

Report on a QI Project Eligible for Part IV MOC

Improving documentation of controlled substance agreements, drug screening, and Michigan Automated Prescription System verification for patients prescribed controlled substances on a chronic basis

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 “☑” over the blank box.

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

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Report Outline

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B. Plan	7-10. General goal, patient population, IOM quality dimensions addressed, experimental design 11-12. Baseline measures of performance, specific performance objectives 13. Data review and identifying underlying (root) causes
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G. Recheck	22-23. Post-adjustment performance measurement, data collection, performance level
H. Readjust plan	24. Review, continuing/new underlying causes to address
I. Future plans	25-28. Subsequent PDCA cycles, standardize processes, “spread” to other areas
J. Physician involvement	29-31. Physician’s role, requirements, reports, reflections, participation, number
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QI Project Report for Part IV MOC Eligibility

A. Introduction

1. **Date** (*this version of the-report*): 11/8/15
2. **Title of QI project:** Improving documentation of controlled substance agreements, drug screening, and Michigan Automated Prescription System verification for patients prescribed controlled substances on a chronic basis.
3. **Time frame**
 - a. **Date physicians begin participating (may be in design phase):** 1/1/15
 - b. **End date:** 10/15/15
4. **Key individuals**
 - a. **QI project leader** [*also responsible for attesting to the participation of physicians in the project*]
Name: Heather Holmstrom, MD
Title: Clinical Assistant Professor
Organizational unit: Department of Family Medicine
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 - a. **Clinical leader to whom the project leader reports regarding the project** [*responsible for overseeing/"sponsoring" the project within the specific clinical setting*]
Name: David Serlin, MD
Title: Clinical Assistant Professor
Organizational unit: Department of Family Medicine
Phone number: 734-232-6222
Email address: dserlin@med.umich.edu
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5. **Approximately how many physicians were involved in this project categorized by specialty and/or subspecialty?**
66 family physicians
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?

Prescribing controlled substances may be an important and appropriate aspect of patient care in the management of chronic pain as well as anxiety. Patients on these medications are susceptible to becoming medically addicted, tolerant, may experience withdrawal if they stop taking adequate doses or skip doses, may take increasing amounts without physician guidance, and/or may take non-prescription illicit substances placing their health and safety at grave risk.

To reduce these risks the University of Michigan Medical Group’s Controlled Substances Quality Improvement Steering Committee has recommended three monitoring activities for patients on controlled substances to help assure patients safely and appropriately use these substances. The monitoring activities are:

- CSA. Establish a formal Controlled Substance Agreement (CSA) with the patient and document this in the medical record
- MAPS. Annually (or more frequently) review the Michigan Automated Prescription System (MAPS) for controlled substance prescriptions from other sources
- Urine drug screen. Annually (or more frequently) obtain a random urine sample to screen for both the presence of the prescribed agent and the absence of non-prescribed agents and illicit drugs with either a point of care “drug 10” immunoassay, a urine gas chromatography test, or lab-based “drug 6” urine drug screen.

For eligible patients seen in Family Medicine clinics, the rates for these monitoring activities were far below the local benchmarks established by the University of Michigan Medical Group Controlled Substances Quality Improvement Steering Committee. Inadequate monitoring may lead to patient safety at risk and potentially increased prescriber liability.

b. Physician’s role. What is the physician’s role related to this problem?

Physicians are the prescribers of the medications, and they are ultimately responsible for the monitoring of the patients they manage. Therefore, they are responsible for insuring that drug testing is done, for supervising the MA in obtaining MAPS, reviewing the MAPS report, and in creating, modifying, and reviewing the CSA with the patient.

c. Project goal. What general outcome regarding the problem should result from this project? (Specific aims/targets are addressed in #12b.)

Improve the performance and documentation of CSA, MAPS, and Urine Drug testing to a level at or exceeding the UMHS benchmarks for eligible patients on controlled substances.

8. Patient population. What patient population does this project address?

Patients who are in an institutional registry of adults 18 and over who are active patients at family medicine clinics during the project period and who received prescriptions for controlled substances. Patients are attributed to the primary care clinic where they receive the majority of their care (i.e., their medical home) based on at least one visit in the past 13 months, and with at least 2 visits in the past 2 preceding years.

