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

Improving Rates of Developmental Screening in Pediatric Primary Care Clinics

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

A. Introduction

1. Date (this version of the report): Oct. 26, 2016

2. Title of QI effort/project (also insert at top of front page): Improving Rates of Developmental Screening in Pediatric Primary Care Clinics

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): December 1, 2015 sign up

   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): October 21, 2016

4. Key individuals
   a. QI project leader [also responsible for confirming individual’s participation in the project]
      Name: Kelly Orringer
      Title: Division Director, QI Lead
      Organizational unit: General Pediatrics
      Phone number: 647-3552
      Email address: korringe@umich.edu
      Mailing address: NIB 6E12 UMHS

   b. Clinical leader to whom the project leader reports regarding the project [responsible for overseeing/”sponsoring” the project within the specific clinical setting]
      Name: Terry Bravender
      Title: Department QI Lead
      Organizational unit: Pediatrics, Adolescent Medicine
      Phone number: 936-9777
      Email address: tdbrave@med.umich.edu
      Mailing address:

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>40</td>
</tr>
<tr>
<td>Residents/Fellows</td>
<td>50</td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td>0</td>
</tr>
<tr>
<td>Nurses (APNP, NP, RN, LPN)</td>
<td>1</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></td>
<td>20</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>(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
☐ Other (describe): No funding 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):

6-36 month old patients seen in UMHS general pediatric clinics for well exams

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?

The AAP recommends screening of all children for developmental delay routinely at least at ages 9 months, 18 months, and 30 months. Brief validated screening tools can allow for early identification of delays and improve childhood developmental trajectories by intervening earlier with additional services. While the performance of this important aspect of care has been shown to be good (87%) in UMHS General Pediatrics clinics, it can still be improved and monitored for sustained improvement. Also, improvements can occur in following through with billing for developmental screens at health maintenance exam (HME) visits and in the use of HME smartsets in this age range.

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 rate of screening for children such that at least 90% of young children (6-36 months old) are screened at their HME visits.
• Increase the proportion of developmental screens performed that are billed at HME visits.
University of Michigan Health System Part IV Maintenance of Certification Program

- Increase use of the HME smartsets in this age range in order to facilitate increased developmental screening, charting, and billing.

9. Which Institute of Medicine Quality Dimensions are addressed? [Check all that apply.]
   ☒ Effectiveness  ☒ Equity  ☐ Safety  ☒ Patient-Centeredness  ☒ Timeliness

10. Which ACGME/ABMS core competencies are addressed? (Check all that apply.)
    (http://www.abms.org/board-certification/a-trusted-credential/based-on-core-competencies/)
    ☒ Patient Care and Procedural Skills  ☐ Medical Knowledge
    ☒ Practice-Based Learning and Improvement  ☐ Interpersonal and Communication Skills
    ☐ Professionalism  ☒ Systems-Based Practice

11. Describe the measure(s) of performance: (QI efforts must have at least one measure that is tracked across the two cycles for the three measurement periods: baseline, post-intervention, and post-adjustment. If more than two measures are tracked, copy and paste the section for a measure and describe the additional measures.)

   Note on sampling: Participating physicians each sampled 20 HME visits for patients ages 6 – 36 months seen during each observation period. A few physicians saw fewer than 20 patients for HME visits during an observation period. Where possible those who had not seen enough patients themselves submitted a subsample of their clinic partners’ or their resident’s visits that met criteria.

   Measure 1
   - Name of measure: Developmental screening documented in HME visit note
   - Measure components – for a rate, percent, or mean, describe the:
     - Denominator (e.g., for percent, often the number of patients eligible for the measure):
       # HME visits for children 6-36 months during the reference time frame (20 requested)
     - Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
       # of these visits with documentation in their visit note that a developmental screen was done and its results
   - The source of the measure is:
     - ☒ Internal to our organization and it was chosen because (describe rationale):
       It is important for current and future care to document that developmental screening was performed and the result.
     - ☐ An external organization/agency, which is (name the source): as above
   - 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: Developmental screening billed using 96110 code
• **Measure components** – for a rate, percent, or mean, describe the:
  Denominator *(e.g., for percent, often the number of patients eligible for the measure):*
  # HME visits for children 6-36 months during the reference time frame (20 requested)
  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation):*
  # of these visits with 96110 billed at that HME visit

• **The source of the measure is:**
  ☒ An external organization/agency, which is *(name the source):* We are using the billing code 96110 as a proxy for completion of the screening recommended by the AAP as there is not yet a HEDIS measure available
  ☐ 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 3

• **Name of measure:** Appropriate smartset used for 6-36 month HME visits

• **Measure components** – for a rate, percent, or mean, describe the:
  Denominator *(e.g., for percent, often the number of patients eligible for the measure):*
  # HME visits for children 6-36 months during the reference time frame (20 requested)
  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation):*
  # these visits with the appropriate smartset was used

• **The source of the measure is:**
  ☐ An external organization/agency, which is *(name the source):* as above
  ☒ Internal to our organization and it was chosen because *(describe rationale:*
  Our division developed HME smartsets for every age, has done extensive training on their use at division meetings over the past 4 years since we acquired Epic/MiChart, and the use of these smartsets is now expected.

