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

Improving colorectal cancer screening in patients with HIV

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:
R. Van Harrison, PhD, UMHS Part IV Program Co-Lead, 734-763-1425, rvh@umich.edu
J. Kin, MHA, JD, UMHS Part IV Program Co-Lead, 734-764-2103, jkin@umich.edu
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<td>42. Part of UMHS, AAVA, other affiliation with UMHS</td>
</tr>
</tbody>
</table>
QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date (this version of the report): 2/24/20

2. Title of QI effort/project (also insert at top of front page): Improving colorectal cancer screening in patients with HIV

3. Time frame
   a. MOC participation beginning date – date that health care providers seeking MOC began participating in the documented QI project (e.g. date of general review of baseline data, item #14c): January 2019
   b. MOC participation end date – date that health care providers seeking MOC completed participating in the documented QI project (e.g., date of general review of post-adjustment data, item #29c): February 2020

4. Key individuals
   a. QI project leader [also responsible for confirming individual’s participation in the project]
      Name: Tammy Ellies
      Title: Manager, Quality Program, Internal Medicine
      Organizational unit: Department of Internal Medicine
      Phone number: 734-998-5662
      Email address: tmrice@med.umich.edu
      Mailing address: 1500 East Medical Center Dr., UH South Unit 4, Room F4323, SPC 5220, Ann Arbor, MI 48109
   b. Clinical leader who oversees project leader regarding the project [responsible for overseeing/“sponsoring” the project within the specific clinical setting]
      Name: Jamie Riddell, MD
      Title: Professor, Internal Medicine
      Organizational unit: Internal Medicine Department – Infectious Diseases Division
      Phone number: 734-647-9369
      Email address: jriddell@umich.edu
      Mailing address: 1500 East Medical Center Dr., Infectious Diseases, F4131 UH South, 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):

<table>
<thead>
<tr>
<th>Profession</th>
<th>Number (fill in)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicing Physicians</td>
<td>12</td>
</tr>
<tr>
<td>Residents/Fellows</td>
<td>4</td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td>0</td>
</tr>
</tbody>
</table>
b. Approximately how many physicians (by specialty/subspecialty and by training level) and physicians’ assistants participated for MOC?

<table>
<thead>
<tr>
<th>Profession</th>
<th>Specialty/Subspecialty (fill in)</th>
<th>Number (fill in)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicing Physicians</td>
<td>Internal Medicine/ Infectious Diseases*</td>
<td>12</td>
</tr>
<tr>
<td>Fellows</td>
<td>Internal Medicine/ Infectious Diseases</td>
<td>4</td>
</tr>
<tr>
<td>Residents</td>
<td>n/a</td>
<td>0</td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td>(Not applicable)</td>
<td>0</td>
</tr>
</tbody>
</table>

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

☒ Internal institutional funds (e.g., regular pay/work, specially allocated)
☐ Grant/gift from pharmaceutical or medical device manufacturer
☐ Grant/gift from other source (e.g., government, insurance company)
☐ Subscription payments by participants
☐ Other source (describe):

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

B. Plan

7. Patient population. What patient population does this project address (e.g., age, medical condition, where seen/treated):

Patients aged 51-75 seen by Infectious Disease physicians at the University of Michigan Taubman Medical Center outpatient clinic. Patients are diagnosed with HIV (criteria listed below) and are managed by Infectious Diseases only (patient does not see Primary Care provider at Michigan Medicine). The target patients for intervention are the subset of the population not meeting the current performance measure for colorectal cancer screening.

Patient Criteria:
- UMHS Established Patient: Patients must be alive and seen at least twice by the UMHS HIV/AIDS Treatment Program (HATP) clinic with the last 12 months.
- Eligibility: Patients with at least one encounter in an ambulatory care setting with a diagnosis of HIV in the last three years.
- Colorectal Cancer Screening definition: the proportion of patients, 51 - 75 years of age, who have had one of the following:
  - a colonoscopy in the past 10 years,
  - a flexible sigmoidoscopy in the past 5 years,
  - a stool DNA with fecal hemoglobin immunoassay screen (Cologuard) in the past 3 years,
  - a fecal occult blood test (FOBT) in the past year.
- Excluded: Patients who have had a total colectomy or have a history of colon cancer; patients with a Health Maintenance modifier indicating that colon cancer screening is not appropriate
- Patients who have declined the service are included in the denominator, but not the numerator.
8. General purpose.

a. Problem with patient care ("gap" between desired state and current state)
   (1) What should be occurring and why should it occur (benefits of doing this)?
   HIV-infected patients are at increased risk of several cancers, including colorectal cancer, as compared to the general population. Colorectal cancer screening guidelines for HIV-infected persons are similar to recommendations for the general population.

