

QI Project Application/Report for Part IV MOC Eligibility

Instructions

Complete the project application/report to apply for UMHS approval for participating physicians to be eligible to receive Part IV MOC credit through the Multi-Specialty Part IV MOC Pilot program. 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.

Only a final application describing the completed project is required. However, submitting an earlier version helps assure that planned activities will meet Part IV requirements. Actions regarding the application depend on the stage of the project, as described below. As stages are accomplished, you may submit updates of the application with the description of planned activities replaced by descriptions of actual activities performed.

Preliminary approval. Plans are developed for the expected activities, but little actual work has been performed.

(Complete at least items 1-11, 13a, 16-18a, 19a, 20a, 21, 22a, 23a, 27-36.)

Part IV credit approval. Baseline data have been collected and the intervention performed, with completion of both steps documented on an application (or application update). The project has demonstrated its operational feasibility and the likelihood that subsequent data collections and adjustment will be performed. (Complete at least items 1-18a, 19a, 20a, 21, 22a, 23a, 27-36.)

Participation ("attestation") forms provided. The project has been completed with the expected sequence of activities performed and documented on a complete final application, which is the "final report" on the project.

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

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Application/Report Outline

A. Introduction

1-6. Current date, title, time frame, project leader, specialties/subspecialties involved, funding

B. Plan

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

C. Do

14-16. Intervention(s), who is involved, initiated when

D. Check

17-18. Post-intervention performance measurement, data collection, performance level

E. Act/Adjust

19-20. Review, continuing/new underlying causes, adjustments (second intervention)

F. Recheck

21-22. Post-adjustment performance measurement, data collection, performance level

G. Readjust

23. Review, continuing/new underlying causes to address

H. Future plans

24-26. Subsequent PDCA cycles, standardize processes, "spread" to other areas

I. Physician involvement

27-31. Physician's role, requirements, reports, reflections, participation, number

J. Project Organizational Role and Structure

32-36. Part of larger initiative, organizational structure, resources, oversight, Part IV opportunity

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A. Introduction

1. **Date** (*this version of the application*): 2 February 2013

2. **Title of QI project:** Identifying Spiritual or Religious Concerns during Palliative Care Consultations

3. **Time frame**
 - a. **At what stage is the project?**
 Completed (*UMHS Part IV program began 1/1/11*)

 - b. **Time period**
 - (1) **Date physicians began participating (may be in design phase):** September 1, 2012
 - (2) **End date:** actual 2 February, 2013

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:** Department of Surgery and Palliative Care Program, UM Geriatrics Center and Section of Geriatrics VA Ann Arbor Health Care System
 - d. **Phone number:** (734) 845-3072; cell phone: (734) 904-9732
 - e. **Email address:** hinshaw@umich.edu
 - f. **Mailing address:** Palliative Care Program (11G); VAMC, 2215 Fuller Rd., Ann Arbor, MI 48105

5. **What specialties and/or subspecialties are involved in this project?** Palliative Medicine and Geriatrics

6. **Will the funding and resources for the project come only from internal UMHS sources?**
 Yes, only internal UMHS sources

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**
 - a. **Problem/need. What is the “gap” in quality that resulted in the development of this project?**
Why is this project being undertaken? Addressing the spiritual/religious needs and concerns of patients with advanced illnesses is a major element of the holistic care provided in palliative medicine. Documentation of a spiritual assessment by the palliative medicine specialist at the time of initial consultation provides this important information, informs the consultation process, and demonstrates to the patient the consultant’s respect and concern for this aspect of their life experience. It was hypothesized (based on personal observation) that documentation of this important aspect of patient evaluation and care is often neglected.

b. Project aim. What aspects of the problem does this project aim to improve?

This project aims to improve the documentation and thus the number of spiritual assessments performed by postgraduate medical trainees and palliative medicine specialists during the initial palliative care consultation.

8. Patient population. What patient population does this project address. Inpatients at the VA Ann Arbor Health Care System with advanced illnesses for whom a palliative care consultation has been requested.

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

- | | | |
|---|--|--|
| <input 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)

11. Baseline measures of performance:

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

1. Number of inpatient palliative care consultations [from medical record review]
2. Number of consultations with documentation of acceptable justification for not addressing spiritual or religious concerns (e.g., patient not able to communicate, record of recent discussion) [from medical record review]
3. Number of consultations where spiritual or religious concerns could have been addressed (#1 - #2)
4. Number of consultations with documentation that spiritual or religious concerns were addressed [from medical record review]
5. Percent of consultations where spiritual or religious concerns could have been addressed that also have documentation that they were addressed ($\#4/\#3 \times 100\%$)

b. Are the measures nationally endorsed?

