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

Improving Documentation of an Accurate Problem List for General Pediatrics Inpatients

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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Ellen Patrick, UMHS Part IV Program Administrator, 734-936-9771, partivmoc@umich.edu

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QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date (this version of the report): 6/14/2017

2. Title of QI effort/project (also insert at top of front page): Improving Documentation of an Accurate Problem List for General Pediatrics Inpatients

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 4, 2016 meeting.
   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): May 31, 2017

4. Key individuals
   a. QI project leader [also responsible for confirming individual’s participation in the project]
      Name: Kimberly Monroe, MD, MS
      Title: Assistant Professor
      Organizational unit: Division of Pediatric Hospital Medicine, C.S. Mott Children’s Hospital
      Phone number: 312.543.4674
      Email address: monroek@med.umich.edu
      Mailing address: 1540 E Hospital Dr, Ann Arbor, MI 48109
      Clinical leader who oversees project leader regarding the project [responsible for overseeing/”sponsoring” the project within the specific clinical setting]
      Name: John Schmidt
      Title: Division Head
      Organizational unit: Division of Pediatric Hospital Medicine, C.S. Mott Children’s Hospital
      Phone number: 734.915.7845
      Email address: schmidtj@med.umich.edu
      Mailing address: 1540 E Hospital Dr, Ann Arbor, MI 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                     | 19               |
      | Residents/Fellows                         | 0                |
      | Physicians’ Assistants                    | 0                |
      | Nurses (APNP, NP, RN, LPN)                | 0                |
      | Other Licensed Allied Health (e.g., PT/OT, dieticians, social workers) | 0                |

   b. Approximately how many physicians (by specialty/subspecialty and by training level) and physicians’ assistants participated for MOC? 0
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): All patients admitted to a General Pediatrics Team at C.S. Mott Children’s Hospital

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)?
Problem lists are a list of illnesses, injuries and other factors that affect the health of an individual patient. They are part of the health record and can be an important communication vehicle used throughout the entire healthcare continuum. A well-designed medical problem list provides a clear picture of a patient’s health problems that require consideration or medical intervention. Inaccurate Problem Lists can affect patient safety and quality of care. Specifically, lack of a correct problem list leads to missed/incorrect diagnoses, decreased billing, and decreased severity of illness scores (see below). It is a requirement of Health and Information Technology for Economic and Clinical Health Act as part of “meaningful use” of the electronic health record.

(2) What is occurring now and why is this a concern (costs/harms)?
Initial concern was perception of poor use of Problem Lists, resulting in suboptimal patient care and reimbursement. This anecdotal information was confirmed by General Pediatrics Team physicians, who reported that they were not always updating the Problem List. Further, the template residents used also did not adequately include the Problem List.

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.)
Improve the accuracy and documentation of Problem Lists on the Pediatric Hospital Medicine service. This will in turn improve patient safety, increase revenue, and lead to a more accurate reflection of our Severity of Illness Index.
9. Which Institute of Medicine Quality Dimensions are addressed? [Check all that apply.]

☒ 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.)

The general measure is “mean rating on severity of Illness index.” This measurement is performed separately on four groups of patients:

- Patients admitted to the General Pediatrics Service from the beginning of their hospitalization with:
  - Length of stay < 5 days
  - Length of stay ≥ 5 days

- Patients admitted to another service, then transferred to the General Pediatrics Service.
  - Length of stay < 5 days
  - Length of stay ≥ 5 days

The Severity of Illness Index and its relationship to Problem Lists is explained below. Then the four measures that reflect the different patient groups are described.

Severity of Illness Index (SOI) is defined as the extent of organ system derangement or physiologic decompensation for a patient. It gives a medical classification into minor, moderate, major, and extreme. The SOI class is meant to provide a basis for evaluating hospital resource use or to establish patient care guidelines. Patients are assigned their SOI based on their specific diagnoses (indirectly through ~Problem Lists) and procedures performed during their medical encounter, which is generally an inpatient hospital stay. In general, the more diagnoses (~Problems) are coded, on average, the higher SOI patients are being assigned. SOI is commonly used to adjust for patient complexity, so that physicians and other groups can compare resource utilization, complication rates, and length of stay. As Problem List accuracy and completeness improves, then our SOI will increase. The Severity of Illness Index is calculated through billing data and sent to us. It is given to us by case then we calculate the average for each month.

