Welcome to another Issue of AAP Quality Connections! This Issue is especially important for me since it is my last as Chair of the Council of Quality Improvement and Patient Safety (COQIPS).

I first stumbled into the field of quality soon after finishing my residency in 1999. I started practicing general pediatrics in a rural community health center in West Central Florida. Long waits, dissatisfied patients and getting home late was a very different reality from my vision as a resident of what it meant to practice primary care pediatrics. The breakthrough moment came from a Medical Economics free trial cassette tape that had Don Berwick speaking about the work that IHI had done in the idealized design of the office practice initiative. As I was driving home one day listening to that tape, the epiphany came…there were actually systems that were being used by other industries that could be used in healthcare to improve care. The amazing realization was that this was being driven by clinicians and not by administrators. Soon after that, I attended my first IHI Forum in 2000, and then I was bit by the quality improvement (QI) bug.

The Steering Committee of Quality Improvement and Management (SCOQIM) at the AAP had just started in 2003. It had some of my QI heroes such as Paul Miles, Charlie Homer and Carole Lannon. Back then, the SCOQIM was the face of everything that had to do with quality at the Academy. This was a relatively new field and getting more important every day. AAP Presidents and President-elects would come to our fall and spring meeting to learn more about the field of quality. I joined the Committee in 2006 as a member, and then became the chair in 2009.

The Academy has come a long way in eight years. Now there is no single body that has a "monopoly on quality." Quality has become one of the Academy's pillars and it is spread throughout many functional areas. There are many QI activities taking place at the AAP including: Quality Improvement Innovation Networks (QuIIN), Education in Quality Improvement for Pediatric Practice (EQIPP), Value in Inpatient Pediatrics (VIP) Network and Chapter.
Quality Network (CQN).

In quality, the only constant is change. It was only natural that the SCOQIM should also change and morph into a different form to accommodate the new and evolving quality field. The Council of Quality Improvement and Patient Safety (COQIPS) was born in July 2013 as a place for pediatricians with an interest in quality and patient safety to network and advance the strategy for quality at the Academy.

The Council has now around 400 members, affirming the commitment and mature interest around quality at the Academy. My proudest moment so far in this budding Council has been the decision to include a family member into the Executive Committee of the Council to represent the patient/family point of view. The role of families and patients is going to be key as they go from a passive recipient of care to a partner and collaborator. I look forward to having our Council set the precedent on how families and patients can be active participants in the work of the Academy to advance child health.

Several of our quality leaders are also "retiring" from the Council: **Al Lieberthal** has made great contributions to the quality standards for health care in general pediatrics by chairing various guideline committees, such as the otitis media, and bronchiolitis.

**Greg Randolph** has made important contributions in his native North Carolina to advance the health of children through regional quality improvement collaboratives. Greg has managed and advanced our education subcommittee including this newsletter and other educational offerings for pediatricians.

**Charles Woods** and **Mary Ann Whelan** have both contributed in the field of evidence-based guidelines, advancing the quest to reduce unnecessary variation in the pediatric field.

Finally, there is **Ellen Schwalenstocker**, who we wish a happy retirement. Ellen has been the liaison from the National Association of Children’s Hospitals and Related Institutions (NACHRI), and now the Children’s Hospital Association, for several years. She has provided the critical link and perspective from the inpatient children’s hospital to both SCOQIM and now COQIPS.

I also wish **Wayne Franklin** best of luck in taking over the chairperson position. I know Wayne will propel the Council into new heights with his leadership.

There are still many challenges the lie ahead with the work of quality at the Academy. As this field continues to evolve, it is clear that our definition of quality needs to be expanded to take into account cost of care, as well as improving the care of populations. As we know, the literature notes that medical care only contributes 10% to health improvement. If we really want to achieve improved health for the population at a lower cost, we will need to address the other 90% which includes social determinants of health, lifestyle choices, and other items that we have not done in the past. However, as pediatricians, we are ideally suited to deal with the 90% through prevention and wellness. This is the true value of the work that we do in child health. We can exponentially change the outcomes in adulthood with the work that we do with children.

This is an exciting time to be involved in quality. I invite you to help write the next chapter in this exciting journey to advance health for all children.  

**See Page 6 for More Information!**
Updates from the COQIPS Executive Committee

COQIPS Election Results

The COQIPS election results are in! Please congratulate and welcome the newest COQIPS Executive Committee members who will serve a three year term beginning July 1, 2014:

Dr. Terry Adirim  
Rockville, MD

Dr. David Bundy  
Charleston, SC

Dr. Brigitta Mueller  
St. Petersburg, FL

Dr. Michael Rinke  
Briarcliff Manor, NY

Dr. Joel Tieder  
Seattle, WA

These five incoming Executive Committee members were chosen from a total of nineteen original candidates of which ten were on the 2014 ballot. Every candidate had extremely strong background and experience making the selection and election process difficult. We congratulate our newest Executive Committee members as COQIPS embarks on future quality improvement and patient safety activities and initiatives!

