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Every Day Is "Kid's Day"

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Each year when Mother's Day and Father's Day would come around, my siblings and I would begin our annual query (a.k.a. whine) of our folks about why there was no "Kid's Day." Each year, without fail, my mother would give the four of us the same answer: "Because, every day is kid's day." This of course was met with eight eyeballs all rolling in different directions, a unison of groans and at least two of us dramatically falling to the ground to physically demonstrate our disbelief. How was it fair that kids never got a day of their own that started with breakfast in bed or that carried the promise of no house or yard work? Where was that special day that showered us with fine, handmade gifts crafted from rocks, popsicle sticks or egg cartons? It just was not fair and we knew we were being wronged. But, what we didn't realize at the time was that while we were being wronged, it was for the right reasons.

Two years ago when I took over as the president of AAP-CA Chapter 2, the latest data available showed that some of California's children were being wronged.

Here's how things stacked up for our state's youth:

- While close to 87% of children from birth to 5 years had been breastfed at some time[1], 31% of California's children and teens ended up being overweight or obese; likely related, 58% of kids 12-17 years of age were watching 2 or more hours of TV on weekdays and close to the same percentage did not regularly exercise.[2]

- While the percentage of kids with asthma held steady at 8%[1], 19% of California's children were living in a household where someone smoked and 7% of 12 to 17 year olds reported using cigarettes themselves in the prior month.[2]

- While 30% of California's children between 4 months and 5 years were judged to be at risk for developmental or behavioral problems based on parental concerns, only 14% of kids between 10 months and 5 years were receiving standardized screening for developmental or behavioral problems and only 54% of those whose problems required counseling were receiving mental health care.[2]

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➢ While 80% of children had dental insurance[1] and 87% had received a preventative dental visit in the prior year, the percentage of children with very good or excellent oral health came in at 63.5%.[2]

➢ While 90% of California's children were insured in 2007, by 2009 that number decreased to 86.6% with 38% of the continuously insured group relying on either MediCal or Healthy Families and less than half were covered by employer-based plans.[3]

➢ While 87% of our youth had received a preventative medical visit in the year prior to 2007[1], only 77% of our 2 year olds were fully immunized[2] and some southern California schools reported vaccine exemption rates for entering kindergarteners in 2008 as high as 82%.[4]

➢ While the No Child Left Behind Act had been in place since 2001, only 38% of California's third graders scored "proficient" to "advanced" on the California Standardized Reading test in 2008 and 20% of our high school students had dropped out;[1] it probably didn't help that only 36.5% of children ages 0-5 were being read to every day by their families.[2]

➢ While the percentage of very low birth weight infants has remained close to 1% for the past 8 years, 14% of our children had special health care needs in 2007[1] but only about 50% of our kids had access to a medical home.[2]

➢ Finally, though 73% of California youth between 6-17 years were participating in activities outside of school and over 95% of them had two or more social skills[2], 10% of our 12 to 17 year olds were binge drinking[1] and 90% of our 12 to 20 years olds drinkers were getting their alcohol from others.[5]

Two years later I wish I had the figures to prove that California's youth are better off because of what Chapter 2 did but the data doesn't exist. Even if it did, a two year period is not long enough to reassure ourselves that the positive changes are here to stay, and everyone knows there will always be threats to the well-being of kids. But, what I can prove is that for every area where our kids were being wronged, a Chapter 2 member was working every day to make it right. I can prove that because of the collective efforts of our Chapter members, gains were made and ground was held. I can prove that Chapter 2 made every day "Kid's Day."

Now, back to those four whiney kids who demanded a "Kid's Day" from their parents and the Chapter president who expected a "Kid's Day" from its members: thank you, Mom and Dad, for making every single day of our lives "Kid's Day" and thank you to my colleagues for making every single day of your professional lives "Kid's Day." It has been a true pleasure and honor to be a part of this endeavor.