Measure 1

Name of measure (e.g., Percent of . . ., Mean of . . ., Frequency of . . .): Mean Rating on SOI for General Peds Patients with LOS < 5 days

Measure components – describe the:

- Denominator (e.g., for percent, often the number of patients eligible for the measure): Number of patients admitted to a General Pediatrics team from the beginning of their hospitalization with LOS < 5 days.

- Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation): Sum of each patient’s rating on Severity of Illness Index
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):
   Ease and utility of measurement: the measurement is sent to us monthly already
calculated through billing data, and it captures what we are trying to measure.

This is a measure of:
☒ Process – activities of delivering health care to patients
☐ Outcome – health state of a patient resulting from health care

Measure 2
   Name of measure (e.g., Percent of . . ., Mean of . . ., Frequency of . . .):
Mean Rating on SOI for General Peds Patients with LOS ≥ 5 days

   Measure components – describe the:
• Denominator (e.g., for percent, often the number of patients eligible for the measure):
   Number of patients admitted to a General Pediatrics team from the beginning of their
hospitalization with LOS ≥ 5 days.

• Numerator (e.g., for percent, often the number of those in the denominator who also meet
the performance expectation):
   Sum of each patient’s rating on Severity of Illness Index

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):
   Ease and utility of measurement: the measurement is sent to us monthly already
calculated through billing data, and it captures what we are trying to measure.

This is a measure of:
☒ Process – activities of delivering health care to patients
☐ Outcome – health state of a patient resulting from health care

Measure 3
   Name of measure (e.g., Percent of . . ., Mean of . . ., Frequency of . . .):
Mean Rating on SOI for Transferred Patients with LOS < 5 days

   Measure components – describe the:
• Denominator (e.g., for percent, often the number of patients eligible for the measure):
   Number of patients admitted to another service, then transferred to the General Pediatrics
Service with hospitalization with LOS < 5 days.

• Numerator (e.g., for percent, often the number of those in the denominator who also meet
the performance expectation):
   Sum of each patient’s rating on Severity of Illness Index

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):
   Ease and utility of measurement: the measurement is sent to us monthly already
calculated through billing data, and it captures what we are trying to measure.

This is a measure of:
 ✓ Process – activities of delivering health care to patients
☐ Outcome – health state of a patient resulting from health care

Measure 4
Name of measure (e.g., Percent of . . ., Mean of . . ., Frequency of . . .): Mean Rating on SOI for patients transferred from another service with LOS ≥ 5 days
Measure components – describe the:
• Denominator (e.g., for percent, often the number of patients eligible for the measure): Number of patients admitted to another service, then transferred to the General Pediatrics Service with hospitalization with LOS ≥ 5 days.
• Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation): Sum of each patient’s rating on Severity of Illness Index

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):
Ease and utility of measurement: the measurement is sent to us monthly already calculated through billing data, and it captures what we are trying to measure.

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 baseline data on the measure(s)? 6/1/2014 – 5/31/2015

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.
See table and run chart.

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 increase the mean SOI Index reported for our patients by >0.63 for each of the four patient groups by the end of the second improvement cycle, i.e. by 3/31/17

b. How were the performance targets determined, e.g., regional or national benchmarks? Internal benchmark. We set the aim based on our actual baseline data. We determined this as the minimum target for a meaningful aim, as our baseline data varied by 0.46 – 0.63. An increase of 0.63 or greater will take into account the potential for natural variability.

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) Division of Pediatric Hospital Medicine – Pediatric Hospitalists and Med/Peds Hospitalists.

b. How? (e.g., in a meeting of clinic staff) Division Meeting.

c. When? (e.g., date(s) when baseline data were reviewed and discussed) March 4, 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 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?

Providers do not understand the importance of an accurate Problem List to patient safety or physician group and hospital revenue.

Updating the problem list is not currently part of the workflow as resident do H&Ps.

Hospitalist workflow also does not include updating the problem list.

Updating the billing diagnoses does not automatically include those diagnoses into the Problem List.

