TAHOE FOREST HOSPITAL DISTRICT

2021-08-17 Board Quality Committee Meeting

Tuesday, August 17, 2021 at 12:00 p.m.

Pursuant to Executive Order N-08-21, issued by Governor Newsom, the Board Quality Committee meeting for August 17, 2021 will be conducted telephonically through Zoom.

Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting.

Board Committee Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

If you would like to speak on an agenda item, you can access the meeting remotely: Please use this web link: https://tfhd.zoom.us/j/93054199594

If you prefer to use your phone, you may call in using the numbers: (346) 248 7799 or (301) 715 8592, Meeting ID: 930 5419 9594

TAHOE FOREST HOSPITAL DISTRICT

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TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
AGENDA

Tuesday, August 17, 2021 at 12:00 p.m.

Pursuant to Executive Order N-08-21, issued by Governor Newsom, the Board Quality Committee meeting for August 17, 2021 will be conducted telephonically through Zoom. Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Committee Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

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Meeting ID: 930 5419 9594

Public comment will also be accepted by email to mrochefort@tfhd.com. Please list the item number you wish to comment on and submit your written comments 24 hours prior to the start of the meeting.

Oral public comments will be subject to the three-minute time limitation (approximately 350 words). Written comments will be distributed to the board prior to the meeting but not read at the meeting.

1. CALL TO ORDER

2. ROLL CALL
Michael McGarry, Chair; Alyce Wong, RN, Board Member

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

4. INPUT – AUDIENCE
This is an opportunity for members of the public to address the Committee on items which are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Committee cannot take action on any item not on the agenda. The Committee may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. APPROVAL OF MINUTES OF: 05/13/2021 ..... **ATTACHMENT**

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

6.2. Patient & Family Centered Care

6.2.1. Patient & Family Advisory Council (PFAC) Update ..... ATTACHMENT
An update will be provided related to the activities of the Patient and Family Advisory

Council (PFAC).

6.3. Patient Safety

6.3.1. BETA HEART Program Progress Report.....ATTACHMENT
Quality Committee will receive a progress report regarding the BETA Healthcare Group Culture of Safety program.

6.3.2. BETA OB & ED Quest for Zero .....ATTACHMENT
Quality Committee will receive education on the BETA OB & ED Quest for Zero patient safety initiatives.

6.4. Governance of Quality Assessment (GQA) Tool .....ATTACHMENT
Quality Committee will review the core measures chosen by leadership to focus on. *Framework for Effective Board Governance of Health System Quality* (2018). Daley Ullem E, Gandhi TK, Mate K, Whittington J, Renton M, Huebner J. Boston, Massachusetts: Institute for Healthcare Improvement.

6.5. TFHD Care Compare Quality Metrics……ATTACHMENT
Quality Committee will receive an overview of the Care Compare Quality metrics and plans for improvement.

6.6. Board Quality Education

6.6.1. Centers for Medicare & Medicaid Services. *Overall hospital quality star rating* (2021) **.....ATTACHMENT**
Retrieved July 22, 2021 from https://data.cms.gov/provider-data/topics/hospitals/overall-hospital-quality-star-rating/#measure-included-by-categories

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

8. NEXT MEETING DATE
The next committee date and time will be confirmed.

9. ADJOURN

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions. Equal Opportunity Employer. The telephonic meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed or a reasonable modification of the teleconference procedures are necessary (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

TAHOE FOREST HOSPITAL DISTRICT

QUALITY COMMITTEE
DRAFT MINUTES

Thursday, May 13, 2021 at 9:00 a.m.

Pursuant to Section 3 of Executive Order N-29-20, issued by Governor Newsom on March 17, 2020, the Board Quality Committee meeting for May 13, 2021 will be conducted telephonically through Zoom. Please be advised that pursuant to the Executive Order, and to ensure the health and safety of the public by limiting human contact that could spread the COVID-19 virus, the Eskridge Conference Room will not be open for the meeting. Board Committee Members will be participating telephonically and will not be physically present in the Eskridge Conference Room.

1. CALL TO ORDER

Meeting was called to order at 9:01 a.m.

