APPENDIX H: SBHC BENCHMARKS

Obesity

OBESITY GUIDELINES **Hard guidelines in bold, red font.**				
STANDARD	OVERALL GOAL	BENCHMARK	FREQUENCY	COMMENTS
Weight	N/A		Each visit	Goal by each pt
BMI	Obtain BMI on all patients aged 2 yrs and above and ascertain risk factors for pts with BMIs > 85%ile.	90% of patients	Each visit	Risk Factors : Parental obesity, Fam Hx, Abnormal labs, Lifestyle, BMI trajectory
Blood Pressure	< 90%ile for Ht	75% of patients	Each visit	Use BP chart by age and sex
AST, ALT Check if wt is: >85% + 2 other risk factors >95% all children	< 60	75 % of patients	Every 2 yrs in children 9+ yrs	If abnormal, repeat in 1 month. If result twice abnormal, consult Ped Hepatologist
Lipid profile **All children if weight >85%**	TG ≤ 130 HDL> 40 LDL<110 T CHOL < 170	75% of patients	Every 2 yrs in children 9+ yrs	If high levels (Total Cholesterol>200,LDL>130) Refer to Dietitian If no improvement with diet/exercise refer to Ped Cardio or lipid expert
Blood Sugar, (or Hgb A1C) if Weight **>85% + 2 other risk factors** **>95 % all children**	<100 Blood Sugar < 6 Hgb A1C	75% of patients	Every 2 yrs in children 9+ yrs	If blood sugar >126 OR HbA1c >6, refer to Ped Endocrine
Set patient directed behavior goals for weight loss	All overweight and obese patients	75% of patients	Every 3- 6 months	If no improvement refer to nutrition or more structured wt mgmt program.
Diet Education advice	All overweight and obese patients	85% of patients	Each visit	
Physical activity Education and advice	All overweight and obese patients	85% of patients	Each visit	
Screening for Obstructive Sleep Apnea, Cardiovascular, Psychiatric, Orthopedic, Endo	All overweight and obese patients	85% of patients	Annually	

Asthma

ASTHMA GUIDELINES **Hard guidelines in bold, red font.**				
STANDARD	GOAL	BENCHMARK	FREQUENCY	COMMENTS
Diagnosis	Use medical history and physical examination to determine that symptoms of recurrent episodes of airflow obstruction are present.	90% compliance	As required by symptomology	
Asthma Severity	>90% classification for all asthmatics at every visit	90% compliance	Every 3- 6 months	Use severity chart and questionnaire
Asthma Assessment	Asthma assessed using NAEP guidelines	90% compliance	Each visit	**In the past week, how often did you:** Wheeze, cough at night, tire faster than others with exercise, use albuterol
Asthma Monitoring	-follow up care – 2 to 6 week intervals initially, then every 1 to 6 months depending on status	90% compliance	At least twice a year	
Asthma Control: ER visits/ hospitalizations/exacerbations	- no ER visits -no hospitalizations	75% compliance	Assessed annually	
Peak Flow Monitoring	Stabilized peak flow b/w visits	75% compliance	Q visit	
Asthma Action Plan	100% inclusion on charts of all patients diagnosed with asthma	80 % compliance	Once by the third visit and when therapy changes	
Patient Education	100% documentation that patient education performed -appropriate language and literacy level -asthma triggers documented	90% compliance	At least once and then as indicated on pt understanding	
Patient directed Goals	100% inclusion on charts of all patients diagnosed with asthma	80% compliance	Q visit	Physician and patient design goals
Asthma Pharmacologic Therapy	100% patients on controller meds with mod – severe asthma.	90% compliance	Each visit	
Specialist Referral (asthma clinic or pulmonologist)	Refer all severe persistent asthma or poorly controlled mod persistent	90% compliance	As required	Poorly controlled patients can be tracked through care management (FYI) status
annual influenza vaccine	Offered to 100% patients	90% compliance	annually	

Health Maintenance

STANDARD	BENCHMARK	OVERALL GOAL	FREQUENCY	COMMENTS
Immunizations (2year olds) **4 DTP/DTaP** **3 IPV** **1 MMR** **3 Hib** **3 HepB** **1VZV (Varicella)** **4 Pneumococcal conjugate** **2 HepA** **2 or 3 RV (Rotavirus)** **2 Flu** **4-6yo** All vaccines above and additional booster dose of : DTAP IPV MMR Varicella **Flu: annually**	Increase vaccination by 10% each year for next 5 years	**95% of all 2 year olds are fully immunized**	**Per Immunization Guidelines published annually by Committee on Infectious Diseases**	Vaccines should be reviewed at each visit and catch up doses administered as early as possible

Immunizations (Adolescents) Menactra: 1-2 doses ≥ 11 y HPV: 3 doses ≥ 11 y Tdap: Booster ≥ 11 y **Flu: annually**	Increase vaccination by 10% each year for next 5 years	**80 % adolescents compliant with immunizations**	**Per Immunization Guidelines published annually by Committee on Infectious Diseases**	Vaccines should be reviewed at each visit and catch up doses administered as early as possible

