Texas Department of State Health Services

Perinatal Quality Assessment Performance Improvement, Patient Safety Overview

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QAPI Critical Element to Successful Designation

- Administrative Code 133.205(b)(2)(F) Program Plan:
  - Requires QAPI Program (133.41(r))
  - Demonstrates the evaluation of the provision of Maternal Care on an on-going basis
  - Identifies opportunities for improvement
  - Develops and implements improvement plan
  - Evaluates the plan until event resolution is achieved

Regulatory Requirements

- Administrative Code 133.205(d)(8)
  - Medical Director has the responsibility and authority in collaboration with the PM
  - Developing/revising policies, procedures, and guidelines
  - Assures medical staff and personnel competency
  - Education and training
  - QAPI program is specific to perinatal care, is ongoing, data driven, and outcome based

Regulatory Requirements

- Administrative Code 133.205(e)(3)
  - Requires the PM to have the authority and responsibility to monitor provision of patient care services from admission, stabilization, operative interventions(s) through discharge
  - All phases of care \ inclusive of the QAPI Program
  - Monitoring compliance to established standards of care or best-practice guidelines
  - Review is ongoing, data driven, outcome based

What is Quality Care

The Institute of Medicine defines health care quality as the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Regulations are designed to maximize the quality and safety of health care services, maximize access to healthcare, and promote efficiency.

Quality assessment performance improvement relies on data.

Quality Assessment Performance Improvement

- Structure + processes = outcomes
- Utilizes best-practice or evidence-based practice to standardize care and processes
- Reduces inefficiencies and variations in care
- Reduces opportunity for errors
- Reports through the Multidisciplinary Perinatal Quality and Safety Committee or Operations Committee

Culture of the Perinatal Center

Quality Assessment Performance Improvement Models

- Six Sigma
- Lean Model
- Plan-Do-Study-Act

Plan – Do – Study- Act

PLAN - Identify problem, determine goal, complete cause analysis

DO – Define correction action plan and execute plan

ACT – If desired goal reach, standardize through EBP, hardwire NOTE: If designed goal not reached cycle continues

STUDY – Assess progress, reassess

Culture of Safety

- What is it? Why Change?
- Change in Institutional Culture
- Foster Environment for High Priority
  - Quality
  - Safety
  - High Reliability
- Culture Refers to:
  - Shared Attitudes
  - Values
  - Goals
  - Practices that Define the Institution
- Remove the "Culture of Blame"

➢ Promote "Safety" and Culture of Reporting

Culture of Safety

- Five Characteristics of a Culture of Safety
  - Preoccupation with Failure
  - Sensitivity to Operations
  - Reluctance to Simplify Interpretation
  - Commitment to Resilience
  - Deference to Expertise
- Patient Safety Above All Priorities
- Reduce Unwarranted Variations
- Continuous Learning Environment

(American College of Surgeons, 2017)

Culture of Safety: Resilience

- Team training (TeamSTEPPS)
- Executive Rounding
- Unit-Based Safety Teams – 2 PT ID; Hand-off; Bed-side Report
- Defined Checklist
- SBAR
- Just Culture – Accountability – System Issues
- Engage all levels of staff

Why is Quality Assessment Performance Improvement, Patient Safety Important

- Value Based Health Care
- Validate Safe, Quality, Reliable Care
- Provided by Skilled, Competent Health Professionals
- Useful in Identifying Outliers and Deviations in the Standard of Care Practices
- Identify Innovations, and New Ways to Deliver Quality Care
- Reimbursement / Funding

Perinatal Operational Plan

- Purpose
- Directive
- Program Mission
- Program Vision
- Culture of Safety Integration
- Program Description and Overview
  - Patient Population and Scope of Services
  - Organizational Structure
  - Program Leadership / Chain of Command
  - Staffing Functions
  - Staff Education / Requirements / Competencies
  - Scheduling
  - Communication
- Rounding – Continuum of Care
- Clinical Areas
- Provider Organization
- Designation Functions
- Program Liaisons
- Role of Telemedicine
- Coordination of Care
- Transfer Follow-up
- Psychosocial Support
- QAPI Plan Oversight and Authority
- Role in Data Management
- Perinatal Operations Committee
  - Committee Members: Roles
  - Responsibilities
- Benchmarking / Collaboratives
- Prevention
- Public Education / Outreach
- Disaster Integration
- Collaborative Practices
- Regional Advisory Council Participation
- State Perinatal Advisory Council Participation
- Research
- Recruitment/Retention/Recognition
- Succession Planning
- Occupational Risk

