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

Assessing Opioid Fears and Anxieties in Palliative Care Consultations

Instructions

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

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

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

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

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

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

QI Project Report for Part IV MOC Eligibility

A. Introduction

1. **Date** *(this version of the-report):* 5/6/18

2. **Title of QI effort/project** *(also insert at top of front page)***:**
   Assessing Opioid Fears and Anxieties in Palliative Care Consultations

3. **Time frame**
   a. **MOC participation beginning date – date that health care providers seeking MOC began participating in the documented QI project** *(e.g. date of general review of baseline data, item #14c)**:*** 7/20/17

   b. **MOC participation end date – date that health care providers seeking MOC completed participating in the documented QI project** *(e.g., date of general review of post-adjustment data, item #29c)*: 4 May 2018

4. **Key individuals**

   a. **QI project leader** *[also responsible for confirming individual's participation in the project]*
   Names: Drs. Mazie Tsang, Jane Chargot, and Vani Pinnamaneni
   Title: Hospice and Palliative Medicine Fellows
   Organizational unit: University of Michigan Medical School, Department of Internal Medicine, Division of Geriatric and Palliative Medicine
   Phone number: (734) 845-3066
   Email addresses: mats@med.umich.edu; jchargot@med.umich.edu; pinnaman@med.umich.edu
   Mailing address: Hospice and Palliative Medicine Fellowship, 1500 E Medical Center Drive, Ann Arbor, MI 48109

   b. **Clinical leader who oversees project leaders regarding the project** *[responsible for overseeing/"sponsoring" the project within the specific clinical setting]*
   Name: Daniel B. Hinshaw, M.D.
   Title: Professor Emeritus of Surgery, Consultant in Palliative Medicine
   Organizational unit: University of Michigan Medical School, Hospice and Palliative Medicine Fellowship & Department of Surgery
   Phone number: (734) 904-9732
   Email address: hinshaw@umich.edu
   Mailing address: 3626 N. Dixboro Road, Ann Arbor, MI 48105

5. **Participants**

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

Profession	Number *(fill in)*
Practicing Physicians	7
Residents/Fellows	3
Physicians' Assistants	0
Nurses (APNP, NP, RN, LPN)	0
Other Licensed Allied Health (e.g., PT/OT, pharmacists, dieticians, social workers)	0

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

Profession	**Specialty/Subspecialty** *(fill in)*	**Number** *(fill in)*
Practicing Physicians	Surgery/HPM 1; Internal Medicine/HPM 2; Internal Medicine-Pediatrics/HPM 1; Internal Medicine/Geriatric Medicine/HPM 3	7 (total)
Fellows	Family medicine/Hospice and Palliative Medicine (HPM) Fellow 1; Internal Medicine/HPM Fellow 1; Internal Medicine-Pediatrics/HPM Fellow 1	3 (total)
Residents		0
Physicians' Assistants	*(Not applicable)*	

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

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

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

B. Plan

7. Patient population. What patient population does this project address *(e.g., age, medical condition, where seen/treated)***:**
Patients with advanced life-threatening illnesses at the VA Ann Arbor Health Care System receiving palliative care consultations as inpatients.

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)?
The Centers for Disease Control (CDC) have recently identified the development of an epidemic of opioid misuse in the US that has been associated with the more liberal prescription of opioid analgesics for the management of chronic non-cancer pain. See for example, https://www.cdc.gov/drugoverdose/epidemic/index.html and Manchikanti, L., et. al. Opioid Epidemic in the United States, *Pain Physician* 2012; 15:ES9-ES38 Even though the CDC guidelines for opioid use do not advocate restriction of opioid analgesics for patients suffering from pain related to advanced illnesses (e.g., cancer), many physicians have stopped prescribing opioids altogether and the media have often highlighted the dangers of opioids without providing an appropriate context.

(2) What is occurring now and why is this a concern (costs/harms)?

We hypothesize that patients with advanced illnesses experiencing severe pain, cough, or shortness of breath, who often benefit from opioid therapy, may have heightened fears and anxieties related to opioids because of the accounts of the opioid epidemic in the popular media. We further hypothesize that specific exploration of patients' fears and anxieties related to opioids is not consistently documented in the process of palliative care consultations. This gap in care may affect patient acceptance and compliance regarding opioid recommendations made in palliative care consultations. If patients reject use of these medications based on fears and anxieties, their quality of life may be adversely affected. Patient's fears and anxieties can be resolved through appropriate patient education.

b. Project goal. What general outcome regarding the problem should result from this project?
(State general goal here. Specific aims/performance targets are addressed in #13.)
To improve the documented exploration and discussion during palliative care consultations of inpatients' fears and anxieties regarding opioids.

