have three other examples to get through, but please keep chatting any of your questions in the chat box, and we will get you answers.

All right. Our next performance measure we're going to talk about is safe sleep, and to refresh your memory, this measure looks at the percent of infants enrolled in home visiting that are always placed to sleep on their backs without bed sharing or soft bedding. Now that we understand the definition of the measure, let's talk through the logic statements.

In the safe sleep logic statement we start with: For each index child enrolled in your program, was she or he exactly one year old or younger at any point in the reporting period? Yes, continue on; no, they're not included in the measure; or, information missing.

For the example we're going to use, we have 300 children who were exactly one year or younger at any point in the reporting period. Of those 300 children who were exactly one year or younger at any point in the reporting period, 100 primary caregivers reported that they are always placed asleep on his or her back and without bed sharing or soft bedding. A hundred primary caregivers reported no to at least one of the pieces of the question. Fifty children didn't have any information recorded in the system about safe sleep, and I'm going to throw in an interesting twist. Our awardee data plan states that we don't start measuring safe sleep for children until two months of age, so 50 children didn't reach our first reporting time point of two months. Not everyone uses this data collection strategy. It's just for this example, so please don't worry if your time points aren't exactly the same. So, what do we do with this example? Who is considered missing. Let's go to some poll questions to get your feedback.

All right. So, our first poll question: A child is one month of age and did not reach our first awardee set data collection time point of two months of age. This is according to our performance measurement plan. So, they don't have any information on safe sleep recorded. Do we include them in the denominator? Report them as missing data? Exclude them from the measure? Or, I don't know?

In our second question is: A child is six months at the end of their reporting period and did not have complete information on safe sleep recorded. Do you include them in the denominator? Report as missing data? Exclude them from the measure? Or, I don't know?

All right. Take a couple more seconds to respond to the questions. I see we're still changing a little bit. All right. For both of these, the answer is to report as missing data. And here's why. So, the measure states that anyone under one-year-old should be included in the calculation. If we don't have

information on anyone under two months old, they still don't have that information, so they should be reported as missing data, even though our awardee performance measurement plan says we're not going to collect until two months. They still don't have that information being requested.

So, I'm going to highlight that setting your own data collection time points that work for your program is really important, but it might result in some missing data, so that balance is really key. Not saying [indiscernible] data collection time points, but finding that balance for getting the information you need and not overburdening home visiting staff is really important.

Let's go on to our next slide, I'll take down the poll questions and finish up this safe sleep data example. So, we had 100 children out of 300 that were less than one-year-old during the reporting period that did not have any information about safe sleep. So, keep in mind that any child one year or younger without safe sleep information should be reported as missing data, and this would include those children who did not have safe sleep information because they didn't reach our awardee set first data collection time point of two months old. So, our missing data of 100 children, or about 33%, and a note including the reason for missing data would be expected for this measure. All right. We've got two more examples.

Our next one is about intimate partner violence screening and the measure of looking at the percent of primary caregivers enrolled in home visiting who are screened for intimate partner violence within six months of enrollment using a validated tool. Let's go ahead and talk through the logic statements.

In IPV screening logic statements we start with: For each primary caregiver enrolled in your program, did she or he reach six months post enrollment during the reporting period? Yes, continue on; no, they're not included in the measure; or, information missing. This is really important, and I'm going to highlight it. Primary caregivers need to reach six months post enrollment during the reporting period to be included in the calculation. That means that there might have been a screening that occurred during the previous reporting period and the caregiver wouldn't have been included until the reporting period where they reached six months post enrollment. So, that first piece is really important. Did they reach six months post enrollment during the reporting period?

So, our numbers, we had 200 primary caregivers reaching six months post enrollment during the reporting period. Out of those 200 caregivers, 150 were screened within six months, 30 were screened after six months, and 20 were not screened at all. So, in this example, who is considered missing? Let's go ahead and bring up the poll questions. And there's three this time.

Our first question: A primary caregiver did not reach six months post enrollment during the reporting period. Do you include them in the denominator? Report them as missing? Exclude them from the measure? Or, I don't know?

Our second question: A primary caregiver reaches six months post enrollment. She was screened in the previous reporting period. What do we do? Include in the denominator? Report her as missing? Exclude her from the measure? Or, I don't know?

And our last one is: A primary caregiver reaches six months post enrollment during the reporting period

and was not screened. Do you include them in the denominator? Report as missing? Exclude them from the measure? Or, I don't know? Take about ten more seconds.

For the first one, great job, everybody agrees. We exclude them from the measure. They did not reach six months post enrollment during the reporting period, so we exclude them from the measure.

For our second poll question, they reached, that primary caregiver reached six months post enrollment but she was screened in the previous reporting period, she should be included in the denominator. She is included in the measure where she reaches that six-month post enrollment regardless of when she screened. Most everyone got that one.

