Alabama Early Screening Improvement Training

Saturday, October 29, 2011
Tuscaloosa, Alabama

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™
Alabama Chapter

Produced by the Alabama Department of Public Health
Video Communications and Distance Learning Division

Shared Vision: Goals for the Project

Faculty

Heather Taylor, MD, FAAP
Pediatrician
Tuscaloosa, Alabama

Commercial Interests Disclosure

- **Heather Taylor, MD, FAAP**
  - **Does not intend to discuss any commercial products or services**
  - **Does not intend to discuss any non-FDA approved uses of products/providers of service**
  - **No significant financial relationship**

Why This Project Now

- **20% of all visits to pediatrician's office are for developmental or behavioral concerns**
- **80% of parental concerns are correct and accurate**

Why This Project Now

- **About 16% of children have disabilities, including:**
  - **Speech and language delays**
  - **Mental retardation**
  - **Learning disabilities**
  - **Emotional/behavioral problems**

Why This Project Now

- Only 50% of children with disabilities are identified prior to school entrance
  - Statistics from EQIPP Bright Futures Model

AAP Policy Statement

- AAP published "*Algorithm for Developmental Surveillance and Screening*" in 2006
  - Perform developmental surveillance at each well child visit

AAP Policy Statement

- Use standardized developmental screening tool at 9, 18, and 30 month visits (or 24 month if don't have routine 30 month visit) as well as any time the surveillance yields concerns

AAP Policy Statement

- Schedule early return visits for those with concerns
- Refer children with developmental concerns to early intervention
- Coordinate developmental and medical evaluations

AAP Policy Statement

- Identify those children with developmental concerns as children with special health care needs
- Document surveillance, screening, evaluation, and referral activities in the chart

AAP Policy Statement

- Establish relationships with state/local resources
- Use QI model to integrate surveillance/screening into office

But Majority Still Aren't Doing It

- In 2002, <25% of respondents to AAP survey were consistently screening
  - Denver II was most commonly used screening tool

But Majority Still Aren't Doing It

- In 2009, 47.7% of respondents reported always/almost using 1 or more screening tools
  - ASQ most commonly used
    - Denver II and PEDS (Parents' Evaluation of Developmental Status) were 2nd and 3rd

– Radecki L, Sand-Loud N, O'Connor KG, Sharp S, and Olson LM. Trends in Use of Standardized Tools for Developmental Screening in Early Childhood: 2002-2009. Pediatrics 2011; 128; 14-19.

And it's Doable

- Large project in NC integrated ASQ into primary care settings in 10 counties
  - By 3rd year of project, percentage screened had increased from 15.5% to 70%

– Earls MD, Hay SS. Setting the stage for success: implementation of developmental and behavioral screening and surveillance in primary care practice – the North Carolina Assuring Better Child Health and Development (ABCD) Project. Pediatrics 2006; 118(1)

And it's Doable

- Illinois AAP Chapter increased screening by >86% through their Enhancing Developmentally Oriented Primary Care project

– Allen SG, Berry AD, Brewster JA, Chalasani RK, Mack PK. Enhancing Developmentally Oriented Primary Care: An Illinois Initiative to Increase Developmental Screening in Medical Homes. Pediatrics 2010; 126; S160-164

But There Are Challenges

- AAP's 2006 pilot project in 17 diverse practices
  - 85% of patients were being screened by the end of the project but:
    - Practices struggled during busy times and times of staff turnover

But There Are Challenges

- Did not consistently administer a screen after surveillance suggested concern or track referrals
- Overall, referred only 61% of children with failed screens

– King TM, Tandon SD, acias MM, Healy JA, Duncan PM, Swigonski NL, Skipper SM, Lipkin PH. Implementing Developmental Screening and Referrals: Lessons Learned from a National Project. Pediatrics 2010; 125; 350-360

But There Are Challenges

- So success depends on practice buy-in, collaboration with community resources, QI process that accounts for changes in staffing/workflow and tracks outcomes

Goals for Our Project

- To improve developmental and behavioral screening in pediatric practices, in accordance with the AAP policy statements and Bright Futures guidelines

Goals for Our Project

- To improve provider understanding, utilization and implementation of standardized developmental, behavioral, and psychosocial screening tools

Goals for Our Project

- To educate pediatric providers in proper documentation, coding, and billing of screening tools
- To improve provider awareness of local community resources for evaluation and intervention

Getting Started: Engage Your QI Team

- Team will be the leaders in the office so members should be:
  - Motivated and willing
  - Representative of all the groups who will be affected by project changes
    - Office staff, nursing, physicians

Getting Started: Engage Your QI Team

  - Available to meet regularly with team members
- Role of the QI Team
  - Direct process change and plan new PDSA cycles
    - Use data to direct the change

Getting Started: Engage Your QI Team

- Meet often
  - Weekly to address PDSA cycles
    - Monthly to assess data/report to practice

Engage Your Practice

- Group buy-in is important for project success
- Talk about goals and benefits for practice, patients, and staff/providers
- Listen to concerns about extra time/effort
- Bring back data on outcome changes

Use a Registry

- Identify patients with developmental delay as children with special healthcare needs
- Identify needed services for each patient
- Track them and ensure regular follow-up

Use a Planned Care Approach

- To ensure reliable developmental screening in the office
- Goal is that office staff/providers are working together to ensure screening/follow-up is being done

Use a Planned Care Approach

- Must take into account current practice workflow and what adjustments will need to be made to incorporate project changes
- Work towards practice-wide implementation of protocols/standardized care process

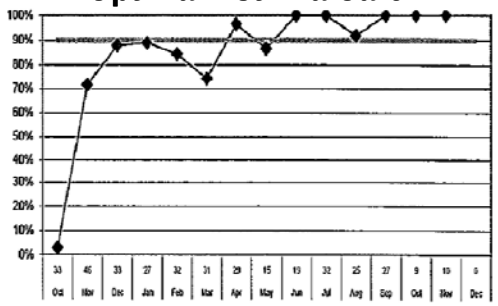
Provide Self-Management Support

- Build supportive/cooperative family and care team relationship
- Patient education materials, contact information for community resources, etc.

So . . . Does This Work

- Yes!

Percentage of Patients with Optimal Asthma Care



UMC Experience with CQN Asthma Project

- Successes of the project
  - Developed new, simple asthma action plans
  - Acquired spirometry and incorporated it into practice for both new diagnosis and follow-up patients

UMC Experience with CQN Asthma Project

- Began using a validated tool to screen asthma control routinely
- Established protocols for follow-up and for phone triage of asthma patients/asthma medication refills

UMC Experience with CQN Asthma Project

- Acquired new asthma education resources
  - Inhaler posters for exam rooms, education packets for families

UMC Experience with CQN Asthma Project

- All providers now on same page about asthma guidelines, optimal asthma care
- Practice worked together as a whole to implement the changes

What We Learned

- MOC credit was a big incentive for our providers
- Data does help drive improvement changes, increase support for project aims
- Important to involve office staff, nursing in core team

What We Learned

- You need to do small, short tests of change before practice-wide implementation
  - But you need practice-wide buy-in to be successful
    - So goal is everyone is following same protocol

What We Learned

- You can benefit from other group experiences in the project
- Our patients noticed and appreciated the changes