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

Shared Decision Making (SDM). SDM is a collaborative process that allows patients, their families, and their providers to make health care decisions together, taking into account the best scientific evidence available as well as the patient's and family's values and preferences. It is the focus of the Institute of Medicine's aim to improve patient-centered care.

Within our Council, we have the opportunity to improve SDM by bringing more patients and families to our table as Affiliate Members. We need to give our Affiliate Members more of a voice on our committees and to engage them in meaningful work within our Council. To this end, we are voting on a change to allow endorsement letters to originate from any AAP member and not just from COQIPS. We hope that this move will facilitate the process for a patient or family advocate to become an Affiliate Member. There is no cost to being an Affiliate Member. Our Parent Liaison, Lisa Rossignol, has been a key champion for encouraging and empowering patients and family members to join.

I am challenging each member of our Council to identify ONE patient/family member within your practice and invite them to join our Council as an Affiliate Member. You know best those individuals who will be excellent patient/family advocates — direct them to the COQIPS web site to complete the application and assure them of your letter of support today!
Updates from the COQIPS Executive Committee

COQIPS Education Update

2016 AAP National Conference & Exhibition
San Francisco, CA
October 22-25, 2016

Call for Abstracts – Due April 8, 2016
The Council on Quality Improvement and Patient Safety (COQIPS) welcomes the submission of abstracts for their program at the 2016 AAP National Conference & Exhibition. For more information and/or to submit your abstract visit: http://www.aapexperience.org/abstracts/.

- Pediatricians, both experienced and in-training, in community-based as well as university-based practice, generalists and specialists alike are encouraged to submit abstracts related to any aspect of quality improvement and/or patient safety, including those that fall into the following broad categories of implementation, pilot programs, education, collaboration, and evaluation.
- We are also accepting abstracts describing quality improvement projects. Submissions that describe quality improvement projects will be judged using a checklist derived from the SQUIRE guidelines. Abstracts describing QI projects that are accepted into the program may also be eligible for 20 free MOC Part 4 points through the AAP’s Maintenance of Certification (MOC) Portfolio. If the requirements are met, all authors listed on the scientific abstract are eligible. More information about MOC Part 4 for abstracts is available here.

Quality Improvement & Patient Safety Education Sessions

Saturday 10/22/2016

- I1046- Building Quality Collaborations: The Primary Care, Emergency Department, Hospital Continuum
  8:30 AM - 10:00 AM
  Jeffrey Bennett, MD, FAAP and Grant Mussman, MD, FAAP

- I1119- Diagnosing our Diagnoses: Reasoning and Error
  2:00 PM – 3:30 PM
  Andrew Olson, MD, FAAP and Emily Ruedinger, MD, FAAP

- S1164- Moving from Volume to Value: The New Frontier in Healthcare Financing
  4:00 PM – 5:30 PM
  Suzanne Berman, MD, FAAP and Jeffrey Schiff, MD, FAAP

Sunday 10/23/2016

  9:00 AM - 2:00 PM

Continued on next page
• **H2145- Joint Program: Council on Quality Improvement & Patient Safety and Council on Clinical Information Technology**
  
  2:30 PM - 5:00 PM
  
  Lalit Bajaj, MD, FAAP, Arti Desai, MD, FAAP and Stephen Downs, MD, FAAP
  
  The presentations will focus on shaping the electronic health record (EHR) to work for you and your practice, navigating the complex world of EHR data to support measurement and improvement, and meaningfully engaging patients in their own health and healthcare through HIT.

**Monday 10/24/2016**

• **F3143- Not Small Adults: Pediatric Medication Safety in Adult Hospital Settings**
  
  4:00 PM - 4:45 PM
  
  Jack Percelay, MD, FAAP
  
  For more information, 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 over 600 members! We would like to welcome and congratulate the following new and renewed members:

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For more information about how to get involved in the Membership Committee please contact Dr Wayne Franklin (waynehfranklin@gmail.com), Membership Committee chairperson, or Cathleen Guch (cguch@aap.org).
On February 9, 2016, the President released the last budget request of his administration for FY 2017. The President’s budget gives direction to Congress on the Administration’s priorities and guidance on how to allocate funding. The President’s budget is not the final budget since Congress is responsible for passing spending bills.

