Data Collection Instructions for the Ambulatory and Community Health Network (ACHN) for the Developmental Screening, Referral, and Follow Up QI Activity

Data collection for quality improvement (QI) is intended to help identify areas for improvement based on current performance. Use the results of the data collection to identify gaps; then use the suggested ideas for change from the Potential Barriers and Ideas for Change grid to design and run Plan, Do, Study, Act (PDSA) cycles to make improvements.

Collecting and Reporting Baseline and Monthly Interval Patient Data

**Note:** Below are instructions for how to answer data collection questions in ICAAP’s Learning Management System (LMS). The learning platform does not record any patient identifying information. You may record patient data in this tool for record-keeping purposes as part of this QI project. You should maintain your own records as proof that chart reviews were conducted. The questions in this tool align with the ACHN’s developmental screening quality assurance (QA) protocol and with Key Clinical Activities (KCAs) identified in this training and activity.

**Data Collection for Quality Improvement**

**Baseline Assessment**

Begin with a baseline measurement to provide a starting point for improvement.

1. Select a minimum of 10 Electronic Medical Records (EMRs) or patient charts for patients you have seen for 9-, 18- and 24- or 30-month well child visits from January 2012 to June 2012 (or longer if you fall short of 10 records). Select the first 10 patient records on the list for each age group.

   Ms. Hu, ACHN Director of Clinical Research, will run a baseline and monthly interval report for providers from each of the five ACHN pediatric sites. Baseline patient lists will be provided to the ACHN sites by January 14, 2013. Providers will enter their baseline data into the learning platform between January 28-31, 2013. Once the baseline data are entered for a provider, the QI data reporting cycle begins. Providers will receive Email reminders from the LMS system one week prior to their next monthly reporting date.

2. Providers review the information documented for each patient.
3. Answer all data collection questions in the online system for each patient (see next page).
4. The system will generate a run chart using the data you have entered. The results will help you identify gaps in your developmental screening processes and procedures, how you make referrals to an EI program, and how you follow up with parents/guardians.

**Interval Data Collection and Reporting**

1. At 4-week intervals, Ms. Hu will generate provider reports that include a new set of 10 records for patients of the appropriate age whom you have seen within the past month. (Note: If you fall short of the suggested minimum of 10 charts within the age group and timeframe, use all available patient charts. In other words, if you have only seen 8 patients in this age category, use all 8 patient charts as your denominator. You will not be penalized if you have not seen 10 or more patients.

2. Review the information documented for each patient.
3. Answer all data collection questions for each patient and enter your responses in the online tool. The system will generate a run chart using the data you have entered. The run chart will display your actual results along with your baseline and goal. Review the run chart to assess your progress. The run chart populates automatically after you submit your data and provides a cumulative picture of progress.

4. Create an improvement plan to help bridge the identified gap and move you closer to your goals. Refer to the training modules, QI tools, and other resources as needed. Conduct a test of change through a Plan Do Study Act (PDSA) cycle and implement successful changes.

5. Repeat steps 1 through 5 at 4-week intervals over a period of 6 months for a total of 6 data collection cycles.
Developmental Screening EI Referral Tracking Log

Participating ACHN pediatric clinics and providers are required to maintain a developmental screening EI referral tracking log excel spreadsheet for each pediatric clinic. See template included in the training resource tab and attached. Be sure someone from your clinic is designated to be responsible for the log. Take time to evaluate your practice's use of the tracking system to support routine implementation of developmental screening procedures. Develop an internal protocol to track patients who have a positive screen to ensure they receive a referral to an EI program. Also, develop a tracking system to ensure patients referred to EI receive a follow-up phone call within 36 clinic working hours from assigned staff to encourage the parents/guardians to follow through on the referral.

Directions: Review each patient chart or record individually. Answer the questions on the next page based on whether or not the activity has been documented in the record. These are the same questions contained in the online tool.

Note: The periodic use of a standardized tool for developmental screening in addition to surveillance is the current standard for well child care and is recommended by the Bright Futures Committee of the American Academy of Pediatrics (AAP). It is recommended that children are developmentally screened as part of the well child visit at 9, 12, 18 and 24 or 30 month intervals. Screening may be done at other intervals based on provider preference to make up with a missed screening or to supplement a clinical finding. Referrals into an Early Intervention program are made for children who fail any area of the developmental screening. http://www.childandfamilyconnections.org/ For this initiative, we are collecting data on the KCAs described below. We are not collecting data on the 12-month visit.

Six Key Clinical Activities Required

This QI initiative only tracks data on KCAs for the 9-, 18 and 24- or 30-month well-child visit. Patients seen one month before or after 9-, 18- or 24- or 30-month well-child visits may be included in data sets.

Exclusion: The only exclusion for each age group is if a child is enrolled in an EI program. In that instance, do not use that patient record in the data set.

Note: A positive ASQ-3 screening result is defined as follows: A referral into an EI Program is made for children who fall below the cutoff point (in the black area on the score sheet) in any area.
Developmental Screening, Referral to Early Intervention, and Follow Up

Patient Name or Record: _______________________________

KCA: Conduct and document that a developmental screening was done at the 9-month well-child visit.
Goal: 90%  
For charts of patients 8 to 10 months:

1. Did the patient receive a developmental screening using a validated tool?
   
   ○ Yes  ○ No

KCA: Conduct and document that a developmental screening was done at the 18-month well-child visit.
Goal: 90%  
For charts of patients 17 to 19 months:

2. Did the patient receive a developmental screening using a validated tool?
   
   ○ Yes  ○ No

KCA: Conduct and document that a developmental screening was done at the 24- or 30-month well-child visit.
Goal: 90%  
For charts of patients 23-25 or 29-31 months:

3. Did the patient receive a developmental screening using a validated tool?
   
   ○ Yes  ○ No

KCA: Patient with positive screening received a documented referral to an EI program.
Goal: 90%  
For charts of patients who screened positive for a developmental screening. Refer to patient record AND EI tracking log.

4. Were patients who screened positive on developmental screening for 9-, 18- and 24- or 30-month well child visits during the data collection period referred to an EI program?

   ○ Yes  ○ No

KCA: Patient with positive screening who received a referral to an EI program had name added to EI referral tracking log.
Goal: 90%  
For charts of patients who screened positive for a developmental screening. Refer to EI tracking log.

5. Was this information documented in the clinic EI referral tracking log? (If no tracking log was in use, answer “no”.)

   ○ Yes  ○ No

KCA: Parent or guardian of patient referred to an EI program received a documented follow-up phone call within 36 clinic working hours from clinic staff encouraging parent/guardian to follow through on the referral.
Goal: 90%  
For charts of patients who screened positive for a developmental screening. Refer to EI tracking log and note in patient record.

6. For patients at 9-, 18- and 24- or 30-month well child visits who received a referral to an EI program, did clinic staff follow up with the parent/guardian with a phone call within 36 clinic working hours to encourage the family to have the child evaluated for EI?

   ○ Yes  ○ No  ○ NA, parent not reachable by phone; note made in patient chart and EI referral tracking log.