Message from the Chairperson
Wayne Franklin, MD, MPH, MMM, FAAP
Chairperson, AAP Council on Quality Improvement & Patient Safety

I hope that everyone had an incredible time at the 2015 National Conference & Exhibition in Washington, DC. With sage guidance and expert oversight from Laura Ferguson, MD, FAAP, our Education Chair, we had another successful education (H) program. We started out our morning with abstract and poster presentations. Many of these were eligible for Maintenance of Certification (MOC) Part 4 credit through our pilot project with the Section on Emergency Medicine organized by Jill Healy, Manager of Quality Improvement and Certification Initiatives. Jill manages the AAP’s MOC Portfolio Program. Our abstracts were peer-reviewed for acceptance into the program by Dr. Ferguson and our Abstract Chairs, Alston Dunbar, MD, FAAP, Gregory Hale, MD, FAAP and Julia Shelburne, MD, FAAP. The abstracts were judged during the Council education (H) program by many Council members: Greg Barretto, MD, FAAP, Alston Dunbar, MD, FAAP, Laura Ferguson, MD, FAAP, Sonal Kalburgi, MD, FAAP, C. Eve Kimball, MD, FAAP, Kamila Mistry, PhD, Brigitta Mueller, MD, FAAP, Greg Randolph, MD, FAAP, Nandeesh Rangaswamy, MD, FAAP, Lisa Rossignol, MA, Julia Shelburne, MD, FAAP and Joel Tieder, MD, FAAP. We thank all of you for participation in making our Council meaningful!

The afternoon was devoted to a learning session for our MOC Part 4 pilot project on Health Literacy. More than 60 AAP members participated in the learning session. The presentations by the faculty were top-notch and very interactive. We want to thank each of the faculty members and MOC Pilot Planning Group: C. Eve Kimball, MD, FAAP, Kamila Mistry, PhD, Laura Noonan, MD, FAAP, Greg Randolph, MD, FAAP, Lisa Rossignol, MA, Lee Sanders, MD, Ulfat Shaikh, MD, FAAP, and Hsiang (Shonna) Yin, MD, FAAP. We could not have completed this session without the invaluable work of these members.

Our Council Executive Committee went to 20 meetings of Executive Committees of sections and councils at the NCE. The purpose of these meetings was to increase our visibility with other groups. We

Continued on next page
offered to partner with them on developing MOC part 2 and 4 programs, invited them to submit educational offerings with us for future national meetings, and made it known to them that we would like to write policy statements and clinical reports with them (if appropriate) or at least to review the policy statements and clinical reports when they are out for peer review. Overall, we were pleased to receive such a warm welcome from so many AAP sections and councils! I will be reaching out to the AAP committees to increase awareness of our Council in the spring and continue to encourage them to become COQIPS members.

I had a brain cramp at our Business Meeting and forgot to thank our incredible staff who allow us to function as we do: Cathleen Guch, Manager of Quality and Health IT Education (COQIPS Education Staff Lead), Lisa Krams, Manager of Quality and Health IT Policy (COQIPS Policy/Advocacy/Measurement Staff Lead); Kymika Okechukwu, Manager of Evidence-Based Practice Initiatives (Clinical Practice Guidelines); Jill Healy, whose support of the MOC portfolio is incredibly intertwined with our work; and last but not least Vanessa Shorte, Director of the Division of Quality, who is our primary staff person and an incredible wealth of knowledge about Quality Improvement, Patient Safety and Politics!

Thank you!
Updates from the COQIPS Executive Committee

COQIPS Education Update

2015 AAP National Conference & Exhibition in Washington, DC
Thank you for a successful National Conference & Exhibition in Washington, DC! Our full-day program on Saturday, October 24th was packed with abstract presentations, a poster session, Council business meeting. We also held our health literacy workshop in the afternoon for those participating in our first Maintenance of Certification (MOC) Part 4 project, as well as anyone interested in health literacy, generally.

Congratulations to our Abstract Best Platform Presentation and Best Poster awardees, listed below. They were recognized in the online December issue of AAP News.

