+Report on a QI Project Eligible for Part IV MOC

Instructions

Determine eligibility. Before starting to complete this report, go to the UMHS MOC website [ocpd.med.umich.edu], 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 UMHS 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. Final confirmation of Part IV MOC for a project occurs when the full report is submitted and approved.

An option for preliminary review (recommended) is to complete a description of activities through the intervention phase and submit the partially completed report. (Complete at least items 1-16 and 27a-b.) Staff from the UMHS 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 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.

For further information and to submit completed applications, contact either:  
Grant Greenberg, MD, UMHS Part IV Program Lead, 763-936-1671, ggreenbe@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

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QI Project Report for Part IV MOC Eligibility

A. Introduction

1. Date (this version of the report): January 22, 2014

2. Title of QI project: Reducing Potentially Preventable Venous Thromboembolism

3. Time frame
   a. At what stage is the project?
      - Design is complete, but not yet initiated
      - Initiated and now underway
      - Completed

   b. Time period
      1. Date physicians begin participating (may be in design phase):
      2. End date: actual 1/14/15

4. QI project leader [responsible for attesting to the participation of physicians in the project]:
   a. Name: Scott A. Flanders, MD
   b. Title: HMS Project Director
   c. Institutional/organizational unit/affiliation: Internal Medicine division of General Medicine/Hospital Medicine
   d. Phone number: 734-647-2892
   e. Email address: flanders@umich.edu
   f. Mailing address: 1500 E. Medical Center Drive, 3119F

5. What specialties and/or subspecialties are involved in this project?
   Internal Medicine/Hospital Medicine, Family Medicine

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: Blue Cross Blue Shield of Michigan

   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?
      Identification of VTE risk is a way in which to ensure that patients who are most at risk for VTE are identified and administered pharmacologic prophylaxis to aid in the prevention of hospital-acquired VTE events. The Consortium identified a gap between expected and actual performance in the
identification of Venous Thromboembolism (VTE) risk and administration of VTE prophylaxis based on risk, in the hospitalized medical patient population.

b. Project goal. What outcome regarding the problem should result from this project?
The consortium's goal is to improve the following:
1. Increase the number of medical patients who are assessed for VTE risk w/in 24 hours of admission
2. Increase the number of medical patients at risk for VTE who receive pharmacologic prophylaxis

8. Patient population. What patient population does this project address.
Adult (>18 years) patients admitted to a medicine service of participating hospitals that do not meet the defined exclusion criteria will be eligible for the data sample. The exclusion criteria are as follows:
• Patient was pregnant
• Patient was under the age of 18
• Patient had surgery (billed Operating Room (OR) time during hospitalization)
• Patient admitted for palliative care
• Patient admitted for less than 2 days, same day or next day
• Patient admitted to an intensive care unit (ICU), same day or next day
• Patient admitted for presumed venous thromboembolism (VTE*)
• Patient diagnosed with presumed VTE* in last 6 months (prior to date of admission)
• Patient discharge falls within the 90-day window of previously recorded admission

The participating hospitals are:
• Beaumont Health System – Grosse Pointe
• Beaumont Health System – Royal Oak
• Beaumont Health System – Troy
• Borgess Medical Center
• Henry Ford Hospital
• Mercy Health Saint Mary's
• MidMichigan - Midland
• Munson Medical Center
• Oakwood Healthcare
• St. Joseph Mercy Ann Arbor
• St. Joseph Mercy Livingston
• St. Mary Mercy Livonia
• Spectrum Health

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

10. What is the experimental design for the project?
    ☒ Pre-post comparisons (baseline period plus two or more follow-up measurement periods)
    ☐ Pre-post comparisons with control group
    ☐ Other: ______________________________
### PROJECT TIMELINE

