

Report on a QI Project Eligible for MOC – ABMS Part IV and NCCPA PI-CME**Transforming Trauma Informed Care****Wave 1****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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Report Outline

Section	Items
A. Introduction	1-6. Current date, title, time frame, key individuals, participants, funding
B. Plan	7-8. Patient population, general goal 9-11. Measures, baseline performance, specific aims 12-15. Baseline data review, underlying (root) causes, interventions, who will implement
C. Do	16. Intervention implementation date
D. Check	17-18. Post-intervention performance
E. Adjust – Replan	19-22. Post-intervention data review, underlying causes, adjustments, who will implement

- F. Redo** 23. Adjustment implementation date
- G. Recheck** 24-26. Post-adjustment performance, summary of individual performance
- H. Readjust plan** 27-30. Post-adjustment data review, underlying causes, further adjustments, who will implement
- I. Participation for MOC** 31-33. Participation in key activities, other options, other requirements
- J. Sharing results** 34. Plans for report, presentation, publication
- K. Organization affiliation** 35. 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*): 11/06/2019

2. **Title of QI effort/project** (*also insert at top of front page*): Transforming Trauma Informed Care

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*): Wave 1 began in April 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*): Wave 1 finished in October 2019

4. **Key individuals**
 - a. **QI project leader** [*also responsible for confirming individual’s participation in the project*]
Name: Yam Hoon Lim, M.Ed.
Title: CE Accreditation Manager
Organizational unit: Altarum Institute
Phone number: 734-302-4652
Email address: yamhoon.lim@altarum.org
Mailing address: 3520 Green Court, Suite 300, Ann Arbor, MI 48105

 - b. **Clinical leader who oversees project leader regarding the project** [*responsible for overseeing/“sponsoring” the project within the specific clinical setting*]
Name: Maria Muzik, M.D
Title: Associate Professor
Organizational unit: University of Michigan, Department of Psychiatry and Department of Obstetrics and Gynecology
Phone number: 734-846-8027
Email address: muzik@med.umich.edu
Mailing address: 4250 Plymouth Road, Ann Arbor, MI 48109

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

Participating for MOC	Primary Specialty	Subspecialty, if any	Number
Practicing Physicians	Family Medicine Physicians		5
	Pediatrics		3

	Internal Medicine Physicians		(N/A)
	OB/GYN		(N/A)
	Psychiatrists		1
	Neurologists		(N/A)
Other Licensed Allied Health (e.g., PT/OT, pharmacists, dieticians, social workers)	Limited Licensed Psychologists		3
Residents/Fellows			(N/A)
Physicians' Assistants	Family Medicine	(N/A)	1

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):

Target population: Pediatric and adult patients seen for Well-Child or Annual Visits in participant sites, including Family Medicine, Internal Medicine, Pediatrics, OB/GYN, Neurology and Psychiatry practices. As stipulated in the award of federal funds supporting the Network, the practices are not part of Accountable Care Organizations. The list of participating sites is included in Appendix B.

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)?

Evidence-based research demonstrates that approximately two-thirds of both inpatients and outpatients in the behavioral health care system have a history of exposure to multiple traumatic events, often of an invasive, interpersonal nature, and wide-ranging. This prolonged exposure to traumatic events is defined as complex trauma. Not surprisingly, the single most significant predictor that an individual will end up in the behavioral health care system is a

history of complex trauma. The more severe and prolonged the trauma, the more severe are the psychological and physical health consequences.

In order to mitigate the negative health consequences of complex trauma, both pediatric and adult patients should be screened, and patients who screen positive for complex trauma should be offered follow up care.

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

Complex trauma is a relatively new term within behavioral health research, and the condition has limited recognition within practice. Consequently, both behavioral and medical health care providers are ill equipped to effectively screen and coordinate care for those who may be struggling with complex trauma.

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 proposed project goal is to integrate complex trauma screening and coordination of care into traditional Trauma-Informed Care (TIC) within behavioral, pediatric, and family health care settings by:

1. Increasing the use of standardized trauma and stressor related disorder screening tools by health care providers.
2. Improving the coordination of care for patients who screened positive for trauma and stressor related disorder(s). We achieve this by training health care providers to utilize the American Academy of Pediatrics (AAP) Visit Discharge and Referral Summary for Family Form, the Michigan Behavioral Health Consent Form (Version 5.0 MDHHS-5515), or an equivalent consent form to facilitate referrals. Additionally, providers should encourage conversation and patient engagement during the referral and care process.

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 . . .): Trauma and Stressor Related Disorder Screening Tools Utilization Rate

Measure components – describe the:

- **Denominator** (e.g., for percent, often the number of patients eligible for the measure): Number of Well-Child or Annual Wellness Visit patient charts pulled, excluding patients with a current diagnosis of any one of the following trauma and stressor related disorders currently listed within the DSM-5: reactive attachment disorder, disinhibited social engagement disorder,

posttraumatic stress disorder, acute stress disorder, adjustment disorders, other specified trauma and stressor-related disorder, and unspecified trauma and stressor-related disorder.

