Societies, Physicians, and Boards: Partners in Improvement

Katherine Remick, MD, FAAP, FACEP, FAEMS
Kristi Gilreath, American Board of Pediatrics
Patrick Dolan, MD, FAAP, University of Chicago
Disclosure

• Relevant Financial Relationship(s):
  • The Group presenting has no relevant financial relationship(s) to disclose.
Learning Objectives

• Explain the unique roles of societies, clinicians, and boards in the healthcare space

• Show how partnership and collaboration between societies, clinicians, and boards can facilitate quality improvement

• Highlight one example that bridges all three entities: EMS for children Pediatric Readiness Quality Collaborative (PRQC)

• Show how local/regional changes can impact delivery of healthcare
The State of Emergency Care for Children

- Variability in pediatric emergency care
  - Imaging and radiation exposure
  - Pediatric resuscitation performance
  - Patient-centered outcomes

Knapp et al. Pediatrics 2013
Li et al. Ped Emerg Care. 2017
Michelson et al. Pediatrics. 2018
Niles et al. Pediatrics. 2017
MOC Improvement Cascade

Societies

American Academy of Pediatrics

American College of Emergency Physicians

ENA

Clinicians

Needs Identified
Clinicians Overview

Monitor work they are doing for Gaps

Formulate PSDA cycles to test a change

Implement proven changes in their practice

Continue monitoring, and studying changes to assure success

Sustain changes by cementing it into everyday practice

Spread changes to other departments, providers or processes

Advocate for Societies to formulate national or international guidelines/polices

Join other projects already started by other clinical teams
Societies Overview

Create one voice of common interest, advocating for that population

Receive feedback for frontline clinical staff

Monitor frontline and current research for new or updated evidence-based medicine

Help create, give guidance and fund frontline projects

Help provide infrastructure and support for project success

Gather clinical experts to create a guideline/policy

Coordinate with other societies on a common goals (e.g. ENA, AAP, ACEP, ACS COT)

Disseminate guidelines/policies to clinicians

Create a trusted, up-to-date source of information on evidence-based practices
AAP Mission, Vision, Values

Mission
The mission of the AAP, founded in 1930, is to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults.

The AAP is a national non-profit organization of 67,000 pediatricians and 450 staff headquartered in Itasca, IL with an office in Washington DC.

Nearly 100 AAP expert advisory groups and AAP chapters in every state support furthering this mission. To accomplish this

Core Values

AAP introduction
We believe:

❖ In the inherent worth of all children. They have unique needs and are our most enduring and vulnerable legacy.

❖ Children deserve optimal health and high-quality health care.

❖ Pediatricians, pediatric subspecialists, and pediatric surgical specialists are best qualified to provide this care.

❖ Multidisciplinary teams including patients and families play an important and integral role.

❖ AAP is the lead organization to advance child health and well-being and the profession of pediatrics thru Advocacy, Education, Policy, & Research.
Joint Policy Statements to Promote Child Health and Wellbeing

• AAP’s Committee for Pediatric Emergency Medicine
  • 32 Policy Statements
    • 17 Joint Policy Statements

• Purpose of a policy statement
  • Develop a standard for care/practice
  • Drive efforts to achieve desired changes in practice
  • Joint policy statement carry added influence as
The EMS for Children Program

• Designed to reduce childhood death and disability due to severe illness or injury
• Enhances the pediatric capability of existing emergency care systems designed for adults
Securing Partnerships to Ensure Success

• Leverage common missions
  • EMSC: Decrease morbidity and mortality in children due to critical illness
  • AAP: Improve the health and wellbeing of all children

• EMSC Performance Measures
  • Required to report to Congress on progress made in key areas to secure continued funding
  • 9 core performance measures
EMSC Performance Measures

- EMSC 01: Submission of NEMSIS Compliant Version 3.x- Data
- EMSC 02: Pediatric Emergency Care Coordinator (PECC)
- EMSC 03: Use of Pediatric-Specific Equipment
- EMSC 04: Hospital Recognition for Pediatric Emergencies
- EMSC 05: Hospital Recognition for Pediatric Trauma
- EMSC 06: Inter-Facility Transfer Guidelines
- EMSC 07: Inter-Facility Transfer Agreements
- EMSC 08: Permanence of EMSC
- EMSC 09: Integration of EMSC Priorities into Statutes or Regulations
Case and Point: Societies Working Together for a Common Goal

