

SBHC Office Report Tool for Adolescents (SORTA)

Project: **Improving Access to and Quality of Adolescent Well Care Services through Partnerships with School Based Health Centers**

Practice Name: _____

Practice Facilitator: _____

Clinic Contact Name: _____

Clinic Contact Email/Phone: _____

Project Timeframe: _____

Introduction

This project seeks to improve the **provision and quality of adolescent well-visits** at a community-level through leveraging partnerships with School Based Health Centers (SBHCs). As part of this effort, OPIP is working with your site as a facilitator, helping to plan and implement changes you want to make.

A key part of this process is gathering information about the current systems and processes in your practices so that we can tailor our facilitation to opportunities for improvement. The information gathered is also used to track and evaluate where you make improvements – it is basically a way to quantitatively – in numbers – describe what systems and processes your practice focused on in this project. This tool includes open-ended questions to understand your practice and also uses standardized tools that have fixed responses. Based on these responses we will be creating scores, or scales, of where you practice is now and that will be used to track improvements. Your answers to these questions will be used to identify specific opportunities of focus for site-level practice facilitation and the learning curriculum design – meaning the specific improvement tools and resources that would be most useful to you.

Through our conversations, we want to better understand your systems and processes related to the following 5 sections:

Section 1: Quality Improvement

Section 2: General Questions about Your Practice

Section 3: Education about Services in your SBHC

Section 4: Content of Adolescent Well Visits

Section 5: Population Management and Care Coordination

How this will be collected:

1. Your practice facilitator will send an outline of the questions in this tool. It is valuable to you to read through the questions to get an idea of the topics you will be discussing with your facilitator. **Please do not complete the questions on your own. This tool is meant to be facilitated with your multidisciplinary project team via a discussion with your practice facilitator.**
2. Your practice facilitator will walk through each question and help you identify an accurate score for each item. A score will be noted based on a) your teams' facilitated consensus and b) the practice facilitator assessment. At this time the facilitator will also identify potential opportunities for improvement to note for improvement planning later.
3. Your facilitator will leave with the completed tool, and the OPIP team will analyze results and provide a summary to your team on the results and priority improvement opportunities identified. Throughout the project, key elements in the SCORT will be re-measured and assessed to track and demonstrate your improvements.

IMPORTANT NOTE ABOUT THE TEAM APPROACH TO ANSWERING THIS ASSESSMENT:

It is **imperative** that the responses are from a **practice team** to ensure consensus and shared understanding of what exists. Often the various responses lead to the most meaningful conversations and learnings about what processes do and do not exist.

Developers of office report tools recommend (at a minimum) champions at the **provider, nurse, office manager, and front-office level** review and provide input for the responses as a multidisciplinary team. This core team is also a helpful infrastructure for the QI work that needs to happen, as it ensures champions at the various levels within the office workflow participate and are central to ensuring sustained change.

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SECTION 1: QUALITY IMPROVEMENT

Quality Improvement infrastructure refers to systems, processes, and allocated resources for continuous improvement within your clinic. The collection of this information helps to inform Facilitation activities, as understanding QI means understanding how change is implemented in your practice. Additionally, it is known that sites with intentional systems, processes, and resources for QI are more likely to be able to implement and sustain improvements → which is a primary goal for OPIP's facilitation efforts.

-Have you done QI projects in the past? What were they, and how did they go? What change have you made in the last 2 years that you are most proud of?

-What motivated you to participate in this project? What are you excited about?

- Were there internal or external motivators? Both?

-How would you characterize involvement and support for QI from your practice's leadership? How would you describe the involvement of your sponsor organization in QI efforts?

- a) Leadership is not aware of QI
- b) Leadership is aware of QI
- c) Leadership approves of QI, but is not really engaged
- d) Leadership is actively engaged in QI

-Describe how the culture of the practice supports/doesn't support change and improvement.

-Describe your Quality Improvement processes. What is the process for change to occur in your practice? How are decisions made? Do you have a formal policy related to QI?

