GETTING CONNECTED

Xavier Sevilla, MD, FAAP
Chairperson, AAP Steering Committee on Quality Improvement & Management

Happy New Year! I hope you all had a wonderful holiday. It’s my pleasure to introduce our next issue of AAP Quality Connections. We have received a lot of positive feedback about this newsletter and we hope to continue to offer practical updates and useful tips that can be incorporated into your practice.

Many of the articles included in this issue highlight ways in which quality improvement has led to improvements in practice. One central theme among all of these articles is how small improvements, or improvements at the local level, can lead to system-wide improvements. Developing quality improvement strategies and techniques for one project can be applied and spread to other areas in your practice as well.

Tim Bell PA-C, MPH describes the changes his practice made to improve access and efficiency, and how these process changes laid the foundation for establishing a patient-centered medical home. Dr Amy Belisle shares her journey from learning about strategies for improving the quality of care for pediatric asthma patients as a resident to building a state-wide program to spread these best practices. Two subspecialty groups – pediatric nephrology and pediatric cardiology and cardiovascular surgery – are building a network of practices/clinics and physicians to improve care for their pediatric populations. The National Association of Children’s Hospitals and Related Institutions (NACHRI) is leading an effort to reduce peritonitis and exit site infections among children on peritoneal dialysis, and the engagement of families and other home care providers is a focus on this work. Dr. Wayne Franklin, a member of the AAP’s Steering Committee on Quality Improvement and Management (SCOQIM), shares the breadth of quality improvement topics focused on Pediatric Cardiology and Cardiovascular Surgery at the AAP’s 2011 National Conference and Exhibition.

We have also included some important updates on quality improvement

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“Whatever we do, it can’t be any worse than what we are doing now.” With those prophetic words uttered by one of our senior physicians, Lumberton Children’s Clinic began its journey to open access scheduling. The conversation actually began a few months earlier when physicians from the University of North Carolina contacted me to see if our office would be interested in participating in an Institute of Healthcare Improvement collaborative entitled “Improving Access and Efficiency in Clinical Office Practices.” Our office had worked with the University of North Carolina group on various quality improvement activities in the past, including improving vaccination rates of children birth to two years old. We viewed the IHI collaborative as a great opportunity to improve in areas that sorely needed improvement—continuity of care, scheduling, and office processes.

To begin the improvement process, we established a QI team that consisted of a physician champion, administrator, provider, a newly created position—the floor manager (similar to a hostess at a restaurant responsible for overseeing patient flow), and staff members from the office.

The team set two broad aims—45-minute patient throughput time and same-day appointment availability for all visits. To accomplish these aims, we utilized QI tools and methods, including value-stream mapping of patient flow, telephone volume monitoring, measuring third available appointment (to ensure access), patient visit times (often called “cycle times”), backlog of patients waiting for appointments, and completed dozens of PDSA cycles. Early on we decided to measure patient and staff satisfaction while the changes were being made to monitor the effectiveness from both perspectives.

As in most busy practices, it was difficult to perform our daily duties and meet, measure, refine and improve our processes. Fortunately, the senior management team recognized quality improvement activities as a strategic priority years earlier, so we allotted additional time to accomplish our goals while doing our daily work. Amazingly, we met our lofty goals and then some. Little did any of us realize that what we were addressing in 2001-02 was setting a solid foundation to our next big challenge – the establishment of a patient-centered medical home.

The patient-centered medical home (PCMH) concept incorporates many of the same principles of the IHI collaborative dealing with efficiency and access. The principles of the PCMH include the patient having their personal physician (continuity), care that is coordinated (which requires good access), and focusing on the patient as a whole person. Much of the work required by the National Committee for Quality Assurance (NCQA) for accreditation as a PCMH involves many of the same tools that we used in our QI activities to achieve our goals with open access and related office efficiencies.

