

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

Improving Diabetic Patient Care by Improving Percent of Tests Up-to-Date at Time of Visit

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. (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 1-20.) 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. 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
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B. Plan	7-10. Patient population, general goal, IOM quality dimensions, ACGME/ABMS competencies 11-13. Measures, baseline performance, specific aims 14-17. Baseline data review, underlying (root) causes, interventions, who will implement
C. Do	18. Intervention implementation date
D. Check	19-20. Post-intervention performance
E. Adjust – Replan	21-24. Post-intervention data review, underlying causes, adjustments, who will implement
F. Redo	25. Adjustment implementation date
G. Recheck	26-28. Post-adjustment performance, summary of individual performance
H. Readjust plan	29-32. Post-adjustment data review, underlying causes, further adjustments, who will implement
I. Reflections & plans	33-37. Barriers, lessons, best practices, spread, sustain
J. Participation for MOC	38-40. Participation in key activities, other options, other requirements
K. Sharing results	41. Plans for report, presentation, publication
L. Organization affiliation	42. 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*):
July 29, 2016

2. **Title of QI effort/project** (*also insert at top of front page*):
Improving diabetic patient care by improving % tests up-to-date at time of visit

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 #14*):
May 15, 2014

 - 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 #33*):
June 30, 2016

4. **Key individuals**
 - a. **QI project leader** [*also responsible for confirming individual's participation in the project*]
Name: Diana Rooks
Title: Quality Project Manager
Organizational unit: IHA Central Office
Phone number: 734.747.6766 x10857
Email address: Diana_Rooks@ihacares.com
Mailing address: 24 Frank Lloyd Wright Dr, Lobby J2000; Ann Arbor, MI 48105

 - b. **Clinical leader to whom the project leader reports regarding the project** [*responsible for overseeing/"sponsoring" the project within the specific clinical setting*]
Name: Tendai Thomas, MD
Title: IHA Internal Medicine Associate Division Head
Organizational unit: IHA Internal Medicine Division
Phone number: 734.995.0303
Email address: Tendai_Thomas@ihacares.com
Mailing address: 4200 Whitehall Dr, Suite 130; Ann Arbor, MI 48105

5. **Participants**
 - a. **Approximately how many health care providers (by training level for physicians) participated in this QI effort** (*whether or not for MOC*):

Profession	Number (<i>fill in</i>)
Practicing Physicians	95
Residents/Fellows	0
Physicians' Assistants	0
Nurses (APNP, NP, RN, LPN)	20
Other Licensed Allied Health (e.g., PT/OT, pharmacists, dieticians, social workers)	0

b. Approximately how many physicians (by specialty/subspecialty and by training level) and physicians’ assistants participated for MOC?

Profession	Specialty/Subspecialty (fill in)	Number (fill in)
Practicing Physicians	Family Medicine	60
	Internal Medicine	35
Fellows		0
Residents		0
Physicians’ Assistants	(Not applicable)	0

6. How was the QI effort funded? (Check all that apply.)

- Internal institutional funds
- Grant/gift from pharmaceutical or medical device manufacturer
- Grant/gift from other source (e.g., government, insurance company)
- Subscription payments by participants
- Other (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):

This project includes patients ages 18-75 with diabetes. The project will involve diabetic patients seen in IHA’s Internal Medicine and Family Medicine practices. The average interval of follow up for adults with diabetes varies between 3 months and 6 months depending upon disease control.

8. General goal

a. Problem/need. What is the problem (“gap”) in quality that resulted in the development of this project? Why is important to address this problem?

Diabetes is a widespread chronic disease that results in a major burden of morbidity and mortality in the U.S. and the developed world. Appropriate preventive care can delay or prevent the onset of complications of diabetes. This care includes screening blood glucose (e.g., HbA1C) level so that treatment can be initiated if they are out of control, screening for kidney complications (urine microalbumin level) so that kidney disease can be identified and treated, examining feet to detect neuropathy and initiate preventive surveillance and care to reduce the instance of amputation, and screening retinal exams to detect and treat microvascular disease that could lead to blindness. However, preliminary examinations of data from medical records indicate that all of these preventive care screening activities are not routinely provided to our patients with diabetes in a timely manner.

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 #13.)

The goal of this project is to increase the performance of preventive care screening for patients, ultimately to reduce the progression of complications to significant morbidity and to mortality.

