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

Chlamydia Screening for patients with HIV

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:
Tasha Vokally, JD, Michigan Medicine Part IV Program Co-Lead, tcronenw@med.umich.edu
Ellen Patrick, MA, Michigan Medicine Part IV Program Administrator, partivmoc@umich.edu

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	19-22.	Post-intervention data review, underlying causes, adjustments, who will implement
F. Redo	23.	Adjustment implementation date
G. Recheck	24-26.	Post-adjustment performance, summary of individual performance
H. Readjust plan	27-30.	Post-adjustment data review, underlying causes, further adjustments, who will implement
I. Participation for MOC	31-33.	Participation in key activities, other options, other requirements
J. Sharing results	34.	Plans for report, presentation, publication
K. Organization affiliation	35.	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):* **2/16/21**

2. Title of QI effort/project *(also insert at top of front page)***:** Chlamydia Screening for patients with HIV

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):* December 2019

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)*: February 2021

4. Key individuals

a. QI project leader *[also responsible for confirming individual's participation in the project]*
Name: Tammy Ellies
Title: Manager, Quality Program
Organizational unit: Internal Medicine Department
Phone number: 734-998-5662
Email address: tmrice@med.umich.edu
Mailing address: 1500 East Medical Center Dr., UH South Unit 4, Room F4323, SPC 5220, Ann Arbor, MI 48109

b. Clinical leader who oversees project leader regarding the project *[responsible for overseeing/"sponsoring" the project within the specific clinical setting]*
Name: Jamie Riddell, MD
Title: Professor, Internal Medicine
Organizational unit: Internal Medicine Department – Infectious Diseases Division
Phone number: 734-647-9369
Email address: jriddell@umich.edu
Mailing address: 1500 East Medical Center Dr., Infectious Diseases, F4131 UH South, 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	Number
Practicing physicians	12		12
Residents/Fellows	4		4
Physicians' Assistants	(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 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+ seen by Infectious Disease providers at the University of Michigan Taubman Center outpatient clinic. The target patients for intervention are the subset of the population not meeting the current performance measure for chlamydia screening.

Patient Criteria:

- Established Patient: Patients must be alive and seen at least twice in a Michigan Medicine Taubman Infectious Disease clinic with the last 12 months.

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)?
Patients with HIV are at increased risk for chlamydia. HIV screening is recommended at least once annually for all patients infected with HIV, regardless of symptoms. Reference: Health Resources and Services Administration's (HRSA) Ryan White HIV/AIDS Program, Adult and Adolescent Performance Measures (https://hab.hrsa.gov/sites/default/files/hab/clinical-quality-management/adolescentadultmeasures.pdf)

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

As of December 2019, only 69% of HIV patients seen in the Taubman Infectious Disease Clinic had been screened for chlamydia.

Chlamydial infections are often asymptomatic in women; however, asymptomatic infection may lead to pelvic inflammatory disease (PID) and its associated complications, such as ectopic pregnancy, infertility, and chronic pelvic pain. Newborns of women with untreated infection may develop neonatal chlamydial pneumonia or gonococcal or chlamydial ophthalmia. Infection may lead to symptomatic urethritis and epididymitis in men. Source: U.S. Preventative Task Force Recommendation Statement, 9/22/14

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.)*

This project is designed to increase the percent of patients who have the recommended chlamydia screening to 79% (the University of Michigan Medical Group (UMMG) 75th percentile for chlamydia screening).

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

Percent of patients who receive chlamydia screening within the established guidelines.

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

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

Number of patients in the HIV patient population as described in #7.

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

The proportion of patients, who have had a completed chlamydia screening by urine test in the last 12 months.

- **The source of the measure is:**
  - ☐ An external organization/agency, which is *(name the source, e.g., HEDIS)*:
  - ☒ Internal to our organization
- **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)?

12/1/19 – 12/31/19

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.*

The performance level in December 2019 was 69%. See data table and chart at end of report.

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 aim is to increase the percent of patients receiving chlamydia screening from 69% in December 2019 to 79% by December 2020.

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

The goals were determined by the UMMG Quality Analytics group based on a review of the baseline data. UMMG's overall 75th percentile rate was 79%.

