

Measuring and Evaluating Developmental Services: Strategies and Lessons from the ABCD II Consortium States

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Measuring and Evaluating Development Services: Strategies and Lessons from the ABCD II Consortium States

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PART A: BACKGROUND AND PURPOSE

Research demonstrates that children’s healthy social and emotional development is essential to school readiness, academic success, and overall well-being.¹ In addition:

- Young children from low-income families are at a higher risk for developmental delays than are their more affluent peers. For example, one report found that first time kindergartners in the bottom fifth of the income distribution were less likely to exhibit social competence than those from families with higher incomes.²
- Early diagnosis and intervention increase the effectiveness and efficacy of services delivered to children with social risk factors.³
- Often children who could benefit from treatment are not identified as needing treatment. For example, physicians often do not identify young children with a clearly defined developmental problem, those who have a low intensity problem, or those who are at risk of substantive problems.⁴

Medicaid is the largest health financing program in the United States and covers the greatest number of children of any health insurance or health care financing program. Currently, nearly 25 million children, or 35% of children under age 18, receive health care through Medicaid.^{5,6} The children covered by Medicaid are from the lowest income families, are in the poorest health, and have the greatest health care needs.^{7,8}

Medicaid can do much to improve young children’s healthy mental development, and a number of state Medicaid agencies have expressed interest in doing so. To assist states in these efforts the National Academy for State Health Policy (NASHP), with funding from The Commonwealth Fund, administers the Assuring Better Child Health and Development (ABCD) initiative. The current initiative, ABCD II, is a three-year project designed to build state capacity to deliver care that supports

The Assuring Better Child Health and Development initiative (ABCD II), sponsored by The Commonwealth Fund, is designed to strengthen primary health care services and systems that support the social and emotional development of young children, 0-3. The program focuses on promoting the healthy mental development of children whose health care is covered by state programs, especially Medicaid.

¹ Institute of Medicine, *From Neurons to Neighborhoods: The Science of Early Childhood Development* (Washington, DC: National Academy Press, 2000).

² Brett Brown, PhD, et al. *Early Child Development in Social Context: A Chartbook*, 2004. The Commonwealth Fund. Retrieved 4 February 2005. http://www.cmwf.org/publications/publications_show.htm?doc_id=237483.

³ Institute of Medicine, *From Neurons to Neighborhoods*.

⁴ Laura Sices, MD, et al. "How do Primary Care Physicians Identify Young Children with Developmental Delays? A National Survey with an Experimental Design," *Pediatrics* 113, No.2 (Feb. 2004): 274-282.

⁵ Enrolling uninsured low-income children in Medicaid and SCHIP. Kaiser Commission on Medicaid : Medicaid Facts, March 2005.

⁶ U.S. Census Bureau, Census 2000 Summary File.

⁷ Paul W. Newacheck, Dana C. Hughes, Yun-Yi Hung, Sabrina Wong, and Jeffrey J. Stoddard. The Unmet Health Needs of America’s Children, *Pediatrics*, Apr 2000; 105: 989 - 997.

⁸ Edward L. Schor, MD and Melinda Abrams, MS Medicaid: Health Promotion and Disease Prevention for School Readiness

children’s healthy mental development. Five states – California, Illinois, Iowa, Minnesota, and Utah – participate in the ABCD II Consortium, which began its work in early 2004.

Common threads of the ABCD II states’ efforts to improve children’s mental health development are to:

- **Create models of service delivery and financing that promote good quality services** supporting children’s healthy mental development for Medicaid eligible children, 0-3, especially those with less intense needs, those who need only preventive care, and those who are identified as "at risk" or in need of low-level intervention; and
- **Develop policies and programs that assure that health plans and pediatric providers** serving these children and their parents have the knowledge and skills needed to furnish health care in a manner that supports a young child’s healthy mental development.

Measurement: An integral component to implementation, evaluation, and sustainability

One early issue faced by the ABCD II states was how to measure the effectiveness of their efforts to improve the delivery of mental health services for very young children. The five participating states needed reliable and valid measures to inform program implementation efforts, guide improvements and ongoing program evaluation, and demonstrate the value of the programs for sustained funding and focus.

Other states wishing to improve in this area will have a similar need.

Measurement needs to be a primary component of a project from the start. Reliable and valid measures will only be collected if the measurement strategy is thoughtfully and carefully designed to ensure that the tools and methods accurately assess the objectives of focus.

The purpose of this paper is to provide states that seek to implement efforts similar to those in the ABCD II Consortium with information on:

- Methodologies and opportunities for evaluation measures related to screening children’s social and emotional development, referral, and follow-up care for children identified at risk.
- Real-world examples and lessons learned from the ABCD II states in their measurement efforts.

**Mental Development.
Psychological Development.
Social Development,
Emotional Development.
Behavioral Development.
Psychosocial Development.**

The literature on child development describes various aspects of childhood development using different terms—often interchangeably. In this paper we have sought to be consistent in our use of terminology.

In this paper, **ensuring children’s healthy mental development** means identifying and addressing emotional, behavioral and social developmental needs.

The approaches and strategies used across the ABCD II states were varied while focused on similar goals and objectives. Consequently, there is a core set of evaluation measures collected by all of the ABCD II states. Additionally, there are state-specific measures used to further capture individual state's policy and improvement efforts.

Therefore, this paper is structured in the following manner:

- Global issues that apply to any measurement activity (Part B)
- Description of guidelines and approaches in three standardized evaluation measures used across all of the ABCD II states (Part C). These measures focus on three aspects of the ABCD II efforts – screening, referral, and follow-up.

- Measure #1. The percent of children aged 0-3 **screened to identify concerns related to social and emotional development;**
- Measure #2. The percent of children aged 0-3 **referred for services to prevent or treat concerns related to delays in social and emotional development;** and
- Measure #3. The percent of children aged 0-3 **treated for delays in social and emotional development** (including treatment to prevent such delays).

- Information about additional evaluation methods used by the ABCD II states (Part D). This section highlights additional evaluation methods used by one or more of the ABCD II states, and are focused on provider, office, and/or parent experiences; feedback from referral organizations; and measures anchored to whether parents of young children were screened for depression.
- Lastly, potential areas of leverage for State Medicaid agencies to implement the evaluation measures are highlighted (Part E).

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PART B: GLOBAL MEASUREMENT ISSUES

Before presenting options and issues specific to the three measures used by the states participating in the ABCD II Consortium, it is important to consider global issues related to quality measurement.

Measures need to be designed at the beginning of a project

Measures cannot be designed and collected after a program has been implemented. In order for the evaluation measures to be reliable, valid, and feasibly collected, they need to be specified and the measurement strategy designed during the project planning phase.

Measures evaluating an implementation process need to be collected, at a minimum:

- 1) Before or during the initial implementation phases and then,
- 2) After the program(s) has been implemented.

Additionally, it is valuable to collect evaluation measures periodically so that they can inform improvements and enhancements to implementation.

It is important the following attributes of the measures and measurement strategy are examined at the beginning of the project:

- **Reliability:** Reliability is the "consistency" or "repeatability" of measures.⁹ "Commonly, reliability refers to the stability of a measurement: how far it will give the same results on separate occasions."¹⁰
- **Validity:** "The extent to which a measurement method measures what it is intended."¹¹
- **Feasibility** of the measurement approach: Given the time and resources available, can the measurement strategy that is developed be implemented consistently and for the amount of time that is needed?

A measure must have certain attributes

A measure has the following attributes:

- A denominator: For example, a specified group of children of interest who are eligible to be included in the measurement denominator.
- A numerator: For example, a specified group of children included in the denominator who have received the specific aspect of health care of interest.
- A defined and standardized strategy for data collection: A standardized method for sampling, a defined unit of analysis, and a standardized method for data collection.

⁹ <http://www.socialresearchmethods.net/kb/reotypes.html>. Copyright 2006. William M.K. Trochim.

¹⁰ Ian McDowell, Claire Newell. *Measuring Health: A guide to rating scales and questionnaires*. 2nd edition. Copyright 1996 by Oxford University Press.

¹¹ Ian McDowell, Claire Newell. *Measuring Health: A guide to rating scales and questionnaires*. 2nd edition. Copyright 1996 by Oxford University Press.

- A clearly specified scoring methodology.
- Mechanisms for reporting and interpreting results.

The three standardized evaluation measures used by the ABCD II states are percentages. A percentage is a proportion multiplied by 100.

Here are some examples of data collected that, alone, do not result in a measure:

- The number of standardized social and emotional developmental screens conducted: A count of the number of standardized screening tools administered is a valuable piece of information; however, it is not a measure. This count is the numerator for a measure. One would need to know how many children should have been screened (the denominator) in order to calculate a measure of what share of children were screened.
- The number of referrals: A count of the number of referrals is also a valuable piece of information; however, it is not a measure. A referral count is the numerator for a measure. One would need to know how many children should have received a referral (the denominator) in order to calculate a measure of the prevalence of children referred for follow-up care.
- Claims data related to follow-up care for the child: Identifying how many children had specific claims billed that indicate follow-up services were received (e.g. speech and language testing) is a valuable piece of information, Again, it is not a measure. This information is the numerator for a measure. One would need to know how many children were at risk and should have received follow-up care in order to calculate a measure of how many referred children actually received appropriate follow-up care.

Child-level measurement

An ideal measurement system allows information to be collected at a child level so that one could look across the multiple aspects of care each child should receive and the multiple systems where the child received care.

Therefore, it may be difficult for data systems within different departments and disciplines to share information about the same child (e.g., Medicaid, state mental health agencies, Title V/Maternal and Child Health programs, etc).

Parent-reported surveys allow investigators to ask the parent about the multiple systems that the child may have encountered, providing information not easily obtained by administrative and electronic data systems. This will often provide a child-level picture of the health care system.

Measures using denominators based on descriptive data gathered

As was noted previously, a measure must have a numerator and a denominator. Given that data systems may not “talk” well to each other, it is sometimes difficult to identify both the numerator and denominator in the same data source for each eligible child. For example, encounter data can

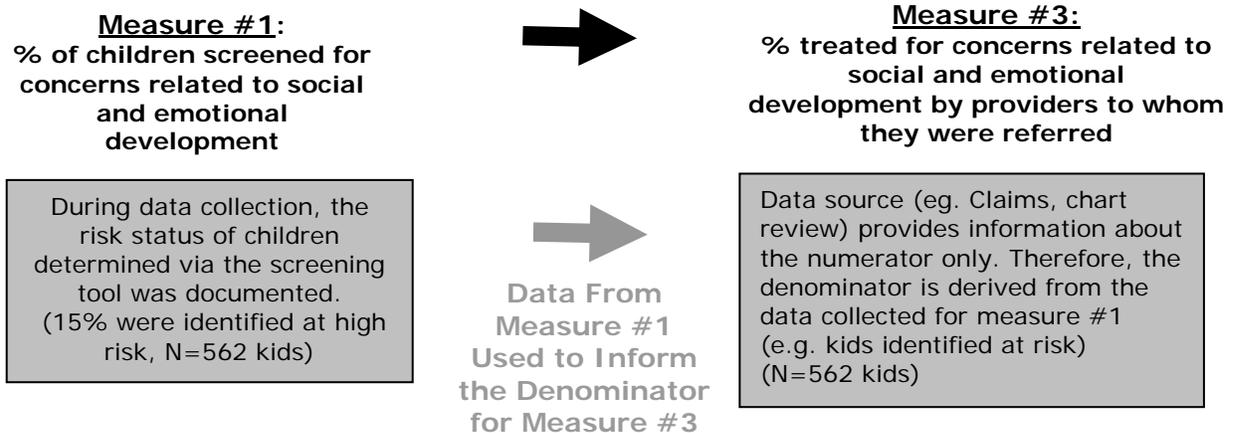
tell you whether a child received a treatment service outside the primary care office (the numerator for a measure). However, encounter data does not include information about children that should have received a treatment service (the denominator of the measure).

Therefore, for some measures, it may be necessary to use prevalence data to make an informed estimate of what the denominator for the measure should be.

Example of estimating a denominator based on data gathered

The following example illustrates how a state might take information gathered for Measure #1 (the percent of children screened) and Measure #2 (the percent of children referred for services) to make an informed assumption about the appropriate denominator for Measure #3 (the percent of children treated for delays in social and emotional development):

1. Measure #1: Practice A determines that in the last year it had 5,000 children aged 0–3 who had a well-child visit. Seventy-five percent of those children (3,750) were screened.
2. Measure #2: Of those 3,750 children, 15 percent (562 children) were identified as being at high risk and should have been referred.
3. Measure #3: Practice A then made an informed assumption by examining its billing code data to identify children who received treatment from Medicaid providers outside the primary care office.



Because Practice A’s claims data only provide information about children who are referred and who receive services, no information is available from that data to determine who should have been referred and received services, which should be the denominator. Therefore, Practice A uses information gathered for Measure #1 to make an informed assumption about the number of children who should be included in the denominator for Measure #3. As was described above, 562 children were identified as being at high risk and should have been referred and received services. This serves as the denominator.

Measurement strategies need to be specified for each unit of analysis

Many of the ABCD II state projects were implemented in multiple settings. Therefore, standardized methodologies had to be used to collect the data and to identify the numerator and denominator for each implementation setting.

Separate sample sizes and data collection methodologies needed to be clearly specified for each discrete unit of data collected in the various setting in which an intervention is implemented (e.g. individual practice settings).

Avoid measures based on incomplete, non-valid data systems

States should plan to conduct a pilot test of their measurement strategy before implementing a full measurement strategy in order to ensure that the data systems employ valid indicators for the aspects of care that are being measured.

States should avoid non-valid and/or incomplete data systems. Pilot testing of your measurement strategy with a specific data source will ensure a primary check for its validity. For example, if the measure is whether or not children receive follow-up care, the data systems must include information about all the places where the child may receive such care. If the data systems are incomplete (e.g., only include medical providers and not other kinds of services in the community) then the data system is not a valid data source for the measure and will yield incomplete and inaccurate information. Alternate strategies, such as those discussed previously in this section, will then need to be specified.

“Same point in time” collection of data

An important step in measurement is ensuring that when data are collected they capture a number of variables at the child level and that they do so at the same point in time. In particular, the projects should collect the following variables for each child included in the measurement:

- ***Age of the child, in months:*** This is a powerful variable for analysis as it allows for targeted assessment of the quality of care provided for children in different age groups. In addition, recommendations for identifying a child with delays and for appropriate follow-up care are different based on the age of the child.
- ***Type of health insurance:*** The type of health insurance a child has may influence the kinds of services the child is eligible to receive and may influence the construction and/or interpretation of measure findings. In addition, for some measures, Medicaid data may be the only data available. It is critical to show the findings according to whether or not a child is enrolled in Medicaid.
- ***If billing/encounter data are used,*** states should collect information about the number and kinds of visits the child has had in the last 12 months. Specifically, information should be collected about the number of well-child visits the child has had during that same time period.

- If *different sites participating in the project are allowed to use various screening tools*, states need to document the specific screening tools that are being used and ensure that measurement strategies and data collection are specific to the tool. This will enable states to analyze whether screening, referral, and treatment are more likely to occur when a specific tool is used.

Pilot testing of measurement approach is crucial

It is always valuable to pilot test the specific data collection tools and measurement strategies that are developed. This allows fine-tuning and modification of the documents based on problems that arise. Pilot testing should be conducted in each of the sites in which data collection is expected.

Continued technical assistance and periodic quality checks are important

It is important to remember that the field of quality measurement is relatively new. Therefore, continued and persistent technical assistance and quality checks are essential for valid and meaningful data collection.

This is particularly important if the data collection is to be conducted by health care providers and/or office staff. If the person(s) in the office responsible for the data collection is replaced, then it is imperative that the new person be trained about the purpose of the data collection and how to use the tools and strategies provided. One should never assume that providers and/or office staff understand the terms and data collection tools. The time invested on the front end of a project in one-to-one training is well worth the enhanced probability of reliable and robust data gathered.

Periodically reporting measurement findings is essential to continued participation

Data collected is not translated into meaningful information unless it is communicated effectively. Periodic and sustained data collection can only occur if the persons who are responsible for the data entry understand the value and importance of the information they are responsible for collecting.

Therefore, it is imperative that the measurement findings be periodically reported back to the persons who are a) collecting the data, and b) implementing the screening, referral, and follow-up processes being measured.

Be sure to thoughtfully consider the format and level of information that is provided in the reports. Consider what pieces of information are most important to the reader of the report. Consider using both graphical and textual presentation of information and always include background information about the data upon which the measures are based. Lastly, always include contact information for whom to contact if the reader has questions.

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PART C: STANDARDIZED EVALUATION MEASURES USED ACROSS ALL OF THE ABCD II STATES

An important consensus reached within the ABCD II Consortium was the identification of common measures that should be collected across all of the ABCD II states. The ABCD II states worked to strengthen Medicaid's capacity to support young children's healthy mental development. Each proposed to develop and test new policies and procedures that, if effective, could be implemented statewide. Early in their project development the five states agreed that they would consider policies/procedures tested effective if the pilot site achieved three goals:

- Increase the use of effective standardized screening methodologies to identify social and emotional developmental issues;
- Increase in the number of referrals for children identified at risk; and
- Increase in children who received treatment.

These goals were selected because the states believed that these three aspects of improvement covered the three major parts of the system they were planning to improve (screening, referral, and treatment) and that the project sites would be able to achieve change in these areas within the three years of the collaborative. Having agreed on three common goals, all five of the states agreed to collect three common measures in a standardized manner, one for each of the goals.¹²

1. The percent of children aged 0-3 **screened to identify concerns related to social and emotional development**;
2. The percent of children aged 0-3 **referred for services to prevent or treat concerns related to delays in social and emotional development**; and
3. The percent of children aged 0-3 **treated for delays in social and emotional development** (including treatment to prevent such delays).

General measurement guidelines and issues to consider for each of the three measures are described on the following pages. These specifications were developed for the ABCD II states and anchored to their financial and data constraints.¹³

¹² States implementing strategies focused on a different age group (e.g., 0-12 months, 0-5 years) will collect measures for that specific age group. Throughout, this discussion guide focuses on children aged 0-3 years.

¹³ It is important to note that although the ABCD II states were committed to implementing these measures, they all had limited financial and data resources. As a result, the measurement strategies outlined took into account what is known about these constraints and represent what may be feasible in the short term, rather than strategies that might be more ideal (i.e., more valid and reliable) but less feasible to implement. Measurement costs will vary in each system and for each practice. Costs for data based on claims or billing code data are those related to the time and resources needed for analyst to obtain and run the analyses set forth in the paper. Costs for data collected from medical charts is based the time needed to pull and examine each of the medical charts and to analyze the aggregate data gathered. This work needs to be done by a trained person who is familiar with and able to read through medical charts. Measurement effort and time can be reduced if standardized forms related to screening and the provider's follow-up steps related to the screening results are created and inserted in the chart at the time care is provided. Costs based on data gathered from surveys depends on the length and mode of survey administration (e.g. by phone, mail, in the office). Surveys usually have higher front-end costs related to data collection and analysis, but can be efficient in that they collect information about all three of the measures through one data collection process, collect additional measures related to health care quality and descriptive information about the child and family health.

For each of the three measures, the following information is presented:

- Assumptions about the measure and how it will be used,
- An overview of the measure, including the questions that need to be clarified in order to implement the measure,
- Recommended data sources,
- Methodological issues to consider, and
- Example(s) of measurement approaches used by the ABCD II states and key lessons learned.

In developing the methodologies specified, the authors analyzed detailed information about the state projects in order to understand the context in which the three measures would be implemented and used in each of the five states. Other state efforts using the measures described in this paper need to be similarly grounded. Specifically, the following needs to be examined:

- Confirm that the measures will be anchored to standardized, validated screening tools. The Child and Adolescent Health Measurement Initiative (CAHMI) anchored the measurement strategies to the implementation of standardized, validated screening tools of social and emotional development. The implementation of these tools was a primary goal for the ABCD II states and therefore the measurement strategies were anchored to the implementation of screening tools. This measurement approach therefore does NOT capture screenings that doctors and other health care providers may conduct without using a standardized, validated screening tool.
- Review the administration and scoring methods for each screening tool(s)¹⁴ used. It is important that the measurement strategies are anchored to the screening tool(s) implemented. Specifically, in order to validly implement the three measures one must understand the following:
 - How the tools are administered,
 - The number and characteristics of children identified using these tools, and
 - The follow-up steps that are recommended based on screening results for each child.
- If different screening tools are used, then tool-specific measures must be collected and then combined into the larger, more global measure of percent of children aged 0-3 screened to identify concerns related to social and emotional development. If a state changes the screening tools it uses over the course of the project (e.g., in the first year the Parents' Evaluation of Developmental Status (PEDS) is used, in the second year the Ages and Stages Questionnaire[®] (ASQ) is used, and in the third year the ASQ-SE is adopted, then we recommend that the state first separately calculate measures for each screening

¹⁴ Each ABCD II state selected one or more standardized, documented screening tools to use in their projects. As will be discussed later, the specific tool selected will impact the resulting measures and strategies for measurement. For more information on screening tools that detect social and emotional development delays, please refer to: David Bergman. *Screening for Behavioral Developmental Problems: Issues, Obstacles, and Opportunities for Change* (Portland, ME: National Academy for State Health Policy, 2004).

tool and then compare the tool-specific findings at baseline versus intervention for each measure.

- The measurement methodology described assumes the active participation of the intervention sites – it assumes that the providers and plans participating in the pilots will collaborate with the state, share information, and, in some cases, implement new procedures designed to gather the information needed to produce the measure. There are some measurement options discussed in the paper that are not feasible without the active participation of providers and plans.

Measure #1: Percent of Children Aged 0-3 Screened to Identify Concerns Related to Social and Emotional Development

Screening is the process by which a large number of individuals are tested for the presence of a particular trait. Standardized, validated screening tools offer a systematic approach to this process. Ideally, tools that screen for the mental development of young children should:

- Identify those children who may need social or emotional development care,
- Be accurate enough to avoid mislabeling many children,
- Differentiate between those in need and those not in need of follow-up,
- Be quick and inexpensive to administer, and
- Provide information that can lead to action.¹⁵

Early in the development of their individual projects each collaborative state selected a menu of standardized tools that they believed met these criteria. In each state this first measure is keyed to the specific screen selected by the intervention site(s) from this menu.¹⁶

Measurement assumptions

- Only screening that is conducted with a standardized, documented tool or set of tools will be counted.
 - The completed tools must be kept in the child’s medical chart if medical chart reviews are going to be used as the method for collecting information. This requirement must be clearly explained to health care providers at the start of the project if medical chart reviews are going to be used.
- Measurement will be conducted and specified for each tool used. If a state allows the use of more than one tool, then the measurement methodology will need to be adjusted for each tool, thereby decreasing the standardization of the measures and compromising the

¹⁵ David Bergman. *Screening for Behavioral Development Problems*, Newsbrief. (Portland, ME: National Academy for State Health Policy, 2004).

¹⁶ As part of the technical assistance provided to collaborative states, NASHP staff prepared a paper discussing the use of screening tools and comparing some of the major tools on characteristics that states need to consider when selecting tool. For more information on screening tools that detect social and emotional development delays, please refer to: David Bergman. *Screening for Behavioral Developmental Problems: Issues, Obstacles, and Opportunities for Change* (Portland, ME: National Academy for State Health Policy, 2004).

ability to summarize the information at a state level. If different tools are used, then the findings should be stratified according to the tool used. This adjustment and stratification is necessary because tools vary in terms of recommended periodicity schedules (how often they should be administered), modes of administration (interviewer vs. self-administered), the populations they identify at risk, and steps that should be taken for children identified at risk.

- Only intervention sites are being measured.

Overview of the Measure

Numerator: Children aged 0-3 screened to identify concerns related to social and emotional development

x 100

Denominator: Children aged 0-3 who *should have* been screened to identify concerns related to social and emotional development and who had a visit at the intervention site during the intervention time period

Important clarifying questions

The key to this measure is to clarify and define the numerator and denominator to determine reliable and valid data sources for this information. Important questions to ask while developing a measurement methodology include the following:

Examples of clarifying questions about the numerator

- What counts as a screen? What specific tools meet your criterion for standardized developmental screening?
- How will you know if a screen occurred?
 - Must it be documented in the chart?
 - Will you require the providers to submit a claim for the screening?
If so, then providers need to be informed at the beginning of the project that the chart and/or claims data will be used to measure their efforts).
- When and how often should the screening occur – every 12 months?
- What level of screening should occur for children who have already been identified at risk for social or emotional developmental delays?

Examples of clarifying questions about the denominator

- Who should be included in the denominator?
- Should the denominator be limited to children who have had a well-child visit during the implementation period?
- Should non-well-child care visits be included?

Recommended possible data sources for Measure #1

- Medical chart,¹⁷
- Parent report, and
- Claims or billing data (Note: This data source should ONLY be used to assess whether program implementation efforts are successful if there is prior knowledge that providers routinely place a claim for the screening conducted. Pilot testing should focus on examination of the use and frequency of these codes being used)

Table 1 provides a brief overview of possible data sources, example measurement strategies, and key methodological issues to consider in using these data sources.

¹⁷ Several states implemented a tracking form used by office staff to measure intervention efforts. For these states's measurement project, it was assumed that this tracking form was part of the child's medical chart and that it would be included in the medical chart review. If the tracking form was not included as part of the medical chart, then the general measurement design parameters specified for the medical chart review applied to the use of the tracking form independently.

