

Report on a QI Project Eligible for Part IV MOC

Breast and Colon Cancer Best Practice Advisory utilization rates in Family Medicine House Officers

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. Final confirmation of Part IV MOC for a project occurs when the full report is submitted and approved.

An option for preliminary review (recommended) is to complete a description of activities through the intervention phase and submit the partially completed report. (Complete at least items 1-16 and 27a-b.) 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 and answers should be in regular font (generally immediately below the questions). To check boxes electronically, either put an “X” in front of a box or copy and paste “☑” over the blank box.

For further information and to submit completed applications, contact either:

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Report Outline

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J. Physician involvement	29-31. Physician’s role, requirements, reports, reflections, participation, number
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QI Project Report for Part IV MOC Eligibility

A. Introduction

1. **Date** (*this version of the-report*): October 1, 2015

2. **Title of QI project:** Breast and Colon Cancer Best Practice Advisory utilization rates in Family Medicine House Officers

3. **Time frame**
 - a. **Date physicians begin participating (may be in design phase):** April 29, 2015
 - b. **End date:** September 30, 2015

4. **Key individuals**
 - a. **QI project leader** [*also responsible for attesting to the participation of physicians in the project*]
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Title: Clinical Lecturer, Assistant Residency Director
Organizational unit: Department of Family Medicine
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 - a. **Clinical leader to whom the project leader reports regarding the project** [*responsible for overseeing/"sponsoring" the project within the specific clinical setting*]
Name: David Serlin, MD
Title: Assistant Professor, Associate Chair for Clinical Programs
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5. **Approximately how many physicians were involved in this project categorized by specialty and/or subspecialty?** Family Medicine House Officers: classes of 2016 and 2017 (22 physicians)

6. **Will the funding and resources for the project come only from internal UMHS sources?**
 - Yes, only internal UMHS sources
 - No, funding and/or resources will come in part from sources outside UMHS, which are: _____

The Multi-Specialty Part IV MOC Program requires that projects engage in change efforts over time, including at least three cycles of data collection with feedback to physicians and review of project results. Some projects may have only three cycles while others, particularly those involving rapid cycle improvement, may have several more cycles. The items below are intended to provide some flexibility in describing project methods. If the items do not allow you to reasonably describe the methods of your specific project, please contact the UMHS Part IV MOC Program office.

B. Plan**7. General goal****a. Problem/need. What is the “gap” in quality that resulted in the development of this project? Why is this project being undertaken?**

Screening rates for breast and colon cancer are not at goal at the Department of Family Medicine residency continuity clinics. As is true for of all primary care providers, the house officers are expected to address breast and colon cancer screening. Below is a table displaying annualized, site-wide screening rates for 2014 calendar year of active clinic patients, which indicates room for improvement.

1/1/14-12/31/14	FGP 75% goal	FGP 90% goal	Performance	Site
Breast Cancer Screening	76%	80%	75%	Clinic A
			72%	Clinic B
Colorectal Cancer Screening	67%	72%	75%	Clinic A
			71%	Clinic B

Although there have been department-wide and clinic-wide attempts to improve these quality measures, no interventions to date have specifically targeted our resident physicians who serve as primary care providers. A point of care decision alert, or Best Practice Advisory (BPA), has been established to remind physicians of a gap in cancer screening during an office visit. Use of these BPA's to facilitate an increase in cancer screening rates has been inconsistent by Family Medicine Resident physicians.

b. Physician's role. What is the physician's role related to this problem?

Physicians are ultimately responsible for recognizing cancer screening gaps, discussing appropriate screening with patients, and addressing the BPA which can facilitate initiating/ordering cancer screening tests irrespective of the reason for the clinic visit or assignment of PCP to another physician.

c. Project goal. What general outcome regarding the problem should result from this project? (Specific aims/targets are addressed in #12b.)

Improve screening of patients for breast and colon cancer by increasing House Officer's utilization of breast and colorectal cancer screening Best Practice Advisories (BPAs).