Yes. In Schenck, A., et al. The PEACE Project: Identification of Quality Measures for Hospice and Palliative Care *J Pall. Med.* 2010; 13: 1451-1459, the authors have recently presented a comprehensive list of many potential measures of quality palliative care, including monitors related not only to pain and other forms of physical distress but also psychosocial and spiritual concerns that were developed in response to a request from the Centers for Medicare and Medicaid Services (CMS). One of the quality measures they have listed in the article is: *Percent of patients who have documented discussion to identify spiritual or religious concerns as they affect care.* The proposed measure in this application will look at the quality of the documentation by the physician of spiritual assessments/discussions as part of the initial palliative care consultation.

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

Medical records – review of the palliative care consultation in the electronic medical record.

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

Data were abstracted from the medical record.

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

They should be quite reliable. The documentation is either present or not. It is an expectation within the system and the training program that trainees (or attending physicians in the absence of trainees) provide a written consultation in the medical record (at least with initial recommendations) within one business day of a consult request. Availability of material for review should be high.

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

g. To whom are data reported? The data is reported to the Chief (supervisor) of the Geriatrics Section at the VA Ann Arbor Health Care System – Dr. Robert Hogikyan. They are also reported to participating physicians (postgraduate medical trainees and attending physicians) on the inpatient palliative care consultation service at the VA Ann Arbor Health Care System.

h. For what time period were baseline data collected? September 1-30, 2012

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)?

Time Period	N of Inpatient Palliative Care Consults	N with justification for not addressing spiritual concerns	N where spiritual concerns could be addressed	N with documentation of addressing spiritual concerns	% with documentation of addressing when could be addressed
Baseline: 9/1-30/12	27	1	26	13	50% (13/26)

b. What are the targets for future performance on the measures? The target for improvement in this process will be to see that $\geq 90\%$ of palliative care consultations where spiritual or religious concerns could have been addressed have documentation of a spiritual assessment as part of the initial consultation.

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

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? During the last week of November, 2012 the initial baseline data from September 2012 that had been obtained by chart review was reviewed with participating physicians (attending palliative care physicians and postgraduate medical trainees) via email and during discussion in a teaching conference to identify potential reasons for lack of compliance with the performance measure. The article describing the PEACE project was also distributed to all participating physicians for their review to help familiarize them with the types of quality measures that have been developed of which this particular measure is representative.

b. What are the primary underlying/root causes for the problem(s) that the project can address? (List each cause separately. How the intervention(s) address each underlying cause will be explained in #14.c.) Participants identified several potential root causes for poor compliance with this performance measure. These included:

1. Physicians’ priorities:
 - a. Simple omission due to haste
 - b. Not a priority - forgetting its importance
 - c.. Competing priorities – too busy
2. Physician’s unable/reluctant to perform:

- a. For physicians, ignorance or discomfort with a topic commonly not addressed by physicians and some have not felt confident how to approach the topic with patients
- 3, Factors beyond the physician's control:
 - a. Patient was unwilling or unable to discuss (e.g., cognitively impaired) abstract issues like spirituality or the topic was deemed too sensitive to discuss at the first visit
 - b. Sometimes, the palliative care consult request is focused on one issue (e.g., pain assessment) only or the issue had been addressed and documented in a prior palliative care consultation.

C. Do

14. Intervention(s).

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

Participants and setting. The intervention has been targeted to all trainees on the service including hospice and palliative medicine fellows, geriatrics fellows, hematology/oncology fellows, pain fellows, and other postgraduate medical residents on elective, any of whom may be serving as consultants on the inpatient palliative care consultation service. The leader of the project (Dr. Hinshaw) met with the postgraduate medical trainees newly rotating on the palliative care consultation service on Monday, December 3 and Tuesday, December 4. Email communications were also used.

Education about importance of spiritual assessment. Dr. Hinshaw reviewed the performance measure and the importance of spiritual assessment to a complete and holistic palliative care consultation. He then led a group discussion regarding the need to perform and document this assessment routinely.

Training in a method to perform spiritual assessment. Dr Hinshaw explained a simple method for taking a spiritual history developed by Dr. Christina Puchalski (*J. Palliat. Med.* 2000; 3(1): 129-137) under the acronym of FICA:

F = faith – Do you have a religious faith? What are major sources of meaning in your life?

I = importance – How important are your faith and other sources of meaning to you?

C = community – Do you belong to a faith community or other community that provides support in the context of being a source of meaning (e.g., alcoholics anonymous, political organizations)?

