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

Improving the delivery of confidential care to adolescent patients – Wave 2

Instructions

Determine eligibility. Before starting to complete this report, go to the UMHS MOC website [ocpd.med.umich.edu], 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 3 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 1-20.) 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	
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B. Plan	7-10.	Patient population, general goal, IOM quality dimensions, ACGME/ABMS competencies
	11-13.	Measures, baseline performance, specific aims
	14-17.	Baseline data review, underlying (root) causes, interventions, who will implement
C. Do	18.	Intervention implementation date
D. Check	19-20.	Post-intervention performance
E. Adjust – Replan	21-24.	Post-intervention data review, underlying causes, adjustments, who will implement
F. Redo	25.	Adjustment implementation date
G. Recheck	26-28.	Post-adjustment performance, summary of individual performance
H. Readjust plan	29-32.	Post-adjustment data review, underlying causes, further adjustments, who will implement
I. Reflections & plans	33-37.	Barriers, lessons, best practices, spread, sustain
J. Participation for MOC	38-40.	Participation in key activities, other options, other requirements
K. Sharing results	41.	Plans for report, presentation, publication
L. Organization affiliation	42.	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):* 10/4/16

2. Title of QI effort/project *(also insert at top of front page)***:** Improving the delivery of confidential care to adolescent patients.

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 #14c)**:***
Wave 2 began 9/1/15.

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 #29c)*:
Wave 2 ended 9/30/16.

4. Key individuals

a. QI project leader *[also responsible for confirming individual's participation in the project]*
Name: Margaret Riley, MD
Title: Medical Director, Adolescent Health Initiative
Organizational unit: Family Medicine
Phone number: 734-998-2163
Email address: marriley@med.umich.edu
Mailing address: 2025 Traverwood Dr, Suite A6 Ann Arbor, MI 48105

b. Clinical leader who oversees project leader regarding the project *[responsible for overseeing/"sponsoring" the project within the specific clinical setting]*
Name: Terrill Bravender, MD
Title: Division Chief
Organizational unit: Division of Adolescent Medicine, Department of Pediatrics
Phone number: 734-936-4185
Email address: tdbrave@med.umich.edu
Mailing address: C.S Mott Children's Hospital Floor 8
1540 E Hospital Dr SPC 4259
Ann ArborMI48109

5. Participants

a. Approximately how many health care providers (by training level for physicians) participated in this QI effort *(whether or not for MOC)***:**

Profession	**Number** *(fill in)*
Practicing Physicians	35
Residents/Fellows	0
Physicians' Assistants	0
Nurses (APNP, NP, RN, LPN)	0
Other Licensed Allied Health (e.g., PT/OT, pharmacists, dieticians, social workers)	0

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

Profession	**Specialty/Subspecialty** *(fill in)*	**Number** *(fill in)*
Practicing Physicians	Family Medicine	9
	Pediatrics	17
	Medicine-Pediatrics	7
	OB/GYN	2
Fellows		0
Residents		0
Physicians' Assistants	*(Not applicable)*	0

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

☒ Internal institutional funds (Funding for the broader Adolescent Champion project comes from the Michigan Department of Health and Human Services, but no funding was used for this MOC specifically)

☐ Grant/gift from pharmaceutical or medical device manufacturer

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

☐ Subscription payments by participants

☐ Other *(describe)*:

The Multi-Specialty Part IV MOC Program requires that QI efforts include at least two linked cycles of data-guided improvement. Some projects may have only two cycles 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)***:**

Patients ages 12-17 in participating Pediatrics, Family Medicine, OB/GYN, and Medicine-Pediatrics practices.

8. General goal

a. Problem/need. What is the problem ("gap") in quality that resulted in the development of this project? Why is important to address this problem?

Adolescent patients frequently do not receive recommended confidential care resulting in missed opportunities for addressing health concerns specific to this age group. Physicians support confidential care for adolescent patients, but have knowledge gaps around Michigan's minor consent and parental notification laws. Confidential care may also be difficult to provide in a busy ambulatory care setting with parents present.

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 #13.)

