

**P102: Facilitation of patient-oriented research in primary care practice-based research networks in Quebec, Canada: defining, implementing and strengthening the approach used by Research Facilitators in a network of networks**

*Annie LeBlanc, PhD; Shandi Miller, MSc;*

**BACKGROUND/SIGNIFICANCE:**

Réseau-1 Québec is a network of four practice-based research networks established in 2013 to support their development as a common infrastructure for patient-oriented primary care research in Quebec. Through provincial health research funds, Réseau-1 Québec funds a part-time patient-oriented Research Facilitator in each of the four networks. Funded since 2014 via the national Strategy for patient-oriented research of the Canadian Institutes of Health Research, the Quebec SUPPORT Unit aims to transform primary care clinical and organizational practices, and to promote the integration of care and services through patient-oriented research. In 2017, the Ministry of Health in Quebec established a new management framework for Family Medicine university-associated clinics. As a result, each of these clinics now has access to a continuous quality improvement agent. In this context, practice facilitation is conducted by the Ministry of Health funded quality improvement agents, who are predominantly (although not exclusively) oriented towards continuous quality improvement activities. Research facilitators are employed by the practice-based research networks, each based in one of the four departments of family (and emergency) medicine. Research facilitators are focused predominantly on facilitating research activities in clinical settings, and bridging researchers with healthcare providers in that context. Practice facilitators and research facilitators work closely together in many cases, given the complementary nature of and shared context for much of their work. However, the practice-based research networks do not currently have the capacity to respond to actual demand for research facilitation services. There is also a need to clarify the complementary and yet distinct aspects of the roles of Practice Facilitators and Research Facilitators in the Quebec context. The objective of this study is to clarify the approach used by research facilitators in this context, as well as barriers and factors facilitating their integration in practice, in order to be able to measure (and ultimately increase) their capacity.

**SETTING/METHODS:**

A common project is currently underway in clinics of each of the networks, providing a setting in which to understand the Research Facilitator role. In addition, key stakeholder interviews will be conducted, in order to understand their familiarity with and expectations of Practice Facilitators. These efforts will inform: an initial description of the role of research facilitators; recommendations as to services to potentially be developed; and an evaluation of the impact of research facilitators.

**RESULTS AVAILABLE OR PLANNED:**

As a result of this study, the role of Research Facilitation will be more clearly defined (and thus presumably better communicated to and understood by key stakeholders). The role and its various tasks will be measured in the context of the common project, thereby improving understanding of how it is employed in practice.

The deliverables available in 2018 (phase 1) include:

- A partnership agreement between the four practice-based research networks, Réseau-1 Québec, and the Quebec SUPPORT Unit
- A Research Facilitator job description, outlining roles, responsibilities and competencies.
- A comparative analysis of the roles of Practice Facilitators and Research Facilitators (in the Quebec context)

The deliverables planned for 2019 (phase 2) include:

- An analysis of the tasks completed by the Research Facilitators in the context of the common project
- An evaluation of the capacity of the networks to continue providing Research Facilitation services
- Development of training activities for the Research Facilitators

**CONCLUSION/NEXT STEPS:**

The results of this study will inform the development of tools used to continually measure and reflect on the quantity and nature of services to which the Research Facilitators respond. Ultimately, this study aimed to enable the networks to increase their capacity to facilitate large scale, high-quality patient-oriented research initiatives. The partnership mobilised by this study has already become more concrete and dynamic, and several new common projects and development initiatives are now underway.

**P103: Designing for Improvement: Enabling Primary Care Teams to Improve Care for Elderly Patients Living with Polypharmacy**

*Patricia O'Brien RN, MScCH; Christina Southey MSc;*

**BACKGROUND/SIGNIFICANCE:**

Designing a large-scale quality improvement (QI) initiative requires attention to the development of practices and resources that are capable of supporting diverse community-based primary care teams to collaborate toward achieving 'better'. Focused on a research and quality improvement collaboration to improve care for elderly patients living with polypharmacy, the initiative design for SPIDER (a research and QI collaboration supporting practices improving care for complex elderly patients), was influenced by patient advisors, primary care teams, and QI specialists. Acknowledging the national scale of the QI initiative, the variation in context, readiness, and improvement capacity of each participating team was also considered in the design. The varied roles of the QI coach served as an enabler for the initiative, both in the application of QI methods but also importantly as a networking and sharing link between participating teams.

