

A. Cover Page

Using Academic Detailing and Practice Quality Improvement to Increase Implementation of the American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents

A Proposal from
the Child Health and Development Institute of Connecticut
in collaboration with:
Connecticut Children's Medical Center Office for Community Child Health
And
CT Family Support Network

The Child Health and Development Institute of Connecticut (CHDI) proposes to use its successful Educating Practices in the Community (EPIC) program to train pediatric primary care sites in Connecticut to use the AAP Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents (AAP ADHD Guidelines). We will partner with the Practice Quality Improvement (PQI) program at Connecticut Children's Medical Center Office for Community Child Health (OCCH) to develop and implement a data-driven, practice quality improvement activity that engages practices in using monthly plan-do-study-act cycles to improve care on targeted measures. The CT Family Support Network (CT FSN), a statewide family governed and operated organization serving families of children with special health care needs, will bring family experience to training and technical support to participating practices. CT FSN is a long time collaborator with EPIC in efforts to support pediatric sites in transforming care to the medical home model. Together we will ensure that ten pediatric sites improve on their implementation of one or more components of the AAP ADHD Guideline. Core components of our work include: 1) onsite visits to pediatric practices using the principles of academic detailing; 2) practice participation in a data-driven quality improvement activity; and 3) provision of technical assistance to support adoption of guidelines and PQI work. We will also implement an overall project quality improvement (QI) methodology to guide implementation of project activities.

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C. Main Section of Proposal

1. Goal and Objectives

Using Academic Detailing and Practice Quality Improvement to Increase Implementation of the American Academy of Pediatrics Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents is designed to address three of the six recommendations in the AAP ADHD Guideline.¹ Training and QI work will focus on implementation of key action statements 1, 3 and 4, which include:

1. Initiating an evaluation for ADHD for any child ages 4 through 18 who presents with academic or behavioral problems and symptoms of ADHD or who scores at risk for attention problems on the 17-item Pediatric Symptom Checklist (PSC 17).²

Goal: by the end of the project period achieve the following: 1) each practice will achieve 90% of patients with follow-up of parental concerns about attention or attention concerns identified through screening with the PSC addressed with initiation of the NICHQ Vanderbilt Assessment Scales;³ and 2) each practice will achieve 90% of patients with a physician-completed Vanderbilt also having at least one other completed assessment form in their medical record (from a parent or teacher).

2. Ensuring that the diagnosis of ADHD includes assessment for co-existing conditions.

Goal: By the end of the project period, 80% of patients who receive a diagnosis of ADHD will have a completed PSC in their medical record for each well child visit during the project period.

3. Supporting the application of family-centered care and care coordination with the medical home model for children with special health care needs in the care of children diagnosed with ADHD.

Goal: By the end of the project period: 1) 90% of parents whose children have an ADHD diagnosis will receive parent support materials; 2) 80% of children who receive an ADHD diagnosis will be referred to behavior therapy; and 3) 90% of patient charts for children with an ADHD diagnosis will contain at least one school communication.

The need for practice improvement in these three key areas of ADHD care is supported by research on implementation of the AAP ADHD Guideline.⁴ The Chapter Quality Network ADHD pilot program identified several challenges that pediatric primary care providers face in implementing the ADHD Guideline. These include: follow up to obtain rating scales from other than health care providers, linking children to community-based mental health services, and lack of practice support to diagnose ADHD and identify co-morbid conditions. Our proposed work relies on validated tools to screen children for ADHD and other mental health conditions, and a validated methodology to change practice.⁵ These processes are discussed further in the project design and measurement strategy section of this proposal.