Although it takes a substantial effort to accomplish, attaining a patient-centered medical home is a very important strategic goal for your practice. It can be will within your reach if you lead off with making changes to improve office efficiency and converting to open access scheduling to improve your patients’ access.

AAP Open Access Scheduling Resources

Open access scheduling allows pediatric practices to provide timelier health care and more patient-centered and efficient care for children. Open access involves redesigning scheduling systems to allow practices to offer same day appointments to all patients, regardless of the nature of their problems, whether routine or urgent. The guiding principle is, “do today’s work today.” This is accomplished by gradually eliminating the preexisting backlog of patients from practice schedules and carefully matching the daily supply of clinicians to the daily demand for visits. The underlying theory is that demand is predictable. Thus, practices can match their appointment supply to demand on an ongoing basis.

For more information, visit AAP Practice Management Online at http://practice.aap.org/
QI: COMING FULL CIRCLE
Amy Belisle, MD, FAAP
Director, Child Health Quality Improvement, Maine Quality Counts

In 1998-2001, when I was a medical student and resident at the Barbara Bush Children’s Hospital in Portland, Maine, I was fortunate to witness the inception of the AH! Asthma Health Program. The program was led by Dr. Barbara Chilmonczyk, a local asthma expert, who was trying to improve the quality of care for pediatric asthma patients. As a resident, we learned about asthma action plans, the proper use of medications and devices, how to help patients learn to use peak flow meters, and the importance of flu shots. Little did I know what a long-term impact this quality initiative would have on my work.

Soon after I left residency, I was assigned to improve the care of asthma patients at my military pediatric clinic in Japan, both in the clinic and in schools. I quickly contacted the AH! Program to get the materials to institute an asthma clinic and educational sessions for families, clinic staff, and the schools.

Fast forward five years and a return to my home state, I was asked to champion the Maine AAP Chapter’s Asthma Pilot with the AAP Chapter Quality Network in the spring of 2009. I agreed to be the champion as long as our local experts, Dr. Chilmonczyk and Rhonda Vosmus, AE-RT, and the AH! Program would help co-lead the project. Maine was one of 4 states (along with OH, AL, and OR) chosen as a pilot site to work with the AAP and QI coaches from Cincinnati Children’s Hospital to improve asthma care, as well as develop a quality improvement infrastructure. For the AAP pilot, we had 12 practices and 50 pediatric providers participate in Maine in the year-long collaborative. We were fortunate because we were building on the work of two previous asthma pilots in the state led by the AH! Program within the past 8 years, so many groups were already familiar with the use of action plans, asthma control screening tools, and how to do asthma education in the office.

We saw some major improvements across the collaborative. For example, 91% of the pilot groups were using a registry at the end up from 50%; optimal care scores increased from 45% to 75%; well controlled patients increased from 60 to 82%; and spirometry increased from 40 to 65%. One practice even increased their rate of spirometry from 0 to 70%.

In addition to medical management of asthma, we worked with practices on QI methods and tools, such as PDSA cycles, and planned care approaches so they could build their internal infrastructure. We also started to engage health care system leaders to build pediatric quality improvement capacity and sustain the progress of the pilot.

This work has had other very positive spinoffs. One year afterwards, the Maine Chapter of the AAP is partnering with other groups in the state including Maine Quality Counts, MaineCare (Medicare), the Maine CDC, The Muskie School of Public Service, University of Southern Maine, health care systems, residency programs, the Maine

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AAP Chapter Quality Network

Chapter Quality Network (CQN2) projects work at the practice, state and national levels to build a network of AAP chapters, enhancing their ability to lead a quality improvement collaborative to achieve measurable improvements in the health outcomes of children.

Phase 2 of the CQN asthma collaborative was launched in March 2011 with a focus on moving toward full population data, building payer engagement, and improving parent involvement. The project is currently spreading to additional practices in Ohio and Alabama through the state chapters as well as an Ohio physician’s hospital organization, Partners for Kids.

