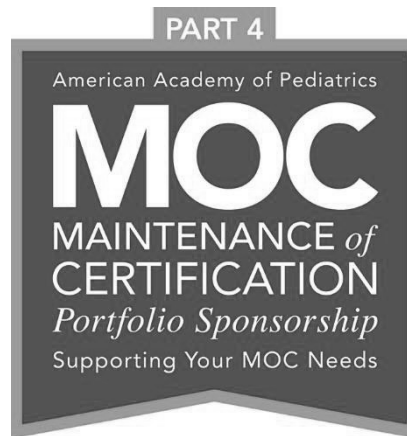


American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



# American Academy of Pediatrics Application for Maintenance of Certification Part 4



If you have questions about this application, please contact Jill Healy, MS, Manager, Quality Improvement and Certification Initiatives at the information provided below.

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## CLINICAL TOPIC

9. Describe the gap in quality that is causing this quality improvement effort to be undertaken. This can be done by comparing the current state of care within your organization relative to this quality improvement effort with the state of care in other settings.

A growing body of evidence supports family-centered care and its impact on health outcomes for children and families. The 2001 Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century* discusses the need to engage patients in their own health care decisions, inform patients of various treatment options, and improve access to information for patients and families.<sup>1</sup> These core components of family-centered care are also supported by the American Academy of Pediatrics (AAP). The American Academy of Pediatrics policy statement “Family-Centered Care and the Pediatrician’s Role”, published in *Pediatrics*, indicates that family-centered care has been shown to improve patient and family outcomes, increase family and professional satisfaction, decrease health care costs, and improve effective use of health care resources.<sup>2</sup>

Despite research supporting implementation of family-centered care, only 67% of families indicated that their children received family-centered care over the last 12 months, as evidenced by data from the 2011/12 National Survey of Children’s Health. In addition, only 54% of families indicated that their children receive coordinated, ongoing, comprehensive care within a medical home.<sup>3</sup> Since family-centered care is a key component of the patient-centered medical home, the standard of care for all children and youth, it is important to implement strategies and provide resources to enhance family-centeredness across pediatric practices.<sup>4</sup>

This project aligns with AAP recommendations for provision of family-centered care in pediatric practice. Specifically, the project will provide tools and strategies to assist pediatricians and their teams to work with families in decision-making and information sharing across all practice settings, create opportunities for families to serve as advisors, and explore strategies to ensure the core concepts of family-centered care are incorporated into all aspects of professional pediatric practice.

10. Is the quality improvement effort related to a national, regional, or local initiative?

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<sup>1</sup> Institute of Medicine, Committee on Quality of Health Care in America. *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*. Washington, DC: The National Academies Press, 2001.

<sup>2</sup> American Academy of Pediatrics, Committee on Hospital Care. Family-Centered Care and the Pediatrician’s Role. *Pediatrics*. 2003;112(3):691 – 696

<sup>3</sup> National Survey of Children's Health. NSCH 2011/12. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 2/29/16 from [www.childhealthdata.org](http://www.childhealthdata.org)

<sup>4</sup> American Academy of Pediatrics, Medical Home Initiatives for Children with Special Needs Project Advisory Committee. The Medical Home. *Pediatrics*. 2002; 110(1): 184-186.

Yes

No

What initiative? [Click here to enter text.](#)

## **GOALS AND OBJECTIVES**

11. What is the specific aim of the quality improvement effort? *Note: an aim answers the questions how much improvement and by when. Your response should be a measureable goal within an identified timeframe.*

By January 2017, 10 pediatric primary care practice teams will work individually and collaboratively to test, implement, disseminate, and plan to sustain strategies that lead to improved family engagement in clinical practice through enhanced shared decision-making and connection of families to appropriate supports and services.

Using a convenience sample of 10 patient medical records reviewed each month, participating teams will make improvements so that by the final month:

1. 80% or more of patient medical records (ie at least 8 of 10 medical records reviewed) have documentation that patient/family concerns were elicited at the most recent health supervision visit.
2. 80% or more of patient medical records (ie at least 8 of 10 medical records reviewed) have documentation that patient/family concerns were addressed at the most recent health supervision visit or a plan to address the concerns was made.
3. 80% or more of patient medical records (ie at least 8 of 10 medical records reviewed) have documentation that family strengths were identified and discussed at the most recent health supervision visit.
4. 80% or more of patient medical records (ie at least 8 of 10 medical records reviewed) have documentation that a post-visit medical summary or a comprehensive care plan was created or updated/maintained at a most recent health supervision visit.
5. 80% or more of patient medical records (ie at least 8 of 10 medical records reviewed) have documentation that a current copy of their post-visit medical summary or comprehensive care plan was reviewed through an active form of family engagement and offered to patients/families at a most recent health supervision visit.
6. 80% or more of patient medical records (ie at least 8 of 10 medical records reviewed) have documentation that families received a follow-up discussion of age-appropriate screening results on the same day as the screening.

