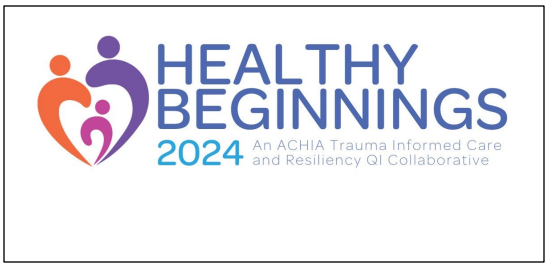


Data Packet

This packet contains tools to assist in collecting quality improvement data.
Please have this packet available for review during the Dec 14th data meeting.
Packet content is also available on the ACHIA website.

- Measure Definitions
- Baseline Data Instructions
    - TICR Baseline Data Excel Printout
    - Worksheet: Strengths-Based Approaches and Screening
- Infographic: Data Due Calendar
- Monthly Data Instructions
    - TICR Monthly Data Excel Printout

Bonus:
Worksheet: Implementing a Screening Process

HEALTHY BEGINNINGS 2024 An ACHIA Trauma Informed Care and Resiliency QI Collaborative

Measure Definitions

Name	Definition	Measure Source/ Type	Calculation	Exclusion	Data Source	Goal	Collection Frequency	Associated Questions
Data Set #1								
Measure 1 **Strengths Based Approaches Utilized**	% of patients with documentation of strengths based approach a targeted WCC	AAP Best Practices Process	**Target Population:** All patient WCC visits for the targeted ages **Numerator:** # WCC visits with one or more strengths based approaches documented **Denominator:** # of target patients	None	Patient Chart RedCAP data collection tool	80%	**Baseline:** Abstract all targeted ages June- November 20 random visits Generate visit list by end of December Data entry due in January --- **Intervention:** Abstract practice selected targeted ages Monthly 10 random charts (or all available) February – July 2024	**Targeted ages:** PPD: 1, 2, 4, 6 month visit SDoH: 6, 15, 24, 48 month visit SE: 6, 15, 24, 48 month visit Examples: • Bright Futures Previsit Questionnaire • Promoting First Relationships • Reach Out and Read • HOPE • NM 3 Questions
Measure 2a **Screen for Barriers to Early Relational Health Completed**	% of patient visits with documentation that screen was appropriately completed at the targeted age	AAP Best Practices Process	**Target Population:** All patient WCC visits for the targeted ages **Numerator:** # with an appropriately completed screen **Denominator:** # of target patients	Postpartum Depression (PPD): mother is not present for WCC SDoH (Social Determinants of Health): None	Patient Chart RedCAP data collection tool	80%	**Baseline:** Abstracted all targeted ages June- November 20 random charts Due in January **Intervention:** Abstract practice selected targeted ages	Targeted Ages and Example Tools PPD: 1, 2, 4, 6 month visit • PHQ9 • Edinburgh • PHQ2 SDoH: 6, 15, 24, 48 month visit • SWYC • AAFP • SEEK

Name	Definition	Measure Source/ Type	Calculation	Exclusion	Data Source	Goal	Collection Frequency	Associated Questions
				Social-Emotional Health (SE): None			Monthly 10 random charts (or all available) February – July 2024	• Healthy Steps Family Needs Questionnaire • Hunger Vital signs SE: 6, 15, 24, 48 month visit • SWYC • Pediatric Symptom Checklist ≥ 4YO • Baby Pediatric Symptom Checklist < 4YO • Strengths and Difficulties ≥ 2YO • ASQSE For a comprehensive list of screening tools, see the ACHIA website --- **Appropriately completed:** □ screen completed by caregiver □ scored accurately for selected screen □ score documented □ screen interpretation documented --- **Of completed screens, was the screen positive?** Positive screen criteria will be reviewed after screens selected
Measure 2b **Interventions Documented for Positive Screens for Barriers to Early Relational Health**	% patients with positive screens with intervention documented for the targeted ages	AAP Best Practices Process	**Target Population:** All patient WCC visits for the targeted ages with a positive screen **Numerator:** # patients who have intervention plan(s) documented **Denominator:** # of patients with positive screen	None	Patient chart Data Collection Tool for REDCap	80%	**Baseline:** Abstract all targeted ages June- November 20 random charts Due in January **Intervention:** Abstract practice selected targeted ages Monthly 10 random charts (or all available) February – July 2024	Were interventions for a positive screen based on the practice defined standard of care documented appropriately in the EHR? Were the recommended interventions placed on the practice's referral tracking tool for follow up?