For more information about the CQN, visit www.aap.org/member/chapters/caqi. For more information about the CAQI and CQN, visit www.aap.org/member/chapters/caqi.
National Nephrology Collaborative Uses Quality Improvement to Engage Families

Jayne Stuart, MPH
Director, Quality Transformation, National Association of Children’s Hospitals and Related Institution

Although most pediatric nephrology centers around the country have been submitting data into collaborative databases for decades, data have not been used in a coordinated effort to improve care – until now. In June, the National Association of Children’s Hospitals and Related Institutions (NACHRI) launched the Exit Site and Peritonitis Transformation Collaborative with centers from across the country. Why make such a shift? “It was time we started harvesting and sharing the learning from our accumulated data to address an important clinical issue,” commented Alicia Neu, MD (Clinical Director, Division of Pediatric Nephrology and Medical Director, Pediatric Kidney Transplantation and Dialysis Program, Johns Hopkins Children’s Center and Collaborative Faculty member).

Collaboration is key. The 28 participating centers are learning how to share ideas and problem solve together on behalf of patients receiving chronic peritoneal dialysis. Teams agree to implement a standard set of care bundles designed to reduce the rate of infection; submit monthly data on how well they adhere to the recommended bundles and outcome data on infections; and meet twice yearly for two-day workshops to learn about care bundles, discuss implementation strategies, and share ideas about overcoming common barriers. Most importantly, teams learn quality improvement science methods that help them move from ideas to implementation.

A key focus of the Collaborative is engaging families and other home care providers. “It’s exciting to focus efforts on engaging families and offering them best practices to help prevent infections,” commented Nancy McAfee, MN, RN (Pediatric Dialysis Clinical Nurse Specialist, Seattle Children’s Hospital and Collaborative Faculty member). Teams are teaching parents, patients and other care providers specific protocols for aseptic technique, hand hygiene, dialysis catheter exit-site care and what to do with touch contamination.

How do teams find time in a busy clinic schedule to add more? By starting small – sometimes testing out a new idea or bundle element with just one patient; and, after implementing a series of small tests to provide evidence that the change will improve care, teams roll-out the new strategies/approaches throughout the clinic. Although at first glance this seems like it could take a long time, teams conduct multiple tests each week and after only a few months can start to see real improvements.

The benefits of collaboration have been demonstrated in multiple other clinical areas, and the group leading this effort sees this clinical focus of peritoneal dialysis as just the beginning.

Next up: Prevention of infections in hemodialysis catheters.

AAP Section on Nephrology

The Section on Nephrology is committed to improving the care of infants, children, and adolescence with disorders of the kidneys and urinary tract by providing an educational forum for the discussion of problems and treatments relating to Nephrology.

Membership in the Section is open to all Fellows who are actively involved or interested in some aspect of the care and study of nephrology in infants, children or adolescents.

For more information or to join the section, contact Suzanne Kirkwood at skirkwood@aap.org.
This year’s program at the American Academy of Pediatrics’ 2011 National Conference and Exhibition (NCE) featured an exciting group of topics focused on quality in Pediatric Cardiology and Cardiovascular Surgery. The audience was packed and the feedback was very positive. Attendees could be overheard in between sessions in the halls of the convention center discussing their forays into quality improvement in their own institutions. Members were truly engaged in implementing quality improvement as a key pillar in the care of their patients. Long gone were the days where a solitary quality improvement topic was relegated to the final talk at a week-long NCE. In Pediatric Cardiology and Cardiovascular Surgery, quality improvement is now front and center!

Chris Snyder, MD, pediatric cardiac electrophysiologist from the Ochsner Health System, was the program director for NCE 2011. The quality program was chaired by Kathy Jenkins, MD, MPH, Senior Vice President, Program for Patient Safety and Quality at The Children’s Hospital, Boston, and Robert Beekman, III, MD Professor of Pediatrics at Cincinnati Children’s Hospital Medical Center.

