QI Project Application/Report for Part IV MOC Eligibility

Instructions

Complete the project application/report to apply for UMHS approval for participating physicians to be eligible to receive Part IV MOC credit through the Multi-Specialty Part IV MOC Pilot program. 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.

Only a final application describing the completed project is required. However, submitting an earlier version helps assure that planned activities will meet Part IV requirements. Actions regarding the application depend on the stage of the project, as described below. As stages are accomplished, you may submit updates of the application with the description of planned activities replaced by descriptions of actual activities performed.

Preliminary approval. Plans are developed for the expected activities, but little actual work has been performed. (Complete at least items 1-11, 13a, 16-18a, 19a, 20a, 21, 22a, 23a, 27-33.)

Part IV credit approval. Baseline data have been collected and the intervention performed, with completion of both steps documented on an application (or application update). The project has demonstrated its operational feasibility and the likelihood that subsequent data collections and adjustment will be performed. (Complete at least items 1-18a, 19a, 20a, 21, 22a, 23a, 27-33.)

Participation ("attestation") forms provided. The project has been completed with the expected sequence of activities performed and documented on a complete final application, which is the "final report" on the project.

For further information and to submit completed applications, contact either:
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Application/Report Outline

Section	Items	
A. Introduction	1-6.	Current date, title, time frame, project leader, specialties/subspecialties involved, funding
B. Plan	7-10.	General goal, patient population, IOM quality dimensions addressed, experimental design
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	13.	Data review and identifying underlying (root) causes
C. Do	14-16.	Intervention(s), who is involved, initiated when
D. Check	17-18.	Post-intervention performance measurement, data collection, performance level
E. Adjust – Replan	19.	Review, continuing/new underlying causes,
F. Redo	20.	Second intervention
G. Recheck	21-22.	Post-adjustment performance measurement, data collection, performance level
H. Readjust plan	23.	Review, continuing/new underlying causes to address
I. Future plans	24-26.	Subsequent PDCA cycles, standardize processes, "spread" to other areas
J. Physician involvement	27-31.	Physician's role, requirements, reports, reflections, participation, number
K. Project Organization	32-34.	Part of larger initiative, organizational structure, resources, oversight, Part IV opportunity

QI Project Application/Report for Part IV MOC Eligibility

A. Introduction

1. Date *(this version of the application):* November 15, 2013

2. Title of QI project: Use of Family History for CRC Risk Assessment in Outpatient Colonoscopy

3. Time frame

a. At what stage is the project?

☐ Design is complete, but not yet initiated
Initiated and now underway
☒ Completed *(UMHS Part IV program began 1/1/11)*

b. Time period

(1) Date physicians begin participating (may be in design phase):
(**2) End date**: ☒ actual _____ expected _____November 15, 2013____

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

a. Name: Elena M. Stoffel, MD, MPH
b. Title: Assistant Professor of Internal Medicine
c. Institutional/organizational unit/affiliation: Department of Internal Medicine, Division of GI
d. Phone number: 734-615-9712
e. Email address: estoffel@med.umich.edu
f**. Mailing address**: 3A20 NIB SPC 5429, 300 North Ingalls , Ann Arbor MI 48109

5. What specialties and/or subspecialties are involved in this project?
Gastroenterology

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

X Yes, only internal UMHS sources
☐ No, funding and/or resources will come in part from sources outside UMHS, which are: _____

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?
Knowledge of patients' family history of cancer is crucial for assessing cancer risk. Colonoscopy is effective at preventing CRC. Approximately 30% of CRC diagnoses occur in individuals with a family history of CRC and 5% are associated with hereditary cancer syndromes. Published guidelines recommend that colonoscopy surveillance intervals be tailored according to individuals'

family history and that individuals whose family history meets criteria for risk for hereditary cancer syndromes should be referred for genetic evaluation.