Action statements 1, 3 and 4 are also practice areas that CHDI's EPIC program and CT Children's PQI initiative are ideally suited to address. CHDI is a leader in Connecticut in integrating behavioral health and primary care for children and increasing the capacity of primary care providers to address mental health issues. In 2006, CHDI led the development of state regulations requiring mental health agencies to have formal memoranda of agreement

with pediatric practices in order to receive enhanced Medicaid reimbursement and subsequently evaluated that policy.⁶ With funding from the Children's Fund of Connecticut, we supported four pediatric primary care sites in working with mental health providers to implement their memoranda of understanding.⁷ More recently, CHDI developed and evaluated an initiative to increase the capacity of pediatric primary care providers to address anxiety and depression through implementation of algorithms, improved connections with community mental health providers, and participation in practice quality improvement.^{8,9,10} We also have used our EPIC program to support pediatric primary care sites in implementing behavioral health screening. Through these initiatives, we have gained experience with and commitment to supporting child health providers in expanding the scope of care they provide by screening, performing next level assessments, connecting children to mental health services, and continuing to monitor progress toward treatment goals for mental health conditions.

CHDI also has a longstanding commitment to the medical home model of care, supporting pediatric sites to meet National Committee on Quality Assurance (NCQA) medical home recognition standards, which include identification of mental health issues and collaboration with mental health services. This work is well-aligned with Connecticut's adoption of person centered medical home as the platform for the State Medicaid system.¹¹ Action statement 3 of the AAP ADHD Guideline is well within CHDI's organizational goals and presents an opportunity to build on our existing successes to improve ADHD care.

OCCH's PQI program also is committed to improving how pediatric primary care providers address mental health issues. For example, recognizing the delayed age of identification of Autism Spectrum Disorders (ASD) despite the existence of validated screening tools, CHDI and OCCH implemented a QI module that aims to improve the rate of screening and connection to services for ASD. As part of the project, a trained pediatric primary care provider visits pediatric practices and presents the ASD EPIC module, which features the AAP recommendation of the Checklist for Autism in Children (CHAT) or Modified Checklist for Autism in Children (M-CHAT) at 18 and 24 month visits. Following the presentation, practices participate in a self-completed chart audit of well-child visits for 18 and 24 month old children. Similarly, PQI has implemented a project that aims to: 1) engage providers in implementing and improving screening for postpartum depression; 2) ensure that providers document referral to community services/resources; 3) encourage pediatricians to maintain a child and family mental health history; and 4) increase providers' routine solicitation of parental concerns about development and behavior during the first six months of well-child exams. The maternal depression project is also connected to an EPIC training module.

Through projects such as those described above, the PQI program supports pediatricians in improving the quality of care they deliver to patients through the implementation of data-driven continuous quality improvement rooted in the Institute for Healthcare Improvement's Model for Improvement. As a pediatric Maintenance of Certification (MOC) Part 4 portfolio sponsor approved by the American Board of Pediatrics, the PQI program provides MOC Part 4 credits to all participating pediatricians. In addition, pediatricians and other healthcare providers participating in PQI projects earn AMA PRA Category 1 credits™.

The following objectives will guide project activities to meet the overall goal of increasing implementation of three key action statements from the AAP ADHD Guideline:

1. Enroll 10 pediatric primary care sites in the initiative to improve implementation of the AAP ADHD guideline
2. Draft and implement a practice assessment tool that measures where each enrolled practice is on implementation of each of the three key activity statements outlined above.
3. Develop targeted goals for each enrolled practice
4. With input from a family representative, primary care provider, and ADHD expert, develop targeted educational presentations and associated resources and PQI activity for each key activity statement discussed above.
5. Deliver trainings in ten pediatric primary care sites in Connecticut per the needs and goals identified by the practice assessment tool.
6. Support the ten sites in implementing the key action statements identified.
7. Develop a PQI activity for each key activity statement that includes nine cycles of monthly data collection and reporting as well as completion of plan-do-study-act (PDSA) work sheets.
8. Provide technical assistance to the ten practices as they complete PDSA cycles.
9. Convene practices virtually to share practice strategies for implementing the three key activity statements from the AAP ADHD Guideline.
10. Participate in the multi-organization learning community to explore options from other sites for improving practice performance in implementing the AAP ADHD Guideline.
11. Disseminate work to other states through OCCH national network.
12. Prepare and submit a manuscript with project findings to a peer reviewed journal.