Name	Definition	Measure Source/ Type	Calculation	Exclusion	Data Source	Goal	Collection Frequency	Associated Questions
Dataset #2								
Measure 3 **Recommended Interventions Assessed or Completed within 30 days**	% of patients with positive screens and the recommended intervention(s) assessed or completed within 30 days	AAP Best Practices Outcome	**Target Population:** All patient WCC visits for the targeted ages with an intervention plan for positive screen **Numerator:** # interventions completed within 30 days or assessed within 30 days as having a future appointment **Denominator:** cumulative # of interventions recommended	None	Practice Tracking Tool	No goal: This is an Innovative Measure for practices to learn which interventions are most actionable	**Baseline data:** None **Intervention** Monthly All patients with a positive screen and recommended interventions. March – July 2024	Was recommended intervention completed within 30 days or assessed as having known appointment /intervention scheduled for beyond 30 days? Yes Comment if any Note: Continue to track future appointments /interventions through scheduled date. No (choose one): o Intervention not scheduled o Intervention scheduled but appointment missed o Provider unable to reach family for more information o Other, please specify: _____

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

Content

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.

Baseline: Strengths-Based Approaches

1. Patient Name or MRN #	Date of Screen/ Visit	Which standard strengths-based approach(es) is/are being assessed?	Please specify if other approach(es) or multiple approaches was selected.	1. Was a strengths-based approach documented?

The information in the white boxes below is automatically calculated for you. Enter the whitebox data into REDCap.	
1. Total # of WCC in selected age group seen during the baseline period	
1. Total # of WCC with strengths-based approach documented	

Baseline: Postpartum Depression Screening

2a. Patient Name or MRN #	Date of Screen/ Visit	Which validated screening tool is being assessed?	Please specify if other tool(s) or multiple tools was selected.	2a. Was the screen appropriately completed?	2b. Was the screen positive?	2b. For positive screens: were appropriate interventions documented?

HEALTHY BEGINNINGS 2024 An ACHIA Trauma Informed Care and Resiliency QI Collaborative

The information in the white boxes below is automatically calculated for you. Enter the whitebox data into REDCap.	
2a. Total # of WCC in selected age group seen during the baseline period	
2a. Total # of WCC with PPD screening appropriately completed	
2b. Total # of WCC with positive PPD screening documented	
2b. Total # of WCC with positive PPD screening and intervention documented	

Baseline: Social Determinants of Health Screening

2a. Patient Name or MRN #	Date of Screen/ Visit	Which screening tool is being assessed?	Please specify if other tool(s) or multiple tools was selected.	2a. Was the screen appropriately completed?	2b. Was the screen positive?	2b. For positive screens: were appropriate interventions documented?

The information in the white boxes below is automatically calculated for you. Enter the whitebox data into REDCap.	
2a. Total # of WCC in selected age group seen during the baseline period	
2a. Total # of WCC with SDOH screening appropriately completed	
2b. Total # of WCC with positive SDOH screening documented	
2b. Total # of WCC with positive SDOH screening and intervention documented	

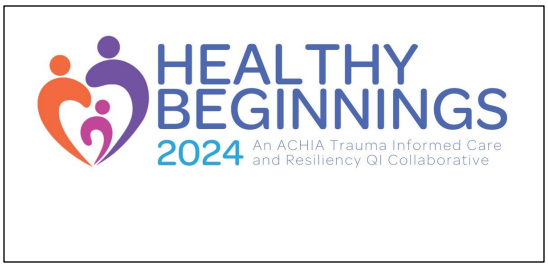
Baseline: Social Emotional Health Screening

2a. Patient Name or MRN #	Date of Screen/ Visit	Which validated screening tool is being assessed?	Please specify if other tool(s) or multiple tools was selected.	2a. Was the screen appropriately completed?	2b. Was the screen positive?	2b. For positive screens: were appropriate interventions documented?

