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Texas Department of State Health Services

Perinatal Quality Assessment Performance Improvement, Patient Safety Overview

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Goal

- Establish a consistent structure and processes for the Maternal and Neonatal Quality Assessment, Performance Improvement, Patient Safety Plan.

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Objectives

- Review the Administrator's, Medical Director's, and Program Manager's critical role in the process
- Review the structure and processes for a successful QAPI, PS Plan
- Demonstrate an understanding of the Levels of Harm
- Demonstrate an understanding of the actions taken during the Levels of Review
- Define the expectations of the QAPI PS Oversight Process
- Examine what is needed to demonstrate event resolution
- Examine how the QAPI, PS documents are integrated into the site survey planning process

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Maternal Rules

- QAPI Plan--Quality Assessment and Performance Improvement Plan. QAPI is a data-driven and proactive approach to quality improvement. It combines two approaches – Quality Assessment (QA) and Performance Improvement (PI). QA is a process used to ensure services are meeting quality standards and assuring care reaches a defined level. PI is the continuous study and improvement process designed to improve system and patient outcomes.

- The written Maternal Program Plan must be reviewed and approved by Maternal Program Oversight and be submitted to the facility's governing body for review and approval. The governing body must ensure that the requirements of this section are implemented and enforced.

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Maternal Rules

- The facility must demonstrate that the maternal QAPI Plan consistently assesses the provision of maternal care provided. The assessment will identify variances in care, the impact to the patient or level of harm, and the appropriate levels of review. This process will identify opportunities for improvement and develop a plan of correction to address the variances in care or the system response. An action plan will track and analyze data through resolution or correction of the identified variance.

- Maternal facilities must review their incidence and management of placenta accreta spectrum disorder through the QAPI Plan and report the incidence and outcomes through the Maternal Program Oversight.

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Neonatal

- Neonatal Program Oversight--A multidisciplinary process responsible for the administrative oversight of the neonatal program and having the authority for approving the defined neonatal program's policies, procedures, and guidelines for all phases of neonatal care provided by the facility, to include defining the necessary staff competencies, monitoring to ensure neonatal designation requirements are met, and the aggregate review of the neonatal Quality Assessment and Performance Improvement (QAPI) Patient Safety (PS) initiatives and outcomes. Neonatal Program Oversight may be performed through the neonatal program's performance improvement committee, multidisciplinary oversight committee, or other structured means.
- The facility must demonstrate that the neonatal QAPI Plan consistently assesses the provision of neonatal care provided. The assessment must identify variances in care, the impact to the patient or level of harm, and the appropriate levels of review. This process must identify opportunities for improvement and develop a plan of correction to address the variances in care or the system response. An action plan will track and analyze data through resolution or correction of the identified variance.

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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***.

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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 Oversight Process
- Note: Each facility has the opportunity to define their oversight structure

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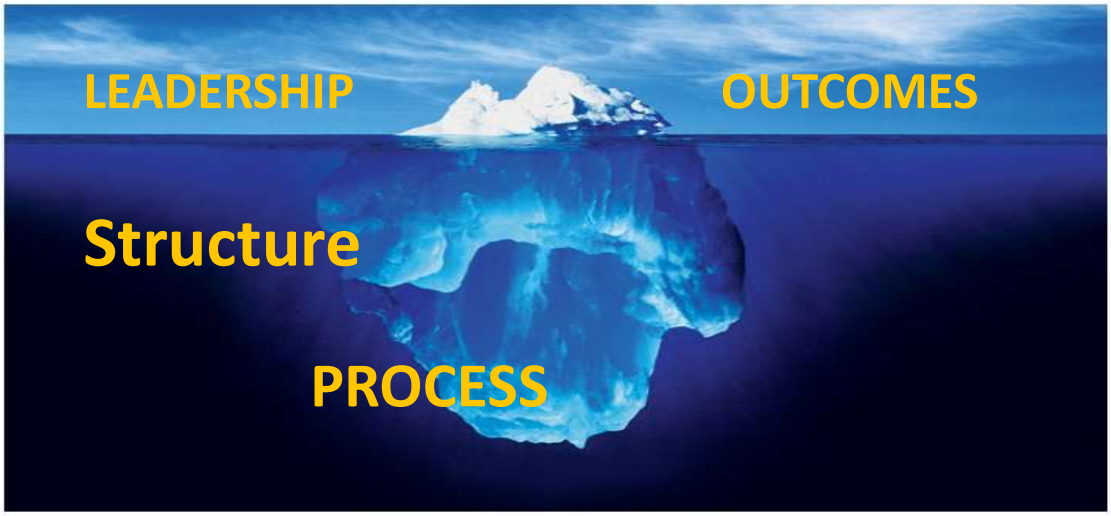
Culture of the Perinatal Center



