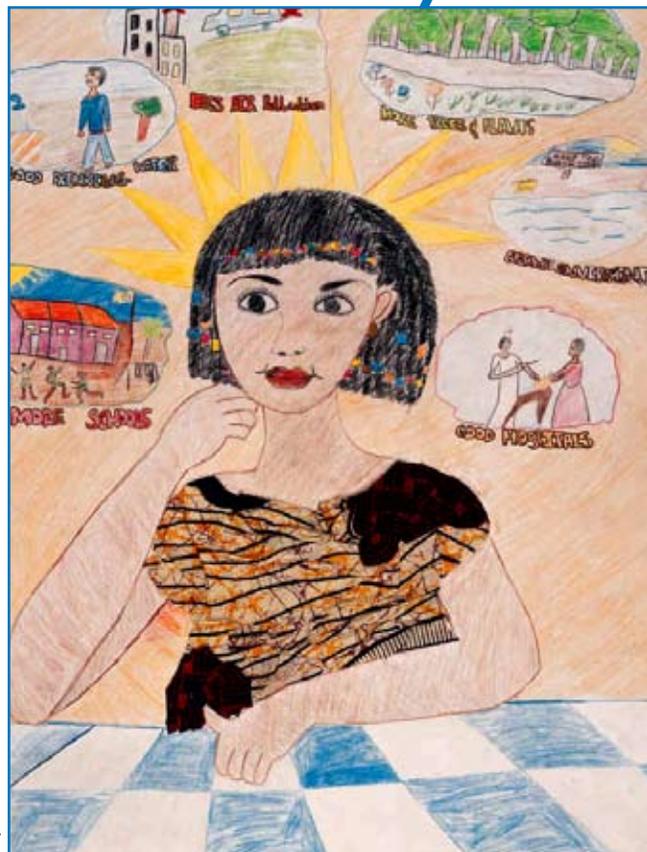


Module 4:

Measurement for Improvement: Monthly Metrics



Painting by

Fatma Semega Janneh, age 11, from The Gambia www.icafo.org

Learning Outcomes for Faculty

The establishment of measurement or data collection systems that provide feedback on agencies' efforts to implement and adopt a new treatment or practice is central to the Learning Collaborative methodology. This module focuses on the key features of measurement as an aspect of the Model for Improvement. Learning objectives for faculty are:

- ▶ Faculty will be able to identify benefits of utilizing monthly improvement metrics to support the implementation and adoption of a new practice.
- ▶ Faculty will be able to make appropriate recommendations on metrics that participating teams may use to track progress toward implementation of the practice.
- ▶ Faculty will be able to offer teams' suggestions about how to use the monthly metrics and also be able to use metrics to gauge teams' progress toward collaborative goals.
- ▶ Faculty will be able to describe their role in supporting teams' efforts to implement monthly metrics and incorporate measurement for improvement into standard practice.

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“I felt like this was something my whole agency took on, versus me just learning something new. We were making changes and evaluating them at all levels.”

Donna Potter

The Center for Child and Family Health-North Carolina

Participant, Breakthrough Series and CPP Learning Collaborative

Priority Tasks for Faculty

- 1. Understand and communicate the value of monthly improvement metrics.** The ability for an agency to measure progress and performance is crucial in the process of learning, implementing, and sustaining a new practice. Measurement plays an important role in evaluating how well collaborative activities are supporting implementation and adoption efforts and in ensuring that the collaborative meets its objectives.



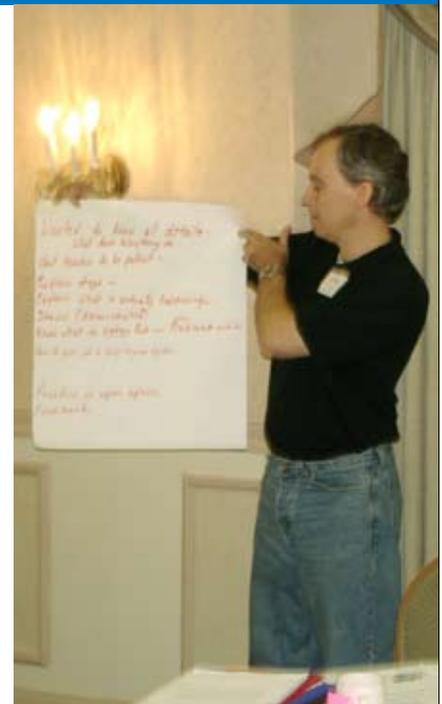
- 2. Emphasize the use of measurement for improvement, NOT for research.** Participating agencies may be accustomed to collecting data for others' use—for example, to meet the reporting requirements of government agencies or for research. In contrast, the purpose of improvement metrics is to provide timely feedback to participating agencies on their progress toward implementation and adoption and to help facilitate and sustain that progress. Faculty, in conjunction with NCCTS improvement consultants, will play a key role in assisting teams to understand, implement, and utilize metrics to improve practice.

