

Measuring Your Progress:

Approaches, Experience, and Considerations

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Agenda for Today

- **Req. #1: Measurement of the % of Children Screened**
 - From Planning to Action
 - Re-review key criteria and issues to consider by potential data source
 - Tips for improving/enhancing current planned approaches submitted in pre-work reports

- **Req. #2: Additional Evaluation Measure**
 - Review the goal for the add. evaluation measure
 - Review potential measures to consider, related issues

Measure Mantra –

What must you have to create a measure

- A denominator
- A numerator
- A clearly specified, standardized strategy for **collecting** the data
- Clearly specified scoring methodology
- Mechanisms for reporting and interpreting results
 - Think of how the reporting can guide improvements
 - Characteristics of those NOT screened

Evaluation Measure Mantra –

- Need a pre (baseline) and post (follow-up) data
- Measure and measurement data collection strategy need to be anchored to the intervention

Required Measure #1: % of Children Screened

Numerator: Children aged 0-3 screened to identify developmental *and* (if applicable to project) social-emotional concerns

Denominator: Children aged 0-3 who should have been screened to identify development *and* (if applicable to project) social-emotional concerns

* Important to note that this is a child-level, not a provider or office-level, measure (so can't use a provider survey)

Important Clarifying Questions: Need to be Confirmed for Each “Unit of Analysis”

Clarifying Questions About the Numerator:

- **What** “counts” as a screen?
- **Who** should have been screened?
- **When** should the screening occur?

Important Clarifying Questions: Need to be Confirmed for Each “Unit of Analysis”

Clarifying Questions About the Denominator:

- Who should be included in the denominator?

OR in other words

What children should have been screened?

- **Age requirement**
- **Visit requirement**
- **Need requirement?**

Measurement Tips Specific to Each Data Source

Data Source #1: **CLAIMS DATA**

Key Issues to Clarify When Using Claims Data:

Numerator:

- **What billing code(s) will be used to identify whether standardized screening occurred?**
- **Is that code routinely used?**
 - For the required measurement of screening in the pilot practices, claims data should **ONLY** be used in the states with established use of and understanding about the applicable billing codes
- **Can that code be routinely used in the context of well-child care?**
- **Are there limits to when and at what visits that code can be used?**
- **When and how often should screening occur?**
- **Data lag?**

Data Source #1: **CLAIMS DATA**

Denominator:

- **Who should have received screening?**
- **Potential criteria for defining “eligible” children”**
 - Visit
 - Age of child
 - Length of enrollment
 - Language
 - Need (e.g.: What if child has already been identified with delays or at risk?)

Data Source #1: CLAIMS DATA

Tips/Issues to Consider Based on Review of Pre-Work Reports:

- **I need to “claim” my worry about claim’s data for evaluating the practices**
 - **#1: Policy-level, practice-level improvements most likely needed in order to make the claims data valid measurement purposes**
 - **#2: Ability to analyze the data at the practice-level**
 - **#3: Ability to quarterly report data to the practices (data lag issues, etc)**

Data Source #1: CLAIMS DATA

Tips/Issues to Consider Based on Review of Pre-Work Reports:

- **Pilot test approach BEFORE you begin (e.g. ASAP)**
 - **Validity of the Claims data for this purpose**
 - Go beyond whether the claim for screening is valid and feasible for practices to use, but whether the claim when submitted with the identified visits and for the age-specific groups is feasible.
 - If the screening is inc. into the EPSDT claim reimbursement (so only an EPSDT visit claim submitted), it is not rec. to simply use EPSDT rates
 - Can't assume that if EPSDT visit billed than screening occurred.
 - **Practice-level and/or provider-level data**
 - Key Issues Observed in Using Enrollment/Claims Data
 - If there is one central billing office for more than one office, it can make office and/or provider-level analysis unreliable
 - Provider-level analysis (if not all providers participating in the office)
 - » Medicaid claims data – Provider identified for the visit is the one to which the child is “enrolled”
 - » May not be who they actually saw.
 - **Data Lag**
 - Length of time from when the claim submitted to when it can be gathered and reported to the practice.