Using a convenience sample of 10 patient surveys per month, participating teams will make improvements so that by the final month:

7. 80% of parents/families (ie. 8 of 10 parents surveyed) will indicate that they can be honest with their child's doctors and nurses about the choices they make for their child.
8. 80% of parents/families (ie. 8 of 10 parents surveyed) will indicate that doctors and nurses explained things about their child's health in a way that was easy to understand.

9. 80% of parents/families (ie. 8 of 10 parents surveyed) will indicate that doctors and nurses listened to what the family had to say.
10. 80% of parents/families (ie. 8 of 10 parents surveyed) will indicate that doctors and nurses gave thoughtful responses to their questions and concerns.
11. 80% parents/families (ie. 8 of 10 parents surveyed) will indicate that receptions and other clinic staff treated them with respect.
12. 80% parents/families (ie 8 of 10 parents surveyed) will indicate that doctors and nurses involved them in decisions about their child's health.

In addition, two balancing measures will be incorporated throughout the project, including the following:

1. Think about the changes your team has implemented as part of the "Family Engagement Quality Improvement Project." Because of this project, the amount of time it takes staff and physicians to communicate with patients and families has taken (5= much less time, 1= much more time).
2. Think about the changes your team has implemented as part of the "Family Engagement Quality Improvement Project." Because of this project, the care team's confidence about engaging families in shared decision-making has become (5 = much more confident, 1= much less confident).
12. What is the specific patient population for this quality improvement effort? Pediatric primary care practices (pediatricians and office staff) caring for children and youth 0-18 years of age; parent/caregivers of patients at aforementioned practices.
13. Select the IOM Quality Dimensions addressed as part of this quality improvement effort:
  - Effectiveness
  - Efficiency
  - Equity
  - Patient-Centeredness
  - Safety
  - Timeliness

**14. Measure Table.**

Attach a table/spreadsheet that includes the following information for each measure used with the project. If the measures are not nationally endorsed, please explain how they were selected and developed. See Appendix A.

The project expert work group developed the project measures. The project measures are based on previous quality improvement efforts implemented across the AAP, including those implemented through the Bright Futures Preventive Services Improvement State Spread (PreSIPS) project, the Florida Child Health Insurance Program Reauthorization Program (CHIPRA) Pediatric Medical Home Demonstration project, and the AAP Council on Quality Improvement and Patient Safety health literacy project.

- Measure Name and Type
- Measure Definition
- Source of Measure (eg, NQF, HEDIS, etc)
- Measure Calculation

- Measure Exclusion
- Data Source/Associated Data Collection Tool
- Measure Benchmark
- Measure Target/Goal (%)
- Collection Frequency
- Associated Questions

15. How are results captured and displayed over time?

- Annotated run chart
- Bar graph
- Control chart
- Data table
- Narrative
- Run chart
- Other

Attach results for the quality improvement showing data over time. If project is in beginning stage, please provide examples of how results are displayed.

*Note: The attached file should contain the display format/s indicated above.*

See Appendix B for a sample run chart.

Are results provided to participants in the format selected above?

- Yes
- No

16. Sampling strategy:

- Consecutive cases
- Convenience sample
- Entire population
- Random sample
- Other

Describe the sampling strategy: Participating practice teams will be asked to conduct medical record reviews for the first 10 patients age 0 – 18 years that are seen in that practice for a health supervision visit during each month/Action Period. At baseline, participating practice teams will be asked to review medical records of the first 20 patients age 0 -18 years seen at the practice for health supervision visits. A medical record review tool, with an accompanying tip sheet (Appendix C), will be provided to participating practices prior to beginning the project. Medical record reviews will be conducted using the Academy’s Quality Improvement Data Aggregator (QIDA). Practice teams will be given detailed instructions on how to use the QIDA prior to beginning the project. To protect patient privacy, each core improvement team will designate one team member to conduct medical record reviews and enter data into the QIDA system.

