Illinois Chapter, American Academy of Pediatrics

Anxiety Quality Improvement Project

Final Report

Prepared by the American Academy of Pediatrics
Area of Quality, Analytics & Evaluation
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Background

Anxiety disorders are among the most common mental health conditions of childhood and adolescence, yet they are frequently under-identified and inconsistently managed in pediatric primary care. Brief, validated screening at well-child visits, paired with structured follow-up assessment and a clear plan of care, can improve early identification and connect adolescents to appropriate next steps. Despite this evidence, anxiety screening and follow-up are delivered unevenly across primary care settings. Common barriers include limited visit time, the absence of standardized documentation prompts, variable comfort discussing mental health concerns, and inconsistent referral pathways.

The ICAAP Anxiety Quality Improvement (QI) Project was designed to address these gaps by supporting Illinois pediatric primary care practices in implementing evidence-based anxiety screening, structured follow-up assessment, and reliable follow-up planning for adolescents ages 11 to 17. The project used the Model for Improvement, with practices testing and refining changes through Plan-Do-Study-Act (PDSA) cycles and submitting monthly, chart-level data to the AAP Quality Improvement Data Aggregator (QIDA). Results were displayed as run charts to track progress over time and to anchor facilitated data review and peer-to-peer learning during project webinars.

The project's global aim was to improve identification and follow-up care for anxiety in pediatric primary care through evidence-based screening, structured assessment, and reliable follow-up workflows. From February through June 2026, the project pursued three specific, measurable aims: (1) that 90% of eligible well visits for patients ages 11 to 17 would include a documented, scored validated anxiety screening tool; (2) a 20% improvement from baseline in the percentage of positive screens with a documented differential-diagnosis assessment; and (3) a 20% improvement from baseline in the percentage of positive screens with a documented follow-up plan.

Key Project Activities

The project was structured as a learning collaborative that paired clinical education on pediatric anxiety with hands-on quality improvement support. Following an enrollment and onboarding period in January and February 2026, participating practices joined five monthly one-hour webinars held from February through June 2026. Each session combined a clinical education segment on the recognition, assessment, and management of pediatric anxiety with a facilitated QI segment that included data review, run-chart interpretation, and a PDSA roundtable for peer learning. Between sessions, the project team offered quality improvement office hours and ongoing technical assistance to help teams troubleshoot workflows and resolve data submission questions. Table 1 summarizes the webinar series.

Table 1. Project webinar series

Session	Clinical Education Topic	Quality Improvement Topic
1 February 12, 2026	Why Diagnose and Treat Anxiety in Primary Care?	Project kick-off: introduction to the Model for Improvement, the project measures, and the QIDA data collection tool
2 March 12, 2026	Pediatric Anxiety Screening as Part of Routine Well-Visits in Children 11-17	Conducting and scaling up PDSA cycles; rapid-cycle testing; annotating and interpreting run charts

Session	Clinical Education Topic	Quality Improvement Topic
3 April 16, 2026	Follow-Up and Differential Diagnosis in Pediatric Anxiety	Leading change; PDSA roundtable; data review
4 May 14, 2026	Medication Management for Pediatric Anxiety	Planning for sustainability (from QI to quality control); PDSA roundtable; QIDA data review
5 June 11, 2026	Cognitive Behavioral Therapy and Other Tools for the Pediatric Primary Care Setting	Next steps and resources; sustainability and final data review

Practices focused on three core measures aligned with the project aims: the anxiety screening rate at eligible well visits, consideration of differential diagnoses following a positive screen, and documentation of a follow-up plan following a positive screen. Two optional measures, the proportion of positive screens with a follow-up visit scheduled and the proportion referred to a specialist, were collected for informational purposes. Each month, practices reviewed a convenience sample of approximately 20 eligible well visits (or all eligible visits if fewer) and submitted chart-level data to the AAP's Quality Improvement Data Aggregator (QIDA). The QIDA system automated measure calculations and generated run charts, which were reviewed during webinars to identify trends, assess the impact of tests of change, and plan subsequent PDSA cycles. Table 2 presents the core measures, goals, and collaborative-level results.