Perinatal Quality Assessment Performance, Patient Safety Plan

Perinatal QAPI PS Plan

- Scope and Authority
- Links with Perinatal Operational Plan
- Events or variations from standard of care – system or clinical
  - Standardized Audit Reviews or "Triggers"
  - Identified Core Measures
  - System Variations
  - Benchmarking Elements
  - Designation Criteria Compliance
- Processes for event identification
- Levels of Review
- Validation, Documentation, Tracking Process
- Integration of Physicians and Leaders
- Operations Committee
- M&M / Peer Review
- Event Resolution

Perinatal Progression of Care

- QAPI Plan Continuum of Care
  - Pre-Hospital
  - Emergency Care
  - Imaging / Diagnostics
  - Labor and Delivery
  - OR
  - OB ICU/Neonatal ICU
  - Specialty Services / Psychosocial Support
  - Nutrition Services
  - Lactation Counselors
  - General Unit / Support Services
  - Discharge Planning
  - Rehabilitation

System QAPI PS – Events

- Field Triage Not Followed
- Telemedicine / Telehealth Issues
- Transfer Process Delayed
- Transfer Method Delayed
- Transfer Documents Incomplete
- ED Triage Issue
- OB Trauma >20 Weeks
- ED OB Hypertension / Fever >20 Weeks
- Care Prior To Arrival Does Not Meet SOC
- Facility Overload
- Activation of Disaster Response
- Security Systems Fail
- Failure to Meet Designation Essential Criteria

Perinatal QAPI PS Plan

- How, When, Events are Identified and Common Sources
- Event Documentation and Validation
- Impact to the Patient
- Defined ***Level of Harm***
- Structure and Processes for ***Levels of Review***
- Define Processes for Appropriate Cases for
  - Primary Level of Review (Program Manager)
  - Secondary Level of Review (Medical Director)
  - Tertiary Level of Review (Medical Director - Operations, M&M, Peer Review)

Perinatal PIPS Plan

- Structure of Event Review
  - Event – Impact on Patient = Level of Harm
  - Type: Communication, Clinical Decisions, Coordination of Care Issues
  - Domain: Who, Where, Phase of Care Event – Impact or Level of Harm
  - Factors: What Led to Event
  - Determination of Opportunities for Improvement
  - Action Plan
  - Tracking Action Plan's Outcomes
  - Event Resolution

Perinatal PIPS Plan Committees

- Perinatal Operations Committee
  - Establish Perinatal Culture
  - Defines and Approves Operational Processes
  - Approves Standards of Care
  - Reviews Compliance to Designation Requirements
  - Focuses on System Operations and System Performance
  - Reviews Identified "Perinatal Dashboard" of selected QAPI PS Elements- monthly, quarterly, annually

Types of Clinical Reviews

- Case Review for Single Discipline
- Case Review for Multidisciplinary Teams
- Peer Review of Individual
- Educational Review Conferences

Perinatal QAPI PS Committees

- Morbidity and Mortality Review
  - Confidentiality
  - Focuses on Educational Opportunities
  - Associated Literature and Best Practices
  - Outcome Review
  - Identify Opportunities for Improvement
- Peer Review
  - Peer to Peer Review of Physician Clinical Decisions and Priorities
  - Confidentiality
  - Identify Opportunities for Improvement
  - Recommendations
  - Action Plan

Clinical Reviews

- Single Peer Review
  - Physicians
  - Nurses
  - Less Common
  - Repetitive Issues
  - Most Commonly Managed By Hospital or Academic Department

Perinatal QAPI PS Plan

- Data Management
  - Confidentiality
  - Data Definitions
  - Data Storage (Electronic)
  - Who Has Access to Data
  - Standardized Reports
    - Dashboards
    - Designation Compliance Reports
    - Follow-up Action Items

Perinatal QAPI PS Plan

- Integration with Hospital Quality and Risk
  - Their Role in PI Review Process
  - What Events Are Forwarded?
  - When Does Perinatal Report to Hospital Committee
    - What Do you Report?
  - When Do You Report To Board?

