

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

Pneumococcal Vaccine: Specialty-Focus Ambulatory Care Unit (ACU) Quality Measure Improvement 2019

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*): 2/17/2020

2. **Title of QI effort/project** (*also insert at top of front page*):

Pneumococcal Vaccine: Specialty-Focus ACU Quality Measure Improvement 2019

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*): January-March, 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*): February 5, 2020

4. **Key individuals**

a. **QI project leader** [*also responsible for confirming individual's participation in the project*]

Name: Katie Grzyb

Title: Continuous Improvement Specialist

Organizational unit: Department of Internal Medicine

Phone number: 734-417-8367

Email address: kschwalm@med.umich.edu

Mailing address: 1500 East Medical Center Dr., UH South Unit 4, Room F4323, SPC 5220, Ann Arbor, MI 48109

b. **Clinical leader who oversees project leader regarding the project** [*responsible for overseeing "sponsoring" the project within the specific clinical setting*]

Name: Dr. Mike Heung, Dr. Pat Gipson

Title:

Organizational unit: Division of Nephrology

Phone number: 734-936-4678,

Email address: mheung@med.umich.edu, pgipson@med.umich.edu

Mailing address:

Name: Dr. Mark McMorris, Dr. Raj Ravikumar

Title:

Organizational unit: Division of Allergy

Phone number: 734-936-5634,

Email address: mmcmor@med.umich.edu, rajanr@med.umich.edu

Mailing address:

Name: Dr. Jennifer Wyckoff

Title:

Organizational unit: Division of Metabolism, Endocrinology & Diabetes (MEND)

Phone number:

Email address: jwyckoff@med.umich.edu

Mailing address:

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	Nephrology		42
	Allergy		16
	MEND		25
Residents/Fellows	Nephrology		10
	MEND		7
Physicians' Assistants	MEND		2

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):

Adult patients treated in the following clinics

- [Nephrology: CKD \(Chronic Kidney Disease\) - Group 1 \(Stages 3b, 4, And 5\) \(Site 3\)](#)
- [Allergy: Asthma – Adults \(Site 1\)](#)
- [MEND: Diabetes – Adults \(Site 2\)](#)

and who meet criteria for pneumococcal vaccination:

- Patients < 65, without at least one dose of 23-valent pneumococcal polysaccharide vaccine (PPSV23). Patients 65-67 need who have not had at least one dose of 13-valent pneumococcal conjugate vaccine (PV13) and/or one dose of PPSV23 received in the past 5 years.
- Patients >=68, and who have not received at least one dose of PV13 and one dose of PPSV23.
- Re-vaccination not yet obtained for those patients who are >= 65 years of age and who received their first PPSV23 vaccination prior to 65 years if 5 or more years have passed since the first vaccination.

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)?

All the populations of patients described above (*CKD, Asthma, and Diabetes*) are at an increased risk for pneumococcal disease. Pneumococcal disease can cause pneumonia, meningitis, or sepsis, which can lead to severe complications, hospitalization, or death. Getting vaccinated against pneumococcal disease is safe and effective in preventing pneumococcal disease and its complications.

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

Our specialty ambulatory clinics (*Nephrology, Allergy, and MEND*) have not made it a consistent practice to address this clinical need for their patients with CKD, Asthma, and Diabetes who meet the criteria to be vaccinated. Almost all Nephrology, Allergy, and MEND clinic locations are under the 75th percentile (of UM Medical Group) for vaccinating their CKD population, Asthma population, and Diabetes population (respectively). CDC recommends vaccination for all of these patients with chronic illnesses, for the reasons outlined above.

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.)

The project goal is to increase pneumococcal vaccination at each of these specialty division's main site. Ultimately, UMMG would like us to reach the 75th percentile (or 88%, 83%, and 86%) for the Site 3 clinic (Nephrology) and Sites 1 & 2 clinics (Allergy & MEND), respectively, by end of CY 2019. We would also like to push all best practices developed in the main clinic sites to all remaining specialty clinics by end of CY 2019.)

9. Describe the measure(s) of performance: (QI efforts must have at least one measure that is tracked across the two cycles for the three measurement periods: baseline, post-intervention, and post-adjustment. If more than two measures are tracked, copy and paste the section for a measure and describe the additional measures.)

Measure 1

- **Name of measure** (e.g., *Percent of . . . , Mean of . . . , Frequency of . . .*):

Percent of Patients Who Met Pneumococcal Vaccination Measure

- **Measure components – describe the:**

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

The denominator for each specialty must meet the following

Patient attribution criteria:

“All patients must be alive and have been seen in an ambulatory care setting at least twice in the past two year by primary care or relevant specialty, with one of those visits completed in the past 395 days.”

