Report on a QI Project Eligible for MOC – ABMS IHHC and NCCPA PI-CME

Improving the Delivery of Confidential Care to Adolescent Patients - Wave 7

Instructions

Determine eligibility. Before starting to complete this report, go to the Michigan Medicine MOC website [http://www.med.umich.edu/moc-qi/index.html], 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 Michigan Medicine 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 1-18.) Staff from the Michigan Medicine 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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Report Outline

Section	Items	
A. Introduction	1-6.	Current date, title, time frame, key individuals, participants, funding
B. Plan	7-8.	Patient population, general goal
	9-11.	Measures, baseline performance, specific aims
	12-15.	Baseline data review, underlying (root) causes, interventions, who will implement
C. Do	16.	Intervention implementation date
D. Check	17-18.	Post-intervention performance
E. Adjust – Replan	19-23.	Post-intervention data review, underlying causes, adjustments, who will implement
F. Participation for MOC	24-26.	Participation in key activities, other options, other requirements
G. Sharing results	27.	Plans for report, presentation, publication
H. Organization affiliation	28.	Part of UMHS, AAVA, other affiliation with UMHS

QI Project Report for Part IV MOC Eligibility

A. Introduction

1. **Date** *(this version of the report):* September 9, 2021

2. **Title of QI effort/project** *(also insert at top of front page)***:**
   Improving the Delivery of Confidential Care to Adolescent Patients – Wave 7

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 #12c)**:***

      February 1, 2021

   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 #26c)*:

      August 31, 2021

4. **Key individuals**

   a. **QI project leader** *[also responsible for confirming individual's participation in the project]*
      Name: Kaleigh Cornelison
      Title: Lead Program Specialist
      Organizational unit: Community Health Services
      Phone number: 734-998-2034
      Email address: kaleighc@med.umich.edu
      Mailing address: 3621 S. State St., Ann Arbor, MI 48108

   b. **Clinical leader who oversees project leader regarding the project** *[responsible for overseeing/"sponsoring" the project within the specific clinical setting]*
      Name: Terrill Bravender, MD, MPH
      Title: Division Director, Adolescent Medicine
      Organizational unit: Division of Adolescent Medicine, Department of Pediatrics
      Phone number: 734-936-9777
      Email address: tdbrave@med.umich.edu
      Mailing address: 1500 E. Medical Center Dr, D2103 Ann Arbor, MI 48109

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

Participating for MOC	Primary Specialty	Subspecialty, if any	Number
Practicing physicians	Pediatrics	(N/A)	8
Residents/Fellows	(N/A)	(N/A)	(N/A)
Physicians' Assistants	(N/A)	(N/A)	(N/A)

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 one complete cycle of data-guided improvement. Some projects may have only one cycle 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 ages 12-17 in participating Pediatrics, Family Medicine, OB/GYN, and Medicine-Pediatrics practices. The health centers that participated in the project are listed below:

- Bellin Health East De Pere
- Esperanza Health Center
- Heartland Health Services – Knoxville
- Hennepin Health Brooklyn Park Clinic

8. General purpose.

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

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

Physicians should be providing confidential care to minor adolescents at annual well child visits by spending time alone with the patient, explaining confidentiality laws to the patient, and performing confidential risk screening. Minor adolescent patients are more likely to discuss their health openly and honestly when they are aware of what information can and cannot be shared without their permission.

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

Adolescent patients frequently do not receive recommended confidential care resulting in missed opportunities for addressing health concerns specific to this age group. Physicians support confidential care for adolescent patients but have knowledge gaps around minor consent and parental notification laws. Confidential care may also be difficult to provide in a busy ambulatory care setting with parents present.

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 #11.)

Physicians will improve the provision of confidential care to minor adolescents by more frequently spending time alone with adolescents during an annual well child visit, explaining confidentiality laws to the patient, and performing confidential risk screening.

9. Describe the measure(s) of performance: *(QI efforts must have at least one measure that is tracked across the baseline and post-intervention periods. 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 . . .)***:**

Percent of adolescent patients that had confidential time with physician

- **Measure components** – *describe the:*

  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:

  20 patient charts of adolescents seen for new patient (OB/GYN) or annual well exams (for peds, fam med, and med peds), (Or the total number seen in the past 3 months if less than 20).

