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

Fever Pathways for 7-59 Day-Olds

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](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

Report Outline

<table>
<thead>
<tr>
<th>Section</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Introduction</strong></td>
<td>1-6. Current date, title, time frame, key individuals, participants,</td>
</tr>
<tr>
<td></td>
<td>funding</td>
</tr>
<tr>
<td><strong>B. Plan</strong></td>
<td>7-8. Patient population, general goal</td>
</tr>
<tr>
<td></td>
<td>9-11. Measures, baseline performance, specific aims</td>
</tr>
<tr>
<td></td>
<td>12-15. Baseline data review, underlying (root) causes, interventions,</td>
</tr>
<tr>
<td></td>
<td>who will implement</td>
</tr>
<tr>
<td><strong>C. Do</strong></td>
<td>16. Intervention implementation date</td>
</tr>
<tr>
<td><strong>D. Check</strong></td>
<td>17-18. Post-intervention performance</td>
</tr>
<tr>
<td><strong>E. Adjust – Replan</strong></td>
<td>19-22. Post-intervention data review, underlying causes, adjustments,</td>
</tr>
<tr>
<td></td>
<td>who will implement</td>
</tr>
<tr>
<td><strong>F. Redo</strong></td>
<td>23. Adjustment implementation date</td>
</tr>
<tr>
<td><strong>G. Recheck</strong></td>
<td>24-26. Post-adjustment performance, summary of individual performance</td>
</tr>
<tr>
<td><strong>H. Readjust plan</strong></td>
<td>27-30. Post-adjustment data review, underlying causes, further</td>
</tr>
<tr>
<td></td>
<td>adjustments, who will implement</td>
</tr>
<tr>
<td><strong>I. Participation for MOC</strong></td>
<td>31-33. Participation in key activities, other options, other</td>
</tr>
<tr>
<td></td>
<td>requirements</td>
</tr>
<tr>
<td><strong>J. Sharing results</strong></td>
<td>34. Plans for report, presentation, publication</td>
</tr>
<tr>
<td><strong>K. Organization affiliation</strong></td>
<td>35. 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): 9/20/2019.

2. Title of QI effort/project (also insert at top of front page): Fever pathways for 7-59 day olds brought in from home

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 #12c): 6/25/18
   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): 6/19/19

4. Key individuals:
   a. QI project leader [also responsible for confirming individual’s participation in the project]
      Name: Kimberly Monroe
      Title: Pediatric Hospitalist, C.S. Mott Children’s Hospital, Michigan Medicine
      Organizational unit: 12E/12W/11W/7E – General care floors and CES
      Phone number: 312.543.4674 (cell)
      Email address: monroek@med.umich.edu
      Mailing address: CW 12-525
                      1540 E. Hospital Drive
                      Ann Arbor, MI 48109-4280
   b. Clinical leader who oversees project leader regarding the project [responsible for overseeing/“sponsoring” the project within the specific clinical setting]
      Name: Terrill D. Bravender, M.D., MPH
      Title: Professor of Pediatrics; Director of Quality Improvement
      Organizational unit: Department of Pediatrics, University of Michigan
      Phone number: 734 936-9777
      Email address: tdbrave@umich.edu
      Mailing address: 1500 E. Medical Center Drive, D2215, Ann Arbor, MI 48109

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>Pediatrics and Med/Peds</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Residents/Fellows</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Physicians’ Assistants</td>
<td>(N/A)</td>
<td>(N/A)</td>
<td>0</td>
</tr>
</tbody>
</table>

6. How was the QI effort funded? (Check all that apply.)
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):
   The febrile, well-appearing infant, age 7-59 days old, who is brought from home to C.S. Mott Children's Hospital

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)?
      Febrile infants should be treated according to evidence-based guidelines. There should be little to no variation in terms of labs ordered, antibiotic choice and length of stay.

      (2) What is occurring now and why is this a concern (costs/harms)?
      C. S. Mott Children's Hospital has not had a specific set of guidelines for the management of the febrile newborn (age 7-59 days, brought in from home). Therefore, care has been variable across clinicians. Inappropriate or inadequate care of infants with fevers can result in serious health consequences, including sepsis and death as well as performing procedures, initiating cares that are unnecessary. Although various national guidelines are available, they all exhibit some degree of variability from one another. In 2016, a national quality improvement initiative was launched to help reduce this variation in care: REVISE (Reducing Excessive Variability in Infant Sepsis Evaluation).

   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.)
      Increase the consistency of providing evidence-based, high quality care to well-appearing infants, age 7-59 days, presenting with a fever and admitted to C.S. Mott Children's Hospital.

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 . . .):
     Average Length of Stay (in hours/minutes) for all patients, 7-59 days old, presenting with a fever and admitted
• **Measure components** – describe the:
  Denominator (e.g., for percent, often the number of patients eligible for the measure):
  Number of patients
  Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
  Total number of hours/minutes of stay across all patients

• **The source of the measure is:**
  □ An external organization/agency, which is (name the source, e.g., HEDIS):
  ✗ Internal to our organization – chosen by local clinical leaders as a realistic target.

• **This is a measure of:**
  ✗ Process – activities of delivering health care to patients
  □ Outcome – health state of a patient resulting from health care

Measure 2

• **Name of measure** (e.g., Percent of . . ., Mean of . . ., Frequency of . . .):
  Percent of infants tested for HSV PCR whole blood testing

• **Measure components** – describe the:
  Denominator (e.g., for percent, often the number of patients eligible for the measure):
  Number of patient who, per the pathway, should have been tested for HSV PCR whole blood
  Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
  Number of these patients who were tested for HSV PCR whole blood

• **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): the measure was selected as an important aspect of evidence-based care for this population

• **This is a measure of:**
  ✗ Process – activities of delivering health care to patients
  □ Outcome – health state of a patient resulting from health care

(If more than two measures are tracked across the two cycles, copy and paste the section for a measure and describe the additional measures.)

