| **MEASURES TO ASSESS IMPROVEMENT IN HEALTH SUPERVISION CARE** | | |
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| **Measure Name/Type** | **Measure Calculation (Numerator/Denominator)** | **Associated Questions** |
| 1) **Elicit and Address Patient/Family Concerns**  (*Process)* | **Target Population:**  All patients birth to 3 seen in practice for health supervision care.  **Numerator:**  # of patients birth to 3 with documentation in chart that patient/family concerns were elicited.  **Denominator:**  All patients birth to 3 seen in practice for health supervision care whose charts are reviewed. | Is there documentation in the medical record indicating that patient/family concerns were *elicited* at the most recent health supervision visit? |
| 2) **Elicit and Address Patient/Family Concerns**  (*Process)* | **Target Population:**  All patients birth to 3 seen in practice for health supervision care.  **Numerator:**  # of patients birth to 3 with documentation in chart that identified patient/family concerns were addressed.  **Denominator:**  All patients birth to 3 seen in practice for health supervision care with a documented parental concern whose charts are reviewed. | If the parent expressed concerns, is there documentation in the medical record that concerns were *addressed*? |
| 3) **Perform Age Appropriate Risk Assessment**  (*Process)* | **Target Population:**  All patients birth to 3 seen in practice for health supervision care.  **Numerator:**  # of patients birth to 3 with documentation in chart that age appropriate risk assessment was performed at most recent health supervision visit.  **Denominator:**  All patients birth to 3 seen in practice for health supervision care whose charts are reviewed. | Is there documentation in the medical record indicating that *all age appropriate risk assessments* were performed at the most recent health supervision visit? |
| 4) **Perform Age Appropriate Risk Assessment**  *(Process)* | **Target Population:**  All patients birth to 3 seen in practice for health supervision care.  **Numerator:**  # of patients birth to 3 with documentation in chart that identified risks were addressed at the most recent health supervision visit.  **Denominator:**  All patients with documented risk, birth to 3, seen in practice for health supervision care whose charts are reviewed. | If any risks were identified, is there documentation in the medical record that these risks were addressed? |
| 5) **Provide Anticipatory Guidance**  *(Process)* | **Target Population:**  All patients birth to 3 seen in practice for health supervision care.  **Numerator:**  # of patients birth to 3 with chart documentation that at least three of the Bright Futures priorities (anticipatory guidance) were discussed at the most recent health supervision visit.  **Denominator:**  All patients birth to 3 seen in practice for health supervision care whose charts are reviewed. | Is there documentation in the medical record that *at least 3 of the Bright Futures Priorities* (anticipatory guidance) were discussed at the most recent health supervision visit? |
| 6) **Identify and Discuss Family Strengths**  *(Process)* | **Target Population:**  All patients birth to 3 seen in practice for health supervision care.  **Numerator:**  # of patients birth to 3 with documentation in chart that family strengths were identified.  **Denominator:**  All patients birth to 3 seen in practice for health supervision care whose charts are reviewed**.** | Is there documentation in the medical record indicating that *family strengths* were identified at the most recent health supervision visit? |
| 7) **Identify and Discuss Family Strengths**  *(Process)* | **Target Population:**  All patients birth to 3 seen in practice for health supervision care.  **Numerator:**  # of patients birth to 3 with documentation in chart that family strengths were discussed at the most recent health supervision visit.  **Denominator:**  All patients birth to 3 seen in practice for health supervision care whose charts are reviewed. | If family strengths were identified is there documentation in the medical record that family strengths were discussed at the most recent health supervision visit? |
| 8) **Ask about and Discuss Social Determinants of Health**  (*Process)* | **Target Population:**  All patients birth to 3 seen in practice for health supervision care.  **Numerator:**  # of patients birth to 3 with documentation in chart that were asked about social determinants of health at the most recent health supervision visit.  **Denominator:**  All patients birth to 3 seen in practice for health supervision care whose charts are reviewed | Is there documentation in the medical record indicating that questions regarding social determinants of health were asked at the most recent health supervision visit? |
| 9) **Ask about** **and Discuss Social Determinants of Health**  (*Process)* | **Target Population:**  All patients birth to 3 seen in practice for health supervision care.  **Numerator:**  # of patients birth to 3 with documentation in chart that concerns about social determinants of health were discussed at the most recent health supervision visit.  **Denominator:**  All patients birth to 3 seen in practice for health supervision care whose charts are reviewed | If the parent expressed concerns about social determinants of health, is there documentation in the medical record that concerns were *discussed*? |
| 10) **Perform Age Appropriate Medical Screening – Measure and Plot Weight for Length**  (*Process)* | **Target Population:**  All patients seen in practice for the 9 month health supervision visit.  **Numerator:**  # of patients with documentation in chart that weight for length was measured and plotted on the percentile curves according to age and sex at the 9 month health supervision visit.  **Denominator:**  All patients seen in practice for 9 month health supervision visit whose charts are reviewed. | Was weight for length measured and plotted on the percentile curves according to age and sex? |