  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:

  Number of patients who had alone time with the physician

- **The source of the measure is:**

  ☒ An external organization/agency, which is *(name the source, e.g., HEDIS)*: Best practice in adolescent health care as recommended by the Society for Adolescent Health and Medicine, and the American Academy of Pediatrics

  ☐ 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** *(e.g., Percent of . . ., Mean of . . ., Frequency of . . .)***:**

Percent of adolescent patients to whom confidentiality laws/limits were explained.

- **Measure components** – *describe the:*

  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:

  20 patient charts of adolescents seen for new patient (OB/GYN) or annual well exams (for peds, fam med, and med peds), (or the total number seen in the past 3 months if less than 20).

  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:

  Number of patients to whom the confidentiality laws/limits was explained.

- **The source of the measure is:**

  ☒ An external organization/agency, which is *(name the source)*: Best practice in adolescent health care as recommended by the Society for Adolescent Health and Medicine, and the American Academy of Pediatrics

  ☐ 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 3

- **Name of measure** *(e.g., Percent of . . ., Mean of . . ., Frequency of . . .)***:**
  Percent of adolescent patients who confidentially completed a standardized risk screening assessment.
- **Measure components** – *describe the:*

  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:
  20 patient charts of adolescents seen for new patient (OB/GYN) or annual well exams (for peds, fam med, and med peds), (or the total number seen in the past 3 months if less than 20).

  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:
  Number of patients who confidentially completed a standardized risk screening assessment.
- **The source of the measure is:**

  ☒ An external organization/agency, which is *(name the source)*:
  Best practice in adolescent health care as recommended by the Society for Adolescent Health and Medicine, and the American Academy of Pediatrics

  ☐ Internal to our organization and it was chosen because *(describe rationale)*: Data can be pulled via chart reviews.
- **This is a measure of:**

  ☒ Process – activities of delivering health care to patients

  ☐ Outcome – health state of a patient resulting from health care

10. Baseline performance

a. What were the beginning and end dates for the time period for <u>baseline</u> data on the measure(s)?
November 1, 2020 – January 31, 2021

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.*

Chart Analysis	Baseline
Confidential time spent with patient	
Yes	124
No	16
n	140
PERCENTAGES (Yes/Total)	89%
Confidentiality laws/limits explained to patient	
Yes	99
No	42
n	141
PERCENTAGES (Yes/Total)	70%
Standardized risk screening	
Yes	14
No	131
n	145
PERCENTAGES (Yes/Total)	10%

11. 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 targets for the three main performance measures are that 95% of adolescent patients seen for well child checks within family medicine, pediatrics, or medicine-pediatrics, or new patient visits in OB/GYN will have their physician:
(a) spend time alone with them,
(b) explain minor consent laws to them, and
(c) have them complete a confidential risk screening tool.
Physicians will work to reach these goals by August 31st, 2021

b. How were the performance targets determined, e.g., regional or national benchmarks?
The target was set at 95% based on leadership's experience in clinic. Occasionally confidential time and risk screening is not appropriate or possible (i.e. a special needs adolescent unable to independently complete a risk screening tool).

12. 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 physicians and residents at each individual health center.

b. How? *(e.g., in a meeting of clinic staff)* In person at provider meetings and/or via e-mail.

c. **When?** *(e.g., date(s) when baseline data were reviewed and discussed)* Between March 1st and March 31st, 2021

Use the following table to outline the plan that was developed: #13 the primary causes, #14 the intervention(s) that addressed each cause, and #15 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.*

13. What were the primary underlying/root causes for the problem(s) at baseline that the project can address?	**14. What intervention(s) addressed this cause?**	**15. Who was involved in carrying out each intervention?** *(List the professions/roles involved.)*
Providers/Care Teams do not know the rules for teen confidentiality.	Educate the rules on teenage confidentiality to Providers and Care Teams	Physicians, providers, and care teams
Limited information in our clinic about the rules of confidentiality for teenagers.	Have information clearly displayed in the clinic and exam rooms regarding confidentiality. Have letter for Pt and parent explaining this for the visit.	Staff members
Not all providers spend 1:1 time with their teenage patients.	Clinic norm to have 1:1 time with patient. Adolescent Social Determinants of Health (SDOH) questionnaire.	Physicians, providers. and other staff members
Not all teenagers have a Patient Portal account	Get teenage patients signed up for portal account.	Front desk, providers, medical assistants
Variety of providers, no consistent screening tool	With all providers, identify screening tool and implement. Allow some time saving to tailor provider time with patient	Physicians. providers
Staff turnover at front desk and with MAs, no consistent adolescent rooming process	Include screening tool at front desk with other developmental screening tools so MAs don't have to remember to get it during rooming; all teens receive it	Front desk, MAs
Adolescents may not feel comfortable to disclose information	Include confidentiality notice from AHI with screener	Staff members

Time constraints during visit time with provider	With all providers, identify screening tool and implement. Allow some time saving to tailor provider time with patient	Physicians, providers

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

C. Do

16. By what date was (were) the intervention(s) initiated? *(If multiple interventions, date by when all were initiate*d.)
April 1, 2021

D. Check

17. Post-intervention performance measurement. Are the population and measures the same as those for the collection of baseline data (see item 9)?

