

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

### Improving the Effectiveness and Efficiency of Inpatient Medicine Rounds: Awareness of Need for DVT Prophylaxis, Satisfaction with Process

#### Instructions

**Determine eligibility.** Before starting to complete this report, go to the Michigan Medicine MOC website [<http://www.med.umich.edu/moc-qi/index.html>], 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 Michigan Medicine 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 1-18.) Staff from the Michigan Medicine 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
<b>A. Introduction</b>	1-6. Current date, title, time frame, key individuals, participants, funding
<b>B. Plan</b>	7-8. Patient population, general goal 9-11. Measures, baseline performance, specific aims 12-15. Baseline data review, underlying (root) causes, interventions, who will implement
<b>C. Do</b>	16. Intervention implementation date
<b>D. Check</b>	17-18. Post-intervention performance
<b>E. Adjust – Replan</b>	19-22. Post-intervention data review, underlying causes, adjustments, who will implement
<b>F. Redo</b>	23. Adjustment implementation date
<b>G. Recheck</b>	24-26. Post-adjustment performance, summary of individual performance
<b>H. Readjust plan</b>	27-30. Post-adjustment data review, underlying causes, further adjustments, who will implement
<b>I. Participation for MOC</b>	31-33. Participation in key activities, other options, other requirements
<b>J. Sharing results</b>	34. Plans for report, presentation, publication
<b>K. Organization affiliation</b>	35. 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*):  
7/11/19
2. **Title of QI effort/project** (*also insert at top of front page*):  
**Improving the Effectiveness and Efficiency of Inpatient Medicine Rounds: Awareness of Need for DVT Prophylaxis, Satisfaction with Process**
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 #12c*):  
11/26/2018
  - 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 #27c*):  
6/26/2019
4. **Key individuals**
  - a. **QI project leader** [*also responsible for confirming individual's participation in the project*]  
**Name:** Gabriel Solomon  
**Title:** MD  
**Organizational unit:** Inpatient Medicine, Ann Arbor VA  
**Phone number:** 734-678-5714  
**Email address:** gsolomn@umich.edu  
**Mailing address:** 2215 Fuller Rd, Ann Arbor MI, 48105
  - b. **Clinical leader who oversees project leader regarding the project** [*responsible for overseeing/"sponsoring" the project within the specific clinical setting*]  
**Name:** Mark Hausman  
**Title:** MD  
**Organizational unit:** Chief of Staff, Ann Arbor VA  
**Phone number:** 734-769-7100  
**Email address:** Mark.Hausman@va.gov  
**Mailing address:** 2215 Fuller Rd, Ann Arbor MI, 48105
5. **Participants. Approximately how many physicians (by specialty/subspecialty and by training level) and physicians' assistants participated for MOC?**

Participating for MOC	Primary Specialty	Subspecialty, if any	Number
Practicing physicians	Internal Medicine	Geriatrics Hospitalist	10-15
Residents/Fellows	Residents- Internal Medicine		0
Physicians' Assistants	(N/A)	(N/A)	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):*

Any patient admitted to inpatient general medicine wards at the Ann Arbor VA.

**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)?**

Relevant patient information should be readily available during rounds. Having needed information efficiently available helps assure optimal provision of care across the rotation of teams responsible for care and the satisfaction of care providers with the care process.

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

Currently the majority of the medical teams are relying on the traditional CPRS (the VA’s Computerized Patient Record System). Pertinent patient information is scattered across the EHR, and teams must create their own notes for rounding. Searching the CPRS is a lengthy process with a greater probability of missing important information. For example, DVT (deep vein thrombosis) prophylaxis is not as readily visible in CPRS, and thus is more frequently overlooked. Difficulties in finding relevant patient information can negatively impact care (e.g., not aware of need for DVT prophylaxis) and the satisfaction of team members with the rounding process.

