

# Quality Improvement: A Lever for Increasing Adult Immunizations? August, 2015

# Objectives

- Drivers of Quality Improvement
- The Backlash
- Future Drivers
  - Where will that leave adult immunizations?
- Approaches: ACP Examples

# Quality Improvement Works

- Quality improvement activities in health care settings can work
- Requires:
  - Strong leadership
  - Sound data
  - Evidence-based approach (e.g., PDSA)
  - Customized to local culture
  - Aligned incentives

# Example: ACP Adult Immunization Pilot Program

	Baseline (%)	Follow-up (%)	Improvement (%)
<b>Herpes Zoster (shingles) Vaccination</b>	51.92	66.18	14.26
<b>High Risk Pneumococcal Vaccination</b>	69.13	92.65	23.52
<b>Influenza Immunization</b>	79.34	97.64	18.3
<b>Influenza Vaccination Coverage Among Healthcare Personnel</b>	75	100	25
<b>Pneumococcal Vaccination Status for Older Adults</b>	96.12	99.01	2.89
<b>Tdap Vaccination</b>	76.56	91.23	14.67

# Incentives for QI

- Performance reporting for reimbursement – PQRS, BTE, Medicare Star Advantage, PCMH, ACO, CHC
- Public reporting
- Residency training: ACGME requirements
- MOC practice assessment

# ACGME

- Accreditation Council for Graduate Medical Education
- is the body responsible for accrediting the majority of graduate medical training programs (i.e., internships, residencies, and fellowships) for U.S. physicians
- Six core competencies: patient care, medical knowledge, practice based learning and improvement, systems based practice, professionalism, and interpersonal skills and communication
- Two require QI:
  - Practice-based learning and improvement: systematically analyze practice using quality improvement methods and implement changes with the goal of practice improvement;
  - Systems-based practice: Work in inter-professional teams to enhance patient safety and improve patient care quality

# The Backlash

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## Some call MOC process an unreasonable money grab

14,000 petition signers want the ABIM to overhaul its maintenance of certification process.

BY ALICIA AULT

Resistance against the American Board of Internal Medicine's maintenance of certification process is growing, with an online petition to overturn the board's most recent changes having collected more than 14,000 signatures at press time.

Nonetheless, the ABIM says that "a substantial majority" of the nation's internists have met the new MOC requirements as of May 1, the deadline for doctors to be listed publicly on the ABIM's website as having met those standards.

The petition was organized by Dr. Paul Teirstein, chief of cardiology and director of interventional cardiology for Scripps Clinic in La Jolla, Calif.

The ABIM reported that "despite vocal criticism" from physicians for activities physicians already are doing to maintain their knowledge base and improve their practices. It said that 32,900 ABIM diplomates already have fulfilled some requirements of MOC using more than 270 programs created by medical societies, health systems, and others.

"We recognize that the MOC program is not perfect, and we are committed to constant assessment of it," said Dr. Baron in a statement.

The ABIM asserted that the MOC process is needed because it is de-

computers based exams at test centers nationwide, as well as the ongoing development and release of all ABIM self-assessment products," he said.

Petition signers also claim that, contrary to the board's contention, neither patients nor payers value the MOC process, nor are they demanding that physicians prove they've met the requirements. They also say that there is no evidence that MOC improves quality of care.

The ABIM board does not agree. "There is a good deal of research demonstrating the value of MOC. From the validity of the examination, to the importance of independent assessments - clinicians are not good at evaluating their own weaknesses," according to Dr. Baron's statement.

The ABIM's open letter shows that "the petition has definitely had an impact," Dr. Teirstein said.

**Linked licensure, MOC feared**  
Dr. Ron Barouh, a reformer of

tion with the ABIM maintenance of certification requirements. He e-mailed some physicians he knew and encouraged them to sign. The petition went viral soon after being posted on March 20, Dr. Teirstein said.