In addition to medical record reviews, each Action Period teams will collect a maximum of 10 post-visit family surveys (Appendix D) from the first 10 families with children between 0-18 years of age seen at

the practice during that particular Action Period. Post-visit surveys will be completely anonymous and optional for families to complete. Surveys will be distributed in paper format (hard copies) and collected by a designated core improvement team member. The team member will then enter survey responses into the QIDA using a post-visit family survey data entry tool (Appendix D).

17. How often are data collected and submitted over the course of the quality improvement effort?

- Continuous
- Daily
- Weekly
- Monthly
- Quarterly
- Other

What is the frequency?

At baseline, 20 medical records will be reviewed by each practice team. Through each Action Period (one month in length, six Action Periods total), each practice team will review 10 medical records, for a total of 80 medical records reviewed throughout the project, per practice team.

At baseline, 10 post-visit family surveys will be collected from each practice. Throughout each Action Period, each practice team will collect up to 10 post-visit family surveys, for a maximum of 70 post-visit family surveys collected throughout the project per practice team.

In addition, each practice team will be required to submit one monthly progress report each month of the project (six monthly progress reports in total). At the beginning of the project and at the end of the project practice teams will be required to submit one pre-implementation survey and one post-implementation survey, respectively. Please view Appendix E and F for the monthly progress report and pre-/post- implementation surveys, respectively.

18. What is your system for data collection? The pre-implementation survey will be disseminated to practice teams through Survey Monkey at the beginning of the project (May 2016), after participants have been selected for participation and completed appropriate consent forms. The pre-implementation survey provides baseline information about each practice team's knowledge and processes related to family engagement and shared decision-making.

Data from the 20 medical records reviewed by each practice team as part of the baseline data collection period will be entered into the Academy's QIDA by a designated core improvement team member, using the medical record review tool and accompanying instructions/tip sheet (Appendix C). Throughout each monthly Action Period, designated core improvement team members will review 10 medical records and enter data into the QIDA using the same medical record review tool. Medical records will be reviewed for patients age 0-18 years seen at the practice for a health supervision visit.

During the baseline data collection period and throughout each Action Period, 10 paper-based

post-visit family surveys will be collected from families with children 0-18 years of age seen at the practice for a health supervision visit (Appendix D). A designated core improvement team member will enter data from the anonymous paper-based surveys into the QIDA post-visit family survey data entry tool.

Each month, teams will also complete monthly progress reports (Appendix E). These reports are designed to capture additional qualitative information about tests of change conducted by each practice team, the project's balancing measures, and identify surprises, successes, challenges and barriers to implementing tests of change. Monthly progress reports will be collected via Survey Monkey.

At the completion of the 6-month action period, practice teams will complete a post-implementation survey via Survey Monkey (Appendix F). This survey will assess if improvements have been made by each practice team, and will be compared to responses from the pre-implementation survey.

19. Explain methods used to assure data quality and completeness. The measures included in this quality improvement project were carefully considered by members of the project's expert work group, which is comprised of quality improvement experts, pediatric researchers, pediatric clinicians, a national recognized family leader with expertise in quality improvement, and an evaluation consultant. All data from the medical record reviews and post-visit family surveys will be entered into the Academy's QIDA. A quality check for data entry errors and data completeness will be done by AAP staff (the program manager), the evaluation consultant, and the quality improvement advisor.

Project staff will send participating teams monthly reminders of data entry deadlines. Each team will receive a reminder approximately one week before data entry is due. Additional follow-up will be conducted for teams with no data entered a few days before each monthly deadline.

The quality improvement advisor will be available as needed for coaching and to address any data collection questions. In addition, project staff will use a spreadsheet to keep track of data entry by participants as well as participant attendance on monthly educational conference calls to ensure that all MOC requirements are met.

20. Attach a copy of a report to leadership for this quality improvement effort. See Appendix G for a report to the Maternal and Child Health Bureau. The expert work group members for this activity will be kept informed of the quality improvement efforts during monthly expert work group calls and through continuous email communications. In addition, expert work group members will participate in monthly project conference calls/educational webinars and will be subscribed to the project listserv. Expert work group members will also have access to the project's workspace through the Academy's QIDA.
21. How are data used to drive improvement throughout the quality improvement effort? This project uses data to drive improvements in several ways. Data will be used to measure the impact of the project on practice change and efforts to improve office systems and processes.

