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

Michigan Oncology Quality Consortium (MOQC)
Tobacco Cessation Quality Improvement Project – Wave 1 (Newland Practice)

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:
R. Van Harrison, PhD, Michigan Medicine Part IV Program Co-Lead, 734-763-1425, rvh@umich.edu
J. Kin, MHA, JD, Michigan Medicine Part IV Program Co-Lead, 734-764-2103, jkin@umich.edu
Ellen Patrick, Michigan Medicine Part IV Program Administrator, 734-936-9771, 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*:* December 20, 2019

2. Title of QI effort/project: Michigan Oncology Quality Consortium (MOQC) Tobacco Cessation Quality Improvement Project – Wave 1 (Newland Practice)

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):* May 6, 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 #27c)*: November 27, 2019

4. Key individuals

a. QI project leader *[also responsible for confirming individual's participation in the project]*
Name: Kelly Procailo, PharmD, BCOP
Title: Senior Project Manager
Organizational unit: Michigan Oncology Quality Consortium (Blue Cross Blue Shield-funded)
Phone number: 734-764-2829
Email address: kprocail@med.umich.edu
Mailing address: 2800 Plymouth Rd, Bldg 14 G210, 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: Jennifer Griggs, MD, MPH, FACP, FASCO
Title: Program Director
Organizational unit: Michigan Oncology Quality Consortium (Blue Cross Blue Shield-funded)
Phone number: 734-276-4430
Email address: jengrigg@med.umich.edu
Mailing address: 2800 Plymouth Rd, Bldg 14 G226, Ann Arbor, MI 48109

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

Participating for MOC	Primary Specialty	Subspecialty, if any	Number
Practicing physicians			10
Residents/Fellows	(N/A)	(N/A)	
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) Michigan Oncology Quality Collaborative (MOQC): Blue Cross Blue Shield of Michigan (BCBSM)-funded

☐ 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 with a cancer diagnosis who are: 1) at least 18 years of age, 2) use tobacco products, and 3) are seen by an oncology provider (practice member of MOQC) in the state of Michigan

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)?

Smoking increases the risk of morbidity and mortality. Quitting smoking can reduce the amount of increased risk. Cancer patients are at particular risk because tobacco use can affect the efficacy of their cancer treatment, increase toxicities, contribute to reoccurrence, and increase the risk of developing a second primary cancer diagnosis. Research has shown that patients who enroll in a tobacco cessation program and receive nicotine replacement therapy are more successful in their effort to quit. The US Preventive Services Task Force and other national groups recommend that care providers assess the tobacco use of patients, encourage tobacco use cessation and refer patients to tobacco cessation services.

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

These recommendations are not consistently followed across MOQC practices. While the practice of discussing tobacco use with patients has significantly improved with the onset of Meaningful Use, that has not translated into patients being consistently referred for cessation support. The lack of referral continues the risks and harms caused by continuing tobacco use. Barriers for cancer patients to have access to cessation services include the availability of coaching services and financial burdens due to insurance coverage and the ability to purchase nicotine replacement therapies.

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.)

For cancer patients who utilize tobacco products, the goal of this project is to increase the rate of counseling and/or referrals to tobacco cessation services. Increasing referrals can also address financial burden because patients referred to Michigan's state Quitline will receive free nicotine replacement therapy.

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 cancer patients who are tobacco users who were counseled and/or referred to tobacco cessation services.
- **Measure components** – *describe the:*
  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:
  15-20 randomly selected patients' charts from a list of patients who have been identified as tobacco users.

  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:
  Number of patients who were counseled and/or referred to tobacco cessation services, as documented in the patient chart.

- **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, 2019-January 31, 2019

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.*

See end of report for performance level for all time periods

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]."*

For patients ≥ 18 years old, are tobacco users, and have a cancer diagnosis at Newland Medical Associates, improve the rate of tobacco counseling and/or MI Quitline referral from 12% to 50% by December 2019.

