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

IHA (Integrated Health Associates) Improving Diabetic Patient A1c Control

Instructions

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

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

An option for preliminary review (strongly recommended) is to complete a description of activities through the intervention phase and submit the partially completed report. (Complete at least items 1-18.) Staff from the Michigan Medicine Part IV MOC Program will provide a preliminary review, checking that the information is sufficiently clear, but not overly detailed. This simplifies completion and review of descriptions of remaining activities.

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

For further information and to submit completed applications, contact either:
   R. Van Harrison, PhD, Michigan Medicine Part IV Program Co-Lead, 734-763-1425, rvh@umich.edu
   J. Kin, MHA, JD, Michigan Medicine Part IV Program Co-Lead, 734-764-2103, jkin@umich.edu
   Ellen Patrick, Michigan Medicine Part IV Program Administrator, 734-936-9771, partivmoc@umich.edu

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</tr>
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A. Introduction

1. Date (this version of the report): June 12, 2019

2. Title of QI effort/project: IHA Improving Diabetic Patient A1c Control

3. Time frame
   a. MOC participation beginning date – date the health care providers seeking MOC began participating in the documented QI project (e.g. date of general review of baseline data, item #12c): January 1, 2018
   b. MOC participation end date – date that health care providers seeking MOC completed participating in the documented QI project (e.g., date of general review of post-adjustment data, item #27c): April 30, 2019

4. Key individuals
   a. QI project leader [also responsible for confirming individual’s participation in the project]
      Name: Diana Rooks
      Title: Project Manager, Quality
      Organizational unit: IHA Central, Quality & Performance Improvement
      Phone number: 734.747.6766 x10857
      Email address: Diana_Rooks@ihacares.com
      Mailing address: 24 Frank Lloyd Wright Drive, Lobby J2000, Ann Arbor, MI 48105
   b. Clinical leader who oversees project leader regarding the project [responsible for overseeing/sponsoring the project within the specific clinical setting]
      Name: Dr. Tendai Thomas
      Title: Associate Division Head of Quality, Internal Medicine
      Organizational unit: IHA Internal Medicine Division
      Phone number: 734.995.0303
      Email address: Tendai_Thomas@ihacares.com
      Mailing address: 4100 Whitehall Drive, Ann Arbor, MI 48105

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

<table>
<thead>
<tr>
<th>Participating for MOC</th>
<th>Primary Specialty</th>
<th>Subspecialty, if any</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practicing physicians</td>
<td>Family, Internal Medicine</td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>Residents/Fellows</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td>(N/A)</td>
<td>(N/A)</td>
<td></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):
   Established IHA diabetic patients ages 18 to 64 years of age who have been seen in the last three years

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)?
         Some adult diabetic patients in our practices have poorly controlled diabetes (A1c value greater than 8.0%). Poorly controlled diabetes contributes to excess morbidity (e.g. organ failure including kidney disease, cardiovascular disease, and eye disease among other complications) resulting in higher cost of care and over-utilization of health care resources. Goals of diabetic patient care are to reduce A1c levels to decrease patient illness/complications and costs, as well as improve patient and provider satisfaction with care.

      (2) What is occurring now and why is this a concern (costs/harms)?
         Continued poorly controlled A1c levels lead to poor health outcomes.
         • Many diabetic patients are not compliant in their care and follow up.
         • Providers have limited time and ability to monitor blood sugar levels routinely due to the large patient population.
         • There are limited tools/resources available to educate both patients and providers on how to improve blood sugar control in both the short and long term.

   b. Project goal. What general outcome regarding the problem should result from this project?
      (State general goal here. Specific aims/performance targets are addressed in #11.)
      • Improve the A1c values in diabetic patients by educating patients at all visits about the importance of controlling blood sugars and engaging in their own care.
      • Concurrently improve patient and provider satisfaction with diabetes care.

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

   Measure 1
   • Name of measure (e.g., Percent of . . ., Mean of . . ., Frequency of . . .):
     % of active IHA diabetic patients ages 18 to 64 with A1c value less than 8.0%
   • Measure components – describe the:
     Denominator (e.g., for percent, often the number of patients eligible for the measure):
     All established adult diabetic patients ages 18-64 years of age who have been seen within the last three years
     Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
     Number of these patients whose most recent A1c value is less than 8.0%
The source of the measure is:
- ☐ An external organization/agency, which is (name the source, e.g., HEDIS):
- ☒ Internal to our organization

This is a measure of:
- ☐ Process – activities of delivering health care to patients
- ☒ Outcome – health state of a patient resulting from health care

10. Baseline performance

a. What were the beginning and end dates for the time period for baseline data on the measure(s)?
   January 1, 2017 – December 31, 2017

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.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Number of Patients</th>
<th>% Diabetic patients who have A1c value &lt; 8.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: 12/31/17</td>
<td>6,104</td>
<td>60.0%</td>
</tr>
</tbody>
</table>

