

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

### Rx Card Collection to Decrease Discharge Delay

#### 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
<b>A. Introduction</b>	1-6. Current date, title, time frame, key individuals, participants, funding
<b>B. Plan</b>	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
<b>C. Do</b>	18. Intervention implementation date
<b>D. Check</b>	19-20. Post-intervention performance
<b>E. Adjust – Replan</b>	21-24. Post-intervention data review, underlying causes, adjustments, who will implement
<b>F. Redo</b>	25. Adjustment implementation date
<b>G. Recheck</b>	26-28. Post-adjustment performance, summary of individual performance
<b>H. Readjust plan</b>	29-32. Post-adjustment data review, underlying causes, further adjustments, who will implement
<b>I. Reflections &amp; plans</b>	33-37. Barriers, lessons, best practices, spread, sustain
<b>J. Participation for MOC</b>	38-40. Participation in key activities, other options, other requirements
<b>K. Sharing results</b>	41. Plans for report, presentation, publication
<b>L. Organization affiliation</b>	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*): 8/5/2016
  
2. **Title of QI effort/project** (*also insert at top of front page*): Rx Card Collection to decrease discharge delay
  
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 #14*): 6/1/2015
  
  - 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 #33*): 6/8/2016
  
4. **Key individuals**
  - a. **QI project leader** [*also responsible for confirming individual's participation in the project*]  
**Name:** Heather Eid-Hubert, PA-C  
**Title:** Physician Assistant  
**Organizational unit:** Department of Orthopaedics Lower Extremity Reconstruction  
**Phone number:** (734)936-5780  
**Email address:** heid@med.umich.edu  
**Mailing address:** 2912 Taubman Center, 1500 East Medical Center Drive, SPC 5328 Ann Arbor, Michigan 48109-5328
  
  - b. **Clinical leader to whom the project leader reports regarding the project** [*responsible for overseeing/"sponsoring" the project within the specific clinical setting*]  
**Name:** Dr. Brian Hallstrom  
**Title:** Clinical Assistant Professor  
**Organizational unit:** Department of Orthopaedics Lower Extremity Reconstruction  
**Phone number:** (734)647-9961  
**Email address:** hallstro@med.umich.edu  
**Mailing address:** 2912 Taubman Center, 1500 East Medical Center Drive, SPC 5328 Ann Arbor, Michigan 48109-5328
  
5. **Participants**
  - a. **Approximately how many health care providers (by training level for physicians) participated in this QI effort** (*whether or not for MOC*):  
4 Physician Assistants; 2 Nurse Practitioners; 1 Pharm D; 1 physician: Heather Eid-Hubert, PA-C; Jean Hergott, PA-C; Tamara Bennett, PA-C; Lindsay Barazsu, PA-C; Michelle Davis, NP; Alexandra Offerman, NP; Lindsay Clark, PharmD; Brian Hallstrom, MD; Dorothy Nalepa.

Profession	Number (fill in)
Practicing Physicians	1
Residents/Fellows	0
Physicians' Assistants	4
Nurses (APNP, NP, RN, LPN)	2
Other Allied Health	2

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	Orthopedic Surgery	1
Fellows		
Residents		
Physicians' Assistants	(Not applicable)	4

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

- Internal institutional funds
- Grant/gift from pharmaceutical or medical device manufacturer
- Grant/gift from other source (e.g., government, insurance company)
- Subscription payments by participants
- Other (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):

All patients discharged from the inpatient unit after receiving lower extremity joint reconstruction surgery (total knee arthroplasty and total hip arthroplasty) by the Department of Orthopaedic Surgery at University of Michigan Health System.

8. General goal

a. Problem/need. What is the problem (“gap”) in quality that resulted in the development of this project? Why is important to address this problem?

Prescription card information is not readily available when initiating discharge medication prescriptions, although the capability exists to “image” this information directly into the patient’s electronic health record. Some medications require a prior authorization process which can be time consuming and result in delays in discharging patients to home. Having the prescription card/insurance information available can facilitate more timely authorization for discharge medication prescriptions and consequently decrease both preventable delays and related, avoidable complications.

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.)

Improve imaging of Rx Card prior to surgery to facilitate more timely hospital discharge and decrease preventable delays and complications.

