Chair’s Letter
The AAP and Pediatric Nephrologists
Larry Greenbaum, MD, PhD

I am often asked about the interaction between pediatric nephrologists and the AAP. The American Society of Pediatric Nephrology (ASPN) is clearly the principal society for American pediatric nephrologists. However, the AAP provides a crucial role in areas that are beyond the capabilities of the ASPN. For example:

- The AAP produces PREP Nephrology, an excellent mechanism to test and increase your knowledge and earn CME/MOC credit. The editors of PREP nephrology are AAP members Tej Matoo and Doug Silverstein and they are assisted by an outstanding editorial board (Manju Chandra, Prasad Devajaran, Dan Feig, Lenny Feld, Rick Kaskel, John Mahan, James Springate, Poyyapakkam Srivaths, and Jordan Symons). PREP Nephrology utilizes the AAP PREP infrastructure, enabling the creation of a sophisticated online product.

- The AAP is conducting an extensive workforce survey of pediatric nephrologists. The survey will include a general survey that will be given to all subspecialists, enabling us to compare ourselves to other pediatric subspecialists. Bill Primack, Kevin Meyers, and I are developing a pediatric nephrology specific survey. This is being done in collaboration with the ASPN, but the AAP is providing the infrastructure and funding. We believe this survey will provide invaluable information about our workforce.

- The AAP is developing an EQIPP course on hypertension. This course, which will cost approximately $150,000 to 250,000 to develop, will provide a mechanism for doing quality improvement work centered on hypertension. There will be separate modules for subspecialists (i.e., pediatric nephrologists and cardiologists) and general pediatricians. This course will fulfill MOC part IV, and also provide CME. I also believe it will significantly improve the care of children. The course is being developed under the leadership of Joseph Flynn and Don Batisky, with a team that includes AAP section of nephrology members David Kershaw, Kevin Meyers and Dan Feig. Funding is currently being sought to support the development of this valuable course and any suggestions in this regard are welcome.

There are innumerable additional ways that the AAP

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serves pediatric nephrologists. The AAP has a powerful voice in Washington, and frequently advocates for issues that directly affect pediatric nephrologists (e.g., loan repayment, increased medicaid reimbursement). There are opportunities within the AAP for Section of Nephrology members to participate in creating CME for pediatricians (e.g., Christine Sethna is the Nephrology Section Editor of AAP Grand Rounds).

Let me conclude by encouraging you to become more involved in the AAP. The AAP section of Nephrology executive committee welcomes volunteers. There are many opportunities to get involved in creating CME or speaking at AAP conferences. While these activities take time, they are quite fulfilling. Write to me if you are interested!

Larry Greenbaum, MD, PhD
Chair, Section of Nephrology Executive Committee
lgreen6@emory.edu

The Section on Nephrology Executive Committee

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Welcome to Our New Members

The Section on Nephrology welcomes the following new members:

Ghazala Abuazza, MD, FAAP
Namrata Jain, MD
Annelise Ribeiro, MD
Alcia Richards, MD
Christine Sethna, MD, FAAP

For Upcoming Newsletters . . .

We welcome your input and encourage you to submit ideas or information by email to Larry Greenbaum, MD at lgreen6@emory.edu or Suzanne Kirkwood at skirkwood@aap.org for future issues of the newsletter.
The 2012 recipient of the Henry L. Barnett award is Sandra Watkins, MD. The Barnett award is given to a pediatric nephrologist who has shown lifetime achievement in the field of pediatric nephrology through distinguished clinical service, dedication to patient care and teaching of pediatric nephrology.

Dr. Sandra Watkins was chosen to receive the Henry L. Barnett award as a result of her outstanding commitment to patient care and education over the course of her professional career. As a clinician, she has been recognized as a leader in the care of patients with chronic kidney disease and those receiving chronic dialysis. In turn, she has used that expertise to educate our colleagues in nephrology and pediatrics through her many publications, book chapters and invited lectureships. Equally important has been her integral role in the education and mentorship of 30 Pediatric Nephrology fellows in Seattle, many of whom have become leaders themselves in their respective medical communities.

Sandy’s substantial administrative activities on behalf of Pediatric Nephrology also had a strong influence on her selection. Her contributions to the American Academy of Pediatrics, the American Society of Pediatric Nephrology, the Renal Physician’s Association, the International Pediatric Nephrology Association and the North American Pediatric Renal Trials and Collaborative Studies (NAPRTCS) are well documented and serve as a model for one who wishes to “get involved and make a difference”.