Physicians will improve the provision of confidential care to minor adolescents by more frequently spending time alone with adolescents during an annual well child visit, explaining confidentiality laws to the patient, and performing confidential risk screening.

9. Which Institute of Medicine Quality Dimensions are addressed? *[Check all that apply.]* *(http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf)*

☒ Effectiveness	☒ Equity	☐ Safety
☐ Efficiency	☒ Patient-Centeredness	☐ Timeliness

10. Which ACGME/ABMS core competencies are addressed? *(Check all that apply.)* (http://www.abms.org/board-certification/a-trusted-credential/based-on-core-competencies/)

☒ Patient Care and Procedural Skills	☐ Medical Knowledge
☒ Practice-Based Learning and Improvement	☒ Interpersonal and Communication Skills
☒ Professionalism	☐ Systems-Based Practice

11. Describe the measure(s) of performance: *(QI efforts must have at least one measure that is tracked across the two cycles for the three measurement periods: baseline, post-intervention, and post-adjustment. 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 adolescent patients that had confidential time with physician.
- **Measure components** – *describe the:*

  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:
  20 patient charts of adolescents seen for new patient (OB/GYN) or annual well exams (for peds, fam med, and med peds), (or the total number seen in the past 3 months if less than 20).

  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:
  Number of patients who had alone time with the physician

- **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)*: Data can be pulled via chart reviews.
- **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 adolescent patients to whom confidentiality laws/limits were explained.
- **Measure components** – *describe the:*

  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:
  20 patient charts of adolescents seen for new patient (OB/GYN) or annual well exams (for peds, fam med, and med peds), (or the total number seen in the past 3 months if less than 20).

Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:

Number of patients to whom the confidentiality laws/limits was explained.

- **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)*: Data can be pulled via chart reviews.
- **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 the two cycles, copy and paste the section for a measure and describe the additional measures.)

Measure 3

- **Name of measure** *(e.g., Percent of . . ., Mean of . . ., Frequency of . . .)***:**
  Percent of adolescent patients who confidentially completed a standardized risk screening assessment.
- **Measure components** – *describe the:*

  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:
  20 patient charts of adolescents seen for new patient (OB/GYN) or annual well exams (for peds, fam med, and med peds), (or the total number seen in the past 3 months if less than 20).

  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:
  Number of patients who confidentiality completed a standardized risk screening assessment.
- **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)*: Data can be pulled via chart reviews.
- **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 the two cycles, copy and paste the section for a measure and describe the additional measures.)

12. Baseline performance

a. What were the beginning and end dates for the time period for <u>baseline</u> data on the measure(s)?
For Wave 2, July 1st, 2015 – September 30th, 2015

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.*

Chart Analysis	Baseline
Confidential time spent with patient	
Yes	348
No	122
n	470
PERCENTAGES (Yes/Total)	**74%**
Confidentiality laws/limits explained to patient	
Yes	276
No	194
n	470
PERCENTAGES (Yes/Total)	**59%**
Standardized risk screening (e.g. RAAPS)	
Yes	264
No	207
n	471
PERCENTAGES (Yes/Total)	**56%**

13. 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]."*

The targets for the three main performance measures are that 95% of adolescent patients seen for well child checks within family medicine, pediatrics, or medicine-pediatrics, or new patient visits in OB/GYN will have their physician (a) spend time alone with them, (b) explain minor consent laws to them, and (c) have them complete a confidential risk screening tool. Physicians will work to reach these goals from November 1st, 2015 through July 31st, 2016.

b. How were the performance targets determined, e.g., regional or national benchmarks?
The target was set at 95% based on leadership's experience in clinic. Occasionally confidential time and risk screening is not appropriate or possible (i.e. a special needs adolescent unable to independently complete a risk screening tool).

