

The Council on Quality Improvement & Patient Safety (COQIPS) is pleased to invite you to participate in a free, innovative Maintenance of Certification (MOC) Part 4 project focused on improving health literacy, which uses the COQIPS education (H) program at the 2015 AAP National Conference and Exhibition as a required face-to-face Learning Session. Participants in the project will focus on improving use of teach back techniques with patients/families, utilize easy-to-understand written materials with patients/families, and employ patient-reported outcomes (through a patient survey) to determine if they are achieving their aims.

Benefits for Participants

- Test strategies for using health literacy informed strategies to enhance communication with families.
- No monetary cost to participate.
- Receive 25 American Board of Pediatrics Part 4 Maintenance of Certification (MOC) credits.
- Receive support to earn 20 American Board of Pediatrics Part 2 MOC credits.
- Receive 4.5 AMA PRA Category 1 Credits™ for participating in the COQIPS education (H) program at the 2015 National Conference & Exhibition in Washington, DC on Saturday, October 24, 2015 from 1:30 PM – 6:30 PM.
- Learn and network with your peers in-person at the Learning Session and throughout the project via webinars and listserv communication.
- Learn and receive feedback directly from national experts in quality improvement and health literacy, and receive ongoing support for improvement.
- Be the first to participate in a pilot MOC Part 4 model that may be used by other Sections/Councils in the future.

Estimated Time Commitment

- 4 hours per month over 4 months (includes participation in webinars, data collection, reporting, PDSA cycles).
- 5 hours at the in-person Learning Session during the COQIPS 2015 education (H) program at the AAP National Conference & Exhibition in Washington, DC on Saturday, October 24, 2015 from 1:30 PM – 6:30 PM.

This project will be the first of its kind to utilize the AAP National Conference & Exhibition council/section education (H) program as part of a larger QI project. Your feedback on this project will help guide and prioritize other AAP MOC projects. After evaluation, this model may be used by other AAP sections/councils to offer MOC Part 4 to their members.

Requirements for Participation

Important! Failure of the participant to meet any of the expectations outlined below will result in loss of eligibility for MOC Part 4 credits. It is the responsibility of the participant to ensure all expectations are met in order to receive MOC Part 4 credits.

- Participate over a 5 month period (September 2015-January 2016).
- Submit baseline data (September) and 3 months of follow-up data (November, December, January) for 20 patients (direct or consultative care to patients) using the AAP Quality Improvement Data Aggregator (QIDA) system. Data collection will include use of a patient survey.
- Participate in live or recorded Orientation Webinar.
- Attend COQIPS education (H) program (Learning Session required only) on **Saturday, October 24, 2015 from 1:30 – 6:30 PM**
- Participate in 3 live or recorded webinars where data is presented and PDSAs are discussed within the allotted timeframe.
- Review run chart data via the QIDA system on a monthly basis and implement PDSAs based on learnings from the data.

Attached please find the project charter with project details and expectations for participants.

To express interest in project participation, please submit a brief participant information survey:

<https://www.surveymonkey.com/r/MOCPilot>. A PDF of the survey is attached for your reference. Priority enrollment will be given to COQIPS members through July 15, 2015. After this date, recruitment will be open to other AAP Sections/Council memberships and will be accepted until August 19, 2015. COQIPS members may still enroll after July 15th, however, enrollment will be first come, first served. Project staff will notify participants about their project participation status and next steps on August 21, 2015.

If you have any questions please contact Cathleen Guch, MPH, at cguch@aap.org. Thank you for your interest in this exciting project.

Sincerely,

Ulfat Shaikh MD, MPH, MS, FAAP, Project Leader

Laura Ferguson, MD, FAAP, Chairperson, COQIPS Education Subcommittee

ENHANCING FAMILY-CENTERED COMMUNICATION BY ADDRESSING HEALTH LITERACY PROJECT CHARTER

STATEMENT OF NEED

Health literacy is defined as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”^{1,2} Health literacy includes an individual’s ability to read and understand written health information (print literacy), comprehend mathematical concepts such as risks/benefits of treatment choices (numeracy), listen to and understand spoken health information (oral literacy), and navigate the healthcare system (e.g. apply for health insurance).^{3,4} Between a third to a half of US adults have limited health literacy skills;^{2,5,6} racial/ethnic minorities, immigrants, the elderly, and low income groups are disproportionately affected.⁷