Operationally, eligible patients are defined being active, who also received at least one of the following prescriptions in the past 365 days:

- A new prescription for Schedule II, III, IV Opioid with qty >150, or
- A renewal for a Schedule II Opioid with qty > 30, or
- A renewal for a Fentanyl Patch with qty > 10, or
- A renewal for a Schedule III or IV Opioid with qty > 90 and > 2 refills, or
- A new prescription for Benzodiazepine with qty > 90, or
- A renewal for Benzodiazepine with qty > 90 and > 2 refills

9. Which Institute of Medicine Quality Dimensions are addressed? [Check all that apply.]

- | | | |
|--|---|--|
| <input type="checkbox"/> Effectiveness | <input type="checkbox"/> Equity | <input checked="" type="checkbox"/> Safety |
| <input type="checkbox"/> Efficiency | <input type="checkbox"/> Patient-Centeredness | <input type="checkbox"/> Timeliness |

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?**

This project uses three measures (CSA, MAPS, Drug Screen) based on the status of patients in our controlled substances registry. The status of all patients in the registry was measured on the last day of each calendar month. The same denominator (population) is used for all of the measures.

Denominator: At the time of measurement the number of active eligible patients included in the controlled substance registry and assigned to UM Fam Med PCP.

CSA. Numerator: The proportion of patients, > 18 years of age, who met either the opioid or benzodiazepine criteria with a CSA documented.

CSA is an agreement between a prescribing physician and the patient outlining the agreed upon conditions under which the prescriber will continue to prescribe the controlled substance, and listing conditions under which the patient would no longer be prescribed these medications.

MAPS. Numerator: The proportion of patients, > 18 years of age, who met either the opioid or benzodiazepine criteria with a MAPS assessment in the past year.

Michigan Automated Prescription System (MAPS) for controlled substance prescriptions from all sources.

Drug Screen. Numerator: # patients with drug screen (Drug10, Drug Comp, GCMS or Drug6) documented as completed in EHR within last 365 days

Drug-10 Point-of-care urine immunoassay test used to detect prescribed and abused substances. A Urine Drug 6 and Urine Gas Chromatography would also meet this drug screen requirement.

Note: Most patients followed for controlled substances are seen every 1-3 months (the majority every 2 months). Therefore, most of the effect of an intervention can be measured over the 2 months after an intervention is initiated. This approach has two minor methodological limitations:

- A few people will have been seen before, but not during the 2 months after an intervention is initiated. Therefore a few patients may have been only seen in the 3 to 12 months before an intervention is initiated at two months before a measurement date. The intervention will not have been applied to these individuals and the registry-based data will slightly underrepresent the actual effect of the intervention.*
- A few people will have more than one visit during the 2 months after an intervention is initiated. Multiple exposures to the intervention during a short time period may slightly overestimate the actual effects of the intervention for individuals with one typical time periods between visits.*

These methodological limitations apply to relatively small groups of individuals. For our project measures using the controlled substance registry provide reasonable assessments of the general level of performance and of meaningful changes in the level of performance.

b. Are the measures nationally endorsed? If not, why were they chosen?

No. These are the metrics that the UMMG has identified based on internal clinical care guidelines.

c. What is the source of data for the measure (e.g., medical records, billings, patient surveys)?

The electronic health record is the source of the data, an Epic system called Michart in the University of Michigan Health System.

d. What methods were used to collect the data (e.g., abstraction, data analyst)?

Automated, monthly report queried directly from the EHR

e. For what time period was the sample collected for baseline data?

The status of Family Medicine patients in the registry on 12/31/14, reflecting whether they had a CSA, whether MAPS had been checked within the previous 12 months, and whether a drug screen had been performed within the previous 12 months.

12. Specific performance objectives

a. What was 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.)

Measure	Baseline (12/31/14)	Goal UMHS 90 th Percentile
N patients in registry	800	
% with Controlled Substance Agreement	43%	83%
% with Michigan Automated Prescription System	39%	87%
% with Urine Drug Screen	38%	71%

b. Specific aim: What was the target for performance on the measure(s) and the timeframe for achieving the target?

Our goal was for performance on each of the measures to be at or above the respective institutional goals for CSA, MAPS, Drug testing by August 31, 2015. (See the specific goals and baseline points in the table above.)

