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

**Appetite Assessment During Palliative Care Consultations**

**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, gggreenbe@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

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</tr>
</tbody>
</table>
QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date (this version of the report): 1/23/17

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

Appetite Assessment During Palliative Care Consultations

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 #14c): 7/28/16

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 #29c): 1/19/17

4. Key individuals

a. QI project leader [also responsible for confirming individual’s participation in the project]
   Name: Daniel B. Hinshaw, M.D.
   Title: Professor
   Organizational unit: Palliative Care Program
   Phone number: (734) 845-3072
   Email address: hinshaw@umich.edu
   Mailing address: VAMC (11G), 2215 Fuller 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: Robert Hogikyan, M.D.
   Title: Section Head
   Organizational unit: Geriatric Medicine
   Phone number: (734) 845-3072
   Email address: hogikyan@med.umich.edu
   Mailing address: VAMC (11G), 2215 Fuller Road, Ann Arbor, MI 48105

5. Participants

a. Approximately how many health care providers (by training level for physicians) participated in this QI effort (whether or not for MOC):

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number (fill in)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicing Physicians</td>
<td>6</td>
</tr>
<tr>
<td>Fellows</td>
<td>8</td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td>0</td>
</tr>
<tr>
<td>Nurses (APNP, NP, RN, LPN)</td>
<td>0</td>
</tr>
<tr>
<td>Other Licensed Allied Health (e.g., PT/OT, pharmacists, dieticians, social workers)</td>
<td>0</td>
</tr>
</tbody>
</table>
b. Approximately how many physicians (by specialty/subspecialty and by training level) and physicians’ assistants participated for MOC?

<table>
<thead>
<tr>
<th>Profession</th>
<th>Specialty/Subspecialty (fill in)</th>
<th>Number (fill in)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicing Physicians</td>
<td>Surgery/HPM (1); Geriatric Medicine/HPM (4); Medicine/HPM (1)</td>
<td>6</td>
</tr>
<tr>
<td>Fellows</td>
<td>Geriatric Medicine (4); HPM (4)</td>
<td>8</td>
</tr>
<tr>
<td>Residents</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td>(Not applicable)</td>
<td></td>
</tr>
</tbody>
</table>

6. How was the QI effort funded? (Check all that apply.)

- [X] 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): The patient population includes veterans admitted to the VA Ann Arbor Health Care System with serious life-threatening illnesses who are mostly elderly (> 65 years of age) and who receive inpatient palliative care consultations.

8. General goal

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

Weight loss and/or concerns about poor appetite are highly prevalent in patients with advanced illnesses (e.g., greater than 50% in patients with advanced cancer\(^1\), greater than 30% in patients with advanced congestive heart failure\(^2\), and almost 20% of patients with advanced chronic obstructive pulmonary disease\(^3\)). These concerns not only are a source of distress for patients, but also represent a significant concern for family members and loved ones. Even though poor appetite is a very common source of distress in palliative care patients, we have found in a recent audit of clinical data that it is not consistently being screened for in our inpatient palliative care consults at the VAAAHCS.

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 #13.)

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To improve assessment and documentation of disturbances/changes in appetite in patients receiving inpatient palliative care consultations at the VAAHCS.

9. Which Institute of Medicine Quality Dimensions are addressed? [Check all that apply.]

- Effectiveness
- Efficiency
- Safety
- 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 cognitively capable patients with appetite assessed
- **Measure components** – for a rate, percent, or mean, describe the:
  - Denominator (e.g., for percent, often the number of patients eligible for the measure):
    The total number of patients receiving palliative care consults who are cognitively capable of evaluation.
  - Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
    The number of patients screened for changes in appetite.
- **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 was chosen based on quality measures of similar format used in the past by our team that have been modeled on national measures.
- **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**: Percent of patients with poor appetite who have documentation of poor appetite in consult recommendations
- **Measure components** – for a rate, percent, or mean, describe the:
  - Denominator (e.g., for percent, often the number of patients eligible for the measure):
    The number of patients undergoing palliative care consultations who were assessed for appetite and found to have a poor appetite.
  - Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
The number of patients undergoing palliative care consultations determined to have a poor appetite for whom this finding and related recommendations were documented in the Recommendations Section of the consult.

