What is a High Reliability Organization?
According to the Agency for Healthcare Research and Quality (AHRQ) high reliability organizations, or HROs, are “organizations that operate in complex, high-hazard domains for extended periods without serious accidents or catastrophic failures.” The airline, nuclear power, and amusement park industries are all high reliability organizations. When you board a plane or get on a roller coaster, what chance of a fatal accident are you willing to accept—one in a hundred, one in a hundred thousand, one in a million? HROs share the characteristic of having developed the tools, processes, and culture to allow them to realistically reach for a zero-harm goal.

Do HROs apply to health care?
Absolutely. The medical field is certainly a complex, high-hazard domain, operating in a manner which at times can result in serious accidents or catastrophic failures. According to a May 2016 article in BMJ, medical errors are now the third leading cause of death in the United States. We can and must do better.

How can my practice become an HRO?
The Agency for Healthcare Research and Quality has identified five readiness characteristics for becoming an HRO: 1) Preoccupation with Failure (being universally and constantly aware of the potential and risk for failure); 2) Reluctance to Simplify (acknowledging that systems are complex); 3) Sensitivity to Operations (having a “big picture awareness”); 4) Deference to Expertise (understanding that people who do the work know how to improve it best) and 5) Commitment to Resilience (responding before or mitigating the impact of a safety event).

How is leadership involved in becoming an HRO?
There are three components necessary at the organizational leadership level: 1) a commitment from the Board and CEO to get to zero-harm. For example, this means starting every Board meeting with a quality report. Everyone is focused on safety (Continued on page 2)
Continued from previous page, Message from the Chairperson

and if safety is considered the number one priority, then all other priorities will follow: financial, market share, patient and employee satisfaction, etc.  2) A culture of safety where safety is the highest priority and 3) Process improvement tools need to be in place, fully implemented, and accessible to all within the institution. If these three components are in place, then your institution can get to a zero-harm goal. If it is not, then you can still work on getting these components in place…but you need commitment from the top first.

Benjamin Franklin (no relation) has said that the only two things that are certain are death and taxes. The airline, nuclear power and amusement park industries should not have anyone die on their watch. Although the medical field cannot eliminate death, it is a fact that many patient deaths are both avoidable and attributable to the healthcare system.

We need to get on the road to Zero-Harm. As physician leaders, we cannot continue to allow errors in health care to be the third leading cause of deaths in the United States. The Joint Commission has many tools to help your organization to get on the road.
Updates from the COQIPS Executive Committee

Education Committee Update

Quality Improvement & Patient Safety Education Sessions at the 2016 National Conference & Exhibition in San Francisco, CA

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

- **H2067** - Council on Quality Improvement & Patient Safety Program: Scientific Abstracts Session
  9:00 AM - 2:00 PM

- **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.

2015 – 2016
COQIPS Executive Committee

Wayne Franklin, MD, MPH, MMM, FAAP
Chairperson

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Michael Rinke, MD, PhD, FAAP

Elizabeth Vickers Saarel, MD, FAAP

Hsiang Yin, MD, MS, FAAP

AAP Quality Connections
Editors

Allison Markowsky, MD, FAAP

Tricia Pil, MD, FAAP

Continued on next page
Implementation Committee Update

We are excited to announce the brand new Quality Improvement Implementation Tools and Resources page. While still in its initial development phase, this page will be a central clearinghouse for tools, ordersets, measures, educational materials, and everything else pediatricians need to implement rigorous quality improvement projects. Planned to support both AAP clinical practice guidelines and other quality improvement topics of interest, the site is looking for feedback from members on which topics to include and which resources are most useful. Also, we hope members will submit useful tools, ordersets, and other quality improvement resources to the website for posting. Our first posted topic relates to the new Brief Resolved Unexplained Events (Formerly Apparent Life-Threatening Events) and Evaluation of Lower-Risk Infants published on April 25, 2016. The site currently contains links to the BRUE quality metrics, patient education brochure, key driver diagram, and the clinical practice guideline. Please contact us at implementation@listserv.aap.org to submit additional content for consideration.