3. Utilize metrics that are linked directly to the goals of the Learning Collaborative. Improvement metrics should be closely linked to the Collaborative Goals as stated in the Change Package. Some metrics will focus specifically on the primary objective(s) of the collaborative (e.g., to implement and adopt a new treatment). Others may track changes in agency practice or other improvements necessary for teams to achieve those objectives (e.g., the development of supervisory capacity in the treatment model). Faculty are encouraged to clearly explicate and repeatedly emphasize the link between goals and metrics.

4. Ensure that data collection is quick and easy. It is essential that Faculty “think small” in selecting improvement metrics. This contrasts practice in research, where brevity and ease of administration is often no a primary consideration.

5. Know a good improvement metric when you see it. An improvement metric is a single value intended to summarize a team’s current performance in a particular area and track performance or progress in that area from month to month. Therefore, metrics must be responsive to change and provide meaningful information in a single number.

6. Plan to provide timely feedback that is visually displayed. In order for participating teams to utilize the information from monthly metrics to inform improvement strategies, the information must be up-to-date and easily digestible. Similarly, current and informative summaries of team progress allow faculty to tailor collaborative activities to meet Collaborative Goals. Metrics are typically displayed as time series graphs referred to as “run charts.”



“The benefit of focusing on new skills, while simultaneously hearing how other sites were implementing TARGET, led to a greater understanding of the range of possibilities for using TARGET. The continual exposure to the process of implementing new strategies also contributed to continued attempts to implement across settings.”

Connie Black-Pond

Southwest Michigan Children’s
Trauma Assessment Center
Participant, Target Learning
Collaborative

Priority 1:

Understand and communicate the value of monthly improvement metrics.

Tips:

Key reasons for collecting monthly metrics to recognize and convey to collaborative participants:

- ▶▶ Measures are crucial elements teams use to evaluate their progress toward the Collaborative Goals.
- ▶▶ Measures are necessary to determine if the changes teams are testing (e.g., PDSA cycles) result in improvements.
- ▶▶ Measures can be used to refine changes and focus the team's efforts where they are most needed.
- ▶▶ Continuing to measure progress over time has proved critical for sustaining best practices.



Presentation Idea

Communicate the potential value of monthly metrics by using a “real life” analogy, for example, beginning a weight loss or fitness program. Without a metric such as weight, inches, or heart rate, how would one determine if one was making consistent progress toward a goal? Similarly, without any type of measurement, it would be difficult to ascertain if one's change efforts, be they diet or exercise, were having the intended effects. Finally, sustaining one's gains (or in using this example, losses) is likely to depend on continued measurement, at least in the short term.

Priority 2:

Emphasize the use of measurement for improvement, NOT for research.



Tips:

First and foremost, improvement metrics should provide meaningful and useful feedback to collaborative participants.

- Remember this information is for THEM. As much as the planning team, developers, and faculty would like to know about the use of the practice in community settings, monthly metrics are a means for teams to assess their own progress toward implementation and adoption and factors affecting that progress.
- Faculty should carefully consider which measures can usefully and feasibly be collected monthly and which need only be administered once or twice and are therefore better suited to the overall evaluation of the collaborative. (See Module 5: Evaluation)
- Faculty can provide valuable examples of how monthly metrics can be used to support implementation and adoption or make the case for more consistent usage or widespread implementation of the practice (e.g., in team meetings or supervision, in presentations to boards or potential funding sources). For example, in a prior collaborative, metrics data helped one team secure funds to support broader implementation of the practice. Metrics data also alerted teams to low levels of caregiver participation in treatment, therefore indicating the need for greater support for improvements in this area.



Presentation Idea

Provide an opportunity, preferably at a Learning Session, for participants to become familiar with how to use metrics. For example, distribute sample data for metrics and ask participants to brainstorm about their meaning and possible reasons for the patterns observed, with practical suggestions and discussion of how they might apply this information.

Priority 3:

Utilize metrics that are linked to the goals of the Learning Collaborative.