<table>
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<tr>
<th>STAGE</th>
<th>ACTIVITY</th>
<th>DATE OR TIME PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PLAN</strong></td>
<td>Define problem</td>
<td>January 2013</td>
</tr>
<tr>
<td></td>
<td>Baseline data measurement period</td>
<td>January – March 2013</td>
</tr>
<tr>
<td></td>
<td>Baseline data collection and report preparation</td>
<td>April – June 2013</td>
</tr>
<tr>
<td></td>
<td>Review baseline results, identify underlying causes, and likely interventions</td>
<td>July 2013</td>
</tr>
<tr>
<td><strong>DO</strong></td>
<td>Implement interventions</td>
<td>July – August 2013</td>
</tr>
<tr>
<td><strong>CHECK</strong></td>
<td>Post-intervention data measurement period</td>
<td>October – December 2013</td>
</tr>
<tr>
<td></td>
<td>Post-intervention data collection and report preparation</td>
<td>January – March 2014</td>
</tr>
<tr>
<td><strong>ADJUST – REPLAN</strong></td>
<td>Review post-intervention results, identify underlying causes, and likely adjustments (second interventions)</td>
<td>April 2014</td>
</tr>
<tr>
<td><strong>REDO</strong></td>
<td>Implement adjustments (second interventions)</td>
<td>April – May 2014</td>
</tr>
<tr>
<td><strong>RECHECK</strong></td>
<td>Post-adjustment data measurement period</td>
<td>July – September 2014</td>
</tr>
<tr>
<td></td>
<td>Post-adjustment data collection and report preparation</td>
<td>October – December 2014</td>
</tr>
<tr>
<td><strong>READJUST PLAN</strong></td>
<td>Review post-adjustment results, identify underlying causes, and further likely adjustments</td>
<td>January 2015</td>
</tr>
</tbody>
</table>

11. **Baseline measures of performance:**

   a. **What measures of quality are used? If rate or %, what are the denominator and numerator?**

   The key areas of performance are:

   1) Percent of eligible medical inpatients who have a VTE risk assessment documented upon hospital admission where the numerator will be the number of eligible medical inpatients in the sample who have a documented risk assessment within 24 hours of admission and the denominator will be the number of eligible medical inpatients in the sample.

   2) Percent of high-risk patients with appropriate pharmacological prophylaxis ordered and administered. The numerator will be the number of eligible high risk patients who did not have contraindications to pharmacological prophylaxis who received pharmacological prophylaxis within 24 hours of admission and the denominator will be the number of eligible high risk patients without contraindications.
b. Are the measures nationally endorsed? If not, why were they chosen?
The measures we have chosen are not nationally endorsed. Our measures are more stringent than
the nationally endorsed VTE related measures and they were chosen as they were believed to be
more clinically meaningful.

c. What is the source of data for the measure (e.g., medical records, billings, patient surveys)?
Data is obtained through medical records and patient phone calls.

d. What methods were used to collect the data (e.g., abstraction, data analyst)?
Dedicated data abstractor for this collaborative quality improvement initiative collects the data at
each hospital.

e. How reliable are the data being collected for the purpose of this project?
The data for this project are very reliable. Data are audited 1-2x/year to ensure accuracy.

f. How are data to be analyzed over time, e.g., simple comparison of means, statistical test(s)?
Data are analyzed and presented using various mechanisms. However, for the purposes of this
project we will be comparing rates across quarters.

g. To whom are data reported?
Data are reported to all team members participating in the collaborative. At the regional
collaborative meeting this includes at a minimum, the physician champion, quality improvement
lead, and the data abstractor. Then at each site the physician champion and others above present
the data to participating physicians and other relevant personnel. Aggregate data are reported to
Blue Cross Blue Shield.

h. For what time period is the sample collected for baseline data?
January–March 2013, reported in July 2013.

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.)

See Tables 1 and 2 on page 14.

b. Specific aim: What is the target for performance on the measure(s) and the timeframe for
achieving the target?
Performance targets are set as part of the BCBSM CQI Performance Index. The following are the
2014 Performance Index Targets:
Eligible Medical inpatients have VTE risk assessment on admission = 100% – need to increase
from baseline average rate of 84%.
Eligible High Risk Patients without Contraindications Who Received Appropriate Pharmacologic
Prophylaxis on Admission = 90% – need to increase from average baseline rate of 72%.
For both measures the aim is to reach the target performance level by the second intervention
(data for July-Sept, 2014).

c. How were the performance targets determined, e.g., regional or national benchmarks?
The target measures are based on collaborative performance and we are looking to push the
participating hospitals to achieve more than is required of them per the national
measures/benchmarks.

13. Data review and identifying underlying (root) causes.
General overall information presented here. See details by site in the separate PDF document detailing Physician Project Reports by site.

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.

A physician champion from each participating hospital met at the quarterly meeting in July 2013. Then at each participating site, the members of their VTE committee as well as physicians participating in intervention projects were part of the baseline data review process. The meetings at which time the data were reviewed and interventions discussed and implemented occurred between July 2013 and August 2013 (specific dates for each hospital are detailed on the attached reports).

c. 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.)

