Quest for Zero: Excellence in OB

BETA Healthcare Group (BETA) is focused on improving reliability and reducing risk exposure in perinatal services. As your partner in patient safety, BETA provides our fully insured members and insureds the opportunity for significant reduction in contribution or premium each policy year. The Quest for Zero: Excellence in OB program offers a tiered approach to this award. BETA organizations that provide perinatal services are eligible to participate on an annual basis in project work designed to enhance the quality of care in this high-risk clinical setting.

Menu Selection:

BETA is pleased to continue to fully sponsor the Relias Platform (formerly GNOSIS™) for our members and insureds. Tier One participants must complete the *Fetal Heart Monitoring V2* personalized learning module to assess clinical knowledge and judgment pertaining to electronic fetal heart rate monitoring and maternal physiology. Organizations must meet 100% compliance in all the components of Tier One to qualify for credits in Tier Two. Note: the assessment component now includes a performance improvement measure for those organizations taking a re-assessment of the Relias Platform that must be met to achieve compliance in Tier One.

Organizations receive additional benefits for implementing optional Tier Two strategies customized to meet the needs of the individual member's risk profile. A description of each strategy, subcomponents and the associated metrics are contained within this OB Guideline applicable to the 2024 policy period (7/1/2024-6/30/2025).

Value of Participation:

Tier One is valued at 2% of your total annual premium, related to the first $5 million in limits purchased. There is the opportunity to gain additional credits by choosing up to two additional loss prevention options in Tier Two, each worth 2% if all criteria are met. This represents a potential annual contribution renewal credit of up to 6%.

Get Started:

Please review the Quest for Zero: OB Guideline carefully. Please note: The clock starts ticking at the beginning of your policy period and validation surveys must be completed 60 days prior to policy renewal.

We value our members and insureds and appreciate your continued interest in BETA's Quest for Zero, as we strive to maintain excellence in perinatal services. Please do not hesitate to reach out to BETA's risk management staff that will assist you in designing a plan for success.

For additional information about the OB Quest please contact Narcisa Palma, Manager, Risk Management and Patient Safety-Perinatal at narcisa.palma@betahg.com or at 818-242-0123.

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Annual EFM Assessment
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
The Relias Platform personalized learning module *Fetal Heart Monitoring V2* is completed by all perinatologists, obstetricians, family practitioners, certified nurse midwives and residents with privileges to perform delivery within 3 months of credentialing and/or after July 1 and before May 1 of the policy year.* This includes all new employees of the medical staff and independent practitioners. *HealthPro insureds must meet the requirement within their annual policy period	☐ **Met** ☐ **Not Met**	☐ Medical staff roster is due to BETA on date of validation survey ☐ Relias report to demonstrate completion of assessment
All nursing staff, to include travelers and registry who deliver babies, must complete the Relias Platform personalized learning module *Fetal Heart Monitoring V2* within 3 months of hire, or assignment and/or after July 1 and before May 1 of the policy year.* *HealthPro insureds must meet the requirement within their annual policy period	☐ **Met** ☐ **Not Met**	☐ Nursing staff roster is due to BETA on date of validation survey ☐ Relias report to demonstrate completion of assessment
Based on the Relias Individual Learning Path, participant must complete all designated "Red & Yellow Zones" by May 1 of the policy year.* *HealthPro insureds must meet the requirement within their annual policy period	☐ **Met** ☐ **Not Met**	☐ Evidence of Individual Learning Path completions
Perinatal units performing reassessment of the Relias Platform personalized learning module *Fetal Heart Monitoring V2* must show a combined average score improvement of 1.5% in the knowledge domain. A provider and/or nurse unit average in the upper 25th percentile need only maintain that upper quartile.	☐ **Met** ☐ **Not Met**	☐ Relias analytics report showing an overall increase in Knowledge Domain scores of 1.5% (or scores in upper quartile)

The requirement for an ACOG approved educational course on EFM principles and assessment upon initial credentialing and at a minimum of every two years thereafter. This is contained in OB privilege form and/or adopted as a Rule and Regulation of the department.	☐ **Met** ☐ **Not Met**	☐ Review of OB privilege form and/or R&R of department for policy language stipulating this as a requirement for privileging
The requirement for an ACOG or AWHONN approved educational course on EFM principles and assessment upon initial hire and at a minimum every two years thereafter. This is contained in the L&D nurse job description or annual competency assessment.	☐ **Met** ☐ **Not Met**	☐ Review of nursing job description, annual competency, and/or human resources policy which stipulates this requirement

Standard Nomenclature
National Institute of Child Health and Human Development (NICHD)
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Standard terminology in accordance with NICHD (2008) and endorsed by ACOG and AWHONN is reflected throughout documentation of clinical practice. • "Reassuring" and "non-reassuring" is no longer utilized and, instead, replaced with Category descriptors • "Hyperstimulation" is replaced with the term "tachysystole" • Fetal distress" and "perinatal asphyxia" are no longer utilized • Descriptors in accordance with NICHD are used when describing variability such as absent, minimal, moderate, or marked All narrative documentation by physician and nurses are compliant with the above terminology.	☐ **Met** ☐ **Not Met**	☐ Medical records of the last ten deliveries occurring at the facility for review
All electronic medical record documentation fields are compliant with the above terminology.	☐ **Met** ☐ **Not Met**	☐ Review of, the electronic medical record documentation to include electronically stored fetal heart rate tracings
All paper documentation records are compliant with the above terminology to include all flow sheets and order sets.	☐ **Met** ☐ **Not Met**	☐ Review of, all paper documentation, scanned or in print, which pertains to the delivery of the above population
All policy and procedures of the department reflect the above changes in terminology.	☐ **Met** ☐ **Not Met**	☐ Review of policy and procedures applicable to the Labor and Delivery setting

OB Rapid Delivery Bundle – Readiness
Must complete Readiness, Recognition, Response & Reporting/Learning Systems
OB Rapid Delivery can be implemented over a two-year period
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
An interdisciplinary OB emergency response protocol is in place and approved by medical staff. Protocol must include: • Requirements for a timely response to maternal and fetal indications • A process for assembling the team (OB, Anesthesia, OR Support), including a mechanism for team notification • Readiness and availability requirements for an operating room and OR support personnel • Fetal monitoring guidelines in the OR • Nurse authority to move patient to the OR, open OR	☐ **Met** ☐ **Not Met**	☐ Emergency Response policy
Assessment of physical plant in relation to achieving a rapid cesarean section, including a remediation plan for potential barriers.	☐ **Met** ☐ **Not Met**	☐ Physical plant self-assessment and remediation plan, if applicable
Conduct drills/simulations in performance of emergency cesarean deliveries, including neonatal resuscitation on an annual basis. Team members who respond to emergent cesareans will be identified and shall be included in the simulation/drill exercise. This may include anesthesia, obstetrics, neonatal team members (neonatologist, RN, RT), techs, lab, etc. All drills include a debrief to inform PI activities.	☐ **Met** ☐ **Not Met**	☐ Dated sign-in-sheets indicating participation by all staff and providers ☐ Debrief forms

