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

Advancing Responsible Opioid Prescribing

Wave 3

Instructions

Determine eligibility. Before starting to complete this report, go to the UMHS MOC website [ocpd.med.umich.edu], click on “Part IV Credit Designation,” and review sections 1 and 2. Complete and submit a “QI Project Preliminary Worksheet for Part IV Eligibility.” Staff from the UMHS Part IV MOC Program will review the worksheet with you to explain any adjustments needed to be eligible. (The approved Worksheet provides an outline to complete this report.)

Completing the report. The report documents completion of each phase of the QI project. (See section 3 of the website.) Final confirmation of Part IV MOC for a project occurs when the full report is submitted and approved.

An option for preliminary review (strongly recommended) is to complete a description of activities through the intervention phase and submit the partially completed report. (Complete at least items 1-20.) Staff from the UMHS Part IV MOC Program will provide a preliminary review, checking that the information is sufficiently clear, but not overly detailed. This simplifies completion and review of descriptions of remaining activities.

Questions are in bold font. Answers should be in regular font (generally immediately below or beside the questions). To check boxes, hover pointer over the box and click (usual “left” click).

For further information and to submit completed applications, contact either:
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  R. Van Harrison, PhD, UMHS Part IV Program Co-Lead, 734-763-1425, rvh@umich.edu
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QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date (this version of the report): 3/21/2018

2. Title of QI effort/project (also insert at top of front page): Advancing Responsible Opioid Prescribing

3. Time frame
   a. MOC participation beginning date – date that health care providers seeking MOC began participating in the documented QI project (e.g. date of general review of baseline data, item #14c):
      See Appendix A for the overall project timeline. Nineteen “waves” of groups of medical practices will initiate their participation in the project monthly for 19 months. Wave 3 began in August 2017.
   b. MOC participation end date – date that health care providers seeking MOC completed participating in the documented QI project (e.g., date of general review of post-adjustment data, item #29c):
      Each “wave” of groups of medical practices will perform two cycles of improvement effort over six months. The final wave will be completed about May 2019. Wave 3 finished in January 2018.

4. Key individuals
   a. QI project leader [also responsible for confirming individual’s participation in the project]
      Name: Carley Kirk, MS
      Title: Physician Engagement Lead
      Organizational unit: Altarum Institute
      Phone number: 734-302-4727
      Email address: carley.kirk@altarum.org
      Mailing address: 3520 Green Court, Suite 300, Ann Arbor, MI. 48105
   b. Clinical leader to whom the project leader reports regarding the project [responsible for overseeing/“sponsoring” the project within the specific clinical setting]
      Name: Daniel Berland, MD, FACP, FASAM, ABAM
      Title: Clinical Associate Professor of Medicine, Department of Internal Medicine and Department of Anesthesiology
      Organizational unit: University of Michigan
      Phone number: 734-936-5582
      Email address: danielbe@med.umich.edu
      Mailing address: University of Michigan Internal Medicine Taubman Center Floor 3 Reception B, 1500 E. Medical Center Dr. SPS 5352, 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 for Wave 3</th>
<th>Estimated Number for Entire Project</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

2
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 for Wave 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicing Physicians</td>
<td>Emergency Medicine</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Family Medicine</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Internal Medicine</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Neurologists</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>OB/GYNs</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Psychiatrists</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Surgeons</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Urologists</td>
<td>0</td>
</tr>
<tr>
<td>Fellows</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Residents</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td>(Specialty 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): Centers for Medicare and Medicaid Services: Transforming Clinical Practice Initiative
☐ 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 18 and older taking an opioid medication who are treated in practices in Michigan, Ohio, Kentucky, Indiana, Illinois, Wisconsin, and Minnesota that are not part of an Accountable
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?
   Based on American Medical Association (AMA) and Centers for Disease Control and Prevention (CDC) recommendations, providers should carefully:
   • determine when to initiate or continue opioids for chronic pain,
   • evaluate opioid selection, dosage, duration, follow-up, and discontinuation,
   • most importantly, assess the risks and harms of opioid use.
   Key steps to integrating safe opioid prescribing habits into practice include:
     1) effective use of state Prescription Drug Monitoring Program (PDMP) systems,
     2) incorporating evaluation for risk of opioid misuse; and
     3) completing follow-up evaluations for patients.
   Many physicians are not well prepared to initiate safe pain management treatment that includes opioid therapy. They lack education, training, and tools to perform appropriate risk assessment, safe prescribing, and monitoring to prevent opioid dependency or misuse. The rate of opioid related inpatient stays and emergency department visits rose an average of 200% across the country, between 2005 and 2014.