Table 2. Core measures, goals, and collaborative-level results

Measure	Definition	Numerator	Denominator	Goal	Result[1]
Anxiety screening rate	Well visits (ages 11-17) with a validated anxiety screening tool (GAD-7, GAD-2, or SCARED) administered and scored	Well visits with a validated tool administered and scored	All well visits for patients ages 11-17 in the cycle	90%	53.9% to 93.7%
Consideration of differential diagnoses	Positive screens with a structured assessment for differential diagnoses (e.g., trauma, sleep, ADHD)	Positive screens with a documented differential-diagnosis assessment	Patients with a positive screen in the cycle	20% improvement from baseline	62.9% to 78.0%
Documentation of follow-up plan	Positive screens with a follow-up plan documented in the chart	Positive screens with a documented follow-up plan	Patients with a positive screen in the cycle	20% improvement from baseline	82.9% to 98.3%

[1]*Results show the change from baseline (Cycle 1) to the final complete cycle (Cycle 5).*

Maintenance of Certification Requirements

The project was approved for American Board of Pediatrics (ABP) Maintenance of Certification (MOC) Part 4 credit through the AAP MOC Portfolio Program. To earn credit, physicians were expected to be intellectually engaged in planning and executing the project, to implement the project interventions, to review their data in keeping with the measurement plan, and to collaborate actively across the collaborative. Specifically, participating physicians were asked to attend at least three of the five live

webinars (and to view recordings of any sessions missed) and to contribute to their practice's PDSA cycles and data collection.

At the practice-team level, practices were encouraged to assemble a team that could include physicians, nurses, medical assistants, and practice managers, with one physician designated as the local leader. Practice teams were asked to have at least one member attend four of the five webinars live, to complete and share at least one PDSA cycle during a project webinar, and to submit practice-level data across the monthly data cycles. A total of 18 physicians across 12 practices met the criteria for MOC Part 4 credit.

Site and Participant Characteristics

The collaborative drew participation from a diverse set of Illinois pediatric primary care practices, including federally qualified and community health centers, large health-system and multispecialty group practices, and independent and rural practices. Forty clinicians representing 27 practices and organizations registered for the collaborative. Registrants were predominantly physicians: 34 of the 40 (85%) held an MD or DO, and the remaining registrants were nurses (4) or did not list a credential (2). Among the eight clinicians who completed the post-project survey, all were physicians, with a median of 26 years in practice (range, 15 to 36), reflecting a highly experienced clinician group.

Participation and Engagement

Engagement followed the pattern typical of time-limited QI collaboratives, with broad initial registration narrowing to a committed core of practices that carried the work through data submission and MOC completion. Of the 40 clinicians who registered, 32 attended at least one of the five monthly webinars, representing 20 sites, and 13 practices submitted chart-level data to QIDA. Across the five data cycles, these practices contributed 1,242 chart reviews. Live webinar attendance was steady across the series, ranging from 15 to 22 clinicians per session. Table 3 summarizes engagement across the collaborative.

Table 3. Engagement across the collaborative

Engagement milestone	Count	Notes
Clinicians registered	40	Representing 27 practices and organizations
Clinicians attending at least one webinar	32	Of 5 monthly sessions
Sites attending at least one webinar	20	Of 5 monthly sessions
Practices submitting chart-level QI data	13	1,242 chart reviews submitted to QIDA
Physicians meeting MOC Part 4 criteria	18	Representing 12 practices