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Quality Assessment Performance Improvement Models

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Performance Improvement Models

Six Sigma

Lean Model

Plan-Do-Study-Act

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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

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Culture of Safety

Change in	Change in Institutional Culture
Foster	Foster Environment for Safety and Reliability
Remove	Remove the “Culture of Blame”
Promote	Promote “Safety” and the Culture of Reporting

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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

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Culture of Safety: Resilience

- Team training
- Executive Safety Rounding
- Unit-Based Champion / Safety Teams – 2 PT ID; Hand-off; Bed-side Report
- Defined Checklists
- SBAR
- Just Culture – Accountability – System Issues
- Engage all levels of staff
- Safety Briefings

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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

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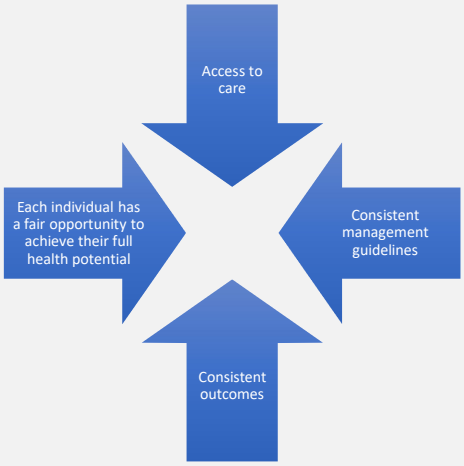
Equity



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Disparities or Inequities in Care

Differences in care

Access	Management guidelines or treatment	Outcomes

Differences between individuals across populations that are systemic, avoidable, or predictable

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Perinatal Program / Operational Plan - Structure

- Purpose
- Directive
- Program Mission
- Program Vision
- Culture of Safety Integration
- Program Overview
  - Patient Population and Scope of Services
  - Organizational Structure
  - Program Leadership / Chain of Command
  - Staffing Functions
  - Staff Education / Requirements / Competencies
  - Scheduling
  - Communication
- Clinical Areas
- Designation Requirements
- Program Liaisons
- Role of Telemedicine
- Rounding / Coordination of Care / Continuum of Care Functions
- Transfer Follow-up
- Discharge Planning and Follow-Through
- Psychosocial Support

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Operational Plan

- EBP Standards of Care
- Plan Oversight and Authority
- Role in Data Management
- Physician / APP Credentialing
- Staff Education and Credentialing Requirements
- Perinatal Oversight Process
- Benchmarking / Collaboratives
- Public Education / Outreach
- Disaster Integration
- Collaborative Practices
- Perinatal Care Regions - Regional Advisory Council Participation
- State Perinatal Advisory Council Participation
- Research
- Succession Planning
- Occupational Risk
- Appendices – Standards of Care, EBP, CPG, BPG

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Perinatal Quality Assessment Performance, Patient Safety Plan (QAPI PS)

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Perinatal QAPI PS Plan - Structure