2. Current Assessment of Need

In 2006, CHDI supported a faculty member at the University of Hartford Graduate Institute of Professional Psychology to survey pediatric primary care providers in a large Connecticut network to assess their capacity to address mental health issues.¹² Forty-eight physicians participated in the survey. Respondents overwhelmingly rated ADHD as the top mental health condition for which they assess; 30% reported occasionally using the Connors or Vanderbilt to assess for ADHD; and another 15% reported using one those tools regularly or more often than not. Respondents also reported being more comfortable assessing for and managing ADHD than other mental health conditions and said they would be least likely to refer a patient with ADHD to a mental health provider than they would be for other conditions. More than 80% responded that they prescribe ADHD medications, 80% report doing diagnostic assessments, and only half reported referring to a mental health provider. Although these findings suggest a high level of participation in ADHD care by primary care providers, they suggest that much of the AAP ADHD Guideline is not implemented, particularly referral to behavioral health services.

In 2011, CHDI examined patterns of pediatric psychopharmacology in Connecticut.¹³ With data from our State Medicaid behavioral health Administrative Services Organization, we learned that patterns of psychopharmacology prescribing in Connecticut mirror those of the United States as a whole. Almost 10% of Connecticut's children insured by Medicaid (321,053 total child enrollment in Medicaid) received a psychotropic medication in 2010. More than half of these children (53%) received a stimulant medication, with 65% of stimulant medication prescriptions written by primary care providers. An earlier analysis (1999)¹⁴ showed that almost

half of the prescriptions for psychotropic medications written for children in Connecticut's Medicaid program were for stimulants, with 45% of these written by a primary care physician. The results indicate that pediatric primary care providers are playing an increasingly significant role in prescribing stimulant medication for children in Connecticut.

At the same time that data show an increase in pediatric primary care prescribing for ADHD, estimates of the proportion of all children with a mental health condition who were diagnosed with ADHD in Connecticut's Medicaid program have remained stable over the past several years.¹⁵ In 2004/5, 29.8% of children insured by Medicaid and diagnosed with a mental health disorder received an ADHD diagnosis. This was true of 29.3% in 2012/13. While percentages remained stable, the number of children diagnosed with ADHD in Connecticut's Medicaid program almost doubled from 2004/5 to 2012/13 from 6,104 children to 12,001, suggesting that primary care providers are doing prescribing for many more children than in the years prior to 2000. Also noteworthy in the Connecticut Medicaid data, is that ADHD is the leading mental health diagnosis for children in both years studied.

The numbers reported above reflect Connecticut's Medicaid recipients only. As part of our preparation of this proposal, we surveyed pediatric primary care sites that have participated in our EPIC program about their use of the AAP ADHD Guideline hoping to broaden our understanding of the current need in Connecticut for primary care training related to ADHD. We were looking for information on practices' management of ADHD beyond what we learned from Medicaid claims data, for children with all insurance types, and for a more recent accounting of primary care participation in the care of children with ADHD. Twenty-seven pediatric primary care sites responded to an electronic survey within a week. Pediatricians reported having between 20 and 200 children in their practices with ADHD, with most practices reporting in the range of 150 to 200. All but two respondents said they currently use the Vanderbilt to assess children suspected to have attention problems. Twenty-two practices said that they use some of the AAP's ADHD Guideline, and three practices do not use the Guideline at all. Twenty-three of the twenty-five respondents said that they would be interested in receiving more training on implementation of the guideline. Although most of the surveyed practices reported using some of the guideline, they also reported, and we will respond to, a need for training to equip them to implement the guideline more comprehensively and within a QI model.

3. Target Participants and Recruitment

CHDI will recruit practices from the population of 27 Connecticut-based pediatric primary care sites that have participated in the EPIC program and at least one PQI activity over the past five years. If we are not successful in recruiting ten practices from this initial group, we will move on to the larger list of practices that have received an EPIC training but have not participated in a PQI activity. This group includes 240 sites, which include private practices, community health centers and hospital-based primary care clinics. We believe that the incentives offered through this project (Continuing Medical Education and MOC credits) will encourage practices to participate.