Several of the topics focused on the Joint Committee on Congenital Heart Disease (JCCHD) National Pediatric Cardiology Quality Improvement Collaborative (NPC-QIC), which is based at the James M. Anderson Center for Health Systems Excellence at Cincinnati Children’s Hospital Medical Center. The focus of the JCCHD collaborative is to:

- Build a sustainable collaborative network of pediatric cardiologists in North America, including a registry database, to inform and foster improvement.
- Plan and implement a quality improvement project for survival and quality-of-life of infants with Hypoplastic Left Heart Syndrome (HLHS) during the “interstage” period between discharge from Stage 1 Norwood admission for Stage 2 bidirectional Glenn.

The program highlighted the following topics during the three-day conference:

*Moderator: Kathy Jenkins, MD*

- Developing a Pediatric Quality Improvement Program (*Carole Lannon, MD*)
- Measuring Quality of Care: Lessons from Adult Cardiovascular Disease (*Frederick Masoudi, MD, MSPH*)
- Pediatric Cardiology Quality Measures Working Group (*Kathy Jenkins, MD*)

**Day 2: Pediatric Cardiology Quality Improvement**
*Moderators: Robert Beekman, III, MD and Kathy Jenkins, MD*

- Pediatric Echocardiography (*Leo Lopez, MD*)
- Understanding and Measuring Pediatric Populations Undergoing Diverse Procedures and Interventions (*Lisa Bergersen, MD, MPH*)
- Pediatric Electrophysiology (*John Kugler, MD*)
- Adult Congenital Heart Disease (*Michelle Gurvitz, MD*)
- Quality Improvement in the Cardiovascular Intensive Care Unit (*Panel*)

**Day 3: Quality Improvement**
*Moderators: James Tweddell, MD and W. Robert Morrow, MD*

- The JCCHD National Quality Improvement Collaborative (*Robert H. Beekman, III, MD*)
- Nomenclature/Database of Surgical Treatment of Congenital Heart Disease (*Jeffrey Jacobs, MD*)
- Linking Databases to Evaluate Outcomes and Quality (*Sara Pasquali, MD*)
- Planning for Surgery (*Michael Mitchell*)
- Assessment of Technical Competency in Pediatric Cardiac Surgery (*Emile Bacha, MD*)

For more information on the NPC-QIC collaborative, go to [http://jcchdqi.org/](http://jcchdqi.org/)
ACCOUNTABLE CARE ORGANIZATIONS (ACO) UPDATE

Xavier Sevilla, MD, FAAP
Chairperson, AAP Steering Committee on Quality Improvement & Management

Accountable Care Organizations (ACOs) have been billed as having the potential to get better quality at lower cost by aligning incentives to promote coordination among providers, hospitals and payers. They have been hailed as an innovation that will help healthcare achieve the Triple Aim – improved experience of care, improved health of the population and reduced health care costs.

This fall has seen a lot of activity in the ACO world, but almost exclusively in adult medicine. On October 20, 2011, the Centers for Medicare & Medicaid Services (CMS) released the final rule of the Medicare Shared Savings Program. CMS received more than 1200 formal comments on their proposed rule released in March, 2011. The Academy submitted a set of comments on the proposed rule. CMS changed some key provisions in their final proposal that addressed those comments, especially from physician organizations. Key changes include:

- a decrease in the number of quality measures from 65 to 33
- multiple start dates in 2012
- elimination of the requirement that providers need to be using an EMR in order to participate
- inclusion of community health centers and rural hospitals as participants in ACOs

So far the reactions from physicians groups, consumer advocates and plans have been favorable. There are already hot beds of ACO creation, especially in Texas, California, and Michigan. CMS expects between 50 to 270 ACOs to be created with projected savings of 940 million in the first 4 years, according to a study by the Urban Institute and RWJ Foundation.