- **Numerator** (e.g., for percent, often the number of those in the denominator who also meet the performance expectation): Number of eligible pediatric patients screened using the Children's Trauma Assessment Center Trauma Screening Checklist (CTAC TSC) (or equivalent tool) plus the number of eligible adult patients screened using the Trauma History Screen (THS) (or equivalent tool).

The percentage will be calculated by dividing the number of patients screened using a standardized trauma screening tool by the total number of eligible charts selected.

- **The source of the measure is:**
 - An external organization/agency, which is (*name the source, e.g., HEDIS*):
 - Internal to our organization
 1. The Children's Trauma Assessment Center Trauma Screening Checklist—Ages 0-5 and 6-18 (CTAC TSC) was sourced from the Southwest Michigan Children's Trauma Assessment Center at Western Michigan University. It was selected as the pediatric screening tool due to evidenced strong psychometric properties for children/youth 0-18.
 2. The Trauma History Screen (THS) was sourced from the U.S. Department of Veteran Affairs National Center for PTSD and was selected as the adult specific screening tool due to evidenced strong psychometric properties for adults 18+.

The structure of these measure is based on measures that have been used in previous projects that were inspired by or in alignment with PQRS/NQF measures.

- **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 . . .*):

Percent of Positively Screened Patients with Completed Consent Forms.

Measure components – describe the:

- Denominator (e.g., for percent, often the number of patients eligible for the measure): Number of eligible patients who screen positive for trauma symptoms.
 - Numerator (e.g., for percent, often the number of those in the denominator who also meet the performance expectation): Number of eligible patients who screen positive for trauma symptoms and were referred to treatment utilizing either of the following forms (or equivalent):
 - i) AAP Visit Discharge and Referral Summary for Family Form
 - ii) Version 5.0 MDHHS-5515
- **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*):

Version 5.0 of MDHHS-5515 was sourced from the Michigan Department of Health & Human Services (MDHHS). It was selected as the tool for the follow up plan to be utilized for coordination of care purposes. Further, it is in full compliance with state and federal regulations regarding the release and coordination of protected behavioral health information.

- **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)?

Previously collected national information regarding low rates of performance will be used as the general baseline for discussion at the initial meeting (month 1). Each practice will confirm the relevance of the national rates by retrospectively collecting data from 1 month prior to the training activity. For example, for a cycle with initial discussion and training occurring in February 2019, the practices will retrospectively collect data for January 2019. For Wave 1 it was March 2019.

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.*

See Appendix B, first column of data, for the baseline percent of patients with services performed by Wave.

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].”*

By the end of the second cycle of improvement over a 7-month period (October 2019 for Wave 1):

- 50% of eligible patients will be screened for complex trauma with standardized screening tools
- 50% of positively screened patients will have a documented consent forms in order to be referred for treatment

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

Given that complex trauma is a relatively new term within behavioral health, and the condition has limited recognition within practice, project leaders set the performance targets at 50%, based on their judgement of what would be achievable.

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)
Participating physicians, specialists, psychologists, nurse practitioners, physician assistants, and clinical staff.
- b. **How?** (e.g., in a meeting of clinic staff)
During clinical staff meetings.
- c. **When?** (e.g., date(s) when baseline data were reviewed and discussed)
Before the end of month 2 of the cycle. For Wave 1 it was before the end of May 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> in section 2a. As background, some summary examples of common causes and interventions to address them are:

Common Causes	Common Relevant Interventions
<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>

13. What were the primary underlying/root causes for the problem(s) at baseline that the project can address?	14. What intervention(s) addressed this cause?	15. Who was involved in carrying out each intervention? (List the professions/roles involved.)
<u>Clinical Education</u> Providers may not be aware of recommendations regarding screening and monitoring for trauma and stressor related disorders.	Direct-to-provider education about trauma and stressor related disorders. A 1 hour training will address how providers can screen children and adults for complex trauma symptomology	A Certified Trainer (CT) will deliver an hour of either in-person or remote training to providers, and will provide clinic personnel (e.g. physicians, nurse clinicians,