**SETTING/METHODS:**

Enabling community-based primary care teams to improve healthcare outcomes for elderly patients living with polypharmacy requires attention to patient engagement, team composition, availability of patient-level data related to prescribing patterns, and exposure to improvement science. Designed as a learning collaborative, SPIDER incorporates project elements shown to increase success of local improvement and support diverse teams such as group learning, consistent communication and feedback loops. The development of a common QI pathway based on the Model for Improvement enables teams to focus on a sequence of work with QI coach support that is contextually appropriate to them. The QI pathway also serves as a key mechanism for building capacity for improvement for teams new to QI. By pre-populating common system diagnostic tools such as process map and cause and effect diagram, and by linking those tools to the plethora of evidence-based patient and professional resources for deprescribing, teams are able to efficiently use their prescribing data to engage patients and effect improvement.

**RESULTS AVAILABLE OR PLANNED:**

SPIDER launched in September 2018 at the Department of Family and Community Medicine, University of Toronto as a feasibility site ahead of a broader, staged national research project. The engagement of the participating teams has been encouraging to date. Accessing the QI coach has been consistent and varied in intensity across the 12 teams; application of QI methods, including system diagnostic tools that describe the nuance of respective practices and communities has been observed; the collaboration between teams, encouraged by the coach and enabled by the learning collaborative design, has resulted in cross-community learning.

The nature of these teams being first in a series of cohorts has necessitated some flexibility in design and support to respond, in real time, to needs of participating teams. The lessons learned from this first cohort will be used to assist future cohorts to move forward more quickly and anticipate the realities of this type of improvement work.

**CONCLUSION/NEXT STEPS:**

The challenge in any QI initiative design is engaging diverse primary care teams across a community and country who come together to improve. The design of SPIDER as a QI initiative has demonstrated that despite variation in team composition, experience with improvement, and comfort level with data, the availability of coaching and provision of resources is impactful in achieving 'better' and that the initiative design matters.

**P104: Lung Cancer Screening in Appalachia Kentucky: The Impact of Lung-RADS on Subsequent Testing and Cancer Identification**

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**BACKGROUND/SIGNIFICANCE:**

Lung cancer is the leading cause of cancer related mortality in the United States, accounting for 1 in 4 cancer related mortalities. Kentucky has the highest incidence of lung cancer in the country at 91.4 per 100,000 compared to the national rate of 58.3 per 100,000. While there have been tremendous strides in screening for other types of cancers, such as colon, prostate, and cervical, lung cancer screening still remains an area of controversy. The National Lung Cancer Screening Trial (NLST) was a large, multicenter, randomized controlled trial that compared annual low dose helical computed tomography (LDCT) to chest x-ray in high risk individuals as a tool for lung cancer screening. The NLST demonstrated a statistically significant improvement in survival with annual LDCT in individuals who are high risk for lung cancer. However, because site selection for the study was among 33 urban or metropolitan institutions across the country, the feasibility of implementing a screening program similar to NLST in a rural population is unknown. Additionally, the NLST was conducted prior to the advent of Lung CT Screening Reporting and Data System (Lung-RADS). Lung-RADS is an effort by the American College of Radiology (ACR) to standardize reporting of the screening LDCT results based on lung cancer risk. Retrospective application of the Lung-RADS criteria to the NLST results showed a potential reduction in the false positive rate, but also a decrease in sensitivity. The purpose of this study was to evaluate the distribution of LDCT findings by Lung-RADS categories in a rural Appalachia community hospital, determine the number of subsequent testing after baseline LDCTs, and the number of cancers identified and to compare these results to NLST baseline data.

