

Report on a QI Project Eligible for Part IV MOC

Assessment of Fall Risk in Patients Receiving Palliative Care Consultations

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. Final confirmation of Part IV MOC for a project occurs when the full report is submitted and approved.

An option for preliminary review (recommended) is to complete a description of activities through the intervention phase and submit the partially completed report. (Complete at least items 1-16 and 27a-b.) 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 and answers should be in regular font (generally immediately below the questions). To check boxes electronically, either put an “X” in front of a box or copy and paste “☑” over the blank box.

For further information and to submit completed applications, contact either:

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Report Outline

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QI Project Report for Part IV MOC Eligibility

A. Introduction

1. **Date** (*this version of the-report*):

June 15, 2015

2. **Title of QI project:** Assessment of Fall Risk in Patients Receiving Palliative Care Consultations

3. **Time frame**

a. **Date physicians begin participating (may be in design phase):** June 2, 2014

b. **End date:** June 11, 2015

4. **Key individuals**

a. **QI project leader** [*also responsible for attesting to the participation of physicians in the project*]

Name: Daniel B. Hinshaw, M.D.

Title: Professor of Surgery and Consultant in Palliative Medicine

Organizational unit: Geriatrics Section, VA Ann Arbor Healthcare System

Phone number: (734) 845-3072

Email address: hinshaw@umich.edu

Mailing address: Palliative Care Program (11G), VA Ann Arbor Healthcare System

2215 Fuller Road, Ann Arbor, MI 48104

a. **Clinical leader to whom the project leader reports regarding the project** [*responsible for overseeing/"sponsoring" the project within the specific clinical setting*]

Name: Robert Hogikyan, M.D.

Title: Chief Section of Geriatrics

Organizational unit: Geriatrics Section, VA Ann Arbor Health Care System

Phone number: (734) 845-3072

Email address: hogikyan@med.umich.edu

Mailing address: Palliative Care Program (11G), VA Ann Arbor Health Care System

2215 Fuller Road, Ann Arbor, MI 48104

5. **Approximately how many physicians were involved in this project categorized by specialty and/or subspecialty?**

Internal Medicine (8); Geriatric Medicine (6 including 3 fellows); Pediatrics (2 Hospice and Palliative Medicine fellows); Physical Medicine & Rehabilitation (1 as a Hospice and Palliative Medicine Fellow); General Surgery (1); and Hospice and Palliative Medicine (7 including 3 fellows)

6. **Will the funding and resources for the project come only from internal UMHS sources?**

Yes, only internal UMHS sources

No, funding and/or resources will come in part from sources outside UMHS,
which are: Project was conducted at the VA Ann Arbor Health Care System

The Multi-Specialty Part IV MOC Program requires that projects engage in change efforts over time, including at least three cycles of data collection with feedback to physicians and review of project results. Some projects may have only three cycles while others, particularly those involving rapid cycle improvement, may have several more cycles. The items below are intended to provide some flexibility in describing project methods. If the items do not allow you to reasonably describe the methods of your specific project, please contact the UMHS Part IV MOC Program office.

B. Plan**7. General goal****a. Problem/need. What is the “gap” in quality that resulted in the development of this project? Why is this project being undertaken?**

Falls are a major source of morbidity and mortality in elderly hospitalized patients. In palliative care patients, many of whom are elderly, the risk for falls may be further increased by the debility and cachexia so often experienced in this population. Delirium has been another major factor associated with falls in hospitalized cancer patients (Pautex, S. et al. *J Pall Med* 11: 878-884, 2008). Fractures and head injuries associated with falls contribute to hastening of death as well as increased distress for the suffering patients and their loved ones. Costs of inpatient care can be dramatically increased by this complication.

As demonstrated in the baseline data presented in the table below in section 12a, screening and documentation of fall risk are not a routine part of palliative care consultations, even though this could be a major opportunity to improve the safety and quality of inpatient care for those suffering with advanced illnesses. In a systematic review and meta-analysis of the literature on falls among the elderly in nursing homes and hospital settings, a history of falls was identified as the strongest predictor for falls (S. Deandrea et al. *Archives of Gerontology and Geriatrics* 56 (2013) 407–415).

b. Project goal. What general outcome regarding the problem should result from this project? (Specific aims/targets are addressed in #12b.)