<p>Even if providers are aware of recommendations, they may lack the training to be able to implement best practices for assessing trauma and stressor related disorders.</p>	<p>and refer to treatment utilizing the Michigan Behavioral Health Standard Consent Form as a part of the clinical workflow.</p>	<p>physician assistants, and clinic staff) with educational materials.</p>
<p><u>Lack of resources</u> Providers do not know where to refer patients who struggle with trauma and stressor related disorders.</p>	<p>Local solutions will be identified to counsel patients who are identified as experiencing clinically significant trauma and stressor related symptomology. Additionally, local referral resources will be provided.</p>	<p>Program staff in coordination with providers and clinic personnel</p>
<p><u>No systematic processes</u> Office processes and work flow do not support best practices and standard of care guidelines for trauma and stressor related disorders</p>	<p>Local provider groups will determine specific operational changes based on the general recommendations for improving trauma and stressor related disorders screening and referral to treatment processes. Technical assistance is provided to help identify potential barriers in office workflow and how to address them.</p>	<p>(same as above)</p>
<p><u>Inadequate documentation</u> When activities are performed, they may not be documented because providers do not know what to document or where to document it. Providers may lack time to make entries in the medical record.</p>	<p>Technical assistance is provided on efficiently documenting completion of the services into the practice's workflow</p>	<p>(same as above)</p>

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.)

The initial general education and technical assistance will be provided during the meeting in month 1 of each group's 7-month cycle. After providers collect and report their individual practice retrospective baseline data during month 2, technical assistance will be deployed as needed and interventions implemented by the end of month 2 . For Wave 1 it was May 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)?

Month 3 of each group's cycle. For Wave 1 it was June 2019.

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.

See Appendix B, middle column of data, for the post-intervention percent of patients with services performed and documented within the practice.

c. Did the intervention(s) produce the expected improvement toward meeting the project's specific aim (item 11.a)?

Yes, a majority of participating practices showed improvement.

Measure 1 (Screening) - Across all practices, Measure 1 reached a mean performance level of 60%, exceeding the goal of 50%.

Measure 2 (Consent) - Performance for Measure 2 also increased appreciably, because at baseline only one practice was even identifying eligible patients (Measure 1). In month 3, nine out of 10 practices were identifying eligible patients, and three of those practices reported 100% completed consent forms.

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)

Before the end of month 4 of the cycle. For Wave 1 this was July 2019.

Use the following table to outline the next plan that was developed: #20 the primary causes, #21 the adjustments(s)/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.

20. What were the primary underlying/root causes for the <u>problem(s) following the intervention(s)</u> that the project can address?	21. What adjustments/second intervention(s) addressed this cause?	22. Who was involved in carrying out each adjustment/second intervention? (List the professions/roles involved.)
<p><u>No systematic workflow</u> Needed additional guidance for providers and office staff to know how often to administer and who was to administer specific services related to trauma and stressor related disorders</p> <p>Office champions or critical staff being out of the office causes delays and/or confusion in the workflow</p>	<p>Review workflow and assign clear responsibility and backup personnel for tasking</p>	<p>Program personnel, local office champion and all clinic personnel (e.g., physicians, nurse clinicians, physician assistants, and office staff).</p>
<p><u>Documentation</u> Difficulty standardizing documentation process and/or pulling data accurately using the clinics coding and reporting systems</p>	<p>Working with providers and clinic staff on how to adjust data collection process to appropriately select patients for the clinical performance measures, and if needed finding alternative documentation processes</p>	<p>(same as above)</p>
<p><u>Delays in Communication with Counselor</u> Wait time between the counselor and referring office prevented proper documentation of completed consent forms</p>	<p>Guiding the participating providers to complete the consent form in advance instead of the referring office if that makes sense for their workflow, and being sure to properly document the forms for patients when ready</p>	<p>(same as above)</p>

<p>Some providers felt it wasn't appropriate to fill out forms for all positively screened patients until a behavioral health clinic was identified.</p>		
<p><u>Continued resources on how to handle positively screened patients</u> Concerns and questions regarding how to manage positively screened patients. Questions regarding how to carry out the discussion on signing the consent form with positively screened patients.</p>	<p>Program staff offered additional resources and technical assistance to connect with local behavioral health practices and addressed any concerns on how to discuss the screening, consent forms, and follow-up with positively screened patients.</p>	<p>(same as above)</p>

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.)*

The beginning of month 5 of the cycle. For Wave 1 it was August 2019.

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)?

During month 6 of the group's participation. For Wave 1 it was September 2019.

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.*

See Appendix B, last column of data, for the post-adjustment percent of patients with services performed within the practice.

c. Did the adjustment(s) produce the expected improvement toward meeting the project's specific aim (item 11.a)?

Partially. A majority of practices showed substantial improvement and exceeded the goal for at least one measure

Measure 1 (Screening) -. Eight of ten participating practices improved or maintained their performance for Measure 1. Aggregate performance on screening improved from 60% post-intervention to 71% post-adjustment, continuing to surpass the goal of 50%.

Measure 2 (Consent)- Three participating practices maintained or improved performance for measure 2. One practice saw a decrease in Measure 2 by 5% due to expired consent forms and patients who had yet to return to the office, but those charts have been flagged to get consents updated at the next patient visit. The aggregate performance for Measure 2 increased from 33% post-intervention to 34% post-adjustment, not meeting the goal of 50%.