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:

Alaine Ainsley  Nicki Alwan  Rajan Arora  Irene Aryee  David Bank  Carlos Barahona  Holly Belgum  Ravleen Bhatia  Ryan Bishop  Carly Blatt  Monica Boggs  Cindy Bowens  Colin Bridgeman  Anita Chaphekar  Pamela Chawla  Jane Chung  David Cooperberg  Catherine Coughlin  Jessica Daigle  

Jack D'Angelo  Paul Darden  Stephanie Deutsch  Maya Dewan  Doel Dhar  Tanya Drews  Tori Endres  Nicholas Ettinger  Aida Francis  Katheryn Frazier  Marie-Christine Gélinas  Sumeet Gill  Gillian Gonzaba  Samuel Hanke  Irfan Helmy  Robin Horak  Brenna Hughes  Marybeth Jones  Julie Klensch


Patricia Shearer  William Stewart  Kimberly Stone  Wesley Thomas  Jeannette Tokarz  Carrie Torr  Jonathan Uhl  Madhuri Viswanadham  Mary Wearden  Teresa Witscher  Brian Wu  Mira Yazigi  Shiva Zargham  Mona Zawaideh  Aaron Zelikovich

For more information about how to get involved in the Membership Committee please contact Dr Wayne Franklin (waynef@wisc.edu), Membership Committee chairperson, or Cathleen Guch (cguch@aap.org).
Improvements in Children’s Health Care Coverage

A May report released by the Urban Institute and the Robert Wood Johnson Foundation revealed that, since the implementation of the Affordable Care Act (ACA), there has been a significant reduction in children without health care insurance from 5.4 million uninsured in 2013 prior to ACA to 4.5 million uninsured in 2014, one year after full implementation. Other key findings include that, in 2014: 91 percent of children eligible for CHIP are enrolled, up from 88.7 percent in 2013 and 81.7 percent in 2008; more than half of states have Medicaid/CHIP participation rates of over 90 percent, with the biggest gains in Medicaid/CHIP coverage of children occurring in states that expanded Medicaid to their adult populations; and more than 60 percent of the country’s remaining 4.5 million uninsured children were eligible for Medicaid/CHIP enrollment. Thus, while progress has been made, there is still room for improvement through advocacy by the pediatric community to ensure that all eligible children are enrolled in Medicaid or CHIP. The full report can be accessed at: http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf429061

Affordable Care Act Under Threat Again

In May, a district court sided with U.S. House Republicans in their lawsuit against the Obama Administration over allegations that the Administration illegally spent funds not appropriated by Congress for the Affordable Care Act’s (ACA) cost-sharing provisions. These provisions include reductions in deductible, copayment and coinsurance that an estimated 5.6 million Americans receive based on income for health plans purchased through ACA insurance marketplaces. The ruling was stayed pending appeal, which means that the cost reductions will remain in effect for the 2017 season, but later cycles may be affected depending on the outcome of the Administration’s appeal to an Appeals Court or even the Supreme Court. If higher courts allow this ruling to stand, the result will likely be an increase in insurance premiums to make up for the loss in money.

MACRA Proposed Rulemaking Release

On April 27, 2016, the Department of Health and Human Services issued a Notice of Proposed Rulemaking (NPRM) to implement key provisions of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), bipartisan legislation that replaced the Sustainable Growth Rate formula with a new approach to paying clinicians for the value and quality of care they provide. The proposed rule would implement these changes through the unified framework called the “Quality Payment Program,” which includes two paths: the Merit Based Incentive System (MIPS) or Advanced Alternative Payment Models (APMs).

