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Improving Social-Emotional Screening and Documentation in a Family Medicine Practice

Advocate Children's Hospital HealthySteps Program at Advocate Ravenswood Family Medicine Clinic

Why It Matters

For over 20 years, the Advocate Children's Hospital HealthySteps Program has operated at Advocate Ravenswood Family Medicine Clinic in the heart of Chicago's Ravenswood neighborhood. Our practice meets the health needs of a diverse patient population, including patients from Uptown, a neighboring community area known as a point of entry for immigrants. Patient care is provided by a staff of 14 attending physicians; 2 nurse practitioners; 24 residents; and a complement of other health professionals, including our HealthySteps Specialist. The HealthySteps program fosters relationships between health care providers and families to address the physical, emotional, and intellectual growth and development of children from birth through age 3.

A child's ability to regulate emotions and navigate social interactions is vital to their development and future success. Social-emotional screening, a primary focus of the HealthySteps model, can identify possible delays in areas of social-emotional development such as communication, interaction with people, affect, and autonomy. Research shows that screening, early identification of concerns, and connection to services can help strengthen the parent-child relationship and change the trajectory of social-emotional development and mental and behavioral health.

Our practice began screening for child development when we initiated HealthySteps in 2000. We started administering social-emotional screens at the 18-month well-child visit in 2002 and added a second social-emotional screening at the 6-month visit in 2018. Our providers

administer social-emotional screens to families, and when concerns arise, make a warm handoff to the HealthySteps Specialist who provides psycho-education, facilitates successful referrals, and connects patients to community resources and early intervention services. The HealthySteps Specialist also trains residents about social-emotional development and self-regulation to facilitate conversations with caregivers, and they share information and activities with families to support children's healthy social-emotional development.

Where We Started

We chose social-emotional screening for our second continuous quality improvement (CQI) project for two reasons. First, our information technology (IT) team recently added a social-emotional screening flowsheet to Epic—our electronic health record (EHR) system—to help improve screening, documentation and reporting of screening results, and submission of billing codes for reimbursement. Second, while our EHR did not initially have a way to systematically capture social-emotional screens, we knew that our developmental screening rates were lower than expected. As social-emotional screening rates reliably lag behind those for developmental screening, we felt confident this was an important focus for our CQI project.

In January 2020, we began collecting baseline data on the number of Ages & Stages Questionnaires®: Social-Emotional, Second Edition (ASQ:SE-2) screenings completed and the number of completed screenings documented in the flowsheet. Documentation using the screening flowsheet was a priority for our practice because it allowed us to extract the data for analysis and reimbursement. Our HealthySteps Coordinator conducted chart reviews to determine which children had a completed ASQ:SE-2 at their 6- or 18-month well-child visit and how screening results were documented (e.g., screening flowsheet, patient notes, uploaded PDF of screen). Baseline data collection continued through May 2021, even as the COVID-19 pandemic disrupted clinic activities and delayed the next phase of the project.

An intensive chart review conducted by our HealthySteps Coordinator showed that 79% of all children had a completed ASQ:SE-2, but only 59% of completed screens were captured in the screening flowsheet. This distinction was important to explore because only those screenings captured in the flowsheet could be extracted and reported; screenings captured in the patient notes or uploaded as a PDF to the patient chart would go unreported, lowering our screening rate and reducing our ability to submit for reimbursement. In light of this finding, we directed our focus to **improving documentation of completed ASQ:SE-2 screens** rather than increasing the number of screens administered. We then created a process map of our social-emotional screening process, discovering variations in how medical assistants and providers work together to administer and document the screening.

Our team developed this goal (SMART Aim):

By August 13, 2021, the percentage of ASQ:SE-2 screenings completed and documented in the screening flowsheet will increase from 59% to 69%.

How We Diagnosed the Problem

We conducted several activities to better understand variations in how providers document ASQ:SE-2 screenings. The team asked the HealthySteps Coordinator to disaggregate the data by provider to look for patterns in documentation. The data showed that five providers were responsible for most of the missing documentation in the flowsheet. Interestingly, we found that some of our strongest champions for screening were the providers not documenting them properly. And it was not just medical residents who documented inconsistently, but also experienced attending physicians. This information suggested to the team that documentation issues may be attributed to workflow challenges and that we would need to include all providers when testing our selected change strategy.