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

We used the University of Michigan Medical Group internal 90th percentile goals.

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

a. Who 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 was involved?

Physicians, Advance Practice Providers (APP’s: PA’s and NP’s), Medical Assistants, nurses, LPNs and health center management staff were all involved in the understanding of baseline data, underlying root causes, and discussion of possible interventions

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

- Discussed in detail at our departmental Practice Improvement Group, which is inclusive of all of these team members. Practice Improvement Group Meetings are held on a monthly basis. (January 21, 2015 and February 18, 2015 during this review period).
- Faculty business forums held bi-weekly
- Clinic/Site team meetings held at each clinic, on each team, monthly (dates vary based on site)

- E-mail Communication was encouraged as a venue for follow up questions, input, and discussion after each of the various in-person meetings.
- **When?**
1/1/15 – 2/24/15

b. What were 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.)*

People

1. Lack of agreement on drug testing. There was initially inconsistency in opinion about the appropriateness and type of drug testing. Specifically, some physicians did not feel that marijuana (THC) was a problem despite UMMG and UMHS Policy to the contrary.
2. MAPS not done consistently by MA: not all MA's were aware that they could run this report using the login and password of the physician they worked with or the site medical director. Not all MA's were familiar with how to request a MAPS report online.
3. MAPS not consistently reviewed by physician. They either didn't receive it, or if they did receive it were not aware of how to read the report, what the implications of the report were, and how to document their review for appropriate capture in the EHR
4. Lack of knowledge on the part of all care team members with respect to which patients should complete CSA, MAPS, Urine Drug Testing
5. Physicians not knowing where and how to document a CSA in the EHR.
6. Inconsistent understanding and lack of consensus on standards for managing unexpected drug test results by physicians.

Process

1. FYI flag was not in place for eligible patients. Therefore BPA, which depends on the FYI flag, was not present. When the BPA was not present, there is no reminder of a gap in the desired metrics visible during the patient encounter, and therefore negatively impacts completion rates.
2. Non-standard process for MA intake (obtaining urine not standard)

Information Technology

1. Ongoing issues with PCP assignment affected physicians willingness to address controlled substance surveillance. Prescriptions may have been provided by specialty physicians but monitoring requirements are attributed to the PCP who was not the prescriber.

Although there are many causes, this project was deemed important enough to address all of the above root causes over the course of the project. A coordinated, concerted effort which was a priority for all clinics in the Department of Family Medicine by Departmental Leadership. Although not measured, the FYI flag which triggers the reminder for the 3 metrics measured in this project was the fundamental intervention that triggered other aspects of the project.

C. Do

14. Intervention(s). Describe the interventions implemented as part of the project.

- Developed consensus in the Department of Family Medicine during a faculty business forum on January 28, 2015 regarding: agreement to perform drug testing on eligible patients, agreement on the need for MAPS, and agreement regarding the UMMG prescribing policy.
- During the week of February 24-28 2015: a staff member at each of the 6 family medicine sites, under the supervision of the physicians and with their review and approval, identified eligible patients without a current FYI flag and manually added a FYI flag to that patient's EHR. The staff member used EHR data indicating eligibility for controlled substance surveillance following established definitions. This caused a BPA to appear when the patient visited their PCP office.
- Educated physicians about UMMG policy, guidelines, and standards of care with respect to controlled substance prescribing. This included inclusion of THC as a contraindication to prescribing controlled substances, and training in use of the EHR to facilitate documentation.

- Educated physicians about expected MA workflow and their role in reinforcing and supporting collection of MAPS and Urine Drug Screens for eligible patients.
- Educated physicians on review and interpretation of MAPS, and Drug screening results
- Developed standard process across all Family Medicine Clinics on how to address unexpected results of MAPS, Urine drug tests.

15. Who was involved in carrying out the intervention(s) and what were their roles?

Physicians: Completed and reviewed the CSA with patients, supervised the MA process, reviewed the MAPS, requested the urine drug tests, signed orders for the urine drug tests, and reviewed results.

MA: Completed process for urine drug screen on intake of the patient, advised them about the Controlled Substance Agreement, retrieved the maps report, and addressed any refill needs in order to present to the physician/provider.