2. ROLL CALL

Board: Michael McGarry, Chair; Alyce Wong, RN, Board Member

Staff in attendance: Harry Weis, President & Chief Executive Officer; Judy Newland, Chief Operating Officer; Karen Baffone, Chief Nursing Officer; Dr. Shawni Coll, Chief Medical Officer; Dr. Peter Taylor, Medical Director of Quality; Janet Van Gelder, Director of Quality & Regulations; Dorothy Piper, Director of Medical Staff Services; Lorna Tirman, Patient Experience Specialist

3. CLEAR THE AGENDA/ITEMS NOT ON THE POSTED AGENDA

No changes were made to the agenda.

4. INPUT – AUDIENCE

Janet Van Gelder, Director of Quality, thanked board members for participating in Medical Staff Quality meeting.

5. APPROVAL OF MINUTES OF: 02/09/2021

Director Wong asked for a correction on page 4 from “five” to “four” items to focus on.

Director Wong moved to approve the February 9, 2021 Board Quality Committee minutes with correction, seconded by Director McGarry.

6. ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION

6.1. Safety First

The Safety First discussion was held on listening to patients.

6.2. Patient & Family Centered Care

6.2.1. Patient & Family Advisory Council (PFAC) Update

Lorna Tirman, Patient Experience Specialist, provided an update related to the activities of the Patient and Family Advisory Council (PFAC).

PFAC will take a break in July and August. PFAC is hopeful to resume in person meetings after summer

break.

The SHIP grant will provide discharge folders for inpatient and OB for a year. Discharge instructions has been an opportunity for improvement from HCAPHS.

PFAC has provided feedback on the mental health flyer for community.

6.3. Patient Safety

6.3.1. BETA HEART Program Progress Report

Patient Experience Specialist reviewed a progress report regarding the BETA Healthcare Group Culture of Safety program.

The SCOR survey response rate was 90%, against a goal of 85%.

Patient Experience Specialist has begun a debrief of survey results at the department level. The Board of Directors will receive the survey results in June.

The BETA HEART validation survey was held on Tuesday. They received all of our documents. We should hear back within the month as to whether the District will receive validation in all five domains.

BETA holds trainings in February, May and September. 80 employees have participated because most are virtual during the pandemic.

The District received approximately $98,000 in premium savings last year.

6.4. Governance of Quality Assessment (GQA) Tool

President & CEO and COO reviewed current and future actions for each of the following items:

Category 2, #2 – Board annually reviews management's summary of the financial impact of poor quality on payments and liability costs.

Category 4, #5 – Board ensures that all patient populations, especially the most vulnerable, are provided effective care by evaluating variations in care outcomes for key conditions or service lines based on race, gender, ethnicity, language, socioeconomic status/payer, type, and age.

Category 5, #1 – Board reviews metrics related to access to care at all point in the system (e.g. hospital, clinics, behavioral health, nursing home, home care, dental) and ensures that access is equitable and timely for all patients.

Category 6, #3 – Board evaluates approach to integration and continuity of care for behavioral health patients.

6.5. Board Quality Education

Director of Quality is open to suggestions for education topics. President and CEO would like articles focused on quality improvement.

7. REVIEW FOLLOW UP ITEMS / BOARD MEETING RECOMMENDATIONS

-SCOR survey results will be shared with the board in June.
-Governance Quality Assessment presentation to the board.

8. NEXT MEETING DATE

The next committee meeting will be confirmed for August.

9. ADJOURN

Meeting adjourned at 10:19 a.m.

Patient and Family Advisory Council (PFAC) Summary Report

February 2021 to June 2021

Submitted by: Lorna Tirman, RN, PhD

Patient Experience Specialist

- Some members have shown an interest in volunteering in other areas of the hospital, in addition to the monthly PFAC meetings.
    - Kevin Ward assists the Quality Department tracking our service recovery toolkits. He is also attends the quarterly Board Quality Committee meetings.
    - Pati Johnson attends the quarterly Cancer Committee meetings.
    - Alan Kern is now serving on our Medical Staff Quality Committee.

- Meetings focus on improving processes and behaviors to continue to provide the Perfect Care Experience to our community and visitors.

- Plan for 2021 is to continue to review patient feedback and comments from patient experience surveys, help improve quality, safety, and patient experiences. Goals to help educate community on mental health services expand support for community both during and post COVID. Continue to educate community on COVID vaccination, safety as well as access to health care services other than COVID, making sure access is meeting the needs of our community and its growth.

- We agreed to continue to invite departments to PFAC meetings to illicit input where needed, to improve processes or strategies in that specific area.

- At some of our meetings, an example of a patient complaint is shared, to illicit input on how to best perform service recovery and improve the process so the complaint will not happen again to another patient.

