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

Cardiovascular Center Structural Heart ACTIVATE (Advancing Care, Treatment Efficiency, Innovation, Value, and Teamwork for Cardiac Episodes)

11.06.2020

Instructions

Determine eligibility. Before starting to complete this report, go to the Michigan Medicine MOC website [http://www.med.umich.edu/moc-qi/index.html], click on “Part IV Credit Designation,” and review sections 1 and 2. Complete and submit a “QI Project Preliminary Worksheet for Part IV Eligibility.” Staff from the Michigan Medicine Part IV MOC Program will review the worksheet with you to explain any adjustments needed to be eligible. (The approved Worksheet provides an outline to complete this report.)

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

An option for preliminary review (strongly recommended) is to complete a description of activities through the intervention phase and submit the partially completed report. (Complete at least items 1-18.) Staff from the Michigan Medicine Part IV MOC Program will provide a preliminary review, checking that the information is sufficiently clear, but not overly detailed. This simplifies completion and review of descriptions of remaining activities.

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

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

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A. Introduction

1. Date (this version of the report): 11/06/2020

2. Title of QI effort/project (also insert at top of front page): Cardiovascular Center Structural Heart ACTIVATE: Advancing Care, Treatment Efficiency, Innovation, Value, and Teamwork for Cardiac Episodes

3. Time frame
   a. MOC participation beginning date – date that health care providers seeking MOC began participating in the documented QI project (e.g. date of general review of baseline data, item #12c): 03/21/2019
   b. MOC participation end date – date that health care providers seeking MOC completed participating in the documented QI project (e.g., date of general review of post-adjustment data, item #27c): 10/14/2020

4. Key individuals
   a. QI project leader [also responsible for confirming individual’s participation in the project]
      Name: Stanley Chetcuti, MD
      Title: Professor, Director, Cardiac Catheterization Lab, MD
      Organizational unit: Interventional Cardiology
      Phone number: 734-615-3632
      Email address: chetcuti@med.umich.edu
      Mailing address: 1500 E. Medical Center Dr. Ann Arbor MI 48109 CVC 181B

   b. Clinical leader who oversees project leader regarding the project [responsible for overseeing/"sponsoring" the project within the specific clinical setting]
      Name: David Miller, MD
      Title: Chief Clinical Officer, University Hospital and Cardiovascular Center
      Organizational unit: Michigan Medicine
      Phone number: 734-647-6313
      Email address: dcmiller@med.umich.edu
      Mailing address: Urology, 3747 Taubman Center, Ann Arbor MI 48109-5330

5. Participants. Approximately how many physicians (by specialty/subspecialty and by training level) and physicians’ assistants participated for MOC?

<table>
<thead>
<tr>
<th>Participating for MOC</th>
<th>Primary Specialty</th>
<th>Subspecialty, if any</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faculty physicians</td>
<td>Cardiac Surgery</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Faculty physician</td>
<td>Cardiology</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Faculty physician</td>
<td>Urology</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Faculty physician</td>
<td>Thoracic Surgery</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Faculty physician</td>
<td>Anesthesia</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Physician Assistants</td>
<td>Cardiac Surgery</td>
<td></td>
<td>27</td>
</tr>
</tbody>
</table>
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): Adult (age >/= 18) patient population undergoing transcatheter aortic valve replacement (TAVR) or minimally invasive percutaneous mitral valve replacement (Mitral and Tricuspid = MATRIx).

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)?

There should be a standard practice to follow to help with clinical decision-making and patient throughput after minimally invasive valve replacement procedures. By establishing standard guidelines and metrics to follow, patients receive consistent, standard care, and the Advanced Practice Teams (APTs, including Physician Assistants and Nurse Practitioners), and physicians can be educated and feel empowered to independently act on the next clinical steps.

Patients should have appropriate disposition after minimally invasive valve replacement procedures to either the ICU, moderate care, or stepdown unit. All providers involved in the care of Structural Heart patients (defined as transcatheter aortic valve replacement [TAVR] and minimally invasive percutaneous mitral valve replacement [MATRIx] patients) should be following “best practices” in a standard way in order to reduce complications and create equity in care.