On November 22, the National Committee for Quality Assurance (NCQA) released its accreditation standards for ACOs. These follow a very similar format outlined in the NCQA Patient Centered Medical Home accreditation program. ACOs will not be required to be recognized in order to participate in the Shared Savings Program from Medicare, but it will provide a blueprint for organizations attempting to become ACOs in the future. The new program will have 7 standards including program operations, access and availability, primary care, care management, care coordination and transitions, patient rights and responsibilities, and performance reporting. Each standard will have different elements with different point weightings. The total number of points will determine which of 3 different levels the ACO will be accredited. Level I designation is designed for organizations that are in the process of becoming an ACO.

Level II will be an organization that can demonstrate all ACO capabilities, and finally, Level III will have demonstrated all ACO capabilities, as well as having demonstrated strong financial and organizational performance and significant improvements.

So where does this leave us in pediatrics? There is a section (2760) of the Affordable Care Act that establishes a demonstration project for pediatric ACOs. However, as of this date, this project has not been funded.

Some will say that there are greater savings found in adult medicine with its high prevalence of chronic disease and higher costs. This cannot be further from the truth. Pediatrics has the biggest opportunity to bend the cost curve long-term through prevention. As we all know, every major costly chronic disease has its roots earlier in life and many can be successfully prevented in childhood. For example, by promoting a healthy lifestyle we can prevent childhood obesity, which would then prevent type II diabetes. In addition, most smokers begin their deadly habit in adolescence. Therefore, pediatricians can hold the key to achieving the greatest impact on the triple aim of delivering a better experience of care, improving the health of the population, and decreasing health care costs.

In response to the potential growth in ACOs, the Academy provided

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Blue was prototypical however, contracting with eligible England traditionally a Pediatric model. One Practice's Experience

BCBS Alternative Care Quality Contract: One Practice’s Experience
Peter D. Rappo, MD, FAAP, Chair, AAP Private Payer Advocacy Advisory Committee

Increasingly, payers are incorporating quality and efficiency incentives and pay for performance (P4P) programs. If structured appropriately, there is potential for enhanced payments, but there are also risks to the practice. Below is a description of a quality incentive program in Massachusetts from the perspective of a pediatric practice.

Our pediatric practice had traditionally negotiated contracts with insurers. It became apparent, however, that our nine pediatrician practice was too small to have significant leverage. Five years ago, we joined a PHO, and then more recently affiliated with NEQCA (New England Quality Care Alliance) as our contracting representative. One prototypical model that we accepted was Massachusetts’ Blue Cross & Blue Shield’s AQC or Alternative Quality Contract.

The AQC is a contracting model that includes components of global budgeting and pay for performance. The budget component encompasses the entire spectrum of inpatient and outpatient care with both upside and downside potential. AQC groups are eligible for performance bonuses of up to 10% of their budgets. This bonus is substantially greater than typical P4P payments and is graded through various performance gates that increase with improved performance. Pediatric measures include well care (infants, children and adolescents), Chlamydia screening, testing for pharyngitis, and non-antibiotic treatment for URI. Efficiency savings to date seem to be primarily driven by the use of lower cost providers and facilities. It is my opinion that this model can serve as a prototype for ACOs. However, there may be a fly in the ointment. NEQCA is presently negotiating with BC/BS with the plan’s intent to decrease the global budget substantially. Stay tuned — this may be an example of no good deed goes unpunished.

AAP Private Payer Advocacy Advisory Committee (PPAAC)

The AAP Private Payer Advocacy Advisory Committee (PPAAC) was established to identify strategies to enhance access through improved payment and health care benefits coverage for children and to advise the AAP and its leadership on opportunities to improve pediatrician's economic and organizational position in the private marketplace. Through the AAP PPAAC, assistance and resources are available to help members and chapters in addressing private payer issues.

