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, 27-33.)

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, 27-33.)

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:

Terry Kowalenko, MD, UMHS Part IV Program Lead, 763-936-1671, terryk@med.umich.edu
R. Van Harrison, PhD, UMHS Part IV Program Co-Lead, 763-1425, rvh@umich.edu
Chrystie Pihalja, UMHS Part IV Program Administrator, 763-936-1671, cpihalja@umich.edu

Application/Report Outline

<table>
<thead>
<tr>
<th>Section</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Introduction</td>
<td>1-6. Current date, title, time frame, project leader, specialties/subspecialties involved, funding</td>
</tr>
<tr>
<td>B. Plan</td>
<td>7-10. General goal, patient population, IOM quality dimensions addressed, experimental design</td>
</tr>
<tr>
<td></td>
<td>11-12. Baseline measures of performance, specific performance objectives</td>
</tr>
<tr>
<td></td>
<td>13. Data review and identifying underlying (root) causes</td>
</tr>
<tr>
<td>C. Do</td>
<td>14-16. Intervention(s), who is involved, initiated when</td>
</tr>
<tr>
<td>D. Check</td>
<td>17-18. Post-intervention performance measurement, data collection, performance level</td>
</tr>
<tr>
<td>E. Adjust – Replan</td>
<td>19. Review, continuing/new underlying causes,</td>
</tr>
<tr>
<td>F. Redo</td>
<td>20. Second intervention</td>
</tr>
<tr>
<td>G. Recheck</td>
<td>21-22. Post-adjustment performance measurement, data collection, performance level</td>
</tr>
<tr>
<td>H. Readjust plan</td>
<td>23. Review, continuing/new underlying causes to address</td>
</tr>
<tr>
<td>I. Future plans</td>
<td>24-26. Subsequent PDCA cycles, standardize processes, “spread” to other areas</td>
</tr>
<tr>
<td>J. Physician involvement</td>
<td>27-31. Physician’s role, requirements, reports, reflections, participation, number</td>
</tr>
<tr>
<td>K. Project Organization</td>
<td>32-34. Part of larger initiative, organizational structure, resources, oversight, Part IV opportunity</td>
</tr>
</tbody>
</table>
QI Project Application/Report for Part IV MOC Eligibility

A. Introduction

1. Date (this version of the application): September 12, 2013

2. Title of QI project: Eliminating Non-Medically-Indicated Planned Delivery

3. Time frame
   a. At what stage is the project?
      - Design is complete, but not yet initiated
      - Initiated and now underway
      - Completed (UMHS Part IV program began 1/1/11)

   b. Time period
      (1) Date physicians begin participating (may be in design phase): April, 2012
      (2) End date: expected September 30, 2013

4. QI project leader [responsible for attesting to the participation of physicians in the project]:
   a. Name: Roger Smith, MD
   b. Title: Director QI Ob/Gyn
   c. Institutional/organizational unit/affiliation: Department Ob/Gyn
   d. Phone number: 7340936-3110
   e. Email address: rogersmi@umich.edu
   f. Mailing address: 1500 E. Medical Center Dr., L4000 Womens, Ann Arbor, MI 48109

5. What specialties and/or subspecialties are involved in this project?
   Obstetrics

6. Will the funding and resources for the project come only from internal UMHS sources?
   - Yes, only internal UMHS sources
   - No, funding and/or resources will come in part from sources outside UMHS, which are: _______________________________________________________________

   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?
      Non-Medically-Indicated early (prior to 39 weeks’) planned delivery is common nationally and at the VonVoightlander Women’s Hospital (VVWH). It is associated with excess neonatal morbidity.
      Appropriately delaying non-medically-indicated planned deliveries to 39 weeks reduces neonatal morbidity, reduces admission to the NICU, and lowers costs.
b. Project goal. What outcome regarding the problem should result from this project?  
VVWH aims to eliminate non-medically-indicated early term planned delivery.

8. Patient population. What patient population does this project address.  
Parturients with no fetal or maternal medical indications for delivery.