Below are two of the most frequently chosen goals and most common causes that prevent hospitals from meeting those goals. Individual hospital specific goals and most common causes are outlined for each hospital in their individual reports.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Common Causes for problems in meeting goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the number of medical patients who are assessed for VTE risk w/in 24 hours of admission</td>
<td>Providers are unaware of effective and appropriate risk assessment models and/or have beliefs that conflict with national guidelines System level barriers such as the EMR does not integrate VTE risk assessments into admission orders or a mechanism is not in place to require risk assessment at admission</td>
</tr>
<tr>
<td>Increase the number of medical patients at risk for VTE who receive pharmacologic prophylaxis</td>
<td>Providers have a lack of knowledge and/conflicting beliefs toward prophylaxis recommendations and contraindications System level barriers such as lack of audit tools and feedback systems regarding VTE prophylaxis rates, undefined roles/responsibilities of those involved in ordering and administration of VTE prophylaxis, and numerous guidelines with conflicting recommendations (for example prophylaxis guidelines for medical patients differ from those for orthopaedic patients or surgical patients)</td>
</tr>
</tbody>
</table>

C. Do

General overall information presented here. See details by site in the separate PDF document detailing Physician Project Reports by site.
14. Intervention(s).

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

Below are the most frequently chosen interventions that address the common causes of problems in meeting the goals. See individual reports for specific interventions at the institutions.

<table>
<thead>
<tr>
<th>Goal</th>
<th>Common Causes for problems in meeting goal</th>
<th>Examples of Interventions</th>
</tr>
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<tbody>
<tr>
<td>Increase the number of medical patients who are assessed for VTE risk w/in 24 hours of admission</td>
<td>Providers are unaware of effective and appropriate risk assessment models and/or have beliefs that conflict with national guidelines System level barriers such as the EMR does not integrate VTE risk assessments into admission orders or a mechanism is not in place to require risk assessment at admission</td>
<td>Provider audits and feedback on VTE risk assessment rates on a quarterly basis Standardized risk assessment selected and used throughout hospital Integration of risk assessment into EMR Best Practice Alerts (BPA) to notify physicians when a risk assessment should be performed</td>
</tr>
<tr>
<td>Increase the number of medical patients at risk for VTE who receive pharmacologic prophylaxis</td>
<td>Providers have a lack of knowledge and conflicting beliefs toward prophylaxis recommendations and contraindications System level barriers such as lack of audit tools and feedback systems regarding VTE prophylaxis rates, undefined roles/responsibilities of those involved in ordering and administration of VTE prophylaxis, and numerous guidelines with conflicting recommendations (for example prophylaxis guidelines for medical patients differ from those for orthopaedic patients or surgical patients)</td>
<td>Provider audits and feedback on rates of patients who received pharmacologic prophylaxis Revisions to order set to include VTE risk score and recommended prophylaxis measures Integration of VTE protocol into EMR system</td>
</tr>
</tbody>
</table>

b. How are underlying/root causes (see #13.b) addressed by the intervention(s)? (List each cause, whether it is addressed, and if so, how it is addressed.)

See linkage shown in 14b.

15. Who is involved in carrying out the intervention(s) and what are their roles?

At each participating organization, a team of individuals, including participating physicians, are carrying out the intervention (see the site-specific reports). The overall project within their institution receives oversight by their VTE Committee.

16. The intervention will be/was initiated when? (For multiple interventions, initiation date for each.)
Interventions were implemented July 2013 – August 2013. See individual reports for specific dates by hospital.

D. Check

General overall information presented here. See details by site in the separate PDF document detailing Physician Project Reports by site.

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:

Will occur for the period:
Has occurred for the period: October–December 2013

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.)

See Tables 1 and 2 on page 14.

For the measure “Eligible Medical inpatients have VTE risk assessment on admission,” from the baseline average rate of 84%, the intervention average rate increased to 89%, closer to the 100% goal.

For the measure “Eligible High Risk Patients without Contraindications Who Received Appropriate Pharmacologic Prophylaxis on Admission,” from the baseline average rate of 72%, the intervention average rate increased to 76%, closer to the 90% goal.

While these are moderate gains, this still demonstrates progress toward the goals.

E. Adjust – Replan

General overall information presented here. See details by site in the separate PDF document detailing Physician Project Reports by site.


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.

A physician champion from each participating hospital met at the quarterly meetings in April 2014. Then at each participating site, the members of their VTE committee as well as physicians participating in intervention projects were part of the data review process. The meetings at which time the data were reviewed and interventions discussed occurred between April and May of 2014 (specific dates by hospital are detailed on the attached reports).
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.)