Eligibility includes:**Allergy: Asthma - Adults**

“Patients \geq 18 years of age with:

- At least two encounters in an inpatient, ER, and/or ambulatory care setting with a diagnosis of asthma within the past 395 days and any one of the clinical validation criteria,

or

- At least one encounter in an inpatient, ER, and/or ambulatory care setting with a diagnosis of asthma in the past 395 days and both clinical validation criteria.”

Nephrology: CKD - Group 1 (Stages 3b, 4, And 5)

“Patients 18 – 85 years of age with most recent outpatient estimated glomerular filtration rate (eGFR) $<$ 45 mL/min (Stages 3B, 4, 5) in the past two years.”

MEND: Diabetes – Adults

“Patients 18 – 75 years of age with a diagnosis of diabetes on the Problem List.”

Clinical Validation includes:**Allergy: Asthma - Adults**

“Documentation of asthma on the Problem List, and/or documentation of an asthma controller in medications.” “Excluding patients with chronic respiratory diseases (bronchiectasis, cystic fibrosis) and patients less than 6 years of age with bronchopulmonary dysplasia, bronchomalacia or tracheomalacia.”

Nephrology: CKD - Group 1 (Stages 3b, 4, And 5)

No additional validation criteria. However, majority of these patients also have more than one eGFR < 45 mL/min, CKD-related utilization, and/or a CKD listed on the Problem List." "Excluding patients with kidney transplant or dialysis."

MEND: Diabetes – Adults

No additional validation criteria.

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

The sum of the number of patients who are:

- < 65 and who have at least one dose of 23-valent pneumococcal polysaccharide vaccine (PPSV23). Patients 65-67 need who have not had at least one dose of 13-valent pneumococcal conjugate vaccine (PV13) and/or one dose of PPSV23 received in the past 5 years.
- >=68 and who have received at least one dose of PV13 and one dose of PPSV23.
- >= 65 years of age and who received their first PPSV23 vaccination prior to 65 years, 5 or more years have passed since the first vaccination, and they received revaccination.

- **The source of the measure is:**

- An external organization/agency, which is (*name the source, e.g., HEDIS*): HEDIS
- Internal to our organization (selected by UM Medical Group leadership, in reference to HEDIS/P4P measure)

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

Percent of Patients with a Completed or Addressed "Due for Pneumococcal Vaccination" Best Practice Alert (BPA) During a Clinic Visit

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

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

All patients with a subsequent visit in one of the specialty clinics (Allergy, MEND, Nephrology) that have the Pneumococcal Vaccine BPA present during that clinic visit. (This measure cannot delineate the reason for the vaccination, so it represents a larger audience than what UMMG is incentivizing these specialties to improve. But it still gives us a more real-time process measure to track and understand if we are getting "better.")

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

The patients within the denominator that had the vaccine administered during that visit or had the BPA addressed during that visit (may include ordering the vaccine, documenting a deferral, or entering a historical immunization).

- **The source of the measure is:**

- An external organization/agency, which is (*name the source*):
- Internal to our organization and it was chosen because (*describe rationale*): It reflects performance in addressing best practice alerts for pneumococcal vaccination.

- **This is a measure of:**

- Process – activities of delivering health care to patients

- Outcome – health state of a patient resulting from health care

(If more than two measures are tracked across the two cycles, copy and paste the section for a measure and describe the additional measures.)

10. Baseline performance

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

Measure 1

November for Nephrology
November 2018 – December 2018 for MEND
November 2018 – January 2019 for Allergy

Measure 2

No baseline data reviewed, initially, on Measure 2. This measure was introduced and tracked after the first intervention.

- 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

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].”*

Increase pneumococcal vaccination in each specialty clinic’s targeted patient population to the 75th percentile by December 2019. The 75th percentile for each population is as follows;

- Allergy (Asthma Population): Increase from baseline 63% (Site 1) to **83%**
- MEND (Diabetes Population): Increase from baseline 62% (Site 2) to **86%**
- Nephrology (CKD Group 1 Population): Increase from baseline 63% (Site 3) to **88%**

Work towards 100% of the “Due for Pneumococcal Vaccination” Best Practice Alerts (BPAs) populating for patients during a clinic visit to be completed or addressed.

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

Performance targets were determined and shared by UMMG leadership. This is a HEDIS based measure and a “P4P” measure for Michigan Medicine.