Medical record review data entered into the medical record review tool, as well as post-visit

family survey responses entered into the post-visit family survey data entry tool, will be converted into run charts that will report progress over time in the project's twelve identified measures. These run charts will be discussed and shared with practices during monthly educational conference calls/webinars as well as individual quality improvement coaching calls between individual practice teams and the quality improvement advisor. In addition, the project's evaluation consultant will analyze data from monthly medical record reviews and post-visit family surveys for incremental improvements over baseline. These data will drive discussions during these calls/webinars about tests of change that resulted in improvements in practice, tests of change that did not result in improvements and required modifications, sustainability, and strategies to overcome barriers and challenges encountered during tests of change.

Participants will have access to aggregate run charts (with no patient or physician-level identifiers). This will facilitate collaborative learning and sharing of promising practices.

Results and feedback from monthly progress reports will also be discussed during monthly educational calls/webinars with all practice teams and during quality improvement coaching calls between individual teams and the quality improvement advisor. Monthly progress reports will provide additional details, including qualitative data, about successful tests of change, barriers and challenges to testing changes, and promising practices. During each educational monthly conference call/webinar, the quality improvement advisor and project leader will present strategies for making improvements in practice based on results from the monthly progress reports and run charts. Practice teams will also share and discuss their successes and challenges during these monthly calls.

Participants will use Plan-Do-Study-Act (PDSA) cycles to test interventions provided by the project. Each month, participants will develop small tests of change to measure the impact of the intervention with the ultimate goal of making process improvements. Participants will go through several PDSA cycles each month on a small scale to measure the impact of the intervention and to improve upon each intervention, if necessary, before implementing the change on a larger scale. Baseline medical record review data and post-visit family survey data will help guide these efforts when the project begins.

22. How frequently is feedback provided to the participating physicians?

Daily

Weekly

Monthly

Other: practice teams will each be required to participate on at least two individual quality improvement coaching calls with the quality improvement advisor throughout the project period. This will provide an additional opportunity for the provision of feedback to practice teams.

23. Classify the types of interventions used in the quality improvement effort.

Note: This list is not exhaustive and other intervention types are allowed.

Education

Reminders (daily, weekly, etc)



Use of a checklist

Use of a registry

Other: Each participant will be provided with a change package that will provide practical tools and resources focused on the project's measures for practice teams to test implementing within practice.

24. Describe the interventions that were or are being implemented that directly relate to achieving the aim of the quality improvement effort.

*Note: This response may be supplemented by attaching a logic diagram or key driver diagram.*

At the beginning of the project (May 2016), teams will participate in a "flipped classroom" orientation webinar that will provide an introduction to quality improvement methodology, as well as an overview of the project's aim/measures and individual practice team roles and responsibilities. Participants will be assigned homework (also known as pre-work) to complete prior to the call. The "flipped classroom" approach enhances engagement of participants and collaborative learning.

Prior to beginning the project's 6-month action period, practice teams will participate in an in-person learning session (Learning Session 1). The learning session will include educational sessions related to family engagement, quality improvement methodology, sustainability, and provide time for teams to plan their first PDSA cycle. Faculty with knowledge and expertise in family-centered care, family engagement, and quality improvement will facilitate educational sessions at the learning session. Parent/caregiver partners will attend the learning session and will participate in breakout sessions with a nationally recognized family leader with expertise in quality improvement. Education provided during the first in-person learning session will allow practice teams to successfully begin the project's 6-month Action Period with baseline knowledge about quality improvement, family engagement, and expectations throughout the project.

Practice teams will implement tools, strategies, and measures included in the change package (Appendix H) to improve and enhance family-centered care through family engagement for patients and families. The change package presents tools and resources that specifically relate to the project measures. Areas of focus and key content include: shared decision-making strategies, decision aids in practice, and strategies to connect families to appropriate supports and services.

Practice teams will conduct tests of change each month utilizing the tools and resources provided. Expert faculty will present on topics related to family centered-care (including family engagement and shared decision-making) during monthly educational conference calls/webinars. These faculty members will also introduce helpful tools and resources from the change package and provide examples of how they can be used in practice.

Every month throughout the 6-month action period practice teams will participate on educational calls/webinars. Each call/webinar will feature an expert guest faculty member that will provide a 20-30-minute presentation on a particular educational topic relevant to the project. The call/webinar will also include a discussion facilitated by the project's quality improvement advisor that will focus on reviewing monthly aggregate run charts (project data), sharing promising practices among practice teams, and providing examples of successful PDSA cycles implemented throughout that particular month by practice teams.

