

How States Are Working with Physicians to Improve the Quality of Children's Health Care

Helen Pelletier

April 2006

Funded by The Commonwealth Fund



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EXECUTIVE SUMMARY

States are increasingly interested in working with physicians, provider organizations, and other entities to support efforts aimed at improving the quality of children's health care, particularly for those children who are underserved and members of at-risk populations. States are primarily interested in supporting these efforts as a means to improve both the quality and coordination of care. However, they also view such quality improvement partnerships as an opportunity to shift their relationship with the provider community from that of regulator to that of collaborator. Providers engaged in these activities note that working collaboratively with states on these initiatives can indeed lead to improved quality and coordination of care and to more productive relationships with state officials.

A recent survey by the National Academy for State Health Policy found that half of all states provide some resources or materials to primary care providers to encourage them to focus on young children's early mental health development. An additional 13 states indicate that they are "planning for the future" to implement such activities. Medicaid agencies have often been the most involved state players, but other agencies—among them public health, early intervention, and maternal and child health—are also interested in working with and supporting physicians in their efforts to enhance the quality of care delivered to young children. In addition, state agencies are partnering with other organizations in their states to support primary care providers seeking to enhance the quality of care they deliver to children. These partners include state chapters of the American Academy of Pediatrics and the American Academy of Family Physicians, state infant or child mental health associations, university-associated academic medical centers, Head Start, and advocacy groups.

These partnerships are not always easy to establish and maintain. Physicians who have participated in them note that it can be difficult to overcome long-held assumptions about government bureaucracies, and state officials report that working with busy physicians can pose challenges. Meetings and calls cannot be quickly scheduled, and practices may not have sufficient time to focus on a specific quality improvement initiative. Also, partners often come to the table with different goals and priorities, and these differences can slow or stop progress.

The survey reveals that while many of the formats adopted or supported by states and their partners are fairly traditional, new models are emerging: some in response to past experience, some based on research on physician behavior change, and others based on quality improvement principles or new technologies that have made it possible to deliver information in new ways. A number of states have begun to adopt these newer models which include:

- **Learning collaboratives.** A learning collaborative is a long-term effort (often a year or more) that brings together a number of practice teams that are seeking improvement in a focused topic area. Learning collaboratives feature multiple learning sessions, ongoing technical assistance, and frequent small-scale measurement to help determine whether the intervention needs to be modified. This model was popularized by the Breakthrough Series developed by the Institute for Healthcare Improvement (www.ihl.org).

- **Modified learning collaboratives.** Modified learning collaboratives differ from formal learning collaboratives in a variety of ways. They typically involve fewer or shorter learning sessions; less frequent support and technical assistance; and less stringent evaluation protocols than more traditional collaboratives. These adaptations are often made in response to financial or geographic limitations.
- **Practice-based seminars.** These programs are typically developed in consultation with physicians, teach multi-disciplinary teams within medical offices, and are taught by peer educators (i.e., practicing health care providers). Practicality dictates that sessions are brief, typically 60 to 90 minutes. Programs are often followed by some form of technical assistance.
- **Off-site workshops.** A number of states have instituted off-site workshops designed to support or reinforce state policies and initiatives. These workshops are typically held in local communities and attended by clinicians and office staff from multiple practices.
- **Models that use technology.** Several states and state-supported partnerships have begun developing comprehensive Web-based resources that are designed to support providers and their efforts to improve the quality of services delivered to young children.

Each of the models profiled in this report is significantly different from the others and offers unique lessons for those interested in replicating them. However, a number of lessons were common to most, if not all, of the models. Among them:

- States that have been successful in supporting efforts aimed at improving the quality of children's health care appear rarely—if ever—to act alone. The involvement of the physician community in all aspects of the development and implementation of these programs has been critical to their success.
- States emphasize that partnering with health care providers is essential to these initiatives and that the needs and interests of providers must be central to all efforts.
- States also note the importance of helping physicians connect with community resource agencies as part of their efforts to work with physicians to enhance the quality of care for very young children, as these are the agencies to which physicians will refer families in need of follow-up services.
- States interested in partnering with providers have found success by starting with a small group of physicians or practices, tracking the progress of the initiative, ironing out the kinks, and building both support and demand for the work.
- Those working with physicians to support improvements in the quality of children's health care note the importance of building flexibility into their efforts. Each model must be flexible enough to account for and meet the various needs of different practices.

TABLE OF CONTENTS

Introduction.....	1
Methodology.....	3
States and Providers Working Together to Support Quality Improvement.....	5
What Is the State Role?.....	5
What’s In It for Medicaid and Other State Agencies?.....	5
What’s In It for Providers?	7
Overview of Current Activity	9
A Snapshot of State Practices from an All-state Survey.....	9
Emerging Trends and Models.....	11
Profiles of Five Promising Models	16
An Overview of the Profiled Projects.....	16
Profiles of Promising Models	18
Washington: Children’s Preventive Health Care Collaborative	19
Utah: The Learning Collaboratives of the Utah Pediatric Partnership to Improve Children’s Healthcare Quality (UPIQ)	26
Illinois: Practice-Based Education and Seminars	34
North Carolina: Off-Site Workshop to Support State Policy and Quality Improvement in Private Practice.....	41
The District of Columbia: Technology-Based Effort to Enhance Provider Understanding of EPSDT Requirements	45
Summary of Lessons Learned.....	50
The Importance of Partnerships	50
Supporting State Policy Goals	51
Replication	52
Costs.....	53
Flexibility	53

Appendices

INTRODUCTION

A 2005 National Academy for State Health Policy survey of Medicaid, maternal and child health, and children’s mental health agencies suggests that states are increasingly interested in working with physicians, provider organizations, and other entities to support efforts aimed at improving the quality of children’s health care. The survey, which focused on state efforts to strengthen care related to the healthy mental development of children ages birth to three, found that half of all states (26 of 51) provide some resources or materials to primary care providers to encourage them to focus on young children’s early mental health development. An additional 13 states indicated that they were “planning for the future” to implement such activities.¹

Although the survey reveals that many of the formats adopted or supported by states are fairly traditional—materials, workshops, and grand rounds—states are also adopting newer formats, among them learning collaboratives, Web-based conferences, and office- or practice-based training.

The survey findings—although focused only on issues related to healthy mental development—suggest that states are increasingly interested in forming partnerships with physicians and other providers to support efforts to improve the quality of children’s health care. Anecdotal evidence from a number of states (including the eight that are or have been involved in the Assuring Better Child Health and Development initiative) indicate a strong and growing interest on the part of both state agencies and providers in working together to improve the quality of health care for children, particularly for those who are underserved and members of at-risk populations.

This paper was prepared in response to this growing interest and is designed to:

- provide an overview of current efforts;
- provide a detailed profile of five different models;
- describe the benefits that partners see in working together, as well as the roles that states can play in supporting efforts to improve the quality of children’s health care; and
- summarize the lessons learned from these efforts.

¹ The survey of the 50 states and the District of Columbia was conducted in 2005 as part the Assuring Better Child Health and Development (ABCD II) program, funded by The Commonwealth Fund and administered by the National Academy for State Health Policy. For additional information about the survey and its findings, see Jill Rosenthal and Neva Kaye, , *State Approaches to Promoting Young Children’s Healthy Mental Development: A Survey of Medicaid, Maternal and Child Health, and Mental Health Agencies* (Portland, ME: National Academy for State Health Policy), November 2005. For additional information about ABCD II, visit the NASHP Web site at www.nashp.org.

Five efforts were selected for in-depth examination.

- In Illinois, the state chapter of the American Academy of Pediatrics (AAP) has worked with a variety of state agencies to develop and deliver practice-based training programs.
- In Washington State, Public Health of Seattle & King County and the University of Washington's Child Health Institute have established the Children's Preventive Health Care Collaborative, a six-month learning collaborative of 15 to 20 medical practice teams that is focused on disseminating successful approaches for improving the delivery of comprehensive preventive services to low-income young children.
- The Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) is led by physicians and has sponsored a series of modified learning collaboratives for providers and their practice teams. UPIQ's partners include the state chapter of the AAP and the University of Utah School of Medicine, as well as state agencies representing Medicaid, maternal and child health, public health, and major networks of health care providers.
- In North Carolina, the North Carolina Pediatric Society and the North Carolina Academy of Family Physicians have been instrumental in working with state agencies to bring about changes both in state policy and—through provider training programs they have helped develop and deliver—in the quality of health care delivered to young children across the state.
- In the District of Columbia, a collaborative of Medicaid medical directors has worked closely with the District's Medical Assistance Administration and Georgetown University's Well Child/Bright Futures Project to provide direction and feedback on the development of a comprehensive Web-based training that is focused on enhancing the delivery of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

Table 1: Key characteristics of the five profiled models

	Model	Length	Venue	Focus	Involves practice teams	Providers as primary partner
IL	Office-based seminars	90 minutes	Office-based	Social-emotional development for children under three and perinatal depression screening.	✓	✓
WA	Learning collaborative	6 months	Off-site	Improving preventive services.	✓	✓
UT	Modified learning collaborative	Up to 12 months	Off-site	Improving children's health by assisting pediatric and family medicine practices to deliver the highest possible quality of care to their infant, child, and adolescent patients.	✓	✓
NC	Programs to support state policy and quality improvement in private practice	One day	Off-site	Supporting best practices for developmental screening and surveillance.	✓	✓
DC	Technology based	On demand	Web based	Enhancing health professionals' understanding of the requirements for delivering and documenting EPSDT services.	✓	✓

Methodology

NASHP gathered information for this report from a variety of sources. To determine what states are doing to strengthen care related to children's healthy mental development, NASHP—in consultation with both the Commonwealth Fund and state officials participating in the ABCD II initiative—developed and field tested a survey containing 75 questions. The survey was distributed to Medicaid, children's mental health, and maternal and child health agencies in all 50 states and the District of Columbia and was conducted in February of 2005. NASHP received a total of 101 responses to the survey, including at least one from each state and the District. Findings from the survey that are related to state-based partnerships focused on improving the quality of children's health care are included in this report. A more detailed summary of survey findings is included in another NASHP publication which is available at www.nashp.org: *State Approaches to Promoting Young Children's Healthy Mental Development: A Survey of Medicaid, Maternal and Child Health, and Mental Health Agencies*.

Based upon the results of the survey, Web-based research, NASHP's experience with the ABCD I and II states,² and feedback from state officials participating in the ABCD II initiative, NASHP staff then identified a number of states that have developed or refined a variety of promising activities designed to support providers' quality improvement efforts as they relate to young children's healthy development. Five of those state projects are highlighted in this report. In selecting state activities to feature in this paper, we sought a variety of formats and approaches so that states with a common goal of improving health care for young children but with different levels of resources—of time, money, technology, and human capital—might find approaches that best meet their needs and realities.

Having identified the states and activities we wanted to profile, we asked each selected state to provide us with detailed information about its project. We then conducted phone interviews with the leaders of each of the selected projects, and we solicited the perspective of physicians involved in these activities. NASHP staff also observed and participated in learning collaborative sessions in Vermont³ and Utah. Finally, NASHP sponsored a workshop on this topic at its annual state health policy conference in Nashville, TN, on August 8, 2005. The faculty for that session represented projects in three of the states profiled in this report (Illinois, North Carolina, and Utah).

We also solicited feedback on an outline of this paper from the members of the ABCD II Consortium. Finally, state officials and others who served as leaders of the projects featured in this report reviewed and commented on drafts of this paper.

² A total of eight states have participated in the ABCD initiative. The ABCD I Consortium included North Carolina, Utah, Vermont, and Washington. The ABCD II initiative includes California, Illinois, Iowa, Minnesota, and Utah. More information about the program is available at www.nashp.org.

³ In Vermont, the Healthy Development Learning Collaborative—a partnership of health care providers, state government agencies, and academic institutions—has developed and implemented a 12- to 18-month learning collaborative for pediatric and family care practices designed to improve preventive and developmental care for children up to age five. More information about the collaborative is available on the Web site of the [Vermont Child Health Improvement Program](#).

STATES AND PROVIDERS WORKING TOGETHER TO SUPPORT QUALITY IMPROVEMENT

Both the NASHP survey and conversations with state officials reveal an increasing interest on the part of states and physicians to work together to improve the quality of children's health care. A number of the activities examined in this paper suggest that state agencies and physicians are interested in adopting new approaches to this work and interested in partnering in new ways to achieve a common goal. In many instances and for reasons detailed below, Medicaid agencies have often been the most involved state players, but other agencies—among them public health, early intervention, and maternal and child health—are also interested in working with and supporting physicians in their efforts to enhance the quality of care delivered to young children.

What Is the State Role?

States are not, in most instances, direct providers of care, and are not in a position to directly improve the quality of care being delivered to young children. The states whose projects are highlighted here have sought—in their roles as payers, policymakers, and regulators—to work with physicians to support, encourage, and shape quality improvement efforts. These states and others have done this by:

- developing a joint agenda with the provider community;
- listening to the concerns of providers and addressing barriers in program policies, rules, and regulations that may inhibit quality improvement;
- blending, braiding, and matching resources;
- providing technical support such as data reporting and analysis; and
- bringing together a variety of providers and program administrators to improve relationships, streamline services, and maximize resources.

Officials in the states highlighted in this report stress the importance of working in close and collaborative partnership with physicians. As one official noted: “States should let physicians drive the agenda and then partner with them by providing technical support to enable the work. It helps with buy-in to know that [their] peers are driving the work.” In her state, technical support has included providing state generated data reports and analysis to individual practices, the dissemination of best practices, and the distribution of tools and resources designed to support changes in office processes.

What's In It for Medicaid and Other State Agencies?

States cite a number of reasons for this interest and involvement. As one state official interviewed for this paper noted: “States have a right and a responsibility to know what they are paying for and to tie payment to identified and specified outcomes. If developmental screening, referral, and interventions are covered by Medicaid programs, [Medicaid programs] should do whatever they can to assure that services are provided, using whatever sticks and carrots are

available to them.” This official went on to note that when states have payment policies that support the delivery of preventive services, the policies create a demand among providers to learn how to do more preventive services. Learning collaboratives and other state-supported activities can address that demand and have the potential to support and enhance pay-for-performance policies that seek to ensure the delivery of high-quality care.

Because developmental services⁴ and early childhood intervention programs and policies vary considerably by state, states have a unique role in structuring how the health care and early childhood intervention systems interact with one another. Both are complex systems that tend to operate independently of each other unless explicit policies and projects call for integration. Partnerships between state agencies and providers offer opportunities for these health and education systems to work together more closely. The successful integration of early preventive services can lead to improved quality and can also save the state, providers, and health plans the costs of later hospitalizations.

Although states are interested in supporting these efforts as a means to improve both quality and the coordination of care, these are not the only reasons they cite for engaging in these activities. As one state official noted, “Working on quality improvement efforts with physicians is a nice way to seek out and destroy adversarial relationships which can be damaging to our efforts to provide high-quality, accessible care for kids.” Other officials agreed, noting that these activities help change the face of state agencies from that of regulator to that of collaborator.

Another official noted that Medicaid agencies now have available to them increasingly sophisticated data that can be of significant interest and importance to providers. Public health data help providers better understand community needs and adapt services accordingly, while personalized feedback to providers based on billing and documentation records can encourage internal systems changes and new practice-wide policies. Partnerships between state agencies and providers enable the state to make these data accessible to providers.

⁴ In this context, the term developmental services is used to describe a continuum of care that includes: surveillance, screening and assessment; anticipatory guidance and parent education; and referral, follow-up and care coordination. For more on developmental services in the primary care setting, see M. Regalado, N. Halfon, “Primary Care Services Promoting Optimal Child Development From Birth to Age 3 Years,” *Archives of Pediatric and Adolescent Medicine* 155 (2001):1311-1322.

What's In It for Providers?

Physicians, members of their practice teams, and the leaders of medical professional associations (AAP, AAFP, etc.) who have participated in the activities discussed in this paper cite a number of reasons for their active and continued involvement in these kinds of partnerships.

Providers note that working collaboratively with states on quality improvement initiatives enables them to establish productive relationships with state officials, relationships that open the lines of communication when new issues for providers arise. Similarly, providers note that such collaborations can result in an opportunity to shape policy.

Providers also acknowledge that a number of these partnerships—even in their pilot phases—have resulted in improved office efficiency and family satisfaction and helped to facilitate care coordination between the medical office and community service providers. They note that their involvement in these activities often provides a way to spread improvements quickly and efficiently. In addition, these partnerships offer occasional incentives that are noticed and appreciated by the provider community, including financial incentives (through enhanced reimbursement) and public acknowledgment of efforts to strengthen the quality of care for young children.

Although many of the activities described in the paper are between Medicaid agencies and their partners in the provider community, other state agencies are also working with providers to improve the quality of children's health care. Scott Allen, the executive director of the Illinois Chapter of the American Academy of Pediatrics, is quick to point out some of the benefits his organization has realized by partnering with a number of different state agencies:

For instance, we partner with Public Health on our immunization programs and have much the same relationship as with Medicaid; they do audits of immunization coverage and so could be seen as the enemy... But those audits (CASAs) provide us with the data we wouldn't have otherwise to review outcomes. We also partner with Early Intervention on our developmental screening programs. We invite the local EI representatives to our office-based programs, and this has been useful to suggest statewide EI policy changes when we learn about barriers.

Participants in the Utah Pediatric Partnership to Improve Healthcare Quality are frequently asked to provide feedback on their involvement in the partnership. At NASHP's 2005 annual conference, Julie Olson, Utah's Medicaid managed care director and a UPIQ leader, shared some of their comments. As she explained, these are comments from practices currently participating in the learning collaborative on screening infants for healthy mental development/social-emotional development. These practices are almost through the learning collaborative process, and the comments reflect their experience using the screening tools they selected.

- *Parents are more involved and know what questions to ask.*
- *This has been a wonderful change in our office.*
- *Parents feel more involved.*

- *It's given an objective view rather than subjective view of what is going on with the child.*
- *The screening saves pediatricians time from having to ask so many questions.*
- *The tool we use now is more comprehensive than the form we used to give out.*

These partnerships are not, of course, without their challenges. Physicians who have participated in them note that it is sometimes difficult to overcome their medical colleagues' long-held assumptions about working with a government bureaucracy.

On the other side, the nuts and bolts of working with busy medical providers can be challenging for their partners in state government and elsewhere. Meetings and calls—necessary to advance the project and nurture relationships—are often difficult to schedule. And busy practices often find it difficult to focus on a specific quality improvement initiative.

Public and private participants in these activities also note that the different goals and priorities of the partners can slow or stop progress. As one state official notes about her agency's ability to be flexible and innovative: "We do need to remember that we have limitations based on the federal rules under which we operate." At times, a state's need to establish clear standards and guidelines bumps up against the provider community's desire for flexibility that takes into consideration variations in practice size and community needs.

OVERVIEW OF CURRENT ACTIVITY

There is not only increased state and provider interest in partnering together on efforts to improve children's health care quality, there is also increased activity in this area as demonstrated by both the results of the NASHP survey and some recently released reports.

