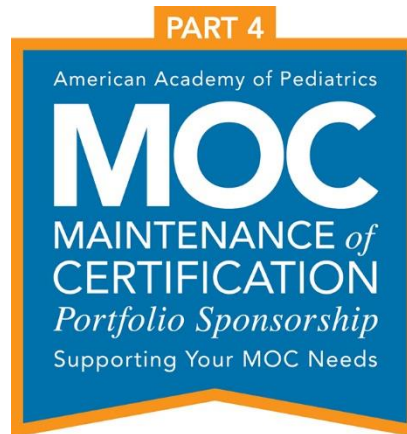




American Academy of Pediatrics Application for Maintenance of Certification Part 4



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

Jill Healy, MS
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American Academy of Pediatrics
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INSTRUCTIONS:

Use this form to describe a quality improvement project seeking approval by the American Academy of Pediatrics as a Maintenance of Certification activity.

- Be sure you review Appendix B and related American Board of Pediatrics *Standards and Requirements for Quality Improvement Projects* before you complete this form.
- This form should be completed by the Quality Improvement Project Leader.
- To apply for MOC Part 4 Credit through the AAP, you must use this form and address all items. Incomplete forms will not be accepted.
- Please be concise.
- Submit your completed form to Jill Healy, MS, Manager, Quality Improvement and Certification Initiatives at jhealy@aap.org.
- The initial review of your application will take place within 2-4 weeks of submission.

DESCRIPTION OF QUALITY IMPROVEMENT EFFORT

1. Date of Application **December 30, 2016**
2. Title of quality improvement effort: **Early Hearing Detection and Intervention (EHDI) Quality Improvement Project, Phase 2**
3. Type of quality improvement efforts:

- Continuous Quality Improvement (CQI)
- FADE
- IHI Collaborative Model
- LEAN
- Model for Improvement (PDSA/PDCA)
- Six Sigma (DMAIC)
- Total Quality Management (TQM)
- Other

4. Status of the quality improvement effort at the time of submission:

- Beginning
- Completed
- Ongoing with a planned end date
- Ongoing with no planned end date

Start date of the quality improvement effort: **January 5, 2017 (orientation webinar and baseline data collection begins; action period begins on February 1)**

End date of the quality improvement effort: **September 1, 2017 (last action period data due on August 1; post-project feedback call and post-project feedback survey will take place in August)**

5. Project Leader
 1. Name:
 2. Title:
 3. Institutional/Organizational Affiliation:

4. AAP Group Providing Oversight to this Project: AAP Division of Children with Special Needs; EHDl Quality Improvement Project Expert Group
5. Phone:
6. Email:

Attach or include a brief bio of the Quality Improvement Project Leader highlighting experience and expertise relevant to quality improvement.

INSERT BIO HERE

6. Project Staff
 - Name:
 - Email Address:
 - AAP Group:
7. Has the quality improvement effort been approved by one or more participating ABMS Boards?
 - Yes
 - No

Please list which Boards: [Click here to enter text.](#)

8. How is the quality improvement effort funded?
 - Grant
 - Internal
 - Pharma or device funding
 - Subscription
 - Other

Is funding for quality improvement part of the organization's annual budget?

- Yes
- No, the AAP EHDl Program is funded through a cooperative agreement with the Maternal and Child Health Bureau, Health Resources and Services Administration.

CLINICAL TOPIC

1. 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. Hearing loss is one of the most common congenital conditions appearing in infants and children. In 2012, it was found that of the newborns who underwent newborn hearings screening (96.6% of infants born), 1.6% of newborns did not pass their most recent or final newborn hearing screening and two to three infants per 1,000 live births born deaf or hard of hearing (D/HH).¹² Additionally, significantly

¹ Vohr, B. Overview: Infants and children with hearing loss—part I. Mental Retardation and Developmental Disabilities Research Review. 2003; 9:62-64.