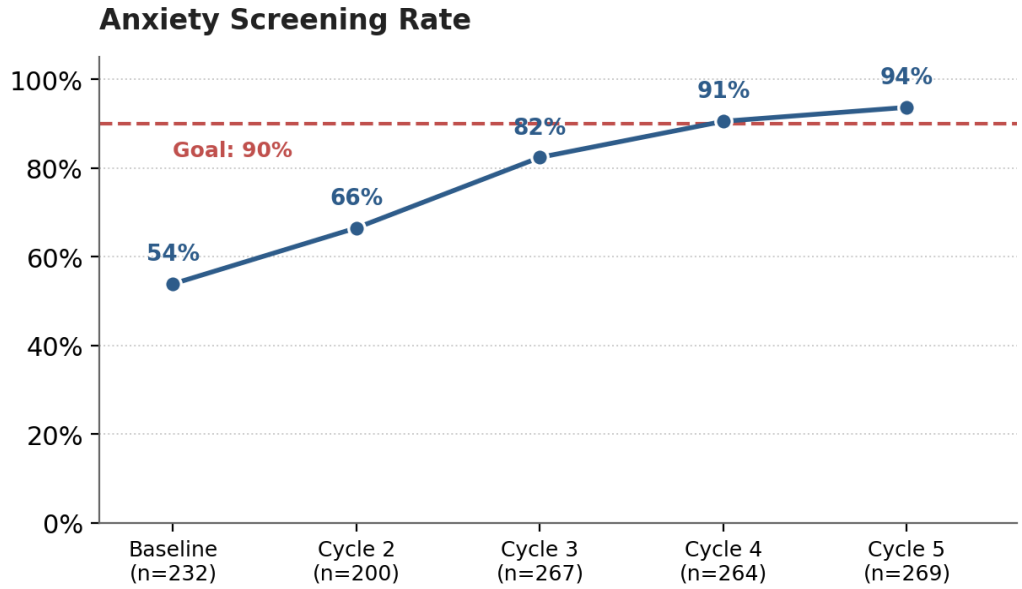
Quality Improvement Results

Participating practices increased the consistent delivery and documentation of anxiety screening and follow-up care over the project period. Run charts below display the collaborative-level result for each data cycle. Where the project defined a target, the goal is shown as a dashed reference line; because the

project comprised a single baseline cycle plus four monthly cycles, a median centerline and formal run-chart rules were not applied to so few data points.

The most pronounced gains were in the anxiety screening rate, which rose steadily from 53.9% of eligible well visits at baseline to 93.7% in the final complete cycle, an improvement of nearly 40 percentage points. Practices met the project's 90% screening goal by the fourth cycle (90.5%) and exceeded it in the final cycle.

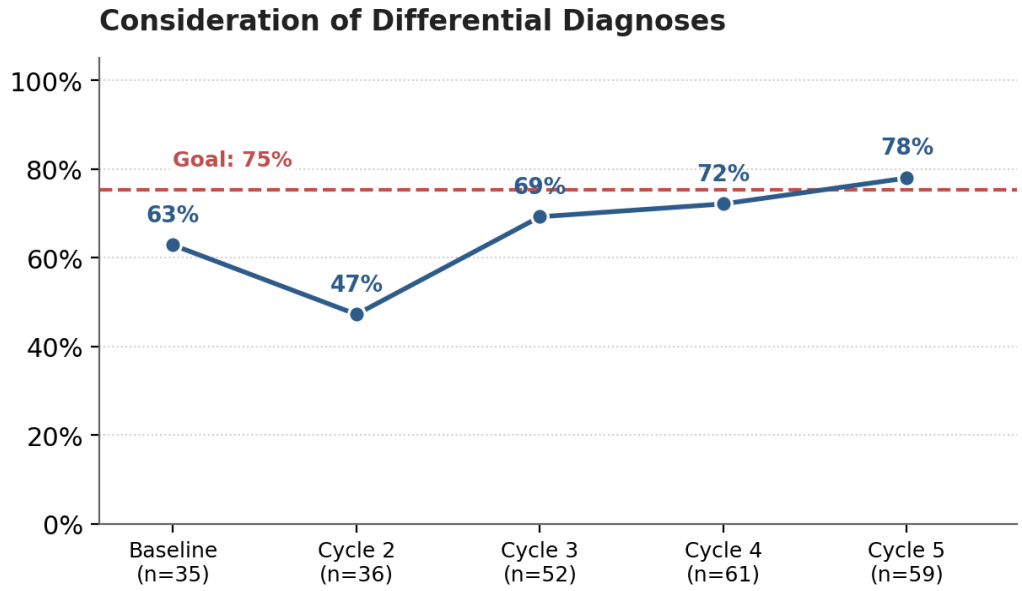
Figure 1. *Collaborative-level anxiety screening rate by data cycle (n = eligible well visits per cycle).*



Among screened visits, practices most often used the GAD-7 (77.9% of screens), followed by the GAD-2 (21.0%) and the SCARED (1.1%). Roughly one in four screened adolescents (25.1%) had a positive screen, underscoring the clinical yield of routine screening and the importance of reliable follow-up workflows for the substantial subset of patients with elevated anxiety symptoms.