• **This is a measure of:**
  ☒ Process – activities of delivering health care to patients
  ☐ Outcome – health state of a patient resulting from health care

12. Baseline performance

a. What were the beginning and end dates for the time period for baseline data on the measure(s)?
   September 1 to November 30, 2015

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 the tables with data presented on the last page of this report.

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].”

**Developmental screening:** At baseline, performing developmental screening at HME visits was 95%, already higher than our planned goal of ≥ 90%. The aim was to maintain performing screening at each HME visit above ≥ 90% through two improvement cycles ending, September 30, 2016.

**Billing:** Increase billing for developmental screening performed at HME visits from the baseline of 82% to ≥ 90% through two improvement cycles ending, September 30, 2016.

**Appropriate smartest:** Increase use of the appropriate smartest for HME visits from the baseline of 82% to ≥ 90% through two improvement cycles ending, September 30, 2016.

b. **How were the performance targets determined, e.g., regional or national benchmarks?**

Based on internal baseline data for fiscal year 2015 collected by QMP using a slightly different measure, internal UMHS benchmarks were set. The 90%ile for UMHS clinics was 87% so we chose ≥ 90% as a reasonable goal for this project.

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)*
   Pediatric faculty and residents.

   b. **How?** *(e.g., in a meeting of clinic staff)*
   Division meeting for faculty, resident outpatient QI meetings and weekly continuity clinic meeting for the residents

   c. **When?** *(e.g., date(s) when baseline data were reviewed and discussed)*
   February 16, 2016 division meeting
   February 18, 2016 resident QI meeting
   Continuity clinic precepting sessions week of February 15th – 19th

   **Use the following table to outline the plan that was developed: #15 the primary underlying/root 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**

16. **What intervention(s) addressed this cause?**

17. **Who was involved in carrying out each**
### for the problem(s) at baseline that the project can address?

<table>
<thead>
<tr>
<th>Problem Description</th>
<th>Intervention Provided</th>
<th>Involved Professions/Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some faculty did not know their rate</td>
<td>Provided individual performance scores to all providers as feedback so that low performers were aware and could focus on what they could do to increase their rates</td>
<td>Faculty MDs</td>
</tr>
<tr>
<td>No common agreement on which ages the screening is done across our sites</td>
<td>Reviewed the AAP recommendations for screening at a minimum at 9/18/30 month HME visits, then agreed on standardized ages at which screening is done</td>
<td>All faculty and resident MDs</td>
</tr>
<tr>
<td>Some families miss the 9 &amp; 30 month visits which are 2 of the 3 designated minimum ages at which to screen</td>
<td>Expanded doing developmental screening to all HME visits in this age range (Addressed lack of reminder system to get families to come for those visits – not yet implemented, work in progress)</td>
<td>Same</td>
</tr>
<tr>
<td>Inadequate time to perform the screen during visit</td>
<td>Maximize collection of relevant information ahead of time with physician: worked with check in staff to give at check in, med assistants to remind family to finish before MD enters, increase portal use to complete before visit</td>
<td>Same plus clinic clerical staff &amp; medical assistants</td>
</tr>
<tr>
<td>Challenge to remember to bill each time the screening is completed</td>
<td>Reminded providers that the billing code 96110 is embedded in the smartsets, then demonstrated the smartsets (again)</td>
<td>All faculty and resident MDs</td>
</tr>
</tbody>
</table>

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.)*
   March 1, 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)?
      March 1 – April 30, 2016
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 the tables with data presented by patient and by provider on the last page of this report.

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

Improvement occurred on all three measures. Screening remained above ≥ 90% target and both billing and use of the smartest increased above the 90% target.

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)
   May 10, 2106 Division Meeting
   May 12, 2016 Resident QI meeting
   Week of May 9-14 continuity clinic meetings

   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 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>Some faculty had improved, but did not realize performance was still below target rate</td>
<td>Provided individual performance scores to all providers as feedback so that low performers were aware and could focus on what they could do to increase their rates</td>
<td>Faculty MDs</td>
</tr>
<tr>
<td>Children with known significant developmental delays are less likely to be screened</td>
<td>(Decided to make this situation an exception and not to intervene. Significant delays have already been identified and relevant clinical decisions made. Frequently repeating developmental screening would not improve care and reduce time to perform other needed care activities for this group of patients.)</td>
<td>(Physicians, residents)</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| Children whose parents speak a foreign language are less likely to be screened | 1. Have screening forms given out at check-in and interpreter help complete them  
2. (Would like to have more languages available for screens – Spanish only other language easily available at this time. Need to work with hospital interpreter services to translate screens for each age into other languages – have not done this yet.)  
3. Add extra time for visits when no live interpreter available, will need to work via phone for interpreter to do the screen | Physicians, residents, office manager and clerical staff, medical assistants  
Interpreter services |
| | Clerical staff, MDs identify these patients ahead of time |

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.)  
June 1, 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)?  
July 1 – August 31, 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.)