A = address – How would you want us to address this in the care we provide you?

b. How are underlying/root causes (see #12.b) addressed by the intervention(s)? (List each cause, whether it is addressed, and if so, how it is addressed.)

- 1. Physicians' priorities:
 - a. Simple omission due to haste
 - b. Not a priority - forgetting its importance
 - c.. Competing priorities – too busy

The education and discussion about the importance of spiritual assessment explained its central importance to address along with other priorities.

- 2. Physician's unable/reluctant to perform:
 - a. For physicians, ignorance or discomfort with a topic commonly not addressed by physicians and some have not felt confident how to approach the topic with patients

Training in the use of the FICA method helped physicians know how to address the topic and feel comfortable doing so.

- 3, Factors beyond the physician's control:

- a. Patient was unwilling or unable to discuss (e.g., cognitively impaired) abstract issues like spirituality or the topic was deemed too sensitive to discuss at the first visit
- b. Sometimes, the palliative care consult request is focused on one issue (e.g., pain assessment) only or the issue had been addressed and documented in a prior palliative care consultation.

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

The attending physician on the palliative care consultation team (Dr. Hinshaw) provided the educational intervention/reminder as well as collected and analyzed the data for later review with the postgraduate medical trainees and other attending physicians. The other attending physicians will also provide the educational materials about the measures to trainees during their months of service to help sustain the effort. In addition, Dr. Hinshaw met with two members of the VA Ann Arbor Health Care System QA Department and two nursing members as well as the palliative care coordinator of the palliative care consultation team on December 20, 2012 to review the quality measure, its significance, and current progress with the project. The members of the group expressed their support for the project and offered assistance, if needed.

- 16. The intervention was initiated when?** (For multiple interventions, initiation date for each.)
December 3 and 4, 2012

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

18. Performance following the intervention.

- a. The time period for collection of performance data following the intervention either:**
Has occurred for the period: December 3-31, 2012

- 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)?**

Time Period	N of Inpatient Palliative Care Consults	N with justification for not addressing spiritual concerns	N where spiritual concerns could be addressed	N with documentation of addressing spiritual concerns	% with documentation of addressing when could be addressed
Baseline: 9/1-30/12	27	1	26	13	50% (13/26)
Post-Intervention: 12/3-31/12	25	4	21	19	90% (19/21)

E. Act/Adjust

- 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? The attending physician responsible for this project reviewed the post-intervention data and then, in collaborative discussions with the other attending physicians and postgraduate medical trainees rotating on the palliative care consultation service, determined that the target for the performance measure had been met ($\geq 90\%$ compliance) after the intervention. No further adjustments to the intervention were deemed necessary pending another intervention cycle to determine the reproducibility of the outcome of the first cycle.

b. What are the primary underlying/root causes for the continuing problem(s) that the project can address? (*List each cause separately. How the adjustment addresses each underlying cause will be explained in #20.c.*)

Only root causes beyond the control of the physicians (listed below) accounted for all palliative care consultations in which a spiritual assessment was not performed and documented.

Factors beyond the physician’s control:

- a. Patient was unwilling or unable to discuss (e.g., cognitively impaired).
- b. Sometimes, the palliative care consult request is focused on one issue (e.g., pain assessment) only.

20. The adjustment (second intervention).

a. The adjustment (second intervention) was initiated when? (For multiple interventions, initiation date for each.) January 2, 2013

b. If the adjustment has occurred, what adjustments/interventions were implemented?

No adjustment in the intervention occurred. The same successful educational intervention described in 14a above was presented again to a new set of post-graduate medical trainees on 2 January, 2013 to determine the durability and reproducibility of the intervention.

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

- 1. Physicians’ priorities:
 - a. Simple omission due to haste
 - b. Not a priority - forgetting its importance
 - c. Competing priorities – too busy

The education and discussion about the importance of spiritual assessment explained its central importance to address along with other priorities.

- 2. Physician’s unable/reluctant to perform:
 - a. For physicians, ignorance or discomfort with a topic commonly not addressed by physicians and some have not felt confident how to approach the topic with patients.

Training in the use of the FICA method helped physicians know how to address the topic and feel comfortable doing so.

- 3. Factors beyond the physician’s control:
 - a. Patient was unwilling or unable to discuss (e.g., cognitively impaired) abstract issues like spirituality or the topic was deemed too sensitive to discuss at the first visit
 - b. Sometimes, the palliative care consult request is focused on one issue (e.g., pain assessment) only or the issue had been addressed and documented in a prior palliative care consultation.

F. Recheck

21. Post-adjustment 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

22. Performance following the adjustment.

a. The time period for collection of performance data following the adjustment(s) either:
Has occurred for the period: January 2-31, 2013

b. If the data collection has occurred, what is post-adjustment performance level (e.g., for each measure: number of observations or denominator, numerator, percent)?