8. Patient population. What patient population does this project address? Patients seen at the site by Family Medicine House Officer providers between the dates of April 29 and September 30, 2015 who are identified as due for breast and/or colorectal cancer screening by the Electronic Health Record.

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

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

10. What is the experimental design for the project?

- Pre-post comparisons (baseline period plus two or more follow-up measurement periods)
 Pre-post comparisons with control group
 Other: _____

11. Baseline measures of performance:**a. What measures of quality are used? If rate or %, what are the denominator and numerator?**Breast Cancer BPA Utilization

- Numerators: sum of the following:
 - Number of mammogram orders signed through the BPA SmartSet in MiChart by FM House Officer encounter physicians at the sites, plus

- Number of mammogram orders declined by the patient, plus
- Number of mammogram orders done elsewhere and entered into the record at the time of visit, plus
- Number of BPAs designated as “No mammogram: bilateral mastectomies”, plus
- Number of BPAs designated as “No mammogram: medical comorbidities”
- Denominator:
 - Number of Patients seen by House Officer physicians at the sites with active breast cancer screening BPAs (i.e. EHR identifies the patient as due for screening)

Colorectal Cancer BPA Utilization

- Numerators: sum of the following
 - Number of colorectal cancer screening test orders signed through the BPA SmartSet in MiChart by FM House Officer encounter physician at YHC and CHE, plus
 - Number of colorectal cancer screening test orders declined by the patient, plus
 - Number of colorectal cancer screening tests done elsewhere and entered into the record at the time of visit, plus
 - Number of BPAs designated as “No colorectal screening: surgical absence”, plus
 - Number of BPAs designated as “No colorectal screening: medical comorbidities”
- Denominator:
 - Number of Patients seen by House Officer physicians at the Health Centers with active colorectal cancer screening BPAs. BPAs (i.e. EHR identifies the patient as due for screening)

b. Are the measures nationally endorsed? If not, why were they chosen?

The measures are not nationally recognized. These are process metrics selected to address the ordering of cancer screening for eligible patients based on utilization of decision support in our local electronic health record.

c. What is the source of data for the measure (e.g., medical records, billings, patient surveys)?

Electronic health record

d. What methods were used to collect the data (e.g., abstraction, data analyst)?

Monthly EHR reports on the use of Best Practice Advisories were analyzed through direct comparison over time using an excel spreadsheet.

e. For what time period was the sample collected for baseline data?

January 1, 2015 – March 31, 2015

12. Specific performance objectives

a. What was the overall 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 attached data table 1, column for baseline data.

b. Specific aim: What was the target for performance on the measure(s) and the timeframe for achieving the target?

By the end of the project on September 30, 2015, we set goals of improvement for each metric of 30% above baseline. Specifically, across both sites we aim to increase action on the BPA for breast cancer screening from 36% to 47% and to increase action on the BPA for colon cancer screening from 37% to 48%.

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

There are no national benchmarks for BPA response rates, as the BPAs are simply tools within the electronic record to remind providers of overdue screening tests and streamline the ordering of such tests. Based on response rates to BPAs for other topics, a 30% improvement above baseline was considered a realistic target.

13. Data review and identifying underlying (root) causes.**a. Who was involved in reviewing the baseline data, identifying underlying (root) causes of the problem(s), and considering possible interventions (“countermeasures”) to address the causes? Briefly describe:**

- **Who was involved?** Participating Family Medicine House Officers, residency leadership team, clinic site panel managers.
- **How?** (e.g., in a meeting of clinic staff) At residency meetings and via email.
- **When?** April 29, 2015

c. What were the primary underlying/root causes for the problem(s) that the project can address? (Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately.)People:

- House officers are insufficiently EHR trained related to Best Practice Advisories (BPAs) and associated “smart sets” which facilitate orders related to the gap in care indicated by the BPA.
- Faculty preceptors inconsistently remind House Officers to address BPAs during outpatient visits.