Data Source #1: CLAIMS DATA

Tips/Issues to Consider Based on Review of Pre-Work Reports:

- **Remember this is a child-level measure**
 - So did a child with a specific visit, get the rec. care.
 - NOT a measure that is based on counts for the numerator and counts for the denominator
 - Example of a problem with this approach: *One child (e.g. child 18 months old) may have been screened twice*
- **Maintain consistency in the unit of analysis**
 - Collect data over time for the same unit of analysis
 - For example: Avoid doing practice-level at baseline and health plan level at follow-up

Data Source #1: CLAIMS DATA

Tips/Issues to Consider Based on Review of Pre-Work Reports:

- **Consider each aspect of the denominator, improve definitions**
 - Most states identified criteria based on age, visit
 - Other criteria to consider/specify
 - **Length of enrollment criteria**
 - Especially imp. if you are assessing whether screening happened over a length of time (e.g. In the last 12 months)
 - **Consider the age criteria and make sure it is anchored to screening recs. In your state**
 - Example: Age range of **0-3**, **0-5** or **3-36** months?
 - » AAP Statement: Children younger than 9 months not rec. to have screening (*State could choose to make a state-specific recommendation*)
 - Example: Children 26 months of age, screened at any time since 12 months
 - » This allows for a 2 month lag in visit (perhaps consider 26.99)
 - » Assesses 12 month, 18 month and 2 year visit (Is state rec. screening at 12 month visit?)
 - **Need**
 - Example: Should children from whom certain diagnoses and/or referred services be excluded?

Data Source #2: **Medical Charts**

Numerator:

- **What specific tools count for standardized screening?**
- **Do the completed tools need to be in the chart?**
 - If so, this needs to be clearly explained to the sites being measured
- **What if the practice gave the survey to the parent to fill out at home?**
- **When and how often should screening occur?**

Denominator:

- **Who should have received screening?**
 - Potential criteria for defining “eligible” children”**
 - Visit
 - Age of child
 - Language
 - Need (e.g.: What if child has already been identified with delays or at risk?)

Data Source #2: Medical Charts

- Unit of analysis
 - Office?
 - Provider-level?

 - Age-specific sampling strategy
 - Stratified by age?
 - An example is to anchor the sampling to the AAP recommendations:
 - 5 charts – 9 month visit*
 - 5 charts – 18 month visit*
 - 5 charts – 30 (or 24 month) visit*
- * Very important to take into account delays from when the child comes in for the 9-month visit. (e.g.. Child is 10-months old when they have the “9-month” visit)

Data Source #2: Medical Charts

Tips/Issues to Consider Based on Review of Pre-Work Reports:

- Consider easy approaches for the practices to collect this data
- Make sure completed tools are in the charts, or there are standardized methods for where tool results are documented
- Clarify additional eligibility criteria for who should have been screened beyond visit and age
 - Language
 - Need (*e.g. What if the child has already been identified with delays or at risk?*)
- Pilot test medical chart abstract instructions.
- Determine a starting sample that will give you valid and useful information that is also feasible for the practices to collected
 - Example #1: 30% of Medicaid eligible children
 - Example #2: Pick X number of charts per month
 - Again, here try and make it specific to the people conducting the QI
 - If you using the medical chart reviews to gather information about care for children identified at risk, need to consider this in determining sample size

Data Source #2: Medical Charts

Tips/Issues to Consider Based on Review of Pre-Work Reports:

- **If possible, collect information about the results from the tool**
 - Number of children identified at risk
 - Kinds of risk identified
 - This descriptive information can help guide program and policy level improvements
 - Puts a number on “what to expect” should state start screening