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)

Before the end of Month 7 of the cycle. For Wave 1 it was October 2019.

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> 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.

27. What were the primary underlying/root causes for the <u>problem(s)</u> following the <u>adjustment(s)</u> that the project can address?	28. What further adjustments/ intervention(s) might address this cause?	29. Who would be involved in carrying out each further adjustment/intervention? (List the professions/roles involved.)
<u>Expired Consent Forms</u>	Flagging expired consent forms and following up with patients	Clinic personnel ((e.g., physicians, nurse clinicians,

Expired forms from patients who had not been back in the office recently.	to update the forms as soon as patient returns to the office.	physician assistants, and office staff).
<u>Language Barriers</u> Newly immigrated patients need a translated version of the screening tool	Work to find a translation of the tool in order to provide the screening for a greater number of patients.	(same as above)
<u>Documentation Issues</u> Trouble organizing and documenting consent forms, or being forgetful	Continuing the PDSA cycle and creating systematic processes to make documentation more efficient	Program personnel, local office champion and all clinic personnel (e.g., physicians, nurse clinicians, physician assistants, and office staff).

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?

No further cycles will occur.

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

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 # 38.*

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 # 38. If “No,” continue to #37c.*

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: Collect or oversee collection of data in the practice.*

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):
- **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):
- **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*): Project-specific agreement between UMHS and Altarum Institute for joint providership of activities for the Transforming Trauma Informed Care improvement initiative.

Appendix A. Timeline for Waves of Groups of Participating Medical Practices

Each wave participates in two cycles of data-guided improvement over seven months. This project will have one wave which will start April 1, 2019 and end on October 31, 2019.

Cycles of Participation

Trauma Informed Care (TIC)	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7
	(Training)	(Baseline)		(Midway)			(Final) + End Date
2019							
April	1 April	May	June	July	August	September	October 31st

Appendix B. Performance for Wave 1 of Practices for Percent of Patients with Service Performed

Service	Baseline Month 1	Post- Intervention Month 3	Post- Adjustment Month 6	Goal
<u>Site A</u>				
Documentation of Risk of Trauma Screening	0% (n=20)	100% (n=11)	100% (n=7)	50%
Documentation of Consent Form	N/A (n=0)	0% (n=4)	0% (n=1)	50%
<u>Site B</u>				
Documentation of Risk of Trauma Screening	0% (n=20)	86% (n=14)	67% (n=18)	50%
Documentation of Consent Form	N/A (n=0)	0% (n=12)	0% (n=9)	50%
<u>Site C</u>				
Documentation of Risk of Trauma Screening	0% (n=20)	88% (n=17)	70% (n=20)	50%
Documentation of Consent Form	N/A (n=0)	0% (n=11)	0% (n=7)	50%
<u>Site D</u>				
Documentation of Risk of Trauma Screening	0% (n=60)	25% (n=59)	78% (n=49)	50%
Documentation of Consent Form	N/A (n=0)	0% (n=5)	14% (n=14)	50%
<u>Site E</u>				
Documentation of Risk of Trauma Screening	0% (n=20)	90% (n=19)	90% (n=20)	50%
Documentation of Consent Form	N/A (n=0)	0% (n=10)	0% (n=11)	50%
<u>Site F</u>				
Documentation of Risk of Trauma Screening	0% (n=2)	33% (n=15)	50% (n=10)	50%
Documentation of Consent Form	N/A (n=0)	100% (n=5)	100% (n=5)	50%
<u>Site G</u>				
Documentation of Risk of Trauma Screening	0% (n=20)	100% (n=24)	100% (n=25)	50%
Documentation of Consent Form	N/A (n=0)	100% (n=24)	100% (n=25)	50%

<u>Site H</u>				
Documentation of Risk of Trauma Screening	0% (n=40)	15% (n=40)	67% (n=39)	50%
Documentation of Consent Form	N/A (n=0)	0% (n=1)	0% (n=1)	50%
<u>Site I</u>				
Documentation of Risk of Trauma Screening	67% (n=83)	59% (n=110)	71% (n=87)	50%
Documentation of Consent Form	100% (n=31)	100% (n=40)	95% (n=43)	50%
<u>Site J</u>				
Documentation of Risk of Trauma Screening	0% (n=20)	0% (n=5)	13% (n=16)	50%
Documentation of Consent Form	N/A (n=0)	N/A (n=0)	N/A (n=0)	50%
<u>Wave 1 – Mean of 10 Practice Means</u>				
Documentation of Risk of Trauma Screening	7%	60%	71%	50%
Documentation of Consent Form	100% for 1 site, N/A for 9 sites	33% for 9 sites, N/A for 1 site	34% for 9 sites, N/A for 1 site	50%