The Obama Administration proposed budget requests significant investments directly benefiting children. Some of these include:

**Expanding Health Coverage by Improving Access to Medicaid and CHIP Coverage and Services.**
The Budget gives States the option to streamline eligibility determinations for children in Medicaid and CHIP and to maintain Medicaid coverage for adults by providing one-year of continuous eligibility. Also, it extends full Medicaid coverage to pregnant and post-partum Medicaid beneficiaries and ensures children in inpatient psychiatric treatment facilities have access to comprehensive benefits such as Early and Periodic Screening Diagnosis and Treatment (EPSDT).

**Maintaining Express Lane Eligibility.**
Improves coverage for eligible but unenrolled children in Medicaid and CHIP by allowing states the option to use eligibility from other public programs (e.g. Head Start, National School Lunch Program, WIC, etc.) to identify, enroll or recertify children for Medicaid or CHIP rather than requiring further analysis and applications to determine eligibility.

**Preserving Coverage through CHIP.**
CHIP currently serves more than eight million children of working parents who are not eligible for Medicaid. While the Medicare Access and CHIP Reauthorization Act (MACRA) extended CHIP funding through 2017, the Budget proposes to extend funding for CHIP through 2019, ensuring continued, comprehensive, affordable coverage.

**Making Targeted Reforms to Increase Quality and Maximize Cost-Effectiveness in Medicaid and CHIP.**
Limits the portion of Medicaid and CHIP managed care dollars spent on administration and incentivizes more investments in quality health care services by establishing a Medical Loss Ratio (MLR) ratio of 85 percent. This would align program requirements with those in Medicare Advantage and private insurance. Furthermore, it will require return of payments in excess of the minimum MLR. The Budget proposes better aligning Medicaid Disproportionate Share Hospital Payments, which compensate hospitals that treat high numbers of uninsured patients, with expected levels of uncompensated care.

**Promoting Permanency, Safety, and Well Being for Children and Youth in Foster Care.**
Includes a package of investments designed to do more to prevent the need for foster care and assist children and families so that children can either be reunited with their biological parents or placed in a permanent home where they can thrive. The Budget includes funding to provide critical preventative services to vulnerable families and children to address hardships early, keeping more children out of foster care and with their families, as well as funding to promote family-based care for children with behavioral and mental health needs to reduce the use of congregate care—which can have negative effects on children.

**Improving Health Outcomes for Children and Youth in Foster Care.**
The Budget continues to propose a Medicaid demonstration project in partnership with HHS’s Administration for Children and Families to encourage States to provide evidence-based psychosocial interventions to address the
behavioral and mental health needs of children in foster care and reduce reliance on psychotropic medications to improve overall health outcomes.

**Ensuring Adequate Food for Children throughout the Year.**
Nearly 22 million low-income children rely on free and reduced price school meals. However, only a fraction of those children receive free and reduced price meals in the summer months. As a result low-income children are at higher risk of food insecurity and poorer nutrition during the months when school is out of session. Rigorous evaluations of USDA pilots have found that providing additional food benefits on debit cards to low-income families with school-aged children during summer months can significantly reduce food insecurity. The Budget invests $12 billion over 10 years to create a permanent Summer Electronic Benefits Transfer for Children program that would provide all families with children eligible for free and reduced price school meals access to supplemental food benefits during the summer months.

Also, included are significant other investments in fighting child hunger including $6.35 billion for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and $81.69 billion for the Supplemental Nutrition Assistance Program (SNAP). Total investments requested to fight hunger and improve nutrition are over $120 billion.

