**Undersea and Hyperbaric Medicine**

**ABPM Maintenance of Certification Part IV   
Patient Care Practice Improvement (PCPI Activity)**

**Note: This packet is for diplomates undergoing the Board Certification process through American Board of Preventive Medicine to satisfy Maintenance of Certification Part 4 requirement.**

Diplomates must complete two practice assessment and improvement activities during each ten-year certification cycle. One assessment is to be completed in the first five years of the cycle and a second in the last five years. For those diplomates maintaining certification with another ABMS specialty board or a Canadian specialty board, Part 4 requirements may be satisfied by completing the MOC requirements of that specialty board. Further information can be found on the ABPM website here: <https://www.theabpm.org/moc/moc_requirements.cfm>

**Demographic Information:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full Name:** |  | | **Work Phone:** | | |  | | | |
| **City:** |  | | **Cell Phone:** | | |  | | | |
| **State:** |  | | **Preferred method of contact:** | | | | | | |
| **Birth Year:** |  | |  | **Email** |  | | **Work Phone** |  | **Home Phone** |
| **Email:** |  | | **Date ABPM Board Certification Expires (MM/DD/YYYY):** | | | | | |  |
| **Year of Initial ABPM Certification (YYYY):** | |  | | | | | | | |

**Practice Setting** (please check box below):

Clinical Practice  Academic Setting  Government/Military  Corporation  
 Other (Please specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Time Distribution** (What percentage of time do you spend in the following):

|  |  |
| --- | --- |
| Clinical Undersea/Hyperbaric Medicine | % |
| Administrative/Management: | % |
| Research: | % |
| Academic: | % |
| Other (Please Specify): | % |

**If you practice a medical specialty or are Board Certified in addition to Undersea and Hyperbaric Medicine, please specify:**

|  |  |  |  |
| --- | --- | --- | --- |
| Other Specialty: |  | Expiration Date (YYYY): |  |

**PART FOUR: Patient Care Practice Improvement (PCPI) Activity**

There are four required steps in the Patient Care Practice Improvement Activity. Please detail your activity identified, the process used and outcomes measured below by typing under the highlighted sections. It is estimated this process will take 6 months from beginning to end.

1.  Identify an area in your current practice that you will target for improvement (Either A or B).

**A. If your time is spent in direct clinical patient care is 10% or greater**, review patient care clinical information from ten patients undergoing hyperbaric oxygen therapy and who are under your care. The information may be related to clinical care processes, feedback from patients that relates to the clinical care given or outcomes of clinical care. Group data and data collected through a national, regional, or local practice improvement program in which you participate is acceptable. OR;

**B. If less than 10% of your time is spent in direct clinical patient care,** identify an area where you could pursue improvement. Recommendations for an activity may be personally identified, obtained from a supervisor or colleague, or selected from an acceptable PCPI noted below.

**Enter your patient care practice improvement title below and why you chose this area to target for improvement:  
Answer:**

2. Compare the data to evidence based guidelines and standards. Evidence based guidelines must be founded on published research and subject to peer review. If specialty guidelines are not available, recommendations proposed by expert consensus or comparable peer data is acceptable. Guidelines set by expert consensus should be published, accepted, and viewed as national standards. Guidelines set by peer data are set by individuals who practice in comparable environments.

**Describe what data or evidence based guidelines you followed and what you found comparing your data the thse guidelines:**

**Answer:**

3. Develop and implement a plan to improve the practice issue, safety initiative or outcome measured in Step #1. An individual or group improvement effort may be utilized.

**Describe in detail the plan you developed and how outcomes were measured:**

**Answer:**

4. After implementing the improvement plan for at least three months, review patient care clinical information from ten additional patients undergoing hyperbaric oxygen therapy. Use this data to evaluate whether clinical performance has regressed, improved or maintained.

**Describe if improvements were positive, negative or had no change? It is not required to have a positive change, but it must be measured:**

**Answer:**

**A. If your time is spent in direct clinical patient care is 10% or greater**, review patient care clinical information from ten patients undergoing hyperbaric oxygen therapy and who are under your care. The information may be related to clinical care processes, feedback from patients that relates to the clinical care given or outcomes of clinical care. Group data and data collected through a national, regional, or local practice improvement program in which you participate is acceptable. OR;