**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 #11.)*

The project’s goal is to improve the effectiveness and efficiency of the provision of relevant patient information during the inpatient rounding process. This will be achieved by implementing an Inpatient Dashboard tool that allows attending and resident physicians to electronically access/print a rounding list that encompasses all of their patients. The rounding list consolidates patient information and includes patient name, location, diagnosis, code status, vitals, DVT and Foley information. It also adds information about hospital errors/complications. The Inpatient Dashboard also includes a printable sign out list to facilitate handoffs. Use of this tool will improve efficiency and comprehensiveness of rounding (e.g., improve awareness of need for DVT prophylaxis), improve the safety of handoffs between teams, and improve satisfaction of the team with the rounding process.

**9. Describe the measure(s) of performance:** (*QI efforts must have at least one measure that is tracked across the two cycles for the three measurement periods: baseline, post-intervention, and post-adjustment. If more than two measures are tracked, copy and paste the section for a measure and describe the additional measures.*)

Measure 1

- **Name of measure** (*e.g., Percent of . . . , Mean of . . . , Frequency of . . .*):  
Number of rounding lists printed
- **Measure components** – *describe the:*  
Denominator (*e.g., for percent, often the number of patients eligible for the measure*):  
The observation periods (3 months)  
Numerator (*e.g., for percent, often the number of those in the denominator who also meet the performance expectation*):  
Number of rounding lists printed
- **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*): an easily trackable metric to help assess implementation of the intervention
- **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 . . .*):  
Number of sign outs printed
- **Measure components** – *describe the:*  
Denominator (*e.g., for percent, often the number of patients eligible for the measure*):  
The observation periods (3 months)  
Numerator (*e.g., for percent, often the number of those in the denominator who also meet the performance expectation*):  
Number of sign outs printed
- **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*): an easily trackable metric to help assess implementation of the intervention
- **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 . . .*):  
Percent of team members with self-described greater awareness of DVT prophylaxis
- **Measure components** – *describe the:*  
Denominator (*e.g., for percent, often the number of patients eligible for the measure*):  
Number of physicians surveyed  
Numerator (*e.g., for percent, often the number of those in the denominator who also meet the performance expectation*):

Number of physicians with self-described greater awareness of DVT prophylaxis

- **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)*: to learn if the tool was likely to have an impact on a specific clinical condition
- **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 . . .)*:  
Percent of team members highly satisfied with using the Inpatient Dashboard
- **Measure components** – *describe the:*  
 Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:  
 Total number of physicians surveyed  
 Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:  
 Number of team members highly satisfied with the Dashboard
- **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)*: to track user satisfaction with the tool
- **This is a measure of:**
  - Process – activities of delivering health care to patients
  - Outcome – health state of a patient resulting from health care

**10. Baseline performance**

**a. What were the beginning and end dates for the time period for baseline data on the measure(s)?** 11/6-11/20/2018

**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.*

Measures	Baseline * 11/6-20/18
Number of rounding lists printed (3 months)	0
Number of sign outs printed (3 months)	0
% (N) of team members with greater awareness of patients needing DVT prophylaxis (self-report)	NA
% (N) of team members highly satisfied with using the inpatient dashboard (self-report)	NA

\* Not yet using Dashboard

**11. Specific performance aim(s)/objective(s)**

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

By June 1<sup>st</sup>, 2019,

1. The number of rounding lists printed in a 3-month period will be 3000 prints
2. The number of sign outs printed in a 3-month period will be 1500 prints
3. The % of team members with greater awareness of patients needing DVT prophylaxis will be 50% or greater.
4. The % of team members highly satisfied with using the inpatient dashboard will be 90% or greater.

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

The specific aims were based on previous experience piloting the Dashboard tool, and projecting that experience to the entire medicine inpatient population and service.