**Reducing Rural Child Poverty.**
The Budget provides $20 million for two-generation demonstration projects within USDA to fight rural child poverty and $16 million to support an integrated model for early childhood development and parental involvement for American Indian families in BIE-funded schools. The Budget also introduces a new rural home visiting program that complements HHS’s evidence-based Maternal, Infant, and Early Childhood Home Visiting program to serve more high-risk, high-need children and families in remote rural areas.

**Invests in early learning for children with disabilities.**
The Budget provides increased funding for the Individuals with Disabilities Education Act (IDEA) Preschools Grants and the IDEA Infants and Families program, an increase of $80 million compared to 2016, including funding to help identify, develop and scale-up evidence-based practices for early identification of and intervention for learning and developmental delays.

**Supporting universal preschool.**
The Preschool for All initiative, in partnership with the States, provides all four-year-olds from low- and moderate-income families with access to high-quality preschool, while encouraging States to expand those programs to reach additional children from middle-class families and establish full-day kindergarten policies. The Budget increases funding for Preschool Development Grants (PDGs), which lay the groundwork for universal preschool. With the support of Federal funding made available through the PDG program, 18 States are currently developing and expanding high-quality preschool programs in targeted, high-need communities.

I would like to believe that my quality journey began the first moment I stepped foot into the health care system as a physician. However, I don’t think I can say that and it is safe to say that most people who entered medicine when I did in the early 1990s could not say that either. Back then, the concept of patient-centered health care was not a “thing”. Quality and process improvement did not have a prominent role in health care institutions and was, in fact, relegated to nursing and non-clinical administrators. In many places there was only one nurse within the risk management department who was responsible for reviewing cases with bad outcomes. There was little to no feedback to practitioners about medical errors unless a malpractice case was involved. Moreover, aside from the occasional morbidity and mortality conference, there was little to no formal discussion or education about how any medical errors could have been prevented. Quality improvement as a field was small and in many places, essentially non-existent until the publication in 1999 and 2001 of the landmark Institute of Medicine reports, “To Err is Human” and “Crossing the Quality Chasm: A New Healthcare System for the 21st Century”. These reports piqued my interest in the subject and I began to seek opportunities to work on improving health care for children.

As a junior attending physician, I was asked to represent my department on hospital pathway committees. I’m certain I was asked because no one else wanted to do it but I eagerly committed to the work. I found these multidisciplinary committee experiences to be educational if not illustrative. On these committees, evidence for best practices was introduced but often there were challenges with implementation. Clinicians would push back with “this is how we always do it” or complain, “this is cookbook medicine”. The results were mixed with regard to standardizing care at my institution.

My quality journey continued when I became interested in the quality of care that medically complex children received in the prehospital environment. In 1998, I was awarded funding by the Emergency Medical Services for Children (EMSC) program for a project to improve the prehospital care of children with special health care needs. As is often is the case, one clinical incident led to my searching for a better way to care for these medical complex, often technology assisted children. A young girl with multiple medical conditions was carried by her mother into my emergency department in respiratory distress and in shock. After stabilizing her condition, we found she had a perforation of her bowel necessitating immediate surgery. I asked the child’s mother why she did not call 911 and the mother responded that she didn’t trust the paramedics to bring the child to the right hospital. Finding little information about the care of children with complex medical conditions for paramedics, my project colleagues and I wrote a textbook for emergency medical technicians (EMTs) and paramedics and also developed a case-based simulation education program, which we taught to many thousands of prehospital professionals. Additionally, we developed evidence-based care guidelines for these children and drafted model prehospital protocols for use by emergency medical services systems.

