

QI Project Preliminary Worksheet for Continuing Certification Credit Eligibility (ABMS IHC, NCCPA PI-CME)

Basic components of an eligible project are outlined below. Briefly highlight plans for each step.

- If not yet known, enter "TBA."
- To check boxes, hover pointer over the box and click (usual "left" click).

Review the overview with either of the following individuals for suggestions to facilitate completing the formal application for MOC credit.

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1. Date (this version): 2/25/15

2. Key individuals

- a. Project leader: Heather Holmstrom, MD
- b. Clinical leader who oversees the project leader regarding the project: Grant Greenberg, M.D., and David Serlin M.D.

3. Title of QI project: Improving management and monitoring of use of controlled substance by patients prescribed these medications on a chronic basis.

4. Approximate number (by specialty/subspecialty for physicians) for MOC:

| Participating for MOC | Primary Specialty | Subspecialty, if any | Number |
|------------------------|-----------------------------|----------------------|--------|
| Practicing physicians | Family Medicine | | 50 |
| Residents/Fellows | Residents – Family Medicine | | 15 |
| Physicians' Assistants | (N/A) | (N/A) | 4 |

5. Patients involved (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

PLAN

6. General purpose

a. Problem with patient care ("gap" between desired state and current state) (from logic diagram):

(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 (from logic diagram): Improve performance and documentation of CSA, MAPS, and Urine Drug testing for eligible patients on controlled substances.

7. Measure(s). For each performance measure, list its name (e.g., Percent of . . . , Mean of . . . , Frequency of . . .) and how it is calculated (denominator and numerator):

- Percent of patients with a CSA. Of the number of patients in the defined population (denominator), the number with a CSA documented in the medical record (numerator).
- Percent of patients with MAPS assessment in the past year. Of the number of patients in the defined population (denominator), the number with a MAPS assessment in the past 365 days (numerator).
- Percent of patients with a drug screen within the past year. Of the number of patients in the defined population (denominator), the number with a drug screen (Drug10, Drug Comp, GCMS, or Drug 6) in the past 365 days (numerator).

(Data 1) **8. Baseline performance**

- a. What are the beginning and ending dates for the baseline measurement period (from timeline)?

The UMHS registry of patients on controlled substances was checked for the status of Family 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. By when will the data be collected and reported (from timeline)?

1/31/15

- c. Insert or attach an example of a table or figure that will be used to present the results. (It should display the time periods, the measures, and places to enter the sample sizes and results).

| Measures | Time Periods | |
|---|---------------------|--|
| | Baseline (12/31/14) | 2 Months Post-Intervention (4/30/2015) |
| N patients in registry | N | N |
| % with Controlled Substance Agreement | % | % |
| % with Michigan Automated Prescription System | % | % |
| % with Urine Drug Screen | % | % |

9. Review baseline results, identify causes, and plan interventions

- a. Who is 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 will they meet (e.g., clinic staff meeting)?

- Departmental Population Improvement Group, which 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. On approximately what date will the review of baseline data and planning occur (from timeline)?
1/31/15 – 2/24/15

10. Baseline underlying/root cause(s) and planned interventions to address each cause.

As background, some summary examples of common causes and interventions to address them are presented in the table immediately below. The entries reflect linked causes and interventions illustrated in the center section of logic diagram for structured problem.

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

For the baseline results, list the primary underlying/root causes for the problem(s) that the project can address and the planned intervention(s) to address each cause – from logic diagram resulting from review of baseline data. (If baseline results are not yet available, list the currently hypothesized causes and likely interventions to address them. After baseline data are reviewed, the causes and interventions identified at that time will be included on the report of the project.)

| Cause(s) of Baseline Results | Planned Intervention(s) to Address |
|--|--|
| Health care providers not aware of expectations regarding controlled substance monitoring. | Educate providers and teams regarding monitoring expectations and reasons for them. |
| 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. |
| "FYI" flag that patient is on controlled substance not noted in electronic medical record, so electronic "best practice alert" prompts for monitoring do not occur | Educate physicians on how to initiate in the medical record a "FYI" flag that controlled substance have been prescribed. |
| | |

- DO** 11. **Intervention implementation.** By what date are the intervention(s) implemented (from timeline)?
2/28/15

- CHECK**
(Data 2) 12. **Post-intervention performance**
- a. What are the beginning and ending dates for the post-intervention measurement period (from timeline)? 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. By when will the data be collected and reported (from timeline)? 5/10/15

ADJUST – REPLAN 13. **Review post-intervention results, identify causes, and plan interventions**

- a. Who is involved (e.g., by profession or role)?
 Same as #9a? Different than #9a (describe):
- b. How will they meet (e.g., clinic staff meeting)?
 Same as #9b? Different than #9b (describe):
- c. On approximately what date will the review of post-intervention data and planning occur (from timeline)? 5/11/15 – 5/30/15

14. Post-intervention underlying/root cause(s) and planned interventions to address causes

For the post-intervention results, list the primary underlying/root causes for the problem(s) that the project can address and the planned intervention(s) to address each cause – from logic diagram resulting from review of post-intervention data. (If post-intervention results are not yet available, list “TBA.”)

| Cause(s) of Post-intervention Results | Planned Intervention(s) to Address |
|---|------------------------------------|
| (To be determined when data available.) | |
| | |
| | |
| | |

PARTICIPATION FOR MOC

15. Do individuals desiring credit participate in all of the following?

1. Identify and/or acknowledge a gap(s) in outcomes or in care delivery. (#6)
2. Identify and/or review data related to the gap(s). (#7-8)
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). (#9-10)
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). (#11)
5. Review post-intervention data related to the gap(s). (#12-14)
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

OPERATIONAL PLANS

16. How will you provide a list of individuals who plan to participate for MOC as described in #19?

- Have participants individually enroll through an online form provided by the UMHS Part IV Program.
- Project lead will provide to the UMHS Part IV Program a list of individuals planning to participate.

17. Are you applying also to have “Performance Improvement” CME credit (30 AMA PRA Category 1 credits) designated for physicians participating in this QI project?

- Yes No

18. 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?