HEALTHY BEGINNINGS 2024 An ACHIA Trauma Informed Care and Resiliency QI Collaborative

The information in the white boxes below is automatically calculated for you. Enter the whitebox data into REDCap.	
2a. Total # of WCC in selected age group seen during the baseline period	
2a. Total # of WCC with SE screening appropriately completed	
2b. Total # of WCC with positive SE screening documented	
2b. Total # of WCC with positive SE screening and intervention documented	

Complete this worksheet prior to abstracting baseline data. Information is for internal use to guide discussions regarding current processes.



Worksheet: Screening Process

- ❑ Postpartum Depression Screening
- ❑ Social Determinants of Health
- ❑ Social Emotional Health

Date:

Tool(s) and rationale for selecting:

Screen:

- ❑ Caregiver completes screen (how, where, when):

- ❑ Accurately scored screens means:

- ❑ Score documented means (where is score recorded in recorded):

- ❑ Score interpretation documented?:

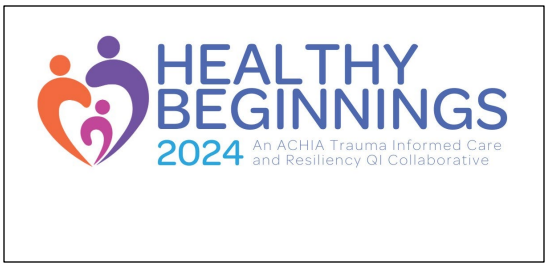
Clinic approach/resources for positive screen includes:

Pressure Points:

Ideas for change:

- ❑ Revised date:
- ❑ Revised date:
- ❑ Revised date:

Worksheet: Strengths-Based Process



Date:

Strengths-based Tool/Approach and rationale:

Clinic approach for Strengths-based Tool/Approach:

Pressure Points:

Ideas for Change:

- ❑ Revised date:
- ❑ Revised date:
- ❑ Revised date:

Data Collection and Entry Guidance

	Data Entry Month	Jan	Feb	Mar	Apr	May	Jun	July
	Cycle Timeframe	6/2023-11/2023	1/22-2/21	2/22-3/21	3/22-4/21	4/22-5/21	5/22-6/21	6/22-7/21
	Data Entry Due	1/31	2/29	3/31	4/30	5/31	6/30	7/31
	# Charts Needed	20	10 *or all available*	10 *or all available*	10 *or all available*	10 *or all available*	10 *or all available*	
		Baseline	Intervention					
Run Chart Data	Measures 1 & 2 Cycle #		#1	#2	#3	#4	#5	#6
	*s*trengths-Based Approach Utilized *S*creening for Early Relational Health	*Only abstract data for existing process(es)*	✓	✓	✓	✓	✓	✓
	Measure 3 Cycle #			#1	#2	#3	#4	#5
	Interventions completed or assessed within 30 days *For positive screens from previous cycle*			✓	✓	✓	✓	✓
	Annotate run charts **optional*			✓	✓	✓	✓	✓
PDSA			✓	✓	✓	✓	✓	✓

Monthly Data Instructions

Measure Definitions

Practices abstract data for the following measures on a monthly basis:

1. Strengths-Based Approach Utilized
2a. Screen for Potential Barrier to Early Relational Health Completed
2b. Intervention(s) Documented for Positive Screens
3. Recommended Interventions Assessed or Completed within 30 days

Step 1: Identify a Strengths- Based Approach

Practices will identify one strengths-based approach to add or improve over the course of the collaborative. It can be a current process that would benefit from improvement or a new approach may be selected. Explore the ACHIA website for strengths-based options. We will discuss this further in February.

Step 2: Identify a Screen for Potential Barriers to Early Relational Health

Practices will identify one screen to add or improve over the course of the collaborative. The screen can be one currently utilized in the practice that would benefit from an improved process or a new screen may be selected. Explore the ACHIA website for information on selecting a screen. Also included in this packet is the Worksheet: Implementing a Screening Process. We will discuss this further in January.