Petition signers agree that:

- ▶ ABIM has made unreasonable changes in MOC requiring more frequent participation and higher fees.
- ▶ Scientific data showing the benefit of MOC are lacking.
- ▶ MOC activities are complex, of questionable value, and detract from other worthwhile



# The Changes

## **ABIM Announces Immediate Changes to MOC Program**

Philadelphia, PA, February 3, 2015 – Today, the American Board of Internal Medicine (ABIM) announced substantial changes to its Maintenance of Certification (MOC) program and indicated a desire to work more closely with the internal medicine community. ABIM President and CEO Richard J. Baron, MD, reached out to diplomates via e-mail to open a conversation on how to improve MOC.

For media inquiries, please e-mail [press@abim.org](mailto:press@abim.org) or call 215-399-1766.

Dear Internal Medicine Community:

ABIM clearly got it wrong. We launched programs that weren't ready and we didn't deliver an MOC program that physicians found meaningful. We want to change that.

# MOC Requirements

- Possess a valid and unrestricted medical license
- Enroll in MOC
- Earn 100 MOC points every 5 years, with at least 20 in medical knowledge
- Pass the MOC exam in your specialty(ies) every 10 years
- No practice assessment points – MOC part IV – required currently

# Which of the following do you perceive to be barriers to QI in your practice (select all that apply)?

- 69% in Adult Immunization QI program = Lack of Time
- 62% = Lack of Staffing
- 48% = Administrative Burden
- 48% = Other priorities more pressing

# But that horse



# Value Based Payment

- PQRS
- QCDR
- MU
- MACRA (Medicare Reform Law and CHIP Reauthorization Act of 2015)

# MACRA: Starting in 2019\*, physicians will choose from one of two paths: MIPS or APMs?



# Two pathways: MIPS versus APMs

- MIPS adjusts traditional fee-for-service payments upward or downward based on new reporting program (starting in 2019), *replacing PQRS, Meaningful Use, and Value-Based Modifier*
- Measurement categories:
  - Clinical quality (30%)
  - Meaningful use (25%)
  - Resource Use (30%)
  - Practice improvement (15%)
- 5% annual bonus FFS payments for physicians who get substantial revenue from *alternative payment models* that
  - Involve upside and downside financial risk, e.g. ACOs or bundled payments
  - OR
  - PCMHs, if shown to improve quality w/o increasing costs, or lower costs w/o decreasing quality

**QI Required Either Way**

# Which of the following are the highest priorities for your QI program?

- Patient-Centered Medical Home or Neighborhood (PCMH/N) recognition (52%)
- Enhanced team-based care (45%)
- Completion of performance reporting/reimbursement requirements (41%)

# Clinical Registry Boom

- 123 registries currently in development or in operation
  - Largely supported by medical societies
  - Most medical societies host a single registry; some as many as 8
  - Most registries focus on a procedure or specific disease

# Is Adult Immunization as a Clinical Issue Taking Advantage of the QI Policies and Tools?

- What programs exist?
- Have we positioned our measures to be included in various performance reporting programs?

# ACP Quality Connect Approach

- Champion training and support: Learn, Do, Coach
- Practice assessment – guides QI activity
- Performance measure data – streamlining the approach – to reduce burden on practices
- PDSA cycles, beginning with low hanging fruit
- Practice coaching – telephonic
- Emphasis on adapting to workflow and increasing team-based approach (to reduce burden on physician)

# ACP Quality Connect: Adult Immunization and Residency Training

# Adult Immunization Residency QI Program Overview

- Partners: UAMS and Johns Hopkins School of Medicine
  - Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center
- PIs: UAMS – Bob Hopkins, JHU – Trish Perl
- 6 month period of engagement with residents, grand rounds, including use of social media
- Evaluation led by JHMI investigators
- Similar to HVC Residency Training program model
- Will be adapted for *I Raise the Rates* residency and other training programs by UAMS

# Webinar on Materials for Resident Program Directors

- 45 minute webinar with 15 minutes Q&A
- Bob Hopkins will present the materials, lessons learned, examples
- Direct outreach to Resident Program Directors
  - Email
  - ACP Calendar of Webinars
  - Resident related newsletters
- Two webinar opportunities to reach directors in different time zones
- August 27 afternoon/evening and September 1 morning

# Adult Immunization Residency QI Program Content

A **Facilitator Guide** to help with delivery of the module, including needed equipment, timing and instruction of the program, and active learning tools (see guide, modules, example QI projects, and resource list in folder)

**Module Presentations & Handouts** in PowerPoint and Word format.

- A list of **Example Quality Improvement Projects** to facilitate brainstorming of appropriate projects.
- A comprehensive **Resource List** containing patient education materials, clinical guidelines, and provider tools.
- **Program Evaluations** to assess program impact.

