

## Report on a QI Project Eligible for Part IV MOC

### 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. Final confirmation of Part IV MOC for a project occurs when the full report is submitted and approved.

An option for preliminary review (recommended) is to complete a description of activities through the intervention phase and submit the partially completed report. (Complete at least items 1-16 and 27a-b.) 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 and answers should be in regular font (generally immediately below the questions). To check boxes electronically, either put an “X” in front of a box or copy and paste “☑” over the blank box.

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

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### Report Outline

Section	Items
<b>A. Introduction</b>	1-6. Current date, title, time frame, project leader, specialties/subspecialties involved, funding
<b>B. Plan</b>	7-10. General goal, patient population, IOM quality dimensions addressed, experimental design 11-12. Baseline measures of performance, specific performance objectives 13. Data review and identifying underlying (root) causes
<b>C. Do</b>	14-16. Intervention(s), who is involved, initiated when
<b>D. Check</b>	17-18. Post-intervention performance measurement, data collection, performance level
<b>E. Adjust – Replan</b>	19. Review, continuing/new underlying causes,
<b>F. Redo</b>	20. Second intervention
<b>G. Recheck</b>	21-22. Post-adjustment performance measurement, data collection, performance level
<b>H. Readjust plan</b>	23. Review, continuing/new underlying causes to address
<b>I. Future plans</b>	24-26. Subsequent PDCA cycles, standardize processes, “spread” to other areas
<b>J. Physician involvement</b>	27-31. Physician’s role, requirements, reports, reflections, participation, number
<b>K. Project Organization</b>	32-34. Part of larger initiative, organizational structure, resources, oversight, Part IV opportunity

## QI Project Report for Part IV MOC Eligibility

### A. Introduction

1. **Date** (*this version of the-report*): 20 August 2014
  
2. **Title of QI project:** Numerical Rating of Pain in the Initial Symptom Assessment during Inpatient Palliative Care Consultations
  
3. **Time frame**
  - a. **At what stage is the project?**
    - Design is complete, but not yet initiated
    - Initiated and now underway
    - Completed
  
  - b. **Time period**
    - (1) **Date physicians begin participating (may be in design phase):** 16 December 2013
    - (2) **End date:** X actual 20 August 2014
  
4. **QI project leader [responsible for attesting to the participation of physicians in the project]:**
  - a. **Name:** Daniel B. Hinshaw, M.D.
  - b. **Title:** Professor
  - c. **Institutional/organizational unit/affiliation:** Section of General Surgery, Department of Surgery and Geriatrics Center, University of Michigan and Section of Geriatric Medicine, VA Ann Arbor Healthcare System
  - d. **Phone number:** (734) 845-3072
  - e. **Email address:** hinshaw@umich.edu
  - f. **Mailing address:** VAMC (11G), 2215 Fuller Road, Ann Arbor, MI 48105
  
5. **What specialties and/or subspecialties are involved in this project?** Surgery, Internal Medicine, Hospice & Palliative Medicine, and Geriatric Medicine
  
6. **Will the funding and resources for the project come only from internal UMHS sources?**
  - Yes, only internal UMHS sources
  - No, funding and/or resources will come in part from sources outside UMHS, which are: \_\_\_\_\_

*The Multi-Specialty Part IV MOC Program requires that projects engage in change efforts over time, including at least three cycles of data collection with feedback to physicians and review of project results. Some projects may have only three cycles while others, particularly those involving rapid cycle improvement, may have several more cycles. The items below are intended to provide some flexibility in describing project methods. If the items do not allow you to reasonably describe the methods of your specific project, please contact the UMHS Part IV MOC Program office.*

### B. Plan

7. **General goal:** To improve the quality of initial pain assessments made during inpatient palliative care consultations in patients with advanced life-threatening illnesses.
  - a. **Problem/need. What is the “gap” in quality that resulted in the development of this project? Why is this project being undertaken?** A major initiative in most hospitals in the US in the past decade has been to encourage adoption of “pain as the fifth vital sign.” The Joint Commission has added standards (*Comprehensive Accreditation Manual for Ambulatory Care*. Oakbrook Terrace,

IL: Joint Commission on Accreditation of Healthcare Organizations; 2006.) specifically designed to encourage assessment for pain and other forms of patient distress as part of the standard of care. The Department of Veterans Affairs has followed suit such that it is an expectation that pain will be rated by nursing staff while taking the routine vital signs, typically using a numerical analog scale (local VA policy) from 0-10 in which 0 = no pain and 10 = the worst pain imaginable to the patient. Typically, the scores are then recorded in the nursing notes as fractions (e.g., 0/10 – 10/10). The template adopted for palliative care consultations in the VA electronic medical record at the VA Ann Arbor Healthcare System has adopted this system and has prompts to encourage its use by physician trainees and attending physicians in the documentation of their findings during palliative care consultations. Although its use has also been advocated within the medical literature with some caveats (e.g., *J Gen Intern Med* 22(10):1453–8, 2007), it has not been clear how compliant physicians performing palliative care consultations have been with use of this means of rating pain.