- Scope and Authority
- Links with Perinatal Oversight Process
- Events or variations from standard of care – system or clinical
  - Standardized event reviews or "Triggers"
  - System Variations
  - Core Measures
  - Benchmarking Elements (Collaboratives)
  - Designation Requirements
- Processes for event identification
- Validation, Documentation, Define Level of Harm
- Levels of Review
- Integration of Physicians and Leaders
- Action Plans
- Tracking Action Plan and Analyzing Data
- Operations Committee
- M&M / Peer Review
- Event Resolution

(Child Health Corporation of America, Vermont Oxford Network and Institute for Healthcare Improvement)

(Maternal Quality Improvement Program)

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Perinatal Progression of Care

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

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System QAPI PS – Events

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 / Diversion
Activation of Disaster Response (Specific issues for mothers and babies)
Security System Failure
Failure to Meet Designation Requirements

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Perinatal QAPI PS Processes

- How, When, Events are Identified and Common Sources
- Event Documentation and Validation
- Impact to the Patient or ***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)

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Perinatal QAPI PS Plan

Structure of Event Review

- Event – Impact on Patient = Level of Harm
- Factors: What Led to Event
- Identify Opportunities for Improvement
- Creating Action Plan (Desired Change)
- Tracking Action Plan's Outcomes
- Event Resolution

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Perinatal Oversight

- Perinatal Oversight (Perinatal Administrative Committee)
  - May be the Perinatal Performance Improvement Committee (PIC)
  - Establish Perinatal Culture
  - Defines and Approves Operational Processes
  - Approves Management Guidelines
  - Reviews Compliance to Designation Requirements
  - Focuses on System Operations and System Performance
  - Reviews Identified "Perinatal Dashboard" of selected QAPI PS Elements- monthly, quarterly, annually
    - Neonatal Events
    - Maternal Events

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Perinatal QAPI PS Meetings / Committees

- Secondary Level of Review with Medical Director – Meeting
- Morbidity and Mortality Review (Meeting or Committee)
- Multidisciplinary Peer Review Committee
- OB / Neonatal Department Review Committee

- Plan Must Define Purpose and Role, Frequency of Meetings,
  - Attendance Requirements
  - Chair
  - Role in QAPI PS

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Perinatal QAPI PS Plan

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

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Perinatal QAPI PS Plan

- Integration with Hospital Quality and Risk
  - Their Role in QAPI Process
  - What Events Are Forwarded to Risk
  - When Does Perinatal Report to Hospital Quality Committee
    - What data is shared?
  - When Do You Report To Board?

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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

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Perinatal Program Authority

- CEO / CNO / VP / Administrative Leader
- Medical Director
- Program Manager / Director
- Commitment from Board and Executives
- Commitment from Medical Staff
- Job Descriptions
- Operational Plan (Scope of Service / Functions)
- Quality Assessment Performance Improvement Patient Safety Plan

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Getting Started

Establish Authority
Job Descriptions
Commitment
Management Guidelines and Established Processes
Admission / Scope of Service Guidelines
Transfer Guidelines
Educational Standards
Documentation Standards
Oversight Process
Written QAPI PS Plan
Staff Education and Credentials
Staffing Needs
Implementation Timeline
Tracking Process
Updates

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Perinatal QAPI PS Plan

What is the status of your Perinatal QAPI PS Plan?

How do you identify events?

How do you validate and document the event?

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Routine EVENT Screening

Routine Event Screening
- Indicators
- Audit Filters
- "Triggers"

Typical Elements of Care
- Linked to Regulatory, Designation Requirements or Mandatory Review
- Action in the Defined Management Guidelines
- Serve as a "Trigger" for a Deeper Review of the Case

Complications, Variances in Care, Delays in Care, Exceeds Expected LOS

Must Be Defined

May Have Time Parameters Established

All Deaths

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Management Guidelines

Institutional Specific Written Management Guidelines
- 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

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Required Maternal Management Guidelines

