I am humbled to be the new Chair of the Council on Quality Improvement and Patient Safety (COQIPS). I have been privileged to have worked on the Steering Committee on Quality Improvement and Management (SCOQIM) for the past several years and have seen the commitment of committee members and staff for improving quality and patient safety for children. We realized that we needed to become a council and under the superb leadership of Xavier Sevilla, MD, MBA, FAAP the committee morphed into COQIPS last summer. In one short year, we have grown from a committee of 11 to a council of over 400! That is phenomenal!

Over the past several years I “drank the Kool-Aid” for quality improvement (QI) and patient safety. All different flavors! I am a pediatric cardiology electrophysiologist whose career initially was going in the education direction. I was a pediatric cardiology fellowship director in two institutions and the physician director of Continuing Medical Education at Children’s Memorial Hospital (now the Ann and Robert H. Lurie Children’s Hospital of Chicago). I was bitten by the quality bug at Children’s and worked on QI projects there. We became one of the first portfolio sponsors for Maintenance of Certification through the American Board of Pediatrics. I continued my work in QI and patient safety while I was at the University of Illinois Hospital and Health Sciences System. Process improvement has also been a key component in my work in quality with Lean Healthcare Certification and completion of Lean Six-Sigma Black-belt training.

Patient-centered care is essential for quality improvement and patient safety. To that end, COQIPS is one of the few groups at the AAP to have a parent liaison serve on its Executive Committee. Lisa Rossignol, MA, was selected from a highly qualified group of individuals who applied. Her role will be essential to the future direction of the council as well as the AAP. We are excited to have her on the Executive Committee. To learn more about Lisa and her role on the Executive Committee, please read her introduction, “Changing Hearts; Changing Minds” in this issue of Quality Connections.

Continued on next page
As you will see in the Committee Updates section within this issue of Quality Connections, we will have our first full-day council educational program (“H” program) at the National Conference & Exhibition in San Diego. I want to personally thank Greg Randolph, MD, MPH, FAAP, and Laura Ferguson, MD, FAAP, (Education Co-Chairs) for the remarkable amount of work that they have done in developing and organizing this program. We will have abstract presentations and a poster session, as well, during the H program. It is going to be fantastic. Although Greg has recently rotated off of the Executive Committee, he remains very involved in our programs.

Our first Council Membership/Business Meeting will take place during the H program in San Diego on Monday, October 13th at 1PM. Please come and meet the Executive Committee and let us know how the council can better serve you as a member.

On that note, thanks to all of the COQIPS members who completed the council needs assessment. It will help tremendously in setting our priorities for the next two years. As our projects grow in scope and depth, we will look to our council membership to spearhead activities on our council committees, so please read your listserv announcements!

We want to welcome the newly elected Executive Committee members who began their terms officially on July 1, 2014: Terry Adirim, MD, MPH, FAAP; David Bundy, MD, FAAP; Brigitta Mueller, MD, MHCM, FAAP; Michael Rinke, MD, FAAP; and Joel Tieder, MD, MPH, FAAP. Each of these members brings additional special talents to the Executive Committee and we are looking forward to working with them.

This is my first message as a chair and as such, I need to end with some special thanks. I promise that I will not thank our staff in each of my messages, but we have to recognize the tremendous work that they do on a daily basis for the members of this council. Vanessa Shorte, MPH, is the lead staff person for COQIPS and is the Director of the Division of Quality at the AAP. Cathleen Guch, MPH, is the Manager of Quality and Health IT Education within the Division of Quality who focuses her efforts on education within the council. Lisa Krams, MS, CHES, is the Manager of Quality and Health IT Policy within the Division of Quality who focuses her efforts on policy and advocacy. The Executive Committee could not do the work that we do without their incredible efforts.
COQIPS Identifies MOC Project Planning Members to Lead an Innovative Quality Improvement Project

At the end of July, the COQIPS Education Committee put out a call for quality improvement (QI) and health literacy topic experts to assist with a pilot project that would incorporate Maintenance of Certification (MOC) Part 4 as part of the 2015 National Conference & Exhibition COQIPS Education Program, also called the H Program. The focus of the 2015 program will be on health literacy with the overall aim of improving care of patients by utilizing clear communication strategies and removing literacy-related barriers, regardless of health literacy level. Specific program objectives, key drivers, and measures will be developed by the COQIPS Pilot Project Planning Group. This pilot project will be the first of its kind to incorporate MOC Part 4 credits into a council/section Education H Program at the AAP NCE, the Academy's largest gathering of members.

We received many exceptional applications and we are pleased to announce that the following COQIPS members have been selected as Pilot Project Planning Group members:

- C. Eve Kimball, MD, FAAP
- Ulfat Shaikh, MD, FAAP
- H. Shonna Yin, MD, FAAP

This effort will pilot a method and process that can be replicated by any AAP Section or Council that is interested in conducting QI projects that meet the standards established by the American Board of Pediatrics (ABP) for MOC Part 4 and the educational needs of their group using the AAP NCE Education Program (H Program) as the Learning Session.