- b. Project goal. What outcome regarding the problem should result from this project?** Greater than 90 percent of patients, who can use numerical scales during palliative care consultations to rate their pain, have had their pain assessed and rated in this manner, as documented in the palliative care consultation within the electronic health record.

**8. Patient population. What patient population does this project address?** This project addresses military veterans with serious life-threatening illnesses, who are inpatients at the VA Ann Arbor Healthcare System and have been referred by their primary inpatient medical team for palliative care consultation.

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

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

**10. What is the experimental design for the project?**

- Pre-post comparisons (baseline period plus two or more follow-up measurement periods)  
 Pre-post comparisons with control group  
 Other: \_\_\_\_\_

**11. Baseline measures of performance:**

**a. What measures of quality are used? If rate or %, what are the denominator and numerator?**

The measure of quality used was the percentage of palliative care consultations in which a standard numerical rating scale was used when pain was assessed. The denominator for this measure was derived by first determining the number of palliative care consultations in which it was not possible to assess pain due to cognitive impairment and also those consultations in which pain was categorically denied by the patient. The sum of these two groups was then subtracted from the total number of inpatient palliative care consultations to identify those remaining palliative care consultations in which numerical rating of pain should have been possible, i.e., the denominator. The numerator was the actual number of patients in the denominator for whom documentation of numerical rating of a pain score within the consultation was confirmed by chart review of the electronic health record.

**b. Are the measures nationally endorsed?**

Yes

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

Medical records

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

Chart review/abstraction

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

Extremely reliable

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

Simple comparison of means

**g. To whom are data reported?**

Data were reported via email and direct discussion with medicine service attending physicians who serve as faculty for the inpatient palliative care consultation and geriatric services at the VA Ann Arbor Healthcare System, hospice and palliative medicine fellows (trainees) who rotate on the service and other members of the interdisciplinary palliative care consultation team including the Chief of the Geriatric Medicine section at the VA Ann Arbor Healthcare System (Dr. Robert Hogikyan).

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

12/16/13 – 1/15/14

**12. Specific performance objectives**

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

Time Period	N of Inpatient Palliative Care Consults	N (%) of Consults Where Impaired Cognition Limited Assessment of Pain	N (%) of Consults Where Patient Denied Pain	N (%) of Consults Where Cognition Intact and Pain Present	N (%) of Consults Where Cognition Intact and Pain Present in which Numerical Rating Scale Used to Rate Pain
Baseline: 12/16/13 – 1/15/14	28	2/28 (7.1%)	9/28 (32.1%)	17/28 (60.7%)	<b>9/17 (52.9%)</b>

**b. Specific aim: What is the target for performance on the measure(s) and the timeframe for achieving the target?**

Greater than 90 percent of patients, who can use numerical scales during palliative care consultations to rate their pain, have had their pain assessed and rated in this manner, as documented in the palliative care consultation within the electronic health record. The timeframe for achieving this target was at the end of two intervention cycles of 30 days each.

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

Based on best clinical judgment in the context of national benchmarks (Department of Veterans Affairs and Joint Commission).

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

**a. Who was involved in reviewing the baseline data, identifying underlying (root) causes of the problem(s), and considering possible interventions (“countermeasures”) to address the causes? Briefly describe who is involved, how (e.g., in a meeting of clinic staff), and when.**

In the month of February, 2014 the baseline data were shared via email and direct discussion with medicine service attending physicians who serve as faculty for the inpatient palliative care and geriatrics consultation services at the VA Ann Arbor Healthcare System, other medical faculty in the hospice and palliative medicine fellowship, hospice and palliative medicine fellows (trainees) who

rotate on the service and other members of the interdisciplinary palliative care consultation team including the Chief of the Geriatric Medicine section at the VA Ann Arbor Healthcare System (Dr. Robert Hogikyan) to obtain their reactions and thoughts in response to the data and to solicit their feedback and suggestions regarding ways to improve compliance with this measure. Initially, there was a general consensus that although the numerical rating system for assessment of pain has some significant limitations (e.g., some patients, especially elderly patients, are not able to use the scale), it would be extremely worthwhile to try to improve compliance with use of the scale, before making major modifications or abandoning it in favor of another approach.