A Snapshot of State Practices from an All-state Survey

NASHP's 2005 survey, which focused on state efforts to strengthen care related to the healthy mental development of children ages birth to three, found that half of all states (26 of 51) provide some materials or resources to primary care providers to encourage them to focus on young children's early mental health development. An additional 13 states indicated that they were "planning for the future" to implement some type of activity.⁵

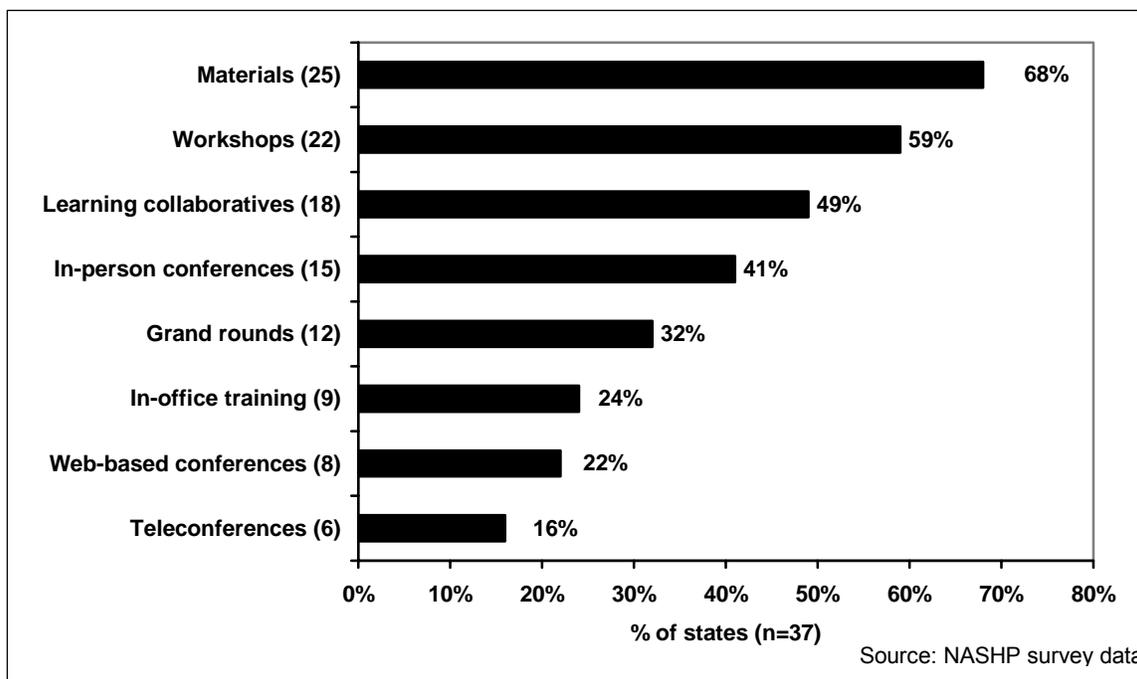
Formats

Although the survey reveals that many of the formats adopted or supported by states to support physicians in their efforts to enhance healthy mental development are fairly traditional—materials, workshops, and grand rounds—states are also adopting newer formats, among them learning collaboratives (or improvement partnerships), Web-based conferences, and practice-based training. (See Figure 1.)

⁵ For additional information about the survey and its findings, see Jill Rosenthal and Neva Kaye, [*State Approaches to Promoting Young Children's Healthy Mental Development: A Survey of Medicaid, Maternal and Child Health, and Mental Health Agencies*](#) (Portland, ME: National Academy for State Health Policy), November 2005.

Figure 1 States use a variety of formats to support efforts to enhance healthy mental development

37 states provided information on the formats they use or plan to use⁶



Topics

The results of NASHP’s 2005 survey of state Medicaid, maternal and child health, and children’s mental health agencies indicate that almost all of the agencies that provide, or plan to provide, support to primary care providers on social-emotional development are focusing some of their efforts on screening (17 of the 26 states). In addition, survey respondents noted a number of other topics being addressed through partnerships with providers. These include: issues that pertain to general developmental screening, assessment, and referral; early intervention; the federal early and periodic screening, diagnosis and treatment (EPSDT) requirements; and billing issues.

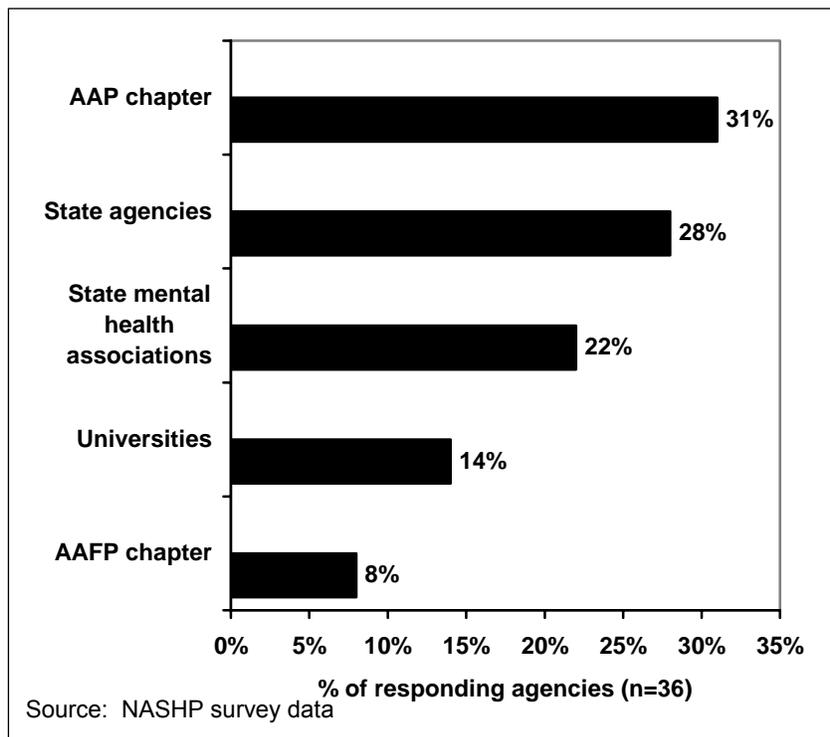
Activities conducted by other organizations

In addition, many respondents to the survey indicated that other organizations in their states are providing support to primary care providers seeking to enhance the quality of care they deliver to young children. This support is being provided either independently of state agencies or in collaboration with them. Eleven respondents mentioned state chapters of the American Academy of Pediatrics, and three mentioned state chapters of the American Academy of Family Physicians. Others noted the involvement of state infant or child mental health associations;

⁶ This table is derived from state responses to the following question: *Please describe the format of the education provided to primary care providers to encourage them to focus on young children’s healthy mental development.*

university associated academic medical centers, including hospitals; Head Start; advocacy groups; and local mental health authorities. (See Figure 2.)

Figure 2 Organizations other than state agencies provide training on infant mental health screening



As Figure 2 suggests, states are not alone in their efforts to work with physicians to improve the quality of children’s health care. The Accreditation Council for Continuing Medical Education (ACCME), which accredits providers of continuing medical education (CME), reported over 71,000 CME activities in 2004.⁷ A sizeable majority of these activities were either courses or conferences (65 percent). Enduring materials on the Internet and elsewhere accounted for 30 percent of activities. Those based on journal articles accounted for 4 percent, and less than 1 percent involved live presentations using the Internet.⁸

Emerging Trends and Models

The current activities reported by states in NASHP’s survey and the 2004 CME activities detailed by the ACCME suggest that most CME activities continue to use fairly traditional

⁷ Accreditation Council for Continuing Medical Education, ACCME Annual Report Data 2004, Table 1. Retrieved 6 June 2005. <http://www.accme.org/>.

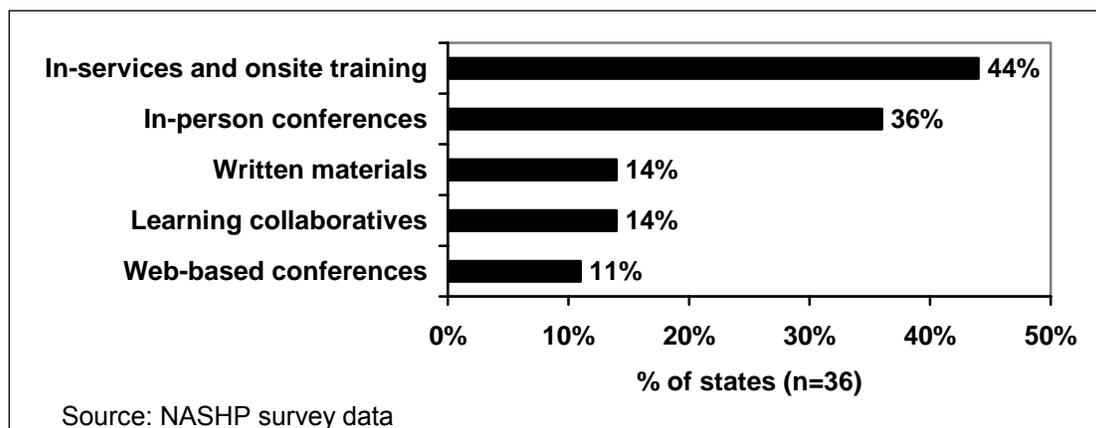
⁸ Ibid.

methods of information dissemination, mostly notably workshops and materials. However, new models are emerging: some in response to past experience with a particular model (either good or bad), some based on research on physician behavior change, some based on quality improvement principles, and some because new technologies have made it possible (and affordable) to deliver information in new ways. A number of states have begun to adopt these newer models. Their innovations are detailed in the project profiles that follow.

Experience with particular models

As Figure 1 illustrates, the three most common formats currently used by states to support providers' efforts to improve the quality of young children's mental health development are materials, workshops, and learning collaboratives. In states that are planning activities for the future, the focus is on grand rounds, learning collaboratives, and workshops. What is perhaps most telling is the shift in focus away from materials: 68 percent of survey respondents who said they used one of the formats listed in the survey listed materials, but only 20 percent of states that are planning some activity for the future listed materials. One reason for the shift away from materials may be found in the responses to another survey question. When asked what types of provider education states have found to be most effective, respondents most frequently mentioned on-site training, followed by in-person conferences. (See Figure 3.)

Figure 3 States view in-services and on-site training⁹ as most effective



Research on physician behavior change

In a paper prepared for the Michael Reese Health Trust, Scott Allen, executive director of the Illinois Chapter of the American Academy of Pediatrics, summarizes a growing body of literature that has helped the medical profession and related organizations better understand key characteristics of how to effect physician behavior change. According to these studies, interventions should strive to:

- take into account the complexity of the medical practice environment by understanding the office as a complex system of competing demands;
- be learner-centered, self-directed, and relevant to clinical practice;
- include a combination of approaches that offer providers a menu of tools; and
- be interdisciplinary in nature, providing training to practice teams composed of both medical and office staff and/or to teams of professionals who represent the various providers of child health services within a community.¹⁰

A number of the projects highlighted in this paper have incorporated several or all of these characteristics into their models.

⁹ In-services and on-site training were terms used in the NASHP survey to describe quality improvement activities that were practice-based, conducted on site.

¹⁰ Scott G. Allen, *Emerging Models for Pediatric Education Nationally and in Illinois* (Chicago, IL: prepared for the Michael Reese Health Trust Health Care Issues Roundtable, May 6, 2005).

Quality improvement principles

Several of the models states are using to support physicians in their efforts to improve the quality of children's health care have begun to incorporate principles from the quality improvement (QI) movement.¹¹ Most of these state models use the Model for Improvement developed by Associates in Process Improvement,¹² a model that includes the Plan-Do-Study-Act (PDSA) cycle developed by Walter Shewhart of Bell Telephone Laboratories and popularized by W. Edwards Deming.

In a nutshell, the model asks three basic questions:

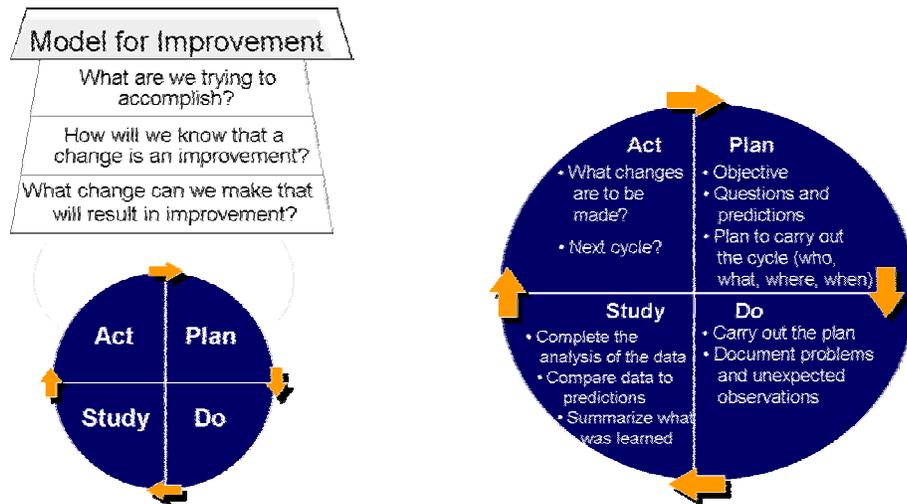
- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in an improvement?

And it offers a simple method—the PDSA cycle—for testing changes. As the Institute for Healthcare Improvement describes it, the Plan-Do-Study-Act (PDSA) cycle (see Figure 4) is shorthand for testing a change in the real work setting—by planning it, trying it, observing the results, and acting on what is learned. The method is designed to enable rapid change by using small-scale tests and simple measurements. The cycles are meant to be small and rapid rather than large and conducted over a long period of time. The PDSA can be an especially useful tool for busy medical practices that have little time to focus on implementing large-scale change. As one state official notes: “Since these are small changes, they are not as threatening to the physician or the staff. The rapid cycle lets the practice see that improvement and change are possible. The idea is that these small, quickly measured steps are not terribly threatening to a busy practice.”

¹¹ Much of this discussion on quality improvement principles was informed by information on the Web site of the Institute for Healthcare Improvement at www.ihl.org. The site includes numerous tools for organizations and providers interested in implementing quality improvement initiatives.

¹² GL Langley, KM Nolan, TW Nolan, et al. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (San Francisco, CA, USA: Jossey-Bass Publishers, 1996).

Figure 4 Plan-Do-Study-Act Cycle



New technologies

To date, relatively few efforts designed to support physicians in their efforts to improve the quality of children’s health care appear to have used interactive or live Web-based technologies. According to the ACCME, about 21 percent of CME activities conducted in 2004 used enduring materials posted to the Internet, but less than one percent of 2004 activities used the Internet for live presentations.¹³ However, in their responses to the NASHP survey, five states reported using Web-based conferences for primary care provider education activities, and another three stated that they planned to do so in the future.

¹³ Accreditation Council for Continuing Medical Education, ACCME Annual Report Data 2004, Table 1. Retrieved 6 June 2005. <http://www.accme.org/>.

PROFILES OF FIVE PROMISING MODELS

An Overview of the Profiled Projects

We came to view the different projects profiled in this report as representing a continuum. On one end are those that require a long-term commitment and that target a relatively small number of providers. On the other are those that require little commitment on the part of providers and practices and that are designed to reach a much broader audience. The continuum (and the projects profiled in this paper) includes the following.

Learning collaboratives

A learning collaborative is a long-term effort (typically a year or more) that brings together a number of practice teams to seek improvement in a focused topic area.¹⁴ We are aware of five states currently engaged in learning collaboratives focused on improvements in child preventive and developmental services. They include two initiatives that are detailed in this paper (in Utah and Washington State), plus three others in New Mexico,¹⁵ North Carolina, and Vermont.¹⁶

Modified learning collaboratives

Modified learning collaboratives differ from formal learning collaboratives in a variety of ways. For instance, they typically involve fewer or shorter learning sessions; less frequent support and technical assistance; and less stringent evaluation protocols. These adaptations are often made in response to financial or geographic limitations. Drawing on the experience and expertise of the Vermont Healthy Development Learning Collaborative, the Utah Pediatric Partnership to Improve Healthcare Quality launched a series of modified learning collaboratives.

¹⁴ The Vermont Child Health Improvement Program (VCHIP) refers to its learning collaboratives as improvement partnerships and defines them as “a durable regional collaboration organized within a state or other governmental geographical unit (e.g., city, county) focused on improving the quality of children’s health care using a systems approach.” Presentation by R. “Mort” Wasserman at the National Academy for State Health Policy’s Annual State Health Policy Conference, August 2005.

¹⁵ For information about Envision New Mexico: The Initiative for Child Health Care Quality, go to <http://www.nmpeds.org/EnvisionNM.html>. Accessed 16 August 2005.

¹⁶ More information about the Healthy Development Learning Collaborative in Vermont and North Carolina is available on the Web site of the [Vermont Child Health Improvement Program](#).

Practice-based seminars

A number of states and their partners have developed office- or practice-based programming (also known as academic detailing) that incorporate many of the characteristics that have been identified as contributing to provider behavior change. Chapters of the American Academy of Pediatrics in Georgia, Illinois, Pennsylvania, and elsewhere have partnered with state agencies to develop office-based activities on a variety of topics. These programs are developed in consultation with physicians, teach multi-disciplinary teams within medical offices, and are often taught by peer educators (i.e., practicing health care providers). Practicality dictates that sessions are brief, typically 60 to 90 minutes. Programs are often followed by some form of technical assistance.

Off-site workshops

A number of states have instituted off-site workshops designed to support or reinforce state policies and initiatives. For example, North Carolina worked closely with the pediatric and family practice community to develop training sessions designed to reinforce the state's Medicaid policy mandating the use of developmental screens and support practices in implementing that policy. These workshops were held in local communities across the state and each was attended by clinicians and office staff from multiple practices.

Several years ago, as part of its ABCD I initiative and in an effort to shift its approach to providing child development services for low-income children, Vermont trained 900 physicians, public health providers, child care providers, and government officials using the Touchpoints model (a curriculum that emphasizes the building of supportive alliances between parents and professionals around key points in the development of children).¹⁷ The trainings were critical to Vermont's efforts to change the focus of its work with families to a developmental, rather than a risk-based, approach.

¹⁷ Touchpoints is a community-building model informed by Dr. T. Berry Brazelton's early body of work which demonstrated that when pediatricians and other health and child care professionals work as partners with parents, to take advantage of the key developmental opportunities for growth and development, children enjoy better outcomes in health, social, emotional, and cognitive well-being. For more information about the Touchpoints model, go to <http://www.touchpoints.org/>. For more information about the ABCD I initiative, see Helen Pelletier and Melinda Abrams, *ABCD: Lessons from a Four-State Consortium* (Portland, ME: National Academy for State Health Policy, 2003).

Models that use technology

Several states and state supported partnerships have begun developing comprehensive Web-based resources that are designed to support providers and their efforts to improve the quality of services delivered to young children. The HealthCheck Provider Education System is an interactive, Web-based tool to provide training and resources to assist in enhancing health professionals' understanding of the requirements for delivering and documenting EPSDT¹⁸ services to Medicaid-eligible children in the District of Columbia. It is based primarily on information from the District's periodicity schedule, Bright Futures materials developed by Georgetown University, and Medicaid information from the Centers for Medicare & Medicaid Services. The development of the District-specific on-line curriculum has, in part, given rise to a national EPSDT distance learning curriculum funded by the U.S. Maternal and Child Health Bureau.¹⁹

Another example of a Web-based model is the Utah MedHome Portal at www.medhomeportal.org. The portal is designed to offer tools and resources to aid primary care physicians in caring for children with special health care needs (CSHCN) and in providing a medical home for all of their patients. The portal is a collaborative effort of the University of Utah's Health Sciences Center's Department of Pediatrics and Spencer S. Eccles Health Sciences Library; the Utah Department of Health's Bureau of Children with Special Health Care Needs; Utah Family Voices; and the Intermountain Pediatric Society/Utah Chapter of the American Academy of Pediatrics. Supporters include the Primary Children's Medical Center Foundation, the Utah Department of Health (and its ABCD II initiative), and the U.S. Maternal & Child Health Bureau.

Profiles of Promising Models

In each of the following profiles we first describe the project by identifying its purpose, mission, goals, and design. We then report on any evaluation activities and results. Finally, we report on lessons learned from the effort, as well as the benefits and drawback of each model.