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

Patient care and outcomes are being impacted by capacity constraints, variance in clinical practice, and communication barriers. Patients should have appropriate post-procedure disposition to the level of care that is appropriate to their clinical needs. In the past, there has been lack of clarity surrounding which provider teams maintain responsibility for the care of patients post-operatively and nursing is often left without knowing who to reach when there’s an urgent situation (like low blood pressure or concern for bleeding). There are also differences among providers in understanding the level of nursing care provided on a moderate care unit versus a stepdown/floor unit. Patients were often placed in a moderate care setting based solely on previous practice. The lack of a standard approach causes delays in reaching best practice care milestones such as transvenous pacer wire removal, increased length of stay (LOS), and missed opportunities for earlier discharge, which impacts stepdown unit bed availability and throughput of other patients from the ICU to stepdown unit beds.
b. Project goal. What general outcome regarding the problem should result from this project? (State general goal here. Specific aims/performance targets are addressed in #11.)

The goal is to reduce LOS, discharges to Skilled Nursing Facilities (SNFs), and 30-day readmission rate for Structural Heart (TAVR and MATRIx) ACTIVATE patients by creating best practices in patient care to facilitate safe patient flow throughout the episode of care.

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

Measure 1
- **Name of measure** (e.g., Percent of . . ., Mean of . . ., Frequency of . . .):
  
  Median LOS of Structural Heart ACTIVATE patients

- **Measure components** – describe the:
  - **Denominator** (e.g., for percent, often the number of patients eligible for the measure):
    Number of Structural Heart ACTIVATE patient inpatient hospital days total

  - **Numerator** (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
    Number of Structural Heart ACTIVATE patient inpatient stays/events total

- **The source of the measure is:**
  - ☒ Internal to our organization and it was chosen because both the clinical team and leadership felt that there was opportunity for improvement based on external benchmarking.

- **This is a measure of:**
  - ☒ Outcome – health state of a patient resulting from health care

Measure 2
- **Name of measure** (e.g., Percent of . . ., Mean of . . ., Frequency of . . .):
  
  Percent of Structural Heart ACTIVATE patients Utilizing SNFs upon discharge for ACTIVATE patients

- **Measure components** – describe the:
  - **Denominator** (e.g., for percent, often the number of patients eligible for the measure):
    Number of Structural Heart ACTIVATE patients discharged total

  - **Numerator** (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
    Number of Structural Heart ACTIVATE patients discharged to SNFs

- **The source of the measure is:**
  - ☐ An external organization/agency, which is (name the source):
Internal to our organization and it was chosen because based on clinical team member and leadership input, along with external benchmarking, it was felt there was opportunity for improvement on SNF utilization.

- **This is a measure of:**
  - ☐ Process – activities of delivering health care to patients
  - ☒ Outcome – health state of a patient resulting from health care

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

**Measure 3**

- **Name of measure** (e.g., Percent of . . ., Mean of . . ., Frequency of . . .):
  Percent of 30-Day Hospital readmissions

- **Measure components** – describe the:
  - Denominator (e.g., for percent, often the number of patients eligible for the measure):
    Number of Structural Heart ACTIVATE patient total discharges
  - Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation):
    Number of Structural Heart ACTIVATE patients re-admitted within 30 days of discharge date

- **The source of the measure is:**
  - ☒ Internal to our organization and it was chosen because both the clinical team and leadership felt there was room for improvement on this based on external benchmarking. It was also something used to measure sustainable quality measures when LOS and SNF usage decreased.

- **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.)*

10. **Baseline performance**

   a. **What were the beginning and end dates for the time period for baseline data on the measure(s)** CY18 (01/01/2018 – 12/31/2018)

   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.
### 11. Specific performance aim(s)/objective(s)

**a. What is the specific aim of the QI effort?**

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

Our specific aims are to decrease LOS to \(\leq 2\) days for both TAVR and MATRIx patients, decrease utilization of SNFs to \(<10\%\) for TAVR patients and \(<5\%\) for MATRIx patients, and decrease 30-day readmissions to \(<8\%\) for both TAVR and MATRIx patients by January 1, 2020.

