

Welcome to NICHQ's Annual Forum for Improving Children's Healthcare.

We're delighted you can be with us this week, from all the disciplines of children's health care, all here to learn together how to make care better for kids.

We child health professionals are a special group. Most people, including most of our colleagues in health care, view the world in cross section, as snapshots, at single points in time. We don't see things that way. We view the world over time, in trajectories. We see a child at any given time as a point on an arc, a reflection of what came before and a foreshadowing of what will come in the future.

Our closest colleagues in health care, geriatricians and nurses who care for the elderly, also see the world in terms of trajectories. But their focus, inevitably, is the waning trajectory in the last stage of our lives.

We, on the other hand, focus on the upwards curve, on the trajectory that starts with dependency and potential and matures—through physical, cognitive, social and emotional growth—to, we hope, autonomy and adulthood.

Today I want to talk to you about arcs and trajectories. About the trajectory of children's lives and the trajectory of our movement, and how they relate to each other. About what it takes to move from one point on a developmental growth curve to another, higher point, and about what it takes to move the trajectory of all of our children to another higher curve. And especially I want to talk about where we've come as a movement, about the challenges our movement needs to address, and what we need to do so we succeed.

Today marks a special point on the rising curve of the life trajectory of our movement, the movement to improve the quality of health care for children. It is NICHQ's 10th birthday. We are thrilled you're here today and this week to help us celebrate 10 years of working towards achieving better healthcare for all children.

Because it is our tenth birthday, let's talk first about being ten. Do you remember being ten? Let me pause for a few moments and give you a chance to think back in your own lives.

For me, well over four decades ago, ten was a good time. I'd mastered some key fundamentals—I could read and do arithmetic, I knew how to make friends and had a few good ones that remain with me today. I had developed enough motor skills to accomplish the tasks of daily living and play (barely).

I'd like to think that my teachers and doctors would have assessed me as developmentally on target, more or less.

What about our movement? How would we assess the developmental progress of our movement?

Cognitively, you'd have to say we're on track. The special issue of *Pediatric Clinics of North America* this past year, edited by Lenny Feld and Shabnam Jain, is rich with methods and measures, advances in the tools of our trade. It describes the model for improvement, a tool that we in NICHQ have used in every project we have done for ten years. It describes other tools, too, the Toyota Production System which you learned about last night, measures of safety, measures of quality of life. Clearly we can check off the cognitive development.

Socially, we're making good progress there, too. We have learned that accelerating improvement requires collaborative learning and sharing, transparency with our results and our processes. NICHQ alone has conducted dozens of collaborative learning projects, promoting sharing across practices, across health plans, across hospitals and health centers, across states. Many of you participate in other collaborative improvement programs among hospitals and NICU's, specialty groups and the like as well. All of us here have well learned the value of sharing!

Another indicator of our fundamentally sound social skill development is not only our success in bridging sites and discipline, but bridging the divide between health care professional and patients and families. Our movement has led the nation in demonstrating how health professionals and families working together on improvement better identify the right goal, accelerate the pace of change toward that goal, and sustain the change over a longer time. The tireless dedication and involvement of families in advocating for and participating in the redesign of healthcare has resulted in wonderful strides forward. Bravo!

And as a result of acquiring these fundamental skill sets, we have already accomplished a great deal—more than a typical ten year old.

In ambulatory care, we've improved immunization rates by applying quality improvement approaches to office systems. We've helped practices care for children with asthma far more effectively through using registries, creating care teams, assessing severity, using management plans. We've applied what we learned improving care for children with asthma to the care of children with other chronic conditions, including attention deficit hyperactivity disorder—a condition whose care you know I am personally passionate about fixing because of the disjointed and non-evidence based care my son received. Our quality improvement work made an enormous difference in accelerating the transformation of the medical home concept from a vague, aspirational idea to a practical reality, now broadly endorsed by many.

And the progress on the hospital side has been at least as great... In ten years, through applying the tools of quality and safety, we've seen hospitals reduce rates of many preventable errors and complications, such as to catheter associated blood stream infections, ventilator acquired pneumonias and decubitus ulcers, all now tracked through the whole system measures many hospitals use and we will learn about from Dr. Dan Salinas this afternoon. Many children's hospitals now are far more effective in recognizing a child's early deterioration and acting before a catastrophic event occurs. A few hospitals are using operations research and system engineering to increase their efficiency and reduce waste.