Interested in Participating? Come to the 2014 COQIPS H Program in October for more information!

COQIPS will host its very first Education H Program on Monday, October 13, 2014 from 9:00 – 5:00 PM. Additional information regarding the pilot project, requirements for participation, and key elements of the project will be announced during the Business Meeting at 1:00 PM. We envision that participant recruitment and enrollment efforts will take place in the late spring/early summer of 2015. Those who participate in the full project and meet the requirements will be eligible to earn 25 MOC Part 4 Credits. We will communicate additional information regarding the project via the COQIPS listserv and future issues of Quality Connections. Stay tuned!

We are looking forward to spearheading this program and hope that many of you will decide to participate in what we hope will be a win for COQIPS and the Academy as a whole. For more information, contact either Cathleen Guch at cguch@aap.org or COQIPS Education Chairperson, Laura Ferguson, MD, FAAP at lferguson@medicine.tamhsc.edu.

Continued on next page
SAVE THE DATE! COQIPS-sponsored programs at the 2014 AAP National Conference & Exhibition

The 2014 National Conference & Exhibition in San Diego is right around the corner! Please consider attending the COQIPS-sponsored education sessions listed on page 17.

The COQIPS Education (H) Program will take place on Monday, October 13th from 9:00 AM – 5:00 PM. The program agenda is located on page 18. Abstract presentations will take place in the morning. The afternoon part of the program will consist of the abstract poster viewing/networking reception with light snacks, business meeting, best platform presentation & best poster awards, and presentations.

The afternoon presentations will feature a stellar line-up of faculty focused on the future of pediatrics – the future direction of quality and patient safety as it relates to pediatrics and the Academy’s role, the future of payment, and emerging challenges in ambulatory patient safety.

You will leave this program with practical, implementable changes to help you improve the care you provide to your patients. For up-to-date location information, visit: www.aapexperience.org/planner. We hope to see you there!

If you have any questions, please contact either Cathleen Guch at cguch@aap.org or COQIPS Education Chairperson, Laura Ferguson, MD, FAAP at lFerguson@medicine.tamhsc.edu.

COQIPS Membership Update - Welcome New & Renewed Members!

Council membership continues to increase. To date, COQIPS has 447 members! We would like to welcome and congratulate the following new and renewed members:

<table>
<thead>
<tr>
<th>Heather Abraham</th>
<th>Michelle Cormran-Thomas</th>
<th>Shesha Katakam</th>
<th>Carolyn Milana</th>
<th>Francis Rushton</th>
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<tr>
<td>Alanna Albano</td>
<td>Cory Darrow</td>
<td>Lorne Katz</td>
<td>Christopher Miller</td>
<td>Kelly Sandberg</td>
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<td>Noorjahan Ali</td>
<td>Ann Downey</td>
<td>C Eve Kimball</td>
<td>Deana Miller</td>
<td>Colleen Schelzig</td>
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<td>Aba (Eba) Al-Kaabi</td>
<td>Danielle Ehret</td>
<td>Susan Kressly</td>
<td>Anna Miller-Fitzwater</td>
<td>Patricia Scherrer</td>
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<td>Jane Amati</td>
<td>Jerrold Eichner</td>
<td>Deepa Kulkami</td>
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<td>Sara ElleOf Van Durme</td>
<td>Eric Langerman</td>
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<td>Julia Shelburne</td>
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<td>Maryam Nobari Tabrizi</td>
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<td>Eleanor Gradidge</td>
<td>Deb Lonzer</td>
<td>Shilpa Patel</td>
<td>Saurabh Talathi</td>
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<td>Rudy Carbaugh</td>
<td>Kristen Hendrix</td>
<td>Jamie Macklin</td>
<td>Christina Peacock</td>
<td>Marisa Toomey</td>
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<td>Natasha Holt</td>
<td>Rita Mangione-Smith</td>
<td>Yasmin Pedrogo</td>
<td>Anne VandenBelt</td>
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<tr>
<td>Ken Cheyne</td>
<td>Patricia Hopkins-Braddock</td>
<td>Preethi Marri</td>
<td>Thomas Phelps</td>
<td>Karen Wasilewski</td>
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<td>Mohammad Janjua</td>
<td>Lauren Maskin</td>
<td>Kathryn Phillipi</td>
<td>Kara Wong Ramsey</td>
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<td>Nana Coleman</td>
<td>Tiffany Kamerman</td>
<td>Elisha McCoy</td>
<td>Jewel Ponvelli</td>
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<tr>
<td>David Cooperberg</td>
<td>Emily Kane</td>
<td>Michael McNerney</td>
<td>Yagnaram Ravichandran</td>
<td>David Zipes</td>
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Congratulations to Sanjeev Vasishtha, MD, FAAP! Dr. Vasishtha is the COQIPS Membership Survey raffle winner who received a Quality Improvement or Patient Safety book of his choice (up to $150 value).