Below are two of the most frequently chosen goals and most common causes that prevent hospitals from meeting those goals. Individual hospital specific goals and most common causes are outlined for each hospital in their individual reports.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Increase the number of medical patients who are assessed for VTE risk w/in 24 hours of admission</td>
<td>Providers have a lack of knowledge and/conflicting beliefs toward prophylaxis recommendations and contraindications</td>
</tr>
<tr>
<td>Increase the number of medical patients at risk for VTE who receive pharmacologic prophylaxis</td>
<td>System level barriers such as lack of audit tools and feedback systems regarding VTE prophylaxis rates, undefined roles/responsibilities of those involved in ordering and administration of VTE prophylaxis</td>
</tr>
</tbody>
</table>

F. Redo

General overall information presented here. See details by site in the separate PDF document detailing Physician Project Reports by site.

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

   April and May 2014.  (See individual reports for specific dates by hospital.)

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

   Below are the most frequently chosen interventions that address the common causes of problems in meeting the goals. See individual reports for specific interventions at the institutions.

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<th>Examples of Interventions</th>
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<tr>
<td>Increase the number of medical patients who are assessed for VTE risk w/in 24 hours of admission</td>
<td>Providers have a lack of knowledge and/conflicting beliefs toward prophylaxis recommendations and contraindications</td>
<td>Provider audits and feedback on VTE risk assessment rates on a quarterly basis</td>
</tr>
<tr>
<td>Increase the number of medical patients at risk for VTE who receive pharmacologic prophylaxis</td>
<td>System level barriers such as lack of audit tools and feedback systems regarding VTE prophylaxis rates, undefined roles/responsibilities of those involved in ordering and administration of VTE prophylaxis</td>
<td>Integration of VTE protocol into EMR system</td>
</tr>
</tbody>
</table>
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.)

See linkage shown in 20b.

G. Recheck

General overall information presented here. See details by site in the separate PDF document detailing Physician Project Reports by site.

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: July-September, 2014

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.)

See Tables 1 and 2 on page 14.

For the measure “Eligible Medical inpatients have VTE risk assessment on admission,” from the baseline average rate of 84%, the second intervention average rate increased to 92%, closer to the 100% goal.

For the measure “Eligible High Risk Patients without Contraindications Who Received Appropriate Pharmacologic Prophylaxis on Admission,” from the baseline average rate of 72%, the intervention average rate increased to 80%, closer to the 90% goal.

While these are moderate gains, this still demonstrates progress toward the goals.

H. Readjust

General overall information presented here. See details by site in the separate PDF document detailing Physician Project Reports by site.


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.

A physician champion from each participating hospital met at the quarterly meeting in January 2015. Then at each participating site during January 2015, the members of their VTE committee as well as physicians participating in intervention projects will be part of the post-second intervention review process.
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.)

Below are two of the most frequently chosen goals and most common causes that prevent hospitals from meeting those goals. Individual hospital specific goals and most common causes are outlined for each hospital in their individual reports.

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<td>Increase the number of medical patients at risk for VTE who receive pharmacologic prophylaxis</td>
<td>System level barriers such as lack of audit tools and feedback systems regarding VTE prophylaxis rates, undefined roles/responsibilities of those involved in ordering and administration of VTE prophylaxis</td>
</tr>
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</table>

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

General overall information presented here. See details by site in the separate PDF document detailing Physician Project Reports by site.

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?

This is an ongoing project that will last into 2015. Several more PDCA cycles will occur.

25. How will the project sustain processes to maintain improvements?

The Coordinating Center will continue to collect data from the individual hospitals, through their data abstractors and analyze the data to assess the individual hospital performance. The conditions for participation in the BCBSM collaborative will ensure the sustenance of their performance.

26. Do other parts of the organization(s) 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?
Yes, the project has implication for other hospital populations. The interventions and best practices identified through this improvement project can be applied to other departments treating patients at risk for VTE. These can be communicated through the VTE committee and other internal hospital communication mechanisms.

