QI Project Application/Report for Part IV MOC Eligibility – Example

Instructions

Complete the project application/report to apply for UMHS approval for participating physicians to be eligible to receive Part IV MOC credit through the Multi-Specialty Part IV MOC Pilot program. 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.

Only a final application describing the completed project is required. However, submitting an earlier version helps assure that planned activities will meet Part IV requirements. Actions regarding the application depend on the stage of the project, as described below. As stages are accomplished, you may submit updates of the application with the description of planned activities replaced by descriptions of actual activities performed.

Preliminary approval. Plans are developed for the expected activities, but little actual work has been performed. (Complete at least items 1-11, 13a, 16-18a, 19a, 20a, 21, 22a, 23a, 27-33.)

Part IV credit approval. Baseline data have been collected and the intervention performed, with completion of both steps documented on an application (or application update). The project has demonstrated its operational feasibility and the likelihood that subsequent data collections and adjustment will be performed. (Complete at least items 1-18a, 19a, 20a, 21, 22a, 23a, 27-33.)

Participation (“attestation”) forms provided. The project has been completed with the expected sequence of activities performed and documented on a complete final application, which is the “final report” on the project.

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

- Grant Greenberg, MD, UMHS Part IV Program Lead, 763-936-1671, ggreenbe@med.umich.edu
- R. Van Harrison, PhD, UMHS Part IV Program Co-Lead, 763-1425, rvh@umich.edu
- Chrystie Pihalja, UMHS Part IV Program Administrator, 763-936-1671, cpihalja@umich.edu

Application/Report Outline

<table>
<thead>
<tr>
<th>Section</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Introduction</td>
<td>1-6. Current date, title, time frame, project leader, specialties/subspecialties involved, funding</td>
</tr>
<tr>
<td>B. Plan</td>
<td>7-10. General goal, patient population, IOM quality dimensions addressed, experimental design</td>
</tr>
<tr>
<td></td>
<td>11-12. Baseline measures of performance, specific performance objectives</td>
</tr>
<tr>
<td></td>
<td>13. Data review and identifying underlying (root) causes</td>
</tr>
<tr>
<td>C. Do</td>
<td>14-16. Intervention(s), who is involved, initiated when</td>
</tr>
<tr>
<td>D. Check</td>
<td>17-18. Post-intervention performance measurement, data collection, performance level</td>
</tr>
<tr>
<td>E. Adjust – Replan</td>
<td>19. Review, continuing/new underlying causes,</td>
</tr>
<tr>
<td>F. Redo</td>
<td>20. Second intervention</td>
</tr>
<tr>
<td>G. Recheck</td>
<td>21-22. Post-adjustment performance measurement, data collection, performance level</td>
</tr>
<tr>
<td>H. Readjust plan</td>
<td>23. Review, continuing/new underlying causes to address</td>
</tr>
<tr>
<td>I. Future plans</td>
<td>24-26. Subsequent PDCA cycles, standardize processes, “spread” to other areas</td>
</tr>
<tr>
<td>J. Physician involvement</td>
<td>27-31. Physician’s role, requirements, reports, reflections, participation, number</td>
</tr>
<tr>
<td>K. Project Organization</td>
<td>32-34. Part of larger initiative, organizational structure, resources, oversight, Part IV opportunity</td>
</tr>
</tbody>
</table>
QI Project Application/Report for Part IV MOC Eligibility

A. Introduction

1. Date (this version of the application):
   10/28/2013

2. Title of QI project:
   Reducing re-admissions by improving post-discharge follow up care

3. Time frame
   a. At what stage is the project?
      - Design is complete, but not yet initiated
      - Initiated and now underway
      - Completed (UMHS Part IV program began 1/1/11)

   b. Time period
      - (1) Date physicians begin participating (may be in design phase):
      - (2) End date: ☒ actual 11/31/13 ☐ expected

4. QI project leader [responsible for attesting to the participation of physicians in the project]:
   a. Name: Jason Harris
   b. Title: Associate Director, Population Health
   c. Institutional/organizational unit/affiliation: Quality & Performance Improvement
   d. Phone number: 734-747-6766 x10521
   e. Email address: Jason_harris@ihacares.com
   f. Mailing address: 24 Frank Lloyd Wright Drive, Ann Arbor, MI 48106

5. What specialties and/or subspecialties are involved in this project?
   Internal Medicine, Family Medicine

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: Integrated Health Associates

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?
      IHA patients discharged from St. Joseph Mercy Ann Arbor experience a higher re-admission rate than the national average. Re-admissions are a symptom of gaps in care transitions and are costly for patients and the health system.

   b. Project goal. What outcome regarding the problem should result from this project?
Reduce the re-admission rate for high-risk IHA patients discharged from St. Joseph Mercy Ann Arbor by having them seen within 7 days by a PCP.