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

a. What is the specific aim of the QI effort? “The Aim Statement should include: (1) a specific and measurable improvement goal, (2) a specific target population, and (3) a specific target date/time period. For example: We will [improve, increase, decrease] the [number, amount percent of [the process/outcome] from [baseline measure] to [goal measure] by [date].”
   The % of Family and Internal Medicine division IHA diabetic patients ages 18-64 who have an A1c value less than 8.0% in the calendar year will increase from 60.0% to 65.0% by December 31, 2018.

b. How were the performance targets determined, e.g., regional or national benchmarks?
   The IHA leadership team set the performance target based on review of baseline performance and expert opinion regarding an achievable goal given practical limitations (e.g. patient compliance with all visit recommendations).

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

a. Who was involved? (e.g., by profession or role)
   Providers, Subject Matter Expert on the A1c measure, other clinical office staff; administrative and IT support

b. How? (e.g., in a meeting of clinic staff)
   Core team consisting of a provider champion, a provider subject matter expert, and some clinical staff met to review data. This team prepared materials for presentation to all participating professionals, planned for interventions, and determined how plans were to be implemented across the Family and Internal Medicine divisions. Data, preliminary considerations of causes,
interventions, and proposed implementation were provided to all participating physicians and staff members at all locations for review and discussion during clinical and divisional meetings.

c. **When?** *(e.g., date(s) when baseline data were reviewed and discussed)*

Divisional meetings occurred in February 2018.

*Use the following table to outline the plan that was developed: #13 the primary causes, #14 the intervention(s) that addressed each cause, and #15 who carried out each intervention.* This is a simplified presentation of the logic diagram for structured problem solving explained at [http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation](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>Individuals: Are not aware of, don’t understand.</td>
<td>Education about evidence and importance of goal.</td>
</tr>
<tr>
<td>Individuals: Believe performance is OK.</td>
<td>Feedback of performance data.</td>
</tr>
<tr>
<td>Individuals: Cannot remember.</td>
<td>Checklists, reminders.</td>
</tr>
<tr>
<td>Team: Individuals vary in how work is done.</td>
<td>Develop standard work processes.</td>
</tr>
<tr>
<td>Workload: Not enough time.</td>
<td>Reallocate roles and work, review work priorities.</td>
</tr>
<tr>
<td>Suppliers: Problems with provided information/materials.</td>
<td>Work with suppliers to address problems there.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13. What were the primary underlying/root causes for the problem(s) at baseline that the project can address?</th>
<th>14. What intervention(s) addressed this cause?</th>
<th>15. Who was involved in carrying out each intervention? <em>(List the professions/roles involved.)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers: Lack of diabetic education surrounding drug classes, medication costs, and side effects</td>
<td>Designed diabetic guideline for medication therapies including drug class, mechanism of action, efficacy, potential side effects and cost.</td>
<td>Clinical pharmacist, Associate Division Heads developed guideline and distributed to all FM-IM providers for their reference in caring for their diabetic patients.</td>
</tr>
<tr>
<td>Providers: Lack of diabetic education surrounding treatment algorithm / plans</td>
<td>Developed an evidence-based approach/guideline on how to manage/treat diabetes based on A1c control</td>
<td>Associated Division Heads and Endocrinologists used ADA guidelines to draft visual algorithm for providers to use when treating diabetic patients.</td>
</tr>
<tr>
<td>Patients: Lack of education surrounding the disease itself, causes of the disease, and healthy lifestyle choices like weight management, nutrition and medications</td>
<td>Revise existing “diabetic binder” given to patients at diagnosis. Developed resource document listing tools/resources the patient could use including apps, websites, books, magazines and worksheets i.e. blood sugar logs, carbohydrate counts/serving sizes, and food label reading.</td>
<td>Certified Diabetic Educators and members of the Diabetes Collaborative team including key providers provided suggestions and resources to update various sections of the binder.</td>
</tr>
<tr>
<td>Providers: Lack of a standardized approach regarding refilling diabetic medications for patients. Patients could get refills without being seen at the recommended intervals.</td>
<td>Revised our medication refill guideline to include appropriate intervals for medication refills and expected office visit time intervals. Educated all providers and clinical staff at divisional meetings on the new guideline.</td>
<td>Associate Division Heads and Medical Assistants on the Diabetes Collaborative team provided input to update the guideline and train all providers and staff.</td>
</tr>
</tbody>
</table>

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

16. By what date was (were) the intervention(s) initiated? *(If multiple interventions, date by when all were initiated.)*
   April 1, 2018

D. Check

17. Post-intervention performance measurement. Are the population and measures the same as those for the collection of baseline data (see item 9)?
   ☒ Yes  ☐ No – If no, describe how the population or measures differ:

18. Post-intervention performance
   a. What were the beginning and end dates for the time period for post-intervention data on the measure(s)?
      April 1, 2018 – June 30, 2018
   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.

