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

Decreasing missed opportunities for HPV vaccination in General Pediatrics

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

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<tr>
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<td>42. Part of UMHS, AAVA, other affiliation with UMHS</td>
</tr>
</tbody>
</table>
QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date (this version of the report): 9/27/16

2. Title of QI effort/project (also insert at top of front page): Decreasing missed opportunities for HPV vaccination in General Pediatrics

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 #14): 7/1/2015
   
   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 #33): Division meeting held on 9/20/16; Participants who were not present at this meeting communicated their thoughts electronically from 9/20-10/3/16.

4. Key individuals
   
   a. QI project leader [also responsible for confirming individual’s participation in the project]
      Name: Heather L Burrows, MD PhD
      Title: Clinical Associate Professor
      Organizational unit: Pediatrics and Communicable Diseases
      Phone number: 734-936-8970
      Email address: armadill@umich.edu
      Mailing address: D3237 MPB 1500 E Medical Center Dr SPC 5718
   
   b. Clinical leader to whom the project leader reports regarding the project [responsible for overseeing/“sponsoring” the project within the specific clinical setting]
      Name: Kelly Orringer, MD
      Title: Director
      Organizational unit: Division of General Pediatrics
      Phone number: 734-647-3552
      Email address: korringe@umich.edu
      Mailing address: North Ingles Building 6e12
      300 N Ingles St
      Ann Arbor, MI 48109

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

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number (fill in)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicing Physicians</td>
<td>50</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>General Pediatrics</td>
<td>19</td>
</tr>
<tr>
<td>Fellows</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Residents</td>
<td>General Pediatrics</td>
<td>7</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):

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 11-21 seen at UMHS Department of General Pediatrics outpatient clinic visits

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 Advisory Committee on Immunization Practices (ACIP) currently recommends routine vaccination of youth ages 11 - 26 with 3 doses of human papilloma virus (HPV) vaccine (1). Several factors have been associated with low HPV vaccination rates. A critical barrier reported by parents is not receiving a recommendation for the HPV vaccine from a health care professional (2). A prior study done at UMHS with an electronic prompt has demonstrated increased HPV initiation and timely completion (3). In 2014, 26.4% of females and 16.7% of males (averaged amongst clinics) completed the HPV vaccine series. Decreasing missed opportunities to provide HPV vaccination will significantly improve vaccination rates. Physicians are missing opportunities to counsel patients on the benefit, and to offer HPV vaccination at ambulatory care clinic appointments.

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.)

Decrease missed opportunities to provide HPV vaccination.
References

   ☒ Effectiveness
   ☐ Efficiency
   ☒ Patient-Centeredness
   ☒ Timeliness

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

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: Percent of visits with missed HPV Vaccination Opportunity

• 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 visits where a patient was eligible to receive the HPV vaccine (based on BPA firing).
  Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation): number of these visits where HPV vaccine was not given. This includes when vaccine is declined, and when the physician does not offer vaccination.

• The source of the measure is:
  ☐ An external organization/agency, which is (name the source): ☒ Internal to our organization and it was chosen based on consensus in the UMHS pediatric QI committee.

• 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)?
August 1, 2015 - October 31, 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.)

61% of the time HPV vaccine was NOT given to eligible patients during clinic visits – this includes when the vaccine is declined, and when the physician did not offer vaccination. (Please see #27 for data table)

13. Specific performance aim(s)/objective(s)

a. What is the specific aim of the QI effort? “The Aim Statement should include: (1) a specific and measurable improvement goal, (2) a specific target population, and (3) a specific target date/time period. For example: We will [improve, increase, decrease] the [number, amount percent of [the process/outcome] from [baseline measure] to [goal measure] by [date].”

In patients aged 11-21 seen at UMHS Department of General Pediatrics ambulatory clinics, to decrease missed opportunities to give the HPV vaccine by from 60% to 45%. with a goal to reach this target after 2 three-month intervention cycles, by August 31, 2016.

b. How were the performance targets determined, e.g., regional or national benchmarks?
Based on consensus in the UMHS pediatric QI committee, a decision was made to improve relative % in each clinical area by 20%.

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.)

- **Who was involved?** (e.g., by profession or role) All participating physicians.

- **How?** (e.g., in a meeting of clinic staff) During discussion at resident-faculty meeting, and via a Qualtrics survey sent over e-mail.

- **When?** (e.g., date(s) when baseline data were reviewed and discussed) Data was reviewed on November 16th and planning for the intervention occurred between Nov 16 and December 15th, 2015.