² CDC. Identifying infants with hearing loss—United States, 2006 – 2012. MMWR Morbidity and Mortality Weekly Report 2015; 64(13); 351-356.

more children are at risk for delayed or late-onset hearing loss due to genetics, infection, and complication after birth, among other risk factors.² Numerous studies have shown that hearing loss is associated with significant delays in language development and academic achievement, even for children diagnosed with mild or moderate hearing loss. However, early identification and implementation of the appropriate intervention for a child who has been diagnosed as D/HH, have been associated with improved language, social, and academic outcomes.³⁴ The number of children considered lost to follow-up or lost to documentation (LTF/D) following a do not pass newborn hearing screen has decreased from 47.7% to 35.9% from 2006 to 2012 respectively. Although these gains are significant, it is still crucial to diagnose children who may have, or be at risk for hearing loss by 3 months of age and enroll these identified infants into the appropriate early intervention programs by 6 months of age, according to the Joint Committee on Infant Hearing (JCIH) recommendations.⁵ The primary care pediatrician—the child/families' medical home—is an important player in this process for children who fail a newborn hearing screen or may be at risk for delayed or late-onset hearing loss. The medical home is the appropriate place in which the results of the newborn hearing screening should be discussed with the family, to assess the infant or child for risk factors for hearing loss, to refer the child for follow-up diagnostic hearing screening if necessary, and to develop an individualized care plan for a child who is diagnosed with, or at risk for childhood hearing loss.

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

Yes

No

What initiative? AAP EHDI Program

GOALS AND OBJECTIVES

3. 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 measurable goal within an identified timeframe.*

By July 2017, five pediatric offices will make practice-based improvements that lead to enhanced care across the delivery system and strengthen the role of the medical home within the EHDI system. The participating pediatric practices will make improvements so that:

-97% or more of all newborns have documentation of the results of their final newborn hearing screening in their medical records by 6 weeks of age

-97% of newborns have documentation in their medical record that the results of the newborn hearing screening were discussed with the family no later than 6 weeks of age

-97% or more of all newborns identified to have risk factors associated with hearing loss will

³ Yoshinaga-Itano, C, Sedey, AL, Coulter, DK, et al. (1998). Language of Early- and Later-identified Children With Hearing Loss. *PEDIATRICS*, 102(5):1161-1171.

⁴ Moeller, MP. (2000). Early Intervention and Language Development in Children Who are Deaf and Hard of Hearing. *PEDIATRICS*, 106(3). DOI: 10.1542/peds.106.3.e43.

⁵ Joint Committee on Infant Hearing. (2007). Year 2007 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs. *PEDIATRICS*. 120(4):898-921.

have documentation of those risk factors in their medical record by 6 weeks of age and will have an individualized care plan by the 4 months of age

-100% of children who do not pass their newborn hearing screening have completed an audiological evaluation by 3 months of age and documentation will be in their medical record by 4 months of age

Balancing Measure (to be included in Monthly Progress Report):

Think about how you handled EHDI care processes and the impact of the EHDI Quality Improvement Project. Because of this project, overall patient wait time has:

- Decreased greatly
- Decreased slightly
- Has not changed
- Increased slightly
- Increased greatly

4. What is the specific patient population for this quality improvement effort?

Practice teams will review charts for the following patient populations:

-All children at least 6 weeks old who their practice identified as having a “do not pass” newborn hearing screening result

-20 medical records for children at least 6 weeks old who passed the newborn hearing screening

-All children at least 4 months old who your practice identified as having a “do not pass” newborn hearing screening result

-20 medical records for children at least 4 months old who passed the newborn hearing screening

5. Select the IOM Quality Dimensions addressed as part of this quality improvement effort:

- Effectiveness
- Efficiency
- Equity
- Patient-Centeredness
- Safety
- Timeliness

6. 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.