8. Patient population. What patient population does this project address.
High risk patients, identified as PRISM 1, 2 or 3 risk scores, discharged from St. Joseph Mercy Ann Arbor with disposition home or home health. *See note regarding PRISM at end

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

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?
   **Outcome:** 30 day re-admission rate for PRISM 1/2/3 (high risk) patients discharge home or home with home health. Numerator = # of re-admissions, Denominator = # of PRISM 1/2/3 patients discharged home or home with health.
   **Intermediate:** % of patients seen by PCP within 7 days of discharge. Numerator=# of patients seen by an IHA PCP within 7 days, Denominator = # of PRISM 1/2/3 patients discharged home or home with health.

b. Are the measures nationally endorsed? If not, why were they chosen?
   30 day all cause re-admission rate is a nationally endorsed measure.

c. What is the source of data for the measure (e.g., medical records, billings, patient surveys)?
   Data on discharges is pulled directly from St. Joseph Mercy’s ADT feed to IHA. This data are then merged with appointment data to determine if patients are seen in 7 days by a PCP.

d. What methods were used to collect the data (e.g., abstraction, data analyst)?
   Outcome and intermediate measures are collated automatically via IHA’s IT systems.

e. How reliable are the data being collected for the purpose of this project?
   The data are highly reliable. At the outset of the project, chart reviews were conducted to validate the data.

f. How are data to be analyzed over time, e.g., simple comparison of means, statistical test(s)?
   The data will be analyzed comparison of re-admission rates and % patients seen in 7 days by practice by month.

g. To whom are data reported?
   Data are reported directly to physicians, practice administration and IHA leadership through weekly TOC dashboard emails.

h. For what time period is the sample collected for baseline data?
   Jan 1 2012 – Dec 31 2012

12. Specific performance objectives

a. What is 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 table at end

b. Specific aim: What is the target for performance on the measure(s) and the timeframe for achieving the target?
The goal for 30 day re-admission rates was 20%.
The goal for % of patients seen in 7 days was 70%.

c. How were the performance targets determined, e.g., regional or national benchmarks?
There are no regional or national benchmarks. The goals set were considered challenging, but realistic.

13. Data review and identifying underlying (root) causes.

a. Who will be/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 is involved, how (e.g., in a meeting of clinic staff), and when.
  Participating physicians were involved in the review, identification of underlying causes, and consideration of interventions. The project lead met with them in groups by clinic or individually if they could not attend the group discussion. The discussions occurred during February and March 2013.

b. What are 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. How the intervention(s) address each primary underlying cause will be explained in #14.c.)
  Discharge Lag – Faxied discharge summaries from the hospital were received 24-96 hours after discharge and sometimes were never received.
  No standard workflow – No standard process was in place for practice staff to help prioritize patient access for follow up appointments.
  Access – Providers did not have access on their schedules to accommodate all hospital follow up visits.
  No feedback loop – Practice staff, administration and providers had no feedback on their performance.

C. Do

14. Intervention(s).

a. Describe the interventions implemented as part of the project.
  A new process was developed that included several key components:
  1. Providers were educated on the PRISM risk score and the implications for managing their patients post discharge.
  2. An ADT feed from St. Joseph Mercy Ann Arbor was used to gain real-time access to discharge information and risk scores.
  3. Practices and providers were notified the morning after an admission or discharge.
  4. A new workflow was developed at practices to prioritize PCP appointments for high-risk patients.
  5. Weekly reports were emailed to practices, providers and administration showing progress in getting high risk patients in to see a PCP within 7 days.
b. How are underlying/root causes (see #13.b) addressed by the intervention(s)? (List each cause, whether it is addressed, and if so, how it is addressed.)

Real time notification – An admissions, transfers and discharges feed was put in place to notify providers and nurses of admissions and discharges from the previous day.
Practice Workflow – Nurses are placing follow up phone calls to all high risk patients within 24 hours to schedule a PCP appointment within the time frames if one is not already scheduled.
Creating Access - Physicians created access for these patients on their practice schedules
Feedback Loop – Weekly reports are emailed to practices with metrics for the week and patients that missed guidelines

15. Who is involved in carrying out the intervention(s) and what are their roles?
The physician lead for the project provided the physician education and oversaw the development and implementation of changes in process.
Physicians were responsible implementing the workflow at their practice and providing access for high risk patients.
Administrative leads helped manage the project, implement the ADT feed and manage the weekly reporting process.