Tips:

- ▶ All improvement requires change, but not all changes lead to improvement. It is crucial that participants understand the relationship between Collaborative Goals, metrics, and their efforts to change and innovate. Help teams understand this vital connection so that they are not developing small tests of change without carefully considering their goals and spreading those changes without consulting their metrics.
- ▶ There are two broad categories of metrics—outcome and process. Outcome metrics follow directly from the collaborative’s primary goal(s). Where the primary goal is to provide training in a new treatment and support its implementation and adoption, measures of use and fidelity are logical outcome metrics. Examples include number of youths receiving the treatment during the past month and percentage of therapists implementing all components of the treatment (for all cases seen) during this period.
- ▶ Process metrics focus on changes in organizational practices or other systems and procedures that may require improvement to successfully implement and adopt the new treatment. These practices (e.g., use of standardized assessments to measure client progress, the capacity to provide ongoing supervision in the treatment) should be outlined in the Change Package. Examples of process metrics include the percentage of clients receiving the treatment who have completed the NCTSN Core Data Set and the average number of hours of supervision specific to the treatment or practice received during the past month.



Activity

At the Learning Session, during a phone consultation or other forum in which faculty can serve as improvement consultants, give participants the opportunity to get hands-on experience working with goals, metrics, and PDSAs. Ask teams to use the Change Package and Collaborative Goals to (1) identify an area or process in which an improvement would be beneficial, (2) develop a metric to track progress in that area, (3) discuss the area or process and come to a shared understanding of potential barriers and limitations to making changes, and (4) identify one or more small tests of change to improve the process.

Priority 4:

Ensure that data collection is quick and easy.



Tips:

- ▶ Consider developing a small number of metrics (two or five) required of all participating teams. Then, work with teams to identify one or two additional metrics specific to potential implementation challenges faced by their particular agency (e.g., the use of standardized assessments or obtaining appropriate referrals from schools).
- ▶ Use instruments that are brief and straightforward (one to five items). In some cases, a single measure can be used to generate more than one metric, thereby minimizing burden while maximizing information that is gathered.
- ▶ Utilize existing data wherever possible (e.g., information in electronic record systems, case notes, and assessment tools already being used).
- ▶ Leverage technology. In some cases, collection of data for metrics can be automated by incorporating requisite information into electronic record systems. For example, including a field that codes any type of evidence-based treatment clients are receiving allows an agency to automatically track the total number of current cases receiving a particular treatment. Additionally, commercially available programs, such as Microsoft Excel, can be used to streamline the process of computing and graphing metrics.

“The overall structure, mission and design of the BSC/Learning Collaborative provided a format—including the use of specific measures—which “holds your hand to the plow”, so to speak, and was very helpful for keeping our energy and focus on implementing the model.”

Roy Van Tassell

Family and Children’s Services/Oklahoma Child Traumatic Stress Treatment Collaborative
Participant in Breakthrough Series and Faculty for Western TF-CBT Learning Collaborative

Priority 5:

Know a good improvement metric when you see it.



Tips:

In general, a measure does not constitute a metric. Instead a single value or statistic must be calculated from a measure or other data. To be useful indicators of improvement, metrics must be appropriately responsive to change. In creating metrics:

- Be certain that baseline levels are not too high (e.g., you want a fidelity metric that can show improvements over the course of the collaborative).
- Make sure that change could be expected within the time frame specified. For example, it is best not to use metrics requiring data that cannot be collected until the end of treatment, such as percentage of youth completing treatment.
- Use statistics that are not unduly affected by outliers (e.g., median, or middle score, rather than mean or average).
- Consider “extreme percentage” statistics to measure the high or low end of the scale (e.g., the percentage of clinicians receiving less than one-hour of supervision in the treatment during the past month rather than average hours of supervision).
- Use ratios (percentages) to adjust for the impact of natural changes to the system (e.g., the percentage of children seen at an agency that are screened for referral to the treatment rather than the number of children screened).

“There were so many things that impacted the way I think and do business in my position at Chadwick. Learning about PSDA cycles has been invaluable to our office and has helped us to make some great changes to our policies and procedures. Also, thinking about monitoring the changes we make and whether or not they are working has been very helpful.”