The EHDI QI Expert Group developed project measures based on personal and professional experience as well as information gathered from the 2012 National Center for Hearing Assessment and Management (NCHAM) Physician Survey. This survey sought to measure pediatric clinician knowledge and practice regarding EHDI-related care.

The measures used in this phase of the project are the same measures that were used during phase 1 of the project, which was approved for MOC Part 4 credit.

See Appendix A for a full list of project measures.

- 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

7. 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 sample run chart and narrative reports, including the monthly progress report and pre/post implementation survey.

Are results provided to participants in the format selected above?

- Yes
- No

8. Sampling strategy:

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

Describe the sampling strategy:

During the baseline/prework period, which begins in January 2017, retrospective medical record

reviews will be performed on a sample of patients within the practice who are at least 6 weeks and 4 months of age. The practice teams will review medical records from the immediate past 3-months (November 2016 through January 2017) for all children at least 6 weeks old and 4 months old who they identify as having a “do not pass” newborn screening result. Expert group members expect that there will be less than 15 medical records total per practice over a 3-month period for children who did not pass the newborn hearing screening.

During the baseline/prework period, which begins in January 2017, the practice teams will also review a random sample of 20 medical records from the immediate past 3-months (November 2016 through January 2017) for children at least 6 weeks old and a random sample of 20 medical records from the past 3-months for children at least 4 months old who they identify as having passed the newborn hearing screening.

During the action period, practice teams will be asked to review the medical records of all infants ages 6 weeks and 4 months who they identify as having a “do not pass” newborn hearing screening result each month during the Action Period (February through July). This will likely be no more than 4 patient medical records per month per practice. Circumstances may exist when practice teams do not have the requisite number of patients at the 6 week or 4-month age frame who have a “do not pass” result on their newborn hearing screen.

Practice teams will also be asked to review the randomly selected medical records of 20 infants ages 6 weeks and 4 months (40 medical records total) who they identify as having passed the newborn hearing screening each month during the Action Period (February 2017 through July). These medical record reviews of newborns who have passed the newborn hearing screening will help ensure that the initial newborn hearing screening results are documented in the medical records of all infants, that the pediatrician discusses those results (whether the infant passed or did not pass the hearing screening) with all families, and that risk factors for late-onset hearing loss are discussed with families.

9. 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? Although the action periods will be two months in length (similar to Phase 1), data will be submitted by practice teams on a monthly basis to ensure that teams remain actively engaged in the project and are reviewing data on a monthly basis. Record review data will be submitted via the Quality Improvement Data Aggregator monthly. Progress reports will be submitted on a monthly basis via SurveyMonkey. In addition, a pre- and post-implementation surveys will be completed by practice teams at baseline in January and after the

action period in August 2017. Data will be due on the first of every month to give practice teams a full month to submit data. For example, baseline data will be due on February 1st and February data will be due on March 1st.

10. What is your system for data collection? Data will be collected in a number of ways, including: a pre- and post-implementation survey, record reviews, quality improvement coaching calls, and monthly narrative progress reports.

The pre-implementation survey will be disseminated to participants via Survey Monkey in January 2017 during the baseline data collection/pre-work period. The survey will provide baseline information on each practice's systems and processes related to early hearing detection and intervention.

The record reviews will be conducted on a monthly basis (except for baseline, which will include data over a 3-month period) on all patients ages 6 weeks and 4 months who did not pass a newborn hearing screening and 20 randomly selected records each for patients ages 6 weeks and 4 months who did pass a newborn hearing screening (at least 40 records total each month). All data will be entered into the AAP Quality Improvement Data Aggregator by the first of the following month to give practice teams a full month to review and enter data.

The monthly narrative progress reports will be submitted by the 1st of each month via Survey Monkey. The monthly progress report will provide the Expert Group and staff with additional information about changes tested within each practice using Plan, Do, Study, Act cycles, the impact/learning from the change, and the tools/resources from the project that were tested. In addition, the monthly progress reports will provide additional information related to biggest accomplishments each month, biggest barriers each month, and topics they would like to discuss via webinar or listserv. The report will also assess the project's overall impact on overall patient wait time (balancing measure).