☒ Yes ☐ No – If no, describe how the population or measures differ:

18. Post-intervention performance

a. What were the beginning and end dates for the time period for post-intervention data on the measure(s)?
April 1st – June 31st 2021

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

Chart Analysis	Baseline	Post Intervention
Confidential time spent with patient		
Yes	124	139
No	16	13
n	140	152
PERCENTAGES (Yes/Total)	89%	91%
Confidentiality laws/limits explained to patient		
Yes	99	118
No	42	35
n	141	153
PERCENTAGES (Yes/Total)	70%	77%
Standardized risk screening		
Yes	14	86
No	131	67
n	145	153
PERCENTAGES (Yes/Total)	10%	56%

c. Did the intervention(s) produce the expected improvement toward meeting the project's specific aim (item 11.a)?

There were improvements in each of the 3 measurement areas with the greatest improvement in implementation of a standardized risk screening tool. However, none of the measures met the goal of 95% by the end of the post-intervention period.

E. Adjust – Replan

19. 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 #12? ☐ Different than #12 *(describe):*

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

☒ Same as #12? ☐ Different than #12 *(describe):*

c. **When?** *(e.g., date(s) when post-intervention data were reviewed and discussed)*
Between August 1st – August 31st 2021

Use the following table to outline the next plan that was developed: #20 the primary causes, #21 the adjustments(s)/second intervention(s) that addressed each cause, and #22 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 adjustments should be to continue the interventions initiated in intervention.

20. What were the primary underlying/root causes for the problem(s) following the intervention(s) that the project can address?	**21. What adjustments/second intervention(s) addressed this cause?**	**22. Who was involved in carrying out each adjustment/second intervention?** *(List the professions/roles involved.)*
Many jobs the MA/LPN has to do prior to the appointment	Look at workflow	MA/LPN, care team
Waiting room time not effectively used to fill out SDOH questionnaire.	Be sure front desk staff is handing out questionnaire (soon we are implementing iPads as well)	Front desk, care team
Providers do not verify it is done during the appointment	Providers verify as part of visit.	Physicians, providers
Teens not checking in on their patient portal where the questionnaire could be done also.	Teens check in and answer questions on patient portal	MA/LPN, providers

Time constraints during visit time with provider	Individually update with MAs and front desk staff. Present at staff meeting to update all. Meet with lead front desk staff to identify new barriers Work with health information office to ensure screener will remain confidential if inadvertently scanned.	Providers, Clinic Manager, front desk, HIT

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

23. 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:*

F. Minimum Participation for MOC

24. 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 #32.*

b. Did these individuals participate in the following key activities over the one cycle of data-guided improvement?

1. Identify and/or acknowledge a gap(s) in outcomes or in care delivery as described in #8.
2. Identify and/or review data related to the gap(s) as described in #9-10.
3. Identify or acknowledge appropriate intervention(s) designed to improve the gap(s), OR participate in the planning and selection of intervention(s) designed to improve the gap(s) as described in #11-15.
4. Implement intervention(s) for a timeframe appropriate to addressing the gap(s), OR monitor and manage implementation of intervention(s) for a timeframe appropriate to addressing the gap(s) as described in #16.
5. Review post-intervention data related to the gap(s) as described in #17-22.
6. Reflect on outcomes to determine whether the intervention(s) resulted in improvement. If no improvement occurs after an intervention, participants must reflect on why no improvement occurred (this will take place during the attestation process).

☒ Yes ☐ No *If "Yes," individuals are eligible for MOC unless other requirements also apply and must be met – see item # 33.*

25. 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 26.*

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 # 26. If "No," continue to #25c.*

c. Did the individual(s) supervise 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 # 26.*

26. 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.

G. Sharing Results

27. 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?

H. Project Organizational Role and Structure

28. 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):* Department of Pediatrics
- **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)***:**
- **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):*