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

Improving Communication with Families

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

Section	Items	
A. Introduction	1-6.	Current date, title, time frame, key individuals, participants, funding
B. Plan	7-10.	Patient population, general goal, IOM quality dimensions, ACGME/ABMS competencies
	11-13.	Measures, baseline performance, specific aims
	14-17.	Baseline data review, underlying (root) causes, interventions, who will implement
C. Do	18.	Intervention implementation date
D. Check	19-20.	Post-intervention performance
E. Adjust – Replan	21-24.	Post-intervention data review, underlying causes, adjustments, who will implement
F. Redo	25.	Adjustment implementation date
G. Recheck	26-28.	Post-adjustment performance, summary of individual performance
H. Readjust plan	29-32.	Post-adjustment data review, underlying causes, further adjustments, who will implement
I. Reflections & plans	33-37.	Barriers, lessons, best practices, spread, sustain
J. Participation for MOC	38-40.	Participation in key activities, other options, other requirements
K. Sharing results	41.	Plans for report, presentation, publication
L. Organization affiliation	42.	Part of UMHS, AAVA, other affiliation with UMHS

QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date *(this version of the report):* 12/4/2017

2. Title of QI effort/project *(also insert at top of front page)***:** Improving Communication with Families by providing patient-specific written instructions regarding medication management, laboratory evaluation and follow-up.

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)**:*** 2/1/17

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)*: 12/4/2017

4. Key individuals

a. QI project leader *[also responsible for confirming individual's participation in the project]*
Name: Dr Rama Jasty
Title: Attending Physician
Organizational unit: Pediatric Oncology
Phone number: 734-936-9814
Email address: rjasty@umich.edu
Mailing address: 1540 E Medical Center Drive, Ann Arbor, MI 48109

b. Clinical leader who oversees project leader regarding the project *[responsible for overseeing/"sponsoring" the project within the specific clinical setting]*
Name: Lynn Slagle
Title: Nurse Practitioner
Organizational unit: Pediatric Oncology
Phone number: 734-936-9814
Email address: sink@umich.edu
Mailing address: 1540 E Hospital Drive, Ann Arbor, MI

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	11
Residents/Fellows	2
Physicians' Assistants	
Nurses (APNP, NP, RN, LPN)	6
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	Pediatric Hematology Oncology	11
Fellows	Pediatric Hematology Oncology	2
Residents		
Physicians' Assistants	*(Not applicable)*	

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

- ☒ Internal institutional funds (e.g., regular pay/work, specially allocated)
- ☐ Grant/gift from pharmaceutical or medical device manufacturer
- ☐ Grant/gift from other source (e.g., government, insurance company)
- ☐ Subscription payments by participants
- ☐ Other source *(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)***:**
Pediatric Oncology Patients in the Pediatric Hematology/Oncology Clinic at the University of Michigan.

8. General purpose.

a. Problem with patient care ("gap" between desired state and current state)

(1) What should be occurring and why should it occur (benefits of doing this)?
Studies have shown that patients generally cannot remember the details of all of the information and instructions provided verbally during a visit, particularly visits for a significant medical condition involving complex information regarding diagnosis, treatment, and management. Studies have also demonstrated that providing patients with written copies of instructions that they are to perform following the visit increases the likelihood that patients will remember and follow the instructions. We should be providing families with written instructions regarding medication changes, additions, deletions, schedule of when to have labs checked and any other important patient instructions that they need to follow.

(2) What is occurring now and why is this a concern (costs/harms)?
We are not consistently providing families with written documentation of our instructions which can lead to miscommunication and errors in treatment.

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.)
By providing written instructions to families at the time of visit, we expect that the patient and family will have a better understanding of the care plan and be more likely to follow the plan. Written instructions should also increase the confidence and comfort level of the family in caring for the patient.

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** *(e.g., Percent of . . ., Mean of . . ., Frequency of . . .)***:**
  Percent of patient visits with documentation of "patient instructions" in EMR (MiChart)

Measure components – *describe the:*

- Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:
  210 randomly selected patient charts from visits in the Pediatric Hematology/Oncology Clinic (30 charts from each sub-specialty clinic type of 5 services: Oncology [3 clinic days], Immuno-Hematology, Coagulation, Sickle Cell and Brain Tumor)

- Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*: Number of charts showing visits with patient instructions given and documented in EMR (MiChart).