Each practice team will participate in at least one quality improvement coaching call with the quality improvement advisor. These calls are designed to provide technical assistance and support to each practice team related to planning, testing, and sustaining changes in practice. Since these calls are held with only one practice team at a time, each team will receive individualized support tailored to their particular practice setting and situation. Project staff will participate on these calls and provide further technical assistance if necessary. Successes and challenges shared with the quality improvement advisor by practice teams during these calls will be shared with other practice teams via listserv and monthly webinars.

The post-implementation survey will be disseminated via Survey Monkey at the end of the project and will be due in August 2017. Data will be compared with pre-implementation survey results to see if teams made improvements in systems and processes related to early hearing detection and intervention because of the project's interventions.

11. Explain methods used to assure data quality and completeness.

Several methods will be incorporated to ensure data quality and completeness. We have taken several steps to optimize the level of data quality. A pre-work packet and instructions document will be distributed to practice teams before baseline data collection begins to ensure teams understand data collection methodologies and instructions. In addition, all practice teams are required to attend an orientation webinar, which will describe the measures and next steps related to baseline data collection. In addition, a demonstration related to entering data via the Quality Improvement Data Aggregator will be conducted during the orientation webinar. During the webinar (and afterwards via email and phone), practice teams will also be provided an opportunity to ask questions.

The measures included in this QI project were carefully considered by members of the Expert Group comprised of the following: pediatric quality improvement (QI) experts; pediatric specialists; general pediatricians; an audiologist; a QI Advisor; and a family representative. A table with all measures clearly defined will be shared with all practice team members.

Data that is entered into QIDA represents a sample of the patients in the practice. A beta test will be conducted by the QIDA Manager and project staff before data is entered by practice teams to ensure that the data collection tool is working properly.

Reminders will be sent to each practice team, via project listserv, on a monthly basis approximately one week before the monthly data entry deadlines and follow-up will occur a few days before the deadlines for those practice teams that have not yet entered data. Each practice team will identify one member of the team to serve as the QIDA group administrator. Only the group administrator is provided access to enter data into QIDA.

The QI Advisor will be available as needed for coaching and to address any data collection questions. The QIDA manager will be available as needed to address data entry or QIDA functionality questions.

In addition, project staff will use a spreadsheet to keep track of data entry by practice teams and practice team attendance on webinars to ensure that all MOC requirements are met.

12. Attach a copy of a report to leadership for this quality improvement effort. Please see Appendix C for the final report from Phase 1 of the project.

13. How are data used to drive improvement throughout the quality improvement effort?

This project uses data to drive improvement in several ways. The data will be used to measure the impact of the project on practice change and efforts to improve office systems and processes. Record review data will be converted to run charts to help practice teams determine if there was a change and if the change resulted in an improvement. The run charts will help practice teams identify areas that require more effort as well as areas they are excelling in.

Practice teams will have access to aggregate run charts and individualized run charts from record review data in QIDA for “real time” feedback to enhance their learning effort and to identify opportunities for improvement. The aggregate run charts will be discussed during

monthly webinars. During each webinar, the QI Advisor and Expert Group members will present strategies to make improvements based on monthly run charts and monthly narrative progress reports.

Practice teams will use PDSA cycles to test interventions provided by the project. Each month practice teams will develop small tests of change to measure the impact of the intervention with the ultimate goal of making process improvements. Practice teams will go through several PDSA cycles each month on a small scale to measure the impact of the intervention and to improve upon the intervention (if necessary) before implementing the change on a larger scale. Baseline data (pre-implementation survey, record review data) will help guide these efforts when the project begins.