Appointment of the Council on Quality Improvement and Patient Safety Parent Liaison

The Council would like to welcome Lisa Rossignol, who has been appointed as the COQIPS Parent Liaison! In this newly established role, Ms. Rossignol will strengthen the committee’s understanding of quality improvement and patient safety issues by providing the viewpoint of a parent or care giver.

She will serve a three year term as parent liaison to the Executive Committee.

Lisa Rossignol, MA  
Ms Rossignol received an MA in Health Communication from the University of New Mexico. Her areas of research focus on indoctrination of Patient- and Family-Centered Care practices in pediatric hospital units and medical school education about patient-provider communication. She has served as parent representative to many executive committees and advisory panels including: the ARC of New Mexico, New Mexico’s Carrie Tingley Hospital, the University of New Mexico Hospital and the Patient Centered Outcomes Research Institute (PCORI). She is also a member of the New Mexico Senate Memorial 20 task force. She is the mother of two daughters, one with multiple disabilities; her oldest daughter had a hemispherectomy in 2008 due to catastrophic epilepsy.

COQIPS Membership Update - Council Membership on the Rise!

The Council continues to experience a steady growth of new members. To date, COQIPS represents over 400 primary care and subspecialists interested in quality improvement and patient safety! We would like to welcome and

Continued on next page
congratulate the following new members:

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<tr>
<th>Natasha Afonso</th>
<th>Christopher DeRienzo</th>
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<th>Dana Mueller</th>
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<td>Aba (Eba) Al-Kaabi</td>
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<td>Amber Allen</td>
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<td>Shephali Katira</td>
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<td>Kathleen Bradford</td>
<td>Jonathan Goldenthal</td>
<td>Hiba Khankan</td>
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<td>Jeffrey Britton</td>
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<td>Kathleen Butler</td>
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<td>Stephanie Kuhlmann</td>
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<td>Naijah Coleman</td>
<td>Michelle Haley</td>
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<td>Mary Schultz</td>
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<td>Lisa Cosgrove</td>
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<td>Daniel McKenney</td>
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<td>Peggy DeFelice</td>
<td>Abimbola Iyanoye</td>
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As the Council continues to grow the Executive Committee would like to learn more from COQIPS members about their backgrounds, interests, expertise as well as get their thoughts on the value of Council membership. As such, a Council needs assessment will be conducted in late spring/early summer. We strongly encourage COQIPS members to complete this survey and share your thoughts/ perspectives on how to build value for Council membership.

For more information about how to get involved in the membership subcommittee please contact Dr Wayne Franklin (waynehfranklin@gmail.com), subcommittee chairperson or staff, Vanessa Shorte (vshorte@aap.org).

**COQIPS Education Update – Come One, Come All!**

The 2014 National Conference and Exhibition is right around the corner! Don’t forget to attend the following COQIPS-sponsored sessions on the following page.

The Council will host its inaugural council program at this year’s National Conference & Exhibition! The morning program will be dedicated to abstract presentations, a poster viewing, and networking reception. We are thrilled that we have confirmed Dr Thomas K. McInerny, AAP Immediate Past President, and Dr Patrick Conway, Deputy Administrator for Innovation and Quality and CMS Chief Medical Officer as speakers for the program. Dr Conway will also present a plenary the following day.

The full COQIPS education (H) program agenda will be included in the Fall Issue of *Quality Connections*.

You won’t want to miss these events!

For more information about how to get involved in the education subcommittee please contact Dr Laura Ferguson (L Ferguson@tamhsc.edu) or Dr Greg Randolph (randolph@unc.edu), subcommittee co- chairs or staff, Cathleen Guch (cguch@aap.org).

**PAGE 4 AAP QUALITY CONNECTIONS**
2014 National Conference & Exhibition Important Dates

October 11 – 14, 2014 • San Diego

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Council on Quality Improvement & Patient Safety-Sponsored Programs

October 12, 2014

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

October 13, 2014

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

October 14, 2014

P4047 - Health System Transformation: The Future of Payment and Implications for Pediatricians
11:50 AM – 12:10 PM
Speaker: Patrick Conway, MD, MSc, FAAP
EARN PART 4 MOC CREDIT FOR QI POSTERS!
Physicians should review and assess the care they provide patients, and regularly make improvements in quality. Part 4 of the American Board of Medical Specialties Maintenance of Certification (MOC) program is intended to assure the public that physicians meet this standard. The American Board of Pediatrics (ABP) grants MOC Part 4 credit to diplomates involved in an ABP-approved quality improvement (QI) activity. The ABP also recognizes authorship of peer-reviewed posters presented at a national meeting that describes the implementation and outcomes of a quality improvement project.