Upon the completion of the 6-month action period, a second in-person learning session (Learning Session 2) will be held for practice teams. The learning session will include further educational sessions on family engagement, shared decision-making, and sustainability and spread of quality improvement efforts. Nationally recognized faculty and family leaders will assist with facilitating Learning Session 2.

These educational interventions will help participants confidently implement tests of change. Repeated analysis of data based on medical record reviews and post-visit family surveys will be used to track changes in practice throughout the project's 6-month action period.

How are the interventions expected to improve patient care?

By utilizing evidence-based and evidence-informed tools and strategies for enhancing family-centered care through family engagement in practice, and, through a quality improvement learning collaborative, primary care pediatricians, their staff, and parent/caregiver partners will work to provide optimal, high quality care for patients and families.

25. How will improvements from the interventions be sustained and spread?

This quality improvement project has a strong focus on sustainability and spread. These two concepts are emphasized throughout the entire project, starting with the application process. All interested applicants are required to indicate on the project application if practice leadership has been informed of and approved of the team's participation in the project. The project's first in-person learning session will include a session focused on leadership buy-in, sustainability, and spread of quality improvement efforts. This topic will also be discussed during the monthly educational conference calls/webinars as well as individual quality improvement coaching calls.

Throughout the project, teams will be expected to conduct small tests of change in practice. If a test of change has resulted in improvements, the team will then be encouraged to spread that change throughout the entire practice, and put practice-based systems in place to sustain successful changes. Obtaining leadership buy-in and support from the beginning of the project will further enhance a team's ability to spread successful improvements throughout the project and assure sustainability.

26. What resources and/or tools are provided by the organization to assist with the implementation of the interventions?

A change package, with resources specific to family-centered care and shared decision-making will be provided to participating practice teams by project staff. The change package includes resources from the AAP, Bright Futures, Family Voices, National Institute for Child Health Quality, Agency for Healthcare Research and Quality, among others. View Appendix H for the change package.

In addition, the project will utilize the Academy's QIDA to host a project workspace. This workspace will include the change package, an archive of the learning session materials, monthly educational calls/webinars and associated PowerPoint slides, as well as any additional tools/resources that are useful to practice teams. The workspace will also include an area for practices to upload resources and documents in a central location to use as the practice's personal resource repository. The

project will also create an interactive listserv, which will foster collaborative learning among practice teams, expert work group members, quality improvement experts, and project staff.

## PHYSICIAN PARTICIPATION

27. What are, were, or will be the specific requirements for meaningful physician participation in the quality improvement effort?

*Note: Describe the requirements relative to the standards and guidelines of the ABP Standards for active participation.*

### Active Role

For MOC purposes, an “active role” means the pediatrician must (revised 5/2015):

- Be intellectually engaged in planning and executing the project.
- Implement the project’s intervention (the changes designed to improve care).
- Review data in keeping with the project’s measurement plan.
- Collaborate actively by attending team meetings
- Participate in the project over a 10-month period (May – February 2017)
- Complete a web-based pre-implementation survey with the practice team (one report per team)
- Submit baseline data (medical record reviews for 20 patients 0-18 years seen for health supervision visits, 10 post-visit family surveys collected) using the Academy’s Quality Improvement Data Aggregator (QIDA)
- Participate in a project “flipped classroom” orientation webinar
- Attend an in-person Learning Session on June 3-4, 2016, near the AAP Headquarters in Elk Grove Village, IL
- Submit monthly progress reports with the practice team (one report per team per month, six reports in total)
- Participate in monthly educational conference calls/webinars
- Submit monthly data over the course of the 6-month action period (10 medical record reviews for the first 10 patients 0-18 years seen in the practice for a health supervision visit, 10 post-visit family surveys) using the Academy’s Quality Improvement Data Aggregator (QIDA)
- Participate in at least two quality improvement coaching calls with the quality improvement advisor
- Complete a web-based post implementation survey with the practice team (one report per team)
- Attend a second in-person Learning Session (January 2017, exact date to be determined) at or near the AAP headquarters in Elk Grove Village, IL

Minimum criteria for physician participants who are not members of the core-improvement team:

- Implement the project’s core changes/interventions throughout the project’s 6-month action period.
- Contribute to monthly progress reports.

- Attend local team meetings with the practice team during the project's 6-month action period.

28. How do physicians participate?

- Individually
- Team
- Individually and Team

What is the unit of analysis?

