

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

Decreasing missed opportunities for HPV vaccination at University Health Services

Instructions

Determine eligibility. Before starting to complete this report, go to the UMHS MOC website [ocpd.med.umich.edu], click on “Part IV Credit Designation,” and review sections 1 and 2. Complete and submit a “QI Project Preliminary Worksheet for Part IV Eligibility.” Staff from the UMHS Part IV MOC Program will review the worksheet with you to explain any adjustments needed to be eligible. (The approved Worksheet provides an outline to complete this report.)

Completing the report. The report documents completion of each phase of the QI project. (See section 3 of the website.) Final confirmation of Part IV MOC for a project occurs when the full report is submitted and approved.

An option for preliminary review (strongly recommended) is to complete a description of activities through the intervention phase and submit the partially completed report. (Complete at least items 1-20.) Staff from the UMHS Part IV MOC Program will provide a preliminary review, checking that the information is sufficiently clear, but not overly detailed. This simplifies completion and review of descriptions of remaining activities.

Questions are in bold font. Answers should be in regular font (generally immediately below or beside the questions). To check boxes, hover pointer over the box and click (usual “left” click).

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

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Report Outline

Section	Items
A. Introduction	1-6. Current date, title, time frame, key individuals, participants, funding
B. Plan	7-10. Patient population, general goal, IOM quality dimensions, ACGME/ABMS competencies 11-13. Measures, baseline performance, specific aims 14-17. Baseline data review, underlying (root) causes, interventions, who will implement
C. Do	18. Intervention implementation date
D. Check	19-20. Post-intervention performance
E. Adjust – Replan	21-24. Post-intervention data review, underlying causes, adjustments, who will implement
F. Redo	25. Adjustment implementation date
G. Recheck	26-28. Post-adjustment performance, summary of individual performance
H. Readjust plan	29-32. Post-adjustment data review, underlying causes, further adjustments, who will implement
I. Reflections & plans	33-37. Barriers, lessons, best practices, spread, sustain
J. Participation for MOC	38-40. Participation in key activities, other options, other requirements
K. Sharing results	41. Plans for report, presentation, publication
L. Organization affiliation	42. Part of UMHS, AAVA, other affiliation with UMHS

QI Project Report for Part IV MOC Eligibility

A. Introduction

1. **Date** (*this version of the report*): 9/20/16
2. **Title of QI effort/project** (*also insert at top of front page*): Decreasing missed opportunities for HPV vaccination at University Health Service
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 #14*): 7/1/2015
 - 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 #33*): 9/13/2016

4. Key individuals

- a. **QI project leader** [*also responsible for confirming individual's participation in the project*]

Name: Amelita Maslach, MD
Title: Family Physician
Organizational unit: University Health Service
Phone number: 734-615-9290
Email address: amaslach@med.umich.edu
Mailing address: 207 Fletcher St
 Ann Arbor, MI 48109
- b. **Clinical leader to whom the project leader reports regarding the project** [*responsible for overseeing/"sponsoring" the project within the specific clinical setting*]

Name: Michael Corrigan, MD
Title: Interim Medical Director
Organizational unit: University Health Service
Phone number: 734-647-2573
Email address: Corrigan@med.umich.edu
Mailing address: 207 Fletcher St
 Ann Arbor, MI 48109

5. Participants

- a. **Approximately how many health care providers (by training level for physicians) participated in this QI effort** (*whether or not for MOC*):

Profession	Number (fill in)
Practicing Physicians	14
Residents/Fellows	0
Physicians' Assistants	2

Nurses (APNP, NP, RN, LPN)	1
Other Allied Health	0

b. Approximately how many physicians (by specialty/subspecialty and by training level) and physicians’ assistants participated for MOC?