Table 1 Possible data sources for measuring the percent of children aged 0-3 screened to identify concerns related to social and emotional development

Data Source	Numerator	Denominator	Examples of Data Collection Tools Used for Measurement	Issues Related to Data Collection	Topics for Which Discussion/Consensus Needed
Medical Chart	Number of children whose charts have a completed, standardized screening during the specified time period.	Number of eligible children who have received well-child care during the intervention time period whose charts were reviewed.	<ul style="list-style-type: none"> • Appendix A provides example directions used in the <i>Healthy Development Learning Collaborative</i>.¹⁸ • Appendix B provides example directions used by <i>Utah</i> for its monthly medical chart audits. • Appendix C provides example directions used by <i>Iowa</i> for its medical chart reviews. 	<ul style="list-style-type: none"> • It is important that providers know that the completed screening tools must be kept in the medical chart. • The current denominator is specified to represent children who have had a visit. This biases the findings to only represent those children who have accessed the health care system. • This methodology will not capture data on screening that occurs outside of the office/or public health setting. • A number of the ABCD II states incorporated checklists to guide well-child visits. The screener was added to this checklist and used for measurement purposes. • States should consider age-specific chart review quotas to ensure periodic and longitudinal screening and surveillance. 	<ul style="list-style-type: none"> • Eligibility for the chart review and process by which the charts will be selected. • Recommended periodicity for when screening should occur. This will influence what charts should be pulled and the reference period used by the chart review staff to determine whether the child was screened during the appropriate time period. • Unit of analysis and sample size needed for each unit of analysis and for each age group of children (e.g., different sample sizes needed to pull a statistically significant sample in larger vs. smaller office, public health centers, etc.).
Parent Report	Number of children whose parents indicated their child had been screened through a series of items asking about processes that would indicate that screening had occurred.	Number of eligible children whose parents completed the survey and/or who were asked questions via an interviewer-administered survey. Eligible children are those who have had a visit during the intervention time period.	The Child and Adolescent Health Measurement Initiative (CAHMI) developed survey items that measure whether a parent-completed standardized developmental and behavioral screening tool was administered. Appendix D provides the <i>Users Tip Sheet</i> for these survey items. ¹⁹	<ul style="list-style-type: none"> • Use of parent-report is ideal for screening tools that are completed by the parent. If the items are worded appropriately, this approach can capture screening conducted in multiple settings. Parent report is less valid for tools that providers or staff members complete. • Survey can be administered by mail, telephone, online, or in the office. Survey questions can also be administered by an interviewer and included as part of a more general discussion such as those conducted by care coordinators. • Survey can also include items related to Measures #2 and #3 and additional evaluation measures. 	<ul style="list-style-type: none"> • Eligibility for the survey: Should it be only children who have had well-child visits or all enrolled children? (<i>Note: The parent who is most responsible for the child's health care should be chosen for survey administration.</i>) • Mode of administration for the survey (e.g. telephone, mail, in the office, in-person). • Recommended periodicity for when screening should occur. This will influence what should be the reference period for the items in the

¹⁸ The *Healthy Development Learning Collaborative* was a year-long quality improvement initiative in which primary care practices in Vermont and North Carolina used improved office systems to engage families in efforts to promote positive developmental outcomes. More information about the *Healthy Development Learning Collaborative* can be found on The Commonwealth Fund website at: http://www.cmwf.org/tools/tools_show.htm?doc_id=372065

¹⁹ The *Healthy Development Learning Collaborative* was a year-long quality improvement initiative in which primary care practices in Vermont and North Carolina used improved office systems to engage families in efforts to promote positive developmental outcomes. More information about the *Healthy Development Learning Collaborative* can be found on The Commonwealth Fund website at: http://www.cmwf.org/tools/tools_show.htm?doc_id=372065

					<p>parent survey.</p> <ul style="list-style-type: none"> • Unit of analysis and sample size needed for each unit of analysis and for each age group of children. (See comments above)
<p>Claims or Billing Code Data</p>	<p>Number of children for whom a claim (such as CPT codes 96110, 96111, 99420) of standardized screening was submitted during the specified time period and who had 1 or more well-child visits.</p>	<p>Number of eligible children who have received well-child care during the intervention time period.</p>	<ul style="list-style-type: none"> • The <i>American Academy of Pediatrics Statement on Identifying Infants and Young Children with Developmental Disorders in the Medical Home</i> (July, 2006)²⁰ provides a detailed description of claims that can be used for standardized screening. • DBpeds.org also has a section focused on claims that can be used: http://www.dbpeds.org/articles/detail.cfm?id=123 • The <i>Using Medicaid to Support Young Children's Health Mental Healthy Development</i> report by Johnson and Kaye on the NASHP website (www.nashp.org) also highlights financing strategies for screening and surveillance. 	<ul style="list-style-type: none"> • It is important to first examine the claims data to ensure that providers know about and are routinely using the claims that are related to standardized screening. If these claims are not routinely used, then the claims data will not be valid for measuring whether screening is occurring. • The current denominator is specified to represent children who have had a visit. This biases the findings to only represent those children who have accessed the health care system. • This methodology will only capture data on screening that occurs in sites for which claims can be submitted and are available (e.g. it may not include screening conducted in Head Start or public health setting.) 	<ul style="list-style-type: none"> • Specific claims that will be used to identify children who had a well-child visit. Specific claims data codes that will be used to determine children for whom a standardized screening tool was administered. • Unit of analysis and sample size needed for each unit of analysis and for each age group of children (see comments on previous pages).

²⁰ www.pediatrics.org/cgi/doi/10.1542/peds.2006-1231

Possible data sources for Measure #1 that are not currently recommended

Data sources that are not currently recommended for Measure #1 are:

- **The DC:0-3™** (The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood): The DC:0-3 was designed to address the need for a systematic, developmentally based approach to the classification of mental health and development difficulties in the first 4 years of life. It seeks to complement, but not replace the Diagnostic and Statistical Manual of Mental Disorders (current version DSM-IV-TR) and the International Classification of Diseases, Ninth Edition (ICD-9) systems. Therefore, the DC:0-3 provides rich information about children who are being screened, but alone is not a data source that can be used to calculate estimates of the proportion of children who are screened.
- **Provider survey:** The measures identified by the ABCD II states are the percent of children screened. Using a provider survey would determine the percent of providers who use a screener. Furthermore, numerous studies demonstrate the poor validity of provider estimates on the percentage of children for which they conduct specific activities.

Important information needed during data collection for Measure #1

If the medical chart and/or the parent survey are used, information should be collected about the child's risk status as determined by the completed screening tool. This information is needed to determine the appropriate denominator for Measure #2 and Measure #3.

A categorical variable should be created for the data entry form that includes the following response options:

- a) *Child not currently at risk.*
- b) *Child at a level of risk that can be handled by their primary care provider.* This includes a child who should be watched and/or for whom follow-up can be delivered by the providers who conducted the initial screening (therefore, external referrals not recommended). This group will represent the denominator for Measure #3a.
- c) *Child at a level of risk for which referrals outside the primary care provider's office are needed.* This includes children who should be referred for services. This group will determine the relative number of children who should be represented in the denominator for Measure #2. This data will also be useful in providing the practice sites with descriptive data about their population.

Here's a methodological note: If a parent survey is used, you can include items from parent-completed screening tools (e.g. The Parents Evaluation of Developmental Status[®] (PEDS) and/or the Ages and Stages Questionnaire[®]) to identify children at risk. This strategy is used in the Promoting Healthy Development Survey (PHDS). More information about the PHDS can be found on the CAHMI website at www.cahmi.org.

Example of a possible measurement approach

Practice A uses the Ages and Stages Questionnaire® (ASQ) to screen children. Children are screened at the 12-month, 18-month, and 24-month-old well-child visit.

The first day of each month, data collection begins. During this time period, all charts for children who are having their 12-, 18-, or 24-month-old well-child visit are flagged for the chart reviewer. At the end of each month, the chart reviewer examines each flagged chart. Children who were scheduled for well-child visits but who did not come in are excluded from the chart review. The chart reviewer counts the total number of eligible charts (denominator) and then looks for at least one completed ASQ form in the last 12 months in the chart (numerator).

ABCD II states measurement strategies and lessons learned

A majority of the ABCD II states used medical chart reviews as the data source for Measure #1.

- Appendix B Provides example directions used by Utah for its monthly medical chart audits.
- Appendix C provides example directions used by Iowa for its medical chart reviews.

Illinois examined its paid claims data related to developmental screening to assess whether, overall, the number of claims submitted increased over the course of the project.

Key lessons learned from the ABCD II measurement efforts useful for other states include the following:

- **The data collection strategies need to be feasible and easy to understand.**
 - The data collection strategies and materials need to be thoughtfully designed so that they are:
 - ✓ Easy to understand by the persons responsible for completing them. This involves ensuring that the directions are clear and that all terms are thoroughly defined. It is particularly important to define the specific tools and strategies that meet the definition of standardized screening.
 - ✓ Easy to complete.
 - ✓ Easy to return.
 - Be sure to include directions and specifications in the medical chart abstraction for identifying the risk status of the child and level of follow-up care the child should receive. As mentioned previously, this is important information for determining the denominator for Measures #2 and #3. Many of the ABCD II states did not have this detailed information in their chart abstraction tools and therefore experienced denominator problems for the other measures.
 - **ALWAYS do a pilot test of the data collection tools** that will be used. This allows for identification of common data collection errors or problems with the process that can be modified at the beginning.

- **Incorporate the measurement as part of the implementation**
 - An important part of implementing program efforts is a shared understanding and commitment to routine and periodic measurement. If measurement is seen as an “additional” or “side” component of the project, then it will not remain a high priority and consistent data collection will not occur.
 - Many of the ABCD II states created easy-to-use checklists for providers that not only guided them in the screening and assessment process, but were also in a checklist format that could be used for medical chart reviews.
 - Again, if you design a form to be used by health care providers, be sure to include a section that allows the provider to indicate the risk status of the child and level of follow-up care needed.

- **Proxy denominator for Measure #1: Well-child visit count**
 - As was described in Step B, sometimes general information is used to determine the denominator for a measure.
 - Here’s an example of a proxy denominator: California used a version of a screening tool that included two pages: 1) the front page the provider filled out, and 2) the second page was a carbon copy of the provider responses. Providers were asked to detach the carbon copy from their completed tool and place it in a basket located in the office. The project team periodically collected the carbon copies. These carbon copies represented the number of children screened (the numerator). In order to determine the denominator for the measure (number of eligible children who had a well-child visit and who should have been screened) the project staff asked the office to count the number of eligible well-child visits they had scheduled.

- **Routine check-ins and technical assistance is needed.**
 - If the medical charts are going to be conducted by the office staff and/or front-line health care providers, significant assistance and routine check-ins are needed to ensure that routine and valid data collection occurs.
 - Many of the ABCD II states could not emphasize enough the importance of technical assistance in motivating providers to continue data collection and to answer any questions that providers have.
 - Many of the ABCD II states recommended periodic in-person meetings to ensure buy-in of the measurement process.

- **Consider the length of time and the amount of chart audits.**
 - Some of the ABCD II states had a difficult time maintaining commitment from the providers for monthly medical chart audits over a 12-month or longer time period. This has been experienced in other studies requiring providers to submit monthly data.
 - It may be valuable to consider periodic data collection at discrete amounts of time. This strategy does not allow one to assess month-by-month improvements, which have been valuable in improvement efforts modeled after the Institute of Healthcare Improvement’s Breakthrough Series, but it does address the burden of data collection on the practices.

Example options that can be presented to the practice for a year-long measurement process are the following:

- Option 1. Monthly data collection, small number of charts.
- Option 2. Every-other-month data collection, small to medium number of charts.
- Option 3. Quarterly data collection, medium number of charts.
- Option 4. Baseline and follow-up data collection, large number of charts.*

* This strategy does not provide practices with iterative feedback that is often valuable in modifying and enhancing improvement and implementation efforts.

- **Report data back to providers or other persons responsible for data collection.**
 - Many of the ABCD II states felt that if they had been more active in disseminating the results from the measurement effort, then it may have increased the perception about the importance of data collection.
 - It is important to share the measurement findings with the persons who are a) collecting the data, and b) implementing the screening, referral, and follow-up processes being measured.
 - Be sure to thoughtfully consider the format and level of information that is provided in the reports. Consider what pieces of information are most important to the reader of the report. Consider using both graphical and textual presentation of information and always include background information about the data upon which the measures are based.

- **Measurement can enhance implementation and awareness.**
 - Illinois used the findings from Measure #1 to educate and influence providers about the value of standardized screening and to make them aware of the specific claims they could use to bill for the screening tools.
 - Illinois periodically presented providers and health plans with the data derived from the claims from CPT Codes 96110, 96111, 99420. State staff explained that these claims data would be used to measure whether standardized screening was occurring.
 - When they presented the data, the rates of screening were low. They believed that their low rates were partially due to a) providers not conducting standardized developmental screening, and b) providers not billing for the standardized tools they were using.
 - The periodic reports of the measures derived from the claims data helped to incentivize and educate providers about the importance of screening and the availability of reimbursement. Over the next year, Illinois observed a marked increase in the number of providers submitting claims for standardized screening.

Measure #2: Percent of Children Aged 0-3 Referred for Services to Prevent or Treat Concerns Related to Social and Emotional Development

Once a child is identified as having or being at risk for a social or emotional developmental delay, the child needs to be treated to prevent the development or deterioration of the condition. The recommended standard of care will not necessarily require the child be served by a provider other than their primary care provider. When the standard of care does recommend external treatment, a referral from the primary care provider to another provider is an important first step to receiving treatment. This measure looks specifically at referrals to external sources of care.

Measurement assumptions

- Not all children identified at risk should be referred externally for services. The denominator for this measure will be specific to children identified at risk, for which the recommended standard of care is to refer to them to services external to the primary care provider's office.
- The denominator for this measure will be specific to the tools being used and the standards recommended for the identified risk groups via the screening tool.
- Only the intervention sites are being measured.

Overview of the measure

Numerator: Children aged 0–3 referred for services to prevent or treat concerns related to social and emotional development.

x 100

Denominator: Children aged 0–3 who were *identified at significant risk* who should be referred for services to prevent or treat concerns related to social and emotional development.

Important clarifying questions

The key to this measure is to clarify and define the numerator and denominator to determine reliable and valid data sources for this information. Important questions to ask as you are developing your measurement methodology include the following:

Examples of Clarifying Questions About the Numerator:

- For the risk categories identified via the screening tool, to which services should the child be referred?
- What data systems have information about these referrals?

Examples of Clarifying Questions About the Denominator:

- How will the denominator for this measure be identified, that is, those children who should have received a referral?

There are two options:

- Option #1: Children who were screened, identified as at significant risk, and who needed to be referred for services.
 - Option #2: An estimate of the number of children who should have received a referral service given the characteristics of the population and the screening tool used. This option should only be used if risk specific information was not obtained for the child during the data collection for Measure #1.
- What data systems have information about these referrals? If these data systems are incomplete, it may be impossible to collect valid/reliable information about referrals.

Recommended possible data sources for Measure #2

Recommended possible data sources for Measure #2 are:

- Medical chart, and
- Parent report.

Table 2 provides a brief overview of possible data sources, measurement strategies, and key methodological issues to consider.

Table 2 Possible data sources for measuring the percent of children aged 0-3 referred for services to prevent or treat concerns related to social and emotional development

Data Source	Numerator	Denominator	Examples of Data Collection Tools Used for Measurement	Issues Related to Data Collection	Discussion/Consensus Needed
Medical Chart	Number of children whose charts have a completed screening tool identifying them at significant risk for which the provider referred the child for additional services.	Number of children who have received well-child care in the intervention time period whose charts were reviewed and who were identified at significant risk.	<ul style="list-style-type: none"> • Appendix A provides example directions used in the <i>Healthy Development Learning Collaborative</i>²¹ for identifying whether children received follow-up services. • Appendix E provides an example of a chart-based form used in California that lists specific referral resources to guide providers that was also used for measurement purposes. 	<ul style="list-style-type: none"> • See issues listed in Table 1. • The level of completeness of the charts regarding the need for referrals may vary. 	<ul style="list-style-type: none"> • See items listed in Table 1. • Define what referrals should be identified for each risk group. • These specifications are needed for each screening tool used.

²¹ The *Healthy Development Learning Collaborative* was a year-long quality improvement initiative in which primary care practices in Vermont and North Carolina used improved office systems to engage families in efforts to promote positive developmental outcomes. More information about the *Healthy Development Learning Collaborative* can be found on The Commonwealth Fund website at: http://www.cmwf.org/tools/tools_show.htm?doc_id=372065

Data Source	Numerator	Denominator	Examples of Data Collection Tools Used for Measurement	Issues Related to Data Collection	Discussion/ Consensus Needed
Parent Report	Number of children whose parents answered items indicating that their child was identified at significant risk and who also reported that the child was referred for services.	Number of eligible children whose parents completed the survey and/or who were asked questions via an interviewer-administered survey whose child was identified at significant risk, and who had a well-child visit during the intervention time period.	<ul style="list-style-type: none"> • The CAHMI's Promoting Healthy Development Survey (PHDS) has items derived from the Parent Evaluation of Developmental Status © (PEDS) in order to identify children at risk for delays. Additional items in the PHDS ask the parent about services the child was referred. Additional information about the PHDS can be found at www.cahmi.org. • Other surveys include items focused on services to which the child may have been referred, such as the National Survey of Children with Special Health Care Needs, the National Survey of Children's Health, and the Consumer Assessment of Health Plans Survey with the Children with Chronic Conditions module.²² 	<ul style="list-style-type: none"> • See issues listed in Table 1. • Child may be identified at significant risk by the survey, but was not screened in the office, and therefore the provider did not know the child was at risk. • Only parent-completed screening tools can be used for parent-report. If non-parent completed tools, then the number and type of children identified at risk and for whom referral services are needed may not be comparable. 	<ul style="list-style-type: none"> • See items listed in Table 1. • Define what referrals should be identified for each risk group. • These specifications are needed for each screening tool used.

²² The [National Survey of Children with Special Health Care Needs \(CSHCN\)](http://www.cshcn.org) provides information about children and youth with special health care needs in all 50 states and the District of Columbia. In each state, telephone interviewers screened at least 3,000 households with children to identify children and youth with special health care needs. In-depth interviews were conducted with the parents of 750 of these children in each state. More information about the National Survey of Children with Special Health Care Needs can be found at <http://www.cshcn.org>. The [National Survey of Children's Health](http://www.cdc.gov/nchs/about/major/slats/nsch.html) is sponsored by the Maternal and Child Health Bureau of the U.S. Department of Health & Human Services' Health Resources and Services Administration. The survey is designed to examine the physical and emotional health of children ages 0–17. Special emphasis is placed on factors that may relate to the well-being of children, including medical homes, family interactions, parental health, school and after-school experiences, and safe neighborhoods. Data was collected in 2003, with national and state-level estimates available in late 2004. More information about the National Survey of Children's Health can be found at <http://www.cdc.gov/nchs/about/major/slats/nsch.html>. The [Consumer Assessment of Health Plans Survey \(CAHPS®\)](http://www.cdc.gov/nchs/about/major/slats/nsch.html) is a patient-reported experience of care survey. Adult and child versions are available. Commercial and public purchasers, health plans, and purchasing coalitions can use the CAHPS® survey and reporting kit to gather and disseminate comparable information on health care quality from the patient's perspective. Development of the CAHPS® is funded by the Agency for Healthcare Research and Quality (AHRQ). The [CAHPS-CCC](http://www.cdc.gov/nchs/about/major/slats/nsch.html) is CAHPS survey with the Children with Chronic Conditions module (from TalkingQuality.gov)

Possible data sources for Measure #2 that are not currently recommended

Data sources that are not currently recommended for Measure #2 are:

- **Billing/encounter data:** Billing and encounter data are limited to visits and/or services that have been received. Therefore, it is not clear whether referrals alone can be found in the billing/encounter data systems.
- **Provider survey:** Measure #2 is anchored to the percent of children who were identified at significant risk and who were referred for services. Using a provider survey would determine the percent of providers who estimated the number of children they properly identified at risk AND who they referred to external services. Proxy measures such as this have not been shown to be a valid measure for determining child-level measures of whether specific aspects of care were received.

Methodological issues to consider in calculating Measure #2

- The denominator for this measure is children identified at significant risk who should have been referred for additional services: Only those children who are screened and identified at a significant risk level for which a referral is the standard of care are included in the denominator. The data source chosen needs to be thoroughly examined for its validity for this type of measurement. There is evidence in the literature to show that referrals may not be well-documented in the medical chart.
 - This excludes children identified at risk, but who could be managed by the primary care provider.
 - This also excludes the children who are not screened and therefore were not referred to needed services. States should take this into consideration and understand that the findings are a best case scenario and do not represent care for the children identified in Measure #1 who were not screened.
- If claims/billing data are used, lag times between when the claim is made and when it appears in the billing data needs to be considered and the measurement approach adjusted accordingly.

Example of a possible measurement approach

Practice A used a medical chart review to collect data for Measure #1 and Measure #2. At the time of data collection for Measure #1, for each completed tool found in the chart, the practice identified children who were at significant risk. Practice A then reviewed **ONLY** the charts of those children who were identified at significant risk (denominator for Measure #2) and examined the charts for the presence of a referral to an external provider.

ABCD II states measurement strategies and lessons learned

This measure was a difficult one for the ABCD II states to accurately collect due to barriers in obtaining information about how many children were identified at significant risk and should have referred to other resources (the denominator for the measure).

A majority of the ABCD II states used medical chart reviews as the data source for Measure #2.

- Appendix E provides an example of a chart-based form used in California. This tool was particularly helpful to providers in California because it listed all of the specific referral resources available. Secondly, the tool was helpful in providing detailed, specific information for data collection for Measure #2 and Measure #3.

Furthermore, many of the ABCD II states used reports from the referral entities and/or claims data to determine how many children were referred. This information was valuable in providing information about the numerator for the measure.

Key lessons learned from the ABCD II measurement efforts useful for other states include the following:

- Many of the lessons learned that were noted for Measure #1 also apply for the data collection for Measure #2, including the following: 1) the data collection strategies need to be feasible and easy to understand, 2) where possible, the measurement should be incorporated as part of the implementation, 3) routine check-ins and technical assistance is needed, 4) the length and amount of data collection needs to be considered, and 5) findings need to be reported back to key stakeholders.
- **Proxy numerator for Measure #2: Number of children who received referred services**
 - A number of the ABCD II states were only able to accurately identify the number of children who received referred services.
 - This does not identify children who were referred for services, but from whom the service was not received (*e.g. the parent did not take the child to the visit; the referral entity did not have any free appointments*).
 - Therefore, this numerator is a “best case” scenario for Measure #2 because it is only anchored to children who received the service.
- **Proxy denominator for Measure #2: Tool-specific information about the number of children who should be referred**
 - As mentioned earlier, a number of the ABCD II states were only able to accurately identify the number of children who were referred services (numerator). They were not able to identify children who should have been referred for services. To address this limitation, states such as Illinois examined the specific tools used and estimated the number of children *who should have been referred* based on the population to which the screening tool was being administered. Illinois expected that between 6-

12% of children screened should be referred out and used this proxy estimate as a denominator for their measure.

- **Children referred who were not identified at risk**
 - Utah used a medical chart abstraction tool that asked office staff to review medical charts and identify whether the child had been 1) screened, 2) referred, and 3) whether there was documentation of follow-up care being provided either by the primary care provider or communications from another provider about referred services. Utah found that there were some children who were referred who had not been screened. Future users should assure the following are clearly specified in the medical chart abstraction tool to potentially avoid this ambiguous data:
 - Clearly explain that medical chart abstraction tool is anchored to referrals that are based on the results of the screening. An additional column should be added for the provider to indicate that they referred the child for other services based on clinical observations and/or past surveillance or screening methods.
 - The greater the specificity in the kinds of referrals that can be found, the more precise the measurement effort.
- **Decrease in the number of children referred**
 - Iowa found a decrease in the number of children who were referred outside the primary care provider's office. This was an unexpected finding that could be due to a number of factors such as the following:
 - a) Through the training and implementation of the ABCD II efforts, the providers felt better equipped to handle the issues identified internally.
 - b) The implementation process increased the number of children identified at risk who should have been referred (the denominator). Therefore, the numerator might have increased, but because the efforts were targeted to improve the screening, the denominator increased as well.
 - c) Other factors related to medical chart documentation, etc.
 - It is important to consider that this might happen, and options should be in place for collecting additional descriptive information that will help to explain the findings.

Measure #3: Percent of Children Aged 0-3 Treated for Concerns Related to Social and Emotional Development

The ABCD II Consortium states recognized that, at times, the appropriate treatment for a child identified as at-risk for social or emotional development concerns can be provided by the primary provider. Therefore they wished to produce a measure of 'children treated' that accommodated treatment provided by the primary care provider, as well as other providers.

Measurement assumptions

- Children who should have been treated for delays related to social and emotional development are those identified by selected standardized tools as having concerns related to social and emotional development.

- Treatment includes all services that address concerns identified via the screening tool. This can include services provided by the primary care provider such as anticipatory guidance and parent education, continued surveillance, and re-testing using the same or a different tool. It can also include services provided outside the primary care provider’s office such as enhanced testing and assessment, referral to another health care provider for enhanced testing and assessment of the child or follow-up care, and/or referral to resources in the community.
- Appropriate treatment steps will be identified based on the screening tools that were used and the risk groups identified by each tool. If the screening tools are different within/across states, then the measurement methodology will need to be adjusted for each tool, therefore decreasing the standardization of the measures and lowering the ability to summarize the information at the state level. If different tools are used, then the findings should be specifically stratified according to the tool used.
- Only the intervention sites are being measured.

Overview of the measure

Numerator: Children aged 0–3 who were *identified at significant risk* who were treated for concerns related to social and emotional development.

x 100

Denominator: Children aged 0–3 who were *identified at significant risk* and *who should have been treated* for concerns related to social and emotional development that had a visit during the intervention time period.

Important clarifying questions

The key to specifying this measure will be to clarify and define the numerator and denominator to determine reliable and valid data sources for this information.

Examples of clarifying questions related to the numerator:

- What services will be considered “treating the child”?
- It is important to list and define the treatment that should be provided within the primary care provider’s office and what services should be provided outside the primary care provider’s office.
- It is important to remember that treatment includes all services that address the concern identified via the screening tool, including anticipatory guidance and parent education (or guidance), continued surveillance and re-testing according to the recommended periodicity in the primary office, enhanced testing and assessment of the child in the primary office, referral to another health care provider for enhanced testing and assessment of the child or follow-up care, and referral to resources in the community. The measurement team will need to define the appropriate indicators that will be used to capture information about each of the appropriate treatment categories. Depending on the

tool, appropriate treatment steps need to be listed by the risk groups identified via the screening tool.