OB Rapid Delivery Bundle – Recognition
Must complete Readiness, Recognition, Response & Reporting/Learning Systems
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
A standardized approach for management of Category II FHR tracings is in place and approved by medical staff. Recommend the Algorithm for Management of Category II tracings or the 5-Teir Fetal Heart Classification	☐ **Met** ☐ **Not Met**	☐ Policy/protocol review & algorithm review ☐ Review of medical records
Ability of providers to review tracings off-site/on-site. Providers have access to and can review tracings 24/7 either through computer system, smartphone, faxing, central monitoring, or remote monitoring in call rooms/office	☐ **Met** ☐ **Not Met**	☐ Observation
A policy/protocol is in place to safeguard against signal ambiguity. • On admission maternal and fetal pulses are distinguished as separate • Pulse oximeter or palpation is used to differentiate maternal/fetal heart rates and if the technology exists, maternal pulse is shown on the fetal heart tracing • Pulse Ox is used continuously in the second stage of labor, while fetal monitor is being used • Nurses are educated/trained on signal ambiguity	☐ **Met** ☐ **Not Met**	☐ Policy/protocol review ☐ Signal ambiguity education reflected in dated sign-in sheets ☐ New nurse orientation education requirements

Interdisciplinary strip rounds/huddles are conducted at a minimum of once per shift Ideally on real time tracings, but less busy hospitals may use other methods such as Perifacts Recommended more frequently to maintain situation awareness Huddles may be called by any member of the team at any time to discuss the plan of care or a tracing	☐ **Met** ☐ **Not Met**	☐ Strip review rounds/huddles documented on daily staffing sheet, charge RN board, or sign-in sheets
Credentialing: Staff and providers (excluding residents) must be in the top 25th percentile for knowledge score in the Relias Platform personalized learning module, *Fetal Heart Monitoring V2* to use as an alternative Tier 1 strategy.*	☐ **Met** ☐ **Not Met**	☐ Relias analytics report showing scores in upper quartile

*The OB Rapid Delivery Bundle may be used as an alternative strategy to meet Tier 1 criteria provided members meet the following:
- *Evidence of both staff and providers having completed and maintained scores in the upper quartile for The Relias Platform personalized learning module Fetal Heart Monitoring - Knowledge domain.*
- *Members are still required to maintain compliance with NICHD standard nomenclature.*
- *Please contact Narcisa Palma, Manager, Risk Management and Patient Safety-Perinatal at narcisa.palma@betahg.com or at 818-242-0123 to confirm your eligibility.*

TIER 1 or TIER 2
OB Rapid Delivery Bundle – Response
Must complete Readiness, Recognition, Response & Reporting/Learning Systems

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
A protocol addressing role delineation and responsibilities for OB emergencies is in place and includes: • Standard work for assignment of nursing emergency roles each shift • Visual indicators of roles and responsibilities in the OR (e.g., color-coded cards, laminated wall posters • All members of OB Emergency Response Team (including anesthesia, respiratory technicians, and other extra-departmental staff) must receive training on the roles and responsibilities of staff in response to OB Emergencies.	☐ **Met** ☐ **Not Met**	☐ Protocol for role delineation ☐ Evidence of training for role delineation (agenda and dated sign-in sheets)
All staff and providers in L&D, antepartum, postpartum, and NICU must complete training in a systematic means of communication used in health care (for example, the module *Structured Communication for Healthcare Providers* offered through the Relias Platform, or TeamSTEPPS). Implement and utilize I*SBAR+R* or similar tool during anticipated or actual OB emergency Communication during an emergency is reviewed during debrief, including use of I*SBAR+R* or similar tool	☐ **Met** ☐ **Not Met**	☐ Evidence of communication training reflected in Relias completion reports or dated sign-in sheets ☐ Review of communication tool ☐ Observation on unit ☐ Review of debrief tool

Implement a unit-specific chain of command policy.	☐ **Met** ☐ **Not Met**	☐ Review of chain of command policy with flow diagram
A protocol addressing standardized nomenclature for clinical urgency of cesarean birth is in place and readily available to all members of the team. Standardized nomenclature is used in practice and reflected in documentation when communicating about anticipated or actual cesareans All members of the team are trained in use of this nomenclature	☐ **Met** ☐ **Not Met**	☐ Protocol review ☐ Evidence of training is reflected in dated sign-in sheets ☐ Medical record review
Implement a policy or protocol with indications/triggers on when to obtain umbilical arterial and venous cord gases. At minimum, this should include all emergently delivered cases and those with low Apgar scores (<7 at 5 minutes).	☐ **Met** ☐ **Not Met**	☐ Policy / protocol review ☐ Medical record review
Implement a policy or protocol with indications/triggers for placental pathology, to include at minimum all emergently delivered cases and those with low Apgar scores.	☐ **Met** ☐ **Not Met**	☐ Policy review ☐ Medical record review

OB Rapid Delivery Bundle - Reporting/Learning Systems

Must complete Readiness, Recognition, Response & Reporting/Learning Systems

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Post event team debriefs are held, at minimum, following each emergent cesarean delivery.	☐ **Met** ☐ **Not Met**	☐ Review of debrief forms
PI process is in place for tracking and follow up on identified issues. Process for tracking process improvement (log)	☐ **Met** ☐ **Not Met**	☐ Review of PI log
Monitor decision-to-incision (D2I) or decision-to-delivery (D2D) times for evidence of operational response to level of urgency classification.	☐ **Met** ☐ **Not Met**	☐ Review data for D2I or D2D times for all levels of urgency
Post-Event review processes are in place. Multi-disciplinary review of serious events for system issues Criteria for peer review/accountability of providers and staff	☐ **Met** ☐ **Not Met**	☐ Review criteria for multi-disciplinary or peer review

TIER 2
Burnout & Well-Being Bundle - Readiness
Must complete Readiness, Recognition, Response & Reporting/Learning Systems
Burnout can be implemented over a two-year period
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Establish an interdisciplinary Wellness Committee that includes an Executive Leader Sponsor/Champion. The Wellness Committee should be unit-based or have ample OB representation on an established hospital-wide committee. The Wellness Committee meets on a regular and continuing basis.	☐ **Met** ☐ **Not Met**	☐ Evidence of Wellness Committee meeting minutes/charter
Clinicians (providers, nursing, ancillary staff) have been educated on the issue of burnout. The education should include: • Definition of burnout • Scope of the problem • Signs and symptoms of burnout • Degrees of burnout (emotional exhaustion, cynicism, disengaged) • Culture supporting open discussion of burnout/well-being – normalization • Impact of burnout on patient safety • Interventions to prevent/address burnout	☐ **Met** ☐ **Not Met**	☐ Unit staff roster; Medical staff roster ☐ Review of educational content and evidence of staff/provider education reflected in dated sign-in sheets ☐ Review of medical staff meeting minutes

TIER 2
Burnout & Well-Being Bundle - Recognition
Must complete Readiness, Recognition, Response & Reporting/Learning Systems
Burnout can be implemented over a two-year period
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Assess the scope of the problem in Perinatal Services by administering a Culture of Safety or Engagement Survey that includes questions related to burnout (may also include resilience, emotional thriving, and emotional recovery). In lieu of a culture/engagement survey, you may administer published burnout inventories such as the Mini-Z Burnout Survey or Maslach Burnout Inventory.	☐ **Met** ☐ **Not Met**	☐ Evidence of survey results or inventories specific to burnout in perinatal services
Debriefs, or facilitated discussions, are held with staff and providers to gain insight into the causes of burnout and possible solutions.	☐ **Met** ☐ **Not Met**	☐ Evidence of debrief sessions and findings

Burnout & Well-Being Bundle – Response
Must complete Readiness, Recognition, Response & Reporting/Learning Systems
Burnout can be implemented over a two-year period
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Select at least one intervention to address burnout based on survey data, debrief sessions, and provider/staff input. Interventions may include, but are not limited to: • Techniques from positive psychology literature, positive rounding (executive leader rounding) • Decreasing administrative burdens, unnecessary work, time flexibility • Enhancing teamwork, camaraderie, peer support • Briefings and huddles • Mindfulness training	☐ **Met** ☐ **Not Met**	☐ Review of selected intervention ☐ Review of staff/committee meeting minutes

