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

Improving Multidisciplinary Discharge Planning on 8A

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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J. Participation for MOC	38-40.	Participation in key activities, other options, other requirements
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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):* 6/27/2018

2. Title of QI effort/project *(also insert at top of front page)***:** 8A Multidisciplinary Discharge Planning

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)**:*** September 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)*: May 2018

4. Key individuals

a. QI project leader *[also responsible for confirming individual's participation in the project]*
Name: Alice Cusick, MD
Title: Assistant Professor, Internal Medicine
Organizational unit: Internal Medicine Department – Hematology/Oncology Division
Phone number: 734-647-0936
Email address: mccoyag@med.umich.edu
Mailing address: Internal Medicine
Med Inn C351
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: David Smith, MD
Title: Professor, Internal Medicine & Urology
Organizational unit: Internal Medicine – Hematology/Oncology Division
Phone number: 734-764-3066
Email address: dcsmith@med.umich.edu
Mailing address: Int Med/Hematology-Onc
7302 CCGC SPC 5946

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	10
Residents/Fellows	1
Physicians' Assistants	0
Nurses (APNP, NP, RN, LPN)	3
Other Licensed Allied Health (e.g., PT/OT, pharmacists, dieticians, social workers)	9

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	Internal Medicine / Hematology&Oncology	1
Fellows	*(Not applicable)*	0
Residents	*(Not applicable)*	0
Physicians' Assistants	*(Not applicable)*	0

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)***:**

Cancer patients admitted to the 8A unit in the University Hospital at Michigan Medicine, on the Medical Hematology (MHE) and Medical Oncology (MON) services. These are patients with hematologic malignancies and solid tumors who have complex discharge planning needs.

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?

Cancer patients on 8A have complex discharge needs including coordination of home care or hospice, transfusion requirements, chemotherapy, medications and outpatient appointments. Assessments via survey and direct observation on 8A in 2016 revealed frustration with discharge planning by all members of the patient care team. Unit performance dashboard data from 2016 cited the need for improvement in the speed of the discharge process with specific mention by patients about the lack of communication amongst care providers.

In an effort to improve coordinated planning for timely discharge, we assembled representatives from the 8A care team to develop an infrastructure for discharge communication that would lead to efficient and quality discharges for Oncology patients on 8A, thereby enhancing patient satisfaction and safety.

Identified problem: Many pieces have to fall into place prior to discharging these complex patients from the unit. There are no easily accessible communication methods or tools that can be used collaboratively by all disciplines contributing to the plan for discharge.

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.)*

The project goal is to improve multidisciplinary communication around planning for discharge, expecting that this will reduce delays in the discharge 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:** Mean communication score on survey of 8A care team members.
- **Measure components** – for a rate, percent, or mean, describe the:

  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*: Number of faculty and staff who completed the communication survey at baseline and, subsequently, after each cycle of improvement.

  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*: Sum of communication rating scores from all completed surveys at baseline and, subsequently, after each cycle of improvement.

- **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)*: The team wanted to establish a baseline of where faculty and staff felt the unit was at in regards to communication around planning for discharge as a basis for comparison along the trajectory of the project.
- **This is a measure of:**
  - ☒ Process – activities of delivering health care to patients
  - ☐ Outcome – health state of a patient resulting from health care

(If more than two measures are tracked across the two cycles, copy and paste the section for a measure and describe the additional measures.)

12. Baseline performance

a. What were the beginning and end dates for the time period for <u>baseline</u> data on the measure(s)? 11/1/16-11/30/16.

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.)*

Measure 1 – Mean Communication Score
The mean communication score was 3.58 at baseline. (See table below for elements of the score).