In addition, as part of pre-work, practice teams will be asked to interview/hold a discussion with a family or parent regarding their experience with the newborn hearing screening and diagnostic process at their practice. Each practice team will choose a family/parent within their practice to interview who either has an infant who did not pass their newborn hearing screen or has an infant that has been diagnosed with hearing loss. Although practice teams will not be submitting this information as part of the project (they will be verbally sharing a lesson learned or surprising finding during the Learning Session), the discussion may help practice teams to identify gaps in care or opportunities for improvement related to their EHDl processes that they can focus on at the beginning of the project. Teams will be provided with a discussion guide that was developed by the EHDl QI Expert Group to help facilitate this conversation.

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

- Daily
- Weekly
- Monthly
- Other

15. 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

Practice teams will be provided with a change package with resources/tools to test to help improve EHDl processes.

16. 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.

The EHDl measures being tested are based on results from the NCHAM 2012 Physician Survey, which identified particular areas of pediatric practice that could be improved related to EHDl care

for patients. Practice teams will implement tools, strategies, and measures designed to improve and enhance EHDI care and ensure the necessary follow-up for patients. Areas of focus include: documenting newborn hearing screening results, ensuring the necessary diagnostic audiology referrals are made and results are documented, identification of risk factors for late-onset or progressive hearing loss, and conducting conversations with families regarding hearing screening results and individual care plans following the identification of risk factors.

One of the goals of this QI project is to test previously created tools for efficacy in improving EHDI care in the pediatric practice. Among these are AAP resources such as algorithms and checklists created for management of patients from birth through six months of age, referral lists should infants have a “do not pass” result for their newborn hearing screening or be diagnosed as deaf/hard of hearing, and guidelines for rescreening. Additionally, other organizations such as NCHAM and Hands & Voices have offered other flow charts for EHDI care within the pediatric practice and scripts for conducting conversations with parents and families should a child have a “do not pass” result for their newborn hearing screening or be diagnosed as D/HH, which will be tested. These tools and resources will be included in the project change package and will be shared with teams at the beginning of the project action period for them to test implementing in practice throughout the project.

This project will also aim to work with each pediatric practice to determine what improvements in electronic health record (EHR) coding can be made in order to improve documentation of EHDI care and tracking of newborn hearing screening results, the identification of risk factors, and referrals for audiological diagnostic evaluations.

The quality improvement project will provide practice team members with education on QI science through an in-person learning session scheduled for February 2017. The education provided will help the participants confidently implement tests of change/PDSA cycles. A learning collaborative approach will be used, and the quality improvement project will occur over a period of 8 months (including baseline data collection). This learning session will serve to kick-off the EHDI QI project and will provide an opportunity for educational sessions regarding EHDI topical content and QI practice. Additionally, practice teams will be encouraged to work with the EHDI QI Expert Group and with other practices to develop tangible strategies for improving EHDI care within their practice, throughout the project period.

Practice teams will also interview a family/parent within their practice who either has an infant who did not pass their newborn hearing screen or has an infant that has been diagnosed with hearing loss. The discussion may help practice teams to identify gaps in care or opportunities for improvement related to their EHDI processes.

Monthly educational webinars will be held with all practice teams throughout the action periods where the teams will receive QI coaching, data and progress will be reviewed, EHDI care education will be provided, and practice teams will be able to share challenges and successes encountered during the previous month of implementing changes. Repeated measurements of the practices' care processes, using patient record review, will be used to track changes in practice. The measurements

will be conducted at baseline and during the three, two-month long, action periods (data will still be submitted and reviewed monthly).

How are the interventions expected to improve patient care?

This project will use collaborative quality improvement methods to improve care in practice by setting specific goals for the improvement of care at the level of the individual patient and by providing practice teams with the training, tools, and support to accomplish these changes. Practice teams will incorporate small tests of change using Plan, Do, Study, Act (PDSA) cycles to improve patient care. Tools, resources, education, and strategies provided by the project and the EHDI QI Expert Group will be implemented within each practice and tested to see if these changes result in improvements in care.