| 11) **Perform Maternal Depression Screening and Follow Up**  *(Process)* | **Target Population:**  All patients seen in practice for their 9 month health supervision visit.  **Numerator:**  # of patients seen at their 9 month health supervision visit with chart documentation of at least 1 maternal depression screen completed by the 9 month visit.  **Denominator:**  All patients seen for their 9 month health supervision visit whose charts are reviewed. | Is there documentation in the medical record that at least 1 *maternal depression screen* was completed by the patient’s 9 month health supervision visit? |
| 12) **Perform Maternal Depression Screening and Follow Up**  *(Process)* | **Target Population:**  All patients seen in practice for their 9 month health supervision visit.  **Numerator:**  # of patients seen at their 9 month health supervision visit with chart documentation of at least 1 maternal depression screen completed by the 9 month visit.  **Denominator:**  All patients seen for their 9 month health supervision visit with documentation of a positive maternal depression screen whose charts are reviewed. | If a positive screen was identified, is there documentation in the medical record that a follow up plan was established? |
| 13) **Perform Developmental Screening and Follow Up**  *(Process)* | **Target Population:**  All patients seen in practice for their 9 month health supervision visit.  **Numerator:**  # of patients with chart documentation of completed age appropriate developmental screenings at the 9 month health supervision visit.  **Denominator:**  All patients seen for their 9 month health supervision visit whose charts are reviewed. | Is there documentation in the medical record that appropriate developmental screenings were completed at the 9 month health supervision visit? |
| 14) **Perform Developmental Screening and Follow Up**  *(Process)* | **Target Population:**  All patients seen in practice for their 9 month health supervision visit.  **Numerator:**  # of patients with positive developmental screen with chart documentation of follow-up plan established at the 9 month health supervision visit.  **Denominator:**  All patients with a positive developmental screen, at the 9 month health supervision care visit whose charts are reviewed. | If a positive screen was identified, was a follow up plan established and documented in the patients’ medical record? |
| 15) **Perform Oral Health Risk Assessment**  (*Process)* | **Target Population:**  All patients seen in practice for their 9 month health supervision visit.  **Numerator:**  # of patients with documentation in the chart that an oral health risk assessment was performed at the 9 month health supervision visit.  **Denominator:**  All patients seen in practice for the 9 month health supervision visit whose charts are reviewed. | Is there documentation in the medical record that an *oral health risk assessment* was performed by the 9 month health supervision visit? |
| 16) **Perform Age Appropriate Medical Screening – Measure BMI**  (*Process)* | **Target Population:**  All patients seen in practice at the 24 month visit for health supervision care.  **Numerator:**  # of patients with chart documentation that BMI was measured and plotted on the percentile curves according to age and sex at the 24 month health supervision visit.  **Denominator:**  All patients seen in practice for 24 month health supervision visit whose charts are reviewed. | Was BMI measured and plotted on the percentile curves according to age and sex? |
| 17) **Perform** **Autism Specific Screening and Follow Up**  (*Process)* | **Target Population:**  All patients seen in practice for 24 month health supervision visit.  **Numerator:**  # of patients with documentation of age appropriate autism specific screenings completed at the 24 month health supervision visit.  **Denominator:**  All patients seen in practice for the 24 month health supervision visit whose charts are reviewed | Is there documentation in the medical record that age appropriate autism screenings were completed for this patient at the 24 month health supervision visit? |
| 18) **Perform** **Autism Specific Screening and Follow Up**  *(Process)* | **Target Population:**  All patients seen in practice for a 24 month health supervision visit.  **Numerator:**  # of patients with a positive autism screen with chart documentation that a follow-up plan was established.  **Denominator:**  All patients with a positive autism screen seen in practice for a 24 month health supervision visit whose charts are reviewed. | If a positive autism screen was identified, was a follow up plan established and documented in the patient’s medical record? |
| 19) **Perform Developmental Screening and Follow Up**  *(Process)* | **Target Population:**  All patients seen in practice for their 24 month health supervision visit.  **Numerator:**  # of patients with chart documentation of completed age appropriate developmental screenings at the 24 month health supervision visit.  **Denominator:**  All patients seen for their 24 month health supervision visit whose charts are reviewed. | Is there documentation in the medical record that age appropriate developmental screenings were completed for this patient at the 24 month health supervision visit? |
| 20) **Perform Developmental Screening and Follow Up**  *(Process)* | **Target Population:**  All patients seen in practice for their 24 month health supervision visit.  **Numerator:**  # of patients with positive developmental screen with documentation in chart that a follow-up plan was established at the 24 month health supervision visit.  **Denominator:**  All patients with a positive developmental screen seen in practice for 24 month health supervision visit whose charts are reviewed. | If a positive screen was identified, was a follow up plan established and documented in the patient’s medical record? |