And we seem to be pretty split about the last one. A primary caregiver reaches six months post enrollment during the reporting period and was not screened. She should be, she or he, should be included in the denominator. Just because they were not screened, that's not -- they're still going to be included in that denominator since we're measuring screening for intimate partner violence.

So, let's go to this last slide, and we'll talk through it a little bit more. All right. So, for this example, we had 150 primary caregivers out of 200 that reached six months post enrollment in the reporting period and were screened within that six-month time point. So, the 150 primary caregivers were screened. And the screening measures have slightly different instructions for how to record missing data. So, if the only thing that's missing is documentation of whether the screen occurred, the primary caregiver is going to be included in the denominator but not in the numerator, if they reach that six-month post enrollment during the reporting period. So, there's no missing data to record for this measure. And just to note, awardees should still include a note in the performance measure stating that there's no missing data. It's just a good practice to have.

Our last example that's going to build off the intimate partner violence screening, we're going to talk about the intimate partner violence referral performance measure. This measure is a percent of primary caregivers enrolled in home visiting with positive screens for intimate partner violence using a validated tool who receive referral information to IPV resources. So, keep in mind for this performance measure, if there is no documentation of whether a referral was provided, but all other data elements are available and inclusion in the denominator can be determined, then the primary caregivers should be included in the denominator but not the numerator. I know that was really wordy, so we're going to talk through an example of this.

We had 15 primary caregivers that screened positive within the first six months of enrollment. Ten primary caregivers were referred to IPV resources, three did not receive any referral to IPV resources, and two were referred, but it was not documented in the system. Remember for this measure, primary caregivers who are eligible to be included in the denominator will be included in each annual report until the conditions in the numerator have been met. So, there may be some caregivers included in the measure that screened positive last year and did not receive referral information at that time that would be included in this year's measure.

And another piece of this, so any primary caregivers that are missing in IPV screening should be included as missing data for this measure. There is no screening completed, so we don't know if they would be a positive screen. So, from our previous example around IPV screening, there were 20 primary caregivers that did not receive an IPV screen, and these 20 primary caregivers are included as missing data for the referral measure. So, I know this is a lot of information. Let's go to the poll questions to gauge our

knowledge about missing data for this example. And then we'll wrap up this section.

So, our first question: A primary caregiver screened positive in a prior reporting period, but they did not receive a referral during the reporting period. Do you include them in the denominator? Report them is missing? Exclude them from the measure? Or, I don't know?

And the last one: A primary caregiver reaches six months post enrollment during the reporting period and was not screened. Do you include them in the denominator? Report them as missing? Exclude them from the measure? Or, I don't know? So take a couple more seconds.

Okay. For this first one, a primary caregiver screened positive in a prior reporting period but they didn't receive a referral during the reporting period, so they should be included in the denominator as long as they were still enrolled during our current reporting period. So, we would include them in this year.

And then, our last poll question was, a primary caregiver reaches six months post enrollment during the reporting period and was not screened, and these people are going to be reported as missing data for this measure. And the majority of you all got that. So, good job. So, those primary caregivers that weren't screened, we don't know if they were -- would have had a positive screening, so they would be missing data for this measure.

So, let's wrap this one up. For this example, we had 20 primary caregivers who were not screened, and they should be included as missing data since we don't know if they were positive screens. And the two primary caregivers that were missing documentation of their referral status should be included in the denominator. The only thing missing was the documentation and the guidance states that those cases should be included in the denominator. So, the missing data for this measure is 20, and possible reasons for why the data is missing should be given in the annual reporting submission.

We have talked through four examples and a lot of information. We now know how to report missing data in Form 2 for each of those four measures, but what can we do about missing data throughout the year?

Listed on the slides are some strategies you can take to improve missing data, but to improve that missing data, you need to have -- you have to know how much missing data you have and why the data are missing. Some of the strategies to help address data quality can help you address missing data as well. So, remember that first section that we talked about. It's important to have standardized processes in the field and in the office for data collection and entry. Running reports periodically can help you identify missing data throughout the year. Training for home visitors, both initially and ongoing, is really, really helpful. Also, informed decisions about data collection time points; it's not to collect data more often. There's an important balance between reducing missing data and not overburdening home visiting staff. And lastly, that data system capability, ways to document this information is really important, and when you rely on it, just a check box that says "yes, a postpartum visit was completed," it's unclear if the checkmark is unclicked, if a mother did not complete the visit, was it true no, or if this information was never asked or skipped. An ideal system would have the capability to distinguish yes, no, or missing. And missing data can be a struggle in performance measure reporting, but if you

implement different strategies to address it, it becomes more manageable. Waiting until the last minute to identify and address missing data leads to a lot of stress. So, please use your resources that you have available: the guidance, the toolkits, TA Specialists throughout the year to help alleviate missing data issues.

And with that, I'm going to throw it to Sara, I think.

>> Great. Thank you, Rachael. And we have some time now to take some questions. I know you've been chatting them in, and if anyone would like to ask a question over the phone line, raise your hand, and we'll be monitoring those.