Baseline Data - November 2016 - *Likert Scale 1 = Strongly Disagree, 5 = Strongly Agree*				
Participants: 11 Attending MDs, 9 Fellows, 10 RNs, 1 CM, 1 SW, 1 RA, & 2 Pharmacists				
Scaled Communication Survey Question:	**Response Count**	**Mean Score**	**Std Deviation**	**Variance**
Overall, our patient care team communicates in a positive manner to one another.	29	4.21	0.61	0.37
Overall, our patient care team coordinates it's actions, decisions and communications around discharge planning well.	29	3.52	0.97	0.94
I am kept well informed about my patient care team's plans and progress for discharge.	28	3.39	1.01	1.02
I am actively involved, and impact the decisions around discharge planning.	28	3.54	0.94	0.89
There is good communication around discharge planning in my role type.	27	3.22	1.03	1.06
There is good communication around discharge planning between people in different role types related to the 8A MHE/MON services.	28	3.46	1.09	1.18
I have the authority/empowerment to solve problems around discharge planning as they present themselves.	28	3.61	0.82	0.67
My work role and responsibilities around discharge planning are generally clear.	29	3.76	1.07	1.15
I get the training I need to do a good job related to the process of discharge.	29	3.62	1	0.99
I get the tools and resources I need to provide the best service for our patients, related to discharge.	29	3.48	0.97	0.94
Total Baseline Communication Mean:	29	**3.58**		

SEE ALSO DATA TABLE AT END OF REPORT

13. Specific performance aim(s)/objective(s)

a. What is the specific aim of the QI effort? *"The Aim Statement should include: (1) a specific and measurable improvement goal, (2) a specific target population, and (3) a specific target date/time period. For example: We will [improve, increase, decrease] the [number, amount percent of [the process/outcome] from [baseline measure] to [goal measure] by [date]."*

Our expectation is the team will improve collaborative, multidisciplinary communications related to discharge planning.

By the end of 2 cycles of improvement (May 2018), we will increase the overall mean communication score for the 8A care team from our baseline of 3.58 to 3.59.

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

The performance target was determined by the multidisciplinary work group.

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)*

- Unit Leaders – 8A Unit Medical Director and Nursing Manager
- 8A Unit Staff – Nursing Supervisor, Nurses, Social Worker, RN Care Manager, Resident Assistants
- UH – Pharmacists, PT/OT

- Division of Hematology/Oncology – Division Administrator, Identified Physician Quality Leads (sit on Internal Medicine Quality Council)
- Department of Internal Medicine – Department Continuous Improvement Consultant (Quality & Performance Improvement)
- Patient/Family Advisors (2)

b. How? *(e.g., in a meeting of clinic staff)*
Scheduled meetings: monthly multidisciplinary work group put together by this project team, quarterly divisional quality/performance improvement meeting, daily nursing huddles on 8A

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

- December 19th, 2016 – Quarterly Division Quality/Performance Improvement Meeting

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.)*
No documentation of the roles of the care team members in discharge planning	The established work group outlined and documented the role of each of the 8A care team members in planning for a patient's discharge. Document was circulated, edited, and used in identifying how to coordinate and communicate more effectively on the unit.	Physicians Nurses Social Work Care Management Resident Assistant Pharmacist PT/OT Patient Advisors
No standard for documentation around discharge planning	Work group identified elements of a check list that were essential to planning for an efficient discharge on MHE/MON services. This first PDSA cycle focused on the use in paper format, to be kept in the room (centrally) for all members of the care team to use and work off of.	Physicians Nurses Social Work Care Management Resident Assistant Pharmacist PT/OT Patient Advisors

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.)* March 1, 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)? March 2017 – April 2017 (approximately 1 month)

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.)*

Measure 1 - Mean Communication Score
The overall mean communication score increased by 0.01 from to 3.58 at baseline to 3.59 post-intervention. This was a small, but not statistically significant, improvement. We did meet our defined goal of 3.59.