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Vaccine Refusal: Teaching Residents How to Respond

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Overall rates of immunization for children ages 19-35 months in California are at or near 90%. In spite of these high rates of vaccination, the state continues to experience outbreaks of vaccine preventable diseases in localized areas. San Diego had 12 cases of measles in 2008 and San Francisco had cases earlier this year. Pertussis appears to be on the rise in the Central Valley and a mumps alert was issued in January of this year warning of possible spread from an outbreak in New York, New Jersey and Canada. Many of these outbreaks have occurred in locales where there are pockets on un-immunized of under-immunized children.

The number of children who present to kindergarten without routine immunization has been increasing since 2000. Attendance is permitted if parents request a "personal belief exemption" (PBE) that frees them from the requirement of vaccinating their children. Between 2000 and 2008 the rates of PBEs in California increased from 0.7% to 1.9% and the percent of schools with greater than 10% PBEs increased from 2.6% to 6.8%. (Presented at the 44th National Immunization Conference by Theresa Lee MPH of the CDPH, Immunization Branch)

Outbreaks of vaccine preventable diseases have largely come from these schools. Analysis of schools where PBEs are prevalent indicates that they tend to be public charter schools and non-catholic private schools in affluent areas where the parents are well educated. (LA Times March 29, 2009).

The primary concern of these parents is that vaccines are not safe. This fear is an increasingly significant barrier to immunization.

One approach to reduce parental concerns is to improve the training of physicians so that they are able to more effectively communicate with parents regarding the risks and benefits of vaccines.

In 2009, the AAP-CA Foundation of AAP California District IX (Children's Health Systems Inc.) partnered with UC San Diego, UC Davis, Stanford University and Childrens Hospital Los Angeles in applying for a grant offered by the American Recovery and Reinvestment Act (ARRA), "Partnerships to Address Immunization Training and Information Needs of Health Department Staff, Coalitions, Nurses, and Medical Residents."
The proposal submitted in response to the RFA focused on training of medical residents to effectively communicate information on vaccine safety to parents. The proposal was successful and was funded for 2 years.

Resident education on immunizations occurs during rotations in clinics and other primary care settings and through didactic lectures presented during conferences. Most training programs lack a formal curriculum on immunizations. A major goal of this project was to develop a consistent evidence-based curriculum that could be applied in many programs across the nation.

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As an initial step in this process, an assessment of what is currently being taught in this area was necessary and what residents, residency directors and practicing physicians felt would be the most effective methods to inform trainees regarding vaccine safety. To accomplish this 6 focus groups that included pediatric, family medicine and internal medicine residents were held as well as 3 focus groups with practicing pediatricians. In addition an online survey was held with 150 residents and individual interviews we done with several residency directors. The programs selected for the focus groups were geographically diverse.