Dr. Sandra Watkins has served Pediatric Nephrology in an extraordinary manner throughout her career and is deemed to be most deserving as the recipient of the Henry L. Barnett award for 2012. Please join us in congratulating Dr. Watkins.

Nominations for the 2013 award will be accepted beginning in July, 2012 and the form can be found at: http://www2.aap.org/sections/nephrology/articles/2.htm
The Medical Home and Its Neighborhood  
- Will You be My Neighbor?  

*By John Foreman, MD FAAP and William Primack, MD FAAP*

In 1967 the American Academy of Pediatrics first developed the concept of the “medical home” (MH) as the optimal method to deliver healthcare. It has subsequently been endorsed by the American College of Physicians (ACP), the American Academy of Family Practice, and the American Osteopathic Association. The principles of the medical home are: (1) a personal physician within a (2) physician-directed practice with (3) family “centeredness”; (4) care is coordinated and integrated across the healthcare spectrum by the medical home, (5) quality and safety are promoted within the medical home, and there is (6) enhanced access to care. The MH is the hub of patient information, primary care provision, and care coordination. MH care is family centered with family involvement and preferences given high priority.

A natural extension of the MH concept is the “medical neighborhood (MN)”, that is specialists, subspecialists, and other healthcare entities that support the MH and serve the patient and his family. The ACP developed the following attributes of a good medical home neighbor practice. (1) It effectively communicates, coordinates and integrates with the MH in a bidirectional and timely manner. (2) It ensures timely consultations that complement the MH. (3) A good MN works with the family and the MH to determine who is responsible for what in co-management. (4) A good MN supports family centered care with enhanced access. (5) A good MN has high levels of quality and safety. The MN supports the MH as the provider of whole family primary care and having overall responsibility for ensuring that the care delivered by all the providers is coordinated and integrated.

A good MN provides pre-consultation or a “curbside consult” services as well as formal consultation for a specific question or procedure. This may be a single consultation or ongoing care, which usually involves a co-management arrangement. Ongoing care could take the form of at least 3 different levels of responsibility by the specialist: shared management of a disease (VUR and recurrent UTIs); principal care of a disease (nephrotic syndrome); and principal care of the patient for a period of time (initial post-transplant period). In this progression, the specialist assumes a greater level of responsibility for the overall care of the patient and the MH a smaller part. In rare instances, the entire care may be assumed by the specialist (e.g., a hemodialysis patient). The ACP has advocated for written care coordination agreements between the MH and specialist practices that articulate the role of each for a specific patient or group of patients. With changes in the patient’s disease, these roles will shift so there will need to be flexibility in these documents.

In May 2012, the AAP convened a task force of PCPs and specialists to discuss the relationship between the MH and pediatric subspecialists. This group identified good bidirectional communication between the MH and the specialist both at the time of the initial referral and subsequently as a key attribute of effective MH/specialist interaction. One part of this is clear question or procedure request to the specialist along with appropriate and timely information prior to the referral visit. Similarly, the specialist should respond in a timely manner to the specific question posed by the MH. For patients with shared management, this communication should be ongoing and bidirectional. The group also discussed the concept of shared management and developing tools/documents that articulate the roles of the MH and the specialist that are mutually agreed upon in concert with the family’s wishes.

Barriers that interfere with good MH and specialist interactions were also discussed. Important barriers include the lack of interoperability and nonstandard electronic health record systems, lack of adequate payment for care co-ordination, and the absence of methods to determine the apportionment of the payment between the specialist and the MH. Medical-legal issues around co-management are another potential barrier.

The AAP plans to build on these discussions to develop structures and tools to improve the interface between the MH and the specialist. It also plans to advocate for better payment structures to reward a good medical neighborhood. Stay tuned for future developments.
Measuring and Improving the Quality of Care for Pediatric Kidney Disease

There are numerous national efforts to measure the quality of care delivered for pediatric kidney disease. At the forefront of these efforts is the National Quality Forum (NQF - http://www.qualityforum.org/Home.aspx), a non-profit membership organization established to promote quality health care through quality measurement and public reporting. The NQF is comprised of a diverse group of organizational members representing consumers, public and private purchasers, health professionals, hospitals, accrediting and certifying bodies, supporting industries, and healthcare research and quality improvement. The AAP has been a member of the NQF and its Health Professional Council since 2005.

