

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

Decreasing missed opportunities for HPV vaccination in General Medicine

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:

Grant Greenberg, MD, MHSA, MA, UMHS Part IV Program Lead, 763-232-6222, ggreenbe@med.umich.edu
 R. Van Harrison, PhD, UMHS Part IV Program Co-Lead, 734-763-1425, rvh@umich.edu
 Ellen Patrick, UMHS 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	7-10. 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*): 10/11/16
2. **Title of QI effort/project** (*also insert at top of front page*): Decreasing missed opportunities for HPV vaccination in General Medicine
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*): 7/1/2015
 - 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*): 10/4/16

4. Key individuals

- a. **QI project leader** [*also responsible for confirming individual's participation in the project*]
Name: Julia Chen, MD
Title: Clinical Instructor
Organizational unit: General Medicine
Phone number: 734-647-5650
Email address: juliach@med.umich.edu
Mailing address:
General Medicine Clinic
East Ann Arbor Health Center
4260 Plymouth Road
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: Connie Standiford, MD
Title: Executive Medical Director
Organizational unit: Ambulatory Care
Phone number: (734) 998-7207
Email address: cstandif@med.umich.edu
Mailing address:
375 Briarwood Circle
Ann Arbor, MI 48108

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 (fill in)
Practicing Physicians	64
Residents/Fellows	100
Physicians' Assistants	8
Nurses (APNP, NP, RN, LPN)	5
Other Allied Health	

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		36
Fellows		
Residents		
Physicians' Assistants	(Not applicable)	1

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): Patients aged 11-26 seen at UMHS Department of General Medicine Outpatient Clinics

8. General goal

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

The Advisory Committee on Immunization Practices (ACIP) currently recommends routine vaccination of youth ages 11 – 26 with 3 doses of human papilloma virus (HPV) vaccine (1). Several factors have been associated with low HPV vaccination rates. A critical barrier reported by parents is not receiving a recommendation for the HPV vaccine from a health care professional (2). A prior study done at UMHS with an electronic prompt has demonstrated increased HPV initiation and timely completion (3). In 2014, 26.4% of females and 16.7% of males (averaged amongst clinics) completed the HPV vaccine series. Decreasing missed opportunities to provide HPV vaccination will significantly improve vaccination rates. Physicians are missing opportunities to counsel patients on the benefit, and to offer HPV vaccination at ambulatory care clinic appointments.

- d. **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.)

Decrease missed opportunities to give the HPV vaccine by 20%, with a goal to reach this target after 2 three-month intervention cycles.

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>)

- Effectiveness Equity Safety
 Efficiency Patient-Centeredness 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/>)

- Patient Care and Procedural Skills Medical Knowledge
 Practice-Based Learning and Improvement Interpersonal and Communication Skills
 Professionalism 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 visits with missed HPV Opportunity
- **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 visits where a patient was eligible to receive the HPV vaccine.

Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation): number of these visits where HPV vaccine was not given. This includes visits where the vaccine was offered and documented as declined.
- **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): Based on consensus in the UMHS pediatric QI committee.
- **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**

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

August 1, 2015 – October 31, 2015

- f. **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.)

Please see data table at the end.

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].”*

In patients aged 11-26 seen at UMHS Department of General Medicine ambulatory clinics, to decrease missed opportunities to give the HPV vaccine, from 71% to 57% (20% decline) with a goal to reach this target after 2 intervention cycles, by August 31st, 2016.

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

Based on consensus from the physician representatives of the UMHS pediatric preventive care QI committee.

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) All participating physicians.
- **How?** (e.g., in a meeting of clinic staff) During a clinical council meeting of lead physicians from each clinic and via a Qualtrics survey sent over e-mail.
- **When?** (e.g., date(s) when baseline data were reviewed and discussed) November 16th – December 15th, 2015

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.)
Physicians don’t notice the point of care alert- Best Practice Advisory (BPA) that	Clinics will pilot having MAs print MCIR immunization reports (Michigan Care Improvement	Physicians, MAs, and clinic managers will institute this workflow as another method

indicates that the HPV vaccine is due	Registry) for every patient at every visit.	to increase physicians offering the vaccine.
Physicians find it difficult to counsel on the HPV vaccine during urgent visits	A standardized education sheet will be laminated and placed in the exam rooms for patients to review while waiting to see the provider.	Participating physicians and clinic staff.
Physicians have varying success in encouraging patients to consent for the vaccine	Best practices in “pitching” the vaccine were reviewed with physicians over e-mail.	Physicians received information regarding best practices from the CDC.
Patients decline the vaccine	Education will be standardized via the laminated form, physicians will work to recommend the vaccine with the same enthusiasm as they do all other vaccines.	Participating physicians and clinic staff.
MAs don’t always pend the vaccine order to make it easier for the clinician to sign the order despite the BPA firing	Clinic managers will reinforce that the MAs should pend the order whenever the BPA fires and given standardized handout.	Clinic managers and MAs, to be reinforced by physicians.

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.)
 December 16th, 2015[GG1]

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)?** December 16th, 2015- March 15th, 2016

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.)

Please see data table at the end.

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

Yes, but the percentage of visits with no HPV offered or no HPV given decreased by only 5% as compared to baseline.