Several interventions will be implemented to improve patient care. All practice teams will be required to attend a Learning Session in which baseline data will be presented (record review data and pre-implementation survey data), so practice teams can identify areas of strength and areas that need improvement. During the Learning Session, presentations related to quality improvement science, practical tips related to Early Hearing Detection and Intervention, strategies to engage parent/caregiver partners, an overview of state EHDI programs, and strategies for identifying and managing risk factors will be given by experts in the field. These educational sessions will provide practice teams with strategies to apply quality improvement to improve EHDI processes.

A change package with links to resources and tools that teams can test implementing within their practice will also be provided to practice teams. The change package includes resources related to reviewing screening results with families, developing care plans for children with risk factors for late or progressive hearing loss, referring families to appropriate resources when a child does not pass the newborn hearing screening, and engaging families in quality improvement efforts. The change package also includes ideas for change that teams can test within their practices.

Monthly webinars will also be held during the action period. These webinars will provide additional education to practice teams and provide an overview of aggregate run chart data. The webinars will be very interactive and will focus on strategies to improve patient care based on the monthly data (both run charts and monthly progress reports). The QI Advisor will facilitate the webinars and provide advice to practice teams on changes they could make to improve patient care. Practice teams will also share their strategies, challenges, and successes, so they are able to learn from each other. In addition, the QI Advisor will host one quality improvement coaching call with each practice team to further assist them with PDSA cycles and overcoming any challenges they are facing in their practice.

It is important to note that this project builds on lessons learned from the first phase of the Early Hearing Detection and Intervention Quality Improvement Project. One change that was made is to actively engage parent/caregiver partners at the beginning of the project by including them on the quality improvement teams.

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

Project staff will document changes suggested by practice teams during the monthly educational calls and e-mail communication. All results of the project will be documented and will help inform future spread. Additionally, data collected from the participating practice teams will be analyzed by the QI Advisor to determine which changes practices prioritize and whether or not a particular

sequence of changes facilitates improvement. This analysis will inform small-scale PDSA cycles during the project as well as dissemination efforts following the project.

In addition, at the end of the collaborative, the QI Advisor will present on strategies for sustainability and spread during one of the monthly webinars. During the post-project feedback call, the QI Advisor will also inquire about each practice team's plans for sustainability once the project ends.

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

The Expert Group for this project has developed measures, a practice survey, a record review tool and a monthly progress report tool, as well as instructions related to same, designed to support the improvement efforts for EHDI care in the pediatric practice. During the Action Periods, practices will use provided resources, strategies, and data collection instruments included in the project change package to track the measures in their settings in a sequential series of activities guided by the QI Advisor. A simple time-series design will be used to determine change over time for each clinical care process measured among the participating practices.

Monthly record reviews will be conducted by practice teams during the prework and during the action period. Practice teams will review patient records for children in their practice who have a "do not pass" result on their newborn hearing screening as well as a sample of children who "pass" their newborn hearing screening. The data will be entered into QIDA will be analyzed in QIDA and annotated run charts will be provided to the practice teams. The lead physician from each team will, on a monthly basis, review run charts displaying data obtained from their record review. Annotated run charts will help teams visualize change over time, as well as decide where to focus future efforts. The data will ultimately guide the improvement efforts.

Additionally, the QI Advisor will lead monthly educational webinars/conference calls with all practice teams to review data, share practice teams' successes and challenges with regards to team's improvement efforts. A portion of these monthly calls will include coaching from the QI advisor, as well as education on EHDI from experts in the field.

The QI Advisor will also be available to provide support to the teams through the project listserv, to which all practice team member and EHDI QI Expert Group members will be subscribed.