Step 3: Calendar Data Due Dates

Entering data on time is essential for the TICR Faculty to be able to review in a timely fashion, create and distribute your run charts. Note that each monthly cycle ends on the 21st of each month. REDCap (the platform for data entry) opens on the 22nd of each month. Data must be entered by the last day of the month. We recommend having 2 or more people able to abstract and enter data to cover for vacation, illness, jury duty, etc. Late data entry jeopardizes the ability to meet MOC Part 4 criteria.

Data Parameters to Generate Monthly Visit Lists for Data Abstraction

Six Cycles: February, March, April, May, June, July
Cycles Begin: 22nd of the month starting in January
Cycles End: 21st of the month starting in February
Include all target age WCC visits based on screen selected for improvement:

- Postpartum Depression: 1-, 2-, 4-, 6- month WCC
- Social Determinates of Health: 6-, 15-, 24-, 48- month WCC
- Social-Emotional Screening: 6-, 15-, 24-, 48-month WCC

Include all visits to providers included in Baseline data
Sort visits in chronological order
Select 10 chronological visits to abstract
If fewer than 10 visits available, include all available
Exclusions: for practices improving postpartum depression screen, exclude visits where the mother is not present.

Before Abstracting Data

Determine as a core team what appropriate care and documentation looks like in your clinic *before* you begin chart abstractions. Write this down. The process will look different in each practice. TICR tools to aid in this discussion include the *Worksheet: Strengths-Based Approaches and Screening* that some completed prior to abstracting baseline data as well as the *Worksheet: Implementing a New Screen* document that is useful when introducing a new screen. Review the ACHIA website for more examples on utilizing and documenting strengths-based approaches and screens.

Also discuss what interventions you will recommend for positive screens. As part of this collaboration, you will follow up with families to ascertain which interventions are most effective and actionable.

Throughout the collaborative, we will engage in peer-to-peer learning. As a result, your strengths-based approaches and screening should evolve as you incorporate tips and ideas from TICR colleagues. Update your notes as your process evolves.

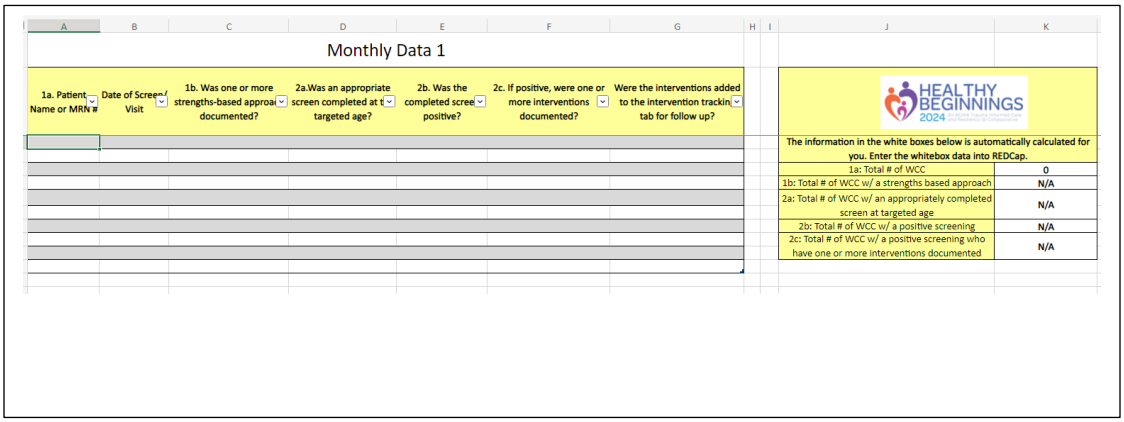
Data to Be Abstracted

Monthly data excel sheets assist in organizing practice data. These tools are optional. They are not submitted to ACHIA. Only the final tally is entered into secure REDCap database . If the practice has an alternative method to abstract data, they are welcome to utilize their preferred approach.