**b. What are the primary underlying/root causes for the problem(s) that the project can address?** *(Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately. How the intervention(s) address each primary underlying cause will be explained in #14.c.)*

Factors affecting compliance with this quality measure that were identified:

- 1) Related to people – lack of experience with numerical rating scales (this was a contributing factor for some trainees); lack of consistent use of the consultation template which prompted for numerical rating of pain (this was due to frustrations with template design, which could not be addressed locally since the template is a national VA template)
- 2) Related to processes – the VA consultation template automatically populates the consult with the most recent numerical rating score for pain entered in the electronic health record by nursing staff. Although this information could be useful, it cannot substitute for the assessment performed by the consultant, but in some instances had been the only numerical rating recorded because of inconsistent use of the numerical rating scale by consultants.
- 3) Related to information infrastructure – the VA has an excellent electronic health record which should make the process easier. However, the availability of templates within the system has been a two-edged sword sometimes serving as a substitute for careful assessments when consultations are performed in haste.
- 4) Related to equipment – none
- 5) Related to environment - none

## C. Do

### 14. Intervention(s).

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

An educational intervention was made via email and direct communication to medical attending physicians, physician trainees, and other members of the palliative care interdisciplinary team regarding the importance of the consistent use of the numerical rating scale in assessing pain during palliative care consultations at the VA Ann Arbor Healthcare System. The baseline data presented in # 12a above were discussed and it was recognized that although the numerical rating scale has limitations, its value may lie in its potential to be a more objective means of assessment across different raters and in assuring the safety of the rapid titration of opioid analgesics to relieve severe pain.

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

Factors affecting compliance with this quality measure that were identified:

- 1) Related to people – lack of experience with numerical rating scales (this was a contributing factor for some trainees); lack of consistent use of the consultation template which prompted for numerical rating of pain (this was due to frustrations with template design, which could not be addressed locally since the template is a national VA template)  
*People-related factors were addressed by educational discussions via email and in-person with all of the participants, allowing them to express their frustrations with the consultation template while at the same time achieving consensus that numerical rating of pain is quite useful for many palliative care patients, especially in guiding the care of those who are receiving escalating doses of strong analgesic medications to control their pain.*

2) Related to processes – the VA consultation template automatically populates the consult with the most recent numerical rating score for pain entered in the electronic health record by nursing staff. Although this information could be useful, it cannot substitute for the assessment performed by the consultant but in some instances had been the only numerical rating recorded because of inconsistent use of the numerical rating scale by consultants.

*The intervention for the people-related factors was also applicable for this root cause. All consultants were informed that automatically populated data from nursing charting of pain scores would not be considered in chart reviews to determine compliance with this measure.*

3) Related to information infrastructure – the VA has an excellent electronic health record which should make the process easier. However, the availability of templates within the system has been a two-edged sword sometimes serving as a substitute for careful assessments when consultations are performed in haste.

*Again, the interventions for the people-related and process-related factors were also applicable for this root cause. All consultants were informed that automatically populated data from nursing charting of pain scores would not be considered in chart reviews to determine compliance with this measure.*

4) Related to equipment – none  
N/A

5) Related to environment - none  
N/A

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

Daniel B. Hinshaw, M.D., in collaboration with the other participating physicians in this project (Drs. Montagnini, Hogikyan, Alexander, Hummel, Vitale, and Marks), provided the educational intervention. The other participating physicians provided refinements to the intervention through the analysis and discussion of the root causes of the poor compliance with this quality measure.