For more information about how to get involved in the membership Subcommittee please contact Dr Wayne Franklin (waynefranklin@gmail.com), Subcommittee Chairperson or Staffperson, Vanessa Shorte (vshorte@aap.org).
Welcome to our first column of updates on selected federal and national healthcare quality and safety policies and activities. For each newsletter, we will provide information and updates on quality and safety topics of interest to pediatricians and child health advocates.

**Agency for Healthcare Research and Quality (AHRQ)**

AHRQ has sponsored a special supplemental issue of Academic Pediatrics for its September/October 2014 issue, which is devoted entirely to pediatric healthcare quality, specifically focusing on the Children’s Health Insurance Program Reauthorization Act (CHIPRA) and CHIPRA measures. COQIPS AHRQ Liaison Kamila Mistry, PhD, is one of the supplement’s editors. It is available for free at: http://www.academicpedsjnl.net/issue/S1876-2859(14)X0008-2.

Did you know that AHRQ supports a Patient Centered Medical Home Resource Center, which provides information and tools to support primary care practices as medical homes? Their Medical Home resources can be found at: http://www.pcmh.ahrq.gov/.

**Centers for Medicare and Medicaid Services (CMS)**

On August 29, CMS published a final rule that allows health care providers more flexibility in how they use electronic health records to meet meaningful use for the 2014 EHR incentive program reporting period. The purpose of this rule is to allow more providers to participate and meet meaningful use objectives such as drug interaction and drug allergy checks, providing clinical summaries to patients, electronic prescribing, reporting on key public health data and reporting on quality measures. For more information, http://cms.hhs.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-08-29.html.

On September 3, 2014, CMS published a report in Health Affairs that announced that the number of uninsured people is projected to decrease by nearly half from 45 million in 2012 to 23 million by 2023 and that health expenditures will grow as coverage expands and the economy improves. The report can be accessed at: http://content.healthaffairs.org/content/early/2014/08/27/hlthaff.2014.0560.

In July 2014, CMS stopped reporting on eight high-risk hospital acquired conditions on their hospital compare website. These eight conditions include: air embolism, blood incompatibility, catheter-associated infections, falls and trauma, foreign objects left in body after surgery, pressure ulcers, uncontrolled blood sugar levels, and urinary tract infections. On September 7th, CMS said that they will resume making this data publicly available but will not use the information in their hospital compare program. Instead this information will be used in other safety rating programs such as the Leapfrog Group’s ratings.
My Quality Journey
Laura Ferguson, MD, FAAP
COQIPS Education Chairperson

When I first heard about the need to do a quality improvement (QI) project for Maintenance of Certification (MOC) like many physicians, I was a bit defensive; I had participated in lots of Continuing Medical Education (CME) and lots of self-assessment. I am a champion of learning more about Evidence Based Medicine and an “early adopter” of evidence based clinical practice, whether in the nursery, the clinic or the inpatient ward. Who was questioning my “quality”?

When the AAP Quality Improvement Innovation Network (QuIIN) was established and I started to receive invitations to participate, my whole frame of mind changed! Since I worked in a fairly typical setting for the “other than” private practitioner (at the time in academic practice), I thought one way to build a team might be to attend a learning collaborative and work on a QI project where everyone had a role. Initially, we gathered two teams from a county hospital in Houston, TX: two physicians, a lactation consultant, two nurses and a nurse practitioner. The group journeyed to AAP Headquarters with our “story boards” to work on “Safe and Healthy Beginnings” (a QI project for optimal management of neonatal jaundice and lactation) and then, a year or so later to work on “Practicing Safety” (a similar project to help parents with prevention of child abuse).

Our teams not only learned about the content of the QI projects but also about ourselves as individual team members and about our function as a team and how we provide care, stuff we thought we already knew.

I began to realize that the key word in “Quality Improvement” was “improvement”; physicians and care teams who provide quality care can always improve. Even when the care itself is excellent and evidence based, there is more to do in terms of cost effectiveness, patient and family centeredness, the equity of delivery and even provider satisfaction and workflow.

Soon after these adventures in QI, I relocated to another city. Instantly I became the QI “expert” in my new location and became a co-chair of the children’s quality council. Interesting how with new paradigms for practice, we return to the “see one, do one, teach one” model we learned in residency!

After a year or two, I assumed responsibility for teaching QI and patient safety as a thread at the medical school where my clinical work is done and undertook this new approach to dissemination of QI knowledge and methodology for a next generation of physicians. There, I discovered that faculty development remains an important part of this effort. Perhaps even more fascinating for me is the application of QI methodology to elements of medical education outcomes at the Undergraduate Medical Education (UME), Graduate Medical Education (GME) and CME levels. Likely, that’s my next exciting venture.