- Individual
- Team/Practice/Unit
- Aggregate

29. Describe how physician participation is monitored through this quality improvement effort (ie, how does your AAP group provide oversight to the project, including physician participation)?  
Note: AAP staff or the Project Leader should be involved in the tracking and monitoring of physician participation.

The project expert work group has been involved in all aspects of project planning, including measure development, aim statement development, participation criteria, and MOC Part 4 requirements for physician participants. Project staff will develop a spreadsheet to track physician participation and engagement, including if data was submitted on a monthly basis. This spreadsheet will be updated at least on a monthly basis after each webinar. Attendance will also be taken on each call and webinar. If a physician has been disengaged and not responsive to staff requests, this information will be shared with the expert work group and a decision will be made as to next steps

30. Describe the process used to resolve disputes related to physician participation in this quality improvement effort.

Project staff will work with the Project Leader and quality improvement advisor to resolve any disputes that may arise related to physician participation. All aspects of the physician's participation based on the tracking spreadsheet will be taken into account when assessing whether a physician qualifies for MOC Part 4 points or not. For instance, if a physician misses a "live" educational call/webinar but has still been very engaged in the project, there may be an opportunity for this physician to attend a recorded call/webinar and still receive MOC points. If there is still a dispute after the Project Leader and quality improvement advisor are involved, the issue will be taken to the full expert work group for discussion of next steps during one of the monthly calls held with the expert work group.

31. How many months does the project expect a physician to be actively involved in order to receive MOC Part 4 credit? *Please note: the ABP looks to Project Leaders to set requirements for length of participation based on the nature and needs of the project. Most MOC-approved projects to date have required 6-12 months participation.*

Physicians will be involved in the project for ten months, including baseline data collection which begins in May 2016.

32. What is the estimated number of pediatricians that will participate in this effort?

- 1-10
- 11-50
- 51-100
- 101-1,000
- More than 1,000

If more than 100 participants, please explain how you plan to monitor physician participation:  
[Click here to enter text.](#)

33. In what form is quality improvement education offered?

- Formal course
- Lectures
- Recommended reading
- Other

Describe in what form education is offered. Education will be offered through in-person learning sessions, group monthly conference calls/webinars (which include interactive discussions between participants), individual quality improvement coaching calls with the quality improvement advisor, and written educational materials and tools provided in the project's change package.

34. Pediatricians seeking MOC credit must complete the ABP Attestation Form, which is co-signed by the Project Leader or by a "Local Leader," depending on the project's structure. This co-signing leader is responsible for adjudicating any disputes with physicians who wish to claim credit for MOC. Because this process could affect a physicians' certification status, the co-signing Leaders should be active participants in approved projects who are in a position to determine participation of each physician. Physician attestations for this project will be co-signed by:

- Project leader who is a physician
- Project leader who is not a physician
- Local leader who is a physician
- Local leader who is not a physician

35. Indicate any roles supporting this project in addition to project leadership. Check all that apply.

- QI expert
- QI coaches
- Data manager
- Data analyst
- Statistician
- Program coordinator/project manager
- Other: Evaluation Consultant

36. Is the project HIPAA compliant?

- Yes
- No

37. Check this box if you consider this project research:

*(Note: if you have any questions about determining whether your project is research, please contact Erin Kelly, IRB Administrator at 847/434-4075 or [ekelly@aap.org](mailto:ekelly@aap.org))*

If yes to the above, does the project have IRB approval? (Check one)

We did not seek IRB approval.

IRB approval is pending. Please submit a copy of the IRB approval letter/form when obtained.

What organization's IRB is reviewing the project? American Academy of Pediatrics

IRB approval is obtained. Please submit a copy of the IRB approval letter/form. Date of IRB approval: April 7, 2016 What organization's IRB approved the project? American Academy of Pediatrics, Please see Appendix I for a copy of the IRB approval letter.

38. Attach any relevant files regarding the quality improvement effort that you wish to share with the reviewers. List attachments here: Project measures grid, sample run chart, medical record review tool and tip sheet, post-visit family survey and data entry tool, monthly progress report templates, pre- and post- implementation surveys, progress report to the Maternal and Child Health bureau, change package.

### **ABP PROFILE INFORMATION**

Please complete the following information that will be used to populate the ABP Web site.