See the data tables on the last page of this report.
c. Did the adjustment(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)?

All measures continued to meet the target of ≥ 90%. The measures for performing screening and using HME smartsets remained stable. However, the billing rate dropped from 97% to 91%.

28. Summary of individual performance
   a. Were data collected at the level of individual providers so that an individual’s performance on target measures could be calculated and reported?
      ☒ Yes ☐ No – go to item 29

   b. If easily possible, for each listed group of health care providers:
      • Participants with data available:
         ○ Indicate the number participating (if none, enter “0” and do not complete rest of row)
         ○ if any are participating, are data on performance of individuals available? (If “No”, do not complete rest of row.)
      • if data on performance are available, then enter the number of participants in three categories regarding reaching target rates (i.e. the specific aims for measures). (If you do not have this information or it is not easily available, leave the table blank.)

<table>
<thead>
<tr>
<th>Profession</th>
<th>Participants with Data Available</th>
<th>Number of These Participants Reaching Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Participating in QI Effort (from #5.a)</td>
<td>Data on Performance of Individuals Available? (Enter Yes or No)</td>
</tr>
<tr>
<td>Practicing Physicians</td>
<td>20</td>
<td>yes</td>
</tr>
<tr>
<td>Residents/Fellows</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians Assistants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses (APNP, NP, RN, LPN)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Licensed Allied Health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)
October 18, 2016 Division meeting
October 13, 2016 resident QI meeting
October 17-21 continuity clinic meetings

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>
<tbody>
<tr>
<td>2 faculty noted that the smartsets had been adjusted so that the billing box for the 96110 code was in a different location.</td>
<td>Resident QI group with select faculty preceptors are revising and standardizing the HME smartset format to make them easier to use</td>
<td>Pediatric faculty and residents</td>
</tr>
<tr>
<td>New residents (started July 1) were less likely to be routinely billing the 96110 code</td>
<td>Reminder and refresher demo on use of smartsets for HME visits Additional faculty preceptor oversight of billing/charting with new residents in clinic. (Will need to anticipate each July.)</td>
<td>Pediatric faculty and residents at division meeting and am/noon conferences</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.
   ☐ Further cycles will occur, but will not be documented for MOC. If checked, summarize plans:

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

I. Reflections and Future Actions

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

Time barrier with foreign language: We continue to struggle how best to prioritize completion of screening for families who do not speak English or Spanish – for whom we must translate line by line in person the screening form. We plan to 1. submit the screening form for each age to interpreter
services and pay to have the screens translated into other languages and also 2. work with clerical staff to proactively identify families with language barriers so their HME appointments have extra time to do this screening.

34. Describe any key lessons that were learned as a result of the QI effort.
   1. Providing faculty with their performance data and reminding them of need to do this screening, document it, and bill for it had good initial effect
   2. Smartset use is high across our faculty and vast majority find them useful
   3. Need for resources and screening tools in other languages
   4. Need for additional resources to offer for children with developmental delays

35. Describe any best practices that came out of the QI effort.
    Standardize the smartsets and train all faculty and new residents on their use annually.
    If can offer the screening at all the HME visits, will have a better chance to screen every child annually.
    Ideally the screen should be done ahead of time or prior to the MD portion of the HME visit.

36. Describe any plans for spreading improvements, best practices, and key lessons.
    Share work at next UMHS Quality Month presentation
    Share results with other members of the Pediatric Preventive QI Committee

37. Describe any plans for sustaining the changes that were made.
    Smartset revision, standardization of location for billing this screening, and demonstration/retraining for faculty and residents.

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.
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:*

Each participant was required to do chart review on 20 charts of patients in the target age range for HME for each round of the project. A couple of providers had a cycle where they saw fewer than that # of HME visits due to scheduling or time off.

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?  Maybe

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):* Division of General Pediatrics

• Is the activity part of a larger UMHS institutional or departmental initiative?

☐ No  ☒ Yes – the initiative is *(name or describe):* This measure is a current focus measure for UMMG for Fiscal Year 2016.
### Overall Performance

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<tr>
<td>Appropriate smartset used for HME visits</td>
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<td>% with appropriate smartest used</td>
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### Providers Categorized by Level of Performance

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<td>N providers with:</td>
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