Because of my academic interests and activities on systems of care for children, I was interested in how federal policies impact health care, and so I applied for and was chosen for the American Association for the Advancement of Science (AAAS) Science and Technology Policy Fellowship in Washington, DC. This program places scientists, physicians and
other medical professionals with advanced degrees within the federal government to learn how government policy-making works. I really thought that federal policies drove local policies, but I found that was often not true. After my one-year fellowship, I stayed and eventually ended up at the Department of Health and Human Services (HHS) where among other responsibilities, I worked on quality and health information technology policy issues on behalf of my agency, the Health Resources and Services Administration (HRSA). During this time, I served on a variety of quality committees within HHS and externally including the National Quality Forum (NQF) board on which I served for three years. As a member of the NQF board, I learned how the quality measurement enterprise works and how the Centers for Medicare and Medicaid Services (CMS) programs operate and were/are transforming health care. In order to more fully understand quality improvement, I sought training in Six-Sigma and Lean management in order to prepare myself to apply these skills in the clinical environment.

I recently returned to academic clinical medicine where I have brought my interests in quality improvement from the 30,000-foot level to the front lines. I have been working with trainees on their quality improvement projects and I engage in health services research with a focus on improving pediatric health care. Being back more fully in clinical academic medicine has focused and broadened my view of clinical quality improvement. It has focused my interests in quality improvement activities within my field of emergency medicine specifically on the importance of teamwork, communication, and clear transitions of care. My view of quality has broadened so that it’s clear to me now that in order to improve child health, we need to expand beyond improving medical care to addressing the developmental, educational and environmental needs that impact a child’s health now and into adulthood.
New Leadership Transforms the National Institute for Children’s Health Quality (NICHQ)

Suzette Oyeku MD, MPH, FAAP
Medical Director, Sickle Cell Disease Treatment Demonstration Program at NICHQ
Associate Division Chief for Academic Affairs, Division of Academic General Pediatrics, Children’s Hospital at Montefiore

This fall ushered in a new era for NICHQ (National Institute for Children’s Health Quality). While our nearly two-decade old mission of improving children’s health remains the same, a new leadership team is driving a major evolution about how the organization continues to achieve dramatic, system-level improvements across a broad spectrum of child health issues.

Scott D. Berns, MD, MPH, FAAP, was named the new President and CEO in October. Berns joined NICHQ from the March of Dimes National Office, where he was the Senior Vice President of Chapter Programs and Deputy Medical Officer. Berns is also a Clinical Professor of Pediatrics at the Warren Alpert Medical School of Brown University and Clinical Professor of Health Services, Policy and Practice at the Brown School of Public Health in Providence, RI. [Read full bio.]

In January, Judith Gooding joined NICHQ as the Chief Operating Officer and Katherine Flaherty, ScD the Vice President of Development. [Read full bios.] Both women have extensive maternal and child health experience in the public and private sectors. The trio is well positioned to help NICHQ expand its current portfolio into new and exciting directions, while maintaining focus on partnering with professionals and organizations to make everyday practices and processes better to improve children’s health.

In some of our current projects, we’re seeing incredible progress. In our current signature program, the Collaborative Improvement and Innovation Network to Reduce Infant Mortality (IM CoIIN), NICHQ is leading federal, state and local leaders, public and private agencies, professionals and communities in a national effort to reduce infant mortality and improve birth outcomes. This initiative has a strong focus on addressing disparities in its six key strategy areas: safe sleep, smoking cessation, pre-term birth, perinatal regionalization, pre- and inter-conceptual care, and social determinants of health. In December, the Centers for Disease Control and Prevention (CDC) reported a new low in infant mortality rates. At the same time, state-level engagement in the initiative continues to grow, with more pilot teams submitting data for collaborative review and learning.

NICHQ also recently expanded its portfolio to include a focus on vision screening, partnering with the National Center for Children’s Vision and Eye Health at Prevent Blindness (NCCVEH) on a new project to increase the detection and diagnosis of visual impairment in children under 5.

NICHQ has also been selected to join NewSTEPs 360, an unprecedented national collaboration, which aims to improve newborn screening programs across the nation.