We've had a few questions come in about how to calculate percent of missing data for Form 2. And so our recommendation for that would be to take the number of missing divided by all the clients who have the potential to be included in the denominator. So, it would be your missing divided by the sum of your recorded denominator and your missing. If you have more detailed questions about that, you can reach out to your TA Specialist. They'd be happy to work through those with you.

I see we have a question: For missing data, do you want specific reasons why data are missing or just the total number of missing? And Rachael, I wonder if you would like to respond to that? Rachael, you might be muted.

>> Sorry, Sara. I always do that for some reason. Can you ask the question one more time please of which one you brought up?

>> Sure. For reporting missing data, should awardees include the specific reason why data are missing or just the total number of missing?

>> I think it's good practice, definitely include the total number of missing, but if that number is over 10%, then include reasons of why the data was missing.

>> We see that there have been a few questions about -- asked us to -- other awardees performance data or seeing an average, we will share those questions with the HRSA team, those suggestions with the HRSA team and see. I know in the past sometimes overall performance data has been shared back through presentation.

Okay. And we have a question from Jessica for IPV, and I think this is the IPV referral measure: Would we need to report the number of caregivers missing screening data that are included in the denominator in the notes to HRSA? Rachael, I'm going to throw that one to you again.

>> Sure. So, for the IPV, anyone who wasn't screened during the reporting year would be included in the notes for IPV referrals as missing data. I'm pretty sure that's what you're asking, but if that's not exactly, just let me know. Okay. Good.

>> Okay. Please continue to put your questions in the chat box, and we'll respond to them when we can or follow-up after the call if we need to, but in the interest of time, I want to turn things over to Susan now so she can share some information about a new TA opportunity.

>> Thanks, Sara. Good afternoon, everyone. I'm Susan Zaid, and I work with the Region II awardees. HV-PM/CQI is excited to offer an optional TA opportunity to interested awardees. Your HV-PM/CQI TA Specialist is available to support you with an interim review of performance data. These reviews will be tailored to meet your program's unique needs and driven by your own goals and questions. Regular data

reviews are essential for monitoring in improvement work and can benefit multiple aspects of your program. In addition to addressing questions related to data quality and analysis, a review of your performance data can uncover opportunities for CQI, topics for LIA training and technical assistance, and areas for program improvement.

If you're thinking about requesting an interim data review, how much time should you set aside? The time required will depend on your specific goals for the review. Awardees should plan for at least two 60-minute conference calls with TA Specialists and HRSA Project Officer. In the first call, you'll work together to identify key questions to be explored during the review, reflect on any challenges with your most recent data submission, and decide what data will be shared and in what format.

The second call will focus on discussing the written feedback provided by your TA Specialist and some suggested next steps. In between calls, awardees will need to dedicate some time to gathering data and reviewing feedback. We recommend that awardees include multiple staff members and roles in these discussions to engage diverse perspectives on the data and benefit the full range of your work.

There are many benefits of requesting an interim data review of your performance measures, many of which are listed on this slide. Some awardees have taken advantage of this opportunity in previous years, and these reviews have helped them to identify and address challenges prior to the annual submission deadline. Look for preliminary test changes in the data systems or processes, use data from interim reviews to provide feedback to LIAs, and improve the quality of their annual data submission, which will reduce the need for multiple revisions. More information on interim data reviews was provided to you all through the MIECHV LISTSERV, so you can refer to that handout for more details.

If you're interested in taking part in an interim data review, feel free to reach out to your PM/CQI TA Specialist and HRSA Project Officer. We welcome any questions you have right now, and also if there are any awardees on the line who have taken advantage of an interim review in the past and would like to share their experience, feel free to do so now.

>> Okay. Thank you, Susan, and thank you, everyone, for your questions and comments. As we said before, please feel free to reach out to your PM/CQI TA Specialist and Project Officers with any follow-up questions. We've noted a few here that we didn't quite get to, and we will be following up with you to try and get more information so that we can answer your questions.

At this point, we would like to ask you to take just a moment and reflect on any action steps you can take based on the information that you heard today. So, you'll see some poll questions have appeared at the bottom of your screen. Do you plan to take an action step based on this webinar? Yes or no. If yes, please let us know what that action will be, and if no, we'd like to hear from you about what would have been helpful to you in identifying a future action step. You can continue to type in your responses. We're seeing some good action steps here, and that looks like some potential opportunities for some follow-up TA.

We want to close by saying thank you again for joining us today, for sharing your time, questions, and feedback with us. We are always looking for ways to improve, and we want to use your input to help guide that improvement, so we would greatly appreciate it if you would take a few extra minutes of your time to complete a short survey and share your thoughts on today's webinar. There's a link at the bottom of your screen, and once we end the webinar, the survey will appear in your web browser. Just as a reminder, the slides from today's webinar are available in the File Share box, and we will email

those out with a thank you email for attending.

So, thank you again, and please feel free to reach out with any questions. Have a wonderful day.