Monthly Data Excel Workbook: Download Excel file from ACHIA website

- Collect MRN/or Patient name to prevent duplication
- Date of Visit
- Was strengths Based approach documented?
- Was the screen appropriately completed?
  - □ screen completed by caregiver
  - □ scored accurately for selected screen
  - □ score documented
  - □ screen interpretation documented
- Was the screen positive?
- If positive, was one or more interventions recommended?
- If interventions recommended, were they added to Intervention Tracker

Data tallies are automatically calculated in excel. You then enter the tallies into REDCap.



Monthly Data 1

1a. Patient Name or MRN #	Date of Scree-/ Visit	1b. Was one or more strengths-based approai documented?	2a.Was an appropriate screen completed at t targeted age?	2b. Was the completed scree positive?	2c. If positive, were one or more interventions documented?	Were the interventions added to the intervention trackin tab for follow up?

HEALTHY BEGINNINGS 2024

The information in the white boxes below is automatically calculated for you. Enter the whitebox data into REDCap.

1a: Total # of WCC	0
1b: Total # of WCC w/ a strengths based approach	N/A
2a: Total # of WCC w/ an appropriately completed screen at targeted age	N/A
2b: Total # of WCC w/ a positive screening	N/A
2c: Total # of WCC w/ a positive screening who have one or more interventions documented	N/A

Each cycle is a complete and independent data set. A new visit list for abstraction is generated each month.

Intervention Tracker

Practices track whether recommended interventions for positive screens were completed. This aids in determining which are the most effective and actionable recommendations from the family's viewpoint. This is also an optional tool that is not submitted to ACHIA. Practices are welcome to utilize alternative approaches to collecting these data.

Data Parameters for Intervention Data

Five cycles: March, April, May, June, July
Data are cumulative
Use the visits selected for abstracting strengths-based approaches and the screen to abstract intervention data.

Data to be Abstracted

The intervention tracker is the last tab on the Monthly Dataset worksheet.

Information collected helps practices understand which interventions are most actionable/helpful for families.

Practices will follow up with families within 30 days of the initial visit to assess if the intervention was completed or if the intervention (such as referral to mental health provider) is scheduled for a future date. If scheduled for a future date, practices should continue to follow that intervention until it either is or is not completed.

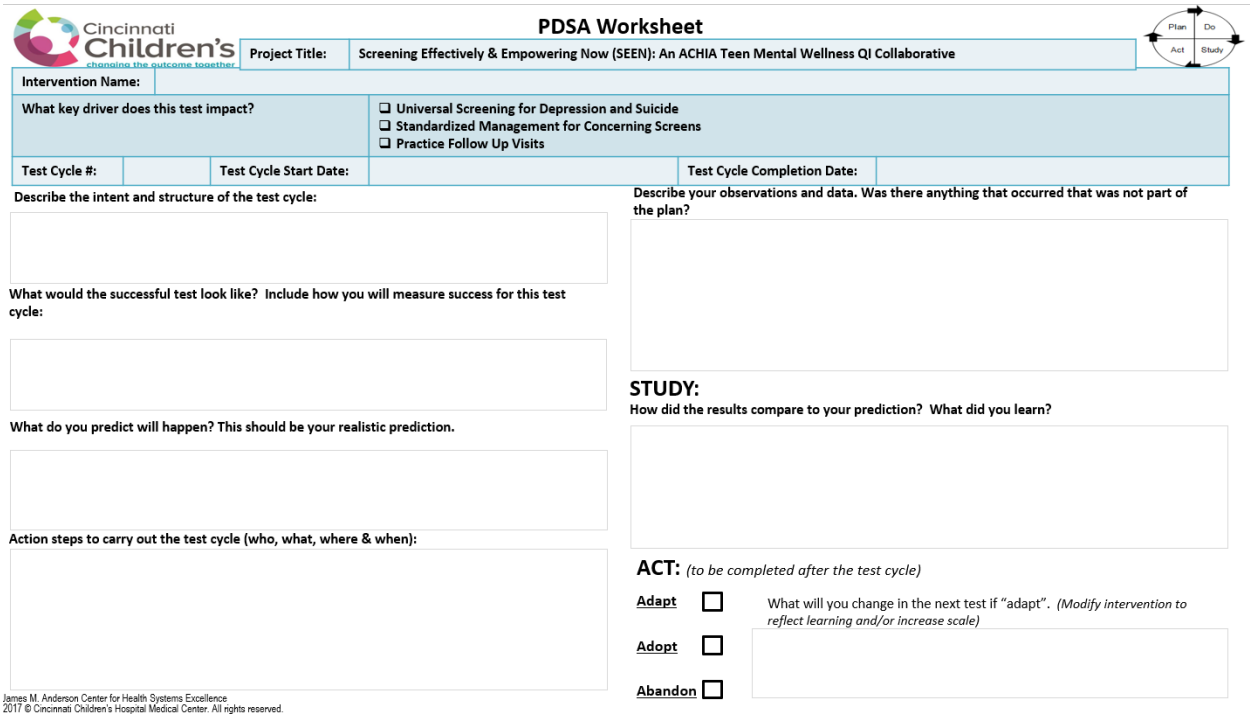
For learning, practices should note 'what happened' and include insights. If a family cannot be reached, that should be assessed as an intervention neither scheduled for a future date nor completed.

