New York State Perinatal Quality Collaborative
Recruitment and Pre-Work Package

nypQC
New York State Perinatal Quality Collaborative
This document provides details about the New York State Perinatal Quality Collaborative (the Collaborative). The package is divided into two sections. The first section includes information related to the Collaborative’s recruitment process. The second section includes information to prepare for the Informational Call and first Learning Session.

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**Attachments**
- Attachment 1: New York State Perinatal Quality Collaborative Participant Form
- Attachment 2a: New York State Perinatal Quality Collaborative Scheduled Delivery Form
- Attachment 2b: New York State Perinatal Quality Collaborative Scheduled Delivery Form Data Collection Field Guide
- Attachment 2c: Stillbirth Log
- Attachment 2d: Stillbirth Individual Log
- Attachment 3: Storyboard Instructions and Template
New York State Perinatal Quality Collaborative

Part One: Recruitment
Overview of the Collaborative

Purpose and Goals of the Learning Collaborative
This Learning Collaborative is an innovative project designed to enable improvement teams to share, test and implement strategies to reduce elective deliveries, without medical indication, prior to 39 weeks. This exciting and challenging project will require that teams engage with energy and skill to try new ways of delivering care. Together, we can determine and disseminate strategies that will serve as a model of how to improve care.

The goals of the Learning Collaborative are to:

- Improve maternal and newborn outcomes;
- Improve capability within New York State for ongoing quality improvement and transformation of healthcare by applying evidence-based healthcare system change interventions in Regional Perinatal Centers (RPCs’) and hospitals’ obstetrical units;
- Reduce the number of scheduled deliveries of newborns 36\(^{0/7}\) and 38\(^{6/7}\) weeks gestation performed without medical indication;
- Assure that all initiations of labor or planned caesarean sections for women who are not in labor occur only when obstetrically or medically indicated; and
- Increase education of pregnant women about the risks and benefits of scheduled delivery between 36\(^{0/7}\) and 38\(^{6/7}\) weeks gestational age.

RPCs, birthing hospitals, the New York State Department of Health (NYSDOH) and the NYS Partnership for Patients (the Partnership) will work together for approximately eighteen months to implement evidence-based interventions to improve obstetrical outcomes. Participating organizations will learn and apply key principles to improve care and implement the core intervention, and associated measures, as the primary focus of work. These core interventions are based on current available scientific evidence. As part of the improvement process, teams will collect process and outcome data that are sensitive to the changes they will be testing and implementing to track performance and results over the eighteen month period.

The Collaborative will use a learning model, the Institute for Healthcare Improvement’s Breakthrough Series (BTS)\(^1\) (Appendix A, p. 10) modified to meet the requirements and unique needs of this topic and context, and a change model, the Model for Improvement (Appendix C, p. 14), that have demonstrated effectiveness in previous NYSDOH projects. The Collaborative will assist participating teams in embedding strategies to measure and address disparities in care and outcomes throughout the process.

A BTS Collaborative is a vehicle for identifying, testing, and spreading changes that are effective for improving care and outcomes for defined populations.

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\(^1\) Institute for Healthcare Improvement (IHI), Boston MA
Collaborative Benefits

Facilities participating in the Collaborative will receive benefits that include:

- Support from national and regional faculty, including trained quality improvement and obstetrics experts;
- Coaching and technical assistance, including in-person Learning Sessions, regular Coaching Calls, support to implement and test improvements, and real-time feedback on data to make improvements;
- Access to the project Web site, a virtual learning community that will be used to share resources and engage participants in ongoing discussions;
- Opportunities to connect with other participating hospital teams to share strategies, identify lessons learned, overcome barriers and expedite the implementation of project goals; and
- Building quality improvement knowledge and capacity that can be applied beyond the scope of this project.

The Collaborative will provide a unique opportunity to learn and practice change. The experience can be expected to improve staff satisfaction as well as the care delivered to the patients. Higher staff morale and retention should be considered one of the cost benefits of the time devoted to the effort.

Collaborative Planning Group

The Collaborative planning group and faculty includes: Dr. Marilyn Kacica, Dr. Chris Kus, Lorraine Ryan, Christa Christakis, Dr. Peter Cherouny (Obstetrical Clinical Expert) and Patricia Heinrich (RN, MSN, Quality Improvement Advisor), and your obstetrical colleagues from across New York State. Clinical and subject matter experts will join the team as needed during the project. This planning group will:

- Share evidence-based information and examples of best practice from across the country;
- Create and refine the change package of concepts and ideas for improvement;
- Coach teams on improvement methodology;
- Provide communication strategies to keep participants connected to the faculty and their colleagues during the Learning Collaborative; and
- Share tools, forms, and other aides to facilitate implementation of and spread of effective changes.