39. Primary Project Contact

- Name: Alex Kuznetsov
- Email: [akuznetsov@aap.org](mailto:akuznetsov@aap.org)
- Phone: 847/434-7087
- Organization Mailing Address: 141 Northwest Point Boulevard, Elk Grove Village, IL, 60007

40. Description of the activity in 300 words or less to be listed on ABP website

*The Family Engagement Quality Improvement Project (Family-Centered Care Quality Improvement Project: Round Two)* is a project of the National Center for Medical Home Implementation (NCMHI), a cooperative agreement between the American Academy of Pediatrics (AAP) and the Maternal and Child Health Bureau, Health Resources and Services Administration. Throughout the project 10 pediatric primary care practice teams will work individually and collaboratively to test, implement, disseminate, and plan to sustain strategies to improve family engagement in clinical practice through enhanced shared decision-making and connection of families to appropriate supports and services. The project will include the following components: 1) formation of multidisciplinary practice teams that include a parent/caregiver partner; 2) collaborative/peer-based learning on topics related to the Model for Improvement and family engagement via two in-person learning sessions and monthly interactive conference calls/webinars; 3) using a list of recommended or evidence-based strategies and tools, teams test and implement changes designed to improve family engagement; 4) teams participate in individualized one-on-one coaching from a quality improvement advisor.

41. Completion Criteria to be listed on ABP website.

- Be intellectually engaged in planning and executing the project
- Implement the project’s intervention (the changes designed to improve care)
- Review data in keeping with the project’s measurement plan
- Collaborate actively by attending team meetings
- Participate in the project over a 10-month period (May – February 2017)
- Complete a web-based pre-implementation survey with the practice team (one report per team)
- Submit baseline data (medical record reviews for 20 patients 0-18 years seen for health supervision visits, 10 post-visit family surveys collected) using the Academy’s Quality Improvement Data Aggregator (QIDA)
- Participate in a project “flipped classroom” orientation webinar
- Attend an in-person Learning Session on June 3-4, 2016, near the AAP Headquarters in Elk Grove Village, IL
- Submit monthly progress reports with the practice team (one report per team per month, six reports in total)
- Participate in monthly educational conference calls/webinars
- Submit monthly data over the course of the 6-month action period (10 medical record reviews for the first 10 patients 0-18 years seen in the practice for a health supervision visit, 10 post-visit family surveys) using the Academy’s Quality Improvement Data Aggregator (QIDA)
- Participate in at least two quality improvement coaching calls with the quality improvement advisor
- Complete a web-based post implementation survey with the practice team (one report per team)
- Attend a second in-person Learning Session (January 2017, exact date to be determined) at or near the AAP headquarters in Elk Grove Village, IL

Minimum criteria for physician participants who are not members of the core-improvement team:

- Implement the project's core changes/interventions throughout the project’s 6-month action period.
- Contribute to monthly progress reports.
- Attend local team meetings for the practice team during the project period during which data is reviewed.

42. Relevant Topics. Choose 3.

<input type="checkbox"/> ADHD	<input type="checkbox"/> Genetics and Birth Defects	<input type="checkbox"/> Patient Safety
<input type="checkbox"/> Abuse and Neglect	<input type="checkbox"/> Handoffs	<input type="checkbox"/> Patient-Centered Care
<input type="checkbox"/> Access to Care	<input type="checkbox"/> Health Promotion	<input checked="" type="checkbox"/> Practice Improvement
<input type="checkbox"/> Anticipatory Guidance	<input type="checkbox"/> Hypoplastic Left Heart Syndrome	<input type="checkbox"/> Practice Redesign
<input type="checkbox"/> Asthma	<input type="checkbox"/> Immunization	<input type="checkbox"/> Practice Redesign-Documentation
<input type="checkbox"/> Auditory Screening	<input type="checkbox"/> Improvement Methods	<input type="checkbox"/> Prematurity
<input type="checkbox"/> Autism		