Profession	Specialty/Subspecialty (fill in)	Number (fill in)
Practicing Physicians	Family Medicine	8
	General Internal Medicine	5
	Obstetrics and Gynecology	1
Fellows		
Residents		
Physicians’ Assistants	(Not applicable)	2

6. How was the QI effort funded? (Check all that apply.)

- Internal institutional funds
- Grant/gift from pharmaceutical or medical device manufacturer
- Grant/gift from other source (e.g., government, insurance company)
- Subscription payments by participants
- Other (describe):

The Multi-Specialty Part IV MOC Program requires that QI efforts include at least two linked cycles of data-guided improvement. Some projects may have only two cycles while others may have additional cycles – particularly those involving rapid cycle improvement. The items below provide some flexibility in describing project methods and activities. If the items do not allow you to reasonably describe the steps of your specific project, please contact the UMHS Part IV MOC Program Office.

B. Plan

7. Patient population. What patient population does this project address (e.g., age, medical condition, where seen/treated): Patients aged 11-26 seen at University Health Service

8. General goal

a. Problem/need. What is the problem (“gap”) in quality that resulted in the development of this project? Why is important to address this problem?

The Advisory Committee on Immunization Practices (ACIP) currently recommends routine vaccination of youth ages 11 - 26 with 3 doses of human papilloma virus (HPV) vaccine (1). Several factors have been associated with low HPV vaccination rates. A critical barrier reported by parents is not receiving a recommendation for the HPV vaccine from a health care professional (2). A prior study done at UMHS with an electronic prompt has demonstrated increased HPV initiation and timely completion (3). In 2014, 26.4% of females and 16.7% of males (averaged amongst clinics) completed the HPV vaccine series. Decreasing missed opportunities to provide HPV vaccination will significantly improve vaccination rates.

b. Project goal. What general outcome regarding the problem should result from this project?
(State general goal here. Specific aims/performance targets are addressed in #13.)

Decrease missed opportunities to provide HPV vaccination to eligible patients.

9. Which Institute of Medicine Quality Dimensions are addressed? *[Check all that apply.]*
<http://www.nationalacademies.org/hmd/~media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf>)

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

10. Which ACGME/ABMS core competencies are addressed? *(Check all that apply.)*
<http://www.abms.org/board-certification/a-trusted-credential/based-on-core-competencies/>)

- | | |
|---|--|
| <input checked="" type="checkbox"/> Patient Care and Procedural Skills | <input checked="" type="checkbox"/> Medical Knowledge |
| <input checked="" type="checkbox"/> Practice-Based Learning and Improvement | <input checked="" type="checkbox"/> Interpersonal and Communication Skills |
| <input type="checkbox"/> Professionalism | <input checked="" type="checkbox"/> Systems-Based Practice |

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

Measure 1

- **Name of measure:** Percent of visits with missed HPV opportunity
- **Measure components** – for a rate, percent, or mean, describe the:
 Missed opportunities for providing HPV vaccination (ie: if HPV vaccination is not appropriately provided to an eligible patient seen at an outpatient visit) This includes when the vaccine is declined, and when the physician does not offer vaccination.

The denominator is the number of visits where the patient was eligible to receive the HPV vaccine .

The numerator is the number of these visits where HPV vaccine was not given.

- **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)*: Based on consensus in the UMHS pediatric QI committee
- **This is a measure of:**
 - Process – activities of delivering health care to patients
 - Outcome – health state of a patient resulting from health care

12. Baseline performance

a. What were the beginning and end dates for the time period for baseline data on the measure(s)?

August 1, 2015 - October 31, 2015

b. What was (were) the performance level(s) at baseline? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

Measure	Baseline (8/1/15 – 10/31/15)	Post-Intervention (12/16/15-3/15/16)	Post-Adjustment (5/1/16 – 8/31/16)	Goal
<u>Missed HPV Opportunity</u>				
N eligible visits	3792			
N HPV not given	3591			
% HPV NOT Given	95%			75%

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

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

Decrease missed opportunities to give the HPV vaccine to patients age 10-26 seen in clinic from 95% down to 75%, with a goal to reach this target by 8/31/16.

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

Local benchmark based on consensus in the UMHS pediatric QI committee.