Best Platform Presentation Award
Daniel M. Cohen, MD, FAAP
“Emergency Department Diversion for Epilepsy Patients Using Quality Improvement Methodology”

Best Poster Award
Kimberly A DeQuattro, MD, FAAP
“Facilitating Transition: My Care Notebook for Adolescents with Chronic Illness”

Also, we would like to recognize and thank our health literacy workshop faculty and facilitators. Much time and effort went into the development and implementation of this workshop. Everyone went above and beyond to ensure that our participants received practical information that could be used in any setting.

C. Eve Kimball, MD, FAAP
Kamila Mistry, PhD, MPH
Laura Noonan, MD, FAAP
Greg Randolph, MD, MPH, FAAP
Lee Sanders, MD, MPH
Ulfat Shaikh, MD, MPH, FAAP
Shonna Yin, MD, FAAP


MOC Part 4 for Poster and Podium Abstract Presentations
Through the Academy’s MOC Portfolio Program, we will be offering 20 MOC Part 4 points for podium and poster abstracts accepted into the 2016 COQIPS scientific abstracts program, if they meet the established American Board of Pediatrics’ requirements. If the requirements are met, all authors listed on the scientific abstract are eligible. More information on this opportunity will be announced in January/February through the COQIPS listserv.

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
Continued from previous page, *Updates from the COQIPS Executive Committee*

**COQIPS Membership Update - Welcome New & Renewed Members!**

Council membership continues to increase. To date, COQIPS has over 540 members! We would like to welcome and congratulate the following new and renewed members:

- Kathleen Asas
- Hari Bandla
- John Beuerlein
- Jacquelyn Crews
- Rhanda Darville
- Jessica Davidson
- Christopher DeRienzo
- Laura Diaz de Ortiz
- Margaret Ellis
- Adel Elsharkawy
- Ahmed Fageer Osman
- Kori Flower
- Linda Gallo
- Bracha Goldsweig
- Bradford Harris
- Erin Herstine
- Azada Ibrahimova
- Yae Sul Jeong
- Susan Kressly
- Mohamed Lafeer
- Keith Loud
- Mohammad Malik
- Karl Maurer
- Margaret Menoch
- Carolyn Milana
- Melinda Murphy
- Maria Ossa
- Yomayra Perez
- An Pham
- Markus Renno
- Elizabeth Robbins
- Kristina Rosbe
- Lisa Rossignol
- Ruba Sahab
- Matthew Scheff
- Xavier Sevilla
- Julia Shelburne
- Hali Sherman
- Camille Smith
- Kelly Thorstad
- Danielle Thurtle
- Dina Wallin
- Jeffrey Winer
- Brian Wood
- Philip Zachariah

For more information about how to get involved in the Membership Committee please contact Dr Wayne Franklin (waynehfranklin@gmail.com), committee chairperson or staffperson, Vanessa Shorte (vshorte@aap.org).
Congress passes budget deal:
At the end of October 2015, Congress passed a two-year budget deal that raises overall funding levels and suspends the debt limit until 2017. The Bipartisan Budget Act of 2015 increases the discretionary spending caps by $50 billion in FY 2016 and $30 billion in FY 2017, with the increases split evenly between defense and non-defense discretionary programs. The agreement increases the FY 2016 non-defense discretionary spending cap by $25 billion (5.1 percent) to $518.5 billion.

The new budget has mixed news for healthcare – there is an increase in the budget for the National Institutes of Health but a 2% cut to Medicare provider payments and cuts for health care services provided in a hospital’s outpatient department (otherwise known as “site neutral” payments).

Also included in the budget deal are significant cuts to the Agency for Healthcare Research and Quality (AHRQ), which is the agency focused on health services research, quality and patient safety. There is a twitter campaign underway to #SaveAHRQ.

Health Policy Focus: MIPS, what is it and how will it affect clinicians?

What is MIPS?