So, after initial skepticism about the need for QI in my professional life, not only has my journey taken me to a place where I consider it essential but it has indeed provided a basis for my current career undertakings and a passion for dissemination. The opportunity to serve on the Executive Committee of the Council on Quality Improvement and Patient Safety with the support of the high “quality” staff at the AAP (pun intended), especially Cathleen Guch, MPH, Manager of Health IT and Quality Education, is the best destination on my Quality Journey thus far.

Continued on next page
Changing Hearts; Changing Minds
Lisa Rossignol, MA
COQIPS Executive Committee Parent Liaison

At six months old, my daughter, Lily, was diagnosed with Infantile Spasms resulting from a right cerebral vascular accident that occurred prenatally. At nine months old, she was diagnosed with intractable epilepsy and was referred to the Cleveland Clinic for a hemispherectomy.

“Hello. I’m Dr. William Bingaman. I have three children. They are all healthy. I can’t imagine what this experience must be like for you. I’m going to do my best to get your daughter the best possible outcome.”

I looked up from the magazine I was reading to see a man in his white coat as he looked directly into my eyes with his hand extended to shake. His statement stunned me – it was revolutionary in the context of any previous clinical interactions I had experienced.

Why was Dr. Bingaman’s statement breathtaking to my husband and I? Why does it inspire awe in families and healthcare workers every time I recount the event? Why did that interaction change my entire professional career? Simply put; it was the first time I was really acknowledged as an expert and partner in my child’s care. I learned, in that brief encounter, it was possible for a physician to understand his or her important role in an entire system of care for my child. I have come to learn that many physicians hold these values but few articulate it so clearly. This world-renowned neurosurgeon conceded that no matter how many baby brains he fixed, there was a part of our experience he was never going to understand. No matter what happened to Lily, we were the ones who would live with the consequences of our actions and inactions.

Lily had a functional hemispherectomy (devascularizing the area of the brain with the seizure focus but leaving the hemisphere in situ) on April 4, 2008 and began seizing again on April 6. On April 14, after honest, sad conversations weighing our options, in partnership with Dr. Bingaman, my husband and I sent Lily back into surgery for an anatomical hemispherectomy. She has been seizure free since then. Dr. Bingaman’s initial statement to us insured that we were compliant and willing to communicate clearly with him.

Throughout Lily’s early care in New Mexico, we had been exposed to physicians that were very skilled clinicians; but many had not articulated the same sense of empathy and care we received from virtually everyone we interacted with at the Cleveland Clinic. The care in New Mexico was always systems-centered—appointments were only available during the day, each department did not communicate with one another, we did not have a multidisciplinary team helping us to manage her care, we were never asked about our wellbeing, and we weren’t included in rounds. In Cleveland, we were introduced to “clustering of care” where several sedated procedures and labs were coordinated so Lily only had to be sedated one time. The hospital provided additional nursing staff to the Epilepsy Monitoring Unit (EMU) on Thursday afternoons so that the families could leave their child’s bedside and attend a support group down the hall. I was able to carry my sweet baby all the way into the operating room both times and was so relieved to feel the cool, sterile air and to see the bright eyes of her care team. Additionally, my husband and I were invited to participate in bedside rounds which added to our feeling of partnership and sense of security about our daughter’s treatment plan. I wondered why all systems of care didn’t feel and act that way.

I returned home to New Mexico to a career as a very successful advertising executive but it only lasted a month. I knew that having a near-death experience with a medically fragile child, five weeks of living in an ICU in a faraway hospital, and the care we were given had changed me forever.

I resigned from my job and went to work for a statewide parent organization

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Continued from previous page, *Changing Hearts; Changing Minds*

in New Mexico called Parents Reaching Out (PRO) ([www.parentsreachingout.org](http://www.parentsreachingout.org)). I became Program Manager for Families as Faculty, which teaches medical students the principles of Patient- and Family-Centered Care (PFCC). PFCC encapsulates all of the things that I loved about our experience at Cleveland Clinic. The PFCC principles are: dignity, unbiased information sharing, partnership, and collaboration ([www.pfcc.org](http://www.pfcc.org)). In that role, I paired third year medical students, in their pediatric rotation, with a family that had a child with special healthcare needs (CSHCN). The students would travel in pairs to conduct a home visit with the family. Families volunteer to participate as Family Faculty and are provided regular instruction in the principles of PFCC, including reflection on past experiences to articulate to providers and trainees what is perceived in a positive way by families. Families are coached in ways to share their past experiences with healthcare providers, both positive and negative in a supportive way so trainees have an opportunity to learn best practices in family/provider interactions. Negative experiences provide opportunities for improvement. The medical students often reported that the home visits revolutionized the ways they viewed families and how they thought about the care plans and equipment they prescribe for children. I enjoyed my time as program manager but wanted to expand my work to the national level so I resigned in 2009 to go to graduate school.