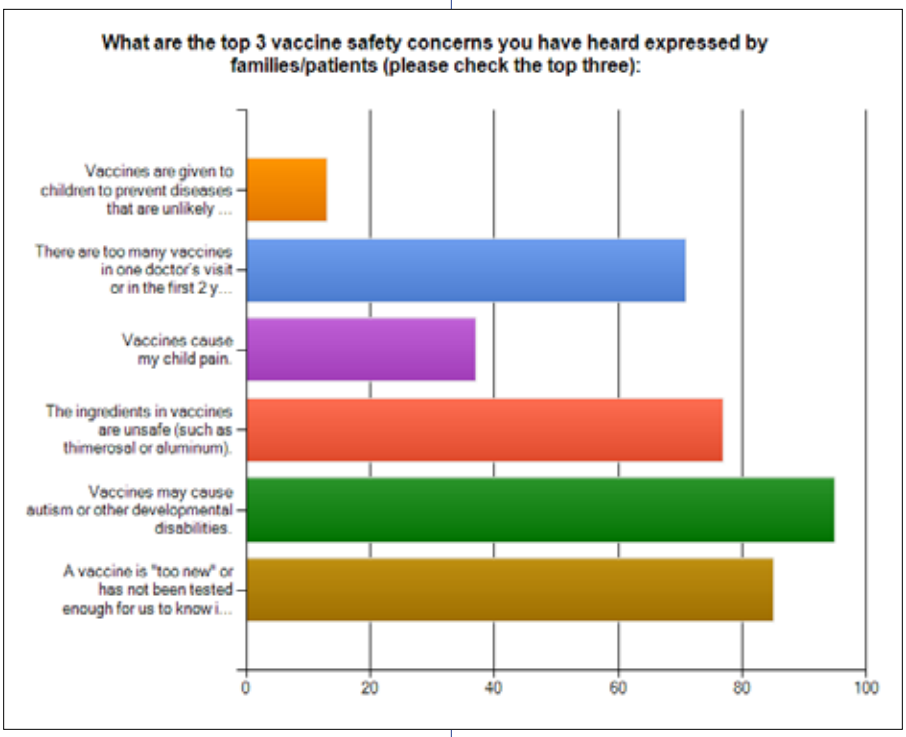

Fig. A

The results of the analysis are not complete but some of the information from residents was very enlightening.

The top vaccine safety concerns of families as perceived by residents were the fear of the development of autism or other developmental disabilities, some vaccines are too new and untested (especially with respect to the H1N1 vaccine), ingredients in vaccines are unsafe. *(Fig. A)*

Do residents perceive that they have learned vaccine safety concerns in their program? One third responded yes, 22% said no and 44% responded somewhat.

What teaching methods did residents prefer? About 70% preferred in-person didactic lectures, 50% were interested in role-modeling exercises, and 40% liked written materials. Slightly over 30% preferred online modules. Finally, did residents want to learn more about vaccine safety concerns in their training? Resoundingly, 84% said yes and only 8.6% said no.

Using the information from the focus groups and survey, the study group is now building both online and didactic curricula that will be tested in medical school settings.

Members of the research team include Dr. Mark Sawyer of UCSD who is leading the project and whose experience at UCSD in developing a training curriculum for immunization there has been crucial to the project. The project evaluation is headed by Dr. Bonnie Maldonado of Stanford and other participants include Drs. Jeffery Luther, Richard Pan, Clea Sarnquist, and Dean Blumberg. Kris Calvin CEO of AAP California and Children's Health Systems Foundation has been responsible for the focus groups, online survey administration and data collection and analysis so far.

Results of the work so far were presented at the 44th NIC meeting in Atlanta, Georgia in April of this year.

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"Reach Out and Read" Los Angeles: Improving Literacy One Book at a Time

Kathleen Swec, MD, FAAP
AAP California, Chapter 2 Liason, Reach Out and Read

Many of you are already familiar with *Reach Out and Read*, but for those of you who are not, here is a brief background. *Reach Out and Read* was developed two decades ago by pediatricians and early childhood educators to make literacy a part of routine pediatric care so that children enter school prepared to succeed. In the *Reach Out and Read* model, pediatric providers use the opportunity of the well-child visit between ages 6 months and 5 years to discuss with parents the importance of reading to their child on a routine basis. At these visits, young children are also given an age and culturally-appropriate book to take home. Fourteen published, peer-reviewed studies clearly demonstrate that *Reach Out and Read* is effective in promoting a literacy rich home environment and in enhancing early language development.

There are several advantages to participating in *Reach Out and Read* apart from the immediate benefits described above. Observing young patients interact with their new book in the office offers a wonderful opportunity to assess developmental milestones. For those young patients with developmental delays including autism spectrum disorders, *Reach Out and Read* can facilitate literacy development by making reading an anticipated part of the daily routine and encouraging joint attention, pointing, rhyming, singing, and sharing emotions. *Reach Out and Read* is also currently working with the *American Board of Pediatrics* in an effort to make participation in *Reach Out and Read* quality improvement measures satisfy the Part 4 Maintenance of Certification requirement. An update on the status of that development will be available this summer.

In the Los Angeles area, there are currently 119 clinics that participate in *Reach Out and Read*. Through these Sites, more than 155,000 books were distributed to young patients last year. The ultimate goal of *Reach Out and Read* is to ensure that pediatric providers give literacy-related advice and children's books as routinely as immunizations. For those of you who are currently participating in *Reach Out and Read*, thank you for your sustained dedication to such an important cause. I look forward to working with you as the new Chapter 2 liaison for *Reach Out and Read*. For those of you who would like more information about becoming a *Reach Out and Read* Site, please contact me at kathleenomara@yahoo.com.

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Mental Health Care in Pediatrics: Is True Parity on the Way?