14. Baseline data review and planning. Who was involved in reviewing the baseline data, identifying underlying (root) causes of problem(s) resulting in these data, and considering possible interventions (“countermeasures”) to address the causes? (Briefly describe the following.)

- **Who was involved?** (e.g., by profession or role) All participating physicians and physician assistants. The Chief of the Medical Clinics, Nurse Manager, and Administrative Manager Intermediate Healthcare were also involved.
- **How?** (e.g., in a meeting of clinic staff) During discussion at clinician and med staff meetings, small group meetings, and via a Qualtrics survey sent over e-mail.
- **When?** (e.g., date(s) when baseline data were reviewed and discussed) November 16th – December 15th, 2015

Use the following table to outline the plan that was developed: #15 the primary causes, #16 the intervention(s) that addressed each cause, and #17 who carried out each intervention. This is a simplified presentation of the logic diagram for structured problem solving explained at <http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation> in section 2a. As background, some summary examples of common causes and interventions to address them are:

Common Causes	Common Relevant Interventions
Individuals: Are not aware of, don't understand.	Education about evidence and importance of goal.

<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>

15. What were the primary underlying/root causes for the <u>problem(s)</u> at baseline that the project can address?	16. What intervention(s) addressed this cause?	17. Who was involved in carrying out each intervention? (List the professions/roles involved.)
People Problems		
Physicians don't notice the BPA	It was decided that instead of physicians addressing HPV status, MAs would ask all patients in the eligible age range (11-26) regarding their HPV status.	MAs
No process in place to consistently offer the vaccine to patients	We developed a process in which MAs will offer the vaccine to all eligible patients	MAs
Lack of patient immunization records, especially since many patients are from out of state	MAs will ask patients re: immunization status and offer the vaccine to all eligible patients.	MAs Patients
Patients unaware of need for vaccine	MAs will offer all eligible patients the HPV VIS and document this in the record. Clinicians will further educate eligible patients and emphasize the health benefits of the vaccine TV ads were created and played on waiting room TVs to help educate patients as to the benefits of the vaccine	MAs Clinicians Wolverine wellness staff (public-health/outreach staff at UHS)
Unknown insurance coverage for vaccine	At the check-out desk, when clerical staff identifies that the HPV vaccine was ordered for the patient, clerical staff will educate patients on how to check insurance coverage. Clerical staff will not notify the nurse that the patient needs the vaccine until insurance coverage is confirmed by the patient.	Check out clerical staff

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

C. Do

18. By what date was (were) the intervention(s) initiated? (If multiple interventions, date by when all were initiated.)
December 16th, 2015

D. Check

19. Post-intervention performance measurement. Are the population and measures the same as those for the collection of baseline data (see items 10 and 11)?

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

20. Post-intervention performance

a. What were the beginning and end dates for the time period for post-intervention data on the measure(s)? December 16th, 2015- March 15th, 2016

b. What was (were) the overall performance level(s) post-intervention? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

Measure	Baseline (8/1/15 – 10/31/15)	Post- Intervention (12/16/15- 3/15/16)	Post- Adjustment (5/1/16 – 8/31/16)	Goal
<u>Missed HPV Opportunity</u>				
N eligible visits (BPA fired)	3792	4094		
N HPV not given	3591	3576		
% HPV NOT Given	95%	92%		75%

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

No

E. Adjust – Replan

21. Post-intervention data review and further planning. Who was involved in reviewing the post-intervention data, identifying underlying (root) causes of problem(s) resulting in these new data, and considering possible interventions (“countermeasures”) to address the causes? (Briefly describe the following.)

- **Who was involved?** (e.g., by profession or role)
 - Same as #14? Different than #14 (describe): All participating clinicians and MAs, their managers, the Administrative Manager Intermediate Healthcare (manager of clericals and MAs), the Nurse Manager, and representatives from the billing office.
- **How?** (e.g., in a meeting of clinic staff)

Same as #14? Different than #14 (*describe*): Group discussion was through a medical staff meeting and Qualtrics survey. The Project Leader also gathered feedback during one-on-one and smaller group discussions with clinicians, the lead MA, the Administrative Manager Intermediate Healthcare, the Nurse Manager, and the Chief of the Medical Clinics.