<input type="checkbox"/> Bloodstream Infection <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Cancer <input type="checkbox"/> Care Coordination <input type="checkbox"/> Care Transitions <input type="checkbox"/> Chlamydia <input type="checkbox"/> Chronic Care Management <input type="checkbox"/> Chronic Disease <input type="checkbox"/> Communication <input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Depression <input type="checkbox"/> Developmental Screening <input type="checkbox"/> Diabetes <input type="checkbox"/> Exercise <input type="checkbox"/> Febrile Infant <input type="checkbox"/> Gastroesophageal Reflux <input type="checkbox"/> Gastroesophageal Reflux Disease	<input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Influenza <input type="checkbox"/> Intubation in PICU <input type="checkbox"/> Juvenile Idiopathic Arthritis <input type="checkbox"/> Leadership <input type="checkbox"/> Learning Disabilities <input type="checkbox"/> Literacy <input type="checkbox"/> Low Birth Weight <input checked="" type="checkbox"/> Medical Home <input type="checkbox"/> Mental Health <input type="checkbox"/> Motivational Interviewing <input type="checkbox"/> Newborn Screening <input type="checkbox"/> Nurse Triage <input type="checkbox"/> Nutrition <input type="checkbox"/> Oral Health <input type="checkbox"/> Otitis Media/Otitis Media with Effusion <input type="checkbox"/> Overweight and Obesity <input type="checkbox"/> Parent Education <input type="checkbox"/> Patient Flow	<input type="checkbox"/> Preventative Services <input checked="" type="checkbox"/> Quality Improvement <input type="checkbox"/> Referral <input type="checkbox"/> Reliability <input type="checkbox"/> School Health <input type="checkbox"/> Self-management Support <input type="checkbox"/> Sepsis <input type="checkbox"/> Sexuality <input type="checkbox"/> Sexually Transmitted Disease <input type="checkbox"/> Sleep <input type="checkbox"/> Spread <input type="checkbox"/> Teamwork <input type="checkbox"/> Tobacco Cessation <input type="checkbox"/> Univentricular Heart <input type="checkbox"/> Varicella-Zoster Virus <input type="checkbox"/> Very Low Birth Weight <input type="checkbox"/> Violence Prevention <input type="checkbox"/> Vision Screening
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43. Does your project offer CME?

- Yes  
 No

44. Relevant Pediatric Subspecialties (choose all that apply):

<input type="checkbox"/> All Specialties <input checked="" type="checkbox"/> Adolescent Medicine <input type="checkbox"/> Child Abuse Pediatrics <input type="checkbox"/> Developmental-Behavioral Pediatrics <input checked="" type="checkbox"/> General Pediatrics <input type="checkbox"/> Hospice and Palliative Medicine <input type="checkbox"/> Hospitalist <input type="checkbox"/> Medical Toxicology	<input type="checkbox"/> Neonatal-Perinatal Medicine <input type="checkbox"/> Neurodevelopmental Disabilities <input type="checkbox"/> Pediatric Cardiology <input type="checkbox"/> Pediatric Critical Care Medicine <input type="checkbox"/> Pediatric Emergency Medicine <input type="checkbox"/> Pediatric Endocrinology <input type="checkbox"/> Pediatric Gastroenterology <input type="checkbox"/> Pediatric Hematology-Oncology	<input type="checkbox"/> Pediatric Infectious Diseases <input type="checkbox"/> Pediatric Nephrology <input type="checkbox"/> Pediatric Neurology <input type="checkbox"/> Pediatric Pulmonology <input type="checkbox"/> Pediatric Rheumatology <input type="checkbox"/> Pediatric Transplant Hepatology <input type="checkbox"/> Sleep Medicine <input type="checkbox"/> Sports Medicine
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45. Participation in approved quality improvement efforts is limited to:

- Physician members of the society/collaborative/association  
 Physicians employed or contracted by the organization  
 Physicians in the organization's health system or network  
 Other, define: [Click here to enter text.](#)

46. Is there a direct diplomate cost to participate?

- Yes  
 No  
 Unknown



47. Web Site URL (if applicable) Click here to enter text.
48. As the Project Leader, I accept responsibility for managing this project in compliance with the standards and requirements of the American Board of Pediatrics on behalf of the American Academy of Pediatrics.
1. Maintaining Standards: I will ensure that our QI Project maintains the ABP standards for QI projects for MOC.
  2. Attestations: I will attest to the participation of individual physicians and resolve disputes about attestations. Or, I will ensure that Local Leaders are designated to attest to the participation of individual physicians for MOC credit, and that they agree in writing to resolved any disputes about attestations.
  3. Meaningful Participation Criteria: I will ensure that our QI project's requirements for length of physician participation is documented and communicated to physician participants, and that this and all requirements for meaningful participation are upheld.
  4. Progress Report: I will ensure that AAP receives project updates every 6 months and that a formal Progress Report is completed annually (if selected) and at project completion.
  5. AAP Group Oversight: I will ensure that the AAP group listed in this application is responsible for monitoring project progress and physician participation.

I accept

I do not accept

Project Leader Signature: Megan Tschudy, MD, MPH Date: 7/12/16  
MEGAN TSCHUDY