Dr. Kenneth Spiegelman, the project physician champion, will make initial contact with targeted practices. Dr. Spiegelman currently recruits practices to participate in both EPIC and PQI. His credentials are described in the Leadership and Staff Capacity section of this proposal.

We expect that participating practices will do the following:

- Complete an initial practice assessment that addresses their current practices in: 1) identification of children who may have ADHD; 2) identification of co-morbid conditions for children diagnosed with ADHD; and 3) connection of children who are diagnosed with ADHD to behavioral services.
- Receive training in areas where their current practice is not in accordance with AAP ADHD Guideline
- Set practice goals for key action statements areas
- Complete QI training if they have not already (will only be applicable if we need to recruit practices that have not participated in PQI)
- Complete chart audits each month for nine months according to PQI data collection processes and enter data monthly into QInsight, PQI's online data management and reporting system
- Complete PDSA worksheets monthly for nine months. Practices will be encouraged to do more frequent (e.g., weekly) PDSA cycles based on weekly review of their data patterns.
- Participate in monthly practice meetings to discuss results and plan changes to improve implementation of AAP ADHD Guideline in areas selected
- Participate in virtual project meetings to share lessons learned with other participating practices

There will be several beneficiaries from the proposed project. Most important, children with ADHD and their families will benefit from receiving evidence-informed care that ensures early detection, connection to behavioral and other interventions, care that is coordinated across settings (home, school, and community), and family support opportunities. Pediatric practices will also benefit from the proposed project. They will expand their capacity to effectively meet patient needs in an increasingly important area of care. This project may enhance their revenues as they bill at higher levels of care,⁸ improve their efficiency, and support them in meeting medical home standards, which can increase their payment from Connecticut's Medicaid program and qualify them to participate in the State's value based payment programs. Health, behavioral health, educational, and social service systems also benefit when children with ADHD receive evidenced-informed, coordinated care initiated within the medical home.¹⁶

The training and QI components of the proposed project will remain active beyond the funding period. CHDI will incorporate the training into its EPIC program, and the PQI program will maintain the associated QI activities. This will allow our partnership to continue to recruit practices that are interested in improving care to children with ADHD and implementing the AAP ADHD Guideline. We have a track record of testing and refining several EPIC modules and PQI activities as part of grant-funded work and then maintaining them for continued dissemination in Connecticut and beyond. Notable examples of this include: our training and PQI activities in maternal depression screening and infant mental, which was originally funded by the State's Office of Early Childhood; autism and development monitoring; and follow-up from newborn hearing screening.¹⁷

Through OCCH, we also have the opportunity to use EPIC and PQI beyond Connecticut. Several of our training modules and PQI activities are being used by pediatric primary care providers in states that participate in the Help Me Grow national affiliate network,¹⁸ which is coordinated by OCCH. Our EPIC/PQI partnership has enabled pediatric practices in 20 states to improve developmental promotion, early detection of children at risk for developmental delay, and linkage to evaluation and intervention services. EPIC is the exemplary physician outreach strategy for Help Me Grow systems across the country, and pediatric practices from CA, FL, KY, NJ, NY, OK, VT, and WA have participated in PQI projects. EPIC and PQI are currently working with practices in three states to enhance their ability to mitigate the effects of toxic stress. We expect that development, testing and evaluation of the training and QI components in the proposed project will also result in dissemination of the AAP ADHD Guideline through OCCH's national network of partners interested in building the capacity of pediatric primary care to contribute to health and developmental outcomes for children.

4. Project Design and Measurement Strategy

The proposed project has three main components: 1) EPIC - onsite visits to pediatric practices using the principles of academic detailing, 2) PQI - practice participation in a data-driven quality improvement activity, and 3) TA - provision of technical assistance to support adoption of guidelines and QI work. Each is discussed below.