Data Source #3: **Parent Report**

Key Issues Specifically Related to Using Parent Report:

Numerator:

- What survey items accurately assess the standardized screening conducted?
- Potential criteria for identifying eligible children whose parents will receive the survey:
 - Visit
 - Age
 - Language
 - Readability
 - Need requirement? What if the child is already identified at risk/with delays

Potential Data Source #3: **Parent Report**

Other Key Issues Specifically Related to Using Parent Report

- Mode effect
 - Systematic differences in survey responses obtained by mail vs. telephone vs. in-office vs. online
 - Needs to be considered if one mode is used at “baseline” and a different mode is used at “follow-up”

Potential Data Source #3: Parent Report

Tips for Enhancing Feasibility of Measurement Efforts

- **Be sure to give the survey to those who should have received the intervention and can report on the intervention**
 - Sampling and time frame used in the survey needs to be anchored to intervention
- **Use valid survey items** already developed to assess whether a parent-completed developmental and behavioral screening tool was administered.
 - Developed by the CAHMI. More info at: <http://www.cahmi.org/>
 - Items are also included in the 2007 National Survey of Children's Health
- **If developing new survey items**, it is important to do conduct **cognitive testing** on items
- **Consider a survey that includes items on screening AND other evaluation measures**
 - Again, consider adding items from validated surveys for which national and/or benchmark data is available

Questions?

Requirement #2: Additional Evaluation Measure

Additional Evaluation Measure

- Development process for eval. measures
- Potential data sources noted by Screening Academy states and potential measures/strategies to consider
 - Claims Data, Medical Chart Review, Parent Report
 - Provider and office staff experiences
 - Parental experiences
 - Screening for maternal depression

Additional Evaluation Measure: Impt. Development Process

- Identify informational needs of key stakeholders
 - Information to **guide and inform** policy-level improvements
 - Information to **aid in the “push” for policy-change** (e.g. to “sell” this approach in terms of the validity and value)
 - Information to aid in the **“spread” of screening to other practices**

- Ask the question of your stakeholders – what information do you need to believe the value and relevancy of developmental screening in our state?

Additional Eval. Measure

Screening for Maternal Depression

- Issues very similar to what is outlined for the % of children screened
 - The measure is still anchored to the child: % of children whose parent was screened OR whose mother was screened.
- Build off ABCD II state experiences
- Potential data sources:
 - Claims data
 - Medical charts
 - Parent report
 - Here you can include items that assess whether the parent is currently experiencing symptoms of depression to see if depressed parents were screened.

Additional Eval. Measure

Potential Data Source: **CLAIMS DATA**

Examples of Potential Evaluation Measures Assessing Child's Care:

– **Referral Rates**

- Again, a measure has a numerator and denominator
- Most states only able to create an indicator (numerator only)

– **Well-Child Visit Rates**

- Hypothesis: Screening enhances the value and relevancy of the well-child visit to the parent and he/she may be more likely to bring the child in for a future well-child visit
- Recommend an age-stratified approach
- Most likely not able to be fully assessed during the length of the screening academy (especially for children 2 and older who come in annually)
 - Consider this as an ongoing measure – beyond SA
 - Consider the 18 month and 3 year visit (HEDIS measures)

Additional Eval. Measure

Potential Data Source: **Medical Chart**

- Review learnings from ABCD II states regarding the feasibility referral/treatment measures
 - Many had difficulty collecting information and defining a numerator and denominator that could easily be identified in the medical chart

Examples of potential additional evaluation measures:

- Children at risk, % referred for services* (ABCD II, Measure #2)
 - To be feasible, valid need to define what services should be referred for what risk
 - Chart abstraction form needs to be specific to the tool used
 - Not all children identified at risk should be referred
- Children at risk, % who received follow-up services by the primary care provider who screened the child* (ABCD II, Measure #3A)*
 - For some risks, appropriate care can be provided by PCP
 - » Can include screening using another tool (e.g. ASQ-SE)
 - » Depends on the screening tool used
 - » Depends on the internal resources to that office