Overall Structure of the Collaborative

The Collaborative will facilitate the RPC hospital teams and their affiliate hospitals working together for approximately eighteen months. Over the course of the Collaborative, representatives from these hospital teams will participate in two one-day in-person Learning Sessions and two virtual Learning Sessions. In addition, regular contact with participating teams through e-mail, conference calls and webinars will be facilitated. Participants can access a private project Web site, which includes journal articles, facility policies and protocols, and patient and staff education materials, information on other state initiatives, practice guidelines and quality improvement tools.
Collaborative Expectations

Pre-Work Activities for Hospital Teams
Prior to the first Learning Session, teams complete multiple activities that will accelerate the start-up of their improvement efforts and equip them to gain the most from the first Learning Session. These Pre-Work activities include: holding a team meeting; collecting baseline data; developing their own SMART AIM (Specific, Measureable Achievable, Realistic, Time bounded) aligned with overall project goals and based on a review of baseline data; and preparing a Storyboard to share with other teams.

Informational Call
Hospital teams involved in the initiative will participate in an Informational Call to review Pre-Work activities. Hospital staff will also have the opportunity to ask questions at this time. There will be two options for a representative from your team to participate in the Informational Call:

- Thursday, May 10 from 3 to 4 p.m., and
- Friday, May 11 from 3 to 4 p.m.

Please e-mail Kristen Farina, Program Coordinator, at NYSPQC@health.state.ny.us, with the date of the Informational Call you plan to attend. To join the calls, use:

- Participant Line: (866) 527-7795; and
- Password: Obstetric Safety.

Learning Sessions
Learning Sessions are the major integrative events of the Collaborative where all teams come together in person or virtually for focused content and quality improvement learning. Through plenary sessions, small group discussions and team meetings, attendees have the opportunity to:

- Learn from faculty and colleagues;
- Receive individual coaching from faculty members;
- Gather new knowledge on the subject matter and process improvement;
- Share experiences and collaborate on improvement plans; and
- Problem solve strategies to overcome improvement barriers.

A minimum of two key members from each facility team are expected to attend the Learning Sessions. Information regarding the Learning Sessions will be forthcoming.

Action Periods
In between the in-person and virtual Learning Sessions—times called Action Periods—hospital teams will be expected to make changes within their organizations to accomplish the overall project goal of reducing scheduled deliveries before 39 weeks without a medical indication. They will do so by applying the Model for Improvement, beginning with small changes and increasing in scope and scale.
## Initial Learning Collaborative Schedule

<table>
<thead>
<tr>
<th>Action Item</th>
<th>Date and Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Recruitment and Pre-Work packets sent to hospitals</td>
<td>Week of April 30</td>
</tr>
<tr>
<td>☐ Register for one of two Informational Calls by sending an email to Kristen Farina at <a href="mailto:NYSPQC@health.state.ny.us">NYSPQC@health.state.ny.us</a></td>
<td>Register by Wednesday, May 9</td>
</tr>
</tbody>
</table>
| ☐ Informational Call - Option 1  
Participant Line: (866) 527-7795  
Password: Obstetric Safety | Thursday, May 10, 3–4 p.m. |
| ☐ Informational Call - Option 2  
Participant Line: (866) 527-7795  
Password: Obstetric Safety | Friday, May 11, 3–4 p.m. |
| ☐ Facilities will need to complete a three step process:  
1. Review the materials in Part Two: Pre-Work;  
2. Read Appendices A and B in detail; and  
3. Complete and submit the NYSPQC Participant Form (Attachment 1) electronically to NYSPQC@health.state.ny.us. | Friday, May 25 |
| ☐ Acknowledgement of NYSDOH of receipt of Participant Form | Ongoing |
New York State Perinatal Quality Collaborative

Part Two: Pre-Work

Information that will help prepare your facility to participate in the New York State Perinatal Quality Collaborative - Obstetrics Improvement Project
Team Preparation Checklist of Pre-Work for First Learning Session

Thank you for joining the New York State Perinatal Quality Collaborative (the Collaborative). We are delighted to have the opportunity to work with your team to make improvement happen together!

This section of the package contains information that will help your team prepare to participate in the Collaborative. This packet includes specific activities that we ask you to complete prior to the first Learning Session, as well as detailed instructions for completing these tasks.

Some technical language used in this packet may be unfamiliar. Please check the glossary (Appendix G, p. 25) of this document for clarification. More detailed explanations will follow at the first Learning Session.

If you have any questions, please contact Kristen Farina, New York State Perinatal Quality Collaborative Program Coordinator, at NYSPQC@health.state.ny.us, or by calling (518) 402-5278.