												MEASUREMENT 3 TRACKING		
3a. Patient Name or MRN#	3a. Screening date	Concern (PPD, SDH, St)	Intervention Plan	3b. Anticipated date Intervention Complete	3b. Assessment Date	Parent contacted (name/date)	Left message for patient	Sent letter to patient	Other	What Happened	Insights (changes ideas)	3b. Intervention scheduled for known future date	3b. Intervention Completed	3b. Intervention neither scheduled for a future date nor completed

Unlike monthly data, the interventions are cumulative. New interventions are added each month.

Monthly Plan-Do-Study-Act Cycles

Starting in February, practices will submit one or two complete Plan-Do-Study-Acts for each cycle Feb-July. PDSAs are QI tools to rapidly assess small tests of change. PDSAs will be discussed frequently throughout the collaborative and before the first one is due.



PDSA Worksheet

Cincinnati Children's — changing the outcome together

Plan Do Act Study

Project Title:	**Screening Effectively & Empowering Now (SEEN): An ACHIA Teen Mental Wellness QI Collaborative**
Intervention Name:	
What key driver does this test impact?	❑ Universal Screening for Depression and Suicide ❑ Standardized Management for Concerning Screens ❑ Practice Follow Up Visits

Test Cycle #:		**Test Cycle Start Date:**		**Test Cycle Completion Date:**	

Describe the intent and structure of the test cycle:

What would the successful test look like? Include how you will measure success for this test cycle:

What do you predict will happen? This should be your realistic prediction.

Action steps to carry out the test cycle (who, what, where & when):

Describe your observations and data. Was there anything that occurred that was not part of the plan?

STUDY:

How did the results compare to your prediction? What did you learn?

ACT: *(to be completed after the test cycle)*

Adapt ☐ What will you change in the next test if "adapt". *(Modify intervention to reflect learning and/or increase scale)*

Adopt ☐

Abandon ☐

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Monthly Data 1

1a. Patient Name or MRN #	Date of Screen/ Visit	1b. Was one or more strengths-based approach documented?	2a.Was an appropriate screen completed at the targeted age?	2b. Was the completed screen positive?	2c. If positive, were one or more interventions documented?	Were the interventions added to the intervention tracking tab for follow up?

The information in the white boxes below is automatically calculated for you. Enter the whitebox data into REDCap.

