6C Enhanced Well-Baby Visits

Description

- Enhanced Well-Baby Visits are the annual number of visits to family physicians or paediatricians for services identified as fee-for-service OHIP claims for Enhanced Well-Baby Visits (EWBV)

Specific Indicators and Method of Calculation

- Proportion of children with fee-for-service OHIP claims for Enhanced Well-Baby Visits

$$\frac{\text{Number of patients with fee-for-service OHIP claims for A002 \& A268}}{\text{Population of children aged 12-24 months}} * 100$$

Basic Categories

- Geographic areas of patient residence:
  - Ontario, public health unit, municipality, and smaller areas of geography based on aggregated postal code

Data Sources

Numerator: Medical Services Data
Original source: Ontario Health Insurance Plan (OHIP) Approved Claims files
Distributed by: Ontario Ministry of Health and Long-Term Care (MOHLTC): IntelliHEALTH ONTARIO (IntelliHEALTH)
Suggested citation (see Data Citation Notes): Ontario Medical Services Data [years], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Extracted: [date].

Denominator: Population Estimates
Original source: Registered Persons Database (RPDB)
Distributed by: Ontario Ministry of Health and Long-Term Care (MOHLTC): IntelliHEALTH ONTARIO (IntelliHEALTH)
Suggested citation (see Data Citation Notes): Population Estimates [years], Ontario Ministry of Health and Long-Term Care, IntelliHEALTH ONTARIO, Date Extracted: [date].

Fee Schedule Codes (FSC)

- (A002) 18 MONTH WELL BABY CHECK – GP/FP
- (A268) 18 MONTH WELL BABY CHECK – PAEDS

Analysis Check List

- The IntelliHEALTH licensing agreement does not require suppression of small cells, but caution should be used when reporting at a level that could identify individuals, (e.g., reporting at the postal code level by age and sex). Please note that privacy policies may vary by organization. Prior to releasing data, ensure adherence to the privacy policy of your organization.
- Consider aggregation of data values and/or cell suppression when dealing with small numbers to

avoid risk of confidentiality breach. A new resource is currently under development to provide more detailed information on this issue.

    - If small numbers are an issue multiple years of data may be summed in the numerator to create a more stable rate. In this case, be sure to sum an equal number of years of population data for the denominator.

- **Note:** There is a standard report created in IntelliHEALTH in the folder: Ad hoc Report Requests\PHU\18-month well baby visits, by PHU.
- To extract the numerator from IntelliHEALTH:

    - Use Medical Service data source from the *Medical Services* folder in Intellihealth, select *# Pts (D-HN)* measure (distinct count of the number of patients with a valid health card number).
    - Select appropriate geography from *Patient Information* folder (patient PHU or patient LHIN).
    - Select Fee Schedule Code from Service Information and create a custom filter equal to A002, A268.
    - Select the data item Shadow Billed from the *Service Information* folder (will provide Y/N).

- To extract the denominator from IntelliHEALTH:

    - For population estimates, use the *Population Estimates PHU County Municipality* (Population Estimates County Municip) or *Population Estimates LHIN* (Pop Est LHIN) in the Populations folder in Intellihealth;
    - Select the # people measure and the appropriate geography (PHU or LHIN).
    - To identify children and adolescents, an age grouping needs to be selected from Population Information. Select Age and create a custom filter for 01-02 years (representing children aged 12-24 months).
    - It is recommended to use denominator data for the corresponding numerator data due to the small number of children in this age group (i.e. if reporting a trend over time, use 2010 population estimates for claims in 2010, 2011 for 2011, etc.)
    - Note: Inpatient data are reported by fiscal year (April 1 - March31). Any changes in the source data occur on a fiscal year basis (e.g., ICD10 reporting began on April 1 2002) and will affect reporting by calendar year.

