

AMCHP 2007 ANNUAL CONFERENCE

HEALTHY COMMUNITIES

March 3rd to 7th, 2007

Triumphs & Tribulations: Community Health Through Evidence-Based, Family-Centered Pediatric Care

ANGELIKA CLAUSSEN: Well hello and good afternoon. I hope you all enjoyed your lunch, I certainly did and I'm really glad to be here to talk to you about the evaluation piece of this. I'm with the CDC with the National Center on Birth Defects and Developmental Disabilities and we got the money to pass thru to them to go ahead and not only implement this program but also find out some ways of measuring whether they were successfully implementing the program and to learn something about the population and the outcomes. So my piece is the evaluation and the first thing I have to do is thank two people, Carla White who was my team member and who started the project, the evaluation piece but she went to a different team so I took over for her and she helped designed some of the evaluation component and then of course Missy Linebaugh. She's our data guru at the site and she and I talk data sheets and how to best capture some of the information because we know it's in there and we know it's out there but how to get it into a spread sheet that I can then deal with. Particularly since of course as the CDC, we don't get identifying information. We just have to try to get it in the distilled format.

So the Healthy Steps implementation, we're talking about the first year results. We're trying to get some information not only about how Healthy Steps worked for this site but also maybe get some information how it might work at other sites. What we can learn from this project and how it works particularly in this type of population which is low income, minority, inner city and city area. We're trying to find some evidence on this family centered care really can promote overall child health. You know my project, my team at the CDC, one of the things that we really look into is developmental screening because we're child development studies team so we're trying to see what can we do to identify children that are out there with risks for developmental disabilities. But we know that's not— shouldn't just be the focus so I'm really excited to talk about a project that talks about child health and development all together because often they tend to be separated.

So the public health prospective specifically is that AP, they recommend development screening and surveillance in a systematic way. Pediatricians do a good job even without systematic screening to pick out certain types of disabilities but other things can fall thru the cracks. So we're trying to get pediatricians to do systematic screening and to also do family centered care and Dr. J has already talked about that. And then of course Medicaid mandates regular physical check-ups for the children, EPSDT. And then there's a specific need in the Swope area is there is under and uninsured children without regular prevention pediatric care. So one of the goals was to try to address that need.

So these are some of the numbers. For the most part I will be speaking about the zero to five years because that's what we funded. There's one goal that includes the whole pediatric population but this is my specific data is mostly about the zero to five. There were 1,400 kids seen during the year, 2,700 something visits conducted. So if you look at these numbers they kind of make you tired because that's a lot of kids and a lot of visits and a lot of intervention provided. As you can see predominately African American population with some other ethnicities also included. And as you can see from the income this is really a very low income population. Most families are very poor and therefore of course at risk.

These are the ages for the children as visits. As you see there's a lot of little kids. Newborns and a lot of kids throughout the first year. This kind of maps onto the typical well child EPSDT visits when they should come for their immunizations so the data of course will have to come in a little bit more in the first couple years so the population leans towards that end. So these are the evaluations measures that we were trying to get at the success, you know, what would be the success. One of the success, we were trying to increase the number of children served from these target zip codes and the target zip codes were the ones particularly at need for more services. We were looking at the percent of the children that received untimely EPSDT visits and that's defined by AP and if children miss their physical checkups often enough they never will become timely so that's one of the problems with this. You are trying to get kids to get timely visits but if you

get children that have missed them in the pass you have to try to catch them up but you might not be able to.

We are also looking at the percent that did receive a developmental screening as part of their EPSDT visits. And after stated some children also received screening when they came in for other issues but I'm focusing on the ones who came in as part of EPSDT because they're—that's the population that is supposed to get it. We are also looking at the number of children who failed the developmental screen. There wasn't so much a goal as for us to try and figure out exactly how many children were detected. And then the number and type of referral is the result of failed screen and you already have in your first part handout detailed information about the types of referrals that were received so I'm not going to go about the types.