- a) Do you use standardized QI template sheets?
- b) Do you meet periodically to ensure progress?

-Describe the major team roles and responsibilities within the practice related to QI. What QI skills and experience exists within the practice? (ie: Model for Improvement, PDSA cycles, etc.)

-What (if any) resources have been allocated for Quality Improvement?

-What system-level requirements, incentives, and restrictions are considerations for you in your QI work?

-Are there any QI projects/roles that come from your Sponsor Organization? What are examples and how is that supported?

-Are there any major changes that you expect to occur over the duration of the project? (ie: EMR change, renovations, new staff positions, etc.)

Do you currently have any methods to include the adolescent voice in your improvement efforts (ie. Youth advisory councils etc.)? Do you do surveys- which one? What are your scores (general pulse is fine) for **access, communication and coordination (these are tied to PCPCH)**?

a) *Pt representation on a committee*

b) *Patient advisory committee*

c) *Patient input obtained on specific care processes*

d) *Focus group or group-level conversations with patients to get their feedback*

e) *Engagement of YAC in QI goals*

SECTION 2: GENERAL QUESTIONS ABOUT YOUR PRACTICE

This section includes a few questions that are more general in nature, and address high level policies and/or procedures that are relevant to your work on this project.

- Please describe (verify) your staffing strategy and hours of operation for the SBHC.

- **FOR TIGARD:** As a Patient Centered Primary Care Home (PCPCH), do you get patients auto-assigned to you for primary care?

a. If so, how are you made aware of the kids assigned to you?

-Do you bill for Adolescent Well Visits? Is this for ALL patients? Is this the same across ALL providers?

b. If so, do you follow the CCO/KPM metrics for billing?

-Do you provide sports physicals? If so, how is this different from a well visit? Is it billed differently? Is this the same across all providers?

-What are some **STRENGTHS** your SBHC has in place to make the kinds of changes described in the objectives of this project?

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SECTION 3: EDUCATION ABOUT SERVICES IN YOUR SBHC

The purpose of this section is to collect information about how your practice educates different audiences about the services you provide as an SBHC, and also how you educate and who you educate about well-care visits in particular. This will help inform the work we do for the objectives of the project that relate to both engaging teens around well-care, and also objectives that relate to communicating and coordinating with primary care practices in the community.

-How are patients informed about access to the clinic (i.e. hours, drop-in, phone, etc.)?

-Do you have a process to educate ADOLESCENTS about services that can be provided at a School-Based Health Center? (*Facilitator NOTE: reactive vs. proactive*)

- a. If so, what is communicated?
- b. What does that process look like to educate adolescents? (e.g. Back to School Night, Health Classes, Posters in School, etc.)

-Do you have a process to educate PARENTS/FAMILIES about services that can be provided at a School-Based Health Center?

- c. If so, what is communicated?
- d. If so, what does that process look like? (e.g. Back to School Night, materials sent to the home, etc.)

-Do you have a process to educate PRIMARY CARE PROVIDERS IN THE COMMUNITY about services that can be provided at a School-Based Health Center?

- a. If so, what is communicated?
- b. If so, what does that process look like? (e.g. Letters to the office, informal meetings, phone or electronic communication, etc.)

-Do you have a process to educate ADOLESCENTS about the purpose of, services that can be provided at, and topics that can be discussed as part of an ADOLESCENT WELL VISIT specifically?

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- a. If so, what is communicated?

- b. What does that process look like to educate adolescents? (e.g. Back to School Night, Health Classes, Posters in School, etc.)

-Do you have a process to educate PARENTS/FAMILIES about purpose of, services provided at, and topics that can be discussed as part of an ADOLESCENT WELL VISIT specifically?

- a. If so, what is communicated?
- b. If so, what does that process look like? (e.g. Back to School Night, materials sent to the home, etc.)

-In starting our work together on this project, what **STRENGTHS** exist in your practice in this area that we could build off of to successfully educate adolescents and families about the importance of adolescent well-care.

