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

Title: Safe Opioid Prescribing in Pediatric Palliative Care

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):* September 28, 2018

2. **Title of QI effort/project** *(also insert at top of front page)*: Safe Opioid Prescribing in Pediatric Palliative Care

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):* 3/20/2018

    b. **MOC participation end date – date that health care providers seeking MOC completed participating in the documented QI project** *(e.g., date of general review of post-adjustment data, item #27c)*: 9/23/2018

4. **Key individuals**

    a. **QI project leader** *[also responsible for confirming individual's participation in the project]*
    Name: Patricia Keefer
    Title: MD
    Organizational unit: Pediatrics
    Phone number: 7346157845
    Email address: pkeefer@med.umich.edu
    Mailing address: 1540 E. Hospital Drive, SPC 4280, 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: John Schmidt
    Title: MD, Division Director, Pediatric Hospital Medicine
    Organizational unit: Pediatrics
    Phone number: 7346157845
    Email address: pkeefer@med.umich.edu
    Mailing address: 1540 E. Hospital Drive, SPC 4280, 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	Pediatrics, Internal Medicine	Hospice and Palliative Medicine	5
Residents/Fellows	Pediatrics	Hospice and Palliative Medicine	1
Physicians' Assistants	(N/A)	(N/A)	
Nurses (APNP, NP, RN, LPN)			4

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)***: Pediatric Hospice and Palliative Medicine Patients**

8. **General purpose.**

   a. **Problem with patient care ("gap" between desired state and current state)**
      (1) <u>What should be occurring and why should it occur (benefits of doing this)?</u> (2) <u>What is occurring now and why is this a concern (costs/harms)?</u>

   Opioid therapy is indicated in many patients of varying diagnoses followed by the Pediatric Palliative Care Program. Due to the risks associated with opioids, clear guidelines are important to ensure the safety and efficacy of these medications. Opioid overdoses and abuse have also led to new regulations in the state of Michigan providing better oversight and guidance to physicians. As such, our program is working to ensure best practices in safe prescribing, including better documentation, education, and safety planning surrounding opioid prescriptions.

   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.)

   Our program is working to ensure best practices in safe prescribing, including better documentation, education, and safety planning surrounding opioid prescriptions.

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. **Percent of PPC Patients with agreements** = $\dfrac{\textit{PPC Patients getting scheduled medications (II-V) with agreements documented/scanned}}{\textit{PPC Patients getting scheduled medications (II-V)}}$

documented and scanned

- **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)*: This measure reflects performance encouraged by the Departments of Pediatrics and Internal Medicine at Michigan Medicine.
- **This is a measure of:**
  - ☒ Process – activities of delivering health care to patients
  - ☐ Outcome – health state of a patient resulting from health care

2. **Percent of PPC Patients with MAPS review documented** = *PPC Patients getting scheduled medications (II-V) with MAPS review documented* / *PPC Patients getting scheduled medications (II-V)*

- **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)*:   This measure reflects performance encouraged by the Departments of Pediatrics and Internal Medicine at Michigan Medicine.
- **This is a measure of:**
  - ☒ Process – activities of delivering health care to patients
  - ☐ Outcome – health state of a patient resulting from health care

3. **Percent of PPC Patients with documentation phrases used** = *PPC Patients getting scheduled medications (II-V) with SmartPhrase for documentation used* / *PPC Patients getting scheduled medications (II-V)*

- **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)*: This measure reflects performance encouraged by the Departments of Pediatrics and Internal Medicine at Michigan Medicine. .
- **This is a measure of:**
  - ☒ Process – activities of delivering health care to patients
  - ☐ Outcome – health state of a patient resulting from health care

a. **What were the beginning and end dates for the time period for <u>baseline</u> data on the measure(s)?**   January 1, 2018-March 1, 2018 (2 months)

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.* **Please see attached run charts.**

Measures	Baseline Period

	(1/1/18 – 3/1/18)
% with agreements documented/scanned	9.1%
% with MAPS review documented	0%
% with SmartPhrase for documentation used	12.5%

11. Specific performance aim(s)/objective(s)

a. **What is the specific aim of the QI effort?** Please see attached Key Driver Diagram.
Increase compliance with opioid initial management and refills and best practices for:
- Completing prescribing agreements and entering them into the medical record (from 12.5%)
- Performing and documenting MAPS for other controlled prescriptions (from 0%)
- Using standard phrasing (SmartPhrase) in documentation (from 12.5%)

to 90% performance on each measure by the end of two cycled of improvement effort (June 2018).

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

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?** *all physicians and nurses*

b. **How?** *Regular team meeting*

c. **When?** *3/12/2018*

13. What were the primary underlying/root causes for the <u>problem(s) at baseline</u> that the project can address? Please see KDD.

a. Team members not aware of documentation requirements and of tools and strategies to accomplish them.

b. Team members do not have adequate time to give full attention to performing and documenting these activities.

c. Tools (MAPS integration, "Start Talking" form, SmartPhrases) not conveniently set up and located for use.

d. Team members not aware that performance is deficient.