To improve the quality and safety of care provided to patients with advanced life-threatening illnesses, who receive inpatient palliative care consultations, by identifying risk for falls so that appropriate preventive actions may be taken.

8. Patient population. What patient population does this project address?

Patients with advanced illnesses receiving palliative care consultations as inpatients at the VA Ann Arbor Health Care System

9. Which Institute of Medicine Quality Dimensions are addressed? [Check all that apply.]

- | | | |
|---|--|--|
| <input checked="" type="checkbox"/> Effectiveness | <input checked="" type="checkbox"/> Equity | <input checked="" type="checkbox"/> Safety |
| <input checked="" type="checkbox"/> Efficiency | <input checked="" type="checkbox"/> Patient-Centeredness | <input checked="" type="checkbox"/> Timeliness |

10. What is the experimental design for the project?

- Pre-post comparisons (baseline period plus two or more follow-up measurement periods)
- Pre-post comparisons with control group
- Other: _____

11. Baseline measures of performance:**a. What measures of quality are used? If rate or %, what are the denominator and numerator?**

1) Number of inpatient palliative care consultations.

2) Number of inpatient palliative care consultations in which screening for fall history is possible (e.g., willing to speak to consultant, lucid (not confused), not near death.

3) Number and percent of eligible patients where Morse Falls Scale documented (primary measure)

Denominator: number of patients where screening for fall history is possible

Numerator: number of these patients with fall risk documented using Morse Falls Scale

4) Number and percent of at high risk for falls with high risk for falls documented in consult recommendations (to consider when deciding other palliative care recommendations such as pain medications) This measure was added at the time of the intervention.

Denominator: Number of eligible patients where Morse Falls Scale used.

Numerator: Of these patients, number with high risk (Morse Falls Scale \geq 51) documented in consult recommendations.

b. Are the measures nationally endorsed? If not, why were they chosen?

The Morse Falls Scale is nationally recognized as a measure of fall risk. In a systematic review and meta-analysis of the literature on falls among the elderly in nursing homes and hospital settings, a *history of falls* was identified as the strongest predictor for falls (S. Deandrea et al. Archives of Gerontology and Geriatrics 56 (2013) 407–415).

c. What is the source of data for the measure (e.g., medical records, billings, patient surveys)?

Electronic medical record (EMR)

d. What methods were used to collect the data (e.g., abstraction, data analyst)?

Review of the EMR

e. For what time period was the sample collected for baseline data?

June 2-30, 2014

12. Specific performance objectives

a. What was the overall 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.)

Time Period	N of Inpatient Palliative Care Consults	N of Consults in Which Screening for Fall History Possible ^a	Morse Falls Scale Documented N & % Screening Possible and Documented Using Morse Falls Scale	High Risk for Falls Documented N & % at High Risk for Falls (Morse Falls Scale \geq 51) with High Risk Documented in Consult Recommendations ^b
Baseline: 6/2/14 – 6/30/14	25	23	2 ^c 9% ^c	NA

^a Reasons patients could not be assessed include unwillingness to speak to consultant, confusion, or in extremis (near death).

^b This measure was added at the time of the intervention.

^c Only partial Morse Falls Scales were used during baseline period.

b. Specific aim: What was the target for performance on the measure(s) and the timeframe for achieving the target?

For the primary measure of documenting fall risk using the Morse Falls Scale, increase performance from baseline of 9% to > 85% by the completion of two intervention cycles (by May 2015).

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

Based on review of the literature and team discussions/consensus

13. Data review and identifying underlying (root) causes.**a. Who was involved in reviewing the baseline data, identifying underlying (root) causes of the problem(s), and considering possible interventions (“countermeasures”) to address the causes? Briefly describe:****• Who was involved?**

Medicine Service attending physicians who serve as faculty for the inpatient palliative care consultation service at the VA Ann Arbor Health Care System, hospice and palliative medicine fellows, geriatric medicine fellows, and other postgraduate medical trainees who rotate on the consultation service, as well as other members of the interdisciplinary palliative care consultation team including the Chief of the Geriatrics Section at the VA Ann Arbor Health Care System (Dr. Robert Hogikyan). They were included to obtain their reactions and thoughts in response to the data and to solicit their feedback and suggestions regarding ways to more effectively address this important safety and quality issue in this vulnerable patient population.

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

The baseline data were shared via email and direct discussion.

• When?