Our HealthySteps Specialist then used the 5 Whys technique with two of the identified providers—one attending physician and one resident—to identify the root cause of gaps in flowsheet documentation. For example, why did some providers not use the screening flowsheet? The attending physician shared that he often forgets to complete the flowsheet despite receiving training on it.

How We Tested Solutions

We brainstormed and identified potential change strategies to help providers remember to complete the screening flowsheet. A provider champion suggested we create simple reminders to help providers build the flowsheet into their typical process.

Over eight weeks, we tested the following change strategy:

> ***Change Strategy #1: Create desktop reminder for providers to complete ASQ:SE-2 screening flowsheet (adopted)***—Our HealthySteps Specialist and HealthySteps Coordinator developed the ASQ:SE-2 screening flowsheet reminder and gathered feedback from residents and attending physicians on content. They emphasized the importance of keeping the reminder short and suggested it reflect all required screenings to maximize its benefit. Our HealthySteps Specialist then placed the reminder on the desks in a visible location and monitored the well-child visit appointments each week to identify those that were due for ASQ:SE-2 screening. She followed up weekly with each provider to learn if the reminder helped to improve completion of the flowsheet.

The Reminder:

Dear Provider,

Please remember to use the flowsheets on the screening tab to document screening results:

ASQ-3 – ASQ:SE-2 – M-CHAT – EPDS

Results

The percentage of total ASQ:SE-2 screenings completed and entered into the screening flowsheet decreased slightly from 59% to 56%. Although we did not reach our aim, our project was a success as we gained valuable insight into the screening and documentation process. It is unclear why we did not see improved documentation while testing our change strategy. During the project debrief, our team discussed potential barriers to achieving our aim, including turnover in key staff positions that supported our screening processes. Our team was able to build-up momentum and buy-in among our providers, and we plan to continue monitoring our data while developing and testing new change strategies.

Our team identified several change strategies for future testing:

- Link the provider smart phrase note directly to the flowsheet
- Revise the resident training on screening completion and documentation
- Email providers regular reminders to complete screenings and document in flowsheets
- Create a dashboard to help providers track their screening completion, documentation, and billing rates

What the Experience Was Like

The project had several successes. We involved faculty, residents, and other clinical staff in our CQI efforts. We found strong commitment to screening and recognition that documentation was not where it needed to be. We had buy-in for improvement in this area and providers who were willing to work with us on generating and testing change strategies. This work also led our practice to add a screening for social-emotional development at the 30-month well-child visit. As a team, we are passionate about CQI and eager to continue learning. We work well together and have grown our knowledge and skills to apply CQI in daily practice.

The CQI project was not without its challenges. We conducted the project at a time of competing demands and changes at the practice. The clinic experienced high staff turnover in summer 2021. Our medical assistant, who was responsible for copying screening tools and ensuring that nursing stations had enough copies, left the practice, and it took longer than expected to fill this role. New residents were juggling extensive training and competing priorities, and attending physicians were busy with patient caseloads and the mentoring of new residents. We were also still functioning in a hybrid work model due to the ongoing COVID-19 pandemic; however, we found that virtual meetings and quick email check-ins helped staff communicate regardless of their location. We also had difficulty finding sufficient time and support for CQI, particularly as our HealthySteps Specialist and providers welcomed back patients—many with complex needs—who had fallen behind on their well-child visits because of the pandemic. To strengthen our CQI sustainability and support, we discussed ideas for connecting our HealthySteps CQI goals to our clinic's overarching CQI goals. We are also considering opportunities to partner with residents on future CQI projects.

Our CQI Team

Team members who led us through this CQI project include our Manager of Community Outreach and Population Health (Alix McNulty), HealthySteps Specialist (Catalina Ariza), HealthySteps Coordinator (Sasha Zaikova), Physician Champions (Jose Elizondo and Catherine Plonka), Data Champion (Phil Gutsell), Nurse Coordinator (Jacklyn Kafka), and Practice Manager (Mary Zimmers).

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