Educating Practices in the Community (EPIC)

CHDI initiated EPIC in 2004 to promote early detection of children at risk for developmental delay and connection to evaluation and intervention services. EPIC uses an academic detailing strategy, modeled on what pharmaceutical companies do to market new products, to support pediatric practices in making targeted changes. Trained presenters, who are peers and experts in their topic areas, visit practices, bring breakfast or lunch, and discuss how specific practice changes are supported by best practice guidelines as well as community resources. The presentation is geared to the entire practice team (nursing and administrative staff), recognizing that change is more likely when everyone has a role in ensuring implementation of new processes. CHDI's EPIC program currently includes 17 training modules that cover several health, behavioral, and developmental domains. Half of the modules address some aspect of behavioral health. We visit more than 80 practices each year and have worked with 75% of Connecticut's pediatric primary care sites.

We have demonstrated the effectiveness of EPIC in changing practices in several ways.¹⁹ Retrospective chart audits have shown sustained implementation of screening for Autism.⁵ Medicaid claims data (see Table 1 below) show growth in developmental screening. According to feedback surveys, which are completed by all participants following each EPIC presentation, more than 90% of providers and staff will make practice changes as a result of what they learned.

Table 1. Developmental Screens Billed to Medicaid for Children 3 and Younger 2009 to 2016

	2009	2010	2011	2012	2013	2014	2015	2016
Number of Practices	103	128	147	155	169	184	210	222
Number of Providers	281	362	475	544	614	700	799	879
Number of Screenings	12,369	13,563	13,022	24,108	27,963	34,253	46,215	52,189

For the proposed project, we will develop an EPIC module for each of the three key action statements that we are proposing to address. Each module will contain the core elements of every EPIC module: definition of the problem, evidence for solutions, role of the pediatric practice, resources available for supporting practice change, family support opportunities, billing considerations, and opportunities to use QI to monitor progress in implementing change. The AAP ADHD Guideline will provide the best evidence and key recommendations for the new modules. The physician champion, clinical expert, family representative, and EPIC staff will guide development of and approve the three new modules. All of these perspectives are essential to ensuring that the messages and recommendations for action are feasible, family centered, and reflect best practice.

We plan to complete 20 to 30 EPIC presentations during the project period, expecting that all practices will not need all three modules. The practice assessment survey will allow CHDI to target training where it is needed. Dr. Kenneth Spiegelman, the project physician champion, and two other pediatric primary care providers will deliver the EPIC presentations in practices.

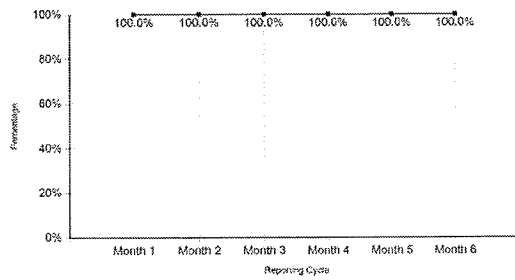
Critical to the success of EPIC is the inclusion of resources that support change. For the proposed modules, we will identify community-based behavioral services that practices can use for referral of families and children. The AAP's Caring for Children with ADHD: A Resource Toolkit for Clinicians will also provide a robust set of resources for us to share with practices as they work towards improving their implementation of key action statements.

Practice Quality Improvement (PQI)

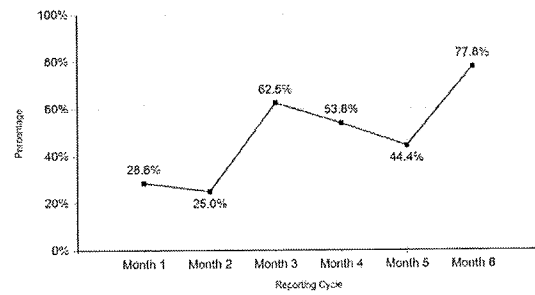
Originally named Connecticut Children's MOC Program, the Connecticut Children's Practice Quality Improvement (PQI) program began in May 2013 when Connecticut Children's Medical Center became an ABP-approved MOC Part 4 portfolio sponsor. The PQI program supports pediatricians nationwide in improving the quality of care they deliver, while conducting data-driven QI and earning MOC Part 4 credits and AMA PRA Category 1 credits™.