# Adult Immunization and Quality Improvement for Residents

## Module 1 – The Science of Adult Immunization

# Overview

- Module 1 – Science of Adult Immunization
  - Adult immunization rates and recommended vaccine schedule
  - Vaccination among special populations:
    - Diabetics
    - Healthcare workers
    - Pregnant women
    - The elderly
- Module 2 – Quality Improvement in Adult Immunization

# Adult Immunization and Quality Improvement for Residents

## Module 2 – Quality Improvement in Adult Immunization

# Overview

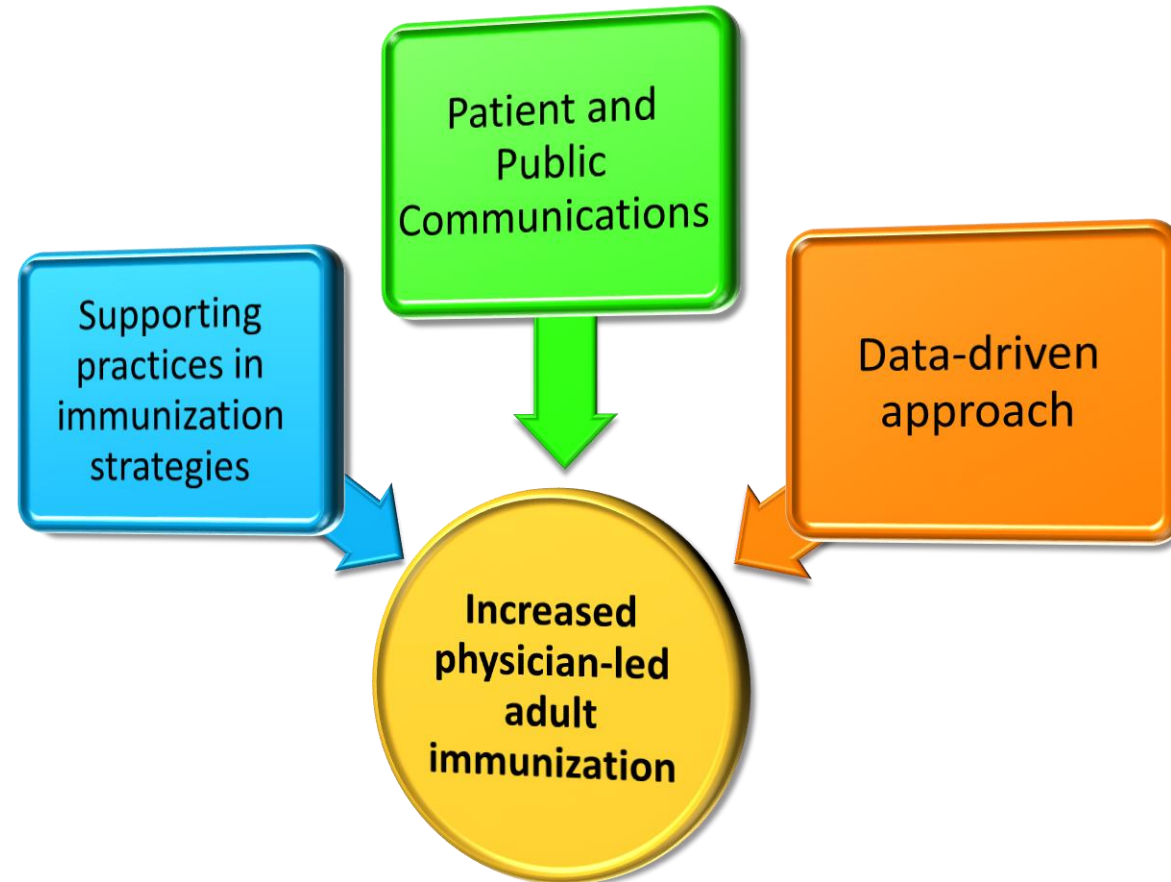
- Module 1 – Science of Adult Immunization
- Module 2 – Quality Improvement in Adult Immunization
  - Standards for Adult Immunization Practice
  - Strategies to Increase Adult Immunization
  - What is Quality Improvement?
  - Example QI Projects
  - Additional Resources