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:
   July 2013 – August 2013
   Attend local meeting and review HMS collaborative and individual hospital data
   Discuss underlying causes and plan interventions based on the data

c. Implementing intervention:
   July 2013 – August 2013
   Implement intervention(s) locally
   Monitor implementation
   Attend local meeting and review HMS collaborative and individual hospital data
   Continue monitoring implementation

d. Interpreting post-intervention data and planning changes:
   April – May 2014
   Attend local meeting and review HMS collaborative and individual hospital data
   Review the impact of the intervention(s) and consider unresolved causes and further adjustments/interventions

e. Implementing further intervention/adjustments:
   April – May 2014
   Implement further intervention(s) locally
   Monitor implementation
   Attend local meeting and review HMS collaborative and individual hospital data
   Continue monitoring implementation

f. Interpreting post-adjustment data and planning changes:
   January 2015
   Attend local meeting and review HMS collaborative and individual hospital data
   Review the impact of the intervention(s) and consider unresolved causes and future adjustments/interventions

28. How are reflections of individual physicians about the project utilized to improve the overall project?

The physician champion at each hospital assured that ideas and reflections of individual participating physicians are communicated to relevant leaders at the hospital to the coordinating center. This information is incorporated into the overall project planning.

29. How does the project ensure meaningful participation by physicians who subsequently request credit for Part IV MOC participation?
The HMS Program Director monitors participation of the individual hospital physician champions. The individual physician champions monitor the physicians involved at their institutions.

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?

Internal Medicine/Hospital Medicine: 23
Family Medicine: 1

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?
  • Is the activity part of a larger UMHS institutional or departmental initiative?
    ☐ No ☐ Yes – the initiative is:

☐ 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):
      Hospital Medicine Safety Consortium
    ☐ Other (specify):

• Who is the individual at UMHS responsible for oversight of the QI project regarding Part IV requirements?
  Name: Jack Billi, MD
  Title: Associate Vice-President for Medical Affairs
  Institutional/organizational unit/affiliation: Office of the EVPMA
  Phone number: 734-936-5214
  Email address: jbilli@umich.edu

32. What is the organizational structure of the project? [Include who is involved, their general roles, and reporting/oversight relationships.]

Participating physicians operate under the oversight of the local physician champions at the individual hospitals.
The local physician champions operate under the oversight of the HMS Coordinating Center, led by Scott Flanders, MD and Julie Wietzke, Project Manager.

The coordinating center operates under the dual oversight of Jack Bili, MD at UMHS in the Office of the Executive Vice President of Medical Affairs and the funding source, BCBSM.

33. To what oversight person or group will project-level reports be submitted for review?

The project-level reports will be submitted to Jack Bili, MD at UMHS in the Office of the Executive Vice President of Medical Affairs and the funding source, BCBSM.

### Table 1. Number of Eligible Medical Inpatients and Percent with VTE Risk Assessment on Admission

<table>
<thead>
<tr>
<th>Site ID #</th>
<th>Baseline: Jan-Mar 2013</th>
<th>Post-Intervention: Oct-Dec 2013</th>
<th>Recheck: Jul-Sep 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>870</td>
<td>57</td>
<td>88%</td>
<td>188</td>
</tr>
<tr>
<td>817</td>
<td>177</td>
<td>51%</td>
<td>174</td>
</tr>
<tr>
<td>804</td>
<td>163</td>
<td>94%</td>
<td>165</td>
</tr>
<tr>
<td>893</td>
<td>180</td>
<td>93%</td>
<td>163</td>
</tr>
<tr>
<td>897</td>
<td>199</td>
<td>87%</td>
<td>193</td>
</tr>
<tr>
<td>890</td>
<td>199</td>
<td>84%</td>
<td>173</td>
</tr>
<tr>
<td>822</td>
<td>154</td>
<td>91%</td>
<td>191</td>
</tr>
<tr>
<td>852</td>
<td>159</td>
<td>79%</td>
<td>174</td>
</tr>
<tr>
<td>Total</td>
<td>1288</td>
<td>84%</td>
<td>1421</td>
</tr>
</tbody>
</table>

### Table 2. Eligible High Risk Patients without Contraindications Who Received Appropriate Pharmacologic Prophylaxis on Admission

<table>
<thead>
<tr>
<th>Site ID #</th>
<th>Baseline: Jan-Mar 2013</th>
<th>Post-Intervention: Oct-Dec 2013</th>
<th>Recheck: Jul-Sep 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>872</td>
<td>13</td>
<td>54%</td>
<td>11</td>
</tr>
<tr>
<td>844</td>
<td>22</td>
<td>58%</td>
<td>22</td>
</tr>
<tr>
<td>877</td>
<td>14</td>
<td>82%</td>
<td>11</td>
</tr>
<tr>
<td>891</td>
<td>19</td>
<td>78%</td>
<td>17</td>
</tr>
<tr>
<td>834</td>
<td>17</td>
<td>85%</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>72%</td>
<td>75</td>
</tr>
</tbody>
</table>