

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

IHA Improving Rate of Pediatric Well Visits 3-18 Years

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	19-22. 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*): April 12, 2019
2. **Title of QI effort/project**: IHA Improving Rate of Pediatric Well Visits 3-18 Years
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, 2018
 - 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 #27c*): February 15, 2019
4. **Key individuals**
 - a. **QI project leader** [*also responsible for confirming individual's participation in the project*]
Name: Diana Rooks
Title: Project Manager, Quality
Organizational unit: IHA Central, Quality & Performance Improvement
Phone number: 734.747.6766 x10857
Email address: Diana_Rooks@ihacares.com
Mailing address: 24 Frank Lloyd Wright Drive, Lobby J2000, Ann Arbor, MI 48105
 - b. **Clinical leader who oversees project leader regarding the project** [*responsible for overseeing/"sponsoring" the project within the specific clinical setting*]
Name: Dr. Jessica Huhn
Title: Associate Division Head of Quality, Pediatrics
Organizational unit: IHA Pediatric Division
Phone number: 810.494.6820
Email address: Jessica_Huhn@ihacares.com
Mailing address: 2305 Genoa Business Park Drive, Brighton, MI 48114
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		60
Residents/Fellows			
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):

Established IHA pediatric patients – children ages 3-18 years of age – who have been seen in the last three years

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 between the ages of 3 and 18 years of age should be seen yearly for a well-child physical exam. The importance of well visits includes preventive care which involves vaccinating on time, screening for conditions such as anemia, hearing loss, and vision. It is also important for tracking growth and development which helps providers to identify issues with learning and any concerning social or behavioral issues. Finally, regular visits create strong trusting relationships between parents and providers which allow discussions about concerns relating to all aspects of the child.

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

Many pediatric patients between the ages of 3 and 18 years of age are not receiving well child physical exams. Missed screenings and touch points could lead to poor health or social outcomes. This occurs because parents don't fully understand the importance of routine well child care and providers are not emphasizing this consistently enough. Also, there are missed opportunities at the practice level for capturing patients who are due for their well child exams.

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.)

Improve the rates of well child physical exams in patients 3-18 years of age by educating patients at all visits about the importance of routine physicals to monitor a child's growth and development while increasing the quality of documentation of these components of care.

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 . . .):

% of active IHA pediatric patients ages 3-18 receiving recommended well child visits

- **Measure components** – describe the:

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

All established pediatric patients ages 3-18 years of age who have been seen within the last three years

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

Number of these patients who have received all recommended well child visits in the measurement period

- **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 baseline data on the measure(s)?**

January 1, 2017 – December 31, 2017

- 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.*

Time Period	Number of Patients	% Patients who have received all recommended well visits
Baseline: 12/31/17	57,494	75.7%

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 % of pediatric division IHA patients ages 3-18 who received recommended well child visits in the calendar year will increase from 75.7% to 79.0% by December 31, 2018.

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

The IHA leadership team set the performance target based on review of baseline performance and expert opinion regarding an achievable goal given practical limitations (e.g. patient compliance with all visit recommendations).

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*)

Providers, Subject Matter Expert on the well child visit measure, other clinical office staff; administrative and IT support

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

Core team consisting of a provider champion, a provider subject matter expert, and some clinical staff met to review data. This team prepared materials for presentation to all participating professionals, planned for interventions and how plans were to be implemented across the Pediatric division. Data, preliminary considerations of causes, interventions, and proposed implementation were provided to all participating physicians and staff members at all locations for review and discussion at clinical and divisional meetings.

- c. **When?** (e.g., date(s) when baseline data were reviewed and discussed)
Divisional meetings occurred in January 2018.

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
<i>Individuals: Are not aware of, don't understand.</i>	<i>Education about evidence and importance of goal.</i>
<i>Individuals: Believe performance is OK.</i>	<i>Feedback of performance data.</i>
<i>Individuals: Cannot remember.</i>	<i>Checklists, reminders.</i>
<i>Team: Individuals vary in how work is done.</i>	<i>Develop standard work processes.</i>
<i>Workload: Not enough time.</i>	<i>Reallocate roles and work, review work priorities.</i>
<i>Suppliers: Problems with provided information/materials.</i>	<i>Work with suppliers to address problems there.</i>

13. What were the primary underlying/root causes for the <u>problem(s)</u> at <u>baseline</u> 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.)
Medical Assistants: Inconsistent use of provider half sheets during visits.	Educating at Pediatric Clinical Quality Meetings on the importance of documenting the due date of the next physical exam at all visits.	Associate Division Head of Pediatrics (Subject Matter Expert) worked with lead MAs at each practice to educate staff.
Providers: Inconsistent emphasis on importance of routine well child visits. Lack of consistency when approaching parents and/or guardians.	Reviewed importance of provider engagement with patients to reinforce the importance of routine physical exams at divisional and provider meetings.	Associate Division Head of Pediatrics (Subject Matter Expert) and Site Medical Directors educated all pediatric providers and engaged in active discussions.
Reception Staff: Inconsistent review of half sheets at acute care (sick) visits to ensure next physical exam is scheduled within recommended timing. Inconsistent offering of physical exam appointments during these opportunities.	Implemented reception staff education modules in all pediatric offices. This education reinforced the importance of offering a physical exam appointment to all patients at every visit.	Reception leaders and Practice Managers under direction from Divisional Leadership educated all MA and reception staff in all practices.