Indicator Comments

- In October 2009, the Ontario Ministry of Health and Long-term Care and the Ministry of Children and Youth Services introduced new fee codes (A002 for family physicians and A268 for paediatricians, valued at $62.20 and $61.00 respectively).[1] The billing requirement to claim this increased fee is documentation of a discussion of the child's development using screening tools completed by the caregiver and the physician. Medical services information was obtained from the Claims History Database based on the aforementioned Ontario Health Insurance Plan (OHIP) billing codes.
- The Claims History Database contains service and payment information for both fee-for-service claims submitted by physicians and other licensed health professionals and some of the "shadow billings" by providers in organizations covered by alternate payment arrangements. Since only some of the claims from the MOHLTC's various alternate payment programs or "shadow billers" are included there may be undercounting of total volume of certain services. This could include physician and nurse-practitioner services in some community health centres (CHCs). In 2014, the

proportion of Ontario children who received primary care at CHCs was approximately 8,188 (provided by a data request to the Association of Ontario Health Centres; Refer to Appendix). However, across public health units, the proportion of children receiving primary care at CHCs ranged from 0 to 27% of the target population. Refer to the appendix to see the distribution of children by public health unit. In public health units where a large proportion of children are seen at CHCs, the rate of visits may be underestimated.

- In rural communities, where a larger proportion of children may receive primary health care from providers other than physicians (i.e. nurse practitioners or registered nurses who do not use fee-for-service billing), there may be undercounting of the total volume of visits.
- Data counts include the number of distinct patients with a valid health care number in the given time period. Children without a fixed address and recent newcomers to Ontario may be missed. These children are of particular interest because they represent vulnerable populations who may be in need of additional services.
- Residence is determined by the patient's residence, not where the service was provided.
- OHIP billings are considered complete six months following the service date. There may be additional time required for the information to be available in intelliHEALTH.
- When conducting analysis by smaller geographic area, such as postal code, there is a known discrepancy where the number of OHIP claims per postal code may exceed the number of children registered in the Registered Persons Database. This issue is likely caused by the limited options for restricting search criteria using aggregated data sources (like IntelliHEALTH). To reduce the impact of this, data counts should be summed across years to produce a rate for multiple years combined.
- In March 2016, the Canadian Taskforce on Preventive Health Care recommended "against screening for developmental delay using standardized tools in children aged 1 to 4 years with no apparent signs of developmental delay and whose parents and clinicians have no concerns".[2] They found that the Nipissing District Developmental Screen, a tool used in the EWBV, is not effective or reliable for diagnosing developmental delay. However, the Taskforce did also state that all clinicians should continue with developmental surveillance for every child and use case finding to identify children with developmental delay. It is currently unclear if the Ministry of Health and Long-Term Care will be making adjustments to the EWBV billing code criteria based on these recommendations.

Ontario Public Health Standards (OPHS)

- The Ontario Public Health Standards (OPHS) establish requirements for the fundamental public health programs and services carried out by boards of health, which include assessment and surveillance, health promotion and policy development, disease and injury prevention, and health protection. The OPHS consist of one Foundational Standard and 13 Program Standards that articulate broad societal goals that result from the activities undertaken by boards of health and many others, including community partners, non-governmental organizations, and governmental bodies. These results have been expressed in terms of two levels of outcomes: societal outcomes and board of health outcomes. Societal outcomes entail changes in health status, organizations, systems, norms, policies, environments, and practices and result from the work of many sectors of society, including boards of health, for the improvement of the overall health of the population. Board of health outcomes are the result of endeavours by boards of health and often focus on changes in awareness, knowledge, attitudes, skills, practices, environments, and policies. Boards of health are accountable for these outcomes. The standards also outline the requirements that boards of health must implement to achieve the stated results.

Outcomes Related to this Indicator

- Societal Outcome (Child Health): An increased proportion of children reach growth and

development outcomes.
- Societal Outcome (Child Health): An increased proportion of children beginning school are ready to achieve success.

Assessment and/or Surveillance Requirements Related to this Indicator

- The board of health shall conduct epidemiological analysis of surveillance data, including monitoring of trends over time, emerging trends, and priority populations, in accordance with the Population Health Assessment and Surveillance Protocol, 2008 (or as current) in the areas of: growth and development (Child Health).

Protocol Requirements Related to this Indicator

- The board of health shall collect or access the following types of population health data and information: Growth and Development (Population Health Assessment and Surveillance Protocol, 1b).

  http://www.ontario.ca/publichealthstandards

Corresponding Health Indicator(s) from Statistics Canada and CIHI

None

Definitions

- Enhanced Well-Baby Visit: service rendered when a physician performs all of the following for a child aged 17-24 months: (1) those services defined as "well baby care"; (2) An 18-month age appropriate developmental screen; and (3) review with the patient's guardian of a brief standardized tool that aids in the identification of children at risk of development disorder
- Rate of Enhanced Well-Baby Visits: number of children receiving the visit over the total population of children between ages 1-2 registered for OHIP.