LPN/MA Panel Manager: Added manually the FYI I flag to eligible patient’s records. Informed patient’s during phone or portal encounters about new policies and guidelines. Scheduled follow-up appointments for patients due to complete Controlled Substance Agreements, review MAPS reports, or complete drug screens.

16. When was the intervention initiated? (For multiple interventions, initiation date for each.)

All interventions were in place by 2/28/25. Education of physician occurred throughout the months of January and February, 2015. FYI flag placement was completed by 2/28/15. Formal initiation of standard process to obtain urine, MAPS, and enforce addressing of the BPA during patient visit started concurrent to addition of the FYI flags on 2/28/15.

D. Check

17. Post-intervention performance measurement. Did this data collection 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 occurred for the time period:

4/30/2015*

b. What was 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.)

Measure	Baseline (12/31/14)	2 Months Post-Intervention 1 (4/30/2015) *	Goal UMHS 90 th Percentile
N patients in registry	800	783	
% with Controlled Substance Agreement	43%	60%	83%
% with Michigan Automated Prescription System	39%	66%	87%
% with Urine Drug Screen	38%	57%	71%

- * Most patients were seen within the 2-month period, but a few were seen only in the 10 months before the period and a few were seen multiple times during the 2-month period.

c. Did the intervention produce the expected improvement toward meeting the project's specific aim (item 12.b)?

No. The interventions increased performance, but only about half-way between baseline performance and goals.

E. Adjust – Replan

19. Review of post-intervention data and identifying continuing/new underlying causes.

a. Who 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 was involved?**

Physicians, APPs, Medical Assistants, nurses, LPNs and health center management staff were all involved in the review and assessment of data, underlying root causes, and discussion of possible next interventions.

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

- Discussed in detail at our May 20, 2015 departmental Practice Improvement Group, which is inclusive of all of these team members. Practice Improvement Group Meetings are held on a monthly basis.
- Faculty business forum held on 5/27/15
- Clinic/Site team meetings held at each clinic, on each team, monthly (dates vary based on site)
- E-mail Communication was encouraged as a venue for follow up questions, input, and discussion after each of the various in-person meetings.

- **When?**

5/11/2015- 5/31/2015

c. What were 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.)

People

1. Persistent lack of agreement on drug testing. There was initially inconsistency in opinion about the appropriateness and type of drug testing. Some physicians still did not feel that marijuana (THC) was a problem despite UMMG and UMHS Policy to the contrary.
2. MAPS not done consistently by MA: despite prior efforts, there was persistence of some MA's not being aware that they could run this report using the login and password of the physician they worked with or the site medical director.
3. MAPS not consistently reviewed by physician. Because the MA's were still not running the MAPS, they physicians both didn't receive it and if received, still were not consistently documenting review as a discrete data element for “credit” in the EHR
4. Lack of knowledge on the part of all care team members with respect to which patients should complete CSA, MAPS, Urine Drug Testing. This was particularly an issue as some patients dropped off the lists, and new patients appeared on the list due to the registry definitions.
5. Physicians not knowing where and how to document a CSA in the EHR.
6. Inconsistent understanding and lack of consensus on standards for managing unexpected drug test results by physicians.
7. Resistance by patient's who did not willingly agree to complete drug screens.

Process

8. Some completed drug screens were not included because the lab had unknowingly changed the name of the code, which impacted whether the data search revealed that the drug test had been done.
9. Standardized process for Medical Assistants obtaining urine was applied inconsistently.

Information Technology

10. Ongoing issues with automated algorithm linking patients to PCPs affected physician's willingness to address controlled substance surveillance for patients not felt to be theirs.
11. Additional patients met criteria for FYI flag, but did not have active FYI flag in the EHR.

F. Redo**20. Second intervention. What additional interventions/changes were implemented?**

1. Supplemental education and reminders to physicians, focusing on how to document CSA, MAPS appropriately occurred at the faculty business forum
2. Clinic/Site team meetings held at each clinic, on each team, monthly (dates vary based on site) stressing operational clinic process, MA role, and physician supervision of MA obtaining MAPS and Urine for screening.
3. E-mail Communication was encouraged as a venue for follow up questions, input, and discussion after each of the various in-person meetings.
4. Physicians were given the opportunity to receive provider-level data for themselves in order to provide additional feedback as well as to consider patient-specific interventions (such as directed calls, personal reminders to themselves, etc.).
5. The lab name of the drug screen was corrected in the EHR system to promote more accurate acknowledgment of completion of the drug screen.
6. Increasing support between clinic sites via communication at Practice Improvement Group and via email was given, to help physicians and staff standardize and more easily address the consequences of a positive drug screen.
7. Physician engagement improved through repeated reminders occurring during the faculty business forum, team meetings, and with leadership reminders to support and oversee the MAPS review, urine drug screening, and completion of CSA.