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.)
   • Increase identification of patients at risk for opioid medication misuse
   • Increase documentation of a follow-up evaluation for patients prescribed opioids.

9. Which Institute of Medicine Quality Dimensions are addressed? [Check all that apply.]
   ☒ 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: Documentation of Evaluation for Risk of Opioid Misuse – calculated for all eligible patients
    • 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 patient charts pulled, excluding patients without a current opioid prescription.
      Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
Number of these patients with evaluation for risk of opioid misuse documented in the medical record at least once annually during current opioid therapy using a standardized opioid risk assessment tool or interview.

- **The source of the measure is:**
  - ☒ An external organization/agency, which is *(name the source)*: Documentation evaluation for risk of misuse – This is based on the National Quality Forum (NQF) measure #414: Evaluation for Interview of Risk for Opioid Misuse
  - ☐ Internal to our organization and it was chosen because *(describe rationale)*:

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

**Measure 2**

**Name of measure:** Documentation of Follow-Up Evaluation – calculated for all eligible patients

- **Measure components** – for a rate, percent, or mean, describe the:
  - **Denominator** *(e.g., for percent, often the number of patients eligible for the measure)*:
    Excluding patient charts on opioid therapy for less than 3 months, number of eligible patient charts selected
  - **Numerator** *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:
    Number of these patients with a follow-up evaluation conducted either during the patient’s visit in the observation months* or within a 3-month period preceding that visit documented in the medical record

  * Observation months are baseline (month prior to training month), post intervention is month 3 of the 6 month participation period, and post adjustment is month 5 of the 6 month participation period.

- **The source of the measure is:**
  - ☒ An external organization/agency, which is *(name the source)*: Documentation of Follow-up Evaluation - This is based on the National Quality Forum (NQF) measure #408: Opioid Therapy Follow-up Evaluation
  - ☐ Internal to our organization and it was chosen because *(describe rationale)*:

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

*(If more than two measures are tracked across the two cycles, copy and paste the section for a measure and describe the additional measures.)*

**12. Baseline performance**

a. What were the beginning and end dates for the time period for baseline data on the measure(s)?

For Wave 1 it was for July 1 – 31, 2017.
Previously collected general baseline data from national information regarding low rates of performance will be used as the general baseline for discussion at the initial meeting (month 1). Each practice will confirm the relevance of the national rates by retrospectively collecting data from 1 month prior to the training activity. For example, for the first cycle with initial discussion and training occurring in June 2017, the practices will retrospectively collect data for May 2017.

The retrospective confirmation of actual baseline data within each participating provider’s practice will be performed as the provider initiates participation in the program during thirty days from the initial training meeting (month 1).

b. **What was (were) the performance level(s) at baseline?** (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

See Appendix B, first column of data, for the baseline percent of patients with service performed by Wave.

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].”

   By the end of the second cycle of improvement effort (January 2018 for this wave):
   - 50% of eligible patients will have an evaluation of risk of opioid misuse documented in the medical chart
   - 50% of eligible patients will have a follow-up evaluation documented in the medical chart

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

   The performance targets were determined locally by project leaders, based on their assessment of what would be feasible over the time of two short cycles.

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)

   Participating physician and clinical support staff in the practice.

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

   During clinical staff meetings.

   c. **When?** (e.g., date(s) when baseline data were reviewed and discussed)

   Before the end of month 1 of the “Wave.” For Wave 1, it was before the end of June 2017.

   **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](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>15. What were the primary underlying/root causes for the problem(s) at baseline that the project can address?</td>
<td>16. What intervention(s) addressed this cause?</td>
</tr>
<tr>
<td>---</td>
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</tr>
</tbody>
</table>
| **Clinical education**<br>Providers may not be aware of recommendations regarding initiating and actively monitoring opioid medication treatment. Providers often lack the training needed to be able to implement strategies for preventing opioid abuse and dependency. | Direct-to-provider education on:  
- Opioid prescribing best practices  
- Pain management  
- Risk assessment tools, and effective technique for follow-up evaluation | Quality Improvement Advisers (central program personnel) will provide local office champion and all clinic personnel (e.g., physicians, nurse clinicians, physician assistants, and office staff) with educational materials. |
| **Patient Disapproval**<br>Providers experiencing disapproval of patients not offered opioid prescriptions. | Providers offered education resources on motivational interviewing and techniques to make patients more comfortable with alternative treatments. | (Same as above) |
| **Resources**<br>Resources for providers to effectively manage patient opioid therapy to avoid opioid dependency are unknown or are unavailable and/or not easily accessible. Insurance companies may not offer alternative methods of pain management. | • Local solutions are identified to counsel patients who are abusing opioids (e.g., medication assisted treatment and pain clinics)  
• Local referral resources are provided.  
• Assistance working with insurance companies to determine what alternative forms of pain management are covered, and how to navigate prior authorization procedures for those services requiring prior authorization | (Same as above) |
| **Routine office processes**<br>Office processes do not align care practices with opioid prescribing and monitoring | • Local provider groups determine specific operational changes in opioid prescribing and monitoring based on the general | Central program personnel, local office champion and all clinic personnel (e.g., physicians, nurse clinicians, physician assistants, office staff) with educational materials. |
best practices and standard of care guidelines.  