Robyn Igelman

Chadwick Center

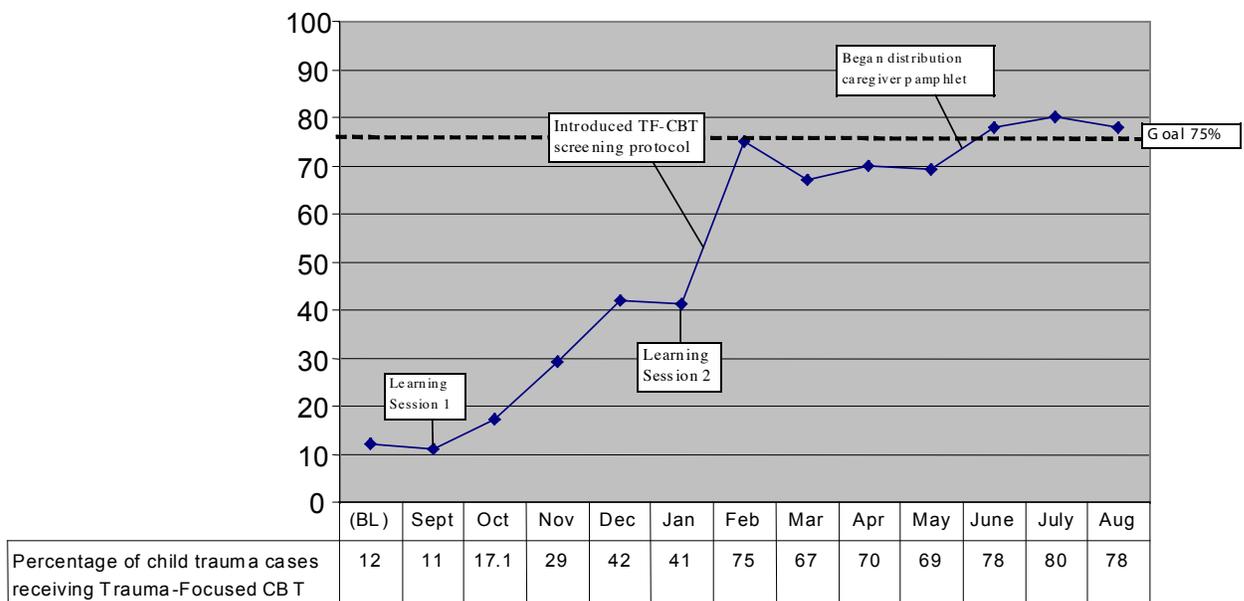
Participant, Breakthrough Series and
Faculty, Western TF-CBT Learning Collaborative

Priority 6:

Plan to provide timely feedback that is visually displayed.

Tips:

- Metrics should be plotted in time order on a regular basis. These plots are called “run charts.”
- Ensure that visual displays of metrics are easy to understand and informative. Annotating run charts with key changes tested by teams and other events (e.g., collaborative activities) can provide useful feedback.
- If faculty assume responsibility for computing and plotting metrics, be sure to provide feedback to teams in a timely fashion (e.g., within five business days).
- Faculty should review run charts/metrics regularly to assess teams’ progress and glean other information to guide collaborative activities. Charts can be integrated into a monthly (or bi-monthly) collaborative progress report.





Frequently Asked Questions

Q: When should teams establish monthly metrics?

A: In collaboratives where participants are receiving training in a treatment that they have not implemented previously, we recommend that teams begin collecting metrics when they first begin implementing the new treatment. To meet that target, faculty should be ready to introduce an initial set of metrics at or before the first Learning Session. It is recommended that teams be given the option to subsequently add one or two individualized metrics once they have identified implementation goals and challenges specific to their agency (e.g., through consultation faculty at the second Learning Session).

Q: Should one person on a team be responsible for tracking and reporting the monthly metrics, or should the responsibility be shared among team members?

A: Procedures for tracking and reporting metrics are likely to vary across teams. For example, in some cases one person will be responsible for all functions related to metrics, whereas in other cases one person may collect the data, another person enter it, while a third person is responsible for providing feedback to the team. At the same time, we suggest that each team identify a primary contact person to whom faculty and other collaborative participants can direct communications regarding metrics.

Q: How is a metric different from a typical measure or assessment instrument?

A: A metric is a single value which may be generated from an existing instrument or from a newly developed short reporting form. In either case, the key is that the resultant metric is meaningful and useful as a stand-alone value (i.e., without having to refer to each individual assessment). It is also critical that the measure chosen to produce this metric be brief and easy to implement in a community agency setting.



Frequently Asked Questions continued...

Q: Do faculty need IRB approval to receive and share metrics among collaborative participants?

A: By definition, improvement metrics are collected for purposes of quality improvement, not research. Moreover, reported metrics should not include private health information or any identifiable information on clients receiving the treatment. As long as these parameters are adhered to, implementing improvement metrics should not require IRB review. However, if faculty plan to ask collaborative participants to collect additional data for research while gathering metrics, such efforts must be approved (or designated exempt) by the faculty's local IRB.

Q: Should teams continue to collect and review metrics after the third Learning Session?

A: Across a variety of healthcare improvement initiatives, continuing to measure progress and performance, along with ongoing support from senior leaders, has proved to be a critical factor for sustaining best practices. Moreover, teams often do not fully meet their implementation goals by the end of the collaborative. Therefore, we recommend that teams continue to collect and actively use improvement metrics even after the collaborative formally ends. However, teams may want to use fewer metrics, or different ones, or collect and review metrics less frequently (e.g., quarterly rather than monthly).

Glossary of Terms for Module 4

Monthly Improvement Metrics: Monthly improvement metrics are measures designed to summarize a team's current progress toward the collaborative's goals and to track progress toward those goals over time. Each metric is a single value which may be generated from an existing instrument or from a newly developed short reporting form.