9. Which Institute of Medicine Quality Dimensions are addressed? [Check all that apply.]
 (<http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf>)

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

10. Which ACGME/ABMS core competencies are addressed? (Check all that apply.)
 (<http://www.abms.org/board-certification/a-trusted-credential/based-on-core-competencies/>)

- | | |
|---|---|
| <input checked="" type="checkbox"/> Patient Care and Procedural Skills | <input checked="" type="checkbox"/> Medical Knowledge |
| <input checked="" type="checkbox"/> Practice-Based Learning and Improvement | <input type="checkbox"/> Interpersonal and Communication Skills |
| <input type="checkbox"/> Professionalism | <input checked="" type="checkbox"/> Systems-Based Practice |

11. 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:** Percent of adult diabetic patients with recommended screening performed (changes in 2016)
- **Measure components** – for a rate, percent, or mean, describe the:
 - Denominator (e.g., for percent, often the number of patients eligible for the measure):
 Number of patients age 18-75 with diabetes who had an office visit
 - Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
 In 2014 and 2015 the numerator was the number of these patients who had all of the following five screening services performed, with the time frame measured from the end of the day that the office visit occurred:
 - HbA1c – if ≥ 8.0 , then within past 3 months; if < 8.0 , then within past 6 months
 - Microalbumin – within past year (365 days)
 - Retinal eye exam – within past year (365 days)
 - LDL cholesterol – within past year (365 days)
 - Diabetic foot exam – within past year (365 days)
 In 2016 the numerator two screening tests (LDL cholesterol and diabetic foot exam) were dropped as key prevention screens and blood pressure was added as a key prevention screen. (New studies reduced the importance of LDL cholesterol and increased the importance of blood pressure screening. Foot examination was dropped to better align with our provider dashboard measures.) The numerator became the number of the patients in the denominator who had all of the following four screening services performed, with the time frame measured from the end of the day that the office visit occurred:
 - HbA1c – if ≥ 8.0 , then within past 3 months; if < 8.0 , then within past 6 months
 - Microalbumin – within past year (365 days)
 - Retinal eye exam – within past year (365 days)
 - Blood pressure – within past year (365 days)
- **The source of the measure is:**
 - An external organization/agency, which is (name the source): The American Diabetes Association recommends each of the services and their time intervals. Combining the services into one measure for all services performed is a locally developed measure.
 - 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:** Percent of adult diabetic patients with HbA1c, microalbumin, and retinal eye exam screening performed (consistent across 2014-2016)
- **Measure components** – for a rate, percent, or mean, describe the:
 Denominator (e.g., for percent, often the number of patients eligible for the measure):
 Number of patients age 18-75 with diabetes who had an office visit
 Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
 The number of these patients who had all of the following three screening services performed, with the time frame measured from the end of the day that the office visit occurred:
 - HbA1c – if ≥ 8.0, then within past 3 months; if < 8.0, then within past 6 months
 - Microalbumin – within past year (365 days)
 - Retinal eye exam – within past year (365 days)
- **The source of the measure is:**
 - An external organization/agency, which is (name the source): The American Diabetes Association recommends each of the services and their time intervals. Combining the services into one measure for all services performed is a locally developed measure.
 - 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

12. Baseline performance

a. **What were the beginning and end dates for the time period for baseline data on the measure(s)?**

January 1 – March 31, 2014

b. **What was (were) the 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.)

The overall performance across 10 Family Medicine sites and 9 Internal Medicine sites is shown below.

Time Period	Number of Patients	% Patients with All Tests *	% Patients with HbA1c, Microalbumin, & Retinal Exam
Baseline (1/1/14 – 3/31/14)	6,156	29%	39%

* In 2014 and 2015 “all tests” included five recommended screening tests: HbA1c, urine microalbumin, retinal exam, LDL, foot exam

13. 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].”

At the beginning of the project in 2014 the specific aim was the percentage of all adult diabetic patients receiving all of the recommended services (initially five screening tests HbA1c, urine microalbumin, retinal exam, LDL, foot exam) would increase from 29% at 3/31/14 to ≥ 50% by 7/31/15 when two major cycles of improvement effort would be completed. However, work on this project was delayed by changes in key personnel. The time frame to complete the second cycle and achieve the aim was extended to 5/31/16.

At the beginning of 2016 the recommended services were modified and point-of-care testing was introduced. The specific aim was modified to be that the percentage of all adult diabetic patients to receive all of the recommended services (in 2014 and 2015: five screening tests HbA1c, urine microalbumin, retinal exam, LDL, foot exam; in 2016 four screening tests: HbA1c, urine microalbumin, retinal exam, and blood pressure) would increase from 29% at 3/31/14 to ≥ 60% by 5/31/16 when two major cycles of improvement effort would be completed.

