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Measuring the "Fruits of Your Labor"

Tips and strategies to identify, develop and implement measures to assess screening and evaluate your Screening Academy Efforts

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Goals for Today

- General overview of key measure attribute and data sources

- Outline design parameters and issues to consider in measuring the **percent of children** aged 0-3 screened to identify developmental concerns
  - Discussion anchored to three potential data sources, key issues to consider, and tips for enhancing the feasibility of measurement activities.
    - Claims Data
    - Medical Chart Review
    - Parent Report
  - Discussion by ABCD Alumnae about their experiences in using these data sources and tips for enhancing your efforts.

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"Not everything that can be counted counts, and not everything that counts can be counted."

Albert Einstein

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Why Measure?

*Why is this a **required component** of the Screening Academy?*

- Goal for the Screening Academy is to influence:
  - Policy-level improvement
  - Practice-level improvement
- What is measured is what is focused on
  - Valid and standardized measures can speak volumes
    - Testimonies can actually increase in value and saliency when proceeded with quantitative data
- Measures answer the questions "why is this activity important"
  - Measurement will enable/empower informed policy level improvement
  - Measurement can empower practice-level improvement.
  - Evaluation measurement informs improvements to implementation
- Measurement needs to be a primary component of a project, **FROM THE START**
  - Reliable and valid measures only collected if the measurement strategy is thoughtfully and carefully designed at the beginning
  - Measurement needs to be feasible

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Value of Quality Measures

- Measurement of Implementation in Pilot Practice(s)
  - Percent of children screened
  - Other evaluation measure
- Consider the role of quality measures as part of the policy-level improvements.
- Potential examples:
  - Measures assessing state quality strategy
  - Measures evaluating ESPDT care
  - Req. performance measures of MCOs
  - Required measures evaluating Performance Improvement Activities
  - Measures for Pay-for-Performance

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What is a "measure?"

- A concept is not a measure!
- A measure has:
  - A denominator
  - A numerator
  - A clearly specified, standardized strategy for collecting the data
  - Clearly specified scoring methodology
  - Mechanisms for **reporting and interpreting** results

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Desirable Measure Attributes:

- Valid
- Reliable
- Standardized Methodology
- Feasible
- Sustainable
  - May be valuable to think about measures used to evaluate the practices that could be incorporated into other state activities
    - Req. performance measure
    - Measure to assess performance improvement project activities

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Additional General Measurement Issues Learned from the ABCD Experiences

- Importance of child-level measures
  - Measures of how one child experiences multiple components of care
- Measurement strategies need to be specific for each unit of analysis
  - For example, if there are multiple practice sites
    - Sample size and data collection need to be adjusted per site, but standardized methods maintained.
- Pilot testing of measurement approach is crucial
  - Avoids measures with incomplete, non-valid data
  - Identifies areas of confusion in measurement approach.
- Continued technical assistance and periodic quality checks necessary
- **Periodic reporting of measurement findings is essential to continue participation and buy in about the value of measurement**

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CAVEATS

- Quality measurement is complex
- No perfect measures
- No perfect method or source for data
  - All data sources have benefits and drawbacks.
  - All approaches have strengths and weaknesses

Goal:

Chose the measurement approach that feasibly yields the most valid and reliable measure possible

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Sources of data for quality measurement: Claims Data

- Pros
  - **Codes are tied to costs**
    - **Improvement in measures = Increased Payment for Practices**
  - **Diagnostic specific codes**
  - **Can be relatively easy to obtain**
    - **Many systems have built in infrastructure (staff, capacity and skill) to run this data**

- Cons
  - **Claims data limited to the "owner" of the claim**
    - **Practice-level data can be difficult given the multiple payers**
  - **Completeness, quality and accuracy of data vary**
  - **Just because a code is there, does not mean it is used**
    - **Screening codes may be "blocked' by algorithms related to well-child care**
  - **Time lag in availability of data for new enrollees**
  - **"Carve outs"**
  - **Limited to "users" -- tells if service used not if those who needed it "got it" or those who "got it" needed it or if those who "got it and needed it got good care"**
  - **Denominator of children will vary depending upon type & number of codes chosen for inclusion**

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Sources of data for quality measurement: Medical record

- Pros
  - **High level of clinical detail about diagnostic data, provider assessment and plan**
  - **Screening tools may be in the chart**
    - **This is important to confirm**
  - **Condition-specific information, if the condition has been identified**
  - **May contain info not available thru administrative or patient reported data**
  - **Data is within the participating practices, therefore it may be easier to obtain from them through the participation in the pilot**

