VCHIP CHAMP Collaborative:
Shared Learning for Improvement

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October 8, 2019
Disclosure

• I have no relevant financial relationships to disclose or conflicts of interest to resolve
• I will discuss no unapproved or off-label pharmaceuticals
1. FY 2019 CHAMP Collaborative Results: Caring for our Patients, Caring for Ourselves: Adolescent Mental Health and Substance Use and Provider Wellness

2. FY 2018 CHAMP Collaborative Results: SDoH: Family Well-Being and Food Security

3. FY 2020 CHAMP Collaborative: Office Systems Inventory Strategies to improve ADHD Diagnosis, Evaluation, and Treatment in your office
Core Elements of a VCHIP CHAMP Collaborative

1. Specific healthcare topic
2. Group of experts (clinical and QI)
3. A model or framework for improvement
4. Set of structured activities
5. Multiple teams from multiple sites

(A huge thank you to you, our network)
Adolescent Mental Health and Substance Use and Provider Wellness

Clinical and QI expertise

Planning Committee
- Wendy Davis, MD CHAMP PI
- Breena Holmes, MD
- Ilisa Stalberg, MSS, MLSP
- Erica Gibson, MD
- Barb Frankowski, MD
- Stan Weinberger, MD
- Anya Koutras, MD
- Michelle Shepard, MD
- Laurel Omland, MS
- Maya Strange, MD
- Chris Pellegrino, MS, Director
- Julia Walsh, Data Manager
- Ethan Rogers, BS, Coordinator

Reviewers/Presenters
- Laura Bernard, MPH
- Steven Broer, PsyD
- Rebecca Chaplin, MS
- Steven Chapman, MD
- Andrea Green, MD
- Michael Hoffnung, DO
- Danielle Jatlow, LICSW, LADC
- Jody Kamon, PhD
- Laurel Leslie, MD, MPH
- Eliza Pillard, LICSW
- Susan Pullen, LICSW
- Andrew Rosenfeld, MD
- Win Turner, PhD, LADC

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Vermont Child Health Improvement Program
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Model or Framework for Improvement

Goals and Measures set to improve:

- Adolescent Depression Screening and Follow-up
- Adolescent Substance Use Screening and Follow-up
- Anxiety Screening/Assessment and Follow-up
- Emotional Well-Being Assessments and Discussions
- Provider Wellness
Multiple Teams
Evidence-Based Structured Interventions

Promote a Collaborative Process:

October: Learning Session/Project Launch

November – May:
- Teams meet: submit/review data/activities
- Monthly Topic-specific Webinar/Phone Calls
- Discuss challenges and successes
- Share interventions/resources

Tools, Resources, and Shared Learning:
- Screening Tools
- Plans of Care
- SBIRT; Motivational Interviewing, Brief Negotiated Interview
- Mental Health Survey
- Office Systems Inventory
- Webinar Calls
Adolescents Age 11-21 Screened for Depression with a Validated Tool

Screening Type | # Total
---|---
PHQ-2 | 573
PHQ-9 | 711
PHQ-9a | 642
DART | 78

Goal, 92%
Adolescents Age 11-21 with a Plan of Care if Positive Screen for Depression

![Graph showing the percentage of adolescents with a plan of care over a 6-month period. The graph indicates a consistent percentage ranging from 94% to 100%.]

- Month 1: 97%
- Month 2: 100%
- Month 3: 100%
- Month 4: 97%
- Month 5: 97%
- Month 6: 94%
Adolescents Age 11-21 Screened for Alcohol and Drug Use with a Validated Tool

CRAFFT was used 85% of the time

good, 38%
Adolescents Age 11-21 with a Plan of Care if they had a Positive Screen for Alcohol/Drug Use

% with Plan of Care

Month

B1 B2 B3 1 2 3 4 5 6

67% 75% 67% 67% 71% 95% 100% 94%

goal, 66%
Adolescents 11-21 with a Plan of Care if they had a Positive Screen for Anxiety
Adolescents 11-21 assessed for Emotional Well-Being

Assessed for Emotional Well-being (EWB)