**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> )

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

- |   |  |
|---|--|
| <input type="checkbox"/> Patient Care and Procedural Skills                 | <input type="checkbox"/> Medical Knowledge                                 |
| <input checked="" type="checkbox"/> Practice-Based Learning and Improvement | <input checked="" type="checkbox"/> Interpersonal and Communication Skills |
| <input type="checkbox"/> Professionalism                                    | <input checked="" type="checkbox"/> 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:** Percent of patients with Rx card imaged in Media Tab
- **Eligible population:** Patients, of any age, who received lower extremity joint reconstruction surgery (hip and knee arthroplasty).
- **Measure components** – for a rate, percent, or mean, describe the:
  - Denominator: Patients discharged after lower extremity joint reconstruction surgery
  - Numerator: patients with imaged Rx Card under Media tab prior to surgery
  - The source of this measure is:**
    - An external organization/agency, which is (name the source):
    - Internal to our organization and it was chosen because (describe rationale): Measure was chosen as it correlates with the purpose of the study.
  - This is a measure of:**
    - X 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 baseline data on the measure(s)?**

3/2/2015-3/31/2015

**b. What was (were) the 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.)

Project began with 0% of patients having imaged Rx cards upon admission to hospital.

**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].”*

For patients undergoing lower extremity joint replacement, improve from 0% capture/imaging to 80% capture/imaging of Rx Cards into Michart (University of Michigan Health System Electronic Medical Record) prior to the patient’s date of scheduled surgery. Attain this goal by the completion of this project (5/31/16).

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

Target performance was determined by the Orthopaedic Surgery Department leadership based on knowledge of local process. Recommendations were set forth by the Department of Pharmacy.

**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.)*

- **Who was involved?** Brian Hallstrom, MD, Heather Eid-Hubert, PA-C; Jean Hergott, PA-C; Tamara Bennett, PA-C; Lindsay Barazsu, PA-C; Michelle Davis, NP; Alexandra Offerman, NP; Lindsay Clark, PharmD.
- **How?** *(e.g., in a meeting of clinic staff)* Meeting and regular discussions.
- **When?** *(e.g., date(s) when baseline data were reviewed and discussed)* Weekly/Biweekly Joint Improvement Initiative Team meetings and with PharmD. Reviewed baseline data on 5/11/15 and briefly updated review on 5/25/15.

**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:*

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

<b>15. What were the primary underlying/root causes for the <u>problem(s)</u> at baseline that the project can address?</b>	<b>16. What intervention(s) addressed this cause?</b>	<b>17. Who was involved in carrying out each intervention? (List the professions/roles involved.)</b>
Prescription cards not obtained prior to surgical intervention. This was due to clerical staff	Clerical staff were trained to initiate collection of Rx cards at time of surgical scheduling and upon	PA/NP and Clerical/Administrative Staff

not requesting/imaging.	presentation to the Education Class with documentation imaged into Media section of MiChart.	
Patients do not have Rx cards available when in clinic.	Patients were notified verbally and in writing, in advance of the education class, to bring a copy of their Rx Card to the Education Class if the patient did not have a copy at the time of surgical scheduling.	PA/NP and Clerical/Administrative Staff

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.) June 2, 2015.

**D. Check**

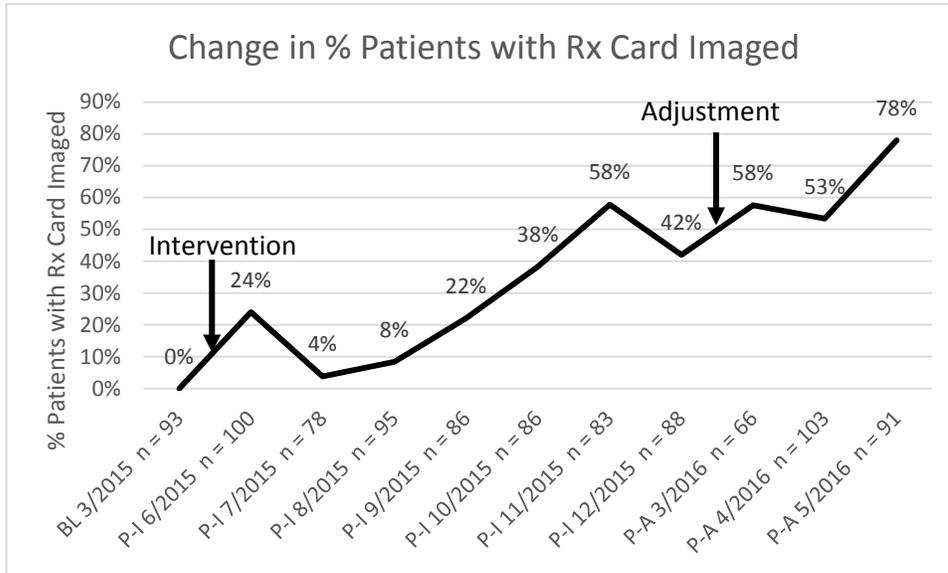
19. **Post-intervention performance measurement. Are the population (item 10), measures (item 11), and the data collection procedures the same as those for the collection of baseline data?**