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:

<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>
</tbody>
</table>

**15.** What were the primary underlying/root causes for the problem(s) at baseline that the project can address?

Physicians don’t notice the BPA and therefore don’t realize that the HPV vaccine is due

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

Clinics will pilot having MAs print MCIRs for every patient at every visit. This reinforces the importance of reviewing vaccines at every visit. It provides an additional visual reminder and can be a way to visually reinforce this with patients as well (when the MICR is shared with the patient/family)

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

Participating physicians, Medical Directors, Clinic Managers, and MAs will instate this workflow as an additional method to increase physicians offering the vaccine.

Clinic managers and MAs will develop a process for printing and providing the MICRs.

Physicians will review them and incorporate them into their workflow.

Medical Directors will reinforce this process.

| Physicians find it difficult to counsel on the HPV vaccine during urgent visits | A standardized education sheet will be hung in the exam rooms for reference during all visits. | This education sheet was approved by physicians and clinic staff at the populations management group. |

| Physicians have varying success in encouraging families and patients to consent for the vaccine | Best practices in “pitching” the vaccine were reviewed at resident-faculty meeting and over e-mail | Physicians practiced techniques that have been effective and shared their process for giving a strong recommendation. |

| Patients and families decline the vaccine | Education will be standardized via the provided poster, physicians will work to recommend the vaccine with the same enthusiasm as they do all other vaccines | All participating physicians and office staff will reinforce the common message. |

| MDs don’t always discuss vaccines at non-well visits despite the BPA firing. | Language about addressing vaccines will be added to many frequently used urgent visit templates to reinforce the importance of addressing immunizations at these visits. | Physician leads edited shared templates. Clinic managers reinforced with MA’s printing of MICR’s at urgent visits. |
MICR sheets are provided at urgent visits as well as well visits.

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.)
   December 16th, 2015

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)? December 16th, 2015- March 15th, 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.)

   During the intervention period 56% of the time HPV vaccine was NOT given to eligible patients during clinic visits, an INCREASE in missed opportunities by 9%. (Please see #27 for data table)
   c. Did the intervention(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)?
      No. Surprisingly, the percentage of visits with HPV not given increased by 9 percentage points.

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.)
   • Who was involved? (e.g., by profession or role)
     ☒ Same as #14?   ☐ Different than #14 (describe):
   • How? (e.g., in a meeting of clinic staff)
     ☒ Same as #14?   ☐ Different than #14 (describe):
   • When? (e.g., date(s) when post-intervention data were reviewed and discussed)
     faculty meeting on April 19, 2016 and via email. Suggestions for intervention were collected at this meeting and via a Qualtrics survey.
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](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>During the winter months, a higher percentage of visits in the pediatric office are for urgent visits (in particular for illnesses) than for well visits. During these visits, time to discuss immunizations is limited. Although it is generally appropriate to vaccine despite illness, parents and teens are often hesitant to agree to HPV vaccine in particular at these visits since they often perceive it to be an &quot;optional&quot; vaccine. In addition, if parents are hesitant to consent to the vaccine, there is not as much time to discuss it in a 15 minute urgent visit with a sick child in the midst of an overbooked clinic.</td>
<td>All providers will include documentation about immunizations in their notes for urgent visits as well as well visits. This is being done to again reinforce the importance of discussing the vaccine even at urgent visits.</td>
<td>Participating physicians</td>
</tr>
<tr>
<td>Practitioners continued to miss the BPA</td>
<td>A standing order has been developed and incorporated into clinical workflow to facilitate administration of HPV vaccine for doses 2 and 3. This will allow MAs to give the remainder of the series without having to get an order from the provider.</td>
<td>Physicians and office staff are incorporating the standing order into the workflow.</td>
</tr>
</tbody>
</table>
Parents continue to decline the vaccine despite strong recommendations.

Continue to operationalize the standard educational materials and provide a strong provider recommendation

Physicians and office staff

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.)

Second intervention began in April 2016 and was in place by April 30, 2016.

- additional language about immunizations to urgent visit templates occurred throughout the month of April.

- 4/18/16 for standing order for HPV doses 2/3/

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)?
   May 1, 2016- 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.)