- February: Eileen Knudsen, Natasha Lukasiewich, and Karen Grow gave an update on current mental health resources at TFHD as well as in the community. PFAC providing updates to create a one-page flyer as soon as we have all the resources and information we need to promote these important services.

- March: Reviewed discharge folders for Inpatient and OB, that are being paid for by the CA SHIP Grant, to improve communication to our patients upon discharge from our inpatient units.

- April: Svieta Schopp gave an update on COVID, COVID variants, vaccines, and answered questions. Jim Sturtevant gave a summary of his presentation “Humor in Medicine”.

- May: Maria Martin and Wendy Buchanan presented on our population health, and community wellness programs. Input from PFAC on how to best get information out to the community regarding all the wonderful programs and services TFHD offers.

- June: Reviewed accomplishments last year. Discussed goals for 2021-2022. Will continue our focus on improving patient experiences, processes to improve clinic and outpatient visits and experiences.

- The Tahoe Forest Hospital Patient and Family Advisory Council meets every month, 9 months in the year. We do not meet July, August, or December.

- Next PFAC Meeting is September 21, 2021.

Current members:

Name of PFAC Volunteer	**Start Date**	
1. Doug Wright	2/4/2015	
2. Anne Liston	3/9/2016	
3. Mary K. Jones	5/17/2017	
4. Dr. Jay Shaw	8/11/2017	
5. Pati Johnson	3/22/2018	
6. Helen Shadowens	5/24/2018	
7. Sandy Horn	9/5 /2019	
8. Kevin Ward	9/20/2018	
9. Violet Nakayama	10/31/2019	
10. Alan Kern	2/20/2020	
11. Kathee Hansen	4/1/2021	
~~12. Parminder Hawkesworth~~	~~9/20/2018~~	~~(Resigned July, 2021)~~

Beta HEART Progress Report for Year 2021

(Updated July, 2021)

Beginning in 2020, Beta Healthcare Group changed their annual Incentive process to be "Annual", meaning that each year the five (5) domains have to be re-validated each year to be eligible for the incentive credit. General updates for 2021:

- Beta Heart Validation Survey complete with validation in all 5 domains with a total cost savings of $108, 652.00

Domain	History of Incentive Credits (2% annually)	Readiness for next Validation	Goal	Comments
Culture of Safety: A process for measuring safety culture and staff engagement (Lead: Lorna Tirman, Patient Experience Specialist, (Beta Heart Lead)	Validated 2019: $13,101 2020: $19,829 2021:$21,730.40	100%	Goal= Greater than 85% Response rate Actual Response Rate = 90%	SCOR survey for 2021 complete. Departmental de-briefs May to September 2021. Board report June 2021. To date 43 debriefs have taken place with action plans being developed by leaders to place on their PI plan dashboards and share with their staff.
Rapid Event Response and analysis: A formalized process for early identification and rapid response to adverse events that includes an investigatory process that integrates human factors and systems analysis while applying Just Culture principles (Lead: Theresa Crowe, Risk Manager)	Validated 2020: $19,829 2021:$21,730.40	100%	Reinforce education related to timely event reporting and implementation of corrective action items.	TFHD incorporates the transparent and timely reporting of safety events to ensure rapid change in providing safer patient care. All investigations utilize "just culture" and high reliability principles and encourage accountability. This domain was reviewed at the Beta Workshop 1 in February 2021 and we had 21 employees/providers participated in the virtual learning.
Communication and transparency: A commitment to honest and transparent communication with patients and family members after an adverse event (Lead: Theresa Crowe, Risk Manager)	Validated 2020: $19,829 2021: $21,730.40	100%	Reinforce Beta HEART principles through targeted education at meetings, emails, Pacesetter, weekly Safety First etc.	Disclosure checklist recently updated and refined as we update process and leaders trained to respond to events. This domain was reviewed at Beta Workshop 2 on April 22-23, 2021 and 9 employees/providers participated in the virtual learning. An Intermediate Communication skill development session was May 19-20, 2021 and 20 employees attended virtually.
Care for the Caregiver: An organizational program that ensures support for caregivers involved in an adverse event (Lead: Stephen Hicks, Peer Support Lead)	Validated 2020: $19,829 2021: $21,730.40	100%	Proactive support to peers, not just after adverse events	Ongoing training and monthly peer support meetings organized by lead, Stephen Hicks. Peer support training by Beta was held virtually June 2021, with 18 peer supporters in attendance.
Early Resolution: A process for early resolution when harm is deemed the result of inappropriate care or medical error (Lead: Theresa Crowe, Risk Manager)	Validated 2020: $19,829 2021: $21,730.40	100%	"Pacesetter Article" and "Safety Firsts" to enforce the principles of the 5 Domains	Early Resolution is the final domain and is only achieved by successfully completing all 4 prior domains. TFHD utilizes the BETA Heart Dashboard to monitor the effectiveness of meeting these goals. Topic for Beta Workshop 3 to be held September 30-Oct.1, 2021. 12 employees to attend.