Examples of acceptable PCPI include:

|  |  |  |
| --- | --- | --- |
|  | Appropriate use of Hyperbaric Oxygen Therapy (HBOT) for Patients with Diabetic Foot Ulcers (DFUs) | The % of patients with DFU graded stage or higher on the Wagner Grading System for diabetic foot Infections that appropriately received HBOT. |
|  | Patient Assessment Prior to Each HBOT Treatment | % of patients for whom BP, pulse, temperature and pain are measured PRIOR to HBOT. |
|  | Blood Glucose Assessment Prior to Each HBOT Treatment | Finger stick glucose prior to HBOT in DM patients on glucose lowering medication – % of patients who receive this assessment. |
|  | Healing Rate of Wagner Grade 3, 4 and 5 Diabetic Foot Ulcers Following HBOT | % of healing rate of these patients following completion of HBOT. |
|  | Major Amputations in Patients with Diabetic Foot Wounds Receiving HBOT | Amputation rate for patients with Wagner 3, 4 and 5 DFU who undergo major amputation (BKA, AKA, higher) |
|  | Preservation of Function | % of DFU patients treated with HBOT for Wagner 3 DFU whose level of prior ambulation is preserved (healing or minor amputation). |
|  | Side Effect Reporting | Reporting of possible HBOT side effects: otic pain (barotrauma), sinus pain or pressure, nausea or vomitng, pneumothorax, AGE, DCI,seizure, anxiety (confinement), acute pulmonary edema or new fluid overload, SOB, hypoglycemia, and vision changes. |
|  | Risk Assessment Completed at Time of Consultation | Reporting the rate of assessments of following possible risks related to HBOT at the time of consultation: COPD, history of otic surgery, history of pneumothorax, history of CHF or pulmonary edema, cataracts, diabetes on glucose lowering medication, presennce of an implnated device (pacer, defibrillator, neural stimulator, insulin pump, baclofen pump, etc). |
|  | Risk Assessment Completed During HBOT Treatment Visit | Reporting of the completion of the following assessments during the HBOT treatment visit: fever, risk for otic barotrauma (URI), evaluation for unapproved items prior to entering chamber, use of blood glucose lowering medication, and pulmonary edema. |
|  | Operational Safety | % of HBO treatments that have had validation of effective electrical grounding on each patient prior to treatment. |
|  | Operational Safety | % of HBO treatments that have had daily visual acrylic inspections conducted prior to treatment |
|  | Operational Safety | % of HBOT patients inspected prior to each treatment to ensure thee are no unapproved material |
|  | Operational Safety | % of HBO patients who had NFPA approved clothing and linen in chamber during treatment. |

**B. If less than 10% of your time is spent in direct clinical patient care,** identify an area where you could pursue improvement. Recommendations for an activity may be personally identified, obtained from a supervisor or colleague, or selected from an acceptable PCPI noted below.

Examples of acceptable PCPI include:

|  |  |  |
| --- | --- | --- |
|  | Law and Regulations | Recognize and address ethical dilemmas in the practice of UHM, using relevant guidelines, such as the AMA codes of ethics. |
|  | Law and Regulations | Provide medical-legal reports and expert opinions and testimony on UHM issues. |
|  | Safety, Evaluation, and Control | Recommend and implement policies and control measures to reduce or mitigate operational safety and health hazards. |
|  | Safety, Evaluation, and Control | Assist employees and employers with the management of the effects of work and short/long term health management in a hyperbaric environment |
|  | Safety, Evaluation, and Control | Perform a risk assessment. |
|  | Emergency Management | Participate in the development of emergency or disaster plans for the hyperbaric workplace and/or the community. |
|  | Emergency Management | Establish emergency procedures and protocols for the clinical management of individuals involved in disaster incidents or emergent side effects, including specific medical management protocols. |
|  | Public Health, Surveillance, and Disease Prevention | Apply individual or community-based interventions to prevent or mitigate exposure and/or resultant health effects. (i.e. carbon monoxide exposure and poisoning) |
|  | Management and Administration | Design, implement, and evaluate clinical practice guidelines, quality management/quality improvement programs, utilization management, case management, and other activities to enhance an organization’s performance. |
|  | Management and Administration | Identify potential customers and develop a marketing plan for an Undersea and Hyperbaric Medicine program. |
|  | Management and Administration | Communicate technical and clinical information to professional and lay audiences. |
|  | Management and Administration | Determine management information needs and apply medical informatics, electronic health and patient care data, management information systems, and other computer technologies to an UHM program. |
|  | Management and Administration | Establish protocols to manage patient records and protect confidentiality. |
|  | Research and Education | Design and conduct a scientific investigation. |
|  | Research and Education | Write a report suitable for publication. |
|  | Research and Education | Design a curriculum, conduct a course, and evaluate learning outcomes. |
|  | Research and Education | Interpret and present technical and clinical data for a variety of audiences. |

**Verification:** Verification of your participation in this MOC activity will require an independent verifer. This person must have direct oversight or knowledge of the practice performance. This is commonly a hospital board chair or member of the hospital board of directors, a department chair, a chief of staff, a medical director, or a practice administrator in a non-hospital setting. Ten percent (10%) of MOC activities will be randomly selected and audited for verification. The Verifers will be asked to affirm that all of the noted requirements have been met.