¹⁸ The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) service is Medicaid's comprehensive and preventive child health program for individuals under the age of 21.

¹⁹ To learn more about the on-line curriculum "Well-Child Care: A Bright Futures Curriculum for Providers in MCH and EPSDT/Medicaid Settings", go to <http://www.brightfutures.org/wellchild>.

Washington: Children’s Preventive Health Care Collaborative

Purpose and mission

The Children’s Preventive Health Care Collaborative seeks to disseminate successful approaches for improving the delivery of comprehensive preventive services to low-income young children. To that end, the collaborative is designed to increase the delivery of well-child visits and to integrate oral health²⁰ and developmental screening and referrals into well-child visits.

Goals

The collaborative has focused on integrating developmental screening and oral health and referrals into children’s primary care services. The measures selected reflect the aims of the project.

- To increase the number of children receiving appropriate developmental screening and appropriate referrals.
- To increase fluoride varnish applications for Medicaid patients up to three applications per child (birth through 4 years) per year and appropriately increase dental referrals.

In addition, participating medical practices could choose to use several optional measures:

- number of referrals for 1-4-year-olds for developmental concerns;
- number of referrals for 1-4-year-olds for socio-emotional concerns;
- fluoride varnish applications for Medicaid patients up to age 18;
- patients, 1-4-year-olds, who have not seen a dentist in the last twelve months; and
- number of dental referrals for 1-4-year-olds who have not seen a dentist in the last twelve months.

The project has also established a number of “balancing goals” for the practices which include: no increase in office cycle time; no decreases in staff satisfaction, immunization rates, or average number of well-child visits per month; and no increase in waiting times for acute care appointments.

²⁰ Please note that this effort is presented here as an example of a learning collaborative—the Commonwealth Fund does not fund oral health projects.

Project design

Based on the Breakthrough Series created by the Institute for Healthcare Improvement,²¹ the Children's Preventive Health Care Collaborative is a quality improvement effort in which 15 to 20 medical teams work to measure and improve the quality of care delivered by their practices during the project period. Washington's learning collaborative is currently in its second year, having completed a successful pilot stage in 2005.

The project uses a more narrow approach to learning collaboratives than some other models. It is conducted over six months rather than the more typical one year, and participants attend three meetings, in contrast to a schedule of six to eight meetings.

The 2005 learning collaborative consisted of 16 practice teams typically comprised of a physician, a nurse, and an office staff person. These teams attended each of the three, one-day learning sessions. The sessions were led by quality improvement experts, children's preventive health experts, and clinical staff and included discussions of specific clinical content along with the plan-do-study-act model for improvement within each practice.

The three face-to-face learning sessions were conducted in January, March, and June of 2005. During the time between learning sessions (known as action periods), practice teams tested and implemented changes. They were supported in this work by learning collaborative staff who provided technical assistance through monthly conference calls, a group listserv, and site visits. In addition, the conference calls and listserv were designed to provide practice teams with an opportunity to share experiences and receive guidance from one another.

Participants in the 2005 collaborative collected baseline data about their office practices before the first meeting, identified needed changes in their practice, implemented change strategies introduced during the face-to-face meetings, reported results monthly for each objective, and participated actively in the face-to-face meetings and conference calls.

According to project staff, participating practices were expected to:

- perform pre-work activities to prepare for Learning Sessions.
- collect baseline data.
- sign a data use agreement for de-identified data.
- connect the collaborative goals to their organization's strategic initiative.
- identify a physician champion to work with the team to implement the quality improvement initiative.
- identify a senior leader to sponsor the team(s) working in the collaborative, and demonstrate that leader's commitment to supporting the success of the team and sustaining and spreading its accomplishments (including but not limited to attending at least one learning session).

²¹ See *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement* at <http://www.ihl.org/IHI/Products/WhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchieving+BreakthroughImprovement.htm>.

- send a multidisciplinary team to all three learning sessions.
- provide resources and support to the team.
- perform tests of changes that will lead to widespread implementation in the practice and the agency.
- select well-defined measurements that relate to the organization's aims and plot them at least monthly over time for the duration of the collaborative.
- share data and reports with other collaborative teams.

The Children's Preventive Health Care Collaborative is funded by the Washington State legislature with additional support from local funding agencies. The Collaborative is staffed by the King County Health Action Plan at Public Health-Seattle & King County; and QIPartners at the Child Health Institute,²² which is comprised of faculty and staff from the Schools of Medicine, Dentistry, and Public Health and Community Medicine at the University of Washington.

Costs

Full-blown learning collaboratives can cost up to \$500,000 or more depending on the number of sites involved, local versus national travel, and subcontracts for experts or evaluation services (often with academics). But they can also be done, with variations to the model, for less. Kirsten Wyses, who staffs the Children's Preventive Health Care Collaborative, notes that their project cost about \$100,000 in its first year. Although this collaborative was less costly than other similar initiatives, she cautions: "We couldn't attract too many practices from outside the greater Seattle area because we couldn't pay for travel costs. One practice came on [its] own dime from Spokane."

Evaluation

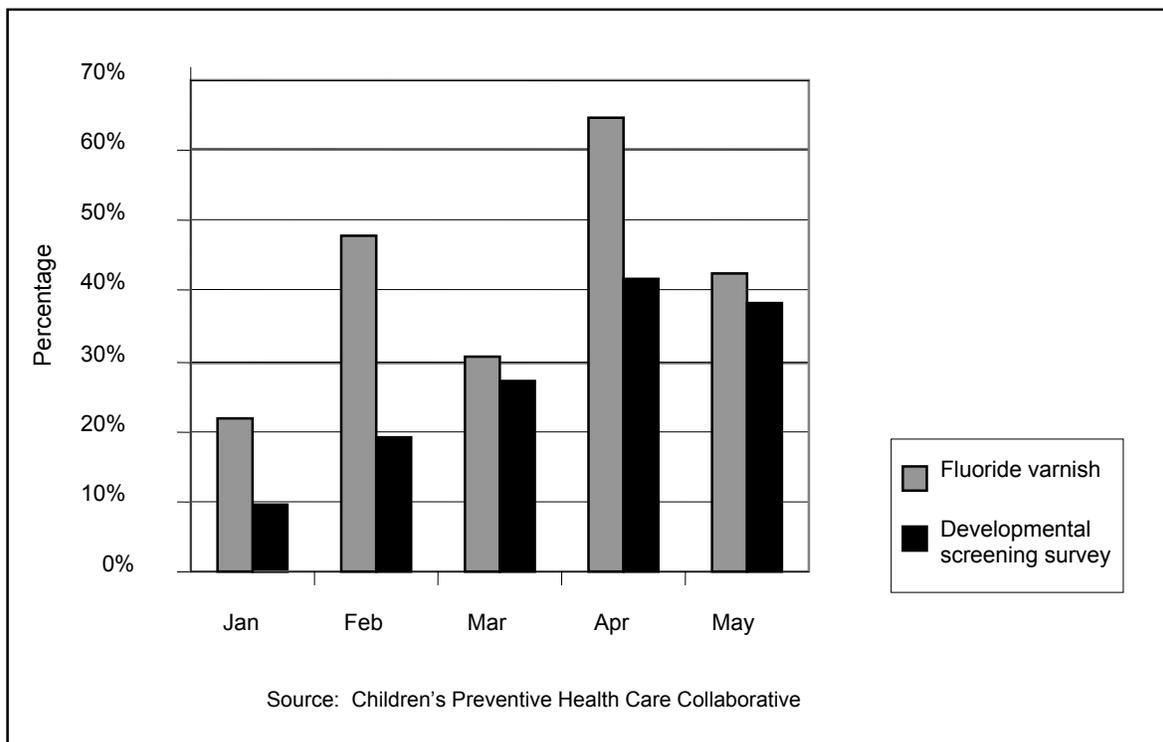
Participating medical practices collected baseline data before the first learning session. They provided basic patient volume data and demographic information about their practices, and they conducted a small chart review to assess baseline levels of fluoride varnish application and developmental survey use. Thereafter, they reported monthly rates of developmental survey and fluoride varnish per well-child visit. This information was entered into a spreadsheet by University of Washington staff, who shared the progress and graphs with the teams every month. During the last learning session, participants reported to the group on their achievements and barriers during the project. Medical practices also collected data on the process changes they made along the way, collecting small samples of process measure data for their plan-do-study-act cycles. Notable successes and failures were shared during the conference calls and at the third learning session.

²² For more information about the Child Health Institute, go to <http://www.childhealthinstitute.org>.

Results

Project staff report that, between January and April 2005, participating practices increased the percentage of children receiving structured developmental questionnaires from 10 percent to 42 percent and increased the percentage of children receiving fluoride varnishes from 22 percent to 65 percent. In May there was a slight fallback and 38 percent had a developmental survey during a well-child visit and 42 percent of children received a fluoride varnish. (See Figure 5.)

Figure 5 Participating practices increased the percentage of children receiving fluoride varnishes and developmental screens



Lessons learned

Through evaluations and anecdotal feedback, project staff identified a number of lessons that emerged from the first year of the project.

- **Active participation by practice teams is important.** Active participation in each of the scheduled meetings and conference calls was important, since many of the most significant insights from this type of group process come as the participants learn from each other.
- **Site visits can be of tremendous importance.** Somewhat unexpectedly, Washington State found that the site visits to the participating medical practices were instrumental in helping the projects to adopt changes. During the site visits, medical practice staff felt more comfortable raising questions, bringing barriers to light, and brainstorming tests of

change than they did during the group meetings and conference calls. For the second year of the project in 2006, University of Washington staff are conducting the site visits earlier on in the collaborative, right after the first learning session.

- **Learning collaboratives can do a great deal to link medical practices with community resources.** The second learning session received the highest evaluation scores from participants. During this one-day meeting, the participating medical practices were introduced to representatives from community resources in their counties. Several of the medical practices had initially indicated that they were hesitant to implement structured developmental survey tools because they lacked reliable referral resources for children who were discovered to have needs. Similarly, several participants were frustrated with their efforts to refer Medicaid patients to dentists who would accept Medicaid payment or who would provide preventive oral health services to toddlers and pre-schoolers.

At the second learning session, the medical practices heard brief presentations from the developmental intervention community agencies in the morning and from dentists and oral health program representatives in the afternoon. The developmental intervention presenters included state and county representatives from the Infant Toddler Early Intervention Program, the state Children with Special Health Care Needs program, the state Special Education Learning Improvement program and the state and local representatives of the “Parent to Parent” support program. The dental resources included a group of dentists trained by the University of Washington to treat very young children, through the Access to Baby and Child Dentistry program, the Washington Dental Service Foundation, and dental clinics linked to community health centers and public health clinics.

After the presentations, the medical practices were divided into groups by county, where they worked together with their local developmental and oral health experts to discuss referral opportunities and protocols. Many referral relationships were born that day. One of the medical practices noted: “I don’t refer to a phone number, but I will refer families to community resources I know and trust.” Another said the connections forged that day to the local “Parent to Parent” group in Olympia had “revolutionized” her practice for kids with special needs and developmental issues. Another clinic found that two weeks after the learning session staff had already made three referrals to the county Family Resource Counselor. The three children were identified at an early age through the ASQ and were immediately linked to services, and in one case to a Head Start preschool program.

- **Interactive presentations during learning sessions tend to be most effective.** According to participants’ evaluations of the learning sessions, purely didactic presentations with lengthy slide shows were not as useful as interactive presentations. Although some amount of information about the clinical need, the effectiveness of particular interventions, and the rationale for the measures, along with instruction on improvement and care models, is necessary to share, participants scored the shorter and

more interactive versions of presentations higher than longer, uninterrupted presentations of information.

- **Recruitment posed a challenge for the Washington project.** Developmental screening and oral health were chosen as clinical focus areas for the Washington State collaborative as a way to spread best practices learned during the implementation of the Kids Get Care program, a federally funded program that improves the delivery of comprehensive preventive services to low-income children. In recruiting practices to participate in the second year of the collaborative, project staff encountered challenges. Mailings were sent to all pediatricians, family physicians, physician assistants, and nurse practitioners treating Medicaid patients in four counties near Seattle, information was posted on several provider websites, and mailings went out to health plan provider networks. Several medical practices participated in informational conference calls before the learning collaborative started but did not sign up to participate because they could not take three days away from their practices. Without the ability to compensate medical practices, especially small ones, for lost revenue due to attending full-day meetings, it was difficult to attract many participants willing to focus on these two clinical areas.

To address the recruitment challenges for the third year of the collaborative, Washington project staff plan to work more closely with provider associations to select clinical focus areas that are high priorities for practitioners. They are planning in 2007 to offer tracks, so that medical practices can choose from asthma management, adolescent depression, attention deficit hyperactivity disorder, and obesity prevention, in addition to developmental screening and oral health.

Benefits and drawbacks of the model

In Washington's experience, learning collaboratives can motivate measurable and meaningful changes in medical practices. These collaboratives can be expensive and labor-intensive and require a significant commitment of time and resources on the part of both sponsors and providers. Nonetheless, Washington has found that the investment pays off by supporting practice changes in a collegial and synergistic way as the participants transform how they provide preventive services. A drawback is that only a small number of medical practices are affected by the effort. Less intensive ways to spread changes would be more economical and could have a broader reach.

While the Washington project has discovered that early adopters—those practice teams eager to tackle new strategies and interventions—will take the time to come to learning collaboratives, other dissemination methods may be needed to reach farther into the state's group of providers. As they go forward, Washington State staff are thinking about regional approaches, where an early adopter team from a remote part of the state could get staffing support to disseminate its lessons learned to local colleagues. Similarly, an intranet site and Web exercises could help extend the collaborative's reach or support past participants in sustaining changes.

With some refinements to enhance both dissemination and the capacity of teams to sustain their progress, Washington project staff are convinced that the model will be

effective over time in motivating and supporting profound changes within medical practices and will play an important role in improving the quality of preventive services delivered to low-income children.

Adding state purchasing policies that financially reward medical practices who can demonstrate improvements and high performance levels would complement learning collaborative efforts. For example, when Medicaid pays for fluoride varnishes or developmental services, medical practices receive financial compensation for their efforts to assure that their patients receive such services, an important carrot for the pediatricians, family physicians and clinics treating predominantly low-income children on the front line.

Utah: The Learning Collaboratives of the Utah Pediatric Partnership to Improve Children’s Healthcare Quality (UPIQ)

Purpose and mission

UPIQ was established in 2003 to improve children’s health “by assisting pediatric and family medicine practices to deliver the highest possible quality of care to their infant, child, and adolescent patients.”²³ It is a partnership among the Intermountain Pediatric Society, the University of Utah Health Sciences Center’s Department of Pediatrics, the Utah Department of Health’s Division of Health Care Financing, the Utah Department of Health’s Division of Community and Family Health Services, HealthInsight,²⁴ and the Intermountain Health Care Primary Care Clinical Program.

The partnership’s acronym (pronounced “you pick”) is meant to reinforce its focus on provider driven change. By providing physicians and their practice teams with information and a variety of useful tools, UPIQ seeks to support—not dictate—providers’ quality improvement efforts. Its work is grounded in the belief that long-term, successful change requires physician buy-in and needs to be driven by the specific needs and concerns of individual doctors and their practice teams.

UPIQ’s Vision

UPIQ is committed to the concept that every child deserves a medical home and that, in their medical home, they and their families will receive the highest quality of care, and that the providers of that care will be supported in and rewarded for their efforts to practice high quality, evidence-based medicine.

--from the UPIQ charter

Goals and project design

UPIQ’s learning collaboratives are designed to bring practice leaders together to share ideas and experiences and are meant to provide education and support so practitioners can bridge the gap between knowing best practices and implementing them.

By June 2005, the partnership had sponsored four collaboratives (on preventive services, developmental screening, social-emotional screening for infants and for toddlers, and best practices in attention-deficit/hyperactivity disorder) and had involved 53 practice teams in those initiatives.

²³ Charter, Utah Pediatric Partnership to Improve Children’s Healthcare (UPIQ).

²⁴ HealthInsight is the quality improvement organization for the state of Utah.

Although they are modeled after other learning collaboratives and incorporate the quality improvement principles described elsewhere in this paper, Utah’s learning collaboratives are designed to be more limited in scope than the model currently being used in Washington State. Participating practice teams (of both medical and administrative staff) attend a single, day-long session in which they are presented with detailed information and tools related to a specific improvement topic; are taught the fundamentals of the PDSA cycle; and are then asked to identify:

- an aspect of their practice related to the topic that they want to improve;
- what changes will enable that improvement; and
- how they will measure whether the change was indeed an improvement.

In the course of a day—with assistance from collaborative leaders and UPIQ staff and the use of a number of planning tools—the practices develop individualized goals and action plans for implementing change within their offices.²⁵ These plans are informed by a baseline chart review that the teams have conducted in advance of the learning session. By the end of the day, practices have set specific goals, and they have developed a clear plan of action, including what they plan to accomplish “by next Tuesday.”²⁶ (See Appendix B for additional information on the collaborative and its curriculum.)

Following the one-day session, practices implement their plans on a small scale (for example, with five patients or for a week), assess how well the change worked, and then tweak their plans as needed. This PDSA cycle is repeated as the change is incorporated into the practice’s systems and culture.

UPIQ staff members provide regular contact with the practice teams through monthly half-hour conference calls, conducted during the lunch hour,²⁷ and through occasional site visits to the practices. Practice teams are expected to conduct a small monthly chart audit (which involves five charts and a few questions). UPIQ assembles and analyzes data from the chart audits and provides this information on a quarterly basis during the practice team conference calls. These follow-up activities typically last about 12 months.

Costs

UPIQ estimates that the cost of conducting one collaborative for 10 to 15 practice teams ranges from \$15,000 to \$23,000, with the largest expense being the personnel needed to develop and

²⁵ UPIQ staff offer examples of goals as part of the learning session. See Appendix B for some of the suggested goals for each of the three learning collaboratives held to date.

²⁶ The Institute for Healthcare Improvement encourages those seeking to improve the quality of health care to ask: “What can we do by next Tuesday.” For more on this recommendation, go to: <http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/Literature/ImprovementTipAskWhatCanWeDobyNextTuesday.htm>.

²⁷ Calls are held on the third Wednesday of every month, from 12:30 to 1:00 pm. Practices can call in on a toll-free number, and each month, the call originates from a different participating practice.

administer the project.²⁸ UPIQ's activities are funded through a mixture of sources including grants for specific learning collaborative topics, Title V dollars, and in-kind contributions from the partners. The Utah Department of Health's Division of Health Care Financing works with UPIQ to match with federal Title XIX dollars as appropriate. As is true of the North Carolina and Vermont collaborative, physicians who participate in the UPIQ collaboratives receive CME credit.

Evaluation

As noted above, practice teams are expected to conduct a monthly chart audit, providing data that allows UPIQ to analyze changes and improvements within practices. The information is made available to the practices on a quarterly basis, as part of the practice team conference calls. At the end of the learning collaborative, UPIQ asks each participating practice to conduct a broader final chart audit, similar to the initial audit. UPIQ staff share information about change in the practices by comparing the baseline (initial audit) to the final audit and present this information to each participating practice. The practices get their own data and also see progress made by the other practices (although the other practices are not identified). UPIQ shares this information with the practices as part of a closing or wrap-up meeting among the practices.

Results

Results from chart audits conducted as part of UPIQ's first collaborative on preventive services (held in October 2003) show consistent improvement in the delivery of a number of preventive services within participating practice teams. (See Figures 6-8.)

²⁸ Julie Olson, *Building Partnerships to Improve the Quality of Healthcare: A Medicaid Perspective*, presentation delivered at the National Academy for State Health Policy's Annual State Health Policy Conference, August 8, 2005.