When I was ten, my parents threw my brothers and me in the back seat of our Chrysler (probably without seatbelts) and we drove across the country, from New Jersey to California and back, seeing many of the great historic and natural sites of our nation.

For a recent meeting, I asked my staff to put together a map showing NICHQ's reach across the country, places where we have worked over the past decade. Even knowing and being personally involved in pretty much each and every one of our projects, I was still a little stunned when I opened it up to find that nearly every state was highlighted – many with several projects.

If I were to take a cross-country trip today, I could—and would love nothing more than to spend weeks meeting with friends and colleagues and their organizations on the way – those with whom we’ve worked and those with whom we haven’t yet, but all who are making wonderful contributions to better care for children. I would be able to learn how to create a stronger safety culture from friends at Boston Children’s, to see the Child Overweight collaborative in Nashua, New Hampshire works, to study the use of Health IT to facilitate developmental screening in Philadelphia, advancing cultural competency in Minneapolis and Oakland, Lean in Seattle, improving care for kids with complex conditions in Wisconsin, and with sickle cell disease here in Atlanta. Indeed, we have gathered these sites together to shorten your travel time. These are great national sites, not as famous as Mt. Rushmore, perhaps, but to the families they have touched, more important.

How important? Sometimes the figures and the charts don’t quite capture it, the technical excitement about “getting to zero” not quite capturing the human side. Listen to Jean Paul Damme’ from North Carolina as he describes what happened to his daughter Gabby, who was conceived after a long period of infertility treatments, born at 25 weeks, 614 grams and had come through some rough times early in her course. [Listen](#), and you will know that the work out movement is doing is essential.

We have accomplished a great deal as a movement, but clearly we have not yet accomplished enough. Knowing is not enough, we must do. We must extend our tools, our methods and our improvement culture—our obsession with failure and reliability--so that all the future Gabby’s will benefit.

And, as though that were not hard enough, there are challenges beyond that, **challenges that will require us to change and to grow** just as we did through our own adolescence.

As clinicians, our work with each individual child seeks to assure that the child achieves his or her greatest potential... at its most basic, that a medical problem like prematurity, infections—hospital acquired or otherwise, or asthma—not impair that opportunity. More broadly, though, the impediments to a child reaching his or her potential extend far wider than the medical conditions that we typically treat or even prevent. Remember, we child health professionals see a child at any given time as a point on an arc, as a reflection of what came before—including what came before in that child’s mother’s and father’s lives, and what came before and what happens now in a child and family’s life are broader than the medical issues alone.

So if we seek to improve each child’s potential, to keep each child on their highest trajectory, and collectively if we seek to optimize the potential of all of our children—raising the trajectory of our children’s lives taken together to a higher level than they would otherwise achieve—we must apply our methods of improvement to a broader stage. The first law of quality improvement is that each system is perfectly designed to achieve the results it gets. If we are not satisfied with the trajectory we can now anticipate for all of our children’s lives—those who are poor as well as those who are not, those who are minorities and those who are not, those with chronic conditions or in foster care or otherwise challenged—we must change the systems to get a better result.

Long time attendees at our Forum will recall Geoffrey Canada from the Harlem Children’s Zone when he spoke to us of his experience as a middle aged black man. He reported hearing from others over and over again when they met him, “you look goood,” meaning, he came to learn, that he was still alive, still healthy and contributing—then in his mid forties. And Canada knew that his being able to be contributing, vibrant and healthy when many of his peers and acquaintances no long could was the result not only of good medical care, although that was one element for sure; but also a good education, too; and having a family providing emotional stability and security. And so that is why he designed such a broad model system now being replicated across the nation.