Currently the UMHS endoscopy units do not have a standard process for assessing family history of cancer for patients referred for outpatient colonoscopy. Consequently, physicians have insufficient data needed to determine the optimal surveillance interval and/or identify individuals with family history that meets criteria for genetic evaluation.

b. Project goal. What outcome regarding the problem should result from this project?
The goal of this project is to systematize collection of family history in patients presenting for outpatient colonoscopy to improve the accuracy of CRC risk assessment. This will help physicians make appropriate recommendations for colonoscopic surveillance intervals and/or identify patients who may benefit from further genetic risk assessment.

8. Patient population. What patient population does this project address.
This project includes adult patients age 18 and older who present for outpatient colonoscopy at UMHS.

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

☐ Safety ☐ Equity ☐ Timeliness
☒ Effectiveness ☒ Efficiencyx☒ Patient-Centeredness

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?

Direct measures of quality are:

(1) Percent of patients with family history of cancer or polyps. Denominator: the number of patients undergoing outpatient colonoscopy. Numerator: the number of these patients with documentation of family history of cancer or polyps in the medical record.

(2) Percent of patients with CRC surveillance recommendations who received appropriate recommendations. Denominator: the number of patients undergoing colonoscopy who received a recommendation for CRC surveillance. Numerator: the number of these patients for whom the recommendation for CRC surveillance was consistent with guideline recommendations for surveillance. Consistency with guidelines was determined by chart review, using personal and family history of colorectal neoplasia to stratify CRC risk according to published guidelines. (Note: In cases where no relevant risk factors are documented and routine surveillance is recommended, the recommendation is considered to be consistent.)

To better understand our patient population, we also measured:

Percent of patients with family history meeting criteria for genetic evaluation. Denominator: number of patients undergoing colonoscopy. Numerator: the number of these patients whose family history was determined to be high risk prompting referral for genetic evaluation.

To understand the views of physicians regarding the intervention (the form that was developed and the standard procedures regarding its use), we administered a questionnaire to GI physicians that asked about the following: how frequently did they use the form, did they find it

helpful, did use of the form have an impact on recommendations for colonoscopic surveillance intervals, and did the form result in identification of high risk patients who met criteria for genetic evaluation and would benefit from referral for genetic counseling. These secondary (process) measures were used to guide adjustments to the intervention and the results are reported only following the intervention.

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

The first measure (% with family history) reflects national guidelines. Family history of cancer is an essential component of cancer risk assessment. The second measure (% with appropriate surveillance recommendations) also reflects national guidelines. The joint guidelines of the GI Multisociety task force recommend assessment of family history for patients undergoing colonoscopy and use this information for determining surveillance intervals.

The measure of % meeting criteria for genetic evaluation is an observational measure for this study. The survey measures were developed locally to reflect activities of the project.

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

For the first three measures (family history, appropriate surveillance, criteria for genetic evaluation) sources of data include medical records (colonoscopy report, biopsy results letters, outpatient clinic notes, and MiChart family history grid) and family history survey forms (implemented with this Q! study based on a validated instrument), which are completed by patients immediately prior to colonoscopy.

For the survey measures, questionnaires were completed by physicians (faculty and fellows) in the gastroenterology division.

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

For the first three measures, data were abstracted from electronic medical records and from the completed family history forms. Participating physicians reviewed medical records to assess whether family history of cancer was referenced in the colonoscopy report and to assess concordance between surveillance recommendations made by the endoscopist and practice guidelines. Additionally, they recorded how many individuals met high risk criteria for genetic evaluation.

For the staff surveys, the questionnaire was distributed by email (using SurveyMonkey) and results were reviewed by the physician leads (Drs. Stoffel and Guivatchian).

e. How reliable are the data being collected for the purpose of this project?

The data are very reliable. Family history of cancer provided by patients is considered one of the most accurate sources for this information. The other data come from the electronic health record. The physician response survey was also reliable because the identify of individuals providing information was not disclosed.

f. How are data to be analyzed over time, e.g., simple comparison of means, statistical test(s)?

The data for the first three measures will be analyzed descriptively and as a comparison of proportions over time. The survey data will be similarly be analyzed descriptively and as a comparison of means over time.

g. To whom are data reported?