- **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 was chosen based on quality measures of similar format used in the past by our team that have been modeled on national measures. It represents a secondary refinement of the first measure.

- **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.)*

12. Baseline performance

   a. What were the beginning and end dates for the time period for **baseline** data on the measure(s)? 5/9 to 6/9/2016

   b. 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.)*

<table>
<thead>
<tr>
<th>Period</th>
<th>N of Consults</th>
<th>N of Patients Capable of Being Screened</th>
<th>% of Capable Patients That Were Screened for Appetite</th>
<th>% of Patients Screened That Had Poor Appetite</th>
<th>% of Patients with Poor Appetite That Had It Documented in Consult Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline data: 5/9 to 6/9/2016</td>
<td>26</td>
<td>23</td>
<td>16/23 (70%)</td>
<td>8/16 (50%)</td>
<td>4/8 (50%)</td>
</tr>
</tbody>
</table>

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].)*

   Our goals are:
   - For consults on patients capable of being screened, to improve the percent of patients screened for appetite from a baseline of 70% to ≥ 90%
   - For patients found to have poor appetite, to improve the percent of patients with poor appetite documented in consult recommendations from a baseline of 50% to ≥ 90%

   Both goals are to be achieved from the beginning of the project in July 2016 to the end of the monitoring period (mid-January, 2017) following the second intervention cycle.

   b. How were the performance targets determined, e.g., regional or national benchmarks?
90% thresholds for compliance are common targets for regional as well as national measures.

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.)

a. Who was involved? (e.g., by profession or role) Eight postgraduate fellows training in Geriatric Medicine and Hospice and Palliative Medicine (from 7/1/16 – 6/30/17) and six attending physicians who serve as faculty in the same fellowship training programs at the VAAAHCS.

b. How? (e.g., in a meeting of clinic staff)
Via email discussion and face-to-face meeting on 28 July, 2016.

c. When? (e.g., date(s) when baseline data were reviewed and discussed)
Several days prior to and during face-to-face meeting on 7/28/16.

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:

<table>
<thead>
<tr>
<th>Common Causes</th>
<th>Common Relevant Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals: Are not aware of, don’t understand.</td>
<td>Education about evidence and importance of goal.</td>
</tr>
<tr>
<td>Individuals: Believe performance is OK.</td>
<td>Feedback of performance data.</td>
</tr>
<tr>
<td>Individuals: Cannot remember.</td>
<td>Checklists, reminders.</td>
</tr>
<tr>
<td>Team: Individuals vary in how work is done.</td>
<td>Develop standard work processes.</td>
</tr>
<tr>
<td>Workload: Not enough time.</td>
<td>Reallocate roles and work, review work priorities.</td>
</tr>
<tr>
<td>Suppliers: Problems with provided information/materials.</td>
<td>Work with suppliers to address problems there.</td>
</tr>
</tbody>
</table>

15. What were the primary underlying/root causes for the problem(s) at baseline that the project can address?

Individual physicians: Are not aware of, don’t understand the importance of assessing appetite in this patient population.

16. What intervention(s) addressed this cause?

Educational discussion, review of published data done during meeting on 28 July 2016.

17. Who was involved in carrying out each intervention? (List the professions/roles involved.)

Physicians – both attendings and fellows
appetite now and how has it been over the past six months?” in assessing patients’ appetites during inpatient palliative care consultations. This was felt to be an effective means of eliciting a more detailed description from the patient of any changes or disturbances in appetite, both recent and more remote that would be relevant to the patient’s wellbeing.

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.) 9/1/16

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)?  9/1-30/16.

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.)