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)*

- UMMG Quality Office – Chief Quality Officer, Associate Chief Quality Officer, Project Manager
- Taubman Infectious Diseases Ambulatory Care Unit (ACU) – Medical Director, faculty physicians and fellows who see HIV patients at Taubman Center clinic, Registered Nurses, Medical Assistants, and Social Workers.
- Division of Infectious Diseases – Division Administrator
- Department of Internal Medicine - Department Continuous Improvement Consultant

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

c. **When?** *(e.g., date(s) when baseline data were reviewed and discussed)*
March 4, 2020

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.)*
Screening test not completed because provider unaware -	Discussion at faculty meeting	Faculty physicians and fellows Medical assistants Clerical staff Social workers

		Admin manager
Screening test not completed because patient is resistant or forgets to leave sample at lab	Updated workflow for Medical Assistants to ask patients for urine sample at clinic visit instead of sending patient to the lab after visit Patient education and discussion at visit, using social work if needed	Faculty physicians and fellows Medical assistants Clerical staff Social workers Admin manager
Screening test completed but not documented (often external lab or health department)	Review gap list and enter documentation	Medical assistants Clerical staff Admin manager Faculty physicians and fellows

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, 2020

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 <u>post-intervention</u> data on the measure(s)?

4/1/20 – 4/30/20

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. Can show baseline and post-intervention data incrementally here or refer to a display of data for all time periods attached at end of report. Show baseline and post-intervention time periods and measure names and for each time period and measure show number of observations and performance level.*

Performance level in April 2020 was 59%. See data table and chart at end of report.

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

No, the screening rate decreased to 59%.

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)*

Faculty meeting on 6/17/20 and 7/29/20.

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 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.

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.)*
Screening test not completed – provider not aware	Created automated alerts in the electronic medical record (Best Practice Alert (BPA) and Smart Set) with orders to alert nurse and providers that screening was needed Monitored BPA utilization at provider level Patient education and discussion at visit, using social work if needed	Faculty physicians and fellows Medical assistants Social workers Admin manager
Screening test not completed because patient left clinic and didn't go to lab	Ask patient for urine sample during clinic visit instead of sending them to the lab after the visit is complete	Faculty physicians and fellows Medical assistants Social workers Admin manager Front desk clerks

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

F. Redo

23. By what date was (were) the adjustment(s)/second intervention(s) initiated? *(If multiple interventions, date by when all were initiate*d.)

8/1/20

G. Recheck

24. Post-adjustment performance measurement. Are the population and measures the same as indicated for the collection of post-intervention data (item #19)?

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

25. Post-adjustment performance

a. What were the beginning and end dates for the time period for <u>post-adjustment</u> data on the measure(s)?

8/1/20 – 8/31/20

b. What was (were) the overall performance level(s) post-adjustment? *Add post-adjustment data to the data table, bar graph, or run chart (line graph) that displays baseline and post-intervention data. Can show here or refer to a display of data for all time periods attached at end of report. Show time periods and measure names and for each time period and measure show the number of observations and performance level.*

Performance level in August 2020 was 59%. See data table and chart at end of report.

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

No, the screening rate stayed the same at 59%.

H. Readjust

26. 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 #19? ☐ Different than #19 *(describe):*

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

☒ Same as #19? ☐ Different than #19 *(describe):*

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

February 2021

Use the following table to outline the next plan that was developed: #27 the primary causes, #28 the adjustments(s)/second intervention(s) that addressed each cause, and #29 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.

27. What were the primary underlying/root causes for the problem(s) following the adjustment(s) that the project can address?	**28. What further adjustments/ intervention(s) might address this cause?**	**29. Who would be involved in carrying out each further adjustment/intervention?** *(List the professions/roles involved.)*
9/15/20 – national shortage of tubes for urine testing due to COVID repurposing by manufacturer. Test ordering turned off by Michigan Medicine Pathology.	Discussed option to use other screening methods, but those were deemed too invasive for asymptomatic screening. Decided to wait until supplies were available and option to order test were turned back on. This happened in late January 2021 and now improvement efforts will continue. The physicians will begin using the BPA and ordering the test again.	Faculty and fellows Nurses

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

30. 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:*

I. Minimum Participation for MOC

31. 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 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 #12.
- Implementing interventions described in item #14.
- Reviewing and interpreting post-intervention data, considering underlying causes, and planning intervention as described in item #19.
- Implementing adjustments/second interventions described in item #21.
- Reviewing and interpreting post-adjustment data, considering underlying causes, and planning intervention as described in item #26.

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

32. 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 33.*

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 # 33. If "No," continue to #32c.*

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 # 33.*

33. 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.

J. Sharing Results

34. 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?

K. Project Organizational Role and Structure

35. 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*): UMMG Quality Focus Measures

☐ **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):*