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

IHA – Improving Care of Pediatric Asthma Patients

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

Report Outline

Section	Items	
A. Introduction	1-6.	Current date, title, time frame, key individuals, participants, funding
B. Plan	7-10.	Patient population, general goal, IOM quality dimensions, ACGME/ABMS competencies
	11-13.	Measures, baseline performance, specific aims
	14-17.	Baseline data review, underlying (root) causes, interventions, who will implement
C. Do	18.	Intervention implementation date
D. Check	19-20.	Post-intervention performance
E. Adjust – Replan	21-24.	Post-intervention data review, underlying causes, adjustments, who will implement
F. Redo	25.	Adjustment implementation date
G. Recheck	26-28.	Post-adjustment performance, summary of individual performance
H. Readjust plan	29-32.	Post-adjustment data review, underlying causes, further adjustments, who will implement
I. Reflections & plans	33-37.	Barriers, lessons, best practices, spread, sustain
J. Participation for MOC	38-40.	Participation in key activities, other options, other requirements
K. Sharing results	41.	Plans for report, presentation, publication
L. Organization affiliation	42.	Part of UMHS, AAVA, other affiliation with UMHS

QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date: March 10, 2017

2. Title of QI effort/project: IHA – Improving Care of Pediatric Asthma Patients

3. Time frame

a. MOC participation beginning date – date that health care providers seeking MOC began participating in the documented QI project: February 1, 2016

b. MOC participation end date – date that health care providers seeking MOC completed participating in the documented QI project: March 1, 2017

4. Key individuals

a. QI project leader:
Name: Diana Rooks
Title: Project Manager
Organizational unit: Quality & Performance Improvement
Phone number: 734.747.6766 x10857
Email address: Diana_Rooks@ihacares.com
Mailing address: 24 Frank Lloyd Wright Dr, Lobby J2000, Ann Arbor, MI 48105

b. Clinical leader who oversees project leader regarding the project:
Name: Melissa Heinen, DO, MPH
Title: Associate Division Head of Pediatrics
Organizational unit: IHA Pediatrics Division
Phone number: 734.455.4600
Email address: Melissa_Heinen@ihacares.com
Mailing address: 990 W. Ann Arbor Trail, Suite #210, Plymouth, MI 48170

5. Participants

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

Profession	Number *(fill in)*
Practicing Physicians	48
Residents/Fellows	
Physicians' Assistants	
Nurses (APNP, NP, RN, LPN)	30
Other Licensed Allied Health (e.g., PT/OT, pharmacists, dieticians, social workers)	

b. Approximately how many physicians (by specialty/subspecialty and by training level) and physicians' assistants participated for MOC?

Profession	Specialty/Subspecialty *(fill in)*	Number *(fill in)*
Practicing Physicians	Pediatrics	40
Fellows		
Residents		
Physicians' Assistants	*(Not applicable)*	

6. How was the QI effort funded? *(Check all that apply.)*

- ☒ Internal institutional funds (e.g., regular pay/work, specially allocated)
- ☐ Grant/gift from pharmaceutical or medical device manufacturer
- ☐ Grant/gift from other source (e.g., government, insurance company)
- ☐ Subscription payments by participants
- ☐ Other source *(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)***:**

Established IHA patients 2-18 years of age who have been seen within the last three years with a diagnosis of asthma and who have been on a controller medication in the last two years.

8. General purpose.

a. Problem with patient care ("gap" between desired state and current state)

(1) <u>What should be occurring and why should it occur (benefits of doing this)?</u>

Asthma is a chronic condition that can limit a patient's ability to function and can be life threatening. Ongoing management depends on the coordination of activities of care providers to monitor disease status and modify treatment as needed and on self-management by patients to follow treatment and implement actions to deal with exacerbations. Ongoing management can improve patients' lives, avoid unnecessary visits to the emergency department, prevent unneeded hospitalizations, and avoid potentially life-threatening exacerbations. Risks are particularly acute for pediatric patients who may be less able to follow care plans and recognize need for treatment of exacerbations and for whom exacerbations may have more immediate and severe consequences.

