

**Maintenance of Certification Part IV**

**Quality Improvement Project Credit Application**

**Section II: Implementation**

**Form Guidelines**: Project leader(s) must submit for review a completed **Credit Application Section II** and attach an **updated Section I .** The UK HealthCare CECentral MOC Part IV Review Committee team leader will determine whether the project was carried out with appropriate QI methods and required engagement of participating physicians and other healthcare professionals. The review process may take up to four weeks.

**Participation Attestation:** Upon approval of the Credit Application by the Review Committee team leader, CECentral will notify participating physicians and other healthcare professionals to complete and submit an online **QI Project Participation Attestation Form**. CECentral will forward the submitted attestation forms to the project leader or co-leader for participation verification. For projects without a co-leader, the project leader attestation may be verified by the Review Committee team leader. Upon verification, CECentral will forward physician data with MOC Part IV credit approval to the Multi-Specialty MOC Portfolio Approval Program for participating ABMS boards. The Portfolio Program then will notify the appropriate ABMS board(s). Credit should be recorded by each certifying ABMS specialty board within 4-6 weeks.

MOC Part IV is typically granted at the conclusion of the project. For long-term projects, consult with UK HealthCare CECentral to determine when a project is eligible for credit.

**Form Instructions:** One complete Credit Application (Sections I and II) is required per QI project,despite the number of participating physicians and other health care professionals or ABMS boards participating in the Multi-Specialty MOC Provider Approval Program.

Text responses are open-ended. To mark a checkbox, double click the checkbox and choose “checked” and “OK”.

Submit questions or a completed Credit Application (Sections I and II) to:

**Chris Dennison**

Accreditation Manager

UK HealthCare CECentral

(859) 218-0329

[christopher.dennison@uky.edu](mailto:christopher.dennison@uky.edu)

**MOC Part IV Credit Application Section I: Design**

Please revise the pre-approved section I, as needed, and include with submission of section II as a separate document with the text “revision” in the file name.

**MOC Part IV Credit Application Section II: Implementation**

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| **QI PROJECT** | |
| Beginning and Ending Dates |  |
| Title |  |
| Clinical Site or Service Initiator |  |

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| **Interventions and Tools** |
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| Classify the types of interventions and tools that are being, were, or will be used by participants in the quality improvement effort and describe how each is expected to impact patient care and physician practice.  Intervention/Tool Type:  ***E.G.; Checklist***    Intervention/Tool Description:  ***E.G.; We have a checklist that prints from our EMR for adult PCP visits; we worked with IT to have hypertension screening added to that checklist as well as visits that are “other than” PCP visits such that it now is available for every visit for every patient 18+***    How will this impact patient care?  ***E.G.; This change ensures that every patient 18 + who is seen at least annually is screened for hypertension regardless of the type of visit***    How will this impact physician practice?  ***E.G.; Will lengthen physician visit time for every patient who screens high*** |
| What are, were, or will be the specific requirements for meaningful participation in the quality improvement effort? **Please note that your answer should (a) relate to the items listed in the tools and intervention section above and (b) include participation at all levels (planning meetings, implementing interventions, data review, attending education meetings, etc)**  Intervention/Tool Description:  ***E.G.; Checklist***    Direct Physician Role:  ***E.G.; After RN has performed second B/P and confirmed elevation, MD enlists protocol of: repeat B/P, educate PT about risks of HTN, lifestyle changes, potential medications and schedules repeat visit; documents all in EMR***    Expected Time to Reassess (in Days, Weeks or Months)  ***E.G.; Physician level reports will be generated and distributed every month from the EMR showing: pts screened, pts seen, new HTN patients/pts screened, protocol completed/new HTN patients—physicians must assess and analyze these data for a minimum of 5 months (baseline, 3 interventions, completion)*** |
| To the best of your ability, indicate the number of participants from each category who have achieved all measurement Target Rates, achieved at last one measurement Target Rate, or did not yet reach any of the measurement Target Rates.  Physicians: *Achieved All*       *At least one Achieved*       *None Yet Achieved*  PAs: *Achieved All*       *At least one Achieved*       *None Yet Achieved*  Residents: *Achieved All*       *At least one Achieved*       *None Yet Achieved*  Nurses: *Achieved All*       *At least one Achieved*       *None Yet Achieved*  Other: *Achieved All*       *At least one Achieved*       *None Yet Achieved* |

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| **OUTCOMES** |
| Describe the overall outcomes of the quality improvement project, including data demonstrating the impact of the project. **Data must include 3 data points; baseline, post PDSA-1 data and post PDSA-2 data. Continuous data collection is preferable when possible.**  Best Practice or Lesson Learned:  ***E.G.; We learned that our BP cuffs were in need of recalibration***    How Identified:  ***E.G.; Out of 27 patients screened, we identified all of them as having dangerously high BP, though they showed no other symptoms***    Barrier(s) Encountered:  ***E.G.; Contacting the cuff technicians to schedule calibration; time it took for them to arrive and recalibrate all cuffs***    Barrier(s) Resolution:  ***E.G.; While the technician was there, we identified the proper schedule for maintenance and scheduled them out for the next 3 years***  Sustainment Plan:  ***E.G.; A policy was written for the department that every 9-12 months, we need to have BP cuffs recalibrated. We also included the policy to plan the subsequent 3 year plan at the last visit in the current cycle.***    Spread Plan (if applicable):  ***E.G.; This information was shared with all IM, FM, Peds and Cardiac clinic in order that they too schedule cuff recalibration on a regular basis.*** |

**By signing below, I certify that at least 2 PDSA cycles were completed and at least 3 data points were submitted.**

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| Project Leader Signature |  |
| Project Co-leader Signature (if applicable) |  |
| Submission Date | mm/dd/yyyy |

**By signing below, I certify that at least 2 PDSA cycles were completed and at least 3 data points were submitted.**

|  |  |
| --- | --- |
| Review Committee Team Leader Signature |  |
| Date | mm/dd/yyyy |

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