ICAP Project: Project Updates & Spotlight on Sites

JUNE 16, 2015
## Agenda

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Speaker</th>
<th>Time</th>
</tr>
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<tbody>
<tr>
<td>Welcome and Introductions</td>
<td>Faiza Wasif, MPH</td>
<td>5 mins</td>
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<tr>
<td>Kudos &amp; Upcoming Events</td>
<td>Kavita Parikh, MD, Eric Biondi, MD</td>
<td>5 mins</td>
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<tr>
<td>Nearing End of ICAP Project</td>
<td>Faiza Wasif, MPH</td>
<td>5 mins</td>
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<tr>
<td>Review of Project to Date</td>
<td>Kavita Parikh, MD, Eric Biondi, MD</td>
<td>15 mins</td>
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<td>Success at Participating ICAP Sites:</td>
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<tr>
<td>• Sparrow Hospital</td>
<td>Timur Raghib, MD</td>
<td>10 mins</td>
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<tr>
<td>• Children’s Hospital San Antonio Texas</td>
<td>Manoj Nepal, MD</td>
<td>10 mins</td>
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<tr>
<td>Question &amp; Answer</td>
<td>Kavita Parikh, MD, Eric Biondi, MD</td>
<td>10 mins</td>
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Kudos: ICAP Conference Presentations

- Improving Community-Acquired Pneumonia (ICAP): Findings of a Multi-Site National Quality Improvement Collaborative
  - Type of Session: Oral Presentation
  - Presenter: Kavita Parikh, MD, FAAP
  - Date and Time: Saturday, July 25, 10:00 – 10:15am

- Posters authored by VIP Network Improving Community-Acquired Pneumonia Management QI Project (ICAP)
  - Increasing Narrow-Spectrum Antibiotic Use in the Management of Community Acquired Pneumonia: the Rural Community Hospital Experience (Danielle P. Wales, MD, MPH)
  - Variation of Narrow-Spectrum Antibiotic Utilization for Uncomplicated Community-Acquired Pneumonia across Patient Hospitalization Among Diverse Hospitals (Joanne Nazif, MD, FAAP)
  - A Successful Partnership between Emergency Department Physicians and Pediatric Hospitalists to improve narrow spectrum antibiotic use in the ED for Community Acquired Pneumonia (Sarah Donahue, MD, FAAP)
  - Multidisciplinary Interventions to Improve Narrow Spectrum Antibiotic Use in Community Acquired Pneumonia (Michelle Katzow, MD, FAAP)
  - Value in Inpatient Pediatrics Network Improving Community-Acquired Pneumonia Management Quality Improvement Project (Natalie Evans, MD, FAAP)
VIP Events at PHM 2015

Value in Inpatient Pediatrics (VIP) Member Business meeting
Date: Friday, July 24
Time: 6:30 – 7:30pm
Location: Salon J

Liz Rice-Conboy will be the VIP Network staff at PHM this year.

UTI Management Beyond the AAP Guideline: New Evidence, Current Controversies, and Quality Improvement
Type of Session: Concurrent Session
Presenters: Richard Engel, MD, FAAP and Brian Pate, MD, FAAP
Date and Time: Friday, July 24, 1:25-2:40PM AND Saturday, July 25, 3:00-4:15PM
Poster Session: Reception with Exhibits and Poster Session A
Friday, July 24, 5:25-6:30PM
Nearing End of ICAP Project

<table>
<thead>
<tr>
<th>Month</th>
<th>Date</th>
<th>Time</th>
<th>Type of Activity</th>
<th>Additional Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>06/15</td>
<td>UPCOMING DUE DATE</td>
<td>DUE DATE: Signed consent forms due</td>
<td>E-mail to site contact for the after data update by 7/15. Share with: [email protected]</td>
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<tr>
<td>July</td>
<td>06/15</td>
<td>UPCOMING DUE DATE</td>
<td>DUE DATE: Project update due</td>
<td>[email protected]</td>
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<tr>
<td>July</td>
<td>06/15</td>
<td>Live Webinar #1</td>
<td>Project Orientation, QIDA introduction, Action Plan etc.</td>
<td>Registration link: [Registration link]</td>
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<td>July</td>
<td>06/15</td>
<td>Live Webinar #1</td>
<td>View pre-recorded webinar #1: QIDA Data Entry Sessions with唷 Site WF users</td>
<td>Live stream link: [Link to webinar]</td>
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<td>August</td>
<td>06/30</td>
<td>UPCOMING DUE DATE</td>
<td>DUE DATE: Send back to coach</td>
<td>To view the webinar, please join ICAP data entry team on Zoom</td>
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<tr>
<td>August</td>
<td>06/30</td>
<td>Live Webinar #2</td>
<td>Review and compare 2014-2015 data to 2013-2014 baseline data; plan sustainability and next steps</td>
<td>Registration link: [Registration link]</td>
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<tr>
<td>September</td>
<td>06/30</td>
<td>Live Webinar #3</td>
<td>Review and compare 2014-2015 data to 2013-2014 baseline data; plan sustainability and next steps</td>
<td>Registration link: [Registration link]</td>
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<tr>
<td>October</td>
<td>07/15</td>
<td>Live Webinar #4</td>
<td>Review and compare 2014-2015 data to 2013-2014 baseline data; plan sustainability and next steps</td>
<td>Registration link: [Registration link]</td>
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<tr>
<td>November</td>
<td>07/15</td>
<td>Live Webinar #4</td>
<td>Review and compare 2014-2015 data to 2013-2014 baseline data; plan sustainability and next steps</td>
<td>Registration link: [Registration link]</td>
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<tr>
<td>December</td>
<td>07/15</td>
<td>Live Webinar #4</td>
<td>Review and compare 2014-2015 data to 2013-2014 baseline data; plan sustainability and next steps</td>
<td>Registration link: [Registration link]</td>
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**SLIDE USED WITH PERMISSION FROM K. PARIKH, AND E. BIONDI, “PROJECT UPDATES & SPOTLIGHT ON SITES” ORIGINALLY PRESENTED 06/16/15 TO THE VIP NETWORK ICAP QI PROJECT TEAMS**