Process:

Medical assistants are inconsistent in providing support to facilitate BPA usage. Medical assistants (MAs) have many responsibilities when rooming patients during outpatient visits, including but not limited to reviewing BPAs, reminding physicians to address those BPAs, and in the case of breast cancer screening, opening the SmartSet (order entry set), selecting mammogram order, and queuing or “pending” it. When these steps are taken by the MAs, physicians only have to click a single “sign” button to complete the order. MAs were inconsistently providing this support. In the case of colorectal cancer screening, MAs do not have the clinical training to select appropriate colon cancer screening tests (colonoscopy versus sigmoidoscopy versus Cologuard versus fecal occult blood). In this case, they are asked to write a reminder on the patient router triggering the physician to address this concern. This also happened only sporadically.

Patients: Patients’ other conditions and competing clinical priorities during limited time of non-preventative care visits

C. Do**14. Intervention(s). Describe the interventions implemented as part of the project.**

New tool. The precepting sheets (mainly used to track resident visits for billing reconciliation purposes) were redesigned to document addressing BPAs. This BPA documentation encourages faculty preceptors to review and educate House Officers to address BPAs during both preventative care and non-preventative care visits.

People: Insufficient EHR training and irregular staff support to facilitate BPA usage

At resident-Faculty business meetings both groups were educated regarding:

- SmartSets and Best Practice Advisories
- Use of re-designed precepting sheets

Medical assistants were provided education and told they were accountable for managing patient flow in a standard manner for all visits regardless of House Officer or faculty physician patient. Specifically, they were educated and held accountable to queue SmartSets for House Officers during ALL visits – preventative and non-preventative (as is already expected for faculty patient visits).

15. Who was involved in carrying out the intervention(s) and what were their roles?

- Residency leadership coordinated the intervention.
- Clinical leadership delegated MA training at the clinical sites to MA leads.
- MA leads reinforced appropriate support from each MA.
- Faculty preceptors encouraged discussion of cancer screening during all clinic visits regardless of presenting complaint.
- House Officers addressed BPAs directly during clinic visits. House Officers were also expected to reinforce the process support for both MAs and faculty preceptors.

16. When was the intervention initiated? (For multiple interventions, initiation date for each.)

April 29, 2015

D. Check

17. Post-intervention performance measurement. Did this data collection follow the same procedures as the initial collection of data described in #11: population, measure(s), and data source(s)?

Yes No – If no, describe how this data collection

18. Performance following the intervention.

a. The collection of the sample of performance data following the intervention occurred for the time period: April 29-June 30, 2015

b. What was post-intervention performance level? (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 attached data table 1, column for post-intervention data. Of note, total number of eligible visits were significantly fewer within the intervention cycle due to a shorter period of time as compared baseline data collection. Additionally, the majority of House Officers had fewer continuity clinic dates because they were covering inpatient services.

c. Did the intervention produce the expected improvement toward meeting the project's specific aim (item 12.b)?

Breast cancer screening: Both Residency clinics improved, with Clinic B meeting the goal of an increase of 30%.

Colon cancer screening: both clinics experienced a small decrease in performance on addressing the colon cancer BPA.

E. Adjust – Replan

19. Review of post-intervention data and identifying continuing/new underlying causes.

a. Who was involved in reviewing the post-intervention data, identifying underlying (root) causes of the continuing/new problem(s), and considering possible adjustments to interventions (“countermeasures”) to address the causes? Briefly describe:

- **Who was involved?** Participating Family Medicine House Officers and residency leadership team, clinic site panel managers.
- **How?** (e.g., in a meeting of clinic staff) Residency meetings, email.
- **When?** House Officers reviewed data throughout the month of July while they were in clinic. Project leaders met with staff in mid July to analyze data and propose next steps of the intervention. This was presented to all residents on July 29, 2015, at which time they were able to respond and critique. The plan was finalized at this meeting and implemented Aug 1.

b. What were the primary underlying/root causes for the continuing/new problem(s) that the project can address? (Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately.)

People:

- Staff turnover (medical assistants, clinical leadership).
- There also continued to be inconsistent encouragement from faculty preceptors to remind House Officers to address BPAs during outpatient visits, and vice versa.

Process: MAs continue to provide inconsistent staff support to facilitate BPA usage, exacerbated by staff turnover.