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 Advanced Practice Strategies' GNOSIS™) for our members and insureds. Tier 1 participants must complete the *Fetal Heart Monitoring* personalized learning module to assess clinical knowledge and judgment pertaining to electronic fetal heart rate monitoring and maternal physiology strategy via the Relias Platform. Hospitals must meet 100% compliance in the components of Tier 1, the assessment and standardized terminology to qualify for credits in Tier 2. 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 1.

Organizations receive additional benefits for implementing optional Tier 2 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 2021 policy period (7/1/2021-6/30/2022).

Value of Participation:

Tier 1 is valued at 2% of your hospital premium, related to the first $5 million in limits purchased. There is opportunity to gain additional credits by choosing up to two additional loss prevention options in Tier 2, 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. Utilize the tools and resources contained in our Perinatal Toolkit, as the tools contained therein represent best practice models. 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 Lisa Matheny, Director, Risk Management and Patient Safety at lisa.matheny@betahg.com or at 818-507-9648.

DEMOGRAPHIC

Date of Assessment: _____

Facility Name: _____

BETA Risk Director: _____

OB Director: _____

Facility Leadership

Chief Executive Officer: _____
Chief Financial Officer: _____
Chief Nursing Officer: _____
Chair of OB: _____
Nurse Manager: _____
Clinical Nurse Specialist: _____

Broker: _____ Date Notified: _____

Licensed Beds

Labor & Delivery: _____ Newborn: _____
Antepartum: _____ NICU: _____ Level: I II III
Postpartum: _____ OR Suite: _____ PACU: _____

Collaborative Involvement

CHPSO: □ Y □ N
CMQCC:
- Data □ Y □ N
- Preeclampsia □ Y □ N
- Hemorrhage □ Y □ N

CPQCC: □ Y □ N
IHI: □ Y □ N
MOD: □ Y □ N
Regional Hospital Association: □ Y □ N

TIER 1

Annual EFM Assessment

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

Requirement	Goal	Validation
The Relias Platform personalized learning module *Fetal Heart Monitoring* 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 Produce 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* 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 Produce 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 and confirmation of completions
Perinatal units performing reassessment of the Relias Platform personalized learning module *Fetal Heart Monitoring* 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**	Produce Relias analytics report showing with an overall increase in Knowledge Domain scores of 1.5% (or scores in upper quartile)

The requirement for annual assessment of EFM principles is contained in OB privilege form and/or adopted as a Rule and Regulation of the department.	□ **Met** □ **Not Met**	Review OB privilege sheet and/or R&R of department for policy language stipulating this as a requirement for privileging
The requirement for annual assessment of EFM principles is contained in the L&D nurse job description.	□ **Met** □ **Not Met**	Review job description and/or human resources policy which stipulates this requirement

TIER 1

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	Findings	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**	Provide medical records of the last 10 deliveries occurring at the facility
All electronic medical record documentation fields are compliant with the above terminology.	□ **Met** □ **Not Met**	Access to, and 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**	Access to, and review of, all paper documentation, scanned or in print, that 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 all policy and procedures applicable to the Labor and Delivery setting

TIER 1 or TIER 2

OB Rapid Delivery Bundle – 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
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 *See sample protocol contained in BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	Emergency Response policy review
Assessment of physical plant in relation to achieving a rapid cesarean section, including a remediation plan for potential barriers. *See self-assessment tool contained in BETA's Perinatal Toolkit.*	□ **Met** □ **Not Met**	Review of 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. • Credit for live situation with robust debrief	□ **Met** □ **Not Met**	Evidence of participation by all staff and providers reflected in dated sign-in sheets Review of debrief forms