PHYSICIAN PARTICIPATION

19. 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:

- Provide direct or consultative care to patients as part of the QI project
- Implement the project's interventions (the changes designed to improve care)

- Collect, submit, and review data in keeping with the project’s measurement plan
- Collaborate actively by attending at least 5 project meetings

In order to receive MOC Part 4 points, practice teams must:

- Devote necessary resources and time to testing and implementing changes in the practice over the specified quality improvement period and working to obtain buy-in from additional members of the practice.
- Test and implement appropriate changes in the structure of how newborn hearing screening results are accessed and utilized to identify infants who do not pass their initial screening and need diagnostic follow up, using QI methodology.
- Review records of all infants ages 6 weeks and 4 months who do not pass the newborn hearing screen as well as the records of 20 infants ages 6 weeks and 4 months who do pass the newborn hearing screen per practice (up to 44 medical records total), seen in the practice during the review month of the Action Period.
- During project pre-work/baseline, review records from the past three months of all infants ages 6 weeks to 4 months who did not pass the newborn hearing screen as well as the records of 20 infants ages 6 weeks and 4 months who did pass the newborn hearing screen per practice (up to 55 medical records total).
- As part of project pre-work, hold a brief interview/discussion with a family from the practice who has a child diagnosed with hearing loss or who has a child who failed the initial hearing screen to assess gaps in patient care and to develop change strategies based on these gaps.
- Attend a one-day improvement workshop (in-person Learning Session) at the beginning of the action period on February 12, 2017. Identify a parent/caregiver partner to attend this workshop as a member of the practice quality improvement team.
- Complete monthly progress reports from February 2017-July 2017.
- Test innovations in care delivery to improve newborn hearing screening follow up in the medical home.
- Complete a pre- and post- implementation survey.
- Participate in one (1) one-on-one coaching call with the Quality Improvement Advisor during the project period.

20. How do physicians participate?

- Individually
- Team
- Individually and Team

What is the unit of analysis?

- Individual
- Team/Practice/Unit
- Aggregate

21. 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.

Participation on the orientation and monthly educational webinar/conference calls will be tracked by the QI Advisor and AAP staff and will be documented along with the webinar/conference call

notes. Practice team leaders will be responsible for tracking participation of other pediatricians within the practice in terms of interventions implemented, record review and data submission, and participation in monthly team meetings. These results will also be reported to the QI Advisor and AAP staff. Practices must also submit data collection on a monthly basis via QIDA, and present monthly update reports during the monthly calls. Attendance/participation on the monthly calls will be recorded by AAP staff.

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

If the dispute is with a participating physician who is not the lead physician of the practice team, the dispute will be reviewed and resolved by the Local Leader (practice team lead physician). If the dispute is with the lead physician for a practice improvement team, the dispute will be reviewed and resolved by the Project Leader for the QI project.

23. 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.*

Practice teams will be involved in the project for 8-months, including baseline data collection (beginning in January 2017) and post-project feedback call and post-implementation survey (taking place in August 2017).

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

- 1-10
- 11-50 (including other physicians in each practice)
- 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.](#)

25. In what form is quality improvement education offered?

- Formal course
- Lectures
- Recommended reading
- Other

Describe in what form education is offered. Interactive monthly conference calls to exchange ideas, and help resolve challenges.

26. 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 physicians who are active participants in approved projects. 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

27. 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

28. Is the project HIPAA compliant?

- Yes
- No

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

(Note: if you have any questions about determining whether your project is research, please contact Margaret Wright, PhD, IRB Administrator at 847/434-4075 or mwright@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?