- Behavioral Health Disorders
- Discharge Planning and Follow-up
- Disaster Response – specific to mothers and babies
- Hypertensive Disorders
- Massive Transfusion Guidelines
- Obstetrical Hemorrhage
- Placenta Accreta Spectrum Disorder
- Sepsis or System Infection
- Shoulder Dystocia
- TOLAC- Immediately Available Response Guidelines
- Level III Facilities – MFM consult and response guidelines
- VTE
- Telemedicine Utilization
- Transfer Guidelines
- Bereavement Guidelines
- Lactation Guidelines

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Neonatal Required Management Guidelines

- Neonatal Resuscitation Guidelines
- Transfusion Guidelines
- Transfer Guidelines
- Psychosocial/Spiritual Care Guidelines
- Telemedicine Guidelines
- Retinopathy of Prematurity Screening Guidelines
- Lactation Guidelines

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Established Management Guidelines

- Evidence of education and training
- All staff and all areas providing care
- Resources required available
- What is monitored to validate compliance?
- How is non-compliance managed?

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Maternal Screening Events

- Adherence to Policies / Procedures
- Maternal Deaths
- Transfers
- Resuscitation Events
- Breastfeeding / Lactation
- Emergency Cesarean
- Imaging – Changes in Initial Read
- Lack of Pastoral/Spiritual Care
- Complications
- PASD Screening, Management, Outcomes
- Telehealth response
- Level III MFM Response Guidelines
- TOLAC – Physician Immediately Available Response
- Imaging Interpretation of CT, MRT, Echocardiography Appropriate for patient condition
- Unplanned or Unexpected admission to the ICU or OR

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Maternal Screening Events

- **Texas Collaboratives of Health Mothers and Babies (TCHMB)**
  - Obstetrical Hemorrhage
  - Perinatal Depression
  - Reduction in Racial/Ethical Disparities
- **Texas AIM**
  - Obstetrical Hemorrhage
  - Severe Hypertension
  - Obstetrical Care for Women with Opioid Use Disorder
- **Joint Commission**
  - Elective Delivery
  - Cesarean Section
  - Exclusive Breast Mild Feeding
  - Unexpected Complications in Term Neonates
  - Reduce Likelihood of Harm Related to Maternal Hemorrhage
  - Reduce the Likelihood of Harm Related to Maternal Hypertension/Preeclampsia

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Neonatal Screening Events (All Facilities)

- Accuracy of Medical Compounding
- Adherence to Policies / Procedures
- Blood Administration
- Neonatal Deaths
- Transfers
- Resuscitation Measures and Outcomes
- Changes in Initial Imaging Reads
- Pastoral/Spiritual Care Availability
- Urgent Response Request – Response Times
- Speech, Occupational or Physical Therapy Consult Response
- Lactation Support Availability
- Telehealth / Telemedicine Services
- Retinopathy of Prematurity Evaluation and Referral

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Neonatal Screening Events

- **TCHMB**
  - Increasing Breastfeeding and Human Milk Use in NICU
  - Infant Mortality
  - Neonatal Transitions in Care
- **Joint Commission**
  - Breastfeeding / Human Milk
  - Endotracheal Intubation
  - Evidence-Based Guidelines
  - Exclusive Breastmilk feeding
  - Feeding Techniques
  - Hospital – Acquired Infection
- **Joint Commission Cont'd**
  - Infant Mortality / Morbidity
  - Medication and Oxygen Admin.
  - Newborn Safety
  - Readmission
  - Nosocomial Infections
  - Resuscitation Events
  - Skin-to-Skin
  - Social Services Availability
  - Thermoregulation
  - Umbilical Line Placement
  - Unexpected Complications

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Vermont Oxford Network (VON)

- Brain Care
- Antibiotic Stewardship
- Chronic Lung Disease
- Cystic Periventricular Leukomalacia
- Golden Hour Interventions
- Human Milk
- Hypoxic Ischemic Encephalopathy
- Infections
- Initial Resuscitations
- Length of Stay
- Meconium Aspiration
- Mortality and Morbidity
- Nosocomial Infections ax
- Necrotizing enterocolitis
- Patient care resources – limited settings
- Pneumothorax
- Readmissions
- Retinopathy of Prematurity Evaluation
- Seizures
- Severe Interventricular Hemorrhage (SIVH)
- Surgery
- Therapeutic Hypothermia
- Transfers
- Transitions in care

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Adverse Events

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

Neonatal - An injury, large or small, caused by the use (including non-use) of a drug, test, or medical treatment.