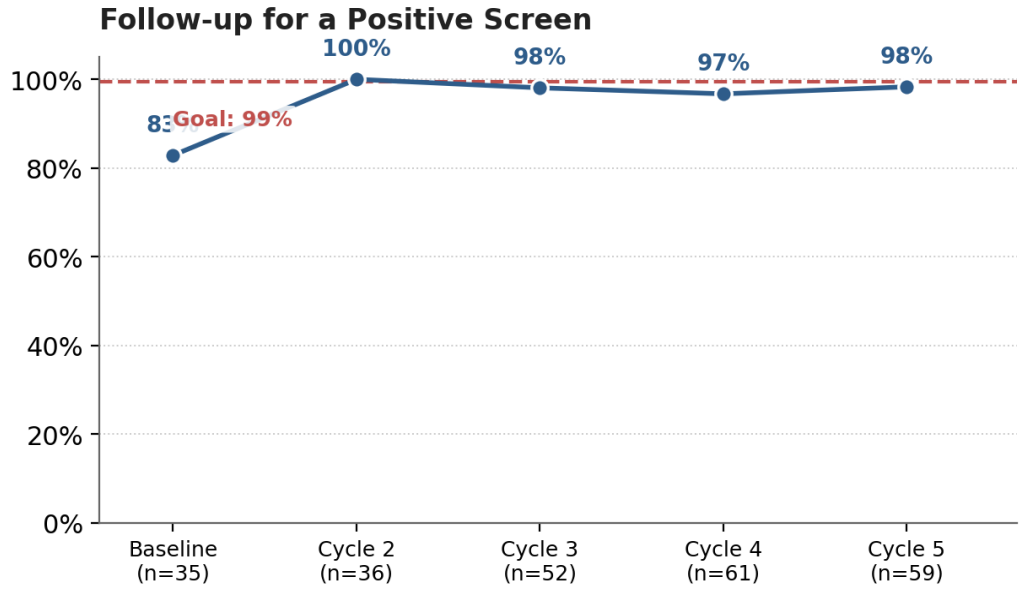
Care delivered after a positive screen also improved. Consideration of differential diagnoses, documented through structured follow-up assessment for conditions such as trauma, sleep disorders, and ADHD, rose from 62.9% of positive screens at baseline to 78.0% in the final complete cycle. After an early dip in the second cycle (47.2%), the measure climbed steadily across the remaining cycles and exceeded the project's goal of a 20% relative improvement from baseline (a target of approximately 75%).

Figure 2. *Consideration of differential diagnoses, among patients with a positive anxiety screen, by data cycle. Goal line reflects a 20% relative improvement from baseline (approximately 75%).*



Documentation of a follow-up plan following a positive screen was already high at baseline (82.9%) and rose to near-universal levels, ranging from 96.7% to 100% across the four monthly cycles and reaching 98.3% in the final cycle. Because this measure began near ceiling, a 20% relative improvement from baseline (a target of approximately 99%) was not a realistic threshold; the project's primary contribution was to make near-universal follow-up planning reliable and consistent across practices rather than to produce a large numeric increase.

Figure 3. *Documentation of a follow-up plan, among patients with a positive anxiety screen, by data cycle. Goal line reflects a 20% relative improvement from baseline (approximately 99%); because baseline was already high, this target reflects a ceiling effect.*



Two optional measures described the type of follow-up arranged for adolescents with a positive screen and a documented plan. These measures were collected for informational purposes and had no defined goal, since the appropriate next step varies by patient. A primary care follow-up visit was the most common next step, scheduled for roughly half to three-quarters of positive screens across cycles (52.5% to 72.2%). Referral to a specialist was documented for a smaller and gradually increasing share of positive screens, rising from 40.0% at baseline to 49.2% in the final cycle. Because these categories were not mutually exclusive, some adolescents received both a primary care follow-up visit and a referral. Together, the two measures are consistent with a stepped approach in which most adolescents are managed within the medical home, with specialist referral reserved for those who need it. Figures 4 and 5 display these measures over time.

Figure 4. *Follow-up visit scheduled, among patients with a positive anxiety screen, by data cycle.*