Using the National Priorities Partnership as a framework for topic selection, the NQF has issued requests for measures (http://www.qualityforum.org/Measures_List.aspx) on various conditions and cross-cutting areas for consensus endorsement. Measures are submitted from larger measure developers such as the American Medical Association (AMA) Physician Consortium for Performance Improvement (PCPI - http://www.ama-assn.org/ama/pub/physician-resources/physician-consortium-performance-improvement.page) and the National Committee for Quality Assurance (NCQA - http://www.ncqa.org/) as well as from academic institutions, medical associations, and other boutique groups. Measures that are eventually endorsed by the NQF are available for voluntary selection and use by both private and public payers.

The AAP has been actively involved with all aspects of quality measurement, including developing policy on quality measurement, sending representatives to serve on measure development committees, participating on various NQF steering committees and technical panels, and monitoring, reviewing, and commenting on all key pediatric quality measurement sets. The Steering Committee on Quality Improvement and Management (SCQIM), which oversees the AAP's quality measurement activities, has developed a robust plan better position the AAP as leader in the pediatric measurement arena.

Pediatric CKD and ESRD Quality Measurement

In 2008, NQF endorsed 25 measures for end-stage renal disease (ESRD) care on the following areas: anemia; dialysis adequacy; mineral metabolism; vascular access; influenza immunization; mortality; and patient education, perception of care, and quality of life. Most of these measures are for patients over 18 years of age. NQF endorsed 12 additional quality measures on renal care (http://www.qualityforum.org/News_And_Resources/Press_Releases/2012/NQF_Endorses_Renal_Measures.aspx) this past April 2012. The measures address a range of care concerns, for chronic kidney disease, end stage renal disease, and dialysis treatment. Again, the bulk of these measures are targeted at the adult patient population. Some of these measures are endorsed at the facilities level and can be used for the ESRD Quality Incentive Program (http://www.cms.gov/Medicare/End-Stage-Renal-Disease/ESRDQualityImprovementInit/index.html?redirect=/ESRDQualityImprovementInit/). The remaining measures are at the physician level and can be used for the Physician Quality Reporting System (PQRS; formerly PQRI).

Barbara Fivush, MD served on the End Stage Renal Disease Steering Committee and also represented the AAP on the AMA PCPI Kidney Disease Measure Workgroup and chaired the Pediatric Kidney Disease Measure Workgroup. The PCPI previously updated its measures for pediatric kidney disease in 2011.

The American Society for Pediatric Nephrology (ASPN) and Kidney Care Quality Alliance (KCQA - http://www.kidneycarepartners.com/kcp_phase2.html) also has created robust quality measures for pediatric kidney disease. ASPN recently developed a document summarizing the quality issues in pediatric ESRD and noting the specific number of ESRD measures for patients less than 18 years. The Section on Nephrology contributed to this effort. The National Quality Measures Clearinghouse (http://www.qualitymeasures.ahrq.gov/index.aspx) currently lists several ESRD measures developed by the Centers for Medicare and Medicaid Services (CMS) with unspecified target age.

If you have any question on these measure sets, or quality measurement in general, then please contact Junelle Speller, Senior Health Policy Analyst, AAP Department of Practice (jspeller@aap.org), 800/433-9016 ext 7650).
Updated Schedules Include New Pneumococcal Vaccination Requirements for Children with Kidney Disease

By: Alicia Neu, MD FAAP

Background: It has long been recommended that children with nephrotic syndrome and chronic kidney disease (CKD) receive vaccination against Streptococcus pneumoniae, as these patients are at increased risk of invasive pneumococcal infection. The care of children with kidney conditions is often complex and delivery of routine well-child care, including immunizations, can be delayed or overlooked. In fact, data from the United States Renal Data System (USRDS) reveal that among prevalent pediatric end-stage renal disease (ESRD) patients fewer than 10% received vaccination against Streptococcal pneumoniae. In order to minimize the risk for invasive pneumococcal disease in pediatric kidney patients, it is imperative that all who care for these patients partner to maximize pneumococcal vaccination rates. The role of the pediatric nephrology providers is highlighted by the fact that the tracking of pneumococcal vaccination rates is required by CMS’ Conditions for Coverage for dialysis facilities.