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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

Perinatal Care (PC) (v2023A) (jointcommission.org)

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PC.06.01.01 Reduce the Likelihood of Harm Related to Maternal Hemorrhage

- Complete an Assessment Using EBP Tool for Determining Maternal Hemorrhage Risk on Admission to L&D and on Admission to Postpartum
- Develop a Written EBP for State-Based Management of Pregnant and Postpartum patients Who Experience Maternal Hemorrhage
  - Use of EBP set of emergency response medications that are immediately available on the obstetric unit
  - Required response team members and their roles in the event of severe hemorrhage
  - How the response team and procedure is activated
  - Blood bank plan and response for emergency release of blood products and how to initiate the hospital's massive transfusion procedure
  - Guidance on when to consult additional experts and consider transfer to higher level of care
  - Guidance on how to communicate with patients and families during event
  - Criteria for when a team debrief is required immediately after a case of severe hemorrhage

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PC.06.01.01 Reduce the Likelihood of Harm Related to Maternal Hemorrhage

- Where is the standardized, secured, dedicated hemorrhage supply kit?
  - Must have Emergency Hemorrhage Supplies defined by Procedure
  - Must have Hospital's Approved Procedure for Severe Hemorrhage Response
- Conduct Drills at Least Annually – Multidisciplinary Drills
- Review Cases
- Patient and Family Education
  - Signs and Symptoms of Postpartum Hemorrhage (Hospital and Following Discharge)
  - How to Seek Assistance

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PC.06.01.01 Reduce the Likelihood of Harm Related to Maternal Hemorrhage

- What Needs to Be In Place for Compliance?
- Who Needs to Be Educated?
- What Events for Review Might Be Established
- Remembers Event Finding Are Associated with Need for Deeper Review
- How Do You Track the Response Team's Timeliness of Response and Actions
- How to You Track When the Emergency Release of the Blood and When the Blood Transfusion is Initiated?
- How Do You Document Variances from Procedure?

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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
- Restoring Access to Maternity Care in Rural America | Commonwealth Fund
- Rural Maternity and Obstetrics Management Strategies (RMOMS) Program | HRSA

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Patient Safety 2024

- *Incorporate Joint Commission Patient Safety Standards*
- *Improve the accuracy of patient identification*
- *Improve the effectiveness of communication among caregivers*
- *Improve the safety of using medications*
- *Reduce patient harm associated with clinical alarm systems*
- *Reduce the risk of risk of health care –associated infections*
- *Hospital identifies safety risks inherent in its patient population*
- *Improve health care equity*
- *(https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/2024/npsg_chapter)*

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QAPI Roles and Responsibilities

TEXAS Health and Human Services | Texas Department of State Health Services

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Perinatal QAPI PS Roles & Responsibilities

- Administrator
  - Commitment
    - Authority and Scope
    - Hospital Integration
    - Funding
    - Resources
    - Contract Metrics
    - Hospital Leadership
    - Hospital Commitment

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Perinatal QAPI PS Roles & Responsibilities

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

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Perinatal Medical Director Contracts

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

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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
    - Monitors Perinatal Center Designation Criteria Requirements
    - Regional Advisory Council Participation
    - Perinatal Advisory Council
    - Disaster Management

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Perinatal QAPI PS Roles & Responsibilities