Figure 6 The percent of 12 months old who had HGB performed at well-child checks increased after the learning session²⁹

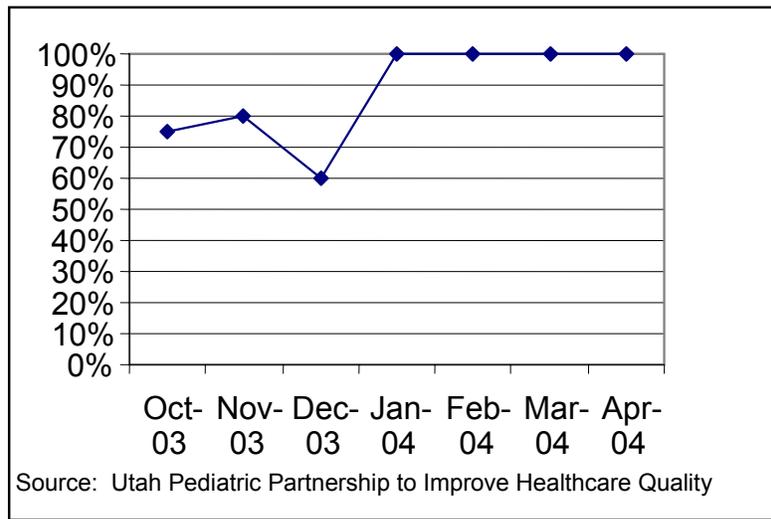
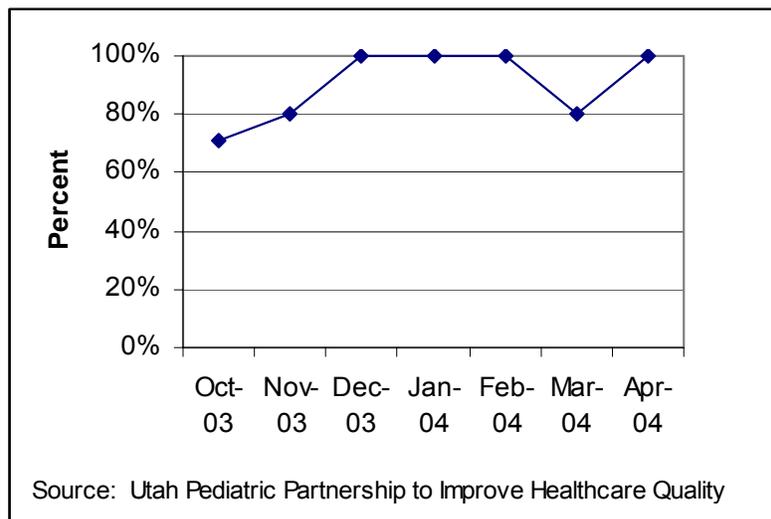
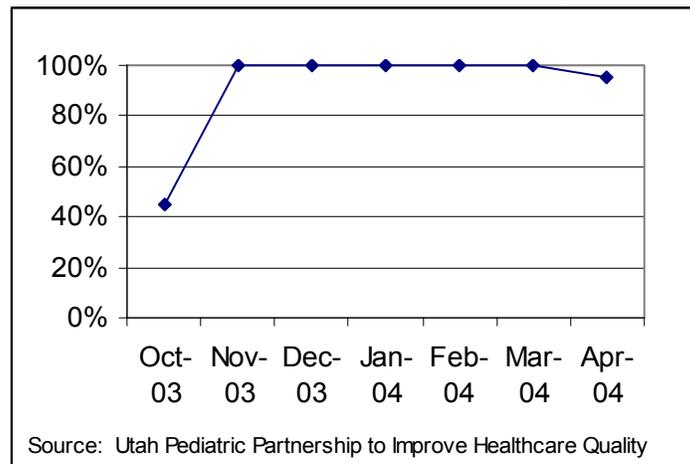


Figure 7 The percent of 2-year-olds who had height, weight, and head circumference plotted at well-child checks increased after the learning session



²⁹ In order to detect anemia, the American Academy of Pediatrics (AAP) recommends that hematocrit or hemoglobin (HGB) screens be performed between 9 and 12 months, with additional screening between the ages of 1 and 5 years for patients at risk. The AAP also recommends the plotting of height, weight, and head circumference at all well-child checks throughout the first two years of life.

Figure 8 The percent of 3-year-olds (and older) who had a vision screen at the well-child check increased after the learning session

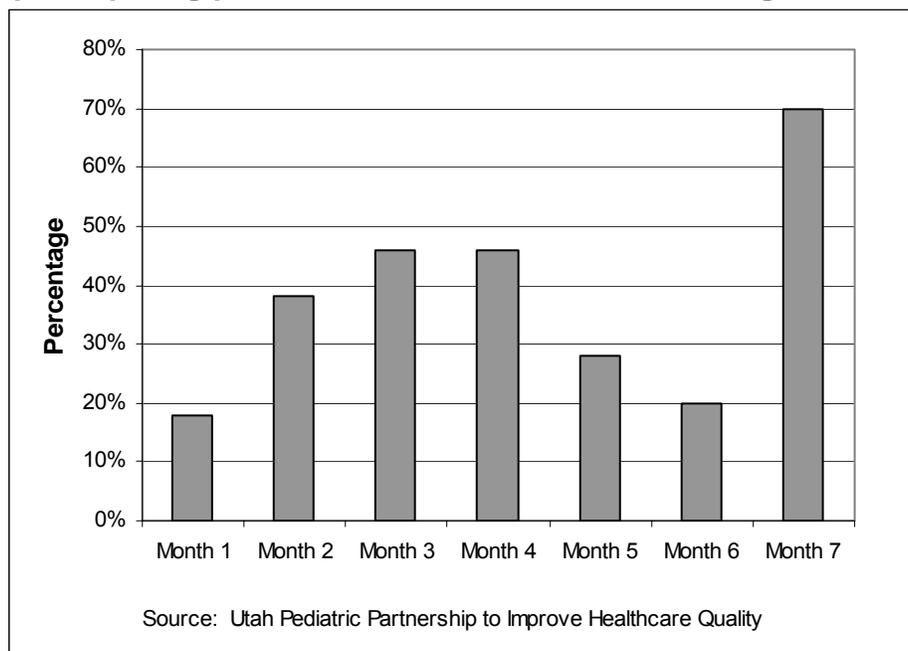


Results from the partnership's second collaborative (on developmental screening) indicate that:

- each participating practice selected one or more validated screening tools;
- each practice decided on a plan to implement regular social-emotional screening at well-child visits;
- each practice has reported on its progress through a monthly chart audit and conference call; and
- practices are collaborating with local resources.

In addition, the chart audits indicate significant improvement in the percentage of children receiving developmental screens in participating practices. (See Figure 9.)

Figure 9 The percent of children receiving developmental services in participating practices increased after the learning session



Julie Olson, the director of Utah’s Bureau of Managed Health Care, notes that the inconsistent data of months five and six are a direct result of changes in project staffing: “We had a huge void in the middle of this learning collaborative when our coordinator left and we had a hard time replacing her. This really speaks to the importance of the technical assistance we provide to the practices and to the importance of nagging them to get their data in!” Nonetheless, the overall results show a significant increase in the number of developmental screens being conducted within the participating practices.

Lessons learned

UPIQ project staff members have identified a number of lessons resulting from their work of the past two years. First and foremost, they believe that these partnerships must be led by physicians if they are to be successful. Other partners—especially those that bring complementary perspectives and resources to the project—are also important to developing and supporting improvement efforts.

Staff in Utah also note that participating practice teams value face-to-face contact with relevant community service providers and that such contact simplifies the development of referral and communication pathways. Utah staff say they learned this lesson by applying quality improvement principles to their own model. As Julie Olson notes: “An improvement partnership needs to practice what it preaches and continuously examine how it can improve itself.” She offers the following example:

We believed, based on feedback from the physicians, that they needed to understand and know the referral resources available within their communities. Initially, we invited representatives from various community service organizations to participate in the learning collaborative, asking them to spend the entire day with the practices. For a number of reasons this did not work well. For the next learning session, we invited the resource people to attend only for the afternoon, for a session in which we presented the community information. This worked much better. For the third session, we tweaked things a little more, so that the teams could spend more one-on-one time with the resource people and less time listening to the vast array of services that were available in their community.

Over the course of three learning sessions, UPIQ leaders identified three specific strategies to ensure that the time practice teams spent with representatives from community resources was productive.

1. Hold a pre-meeting with the community representatives to introduce the concepts that will be covered with the practice teams in the learning session and to define their role as a resource, not a driver.
2. Have the representatives attend only the part of the learning session that is focused on their services and on the planning of referral pathways.
3. Present community resource information to the practice groups in a clear and concise manner. Have one person present all of the information rather than having each program present an overview.

Those providing leadership to the UPIQ learning sessions also note the critical importance of providing ongoing support to participating practices. This support can take many forms but often includes providing practices with the screening tools; visiting with participants in their offices; basing the content of monthly conference calls on the needs and desires of participants; providing technical assistance; and, above all, cheering them on and celebrating their successes.

Benefits and drawbacks of the model

The current structure of the UPIQ model and partnership poses challenges that are primarily related to funding and staffing, and so the partnership is focusing its own quality improvement efforts on these two areas. UPIQ leaders note that although its learning collaboratives to date have addressed areas seen as important by steering committee members and supported by published evidence, the choices have also been driven by grants and available financial support. UPIQ leaders believe that stable and adequate funding would allow both the development of a strong infrastructure and more customer (community physician) driven selection of learning collaborative topics.

The members of the UPIQ steering committee report that they have developed a good working relationship. Nonetheless, they are honest about the challenges and issues that arise because the project is led by a group. These challenges include: the busy schedules of UPIQ leaders; the multiple demands and competing priorities they face; communication problems; and a limited understanding of one another's perspectives, roles, and constraints.

UPIQ has tried to be sensitive to the challenges that physicians and their staff regularly encounter. A day out of the office is typically costly and inconvenient. Implementing change in long-standing office routines and systems is difficult. In addition, medical and office staff may be reluctant to implement best practices, fearing that they may result in more work without an increase in reimbursement. This perception may be valid for some; although UPIQ has helped practices implement the use of a standardized screening tool efficiently (with minimal impact on practice flow).

An additional challenge is spreading the knowledge and skills developed by the participating practice teams to others within their own groups and within the community. UPIQ has seen limited evidence of spread within some group practices.

UPIQ leaders recognize that how the partnership addresses these realities will impact its ability to recruit practices to participate in future learning collaboratives. They believe that if practice teams find UPIQ sensitive to their issues, flexible in addressing challenges, supportive, and determined to help them make improvements, teams are likely to sign up for future collaboratives and to encourage other practices to participate.

Illinois: Practice-Based Education and Seminars

Overview: Purpose, design, and goals

Incorporating many of the characteristics that have been identified as contributing to effective provider behavior change,³⁰ the Illinois Chapter of the American Academy of Pediatrics (ICAAP)—in partnership with a number of organizations and funders, including several state agencies—has developed a series of practice-based activities. The topics for these activities are determined, in part, by annual needs assessments of ICAAP members; the sessions are developed by topic experts from the local academic community in consultation with practicing physicians and allied health care providers; and they are taught by Illinois physicians, nurses, physician assistants, and medical office staff members. Often, these trainers are based in the same communities as those they are training and share an understanding of the unique challenges faced by those participating in the learning session. According to Scott Allen, ICAAP’s executive director, this multi-disciplinary, peer-to-peer approach is often cited by participants as important to the success of the programs.

All of the learning sessions are interactive and include either the use of case studies, problem-based exercises, or hands-on learning tools. In addition, all programs feature segments on coding and billing and on staff roles.

ICAAP is particularly sensitive to the time constraints of doctors and their staffs and has used a number of incentives to make the sessions as convenient as possible. These include flexible scheduling and the opportunity to integrate the program into the practice’s routines; snacks or a light meal; CME and other continuing education credits; and complimentary patient education materials or professional manuals. Programs that require more than 90 minutes are often scheduled over two or more visits to a practice.

In addition to the office session, ICAAP frequently provides additional assistance to participating practices, including periodic topic-specific newsletters and mailings, teleconferences, and follow-up sessions. Some of the programs have also included phone consultation and other technical assistance from presenters to practice leaders.

³⁰ See page 13 of this paper. In brief, Scott Allen, ICAAP’s executive director, identifies the following as key characteristics of quality CME: multifacteted, brief, interdisciplinary, integrated into routine care, supported by leadership, learner-centered, and including feedback.

Recent ICAAP programs have included:

- **Get in the Zone: Asthma Education through Problem-Based Learning.** This program has been supported by GlaxoSmithKline since 2001 and the Illinois Department of Public Health since 2003. It has been conducted in more than 40 practices and served 400 attendees between 2002 and 2004.
- **Reaching our Goals (ROG): Immunization Provider Education.** A partnership between ICAAP and both the Chicago and Illinois Departments of Public Health, this program has reached over 1,300 physicians, nurse practitioners, nurses, and office staff through nearly 140 practice-based, residency program, and grand round presentations.
- **Screening Tools and Education for Pediatric Providers (STEPPS).** Initially sponsored by the Illinois Council on Developmental Disabilities, this project taught developmental screening to 44 medical practices and a total of 340 physicians, nurse practitioners, nurses, and other staff during its pilot phase.
- **STEPPS 2: Early Autism Diagnosis and Referral.** This program, supported by The Autism Program at The Hope School, has trained a total of 400 medical providers and office staff in 60 different sessions.

In addition, ICAAP is currently working with the state's Medicaid agency—the Illinois Department of Healthcare and Family Services (IDHFS)—to provide office-based training to four pilot communities³¹ that are being conducted by IDHFS as part of its ABCD II project, called *Healthy Beginnings* in Illinois.³² The project is focused on two major goals:

- increasing the number of young children who receive comprehensive primary care that addresses social and emotional development; and
- improving the provision of mental health related services to Medicaid-eligible women and their children under age three.

The state is working to achieve these goals by increasing the use of formal screening tools, increasing referrals for intervention services, and providing pediatric providers with improved access to materials on early childhood and perinatal mental health issues. To assist the state in accomplishing these goals, a Provider Information, Training, and Curriculum Committee has developed two office-based training programs: one on social-emotional development for children under three and the second on perinatal depression screening. The committee is chaired by the executive staff of the Illinois Chapter of the American Academy of Pediatrics and the Illinois Academy of Family Physicians, and its membership includes pediatricians, family physicians, nurses, and other individuals who work in the pediatric health and mental health fields.

³¹ Macon County, Kane County, Erie Family Health Center, and the Chicago Department of Public Health (CDPH) Lead Screening Program.

³² Unlike the other ABCD II state initiatives which are funded by the Commonwealth Fund, Illinois's *Healthy Beginnings* is funded by the Michael Reese Health Trust. IDPA serves as the lead agency, and the Ounce of Prevention Fund serves as the administrative agency.

As with other programs developed by ICAAP, these two trainings include an initial needs assessment of participating practices and the collection of baseline data related to current practices. Both of the trainings are designed to last approximately 90 minutes and to be conducted at the clinical site, with all staff present. In the first training, site staff are trained in the use of the Ages and Stages Questionnaire: Social Emotional (ASQ:SE).³³ The second training is devoted to the use of the Edinburgh Postnatal Depression Scale.³⁴ Representatives of local community resources, such as public health departments and early intervention, are invited to participate at the trainings to facilitate connections. Following the trainings, the pilot sites are asked to develop and follow specific protocols for social and emotional and maternal depression screening and referrals and data collection for 12 months. The trainings began in June 2005. Follow up includes monthly calls with pilot community leaders and ongoing collection of data on screenings and referrals. A more detailed overview of the Healthy Beginnings program and the pilot site trainings is available in Appendix C.

Unlike Utah's UPIQ collaboratives, which typically summarize information about available tools and resources and then ask participating practices to choose from a short list the tools they believe will be most effective in their work, the Illinois Healthy Beginnings pilot sites are receiving training in the use of very specific tools and protocols. As noted earlier, UPIQ ("you pick") believes strongly that the most effective way to work with providers in improving the quality of children's health care in Utah is to offer information and options and a framework for implementing choices. Officials in Illinois—also working in collaboration with the provider community in their state—have designed a quite different model, one with a history of success in their state. As Scott Allen of the Illinois chapter of the AAP notes:

We hear repeatedly from primary care providers that they do not have time to review and select tools (there are over 30 developmental screening tools!) and prefer to be given an expert opinion and training up front so they can start implementing the change immediately. We still support variation and provide technical assistance if a practice is not able to use the tool or strategy we promote, but such cases are rare.

Costs

Scott Allen notes that the cost to develop office-based programs and reach an initial 30 to 50 sites has ranged from \$50,000 to \$150,000, and that the costs decline once the development stage of an activity is completed. He also notes that—as is true of many such partnerships—ICAAP and its partners often rely heavily on in-kind services and volunteer energy.

³³ Information about the ASQ:SE is available at <http://www.brookespublishing.com/tools/asqse/>. Accessed 18 August 2005.

³⁴ Information about the Edinburgh Postnatal Depression Scale is available on the Web site of the Illinois Department of Healthcare and Family Services at <http://www.hfs.illinois.gov/mch/edinburgh.html>. Accessed 18 August 2005.

Evaluation

Each of ICAAP's programs includes an evaluation component. Before the training is conducted, participating practices complete a three- to four-page needs assessment to identify problem areas, current practices, and special needs. This provides both baseline data and guidance to the speaker before he or she arrives at the practice site. Each participant completes an evaluation at the end of the training session, and individual programs have used a variety of methods to evaluate the program's overall effectiveness. These have included pre- and post-tests, follow-up surveys, focus groups, and chart reviews.

As part of the evaluation of the pilot site trainings that have been developed for the Healthy Beginnings program, Illinois will collect data for 12 months in order to track, among other things:

- the change in the number of children under the age of three who receive formal social and emotional screenings and referrals as appropriate;
- the change in the number of mothers who receive a formal maternal depression screening and referral as appropriate; and
- the number of children and women identified as needing treatment who receive treatment.

Results

Results from the Healthy Beginnings training programs on social-emotional and maternal depression screening will not be available for some time, as the trainings began in June 2005. However, results from previous ICAAP practice-based education programs suggest that Illinois's model has been highly effective.

Figures 10 and 11 illustrate progress made in seven pilot practice sites that participated in "Get in the Zone: Asthma Education through Problem Based Learning in 2001-2002."

