

Lessons Learned from the ABCD Screening Academy States Measurement Efforts for ABCD III/Future Screening Academies

General Learnings Regarding Measurement

- For some states, eighteen months seemed to be too short a period to recruit demonstration sites, design the intervention, and collect baseline and follow-up data collection.
 - Twelve states were able to report their “follow-up” data findings, while the rest are in the process of obtaining the data. Of the states who did report evaluation data, all of them noted that they planned to collect this data at a time period after the final reports were due:
 - In particular, states using claims data to evaluate their efforts needed to wait until the end of the year and/or until the claims data was accurate for the reporting period before conducting measurement efforts (CT, OH, MN).
 - Five states (CO, MN, NJ, OR, PR) provided baseline data only because they were at the start of the demonstration site implementation at the time the final reports were due. Most of these states had made improvements in policies and planned to continue their ABCD efforts beyond the screening academy timeline.
- Recognize that measurement requires resources to: a) design the measures and measurement strategy and b) to implement the measurement strategy. Ensure that applicants note how these two components will be addressed and what resources will be used. Secondly, limit the number of measures required.
 - States for whom the measurement effort was less than hoped for had limited resources or worked with sites that were limited in resources. Therefore, they focused their efforts primarily on the demonstration site use of developmental screening tools or on policy level improvement.
 - Measurement is still not a routine part of providing care and is something that provider and office staff still struggle with co-participation.
 - Measurement is often seen as crucial in terms of motivating change, spreading changing, or rewarding performance.
 - For all of the sites, the baseline measurement was not being used to motivate them to want to participate in the project. They volunteered and were selected based on their established interest and commitment. Therefore, it seemed that some states had a problem “justifying” the time and resources needed for the baseline measurement.
 - Ensuring that the measurement strategy used for the ABCD III meets the reporting requirements for Part 4B of the certification

could increase the value of measurement efforts and therefore lead to more support and/or resources.

- Allowing flexibility in the approach used by states for measurement limits the standardization of the measures and the ability to summarize data findings across the Screening Academy.
 - The ABCD SA allowed a high-level of flexibility and individuality in the demonstration work of practices (most likely a key to its success). For example, some states focused on statewide spread, while others worked with an individual practice.
 - This flexibility allowed for significant variations in the approach that each state took to how measures were collected and reported.
 - Therefore, while there was standardization in the measure that was required, there was not standardization in the methods used nor in the unit of analysis. This made it cumbersome to summarize the measurement findings across all of the screening academy states.

Team Composition:

- Require applicants to specify who on the team will focus on measurement and past skills/expertise that they have in this area. Just like you have requirements for someone from Medicaid, provider-organization, etc. I think it is important to recognize and note that “measurement” is a component of the work and someone will need to “own” and be responsible for the measurement piece.
 - States who were successful had persons on their team with past measurement experience and/or a person who “woke and worried about” how the measurement piece was going to be developed and implemented.

Interim and Final Report Templates:

- For the required measure(s), ensure that the reporting template requires them to report the numerator, denominator, unit of analysis, and sampling frame.
 - This requirement for the ABCD SA was helpful in anchoring states to what specificity is needed and enabled NASHP/CAHMI staff to quickly identify states with potential issues.
- Enhance the reporting requirement related to the unit of analysis.
 - If they are collecting data at the office-level, ask them to indicate the number of offices for which data was collected. Also ask them to report the office-level data, not just the aggregate across all the offices.
- Add a requirement that states submit their measurement specifications for review. If a state is going to do measurement, they need to create specifications for how the measures are collected. This requirement therefore would not be “additional work”

- If you want detailed information about the “additional” evaluation findings in order to be able to summarize the findings, require the states to submit descriptive materials and key findings.
 - A general question in the report template asking them to provide the descriptive information provided for the required measure was not successful in the ABCD Screening Academy report templates.
 - That being said - I would not recommend that too many measures be required of the ABCD III. Especially given the complexity of measuring care coordination, I would recommend that you think about the measure(s) that are most important and standardized across the possible demonstration sites and keep the focus on those measures.