Section 101 of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repeals the Medicare sustainable growth rate (SGR) methodology for updates to the physician fee schedule (PFS) and replaces it with a new Merit-based Incentive Payment System (MIPS) for MIPS eligible professionals (MIPS Eligible Providers or “EPs”) under the PFS. It ends payment adjustments under the current Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the Electronic Health Records (EHR) Incentive Program and consolidates aspects of those programs into one new MIPS, one single program based on quality, resource use, clinical practice improvement and meaningful use of certified EHRs.

Why is there a change now?

The goal of MIPS is to cut down on the administrative burdens these programs place on providers who participate in them. Currently, physicians are forced to either participate in these programs or incur penalties. Under MIPS, healthcare providers will receive a cumulative score based on participation in these programs and other efforts to improve patient care and optimize treatment outcomes. Medicare reimbursement adjustments, will be increased or reduced based on this cumulative assessment score.

When does MIPS take effect?

MIPS will take effect in 2019. In the interim, CMS is in the process of drafting rules and regulations.

Does MIPS apply to pediatricians?

MIPS is largely applicable to clinicians who see Medicare patients. Of course many pediatricians participate in meaningful use.
What are Alternative Payment Model (APMs)?

In order to qualify for incentives under MACRA, physicians are required to participate in APMs based on the same quality measures set down by MIPS.

Stakeholder organizations will have an opportunity to comment on how the program will be developed and implemented.

AAP’s comments on MIPS and Alternative Payment Models (APMs) can be found here: [http://downloads.aap.org/dofa/11-17-2015-%20AAP%20Comments%20to%20MACRA-MIPS%20RFI.pdf](http://downloads.aap.org/dofa/11-17-2015-%20AAP%20Comments%20to%20MACRA-MIPS%20RFI.pdf).

Although APM options are not yet widely available in much of the country, and/or are unavailable for providers with certain specialties, MACRA establishes options to encourage providers to participate in developing a number of new payment models, including:

- Models for specialty-specific practices
- Models for practices with 15 or fewer physicians
- Models developed together with private payers
- Statewide payment models
- Medicaid-based option models

Examples of APMs used by states including Medicaid programs, are: Health Homes/Primary Care Medical Homes, episodic or bundled payments, accountable care organizations, and global budgets.

Clinicians who receive a significant percentage of payments through APM participation may be exempted from other requirements of the MIPS program. APM participants may also receive lump-sum incentive awards, in effect from 2019 to 2024, meant to offset any financial risks or monetary losses they might incur from this transition.
My Quality Journey
Michael Rinke, MD, PhD, FAAP
COQIPS Implementation Committee Co-Chair

My quality journey began unexpectedly on a regular day in my first year of medical school. I walked into our lecture hall, looking forward to listening to one of our “fluffy lectures” on something called “Patient Safety and Quality Improvement,” which would not appear on any of our anatomy exams. Contrary to my expectations, I spent the next hour enraptured by Dr. Peter Pronovost, one of the world’s leaders in patient safety and quality improvement. As Dr. Pronovost discussed the Institute of Medicine (IOM) reports, the horrible toll medical errors take on our patients, and the amazing work we could do to prevent harm, I became hooked. At the end of his talk, when he offered to have students do quality improvement and research with him over the summer, I jumped to be the first in line.

I learned so much that summer about how to teach and implement rigorous quality improvement efforts. Seeing Dr. Pronovost in action, allowed me to watch a master navigate a complex health care system and push for real and lasting change that would benefit patients. I was fortunate to find another amazing mentor, Dr. Marlene Miller, who allowed me to do a full year of pediatric quality improvement and patient safety research with her between my third and fourth years of medical school. Dr. Miller expertly taught me how to design, study and enact quality improvement projects, and how to make a meaningful difference in the lives of children. We worked on projects including Emergency Department medication errors, pediatric psychiatry error reports, and the efficacy of executive safety walk-rounds. This year was even more meaningful as I was partially supported with funds related to Josie King. Josie was an 18-month old girl who died from medical errors at a major medical center. Dr. Miller and I met with Josie’s mother, Sorrel King, who drove home the urgency with which we needed to act to prevent errors in children.