**SETTING/METHODS:**

St. Claire Healthcare (SCR) is a 159-bed community hospital in NE Kentucky and is registered with ACR to perform lung cancer screening. Their lung cancer screening program commenced in 2015 and includes trained on-site radiologists who read all LDCTs and a data manager to ensure all data is entered into the ACR system. Annual reminders are sent out to patients by the radiology suite but shared decision-making and tobacco cessation must be performed and documented by the ordering provider. All readings follow the ACR Lung-RADS reporting criteria and data is uploaded into the SCR ACR database for tracking and monitoring purposes. In this retrospective cohort study, 1,045 patients received LDCT for lung cancer screening between August 2015 to August 2018 at St. Claire HealthCare (SCR). These LDCTs were reviewed and subsequent testing was performed using the Lung-RADS guidelines. We further assessed the number of subsequent testing (any) performed, and calculated the percentage that resulted in a cancer diagnosis. SCR results were then compared to NLST baseline LDCT results. Subsequent testing included follow-up imaging, biopsies, or any other procedures and the definition was mirrored as it was described in the NLST study. All study procedures were approved by the University of Kentucky and St. Claire Regional Medical Center Institutional Review Boards.

**RESULTS AVAILABLE OR PLANNED:**

There were a total of 1,045 patients who received a baseline LDCT for lung cancer screening between August of 2015 and August of 2018. Among baseline LDCT readings 87.4% were categorized as Lung-RADs 1 or 2, 6.7% as Lung-RADs 3, and 5.9% as Lung-RADs 4A, 4B, or 4X. (Table 2) These rates are comparable to the NLST Lung-RADS categorization rates found in Pinsky et al's retrospective analyses. In terms of subsequent testing and cancer diagnoses, we found 136 patients (13.0%) had further testing performed compared to 24.2% in the NLST study (Table 3). Eighteen (1.8%) of the 1,045 SCR patients screened were ultimately diagnosed with a lung malignancy compared to only 1.1% in the NLST study. More importantly, among those who had subsequent testing (n=136), 13.2% were diagnosed with cancer at SCR compared to 4.6% in the NLST study who had subsequent testing.

**CONCLUSION/NEXT STEPS:**

In this study, we are able to demonstrate how a small rural community hospital successfully screens lung cancer in a region with the highest lung cancer rates in the United States. Furthermore, through the application of Lung-RADS in their screening procedures, fewer subsequent testing procedures were conducted despite the high rate of lung cancer identified. To our knowledge, this is the first study demonstrating the feasibility of implementing LDCT screening guidelines in primary care practices in a rural community. We conclude that the application of the Lung-RADS reduced unnecessary testing; and when testing was warranted, Lung-RADS identified a higher rate of lung cancers compared to the NLST guidelines. Further research is needed to assess whether these findings are replicable in regions where lung cancer is comparable to national rates.

**P105: Feasibility of Targeted Screening for Poverty in a Large Primary Care Team**

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**BACKGROUND/SIGNIFICANCE:**

In Ontario, poverty affects up to 20% of families and is considered to be a very significant influence on the health of individuals. An evidence-based tool for poverty screening and intervention in primary care is available and effective, but physicians may not be able to screen all their patients due to time constraints. Objective: to test the feasibility of targeted screening and intervention for poverty across a large, inter-professional primary care team.

**SETTING/METHODS:**

Design: Process evaluation, survey. Participants: 80 North York Family Health Team (NYFHT) Physicians and their care teams in Toronto, Ontario, Canada looking after over 80,000 patients. Intervention: Following a successful pilot, all 80 family physicians in the NYFHT have been invited to participate in the study. A search for social and material deprivation, using postal codes and the Canada Postal Code Conversion File has been done. An alert will be placed in the EMR of those patients living in the most socially and materially deprived areas, for those physicians who agree to participate. The alert will prompt a member of the care team to screen for poverty, using two questions. Patients screening positive will be referred to a FHT Case Worker for assistance in supplementing income, and to free tax clinics. This will be evaluated at six and 18 months. Main and secondary outcome measures: number of patients identified, number of charts flagged with alert, number of patients screened, number of patients who saw the case worker, patient survey for acceptability of screening questions and satisfaction with case worker referral.