MIPS: The MACRA NPRM proposes to consolidate components of three existing programs for eligible professionals—the Physician Quality Reporting System (PQRS), the Physician Value-based Payment Modifier (VM) and the Medicare Electronic Health Record Incentive Program—into a single set of reporting requirements. The rule would sunset payment adjustments under the current PQRS, VM and the Medicare EHR Incentive programs.

APMs: APMs are the CMS Innovation Center models of care (e.g. Medicare Shared Savings programs, Comprehensive Primary Care Plus, Accountable Care Organizations, etc.). Clinicians who take a further step towards care transformation—participating to a sufficient extent in Advanced Alternative Payment Models—would be exempt from MIPS payment adjustments and would qualify for a five percent Medicare Part B incentive payment.

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Continued from previous page, National Quality & Patient Safety Update

The NPRM is complicated with over 900 pages. An executive summary issued by CMS is available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf

Medical Errors Reported to be the Third Leading Cause of Death In the U.S.

In the May issue of BMJ, safety researchers reported that medical errors are now the third leading cause of death in the United States. The authors analyzed eight years of death data and calculated a rate of over 250,000 deaths attributed to medical error per year. In the study, the authors examined four studies that analyzed medical death rate data from 2000 to 2008. Using hospital admission rates from 2013, they extrapolated that based on the total number of hospitalizations, over 250,000 deaths were the result of medical error. The authors recognize that there hasn’t been a standardized way to calculate deaths due to medical error and others point to the lack of a standard definition. Therefore this study has not been without controversy. However, it does bring to light the issue of medical errors and the need to measure and prevent them.

The BMJ article can be accessed at: http://www.bmj.com/content/353/bmj.i2139

[Image of a stethoscope and medical equipment]
My quality journey began between the isolettes in the Woman’s Hospital NICU. The NICU can be ground zero for nosocomial infections, medical errors, and poorly designed processes. Unfortunately, the adverse events that NICU babies suffer are often seen as inherent to the population and not a product of the system in place to care for them. I was asked to work with our NICU team to improve care, and like many physicians at the time, I had no specific training in safety or improvement. Fortunately, our NICU was a member of the Vermont Oxford Network (VON) where members across the country work together to learn the skill sets necessary to improve the processes that drive NICU outcomes. These Newborn Intensive Collaboratives for Quality (NICQs) provided the foundation for my learning about improvement science and leadership for change. Our team had transformational exposures to microsystems thinking, learned how to use data and measurement for clinical improvement, and gained invaluable training in improvement work through extended coaching. We collaborated with colleagues from many high functioning NICUs to improve care on many levels. This collaborative learning helped our unit dramatically reduce nosocomial infections and chronic lung disease as well as measurably improve discharge efficiencies and transitions of care upon discharge. More importantly, our culture had changed; we have shifted to systems thinking and process redesign. I worked with a team that made progress on many fronts, and my path has been altered.

My journey took a different turn when I was asked to serve as the program director for a new pediatric residency program at Our Lady of the Lake Regional Medical Center. My experience with improvement work in the NICU afforded me the skills to build a program around an improvement philosophy at a time when the ACGME placed more emphasis on improving clinical learning environments. I was able to work with key collaborators including Michael Bolton, the Our Lady of the Lake Children’s Hospital Medical Director for Quality and Patient Safety, to build a robust quality curriculum that was aligned and integrated with the Children’s Hospital priorities. This structure allowed our residents to do improvement work in areas as varied as asthma care, drug dosing, pneumonia management, resident curriculum, and educational content of morning report. Our team developed an ongoing approach to integrate teaching and discussions on patient safety and quality, resident workflow, and faculty development to improve physician reporting of safety events. As a result, physician reporting of safety events has increased to 25% of all reports. This work built the momentum for broader involvement in the AAP Quality Improvement Innovation Networks (QuIIN) programs including a Practice Improvement Network (PIN) collaboration around reducing diagnostic error and Value in Inpatient Pediatrics (VIP) network work around improving care for community acquired pneumonia, urinary tract infections, and bronchiolitis. This array of activity has been an important source of scholarly output for developing a residency program in an independent academic medical center. Graduating residents have carried the approach forward in their quality journeys in many ways, including one who established a quality improvement curriculum for a residency program in Botswana.