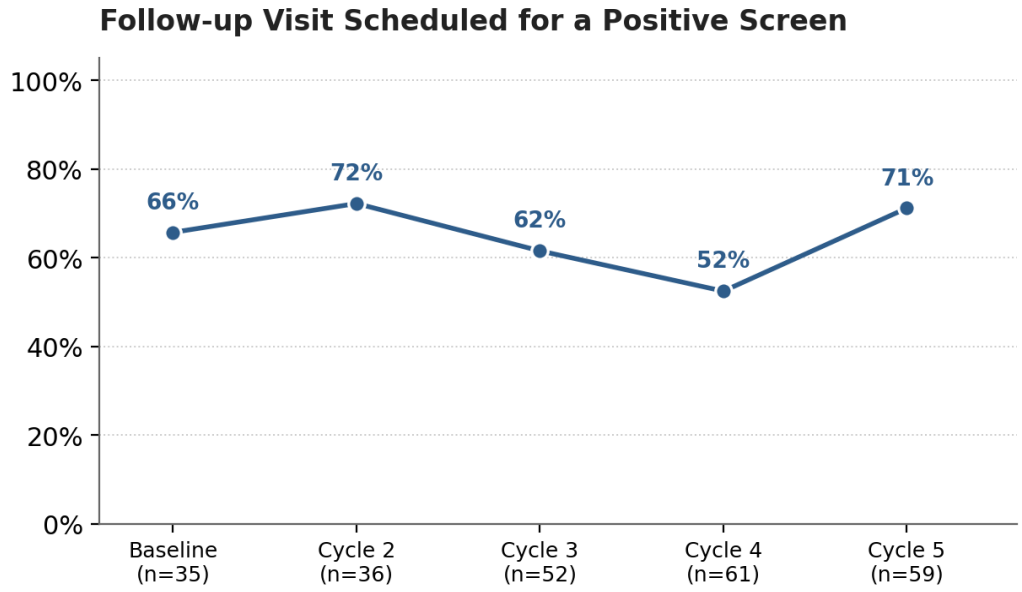
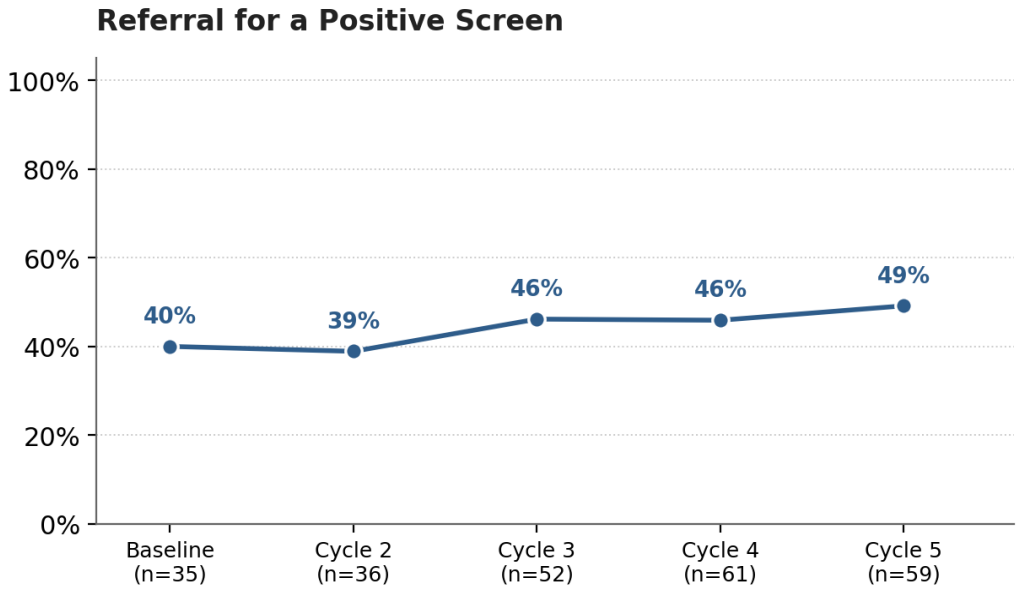
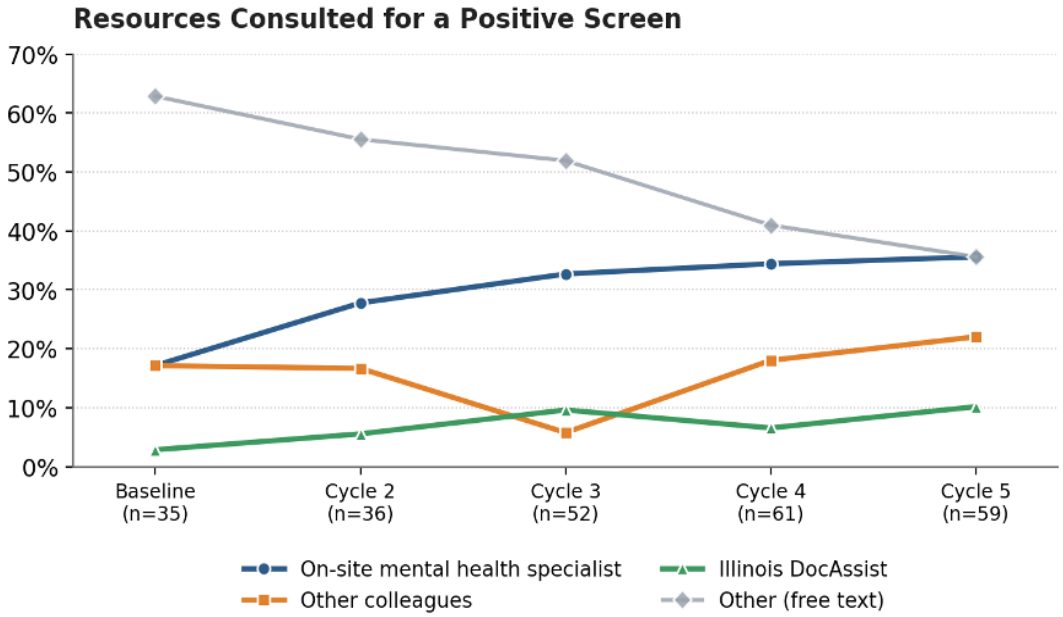