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guidance for its members on factors to consider in evaluating an opportunity to participate in an ACO. Developed by the AAP ACO Work Group, “Pediatricians and ACOs: Evaluation and Engagement,” the document identifies critical success factors for pediatric ACOs and discusses key considerations in ensuring pediatric representation in an ACO including organizational structuring, and clinical and financial performance metrics and monitoring. The document can be accessed using the following link: http://practice.aap.org/content.aspx?aid=2989.

Also, the AAP, together with the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP) and the American Osteopathic Association (AOA) released the Joint Principles for Accountable Care Organizations to reflect those attributes they believe are essential for the effective implementation of the ACO model within the health care system.

The joint principles can be accessed on the AAP Member Center, professional resources link under practice support (financing and link at: http://www.aap.org/en-us/about-the-aap/aap-press-room/Pages/Joint-Principles-for-Accountable-Care-Organizations-Released-by-Organizations-Representing-More-Than-350,000-Primary-Care.aspx.
AAP PreSIP: QuIIN and Bright Futures Partner to Improve Preventive Care

In November 2011, 21 practice teams from across the United States came together for a concluding workshop of the Quality Improvement Innovation Network (QuIIN) Bright Futures Preventive Services Improvement Project (PreSIP). Teams shared lessons learned and began planning for continuing and sustaining improvements. The PreSIP’s goal was to answer the question, “Can Bright Futures be easily implemented, birth to 3, in a busy clinical setting?”

The project began in December 2010 with practice teams completing baseline data and assessing their office systems. Following baseline data collection, the teams came together for a kick-off meeting in January 2011, where they were introduced to the project, Bright Futures content, quality improvement science, and were given the opportunity to develop improvement plans. Following the meeting, the practices worked for 9 months on testing strategies for implementing Bright Futures in their setting using quality improvement science. The specific measures practices addressed over the 9 months included:

- Perform age appropriate risk assessments
- Elicit, address, and document parental concerns
- Developmental screening and follow-up
- Autism-specific screening and follow-up
- Addressing 3 Bright Futures priorities when providing anticipatory guidance
- Maternal depression screening
- Evaluation of parental strengths
- Oral health risk assessment

The full data collection protocol involved patient chart review, survey of clinical care systems, monthly reports and calls, tool evaluation survey, and post-project focus groups completed during the November workshop. At the end of the project, each of the measures above (in aggregate) showed improvements, with at least one team being at 100% for every measure. In addition, many of the measures met or exceeded the goal set by the project. The most challenging measure to implement was the evaluation of parental strengths. A publication is anticipated to report on full results and lessons learned.

PreSIP was approved by the American Board of Pediatrics for Maintenance of Certification Part 4 and received

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Practices that made the PreSIP project possible include:

All About Children Pediatric Partners PC, West Reading, PA
All Pediatrics, Lorton, VA
Atlantic Coast Pediatrics, Merritt Island, FL
Children’s Health Center at St Elizabeth’s Hospital, Appleton, WI
Children’s Hospital Primary Care Center, Boston, MA
CMC Myers Park Pediatrics, Charlotte, NC
Community Medicine Associates, San Antonio, TX
Comprehensive Pediatric Care, Williston, ND
Cook Children’s Physician Network, Hurst, TX
Danis Pediatrics, St Louis, MO
Fair Oaks Children’s Clinic, Redwood City, CA
Haverstraw Pediatrics, Haverstraw, NY
Hays Med Pediatrics Center, Hays, KS
Kressly Pediatrics PC, Warrington, PA
Lutheran Family Health Center - Sunset Park Pediatrics, Brooklyn, NY
Roxborough Pediatrics/ECHA, Philadelphia, PA
San Xavier Clinic, Tucson, AZ
Sandhills Pediatrics, Inc, Southern Pines, NC
Sixteenth Street Community Health Center, Milwaukee, WI
University of Iowa Department of Pediatrics, Iowa City, IA
Wind River Service Unit, Ft Washakie, WY
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developments at the policy level. I outlined the accreditation standards for Accountable Care Organizations (ACOs) that were released in November and some resources developed by the AAP ACO Work Group that can help ensure pediatric representation in an ACO. Dr Peter Rappo, chair of the AAP Private Payer Advocacy Advisory Committee, shares his practice’s experience with a pay for performance program and how this model could serve as a prototype for ACOs.