PQI offers QI projects that allow physicians to focus on topics relevant to their practice. Currently, the PQI portfolio includes 26 QI projects, ranging in focus from the early identification and connection to services of children with autism and other developmental/behavioral concerns to the appropriate management of asthma in pediatric primary care. To date, PQI has engaged more than 250 primary care providers across nine states. Many of PQI's projects utilize QInsight, a web-based data entry and reporting system. QInsight allows for quick and efficient tracking of the participating practices' progress. Participating practices enter chart audit data, which QInsight uses to generate real-time performance reports that allow participants to look at their progress over time. (sample run charts below.) QInsight also allows participants to enter their plan-do-study-act notes with each data cycle, encouraging them to engage in team meetings to discuss and implement small tests of change after reviewing the report from a given data cycle. All participants are required to complete a QI methodology training to guide their project completion. PQI staff offer ongoing technical assistance and QI methodology support as practices navigate project requirements.

Evidence of developmental surveillance: notation about elicitation of parent concerns at 9, 12, 18 month well child visits



Connection of children for whom there are concerns, detected either through surveillance or screening, to evaluation and/or intervention resources



Report Cycle	# of Charts	Total # of Parental Concerns Asked/Noted
1	20	20
2	20	20
3	20	20
4	20	20
5	20	20
6	20	20

Report Cycle	Total Surveys	# of failed developmental screenings	# of children who received services
1	20	7	2
2	20	12	3
3	20	8	5
4	20	13	7
5	20	9	4
6	20	9	7

In addition to providing MOC credits, the PQI program allows practices to position themselves to reap the benefits of delivering high quality care. Practices need QI activities and experience for a variety of contracting and value-based payment initiatives as payers increasingly endorse and reward quality performance. NCQA requires documentation of practice performance across a variety of areas to grant Person-Centered Medical Home recognition, which makes practices eligible for enhanced reimbursement. In addition, Connecticut’s State Innovation Models (SIM) Initiative and other health care reform efforts are increasingly using value-based payment such as payment for performance and outcomes.

Technical Assistance (TA)

Over several years of providing EPIC trainings and PQI work, we have learned that practices need a variety of technical assistance, not all of which can be determined prior to implementation of an EPIC module or PQI activity. We have learned that the key is to maintain staff who are adept at addressing specific problems, which can include everything from locating a mental health provider in the community to finding out from an insurer why some claims are denied to changing user names in QInight. To ensure that practices can implement the changes recommended and complete the PQI requirement, we will maintain a flexible staffing arrangement, where all questions and requests will go through the CHDI EPIC coordinator for immediate response or for triage to a project staff person who can help by finding answers for practices or by connecting a practice to another practice that has been successful in the area of question. We will use virtual cross practice project meetings to provide opportunities for practices to problem solve implementation issues with their peers. This strategy was effective in helping a cohort of pediatric practices implement behavioral health screening,⁷ and expanding care for children with anxiety and depression.^{9,10} Technical assistance will also include onsite visits to practices to assist with specific problems. Such visits have helped practice staff use the QInight system. PQI staff will also offer technical assistance on the application of the Model for Improvement and plan-do-study-act cycles.

Process Measures

- % of patients who have follow-up of parental concerns identified through screening with the PSC addressed with initiation of the NICHQ Vanderbilt Assessment Scales
- % of patients with a physician-completed Vanderbilt who also have at least one other completed assessment form in their medical record (from a parent or teacher)
- % of patients who receive a diagnosis of ADHD and have a completed PSC in their medical record for each well child visit during the project period
- % of parents whose children have an ADHD diagnosis who receive parent support materials
- % of children who receive an ADHD diagnosis who are referred to behavior therapy
- % of patient charts for children with an ADHD diagnosis that contain at least one school communication