Figure 5. *Referral to a specialist, among patients with a positive anxiety screen, by data cycle.*



Participants also recorded the resources clinicians consulted when considering a diagnosis or follow-up for a positive screen (Figure 6). This item was completed only for charts with a positive screen. Across all positive screens, the most frequently recorded entry was a free-text “other” response (47.3% of positive screens), which captured a heterogeneous mix of actions such as initiating medication, noting an existing therapy or psychiatry relationship, or documenting a referral. Among the defined options, consultation with an on-site mental health specialist was most common (31.0%), followed by other colleagues (15.9%) and Illinois DocAssist (7.3%). The pattern shifted over the project period: on-site mental health specialist consultation rose from 17% of positive screens at baseline to 36% in the final cycle, Illinois DocAssist use rose from 3% to 10%, and reliance on free-text “other” entries declined from 63% to 36%. These shifts are consistent with practices drawing more on identifiable consultation resources as workflows matured, though the data do not establish the cause.

Figure 6. *Resources consulted when considering a diagnosis or follow-up for a positive anxiety screen, by data cycle. Denominator = patients with a positive screen; categories were not mutually exclusive.*



Across the three core measures, screening rose substantially over the project period, while consideration of differential diagnoses and documentation of a follow-up plan increased more modestly from higher baselines. The differential-diagnosis measure did not improve linearly: it declined in the second cycle before rising across the remaining cycles. Such early variation can be common in rapid-cycle testing, though the available data do not identify the specific cause, and practices may have been refining documentation workflows and the criteria for a structured assessment during this period.

Post-Project Survey Results

A post-project survey was distributed to participating clinicians to assess satisfaction, self-reported knowledge and confidence, perceived value, barriers, and the operational impact of the project. Eight clinicians, all physicians, completed the survey. Given the small number of respondents, the results below are best interpreted as the experience of the engaged core of participants rather than as precise estimates for the full collaborative.

Satisfaction and Perceived Value

Participants reported high satisfaction with the collaborative. On the likelihood-to-recommend item, respondents produced a Net Promoter Score of 63, with five promoters, three passives, and no detractors. Open-ended comments described the program as *"very helpful and informative"* and as offering *"great information that they would use in everyday practice."* Seven of the eight respondents agreed or strongly agreed that participation enhanced their professional satisfaction, and seven agreed that it contributed to their professional network. On the return-on-investment item, respondents rated the value of their time and effort highly (a mean of 6.6 on a 7-point scale), and all respondents judged the program's return to be comparable to or higher than other training programs they had completed.

Knowledge and Confidence

Respondents rated their knowledge and confidence across ten learning objectives both before the project and at its conclusion, using five-point scales. Self-reported ratings increased on every item. Overall mean knowledge rose from 2.95 to 4.05, and overall mean confidence rose from 3.10 to 4.12. Pre-post differences were tested with the Wilcoxon signed-rank test. All five knowledge items and four of the five confidence items showed statistically significant improvement ($p < 0.05$). The exception was confidence in managing medications for pediatric anxiety, which improved in direction (3.25 to 4.00) but did not reach significance ($p = 0.063$), which could reflect both the small sample and the more specialized nature of medication management in primary care. Table 4 and Figures 6 and 7 summarize the results.