Figure 10 The number of referrals and undesirable health outcomes decreased after the learning session

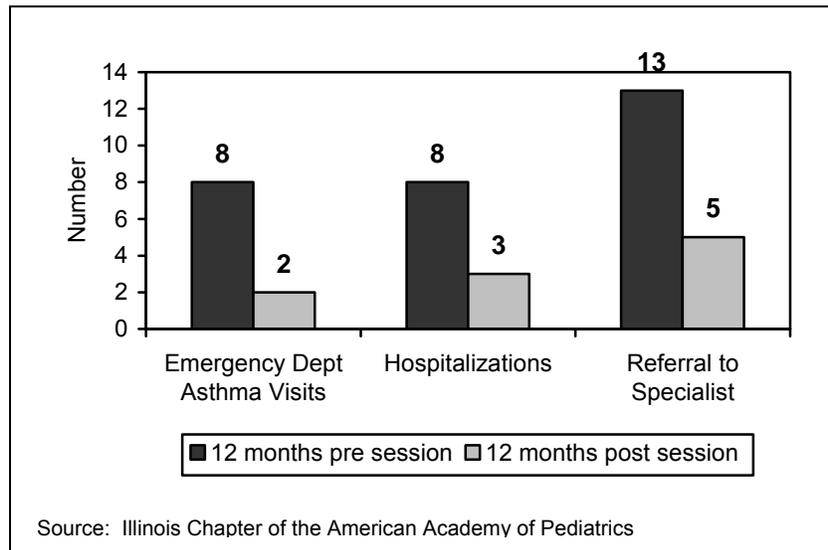
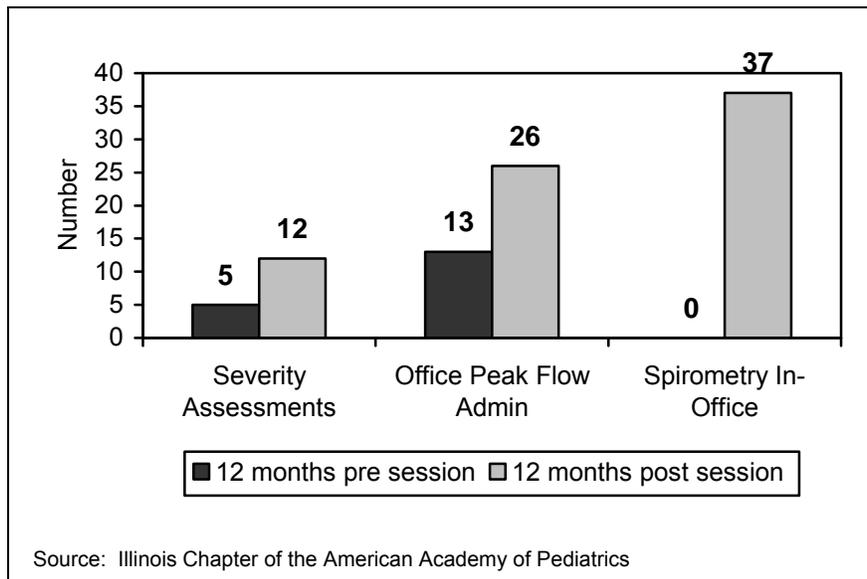


Figure 11 The number of desirable events increased after the learning session



The feedback from participating practices regarding the format and content of the ICAAP sessions is also positive. Of the 111 immunization provider education sessions conducted by ICAAP in 2004, follow-up was completed on 93. Of those 93 sites:

- 98 percent rated the sessions as interactive;
- 97 percent rated them as tailored to the needs of the practice;
- 87 percent of the sites reported changes in the practice due to the IEP session; and
- 61 percent of sites reported improved staff skills.

Lessons learned

Those engaged in Illinois' efforts to help physicians improve the quality of children's health care stress the importance of designing interventions that are learner-centered, self-directed, and relevant to clinical practice. In other words, change that is imposed from outside, or above, is rarely effective. As with the other models profiled in this paper, the most effective strategies are those that are designed in consultation with and/or led by physicians and their practice teams.

Illinois officials also note the critical importance of developing partnerships and leadership at the local and community level; within and among organizations (provider organizations, academic institutions; state agencies); and within practices. They have also found that incentives are important and can take a number of forms: CME credit, materials and resources for use within practices, food during the activity (particularly when scheduled around the noon hour), recognition from peers, reimbursement, and stipends.

Illinois officials have also identified a number of challenges that they have encountered in this work. One key challenge is the difficulty of adapting guidelines for all settings. As they note, small and large practices often have very different needs and realities. What works well for one size or location may not work well for another. Identifying, utilizing, and supporting motivated leaders can also be challenging. Individual providers within a practice setting may be eager to improve services but may face barriers internally and may need the commitment of the entire practice in order to initiate the program and implement new strategies. Finally, the role of consumers (patients, families) remains largely unexplored in terms of their ability to help develop training, express a desire for improved services at both the practice and community levels (and thereby drive practice change), and contribute to evaluation efforts.

Benefits and drawbacks of the model

Benefits

Practice-based activities that are 60 to 90 minutes long require a relatively small commitment of time from providers and their staffs. On-site programming means information can be delivered to all of the health professionals and office staff within a practice, which reduces the burden on practice leaders to explain and encourage change. Illinois officials note that the content of these sessions can be personalized and made relevant to the specific systems and needs within the practice. In turn, information can be more easily adapted by the provider to the practice setting. Illinois' experience also suggests that these types of activities can have a significant impact on the patients served by a participating practice. Finally, by training large and diverse faculty teams rather than relying on a few experts, the model creates resources that might enable the program to continue, through continued volunteer effort or integration into training at hospitals or universities.

Drawbacks

Illinois officials note that the logistics of implementing these types of activities can be problematic. The model requires travel to multiple—often very different—sites; it is labor intensive; expensive (especially faculty time); and often difficult to schedule. They also note that by training small groups, the impact of the overall initiative may be reduced or require additional time to spread. Other challenges include the fact that speaker quality and expertise can vary, given the need to train large faculty teams. And unlike the learning collaborative model, practices do not network and learn from each other as easily.

North Carolina: Off-Site Workshop to Support State Policy and Quality Improvement in Private Practice

Overview: Purpose, design, and goals

North Carolina has worked closely with the pediatric and family practice community in developing training sessions designed to support best practices for developmental screening and surveillance in private practice as well as to reinforce the state's new Medicaid policy mandating the use of a standardized developmental screening tool at certain EPSDT visits.

On July 1, 2004, the North Carolina Medicaid program began requiring that clinicians use a formal standardized developmental screening tool at specified well-child visits. In order to be reimbursed for this activity, clinicians are required to list the screening code on the claim form. Before the new policy took effect, the North Carolina Pediatric Society, the Academy of Family Physicians, Early Intervention, Family Support Network, the North Carolina Office of Research, Demonstrations, and Rural Health Development's ABCD project, and parents worked together to develop and conduct a one-day training in local communities across the state. Providers were offered 5.5 free CME credits for attending the training. The curriculum included information on aspects of the Individuals with Disabilities Act (IDEA) and Early Intervention in North Carolina. In addition, it included components on integrating screening into practice and how to talk with families about developmental issues. A case study was reviewed, parents shared their stories, and clinicians were offered an opportunity to network with local community staff who serve children.

Costs

Sixty-nine providers participated in one of the seven trainings which, in all, cost an estimated \$13,000, a figure that included the costs of mailings, honoraria, materials, meals, and refreshments. Speaker time, travel, and meeting space were all in-kind contributions. The cost of the personnel needed to develop the curriculum, secure speakers, arrange logistics, conduct and analyze evaluations, and otherwise organize the trainings is also not included in this figure.

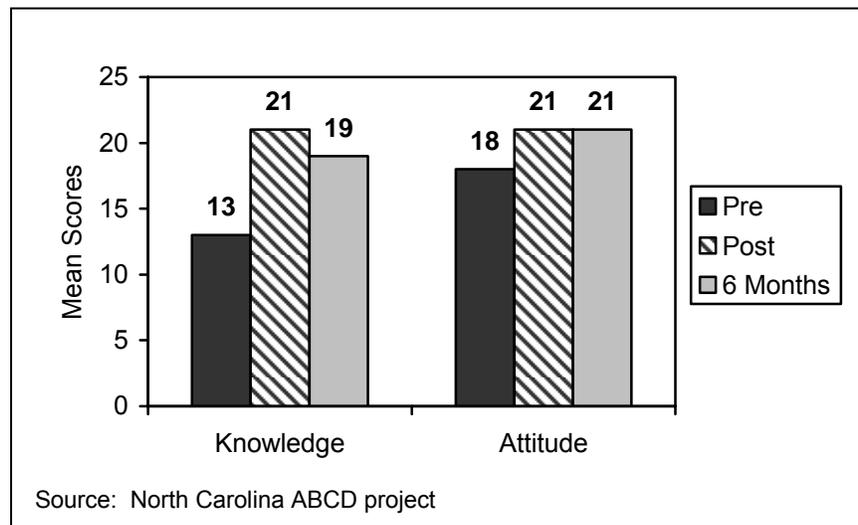
Evaluation

The North Carolina project conducted three surveys of individuals who participated in the day-long training. Pre- and post-surveys were administered on the day of the training to measure baseline knowledge and the perceived impact of the day's training. A third survey was mailed two to six months after the training to measure the long-term impact.

Results

According to project staff, the curriculum was associated with statistically significant positive changes in both providers' knowledge and attitudes about developmental screening. (See Figure 12.)

Figure 12 Provider knowledge and attitude improved after the training



In addition, the project reports that the number of teams responding to all three surveys who indicated that they were using a screening tool increased from 69 percent to 81 percent. The use of a validated screening tool with appropriate sensitivity increased from 27 percent to 54 percent. In addition, the percentage of families receiving information about Early Intervention and services either most of the time or always increased from 55 percent to 78 percent.

Since July 2004, the North Carolina ABCD project and the Office of Research, Demonstrations, and Rural Health Development have offered five, one-day practice trainings on how to integrate developmental screening into the office workflow. In total, 175 people from 60 different practice quality improvement teams attended those trainings. Each team was asked to include a physician champion, nurse manager, office manager, and a member of the billing staff.

The curriculum for the training was developed by a multi-disciplinary team co-chaired by Dr. Marian Earls, a developmental and behavioral pediatrician who serves as medical director of Guilford Child Health, Inc. and is a leader of the North Carolina chapter of the American Academy of Pediatrics, and by Sherry Hay, the ABCD project coordinator for the state. (See Appendix D for the program agenda and a list of those contributing to the program's curriculum development.) The curriculum is divided into five parts and is designed to help teams:

- integrate screening into the well-child visit;
- develop community relationships, identify resources, and make referrals;
- determine an effective and efficient workflow within the office that incorporates developmental screening;
- apply the correct coding and billing procedures; and
- measure the results of their efforts.

Project organizers estimate the cost of the five trainings to be \$6,800. This amount includes materials and meals. Personnel, speaker time, travel, and meeting space were all provided as in-kind contributions.

For practices unable to attend the day-long training on integrating developmental screening into an office's workflow, North Carolina has developed a one-hour video and companion workbook. The video provides clinicians and their staff with four self-contained learning modules that include information from a variety of practices around the state. The video is designed to offer a better understanding of both how practices have successfully integrated developmental screening and surveillance into the office workflow and what challenges these practices have encountered as they have undertaken the work.

Evaluation and results

The North Carolina ABCD project surveyed all the practices who attended the training. Of the 45 percent who responded, all have instituted an office system for using a standardized developmental screening tool at the specified visits. Responses to how the workflow has changed varied from "has actually improved patient flow" to "time necessary for completion requires parents to be in office 5 to 10 minutes longer."

Lessons learned

As with so many other states working to support physician efforts to improve the quality of children's health care, North Carolina officials note the importance of working closely with the physician community. They stress that the place to begin is with the needs and interests of providers. And they strongly recommend both identifying a physician champion to help lead activities and involving that individual from the start of the project. In addition, they note the importance of working to align—again from the start—the goals of all partners, to help ensure success and minimize frustration and dissent as the project is implemented.

The leaders of the North Carolina training programs also stress the importance of providing networking opportunities for physicians, their office teams, and the representatives of community service agencies and programs. They note that face-to-face contact helps to strengthen communication and cooperation among all partners.

Speaking at NASHP's 2005 annual conference, Dr. Marian Earls, medical director of Guilford Child Health in Greenville, NC, and a leader in North Carolina's efforts to strengthen the quality of children's health care, talked about the importance in her state of starting small (with just a few practice teams), collecting data, and being able to show evidence of progress. This

evidence, often presented to physicians and their practice teams in combination with the direct experiences and stories of their colleagues in other practices, has done much to spread change throughout the state.

Finally, Dr. Earls encourages states and others interested in this work to be creative when looking for funding. She suggests looking to all those who—broadly speaking—have an investment in quality improvement.

Benefits and drawbacks to the model

Benefits

According to state officials and those who have helped lead North Carolina's efforts, their programs offer providers opportunities to learn new practices and office systems from other clinicians who have been successful and are enthusiastic about the changes they have accomplished. The sessions are not designed to suggest or impose a single solution to the challenges confronted by practice teams. Rather, providers are free to take information and customize it to meet the realities of their individual practices. Hearing how other providers have adapted recommendations and systems to fit their particular needs can be especially helpful. The model requires a relatively small investment of time from providers.

North Carolina officials also stress the importance of including the expertise and experiences of community partners and parents in the day-long sessions. And they stress that professional associations are involved in the activities from the beginning.

Drawbacks

Although the costs of the North Carolina activities have been relatively low, leaders note that the activities have been heavily dependent on in-kind contributions, including personnel costs. They also note that the activities are labor-intensive to develop.

The District of Columbia: Technology-Based Effort to Enhance Provider Understanding of EPSDT Requirements

Purpose

In an effort to enhance health professionals' understanding of the requirements for delivering and documenting EPSDT services to Medicaid-eligible children in the District of Columbia (DC), the District's Medical Assistance Administration (its Medicaid agency) has contracted with the Well Child/Bright Futures Project at Georgetown University to develop a Web-based, interactive HealthCheck Provider Education System that includes a distance learning training curriculum and corresponding on-line resources.³⁵

Goals

The HealthCheck curriculum and resources are designed to help health professionals to:

- ensure optimal growth and development in all children and teens;
- provide all required HealthCheck/EPSDT services at each preventive health visit; and
- record and document all services provided.³⁶

Project design

Designed as a self-directed, on-line learning experience, the system provides a review of important HealthCheck and EPSDT requirements and services and offers current information and updates about EPSDT services. The curriculum begins by walking users through information about EPSDT, from outreach and coordination to documentation and billing. It then provides an in-depth discussion of the components of a health visit: health and developmental history, physical examination, health screening and laboratory tests, immunizations, and anticipatory guidance. The content of the curriculum is based on:

- the EPSDT HealthCheck Manual developed by DC's Collaborative of Medicaid Medical Directors;
- the Bright Futures materials developed with funding from the U.S. Maternal and Child Health Bureau; and
- Medicaid and EPSDT information from the Centers for Medicare & Medicaid Services.

³⁵ EPSDT is Medicaid's mandated program for ensuring that eligible children (birth to 21) receive comprehensive health services. However, a 2001 study by the U.S. Department of Health and Human Services' Office of the Inspector General found that less than 50 percent of the children in the study sample received any documented EPSDT services. (U.S. General Accounting Office. July 2001. *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*. Washington, DC: U.S. General Accounting Office).

The District of Columbia is one of a number of states currently under court order to improve its delivery of EPSDT services.

³⁶ For additional information, go to Bright Futures at Georgetown University. District of Columbia's HealthCheck Provider Education System. <http://www.brightfutures.org/healthcheck.html>. Retrieved 19 August 2005.

In addition to developing the HealthCheck Manual, the District's medical directors collaborative (made up of both practicing physicians and administrators of managed care organizations) provided feedback to project staff on everything from content to ways to make the system appealing to a provider. Project staff members report that the medical directors' contributions to the process were critically important and that the members of the collaborative were highly motivated to build a system that would improve the quality of services that were being provided to the District's children.

Project staff also note that the system offers providers a substantial storehouse of information, one that—in addition to offering a focused curriculum—is designed to meet ongoing needs. The system includes detailed sections on special health issues (e.g., dental health, HIV, child abuse and neglect) as well as a large body of resources, among them reference materials, family materials, links to growth charts and immunization schedules, and contact information.

The system, which was scheduled to go live in 2006, was pilot tested in the summer of 2005 by a cross-section of health providers, administrators, and managed care representatives. It is expected to serve some 1,500 to 2,000 individuals (both Medicaid health providers and Title V providers) and will award continuing medical education credits to those providers who complete all parts of the training. (The granting of CMEs is based upon successful completion of questions at the end of each unit, and they will be issued through Georgetown University.) The CME sections of the site will be password protected, but the system includes public pages that are accessible at <http://www.brightfutures.org/healthcheck/resources>.

In order to promote the use of the HealthCheck curriculum, the D.C. Medical Assistance Administration will send information about the system to every provider who sees Medicaid-eligible children in the District, and managed care organizations will strongly recommend that providers take the course. In addition, the project is hoping to host a series of breakfasts to introduce the curriculum. Terminals will be available at these breakfast sessions so that providers can start the training immediately and have initial questions answered.

The project will also provide training to providers on how to document EPSDT visits using a new standard medical record form. The forms (there are seven in all, ranging in age from birth to age 21) were developed over the course of a year by a team of five doctors and were scheduled to be introduced for use in January 2006. (For a sample form, see Appendix E.)³⁷ In an effort to encourage proper documentation of services provided to Medicaid eligible children in DC, the Medical Assistance Administration is providing a “pay for performance” monetary compensation to providers who properly fill out each form. In addition, the HealthCheck system is working with a team of physicians to provide training and technical assistance to other physicians and providers in the proper use of the new forms.

The Well Child/Bright Futures Project at Georgetown University has used the experience it has gained in developing the HealthCheck system to create a more encompassing on-line curriculum, “Well-Child Care: A Bright Futures Curriculum for Providers in MCH and EPSDT/Medicaid

³⁷ All seven of the forms are available at <http://www.brightfutures.org/healthcheck/resources/>.

Settings” with funding from the U.S. Maternal and Child Health Bureau. This national EPSDT curriculum is scheduled to be available in early 2006.

Costs

Project staff report that the initial cost of the HealthCheck Provider Education System was approximately \$250,000, a figure that covered a 14-month system design and development process. Subsequently, the District’s Medical Assistance Administration has awarded an annual maintenance contract of approximately \$65,000 to the Well Child/Bright Futures Project at Georgetown to cover the costs of ongoing system support and maintenance and to provide technical assistance to providers on the use of the standard medical record forms.

In addition, the project anticipates that there will be costs associated with the awarding of CME credits for providers who complete the HealthCheck curriculum. The District’s Medical Assistance Administration is working with its collaborative of managed care organizations to work out a mechanism for covering these expenses.

Evaluation

In addition to an extensive pilot test phase, the project intends to evaluate the success of the HealthCheck Provider Education System in a number of ways. Providers who complete the curriculum will be asked to complete a self-assessment immediately after completing the course to track changes in knowledge and attitude. They will also be asked to respond to a follow-up survey asking how they are applying the information in their practices. Because CMEs will only be awarded to providers who score at least 70 percent on content questions at the end of each unit of study, the project will be able to track how well the system is helping to convey information.

Results

According to project staff, those who participated in the pilot testing confirmed that on-line learners need information in short, easy-to-read sections. Most testers also commented that they needed clear learning objectives at the beginning of each module so that they could be alert to the most important issues in each module. Reviewers were enthusiastic about the amount of resources available through quick links. As busy professionals, they noted that they often lack the time to search out such materials themselves.

Lessons Learned

From the beginning of the project, staff were aware of the necessity to involve pediatricians and managed care organizations as active partners in developing the provider training materials. Assuring buy-in from the many entities involved in the project has been crucial to developing the HealthCheck system and the standard medical record forms. Project staff note the difficulty of bringing a large group of contributors to the table but stress that the involvement of so many was essential to ensuring that changes to the system would be accepted.

According to project staff, determining how the project would be funded and maintained has forced a great deal of creative thinking among partners. Building relationships among the District's Medicaid agency, its collaboration of managed care organizations, and university-based maternal and child health professionals has proved to be a driving force in making real change happen.

Benefits and drawbacks of this model

Benefits

Project staff note a number of significant benefits related to Web-based curricular materials: providers can complete materials on their own schedule and on demand; they can return to the Web site, whenever necessary, to get the latest pediatric preventive health care information; the system is available—at any time—to a large group of physicians for whom it was specifically designed; and aspects of the core curriculum, once developed, can be replicated and reworked to serve other settings and populations.

