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

Transforming Depression: A Great Lakes Practice Project – Wave 12

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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</table>
A. Introduction

1. Date (this version of the report): 5/3/18

2. Title of QI effort/project (also insert at top of front page): Transforming Depression: A Great Lakes Practice Project

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):
   See Appendix A for the overall project timeline. Twenty-six “waves” of groups of medical practices will initiate their participation in the project monthly for 26 months. Wave 12 began in October 2017.

   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):
   Each “wave” of groups of medical practices will perform two cycles of improvement effort over six months. The final wave will be completed about May 2019. Wave 12 finished in March 2018.

4. Key individuals
   a. QI project leader [also responsible for confirming individual’s participation in the project]
      Name: Carley Kirk, MS
      Title: Physician Engagement Lead
      Organizational unit: Altarum Institute
      Phone number: 734-302-4727
      Email address: carley.kirk@altarum.org
      Mailing address: 3520 Green Court, Suite 300, Ann Arbor, MI. 48105

   b. Clinical leader to whom the project leader reports regarding the project [responsible for overseeing/“sponsoring” the project within the specific clinical setting]
      Name: Sagar Parikh, MD, FRCPC
      Title: Professor of Psychiatry, Associate Director
      Organizational unit: University of Michigan
      Phone number: 734-936-4400
      Email address: parikhss@med.umich.edu
      Mailing address: Rachel Upjohn Building 4250 Plymouth Rd., SPC 5763, Ann Arbor, MI. 48109-2700

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 for Wave 12</th>
<th>Estimated Number for Entire Project</th>
</tr>
</thead>
</table>

2
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 for Wave 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicing Physicians</td>
<td>Family Medicine</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Pediatrics</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>OB/GYNs</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Internal Medicine</td>
<td>0</td>
</tr>
<tr>
<td>Fellows</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Residents</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td>(Specialty 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): Centers for Medicare and Medicaid Services: Transforming Clinical Practice Initiative
☐ 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 aged 12 and older, not limited by insurance coverage type, in Michigan and Ohio who are treated in practices that are not part of an Accountable Care Organization (ACO).

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?

In the United States, approximately one in three adults will experience a major depressive episode during his or her lifetime, and recent data show that one in twelve have experienced a major
Depressive episode within the past year. Major depression disorder (MDD) and dysthmic disorder (chronic depression) are common in older adults. Patients diagnosed with MDD are often under-dosed, experience lack of follow-up care, and are not likely to have had a standardized depression screening. Although depression results in significant morbidity and mortality, 25% of patients are undiagnosed, and less than one-half of those who are diagnosed receive treatment. More so, national screening rates for depression are extremely low for outpatient clinics; often averaging less than 5% of eligible patients having a documented depression screen. The United States Preventive Services Task Force (USPSTF) has defined goals for depression screening, a necessary task to ensure accurate diagnosis. In addition, the American Medical Association (AMA) and the Physician Consortium for Performance Improvement (PCPI) have outlined clinical performance measures for management of patients with MDD. Furthermore, disparities exist between evidence-based medicine and clinical practice, and clinicians have been slow to adopt best practice changes in practice.

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.)

Improve the early identification and early intervention for patients in primary care settings with depression and/or depressive symptoms by:

- Increasing use of standardized depression screening and
- Increasing documentation of follow-up plans for patients positively screened.

9. Which Institute of Medicine Quality Dimensions are addressed? [Check all that apply.]

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

10. Which ACGME/ABMS core competencies are addressed? (Check all that apply.)

- 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: Standardized Depression Screening Tool Utilization Rate

- 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 patient charts pulled, excluding patients with a current diagnosis of depression and/or bipolar disorder.
  Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
  Number of patients screened using a standardized depression screening tool

- The source of the measure is:
  - An external organization/agency, which is (name the source): Depression Screening-based on the NQF Measure 0418: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan – National Quality Strategy Domain: Community/Population Health.
  - Internal to our organization and it was chosen because (describe rationale):
• 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: Follow-Up Plan Documentation Rate

• 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 eligible patients with a positive depression screening result
  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 documented follow-up plan

• The source of the measure is:
  ☒ An external organization/agency, which is (name the source): Follow-Up Plan- based on the NQF Measure 0418: Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan – National Quality Strategy Domain: Community/Population Health.
  ☐ Internal to our organization and it was chosen because (describe rationale):

• 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)?