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

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

14. 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.)

- **Who was involved?** (e.g., by profession or role)
 - Core collaborative team consisting of three provider champions and four clinical representatives, a quality project manager, and an IT resource
 - Health care providers and staff at each practice location
- **How?** (e.g., in a meeting of clinic staff)
 - Core collaborative team: Routine monthly meetings to review data and issues raised by practice personnel and to address interim status and actions. Periodic meeting to plan engagement of health care providers and staff in major new step in improving care.
 - Health care providers and staff: Routine weekly receipt of performance data, live monthly and quarterly provider meetings, email communications. Periodic focus of meeting and communication on major new step in improving care.
- **When?** (e.g., date(s) when baseline data were reviewed and discussed)

Health care providers and staff: meetings focused on major new step in improving care: May 2014

Use the following table to outline the plan that was developed: #15 the primary causes, #16 the intervention(s) that addressed each cause, and #17 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>

15. What were the primary underlying/root causes for the <u>problem(s) at baseline</u> that the project can address?	16. What intervention(s) addressed this cause?	17. Who was involved in carrying out each intervention? (List the professions/roles involved.)
Busy providers would overlook preventive screening when addressing current care issues	Institute a pre-visit planning process for adult diabetic patients: generating a working report to compile test result data with scheduled appointments and calling patients 1-2 weeks prior to their office visit to discuss gaps in care and how to close those gaps.	Core team developed recommended processes and tools. Local teams of providers and medical assistants adapted the recommendations to the local setting and implemented them.
Chart not always completed for test results from providers external to IHA	(Addressed above)	
Staff not clear on how to accurately document test results in electronic record	The Disease Management Template in the electronic medical record includes entries for preventive screening and personnel were taught how to complete them.	Core team oversaw update of template and provided training. Providers and medical assistants attended training.

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

C. Do

18. By what date was (were) the intervention(s) initiated? (If multiple interventions, date by when all were initiated.)

By September 31, 2014, the interventions had been piloted and rolled out across the 19 family medicine and internal medicine practice sites.

D. Check

19. Post-intervention performance measurement. Are the population and measures the same as those for the collection of baseline data (see items 10 and 11)?

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

20. Post-intervention performance

a. What were the beginning and end dates for the time period for post-intervention data on the measure(s)?

8/1/15 – 10/31/15. The major assessment of performance was delayed by several months longer than anticipated due to changes in project leadership, modifications in data collection and reporting, and modifications to workflows as personnel developed suggestions to improve the efficiency of the processes.

- b. What was (were) the overall performance level(s) post-intervention?** (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.)

The overall performance across 10 Family Medicine sites and 9 Internal Medicine sites is shown below.

Time Period	Number of Patients	% Patients with All Tests *	% Patients with HbA1c, Microalbumin, & Retinal Exam
Baseline (1/1/14 – 3/31/14)	6,156	29%	39%
Post-intervention (8/1/15 – 10/31/15)	7,177	50%	57%

* In 2014 and 2015 “all tests” included five recommended screening tests: HbA1c, urine microalbumin, retinal exam, LDL, foot exam.

- c. Did the intervention(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)?**

Yes. Performance reached the initial specific aim of 50%.

E. Adjust – Replan

- 21. 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.)

- **Who was involved?** (e.g., by profession or role)
 Same as #14? Different than #14 (describe):
- **How?** (e.g., in a meeting of clinic staff)
 Same as #14? Different than #14 (describe):
- **When?** (e.g., date(s) when post-intervention data were reviewed and discussed)
Health care providers and staff: meetings focused on major new step in improving care: November and December 2015

Use the following table to outline the next plan that was developed: #22 the primary causes, #23 the adjustments(s)/second intervention(s) that addressed each cause, and #24 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.