F. Redo

20. Second intervention. What additional interventions/changes were implemented?

While reinforcing and continuing the initial interventions, the following were initiated.

People:

- Education. We initiated formal training of new staff in consistent BPA and rooming protocols.
- Performance feedback/review. Meetings between House Officers and panel managers were scheduled to review individual colorectal and breast cancer BPA response rates. Physicians were given more responsibility for colon cancer screening orders due to lack of delegated authority of support staff to address this topic, as compared to breast cancer screening, for which staff delegation protocols have been well established.

21. The second intervention was initiated when? (For multiple interventions, initiation date for each.)

- August 1, 2015: initiation of second round of cycle

G. Recheck

22. Post-second intervention performance measurement. Did this data collection follow the same procedures as the initial collection of data described in #11: population, measure(s), and data source(s)?

Yes No – If no, describe how this data collection

23. Performance following the second intervention.

- a. The collection of the sample of performance data following the intervention(s) occurred for the time period:** August 1-September 30, 2015

- b. What was the performance level?** (*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 attached data table 1, column for post-adjustment performance.

- c. Did the second intervention produce the expected improvement toward meeting the project's specific aim (item 12.b)?**

Breast Cancer Screening: at both Clinics rates decreased from post-intervention levels. The decreased rates are at or below baseline rates, with no increase toward the goal.

Colon Cancer screening: after performance at both clinics decreased from baseline to post-intervention, both clinics improved slightly from post-intervention to post-adjustment rates. Clinic A remains below baseline with more than a 30% increase needed to achieve the goal. Clinic B increased to 13% above baseline, not quite halfway to the goal of a 30% increase.

H. Readjust

24. Review of post-second intervention data and identifying continuing/new underlying causes.

- a. Who was involved in reviewing the data, identifying underlying (root) causes of the continuing/new problem(s), and considering additional possible adjustments to interventions ("countermeasures") to address the causes? Briefly describe:**

- **Who was involved?** Participating Family Medicine House Officers and residency leadership team, clinic site panel managers, clinic leadership, and clinic staff.
- **How?** (*e.g., in a meeting of clinic staff*) This was reviewed during meetings with the House Officers, meetings with clinic site panel managers, meetings with clinic leadership, meetings with clinic staff, and via email.
- **When?** Throughout the month of October 2015.

- b. What were the primary underlying/root causes for the continuing/new problem(s) that the project can address?** (*Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately.*)

Processes:

- a. Breast Cancer Screening:
- House Officer's workload increase – In July 2015 (coinciding with the beginning of Cycle #2) every House Officer at both sites experienced an increase in patient volume per clinic session. The volume increase was 33% for rising HOIIs and 20% for rising HOIIIs. Individual patient complexity did not change. Every House Officer was expected to complete more tasks per half day of clinic. With less time per patient encounter, House Officers tended to prioritize addressing the reason for the visit and that reason took most of the time allocated for the visit, House Officers lowered the priority of addressing preventive care. This likely contributed to the decrease in breast cancer screening BPA utilization in this time period.
 - We theorize that Clinic B's initial 14% increase during Cycle #1 was largely due to MA pending mammogram orders on behalf of House Officers. Coinciding with the initiation of Cycle #2 there was a leadership transition and turnover of multiple MAs that resulted in a complete halt in all MA work on BPAs. We believe this led to the regression to back to baseline level BPA utilization.
- b. Colon Cancer Screening:

- During Cycle #2, colon cancer screening rate increased at both sites.
- Colon cancer screen ordering was not dependent on MA workflow. House Officers had been trained to order these tests themselves. Therefore the change in MA workflow did not negatively impact colon cancer screening in a similar fashion to breast cancer screening.

People:

Faculty preceptors inconsistent performance. Faculty preceptors continued to be inconsistent in encouraging reminding House Officers to address BPAs during outpatient visits

If no additional cycles of adjustment are to be documented for the project for Part IV credit, go to item #25.

If a few additional cycles of adjustments, data collection, and review are to be documented as part of the project to be documented, document items #20 – #24 for each subsequent cycle. Copy the set of items #20 – #24 and paste them following the last item #24 and provide the information. When the project to be documented for Part IV credit has no additional adjustment cycles, go to item #25.