After completing my pediatric residency, I was again fortunate to have the opportunity to work with Dr. Miller in her Division of Quality and Safety at Johns Hopkins University. Under her guidance, I completed a doctorate in clinical investigation, which allowed me to understand rigorous trial design and statistical analyses. These skills allowed me to not only implement quality improvement projects, but also scientifically study them and prove their benefit. I met amazing colleagues, like Dr. David Bundy, who pushed us to have as large an impact as possible on children’s lives. I also began interacting with the Children’s Hospital Association Central Line-Associated Blood Stream Infection (CLABSI) prevention collaborative, illustrating the power of the “all teach, all learn” model of quality improvement collaboratives. I also received training in lean six sigma methods, and participated in residency and fellow quality improvement education.

A singular moment that changed my quality journey came during a CLABSI meeting on our pediatric oncology floor. We were all anxiously awaiting our infection preventionist’s report on whether a recent positive blood culture would “count against us,” in our efforts to eliminate inpatient CLABSI. When we heard that the patient’s infection would not be considered an inpatient CLABSI because it was drawn only 30 hours after admission, a small cheer went up around the room. And then, someone spoke up and said, “But isn’t she still admitted? Doesn’t she still have an infection? And isn’t she still our patient?” Those simple comments sparked an immediate appreciation in our entire team that we needed to reduce both inpatient and outpatient CLABSIs. It made me appreciate that ambulatory quality improvement and safety is often underfunded and considered not as urgent as inpatient quality improvement and safety. Working with an amazing multidisciplinary team, we discovered that for every 1 inpatient oncology patient CLABSI, we had 3 ambulatory oncology patient CLABSIs. After 3 years of hard work, this stellar team was able to reduce these harmful ambulatory oncology CLABSIs by almost 50%. To this day, I continue to work with a number of inspiring collaborators to identify the epidemiology of all types of ambulatory healthcare-associated infections and find ways to reduce the harm they convey on children.

Continued on next page
As I transitioned in my quality journey to the Children’s Hospital at Montefiore, I further appreciated other gaps in our pediatric quality improvement and patient safety agenda, specifically diagnostic errors. Despite being identified in the original 1999 IOM report, few studies were trying to reduce these harmful errors and even fewer were done in pediatrics. Working with the American Academy of Pediatrics’ Quality Improvement Innovation Network (QuIIN), collaborators around the country, and 25 excited and motivated pediatric practices, we are discovering whether a quality improvement collaborative, using the “all teach, all learn” model, can reduce missed diagnoses of adolescent depression, missed diagnoses of pediatric elevated blood pressure, and delayed diagnoses of actionable laboratory results. As we try to push the science of implementation further, our group applied a randomized clustered stepped-wedge study design, in order to rigorously prove the effects of our work.

Overall, the key to my quality journey has been the same as the key to any good quality improvement project: find dedicated and brilliant mentors and colleagues and urgently work as a team to reduce harm and improve quality in children. Just like the famous proverb, ‘It takes a whole village to raise a child,’ it also takes a whole village to do quality improvement and improve patient safety. I owe everything to the amazing ‘village’ I was lucky enough to have around me.
Pediatric Quality Measures Program (PQMP)

Measure Development
AHRQ has developed a central website which provides detailed information on the measures put forth by the PQMP Centers of Excellence (COE). The website includes a measure index which contains information on measure specifications, data sources, and endorsements. For a select number of measures, a link to printable factsheets is also included. Additional factsheets are being compiled and full specifications for each of the measures will be made available in early 2016. For the latest updates, see: http://www.ahrq.gov/policymakers/chipra/factsheets/index.html.

National Quality Forum (NQF) Pediatric Measures Project
The PQMP COE submitted a number of newly developed measures to the NQF Pediatric Call for Measures for review and endorsement consideration. The NQF Pediatric Measures Project was launched in July 2015 with the goal of “evaluating measures related to child health that can be used for accountability and public reporting for all pediatric populations and in all settings of care”. The COE measures are currently under review (in-person review meeting took place on December 1-2, 2015). Additional COE measures will be submitted to upcoming projects in 2015 and 2016 (e.g. perinatal/reproductive health, pulmonary/critical care). For the latest updates and to follow the process, see: http://www.qualityforum.org/Pediatric_Measures.aspx.