9. Which Institute of Medicine Quality Dimensions are addressed? [Check all that apply.]  
- Safety  
- Effectiveness  
- Patient-Centeredness

10. What is the experimental design for the project?  
- Pre-post comparisons (baseline period plus two or more follow-up measurement periods)
- Other: _____________________________

11. Baseline measures of performance:  

a. What measures of quality are used? If rate or %, what are the denominator and numerator?  
   Denominator: all term deliveries (cesarean or vaginal) 37 weeks + 0 days to 38 weeks +6 days gestation,  
   with Leapfrog / Joint Commission PC-01 exclusion criteria applied, and in addition. (Roughly, this group is  
   spontaneous labor + elective deliveries)  
   Numerator: elective deliveries (induced labor or planned cesarean)

b. Are the measures nationally endorsed? If not, why were they chosen?  
   Yes, by ACOG, California Maternal Quality Care Collaborative, March of Dimes, IHI, Leapfrog, Keystone…

c. What is the source of data for the measure (e.g., medical records, billings, patient surveys)?  
   Denominator captured by: TraceVue queried for deliveries 37+0 to 38+6 (admin—Ken Piehl); CIDSS  
   queries Data Warehouse to apply PC-01 exclusions; additional exclusions (prior uterine scar contraindicating  
   labor) excluded by additional TraceVue query and manual record review  
   Numerator captured by: TraceVue query excludes spontaneous labor, identifies potential elective inductions  
   and elective cesareans; manual review finalizes numerator.

d. What methods were used to collect the data (e.g., abstraction, data analyst)?  
   Database query/abstraction + manual review if identified cases to confirm inclusion criteria

e. How reliable are the data being collected for the purpose of this project?  
   Very reliable. The information of interest is routinely entered in the electronic medical record and  
   the manual review checks dictated information to confirm.

f. How are data to be analyzed over time, e.g., simple comparison of means, statistical test(s)?  
   Simple comparison over time periods of number of deliveries 37 w + 0 d to 38 w + 6 d and the  
   percent of those deliveries that were elective.

g. To whom are data reported?  
   Individual faculty get reports of their instances of elective early term deliveries / rates; and get reports of  
   blinded department instances / rates.  
   QI team, Division Directors get data on everyone.  
   (Rate is also reported to : Leapfrog, Joint Commission, BC/BS PGIP.)

h. For what time period is the sample collected for baseline data?  
   Jan 2011 – Dec 2011 - 12 months
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. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

<table>
<thead>
<tr>
<th>Time Period</th>
<th>N Eligible Deliveries 37+0 to 38+6 Weeks Gestation</th>
<th>N of These Elective</th>
<th>% Elective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: 1/1/11 – 12/31/11</td>
<td>358</td>
<td>54</td>
<td>15%</td>
</tr>
</tbody>
</table>

b. Specific aim: What is the target for performance on the measure(s) and the timeframe for achieving the target?

Target is 0 elective early term deliveries by Dec 31, 2012

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

National benchmark (Leapfrog) and BCBS PGIP is <5%. Department target is ZERO.

13. Data review and identifying underlying (root) causes.

a. Who will be/was involved in reviewing the baseline data, identifying underlying (root) causes of the problem(s), and considering possible interventions (“countermeasures”) to address the causes? Briefly describe who is involved, how (e.g., in a meeting of clinic staff), and when.

Data extraction and Analysis – Ken Piehl – data extraction & presentation, programming (March, 2012)
QI Director – Roger Smith, MD - data collection, analysis, report editing (March, 2012)
QI Team – peer review, analysis, policy decisions (March, 2012)
Department Chair – initiative endorsement and expectation definition. (March, 2012)
Perinatal Joint Practice Committee – analysis, policy decisions, Guideline development (May, 2012)
Faculty – analysis of department and personal performance, giving feedback, planning ‘rollout’
- at Ob/Gyn Division meetings presentation of new Guideline
- by email communication, with feedback invited/encourage
- Women’s health QI steering committee meetings. (June, July 2012)

b. What are the primary underlying/root causes for the problem(s) that the project can address? (Causes may be aspects of people, processes, information infrastructure, equipment, environment, etc. List each primary cause separately. How the intervention(s) address each primary underlying cause will be explained in #14.c.)