DATA TABLE
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Missed HPV Opportunity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N eligible visits (BPA fired)</td>
<td>4140</td>
<td>3215</td>
<td>5567</td>
<td></td>
</tr>
<tr>
<td>N HPV not given</td>
<td>2526</td>
<td>2257</td>
<td>3355</td>
<td></td>
</tr>
<tr>
<td>% HPV NOT Given</td>
<td>61%</td>
<td>70%</td>
<td>60%</td>
<td>45%</td>
</tr>
</tbody>
</table>

c. Did the adjustment(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)? No

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 discipline:
      • Participants with data available:
         o Indicate the number participating (if none, enter “0” and do not complete rest of row)
         o 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>19</td>
<td>Yes</td>
</tr>
<tr>
<td>Residents/ Fellows</td>
<td>7</td>
<td>Yes</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.)
• **Who was involved? (e.g., by profession or role)**
  - ☒ Same as #21?  ☐ Different than #21 (describe):

• **How? (e.g., in a meeting of clinic staff)**
  - ☒ Same as #21?  ☐ Different than #21 (describe):

• **When? September 20, 2016**

*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](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>Parents continue to refuse vaccination. We saw an increase in the rates of documentation of declined vaccines throughout. As we address process issues and vaccinate the patients who consent to immunization, the proportion of patients who are due for vaccine who will refuse it increases-making it more difficult to make an impact.</td>
<td>Continued education for parents/patients. Persistent recommendations by providers over time may address. Adopting a policy of not accepting patients who decline vaccinations would decrease this issue but may have other unintended consequences.</td>
<td>Providers will continue to offer vaccination and address concerns that parents may have. Clinic medical directors and division leadership will discuss policy changes.</td>
</tr>
<tr>
<td>Declined vaccines are not always documented in the chart. Although this does not affect the % missed opportunities data, it does make it more difficult to identify if this is a process issue (no vaccine offered) or a vaccine hesitancy issue.</td>
<td>Developing a standard process for documenting declined vaccines. We do not currently have a plan for how frequently this should be documented (every visit vs annually). This would better clarification of the failure to achieve our goal.</td>
<td>Clinic medical directors and division leadership will discuss a specific policy and then roll this out to the clinics as a whole.</td>
</tr>
</tbody>
</table>
HPV is not always offered when pts are present for non-MD visits

Standing order for doses 2/3 has been in place for only a few months. We do not have data on how often this is being used. A standard plan to offer HPV at flu clinics this fall/winter would capture some patients who are due for vaccine while they are in the clinic

Physicians will develop processes for including HPV during flu vaccine clinics.

Pts who are due for HPV do not always come to the office for appointments

A reminder/recall process will be implemented

Clinic directors will develop a process to identify and contact patients who are due for vaccine and bring them in for vaccine appointments.

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:
Continued discussion of clinic policies re: documenting declined immunizations and patients who refuse vaccines; longer follow up of results of standing order for HPV (will be in place during flu vaccine season this winter when teens do come in for immunization only visits); Development of a callback system for under-immunized patients.

☐ 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 largest barrier to HPV vaccination is still vaccine hesitancy. This is a challenge nationally. Other than a strong provider recommendation there are no other interventions that have been shown to be effective in the literature. We continue to address through patient education. All clinicians agree that the vaccine is safe, effective, and appropriate to provide at 11-21y. We provided a strong, consistent recommendation. We did not have to address differences in practice patterns.

Documenting a declined vaccine can be time consuming in MiChart. Therefore we do not have clear data about our missed opportunities to distinguish vaccine refusal vs not offering the immunization. Interventions to address these two issues are very different and this will be important going forward. This process is being standardized in the clinics.

Teamwork is important in providing excellent care. Ensuring that the entire group has a consistent message (MAs, Clinicians) was identified as an important component of this project. As clinicians do not always open the MiChart encounter in the clinic room, the BPA is not always present in a manner that will trigger care decisions. Opportunities for MAs to pend BPA and/or provide highlighted immunization records are important to augment the BPA.

34. Describe any key lessons that were learned as a result of the QI effort.

A method of data collection that accurately distinguishes between various root causes of the outcome you wish to change is important in designing interventions.
35. Describe any best practices that came out of the QI effort.

Providing standard patient education for exam rooms.
Standing order for HPV doses 2/3.

36. Describe any plans for spreading improvements, best practices, and key lessons.
We are presenting a poster on this project at the UM Quality Month Presentations

37. Describe any plans for sustaining the changes that were made.

The standing order will continue to be a part of clinic workflow.
The processes for identifying patients who are due for immunizations are effective for all immunizations not just HPV and will continue to be utilized in clinics. We will track HPV rates as well as all other immunization rates regularly in our clinics.