Previous recommendations specified that children with nephrotic syndrome and CKD, including those on dialysis and status post kidney transplant, receive immunization with the heptavalent conjugated pneumococcal vaccine (PCV7), as was recommended for healthy children. In addition, children with kidney disease were to receive supplemental immunization with the 23-valent polysaccharide vaccine (PPSV23) after the age of 2 years.

Modifications and Recommendations: Beginning in 2011, immunization schedules (http://www.cdc.gov/vaccines/schedules/hcp/index.html) recommended that the newly licensed 13-valent conjugated pneumococcal vaccine (PCV13) replace the PCV7 in both healthy children and those with kidney disease, in order to expand serotype coverage. The number and timing of doses for PCV13 in children under 24 months is based on the number of previous immunizations with PCV7 (http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5911a1.htm?s_cid=rr5911a1_e; http://pediatrics.aappublications.org/content/126/1/186.full). For children with kidney disease age 24-71 months who received at least 3 doses of either PCV7 or PCV13 before age 24 months, a single dose of PCV13 is recommended at least 8 weeks after the most recent dose. An additional dose of PCV13 should be given after 8 weeks if the patient was previously unvaccinated or had fewer than 3 doses of either PCV7 or PCV13 before age 24 months.

It continues to be recommended that children with CKD and nephrotic syndrome over the age of 2 years receive supplemental immunization with PPSV23. The vaccine should be given at least 8 weeks after the final dose of PCV13. Revaccination with PPSV23 had previously been recommended after 3 years in children less than 10 years of age at the time of first PPSV23 vaccination, and 5 years after the initial immunization in older children, but the new recommendations suggest a second dose of PPSV23 after 5 years for all children.

For children with CKD and nephrotic syndrome ages 6 through 18 years of age, the updated recommendations suggest that a single dose of PCV13 should be given regardless of previous history of vaccination with PCV7 or PPSV23. These high-risk children who have not previously received PPSV23, should receive vaccination with PPSV23 at least 8 weeks after PCV 13, with a repeat dose of PPSV23 after 5 years. The recommended schedules, by age and history of pneumococcal vaccination are summarized in the table and provided in detail on the AAP and CDC websites (http://aapredbook.aappublications.org/; http://www.cdc.gov/vaccines/schedules/hcp/index.html).

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Updated Schedules Include New Pneumococcal Vaccination... Continued from Page 6

Summary of recommended schedule for administering doses of 13-valent pneumococcal conjugate vaccine (PCV13) and 23-valent polysaccharide vaccine (PPSV23) to children with nephrotic syndrome and chronic kidney disease, by age and PCV and PPSV23 vaccination history

<table>
<thead>
<tr>
<th>Age at first dose</th>
<th>Previous PCV7/PCV13 doses</th>
<th>Previous PPSV23 doses</th>
<th>Recommended PCV13 regimen</th>
<th>Recommended PPSV23 regimen</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-23 months</td>
<td>0-4 doses</td>
<td>N/A</td>
<td>Follow schedules for healthy children</td>
<td>At 24 months (at least 8 weeks after last PCV13), repeat after 5 yrs</td>
</tr>
<tr>
<td>24-71 months</td>
<td>Unvaccinated or any incomplete schedule of &lt; 3 doses</td>
<td>None</td>
<td>2 doses, the first dose ≥ 8 weeks after most recent dose and a second dose ≥ 1 dose ≥ 8 weeks after PCV13, repeat after 5 years</td>
<td></td>
</tr>
<tr>
<td>24-71 months</td>
<td>Any incomplete schedule of &lt; 3 doses</td>
<td>None</td>
<td>1 dose, ≥ 8 weeks after most recent dose</td>
<td>1 dose ≥ 8 weeks after PCV13, repeat after 5 years</td>
</tr>
<tr>
<td>24-71 months</td>
<td>4 doses of PCV7 or other age-appropriate complete PCV7 schedule</td>
<td>None</td>
<td>1 supplemental dose, ≥ 8 weeks after most recent dose</td>
<td>1 dose ≥ 8 weeks after PCV13, repeat after 5 years</td>
</tr>
<tr>
<td>24-71 months</td>
<td>4 doses of PCV7 or other age-appropriate complete PCV7 schedule</td>
<td>1 or 2 doses</td>
<td>1 supplemental dose, ≥ 8 weeks after most recent dose</td>
<td>Repeat PPSV23 after 5 years (if only one dose given previously)</td>
</tr>
<tr>
<td>6-18 years</td>
<td>Any vaccination with PCV7, no PCV13</td>
<td>None</td>
<td>1 supplemental dose</td>
<td>1 dose ≥ 8 weeks after PCV13, repeat after 5 years</td>
</tr>
<tr>
<td>6-18 years</td>
<td>Any vaccination with PCV7, no PCV13</td>
<td>1 or 2 doses</td>
<td>1 supplemental dose</td>
<td>Repeat PPSV23 after 5 years (if only one dose given previously)</td>
</tr>
</tbody>
</table>