Perinatal QAPI PS Plan Revisions

- Minimum of Every Three Years or
- Change in Program Manager or Medical Director
- Upgrading Level of Designation
- Downgrading Level of Designation
- Change in Hospital Ownership

Perinatal Program Authority

- CEO / CNO / VP / Administrative Leader
- Medical Director
- Program Manager / Director
- Board Resolution, Commitment from Board
- Medical Staff Resolution, Medical Staff Bylaws
- Job Descriptions
- Operational Plan (Scope of Service)
- Performance Improvement Patient Safety Plan

Getting Started

- Establish Authority
- Job Descriptions
- Resolutions
- Standards of Care and Established Processes
- Admission / Scope of Service Guidelines
- Transfer Guidelines
- Educational Standards
- Documentation Standards
- Operational Plan
- PIPS Plan
- Education
- Implementation Timeline
- Tracking Process
- Updates at the Operations Committee

Perinatal QAPI PS Plan

What is the status of your Perinatal QAPI PS Plan?

How do you identify event?

How do you validate and document the event?

Routine EVENT Screening

- Routine Screening
- Indicators
- Audit Filters
- "Triggers"
- Typically Elements of Care
  - Linked to Regulatory Requirements or Mandatory Review
  - Action in the Defined "Standards of Care" or BPG
  - Serve as a "Trigger" for a Deeper Review of the Case
- Complications, Delays in Care, Exceeds Expected LOS, Deaths
- Must Be Defined
- May Have Time Parameters Established

Standards of Care

- Institutional Specific Written Standards of Care
  - Clinical Practice Guidelines
  - Evidence-Based Guidelines
  - Best-Practice Guidelines
- Set of Evidence-Based Recommendations
  - Assist with Clinical Decisions
  - Decrease Variances in Practice
  - Establish Performance Benchmarks
  - Grades for Supporting Evidence
    - Level I – At least 1 Randomized Controlled Trial
    - Level II – Observational Design
    - Level III – Expert Consensus

Adverse Events

- Event that results in unintended harm to the patient by an act of commission or omission rather than disease or condition of the patient (National Quality Forum Definition)

Core Measures

- National Standards of Care
- Based on Established Evidence
- Measures Are Cosponsored and Explicitly Specified by the Joint Commission and CMS
- Used to Compare Performance
- Can be Publicly Reported
- Each Measure Has a Denominator of Patients / Numerator or Patients Who Received Care Described by the Measure
- Organized into "Measure Sets"
- Volume, Cost, Overall Burden of Illness / Disease

California Maternal Quality Care Collaborative

- 3rd & 4th Degree Lacerations in Vaginal Delivery
- 3rd & 4th Degree Lacerations in Vaginal Delivery with Instruments
- 3rd & 4th Degree Lacerations Vaginal Delivery w/o Instruments
- Birth Trauma: Injury to Neonate
- Cesarean Birth: Risk – NTSV
- Cesarean Birth: Low Risk – NTSV Age Adjusted
- Cesarean Birth: Primary
- Cesarean Birth: Primary, Term, Singleton, Vertex (AHRQ)
- DVT in Women Undergoing CS
- Early Elective Delivery
- Episiotomy Rate
- Exclusive Breast Milk Feeding
- Exclusive Breast Milk Feeding Considering Mother's Choice
- Failed Induction
- Hemorrhage: Blood Products Units Per 1000 Deliveries
- Hemorrhage: Massive Transfusion (>4 Units) per 1000 Delivery Cases
- Hemorrhage: Risk Assessment on Admission
- Induction Rate
- Newborn Bilirubin Screening Prior to Discharge