Burnout & Well-Being Bundle – Reporting/Learning Systems
Must complete Readiness, Recognition, Response & Reporting/Learning Systems
Burnout can be implemented over a two-year period
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Measure burnout scores over time (baseline, annual) using a culture survey, engagement survey, or burnout scale/inventory	☐ **Met** ☐ **Not Met**	☐ Evidence of data collection and performance
Use a performance improvement method such as PDCA. Include outcome and process measure included for each intervention.	☐ **Met** ☐ **Not Met**	☐ Evidence of performance improvement methodology ☐ Review of outcome and process measures developed
Choose at least one additional outcome measure such as: • Nursing turnover rates (perinatal specific) • Patient satisfactions scores • Medical errors, medication errors, maternal or neonatal morbidity and mortality measures, quality measures	☐ **Met** ☐ **Not Met**	☐ Evidence of data collection and performance
Report metrics developed at staff meetings, huddles, and the appropriate medical staff committee meetings.	☐ **Met** ☐ **Not Met**	☐ Review of staff/committee meeting minutes (or excerpt indicating reporting component)

TIER 2
Team Training & Communication
Part 1 (Year 1)
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Team Training Opt-In is completed and there is a unit-based agreement to deploy TeamSTEPPS principles. A baseline readiness assessment is conducted and reviewed by senior leadership. Senior leadership supports the pursuit of team training in the perinatal setting as evidenced by attestation of the baseline assessment.	☐ **Met** ☐ **Not Met**	☐ Signed Opt-In agreement ☐ Evidence of baseline readiness assessment findings and signed attestation of senior leadership's support of the principles
Develop in-house staff (a minimum of 2) as certified trainers utilizing the "train the trainer" methodology to deploy TeamSTEPPS training *BETA has certified Master Trainers who are available to you free of charge.* *For more information about this training please contact Narcisa Palma at narcisa.palma@betahg.com*	☐ **Met** ☐ **Not Met**	☐ Evidence of certificates of completion of training of two master trainers (at a minimum)
All staff that practice in the perinatal service area are trained in TeamSTEPPS principles utilizing an interdisciplinary model of training. This includes all medical and nursing staff to include anesthesia, obstetrics, neonatal services and/or those who respond to OB emergencies.	☐ **Met** ☐ **Not Met**	☐ Review of education and training material. ☐ Evidence of participation by all staff is reflected in dated sign-in sheets.
Perinatal leadership meets monthly with BETA Manager during policy year for project mentorship and support according to opt in agreement.	☐ **Met** ☐ **Not Met**	☐ Evidence of participation in monthly meetings (provided by BETA).

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Reassessment is completed within 6 months of department training.	☐ **Met** ☐ **Not Met**	☐ Reassessment findings are reviewed.
Two or more of the following communication tools and strategies are selected and implemented, all staff, nursing staff and physicians are educated to the process. **Communication-** • SBAR • Call Out • Closed Loop Communication • Teachback, • IPASS **Leading Teams-** • Brief • Huddle • Debrief **Mutual Support-** • Task Assistance • Formative Feedback • Advocacy and Assertion • Two Challenge Rule • CUS • DESC Script **Situation Monitoring-** • I'M SAFE • Cross Monitoring • STAR • STEP	☐ **Met** ☐ **Not Met**	☐ Selected Tools and Strategies are reviewed. ☐ Review of training and education materials. ☐ Evidence of completed education by all staff is reflected in dated sign-in sheets.
Selected tools and strategies are incorporated into the annual department specific skills, simulations and drills. A debrief is conducted upon completion of all simulations and drills.	☐ **Met** ☐ **Not Met**	☐ Evidence of implemented tools and strategies incorporated into annual department skills, simulations and drills. ☐ Review of debrief tool.

Track and Monitor effectiveness of the implemented tools and strategies as a monthly performance improvement measure beginning no later than month 6 of the policy year.	☐ **Met** ☐ **Not Met**	☐ Evidence of data collection and performance.
Perinatal leadership meets monthly with BETA Manager during policy year for project mentorship and support according to opt in agreement	☐ **Met** ☐ **Not Met**	☐ Evidence of participation in monthly meetings (provided by BETA).
Implementation of annual TeamSTEPPS refresher and new hire education.	☐ **Met** ☐ **Not Met**	☐ Review of training and education materials.

Culture of Safety
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Unit specific information regarding staff perceptions of patient safety across perinatal services is gathered utilizing a psychometrically sound, scientifically valid survey instrument. A 60% response rate is required to ensure statistical significance. The following instruments meet this requirement: - SCORE Survey by Vizient Safe & Reliable Healthcare - Press-Ganey Survey - Agency for Healthcare Research & Quality's Survey on Patient Safety Culture (AHRQ SOPS) *RMRF's may be used to offset the cost of the survey.*	☐ **Met** ☐ **Not Met**	☐ Culture survey results must be provided at time of validation
The survey must have been administered within the past year. Goals for improvement are based on findings. There is evidence that an annual survey will be conducted to measure performance.	☐ **Met** ☐ **Not Met**	☐ Culture survey results must be provided at time of validation
Evidence that the culture survey results were shared and discussed at medical staff committee and nursing staff meetings. Evidence of sharing is contained in meeting minutes.	☐ **Met** ☐ **Not Met**	☐ Review of OB Committee meeting minutes ☐ Review of Nursing staff meeting minutes
The culture survey results have been debriefed with nursing and medical staff to understand common themes in response to the results.	☐ **Met** ☐ **Not Met**	☐ Evidence of participation by nursing and medical staff reflected in dated sign-in sheets

To raise staff awareness of safety concerns, at minimum, four case study presentations or M&M rounds are conducted to discuss error and/or near miss activity.	☐ **Met** ☐ **Not Met**	☐ Evidence of participation by staff reflected in dated sign-in sheets and/or meeting minutes
Department specific event trends (incident reports/QRR's) are shared and discussed at minimum, quarterly, at medical staff committee and nursing staff meetings to identify trends and develop potential solutions.	☐ **Met** ☐ **Not Met**	☐ Evidence of participation by staff reflected in dated sign-in sheets and/or meeting minutes
Leadership WalkRounds are implemented by month six of the policy year and are conducted at least monthly. Specific information is obtained, recorded and there is a feedback mechanism in place to address the patient safety issues that providers and staff voice as a concern. These issues are tracked and trended through a point of resolution.	☐ **Met** ☐ **Not Met**	☐ Activity sheets are collected and signed by the CEO, CNE or CMO; whomever is conducting that specific WalkRound ☐ Evidence of tracking, trending, and follow-up

TIER 2
Data Visibility & Transparency
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
The organization participates in, at minimum, one formal or informal performance improvement project to include CMQCC, IHI, CPQCC, MOD, Regional Projects.	☐ **Met** ☐ **Not Met**	☐ Evidence of participation & performance.
Audits are completed for quality of care and the organization studies outcomes utilizing Trigger Tool screening mechanisms.	☐ **Met** ☐ **Not Met**	☐ Trigger Tool metrics, and a review of audits completed
The organization provides incident report trends to medical staff committee and to nursing staff. At minimum, two trends are analyzed, and performance improvement activity is implemented to address these trends.	☐ **Met** ☐ **Not Met**	☐ Medical Staff Committee Minutes ☐ Nursing Staff Meeting Minutes
The unit has adopted a *unit-specific* scorecard designed to provide feedback on performance over time. This scorecard is shared quarterly (at a minimum), and may include metrics such as: • Incident report trends • Trigger Tool trends • Claims frequency data • Patient Satisfaction metrics • Culture survey data • Nurse turnover rates • Leadership WalkRound performance (open/completed items)	☐ **Met** ☐ **Not Met**	☐ Most recent scorecard
A "White Board" designed to address current progress toward goals is visible in the unit. The goal is to provide ongoing feedback on performance and to elicit staff feedback on patient safety related issues returning ownership of risk management to the unit/individual. A digital, interactive learning board to enhance visibility may be found at Safe & Reliable Healthcare: LENS Safe & Reliable	☐ **Met** ☐ **Not Met**	☐ Observation