- What treatment services have reliable and valid data sources? While referral to community resources may be recommended, valid data sources may not exist to measure whether or not the child received appropriate care in the community.

Examples of clarifying questions related to the denominator.

- Which children should receive treatment? This answer is most likely dependent on the screening tool, and findings will have to be stratified according to risk/concern specific categories, as the appropriate treatment will significantly vary depending on the level and type of risk/concern identified.
- Should there be multiple versions of this measure that are specific to the appropriate level of treatment?

Two recommended measures to focus on treatment

Since treatment can occur within and outside of the primary care provider’s office, the CAHMI recommends two measures to assess whether treatment services were provided.

- The first (Measure 3A) addresses measurement of children ages 0-3 who are treated by their primary care provider for concerns related to social and emotional development.
- The second (Measure 3B) addresses measurement of children ages 0-3 who are treated by persons other than their primary care provider for delays related to social and emotional development.

Measure 3A

Numerator: Children who received treatment services from the primary care provider who conducted the screening (e.g. children who received anticipatory guidance and parent education, continued surveillance and re-testing according to the recommended periodicity in the primary office, enhanced testing, and assessment of the child in the primary office).

_____ X 100

Denominator: Children who were screened using a standardized tool and whose screening results indicated that they should receive treatment services that should be provided by the primary care provider.

Measure 3B

Numerator: Children who received treatment services such as enhanced testing and assessment of the child, follow-up care, or a referral to resources in the community from a non-primary care provider.

_____ X 100

Denominator: Children who were screened using a standardized tool and whose screening results indicated that they *should receive* treatment services such as

enhanced testing and assessment of the child, follow-up care, or a referral to resources in the community from a non-primary care provider.

Recommended possible data sources for Measure #3

Recommended possible data sources for Measure #3 are:

- Medical chart,
- Parent report, and
- Billing/encounter data.

Tables 3A and 3B provide brief overviews of possible data sources, measurement strategies, and key methodological issues to consider relative to the two denominators specified above.

Table 3A Possible data sources for measuring the percent of children aged 0-3 treated by their primary care provider for delays related to social and emotional development

Data Source	Numerator	Denominator	Example of Data Collection Tools Used for Measurement	Issues Related to Data Collection	Discussion/Consensus Needed
Medical Chart	Number of children whose charts have a completed screening tool identifying them at significant risk/concern and who received appropriate treatment services in the primary care provider's office.	Number of children whose charts have a completed screening tool identifying them at significant risk and who should have received treatment services in the primary care provider's office	<ul style="list-style-type: none"> • Appendix A provides example directions used in the <i>Healthy Development Learning Collaborative</i>²³ for identifying whether children received follow-up services. • Appendix E provides an example of a chart-based form used in California that lists specific referral resources to guide providers that was also used for measurement purposes. • Appendix F provides an example of a chart-based form used in Minnesota that specifies specific follow-up steps that may have been conducted by the primary care provider. 	<ul style="list-style-type: none"> • See issues listed in Table 1. • It is unclear the level of specificity that will be available in the chart about how the primary care provider addressed the issues identified by the screening tool. Numerous studies have shown that anticipatory guidance and parental education are often not recorded in the chart. 	<ul style="list-style-type: none"> • See items listed in Tables 1 and 2. • Define the appropriate treatment services that should be provided by the primary care provider's office for each "risk group" identified via the screening tool.

²³ The *Healthy Development Learning Collaborative* was a year-long quality improvement initiative in which primary care practices in Vermont and North Carolina used improved office systems to engage families in efforts to promote positive developmental outcomes. More information about the *Healthy Development Learning Collaborative* can be found on The Commonwealth Fund website at: http://www.cmwf.org/tools/tools_show.htm?doc_id=372065

Data Source	Numerator	Denominator	Example of Data Collection Tools Used for Measurement	Issues Related to Data Collection	Discussion/ Consensus Needed
Parent Report	Number of children whose parents answered items indicating their child was at significant risk/concern and who answered positively to items indicating that their child received treatment services in the primary care provider's office.	Number of eligible children whose parents completed the survey and/or who were asked questions via an interviewer-administered survey and who were identified at significant risk/concern who should have received treatment services in the primary care provider's office.	<ul style="list-style-type: none"> The CAHMI's Promoting Healthy Development Survey (PHDS) has items derived from the Parent Evaluation of Developmental Status © (PEDS) in order to identify children at risk for delays. Additional items in the PHDS ask the parent about services the child was referred. Additional information about the PHDS can be found at www.cahmi.org. Other surveys include items focused on services the child may have been referred such as the National Survey of Children with Special Health Care Needs, the National Survey of Children's Health, and the Consumer Assessment of Health Plans Survey with the Children with Chronic Conditions module.²⁴ 	<ul style="list-style-type: none"> See issues listed in Tables 1 and 2. 	<ul style="list-style-type: none"> See items listed in Tables 1 and 2. Define the appropriate treatment services that should be provided by the primary care provider's office for each "risk group" identified via the screening tool.

²⁴ The [National Survey of Children with Special Health Care Needs](http://www.cshcn.org) (CSHCN) provides information about children and youth with special health care needs in all 50 states and the District of Columbia. In each state, telephone interviewers screened at least 3,000 households with children to identify children and youth with special health care needs. In-depth interviews were conducted with the parents of 750 of these children in each state. More information about the National Survey of Children with Special Health Care Needs can be found at <http://www.cshcn.org>. The [National Survey of Children's Health](http://www.cdc.gov/nchs/about/major/slaits/nsch.html) is sponsored by the Maternal and Child Health Bureau of the U.S. Department of Health & Human Services' Health Resources and Services Administration. The survey is designed to examine the physical and emotional health of children ages 0–17. Special emphasis is placed on factors that may relate to the well-being of children, including medical homes, family interactions, parental health, school and after-school experiences, and safe neighborhoods. Data was collected in 2003, with national and state-level estimates available in late 2004. More information about the National Survey of Children's Health can be found at <http://www.cdc.gov/nchs/about/major/slaits/nsch.html>. The [Consumer Assessment of Health Plans Survey \(CAHPS®\)](http://www.talkingquality.gov) is a patient-reported experience of care survey. Adult and child versions are available. Commercial and public purchasers, health plans, and purchasing coalitions can use the CAHPS® survey and reporting kit to gather and disseminate comparable information on health care quality from the patient's perspective. Development of the CAHPS® is funded by the Agency for Healthcare Research and Quality (AHRQ). The [CAHPS-CCC](http://www.talkingquality.gov) is CAHPS survey with the Children with Chronic Conditions module (from TalkingQuality.gov)

Table 3B Possible data sources for measuring the percent of children aged 0-3 treated by persons other than their primary care provider for delays related to social and emotional development

Data Source	Numerator	Denominator	Example of Data Collection Tools Used for Measurement	Issues Related to Data Collection	Discussion/Consensus Needed
Medical Chart	Number of children whose charts have a completed screening tool identifying them at significant risk/concern and who received referred services.	Number of children whose charts have a completed screening tool identifying them at significant risk and who should have received treatment services outside the primary care provider's office.	<ul style="list-style-type: none"> • Appendix F provides an example of a chart-based form used in Minnesota that specifies specific follow-up steps that may have been conducted by the primary care provider. 	<ul style="list-style-type: none"> • See issues listed in Table 1. • This approach requires that the entities that provide the referred services communicate back to the primary care provider. It is unclear whether this happens in a routine and systematic manner, therefore it is unclear whether this data source is valid for measuring whether follow-up services were received. 	<ul style="list-style-type: none"> • See items listed in Tables 1 and 2. • Define the appropriate treatment services that should be referred for each "risk group" identified via the screening tool.
Claims/Encounter Data	Number of children who are at significant risk who received treatment services outside the PCP office.	Number of children who have been diagnosed at significant risk and who should have received treatment services outside the PCP office.	<ul style="list-style-type: none"> • DBpeds.org has a number of articles focused on claims data related to periodic surveillance and treatment for developmental delays. http://www.dbpeds.org/tools/topic.cfm?TopicID=78&textID=123 • The <i>American Academy of Pediatrics Statement on Identifying Infants and Young Children with Developmental Disorders in the Medical Home</i> (July, 2006)²⁵ provides a detailed description of claims that can be used for standardized screening. 	<ul style="list-style-type: none"> • Validity of the billing and encounter data. • Treatment services may be conducted in a variety of places for which the data are not integrated. If this is the case, these services will not be recorded in the billing and encounter data. • It is unclear how the denominator (children at significant risk) for this measure will be identified via billing and encounter data when the DC:0-3 is not present. In the absence of the DC:0-3, many children at significant risk and/or who currently have social, emotional, and developmental delays will be missed. • This measure may have to be narrowed so that it is only for the treatment of services for which there is accurate billing/encounter data. Narrowed in this way, it would not include appropriate treatment through resources in the community. If the measures are narrowed, then the denominator and numerator would have to be adjusted accordingly. 	<ul style="list-style-type: none"> • An "additive" measure may be needed to identify the denominator for this measure, as one will not be able to determine the number of children at significant risk who should have received services external to the office. • Specify and define groups: by diagnostic categories, appropriate levels of treatment.

²⁵ www.pediatrics.org/cgi/doi/10.1542/peds.2006-1231

Data Source	Numerator	Denominator	Example of Data Collection Tools Used for Measurement	Issues Related to Data Collection	Discussion/ Consensus Needed
Parent Report	Number of children whose parents answered items indicating their child was at significant risk/concern and who also responded positively to items about treatment services received outside the PCP office.	Number of eligible children whose parents completed the survey who were identified at significant risk and who should have received treatment services outside the PCP office.	<ul style="list-style-type: none"> • See the resources listed in Tables 2 and 3A. • Appendix G provides an example of a script that was used by case coordinators in <i>Iowa</i> asking about the follow-up services the child received. 	<ul style="list-style-type: none"> • See issues listed in Tables 1, 2 and 3A. 	<ul style="list-style-type: none"> • Specify and define appropriate treatment by risk groups. • Identify appropriate survey items. • See topics listed in Tables 2 and 3a.

Methodological issues to consider

- Limitation of the measure: If claims data are used, only those children who are identified by their health care provider and who received services are included in the denominator. This excludes children who were not screened and therefore were not referred to needed services. States should take this into consideration and understand that the findings are a “best case scenario” and do not represent care for the children identified in Measure #1 who were not screened.
- Problems with data integration: Although a primary component of the ABCD II initiative was the integration across multiple departments in the state, their efforts did not necessarily address systematic problems related to data system integration. The ABCD II states were often unable to combine data sources from different places at a child-level (e.g. Medicaid, Dept of Health, Title V, Part C, etc). When using a data source (e.g. claims data from Medicaid), states will be limited to only the claims present in the Medicaid system. Therefore, states need to explicitly articulate what services are and are not included in the numerator and denominator and assure that biases are the same across their state pilot sites.

Examples of a possible measurement approach

Example 1

Health Plan X used the PEDS to screen children at risk in pediatric offices. Health Plan X utilized a parent survey to collect data for Measures #1-3. The Plan identified a random, representative sample of children 3–35 months who had at least one well-child visit during the intervention time period and administered the parent survey by telephone. The PEDS instrument was included in the survey. Parents whose children were identified at risk in the survey (denominator for Measure #3) were asked specific questions about the appropriate follow-up recommended via the PEDS diagnostic tool. Health Plan X determined which children received appropriate follow-up (numerator) based on the parents’ responses.

Example 2

Public Health Office X decided to implement the DC:0-3. Medicaid identified children aged 0-3 who go to Office X for well-child care and who have diagnoses, via the DC:0-3, during the intervention time period. This group represents the denominator for this measure.

Diagnosis-specific groups were then created based on the kinds of services children identified with the specific diagnoses they should receive. For each diagnostic group, for each child, billing and encounter data were examined for services the child should have received. Children who received these services are counted for the numerator of this measure.

ABCD II states measurement strategies and lessons learned

A majority of the ABCD II states used medical chart reviews as the data source for Measure #3.

Again, a primary problem that the ABCD II states encountered in calculating these measures was the lack of available data for who should be included in the denominator. Most of the ABCD II states used the number of children screened as the denominator for Measure #3A and Measure #3B.

- **Appendix E** provides an example of a chart-based form used in California. This tool included a section focused on follow-up services that were performed by the primary care provider (numerator for Measure #3A) AND services that were referred by the primary care provider (numerator for Measure #3B).
 - This tool was particularly helpful to providers in California because it listed all of the specific referral resources available to providers. Secondly, the tool provided detailed, specific information useful for Measure #2 and Measure #3A and #3B.
- **Appendix F** provides an example of a chart-based form used in Minnesota that specifies specific follow-up steps that may have been conducted by the primary care provider and/or referred services that were received.
- **Appendix G** provides an example of the script that was used by care coordinators in Iowa to assess whether children received follow-up services.
 - This strategy is an example of combining implementation with measurement. The care coordinators were used in this project to follow-up with all children identified at risk. As part of these processes set up to ensure that children were receiving follow-up services, Iowa collected valuable descriptive and quantitative data useful for measurement purposes.

Lastly, many of the ABCD II states used reports from the referral entities and/or claims data to determine how many children were referred.

Key lessons learned from the ABCD II measurement efforts useful for future states include the following:

- Many of the lessons learned noted for Measure #1 also apply for the data collection for Measure #3A and Measure #3B including the following: 1) the data collection strategies need to be feasible and easy to understand, 2) measurement should be incorporated as part of the implementation, 3) routine check-ins and technical assistance is needed, 4) the length and amount of data collection needs to be considered and 5) findings need to be reported back to key stakeholders.
- **Proxy denominator for Measure #3A: Children screened minus the number of children who received referrals**
 - A number of the ABCD II states were not able to obtain accurate information to decipher how many children should have been treated by the primary care provider.

- One method that was used by Utah was to subtract the number of children screened (numerator for Measure #1) from the number of children who received referral services (numerator for Measure #3B).
- While not perfect, this approach allowed Utah to calculate a more accurate estimate percentage of children treated by their primary care provider based on the data they had available. (*Important note: This approach did not allow them to remove from the denominator for Measure #3A children who were referred for services but did not receive them*).
- **Proxy denominator for Measure #3: Tool-specific information about the number of children who should be referred**
 - A number of states were only able to accurately identify the number of children who were referred for services (numerator). They were not able to identify children who should have been referred for services. To address this limitation, states such as Illinois examined the specific tools used and estimated the number of children *who should have been referred* based on the population to which the screening tool was being administered. Illinois expected that between 6-12% of children screened should be referred out and used this proxy estimate as a denominator for their measure.
 - **Maximize, where possible, data available in other systems about referred services**
 - As was mentioned earlier, a key focus of screening and follow-up efforts is to increase the collaboration between different entities responsible for children’s health and well-being.
 - While it may not be possible to combine data sources for children, you may be able to obtain general information about the number of children who received services by these other entities (information that would inform the numerator for the measure). For example:
 - Illinois received information from the Early Intervention Department (Part C) about the number of children who were referred and received services.
 - Minnesota worked with Head Start to identify children who were screened and for whom detailed follow-up services were being provided. This ensured non-duplication across the systems.
 - **Children who received referral services who were not identified at risk**
 - Utah used a medical chart abstraction tool that asked the provider to review charts and identify whether the child had been 1) screened 2) referred and 3) whether there was documentation of follow-up care being provided either by the primary care provider or communications from another provider about referred services. Utah found that there were some children who were referred who had not been screened. Future users should assure the following are clearly specified in the medical chart abstraction tool to potentially avoid the unclear data obtained in Utah:
 - Clearly explain that medical chart abstraction tool is anchored to referrals that are based on the results of the screening. An additional column should be added for the provider to indicate that they referred the child for other services based on clinical observations and/or past surveillance or screening methods.

- The greater the specificity in the kinds of referrals that can be found, the more precise the measurement effort.
- **Decrease in the number of children who received referral services**
 - Iowa found a decrease in the number of children who were referred outside the primary care providers office: This was an unexpected finding that could be due to a number of factors such as the following:
 - a) Through the training and implementation the providers felt better equipped to handle the issues identified internally.
 - b) The implementation process increased the number of children identified at risk who should have been referred (the denominator). Therefore, the numerator might have increased, but because the efforts were targeted to improving the screening, the denominator increased as well.
 - c) Other factors related to medical chart documentation, etc.
 - It is important to consider that this might happen, and options should be in place for collecting additional descriptive information that will help to explain the findings.

Review of General Measurement Design Process for the Three Standardized Measures

To summarize, as you are developing the measurement strategy for each of the standardized measures described, it is imperative that you ensure the following are key components of your measurement design process.

1. **Confirm whether the key assumptions and design parameters** described in for each of the measures are valid for your intended purpose. If not, note how these differences influence the measurement strategy.
2. **Identify the specific standardized tools** that will be counted as part of a standardized screening process. This step is imperative to the success of this project since the recommended measurement methodologies noted in this paper are meant to be anchored to the tools and to the recommended standards of care derived from these tools.
 - a. **Identify the periodicity** for when the screening tools should be administered (e.g., at least one screen by the 24-month well-child visit).
 - b. For each screening tool, **specify recommended follow-up/treatment steps** appropriate for each risk group of identified children.
 - c. For each of these groups, **specify the key treatment steps** recommended and the indicators that will be used to determine whether or not the child received an appropriate level of treatment.

3. **Identify the unit of analysis for the measure** or, in other words, define the “denominator” for each of the measures (e.g., practice-level, health plan level, county-level, patients seen by a public health nurse). This involves clarifying not only the setting of the intervention, but also who should be eligible to be included in the denominator (e.g., all children enrolled, all children who have been continuously enrolled, only children who had a visit during the time period).
4. **Define a standardized methodology** for what will be “counted” for the numerator for each measure.
5. **Pilot test the measurement methodology.**

This is a crucial step to assure that the measures being gathered are feasible and valid. Common problems found in the “pilot testing” phase are:

- A billing/encounter code identified for screening and/or follow-up is not routinely used by providers.
 - Necessary indicators are not in the medical chart, even though program implementation experiences show that the practice and/or provider are implementing the intervention (e.g., screening tools for children not identified at risk may not be in the charts).
 - Data systems are unable to merge (e.g., it is not possible, using the Social Security Number of the child, to merge data from Medicaid, the Department of Health, and Part C).
6. **Modify the measurement methodology** based on lessons learned from the pilot testing.
 7. **Implement a standardized methodology** for collecting the data.
 8. **Analyze and report the findings** to various stakeholders.

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PART D: ADDITIONAL EVALUATION METHODS USED BY THE ABCD II STATES

In addition to the three standardized measures described in Part C, each ABCD II state used other evaluation methods to assess their implementation efforts.

From surveys of providers and office staff, to focus groups, to measures of whether parents were screened for depression, these additional evaluation methods further assessed the impact and value of the ABCD II states' efforts to enhance children's mental health development.

In this section, methods evaluating the following components of state projects will be described, and sample strategies used by the ABCD II states will be provided on::

- **Provider and Office staff** experiences: Interviews, surveys, and focus groups.
- **Parental** experiences: Parental interviews, surveys, and focus groups.
- **Screening for maternal depression.**

Provider and Office Staff Experiences

An integral component of the ABCD II efforts was working with front-line health care providers in implementing systems and processes focused on screening and treatment of children with social and emotional developmental delays, and on increasing referrals for children identified at risk or with delays.

Evaluation of the providers' experiences in implementing these strategies allowed the ABCD II states to assess the value, feasibility, and potential sustainability of these efforts in the practices.

The strategies implemented by the pilot sites of the ABCD II consortium involved participation by the entire office team; including the physician, nurse or nurse practitioner, medical assistant, front-desk, and other office staff. Therefore, feedback about the experience needed to be obtained from the various persons responsible for the implementation of the ABCD II efforts.

Surveys, structured interviews, and focus groups allowed the ABCD II states to collect qualitative and quantitative information about the provider and office-staff experiences.

Evaluation methods based on provider and office experiences focused on the following:

- 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.

Examples of strategies used in the ABCD II states

- Iowa conducted four focus groups with physicians, nurses, and clinic managers from the participating practices. Appendix H provides a summary of these focus groups.
 - A facilitator conducted the focus groups and transcripts provided by reporters. Examples of the kinds of questions asked by the facilitator include the following:
 - How well did the standardized screening fit into the scope of your project? Did it cost additional time or work for your practice?
 - Will you continue to screen after the project has ended?
 - How do Medicaid rules and procedures affect the provider’s ability to participate in screening and follow-up?
 - What follow-up resources did you use most often?
 - How could the referral process be made more effective?
 - How did you treat children identified at risk who did not need to be referred?
 - What could be done to enhance your ability to care for these children?
 - A member of the project evaluation team then analyzed the transcripts and identified themes across all of the focus groups that related to specific aspects of the ABCD II implementation efforts.
- Minnesota conducted structured interviews and administered a survey to providers and office staff.
 - The structured interviews were conducted with five office staff and focused on how the screening tool was implemented, barriers, and changes needed to practice settings and processes developed to accommodate the ABCD II efforts. The one-to-one interviews were held between the evaluator and a clinic employee and lasted approximately 30 minutes. Each interview was tape-recorded and transcribed. Appendix I provides an overview of the questions asked during the interview. Examples of questions asked during the interviews include:
 - How did they previously screen and assess children’s social and emotional development?
 - Barriers encountered?
 - Clinic changes made to incorporate the screening tool?
 - Influence of the tool on their ability to care for and manage children’s healthy mental development?
 - Effect of the tool on the provider’s interactions with the parent?
 - What training and resources do providers need on standardized screening?
 - What other needs do they have?
 - The survey to providers was administered to the pediatricians and nurse practitioners in the pilot sites. The two-page survey examined the provider’s comfort level addressing mental health concerns, perceived impact of the screening tool on their daily practice, frequency and effectiveness of their strategies to address children’s mental health and future needs, and

recommendations they have for sustained screening and treatment. An example of the survey can be found in Appendix J.

- Illinois conducted structured interviews and administered a survey to providers.
 - The structured interviews were with the project leaders in each pilot site and with “pilot community” representatives (e.g. community coordinators, early intervention staff, providers to whom the pilot sites referred). Examples of questions asked in these interviews include:
 - What have you learned about promoting social and emotional development?
 - What was the easiest part of your work? What “easy wins” have there been?
 - What challenges did you encounter?
 - What surprised you the most about this work?
 - If you could start over, what would you do different?
 - What advice would you give to a primary care provider who was interested in promoting social and emotional development?
 - What advice do you have for the state in continuing the ABCD efforts?
 - The survey to providers and office staff was administered before and after the project implementation. An example of the survey can be found in Appendix K. The survey questions focused on the provider’s self-perceptions about their ability, current practice and comfort assessing and treating children’s social and emotional development, as well as comfort with the number of children identified and the places to which they are referred.

- Utah had providers complete a self-assessment of their practices related to screening and treatment of social and emotional development of young children before and after the project implementation.
 - Appendix L provides an example of the self-assessment form.
 - This assessment focused on their current attitudes and activities related to developmental screening.
 - Utah examined and observed practice improvements in their self-assessment and their attitudes and abilities related to developmental screening.

Tips for evaluating provider experiences:

- Collect provider and office staff experience data before AND after the project implementation: Many of the ABCD II sites were only able to obtain information about the provider and office staff’s experiences after the project implementation. If possible, collect baseline information about providers’ self-perceptions and practices before the project implementation. This will allow you to compare and contrast providers’ self-perceived ability to identify and care for children’s social and emotional development.

Tips specific to focus groups and structured interviews:

- Create a structured format/outline for the focus groups and interviews: In order to gather quantifiable information about the provider’s experiences, it is important to create a structured format and outline for the discussions that address key components of the

provider and office staff experiences. Open-ended discussions, while valuable in allowing providers and office staff to “debrief” about their experiences, often do not result in a comprehensive and tangible assessment of their experiences.

- Use an experienced facilitator and, if possible, someone not directly involved in the project: Significant research has shown how focus groups and structured interviews can be used to collect valid data. However, one must be trained on valid focus group and interview techniques in order to ensure that reliable and valid information is gathered. Be sure that the person who conducts the focus groups and/or interviews has significant experience with this type of qualitative research. Secondly, if possible, use a facilitator that has not been involved in the project and has no vested interest in the results. If an external person is used, it is imperative that this person receives sufficient background information about the project so that they can ask informed questions and have enough context to keep the discussion on track.
- Questionnaires, completed before a focus group or interview, collect valuable quantitative information during qualitative research: One valuable method for obtaining quantitative information is to have focus group or interview participants complete a short questionnaire at the beginning of the meeting.

Tips specific to a survey of providers and office staff:

- Where possible, use items from validated surveys: It is difficult to develop reliable and valid survey items. Whenever possible, use survey items that have been tested, validated and for which there is benchmark data available. For example, the American Academy of Pediatrics (AAP) periodically conducts a survey of AAP members and fellows. A list of the survey conducted by the AAP Survey of Fellows can be found at <http://www.aap.org/research/periodicsurvey/>. Secondly, the CAHMI has developed a provider survey focused more globally on developmental services that incorporates items from a number of AAP surveys. This survey can be found in Appendix M.
- Where possible, use validated self-assessment forms. It is difficult to develop reliable and valid assessment forms that office staff can complete. Whenever possible, use tools that have been tested with pediatric providers. An example of a validated tool is the *Office System Inventory (OSI)* developed by the *Healthy Development Learning Collaborative* and found in Appendix N. The OSI captures information about systems and processes the practice has in place related to developmental care for young children.
- Consider options for assuring a high response rate. Providers and office staff receive a lot of information in the mail. It is important to consider options for administering the survey that will make it stand out from the other mail that they receive. Strategies that can be used that increase provider response to surveys include: 1) Use of small incentives (e.g. a \$10.00 gift card to a local coffee house, 2) Disseminate the survey at in-person meetings, 3) Have someone that providers trust and respect clarify the importance of the provider’s response to the survey, 4) Remind providers weekly to complete the survey.