Education remains a central element in my journey as I have had the opportunity to develop a Patient Safety and Clinical Quality Improvement Fellowship at Our Lady of the Lake Regional Medical Center. The program

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was built upon the strength of individuals already in place in the organization who have expertise in improvement science, leadership, informatics, and health care systems. Like me, many of these new faculty had to create their own educational path in safety and improvement. Our goal was to give developing leaders the starter set that we had to piece together in our early careers. The curriculum was designed to develop analytic, change management, and leadership skills to prepare physicians for careers in clinical leadership positions. Fellow projects have focused on the appropriate use of C. Difficile testing and cardiac telemetry use as well as decreasing blood culture contamination. The fellow also serves as a mentor on a variety of resident improvement projects, demonstrating how the fellowship program can enhance the spread of patient safety and quality improvement education to residency programs across the institution.
The Children’s Hospital Association Liaison Update

Mimi Saffer
VP, Quality Improvement and Quality Measurement

The Children’s Hospital Association (CHA) is focused on transforming care for children using the triple aim as the foundation of the work: healthier children through the provision of better care and smarter spending. Priorities and highlights in quality improvement/accountability measurement for 2016 include:

**Quality Improvement**

The Association has launched a collaborative to reduce sepsis mortality and hospital-onset severe sepsis by 75% by 2020 through the Improving Pediatric Sepsis Outcomes Collaborative. The collaborative is targeting diagnosis and treatment across the hospital in multiple care settings including the ED, NICU, ICU, general care units, hematology/oncology and BMT units and pre-hospital and sub-acute settings. The goal is 50 hospitals participating in 2016 with an ultimate goal of 125 children’s hospitals participating in 2017. Twenty-two hospitals have committed as of early May. The AAP Section on Emergency Medicine’s Pediatric Septic Shock Collaborative has provided a strong foundation to build the new collaborative.

The Standardized Care to Improve Outcomes in Pediatric ESRD (SCOPE) Collaborative prevents infections in pediatric peritoneal dialysis (PD) and hemodialysis (HD) patients. SCOPE’s mission is to improve outcomes, care and value for high-impact challenges for pediatric dialysis patients in pediatric dialysis centers, by using large-scale collaboration to rapidly identify and spread effective interventions across pediatric care settings. SCOPE has 37 centers and continues to expand. As of October 2015, SCOPE Collaborative sites prevented an estimated 212 peritonitis infections and 129 hospitalizations and saved an estimated $2.8 million.

The Childhood Cancers and Blood Disorders Network (CCBDN) prevents central line infections in ambulatory pediatric patients with cancer and blood disorders. Patient and family engagement and education are the focus of 2016 work.

**Patient Safety**

CHA’s Child Health Patient Safety Organization (PSO) enables children’s hospitals to share safety event information and experiences to accelerate the elimination of preventable harm. Child Health PSO is the only federally registered pediatric-specific PSO by the Agency for Healthcare Research and Quality (AHRQ) under the 2008 Patient Safety and Quality Improvement Act Final Rule to provide federal privilege protections for confidential event reporting.

**Quality Measurement**

CHA continues to implement a suite of new strategies for quality measures advocacy in response to opportunities emerging in the healthcare environment. Priorities for 2016 include:

- Dissemination of CHA’s Networks for Children with Medical Complexity (CMC) Measure Selection Report, the first of a series of reports comprising measure recommendations for specific use cases, implementation guidance, and gap analysis.
- Respond to America’s Insurance Health Plans (AHIP) pediatric core set.
- Survey CHA members regarding measures they are using in payer contracting and for accountability requirements.
- Identify priority use cases for the next measures report.
- Expand the CHA measure selection toolkit, including the measures catalogue.