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Chair, Pediatric Practice Committee, AAP California, Chapter 2

All of us in general pediatrics struggle to provide screening, assessment, diagnosis and treatment of mental health problems in our patients. Research statistics tell us that 1 in 5 of our patients has a mental health disorder, but the majority of these children and teens do not get the services they need. Many are undiagnosed, and those that are evaluated too often have trouble accessing proper pediatric mental health care. Most of these patients receive services from their primary care provider rather than a mental health specialist. We are not only the first responders for most of these children, but we can often be their mental health care provider and may be their only hope for this care. The shortage of adequately trained and credentialed pediatric mental health providers, together with the fact that health plans often have limited contracts with appropriate pediatric providers, are a significant part of the problem.

We are being asked to do more and more screening for developmental and mental health disorders. These screening tests, which involve some expense to obtain or administer and time from us and our staff, are not currently being reimbursed adequately by most insurance payers. Despite using the proper "limited developmental screening" codes (96110, with a modifier), or for mental health screens the "health risk assessment screening" code (99420, with a modifier), payers routinely deny these charges or make them the family's responsibility to pay.

When we identify a mental health problem needing a referral for specialty care, we are hamstrung by a mental health care system that often forces us to refer our patients into the plan's "black box of mental health providers"—groups or individuals whom we don't know, with whom our communication is nonexistent or very limited, and who may not be the best provider for our kids. This is not how we would choose to refer our patients for medical problems, so why should we tolerate it for mental health care? Like many diseases, mental health problems in children are often the harbinger of adult mental health disorders; and identification and proper treatment in childhood has the potential to reduce or prevent adult psychiatric disorders. But these facts do not seem to be enough to force reform in the insurance industry with regard to mental health care.

Payers don't seem to be motivated by saving money down the road, but instead concern themselves more with cutting costs today. They claim that the market forces them into this position, and it probably does. Never mind that there is evidence that improving access to appropriate mental health care today can save money in healthcare expenditures sooner rather than later[1]. The federal Mental Health Parity and Addiction Equity Act of 2008 (Wellstone and Domenici) which took effect in October 2009 requires that dollar coverage be equivalent between mental and medical benefits—for those plans that offer mental health benefits (plans for businesses employing less than 50 people and individual health plans are exempt). California's Mental Health Parity law enacted in 1999 (AB88) requires plans to offer mental health benefits, but requires this only for "serious mental illnesses" and not all mental health problems. Though these laws

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have improved access and coverage for some mental health problems, significant problems remain.

Current legislation fails to address the major problem of inadequate reimbursement for mental health care. This is the primary reason that many pediatric mental health providers do not contract with these plans. For the amount of time these specialist providers spend managing their patients they are paid at much lower rates than reimbursement for the same time and degree of work we spend on medical problems. This is effectively a subtle form of discrimination against these patients, and is a major barrier to our patients seeking properly trained and effective providers.

Another major problem we face is the health plans that "carve out" mental health care exclusively to their panel of specialists. When I see a child for any mental health diagnosis (including ADHD care or the initial evaluation of complaints that are from any mental health problem), many plans deny payment for the visit because I am not a mental health provider. Payers don't seem to care that I cost them much less than a mental health provider and that I can often triage and manage the milder mental health problems and spare them visits with a specialist. Of course they save even more money when they don't pay at all. In addition, plans often deny visits for a mental health problem where a formal diagnosis has not yet been made (the "V codes" or "problem" codes, such as "anxiety problem" or "inattention problem"). We are forced to dance around these rules and creatively code for the visits so they will get paid. Denying payment for the visit leaves me with the choice of eating it or charging the family to pay out-of-pocket.

Unless federal health care reform includes mandates for improved coverage for minimum mental health benefits, we must continue to advocate for better state laws and better insurance plan policies to improve how our children get the care they need. We will continue to be the main source of mental health care for our patients, as the shortage of pediatric mental health specialists is expected to worsen.