There was one other goal that I didn't—that I'm not going to report on because it was already mentioned but I did want to highlight. The maternal depression screening. There were almost 400 mothers who came in and if you look at the handout 100 percent of the mothers who were eligible actually got screened and I think that's a very important number and has to be highlighted because not all mothers are willing to come into a pediatrician's office and talk about themselves. You know they all should be screened post-partum and probably also in prenatal care and probably (inaudible). But they should be screened because they're at risk and a lot of mothers, particularly low income mothers don't go to their own

providers anymore after they have received the pregnancy visits to some extent because they're busy with the kids or others tend to because they don't have access. And you know when you've been there for nine months almost every week you might just be tired of going to the doctor. So they might not have access to their own care so the pediatrician being able to screen in very important. But, not all mothers are willing. But in this case all the mothers were willing to participate in the screening and I thought that was a really important highlight on how good the Healthy Steps specialists communicate with these mothers to where they would agree and be willing to talk about their own issues when they come to the pediatrician and not be concern that they're being tested on how good of a parent they are because some mother resist screening in their pediatrician office because they're worried if they say I have a problem then they might take my baby away. So those experiences from other projects that I know that didn't apply in this project so I thought I just wanted to highlight it.

So the first goal, very ambitious goal was to try and get 2,000 new pediatric patients from those zip codes in the 0 to 18 year range. They didn't quite meet the goal but they got 1,500 new patients, patients that they hadn't served previously so that's still a very good showing. Then this is the percent from the target communities. Among the new patients as you see we looked at the base line, the first quarter, as the measure of saying are they still on track and they increased their efforts over the time so across a year they were above their base line for percent of pediatric patients from these target communities. The red line

is the project goal again. In some cases there was an absolute goal that we said a certain level of performance, in other cases the base line, the first quarter was considered to be the goal and I'll let you know.

So second question, when the kids come in do they receive their EPSDT visits in a timely fashion. It's very important that they get their checkups in a regular way but it's particularly important that a child come in for a checkup if they haven't had their checkup. And 16 percent of the population came in with not having had timely EPSDT visits prior to their coming in. So I looked at this goal in two ways, number one overall which is the blue bar percent of the children that received a timely EPSDT and the absolute goal that they said where they wanted to serve 80 percent of the children that came in they should have their EPSDT visit. But then also separated out those kids, those 16 percent and that's the red bar, those kids that came in who didn't have timely checkups in the past because those are the ones that really need them at the moment. Another child you may be able to delay and say you know, they can come in for another check up later on. So it's definitely clear that they were doing an amazing job catching up the kids for their well child—for their physicals because they really missed very few. In two quarters one hundred percent of the children that needed a check up actually got it and I think that's pretty amazing.

Here are the tools. You know there was a question about the tools. And as you see for each of the check ups and this is at four months, the newborn, first and second visit only the mothers got screened and as of four months the child got

screened. So as you see they use different tools, ages and stages, the peds and then some other tools. And the question is why might they do that? Well one number, these different tools if systematically used might get you slightly different information about the child and particularly in the second half of the second year when language becomes important a tool that is sensitive to language delays and communications delays is quite appropriate.

But the other question is also how do you get the parents to fill out this information without getting bored or rejecting it and they really did have parents and one of the reasons why they wouldn't use the ASQ every time is because some of the parents said I've seen this before. I answered those questions and they really didn't read them anymore and they just sort of crossed on whatever when they did it a month ago. So that's one of the reasons why they decided to vary the tools because the parents were more receptive to using different— answering different questions. And each of the tools has advantages. You know (inaudible) peds being nice and short. The ages and stages being a really good instrument to talk about what's happening with your child and to try to get some information to the parents about developmental milestones. So each of these tools have advantages so varying them sort of maximizes the efforts.

You will see at the 18 and 24 months and at the 36 months there are two tools that are age appropriate and typically what happen is that they use the first one at 18 and 24 months. They would start with the MCHAT and then they would

follow it up with the ASQ if they felt that there may be some information that wasn't really gotten by the MCHAT or if the mother answered some questions or if there is some additional concerns. Sometimes children got both. And the same with 36 months. They would start with the Peds. It's a relatively short instrument and then follow up with ASQ if there is concerns or they might have used it because the mother reported certain things about the child or the father and then the pediatrician thought maybe that's not right so maybe they gathered more information that way. Because sometimes the parents are not very good reporters.

In addition occasionally they would do a Denver if they felt it was necessary. Particularly when they felt that the parents were not particularly good informants then they just did a Child Direct Assessment which can't be done very nicely in a systematic way because it takes a lot of time. But it's good to have when you need it. If you do need to do a follow up and you're not sure that the screener really tells you something then you want to have a tool that is more intensive and gets around the fact that some parents just are not good observers of children.

