Report on a QI Project Eligible for MOC – ABMS IHHC and AAPA PI-CME

Improving Management and Monitoring of Use of Controlled Substances by Patients Prescribed These Medications on A Chronic Basis

Instructions

Determine eligibility. Before starting to complete this report, go to the UMHS MOC website [www.med.umich.edu/moc-qi], click on "Part IV Credit Designation," and review sections 1 and 2. Complete and submit a "QI Project Preliminary Worksheet for Part IV Eligibility." Staff from the UMHS Part IV MOC Program will review the worksheet with you to explain any adjustments needed to be eligible. (The approved Worksheet provides an outline to complete this report.)

Completing the report. The report documents completion of each phase of the QI project. (See section 5 of the website.) Final confirmation of Part IV MOC for a project occurs when the full report is submitted and approved.

An option for preliminary review (strongly recommended) is to complete a description of activities through the intervention phase and submit the partially completed report. (Complete at least items 1-18.) Staff from the UMHS Part IV MOC Program will provide a preliminary review, checking that the information is sufficiently clear, but not overly detailed. This simplifies completion and review of descriptions of remaining activities.

Questions are in bold font. Answers should be in regular font (generally immediately below or beside the questions). To check boxes, hover pointer over the box and click (usual "left" click).

For further information and to submit completed applications, contact either:
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Report Outline

Section	Items	
A. Introduction	1-6.	Current date, title, time frame, key individuals, participants, funding
B. Plan	7-8.	Patient population, general goal, IOM quality dimensions, ACGME/ABMS competencies
	9-11.	Measures, baseline performance, specific aims
	12-15.	Baseline data review, underlying (root) causes, interventions, who will implement
C. Do	16.	Intervention implementation date
D. Check	17-18.	Post-intervention performance
E. Adjust – Replan	19-23.	Post-intervention data review, underlying causes, adjustments, who will implement
F. Participation for MOC	24-26	Participation in key activities, other options, other requirements
G Sharing results	27.	Plans for report, presentation, publication
H. Organization affiliation	28.	Part of UMHS, AAVA, other affiliation with UMHS

QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date *(this version of the report):* 11/8/15

2. Title of QI effort/project *(also insert at top of front page)***:** Improving management and monitoring of use of controlled substance by patients prescribed these medications on a chronic basis.

3. Time frame

a. MOC participation beginning date – date that health care providers seeking MOC began participating in the documented QI project *(e.g. date of general review of baseline data, item #12c):* 1/1/15

b. MOC participation end date – date that health care providers seeking MOC completed participating in the documented QI project *(e.g., date of general review of post-adjustment data, item #27c)*: 10/15/16

4. Key individuals

a. QI project leader *[also responsible for confirming individual's participation in the project]*
Name: Heather Holmstrom, MD
Title: Department of Family Medicine
Organizational unit: Department of Family Medicine
Phone number: 734-232-6222
Email address: hholmstr@med.umich.edu
Mailing address: 1150 West Medical Center Dr. M7300 Medical Science I. Ann Arbor. MI 4810

b. Clinical leader who oversees project leader regarding the project *[responsible for overseeing/"sponsoring" the project within the specific clinical setting]*
Name: David Serlin, MD
Title: Clinical Assistant Professor
Organizational unit: Department of Family Medicine
Phone number: 734-232-6222
Email address: dserlin@med.umich.edu
Mailing address: 1150 West Medical Center Dr. M7300 Medical Science I. Ann Arbor. MI 48109

5. Participants. Approximately how many physicians (by specialty/subspecialty and by training level) and physicians' assistants participated for MOC?

Participating for MOC	Primary Specialty	Subspecialty, if any	Number
Practicing physicians	Family Medicine		50
Residents/Fellows	Residents – Family Medicine		5
Physicians' Assistants	(N/A)	(N/A)	10

6. How was the QI effort funded? *(Check all that apply.)*

☒ Internal institutional funds (e.g., regular pay/work, specially allocated)

☐ Grant/gift from pharmaceutical or medical device manufacturer

☐ Grant/gift from other source (e.g., government, insurance company)

☐ Subscription payments by participants

☒ Other source *(describe)*:

The Multi-Specialty Part IV MOC Program requires that QI efforts include one complete cycle of data-guided improvement. Some projects may have only one cycle while others may have additional cycles – particularly those involving rapid cycle improvement. The items below provide some flexibility in describing project methods and activities. If the items do not allow you to reasonably describe the steps of your specific project, please contact the UMHS Part IV MOC Program Office.