Time Period	N of Inpatient Palliative Care Consults	N with justification for not addressing spiritual concerns	N where spiritual concerns could be addressed	N with documentation of addressing spiritual concerns	% with documentation of addressing when could be addressed
Baseline: 9/1-30/12	27	1	26	13	50% (13/26)
Post-Intervention: 12/3-31/12	25	4	21	19	90% (19/21)
Post-Adjustment: 1/2-31/13	21	4	17	16	94.1% (16/17)

G. Readjust

23. Review of post-adjustment data and identifying continuing/new underlying causes.

a. Who was involved in reviewing the post-adjustment data, identifying underlying (root) causes of the continuing/new problem(s), and considering additional possible adjustments to interventions (“countermeasures”) to address the causes? The attending physician responsible for this project reviewed the post-adjustment data and then the data were shared in collaborative discussions and via email with the other attending physicians and postgraduate medical trainees rotating on the palliative care consultation service.

b. What are the primary underlying/root causes for the continuing/new problem(s) that the project can address? (List each cause separately.) There are no ongoing problems with compliance with the quality measure. Factors beyond the physician’s control:

- a. Patient was unwilling or unable to discuss (e.g., cognitively impaired); and
- b. Sometimes, the palliative care consult request is focused on one issue (e.g., pain assessment) only; remain the primary reasons preventing a spiritual assessment in every patient.

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.

H. 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 further PDCA cycles will occur.
- 25. How will the project standardize processes to maintain improvements?** Continued reminders as part of the regular orientation of postgraduate medical trainees joining the inpatient palliative care consultation service should help maintain the improvements.
- 26. Do other parts of UMHS 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 shared with the other palliative care consultation teams (adult and pediatric teams at UMMC) during palliative medicine teaching/administrative conferences or via email.

I. 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?

There was only one attending physician who participated in this project for MOC Part IV credit. This project was designed and planned by an attending physician on the palliative care consultation team at the VA Ann Arbor HealthCare System who is also a faculty member in the Hospice and Palliative Medicine and Geriatrics Fellowship programs. This attending physician was responsible for data collection, interpretation, and implementing changes with the consultative support and collaboration of colleagues and postgraduate medical trainees in the process of reviewing the data at the VA and with oversight by the Chief of the Geriatrics section at the VA who provided overall supervision. Active participants in this project who were seeking MOC Part IV credit were directly involved in the planning, implementation, interpretation of performance data, and corrections to the course of the project.

28. If not addressed in #25, in conjunction with each cycle of data collection, what local (physician-level or practice/unit-level) feedback report and what overall project level report will be provided to physicians? See above

29. If not addressed in # 25, how are reflections of individual physicians about the project utilized to improve the overall project? See above

30. How will the project ensure meaningful participation by physicians who subsequently request credit for Part IV MOC participation? See above; one physician expressed strong interest in participating in the project for Part IV MOC credit but was unable to participate due to illness.

31. What is the approximate number of physicians anticipated to participate in this project?
[Provide number or range – by specialties and/or subspecialties if more than one.]

One surgeon/palliative care sub-specialist participated for Part IV MOC credit. Four palliative care attending physicians (including the chief of the Geriatrics section at the VA Ann Arbor Health Care System) plus three postgraduate medical fellows in Hospice and Palliative Medicine participated in the review and provided feedback regarding the project.

J. Project Organizational Role and Structure

32. Is this project part of a larger UMHS institutional or departmental initiative?

No *If No, go to #31.*

a. What UMHS unit/group is overseeing or coordinating the larger initiative?

b. What is the larger initiative?

c. How does this project advance it?

d. Is this project coordinated with related quality improvement activities?

e. Has someone at a higher institutional level authorized/approved this project? If so, who?

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

One surgeon/palliative care sub-specialist who collaborates with 3 other attending physicians and reports to the Chief, Geriatrics Section at the VA Ann Arbor Health Care System has organized the project.

34. Are resources needed beyond those under the control of the project lead(s)?

No *If No, go to #33.*

a. What types of resources are needed and who has agreed to provide them?

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

Robert Hogikyan, M.D., Chief, Geriatrics Section at the VA Ann Arbor Health Care System

36. Have UMHS physicians who will participate in this project had the opportunity to participate in a UMHS Part IV project within the past two years?

No

- a. If “Yes,” why do these physicians need more frequent opportunities for Part IV credit (e.g., board gives additional credit for more Part IV activities in a time period; qualify for CMS incentive payment)?**