- Departments
  - Commitment
    - Management Guidelines Followed For Specific Area
    - Documentation Standards
    - Participation and Follow-Through with PI Action Plans
    - Specific Reports
    - Education Standards
    - Compliance to Perinatal Designation Requirements
    - Assist in Identifying Events
    - Attendance at Perinatal Oversight Committee(s)

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Event Identification

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

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IMPACT = Patient LEVEL OF HARM

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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

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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

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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

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Levels of Harm

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

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Levels of Harm

TEMPORARY HARM – RESOLVED BY HOSPITAL DISCHARGE

PERMANENT HARM – DOES NOT RESOLVE

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VON Neonatal Level Of Harm

- Category E: Contributed to or resulted in temporary harm to the patient and required intervention
- Category F: Contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization
- Category G: Contributed to or resulted in permanent patient harm
- Category H: Required intervention to sustain life
- Category I: Contributed to or resulted in patient's death

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Identify Opportunities for Improvement

- What was the outcome?
- Was the system response appropriate?
- Was the team's response timely?
- What were the pre-existing conditions?
- Were management guidelines followed?
- What were the circumstances surrounding the event?
- Who was involved and what safety goals were related?
- Were staffing and resources appropriate?
- Were there knowledge and skill variations?
- Were there associated performance or behavioral events?

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LEVELS OF REVIEW

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Levels of Review

Primary Review – Event Validation / Documentation – Program Manager

- Evaluate Concurrent Processes
- Validation of event, Impact to Patient or 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

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Levels of Review

Secondary Level of Review

- Medical Director Screening – Triage
- Review Level of Harm, Contributing Factors
- 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

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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

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Levels of Review

Tertiary Review

Provider Peer discussion
Reason For Referral – Captured in Minutes
Discussion of Standard of Care – Opportunities Captured
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

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Identify Opportunities for Improvement

- What was the outcome?
- Was the system response appropriate?
- Was the team's response timely?
- What were the pre-existing conditions?
- Were management guidelines followed?
- What were the circumstances surrounding the event?
- Who was involved and what safety goals were related?
- Were staffing and resources appropriate?
- Were there knowledge and skill variations?
- Were there associated performance or behavioral events?

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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

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QAPI PS Action Plans

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

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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 – Event Resolution Achieved
- Hardwire the Change

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Summary

Understand the Why

Define the Structure

Define the Process

Define the Events to be Reviews

Opportunities for Improvement
What Change is Needed

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Perinatal Quality Assessment Performance Improvement, Patient Safety Committees

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Successful Committee Meetings

- Scope of Work – Plan
- Meeting Frequency - Plan
- Defined Reporting Structure - Plan
- Integration with Other Departments
- Established Quality and Safety Standards
- Data Driven Metrics
- Identifies Opportunities
  - Develops Targeted Interventions
  - Monitors and Analyzes Effectiveness
  - Integrates Change Management Theories
  - Integrates Transformational Principles
- Coordinates External Collaboratives
- Ensure Dissemination of Information
- Bi-Directional Flow of Information

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Multidisciplinary QAPI PS Review

- Led By Medical Director
- Focus on ***Secondary Level of Review***
- Multidisciplinary
- Program Manager – Co-leads – Minutes
- Nursing Leaders
- Support Clinical Services
- All Departments Involved

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Morbidity & Mortality Review

Selected Cases	Opportunities For Improvement
• System Response • Patient Disease Process • Processes of Care: Coordination of Care, Timeliness of Care • Physician • Nursing	• Regional System • Coordination Through Phases of Care • Medical Staff • Nursing Staff • Support Staff • Processes of Care

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Perinatal QAPI PS Peer Review

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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

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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

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QAPI: Change Agent

- Purpose of QAPI – Identify variances in care
- Processes of QAPI – Produce Change
- Change in Care Practices
- Changes in Continuum of Care
- Promotes Safety Culture
- Change in Organizational Processes
- ***IMPROVES CARE***

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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