Adverse outcomes linked to limited health literacy include greater mortality and poorer global health status, increased hospitalizations, and emergency care use.⁸⁻¹² Low health literacy is associated with worse asthma severity, poorer diabetic control, and obesity,^{10,11,13} and is a stronger predictor of outcomes than race/ethnicity, income, and education.¹³⁻¹⁵ Health literacy is considered a critical quality and safety issue by the Institute of Medicine,² Joint Commission,¹⁶ and the World Health Organization.¹⁷ In 2010, a National Action Plan was issued to tackle health literacy across sectors, including in education and research.¹⁸

Professional organizations, including the American Medical Association,^{10,19} recognize that for patients to have improved outcomes, health literacy must be addressed as part of each clinical encounter. A “universal precautions” approach to the use of health literacy-informed clinician-patient communication strategies is recommended,²⁰ and includes use of plain language and avoidance of medical jargon, limiting counseling to 2-3 main concepts, and “chunking” of information into small digestible components.^{19,21-23} Other strategies include teach back/show back, use of drawings/pictures, and supplementing verbal counseling with plain language written information.^{19,21,22} Unfortunately, clinicians do not regularly use health literacy-informed strategies in communicating with patients and their families.^{21,22} There is a clear need for health literacy training for both trainees and clinicians;^{24-27.}

Through quality improvement (QI) programs, healthcare organizations and medical practices have a growing record of success in improving healthcare delivery and implementing evidence based guidelines. However, most clinicians in the United States are not trained in QI methodology to equip them to participate in and promote improvements in healthcare delivery within their practice. Recognizing this education opportunity, the American Board of Pediatrics requires members to participate in approved quality improvement projects as Part 4 Maintenance of Certification (MOC). Through Part 4 MOC activities, pediatricians are guided in self-evaluating and improving their practice performance comprehensively and systematically.

TIMELINE FOR PARTICIPANTS

Participant Enrollment (May-August 2015)	Pework Period (September 2015)	Section H/Learning Session QI and Topical Education (October 2015)	Action Period (November 2015-April 2016)*	Attestation Process (January-February 2016)
	<ul style="list-style-type: none"> Project Orientation Webinar and QIDA demo to understand data collection system (live and recorded) Review resources on QI science Submit data from 20 patient surveys 		<ul style="list-style-type: none"> Submit data from 20 patient surveys monthly for 3 months (can submit for 3 additional months if desired) Participate in 3 (live and/or recorded) Webinars (one per month) Implement interventions using PDSA cycles Communicate with other participants and experts via listserv 	

MISSION

The mission of the project is to bring together pediatricians to improve the use of health literacy informed strategies to enhance communication with families. Participants in the project will focus on improving use of teach back techniques with patients/families, utilize easy-to-understand written materials with patients/families, and employ patient-reported outcomes (through a patient survey) to determine if they are achieving their aims.

The project also intends to pilot a process/method that can be used by AAP Sections and Councils to conduct quality improvement projects that meet the standards established by the American Board of Pediatrics (ABP) for Maintenance of Certification (MOC) Part 4, using the National Conference and Exhibition Section H Program as the Learning Session.

The project will be led by faculty and staff from the American Academy of Pediatrics Council on Quality Improvement and Patient Safety via the identified Project Planning Group.

GOALS AND AIMS

Goal 1: Implement health literacy informed strategies to enhance communication with families.

Aim 1A: Increase the percentage of parents who report that their doctor explained things in a way that was easy for them to understand to 20% over individual baseline performance.

Aim 1B: Increase the percentage of eligible clinical encounters during which teach back is used to verify understanding to 20% over individual baseline performance.

Aim 1C: Use easy-to-understand visual material with parents seen at eligible clinical encounters by 20% over baseline performance.

METHODS

The project involves up to 100 participants working together to achieve significant improvements in the area of health literacy. Over 5 months, participants will attend one face-to-face Learning Session at the Council on Quality Improvement and Patient Safety (COQIPS) H Program at the American Academy of Pediatrics National Conference and Exhibition, three webinars to discuss data and interventions for improvements, and maintain continual contact with each other and faculty members through listserv discussions, email, and monthly data submission using the AAP Quality Improvement Data Aggregator (QIDA) system (baseline and minimum 3 follow-up cycles). Patient survey at the time of the visit will be used to collect data for this project. Participants will be expected to collect surveys from patients and submit the responses via the QIDA system.