As the National Coordinating Center for the Sickle Cell Disease Treatment Demonstration Program (SCDTDP), NICHQ continues to work with regional teams across the country to increase the number of providers treating persons for sickle cell disease or sickle cell related complications and the use of disease-modifying therapies such as hydroxyurea. We recently crafted a strategic communication plan focused on spreading the results and resources developed through this project and look forward to continuing to raise awareness about sickle cell treatment guidelines with providers.

We continue to be leaders in helping hospitals improve their maternity care practices, implement the 10 Steps to Successful Breastfeeding, and achieve Baby-Friendly designation through projects in New York and Texas. The Texas Breastfeeding Learning Collaborative recently completed its largest round of recruitment to date—33 hospitals, while recruitment is open for New York State hospitals to join our Breastfeeding in Hospitals Quality Improvement Collaborative. Continued on next page
We also continue to enhance the NICHQ Collaboratory, a state-of-the-art, integrated online community and data management system specifically built to support learning collaborative participants who are working together to make rapid change on a shared set of objectives. In our ever-increasingly virtual work, this is an exciting asset for any organization seeking to leverage the collective knowledge of a community to make rapid improvement.

I know I look forward to seeing more of the NICHQ evolution to come in the months and years ahead with our fantastic new leadership team.

Interested in learning more about NICHQ? Join our mailing list to receive a monthly e-newsletter containing the latest success stories, toolkits, resources, videos, publications, and thought leadership from NICHQ on the variety of children’s health topics we cover. [Subscribe today.](#)

Acknowledgements: Special thank you to Cindy Hutter, MBA, Interim Director of Marketing and Communications at NICHQ, for her contributions to this update.
When Language Matters

Rachel Adams, PhD
Professor of English and Director of the Center for the Study of Social Difference at Columbia University

When our pediatrician lists my son’s condition on medical forms as “Down’s syndrome” or just “Down’s,” I always wonder whether I should say something. The preferred usage is Down syndrome, without an apostrophe. The name comes from John Langdon Down, the Victorian doctor who first identified the condition. “Down’s” connotes possession. John Langdon Down did not have the syndrome himself, nor did he own the patients who lived in his hospital.

To now, I’ve taken the reasonable advice of a friend (parent to a girl with Down syndrome) who reminds me that I should pick my battles. “Is he a good doctor?” he asks.

“Wonderful,” I tell him.

“Then maybe you should let it go.”

I remember when Dr. H came to the hospital just after Henry was born, and I think my friend may be right. Dr. H found my husband and I sitting by our baby’s incubator in the NICU, exhausted and worried. Gently, he opened the plastic cover and put his stethoscope over our son’s heart to listen to the patent ductus arteriosus (PDA) that had been detected the day before.

“Sir! You cannot do that!” a nurse bore down from across the room. Our doctor didn’t have visiting privileges at this hospital. He had stopped on his way home from work, and, here, he was just an ordinary visitor. “You cannot touch that baby. He needs to stay warm,” the nurse warned sternly.

“I’m sorry, I’m a doctor. I just wanted to listen to his heart,” he backed away. “Didn’t mean to cause a fuss,” he said to us apologetically.

We didn’t mind. It had been less than 48 hours since we learned our new baby had Down syndrome and we were still in shock. We were grateful that our pediatrician would visit on his own time.

I remember when I discovered that the artwork in Dr. H’s office was painted by an artist with Down syndrome, who had been his patient for more than twenty years. When I met the artist’s family, his mother couldn’t speak highly enough of the care he received from Dr. H.

When I ask other parents what they look for in a pediatrician, they say they want doctors to stay up to date on the medical guidelines established for people with Down syndrome, to be aware of distinctive healthcare issues that might arise without treating their children as less capable than anyone else. Dr. H always manages that combination well. He doesn’t treat Henry differently than his typical brother, but he is also well informed about his particular medical needs. Dr. H is sensible and kind, and I trust him to know the latest research regarding the treatment and care of children with Down syndrome.