- 21. The second intervention was initiated when?** (For multiple interventions, initiation date for each.)
While specific interventions were implemented at various times in May and June, all of the above interventions were fully in place by 6/30/15

G. Recheck

- 22. Post-second intervention performance measurement. Did this data collection follow the same procedures as the initial collection of data described in #11: population, measure(s), and data source(s)?**

X Yes No – If no, describe how this data collection

23. Performance following the second intervention.

- a. The collection of the sample of performance data following the intervention(s) occurred for the time period:**

8/31/2015

- b. What was 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.)

Measure	Baseline (12/31/14)	2 Months Post- Intervention 1 (4/30/2015) *	2 Months Post- Intervention 2 (8/31/2015) *	Goal UMHS 90 th Percentile
N patients in registry	800	783	751	
% with Controlled Substance Agreement	43%	60%	70%	83%
% with Michigan Automated Prescription System	39%	66%	82%	87%
% with Urine Drug Screen	38%	57%	69%	71%

* Most patients were seen within the 2-month period, but a few were seen only in the 10 months before the period and a few were seen multiple times during the 2-month period.

c. Did the second intervention produce the expected improvement toward meeting the project's specific aim (item 12.b)?

Substantial additional improvement occurred, but not yet to the goals. Both Urine Drug Screening and MAPS are almost at goal and CSA is more than three-quarters of the way from baseline to goal.

H. Readjust

24. Review of post-second intervention data and identifying continuing/new underlying causes.

a. Who 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 was involved?**

Physicians, APPs, Medical Assistants, nurses, LPNs and health center management staff were all involved in the review and assessment of data, underlying root causes, and discussion of possible next interventions.

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

- Discussed in detail at our departmental Practice Improvement Group, which is inclusive of all of these team members. Practice Improvement Group Meetings are held on a monthly basis.
- Faculty business forums held bi-weekly
- Clinic/Site team meetings held at each clinic, on each team, monthly (dates vary based on site)
- E-mail Communication was encouraged as a venue for follow up questions, input, and discussion after each of the various in-person meetings.

- **When?**

9/1/2015- 10/5/2015

b. What were 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.)

People

1. Continued disagreement on drug testing, particularly as it related to the consequences of drug screens positive for THC.
2. MAPS still not done consistently by MA, although we have seen improvement.
3. MAPS not consistently reviewed by physician
4. Disagreement about eligibility and PCP alignment continued to promote some lack of compliance
5. Lack of understanding of management of drug test results, though we have seen a lot more standardization as individual clinic policies continue to evolve.
6. Resistance by patient's who did not willingly agree to complete drug screens. This continues to present a challenge as new eligible patients are identified, or updated drug screens come due again.
7. Because the data are not in real time, patients may come due for their annual review prior to their visit and consequently show up on the report.
8. Physicians may be disregarding the FYI flag and BPA for reasons of alert fatigue or conscious decision to disregard the alert.

Process

9. Development of standardized process for obtaining urine still ongoing across sites

Information Technology

10. Ongoing issues with automated algorithm that links patients to PCPs affects physicians willingness to address controlled substance surveillance for some patients.

If no additional cycles of adjustment are to be documented for the project for Part IV credit, go to item #25.

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 – #24 for each subsequent cycle. Copy the set of items #20 – #24 and paste them following the last item #24 and provide the information. When the project to be documented for Part IV credit has no additional adjustment cycles, go to item #25.

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

25. 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?

At least 2 more cycles. We plan is to pursue continuous improvement until institutional goals are both met and sustained.

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

There will be ongoing data collection, reporting, and review of data at team meetings. This is a priority for the Department of Family Medicine as identified by its Quality Improvement Committee, therefore ongoing data will be reviewed monthly with leadership until goals are met and sustained. Ongoing feedback will also be given to individual physicians, allowing them to work with their care teams to show continued improvement.