   (2) What is occurring now and why is this a concern (costs/harms)?
   As of December 2018, only 66% of HIV patients seen in the Taubman Infectious Disease Clinic have been screened for colorectal cancer.

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.)

   This project is designed to increase the percent of patients who have the recommended colorectal cancer screening to 73% (the UM Medical Group 90th percentile for colorectal cancer screening among all adults age 51-75).

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 (e.g., Percent of . . ., Mean of . . ., Frequency of . . .):**
  Percent of patients who have had colorectal cancer screening within the established guidelines.

- **Measure components – describe the:**
  Denominator (e.g., for percent, often the number of patients eligible for the measure):
  Total number of patients in the HIV population (described in #7).

  Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation): Number of patients, 51 - 75 years of age, who have had one of the following:
  - a colonoscopy in the past 10 years,
  - a flexible sigmoidoscopy in the past 5 years,
  - a stool DNA with fecal hemoglobin immunoassay screen (Cologuard) in the past 3 years,
  - a fecal occult blood test (FOBT) in the past year.

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

- **This is a measure of:**
  ✓ Process – activities of delivering health care to patients
  □ Outcome – health state of a patient resulting from health care
12. Baseline performance

a. What were the beginning and end dates for the time period for baseline data on the measure(s)?
   May – December 2018

b. What was (were) the performance level(s) at baseline? Display in a data table, bar graph, or run chart (line graph). Can show baseline data only here or refer to a display of data for all time periods attached at end of report. Show baseline time period, measure names, number of observations for each measure, and performance level for each measure.

   Performance level in December 2018 was 66%. See data table and chart at end of report.

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].”

   Increase the percent of patients with HIV who have completed a colorectal cancer screening from 66% in December 2018 to 73% by December 2019.

b. How were the performance targets determined, e.g., regional or national benchmarks?
   The target was determined by project leaders in reference to the University of Michigan Medical Group 90th percentile for colorectal cancer screening among all adults age 51-75.

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

a. Who was involved? (e.g., by profession or role)
   - UMMG Quality Office – Chief Quality Office, Associate Chief Quality Officer, Project Manager
   - Taubman Infectious Diseases ACU – Medical Director, Registered Nurses, Medical Assistants, all faculty and fellows who see ID patients at Taubman clinic
   - Division of Infectious Diseases – Division Administrator
   - Department of Internal Medicine - Department Continuous Improvement Consultant

b. How? (e.g., in a meeting of clinic staff)
   Faculty meetings and adhoc meetings with medical director, nurse, medical assistants

c. When? (e.g., date(s) when baseline data were reviewed and discussed)
   April 24, 2019 – Clinic meeting (faculty and clinical staff)
   May 8, 2019 – Faculty meeting

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:

<table>
<thead>
<tr>
<th>Common Causes</th>
<th>Common Relevant Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
15. What were the primary underlying/root causes for the problem(s) 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.)