Core Measures

- January 2014
- Hospitals with 1,100 or more Births Mandatory Reporting of Core Measures – 5th Measure Set
  - PC – 01: Elective Delivery
  - PC – 02: Cesarean Section
  - PC – 03: Antenatal Steroids (Retired)
  - PC – 04: Health Care – Associated Blood Stream Infections in Newborns (Retired)
  - PC – 05: Exclusive Breast Milk Feeding
  - PC – 06: Exclusive Breast Milk Feeding Considering Mother's Choice

Accountability Core Measures

- PC – 01 Elective Delivery
- PC – 03 Antenatal Steroids (Removed)
- PC – 05a Exclusive Breast Feeding Considering Mother's Choice
- Linked to Performance Improvement Standards and Elements of Performance
  - Expect Hospital to Improve Its Performance
  - Hospital Achieves a Performance Rate of 85%

ePerinatal Core Measures

- ePC-01: Elective Delivery
- ePC-05: Exclusive Breast Milk Feeding
- ePC-02: Cesarean Birth
- ePC-06: Unexpected Complications in Term Newborns
- ePC-07: Maternal Complications

Top Performers on Key Quality Measures

- Another Element of Accountability Measures
- Hospital Must Meet 3 Performance-Based Criteria (12 Month Calendar of Data)
  - Achieve a Composite Rate of = or > 95%
  - Achieve a Performance Rate = or > 95% on Each and Every Applicable Reported Accountability Measure (Must have denominator of 30 cases)
  - Have One Core Measure Set with all Composite Rate is = or > 95% and the Performance Rate of All Applicable Individual Accountability Measures is also = or > 95%

(Joint Commission, November 2013)

Example of MIPS Clinical Quality Measures

- Quality #336: Postpartum Follow-up Care Coordination
  - All patients who gave birth during a 12-month period are seen for postpartum care visit before or at 8 weeks of giving birth
    - Postpartum Visit
      - Breast-feeding evaluation and education, patient reporting breast-feeding
      - Postpartum depression screening
      - Postpartum glucose screening
      - Family and contraceptive planning counseling
      - Tobacco use and cessation education
      - Healthy lifestyle behavioral advice
      - Immunization review and update

Rural Perinatal Health

- Alliance for Innovation on Maternal Health Program: HRSA in Collaboration with ACOG
- Perinatal Quality Collaboratives – CDC
- Maternal Mortality Review Committee – Standardized Data System to Support MMRC
- Quality Reporting – 2019 Core Set – 12 Measures
- Telehealth and Related Technology

Patient Safety Goals

- Incorporate Joint Commission Patient Safety Standards
  - Identify Patients Correctly – two patient identifiers
  - Improve Staff Communication – GET important test results to the right staff person on time
  - Medication Safety
  - Alarm Safety - Alarms on medical equipment are heard and responded to on time
  - Prevent Infection – Hand cleaning guidelines from CDC
  - Identify Patient Safety Risks – Reduce the risk of suicide
  - Prevent Mistakes in Surgery – Correct surgery on correct patient in correct location, mark the correct place on the patient's body, pause before surgery to validate correct information

(https://www.jointcommission.org/-/media.tjc/documents/standards/national-patient-safety-goals/2021)

Perinatal QAPI PS Roles & Responsibilities

- Administrator
  - Commitment
    - Authority and Scope
    - Hospital Integration
    - Funding
    - Resources
    - Contracts

Perinatal QAPI PS Roles & Responsibilities

- Medical Director
  - Commitment
    - Authority and Oversight
    - Responsible for All Phases of Care
    - Responsible for Standards of Care
      - Best Practice Guidelines
      - Evidence Based Practice
    - Responsible for Secondary Level of Review
  - Chairs Perinatal PIPS review, M&M, Peer Review & System Operations Committee
    - Defines Action Plans
    - Event Resolution