TIER 1 or TIER 2

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
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 *See algorithm examples and mobile Apps contained in BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	Policy review/algorithm review Audit 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 *See sample protocol contained in BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	Policy/protocol Review Evidence of signal ambiguity education reflected in dated sign-in sheets Review of 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	□ **Met** □ **Not Met**	Evidence of strip review rounds/huddles documented on daily staffing sheet, charge RN board, or sign-in sheets

• Huddles may be called by any member of the team at any time to discuss the plan of care or a tracing		
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* to use as an alternative Tier 1 strategy.*	□ **Met** □ **Not Met**	Produce 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 Lisa Matheny, Director, Risk Management and Patient Safety at lisa.matheny@betahg.com or at 818-507-9648 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
A protocol addressing role delineation and responsibilities for OB emergencies is in place, • Implement standard work for assignment of nursing emergency roles each shift • Create 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 *See resources contained in BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	Review protocol for role delineation Evidence of training for role delineation (agenda and dated sign-in sheets)
Critical Communication • 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 I*SBAR+R: Structured Communication for Healthcare Providers* offered through the Relias Platform, or TeamSTEPPS). • Implement and utilize SBAR+R or similar tool during anticipated or actual OB emergency • Communication during emergency is reviewed during debrief, including use of SBAR+R or similar tool	□ **Met** □ **Not Met**	Evidence of communication training reflected in Relias completion reports or dated sign-in sheets Review communication tool Observation on unit Review debrief tool
Implement unit-specific chain of command	□ **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 PI log review
Implement a policy or protocol describing triggers to obtain umbilical arterial and venous cord gases, to include at minimum all emergently delivered cases.	□ **Met** □ **Not Met**	Policy / protocol review Medical record review
Define indications/triggers for placental pathology, to include at minimum all emergently delivered cases.	□ **Met** □ **Not Met**	Policy review Medical record review

TIER 1 or TIER 2

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
Post event team debriefs are held, at minimum, following each emergent cesarean delivery	□ **Met** □ **Not Met**	Review 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) times for evidence of operational response to level of urgency classification	□ **Met** □ **Not Met**	Review data for D2I times for all levels of urgency
Post-Event review processes are in place for: • 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

Communication

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

Requirement	Goal	Validation
Deliver training on communication to all staff that practice in perinatal services in an interdisciplinary setting. Examples of training include: • Vital Smarts *Crucial Conversations* training. • TeamSTEPPS Communication module content delivered by certified master trainers. • PURE Communication in Obstetrics *For more information about the required content or to arrange training through BETA, please contact Lisa Matheny at lisa.matheny@betahg.com*	□ **Met** □ **Not Met**	Medical staff roster provided on day of validation Nursing staff roster provided on day of validation Evidence of communication training participation by all staff reflected in dated sign-in sheets
A unit-specific chain of command algorithm is laminated and posted in an area visible to all staff.	□ **Met** □ **Not Met**	Evidence of algorithm - Observation
Implement handoff tool such as SBAR-R to ensure accurate and complete report.	□ **Met** □ **Not Met**	Evidence through chart review or other record keeping if not contained in the chart
Track and monitor effectiveness of the handoff tool as a performance improvement measure monthly beginning no later than month six of the policy year. This measure includes a requirement to observe use of handoff tool for compliance.	□ **Met** □ **Not Met**	Documentation of, at minimum, monthly observations in practice beginning no later than month six of the policy year

TIER 2

Culture of Safety

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

Requirement	Goal	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 Safe & Reliable Healthcare • Pascal HealthBench SAQ • Agency for Healthcare Research & Quality (AHRQ) *To learn more access BETA's Perinatal Toolkit* *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
A baseline survey must be administered by month six of the policy year. Goals for improvement are based on findings. There is evidence that an annual survey will be conducted to measure performance.	□ **Met** □ **Not Met**	As above
Evidence that the culture survey results were shared and discussed at medical staff committee and nursing staff meetings. Evidence of discussion is contained in meeting minutes.	□ **Met** □ **Not Met**	OB Committee meeting minutes 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. *See debriefing resources contained in BETA's Perinatal Toolkit.*	□ **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 all staff reflected in dated sign-in sheets

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 develop potential solutions.	□ **Met** □ **Not Met**	Evidence of participation by all staff reflected in dated sign-in sheets
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. *For more information about Leadership WalkRounds access BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	Activity sheets are collected and signed by the CEO, CNE or CMO; whomever is conducting that specific WalkRound

