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

Confusion Assessment in 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:
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Report Outline

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QI Project Report for Part IV MOC Eligibility

A. Introduction

1. **Date** *(this version of the report):*
   22 August 2016

2. **Title of QI effort/project** *(also insert at top of front page)***:**
   Confusion Assessment in 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)**:***
      9/23/15.

   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)*:
      6/30/16

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; staff physician
      Organizational unit: Geriatric and Palliative Medicine Section VA Ann Arbor Health Care System
      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 and Palliative Medicine Section VA Ann Arbor Health Care System
      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)***:**

Profession	**Number** *(fill in)*
Practicing Physicians	6
Residents/Fellows	9
Physicians' Assistants	
Nurses (APNP, NP, RN, LPN)	
Other Licensed Allied Health (e.g., PT/OT, pharmacists, dieticians, social workers)	

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*	Hospice/Palliative Medicine (4) & Geriatric Medicine (4) & Surgery (1)	6
Fellows	Geriatric Medicine (5) & Hospice and Palliative Medicine (4)	9
Residents		
Physicians' Assistants	*(Not applicable)*	

* Some of the practicing physicians have dual specialization, thus the larger number reflected in parentheses.

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 with advanced illnesses receiving palliative care consultations as inpatients at the VA Ann Arbor Health Care System (VAAAHCS).

8. General goal

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

Cognitive impairment manifested as varying degrees of confusion/delirium is a very common problem in older hospitalized patients. Identifying the presence and degree of confusion/delirium is important for the quality and safety of care provided to these patients. The presence of confusion/delirium can affect treatment, e.g., avoid medications that may exacerbate confusion/delirium, and may initiate referral for formal psychiatric evaluation for delirium.

Although the seriously ill patients seen in consultation by the palliative care service are at substantial risk for confusion, screening for confusion in a consistent fashion has not been a routine component of palliative care consultations performed at our medical center or at other medical centers. The main constraint has been the time required to use the tools typically employed to formally assess for delirium. However, recent studies have demonstrated a high degree of reliability associated with two very simple and rapid measures of attention and level of alertness, i.e., the ability to recite the months of the year in reverse order correctly within 30 seconds and determination of the patient's state of alertness (hypo- or hyper-active vs. normal), respectively.

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.)
To improve the quality of palliative care consultations and the safety of palliative care recommendations based on more consistent evaluation and consideration of patient confusion during the consultation process.

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:** Confusion Screen – Percent of eligible inpatient palliative care consults with confusion assessment documented in consult
- **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 inpatient palliative care consultations for which screening for confusion was documented as possible in the consultation in the electronic health record (EHR)

  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:
  The number of these inpatient consultations in which screening for confusion occurred and was documented in the EHR

- **The source of the measure is:**

At baseline, an internally developed measure was used to determine whether screening for confusion occurred and was documented.

Following review of baseline data, the measure was refined (further restricted) to be whether screening for confusion occurred and was documented using an external ultra-short confusion screening tool, the Bedside Confusion Scale. The scale and its source are noted below.

Parameter	Scoring
I. Assess Level of Alertness	Normal = 0 Hyperactive = 1 Hypoactive = 1
II. Test of Attention – a timed recitation of the months of the year in reverse order starting with December	Delay greater than 30 seconds – add 1 point One omission – add 1 point Two omissions – add 2 points Two omissions, reversal of task or termination of task – add 3 points

	Inability to perform – add 4 points *
Total Score: Combine the scores from sections I & II	0 = normal 1 = borderline 2 and above = confused

Sarhill N, Walsh D, Nelson KA, LeGrand S, Davis MP. Assessment of delirium in advanced cancer: the use of the Bedside Confusion Scale. *Am J Hosp Palliat Care* 2001; 18 (5): 335-341.

- **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 (Note: This measure was added after baseline data collection)

- **Name of measure:** Percent of inpatient palliative care consults with positive confusion assessments documenting concern for confusion 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 inpatient palliative care consultations in which the screen for confusion was positive (from Measure 1)

  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:
  The number of these patients in which confusion was documented as part of the Recommendations section of the consult in the EHR
- **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 is a logical extension of screening for confusion to documentation of positive screens (i.e., confusion and possible delirium) as a part of informing the recommendations offered as the ultimate product of the consultation.
- **This is a measure of:**
  - ☒ Process – activities of delivering health care to patients (*acting on/responding to an outcome, i.e., positive screen for confusion*)
  - ☐ 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 <u>baseline</u> data on the measure(s)?
8/3/15 – 8/27/15

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.)*

Time Period	Number of inpatient palliative care consults	Number of inpatient palliative care consults in which screen for	Percent of inpatient palliative care consults with confusion or

		confusion possible [a]	delirium documented in consult
Baseline: 8/3/15 – 8/27/15	26	25	12% (3/25)

[a] In one consult, patient was comatose and moribund. In three consults delirium was noted, in another three lack of capacity for decision making was noted, and in one a malignant brain tumor was present without direct comment on capacity or confusion.