14. 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)* All participating physicians.

b. How? *(e.g., in a meeting of clinic staff)* In person at provider meetings and/or via e-mail.

c. **When?** *(e.g., date(s) when baseline data were reviewed and discussed)* Between 10/1/2015 and 10/31/2016

Use the following table to outline the plan that was developed: #15 the primary causes, #16 the intervention(s) that addressed each cause, and #17 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.*

15. What were the primary underlying/root causes for the <u>problem(s) at baseline</u> that the project can address?	**16. What intervention(s) addressed this cause?**	**17. Who was involved in carrying out each intervention?** *(List the professions/roles involved.)*
Providers don't think about discussing the details of confidentiality.	Provided all staff confidentiality training. Posted posters, handouts of confidentiality laws.	Physicians and all staff.
No current use of standardized risk screening tool.	Apply for license to use RAAPS and implement it in clinic.	Physicians, clinic manager.
Incomplete documentation by provider for utilization of risk screening tool, confidential time spent with patient, and laws discussed.	Revised current adolescent well child template to incorporate documentation for risk screening, explanation of confidentiality laws, and confidential time spent with patient.	Physicians.
Low provider and staff knowledge of confidentiality laws.	Educate faculty and staff on confidentiality laws.	Physicians and all staff.
Current workflow does not give adolescent alone time.	Change workflow to allow for adolescent alone time.	Physicians and staff.
Not currently expected that a patient will be alone with the provider as a consistent practice.	Establish a uniform process across all the providers to ensure alone time with adolescent patients.	Physicians.
Patients not completing risk screening tool confidentially.	Move to electronic version of risk screening tool and have tablet mounted in private space, or develop a workflow to have the patient complete on paper confidentially.	Physicians, MAs, clinic manager.

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

C. Do

18. By what date was (were) the intervention(s) initiated? *(If multiple interventions, date by when all were initiated.)*

For Wave 2, December 1st, 2015

D. Check

19. Post-intervention performance measurement. Are the population and measures the same as those for the collection of baseline data (see items 10 and 11)?

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

20. Post-intervention performance

a. What were the beginning and end dates for the time period for post-intervention data on the measure(s)?
12/1/15 – 2/29/16

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.*

Chart Analysis	Baseline	Mid Cycle
Confidential time spent with patient		
Yes	348	303
No	122	111
n	470	414
PERCENTAGES (Yes/Total)	**74%**	**73%**
Confidentiality laws/limits explained to patient		
Yes	276	294
No	194	120
n	470	414
PERCENTAGES (Yes/Total)	**59%**	**71%**
Standardized risk screening (e.g. RAAPS)		
Yes	264	269
No	207	154
n	471	423
PERCENTAGES (Yes/Total)	**56%**	**64%**

c. Did the intervention(s) produce the expected improvement toward meeting the project's specific aim (item 13.a)?
Movement was varied from baseline to mid-year for the three main outcome measures. None of the measures reached the specific aim of 95%, and there was a decrease in confidential time spent with patients of 0.8%. While the other measures did show improvement, they were still short of the specific goal. For confidentiality laws/limits explained to patients, there was an increase of 12.3%. Lastly, for use of a standardized risk screening tool confidentially, there was a slight increase of 2.8%.

E. Adjust – Replan

21. 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 #14? ☐ Different than #14 *(describe):*

b. How? *(e.g., in a meeting of clinic staff)*
☒ Same as #14? ☐ Different than #14 *(describe):*

c. **When?** *(e.g., date(s) when post-intervention data were reviewed and discussed)*
4/1/16 – 4/30/16

Use the following table to outline the next plan that was developed: #22 the primary causes, #23 the adjustments(s)/second intervention(s) that addressed each cause, and #24 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.

22. What were the primary underlying/root causes for the problem(s) following the intervention(s) that the project can address?	**23. What adjustments/second intervention(s) addressed this cause?**	**24. Who was involved in carrying out each adjustment/second intervention?** *(List the professions/roles involved.)*
Patient/parents not aware of confidentiality laws.	Put up posters for parents/teens and give handouts.	Physicians and clinic manager.
Time constraints for risk screening.	Develop streamlined workflows for well child exams to include risk screening.	Physicians, MAs, clinic manager.
Parent resistance/ discomfort with confidential time.	Improve communication with parents and explain reasons for confidential time before the well visit so they understand why it is important and aren't shocked when asked to leave the room.	Physicians.
Low rate of adolescent well child exams to provide opportunity to educate adolescents on confidential care.	Work with panel manager to identify adolescents due for well child exam and reach out to schedule.	Physicians, nurses, MAs
Poor understanding of insurance billing for confidential adolescent services	Educate providers and adolescents regarding billing/EOB	Physicians, clinic manager.
Inconsistency in obtaining and documenting adolescent contact information	Develop process for obtaining and recording adolescent contact information	Physicians, MAs, front desk staff.