Post Intervention - April 2017 *- Likert Scale 1 = Strongly Disagree, 5 = Strongly Agree*				
Participants: 2 Attending MDs, 2 Residents, 14 RNs, 1 CM, 1 SW, 1 RA, & 5 PT/OT				
Scaled Communication Survey Question:	**Response Count**	**Mean Score**	**Std Deviation**	**Variance**
Overall, our patient care team communicates in a positive manner to one another.	21	4.14	0.83	0.69
Overall, our patient care team coordinates it's actions, decisions and communications around discharge planning well.	21	3.38	1.25	1.57
I am kept well informed about my patient care team's plans and progress for discharge.	21	3.29	1.2	1.44
I am actively involved, and impact the decisions around discharge planning.	21	3.67	1.28	1.65
There is good communication around discharge planning in my role type.	21	3.48	1.26	1.58
There is good communication around discharge planning between people in different role types related to the 8A MHE/MON services.	21	3.43	1.14	1.29
I have the authority/empowerment to solve problems around discharge planning as they present themselves.	21	3.67	1.08	1.17
My work role and responsibilities around discharge planning are generally clear.	21	3.81	1.1	1.2
I get the training I need to do a good job related to the process of discharge.	20	3.55	1.2	1.45
I get the tools and resources I need to provide the best service for our patients, related to discharge.	21	3.52	1.22	1.49
Total Baseline Communication Mean:	21	**3.59**		

SEE ALSO DATA TABLE AT END OF REPORT

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

Measure 1 - Mean Communication Score
We increased our score to 3.59 post-intervention, which met our target of 3.59.

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)*
- April 19th, 2017 – 8A Multidisciplinary Discharge Planning Workgroup Meeting
- April 2017 – Daily 8A Nursing Huddle, Data Presented/Discussed
- June 19th, 2017 – Quarterly Division Quality/Performance Improvement Meeting

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.)*
Location of checklist tool (in patient room) was not convenient for all care team members to use	A revised version of this checklist was developed within MiChart (our EHR), in the form of a "Shared Note." Education was provided and a one-page tip sheet was created (in conjunction with a multi-page step-by-step MiChart tip sheet for how to utilize the note).	MiChart/HITS staff Nursing Informatics staff Physicians Nurses Social Work Care Management Resident Assistant Pharmacist PT/OT

		Patient Advisors
No process for who should start and complete the checklist = confusion on ownership	Standard work was created for the use of the developed note, with a nursing-based process for started/signing the note to close the loop. Education was provided and a one-page tip sheet was created.	Nursing Informatics staff Physicians Nurses
No awareness or knowledge of the resources for discharge status and progress	Work group team leads disseminated appropriate information and education about the new shared note tool and the role of each care team member in its use.	Physicians Nurses Social Work Care Management Pharmacist PT/OT
Delayed communication around discharge planning due to lack of use by all role types	MiChart/HITS staff helped the work group build the note template to pull in information that is documented throughout other areas of the electronic medical record, related to discharge. The template eliminated double-documentation, and decreased delay in communication as the note pulls in relevant information pertaining to discharge planning.	MiChart/HITS staff Nursing Informatics staff Physicians Nurses Social Work Care Management Resident Assistant Pharmacist PT/OT Patient Advisors

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.)

August 16th, 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 – November 2017

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.)*

Measure 1 – Mean Communication Score
The Mean Communication Score post-adjustment was 3.48.

Post Adjustment - November 2017 *- Likert Scale 1 = Strongly Disagree, 5 = Strongly Agree*				
Participants: 4 Attending MDs, 5 Residents, 18 RNs, 1 CM, 1 SW, 2 PT/OT				
Scaled Communication Survey Question:	**Response Count**	**Mean Score**	**Std Deviation**	**Variance**
Overall, our patient care team communicates in a positive manner to one another.	31	3.9	0.78	0.6
Overall, our patient care team coordinates it's actions, decisions and communications around discharge planning well.	31	3.19	1	0.99
I am kept well informed about my patient care team's plans and progress for discharge.	31	3.13	0.87	0.76
I am actively involved, and impact the decisions around discharge planning.	29	3.41	1.1	1.21
There is good communication around discharge planning in my role type.	31	3.32	0.89	0.8
There is good communication around discharge planning between people in different role types related to the 8A MHE/MON services.	31	3.26	0.72	0.51
I have the authority/empowerment to solve problems around discharge planning as they present themselves.	30	3.53	0.72	0.52
My work role and responsibilities around discharge planning are generally clear.	31	3.71	0.92	0.85
I get the training I need to do a good job related to the process of discharge.	30	3.77	0.84	0.71
I get the tools and resources I need to provide the best service for our patients, related to discharge.	31	3.58	0.79	0.63
Total Baseline Communication Mean:	31	**3.48**		

SEE ALSO DATA TABLE AT END OF REPORT

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

Measure 1 – Mean Communication Score
No, the post-adjustment communication mean of 3.48 is a decrease from the baseline mean of 3.58 and the post-intervention mean of 3.59. (Although the decrease in the mean was not statistically significant).