STEPS IN THE PROCESS:
1. Submit an Application: Log in to the MOC Activity Manager (MOCAM) and complete a detailed “Poster” application. First-time MOCAM users must register.
2. Submit the review/processing fee (currently $50 per poster).
3. ABP Review: Staff and an external committee of practicing pediatricians review and approve completed applications (applicants may be asked to clarify information during the review process).
4. Notification: Please allow up to 12 weeks for review.

Learn more at https://www.mocactivitymanager.org

HOW CAN MY QUALITY IMPROVEMENT POSTER EARN PART 4 MOC CREDIT?
The ABP will grant Part 4 MOC credit (20 MOC points) to diplomates who author or co-author a peer-reviewed poster that describes a quality improvement project. The poster must be presented at a national scientific meeting.

At a minimum, the poster should include:
- The specific aim of the quality improvement project
- The process for improvement
- The progress toward or results of achieving the specific aim
- A discussion of whether the aim was achieved, factors that affected success, and next steps

The project’s ultimate success will not affect the credit, but it should address a recognized gap in care, be prospective, and involve more than one quality improvement cycle.

(The SQUIRE guidelines at www.squire-statement.org are a good source of information to learn how to best report results of this kind of project.)

What won’t earn credit:
- Research publications, including comparative trials, before-and-after studies, and other studies intended to answer a clinical or scientific question
- Descriptions of studies to assess whether an intervention is effective
- Development and validation of tools that could be used for quality improvement
- Quality measure development
- Retrospective studies of administrative claims data
- Pending posters or posters describing projects already approved for MOC Part 4 credit
Update from the Section of Emergency Medicine—Committee on Quality Transformation

In 2010, the American Academy of Pediatrics (AAP) Section of Emergency Medicine (SOEM) created the Committee on Quality Transformation (COQT) with the following goals:

- To educate pediatric emergency medicine (PEM) physicians on national and international quality initiatives.
- To develop quality leaders within PEM.
- To engage and support SOEM members in Maintenance of Certification (MOC) level 4 activities.
- To promote and lead change in the areas of quality and outcomes management for PEM.

We are proud to announce two initiatives that are making great strides to improve the quality of care provided in emergency departments across the country.

**Improving the Handoff Process**

In 2012, the patient safety taskforce, comprised of PEM specialists from approximately 10 academic EDs, considered priorities for patient safety in the ED and determined that patient handoffs should be their first priority for improvement. Handoffs of care at the transition between physician shifts in the ED represent a major potential for medical errors given the often chaotic working atmosphere. While standardized handoffs have been studied in other hospital-based disciplines and non-healthcare related fields, published studies and tools in the ED literature are limited. The taskforce has developed a Part 4 MOC project to improve the quality of ED physician handoffs using a standardized handoff tool and physician education. Physicians will participate in 3 phases of the project – a baseline phase and two follow-up cycles. During each phase, they will have a colleague rate 20 patient handoffs. Feedback will be provided using statistical process control charts at the end of each phase. Participants will use this feedback to discuss basic principles of quality improvement, best practices for patient handoffs, barriers and enablers of good handoffs, and implementation and improvement strategies. The MOC activity will begin enrolling physicians during summer 2014.

**Improving Septic Shock Recognition and Management**

The Pediatric Septic Shock Collaborative (PSSC), which kicked off in fall 2013, aims to improve the quality of care for children with suspected septic shock. Despite the existence of guidelines for goal directed therapy, there continues to be less than desired quality of care delivered to this patient population resulting in suboptimal outcomes. The primary aim of the PSSC is to reduce mortality in septic shock by a relative 20%. The collaborative has two areas of focus: a quality improvement (QI) arm and a research investigations arm. The quality improvement arm involves the implementation of an intervention bundle with strategies for improving rapid recognition, escalation of care, and ongoing management of septic shock. The research component of the PSSC involves the development of proposals for the Pediatric Emergency Care Applied Research Network, the Pediatric Emergency Medicine Collaborative Research Committee and other interested organizations to utilize traditional research methodologies or advanced quasi experimental methods for delineating biomarkers and diagnostic testing modalities for better accuracy in diagnosis and management of septic shock in children. Twenty-five hospitals across the United States are participating in the collaborative - with more expected in years 2 and 3 of the initiative.