(2) <u>What is occurring now and why is this a concern (costs/harms)?</u>

The problems are: a) that patients may miss regular visits for asthma maintenance, and b) that when patients return for asthma maintenance visits all components of routine maintenance care may not be provided and documented.

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 health and well-being of pediatric patients with asthma by increasing rates of regular visits for asthma maintenance and increasing the systematic provision and documentation of important components of care for asthma maintenance.

9. Which Institute of Medicine Quality Dimensions are addressed? *[Check all that apply.] (http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf)*

☒ Effectiveness	☒ Equity	☒ Safety
☐ 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
- ☒ Practice-Based Learning and Improvement
- ☒ Interpersonal and Communication Skills
- ☒ Professionalism
- ☒ Systems-Based Practice

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

Measure 1

- **Name of measure** *(e.g., Percent of . . ., Mean of . . ., Frequency of . . .)***:**
  % of active IHA pediatric patients receiving appropriate maintenance care
- **Measure components** – *describe the:*

  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:
  Number of established IHA patients 2-18 years of age who have been seen within the last three years with a diagnosis of asthma and who have been on a controller medication in the last two years.

  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:
  Number of these patients who have had two or more maintenance visits for asthma within the past twelve months and who have an asthma action plan generated in the past twelve months.
- **The source of the measure is:**
  - ☐ An external organization/agency, which is *(name the source)*:
  - ☒ Internal to our organization and it was chosen because *(describe rationale)*: To provide better patient care and to simultaneously meet the requirements of payer incentive plans
- **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)?
December 31, 2015, and care during the preceding 12 months

b. What was (were) the performance level(s) at baseline? *Display in a data table, bar graph, or run chart (line graph). Can show baseline data only here or refer to a display of data for all time periods attached at end of report. Show baseline time period, measure names, number of observations for each measure, and performance level for each measure.*

Time Period	Number of Patients	% Patients with at least two visits and an asthma action plan
Baseline 12/31/15	2,238	20.6%

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]."*

The % of pediatric asthma patients ages 2-18 that had at least two asthma maintenance visits and an asthma action plan generated in the past twelve months would increase from 20.6% to 28% by December 31, 2016.

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

The IHA leadership team set the performance target based on review of baseline performance and expert opinion regarding an achievable goal given practical limitations (e.g. patient compliance with all visit recommendations).

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)*
Providers, Certified Asthma Educators (CAEs), other clinical office staff; administrative and IT support

b. How? *(e.g., in a meeting of clinic staff)*
Core team consisting of a provider champion, four certified asthma educators, some clinical staff met monthly to review data and issues raised by practice staff. This team prepared materials for presentation to all participating professionals, planned for interventions and how plans were to be implemented across the Pediatrics division. Data, preliminary considerations of causes, interventions, and implementation provided to all participating physicians and staff members at all locations for review at meetings at practice locations.

c. **When?** *(e.g., date(s) when baseline data were reviewed and discussed)*
Divisional and local meetings occurred in February 2016

Use the following table to outline the plan that was developed: #15 the primary causes, #16 the intervention(s) that addressed each cause, and #17 who carried out each intervention. *This is a simplified presentation of the logic diagram for structured problem solving explained at http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation in section 2a. As background, some summary examples of common causes and interventions to address them are:*

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

15. What were the primary underlying/root causes for the problem(s) at baseline that the project can address?	**16. What intervention(s) addressed this cause?**	**17. Who was involved in carrying out each intervention?** *(List the professions/roles involved.)*
Providers: Inconsistent use of provider half-sheets during visits	Implemented formal use of provider half-sheets during visits and educating staff how to complete them accurately. Also introduced huddles to the teams.	Core team developed recommended processes and tools. Local teams of providers and medical assistants adapted the recommendations to the local setting and implemented them.
Providers: Inconsistent use of the asthma maintenance template in EMR	Implemented formal use of the asthma maintenance template in EMR	Core team oversaw use of template and provided training. Providers and medical assistants attended training.
Providers: Staff not clear how to determine / instruct patients on when to schedule upcoming visits	Educated staff and physicians regarding asthma maintenance guidelines and implemented half-sheet communication with front desk staff to schedule these appointments accurately.	Core team developed recommended processes and tools. Local teams of providers and medical assistants adapted the recommendations to the local setting and implemented them.
No established way to track our asthma maintenance visits	Included asthma maintenance visit metric on IHA's provider dashboard which will be a pay for performance metric for each provider	Core team recommended addition of metric to centralized dashboard team for drafting and approval. Providers were updated with regular dashboard communications.