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

☒ Effectiveness ☒ Equity ☒ Safety
☒ Efficiency ☒ Patient-Centeredness ☒ Timeliness

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

☒ Patient Care and Procedural Skills ☒ Medical Knowledge
☒ Practice-Based Learning and Improvement ☒ Interpersonal and Communication Skills
☒ Professionalism ☒ Systems-Based Practice

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

Measure 1

- **Name of measure** *(e.g., Percent of . . ., Mean of . . ., Frequency of . . .)***:**
  Percent of inpatient palliative care consultations with appropriate discussion and documentation of potential opioid fears/anxieties.

- **Measure components** – *describe the:*

  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*: the total number of inpatient palliative care consultations involving patients with cognitive capacity for whom opioids were either prescribed or recommended (excludes patients either already on opioids or not candidates for opioid therapy).

  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*: the number of these inpatients in which a discussion of patients' fears/anxieties regarding opioids is documented.

- **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)*: It is based on our review of the recent medical literature regarding the opioid crisis.

- **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 . . .)***:**
  The percent of documented discussions during inpatient palliative care consultations of potential opioid fears/anxieties in which opioid fears/anxieties were present and documented.
- **Measure components** – *describe the:*

  Denominator *(e.g., for percent, often the number of patients eligible for the measure)*:
  The number of inpatient palliative care consultations involving patients with cognitive capacity for whom opioids were either prescribed or recommended, in which a discussion of patients' fears/anxieties regarding opioids is documented (excludes patients either already on opioids or not candidates for opioid therapy)..

  Numerator *(e.g., for percent, often the number of those in the denominator who also meet the performance expectation)*:
  The number of these patients in which opioid fears/anxieties were present and documented.
- **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)*: It is based on our review of the recent medical literature regarding the opioid crisis and is a logical extension of our first measure.
- **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.)

12. Baseline performance

a. What were the beginning and end dates for the time period for <u>baseline</u> data on the measure(s)? 7/1-8/31/17

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.*

Baseline Data Opioid Anxieties QM Project

Data Collection Period	N of patients with palliative care consults	N of these patients with capacity for being screened	N of these patients for whom opioids were prescribed or recommended	N & % of these patients for whom a discussion of opioid fears/ anxieties was documented		N & % of these patients in whom opioid fears/anxieties were present	
Baseline: 7/1/17-8/31/17	36	25	19	2/19	10.5%	1/2	50%
Post-Intervention: 1/1-31/18							
Post-Adjustment: 3/1-31/18				/	%	/	%

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

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

Over the course of two implementation (PDCA) cycles, it is our goal to consistently assess and document a discussion of opioid fears/anxieties in ≥ 80% of VA inpatients with cognitive capacity receiving palliative care consultations for whom opioids have been either prescribed or recommended.

b. **How were the performance targets determined, e.g., regional or national benchmarks?** Our choice of ≥ 80% compliance is based on the recognition that even though a patient may have cognitive capacity, there may be some reticence to discuss a highly emotionally charged topic, such as opioids, in the current climate created by the reports in the media. Despite this, we hope to achieve ≥ 90% compliance with the measure but with the lower target of ≥ 80% we are making allowances for the unpredictability of responses to this highly charged topic that could potentially inhibit discussions.

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

a. **Who was involved?** *(e.g., by profession or role)* The three Hospice and Palliative Medicine (HPM) Fellows (Drs. Tsang, Chargot and Pinnamaneni) and HPM/Geriatric Medicine faculty: Drs. Hinshaw, Hogikyan, Montagnini, Silveira, Hummel, Taylor, and Alexander.

b. **How?** *(e.g., in a meeting of clinic staff)* Initial in-person formal planning meeting on 7/20/17, virtual meetings through email exchanges between faculty mentor (Hinshaw) and HPM fellows (9/24, 9/27, and 10/13/17) and informal ad hoc in-person meetings between HPM fellows during the two implementation (PDCA) cycles with ongoing email communication with faculty.

c. **When?** *(e.g., date(s) when baseline data were reviewed and discussed)* For all participants, the review was completed by October 24, 2017.