<table>
<thead>
<tr>
<th>Test not ordered</th>
<th>Education of providers and MA/RN staff</th>
<th>Physicians and fellows RN Medical Assistants</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Provider/MA focused on other issues at visit</td>
<td>- ID providers/staff need to review and order (not just primary care responsibility)</td>
<td></td>
</tr>
<tr>
<td>- Provider/MA forgets or doesn’t know how to look at Health Maintenance topics</td>
<td>- How to review HM screens</td>
<td></td>
</tr>
<tr>
<td>- Provider/MA unaware they should be ordering test</td>
<td>Activate BPA so that reminder and order set are easy to access. Updated tip sheet.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Test ordered but not completed</th>
<th>Patient education as to importance. Started using existing patient education materials in AVS.(after visit summary)</th>
<th>Physicians and fellows RN Medical Assistants</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Patient doesn’t understand importance</td>
<td>Let patient know that Cologuard (simple test) can be completed instead of colonoscopy</td>
<td></td>
</tr>
<tr>
<td>- Patient didn’t schedule b/c of time required</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Patient has fallen out of care and not attending appointments</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Test completed externally and not recorded in MiChart</th>
<th>New workflow for RN and MA to check HM screens during intake, ask patient, and notify provider when test needed. RN reviewed gap list, checking external results and Care Everywhere to update documentation in MiChart.</th>
<th>RN Medical Assistants</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Forgot to ask patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Didn’t know how to enter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Entered in other database but not Michart</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Didn’t look in Care Everywhere</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.)
May 16, 2019  (Activation of BPA and review of patient gap list and update documentation in MiChart)

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)?
      June 1 - June 30, 2019

   b. What was (were) the overall performance level(s) post-intervention? Add post-intervention data to the data table, bar graph, or run chart (line graph) that displays baseline data. Can show baseline and post-intervention data incrementally here or refer to a display of data for all time periods attached at end of report. Show baseline and post-intervention time periods and measure names and for each time period and measure show number of observations and performance level.

      Performance level in December 2018 was 78%. See data table and chart at end of report.

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

      Yes, baseline performance was 66%; post intervention performance increased to 79% (exceeding the 90th percentile goal of 73%).

E. Adjust – Replan

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

   a. Who was involved? (e.g., by profession or role)
      ☒ Same as #14?  ☐ Different than #14 (describe):

   b. How? (e.g., in a meeting of clinic staff)
      ☒ Same as #14?  ☐ Different than #14 (describe):

   c. When? (e.g., date(s) when post-intervention data were reviewed and discussed)
      July 10, 2019

   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.

<table>
<thead>
<tr>
<th>22. What were the primary underlying/root causes for the problem(s) following the intervention(s) that the project can address?</th>
<th>23. What adjustments/second intervention(s) addressed this cause?</th>
<th>24. Who was involved in carrying out each adjustment/second intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians not familiar with colonoscopy smart set</td>
<td>UMMC quality physician lead educated physicians at beginning of project. ACU medical director provided a refresher as needed to faculty throughout the project.</td>
<td>Physicians and fellows</td>
</tr>
<tr>
<td>Medical assistants not comfortable interacting with Health Maintenance screens</td>
<td>Review workflow and screens with MAs</td>
<td>RN Medical Assistants</td>
</tr>
</tbody>
</table>

F. Redo

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

August 1, 2019

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)?

August 1 – December 31, 2019

b. What was (were) the overall performance level(s) post-adjustment? Add post-adjustment data to the data table, bar graph, or run chart (line graph) that displays baseline and post-intervention data. Can show here or refer to a display of data for all time periods attached at end of report. Show time periods and measure names and for each time period and measure show the number of observations and performance level.

Performance level in December 2019 was 80%. See data table and chart at end of report.
c. Did the adjustment(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)?

Yes, the goal of 90th percentile (73%) was exceeded, with an average of 80% of patients in compliance with the colorectal cancer screening recommendation.

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 listed group of health care providers:
      - Participants with data available:
        〇 Indicate the number participating (if none, enter “0” and do not complete rest of row)
        〇 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.)

<table>
<thead>
<tr>
<th>Profession</th>
<th>Participants with Data Available</th>
<th>Number of These Participants Reaching Targets</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># Participating in QI Effort (from #5.a)</td>
<td># Not Reaching Target Rate</td>
</tr>
<tr>
<td>Practicing Physicians</td>
<td>12</td>
<td>Yes</td>
</tr>
<tr>
<td>Residents/Fellows</td>
<td>4</td>
<td>Yes</td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Nurses (APNP, NP, RN, LPN)</td>
<td>1</td>
<td>No</td>
</tr>
<tr>
<td>Other Licensed Allied Health</td>
<td>0</td>
<td>NA</td>
</tr>
</tbody>
</table>

H. Readjust

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

a. Who was involved? (e.g., by profession or role)
   ☒ Same as #21? ☐ Different than #21 (describe):

b. How? (e.g., in a meeting of clinic staff)
   ☒ Same as #21? ☐ Different than #21 (describe):

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

February 11, 2020
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](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.