If you are interested in learning more about the projects described or future COQT initiatives, please contact Charles Macias at cgmacias@texaschildrens.org.
Candidates for President-elect Answer the Question—How Can You Help ME Take Care of Children?

Every year, the two candidates for President-elect of the American Academy of Pediatrics are asked to submit brief responses to questions about their respective visions and priorities for the Academy. This year, Dr. Joseph Hagan of Burlington, VT and Dr. Benard Dreyer of New York, NY have responded to the question: “How can you help ME take care of children?”

**Joseph Hagan, MD**

The AAP is committed to the care of children and families, and the AAP must also care for pediatricians. The health of youth depends upon primary care, specialty care, and academic pediatricians for both health care and advocacy in policy and in media.

As I practice primary care pediatrics, my AAP experience revolves around collaboration with pediatric subspecialists, allied professionals and families in projects related to theory, practice and systems to enhance child health. In The Bright Futures Guidelines, we ask specialists to provide evidence for what we do. We help primary care clinicians to select what is important for their patient and practice, with the intent to help pediatricians accomplish what they know to be important, not to dictate what they do. I am committed to continuing this work.

Pediatric practice has to thrive and remain not just viable, but strong in both the traditional fee-for-service setting and in the new Accountable Care environment.

Pediatric practice must continue to be personally and professionally rewarding. I founded a small practice, serve on the board of a PPO and am clinical faculty in an academic Pediatrics department. I am committed to the business of pediatrics, the science underpinning our work and teaching and mentoring those who will carry this work forward.

I will seek and utilize your input to serve you effectively. Our leaders must understand the needs of children, the realities of practice, the demands of academia and the ability of the AAP to empower each of us.

**Benard P. Dreyer, MD**

I am committed to making sure that the AAP continues to take care of pediatricians in practice because they are on the front-line taking care of children and families, the center of our mission. We must work with large private payers to ensure that pediatricians are paid fairly for the services they provide. We should seriously respond to a top 10 resolutions at Annual Leadership Forum this year that asked the AAP to create its own certification process for the Pediatric Medical Home. We must also help pediatricians adapt to new models of payments based on quality and population health, not fee for service.

Of equal importance, I am committed to the increasing number of pediatricians, in hospital medicine or primary care, who need leadership skills to advance their careers. We will need to teach organizational and business leadership to our members, including young physicians, sooner rather than later. We must help young physicians with the large debt they face and invest in our electronic platform so that the AAP becomes the electronic portal for all pediatricians seeking tools to take better care of patients.

Finally, I know that many of you are passionate about the issues of child poverty, firearm safety, obesity, and early childhood and brain development, as am I. My pledge to you is to actively lead the AAP in making policy and advocacy, education of our trainees and members, and improvements in health care come together to make a real difference for the most vulnerable children and families.
As a board certified pediatrician, now also the Chief Medical Officer and Chief Quality Officer of our Federally Qualified Health Center (FQHC) in Texas, I am often asked about how and why I am involved in so many different initiatives! Healthcare quality permeates my daily activities:

- Directing the pediatrics department
- Assisting clinic teams in family medicine, obstetrics/gynecology, and psychiatry with determining appropriate quality metrics
- Evaluating and recommending care standards and measures for providers
- Leading maintenance of Joint Commission Ambulatory accreditation and NCQA Patient Centered Medical Home certification (Level 3) efforts
- Chairing the organizational Quality Council

My journey in health care quality has taken a convoluted, although not unexpected, path. After earning a degree in medical technology, I worked in an acute care laboratory. Knowing that the results I reported were used to make treatment decisions on individual patients, I appreciated the importance of quality control, “run charts”, instrument maintenance and staff training to ensure quality assurance. I simultaneously earned an MBA as the “business of medicine” was becoming increasingly important, even in the lab.

I wanted to become a physician. After earning another master’s degree in behavioral sciences, focusing on management psychology and organizational development, I earned an MD at The University of Texas Medical Branch at Galveston.

After completing my pediatric residency, as a pediatric generalist in a small city in East Texas, I served as preceptor for family medicine residents and medical director of pediatric and pediatric pulmonary clinics. I also served as Chief Quality Officer for the organization participating in performance improvement projects with others with interest in quality improvement and patient safety. Some of those projects aligned with the Institute for Healthcare Improvements 100,000 Lives/5 Million Lives initiatives (http://www.ihi.org/Engage/Initiatives/Completed/5MillionLivesCampaign/Pages/default.aspx). Joint Commission re-accreditation activities, hospital safety rounds, and chairing the quality council were aspects of my job that I loved; they provided opportunities to explore multiple aspects of “quality.”

