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

Constipation, Screening and Management in Palliative Care Patients Prescribed Opioids (Continued, Titrated, or Initiated)

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:
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

<table>
<thead>
<tr>
<th>Section</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Introduction</td>
<td>1-6. Current date, title, time frame, key individuals, participants, funding</td>
</tr>
<tr>
<td>B. Plan</td>
<td>7-10. Patient population, general goal, IOM quality dimensions, ACGME/ABMS competencies</td>
</tr>
<tr>
<td></td>
<td>11-13. Measures, baseline performance, specific aims</td>
</tr>
<tr>
<td></td>
<td>14-17. Baseline data review, underlying (root) causes, interventions, who will implement</td>
</tr>
<tr>
<td>C. Do</td>
<td>18. Intervention implementation date</td>
</tr>
<tr>
<td>D. Check</td>
<td>19-20. Post-intervention performance</td>
</tr>
<tr>
<td>E. Adjust – Replan</td>
<td>21-24. Post-intervention data review, underlying causes, adjustments, who will implement</td>
</tr>
<tr>
<td>F. Redo</td>
<td>25. Adjustment implementation date</td>
</tr>
<tr>
<td>H. Readjust plan</td>
<td>29-32. Post-adjustment data review, underlying causes, further adjustments, who will implement</td>
</tr>
<tr>
<td>I. Reflections &amp; plans</td>
<td>33-37. Barriers, lessons, best practices, spread, sustain</td>
</tr>
<tr>
<td>J. Participation for MOC</td>
<td>38-40. Participation in key activities, other options, other requirements</td>
</tr>
<tr>
<td>K. Sharing results</td>
<td>41. Plans for report, presentation, publication</td>
</tr>
<tr>
<td>L. Organization affiliation</td>
<td>42. Part of UMHS, AAVA, other affiliation with UMHS</td>
</tr>
</tbody>
</table>
QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date (this version of the report): November 4, 2016

2. Title of QI effort/project:

Constipation, Screening and Management in Palliative Care Patients Prescribed Opioids (Continued, Titrated, or Initiated)

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):

      March 14, 2016

   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):

      November 2, 2016

4. Key individuals
   a. QI project leader [also responsible for confirming individual’s participation in the project]
      Name: Patricia Keefer, MD and Adam Marks, MD
      Title: Clinical Assistant Professors
      Organizational unit: Division of Geriatrics and Palliative Medicine, Adult Palliative Care Program
      Phone number: 734-615-7845 (Keefer)
      Email address: pkeefer@med.umich.edu
      Mailing address: 1540 E Hospital Drive, Ann Arbor, MI 48109

   b. Clinical leader to whom the project leader reports regarding the project [responsible for overseeing/"sponsoring” the project within the specific clinical setting]
      Name: Phil Rodgers, MD
      Title: Clinical Associate Professor
      Organizational unit: Adult Palliative Care Program
      Phone number: 734-936-8357
      Email address: prodgers@med.umich.edu
      Mailing address: 1500 E Medical Center Drive, Ann Arbor, 48109

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        | 7                |
      | Residents/Fellows            | 0                |
      | Physicians’ Assistants       | 0                |
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>Hospice and Palliative Medicine (Family Medicine, Internal Medicine, Pediatrics)</td>
<td>7</td>
</tr>
<tr>
<td>Fellows</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Residents</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td>(Not applicable)</td>
<td>0</td>
</tr>
</tbody>
</table>

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 receiving new consultation after discharge and rehospitalization from the University Hospital Adult Inpatient Palliative Care Service

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?

Palliative Care consultations frequently involve challenging symptom management, including initiation and titration (up or down) of opioid pain medications. One of the most common side effects of opioids can also be the most challenging to address and relieve: constipation. While this side effect is well known, it is also under-recognized and under-treated. This project aims to improve screening for constipation and bowel regimen and then improve management in patients who screen positive for constipation or opioid use.