Additional Eval. Measure

Potential Data Source: **Medical Chart**

- Children at risk, % who received referred services (ABCD II, Measure 3B)*
 - Lag time between when the child is referred, when they receive the service, and when communication back to the primary care provider is received needs to be accounted for in designing the measurement approach.
- ***Important Note:**
 - If you choose a measure that specific to children identified at risk, you need to consider this in the proposed sampling.
 - Only a % of children will be at risk (depends on the tool – can be 7-25%)
 - » Therefore if the overall starting sample size is too small, you get too few charts with children identified at risk

Additional Eval. Measure

Potential Data Source: **Parent Report**

Examples of additional evaluation measures:

– **Developmental Surveillance**

- Whether he/she parent asked if he/she had concerns about their child's learning, development or behavior and whether these concerns were addressed.
- These items are included in the 2007 National Survey of Children's Health and the Promoting Healthy Development Survey.

– **Anticipatory Guidance and Parental Education**

- Recommended anticipatory guidance and parental education and whether parents' informational needs are met on these topics.
- Topics assessed include physical care of the child, development and behavior, and injury prevention.

– Whether the child's parent was **screened for depression**

– **Medical home**

- Items assessing components of the American Academy of Pediatrics definition of medical home.

– **Care Coordination**

- Related items are in the NSCH, NS-CSHCN, NSECH and PHDS.

Additional Eval. Measure

Potential Data Source: Parent Report

Examples of additional evaluation measures:

- **Parental experiences of care and satisfaction with the screening implemented through the Screening Academy.**
 - Quality of discussions with their child's health care provider focused on their child's social and emotional development.
 - Experiences with completing standardized screening tools.
 - Effect of the standardized development screening tool on discussions with the child's health care provider and perceived value of the well-child visit
 - Experiences with how their child's health care providers communicated the results of the screening tool to them.
 - Potential increased knowledge about their child's social and emotional development. Potential increased knowledge about what they can do to enhance their child's social and emotional development.
 - Suggestions for improvements to the screening, referral and follow-up process.
- **Items about child and parental health and parenting behavior outcomes**
 - Measures related to child and parental health outcomes are included in the NSCH, NS-CSHCN and PHDS.

Additional Eval. Measure

Potential Data Source: Providers & Office Staff

- Potential data sources:
 - Survey
 - Structured interviews
 - Focus groups
 - Office system inventories
 - Carefully think about the design so you get qualitative and quantitative information

- Get input/feedback from the team that had a part in making the screening happen
 - Providers
 - Office team; including the physician, nurse or nurse practitioner, medical assistant, front-desk, and other office staff.

Additional Eval. Measure

Potential Data Source: **Providers & Office Staff**

Potential topics to focus on:

- Influence on knowledge and comfort with assessing a child's social and emotional development.
- Experience with implementing standardized screening.
- Experience with treating children identified with social and/or emotional delays.
- Influence on knowledge and comfort with addressing children with delays in social and/or emotional development.
- Experience with referring children for follow-up services.
- Influence on knowledge of referral resources.
- Suggestions for improvements and suggestions for increasing the sustainability of the ABCD II efforts.
- Standardized office systems related to prev. and developmental care

Additional Eval. Measure

Potential Data Source: Providers & Office Staff

*Build off existing provider surveys, data collection mechanisms**

- Examples from the ABCD II states in the Measurement Paper
- AAP Surveys of Fellows
 - A list of the surveys conducted by the AAP Survey of Fellows can be found at <http://www.aap.org/research/periodicsurvey/>
 - CAHMI developed provider survey that inc. items from various AAP surveys and developed new items (App K in paper)
- Office System Inventory
 - *Office System Inventory (OSI)* developed by the *Healthy Development Learning Collaborative* and found in Appendix N of the measurement paper.