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)
 - Qualtrics survey from 5/2/16-5/9/16.

Use the following table to outline the next plan that was developed: #22 the primary causes, #23 the adjustments/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) following the 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.)
Practitioners continued to miss the BPA and commented that it was not as functional as they would like (many would like to be able to click a single box to document a vaccine as declined).	A standing order was developed and incorporated into clinical workflow to facilitate administration of HPV vaccine for doses 2 and 3. This will allow MAs to give the remainder of the series without having to get an order from the provider.	Physicians and clinic staff.
Patients continue to decline the vaccine despite strong recommendations.	Continue to operationalize the standardized education, ensure patient information is posted in all patient rooms, and provide a consistent strong recommendation for vaccine	Physicians and staff.
MAs are not consistently pending the HPV vaccine order when the BPA fires.	Medical directors, clinic managers, and lead MAs were contacted to review that each clinic had a consistent plan in place for MAs to pend HPV vaccine and give handout.	Medical director, clinic manager, lead MAs,

Physicians are concerned about possible lack of insurance coverage for the vaccine and a subsequent charge to patients. There is no standardized process in place to verify insurance coverage.	Physicians were informed by email of the major insurance carriers that we know cover the vaccine. We attempted to update an insurance coverage guideline that had been developed previously, but were unable to update it in a timely fashion for this project.	Physicians and staff.
Physicians may not know if the HPV vaccine is making an impact on HPV prevalence or cervical dysplasia.	A recent article in Pediatrics reviewing NHANES data and showing a significant decline in HPV vaccine specific serotypes was referenced in an email to all participating physicians.	Physicians.

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.)

Second intervention began on:

- 5/1/2016

- 4/18/16 for standing order for HPV doses 2/3

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:

27. Post-adjustment performance

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

May 1, 2016- August 31, 2016

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.)

Measure	Baseline (8/1/15 – 10/31/15)	Post- Intervention (12/16/15- 3/15/16)	Post- Adjustment (5/1/2016- 8/31/2016)	Goal

<u>Missed HPV Opportunity</u>				
N eligible visits (BPA fired)	1147	1097	1371	
N HPV not given	809	787	849	
% HPV not given	71%	72%	62%	57%

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

There was an improvement with a decrease in missed opportunities by 13% from baseline, but the improvement did not reach the goal of decreasing missed opportunities by 20%.

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 discipline:

- **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	64	Y	23/36 participating in MOC	13/36 participating in MOC	NA
Residents/ Fellows	100	No			
Physicians’ Assistants	8	Y	1/1 participating in MOC	0/1 participating in MOC	NA
Nurses (APNP, NP, RN, LPN)	5	No			
Other Allied Health					

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)
 - 9/10/16 – 10/11/16

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 <u>adjustment(s)</u> that the project can address?	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.)
Medical Assistants (MAs) weren't aware that there was a standing order for the 2 nd and 3 rd shots in the series.	Broadly inform MAs about this change.	Physicians, clinic managers, lead MAs.
Patients continue to decline the vaccine.	Continue to work on standardized patient education, such as a video, more compelling handouts, etc.	Physicians and clinic managers.
MAs at some sites don't consistently pend the vaccine, give out the standardized education.	Work with managers and lead MAs at those sites on standardization.	Physicians, clinic managers, lead MAs.
Minimal time to discuss vaccine during urgent visits.	Continue to give standardized patient education at every visit to increase awareness of the HPV vaccine.	Physicians and MAs.
Some physicians significantly lowered their rates of "missed opportunities," others continue to have low rates of giving the vaccine.	Continue to gather and share best practices in discussing the vaccine with patients and families.	Physicians.

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.

Barriers noted included high levels of patient declination of the vaccine and staff not aware of or choosing to not consistently use the best practice workflows due to competing priorities when rooming a patient. These were addressed by attempting to standardize the education provided to parents about the vaccine, improve provider comfort with recommendation of the vaccine, and working with MAs and office managers on implementing standardized workflows.

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

We were surprised how difficult of a measure this was to move – likely due to the somewhat charged emotions for some families around HPV vaccination, and provider hesitation to take the time to discuss the vaccine during urgent visits. A multi-pronged approach to educate both the healthcare team and the patient was needed to make any improvements.

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

Having MAs consistently pend the vaccine whenever the prompt fires, using standardized education, and giving the HPV vaccine the same strong recommendation as all other vaccines were identified as best practices.

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

We are presenting the project as a poster at the UMHS quality improvement conference in October.

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

HPV vaccination remains a key quality measure followed by the department and wider institution, and may become a pay for performance measure in the next upcoming cycles. This focus on HPV vaccination rates will encourage continued attempts to maximize HPV vaccination.

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):* Multi-departmental effort overseen by Pediatric QI Committee

- **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):**

Attached data:

Measure	Baseline (8/1/15 – 10/31/15)	Post- Intervention (12/16/15- 3/15/16)	Post- Adjustment (5/1/2016- 8/31/2016)	Goal
<u>HPV Vaccine not given</u>				
N eligible visits (BPA fired)	1147	1097	1371	
N HPV not given	809	787	849	
% of visits where HPV was not given	71%	72%	62%	57%