TIER 2
Hyperbilirubinemia Screening
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Develop protocol and education for all nursing staff pertaining to Pathological & Physiological Jaundice to include the following: • Risk factors • Signs & symptoms • Assessment • Distinguishing between pathological vs physiological jaundice • Management & treatment • Required documentation Competencies completed upon hire & yearly thereafter.	☐ Met ☐ Not Met	☐ Policy and procedure review ☐ Review of nursing education ☐ Review nursing competencies
A standing protocol exists for nurse initiated TcB or TsB measurement in accordance with AAP recommendations.	☐ Met ☐ Not Met	☐ Policy and procedure review
Comprehensive discharge instructions include information to patients including explanation of jaundice, the need to monitor infants for jaundice and advice on how monitoring should be done. *Examples may be found at:* https://www.healthychildren.org/English/ages-stages/baby/Pages/jaundice.aspx	☐ Met ☐ Not Met	☐ Review discharge instructions provided to parents
Discharge instructions include evidence of discussion with parents pertaining to the importance of timely follow-up with pediatrician post-discharge.	☐ Met ☐ Not Met	☐ Review the medical records of the last ten deliveries occurring at the facility
100% of newborn readmits for hyperbilirubinemia are audited and reviewed for quality improvement purposes.	☐ Met ☐ Not Met	☐ Review audits completed on the last five readmits.
Findings and any plans for process improvement are shared with staff & physicians.	☐ Met ☐ Not Met	☐ Review of reporting component and communications to staff and physicians

Discharge phone calls are implemented, and performance is measured to ensure 90% compliance at minimum.	☐ **Met** ☐ **Not Met**	☐ Review of phone call log

Hypertensive Disorders in Pregnancy

California Maternal Quality of Care Collaborative (CMQCC)

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
A multi-departmental, interdisciplinary protocol for management and treatment of hypertensive disorders in pregnancy is in place and is approved by medical staff.	☐ **Met** ☐ **Not Met**	☐ Review of Hypertensive Disorders in Pregnancy policy/protocol and Magnesium protocol
Preeclampsia with Severe Features: Timely administration of first line medications after confirmatory blood pressure. 100% of cases of preeclampsia with severe features are reviewed to ensure that first line medications were administered within 60 minutes of confirmatory blood pressure per ACOG & CMQCC guidelines *Confirmatory blood pressure = 2nd elevated pressure ≥ 160 systolic and/or ≥ 105-110 diastolic*, taken 15 minutes after the first elevated blood pressure. (*Guidelines ≥105-110 diastolic per CMQCC, ≥110 diastolic per ACOG's Hypertension in Pregnancy)* This measure is adopted as a formal quality improvement metric, is monitored through quality, and compliance is reported up through the appropriate medical staff committee. *Examples may be found at www.CMQCC.org*	☐ **Met** ☐ **Not Met**	☐ Evidence of data collection and trending report of quality measure ☐ Committee meeting minutes (or excerpt indicating reporting component)
100% of preeclampsia with severe features and/or eclampsia cases are debriefed and reviewed for quality improvement purposes. Preeclampsia with severe features and/or eclampsia cases to be sent for peer review are defined in policy. *Examples may be found at www.CMQCC.org*	☐ **Met** ☐ **Not Met**	☐ Evidence of completed debriefing forms ☐ Hypertensive disorders or peer review policy
All providers and staff in L&D, antepartum and postpartum must complete training and	☐ **Met** ☐ **Not Met**	☐ Review of certificates of completion (or Relias completion reports)

education on hypertensive disorders in pregnancy. This may be accomplished by completing the Relias Platform modules listed below: • *Medical Management of Hypertensive Disorders in Pregnancy (Providers)* • *Nursing Care of the Patient with Hypertensive Disorders in Pregnancy (Nurse)*		
Simulation and/or drills specific to preeclampsia/eclampsia *(ex: tabletop simulation, escape room, jeopardy, etc.)* occur annually. All physicians, nurses, family practitioners, CNM's, surgical scrub technicians, lab/blood bank, pharmacy and anesthesia participate. Debriefing occurs to inform PI activities *Examples may be found at www.CMQCC.org*	☐ **Met** ☐ **Not Met**	☐ Medical staff roster & Nursing staff roster ☐ Evidence of participation by all staff reflected in dated sign-in sheets ☐ Review of simulation scenarios ☐ Evidence of completed debriefing forms for each simulation
A Preeclampsia Medication Kit is created, managed, and stored in the ADM. All staff are oriented to its contents and use. *Examples may be found at www.CMQCC.org*	☐ **Met** ☐ **Not Met**	☐ Observation ☐ Evidence of orientation attended by all staff reflected in dated sign-in sheets

Interdisciplinary Fetal Strip Review
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Interdisciplinary fetal strip reviews are provided by the institution and attended by all care providers, at minimum, six times per year. Various forms may be utilized to include: • Morbidity & Mortality Rounds • Formal strip review via in-service • Immediate post-delivery debrief • Change of shift report • Interdisciplinary attended webinar activity	☐ **Met** ☐ **Not Met**	☐ Medical staff roster provided on day of validation ☐ Nursing staff roster provided on day of validation ☐ Review interdisciplinary strip review format utilized
Fetal strip review activity must be interdisciplinary led by a physician and attended by, at minimum, one nurse. This may be documented by a sign-in process.	☐ **Met** ☐ **Not Met**	☐ Evidence of participation by all staff and providers reflected in dated sign-in sheets
Documentation of the fetal strip reviews include Category I, II or III fetal tracings and the date that the strip review occurred. Individuals with their credentials who facilitate the reviews must be indicated on the form.	☐ **Met** ☐ **Not Met**	☐ Evidence of documentation may be included in dated sign-in sheets

Maternal Early Warning System (MEWS)
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Develop MEWS/MEOWS criteria/triggers that are approved by medical staff.	☐ **Met** ☐ **Not Met**	☐ Review of MEWS criteria/triggers
Implement Maternal Early Warning System Protocol to include: • Triggers that prompt notification, immediate action and/or bedside evaluation by provider • Pathway (condition) specific flow diagram for evaluation and management of MEWS triggers • Consultation recommendations (e.g., if MEWS conditions(s) persist after corrective measures, then MFM consult, Intensivist consult &/or Rapid Response Team should be requested) • Continued process for ongoing evaluation and treatment of underlying condition until triggering criteria resolves All nurses (L&D, PP) and providers are trained on MEWS criteria/protocol	☐ **Met** ☐ **Not Met**	☐ Review of MEWS policy/protocol ☐ Evidence of training reflected in dated sign-in sheets ☐ Review of medical staff meeting minutes
Implement unit-specific escalation policy/chain of command.	☐ **Met** ☐ **Not Met**	☐ Review of chain of command policy
Review processes are in place for MEWS triggering events: • Multi-disciplinary review of serious MEWS events and/or cases with variances in policy • Criteria for peer review/accountability of providers and staff PI process is in place for tracking metrics to include: • Cases triggered/those confirmed with diagnoses of hemorrhage, sepsis, HTN, cardiac condition, etc.	☐ **Met** ☐ **Not Met**	☐ Review criteria for multi-disciplinary review and peer review ☐ Review data on #cases triggered/#confirmed diagnoses ☐ Medical record review

