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

Improving the rate of returning Conner’s Scales for patients who may have ADHD

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:
- R. Van Harrison, PhD, UMHS Part IV Program Co-Lead, 734-763-1425, rvh@umich.edu
- Ellen Patrick, UMHS Part IV Program Administrator, 734-936-9771, partivmoc@umich.edu

**Report Outline**

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</tr>
</tbody>
</table>
QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date: 12/21/2016

2. Title of QI effort/project:
   Improving the rate of returning Conners Scales for patients who may have ADHD

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): Baseline data collection- April 1, 2016 - April 30, 2016
   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): December 13, 2016

4. Key individuals
   a. QI project leader
      Name: Dr. Megan Pesch, Dr. Jacqueline Branch, and Dr. Tiffany Munzer (primary contact)
      Title: DBP fellow
      Organizational unit: DBP
      Phone number: 734-936-9777
      Email address: chungti@umich.edu
      Mailing address: 1540 E. Hospital Dr., Ann Arbor, MI, 48109
   b. Clinical leader to whom the project leader reports regarding the project
      Name: Dr. Barb Felt
      Title: DBP Fellowship Director
      Organizational unit: DBP
      Phone number: 734-936-9777
      Email address: truefelt@umich.edu
      Mailing address: 1540 E. Hospital Dr., Ann Arbor, MI, 48109

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

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number (fill in)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicing Physicians</td>
<td>4</td>
</tr>
<tr>
<td>Residents/Fellows</td>
<td>3</td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td>0</td>
</tr>
<tr>
<td>Nurses (APNP, NP, RN, LPN)</td>
<td>1</td>
</tr>
<tr>
<td>Other Licensed Allied Health (e.g., PT/OT, pharmacists, dieticians, social workers)</td>
<td>0</td>
</tr>
</tbody>
</table>

   b. Approximately how many physicians (by specialty/subspecialty and by training level) and physicians’ assistants participated for MOC?
<table>
<thead>
<tr>
<th>Profession</th>
<th>Specialty/Subspecialty (fill in)</th>
<th>Number (fill in)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicing Physicians</td>
<td>DBP</td>
<td>4</td>
</tr>
<tr>
<td>Fellows</td>
<td>DBP</td>
<td>3</td>
</tr>
<tr>
<td>Residents</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td>(Not applicable)</td>
<td>0</td>
</tr>
</tbody>
</table>

6. **How was the QI effort funded?** *(Check all that apply.)*
   - [ ] Internal institutional funds
   - [ ] Grant/gift from pharmaceutical or medical device manufacturer
   - [ ] Grant/gift from other source (e.g., government, insurance company)
   - [ ] Subscription payments by participants
   - [x] Other *(describe)*: funds not required

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 3 years and older evaluated in developmental behavioral pediatric consultation clinic with behavior problems where ADHD is part of the differential and the clinician requests Conners rating scales is indicated in the “plan” portion of the clinic note in the chart.

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? **Problem (“gap”) in patient care:** Diagnosis of ADHD requires presence of symptoms in two or more settings (typically home and school). Conners rating scales are a useful diagnostic tool for ADHD. These are often emailed to families at the end of the patient visit and they will fill out an online link. The results are then scored automatically by the computer and we are then able to make an ADHD diagnosis or rule it out. With this process, the typical rate of return of these forms is less than 50% and the typical rate of return within 1 month is about 40%. When the rating scales are not completed and returned, the identification of the appropriate diagnosis is delayed, which in turn delays the initiation of appropriate treatment to improve patient well-being. Additionally, more resources have to be used to follow up on obtaining completed forms.

    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.)* **Project goal:** Shorten the time to treatment for ADHD and reduce unnecessary use of resources by increasing the rate of parent Conners returns within 1 month of request date to 80%.