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Perinatal Oversight

- 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***
  - ***Performance Improvement Initiatives***
    - *Actions Plans Defined Through QAPI Review Process*
  - *Old Business*
  - *New Business*
  - *Open Discussion*
  - *Action Items*
  - *Priorities for Next Committee*
  - *Next Committee Date*
  - *Adjourn*

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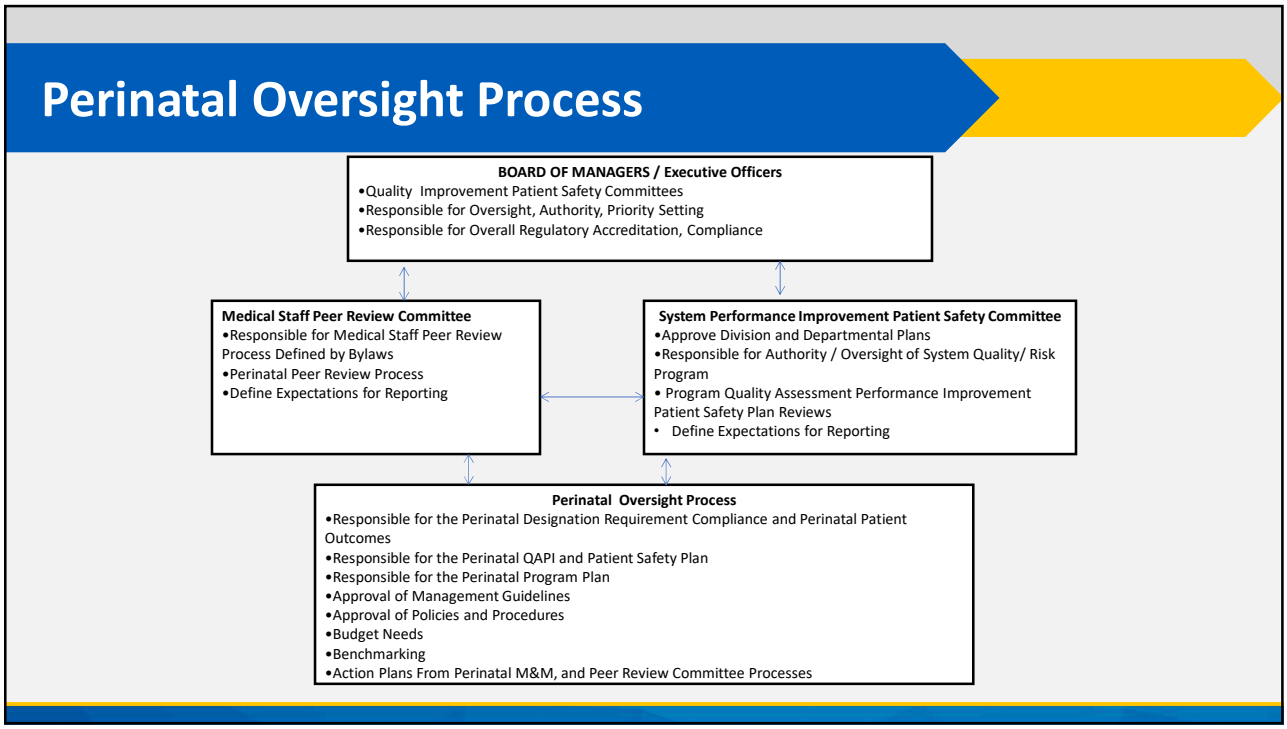
Perinatal Oversight Process



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Perinatal QAPI PS System Integration

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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