The above table is a summary of the CDC and AAP guidance.
The Court considered several challenges brought by states in *Florida et al v. Department of Health and Human Services*, and upheld the Affordable Care Act, ruling:

- The Affordable Care Act’s individual mandate, while not valid under the Constitution's Commerce Clause, is valid under Congress's taxing authority; and
- The law's Medicaid expansion to individuals earning about one-third more than the federal poverty level (FPL) is valid; however, its provisions allowing the federal government to withdraw Medicaid funding for states that fail to enact the expansion is not. For more regarding the Medicaid payment increase contained in the ACA see the July, 2012 AAP News article at: [http://aapnews.aappublications.org/content/33/7/1.1.full.pdf](http://aapnews.aappublications.org/content/33/7/1.1.full.pdf)

**What the Court Found**

At the centerpiece of the multi-state lawsuit against the Affordable Care Act’s individual mandate—which requires all legal U.S. residents to buy health insurance by Jan. 1, 2014, or pay a penalty—was the issue of states’ rights.

Chief Justice Roberts, along with Justices Kennedy, Scalia, Thomas and Alito, rejected the federal government’s theory that the mandate was constitutional under the Commerce Clause. However, a different set of five Justices—the Chief Justice along with Justices Ginsburg, Breyer, Sotomayor and Kagan—agreed that it was constitutional because the mandate imposes a “tax” on people who do not buy health insurance, and Congress can impose that tax using its power to levy taxes. Though the mandate is intended to encourage people to buy health insurance rather than to raise federal funds, the Chief Justice still classified it (and its accompanying penalty) as a tax.

The final issue before the Court was the law’s expansion of the Medicaid program (to individuals earning about $11,170 and families of four earning about $30,000). The Court found that Congress may offer states funding to expand Medicaid, and that states can agree to expand coverage in exchange for those new funds. If a state accepts the expansion funds, it must comply with the new rules and expand coverage, but—and this is the key underpinning of the decision—a state can refuse to participate in the expansion without losing other Medicaid funding. In other words, each state may choose to continue its current Medicaid program as-is.

The Affordable Care Act had assumed Congress could use its spending power to require states to expand Medicaid by threatening to withhold funds for the entire Medicaid program should a state fail to do so. The Court found this specific provision—by a vote of 7-2—“coercive,” and as a result, unconstitutional.

**What the Court’s Decision Means for Children and Pediatricians**

The AAP commended the Court’s decision to uphold the Affordable Care Act, and has been at the forefront of state and federal advocacy throughout the litigation process in support of the law’s continued implementation. While the ultimate fate of the law will depend on the outcome of the Nov. 6 Congressional and Presidential elections—with candidates from both political parties vowing to overturn or uphold the law, respectively—the Supreme Court decision established a constitutional justification for protecting its gains for children and pediatricians.

Existing protections already in effect as part of the law’s implementation can therefore remain in place, and provisions set to take effect in the coming two years—such as an unprecedented increase in Medicaid payment rates to at least those of Medicare in 2013 and 2014 for certain primary care and immunization services—are on the path toward full implementation, unless Congress or the next administration changes the law.

As a result of the Court’s decision on the law’s Medicaid expansion in 2014, the Academy is concerned that states may choose to opt out of the expansion altogether and leave millions of vulnerable parents and childless adults without access to health insurance. The federal government currently pays between 50 and 60 percent of the cost for the Medicaid program to states, though as part of the law’s Medicaid expansion to 133 percent FPL, the government match would increase to 100 percent for three years, then fall to 90 percent after 2020. Should states covering less than 133 percent of the FPL still opt out of the expansion, however, a majority of the state’s uninsured would be in the same situation they are in...
now, earning too much to qualify for Medicaid but too little to afford private insurance. While the high federal match rate may encourage states to expand the program, the Court’s ruling on this issue leaves the ultimate decision on whether to forgo the expansion up to the states.