9. **Which Institute of Medicine Quality Dimensions are addressed?** *(Check all that apply.)*
University of Michigan Health System Part IV Maintenance of Certification Program

☒ 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/](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/components:** Percent of patients receiving printed instructions on how to return ADHD forms (Connor’s scale)
- **Measure components – describe the:**
  - Denominator *(e.g., for percent, often the number of patients eligible for the measure):*
    Number of charts with parent Connor’s scale requested by provider
  - Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation):*
    Number of these charts where the provider used a “dot phrase” in the EMR that adds to the visit summary (printed for patients at the end of the visit) instructions for returning the ADHD forms (Conners Scale).
- **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):* is something we use regularly
- **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/components:** Percent of ADHD forms (Conners scale) returned
- **Measure components – describe the:**
  - Denominator *(e.g., for percent, often the number of patients eligible for the measure):*
    Number of charts with parent Connor’s scale requested
  - Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation):*
    Number of these charts with Connor’s scale returned
- **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):* is something we use regularly
• This is a measure of:
  ☒ Process – activities of delivering health care to patients
  ☐ Outcome – health state of a patient resulting from health care

Measure 3
• Name of measure/components: Percent of ADHD forms (Conner’s scale) returned within 1 month
• Measure components – describe the:
  Denominator (e.g., for percent, often the number of patients eligible for the measure): Number of charts with parent Connor’s scale requested
  Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation): Number of these charts with Connor’s scale returned within 1 month
• 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): is something we use regularly
• 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 baseline data on the measure(s)? April 1, 2016 - April 30, 2016

b. What was (were) the performance level(s) at baseline? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Number of patients where ADHD forms were requested in clinic</th>
<th>% of patients receiving instructions on how to return ADHD forms</th>
<th>% of total ADHD forms returned</th>
<th>% of total ADHD forms returned within 1 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline data</td>
<td>19</td>
<td>21%</td>
<td>47%</td>
<td>42%</td>
</tr>
<tr>
<td>4/1-4/30/16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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].”

By the end of the second cycle of data collection (12/9/16), we aim to improve:

- the percent of patients receiving instructions on how to return Conners forms from 21% to 80%.
- the overall percent of parent’s Conners forms returned from 47% to 90%.
- the percent of parent’s Conners forms returned within one month of request date from 42% to 80%.

b. How were the performance targets determined, e.g., regional or national benchmarks?
There are no regional or national benchmarks available for this outcome. We chose targets that we felt were realistic given external factors that limit patients completing the scales and within the timeframe of the efforts.

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?** Dr. Barbara Felt, Dr. Jenny Radesky, Dr. Prachi Shah, Dr. Julie Lumeng, Dr. Megan Pesch, Dr. Jacqueline Branch, Maithri Malladi, and Dr. Tiffany Munzer

b. **How?** Clinical staff meeting

c. **When?** August 9, 2016

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_Using 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](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:

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

15. **What were the primary underlying/root causes for the problem(s) at baseline 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.)

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Email format: parents not sure who the email is from, the email is encrypted so they are unable to access the Change subject and content of email so it does not need to be encrypted. Dr. Munzer, Dr. Pesch, Dr. Felt and Dr. Radesky crafted the updated email template that did not need
Parents do not know who the Conners is coming from and so do not open the email.

Add a dot phrase in the after visit summary noting that parents will be receiving an email from Maithri Malladi requesting they complete a survey to assess for ADHD.

All physicians, the NP and fellows.

Parents do not know where instructions are written in the after visit summary.

Show parents in clinic where these instructions are so they can refer to them at home.

All physicians, the NP and fellows.

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.) August 15, 2016

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)? August 15, 2016-September 10, 2016

What was (were) the overall performance level(s) post-intervention? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Number of patients where ADHD forms were requested in clinic</th>
<th>% of patients receiving instructions on how to return ADHD forms</th>
<th>% of total ADHD forms returned</th>
<th>% of total ADHD forms returned within 1 month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline data 4/1-30/16</td>
<td>19</td>
<td>21%</td>
<td>47%</td>
<td>42%</td>
</tr>
<tr>
<td>Post-intervention data 8/15/16 – 9/10/16</td>
<td>11</td>
<td>90%</td>
<td>54%</td>
<td>36%</td>
</tr>
</tbody>
</table>

c. Did the intervention(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)?

Only the performance of personnel within the clinic improved appreciably, the return rate by patients did not. The % of parents receiving instruction on how to return the Conners surpassed the
aim of 80%. The % of parent Conners returned overall increased slightly and the % of parent Conners returned within one month decreased slightly.

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)
   10/14/2016

Use the following table to outline the next plan that was developed: #22 the primary causes, #23 the adjustments/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](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.