Table 4. Self-reported knowledge and confidence, before and after the project (mean rating, 1 to 5)

Item	Before	After	p-value
Knowledge			
Common presentations of anxiety in pediatric patients	3.00	4.00	0.008
Scoring and interpretation of validated screening tools	3.12	4.38	0.016
Common differential diagnoses for pediatric anxiety	2.88	4.12	0.008
Medication management for pediatric anxiety	3.12	4.00	0.031
Brief CBT-based coping strategies	2.62	3.75	0.031
Confidence			
Screening patients ages 11-17 with a validated tool	3.12	4.38	0.031
Conducting structured follow-up assessment for differential diagnoses	3.12	4.12	0.031
Developing a follow-up plan for a positive screen	3.38	4.38	0.031
Managing medications for pediatric anxiety	3.25	4.00	0.063
Conducting a PDSA cycle	2.62	3.75	0.008

p-values from Wilcoxon signed-rank tests (n = 8 paired responses per item).

Figure 6. *Mean self-reported knowledge ratings before and after the project, by topic. Asterisks denote items with a statistically significant change (p < 0.05).*

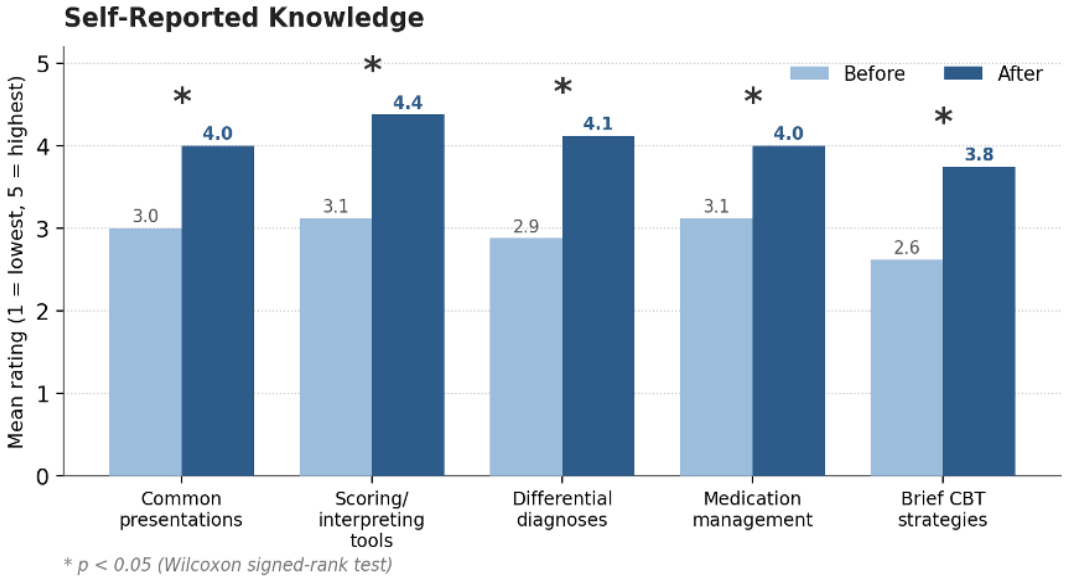
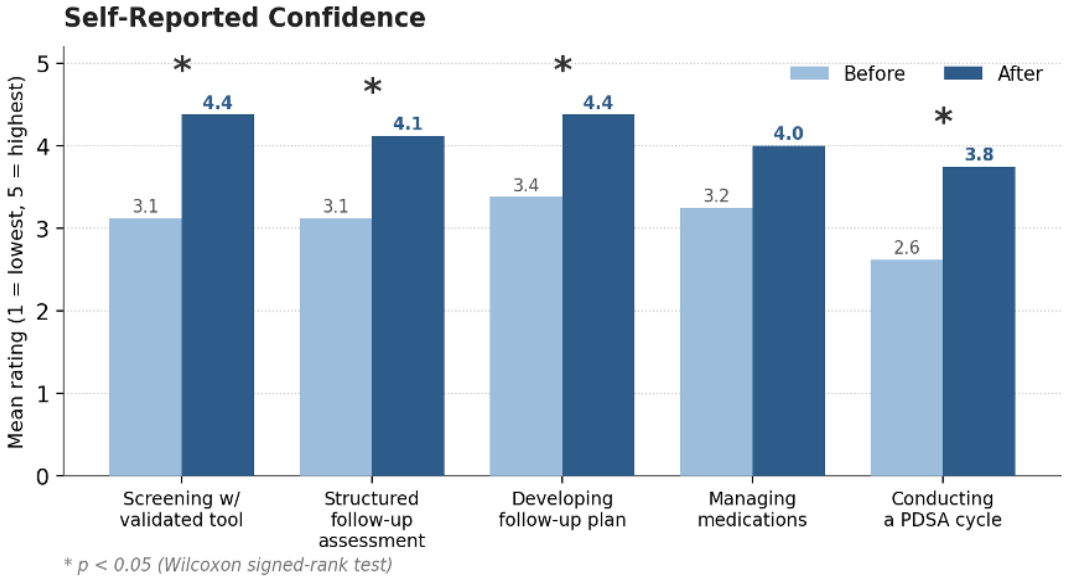