When he writes “Down’s syndrome,” Dr. H may just be using the terminology

As Parent Liaison for COQIPS, I have been asked to write and curate articles from families, patients, and experts about patient and family engagement in healthcare. This article is an introduction to a family experience of language used by providers and the impact word choice can have on a family’s experience of healthcare. The intent of including this piece, and future family reflections on care, is to allow the beginning of dialogue and to imbue the future work of COQIPS and AAP with the voice of patients and families so that we might work to build mutually beneficial relationships that result in the best care for children.

Dr. Adams provides a compelling case for the use of language that implies an underlying respect for individuals with Down syndrome and includes those with intellectual or cognitive disabilities. This is rooted in the Person First Language movement that is largely supported by parents and caregivers of people with disabilities. However, a counter movement has also gained momentum in recent years called Identity First Language, led by adult advocates who have disabilities. A basic example of the ways these two movements converge can be viewed here. It is unclear if one will prevail so we at COQIPS recommend, as is often the case—just ASK.

Lisa Rossignol, MA
Continued on next page
he learned as a student. But shouldn’t he be apprised of the social norms surrounding the treatment of people with the condition just as he keeps his medical knowledge up to date? Preferred terms change with time. Over the last hundred years, the polite way of referring to a person of African descent has varied from Negro to black (or Black) to African American (or African-American). There is nothing inherently wrong with any of these choices. But it is a sign of respect and awareness to use the term most appropriate to its time and place. The same is true for people with Down syndrome. Today, people with Down syndrome have made progress toward eliminating the use of the offensive word “retarded” (the preferred term is intellectually or cognitively disabled), but they continue to be called “Down’s kids” (implying that they are defined by the condition) and described as “suffering from” or “afflicted with” Down syndrome (implying disease or painful and unwanted condition) by otherwise well-meaning people.

After thinking further about my friend’s advice, I’ve decided that it’s important to say something to Dr. H. Language does matter. The term “mongoloid idiot” was scientifically accepted until well into the twentieth century. When doctors used it, they also reinforced the belief that people with Down syndrome were a throwback to an inferior foreign race, the Mongols of inner Asia. The words we use to describe other people are the first indication of how we understand and value them. In turn, those words establish how the people they describe will be understood and treated. Taking control of language has been a powerful way for people with disabilities and their advocates to represent themselves and manage how they are to be represented by others. Until Henry can represent himself, it is my responsibility to speak for him. Out of respect for my son and the fine doctors who have cared for him, it is up to me to set the record straight. This essay is my first try.
QuIIN celebrated its 10th anniversary this past year. The networks continue to evolve and adapt to the changing needs of pediatric medicine. QuIIN currently has over 700 participating pediatricians including primary care pediatricians and pediatric hospitalists.

To date the majority of the QuIIN work has been based on testing and piloting AAP guidelines and recommendations. These include AAP initiatives on Bright Futures, developmental screening, child abuse prevention, immunizations, newborn care, chronic disease management, bronchiolitis, community acquired pneumonia, urinary tract infections, and the broad concept of the patient centered medical home. This work has been very successful with 11 publications in peer-reviewed journals, 49 national presentations and multiple AAP toolkits being products of the work.

QuIIN has also adapted so that all of its learning collaboratives are now approved for MOC Part 4 credit. The data is being stored and compiled by the AAP’s Quality Improvement Data Aggregator (QIDA).

Quality Improvement continues to be an expanding priority for the AAP. Dr Ramesh Sachdeva now directs the AAP Division on Quality. The Council on Quality Improvement and Patient Safety (COQIPS), was formed two years ago to encourage member engagement in quality improvement processes, especially implementation of guidelines and development of measures. The Chapter Quality Network (CQN) works on increasing chapter efforts around quality improvement at the State level. Individual divisions of the AAP have organized individual learning collaboratives to meet the goals of their grants and projects. Most recently, AAP districts have been tasked with developing quality improvement initiatives that include the various state chapters of their districts.