**12. 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)* Attending Physicians
- b. How?** *(e.g., in a meeting of clinic staff)* Clinical staff meeting with Attendings to introduce Dashboard
- c. When?** *(e.g., date(s) when baseline data were reviewed and discussed)*  
11/26/2018

**Use the following table to outline the plan that was developed: #13 the primary causes, #14 the intervention(s) that addressed each cause, and #15 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:

<b>Common Causes</b>	<b>Common Relevant Interventions</b>
<i>Individuals: Are not aware of, don't understand.</i>	<i>Education about evidence and importance of goal.</i>
<i>Individuals: Believe performance is OK.</i>	<i>Feedback of performance data.</i>
<i>Individuals: Cannot remember.</i>	<i>Checklists, reminders.</i>
<i>Team: Individuals vary in how work is done.</i>	<i>Develop standard work processes.</i>
<i>Workload: Not enough time.</i>	<i>Reallocate roles and work, review work priorities.</i>
<i>Suppliers: Problems with provided information/materials.</i>	<i>Work with suppliers to address problems there.</i>

<b>13. What were the primary underlying/root causes for the <u>problem(s) at baseline</u> that the project can address?</b>	<b>14. What intervention(s) addressed this cause?</b>	<b>15. Who was involved in carrying out each intervention? (List the professions/roles involved.)</b>
No standard rounding strategy amongst physicians	Use Dashboard to print rounding list	Physicians

CPRS ineffective at displaying an overview of patients for rounds	Use Dashboard for a user-friendly patient layout	Physicians
DVT information not easily accessible within CPRS	Dashboard makes DVT information readily accessible	Physicians
Rounding team members not aware of Inpatient Dashboard tool	Educated team members on what Dashboard is and how to use it	Dr. Gabe Solomon + physicians

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

**C. Do**

**16. By what date was (were) the intervention(s) initiated?** (If multiple interventions, date by when all were initiated.)

First intervention: 12/1/2018. Continued implementation with new attendings each rounding cycle, 12/16/2018, 1/1/2019, 1/16/2019, 2/1/2019, and 2/16/2019

**D. Check**

**17. Post-intervention performance measurement. Are the population and measures the same as those for the collection of baseline data (see item 9)?**

Yes       No – If no, describe how the population or measures differ:

**18. Post-intervention performance**

**a. What were the beginning and end dates for the time period for post-intervention data on the measure(s)?**

12/1/2018-2/28/2019

**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.

Measures	Baseline * 11/6-20/18	Post-Intervention 12/1/2018-2/28/2019
Number of rounding lists printed (3 months)	0	3,032
Number of sign outs printed (3 months)	0	919
% (N) of team members with greater awareness of patients needing DVT prophylaxis (self-report)	NA	63% (9/14)
% (N) of team members highly satisfied with using the inpatient dashboard (self-report)	NA	93% (14/15)

\* Not yet using Dashboard

**c. Did the intervention(s) produce the expected improvement toward meeting the project's specific aim (item 11.a)?**

The interventions produced the expected improvement toward meeting the project's specific aim in 3 of the 4 categories. We exceeded the 3000 rounding list mark, the 50% greater awareness of DVT prophylaxis, and the 90% satisfaction mark. We did not reach the mark for sign out prints and will address this with our adjustment phase.

**E. Adjust – Replan**

**19. 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 #12?     Different than #12 (describe):

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

Same as #12?     Different than #12 (describe):

**c. When?** (e.g., date(s) when post-intervention data were reviewed and discussed) 3/1/2019

**Use the following table to outline the next plan that was developed: #20 the primary causes, #21 the adjustments(s)/second intervention(s) that addressed each cause, and #22 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.*

20. What were the primary underlying/root causes for the <u>problem(s)</u> following the <u>intervention(s)</u> that the project can address?	21. What adjustments/second intervention(s) addressed this cause?	22. Who was involved in carrying out each adjustment/second intervention? (List the professions/roles involved.)
Discontent with format of current sign-out tool	Redesigned sign-out tool within Dashboard based on user feedback Educate physicians about changes	Dr. Gabe Solomon; Yehuda Bechar, using feedback of physician users. Physicians
Discontent with sign-out handoff print out	Redesigned sign-out tool handoff print out based on user feedback Educate physicians about changes	Dr. Gabe Solomon; Yehuda Bechar, using feedback of physician users. Physicians