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]."*

1) The primary aim is for patients presenting for inpatient palliative care consultations at VAAAHCS, to increase the percentage who are screened for confusion during palliative care consultations from a baseline of 12% to ≥ 90% during the two cycles of improvement from 9/25/15 to 8/10/16.

2) After baseline data collection a second aim was added: for the above patients who screen positive for confusion, to increase the percentage whose consultation recommendations include a direct reference to the positive confusion screen to ≥ 90% (no pre-intervention baseline) during the two cycles of improvement from 9/25/15 to 8/10/16.

b. How were the performance targets determined, e.g., regional or national benchmarks? The targets of ≥ 90% were developed internally as reasonable targets given the importance of this aspect of care and the more efficient methods available to provide the screening.

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)* Fifteen physicians participated in the project. They included six attending physicians and nine postgraduate fellows training in Geriatric Medicine or Hospice and Palliative Medicine

b. How? *(e.g., in a meeting of clinic staff)* Discussions occurred both via email review as well as face-to-face meetings between project leads and trainees.

c. **When?** *(e.g., date(s) when baseline data were reviewed and discussed)* In addition to email exchanges earlier in September 2015, a face-to-face meeting occurred with postgraduate medical fellows on 9/23/15 at the VA GRECC conference room in which the baseline data shown above were reviewed in detail, especially in light of recent literature describing more user-friendly, rapid screening methods for confusion.

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***

Individuals: Are not aware of, don't understand.	*Education about evidence and importance of goal.*
Individuals: Believe performance is OK.	*Feedback of performance data.*
Individuals: Cannot remember.	*Checklists, reminders.*
Team: Individuals vary in how work is done.	*Develop standard work processes.*
Workload: Not enough time.	*Reallocate roles and work, review work priorities.*
Suppliers: Problems with provided information/materials.	*Work with suppliers to address problems there.*

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 uncertain about the importance of routine confusion assessments	Education about the importance of routine confusion assessments.	Attending physicians and physician postgraduate medical trainees (fellows)
Physicians unaware of low performance of routine confusion assessments	Feedback of baseline performance data showing low assessment rate.	Same
Inconvenience and time-consuming nature of previous screening methods.	Education about new, more rapid screening tools, how to use them, and the clinical implications of the screening results.	Same
Different approaches regarding screening, documentation, and actions based on screening results	Standard procedures for: • Screening for confusion during the initial palliative care consultation using an ultra-brief screening tool. • Documenting the result in the consult. • If screening result is positive, add in the formal recommendation section of the consult: - a specific recommendation to consider further evaluation for delirium and/or - additional relevant recommendations related to the impact of confusion on the other recommendations being considered/offered by the palliative care consultant.	Same

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 initiate*d.) 9/23/15

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:
The population is the same. After evaluating the baseline data, the measure of screening performed was refined to be specifically the use of the Bedside Confusion Scale – a more restrictive operational measure than used at baseline. A second measure was added to assess the documentation for positive confusion screens in the Recommendations section of inpatient palliative care consults.

20. 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)? 12/21/15 – 1/17/16

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.)*

Time Period	Number of inpatient palliative care consults	Number of inpatient palliative care consults in which confusion assessment possible	Percent of eligible inpatient palliative care consults with confusion assessment documented in consult	Percent of inpatient palliative care consults with positive confusion assessments documenting concern for confusion in consult recommendations
Baseline: 8/3/15 – 8/27/15	26	25	12% (3/25)	(NA)
Post-intervention 12/21/15 – 1/17/16	33	29 [a]	100% (29/29)	94% (15/16)

Note that 16/29 patients seen by the palliative care consultation service (~55%) who could be evaluated using the bedside confusion scale were confused (and likely delirious).

[a] Of the four patients who could not be evaluated using the bedside confusion scale, three were either too fatigued or obtunded to participate and one was so short of breath, he could not participate.

c. Did the intervention(s) produce the expected improvement toward meeting the project's specific aim (item 13.a)?
Yes. Overall, we had an excellent performance in the first intervention cycle with 100% compliance with the primary measure and > 90% compliance with the secondary measure. It was particularly interesting and important to note that *more than half* of patients seen by the palliative care consultation service screened positive for confusion on the bedside confusion scale. This reinforces other observations in the literature of the high incidence of delirium in very ill elderly hospitalized patients and also validates the importance of using this screening tool.

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):*

c. **When?** *(e.g., date(s) when post-intervention data were reviewed and discussed)*
The data were initially reviewed and discussed via email with all participants in late January and early February of 2016. They were also reviewed again in person with trainees and staff before starting collection of the second intervention cycle data in early May 2016.

Use the following table to outline the next plan that was developed: #22 the primary causes, #23 the adjustments(s)/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 problem(s) following the intervention(s) 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.)*
The initial interventions resulted in the performance achieving the targeted specific aims. Our review of post-intervention data identified no further causes that were feasible or cost/effective to address. The concern was whether the high rate of performance would be sustained over time.	Feedback was provided regarding the major performance improvement and participants were encouraged to continue the changes previously implemented. (No other changes/adjustments.)	Attending physician and postgraduate medical trainee participants.

