Baseline Data Instructions

Overview

These instructions detail how to generate the baseline data visit list(s) and how to complete the baseline data abstraction. Only abstract baseline data for measures currently utilized in your practice.

There are 4 potential measures for baseline data:

- Strengths based approaches utilization
- Screening for postpartum depression
- Screening for social determinants of health
- Screening for social-emotional health

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Generating Visit List(s) For Baseline Data Abstraction

Establish which practice clinicians to include in baseline data
Determine which measure(s) have baseline data list to abstract
Visit list parameters for baseline data
Identify visits to abstract

Baseline Data Abstraction Guidance

Strengths Based Approaches Abstraction
Screening for Barriers to Relational Health
Postpartum Depression
Social Determinants of Health
Social-Emotional Screening

Have Handy

- Measure Definitions
- Baseline Data Excel Form
- Strengths-Based Approaches and Screening Worksheet

GENERATING VISIT LISTS FOR BASELINE DATA ABSTRACTION

Establish which practice clinicians to include in data for this collaborative

Option 1: Abstract data for every practice physician/nurse practitioner (NP)

Pro: Data will reflect whether practice as a system has improved.

Con: If only a few clinicians are engaged in the collaborative, abstracting data from every clinician will not allow data to show if small tests of change are leading to an improvement.

Abstracting data for every practice clinician may be a good option if:
All physicians/NPs are participating in the collaborative and will be testing improvements

And/or

Practice currently has system wide standards of care utilized by all physicians/NPs for one or more of the following and wants to assess how well current system works for one or more of the following:

- utilizing strengths-based approaches
- screening for Postpartum Depression (PPD), Social Determinants of Health (SDoH), or Social-emotional health (SE health.)

Option 2: Abstract data only for physicians/NPs participating in Trauma Informed Care and Resiliency (TICR) collaborative

Pros: Data from engaged participants better reflects whether interventions are leading to an improvement.

Cons: Data will not reflect whether the system as whole has improved.

Abstracting only TICR participant data may be a good option if:
A small proportion of practice physicians/NPs are testing improvements

And/or

Practice currently does not have a system wide standard of care for utilizing strengths-based approaches, screening for PPD, SdoH, or SE health and will be introducing strengths-based approach or a new screen.

Determine which measures have baseline data to abstract

Only abstract baseline data for processes currently utilized in your practice.

Strengths-Based Approaches

Does the practice currently utilize strengths-based approaches at the 1-, 2-, 4-, 6- , 15-, 24-, and/or 48-month WCC?

- No – you **do not** need baseline data for the strengths-based measure
- Yes- you **do** need baseline data for the strengths-based measure

  Examples:
  - Bright Futures Previsit Questionnaire
  - Promoting First Relationships
  - Reach Out and Read
  - HOPE
  - New Mexico 3 Questions

Postpartum Depression (PPD)

Does the practice currently screen for PPD at the 1-, 2-, 4-, and/or 6- month WCC?

- No – you **do not** need baseline data for the PDD measure
- Yes- you **do** need baseline data for the PPD measure

  Examples:
  - PHQ9
  - Edinburgh
  - PHQ2

Social Determinants of Health (SDoH)

Does the practice currently screen for any SDoH at the 6- , 15-, 24-, and/or 48- month WCC?

- No – you **do not** need baseline data for the SDoH measure
- Yes- you **do** need baseline data for the SDoH measure

  Examples:
  - SWYC
  - AAFP
  - SEEK
  - Healthy Steps Family Needs Questionnaire
  - Hunger Vital Signs

Social Emotional (SE) Screening

Does the practice currently screen for SE health at the 6- , 15-, 24-, and/or 48- month WCC?

- No – Stop. you **do not** need baseline data for the SE measure
- Yes- you d**o** need baseline data for the SE measure

  Examples:
  - SWYC
  - Pediatric Symptom Checklist
  - Baby Pediatric Symptom Checklist < 4YO
  - Strengths and Difficulties ≥ 2YO
  - ASQSE

If your practice currently addresses one of the topics above but utilizes an approach not listed in the examples, reach out to Rachel Latham for clarification rlatham@alaap.org.

STOP HERE: If your practice is currently not utilizing strengths-based approaches, nor screening for PPD, SDoH or SE health as you do not have baseline data to abstract. At the end of January, when it is time to enter baseline data into REDCap, you will indicate that the practice does not currently use a strengths-based approach/screen for the potential barriers to early relational health.

CONTINUE: If you answered "Yes" your practice is currently utilizing one or more of the following: strengths-based approaches, or screening for PPD, SDoH or SE health.

Visit list parameters for baseline data

Use the following parameters to generate a list of patient visits for data abstraction. Depending on which measure(s) you need to abstract, you will have one or two visit lists: One for 1-, 2-, 4-, 6- month WCCs and/or one for 6-, 15-, 24-, 48- month WCCs.

- Time Frame: June- Nov 2023
- Include visits to practice clinicians identified on page 1
- For measures that need baseline data, use the following visits.
    - Screening for PPD: 1-, 2-, 4-, 6- month WCC
    - Screening for either SDoH and/or SE data: 6-, 15-, 24-, 48- month WCC
    - Strengths-based approaches:
        - Utilize the baseline data visit list generated for PPD ***Or*** SDoH ***Or*** SE.

    Or

        - If the strengths-based measure is the *only* measure for which you will have data, choose one of the age groups for your data abstraction:
            - 1-, 2-, 4-, 6- month WCC

            Or

            - 6-, 15-, 24-, 48-month WCC
- Sort chronologically by visit date.