**16. The intervention was initiated when? (For multiple interventions, initiation date for each.)**

Late March via emails and April 1, 2014 in person

**D. Check**

**17. Post-intervention performance measurement. Is this data collection to follow the same procedures as the initial collection of data described in #11: population, measure(s), and data source(s)?**

X Yes       No – If no, describe how this data collection

**18. Performance following the intervention.**

**a. The collection of the sample of performance data following the intervention either:**

Has occurred for the period: April 1-30, 2014

**b. If the data collection has occurred, what is post-intervention performance level? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)**

Time Period	N of Inpatient Palliative Care Consults	N (%) of Consults Where Impaired Cognition Limited Assessment of Pain	N (%) of Consults Where Patient Denied Pain	N (%) of Consults Where Cognition Intact and Pain Present	N (%) of Consults Where Cognition Intact and Pain Present in which Numerical Rating Scale Used to Rate

					Pain
Baseline: 12/16/13 – 1/15/14	28	2/28 (7.1%)	9/28 (32.1%)	17/28 (60.7%)	9/17 (52.9%)
First Intervention Period: 4/1 – 4/30/14	27	8/27 (29.6%)#	4/27 (14.8%)	15/27 (55.6%)	<b>11/15 (73.3%)*</b>

\*One patient could not use the numerical rating scale, although cognitively intact. In two consults, the numerical pain score obtained by nursing that automatically populates the template was the only numerical rating of pain that was recorded (i.e., there was no documented evidence of an attempt by the consultant to perform this assessment). One patient at first denied pain but indicated that he had discomfort that was not rated with the numerical rating scale. There was modest improvement in the use of the numerical rating scale (verbal analog scale) for pain assessment in those patients who potentially could use it from 52.9% of patients at baseline to 73.3% after the first intervention.

# Of note, almost a third of patients receiving inpatient palliative care consultations were cognitively impaired, precluding assessment with the numerical rating scale (verbal analog scale). This underscores the inherent difficulty in achieving a uniform approach to pain assessment in a population of patients receiving inpatient palliative care consultations. Six of the eight patients with cognitive impairment were suspected of being in significant pain (documented) based on observation and recommendations were made for their comfort.

## E. Adjust – Replan

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

- a. Who was involved in reviewing the post-intervention data, identifying underlying (root) causes of the continuing/new problem(s), and considering possible adjustments to interventions (“countermeasures”) to address the causes? Briefly describe who is involved, how (e.g., in a meeting of clinic staff), and when.**

Post-intervention data were shared via email and direct discussion in early May 2014 with medicine service attending physicians who serve as faculty for the inpatient palliative care and geriatrics consultation services at the VA Ann Arbor Healthcare System, other medical faculty in the hospice and palliative medicine fellowship, hospice and palliative medicine fellows (trainees) who rotate on the service and other members of the interdisciplinary palliative care consultation team including the Chief of the Geriatric Medicine section at the VA Ann Arbor Healthcare System (Dr. Robert Hogikyan) to obtain their reactions and thoughts in response to the data and to solicit their feedback and suggestions regarding ways to further improve compliance with this measure. There still was consensus that it would be extremely worthwhile to achieve greater compliance with the numerical rating system for assessment of pain, notwithstanding its limitations (e.g., some cognitively intact patients, especially the elderly are not able to use the scale).

- b. What are the primary underlying/root causes for the continuing/new problem(s) that the project can address? (Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately. How the intervention(s) address each primary underlying cause will be explained in #20.c.)**

Factors affecting compliance with this quality measure that were initially identified had not changed appreciably except that trainees were more familiar with use of numerical rating scales:

- 1) Related to people –lack of consistent use of the consultation template which prompted for numerical rating of pain (this was due to frustrations with template design, which could not be addressed locally since the template is a national VA template)
- 2) Related to processes – the VA consultation template automatically populates the consult with the most recent numerical rating score for pain entered in the electronic health record by nursing staff. Although this information could be useful, it cannot substitute for the assessment performed by the consultant but in some instances had been the only numerical rating recorded because of inconsistent use of the numerical rating scale by consultants.
- 3) Related to information infrastructure – the VA has an excellent electronic health record which should make the process easier. However, the availability of templates within the system has been a two-edged sword sometimes serving as a substitute for careful assessments when consultations are performed in haste.
- 4) Related to equipment – none
- 5) Related to environment - none

## F. Redo

### 20. Second intervention.

- a. **The second intervention will be/was initiated when?** (For multiple interventions, initiation date for each.)

