

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

### Transforming Depression: A Great Lakes Practice Project – Wave 1

#### 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:

Grant Greenberg, MD, MHSA, MA, UMHS Part IV Program Lead, 763-232-6222, [ggreenbe@med.umich.edu](mailto:ggreenbe@med.umich.edu)

R. Van Harrison, PhD, UMHS Part IV Program Co-Lead, 734-763-1425, [rvh@umich.edu](mailto:rvh@umich.edu)

Ellen Patrick, UMHS Part IV Program Administrator, 734-936-9771, [partivmoc@umich.edu](mailto:partivmoc@umich.edu)

#### Report Outline

Section	Items
<b>A. Introduction</b>	1-6. Current date, title, time frame, key individuals, participants, funding
<b>B. Plan</b>	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
<b>C. Do</b>	18. Intervention implementation date
<b>D. Check</b>	19-20. Post-intervention performance
<b>E. Adjust – Replan</b>	21-24. Post-intervention data review, underlying causes, adjustments, who will implement
<b>F. Redo</b>	25. Adjustment implementation date
<b>G. Recheck</b>	26-28. Post-adjustment performance, summary of individual performance
<b>H. Readjust plan</b>	29-32. Post-adjustment data review, underlying causes, further adjustments, who will implement
<b>I. Reflections &amp; plans</b>	33-37. Barriers, lessons, best practices, spread, sustain
<b>J. Participation for MOC</b>	38-40. Participation in key activities, other options, other requirements
<b>K. Sharing results</b>	41. Plans for report, presentation, publication
<b>L. Organization affiliation</b>	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*): June 8, 2017

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 1 began in November 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*):

Each “wave” of groups of medical practices will perform two cycles of improvement effort over seven months. The final wave will be completed about July 2019. Wave 1 finished in April 2017.

#### 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, FRCP

**Title:** Professor of Psychiatry, Associate Director

**Organizational unit:** University of Michigan

**Phone number:** 734-936-4400

**Email address:** parikhsa@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*):

Profession	Number for Wave 1	Estimated Number for Entire Project

Practicing Physicians	4	400
Residents/Fellows	0	0
Physicians' Assistants	0	50
Nurses (APNP, NP, RN, LPN)	3	50
Other Licensed Allied Health (e.g., PT/OT, pharmacists, dieticians, social workers)	0	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 for Wave 1
Practicing Physicians	Family Medicine	0
	Pediatricians	2
	OB/GYNs	1
	Internal Medicine	1
Fellows		0
Residents		0
Physicians' Assistants	(Specialty not applicable)	0

**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 dysthymic 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.]**

<http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf> )

- |   |   |  |
|---|---|--|
| <input checked="" type="checkbox"/> Effectiveness | <input checked="" type="checkbox"/> Equity    | <input checked="" type="checkbox"/> Safety     |
| <input checked="" type="checkbox"/> Efficiency    | <input type="checkbox"/> Patient-Centeredness | <input checked="" type="checkbox"/> 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/> )

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Patient Care and Procedural Skills      | <input checked="" type="checkbox"/> Medical Knowledge                      |
| <input checked="" type="checkbox"/> Practice-Based Learning and Improvement | <input checked="" type="checkbox"/> Interpersonal and Communication Skills |
| <input type="checkbox"/> Professionalism                                    | <input checked="" type="checkbox"/> 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 1 it was for October 1 - 31, 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.)

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 (October 2016 through April 2017 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 1 it was before the end of month 1, November 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:**

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

<b>15. What were the primary underlying/root causes for the <u>problem(s) at baseline</u> that the project can address?</b>	<b>16. What intervention(s) addressed this cause?</b>	<b>17. Who was involved in carrying out each intervention? (List the professions/roles involved.)</b>
<p><u>Clinical education</u></p> <p>Providers may not be aware of recommendations regarding depression screening and management and the basis for them. Providers often lack the training needed to</p>	<p>Central program personnel train physicians, and any relevant nurse clinicians and physician assistants in the practice to:</p> <ul style="list-style-type: none"> <li>• Be cognizant of depression screening recommendations</li> <li>• Perform depression screens</li> </ul>	<p>Central program personnel, local office champion and all clinic personnel (e.g., physicians, nurse clinicians, physician assistants, and office staff)</p>

<p>be able to apply the collaborative care model for patients with depression.</p>	<ul style="list-style-type: none"> <li>• Understand the management of depression when identified, and make follow-up plans</li> <li>• Make operational changes in the process of patient care that facilitate the provision and documentation of appropriate care.</li> <li>• Collect and report individual practice data.</li> </ul>	
<p><u>Routine office processes</u></p> <p>Processes do not systematically incorporate recommended activities.</p> <p>No routine processes to coordinate office staff in delivering the care</p>	<ul style="list-style-type: none"> <li>• Local provider groups determine specific operational changes based on the general recommendations for improving care.</li> <li>• 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.</li> </ul>	<p>(Same as above.)</p>
<p><u>Resources</u></p> <p>Resources for managing patients with depression are unknown or are unavailable and/or not easily accessible.</p>	<ul style="list-style-type: none"> <li>• Local solutions and resources are identified to manage patients with depression and/or patients who are suicidal.</li> </ul>	<p>(Same as above.)</p>
<p><u>Documentation</u></p> <p>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.</p>	<ul style="list-style-type: none"> <li>• Training includes how providers can efficiently incorporate documentation into the workflow for depression screening, and plans for patient follow-up.</li> </ul>	<p>(Same as above.)</p>

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 1, before the end of month 1, November 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)?**