General baseline data were checked as part of a national survey of outpatient clinic providers during the timeframe of 2005-2010, and were reported in 2013. The National Ambulatory Medical Care Survey (NAMCS) conducted an annual cross-sectional survey of visits to office-based physicians across the United States as part of the National Center for Health Statistics, Centers for Disease Control and Prevention. This survey confirmed that based on the average of 947 million annual patient visits, the average frequency of documented depression screening was less than 5% for primary care physicians. This initial data will be reported to participating providers as the baseline assumption at the initial meeting (month 1) of their participation group.

A retrospective confirmation of actual baseline data within each participating provider’s practice was performed. Baseline data were collected for the month prior to the beginning of a wave of participants. For Wave 12 it was for September 1 – 30, 2017.

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.)

See Appendix B, first column of data, for the baseline percent of patients with service performed by Wave.

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].”

From the month prior to initial interventions to the end of the second cycle of improvement effort (September 2017 through March 2018 for this wave):
- 50% of eligible patients will be screened using a standardized depression screening tool
- 50% of positively screened patients will have a follow-up plan documented

b. How were the performance targets determined, e.g., regional or national benchmarks?
The performance targets were determined locally by project leaders, based on feasibility of amount of increase over the time of two short cycles.

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)
   Participating physicians and any relevant nurse practitioners, physician assistants, and clinical support staff in the practice.

b. How? (e.g., in a meeting of clinic staff)
   During clinical staff meetings.

c. When? (e.g., date(s) when baseline data were reviewed and discussed)
   Before the end of month 1 of the “Wave.” For Wave 12 it was before the end of month 1, October 2017.

Use the following table to outline the plan that was developed: #15 the primary underlying/root causes for the problem(s) at baseline that the project can address, #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?

Clinical education
Providers may not be aware of recommendations regarding depression screening and management and the basis for them. Providers often lack the training needed to

16. What intervention(s) addressed this cause?

Central program personnel train physicians, and any relevant nurse clinicians and physician assistants in the practice to:
- Be cognizant of depression screening recommendations
- Perform depression screens

17. Who was involved in carrying out each intervention? (List the professions/roles involved.)

Central program personnel, local office champion and all clinic personnel (e.g., physicians, nurse clinicians, physician assistants, and office staff)
### University of Michigan Health System Part IV Maintenance of Certification Program

| be able to apply the collaborative care model for patients with depression. | • Understand the management of depression when identified, and make follow-up plans  
• Make operational changes in the process of patient care that facilitate the provision and documentation of appropriate care.  
• Collect and report individual practice data. |
|---|---|
| Routine office processes  
Processes do not systematically incorporate recommended activities.  
No routine processes to coordinate office staff in delivering the care | • Local provider groups determine specific operational changes based on the general recommendations for improving care.  
• Technical assistance provided to help improve the management of patients with MDD and dysthymic disorder, including adherence to related AMA, PCPI, Physician Quality Reporting System (PQRS) clinical performance expectations and measures. Training includes how providers can incorporate validated evidence-based depression screening tools into clinical work flow, and develop patient follow-up plans, including implementation of the collaborative care model when appropriate. |
| Resources  
Resources for managing patients with depression are unknown or are unavailable and/or not easily accessible. | • Local solutions and resources are identified to manage patients with depression and/or patients who are suicidal. |
| Documentation  
Even when activities are performed, they may not be documented because the expectations for documentation are not clear or time to make entries in the medical record is limited. | • Training includes how providers can efficiently incorporate documentation into the workflow for depression screening, and plans for patient follow-up. |

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.)*  
Before the end of month 1 of the group’s participation. For Wave 12, before the end of month 1, October 2017.

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)?
   From the beginning to the end of month 3 of the cycle. For Wave 12, during month 3, December 1 – 31, 2017.

b. 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.)
   See Appendix B, middle column of data, for the post-intervention percent of patients with service performed and documented within and across the practices.

c. Did the intervention(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)?
   There was no improvement from baseline to post-intervention. For Wave 12, the baseline performance for the participating practice was 0% for both measure #1 and measure #2. Measure 1 (depression screening) performance remained at 0% for post-intervention, and as a result there were no eligible patients identified for measure #2 (follow-up plan documentation). Both measure goals of 50% were not met. This lack of improvement was a result of EHR issues and lack of a standardized workflow leading to improper documentation.