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

**F. Redo**

**23. By what date was (were) the adjustment(s)/second intervention(s) initiated?** (If multiple interventions, date by when all were initiated.)  
3/2/2019

## G. Recheck

24. **Post-adjustment performance measurement. Are the population and measures the same as indicated for the collection of post-intervention data (item #19)?**

Yes       No – If no, describe how the population or measures differ:

25. **Post-adjustment performance**

a. **What were the beginning and end dates for the time period for post-adjustment data on the measure(s)?**

3/2/2019- 6/1/2019

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.**

Measures	Baseline * 11/6-20/18	Post-Intervention 12/1/2018-2/28/2019	Post-Adjustment 3/2/19- 6/1/19
Number of rounding lists printed (3 months)	0	3,032	3,617
Number of sign outs printed (3 months)	0	919	2,120
% (N) of team members with greater awareness of patients needing DVT prophylaxis (self-report)	NA	63% (9/14)	66% (15/23)
% (N) of team members highly satisfied with using the inpatient dashboard (self-report)	NA	93% (14/15)	96% (22/23)

\* Not yet using Dashboard

c. **Did the adjustment(s) produce the expected improvement toward meeting the project's specific aim (item 11.a)?**

The interventions produced the expected improvement toward meeting the project's specific aim in all 4 categories. We exceeded the 3000 rounding list mark, the 1500 sign out prints mark, the 50% greater awareness of DVT prophylaxis, and the 90% satisfaction mark. We improved all 4 categories from the intervention phase as well.

## H. Readjust

26. **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 #19?       Different than #19 (describe):

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

Same as #19?       Different than #19 (describe):

c. **When? (e.g., date(s) when post-adjustment data were reviewed and discussed) 6/26/2019**

**Use the following table to outline the next plan that was developed: #27 the primary causes, #28 the adjustments(s)/second intervention(s) that addressed each cause, and #29 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.*

<b>27. What were the primary underlying/root causes for the <u>problem(s)</u> following the <u>adjustment(s)</u> that the project can address?</b>	<b>28. What further adjustments/ intervention(s) might address this cause?</b>	<b>29. Who would be involved in carrying out each further adjustment/intervention? (List the professions/roles involved.)</b>
While some minor underlying problems continue to occur, performance is above the current specific aim. Changes already implemented will be sustained.	The previously implemented changes will be maintained to sustain the current level of performance	VA Clinical Informatics; Dr. Solomon, Yehuda Bechar, physicians

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

**30. 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: Continue tracking tool usage through print outs, and tracking satisfaction and DVT prophylaxis awareness through Qualtrics surveys*
- 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. Minimum Participation for MOC

**31. 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 #32.*

**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 #12.
- Implementing interventions described in item #14.
- Reviewing and interpreting post-intervention data, considering underlying causes, and planning intervention as described in item #19.

- Implementing adjustments/second interventions described in item #21.
- Reviewing and interpreting post-adjustment data, considering underlying causes, and planning intervention as described in item #26.

Yes     No    *If “Yes,” individuals are eligible for MOC unless other requirements also apply and must be met – see item # 38.*

**32. 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 33.*

**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 # 33. If “No,” continue to #27c.*

**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 # 33.*

**33. 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.*

**J. Sharing Results**

**34. Are you planning to present this QI project and its results in a:**

Yes     No    Formal report to clinical leaders? Results have been presented to Clinical Executive Board and Executive Quality Leadership Board; Project submitted to VA Shark Tank

Yes     No    Presentation (verbal or poster) at a regional or national meeting?

Yes     No    Manuscript for publication?

**K. Project Organizational Role and Structure**

**35. 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*): Informatics

• **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*):