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

Metrics were determined by looking to calendar year 2018 data from the Society of Thoracic Surgery National Registry and comparing to internal historical data.

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

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

Attending Physicians, Advanced Practice Providers (APPs: Physician Assistants and Nurse Practitioners), nurses, unit clerks, bed management staff, and Michigan Medicine administration.

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

Every other week Structural Heart ACTIVATE meetings

**c. When? (e.g., date(s) when baseline data were reviewed and discussed)**

03/21/2019

*Use the following table to outline the plan that was developed: #13 the primary causes, #14 the intervention(s) that addressed each cause, and #15 who carried out each intervention. This is a simplified presentation of the logic diagram for structured problem solving explained at [http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation](http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation) in section 2a. As background, some summary examples of common causes and interventions to address them are:*

<table>
<thead>
<tr>
<th>Common Causes</th>
<th>Common Relevant Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals: Are not aware of, don’t understand.</td>
<td>Education about evidence and importance of goal.</td>
</tr>
<tr>
<td>Individuals: Believe performance is OK.</td>
<td>Feedback of performance data.</td>
</tr>
<tr>
<td>Individuals: Cannot remember.</td>
<td>Checklists, reminders.</td>
</tr>
<tr>
<td>Team: Individuals vary in how work is done.</td>
<td>Develop standard work processes.</td>
</tr>
<tr>
<td>Workload: Not enough time.</td>
<td>Reallocate roles and work, review work priorities.</td>
</tr>
<tr>
<td>Suppliers: Problems with provided information/materials.</td>
<td>Work with suppliers to address problems there.</td>
</tr>
<tr>
<td>13. What were the primary underlying/root causes for the problem(s) at baseline that the project can address?</td>
<td>14. What intervention(s) addressed this cause?</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Barriers in communication between teams caring for patients</td>
<td>Held biweekly Structural Heart ACTIVATE team meetings</td>
</tr>
<tr>
<td>Variance in clinical practice</td>
<td>Set goals for standard practice in PACU and on floor 1. Temporary pacer removal within 4 hours 2. Limit patients admitted to ICU or moderate care setting to &lt;15% 3. Discharge order entered by 0930 4. Discharge by 1100</td>
</tr>
<tr>
<td>Variance in faculty member and APP practice</td>
<td>Build consensus among key stakeholders on goals for care processes.</td>
</tr>
<tr>
<td>Frequent use of SNFs as discharge destinations for follow up care may have led to more frequent readmissions.</td>
<td>Anticipate and address post-discharge plan with patient and family at pre-operative visit. Establish and assign a family member who will act as a support coach.</td>
</tr>
<tr>
<td>Barriers in inconsistent post-operative ordering.</td>
<td>Work to streamline TAVR post-operative orderset to be inclusive of floor status post-procedure disposition.</td>
</tr>
</tbody>
</table>

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

C. Do

16. By what date was (were) the intervention(s) initiated? (If multiple interventions, date by when all were initiated.) 05/07/2019

D. Check

17. Post-intervention performance measurement. Are the population and measures the same as those for the collection of baseline data (see item 9)?

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

18. Post-intervention performance

   a. What were the beginning and end dates for the time period for post-intervention data on the measure(s)? 05/07/2019 – 02/19/2020
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.

<table>
<thead>
<tr>
<th></th>
<th>LOS Post-Intervention</th>
<th>SNF Utilization Post-Intervention</th>
<th>30 – Day Readmission Post-Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAVR</td>
<td>2.0 days</td>
<td>3.9%</td>
<td>6.7%</td>
</tr>
<tr>
<td>MATRIX</td>
<td>1.0 days</td>
<td>0.0%</td>
<td>7.1%</td>
</tr>
</tbody>
</table>

c. Did the intervention(s) produce the expected improvement toward meeting the project’s specific aim (item 11.a)?
Yes, the interventions of the Structural Heart ACTIVATE project enabled us to improve and achieve our targets on LOS, SNF utilization, and readmissions measures. Additionally, the project helped us realize that there were still areas of opportunity to improve our processes.