June 2, 2014

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

An educational intervention was made via email and direct communication to medical attending physicians, physician trainees, and other members of the palliative care interdisciplinary team regarding the importance of the consistent use of the numerical rating scale in assessing pain during palliative care consultations at the VA Ann Arbor Healthcare System. The data from the first intervention cycle in # 18b above were presented and discussed and it was recognized that although the numerical rating scale has limitations, its value may lie in its potential to be a more objective means of assessment across different raters and in assuring the safety of the rapid titration of opioid analgesics to relieve severe pain. Two excellent suggestions that were made by one of the participants in the project after review of the data from the first intervention cycle were incorporated into the revised educational intervention. These included more training in the assessment of pain in cognitively impaired patients and placing a stronger emphasis on the need to document in the palliative care consultation, the inability of cognitively impaired patients to use the numerical rating scale.

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

Factors affecting compliance with this quality measure that were initially identified had not changed appreciably except that trainees were more familiar with use of numerical rating scales:

- 1) Related to people –lack of consistent use of the consultation template which prompted for numerical rating of pain (this was due to frustrations with template design, which could not be addressed locally since the template is a national VA template)  
*People-related factors were again addressed by educational discussions via email and in-person with all of the participants, allowing them to express their frustrations with the consultation template while at the same time achieving consensus that numerical rating of pain is quite useful for many palliative care patients, especially in guiding the care of those who are receiving escalating doses of strong analgesic medications to control their pain. Additionally, methods for the assessment of pain in cognitively impaired patients were reviewed and discussed.*
- 2) Related to processes – the VA consultation template automatically populates the consult with the most recent numerical rating score for pain entered in the electronic health record by nursing staff. Although this information could be useful, it cannot substitute for the assessment performed by the consultant but in some instances had been the only numerical rating recorded because of inconsistent use of the numerical rating scale by consultants.

*The intervention for the people-related factors was still applicable for this root cause. All consultants were informed that automatically populated data from nursing charting of pain scores would not be considered in chart reviews to determine compliance with this measure. In addition, the importance of documenting the incapacity of a patient to perform the numerical rating scale due to cognitive impairment was emphasized.*

- 3) Related to information infrastructure – the VA has an excellent electronic health record, which should make the process easier. However, the availability of templates within the system has been a two-edged sword sometimes serving as a substitute for careful assessments when consultations are performed in haste.

*Again, the interventions for the people-related and process-related factors were also applicable for this root cause. All consultants were again informed that automatically populated data from nursing charting of pain scores would not be considered in chart reviews to determine compliance with this measure.*

- 4) Related to equipment – none  
N/A
- 5) Related to environment – none  
N/A

**G. Recheck**

**21. Post-second intervention performance measurement. Is this data collection to follow the same procedures as the initial collection of data described in #11: population, measure(s), and data source(s)?**

- X Yes       No – If no, describe how this data collection

**22. Performance following the second intervention.**

**a. The collection of the sample of performance data following the intervention(s) either:**

Has occurred for the period: June 2-30, 2014

**b. If the data collection has occurred, what is the performance level? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)**

Time Period	N of Inpatient Palliative Care Consults	N (%) of Consults Where Impaired Cognition Limited Assessment of Pain	N (%) of Consults Where Patient Denied Pain	N (%) of Consults Where Cognition Intact and Pain Present	N (%) of Consults Where Cognition Intact and Pain Present in which Numerical Rating Scale Used to Rate Pain
Baseline:  12/16/13 –  1/15/14	28	2/28 (7.1%)	9/28 (32.1%)	17/28 (60.7%)	9/17 (52.9%)

First Intervention Period: 4/1 – 4/30/14	27	8/27 (29.6%)#	4/27 (14.8%)	15/27 (55.6%)	11/15 (73.3%)*
Second Intervention Period: 6/2- 6/30/14	25	7/25 (28.0%)	5/25 (20.0%)^	13/25 (52.0%)^	<b>13/13 (100%)</b>

(After Second Intervention)

^ Fourteen patients reported having pain, although only 13 could use a numerical rating scale consistently. The fourteenth patient was delirious.

## H. Readjust

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

- a. **Who was involved in reviewing the data, identifying underlying (root) causes of the continuing/new problem(s), and considering additional possible adjustments to interventions (“countermeasures”) to address the causes? Briefly describe who is involved, how (e.g., in a meeting of clinic staff), and when.**

Data from the second intervention cycle were shared via email and direct discussion in August 2014 with medicine service attending physicians who serve as faculty for the inpatient palliative care and geriatrics consultation services at the VA Ann Arbor Healthcare System, other medical faculty in the hospice and palliative medicine fellowship, hospice and palliative medicine fellows (trainees) who rotate on the service and other members of the interdisciplinary palliative care consultation team including the Chief of the Geriatric Medicine section at the VA Ann Arbor Healthcare System (Dr. Robert Hogikyan) to obtain their reactions and thoughts in response to the data.