• EMSC PM 04: Development of a statewide program to identify emergency departments that are pediatric ready
• Prohibited from lobbying or taking political stance
• American Academy of Pediatrics, American College of Emergency Physicians, and Emergency Nurses Association support the performance measures
  • Legislative success: H.R. 776, the "Emergency Medical Services for Children Program Reauthorization Act of 2019"

HEARING ON "REAUTHORIZING VITAL HEALTH PROGRAMS FOR AMERICAN FAMILIES"
Creating Opportunities that Support these Activities Among Clinician Members

• Achieving PM requires:
  • Engagement of AAP state chapters
  • Engagement of membership
  • Establishing mechanisms that both support PM and clinician needs
    • Pediatric Emergency Care Coordinators
  • Utilization of technologies and platforms
    • Social media
    • Maintenance of certification project
POLICY STATEMENT  Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN

Pediatric Readiness in the Emergency Department

Katherine Remick, MD, FAAP, FACEP, FAEMS, a,b,c Marianne Gausche-Hill, MD, FAAP, FACEP, FAEMS, d,e,f Madeline M. Joseph, MD, FAAP, FACEP, g,h Kathleen Brown, MD, FAAP, FACEP; Sally K. Snow, BSN, RN, CPEN; Joseph L. Wright, MD, MPH, FAAP; k,l AMERICAN ACADEMY OF PEDIATRICS Committee on Pediatric Emergency Medicine and Section on Surgery, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS Pediatric Emergency Medicine Committee, EMERGENCY NURSES ASSOCIATION Pediatric Committee
Transforming Policy Statements into Practice

- Lags in knowledge translation and dissemination
- Mechanisms that help transform policy into practice
  - EQIPP
  - Quality Improvement Innovation Network (QuINN)
  - National QI Collaboratives
  - Partnerships with other organizations
  - Link to AAP sections that support integration of statement into National Educational conferences
National Partnerships Form Around A Common Mission
Of 5,017 assessments sent - 4,149 (82.7%) responded
NPRP Assessment Results: Clinician Engagement

83% of EDs across the US participated in the assessment (n=4,149)

- Presence of physician (47.5%) and nurse (59.3%) pediatric emergency care coordinators (PECC);
- Presence of QI plans that include children (45.1%);
- Process to ensure pediatric weights are measured in kilograms (67.7%);
- Presence of inter-facility transfer guidelines (70.6%);
- Presence of disaster plans that include pediatric-specific needs (46.8%).
AAP and the National Pediatric Readiness Project

➢ AAP has been a partner in the National Pediatric Readiness Project (NPRP) since inception.

➢ AAP led the 1st national ED preparedness assessment in 2003

➢ The NPRP is based on the joint AAP-ACEP-ENA policy statement, published Nov 2018, *Pediatric Readiness in the Emergency Department.*

➢ AAP promotes implementation of pediatric emergency and disaster readiness recommendations to all AAP members and advocates for this at the local state, national and federal level.

➢ Oversight is provided by the AAP Committee on Pediatric Emergency Medicine, Council on Disaster Preparedness & Recovery, and Section on Emergency Medicine’s NPRP Special Interest Group.
Two National Collaborative Opportunities for Clinicians

**Facility Recognition Collaborative** (state chapter-centered approach)

- A national QI collaborative of 14 states
- Garnered stakeholder engagement and agreement around pediatric recognition programs

**Pediatric Readiness Quality Collaborative** (clinician-centered approach)

- A national QI collaborative of >100 EDs across 17 states
- Train-the-trainer model
- Nearly all trainers are AAP members/pediatric emergency medicine physicians
Pediatric Facility Recognition Collaborative
Pediatric Readiness Quality Collaborative

