Report on a QI Project Eligible for Part IV MOC

Instructions

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

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

An option for preliminary review (recommended) is to complete a description of activities through the intervention phase and submit the partially completed report. (Complete at least items 1-16 and 27a-b.) Staff from the UMHS Part IV MOC Program will provide a preliminary review, checking that the information is sufficiently clear, but not overly detailed. This simplifies completion and review of descriptions of remaining activities.

Questions are in bold font and answers should be in regular font (generally immediately below the questions). To check boxes electronically, either put an “X” in front of a box or copy and paste “X” over the blank box.

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

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QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date (this version of the report):
   8/25/2014

2. Title of QI project:
   Reducing Avoidable ER Utilization

3. Time frame
   a. At what stage is the project?
      - Design is complete, but not yet initiated
      - Initiated and now underway
      - Completed

   b. Time period
      (1) Date physicians begin participating (may be in design phase): January 2013
      (2) End date: actual August 2014 □ 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: IHA Quality & Performance Improvement
   d. Phone number: 734.747.6766 x10521
   e. Email address: Jason_harris@ihacares.com
   f. Mailing address: 24 Frank Lloyd Wright Dr., Suite J2000, Ann Arbor, MI 48105

5. What specialties and/or subspecialties are involved in this project?
   Pediatrics

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

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

B. Plan

7. General goal

   a. Problem/need. What is the “gap” in quality that resulted in the development of this project? Why is this project being undertaken?
      Visits to the ER for avoidable issues pose a significant cost to our patients, communities and the healthcare system. Using the NYU algorithm, 45% of ER visits for IHA pediatric patients could be avoided. Given ER Visits are 5-10x more costly than urgent care or PCP visits, this represents a significant opportunity for our patients and our system.

   b. Project goal. What outcome regarding the problem should result from this project?
By reducing avoidable ER utilization, we can provide more continuity of care while reducing the overall cost burden on our patients, communities and health systems.

8. Patient population. What patient population does this project address.
All IHA patients of our pediatric practices.

9. Which Institute of Medicine Quality Dimensions are addressed? [Check all that apply.]
- Safety
- Equity
- Effectiveness
- 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?
      % Primary Care Sensitive ER Utilization.
      Numerator = # Non Urgent + Urgent, PCP Treatable + Urgent, Preventable/Avoidable
      Denominator = Total ER Visits
   b. Are the measures nationally endorsed? If not, why were they chosen?
      Yes, % Primary Care Sensitive is a standard measure used by health plans to compare utilization across P0s and populations.
   c. What is the source of data for the measure (e.g., medical records, billings, patient surveys)?
      St. Joseph Mercy Ann Arbor, Chelsea and Livingston ER data.
   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?
      Highly reliable. We have gone through several iterations of data validation to ensure accurate attribution of patients to physicians and practices.
   f. How are data to be analyzed over time, e.g., simple comparison of means, statistical test(s)?
      Data are analyzed over time as simple comparisons of means and monthly, quarterly trends by practice.
   g. To whom are data reported?
      Data are reported directly to physicians, practice administration and IHA leadership through weekly emails showing lagging 4 week performance and on Physician's Dashboards showing quarterly performance.
   h. For what time period is the sample collected for baseline data?
      January 2011 – December 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 data table at end
b. Specific aim: What is the target for performance on the measure(s) and the timeframe for achieving the target?

Our goal was to achieve less than 40% Primary Sensitive ER Utilization by July 2014.

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

Performance targets were set based on BCBSM benchmark performance relative to physician organizations across the state.

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.

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.)

Non Urgent and/or Urgent but PCP Treatable
1. Patient education on appropriate use – patients unaware that their symptoms do not require immediate care.
2. Patient awareness of services – patients unaware of the alternatives such as IHA’s After Hours, same day access policies, walk-in hours or Call Us First program.
3. Access (office & phone) – patients cannot get in to see their PCP in a short enough time frame, or have trouble getting through via the phone. Patient use the ER instead for convenience / relief.
4. Phone triage protocols – when patients do call us first, incorrectly triaging patients to the ER or not giving them quick enough appointments to avoid ER visits.

C. Do

14. Intervention(s).

a. Describe the interventions implemented as part of the project.