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

Common Causes	***Common Relevant Interventions***
Individuals: Are not aware of, don't understand.	*Education about evidence and importance of goal.*
Individuals: Believe performance is OK.	*Feedback of performance data.*
Individuals: Cannot remember.	*Checklists, reminders.*
Team: Individuals vary in how work is done.	*Develop standard work processes.*
Workload: Not enough time.	*Reallocate roles and work, review work priorities.*
Suppliers: Problems with provided information/materials.	*Work with suppliers to address problems there.*

15. What were the primary underlying/root causes for the problem(s) at baseline that the project can address?	**16. What intervention(s) addressed this cause?**	**17. Who was involved in carrying out each intervention?** *(List the professions/roles involved.)*
Consultants have not prioritized discussions	Educational discussion about the opioid crisis	Providers on the service
Time constraints	Emphasize time saving in the long term by improving patient compliance	Providers on the service
Multiple competing tasks	Residents, fellows and faculty will receive reminders each month. Initiated by the HPM fellows and endorsed by the faculty.	Providers on the service
Lack of standard approach	Participants develop standard process for screening all patients with opioid recommendations and commit to using it. Standard approach initiated by the HPM fellows who will inform the faculty and others rotating on the service (e.g., residents).	Providers on the service

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

C. Do

18. By what date was (were) the intervention(s) initiated? *(If multiple interventions, date by when all were initiated.)* 10/31/17

D. Check

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

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

20. Post-intervention performance

a. What were the beginning and end dates for the time period for post-intervention data on the measure(s)?
1/1-1/31/18

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.*

Post-Intervention Performance Opioid Anxieties QM Project

Data Collection Period	N of patients with palliative care consults	N of these patients with capacity for being screened	N of these patients for whom opioids were prescribed or recommended	N & % of these patients for whom a discussion of opioid fears/ anxieties was documented		N & % of these patients in whom opioid fears/anxieties were present	
Baseline: 7/1/17-8/31/17	36	25	19	2/19	10.5%	1/2	50%
Post-Intervention: 1/1-31/18	22	14	10	8/10 *	80%	6/8	75%
Post-Adjustment: 3/1-31/18				/	%	/	%

c. Did the intervention(s) produce the expected improvement toward meeting the project's specific aim (item 13.a)? Yes.
* One additional patient (9/10) was in too much distress to discuss his fears directly, but these were explored with the patient's son and documented. Thus, there was 90% compliance with this measure considering the limitations of the clinical situation at the time.

In another patient for whom opioids were not prescribed, his fears about opioids were addressed.

For five other patients without capacity, discussions did occur with family members.

E. Adjust – Replan

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

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

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

c. **When?** *(e.g., date(s) when post-intervention data were reviewed and discussed)*
2/26/18

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

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

22. What were the primary underlying/root causes for the problem(s) following the intervention(s) that the project can address?	**23. What adjustments/second intervention(s) addressed this cause?**	**24. Who was involved in carrying out each adjustment/second intervention?** *(List the professions/roles involved.)*
Some consultants were not oriented to the project and have not prioritized discussions	Provide and reinforce educational discussion about the opioid crisis	Providers on the service
Time constraints	Reemphasize time saving in the long term by improving patient compliance.	Providers on the service
Multiple competing tasks	Continue to send reminders each month to residents, fellows and faculty that this information should be a part of the note template.	Providers on the service
Lack of standard approach	Project leaders are placing the screening system into their initial note template in the electronic record. HPM fellows will inform clinicians rotating on the service (e.g., residents).	Providers on the service

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

F. Redo

25. By what date was (were) the adjustment(s)/second intervention(s) initiated? *(If multiple interventions, date by when all were initiated.)*
3/1-31/18

G. Recheck

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

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

27. Post-adjustment performance

a. What were the beginning and end dates for the time period for post-adjustment data on the measure(s)? 3/1-31/18

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.*

Post-Adjustment Performance Opioid Anxieties QM Project

Data Collection Period	N of patients with palliative care consults	N of these patients with capacity for being screened	N of these patients for whom opioids were prescribed or recommended	N & % of these patients for whom a discussion of opioid fears/ anxieties was documented		N & % of these patients in whom opioid fears/anxieties were present	
Baseline: 7/1/17-8/31/17	36	25	19	2/19	10.5%	1/2	50%
Post-Intervention: 1/1-31/18	22	14	10	8/10 *	80%	6/8	75%
Post-Adjustment#: 3/1-31/18	24	11	3	3/3	100%	2/3	66.6%

The 2nd PDSA cycle was remarkable in that during this period there was a much higher number of patients, who did not have capacity for being screened but who did receive opioids. Eight additional patients who did not have capacity for screening received opiates. Family members for 6/8 (75%) of these patients were queried about concerns regarding opioid therapy. Concerns about opioid-related sedation, confusion, and constipation were identified for one of the 8 without capacity for screening, when family members were queried. One of the 8 consults in patients without capacity for screening was performed by a health care provider, who had not been informed about the QI project, because the HPM fellow responsible for overseeing the project was not made aware of the trainee's participation on the service at that time. Another patient's family was not available to query regarding opioid-related concerns. These account for the two patients without capacity for screening for whom family members were not queried.