*Only about half of the patients during the second intervention period were able to consciously acknowledge the presence of pain. The good news is that the numerical rating scale was used in 100% of these individuals. Nonverbal behaviors were noted to be important clues to the presence of pain/discomfort in patients whose cognition was not intact. A useful byproduct of the effort to more consistently use the numerical rating scale was a conscious awareness of the possibility that pain might be present, so that individuals with cognitive impairment likely benefitted from the increased scrutiny.*

- b. **What are the primary underlying/root causes for the continuing/new problem(s) that the project can address? (Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately.)**

The problems underlying the prior poor compliance with this measure were resolved with 100% compliance, exceeding our goal of > 90%.

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

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

*If several more cycles are included in the project for Part IV credit, contact the UM Part IV MOC Program to determine how the project can be documented most practically.*

## I. Future Plans

**24. How many subsequent PDCA cycles are to occur, but will not be documented as part of the “project” for which Part IV credit is designated?**

No more cycles are planned.

**25. How will the project sustain processes to maintain improvements?**

Senior faculty involved in the project have been thoroughly sensitized to the need to emphasize the importance of more precise assessment and documentation of pain in this population of patients and will continue to prioritize this in their teaching and practice.

**26. Do other parts of the organization(s) face a similar problem? If so, how will the project be conducted so that improvement processes can be communicated to others for “spread” across applicable areas?**

The results of this project will be made available to all other clinical sites in the hospice and palliative medicine and geriatric medicine training programs.

## **J. Physician Involvement**

*Note: To receive Part IV MOC a physician must both:*

- a. *Be actively involved in the QI effort, including at a minimum:*
  - *Work with care team members to plan and implement interventions*
  - *Interpret performance data to assess the impact of the interventions*
  - *Make appropriate course corrections in the improvement project*
- b. *Be active in the project for the minimum duration required by the project*

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

- a. Interpreting baseline data and planning intervention: Yes
- b. Implementing intervention: Yes or by delegation
- c. Interpreting post-intervention data and planning changes: Yes
- d. Implementing further intervention/adjustments: Yes
- e. Interpreting post-adjustment data and planning changes: Yes

**28. How are reflections of individual physicians about the project utilized to improve the overall project?**

They were directly applied to help refine the intervention.

**29. How does the project ensure meaningful participation by physicians who subsequently request credit for Part IV MOC participation?**

By creating an ongoing conversation and discussion via email and face-to-face meetings

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

Surgery (1), Internal Medicine (6), Hospice and Palliative Medicine (7) and Geriatric Medicine (4)

## **K. Project Organizational Role and Structure**

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

- University of Michigan Health System

- **Overseen by what UMHS Unit/Group?**

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

X No     Yes – the initiative is:

X **Veterans Administration Ann Arbor Healthcare System**

- **Overseen by what AAVA Unit/Group?**

Section of Geriatric Medicine

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

X No     Yes – the initiative is:

**An organization affiliated with UMHS to improve clinical care**

- **The organization is:**

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

**Accountable Care Organization type** (*specify which*):

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

**Other** (*specify*):

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

**Name:** R. Van Harrison, Ph.D.

**Title:** UMHS Part IV Program Co-Lead

**Institutional/organizational unit/affiliation:** Department of Continuing Medical Education

**Phone number:** (734) 763-1425

**Email address:** [rvh@umich.edu](mailto:rvh@umich.edu)

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

Daniel Hinshaw, M.D. (Project lead – reporting to Robert Hogikyan, M.D.)

Marcos Montagnini, M.D. (Participating attending physician – reporting to Robert Hogikyan, M.D.)

Caroline Vitale, M.D. (Participating attending physician – reporting to Robert Hogikyan, M.D.)

Ellen Hummel, M.D. (Participating attending physician – reporting to Robert Hogikyan, M.D.)

Robert Hogikyan, M.D. (Participating attending physician and oversight person)

Neil Alexander, M.D. (Participating attending physician – reporting to Robert Hogikyan, M.D.)

Adam Marks, M.D. (Participating attending physician/faculty member HPM fellowship – reporting to Marcos Montagnini, M.D. as HPM fellowship director)

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

Robert Hogikyan, M.D. Chief of the Section of Geriatric Medicine at the VA Ann Arbor Healthcare System