Maternal Sepsis- Readiness

Must complete Readiness, Recognition, Response & Reporting/Learning Systems

Maternal Sepsis can be implemented over a two-year period

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Form a Multi-disciplinary Maternal Sepsis Team (Physician champion/ nurse champions, pharmacy, lab, ICU) to lead project. Team will meet at least monthly and attend hospital wide sepsis committee meeting at least quarterly.	☐ **Met** ☐ **Not Met**	☐ Multidisciplinary team charter and meeting minutes
Implement Staff/MD training for both maternal SIRS criteria for sepsis and the facility's sepsis protocol. *Maternal Sepsis education is offered through The Relias Platform*	☐ **Met** ☐ **Not Met**	☐ Nursing staff roster; Medical staff roster ☐ Review of educational content (SIRS/Sepsis and facility protocol) and evidence of staff education reflected in dated sign-in sheets
Complete Drills/Simulations on Maternal Sepsis to include all staff/providers involved in patient's care. *Simulation examples may be found at www.CMQCC.org*	☐ **Met** ☐ **Not Met**	☐ Evidence of drill/simulation participation by all staff reflected in dated sign-in sheets ☐ Evidence of completed debriefing forms for simulations

Maternal Sepsis – Recognition
Must complete Readiness, Recognition, Response & Reporting/Learning Systems

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
An interdisciplinary Maternal Sepsis protocol is in place and approved by medical staff. Protocol must include: • Maternal SIRS criteria for early recognition • Underlying causes • Diagnosis • Treatment – one-hour bundle requirements at minimum	☐ **Met** ☐ **Not Met**	☐ Maternal Sepsis Protocol/SIRS Criteria review

Maternal Sepsis – Response
Must complete Readiness, Recognition, Response & Reporting/Learning Systems
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Develop a coordinated response to Maternal Sepsis – Code Sepsis in OB – to include response of specialties such as Respiratory Therapy, Infectious Disease, Intensivist, ICU RN.	☐ **Met** ☐ **Not Met**	☐ Maternal Sepsis Protocol review
Develop indications for maternal transfer to ICU/tertiary center for higher level of care and neonatal ICU/tertiary center for higher level of care.	☐ **Met** ☐ **Not Met**	☐ Maternal Sepsis Protocol review

Maternal Sepsis- Reporting/Learning Systems

Must complete Readiness, Recognition, Response & Reporting/Learning Systems

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Debrief all positive sepsis screens and/or initiations of sepsis alerts on peripartum patients as soon as patient is determined to be stable and initial assessments and interventions have been completed. *Debrief examples may be found at www.CMQCC.org*	☐ **Met** ☐ **Not Met**	☐ Review of debrief forms
Perform interdisciplinary case review of all peripartum patients with diagnosis of sepsis, severe sepsis, and/or septic shock (will include evaluation of treatment protocol compliance and timeliness of diagnosis/care). *Severe Maternal Morbidity Review Form can be found at Sepsis in Obstetric Care	AIM (saferbirth.org)*	☐ **Met** ☐ **Not Met**	☐ Evidence of interdisciplinary case review – meeting minutes, case review forms, etc..
Report interdisciplinary case review findings and measurements intra-departmentally via quality dashboards, grand rounds, staff education events, or other means, at a frequency determined by each institution based on its volume and number of maternal sepsis cases	☐ **Met** ☐ **Not Met**	☐ Review of staff/committee meeting minutes (or excerpt indicating reporting component)
Data: Track and trend number of sepsis alerts triggered and number of confirmed sepsis cases among peripartum patients.	☐ **Met** ☐ **Not Met**	☐ Evidence of data collection and performance
Data: Choose one additional measure, at minimum: • Track and trend number of sepsis screens conducted, and number of sepsis alerts triggered among peripartum patients	☐ **Met** ☐ **Not Met**	☐ Evidence of data collection and performance

• Track number of ICU admissions for maternal sepsis, including elapsed time between request for ICU bed and transfer of patient to unit, LOS, and disposition at discharge • Review all externally reported cases of SMM (e.g., through CMQCC Maternal Data Center) for consistency between sepsis-related diagnosis codes and provider documentation. Provide targeted feedback or education based on findings.		

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TIER 2
NCC Certification (RNC) Credential
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

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Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
All eligible staff* in the departments listed below will sit for the RNC exam by May 1 of policy year. **Exams Offered:** • Inpatient Obstetrical Nursing (L&D) • Inpatient Antepartum Nursing (L&D/Antepartum) • Electronic Fetal Monitoring (L&D) • Maternal Newborn • Nursing (Postpartum/Antepartum) • Neonatal Intensive Care Nursing (NICU) • Low Risk Neonatal Intensive Care Nursing (Newborn) *Content guides are located at this link:* *http://www.nccwebsite.org/Certification/Certification-Exams.aspx* *Eligibility rests on the following: Currently licensed in U.S. Two years of experience comprised of 2,000 hours in clinical specialty Employed in designated exam specialty in last 24 months *RMRF's may utilized to offset the costs of the exam*	☐ **Met** ☐ **Not Met**	☐ Nursing staff roster provided on day of validation to include evidence of staff having greater than two years' experience in clinical specialty
Evidence of enrollment and participation in exam is required to meet the goal. Evidence of pass/fail is not required.	☐ **Met** ☐ **Not Met**	☐ Evidence produced through certificate of eligibility for exam

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
The perinatal unit has developed clear clinical definitions for normal and abnormal labor in accordance with current professional organization recommendations (ACOG, SMFM, IHI) and this is established in medical staff approved policy. Definitions should include the following: First Stage of Labor (latent phase, arrest of labor in the first stage, active labor/active phase arrest) Failed induction of labor Second stage arrest (with and without epidural)	☐ **Met** ☐ **Not Met**	☐ The following policies are reviewed: • Induction of Labor/ Augmentation Policy • EFM Policy • Second Stage of Labor Policy
Using the Labor Audit tool, evaluate all nulliparous cesarean deliveries performed at the facility over a 3-month period at minimum. Audits to include evaluation of interventions performed during management of 1st and 2nd Stages of Labor *Audit tool examples may be found at www.CMQCC.org* Summarize findings and choose area of focus for future reduction in nulliparous cesarean section rate based on those findings. Report findings through staff meetings, Quality, and appropriate medical staff committee (OB Committee).	☐ **Met** ☐ **Not Met**	☐ Evidence of data collection and performance ☐ Summary of findings and area of focus ☐ Committee meeting minutes (or excerpt indicating reporting component)