Parental Experiences

A common thread in the ABCD II consortium was the use of standardized tools and strategies guiding providers in discussions with the parent about their child's social and emotional development. A majority of the ABCD II states focused on efforts that utilized parent-completed, standardized screening tools.

Therefore, an invaluable component to a comprehensive evaluation includes an assessment of parental experiences.

Through surveys, interviews, and focus groups parents can provide evaluative feedback about the following:

- 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.
- Experiences with how their child's health care providers communicated the results of the screening tool to them.
- Experiences with treatment received from their child's primary care provider to address delays in their child's social and emotional development.
- Experiences with accessing referred services.
- Experiences and quality of treatment services received outside the primary care provider's office.
- Potential increased knowledge about their child's social and emotional development. Potential increased knowledge about what they can do enhance their child's social and emotional development.
- Suggestions for improvements to the screening, referral and follow-up process.

Examples of strategies used in the ABCD II states:

- Illinois administered a survey to parents that focused on their satisfaction and experience with completing the Ages and Stages Questionnaire®-Social and Emotional (ASQ-SE).
 - The one-page survey included eight items that focused on the parents perceptions of the ASQ-SE, the discussions that they had with the provider about their responses to the ASQ-SE and whether they felt that the ASQ-SE was a valuable addition to the well-child experience.
 - An example of the survey can be found in Appendix O.
- Iowa's ABCD II program focused on the use of a care coordinator for all children identified at significant risk. This care coordinator was responsible for periodically checking in with the family and assuring that they received the referral resources identified by their child's primary care provider.
 - Iowa maximized this contact with the parent by having the care coordinator ask the parent about their experiences with the screening conducted in their primary care provider's office and with referral resources.

- An example of questions asked by the care coordinator can be found in Appendix G. Examples of questions asked included:
 - At your appointment did provider *or* others in the *provider* office talk to you about your concerns about your child’s growth, learning, development or behavior? Were your questions answered about your child’s growth, learning, development or behavior?
 - Were you able to make a connection with the place or person *provider* asked you to go see?
 - Were you able to get an appointment for services (at primary provider or referral source)?

Tips for evaluating parental experiences:

In addition to the tips noted for assessing provider and office staff experiences, the following are important to consider when focused on parental experiences:

- ✓ Assess a potential increase in the perceived value of the well-child visit: The CAHMI recently conducted cognitive interviews with parents who had completed standardized screening tools. A majority of the parents interviewed noted that the screening tool increased the value of the well-child visit experience and enhanced their discussions with their child’s health care provider. Furthermore, it may be valuable to assess whether parents who completed tools are more likely to bring their child in for future well-child visits.
- ✓ Where possible, use items from validated surveys: Whenever possible, use survey items that have been tested, validated and (if possible) for which there is benchmark data. In addition to the surveys from the ABCD II states, survey items about referral, screening and treatment can be found in the following surveys:
 - **National Survey of Early Childhood Health (NSECH)**
www.cdc.gov/nchs/about/major/slaits/nsech.htm
 - **National Survey of Children’s Health (NSCH)**
www.cdc.gov/nchs/about/major/slaits/nsch.htm and www.nschdata.org
 - **National Health Interview Survey (NHIS)**
www.cdc.gov/nchs/nhis
 - **National Survey of Children with Special Health Care Needs (NS-CSHCN).**
www.cshcndata.org
 - **Behavioral Risk Factor Surveillance Survey (BRFSS)**
www.cdc.gov/brfss/
 - **Promoting Healthy Development Survey (PHDS).**
www.cahmi.org.

(Note: The list above represents a few surveys that may be considered and does not include all surveys focused on screening, referral, and follow-up).

Screening for Maternal Depression

A number of the ABCD II states determined that an integral component of projects focused on children's social and emotional development is the assessment of the parent's emotional status. Specifically, "studies have found that children of depressed women exhibit more problem behavior and have more difficulty achieving age appropriate developmental and cognitive milestones."²⁶ Additional evaluation measures collected by these ABCD II states focused on the rates of maternal depression screening.

Examples of strategies used in the ABCD II states:

- Illinois' ABCD II projects focused extensively on creating policies and processes focused on providers screening the mothers of all infants covered by Medicaid for perinatal depression. (More information about these policies can be found at www.nashp.org/Files/IL_Screening_Summary_3-4-05.pdf)
 - Illinois collected information from the medical chart to assess the screening rates for maternal depression.
 - Illinois' evaluation measure was anchored to the percentage of enrolled women who were screened for depression during the pre-natal or postpartum period.
 - Illinois utilized its External Quality Review Organization (EQRO) to conduct medical chart abstractions that identify whether mothers of infants covered by Medicaid were being screened for depression.
 - The Medical Chart abstraction tool developed by their EQRO (Health Services Advisory Group) included a section focused on subjective and objective screening that may have occurred, the outcome of the screening, and possible referral and treatment.
 - An example of the medical chart abstraction tool guidelines can be found in Appendix P. The review period used for the medical chart abstraction was from the onset of pregnancy through 56 days after the delivery date for women who had a live birth.
 - Evaluation data was also collected by the pilot sites.
 - For example, one pilot site used the Edinburgh tool to screen for depression. Chart reviews were conducted to assess how many children's mothers were screened using the Edinburgh tool.
 - Additional data collected focused on whether at-risk mothers were followed and/or treated based on the Edinburgh results. These follow-up and/or treatment steps included:
 - Re-screening (a recommended follow-up step for some women).
 - Referral to a community mental health agency (this included information about whether the mother refused this referral).
 - Escorting by the primary care provider for crisis evaluation and treatment.

²⁶ Illinois State Medicaid Policy for Reimbursement of Maternal Depression Screening

- Lastly, Illinois examined its paid claims data and assessed for the following:
 - Number of providers billing for perinatal depression.
 - Number of screenings conducted.
 - Unduplicated number of women who were screened.
- Utah also focused on maternal depression screening.
 - At the beginning of its improvement work, Utah had each provider complete a self-assessment about their current practices related to maternal depression screening. Appendix Q provides an example of the self-assessment used by provider.
 - Utah then conducted periodic chart reviews to measure improvements in screening rates. Appendix R provides an example of the medical chart abstraction tool used to collect data related to maternal depression screening.
- Iowa also conducted medical chart reviews to assess whether mothers had been screened for depression.
 - Iowa anchored its measure to whether parents (not just the mother) were screened for depression issues.

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PART E: POLICY OPTIONS TO ENCOURAGE STATE MEASUREMENT OF DEVELOPMENTAL SERVICES

This paper has highlighted a number of measures and strategies used by the ABCD II states to evaluate their efforts focused on screening, referral and treatment. A primary audience for this paper is state Medicaid agencies. Medicaid has a number of potential policy options arms related to current quality measurement and improvement requirements under which these evaluation measures may fit.

Potential policy options for state Medicaid agencies to measure developmental services:

- **Include developmental screening and surveillance in your state quality strategy** as well as in **routine assessment and audit of state systems**
 - According to federal regulations, each state Medicaid agency is required to have a written strategy for assessing & improving quality of managed care organizations (MCOs). Furthermore, states are required to audit and ensure that MCOs comply with state-established standards.
 - Make clear to providers and plans the Medicaid agency's expectations for collecting and reporting **routine and periodic screening, surveillance of children's development (general and social and emotional)**, and treatment for children identified at risk for or with delays. Subsequently, measures can then be required to assess the quality of this component of health care.
- **Enhance Reporting of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)**
 - Periodic screening and surveillance is a core component of EPSDT services.
 - Annually, states are required to report the Center for Medicare and Medicaid Services (CMS) Form 416. This report provides basic information about how many children are accessing and receiving EPSDT services.
 - Require specific documentation (and measures of) standardized screening for children's development (general and social-emotional development) as part of the core services required to be provided during an EPDST visit.
- **Use Claims and Enrollment Data Effectively**
 - States have a wealth of information in their claims and enrollment data systems. They can use this data source to address one more of the measures described in the paper.
 - Additionally, states can **examine other possible affects of improvement projects focused on increased screening and treatment**. For example, states may want to examine whether practices using standardized screening tools have higher well-child visit rates. The theory behind this analysis is that the use of standardized tools may enhance the value of the well-child visit for the parent and he/she may be more likely to bring their child in for periodic well-child visits.

- **Partner with other state agencies to collect robust, child-centered data**
 - **Cross-agency collaboration** between Medicaid/SCHIP and other agencies such as Title V, Part C, the Department of Health is essential to fully understanding the services children are receiving and to identify gaps in the care provided.
 - Medicaid agencies can work with other agencies to identify strategies allowing them to share data about the services each provide for children.
 - The value of a parent-based survey was noted throughout this paper. Agencies can **co-sponsor the administration of a survey** collecting valuable information about the child and family.

- **Monitor national efforts related to measuring early childhood care**
 - A number of **national surveys** collect information related to a child’s social and emotional development. State-specific data from these national surveys is often available. Examples of applicable surveys include the National Survey of Children’s Health (NSCH), National Survey of Children with Special Health Care Needs (NS-CSHCN) and the National Survey of Early Childhood Health (NSECH).

State Medicaid agencies can strengthen measurement of developmental services through their managed care contracts

- The **Balanced Budget Act** (BBA) regulations finalized in 2003 require State Medicaid programs that enroll children in managed care organizations to develop and demonstrate results on health care quality. This is especially true for those with special health care needs such as, children and youth with ongoing mental, emotional or behavioral health problems. The evaluation measures described in this paper could be part of one or more of the following activities required through the BBA. Examples include the following:
 - Require **performance measures** focused on screening, treatment, and follow-up in their contracts with Managed Care Organizations and/or Primary Care Case Management (PCCM) providers.
 - Require one or more of the MCO’s **Performance Improvement Projects** (PIP) to be focused on screening of children’s social and emotional development, follow-up, and treatment for those children identified at risk.

State Medicaid agencies can strengthen the measurement of developmental services through their EQRO contract

- Direct the **EQRO to validate whether children who accessed EPSDT care** were screened for their social and emotional development. As part of this work, states can require detailed measures related to whether children are screened and whether at-risk children receive treatment and follow-up care.
- Use the EQRO to lead a **state-wide improvement effort** focused on children’s development (general or social-emotional). As part of this effort, it is required that the EQRO collect evaluation data of their efforts.

- If **performance measures** of screening, referral and treatment are included in the MCO contract, then the **EQRO will be responsible for validating** the findings of these measures.
- If the MCO's are required to conduct a PIP on screening of children's social and emotional development, then the **EQRO is responsible for validating the PIP projects.**

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APPENDICES

Appendix A: Healthy Development Learning Collaborative Medical Chart Abstraction Tool (Used to collect measures of screening, referral, and treatment)

Appendix B: Utah Medical Chart Abstraction Tool (Used to collect measures of screening, referral, and treatment)

Appendix C: Iowa Medical Chart Abstraction Tool (Used to collect measures of screening, referral, and treatment)

Appendix D: Users Tip Sheet for Parent Reported Items Assessing Whether Standardized Developmental and Behavioral Screening Occurred (Developed by the Child and Adolescent Health Measurement Initiative [CAHMI])

Appendix E: California Referral Resources List (Form was inserted into the medical chart)

Appendix F: Minnesota form with follow-up steps for children identified at risk or with current delays (Form was inserted into the medical chart)

Appendix G: Iowa telephone script of questions used by care coordinators

Appendix H: Summary of Iowa Focus Groups with Providers and Office Staff

Appendix I: Minnesota Outline and Format of Structured Interviews with Providers and Office Staff

Appendix J: Minnesota Provider Survey

Appendix K: Illinois Provider Survey

Appendix L: Utah Practice Self-Assessment Form of Current Practices Related to Developmental Services

Appendix M: CAHMI Provider Survey (Titled Pediatric Preventive & Developmental Health Care: Current practices and perceptions)

Appendix N: Office System Inventory (Developed by the Healthy Development Learning Collaborative)

Appendix O: Illinois Parent Survey: Satisfaction with the ASQ-SE

Appendix P: Illinois Medical Chart Abstract Tool for Measures of Screening for Maternal Depression (Developed by Health Services Advisory Group)

Appendix Q: Utah Practice Self-Assessment Form of Current Practices Related to Maternal Depression Screening

Appendix R: Utah Medical Chart Abstract Tool for Measures of Screening for Maternal Depression

APPENDIX A:

Healthy Development Learning Collaborative Medical Chart Abstraction Tool (Used to collect measures of screening, referral, and treatment)

Healthy Development Learning Collaborative Chart Review Tool

Inclusion criteria:

The first 5 children seen in your office this week who meet the following criteria:

1. Age 0 to 48 months
2. Visit in office for a well-child visit (A “well-child” visit involves a general check of the child’s health, growth, development, and anticipatory or guidance; even if a problem is determined during the well child visit, such as otitis media, still classify it as a well-child visit)

NOTE: Some practices may wish to do the chart abstraction monthly — on the first 20 children (0-48 months) seen in your office this month, rather than doing it weekly...either way is fine.

Chart Review:

- Review the chart visits to ensure that the child had a well-child visit to your practice during the month
- Also, verify that the child's date of birth puts him/her at the age of 0-48 months on the date of today’s office visit

Other important points:

- We want consecutive children (0-48 months old) who have come in for a well-child visit each week.
- Create a system to ensure that patients seen this week meeting the above criteria are obtained for your review every week. We suggest that you set up a certain day each week to identify children who meet the inclusion criteria (e.g., Friday) and do the chart review on that day.
- Once you have reviewed 5 charts, you are done for the week (if you do not have 5 or more patients meeting inclusion criteria that is OK, complete forms on all you have and continue)
- Send the forms at the end of the month with your other data using the envelopes we provided
- It is possible that the same child could appear in your weekly consecutive patient list multiple times — exclude any second or subsequent visits for children whose charts you have reviewed (in other words, we only want their chart data one time). The patient log explained below will assist you in identifying these situations.

Patient Log

This log is a tool for you to track the patients you have selected for the chart review. It will also allow you to check for or correct errors at a later time. You will want to record the following information for each patient:

- Patient Log # (the Log number listed on the Patient Log sheet)
- Date of Office Visit (well-child ONLY)
- Patient Name
- Patient ID (if applicable) such as a medical record #

Only list patients who meet the inclusion criteria. It is important that the log with the names of patients be kept in a safe, secure place in your office to maintain patient confidentiality. **Do not send the logs to VCHIP.** This is a tool for your office to use only.

Recording Data:

- **Be sure to complete all questions (all questions are required).**

Specific instructions for each section are below.

Chart Review Tool

Inclusion Criteria:

- Patient must have been to your office for a well-child visit to be included.
- If not, go to next patient

	Site Name	• Enter the name of your practice
	Patient Log #	• Enter the Log number listed on the Patient Log sheet
	Chart Abstraction Date	• Enter the Date that chart abstraction is performed (mm/dd/yyyy)
#1	Date (mm/dd/yyyy) of most recent well-child visit	<ul style="list-style-type: none"> • This is the well-child visit date this week that made them eligible for the chart review • Enter month, day, and year
#2	Patient’s age in months at most recent well-child visit	<ul style="list-style-type: none"> • Age, in months, of patient whose chart is being reviewed (<i>round to the nearest whole month</i>) • Eligibility criteria for chart audit are patients who are 0-48 months old
#3	Insurance Type: Does this child have Medicaid?	Check YES if the child has Medicaid according to the practice records. This includes children with other insurance in addition to Medicaid.
#4	Was a structured developmental screening ever documented in the chart for this child?	<p>Screening is used to identify those children at risk and to flag those who need further assessment. Types of structured developmental screening tools include Ages and Stages (ASQ), the Parent’s Evaluation of Developmental Status (PEDS), and the Child Development Inventory (CDI).</p> <ul style="list-style-type: none"> • Check YES if there is documentation of a structured developmental screening on the chart. The screening tool must include the following areas: 1) fine motor skills, 2) gross motor skills, 3) language development, and 4) cognitive/problem solving.

- Check NO if there is no documentation of a developmental screening on the chart OR if the screening tool does not include all of the 4 topic areas mentioned above.
 - If answer is NO, skip to Question 6.
- #5 At which well-child visits did this child receive a structured developmental screening?
- The AAP Committee on Children with Disabilities recommends the use of structured screening tests at each well child visit.
- Place a checkmark in the appropriate box to show at which well-child visits a structured developmental screening occurred. The screening tool must include the following areas: 1) fine motor skills, 2) gross motor skills, 3) language development, and 4) cognitive/problem solving.
 - Give credit for developmental screenings that include the 4 key topic areas mentioned above.
- #6 Was a psychosocial screening ever documented in the chart for this child and/or the family?
- Screening is used to identify those children at risk and to flag those who need further assessment. Psychosocial screening can be done by using a standardized screening tool such as the Family Psychosocial Screening and the Orr Social Inventory or the provider may informally ask parents a few simple questions at key times when a child's behavior may be creating stress in the home (e.g. colic, toilet training)
- Check YES if there is documentation of a psychosocial screening on the chart. The psychosocial screening should include **at least** one of the following areas: 1) maternal depression, 2) domestic violence, and 3) substance abuse.
 - Check NO if there is no documentation of a psychosocial screening on the chart OR if the screening tool does not include at least one of the three topic areas mentioned above.
 - If answer is NO, skip to Question 9.
- #7 At which well-child visits did this child/family receive a psychosocial screening?
- Place a checkmark in the appropriate box to show if a psychosocial screening occurred:
 - During at least one of the 0-4 month well-child visits
 - During at least one well-child visit between 5 months and 4 years
 - Give credit for psychosocial screenings that include at least one of the 3 key topic areas mentioned above.

- #8** Which of the following psychosocial screening topics were included?
- Place a checkmark in the appropriate box to show which topics were discussed as part of the psychosocial screening:
 - Maternal Depression
 - Domestic Violence
 - Substance Abuse
 - Check NONE OF THE ABOVE if there is no documentation that screening occurred for at least one of the topic areas above.
- #9** Was this child ever identified as “at-risk” for poor developmental outcomes?
- “At-risk” may be defined based on a positive screen using a formal screening tool (e.g. PEDS), based on the provider’s assessment of the child and family, or from a parent concern that was expressed at the well-child visit.
 - “At-risk” status may be found in the chart on a patient problem list, intake sheet, family history form, hospital newborn history form, parent questionnaire, on a formal screening tool, or on any care notes in the chart (i.e. provider, nurse, social worker)
 - Check YES if there is documentation anywhere in the chart that this child is “at-risk” as defined above.
 - Check NO if there is no documentation that the child was identified as “at-risk”.
- #10** At what age was this child identified as “at-risk”?
- Place a checkmark in the appropriate box to show at what age this child was first identified as “at-risk” for poor developmental outcomes
 - At birth
 - Age, in months (*round to the nearest whole month*)
 - Check NO if there is no documentation of the age that this child was identified as “at-risk”.
- #11** What course of action took place after the child was identified as “at-risk”?
- Place a checkmark in the appropriate box that describes the course of action that took place after the child was identified as “at-risk” for poor developmental outcomes. Follow-up care includes:
 - Planned follow-up for “at-risk” issue at a later office visit
 - Child referred to community resource for additional care
 - Referral made, but parent declined referral
 - Check “No follow-up care or referral documented in chart” if there is no documentation in the chart of follow-up care or that a referral was made once this

child was identified as “at-risk”.

➔ Please retain a copy of the Chart Review Tool for your own records. During the last week of each month please send the originals in the Pre-Addressed Manila Envelope provided to:

Rachael Beddoe
VCHIP
Room 5445
Arnold 5 UHC Campus
One South Prospect Street
Burlington, VT 05401

Be careful to include the practice site name and patient log number but no other identifying information on the completed abstraction form. **We strongly advise you to keep copies of the completed chart review tools until notified by VCHIP that all of your completed Healthy Development Chart Review Tools have been received.** These completed abstraction tools may also be helpful in identifying children who may need to be receive follow-up care or be referred to a community resource in the future.

Healthy Development Chart Review Tool

Site Name: _____ Patient Log #: _____

Chart abstraction Date (mm/dd/yyyy): ___ / ___ / 200___

Patient charts will be pulled for well-child visits ONLY on children ages 0-48 months.

1. DATE OF MOST RECENT WELL-CHILD VISIT (MM/DD/YYYY): ___ / ___ / _____

2. PATIENT'S AGE IN MONTHS AT MOST RECENT WELL-CHILD VISIT (ROUND TO THE NEAREST WHOLE MONTH):
_____ MONTHS OLD

3. INSURANCE TYPE: DOES THIS CHILD HAVE MEDICAID? YES NO

4. Was a structured developmental screening ever documented in the chart for this child? (The screening must address the following areas: 1] fine motor skills, 2] gross motor skills, 3] language development, and 4] cognitive/problem solving.)

- Yes
 No or not documented (*Skip to Question 6*)

5. AT WHICH WELL-CHILD VISITS DID THIS CHILD RECEIVE A STRUCTURED DEVELOPMENTAL SCREENING?
(PLEASE CHECK ALL THAT APPLY)

- | | | |
|-------------------------------------|--------------------------------------|---------------------------------|
| <input type="checkbox"/> 0-3 month | <input type="checkbox"/> 12-14 month | <input type="checkbox"/> 2 year |
| <input type="checkbox"/> 4-5 month | <input type="checkbox"/> 15-17 month | <input type="checkbox"/> 3 year |
| <input type="checkbox"/> 6-11 month | <input type="checkbox"/> 18-23 month | <input type="checkbox"/> 4 year |

6. Was a psychosocial screening ever documented in the chart for this child and/or the family? (The psychosocial screening should include at least one of the following areas: 1] maternal depression, 2] domestic violence, and 3] substance abuse.)

- Yes
 No or not documented (*Skip to Question 9*)

7. AT WHICH WELL-CHILD VISITS DID THIS CHILD/FAMILY RECEIVE A PSYCHOSOCIAL SCREENING? (CHECK ALL THAT APPLY)

- 0-4 months
 5 months to 4-4 ½ years

8. WHICH OF THE FOLLOWING PSYCHOSOCIAL SCREENING TOPICS WERE INCLUDED? (CHECK ALL THAT APPLY)

- Maternal Depression
 Domestic Violence
 Substance Abuse
 None of the above

9. Was this child ever identified as “at-risk” for poor developmental outcomes? (“At-risk” may be defined based on a positive screen using a formal screening tool (e.g. PEDS), based on the provider’s assessment of the child and family, or from a parent concern that was expressed at the well-child visit.)

- Yes
 No or not documented (*STOP*)

10. At what age was this child identified as “at-risk”?

- At birth
 _____ months old (*round to the nearest whole month*)
 Not documented in chart

11. What course of action took place after the child was identified as “at-risk”?

- Planned follow-up for “at-risk” issue at a later office visit
 Child referred to community resource for additional care
 Referral made, but parent declined referral
 No follow-up care or referral documented in chart

This chart review is complete. Thank you!

Healthy Development Chart Review Log Sheet

Month/Year: _____

Only list patients who meet the inclusion criteria. It is important that the log with the names of patients be kept in a safe, secure place in your office to maintain patient confidentiality. **Do not send the logs to VCHIP.** This is a tool for your office to use only.

Patient Log #	Date of Office Visit (well-child ONLY) (mm/dd/yyyy)	Patient Name	<u>PATIENT'S ID #</u> (if applicable)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

16.			
17.			
18.			
19.			
20.			

Practice ID number (3 Digits) ____ _

Practice Name:

Date: ____ / ____ / ____

Healthy Development Staff Satisfaction Survey

- This tool will help us learn about your office staff's satisfaction with the preventive service delivery in your office.

Who should complete this survey:

All of your staff, including physicians, nurse practitioners, PA's, and all administrative or clinical staff who work in your practice location.

Data collection process

- Distribute the staff satisfaction surveys to all of your staff the week after Learning Session 1. Subsequent data collection will occur quarterly - we will remind you during the appropriate months
- Remind staff to write legibly, to not doodle or place stray marks on the forms, and to use black ink pens
- Verify that all surveys have the date on them, if not write in today's date yourself.
- Note, if you wish to collect additional open-ended questions or comments, paper clip a second page for comments and do not send this portion to the data center.

➔ **Call Rachael Beddoe at 802-847-4220 if you have any questions about this form.**

➔ **All staff should be instructed to complete the survey to be turned in with all of the data collection tools for that month. Send all of your staff surveys at the end of the survey month to:**

**Rachael Beddoe
VCHIP
Room 5445
Arnold 5 UHC Campus
One South Prospect Street
Burlington, VT 05401**

APPENDIX B:

Utah Medical Chart Abstraction Tool (Used to collect measures of screening, referral, and treatment)

THIS IS EASY!