1a: Total # of WCC	
1b: Total # of WCC w/ a strengths based approach	
2a: Total # of WCC w/ an appropriately completed screen at targeted age	
2b: Total # of WCC w/ a positive screening	
2c: Total # of WCC w/ a positive screening who have one or more interventions documented	

Intervention Tracker

3a. Patient Name or MRN#	3a. Screening date	Concern (PPD, SDH, SE)	Intervention Plan	3b. Anticipated date Intervention Complete	3b. Assessment Date	Parent contacted (name/date)	Left message for patient	Sent letter to patient	Other	What Happened	Insights (change ideas)	MEASUREMENT 3 TRACKING		
												3b. Intervention scheduled for known future date	3b. Intervention Completed	3b. Intervention neither scheduled for a future date nor completed

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The information in the white boxes below will be automatically calculated for you and must be entered into REDCap

Cycle 1 measures	3a. Cumulative total # of interventions recommended during collaborative	
	3b. Cumulative total # of interventions completed or scheduled for future date during collaborative	
Cycle 2 measures	3a. Cumulative total # of interventions recommended during collaborative	
	3b. Cumulative total # of interventions completed or scheduled for future date during collaborative	
Cycle 3 measures	3a. Cumulative total # of interventions recommended during collaborative	
	3b. Cumulative total # of interventions completed or scheduled for future date during collaborative	
Cycle 4 measures	3a. Cumulative total # of interventions recommended during collaborative	
	3b. Cumulative total # of interventions completed or scheduled for future date during collaborative	
Cycle 5 measures	3a. Cumulative total # of interventions recommended during collaborative	
	3b. Cumulative total # of interventions completed or scheduled for future date during collaborative	
Cycle 6 measures	3a. Cumulative total # of interventions recommended during collaborative	
	3b. Cumulative total # of interventions completed or scheduled for future date during collaborative	

GETTING STARTED:
IMPLEMENTING A SCREENING PROCESS

This worksheet is for practices selecting a new screen to integrate rather than improve processes for an existing screen.

The following worksheet has been created as a guide to help you in developing a *screening process* workflow for your practice. For the purposes of this worksheet, a screening process is defined as the method of early identification and intervention for potential risks to a child's development through ongoing surveillance, routine screening per AAP guidelines, family-centered discussion of results, interpretation, and—when concerns are identified—referral and follow-up.

STEP 1: Which screen are you most interested in utilizing?

Social-emotional screening: _____

Postpartum depression screening: _____

Social drivers of health tool(s)/questions: _____

Resources:

AAP STAR Screening Tool Finder
The Screening Tool Finder can help you identify tools to screen or assess for child development, perinatal depression, social drivers of health, and more.
https://www.aap.org/en/patient-care/screening-technical-assistance-and-resource-center/screening-tool-finder/

Bright Futures: Links to Commonly Used Screening Instruments and Tools
https://publications.aap.org/toolkits/resources/15625/Bright-Futures-Toolkit-Links-to-Commonly-Used

STEP 2: Select the screening tool(s) and educational materials that will be used. *What fits best with our practice structure and patient population?*

Social-emotional screening: _____

Postpartum depression screening: _____

Social drivers of health screening tool/questions: _____

Educational materials:

_____

_____

_____

_____

Questions to consider when selecting a screen

Table 3 Screening checklist questions

Screening checklist questions
What is the focus of the screen? (broad compared with problem-focused)
How does it measure what it says it measures? (types of questions, strength-based or deficit-based)
Who will administer the screening measure and what does it take to administer the screen? (Does the parent complete the measure in the waiting room; what is required of office staff time?)
Who provides the information for the screen? (parent report, child report, direct observation)
Who scores the screen and how complex is the screening methodology? (office staff compared with physician scoring, requires computer to score or by hand)
What is the age range of children who can be screened with this instrument?
How long does it take to administer the screen?
What does it cost to administer this screen? (Can the measure be photocopied or is it copyright-protected?)
What are the psychometrics of the screen?
Is the screen culturally relevant to the population that will be screened? (normative population)
What is the literacy level required for parents to complete the screen?

This table has been adapted from Bergman D. Screening for Behavioral Developmental Problems: Issues, Obstacles, and Opportunities for Change. National Academy for State Health Policy; 2004. pp. 1–20.

Also consider if insurance will pay for the screen.

Screening for behavioral health problems in primary care. Weitzman and Leventhal Current Opinion in Pediatrics 2006, 18:641-648

STEP 3: Plan key parts of the workflow/process for each of the screening categories. *How will we get this done?*

See Workflow Planning Worksheet on the following 2 pages.