22. What were the primary underlying/root causes for the <u>problem(s)</u> following the <u>intervention(s)</u> that the project can address?	23. What adjustments/second intervention(s) addressed this cause?	24. Who was involved in carrying out each adjustment/second intervention? (List the professions/roles involved.)
Limited time to perform pre-visit planning.	Identified and implemented priorities for whom to call: No need to call a patient if either tests are already up-to-date or the needed tests can be completed at point-of-care.	Core team oversaw agreement on revised priorities. MAs implemented priorities in calling patients.
Tests that could be done at point-of-care sometimes overlooked.	Updated rooming protocols to emphasize point-of-care testing and collecting HbA1c and microalbumin and measuring BP	Core team oversaw agreement on rooming protocols. MAs implemented.
Eye examination rate was low.	Developed for patients a “take home” sheet for eye exams. Information for patients includes recommended providers and exam importance. Information for exam providers on how to communicate results to primary care provider.	Core team oversaw development of the sheet. Providers and staff implemented local process for giving it to patients.
Pre-visit planning not always occurring.	Implemented a weekly audit report to help local sites identify trends of non-performance (e.g., by provider-MA teams, by specific test). Results discussed at regular staff meetings and individual feedback provided as needed.	Core team oversaw development of audit reports. Local providers and staff review reports.

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

F. Redo

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

By March 31, 2016, the new interventions were implemented across the 19 sites.

G. Recheck

26. Post-adjustment performance measurement. Are the population and measures the same as indicated for the collection of post-intervention data (item #21)?

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

Both LDL cholesterol screening and diabetic foot examinations were removed as key screening activities. Blood pressure screening was added as a key screening activity. The measure became performance of all four screening tests: HbA1c, urine microalbumin, retinal exam, blood pressure.

With the increase in ability to test at point of care, the specific aim was increased from 50% to 60% of patients with all four tests.

27. Post-adjustment performance

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

4/1/16 – 5/31/16

b. What was (were) the overall performance level(s) post-adjustment? (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.)

The overall performance across 10 Family Medicine sites and 9 Internal Medicine sites is shown below.

Time Period	Number of Patients	% Patients with All Tests (changes in 2016)*	% Patients with HbA1c, Microalbumin, & Retinal Exam
Baseline (1/1/14 – 3/31/14)	6,156	29%	39%
Post-intervention (8/1/15 – 10/31/15)	7,177	50%	57%
Post-adjustment (4/1/16 – 5/31/16)	4,970	56%	56%

* In 2014 and 2015 “all tests” included five recommended screening tests: HbA1c, urine microalbumin, retinal exam, LDL cholesterol, foot exam. In 2016 “all tests” included four recommended screening tests: HbA1c, urine microalbumin, retinal exam, blood pressure.

c. Did the adjustment(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)?

Performance on the modified “all tests” measure did not reach the new target rate of 60%, but was stable. Performing 3 tests was essentially unchanged from the post-observation period (57%) to the post-adjustment period (56%). Also, performing 3 tests matched performing the three tests plus blood pressure, the new “all tests” measure, indicating that when the 3 tests were performed, blood pressure was also performed. This pattern in the “3 test” measure indicates that the increase in the “all tests” measure from 50% at post-intervention to 56% at post-observation is due to modifying the measure (dropping LDL cholesterol and foot exam).

We believe that performance will improve over time as more practice staff become familiar with the process of point-of-care testing and practices continue to increase their use of point of care testing.

28. Summary of individual performance

a. Were data collected at the level of individual providers so that an individual’s performance on target measures could be calculated and reported?

Yes No – go to item 29

b. If easily possible, for each listed group of health care providers:

• **Participants with data available:**

- **Indicate the number participating** (if none, enter “0” and do not complete rest of row)
- **If any are participating, are data on performance of individuals available?** (If “No”, do not complete rest of row.)

- if data on performance are available, then enter the number of participants in three categories regarding reaching target rates (i.e. the specific aims for measures).
(If you do not have this information or it is not easily available, leave the table blank.)

Profession	Participants with Data Available		Number of These Participants Reaching Targets		
	# Participating in QI Effort (from #5.a)	Data on Performance of Individuals Available? (Enter Yes or No)	# Not Reaching Any Target Rate	# Reaching at Least One Target Rate	If Multiple Target Rates, # Reaching All Target Rates (If only one rate, enter NA.)
Practicing Physicians	95	Yes	31	64	(NA: only 1 rate)
Residents/ Fellows		No			
Physicians' Assistants		No			
Nurses (APNP, NP, RN, LPN)		No			
Other Licensed Allied Health		No			

H. Readjust

29. 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.)

- Who was involved? (e.g., by profession or role)
 - Same as #21? Different than #21 (describe):
- How? (e.g., in a meeting of clinic staff)
 - Same as #21? Different than #21 (describe):
- When? (e.g., date(s) when post-adjustment data were reviewed and discussed)

Health care providers and staff: meetings focused on major new step in improving care: June 2016.