<table>
<thead>
<tr>
<th>30. What were the primary underlying/root causes for the problem(s) following the adjustment(s) that the project can address?</th>
<th>31. What further adjustments/intervention(s) might address this cause?</th>
<th>32. Who would be involved in carrying out each further adjustment/intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustaining 80% level could be problematic if physicians are no longer focusing on this measure. The BPA will continue to activate. The nurse and MA will continue to monitor the BPA in clinic and continue the education interventions. The dashboard provides monthly updates, and if the measure starts to fall, a gap report can be run and the group can discuss interventions.</td>
<td>Physicians and clinical staff Clinic administrator Medical Director</td>
<td></td>
</tr>
</tbody>
</table>

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.

- Physicians and staff not aware of Health Maintenance screens and process – educated and activated BPA, changed clinic workflow
• Some patients were getting referred but not completing test – starting using patient education materials in clinic and on AVS, gave option for lower effort test (cologuard instead of colonoscopy)

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

• Physicians do not always check HM screens, particularly in specialty clinics
• External test results are sometimes not entered in MiChart
• Patients do not follow instructions on testing recommendations if they do not understand the importance and options available.

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

• Paying attention to Health Maintenance reminders for all primary care measures in HATP clinic.
• Identification of new project to convert a clinic paper flow sheet into MiChart (in progress now).

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

• Attending to Health Maintenance reminders will help the clinic improve rates for other preventive care screening that is important to patients with HIV.

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

• The lead nurse, physician, and administrator will continue to monitor the rates on the existing dashboard.

J. Minimum Participation for MOC

38. Participating directly in providing patient care.

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

☒ Yes ☐ No If “No,” go to item #39.

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

– Reviewing and interpreting baseline data, considering underlying causes, and planning intervention as described in item #14.
– Implementing interventions described in item #16.
– Reviewing and interpreting post-intervention data, considering underlying causes, and planning intervention as described in item #21.
– Implementing adjustments/second interventions described in item #23.
– Reviewing and interpreting post-adjustment data, considering underlying causes, and planning intervention as described in item #29.

☒ Yes ☐ No If “Yes,” individuals are eligible for MOC unless other requirements also apply and must be met – see item #40.

39. Not participating directly in providing patient care.

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

☐ Yes ☒ No If “No,” go to item 40.
b. Were the individual(s) involved in the conceptualization, design, implementation, and assessment/evaluation of the cycles of improvement? (E.g., a supervisor or consultant who is involved in all phases, but does not provide direct care to the patient population.)

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

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

☐ Yes  ☒ No  If “Yes,” individuals are eligible for MOC unless other requirements also apply and must be met – see item # 40.

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

☐ Yes  ☒ No  If “Yes,” describe:

Individuals who want their participation documented for MOC must additionally complete an attestation form, confirming that they met/worked with others as described in this report and reflecting on the impact of the QI initiative on their practice or organizational role. Following approval of this report, the UMHS QI MOC Program will send to participants an email message with a link to the online attestation form.

K. Sharing Results

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

☒ Yes  ☐ No  Formal report to clinical leaders?

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

☐ Yes  ☒ No  Manuscript for publication?

L. Project Organizational Role and Structure

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

☒ University of Michigan Health System

• Overseen by what UMHS Unit/Group? (name): Internal Medicine Department, Infectious Diseases Division, UMMG

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

☐ No  ☒ Yes – the initiative is (name or describe): Improving colorectal cancer screening for adults aged 51-75.

☐ 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):

Performance Data:

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Number of patients with HIV who qualify for the colorectal screening measure (see #7)</td>
<td>190</td>
<td>233</td>
<td>234</td>
</tr>
<tr>
<td>Percent of these patients who have had colorectal cancer screening within the established guidelines.</td>
<td>66%</td>
<td>79%</td>
<td>80%</td>
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