**Measurement is a critical component of every quality improvement effort.
This audit will measure your practice's starting point.**

Even if you do not currently use a screening tool, please perform the following brief audit. Select 10 charts of toddlers (12 to 36 months) seen for well child visits within the last month. Of these charts, 5 should be toddlers with Medicaid. Gather the following information about this most recent visit from the chart:

Chart 1
1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage: Private Insurance Medicaid Self Pay CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used? Yes (Go to Question 5) No (<i>Continue with next chart</i>)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral? Yes (Go to Question 7) No (<i>Continue with next chart</i>)
7. If the answer to question 6 was yes, did any of the following take place: Scheduled a follow-up visit. The child was referred for further assessment. The child was referred for treatment. The parent was counseled. The issue was dealt with at this appointment: Parent given activity sheets Anticipatory guidance brochures Ongoing in-office treatment plan Other (please list) _____ None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to: Local Mental Health Agency (i.e. Valley Mental Health) Early Intervention Early Head Start Children with Special Health Care Needs Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (<i>Please mark all that apply</i>) Yes Received assessment report Received treatment report Not eligible for services No

Chart 2

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
Private Insurance Medicaid Self Pay CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
Yes (Go to Question 5) No (*Continue with next chart*)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
Yes (Go to Question 7) No (*Continue with next chart*)
7. If the answer to question 6 was yes, did any of the following take place:
Scheduled a follow-up visit.
The child was referred for further assessment.
The child was referred for treatment.
The parent was counseled.
The issue was dealt with at this appointment:
Parent given activity sheets
Anticipatory guidance brochures
Ongoing in-office treatment plan
Other (please list) _____
None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
Local Mental Health Agency (i.e. Valley Mental Health)
Early Intervention
Early Head Start
Children with Special Health Care Needs
Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
Yes
Received assessment report
Received treatment report
Not eligible for services
No

Chart 3

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
Private Insurance Medicaid Self Pay CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
Yes (Go to Question 5) No (*Continue with next chart*)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
Yes (Go to Question 7) No (*Continue with next chart*)
7. If the answer to question 6 was yes, did any of the following take place:
Scheduled a follow-up visit.
The child was referred for further assessment.
The child was referred for treatment.
The parent was counseled.
The issue was dealt with at this appointment:
Parent given activity sheets
Anticipatory guidance brochures
Ongoing in-office treatment plan
Other (please list) _____
None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
Local Mental Health Agency (i.e. Valley Mental Health)
Early Intervention
Early Head Start
Children with Special Health Care Needs
Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
Yes
Received assessment report
Received treatment report
Not eligible for services
No

Chart 4

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
Private Insurance Medicaid Self Pay CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
Yes (Go to Question 5) No (*Continue with next chart*)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
Yes (Go to Question 7) No (*Continue with next chart*)
7. If the answer to question 6 was yes, did any of the following take place:
Scheduled a follow-up visit.
The child was referred for further assessment.
The child was referred for treatment.
The parent was counseled.
The issue was dealt with at this appointment:
Parent given activity sheets
Anticipatory guidance brochures
Ongoing in-office treatment plan
Other (please list) _____
None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
Local Mental Health Agency (i.e. Valley Mental Health)
Early Intervention
Early Head Start
Children with Special Health Care Needs
Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
Yes
Received assessment report
Received treatment report
Not eligible for services
No

Chart 5

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
Private Insurance Medicaid Self Pay CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
Yes (Go to Question 5) No (*Continue with next chart*)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
Yes (Go to Question 7) No (*Continue with next chart*)
7. If the answer to question 6 was yes, did any of the following take place:
Scheduled a follow-up visit.
The child was referred for further assessment.
The child was referred for treatment.
The parent was counseled.
The issue was dealt with at this appointment:
Parent given activity sheets
Anticipatory guidance brochures
Ongoing in-office treatment plan
Other (please list) _____
None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
Local Mental Health Agency (i.e. Valley Mental Health)
Early Intervention
Early Head Start
Children with Special Health Care Needs
Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
Yes
Received assessment report
Received treatment report
Not eligible for services
No

Chart 6

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
Private Insurance Medicaid Self Pay CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
Yes (Go to Question 5) No (*Continue with next chart*)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
Yes (Go to Question 7) No (*Continue with next chart*)
7. If the answer to question 6 was yes, did any of the following take place:
Scheduled a follow-up visit.
The child was referred for further assessment.
The child was referred for treatment.
The parent was counseled.
The issue was dealt with at this appointment:
 Parent given activity sheets
 Anticipatory guidance brochures
 Ongoing in-office treatment plan
 Other (please list) _____
None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
Local Mental Health Agency (i.e. Valley Mental Health)
Early Intervention
Early Head Start
Children with Special Health Care Needs
Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
Yes
 Received assessment report
 Received treatment report
 Not eligible for services
No

Chart 7

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
Private Insurance Medicaid Self Pay CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
Yes (Go to Question 5) No (*Continue with next chart*)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
Yes (Go to Question 7) No (*Continue with next chart*)
7. If the answer to question 6 was yes, did any of the following take place:
Scheduled a follow-up visit.
The child was referred for further assessment.
The child was referred for treatment.
The parent was counseled.
The issue was dealt with at this appointment:
Parent given activity sheets
Anticipatory guidance brochures
Ongoing in-office treatment plan
Other (please list) _____
None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
Local Mental Health Agency (i.e. Valley Mental Health)
Early Intervention
Early Head Start
Children with Special Health Care Needs
Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
Yes
Received assessment report
Received treatment report
Not eligible for services
No

Chart 8

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
Private Insurance Medicaid Self Pay CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
Yes (Go to Question 5) No (*Continue with next chart*)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
Yes (Go to Question 7) No (*Continue with next chart*)
7. If the answer to question 6 was yes, did any of the following take place:
Scheduled a follow-up visit.
The child was referred for further assessment.
The child was referred for treatment.
The parent was counseled.
The issue was dealt with at this appointment:
Parent given activity sheets
Anticipatory guidance brochures
Ongoing in-office treatment plan
Other (please list) _____
None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
Local Mental Health Agency (i.e. Valley Mental Health)
Early Intervention
Early Head Start
Children with Special Health Care Needs
Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
Yes
Received assessment report
Received treatment report
Not eligible for services
No

Chart 9

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
Private Insurance Medicaid Self Pay CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
Yes (Go to Question 5) No (*Continue with next chart*)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
Yes (Go to Question 7) No (*Continue with next chart*)
7. If the answer to question 6 was yes, did any of the following take place:
Scheduled a follow-up visit.
The child was referred for further assessment.
The child was referred for treatment.
The parent was counseled.
The issue was dealt with at this appointment:
 Parent given activity sheets
 Anticipatory guidance brochures
 Ongoing in-office treatment plan
 Other (please list) _____
None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
Local Mental Health Agency (i.e. Valley Mental Health)
Early Intervention
Early Head Start
Children with Special Health Care Needs
Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
Yes
 Received assessment report
 Received treatment report
 Not eligible for services
No

Chart 10

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
Private Insurance Medicaid Self Pay CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
Yes (Go to Question 5) No (*Continue with next chart*)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
Yes (Go to Question 7) No (*Continue with next chart*)
7. If the answer to question 6 was yes, did any of the following take place:
Scheduled a follow-up visit.
The child was referred for further assessment.
The child was referred for treatment.
The parent was counseled.
The issue was dealt with at this appointment:
Parent given activity sheets
Anticipatory guidance brochures
Ongoing in-office treatment plan
Other (please list) _____
None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
Local Mental Health Agency (i.e. Valley Mental Health)
Early Intervention
Early Head Start
Children with Special Health Care Needs
Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
Yes
Received assessment report
Received treatment report
Not eligible for services
No

APPENDIX C:

Iowa Medical Chart Abstraction Tool (Used to collect measures of screening, referral, and treatment)

ABCD II Chart Review Process

ABCD II Evaluation Pilot 2

ABCD II Chart Review Codes Post Implementation

ABCD II CHART REVIEW PROCESS

IOWA

Chart Selection:

Names of children for chart selection were requested from Iowa Medicaid Enterprise (IME) at the Iowa Department of Human Services. The request was made to the Medicaid Policy Specialist who is the ABCD II project staff contact at IME.

Age Stratification:

Based on the evaluation plan, we sought to select a total of 400 charts stratified by age both at baseline and post-implementation of ABCD II tools and guidance (for a total of 800 charts). The age strata were not based on equal intervals of months, but rather on covering critical developmental periods when office visits would be occurring (i.e., early months; starting to stand and walk; walking and talking; and toddler social, speech, and motor skill development). These age ranges are listed in Table 1.

Table 1: Number of charts by age

2weeks through 7 months	100
8 months through 13 months	100
14 months through 22 months	100
23 months through 47 months	100
Total sample	400

Initially, we attempted to seek 200 names from IME for each age stratum with clinic visits during the specified time period, but there were insufficient numbers of Medicaid-enrolled children at each demonstration site to successfully extract the names using that method. Although age at date of service for children under 12 months was not available from IME, it was calculated by subtracting date of birth from date of service.

Approach:

1. The request was changed to seek ALL children who received service during the time period.
2. Age at date of service was determined in-house using Excel functions.
3. An age sort was completed prior to requesting charts be booked for review by the medical practice.
4. Charts were chosen by age using random numbers. However, given the number of children in the practice, the occurrence of duplicate visits, and the uncertain availability of charts at the practice level, random number selection was not the only determinant in chart selection.
5. Given the size of the Medicaid-enrolled population of both demonstration sites, data was gathered over one-year periods for both baseline and follow-up phases. The rural practice did not have sufficient population to select a sample of 200 unduplicated charts within the time frame; therefore, the urban site was oversampled to reach the desired sample size.

ABCD II Chart Review Process 10-02-06.doc

Suggestions for Design of the Review Process:

Plan chart review once within the first quarter of the implementation process to monitor implementation issues. Following the initial review, technical assistance can be provided early to make adjustments in the process. If the number of cases in each practice can be accurately estimated and sufficient time for follow-up is available, the remaining charts should be reviewed at the end of the project. This prevents the need for oversampling, minimizes duplication of charts, and makes stratification by age a simpler process.

ABCD II Evaluation Pilot 2

ABCD II Evaluation Pilot 2																						
Reviewer Name								Screening (code A P N)				Other		Concerns					Follow up Care Code			Comments
Medicaid Number/ Unique identifier	Last name	First Name, MI	Gender	Age (mo)	Date of Birth	Race	Date of Service	DM	SE	FS	MD	Lead (A/B)	AG	DM	SE	FS	MD	OTHER	In office	Out of Office	Supports codes	

ABCD II Chart Review Codes Post Implementation

Screening - Developmental, Social Emotional, Family Stress, Maternal Depression:

A= Adequate if all milestones/questions are marked yes or no

P = Partial if only some milestones/questions are marked yes or no

N= Not completed – left blank

Other

Lead

A = Assessed environmental risk

B = Blood

N = Not completed –left blank

AG = Anticipatory Guidance

A = Adequate if item is marked

P = Partial if some items are marked

N = Not completed – if items are left blank

Concerns

Developmental (DM) = List number underlined that are noted as “no”

Social Emotional (SE) = List number underlined noted as “no”

Concerns Family Stress (FS)

Note level of concern with type of stress

(example 1F = slight financial stress)

N = not completed -blank

O = no concerns

1 = slight

2 = moderate

3 = severe

Stress Type

Relationship = A

Drugs = B

Alcohol = C

Violence/abuse = D

Lack of help = E

Finance = F

Health insurance = G

Child Care = H

Other = I (add to comments if noted)

Concerns Maternal Depression (MD)

Note response to either question as:

0= no

1 = sometimes

2 = often

N = left blank

Comments Note information to help clarify R

Referral: Note purpose for In office or Out of office referral

0= No referral noted

1= Developmental screen

2 = Problem-focused counseling and education

3 = Further evaluation and assessment

4 = Treatment or intervention

Supports Code for Referral/follow up

5= Care Coordination

6 = Dental

7= Early ACCESS/Compass

8 = Food Stamps

9 = Health Insurance

10 = Iowa Healthy Families Line

11 = Parenting Counseling

12 = Social Services

13= Specialist

14 = SSI

15 = WIC

16 = Other

Other Concern

Add for reason for referral

J =Height Wt FOC

K = Vision

L= Hearing

M=ENT

N=Dental

O = Cardio/Pulmonary

P = CNS

Q= Nutrition

R = Other Physical

S= Speech

Race:

1 White

2 Black

3 American Indian

4 Asian

5 Hispanic

6 Pacific Islander

7 Hispanic Multiple races

8 Multiple other races

9 Unknown

Colored Highlighted Rows

Blue = Chart not available

Yellow = Dictated chart/Old form

Green = sick child exam only

Red = ASQ & SE on file

Pink = Duplicate file select age needed

APPENDIX D:

Users Tip Sheet for Parent Reported Items Assessing Whether Standardized Developmental and Behavioral Screening Occurred (Developed by the Child and Adolescent Health Measurement Initiative [CAHMI])

Measure of Whether a Parent-Completed Standardized Developmental and Behavioral Screening (SDBS) Tool was Administered

USERS TIP SHEET

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This Users Tip Sheet includes the following information:

Background Information, Design Parameters for the Measure	Page 1-2
Survey Items to Measure Whether a Parent-Completed Standardized Developmental and Behavioral Screening (SDBS) Tool was Administered:	Pages 3-4
Implementation and Scoring Guidelines	Pages 5-6

Background Information

The American Academy of Pediatrics Statement on Identifying Infants and Young Children with Developmental Disorders in the Medical Home (July, 2006) states the importance of routine screening by pediatric health care providers for developmental and behavioral problems and delays using standardized developmental screening tools.²⁷ Furthermore, the AAP Statement highlight that **parent-completed standardized developmental and behavioral screening (SDBS) tools** are a feasible and cost-effective strategy to routine screening and surveillance.

Integral to assuring whether children are being screened in this way is the use of standardized measures to track the current level of screening and to monitor implementation efforts over time. No standardized and validated methods are available to health systems for this purpose. Some health systems examine medical charts for evidence of standardized screening of children. However, it is not know whether this data source is reliable or valid for measurement purposes due to variations in whether and how care providers document their screening activities, including whether or not completed tools are included in the chart.

Currently available validated developmental and behavioral screening tools for use in pediatric practices involve discussions with parents. Therefore, parents are an obvious source of data for determining whether a standardized screening occurred for their child.

²⁷ www.pediatrics.org/cgi/doi/10.1542/peds.2006-1231

The CAHMI received funding from The Commonwealth Fund to develop parent reported survey items that measure whether a standardized, parent-completed developmental and behavioral screening tool was administered. As part of this development work, the CAHMI did the following:

1. Analysis on existing databases with potential items from the Promoting Healthy Development Surveys (PHDS, ProPHDS, PHDS-PLUS) and the National Survey of Early Childhood Health (NSECH)
2. Convened an advisory group of key leaders in the child health services research field to review and provide feedback about the development of these survey items.
3. Developed new survey items to address the limitations observed in these databases.
4. Conducted N=23 cognitive interviews with parents who had and had not completed an SDBS tool.

The survey items, implementation and scoring guidelines presented are based on this development work and endorsed by our advisory committee. More detailed information about the analysis and development process can be found on the CAHMI website (www.cahmi.org) and by contacting Colleen Reuland at reulandc@ohsu.edu.

Design Parameters

The following design parameters were established for this survey-based measure based on input from the SDBS advisory group and on the item-number limitations present in potential tools for inclusion such as the National Survey of Children's Health.

1. Items can total no more than three items or equivalent per child.
2. When scored, items should be sensitive to validated, endorsed, standardized screening methods that are:
 - a. Parent-completed
 - b. Go beyond fine and gross motor development to include language, behavior, etc.
 - c. Pick up both the concerns and observations based methods currently in use in the field (Parents Evaluation of Developmental Status, Ages and Stages Questionnaire) and other parent survey based methods anticipated to emerge over time.
3. The measure will be anchored to whether annual screening occurred.
4. The measure should only be scored for children 12 months old or older.
5. When scored, items should be sensitive to validated, endorsed, standardized screening methods that are:
 - a. Parent-completed
 - b. Go beyond fine and gross motor development to include language, behavior, etc.
 - c. Pick up both the concerns and observations based methods currently in use in in the field (Parents Evaluation of Developmental Status®, **Ages & Stages** Questionnaires®) and other parent survey based methods anticipated to emerge over time.

**Survey Items to Measure Whether a Parent-Completed
Standardized Development and Behavior Screening (SDBS) Tool was Administered**

*Intro Text: Sometimes a child's doctor or other health care provider will ask a parent to fill out a questionnaire **at home or during their child's visit**.*

Q1: In the last 12 months, did your child's doctor or other health care provider have you fill out a questionnaire about specific concerns or observations you may have about your child's development, communication or social behaviors?

If yes to Q1:

Children 12-23.99 months old:

- 1a) Did this questionnaire ask about your concerns or observations about how your child talks or makes speech sounds?
- 1b) Did this questionnaire ask about your concerns or observations about how your child interacts with you and others?

Children 24-47.99 months old:

- 1a) Did this questionnaire ask about your concerns or observations about words and phrases your child uses and understands?
- 1b) Did this questionnaire ask about your concerns or observations about how your child behaves and gets along with you and others?

Children 48-60 months old:

- 1a) Did this questionnaire ask about your concerns or observations about words and phrases child uses and understands?
- 1b) Did this questionnaire ask about your concerns or observations about how your child behaves and gets along with you and others?

If no to Q1:

Q1-No: In the last 12 months, has anyone else ever asked you to fill out a form or questionnaire about specific concerns or observations you have about your child's development, communication or social behaviors?

If Yes to Q1-No :

Children 12-23.99 months old:

- 1-NO-a) Did this questionnaire ask about your concerns or observations about how your child talks or makes speech sounds?
- 1-NO-b) Did this questionnaire ask about your concerns or observations about how your child interacts with you and others?

(Continued on next page)

Children 24-47.99 months old:

1-NO-a) Did this questionnaire ask about your concerns or observations about words and phrases your child uses and understands?

1-NO-b) Did this questionnaire ask about your concerns or observations about how your child behaves and gets along with you and others?

Children 48-60 months old:

1-NO-a) Did this questionnaire ask about your concerns or observations about words and phrases child uses and understands?

1-NO-b) Did this questionnaire ask about your concerns or observations about how your child behaves and gets along with you and others?

**Implementation and Scoring Guidelines:
Measure of Whether a Parent-Completed
Standardized Developmental and Behavioral Screening (SDBS) Tool was Administered**

The SDBS items will be formally added to the Promoting Healthy Development Survey (PHDS) tools and are recommended for inclusion in surveys focused on child health and health care quality. Therefore, the sampling and implementation of the SDBS items will be dependent on the sampling and implementation guidelines for the larger survey to which the items are included.

Below are some general guidelines for the sampling, placement and scoring of the SDBS items.

Sampling:

- The primary survey the SDBS items will be included in is the Promoting Healthy Development Survey (PHDS). Sampling for the PHDS includes a requirement that the child be continuously enrolled in the system and had a least one HEDIS defined well-child visit in the last 12-months or since the child's birth.
- If the SDBS items are included in a survey that does not have these requirements, then they the items should be scored for those children who meet one or both criteria (to the degree that this is feasible).

Placement:

- The items are anchored to a questionnaire that is provided by a child's doctor or other health provider before or during a child's visit. Therefore, the items should be placed in the section of the survey asks similar questions about health care the child may have received.
- The items must be preceded by a definition of the term "doctor or other health care provider".

Scoring:

Numerator: Children Annually Screened Parent-Completed SDBS Tool

- In order for a child to be identified as having an SDBS completed by the parent or caregiver, the respondent must have answered positively to the stem question AND both follow-up items.
 - Screening by child's doctor other health provider: Only those respondents who said Yes to Q1 AND Q1a AND Q1b are identified as having an SDBS.
 - Screening by someone else in the community: Only those respondents who said Yes to Q11-NO AND 1-NO-a AND 1-NO-b are identified as having an SDBS.

Denominator: Eligible Children for Screening

- The SDBS items should only be scored for children 12 months to 3 years old (up to 48 months old).²⁸
- As noted above, if the sampling for the survey does not require the child to be cont. enrolled or have had a visit, then the various scoring options should be explored (where feasible) to determine the appropriate denominator for the measure.

Denominator Options:

1. All children 12 months old- 3 years old.
2. All children 12 months old- 3 years old who had one more visit in the last 12 months to their child's doctor or other health provider
3. All children 12 months old- 3 years old who had one or more well-child visit in the last 12 months to their child's doctor or other health provider.
4. All children 12 months old- 3 years old who meet a cont. enrollment requirement (12 or 6 months or since the child was born).
5. All children 12 months old- 3 years old who meet a cont. enrollment requirement AND who had one or more visits in the last 12 months to a doctor or other health provider.
6. All children 12 months old- 3 years old who meet a cont. enrollment requirement AND who had one or more well-child visits in the last 12 months to a doctor or other health provider.

Important Note: A detailed report displaying the cognitive interview and analytic findings described in the background section of this Users Tips Sheet is available on the CAHMI website.

CAHMI Contact Information: www.cahmi.org 503-494-1930
Authors: Colleen Peck Reuland, MS and Christina Bethell, PhD

²⁸ The upper-age limit for the SDBS is dependent on your goal for measurement and what is expected of providers. The current AAP statement recommends standardized screening up to 30-months old. The items have been tested and validated for children up to 4 years old.

APPENDIX E:

California Referral Resources List

(Form was inserted into the medical chart)

ABCD

Assuring Better Child Health and Development Project

Today's Date: _____

Patient: _____

Medical Record # (if applicable): _____

Parent/Guardian: _____

Phone: (H) _____ (W) _____ (C) _____

Provider Name: _____

In-office Services:

- Return visit in 3 months. Counseling/education provided. Written developmental materials provided.

Alameda County Referrals:

HEALTH SERVICES

- CCS 510 208-5970
- Denti-Cal 800 322-6384
- Healthy Families Program 888 747-1222
- Medi-Cal 510 639-1000
- Public Health Clearinghouse 888 604-4636
- Berkeley Advice Line 510 981-5300

MENTAL HEALTH SERVICES

- ACCESS (all ages) 800 491-9099

EPSDT MENTAL HEALTH SERVICES

(focusing on children birth to 5)

- A Better Way 510 601-0203 x222
- Behavioral Health Care Services: 510 777-2103
Early Childhood Consult. & Treatment
- Asian Community Mental Health 510 869-6005
- Children's Hospital & Research Center at Oakland:
 - Behavior Disorders Program 510 428-3351
 - CARE Program 510 428-8425
 - Psychopharmacology Clinic 510 428-3351
- City of Fremont Youth & Family Services: *Infant-Toddler Program* 510 574-2100
- Jewish Family & Children's Services 510 704-7480 x700
of the East Bay: *First Steps* (Spanish) x804
- Kidango 510 744-9280 x25
- La Clinica: 510 535-6200
Casa del Sol Counseling Service
- Parental Stress Service: 510 893-9230 x402
Early Childhood Mental Health
- Perinatal Council 510 437-8945
- Through The Looking Glass 510 848-1112
- Tiburcio Vasquez Health Center: 510 471-5880 x1211
Family Support Services

FAMILY ASSISTANCE PROGRAMS

- Food Stamps 510 596-0110
- Housing 510 537-2552
- SSI 800 772-1213
- WIC 888 942-9675
 - Berkeley WIC 510 981-5360

FAMILY SUPPORT & ADVOCACY

- Child Care:
 - North County 510 658-0381
 - Mid County 510 582-2189
 - Tri Valley 925 417-8733
- Family Resource Network (FRN) 510 547-7322
- Family Violence Law Center 510 208-0255
- Parental Stress Services Hotline 800 829-3777

EDUCATIONAL & DEVELOPMENTAL SERVICES

- Early Start 510 383-1355
- Head Start:
 - Alameda 510 865-4500
 - Berkeley 510 848-9092
 - Oakland 510 238-3165
 - South County 510 796-9512
 - Tri Valley 925 443-3434
- Regional Center (RCEB):
 - Early Start: Under 3 years old 510 383-1355
 - 3 years old and over 510 383-1200
- Special Education Local Plan Area (SELPA):
 - Alameda, Albany, Berkeley, Emeryville & Piedmont 510 337-2352
 - Oakland 510 879-8223
 - Castro Valley, San Leandro, Hayward & San Lorenzo 510 537-3000
 - New Haven, Newark, Fremont 510 659-2569
 - Dublin, Livermore, Sunol Glen, Pleasanton & Mtn. House Elementary 925 426-9144
- Vocational Rehab 510 622-2764

Referral Follow-up: (For ABCD Project staff use only)

- Date: _____ Parent/Guardian did not contact referral agency. Parent/Guardian has received contact.
- Agency Contact(s): _____ No services initiated yet.
- Agency Contact(s): _____ Expected start date: _____
- Agency Contact(s): _____ Patient receiving needed services.
- Comments: _____

If you have questions, please call Every Child Counts/First 5 Alameda County at (510) 875-2477



FIRST 5



Alameda County Medical Home Project



Alameda Alliance for Health

ABCD_RF_1205E.pdf

APPENDIX F:

Minnesota form with follow-up steps for children identified at risk or with current delays

Data Collection Tools – Screening Data

(Form was inserted into the medical chart).

Patient Information and Referral Sheet

Patient Information:	
Gender: M / F	<i>Race/Ethnicity: (check all that apply)</i>
Age: _____years _____months	<input type="checkbox"/> African-American
City of residence: _____	<input type="checkbox"/> Asian
Zip code: _____	<input type="checkbox"/> Native American
	<input type="checkbox"/> White/Caucasian
	<input type="checkbox"/> Hispanic/Latino
<i>Primary language (caregiver):</i>	<i>Type of Insurance:</i>
<input type="checkbox"/> English	<input type="checkbox"/> Medicaid/ MA
<input type="checkbox"/> Spanish	<input type="checkbox"/> BC/BS
<input type="checkbox"/> Somali	<input type="checkbox"/> HMO/MCO
<input type="checkbox"/> Hmong	<input type="checkbox"/> Private Pay
<input type="checkbox"/> Other: (specify) _____	<input type="checkbox"/> No insurance
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other: (specify) _____

Screening Information:

Date of screening: ___/___/___
ASQ:SE Version Used (Age, Language): _____
Interpreter present? YES / NO
ASQ: SE Score: _____
Elevated? YES / NO

Referral Information:

Physician referral:
<input type="checkbox"/> mental health assessment
<input type="checkbox"/> medical assessment
<input type="checkbox"/> parenting class/support group
<input type="checkbox"/> no referral
<input type="checkbox"/> other (specify): _____

Notes:

--

Mental Health Assessment Information:

Date of Assessment: ___/___/___	
Diagnosis: _____	
Intervention:	
<input type="checkbox"/> child - individual therapy	<input type="checkbox"/> parent – parenting classes
<input type="checkbox"/> child – medication evaluation	<input type="checkbox"/> parent – individual therapy
<input type="checkbox"/> child and parent – family therapy	<input type="checkbox"/> other: _____
<input type="checkbox"/> child and parent – Early Head Start	_____

Database Headings – Children’s Hospital and Clinics

The following fields were used to collect patient data from Children’s Hospital and Clinics. Additional information may have been maintained by clinic staff, but were not shared with the principal investigator.