Cited Reference(s)

1. Guttmann A, Klein-Geltink J, Kopp A, Cairney J. Uptake of the New Fee Code for Ontario's Enhanced 18-Month Well Baby Visit: A Preliminary Evaluation. Toronto: Institute for Clinical Evaluative Sciences; 2011. Available at: http://www.ices.on.ca/Publications/Atlases-and-Reports/2011/Uptake-of-the-new-fee-code (Accessed April 15, 2016).
2. CTFPHC. Screening and Treatment for Developmental Delay in Early Childhood. Ottawa: Canadian Task Force on Preventive Health Care; 2016. Available at: http://canadiantaskforce.ca/ctfphc-guidelines/2015-developmental-delay/ (Accessed April 15, 2016).

Other Reference(s)

3. Expert Panel on the 18 Month Well-Baby Visit. Getting it right at 18 months…Making it right for a lifetime, 2005. Available at: http://www.children.gov.on.ca/htdocs/English/topics/earlychildhood/gettingitright.aspx (Accessed April 15, 2016).

- Williams R, Clinton J. Canadian Paediatric Society, Early Years Task Force. Getting it right at 18 months: In support of an enhanced well-baby visit. *Paediatric & Child Health* 2011;16(10):647-50 Available at: http://www.cps.ca/documents/position/enhanced-well-baby-visit (Accessed April 15, 2016).

Acknowledgements

Lead Author(s)	Katrice Carson, City of Hamilton Public Health Services
Contributing Author(s)	Sarah Collier, Toronto Public Health Kandace Ryckman, Toronto Public Health
CIWG Reviewers	Fangli Xie, Durham Region Health Department Amy Romagnoli, Niagara Region
External Reviewers	Katherine Russell, Ottawa Public Health Astrid Guttmann, ICES

Changes made

Date	Type of Review- Formal Review or Ad Hoc?	Changes made by	Changes
November 2015		Katrice Carson	First draft of page
January 2016		Kandace Ryckman (Student at Toronto Public Health)	• Selecting RPDB data as the denominator to be consistent with the numerator. • Additions to Indicator Comments based on research on OHIP billing, CHCs and nurse practitioners.
April 2016		Kandace Ryckman (Student at Toronto Public Health)	• Addition to Indicator Comments to reflect the recent recommendations of the Canadian Taskforce on Preventive Health Care. • Edits, as suggested by Amy & Katherine
February 2017		Kandace Ryckman	• Clarified analysis checklist for capturing shadow billings

APPENDIX: INTERNAL USE ONLY

Children Seen by Community Health Centres in Ontario, 2014

	Children aged 1-2	
Public Health Unit	**Number[1]**	**%[2]**
ALGOMA	12	1%
BRANT	67	4%
CHATHAM-KENT	118	11%
DURHAM	103	1%
EASTERN	403	19%
ELGIN	128	12%
GREY-BRUCE	149	10%
HALDIMAND-NORFOLK	0	0%
HALIBURTON KAWARTHA PR	87	7%
HALTON	0	0%
HAMILTON	194	3%
HASTINGS PRINCE EDWARD	273	16%
HURON	0	0%
KFL&A	153	8%
LAMBTON	253	20%
LEEDS,GRENVILLE,LANARK	392	25%
MIDDLESEX-LONDON	58	1%
NIAGARA	183	4%
NORTHBAY PARRYSOUND	88	8%
NORTHWESTERN	36	3%
OTTAWA	1163	11%
OXFORD	23	2%
PEEL*	NA	NA
PERTH	0	0%
PETERBOROUGH	0	0%
PORCUPINE	67	6%
RENFREW	10	1%
SIMCOE MUSKOKA*	42	1%
SUDBURY	148	7%
THUNDER BAY	442	27%
TIMISKAMING	85	27%
TORONTO	2704	9%
WATERLOO	470	7%
WELLINGTON-DUFFERIN	160	5%
WINDSOR-ESSEX	97	2%
YORK	80	1%

* PHU contains one community health centre that is not currently included in the Association of Ontario Health Centres (AOHC) database.

[1] Number of children seen by CHCs in 2014 (provided from a data request to the AOHC).

[2] Percentage was determined using denominator data from the Registered Persons Database, IntelliHEALTH ONTARIO, 2013.