In the months of August, October, and November 2014

b. What were the primary underlying/root causes for the problem(s) that the project can address? (Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately.)

Underlying/Root Causes:

- 1) *Decreased awareness of the problem among consultants*
- 2) *Low priority among other competing priorities*
- 3) *Not a standard part of the palliative care consultation process*

C. Do**14. Intervention(s). Describe the interventions implemented as part of the project.**

Education about fall risk and priority. After reviewing information about fall risk and effects of falls and the baseline data there was general consensus that falls are major complications of hospitalization for which patients with advanced illnesses are particularly at risk and a priority to address. Excellent feedback was received regarding potential ways to improve the project.

Use of Morse Falls scale. In the discussions it was noted that as a part of standard patient assessments, nursing staff at the VA Ann Arbor Healthcare System use an adaptation of the Morse Fall Scale (Morse JM, Morse RM, Tylko SJ. Development of a scale to identify the fall-prone patient. *Can J Aging* 1989; 8:366-7. Also, see <http://www.networkofcare.org/library/Morse%20Fall%20Scale.pdf> and http://www.patientsafety.va.gov/docs/fallsToolkit/morse_falls_pocket_card.pdf).

The Morse Fall Scale includes the following parameters that are associated with fall risk:

- 1) history of falling, immediate or in last three months – yes or no;
- 2) the presence of secondary diagnoses – yes or no;
- 3) Use of an ambulatory aid that is stratified from bed rest to crutches/cane/walker to use of furniture (“furniture surfing”);
- 4) Gait/Transferring, stratified from normal/bed rest/immobile to weak to impaired; and
- 5) Mental Status which is either oriented to own ability or forgets limitations.

Numerical scores are assigned to the various parameters and summed with scores of 0-24 often referred to as 'no risk,' 25-50 as low-moderate risk, and ≥ 51 as high risk. However, Dr. Neil Alexander, the institutional expert on falls in the elderly, believes that all hospitalized, seriously ill patients in the VA system are at risk for falls. To refine our measure, we used a history of falls as our primary QI measure but also placed it within the context of the Morse Fall Scale of which it is the first component.

Routine assessment implemented for fall risk. There was a consensus recognition that assessment for fall risk should be a part of the palliative care consultation process as much as possible, after the discussion and interchanges described above.

15. Who was involved in carrying out the intervention(s) and what were their roles?

Attending physicians and physician trainees rotating on the VA palliative care consultation team when acting in their role as consultants were trained in use of the Morse Falls Scale, which was to be documented in the written consultation provided in the EMR.

16. When was the intervention initiated? (For multiple interventions, initiation date for each.)

December 1, 2014

D. Check

17. Post-intervention performance measurement. Did this data collection follow the same procedures as the initial collection of data described in #11: population, measure(s), and data source(s)?

Yes No – If no, describe how

This data collection was refined to include the Morse Falls Scale and to identify a secondary outcome, documentation of those patients at highest risk for falls within the consult recommendations as described in 14 above.

18. Performance following the intervention.

a. The collection of the sample of performance data following the intervention occurred for the time period: December 1-31, 2014

b. What was post-intervention performance level? (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.)

Time Period	N of Inpatient Palliative Care Consults	N of Consults in Which Screening for Fall History Possible ^a	Morse Falls Scale Documented N & % Screening Possible and Documented Using Morse Falls Scale	High Risk for Falls Documented N & % at High Risk for Falls (Morse Falls Scale ≥ 51) with High Risk Documented in Consult Recommendations ^b
Baseline: 6/2/14 – 6/30/14	25	23	2 ^c 9% ^c	NA
Post-intervention: 12/1/14 – 12/31/14	17	17	16 94%	9 56%

^a Reasons patients could not be assessed include unwillingness to speak to consultant, confusion, or in extremis (near death).

^b This measure was added at the time of the intervention.

^c Only partial Morse Falls Scales were used during baseline period.

c. Did the intervention produce the expected improvement toward meeting the project's specific aim (item 12.b)?

Yes. Ninety-four % of patients who could be assessed using the Morse Falls Scale were assessed and their score (fall risk) was documented in the consultation report placed within the EMR. Interestingly, the new measure provided additional educational value and insight into the prevalence of patients at high risk for falls, who were seen by the consultation team (> 50%), all of whom were additionally highlighted as being at high risk for falls in the recommendations section of the consultation report.