Use the following table to outline the next plan that was developed: #30 the primary causes, #31 the adjustments(s)/second intervention(s) that addressed each cause, and #32 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.

30. What were the primary underlying/root causes for the <u>problem(s)</u> following the	31. What further adjustments/ intervention(s) might address this cause?	32. Who would be involved in carrying out each further adjustment/intervention? (List the professions/roles involved.)
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<u>adjustment(s)</u> that the project can address?		
Issues concerning care for diabetic patients at a practice site are not always coordinated and addressed.	Identify a local/embedded "diabetes point-person" (diabetes champion) to oversee and monitor local initiatives	Physicians, Nurses, Clinical Coordinators / MAs
Point-of-care testing not performed if provider is not confident of accuracy of results	Peer attestations that point of care testing is accurate and reliable When physicians may want additional testing outside of the diabetic testing, complete pre-visit planning activity with sufficient timeframes to ensure tests completed by time of office visit.	Physicians, MAs
Sometimes testing is not accurately documented	Review appropriate documentation processes and needs at all monthly clinical meetings.	Physicians, Nurses, MAs

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

33. 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:*

Further cycles will occur and are to be documented for MOC. *If checked, contact the UM Part IV MOC Program to determine how the project's additional cycles can be documented most practically.*

I. Reflections and Future Actions

33. Describe any barriers to change that were encountered during this QI effort and how they were addressed.

Some of the barriers that were encountered include: time and priorities for staff, staff turnover and documentation issues affecting the data reporting to the practices. Many times when practice staff were short-handed, the pre-visit planning process was one that would get reduced or eliminated to cover other duties. This was addressed by thinking through the staff's list of prioritized duties and consciously moving pre-visit planning to the upper third of the list. Also, a review of work requirements allowed some wasteful or redundant work to be eliminated. Secondly, staff turnover in some offices is high resulting in the need to constantly train. This issue was addressed by the creation of a diabetic pre-visit planning best practices document that could be reviewed with any new or existing staff members. Protocols and guidelines were simplified and distributed to all practice managers for use. Lastly, through reporting data reviews, issues with how data was entered into the system were uncovered. If the data was not entered into the system (EMR) correctly, it did not transfer into the outcome report accurately. Issues like this were discussed with practice managers and clinical staff as they were identified. Further education, training and examples were used to correct the data entry methods as needed.

34. Describe any key lessons that were learned as a result of the QI effort.

While the underlying causes were similar across practice locations, the operational details of interventions had to be modified to follow somewhat different established workflows in each practice location. Also, need to allow time to train new staff as rapid growth and staff transitions continue at IHA.

35. Describe any best practices that came out of the QI effort.

Three primary best practices that were developed during this project were huddles, the Q&PI Weekly Dashboard, and disease registries. First, huddles were implemented during the first intervention and were originally intended for providers and MAs to discuss the diabetic patients to be seen that day. The process became so beneficial that the practices began huddling daily for all patients seen that day, not only the diabetic ones. Secondly, the Q&PI Weekly Dashboard (published to all weekly) showing the outcome measures became the mechanism for communication of current performance as well as the vehicle to drill down into the patient-level data. This drill down and stratification of data is what allows the practices to identify areas of concern and/or areas that require education and improvement. Lastly, a diabetic registry of patients was created for this process. Soon thereafter many more disease-specific registries were created and have been used to manage specific patient populations more effectively.

36. Describe any plans for spreading improvements, best practices, and key lessons.

All primary care practices in our health care system are already participating and sharing improvements, best practices, and key lessons.

37. Describe any plans for sustaining the changes that were made.

The creation of a "diabetes champion" at each practice location will help assure that changes are sustained by overseeing and monitoring performance.

J. Minimum Participation for MOC

38. 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 #39.*

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 #14.
- Implementing interventions described in item #16.
- Reviewing and interpreting post-intervention data, considering underlying causes, and planning intervention as described in item #21.
- Implementing adjustments/second interventions described in item #23.
- Reviewing and interpreting post-adjustment data, considering underlying causes, and planning intervention as described in item #29.

Yes No *If "Yes," individuals are eligible for MOC unless other requirements also apply and must be met – see item # 40.*

39. 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 40.*

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 # 40. If "No," continue to #39c..*

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 # 40. .*

40. 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:*

K. Sharing Results

41. 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?

L. Project Organizational Role and Structure

42. 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*):