% Assessed for EWB

84% 87% 91% 91% 87% 85% 92% 91% 93%

B1 B2 B3 1 2 3 4 5 6

Month
### Abbreviated Maslach Burnout Inventory™

<table>
<thead>
<tr>
<th>Item</th>
<th>Every day</th>
<th>A few times a week</th>
<th>Once a week</th>
<th>A few times a month</th>
<th>Once a month or less</th>
<th>A few times a year</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>I deal very effectively with the problems of my patients</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>I feel I treat some patients as if they were impersonal objects</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>I feel emotionally drained from my work</td>
<td></td>
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</tr>
<tr>
<td>I feel fatigued when I get up in the morning and have to face another day on the job</td>
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<tr>
<td>I've become more callous towards people since I took this job</td>
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<tr>
<td>I feel I'm positively influencing other people's lives through my work</td>
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</tr>
<tr>
<td>Working with people all day is really a strain for me</td>
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<tr>
<td>I don't really care what happens to some patients</td>
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<td></td>
</tr>
<tr>
<td>I feel exhilarated after working closely with my patients</td>
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<td></td>
</tr>
</tbody>
</table>
In other news …

Child Health Advances Measured in Practice (CHAMP)

Social Determinants of Health:

Why choose food insecurity and parental depression?

1. Household hardships do not occur in isolation - they are a constellation
2. Food insecurity and parental depression cost the health care system billions of dollars each year
3. Food insecurity and parental depression are devastating to children’s health and wellbeing
Family Well-Being

Parent/Caregiver Assessed for Depression

2016: 60%
2018: 72%

Mother Assessed for Depression

2018: 63%
Family Well-Being

% Mothers Assessed with Validated Tool

Year

2016  32%

2018  68%
Food Security

% Assessed for Food Security

Year

2016 2017 2018

30mo 6yr 13yr

16% 27% 48%

12% 15% 32%

8% 12% 30%

10 20 30 40 50 60

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Vermont Child Health Improvement Program
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ADHD CHAMP Collaborative
Clinical and QI expertise

Learning Session and Project Committee/Work Group

- Wendy Davis, MD, CHAMP PI
- Breena Holmes, MD
- Ilisa Stalberg, MSS, MLSP
- Stan Weinberger, MD
- Anya Koutras, MD
- Michelle Shepard, MD
- Joseph Hagan, MD
- Laurel Omland, MS
- David Rettew, MD
- Sharonlee Trefry, MSN, RN, NCSN
- Leah Costello, MD, FAAP
- Susan Richardson, PhD
- Avery Rasmussen, BS, Coordinator
- Chris Pellegrino, MS, Director
Office Systems Inventory for ADHD

Strategies to Improve ADHD Diagnosis, Evaluation and Treatment for Children and Adolescents in Primary Care

Following are strategies your practice can use to improve office systems to improve their diagnosis, evaluation, and treatment for children and adolescents with ADHD. Read each strategy and check the response as it applies to your practice.

Use the following rating system to evaluate your practice by making a check mark in the correct column.

1. Not done
2. Done less than 75% of the time
3. Consistently done (75% of the time or more)
4. Consistently done and based on best practice

<table>
<thead>
<tr>
<th>Strategy</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use AAP guidelines and Process of Care Algorithms for ADHD diagnosis and management</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>We have identified a clinician champion or practice team that is well-versed in the AAP ADHD guidelines to lead changes in our practice.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>We provide clinicians and staff with educational opportunities to review the new AAP ADHD guidelines and associated DSM-V criteria.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Improving diagnostic accuracy

| Use DSM-5 criteria for diagnosing ADHD (identifying core symptoms; impairment in >1 major setting; symptom onset before 12 years old). | 1 | 2 | 3 | 4 |
| We use validated ADHD screening tools in our practice that are appropriate for children and youth who are 4–21 years of age. | 1 | 2 | 3 | 4 |
| We collect parent rating scales as part of the ADHD diagnostic process for children/youth aged 4-17 years of age. | 1 | 2 | 3 | 4 |
| We collect ADHD rating scales from teachers or other community informants as part of the ADHD diagnostic process. | 1 | 2 | 3 | 4 |
| We collect self-report scales from adolescents, when appropriate. | 1 | 2 | 3 | 4 |
| Our clinicians and staff have training to accurately administer and score ADHD screening tool(s). | 1 | 2 | 3 | 4 |
| We have a process to follow-up when we have not been able to obtain ADHD rating scales from key informants in the diagnostic process. | 1 | 2 | 3 | 4 |
| We have identified and assigned roles/responsibilities related to the screening process across the practice (team-based approach). | 1 | 2 | 3 | 4 |
| We have appropriate processes in place to support parent/caregiver screening for children with low literacy, limited English proficiency, or varying cultural norms related to ADHD. | 1 | 2 | 3 | 4 |