The following set of interventions were implemented. Different practices focused on different areas for each cycle based on the root causes that were their drivers.

1. Follow up phone calls
2. Improving access for same day appointments
3. Expanding walk-in hours
4. Improving phone access / live answer
5. In office education – Call Us First cards
6. Provider-patient education – Reminding at risk patients of After Hours locations and hours and appropriate utilization at office visits

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.)

<table>
<thead>
<tr>
<th>Root Cause</th>
<th>How Addressed</th>
</tr>
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</table>
### 15. Who is involved in carrying out the intervention(s) and what are their roles?

- **The physician lead for the project** helped physicians interpret their data and share insights from other providers.
- **Physicians** were responsible for identifying root causes, planning and implementing interventions specific to their practice.
- **Practice managers and staff** were responsible for planning and implementing interventions specific to their practice.
- **Administrative leads** helped manage the project, implement interventions and manage the weekly reporting process.

### 16. The intervention will be/was initiated when?

Interventions were implemented at different practices at different times, but all between January 2013 and June 2013.

### 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: July 2013 – December 2013
  - Has occurred for the period: July 2013 – December 2013

- 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 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

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<table>
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<tr>
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- **Table:**

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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.

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)

F. Redo

   a. The second intervention will be/was initiated when? (For multiple interventions, initiation date for each.)

      January 2014 – April 2014

   b. If the second intervention has occurred, what interventions were implemented?

      The following set of interventions were implemented. Different practices focused on different areas for each cycle based on the root causes that were their drivers.

      1. Follow up phone calls
      2. Improving access for same day appointments
      3. Expanding walk-in hours
      4. Improving phone access / live answer
      5. In office education – Call Us First cards
      6. Provider-patient education – Reminding at risk patients of After Hours locations and hours and appropriate utilization at office visits

   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.)

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<td>Re-training of staff on common protocols</td>
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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: May 2014 – Aug 2014

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 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.

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.)

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. % PCS ER visits 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 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. There are similar root causes in terms of patient education, access, phone triage that drive specialty specific ER utilization. They will have different root causes and different interventions, but there is best practices to communicate and share.

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.

Additionally, feedback is collected through IHA’s divisional structure. This project is discussed at Pediatric division meetings that all providers attend.

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

The project lead and physician leadership within pediatrics monitor 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?
K. Project Organizational Role and Structure

31. UMHS QI/Part IV MOC oversight – this project occurs within:
   - [ ] University of Michigan Health System
     - Overseen by what UMHS Unit/Group?
     - Is the activity part of a larger UMHS institutional or departmental initiative?
       - [ ] No  [ ] Yes – the initiative is:
   - [ ] Veterans Administration Ann Arbor Healthcare System
     - Overseen by what AAVA Unit/Group?
     - Is the activity part of a larger AAVA institutional or departmental initiative?
       - [ ] No  [ ] Yes – the initiative is:
   - [ ] An organization affiliated with UMHS to improve clinical care
     - The organization is:
     - The type of affiliation with UMHS is:
       - [X] Accountable Care Organization type *(specify which)*: POM ACO, 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 (Melissa Heinen) 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.
Table 1: Summary of Outcome Metrics - % Primary Care Sensitive ER Visits

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Site A</td>
<td>43.0%</td>
<td>44.1%</td>
<td>39.7%</td>
</tr>
<tr>
<td>Site B</td>
<td>41.6%</td>
<td>39.9%</td>
<td>32.9%</td>
</tr>
<tr>
<td>Site C</td>
<td>36.9%</td>
<td>33.6%</td>
<td>32.3%</td>
</tr>
<tr>
<td>Site D</td>
<td>45.4%</td>
<td>42.1%</td>
<td>41.5%</td>
</tr>
<tr>
<td>Site E</td>
<td>47.1%</td>
<td>43.9%</td>
<td>47.3%</td>
</tr>
<tr>
<td>Site F</td>
<td>48.7%</td>
<td>46.5%</td>
<td>43.7%</td>
</tr>
<tr>
<td>Site G</td>
<td>41.4%</td>
<td>37.2%</td>
<td>30.6%</td>
</tr>
<tr>
<td>Grand Total</td>
<td>44.7%</td>
<td>42.4%</td>
<td>40.7%</td>
</tr>
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