Please complete the following activities before the first Learning Session. Details on each section can be found in the Appendices and related attachments:

- ✔️ Read the Overview of a Learning Collaborative (Appendix A, p. 10) to get an understanding of the Collaborative process.
- ✔️ Formalize your team members, keeping in mind team expectations (Appendix B, p. 12). Review Collaborative goals, structure, and expectations with team.
- ✔️ Review the Model for Improvement (Appendix C, p.14).
- ✔️ Review the Field Guide (Attachment 2a) and complete and submit baseline data (Attachment 2b).
- ✔️ Complete your team AIM Statement (Appendix D, p. 16).
- ✔️ Develop a Storyboard with your team and submit the final product electronically to Kristen Farina at NYSPQC@health.state.ny.us (Appendix E, p. 17).
- ✔️ Review NYSPQC- Obstetrics Improvement Project Charter and Measures including high leverage change concepts (Appendix F, p. 18).
Appendix A: Overview of a Learning Collaborative

A Learning Collaborative is a time-limited effort by multiple organizations that come together with faculty to learn about and create improved processes in a specific topic area. The expectation is that the teams share expertise and data with each other; thus, “everyone learns, everyone teaches.” The New York State Perinatal Quality Collaborative’s Obstetrics Improvement Project will be approximately eighteen months in length.

A Collaborative provides a systematic approach to healthcare quality improvement. Each team in the Collaborative will learn quality improvement fundamentals to create small tests of change before a broader organizational rollout of successful interventions. At the same time, each team will collect monthly data on measures to track improvements. Learning is accelerated as the Collaborative teams work together and share their experiences through monthly reports, Learning Sessions, conference calls and e-mail.

The three phases of the Learning Collaborative are: Pre-Work activities, Learning Sessions and Action Periods.

What is Pre-Work?
Collaborative teams will be involved in Pre-Work from the time they join the Collaborative in May 2012 until the first Learning Session. The purpose of the Pre-Work is to prepare the participating teams to launch the improvement initiative at their site and prepare for this first face-to-face meeting. During this time, the Collaborative team has several important tasks to
accomplish, including: creating an AIM statement\(^1\), collecting baseline data, developing a Storyboard, and participating in one of the Pre-Work calls. A Pre-Work packet, with more detailed information about this phase, follows in Part Two of this package.

**What is a Learning Session?**
Learning Sessions bring teams together to become skilled in quality improvement fundamentals through theoretical application with real time coaching. Through plenary addresses, small group discussions and team meetings, attendees have the opportunity to:

- Learn from faculty and colleagues;
- Receive coaching from faculty members;
- Gather new information on the subject matter and process improvement; and
- Share information and create detailed improvement plans.

The Learning Collaborative will include two Learning Sessions facilitated by the Collaborative’s project team and expert faculty. One of these will occur at the start of the Collaborative, and the other at the end. A minimum of two key members from each facility team are expected to attend the Learning Sessions.

**What are Action Periods?**
The time between Learning Sessions (both in-person and virtual) is called an Action Period. During Action Periods, Collaborative teams work within their organizations toward major, breakthrough improvements by initiating small tests of change. Although each participant focuses on his/her own organization, continuous contact with other Collaborative participants and faculty is provided.

Monthly conference calls, regular e-mails and webinars maintain this continuous contact during the Action Period. Each organization collects data to learn if the tests of change are resulting in improvement. Monthly data is reviewed by each team and then submitted to NYSDOH. Teams are encouraged to include additional staff in Action Period activities.

\(^1\) An AIM statement is "a specific statement summarizing what your organization hopes to achieve. It should be time specific and measurable." (Institute for Healthcare Improvement, www.ihi.org)
Appendix B: Collaborative and Team Expectations

Form a Team and Review Team Expectations
An appropriate and effective team is a key component of successful improvement efforts. Team members should be selected based on their knowledge of the hospital systems that will be impacted by improvement efforts and their commitment to make the changes encompassed in the Change Package (See Appendix F, p.18 for measures). The complete Change Package will be shared prior to the first Learning Session. Members should include multidisciplinary staff from appropriate departments who will work together to achieve the project goals and be impacted by improvement efforts.

Selecting Team Leaders
Team activities will be guided by an MD Champion and a Day-to-Day Leader/Key Contact. Individuals in these roles will represent the team at the Learning Sessions and share their learning with other team members. Ideally team members should have the following attributes:

MD Champion
- Is a practicing provider who is an opinion leader and is well respected by peers;
- Has authority to allocate the time and resources needed to achieve the team’s improvement efforts;
- Has authority over areas affected by the change;
- Will champion the spread of successful changes;
- Understands the processes of care in all units caring for pregnant women, their newborns and families;
- Has a good working relationship with colleagues and the Day-to-Day Leader; and
- Wants to drive improvements in the hospital system.

