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?

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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: _____