I received a Master’s of Health Communication with a focus on patient-provider communication and provider-provider communication about families and I served as a family fellow to the New Mexico Leadership Education in Neurodevelopment and Related Disabilities (NM LEND) ([http://www.cdd.unm.edu/nmlend/](http://www.cdd.unm.edu/nmlend/)) program at the University of New Mexico where I worked closely with multidisciplinary fellows from diverse sectors of healthcare to teach them effective strategies for including families in patient care and policy. In 2013, I began serving as a family representative on the Improving Healthcare Systems Advisory Panel (IHS) for the Patient Centered Outcomes Research Institute (PCORI) and will continue serving through 2015.

I am honored to be selected to serve as Parent Liaison to COQIPS. I hope to work with COQIPS to assist both families and healthcare providers in increasing awareness of the range of possibilities in family-centered care and to develop caring and innovative policies regarding patients and their families. Additionally, I hope to assist the AAP in fostering parent involvement and to include family members, as indicated and desired by AAP members and leadership, such that the voice of children, parents and their families becomes integrated into the work of the Academy in a meaningful way. The goal for family involvement is not to diminish the jurisdiction of physicians or to disregard hard earned expertise. Rather, the goal of family involvement is to create mutually beneficial relationships that maximize positive outcomes for children. Please feel free to contact me with any questions at lnrossignol@gmail.com.

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Let the AAP help your practice complete and organize the 2011 National Committee for Quality Assurance (NCQA) Standards. The Digital Navigator provides step-by-step guidance through practice transformation into the Patient-Centered Medical Home model of care. Utilize over 400 forms, templates, sample policies, reports, and other resources as your practice goes through the transformation process. Visit [http://digitalnavigator.aap.org](http://digitalnavigator.aap.org) to learn more. Contact [DNSales@aap.org](mailto:DNSales@aap.org) to set up a demo of the tool.
Quality Improvement Case Study

Project Title: Follow-Up Skeletal Surveys for Suspected Physical Abuse

Dates of Project: June 2012 – June 2014

Project Leader: Jonathan Thackeray, MD, FAAP – Chief of Division of Child and Family Advocacy at Nationwide Children’s Hospital

Process for developing the project design and topic:
When evaluating a child less than two years of age for suspected physical abuse, it is standard of care to obtain a skeletal survey to identify fractures. As fractures may be missed and/or overcalled on the initial study, a growing body of literature suggests that it is also important to obtain a follow-up skeletal survey (FUSS) approximately 10-14 days following the initial study. For children admitted to our hospital who receive a child abuse consult, there is an existing mechanism to ensure these children receive their follow-up skeletal survey using our team of Child Abuse Pediatricians. There were, however, approximately 175 children each year who were seen in the emergency department for whom a report of suspected physical abuse was made, but the child was then discharged to a safe environment directly from the emergency department (ED). Analysis of a sample of these children from a two-month time interval demonstrated that less than 35% received a FUSS. To address this gap in care, a project team composed of child abuse pediatricians, ED physicians, clinical social workers, quality improvement specialists and child protective service representatives was convened.

Below are process maps depicting the initial and desired states:

Diagram A on the next page depicts the key drivers and proposed interventions compiled from this team.

Methods:
Data collection consisted of one process measure (ordering of the FUSS) and one outcome measure (completion of the FUSS).

The aim of this project was to increase the percentage of follow-up skeletal surveys completed within 30 days, for a population of children less than two years old discharged from the ED for whom a report is made, from the baseline of 34% to 75% within twelve months and sustain that increase indefinitely.

We developed a system utilizing our electronic medical record by which any child for whom a skeletal survey is ordered and meets our criteria triggers an alert to an ED “outreach” nurse. Continued on next page
This nurse then forwards the child’s medical record to an advanced practice nurse (APN) within our Division. The APN orders the FUSS and has developed a protocol for contacting the family by phone at 7, 14 and 21 days, as well as contacting the child’s caseworker at 14 and 21 days.

There also exist barriers related to contacting the family to schedule the FUSS, getting the child physically to our radiology department to have the study completed and reminding the family and/or caseworker of the need for the study. The ED social worker now verifies contact information for these families, including identification of the preferred method of contact. A handout is provided at the time of the initial ED assessment explaining the importance of the FUSS, so that the family and caseworker have a visual reminder of the need for the follow-up study.

**DIAGRAM A**

**Specific Aim**

We will increase the percentage of follow-up skeletal surveys completed within one month in children suspected of physical abuse from the current baseline of 0% to 50% by November/December 2012 and sustain that increase for the two month period of March/April 2013.