27. 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, will share with other departmental leadership as appropriate.

28. What lessons (positive or negative) were learned through the improvement effort that can be used to prevent future failures and mishaps or reinforce a positive result??

Positive:

1. Utilizing the practice improvement group, which has representatives from all care team member groups, allowed us to have a more standardized approach from the beginning.
2. Assigning specific care team members to be responsible for different tasks in the process allowed shared work and collaboration (MAs obtain drug screen and MAPS, LPN helps with FYI flags, panel managers and others disseminate data). This was found to be particularly pertinent when MAs and LPN/Panel managers were assisting with a project that was overseen by the physicians.
3. Incorporating each care team member in the surveillance of controlled substance prescriptions in our department allows us to be more accurate, consistent, and complete in this important surveillance process.

Negatives:

4. Inaccuracies in data collection can have a negative impact on team member's willingness to continue to support the effort. Examples in this case included PCP assignment issues, change of name of the drug screen, and inaccuracy's of the drug screen itself.
5. Personal and ethical issues surrounding sensitive subjects such as controlled substance prescriptions can impact the outcomes significantly.
6. Delay in the data, as opposed to real-time data, is a barrier to running PDSA cycles

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*

29. Physician's role. What were the minimum requirements for physicians to be actively involved in this QI effort? *(What were physicians to do to meet each of the basic requirements listed below? If this project had additional requirements for participation, also list those requirements and what physicians had to do to meet them.)*

- a. *Interpreting baseline data, considering underlying causes, and planning intervention. (As appropriate, use or modify the following response.)*
 - Attendance at faculty business forums .
 - Participation during clinic/Site team meetings including open discussion about the process, review of data, and suggestions for improvements.
 - E-mail Communication with information and opportunity for physician feedback was an ongoing part of the project.
- b. *Implementing intervention. (As appropriate, use or modify the following response.)*
 - Physicians actively completed the CSA, enforced and supported the MA process, reviewed the MAPS and drug screen, and signed orders for the above.
 - Physicians contributed to development of standardized processes at the site level that affected plans when unexpected drug screen results were obtained.
- c. *Interpreting post-intervention data, considering underlying causes, and planning changes. (As appropriate, use or modify the following response.)*
 - Physicians were involved in the review and assessment of data, assessing underlying root causes, and discussion of possible next interventions. Forums included live discussion at faculty meetings, clinic and site meetings, and electronic communication via email.
- d. *Implementing further intervention/adjustments. (As appropriate, use or modify the following response.)*
 - Continued education of physicians about the importance of use and compliance with the controlled substance agreement, MAPS and drug screening Physicians reviewed UMMG and

UMHS compliance policies regarding prescribing of controlled substances that they are expected to follow.

- Physicians identified and assessed the drug screen results, improved by correction of lab names for the tests, to confirm that testing is completed and to take action on results.
- Increasing support between clinic sites was given, so physicians and staff can more easily address the consequences of an unexpected drug screen.

e. Interpreting post-adjustment data, considering underlying causes, and planning changes. *(As appropriate, use or modify the following response.)*

- Physicians were involved in the review and assessment of data, assessing underlying root causes, and discussion of possible next interventions. Forums included life discussion of faculty meetings, clinic and site meetings, and electronic communication via email.

30. How were reflections of individual physicians about the project utilized to improve the overall project?

Through live meetings as well as electronic communication, physicians involved in the project were able to provide input and feedback. This was taken into consideration for the implementation phase, as determined by project, Department, and site leadership..

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

Participants were identified at beginning. Targeted emails were sent to all participants on a regular basis to provide feedback and process suggestions. We encouraged participants to make recommendations and modifications based on their experiences and the data they received. There was ongoing and lively discussion of faculty meetings about the process, and issues surrounding the surveillance of controlled substance prescriptions.

K. Sharing Results

32. 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? Society of Teachers of Family Medicine (STFM)
- Yes No Manuscript for publication?

L. Project Organizational Role and Structure

33. 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:**

- Accountable Care Organization type** (*specify which*):

- BCBSM funded, UMHS lead state-wide Collaborative Quality Initiative** (*specify which*):

- Other** (*specify*):