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 initiate*d.)
On 5/9/16 the feedback and discussion to continue existing interventions occurred.

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 <u>post-adjustment</u> data on the measure(s)? 5/9/16 – 6/9/16

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.)*

Time Period	Number of inpatient palliative care consults	Number of inpatient palliative care consults in which confusion assessment possible	Percent of eligible inpatient palliative care consults with confusion assessment documented in consult	Percent of inpatient palliative care consults with positive confusion assessments documenting concern for confusion in consult recommendations
Baseline: 8/3/15 – 8/27/15	26	25	12% (3/25)	(NA)
Post-intervention 12/21/15 – 1/17/16	33	29	100% (29/29)	94% (15/16)
Post-adjustment 5/9/16 – 6/9/16	26	23	91% (21/23)	92% (11/12)

Note: of the 21 patients screened for confusion in the second intervention cycle, 12/21 (57.%) screened positive for confusion using the Bedside Confusion Scale. This is quite comparable with the percentage of patients who screened positive for confusion (16/29 or 55.2%) in the first intervention cycle. The quick screening tool is identifying slightly more than half of all inpatients receiving palliative care consultations as being confused. This observation highlights the value of using this quick screen for confusion as a standard part of palliative care consultations, especially in hospitalized elderly patients with advanced illnesses.

c. Did the adjustment(s) produce the expected improvement toward meeting the project's specific aim (item 13.a)?
Yes. Improvement was sustained above the targets of ≥ 90%.

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):*

c. **When?** *(e.g., date(s) when post-adjustment data were reviewed and discussed)* During early August 2016 via email, predominantly, due to departures of postgraduate medical trainees.

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 problem(s) following the adjustment(s) 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.)*
An ongoing concern is that external factors (e.g., staff turnover, changes in EMR documentation) might result in performance not being sustained.	Feedback on continued high performance was provided. Ideally, electronic prompts for the bedside confusion scale could be added in the palliative care and geriatric medicine consult templates in the EHR.	Attending physician and postgraduate medical trainee participants.

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 (i.e. problems in implementing interventions listed in #16 and #23) that were encountered during this QI effort and how they were addressed.
There were no major barriers to implementing the interventions listed. There were some challenges in data collection and recording for the second intervention cycle, which were resolved after further review of the EHR. (See "key lessons" below.)

34. Describe any key lessons that were learned as a result of the QI effort.
The old adage about "too many cooks in the kitchen" applies to projects involving multiple reporters. However, the educational value of having multiple participants directly involved in data collection and review outweighs the challenges of potential confusion caused by misinterpretation of categories in Excel Spreadsheets where sometimes "yes" may seem to mean "no" or vice versa. Ultimately, such problems are resolved by double-checking the data in the EHR against the defined categories listed in the spreadsheet.

35. Describe any best practices that came out of the QI effort.
Clearly, screening for confusion in the inpatient palliative care consult population is a valuable addition to the standard consult process, since there was a consistent finding of over 50% of patients screening positive for confusion, which has important implications for the recommendations made in such consults. The ultra-fast screening tool makes the process very simple and easy to perform. The challenge is to remember to document the findings and not to over interpret a positive screen. A positive screen should raise concerns about the very real possibility of delirium being present and the need for caution in recommending medications that may exacerbate confusion/delirium as well as serious consideration, if appropriate, for further formal (psychiatric) evaluation for delirium.

36. Describe any plans for spreading improvements, best practices, and key lessons.
The findings in this report will be shared with, and the report itself offered to, colleagues in other venues within the VAAAHCS and UMHS.

37. Describe any plans for sustaining the changes that were made.
Standard training for new faculty and for new fellows now includes performing and documenting the screening for confusion and documenting relevant concerns in the consultation notes.

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?
This report will be shared with the clinical supervisor at VAAAHCS (Dr. Hogikyan) and the Division Chief of Geriatric Medicine and Hospice and Palliative Medicine at UMHS (Dr. Ray Yung) who may share it with other clinical units and the medical centers' QA programs.

☐ 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):*
- **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):* Geriatrics and Palliative Medicine Section
- **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):*

Participants Seeking 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.

Geriatric Medicine Fellows (2015-2016):
Jonathan Beaulac, D.O.
Rabeya Begum, D.O.
Fareeha Khan, M.B., B.S.
Shirley Tom, M.D.
Lyle Walton, M.D.

Hospice and Palliative Medicine Fellows (2015-2016):
Roman Barraza, M.D., Ph.D.
Anthony Grech, M.D.
Tracy Hills, D.O.
Lauren Wancata, M.D.*
*Dr. Wancata will complete her primary specialty training in General Surgery in 2018 and thus may not need or qualify for MOC credit at this point.