We did see an increase in mean scores for questions related to staff having the tools, resources and training related to discharge. This was an expected result and the team felt this was a positive effect due to the adjustments.

In addition, data was collected just for this particular adjustment phase, separate from our two metrics:

- The use of the shared note triggered order entry on multiple occasions (documented in free text comments of the communication survey).
- Patient feedback (n=17): 60% described no delay in discharge and 0% experienced issues in receiving equipment of 'self-care' teaching prior to discharge.
- From a selective chart review: 95% of nurse users "refreshed" the note to properly populate the information, and 37% added additional text/notes (beyond what was required of them).

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)*

- November 29th, 2017 – 8A Multidisciplinary Discharge Planning Workgroup Meeting
- December 2017 – Daily 8A Nursing Huddle, Data Presented/Discussed
- January 10th, 2018 – 8A Multidisciplinary Discharge Planning Workgroup Meeting
- January 15th, 2018 – Quarterly Division Quality/Performance Improvement Meeting

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.)*
With pilot of the shared note limited to MHE/MON services on 8A - nursing staff not always remembering the shared note standard work	Expanded shared note to all services housed on the 8A unit in April 2018 with MiChart (our electronic health record) Clinical Advisory Committee approval.	MiChart/HITS staff Nursing Informatics staff Physicians Nurses
Lack of participation/use of the shared note by attending physicians and residents	Working to incorporate use/review of the shared note into morning rounds. Education at monthly resident introductory meeting. More education at provider level for how this is useful for them and their care team(s).	Physicians Nurses Social Work Care Management Resident Assistant

Not all roles have access to document on the shared note	Expand security access to the resident assistant role to be able to document on the 8A share note	HRSC (subcommittee of ECCA) MiChart/HITS staff Physicians Nurses Resident Assistant

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:*

- Still documenting use of the shared note as it has been expanded to the rest of the 8A unit, the Medical and Nursing leadership on 8A will continue to PDSA as appropriate
- Further considerations for expansion to other units is in progress with MCAC and the Priority Discharge groups

☐ 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.

- Participation of all contributing care team members in understanding the problems, identifying interventions, and using the tools created

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

- Having strong project leadership that is motivated and engaged to make change happen
- Work to provide transparency to access all relative information in the electronic medical record as needed for a task

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

- Promote a culture in with discharge planning starts on the day of admission: planning for the patient's **entire stay** and **not just the day**
- Developing a work group comprised of all roles within the care team is vital to understanding the workflow and efficiencies to be gained

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

- The Priority Discharge group is interested in staying updated on the progress of the expansion to the rest of the 8A unit for consideration of spreading this tool (in some capacity) to the rest of the health system
- Looking to expand the security access for resident assistants to be able to document on the Shared Note regarding transitions back to the outpatient environment

37. Describe any plans for sustaining the changes that were made.

- Nursing orientation includes training for utilization of the shared note
- Training has been incorporated in the introductory sessions for the monthly resident rotation on the MHE/MON service
- Utilization and the closing of the notes is being tracked on a monthly basis

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):* UH/CVC, 8A Unit, MPlan Leadership
- **Is the activity part of a larger UMHS institutional or departmental initiative?**

  ☐ No ☒ Yes – the initiative is *(name or describe*): MiPART an institutional strategic initiative to optimize capacity and optimize patient flow.

☐ **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):*

Multidisciplinary Discharge Planning Project Performance Measures at 3 Points in Time

Time Period	Baseline (Nov 16)	Post-intervention (April 2017)	Post-Adjustment (Nov 2017: Measure #1)	Goal
Mean Communication Score	3.58	3.59	3.48	3.59