(1) There is a gap in understanding the risks of elective early term delivery.
(2) Logistic barriers exist which promote a ‘need’ to perform deliveries prior to 39 weeks. E.g., provider availability and schedules, Birth Center Operating Room schedule constrictions.
(3) Peer environment – the practice is common

C. Do

14. Intervention(s).

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

(1) Education:
- Educate providers about evidence that suggests early elective delivery is associated with significant neonatal risk.
- Educate about the multiple national efforts directed toward reducing the rate of elective early delivery.
• Educated about standard of care that has been defined due to these widespread efforts.
• Define department expectations (0 early elective deliveries.)
• Methods
  o M&M presentation (August 2012)
  o Division mtg presentations, WH QI steering committee mtgs (June 2012; July 2012)
  o Department-wide communication (September, 2012)
    • e-mail to all disciplines (including staff nurses)

(2) Define QI process (peer review) that will address non-compliance.
• Early non-medically-indicated delivery is now QI Indicator (June 2012)
• Pernatal Joint Practice Committee Guideline endorses the avoidance of early non-medically
indicated delivery. (May 2012)
• All Early non-medically-indicated deliveries (QI Indicator) reviewed by QI Committee peer review.
  Determination and action taken (verbal, written feedback to surgeons, department action via OPPE
  when necessary) QI ‘Advisory Letters’ sent to non-compliers.

(3) Inform department about rates
• Present to individual faculty their 2011 data and department data (blinded) (August, 2012)

b. How are underlying/root causes (see #9) addressed by the intervention(s)? (List each cause,
whether it is addressed, and if so, how it is addressed.) [Note: The underlying causes should be
thought through and described in #9 and one or more interventions to address causes described in
14 a. In 14b you show the link between the underlying causes and the interventions.]
  1. Educate providers. Addressed by (1), (2), and (3) above.
  2. Logistic barriers that promote a ‘need’ to perform deliveries prior to 39 weeks: Not addressed yet.
  3. Peer Environment – addressed by (2) and (3)

15. Who is involved in carrying out the intervention(s) and what are their roles?
 QI Director – Roger Smith, MD - Education, reporting, individual faculty communications
 QI Team – peer review, analysis
 Medical Director / Nursing administration / Residency Directors / Staff nurses- expectation definition,
 education, endorsement of policy, peer pressure to comply.
 Department Chair—repeated endorsements
 Providers – compliance with standard, analysis of personal performance

16. The intervention will be/was initiated when? (For multiple interventions, initiation date for each.)
 (dates listed in ‘14’, above.)

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)?
   ☑ Yes □ No – If no, describe how this data collection

18. Performance following the intervention.

a. The collection of the sample of performance data following the intervention either:
   Has occurred for the period: July 1, 2012 - September 30, 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. Can display in a data
  table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)
E. Adjust – Replan


   a. Who will be/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? Briefly describe who is involved,
      how (e.g., in a meeting of clinic staff), and when.
      
      • QI Director presented data to faculty at M&M and Faculty meetings in November and Dec
        2012.
      • Individual rates reported to faculty, QI Letters sent to non-compliers November,
        December, 2012.
      • QI Director presented data to faculty at M&M, Faculty meetings, Women’s health QI steering
        committee meetings. Faculty feedback invited and received. (Nov. and Dec., 2012)

   b. What are the primary underlying/root causes for the continuing/new problem(s) that the
      project can address? (Causes may be aspects of people, processes, information infrastructure,
      equipment, environment, etc. List each primary cause separately. How the intervention(s) address
      each primary underlying cause will be explained in #20.c.)

      Remaining barriers:
      (1) education. Convincing some patients of the rationale for waiting for their scheduled delivery
          has proven difficult.
      (2) logistic. Some cesareans were schedule long ago. Faculty scheduling availability remains
          limited.

F. Redo


   a. The second intervention will be/was initiated when? (For multiple interventions, initiation date
      for each.)

   b. If the second intervention has occurred, what interventions were implemented?