TIER 2

Data Visibility & Transparency

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

Requirement	Goal	Validation
The organization participates in, at minimum, one formal or informal performance improvement projects to include CMQCC, IHI, CPQCC, MOD, Regional Projects.	□ **Met** □ **Not Met**	Evidence of participation & performance.
The organization studies outcomes utilizing Trigger Tool screening mechanisms. *See BETA's Perinatal Toolkit for examples.*	□ **Met** □ **Not Met**	Trigger Tool metrics
The organization provides incident report trends to medical staff committee and to nursing staff. At minimum of 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 one-page *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) *See BETA's Perinatal Toolkit for example.*	□ **Met** □ **Not Met**	Most recent scorecard
A "White Board" designed to address current progress to goal 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 *See BETA's Perinatal Toolkit for other examples*	□ **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
BETA member facility has achieved World Health Organization's Baby Friendly status.	□ **Met** □ **Not Met**	Evidence of certification
Elective delivery does not occur prior to 39 weeks gestation. This is defined in policy and is approved by medical staff. PC-01 Elective Delivery	□ **Met** □ **Not Met**	Induction of Labor Policy Operating Room Scheduling Policy
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. Compliance with this measure must be met at minimum of 90% compliance averaged over 12-month period.	□ **Met** □ **Not Met**	Evidence of data collection and performance Committee meeting minutes (or excerpt indicating reporting component)
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 in the Perinatal Toolkit or at the following CDC link: https://www.cdc.gov/ncbddd/jaundice/documents/jaundicemgmtbrochure.pdf	□ **Met** □ **Not Met**	Discharge instruction 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**	Provide medical records of the last 10 deliveries occurring at the facility
Discharge phone calls are implemented, and performance is measured to ensure 90% compliance at minimum. *Example may be found in BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	Review phone call log

TIER 2

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
A multi-departmental and interdisciplinary protocol for management and treatment of preeclampsia/eclampsia is in place and is approved by medical staff.	□ **Met** □ **Not Met**	Preeclampsia/Eclampsia policy/protocol Magnesium protocol
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 or in BETA's Perinatal Toolkit.*	□ **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 cases to be sent for peer review are defined in policy. *Examples may be found at www.CMQCC.org or in BETA's Perinatal Toolkit.*	□ **Met** □ **Not Met**	Evidence of debriefing forms Preeclampsia or peer review policy
All staff in L&D, antepartum and postpartum must complete training and 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)*	□ **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 antepartum, labor and delivery and postpartum

• *Nursing Care of the Patient with Hypertensive Disorders in Pregnancy (Nurse)*		
Simulation and/or drills specific to preeclampsia/eclampsia occur annually. All physicians, nurses, family practitioners, CNM's, surgical scrub technicians, lab/blood bank, pharmacy and anesthesia participate. *Examples may be found at www.CMQCC.org or in BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	Medical staff roster Nursing staff roster Evidence of participation by all staff reflected in dated sign-in sheets
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 or in BETA's Perinatal Toolkit.*	□ **Met** □ **Not Met**	Observation Evidence of orientation attended by all staff reflected in dated sign-in sheets

TIER 2

Interdisciplinary Fetal Strip Review

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

Requirement	Goal	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
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 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 contained in dated sign-in sheets

TIER 2

Maternal Early Warning System (MEWS)

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

Requirement	Goal	Validation
Develop MEWS/MEOWS criteria/triggers that are approved by medical staff. *Examples may be found in BETA's Perinatal Toolkit.*	□ **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 *Protocol example may be found in BETA's Perinatal Toolkit* 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
System Learning/Evaluation: 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

TIER 2

Maternal Sepsis- Readiness

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

Maternal Sepsis will 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
Form a Multi-disciplinary Maternal Sepsis Team (Physician champion/ nurse champions, pharmacy, lab, ICU) to lead project. Team will meet at least quarterly *Sample charter may be found in BETA's Perinatal Toolkit*	□ **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

TIER 2

Maternal Sepsis- Recognition

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

Maternal Sepsis will 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
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 *See sample protocol contained in BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	Maternal Sepsis Protocol/SIRS Criteria review

TIER 2

Maternal Sepsis- Response

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

Maternal Sepsis will 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
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. *See sample protocol contained in BETA's Perinatal Toolkit*	□ **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

TIER 2

Maternal Sepsis- Reporting/Learning Systems

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

Maternal Sepsis will 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
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 the Council on Patient Safety in Women's Health Care*	□ **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. *See data tracking spreadsheet contained in BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	Evidence of data collection and performance
Data: Choose on additional measure, at minimum: 1. 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

2. 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 3. 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.		