Other AHRQ Child Health Updates

Patient Safety – Growing Focus on Ambulatory Care Settings
AHRQ recently published RFA-HS-15-002, AHRQ Health Services Research Projects: Making Health Care Safer in Ambulatory Care Settings and Long Term Care Facilities (R01). Three pediatric proposals were funded under this Request For Applications (RFA):

1) ALBERT EINSTEIN COLLEGE OF MEDICINE: Pediatric Ambulatory Healthcare-Associated Infections
2) CASE WESTERN RESERVE UNIVERSITY: Epidemiology, Exploration and Evaluation: Addressing potentially dangerous medications in Medicaid children with a mental health diagnosis
3) CINCINNATI CHILDREN’S HOSPITAL MEDICAL CENTER: Human and System Factors Contributing to Pediatric Medication Error and Injury


Conference/Meeting News

Annual Science of D and I Conference
December 14-15 | Washington, DC

AHRQ co-sponsored the 8th Annual Conference on the Science of Dissemination and Implementation on December 14-15, 2015 with a Technical Assistance Workshop on December 16, 2015 in Washington, DC. This was a forum for discussing the science of dissemination and implementation and growing the research base by bridging the gap between evidence, practice, and policy in health and medicine. Meeting proceedings can be reviewed here: http://diconference.academyhealth.org/home.

Save the Date: 2016 National Child Health Policy Conference (Academy Health)
February 3 | Washington, DC

For additional information, please contact:
Kamila B. Mistry, PhD MPH - Senior Advisor, Child Health and Quality Improvement
Email: kamila.mistry@ahrq.hhs.gov
Engaging Patient/Family Members in Our Work

Lisa Rossignol, MA
COQIPS Executive Committee Parent Liaison

Led by COQIPS Chair, Wayne Franklin, MD, MPH, MMM, FAAP, our membership subcommittee has created a process to engage families to meet the needs and interests of the AAP, physician members of COQIPS, and family/patient advocates. I’d like to share our experiences with the COQIPS readership and some of the lessons we have learned together along the way.

Our first challenge was balancing the AAP requirement for families seeking affiliate membership to meet the same high standards for general AAP membership while still keeping the application process reasonable and relatively easy for families to complete. The mission of AAP and COQIPS is best served through positive interactions with experienced family advocates, and families benefit from contributing to efforts to develop high quality best practices that reflect both scientific rigor and the patient/family viewpoint.

We first created an application for families for affiliate Council membership and posted it online to AAP’s Web site. We were able to specify a distinct membership category for patients/families and to set membership dues at $0, a not insignificant feat that took months to enact and involved significant debate and a vote from both our Council executive committee and the executive Board of AAP.

Next, with the help of AAP membership staff, we drafted bylaws for family affiliate membership and requiring a letter of support from a COQIPS physician member to support a family member applicant, measures that are commensurate with requirements for all AAP affiliates. After submission, the support letter is then reviewed and voted upon by the membership subcommittee. Once again, the proposal for the bylaws and COQIPS affiliate letter required a vote by our executive committee, the executive board for AAP, and finally the general membership of COQIPS. Finally, in July 2015, we were cleared to open up applications for family and patient affiliates! I put out a call to the Family Voices listserv and received a very enthusiastic response, with 15 family advocates indicating that they were beginning the application process.

One of the biggest challenges we have found is the requirement that the letter of support be from a COQIPS member. There is currently no publicly available COQIPS membership list on the AAP Web site, making it difficult for potential family affiliates to identify a COQIPS member and request a letter of support. One family leader did request to be notified of names of COQIPS physicians in her area and AAP membership was able to quickly provide her with some options.

We can do better and we are going through our own PDSA cycle to improve it! We have requested that the bylaws be changed to allow the affiliate letter to come from any AAP member, not only those who belong to COQIPS. This request was approved by our executive committee at the National Conference and Exhibition this past month! The next steps are to have the bylaw revisions approved by the AAP executive board and then by the general COQIPS membership by July 2016. AAP is also improving our COQIPS website to make it more family friendly and to include a list of all COQIPS members (unless members opt-out). We have also challenged our COQIPS members to support one patient or family affiliate through this process from their own practices. Our executive committee appealed to numerous AAP sections and committees at the NCE for involvement in family engagement.