Drawbacks

The cost of developing a system similar to the District's HealthCheck Provider Education System may be prohibitive for some states. Nonetheless, a system that is able to disseminate training modules to a large number of providers has the potential to significantly improve compliance with state and federal regulations and enhance the quality of care.

Although the curriculum can be completed in approximately four hours, busy providers may find it difficult to complete the curriculum in one sitting. Those who are unable to do so may find it a challenge to complete the program at a later date. In addition, disseminating information about the system and enticing large numbers of physicians to complete the curriculum may prove to be challenging.

Project staff also note that some providers are significantly more comfortable with the system's technology than others. Those with little Web experience may find the curriculum more of a challenge than others. And, finally, the system does not allow for a great deal of interaction among physicians. It is a self-directed program, and although the project has worked to provide opportunities for physicians to explore the curriculum together, through group sessions in a computer lab, completing the curriculum is, ultimately, a fairly solitary activity.

SUMMARY OF LESSONS LEARNED

In researching this paper, we sought to identify a number of promising models used by states and their partners to improve children's health care quality. Some of the models are long-term, quality improvement initiatives that are fairly costly to implement and target a relatively small number of physicians and their practices. Others are designed to reach a wider audience and require less of a time commitment on the part of providers and fewer financial resources. Some are conducted in the providers' offices; others are held in off-site locations. Those that use technology are meant to reach as wide an audience as possible and to allow physicians to access the information whenever they wish.

Each of the models is significantly different from the others. As a result, many of the lessons learned by the leaders and participants of each model are somewhat unique. Therefore, each profile contains its own summary of lessons learned by those who helped shape and lead the effort. This section is designed as a summary of lessons that were common to most, if not all, of the models.

The Importance of Partnerships

States that have been successful in supporting efforts aimed at improving the quality of children's health care appear rarely—if ever—to act alone. According to those interviewed for this paper, the involvement of the physician community in all aspects of the development and implementation of these programs has been critical to their success.

Partnerships among agencies and programs that are involved in the health care of children are important, but the involvement and leadership of health care providers is essential; **the needs and interests of providers must be central to all efforts.** To ensure that providers are driving the work, it is important to identify and partner with provider organizations (the American Academy of Pediatrics, the American Academy of Family Physicians) and with individual physician champions, well respected doctors who care deeply about improving the quality of health care for children and who can articulate and spread the message. These partnerships need to be forged at the very beginning of the work. And providers need to play a prominent role as advocates for the programs and as peer educators. In all of the models profiled here, physicians have played lead roles in setting goals and priorities, developing the curriculum and training materials, and serving as peer educators.

States that have worked hard to build productive partnerships with providers note that the effort can pose a series of challenges. As one state official notes, potential partners may see Medicaid as nothing more than a funding source at best, and the bad guys at worst. Providers may need to be convinced that Medicaid or other state agencies share the same quality goals as they do. Julie Olson, Utah's Medicaid managed care director and a leader of the UPIQ partnership, told a session at NASHP's 2005 annual conference:

Many providers see Medicaid as the enemy. Honestly, we haven't always been wonderful to work with. We are making a shift from payers to partners and

recognizing that we are an important part of public health. We are just so good at saying no that it can be a culture shift for some.

She goes on to note that the effort involved in changing those perceptions can be well worth it:

A nice thing about these partnerships is that they provide us with a better understanding of the challenges faced both by Medicaid and by providers. It's harder to view the other team as the bad guys when you're engaged in productive dialogue.

Working with community partners

Keeping the needs of the physician practice central means that it is important to introduce community resources to help support quality improvement efforts within the practices. In other words, involving other partners is extremely important to ensuring that community resources are integrated and used to enhance the quality of care:

An important component of our collaborative was the learning session where each participating county's early childhood education and developmental professionals attended. At this meeting state representatives and representatives from five counties presented referral information and had working sessions with the medical providers in their vicinity. This session was very well received by the collaborative participants, and they have reported success in connecting with their county's Family Resource Counselor and preschools since then.

--Kirsten Wysen, Washington State

Supporting State Policy Goals

Activities designed to support providers' quality improvement efforts will be of greatest value to states if the work supports other state policy goals. For example, North Carolina's Medicaid agency established a new policy requiring that clinicians use a formal standardized developmental screening tool at specified well-child visits. Because the agency recognized that providers and their office teams would need assistance in changing their practices to comply with the policy, they worked with physicians and their professional associations to develop a series of day-long trainings across the state. The fact that the training would help the state meet its policy goals increased the states' interest in and support of the project. And the fact that providers had to find ways to comply with the new policies increased provider interest in the training.

Washington State is working to turn its regional Children's Preventive Health Care Collaborative into a statewide program. As part of that effort, county staff are looking at how the quality improvement measures disseminated through the collaborative's learning sessions can be used to support Medicaid purchasing policies. One strategy might be to introduce a small payment increase to capitated rates for the health plans that can demonstrate improved delivery of preventive services using specific quality measures.

Replication

Some of the models profiled in this report are designed to reach large numbers of providers. Others—as they are currently designed—target significantly fewer. For most states and their partners, reaching a large audience has proved to be costly and labor intensive.

Those who have been able to begin expanding their work to reach greater and greater numbers of providers have done so by starting small, tracking their progress (through data collection and evaluation), ironing out the kinks, and building both support and demand for the work. North Carolina is a good case in point. The state originally began with a pilot project, in which it partnered with a small number of primary care practices to support them in their efforts to coordinate and strengthen the early childhood development services they provided to low-income children and their families.³⁸ A centerpiece of this work was the introduction and integration of a validated developmental screening tool into the practice workflow. During the pilot, the participating practices gathered basic data about their current screening practices, information that was later used to demonstrate the success of the pilot. With this evidence from the pilots in hand, the state and its partners (including a physician champion and leadership of both the AAP and AAFP) were able to begin building support and demand for trainings. The success of the pilot also helped lead to changes in state policy. On July 1, 2004, the North Carolina Medicaid program began requiring that clinicians use a formal standardized developmental screening tool at specified well-child visits. As a result, the state and its partners have increased their training activities, offering a series of sessions across the state.

³⁸ For more about North Carolina's work in this area, see: H. Pelletier, M. Abrams, [*The North Carolina ABCD Project: A New Approach for Providing Developmental Services in Primary Care Practice*](#) (Portland, ME: National Academy for State Health Policy, July 2002).

Costs

Because the scope, duration, number of participants, and delivery methods of the models profiled here differ dramatically, it is difficult to make general statements about the cost of these activities. Some of the activities that are fairly brief and involve little follow-up have been conducted on a shoestring, with a great many in-kind contributions helping to defray the costs. Other models, designed to engage providers for long periods of time and/or that include a number of sites, the cost of travel for national experts, the development of technology-based tools, and subcontracts for evaluation services, can cost hundreds of thousands of dollars.

Sherry Hay, a leader of North Carolina's efforts to develop trainings that support or reinforce state policies and initiatives, notes that it's important to think broadly about possible funding sources:

Be creative and look to those partners who also have an investment in quality improvement. Share the costs and be practical in material design, etc. There are wonderful desktop systems that can produce professional materials. Keep evaluation simple and look to existing resources to help offset costs. State centers for health statistics as well as university systems can be invaluable.

Flexibility

Finally, nearly all of those working with providers and their practices to support improvements in the quality of children's health care note the importance of building flexibility into their efforts. Each model must be flexible enough to account for and meet the needs of various types and sizes of provider practices. In addition, no one model can do it all. Each model—as we note in the profiles—has its strengths and weaknesses. States and their partners would do well to consider the specific needs, issues, and realities of their provider community before choosing to adopt or adapt a model.

APPENDICES

- Appendix A** Materials from Washington’s Children’s Preventive Health Care Collaborative
- Appendix B** Materials from the Utah Pediatric Partnership to Improve Children’s Healthcare Quality (UPIQ)
- Appendix C** Overview of Illinois Healthy Beginnings Program and its Pilot Process
- Appendix D** North Carolina curricular materials
- Appendix E** District of Columbia Standard Medical Reference Form
- Appendix F** Contact Information

Appendix A

Materials from Washington's Children's Preventive Health Care Collaborative

- Overview
- Application Materials



PROJECT DESCRIPTION

The Children's Preventive Health Care Collaborative is an initiative to disseminate successful approaches—reinforced during the implementation of the Kids Get Care program—for improving the delivery of preventive services to low-income children. A comprehensive, integrated set of preventive services, including medical, dental, developmental and mental health services, is vital for children. This collaborative will focus on integrating oral health and developmental screening and referrals into children's primary care services.

The Children's Preventive Health Care Collaborative will focus on the adoption of fluoride varnish and the Ages and Stages Questionnaire within medical practices.

- Fluoride varnish has been demonstrated to reduce caries by 38%. Medicaid will pay medical providers \$13.39 to varnish children's teeth, up to three times per year. In most medical practices using this treatment, nurses or medical assistants apply fluoride varnish right before immunizations are provided.
- The Ages and Stages Questionnaire (ASQ) is a parent administered developmental survey. It takes parents about 10 minutes to fill out and typically takes providers two to three minutes to go over during a well child visit. It can detect 70 to 80 percent of children with developmental problems. By contrast, typically only 30 percent of children with developmental issues are identified before they reach kindergarten.

To get more information about the Children's Preventive Health Care Collaborative, please plan to join us for an informational teleconference call from **12 to 1 PM on Friday, October 29 or from 12 to 1 PM on Tuesday, November 9**. Dial (206) 205-1111 to hear more about the Collaborative.

Up to 10 pediatric and family practices that provide services predominantly to Medicaid children and up to 10 community health centers throughout Washington State will participate in the project from December 2004 to June 2005. It will be staffed by the National Initiative for Children's Health Care Quality and Child Health Institute personnel, more information about these organizations is available at www.nichq.org and www.childhealthinstitute.org.

The Collaborative will disseminate evidence-based best practices in delivering comprehensive preventive services to low-income children. Funding is being sought to

support additional case managers for the participating physician offices and/or community health centers that show the greatest engagement in the improvement process at the end of the first year of the Collaborative.

We will accomplish this mission by:

- Creating more efficient practice-based systems to organize oral health and developmental care,
- Integrating standardized, formal screening tools and anticipatory guidance into the practice workflow,
- Adopting innovative approaches and tools for assessing health care quality using family-centered tools, and
- Implementing techniques for streamlining referral processes and making connections to area pediatric dentists and community support agencies for the provision of oral health and developmental family-based services.

COST

Participation in the Children's Preventive Health Care Collaborative costs \$800 per team. This includes all the conference calls, meals, meetings and educational materials. Certification for Continuing Medical Education (CME) is in the approval process. A limited number of scholarships are available.

APPROACH

The project will take a focused approach in the form of a learning collaborative similar to the more traditional health care learning collaboratives: the Washington State Diabetes Collaborative and the Institute for Healthcare Improvement's Breakthrough Series Collaboratives. The Breakthrough Series brings together organizations that share a commitment to making substantial, rapid changes that will produce major improvements in health care.

There will be three face-to-face learning sessions in the Washington State Children's Preventive Health Care Collaborative—in January 2005, March 2005 and June 2005. Conference calls will be held before the meetings. Participants will learn from quality improvement experts, children's preventive health experts and experienced Kids Get Care clinic staff. Clinical teams will consist of three representatives: a physician, a nurse or medical assistant and an administrative staffperson. For clinics with co-located medical and dental clinics, a dentist will need to attend at least one of the learning sessions focusing on oral health.

Participants will be expected to collect baseline data before the first meeting, implement change strategies, report results monthly for each, and participate actively in the face-to-face meetings and conference calls. Active participation in each of the scheduled meetings and conference calls is important, since many of the most significant insights from this type of group process come as the participants learn from each other.

The King County Health Action Plan and Kids Get Care

Both the Collaborative and Kids Get Care are programs of the King County Health Action Plan, a seven-year-old coalition of health care and community organizations convened by Public Health-Seattle & King County. See www.metrokc.gov/health/kchap.

The Kids Get Care program has been in place in King County, Washington for three years at seven medical practices. Through a new federal grant, it will be expanding to additional sites in Snohomish and Pierce Counties in 2004 and 2005. The program pays for a case manager at participating clinics to assist in clinical administrative improvements as well as to undertake case management for high-risk families. Kids Get Care also provides training on preventive health care by a public health nurse for staff of nearby community "feeder" agencies, such as child care centers, or other organizations serving children in the target populations.

The program has demonstrated significant clinical improvements in the clinics' delivery of preventive services that translate into cost savings from reduced use of hospital services. For example, the Kids Get Care program increased the percentage of two-year-old clinic patients at three of the clinics who are up-to-date with well-child visits by 22 percentage points, from 53 to 75 percent. It is estimated that Kids Get Care reduced the cost of avoidable hospitalizations for these children by 19 percent.

The program also has increased the integration of medical, dental, mental health and developmental services at these clinics. At one participating medical clinic the number of oral health screenings completed by medical providers increased 14-fold from 7 per month in 2002 to 95 per month in the first half of 2004.

EXPECTATIONS FOR PARTICIPATION

Participating practices are expected to:

- Perform pre-work activities to prepare for Learning Sessions.
- Collect baseline data.
- Sign a data use agreement for de-identified data.
- Connect the Collaborative goals to their organization's strategic initiative.
- Identify a physician champion to work with the team to implement the quality improvement initiative.
- Identify a senior leader to sponsor the team(s) working in the Collaborative, and demonstrate that leader's commitment to supporting the success of the team and sustaining and spreading its accomplishments (including but not limited to attending at least one Learning Session).
- Send a multidisciplinary team to all three Learning Sessions.
- Provide resources and support to the team.
- Perform tests of changes that will lead to widespread implementation in the practice and the agency.
- Select well-defined measurements that relate to the organization's aims and plot them at least monthly over time for the duration of the Collaborative.
- Share data and reports with other Collaborative teams.

SCHEDULE OF EVENTS:

To help you decide about participating, please call in to one of our Information Calls.

Information Calls

*Please plan to attend **one** of these calls to get more information about this Collaborative.*

Call (206) 205-1111 to connect to the conference call.

Friday, October 29th, 12:00 – 1:00 p.m.

Tuesday, November 9th, 12:00 – 1:00 p.m.

If you join the Children's Preventive Health Care Collaborative, please plan to attend:

Pre-work Calls

*Please plan to have team members attend **one** of these calls.*

Call (206) 205-1111 to connect to the conference call.

Tuesday, January 4th, 12:00 – 1:00 p.m.

Friday, January 7th, 8:00 – 9:00 a.m.

Learning Sessions

All Learning Sessions will take place in the SeaTac area. All team members should plan to attend all Learning Sessions. The Senior Leader should plan to attend on Learning Session. (Dates are subject to change.)

LS1 – Tuesday, January 25th, 9:00 a.m. – 6:00 p.m.

LS2 – Tuesday, March 22nd, 9:00 a.m. – 6:00 p.m.

LS3 – Tuesday, June 14th, 9:00 a.m. – 6:00 p.m.

Conference Calls

During the period of time between Learning Sessions, called Action Periods, there will be monthly conference calls. The dates and times for these will be decided by LS1.

Listserv and email

Support for teams will be available through a Collaborative listserv and through email. Information of the listserv will be provided at LS1.

FORM YOUR IMPROVEMENT TEAM

Identify members of **your improvement team**. Each **practice** will assemble an improvement team consisting of a physician leader, an office staff member, and a nurse. Your team might expand as you see fit, but the team should not get so large as to make it difficult to get work done. Four to six members is generally a good maximum size for a team. If you include additional people, be advised that the three core members will need to attend the Learning Sessions. Optimally, you want to have input from different disciplines/perspectives at your clinical site (or individuals involved in different parts of the care process: physician, dentist, nursing, and administrative/front desk, medical records, information systems/data, etc). You may choose to invite certain participants to join a team meeting on an ad hoc basis. Do try to keep your core members as consistent as possible throughout the Collaborative.

Your improvement team will be identifying and carrying out tests of change. The Model for Improvement will be the structural basis for identifying and testing these changes. Choose your team members based upon their knowledge and daily involvement with the processes involved in caring for your patients. Consider their interest and energy to make improvements in the care experiences for children and families. By improving care your team will also be improving staff experiences providing care. It is helpful to choose a **Day-to-Day Leader** from your team who is the critical driving force, someone who can assure that tests of change are implemented, data collection and entry completed, and care improved for children. The day-to-day leader needs to be able to work effectively with everyone involved in improvement efforts; the leader functions as the “key communication contact” between your team and Learning Collaborative staff. This leader needs to be someone with delegated authority to “get things done”, such as a clinic manager or head nurse.

Finally, each team should have a **Senior Leader**. This role is critical to the success of a Collaborative team. The Senior Leader is the visionary for your Collaborative team and is someone who works at an organization-wide level. This person ensures that the work of their Collaborative team is aligned with the organization's strategic goals, promotes the work of the Collaborative team within their organization or system, monitors the progress of the team, and facilitates the spread of the improvements throughout the organization. Generally, the Senior Leader should come to the first Learning Session.

If you have any questions regarding this Collaborative, please contact Nicole Reavis by phone at 206-616-3307 or by email at nreavis@u.washington.edu.

APPLICATION FORM

Practice Name: _____

Mailing Address: _____

Main Phone Number: _____

Main Fax Number: _____

Physician Champion: _____

Title: _____

Direct Phone: _____

Direct Fax: _____

E-mail: _____

Nurse: _____

Title: _____

Direct Phone: _____

Direct Fax: _____

E-mail: _____

Office Staff Member: _____

Title: _____

Direct Phone: _____

Direct Fax: _____

E-mail: _____

Please identify the **Day-to-Day Leader**/primary contact person: _____

I am including a check for \$800 made out to Public Health-Seattle & King County_____

Please put "KCHAP/8015/102" in the "For" part of the check.

Please invoice me for \$800 _____.

In order to accomplish project learning and reporting, will team members have access to the internet at work?

Yes _____ No _____

Senior Leader/Administrator

(This person will be the contracting authority for your agency.)

Name: _____

Title: _____

Organization: _____

Direct Phone: _____

Direct Fax: _____

E-mail: _____

We wish to apply for participation in the Children's Preventive Health Care Collaborative. As the Senior Leader, I fully understand the project's objectives and expectations. Furthermore, I agree to support the team and will work with them to remove any barriers and/or provide the resources necessary for them to achieve their improvement goals. Finally, I understand that I will be invited to attend the first Learning Session with my improvement team.

Senior Leader Signature: _____

This signature page must be faxed to Nicole Reavis, Project Director, at 206-616-4623 before your application can be accepted. The remainder of the application can be sent via email to nreavis@u.washington.edu or by mail to Nicole Reavis, Child Health Institute, University of Washington, Box 354920, Seattle, Washington 98195-4920.

The deadline for applications is November 30, 2004.

Appendix B

Materials from the Utah Pediatric Partnership to Improve Children's Healthcare Quality (UPIQ)

- UPIQ Charter
- Provider/practice worksheets
- Overview of collaborative activities
(post-training)

CHARTER

Utah Pediatric Partnership to Improve Children's Healthcare Quality (UPIQ)

Background

UPIQ was established in 2003 by the:

- Intermountain Pediatric Society/Utah chapter, American Academy of Pediatrics
- Department of Pediatrics, University of Utah Health Sciences Center
- Utah Department of Health Division of Health Care Financing
- Utah Department of Health Division of Community and Family Health Services
- HealthInsight, the federal contracted Quality Improvement Organization for the state of Utah
- Intermountain Health Care Primary Care Clinical Program

Each of these organizations shares a commitment to improving the health of Utah's children.

Mission

UPIQ's mission is to improve children's health by assisting pediatric and family medicine practices to deliver the highest possible quality of care to their infant, children and adolescent patients.