E. Adjust – Replan

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

a. Who was involved? (e.g., by profession or role)
   ☒ Same as #12? ☐ Different than #12 (describe):

b. How? (e.g., in a meeting of clinic staff)
   ☒ Same as #12? ☐ Different than #12 (describe):

c. When? (e.g., date(s) when post-intervention data were reviewed and discussed) 03/05/2020

Use the following table to outline the next plan that was developed: #20 the primary causes, #21 the adjustments/second intervention(s) that addressed each cause, and #22 who carried out each intervention. This is a simplified presentation of the logic diagram for structured problem solving explained at http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation in section 2a.

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

<table>
<thead>
<tr>
<th>20. What were the primary underlying/root causes for the problem(s) following the intervention(s) that the project can address?</th>
<th>21. What adjustments/second intervention(s) addressed this cause?</th>
<th>22. Who was involved in carrying out each adjustment/second intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workload and comfort of Cardiac Surgery Operating</td>
<td>Adjusting the personnel who would remove the TVPs to the</td>
<td>Physicians, APPs, Michigan Medicine administration</td>
</tr>
<tr>
<td>Room PAs in removing transvenous pacemakers (TVPs).</td>
<td>Cardiology Faculty members and the Cardiac Surgery Stepdown Unit APPs.</td>
<td>Trialled pilot process of housing Cardiac Surgery (STC) APP in PACU to address immediate concerns.</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Uncertainty of which service providers were responsible for patients in PACU should they have specific care needs during their PACU stay.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

F. Redo

23. By what date was (were) the adjustment(s)/second intervention(s) initiated?  *(If multiple interventions, date by when all were initiated.)* 09/17/2020

G. Recheck

24. Post-adjustment performance measurement. Are the population and measures the same as indicated for the collection of post-intervention data (item #19)?
   ☒ Yes  ☐ No – If no, describe how the population or measures differ:

25. Post-adjustment performance

   a. What were the beginning and end dates for the time period for post-adjustment data on the measure(s)? 09/17/2020 – 10/14/2020.  *Note:* Data collection paused Spring 2020 due to COVID.

   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.*

<table>
<thead>
<tr>
<th>LOS</th>
<th>SNF Utilization</th>
<th>30 – Day Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>TAVR</td>
<td>2.0 days</td>
<td>4.4%</td>
</tr>
<tr>
<td>MATRIX</td>
<td>1.0 days</td>
<td>0%</td>
</tr>
</tbody>
</table>

   c. Did the adjustment(s) produce the expected improvement toward meeting the project’s specific aim (item 11.a)? Yes, the interventions allowed for sustainment of Structural Heart ACTIVATE results and provided re-engagement, as providers were not having to manually collect data anymore. As an aside, there was also a follow up ACTIVATE socialization in 09/2020 post-COVID to re-engage the teams and re-orient them to this process after the first COVID wave.

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

   a. Who was involved? (e.g., by profession or role)
      ☒ Same as #19? ☐ Different than #19 (describe):

   b. How? (e.g., in a meeting of clinic staff)
      ☒ Same as #19? ☐ Different than #19 (describe):

   c. When? (e.g., date(s) when post-adjustment data were reviewed and discussed) 10/15/2020

   Use the following table to outline the next plan that was developed: #27 the primary causes, #28 the adjustments(s)/second intervention(s) that addressed each cause, and #29 who would carry out each intervention. This is a simplified presentation of the logic diagram for structured problem solving explained at [http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation](http://ocpd.med.umich.edu/moc/process-having-part-iv-credit-designation) in section 2a.