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.)*

By March 1, 2016, the interventions had been rolled out across the 8 pediatric practice sites.

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)?

June 30, 2016, and care during the preceding 12 months

b. What was (were) the overall performance level(s) post-intervention? *Add post-intervention data to the data table, bar graph, or run chart (line graph) that displays baseline data. Can show baseline and post-intervention data incrementally here or refer to a display of data for all time*

periods attached at end of report. Show baseline and post-intervention time periods and measure names and for each time period and measure show number of observations and performance level.

The overall performance across (8) Pediatric sites is shown below. Data for each site are appended at the end of this report.

Time Period	Number of Patients	% Patients with at least two visits and an asthma action plan
Baseline 12/31/15	2,238	20.6%
Post – intervention 6/30/16	3,745	20.5%

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

No. The team recognized that the time from implementation of these interventions to the end of the measurement period was not necessarily sufficient to see largely improved results. These interventions were kept in place with the intention of reviewing data again after six more months.

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)*
Health care providers and staff reviewed data in August 2016.

Use the following table to outline the next plan that was developed: #22 the primary causes, #23 the adjustments(s)/second intervention(s) that addressed each cause, and #24 who carried out each intervention. *This is a simplified presentation of the logic diagram for structured problem solving explained at http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation in section 2a.*

Note: Initial intervention(s) occasionally result in performance achieving the targeted specific aims and the review of post-intervention data identifies no further causes that are feasible or cost/effective to address. If so, the plan for the second cycle should be to continue the interventions initiated in the first cycle and check that performance level(s) are stable and sustained through the next observation period.

22. What were the primary underlying/root causes for the problem(s) following the	23. What adjustments/second intervention(s) addressed this cause?	24. Who was involved in carrying out each adjustment/second intervention? *(List the*

intervention(s) that the project can address?		*professions/roles involved.)*
Providers: Staff time management and task prioritization	Providers taking time to review their IHA dashboard metrics and prioritizing who needs to be seen for asthma maintenance	Core team developed recommended processes and tools. Local teams of providers and medical assistants adapted the recommendations to the local setting and implemented them.
Workload: Providers do not have time to review detailed reports and make outbound patient calls	Tasks are sent by providers to asthma educators so follow up phone calls and recalls for appointments can be completed.	Core team developed recommended processes and tools. Local teams of providers and asthma educators adapted the recommendations to the local setting and implemented them.
Resources/Training: No one available in each office to assist with report review and patient asthma inhaler/medication education (e.g. asthma educator)	Added a certified asthma educator (CAE) at most pediatric practice locations. This person would provide increased levels of patient education i.e. correct use of inhalers, etc. and assist in breaking down detailed reports and providing feedback at the provider level.	Certified Asthma Educators were added to the designated locations. Local teams of providers, CAEs, MAs and Care Coordinators adapted workflows to accommodate expertise from new staff.
The IHA asthma EMR registry did not accurately match the IHA dashboard for asthma patients	Had each practice / provider become more aggressive in their use of registries and reports to proactively reach patients who are due for a maintenance visit. Closing gaps and correcting discrepancies between listings.	Core team developed recommended processes and tools. Local teams of providers and medical assistants adapted the recommendations to the local setting and implemented them.
No monthly meetings with asthma educators and care coordination nurses in the offices to share and work issues	Care Coordinators at each practice location began meeting monthly with asthma educators to discuss asthma care and issues.	Care Coordinators and Asthma Educators began meeting with the support from the Associate Division Head and cooperation from the providers at each location.

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 initiat*ed.)