In summary, the most notable aspect of the last PDSA cycle was the much higher proportion of patients lacking capacity for screening (many of the consults during the month related to care at the very end of life for patients who were cognitively impaired). This is an issue that clearly will vary over time but emphasizes the need to frequently include family caregivers in conversations about opioid concerns.

c. Did the adjustment(s) produce the expected improvement toward meeting the project's specific aim (item 13.a)? Yes

28. Summary of individual performance

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

☐ Yes ☒ No – go to item 29

H. Readjust

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

a. Who was involved? *(e.g., by profession or role)*

☒ Same as #21? ☐ Different than #21 *(describe):*

b. How? *(e.g., in a meeting of clinic staff)*

☒ Same as #21? ☐ Different than #21 *(describe):*

c. **When?** *(e.g., date(s) when post-adjustment data were reviewed and discussed)* Between April 19 and May 4, 2018 via email review and discussion

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

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

30. What were the primary underlying/root causes for the problem(s) following the adjustment(s) that the project can address?	**31. What further adjustments/ intervention(s) might address this cause?**	**32. Who would be involved in carrying out each further adjustment/intervention?** *(List the professions/roles involved.)*
No change from # 22 above.	No change from # 23 above.	No change from # 24 above.

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

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

☒ No further cycles will occur.

☐ Further cycles will occur, but will not be documented for MOC. *If checked, summarize plans:*

☐ Further cycles will occur and are to be documented for MOC. *If checked, contact the UM Part IV MOC Program to determine how the project's additional cycles can be documented most practically.*

I. Reflections and Future Actions

33. Describe any barriers to change (i.e. problems in implementing interventions listed in #16 and #23) that were encountered during this QI effort and how they were addressed. The single instance of a consultation being performed by a trainee provider, who had not been informed about the QI project, has been reviewed within the team. Although the patient who was seen in this instance did not have capacity for participation in the project, nevertheless, the team elected to extend their efforts to query the family caregivers of patients without capacity, who were receiving opioids, regarding caregiver concerns about opioids even though this was beyond the scope of the original project. Thus, this instance of non-compliance with the educational protocol did not adversely impact achievement of the project's specific goals.

34. Describe any key lessons that were learned as a result of the QI effort.
The variability of cognitive capacity among palliative care patients receiving consultation was impressive and clearly is a reflection of factors beyond the control of the consultants. Specifically, the stage in a terminal illness at which patients present for palliative care consultative services will have a marked influence on the level of cognitive capacity present. Patients who are in the terminal phase of an advanced illness, often experience delirium, which may complicate efforts to discuss with them any anxieties or fears regarding treatment they may have.

In those palliative care patients who had cognitive capacity and were candidates for opioid therapy, a significant percentage ($\geq$ 50%) consistently expressed concerns about opioid therapy. This observation supports the team's hypothesis and rationale for this project. In this era of heightened public awareness and concern regarding opioid therapy, it is clearly important to explore these issues with patients during palliative care consultations.

35. Describe any best practices that came out of the QI effort.
Screening for fears/concerns regarding opioid therapy during palliative care consultations in patients who are/may be candidates for opioid therapy should be a routine part of the consultative process. This may also entail exploring these fears/concerns with family caregivers of patients lacking cognitive capacity.

36. Describe any plans for spreading improvements, best practices, and key lessons.
This report will be shared with other members of the palliative care program throughout the UM Health System and HPM Fellowship.

37. Describe any plans for sustaining the changes that were made.
Consideration may be given to potential modification of existing consultation templates in the EHR to include prompts regarding querying patients/family caregivers about opioid fears/concerns.

J. Minimum Participation for MOC

38. Participating directly in providing patient care.

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

☒ Yes ☐ No *If "No," go to item #39.*

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

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

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

39. Not participating directly in providing patient care.

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

☒ Yes ☐ No *If "No," go to item 40.*

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

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

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

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

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

☐ Yes ☒ No *If "Yes," describe:*

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

K. Sharing Results

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

☒ Yes ☐ No Formal report to clinical leaders?

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

☐ Yes ☒ No Manuscript for publication?

L. Project Organizational Role and Structure

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

☐ **University of Michigan Health System**

- **Overseen by what UMHS Unit/Group?** *(name):*
- **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):* Section of Geriatrics VA Ann Arbor HCS
- **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):*