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 initiated.)
April 1, 2018

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 1, 2018 – June 30, 2018

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.*

Time Period	Number of Patients	% Patients who have received all recommended well visits
Baseline: 12/31/17	57,494	75.7%
Post Intervention: 6/30/18	57,772	74.6%

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

No. The team recognized that the time from implementation of these interventions to the end of the measurement period was not necessarily sufficient to see improved results. These interventions were kept in place and data will be re-evaluated.

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)

Divisional meetings occurred in July 2018.

Use the following table to outline the next plan that was developed: #20 the primary causes, #21 the adjustment(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 <u>problem(s)</u> following the <u>intervention(s)</u> 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.)
Data: Practice Managers were struggling with identifying patients who were not meeting the metric	Developed a well-child registry listing that allows the practice managers to track all patients ages 3-18 not yet scheduled for next recommended well visit.	IT with input from the Associate Division Head and practice managers
Medical Assistants: Continued inconsistency with documenting next physical exam on half sheet	Developed a medical assistant auditing tool to track performance. The audit is reviewing the MA documentation on the half sheet of next well visit type and due date. Lead MA reviews any issues in practice clinical meetings to discuss and implement improvements.	Practice Managers and MAs worked to develop the audit framework and checklist. They also contributed to the methodology for providing feedback to MA staff.
Practice management: When patients leave the practice, there was a lack of tracking of patient records release. Patients were remaining on panels when they had actually moved out of state or to another PCP.	Created a records release workflow to standardize the patient release process throughout the pediatric division. This will accurately remove patients from panels upon transfer as long as the practice is aware of the move.	Associate Division Head and Pediatric Clinical Quality team members worked to create and perfect this audit process.

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 initiated.)
August 1, 2018

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 post-adjustment data on the measure(s)?

October 1, 2018 – December 31, 2018

- 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.

Time Period	Number of Patients	% Patients who have received all recommended well visits
Baseline: 12/31/17	57,494	75.7%
Post Intervention: 6/30/18	57,772	74.6%
Post Adjustment: 12/31/18	55,499	77.5%

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

Although the target of 79% was not achieved, there was improvement in the metric. The team recognized that the time from implementation of these interventions to the end of the measurement period was not necessarily sufficient to see the full extent of improved results. These interventions were kept in place with the intention of reviewing data again after six more months.

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)

Data will be monitored during the 2019 calendar year and reviewed again in detail at year end, December 31, 2019.

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 <u>problem(s)</u> following the <u>adjustment(s)</u> 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.)
Causes listed in #13 and #20 continue to be a concern	Interventions listed in #14 and #21 will be continued to check longer term results	Individuals listed in #15 and #22

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 # 38.*

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 # 38. If "No," continue to #37c.*

- 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):

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): IHA

• **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):

Baseline Data: December 31, 2017

Dashboard Summary Report Q4 2017				
Well Child Visits 3-18 Years				
Division	Provider	Numerator	Denominator	Score
Pediatrics	Pediatrics	43,526	57,494	75.7%
	Clinic A	1,335	1,654	80.7%
	Clinic B	8,829	11,369	77.7%
	Clinic C	5,669	6,495	87.3%
	Clinic D	3,203	4,442	72.1%
	Clinic E	7,156	9,920	72.1%
	Clinic F	5,867	8,101	72.4%
	Clinic G	8,061	11,113	72.5%
	Clinic H	3,406	4,400	77.4%
Total		43,526	57,494	75.7%

Post Intervention Data: June 30, 2018

Dashboard Summary Report Q2 2018			
Well Child Visits 3-18 Years			
Row Labels	Sum of numerator	Sum of denominator	Calculated_Score
Clinic A	1385	1724	80.3%
Clinic B	8456	11103	76.2%
Clinic C	5228	6447	81.1%
Clinic D	3666	4757	77.1%
Clinic E	7199	10173	70.8%
Clinic F	5671	8102	70.0%
Clinic G	8088	11059	73.1%
Clinic H	3420	4407	77.6%
Grand Total	43113	57772	74.6%

Post Adjustment Data: December 31, 2018

Dashboard Summary Report Q4 2018				
Well Child Visits 3-18 Years				
Division	Provider	Numerator	Denominator	Score
Pediatrics	Pediatrics	42,994	55,499	77.5%
	Clinic A	1,459	1,718	84.9%
	Clinic B	8,542	10,723	79.7%
	Clinic C	5,607	6,383	87.8%
	Clinic D	3,614	4,677	77.3%
	Clinic E	7,247	9,865	73.5%
	Clinic F	5,524	7,899	69.9%
	Clinic G	8,193	10,688	76.7%
	Clinic H	2,808	3,546	79.2%
Total		42,994	55,499	77.5%