Perinatal Medical Director Contracts

- Committed to Perinatal Center
- Physician Oversight
- Time Dedicated to QAPI
- Hours Dedicated to Meetings
  - Staff Education
  - Public Education & Perinatal Care Prevention Programs
  - System Operations Committee
  - M&M, Peer Review
  - Regional Advisory Council System Participation
  - Perinatal Advisory Council Meetings
- Disaster Response & Integration

Perinatal QAPI PS Roles & Responsibilities

- Program Manager / Director
  - Commitment
  - Authority and Oversight
    - Primary Level Of Review
    - Minutes & Tracking of QAPI Activities
    - Monitoring Outcomes
    - Daily, Weekly, Monthly, Quarterly, Annual Reports
    - Data Management
    - Confidentiality
    - Operationalize Action Plans
    - Track Action Plan Outcomes
    - Prepares for Committees
    - Minutes / Attendance
    - Alignment with Perinatal Center Designation Criteria Requirements
    - Regional Advisory Council Participation
    - Disaster Management

Perinatal Program Manager

- Dedicated to Perinatal
- Or have other responsibilities
  - Maternal or Neonatal
  - Stroke
  - STEMI
  - Disaster
  - Emergency Department
- Does it matter?

Perinatal QAPI PS Roles & Responsibilities

- Departments
  - Commitment
    - Standard of Care Followed For Specific Area
    - Documentation Standards
    - Participation and Follow-Through with PI Action Plans
    - Specific Reports
    - Education Standards
    - Compliance to Perinatal Designation Criteria
    - Assist in Identifying Events
    - Attendance at Perinatal Operations Committee

Event Identification

- Event = Variation from Standard of Care or Standard of Practice or System Standard
- Events – Require Data Definitions
- Standard Event Review (Audit Filters/Indicators, Core Measures, Standards of Care, EBP Review)
- Patient Complications, Unexpected Outcomes
- Mortality
- Step 1: Event Identification and Validation
- Step 2: Define Impact To Patient Which is The ***Level of Harm***

IMPACT = Patient LEVEL OF HARM

Levels of Harm

- **No Harm** – Standard of care provided with some deviations with no impact to the patient
- **No Detectable Harm** – Event occurred but did not reach or impact patient; no treatment necessary
- **Minimal Harm** – Impact to patient, is **symptomatic, symptoms are mild, loss of function is minimal or intermediate** but short term, and **no or *minimal intervention necessary*** (extra observation, investigation review, minor treatment) is required

Levels of Harm

- **Moderate Harm** – Patient is **symptomatic, requiring an intervention (e.g. operative intervention,** therapeutic treatment), and increase in the length of stay, or **causing long term loss of function; requires higher level of care**; expected to resolve prior to discharge

Levels of Harm

- **Severe Harm** – Patient is symptomatic, requiring ***life-saving intervention*** or major **surgical/medical critical care intervention**, shortening life expectancy or causing major permanent or long term harm or loss of function; error in judgment, deviation from practice, system delays; impact quality of care; quality of life

Levels of Harm

- **Death** – death was caused or brought forward by the event

Levels of Harm

- **Temporary Harm** – Resolved by hospital discharge
- **Permanent Harm** – Does not resolve

LEVELS OF REVIEW

Levels of Review

- Primary Review – Event Validation / Documentation – Program Manager
  - Evaluate Concurrent Processes
  - Validation of event, Impact to Patient, Level of Harm, Patient Status
  - System Issue or Patient Impact
    - Level of Harm
    - Type of Event
    - Domain
  - Management Process Written in QAPI PS Plan
    - System issues with No Harm to Patient - Program Manager
    - Patient Impact with Harm – Medical Director Must Review
    - Physician Issues – Medical Director Must Review / Address
    - Complications, Failure to Provide Standard of Care, Death – Medical Director

Levels of Review

- Secondary Level of Review
  - Medical Director Screening – Triage
  - Review Impact, Level of Harm, Type of Event, Domain
  - Medical Director Confirms Level of Harm
  - Identifies and Defines the "Opportunity(ies) for Improvement"
  - Owns Review or Triages for Further Review
    - Referral To Specific Group with Timeline
    - PI Workgroup With Defined Action Plan and Timeline
    - Request Additional Data
    - Close
- Processes Written in QAPI PS Plan
- Secondary Level of Review - ALWAYS SCREENED BY Medical Director

