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

Delays in Seeing Patients in the Sleep Disorders Fellow Outpatient Clinic

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	
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B. Plan	7-10.	Patient population, general goal, IOM quality dimensions, ACGME/ABMS competencies
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	14-17.	Baseline data review, underlying (root) causes, interventions, who will implement
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D. Check	19-20.	Post-intervention performance
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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):*
05/01/2018

2. Title of QI effort/project *(also insert at top of front page)***:**
Delays in Seeing Patients in the Sleep Disorders Fellow Outpatient Clinic

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)**:*** 10/25/2017

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)*: 04/25/2018

4. Key individuals

a. QI project leader *Jenna Kado*
Name: Jenna Kado
Title: Sleep Fellow
Organizational unit: Neurology/Sleep
Phone number: 734-936-9068
Email address: kadoje@med.umich.edu
Mailing address: 1500 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: Anita Shelgikar
Title: Sleep Medicine Fellowship Director
Organizational unit: Neurology/Sleep
Phone number: 734-936-9068
Email address: avalanju@med.umich.edu
Mailing address: 1500 E. Medical Center Drive, 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	1
Residents/Fellows	4
Physicians' Assistants	0
Nurses (APNP, NP, RN, LPN)	0
Other Licensed Allied Health (e.g., PT/OT, pharmacists, dieticians, social workers)	4

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	Neurology/Sleep Medicine	1
Fellows	Psychiatry/Sleep Medicine	1
	Neurology/Sleep Medicine	1
	Family Medicine/Sleep Medicine	1
	Internal Medicine/Sleep Medicine	1
Residents		0
Physicians' Assistants	*(Not applicable)*	0

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)***:**

Patients with sleep disorders (including sleep-disordered breathing, insomnia, parasomnias, movement disorders and narcolepsy) who were evaluated in the fellow sleep disorders clinic at Michigan Medicine. Ages ranged from 18-89 years old.

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)?

There should be efficient, thorough care for the patients during their clinic visit. Patient visits are scheduled so that clinicians have adequate time to make decisions regarding each patient and to explain the patient's current treatment status, ensuring that patients understand their care. Initiation of the patient encounter (e.g., time fellow enters the exam room) should be no later than 10 minutes after the scheduled appointment time.

(2) What is occurring now and why is this a concern (costs/harms)?

Currently, the initiation of the visit (when the fellow enters the room) is significantly later than the scheduled appointment start time. The clinician must choose between taking the expected amount of time for the visit thereby delaying subsequent appointments throughout the day or shortening the visit time to "catch up," but potentially making rushed clinical decisions, providing less thorough explanations to the patient, and scheduling follow up sooner to address items for which time was

not adequate Either choice results in patient dissatisfaction and in physician frustration at being unable to provide optimal care in a timely manner.

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 timeliness of initiating clinic visits.

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:** The mean time from the time the patient was supposed to meet the clinician until the time the clinician enters the room.

- **Measure components** – *describe the:*

  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:

  The number of adult patients with sleep disorders seen in the sleep medicine fellow clinic.

  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:

  The sum of the differences for each patient between the time that the patient was supposed to meet the clinician and the time the clinician actually enters the room. (assuming there were no delays in rooming the patient).

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

- **This is a 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)? 12/26/17 - 01/05/18

c. **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 "Baseline" column below.

The primary process measure is highlighted below.

Measure	Baseline (12/26/17-01/05/18)	Post-Intervention (3/13/18-3/19/18)	Post-Adjustment (4/9/18-4/17/18)
Number of patients	**32**	**22**	**26**
Check in time	-14 minutes	-15 minutes	-12 minutes
Time chart ready for MA	-12 minutes	-14 minutes	-9 minutes
Time download started	-7 minutes	-16 minutes	-18 minutes
Was download wireless or SD?	---	---	---
Time download completed	-6 minutes	-11 minutes	-14 minutes
Time patient taken for vitals	-1 minutes	-3 minutes	-3 minutes
Appointment time	0 minutes	0 minutes	0 minutes
Time patient in room ready for fellow	5 minutes	2 minutes	2 minutes
Time fellow in room	**19 minutes**	12 minutes	7.5 minutes
Time fellow ready to staff	47 minutes	37 minutes	34 minutes
Time fellow staffs	51 minutes	40 minutes	38 minutes
Time fellow checks out patient	64 minutes	54 minutes	52 minutes

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]."*

Across all patients seen in the fellow sleep disorder clinic, we will decrease the delay from the patient's ready to be seen, and the time that fellows start to see the patient from an average of 19 minutes to <10 minutes for the patient to be ready to be seen by our project end date.

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

The performance targets were determined by a group-agreed number on what is an appropriate amount of reduction based on current performance and potential to effect change through two rapid cycles of improvement.