| We collaborate with the family, school, and youth to set treatment goals. | 1 | 2 | 3 | 4 |
| We identify patients with ADHD as “Children or Youth with Special Health Care Needs” and coordinate their care in the medical home similar to other CSHCN. | 1 | 2 | 3 | 4 |
| We identify a treatment team (patient, parents, teachers, therapists, specialists or other key professionals) | 1 | 2 | 3 | 4 |

| Medication | 1 | 2 | 3 | 4 |
| We have a system in place to ensure patients prescribed an ADHD medication for the first time have a follow-up visit with a prescriber within 30 days of medication initiation. | 1 | 2 | 3 | 4 |
| We advocate for behavioral classroom interventions where appropriate. | 1 | 2 | 3 | 4 |
| We assess for and provide counseling around wellness and health promotion (exercise, nutrition, sleep, screen time, mindfulness). | 1 | 2 | 3 | 4 |
| We follow children and adolescents with ADHD as CSHCN with at least 2 visits annually to monitor for ADHD symptoms. | 1 | 2 | 3 | 4 |

Ensure effective identification, follow-up, and surveillance for co-morbidities

| We screen for co-morbidities and consider them in the differential diagnosis of ADHD (emotional/behavioral or developmental problems). | 1 | 2 | 3 | 4 |
| We initiate treatment for comorbid conditions such as depression and anxiety in patients with ADHD as indicated. | 1 | 2 | 3 | 4 |
| We have a process in place for referring patients to a mental health professional if there are complex co-morbidities. | 1 | 2 | 3 | 4 |
| We have access to specialists for referrals and management of complex ADHD or co-morbidities (Psychiatry, Developmental Behavioral Pediatrics). | 1 | 2 | 3 | 4 |
| We follow-up referral for co-morbid conditions at subsequent visits, and track progress until completion. | 1 | 2 | 3 | 4 |

Partner with patients, school personnel, and mental health colleagues for effective ADHD management

| We have a process for competing releases of information to enable communication with all members of the treatment team. | 1 | 2 | 3 | 4 |
| We have methods for communicating with the treatment team to allow collaboration (secure email, phone, letters). | 1 | 2 | 3 | 4 |
| We maintain a list of community providers offering evidence based services for ADHD (Parent Training, Behavior Management, Behavioral Therapy, Training Interventions). | 1 | 2 | 3 | 4 |
| We provide resources and educational materials to parents that address parent support, teacher/school communication and behavioral health. | 1 | 2 | 3 | 4 |
| We help families advocate for educational supports and interventions, including supporting evaluations for special education services through a 504 or IEP. | 1 | 2 | 3 | 4 |
| We utilize electronic platforms to facilitate communication/care coordination between settings. | 1 | 2 | 3 | 4 |

Population Health and Delivery System Redesigns for Children/Adolescents with ADHD

| We have a documented office flow or an algorithm for management of ADHD at all points along the continuum of care. | 1 | 2 | 3 | 4 |
| We use a population-based ADHD registry to track and monitor patients along the continuum of care. | 1 | 2 | 3 | 4 |
| We document protocols, standing orders and delegate roles to distribute work across the care team. | 1 | 2 | 3 | 4 |
| We optimize coding and billing for ADHD care activities. | 1 | 2 | 3 | 4 |
What’s next

Review/Complete if possible:
Office Systems Inventory (folder)

10:30 – 10:45: Refreshment Break

10:45 Diagnostic Tools for the Initial Evaluation of ADHD and Monitoring Treatment Success