Levels of Review

- Tertiary Review
  - Formal Review: Peer Review or System Operations
  - Morbidity / Mortality
  - Hospital Performance Improvement Meeting
  - Regional System Performance Improvement Meeting
  - EMS Performance Improvement Meeting
- Record Discussion (Matches Why Referred)
- Document Defined Action Plan
- Implement and Track Action Plan

Levels of Review

- Tertiary Review
  - Provider Peer discussion
  - Reason For Referral – Captured in Minutes
  - Discussion of Decision Making – Captured in Minutes
  - Factors that Led to Event
  - Discussion of How to Prevent or Mitigate in Future
  - Corrective Actions Plan – SMART Goals
  - Implement Corrective Action Plan
  - Beginning Tracking Process
- Caution – Track Referrals

Levels of Review

- Quaternary Review
  - External Review
  - Forums
    - External Peer Review
      - Region, State, Expert
    - Hospital Medical Staff Peer Review
    - Other Hospital Review
    - Affiliate Hospital Review

Perinatal QAPI PS Classification Process

- Event / Impact: Level of Harm to Patient
- Type: Communication, Clinical Management (Clinical Decisions), Patient Management (Coordination of Care)
- Domain: Who was Involved Setting; Where Incident Occurred; Phase of Care; When (day of week, time)
- Factors That Led To Event
  - Organizational Structure
  - Human (Patient, Provider, Staff)
- Corrective Action Plans
- Implement Corrective Action Plan
- Track Outcome of the Corrective Action Plan

Taxonomy or Classification Review Process

Taxonomy Review Process

EVENT IMPACT On PATIENT

Medical
- Psychological
- Physical

Non-Medical
- Legal
- Risk
- Social
- Economic

LEVEL OF HARM

Type of Event

- TYPE
  - Communication
  - Patient Management – Coordination of Care
  - Clinical Management – Clinical Decisions

TYPE

Communication
- Inaccurate or Incomplete Info
- Questionable Consent
- Questionable Advice or Interpretation
- Questionable Documentation

Patient Management
- Questionable Delegation
- Questionable Follow-up
- Questionable Referral or Consultation
- Questionable Utilization of Resources
- Timeliness of Activities
- Sequencing of Activities

Clinical Management
- Correct Procedure
  - Complicated / Disease Process
  - Untimely
  - Omission of Essential Procedure
  - Other
- Protocol / CPG Not Followed
- Wrong Procedure
  - Not indicated
  - Contraindicated
  - Wrong Patient
- Admit to Wrong Service
- Delayed Physician Response
- Lack of Follow-Through or Coordination
- Lack of Discharge Planning
- Excellent Outcomes

Taxonomy

- DOMAIN
  - Setting: Where in Hospital
  - What Phase of Care
  - When - Time of Day; Day Shift; Night Shift
  - When - Weekday vs Weekend
  - Who Was Involved – Staff, Physician, Nurse, Therapist, Other
  - Patient Population
  - Targeted Outcome

Contributing Factors

- Factors
  - Organization System Structure / Culture
  - Regional System
  - Hospital System
  - Technical
  - Medications
  - Human: Patient / Provider / Staff
  - Other

Contributing Factors

Structure / Process
- Resource Management
- Diversion / Bypass
- Service Capacity
- Bed Availability
- Translator Availability

Organizational Culture
- Coordination of Care
- Perinatal Designation Requirements Compliance
- Regulatory Compliance
- Ineffective Patient Safety Measures
- Standard of Care Not Defined

System Response
- Field Triage / Care
- Transfer Delay
- Transfer Transport
- Telemedicine Failures
- Other

Technical Issues
- IT/ EMR Issues
- Notification Process
- Equipment Failure
- Translator Availability