Information Fields	Possible Entries	Purpose
Gender	Male/Female	Describe population of children screened, identify any possible referral bias
DOB	dd/mm/yyyy	Describe the population of children screened, ensure correct screening tool is used
Type of insurance	Medicaid/MA; BC/BS; HMO/MCO; Private Pay; No Insurance; Other	Describe the population of children screened; MA-insurance as proxy for low-income
County of Residence	MN/WI counties	Describe the population of children screened
Culture/Language	English; Spanish; Hmong; Somali; Other	Describe the population of children screened, identify
ASQ:SE test	Language used; Interpreter present?; Written/Electronic version	Identify possible language/literacy barriers to screening
ASQ:SE results	Actual score; Elevated/Non-elevated	Determine which children had scores that should lead to referral
Date (well-child exam)	dd/mm/yyyy	Used with DOB to determine age at time of visit
Physician referral	Mental health assessment; specialty services (speech therapy, etc.); community services	Identify common referral sources used by medical providers
Date of mental health assessment (when applicable)	dd/mm/yyyy	Determine length of time that passes between referral and follow-up appointment
Outcome	Includes diagnosis; whether parent kept appointment; recommended therapy	Gather qualitative data that impacted screening process
Zip Code	#####	Used as a proxy to determine average income level
Notes	Open field for qualitative information about why referral was/was not made; problems with screening tool; etc.	Identify potential screening problems

APPENDIX G:

Iowa telephone script of questions used by care coordinators

Iowa Telephone Script for Care Coordinators

This protocol is to be used for children birth through age 47 months of age. The follow up will be piloted for children who have NAME as their Medical Home. Continue your follow up for all children according to your standard practice.

Initial Periodic visit contact

- 1) As per agency protocol
- 2) Remind families that the periodic visit is due.
- 3) Educate families about the importance of preventive medical appointment.
 - i) Discuss what to expect at the (age) visit.
 - ii) Ask, do you have any concerns about your child's growth or behavior?
 - iii) Ask, do you have any health concerns to talk to the physician (provider) about?
- 4) Assist families to locate primary care medical and dental providers.
- 5) Assist families to schedule appointments.
- 6) Provide linkages to support services such as transportation and child care.
- 7) Remind the parent to complete the Ages and Stages Questionnaire sent to them in the mail. Ask if they need assistance to complete it or if they want you to go through it with them.
- 8) Tell family you will contact them about two weeks following the visit to see how everything went. Check when the best time for that call will be.

Follow up contact: within 2 weeks of periodic visit, 6 months following periodic visit. (This may include Interperiodic, Diagnosis or Treatment visits if the child is not going for scheduled periodic visits.)

The purpose of the family follow up is to

- 1) Identify if the family's needs were met
- 2) Identify if the family has additional needs
- 3) Assist the family to identify sources of assistance as needed
- 4) To assist the family to advocate for their child
- 5) To identify if the family needs assistance to link to additional services.

2 weeks

Within two weeks following the scheduled provider periodic visit contact the family to:

- 1) Arrange follow up on missed appointments
- 2) Assist the family with any visits to the primary provider for further care to meet the needs identified at the recent periodic visit.
- 3) Assist the family with any referrals for further care to meet needs identified at the recent periodic visit.

Care for Kids Follow up Protocol 6-05

- 4) Follow up to determine if all medically necessary diagnostic and treatment services have been scheduled or received.
- 5) Assist families in making and keeping referral or follow up appointments
- 6) Link families to other needed services.
- 7) Serve as the family advocate
- 8) Provide support and assistance as families become independent health care consumers.

Introduction:

*Hello, Introduce self. I am calling to follow up on *child's name* visit to *Provider Name* a couple weeks ago to be sure that you had no further concerns or to answer any questions you might have. This is a new service we have begun to make sure things are going well for you and *Childs name*. I can also help you with any follow up care provider wants you to have.*

Ask these questions at the 2 week follow up to a periodic visit. Use child or provider name where italicized in red. You may make questions more conversational to fit your style.

1 At *name of child's age* growth and development are very important.

- 1a At your appointment did provider *or others* in the *provider* office talk to you about your concerns about your child's growth, learning, development or behavior? Is *provider* concerned that *child's name* is not doing what other children his/her age are doing?
- 1b Were your questions answered about your child's growth, learning, development or behavior?
 - Do you still have any other concerns about your child's health, development or behavior?
- 1c Did they do anything else while you were there such as complete additional tests, ask more questions about *child's name* or give you reading material to take home?
- 1 d. Did the *provider or others* in the *provider* office refer you to someone to follow up on any growth, learning, development, behavior or other health concerns?

2. Sometimes family stress or concerns makes getting through the day with children harder.

- 2 a. Did the *provider or others* in the *provider* office talk to you about family concerns or stresses or refer you to someone to help you with family concerns or stresses?

Care for Kids Follow up Protocol 6-05

- 2b. Did the *provider* or others in the *provider* office talk to you about how you are feeling?
- . Did the *provider* or others in the *provider* office refer you to anyone else for any other concerns or problems?
3. For all instances of follow up care needed:
- Were you able to make a connection with the place or person *provider* asked you to go see?
 - Were you able to get an appointment for services (at primary provider or referral source)?
 - Do you need assistance to make an appointment for the service?
 - Do you need assistance with transportation to ____?

Continue to complete your contact with other care you give at this time.
Interviewer comment

Ask these questions 6 months after a periodic visit. Use provider name where italicized.

- 1) Have you had any concerns about your child's health, learning, development or behavior since your *date six months ago to provider*?
- 2) If a referral was made, were you able to meet with the *provider* as scheduled?
- 3) Are you going to *provider* for care other than well child examinations? If so, what care are you receiving?
- 4) Did you or are you receiving the services from someone other than your provider that your *provider* suggested? If not why not?
- 5) Are services continuing? If yes, are the services meeting the needs you have concerns about? the concerns *provider* had about your child?

Add any comments about the interview as needed. You may want to add that "the parent was in a hurry to end the interview" etc. Remember, as always, the client's chart is a legal document.

Enter the answers to the above questions in the CARES program under "notes." Also complete the other sections of CARES following the guidelines in the *CAREs User Manual*.

The service for the above follow up protocol is considered a Care Coordination service. Document service and needs and bill accordingly.

APPENDIX H:

Summary of Iowa Focus Groups with Providers and Office Staff

ABCD II

Post-Project Focus Groups Summary Report

DRAFT - May 23, 2006

Introduction

The focus groups were conducted with four provider groups on four separate occasions in April and May, 2006. At the time of the focus groups, no quantitative data regarding pre- and post-intervention screening rates was available; therefore, the practices were unaware of the magnitude of change in their developmental screening activity. The focus groups and number of participants per group follow:

- Group 1: Dubuque Medical Associates pediatricians and nurse practitioners (ARNPs) (n = 5 – 3 MDs; 1 ARNP; 1 RN clinic manager)
- Group 2: Dubuque Medical Associates office nurses (RNs) and nurse practitioner (n = 7 – 6 RN's and 1 nurse practitioner)
- Group 3: Pella UI Family Practice Clinic family physicians (n = 5 – all MDs)
- Group 4: Pella UI Family Practice Clinic office nurses (RNs) [n =].

Due to logistical problems – mostly related to scheduling an hour-long focus group in the midst of busy office practices – the groups were less distinct, less complete, and less structured than ideal. Also, different facilitators and different recorders staffed each group. Finally, it is not clear from the transcripts whether multiple similar responses to a given topic question were from multiple respondents or an exuberant single respondent.

Despite these methodological shortcomings – not unexpected given project resources and clinical priorities of the practices – much useful information was obtained.

Method of Analysis

Transcripts for each focus group were produced by the focus group recorders and reviewed by the facilitator. Transcripts were given to one member of the project evaluation team for preliminary analysis. Responses were organized on an Excel spreadsheet by related topic question category – for example, all responses related to how well the new screening activity fit within the scope of a practice's clinical services were grouped together. Within a given topic question category, the responses were sorted by the particular focus group from which the response was elicited. After all responses were organized, notations were made regarding relevant themes, issues, criticisms, or suggestions. Seemingly extraneous comments were deleted. Results were presented as a summary distillation of all responses to a generalized version of each specific topic question. The draft report was then shared with the project work team, as well as the focus group facilitators for final editing.

Results

How were you informed about the project and was it helpful?

All groups felt the orientation was generally helpful, especially because it was done “in-person” by project staff. Enthusiasm by project staff, explanation of the project purpose, and upfront acknowledgment of practice staff concerns is important.

What were your initial reactions to the project?

Initial reactions were mixed across all groups. Positive responses were that the project (to perform standardized developmental screening and offer appropriate follow-up screening or referral) was a good idea, was important, and made sense. Reluctant responses clustered around the concern that the project would require more time or too much work.

How well did the screening fit your scope of practice – for example, did the screening and follow-up cost additional time or work for your practice? Will you continue to screen post-project?

The Dubuque practice clearly felt developmental screening fits and they intend to continue screening. The major change was the addition of the family stress and maternal depression questions. They found this valuable and intend to continue with modifications to the questions. They report the Health Maintenance Clinical Notes (HCMN) form took a small amount of additional time, but the benefit to patients and families warrants the extra time and effort. Although the screening takes little or no additional time, it does take longer if providers “listen” to the answers and respond to identified problems.

The Pella practice found the form provided more standardization of the screening exam and charting for the practice. Several physicians use dictation for charting and prefer to complete the form during the screening and follow with dictation for a more complete record. Several agreed that they liked the questions on the left column of the front page particularly related to diet. Pella physicians also expressed that the HCMN form takes only a little more time. Further, they expressed an interest and willingness to continue screening, but likely using a modified version of the HCMN, especially if the form could somehow be incorporated into the clinic’s electronic medical record. Suggestions for modification were related primarily to anticipatory guidance and portions of the form unrelated to the developmental milestones.

A difference between the pilot sites is worth noting here. In Dubuque, the office nurses performed the screening and the physicians reviewed the results. The ARNPs and RNs would then initiate and monitor any referrals. In Pella, the office nurses were generally not involved with the developmental screening, while the physicians

tended to perform all aspects of the process – screening, review, counseling, and referral.

How useful was the HMCN screening form and how would you suggest changing it?

There was general agreement that the questions were useful reminders of what to screen for. This resulted in less overlooking of important risk factors and improved the consistency of asking about specific risks. Also, the order of the questions was felt to produce a good flow of information.

There were, however, several comments for form improvements. There was some criticism about the spacing and layout of the form – for example, there wasn't enough space to write about the social history, socio-emotional risks, results of the physical exam and any follow-up plans. There was a preference to use a “fill in the blank” format for the stress questions, rather than a checklist. Another respondent liked the check boxes, but just not quite so many. Dubuque generally wanted more space and Pella wanted all information on one page. There was confusion from one practice that child care as a source of stress was unclear as to what it was asking about- caring for the child, finding child care, or needing respite. And one respondent suggested adding a “subsequent visit” check box accompanied by a “things to review at next visit” section.

Several respondents felt the stress questions were redundant and elected to not ask them all. When time was short maternal depression questions were most often skipped in Dubuque. Pella physicians thought the anticipatory guidance section was too long and tended to choose which items to discuss with families. They found some suggested topics “insulting” to parents. They suggested adding discussions about gun safety. In general, it seemed that respondents felt the referral sources check list section was not particularly useful. This seemed to be because there are many more referral possibilities than the form contained.

Finally, there was concern about how the HMCN form would interface with evolving electronic medical record system in both practices.

It is worth noting here that the form in Dubuque was modified to fit on one page. The two page form was used in Pella which may account for some of the differences in the comments.

How do Medicaid rules or procedures affect ability to participate in developmental screening and follow-up?

There was very little response to this question, but of the responses, Medicaid rules and procedures appear to have little influence on ability or commitment to participate.

It is worth noting here that both practices elected to use the screening and referral protocols with all their patients birth to age 3 years, not just those receiving Medicaid. Both practices choose to offer one standard of care for all their patients and neither clinical groups tracks insurance information for their patients.

How comfortable are you asking maternal depression and other risk history questions?

The Dubuque physicians and nurse practitioners claimed initial discomfort, which dissipated with increased patient rapport and increased practice asking the questions. When questions were asked, parents were perceived to be appreciative. It was noted depression is important to ask all caregivers about, but it may be harder to ask these questions if both parents are in the room at the same time.

It is important to note that the maternal depression and stress questions could be overlooked if: the clinic was busy, the questions were asked at a prior visit, the mom “looked happy,” or the mom had older children. Sometimes questions were felt to be redundant so, although not overlooked completely, were skipped or blended.

The Pella physicians seemed comfortable with the concept and importance of maternal depression, although it appears they felt the HMCN form was not necessary for identification and follow-up.

What did you do for follow-up resources and what would make the referral process more effective?

Many comments from the Dubuque groups suggested the HMCN form was inadequate to document and/or guide the referral process. They did not use the check list, but rather preferred to write in what referral was made to sources outside the practice only and not note what was done for follow up in the office. One Dubuque nurse stated that some physicians don’t address red flags because they think the nurse has addressed the flagged issue or the nurse should “remind” the physician to address the issue. The EPSDT coordinator for Dubuque was felt to be helpful in finding resources and keeping the practice informed of patients’ status. In Pella, the referral process itself seemed to be implemented in a mostly unsystematic manner as evidenced by questions such as: who makes the referral; who is in charge of follow-up; and where to go or who to go to. The Pella nurses reported they many not know if the physician has made a referral. The EPSDT coordinator for Pella was used, but not by all referrers – some physicians preferred to continue using their long-established resources, e.g. Blank Children’s Hospital and the AEA.

How did your practice deliver anticipatory guidance?

The HMCN form may be confusing regarding anticipatory guidance suggestions and needs more explanation of what should be conveyed.

Dubuque had specific issues they were used to talking to parents about and wanted to add more to the list.

In Pella one physician delivers anticipatory guidance based on knowledge of the family, others use clinical judgment to pick and choose their anticipatory guidance. One physician thought that some items were just common sense and didn't want to insult the parents' intelligence. A more fundamental problem than HMCN form confusion may be that provider roles with respect to delivery of anticipatory guidance are unclear.

Do you feel the screening standards are appropriate and comfortable to use?

Although not much response was obtained for this question, there seems to be general support for use of screening standards, as a Pella nurse states, "so things aren't missed through the cracks."

Are there people in your practice that deliver level 2 services or do you refer out?

The Dubuque practice providers seem more likely to do level 2 services in-office, while the Pella practice seems more likely to refer out-of-office.

Do you use the EPSDT website?

There was little reported use of the website by focus group participants. All but one had not visited the site. The clinic manager for Dubuque is using the site to help guide policy decisions and billing.

Where do you go to find answers to clinical-related problems?

Focus group participants report using a wide selection of information resources – print, electronic (including web-based search engines), and conference presentations. There was some sense of not having enough time to keep up.

What suggestions or encouragements do you have for another practice(s) interested in doing developmental screening and follow-up?

This part of the session produced a variety of helpful suggestions from each focus group:

- You'll provide better patient care.
- The screener helps minimize the likelihood of forgetting something.
- Well-child screening is a good time to build rapport with the family.
- It's critical to build relationships with other local service providers.
- Be patient.
- This should be incorporated into the medical education curriculum.
- The HMCN form opens discussion about what's happening at home.
- It leads to interesting discoveries.
- Make sure that with respect to referrals, the role of the EPSDT coordinator is clear.
- Have ABCD II project staff come to the practice site to reinforce, explain, and address concerns. Also, bring food.
- Meeting the project staff lends a personal touch and makes the effort more real.
- Project staff enthusiasm transfers to the adopting office practice staff. Take a lesson from the drug reps!
- Let new practices meet staff from the practices that have finished the project.
- Parents love the information.
- Get support from the IAAP and IAAFP.
- The continuing education programs were good and informative.
- Have a solid contact person at each participating clinic.
- Talk to the physicians first to find out how best to implement the project because each practice is different.
- Emphasize importance of the form.

Do you have any final thoughts or impressions to share?

The Dubuque physician and nurse practitioner group claimed a key to project success is to have a "community resource base" that's up-to-date, accessible, and available. The Pella physicians felt the HMCN form has been handy and probably of continuing usefulness.

Conclusion

Four focus groups were held with provider staff from the two ABCD II pilot project clinics. Due to logistical barriers, prescribed focus group methods were relaxed; however, useful qualitative data was obtained to help promote and spread developmental screening as a standard of practice.

Both practices recognized the potential value of developmental screening and follow-up, although they were initially wary of the extra time and work it might require. Both found that using the HMCNs added no or very little time to the exam although addressing the additional issues raised with the parents did add time. Initially, there was apprehension about asking adult caretakers about maternal

depression and other socio-emotional risk factors. These doubts and discomforts generally disappeared with practice doing the screening and realizing the value of screening to the health of the children and families. Both practices will probably continue using some version of the screening standards and/or HMCNs.

Persisting unresolved issues include: 1) the optimum layout and contents of the developmental screening form; 2) division of labor regarding screening, follow-up, anticipatory guidance, and community referral responsibilities; and 3) inconsistent use of screening protocols due to both clinic logistics and alternative clinician preferences.

Both pilot sites offered a variety of valuable suggestions for how to successfully spread the concept of developmental screening to other primary care practices – pediatric and family medicine – throughout the state.

APPENDIX I:

Minnesota Outline and Format of Structured Interviews with Providers and Office Staff

Key Informant Interview

I am interviewing a number of different types of staff and providers to better understand how the screening process has been implemented at Children's Hospital and Clinics. Can you please describe your role at the clinic as it relates to mental health screening? Is this different than the role you had prior to the clinic beginning to use the ASQ:SE? (If yes: How so?)

Process Questions:

1. Prior to using the ASQ:SE, how were children referred to you in the clinic?
2. What type/s of background information/education did you receive about using mental health screening in pediatrics clinics before beginning this project?
3. What barriers were present as the clinic began to use the screening tool?
4. How did you overcome those barriers?
5. What types of clinic or system changes have been made to successfully incorporate the screening tool into regular practice?
6. Are there any changes that you or your department has made or championed to effectively implement the screening tool?
7. Do you believe this change in practice has been received well, poorly or with indifference by your co-workers? Have those feeling changed over time?

Parent Involvement Questions

My next questions focus on interactions with parents. Have you had any opportunities to meet with parents whose children have been screened?

If YES:

1. What feedback, positive and/or negative, have you heard from parents who have used the screening tool?
2. Since using the tool, have you noticed any changes in the quality of conversations you have with parents about their child's development?
3. Have you found parents who have used the screening tool to be any more or less likely to discuss their child's social and emotional development with you than those who have not?

If NO:

Because you haven't had direct conversations with parents about the screening process, I will move on to ask you some questions about resources and training opportunities.

Resource/Training Questions

1. Have you ever received any training on a standardized developmental screening tool? What tool/s?
2. What training, if any, have you received on children's mental health/social-emotional development in children?
3. What resources, if any, do you provide to parents who want additional information on socio-emotional development?
4. What types of information do you think the pediatric clinics should have available to provide to parents?
5. What additional information/training would you like to receive in order to feel more comfortable addressing the questions/concerns parents may have?

Future Needs/Recommendations

These final questions will ask for your opinions about anticipated barriers and future recommendations.

1. During your professional career, have you had other experiences implementing new tools/procedures into a clinic environment? If so, what factors have made this change in practice more or less difficult to achieve?
2. What barriers do you foresee that would impact how well this tool continues to be used in its current capacity?
3. Are there other barriers that you would anticipate if the tool was used daily in the clinic? (Children's Clinic only)
4. What suggestions or recommendations do you have for other clinics that are considering implementing a similar screening protocol?

APPENDIX J:

Minnesota Provider Survey

The following survey focuses on your professional experiences working with children ages 0-5 and their families. Please consider only this age group when responding to the following questions.

Section A: Please mark an 'X' in the box that best describes how often the following statements describe how you feel in your practice when using the ASQ:SE screening tool.

	Never	Occasionally	Frequently	Always
A1. I have had an adequate level of prior training in social-emotional development for children 5 years of age and younger.				
A2. I am familiar with the anticipatory guidance guidelines I should use to discuss social-emotional development with parents.				
A3. When using the ASQ:SE, I am better able to address concerns of parents regarding their child's development.				
A4. Discussing the ASQ:SE screening results with parents has enhanced the conversations we have about their child's development.				
A5. I find the ASQ:SE scores difficult to interpret.				
A6. I have a strong understanding of the mental health referral options available for children I see in practice who are under the age of 5.				
A7. I feel comfortable knowing when to refer children I see in practice for a psychological assessment.				
A8. I feel comfortable knowing when to refer children I see in practice to other community mental health services.				
A9. I feel I do not have adequate written resources available on social and emotional development to provide to parents.				
A10. When using the ASQ:SE, I feel that I identify children with mental health problems that I may have missed before.				
A11. Using this tool has helped me feel more empowered to work with children who have a developmental or social-emotional delay.				

Section B: Please mark an 'X' in the box that best describes how frequently the following things occur when you use the ASQ: SE in your practice.

	Never	At a few well-child visits	At half of all well-child visits	At most well-child visits	At all well-child visits
B1. The patient's caregiver has had adequate time before the appointment to complete the ASQ:SE					
B2. I see the screening results for the child prior to entering the examination room.					
B3. I have adequate time to address all items the caregiver has identified as areas of concern on the ASQ:SE.					
B4. The discussion I have with the parent about the screening results enhances the quality of the visit.					
B5. Using the ASQ:SE has made my appointments with patients longer than the time allocated for a well-child exams.					
B6. I take time to consult with another colleague about the ASQ:SE screening results prior to making a referral.					
B7. At the end of the appointment, I feel confident I made the most appropriate referral (or non-referral).					

Section C: Please mark an 'X' in the column that best indicates how often the following practice strategies are part of your well-child appointments with children 5 years of age and younger.

	I rarely or never do this	I sometimes do this, it depends on the child	I usually do this with most children	I always do this with all children
C1. I provide <u>anticipatory guidance</u> to parents about social-emotional development.				
C2. I specifically ask about the <u>child's behavior</u> at home and in other settings (at school, in day care, with peers).				
C3. During the appointment, I <u>observe the relationship</u> between the child and caregiver.				
C4. I have a list of <u>mental health referral resources</u> I can provide to parents.				
C5. I describe what parents can <u>expect</u> from the different mental health services I refer them to.				
C6. I write <u>mental health recommendations</u> on prescription pads or clinic letterhead.				
C7. I include information about the child's social-emotional development as <u>part of my dictation</u> .				

Section D: Please write your responses to the following questions. Additional comments can be made on the back of this sheet.

What types of additional training/resources would help you interpret and use screening results more effectively in your practice? _____

What additional changes need to be made in the clinic to help you use mental health screening as a regular part of your practice? _____

What advantages and disadvantages, if any, do you see in making mental health screening a permanent part of your practice?
 Advantages: _____

Disadvantages: _____

What steps do you think are necessary to effectively incorporate mental health screening into primary care settings? _____

Thank you for participating in this survey!

APPENDIX K:

Illinois Provider Survey

June 25, 2004

Dear Illinois Pediatrician:

As you know, the Illinois Chapter of the American Academy of Pediatrics (ICAAP) has grown significantly in recent years. We hope to maintain this growth and continue to enhance services for the pediatricians and families of Illinois in the coming years. However, to do so, we must have input on your needs.

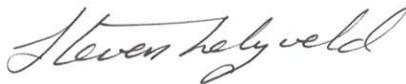
Our newest efforts involve soliciting input from the ICAAP membership about child development. Input will help us develop a range of strategies that primary care settings can implement to most effectively provide comprehensive, developmentally-oriented health care to our youngest children. Our ultimate goal is to design and implement multiyear projects that provide education and support on topics like developmental and social/emotional screening, maternal depression, and literacy promotion to Illinois primary care providers. Your response will assist our effort to design projects that meet the needs of ICAAP members and help us leverage additional funds to make these projects possible.

<p>The attached survey is being sent to a random sample of ICAAP members and your response is crucial to ensuring sufficient feedback from the membership.</p>
--

The Chapter will report results of this survey back to Chapter members. Data will also be useful to the Chapter's effort to secure additional funding for developmental screening and referral programs and to advocate for changes that will improve the health of children and families. However, your individual response to this survey will remain confidential. An identification number appears so that we can track respondents. Identifying information of participants will not be included as a part of reports or shared with any state or federal officials.

Please complete the attached survey and return it in the envelope provided or fax it to 312-733-1791 **by July 26, 2004**. Thank you for your support and input.

Sincerely,



Steven Lelyveld, MD, FAAP
President, Illinois Chapter, American Academy of Pediatrics

enclosures

cc: ICAAP Executive Committee

- Health Maintenance Organization (staff model)
- Non-government hospital
- Non-profit community health center
- County/state/federal hospital or clinic
- Medical school/affiliated training program (or parent university)
- Other (specify) _____

9. If you work in a group, how many pediatric care providers (MD, DO, PA, NP) including yourself are at your practice? _____ providers

10. Approximately what % of your patients are covered by the following insurance sources?

_____ % private insurance – fee for service or managed care (HMO, PPO, IPA, etc)

_____ % Medicaid/KidCare

_____ % Uninsured

100% TOTAL

11. Does the main office where you work conduct development surveillance (eliciting and attending to parental concerns; obtaining a developmental history; making informative clinical observations)?

- No
- Yes

12. Does the main office where you work have a policy/procedure to ensure that every child age 0-5 is screened *using a standardized tool* to check for developmental problems/delays?

- No
- Yes, at every well child visit
- Yes, at regularly pre-determined intervals (specific well-child visits)

12a. If Yes, please indicate the number performed in the first 3 years: _____

13. Does the main office where you work have a policy/procedure to ensure that every child age 0-5 is screened *using a standardized tool* for social/emotional health?

- No
- Yes

13a. Are you familiar with tools used to screen for social/emotional health?