By October 1, 2016, the new interventions were implemented across the 8 sites.

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 <u>post-adjustment</u> data on the measure(s)?

December 31, 2016, and care during the preceding 12 months

b. What was (were) the overall performance level(s) post-adjustment? *Add post-adjustment data to the data table, bar graph, or run chart (line graph) that displays baseline and post-intervention data. Can show here or refer to a display of data for all time periods attached at end of report. Show time periods and measure names and for each time period and measure show the number of observations and performance level.*

The overall performance across (8) Pediatric sites is shown below. Data for each site are appended at the end of this report.

Time Period	Number of Patients	% Patients with at least two visits and an asthma action plan
Baseline 12/31/15	2,238	20.6%
Post-intervention 6/30/16	3,745	20.5%
Post-adjustment 12/31/16	3,348	33.3%

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

Yes. Performance exceeded the target value of 28%.

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.)

Profession	Participants with Data Available		Number of These Participants Reaching Targets		
	# Participating in QI Effort (from #5.a)	Data on Performance of Individuals Available? *(Enter Yes or No)*	# Not Reaching Any Target Rate	# Reaching at Least One Target Rate	If Multiple Target Rates, # Reaching All Target Rates *(If only one rate, enter NA.)*

Practicing Physicians	48	Yes	14	34	(NA: only 1 rate)
Residents/ Fellows		No			
Physicians' Assistants		No			
Nurses (APNP, NP, RN, LPN)		No			
Other Licensed Allied Health		No			

H. Readjust

29. Post-adjustment data review and further planning. Who was involved in reviewing the post-adjustment data, identifying underlying (root) causes of problem(s) resulting in these new data, and considering possible interventions ("countermeasures") to address the causes? *(Briefly describe the following.)*

a. Who was involved? *(e.g., by profession or role)*

☒ Same as #21? ☐ Different than #21 *(describe):*

b. How? *(e.g., in a meeting of clinic staff)*

☒ Same as #21? ☐ Different than #21 *(describe):*

c. **When?** *(e.g., date(s) when post-adjustment data were reviewed and discussed)*
Core team, health care providers and staff reviewed data in February 2017.

Use the following table to outline the next plan that was developed: #30 the primary causes, #31 the adjustments(s)/second intervention(s) that addressed each cause, and #32 who would carry out each intervention. *This is a simplified presentation of the logic diagram for structured problem solving explained at http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation in section 2a.*

Note: Adjustments(s) may result in performance achieving the targeted specific aims and the review of post-adjustment data identifies no further causes that are feasible or cost/effective to address. If so, the plan for a next cycle could be to continue the interventions/adjustments currently implemented and check that performance level(s) are stable and sustained through the next observation period.

30. What were the primary underlying/root causes for the problem(s) following the adjustment(s) that the project can address?	**31. What further adjustments/ intervention(s) might address this cause?**	**32. Who would be involved in carrying out each further adjustment/intervention?** *(List the professions/roles involved.)*
The chronic problem list in EMR is not updated to reflect that the patient has asthma, so the MA was unable to prep for the visit.	Now, we have cross-referenced our patients with our registries to reflect that the patient does indeed have asthma.	Lead clinical quality care management team consisting of lead nurses and asthma educators.
In order to classify patients as an asthmatic needing maintenance visits, we identify them by their active medication list including an	We have implemented a medication reconciliation policy within the organization that encourages all providers to review the medication list at	The team of medical assistants at each visit as well as providers.

asthma controller medication. This medication list was often inaccurate and needed updating.	every visit and update appropriately.	

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.

Some of the barriers that we encountered included: time and priorities for staff, staff turnover and documentation issues affecting the data reporting to the practices.