# *I Raise the Rates: Initiative to Raise the Adult Immunization Rates in Primary Care*

An ACP Quality Connect Program



# *I Raise the Rates* Approach to Increasing Adult Immunizations



# Measure Requirements

- Required
  - Influenza Vaccination
  - Pneumonia Vaccination for Older Adults
  - Pneumonia Vaccination for High Risk Individuals
  
- Optional depending on data availability
  - Herpes Zoster (Shingles) vaccination
  - Tetanus, Diphtheria, Acellular, Pertussis (Tdap) vaccination

# Medconcert: Learning and Performance Monitoring Platform

## Welcome Page

The screenshot shows the Medconcert website interface. At the top, there is a navigation bar with the Medconcert logo and several menu items: HOME, APPS, POPULATION, PERFORMANCE, WAYS TO IMPROVE, COMMUNITY, and PORTFOLIO. A search bar and a user profile for James Wrigley are also visible. Below the navigation bar, the main content area features the 'i-RAISE' logo and the title 'ACP I Raise the Rates Platform'. A brief description explains that this is an online tool for collecting, aggregating, and analyzing patient data related to influenza, pneumococcal, shingles, and Tdap vaccinations. To the right, it states 'PROVIDED BY ACP American College of Physicians'. Below this, there is a secondary navigation bar with options: HOME, POPULATION, PERFORMANCE, NETWORK PERFORMANCE, WAYS TO IMPROVE, and CERTIFICATION PROGRAMS. The main heading reads 'Welcome to the American College of Physicians I Raise the Rates Platform'. A sub-heading states 'This powerful tool enables health care providers to:' followed by a bulleted list of benefits: benchmarking performance, identifying care gaps, accessing resources from quality leaders, and connecting with peers. Below the list is a large image of a smiling female doctor. Underneath the image are four circular icons representing key features: 'View Performance' (bar chart), 'Identify Patient Outliers' (person with checkmark), 'View Improvement Tools' (line graph), and 'Quality Reporting' (document). Each icon has a short description of its function. At the bottom, there is a section titled 'What is the ACP I Raise the Rates Platform?' with a paragraph explaining the partnership with CECity and Pfizer.

# The State Partners and Models

## Arkansas

- Lead Partners: ACP Chapter, UAMS, Department of Health, State Registry, Arkansas Pharmacist Association
- Main Data Sources: UAMS EHR, State Registry

## Louisiana:

- Lead Partners: ACP Chapter, LSU HCSD
- Main Data Sources: LSU Clinical Data Warehouse

## New Jersey

- Lead Partners: ACP Chapter, NJIN, St. Francis Medical Center
- Main Data Sources: Aetna, Horizon BCBS

## Florida

- Lead Partners: ACP Chapter
- Main Data Sources: Aetna, Hospital Corporation of America

# *I Raise the Rates* Improvement Tools

- Champion Training
- Practice Assessment Tool
- Practice Coaching
- Webinars
- Focus on Topics Important to Practices (costs, team-based approaches, referral tools, recommendation)
- Data feed into platform

# Webinar and Coaching Calls

- Practices will have opportunity to sign up for individual practice coaching from QI experts
- Webinars: 1 hour webinars at 1PM/ 12 PM CT
  - September 16, 2015: Raising your Rates – Developing Your PDSA – Kathryn Eiler
  - October 22, 2015: Helping Your Patients Raise the Rates: Effectively Recommending Adult Immunizations – Dr. Marie Brown
  - November 2015: Standing Orders – A Model to Fit Your Practice – Drs. Bob Hopkins and LJ Tan
- Future Webinar topics to be scheduled
  - Reminder Recall, Using the Immunization Neighborhood – Immunization Referrals, Ordering, Storage and Handling, IISs, RTI Immunization Business Tool

# Is Adult Immunization as a Clinical Issue Taking Advantage of the QI Policies and Tools?

- What programs exist?
- Have we positioned our measures to be included in various performance reporting programs?