About that time, the Josie King Story was published (http://www.josieking.org/whathappened). This event was among the first where a mother spoke openly about the devastating experiences of her toddler, Josie, who died in one of the best health care facilities in the country. She tells her personal story of trying to express her concerns to residents and nurses that something “was not quite right” with her child, but no one listened. Josie’s death was preventable. The story is heartbreaking and difficult to hear, especially for a pediatrician.

We used this video to introduce healthcare quality and patient safety initiatives, including appropriate hand-offs, in our organization. Successful multi-disciplinary collaborations with others passionate about improving patient outcomes led me to further training in health care quality. I became a Certified Professional in Healthcare Quality (CPHQ) and Certified in Medical Quality (CMQ).

Continued on next page
My efforts are about caring for patients, ensuring that the quality and safety of the health care provided is the best evidence-based, cost effective care available no matter how it is funded. Patients often assume that more “care” is better. Physicians understand this is not necessarily true. Each patient encounter is an opportunity for things to go well AND for things to go wrong. Sometimes the best care requires detailed explanations regarding treatment options (or reasons why tests or treatments are not appropriate) in a way patients understand. “Best” care does not always mean expensive care.

One example, is pediatric asthma. Patient and parent education are essential to best practice, from discussions of triggers and symptoms, appropriate use of medications, completion of an asthma action plan, demonstrating use of medication and devices, etc. Relatively inexpensive interventions can result in dramatic improvement in quality of life measures, lost school/work days, decreased inappropriate use of urgent care or reduced lengths of stays during hospitalizations. We measure provider performance in managing asthma against several HEDIS metrics organizationally as well as for individual providers. Posted individual provider, service line and organizational metrics, are compared with available regional/national benchmarks on dashboards available to providers and leadership. We participate in multi-organization collaboratives focusing on improvements in asthma care in pediatrics and diabetes care in adults.

After joining this FQHC six years ago I engaged with leaders with shared vision and expectations for safe, affordable, quality health care. We patiently teach the medical, nursing and allied health staff; sometimes we have to push or pull staff in the right direction, but always we keep in our sights the reasons we do what we do every day: our patients.

In an interview in 2007 about health care quality, I stated that “being good enough” is NOT good enough because it implies mediocrity¹. Patients deserve better. We can get there by continuously raising the standards we accept. Slowly but surely we are making a difference. If only one life is saved, our efforts will have been worth it.


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AAP MOC Portfolio Program

In November 2012, the American Board of Pediatrics (ABP) granted the AAP Portfolio Sponsorship status, allowing the AAP to review and approve its own projects for Part 2 and Part 4 Maintenance of Certification (MOC). Projects submitted through the Portfolio Program must:

- Follow the standards set forth by the ABP
- Have direct oversight from national AAP
  - AAP group must be meaningfully involved in the design and implementation of the Project
  - Typically, AAP members interested in conducting a quality improvement project through the Portfolio Program work within established AAP groups (eg, Sections, Councils) to develop a system for oversight for that project
- Complete an AAP MOC Application Form
- If approved, monitor physician participation and provide ongoing reports to the AAP

Applying through the AAP MOC Portfolio Program is free. For more information, or to apply, contact Jill Healy, MS, Manager, Quality Improvement and Certification initiatives at MOCPortfolio@aap.org.
What does success look like in health care? The answer to that question very much depends on who you are asking since one organization’s expenses are another’s revenues. The development of a better system-based measurement evolved over time. The best current answer to that question is the Triple Aim framework proposed by Berwick, Nolan and Whittington in 2008⁴. In the Triple Aim, success is defined as:

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

The challenge this definition creates is the difficulty any one actor has in being able to meaningfully impact the system sufficiently to accomplish triple aim success. This challenge has driven the growing attention on the Accountable Care Organization (ACO). An ACO is typically a provider-based organization that has the scope and resources to take responsibility for a population of patients and is accountable for achieving Triple Aim success. Health plans, previously the only type of organization taking responsibility for a population, must work at a distance through others to influence patient outcomes. The ACO, with its combination of physicians, hospitals, and population-focused support infrastructure, can directly apply its resources to the point of impact. The closer the decision-making and influence is to the point of care, the better the structure is able to balance the sometimes competing aims for overall success.