Now that the Supreme Court has upheld the Affordable Care Act, the Academy and AAP chapters will continue working with states and the administration to ensure that all of the law’s provisions are implemented, and that children will continue to receive the “ABCs:” access to health care services, age-appropriate benefits in a medical home and health care coverage to meet their unique needs.

To access the most recent Academic & Subspecialty Advocacy report go to: http://federaladvocacy.aap.org/index.cfm/key/52608c19-c256-414a-9216-86665ab668ae

To learn how to help AAP “Get Out the Vote” in advance of the Nov. 6 elections, visit www.aapGOTV.org.

PediaLink for Fellowship Programs

This new online program is being offered to Fellowship Programs and is designed so that users spend more time learning and less time documenting. Access it at: http://www.pedialink.org and click on the Fellow in Training or Program Director boxes for more information.

Benefits for Training Fellows:

• Create scholarly activity projects
• Document progress on quality improvement projects
• Assess core competencies and personal attributes with the Learning Plan
• As an AAP member there is no additional cost for this program
• Access the program by logging into PediaLink using your AAP ID and password on the home page

Step 1 for all Program Directors – Start using PediaLink for Fellowship programs by contacting us at AddFellow@aap.org with your Name, Program Name, and Subspeciality to connect you to your program.

Benefits for Program Directors

• Document, track, and evaluate your fellows’ progress
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The American Academy of Pediatrics (AAP) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The AAP designates this educational activity for a Maximum of 24 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.
Quality Connections Newsletter

The AAP Quality Connections newsletter was launched by the AAP Steering Committee on Quality Improvement and Management (SCOQIM) to communicate timely information and increase awareness of the importance of quality improvement. The newsletter also provides updates on current AAP quality improvement programs and projects.

Highlights from the spring issue follow:

- Can a Resident Continuity Clinic Become a “Cadillac” Practice?
- Benchmarking Bronchiolitis
- QuIIN Partners with Genetics in Primary Care Institute
- Performance Measures: Outcome vs Process

The newsletter can be accessed at: http://www2.aap.org/visit/Spring2012QICOnnections.pdf.

The winter issue of AAP Quality Connections is also available and can be accessed at: http://www2.aap.org/visit/Winter2012QICOnnections.pdf. Some highlights from the winter issue include:

- Improving Access and Efficiency: The Foundation of a Patient-Centered Medical Home
- QI: Coming Full Circle
- National Nephrology Collaborative Uses Quality Improvement to Engage Families
- Building a Quality Improvement Network in Pediatric Cardiology and Cardiovascular Surgery
- BCBS Alternative Care Quality Contract: One Practice's Experience

For questions regarding the newsletter please contact, Junelle Speller, Senior Health Policy Analyst, Quality Improvement, jspeller@aap.org, 847-434-7650 office, 847-434-4996 fax.

Volunteers Needed

One of the goals of the Executive Committee is to increase its level of communication with and participation of Section members. As a result, we are currently looking for members who might be interested in serving to:

- Contribute to the Section Newsletter or assist in identifying members and content for future newsletter articles.
- Review existing or develop new articles directed at parents for the Academy’s parent website at http://www.healthychildren.org/English/Pages/default.aspx
- Write an article for the Focus on Subspecialties column in AAP News regarding pediatric nephrology topics. Examples of past articles can be accessed at: http://www2.aap.org/sections/nephrology/articles/1.htm
- Participate in the Section Nominations Committee. The Committee is responsible for identifying candidates to serve on the Section on Nephrology Executive Committee and creating the election ballot. Individuals serve for two years or two election cycles.
- Participate on the Henry Barnett Awards Committee. Individuals serve a two year term.

Please contact Suzanne Kirwood at skirkwood@aap.org if you are interested in serving in any of the above positions or have additional questions.
Upcoming Meetings

RPA Southern Nephrology Regional Coding and Billing Seminar
September 28, 2012
Charlotte Marriott Executive Park Hotel
Charlotte, NC

ASN Kidney Week 2012
October 30 – November 4, 2012
San Diego, CA
http://www.asn-online.org/education_and_meetings/

NKF 2013 Spring Clinical Meetings
April 2-6, 2013
Orlando, FL

16th Tri-Annual IPNA Congress
August 31–September 4, 2013
Shanghai, China
http://www.ipna-online.org/2012/03/ipna-congress-2013-shanghai/