• Collaboration of 117 EDs across 17 states
• Characterized by:
  • Pediatric champions and trainers
  • Quality improvement science
  • Support from subject matter experts
  • Pediatric readiness interventions:
    1) weight in kg,
    2) abnormal vital signs,
    3) interfacility transfers,
    4) disaster planning
• Improvement monitored by dashboards that highlight structural, process, and outcome measures
MOC Improvement Cascade

Guidelines/Consensus Related to Emergency Care of Children

- Weight in Kg
  - Dosing medications
  - Safe practices and Family-centered Care

- Transfers of patient
  - Guideline
  - Feedback
  - Appropriateness

- Disaster preparedness
  - Create disaster plans
  - Pediatric patient in table-top planning

- Abnormal vital signs
  - Notification to providers
  - Identification
  - Interventions

Needs Identified

Best Practices

Clinicians

Societies
# Pediatric Readiness Quality Collaborative

## Process and Outcome Measures

### Overall Process/Outcome Measures Information

<table>
<thead>
<tr>
<th>Intervention Bundle</th>
<th>Sum of Sites Participating</th>
<th>Max Current Cycle</th>
<th>Total No of Charts Entered</th>
<th>Measure Name</th>
<th>Average Measure Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight in Kilograms</td>
<td>31</td>
<td>5</td>
<td>1,262</td>
<td>OM1 - % of Dosing Errors</td>
<td>51%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PM1 - % with Weights Documented in Kilos Only</td>
<td>79%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PM1 - % of Patients with standard vitals</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PM2 - % of Patients with abnormal vitals included in notification process</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PM3 - % of Patients with pain assessed</td>
<td>74%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PM4 - Median time from recognition of abnormal vital signs/pain to first intervention</td>
<td>33.6 min</td>
</tr>
<tr>
<td>Abnormal Vital Signs</td>
<td>46</td>
<td>5</td>
<td>1,872</td>
<td>OM1 - % of Dosing Errors</td>
<td>51%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PM1 - % with Weights Documented in Kilos Only</td>
<td>79%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PM1 - % of Patients with standard vitals</td>
<td>50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PM2 - % of Patients with abnormal vitals included in notification process</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PM3 - % of Patients with pain assessed</td>
<td>74%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PM4 - Median time from recognition of abnormal vital signs/pain to first intervention</td>
<td>33.6 min</td>
</tr>
<tr>
<td>Interfacility Transfer</td>
<td>11</td>
<td>1</td>
<td>248</td>
<td>OM1 - % of Transferred patients who were discharged from ED at receiving center</td>
<td>0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PM2 - % of Transfers met minimum criteria</td>
<td>24%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PM3 - % of Families that received transfer packet</td>
<td>0%</td>
</tr>
</tbody>
</table>
Pediatric Readiness Quality Collaborative

PDSA Metrics for All in All

Team Name: (All)
Site Acronym: (All)
Intervention Bundle: Interfacility Transfer

PDSA Metrics for: Interfacility Transfer

Charts count:

- Cumulative median time from arrival to transport
- Cumulative % of families that received transfer packet
- Cumulative % of transferred patients who were discharged f...
- Cumulative % of transfers met minimum criteria

Load Date [2019]:
- Apr 14
- Apr 28
- May 12
- May 26
- Jun 9
- Jun 23
- Jul 7
- Jul 21
- Aug 4
- Aug 18
- Sep 1
- Sep 15

Value:
- 0%
- 3%
- 9%
- 14%
- 19%
- 57%
- 66%
- 72%
- 79%
- 80%
- 82%
- 83%
- 100%
EMSC Performance Measure: Inter-Facility Transfer

The percentage of hospitals that have written inter facility transfer guidelines with defined essential components.