SECTION 4: CONTENT OF ADOLESCENT WELL VISITS

The purpose of the items in this section are to attain information about the content of the adolescent well care visits you provide. Specifically, the items in this section identify the alignment of adolescent well visits to Bright Futures recommendations, the CCO Incentive Metric and SBHC Key Performance Measure for depression screening. As mentioned above, OHA has named access to and quality of adolescent well visits as a state priority.

-Do you have a process to inform ADOLESCENTS about CONFIDENTIALITY?

- a. If so, how? (posters, handouts, etc.)
- b. Are the following considerations systematically addressed?
 - i. Private time with the provider
 - ii. Conditional confidentiality. If so, what does that process look like?
 - iii. Ensuring confidentiality in after-visit summaries. If so, what does that process look like?
 - iv. Ensuring confidentiality on patient portal. If so, what does that process look like?
 - v. Ensuring confidentiality on bills submitted that would be part of the EOB's. If so, what does that process look like?

-Do you have a process to inform PARENTS AND FAMILIES about CONFIDENTIALITY?

- a. If so, how? (posters, handouts, etc.)
- b. Are the following considerations systematically addressed?
 - i. Private time with the provider
 - ii. Conditional confidentiality. If so, what does that process look like?
 - iii. Ensuring confidentiality in after-visit summaries. If so, what does that process look like?

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iv. Ensuring confidentiality on patient portal. If so, what does that process look like?

-What is the structure of your current comprehensive health assessment? Can we get a copy?

-Do you have a standardized process across providers to structure the content of adolescent well visits specifically? Is this structure discussed and communicated to adolescents at the start of the visit?

-Indicate the elements below that are currently included in your well visit structure, and explain how they are addressed. **NOTE:** we will get into more detail later about *Depression screening, Substance Abuse Screen and One Key Question® (CCO and/or KPM Metrics)*.

Component of Bright Futures Aligned Well-Visit	Yes	No	If so, how
Adolescent Driven or Indicated Interests			
a. Teen is provided a list of topics that could be covered at the visit			
b. The teen is given the opportunity to indicate what THEY would like to cover at the visit			
Anticipatory Guidance and Parental Education			
a. Physical growth and development			
b. Social and academic competence			
c. Emotional well being			
d. Risk reduction-tobacco, alcohol, drug use, pregnancy, STIs			
e. Violence and injury prevention			
Use of Adolescent Completed Tool to Conduct Reliable and Valid Screening			
a. Questions related to strengths, hopes and wishes			
b. Risk assessments, screening			<i>What screenings do you currently do?</i>
c. Follow up steps when risk is identified			
d. Family/social/cultural considerations- social determinants of health			
Parent Completed Tool			

Now I am going to ask you about screening and assessments that are supposed to occur at well-visits
(See Appendix A for a Bright Futures Periodicity Table)

1. Psychosocial/Behavioral Assessment including asking about social determinants of health
2. Alcohol and Drug Use Assessment
3. Depression Screening
4. One Key Question®

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Psychosocial/Behavioral Assessment including Social Determinants of Health

- Do you use a tool to assess for psychosocial/behavioral health? Does this include questions regarding social determinants of health? Describe.

-Please describe how the results of this tool are documented. Include the process for all providers if there are differences.

Screening Adolescents for Alcohol and Drug Abuse

- Do you use the CRAFFT screening tool to screen **adolescents seen by the SBHC at least once annually** for alcohol and substance abuse? A different tool? Is this across all providers? Describe.

-Please describe how the results of the screening are documented. Include the process for all providers if there are differences.

Follow-Up Steps for Alcohol and Drug Abuse

- Do you use the **Brief Intervention model** to address substance abuse? Describe.

-How is this process documented? Is this the same across providers?

- Do you have a standardized process to create a **plan of care** for adolescents that screen positive? Is this standard across providers?

This may include elements such as a referral to another practitioner or entity for further treatment

- Do you have a process to consider **social determinants of health** identified for each adolescent when conducting follow-up steps for adolescents that screen positive? Describe.