The results will be reported to the Chief and staff of the Division of Gastroenterology.

h. For what time period is the sample collected for baseline data?

Baseline data are collected for colonoscopy procedures performed from July 1–31, 2013,

12. Specific performance objectives

a. What is 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	Family History Documented			Surveillance Recommendations			Risk Assessment of Patients with Outpatient Colonoscopy			
	Patients with outpatient colonoscopy procedures reviewed	Patients with colonoscopy report that included documentation of family history		Patients with surveillance recommend-dations	Patients with appropriate recommend-ations		Patients with family history conferring "increased risk" for CRC		Patients meeting criteria for "high risk" referred for genetic evaluation	
	N	N	%	N	N	%	N	%	N	%
Baseline July 1-31, 2013	200	36	18%	177	156	88%	41	21%	6	3%

b. Specific aim: What is the target for performance on the measure(s) and the timeframe for achieving the target?
(1) The target for patients to have family history of cancer/polyps documented in is ≥ 50%.
(2) The target for patients to have appropriate surveillance recommendations in ≥ 90%.
(No target for patients who meet criteria for genetic evaluation. It is a descriptive measure.)

c. How were the performance targets determined, e.g., regional or national benchmarks?
No national benchmarks exist. This goal was considered reasonable.

13. Data review and identifying underlying (root) causes.

a. Who will be/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 is involved, how *(e.g., in a meeting of clinic staff)***, and when.**
Tannaz Guivatchian, GI fellow, and Elena Stoffel, MD, the Physician Lead, performed the initial review of performance data. The general findings, their causes, and suggested interventions were discussed at a faculty meeting on Aug. 13, 2013, and with some individual faculty before and after the meeting. More detailed findings were shared at a project meeting on Sep. 11, 2013.

b. What are 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. How the intervention(s) address each primary underlying cause will be explained in #14.c.)*

Not aware of importance and use. Some personnel were not aware of importance of routinely collecting family history or how to use it effectively.
Not aware of low performance rate. Some personnel were not aware of the low rate for collecting family history.
Time. The collection of the information is time-consuming.
Variability in performing relevant activities. Individual staff and clinicians differed in procedures for collecting family history, the information collected, reviewing the history and speaking with patients prior to starting the procedure, and in documenting the assessment.

C. Do

14. Intervention(s).

a. Describe the interventions implemented as part of the project.

Education. At the Faculty meeting on Aug 13 the project leads reviewed the importance of collecting the family history and how to utilize the information in counseling patients and when to refer patients for genetic counseling.

Feedback on performance. At the Faculty meeting on Aug 13 the project leads reviewed information regarding the low rates of performing the expected activities of obtaining relevant family histories.

Tool to facilitate collecting standard information. The project leads adapted a one-page questionnaire with 5 items on which relevant information regarding family history can be easily provided by patients and easily used by clinicians to review familial risk. The form was adapted from an instrument previously developed and validated for screening family history for features of possible inherited risk in colonoscopy patients (Kastrinos et al, Am. Journal of Gastroenterology 2009; 104:1508-1518). This tool was shared with physicians and MPU staff on Aug 5 and discussed at the meeting on Aug 13.

Standard procedures for collecting and utilizing the information. The project leads drafted recommended procedures for systematic collection and utilization of the information, which were discussed at the Aug 13 meeting. The procedures agreed to include:

- Nurses give the form to patients to complete in the pre-procedure area.
- Patients return the form to nurses.
- Nurses include the completed form with procedure-related paperwork presented to the gastroenterologist performing the colonoscopy.
- The gastroenterologist reviews the form and takes the information into account performing the colonoscopy and when preparing the procedure report and making the surveillance recommendation for the patient.