E. Adjust – Replan

19. Review of post-intervention data and identifying continuing/new underlying causes.

a. Who was involved in reviewing the post-intervention data, identifying underlying (root) causes of the continuing/new problem(s), and considering possible adjustments to interventions (“countermeasures”) to address the causes? Briefly describe:

- **Who was involved?**

Medicine Service attending physicians who serve as faculty for the inpatient palliative care consultation service at the VA Ann Arbor Health Care System, hospice and palliative medicine fellows, geriatric medicine fellows, and other postgraduate medical trainees who rotate on the consultation service as well as other members of the interdisciplinary palliative care consultation team including the Chief of the Geriatrics Section at the VA Ann Arbor Health Care System (Dr. Robert Hogikyan). They were involved in reviewing the post-intervention data and identifying continuing/new underlying (root) causes.

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

Via email and face-to-face meetings/discussions

- **When?**

During the month of January 2015

b. What were the primary underlying/root causes for the continuing/new problem(s) that the project can address? (*Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately.*)

Previous Underlying/Root Causes:

- 1) *Decreased awareness of the problem among consultants*
- 2) *Low priority among other competing priorities*
- 3) *Not a standard part of the palliative care consultation process*

Upon review of the data from the first intervention cycle, there was a consensus that the underlying (root) causes listed above had been successfully addressed through the educational intervention, brainstorming and discussions described in 14 above. No new problems/underlying issues were identified in the review of the data from the intervention cycle.

The question remaining for the group was to determine the sustainability of the compliance with the QI measure on a busy palliative care consultation service.

F. Redo

20. Second intervention. What additional interventions/changes were implemented?

No new interventions/changes were implemented during the second intervention cycle, since the goal was now to determine sustainability of the excellent compliance with the refined QI measure and also to learn more about the prevalence of palliative care patients at high risk for falls seen during inpatient palliative care consultations at the VA Ann Arbor Health Care System.

21. The second intervention was initiated when? (For multiple interventions, initiation date for each.)

May 4, 2015

G. Recheck

22. Post-second intervention performance measurement. Did this data collection follow the same procedures as the initial collection of data described in #11: population, measure(s), and data source(s)?

X Yes No – If no, describe how this data collection
 With the modifications described in 17 & 18 above for the first intervention cycle

23. Performance following the second intervention.

a. The collection of the sample of performance data following the intervention(s) occurred for the time period:

May 4 – June 4, 2015

b. What was the performance level? (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.)

Time Period	N of Inpatient Palliative Care Consults	N of Consults in Which Screening for Fall History Possible ^a	Morse Falls Scale Documented N & % Screening Possible and Documented Using Morse Falls Scale	High Risk for Falls Documented N & % at High Risk for Falls (Morse Falls Scale ≥ 51) with High Risk Documented in Consult Recommendations ^b
Baseline: 6/2/14 – 6/30/14	25	23	2 ^c 9% ^c	NA
Post-intervention: 12/1/14 – 12/31/14	17	17	16 94%	9 56%
Post-adjustment: 5/4/15 – 6/4/15	25	19	17 90% ^d	12 71% ^e

^a Reasons patients could not be assessed include unwillingness to speak to consultant, confusion, or in extremis (near death).

^b This measure was added at the time of the intervention.

^c Only partial Morse Falls Scales were used during baseline period.

^d Both patients who were able to be assessed but were not assessed with the full Morse Falls Scale, were assessed for a history of falls.

^e Two of the twelve patients who were documented in the consult recommendations to be at high risk for falls based on the Morse Falls Scale actually had intermediate scores of 40 and 45, thus strictly speaking, 10/17 (59%) met full criteria of having Morse Falls Scores ≥ 51.

c. Did the second intervention produce the expected improvement toward meeting the project’s specific aim (item 12.b)?

Yes.

Of the 19 patients who could be assessed using the Morse Falls Scale, 90% were assessed with documentation of the assessment in the EMR. The two remaining patients did have documentation of a falls history in the EMR but the full Morse Falls Scale was not recorded.

Interestingly, consistent with the experience from the first intervention cycle, more than half of the patients who were fully assessed with the Morse Falls Scale were also at high risk for falls, all of whom were documented in the recommendations section of the written consultations in the EMR. Thus, the value of assessing for fall risk among hospitalized patients receiving palliative care consultations is supported by the data from this project.