TIER 2

NCC Certification (RNC) Credential

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

Requirement	Goal	Validation
All eligible staff* in the departments listed below will sit for the RNC exam by May 1 of policy year. Four exams exist: • Inpatient Obstetrical Nursing (L&D) • Maternal Newborn Nursing (Postpartum/Antepartum) • Neonatal Intensive Care Nursing (NICU) • Low Risk Neonatal 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 2 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

TIER 2

Nulliparous Cesarean Section

Institute for Healthcare Improvement

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

Requirement	Goal	Validation
Perform a baseline perinatal structure analysis at the beginning of this strategy. • The perinatal structure deep dive tool should be completed by 15-20 nurses and physicians • Collate results and enter data into provided Excel audit spreadsheet *See BETA's Perinatal Toolkit for the Perinatal Structure tools* Report findings to team through staff meetings and appropriate medical staff committee (Quality or OB Committee).	□ **Met** □ **Not Met**	Evidence of data collection and results Staff/Committee meeting minutes (or excerpt indicating reporting component)
Using the Labor Deep Dive tool, evaluate all nulliparous cesarean deliveries performed at the facility over a 3-month period. *See Perinatal Toolkit for labor deep dive tools and process review map* 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)
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) *See Perinatal Toolkit for examples of definitions*	□ **Met** □ **Not Met**	Induction of Labor/ Augmentation Policy EFM Policy Second Stage of Labor Policy Operating Room Scheduling Policy

TIER 2

Nulliparous Cesarean Section

Part II – Year II

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

Requirement	Goal	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. *See Perinatal Toolkit for examples of definitions*	□ **Met** □ **Not Met**	Induction of Labor/ Augmentation Policy EFM Policy Second Stage of Labor Policy Operating Room Scheduling Policy Evidence of data collection and performance
Based on Labor Deep Dive 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 Lisa Matheny @ lisa.matheny@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 the Labor Deep Dive tool, evaluate all nulliparous cesarean deliveries performed at the facility over a 3-month period. • Collate results into Excel spreadsheet *See Perinatal Toolkit for labor deep dive tools* 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)

TIER 2

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
All 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
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 or in BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	Hemorrhage policy/protocol Massive transfusion protocol
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. *Examples may be found at www.CMQCC.org or in BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	Medical staff roster Nursing staff roster Evidence of participation by all staff reflected in dated sign-in sheets
An emergency OB hemorrhage cart is in place in L&D and Postpartum. All staff are oriented to its contents and use. *Example hemorrhage cart contents may be found at www.CMQCC.org or in BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	Nursing staff roster Evidence of orientation/in-service attended by all staff reflected in dated sign-in sheets
The Quality department conducts 100% review of blood utilization.	□ **Met** □ **Not Met**	Trending report of Quality metric: Blood Utilization

TIER 2

Patient and Family Centered Care

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

Requirement	Goal	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. *See Readiness Assessment in BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	Evidence of executed Readiness Assessment
A policy is in place in perinatal services that is designed around including patients on improvement teams. This may be accomplished through the formation of a Patient & Family Advisory Council which includes perinatal services.	□ **Met** □ **Not Met**	Patient & Family Advisory Council Policy & Procedure
In partnership with a patient partner, identify 3 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 Copy of staff minutes and medical staff committee meeting minutes discussing the findings and action plan Provide evidence of implementation of the changes and sustained gains
Disclosure Communication and Transparency: All staff, to include physicians, nurses, nurse midwives, family practitioners, and anesthesia, have viewed the DVD, ***When Things Go Wrong: Voices of Patients and Families***, available in BETA's lending library. Contact Mya Zaka at mya.zaka@betahg.com to order your copy.	□ **Met** □ **Not Met**	Nursing staff roster Medical staff roster Evidence of participation by all perinatal staff reflected in dated sign-in sheets
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

TIER 2

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
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
Identify a mechanism within the organization for driving the adoption of the identified screening tools and response protocol.	□ **Met** □ **Not Met**	Review of process identified
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. *See BETA's Perinatal Toolkit for example pamphlets/resources*	□ **Met** □ **Not Met**	Review of community resources/referral documents