The MD Champion will be a critical member of the team, and should plan to attend all Learning Sessions.

Day-to-Day Leader/Key Contact
- Drives the project, ensuring that cycles of change are tested and implemented;
- Coordinates communication between the team, Collaborative faculty and other teams;
- Oversees data collection; and
- Works effectively with the MD Champion.

The Day-to-Day Leader/Key Contact should understand how changes will affect hospital systems, and should plan to attend all Learning Sessions.

Selecting Other Members
In addition to team leaders, the team should include members from areas potentially affected by system changes. These members might include individuals who represent multiple roles in your delivery of care such as: Registered Nurses (antenatal, labor and delivery, postpartum, nursery), Midwives, Obstetricians, Quality Improvement, Information Technology staff, etc.
**Team Members who should attend the Learning Session**
Teams should choose a minimum of two individuals who can most effectively work together, learn the methodology and plan for action when returning to their hospital. Different team members can attend the Learning Sessions; however, past teams have found it beneficial to send the same members to the Learning Sessions.

**Team Expectations**
Hospital teams participating in the Learning Collaborative are expected to:

- Engage with senior leaders to communicate and collaborate in order to promote change and improve processes;
- Select a team of at least five people, including one MD Champion and one Day-to-Day Leader/Key Contact;
- Complete Pre-Work activities to prepare for the first Learning Session;
- Create and share Storyboards at the first Learning Session. The Storyboard will describe your team and your goals. At the Collaborative Summit, the Storyboard will illustrate your team’s efforts and lessons learned;
- Use rapid change cycles (Plan-Do-Study-Act (PDSA) tests) to implement the Change Package;
- Participate in monthly Collaborative Coaching Calls;
- Regularly communicate with faculty, RPCs and other teams; and
- Report on the achievement of selected process and outcome measures, including details of changes made and data to support these changes.
Appendix C: Model for Improvement

The Model for Improvement\(^3\) is a simple yet **powerful strategy for making improvements in the care you provide to your patients.** Developed by Associates in Process Improvement, the application of the model has two components. First, your team will address three fundamental questions. These questions will guide your team in creating an AIM Statement, measures and specific change ideas. Secondly, your team will use Plan-Do-Study-Act (PDSA) cycles to easily test these changes in your work environment. Successful tests of change pave the way for full scale implementation within your system. A brief synopsis of the model is presented below. More detail is available on the Institute for Healthcare Improvement (IHI) Web site at: [www.ihi.org](http://www.ihi.org).

### Associates in Process Improvement

#### Three Key Questions for Improvement

1. **What are we trying to accomplish?** *(AIM Statement)*
   
   When you answer this question, you are creating an AIM Statement – a statement of a specific, intended goal. A strong, clear AIM Statement gives necessary direction to your improvement efforts. Your AIM Statement should include a general description of what your team hopes to accomplish and a specific patient population on which your team will focus. A strong AIM Statement is specific, intentional and unambiguous. It should be aligned with organizational goals and all team members involved in the improvement process should support it.

2. **How will we know that a change is an improvement?** *(Measures)*
   
   Your team will use a set of defined measures to determine if the rapid cycle changes in care are working. They can also be used to monitor performance over time. These measures are designed to help you know if the changes you are testing are resulting in improvement. This quality improvement measurement strategy should not be confused with the type of measurement

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\(^3\) *The Model for Improvement was developed by Associates in Process Improvement. [www.apiweb.org/API_home_page.htm](http://www.apiweb.org/API_home_page.htm)*
used for research. Where research focuses on one fixed and testable hypothesis, the methods for measuring improvement rely on sequential testing using practical measurement strategies. The measures for this Collaborative are based on those used by the NYSDOH and other State Collaboratives; they have been edited for specific use in this project by the Collaborative’s project team in partnership with representatives from RPCs which participated in the initial phase of the initiative.

3. **What changes can we make that will result in an improvement? (Best Practices and ideas)**
   As with the measures, the collection of evidence-based changes that we will use in this Collaborative are based on those used by the NYSDOH and other State Collaboratives; they have been edited for specific use in this project by the Collaborative’s project team in partnership with representatives from RPCs which participated in the initial phase of the initiative. This collection of changes is called the Change Package and includes multiple opportunities for improving care at your site. More detail on the use of the Change Package will be provided at that first Learning Session.