Yes     No – If no, describe how the population, measures, and/data collection differ: The population and the measure are the same, but the method of data collection changed. During the baseline period Rx cards were not being imaged or requested, so no review of individual records was needed to know that performance was 0%. During the post-intervention period, data collection was performed by printing a list of the OR patients per month and looked up in the media tab of the electronic medical record to see who had an imaged prescription card stored there. [ ]

**20. Post-intervention performance**

a. **What were the beginning and end dates for the time period for post-intervention data on the measure(s)?** 6/5/2015-12/31/2015.

b. **What was (were) the overall performance level(s) post-intervention?** (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.)



Note: BL = Baseline data. P-I = Post-Intervention data. P-A = Post-Adjustment data.

c. Did the intervention(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)? No. Overall, the intervention did produce the expected improvement toward meeting the project’s specific aim, going from a mean of 0% at baseline to a mean of 28% for the 616 patients discharged during the post intervention period. However, this 28% fell appreciably short of the 80% goal.

**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.)

- **Who was involved?**
  - Same as #14?     Different than #14 (describe):
- **How?** (e.g., in a meeting of clinic staff)
  - Same as #14?     Different than #14 (describe):
- **When?** (e.g., date(s) when post-intervention data were reviewed and discussed):
 

Weekly/Biweekly Joint Improvement Initiative Team meetings and with PharmD. Post-intervention data were reviewed and planning for adjustments occurred 1/6/2016; 1/20/2016; 2/3/2016; 2/17/2016.

**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 <u>problem(s)</u> following the <u>intervention(s)</u> 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.)
Prescription cards not obtained prior to surgical intervention. This was due to clerical staff not requesting/imaging.	<ol style="list-style-type: none"> <li>1. Collection of Rx cards reinforced for those clerical staff still not consistently asking for or collecting at time of surgical scheduling and upon presentation to the Education Class with documentation imaged into Media section of MiChart.</li> <li>2. Bright labels placed on surgical scheduling paperwork as reminders.</li> <li>3. Alerts placed on OR schedule sheet as reminder to PA/NP.</li> </ol>	PA/NP; Clerical/Administrative staff.
Patients do not have Rx cards available when in clinic.	Patients continued to be notified verbally and in writing to bring a copy of their Rx Card to the Education Class if the patient did not have a copy at the time of surgical scheduling. Bright labels placed on surgical scheduling paperwork as reminders.	PA/NP; Clerical/Administrative staff.

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.) 3/1/2016.

**G. Recheck**

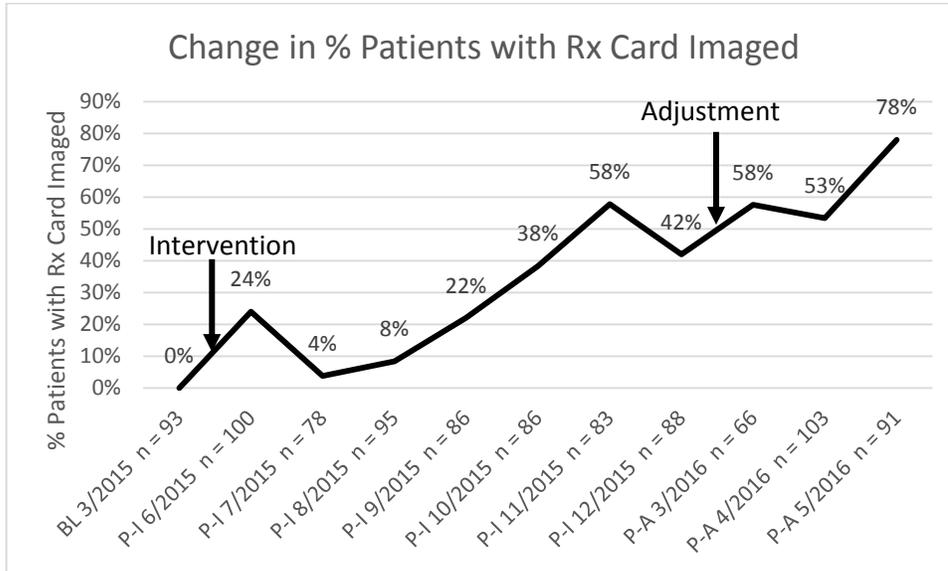
26. Post-adjustment performance measurement. Are the population, measures, and the data collection procedures the same as indicated for the collection of post-intervention data (item #21)?