| 21) **Perform Oral Health Risk Assessment**  *(Process)* | **Target Population:**  All patients seen in practice for their 24 month health supervision visit.  **Numerator:**  # of patients without a dental home with documentation in chart that an oral health risk assessment was performed at the 24 month health supervision visit.  **Denominator:**  All patients seen in practice for the 24 month health supervision visit whose charts are reviewed. | Does this patient have a dental home?  If no, is there documentation in the medical record that an *oral health risk assessment* was performed at the 24 month health supervision visit? |

| **MEASURES TO ASSESS IMPROVEMENT IN PRACTICE PROCEDURES FOR HEALTH SUPERVISION CARE** | | |
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| **Measure Name/Type** | **Measure Calculation (Numerator/Denominator)** | **Associated Questions** |
| 1) **Utilize a Preventive Services Prompting System** | **Target Population:**  All practices in collaborative.  **Numerator:**  % practices with preventive services prompting system.  **Denominator:**  All practices completing the practice inventory. | My practice uses a system to assess the services and risk screenings (Preventive Services  Prompting sheet) each patient needs at each health supervision visit.  My practice uses our practice EHR to assess the services and risk screenings each patient  needs at each health supervision visit.  My practice has a system for pre-visit planning.  My practice uses our practice EHR for pre-visit planning |
| 2) **Accessible Community Resources** | **Target Population:**  All practices in collaborative.  **Numerator:**  % practices with community resources list.  **Denominator:**  All practices completing the practice inventory. | My practice maintains an organized list of community resources for families.  This list is easily accessible to staff.  This list is easily accessible to families.  My practice uses our practice EHR to maintain an organized list of community resources for  families. |
| 3) **Person Responsible for Updating Resources** | **Target Population:**  All practices in collaborative.  **Numerator:**  % practices with an identified community resources staff person.  **Denominator:**  All practices completing the practice inventory. | Someone in my practice is responsible for regularly updating the practice’s community resource  information (eg, checking contact information, confirming eligibility). |
| 4) **Contact Families Behind on Preventive Services** | **Target Population:**  All practices in collaborative.  **Numerator:**  % practices with a recall/reminder system.  **Denominator:**  All practices completing the practice inventory. | My practice has a process to identify and contact patients who are behind schedule for  preventive services (eg chart review, practice management data).  My practice uses our practice EHR as part of our process to identify and contact patients who  are behind schedule for preventive services (eg chart review, practice management data). |
| 5) **Uses Motivational Interviewing/Shared-Decision Making Strategies** | **Target Population:**  All practices in collaborative.  **Numerator:**  % practices that use motivational interviewing and/or shared-decision making strategies with patients.  **Denominator:**  All practices completing the practice inventory. | My practice uses motivational interviewing or shared decision making strategies in discussions  with families. |
| 6) **Identify Children with Special Health Care Needs** | **Target Population:**  All practices in collaborative.  **Numerator:**  % practices with a system to identify patients with special health care needs.  **Denominator:**  All practices completing the practice inventory. | My practice has a system to identify patients with special health care needs.  My practice uses our practice EHR to identify patients with special health care needs.  My practice can generate a list of CYSHCN for population planning and management.  My practice uses our practice EHR to generate a list of CYSHCN for population planning and  management. |
| 7) **Track Referrals** | **Target Population:**  All practices in collaborative.  **Numerator:**  % practices with a system for tracking referrals.  **Denominator:**  All practices completing the practice inventory. | My practice has a system to track referrals using a paper-based or electronic system.  My practice’s referral tracking system is: (paper based/electronic) |
| 8) **Family Involvement** |  | My practice attempts to learn from families about their experience of care (eg face to face  inquiries, focus group discussions, use of a family survey tool).  My practice shares family feedback with all staff.  My practice shares family feedback with families.  My practice uses family feedback for planning practice innovations to improve patient  satisfaction and/or care delivery.  My practice engages families as advisors for practice improvement planning. |
| 9) **Time Spent in Visit** (9 mos visit)  *(Balancing)* | **Target Population:**  All practices in collaborative.  **Numerator:**  Time (in minutes) spent in 9 mos visit  **Denominator:**  All practices completing the practice inventory. | What is the average length of time (in minutes) that the pediatrician, family physician, nurse practitioner, PA, or resident spends with the patients/ parents in a typical preventive care visit (9 month visit)? |
| 10) **Time Spent in Visit** (24 mos visit)  (*Balancing)* | **Target Population:**  All practices in collaborative.  **Numerator:**  Time (in minutes) spent in 24 mos visit  **Denominator:**  All practices completing the practice inventory. | What is the average length of time (in minutes) that the pediatrician, family physician, nurse practitioner, PA, or resident spends with the patients/parents in a typical preventive care visit (24  month visit)? |