- **06/30/15**: March – May 2015 data due in QIDA by June 30
- **07/31/15**: Submit post-project survey by July 31 (Survey Monkey link to be shared soon)
- **Date TBD (early August)**: Live Webinar to review and compare 2014-2015 data to 2013-2014 baseline data; plan sustainability and next steps
ICAP MOC Eligibility Criteria

AAP-Established Minimum Criteria for Participation
The project requires active physician participation for 9 months. Physicians must:

☑ Lead the implementation for the Improving Community-Acquired Pneumonia Management Quality Improvement (ICAP) project core changes for 9 months
☑ Provide direct or consultative care to patients as part of the project
☑ **Physician Leader:** Attend 4 meetings that can be learning session webinars or conference calls/webinars where collaborative data are reviewed or plans for new improvement activities are made.

**Other participating physicians:** Attend at least 4 meetings at which collaborative data are reviewed and plans for improvement activities are made (can be local team meetings, conference calls/webinars, or learning sessions)

☑ Collect and submit data on a subset of patients as defined by the project
☑ Review periodic (3-month) run charts
☑ Implement change package ideas/tools designed to improve CAP care
Claiming MOC Credit (25 Points)

- Complete and sign your Attestation Form at the end of the project
  - Your Attestation Form is downloadable via your ABP profile online, instructions will be sent at the end of June.

- Return completed, signed and scanned form to Faiza Wasif (fwasif@aap.org) by August 31, 2015

- Lead physician “attest” for any participating physician in your practice (sign off on their form)

- Project leader(s) “attest” for any lead physicians (sign off on your form)

- The information in the Attestation Form will be sent by AAP to the ABP

- The ABP will update your ABP Portfolio at www.abp.org indicating that credit has been earned toward MOC Part 4
Comments from ICAP Project: Working with the ED

It has been great to see the progress, especially in our narrow-spectrum use! And, not seeing the same progress in the ED has led us to think about larger systems issues (such as having the medication readily available in the ED).

It helped to identify that we needed to focus on the ED (going through charts).

As we were entering in the third data cycle, we noticed that providers (residents, ED staff) had forgotten who the guidelines were written for. We had patients (ex. with cystic fibrosis, under 2 y/o with viral illnesses) who were inappropriately receiving narrow spectrum antibiotics.

A lot of the initial decisions (cbc, CXR) are made in the ED, so we question the utility of our efforts if we don't reach out to the ED.

Involving an ER physician in our group has helped engage and get people on the right treatment from the get-go.

We need to partner better with the ED for seamless transition of care. When we met the ED docs admitted they don't have time to keep up with pediatrics specific literature and were happy to listen to our summary.

...Also, struggling to decrease the use of ceftriaxone in ED.

That there are a few particular clinical scenarios in which broad spectrum antibiotics often get inappropriately prescribed...Our ED colleagues have brought up the point about convenience and minimizing opportunity for error when using a once/day antibiotic (ceftriaxone) rather than a 4x/day antibiotic (ampicillin), which had never occurred to me before and I haven't seen written about much.

Loved the buy in from ED and hospitalists and clear improvement

A lot of the initial decisions (cbc, CXR) are made in the ED, so we question the utility of our efforts if we don't reach out to the ED.
In our ED, antibiotic selection was identified as a problem and the most important measure we wanted to tackle in order to be compliant with IDSA guidelines. In the inpatient setting, probable over-diagnosing of pneumonia in asthmatics was identified as the measure we were most off on.

The greatest barrier in this regard is culture change, and the large number of ED faculty members involved in this decision making process. All of the patients treated for asthma and pneumonia were first treated for asthma, but once an xray was obtained in the ED, antibiotic therapy was initiated. Because the LOS in the ED is so long, by the time the floor team evaluates the patient, they have received 1-2 days of antibiotics and the inpatient team is reluctant to change the plan of care.

Concurrent asthma diagnosis and treatment is very important to us. If we are successful though, it seems we will not decrease the number of children with pneumonia being treated for asthma, but we hope to decrease the number of children with asthma being treated for pneumonia. In the end, the total number of kids with dual diagnoses will go down.

Discussion/education with ED physicians about not ordering CXRs for routine asthmatics. Informal discussion amongst hospitalists about better defining what history and exam findings really are concerning for atypical pneumonia in an asthmatic vs. typical asthma or viral trigger.

This one is hard as we have a lot of asthmatic patients and if they respond to the albuterol, it is hard to ignore this but working on it.
We have begun to re-educate the attending and resident staff. We have also provided inpatient attendings with a personalized report card reflecting how they managed patients with CAP during the prior three months. We attached to the report card email pediatric research articles supporting our recommendations. We used morning conference with residents to re-educate them, sharing with them the latest run charts. We also highlighted the feedback we gave to the inpatient attendings. This session was followed by an email recap, along with supporting research articles.
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