SPECIFIC EXPECTATIONS

Important! Failure of the participant to meet any of the expectations outlined below will result in loss of eligibility for MOC Part 4 credits. It is the responsibility of the participant to ensure all expectations are met in order to receive MOC Part 4 credits.

Expectations of Participants for MOC credit

- Participate over a 5 month period (September 2015-January 2016)
- Submit baseline data for 20 patients (direct or consultative care to patients) using the AAP Quality Improvement Data Aggregator (QIDA) system by the designated deadline
- Attend COQIPS education (H) program (Learning Session required only) on Saturday, October 24, 2015 from 1:30 PM – 6:30 PM
- Submit 3 months of data during Action Period (minimum 20 charts per month) using the QIDA system by the designated deadlines
- Participate in live or recorded Orientation Webinar
- Participate in 3 live or recorded Webinars where data is presented and PDSAs are discussed by the designated deadline
- Review run chart data via the QIDA system on a monthly basis and implement PDSAs based on learnings from the data

Expectations of Council on Quality Improvement and Patient Safety Project Planning Group

- Provide a designated physician leader with expertise in quality improvement, a physician leader with expertise in health literacy, a project manager, and additional faculty who have expertise in the subject matter and in improvement methods
- Provide information on subject matter, application of that subject matter, and methods for process improvement during Learning Session, monthly webinars, and through listserv communication
- Offer guidance and feedback to participants
- Provide communication strategies to keep participants connected to the project faculty and colleagues

DATA SHARING AND REPORTING

No identifiable patient data is collected as part of this project. You do not need to see a minimum number of patients per month to participate in this project, however, data will need to be submitted on 20 patients per month. Data from patient surveys will be submitted via the Quality Improvement Data Aggregator (QIDA) system without identifiers. Data will be shared with project leadership.

Each participant will use the secure password protected QIDA system to view their own run charts compared to the aggregate of the other project participants. Data will be stored on a secure network with password protection. Project data will be stored indefinitely in the QIDA system, but once a project closes, only AAP QIDA staff will have access to the data.

For research and publications that may result from this work, individual data will not be identifiable. If individual data is presented, each participant will receive an ID code in the report.

This project has received exemption from the AAP Institutional Review Board. No identifiable protected health information is being collected for this project; therefore, HIPAA authorization will not be needed from patients in order for you to participate.

APPLICANT CHECKLIST

- Please review the following documents:
 - Project Charter
 - Electronic Participant Information Survey (<https://www.surveymonkey.com/r/MOCPilot>)
- After reviewing the above materials, please submit the electronic survey (due July 15, 2015 [COQIPS priority enrollment]; August 19, 2015 [final])
- Project staff will notify participants about their project participation status and next steps on August 21, 2015
- Please direct questions to Cathleen Guch, MPH: cguch@aap.org or 847/434-7124

References:

1. Healthy People 2010: Understanding and Improving Health. 2nd ed. Washington, DC: US Department of Health and Human Services; 2000.
2. IOM. *Health Literacy: A Prescription to End Confusion*. Washington, DC: National Academies Press; 2004.
3. Parker RM, Williams MV, Weiss BD, et al. Health literacy-Report of the Council on Scientific Affairs. *JAMA*. 1999;281(6):552-557.
4. Baker DW. The Meaning and the Measure of Health Literacy. *Journal of General Internal Medicine*. 2006;21(8):878-883.
5. Rudd RE. Health Literacy Skills of U.S. Adults. *Am J Health Behav*. 2007;31(Suppl 1):S8-S18.
6. Kirsch IS. *Adult Literacy in America: A First Look at the Results of the National Adult Literacy Survey*. US Government Printing Office, Superintendent of Documents, Washington, DC: National Center for Education Statistics;1993.
7. Kutner M, Greenburg E, Jin Y, Paulsen C. *The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy*. NCES 2006-483. Washington, DC: National Center for Education Statistics, US Department for Education;2006.
8. Berkman ND, Sheridan SL, Donahue KE, Halpern DJ, Crotty K. Low Health Literacy and Health Outcomes: An Updated Systematic Review. *Annals of Internal Medicine*. 2011;155(2):97-107.
9. Peterson PN, Shetterly SM, Clarke CL, et al. Health Literacy and Outcomes Among Patients with Heart Failure. *JAMA*. 2011;305(16):1695-1701.
10. Schwartzberg JG, VanGeest JB, Wang CC. *Understanding Health Literacy: Implications for Medicine*. 2005.
11. Berkman ND, DeWalt DA, Pignone MP, et al. *Literacy and Health Outcomes*. Rockville, MD: Agency for Healthcare Research and Quality, US Department of Health and Human Services;2004. Evidence Report/Technology Assessment No. 87.
12. Baker DW, Gazmararian JA, Williams MV, et al. Functional health literacy and the risk of hospital admission among Medicare managed care enrollees. *American Journal of Public Health*. 2002;92(8):1278-1283.
13. Berkman ND, Sheridan SL, Donahue KE, et al. *Health Literacy Interventions and Outcomes: An Updated Systemic Review*. Rockville, MD: Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services;2011. Evidence Report/Technology Assessment Number 199.
14. Osborn CY, Paasche-Orlow MK, Davis TC, Wolf MS. Health Literacy: An Overlooked Factor in Understanding HIV Health Disparities. *American Journal of Preventive Medicine*. 2007;33(5):374-378.
15. Baker DW, Wolf MS, Feinglass J, Thompson JA, Gazmararian JA, Huang J. Health Literacy and Mortality Among Elderly Persons. *Archives of Internal Medicine*. 2007;167(14):1503-1509.
16. *What did the doctor say?: Improving health literacy to protect patient safety*. Oakbrook Terrace, IL: The Joint Commission on Accreditation of Healthcare Organizations;2007.
17. Kickbusch I, Pelikan JM, Apfel F, Tsouros AD. *Health Literacy: The Solid Facts*. World Health Organization Regional Office for Europe;2013. 9289000155.
18. *National Action Plan to Improve Health Literacy*. Washington, DC: US Department of Health and Human Services, Office of Disease Prevention and Health Promotion;2010.
19. Weiss BD, Schwartzberg JG, Davis TC, Parker RM, Sokol PE, Williams MV. *Health literacy and patient safety: Help patients understand Manual for clinicians, Second edition*. American Medical Association Foundation;2007.
20. DeWalt DA, Callahan LF, Hawk VH, et al. *Health Literacy Universal Precautions Toolkit*. Agency for Healthcare Research and Quality, US Department of Health and Human Services;2010.
21. Turner T, Cull WL, Bayldon B, et al. Pediatricians and Health Literacy: Descriptive Results From a National Survey. *Pediatrics*. 2009;124(Supplement 3):S299-S305.
22. Schwartzberg JG, Cowett A, VanGeest J, Wolf MS. Communication Techniques for Patients with Low Health Literacy: A Survey of Physicians, Nurses, and Pharmacists. *Am J Health Behav*. 2007;31(Supplement 1):S96-S104.
23. Abrams MA, Dreyer BP. *Plain Language Pediatrics Health Literacy Strategies and Communication Resources for Common Pediatric Topics*. AAP Books; 2008.
24. Bass III PF, Wilson JF, Griffith CH, Barnett DR. Residents' Ability to Identify Patients with Poor Literacy Skills. *Acad Med*. 2002;77(10):1039-1041.
25. Lindau ST, Tomori C, Lyons T, Langseth L, Bennett CL, Garcia P. The association of health literacy with cervical cancer prevention knowledge and health behaviors in a multiethnic cohort of women. *American Journal of Obstetrics and Gynecology*. 2002;186(5):938-943.
26. Kelly PA, Haidet P. Physician overestimation of patient literacy: a potential source of health care disparities. *Patient Education and Counseling*. 2007;66(1):119-122.
27. Price-Haywood EG, Roth KG, Shelby K, Cooper LA. Cancer Risk Communication with Low Health Literacy Patients: A Continuing Medical Education Program. *Journal of General Internal Medicine*. 2009;25(Supplemental 2):126-129.