If several more cycles are included in the project for Part IV credit, contact the UM Part IV MOC Program to determine how the project can be documented most practically.

I. Future Plans

25. How many subsequent PDCA cycles are to occur, but will not be documented as part of the “project” for which Part IV credit is designated?

A minimum of two additional cycles are planned, with additional cycles if needed to reach and maintain goal.

26. How will the project sustain processes to maintain improvements?

- MA workflows will remain standardized to provide physician support of BPAs.
- For the past few cycles data were distributed directly to House Officers. For subsequent cycles data will also be distributed to MA staff and clinical leadership.
- Faculty preceptors will continue to utilize our redesigned preceptor tracking sheets to document BPA responses.
- The Medical Directors and clinical leadership at both sites will continue to be updated on progress and asked to be involved in implementation.

27. Do other parts of the organization(s) face a similar problem? If so, how will the project be conducted so that improvement processes can be communicated to others for “spread” across applicable areas?

All primary care divisions in our institution are expected to meet multiple quality measures, regarding not only cancer screening, but multiple other preventative care and chronic disease states as well. Many of these are linked to incentive quality payments. Nearly every such clinic has potential room for improvement (see data presented in 7a), and several of these locations are clinical sites for House Officers. The workflow processes that support such care are diverse, not only across departments, divisions, and sites, but within clinical sites as well. Ensuring proper faculty and staff support for all Primary Care House Officers would support the institution as a whole, and has the potential to improve patient care.

28. What lessons (positive or negative) were learned through the improvement effort that can be used to prevent future failures and mishaps or reinforce a positive result?

- Other efforts outside of clinic visits successfully increased actual screening rates. Despite the lack of overall improvement in BPA response rate among House Officers, each clinic site’s actual completion rate of colorectal cancer screening tests and breast cancer screening tests improved for FY16 as compared to FY15, which includes both faculty and House Officer patients (see attached Data Table 2). As compared to the process of BPA response rate, the outcome of actual screening is more significant to the overall quality of care provided to the patients. After the first PDCA cycle, the project was readjusted to include meeting time between individual House

Officers and their panel managers. At these meetings, they reviewed breast cancer and colorectal cancer screening rates among their patient panels regardless of whether those patients had presented during the cycles of data collection for a visit. House Officers and Panel Managers contacted these patients to order screening tests outside the setting of an office visit, and it is theorized that this outside contact resulted in a higher rate of screening tests completed.

- Initial 14% increase in mammogram orders show significant potential for MA workflow to impact patient outcomes, however their role needs to be standardized and reinforced by leadership and clinicians. Such interventions have the potential to increase quality measures in multiple arenas, as BPAs are in place for multiple preventative health measures and chronic diseases.
 - We believe interventions both during the clinic visit and outside of the clinic visit can have a positive impact on cancer screening rates. We favor changing MA workflows to include pending selected BPAs during the clinic visit, as well as House Officer collaborating with panel managers to contact patients outside of clinic visits.
- Address increases in work load. A cause for regression in breast cancer screening BPA utilization between the first intervention and second intervention is likely the increase in patient load for all House Officers starting July 1, by 33% for rising HOIIs and 20% for rising HOIIIs. This resulted in 10 minutes and 5 minutes less time per patient visit for rising HOIIs and rising HOIIIs respectively, though the volume of patients' questions and concerns did not change. With less time per visit than they had been accustomed to, it is theorized that House Officers did not feel they had adequate time to address all patient concerns and all BPAs. While there is no way to avoid the increased patient load due to ABFM/ACGME requirements of Family Medicine House Officers, this highlights the importance of consistent staff support to note and respond to preventative care needs of all patients.
 - Train and monitor new staff. Clinic leadership can be more proactive about ensuring that staff audits are reinstated as swiftly as possible when staff leadership turns over, and that new staff are trained as thoroughly as possible as to standard workflows.
 - Have local project lead. The presence of the Project Lead at the Clinic B site likely supported the project's momentum at that site over Clinic A's. Though a similar physician champion was identified at Clinic A site, the project was never as well integrated. The Project Lead can have more direct involvement with clinical leadership at Clinic A to reinforce the project.
 - Provide feedback to all staff. For the first two cycles of the project, House Officers were given reports of their performance. In the future, we will distribute data directly to Medical Assistants, as well as to their supervisors.
 - Integrate clerical staff. Once orders are signed by the physician, current workflow dictates providing contact information for the scheduling of said tests. Future projects can be aimed at integrating check out staff to schedule appointments for the patient in real time.
 - Communication between providers and staff. When MAs stopped pending mammogram orders at Clinic B, clinic leadership was not immediately made aware of the change. Discussion with House Officers revealed that they were very uncomfortable giving direct feedback to Medical Assistants and to clinic leadership. Future efforts will be aimed at training House Officers to give direct and professional feedback to their MAs and others.