**PDSA Cycles**

The PDSA (Plan-Do-Study-Act) cycle is a method for rapidly testing a change - by planning it, trying it, observing the results, and acting on what is learned. This is a scientific method used for action-oriented learning. After changes are thoroughly tested, PDSA cycles can be used to implement or spread change. The key principle behind the PDSA cycle is to test on a small scale and test quickly. Traditional quality improvement has been anchored in laborious planning that attempts to account for all contingencies at the time of implementation; usually resulting in failed or partial implementation after months or even years of preparation. The PDSA philosophy is to design a small test with a limited impact that can be conducted quickly (days, if not hours!) to work out unanticipated “bugs”. Repeated rapid small tests and the learning gleaned build a process ready for implementation that is far more likely to succeed.
Appendix D: AIM Statement

Identify Your Team’s AIM

An AIM Statement answers the question, “What are we trying to accomplish?” It is an explicit statement summarizing what your practice plans to achieve during the project. An AIM Statement will focus your team’s actions, helping to reduce elective deliveries prior to 39 weeks gestation. The AIM Statement should be **time-specific, population specific and measurable.**

When writing your AIM Statement, state your AIM clearly, and use specific numeric goals. Teams make better progress when they have unambiguous, specific goals. Setting numeric targets clarifies the AIM, helps to focus change efforts, and directs measurement activities.

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**EXAMPLE**

We aim to improve maternal and newborn outcomes and our capacity to provide improved care across all out units that deliver care to pregnant women and their families. The focus of our efforts over the next 18 months will be to reduce the number of scheduled deliveries performed without appropriate indication in women of 36 0/7 to 38 6/7 weeks gestation. To accomplish this, we will form a multidisciplinary team (with members across all units in our hospital that care for pregnant women), and use a combination of strategies that have been successful in other states.

Our goals include:

1. A 50% reduction in the percent of scheduled deliveries performed without appropriate medical indication in women less than 38 6/7 weeks gestation.
2. Education will be provided to pregnant patients about the risks of scheduled inductions and scheduled C/S (those without medical indication) less than 38 6/7 weeks gestation for at least 90% of our patients.
3. Documentation of appropriate gestational age dating in the first 20 weeks or pregnancy for 90% of our patients.

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As you begin to develop your team’s AIM Statement, be sure to:

- **Involve the organization’s senior leaders:** Leadership must ensure the AIM Statement is aligned with the strategic goals of the organization. They should also help identify an appropriate patient population for initial focus of the team’s work.
- **Base the goals in your AIM Statement on existing data or organizational needs:** Examine available information about perinatal care processes within your organization, and focus on issues that matter most to your patients and families.
- **Revise your original AIM Statement as needed during the first Learning Session.**
Appendix E: Storyboards

In preparation for the opening Learning Session, teams are asked to create a Storyboard to share information.

This Storyboard is an opportunity for teams to briefly describe their team and what they plan to accomplish during the Learning Collaborative. Storyboards will also be on display for all participants to review during the Learning Session.

Please bring a copy of your Storyboard to post on a display board at the Learning Session (this display board will be provided to you at the Learning Session) and at least one extra copy for use by your improvement team to make revisions or edits during the Learning Session. In addition, prior to the Learning Session, please e-mail an electronic copy of your Storyboard to NYSPQC@health.state.ny.us.

Your audience will be other participating teams, Collaborative leadership, observers and faculty. Therefore, the Storyboard should be as clear and concise as possible. Detailed instructions and a template are attached to help guide you in completing your Storyboard (see Attachment 3).

Here is a sample outline for what you might include in your Storyboard:

- Name and location of your organization
- Brief description of your Obstetrics Unit (providers, staff, community characteristics, etc)
- Improvement team (names, titles, roles)
- Team’s improvement AIM for project
- Baseline data that shows where you are starting from
- Initial ideas for improvement
- Other relevant information (e.g., current programs/activities targeted to perinatal care)

Storyboard display tips

- Use fewer words and more pictures/graphics
- Use pictures of real people …. at least of your team! (Hint, Hint 😊)
- Make font size as big as possible
- Don’t worry about making the display fancy
- Use color to highlight key messages ➔ If no access to a color printer, use bright highlighters
Appendix F: Project Charter and Measures

New York State Perinatal Quality Collaborative Performance Measures

Mission:
Participating RPCs and hospitals, the NYSDOH and the NYS Partnership for Patients will work together for approximately 18 months to implement evidence-based interventions for improving neonatal and maternal outcomes. Participating organizations will learn and apply key principles to improve care and implement the core intervention, and associated measures, as the primary focus of work. These core interventions are based on current available scientific evidence.

Project AIM:
By February 2014, we aim to improve maternal and newborn outcomes, and improve capability within New York State for ongoing quality improvement/transformation of healthcare by applying evidence-based healthcare system change interventions in Regional Perinatal Centers (RPCs), and Obstetrical Units. The obstetrical intervention is: Reducing the number of scheduled deliveries performed without medical indication between 36 0/7 and 38 6/7 weeks gestation.