E.g. reviews adolescent responses to questionnaires intended to elicit social determinants experienced by adolescents, and takes these into account when identifying appropriate follow-up steps.

Screening Adolescents for Depression

- Do you use the PHQ-2 screening tool to screen **adolescents seen by the SBHC at least once annually** for depression? Is this across all providers? Describe.

Note: If the SBHC uses the PHQ-9 Modified for Teens screening tool in its initial strength- and risk-based screening questionnaire, this screening tool also "counts" as a screen.

-Please describe how the results of the depression screening are documented. Include the process for all providers if there are differences.

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Follow-Up Steps for Depression Screening

- Do you use the **PHQ-9 Modified for Teens** tool to assess the severity of depression in adolescents with a positive result on the PHQ-2 screening tool? Please describe your process/workflow. Is this standard across providers?

- Do you have a standardized process to create a **plan of care** for adolescents that screen positive? Is this standard across providers?

This may include elements such as suicide risk assessment, a referral to another practitioner for further diagnosis and/or treatment, pharmacological interventions, or other interventions or follow-up for the diagnosis or treatment of depression.

- Do you have a process to consider **social determinants of health** identified for each adolescent when conducting follow-up steps for adolescents that screen positive for depression? Describe.

E.g. reviews adolescent responses to questionnaires intended to elicit social determinants experienced by adolescents, and takes these into account when identifying appropriate follow-up steps.

One Key Question®

- Do you use a standardized process across providers to ask females **“Would you like to become pregnant in the next year?”** Describe.

-Please describe how the results of this are documented and followed up on. Include the process for all providers if there are differences.

Lastly, a key component of well-visits are immunizations

-- Do you see it as your role to make sure they are up to date on immunizations?

-Do you check that they are up to date on their **immunizations** in the ALERT system?

-In starting our work together on this project, what **STRENGTHS** could we build off of to improve the content of the adolescent well care visits? (*For example, there is someone on staff to help build EMR templates, the practice has implemented patient-completed screeners before etc.*)

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SECTION 5: Population Management and Care Coordination

Care coordination is a foundational component of primary care and is one of the 6 principles of the Patient-Centered Primary Care Home (PCPCH) in Oregon. The purpose of the items in this section is to identify processes used by SBHCs to ensure and improve the use of models of population management and care coordination. Specifically, the items in this section identify processes for communicating with primary care practices.

Can you help us understand how you view your role with the patients that come to the SBHC. Do you see your role as to provide the best care possible when they come in and ensure follow-up steps?

Do you consider the group of patients that come to you over a year your “panel” of patients that you are not responsible for managing their health? IN other words, once they come in for care, do you see it as your job to make sure that they are getting all the care that is recommended for them, whether it was what they came in for or not?

If the answer is sometimes, how do you make that determination?

-Do you have a process to track and remind your patients for well care? If so, please describe.

- What is your process for referral and coordination WITHIN your practice?

- a. for well-care*
- b. for acute care*
- c. for mental/behavioral health*

-Do you ask patients who their primary care provider is at the time of intake? At any other time? How is this documented?

-Do you have a standard method for communicating with the PCP about:

- Well care
- Mental health services
- Dental Services
- When you are concerned

-Do you ask IF the adolescent would like you to communicate with their PCP? If so, do you ask them WHAT they would like you to and not to communicate? When you do communicate with the PCP, how do you tell the adolescent?

- What is your process for referral, communication, and coordination with entities OUTSIDE your practice?

- a. for well-care*
- b. for acute care*
- c. for mental/behavioral health*

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-For coordination outside of your practice, do you have instructions for transferring records to and from your office, including a point of contact?

-Are there times when you tell adolescents to **follow up with a health concern with their Primary Care Providers?** (i.e labs, hearing vision screens, other concerns that SBHC may not have capacity for)

a. If so when and why?

-What are some **STRENGTHS** your SBHC has in place that we could build off of to improve care coordination. *(For example; strong communication with a certain primary care provider, shared EMR, common referral forms to community based resources)*