1. less than two years old discharged from the emergency department for whom a report is made.

**Key Drivers**

- Knowledge of clinical guidelines
- Ownership of follow-up study
- Time between ED visit and follow-up study

**Interventions**

- Education for providers in emergency department
- Develop EPIC “order pairing” prompt for follow-up study
- Identification of cohort that requires follow-up study
- Identification of individual (within CAT team) to ensure timely follow-up
- Verification of contact information by ED social worker
- Handout to be provided to family and/or caseworker
- ED outreach nurse to verify order placed

**Results:**

With the development of the electronic medical record-based notification in August 2012, ordering of the FUSS (process measure) increased to 100% almost immediately. Completion of the FUSS (outcome measure), however, actually decreased over the first six months. The issue was that ED physicians did not want to be responsible for a test that would be completed days or weeks after the patient encounter. With recognition of this concern, a system was developed to transfer ownership of the FUSS outside the ED. Once this was complete in August 2013, completion of the FUSS increased to the current rate of 79%. Data is depicted in the run chart on the next page (**DIAGRAM B**).

**Lessons Learned:**

This project was developed by a clinic-based child abuse pediatrician, but focused on a process housed within the emergency department. It is imperative that anytime a project is developed involving multiple specialties or systems, representatives from each participate in the development of key drivers and interventions. Collaboration of this type allows for better identification of process barriers and improves buy-in and compliance from all disciplines involved.

Although this project involved a single tertiary children’s hospital, it is reasonable to expect that the gap in care is present at other similar institutions across the country. Several barriers were identified to holding an ED physician

Continued on next page
Continued from previous page, QI Case Study

responsible for insuring a test is completed days or weeks after the ED visit. This project focused on skeletal surveys, but perhaps there are other tests to which the same principles apply.

For more information, please contact Jonathan Thackeray at jonathan.thackeray@nationwidechildrens.org.

References:


DIAGRAM B

ED Skeletal Survey - Study Completion Rate

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The Ohio Chapter of the American Academy of Pediatrics has a history of using quality improvement (QI) methodology to address important issues in child health, such as asthma, childhood obesity, and autism. Now, with the support of a Healthy Tomorrows Partnership for Children grant, the Chapter is expanding the reach of one QI program focused on the prevention of infant mortality. This project uses an innovative combination of providing anticipatory guidance and products, and has shown improvements in pediatric practitioner injury counseling and self-reported changes by parents to practice safer behaviors.

The Injury Prevention Learning Collaborative, which launched a pilot wave in 2012, incorporated a specific focus on safe sleep. The program uses age-appropriate screening tools (birth-4 months and 6 months-1 year) to determine areas where parents may be unaware of injury risks such as co-sleeping or items in cribs, and offers clinicians standard injury prevention advice to discuss with families based on their screened responses. During the second wave of the project, from October 2013 to May 2014, nearly 2,500 sleep sacks were distributed, with injury anticipatory guidance, through participating practices at well-child visits because research has shown that families tend to practice safer behaviors if given the information along with specific products.1,2

Additional questions on the age-appropriate screening tools addressing other safety topics include:

- Car Safety
- Choking
- Fall Prevention
- Family Interactions
- Fire/Burn
- Home Safety
- Play Safety
- Unintentional Ingestions
- Water Safety

Participating practices saw an increase in discussions with families on all age-appropriate injury prevention topics from about 15% at baseline to 84% by the close of the project only 7 months later. Safe sleep discussions in the newborn to 4-month well-child visits increased from 18% to almost 90%. The project also measured self-reported changes in behavior by parents following anticipatory guidance provided at each well-child visit. In the newborn to 4-month visits, 52% of families made at least one change to improve safety practices for their child based on counseling they received from the primary care provider. For 6-month to 12-month visits, 62% of families made a change to at least one parenting practice, reported at subsequent visits.

In addition to safety behavior changes reported by families, providers who participated in the project report that having a method for determining which areas of injury prevention to discuss with a family during the office visit increased their efficiency. During the Learning Collaborative practices also take part in monthly Action Period Calls, where they share experiences and receive focused education on injury prevention topics, including safety around car seats, water, sleep, and food.

Medical Directors Michael Gittelman, MD, FAAP and Sarah Denny, MD, FAAP lead the project. Both work directly with patients in the emergency department, and see many of the injuries addressed in this project firsthand. They used this experience, along with their passion for childhood injury prevention, to develop the screening tool and quality improvement project with the support of the Ohio AAP. Through the 5-year funding commitment of the Healthy Tomorrows grant, Drs. Denny and Gittelman have the opportunity to refine and expand the reach of this project. This includes exploring methods to test the validity of parent responses, extending

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the tool to reach more practitioners nationally, and expanding the tool to screen for children of older ages.