So this is the number of children that they identified. As you see the 24 months and 36 months visits are where the most number of children were identified and this despite the fact that more of the children were younger. So at the older ages when language and verbal development really is a good way of getting at the overall development, that's when you see them. It's not terribly surprising

because this is an environmentally deprived population and that's where a lot of the deficits are mediated is when the child—you know they might not have a lot of gross or fine motor deficits but by the time they need to communicate the lack of input and the lack of resources in the child's environment is really when the development is an issue.

But it's also nice to know that they catch them at those early ages because a lot of these kids typically don't get caught until they're in kindergarten when there more in the school system and the school says okay, you know there's something wrong now because your child doesn't perform in kindergarten level.

This tells you the proportion of the children that received screening and as you see the goal was 95 percent. They really tried to make sure that most of the children that came in for an EPSDT also got screened and as you can see they met the goal and surpassed it for the year so that's a really good showing there.

This slide tells you about the needed referrals that were received. Of those children that failed their screen as you can see only in the first quarter did not all children receive—get referrals and I have to say for the absolute measurement that was the definition but those two children, there's two children in the first quarter, the purpose they were not referred is because the pediatrician decided that a watchful waiting was appropriate. They felt that this was something that they can deal with by providing the parent with some information and both of

those children got assessed later on and turned out not to fail the screen any more. So there was an appropriate lack of referral basically. So it doesn't always mean just because a child fails a screen that you might need to refer right away to outside services. There may be some other interventions.

Also there were a number of children that were identified not thru developmental screening because sometimes children pass a screen and they're still concern both from the pediatrician perspective, from the Healthy Steps perspective or from the parent's perspective. Some of the children, you know the parents have a concern about behavior or language or something so sometimes referrals were made based on a definition as they used a term lack of development. Something is going on that requires services that may not be captured by a screening tool. And so not all the children who were referred were referred just on the basis of a screener.

And then last piece, one of the aims was to provide the children with immunizations in a timely fashion. And so one of the things we wanted to look at is the proportion of the children whose immunizations were current. Now in this case there's a problem with representing these numbers because of the way the clinic worked. The children were first seen by the specialist and the information as to whether they were current on immunizations was gathered at that time and then the child went to get their physical and at the end they might have gotten their shots but there was not way of getting the chart back without major labor

intensive information to see did they really get their shots. Ninety-seven percent or so got the shots but there wasn't any way for me to tell that they got caught up. So I decided since it was not a doing the project good service to just look at the percent that were current at the beginning of visit I spread the data out into children that had been there the first time in that year and children where I knew they had been seen before. So that gives us a better indicator of are they being able to catch the children up to their schedule for immunizations.

So this is the information and also wanted to separate it out by age because as you all know the immunizations for older children, younger ages you might be delayed and you might not have caught up but older children should be caught up. So the first bar are the kids that are repeat visits and the second one are the children that were seen the first time during the data year. Now some of them might have been served or saw before but that's not information that we had in our data sheets. So but we definitely know that the children in the blue bar were children that were seen before during the year and as you see it's very clear that they are doing very well in catching the kids up to the regular shots because the ones that come back in the beginning of visit they obviously were caught up last time because it's going—particularly in the older ages when you think they should have caught up now. Yes, they did catch up so that's a really good indicator of good performance.

So finally the question with all this good information we were able to give them money for one year only. I will be able to help them look at their outcomes and look at their goals for another year but this is not funding based anymore. CDC isn't able to pay them for another year or give them money for another year to try to do this so the question is now that you know this program works pretty well what do you do? Well, you have to try to figure out how to sustain it and that's always an issue. It may also—there may be additional ways that are necessary to get at the target population because as you see, the one goal they didn't meet is to get as many new patients in as they initially thought to try to get in.

And another thing is that for the beginning of the project certain goals were set. We looked at the data a certain way such as percent of children screened but we're also looking at some additional ways of looking at success. For example we're trying to gather a little bit more information about the children once they've received the referrals. Are they getting into programs and/or some of the children are already in program, are they when they're being screened is this a way of identifying additional needs. Because antidotically we know that some children are in Early Head Start or Head Start but they're failing screens in areas where they should be getting intervention and they're not. And then there are other children in other early childhood programs they may need additional services so what is Swope doing in order to help children to get the most interventions. So that's something we're going to be looking at. Trying to find another way of capturing the goals and successes of the program.

So at the end of our handout you have our contact information so if you need additional information feel free to contact us and now is also time for some questions.