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Ensure the definitions for normal and abnormal labor established in medical staff approved policy are demonstrated in clinical practice. • First Stage of Labor (latent phase, arrest of labor in the first stage, active labor/active phase arrest) • Failed induction of labor • Second stage arrest (with and without epidural) Perform chart audits to verify normal and abnormal labor definitions are demonstrated in clinical practice.	☐ **Met** ☐ **Not Met**	☐ The following policies are reviewed: • Induction of Labor/ Augmentation Policy • EFM Policy • Second Stage of Labor Policy ☐ Evidence of data collection and performance
Based on labor audit findings choose an area of focus and develop a performance improvement project. Use PDSA or other similar improvement process. Goal should be reduction in nulliparous cesarean sections unless otherwise approved by BETA. *Contact NarcisaPalma at* narcisa.palma@betahg.com. Report performance improvement through staff meetings, quality, and appropriate medical staff committees (OB Committee).	☐ **Met** ☐ **Not Met**	☐ Evidence of data collection and performance ☐ Area of focus and performance improvement project ☐ Committee meeting minutes (or excerpt indicating reporting component)
Using a Labor Audit Tool, evaluate all nulliparous cesarean deliveries performed at the facility over a 3-month period. *Collate results into Excel spreadsheet.* *Audit tool examples may be found at* www.CMQCC.org Report findings through staff meetings, quality, and appropriate medical staff committee (OB Committee).	☐ **Met** ☐ **Not Met**	☐ Evidence of data collection and results ☐ Committee meeting minutes (or excerpt indicating reporting component)

OB Triage Bundle

==OB Triage Bundle can be implemented over a two-year period.==

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
An interdisciplinary OB triage protocol/standardized procedure is in place and approved by medical staff. Protocol must include: • Determination of qualified medical personnel (QMP) to perform medical screening examination (MSE) • Standardized procedure for MSE • Nurse competency for OB Triage/MSE • Staffing requirements (per AWHONN or CDPH) • OB Triage/MSE documentation standards • Discharge criteria, educational handouts, and follow up information • Transfer process that considers the maternal level of care provided by the organization • Process for patients who leave without being seen (LWBS) or discharge against medical advice (AMA)	☐ **Met** ☐ **Not Met**	☐ Review of standardized procedure/protocol for OB Triage ☐ Review of Medical Staff Bylaws, Rules & Regulations
An emergency severity index for OB is used to inform the triage of OB patients based on severity of condition, urgency, and resources needed for treatment. Possible tools include those embedded in the EMR, AWHONN's MFTI, OTAS (London)	☐ **Met** ☐ **Not Met**	☐ Review of ESI tool for OB ☐ Medical record review of severity index use and timeliness based on urgency
Develop a process/flow diagram, with ED collaboration, for appropriate location of medical screening exam based on presenting complaint and gestational age.	☐ **Met** ☐ **Not Met**	☐ Review of flow diagram/process
A physical, or electronic log is maintained for all patients who present to OB Triage. The log includes those patients who telephone for advice.	☐ **Met** ☐ **Not Met**	☐ Review of Triage Log

Staff and providers have been trained to the ESI/acuity tool, the flow diagram for appropriate location and the OB triage standardized procedure/protocol. Implement competency training and evaluation for those staff designated to act as QMPs. Competency should be verified upon initial designation and then annually.	☐ **Met** ☐ **Not Met**	☐ Review of educational content (MSE standardized procedure protocol) and evidence of staff education reflected in dated sign-in sheets ☐ Review of staff competency evaluation/checklist
Develop quality review and metrics to include, at minimum, review of acuity (severity index) designation and timeliness of medical screening exam. Other suggestions: • # undelivered patients who are discharged from OBT and return within 24hrs. • Audit of triage log for completeness of documentation • Audit of MSE documentation for completeness • Audit of MSE by labor nurses as QMP for appropriateness (only rule out labor and not medical complaints or those with complications needing MD evaluation)	☐ **Met** ☐ **Not Met**	☐ Evidence of data collection and performance
Perform multidisciplinary review or peer review for at minimum, all cases who are discharged from OBT and return in an emergency condition or have birth outside asepsis (BOA) within 24 hours of discharge.	☐ **Met** ☐ **Not Met**	☐ Evidence of multidisciplinary case review (meeting minutes, case review forms, etc.) and/or peer review criteria
Report interdisciplinary case review findings and measurements intra-departmentally via quality dashboards, OB Committee meetings, and staff meetings.	☐ **Met** ☐ **Not Met**	☐ Review of staff/committee minutes (or excerpt indicating reporting component)

Obstetrical Hemorrhage

California Maternal Quality of Care Collaborative (CMQCC)

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
A multi-departmental and interdisciplinary hemorrhage protocol for management of hemorrhage is in place and is approved by medical staff. *Examples may be found at www.CMQCC.org*	☐ **Met** ☐ **Not Met**	☐ Hemorrhage policy/protocol ☐ Massive Transfusion protocol
All providers and staff in L&D, antepartum and postpartum must complete training and education on obstetrical hemorrhage. This may be accomplished by completing the Relias Platform module: • *Medical Management of Obstetric and Postpartum Hemorrhage (Providers)* • *Nursing Care of the Patient with Obstetric and Postpartum Hemorrhage (Nurses)*	☐ **Met** ☐ **Not Met**	☐ Evidence of certificates of completion (or completion reports) for all physicians, family practitioners with OB privileges, nurse midwives and registered nurses in labor and delivery and postpartum
Simulation and/or drills specific to OB hemorrhage occur annually. All physicians, nurses, family practitioners, CNM's, surgical scrub technicians, lab/blood bank, pharmacy and anesthesia participate. Team debriefs are completed after all simulations and drills to determine system issues as part of ongoing quality improvement efforts.	☐ **Met** ☐ **Not Met**	☐ Evidence of participation by all staff reflected in dated sign-in sheets ☐ Evidence of completed debriefs
An emergency OB hemorrhage cart is in place in L&D and Postpartum. All staff are oriented to its contents and use.	☐ **Met** ☐ **Not Met**	☐ Evidence of orientation/in-service attended by all staff reflected in dated sign-in sheets

Example hemorrhage cart contents may be found at www.CMQCC.org		
Criteria for severe hemorrhage cases is established and is approved by medical staff. Debriefs are completed on 100% of cases that meet criteria and are reviewed to evaluate the effectiveness of the care, treatment, and services provided to the patient during the event. *Examples of debrief & case review forms may be found at www.CMQCC.org*	☐ **Met** ☐ **Not Met**	☐ Evidence of approved criteria ☐ Evidence of completed debriefs and review findings
Printed education is provided to patients, support person and families that includes signs and symptoms of postpartum hemorrhage and when to seek immediate care during hospitalization *and* after discharge. *Examples of patient education may be found at www.CMQCC.org*	☐ **Met** ☐ **Not Met**	☐ Evidence of patient education materials

Patient and Family Centered Care
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
A readiness assessment is completed by a multidisciplinary team including senior leadership, a physician lead, nurse lead and one frontline staff member in preparation for deployment of a PFCC structure.	☐ **Met** ☐ **Not Met**	☐ Evidence of executed Readiness Assessment
Formation of a Patient & Family Advisory Council for perinatal services and is designed to include patients on improvement teams.	☐ **Met** ☐ **Not Met**	☐ Patient & Family Advisory Council Policy & Procedure
In collaboration with patient advisors, identify two areas of improvement to enhance the patient experience in your perinatal department. Develop an action plan with reasonable target dates for completion Monitor changes for sustained implementation Provide updates to staff meetings and the appropriate medical staff committee (OB Committee) as evidenced in the meeting minutes.	☐ **Met** ☐ **Not Met**	☐ Copy of the identified patient experience improvement opportunities ☐ Staff meeting minutes and medical staff committee meeting minutes discussing the findings and action plan ☐ Provide evidence of implementation of the changes and sustained gains
The facility measures the patient's experience and satisfaction. A performance measure is outlined in the department. Perinatal services satisfaction scores reflect performance in the 90th percentile at minimum or marked improvement toward that goal.	☐ **Met** ☐ **Not Met**	☐ Avatar, NRC Picker, HCAHPS scores