<table>
<thead>
<tr>
<th>22. What were the primary underlying/root causes for the problem(s) following the intervention(s) that the project can address?</th>
<th>23. What adjustments/second intervention(s) addressed this cause?</th>
<th>24. Who was involved in carrying out each adjustment/second intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents still did not see the instructions about completing Connor’s forms on the after visit summary because it is small and might not be easily visible to parents.</td>
<td>Increase font size of instructions on the after visit summary given to patients/parents. This will make it stand out more and be viewed as separate from the rest of the summary.</td>
<td>Dr. Megan Pesch adjusted the dot phrase for all physicians and fellows to use.</td>
</tr>
</tbody>
</table>

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.) October 17, 2016
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)? October 17, 2016-November 7, 2016

   b. What was (were) the overall performance level(s) post-adjustment? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Number of patients where ADHD forms were requested in clinic</th>
<th>% of patients receiving instructions on how to return ADHD forms</th>
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</tr>
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<tbody>
<tr>
<td>Baseline data 4/1-30/16</td>
<td>19</td>
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<td>11</td>
<td>90%</td>
<td>54%</td>
<td>36%</td>
</tr>
<tr>
<td>Post-adjustment data 10/17/16-11/7/16</td>
<td>20</td>
<td>80%</td>
<td>40%</td>
<td>40%</td>
</tr>
</tbody>
</table>

   c. Did the adjustment(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)?
   The additional intervention did not change the pattern of results. The percent of patients receiving instructions on how to return forms remained at the goal of ≥ 80%. However, the rates for patients returning forms remains essentially unchanged from baseline.

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

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)
   ☒ Different than #21 (describe): Via email review of information.

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

*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.

<table>
<thead>
<tr>
<th>30. What were the primary underlying/root causes for the problem(s) following the adjustment(s) that the project can address?</th>
<th>31. What further adjustments/intervention(s) might address this cause?</th>
<th>32. Who would be involved in carrying out each further adjustment/intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
</table>
| Parents too busy or forget to complete Conners scales after the appointment. | 1. Administer Conners in clinic to parents.  
2. Mail Conners to parents prior to clinic appointment | 1. Clinic coordinator (Kristy Bajcz).  
2. Clinic administrators. |
| Email may still be getting sent to parents’ spam inbox. | Call or email 1 week later to make sure email arrived in inbox. | Maithri Malladi. |
| Parents may not like the idea of labeling their child with ADHD and therefore decline completion of Conners. | Explain Conners scale as general behavior rating scale | Care providers: Dr. Barbara Felt, Dr. Julie Lumeng, Dr. Prachi Shah, Dr. Megan Pesch, Dr. Jackie Branch, Dr. Tiffany Munzer Jess Hamadi NP. |
| Email address provided may be incorrect. | 1. Confirm email address in clinic.  
2. Call 1 week later to make sure email arrived in inbox. | 1. Clinic coordinator (Kristy Bajcz).  

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:
We will consider administering Conners in clinic to parents, mailing Conners to parents prior to clinic appointments, or calling/emailing 1 week after clinic visit to ensure that the email has been received by family.

☐ 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.
Rotating residents were not aware of QI project and thus could not incorporate the MiChart dot phrase into the patient instructions. An email was sent to the pediatric residents and the phrase was shared with residents so they could incorporate these into the instructions. Additionally, the patient instructions may not always be clearly visible to families. Providers were asked via email to show the instructions to families during the clinic visit.

34. Describe any key lessons that were learned as a result of the QI effort.
Though use of the written instructions regarding how to fill out and return ADHD forms online was 80% at the end of the second cycle, there was no improvement in rate of return within 1 month or returns in general. This finding resulted in our questioning whether having patients/parents completing the Connors Scale after they leave the clinic will ever be able to achieve our goals for having completed scales to aid in diagnosis. Current considerations include shifting the model for when patients/parents complete the scale to when they are in clinic and can be assisted and use the model of completing the scale at a later time only when the scale cannot be completed sooner (see #30 - #32).

35. Describe any best practices that came out of the QI effort.
A MiChart dot phrase was created in the electronic medical record that initiates printing instructions for families regarding the process for completing ADHD (Conners) form and for forwarding the information to the clinic.

36. Describe any plans for spreading improvements, best practices, and key lessons.
We plan to spread improvements by sharing the MiChart dot phrase with rotating residents so families receive clear instructions.

37. Describe any plans for sustaining the changes that were made.
We plan to continue use of the MiChart dot phrase in the after visit summary dot phrase, as it is important to communicate instructions clearly and easily to families.

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:

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):
   • 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):
- 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):