J. Physician Involvement

Note: To receive Part IV MOC a physician must both:

- a. *Be actively involved in the QI effort, including at a minimum:*
 - *Work with care team members to plan and implement interventions*
 - *Interpret performance data to assess the impact of the interventions*
 - *Make appropriate course corrections in the improvement project*

b. Be active in the project for the minimum duration required by the project

29. Physician's role. What were the minimum requirements for physicians to be actively involved in this QI effort? (What were physicians to do to meet each of the basic requirements listed below? If this project had additional requirements for participation, also list those requirements and what physicians had to do to meet them.)

- a. Interpreting baseline data, considering underlying causes, and planning intervention. (As appropriate, use or modify the following response.)
Physicians had to attend clinic meetings, review and discuss underlying causes, participate in planning intervention based on baseline data. .
- b. Implementing intervention. (As appropriate, use or modify the following response.)
Physicians had to address BPA for appropriate patients. In addition, they had to record addressing BPA on a precepting sheet and were expected to remind and reinforce the standard MA workflow regarding the cancer screening BPA's.
- c. Interpreting post-intervention data, considering underlying causes, and planning changes. (As appropriate, use or modify the following response.)
Physicians were expected to review data during meetings with clinic site panel managers, clinic leadership, clinic staff, and via email, contribute ideas for adjustments to workflow and provide feedback to planned changes.
- d. Implementing further intervention/adjustments. (As appropriate, use or modify the following response.)
Physicians had to continue to address the BPA's for appropriate patients, reinforce the process with medical assistant staff and preceptors.
- e. Interpreting post-adjustment data, considering underlying causes, and planning changes. (As appropriate, use or modify the following response.)
Physicians were expected to meet with clinic panel managers, attend clinic site meetings and review data in person or by e-mail and review and contribute to discussion of ongoing adjustments.

30. How were reflections of individual physicians about the project utilized to improve the overall project?

Individual physician feedback was utilized at all stages of the project. They were critical in helping the team understand what quality and performance reports were most useful to them, and what support they require in order to improve their performance. Their feedback also helped us understand the variability of the support they receive from MAs.

31. How did the project ensure meaningful participation by physicians who subsequently request credit for Part IV MOC participation?

In addition to being asked to review their own data, they had to confirm with residency support staff that they had indeed done so. Additionally, they met with residency leadership to discuss the design of each cycle. Finally, their face-to-face meetings with the panel managers at their sites ensured continuing participation.

K. Sharing Results

32. 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

33. UMHS QI/Part IV MOC oversight – this project occurs within:

University of Michigan Health System

• **Overseen by what UMHS Unit/Group?**

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

No Yes – the initiative is:

Veterans Administration Ann Arbor Healthcare System

• **Overseen by what AAVA Unit/Group?**

• **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:**

• **The type of affiliation with UMHS is:**

Accountable Care Organization type (*specify which*):

BCBSM funded, UMHS lead state-wide Collaborative Quality Initiative (*specify which*):

Other (*specify*):

Data Table 1. FM House Officer BPA Utilization – Baseline, Post-Intervention 1, Post-Intervention 2