H. Readjust

24. Review of post-second intervention data and identifying continuing/new underlying causes.

a. Who was involved in reviewing the data, identifying underlying (root) causes of the continuing/new problem(s), and considering additional possible adjustments to interventions (“countermeasures”) to address the causes? Briefly describe:

- **Who was involved?**

Medicine Service attending physicians who serve as faculty for the inpatient palliative care consultation service at the VA Ann Arbor Health Care System, hospice and palliative medicine fellows, and geriatric medicine fellows who rotate on the consultation service as well as other members of the interdisciplinary palliative care consultation team including the Chief of the Geriatrics Section at the VA Ann Arbor Health Care System (Dr. Robert Hogikyan). They were involved in reviewing the post-intervention data and identifying continuing/new underlying (root) causes.

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

Via email exchanges and two face-to-face meetings/discussions in early June 2015

- **When?**

The face-to-face meetings occurred on June 7 and 11, 2015

b. What were the primary underlying/root causes for the continuing/new problem(s) that the project can address? (*Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately.*)

Previous Underlying/Root Causes:

- 1) *Decreased awareness of the problem among consultants*
- 2) *Low priority among other competing priorities*
- 3) *Not a standard part of the palliative care consultation process*

Upon review of the data from the second intervention cycle, there was a consensus that the underlying (root) causes listed above continued to be successfully addressed through the educational intervention, brainstorming and discussions described in 14 above. The remaining question of sustainability regarding compliance with the QI measure was confirmed.

As is characteristic of the unpredictable nature of medicine, there was one interesting twist. Several patients were for various reasons (see footnote “a” above) are unable to give histories regarding falls during this intervention cycle. This raised the issue of patient cooperation in fall risk assessment (ideally a part of the Morse Falls Scale). It became clear in reviewing/discussing the data from this second intervention cycle that ultimately health care providers will on occasion be required to be flexible and make their best assessment of patient risk for falls, regardless of the ability to complete a full Morse Falls Scale assessment. To summarize this observation more succinctly, when in doubt, providers should assume that a cognitively impaired patient (*e.g., especially one with agitated delirium*) is at significant risk

for falls, unless the patient is in extremis (very close to death) or comatose. No new problems/underlying issues were identified in the review of the data from the intervention cycle.

If no additional cycles of adjustment are to be documented for the project for Part IV credit, go to item #25.

If a few additional cycles of adjustments, data collection, and review are to be documented as part of the project to be documented, document items #20 – #24 for each subsequent cycle. Copy the set of items #20 – #24 and paste them following the last item #24 and provide the information. When the project to be documented for Part IV credit has no additional adjustment cycles, go to item #25.

If several more cycles are included in the project for Part IV credit, contact the UM Part IV MOC Program to determine how the project can be documented most practically.

I. Future Plans

25. How many subsequent PDCA cycles are to occur, but will not be documented as part of the “project” for which Part IV credit is designated?

No more formal cycles as part of this project

26. How will the project sustain processes to maintain improvements?

Education and orientation of new consultants on the palliative care consultation service will include a review of the importance of this project and its outcomes and the need for continued assessment/documentation of fall risk during the consultation process.

27. Do other parts of the organization(s) face a similar problem? If so, how will the project be conducted so that improvement processes can be communicated to others for “spread” across applicable areas?

The project report will be made available to other members of the UM Division of Geriatric and Palliative Medicine and Palliative Care Program at UMMC and Mott Children’s Hospital.

28. What lessons (positive or negative) were learned through the improvement effort that can be used to prevent future failures and mishaps or reinforce a positive result?

There was excellent feedback and discussion regarding the QI project especially during the meeting on June 11, 2015. The lessons learned from the project and from the team discussion of the results are summarized below:

- 1) Understanding and awareness of common geriatric syndromes (in this case, falls) are of direct relevance to other disciplines (e.g., hospice and palliative medicine) as they evaluate the needs and safety of patients;
- 2) Published evaluation instruments (e.g., Morse Falls Scale) can be valuable adjuncts in the care of very ill patients; however, health care providers also need to be able to improvise in situations where a given instrument may not be used effectively (e.g., in the cognitively impaired patient) – careful clinical observation and judgment are still of paramount importance;
- 3) For patients identified as being at high risk for falls (e.g., Morse Falls Scale score ≥ 51), in addition to recommending intensified fall precautions, it may also be appropriate to recommend physical and occupational therapy evaluations in palliative care patients with prognoses of weeks or greater or who were ambulatory prior to hospitalization in the hope to preserve ambulation with greater safety;
- 4) For younger male patients who may be reluctant to admit to falls, recommend also asking about “stumbles” in taking a fall history;
- 5) If there are inconsistencies in reported fall risk based on the Morse Falls Scale documented in the EMR, recommend erring on the side of caution and assuming greater fall risk rather than less;