**RESULTS AVAILABLE OR PLANNED:**

Results: We expect reasonable feasibility and uptake of targeted screening. The study is currently in the analysis phase.

**CONCLUSION/NEXT STEPS:**

Conclusion: if this approach is feasible, it may provide a clinical pathway towards improved screening for poverty in routine Canadian primary care.

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**P106: Practice Facilitator Self-Assessment Tool Development and Outcomes**

*Wanda Truong, MSc.; Mark Watt, RN, BN; Lori Choma*

**BACKGROUND/SIGNIFICANCE:**

Practice facilitators are a key human resource in realizing transformation of the Alberta primary healthcare system. They are strategically positioned as a re-usable engine for change; can support primary care practices through multiple innovations that result in clinics exhibiting new behaviors' in the patient's medical home (PMH) model. In order to position practice facilitators for success, they need training and development appropriate to the Alberta context and the improvement they are implementing. One of the tools used to guide practice facilitator development at the organizational and individual level, is the Alberta primary care Practice Facilitator Self-Assessment tool.

**SETTING/METHODS:**

In 2013, a practice facilitator self-assessment tool was created with a focus on knowledge, skills and abilities for a specific improvement initiative that focused on improving rates of screening and prevention. However, as Alberta's focus has shifted toward the PMH, that is integrated with the broader primary health care system, further revision of the Practice Facilitator Self-Assessment Tool was required. Revisions have been made using a newly developed competency framework to ensure that practice facilitators are able to strengthen basic and advanced competencies skills, to enable them to support and sustain multiple initiatives beyond the implementation stage.

**RESULTS AVAILABLE OR PLANNED:**

In the journey toward an integrated PMH a robust competency set on which to build practice facilitator self-assessment was needed. This competency set has allowed the layering of knowledge, skills, and abilities to implement initiatives of varying degrees of complexity. It also informs where to focus training and development opportunities.

**CONCLUSION/NEXT STEPS:**

The Practice Facilitator Self-Assessment Tool is useful for individual practice facilitators, the organizations who employ them, and provincial zones to better understand strengths and areas of need in the workforce. Results can inform practice facilitator and program development. It is also an invaluable tool for practice facilitators themselves to reflect on their level of knowledge, skills, and abilities and identify development opportunities. Next steps include; continued content curation and building development opportunities for practice facilitators. There will also be an evaluation to see how practice facilitators themselves use the tool for their own self-directed learning.

**P107: Can I pick your brain..again? Top tips for practice facilitation**

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**BACKGROUND/SIGNIFICANCE:**

Although PBRNs are increasing in quantity and strength, there have been few attempts to expand the learning with the broader PBRN communities of practice. Practice facilitators have been present in PBRNs since the 1990's in the UK and the US but are not common in Canadian PBRNs. In Quebec there are four PBRNs, each affiliated with the Department of Family Medicine at the four medical schools. Building on our research into facilitation, we presented a poster at the NAPCRG PBRN 2018 conference, on which we left a blank space in which participants could answer 4 burning questions posed by our PBRN coordinators and directors, namely: 1) What qualities are most important in a good facilitator? 2) How do facilitators manage and maintain relationships with several clinical settings at a time? 3) What training would you recommend? 4) What are major "no-no's" - things to avoid? We asked experienced facilitators for ideas and comments on successful practice facilitation and facilitation training, with the goal of helping PBRNs to build practice facilitation structures on a solid platform. The objective of this poster is 1) to share the most resonant responses, new questions and comments collected and analyzed, and 2) to report the dynamics of our knowledge translation of these results through our PBRNs

**SETTING/METHODS:**

We content-analyzed participant responses to each of the 4 questions asked during the NAPCRG PBRN 2018, and responses of PBRN representatives to our efforts to disseminate or use the findings from analysis of these responses. The intention was to share what was collected during the previous conference, in expanding the community of practice among PBRN coordinators