Site and Measure	Baseline (1/1/15 – 3/31/15)	Post- Intervention (4/29/15 – 6/30/15)	Post- Adjustment (7/29/15-9/30/15)	Goal (30% > baseline)
Site A				
<u>Breast cancer screening</u>				
N eligible visits (BPA)	172	88	200	
N BPA addressed	53	29	54	
% BPA addressed	31%	33%	27%	40%
<u>Colon cancer screening</u>				
N eligible visits (BPA)	185	98	241	
N BPA addressed	75	36	93	
% BPA addressed	41%	37%	39%	53%
Site B				
<u>Breast cancer screening</u>				
N eligible visits (BPA)	101	47	132	
N BPA addressed	46	28	60	
% BPA addressed	46%	60%	46%	60%
<u>Colon cancer screening</u>				
N eligible visits (BPA)	125	58	132	
N BPA addressed	39	17	46	
% BPA addressed	31%	29%	35%	40%
Total				
<u>Breast cancer screening</u>				
N eligible visits (BPA)	273	135	332	
N BPA addressed	99	57	114	
% BPA addressed	36%	42%	34%	47%
<u>Colon cancer screening</u>				
N eligible visits (BPA)	310	156	373	
N BPA addressed	144	53	139	
% BPA addressed	37%	34%	37%	48%

Data Table 2. UMMG Pay-for-Performance Program Summary for FY 2016

	Total Patients ¹	Total Possible Quality Performance Metrics ²	Achieved 90th Percentile	Achieved 75th Percentile
Family Medicine				
Clinic A	14,672	44	17	5
Clinic B	9,246	44	12	10
Clinic C	16,121	44	21	5
Clinic D	8,216	44	24	5
Clinic E	9,896	44	24	7
Clinic F	2,604	39	13	6
<i>Subtotal</i>	<i>60,755</i>	<i>259</i>	<i>111</i>	<i>38</i>
General Medicine				
Clinic A	12,913	34	13	8
Clinic B	14,919	34	12	6
Clinic C	12,006	34	11	8
Clinic D	10,615	34	10	7
Clinic E	3,710	34	18	6
Clinic F	4,698	34	13	6
Clinic G	4,753	34	10	6
Clinic H	4,881	34	8	3
Clinic I	6,393	34	17	5
<i>Subtotal</i>	<i>74,888</i>	<i>306</i>	<i>112</i>	<i>55</i>
General Pediatrics				
Clinic A	4,124	10	10	0
Clinic B	5,404	10	9	1
Clinic C	4,706	10	9	1
Clinic D	4,149	10	9	1
Clinic E	3,505	10	3	6
Clinic F	3,426	10	10	0
Clinic G	2,228	10	6	2
Clinic H	1,487	10	9	1
Clinic I	2,653	10	8	0
<i>Subtotal</i>	<i>31,682</i>	<i>90</i>	<i>73</i>	<i>12</i>
Geriatrics				
Clinic A	6,161	33	6	5
<i>Subtotal</i>	<i>6,161</i>	<i>33</i>	<i>6</i>	<i>5</i>
Med/Peds				
Clinic A	7,918	44	20	8
Clinic B	5,251	44	25	8
<i>Subtotal</i>	<i>13,169</i>	<i>88</i>	<i>45</i>	<i>16</i>
Primary Care Total	186,655	776	347	126
UMMG Total	241,342	970	437	148

¹ Sum of all attributed patients for each clinic and includes all eligible patients for each registry. Patients may be counted in multiple registries.

² One performance point per clinic is given for each incentivized measure, except for childhood immunizations, which is worth 3 points.

³ Unadjusted payment is the sum product of performance points achieved and its monetary value. Each performance point achieved for meeting 90th or 75th percentile goal is worth \$1,500 or \$500, respectively.

⁴ Payment adjustment factor is the total number of patients divided by the average number of patients across either primary care or specialty care. Average number of patients across primary care is 6,913, across specialty care is 1,031 and across OB/GYN is 2,971.

5 Total payment amount is the unadjusted payment multiplied by the payment adjustment factor.

6 Total possible points for Family Medicine Clinic F is lower due to the lack of data for the pediatric immunization measures.