Another example. At the suggestion of one of my wonderful staff, I just read *Three Cups of Tea*, the story of Greg Mortenson’s efforts to change the life trajectory for the rural poor of Pakistan and Afghanistan. Mortenson’s passion is education—especially educating girls. He recognized the critical role that women can play in their communities, in promoting health and economic development. Yet, even as he focused on education, his Pakistani advisors told him that the children needed to be healthy in order to learn, so he focused on bringing in fresh water; and in some communities, transportation was the barrier to commerce and economic development, so he built a bridge. Moving a child to a higher trajectory is no simple feat. It requires addressing their multiple needs of children and those of their families.

As everybody in this room knows, one of the greatest threats to the life trajectory of the current generation of our children is obesity. Each week we learn something new and more frightening about this epidemic. For example, children who are overweight at the age of two are at increased lifetime risk of early mortality. We cannot stand by and watch this happen. At NICHQ, we first identified what

behavior changes in families clinicians could confidently promote—more breastfeeding, less TV and no sugar sweetened beverages. Then we identified effective mechanisms to promote desired behaviors—monitoring BMI and using brief focused negotiation and motivational interviewing. Then we built on our previous work on improving office systems for prevention and chronic care management by helping practices organize their care systems so that the right thing happens by default and providing practices with measures to track their progress.

But changing the health care system alone will not change the trajectory of this epidemic. We need to change the physical environment, by providing more sidewalks; we need to change the social environment, by creating safe places to play; we need to enable healthy behaviors by making healthy foods more readily available in schools and in communities and by making harmful foods more costly or more remote.

As health care professionals, we can say, “not our job.” But as child health professionals committed to changing the trajectories of kids’ lives, that seems short sighted. As health professionals, we can have a powerful policy influence.

That is the rationale for our new [Be Our Voice initiative](#), supported by the RWJF and working in partnership with the AAP and the CMA-F. In this initiative, we are working to train health care professionals as advocates for community level policy change—to complement the clinical improvement they are achieving in their care setting.

Obesity is just the most obvious and most topical impediment to a child’s lifetime success whose roots stretch back in time and laterally to many other sectors. America’s poor relative birth outcomes and our disparate educational outcomes are two other examples, just as dependent on multiple sectors, multiple influences, influences over the long term.

This, in my view, is the special challenge we in quality improvement in child health uniquely need to address, the challenge that will require us to change and to grow if we are to help solve. The challenge is learning how to apply our methods and tools of improvement, our understanding of systems, of psychology, of learning, and of variation to the complex, multi-sector, longitudinally rooted threats to our children’s future. Judy Palfrey, current president of the AAP, recently posed the question “can we

match the health care we provide with the health realities that the children and families of the present and future experience?” I would echo that challenge and ask can our movement apply its energies and intellect, its social skills and moral compass to overcome the threats to our children’s life trajectories so that all of our children’s futures are better than they are today.

And the answer is, of course—IF we can develop new skills and strengthen old ones. Strengthen our skills of collaboration, as we have with parents, as we have with each other in our learning collaboratives. Now we must reach out to other communities as well. We must build new skills in policy and, perhaps, even in advocacy. We must take advantage of new technologies—information technology primarily—as a tool to aid this effort. We must learn new languages and cultures—like education or food policy or housing. We should innovate and create new approaches—like accountable care organizations that include not only primary, specialty and hospital care, but nutrition programs and job training and early child education.

And by changing, we will grow, and move further along our own developmental trajectory.

Growth requires confronting challenges we haven’t yet solved. Inevitably, not all of our efforts will succeed right away. We will run into delays and disappointments. In our QI work, we say that failures are simply learning opportunities. While that is true, that doesn’t always help us with the emotional component of change. When I’ve run into a brick wall, I also remember the guidance given by Rabbi Harold Kushner. He points out that, when we are disappointed because we haven’t achieved our desired outcome, we should remember for whom we are working....not who’s paying the check, but for whose benefit and purpose we are working. So whether you are confronting the challenges in your own work, or our movement is confronting the challenge of tackling the major threats to our children’s futures, we must remember we are working for Jean Paul and for Gabby, and all the Gabbies of tomorrow. If we do that, if we remember for whom we are working we won’t stop, we will learn and move forward on our own higher developmental trajectory.

As far as we’ve come, we still have a long way to go. But looking around at all of you, I have no doubt that we will continue our progress and that in ten more years, we will be back together reflecting on how we’ve risen to meet these challenges I’ve just laid out.