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

<table>
<thead>
<tr>
<th>27. What were the primary underlying/root causes for the problem(s) following the adjustment(s) that the project can address?</th>
<th>28. What further adjustments/intervention(s) might address this cause?</th>
<th>29. Who would be involved in carrying out each further adjustment/intervention? (List the professions/roles involved.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barriers in communication of early or Priority Discharge to key stakeholders in echocardiography and physical therapy, particularly on weekends.</td>
<td>Met with echocardiography manager, Physical Therapy supervisor, and Discharge Planning supervisor to allow for TAVR patients to be listed as “Priority Discharge” on weekends in Epic (electronic communication tool for stakeholders).</td>
<td>Physicians, APPs, nurses, Michigan Medicine administration, Physical Therapy, Echocardiography techs and manager, Discharge Planners, and Discharge Planner supervisor.</td>
</tr>
<tr>
<td>Barriers in operationalizing weekend early or “Priority” discharges.</td>
<td>Communicate a “ready for discharge” plan with faculty the day prior to facilitate early discharge the next day.</td>
<td>Physicians, APPs, Michigan Medicine administration.</td>
</tr>
</tbody>
</table>

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

30. Are additional PDCA cycles to occur for this specific performance effort?
   ☒ Further cycles will occur, but will not be documented for MOC. If checked, summarize plans: Goal for metrics will continue to be evaluated based on performance, in addition to continued improvements in communication and processes to facilitate Structural Heart ACTIVATE pathway.
I. Minimum Participation for MOC

31. Participating directly in providing patient care.
   a. Did any individuals seeking MOC participate directly in providing care to the patient population?
      ☒ Yes ☐ No If “No,” go to item #32.

   b. Did these individuals participate in the following five key activities over the two cycles of data-guided improvement?
      – Reviewing and interpreting baseline data, considering underlying causes, and planning intervention as described in item #12.
      – Implementing interventions described in item #14.
      – Reviewing and interpreting post-intervention data, considering underlying causes, and planning intervention as described in item #19.
      – Implementing adjustments/second interventions described in item #21.
      – Reviewing and interpreting post-adjustment data, considering underlying causes, and planning intervention as described in item #26.
      ☒ Yes ☐ No If “Yes,” individuals are eligible for MOC unless other requirements also apply and must be met – see item # 33.

32. Not participating directly in providing patient care.
   a. Did any individuals seeking MOC not participate directly in providing care to the patient population?
      ☒ Yes ☐ No If “No,” go to item 33.

   b. Were the individual(s) involved in the conceptualization, design, implementation, and assessment/evaluation of the cycles of improvement? (E.g., a supervisor or consultant who is involved in all phases, but does not provide direct care to the patient population.)
      ☒ Yes ☐ No If “Yes,” individuals are eligible for MOC unless other requirements also apply and must be met – see item # 33. If “No,” continue to #32c.

   c. Did the individual(s) supervising residents or fellows throughout their performing the entire QI effort?
      ☐ Yes ☒ No If “Yes,” individuals are eligible for MOC unless other requirements also apply and must be met – see item # 33.

33. Did this specific QI effort have any additional participation requirement for MOC? (E.g., participants required to collect data regarding their patients.)
   ☐ Yes ☒ No If “Yes,” describe:

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

J. Sharing Results
34. Are you planning to present this QI project and its results in a:
   ☒ Yes  ☐ No  Formal report to clinical leaders?
   ☒ Yes  ☐ No  Presentation (verbal or poster) at a regional or national meeting?
   ☒ Yes  ☐ No  Manuscript for publication?

K. Project Organizational Role and Structure

35. UMHS QI/Part IV MOC oversight – indicate whether this project occurs within UMHS, AAVA, or an affiliated organization and provide the requested information.
   ☒ University of Michigan Health System
      • Overseen by what UMHS Unit/Group? (name): UH/CVC
      • Is the activity part of a larger UMHS institutional or departmental initiative?
        ☐ No  ☒ Yes – the initiative is (name or describe): Structural Heart ACTIVATE Initiative

   ☐ Veterans Administration Ann Arbor Healthcare System
      • Overseen by what AAVA Unit/Group? (name):
      • Is the activity part of a larger AAVA institutional or departmental initiative?
        ☒ No  ☐ Yes – the initiative is:

   ☐ An organization affiliated with UMHS to improve clinical care
      • The organization is (name):
      • The type of affiliation with UMHS is:
        ☐ Accountable Care Organization (specify which member institution):
        ☐ BCBSM funded, UMHS lead state-wide Collaborative Quality Initiative (specify which):
        ☐ Other (specify):