Measurements Length/ Height & Weight HC: birth to 24mos Wt for length: birth to 18ms BMI: ≥ 2y BP: ≥ 3y	90 % compliance	100% compliance	Each Well Child Visit (3-5d, by 1mo, 2m, 4m, 6m, 9m, 12m, 15m, 18m, 24m, 30m, 3y and annually thereafter)	
Sensory Screening 1. Vision 2. Hearing	80% compliance	100% compliance	1. 3-6y, 8y, 10, 12y, 15y, 18y 2. NB, 4-6y, 8y, 10y	Rescreen uncooperative children within 6 months.
Physical Exam	95% compliance	100% compliance	Each Well Child Visit (3-5d, by 1mo, 2m, 4m, 6m, 9m, 12m, 15m, 18m, 24m, 30m, 3y and annually thereafter)	Patients should be undressed
Procedures 1. NBS 2. **Lead** 3. Hb 4. PPD 5. Dyslipidemia Screen 6. STI Screen 7. Cervical Dysplasia Screen	Perform tests at suggested intervals with 80% compliance	100% compliance	1. 24-48 HOL 2. **12ms, 24ms** 3. 12ms, 24ms 4. ≥ 12ms 5. 24m, 4y, 6y, 8y, 10y and then annually 6. ≥ 11y 7. ≥ 11y	Risk assessment to be performed with appropriate f/u action if + **6. Screen all sexually active patients for STIs** **7. Refer to Gyn/ Teen Clinic for pelvic exam/ screen within 3 years of sexual activity**

Anticipatory Guidance	90% compliance	100% compliance	Each Well Child Visit (3-5d, by 1mo, 2m, 4m, 6m, 9m, 12m, 15m, 18m, 24m, 30m, 3y and annually thereafter)	Specific guidance by age based on Bright Futures Guidelines
Developmental/ Behavioral Screen 1. **Peds questionnaire** 2. **MCHAT** 3. Psychosocial/ Behavioral assessment 4. Alcohol and Drug Use assesment	80% compliance	100% compliance	1. **9m, 18m,** 24m, **30m** 2. **18m**, 24m 3. Each Well Child Visit 4. ≥ 11y	Appropriate F/U action if screen +

Oral Health Screening annually and referral to dentist annually beginning age 3yrs	90% compliance	100% compliance	6m, 9m, 12m, 18m, 24m, 30m, 3y, 6y	Refer to dentist if screen +

Mental Health

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6
Expected Outcomes What do you want to accomplish? List the results you will achieve at the end of the program. Outcomes must support the project goal stated above. Numbers served must tie to expected number served included in application.	**Strategies/Activities** How will you accomplish the outcome – what will participants do? List the activities participants will undertake to achieve each objective listed in Column 1.	**Outcome Measures** How will you show the project worked/ had impact/ that change occurred? Propose numerical results you expect to see that will indicate success. Describe data sources for the measures.	**Mid-Year Outcomes** List the actual results achieved, to date, against the Column 1 proposed outcomes.	**Grant-End Outcomes** List the actual project results achieved against the Column 1 proposed outcomes.	**Lessons Learned/ Project Barriers/ Surprise Successes/ Comments**
Outcome Objective #1 Access to primary care and behavioral health services will be increased by 50% for students	Activity 1 –Application for clinic enrollment to be included in school's registration packet. Activity 2 – Advisory group consisting of teachers, parents, and clinic staff developed to promote and direct clinic enrollment and services. Activity 3 – Health check and behavioral health screening status monitored on all students enrolled in clinic.	• 50% of students enrolled in clinic would have received annual health exam (health check) with behavioral health screening and services			

Outcome Objective #2 Reduce absenteeism by 10% for students with Behavior Health Problems enrolled in tSBHC.	Activity 1 –Behavioral health screenings on all students receiving health checks, sports physical, and for those referred to clinic for behavioral health issues documented in patient chart/EHR Activity 2 –Referral source (s) for mental health services developed and referrals documented into patient charts/EHR. Activity 3 – Students enrolled and treated at SBHC included in monthly clinic enrollment and utilization report. Activity 4- Student attendance obtained from school records and reported out on a quarterly basis within SBHC reports.	• Identify students with Behavior Health Problems by conducting MH screenings on 50% of students accessing SBHC. • Refer 100% of students with positive behavior health screens for behavior health services . • Enroll and treat 25% of students with behavioral health problems into SBHC mental health program. • Monitor attendance rates of students treated at SBHC quarterly
Outcome Objective #3 Reduce disciplinary referrals by 10% for students with Behavioral Health Problems Enrolled in SBHC.	Activity 1 – Diagnosis and treatment of students with targeted behavioral health problems documented in charts Activity 2 – Disciplinary reports on students treated in SBHC reviewed on quarterly basis and entered into patient chart/EHR.	• Identify students with targeted behavioral health conditions to include: anger management, conflict resolution, depression and oppositional defiant behaviors • Provide behavioral health services targeting • Obtain Baseline disciplinary actions from school records