B. Plan

7. Patient population. What patient population does this project address *(e.g., age, medical condition, where seen/treated)***:**

Adult patients (age >=18 years) with 2 visits in the past 2 years and one visit in the past 13 months to a Family Medicine clinic who received either:

- A new prescription for Schedule II, III, IV Opioid with qty 150,or
- A renewal for a Schedule II Opioid with qty > 30, or
- A renewal for a Fentanyl Patch with qty 10, or
- A renewal for a Schedule III or IV Opioid with qty: > 90 and > 2 refills, or
- A new prescription for Benzodiazepine with qty > 90, or
- A renewal for Benzodiazepine with qty > 90 and >2 refills

8. General purpose.

a. Problem with patient care ("gap" between desired state and current state)

(1) What should be occurring and why should it occur (benefits of doing this)?

Prescribing controlled substances may be an important and appropriate aspect of patient care for chronic pain or anxiety. However, controlled substances have several medical and safety concerns. Patients on these medications may become medically addicted, may take increasing amounts without physician guidance, may take non-prescription illicit substances placing their health at grave risk, and may illegally resell their medications. Important monitoring activities that help identify and reduce these risks include:

- A Controlled Substance Agreement (CSA) in place and annually reviewed.
- The Michigan Automated Prescription System (MAPS) checked at least annually for controlled substance prescriptions from other sources
- A random urine drug test performed at least annually to screen for both the presence of the prescribed agent and the absence of non-prescribed agents and illicit drugs.

(2) What is occurring now and why is this a concern (costs/harms)?

The rates of performing these three activities are substantially below the targets established by the UMHS Controlled Substance QI Steering Committee. Low levels of management and monitoring of controlled substances increase medical and safety risks for these patients.

b. Project goal. What general outcome regarding the problem should result from this project?

(State general goal here. Specific aims/performance targets are addressed in #11.)

Improve performance and documentation of CSA, MAPS, and Urine Drug testing for eligible patients on controlled substances.

9. Describe the measure(s) of performance: *(QI efforts must have at least one measure that is tracked across the baseline and post-intervention periods.. If more than two measures are tracked, copy and paste the section for a measure and describe the additional measures.)*

Measure 1

- **Name of measure** *(e.g., Percent of . . ., Mean of . . ., Frequency of . . .)***:**
  Percent of patients with a CSA
- **Measure components** – *describe the:*
  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:
  Number of patients in the population
  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:
  Number of these patients with CSA documented in the medical record
- **The source of the measure is:**
  ☐ An external organization/agency, which is *(name the source, e.g., HEDIS)*:
  ☒ Internal to our organization
- **This is a measure of:**
  ☒ Process – activities of delivering health care to patients
  ☐ Outcome – health state of a patient resulting from health care

Measure 2

- **Name of measure** *(e.g., Percent of . . ., Mean of . . ., Frequency of . . .)***:**
  Percent of patients with MAPS assessment in the past year
- **Measure components** – *describe the:*
  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:
  Number of patients in the population
  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:
  Number of these patients with a MAPS assessment in the past 365 days
- **The source of the measure is:**
  ☐ An external organization/agency, which is *(name the source)*:
  ☒ Internal to our organization and it was chosen because *(describe rationale)*: The UM Medical Group adapted the measure from a UMHS clinical guideline.
- **This is a measure of:**
  ☒ Process – activities of delivering health care to patients
  ☐ Outcome – health state of a patient resulting from health care

(If more than two measures are tracked across, copy and paste the section for a measure and describe the additional measures.)

Measure 3

- **Name of measure:** Percent of patients with a drug screen within the past year
- **Measure components** – for a rate, percent, or mean, describe the:
  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:
  Number of patients in the population
  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:
  Number of these patients with a drug screen ((Drug10, Drug Comp, GCMS, or Drug 6) in the past 365 days)
- **The source of the measure is:**

☐ An external organization/agency, which is *(name the source)*:

☒ Internal to our organization and it was chosen because *(describe rationale)*: The UM Medical Group adapted the measure from a UMHS clinical guideline.