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)*

Department of Internal Medicine – the Department’s Continuous and Quality Improvement team, the physicians in the Division of Allergy, the physicians in the Division of MEND, the physicians in the Division of Nephrology

Physician Champions – identified clinical leaders in each respective Ambulatory Care Unit (ACU)

All physicians in the three specialties – information provided in email and presented at all faculty meetings for physicians to provide input and feedback on the QI initiative

ACU Clinic Leaders – clinic managers at the clinic sites

Medical Assistants (MA) – lead MA’s at each respective clinic location

UMMG Quality – the leadership and project management team within this group

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

Scheduled meetings: monthly faculty meetings within each specialty, monthly multidisciplinary work group put together by each specialty team, weekly ACU huddles within the specialty clinics

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

January 17, 2019 – Nephrology Faculty Meeting

February 15, 2019 – MEND Faculty Meeting

March 12, 2019 – Allergy Faculty Meeting

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) at 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.)
Variability in MA practice for whether or not they address Best Practice Alerts (BPAs) during intake.	<p>Development of standard work for each specialty ACU to recognize and address the BPA during intake.</p> <p>Providers provided input on workflow edits, by specialty, to ensure most efficient process within the clinic.</p> <p>Personal training sessions and examples walked through within the</p>	<p>Physician Champions</p> <p>Providers</p> <p>Clinic Managers</p> <p>Lead MAs</p> <p>Internal Medicine Quality & Continuous Improvement Consultant</p> <p>UMMG Quality Project Manager</p> <p>UMMG Quality Leadership</p>

	<p>MiChart (EHR) training environment with all MA staff at each respective main clinic location.</p> <p>Neph: March 2019 Allergy: April 2019 MEND: April 2019</p>	
<p>Medical Assistants had no ability to know what the BPA for the vaccination was populating for (their age, diabetes, CKD, asthma, etc.) and so an informed discussion with the patient was not possible.</p>	<p>BPA logic was incorporated into the BPA display to include the patient's contributing Problem List diagnoses.</p> <p>January 30th, 2019</p>	<p>HITS Business Systems Analyst UMMG Quality Leadership UMMG Quality Project Manager Internal Medicine Quality & Continuous Improvement Consultant</p>
<p>Medical Assistants did not have a standing order that would allow them to order and provide the vaccine prior to the MD portion of the visit (impacting clinic efficiency).</p>	<p>Creation, build, and roll-out of a new pneumococcal standing order to support staff being able to provide pneumococcal vaccines based off the BPA (not relying on a provider order).</p> <p>March 20, 2019</p>	<p>UMMG Associate Medical Director for Quality UMMG Chief Quality Officer Immunization Committee Clinical Practice Committee</p>
<p>Provider variability in discussion around and/or providing the pneumococcal vaccine to their patient population.</p>	<p>Feedback gathered from providers in each specialty, and changes made to standard workflows.</p> <p>Providers initiated more conversations with patients who were due for vaccination, and imparted its importance and benefits.</p> <p>Continuously working to address concerns and questions in monthly faculty meetings.</p> <p>Ongoing</p>	<p>UMMG Associate Medical Director for Quality Physician Champions Internal Medicine Quality & Continuous Improvement Consultant UMMG Quality Project Manager Providers</p>

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.)

Dates are included in the intervention boxes, above. All initiated by the end of April 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:

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 1, 2019 – June 30, 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 Appendix at end of report

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

Measure 1 - All three clinics in the specialties experienced an increase in their pneumococcal vaccination rates. Allergy increased measure one from 62% to 65%, MEND increased from 62% to 66%, and Nephrology increased from 62% to 68%. No one had reached the 75th percentile by the end of June 2019, but the project leaders viewed the first PDCA cycle as a win.

Measure 2 - "BPAs Addressed" increased dramatically from baseline to post-intervention period. Allergy went from a 9% baseline for addressing the BPA to a 70-80% average of addressing the BPA. MEND went from 21% to a 40-50% average. Nephrology went from 0% to a 50-60% average.

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)

July 2019 –Nephrology Faculty Meeting + email communication(s)

July 2019 – MEND Faculty Meeting + email communication(s)

July 2019 – Allergy Faculty Meeting + email communication(s)

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)</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.)
The two-month delay in the vaccination rate data was a barrier in understanding how each clinic was doing in real time.	<p>Weekly BPA utilization data reports sent to clinic managers, physician champions, and lead MAs for awareness of performance with their new standard work.</p> <p>Utilization data was also available at the provider-level. This data was available, and in some clinics shared in a de-identified way with faculty.</p> <p>Started July 2019</p>	<p>HITS DRA BI Analyst Internal Medicine Quality & Continuous Improvement Consultant UMMG Quality Project Manager Clinic Managers MA Leads Physician Champions Providers</p>
When a patient deferred or declined the pneumococcal vaccine, they were not being provided more education to understand the reason necessity of the vaccine.	<p>A patient education sheet was compiled from existing resources available by the CDC (Centers for Disease Control and Prevention) and the NFID (National Foundation for Infectious Diseases) and distributed for use in each of the clinics. This was modeled after interventions already performed in General Medicine clinics.</p> <p>Providers were encouraged to counsel patients who still declined / refused the vaccination after the MA-rooming process.</p> <p>Started July/August 2019</p>	<p>Assistant Chief, Ambulatory Care Operations Internal Medicine Quality & Continuous Improvement Consultant UMMG Quality Project Manager Clinic Managers MA Leads Providers</p>