      (1) Plan Birth Center O.R process improvement: “Scheduled Cesarean Team” (Nov., 2012-ongoing)
      • Committee comprised of Clinical leaders, Residency leaders, Residents, Nursing leaders, Staff
        nurses, Scrub techs.
      • Improved access: 3 spots per day instead of 2 to 3
      • Defined scheduling guidelines
      • Maintain direct access of surgeons to the schedule (no intermediary)
      • Separate Team (outside of on-duty call team) for scheduled cases (separate faculty, residents,
        anesthesia, operating room staff)

      (2) QI Director presented data to faculty at M&M, Faculty, WH QI steering committee mtgs. Faculty
      feedback invited and received. (Nov. and Dec., 2012)
      • Individual rates reported to faculty, QI Letters sent to non-compliers (ongoing)
• QI Director sent resources to faculty. (January 2013)
  o These included patient education materials to help convince patients of the reason to wait
  o Posters sent to all offices from March of Dimes
  o Communication sent via email about the success of the effort, reminding everyone of the goals.
• QI Director worked with individual faculty to identify barriers, plan strategies for compliance.
  (3) New PJPC Guideline (Feb 2013)
  o with updates, mainly in language.
  o Also added a required consultation with Maternal Fetal Medicine in order to schedule an early planned non-medically-indicated delivery. (“Hard Stop”)

c. How are continuing/new underlying/root causes (see #19.b) addressed by the intervention(s)? (List each cause, whether it is addressed, and if so, how it is addressed.)
  (A) education. Convincing some patients of the rationale for waiting for their scheduled delivery has proven difficult. Addressed by #2, above
  (B) logistic. Some cesareans were schedule long ago. Faculty scheduling availability remains limited. Being addressed by #1 and #3, above

G. Recheck

21. Post-second 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)?
  ☒ Yes  ☐ No – If no, describe how this data collection

22. Performance following the second intervention.

a. The collection of the sample of performance data following the intervention(s) either:
   Will occur for the period:  January1, 2013 – June 30, 2013

b. If the data collection has occurred, what is the performance level? (E.g., for each measure: number of observations or denominator, numerator, percent. Can display in a data table, bar graph, run chart, or other method. Can show here or refer to attachment with data.)

<table>
<thead>
<tr>
<th>Time Period</th>
<th>N Eligible Deliveries 37+0 to 38+6 Weeks Gestation</th>
<th>N of These Elective</th>
<th>% Elective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline: 1/1/11 – 12/31/11</td>
<td>358</td>
<td>54</td>
<td>15%</td>
</tr>
<tr>
<td>Post-intervention: 07/01/2012 – 09/30/2012</td>
<td>90</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td>Post-adjustment: 01/01/2013 – 06/30/2013</td>
<td>129</td>
<td>2</td>
<td>1.6%</td>
</tr>
</tbody>
</table>

H. Readjust


a. Who will be/was involved in reviewing the data, identifying underlying (root) causes of the continuing/new problem(s), and considering additional possible adjustments to interventions (“countermeasures”) to address the causes? Briefly describe who is involved, how (e.g., in a meeting of clinic staff), and when.
   QI Director – Roger Smith, MD - analysis, reporting, individual faculty communications (July, Aug 2013)
   QI Team – peer review, analysis (8/26/13?)
Medical Director / Nursing admin & staff / Residency Directors - O.R. Improvement Team
- Planning and Implementation of Scheduled Cesarean Team (July 1, 2013)
- Presented to faculty at Morbidity & Mortality conference to review, discuss, received feedback to plan next steps. (08/16/2013?)

b. What are the primary underlying/root causes for the continuing/new problem(s) that the project can address?

Education / People – Patients put pressure on surgeons to perform early delivery to solve a patient scheduling issue. Surgeons don’t feel the early delivery is a serious enough breach of standard of care to refuse to comply with the patient’s wishes.

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.

I. 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?
   - Implementation of Scheduled Cesarean Team July 1, 2013
   - Statit OPPE Dashboard will display individuals performance, real-time
   - Additional ‘Hard Stop’ will be added to department’s policy via the Perinatal Joint Practice Committee. In addition to MFM consultation, approval of early delivery by the Department Chair or Department QI Director will be mandatory (September, 2013)
   - This project will continue with quarterly reporting within the department, then twice-yearly reporting to the Joint Commission, annual reporting to Leapfrog.