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.)
Improving screening, assessment, and management of opioid-related constipation

9. **Which Institute of Medicine Quality Dimensions are addressed?** [Check all that apply.]
   
   ![Checklist](http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20report%20brief.pdf)

   ☒ Effectiveness  ☐ Equity  ☒ Safety  

   ☐ Efficiency  ☐ Patient-Centeredness  ☐ Timeliness

10. **Which ACGME/ABMS core competencies are addressed?** (Check all that apply.)

   ![Checklist](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.)*

   The measures were based on all patients receiving new consultation (or re-consultation after discharge and rehospitalization) during the observation period.

   The following checklist will be tallied for each patient based on information in the initial consultation note:

   A. Is the patient already prescribed an opioid and continuing the prescription at the same dose and frequency?  Yes/no

   B. Is the patient who is already prescribed an opioid having a change in the opioid, the dose, or the frequency?  Yes/no

   C. Is the patient not previously on an opioid being prescribed an opioid?  Yes/no

   D. Is there documentation in the initial consultation note of presence or absence of bowel movement concerns, e.g., constipation, diarrhea, or bowel movement?  Yes/no

   E. Is there documentation in the initial consultation note of presence or absence a prior bowel regimen?  Yes/no

   F. Is there documentation in the initial consultation note of the presence or absence of a new or changed bowel regimen?  Yes/no

   G. In the initial consultation note is the current bowel regimen (continuation of previously initiated or new/changed recommended) appropriate?  Yes/no

   **Measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Equation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence/absence of bowel movement concerns is documented in initial consultation note</td>
<td>$\frac{D}{A+B+C}$</td>
</tr>
</tbody>
</table>
University of Michigan Health System Part IV Maintenance of Certification Program

| Presence/absence of prior bowel regimen is documented in initial consultation note | E \_A+B+C |
| Presence/absence of new or changed bowel regimen recommendation is documented in initial consultation note | F \_A+B+C |
| Current bowel regimen (continuation of previous or new/changed) that is documented in initial consultation note is appropriate | G \_A+B+C |

- **The source of the measures is:**
  - ☐ An external organization/agency, which is *(name the source)*:
  - ☒ Internal to our organization and it was chosen because *(describe rationale)*:

- **These are measures 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)?**

      January 1-February 29, 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.)*

      Please see attachment.

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].”)*

      By the end of two cycles of improvement effort (8/31/16) this project aims to improve in the documentation for an initial consultation note:
      - Presence/absence of bowel movement concerns from 67% to 100%
      - Presence/absence of prior bowel regimen at 93% is maintained > 90%
      - Presence/absence of new or changed bowel regimen recommendation from 27% to > 50%
      - Current bowel movement being appropriate from 63% to > 66%

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

      Performance targets were based on standard of care as determined by the physician workgroup.
and based on best practices. No specific targets are set in existing guidelines through the CDC, NICE (UK), Canadian.

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)
      All physician participants
   
   b. How? (e.g., in a meeting of clinic staff)
      Staff meeting, root cause analysis attached
   
   c. When? (e.g., date(s) when baseline data were reviewed and discussed)
      April 15, 2016

   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](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?

16. What intervention(s) addressed this cause?

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

<table>
<thead>
<tr>
<th>Poor documentation of bowel movement – likely due to team members having different views and expectations regarding documentation</th>
<th>Developed template in the EMR for standard information to document regarding bowel movements</th>
<th>Physician, nurse practitioners, residents and fellows</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of perceived importance</td>
<td>Education about importance and how to use template to document</td>
<td>Physician, nurse practitioners, residents and fellows</td>
</tr>
</tbody>
</table>

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.)

   May 1, 2016

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)?

May 1-31, 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 attachment.

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

Interventions improved all four measures except initial bowel regimen documentation (which was essentially stable 93% → 92%).