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

F. Redo

25. By what date was (were) the adjustment(s)/second intervention(s) initiated? *(If multiple interventions, date by when all were initiated.)*
5/1/16

G. Recheck

26. Post-adjustment performance measurement. Are the population and measures the same as indicated for the collection of post-intervention data (item #21)?

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

27. Post-adjustment performance

a. What were the beginning and end dates for the time period for post-adjustment data on the measure(s)?
5/1/16 – 7/31/16

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

Chart Analysis	Baseline	Mid Cycle	Post
Confidential time spent with patient			
Yes	348	303	393
No	122	111	74
n	470	414	467
PERCENTAGES (Yes/Total)	**74%**	**73%**	**84%**
Confidentiality laws/limits explained to patient			
Yes	276	294	385
No	194	120	83
n	470	414	468
PERCENTAGES (Yes/Total)	**59%**	**71%**	**82%**
Standardized risk screening (e.g. RAAPS)			
Yes	264	269	369
No	207	154	99
n	471	423	468
PERCENTAGES (Yes/Total)	**56%**	**64%**	**79%**

c. Did the adjustment(s) produce the expected improvement toward meeting the project's specific aim (item 13.a)?
The adjustments made during mid-year for the three main outcome measures lead to positive improvement during the final cycle of data collection, although none of the measures reached the

aim of 95%. Confidential time spent with adolescent patients increased from 74% at baseline to 84% at year-end. At baseline, providers explained the laws and limits of confidentiality to patients 59% of the time whereas, at year-end, that rose to 82%. Lastly, at baseline, providers were having patients confidentially complete a standardized risk screening tool 56% of the time. At year end, they rose to 79%.

28. Summary of individual performance

a. Were data collected at the level of individual providers so that an individual's performance on target measures could be calculated and reported?

☒ Yes ☐ No – go to item 29

b. **If easily possible, for each listed group of health care providers:**

- **Participants with data available:**
  - **Indicate the number participating** *(if none, enter "0" and do not complete rest of row)*
  - **if any are participating, are data on performance of individuals available?** *(If "No", do not complete rest of row.)*
- **if data on performance are available, then enter the number of participants in three categories regarding reaching target rates (i.e. the specific aims for measures).**

(If you do not have this information or it is not easily available, leave the table blank.)

Profession	Participants with Data Available		Number of These Participants Reaching Targets		
	# Participating in QI Effort (from #5.a)	**Data on Performance of Individuals Available?** *(Enter Yes or No)*	**# Not Reaching Any Target Rate**	**# Reaching at Least One Target Rate**	**If Multiple Target Rates, # Reaching All Target Rates** *(If only one rate, enter NA.)*
Practicing Physicians	35	Yes	5	30	12
Residents/ Fellows					
Physicians' Assistants					
Nurses (APNP, NP, RN, LPN)					
Other Licensed Allied Health					

H. Readjust

29. Post-adjustment data review and further planning. Who was involved in reviewing the post-adjustment 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 #21? ☐ Different than #21 *(describe):*

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

☒ Same as #21? ☐ Different than #21 *(describe):*

c. **When?** *(e.g., date(s) when post-adjustment data were reviewed and discussed)*

9/1/16 – 9/30/16

Use the following table to outline the next plan that was developed: #30 the primary causes, #31 the adjustments(s)/second intervention(s) that addressed each cause, and #32 who would carry 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: Adjustments(s) may result in performance achieving the targeted specific aims and the review of post-adjustment data identifies no further causes that are feasible or cost/effective to address. If so, the plan for a next cycle could be to continue the interventions/adjustments currently implemented and check that performance level(s) are stable and sustained through the next observation period.