- **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)*:
    Based on expert opinion of local leaders that this measure would reflect a meaningful improvement in care delivery to pediatric hem/onc patients and their families.
- **This is a measure of:**
  - ☒ Process – activities of delivering health care to patients
  - ☐ Outcome – health state of a patient resulting from health care

12. Baseline performance

a. What were the beginning and end dates for the time period for <u>baseline</u> data on the measure(s)? 2/1/17-2/28/17

b. **What was (were) the performance level(s) at baseline?** *Display in a data table, bar graph, or run chart (line graph). Can show baseline data only here or refer to a display of data for all time periods attached at end of report. Show baseline time period, measure names, number of observations for each measure, and performance level for each measure.*

Clinic Type	***Baseline 3/29/17*** ***Instructions Present:***
Oncology Monday	***1/30 – 3.3%***
Oncology Tuesday	***1/30- 3.3%***
Oncology Thursday	***0/30- 0%***
Coagulation	***6/30- 20%***
Sickle Cell	***1/30- 3.3%***
Brain Tumor	***2/30- 6.6%***
Hematology	***16/30- 53%***

Total PHO CLINICS 27/210- 13%

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]."*

We will improve the number of pediatric oncology patients who received written instructions in their discharge summary from clinic from 13% to over 50% by December 2017.

b. How were the performance targets determined, e.g., regional or national benchmarks? Locally determined through discussion with providers.

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)* Lynn Slagle PNP, Dr Rama Jasty and PHO providers

b. How? *(e.g., in a meeting of clinic staff)* Discussed in a clinic meeting and via email.

c. **When?** *(e.g., date(s) when baseline data were reviewed and discussed)* March 2017

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 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.)*
Providers are not aware of the availability of tools in the Electronic Medical Record to create patient instructions	Reminded providers of the importance of the goal and educated providers regarding where patient instructions are located in the EMR and what information to put in patient instructions.	Providers in the PHO clinics
Providers experiencing time constraints when seeing patients and feeling that typing patient instructions would be too time consuming.	Created and shared smart phrases for oral medications instructions, instructions for procedures, when to call PHO clinic, how to add lab results. Encouraged others to create their own smart phrases.	Providers in the PHO clinics

Providers have different work flows that don't always incorporate adding patient instructions	Suggested a work flow that would incorporate adding patient instructions (ie. When reviewing medications and labs with patients, type in patient instructions).	Providers in the PHO clinics

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 2017

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)? June 1-30, 2017

b. What was (were) the overall performance level(s) post-intervention? *Add post-intervention data to the data table, bar graph, or run chart (line graph) that displays baseline data. Can show baseline and post-intervention data incrementally here or refer to a display of data for all time periods attached at end of report. Show baseline and post-intervention time periods and measure names and for each time period and measure show number of observations and performance level.*

Clinic Type	Baseline 3/29/17 Instructions Present:	2 months Post Intervention 7/2017
Oncology Monday	1/30- 3%	16/30- 53%
Oncology Tuesday	1/30- 3%	13/30- 43%

Oncology Thursday	0/30 - 0%	17/30- 56%
Coagulation	6/30- 20%	6/30- 20%
Sickle Cell	1/30- 3%	0/30- 0%
Brain Tumor	2/30- 6%	11/30- 37%
Hematology	16/30- 53%	28/30- 93%
Total	**27/210- 13%**	**91/210- 43%**

c. Did the intervention(s) produce the expected improvement toward meeting the project's specific aim (item 13.a)? No, we did not achieve our target of >50% of patients receiving written instructions, but substantial progress was made by 3 of 5 sub-specialty clinics. The Hematology Clinic achieved especially impressive results with a 93% documentation rate for patient instructions. The combined oncology clinics rate increased from 3% to 50%.