- **When?** (*e.g., date(s) when post-intervention data were reviewed and discussed*)
The Qualtrics survey was sent out 4/18/16. The medical staff meeting was on 4/20/16.

Use the following table to outline the next plan that was developed: #22 the primary causes, #23 the adjustments(s)/second intervention(s) that addressed each cause, and #24 who carried out each intervention. This is a simplified presentation of the logic diagram for structured problem solving explained at <http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation> in section 2a.

Note: Initial intervention(s) occasionally result in performance achieving the targeted specific aims and the review of post-intervention data identifies no further causes that are feasible or cost/effective to address. If so, the plan for the second cycle should be to continue the interventions initiated in the first cycle and check that performance level(s) are stable and sustained through the next observation period.

22. What were the primary underlying/root causes for the <u>problem(s)</u> following the <u>intervention(s)</u> that the project can address?	23. What adjustments/second intervention(s) addressed this cause?	24. Who was involved in carrying out each adjustment/second intervention? (<i>List the professions/roles involved.</i>)
Clinicians often missed MA documentation that patients were interested in the vaccine and therefore did not order the vaccine	MAs started using the point of care alert (BPA) indicating eligibility for the immunization to pend the HPV order for the clinician to sign MAs attached brightly colored stickers to the patients' check-in paperwork so that clinicians had another reminder to address HPV.	MAs, Clinicians
We still did not have a good system for confirming insurance coverage, and discussing this with patients was cumbersome and too time consuming for clinicians	A vaccine waiver form that clearly explained to patients how to verify insurance coverage was developed. This form was given by clerical staff to any patient getting the vaccine.	Clerical staff
We still struggled with not having patient immunization records. The baseline number of immunized patients would be higher if we had their records. Students are not required to provide their immunization records when they enroll. A separate study during this time period showed that baseline vaccination rates could be increased substantially (by 70% in our study) if data from MCIR were entered in to the chart.	Clerical staff were given access to MCIR and will pilot test printing out MCIR records for all patients 11-26. They will give this to the MAs to have at intake.	Clerical staff MAs

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

F. Redo

25. By what date was (were) the adjustment(s)/second intervention(s) initiated? (If multiple interventions, date by when all were initiated.) 5/1/16

G. Recheck

26. Post-adjustment performance measurement. Are the population and measures the same as indicated for the collection of post-intervention data (item #21)?

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

27. Post-adjustment performance

a. What were the beginning and end dates for the time period for post-adjustment data on the measure(s)? 5/1/16 – 8/31/16

b. What was (were) the overall performance level(s) post-adjustment? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

Measure	Baseline (8/1/15 – 10/31/15)	Post- Intervention (12/16/15- 3/15/16)	Post- Adjustment (5/1/16 – 8/31/16)	Goal
<u>Missed HPV Opportunity</u>				
N eligible visits (BPA fired)	3792	4094	3880	
N HPV not given	3591	3576	3407	
% HPV NOT Given	95%	92%	88%	75%

c. Did the adjustment(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)? No

28. Summary of individual performance

a. Were data collected at the level of individual providers so that an individual’s performance on target measures could be calculated and reported?

- Yes No – go to item 29

b. If easily possible, for each discipline:

- **Participants with data available:**
 - Indicate the number participating (if none, enter “0” and do not complete rest of row)
 - if any are participating, are data on performance of individuals available? (If “No”, do not complete rest of row.)
- if data on performance are available, then enter the number of participants in three categories regarding reaching target rates (i.e. the specific aims for measures). (If you do not have this information or it is not easily available, leave the table blank.)