- **This is a measure of:**

  ☒ Process – activities of delivering health care to patients

  ☐ Outcome – health state of a patient resulting from health care

10. Baseline performance

a. What were the beginning and end dates for the time period for <u>baseline</u> data on the measure(s)?
The UMHS registry of patients on controlled substances was checked for the status of Family Medicine and General Medicine patients on 12/31/14 regarding: whether they had a CSA, whether MAPS had been checked within the previous 12 months, and whether a drug screen had been performed within the previous 12 months.

b. What was (were) the performance level(s) at baseline? *Display in a data table, bar graph, or run chart (line graph). Can show baseline data only here or refer to a display of data for all time periods attached at end of report. Show baseline time period, measure names, number of observations for each measure, and performance level for each measure.*

Measure	Baseline (12/31/14)	Goal UMHS 90th Percentile
N patients in registry	800	
% with Controlled Substance Agreement	43%	83%
% with Michigan Automated Prescription System	39%	87%
% with Urine Drug Screen	38%	71%

11. Specific performance aim(s)/objective(s)

a. What is the specific aim of the QI effort? *"The Aim Statement should include: (1) a specific and measurable improvement goal, (2) a specific target population, and (3) a specific target date/time period. For example: We will [improve, increase, decrease] the [number, amount percent of [the process/outcome] from [baseline measure] to [goal measure] by [date]."*

Our goal was for performance on each of the measures to be at or above the respective institutional goals for CSA, MAPS, Drug testing by August 31, 2015. (See the specific goals and baseline points in the table above.)

b. How were the performance targets determined, e.g., regional or national benchmarks?
We used the University of Michigan Medical Group internal 90th percentile goals.

12. Baseline data review and planning. Who was involved in reviewing the baseline data, identifying underlying (root) causes of problem(s) resulting in these data, and considering possible interventions ("countermeasures") to address the causes? *(Briefly describe the following.)*

a. Who was involved? *(e.g., by profession or role)* Physicians, Advance Practice Providers (APP's: PA's and NP's), Medical Assistants (MAs), nurses, LPNs, and health center management staff

b. How? *(e.g., in a meeting of clinic staff)*

- Departmental Practice Improvement Group, which is includes representatives of all of these team members. Practice Improvement Group Meetings are held on a monthly basis. (January 21, 2015 and February 18, 2015 during this review period).
- Faculty business forums held bi-weekly
- Clinic/Site team meetings held at each clinic, on each team, monthly (dates vary based on site)
- E-mail Communication was encouraged as a venue for follow up questions, input, and discussion after each of the various in-person meetings.

c. When? *(e.g., date(s) when baseline data were reviewed and discussed)* 1/1/15 – 2/24/15

Use the following table to outline the plan that was developed: #13 the primary causes, #14 the intervention(s) that addressed each cause, and #15 who carried out each intervention. *This is a simplified presentation of the logic diagram for structured problem solving explained at http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation in section 2a. As background, some summary examples of common causes and interventions to address them are:*

Common Causes	***Common Relevant Interventions***
Individuals: Are not aware of, don't understand.	*Education about evidence and importance of goal.*
Individuals: Believe performance is OK.	*Feedback of performance data.*
Individuals: Cannot remember.	*Checklists, reminders.*
Team: Individuals vary in how work is done.	*Develop standard work processes.*
Workload: Not enough time.	*Reallocate roles and work, review work priorities.*
Suppliers: Problems with provided information/materials.	*Work with suppliers to address problems there.*

13. What were the primary underlying/root causes for the problem(s) at baseline that the project can address?	**14. What intervention(s) addressed this cause?**	**15. Who was involved in carrying out each intervention?** *(List the professions/roles involved.)*
Health care providers not aware of expectations regarding controlled substance monitoring.	Educate providers and teams regarding monitoring expectations and reasons for them.	Physicians, Advance Practice Providers (APP's: PA's and NP's), Medical Assistants (MAs), nurses, LPNs, and health center management staff
No agreement regarding roles of team members on processes for checking MAPS and urine collection	Develop standard roles for team members to carry out monitoring processes. Hold training sessions at all sites regarding the processes	(Same as above)
"FYI" flag that patient is on controlled substance not noted in electronic medical	Educate physicians on how to initiate in the medical record a "FYI" flag that controlled	Physicians

record, so electronic "best practice alert" prompts for monitoring do not occur	substance have been prescribed.	