- No
- Yes

14. In the main office where you work, who usually conducts follow-up with parents regarding child developmental screening and referral? (Check all that apply)

- Physician
- Physician Assistant (PA)
- Advance Practice Nurse/NP/PNP
- RN

- LPN
- Medical/Nursing Assistant
- Practice Administrative Staff
- Other (please specify) _____

15. In the main office where you work, who is the main parent educator on child development of children age 0-5?

- Physician
- Physician Assistant (PA)
- Advance Practice Nurse/NP/PNP
- RN
- LPN
- Medical/Nursing Assistant
- Practice Administrative Staff
- Other (please specify) _____

16. Does the main office where you work have patient education (brochures, videos, handouts) on the following issues?

	YES		NO	
	Yes, materials are sufficient	Yes, but would like better materials	No, would like to have	No, not needed
a. Breastfeeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Child care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Community resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Development milestones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Discipline	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Infant mental/social-emotional health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Injury prevention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Literacy promotion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Maternal depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Smoking cessation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Toilet training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PART THREE: Knowledge, Attitude and Practice

Please answer the following questions concerning your knowledge and practices regarding children 0-5 years of age at the **main primary care office** where you work.

17. In the past month, have you conducted developmental screening using a standardized tool to assess development for any child age 0-5?

- No **SKIP TO QUESTION 18**
- Yes

- 17a. If yes, which developmental screening tools did you use? (Check all that apply)
- Ages and Stages (ASQ) Denver II
- Checklist for Autism in Toddlers (CHAT) Modified CHAT (MCHAT)
- Parents' Evaluation of Developmental Status (PEDS)
- Other standardized tools (please specify) _____

18. Please check the **ONE** most significant barrier/challenge you encounter related to developmental screening and referrals.

- Inadequate reimbursement No staff resources to devote
- Lack of training Not enough time
- Don't know where to refer Parent/patient compliance
- Parent does not accept/recognize the problem identified
- Other (please specify) _____

19. How strongly do you agree or disagree that the following are barriers to your provision of social/emotional screening of families?

Check <i>ONE</i> Response for Each Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
a. Inadequate reimbursement for conducting formal social/emotional health assessments	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Inability to bill and be reimbursed for social/emotional health screening of families as distinct from regular well child care	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. Unfamiliarity with CPT codes that reimburse for social/emotional health screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. Time limitations in current practice	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e. Lack of training in assessing social/emotional health problems of families	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
f. Lack of non-physician office staff to perform assessments	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
g. Lack of available providers/programs willing to provide diagnostic and treatment services for families' social/emotional health problems	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
h. Lack of community-based resources to refer parents with social/emotional health problems (i.e. parenting classes, parenting support services)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
i. Unfamiliarity with applicable social/emotional health screening instruments designed for the pediatric office	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

20. Please indicate how often **you** do the following:

Check <i>ONE</i> Response for Each Item	Often	Sometimes	Rarely	Never
a. Ask open-ended questions (“Tell me about your baby”) to elicit concerns from parents/caregivers.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b. Base verbal anticipatory guidance on concerns elicited from the parent/caregiver during the visit.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c. Offer written materials to parents/caregivers to address their stated concerns.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d. Document parent/caregiver questions and responses in the child’s medical record.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e. Discuss childhood literacy/reading skills with parents/caregivers.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f. Discuss <i>family/caregiver</i> issues (violence, substance abuse, depression) during the well child visit.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g. Refer parents/caregivers to community-based parenting support groups.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h. Refer parents/caregivers to mental health service providers.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i. Follow-up with either the parent/caregiver or community agency to determine if a parent/caregiver referral was successful.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
k. Hesitate to ask questions to parents regarding their health habits during the preventive care visit.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

21. How strongly do you agree or disagree with the following statements?

Check <i>ONE</i> Response for Each Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
a. Pediatricians should screen new mothers for maternal depression.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b. Eliciting and attending to parent concerns about child development results in higher patient/family satisfaction.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c. Parents generally give accurate and quality information about their child’s development and behavior.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d. Pediatric practices should distribute books to families to encourage the acquisition of spoken and written language skills.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e. Pediatricians should advise parents on the effects of smoking and exposure to smoke.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
f. Pediatricians are an important resource for parents regarding child care arrangements for their child.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
g. Pediatricians should advise parents on how to meet <i>their own</i> needs.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
h. Pediatricians should be familiar with	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

community resources (ie Early Intervention, child care, and parent support groups).					
i. Talking about psychosocial issues with parents and caregivers raises issues that pediatricians are not prepared to address.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
j. It is more appropriate for child development specialists to assess a child's social/emotional development than pediatricians.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
k. Pediatricians should focus on physical health issues before delving into social/emotional or behavioral problems.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
l. Nurses and other non-MD office staff should discuss parenting skills and child development issues with patients/families.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

22. How likely would you be to use each of the following type of media to learn about child developmental/behavioral issues?

	Likely	EUTRAL	OT LIKELY
a. Continuing Medication Education course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Brief Local Program (grand rounds)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Practice-based/in-office educational session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Journal article (traditional or review)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Teleconferences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Audio cassettes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Videotapes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. CD-Rom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Internet-based Educational Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

THANK YOU for participating!
Please fax this completed survey to ICAAP at
FAX 312-733-1791 or mail it to:
ICAAP, 1358 W. Randolph, Suite 2 East, Chicago, IL 60607

APPENDIX L:

Utah Practice Self-Assessment Form of Current Practices Related to Developmental Services

**UPIQ SOCIAL-EMOTIONAL SCREENING LEARNING COLLABORATIVE
PRE-COLLABORATIVE ASSESSMENT**

Dear Social-Emotional Screening Learning Collaborative Participant,

Thank you for your interest in participating in the Social-Emotional Screening Learning Collaborative. As a reminder, the initial learning session is scheduled for Friday, May 20, 2005 at Thanksgiving Point.

Measurement is an important part of any quality improvement process. In order to determine if your practice is making progress during the learning collaborative, you need a baseline to compare to future measurements.

In preparation for the meeting, and to have a better understanding of what each practice is currently doing, we are asking you and your practice to complete the following survey. Please answer the following questions, followed by a 10 chart audit (this is easy!).

Use your Quality Improvement Team to complete this form, and then return it via fax to: Jenifer Lloyd, UPIQ Coordinator at **(801) 581-3899**.

If you prefer, you may mail your completed forms to:

Jenifer Lloyd, UPIQ Coordinator
Division of General Pediatrics
University of Utah
50 N. Medical Dr.
Salt Lake City, UT 84132

Please return the forms no later than **May 13, 2005**. Thank you and we look forward to seeing you on May 20!



Your practice name: _____

1. Do you use a standardized tool to assess the social, emotional, or behavioral development of infants and young children (age birth to five years)?

Yes No

2. What standardized tool(s) do you use? (Please check all that apply.)

ASQ

ASQ:SE

PEDS

TABS

Other (please specify): _____

3. How satisfied are you with your current method of identifying children with possible social, emotional, or behavioral concerns?

Very satisfied Somewhat satisfied Not at all satisfied

4. When you identify a child with what you believe to be minor social, emotional, or behavioral concerns, what do you do? (Please check all that apply.)

Do “watchful waiting” until next well-child visit

Counsel parent(s)

Provide anticipatory guidance materials

Refer child for services

5. Where would you refer a child with social, emotional, or behavioral concerns that you did not feel comfortable addressing in your office? (Please check all that apply.)

Community Mental Health Center (e.g., Valley Mental Health)

Early Intervention

Early Head Start

Children with Special Health Care Needs

Private family therapist or social worker

Private psychiatrist or psychologist

Primary Children’s Medical Center

Other (please specify): _____

6. If you have referred a child for social, emotional, or behavioral concerns in the past, how satisfied were you with the ease of getting a referral?

Very satisfied Somewhat satisfied Not at all satisfied

7. How satisfied were you with the exchange of information between the referral agency(ies) and your office?

Very satisfied Somewhat satisfied Not at all satisfied

8. Finally, what do you hope to gain from your participation in this project? (You can use additional pages if you wish – just send them with the rest of the assessment.)

THIS IS EASY!

**Measurement is a critical component of every quality improvement effort.
This audit will measure your practice's starting point.**

Even if you do not currently use a screening tool, please perform the following brief audit. Select 10 charts of toddlers (12 to 36 months) seen for well child visits within the last month. Of these charts, 5 should be toddlers with Medicaid. Gather the following information about this most recent visit from the chart:

Chart 1
1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage: ~ Private Insurance ~ Medicaid ~ Self Pay ~ CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used? ~ Yes (Go to Question 5) ~ No (<i>Continue with next chart</i>)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral? ~ Yes (Go to Question 7) ~ No (<i>Continue with next chart</i>)
7. If the answer to question 6 was yes, did any of the following take place: ~ Scheduled a follow-up visit. ~ The child was referred for further assessment. ~ The child was referred for treatment. ~ The parent was counseled. ~ The issue was dealt with at this appointment: ~ Parent given activity sheets ~ Anticipatory guidance brochures ~ Ongoing in-office treatment plan ~ Other (please list) _____ ~ None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to: ~ Local Mental Health Agency (i.e. Valley Mental Health) ~ Early Intervention ~ Early Head Start ~ Children with Special Health Care Needs ~ Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (<i>Please mark all that apply</i>) ~ Yes ~ Received assessment report ~ Received treatment report ~ Not eligible for services ~ No

Chart 2

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
 - ~ Private Insurance ~ Medicaid ~ Self Pay ~ CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
 - ~ Yes (Go to Question 5) ~ No (Continue with next chart)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
 - ~ Yes (Go to Question 7) ~ No (Continue with next chart)
7. If the answer to question 6 was yes, did any of the following take place:
 - ~ Scheduled a follow-up visit.
 - ~ The child was referred for further assessment.
 - ~ The child was referred for treatment.
 - ~ The parent was counseled.
 - ~ The issue was dealt with at this appointment:
 - ~ Parent given activity sheets
 - ~ Anticipatory guidance brochures
 - ~ Ongoing in-office treatment plan
 - ~ Other (please list) _____
 - ~ None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
 - ~ Local Mental Health Agency (i.e. Valley Mental Health)
 - ~ Early Intervention
 - ~ Early Head Start
 - ~ Children with Special Health Care Needs
 - ~ Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
 - ~ Yes
 - ~ Received assessment report
 - ~ Received treatment report
 - ~ Not eligible for services
 - ~ No

Chart 3

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
 - ~ Private Insurance ~ Medicaid ~ Self Pay ~ CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
 - ~ Yes (Go to Question 5) ~ No (Continue with next chart)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
 - ~ Yes (Go to Question 7) ~ No (Continue with next chart)
7. If the answer to question 6 was yes, did any of the following take place:
 - ~ Scheduled a follow-up visit.
 - ~ The child was referred for further assessment.
 - ~ The child was referred for treatment.
 - ~ The parent was counseled.
 - ~ The issue was dealt with at this appointment:
 - ~ Parent given activity sheets
 - ~ Anticipatory guidance brochures
 - ~ Ongoing in-office treatment plan
 - ~ Other (please list) _____
 - ~ None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
 - ~ Local Mental Health Agency (i.e. Valley Mental Health)
 - ~ Early Intervention
 - ~ Early Head Start
 - ~ Children with Special Health Care Needs
 - ~ Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
 - ~ Yes
 - ~ Received assessment report
 - ~ Received treatment report
 - ~ Not eligible for services
 - ~ No

Chart 4

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
 - ~ Private Insurance ~ Medicaid ~ Self Pay ~ CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
 - ~ Yes (Go to Question 5) ~ No (Continue with next chart)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
 - ~ Yes (Go to Question 7) ~ No (Continue with next chart)
7. If the answer to question 6 was yes, did any of the following take place:
 - ~ Scheduled a follow-up visit.
 - ~ The child was referred for further assessment.
 - ~ The child was referred for treatment.
 - ~ The parent was counseled.
 - ~ The issue was dealt with at this appointment:
 - ~ Parent given activity sheets
 - ~ Anticipatory guidance brochures
 - ~ Ongoing in-office treatment plan
 - ~ Other (please list) _____
 - ~ None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
 - ~ Local Mental Health Agency (i.e. Valley Mental Health)
 - ~ Early Intervention
 - ~ Early Head Start
 - ~ Children with Special Health Care Needs
 - ~ Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
 - ~ Yes
 - ~ Received assessment report
 - ~ Received treatment report
 - ~ Not eligible for services
 - ~ No

Chart 5

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
 - ~ Private Insurance ~ Medicaid ~ Self Pay ~ CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
 - ~ Yes (Go to Question 5) ~ No (Continue with next chart)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
 - ~ Yes (Go to Question 7) ~ No (Continue with next chart)
7. If the answer to question 6 was yes, did any of the following take place:
 - ~ Scheduled a follow-up visit.
 - ~ The child was referred for further assessment.
 - ~ The child was referred for treatment.
 - ~ The parent was counseled.
 - ~ The issue was dealt with at this appointment:
 - ~ Parent given activity sheets
 - ~ Anticipatory guidance brochures
 - ~ Ongoing in-office treatment plan
 - ~ Other (please list) _____
 - ~ None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
 - ~ Local Mental Health Agency (i.e. Valley Mental Health)
 - ~ Early Intervention
 - ~ Early Head Start
 - ~ Children with Special Health Care Needs
 - ~ Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
 - ~ Yes
 - ~ Received assessment report
 - ~ Received treatment report
 - ~ Not eligible for services
 - ~ No

Chart 6

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
 - ~ Private Insurance ~ Medicaid ~ Self Pay ~ CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
 - ~ Yes (Go to Question 5) ~ No (Continue with next chart)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
 - ~ Yes (Go to Question 7) ~ No (Continue with next chart)
7. If the answer to question 6 was yes, did any of the following take place:
 - ~ Scheduled a follow-up visit.
 - ~ The child was referred for further assessment.
 - ~ The child was referred for treatment.
 - ~ The parent was counseled.
 - ~ The issue was dealt with at this appointment:
 - ~ Parent given activity sheets
 - ~ Anticipatory guidance brochures
 - ~ Ongoing in-office treatment plan
 - ~ Other (please list) _____
 - ~ None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
 - ~ Local Mental Health Agency (i.e. Valley Mental Health)
 - ~ Early Intervention
 - ~ Early Head Start
 - ~ Children with Special Health Care Needs
 - ~ Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
 - ~ Yes
 - ~ Received assessment report
 - ~ Received treatment report
 - ~ Not eligible for services
 - ~ No

Chart 7

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
 - ~ Private Insurance ~ Medicaid ~ Self Pay ~ CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
 - ~ Yes (Go to Question 5) ~ No (Continue with next chart)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
 - ~ Yes (Go to Question 7) ~ No (Continue with next chart)
7. If the answer to question 6 was yes, did any of the following take place:
 - ~ Scheduled a follow-up visit.
 - ~ The child was referred for further assessment.
 - ~ The child was referred for treatment.
 - ~ The parent was counseled.
 - ~ The issue was dealt with at this appointment:
 - ~ Parent given activity sheets
 - ~ Anticipatory guidance brochures
 - ~ Ongoing in-office treatment plan
 - ~ Other (please list) _____
 - ~ None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
 - ~ Local Mental Health Agency (i.e. Valley Mental Health)
 - ~ Early Intervention
 - ~ Early Head Start
 - ~ Children with Special Health Care Needs
 - ~ Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
 - ~ Yes
 - ~ Received assessment report
 - ~ Received treatment report
 - ~ Not eligible for services
 - ~ No

Chart 8

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
 - ~ Private Insurance ~ Medicaid ~ Self Pay ~ CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
 - ~ Yes (Go to Question 5) ~ No (Continue with next chart)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
 - ~ Yes (Go to Question 7) ~ No (Continue with next chart)
7. If the answer to question 6 was yes, did any of the following take place:
 - ~ Scheduled a follow-up visit.
 - ~ The child was referred for further assessment.
 - ~ The child was referred for treatment.
 - ~ The parent was counseled.
 - ~ The issue was dealt with at this appointment:
 - ~ Parent given activity sheets
 - ~ Anticipatory guidance brochures
 - ~ Ongoing in-office treatment plan
 - ~ Other (please list) _____
 - ~ None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
 - ~ Local Mental Health Agency (i.e. Valley Mental Health)
 - ~ Early Intervention
 - ~ Early Head Start
 - ~ Children with Special Health Care Needs
 - ~ Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
 - ~ Yes
 - ~ Received assessment report
 - ~ Received treatment report
 - ~ Not eligible for services
 - ~ No

Chart 9

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
 - ~ Private Insurance ~ Medicaid ~ Self Pay ~ CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
 - ~ Yes (Go to Question 5) ~ No (Continue with next chart)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
 - ~ Yes (Go to Question 7) ~ No (Continue with next chart)
7. If the answer to question 6 was yes, did any of the following take place:
 - ~ Scheduled a follow-up visit.
 - ~ The child was referred for further assessment.
 - ~ The child was referred for treatment.
 - ~ The parent was counseled.
 - ~ The issue was dealt with at this appointment:
 - ~ Parent given activity sheets
 - ~ Anticipatory guidance brochures
 - ~ Ongoing in-office treatment plan
 - ~ Other (please list) _____
 - ~ None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
 - ~ Local Mental Health Agency (i.e. Valley Mental Health)
 - ~ Early Intervention
 - ~ Early Head Start
 - ~ Children with Special Health Care Needs
 - ~ Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
 - ~ Yes
 - ~ Received assessment report
 - ~ Received treatment report
 - ~ Not eligible for services
 - ~ No

Chart 10

1. Child's age (in completed months) at the visit: _____ months
2. Type of Health Coverage:
 - ~ Private Insurance ~ Medicaid ~ Self Pay ~ CHIP
3. How many well child visits has the child had? (total since birth) _____ visits?
4. Do the chart notes indicate that a social-emotional developmental screening tool has ever been used?
 - ~ Yes (Go to Question 5) ~ No (Continue with next chart)
5. Screening tool(s) used: _____
6. Did the screening tool indicate a need for follow-up or referral?
 - ~ Yes (Go to Question 7) ~ No (Continue with next chart)
7. If the answer to question 6 was yes, did any of the following take place:
 - ~ Scheduled a follow-up visit.
 - ~ The child was referred for further assessment.
 - ~ The child was referred for treatment.
 - ~ The parent was counseled.
 - ~ The issue was dealt with at this appointment:
 - ~ Parent given activity sheets
 - ~ Anticipatory guidance brochures
 - ~ Ongoing in-office treatment plan
 - ~ Other (please list) _____
 - ~ None of the above.
8. Due to concerns about possible social-emotional development, the infant was referred to:
 - ~ Local Mental Health Agency (i.e. Valley Mental Health)
 - ~ Early Intervention
 - ~ Early Head Start
 - ~ Children with Special Health Care Needs
 - ~ Other: (please list all that apply) _____
9. Did you receive information from the referral agency? (*Please mark all that apply*)
 - ~ Yes
 - ~ Received assessment report
 - ~ Received treatment report
 - ~ Not eligible for services
 - ~ No

APPENDIX M:

CAHMI Provider Survey (Titled Pediatric Preventive & Developmental Health Care: Current practices and perceptions)



UNIQUE IDENTIFIER TO BE
INSERTED HERE

PEDIATRIC PREVENTIVE AND DEVELOPMENTAL HEALTH CARE: YOUR CURRENT PRACTICES AND PERCEPTIONS

The survey should take about **10 minutes** to complete.

The purpose of the survey is to learn about: (1) provider perceptions about current practices in the area of preventive and developmental health care for young children; (2) barriers providers encounter; and (3) opportunities for improving care. Findings will help describe care practices.

**ALL SURVEY RESULTS WILL BE KEPT CONFIDENTIAL.
ALL ANSWERS WILL BE GROUPED TOGETHER AND
NO INDIVIDUAL RESPONSES WILL BE SHARED.**

Important Note about the Content of the Survey:

This provider-reported survey focuses on the aspects of care that are measured in the Promoting Healthy Development Survey (PHDS), which is currently being administered to parents of young children who receive well-child care within KPNW. The PHDS focuses on only those aspects of preventive and developmental care about which parents can reliably and validly report. Because of this, the PHDS does not address all aspects of preventive and developmental health care, rather, it is more focused on those aspects of care that are communication dependent (e.g. anticipatory guidance and parental education). This provider-focused survey, therefore, is focused on the aspects of care that are measured in the PHDS.

If you have any questions about this survey or how your responses will be used, please contact Colleen Reuland of the CAHMI at the 503-494-0456 or email her at reulandc@ohsu.edu.

PART 1: CURRENT PRACTICE AND PERCEPTIONS

It is often not feasible to address all of the recommendations for preventive and developmental health care in the time you have for well- and sick-child visits. In addition, there are various levels of evidence that support each of the recommendations and parents' needs differ. We are interested in learning more about your choices regarding what you routinely cover in the short amount of time you have with the parent and child.

1. How often do you routinely cover the following topics during well-child visits with children birth through 48 months of age:

Check *ONE* Response for Each Item

	I <i>rarely</i> do this	I <i>sometimes</i> do this, it depends on the child	I <i>usually</i> do this with most children	I <i>always</i> do this with all children
a) Anticipatory guidance and parental education about the <u>physical care of the child</u> (e.g. issues related to food and feeding, bed and naptime routines, issues related to breastfeeding/using a bottle)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) Anticipatory guidance and parental education about <u>injury prevention</u> (e.g. car seats, house safety, how to avoid burns to child, what to do if the child swallows poisons)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) Anticipatory guidance and parental education about <u>development and behavior issues</u> (e.g. behaviors to expect to see in child, words/phrases the child uses, discipline techniques, reading, toilet training)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) <u>Ask parents whether they have any concerns</u> about the child's learning, development and behavior	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) <u>Check whether the child has reached key developmental milestones</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) Periodic screening of the child's risk for developmental delays or problems <u>using a standardized, validated tool</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) Screening for <u>psychosocial issues in the home</u> (e.g. depression, emotional support, changes or stressors in the home)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h) Screening for <u>safety issues</u> in the home (e.g. firearms)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i) Screening for <u>alcohol or substance abuse</u> in the home	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

PART 2: CURRENT BARRIERS IN YOUR PRACTICE

2. How strongly do you agree or disagree that the following are barriers to your provision of Anticipatory Guidance and Parental Education for children birth through 48 months of age²⁹ⁱ:

Check <i>ONE</i> Response for Each Item	Strongly Agree	Somewhat Agree	Agree	Somewhat Disagree	Strongly Disagree
a) <u>Time limitations</u> during a well-child visit	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b) <u>Lack of non-physician office professionals</u> to provide anticipatory guidance and parental education during a well-child visit	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c) <u>Lack of evidence</u> to support recommended anticipatory guidance and parental education topics	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d) <u>Lack of familiarity</u> with the content of the recommendations regarding anticipatory guidance and parental education	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e) <u>Insufficient training</u> in preventive care counseling	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
f) <u>Lack of information on topics parents</u> in your practice <u>want</u> information and guidance about during a well-child visit	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
g) <u>Language and/or cultural issues</u> with families make it difficult for you to discuss these issues	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
h) <u>Lack of incentives</u> tied to whether you discuss all of the recommended anticipatory guidance and parental education topics	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

²⁹ Item is modified from the American Academy of Pediatrics Survey of Fellows #56.

- CONFIDENTIAL -

3. How strongly do you agree or disagree that the following are **barriers to your provision of Developmental Screening** to identify children at risk for developmental delays or problems for children **birth through 48 months of age**³⁰:

*(For the purposes of this survey: Developmental screening is defined as the screening of pediatric patients for evidence of having or being at risk for **physical or cognitive** developmental delays that may lead to developing motor, language, cognitive, behavioral or emotional delays/problems. **This screening can be done by means of informal or formal methods.**)*

Check <i>ONE</i> Response for Each Item	Strongly Agree	Somewhat Agree	Agree	Somewhat Disagree	Strongly Disagree
a) <u>Time limitations</u> during a well-child visit	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b) <u>Lack of non-physician office professionals</u> to perform screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c) <u>Inadequate reimbursement</u> for conducting developmental screening during routine well-child visits	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d) <u>Inability to be reimbursed for standardized tools</u> that cost money to purchase and copy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e) <u>Lack of referral</u> options	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
f) Belief that developmental screening is <u>not an appropriate role for pediatric primary care providers</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
g) <u>Lack of training in how to screen for child's risk for developmental delays or problems</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
h) <u>Unfamiliarity</u> with applicable <u>developmental screening instruments</u> designed for the pediatric office	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
i) <u>Lack of confidence</u> in the <u>validity</u> of available developmental screening tools	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
j) <u>Language and/or cultural issues</u> with families make it difficult for you to discuss these issues	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

³⁰ Item is modified from the American Academy of Pediatrics Survey of Fellows #53.

– CONFIDENTIAL –

4. How strongly do you agree or disagree that the following are **barriers to your provision** of **Environmental and Psychosocial Screening** of families of children **birth through 48 months of age**³¹:
 (For the purposes of this survey: *Environmental and psychosocial screening is the assessment of environmental and psychosocial risk factors for parents of pediatric patients including parental substance abuse, parental mental health, degree to which the parent has emotional support, changes or stressors in the home, and the presence of firearms in the home.*)

Check <i>ONE</i> Response for Each Item	Strongly Agree	Somewhat Agree	Agree	Somewhat Disagree	Strongly Disagree
a) <u>Time limitations</u> during a well-child visit	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
b) <u>Lack of non-physician office professionals</u> to perform screening	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
c) <u>Inadequate reimbursement</u> for conducting screening during a routine well-child visit	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
d) <u>Inability to be reimbursed for standardized tools</u> that cost money to purchase and copy	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
e) <u>Lack of referral options</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
f) Belief that screening of families is <u>not an appropriate role for pediatric primary care providers</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
g) <u>Lack of training</u> in screening for environmental and psychosocial problems of families	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
h) <u>Unfamiliarity</u> with applicable <u>screening instruments</u> designed for the pediatric office	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
i) <u>Lack of confidence</u> in the <u>validity</u> of available screening tools	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
j) <u>Parents don't want to be asked</u> about these issues during their child's well-child visit	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
k) <u>Language and/or cultural issues</u> with families make it difficult for you to discuss these issues	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

³¹ Item is modified from the American Academy of Pediatrics Survey of Fellows #53.

PART 3: CURRENT MEASURES OF QUALITY OF CARE

The following are some criteria that can be used to evaluate the quality of your pediatric practice.