| Training will include how providers can run prescription reports through the Prescription Drug Monitoring Program (PDMP) to gain a patient prescription history, complete follow-up evaluations, and complete evaluations to identify risk of opioid misuse as part of the clinical workflow. |
| Technical assistance is provided to help improve the management of patients who are opioid dependent, in a manner consistent with the related NQF clinical performance expectations and measures. |
| assistants, and office staff) with educational materials. |

### Documentation

<table>
<thead>
<tr>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Even when activities are performed, they may not be documented because the expectations for documentation are not clear or time to make entries in the medical record is limited.</td>
</tr>
<tr>
<td>Technical assistance is provided on how providers can efficiently document follow-up evaluations and opioid misuse evaluation results in medical records.</td>
</tr>
<tr>
<td>(Same as above.)</td>
</tr>
</tbody>
</table>

Note: If additional causes were identified that are to be addressed, insert additional rows.

### C. Do

18. By what date was (were) the intervention(s) initiated? *(If multiple interventions, date by when all were initiated.)*

   Before the end of month 1 of the group’s participation. **For Wave 3, before the end of August 2017.**

### 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)?

      From the beginning to the end of month 3 of the cycle. **For Wave 3, during month 3, October 1 - 31 2017.**

   b. What was (were) the overall performance level(s) post-intervention? *(E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)*

      See Appendix B, middle column of data, for the post-intervention percent of patients with service performed and documented within and across the practice.
c. Did the intervention(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)?

Yes, the participating practice showed sustained its initial above goal performance on measure 1 (documentation of risk of misuse evaluation), and showed substantial improvement and exceeded the goal on measure 2 (documentation of follow-up evaluation).

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)
   Before the end of month 4 of the group’s participation. For Wave 3, during month 4, November 2017.

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

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

<table>
<thead>
<tr>
<th>22. What were the primary underlying/root causes for the problem(s) following the intervention(s) that the project can address?</th>
<th>23. What adjustments/second intervention(s) addressed this cause?</th>
<th>24. Who was involved in carrying out each adjustment/second intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office workflow. Needed additional guidance for providers and office staff to know who was to administer specific services related to opioid misuse such as the standardized opioid risk assessment tool or interview.</td>
<td>Review workflow and assigned clear responsibility for tasks.</td>
<td>Central program personnel, local office champion and all clinic personnel (e.g., physicians, nurse clinicians, physician assistants, and office staff).</td>
</tr>
<tr>
<td>Documentation Difficulty pulling data accurately using the clinics coding and reporting systems</td>
<td>Working with providers and clinic staff on how to adjust data collection process to appropriately select patients</td>
<td></td>
</tr>
</tbody>
</table>

Office workflow.
Needed additional guidance for providers and office staff to know who was to administer specific services related to opioid misuse such as the standardized opioid risk assessment tool or interview.
F. Redo

25. **By what date was (were) the adjustment(s)/second intervention(s) initiated?** *(If multiple interventions, date by when all were initiated.)*
   Before the end of month 4 of the group’s participation. **For Wave 3, before the end of month 4, November 2017.**

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)?**
      During month 5 of the group’s participation. **For Wave 3, month 5, December 2017.**
   b. **What was (were) the overall performance level(s) post-adjustment?** *(E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)*
      See Appendix B, last column of data, for the post-adjustment percent of patients with services performed within and across practice.
   c. **Did the adjustment(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)?**
      Not yet. Although the practice did surpass the project’s goals on both measures, the practice’s post-adjustment performance did not exceed its baseline performance. The practice has, however, now made improvements in their workflow and consistency in providing services that are expected to result in stabilizing the improvement that was demonstrated in the post intervention period when the data are correctly filtered for eligible patients.

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

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)

Before the end of month 6 of the group’s participation. For Wave 3, by the end of month 6, January 2018.