Barrier:	How Addressed:
Limitations of EMR Capability: In order to carry out our intervention, we needed a template for tracking asthma maintenance visits. The new template could not be created by our EMR (NextGen).	Our quality team took on creation of the template. The metric captured by the template had to be vetted by many providers, MAs, and staff for its ease of use and data tracking. After the template was in place, real time feedback was given to template developers for changes. Provider and MA training meetings happened at several intervals as feedback and changes were made.
Task Prioritization: When practice staff were short-handed, the pre-visit planning process for asthma maintenance visits was sometimes shortened or eliminated to cover other duties.	This was addressed by thinking through the staff's list of prioritized duties and consciously moving pre-visit planning to the upper third of the list. Also, a review of work requirements allowed some wasteful or redundant work to be eliminated.
Instability of Staffing: Staff turnover in some offices is high resulting in the need to constantly train.	This issue was mitigated by the creation of an asthma maintenance pre-visit planning best practice document that could be reviewed with any new or existing staff members. Protocols and guidelines were simplified and distributed to all practice managers for use.
Data Entry Errors: Through reporting data reviews, problems with how data was entered into the system were uncovered. If the data was not entered into the EMR correctly, it did not transfer into the outcome report accurately.	This and similar issues were discussed with practice managers and clinical staff as they were identified. Further education, training and examples were used to correct the data entry methods as needed.

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

While the underlying causes were similar across practice locations, the operational details of interventions had to be modified to follow somewhat different established workflows in each practice location. Educational backgrounds of medical assistants regarding asthma knowledge were varied, so a key lesson was asthma education to staff at different levels. Also, we needed to allow time to train new staff as rapid growth and staff transitions continue at IHA.

35. Describe any best practices that came out of the QI effort.

Three primary best practices that were developed during this project were accurate and more specific diagnosis of asthma in our EMR (instead of just "asthma", diagnosis now stated "mild intermittent asthma"), the Provider Dashboard measures, and disease registries.

First, huddles were implemented during the first intervention and were originally intended for providers and MAs to discuss the asthmatic patients to be seen that day. The process became so beneficial that the practices began huddling daily for all patients seen that day, not only the asthmatic ones.

Secondly, the Provider Dashboard (published to all quarterly) showing the outcome measure became the mechanism for communication of current performance as well as the vehicle to drill down into the patient-level data. This drill down and stratification of data is what allows the practices to identify areas of concern and/or areas that require education and improvement.

Lastly, an asthma registry of patients was created for this process.

36. Describe any plans for spreading improvements, best practices, and key lessons.

All pediatric practices in our health care system are already participating and sharing improvements, best practices, and key lessons at our monthly Clinical Quality Care Team meetings.

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

The creation of a "quality asthma champion" at each practice location will help ensure that changes are sustained by overseeing and monitoring performance.

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:*

Individuals who want their participation documented for MOC must additionally complete an attestation form, confirming that they met/worked with others as described in this report and reflecting on the impact of the QI initiative on their practice or organizational role. Following approval of this report, the UMHS QI MOC Program will send to participants an email message with a link to the online attestation form.

K. Sharing Results

41. Are you planning to present this QI project and its results in a:

☒ Yes ☐ No Formal report to clinical leaders?

☐ Yes ☒ No Presentation (verbal or poster) at a regional or national meeting?

☐ Yes ☒ No Manuscript for publication?

L. Project Organizational Role and Structure

42. UMHS QI/Part IV MOC oversight – indicate whether this project occurs within UMHS, AAVA, or an affiliated organization and provide the requested information.

☐ **University of Michigan Health System**

- **Overseen by what UMHS Unit/Group?** *(name):*
- **Is the activity part of a larger UMHS institutional or departmental initiative?**

☐ No ☐ Yes – the initiative is *(name or describe*):

☐ **Veterans Administration Ann Arbor Healthcare System**

- **Overseen by what AAVA Unit/Group?** *(name):*
- **Is the activity part of a larger AAVA institutional or departmental initiative?**

☐ No ☐ Yes – the initiative is:

☒ **An organization affiliated with UMHS to improve clinical care**

- **The organization is** *(name)***:** IHA
- **The type of affiliation with UMHS is:**
  - ☒ **Accountable Care Organization** *(specify which member institution):* IHA
  - ☐ **BCBSM funded, UMHS lead state-wide Collaborative Quality Initiative** *(specify which):*
  - ☐ **Other** *(specify):*