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):

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

June 21, 2016

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 problem(s) following the | 23. What adjustments/second intervention(s) addressed this cause? | 24. Who was involved in carrying out each adjustment/second intervention? (List the |
### intervention(s) that the project can address?

| Poor documentation of bowel regimen – template was available, but not all team members used it regularly, likely due to poor awareness of new nurse practitioners added in April and May and rotation of residents | Facilitated use of template by adding drop-down menus Email education to entire care team | Physician, nurse practitioners, residents and fellows |
| New staff were not familiar with expectations for assessments to be performed and documented | Training about importance of this care, how to perform it, and how to document it. Now performed on rolling/ongoing basis as new staff come in | Physician, nurse practitioners, residents and fellows |

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.)*

8/1/2016

### 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)?**

   August 1-31, 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.)*

   Please see attachment.

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

   Interestingly, interventions at this point did not all lead to improvements. Bowel movement documentation was sustained as an improvement, although cycle 2 had slightly lower numbers than the first cycle. Bowel regimen documentation was also fairly stable (93-92-91%). New regimen documentation numbers did not show sustained improvement, and actually decreased from prior numbers as did the current regimen appropriate. This suggests that more work needs to be done to improve sustainability after initial cycle and education.
University of Michigan Health System Part IV Maintenance of Certification Program

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)
      October 28-November 2, 2016

   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>30. What were the primary underlying/root causes for the problem(s) following the adjustment(s) that the project can address?</th>
<th>31. What further adjustments/intervention(s) might address this cause?</th>
<th>32. Who would be involved in carrying out each further adjustment/intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New people not knowing about templates – new nurse practitioners added in June – August and new Fellows starting in July, Use of templates not recalled by attendings previously trained, then off service, then rotating back on service</td>
<td>For personnel new to service or rotating back on service, on the work day before starting on the service provide education regarding care expectations and documentation using templates</td>
<td>Physicians, mid-level providers</td>
</tr>
</tbody>
</table>
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.

Building templates was feasible in MiChart, however, more intricate design (drop-downs, forced fields for signing) were beyond the scope of what might be feasible during this time period given long waits for MiChart/EMR changes. In addition, in the midst of improvement, we also greatly expanded our team, going from 2 to 5 nurse practitioners. This led to people with less experience trying to implement improvement while still learning the aspects of their job. Data analysis by chart review was also more onerous in data collection and analysis.

34. Describe any key lessons that were learned as a result of the QI effort.
   - It is difficult to implement change during major team changes.

35. Describe any best practices that came out of the QI effort.
   - Standardizing documentation by using templates improves care by helping everyone communicate and understand clinical information in a similar way — writing, editing, and reading.

36. Describe any plans for spreading improvements, best practices, and key lessons.
   - Share project with Pediatric Palliative Care Program.

37. Describe any plans for sustaining the changes that were made.
   - Ongoing plans to continue use of the template and drop-down menu, continue to educate around this topic.

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): Adult Palliative Care Program
        • 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):
Appendix:
Root Cause Analysis from April 14, 2016 meeting.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Baseline</th>
<th>Post-Intervention</th>
<th>Post-Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Patients</strong></td>
<td>72</td>
<td>24</td>
<td>96</td>
</tr>
<tr>
<td>Presence/absence of bowel movement concerns is documented in initial consultation</td>
<td>67%</td>
<td>75%</td>
<td>73%</td>
</tr>
<tr>
<td>note (goal: 100%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence/absence of prior bowel regimen is documented in initial consultation note</td>
<td>93%</td>
<td>92%</td>
<td>91%</td>
</tr>
<tr>
<td>(goal: &gt;90%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presence/absence of new or changed bowel regimen recommendation is documented in</td>
<td>27%</td>
<td>33%</td>
<td>26%</td>
</tr>
<tr>
<td>initial consultation note (goal: &gt;50%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current bowel regimen (continuation of previous or new/changed) that is documented</td>
<td>63%</td>
<td>71%</td>
<td>55%</td>
</tr>
<tr>
<td>in initial consultation note is appropriate (goal: &gt;66%)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>