Profession	Participants with Data Available		Number of These Participants Reaching Targets		
	# Participating in QI Effort (from #5.a)	Data on Performance of Individuals Available? (Enter Yes or No)	# Not Reaching Any Target Rate	# Reaching at Least One Target Rate	If Multiple Target Rates, # Reaching All Target Rates (If only one rate, enter NA.)
Practicing Physicians					
Residents/ Fellows					
Physicians’ Assistants					
Nurses (APNP, NP, RN, LPN)					
Other Allied Health					

H. Readjust

29. Post-adjustment data review and further planning. Who was involved in reviewing the post-adjustment data, identifying underlying (root) causes of problem(s) resulting in these new data, and considering possible interventions (“countermeasures”) to address the causes? (Briefly describe the following.)

- **Who was involved?** (e.g., by profession or role)
 - Same as #21? Different than #21 (describe):
- **How?** (e.g., in a meeting of clinic staff)
 - Same as #21? Different than #21 (describe): Results were discussed via small group discussion with clinicians and also through a Qualtrics survey. The Project Leader also gathered feedback from the Chief of the Medical Clinics and the Administrative Manager Intermediate Healthcare.
- **When?** (e.g., date(s) when post-adjustment data were reviewed and discussed): Small group discussions occurred between 9/13/16 and 9/20/16. The Qualtrics survey was distributed 9/13/16.

Use the following table to outline the next plan that was developed: #30 the primary causes, #31 the adjustments(s)/second intervention(s) that addressed each cause, and #32 who would carry out each intervention. This is a simplified presentation of the logic diagram for structured problem solving explained at <http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation> in section 2a.

Note: Adjustments(s) may result in performance achieving the targeted specific aims and the review of post-adjustment data identifies no further causes that are feasible or cost/effective to address. If so, the plan for a next cycle could be to continue the interventions/adjustments currently implemented and check that performance level(s) are stable and sustained through the next observation period.

30. What were the primary underlying/root causes for the <u>problem(s)</u> following the <u>adjustment(s)</u> that the project can address?	31. What further adjustments/ intervention(s) might address this cause?	32. Who would be involved in carrying out each further adjustment/intervention? (List the professions/roles involved.)
We often do not have the immunization records at the time of the visit.	<p>Make submission of immunization records mandatory rather than optional</p> <p>Print out MCIR records for all Medical Clinic Visits</p> <p>Have the EMR (MiChart) import all vaccine records from MCIR</p>	<p>UHS/University of Michigan leadership would have to support this requirement</p> <p>Clerical Staff will print out the MCIR records MA staff will enter the MCIR records in to the chart post-visit so that the patient record will be up to date for all future appointments</p> <p>Michart Support staff would have to work with MCIR to enable Michart to pull MCIR records in to each patient record</p>
Clinicians often missed/forgot to act on the MA statement "Patient interested in HPV vaccine."	Have MAs order all HPV shots and pend them	MAs and Clinicians

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

33. Are additional PDCA cycles to occur for this specific performance effort?

- No further cycles will occur.
- Further cycles will occur, but will not be documented for MOC. *If checked, summarize plans:*
- Further cycles will occur and are to be documented for MOC. *If checked, contact the UM Part IV MOC Program to determine how the project's additional cycles can be documented most practically.*

I. Reflections and Future Actions

33. Describe any barriers to change (i.e. problems in implementing interventions listed in #16 and #23) that were encountered during this QI effort and how they were addressed.

Asking patients for their immunization status proved difficult because patients were often unaware of their vaccine status. We piloted having the clerical staff print out MCIR records for all patients. For patients who are from Michigan, this helped decrease uncertainty as to vaccine status and helped us give stronger recommendations for the vaccine.

Staff in general were resistant to additions to their workflows or were unsure how to efficiently incorporate addressing the HPV vaccine in to their workflows. By dividing the burden of offering and ordering the vaccine (MAs), reinforcing the need for the vaccine and signing the order (clinicians), and counseling the patients on vaccine charges (clerical staff), these fears were largely mitigated. Clinicians still struggled to address the vaccine during busy appointments, though, so this barrier was not completely addressed.