Yes       No – If no, describe how the population, measures, and/or data collection 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)? 3/1/2016-5/31/2016

c. What was (were) the overall performance level(s) post-adjustment? (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.)  
See Data table.



Note: BL = Baseline data. P-I = Post-Intervention data. P-A = Post-Adjustment data.

- c. Did the adjustment(s) produce the expected improvement toward meeting the project’s specific aim (item 13.a)? Yes, the capture rate improved from 28% post-intervention to 61% post-adjustment, including 78% capture in the last month, May 2016. However, this is still short of our goal of 80%.

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.)

• Who was involved?

Same as #21?       Different than #21 (describe):

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

Same as #21?       Different than #21 (describe):

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

6/8/2016

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 <u>problem(s) following the adjustment(s)</u> 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.)
Prescription cards not obtained prior to surgical intervention.	1.Reinforce collection of Rx cards at time of surgical scheduling and upon presentation to the Education Class with documentation imaged into Media section of MiChart. 2. Bright labels placed on surgical scheduling paperwork as reminders. 3. Alerts placed on OR schedule sheet as reminder to PA/NP.	PA/NP; Clerical/Administrative staff.
Patients do not have Rx cards available when in clinic.	Reinforce effort to notify patients verbally and in writing to bring a copy of their Rx Card to the Education Class if the patient did not have a copy at the time of surgical scheduling. Bright labels placed on surgical scheduling paperwork as reminders.	PA/NP; Clerical/Administrative staff.
Rx cards not collected when patients present for H&P at the PreOperative Clinic at Domino Farms	Train staff in process similar to Education Class as detailed above.	PA/NP, Clerical/Administrative staff.

*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:*  
 At this time, collection of Rx cards for imaging into MiChart Media section will continue.  
 Collection will be continued:
  1. At the time of surgical scheduling in clinic;
  2. At arrival to the Education Class;
  3. We hope to add in collection of Rx Cards when patient presents for H&P at the PreOperative Clinic at Domino Farms.
 This is pending ongoing discussions with that Department, but with this addition we hope to surpass our 80% goal.

- 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 that were encountered during this QI effort and how they were addressed.** Initially, there was a barrier regarding lack of clarity around job responsibility for imaging Rx Card information into Media from administrative leadership. Meetings were held and a decision was made for our front desk staff and MAs on staff to image these documents into the electronic record.
- 34. Describe any key lessons that were learned as a result of the QI effort.** Patient care can be directly improved by having Rx cards imaged into the UMHS EMR for improved access of Rx coverage by pharmacy staff. Improved patient care and limiting discharge delays can also be addressed by e-prescribing prescriptions to outside pharmacies.
- 35. Describe any best practices that came out of the QI effort.** Imaging insurance information into the medical record is a potential best practice to facilitate prescription management for any patient admitted for any issue to a hospital/surgery service.
- 36. Describe any plans for spreading improvements, best practices, and key lessons.** Plan to capture patient's prescription card information when the patient presents to the PreOperative Clinic at Domino Farms in order to improve upon capture rate. Other services may begin to implement this plan as well per our collaborative discussions with PharmD.
- 37. Describe any plans for sustaining the changes that were made.** At this time, we will continue to collect Rx Cards at the Education class and also when the patient is scheduled for surgery as a new standard operating procedure.

**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:*

## 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): Department of Orthopaedics

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

No     Yes – the initiative is (name or describe): Orthopaedic Joint Improvement Initiative

**Veterans Administration Ann Arbor Healthcare System**

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

• 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: n/a**

• The organization is (name):

• The type of affiliation with UMHS is:

**Accountable Care Organization (specify which member institution): n/a**

- BCBSM funded, UMHS lead state-wide Collaborative Quality Initiative** (*specify which*):  
*n/a*
- Other** (*specify*): *n/a*