<table>
<thead>
<tr>
<th>Change Concept</th>
<th>Specific Changes</th>
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| Assure that all initiations of labor or caesarean sections on women who are not in labor occur only when obstetrically or medically indicated | • Document awareness of risk and expected benefit of near term delivery by patients, consumers and clinicians  
• Document optimal estimation of gestational age  
• Establish hospital and physician practice policies that facilitate ACOG criteria  
• Establish hospital and physician practice policies that create awareness by clinician of risks and benefits of delivery between 36 0/7 and 38 6/7 weeks gestation without medical indication  
• Establish communication across all systems of care and create a culture of safety and improvement |
<table>
<thead>
<tr>
<th>Desired Change</th>
<th>Measure # (Type)</th>
<th>Measure</th>
<th>Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction of scheduled deliveries between 36 0/7 and 38 6/7 weeks gestation without appropriate medical indication</td>
<td>Premature Birth #1 (Process/Outcome)</td>
<td>Percent of scheduled* inductions of labor at 36 0/7 to 38 6/7 weeks without** medical or obstetrical indication documented</td>
<td>Numerator 1a: Number of scheduled inductions of labor at 36 0/7 to 38 6/7 weeks excluding inductions that have medical or obstetrical indication. Denominator 1a: All scheduled deliveries of infants between 36 0/7 to 38 6/7 weeks gestation.</td>
</tr>
<tr>
<td>Reduction of scheduled cesarean sections between 36 0/7 and 38 6/7 weeks gestation without appropriate medical indication</td>
<td>Premature Birth #2 (Process / Outcome)</td>
<td>Percent of scheduled* cesarean sections at 36 0/7 to 38 6/7 weeks gestation without** medical or obstetrical indication documented</td>
<td>Numerator 2a: Number of scheduled cesarean sections occurring at 36 0/7 to 38 6/7 weeks gestation excluding those that have medical or obstetrical indication. Denominator 2a: All scheduled deliveries of infants between 36 0/7 to 38 6/7 weeks gestation.</td>
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<tr>
<td>Desired Change</td>
<td>Measure #</td>
<td>Measure</td>
<td>Calculation</td>
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<tr>
<td><strong>Numerator 2b:</strong></td>
<td></td>
<td></td>
<td>Number of scheduled cesarean sections occurring at 36 0/7 to 38 6/7 weeks gestation excluding those that have medical or obstetrical indication</td>
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<tr>
<td><strong>Denominator 2b:</strong></td>
<td></td>
<td></td>
<td>All scheduled cesarean sections between 36 0/7 to 38 6/7 weeks gestation</td>
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<tr>
<td><strong>Numerator 2c:</strong></td>
<td></td>
<td></td>
<td>Number of scheduled primary cesarean sections occurring at 36 0/7 to 38 6/7 weeks gestation excluding those that have medical or obstetrical indication</td>
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<tr>
<td><strong>Denominator 2c:</strong></td>
<td></td>
<td></td>
<td>All scheduled cesarean sections between 36 0/7 to 38 6/7 weeks gestation</td>
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<td><strong>Numerator 2d:</strong></td>
<td></td>
<td></td>
<td>Number of scheduled primary cesarean sections occurring at 36 0/7 to 38 6/7 weeks gestation excluding those that have medical or obstetrical indication</td>
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<tr>
<td><strong>Denominator 2d:</strong></td>
<td></td>
<td></td>
<td>Scheduled primary cesarean sections of infants between 36 0/7 and 38 6/7</td>
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<tr>
<td>Desired Change</td>
<td>Measure # (Type)</td>
<td>Measure</td>
<td>Calculation</td>
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<tr>
<td><strong>Reduction of scheduled deliveries between 36 $^{0/7}$ and 38 $^{6/7}$ weeks gestational age without medical indication</strong></td>
<td>Premature Birth #3 (Process)</td>
<td>Percent of scheduled* deliveries at 36 $^{0/7}$ to 38 $^{6/7}$ weeks gestational age <strong>without</strong> medical or obstetrical indication documented</td>
<td>Numerator 3: Number of scheduled deliveries of infants at 36 $^{0/7}$ to 38 $^{6/7}$ weeks gestation excluding those that have medical or obstetrical indication.[Sum of above numerators]</td>
</tr>
<tr>
<td><strong>Reduction in the number of infants born by scheduled delivery between 36 $^{0/7}$ and 38 $^{6/7}$ weeks gestational age without medical indication who were admitted to neonatal intensive care for &gt; 4 hours</strong></td>
<td>Premature Birth #4 (Outcome)</td>
<td>Percent of infants born at 36 $^{0/7}$ to 38 $^{6/7}$ weeks gestation by scheduled* delivery who were admitted to neonatal intensive care for &gt; 4 hours</td>
<td>Numerator 4: Number of infants born at 36 $^{0/7}$ to 38 $^{6/7}$ weeks gestation by scheduled delivery and who were admitted to the NICU for &gt; 4 hours</td>
</tr>
<tr>