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Number of Patients</th>
<th>% Diabetic patients who have A1c value &lt; 8.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: 12/31/17</td>
<td>6,104</td>
<td>60.0%</td>
</tr>
<tr>
<td>Post Intervention:6/30/18</td>
<td>7,396</td>
<td>60.1%</td>
</tr>
</tbody>
</table>
   c. Did the intervention(s) produce the expected improvement toward meeting the project’s specific aim (item 11.a)?
      No. The team recognized that the time from implementation of these interventions to the end of the measurement period was not necessarily sufficient to see improved results. These interventions were kept in place and data will be re-evaluated after a longer time interval.

E. Adjust – Replan

19. Post-intervention data review and further planning. Who was involved in reviewing the post-intervention data, identifying underlying (root) causes of problem(s) resulting in these new data, and considering possible interventions (“countermeasures”) to address the causes? *(Briefly describe the following.)*
   a. Who was involved? *(e.g., by profession or role)*
      ☒ Same as #12?  ☐ Different than #12 *(describe):*
   b. How? *(e.g., in a meeting of clinic staff)*
      ☒ Same as #12?  ☐ Different than #12 *(describe):*
c. **When? (e.g., date(s) when post-intervention data were reviewed and discussed)**

Divisional meetings occurred in July 2018.

**Use the following table to outline the next plan that was developed:** #20 the primary causes, #21 the adjustments(s)/second intervention(s) that addressed each cause, and #22 who carried out each intervention. This is a simplified presentation of the logic diagram for structured problem solving explained at http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation in section 2a.

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

<table>
<thead>
<tr>
<th>20. What were the primary underlying/root causes for the problem(s) following the intervention(s) that the project can address?</th>
<th>21. What adjustments/second intervention(s) addressed this cause?</th>
<th>22. Who was involved in carrying out each adjustment/second intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers: Lack of training in motivational interviewing techniques used by care managers resulting in poor provider and patient satisfaction surrounding diabetic care.</td>
<td>Worked with Behavioral Health Leadership to discuss how to motivate patients and increase patient engagement in their own care. Presented topic and basic concepts at a Quadruple Aim session and used role playing to teach providers how to improve communication with patients and patient engagement.</td>
<td>Key provider on the Diabetes Collaborative team and the Behavioral Health team completed the research and created the presentation and education delivered to the providers at the provider education sessions.</td>
</tr>
<tr>
<td>Providers: Lack of consistent agenda-setting methodology for diabetic patient visits. Many patients have other comorbidities resulting in lengthy office visits, fragmented care goals, and poor patient satisfaction.</td>
<td>Educated providers on agenda-setting concepts via literature review and presentation at divisional meetings. Created tool to use during patient office visits allowing the patient to report and prioritize concerns to be discussed with the provider that day.</td>
<td>Diabetes Collaborative team members, Associate Division Head, and providers and staff at the pilot locations developed and implemented the tool and pilot process.</td>
</tr>
<tr>
<td>Providers: Lack of team based-approach to address multiple patient concerns due to illness complexity in limited time visits. Overall poor A1c control despite providers’ best efforts to affect change.</td>
<td>Placed clinical pharmacists within the practices that specifically targeted poorly controlled diabetics. These pharmacists spent more time with patients and interventions included medication changes/additions and patient education on how to improve blood sugar control. Motivational interviewing techniques were widely used to accomplish these interventions.</td>
<td>Director of Clinical Services, Clinical Operations team, including embedded pharmacists and providers, worked to develop workflows, referral processes and patient care team reviews including appropriate patient follow up. Endocrine providers also involved in cases of shared patient treatment.</td>
</tr>
</tbody>
</table>

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

23. By what date was (were) the adjustment(s)/second intervention(s) initiated? (If multiple interventions, date by when all were initiated.)
   August 1, 2018

G. Recheck

24. Post-adjustment performance measurement. Are the population and measures the same as indicated for the collection of post-intervention data (item #19)?
   ☒ Yes    ☐ No – If no, describe how the population or measures differ:

25. Post-adjustment performance
   a. What were the beginning and end dates for the time period for post-adjustment data on the measure(s)?
      October 1, 2018 – December 31, 2018
   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.

```
<table>
<thead>
<tr>
<th>Time Period</th>
<th>Number of Patients</th>
<th>% Diabetic patients who have A1c value &lt; 8.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: 12/31/17</td>
<td>6,104</td>
<td>60.0%</td>
</tr>
<tr>
<td>Post Intervention: 6/30/18</td>
<td>7,396</td>
<td>60.1%</td>
</tr>
<tr>
<td>Post Adjustment: 12/31/18</td>
<td>6,979</td>
<td>61.3%</td>
</tr>
</tbody>
</table>
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   c. Did the adjustment(s) produce the expected improvement toward meeting the project’s specific aim (item 11.a)?
      Although the target of 65% was not achieved, there was a slight improvement in the metric. The team recognized that the time from implementation of these interventions to the end of the measurement period was not necessarily sufficient to see the full extent of improved results. These interventions were kept in place with the intention of reviewing data again after six more months.

H. Readjust

26. Post-adjustment data review and further planning. Who was involved in reviewing the post-adjustment data, identifying underlying (root) causes of problem(s) resulting in these new data, and considering possible interventions (“countermeasures”) to address the causes? (Briefly describe the following.)
   a. Who was involved? (e.g., by profession or role)
      ☒ Same as #19?    ☐ Different than #19 (describe):
   b. How? (e.g., in a meeting of clinic staff)
Michigan Medicine Quality Department Part IV Maintenance of Certification Program

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

When? (e.g., date(s) when post-adjustment data were reviewed and discussed)
Data will be monitored during the 2019 calendar year and reviewed again in detail at year end, December 31, 2019.

Use the following table to outline the next plan that was developed: #27 the primary causes, #28 the adjustments(s)/second intervention(s) that addressed each cause, and #29 who would carry out each intervention. This is a simplified presentation of the logic diagram for structured problem solving explained at http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation in section 2a.

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

<table>
<thead>
<tr>
<th>27. What were the primary underlying/root causes for the problem(s) following the adjustment(s) that the project can address?</th>
<th>28. What further adjustments/intervention(s) might address this cause?</th>
<th>29. Who would be involved in carrying out each further adjustment/intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Causes listed in #13 and #20 continue to be a concern</td>
<td>Educational and workflow interventions listed in #14 and #21 will be continued to check longer term results</td>
<td>Individuals listed in #15 and #22, including all the providers at each site</td>
</tr>
</tbody>
</table>

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

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:

I. Minimum Participation for MOC

31. Participating directly in providing patient care.

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

☒ Yes  ☐ No  If “No,” go to item #32.

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

– Reviewing and interpreting baseline data, considering underlying causes, and planning intervention as described in item #12.
– Implementing interventions described in item #14.
– Reviewing and interpreting post-intervention data, considering underlying causes, and planning intervention as described in item #19.
– Implementing adjustments/second interventions described in item #21.
– Reviewing and interpreting post-adjustment data, considering underlying causes, and planning intervention as described in item #26.

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

32. Not participating directly in providing patient care.
   a. Did any individuals seeking MOC not participate directly in providing care to the patient population?
      ☐ Yes ☒ No  If “No,” go to item 33.
   b. Were the individual(s) involved in the conceptualization, design, implementation, and assessment/evaluation of the cycles of improvement?  (E.g., a supervisor or consultant who is involved in all phases, but does not provide direct care to the patient population.)
      ☐ Yes ☐ No  If “Yes,” individuals are eligible for MOC unless other requirements also apply and must be met – see item # 38.  If “No,” continue to #37c.
   c. Did the individual(s) supervising residents or fellows throughout their performing the entire QI effort?
      ☐ Yes ☐ No  If “Yes,” individuals are eligible for MOC unless other requirements also apply and must be met – see item # 33.

33. Did this specific QI effort have any additional participation requirement for MOC?  (E.g., participants required to collect data regarding their patients.)
   ☐ Yes ☒ No  If “Yes,” describe:

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

J. Sharing Results

34. Are you planning to present this QI project and its results in a:
   ☒ Yes ☐ No  Formal report to clinical leaders?
   ☐ Yes ☒ No  Presentation (verbal or poster) at a regional or national meeting?
   ☐ Yes ☒ No  Manuscript for publication?

K. Project Organizational Role and Structure

35. UMHS QI/Part IV MOC oversight – indicate whether this project occurs within UMHS, AAVA, or an affiliated organization and provide the requested information.
   ☐ University of Michigan Health System
      • Overseen by what UMHS Unit/Group? (name):
      • Is the activity part of a larger UMHS institutional or departmental initiative?
         ☐ No ☒ Yes – the initiative is (name or describe):
☐ Veterans Administration Ann Arbor Healthcare System

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

• 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):  IHA

• 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):

Baseline Data:  December 31, 2017

Post Intervention Data:  June 30, 2018
Post Adjustment Data: December 31, 2018

<table>
<thead>
<tr>
<th>Division</th>
<th>Location</th>
<th>Provider</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>Family Medicine</td>
<td>2,324</td>
<td>3,821</td>
<td></td>
<td>60.8%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>Internal Medicine</td>
<td>1,955</td>
<td>3,158</td>
<td></td>
<td>61.9%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>4,279</td>
<td>6,979</td>
<td>61.3%</td>
</tr>
</tbody>
</table>