IRB approval is obtained. Please submit a copy of the IRB approval letter/form. Date of IRB approval: 12/6/16 What organization's IRB approved the project? American Academy of Pediatrics

30. Attach any relevant files regarding the quality improvement effort that you wish to share with the reviewers. List attachments here: Appendix A: project measures; Appendix B: sample run chart, monthly progress report, and pre/post implementation survey; Appendix C: Phase 1 final report; Appendix D: record review tools; Appendix E: IRB approval letter

ABP PROFILE INFORMATION

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

31. Primary Project Contact

- Name: Christina Boothby, MPA
- Email: cboothby@aap.org
- Phone: 847/434-4311

- Organization Mailing Address: 141 NW Point Blvd, Elk Grove Village, IL 60007

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

The Early Hearing Detection and Intervention (EHDI) program within the American Academy of Pediatrics is dedicated to promoting the role of the medical home and the primary care provider in EHDI. The EHDI program supports a network of over 60 Chapter Champions, who provide ongoing EHDI education and resources to medical home providers, and play a vital role in coordinating health efforts between pediatricians, health care professionals, and state EHDI programs.

This quality improvement project will use the Learning Collaborative model to test strategies that will enhance pediatrician knowledge and practice related to documentation of newborn hearing screening results, referrals to sub-specialists, documentation of risk factors for delayed or late-onset hearing loss, and communication of these results with families. The project will result in potential dissemination of best practices and education on topics of relevance to practicing pediatric primary care clinicians. Up to five practice teams will be recruited and each team will be led by a practicing primary care pediatrician.

33. Completion Criteria to be listed on ABP website.

Specific expectations for physicians include the following:

- Devote necessary resources and time to testing and implementing changes in the practice over the specified quality improvement period and working to obtain buy-in from additional members of the practice.
- Test and implement appropriate changes in the structure of how newborn hearing screening results are accessed and utilized to identify infants who do not pass their initial screening and need diagnostic follow up, using QI methodology.
- Review records of all infants ages 6 weeks and 4 months who do not pass the newborn hearing screen as well as the records of 20 infants ages 6 weeks and 4 months who do pass the newborn hearing screen per practice (up to 44 medical records total), seen in the practice during the review month of the Action Period.
- During project pre-work/baseline, review records from the past three months of all infants ages 6 weeks to 4 months who did not pass the newborn hearing screen as well as the records of 20 infants ages 6 weeks and 4 months who did pass the newborn hearing screen per practice (up to 55 medical records total).
- As part of project pre-work, hold a brief interview/discussion with a family from the practice who has a child diagnosed with hearing loss or who has a child who failed the initial hearing screen to assess gaps in patient care and to develop change strategies based on these gaps.
- Attend a one-day improvement workshop (in-person Learning Session) at the beginning of the action period on February 12, 2017. Identify a parent/caregiver partner to attend this workshop as a member of the practice quality improvement team.
- Complete monthly progress reports from February 2017-July 2017.
- Test innovations in care delivery to improve newborn hearing screening follow up in the medical home.
- Complete a pre- and post- implementation survey.
- Participate in one (1) one-on-one coaching call with the Quality Improvement Advisor during the project period.

34. Relevant Topics. Choose 3.

<input type="checkbox"/> ADHD <input type="checkbox"/> Abuse and Neglect <input type="checkbox"/> Access to Care <input type="checkbox"/> Anticipatory Guidance <input type="checkbox"/> Asthma <input checked="" type="checkbox"/> Auditory Screening <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 checked="" type="checkbox"/> Genetics and Birth Defects <input type="checkbox"/> Handoffs <input type="checkbox"/> Health Promotion <input type="checkbox"/> Hypoplastic Left Heart Syndrome <input type="checkbox"/> Immunization <input type="checkbox"/> Improvement Methods <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 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"/> Patient Safety <input type="checkbox"/> Patient-Centered Care <input type="checkbox"/> Practice Improvement <input type="checkbox"/> Practice Redesign <input type="checkbox"/> Practice Redesign-Documentation <input type="checkbox"/> Prematurity <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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35. Does your project offer CME?

- Yes
 No

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

<input type="checkbox"/> All Specialties <input 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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37. 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.](#)

38. Is there a direct cost to participate?

Yes

No

Unknown

39. Web Site URL (if applicable) <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/pages/early-hearing-detection-and-intervention.aspx>

40. 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: _____ Date: _____