- Cons
  - **Limited to screening that occurs in the practice**
  - **Can be expensive & time consuming to collect, requires practice participation**
  - **Incomplete data about discussions, degree to which parents needs met**
  - **Clinician variability**
  - **Not a reliable, valid source of specific information about the discussions that happened during a visit**

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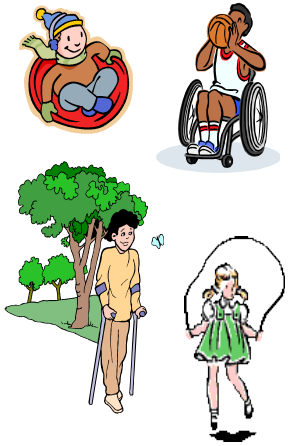
Data Source #3: PARENT REPORT

PATIENT EXPERIENCE of CARE

STRUCTURE of the HEALTH CARE SYSTEM → PROCESSES OF CARE → OUTCOMES OF CARE



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Sources of data for quality measurement: Patient or family survey

- Pros
  - Parents most often the most valid reporter about 1) what happened during the visit and 2) child health characteristics
  - Care experiences from patient perspective can be highly relevant information to providers
  - Can ask the patient about multiple processes of care in multiple settings
    - Screening plus experience with screening, degree to which needs met, developmental surveillance, etc.
  - For screening rates, national data will be available via the National Survey of Children's Health
- Cons
  - Can only assess what is communicated with the parent and/or involves the parent
  - Can be expensive & time consuming to collect
    - Many! opportunities for reducing cost if administered through/in the practice
  - Response rates can be a challenge
  - Misconceptions about the validity of parent report about processes of care

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Required Measure #1: % of Children Screened

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

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

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% of Children Screened: Key Measurement Design Parameters

- **Child-level measure**
  - Percent of children
- **Only screening that is conducted with a standardized, documented tool will be counted.**
- **The screening tools may not be the same within a state.**
  - If so, tool-specific measurement methodologies need to be developed.
  - This will need to be noted as it decreases the standardization of the measures across the state and lowers the ability to summarize the information at a state-level.
- **Measurement needs to be specific to the unit of analysis**
  - Office?
  - Provider-level?
- **For evaluating the practices, the data source needs to be the SAME throughout the measurement process** (e.g.. At baseline and follow-up)
  - Standardization is imperative.

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

Clarifying Questions About the **Numerator**:

- What "counts" as a screen?
  - Which tool (s) meet requirement of "standardized tool"?
- How will you know if a screen occurred?
- When should the screening occur – what is the appropriate periodicity?
  - Example: AAP periodicity: 9, 18 and 24 (or 30 month)
  - Will most likely result in the need for a stratified data collection strategy
- What level of screening should occur for children who have already been identified at risk for delays?
- Does the screening have to be conducted by the practice?
  - If linkages to community systems result in screening and information is shared with the practice, does the practice "get credit"

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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 using a standardized tool
  - **Age requirement?**
  - **Visit requirement**?
    - Only children who had a well-child visit?
      - » Only specific well-child visits?
  - **Need requirement**?
    - Are children already identified with delays include the denominator
      - » If not, are there reliable, valid and feasible ways to remove them from the denominator?

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Potential Data Source #1: CLAIMS DATA

Key Issues Specifically Related to Using Claims Data

Numerator:

- **What billing code(s) will be used to identify whether standardized screening occurred?**
  - For example: CPT Codes 96110 or 96111or state-specific HCPCS codes
- **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?**
  - How long does it take for a claim to appear in the data from when it was submitted?
- **Source for the claims data?**
  - Information then limited to that data source. For example: Medicaid claims date used, you will only know screening rates for the Medicaid clients

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?)

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Potential Data Source #1: CLAIMS DATA

Tips for Enhancing Feasibility Of Measurement Activities

- Develop standardized methods for claims data analysis
- Anchor measures to existing activities and resources
  - Identify staff and resources currently analyzing related data
    - EPSDT measures
    - Well-Child Visit
    - Req. performance measures of MCOs that the state collects
    - Req. performance measures the EQRO collects
- Periodically report and use the measurement findings

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ABCD Alumnae Experiences:

Using **Claims Data**

Debbie Saunders (Illinois Medicaid)

& Sherry Hay (Office of Rural Health and Community Care)

- Highlights and learnings from using claims data?
  - What are key design parameters that needed to be clarified?
  - What were the clear benefits of this data source?
  - What are barriers?
  - What advice to do you have for the Screening Academy states planning to use claims data to create a measure of screening?
    - Issues related to identifying numerator and denominator?
    - Tips for enhancing feasibility?

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Potential Data Source #2: Medical Charts

Primary data source used by the ABCD II States.