16. The intervention will be/was initiated when? (For multiple interventions, initiation date for each.)
Pilot: 10/1/12 – 12/20/12. Go Live: 12/20/12

D. Check

17. Post-intervention performance measurement. Is this data collection to 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 either:
Will occur for the period: 1/1/13 – 3/31/13
Has occurred for the period: 1/1/13 – 3/31/13

b. If the data collection has occurred, what is 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 data table at the end

E. Adjust – Replan


a. Who will be/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 is involved, how (e.g., in a meeting of clinic staff), and when.
Participating physicians were involved. Practice managers reviewed reports with providers a practice-level provider meetings and individually if physicians could not attend. Data were also reviewed at the division level with physician leadership. The Quality & Performance Improvement
team supported the meetings by providing reports and insights from other providers. Data were reviewed from April – June 2013.

b. **What are 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. How the intervention(s) address each primary underlying cause will be explained in #20.c.)

Data were collected weekly on the reasons for patients not being seen within 7 days. The most common reasons were:

- **Cancelled / No-Show Appointments** - Patients cancelled their appointments post discharge for a variety of reasons including: not feeling well, transportation and specialist visits.
- **Declining Appointments** – Patients declined appointments with their provider due to the same reasons as above.
- **Access** – There were no available appointments with the patient’s provider within 7 days.

F. **Redo**

   a. **The second intervention will be/was initiated when?** (For multiple interventions, initiation date for each.)
      June – July 2013
   
   b. If the second intervention has occurred, what interventions were implemented?
      - **Scripting** – How nurses asked patients to follow up with physicians was changed to stress the importance of patient safety.
      - **Confirmation calls** – Patients were contacted within 48 hours of their appointment to confirm. If they cancelled and if possible, their physician would reach out to them directly.
      - **Provider Access** – Providers at most practices agreed to see each other’s patients if they had no access within 7 days.
   
   c. **How are continuing/new underlying/root causes (see #19.b) addressed by the intervention(s)?** (List each cause, whether it is addressed, and if so, how it is addressed.)
      - **Cancelled / No-Show Appointments** - Addressed by confirmation calls and scripting.
      - **Declining Appointments** – Addressed by confirmation calls and scripting
      - **Access** – Addressed by seeing each other’s patients.

G. **Recheck**

21. **Post-second intervention performance measurement.** Is this data collection to 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

22. **Performance following the second intervention.**
   a. The collection of the sample of performance data following the intervention(s) either:
Will occur for the period:  
Has occurred for the period: July 1 - September 30 2013

b. If the data collection has occurred, what is 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 data table at the end

H. Readjust


a. Who will be/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 is involved, how (e.g., in a meeting of clinic staff), and when.

Participating physicians were involved. Practice managers reviewed reports with providers a practice-level provider meetings and individually if physicians could not attend. Data were also reviewed at the division level with physician leadership. The Quality & Performance Improvement team supported the meetings by providing reports and insights from other providers. Review occurred during September and October 2013.

b. What are 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.)

Access remains an important issue, at some practices more than others. Another key issue is specialist follow up. Oftentimes a specialist will be managing a patient’s chronic condition post discharge (i.e. for CHF), but it is important for the PCP to see the patient because half of re-admissions are for conditions other than the index admission. Convincing patients to see both PCP and Specialist can be a challenge.

If no additional cycles of adjustment are to be documented for the project for Part IV credit, go to item #24.

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 – #23 for each subsequent cycle. Copy the set of items #20 – #23 and paste them following the last item #23 and provide the information. When the project to be documented for Part IV credit has no additional adjustment cycles, go to item #24.

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

24. 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? 
This is an ongoing project that will last into 2014. Several more PDCA cycles will occur.

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

The weekly reporting process has been automated and will continue. % seen in 7 days has become a metric on IHA’s physician dashboard starting in 2013 Q4 and it is part of the practice manager’s performance targets for 2013/2014.
26. 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?
Yes, the project has implications for our specialty colleagues as well. Using risk scores to prioritize interventions for patients is a foundational concept we can apply to many more processes at IHA.

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

27. Physician’s role. What are the minimum requirements for physicians to be actively involved in this QI effort?

a. Interpreting baseline data and planning intervention:
   Review initial data at practice-level provider meetings and division meetings. Provide feedback and input on interventions.

b. Implementing intervention:
   Agree to standard interventions. Change practice patterns according to agreed upon interventions.

c. Interpreting post-intervention data and planning changes:
   Review initial data at practice-level provider meetings and division meetings. Provide feedback and input on interventions.

d. Implementing further intervention/adjustments:
   Agree to standard interventions. Change practice patterns according to agreed upon interventions.

e. Interpreting post-adjustment data and planning changes:
   Review initial data at practice-level provider meetings and division meetings. Provide feedback and input on interventions.

