MONTHLY MEASURES USING QIDA REPORTING SYSTEM				
Measure Name	**Measure Definition**	**Measure Calculation (Numerator:/Denominator):**	**Measure Exclusion**	**Associated Questions**
Maternal Depression Screening	% of infants whose mothers completed at least one **maternal depression screening** using a validated tool by the 6- month well child visit.	**Numerator:** Number of infants seen at their 6-mo well child visit with documentation in the health record of at least 1 validated maternal depression screening completed by the mother at the 1-, 2-, 4-, or 6- month well child visit. **Denominator:** All infants seen for their 6-month well child visit whose health records are reviewed. **Target Population:** All infant/mother dyads seen for the 1-, 2-, 4-, or 6- month well child visit.	Exclude records for any of the following: 1. Infant was not seen for a 1-, 2-, 4-, or 6- month well child visit 2. Infant was not accompanied by mother at the 1-, 2-, 4-, or 6- month well child visit 3. A validated tool was not used to complete the screening	Is there documentation in the health record that a validated maternal depression screening was completed at least once (1 time) by the 6-month visit? [1-, 2-, 4-, 6- month visit]
Maternal Depression Screening	% of infants who have 3 or more completed maternal depression screenings using a validated tool by the 6-month well child visit.	**Numerator:** # of infants seen at 6-month visit with documentation of all 4 maternal depression screenings at 1-, 2-, 4- and 6-month visit **Denominator:** All infants/mother dyads seen for the 1-, 2-, 4-, and 6-month well child visit. **Target Population:** All infant/mother dyads seen for the 1-, 2-, 4-, or 6- month well child visit.	Exclude records for any of the following: 4. Infant was not seen for a 1-, 2-, 4-, or 6- month well child visit 5. Infant was not accompanied by mother at the 1-, 2-, 4-, or 6- month well child visit 6. A validated tool was not used to complete the screening	Is there documentation in the health record that a validated maternal depression screening was completed at the 1-,2-, 4, **and** 6- month visit?

MONTHLY MEASURES USING QIDA REPORTING SYSTEM				
Measure Name	**Measure Definition**	**Measure Calculation (Numerator:/Denominator):**	**Measure Exclusion**	**Associated Questions**
Discussion of Maternal Depression Screening Results	% of infants for whom it is documented that the mother participated in a **discussion** of the maternal depression screening results at least once by the 6-month well child visit.	**Numerator:** Number of infants seen at their 6- month well child visit with documentation in the health record of a discussion of maternal depression screening results at the time of the screening at least once at the 1-, 2-, 4-, or 6- month well child visit. **Denominator:** All infants seen for their 6-month well child visit with documentation in the health record of a completed validated maternal depression screening at least once at the 1-, 2-, 4-, or 6- month well child visit. **Target Population:** All infant/mother dyads seen for the 1-, 2-, 4-, or 6- month well child visit.	Exclude records for any of the following: 1. The mother did not receive a maternal depression screening using a validated tool	Is there documentation in the health record that the maternal depression screening results were discussed with the mother at the time of the screening at least once (1 time)? [1-, 2-, 4-, 6- month visit]
Referral for Positive Maternal Depression Screening Results	% of infant/mother dyads with a positive screen for whom a **referral** was made at the 1-, 2-, 4-, or 6-month well child visit.	**Numerator:** Number of infants seen at their 9-month well child visit with documentation of a referral for the mother/infant at the time of the visit. **Denominator:** All infants seen for their 9-month well child visit with a positive maternal depression screening at the 1-, 2-, 4-, or 6- month well child visit. **Target Population:** All infant/mother dyads seen for the 1-, 2-, 4-, or 6- month well child visit.	Exclude records for any of the following: 1. The mother did not receive a maternal depression screening using a validated tool 2. The result of the screening was negative	Individual Chart Review Tool Is there documentation in the health record that a referral was made at the time of the visit at least once for a positive maternal depression screening? [1-, 2-, 4- or 6- month visit]

MONTHLY MEASURES USING QIDA REPORTING SYSTEM				
Measure Name	**Measure Definition**	**Measure Calculation (Numerator:/Denominator):**	**Measure Exclusion**	**Associated Questions**
Social Determinants of Health Assessment	% of families that completed a practice-standardized social determinants of health assessment at the 6-, 15-, 24-, and 48-month interval	**Numerator:** at the time of the visit. Number of children seen at their 6-, 15-, 24-, and 48- month well child visit with documentation in the health record of a completed practice-standardized social determinants of health screening **Denominator:** All children seen for the 6-, 15-, 24-, and 48- month well child visit whose health records are reviewed. **Target Population:** All families seen for their child's 6-, 15-, 24-, and 48-month well child visit	NA	Is there documentation in the health record that a practice-standardized social determinants of health screening was completed? [6-, 15-, 24-, and -48 month visit]
Family Strengths/ Protective Factors	% of children with **documentation of assessment of family strengths/ protective factors** in the health record completed at the 6-, 15-, 24-, and 48-month well child visit	**Numerator:** Number of children seen at their 6-, 15-, 24-, and 48-month well child visit with documentation in the health record specifying family strengths/protective factors. **Denominator:** All children seen for their 6-, 15-, 24-, and 48-month well child visit whose health records are reviewed. **Target Population:** All families seen for their child's 6-, 15-, 24-, and 48-month well child visit.	NA	Is there documentation in the health record specifying family strengths/protective factors? [6-, 15-, 24-, and 48-month visit]