Vision

UPIQ is committed to the concept that every child deserves a medical home and that, in their medical home, they and their families will receive the highest quality of care, and that the providers of that care will be supported in and rewarded for their efforts to practice high quality, evidence-based medicine.

Overview

UPIQ serves as a resource to pediatric and family medicine practices and others who wish to improve the care they deliver to infants, children and adolescents. UPIQ works with practices by encouraging, supporting, facilitating and teaching practice teams to use effective quality improvement techniques and methods. UPIQ subscribes to the "*Model for Improvement*" that asks practices to incorporate three questions into the culture of their practice:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

UPIQ encourages practices to use "rapid cycles of change," that include the: *Plan, Do, Study, Act (PDSA)* framework for quality improvement.

UPIQ works by recruiting practice teams to participate in UPIQ-developed initiatives, such as, improving preventive services, improving developmental screening and assessment, incorporating new approaches to the care of overweight children, or other future objectives. These projects are important, but are only the vehicles for continuous

improvement in all areas of healthcare for the young. As part of this, UPIQ is also able to assist an individual practice or a group of practices in a project of their choosing. Finally, UPIQ welcomes the opportunity to cooperate with agencies, insurance plans, or others who have identified an area of child health care that they feel can be improved.

The Learning Collaborative Model

One model that UPIQ and others have used for practice based quality improvement is the **Learning Collaborative (LC)**. An LC is based on the belief that a group of practices working together will be more effective than a single practice working alone. In phase 1, an LC brings together practice teams who, together, determine:

1. What aspect of their practice they want to improve (what are they trying to accomplish?)
2. Because every improvement requires change, but not every change results in an improvement, practice teams must decide *how* they will know that a proposed change resulted in an improvement. This concept underscores the importance of *measurement* for quality improvement. Practices, working with UPIQ facilitators, decide what they will measure and how they will measure it. For example, UPIQ can provide assistance with tools to conduct chart audits.
3. What changes or innovative approaches can the teams develop that are (based on evidence from the literature or expert opinion or both) most likely to result in improvement?

In the next phase, practices implement (“do”), on a small scale, e.g., the next five patients, the planned change, see how it worked (study) and tweak or fix it (act) as needed. The cycle is then repeated frequently as part of the developing clinic culture of continuous improvement. UPIQ provides regular contact with the practice teams through conference calls, e-mails, phone calls, faxes, etc. to support and facilitate this critical step. Very brief monthly chart audits are conducted that are translated into run charts by UPIQ to help practice teams see their progress.

In the final phase of the Collaborative, practices come together to share their experiences with implementation, measurement and the results of their PDSA cycles. Since it is likely that teams will have had different experiences and results, the sharing of what worked and what didn’t provides a powerful collaborative learning opportunity for accomplishing future projects. UPIQ facilitates this shared learning experience by providing data to practices about what they and the other practice teams have achieved. It is planned through these recurring interactions to eventually redesign the social culture of pediatric healthcare to one of continuous learning and sharing. *Of course complete confidentiality of individual practice data is always maintained.*

Addendum 1

Preventive Services Collaborative Goals & Objectives

Practices are encouraged to “pick” their own goals, and tweak them, if necessary, to reflect the need in their clinic. UPIQ provided the following list as examples of goals the practices might select as their focus of change:

Two Year Old

- 100% of children will have an immunization record in the chart
- 90% of children will be fully immunized by the age of two. “Fully immunized” is defined as having 4 DTaP, 4 HIB, 3 Polio, 3 Hep B, 4 PCV-7, 1 MMR, 1 VZV, 1 Hep A, and Influenza.
- 90% of children will have a hemoglobin or hematocrit performed by 12 months.
- 100% of children aged 15 months – 4 years will be screened for risk of anemia. Risk factors include: low birth weight/prematurity, use of low iron formula, whole milk before 12 months, excessive whole milk (>32 oz) after one year.
- 90 % of children will have a dental assessment consisting of any of the following: fluoride, bottle in bed, advice to clean/brush teeth, advice to see dentist.
- 90% of children will have oral health promotion advice at least twice in the first year, once in the second year, and a recommendation for a dental visit at least once from 12-24 months.
- 100 % of children will be assessed for environmental smoke exposure.
- 100% of parents with children having environmental smoke exposure will receive counseling/literature.
- 100% of children will have a growth chart with height, weight, and head circumference plotted at each well child visit.
- 90% of children will have 9 well child visits in their first 24 months.

Four Year Old

- 100% of children will have a vision screening, or documented attempt, at 3 years. Children who are unsuccessfully screened will be re-screened within 6 months.
- 100% of children will have blood pressure testing, or documented attempt, at 3 years.
- 100% of children will have a growth chart with height and weight charted at each well child visit.
- 90% of children will have BMI calculated and recorded on the growth chart.
- 100 % of children will have a dental referral by age 3.
- 100% of children will have a reminder to use an age-appropriate car seat.
- 90 % of children will be fully immunized. “Fully immunized” is defined as having 4 DTaP, 4 HIB, 3 Polio, 3 Hep B, 4 PCV-7, 1 MMR, 1 VZV, 1 Hep A, and Influenza.

Addendum 2

Developmental Screening Collaborative Goals and Objectives

Objective:

The objective of this Learning Collaborative is that every child in Utah, age birth to three, will receive developmental screening as part of Well Child Care (WCC).

Developmental screening is defined as the use of a standardized tool at WCC visits to identify potential developmental and behavioral issues. A child with a positive developmental screen will receive an in-depth assessment and, if indicated, referral to the appropriate community resource or private provider.

Collaborative Goals:

100% of practices will have a written plan for developmental screening for all children in their practice.

100% of practices will initiate routine developmental screening, according to their written plan, as part of their standard approach to Well Child Care.

100% of practices will have a procedure outlining the referral process for children requiring further assessment.

100% of practices will have a procedure outlining the referral process for children requiring further intervention.

100% of practices will maintain current listings of available community resources and private resources.

Practice Goals:

100% of children will be screened for developmental delay.

100% of children with a positive screening will receive further assessment.

100% of children with an assessment that indicates the need for intervention will be referred.

100% of children needing developmental services will receive them.

100% of children referred for further assessment and/or intervention will have relevant medical information available to the referring agency or practitioner.

100% of children referred for further assessment and/or intervention will have a result of the interaction returned to the referring provider.

Addendum 3

Infant and Toddler age birth to three social emotional screening Learning Collaborative Goals and Objectives

Objective:

The objective of this Learning Collaborative is that every child in Utah, age birth to three, will receive social emotional developmental screening as part of Well Child Care (WCC). Social emotional developmental screening is defined as the use of a standardized tool at WCC visits to identify potential developmental and behavioral issues. A child with a positive social emotional developmental screen will receive an further assessment and, if indicated, referral to the appropriate community resource or private provider.

Collaborative Goals:

100% of practices will have a written plan for social emotional developmental screening for all children in their practice.

100% of practices will initiate routine social emotional developmental screening, according to their written plan, as part of their standard approach to Well Child Care.

100% of practices will have a procedure outlining the referral process for children requiring further assessment.

100% of practices will have a procedure outlining the referral process for children requiring further intervention.

100% of practices will maintain current listings of available community resources and private resources.

Practice Goals:

100% of children will be screened for social emotional developmental delay.

100% of children with a positive screening will receive further assessment.

100% of children with an assessment that indicates the need for intervention will be referred.

100% of children needing developmental services will receive them.

100% of children referred for further assessment and/or intervention will have relevant medical information available to the referring agency or practitioner.

100% of children referred for further assessment and/or intervention will have a result of the interaction returned to the referring provider.

Appendix C

Overview of the Illinois Healthy Beginnings program
and its pilot process

Healthy Beginnings
Illinois' ABCD II Project
Assuring Better Child Health and Development

Overview of
Healthy Beginnings and
The Pilot Process

Lead Agency: Illinois Department of Public Aid
Administrative Agency: Ounce of Prevention Fund

ABCD II is sponsored by The Commonwealth Fund
Technical Assistance is provided by the National Academy for State Health Policy (NASHP)
Healthy Beginnings is funded by the Michael Reese Health Trust

Healthy Beginnings, Illinois' ABCD II Project

OVERVIEW

In 2003 the Commonwealth Fund announced the Assuring Better Child Health and Development (ABCD) II initiative, which would explore the role of state Medicaid programs in promoting the social emotional health of children under age three. The Illinois Department of Public Aid (IDPA) submitted a grant proposal and was chosen to participate in this three-year initiative, along with California, Utah, Minnesota and Iowa. ABCD II started in January 2004.

Illinois has named its ABCD II Project *Healthy Beginnings*. The purpose of *Healthy Beginnings* is to focus on the role of primary care providers in addressing children's social emotional development. Physical and mental health are interconnected, and health care is a natural setting in which to promote social emotional development for young children and their families. The *Healthy Beginnings* effort promotes coordination between primary care providers and the public sector (local health departments, WIC and Family Case Management providers, and Early Intervention).

Healthy Beginnings has three goals:

1. Increase the number of children under age three who receive more comprehensive primary care that includes addressing social emotional development by:
 - Increasing the use of a formal screening tool
 - Increasing referrals for intervention services as appropriate
 - Increasing primary care providers' access to materials and education on social emotional development of children under age three and on perinatal depression
 - Increasing parents' awareness and access to materials on social emotional development, perinatal depression and referral resources
2. Improve the provision of mental health-related services to Medicaid eligible women and their children under age three when issues are identified by primary care providers
3. Provide lessons learned to inform future efforts that will lead to changes in statewide policy and practice in Illinois and in Medicaid programs in other states

The work involved in this project is being moved forward through Illinois' *Healthy Beginnings* Leadership Team and its five subcommittees: (1) Provider Information and Training, (2) Resources and Referral, (3) Client Information, (4) Policy, and (5) Evaluation. To accomplish the project's goals, the work of the subcommittees will include the following key strategies:

- **Develop and Implement Provider Training** with the goal of increasing primary care providers' awareness about appropriate screening and referral protocols for mental health issues among children under age three and perinatal women
- **Identify Resources for Referral** by working with the Bureau of Early Intervention (Part C), Office of Mental Health, and State Board of Education, as well as perform a review of Medicaid enrolled providers for identification of outpatient hospital clinics, mental health clinics and Federally Qualified Health Centers enrolled to provide behavioral health services

- **Clarify Current Policies and Implement Needed Policy Changes** by identifying the policies and reimbursement structures that already support these efforts, the policies and reimbursement structures that need to be clarified and better disseminated to Medicaid providers, and the policies and reimbursements that need to be revised or expanded
- **Increase Awareness of Parents** to become better informed about their children's development and social emotional health, as well as early childhood resources available
- **Enhance Service Delivery** by implementing pilots that test the training and referral protocols developed, and experiment how a social emotional and perinatal depression component can be incorporated in primary care practices
- **Evaluate the Project and Pilots** for lessons learned and inform future efforts that will lead to changes in statewide policy and practice in Illinois

Year one of *Healthy Beginnings* was a planning year. Year two is focused on establishing the pilots. In year three, the project will continue to support and collect data from the pilot communities, and offer the training curricula to 40 additional primary care practices.

Illinois' pilot project has been designed to test the training and referral protocols developed, and the integration of a social emotional and perinatal depression component into primary care practices. The three pilot communities are Macon County, Kane County and Humboldt Park in Chicago. In Macon and Kane the participating primary care practices include a Federally Qualified Health Center (FQHC) and independent pediatric and/or family physician practices. In Chicago, the participating primary care practice is the Humboldt Park family physician practice of Erie Family Health, an FQHC.

Other participating partners in each pilot community include the local health departments, the Child and Family Connections offices (CFC), which is the local entry point for Early Intervention/Part C¹ services, the All Our Kids: Early Childhood Network (AOK)², and community mental health agencies. Pilot communities were selected for their geographic diversity, large Medicaid populations, and the integration of the Early Intervention social emotional component by the local CFC. Once the primary care practices are trained, the pilot project will last 12 months.

The purpose of this document is to explain the *Healthy Beginnings* pilot project that will occur in Kane County, Macon County and Humboldt Park in Chicago. It will review the following:

- I. Pilot Structure/Leadership
- II. Training for primary care practices on social emotional development for children under age three and perinatal depression for new mothers, which will include screening tools and referral protocols

¹ **Early Intervention** is the Part C program from the federal Individuals with Disabilities in Education Act (IDEA) that provides services to children under age three who have developmental delays or disabilities. IDEA also funds Part B also known as special education, which provides services to children ages three to 21 who have disabilities.

² **All Our Kids: Early Childhood Networks** (AOK Networks) are community collaboratives committed to developing a high-quality, well-coordinated, easily accessible system of local services that promotes the positive development of all children under age five.

- III. Implementation of training by the primary care practices
 - a. Screening process to be used by the primary care practices
 - b. Referral protocol to be used by the primary care practices when further assessment, intervention and/or treatment is needed
 - c. Data collection requested of the primary care practices and CFCs for approximately 12 months

- IV. Availability of consultation to the primary care practices

It should be noted there is an additional pilot project that *Healthy Beginnings* has established with the Chicago Department of Public Health (CDPH) that is different from the model explained in this document. The CDPH pilot targets those children who are not receiving primary care services as determined through a data match between Medicaid/SCHIP and the mandatory lead screening reporting system. The CDPH Lead Screening Program's goal is to ensure that these children receive lead screening, immunizations, developmental and social emotional screenings, and appropriate referrals as needed. The highest risk populations in the highest risk communities are the priority of the Lead Screening Program. Deborah Saunders of IDPA Maternal and Child Health will be the liaison from the *Healthy Beginnings* leadership to support CDPH's implementation of a social emotional and perinatal depression screening and referral process as part of their lead screening program.

HEALTHY BEGINNINGS' PILOT PROCESS

PILOT STRUCTURE AND LEADERSHIP

For the pilot project to be successful, the primary care practices and the CFC offices will need support both from the local community and from the Healthy Beginnings' project leadership. The following provides the project structure at the local and state levels.

I. A Steering Committee is Should Be Convened by Each Pilot Community

Kane County, Macon County and Humboldt Park in Chicago each need to convene a steering committee that can support the implementation of the pilot project at the local level. The purpose of the steering committee is to coordinate community efforts and facilitate communication between all participants, identify issues that can be resolved at the local level, and identify issues that need support from the Healthy Beginnings project leadership.

Members of the Steering Committee should include:

- a. Healthy Beginnings Project Coordinator, a designee from the lead agency: Macon and Kane County Health Departments and Erie Family Health in Chicago
- b. Child and Family Connections (CFC)³ Manager and/or Social Emotional Consultant
- c. Representative from each participating primary care practices (administrative assistants or office managers)
- d. AOK Network Coordinator (Kane and Macon)
- e. Representative from community mental health agency, if possible

Specific Activities of the Steering Committee include:

- a. Provide leadership, coordination and guidance in the community
- b. Develop linkage agreements among partners to facilitate information sharing, especially regarding referrals and the sharing of information between the primary care practices and the CFCs
- c. Foster coordination and communication between primary care practices and the public sector as appropriate
- d. Participate in monthly technical assistance calls
- e. Identify ongoing issues, successes and barriers to share with Healthy Beginnings Project Liaison

II. Support is Provided from the Healthy Beginnings Leadership Team

The Healthy Beginnings Leadership Team will provide support to each pilot community. In addition to each pilot having their own liaison to facilitate communication, the Leadership Team will also provide regular technical assistance calls to discuss common issues across all three communities to problem solve and make decisions.

Healthy Beginnings Leadership Liaison for Each Pilot Community

- a. Chicago (Erie) – Dedra Markovich (312) 922-3863 x389
- b. Kane County – Carey McCann (312) 922-3863 x384
- c. Macon County – Denise Roberts (217) 524-7478

³ Child and Family Connections (CFC) is the entry point for children and their families receiving Early Intervention services.

Other Supports from Healthy Beginnings Leadership Team:

- | | | |
|-------------------------|----------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| a. Training – | Scott Allen and
Sarah Baur | Illinois Chapter of the American
Academy of Pediatrics (ICAAP) |
| | Vince Keenan and
Kate Valentine | Illinois Academy of Family
Physicians (IAFP) |
| b. Resources/Referral – | Carolyn Cochran Kopel
Lynn Liston | IDHS
Rockford Hospital |
| c. Evaluation – | Linda Gilkerson and
Katie McDonald
John Lavigne | Erikson Institute

Children’s Memorial Hospital |
| d. Client Information – | Patty Mack
Jan Fowler | Advocate Health Care
IDHS Office of Family Health |
| e. Policy – | Deborah Saunders
Denise Roberts
Dedra Markovich
Steve Saunders
Janet Gully | IDPA: Maternal and Child Health
IDPA: Maternal and Child Health
Ounce of Prevention Fund
IDHS: Office of Family Health
IDHS: Bureau of Early Intervention |

TRAINING

The curriculum for the training was developed by the Provider Information and Training subcommittee. This committee is led by Illinois Chapter of the American Academy of Pediatrics (ICAAP) and the Illinois Academy of Family Physicians (IAFP) and its membership includes pediatricians, family physicians, nurses, and other individuals who work in the pediatric health and mental health fields. Over the last year they have developed the curriculum that will be provided at the Healthy Beginnings training on social emotional development of children under age three and perinatal depression.

I. Attendance

The following participants in each pilot community are asked to participate in the training session or sessions:

- a. Primary Care Practices: Physicians, Nurse Practitioners, Physician Assistants, RNs, LPNs, MAs, Office Managers, Administrative Assistants and/or Clerical Staff
- b. Child and Family Connections (CFC) Manager and/or Social Emotional Consultant
- c. AOK Network Coordinator
- d. Other representatives from the local community's Healthy Beginnings Steering Committee who would like to attend
- e. Healthy Beginnings Project Liaison

II. Pre-Training

Before the training session the following activities will happen:

a. Needs Assessment

Sarah Baur from the Provider Training Committee will send a needs assessment document to each primary care practice prior to the training. Providers are asked to return the document as soon as possible. This assessment will inform the trainers on the current practices in the primary care sites, and will serve as baseline data about knowledge and practices before implementation of the Healthy Beginnings pilot project.

b. Collection of Baseline Data

Katie McDonald from the Evaluation Committee will contact each primary care practice prior to the training to collect data on their current practices regarding developmental screening of children birth to three, and perinatal depression screening for mothers up to one year after the birth of a child. A similar data collection system will remain in place for the duration of the pilot.

III. Training on Social Emotional Development for Children Under Three

The training on social emotional development for children under three will last approximately an hour and a half. The curriculum covers the following topics:

- a. Definition of Social Emotional Development
- b. Implementation of the Screening Process using the Ages and Stages Questionnaire: Social Emotional (ASQ: SE)
 - i. Pulling charts: who needs to be screened, who will screen, etc.
 - ii. Preparing the screening tool

- iii. Introducing the screening tool to the parent
- iv. Administering the tool
- v. Communicating the results to the parent
- c. Explanation of the Referral Process (when appropriate)
- d. Coding and Billing
- e. Accessing Consultation from ICAAP or the CFC Social Emotional Consultant as needed

ICAAP: Billing, record keeping, ordering/finding screening tools

CFC Social Emotional Consultant: Administering the ASQ: SE and referral process

IV. Training on Perinatal Depression

The training on perinatal depression will last approximately an hour and a half. The curriculum covers the following topics:

- a. Importance of screening for perinatal depression
- b. About Perinatal Depression
 - i. Baby Blues
 - ii. Perinatal Depression
 - iii. Perinatal Psychosis
 - iv. Perinatal Obsessive Compulsive Disorder
 - v. Perinatal Panic Anxiety Disorder
 - vi. Consequences of perinatal depression left untreated
 - vii. Effects of perinatal depression on infants
 - viii. The relationship between infant and mother
- c. Illinois' supports for perinatal depression screening
 - i. Reimbursement and Consultation Line
- d. Using the Edinburgh Postnatal Depression Scale
 - i. Introducing the screening tool to the mother
 - ii. Administering the tool
 - iii. Scoring the tool
 - iv. Communicating the results to the mother
- e. Referral and Follow-up
- f. Use of the UIC Consultation Line
- g. Roles within the Primary Care Practice
- h. Coding and Billing

IMPLEMENTATION OF TRAINING

After the completion of the training, the primary care practices are asked to follow specific protocols for coordinating social emotional and maternal depression screening and referrals, and data collection activities for 12 months.