Appetite QM Data from First Intervention Cycle

<table>
<thead>
<tr>
<th>Period</th>
<th>N of Consults</th>
<th>N of Consult Patients Capable of Being Screened</th>
<th>% of Capable Patients That Were Screened for Appetite</th>
<th>% of Patients Screened That Had Poor Appetite</th>
<th>% of Patients with Poor Appetite That Had It Documented in Consult Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline data: 5/9 to 6/9/2016</td>
<td>26</td>
<td>23</td>
<td>16/23 (70%)</td>
<td>8/16 (50%)</td>
<td>4/8 (50%)</td>
</tr>
<tr>
<td>1st Intervention Cycle 9/1-30/16</td>
<td>17</td>
<td>14</td>
<td>11/14 (79%)</td>
<td>6/11 (55%)</td>
<td>4/6 (67%)</td>
</tr>
</tbody>
</table>

c. Did the intervention(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)?
There were definite improvements seen, but we did not fully achieve our targeted goal of > 90% compliance with the two measures (please see percentages highlighted in bold).

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.)

a. Who was involved? (e.g., by profession or role)
   ☒ Same as #14?  ☐ Different than #14 (describe):

b. How? (e.g., in a meeting of clinic staff)
   ☐ Same as #14?  ☒ Different than #14 (describe): Email and personal communication among the participants.

c. When? (e.g., date(s) when post-intervention data were reviewed and discussed)
   12/13-19/16.

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.

<table>
<thead>
<tr>
<th>22. What were the primary underlying/root causes for the problem(s) following the intervention(s) that the project can address?</th>
<th>23. What adjustments/second intervention(s) addressed this cause?</th>
<th>24. Who was involved in carrying out each adjustment/second intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teamwork in addressing the need for reminders. In reviewing the results, one team member felt responsible for providing most of the impetus for the project, which depends heavily on reminders. This problem was brought to the attention of all the participants, especially the attending physicians,</td>
<td>The attending physicians made a commitment to provide daily reminders to the team of consultants regarding the importance and commitment to screening for appetite and documenting poor appetite in the recommendations section of palliative care consultations in which the patient has the capacity to be assessed.</td>
<td>Physicians – both attending physicians and fellows, especially attending physicians, will provide the additional leadership regarding reminders.</td>
</tr>
<tr>
<td>Workload as a barrier to performing quality measures. In the review of the results of the first</td>
<td>Again, the need for team work to address these situations cannot be overstated and will be emphasized in anticipation of similar situations</td>
<td>Physicians – both attending physicians and fellows; attending physicians usually serve as backup to</td>
</tr>
</tbody>
</table>
intervention cycle, another major barrier to achieving full compliance with the goals of the project was identified. The unpredictable nature of the workload on a busy consultation service can produce heavy workload on individual days so that individual consultants may feel the need to prioritize between screening for major dominant complaints (e.g., pain) and the more complete evaluation that ideally would be done when there are fewer time constraints.

arising in the future. Other members of the interdisciplinary team who also see the patients during the consultation process have made a commitment to make sure that screening for this symptom occurs and will inform/remind the individual preparing the consult of the screening results.

fellows in the consultation process. This backup role also applies to assisting in performing the quality measures. Also, other interdisciplinary team members (e.g., nurse, social worker) assist in the process when workload demands surge unexpectedly.

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.)

12/19/16.

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)? 12/19/16 – 1/15/17

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.)

Appetite QM Data from Second Intervention Cycle

<table>
<thead>
<tr>
<th>Period</th>
<th>N of Consults</th>
<th>N of Consult Patients Capable of Being Screened</th>
<th>% of Capable Patients That Were Screened for Appetite</th>
<th>% of Patients Screened That Had Poor Appetite</th>
<th>% of Patients with Poor Appetite That Had It Documented in Consult Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline data: 5/9 to 6/9/2016</td>
<td>26</td>
<td>23</td>
<td>16/23 (70%)</td>
<td>8/16 (50%)</td>
<td>4/8 (50%)</td>
</tr>
</tbody>
</table>
c. Did the adjustment(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)? Yes.