Continued on next page
Continued from previous page, Engaging Patient/Family Members in Our Work

Finally, the Family Partnership Network has agreed to help COQIPS work within AAP to improve the family affiliate membership application process in an ongoing way.

So, this is me, asking you, to help us work with what we have. We all want families and patients on this council. We believe that this inclusion will improve the work we do. We ask you to accept our challenge and walk one patient or family affiliate through the membership process. We look forward to hearing your ideas and feedback. I am confident we will get this right and then this practice will spread throughout AAP.
A Flurry of Firsts
Matthew Garber, MD, FHM, FAAP
Medical Director, Value in Inpatient Pediatrics (VIP) Network
Chief Quality Officer, Children's Hospital, Palmetto Health Richland

Recruitment has just ended for two Value in Inpatient Pediatrics (VIP) Network projects with record-breaking responses from the VIP membership! The first project, Quality Improvement for the Management of Children Hospitalized with Urinary Tract Infection (Q-UTI), finished recruitment on June 15, 2015 with 61 applications, breaking the VIP record for applicants (formerly held by the Improving Community-Acquired Pneumonia (ICAP) Project with 53 hospital site applications). Q-UTI also set a precedent by being the first VIP project topic that was chosen by a plebiscite of VIP members. The co-chairs for Q-UTI are Rick Engel MD, FAAP, Pediatric Hospitalist at Phoenix Children's Hospital; Brian Pate, MD, FHM, FAAP Chair, Department of Pediatrics University of Kansas School of Medicine and Matthew Garber, MD, FHM, FAAP, Chief Quality Officer at Palmetto Health Richland and VIP Network Medical Director, serving as the quality improvement advisor.

The next project, Stewardship in Improving Bronchiolitis (SIB), also set precedents and broke records with 67 applications, breaking the recent Q-UTI record. SIB and Q-UTI are the first VIP projects to concurrently run. SIB is also the first VIP project to engage emergency medicine physicians as part of the improvement team and to collect data from the charts of patients discharged from the emergency department as well as the inpatient hospital setting. The co-chairs for SIB are Grant Mussman, MD, MHSA, FAAP, Attending Physician in the Division of Medicine at Cincinnati Children’s Hospital and Michele Lossius, MD, FAAP, Physician Director of Quality and Safety for Pediatrics at University of Florida Health Shands Children’s Hospital in Gainesville, FL. Kristin Shadman, MD, FAAP, Pediatric Hospitalist at American Family Children’s Hospital in Madison, WI serves as the Lead Coach for SIB, with Jeffrey Bennett, MD, MBOE, FAAP, Director, Kentucky Children's Hospital's Quality, Innovation, and Value Assessments serving as the SIB quality improvement advisor.

Both projects were able to expand beyond their originally planned number of sites (Q-UTI from 33 to 42 and SIB from 30 to 35). To date, all VIP projects have been oversubscribed and the VIP Network Steering Committee has identified expanding its capacity to run larger collaboratives as its number one priority. In the meantime, to support the overwhelming interest, VIP and SIB leadership were able to offer the oversubscribed sites access to SIB project resources for their own self-directed improvement efforts. Response to this innovative implementation model will determine future opportunities for the sharing of collaborative materials. The VIP team is overjoyed at the robust response to these projects. Plans are in the works for the next VIP project, Reducing Excessive Variability in the Infant Sepsis Evaluation (REVISE). It remains my honor to work with such motivated project leaders and passionate and committed hospitalists through the VIP Network projects.