J. Minimum Participation for MOC

38. Participating directly in providing patient care.

   a. Did any individuals seeking MOC participate directly in providing care to the patient population?
      ☒ Yes ☐ No  If “No,” go to item #39.

   b. Did these individuals participate in the following five key activities over the two cycles of data-guided improvement?
      – Reviewing and interpreting baseline data, considering underlying causes, and planning intervention as described in item #14.
      – Implementing interventions described in item #16.
      – Reviewing and interpreting post-intervention data, considering underlying causes, and planning intervention as described in item #21.
      – Implementing adjustments/second interventions described in item #23.
      – Reviewing and interpreting post-adjustment data, considering underlying causes, and planning intervention as described in item #29.
      ☒ Yes ☐ No  If “Yes,” individuals are eligible for MOC unless other requirements also apply and must be met – see item # 40.

39. Not participating directly in providing patient care.

   a. Did any individuals seeking MOC not participate directly in providing care to the patient population?
      ☐ Yes ☒ No  If “No,” go to item 40.

   b. Were the individual(s) involved in the conceptualization, design, implementation, and assessment/evaluation of the cycles of improvement? (E.g., a supervisor or consultant who is involved in all phases, but does not provide direct care to the patient population.)
      ☐ Yes ☐ No  If “Yes,” individuals are eligible for MOC unless other requirements also apply and must be met – see item # 40.  If “No,” continue to #39c..

   c. Did the individual(s) supervising residents or fellows throughout their performing the entire QI effort?
☐ Yes  ☐ No  If “Yes,” individuals are eligible for MOC unless other requirements also apply and must be met – see item # 40.

40. Did this specific QI effort have any additional participation requirement for MOC?  *(E.g., participants required to collect data regarding their patients.)*
☐ Yes  ☒ No  If “Yes,” describe:

K. Sharing Results

41. Are you planning to present this QI project and its results in a:
☐ Yes  ☐ No  Formal report to clinical leaders?
☒ Yes  ☐ No  Presentation (verbal or poster) at a regional or national meeting? We are presenting it as a poster at the UM Quality Month October 2016.
☐ 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):* Multidepartmental, our project was overseen by the division of General Pediatrics
  • Is the activity part of a larger UMHS institutional or departmental initiative?
    ☒ No  ☐ Yes – the initiative is *(name or describe):* multi-departmental project to improve HPV rates

☐ Veterans Administration Ann Arbor Healthcare System
  • Overseen by what AAVA Unit/Group? *(name):
  • Is the activity part of a larger AAVA institutional or departmental initiative?
    ☒ No  ☐ Yes – the initiative is:

☐ An organization affiliated with UMHS to improve clinical care
  • The organization is *(name):
  • The type of affiliation with UMHS is:
    ☐ Accountable Care Organization *(specify which member institution):
    ☐ BCBSM funded, UMHS lead state-wide Collaborative Quality Initiative *(specify which):
    ☐ Other *(specify):
ATTACHMENT: Final data report shared with faculty.

Note that “missed opportunities” in this report refers to patient visits where HPV was not addressed (declines and completed immunizations were both counted as a “success”). “Visits with no HPV given” corresponds to a missed opportunity as defined for the MOC project.
Missed opportunities could be defined in two ways:

1) **No vaccine was offered**—this is best addressed by process issues that identify a need for vaccine. We have so far addressed this as follows:
   - BPA for HPV (having one, some clinics have MA’s pend this when they room the pt)
   - Printing and highlighting the MICR
   - Putting language about vaccines in most of the standard templates (in addition to the well visit templates) to remind folks to discuss at urgent visits as well.
   - Standing order for doses 2&3 so that MA’s can give this without waiting for MD

   Or

2) **Patient did not get the vaccine**—For the most part this is the families that refuse the vaccine, although some clinics found that folks would leave without getting the ordered vaccine. We have so far addressed this as follows:
   - For patient who leave before getting their vaccine: clinics developed a system for the clerks to check to make sure that pts got all ordered vaccines before leaving.
   - For parents who decline the vaccine:
     - educate every provider on the importance of a strong recommendation
     - provide patient education posters for exam rooms

It is only possible to tell that the family declined the imm if it is documented as declined in the chart not just the note (which doesn’t always happen) so we really don’t have a good way to tell the difference between the two issues (clinic process or patient decision).

For our MOC project, missed opportunities was defined as not getting vaccine when it was due. (either because it was not offered, they left without it, or refused it)

As we improve our processes, the patients who are left who need vaccine when they come in will be more heavily weighted to the refusers. I find that harder to address than the process, so our data may actually get worse as we improve the processes--- our overall vaccine rate should improve but not the missed opportunities. Our most recent vaccine rate data only looked at % of kids vaccinated by 13th birthday, so not really able to see if our process is improving delivery of vaccine to the other ages. Food for thought.

For the MOC project: we need to think about if there is a next step…..