**RESULTS AVAILABLE OR PLANNED:**

We refined an initial 45 categories of responses, across all four questions, to three major themes that support optimal facilitation and training for facilitation. These are: relatability, reliability and a technical-interpersonal skills training continuum. These results were disseminated and followed up among our PBRN networks. The results had variable uptake among the PBRNs, depending on time challenges, and the structures and processes of individual PBRNs. In particular, systemic support was the primary determinant of successful translation

**CONCLUSION/NEXT STEPS:**

The results provide a widely transferable guide of specific qualities and training elements for facilitation. They also underline the importance of structural or systemic support for successful knowledge translation efforts

**P108: The Relationship Between Practice Leadership and Key Driver Implementation Scale (KDIS) for Hypertension Practice Facilitation: Preliminary Data from the Southeastern Consortium for BP Control**

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**BACKGROUND/SIGNIFICANCE:**

The Southeastern Consortium for BP Control (SEC), is a large cluster randomized trial in the southeastern US investigating optimal strategies to improve BP control in rural African Americans with a history of uncontrolled BP. The study utilizes practice facilitators (PF's) who employ a standard working process called the Key Driver Implementation Scale (KDIS) to measure and drive improvement in each practice while implementing domains of activities that are rooted in the chronic care model. KDIS was originally developed by the NC AHEC Practice Support Program. The four KDIS domains are: 1) Optimal use of clinical information systems; 2) Standardizing care processes; 3) Engaging patients in self-management support; 4) Optimization of teamwork to provide high quality care. However, little is known about how practice characteristics influence the change in KDIS measures. One particular characteristic of interest is leadership, which is assessed by the PF's monthly rating of this domain along with the KDIS measures.

**SETTING/METHODS:**

The study's practice facilitation intervention was delivered over 12 months in 10 rural primary care practices in NC and AL [5 FQHC; 5 private/health system] by trained practice facilitators. KDIS measures in each of 4 domains were completed monthly in each practice by the practice facilitator and entered into ClinvestiGator, a proprietary web-based data system. KDIS measures for each month were summed to create a total score in each of the 4 domains as well as a Total KDIS score across all domains. The present analysis examined the correlation between these total KDIS scores achieved and level of practice leadership, also rated monthly by the PF, stratified by practice type (FQHC vs. private vs. health system). We also examined the correlation between leadership and the percent of the practice hypertensive patients who have controlled BP at 12-months (from EHR data).

**RESULTS AVAILABLE OR PLANNED:**

KDIS scores improved across all 10 sites during the 12-month intervention with a mean Total KDIS score (all domains) of  $101.7 \pm 19$  (range 80-140). PF rated total practice leadership score was highly correlated with Total KDIS score (Spearman rho = 0.92; p = 0.0001) and with two KDIS domain scores: Total Clinical Information System Score (Spearman rho = 0.93; p = 0.0001) and Total Standardized Care Process Score (Spearman rho = 0.86; p = 0.003). The correlation of total leadership to Total KDIS scores remained significant when the five FQHC practices were examined alone, but not when the five private/health system practices were examined alone. Total leadership score was also highly correlated with percent of patients with BP controlled at 12 months (Spearman rho = 0.77; p = 0.01). While data are presented for our initial 10 practices, we anticipate having complete data on 19 total practices for the June 2019 meeting.

**CONCLUSION/NEXT STEPS:**

These preliminary data underscore the importance of local practice leadership in facilitating the implementation of quality improvement efforts in rural practice settings. However, these relationships need to be examined in a larger sample of practices.