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)
   Before the end of month 4 of the group’s participation. For Wave 12, during month 4, January 2018.

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.

<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>Clinic personnel. Staff were unsure what depression screening tool should be used for pregnant teens.</td>
<td>Central program personnel continued education and shared additional resources related to the newly identified problems: Screening of pregnant teens is important and is supported by using the Edinburgh Postnatal Depression Scale. Resource provided is from JAMA Canadian Clinical Practice Guide.</td>
<td>Central program personnel, local office champion and all clinic personnel (e.g., physicians, nurse clinicians, physician assistants, and office staff)</td>
</tr>
<tr>
<td>There was uncertainty about the strength of the PHQ 2 (Patient Health Questionnaire).</td>
<td>Information about the sensitivity and specificity of the PHQ 2 was reviewed, and further details were added to the training curriculum.</td>
<td>(Same as above.)</td>
</tr>
<tr>
<td>Staff needed additional talking points for families as to why depression screening should occur starting at age 12.</td>
<td>Reinforced the importance of early screening in alignment with the AAP Bright Futures periodicity schedule for well-child visits as well as the USPSTF guidelines.</td>
<td>(Same as above.)</td>
</tr>
<tr>
<td>Office workflow. Needed additional workflow examples to achieve systematic level of screening for eligible patients.</td>
<td>Additional depression screening workflow examples were shared from ACOG and AAFP.</td>
<td>(Same as above.)</td>
</tr>
<tr>
<td>Clinicians were not aware of which patients were eligible for depression screening.</td>
<td>Reviewed appropriate visit types for depression screening to be performed and discussed local clinical roles for flagging these visits.</td>
<td>(Same as above.)</td>
</tr>
<tr>
<td>Documentation. Challenging to identify referral resources for positively screened patients.</td>
<td>Recommended contacting the insurance provider to obtain a list of urgent and long-term care providers available to patients. Set in place periodic reviews of patients screened and recall appointments for patients that need a follow-up visit. Working with EHR vendor and clinic staff to troubleshoot technical difficulties</td>
<td>(Same as above.)</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.)
   Before the end of month 4 of the group’s participation.  For Wave 12, before the end of month 4, January 2018.

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)?
      During month 5 of the group’s participation.  For Wave 12, month 5, February 1 – 28, 2018.
   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.)
      See Appendix B, last column of data, for the post-adjustment percent of patients with services performed within and across practices.
   c. Did the adjustment(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)?
      For Wave 12, performance for both measures improved with better workflow and proper documentation. The participating practices’ post-adjustment performance on measure #1 (depression screening) improved from 0% to 75%, exceeding the goal of 50%. Of the eligible patients for Measure #2, 50% of eligible patients had documented follow-up plans for treatment of depression, meeting the goal of 50%.

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

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)
Before the end of month 6 of the group’s participation. For Wave 12, by the end of month 6, March 2018.

Use the following table to outline the next plan that was developed: #30 the primary causes, #31 the adjustments/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>
<tbody>
<tr>
<td>Clinic personnel. Patients don’t understand the importance of the follow-up plan.</td>
<td>Central program personnel performed an on-site and/or remote technical assistance meeting with the office champion to continue education and sharing of additional resources related to: Patient focused education relating to mental health concerns is helpful in order for clients to recognize the need of the follow-up plan/visit.</td>
<td>Central program personnel, local office champion and all clinic personnel (e.g., physicians, nurse clinicians, physician assistants, and office staff)</td>
</tr>
<tr>
<td>Barriers in access or availability of behavioral health providers for patients.</td>
<td>Identification of telehealth behavioral health support networks.</td>
<td>(Same as above.)</td>
</tr>
<tr>
<td>Office workflow. Staff lack protocol to ensure patients complete follow-up, and documentation of completed follow-up plans is difficult when the task is not specifically assigned to the correct clinical staff member.</td>
<td>Local staff are to assign to a specific clinical staff member the responsibility for ensuring patient’s follow through with what is outlined in the follow-up plan, including referrals.</td>
<td>(Same as above.)</td>
</tr>
</tbody>
</table>

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.