Technical Assistance Needs:

TA Needs: Materials to Guide and Inform Measurement Development

- Create standardized tools and resources for the states.
 - The measurement cheat sheets seemed to be helpful in guiding people through the key questions to ask and issues to consider.
 - However, some states still seemed limited in being able to design a measurement strategy using a flexible framework and had difficulty customizing it to their site(s) needs.
 - If more standardized methods and specific instructions could be required about how a state MUST measure the required indicators, then this may ease the burden on the states.
 - However, this may be very difficult to create this level of specification given the valid and important variations that are expected in the ABCD III states’ approaches to care coordination.

TA Needs: Technical Assistance and Consulting

- **Proactive review** of measurement materials is necessary.
 - Many of the states who needed the most technical assistance were not the states that requested the assistance.
 - A key component of the assistance needed is a review of the measurement specifications created by the state team and used to collect the data. It should be required that states provide their measurement specifications for review and comment before they are finalized.
 - Specific, tailored consultation is needed for states and should be focused on developing valid, sensitive measurement strategies that detect the intervention, specifications for sampling, sample size estimates for each intervention site or statewide, specifications for how both baseline and follow-up data can be collected, specifications for identifying the denominator for the measure, feasible methods for how to collect the data in pediatric office settings, and valid methods for analyzing and scoring the data collected.

- This assistance goes beyond the general tools and materials provided and needs to be tailored and specific to the state’s project and demonstration sites.
- The most common problem that states had was in specifying and identifying the “denominator” of children for the measure.
 - Many states struggled with who should be in the “denominator”. Some states included children who should not be in the denominator (e.g. who should not have been screened) in their measurement specifications. This “diluted” their findings and/or resulted in additional sampling or data collection needing to be performed.
 - For the ABCD III this will be integral issue as it will be important to determine feasible and valid methods for identifying which children should have received care coordination.

TA Needs: Data Collection and Reporting

- For the ABCD III it might be interesting to consider the support of tools and resources that can be used for data collection, analysis and reporting that will require less staff time and resources.
 - For example, standard access data entry forms/online data entry forms built for the specific measures to be collected in the ABCD III.
 - These forms could be used to enable staff or others to enter the child-level data.
 - Automated systems could be built that would score the data for the practice and/or one central consultant could be hired that would analyze the standardized data collected in each site.
- If a parent survey is considered for the ABCD III, CWF could consider building a standard online survey that could be used across all of the ABCD III states.
 - This approach would greatly decrease the costs for administering a survey in the sites, be less time intensive for the sites, and could standardized the data collected and reported.

Limitation to Any Technical Assistance Provided:

- Technical assistance is only valuable to states who have the motivation and resources to improve their measurement and evaluation activities. The structure of the ABCD Screening Academy was such that the implementation of evaluation data methods was dependent on the state team and internal resources secured for these activities. Only through co-participation by the states was the technical assistance provided able to meet the state needs and address weaknesses.

Specific Learnings Regarding Measurement Data Sources:

- **Claims data:** Only one of the states (AR) using state Medicaid claims data was able to provide the demonstration sites with baseline and follow-up measurement data regarding their improvement efforts. The improvement rate they observed was an increase of 14%.
 - Many states used the claims data to track increases in the number of claims submitted (therefore an indicator for screening, but not a measure of screening). This information seemed to be valuable in advocating for policy-level improvements and support for practice-level spread.

- **Medical Charts**
 - A majority of the sites who were able to report baseline and follow-up findings by the time of the final report used medical chart reviews and/or internal office “log” or tracking sheets.
 - States who had problems with obtaining accurate data from the medical charts often did not have detailed measurement specifications and directions for the chart review.
 - Each field or component of data collected in the medical chart needs to be defined accurately (e.g. The field of “screening” should be defined as what specific tools count for screening and what documentation is required) and the staff conducting the chart reviews trained appropriately.
 - Measurement specifications need to include directions for dealing with more “complex” children.
 - Alaska noted difficulty in getting accurate data about what happened during well-child visit when the parent had more than one child with him/her who was having a well-child visit.
 - Some states noted the difficulty of knowing whether a child who had already been identified was included or excluded from the measurement.

- **Parent Survey**
 - A number of the states who used parent surveys reported low response rates. This will be an important issue to address directly, up-front in the ABCD III so that methods and strategies that can be used to ensure high response rates can be used. This includes communication materials used in the office, framing used in the cover letter, and other incentive-based strategies.