The Pediatric Council in California recently took up this issue with the health plan medical directors to educate them about these problems and attempt to get them to look at their internal policies that represent obstacles to proper mental health care. At the outset we are pushing for improved reimbursement for screenings and for primary care visits for mental health problems, and better communication and coordination between PCPs and mental health specialists. Our advocacy efforts in California will merge with efforts on the national level since the AAP's Task Force on Mental Health, along with the American Academy of Child and Adolescent Psychiatry, released its review of this subject in March 2009[1]. This report takes up many other issues that would improve care such as: supporting "collocation" of mental health providers in the same offices as primary care providers; paying for care coordination along with telephone care for these patients; and better reimbursement for evidence-based non-medication interventions as well as psychopharmacologic treatments. From our vantage point in the present system many of these ideals seem utopian and perhaps not achievable, at least not in the near future. But these have to be more than a dream if we want to do the best we can do for our patients afflicted with mental health disorders. We must continue the fight. Like any good fight, we do need more soldiers! If you are interested in helping with this effort and being a part of the solution notify us through Marissa Green, our Executive Director. At least we can claim the better part of logic and magnanimity on our end.

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The Medical Leadership Council: Improving the Delivery Process

Elliot Weinstein, MD, FAAP
Representative, AAP District IX

The Medical Leadership Council is a collaboration of organizations that meets twice a year to discuss issues relating to cultural, access and language barriers to medical care. The most recent meeting was held at the California Endowment headquarters in Los Angeles held on November 18, 2009.

Presentations were made by several groups, detailing projects, reports and best practices. San Joaquin County Medical Society discussed their Decision Medicine Program which was developed to encourage minority high school students to get involved and interested in medical careers. Health Information Technology and Healthcare Reform updates were given. San Francisco Medical Society, UCSF and San Francisco State University representatives gave a report on Lesbian, Gay, Bisexual and Transgender (LGBT) People. The following discussion highlighted the problems the LGBT individuals face when attempting to get health care, as well as some of their specific needs and difficulties. Resources available to help the practitioner with these issues can be found at www.lgbt.ucsf.edu

Medi-Cal has also published a series of booklets to guide patients through the maze of Medi-Cal managed care and Healthy Families Plans. These are available in English, Spanish, Korean, Hmong, and Chinese. Sources for interpreter services are given in these booklets. These are available from Medi-Cal offices in all counties that have these plans.

At future meetings, residents and medical students will be invited to attend. I hope to have a resident in pediatrics join me this May.

Best Bones Forever!
A Bone Health Campaign for Girls

Office on Women's Health
Dept. of Health and Human Services

Osteoporosis is a pediatric disease with geriatric consequences. In terms of bone health, the stage is set early on: girls build close to 90% of their bone mass by age 18. Once they reach adulthood, it becomes increasingly difficult for them to make it up. Unfortunately, most adolescent girls do not get the calcium, vitamin D, and physical activity they need to grow strong, healthy bones.

That's why the U.S. Department of Health and Human Services' Office on Women's Health (OWH) launched *Best Bones Forever!*, a national bone health campaign for girls ages 9-14. Best Bones Forever! focuses on friendship and fun–and encourages girls to "grow strong together, stay strong forever."

The new campaign empowers girls and their BFFs (best friend forever) to build strong bones by choosing snacks and foods with calcium and vitamin D, and getting an hour of physical activity a day.

Campaign materials such as journals, posters, magnets, tattoos, book covers and a website, www.bestbonesforever.gov, get girls excited about bone health with recipes, tips, and fun activities. Parents can get important bone health information from a brochure in both English and Spanish, from the website: www.bestbonesforever.gov/parents

Help make an impact by taking just a few minutes to discuss bone health with your young patients and their parents. If you are interested in ordering our free *Best Bones Forever!* materials, please contact Talia at owh@hagersharp.com

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Wanted: A Pediatric Medical Center in the San Fernando Valley

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In Los Angeles County, there are three voluntary designations for hospitals, whose Emergency Departments receive sick or injured children by ambulance. The most basic designation is Emergency Department Approved for Pediatrics (EDAP) which is an ED approved by Los Angeles County, Department of Health Services, Emergency Medical Services (LAC DHS EMS) Agency to receive sick children transported by ambulance after a 911 call. The highest level is the Pediatric Trauma Center (PTC), which has an ED which is an EDAP, a pediatric intensive care unit (PICU) which cares for the sickest children, and a designated pediatric trauma center. In the middle is the Pediatric Medical Center (PMC) which takes sicker, but not injured children with the hopes of avoiding a secondary transport to a higher level of care. Along with being an EDAP, the hospital's PICU will meet certain requirements. Thus, a PTC is also a PMC; but the reverse is not necessarily true.