16. What intervention(s) addressed this cause?

Overall: Education of the Pediatric Hospitalist group and Residents regarding the importance of an accurate Problem List for each patient.

Change the resident workflow for documenting H&Ps to include updating the Problem List. This includes developing an updated H&P Template.

Change the Hospitalists’ workflow for co-signing notes and getting ready to sign the billing to have the Problem List window open in order to add any diagnosis they are including in the billing to the Problem List.

Engage with MiChart (Electronic Health Record) to see if the diagnoses that are included in billing can automatically populate the Problem List.

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

Pediatric Hospitalists
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.)
   April 30, 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)? June 1 – July 31, 2016
   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.
      See table, run chart
   c. Did the intervention(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)? No, the goal was not achieved for any group. However, small improvements occurred for 3 of the 4 patients groups.

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)
      August 24, 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.

<table>
<thead>
<tr>
<th>22. What were the primary underlying/root causes for the problem(s) following the intervention(s) that the project can address?</th>
<th>23. What adjustments/second intervention(s) addressed this cause?</th>
<th>24. Who was involved in carrying out each adjustment/second intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workflow still cumbersome.</td>
<td>Development of Billing Sheet to improve workflow. Problems can be directly entered into the Problem List field as ICD 10 codes.</td>
<td>Pediatric Hospitalists</td>
</tr>
<tr>
<td>Physicians still forgetting to include all problems.</td>
<td>Organization of Billing Sheet by disease processes with all related codes in that section.</td>
<td>Pediatric Hospitalists/Billers</td>
</tr>
<tr>
<td>Individuals not aware, understand 'how to.'</td>
<td>Provide education on why Problem Lists are important, and “how to” use tools</td>
<td>Pediatric Hospitalists</td>
</tr>
</tbody>
</table>

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.)*
Jan 31, 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 post-adjustment data on the measure(s)?
      2/1 – 3/31/17

   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.
See table/run chart. Improvement seen in the General Pediatric and Transferred groups both with LOS < 5 days. Improvement not seen in the General Pediatric and Transferred groups with LOS of > 5 days.

c. Did the adjustment(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)?
No, One group (transferred with LOS < days ) did show the targeted level of improvement. Another group (General Pediatrics LOS < 5 days) showed continued improvement but not quite to the targeted level. However, the other two groups decreased below baseline levels, with one group decreasing appreciably. Considering this variation in results in patterns over time we are less certain that the changes reflect substantive change, but may instead reflect normal variations at any point in time. A substantively larger change is likely to occur only if billing data are linked to the problem list. This will likely result in appreciably larger increases than the level of change seen here.

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)
      May 1, 2017

   Use the following table to outline the next plan that was developed: #30 the primary causes, #31 the adjustments( )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.) |
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:
Will get SOI from our billers that can be reviewed. Will consider doing ~ yearly chart reviews. At a min., will need to do chart reviews for new hires.

☐ 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.
This is likely the best choice to making change → Engage with MiChart to see if the diagnoses that are included in billing can automatically populate the Problem List. The barrier to this is money. My understanding is that is costs money to make significant changes to Epic. Other barriers include: time and the ability to explain the ‘why’ to residents, hospitalists. There are early adopters and late adopters. It’s difficult to move the late adopters to the early category.

34. Describe any key lessons that were learned as a result of the QI effort.
The current system for adding problems to the problem list is time consuming. A bigger change (having the problem list automatically update when you update billing) might be the ideal way to pursue further improvements. ~ We did a fair number of changes with only fair improvement seen.

Goals for improvement may need to be higher than initially thought in order to have change greater than typical variation within groups across time.

35. Describe any best practices that came out of the QI effort.
A deeper understanding of billing and update on ICD 10 codes as well as the ‘ideal’ way to add items to your Problem List.

36. Describe any plans for spreading improvements, best practices, and key lessons.
Will give the above information to new hires. Do chart reviews yearly, particularly on new hires.

37. Describe any plans for sustaining the changes that were made.
Will continue to review SOI. Consider yearly chart reviews.

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? MAYBE
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): C.S. Mott Children’s Hospital, Division of Pediatric Hospital Medicine

• 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):