MONTHLY MEASURES USING QIDA REPORTING SYSTEM				
Measure Name	**Measure Definition**	**Measure Calculation (Numerator:/Denominator):**	**Measure Exclusion**	**Associated Questions**
Discussion of Social Determinants of Health Assessment	% of children for whom it is documented that the family participated in a **discussion** of the social determinants of health assessment at the 6-, 15-, 24-, and 48-month well child visit.	**Numerator:** Number of children seen at their 6-, 15-24 and 48-month well child visit with documentation in the health record of a discussion of social determinants of health screening results. **Denominator:** All children seen for their 6-, 15-, 24-, and 48-month well child visit with documentation in the health record of a completed practice-standardized social determinants of health screening. **Target Population:** All families seen for their child's 6-, 15-, 24-, and 48-month month well child visit.	Exclude records for any of the following: 1. The family did not receive a social determinants of health assessment using a practice-standardized tool	Is there documentation in the health record that the social determinants of health screening results were discussed with the family? [6-, 15-, 24-, and 48-month visit]
Referral/ Linkage for Positive Social Determinants of Health Assessment Results	% of children with a positive assessment for whom a **referral/linkage** was made at 6-, 15-, 24-, and 48-month well child visit	**Numerator:** Number of children seen at 6-, 15-, 24-, and 48-month well child visit with documentation of a referral/linkage at the time of the visit. **Denominator:** All children seen for their 6-, 15-, 24-, and 48-month well child visit with a positive practice-standardized social determinants of health screening. **Target Population:** All families seen for their child's 6-, 15-, 24-, and 48-month well child visit.	Exclude records for any of the following: 1. The family did not receive a social determinants of health screening using a practice-standardized tool 2. The result of the screening was negative	Is there documentation in the health record that a referral/linkage was made at the time of the visit for a positive practice-standardized social determinants of health screening?

MONTHLY MEASURES USING QIDA REPORTING SYSTEM				
Measure Name	**Measure Definition**	**Measure Calculation (Numerator:/Denominator):**	**Measure Exclusion**	**Associated Questions**
Social Emotional Screening	% of children that completed at least one **social emotional screening** using a validated tool at the 6-, 15- 24-, and 48-month well child visit	**Numerator:** Number of children seen at their 6-, 15-, 24-, and 48-month well child visit with documentation in the health record of at least 1 validated social emotional screening completed during the previous 9 months. **Denominator:** All children seen for their 6-, 15-, 24-, and 48-month visit whose health records are reviewed. **Target Population:** All children seen for their 6-, 15-, 24-, and 48-month well child visit.	N/A	Is there documentation in the health record that a validated social-emotional screening was completed at least once (1 time) during the previous 9 months? [6-, 15- 24 and 48-month]
Discussion of Social Emotional Screening Results	% of children for whom it is documented that the family participated in a **discussion** of the social emotional screening during the visit at which the screening was completed.	**Numerator:** Number of children seen at their 6-, 15-, 24-, and 48-month well child visit with documentation in the health record of a discussion of the social emotional screening results during the visit at which the screening was completed. **Denominator:** All children seen for their 6-, 15-, 24-, and 48-month well child visit with documentation in the health record of a completed validated social emotional screening during the previous 9 months. **Target Population:** All children seen for their 6-, 15-, 24-, and 48-month well child visit.	Exclude records for any of the following: 1. The child did not receive a social emotional screening using a validated tool during the previous 9 months	Is there documentation in the health record that the social-emotional screening results were discussed with the family during the visit at which the screening was completed? [6-, 15-, 24-, and 48-month visit]