Measure 3

• **Name of measure** (e.g., Percent of . . ., Mean of . . ., Frequency of . . .):
  Percent of infants who receive only recommended empiric antibiotic regimens within 24 hours of presentation. (no predata – guideline not in place)

• **Measure components** – describe the:
  Denominator (e.g., for percent, often the number of patients eligible for the measure):
  Number of patients who were 7-59 days old, well-appearing and febrile and admitted
  Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
  Number of patients who received only recommended empiric antibiotics regimens within 24 hours of presentation

• **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): the measure was selected as an important aspect of evidence-based care.

- 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)?
   12/2015 – 08/2017

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.
   - Average length of Stay: 48.3 hours
   - HSV whole blood sent on appropriate patients: <10%
   - Patients who received the correct antibiotics within 24 hours of presentation (not yet measured)

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].”

   By June 2019,
   - We will decrease the length of stay of admitted patients, 7-59 days old, who are well-appearing and febrile from 48.3 hours to <40 hours.
   - We will increase the percentage of 7-59 day old infants who are well-appearing and febrile tested for HSV PCR whole blood testing from < 10% to 50% or greater
   - We will measure and increase the percentage of 7-59 day old infants who are well-appearing and febrile who receive only recommended empiric antibiotics regimens within 24 hours of presentation. (No baseline data. When we collect data, we will aim to improve over baseline, but without a target.)

b. How were the performance targets determined, e.g., regional or national benchmarks?
   - Length of stay: We chose the performance targets in light of evidence-based recommendations, and based on what we thought we could do with two PDCA cycles
   - HSV testing: We chose the performance target based on what we thought would be reasonable based on the anticipated culture change, unfamiliarity of the test and working with two PDCA cycles.
   - Antibiotic use: No predata so difficult to anticipate performance targets.

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) Pediatric and Medicine/Pediatric hospitalists.

b. How? (e.g., in a meeting of clinic staff) Email was sent with baseline data in it, and data was discussed at division meetings.
c. **When?** (e.g., date(s) when baseline data were reviewed and discussed)
   6/25/2018 – Email sent with baseline data

*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>Reallocation of 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>

13. What were the primary underlying/root causes for the problem(s) at baseline that the project can address?
14. What intervention(s) addressed this cause?
15. Who was involved in carrying out each intervention? (List the professions/roles involved.)

| Individuals: Are not aware of evidence-based guidelines. | Policy made based on evidence-based guidelines, then disseminated. | Hospitalists and project leaders. |

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.)
   9/13/17 – Approval and dissemination of policy

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)? October 1, 2017 – March 31, 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.
Michigan Medicine Quality Department Part IV Maintenance of Certification Program

- Average Length of Stay: 35.2 hours on average, median 37 hours
- HSV whole blood sent on appropriate patients: 80% of the time
- Patients who received the correct antibiotics within 24 hours of presentation: 74%

c. Did the intervention(s) produce the expected improvement toward meeting the project's specific aim (item 11.a)? Yes. Achieved target on Measures 1 and 2. Achieved rate of 75% of Measure 3.

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)
   12/17/18

   Use the following table to outline the next plan that was developed: #20 the primary causes, #21 the adjustments/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.</th>
<th>What were the primary underlying/root causes for the problem(s) following the intervention(s) that the project can address?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty with getting timely results on HSV PCR whole blood</td>
<td></td>
</tr>
<tr>
<td>Still seeing provider variability in ordering of antibiotics and LOS</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>21.</th>
<th>What adjustments/second intervention(s) addressed this cause?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussion with lab to see if we can run the HSV PCR whole blood at our institution</td>
<td></td>
</tr>
<tr>
<td>Make an order set to make it more obvious who needs antibiotics and who doesn’t and provide feedback on data from PDCA cycle #1</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>22.</th>
<th>Who was involved in carrying out each adjustment/second intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project leaders and hospitalists; Lab staff</td>
<td></td>
</tr>
<tr>
<td>Project leaders and hospitalists; IT staff</td>
<td></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.)
   7/2/2018 – Order set went live in Epic

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)?
      July, August, September, December (2018), January, February (2019). *October and November 2018 were not included as there were issues with the HSV PCR whole blood order at this time

   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.
      - Average Length of Stay: 37.2 hours on average, median 41.5 hours
      - HSV whole blood sent on appropriate patients: 69%
      - Patients who received the correct antibiotics within 24 hours of presentation: 86%

   c. Did the adjustment(s) produce the expected improvement toward meeting the project's specific aim (item 11.a)? Yes. While performance on measures 1 and 2 deteriorated slightly from the post intervention rate, they sustained above target levels. Measure 3 improved from 74% post intervention to 86%, post adjustment.

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

   c. When? (e.g., date(s) when post-adjustment data were reviewed and discussed)
      6/3/19 – Division meeting

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

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>Provider variability in Children’s Emergency Services (CES) as to when antibiotics are started</td>
<td>Working on a dynamic orderset (previous one was static). A dynamic orderset will help providers decide if antibiotics are needed better than in a static orderset.</td>
<td>Hospitalists; CES providers; IT staff</td>
</tr>
</tbody>
</table>

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

30. 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: Providers were asked to do chart reviews on patients that they may or may not have managed while the patients were inpatient. Chart reviews were not collected on any active inpatient being managed for fever in the 7-59 age group.

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): Department of Pediatrics
      • 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):
  • 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):