5. Existing Projects

The proposed project is well aligned with work that CHDI and OCCH have been partnering on for the past several years. It uses EPIC and PQI, signature programs of our respective organizations, in a new way and with a new topic area. The work that we have outlined, however, is built upon our collective experience in supporting practice change. CHDI has long been interested in expanding the capacity of pediatric primary care to address behavioral health issues and uses EPIC to support practice change that is grounded in national, state, or local policies and/or opportunities. The AAP ADHD Guideline presents such an opportunity and its implementation in pediatric practices can be supported by several resources that we have in place, including a mental health consultation line for pediatricians, a state policy that ensures timely connection to mental health services for children insured by Medicaid, and a movement toward medical home as the predominant primary care delivery models. Similarly, QI is well supported by Connecticut’s current practice environment as well as pediatricians’ need for MOC credits in the area of practice improvement. In addition, EPIC and PQI help practices meet NCQA medical home standards and state medical home performance measures in areas related to identifying patient needs, behavioral health integration, QI, patient-centered care, and care coordination. CHDI and OCCH work with state leaders on all of these initiatives, and will ensure that the proposed project benefits from lessons learned in other state primary care initiatives.

6. Anticipated Project Timeline

	Aug 17 - Oct 17	Nov 17 - Jan 18	Feb 18 – April 18	May 18 – July 18	Aug 18 - forward
Recruit practices	X				
Assess ADHD care in enrolled practices	X				
Develop targeted goals for enrolled practices	X				
Develop/pilot test EPIC training materials	X				
Deliver training in 10 practices	X	X	X		
Support sites in implementing action statements	X	X	X	X	

Develop QI activity/data capture for each training area	X				
Provide technical assistance on PDSA cycles	X	X	X	X	
Convene practices to share strategies	X	X	X	X	X
Disseminate to other practices in CT and to other states				X	X
Prepare and submit manuscripts and abstracts				X	X

7. Dissemination of Results

In addition to preparation of a manuscript for submission to a peer-reviewed journal, we will also highlight project work in CHDI’s IMPACT report series²⁰ and OCCH’s Advancing Kids blog.²¹ We have discussed how we will encourage dissemination of the project components across the OCCH national network, and will use the Help Me Grow National Center website to alert state affiliates of this opportunity. Each year the Help Me Grow National Center has an annual forum where state affiliates gather to share their work. We will submit an abstract to this meeting as well as to other professional meetings, including the CT AAP annual chapter meeting. If funded, we would be willing to participate with other funded organizations in a session at the national AAP Conference and Exhibition.

8. Additional Information

The work proposed is well supported by several opportunities in Connecticut. In 2015, the state legislature approved funding for a pediatric provider consultation line for mental health issues. ACCESS Mental Health is modeled after Targeted Child Psychiatric Service²² in Massachusetts, and in its first two years it has enrolled 218 pediatric sites and fielded calls for more than 300 youth. All practices that will participate in the proposed initiative are enrolled in ACCESS and will benefit from consultation in their increased ADHD care and in linking children to behavioral health services. Project staff will work with ACCESS staff to ensure that consultation provided is synchronized across initiatives. In addition to telephone consultation, Connecticut pays pediatric primary care providers for general behavioral health screening with a formal tool on the same day as a well child exam. Screening helps practices identify children who may be at risk for a variety of mental health issues, including attentional ones. Further, for children insured by Medicaid, Connecticut has rigorous access criteria for children referred to mental health services. These include the initiation of mental health services as follows: two hours for emergency care; two days for urgent care; and two week for routine care. These Connecticut policies will support participating practices in expanding their care for children with ADHD. They will receive payment for screening and assessment, can be assured access to care for their patients when screening and next level assessment show concerns, and they can access psychiatric consultation when they have specific questions about a patient. EPIC training will highlight these supports.

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¹⁹ Honigfeld L, Chandhok L, Morales M. Using Academic Detailing to Change Child Health Service Delivery In Connecticut: CHDI's EPIC Program. Child Health and Development Institute of Connecticut. October 2011.

²⁰ <http://www.chdi.org/publications/#ftid=27&cat=0&yrs=&q=>

²¹ <https://advancingkids.org/>

²² Sarvet B, Gold J, Straus JH. Bridging the divide between child psychiatry and primary care: The use of telephone consultation within a population based collaborative system. *Child and Adolescent Psychiatric Clinics of North America*, 2011:20, 41-53.