Perinatal Mental Health - Readiness

Must complete Readiness, Recognition, Response & Reporting/Learning Systems

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Identify a mental health screening tool, preferably the Edinburgh, to be made available in each perinatal clinical setting.	☐ **Met** ☐ **Not Met**	☐ Review of mental health screening tool
Develop a screening policy to include a stage-based response protocol. *See BETA's Perinatal Toolkit for example policies/protocols*	☐ **Met** ☐ **Not Met**	☐ Perinatal Mental Health protocol review
Educate clinicians (providers, nursing, social work, and other relevant departments) and office staff on use of the identified screening tool and response protocol. *Online education may be accessed at HQI's Perinatal Mental Health Learning Community*	☐ **Met** ☐ **Not Met**	☐ Review of educational content (perinatal mental health and facility protocol) and evidence of staff and provider education reflected in dated sign-in sheets or course completion reports ☐ Medical staff roster Nursing staff roster
Identify community resources or referral for individuals.	☐ **Met** ☐ **Not Met**	☐ Review of community resources/referral documents

Perinatal Mental Health - Recognition
Must complete Readiness, Recognition, Response & Reporting/Learning Systems
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Review/obtain individual and family mental health history (including past and current medications) at intake, with review and update as needed.	☐ **Met** ☐ **Not Met**	☐ Medical record review for evidence of mental health history and mental health screening
Conduct validated mental health screening during appropriately timed inpatient encounters (at minimum on admission).	☐ **Met** ☐ **Not Met**	☐ Review of protocol Medical record review
Provide appropriately timed perinatal depression and anxiety awareness education to women and family members or other support persons. *Patient education tools may be accessed at HQI's Perinatal Mental Health Learning Community*	☐ **Met** ☐ **Not Met**	☐ Review of educational materials provided to patient and family

Perinatal Mental Health - Response

Must complete Readiness, Recognition, Response & Reporting/Learning Systems

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Ensure implementation of a stage-based response protocol for a positive mental health screen.	☐ **Met** ☐ **Not Met**	☐ Perinatal Mental Health protocol review
Create an emergency referral process for women with suicidal/homicidal ideation or psychosis. Provide appropriate and timely support for women, as well as family members and staff, as needed. Have a process to ensure follow-up referral to mental health providers for women in need of treatment.	☐ **Met** ☐ **Not Met**	☐ Perinatal Mental Health protocol review ☐ Medical record review for evidence of stage-based response to positive screen ☐ Review of referral process and follow up mechanism

Perinatal Mental Health – Reporting/Learning Systems
Must complete Readiness, Recognition, Response & Reporting/Learning Systems
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Develop metrics to include, at minimum, # positive screens/total screens. Other suggested metrics: • Percentage of staff trained in trauma informed care, maternal mental health • Percentage of staff trained in administration of the Edinburgh Postpartum Depression Scale • Percentage of patients with a positive screen who received appropriate stage-based follow up/referrals	☐ **Met** ☐ **Not Met**	☐ Evidence of data collection and performance
Monthly reporting of metrics such as screening results and appropriate follow up occurs at the appropriate committees.	☐ **Met** ☐ **Not Met**	☐ Review of staff/committee meeting minutes (or excerpt indicating reporting component)
Perform multidisciplinary review and/or peer review for all cases with a positive screen	☐ **Met** ☐ **Not Met**	☐ Evidence of multidisciplinary case review

TIER 2
Perinatal Risk Assessment
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Perinatal Risk Assessment is scheduled with a BETA Risk Director no later than six months prior to the end of the policy period. *The Perinatal Risk Assessment Questionnaire is completed and submitted to BETA no later than 2 weeks after confirmation of assessment date*	☐ **Met** ☐ **Not Met**	☐ Review of Risk Assessment Questionnaire to BETA Risk Manager
Requested policies and forms must be submitted to BETA at least two weeks prior to assessment date: *The Documentation Request for Perinatal Risk Assessment will be provided at time of scheduling*	☐ **Met** ☐ **Not Met**	☐ Submit policies and forms to BETA Risk Manager
Requested interviews will be scheduled at least 2 weeks prior to the assessment	☐ **Met** ☐ **Not Met**	☐ Interview schedule sent to BETA Risk Manager
At least three performance improvement plans with measurable outcomes will be developed based on the findings of the risk assessment, in collaboration with your BETA Risk Manager: • Establish measurable goals or matrix for use in determining effectiveness of process improvement • Goals must be objective, clearly defined, and measurable • Review plan and modify as indicated to achieve goal • Plans should be developed no later than 90 days prior to the end of the policy period • The performance improvement plans must be submitted to appropriate medical staff and quality committees for review.	☐ **Met** ☐ **Not Met**	☐ Submit performance improvement plans with measurable outcomes ☐ Evidence of committee meeting minutes

One performance improvement plan must be completed by May 1st with evidence of measurable outcomes. Results should be submitted to medical staff and quality committees for review.	☐ **Met** ☐ **Not Met**	☐ Performance improvement plan with evidence of data collection by May 1st ☐ Committee meeting minutes with data review

Perinatal Safety Collaborative
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Identify two leaders to represent your facility in the Perinatal Collaborative: • Team to include a physician leader and a nurse leader from perinatal services. These individuals do not need to be the department directors but should possess leadership authority in some capacity in the department • Identify which of the team members will serve as the primary contact	☐ **Met** ☐ **Not Met**	☐ Name submission on the Perinatal Collaborative Opt-In agreement
Attend two, full day in-person Perinatal Collaborative meetings as outlined in the Perinatal Collaborative Timeline. Actively engage in monthly teleconference calls scheduled throughout the policy period 100% participation is required for all scheduled meetings and calls by at least one member to represent the perinatal team identified	☐ **Met** ☐ **Not Met**	☐ Sign-in rosters will be used to verify attendance at in-person meetings ☐ Attendance will be taken during all scheduled virtual meetings
Participants in the Perinatal Collaborative must lead or co-lead a work group assigned by the collaborative. Participants must also: • Complete assignments by the established deadlines • Participate in initial research • Draft recommended practices • Establish measurable goals or matrix for use in determining effectiveness of recommended practices • Pilot recommendations and provide feedback to the collaborative	☐ **Met** ☐ **Not Met**	☐ Submit recommendations with measurable outcomes ☐ Assignments to be submitted by deadline dates ☐ Participation Assessment – a fair and objective assessment of participation will be done by BETA based on compliance with the requirements outlined in this strategy

Second Stage of Labor Management
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
A policy is in place pertaining to the second stage of labor and incorporates the AWHONN or CMQCC second stage of labor management algorithm. Policy also includes AWHONN or ACOG recommended algorithms for the management of uterine tachysystole and Category II fetal heart tracing. *2nd stage management resources may be found at www.awhonn.org or www.cmqcc.org*	☐ **Met** ☐ **Not Met**	☐ Second Stage of Labor Policy
A performance improvement measure is in place which evaluates appropriate measures taken in the second stage. Metrics include: • Compliance with the AWHONN algorithm for second stage to include interval position changes and open glottis pushing. • Ongoing evidence of fetal evaluation, identification, and management of Category II and III fetal heart rate during second stage of labor. • Compliance with said measures shall be met at 90% averaged over a 3-month period.	☐ **Met** ☐ **Not Met**	☐ Provide medical records of the last ten vaginal deliveries occurring at the facility ☐ Evidence of data collection and compliance
A policy is in place which requires cord gas analysis for established indications which is approved by medical staff.	☐ **Met** ☐ **Not Met**	☐ Cord Gas Analysis policy
A policy/protocol is in place which requires placental pathology for established indications. The policy shall include a 3-day retention period (at minimum), have a labeling mechanism and appropriate storage and allow the neonatologist/pediatrician to order pathological exam should an indication be overlooked.	☐ **Met** ☐ **Not Met**	☐ Placenta Pathology Policy