There is one free standing PMC that is not a PTC, which is Huntington Memorial Hospital in Pasadena. Of the EDAPs, there are now 44 with the recent addition of Sherman Oaks Hospital at the beginning of this year. Two of the EDAP are just outside of LAC. There are 6 PTC's: Cedars-Sinai Medical Center, Children's Hospital Los Angeles, LAC Harbor/UCLA Medical Center, LAC USC Medical Center, and Long Beach Memorial Medical Center, and Ronald Reagan UCLA.

Because there are no PTC's or PMC in the San Fernando Valley, LAC DHS EMS Agency studied the impact of having a PMC there. It is hoped that at least one of the three EDAPs with a PICU in the San Fernando Valley, Northridge Hospital, Providence Tarzana, or Valley Presbyterian, will become a PMC to reduce the number transports out of the valley.

Looking at 2008, there were 2,069 EMS pediatric transports in the San Fernando Valley with pediatrics being defined as age 14 years and under. Of those transports, 344 patients (17%) were transported to PTC/PMC with 1725 patients (83%) staying in the valley. Further analysis of the 344 patients that were transported out of the SF Valley showed that 119 (35%) met criteria to be transferred to a PTC, whereas 111 (32%) met criteria for transport to a PMC. The remainder of the patients were transported for other reasons, specifically base hospital judgement. The ambulance contacts their base hospital and based on a variety of factors may be directed to take a patient to a specific location.

Projecting from the transport criteria, it is estimated that if a PMC existed in the SF Valley in 2008, then 148 pediatric transports (43%) of those 344 patients would have been directed to that hospital. To place that in perspective, most patients transported by ambulance to EDAPs do not get admitted to the hospital. It has been found that most patients that require hospital admission 'walk-in' or get driven in by a private conveyance. Thus, it cannot be assumed that all 148 patients would end up being admitted even though they were deemed sicker at the time of initial transport. One hundred and forty-eight patients translates into approximately one extra pediatric patient every 2 to 3 days, if there was one PMC in the valley and less than that, if there were more San Fernando Valley PMCs.

The impact on the SF Valley community would be a decrease in prolonged transport times and helicopter transports for their pediatric patients who were evaluated after calling 911. Also if the ED visit resulted in a hospital admission, then that child would potentially be hospitalized closer to their home.

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Quality Measurement: In the Eye of the Beholder?

Glenn Takata, MD, FAAP
Alan Lieberthal, MD, FAAP
Steering Committee on Quality Improvement and Management (SCOQIM)

Is quality, like beauty, in the eye of the beholder? As the late Supreme Court Justice Potter Stewart once said of another topic, "…I know it when I see it." Is that also true of quality, and do we want quality, like beauty, to be dependent upon subjective assessment? Quality, unlike beauty, in fact, may not be evident unless measured. In pediatric healthcare the quality of the care we provide may not be evident until later in a child's life, for example the longitudinal course of a child's growth curve, the attainment of developmental milestones over time, and ultimately the role of a child's health in her ultimate contributions to society as an adult, i.e. if you agree with these definitions of health. Unlike beauty, quality must be measured to compare against a standard of care, whether our own or of an external organization, to assess quality among peers, or to gauge the improvement of one's own practice over time.

The American Academy of Pediatrics has chosen Quality as one of the three strategic pillars of the Academy, along with Access to Healthcare and Finance. In the Academy's policy statement *Principles for the Development and Use of Quality Measures*[1] Quality is defined as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge." Various national reports indicate a need to improve the Quality of healthcare provided to children, including the Commonwealth Fund's *Quality of Health Care for Children and Adolescents: A Chartbook, The National Healthcare Disparities Report*, and the *National Healthcare Quality Report*.