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)*

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 <u>problem(s) following the intervention(s)</u> 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.)*
Not everyone attended meeting where we provided info.	Email sent outlining the expectations and reminding providers about the importance of patient instructions. Discussed with providers individually.	QI Project Leaders: Lynn Slagle PNP & Dr Jasty + All PHO Providers (MD and NP)
Instability in staffing – specifically, our sickle cell clinic was going through transition losing their Attending.	Discussed expectations around patient instructions with the NP and provided smart phrases to her.	Lynn Slagle PNP and Sickle Cell Clinic Nurse Practitioner
Providers are busy and forgot about 'patient instructions"	Reinforced and reminded providers about the patient instructions portion of MiChart. Encouraged them to use it.	QI Project Leaders: Lynn Slagle PNP & Dr Jasty + All PHO Providers (MD and NP)

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.) October 2017

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)? October 1-31, 2017

b. What was (were) the overall performance level(s) post-adjustment? *Add post-adjustment data to the data table, bar graph, or run chart (line graph) that displays baseline and post-intervention data. Can show here or refer to a display of data for all time periods attached at end of report. Show time periods and measure names and for each time period and measure show the number of observations and performance level. TBD*

Clinic Type	Baseline 3/29/17 Instructions Present:	2 months Post Intervention 7/2017	2 months post Adjustment 11/2017
Oncology Monday	1/30- 3%	16/30- 53%	21/30 - 70%
Oncology Tuesday	1/30- 3%	13/30- 43%	22/30 - 73%
Oncology Thursday	0/30 - 0%	17/30- 56%	18/30 - 60%
Coagulation	6/30- 20%	6/30- 20%	8/30 - 27%
Sickle Cell	1/30- 3%	0/30- 0%	13/30 – 43%
Brain Tumor	2/30- 6%	11/30- 37%	13/30 – 43%
Hematology	16/30- 53%	28/30- 93%	20/30 – 66%
Total	**27/210- 13%**	**91/210- 43%**	**115/210 – 55%**

c. Did the adjustment(s) produce the expected improvement toward meeting the project's specific aim (item 13.a)?
Yes, in aggregate the clinics achieved a 55% rate of providing written instructions to patients, exceeding our specific aim of 50%.

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

b. **If easily possible, for each listed group of health care providers:**
- **Participants with data available:**
  - **Indicate the number participating** *(if none, enter "0" and do not complete rest of row)*
  - **if any are participating, are data on performance of individuals available?** *(If "No", do not complete rest of row.)*
- **if data on performance are available, then enter the number of participants in three categories regarding reaching target rates (i.e. the specific aims for measures).**

(If you do not have this information or it is not easily available, leave the table blank.)

Profession	Participants with Data Available		Number of These Participants Reaching Targets		
	# Participating in QI Effort (from #5.a)	**Data on Performance of Individuals Available?** *(Enter Yes or No)*	**# Not Reaching Any Target Rate**	**# Reaching at Least One Target Rate**	**If Multiple Target Rates, # Reaching All Target Rates** *(If only one rate, enter NA.)*
Practicing Physicians					
Residents/ Fellows					
Physicians' Assistants					
Nurses (APNP, NP, RN, LPN)					
Other Licensed Allied Health					

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)* chart review results presented at clinic staff meeting

☒ Same as #21? ☐ Different than #21 *(describe):*

When? *(e.g., date(s) when post-adjustment data were reviewed and discussed)*
December 4, 2017

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 <u>problem(s)</u> <u>following the adjustment(s)</u> 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.)*
Time constraints	More smart phrases	Providers in the PHO Clinic.
Forgetting the utility of the Michart patient Instructions.	Reinforcing the importance of patient instructions.	Clinic leadership
	Reminding providers to use the Patient Instruction section.	Clinic leadership

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.
Root causes included time constraints during visits and reliance on human memory to complete the patient instruction section. Creation of a model, efficient workflow and reminders addressed these causes. There were not significant barriers to implementing the model workflow, other than the effort needed to create smart phrases and the normal learning curve associated with changing workflow.

34. Describe any key lessons that were learned as a result of the QI effort.
Written documentation is a very important aspect of patient. Leveraging the EMR (MiChart) patient instruction section is an effective way to document instructions for families.

35. Describe any best practices that came out of the QI effort.
Better use of capabilities of available technology (eg smart phrases)

36. Describe any plans for spreading improvements, best practices, and key lessons.
Continue to think of and share smart phrases that providers can use to facilitate using patient instructions.

37. Describe any plans for sustaining the changes that were made.
Continue to reinforce using patient instructions in staff meetings and via email reminders.

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:*

Individuals who want their participation documented for MOC must additionally complete an attestation form, confirming that they met/worked with others as described in this report and reflecting on the impact of the QI initiative on their practice or organizational role. Following approval of this report, the UMHS QI MOC Program will send to participants an email message with a link to the online attestation form.

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):*
- **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):*