Figure 7. *Mean self-reported confidence ratings before and after the project, by topic. Asterisks denote items with a statistically significant change (p < 0.05).*



Impact, Barriers, and Sustainability

Participants reported that the project had a positive effect on their clinical and operational work, with seven of eight rating the overall impact as improved and one rating it neutral. No respondent reported any unintended negative consequences, such as increased wait times or lost revenue. Seven of the eight respondents reported participating in at least one full PDSA cycle in which they implemented a change, examined the data, and made subsequent adjustments.

When asked about barriers to applying what they learned, respondents most frequently cited limited time during well-child visits, identified by 7 of the 8 respondents. Other reported barriers included limited availability of mental health specialists for referral (4 of 8), caregiver reluctance to discuss anxiety symptoms (3 of 8), the absence of EHR prompts or structured documentation fields for screening and follow-up (2 of 8), and competing clinical and QI priorities and limited team capacity due to staff turnover (1 each). These barriers mirror the feasibility challenges well documented in pediatric mental health integration.

Respondents described concrete and durable changes to their practice. Several instituted or expanded routine anxiety screening at adolescent well visits, including systematic use of the GAD-7 for all well-child checks and adoption of the SCARED questionnaire. Others built EHR templates to support screening and documentation, began initiating pharmacotherapy or brief CBT-based strategies where appropriate, and started using Illinois DocAssist as a consultation resource. One respondent captured a key mindset shift, noting that they now felt *"more comfortable about not having to solve it all at one visit, but planning a return visit."* Asked what the most valuable components were, participants pointed to having a structured reason and process to get started, the standardization of screening across their practice, and the demonstration that routine screening is feasible within visit time while surfacing concerns that *"wouldn't have otherwise been addressed."*

Looking ahead, respondents suggested that future projects measure clinical outcomes, expand screening to additional providers and sites within their organizations, collect data at the provider or site level, account for patients with an existing anxiety diagnosis, and continue the strong educational webinar component. When asked what future projects should stop doing, respondents generally indicated nothing, with several describing the program as effective as designed.

Impact and Conclusion

The ICAAP Anxiety Quality Improvement Project achieved its primary aim: participating practices increased anxiety screening and strengthened the follow-up care that should accompany a positive screen. At the collaborative level, the anxiety screening rate rose from 53.9% at baseline to 93.7% in the final cycle, exceeding the 90% goal. Consideration of differential diagnoses improved from 62.9% to 78.0%, meeting the goal of a 20% relative improvement from baseline, and documentation of a follow-up plan was sustained at near-universal levels throughout the project.

These gains were accompanied by improvements in self-reported knowledge and confidence across all ten learning objectives, high participant satisfaction (a Net Promoter Score of 63 with no detractors), and no reported negative impacts on clinical or operational work. Participants described changes, including routine adolescent anxiety screening, EHR documentation supports, structured follow-up planning, and use of consultation resources, suggesting that the workflows established during the project are well positioned to be sustained.

Sustaining and spreading these gains will likely require continued attention to the feasibility barriers participants identified, particularly limited visit time, gaps in EHR enablement, and the limited availability of mental health specialists for referral. The project's results demonstrate that a structured, time-limited

QI collaborative, pairing clinical education with practical tools, peer learning, and monthly data feedback, can make validated anxiety screening and follow-up reliable components of adolescent preventive care.