25. How will the project standardize processes to maintain improvements?
   Ob/Gyn Database will be fully operational by August, 2013. This will automate much of the data gathering and make manual analysis/review easier to accomplish and to track.

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?
   No. This problem is unique to OB.

J. 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?**

a. Interpreting baseline data and planning intervention:
   - Analysis of department and personal performance, giving feedback, planning ‘rollout’
   - At Ob/Gyn Division meetings presentation of new Guideline
   - By email communication, with feedback invited/encouraged (June – Aug, 2012)

b. Implementing intervention: (June – Sept., 2012)
   - Interactive education about, analysis of, and discussion about the evidence which suggests early elective delivery is associated with significant neonatal risk.
   - Interactive education about, analysis of, and discussion about the multiple national efforts directed toward reducing the rate of elective early delivery.
   - Interactive education about, analysis of, and discussion about the standard of care that has been defined due to these widespread efforts.
   - Discussion about the department expectations, QI process (0 early elective deliveries.)
   - Methods
     - M&M presentation (August 2012)
     - Division meeting presentations (June 2012; July 2012)
     - Department-wide communication (September, 2012)
       - E-mail to all disciplines (including staff nurses)

c. Interpreting post-intervention data and planning changes: (Nov., Dec., 2012)
   - QI Director presented data to faculty at M&M and Faculty meetings
   - Individual rates reported to faculty, QI Letters sent to non-compliers

d. Implementing further intervention/adjustments: (January, 2013)
   - M&M, Faculty meetings presentations invited and received feedback about the Scheduled Cesarean Section Team initiative
   - Offering education resources (pamphlets, posters)
   - Educating about, inviting feedback about new MFM consultation requirement

e. Interpreting post-adjustment data and planning changes:
   - Faculty will provide analysis of 2013 data, and analyze roll-out of Scheduled Cesarean Team, suggest process improvements (August, 2013)

28. **How are reflections of individual physicians about the project utilized to improve the overall project?**
   Feedback about the project and the interventions was used to plan each next intervention.

29. **How does the project ensure meaningful participation by physicians who subsequently request credit for Part IV MOC participation?**
   Individuals were active in the design and implementation. Their feedback was encouraged and received:
   - At data presentations
   - At education and planning forums
   - With each communication about changes, new resources, new processes
   The project lead was aware of who participated since he attended the meetings and reviewed scheduling results of each physician.

30. **What are the specialties and subspecialties of the physician anticipated to participate in the project and the approximate number of physicians in each specialty/subspecialty?**
   40 faculty who are Ob/Gyn certified, who actively do obstetrics.
K. Project Organizational Role and Structure

31. UMHS QI/Part IV MOC oversight – this project occurs within:

☐ University of Michigan Health System
   • Overseen by what UMHS Unit/Group?
     Ob/Gyn Department
   • Is the activity part of a larger UMHS institutional or departmental initiative?
     ☑ No ☐ Yes – the initiative is: Transparency Reporting; reporting to Joint Commission, to Leapfrog; participation PGIP BC/BS

☐ Veterans Administration Ann Arbor Healthcare System
   • Overseen by what AAVA Unit/Group?
   • 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:
       • The type of affiliation with UMHS is:
         ☑ Accountable Care Organization type (specify which):
         ☑ BCBSM funded, UMHS lead Collaborative Quality Initiative (specify which):
           ☑ PGIP BC/BS
         ☐ Other (specify):

     ☑ Who is the individual at UMHS responsible for oversight of the QI project regarding Part IV requirements? (see A. 4.)
       Name:
       Title:
       Institutional/organizational unit/affiliation:
       Phone number:
       Email address:

32. What is the organizational structure of the project? [Include who is involved, their general roles, and reporting/oversight relationships.]
   QI Director – education, analysis, report editing, data capture
   Ken Piehl, CIDDs Team—data capture
   QI Team – analysis, planning, peer review
   Department Chair—initiative endorsement and expectation definition.
   Medical Director / Nursing admin / Staff nurses—O.R. access improvement.
   Faculty—analysis, planning interventions, compliance with standard

33. To what oversight person or group will project-level reports be submitted for review?
   Department leaders,
   Leapfrog, Joint Commission