

CHARTER

Utah Pediatric Partnership to Improve Children's Healthcare Quality (UPIQ)

Background

UPIQ was established in 2003 by the:

- Intermountain Pediatric Society/Utah chapter, American Academy of Pediatrics
- Department of Pediatrics, University of Utah Health Sciences Center
- Utah Department of Health Division of Health Care Financing
- Utah Department of Health Division of Community and Family Health Services
- HealthInsight, the federal contracted Quality Improvement Organization for the state of Utah
- Intermountain Health Care Primary Care Clinical Program

Each of these organizations shares a commitment to improving the health of Utah's children.

Mission

UPIQ's mission is to improve children's health by assisting pediatric and family medicine practices to deliver the highest possible quality of care to their infant, children and adolescent patients.

Vision

UPIQ is committed to the concept that every child deserves a medical home and that, in their medical home, they and their families will receive the highest quality of care, and that the providers of that care will be supported in and rewarded for their efforts to practice high quality, evidence-based medicine.

Overview

UPIQ serves as a resource to pediatric and family medicine practices and others who wish to improve the care they deliver to infants, children and adolescents. UPIQ works with practices by encouraging, supporting, facilitating and teaching practice teams to use effective quality improvement techniques and methods. UPIQ subscribes to the "*Model for Improvement*" that asks practices to incorporate three questions into the culture of their practice:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?

UPIQ encourages practices to use "rapid cycles of change," that include the: *Plan, Do, Study, Act (PDSA)* framework for quality improvement.

UPIQ works by recruiting practice teams to participate in UPIQ-developed initiatives, such as, improving preventive services, improving developmental screening and assessment, incorporating new approaches to the care of overweight children, or other future objectives. These projects are important, but are only the vehicles for continuous

improvement in all areas of healthcare for the young. As part of this, UPIQ is also able to assist an individual practice or a group of practices in a project of their choosing. Finally, UPIQ welcomes the opportunity to cooperate with agencies, insurance plans, or others who have identified an area of child health care that they feel can be improved.

The Learning Collaborative Model

One model that UPIQ and others have used for practice based quality improvement is the **Learning Collaborative (LC)**. An LC is based on the belief that a group of practices working together will be more effective than a single practice working alone. In phase 1, an LC brings together practice teams who, together, determine:

1. What aspect of their practice they want to improve (what are they trying to accomplish?)
2. Because every improvement requires change, but not every change results in an improvement, practice teams must decide *how* they will know that a proposed change resulted in an improvement. This concept underscores the importance of *measurement* for quality improvement. Practices, working with UPIQ facilitators, decide what they will measure and how they will measure it. For example, UPIQ can provide assistance with tools to conduct chart audits.
3. What changes or innovative approaches can the teams develop that are (based on evidence from the literature or expert opinion or both) most likely to result in improvement?

In the next phase, practices implement (“do”), on a small scale, e.g., the next five patients, the planned change, see how it worked (study) and tweak or fix it (act) as needed. The cycle is then repeated frequently as part of the developing clinic culture of continuous improvement. UPIQ provides regular contact with the practice teams through conference calls, e-mails, phone calls, faxes, etc. to support and facilitate this critical step. Very brief monthly chart audits are conducted that are translated into run charts by UPIQ to help practice teams see their progress.

In the final phase of the Collaborative, practices come together to share their experiences with implementation, measurement and the results of their PDSA cycles. Since it is likely that teams will have had different experiences and results, the sharing of what worked and what didn’t provides a powerful collaborative learning opportunity for accomplishing future projects. UPIQ facilitates this shared learning experience by providing data to practices about what they and the other practice teams have achieved. It is planned through these recurring interactions to eventually redesign the social culture of pediatric healthcare to one of continuous learning and sharing. *Of course complete confidentiality of individual practice data is always maintained.*

Addendum 1

Preventive Services Collaborative Goals & Objectives

Practices are encouraged to “pick” their own goals, and tweak them, if necessary, to reflect the need in their clinic. UPIQ provided the following list as examples of goals the practices might select as their focus of change:

Two Year Old

- 100% of children will have an immunization record in the chart
- 90% of children will be fully immunized by the age of two. “Fully immunized” is defined as having 4 DTaP, 4 Hib, 3 Polio, 3 Hep B, 4 PCV-7, 1 MMR, 1 VZV, 1 Hep A, and Influenza.
- 90% of children will have a hemoglobin or hematocrit performed by 12 months.
- 100% of children aged 15 months – 4 years will be screened for risk of anemia. Risk factors include: low birth weight/prematurity, use of low iron formula, whole milk before 12 months, excessive whole milk (>32 oz) after one year.
- 90 % of children will have a dental assessment consisting of any of the following: fluoride, bottle in bed, advice to clean/brush teeth, advice to see dentist.
- 90% of children will have oral health promotion advice at least twice in the first year, once in the second year, and a recommendation for a dental visit at least once from 12-24 months.
- 100 % of children will be assessed for environmental smoke exposure.
- 100% of parents with children having environmental smoke exposure will receive counseling/literature.
- 100% of children will have a growth chart with height, weight, and head circumference plotted at each well child visit.
- 90% of children will have 9 well child visits in their first 24 months.

Four Year Old

- 100% of children will have a vision screening, or documented attempt, at 3 years. Children who are unsuccessfully screened will be re-screened within 6 months.
- 100% of children will have blood pressure testing, or documented attempt, at 3 years.
- 100% of children will have a growth chart with height and weight charted at each well child visit.
- 90% of children will have BMI calculated and recorded on the growth chart.
- 100 % of children will have a dental referral by age 3.
- 100% of children will have a reminder to use an age-appropriate car seat.
- 90 % of children will be fully immunized. “Fully immunized” is defined as having 4 DTaP, 4 Hib, 3 Polio, 3 Hep B, 4 PCV-7, 1 MMR, 1 VZV, 1 Hep A, and Influenza.

Addendum 2

Developmental Screening Collaborative Goals and Objectives

Objective:

The objective of this Learning Collaborative is that every child in Utah, age birth to three, will receive developmental screening as part of Well Child Care (WCC). Developmental screening is defined as the use of a standardized tool at WCC visits to identify potential developmental and behavioral issues. A child with a positive developmental screen will receive an in-depth assessment and, if indicated, referral to the appropriate community resource or private provider.

Collaborative Goals:

100% of practices will have a written plan for developmental screening for all children in their practice.

100% of practices will initiate routine developmental screening, according to their written plan, as part of their standard approach to Well Child Care.

100% of practices will have a procedure outlining the referral process for children requiring further assessment.

100% of practices will have a procedure outlining the referral process for children requiring further intervention.

100% of practices will maintain current listings of available community resources and private resources.

Practice Goals:

100% of children will be screened for developmental delay.

100% of children with a positive screening will receive further assessment.

100% of children with an assessment that indicates the need for intervention will be referred.

100% of children needing developmental services will receive them.

100% of children referred for further assessment and/or intervention will have relevant medical information available to the referring agency or practitioner.

100% of children referred for further assessment and/or intervention will have a result of the interaction returned to the referring provider.