30. What were the primary underlying/root causes for the problem(s) following the adjustment(s) that the project can address?	**31. What further adjustments/ intervention(s) might address this cause?**	**32. Who would be involved in carrying out each further adjustment/intervention?** *(List the professions/roles involved.)*
All of the providers differ in how they have the patients fill out the risk screening forms.	Roll out a standard workflow for patient to come to exam room alone before meeting with provider to fill out risk screening form.	Physicians, MAs, clinic manager.
Providers differ in how/how regularly they ask parents to leave room.	Establish a uniform process across all of the providers in the pitch of spending time confidentially as well has how often we do it.	Physicians.
Parents upset that they need to be left out of the room for so long.	Train a champion at the front desk to provide parents with confidentiality handouts, interact with parents and field their questions and concerns.	Physicians, front desk.

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

33. 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:*

☐ Further cycles will occur and are to be documented for MOC. *If checked, contact the UM Part IV MOC Program to determine how the project's additional cycles can be documented most practically.*

I. Reflections and Future Actions

33. Describe any barriers to change (i.e. problems in implementing interventions listed in #16 and #23) that were encountered during this QI effort and how they were addressed.

Creating a workflow to ensure that risk screening is done confidentially was a challenge. Having staff from different areas of the clinic help design and implement workflows was helpful.

Lastly, modifying the adolescent well child template helped prompt providers to not only discuss the laws, spend alone time with teens, and review the risk screening tool, but also helped streamline documentation of these behaviors.

34. Describe any key lessons that were learned as a result of the QI effort.

Engaging multidisciplinary teams was helpful in workflow design. Engaging physicians via MOC helped shine a light on the unique needs of adolescents in primary care, and can help improve their care overall. Staff and physicians doing professional development together in the spark trainings is a powerful mechanism for change.

35. Describe any best practices that came out of the QI effort.

Adolescents need to be able to complete the risk screening tool privately and confidentially to feel as though they can answer truthfully. Engage staff early when planning workflow changes. Use a standardized risk screening tool for best results.

36. Describe any plans for spreading improvements, best practices, and key lessons.

Results of the first year of this MOC was submitted and accepted for publication.

Riley M, Ahmed S, Lane J, Reed BD, Locke A. Using Maintenance of Certification (MOC) as a Tool to Improve the Delivery of Confidential Care for Adolescent Patients Journal of Pediatric and Adolescent Gynecology. J Pediatr Adolesc Gynecol. 2016 Aug 16. pii: S1083-3188(16)30138-3.

We continue to roll out new cohorts of physicians participating in the MOC, and give them additional guidance on best practices, etc.

37. Describe any plans for sustaining the changes that were made.

Sites continue to hone workflows, train new staff on these workflows in an onboarding plan, and use templates, etc., to automate the best practices identified in this project.

J. Minimum Participation for MOC

38. 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 #39.*

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

- Reviewing and interpreting baseline data, considering underlying causes, and planning intervention as described in item #14.
- Implementing interventions described in item #16.
- Reviewing and interpreting post-intervention data, considering underlying causes, and planning intervention as described in item #21.
- Implementing adjustments/second interventions described in item #23.
- Reviewing and interpreting post-adjustment data, considering underlying causes, and planning intervention as described in item #29.

☒ Yes ☐ No *If "Yes," individuals are eligible for MOC unless other requirements also apply and must be met – see item # 40.*

39. 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 40.*

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 # 40. If "No," continue to #39c.*

c. Did the individual(s) supervising 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 # 40.*

40. 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.

K. Sharing Results

41. 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?

L. Project Organizational Role and Structure

42. 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):* UMHS Adolescent Health Initiative
- **Is the activity part of a larger UMHS institutional or departmental initiative?**

☒ No ☐ Yes – the initiative is *(name or describe*):

☐ **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)***:** IHA Canton Pediatrics, Helen DeVos Pediatrics, Helen DeVos Adolescent Medicine, St. John Provident Pediatrics, St. Mary Mercy MedPeds
- **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):* Primary care practices participating in the UMHS Adolescent Health Initiative's grant-funded Adolescent Champion project.