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)*

Jenna Kado, Hao Cheng, Erika Manis, Harrison Gimbel, Anita Shelgikar, MAs, front desk staff

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

in group meetings, as well as attending morning huddles with the clinic staff to ensure all clinic staff were participating in this project

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

Fridays between from Dec 26, 2017 to Feb 23, 2018

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.)*
Delays in fellow availability to start next appointment due to patient complexity/long previous patient encounter	Implemented using a "black dot" on the EMR, which would signify that the clinician was behind (used at 15 minutes for an RV and 30 minutes for a NP) The process would involve: • Clinicians- assigning a black dots to patients who are expected to take a longer time to be seen during their appointment • MAs- interpreting the black dots as a sign to skip the physician who is behind and instead assign the next roomed patient to the next fellow in queue	Clinicians MAs

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.)*
Feb 27, 2018

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 13-19, 2018

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.*

Measure	Baseline (12/26/17-01/05/18)	Post-Intervention (3/13/18-3/19/18)
Check in time	-14 minutes	-15 minutes
Time chart ready for MA	-12 minutes	-14 minutes
Time download started	-7 minutes	-16 minutes
Was download wireless or SD?	---	---
Time download completed	-6 minutes	-11 minutes
Time patient taken for vitals	-1 minutes	-3 minutes
Appointment time	0 minutes	0 minutes
Time patient in room ready for fellow	5 minutes	2 minutes
Time fellow in room	**19 minutes**	12 minutes
Time fellow seen minus pt ready	15 minutes	11 minutes
Time fellow ready to staff	47 minutes	37 minutes
Time fellow staffs	51 minutes	40 minutes
Time fellow checks out patient	64 minutes	54 minutes

c. Did the intervention(s) produce the expected improvement toward meeting the project's specific aim (item 13.a)?
Our post intervention data does demonstrate a reduction in the time of fellow to room relative to appointment time, but we have not yet achieved our goal.

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)*
04/06/2018

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.)*
Insufficient understanding of application of black dot	Emphasized usage of "black dot" with all the fellows. Clarified with MA on assignment of patients in the setting of "black dot" usage, especially to check "black dot" setting prior to patient assignment	Fellows, MAs
Patients who arrive late further skew the data collected	Decided this root cause was out of scope for this project, thus did not implement an intervention to address this root cause.	
No standardization of dot system; needed to tweak dot system to reflect different types of appointments (Return Visit vs. New Patient)	Increased duration for clinician to mark "black dot" to 20min for RV and 40min for NP.	Fellows

Note: If additional causes were identified that are to be addressed, insert additional rows.

F. Redo

25. By what date was (were) the adjustment(s)/second intervention(s) initiated?
4/9/18-4/17/18

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)?
4/9/18-4/17/18

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 under #12c for all data at all three time periods together.)

Measure	Baseline (12/26/17-01/05/18)	Post-Intervention #2 (4/9/18-4/17/18)
Check in time	-14 minutes	-12 minutes
Time chart ready for MA	-12 minutes	-9 minutes
Time download started	-7 minutes	-18 minutes
Was download wireless or SD?	---	---
Time download completed	-6 minutes	-14 minutes
Time patient taken for vitals	-1 minutes	-3 minutes
Appointment time	0 minutes	0 minutes
Time patient in room ready for fellow	5 minutes	2 minutes
Time fellow in room	**19 minutes**	7.5 minutes
Time fellow seen minus pt ready	15 minutes	5.5 minutes
Time fellow ready to staff	47 minutes	34 minutes
Time fellow staffs	51 minutes	38 minutes
Time fellow checks out patient	64 minutes	52 minutes

c. Did the adjustment(s) produce the expected improvement toward meeting the project's specific aim (item 13.a)?
Our post intervention #2 data does demonstrate a reduction in the time of fellow to room relative to appointment time and meet the goal mean time of fellow in room to be less than 10 minutes relative to appointment time.

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?** 4/20/18

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) 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.)*
Inconsistent usage of "black dot" by fellows	Addressed with continued education/emphasis on the intervention	
Inconsistent assignment of patient by MAs in the setting of "black dot"	We made a clear timeline cut off to be used by the fellow before the MA can start assigning a fellow their next patient (e.g. cannot assign the next patient until 40 minutes into a new patient encounter, and 20 minutes into a return visit encounter).	

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.
Concern on part of providers about uneven distribution of patient load. MAs will balance patient load among fellows by end of clinic session.
Benefit may be limited in clinics with reduced amount of fellows available for reassignment of patients.

34. Describe any key lessons that were learned as a result of the QI effort.
Don't make assumptions about root causes without observing/investigating the process. Previous assumptions of data download causing clinic delays appears to be less of a factor based on data collected during fellows' clinic.

35. Describe any best practices that came out of the QI effort.
Use of the black dot for fellows to communicate delays to MAs was effective in reducing clinic delays.

36. Describe any plans for spreading improvements, best practices, and key lessons.
Presentation of project at Grand Rounds on 04/25/2018

37. Describe any plans for sustaining the changes that were made.
Continue usage of black dot for fellows' clinics moving forward.
Updating placards of dot colors in clinic rooms.
Include discussion of usage during new fellow orientation.
Share results of this implementation with the MAs.

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):*