What should quality measures assess? The Academy recognizes the traditional quality components of structure, process, and outcome. *Structure* measures elements such as how many pediatricians per 100,000 children practice in a certain locale. *Process* measures elements such as what proportion of children with asthma in a practice have an asthma action plan. *Outcome* measures the actual health status of children such as what proportion of children with asthma were hospitalized for status asthmaticus, an intermediate outcome, and how many school days on average a child has missed in a year. Structure and process measures must have an evidence-based link to a health outcome.

The Academy also ascribes to the Institute of Medicine's six dimensions of quality and the Foundation for Accountability's consumer perspectives on healthcare needs. The elements of the IOM and FACCT models are melded in the following matrix. *(Fig. B)*

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Fig. B

National Health Care Quality Report Matrix: Combines 4 of the IOM Health Care Quality Components and the FACCT Consumer Perspectives on Health Care Needs, With Equity as the Third Dimension

Consumer Perspectives on Health Care Needs	Components of Health Care Quality			
	Safety	Timeliness	Effectiveness	Patient-Centeredness
Staying healthy	Fluoride only when needed	Access to well-child care	Immunizations	Social history assessment
Getting better	Drug-allergy check before prescribing medications	Access to urgent care	Appropriate antibiotics for upper respiratory infections	Family involvement during hospital rounds
Living with illness or disability	Medication reconciliation	Access to long-term care	Inhaled steroids for persistent asthma	Family involvement in developing long-term plan of care
Coping with the end of life	Avoid unnecessary painful interventions	Access to hospice care	Effective end-of-life pain management	Advance directive

Components of health care quality include (1) safety: "avoiding injuries to patients from care that is intended to help them"; (2) effectiveness: "providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit (avoiding overuse and underuse)"; (3) patient-centeredness: establishing "a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences"; and (4) timeliness: "obtaining needed care and minimizing unnecessary delays in getting that care." Consumer perspectives on health care needs include (1) staying healthy: preventive care; (2) getting better: acute care; (3) living with illness or disability: chronic care; and (4) coping with the end of life: end-of-life care. Equity is "a crosscutting issue" that is "the provision of health care of equal quality to those who may differ in personal characteristics that are not inherently linked to health, such as gender, ethnicity, geographic location, socioeconomic status, or insurance coverage" and means that "quality of care is based on needs and clinical factors."

Source

Steering Committee on Quality Improvement and Management and Committee on Practice and Ambulatory Medicine, American Academy of Pediatrics. *Principles for the Development and Use of Quality Measures*. Pediatrics 2008;121:411-418.

The IOM's equity dimension serves as a crosscutting aspect of quality and is one of the AAP's universal principles, and efficiency is addressed separately.

The Academy also ascribes to the following principles for quality measures development:

- Pediatric quality measures should address important issues for children.
- Pediatric quality measures should be appropriate for children's health.
- Pediatric quality measures should be scientifically valid.
- Pediatric quality measures should be feasible.
- Pediatric quality measures should address what can be improved.

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The reality is that quality measures are being used to hold pediatricians accountable to standards of care such as Bright Futures, as a requirement for Maintenance of Certification by the American Board of Pediatrics, and as a pre-requisite for pay-for-performance incentive payments by insurance companies. Most importantly, many pediatricians are independently employing quality measures to improve the quality of care they provide their patients, e.g. in the AAP-CA2's Early Developmental Screening Initiative Collaborative. Currently, a virtual alphabet soup of organizations and quality measures exist.

The Academy has been actively involved in all aspects of the quality measures explosion. The Academy's Steering Committee on Quality Improvement and Management (SCOQIM) has served as the focus of these activities. For several years, SCOQIM has reviewed measures from external organizations. Academy members have represented the Academy's interests at meetings of national measurement organizations and medical societies addressing measurement issues. SCOQIM tracks the growth in pediatric quality measures. SCOQIM is actively involved in the current CHIPRA (Children's Health Insurance Program Reauthorization Act of 2009) pediatric quality measures efforts. SCOQIM members, including Allan Lieberthal, are involved in the NQF Child Health Outcomes project to identify key outcome measures for children. Finally, SCOQIM has been collaborating with the AAP's COCIT (Council on Clinical Information Technology), PPI (Partnership for Policy Implementation), COCN (Committee on Coding and Nomenclature), SOAPM (Section on Administration and Practice Management), and QUIIN (Quality Improvement Innovation Network) to further the Academy's quality measures efforts.