The Patient Protection and Affordable Care Act (PPACA) had built into the comprehensive law significant support for ACO development. This development has been largely focused on the adult population (specifically Medicare). Pediatrics has not been as well defined, nor received the degree of attention or funding that has been true for the elderly. Thus the development of pediatric ACOs that are taking responsibility for Triple Aim success is spotty, with significant geographic variation in intensity. Ohio, through a combination of a high concentration of world-class children’s hospitals, and a very active AAP chapter, has been a leader in developing the quality improvement systems to achieve Triple Aim success.

Nationwide Children’s Hospital, through its affiliated ACO Partners For Kids (PFK), has been an early adopter of the ACO model. PFK is a Physician-Hospital Organization (PHO) that contracts with Medicaid managed care companies to accept responsibility to achieve Triple Aim success for nearly 300,000 children 0-18 years in a 34 county area. With this large a population under contract, the importance of quality improvement efforts becomes very important.

PFK benefits from significant quality improvement (QI) work in its base hospital, Nationwide Children’s Hospital (NCH). NCH has embraced the quality improvement culture throughout the organization with the integration of quality improvement specialists into almost all service lines. These QI specialists, experts in the science of QI, but novices to health care, have facilitated dramatic change throughout the organization. Clinically, QI tools are applied to processes from ICU central line management, outpatient immunization administration, and evaluation of the effectiveness of diabetes patient education. Operational business processes from clinic scheduling to employee safety are also subjected to QI scrutiny via leaders graduates of the internal QI Essentials training course modeled after the Advanced Training Program in QI done by Dr. Brent James at Intermountain Healthcare.

The QI successes within NCH are multiplied through collaboration with the other members of the Ohio Children’s Hospital Association (OCHA). The Solutions for Patient Safety is a program coordinated through OCHA that has engaged all of the state’s children’s hospitals to significantly reduce the incidence of central line associated blood stream infections (CLABSI) in children across the state.

Continued on next page
The success of this program has been validated through publications and the CMMI award to spread the program to hospitals throughout the country.

Partners For Kids has both supported and benefitted from QI work in community pediatric offices and hospitals. Clinical programs have been selected that combine the best opportunity to improve care, health, and cost within the population. In the pediatric population that focuses on asthma, ADHD, and neonatology. Asthma QI programs done in coordination with the AAP assist the community pediatrician to provide the best care, improving health and reducing costs. An ADHD program in collaboration with Cincinnati Children’s Hospital and Medical Center uses web-based resources to facilitate communication between physicians, parents, and schools to better manage children with this condition. A QI project engaging birth hospitals and obstetricians has reduced the incidence of elective premature birth, and spread best practice hormonal treatments to extend the duration of high-risk pregnancies.

The Ohio AAP has developed additional QI programs based on the Institute for Healthcare Improvement Breakthrough Series. Physician leaders in injury prevention, behavioral health, and obesity prevention and management have led efforts in improving population-based care. The chapter has contracted with the state Medicaid leadership to provide educational programs to physicians, and sought out donations to support its QI work.

The PFK model of a children’s hospital accepting Triple Aim responsibility for a population of children is spreading across the state as well. Akron Children’s Hospital has partnered with PFK in a CMMI-sponsored project to adopt the same payment model. Clinical teams from both organizations in behavioral health and complex care work together, applying the same QI approach to parallel populations to maximize learning and achieve better outcomes. Cincinnati Children’s has adopted a modified version of the PFK model with the same basic goal, to accept responsibility for a defined population and improve the care, health, and cost profile of the children in the its surrounding community.

The state of Ohio, through the Office of Health Transformation, has been driving QI in healthcare through several initiatives. The Office of Medical Assistance (Medicaid) has placed greater emphasis on quality improvement in HEDIS measures through contracts with the Medicaid managed care companies that emphasize pay for performance by putting money at risk. Ohio has also committed to adoption of payment systems that reflect the total cost of an episode of care across providers and settings. Initially just through reporting, but eventually to include financial bonuses and penalties, all payers will be expected to support these quality improvement programs. Patient Centered Medical Homes will also be encouraged through a program that provides transformational support, data, and financial incentives for physician practices to manage the total cost of care for the populations attributed to them. Basic program outlines mirror the Complex Primary Care Initiative sponsored by CMS.