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.)*

Dates are included in the intervention boxes, above. All completed by August 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:

25. Post-adjustment performance

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

September 1, 2019 – December 31, 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 Appendix at end of report

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

Measure 1 - All three clinics in the specialties experienced an increase in their pneumococcal vaccination rates. Allergy increased measure one from 65% to 71%, MEND increased from 66% to 72%, and Nephrology increased from 68% to 75%. No one reached the 75th percentile tin calendar 2019, but all teams made significant improvement. Most of the areas increased by 10% or more over the course of the interventions/PDCA cycles.

Measure 2 - Performance leveled-off for all three clinics, as is observable from the graphs at the end of the report.

Teams see both improvement and opportunity to continue to work on both measures into 2020.

H. Readjust

- 26. Post-adjustment data review and further planning. Who was involved in reviewing the post-adjustment data, identifying underlying (root) causes of problem(s) resulting in these new data, and considering possible interventions ("countermeasures") to address the causes?** *(Briefly describe the following.)*

- a. Who was involved?** *(e.g., by profession or role)*

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

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

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

c. **When?** (*e.g., date(s) when post-adjustment data were reviewed and discussed*)
 February 5th, 2020

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? <i>(List the professions/roles involved.)</i>
<p>There is not always time for the patient or the MA to review the patient education before talking with the provider if they are unsure if they want the vaccination.</p>	<p>Remind providers to discuss vaccination during clinic visits, if the MA has not had the opportunity, or if the patient is ambivalent.</p> <p>Working with MiChart (EHR) and Patient Portal features to attach the patient education to the visit reminder message within the portal. The patient would have the opportunity to view the education and have informed questions ready prior to being in clinic. <i>(Ticket has been placed with HITS/MiChart)</i></p> <p>This will enable providers to counsel more efficiently during the course of a busy visit, because their patients will have been educated in advance.</p>	<p>MiChart/HITS staff Clinic Managers/ACU Leaders Providers</p>
<p>Not closing the gap for patients who have not yet come in for a clinic visit. Missing opportunities for outreach.</p>	<p>Identify staff to work the ‘gap list’ of patients who have not met this measure and get them into the clinic (or primary care) to get the vaccination.</p>	<p>Clinic Managers MA Leads / Other Identified Staff Physician Champions</p>

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: MEND and Nephrology will be continuing these efforts into 2020 to continue to try and reach the 75th percentile goal. Allergy has completed their PDCA cycles and will continue to monitor data into 2020.*

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?

We shared initial results at our internal Michigan Medicine Quality Month Symposium in October 2019.

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):** UMMG Quality / Internal Medicine
 - **Is the activity part of a larger UMHS institutional or departmental initiative?**
 - No Yes – the initiative is (name or describe): UMMG Clinical Quality and Focus Measures for Calendar Year 2019
- Veterans Administration Ann Arbor Healthcare System**
- **Overseen by what AAVA Unit/Group? (name):**
 - **Is the activity part of a larger AAVA institutional or departmental initiative?**
 - No Yes – the initiative is:
- An organization affiliated with UMHS to improve clinical care**
- **The organization is (name):**
 - **The type of affiliation with UMHS is:**
 - Accountable Care Organization (specify which member institution):**
 - BCBSM funded, UMHS lead state-wide Collaborative Quality Initiative (specify which):**
 - Other (specify):**

**Appendix:
Performance Data**

Measure 1: Percent of Patients Who Met Pneumococcal Vaccination Measure, 2018 & 2019

Clinic	Nov (18)	Dec (18)	Jan (19)	Feb (19)	Mar (19)	Apr (19)	May (19)	June (19)	July (19)	Aug (19)	Sept (19)	Oct (19)	Nov (19)	Dec (19)	75 th Percentile
Site 1	62%	62%	63%	63%	64%	64%	66%	65%	65%	66%	67%	69%	71%	71%	83%
Site 2	61%	61%	62%	62%	63%	64%	65%	66%	67%	67%	69%	70%	71%	72%	86%
Site 3	62%	62%	63%	63%	63%	64%	66%	68%	69%	70%	70%	73%	74%	75%	88%

↓
↓
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Baseline Data Period
Post-Intervention Period
Post-Adjustment Period

Measure 2: Percent of Patients with an Addressed “Due for Pneumococcal Vaccination” Best Practice Alert (BPA) During a Clinic Visit, 2019