- 6) In the outpatient setting, assessing for a history of falls should be a part of standard functional assessment and may herald a significant transition in functional status (e.g., from ECOG 2 to 3), which might preclude further use of disease-modifying treatment;
- 7) The project also stimulated greater attention to discovery of factors in the physical exam that might predict increased fall risk (e.g., foot drop); and
- 8) It was also recognized that beyond the Morse Falls Scale assessment, for patients being assessed for safe discharge home, an assessment of the home living environment (e.g., presence of steps/stairs, clutter in the home, pets underfoot) should also be made prior to discharge.

To summarize, there was consensus among team members that assessment for fall risk should be a part of most inpatient palliative care consults, recognizing that it may not be feasible or as important to make this assessment in patients who are comatose or actively dying.

J. Physician Involvement

Note: To receive Part IV MOC a physician must both:

- a. *Be actively involved in the QI effort, including at a minimum:*
 - *Work with care team members to plan and implement interventions*
 - *Interpret performance data to assess the impact of the interventions*
 - *Make appropriate course corrections in the improvement project*
- b. *Be active in the project for the minimum duration required by the project*

29. Physician's role. What were the minimum requirements for physicians to be actively involved in this QI effort? *(What were physicians to do to meet each of the basic requirements listed below? If this project had additional requirements for participation, also list those requirements and what physicians had to do to meet them.)*

- a. Interpreting baseline data, considering underlying causes, and planning intervention: Yes for all, as described in #13.
- b. Implementing intervention: Yes, if serving directly as a consultant, as described in #14-#16.
- c. Interpreting post-intervention data, considering underlying causes, and planning changes: Yes for all, as described in #19.
- d. Implementing further intervention/adjustments: Yes, if serving directly as a consultant, as described in #20-#21.
- e. Interpreting post-adjustment data, considering underlying causes, and planning changes: Yes for all, as described in #24

30. How were reflections of individual physicians about the project utilized to improve the overall project?

They played a key role in refining the original intervention as well as coming to an understanding of the limitations associated with the use of instruments like the Morse Falls Scale.

31. How did the project ensure meaningful participation by physicians who subsequently request credit for Part IV MOC participation?

By frequent opportunities for face-to-face discussion as well as feedback via email

K. Sharing Results

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

- Yes No Formal report to clinical leaders? June 7 and 11, 2015
 Yes No Presentation (verbal or poster) at a regional or national meeting?
 Yes No Manuscript for publication?

L. Project Organizational Role and Structure**33. UMHS QI/Part IV MOC oversight – this project occurs within:**

University of Michigan Health System

• **Overseen by what UMHS Unit/Group?**

• **Is the activity part of a larger UMHS institutional or departmental initiative?**

No Yes – the initiative is:

Veterans Administration Ann Arbor Healthcare System

• **Overseen by what AAVA Unit/Group?** Section of Geriatrics, Medicine Service

• **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:**

• **The type of affiliation with UMHS is:**

Accountable Care Organization type (*specify which*):

BCBSM funded, UMHS lead state-wide Collaborative Quality Initiative (*specify which*):

Other (*specify*):

Physicians participating in the Project

Daniel B. Hinshaw, M.D. Project Lead

Marcos Montagnini, M.D.

Caroline Vitale, M.D.

Ellen Hummel, M.D.

Robert Hogikyan, M.D.

Neil Alexander, M.D.

Annas Aljasseem, M.D.

Bridget Pekar, M.D.

Ann Snider, M.D., Ph.D

Kurtis Melin, M.D.

Rasha Nakhleh, M.D.

Karen Sobers, M.B., B.S.

Physicians participating for MOC Part IV Credit

Daniel B. Hinshaw, M.D. Project Lead

Marcos Montagnini, M.D.

Caroline Vitale, M.D.

Ellen Hummel, M.D.

Robert Hogikyan, M.D.
Neil Alexander, M.D.
Bridget Pekrul, M.D.