Ohio has become a hotbed of quality improvement transformation in children’s healthcare. The result is improved outcomes for children.
New! EQIPP: Growth Surveillance & Linear Growth Failure
Identify & Close Gaps to Deliver Great Care

Is your care related to growth surveillance and linear growth failure falling short of its potential? Learn where your practice needs improvement—and get the resources to do it—with EQIPP: Growth Surveillance and Linear Growth Failure. General pediatricians and endocrinologists will learn techniques to:

- Demonstrate regular and accurate measurement and plotting of growth at every visit to monitor ongoing growth care, and share results with patient families
- Recognize and evaluate frequent causes of poor growth (general pediatrician track)
- Identify and address patient/family’s growth or development concerns
- Provide education and support when a growth or pubertal development concern is raised or a psychosocial issue is identified
- Create/obtain a written care plan for patients with abnormal growth that is developed in partnership with the patient and family, shared with growth team members, and includes timely health status updates
- Improve communication among growth care team members, facilitating effective referrals and timely updates on the patient’s care plan and health status

Learn more at: bit.ly/eqipp-growth

“Simple, straightforward, and easily implementable. Not only have we implemented the proposed change from this course, we now have a model to take on other desired changes.” - Nathan Wilson, MD, EQIPP User

EQIPP COURSES HELP SATISFY MOC PART 4 REQUIREMENTS

EQIPP: Asthma—Diagnosing and Managing in Pediatrics
EQIPP: Oral Health in Primary Care
EQIPP: Growth Surveillance & Linear Growth Failure
EQIPP: Newborn Screening—Evaluate & Improve Your Practice
EQIPP: STEP Up Diabetes Care—Screening, Testing, Education & Prevention
EQIPP: Immunizations—Improve Your Practice Rates

www.eqipp.org
At the April 2014 QuIIN Steering Committee meeting leaders prioritized goals for the upcoming year.

QuIIN leaders met earlier with the AAP Pediatric Research in Office Settings (PROS) Steering Committee where there was collaborative energy and vibrant conversations ranging from the process of ideas to research to quality improvement (QI) to change in culture on a national level. Concrete steps in this direction include:

- An improvement project based on the PROS Young Driver Parenting Project which is seeking funding
- Laurel Leslie, MD, MPH, FAAP, Associate Director, PROS attending monthly QuIIN leadership calls and annual meetings
- Exploring a shared PROS/QuIIN listserv for project related questions/discussions
- Movement towards a shared parent panel for both networks to access during project design and implementation

An additional focus for 2014 is adding the “Innovation” back into QuIIN by incorporating innovations in primary care, patient engagement as well as expanding the science of QI in the Value in Inpatient Pediatrics (VIP) and Practice Improvement Network (PIN) projects. Of equal importance is to maximize synergy between QuIIN and the new AAP Council on Quality Improvement and Patient Safety (COQIPS) to ensure a seamless Academy approach for valued members.

Current PIN activities include two American Board of Pediatrics (ABP) Maintenance of Certification (MOC) Part 4 Projects in progress:

- Genetics in Primary Care Institute (GPCI) Quality Improvement Project
- Comparison of Immunization Quality Improvement Dissemination Strategies (Ci2QIDS)

Many other funding requests are underway as well for additional PIN projects.

Value in Inpatient Pediatrics (VIP) Network
Matthew Garber, MD, FHIM, FAAP – Medical Director

At the January 2014 VIP Network Steering Committee meeting leaders identified the following four priorities:

1. Translation of evidence based clinical practice guidelines (CPG’s), or best practices when no relevant CPG exists, into meaningful and practical inpatient measures
2. Focus on avoiding overuse and elimination of harm
3. Helping pediatric hospitalists and other providers of pediatric inpatient care collect and analyze their data and implement and test interventions to improve value
4. Designing all projects for American Board of Pediatrics (ABP) Maintenance of Certification (MOC) Part 4

Using these priorities, a more defined audience for VIP Network activities and a new mission statement were formed:

The mission of the VIP Network is to be a healthcare stewardship organization which improves the value of care delivered to any pediatric patient in a hospital bed by helping providers implement clinical practice guidelines and other best practices, with a special focus on eliminating harm and waste caused by overutilization.

VIP has multiple activities in the planning stage as follows:

- 2 ABP MOC Part 4 projects submitted for AAP Friends of Children Funding
- Proposal to the Section on Hospital Medicine (SOHM) for a co-sponsored Bronchiolitis Education in Quality Improvement for Pediatric Practice (EQIPP) course
- Proposal for 2016 Pediatrics for the 21st Century (Peds-21) on Choosing Wisely and overuse for the primary care physician and pediatric hospitalist
- Multiple proposals submitted for the AAP National Conference and Exhibition

Current activities include VIP representation on the AAP Bronchiolitis CPG and 2 ABP MOC Part 4 Projects:

- A Quality Collaborative for Improving Hospitalist Compliance with the AAP Bronchiolitis Guideline (B-QIP)
- Improving Community-Acquired Pneumonia Management Quality Improvement Project (ICAP) (pending approval)
It is because of you that QuIIN is able to contribute to improved care. A recent example includes the Genetics in Primary Care Institute (GPCI) Quality Improvement Project. To date participating practices have had the following improvements to report:

- Uptake of a Family History Standardized Process (↑54% to 100% uptake)
- Family History Process Documented as a Written Policy in the practice (↑40%)
- Creation of established processes/written protocols for identification and tracking of patients with a defined genetic condition (↑54%)
- Use of a policy or procedure for tracking genetic referrals made (↑77%)
- Use of a policy or procedure in place for transitioning pediatric genetics patients to adult services (↑15%)

Much has been accomplished over this past year and we look forward to continuing our momentum in 2014!