For additional information, contact Mimi Saffer, VP, Quality Improvement and Quality Measurement at 919.542.3450.
Section on Medical Students, Residents, and Fellowship Trainees (SOMSRFT) Liaison Update

Amee Patel, MD, MPH
SOMSRFT Liaison to COQIPS

I am both excited and honored to be the new liaison for the AAP section of Medical Students, Residents, and Fellowship Trainees (SOMSRFT) to the Council on Quality Improvement and Patient Safety (COQIPS). I am currently a second year general pediatrics resident at the University of Texas Southwestern Medical Center/Children’s Medical Center in Dallas, TX. My interests in quality improvement began when I was pursuing my Masters in Public Health degree at the University of North Carolina Chapel Hill. During my time as an MPH student, I was involved in a project that focused on reducing the administration of IV antibiotics by preemptively teaching kids how to swallow pills while they were in the hospital. This initiative prevented children from needing a PICC line and also increased awareness of the various strategies available to help children conquer this skill. The outcome of this intervention was so rewarding that it inspired me to continue to brainstorm other ways to enhance the care we provide our patients. Currently as a resident, I am a co-chair for our program’s Resident Safety Council where we are working on strengthening communication between nurses and physicians, encouraging resident participation in root cause analysis meetings, and promoting scholarly projects focused on quality improvement and patient safety.

The former SOMSRFT liaison, Dr. Cory Darrow, has done a wonderful job increasing resident membership and interest in COQIPS. I hope to build on his initiatives and encourage residents to be active in this council and take advantage of the opportunities and activities the council has to offer. One of my goals is to create a listserv for all of the trainees that are currently members of COQIPS. I plan to use this to send timely updates and invite members to participate in council activities, such as writing articles for Quality Connections and sharing trainee experiences about quality improvement and patient safety. In addition, because designing a QI/patient safety project can be intimidating, I would love to pair trainees with mentors in the council who can advise them as they formulate their own projects.

Given my interests in quality improvement, I am very excited to be involved in the COQIPS Executive Committee. After participating in an executive committee conference call, I can already appreciate the passion our leaders have for providing the best quality of care for pediatric patients. I am eager to attend the Executive Committee meeting in San Francisco in October and to learn even more about the council and my role as the SOMSRFT liaison. Please feel free to email me at amee.patel@childrens.com with any questions or suggestions regarding my role. I am looking forward to a wonderful two years in this position!

Cory J. Darrow, MD
Outgoing SOMSRFT Liaison to COQIPS

It has been an honor and a privilege to serve as the first SOMSRFT liaison to COQIPS for the last 2 years. I hadn’t previously held a formal position within the AAP, so getting to see the inner-workings of a national AAP Council was a terrific learning experience. In my position, I had the opportunity to serve as a non-voting member of the COQIPS Executive Committee while sitting on the Membership/Bylaws Committee, and I believe that we have made important progress during this time. The amazing efforts of my fellow liaison, Lisa Rossingnol, and many others that led to affiliate members being brought into COQIPS was surely a great step forward. As the lone trainee on the Executive Committee, I worked hard to bring more SOMSRFT members into the fold as well. Fortunately, through the dissemination of multiple articles in at least 4 different publications, as well as by word of mouth, some real traction was made. When I began the process we had just 71 COQIPS members from SOMSRFT, and at last check that number had nearly doubled to 137! My hope is that Dr. Patel’s upcoming efforts to further engage this group of eager future pediatricians in discussion of their QI/Safety work and a mentorship program will provide real value to these members and further the progress we’ve made thus far. The baton has been passed.
Up to 50% of all antibiotics prescribed are not needed or are not optimally effective as prescribed. Are you judiciously prescribing antibiotics in your practice? Take the new EQIPP course and see how you measure up…

EQIPP has a new course, Judicious Use of Antibiotics, designed to help guide physicians on appropriate use of antibiotics based on accurate diagnosis and effective treatment, as well as how to educate families about appropriate antibiotic prescribing. If proper diagnosis and treatment of common pediatric conditions are followed, fewer antibiotics will be ordered and those that are prescribed will be in the narrow-spectrum category, thus improving cost efficacy, limiting the potential for antibiotic resistance, and improving the quality of care for the child.