Social Emotional Screening: Child arrives for a well-child visit at 6 months, 9 months, 18 months, and 24 months. At these visits the Ages and Stages Questionnaire: Social Emotional (ASQ: SE) is to be administered.

Primary Care Practices Must Develop Systems and Procedures to:

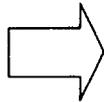
- Identify charts, prepare the tool and determine who will explain the tool to the parent and assist as needed, score the ASQ: SE, discuss results with the parent, and make decisions about referrals
- Accurately bill and keep records of screening results and referral decisions
- Complete and collect ABCD II evaluation cards after each screening, make copies of all the ASQ: SE screening tools and send all documents to the CFCs on the first day of each month
- Refer children to CFC when appropriate – the practices have 48 hours to send paperwork to CFC (protocol is on page 10)

PRIMARY CARE PRACTICES ADMINISTER ASQ: SE

At 6-month, 9-month, 18-month and 24-month well-child visits

THREE POSSIBLE OUTCOMES:

PASSES SCREEN
(BELOW Cutoff)

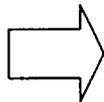


Primary care practices provide the following to the parents:

- Anticipatory guidance & monitor child's development
- Response to any concerns as identified on the ASQ: SE or verbalized by the parent
- Informational materials on infant/toddler development

OR

PASSES SCREEN
(CLOSE to Cutoff)

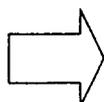


Primary care practices provide the following:

- Anticipatory guidance & monitor child's development
- Response to any concerns as identified on the ASQ: SE or verbalized by the parent
- Informational materials on infant/toddler development
- Determination of date to re-administer tool in the near future and request appointment to be scheduled if appropriate
- Referral to CFC if deemed appropriate based on clinical judgment or family's concerns and situation (protocol on page 9)
- Explanation of the role of the CFC and the reason for referral

OR

FAILS SCREEN
(At or ABOVE)



Primary care practices provide the following:

- Anticipatory guidance & monitor child's development
- Response to any parent concerns as identified on the ASQ: SE or verbalized
- Informational materials on infant/toddler development
- Referral to CFC (protocol on page 9)
- Explanation of the role of the CFC and the reason for referral

May 3, 2005

Maternal Depression Screening: Mother arrives with her infant for a well-child visit at 1 month, 4 months and 9 months. Mother is screened using the Edinburgh Postnatal Depression Scale.

Primary Care Practices Must Develop Systems and Procedures in order to:

- Identify charts, prepare the tool, and identify who will explain the tool to the mother and assist as needed, score the Edinburgh, discuss results with the mother and make decisions about referrals
- Accurately bill and keep records of screening results and referral decisions
- Complete and collect ABCD II maternal depression evaluation cards after each screening and send to the CFCs along with the social emotional documents on the first day of each month
- Identify procedures for emergency referrals

PRIMARY CARE PRACTICES ADMINSTER EDINBURGH

At 1-month, 4-month, and 9-month well-child visits

TWO POSSIBLE OUTCOMES:

SCORES POSITIVE
SCORE OF 10 OR HIGHER
OR
SCORE OF 1 OR HIGHER
ON ITEM #10

SCORES POSITIVE

The primary care provider conducts a further interview with the mother to determine if the mother does or does not have a plan or ideation to harm herself or the infant.

DOES NOT HAVE A PLAN

If the mother does not have a plan to harm herself or the infant, and the primary care provider does not have any immediate concerns for the mother or infant, the primary care provider:

- Makes a referral to a mental health professional and CFC
- Provides mother the ENH 24/7 Hotline in Kane and Chicago 1-866-ENH-MOMS (1-866-364-6667)
- If provider needs case consultation UIC Provider Line 1-800-573-6121

DOES HAVE A PLAN

If the mother has any plan or ideation to harm herself or the infant or based on clinical judgment the primary care provider has any immediate concerns for the mother or infant, the primary care provider:

- Must not leave the mother alone and should implement procedure for emergency referral
- Make referral to the CFC, in addition to implementing the emergency procedure
- Provide mother the ENH 24/7 Hotline in Kane and Chicago 1-866-ENH-MOMS (1-866-364-6667)
- If provider needs to case consultation UIC Provider Line 1-800-573-6121

SCORES NEGATIVE
SCORE OF 9 OR LESS
AND
SCORE OF ZERO ON
ITEM #10

SCORES NEGATIVE

Based on mother's and family's concerns, and clinical judgment, the primary care provider should determine if referral for further assessment is necessary. If the provider decides to make a referral, he/she should use the same process as for a woman that does not have a plan to harm herself or the infant.

RESOURCES AND REFERRAL PROTOCOL

The Healthy Beginnings Resources Committee has been working with the Child and Family Connection (CFC) site in each pilot community in order to generate a list of local early childhood and maternal depression resources for the primary care practices and the CFCs. The list of resources for your community is located in your practice's resource manual that is given to you during the training session.

In general, if a primary care provider has a concern about the social emotional development of a child, that child should be referred to the CFC for further assessment to determine eligibility for Early Intervention services. If the child is not eligible for services, the CFC will refer the family to prevention programs or other appropriate services in the community.

In general, if a primary care provider has a concern about perinatal depression, the mother should be referred to a local mental health agency and the CFC. The CFC will evaluate the child's eligibility based on child factors and relationship concerns between the child and primary caregivers. If the mother is identified as having a plan to harm herself or her infant, she should not be left alone and the primary care provider should implement their procedure for emergency referral to a hospital or community mental health agency.

Referral Protocol

Based on screening results and/or clinical judgment, a primary care provider makes the decision to refer a family for further assessment. Whether it is a referral to Early Intervention or to a mental health agency, the protocol would include:

1. Explanation to the parent as to why further assessment is needed
2. Explanation to the parent about who is the referral agency
 - a. Provide public awareness materials on Early Intervention
3. Ask parent to sign Release of Information
 - a. Disclaimer statement to protect primary care practice and women in regards to the perinatal depression screening and referral
4. Send referral/paperwork to referral agency:
 - a. How to send referral to Early Intervention:
 - b. What information to send to Early Intervention:
 - c. How to send referral to a mental health agency:
 - d. What information to send to a mental health agency:
 - e. Recommendations on emergency referrals perinatal depression
5. Establish a plan for follow-up appointment and/or treatment with parent and child

Individualized Referral Protocol

An individualized referral protocol has been developed for each pilot community. Specific instructions will be included in your practice's resource manual that is given out during the training.

Resources for Children over Three

Some of the primary care providers requested information on resources for children over the age of three. In response, community resources for children ages three to five will be included in your practice's resource manual even though this age group is not the focus of *Healthy Beginnings*.

EVALUATION

As part of the ABCD Project, all states are required to conduct an evaluation of their efforts.

I. Illinois will be collecting data for 12 months to determine:

1. The change in primary care providers' knowledge of social emotional development and perinatal depression.
2. The change in the number of children under the age three who receive formal social emotional screenings and referrals as appropriate.
3. The change in the number of mothers who receive a formal maternal depression screening and referral as appropriate.
4. The number of children and women identified as needing treatment who receive treatment.
5. Whether children in the Healthy Beginnings project are referred to the CFC at similar ages and rates of eligibility as children who are not part of the Healthy Beginnings Project.
6. Implementation dilemmas and solutions to inform future efforts.
7. The primary care practices' need for social emotional or perinatal depression consultation and satisfaction with consultation provided during the ABCD project.

II. Primary Care Providers' Role in the Evaluation Process

1. Identify an evaluation liaison to work with the Evaluation Committee
2. Complete the Needs Assessment prior to the training session and 12 months after the training. (The document will be sent to you from Sarah Baur, ICAAP.)
3. Complete a social emotional or a maternal depression screening card after each screening at the determined well-child visits for the full 12-month evaluation period.
4. Send the social emotional and maternal depression screening cards, along with copies of all completed ASQ: SE tools (whether positive or negative) to the CFCs on the first day of each month.
5. Provide information once a month on the total number of patients seen who were under age three and who were mothers with children under one year seen at the predetermined well-child visit intervals.
6. Participate in the following periodic surveys that will be conducted a few times over the year: knowledge survey, social emotional and maternal depression survey, social emotional consultation satisfaction survey, and a possible parent satisfaction survey. Katie McDonald of the Evaluation Committee will send the primary care practices the surveys when appropriate.

EVALUATION

III. CFCs' Role in the Evaluation Process

1. Identify an evaluation liaison to work with the Evaluation Committee.
2. Collect social emotional and maternal depression screening cards and copies of ASQ:SE screening tools from the primary care practices.
3. Provide to the Evaluation Committee (Katie McDonald) the following information on the first day of each month:
 - a. Number of copies of ASQ:SE screening tools received from each Healthy Beginnings practice
 - b. All social emotional and perinatal depression evaluation cards from each Healthy Beginnings practice
 - c. Number of children referred from each Healthy Beginnings practice/doctor
 - d. Number of ABCD children determined to be eligible for services
 - e. Number of ABCD children who received an IFSP
 - f. Average age of referral and rate of eligibility for non- Healthy Beginnings children

IV. Evaluation Committee's Role in the Evaluation Process

1. Support the primary care providers in completing the cards and providing data
2. Collect the screening cards from the CFCs
3. Support the CFC's collection of data requested
4. Enter the data collected from CFCs and primary care practices' completed forms

AVAILABILITY OF CONSULTATION

There are several topics in which the primary care practices may need consultation as they implement social emotional and perinatal depression screening and referral practices. The following is a list of topics, and the best sources for support and information regarding those topics.

I. Birth to Three Social Emotional Development

Administering and Scoring the ASQ: SE

CFC Social Emotional Consultant

Kane: Gayle Bridger, (630) 879-2277
gbridger@dayonenetwork.org

Macon: Mark Bridge, (217) 429-9275
m.bridge@insightbb.com

Chicago (Erie): Theresa Atchley, (773) 296-8080
tatchley@sbc.global.net

Referring the Family to the CFC

CFC Manager

Kane: Brenda Klemm, (630) 879-2277
bklemm@dayonenetwork.org

Macon: Debbie Floyd, (217) 423-6199
dfloydcfc@aol.com

Chicago (Erie): Melissa Lane, (773) 296-8080
melissa_lane@rush.edu

II. Perinatal Depression

Administering and Scoring the Edinburgh and referring a mother to a hospital or mental health agency

UIC Provider Consultation Line 1-800-573-6121

A 24/7 Hotline for women that is
available to pilots in Kane and
Chicago (not yet in Macon)

**Evanston Northwestern Hospital Healthcare
Postpartum Depression Program/24 hr Crisis Hotline
1-866-ENH-MOMS (1-866-364-6667)**

III. Billing, Coding, Recording Keeping Billing and Coding

ICAAP or IDPA

Sarah Baur, Project Director at ICAAP
(312) 733-1929, sbaur@illinoisAAP.net

IDPA 1-877-782-5565, www.dpainIllinois.com

Record Keeping

ICAAP

Sarah Baur, Project Director at ICAAP
(312) 733-1929, sbaur@illinoisAAP.net

IV. Healthy Beginnings Evaluation Process ABCD Screening Cards & Surveys

Katie McDonald, Evaluation Committee
(708) 769-1484, katiemcd@gmail.com

SUPPORT FOR THE PILOTS IN EACH COMMUNITY

When ABCD pilot participants have questions or issues to discuss about the Healthy Beginnings Project, contact your community's Healthy Beginnings Project Coordinator or your community's Healthy Beginnings Project Liaison as listed below:

Kane County

Alvina Eineke – Kane County's Healthy Beginnings Project Coordinator
Kane County Health Department's AOK Network Coordinator
(630) 232-5829 einekealvina@co.kane.il.us

Carey McCann – Healthy Beginnings Project Liaison
Ounce of Prevention Fund, Policy Associate
(312) 922-3863 x384 cmccann@ounceofprevention.org

Macon County

Michelle Bovyn – Macon County's Healthy Beginnings Project Coordinator
Macon County Health Department's AOK Network Coordinator
(217) 425-1500 x1351 mbovyn@maconcountyhealth.org

Denise Roberts – Healthy Beginnings Project Liaison
Illinois Department of Public Aid
(217) 524-7478 AIDD2042@idpa.state.il.us

Chicago (Humboldt Park)

Angela Rogers – Erie Family Health Center Project Coordinator
Title
Phone arogers@eriefamilyhealth.org

Dedra Markovich – Healthy Beginnings Project Liaison
Ounce of Prevention Fund, Assistant Director of Kids PEPP
(312) 922-3863 x389 dmarkovich@ounceofprevention.org

Appendix D

North Carolina curricular materials

“Setting the Stage for Success”

A Pediatric and Family Practice Training Integrating Developmental Screening into the Office Workflow

Agenda

8:45	Registration & Coffee	All
9:00	Welcome & Introduce the Day	Sherry Hay-“ABCD” Initiative Consultant
9:15	Integrating Screening into Private Practice ■ Family Centered Principles ■ Talking with Families about Developmental Screening	Sherry Hay/Marian Earls, Dev. Behavioral Pediatrician
10:30	Office Process Workflow Exercise	Marian Earls & Sherry Hay
11:15	Referral Process/ ■ Role of the Case Manager	Laniya Pinkston-Jones, Partnership 4 Health Mgmt.
12:15	Lunch & Exhibits/Networking	
1:00	Community Resources:	Laniya Pinkston-Jones,
1:30	Coding & Billing ■ HealthCheck Change	Lisa Gibson/Lisa Catron - DMA Managed Care Consultants
2:00	Performance Measurement	Joe Andrews, Perfect Numbers, Inc.
2:45	Closing	
3:00	Adjourn	

Sponsored jointly by; the Partnership 4 Health Management, the NC Office of Research, Demonstrations and Rural Health Development and the ABCD Initiative.

Appendix E

District of Columbia

-Standard Medical Reference Form

WELL CHILD/0 to 1 MONTH

MR #: _____

NAME		DOB	<input type="checkbox"/> M <input type="checkbox"/> F	DRUG ALLERGIES			<input type="checkbox"/> 1st Visit <input type="checkbox"/> Periodic Visit
DATE/TIME	INSURANCE ID #	AGE YRS	MOS	WEIGHT <input type="checkbox"/> lb. <input type="checkbox"/> kg.	%	HEIGHT <input type="checkbox"/> in. <input type="checkbox"/> cm.	%
ACCOMPANIED BY		PHONE 1	PHONE 2	IF INDICATED:	PULSE Ox	TEMP	RR
							P BP

Birth History/Parent Concerns

Completed

Pregnancy (medication, illnesses, drugs, ETOH) _____

Gestational age: _____ BW: _____ APGARS: _____

Complications: _____

Physical Examination (Unclothed)

NL ABN

General Appearance _____

Head / Fontanelle _____

Eyes / Red Reflex _____

Ears _____

Nose _____

Mouth/Throat _____

Lungs _____

Heart / Pulses _____

Abdomen _____

Genitalia _____

Extremities / Hips _____

Back _____

Skin _____

Neurologic _____

Social/Family History

Completed _____

Child Care: Yes No Type: _____

Review of Systems

Nutrition Assessed: Breastfed Formula _____

Elimination Assessed _____

Environment Assessed _____

Sleep Patterns Assessed _____

Development Assessed: (Use Table on Back) _____

OR DENVER DEVEL. II ADMINISTERED

OR OTHER TOOL ADMINISTERED: _____

Comments: _____

Assessment and Plan

Well Child Additional concerns or identified special health needs (detail below):

Hearing Concern Prematurity Other:

Assessment: _____

Plan: _____

Anticipatory Guidance Provided

Topics discussed and/or handout given

SUGGESTED AGE APPROPRIATE TOPICS ARE ON THE BACK

Immunizations/Screens

Newborn Metabolic Screen: Pending NL ABN _____

Newborn Hearing Screening: Pending Pass Fail

Immunizations Reviewed: First HBV given Date: _____

Immunizations Ordered:

HBV

Medical / Religious Exemptions: _____

Immunization Comments: _____

Referrals

Referral Made: _____

F/U Next Visit: _____

History and physical reviewed with resident at time of visit, agree with the diagnosis of _____ and treatment		
Provider	Print	Signature
Nurse	Print	Signature
Other	Print	Signature

ADDITIONAL COMMENTS: _____

NURSING NOTES: PAIN? No Yes Score _____
 Management: See Treatment Plan

BEHAVIOR AND DEVELOPMENT				
Age	Gross Motor	Fine Motor	Communication	Social
0 to 1 Month	___ Lifts head when prone ___ Equal Movements	___ Follows object with eyes	___ Vocalizes ___ Responds to stimuli	___ Smiles spontaneously ___ Looks at face

Suggested age appropriate topics for anticipatory guidance:

- NUTRITION
 - Breastfeeding
 - Formula
 - No solid food (wait until 4-6 mos)
 - Elimination
 - No honey
 - Review of WIC status
- ORAL HEALTH
 - No bottle in crib
- IMMUNIZATIONS EXPLAINED
- INFANT CARE
 - Skincare/bathing
 - Thermometer use
 - Good sleep habits
- BEHAVIOR & DEVELOPMENT
- PARENT-INFANT INTERACTION
 - Parental depression
 - Talk/read/sing to baby
 - Holding/cuddling
 - Temperament
- INJURY AND ILLNESS PREVENTION
 - Crib safety
 - Back to sleep
 - Child safety seat
 - Falls
 - Burns
 - Water heater
 - Smoke detectors
 - Sun safety
 - Violence/guns
 - Passive smoking
 - Never shake baby

INSTRUCTIONS

If the action was taken or completed, the open box must be marked (☑ or ☒).

If the child is enrolled in Medicaid, please be sure to print and sign your name in the space provided and fax or mail the completed form to:

**HEALTHCHECK REGISTRY
 POST OFFICE BOX 77498
 WASHINGTON, DC 20013-7749
 FAX: (202) 541-5907**

For further information on HealthCheck or Bright Futures go to www.brightfutures.org/healthcheck.html

Appendix F

Contact Information

CONTACT INFORMATION

Illinois

Deborah Saunders
Chief
Bureau of Maternal and Child Health Promotion
Illinois Department of Healthcare and Family Services
201 S Grand Avenue, E, 3rd floor
Springfield, IL 62763-0001
Phone: 217-524-7478
Fax: 217-524-7535
Deborah_Saunders@idpa.state.il.us

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American Academy of Pediatrics, Illinois Chapter
1358 W. Randolph, Suite 2 East
Chicago, Illinois 60607
312-733-1909
sallen@illinoisAAP.com

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Illinois Academy of Family Physicians
4756 Main Street
Lisle, IL 60532
Phone: 630-435-0257
Fax: 630-435-0433
vkeenana@iafp.com

North Carolina

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ACCESS II & III Program
Office of Rural Health
North Carolina Department of Health and Human Services
309 Ashe Avenue, Fisher Building
PO Box 10245
Raleigh, NC 27606
919-715-1511
Sherry.hay@ncmail.net

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1046 E. Wendover Avenue
Greensboro, NC 27405
336-272-1050, x2231
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