Explanations regarding these procedures were provided to all staff involved.

b. **How are underlying/root causes** *(see #13.b)* **addressed by the intervention(s)?** *(List each cause, whether it is addressed, and if so, how it is addressed.)*

Causes and the intervention(s) that address them are:
Not aware of importance and use – educational session
Not aware of low performance rate – information and feedback concerning performance
Time – tool that facilitates collecting information and standard procedures for collecting and utilizing the information
Variability in performing relevant activities – standard procedures for collecting and utilizing the information

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

Project leadership team: Elena Stoffel, MD, MPH, Physician Lead; Tannaz Guivatchian, MD: GI fellow – design initial proposal for intervention, facilitate discussion and agreement on intervention, oversee implementation.
Nurses: Distribute forms to patients, collect the forms from patients, and include the forms in the paperwork that goes to the gastroenterologist.

GI faculty members: Review the information on the forms and take it into account when providing clinical services and surveillance recommendations. A subset of participating faculty members conducted chart reviews.

16. The intervention will be/was initiated when? (For multiple interventions, initiation date for each.)
The formal intervention began August 13, 2013.

D. Check

17. Post-intervention performance measurement. Is this data collection to 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

In addition to repeating the performance measures collected on baseline data, a survey was sent to GI faculty regarding their use of the tool. The methods and item content are described below with the results.

18. Performance following the intervention.

a. The collection of the sample of performance data following the intervention either:
Will occur for the period:
Has occurred for the period: August 13 –September 15, 2013

b. If the data collection has occurred, what is 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.)*

Performance data

Time Period	Family History Documented			Surveillance Recommendations			Risk Assessment of Patients with Outpatient Colonoscopy			
	Patients with outpatient colonoscopy procedures reviewed	Patients with colonoscopy report that included documentation of family history		Patients with surveillance recommend-dations	Patients with appropriate recommend-ations		Patients with family history conferring "increased risk" for CRC		Patients meeting criteria for "high risk" referred for genetic evaluation	
	N	N	%	N	N	%	N	%	N	%
Baseline July 1-31, 2013	200	36	18%	177	156	88%	41	21%	6	3%
Post-intervention Aug 13-Sep 15, 2013	239	52	22%	212	198	93%	83	35%	11	4.6%

Survey of physician participants

The GI faculty were surveyed regarding their use of the tool and views regarding it. The survey was distributed to the 60 gastroenterologists in the Division on 9/08/2013. 24 gastroenterologists had returned completed questionnaires, for a response rate of 40%. Of the 24 respondents:

- 19 (79%) used the family history form at least 25% of the time
- 7 (29%) reviewed for all of their cases13 (56%) found the form helpful
- 9 (38%) reported that the information on the form impacted their colonoscopy recommendations in approximately 25% of cases.
- 2 (8%) physicians identified high risk family history for patients who would benefit from genetic evaluation on the basis of the family history form

In their comments, most physicians noted that lack of visibility of the form was the main issue preventing them from using it in all cases.

E. Adjust – Replan

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

a. Who will be/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 is involved, how *(e.g., in a meeting of clinic staff)***, and when.**

The physician leads (Drs.Stoffel and Guivatchian) met with participating GI faculty on September 11 to review activities performed as part of the intervention, identify causes of problems, and discuss ways the intervention could be improved. Additional performance detail was provided and discussed at a similar meeting on October 9.

b. What are 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. How the intervention(s) address each primary underlying cause will be explained in #20.c.)*

While there was positive feedback on the family history form on physician survey, the following problems were identified:

- The form was not always easy to locate in the chart
- Some age cutoffs on the form extended into ranges that were not clinically useful.
- The form seemed to be missing at one of the endoscopy sites
- Some physicians and nurses were not always following the expected procedures.

F. Redo

20. Second intervention.

a. The second intervention will be/was initiated when? (For multiple interventions, initiation date for each.)
The second phase of the intervention was implemented September 16, 2013—October 18, 2013

b. If the second intervention has occurred, what interventions were implemented?

The following revisions of the intervention were made:

1. Changes to the form:
   - Form was printed on colored paper to make it easier to see.
   - Change made to specify Family history of CRC in first degree relative age<60 (had been age<50).
   - A line was added to the form so the physician could make an assessment of patient CRC risk (average vs above average risk) and mark their initials to show that they reviewed the form.
2. Reminders regarding procedures were sent:
   - Email sent to physicians to remind them the family history form is in endoscopy folder.