Outcome Metric: Outcome metrics follow directly from the collaborative's primary goal, which typically is to implement and adopt a new treatment with good fidelity.

Process Metric: Process metrics focus on changes in organizational practices or other systems and procedures that may require improvement to successfully achieve the collaborative's primary goal.

Run Chart: A run chart, also known as a line chart, tracks progress/performance in a particular area by plotting data over time. Typically monthly improvement metrics are displayed as run charts.



“There was so much ongoing support, consultation, and guidance in this Learning Collaborative. I got to learn so much from my peers, from their successes, failures, and challenges. In the past, when I have been to workshops to learn interventions, without the ongoing support and consultation, it was very difficult to stick with it and fully implement new things that I learned in a workshop-only situation.”

Kristine Buffington

Cullen Center of Toledo Children's Hospital
Participant, Target Learning Collaborative

Support Materials Module 4

List of Support Materials

- Faculty Checklist
- Sample Collaborative Goals and Associated Metrics
- Sample Metrics: The Sample Improvement Metrics Summary Form provides an example of a set of metrics for a Learning Collaborative and describes how these metrics would be collected
- Sample Measures Used for Metrics
- Overview of Metrics Presentation

Faculty Checklist

Measurement for Improvement: Monthly Metrics

- Identify priority areas to track using the monthly metrics; these areas should reflect the goals of the collaborative.
- Specify a set of metrics and develop any forms necessary to collect information required to compute the metrics.
- Develop procedures for gathering data collection forms, computing and graphing metrics, and making metrics available to teams in a timely manner.
- Develop a plan for introducing teams to monthly metrics; plan should clearly convey the potential benefits of utilizing improvement measures as well as instructions for collecting the metrics.
- Develop mechanisms for helping teams use the metrics by incorporating metrics into activities at the Learning Sessions and during the action periods.



Sample Collaborative Goals and Associated Metrics

Assessment

- **General Goal:** Children referred for psychotherapy are screened for referral to TF-CBT using a protocol that incorporates standardized assessments.
- **Specific Measurable Goal:** By December 2007, 80% of all children age 7 or older who are referred for psychotherapy will be screened for referral to Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) using the trauma screen from the NCTSN Core Data Set and the UCLA PTSD-RI.
- **Sample Metric:** Percentage of children age 7 or older who had a psychotherapy intake during the past month who were screened for TF-CBT using the NCTSN trauma screen and UCLA PTSD-RI, as documented in the case record. (Case record should indicate use of these assessments and referral decision.)

Fidelity

- **General Goal:** Clinicians who provide TF-CBT will implement the model with adequate fidelity.
- **Specific Measurable Goal:** By December 2007, clinicians providing TF-CBT will consistently administer all TF-CBT PRACTICE Components unless clinically contraindicated or circumstances preclude (e.g., no caregiver involvement in treatment is possible).
- **Sample Metric:** Percentage of clinicians currently providing TF-CBT who “Almost Always” administered all TF-CBT PRACTICE Components, based on supervisor report. (A comparable metric could be developed from documentation in the client record or case management system.)

Training

- **General Goal:** Agency staff who provide psychotherapy to traumatized children receive basic training in TF-CBT
- **Specific Measurable Goal:** By December 2007, 90% of agency staff who provide psychotherapy to traumatized children will have attended an in-person basic training in TF-CBT or have completed the online TF-CBT training (TF-CBTWeb).
- **Sample Metric:** Percentage of staff providing psychotherapy to traumatized children who have completed basic training in TF-CBT (i.e., attended an in-person training or completed TF-CBTWeb) as documented in their personnel file.

Supervision

- **General Goal:** Clinicians who provide TF-CBT receive ongoing supervision in the model.
- **Specific Measurable Goal:** By December 2007, clinicians who are currently providing TF-CBT will receive a minimum of two hours of supervision in TF-CBT per month. Group supervision, individual supervision, or expert consultation can be used to fulfill this requirement.
- **Sample Metric:** Percentage of clinicians with an open TF-CBT case who reported receiving at least two hours of supervision in TF-CBT during the past month.