In the alternative, a process that retains slide sections of placentas in pathology may be in place		

TIER 2
Shoulder Dystocia
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
A policy is in place pertaining to the management of shoulder dystocia that incorporates the current ACOG recommendations, including physician documentation of counseling if elective cesarean section should be considered and the policy is approved by medical staff. *ACOG Practice Bulletin #178 Shoulder Dystocia, 2017*	☐ **Met** ☐ **Not Met**	☐ Review of Shoulder Dystocia Policy
An evaluation process is in place for patients at risk according to ACOG guidelines. This can be accomplished through technology, or a formalized tool approved by medical staff.	☐ **Met** ☐ **Not Met**	☐ Review of evaluation process
A second stage of labor management protocol is in place and includes algorithms for the management of uterine tachysystole and Category II fetal heart tracings. All staff are oriented to the approved algorithms, and the policy is approved by medical staff.	☐ **Met** ☐ **Not Met**	☐ Review of Second Stage of Labor Policy/protocol
Documentation reflects compliance with all interventions deployed during a suspected shoulder dystocia event utilizing a standardized tool in either paper or electronic format which captures the interdisciplinary approach to management of the shoulder dystocia. Conduct audits to ensure appropriate documentation and practice	☐ **Met** ☐ **Not Met**	☐ Provide medical records of the last ten documented shoulder dystocia deliveries (or 100% of shoulder dystocia deliveries in the last 12-month period if less than ten) ☐ Review of audits for compliance
All staff and providers in L&D must complete training and education on shoulder dystocia. This may be accomplished by completing the Relias Platform's *Managing Shoulder Dystocia* module.	☐ **Met** ☐ **Not Met**	☐ Evidence of certificates of completion (or completion reports) for all physicians, family practitioners with OB privileges, nurse midwives and registered nurses in labor and delivery

Simulation or drills specific to shoulder dystocia management occur, at minimum, annually to include physicians, nurses, nurse midwives, family practitioners, neonatal staff, and anesthesia. Team completes a debrief after all simulations and drills.	☐ **Met** ☐ **Not Met**	☐ Evidence of participation by all staff reflected in dated sign-in sheets.

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
Utilizing an interdisciplinary approach, implement simulation or drills on **two** low frequency, high-risk events, annually. High or low fidelity simulation may be used. Simulation is best conducted in-situ though a simulation center may be utilized.	☐ **Met** ☐ **Not Met**	☐ Documented evidence of two simulation events having been completed annually. ☐ Evidence of completed debriefs for each simulation
Team members who respond to the specified emergency will be identified and shall be included in the simulation/drill exercise. This may include anesthesia, obstetrics, neonatal team members, lab, or others.	☐ **Met** ☐ **Not Met**	☐ Evidence of participation by all staff reflected in dated sign-in sheets
Selection shall be based on events where there is potential for incidence, but rarely encountered, to foster familiarity with clinical management. This may include: • Uterine rupture • Prolapsed cord • OB hemorrhage • Uterine emergency such as abruption or uterine inversion • Maternal code • Neonatal mega code • Maternal seizure/stroke • Shoulder dystocia	☐ **Met** ☐ **Not Met**	☐ Scenario utilized shall be produced on day of validation
A formal debrief process is in place occurs after each drill or simulation. There is an approved debriefing tool that is completed by staff, identifying strengths, and learning opportunities.	☐ **Met** ☐ **Not Met**	☐ Evidence of completed debriefs shall be produced on day of validation
Documentation of one opportunity, the associated corrective action and measure of success shall be provided.	☐ **Met** ☐ **Not Met**	☐ Documentation of corrective action and measure of success shall be produced on day of validation

TIER 2
Vacuum Bundle
Institute for Healthcare Improvement

100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
A policy is in place that defines the maximum application time, number of pulls and pop offs in accordance with manufacturer's guidelines and ACOG recommendations. *ACOG #154 Operative Vaginal Delivery, 2015*	☐ **Met** ☐ **Not Met**	☐ Review Operative Vaginal Delivery/Vacuum Policy
Implement bundle requirements and measure for compliance to meet at minimum 90% compliance for all vacuum deliveries over 3–6-month period (max of ten audits/month).	☐ **Met** ☐ **Not Met**	☐ Provide medical records of the last ten deliveries occurring at the facility involving vacuum ☐ Review of audit results for compliance
Implemented Vacuum Bundle includes: • Documentation of informed consent that includes the risks, benefits, and alternatives of applying a vacuum during delivery and includes discussion of an exit strategy. • Estimated fetal weight is documented in the medical record. • Fetal position and station are documented in the medical record	☐ **Met** ☐ **Not Met**	☐ Medical record review ☐ Vacuum Policy
An interdisciplinary tool to capture the elements of vacuum is in place via paper or electronic documentation. Documentation reflects application time, pressure, and pop-offs when a vacuum is utilized.	☐ **Met** ☐ **Not Met**	☐ Review of approved tool ☐ Medical record review
A surgical team and resuscitation team are immediately available. Immediately available is defined as "in-house." This language is included in policy.	☐ **Met** ☐ **Not Met**	☐ Vacuum Policy

Venous Thromboembolism (VTE) Bundle
100% compliance in Tier 1 is required to receive premium renewal credits in Tier 2

Requirement	Goal	Validation Checklist *The following items will be reviewed during validation:*
A multi-departmental and interdisciplinary VTE policy/procedure for the prevention, diagnosis, and management of VTE is in place and is approved by medical staff. The policy/procedure should include: • Risk assessment frequency • Prophylaxis protocols to include mechanical and pharmacologic methods • Suggested dosing schedule • Diagnostic algorithm for PE/DVT	☐ **Met** ☐ **Not Met**	☐ VTE policy and procedure review
A standardized thromboembolism risk assessment tool for VTE is in place and utilized during: • Antepartum hospitalization • Intrapartum admission • Postpartum period • Discharge *Examples may be found at www.CMQCC.org or* [(Archive) Maternal Venous Thromboembolism	AIM (saferbirth.org)](saferbirth.org)	☐ **Met** ☐ **Not Met**	☐ VTE risk assessment tool review
Audits are completed to evaluate the use of approved screening tool and for the use of appropriate interventions in positive screens. Interdisciplinary case reviews are completed on all positive VTE cases.	☐ **Met** ☐ **Not Met**	☐ Medical record review ☐ Review of audits for compliance ☐ Review of interdisciplinary case review meeting minutes
All staff in L&D, antepartum and postpartum must complete training and education on prevention, diagnosis, and management of VTE. *Teaching slide set for professionals may be found at www.CMQCC.org*	☐ **Met** ☐ **Not Met**	☐ Nursing staff roster; Medical staff roster ☐ Review of educational content and evidence of staff education reflected in dated sign-in sheets

		☐ Evidence of orientation attended by all staff reflected in dated sign-in sheets

Project Planning Worksheet
Contract Year 2024-2025

The (name of hospital) _____

Intends to accomplish: (This usually contains a statement describing what strategies you intend to implement this year)

_____

_____

_____

_____

_____

By: Time frame, i.e., month/year by which you intend to accomplish improvement- recommend July 1, 2024, to May 1, 2025.

_____

Our goals: These are goals for your measures. Your measures for this project should align with your Quest for Zero strategy requirements in this OB Guideline.

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Our Stakeholders: These are the people involved with and affected by your process and improvement strategies. Success often depends on the inclusion and involvement of multiple stakeholders.

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