A third wave of the Injury Prevention Learning Collaborative is scheduled to begin in early spring 2015, and will include practices in Ohio as well as possible participants from other states. Participants in the Injury Prevention Learning Collaborative are eligible to receive up to 25 Maintenance of Certification Part 4 credits from the American Board of Pediatrics. Pediatric practitioners who are interested in learning about participation opportunities for upcoming waves of the project should contact Hayley Southworth at the Ohio AAP at hsouthworth@ohioaap.org. For more information on the Healthy Tomorrows Program, visit: http://www2.aap.org/commpeds/htpcp/.

References:

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**AAP MOC Portfolio Program**

**AAP Maintenance of Certification (MOC) Portfolio Program Web page now available!**

Visit [www.aap.org/mocportfolio](http://www.aap.org/mocportfolio) to learn more about the AAP MOC Portfolio Program, including how you can get involved.

As a Portfolio Sponsor, the AAP can approve its own projects for MOC points. Applying through the AAP MOC Portfolio Program is free. Projects submitted through the Portfolio Program must:

- Follow the standards set forth by the ABP
- Have direct oversight from national AAP
- AAP group must be meaningfully involved in the design and implementation of the project
- Complete an AAP MOC Application Form
- If approved, monitor physician participation and provide ongoing reports to the AAP

For more information, visit [www.aap.org/mocportfolio](http://www.aap.org/mocportfolio) or contact MOCPortfolio@aap.org.
AAP Chapter Quality Network Offers a Fourth Asthma Collaborative
From the Department of Community, Chapter and State Affairs

The AAP's Chapter Quality Network (CQN) has offered a fourth asthma collaborative to interested chapters and work will begin this fall. This grant funded project seeks to increase the reliable implementation of the National Heart, Lung, and Blood Institute (NHLBI) Expert Panel Report (EPR)-3 Asthma Guidelines in pediatric practices by providing access to Quality Improvement (QI) expertise and access to on demand data reporting using a population management based registry. Cross learning activities including face to face learning sessions; webinars and collaborative conference calls provide support and reinforcement of the project goals and activities. In addition, participating chapters and practices receive quality improvement coaching from experienced QI professionals throughout all phases of the project. The Ohio, Alabama, Arizona and Arkansas chapters most recently participated in this year-long learning collaborative and collected data from nearly 9000 patient encounters and 18,796 patient records.

During the third phase of the collaborative, patient visits with “optimal asthma care” (a bundled measure that includes use of a standardized method to measure asthma control, a stepwise approach to treatment, provision of an asthma action plan, and provision or recommendation of a flu shot) increased from 44% to 82% during the project. All 39 participating practices successfully uploaded their asthma populations to a registry to facilitate planning and analysis for key improvement activities such as the administration of flu shots. Participating physicians were also eligible to receive American Board of Pediatrics (ABP) Maintenance of Certification Part 4 credits.

“There is, in my opinion, no better way to introduce yourself and your chapter’s membership to the science and practice of QI.” - CQN Phase 3 Chapter Leader regarding CQN Asthma

In August, CQN announced funding through a generous grant from GlaxoSmithKline for Phase 4 of this highly regarded project, and has presented a Request for Application (RFA) to chapters looking to provide this quality experience for their member practices. The project will commence in November. In addition, CQN is pursuing funding to implement a pilot collaborative focusing on Attention Deficit Hyperactivity Disorder. For more information please visit: http://www2.aap.org/member/chapters/caqi/.
AAP Childhood Immunization Support Program utilizes EQIPP to promote quality improvement through chapter leaders: Feedback from AAP Nebraska Chapter

Meera Varman, MD, FAAP
Professor of Pediatrics and Professor of Medical Microbiology, Creighton University School of Medicine

Childhood Immunization Support Program (CISP) EQIPP Dissemination

The Childhood Immunization Support Program - a cooperative agreement at AAP, funded through a grant from the Centers for Disease Control and Prevention (CDC) - is using immunization leaders in several states to disseminate the Education in Quality Improvement for Pediatric Practices (EQIPP): Immunization – Improve your Practice Rates to pediatricians in their chapter. This course allows immunization providers to measure rates, implement a quality improvement change, and re-measure rates to determine the impact of the intervention. Fourteen pediatricians from 12 states attended a learning session at the AAP headquarters in March, 2014. There they learned about reminder and recall systems, addressing vaccine hesitancy, proper documentation of immunizations, the immunization schedule, assessment of rates, missed opportunities, and more. These 14 pediatricians recruited 90 pediatricians from their chapters to use the EQIPP course and continue to offer them support in implementing their quality improvement changes.

Participation of Nebraska’s Pediatricians

I was the representative from Nebraska. I am an Infectious Disease specialist who serves on the Nebraska Immunization Task Force and is the Immunize Nebraska program co-course director for the 2014 program. After the learning session at the AAP headquarters, I conducted two of my own trainings with local pediatricians. The chosen purpose of these workshops was to encourage physicians to screen their own immunization rates and to be aware of the tools and resources available through the AAP and CDC to help improve rates. The workshop focused on increasing vaccination rates with an emphasis on teen/HPV vaccination.

