Monthly Data Instructions

Measure Definitions

Practices abstract data for the following measures on a monthly basis:

1. Strengths-Based Approach Utilized
2a. Screen for Potential Barrier to Early Relational Health Completed
2b. Intervention(s) Documented for Positive Screens
3. Recommended Interventions Assessed or Completed within 30 days

Step 1: Identify a Strengths- Based Approach

Practices will identify one strengths-based approach to add or improve over the course of the collaborative. It can be a current process that would benefit from improvement or a new approach may be selected. Explore the ACHIA website for strengths-based options. We will discuss this further in February.

Step 2: Identify a Screen for Potential Barriers to Early Relational Health

Practices will identify one screen to add or improve over the course of the collaborative. The screen can be one currently utilized in the practice that would benefit from an improved process or a new screen may be selected. Explore the ACHIA website for information on selecting a screen. Also included in this packet is the Worksheet: Implementing a Screening Process. We will discuss this further in January.

Step 3: Calendar Data Due Dates

Entering data on time is essential for the TICR Faculty to be able to review in a timely fashion, create and distribute your run charts. Note that each monthly cycle ends on the 21st of each month. REDCap (the platform for data entry) opens on the 22nd of each month. Data must be entered by the last day of the month. We recommend having 2 or more people able to abstract and enter data to cover for vacation, illness, jury duty, etc. Late data entry jeopardizes the ability to meet MOC Part 4 criteria.

Data Parameters to Generate Monthly Visit Lists for Data Abstraction

Six Cycles: February, March, April, May, June, July
Cycles Begin: 22nd of the month starting in January
Cycles End: 21st of the month starting in February
Include all target age WCC visits based on screen selected for improvement:

- Postpartum Depression: 1-, 2-, 4-, 6- month WCC
- Social Determinates of Health: 6-, 15-, 24-, 48- month WCC
- Social-Emotional Screening: 6-, 15-, 24-, 48-month WCC

Include all visits to providers included in Baseline data
Sort visits in chronological order
Select 10 chronological visits to abstract
If fewer than 10 visits available, include all available
Exclusions: for practices improving postpartum depression screen, exclude visits where the mother is not present.

Before Abstracting Data

Determine as a core team what appropriate care and documentation looks like in your clinic *before* you begin chart abstractions. Write this down. The process will look different in each practice. TICR tools to aid in this discussion include the *Worksheet: Strengths-Based Approaches and Screening* that some completed prior to abstracting baseline data as well as the *Worksheet: Implementing a New Screen* document that is useful when introducing a new screen. Review the ACHIA website for more examples on utilizing and documenting strengths-based approaches and screens.

Also discuss what interventions you will recommend for positive screens. As part of this collaboration, you will follow up with families to ascertain which interventions are most effective and actionable.

Throughout the collaborative, we will engage in peer-to-peer learning. As a result, your strengths-based approaches and screening should evolve as you incorporate tips and ideas from TICR colleagues. Update your notes as your process evolves.