28. How are reflections of individual physicians about the project utilized to improve the overall project?
   The project lead participates in the meetings where physicians interpret data and make recommendations for changes. The project lead incorporates this information into overall project planning.

29. How does the project ensure meaningful participation by physicians who subsequently request credit for Part IV MOC participation?
   The project lead monitors the participation of the physicians involved.

30. What are the specialties and subspecialties of the physician anticipated to participate in the project and the approximate number of physicians in each specialty/subspecialty?
   Internal Medicine: 123
   Family Medicine: 110

K. Project Organizational Role and Structure

31. UMHS QI/Part IV MOC oversight – this project occurs within:
University of Michigan Health System Part IV Maintenance of Certification Program

☐ 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): IHA

    □ BCBSM funded, UMHS lead Collaborative Quality Initiative (specify which):

    □ Other (specify):

  • Who is the individual at UMHS responsible for oversight of the QI project regarding Part IV requirements?
    Name: Jason Harris
    Title: Associate Director, Population Health
    Institutional/organizational unit/affiliation: IHA
    Phone number: 734 747 6744 x10521
    Email address: Jason_harris@ihacares.com

32. What is the organizational structure of the project? [Include who is involved, their general roles, and reporting/oversight relationships.]
   The administrative project lead (Jason Harris) maintained the program plan, led implementation of data collection systems, communication plans and overall program progress. The physician lead (Theresa Poppe, MD) led provider discussions, championed the project at division and practice level meetings, shaped the program plan and data collection systems and represented IHA in external forums.

33. To what oversight person or group will project-level reports be submitted for review?
   The project results were reported to IHA’s Central Quality Improvement Committee consisting of providers from across all of IHA’s divisions.
**Note 1: PRISM**
PRISM is a predictor of the risk of mortality developed by Mark Cowen, MD at the St. Joseph Mercy Quality Institute. It is published in the Journal of Hospital Medicine (“Mortality predictions on admission as a context for organizing care activities’’). PRISM scores are calculated for patients on admission through the ER and in pre-op for surgery. PRISM scores range from 1-5, with 1 being the highest likelihood of mortality in 180 days and 5 being the lowest.

**Table 1: Summary of Intermediate and Outcome Metrics**

<table>
<thead>
<tr>
<th>PRISM 1/2/3 30 day all cause re-admission rate</th>
<th>Baseline Period</th>
<th>Post Intervention</th>
<th>Post Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1/1/2012 - 12/31/2012</td>
<td>1/1/2013 - 3/31/2013</td>
<td>7/1/2013 - 9/30/2013</td>
</tr>
<tr>
<td>IHA</td>
<td>21.8%</td>
<td>20.6%</td>
<td>17.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% Seen in 7 days</th>
<th>Baseline Period</th>
<th>Post Intervention</th>
<th>Post Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1/1/2012 - 12/31/2012</td>
<td>1/1/2013 - 3/31/2013</td>
<td>7/1/2013 - 9/30/2013</td>
</tr>
<tr>
<td>Site A</td>
<td>51%</td>
<td>70%</td>
<td>69%</td>
</tr>
<tr>
<td>Site B</td>
<td>51%</td>
<td>68%</td>
<td>69%</td>
</tr>
<tr>
<td>Site C</td>
<td>67%</td>
<td>67%</td>
<td>75%</td>
</tr>
<tr>
<td>Site D</td>
<td>52%</td>
<td>50%</td>
<td>67%</td>
</tr>
<tr>
<td>Site E</td>
<td>43%</td>
<td>40%</td>
<td>71%</td>
</tr>
<tr>
<td>Site F</td>
<td>43%</td>
<td>61%</td>
<td>78%</td>
</tr>
<tr>
<td>Site G</td>
<td>52%</td>
<td>73%</td>
<td>78%</td>
</tr>
<tr>
<td>Site H</td>
<td>45%</td>
<td>53%</td>
<td>79%</td>
</tr>
<tr>
<td>Site I</td>
<td>40%</td>
<td>67%</td>
<td>56%</td>
</tr>
<tr>
<td>Site J</td>
<td>51%</td>
<td>63%</td>
<td>59%</td>
</tr>
<tr>
<td>Site K</td>
<td>19%</td>
<td>33%</td>
<td>69%</td>
</tr>
<tr>
<td>Site L</td>
<td>30%</td>
<td>57%</td>
<td>61%</td>
</tr>
<tr>
<td>Site M</td>
<td>53%</td>
<td>64%</td>
<td>70%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>42%</strong></td>
<td><strong>62%</strong></td>
<td><strong>66%</strong></td>
</tr>
</tbody>
</table>