14. What intervention(s) addressed this cause? Please see KDD.

a. Educate team members about documentation requirements and about tools and strategies to accomplish them.

b. Allot to team members adequate time to performing and documenting these activities.

c. Set up and provide convenient access to tools (MAPS integration, "Start Talking" form, SmartPhrases).

d. Send to team members feedback concerning absent documentation.

15. **Who was involved in carrying out each intervention?**

> *Physicians and APRNs primarily carried out prescribing related interventions (primary drivers) while physicians and nurses worked on the above interventions, which facilitated appropriate performance (Secondary Drivers)*

C. Do

16. **By what date was (were) the intervention(s) initiated?**

First intervention implemented as of 3/17/2018 (CPG with smart phrases, agreement).

D. Check

17. **Post-intervention performance measurement. Are the population and measures the same as those for the collection of baseline data (see item 9)?**

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

18. **Post-intervention performance**

   a. **What were the beginning and end dates for the time period for <u>post-intervention</u> data on the measure(s)?**
   Post-intervention data measurement – 4/1/2018-5/1/2018

   c. **What was (were) the overall performance level(s) post-intervention?**
   Please see run charts attached.

Measures	Baseline Period (1/1/18 – 3/1/18)	Post-Intervention Period (4/1/18 – 5/1/18)
% with agreements documented/scanned	9.1%	9.5%
% with MAPS review documented	0%	19%
% with SmartPhrase for documentation used	12.5%	14.3%

   c. **Did the intervention(s) produce the expected improvement toward meeting the project's specific aim (item 11.a)?**   Performance improved, but not yet to the specific aim of 90%.

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)*
     Post-intervention data collection and report – 5/18/2018

19. Cause(s) of Post-intervention Results	20. Intervention(s) to Address	21. Who would be involved in carrying out each further adjustment/intervention?
CPG use improved results, but some still not using	Further education to make sure all group members using it	RN, Physician team
Opioid agreement onerous to use	Revamped to make easier and more standardized location. Also, state mandated use of "Start Talking" form that addressed some topics in agreement, so revamped opioid agreement form needed to reflect only the clinic specific information and not duplicate the form.	RN, Physician team (one APRN primary role). For "Start Talking" form, state team, physician champion helped with training; physicians, nurses, and staff carry out.
Time involved in MAPS checking and documentation	Institutional electronic medical record came out with quick/easy process for MAPS checking and documentation	Epic/MiChart team; physician champion helped with training; physicians, nurses, and staff carry out.

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.) 5/23/2018, 6/1/2018

G. Recheck

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

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

25. Post-adjustment performance

   a. **What were the beginning and end dates for the time period for <u>post-adjustment</u> data on the measure(s)?**
     6/1/2018-6/30/2018

   b. **What was (were) the overall performance level(s) post-adjustment?** *Please see attached run charts*

Measures	Baseline Period (1/1/18 – 3/1/18)	Post-Intervention Period (4/1/18 – 5/1/18)	Post-Adjustment Period (6/1/18 – 6/30/18)
% with agreements documented/scanned	9.1%	9.5%	81.8%

% with MAPS review documented	0%	19%	100%
% with SmartPhrase for documentation used	12.5%	14.3%	27.2%

  c. **Did the adjustment(s) produce the expected improvement toward meeting the project's specific aim (item 11.a)?** The specific aim of 90% was surpassed for MAPS review and almost achieved for documentation. Only modest improvement toward the aim occurred for using SmartPhrase for documentation.

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)*
      Post-adjustment data collection and report reviewed 8/13/2018 and again 9/23/2018

27. Cause(s) of Post-intervention Problems/Results	28. Planned Intervention(s) to Address	29. Who would be involved in carrying out each further adjustment/intervention?
Wording revision of agreement does not reflect practice.	Ongoing revision of agreement to reflect practice	Physicians, nurses on the team
New staff prescribing are not award of expectations.	Education	Physician educators, NP

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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:* we will continue to monitor this as our most recent data points suggested some issues when newer members came onto the team and started prescribing.

  ☐ 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. 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 # 33. If "No," continue to #27c.*

   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):* Pediatric Hospital Medicine

· **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):*

☐ **Other** *(specify):*

Key

- Cycle 1 – development and distribution of CPG
- Cycle 2 – data review, education on CPG, revamping of agreement
- Cycle 3 – system-wide MAPS check integration, data review, revamping agreement

percentage of S2P2 controlled substance patients with agreement completed

percentage of patients with MAPS review documented

percentage of controlled substance patients with smartphrase used for documentation