MONTHLY MEASURES USING QIDA REPORTING SYSTEM				
Measure Name	**Measure Definition**	**Measure Calculation (Numerator:/Denominator):**	**Measure Exclusion**	**Associated Questions**
Referral for Positive Social Emotional Screening Results	% of children with a positive screen for whom a **referra**l was made at the time of the screening.	**Numerator:** Number of children seen at their 6-, 15-, 24-, and 48-month well child visit with documentation of a referral during the visit at which the screening was completed. **Denominator:** All children seen for their 6-, 15-, 24-, and 48-month well child visit with a positive social emotional screening during the previous 9 months. **Target Population:** All children seen for their 6-, 15-, 24-, and 48-month well child visit.	Exclude records for any of the following: 1. The child did not receive a social emotional screening using a validated tool 2. The result of the screening was negative	Is there documentation in the health record that a referral was made for a positive social-emotional screening during the visit at which the screening was completed? [6-, 15-, 24-, and 48-month visit] How many children had a positive social emotional screening during the previous 9 months? [6-, 15-24 and 48-month]

DRAFT: PRACTICE LEVEL SELF-REPORTED MEASURES: Questions asked at end of each action period – October, February, May			
Measure Name	Description/ Definition	Measure Exclusion	Associated Questions
Closing the referral loop	A system is in place and referrals are tracked and followed-up	No positive patient screens identified during time period	1. Tracking system with patients indicating a positive screen or risk is in place - Q: Do you have a tracking system? Yes/No 2. Person on care team assigned to manage the referral tracking system 3. % of families attempted to reach; % of families reached 4. Documentation when health care specialist returned a report to the primary care practice
Office Systems to Support Trauma-Resilience Informed Care	Practice has developed systems and training to complete the elements	NA	1. Involve families at org level in planning and implementation Do you have an actively involved (include definition) family advisor? Yes / No (in pre/post survey) 2.Did trauma and resilience-informed care training occur during this action period? Yes/No If yes, include number of staff for each level/type of staff. Front office? Clinical Support? Nursing? Clinical Providers (pediatrician and nurse practitioner)? Did training include trauma? Yes/No Did training include adversity? Yes/No Did training include protective factors or resilience? Yes/No Did training include self-care? Yes/No 3. Create a welcoming office environment that promotes wellness for staff and families and respects family's different backgrounds and needs. What trauma and resilience-informed practice changes have you made to support families' different backgrounds and needs? (fill in blank) 4. What self-care changes have you made in your office? [Fill in blank]
Established referral and social support networks	#, type and degree to which networks have been established	NA	1. To what degree have relationships with the following services been established (Likert scale) a. Mental Health Specialists b. Social/Community Supports (identify which ones) c. Health care specialists (identify which ones) d. Pre-school/early childhood

Integrate racial equity lens throughout the practice		NA	1. Involve families at org level in planning and implementation – Does family advisor(s) reflect diversity of patients in your clinic? Yes / No 2. Did race/ethnicity and equity lens training include occur during this action period? Yes/No 3. If yes, include number of staff for each level/type of staff. Front office? Clinical Support? Nursing? Clinical Providers (pediatrician and nurse practitioner)? 4. Create a welcoming office environment that promotes wellness for staff and families and respects family's different backgrounds and needs. What race/ethnicity and equity lens practice changes have you made to support families' different backgrounds and needs? (fill in blank)

DEFINITIONS:

(**Child) development** - The typical progression of a child's acquisition of motor, language, cognitive, and social/emotional skills as well as physical growth.

Discussion - Communication with the family in which the clinician explains the screening results, answers questions, elicits, and responds to family concerns, provides anticipatory guidance, and- for positive screens- works with the family to identify next steps.

Follow-up - Action taken to support the family in completing the course of action recommended by a referral, such as making appointments or receiving further testing, and to obtain and document the outcomes of the referral.

Maternal depression - The spectrum of depressive and anxiety symptoms occurring in a mother during pregnancy and within the first year after childbirth, including:

Prenatal depression: Episodes of depression or anxiety beginning during pregnancy and persisting up to a year postpartum.

Postpartum depression: Symptoms of depression or anxiety occurring in a mother within the first year after childbirth and persisting beyond the first 2 weeks after delivery.

Postpartum psychosis: A serious disorder with rapidly developing depressive and psychotic symptoms, typically presenting within the first month after delivery.

Positive screening- A screening result that falls within the range indicating the need for further assessment, as defined by the screening tool.

Practice-standardized – A consistent set of questions selected by the practice that align with the needs of the patient population.

Protective factors - Biological, psychological, or social characteristics that reduce the negative impact of adverse experiences.

Referral - A recommendation given to a family for additional evaluation, treatment, practice-based supports, or other services.

Referral/linkage - A recommendation for community services and supports, typically non-clinical in nature and focused on addressing social determinants of health such as housing, food, and domestic violence services.

Screening - The use of a standardized tool to identify risk and determine the need for further evaluation. For the purpose of this project, a validated tool should be used for developmental, autism spectrum disorder, maternal depression, and social emotional screening, and a practice standardized screening tool should be used for social determinants of health.

Social determinants of health - The social and environmental factors that impact health outcomes.

Social emotional screening - A subset of developmental screening focused on social-emotional skills including communication, autonomy, affect, behavior, and interaction with people.