Sample Improvement Metrics Summary Form from TF-CBT Learning Collaborative

No. Metric Name		Description of Metric	Data Collection Plan
Category 1: Use/Implementation			
1.1	Number of cases receiving TF-CBT	Number of cases identified as receiving at least one session of TF-CBT during the past month. Only clients who are receiving the full TF-CBT treatment model according to the manual are included in this count.	Metric will be computed from QIII of Monthly Tracking Form for Therapists. {Minimum number is 0, Maximum is 25}
Category 2: Fidelity			
2.1	Percentage of TF-CBT clients that are currently receiving or successfully completed TF-CBT	Percentage of clients (i.e. children and their caregivers) who received one or more session of TF-CBT through agency who are still receiving TF-CBT or completed treatment (i.e. percentage who did not drop out before completing treatment).	Metric will be computed based on tally from QIII of Monthly Tracking Form for Therapists. Only clients who began TF-CBT since the start of the collaborative should be included in calculating this percentage. {Min. percentage is 0, Max. is 100}
2.2	Percentage of therapists providing Psychoeducation Component with moderate skill or better	Percentage of therapists who reported implementing the TF-CBT PRACTICE Component– Psychoeducation with moderate skill or better during the past month.	Metric will be computed from QIV.1 of Monthly Tracking Form for Therapists. Only therapists who provided TF-CBT during the past month and used this component are considered in calculating this percentage. Run chart for metric will also indicate the percentage of therapists who provided TF-CBT during the past month, but did not use this component; however, these values will not be graphed. {Min. percentage is 0, Max. is 100}
2.3	Percentage of therapists providing Parenting Skills Component with moderate skill or better	Percentage of therapists who reported implementing the TF-CBT PRACTICE Component–Parenting Skills with moderate skill or better during the past month.	Metric will be computed from QIV.2 of Monthly Tracking Form for Therapists. (See data collection plan for Metric 2.2 for instructions for computing this metric.) {Min. percentage is 0, Max. is 100}
2.4	Percentage of therapists providing Cognitive Coping and Processing Component with moderate skill or better	Percentage of therapists who reported implementing the TF-CBT PRACTICE Component–Cognitive Coping and Processing with moderate skill or better during the past month.	Metric will be computed from QIV.6 of Monthly Tracking Form for Therapists. (See data collection plan for Metric 2.2 for instructions for computing this metric.) {Min. percentage is 0, Max. is 100}
2.5	Percentage of therapists providing Trauma Narrative Component with moderate skill or better	Percentage of therapists who reported implementing the TF-CBT PRACTICE Component–Trauma Narrative with moderate skill or better during the past month.	Metric will be computed from Monthly Tracking Form for Therapists. (See data collection plan for Metric 2.2 for instructions for computing this metric.) {Min. percentage is 0, Max. is 100}
2.6	Percentage of therapists providing Enhanced Safety Skills Component with moderate skill or better	Percentage of therapists who reported implementing the TF-CBT PRACTICE Component–Enhanced Safety Skills with moderate skill or better during the past month.	Metric will be computed from QIV.7 of Monthly Tracking Form for Therapists. (See data collection plan for Metric 2.2 for instructions for computing this metric.) {Min. percentage is 0, Max. is 100}
Category 3: Supervision and Training			
3.1	Percentage of therapists who received 2-hours or more of supervision in TF-CBT	Percentage of therapists with one or more current/open TF-CBT cases who report receiving 2-hours or more of TF-CBT supervision through their agency during the past month.	Metric will be computed from QII of Monthly Tracking Form for Therapists. Any therapists who provided TF-CBT or had an open TF-CBT case during the past month should be considered in calculating this percentage. {Min. percentage is 0, Max. is 100}
Category 4: Family Engagement			
4.1	Percentage of TF-CBT sessions with significant caregiver involvement	Percentage of TF-CBT sessions provided during the past month for which therapists reported that caregiver participated in an individual caregiver meeting or a conjoint meeting of 25 minutes or longer.	Metric will be computed from QIII of Monthly Tracking Form for Therapists. Metric is percentage of total sessions for which a caregiver or conjoint session of 25 minutes or longer was reported. Only clients who received at least one TF-CBT session during the past month should be included in this count. {Min. percentage is 0, Max. is 100}



Sample Monthly Tracking Form for Therapists from TF-CBT Learning Collaborative

Your TF-CBT LC ID: ___ / ___ / ___ Reporting period: ___ / ___ / ___
 Month Year

Please e-mail or fax a copy of this form to [NCCTS RA] on or before the **5th of each month** (e-mail: [NCCTS RA e-mail], fax: 919-667-2350, ph: 919-682-1552, x258).

I. How much consultation in TF-CBT did you receive from the Collaborative faculty (e.g., through participation in conference calls) during the past month? (Check only one)

- 1 Did not receive TF-CBT consultation this past month
- 2 less than 30 minutes
- 3 30-59 minutes
- 4 60-119 minutes
- 5 120-179 minutes
- 6 180 minutes or more

II. How much supervision in TF-CBT did you receive during the past month? Include individual, group, or peer supervision with TF-CBT cases and guidance in TF-CBT components/skills that you received through your agency. Do not include consultation in TF-CBT received from collaborative faculty. (Check only one)

- 0 Did not receive supervision in TF-CBT through agency
- 1 less than 30 minutes
- 2 30-59 minutes
- 3 60-119 minutes
- 4 120-179 minutes
- 5 180-239 minutes
- 6 240 minutes or more

Check here if you had no open TF-CBT cases anytime this month in which case you do not need to complete the remainder of this form.