Medication Related Issue

Contributing Factors

Patient
- Uncooperative /Noncompliant
- AMA
- LWBS
- Pre-Existing Disease / Challenges
- Substance Abuse History
- Homeless
- Translation Issues

Provider Issue
- Skill Based
  - Error in Technique
  - Error in Priorities
- Knowledge Based
  - Error in Judgment
  - Error in Diagnosis
- Rule Based
  - Protocol/CPG/SOC Compliance
  - Regulatory Compliance
  - Credentialing

Fatigue
Behavior
Other

Contributing Factors

Hospital Staff
- Advanced Practice Provider
- Nurse
- Support Services
  - Nutrition
  - Lactation
  - Psychosocial
  - Rehabilitation
  - Pharmacist
  - RT
  - Radiology
- Tech
- Other
- Transferring Facility Staff

Contributing Factors
- Skill Based
- Error in Technique / Skill
- Knowledge Base
- Error in Judgment
- Out of Scope of Practice
- Protocol/Procedure Compliance
- CPG/SOC Compliance
- Failure to Communicate Pt Change in Condition
- Failure to Notify Chain of Command
- Fatigue
- Behavior
- Other

Corrective Action Plan to Address Opportunities

- Action Plan
  - Improve Safety Precautions
  - Improve Continuum of Care / Continuity of Care
  - Referrals
    - Hospital PI Committee
    - Perinatal Operations Committee,
    - M&M, Peer Review
    - Out of Hospital – Transferring Facility
    - Regional Advisory Council System PI
  - Selective Risk Reduction
    - Protocol, BPG Review / Development / Procedure Revision
    - Education – Content, Targeted Participants, Subject Matter Expert
    - PI Workgroup
    - Dashboard Review
    - Other

QAPI PS Action Plans

- SMART GOALS
  - S pecific
  - M easureable
  - A chievable
  - R elevant
  - T ime-Bound

QAPI PS Action Plan Follow-Through

- Implementation of Action Plan
- Process to Measure Achievement
- Achievements Compared to Desired Goal
- Continual Monthly Data Analysis – Shared at the Operations Committee
- Desired Goal Reached for Three Consecutive Months or Selected Time
- Re-visit in a Defined Timeframe
- If Continued Success – Resolution Achieved

Perinatal Quality Assessment Performance Improvement, Patient Safety Committees

Morbidity & Mortality Review

- Selected Cases
  - System Review
  - Educational Focus
  - Processes of Care / System Performance
- Opportunities For Improvement
  - Regional System
  - Coordination Through Phases of Care
  - Medical Staff
  - Nursing Staff
  - Support Staff
  - Processes of Care

Perinatal QAPI PS Peer Review

- Selected Cases (Defined by PI Plan)
- Medical Director Notifies Physicians
- Define Reason for Review
- Ensure All Elements of Review Are Available
- Minutes – Discussion Reflects Why Selected for Peer Review
- Physician Decision-Making and Priority Setting
- Sequencing of Care
- Confidentiality
- Action Plan
- Tracking Action Plan

Peer Review

- Self-Regulation
- Findings Engage Medical Staff
- Identify Elements that Led To Negative Outcomes
  - Communication Breakdown
  - Hand-off Issues
  - Untimely Responses
  - Local Processes That Failed
  - Barriers in Team Building
  - Deviations From Standards of Care
  - Skill or Technique
  - Knowledge
  - Fatigue

Change Agent

- Change Implementation – Changes to Improve Patient Care – Change at the Bedside
- Strategic Renewal – Change in Organizational Structure
- Change – Implementation of a New Standards of Care or Program Process Changes
- Improve Care at the Patient's Bedside Through the Continuum of Care

Data Management

Regional Collaboratives

- Aggregate Multicenter Data Collaboratives
- Community of Interested Colleagues With Common Goal
- Analyze Patient Selection, Processes of Care, and Outcomes
- Cultural and Political Benefits of Relationship Building
- Potential to Secure External Funding with Multi-Institutional Participation
- Data
- Leadership
- Shared Vision
- Multidisciplinary