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**P109: Facilitating improvement to reporting technical infrastructure**

*Claire Ramey; Christie Pizzimenti, PhD; David Dorr, MD, MS, FACMI*

**BACKGROUND/SIGNIFICANCE:**

Extracting accurate clinical quality measures (CQMs) from the electronic health records (EHR) poses a dynamic challenge to clinics, many of which rely on reporting to meet requirements for CQM based incentive programs. Understanding the nuance and complexity of technical reporting can be prohibitively arduous and intimidating to clinic staff tasked with handling quality improvement (QI) efforts, as well as the practice facilitators who support their work. As EHR use has become ubiquitous, healthcare organizations expect more capabilities related to data and QI, and incentive programs expect clinics to be able to deliver increasingly complex reporting measures. Unfortunately, even with the most sophisticated EHR, reliably accessing accurate data remains as challenging as ever. Generally, practice facilitation has focused on clinical QI, but as reporting requirements expand, the need for informed technical practice facilitation, including direct technical assistance (TA), is necessary. Here, a framework and approach for comprehensive technical practice facilitation through the example of CQM reporting barriers is described.

**SETTING/METHODS:**

Forty-three clinics, with diverse staffing resources, reporting processes, reporting or technical knowledge, and roles were recruited to participate in Phase 1 of the Quality Reporting Document Architecture Category One Technical Assistance project (QRDA I TA), a CQM reporting approach, hosted by the Oregon Health Authority. To ensure each organization received comprehensive and tailored TA, we conducted surveys and interviews of key stakeholders and produced gap analyses (GA) detailing each organization's ability to produce CQMs, including in QRDA I format. The surveys and interviews of organization staff members explored the organization and its data challenges, current reporting processes, and barriers to QRDA I utilization, and concluded with recommendations for next steps to move toward QRDA I-based quality reporting.

**RESULTS AVAILABLE OR PLANNED:**

Our GAs uncovered a variety of concerns and gaps from which three themes emerged: (1) difficulties accommodating intricate CQMs or reporting needs in inflexible EHRs; (2) lack of staff time or ability; and (3) the outsourcing of reporting to non-EHR reporting tools or an EHR hosting organization (a decision often driven by the challenges of themes one and two). Informed by the needs highlighted in the GAs, we created vendor guides for seven EHR systems that provided step-by-step instructions for clinic staff responsible for reporting. To facilitate communication and knowledge sharing, we created and hosted weekly user work groups. Finally, a TA and facilitation plan was created to specifically address these gaps, including direct at-the-elbow support and at a distance. This multifaceted approach ensured that clinics were supported and received the resources their clinic needed. The success of the vendor guides, work groups, and finally TA are all dependent on the insight gained during GA research and preparation.

**CONCLUSION/NEXT STEPS:**

In order to meaningfully support clinic staff with varied levels of experience, knowledge, and resources, practice facilitators must tailor TA to the needs of individual clinics. The mixed methods employed herein are a comprehensive approach to ensure TA is appropriate to the needs and skills of a given clinic QI staff member.

**P110: Using Mental Health First Aid to Strengthen Community Behavioral Health Knowledge and Awareness**

*Katherine O'Hare, BSPH; Holly Ozgun, BSPH; Brisa Urquieta de Hernandez, BUS*

**BACKGROUND/SIGNIFICANCE:**

Approximately one in five U.S. adults live with a mental illness (MI). However, only half receive mental health treatment, and few of these patients see a mental health specialist. Even when treatment is recommended, stigma is a major obstacle to recovery. Community initiatives may improve the accessibility of mental health support and knowledge. Mental Health First Aid is an innovative community health program that teaches individuals how to identify, understand and respond to signs of mental illnesses to provide improved crisis intervention support.

**SETTING/METHODS:**

A large integrated healthcare system in North Carolina adopted Mental Health First Aid as a community benefit initiative. MHFA trainers facilitate an 8-hour course at no cost for community members and local organizations. Participants were invited to complete an online survey at 6 months and 12 months post course completion to identify whether respondents interacted with an individual experiencing a mental health crisis. Survey questions collected confidence, knowledge, and preparedness levels, along with qualitative data in the form of personal stories.