STEP 3: Workflow planning worksheet		SOCIAL-EMOTIONAL SCREENING	PERINATAL DEPRESSION SCREENING	SOCIAL DRIVERS OF HEALTH SCREENING
1.)	At what ages of the child will the family receive the screenings? Recommendations:	6, 15, 24, 48 months	1, 2, 4, and 6 months	6, 15, 24, 48 months
2.)	How will parents access the screening tool to complete it? (Ex: EMR portal, paper version in office, laminated wipe-away)			
3.)	If paper, who will ensure that copies of the screening tool are available for parents to complete each day?			
4.)	When in the visit will the parent receive the screening tool?			
5.)	Who will give the parent the screening tool?			
6.)	Who will score the screening tool?			
7.)	When will the provider review the screening results with the parent and work with them to make a plan for next steps?			
8.)	How will referrals be handled for children at risk?			

STEP 5: Workf low planning worksheet		SOCIAL-EMOTIONAL SCREENING	PERINATAL DEPRESSION SCREENING	SOCIAL DRIVERS OF HEALTH SCREENING
9.)	Who will be responsible for facilitating the referrals?			
10.)	Where will referrals be documented?			
11.)	What happens with the screening tool after it has been discussed with the parent? (Ex: results recorded in EMR, scanned into chart, shredded, wiped away)			
12.)	Who will give the parent educational materials? When will these be presented?			
13.)	Where will you keep your supply of educational materials?			
14.)	Who will make sure that materials (including screening tools and educational materials) are restocked and readily available?			
15.)	Who will facilitate following up with families to determine the outcomes of the referral?			
16.)	Where will follow-up notes be recorded?			

STEP 6: Identify program supports. *What partners can we work with to support our patients? What materials do we need for our process?*

RESOURCES FOR DEVELOPMENTAL CONCERNS

Local care coordination service program for children: _____

State Early Intervention services: _____

Developmental behavioral pediatrician: _____

Speech therapist: _____

Occupational therapist: _____

Physical therapist: _____

Child Care Resource and Referral Agency (CCR&R): _____

Child Care Health Consultants: _____

Infant Mental Health Consultants: _____

Head Start: _____

Parents as Teachers: _____

School system preschool coordinator: _____

Local early childhood collaboration: _____

Local family support group: _____

School nurse contact: _____

Exceptional child contact (school system): _____

State/Local education office: _____

Local Easter Seals: _____

Local The Arc: _____

School United Way: _____

MENTAL HEALTH RESOURCES

Maternal depression: _____

Local services identified by Postpartum Support International: _____

Local new moms group: _____

Parental/Caregiver depression: _____

Child psychologist: _____

Child behavioral therapist: _____

Substance use support: _____

Domestic violence support: _____

Additional Resources:

Postpartum Progress
National Alliance on Mental Illness
800-950-NAMI (6264)
National Institute of Mental Health
National Suicide Prevention Lifeline
1-800-273-TALK (8255) or Live Online Chat
Substance and Mental Health Services Administration
SAMHSA Treatment Referral Helpline – 1-877-SAMHSA7 (1-877-726-4727)

FAMILY SUPPORT RESOURCES

State/Local health department: _____

Local home visiting program identified by the Maternal and Child Health Bureau: _____

Parenting groups: _____

Local food pantries listed on Feeding America website: _____

Local homeless shelter: _____

Local contact information for Public Housing Authority programs: _____

Supplemental Nutrition Assistance Program (food stamps): _____

Women, Infants, and Children (WIC) services: _____

National Diaper Network: _____

Local homelessness prevention provider: _____

State/Local legal services agency: _____

STEP 7: Engaging staff in the concepts, principles and process.

How will you work with staff to develop the process? How will new staff receive initial training on the concepts? How will staff be refreshed/reminded of this information?

_____

_____

_____

How will the team monitor progress and make changes as necessary? Will there be regular forums for feedback? Is there a structure to how feedback is presented?

_____

_____

_____

ACKNOWLEDGEMENTS:

This resource was adapted from a version developed by the North Carolina Assuring Better Child Health and Development program as well as the AAP Child Well Being EQIPP Toolkit.