- Endoscopy unit staff reminded to put form where it is visible in the patient folder.

c. How are continuing/new underlying/root causes *(see #19.b)* **addressed by the intervention(s)?** *(List each cause, whether it is addressed, and if so, how it is addressed.)*

- Form not easy to locate – changes to the form: colored paper
- Age cutoffs not always clinically useful – changes to the form: revised age cutoffs
- The form seemed to be missing at one of the sites – reminder: sent to unit staff
- Not always following expected procedures – reminders sent to physicians and staff

G. Recheck

21. Post-second intervention performance measurement. Is this data collection to 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

22. Performance following the second intervention.

a. The collection of the sample of performance data following the intervention(s) either:
Will occur for the period:
Has occurred for the period: September 18-October 18, 2013

b. If the data collection has occurred, what is 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.)*

Performance data

Time Period	Family History Documented			Surveillance Recommendations			Risk Assessment of Patients with Outpatient Colonoscopy			
	Patients with outpatient colonoscopy procedures reviewed	Patients with colonoscopy report that included documentation of family history		Patients with surveillance recommend-dations	Patients with appropriate recommend-ations		Patients with family history conferring "increased risk" for CRC		Patients meeting criteria for "high risk" referred for genetic evaluation	
	N	N	%	N	N	%	N	%	N	%
Baseline July 1-31, 2013	200	36	18%	177	156	88%	41	21%	6	3%
Post-intervention Aug 13-Sep 15, 2013	239	52	22%	212	198	93%	83	35%	11	4.6%
Post-adjustment Sep 16-Oct 18,	219	46	21%	193	181	94%	74	34%	15	6.8%

2013			

Survey of physician participants

The GI faculty were surveyed again regarding their use of the tool and views regarding it. 21 gastroenterologists returned completed questionnaires, for a response rate of 35%.

- 100% used the family history form at least 25% of the time (up from 79% following intervention 1)
- 85% found the form helpful (up from 56% following intervention 1)
- 72% reported that the information on the form impacted their colonoscopy recommendations (up from 38% following intervention 1)
- 29% identified high risk family history for patients who would benefit from genetic evaluation on the basis of the family history form (up from 8% following intervention 1)

Several faculty suggested that the form should continue to be used even after the intervention period since they found it helpful for clinical care.

H. Readjust

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

a. Who will be/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 is involved, how *(e.g., in a meeting of clinic staff)***, and when.**

Review of data was performed by Tannaz Guivatchian, GI fellow, Elena Stoffel, MD, the Physician Lead, and participating faculty. The post-intervention findings were discussed at meetings with participating physicians in attendance (October 9, 2013 and November 15, 2013).

b. What are 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.)*

Although the family history form has been felt by staff to be useful, we identified additional areas for improvement:

Form is not reviewed by MD in 100% of cases: Despite printing the form on different paper, it can be easy to overlook in the paperwork folder. In addition, one of the sites had been less consistent in administering the forms to patients. We had tried to ascertain whether the form had been reviewed by the MD by asking for MD initials; however only a minority of forms were initialed and many MDs were not aware that this requirement had been added during the subsequent revision of the form.

One solution to this would be to add the family history questions to the computerized pre-procedure intake form, which requires physician review and sign off. This would require implementing changes to the template and would additional effort for nurses to input the information (as opposed to patients completing paper forms only).

<u>If no additional cycles</u> of adjustment are to be documented for the project for Part IV credit, go to item #24.

<u>If a few additional cycles</u> of adjustments, data collection, and review are to be documented as part of the project to be documented, document items #20 – #23 for each subsequent cycle. Copy the set of items #20 – #23 and paste them following the last item #23 and provide the information. When the project to be documented for Part IV credit has no additional adjustment cycles, go to item #24.

<u>If several more cycles</u> 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

24. 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 further PDCA cycles will occur.