This course features four tracks related to the most common conditions seen in pediatric patients: acute otitis media, viral upper respiratory infection, acute streptococcal pharyngitis, and acute bacterial sinusitis. Each track will have a specific data collection tool for that condition to assess judicious use of antibiotics.

Each of the four common pediatric conditions in this course will have a related quality improvement activity. You can take one, or all four of the course tracks. Best of all, each track will qualify for 25 American Board of Pediatrics (ABP), Maintenance of Certification (MOC) Part 4 points, for a total of 100 ABP MOC Part 4 points! In addition, you can earn enduring material and performance improvement AMA PRA Category 1 Credit(s)™ for each of the topic areas of the course.

All EQIPP courses are included with AAP membership! They deliver everything you need to identify and close practice gaps—the tools, information and resources you can use to achieve improvement. Learn more now about EQIPP courses at www.eqipp.org.


The EQIPP: Judicious Use of Antibiotics course is supported by an educational grant from GlaxoSmithKline, LLC.

“Helped me realize that QI projects don’t have to be complicated, and they really bring to light the gaps and how to address them.” - Saleh Adi, MD, an EQIPP course subscriber
Ensuring Children’s Access to Specialty Care Act (H.R. 1859/S. 2782)
The AAP has obtained the signatures of over 70 societies in supporting a bill that would strengthen the pediatric subspecialty workforce. The legislation would amend the Public Health Service Act to allow pediatric subspecialists practicing in underserved areas to participate in the National Health Service Corps (NHSC) loan repayment program. The AAP Department of Federal Affairs will be strongly advocating for the passage of this legislation, which serves as a needed step toward curbing today’s demonstrated critical shortage of pediatric medical subspecialists, pediatric surgical specialists, and pediatric mental health specialists to help provide children with timely access to the vital health services they need. Please share the attached letter with your elected representatives. In addition, we encourage AAP members to engage their senators and representative on the issue right now through the AAP federal advocacy action center.

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

Join the Section of Epidemiology, Public Health and Evidence (SOEPHE)
Do you have a passion for public health? Do you feel your knowledge in epidemiology, methodology or even your current research experience could be helpful within the AAP? Then SOEPHE is your section! Join us. We are a group of over 300 pediatricians and public health professionals who use our knowledge and expertise to review AAP policies, guidelines, statements and other academic publications. Our members have opportunities for special seminars and training and are eligible for special awards, too! Be in the forefront of evidence-based medicine and public health and help us improve the health of children. Please join now by clicking here or by calling AAP Division of Member Services at 800/433-9016 ext 5897.

Call for Applications: Innovative and Promising Practices in Pediatric Medical Home Implementation
The National Center for Medical Home Implementation (NCMHI) in the American Academy of Pediatrics is collecting innovative and promising practices in pediatric medical home implementation. All pediatric clinicians are encouraged to apply. All application are reviewed by an expert panel, and selected applications are published on the NCMHI website and promoted through the NCMHI listserv, with over 5,000 subscribers. Apply here!

Ohio: Advancing the Medical Home Model in Pediatrics
In December 2014 Ohio was awarded a two-year, $75 million State Innovation Model (SIM) testing grant to transform the state’s healthcare system. Two key components of the SIM grant include a patient-centered medical home program and an episode-based payment initiative. Read the Ohio State Profile, developed through a partnership with the National Center for Medical Home Implementation in the American Academy of Pediatrics and the National Academy for State Health Policy to learn more about this state’s efforts to advance pediatric medical home implementation.