Note: If additional causes were identified that are to be addressed, insert additional rows.

C. Do

16. By what date was (were) the intervention(s) initiated? *(If multiple interventions, date by when all were initiate*d.)
2/28/15

D. Check

17. Post-intervention performance measurement. Are the population and measures the same as those for the collection of baseline data (see item 9)?

☒ Yes ☐ No – If no, describe how the population or measures differ:

18. Post-intervention performance

a. What were the beginning and end dates for the time period for post-intervention data on the measure(s)?
3/1/15 – 4/30/15. (The registry of patients will be checked for patient status at 4/30/15, 2 months following the intervention. Most patients followed for controlled substances are seen every 1-3 months, the majority every 2 months.)

b. What was (were) the overall performance level(s) post-intervention? *Add post-intervention data to the data table, bar graph, or run chart (line graph) that displays baseline data. Can show baseline and post-intervention data incrementally here or refer to a display of data for all time periods attached at end of report. Show baseline and post-intervention time periods and measure names and for each time period and measure show number of observations and performance level.*

Measure	Baseline (12/31/14)	2 Months Post-Intervention (4/30/2015) *	Goal UMHS 90th Percentile
N patients in registry	800	783	
% with Controlled Substance Agreement	43%	60%	83%
% with Michigan Automated Prescription System	39%	66%	87%
% with Urine Drug Screen	38%	57%	71%

***** Most patients were seen within the 2-month period, but a few were seen only in the 10 months before the period and a few were seen multiple times during the 2-month period.

c. Did the intervention(s) produce the expected improvement toward meeting the project's specific aim (item 11.a)?
No. The interventions increased performance, but only about half-way between baseline performance and goals.

E. Adjust – Replan

19. Post-intervention data review and further planning. Who was involved in reviewing the post-intervention data, identifying underlying (root) causes of problem(s) resulting in these new data, and considering possible interventions ("countermeasures") to address the causes? *(Briefly describe the following.)*

a. Who was involved? *(e.g., by profession or role)*
☒ Same as #12? ☐ Different than #12 *(describe):*

b. How? *(e.g., in a meeting of clinic staff)*
☒ Same as #12? ☐ Different than #12 *(describe):*

c. **When?** *(e.g., date(s) when post-intervention data were reviewed and discussed)*
5/11/15 – 5/30/15

Use the following table to outline the next plan that was developed: #20 the primary causes, #21 the adjustments(s)/second intervention(s) that addressed each cause, and #22 who carried out each intervention. *This is a simplified presentation of the logic diagram for structured problem solving explained at http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation in section 2a.*

Note: Initial intervention(s) occasionally result in performance achieving the targeted specific aims and the review of post-intervention data identifies no further causes that are feasible or cost/effective to address. If so, the plan for the second cycle should be to continue the interventions initiated in the first cycle and check that performance level(s) are stable and sustained through the next observation period.

20. What were the primary underlying/root causes for the problem(s) following the intervention(s) that the project can address?	**21. What adjustments/second intervention(s) addressed this cause?**	**22. Who was involved in carrying out each adjustment/second intervention?** *(List the professions/roles involved.)*
Some team members still did not know how to perform new roles, e.g., some MAs were not aware how to run MAPS report or to obtain urine, some physicians did not know how to document in EHR a "FYI" flag that a patient is now prescribed a controlled substance, having a patient now having a CSA, and having reviewed MAPS.	At clinic/site meetings provided feedback performance with supplemental education, and reminders regarding how to perform new roles. Encouraged email communication for any subsequent questions and suggestions.	Physicians, Advance Practice Providers (APP's: PA's and NP's), Medical Assistants (MAs), nurses, LPNs, and health center management staff Same as above.

Physicians had inconsistent understanding on standards for managing unexpected results for drug tests.	Developed communication system for questions on how to address a positive drug screen	Physicians
Lab changed the name of a code for a drug test, so that test was not ordered.	The new name of one of the drug screens was entered in the EHR prompt. Above supplemental education included update on codes for drug tests and entering on EHR	Pathology and MCIT Physicians

Note: If additional causes were identified that are to be addressed, insert additional rows.