From the beginning to the end of month 3 of the cycle. **For Wave 1, during month 3, January 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)?**

**Yes, participating practices showed substantial improvement, and exceeded goals for both of the measures.**

**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 1, during month 4, February 2017.**

**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 <u>problem(s) following the intervention(s)</u> 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.)
<p><u>Clinic personnel.</u> Staff were unsure what depression screening tool should be used for pregnant teens.</p>	<p>Central program personnel continued education and shared additional resources related to the newly identified problems:</p> <p>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.</p>	<p>Central program personnel, local office champion and all clinic personnel (e.g., physicians, nurse clinicians, physician assistants, and office staff)</p>
<p>There was uncertainty about the strength of the PHQ 2 (Patient Health Questionnaire).</p>	<p>Information about the sensitivity and specificity of the PHQ 2 was reviewed, and further details were added to the training curriculum.</p>	<p>(Same as above.)</p>
<p>Staff needed additional talking points for families as to why depression screening should occur starting at age 12.</p>	<p>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.</p>	<p>(Same as above.)</p>
<p><u>Office workflow.</u> Needed additional workflow examples to achieve systematic level of screening for eligible patients.</p>	<p>Additional depression screening workflow examples were shared from ACOG and AAFP.</p>	<p>(Same as above.)</p>
<p>Clinicians were not aware of which patients were eligible for depression screening.</p>	<p>Reviewed appropriate visit types for depression screening to be performed and discussed local clinical roles for flagging these visits.</p>	<p>(Same as above.)</p>
<p><u>Documentation.</u> Challenging to identify referral resources for positively screened patients.</p>	<p>Recommended contacting the insurance provider to obtain a list of urgent and long-term care providers available to patients.</p> <p>Set in place periodic reviews of patients screened and recall appointments for patients that need a follow-up visit.</p>	<p>(Same as above.)</p>

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 1, before the end of month 4, February 2017.

## 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 1, month 5, March 1 - 31 2017.**

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)?**

**Yes, goals were substantially surpassed for 2 out of 2 measures.**

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 7 of the group's participation. **For Wave 1, by the end of month 6, April 2017.**

**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 <u>problem(s)</u> following the <u>adjustment(s)</u> 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.)
<p><u>Clinic personnel.</u> Patients don't understand the importance of the follow-up plan.</p>	<p>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:</p> <p>Patient focused education relating to mental health concerns is helpful in order for clients to recognize the need of the follow-up plan/visit.</p>	<p>Central program personnel, local office champion and all clinic personnel (e.g., physicians, nurse clinicians, physician assistants, and office staff)</p>
<p>Barriers in access or availability of behavioral health providers for patients.</p>	<p>Identification of telehealth behavioral health support networks.</p>	<p>(Same as above.)</p>
<p><u>Office workflow.</u> 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.</p>	<p>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.</p>	<p>(Same as above.)</p>

*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:
  - Documentation requirements for the activity
  - Ability to customize the current EHR if necessary
  - Comfort level of making referrals to the behavioral health community
  - 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 first wave 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 personal 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.

Transforming Depression: A Great Lakes Practice Project											
Performance and Quality Improvement CME.MOC Cycles											
<b>Cycles of Participant</b>											
<b>2016</b>	<b>Cycle</b>	<b>Month 1</b>	<b>Month 2</b>	<b>Month 3</b>	<b>Month 4</b>	<b>Month 5</b>	<b>Month 6</b>	<b>Legend:</b>			
November	1	November	December	January	February	March	April	2016			
December	2	December	January	February	March	April	May	2017			
<b>2017</b>								2018			
January	3	January	February	March	April	May	June	2019			
February	4	February	March	April	May	June	July	Data Due			
March	5	March	April	May	June	July	August				
April	6	April	May	June	July	August	September				
May	7	May	June	July	August	September	October				
June	8	June	July	August	September	October	November				
July	9	July	August	September	October	November	December				
August	10	August	September	October	November	December	January				
September	11	September	October	November	December	January	February				
October	12	October	November	December	January	February	March				
November	13	November	December	January	February	March	April				
December	14	December	January	February	March	April	May				
<b>2018</b>											
January	15	January	February	March	April	May	June				
February	16	February	March	April	May	June	July				
March	17	March	April	May	June	July	August				
April	18	April	May	June	July	August	September				
May	19	May	June	July	August	September	October				
June	20	June	July	August	September	October	November				
July	21	July	August	September	October	November	December				
August	22	August	September	October	November	December	January				
September	23	September	October	November	December	January	February				
October	24	October	November	December	January	February	March				
November	25	November	December	January	February	March	April				
December	26	December	January	February	March	April	May				

## Appendix B. Performance for Wave 1 of Practices for Percent of Patients with Service Performed

Service	Baseline Month -1	Post-Intervention Month 3	Post-Adjustment Month 5	Goal
<u>Clinic A</u>				
Depression Screening Tool	0%*	33% (n=15)	40% (n=15)	50%
Follow-up Plan Documented	0%*	100% (n=1)	N/A	50%
<u>Clinic B</u>				
Depression Screening Tool	100% (n=25)	100% (n=20)	95% (n=20)	50%
Follow-up Plan Documented	80% (n=10)	85% (n=14)	75% (n=8)	50%
<u>Clinic C</u>				
Depression Screening Tool	0%*	100% (n=19)	100% (n=18)	50%
Follow-up Plan Documented	0%*	100% (n=2)	100% (n=2)	50%
<u>Wave 1 – Mean of 3 Practice Means</u>				
Depression Screening Tool	33%	78%	78%	50%
Follow-up Plan Documented	27%	95%	88%	50%

% = 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