5. How **useful** do you or would you find the following information in **improving the quality of care** you provide?

Check <i>ONE</i> Response for Each Item	Not at all useful	Somewhat useful	Useful	Very useful
a) Immunization rates	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) Well-child visit rates	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) % to PCP – Percentage of your patients who see you	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) % Full – Panel Fullness	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Time to Third Available Appointment/Percent Open	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) Art of Medicine survey results focused on <u>patient satisfaction</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) <u>Patient-based survey findings</u> about whether parents' report that you discussed <u>recommended aspects of care</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
h) <u>Patient-based survey findings</u> about whether <u>parents report their informational needs were met</u> about recommended topics	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
i) <u>Patient-based survey findings</u> about the degree to which the parents feel the care provided is <u>family-centered</u> (partnership, communication, respect)	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

PART 4: GUIDANCE ABOUT POSSIBLE FUTURE ACTIVITIES IN YOUR PRACTICE

Findings from the PHDS could be used to guide future **quality improvement** (QI) efforts focused on young children.

6. Please **rank** the following three quality improvement activities where **1** = QI activity that should be the **highest priority** and **3** = QI activity that should be the **lowest priority**. Indicate rank order on the line next to each activity.

- ___ QI activities focused on anticipatory guidance and parental education topics parents identified in the PHDS survey as they wished had been discussed.
- ___ QI activities focused on implementing developmental screening tools as part of routine well-child care.
- ___ QI activities focused on implementing environmental and psychosocial risk screening tools.

7. How **useful** would the following **quality improvement (QI) strategies** be in helping improve care in your practice?³²

Check <i>ONE</i> Response for Each Item	Not at all useful	Somewhat useful	Useful	Very useful
a) <u>Suggested text</u> that can be added to your <u>dot phrases and after visit summaries</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
b) <u>Parent education materials</u> such as pamphlets and posters	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
c) <u>Handbook of the evidence-base</u> behind preventive and developmental care recommendations	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
d) <u>Resource book</u> of available tools and how they can be implemented	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
e) Topic-specific, QI <u>training sessions</u> held during your office meetings	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
f) Trainings for <u>non-physician office professionals</u> to <u>administer standardized screening tools</u>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
g) <u>Report of your quality of care findings compared to other practices</u> and an overview of processes correlated with higher quality of care findings	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

YOU'RE DONE!! THANK YOU FOR YOUR TIME AND INPUT.

Please return the completed survey in the enclosed inter-office envelope to: Colleen Reuland, OHSU, CDRC-P Room 3214

³² Item is modified from the American Academy of Pediatrics Survey of Fellows.

APPENDIX N:

Office System Inventory (Developed by the Healthy Development Learning Collaborative)

OFFICE SYSTEMS INVENTORY

Instructions: To complete this tool, we recommend including your lead clinician, lead nurse, office administrator, and one or two other clinicians and staff. This tool will help you assess the degree to which systems exist in your office that make it possible for your practice to:



- Meet parents' informational needs and address their concerns about their child's learning, development, and behavior,
- Identify children at risk through the use of structured developmental and psychosocial assessments and screening at appropriate visits,
- Provide a strong and streamlined link to community resources for families who need or want them, and
- Promote optimal parent/child relationships.

1. Eliciting Parents' Informational Needs

Check off each office system your practice currently uses or has in place.

- We utilize a formal and informal survey to focus the visit on the parents' informational needs (e.g., a formal survey such as the Promoting Healthy Development Survey or an informal survey, such as questions routinely asked at beginning of visit).
- We have established practice-wide guidelines on anticipatory guidance and parent education topics.
- We have embedded practice guidelines into a clinical tool, such as a preventive services summary/flow sheet, health maintenance record, or a well-child care record.
- We have established practice-wide guidelines for annually updating and reviewing anticipatory guidance and parent education guidelines.
- We have implemented an annual chart review or parent survey to measure performance of anticipatory guidance and parent education.
- We have circulated results of the chart review to clinicians to plan for system changes.

SCORE: ___/6

2. Identifying Children at Risk

- We use standardized structured screening tools to identify children at risk for developmental delays (e.g., ASQ, PEDS).
- We identify high-risk families through psychosocial screening for maternal depression, substance abuse and domestic violence.
- We elicit parent/family strengths at well-child visits.
- We use tools at each well-child visit that alert the physician to needed preventive and developmental services and risk screenings (e.g., chart screening prior to visit, flag on chart).
- We utilize a screening and prompting system for needed preventive and developmental services at both well-child and non-well child visits.
- We train and utilize office staff to prompt practitioners to use preventive and

developmental screening systems routinely.

- We have established a registry to monitor the care of high-risk patients (e.g., developmentally delayed, at-risk family).
- We utilize a recall system to follow up with children who have missed well-child appointments.

SCORE: __/8

3. Linking Families to Community Resources for Additional Care

- We identify and utilize community resources to meet the needs of the practice population.
- We identify and train a staff person to regularly update a community resources listing.
- We organize and make accessible a listing of community resources.
- We identify and utilize a central contact and referral source in the community for needed referrals.
- We have created/adapted a standard referral form to send information to community agencies.
- We have created/adapted a standard referral form to request information from community agencies.
- We utilize a tracking system to follow up on referrals to community agencies.

SCORE: __/7

4. Promoting Optimal Parent/Child Relationships

- We designate a clinical staff person to train office staff about anticipatory guidance and parent education guidelines.
- We train and utilize clinic personnel (other than the physician) to conduct problem-focused counseling on specific topics (e.g., car seat safety, toilet training).
- We provide patient goal setting and/or written plans to facilitate behavior change.
- We provide patient education materials about specific topics (e.g., toilet training, sleep) that are consistent with the practice guidelines.
- We organize and make accessible patient education materials.
- We have created/adapted a standardized way to document anticipatory guidance and patient education (e.g., flow sheet, computerized record).

SCORE: __/6

	Score	Possible Total	Rating Your Office Systems
Section 1		6	Above 20 points: Your practice likely has a number of well-developed office systems in place.
Section 2		8	10-20 points: It is likely there are some systems within your office that need improvement. The sub-scores for each system will help you identify specific opportunities for improvement
Section 3		7	Lower than 10 points: Your office probably does not have a large number of systems in place
Section 4		6	
Total		27	

APPENDIX O:

Illinois Parent Survey: Satisfaction with the ASQ-SE

ABCD *Healthy Beginnings*
Parent Satisfaction with ASQ:SE

Your child's physician has started something new with their patients under the age of 3 and their families. It's called the *Ages and Stages Questionnaire (ASQ:SE)*. It asks you questions about your child's behavior. Your child's physician or nurse talked to you about it and may have given you some information or even a referral to a place where you can learn more. We would like to ask you a few questions about what you thought of this experience. Please do not write your name on this paper, your feedback is anonymous.

1. Were you able to understand the questions on the form that you were asked about your child's behavior?

- Not really Somewhat Yes

2. How comfortable were you answering the questions on the form about your child's behavior?

- Uncomfortable Somewhat comfortable Very Comfortable

3. Did someone talk to you about your child's responses on the questionnaire?

- No Yes

4. Did you learn something about your child's behavior after completing the questions and speaking with the doctor or nurse?

- Not really Somewhat Yes

5. Did you find the information that you were given about your child's behavior helpful?

- Not really Somewhat Yes
 I was not given any information

6. Did the doctor or nurse give you the name of a program or someone to call for further help?

- No Yes

If yes, who did they tell you to talk to or visit?

Do you plan on calling them? Please explain why or why not.

- No Yes

7. Do you think it is a good thing that your child's doctor is using this new questionnaire?

- Not really Somewhat Yes

8. Is there anything else you would like to share?

Thank you!

APPENDIX P:

Illinois Medical Chart Abstract Tool for Measures of Screening for Maternal Depression (Developed by Health Services Advisory Group)

EPSDT Medical Record Abstraction Tool

EPSDT Medical Record Abstraction Tool Instructions



EPSDT Medical Record Abstraction Tool Instructions.

DATE OF REVIEW: _____ REVIEWER NAME: _____
 MEMBER NAME: _____ DATE OF BIRTH: _____ ID#: _____ # VISITS IN REVIEW PERIOD: _____
 PCP NAME: _____ PCP ID#: _____ PCP ADDRESS: _____ PCP PHONE: _____

Please circle the appropriate response for each date of service.

EPSDT PIP Evaluation Results												
EPSDT VISIT COMPONENTS	Date of Service _____											
1. HEALTH HISTORY												
A. Comprehensive Initial History	YES	NO	REF									
B. Interval History	YES	NO	REF									
2. DEVELOPMENTAL SCREENING												
Subjective	YES	NO	REF									
Objective	YES	NO	REF									
Name of Objective Instrument:	_____			_____			_____			_____		
3. NUTRITIONAL ASSESSMENT												
	YES	NO	REF									
4. COMPREHENSIVE PHYSICAL EXAM												
	YES	NO	REF									
5. DOCUMENTED GROWTH												
A. Height	YES	NO	REF									
B. Weight	YES	NO	REF									
C. Head Circumference (Birth to 24 months)	YES	NO	REF									
D. Plotted on a Growth Chart	YES	NO	REF									

Please circle the appropriate response for each date of service.

EPSDT PIP Evaluation Results												
EPSDT VISIT COMPONENTS	Date of Service _____											
6. VISION												
Subjective	YES	NO	REF									
Objective	YES	NO	REF									
	NOT DOCUMENTED			NOT DOCUMENTED			NOT DOCUMENTED			NOT DOCUMENTED		
7. HEARING												
Subjective	YES	NO	REF									
Objective	YES	NO	REF									
	NOT DOCUMENTED			NOT DOCUMENTED			NOT DOCUMENTED			NOT DOCUMENTED		
8. LEAD LEVEL												
A. Ordered	YES	NO										
B. Performed	YES	NO										
C. Lead Level Result	_____		REF									
D. Follow Up of Elevated Blood Lead Levels	YES	NO	N/A									
9. HEMOGLOBIN or HEMATOCRIT												
A. Ordered	YES	NO										
B. Performed	YES	NO										
C. Level	_____		REF									
10. DENTAL SCREENING												
	YES	NO	REF									
11. ANTICIPATORY GUIDANCE												
A. Anticipatory Guidance	YES	NO	REF									
B. Age Appropriate Components Discussed	YES	NO	REF									
C. Parenting Skills Discussed	YES	NO	REF									



EPSDT Medical Record Abstraction Tool Instructions.

Please circle the appropriate response for each date of service.

EPSDT PIP Evaluation Results				
EPSDT VISIT COMPONENTS	Date of Service _____	Date of Service _____	Date of Service _____	Date of Service _____
12. OTHER REFERRALS and REFERRALS TYPES (Collected from fields #1–#11)				
	YES NO	YES NO	YES NO	YES NO
A. Type				
B. Type				
C. Type				
13. EPSDT DIAGNOSIS (Does this date of service have an EPSDT diagnosis?)				
	YES NO	YES NO	YES NO	YES NO
14. IMMUNIZATIONS (Enter dates of all immunizations administered birth through 12-31-2004)				
DPT	#1 _____	#2 _____	#3 _____	#4 _____
IPV	#1 _____	#2 _____	#3 _____	
HEP B	#1 _____	#2 _____	#3 _____	
HIB	#1 _____	#2 _____	#3 _____	
MMR	_____			
VARICELLA	_____	History of Disease _____		
INFLUENZA	_____	_____	_____	
PNEUMOCOCCAL	_____	_____	_____	_____
15. OTHER VISITS, WHICH ARE NON-FACE-TO-FACE ENCOUNTERS (For example, weight checks)				
Date of Service _____	Date of Service _____			
Date of Service _____	Date of Service _____			

EPSDT MEDICAL RECORD ABSTRACTION TOOL INSTRUCTIONS

Verify the member's name, DOB, HP ID #, PCP name, PCP ID, PCP address, and PCP phone.

Date of Service—Capture all dates of service containing EPSDT components (ill/episodic or EPSDT) from birth to 36 months of age, where there is a face-to-face encounter with the provider, Nurse Practitioner, or Physician Assistant. For each date of service being reviewed, enter the date in the space provided and answer the questions #1 through #15. For any non-face-to-face visits (i.e., weight checks or immunizations only) enter the date of service in the space provided on #15. If a lead, hemoglobin, or hematocrit value is located during the review year, but is not associated with a face-to-face date of service, enter the date of service of the laboratory results at the top of the tool. All fields #1 through #13 will be marked “no,” except the fields containing the laboratory information (i.e., fields #8 and #9).

Referral—If the provider directs the member to see any other provider or initiates a referral during the visit, circle the referral (“ref”) response associated with the EPSDT component. For example, if the provider documents an abnormal dental screening and initiates a referral to a dentist, circle the “ref” response corresponding to the dental screening category (#10). Write in the referral specialty type in field #12.

1a. Comprehensive Initial History—For each date of service, circle “yes” if there is a comprehensive health history completed by the provider for that date. The history should be able to assist the provider in obtaining information regarding past health problems; evaluating the risk for health problems; and information regarding the child's family and social environment. The initial visit for a newborn should include prenatal, birth, and neonatal history. Circle “no” if there is no comprehensive history documented.

See Exhibit A, which outlines the minimum number and type of initial history components necessary to meet EPSDT guidelines.

1b. Interval History—For each date of service, circle “yes” if there is documentation of an interval history between the current and last visit. An interval history should contain information regarding illnesses, accidents, health habits, and developmental changes which may have occurred since the last visit. If the provider notes “no changes” or “no complaints,” this is acceptable for a “yes” response. Circle “no” if there is no documentation of an interval history.

2a. Developmental Screening/Subjective—For each date of service, circle “yes” in the “Subjective” category if there is documentation of a subjective developmental screening. Any documentation related to age-appropriate developmental milestones or the child's social, emotional, fine or gross motor skills, or language development would be acceptable. If there is no subjective developmental screening noted, circle “no” in the “Subjective” category. WDWN does not count for developmental screening. See Exhibit B, which lists age-appropriate developmental milestones. If the provider documents “development age appropriate,” this is sufficient for a “yes” response.

Developmental Screening/Objective—For each date of service, circle “yes” in the “Objective” category if there is documentation of an objective developmental screening documented. Circle “no” in the “Objective” category if there is no documentation of an objective test. Enter the name of the objective instrument used by the provider on the line provided.

See Exhibit C for a list of acceptable objective developmental tests.

3. Nutritional Assessment—For each date of service, circle “yes” if a nutritional assessment was completed. Documentation of well-developed, well-nourished (WDWN), dietary evaluation, anthropometric measurements, or biochemical measurements all qualify for nutritional assessment. If the provider documents “breastfeeding without problems,” “good appetite per mom,” or “eating table food,” these too qualify as nutritional assessment. Enter a “no” if there is no documentation of a nutritional assessment.

4. Comprehensive Physical Exam—For each date of service, circle “yes” if a comprehensive physical exam was performed. To qualify as a comprehensive physical, the following components must be met: examination of the head, neck, eyes, ears, cardiovascular, respiratory, gastrointestinal, reproductive, nervous, musculoskeletal, lymphatic, and integument systems. If no physical exam was completed, or some of the components are not met, circle “no.” To qualify as a “yes” response, 80 percent, or 10 out of 12 physical exam components, must be addressed.

5. Documented Weight, Height, and Head Circumference—For each date of service, circle “yes” if the child’s height (#5a), weight (#5b), and head circumference (#5c) are documented in the medical record for the particular visit. Enter “no” if the height, weight, and head circumference are not measured during the visit.

- Plotted measurements on a growth chart—If the height, weight, and head circumference for children birth to 24 months of age were plotted on a growth chart for that date of service, circle “yes” for #5d. Questions #5a, #5b, and #5c must all be plotted on the growth chart to count as a “yes” response.
- If the height and weight were plotted on a growth chart for children older than 24 months of age (a head circumference is not required after 24 months of age), circle “yes.” Both #5a and #5b must be plotted on the growth chart to count as a “yes” response.
- If none of the measurements are plotted on a growth chart, circle “no” in #5d for either of the age groups. If only one of the required measurements is not plotted on the growth chart, circle “no” in #5d.

6. Vision/Subjective—For each date of service, circle “yes” in the “Subjective” category if there is documentation of a subjective vision screening. An example of a subjective vision screening is the informal observation by the provider or parent that the child follows lights or faces. If there is no documentation of subjective vision screening, circle “no” in the “Subjective” category. If the subjective screening was abnormal and the provider refers the child to a specialist under the “Subjective” category, the subjective “ref” will be circled.

Vision/Objective

- If the provider performs an objective vision test in the office, circle the “yes” response.
- If the provider does not perform an objective vision test in the office, circle “no.”
- If the provider completed a subjective screening and made a referral, but there was no evidence in the record that the objective test was performed, circle “not documented.”
- If the provider performs an objective test in the office and notes that it was abnormal and refers the child to a specialist, circle the “ref” response.

7. Hearing/Subjective—For each date of service, circle “yes” in the “Subjective” category if there is documentation of a subjective hearing screening. An example of a subjective hearing screening is the informal observation by the provider or parent that the child hears sounds or turns toward sound. If there is no documentation of subjective hearing screening, circle “no” in the “Subjective” category. If the subjective screening was abnormal and the provider refers the child to a specialist under the “Subjective” category, circle “ref.”

Hearing/Objective

- If the provider performs an objective hearing test in the office, circle the “yes” response.
- If the provider does not perform an objective hearing test in the office, circle “no.”
- If the provider completed a subjective screening and made a referral, but there was no evidence in the record that the objective test was performed, circle “not documented.”
- If the provider performs an objective test in the office and notes that it was abnormal and refers the child to a specialist, circle the “ref” response.

8a. and 8b. Lead Testing—For each date of service, circle “yes” in the appropriate row if a blood lead test was either performed or ordered by the provider. Circle “no” in the appropriate row if no blood lead test was either performed or ordered during the visit. If a lab is performed, the ordered response will also be marked “yes.”

8c. Lead Level Result—If a blood lead level was documented on the date of service or any time from birth through 12/31/04, enter the level on the line provided. If the provider initiates a referral to a specialist, circle the “ref” response to #8c. If the blood lead level is not associated with an actual visit date, enter the date of the lab result in the date of service space, at the top of the tool. Mark all other components “no” and enter the lab result information in fields #8a, #8b, and #8c. Capture all blood lead levels performed on or before 12/31/04.

8d. Follow Up of Elevated Lead Level—If a blood lead level is $\geq 10\mu\text{g}/\text{dl}$, it is required that the provider follow up the abnormal result. If the provider advises the parent to repeat the test or any other follow-up advice is given, circle the “yes” response for #8d. If the blood lead level is $\geq 10\mu\text{g}/\text{dl}$ and the provider does not document a referral or a follow-up appointment, circle the “no” response. If the blood lead level is $\leq 10\mu\text{g}/\text{dl}$, circle “NA” for #8d.

9a. and 9b. Hemoglobin or Hematocrit—For each date of service, circle “yes” in the appropriate row if a hemoglobin or hematocrit was either performed or ordered by the provider. Circle “no” in the appropriate row if no hemoglobin or hematocrit was either performed or ordered during the visit. If a lab is performed, the ordered response will also be marked “yes.”

9c. Hemoglobin or Hematocrit Level—On the line provided enter the level of the hemoglobin or hematocrit performed on or before 12/31/04. If the lab result is not associated with an actual visit date, enter the date of the lab result in the date of service space, at the top of the tool. Mark all other components “no” and enter the lab result information in fields #9a, #9b, and #9c.

Defer to the hemoglobin result if both a hemoglobin and hematocrit were performed.

10. Dental Screening—For each date of service, circle “yes” if a dental screening was performed. A dental screening involves the examination of the oral cavity and can be done during the physical exam. If the provider documents “HEENT,” credit is given because the mouth is examined to look into the throat. If the provider documents any information regarding teeth, credit will be given for a dental screening. Circle “no” if no dental screening was performed during the visit. If a referral to a dentist was made during the visit, circle the “ref” response.

11a. Anticipatory Guidance—For each date of service, circle “yes” if health education or anticipatory guidance was documented (see Exhibit D). If the provider documents “anticipatory guidance done,” or “education provided,” circle the “yes” response. Circle “no” if health education or anticipatory guidance was not documented during the visit.

See Exhibit D for a suggested list of Anticipatory Guidance topics.

11b. Age-Appropriate Components—If the provider documents discussion of specific age-appropriate anticipatory guidance or health education components, circle the “yes” response (see Exhibit D). If the provider just documents anticipatory guidance or health education on the date of service, as in #11a, circle the “no” response.

See Exhibit D for examples of age-appropriate topics.

11c. Parenting Skills—For each date of service, if the provider discussed parenting skills such as discipline, rewards, and consistency, circle the “yes” response (see Exhibit D). If the provider does not document that he/she discussed parenting skills at the visit, circle the “no” response.

See Exhibit D, which lists examples of anticipatory guidance, health education, and parenting techniques. An asterisk denotes acceptable parenting topics, which fulfill a “yes” response for #11c. If #11c is “yes,” #11a will be “yes.” If the parenting skills in #11c are age-appropriate, #11b will also be “yes.”

12. Other Referrals and Referral Types—If the provider initiates a referral that is not associated with any of the EPSDT components, #1 through #11, enter the provider type in the space provided. If “ref” is circled in fields #1 through #11, enter the referral types in field #12.

13. EPSDT Diagnosis—For each date of service, circle “yes” if the provider documented a diagnosis of an EPSDT visit. If the diagnosis for the date of service was not an EPSDT diagnosis, circle “no.”

14. Immunizations—Fill in the dates of any immunizations administered from birth through 12/31/04. If the record notes the child “had chickenpox,” enter the date of the disease on the line marked “History of disease.” If the provider documents “had chickenpox in March,” enter the month and year and defer to the child’s day of birth to complete the date. For example, the child’s DOB is 04/15/03 and the provider documents “history of chickenpox in March of this year,” the date would appear as 03/15/04. If the abstractor notes “had chickenpox” listed without a date, on a problem log, enter 99/99/99 in the space provided for “history of disease” next to the varicella antigen in #14. “Up to date” (UTD) is not sufficient documentation for any antigen.

15. Other Visits, Which Are Non-Face-to-Face Encounters—If the child does not see the provider during a date of service, enter the date of service in field #14. For example, if the child visits the provider’s office for a weight check or an immunization, enter the date of service in field #15.

APPENDIX Q:

Utah Practice Self-Assessment Form of Current Practices Related to Maternal Depression Screening

**Screening for Post-Partum or Maternal Depression
Learning Collaborative
Initial Assessment**

Practice Name _____

Name and Phone Number of Person Completing Audit: _____

1. What role(s) do you believe that you have in identifying and/or treating post-partum or maternal depression in your practice? (Please check all that apply.)

- I should observe mothers for signs of post-partum or maternal depression
- I should routinely ask mothers about symptoms of post-partum or maternal depression
- I should administer a questionnaire or screening tool to all mothers in my practice to identify those with post-partum or maternal depression
- I should prescribe medications for mothers who I diagnose with post-partum or maternal depression
- I should provide counseling for mothers who have post-partum or maternal depression
- I should refer mothers who have post-partum or maternal depression
- I have no role regarding post-partum or maternal depression

2. How comfortable are you in discussing post-partum or maternal depression with your patients or their mothers?

Very comfortable Somewhat comfortable Not at all comfortable

3. If you HAVE identified a mother with post-partum or maternal depression, how did you do this? (Please check all that apply.)

- I noticed the mother's behavior and/or appearance
- The mother asked me directly about post-partum or maternal depression
- The mother told me she had post-partum or maternal depression
- I suspected depression based on the family dynamics or situation
- I used a questionnaire or screening tool to evaluate the mother
- Other – Please describe briefly: _____

4. If you use a questionnaire or screening tool to evaluate mothers for post-partum or maternal depression, what do you use?

(If possible, please fax or mail a copy of the questionnaire or screening tool when you return your responses to this form.)

5. When you refer a mother for maternal depression evaluation and/or treatment, where do you refer them? (Please check all that apply.)

Community Mental Health Center (e.g., Valley Mental Health)

OB/Gyn or other primary care physician

Private psychiatrist or psychologist

Private family therapist or social worker

I would provide treatment to the mother in my office

Other (please specify): _____

6. Finally, what do you hope to gain from your participation in this project? (You can use additional pages if you wish – just send them with the rest of the assessment.)

Please return this form with your responses by DATE to NAME, FAX NUMBER. Thank you!

APPENDIX R:

Utah Medical Chart Abstract Tool for Measures of Screening for Maternal Depression

Please FAX Your Audit to NUMBER by DATE – Thank You!

Screening for Maternal Depression Monthly Audit

Practice Name _____
 Name and Phone Number of Person Completing Audit _____
 Month _____

What tool(s) did you use this past month to screen for maternal depression? (Please check all that apply.)

- PRIME-MD/ 2 question screen (PHQ-2)
- PRIME-MD/Patient Health Questionnaire-9 (PHQ-9)
- Edinburgh Postnatal Depression Scale (EPDS)
- Family Psychosocial Screening (FPS)
- Beck Depression Inventory (BDI)
- Other- Please specify: _____
- None

Select 5 charts that meet the following criteria:

- Patient age newborn to 12 months
- Had a well child care visit in the past month

Screening			
Chart	Was a maternal depression screening tool completed as part of well-child check? (Y/N)	If yes, please list which tool(s) you used. (PHQ-2, PHQ-9, EPDS, FPS, BDI, Other)	Did the screening results indicate a need for additional evaluation or treatment? (Y/N)
1			
2			
3			
4			
5			

If any of the five moms above had a screening result that indicated a need for additional evaluation or treatment, please complete the following questions:

Referral			
Chart	Was the mother referred for further evaluation? (Y/N)	If yes, where was the mother referred? (Please describe briefly below.)	Was the mother treated or counseled in the office? (Y/N)
1			
2			
3			
4			
5			

Please tell us how you feel this project is going for your practice. Please rate yourself from 1 to 5:

1 2 3 4 5
 (Not started yet) (Just started) (Getting there) (Doing well) (Doing great)

Would you like us to contact your practice for technical assistance? Yes No