**RESULTS AVAILABLE OR PLANNED:**

Since implementing the community program in 2014, approximately 14,000 individuals have completed the Mental Health First Aid training. Between 2016 and 2018, 785 survey respondents reported post training experiences at 6 months: (1) 89% felt more confident in their ability to handle the real-world mental health crisis; (2) 96% felt more knowledgeable about signs, symptoms, and stigmas in mental health; (3) 69% felt more empathy toward someone with a mental health challenge; (4) 97% felt moderately to well-prepared to help someone experiencing a mental health challenge. Several respondents (n=286) noted using elements of the AGLIE MHFA Action Plan to assist the individual in a mental health crisis: 55% Assessed for risk of suicide or harm, 84% Listened non-judgmentally, 74% Gave reassurance and information, 65% Encouraged appropriate professional help, 57% Encouraged self-help and other support strategies.

During the same time period, 136 survey respondents reported post training experiences at 12 months: (1) 86% felt more confident in their ability to handle the real-world mental health crisis; (2) 93% felt more knowledgeable about signs, symptoms, and stigmas in mental health; (3) 76% felt more empathy toward someone with a mental health challenge; (4) 97% felt moderately to well-prepared to help someone experiencing a mental health challenge. Several respondents (n=62) noted using elements of the AGLIE MHFA Action Plan to assist the individual in a mental health crisis: 60% Assessed for risk of suicide or harm, 82% Listened non-judgmentally, 77% Gave reassurance and information, 74% Encouraged appropriate professional help, 42% Encouraged self-help and other support strategies.

Qualitative data shows a sense of community empowerment around addressing mental health.

**CONCLUSION/NEXT STEPS:**

MHFA training is effective for teaching community members how to identify, understand and respond to mental health illnesses. Future research should evaluate sustainability and cost effectiveness of implementing community mental health programs.

**P111: Shared Practice Learning & Improvement Tool. SPLIT**

*Stephanie Kirchner, MSPH, RD; Kellyn Pearson, RN, MSN; Kyle Knierim, MD*

**BACKGROUND/SIGNIFICANCE:**

The University of Colorado Practice Innovation Program was tasked with implementing two large Center for Medicare and Medicaid Innovation (CMMI) grants. The State Innovation Model (SIM) and the Transforming Clinical Practice initiative (TCPi). Both of these projects include working with Practice Transformation Organizations (PTOs) who employed Practice Facilitators (PFs) and Clinical Health Information Technology Advisors (CHITAs). To facilitate coordination, communication and data collection for evaluation and quality assurance we have created a web accessed application.

**SETTING/METHODS:**

Multiple Colorado statewide initiatives that involved primary care and specialty practices and Practice Transformation Organizations that were supporting their practice transformation.

The Shared Practice Learning and Improvement Tool (SPLIT) was created as a data repository for practice demographic including contact information and clinician details such as NPI for tracking purposes for each initiative. Functionality for PFs and CHITAs to be able to enter field notes was incorporated into SPLIT with the ability for task management. Reports were also generated from the data entered into SPLIT or via Qualtrics reports that was easily available to the PTO staff as well as the practice. By applying parameters to user accounts only approved users were able to see each practice's data.

**RESULTS AVAILABLE OR PLANNED:**

SPLIT access and functionality has been implemented with all of the PTOs and participating practices in the SIM and TCPi initiatives. It is being used to collect field notes for both projects from both PFs and CHITAs on an ongoing basis. Initiative specific assessments and tasks to be completed are available in SPLIT with start and end dates to meet deliverables. Reports generated from Clinical Quality Measures (CQM) submissions are available in graph format to the PTOs and practices to evaluate their improvement progress.

**CONCLUSION/NEXT STEPS:**

SPLIT access and functionality has been implemented with all of the PTOs and participating practices in the SIM and TCPi initiatives. It is being used to collect field notes for both projects from both PFs and CHITAs on an ongoing basis. Initiative specific assessments and tasks to be completed are available in SPLIT with start and end dates to meet deliverables. Reports generated from Clinical Quality Measures (CQM) submissions are available in graph format to the PTOs and practices to evaluate their improvement progress.