This growth in quality improvement projects and enthusiasm for quality are very welcome. In response to this expansion of interest, QuIIN has started several major innovations in its own work that we believe will complement the other developments at the AAP.

First is an expansion of our quality improvement initiatives. Whereas for years QuIIN focused on the PDSA cycle and the learning collaborative, now QuIIN utilizes time series design, interrupted time series design, cluster design, qualitative methods, control charts, etc. QuIIN has also partnered with researchers at The Children's Hospital at Montefiore on its first quality improvement research study, a stepped wedge cluster randomized trial analysis of three efforts to reduce ambulatory diagnostic error in primary care pediatrics. This Agency for Healthcare Research and Quality (AHRQ) funded project, Reducing Diagnostic Errors in Primary Care Pediatrics (Project RedDE!), involves 25 sites for the first wave and is recruiting for additional sites for its second wave.

The Value In Inpatient Pediatrics (VIP) Network is also experimenting with new approaches to spread and disseminate improvement work and focusing heavily on evidence-based care that reduces unnecessary care. Its Stewardship in Improving Bronchiolitis across the continuum of care is geared towards developing a new cadre of champions from all parts of the United States. VIP also tries to prioritize the non-university-affiliated community hospitals that care for the large majority of hospitalized children.

The second major change is an effort to expand QuIIN from primary care and hospitalist care to include other providers that are involved in full continuum of care for a child. This would make QuIIN unique in not only being home to national networks of pediatricians but also
able to mount projects that extend from ambulatory care, to the emergency department, to the intensive care unit, to the hospital and to key pediatric subspecialists. Thus to date, conversations have started with the Section on Emergency Medicine, the pediatric intensivists and the Committee on Infectious Disease to collaborate with QuIIN on projects that QuIIN develops and also to bring initiatives and projects from their Sections to QuIIN.

Lastly, QuIIN has welcomed its first family representative to join the QuIIN Steering Committee. Amy Baskin has been a child advocate for a number of years, is based in Wisconsin, and is very eager to bring her background and interests to QuIIN.

We plan to parlay this increase in QuIIN members and family engagement into grant opportunities at the national level, with the national foundations, PCORI, AHRQ and CDC.

For more information on QuIIN please email quiin@aap.org or visit quiin.aap.org.
Quality improvement is, well, always improving! New and better methods are constantly being considered, developed and evaluated to ensure that every pediatrician is at the top of his or her game, with the ultimate outcome of improving care for children. That’s where EQIPP online courses come in. But, that’s not where they end and, in fact, they are now being utilized to close learning gaps even more quickly and improve learning almost simultaneously by working in tandem with live events.

Dr. Ivor Hill, MB, ChB, MD, FAAP, with the Committee on Continuing Medical Education (COCME) strongly believes that using EQIPP data as a baseline and targeting educational intervention at live PPC events can help demonstrate change during follow-up data collection cycles in EQIPP. “As part of the COCME, we are always looking for ways to improve educational events. I am an avid believer that QI is the one way you can improve performance,” Dr. Hill states.

First, EQIPP: GER or GERD? Diagnosis and Management was the course chosen to pilot this process. The next step was to “encourage people who had signed up for the Practical Pediatrics Course (PPC) in Phoenix, AZ to also register for the EQIPP course,” reports Dr. Hill. In his presentation to the course attendees, he showed findings that 86 (of 366 course participants) did register and enter baseline data in the EQIPP GERD course prior to the live event. This group provided the first round of data collection and analysis that was then addressed at the PPC event. “The format, rich material and time length for PPC lends itself to this study. The seminar is 90 minutes, and we spent 30 minutes going over the results,” explains Dr. Hill. The data from the EQIPP course was reviewed, and gaps were identified quickly. Those gaps were immediately addressed in the teaching session. “We could quickly see where the error was,” explains Dr. Hill. “In this course, very few people documented lifestyle changes; we were able to have an interactive discussion on this and I was able to offer them a tool they could quickly download for patients.” The gaps identified were generally the same for those who took the EQIPP course beforehand and those at the live event. The important outcome was the ability to rectify and address the gaps right then and there.