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

2018 – 2019 National Benchmark - American Society for Clinical Oncology Quality - Oncology Practice Initiative (ASCO - QOPI): 41-52%

2018 – 2019 Statewide Benchmark (MOQC): 60-75%

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)*
Oncologists, Practice Manager, Medical Assistants

b. How? *(e.g., in a meeting of clinic staff)*
Practice Staff and Physician meetings

c. **When?** *(e.g., date(s) when baseline data were reviewed and discussed)*
May 6, 2019

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.)*
Clinic Staff: unaware of tobacco cessation Quitline	Staff in-service/education about evidence, the importance of Quitline assistance	Medical Assistants, Practice Manager, Oncologists
Clinic Staff: different referral processes based on individual	Develop and educate staff on the standard referral process	Medical Assistants, Practice Manager, Oncologists
Clinic Staff: lack of communication between physician and MA about smoking cessation	Develop a process that alleviates that gap	Medical Assistants, Practice Manager, Oncologists
Clinic Staff: unaware of proper documentation in the EMR	Develop a standard process and educate both the physician and MA on how to document on their end	Medical Assistants, Practice Manager, Oncologists

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.)*
May 14, 2019

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: Population and measures are the same, but the patients may or may not be the same, since random sampling.

18. Post-intervention performance

a. What were the beginning and end dates for the time period for post-intervention data on the measure(s)?
May 14, 2019-July 9, 2019

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.*

See end of report for all time periods

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

No, the level of counseling/referral post-intervention was lower than expected, increasing from the baseline of 12% to just 13%.

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)*
August 26, 2019

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 <u>problem(s) following the 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.)*
Clinic staff: MA's not reviewing the new patient packet until after the visit (due to time constraints or not completed when they room the patient)	Educate the MA's that the tobacco cessation section needs to be reviewed before they leave the exam room	Medical Assistants, Practice Manger
Clinic staff: physicians are not properly documenting counseling in the chart	Communication to physicians to reiterate process and advise on proper documentation	Practice Manger, Oncologists

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.)
September 9, 2019

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: Population and measures are the same, but the patients may or may not be the same, since random sampling.

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)?
September 9, 2019 – November 4, 2019

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.*

See end of report for performance level for all time periods

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

There was an increase from 13% post intervention to 32% post-adjustment, which is trending in the right direction. The goal of 50% has not yet been attained.

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)*

11/27/19

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.)*
Clinic Staff: lack of documentation in patient chart persists as a root cause	Educate physicians on audit results and MI Quitline referral rates. Re-emphasize need to document counseling conversations and/or referrals to the MI Quitline, at physician meeting.	Practice Manager, Oncologists
Clinic Staff: not all patient charts were identified as "tobacco use"	Re-educate MAs on placing note on patient chart, if patient is a smoker, to remind physician to talk to patient about their tobacco use.	Medical Assistants, Practice Manager

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 #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*):

☐ **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):* Michigan Oncology Quality Consortium (MOQC)
  - ☐ **Other** *(specify):*

PDCA Time Periods

Stage	Activity	Date of Completion
PLAN	Baseline Data Measurement	1/1/19 – 1/31/19
	Baseline Data Collection	4/19/19
	Baseline Data Review	5/6/19
DO	Intervention #1 Implemented	5/14/19
CHECK	Post-intervention Data Measurement	5/14/19 – 7/9/19
	Post-intervention Data Collection	7/17/19
ADJUST	Post-intervention Data Review	8/26/19
REDO	Intervention #2 Implemented	9/9/19
RECHECK	Post-adjustment Data Measurement	9/9/19 – 11/4/19
	Post-adjustment Data Collection	11/26/19
READJUST	Post-adjustment Data Review	11/27/19

Performance Across Time Periods

Time Period	**Baseline** (Jan 2019)	**Post-Intervention** (5/14/19 – 7/9/19)	**Post-Adjustment** (9/9/19 – 11/4/19)	**Goal**
N Patients who use tobacco	17	8	22	
% counseling administered or referred to tobacco cessation services	12%	13%	32%	50%