No formal additional PDCA cycles are planned for this wave of participants. Project leaders will remain an available resource until the end of the grant period (September 2019).

☐ 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 that were encountered during this QI effort and how they were addressed.
   The most significant barrier that was faced by participants is:
   • Not being familiar with referral resources for patients identified as needing further follow-up care.
   Central program personnel worked with office champions to identify referral resources in close proximity to the practice, and also helped to guide the office champion to become familiar with referral sources available based on the patient’s insurance.

34. Describe any key lessons that were learned as a result of the QI effort.
   • Include clinical support staff. Including all clinical support staff in the training significantly increases the practice’s level of readiness to implement depression screening and follow-up plans for patients that are positively screened.
   • Determine local referral resources prior to training. Central program personnel review available referral resources around the practice’s geographic location prior to the training with the office champion during the 15-minute kickoff call to better prepare the clinical support staff to utilize these resources.
   • Office champion and physician collaboration. Technical assistance (TA) staff work to make sure that the physicians at participating practices are engaged with the Office Champion throughout the project period to support swift local level practice changes to improve implementation.

35. Describe any best practices that came out of the QI effort.
   • Facilitating a kick-off call pre-training between the TA staff member and the local Office Champion. This discussion occurs a few weeks prior to the training, and assists the TA staff member to better understand the practice’s current workflow and level of motivation to change. Key topics of the kick-off call include:
     o Documentation requirements for the activity
     o Ability to customize the current EHR if necessary
     o Comfort level of making referrals to the behavioral health community
     o Current clinical workflow process for comparable interventions (e.g., other screenings)
   • Building a rapport with the insurance companies. This connection helps the practices in identifying referral resources for further behavioral health assessments for patients identified in need of further follow-up interventions.

36. Describe any plans for spreading improvements, best practices, and key lessons.
   The local changes that were made by the earlier waves of participants have been an integral part of rapid cycle process improvement to assist the central program personnel in their education, training, and technical assistance efforts for future waves of participants. Project leaders will continue to monitor barrier trends for consistency related to the implementation of depression screening and follow-up plans for patients positively screened for depression among subsequent waves of participants.

37. Describe any plans for sustaining the changes that were made.
   Improvements that have now become part of the clinical workflow should remain self-sustaining over time. TA staff are available to participating practices until September 2019, and during this time, central program personnel will enhance support resources as needed to ensure continued sustainment of the interventions.

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: Collect or oversee collection of data in the practice.

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): Altarum Institute
  • 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): Project-specific agreement between UMHS and Altarum Institute for joint providership of activities for the Transforming Depression: A Great Lakes Practice Project funded by a Centers for Medicare and Medicaid Services.
Appendix A. Timeline for Waves of Groups of Participating Medical Practices

Twenty six “waves” of groups of participating medical practices are included in the project. Each “wave” starts a month after the previous “wave” starts. A “wave” participates in two cycles of data-guided improvement over six months. The first “wave” starts November 1, 2016 and the last “wave” finishes May 31, 2019.
Appendix B. Performance for Wave 12 of Practices for Percent of Patients with Service Performed

<table>
<thead>
<tr>
<th>Service</th>
<th>Baseline Month -1</th>
<th>Post-Intervention Month 3</th>
<th>Post-Adjustment Month 5</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Center A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression Screening Tool</td>
<td>0% (n=18)</td>
<td>0% (n=16)</td>
<td>75% (n=12)</td>
<td>50%</td>
</tr>
<tr>
<td>Follow-up Plan Documented</td>
<td>0% (n=0)</td>
<td>N/A</td>
<td>50% (n=2)</td>
<td>50%</td>
</tr>
<tr>
<td>Wave 12 – Mean of 1 Practice Means</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression Screening Tool</td>
<td>0%</td>
<td>0%</td>
<td>75%</td>
<td>50%</td>
</tr>
<tr>
<td>Follow-up Plan Documented</td>
<td>0%</td>
<td>N/A</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

% = percent of patients that received the service  
 n = number of eligible patient charts pulled  
 * = the clinic did not previously provide the service, so no charts were pulled and the clinic mean at baseline is 0%  
 N/A = the clinic did not have any eligible patients for this measure