23. Are additional PDCA cycles to occur for this specific performance effort?

☐ No further cycles will occur.

☒ Further cycles will occur, but will not be documented for MOC. *If checked, summarize plans:* At least 2 more cycles. We plan is to pursue continuous improvement until institutional goals are both met and sustained.

F. Minimum Participation for MOC

24. Participating directly in providing patient care.

a. Did any individuals seeking MOC participate directly in providing care to the patient population?

☒ Yes ☐ No *If "No," go to item #32.*

b. Did these individuals participate in the following five key activities over the two cycles of data-guided improvement?

1. Identify and/or acknowledge a gap(s) in outcomes or in care delivery as described in #8.
2. Identify and/or review data related to the gap(s) as described in #9-10.
3. Identify or acknowledge appropriate intervention(s) designed to improve the gap(s), OR participate in the planning and selection of intervention(s) designed to improve the gap(s) as described in #11-15.
4. Implement intervention(s) for a timeframe appropriate to addressing the gap(s), OR monitor and manage implementation of intervention(s) for a timeframe appropriate to addressing the gap(s) as described in #16.
5. Review post-intervention data related to the gap(s) as described in #17-22.
6. Reflect on outcomes to determine whether the intervention(s) resulted in improvement. If no improvement occurs after an intervention, participants must reflect on why no improvement occurred (this will take place during the attestation process). ☒ Yes ☐ No *If*

"Yes," individuals are eligible for MOC unless other requirements also apply and must be met – see item # 26.

25. Not participating directly in providing patient care.

a. Did any individuals seeking MOC not participate directly in providing care to the patient population?

☐ Yes ☒ No *If ""No," go to item 26.*

b. Were the individual(s) involved in the conceptualization, design, implementation, and assessment/evaluation of the cycles of improvement? *(E.g., a supervisor or consultant who is involved in all phases, but does not provide direct care to the patient population.)*

☐ Yes ☐ No *If "Yes," individuals are eligible for MOC unless other requirements also apply and must be met – see item # 26. If "No," continue to #25c.*

c. Did the individual(s) supervise residents or fellows throughout their performing the entire QI effort?

☐ Yes ☐ No *If "Yes," individuals are eligible for MOC unless other requirements also apply and must be met – see item # 26*

26. Did this specific QI effort have any additional participation requirement for MOC? *(E.g., participants required to collect data regarding their patients.)*

☐ Yes ☒ No *If "Yes," describe:*

Individuals who want their participation documented for MOC must additionally complete an attestation form, confirming that they met/worked with others as described in this report and reflecting on the impact of the QI initiative on their practice or organizational role. Following approval of this report, the UMHS QI MOC Program will send to participants an email message with a link to the online attestation form.

G. Sharing Results

27. Are you planning to present this QI project and its results in a:

☐ Yes ☒ No Formal report to clinical leaders?

☒ Yes ☐ No Presentation (verbal or poster) at a regional or national meeting?

☐ Yes ☒ No Manuscript for publication?

H. Project Organizational Role and Structure

28. UMHS QI/Part IV MOC oversight – indicate whether this project occurs within UMHS, AAVA, or an affiliated organization and provide the requested information.

☒ **University of Michigan Health System**

- **Overseen by what UMHS Unit/Group?** *(name): UMMG*
- **Is the activity part of a larger UMHS institutional or departmental initiative?**

☐ No ☒ Yes – the initiative is *(name or describe)*: Managing and monitoring the prescribing of controlled substances

☐ **Veterans Administration Ann Arbor Healthcare System**

- **Overseen by what AAVA Unit/Group?** *(name):*
- **Is the activity part of a larger AAVA institutional or departmental initiative?**

  ☐ No ☐ Yes – the initiative is:

☐ **An organization affiliated with UMHS to improve clinical care**

- **The organization is** *(name)***:**
- **The type of affiliation with UMHS is:**

  ☐ **Accountable Care Organization** *(specify which member institution):*

  ☐ **BCBSM funded, UMHS lead state-wide Collaborative Quality Initiative** *(specify which):*

  ☐ **Other** *(specify):*