“In addition, it was beneficial for participants to see what the gaps were,” Dr. Hill continues. Another major benefit was that after the live event, participants signed up for the EQIPP course. Dr. Hill felt this was encouraging; the participants were able to see how easy it was to improve their practice.

The amount of extra work that was involved was minimal, says Dr. Hill, when compared to the benefits. “We had to wait until the very end [of EQIPP course] to get the data, so in the days just before the meeting, I chose the areas I was going to address,” he explains. “I had to develop how I would present, but this wasn’t too hard to do.”

Before this particular analysis, the committee had attempted something similar. However, at that time EQIPP wasn’t included as an AAP membership benefit and a live event was not incorporated. Dr. Hill says they learned from that experience and this time around, “was more effective because it was real life and people could relate to the data.” It was so successful that it will be repeated. “In March, he presented the results of this endeavor at the Annual Leadership Forum (ALF) and hopes to persuade planners of educational activities to consider incorporating other EQIPP courses into their programs in the future,” says Dr. Hill.

About EQIPP

EQIPP courses deliver everything you need to identify and close practice gaps—while helping to satisfy Maintenance of Certification Part 4 requirements. Included with AAP membership, the courses are constantly being revised to keep you completely up-to-date and ready to help improve your care.

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Available EQIPP Courses:

- Growth Surveillance and Linear Growth Failure
- Eliminating Tobacco Use and Exposure to Secondhand Smoke
- Hypertension Identification and Management
- Medical Home
- STEP Up Diabetes Care: Screening, Testing, Education, and Prevention
- GER or GERD? Diagnosis and Management
- Immunizations – this course will be updated in 2016!

Learn more at: [www.eqipp.org](http://www.eqipp.org) and follow us online at pedialink.org, Facebook or Twitter.
New National Center for Care Coordination Technical Assistance

Care coordination should be a team- and family-driven process that improves family and health care practitioner experience. Need help promoting, implementing, or evaluating care coordination activities and measures? Technical assistance (TA) and support is now available through the National Center for Care Coordination Technical Assistance (NCCCTA):

- One hour of introductory TA regarding the Pediatric Care Coordination Curriculum, Care Coordination Measurement Tool and the Pediatric Integrated Care Survey
- Two additional hours of TA in the adaptation, implementation and evaluation of the aforementioned tools
- Assistance and support through email, as necessary

Visit us for more information and links to the above tools
Contact us for TA or questions
Join the NCCCTA Community of Learners listserv

The NCCCTA is a partnership between the National Center for Medical Home Implementation and Boston Children's Hospital Integrated Care Program.

The mission of the NCCCTA is to support the promotion, implementation and evaluation of care coordination activities and measures in child health.

New Clinical Report: IDEA for Children With Special Educational Needs

The Individuals With Disabilities Education Act (IDEA) for Children With Special Educational Needs—a clinical report from the American Academy of Pediatrics—provides guidance to ensure that every child in need receives the early intervention and special education services to which he or she is entitled. An article about the new report, states: “Lack of communication can exist between those working in the health vs. education spheres. Schools may not fully understand a child’s health needs and specifics about their disabilities. Pediatricians may not know what is actually being done for the child during the core part of the school day. ‘With this statement, we hope to close those gaps and encourage communication ... so the care of the child is more unified and collaborative”’ – Paul Lipkin, lead author. Resources for families and professionals are included.

AAP Model for Improvement Webinar

Do you or your colleagues need a refresher on the Model for Improvement? Look no further! This webinar provides an overview of key concepts in less than 1 hour. Visit the AAP YouTube Channel to access the QI 101: Model For Improvement Webinar.