<td><strong>Increased education of women about the maternal and fetal risks and benefits of scheduled delivery between 36 $^{0/7}$ and 38 $^{6/7}$ weeks gestational age</strong></td>
<td>Premature Birth #5 (Process)</td>
<td>Percent scheduled* deliveries with documentation in the medical record that the maternal and fetal risks and benefits of scheduled delivery at 36 $^{0/7}$ to 38 $^{6/7}$ weeks were discussed with the mother</td>
<td>Numerator 5: Number of scheduled deliveries of infants at 36 $^{0/7}$ to 38 $^{6/7}$ weeks gestation for which there is documentation in the medical record that the risks and benefits of scheduled delivery at 36 $^{0/7}$ to 38 $^{6/7}$ weeks were discussed with the mother</td>
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<td>Denominator 5: Total number of scheduled deliveries of infants at 36 $^{0/7}$ to 38 $^{6/7}$ weeks gestation</td>
</tr>
<tr>
<td>Desired Change</td>
<td>Measure # (Type)</td>
<td>Measure</td>
<td>Calculation</td>
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| Increased documentation of gestational age in charts | Premature Birth #6 (Process) | Percent scheduled* deliveries between 36 0/7 and 38 6/7 weeks gestational age with charts that document gestational age using any criteria to establish estimated date of delivery (EDD) | Numerator 6: Number of scheduled deliveries in women 36 0/7 to 38 6/7 weeks gestation where gestational age, using any criteria for determining EDD, was documented in the chart  
Denominator 6: Total number of scheduled deliveries of infants at 36 0/7 to 38 6/7 weeks |
| Increased documentation of optimal verification of gestational age | Premature Birth #7 (Process) | Percent scheduled* deliveries between 36 0/7 and 38 6/7 weeks gestational age with charts that meet optimal criteria of gestational age assessment | Numerator 7a: Number of scheduled deliveries in women 36 0/7 to 38 6/7 weeks for which there is documentation of data that confirmed or established due date AND for which one of the following methods that are considered to be optimal was checked: 1) First or second trimester ultrasound <20 weeks; or 2) Fetal heart tones documented for 30 weeks by Doppler ultrasonography; or 3) 36 weeks since positive serum/urine human chorionic gonadotropin pregnancy test result  
Denominator 7a: Total number of scheduled deliveries at 36 0/7 to 38 6/7 weeks gestation |
<p>| No change / reduction in the number of stillbirths   | Premature Birth #8 (Balancing) | Number of stillbirths per 1000 births of infants and stillbirths at 36 0/7 to 38 6/7 weeks gestation | Numerator 8: Number of stillborn infants to women 36 0/7 to 38 6/7 weeks gestation |</p>
<table>
<thead>
<tr>
<th>Desired Change</th>
<th>Measure # (Type)</th>
<th>Measure</th>
<th>Calculation</th>
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| Increased documentation of fetal lung maturity documented by amniocentesis     | Premature Birth #9 | Percent of all scheduled deliveries at 36 0/7 to 38 6/7 weeks gestation without fetal lung maturity documented by amniocentesis | Denominator 8: Total infants born alive at 36 0/7 to 38 6/7 weeks gestation PLUS number of stillbirths of infants of 36 0/7 to 38 6/7 weeks gestation  
Numerator 9: Number of scheduled deliveries at 36 0/7 to 38 6/7 weeks gestation without documented fetal lung maturity  
Denominator 9: All scheduled deliveries of infants between 36 0/7 and 38 6/7 weeks gestation |
| Increased documentation of Bishop Score measurement for induced deliveries     | Premature Birth #10 | Percent of all deliveries induced at 36 0/7 to 38 6/7 weeks gestation without documentation of a Bishop Score | Numerator 10a: Number of scheduled deliveries induced at 36 0/7 to 38 6/7 weeks gestation without a documented Bishop Score  
Denominator 10a: All induced scheduled deliveries of infants between 36 0/7 and 38 6/7 weeks gestation  
Numerator 10b: Number of scheduled deliveries induced at 36 0/7 to 38 6/7 weeks gestation with a documented Bishop Score and cervical status 8 or greater for a primigravida birth mother or 6 or greater for a multigravida birth mother  
Denominator 10b: All induced scheduled deliveries of infants between 36 0/7 and 38 6/7 weeks gestation |
<table>
<thead>
<tr>
<th>Desired Change</th>
<th>Measure # (Type)</th>
<th>Measure</th>
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<td>deliveries of infants between 36 0/7 to 38 6/7 weeks gestation with a documented Bishop Score</td>
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<td><em>Numerator 10c</em>: Number of scheduled deliveries induced at 36 0/7 to 38 6/7 weeks gestation with a documented Bishop Score and cervical status 8 or greater for a primigravida mother or 6 or greater for a multigravida birth mother</td>
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<td><em>Denominator 10c</em>: All induced scheduled deliveries of infants between 36 0/7 to 38 6/7 weeks gestation with a documented Bishop Score</td>
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Appendix G: Collaborative Glossary