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

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

<table>
<thead>
<tr>
<th>30. What were the primary underlying/root causes for the problem(s) following the adjustment(s) that the project can address?</th>
<th>31. What further adjustments/intervention(s) might address this cause?</th>
<th>32. Who would be involved in carrying out each further adjustment/intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic personnel. New staff are not familiar with the opioid misuse questionnaire and workflows</td>
<td>New clinicians and staff were trained</td>
<td>Central program personnel, local office champion and all clinic personnel (e.g., physicians, nurse clinicians, physician assistants, and office staff)</td>
</tr>
</tbody>
</table>

Note: If additional causes were identified that are to be addressed, insert additional rows.

33. Are additional PDCA cycles to occur for this specific performance effort?
☒ No further cycles will occur. No formal additional PDCA cycles are planned for this wave of participants. Project leaders will remain an available resource until the end of the grant period (September 2019).

☐ 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

34. Describe any barriers to change that were encountered during this QI effort and how they were addressed.
The most significant barrier that was faced by participants is:
• Difficulties with workflow and documentation inconsistencies. Central program personnel and office champions worked with new clinic staff to ensure all office staff were trained consistently to help sustain a standardized workflow process.

35. Describe any key lessons that were learned as a result of the QI effort.
• Include clinical support staff. Including all clinical support staff in the training significantly increases the practice’s level of readiness to implement documentation of evaluation for risk of opioid misuse and follow-up evaluations for patients.
• Office champion and physician collaboration. Technical assistance (TA) staff work to make sure that the physicians at participating practices are engaged with the office champion throughout the project period to support swift local level practice changes to improve implementation.

36. Describe any best practices that came out of the QI effort.
• Facilitating a kick-off call pre-training between the TA staff member and the local Office Champion. This discussion occurs a few weeks prior to the training, and assists the TA staff member to better understand the practice’s current workflow and level of motivation to change. Key topics of the kick-off call include:
  o Documentation requirements for the activity
  o Ability to customize the current EHR if necessary
  o Comfort level discussing opioid risks and helping patients facing addiction
  o Familiarity using PDMP for prescription reporting
  o Current clinical workflow process for comparable interventions (e.g., other evaluations)

37. Describe any plans for spreading improvements, best practices, and key lessons.
The local changes that were made by prior waves of participants have been an integral part of rapid cycle process improvement to assist the central program personnel in their education, training, and technical assistance efforts for future waves of participants. Project leaders will continue to monitor barrier trends for consistency related to the implementation of evaluation for risk of opioid misuse and follow-up evaluations for patients.

38. Describe any plans for sustaining the changes that were made.
Improvements that have now become part of the clinical workflow should remain self-sustaining over time. TA staff are available to participating practices until September 2019, and during this time, central program personal will enhance support resources as needed to ensure continued sustainment of the interventions.

J. Minimum Participation for MOC

39. 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.

40. 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.

41. 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: Collect or oversee collection of data in the practice.

K. Sharing Results

42. 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

43. 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)*: Altarum Institute

• 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)*: Project-specific agreement between UMHS and Altarum Institute for joint proviership of activities for the Advancing Responsible Opioid Prescribing activity funded by a Centers for Medicare and Medicaid Services.
Appendix A. Timeline for Waves of Groups of Participating Medical Practices

Nineteen “waves” of groups of participating medical practices are included in the project. Each “wave” starts a month after the previous “wave” starts. A “wave” participates in two cycles of data-guided improvement over six months. The first “wave” starts June 1, 2017 and the last “wave” finishes May 31, 2019.
Appendix B. Performance for Wave 3 of Practices for Percent of Patients with Service Performed

<table>
<thead>
<tr>
<th>Service</th>
<th>Baseline Month -1</th>
<th>Post-Intervention Month 3</th>
<th>Post-Adjustment Month 5</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinic A</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of Risk of Misuse Evaluation</td>
<td>70% (n=20)</td>
<td>95% (n=20)</td>
<td>70% (n=20)</td>
<td>50%</td>
</tr>
<tr>
<td>Documentation of Follow-Up Evaluation</td>
<td>100% (n=20)</td>
<td>100% (n=19)</td>
<td>100% (n=20)</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Wave 3 – Mean of 1 Practice Means</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of Risk of Misuse Evaluation</td>
<td>70%</td>
<td>95%</td>
<td>70%</td>
<td>50%</td>
</tr>
<tr>
<td>Documentation of Follow-Up Evaluation</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>50%</td>
</tr>
</tbody>
</table>

% = percent of patients that received the service  

n = number of eligible patient charts pulled  

* = the clinic did not previously provide the service, so no charts were pulled and the clinic mean at baseline is 0%  

N/A = the clinic did not have any eligible patients for this measure