Quality Measures Acronyms

AMA-PCPI
American Medical Association Physicians Consortium for Performance Improvement

APQ
Alliance for Pediatric Quality

AQA
Ambulatory Care Quality Alliance

CAHMI
Child and Adolescent Health Measurement Initiative

CHIPRA
Children's Health Insurance Program Reauthorization Act of 2009

HEDIS
Healthcare Effectiveness Data and Information Set

MIG
SCOQIM Measurement Interest Group

NCQA
National Committee for Quality Assurance

NICHQ
National Initiative for Children's Healthcare Quality

NQF
National Quality Forum

P4P
Pay for Performance

SCOQIM
Steering Committee on Quality Improvement and Management

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SCOQIM created the Measurement Interest Group (MIG) in 2006 calling for a broad range of AAP Fellows with expertise in quality improvement from all disciplines and subspecialties to accomplish the following goals:

- Review and comment on draft measures
- Share and discuss summary reports of national measurement committees, i.e. AMA-PCPI, APQ, AQA, NCQA, NQF
- Identify priority areas for measurement and assess current gaps
- Volunteer for various national measurement organizations and subcommittees

The MIG was successful in meeting all these goals and has embarked on an aggressive agenda to further the Academy's leadership in quality measures on behalf of its members.

Pediatric quality measures are coming from all directions, including the AMA-PCPI, the NCQA, the NQF, CAHMI, CHIPRA, and various insurance companies with pay-for-performance programs. The following are examples of some of these measures.

Asthma is high on every measure developer's list of important, common and costly illnesses both for children and adults. The NCQA has been working on new asthma measures for the past 2 years. Recently there was a public comment period for 7 measures of asthma care including an annual visit in which asthma impairment and risk are evaluated, the use of controllers in patients with persistent asthma, and a written asthma plan for patients seen in the ED. NCQA is also testing a set of measures of well child care at various ages. Among these are measures of appropriate developmental screening and anticipatory guidance. If accepted some or all of these measures will become part of the HEDIS which is used to compare health plans.

AMA-PCPI develops numerous measures. Measures for pediatrics include care for OME based on the 2004 AAP/AAFP/AAO guidelines and for acute gastroenteritis. In the near future AMA-PCPI will be proposing performance measures on the care of children with ADHD.

CHIPRA, the federal law reauthorizing the Healthy Families programs, requires a core set of measures to be used to evaluate care received by these patients. The 2010 core measures set primarily includes HEDIS measures currently in use. The law requires that the CHIPRA measures be updated in 2013. The AAP is actively working to influence the updated CHIPRA measures to a set that will fairly evaluate important aspects of pediatric care.

Quality and performance measures will ultimately affect all physicians. Exactly how they will be used is still being debated, although many insurers already use them in pay for performance (P4P) programs. Measurement is also an essential ingredient of MOC Part 4. It is the Academy's goal to play a major role in what measures are developed and how they will be used.

We hope this brief introduction will help you as you hear more about this aspect of the future of medical care. Currently AAP-CA2 has 2 of its members on the SCOQIM, both actively working on the national AAP's measurement program. If you have questions please contact Glenn Takata (gtakata@chla.usc.edu) or Allan Lieberthal (allan.s.lieberthal@kp.org).

Reference

1. Much of the conceptual information presented in this article is from the AAP's *Principles for the Development and Use of Quality Measures* (Pediatrics 2008;121:411-418).

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2009 - 2010

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2009 - 2010 · appointed positions, except Nominating Committee

Committees and Task Forces are the lifeblood of a successful organization. They focus on specific areas of interest and thrive on the interest and dedication of its members in accomplishing its goals.

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for your information

Chapter 2 Election Results!

In May, voting fellows of *AAP-Chapter 2* cast ballots to elect Officers and Members-At-Large to serve on the Board of Directors for the **2010-2012** term.

Congratulations to the new Officers and Members-At-Large who will begin leading the Chapter on July 1, 2010:

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