Defined essential components include:

- Defined process for transfer
- Defined process for initiating transfer including responsibilities
- Plan for sending Medical Record
- Include need to send copy of signed consent
- Process for identifying an appropriate transfer service
- Process for selecting appropriate facility
- Plan for transfer of patient belongings
- Plan for providing directions and referring institution information to the family

Adapted From EMSC PRQC
EMSC Performance Measure: Inter-Facility Transfer

Inter Facility Transfer Toolkit

Adapted From EMSC PRQC
EMSC Performance Measure: Inter-Facility Transfer

Inter Facility Transfer Toolkit Sections

Section 1: Introduction to the Tool Kit
Section 2: Algorithm for Developing Inter Facility Transfer Processes
Section 3: Standards and Regulation
Section 4: Talking Points for Establishing Guidelines
Section 5: Agreements and MOA’s
Section 6: Inter facility Transfer Guidelines
   Specific Service Sample Agreements
   Consultation and Transfer Guideline Links
   Authorization and Consent for Transfer Samples
   Downloadable Transfer Checklists
Section 7: Cultural and Family Considerations
Section 8: Quality Improvement and Follow Up
Section 9: Making a Case for Proactive Transfer Processes
Section 10: Library Resources

Adapted From EMSC PRQC
MOC Improvement Cascade

Societies -> Clinicians

Best Practices

GAPS Identified

MOC Application

Boards

MOC Credit
Boards and PRQC

- Sixteen teams across 17 states (Training and Affiliates Sites)
- 20 training sites
- Up to 240 affiliate sites
- To span over 2 years
- Credit of 25 MOC part 4
- Over 20 CME/CE credits

Training Site

A comprehensive medical center or children's hospital that treats a high annual volume of pediatric patients (>10,000) and has an established clinical quality, patient safety, and risk management program.

Affiliate Sites

Any ED/acute care hospital (may be a free-standing or satellite ED) that agrees to work closely with a Training Site to implement a pediatric QI program in their emergency department.

PEDIATRIC CHAMPION

A physician and/or nurse at an Affiliate Site, identified by the site's Hospital Administrator and ED Leadership, who agrees to implement a pediatric QI program and participate in associated team-based activities.

TRAINER

A physician and/or nurse at a Training site, who serves in the role of PECC, disseminates educational content to Affiliate Sites, and prepares Pediatric Champions to develop and implement a pediatric QI program.
Vision: Inspiring a lifetime pursuit of learning to improve child health

Mission: Advancing child health by certifying pediatricians who meet standards of excellence and are committed to continuous learning and improvement
Boards Overview

• Creating a home where clinicians can find many projects that fit there work and passion

• Set standards for what meaningful participation in MOC means

• Provide credit MOC for projects that have been completed

• Give ability for MOC credit for single clinician, group, hospital projects, or QI oversight of projects

• Created streamlined process for projects to be electronically submitted.

• Work with societies at any phase of project planning and implementation of project to assure project meets requirements

• Provide media toolkit to promote project eligible for credit.
Meaningful involvement:
In order to receive credit, each diplomate attests to meaningful involvement in the work, by meeting all criteria below:

- Be intellectually engaged in planning and executing the project.
- Participate in implementing the project's interventions (the changes designed to improve care).
- Review data in keeping with the project's measurement plan.
- Collaborate actively by attending team meetings.
The Pediatric Readiness Quality Collaborative (PRQC)

Sponsor:
Texas Children's Hospital

Description:
The Pediatric Readiness Quality Collaborative (PRQC) is a two-year, grassroots initiative focused on front line providers in the emergency departments. Sixteen teams across the United States will collaborate to improve their EDs level of pediatric readiness and overall capacity to provide pediatric emergency care. The collaborative will focus on the following: 1) A patient safety initiative focused on collecting and documenting pediatric patients' weight in kilograms; 2) Developing a notification process for abnormal vital signs; 3) Ensuring inter-facility transfer guidelines are patient and family centered; 4) Establishing disaster plans that include children. This QI activity is only open to members of the PRQC.

Completion Criteria:
The requirements for the Pediatric Readiness Quality Collaborative are as follows: - Be actively involved in the project for 8 consecutive months. - Attend the designated number of clinic/department meetings where data is reviewed and interventions are discussed. The designated number of meetings will be dictated by the Pediatric Champion. - Provide direct or consultative care to the target patients in the emergency department. - History of completing QI education.

Activity Contact:
Xuan Tran
Phone: (832) 824-1164
Email: xtran1@texaschildrens.org
Pediatric Portfolio Sponsor

Get **MOC** credit for the **QI** work you are already doing!

PROUD to be an ABP PEDIATRIC PORTFOLIO SPONSOR!
Thank You All

Questions?