The VIP Network Stewardship in Improving Bronchiolitis (SIB) Expert Group members (from left to right, starting in the back): Liz Rice-Conboy, MS (AAP Staff), Drs Michele Lossius, Susan Chu Walley, Grant Mussman, Michele Saysana, Christopher Cunha, Jeffrey Bennett, Lauren Destino, Shawn Ralston, Kristin Shadman and (not pictured) Jennifer K Light.
Innovative Outpatient Pediatric Diagnostic Error Quality Improvement Project Now Recruiting Wave 2

Thousands of children are harmed each year by diagnostic errors. Pediatric clinics nationwide are invited to submit a recruitment application to participate in a first of its kind quality improvement project aimed at reducing pediatric diagnostic errors related to (1) missed elevated blood pressure, (2) missed (select) actionable labs and (3) missed opportunity to diagnose adolescent depression. The AAP Practice Improvement Network (PIN) Reducing Diagnostic Errors in Primary Care Pediatrics, or Project RedDE!, is seeking clinic teams that have 30 well-visit encounters specifically with 11 year olds and above, as well as 30 well-visits with patients three years old and older per month. The ability to query your EHR and/or billing system to pull charts for this 21 month project is helpful to team participation.

- Contact Liz Rice-Conboy, Program Manager at ericeconboy@aap.org for more information, or follow this link to further recruitment information www.aap.org/quin/pinprojects
- Wave 2 participation will be for about 21 months starting in March 2016
- There is an informational webinar for Project RedDE! Wave 2 recruitment on Friday, January 8th at 9AM PT/10AM MT/11AM CT/ 12Noon ET (Registration Link: https://attendee.gotowebinar.com/register/5581977912604433921)
- Applications are due in SurveyMonkey on Feb 22, 2016 (SurveyMonkey application link: www.surveymonkey.com/r/Wave2-projectredde-Application)
- We will be selecting up to 15 practices (practices located outside the US are not eligible for this project)
- Selected practices will be notified by March 7, 2016

Chapter Quality Network (CQN) Practice Improvement to Address Adolescent Substance Use (PIAASU) Project—Now Recruiting Practices

The American Academy of Pediatrics (AAP) has selected the Connecticut (CT), Georgia (GA), and Utah (UT) Chapters to participate in the Chapter Quality Network (CQN) Practice Improvement to Address Adolescent Substance Use (PIAASU) Project. The Chapters are now recruiting practices! The project aim is to increase the use of validated screening tools, successful brief intervention techniques, and referral to treatment (SBIRT) for substance use and mental health concerns among pediatric practices.

Selected practice teams will participate in 4 learning sessions, each followed by an action period where they will have the opportunity to test changes in their clinical setting. During the action periods, sites will measure their progress toward improvement goals. Expert faculty will coach teams to assist them in applying key change ideas into their own organizations.

Twenty-five (25) points of American Board of Pediatrics (ABP) Maintenance of Certification (MOC) Part 4 credit and up to 20 points of Performance Improvement Continuing Medical Education (PI CME) credit will be offered for successful completion of the project.

If you are interested in participating or receiving more information about the CQN PIAASU Project, please contact Stephanie Domain at sdomain@aap.org or 847-434-4776. Thank you very much for your interest in this AAP chapter program. This project would not be possible without the generous support of the Conrad N. Hilton Foundation.

Continued on next page
The AAP Bright Futures National Center Announces the Preventive Services Improvement State Spread Project (PreSIPS2)
The AAP Bright Futures National Center is pleased to announce the launch of the Preventive Services Improvement State Spread project (PreSIPS2), a groundbreaking collaboration to create sustainable, state-to-local improvement in system infrastructure to impact preventive health outcomes for children and families based on Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition. This project also builds upon the lessons learned from the original PreSIP initiative, a successful 9-month modified learning collaborative conducted within the AAP Quality Improvement Innovation Network (QuIIN).

PreSIPS2 is a partnership between the AAP National and AAP chapters. With AAP National support, four chapters will participate in a 17-month quality improvement (QI) state-based modified learning collaborative to include learning sessions and monthly conference calls. Each chapter Leadership Team will assemble a Chapter-State Partnership Team comprised of additional state Maternal and Child Health (MCH) stakeholders and family representatives. To amplify Bright Futures spread at the practice level, chapters will enroll a minimum of ten practices to promote Bright Futures clinical activities and office systems change at the practice level. To further strengthen outreach within each state the Continuity Research NETwork (CORNET) will work with their chapter to identify at least one residency clinic per state to join the project. The AAP National team will assist by offering QI mentoring, state liaison support, and Bright Futures resources. Through participation in this project, pediatricians can earn American Board of Pediatrics Maintenance of Certification Part 4 credit and continuing medical education credit.