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QAPI PS Plan Summary

Written QAPI PS Plan

- Event – Variances in 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

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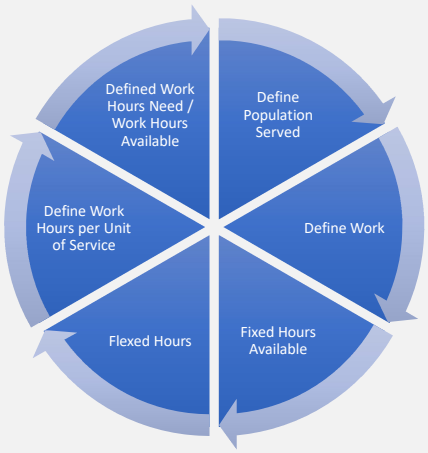
Perinatal Program Staffing Considerations



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Planning for Perinatal Site Survey

Prepare QAPI PS Documents

- Meeting Minutes
  - Complete, Signed by Medical Director, Dated, Attendance Requirements
  - Minutes Reflect Discussion,
  - Meeting PowerPoint and Data Available
- Case Reviews
  - Timely, Complete, Action Plan Defined, Tracked, Analyzed to Event Resolution
  - QAPI PS for Each Case in A Folder with All Relevant Documents
  - Staff Serving as Navigators Can Explain all Processes
  - Prepare for In-Person and Virtual Surveys

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Site Surveyors

- Prepare For Review – Read the QAPI PS Plan
- One Surveyor Assigned to Review Completeness of QAPI PS Plan
- All Surveyors Review the QAPI PS Processes During Medical Record Review
- Identify is Management Guidelines Followed– If Not Was QAPI PS Completed
  - Level of Harm, Level of Review, Action Plan Appropriate, Reached Event Resolution
  - If QAPI PS Not Evident – Ask, Escalate to Program Manager
  - Be Prepared to Review Cases and Associated QAPI PS During Open and Closed Meetings
  - Provide Summary of Case Reviews and QAPI PS Processes

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Questions

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Bibliography

Agency for Healthcare Research and Quality (2019). Levels of Harm Classification. Retrieved from: https://ahrq.gov/levelsofharm.

American College of Surgeons. (2017). Optimal Resources for Surgical Quality and Safety. American College of Surgeons. Chicago, IL.

Burke, W.W. (2014). *Organizational Change: Theory and Practice*. (4th ed.). Los Angeles, CA; Sage.

Chang, A., Schyve, P.M., Croteau, R.J., O'Leary, D.S., Loeb, J.M. (2005). The JCHAO patient safety taxonomy : a standardized terminology and classification schema for near misses and adverse events. *International Journal of Quality in Health Care*. DOI: 10.1093/intqhc/mzi021.

Fair, L.R., Pebbles, C. (2016). Rural level IV trauma center: more than a community hospital. *Journal of Emergency Nursing*. 42(1). DOI: 10.1016/jen.2015.12.002.

Graff, L., Stevens, C., Spaite, D., Foody, J. (2002). Measuring and improving quality emergency medicine. *ACAD Emerg. Med*. 9(11). Retrieved from www.aemj.org.

Hoppes, M., Mitchell, J. (2014). Serious safety events: a focus on harm classifications. *American Society for Healthcare Risk Management.*

Joint Commission (2019) Perinatal Core Measures. Retrieved from: https://manual.jointcommission.org/releases/TJC20201/PerinatalCare.

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Bibliography

Santan, M.J., Straus, S., Gruen, R., Stelfox, H.T. (2012). A qualitative study to identify opportunities for improving trauma quality improvement. *Journal of Critical Care*. DOI: 10.1016/j.jcrc.2013.07.010.

Smith, H.I., Dean, H.C., Sidwell, R.A. (2016). Understanding an inclusive trauma system through characterization of admissions at a level IV center. *American Journal of Surgery*. DOI:10.1016/j.amjsurg.2015.12.023.

Society of Trauma Nurses. (2020). *Trauma Outcomes and Performance Improvement Course*. Lexington, : Society of Trauma Nurses.

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Thank you!

DSHS Perinatal QAPI PS Overview

- Rebecca Wright
- Celia Cantu
- Debra Lightfoot
- Dorothy Courage
- Elizabeth Stevenson
- Jorie Klein

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