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CLAIM MOC CREDIT FOR QI WORK YOU'RE ALREADY DOING

Pediatricians are committed to providing the best care for their patients and to making that care better every day. Thousands of physicians have used online tools, like American Board of Pediatrics (ABP) Performance Improvement Modules (PIMs) and AAP EQIPP modules to help with improvement and to meet Maintenance of Certification (MOC) requirements. The AAP’s PediaLink QI system can also be used to build and manage small-group QI projects for MOC credit. These online tools and modules can be great ways to learn the QI process, but many pediatricians are already doing important QI work, including those projects facilitated by the AAP, in their practices. How can pediatricians claim credit for the quality improvement work they’re already doing?

In addition to the numerous ways in which pediatricians can earn credit through the AAP (see sidebar) and in an effort to continue to offer a wider range of meaningful and practical ways to meet MOC requirements for Improving Professional Practice (Part 4), the ABP has developed simple online applications for pediatricians to report the QI work that they originate where they practice.

For Small Groups
The application – called the Small Group QI Project Application -- is designed specifically for QI teams involving 1-10 pediatricians. Once a QI project is complete, the diplomate leading the project submits a Small Group QI Project Application on behalf of the group. When the project is approved, each participating physician then earns 25 Part 4 points. There is a fee of $75 per project (not per person). Now you can finish your QI project, submit your Small Group QI Project Application and claim your credit!

For the Larger Groups
For those QI teams that include more than 10 pediatricians, the ABP offers a slightly altered version of the Small Group application. The QI Project Application, which is appropriate for long term, ongoing QI projects, is designed for organizations whose QI teams include 11 or more pediatricians. This application costs $250 for the entire team and earns each participant (no maximum) 25 Part 4 points.

Credit can be awarded each time a member of the QI team can attest to meaningful participation -- meaning one project can result in multiple opportunities for its participants to claim MOC credit for their work!

For Those Who’ve Earned NCQA Recognition
MOC Part 4 credit can also be claimed if a practice has earned National Committee for Quality Assurance (NCQA) recognition for either Patient-Centered Medical Home (PCMH) or Patient-Centered Specialty Practice (PCSP). The ABP recognizes the rigorous QI efforts necessary to obtain such recognition. Individual physicians, at no additional charge, can claim 40 Part 4 points if they have meaningfully participated in earning

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NCQA-PCMH or NCQA-PCSP recognition based on either 2011 or 2014 standards.

**For Those Leading Institutions in QI Work**
Those individuals with expertise in quality improvement science who are in positions to lead institutional quality improvement initiatives – such as Vice President of Quality/Safety, or a Chief Quality Officer – can claim 40 Part 4 points for their leadership activities. The QI Program Development application is designed specifically for those developing and leading macro-level QI programs (not necessarily projects) within an organization.

**For Organizations Sponsoring QI Projects**
Organizations that are sponsoring three or more QI projects within a two-year period may apply to become a Portfolio Sponsor. This role as sponsor allows the organization to oversee multiple, simultaneously-running QI projects and approve qualifying projects for 25 Part 4 points. The Portfolio Sponsor is responsible for submitting a progress report to the ABP for each approved project.

Did you know the AAP is a Portfolio Sponsor? The AAP reviews and approves its own QI Projects, based on ABP MOC standards, and then awards credit for participation.

**Connect with AAP for MOC Success**
The American Academy of Pediatrics (AAP) continues to expand its offerings for members to fulfill requirements for Maintenance of Certification (MOC).

The Academy provides solutions for individuals from online QI courses to PREP self-assessments to live CME events. The AAP MOC Portfolio also provides guidance for members interested in developing or providing MOC activities through nationally-affiliated AAP groups (e.g., Sections and Councils).

Discover which MOC solution is right for you, and keep up with developing news at the newly revised [http://www.aap.org/mocinfo](http://www.aap.org/mocinfo).