25. How will the project standardize processes to maintain improvements?

We will continue to include the family history form in the patient folders and will discuss feasibility of implementing these questions into the computerized pre-endoscopy assessment form.

26. Do other parts of UMHS 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?

Collection of family history information is an institution-wide problem. Our team is in the process of developing a web/tablet based tool which can collect family history of cancer from patients so this information can be used for cancer risk assessment.

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

27. Physician's role. What are the minimum requirements for physicians to be actively involved in this QI effort?

a. Interpreting baseline data and planning intervention: Participate in at least 2 meetings (Aug. 13, September 11 (or have met separately with project leads) where the initial performance in collecting and utilizing family history information was discussed, the underlying causes considered, and interventions to improve performance addressed

b. Implementing intervention: Utilize the form in providing patient care. Reinforce with staff the importance of facilitating the completion and availability of the form for the physician's use.

c. Interpreting post-intervention data and planning changes: Provide feedback on the intervention and identify areas for improvement based on personal experience. Conduct at least 25 chart reviews to provide post-intervention performance data. Participate in meeting on Oct 9 (or have met separately with project leads) at which the post-intervention data were discussed, underlying causes of current problems considered, and adjustments (further interventions) addressed.

d. Implementing further intervention/adjustments: In addition to initial intervention expectations, utilize the improved form in providing care, utilize the form more consistently, and encourage staff routinely to perform their expected roles

e. Interpreting post-adjustment data and planning changes: Provide feedback on the adjustments and identify areas for improvement based on personal experience. Conduct 25 chart reviews to provide post-adjustment performance data. Attend end of project meeting on November 15, 2013 (or have met separately with project leads) at which the post-adjustment data were

discussed, underlying causes of current problems considered, and further adjustments/interventions addressed.

28. How are reflections of individual physicians about the project utilized to improve the overall project?
The project lead participates in the meetings where physicians interpret data and make recommendations for improvement. In addition, results of the physician survey were reviewed and incorporated into the revised interventions.

29. How does the project ensure meaningful participation by physicians who subsequently request credit for Part IV MOC participation?
The project lead monitors the participation of the physicians involved, according to the requirements listed above.

30. What are the specialties and subspecialties of the physician anticipated to participate in the project and the approximate number of physicians in each specialty/subspecialty?
Gastroenterology: 13 physicians

K. Project Organizational Role and Structure

31. UMHS QI/Part IV MOC oversight – this project occurs within:

☒ **University of Michigan Health System**

- **Overseen by what UMHS Unit/Group?**
  Internal Medicine, Division of Gastroenterology

- **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?**

- **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 Collaborative Quality Initiative** *(specify which):*

  ☐ **Other** *(specify):*

- **Who is the individual at UMHS responsible for oversight of the QI project regarding Part IV requirements?**

Name: Elena M. Stoffel, MD, MPH
Title: Assistant Professor Internal Medicine
Institutional/organizational unit/affiliation: Internal Medicine, Gastroenterology
Phone number: 734-936-0781
Email address: estoffel@med.umich.edu

32. What is the organizational structure of the project? ***[Include who is involved, their general roles, and reporting/oversight relationships.]***

The project lead (Dr. Stoffel) oversaw the project. She is a faculty member in the division of Gastroenterology and Director of the Cancer Genetics Clinic at UMHS. Dr. Stoffel worked closely with Tannaz Guivatchian, the gastroenterology fellow, in design, implementation, data collection and interpretation, and all other activities related to this project. Participating faculty worked with Dr. Stoffel and Dr. Guivatchian on the project activities outlined in detail above. Dr. Stoffel and Dr. Guivatchian carried out the QI initiative with the approval of Dr. Grace Elta, the Clinical Chief of Gastroenterology and Dr. Chung Owyang, Chief of the Gastroenterology Division.

33. To what oversight person or group will project-level reports be submitted for review?

The project results will be reported to Dr. Elta and Dr. Owyang, Chief of Gastroenterology.