Key Issues Specifically Related to Using 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?)

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Potential Data Source #2: Medical Charts

Other Key Issues Specifically Related to Using 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)

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Potential Data Source #2: Medical Charts

Tips for Enhancing Feasibility of Measurement Activities

- Develop standardized methods for how charts are identified, audited and the findings reported
- Data collection tools need to be feasible and easy to understand
  - Define terms; Easy to complete; Easy to return
  - Pilot test data collection tools with people who will be completing them
- Build off the medical chart abstraction tools dev. by ABCD II states
  - Examples provided as Appendices in the measurement paper
- Require screening tool to be in the chart
  - Examples provided as Appendices in the measurement paper
- If possible, collect other evaluation measures at the same time
  - Pick aspects of care for which there is a clear numerator and denominator identifiable in the chart.
  - If possible, Incorporate chart-based checklists or screening tools as part of the screening implementation that can be used for measurement

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Potential Data Source #2: Medical Charts

Tips for Enhancing Feasibility, Sustainability

- **Periodically report the findings** to the providers of the care being assessed AND to those assisting in the survey administration

- **Consider the length of time and amount of chart audits**
  - Consider "baseline", "middle" and follow-up periods.
  - Set discrete goals and time periods. Then practices know what to expect.

- Where possible, **identify existing medical chart review activities** and "add on" this component
  - EPSDT chart reviews?
  - Required performance measures?

- **Consider methods for reducing the costs** of entering the medical chart data
  - ACCESS forms similar to what is used in North Carolina

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ABCD Alumnae Experiences: Using **Medical Charts**

Scott Lindgren : Iowa Medicaid

- Highlights/Learnings from Using Medical Charts
  - What are key design parameters that needed to be clarified?
  - What were the clear benefits of this data source?
  - What are barriers?
  - What advice to do you have for the Screening Academy states planning to use medical chart data to create a measure of screening?
    - Issues related to identifying numerator and denominator?
    - Tips for enhancing feasibility?

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ABCD Alumnae Experiences: Using **ACCESS Data Entry Forms in Practices**

Sherry Hay : North Carolina Medicaid

- Highlights/Learnings from for developing a data entry form for providers?
  - Value of ACCESS forms?
  - What advice to do you have for the Screening Academy states planning to use practice-based data to create a measure of screening?
    - Issues related to identifying numerator and denominator?
    - Tips for enhancing feasibility?

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Potential Data Source #3: Parent Report

Key Issues Specifically Related to Using Parent Report:

Numerator:

- What survey items accurately assess the standardized screening conducted?
- For current items, screening anchored to term "child health care provider"
  - Can include screening outside practice - Should the items be narrowed to only the practice?
- Periodicity Issues
-

Denominator:

- Who should have received screening and therefore who should get the survey?

  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

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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"

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Potential Data Source #3: Parent Report

Tips for Enhancing Feasibility of Measurement Efforts

- **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

Potential other areas of care to measure:

- Developmental surveillance
- Anticipatory Guidance and parental education
- Whether parent screened for depression
- Medical home
- Access to Care, Care Coordination
- Experience of Care with Screening
  - Experience with completing the tool
  - Affect of tool on care
  - Experience with how results communicated
  - Affect of the tool on perceived value of the well-child visit and/or parental knowledge about development.

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Potential Data Source #3: Parent Report

Tips for Enhancing Feasibility of Measurement Efforts

- Periodically report the findings
- Where possible, identify other surveys or direct-to-parent communications that these items could be "added"
  - State-wide survey
  - Care coordinators

If implementing a new survey:

- Build off established protocols/resources for how to administer a survey to parents of young children

If you are implementing <u>in the pediatric offices</u>

- Again, build off protocols and methods developed by other projects.
  - In-office administration, survey given in the office but completed at home or online
- Determine how and when the survey can be administered within the flow of the practice
  - Pilot test the approach
  - Consider the length of time of survey administration
  - Consider methods for reducing costs for completing and/or entering the survey data.

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Resources to Guide Screening Academy States

- Measuring and Evaluating Developmental Services: Strategies and Lessons from the ABCD II Consortium States
  - http://www.abcdresources.org/resourcesbyNASHPCMWF.html
- Cheat Sheets for Measuring the % of Children Screened
  - Cheat sheets for each potential data source: Claims data, medical chart, parent report
  - Located at : http://www.abcdresources.org/downloads.html
- Discussion Forum for Measuring Results
  - http://www.abcdresources.org/forum/
- Session focused on measurement to be held at July Screening Academy meeting
- Technical assistance from NASHP staff and Colleen Reuland of the CAHMI (reulandc@ohsu.edu, 503-494-0456)