**Verifier Information:**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Full Name:** |  | **Credentials:** | | | | |  | | |
| **Company:** |  | **Title:** | |  | | | | | |
| **Address:** |  | **Cell Phone:** | | | |  | | | |
| **City:** |  | **Work Phone:** | | | | |  | | |
| **State:** |  | **Preferred method of contact:** | | | | | | | |
| **Zip Code:** |  |  | **Email** | |  | | **Work Phone** |  | **Home Phone** |
| **Email:** |  | | | | | | | | |
| **I VERIFY and ATTEST** the appropriate inclusion of the above physician participants and their completion of this required Undersea and Hyperbaric Medicine MOC activity. | | | | | | | | | |
| **Verifier  Relationship  to Diplomate:** |  | | | | | | | | |
| **Verifier position in relation to the PCPI Activity:** |  | | | | | | | | |
| **Signature of Verifier:** |  | | | | | | | | |

**Physician participants involved in this PCPI Activity:**

**Physician Participant #1**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Full Name:** |  | **Credentials:** | |  | |
| **Company:** |  | **Title:** |  | | |
| **Project Start Date:** |  | **Project Completion Date:** | | |  |

**Physician Participant #2**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Full Name:** |  | **Credentials:** | |  | |
| **Company:** |  | **Title:** |  | | |
| **Project Start Date:** |  | **Project Completion Date:** | | |  |

**Physician Participant #3**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Full Name:** |  | **Credentials:** | |  | |
| **Company:** |  | **Title:** |  | | |
| **Project Start Date:** |  | **Project Completion Date:** | | |  |

**Physician Participant #4**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Full Name:** |  | **Credentials:** | |  | |
| **Company:** |  | **Title:** |  | | |
| **Project Start Date:** |  | **Project Completion Date:** | | |  |

**Facilities at which this PCPI activity was conducted:**

|  |  |
| --- | --- |
| **Facility Name:** |  |
| **Address:** |  |
| **City:** |  |
| **State:** |  |
| **Zip Code:** |  |

|  |  |
| --- | --- |
| **Facility Name:** |  |
| **Address:** |  |
| **City:** |  |
| **State:** |  |
| **Zip Code:** |  |

**Checklist to ensure all items are included:**

**Step One:** The physician participants did select a PCPI activity and reviewed the pertinent

patient care data or If less than 10% of your time is spent in direct clinical patient care, you identified an area where you could pursue improvement. Plesae enter your PCPI acitvity title and what

**Step Two:** The physician participants compared the PCPI activity clinical information with evidence-based standards or care (evidence-based guidelines, local, regional or national

benchmarks, expert consensus guidelines, and / or comparable peer data). If less than 10% of your time is spent in direct clinical patient care, you identified an area where you could pursue improvement and developed and implemented a plan to achieve this.

**Step Three:** The physician participants developed and implemented a practice improvement

plain, either individually or as part of a group.

**Step Four:** The physician particpants then reviewed patient care clinical data of an additional group   
 of patients with the same presentation, disease or clinical process to determine if clinical peformance was maintained, improved or regressed.

**Instruction to submit your PCPI completed application:**Your completed ABPM MOC Part 4 application should be sent via email to UHMS CME Coordinator at [stacy@uhms.org](mailto:stacy@uhms.org). Please keep your application and supporting documentation on file for 3 years from your submittal date. The UHMS MOC Committee will review your application and you will receive confirmation in an email that all components are met. The UHMS will submit your completion of this PCPI to the ABPM to apply towards your Board Certification, which will be reflected on your ABPM profile. The UHMS will perform random audits, and if chosen, you will be required to provide proof of all corresoponding documentation of your PCPI activity. If you are unable to provide documentation of your PCPI activity, you may be subject to revokation of your successful completion.

**Payment is due upon submittal of this application.**

**Please check one:**

**$295 (Current UHMS Member)**  **$395 (UHMS Non-Member)**

**Please select payment type:**

Check (please make checks to UHMS and mail to address below)

Visa  American Express  Discover  Mastercard

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Card Number (All major cards accepted) | | | | | | | | | | | | | | | | Expiration Date (mm/yyyy) | Security Code |
|  | | | | | | | | | | | | | | | | |  |
| Card Holder Printed Name | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | |  |
| Signature | | | | | | | | | | | | | | | | | Date |

**Checks should be mailed to this address:**

Undersea and Hyperbaric Medical SocietyAttn: Stacy Harmon

631 US Highway 1, Suite 307

North Palm Beach, FL 33408

Phone: 919.490.5140 | 877.533.8467

Fax: 919.490.5149

Email: [stacy@uhms.org](mailto:stacy@uhms.org)