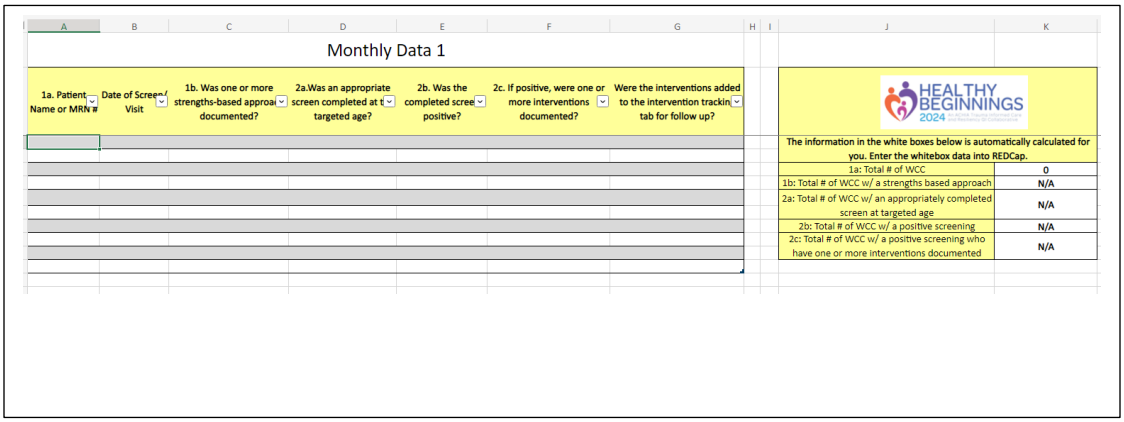
Data to Be Abstracted

Monthly data excel sheets assist in organizing practice data. These tools are optional. They are not submitted to ACHIA. Only the final tally is entered into secure REDCap database . If the practice has an alternative method to abstract data, they are welcome to utilize their preferred approach.

Monthly Data Excel Workbook: Download Excel file from ACHIA website

- Collect MRN/or Patient name to prevent duplication
- Date of Visit
- Was strengths Based approach documented?
- Was the screen appropriately completed?
  - □ screen completed by caregiver
  - □ scored accurately for selected screen
  - □ score documented
  - □ screen interpretation documented
- Was the screen positive?
- If positive, was one or more interventions recommended?
- If interventions recommended, were they added to Intervention Tracker

Data tallies are automatically calculated in excel. You then enter the tallies into REDCap.



Monthly Data 1

1a. Patient Name or MRN #	Date of Scree-/ Visit	1b. Was one or more strengths-based approai documented?	2a.Was an appropriate screen completed at t targeted age?	2b. Was the completed scree positive?	2c. If positive, were one or more interventions documented?	Were the interventions added to the intervention trackin tab for follow up?

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The information in the white boxes below is automatically calculated for you. Enter the whitebox data into REDCap.

1a: Total # of WCC	0
1b: Total # of WCC w/ a strengths based approach	N/A
2a: Total # of WCC w/ an appropriately completed screen at targeted age	N/A
2b: Total # of WCC w/ a positive screening	N/A
2c: Total # of WCC w/ a positive screening who have one or more interventions documented	N/A

Each cycle is a complete and independent data set. A new visit list for abstraction is generated each month.

Intervention Tracker

Practices track whether recommended interventions for positive screens were completed. This aids in determining which are the most effective and actionable recommendations from the family's viewpoint. This is also an optional tool that is not submitted to ACHIA. Practices are welcome to utilize alternative approaches to collecting these data.

Data Parameters for Intervention Data

Five cycles: March, April, May, June, July
Data are cumulative
Use the visits selected for abstracting strengths-based approaches and the screen to abstract intervention data.

Data to be Abstracted

The intervention tracker is the last tab on the Monthly Dataset worksheet.

Information collected helps practices understand which interventions are most actionable/helpful for families.

Practices will follow up with families within 30 days of the initial visit to assess if the intervention was completed or if the intervention (such as referral to mental health provider) is scheduled for a future date. If scheduled for a future date, practices should continue to follow that intervention until it either is or is not completed.