The trainings occurred on April 23 and 24 in Omaha, NE. A total of 25 physicians attended from 15 clinics. Attendees represented Children’s Physicians, Creighton, University of Nebraska Medical Center, Boys Town clinic, and included pediatricians from state capitol, Lincoln, NE. These participants then used the EQIPP module in their practice.

Outcomes and Challenges

Highlighted below are the outcomes and challenges shared by two participants of this program.

Case 1

The change this practice implemented was activating the electronic medical record (EMR) prompt feature. The challenge has been gaining buy-in from all the doctors in their large clinic. It was also time-consuming and cumbersome to activate the prompt feature in the EMR; some staff had to attend a technology training. This intervention proved its value, however. The reporting doctor’s vaccine rates have increased and needed vaccines are easily addressed at all sick visits. This pediatrician started at 0% (April, 2014) for complete immunization records in adolescents, and is up to 90% (July 2014).

Case 2

This practice made two changes. The first included the physician taking charge of recommending the HPV vaccine (as opposed to the nurse); the physician used the newest up-to-date information on the vaccine. The second change included having the nurse who roomed the patients to check each patient’s immunization status. In order to reduce missed opportunities, vaccines due would be noted on the encounter form, which allowed the physician to recommend them. Challenges noted by this team included patients not being prepared to receive immunizations and resisting the opportunity due to illness or just “not feeling up to it”. For example, some parents believed that it was unsafe to vaccinate if their child had a mild illness. Finally, this new process also added time to the physicians encounter because

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they were now discussing vaccines whereas before a nurse had done so. In the short time since the intervention this pediatrician saw a 30% increase in rates and another 40% of patients made follow-up immunization-only appointments. It is too soon to tell whether those appointments will be kept and if rates will rise further.

EQIPP Can Help You Improve Rates
Several other practices responded and reported seeing an increase in rates after using the EQIPP module to implement a change in their office. The EQIPP module Immunization – Improve your Practice Rates is now complementary for AAP members. To register for this course, visit: http://pedialink.aap.org/Default.aspx.

We Hope to See You at the 2014 National Conference & Exhibition in San Diego!
Expect the next issue of Quality Connections in December 2014!
2014 National Conference & Exhibition Important Dates

October 12, 2014
I2143- Yes You Can! Chapters Running QI/Maintenance of Certification Projects
4:00 PM – 5:30 PM
Speaker: Sean Gleeson, MD, MBA, FAAP and Andrew Stubblefield, MD, FAAP

October 13, 2014
H3065- Council on Quality Improvement and Patient Safety Program
9:00 AM – 5:00 PM
Speakers: Patrick Conway, MD, MSc, FAAP, Thomas K. McInerny, MD, FAAP, Greg Randolph, MD, FAAP, and H. Shonna Yln, MD, FAAP

October 14, 2014
P4047- Health System Transformation: The Future of Payment and Implications for Pediatricians
11:50 AM – 12:10 PM
Speaker: Patrick Conway, MD, MSc, FAAP
Council on Quality Improvement & Patient Safety Program
Monday, October 13, 2014 | 9:00 AM – 5:00 PM
Marriott Marquis, Marina Ballroom Salon F

Moderators: Laura Ferguson, MD, FAAP and Greg Randolph, MD, MPH, FAAP

9:00 a.m. Scientific Session
Welcoming Remarks: Laura Ferguson, MD, FAAP

9:15 a.m. Platform Presentations

10:30 a.m. Break

10:45 a.m. Platform Presentations Continued

12:00 p.m. Poster Viewing & Networking Reception

1:00 p.m. COQIPS Business Meeting

1:50 p.m. Break

2:00 p.m. The Future of Pediatrics

2:00 p.m. – 2:45 p.m.
Thomas K. McInerney, MD, FAAP
AAP Immediate Past President

2:45 p.m. – 3:30 p.m.
Part 2: Payment, Reimbursement and Beyond!
Patrick Conway, MD, MSc, FAAP
CMS Deputy Administrator for Innovation and Quality and CMS Chief Medical Officer

3:30 p.m. Break

3:45 p.m. – 5:00 p.m.
Greg Randolph, MD, MPH, FAAP
Director, Center for Public Health Quality
Professor, Department of Pediatrics
Adjunct Professor, Gillings School of Global Public Health
University of North Carolina at Chapel Hill

H. Shonna Yin, MD, FAAP
Assistant Professor of Pediatrics and Population Health
Departments of Pediatrics and Population Health
NYU School of Medicine / Bellevue Hospital Center

5:00 p.m. Best Platform Presentation & Best Poster Awards; Adjourn