The chapters that are currently recruiting practices for participation in the PreSIPS2 project are:
- Georgia
- New Jersey
- South Carolina
- Virginia

Funded in part by the Health Resources and Services Administration, Maternal and Child Health Bureau, under a cooperative agreement to the American Academy of Pediatrics (#U04MC07853), and by the Friends of Children, a Charitable Fund of the American Academy of Pediatrics.

For more information about Bright Futures, visit brightfutures.aap.org.

Now available - Single site version of Digital Navigator
The AAP Practice Excellence (APEX) program announces the release of Digital Navigator 2014. Designed to guide practices as they transition to a high-performing organization under the patient- and family-centered medical home model of care, the tool is a web-based software application that can help members navigate the practice transformation process. Whether seeking formal recognition with the 2014 NCQA Standards, or simply trying to transform to an effective and efficient organization, the Digital Navigator can help a practice lower costs, improve care, and gain NCQA Medical Home recognition which will result in MOC part 4 credit through the American Board of Pediatrics. For questions contact DNSales@aap.org.
Help Your QI Projects Function Better with QIDA

What is QIDA?
QIDA stands for Quality Improvement Data Aggregator, a web-based data collection and aggregation system developed and owned by the Academy. QIDA’s intended use is among Quality Improvement (QI) projects sponsored by the Academy, its councils, sections, and chapter affiliates to help the projects function better. The short-term goal of QIDA is to expand services to AAP staff and members by offering more expertise in QI measure, data analysis and tool development.

Why would I use QIDA?
- The system provides participants the opportunity to continuously monitor improvement by pulling real-time run charts throughout the course of the project.
- You receive flexibility to set up projects and personalize them. For example, you set your project timelines, data collection, level of data collection, reporting, workspace builds, and so on.

QIDA by the Numbers
- To date, there are 16 QI projects that have or are utilizing the system.
- Projects have seen 700+ participants.
- Programmed more than 150 measures.
- Gathered 90,000+ charts.

Current Projects Using QIDA
Pediatricians and Parents Together - California Chapter 3
Enhancing Family-Centered Communication by Addressing Health Literacy
Medical Home Chapter Champions Program on Asthma, Allergy and Anaphylaxis Quality Improvement Project
Early Hearing Detection and Intervention (EHDI) Quality Improvement Project
Quality Improvement for the Management of Children Hospitalized with Urinary Tract Infection (Q-UTI) Project
Don’t Just Wait and See: Improving Developmental Screening and Follow-Up
Value in Inpatient Pediatrics (VIP) Network Stewardship in Improving Bronchiolitis (SIB) Quality Improvement Collaborative
California Adolescent Preventive Health Initiative-Focus: Sexual/Reproductive Health
Improving Shift Transitions with Briefing Checklists in the Emergency Department
Childhood Obesity Performance Improvement (COPI) Collaborative
Section on Emergency Medicine-Improving Shift Transition Handoffs
Eliminate Tobacco Use and Exposure (CEASE) Project
Reducing Diagnostic Errors in Primary Care Pediatrics-Project RedDE! (Advance, Improve and Quality sites)
Improving HPV Vaccination Rates

QIDA projects are not open for open enrollment. For further information, contact Kristen Gerage (QIDA Manager) at kgerage@aap.org.

For other ways to help improve your care for children, don’t forget that all EQIPP courses are included with AAP membership! They deliver everything you need to identify and close practice gaps—while helping to satisfy Maintenance of Certification Part 4 requirements. You’ll walk away with the tools, information and resources you can use to achieve improvement in other practice areas. Learn more now about EQIPP courses at www.eqipp.org.

Happy New Year!
Expect the next issue of Quality Connections in March 2016!