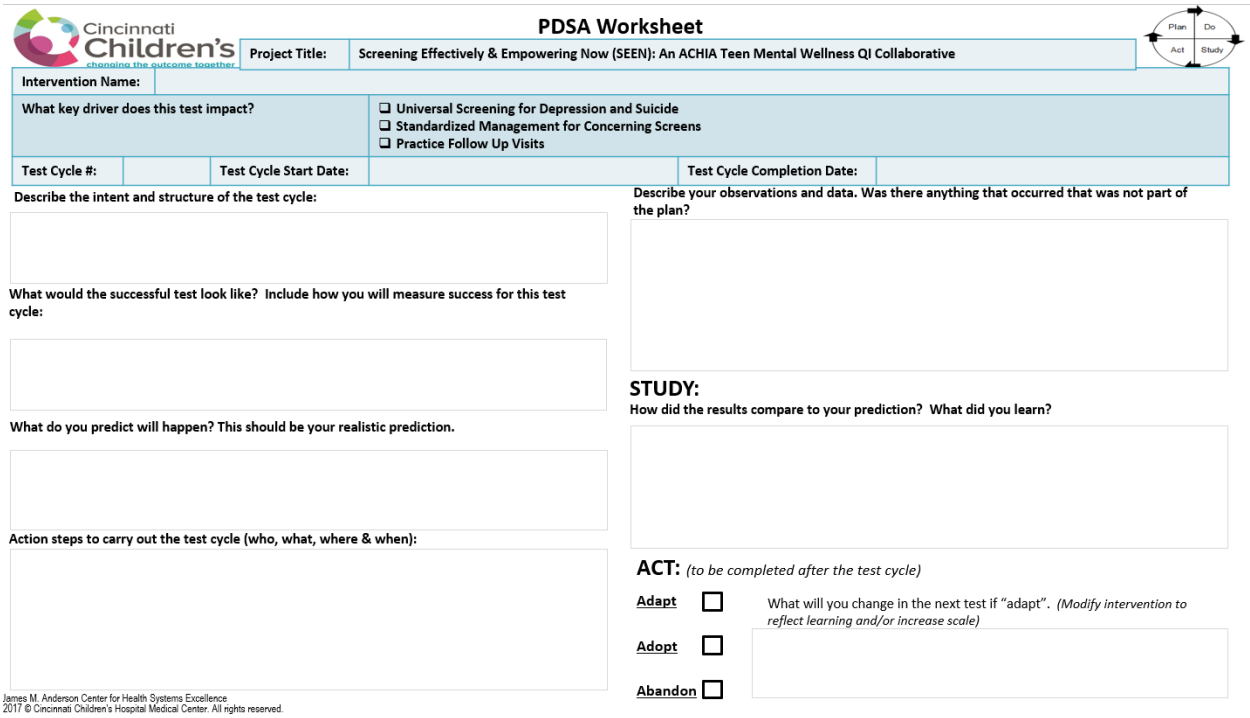
For learning, practices should note 'what happened' and include insights. If a family cannot be reached, that should be assessed as an intervention neither scheduled for a future date nor completed.

												MEASUREMENT 3 TRACKING		
3a. Patient Name or MRN#	3a. Screening date	Concern (PPD, SDH, St)	Intervention Plan	3b. Anticipated date Intervention Complete	3b. Assessment Date	Parent contacted (name/date)	Left message for patient	Sent letter to patient	Other	What Happened	Insights (changes ideas)	3b. Intervention scheduled for known future date	3b. Intervention Completed	3b. Intervention neither scheduled for a future date nor completed

Unlike monthly data, the interventions are cumulative. New interventions are added each month.

Monthly Plan-Do-Study-Act Cycles

Starting in February, practices will submit one or two complete Plan-Do-Study-Acts for each cycle Feb-July. PDSAs are QI tools to rapidly assess small tests of change. PDSAs will be discussed frequently throughout the collaborative and before the first one is due.



PDSA Worksheet

Cincinnati Children's — changing the outcome together

Plan Do Act Study

Project Title:	**Screening Effectively & Empowering Now (SEEN): An ACHIA Teen Mental Wellness QI Collaborative**
Intervention Name:	
What key driver does this test impact?	❑ Universal Screening for Depression and Suicide ❑ Standardized Management for Concerning Screens ❑ Practice Follow Up Visits

Test Cycle #:		**Test Cycle Start Date:**		**Test Cycle Completion Date:**	

Describe the intent and structure of the test cycle:

What would the successful test look like? Include how you will measure success for this test cycle:

What do you predict will happen? This should be your realistic prediction.

Action steps to carry out the test cycle (who, what, where & when):

Describe your observations and data. Was there anything that occurred that was not part of the plan?

STUDY:

How did the results compare to your prediction? What did you learn?

ACT: *(to be completed after the test cycle)*

Adapt ☐ What will you change in the next test if "adapt". *(Modify intervention to reflect learning and/or increase scale)*

Adopt ☐

Abandon ☐

James M. Anderson Center for Health Systems Excellence