This issue also includes an update on the AAP’s Quality Improvement Innovation Network (QuIN) Bright Futures Preventive Services Improvement Project (PreSIP), which wrapped up in November. Several AAP programs and multiple quality improvement resources available to members are also highlighted. Please enjoy this issue of Quality Connections! As always, we welcome your feedback as we strive to make this newsletter a helpful tool for our colleagues.

If you have any comments or suggestions for improvement, please send them on to Junelle Speller atjspeller@aap.org.

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Academy of Family Medicine, families, practices and health care providers to build a Child Health Improvement Partnership in the state that will lead measurement-based efforts to improve the health outcomes of children. Maine Quality Counts, and all the groups in the partnership, are currently working with MaineCare, who has a 5 year CHIPRA grant with Vermont, to lead a learning collaborative on improving immunizations rates and early preventive services.

My QI work has come full circle— and along the way, the impact of our asthma work has expanded greatly to benefit practices, health systems, trainees, and most importantly children and families. I hope many of you are fortunate enough to have similar opportunities as the QI “circle” expands nationally.

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funding from the Health Resources and Services Administration, Maternal and Child Health Bureau, under a cooperative agreement to the American Academy of Pediatrics (# U04MC07853) and from the AAP Friends of Children (FOC) Fund. FOC funds were used to support residency teams selected in partnership with the Academic Pediatric Association Continuity Research Network (CORNET).

For additional information about QuIN, visit http://quin.aap.org.
For additional information about Bright Futures, visit: http://brightfutures.aap.org/.

PEDIALINK®
Hot Topics: Getting Started With QI

Quality Improvement (QI) is a collection of techniques to systematically and scientifically make improvements in health care and health services that will increase the likelihood of desired health outcomes.

After completing this course, you should be able to 1) explain current quality problems; 2) improve quality of healthcare provided to children using a series of Plan-Do-Study-Act cycles; and 3) use one or a combination of approaches to improve healthcare quality in the workplace.

For more information or to register, visit www.pedialink.aap.org.

Early in the planning stages of this project, it seemed that implementing Bright Futures would be a daunting task—especially in a large, multi-provider, continuity clinic like ours. We quickly realized that using the Bright Futures guidelines not only enhanced provider focus during well child care, but also ensured the most comprehensive care. We focused on addressing and reinforcing parental strengths which, we think, enriched the way we practice medicine and the relationships we have with our patients. This was an incredible learning experience and has provided a sustainable framework for patient care.

- Kasey Scannell, MD, FAAP
**What’s New with the Building Your Medical Home Toolkit?**

The Building Your Medical Home toolkit, developed via a cooperative agreement between the American Academy of Pediatrics (AAP) and the Maternal and Child Health Bureau (MCHB), supports the primary care practitioner’s development and improvement of a pediatric medical home.

The Building Your Medical Home toolkit and its six progressive medical home 'building blocks' include content and tools available to help improve care for all children and youth. Tools and related information can be used as they are provided or can be adapted to meet the needs of a practice and its patient population.

One key feature of the toolkit is a crosswalk between each of the toolkit building blocks and the National Center for Quality Assurance (NCQA) Patient Centered Medical Home (PCMH) 2011 program requirements; these requirements were updated in January from a previous 2008 version of the program. To coincide with NCQA’s program changes, the toolkit now crosswalks with both the 2008 and 2011 NCQA PCMH standards, including links to practical tools and resources.

Patient care associated with the medical home improves outcomes, such as health status, timeliness of care, family centeredness and family functioning. Additionally, many private and public health insurance plans and employers are considering or already implementing projects to recognize and compensate practices as patient-centered medical homes.