**Action Period**
The period of time between Learning Sessions (in-person or virtual) when teams work on improvement in their home organizations. During this time, teams will be supported by the Collaborative Project Team and faculty, and are connected to other Collaborative team members.

**AIM Statement**
A written, measurable and time-sensitive statement of the expected results of an improvement process.

**Change Package**
The Change Package includes a list of high leverage key change concepts or “ideas” for changes in your hospital system and specific strategies for those changes. These changes come from evidence provided by previous research.

**Collaborative**
A time-limited effort (usually 12 -24 months) by multiple organizations, which come together with faculty to learn about and to create improved processes in a specific topic area. The expectation is that the teams share expertise and data with each other, thus: “Everyone learns, everyone teaches.”

**Cycle or PDSA Cycle**
A structured trial of a process change. Drawn from the Shewhart cycle, this effort includes:
- **Plan:** a specific planning phase;
- **Do:** a time to try the change and observe what happens;
- **Study:** an analysis of the results of the trial; and
- **Act:** devising next steps based on the analysis.

Consecutive PDSA cycles will naturally lead to the plan component of a subsequent cycle.

**High Leverage Change Concepts**
A high leverage change concept will result in significant improvement in the system of care and result in better care, improved outcomes, reduced hospital stays and lower costs.

**Key Changes – Change Package**
The list of essential process changes that will help lead to breakthrough improvement, usually created by the leadership team and chair based on literature and their experiences.

**Learning Session**
A meeting during which participating organizational teams meet with faculty and collaborate to learn key changes in the topic area, including how to implement them, an approach for accelerating improvement and methods for overcoming obstacles to change. Teams leave this meeting with new knowledge, skills and materials that prepare them to make immediate changes.
Measure
Key measures should be focused, clarify the team’s AIM Statement and be reportable. A measure guides the ability to track patients for delivery of proven interventions and to monitor their progress over time.

Model for Improvement
An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes.

Pre-Work Packet
A packet containing a complete description of the Collaborative, along with expectations and activities to be completed prior to the first meeting of the Collaborative.

Pre-Work Period
The time prior to the first Learning Session when teams prepare for their work in the Collaborative, including selecting team members, scheduling initial meetings, consulting with senior leaders, preparing their AIM Statement and initiating data collection.

MD Champion
The MD Champion supports the team and controls the resources employed in the processes to be changed. The MD Champion works to connect the team’s AIM with the organization’s mission, provides resources for the team and promotes the spread of work of the team to others.

Spread
The intentional and methodical expansion of the number and type of people, units or organizations using the improvements. The theory and application comes from the literature on Diffusion of Innovation (Everett Rogers, 1995).

Storyboard
A Storyboard is a display of information to promote sharing across teams at the Learning Sessions. Storyboards usually include demographic information about the hospital team, the team’s AIM Statement, data and lessons learned during the Action Periods.

Test
A small scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.
Appendix H: Collaborative Leadership and Faculty

New York State Department of Health
Marilyn Kacica, MD, MPH, Executive Director, NYSPQC

Chris Kus, MD, MPH, Project Advisor, NYSPQC

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Elizabeth Berberian, Associate Project Manager, NYSPQC

Todd Gerber, Data Systems and Analysis Manager, NYSPQC

Eileen Shields, Data Systems and Analysis Manager, NYSPQC

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Kathleen Ciccone, Co-Director, NYSPFP

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Vincent Fitts, Data Systems and Analysis Advisor, NYSPFP

Gloria Kupferman, Data Systems and Analysis Advisor, NYSPFP

Quality Improvement Consultants
Peter Cherouney, MD, OB Clinical Expert

Patricia Heinrich, RN, MSN, Quality Improvement Advisor

Planning Group
A steering committee for the Collaborative consisting of the faculty, representatives from NYSDOH and representatives from other sponsoring or stakeholder organizations (see p. 5).
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Division of Family Health
New York State Department of Health
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Albany, NY 12237