Educational Tools Key to Designing QI Activities for MOC

Instructional videos, templated forms, and dedicated websites are all critical tools in the design of a quality improvement (QI) activity, but the number one piece remains a physician champion, according to speakers at the 2016 Organizational QI Forum.

Craig W. Robbins, MD, MPH, Medical Director of the Kaiser Permanente Maintenance of Certification Portfolio at The Permanente Federation, and Mary W. Ales, CHCP, FACEHP, Executive Director of the Interstate Postgraduate Medical Association (IPMA), reviewed key components in the design of a QI activity and how to leverage organizational expertise to enable physicians to receive Maintenance of Certification (MOC) credit through the American Board of Medical Specialties (ABMS) Multi-Specialty Portfolio Program™ (Portfolio Program). They presented at the third annual ABMS QI Forum that bridged public policy, and organizational and professional imperatives driving QI and MOC. Health care leaders, QI experts, policy makers, researchers, and journal editors described quality initiatives and best practices, including examples from Portfolio Program sponsors, as well as explored research, evaluation, and dissemination opportunities.

Regional QI Projects
The Permanente Federation became a Portfolio Program sponsor in May 2012. This national federation encourages collaboration and collegiality among the various independent Permanente Medical Groups located in seven regions serving eight states and the District of Columbia. Each region has a Department of Medical Education that spearheads the local MOC work whereas the national level helps organize the work occurring in the regions, facilitates sharing among them, and fosters their relationship with ABMS.

Since the inception of the Portfolio Program through the end of 2015, nearly 3,000 QI activities were completed by physicians who received MOC credit from their respective Member Boards. Common disease states addressed include cancer, cardiovascular disease, and diabetes. Other MOC efforts have focused on immunizations/vaccinations, sepsis, surgical site infections, and patient-physician communication. Overall, these activities have resulted in varying levels of improvement in care processes. “Although we have not done any formal research with our MOC activities, we are starting to look at some of our data to understand which activities are more effective and which ones need tweaking,” said Dr. Robbins, who is also a family physician with the Colorado Permanente Medical Group.

To foster physician engagement in these efforts, The Permanente Federation developed the QI Activity Documentation Form, which requires all the basic information necessary to get a QI activity approved and submitted to ABMS. For example, it asks about the improvement goal, QI methodologies/tools, patient population, intervention, care gaps addressed, methods used in the performance
improvement/practice modification, and measures. This form also helps identify whether a QI activity is a good fit for the physician, he explained. Physicians who are already performing a high rate of colorectal screening, for example, shouldn’t participate in a QI project focused on colorectal screening. “We want them to choose an area where they have an opportunity for improvement,” Dr. Robbins said. “We try to encourage that starting with the documentation form.”

A dedicated wiki, which is a website that allows users to collaboratively edit its content and structure, is used to house MOC activities, forms, and general information. It includes “a user’s guide” to navigating the MOC Improvement in Medical Practice (Part IV) process. On the wiki, physicians can do everything from review the Portfolio activities available in their region, learn the Plan-Do-Study-Act (PDSA) steps, and submit their attestation of activity completion for review and processing. Kaiser Permanente has approximately 3,600 registered MOC wiki users. “The wiki allows us to provide better support for our physicians and greater opportunities for them to learn from each other, particularly when they’re in different geographic locations,” Dr. Robbins noted.

The QI activities are developed at the regional level. In each region, staff within the continuing medical education (CME), quality, and operations departments work together to understand the high priority issues being focused on in a given year, he explained. Then they help design MOC Portfolio activities that align with these priorities that the physicians will be asked to address. “It usually does take a champion from either the quality or operations space who sees an opportunity to work collaboratively with the education folks, and reinforces the quality work that’s already going on,” Dr. Robbins said. Once an activity is developed, it’s publicized at department meetings, CME sessions, and the like to get physicians and their teams enrolled. “We encourage a team-based approach because if you’re really going to change what is happening, you have to get everybody on board,” he added.

**MOC: A Platform for QI**
Recognizing that care is now being delivered by teams, and not individuals, is one of the reasons why IPMA became a Portfolio Program sponsor in January 2015. When taking a team-based approach, it’s important to engage all team members, including allied health providers. Another reason was recognizing that QI and education have independent avenues and approaches, but are really about the same thing, Ales said. IPMA, which designs and provides independent education for physicians, physician assistants, nurse practitioners, registered nurses, and other health care professionals, wanted to make QI and MOC accessible to physicians working in independent clinics and practices, as well as small regional hospitals and physician groups where a lot of patient care is still being provided. Early on, IPMA recognized that many providers don’t understand how to implement QI, and they’re not going to take a lean six sigma course to learn about it, she noted. Additionally, QI and MOC must be relevant to those physicians.

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Understanding that providers come into the QI process with varying degrees of knowledge about it, IPMA developed some educational tools that it believes are critical for engaging them in QI initiatives. They include audio podcasts and videos that providers can use to learn the QI terminology and steps on their own. Next, they developed QI instruction sheets and templates. Asking a provider to fill out a PDSA cycle may be confusing, but engaging in a conversation about identifying a problem and steps to improve it is easy, said Ales, who noted that IPMA primarily uses a PDSA methodology. “So we turned the PDSA cycle into a worksheet that serves as a conversation for teams. It gets them to exactly the same place,” she noted. The same was true of a process map and root cause analysis. To enable the teams to see their progress, IPMA developed run charts for which the data is automatically populated. Customized data collection worksheets simplify the process and serve as a single repository.

Portfolio Program efforts have included working with a specialty association on chronic kidney disease, an accountable care organization (ACO) with 14 independent practices on cancer screening rates, a health system on chronic pain management, a specialty association on advance directives, and a state Medicaid program on chronic disease management.

A more recent QI activity was started by a family physician in Lincoln, Nebraska who wanted to improve cancer screening rates because the state has high disease rates, but lags behind in screening. The objective is to be the first community in the state to meet the national screening goal of 80 percent by 2018 set by the American Cancer Society. It also aligns with the University of Nebraska Medical Center College of Public Health’s target of increasing the number of Nebraskans who are adequately screened for breast and colon cancer. This physician met with local insurers and the public health department. He was able to get more than 26 primary care clinics representing more than 170 primary care providers on board, and even obtained some funding for it. Although the project began in Lincoln, two other communities have signed on. This effort is now known as the Nebraska Physicians Cancer Screening Initiative and is being implemented by the Partnership for a Healthy Lincoln and funded by Blue Cross and Blue Shield of Nebraska, the COPIC Foundation, and the Nebraska Medical Foundation.

“And underneath it all is MOC,” Ales stated. This particular physician, who had worked at one of the ACOs involved in an IPMA Portfolio Program activity, recognized that MOC can be a platform for change. “He’s passionate about public health and we already have a list of eight other efforts that he wants to get started on,” she said.

The Nebraska initiative illustrates the importance of leaders. Often times, all it takes is one physician who wants to do something better or different to improve care. Then it’s up to IPMA to help identify the problem and a leader “who is willing to take the plunge with us,” Ales said. It also illustrates the importance of positioning MOC as a driver for change. “MOC is an opportunity for us to go into the community and engage physicians and their teams in improvement work so that they can provide better care,” she added.

Offering educational tools to help providers design a QI activity for MOC, whether they are performing a gap analysis, setting improvement targets, selecting QI methodologies, choosing measures, or aligning priorities, is a key step in making that happen.