Clinicians often missed/forgot the MA note indicating the patient was interested in the vaccine. A bright pink sticker was placed on the intake paperwork to signal as an additional reminder.

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

Resource limitations were a major barrier to achieving the project goal. While we were able to have MAs consistently identify patients eligible for the HPV vaccine, we did not have the staffing for the vaccine to be administered at the time of intake. The act of deferring the vaccine until after the appointment led to many clinicians forgetting to order the vaccine (despite the reminder stickers). Additionally, we continued to struggle with not knowing the patients' vaccine status at the time of visits. Many chose to defer the vaccine until they could ask their parents or obtain records. Thus, the vaccine could often not be given at the time of visit due to lack of records. In order for this effort to be successful, we need a better system for obtaining immunization records. We did pilot having the MCIR records printed out prior to appointments. We believe this was a contributing factor to the improvements seen in this last cycle of interventions.

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

We piloted printing out the MCIR records for all scheduled patients. This was very helpful in clarifying vaccine status for the patients, thereby removing one barrier to being able to accurately identify patients who needed the vaccine.

We successfully implemented a waiver for any vaccine, including HPV, to be given and charged to the patients/their insurance.

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

A poster has been submitted for the UM Quality Month summarizing the results at each of the UMHS primary care sites that collaborated on this project.

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

We will continue our current process with the addition of expanding to have all clericals print out MCIR records in the medical clinics.

J. Minimum Participation for MOC

38. Participating directly in providing patient care.

a. Did any individuals seeking MOC participate directly in providing care to the patient population?

Yes No *If "No," go to item #39.*

b. Did these individuals participate in the following five key activities over the two cycles of data-guided improvement?

- Reviewing and interpreting baseline data, considering underlying causes, and planning intervention as described in item #14.
 - Implementing interventions described in item #16.
 - Reviewing and interpreting post-intervention data, considering underlying causes, and planning intervention as described in item #21.
 - Implementing adjustments/second interventions described in item #23.
 - Reviewing and interpreting post-adjustment data, considering underlying causes, and planning intervention as described in item #29.
- Yes No *If "Yes," individuals are eligible for MOC unless other requirements also apply and must be met – see item # 40.*

39. Not participating directly in providing patient care.

a. Did any individuals seeking MOC not participate directly in providing care to the patient population?

- Yes No *If "No," go to item 40.*

b. Were the individual(s) involved in the conceptualization, design, implementation, and assessment/evaluation of the cycles of improvement? *(E.g., a supervisor or consultant who is involved in all phases, but does not provide direct care to the patient population.)*

- Yes No *If "Yes," individuals are eligible for MOC unless other requirements also apply and must be met – see item # 40. If "No," continue to #39c..*

c. Did the individual(s) supervising residents or fellows throughout their performing the entire QI effort?

- Yes No *If "Yes," individuals are eligible for MOC unless other requirements also apply and must be met – see item # 40. .*

40. Did this specific QI effort have any additional participation requirement for MOC? *(E.g., participants required to collect data regarding their patients.)*

- Yes No *If "Yes," describe:*

K. Sharing Results

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

- Yes No Formal report to clinical leaders?
- Yes No Presentation (verbal or poster) at a regional or national meeting?
- Yes No Manuscript for publication?

L. Project Organizational Role and Structure

42. UMHS QI/Part IV MOC oversight – indicate whether this project occurs within UMHS, AAVA, or an affiliated organization and provide the requested information.

University of Michigan Health System

• **Overseen by what UMHS Unit/Group?** *(name):* Michael Corrigan, Interim Medical Director

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

- No Yes – the initiative is *(name or describe):* **Collaboration between primary care departments who care for patients 11-26 years old.**

Veterans Administration Ann Arbor Healthcare System

• **Overseen by what AAVA Unit/Group?** (*name*):

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

No Yes – the initiative is:

An organization affiliated with UMHS to improve clinical care

• **The organization is** (*name*):

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

Accountable Care Organization (*specify which member institution*):

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

Other (*specify*):