Best Regards,

Steven Kairys, MD, MPH FAAP
Matthew Garber, MD, FHM, FAAP

For additional details see:

- QuIIN Medical Director Report
- VIP Network Medical Director Report
While genetics has been viewed as a discipline focused on rare conditions, recent advances highlight the role of genetics in common conditions managed by primary care providers. While family history is considered the first genetic screen, less than 1/3 of pediatricians usually collect detailed histories from their patients.

Thirteen pediatric practices have completed a nine-month quality improvement initiative aimed at integrating genetic services into primary care and strengthening medical homes for more than 130,000 children in 11 states. The initiative, the Genetics in Primary Care Institute (GPCI) Quality Improvement Project (GPCI QIP) is supported by the GPCI, which was established through an agreement between the American Academy of Pediatrics and Health Resources and Services Administration’s Maternal and Child Health Bureau. GPCI’s aim is to improve primary care providers’ knowledge and skills in genetic medicine.

The goal of the Genetics in Primary Care Institute Quality Improvement Project is to enhance the way in which pediatric practices “think genetically” and incorporate genetic medicine into primary care to meet the needs of patients and their families. To achieve this, the initiative focused on strengthening coordination between the primary care provider and genetic specialists; educating and supporting patients and families to manage their own care; and ensuring the efficient exchange of information using health information technology.

Practices worked collaboratively to:
1. improve the assessment and identification of genetic conditions for all patients 0-21 years of age through collection of family health history information during health supervision visits;
2. improve the care and management of patients 0-21 years of age with genetic conditions; and
3. improve practice systems and processes to meet the first two aims.

Practices achieved significant improvements. For example, by the end of the project all practices used a standardized process for taking a family history (FH). The post-project survey also showed that 77% of the practices established processes or written protocols for identification and tracking of patients with a genetic condition. Also, 85% of practices reported in the post-project survey that they have a policy or procedure for tracking genetic referrals. By the end of the project, all participating physicians rated their knowledge of family history as assessing predisposition to disease as ‘very competent’.

While practices will continue to make improvements towards meeting their goals, the most significant result from this quality improvement initiative was the change in mindset of participating practices regarding the value of family history and genetic consultations.

“As a result of this project, I have realized that unless we ask the question we may not find the answer. So going back to the foundation of medicine – the family history – we have learned that we can do a better job of including genetics in the family history,” said Cynthia Nassim, M.D., F.A.A.P, of Nassim and Associates in New Albany, Indiana. “We will continue to commit to making the changes in our practice, such as

Continued on next page
implementing an electronic family history tool and establishing an audit system with our family history to ensure all patients’ histories are being reviewed as part of the health supervision visit.”

Each of the 13 practices established a registry for patients with diagnosed genetic conditions. “We were able to use the AAP health supervision guidelines for known genetic conditions, and this made an incredible difference in our ability to manage patients with complex conditions,” said Aimee B. Biller, M.D., FAAP, a lead physician from the Children’s Hospital of Pittsburgh Primary Care Center.

YouthCare Pediatrics of Bristol, Tenn., learned there is a guideline on Williams syndrome, so it requested that a patient with Williams syndrome come in for a health supervision visit. Her pediatrician was able to discuss issues such as awareness of sexual predators, occupational therapy, physical therapy, long-term planning and career goals.

“All of these discussions are important not only for genetics purposes, but also for a comprehensive medical home and transition to adult care,” said Beth A. Tarini, M.D., FAAP, co-medical director of the Genetics in Primary Care Institute Project and a member of the AAP Committee on Genetics. “Patients should be prepared for a seamless transfer to adult care, including updating family and genetic family history, which would not have been done without this project.”

A comprehensive, step-by-step toolkit (change package) containing the lessons learned, tools developed, and successful strategies for assessing risk and improving care for patients with genetic conditions has been developed and is available on both the GPCI and QuIIN websites. The best practices developed as part of the GPCI QIP also informed the development of a PediaLink course, "Dive into the Gene Pool", which will launch in late summer 2014.

For more information about the GPCI, visit www.geneticsinprimarycare.org.