Perinatal QAPI PS Plan: Reporting

- Reports To
- When and How Often
- Purpose of Meeting
- Agenda / Timelines
- Data Being Reported
- Confidentiality
- Hospital Integration
  - Automatic Referrals
  - Scheduled Reports
- Organizational Process

Perinatal Operations Committee

- Agenda
  - Welcome / Introduction
  - Minutes / Attendance
  - Statistical Report
    - Number of Perinatal Cases
    - Number of Admissions
    - Number of Transfers
    - Distribution of Admissions – L&D, Unit, ICU, Other
    - *Dashboard*
  - ***Perinatal Designation Requirements Compliance***
    - ***Response Times***
    - ***Outreach Education***
    - ***Ongoing Educational Requirements***
    - Continuing Educational Requirements Met
    - RAC Participation
    - Disaster Preparedness Activities
  - ***Performance Improvement Initiatives***
    - *Actions Plans Defined Through Review Process*
  - *Old Business*
  - *New Business*
  - *Open Discussion*
  - *Action Items*
  - *Priorities for Next Committee*
  - *Next Committee Date*
  - *Adjourn*

Perinatal Center Perinatal Quality Assessment Performance Improvement, Patient Safety Plan

Reporting Structure

BOARD OF MANAGERS / Executive Officers
- Quality Improvement Patient Safety Committees
- Responsible for Oversight, Authority, Priority Setting
- Responsible for Overall Regulatory Accreditation, Compliance

Medical Staff Peer Review Committee
- Responsible for Medical Staff Peer Review Process Defined by Bylaws
- Perinatal Peer Review Committee Summary Reports
- Define Expectations for Reporting

System Performance Improvement Patient Safety Committee
- Approve Division and Departmental Plans
- Responsible for Authority / Oversight of System Quality Performance
- Perinatal Performance Improvement Patient Safety Plan Review
- Define Expectations for Reporting

Perinatal Center Performance Improvement Patient Safety Processes
- Responsible for the Perinatal Designation Requirement Compliance and Perinatal Patient Outcomes
- Responsible for the Perinatal QAPI and Patient Safety Plan
- Responsible for the Perinatal Operations Committee Activities
- Responsible for the Perinatal M&M, and Peer Review Committee Activities

Perinatal QAPS PS System Integration

- Overall Hospital QAPI PI Integration / Hospital System
- Local / Regional System Participation and Activities
- EMS and Transport Agencies
- Emergency Center
- Transfers / Diversions
- Regional Data Collaboratives
- Emergency Preparedness & Planning

Perinatal QAPI PS : Event Resolution

- QAPI PS Processes Changed Outcomes
- Desired Measurable Difference
- Desired Outcome Reached
- Rate of Occurrence Changed
- Documented Compliance Achieved

- Defined By Medical Director / Committee

Event Resolution

- Event – Variance to Care Identified
- Level Of Harm
- Level of Review
- Identified Opportunities for Improvement
- Develop Action Plan
- Implement Action Plan – Provide Necessary Training
- Measure and Analyze Data Following Action Plan Implementation
- Identify Any Continuing Events
- Focus on Sustainability and Hard Wiring
- Designed Goal is Met and Sustained
- Event Resolution

Questions

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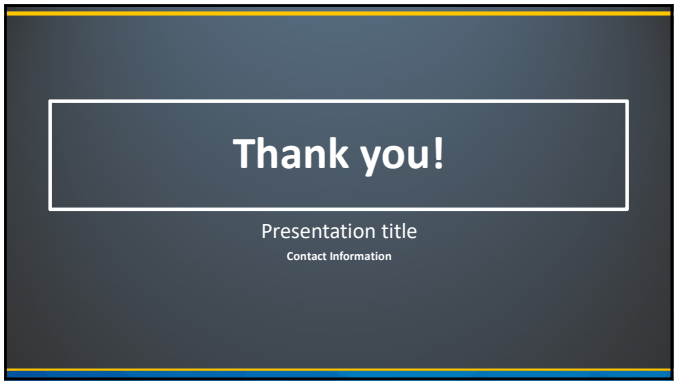
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