The Building Your Medical Home toolkit is free and can be accessed online at www.pediatricmedhome.org. Set up a user account today! For more information on the toolkit, contact the National Center for Medical Home Implementation at medicalhometoolkit@aap.org or 800/433-9016, ext 4311.

**Practice Services Improvement Program**

In May 2010, the Academy’s Board of Directors approved the use of venture capital to establish the Practice Services Improvement Program (PSPIP) to provide innovative services to practices and payers to aid in the successful implementation of the Patient and Family Centered Medical Home (PCMH). PSPIP has recently completed the process of obtaining feedback from member pediatricians on the possible service offerings and launched a series of webinars last fall.

If you have questions or want more information, contact Sherry Fischer at sfischer@aap.org.

**Partnering with Patients and Families in the Medical Home: 2011 CME Webinar Series**

To demonstrate how medical home works in practice, the American Academy of Pediatrics and National Center for Medical Home Implementation hosted a free four-part CME Webinar series from April through June for all child health professionals. These webinars were led by recognized experts with the goal of educating participants about the value of the family-centered primary care medical home for all children and youth across the spectrum of care; the four webinars reviewed the role of the medical home in preventive, acute, and chronic care delivery, as well as the overarching importance of partnering with patients and families for optimal health outcomes. Faculty shared practical tools and resources, as well as strategies for improving quality of care and increasing patient/family partnership and satisfaction.

For archived versions of the series, please visit http://www.medicalhomeinfo.org/training/cme/#1.
The Steering Committee on Quality Improvement Management (SCOQIM) was established in response to the increasing national emphasis on quality in health care and the AAP’s own identification of quality improvement as a top priority. The SCOQIM offers a more integrated voice for quality and enables the AAP to best support its members in providing the highest quality clinical care for children. SCOQIM’s priority areas include advocacy; clinical practice guideline development and evidence; education; implementation; quality measurement; and patient safety.

The SCOQIM has workgroups on evidence, quality measurement, and patient safety. If you are interested in learning more about these groups, please contact Junelle Speller at jsplier@aap.org. For more information, visit http://www.aap.org/visit/scoqim.htm.

EQIPP BRIGHT FUTURES

Give your patients a brighter future, with EQIPP Bright Futures. In as little as four months, the AAP’s EQIPP Bright Futures online course will give you the information, tools and guidance you need to improve your quality of care and put Bright Futures to work for you. To register, visit www.eqipp.org.

What are pediatricians saying about EQIPP Bright Futures ...

"I think Bright Futures is a great course!"
Cindy Henry, DO

"I enjoyed going through this course. I have learned so much and am really looking forward to closing the gaps at our practice."
Vidhu Thaker, MD

Remember: It’s a new year and time to start your quality improvement projects to meet MOC Part 4 requirements. With Bright Futures, you can earn CME AND meet MOC Part 4 requirements all at once.

Regional Extension Centers (REC) were created to support and serve health care providers in the adoption and implementation of electronic health record (EHR) systems. As pediatricians begin efforts to implement EHRs, RECs will serve as a key local resource in selecting a vendor, modifying office procedures and workflows, and complying with the requirements for Meaningful Use. The RECs will also need the support of the national AAP and its chapters to ensure that they can meet the needs of pediatric practices.

To aid in these connections, the Child Health Informatics Center (CHIC) published a grant opportunity for AAP chapters to support them in providing educational programs for their members that assist in the adoption and use of electronic health records (EHRs). The CHIC will award four chapters up to $4,000 each to support educational conferences that:

• Provide education to help chapter members adopt/implement an EHR.
• Involve the chapter’s local Regional Extension Center (REC) and sharing of strategies as to how members can access REC services.
• Share pediatric specific success stories and challenges about EHR adoption.

For more information on the Chapter Educational Grant program, please contact Cathleen Guch MPH, Manager, HIT Education at cguch@aap.org.