III. Please complete the table below for clients who, during the past month, (1) received one or more sessions of TF-CBT or (2) terminated TF-CBT (i.e., dropped out of or completed TF-CBT). Remember to delete client identifiers before submitting.

Client Identifier (e.g., initials, med rec #) <i>delete before submitting</i>	Western TF-CBT LC Client Identification Number (enter 3-digit ID)	Number of TF-CBT sessions received this past month ¹ (circle response)	No. of times– met/spoke individually with caregiver or met conjointly with child & caregiver– for 25 min. or more in the past month (circle response)	Treatment Status as of the end of this reporting period/past month (check one)
		0 1 2 3 4 ≥ 5	0 1 2 3 4 ≥ 5	1 <input type="checkbox"/> continuing 2 <input type="checkbox"/> completed 3 <input type="checkbox"/> dropped out
		0 1 2 3 4 ≥ 5	0 1 2 3 4 ≥ 5	1 <input type="checkbox"/> continuing 2 <input type="checkbox"/> completed 3 <input type="checkbox"/> dropped out
		0 1 2 3 4 ≥ 5	0 1 2 3 4 ≥ 5	1 <input type="checkbox"/> continuing 2 <input type="checkbox"/> completed 3 <input type="checkbox"/> dropped out
		0 1 2 3 4 ≥ 5	0 1 2 3 4 ≥ 5	1 <input type="checkbox"/> continuing 2 <input type="checkbox"/> completed 3 <input type="checkbox"/> dropped out
		0 1 2 3 4 ≥ 5	0 1 2 3 4 ≥ 5	1 <input type="checkbox"/> continuing 2 <input type="checkbox"/> completed 3 <input type="checkbox"/> dropped out
		0 1 2 3 4 ≥ 5	0 1 2 3 4 ≥ 5	1 <input type="checkbox"/> continuing 2 <input type="checkbox"/> completed 3 <input type="checkbox"/> dropped out
		0 1 2 3 4 ≥ 5	0 1 2 3 4 ≥ 5	1 <input type="checkbox"/> continuing 2 <input type="checkbox"/> completed 3 <input type="checkbox"/> dropped out
		0 1 2 3 4 ≥ 5	0 1 2 3 4 ≥ 5	1 <input type="checkbox"/> continuing 2 <input type="checkbox"/> completed 3 <input type="checkbox"/> dropped out

¹Count as one TF-CBT session 1) a session where you met individually with the child only, 2) a session where you met individually with the child and also met individually with his/her caregiver, or 3) a session where you met individually with the child (or caregiver) and also met conjointly with the child and caregiver.

IV. Please choose the response that best describes your understanding and skill in implementing each of the specified components of TF-CBT during the past month. Check here if you did not provide TF-CBT this month .

TF-CBT PRACTICE Component	Your understanding and skill in implementing component during the past month:					
	Did not use	Minimal	Minimal to moderate	Moderate	Moderate to advanced	Advanced
1. Psychoeducation (e.g., directive education about normal reactions to trauma)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
2. Parenting Skills (e.g., time out, praise, selective attention, reinforcement plans)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
3. Relaxation (explained physiology of relaxation and/or instructed on relaxation methods)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
4. Affective Expression (assisted child in accurately identifying feelings) and Regulation (e.g., using imagery, positive self-talk)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
5. Cognitive Coping and Processing (e.g., educating child on "cognitive triangle")	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
6. Trauma Narrative (developing and working with child to modify cognitive distortions throughout narrative)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
7. In Vivo Exposure (worked on in-vivo desensitization plan to resolve avoidant behaviors)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
8. Conjoint Parent-Child Treatment (shared trauma narrative or other conjoint activity)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>
9. Enhanced Safety Skills (e.g., developed a safety plan)	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

Overview of Metrics Presentation



Overview of Monthly Improvement Metrics

Lori Ebert, Ph.D.
NCCTS, Duke University



Introduction

WHY is the SPARCS Collaborative using improvement metrics?

- The ability for an agency to measure progress and performance is critical to the process of learning, implementing, and sustaining a new practice.
- Measurement plays an important role in evaluating how well collaborative activities are supporting implementation efforts and in ensuring that the collaborative meets its objectives.

Introduction

At first you might think:

- This sounds like research



- Blah, blah, blah



- Great, more paperwork



But hear us out...

Why Use Metrics?

- So...WHY use metrics?
- Metrics are crucial for teams to be able to evaluate progress toward the goals of the collaborative.



Why Use Metrics?