Identify 20 visits to abstract

Count consecutive visits to the practice from 1-20 beginning on any day between June 1 -November 30, 2023.

One visit may be used to abstract information for multiple measures.

Examples:

Visit List for 1-, 2-, 4-, 6- mo WCC - may abstract information for PPD and/or strengths-based approaches from same visit

Visit list for 6-, 15-, 24-, 48- month WCC - may abstract information for SDoH screening and/or SE screening and/or strengths-based counseling from same visit

BASELINE DATA ABSTRACTION GUIDANCE

Use Worksheet to Define Current Process

Before starting abstractions, discuss as a practice QI core team what is current approach and documentation standard for each current process. A shared understanding will improve the quality of the abstracted data as well we potentially identify areas for improvement. The *Strengths-Based Approaches and Screening Worksheet* is a tool to guide core team discussion.

Strengths Based Approaches Abstraction (Measure 1)

Reference Baseline: Strengths-Based Approaches Handout

Strengths- based approaches examples:

- Bright Futures PreVisit Questionnaires
- Promoting First Relationships
- Reach out and Read
- HOPE
- New Mexico 3 Questions

This is not a complete list.

1. Which age visit list is being used for the strengths-based approaches abstractions (select one):
   □ 1-, 2-, 4-, 6- month WCC (20 visits)
   □ 6-, 15-, 24-, 48- month WCC (20 visits)

2. Column A: Enter patient name or MRN into strengths-based section of the baseline data workbook (for internal use only to prevent duplication).

3. Column B: Enter date of visit.

4. Column C: Which standard strengths- based approach(es) is/are being assessed? Use Column D if more than one approach is utilized.
   Examples:
   Bright Futures PreVisit Questionnaires
   Promoting First Relationships
   Reach out and Read
   HOPE
   NM 3 Questions
   Other _____

6. Column E: Based on the Core Team's discussion (see Worksheet Strengths-Based Process), was a strengths-based approach documented? Yes/No

5. Column H: Automatically calculated from entered data. These are the two data points to enter into REDCap.

Screening for Barriers to Relational Health Abstraction(s) (Measure 2)

Postpartum Depression Screening

Abstract data from the baseline data visit list for the 1-, 2-, 4-, 6- month WCC
Exclude visits where mother is not present.

1. Column A: Enter patient name or MRN into data workbook (for internal use only to prevent duplication).

2. Column B: Enter date of visit.

3. Column C: Enter screening tool utilized. Column D: optional if an additional tool utilized.
   - □ PHQ9
   - □ Edinburgh
   - □ PHQ2
   - □ Other _____

4. Column E: Was the screen appropriately completed? No – STOP / Yes- CONTINUE
   All must be true for "Yes"
   - □ screen completed by caregiver
   - □ scored accurately for selected screen
   - □ score documented
   - □ screen interpretation documented

5. Column F: Was the screen positive? No- STOP / Yes- CONTINUE

7. Column G: For positive screens, based on the Core Team's discussion (see Worksheet Screening Process), were appropriate interventions documented? Yes/No

8. Column J: Automatically calculated from entered data. These are the three data points to enter into REDCap.

Screening for Social Determinants of Health

Abstract baseline data visits list for the 6-, 15-, 24-, 48- month WCC.

1. Column A: Enter patient name or MRN into data workbook (for internal use only to prevent duplication).

2. Column B: Enter Date of Visit

3. Column C: Enter screening tool utilized. Column D: optional if an additional tool utilized.
   - □ SWYC
   - □ AAFP
   - □ SEEK
   - □ Healthy Steps Family Needs Questionnaire
   - □ Hunger Vital Signs
   - □ Other _____

4. Column E: Was the screen appropriately completed? No – STOP / Yes- CONTINUE

   All must be true for "Yes"

   - □ screen completed by caregiver
   - □ scored accurately for selected screen
   - □ score documented
   - □ screen interpretation documented

5. Column F: Was the screen positive? No- STOP / Yes- CONTINUE

6. Column G: For positive screens, based on the Core Team's discussion (see Worksheet Screening Process), were appropriate interventions documented? Yes/No

7. Column J: Automatically calculated from entered data. These are the three data points to enter into REDCap.

Social Emotional Screening

Abstract baseline data visits list for the 6-, 15-, 24-, 48- month WCC.

1. Column A: Enter patient name or MRN into data workbook (for internal use only to prevent duplication).

2. Column B: Date of Visit

3. Column C: Enter screening tool utilized. Column D: optional if an additional tool utilized.
   - □ SWYC
   - □ Pediatric Symptom Checklist ≥ 4YO
   - □ Baby Pediatric Symptom Checklist < 4YO
   - □ Strengths and Difficulties ≥ 2YO
   - □ ASQSE
   - □ Other _____

4. Column E: Was the screen appropriately completed? No – STOP/ Yes- CONTINUE

   All must be true for "Yes"

   - □ screen completed by caregiver
   - □ scored accurately for selected screen
   - □ score documented
   - □ screen interpretation documented

5. Column F: Was the screen positive? No- STOP / Yes- CONTINUE

6. Column F: For positive screens: Based on what is currently agreed upon by the practice QI core team as the clinical process, were appropriate interventions documented? Yes/No

7. Column J: Automatically calculated from entered data. These are the three data points to enter into REDCap.