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

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.)
   a. Who was involved? (e.g., by profession or role)
      ☒ Same as #21? ☐ Different than #21 (describe):

   b. How? (e.g., in a meeting of clinic staff)
      ☐ Same as #21? ☒ Different than #21 (describe): Via email reporting/feedback but also in a face-to-face meeting scheduled for 1/19/17.

   c. When? (e.g., date(s) when post-adjustment data were reviewed and discussed)
      From 1/16-19/17 via email and in a face-to-face meeting and discussion on 1/19/17.

   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.

<table>
<thead>
<tr>
<th>1st Intervention Cycle</th>
<th>17</th>
<th>14</th>
<th>11/14 (79%)</th>
<th>6/11 (55%)</th>
<th>4/6 (67%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9/1-30/16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2nd Intervention Cycle</th>
<th>20</th>
<th>18</th>
<th>18/18 (100%)</th>
<th>10/18 (56%)</th>
<th>10/10 (100%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cycle 12/19/16 to 1/15/17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

30. What were the primary underlying/root causes for the problem(s) following the adjustment(s) that the
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.)
**University of Michigan Health System Part IV Maintenance of Certification Program**

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 (i.e. problems in implementing interventions listed in #16 and #23) that were encountered during this QI effort and how they were addressed.

No barriers to change were encountered in this last intervention cycle. The key issue identified during the course of the project was the need to make an ongoing commitment as a team and as supervisory attending physicians to facilitate daily reminders regarding the QM screens.

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

An interesting and consistent finding coming out of the data collection from the baseline period of observation and extending through both intervention cycles was the observation that between 50-60% of palliative care patients who were capable of being screened had poor appetites. The finding of such a high prevalence of this symptom in our elderly palliative care consult population underscores the importance of screening for appetite during the consultation process. Poor appetite is often a major contributor to poor quality of life at the end of life. The other practical lessons learned from the project are the need for frequent reminders and a real commitment from the entire team, especially physician leadership, to the process.

Feedback and discussion of the project by participants between 1/16/17 and including the face-to-face meeting on 1/19/17 considered priorities for future improvement in this aspect of care and possible new improvement initiatives related to it.

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

Team and physician leadership investment in the process of screening for poor appetite.

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

This report will be made available to other members of the palliative care program and geriatrics medicine division at the University of Michigan Medical Center, Children’s Hospital, and Geriatrics Center Clinics.

37. Describe any plans for sustaining the changes that were made.
This will require a continuing commitment on the part of all physicians involved in the project. The fact that over 50% of patients screened had poor appetite will serve as a powerful impetus to continue use of the screen.

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? We will share the report with the palliative care services at other training sites (UMMC and Mott Children’s Hospital).
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):
  • 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): Section of Geriatric Medicine
  • 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):

☐ Yes   ☒ No   Presentation (verbal or poster) at a regional or national meeting?
☐ Yes   ☒ No   Manuscript for publication?
Participants in the project: Assessment of Appetite During Palliative Care Consultations

All participants are requesting MOC Part IV credit.

**Attending Physicians:**

Neil Alexander, M.D.
Daniel Hinshaw, M.D.
Robert Hogikyan, M.D.
Ellen Hummel, M.D.
 Marcos Montagnini, M.D.
 Caroline Vitale, M.D.

**Postgraduate Fellows in Geriatric Medicine:**

Jawid Darvesh, M.D.
Sairia Dass Ramcharan, M.D., D. Phil
Meredith Gilliam, M.D.
 Yao Yao Pollock, M.D.

**Postgraduate Fellows in Hospice and Palliative Medicine:**

Shawna O’Reilly, D.O.
Clare O’Keefe Riotte, D.O.
Laura Taylor, M.D.
Lyle Walton, M.D.