Metrics evaluate progress toward the Collaborative goals of:

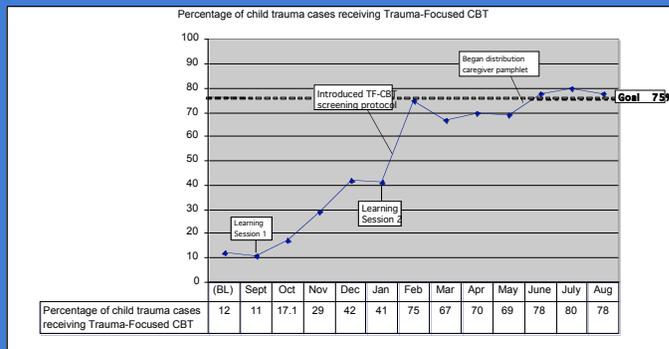
- **Implementation**—Use of SPARCS
- **Fidelity**—Administration of SPARCS with good fidelity
- **Adoption**—Ongoing use of SPARCS after the collaborative



Why Use Metrics?

Metrics can help teams evaluate their progress toward implementation:

- Metrics provide feedback about whether a team is implementing the treatment at the level they had intended.
- To be of benefit, teams need to review metrics and consider factors affecting their progress.



Why Use Metrics?

Metrics can help teams evaluate their progress toward the collaborative goal of fidelity:

- Metrics for one collaborative alerted teams to low levels of caregiver participation in treatment indicating a need for greater support for improvements in this area.
- Metrics for the SPARCS Collaborative will provide feedback about therapists' comfort and skill implementing key components of SPARCS.

Why Use Metrics?

Metrics can help teams evaluate their progress toward the collaborative goal of adoption:

- Continuing to measure progress over time has proved critical for sustaining best practices.
- Measurement is increasingly important for sustainability.
- The availability of ongoing training is essential for adoption; therefore SPARCS metrics will provide feedback about supervisory capacity.

Metrics from another collaborative helped one team secure funding to support broader implementation of the practice





Why Use Metrics?

Looking ahead:

- Metrics help teams evaluate their progress toward collaborative goals.
- Metrics are also necessary to determine if the changes teams are testing result in improvements.

Metrics tell you whether changes are actually helping your team meet its goals



WHAT will the metrics measure?

The metrics will measure progress toward the collaborative goals of:

- **Implementation of SPARCS**
 - _ Number of youth receiving SPARCS during the past month
- **Fidelity to SPARCS**
 - _ Percentage of youth who missed one SPARCS sessions or fewer during the past month
 - _ Percentage of sessions, during the past month, for which therapists report implementing key SPARCS components with moderate skill or better
- **Supervision and training to support adoption of SPARCS**
 - _ Percentage of therapists who received 2-hours or more of supervision in SPARCS during the past month



HOW will we do the metrics?

- NCCTS will help teams get started by computing metrics from information that therapists enter into two forms:
 - _ SPARCS Check-In, Check-Out, & Attendance Log
 - _ SPARCS Monthly Rating Form for Therapists
- Therapists will e-mail or fax a copy the **Rating Form for Therapists** to *Tonya Elliott* at the NCCTS by the 5th of each month. For November metrics, therapists are asked to submit their **Rating Forms** by December 5.
- One therapist from each SPARCS group will also be responsible for submitting a copy of the **SPARCS Check-In, Check-Out, & Attendance Log** to *Tonya* by the 5th of each month.



HOW will we do the metrics?



- To protect therapists' and group members' confidentiality, your team's data manager will assign a SPARCS Learning Collaborative (LC) ID to each member of your team and an Evaluation Number to each adolescent. IDs will be used to label forms for metrics and the SPARCS evaluation.
- The NCCTS will compute and post graphs of your team's metrics on the collaborative intranet by the 15th of each month. Raw data (e.g., individual therapists' ratings) will NOT be posted.



HOW will we do the metrics?



Completing the Monthly Rating Form for Therapists

- Enter your SPARCS Learning Collaborative ID and the Reporting Period.
- If you did not provide SPARCS during the past month, answer Question 1, mark the check box provided, and submit your form to Tonya.
- Complete the SPARCS Components Table:
 - Circle session numbers for SPARCS sessions conducted during the past month.
 - Choose and enter ratings that describe your skill and comfort in implementing SPARCS components applicable to those sessions.
 - E-mail or fax your completed form to Tonya.

WHO are the metrics for?

- Metrics are NOT collected for SAMSHA, the National Center or the SPARCS Faculty.
- Monthly improvement metrics are collected so that YOU can improve your practice.
- The purpose of metrics is (1) to provide timely feedback to teams on their progress toward implementation and adoption of SPARCS and (2) to help facilitate and sustain that progress.