TIER 2

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
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). *Sample protocols may be found in BETA's Perinatal Toolkit*	□ **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

TIER 2

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
Ensure implementation of a stage-based response protocol for a positive mental health screen *Sample protocol may be found in BETA's Perinatal Toolkit*	□ **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 assure 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

TIER 2

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
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
Perinatal Risk Assessment is scheduled with a BETA Risk Director no later than six months prior to the end of the policy period.	□ **Met** □ **Not Met**	Perinatal Risk Assessment scheduled
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 Director
Requested interviews will be scheduled at least 2 weeks prior to the assessment	□ **Met** □ **Not Met**	Interview schedule sent to BETA Risk Director
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 Director: • 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 1 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

TIER 2

Perinatal Safety Collaborative

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

Requirement	Goal	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 Roll-call will be taken during all scheduled phone meetings and webinars
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

TIER 2

Second Stage of Labor Management

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

Requirement	Goal	Validation
A policy is in place pertaining to the second stage of labor and incorporates the AWHONN second stage of labor management algorithm.	□ **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 12-month period.	□ **Met** □ **Not Met**	Provide medical records of the last 10 vaginal deliveries occurring at the facility
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 and protocol is in place which requires placental pathology for established indications. The policy shall include a 7-day retention period (at minimum), have a labeling mechanism and appropriate storage. In the alternative, a process that retains slide sections of placentas in pathology may be in place. The policy shall allow the neonatologist or pediatrician to order pathological exam should an indication be overlooked.	□ **Met** □ **Not Met**	Placenta Policy

TIER 2

Shoulder Dystocia

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

Requirement	Goal	Validation
A risk screening mechanism is in place. This can be accomplished through technology, or a formalized tool approved by medical staff. *See BETA's Perinatal Toolkit for example.*	□ **Met** □ **Not Met**	Review of risk screening mechanism
A policy is in place pertaining to the management of shoulder dystocia that incorporates the current ACOG recommendations, and the policy is approved by medical staff. ACOG Practice Bulletin #178 Shoulder Dystocia, 2017	□ **Met** □ **Not Met**	Shoulder Dystocia Policy
A second stage of labor management protocol is in place, all staff are oriented to the AWHONN approved algorithm, and the policy is approved by medical staff.	□ **Met** □ **Not Met**	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 *See resources contained in BETA's Perinatal Toolkit.*	□ **Met** □ **Not Met**	Provide medical records of the last 10 documented shoulder dystocia deliveries (or 100% of shoulder dystocia deliveries in the last 12-month period if less than 10)
All staff and providers in L&D must complete training and education on shoulder dystocia. This may be accomplished by completing the Relias Platform *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. All staff to include physicians, nurses, nurse midwives, family practitioners, neonatal staff and anesthesia shall participate.	□ **Met** □ **Not Met**	Medical staff roster Nursing staff roster Evidence of participation by all staff reflected in dated sign-in sheets.

TIER 2

Simulation and Drills

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

Requirement	Goal	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
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 • Anesthesia emergency such as high-block or over sedation	□ **Met** □ **Not Met**	Scenario utilized shall be produced on day of validation
A debrief process is in place and there is documented evidence of the debriefs, preferably written by staff, identifying individual learning.	□ **Met** □ **Not Met**	Debrief summary 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

Team Training Techniques

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

Requirement	Goal	Validation
A unit-based agreement to deploy TeamSTEPPS principles and 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. *The baseline assessment tool may be found in BETA's Perinatal Toolkit.*	□ **Met** □ **Not Met**	Evidence of baseline readiness assessment findings and signed attestation of senior leadership's support of the principles
Develop in-house staff as certified trainers utilizing the "train the trainer" methodology to deploy TeamSTEPPS training or other CRM training techniques. BETA has certified Master Trainers who are available to you free of charge. *For more information about this training please contact Lisa Matheny at lisa.matheny@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**	Evidence of participation by all staff reflected in dated sign-in sheets
The CATS model of observation is deployed to measure performance and confirm adoption of CRM principles. Observations shall occur starting at completion of the training. *See resources contained in BETA's Perinatal Toolkit.*	□ **Met** □ **Not Met**	Evidence of documented observations and results shall be provided 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
Implement bundle requirements and measure for compliance to meet at minimum 90% compliance with all elements by May 1 of policy year.	□ **Met** □ **Not Met**	Provide medical records of the last 10 deliveries occurring at the facility involving vacuum
The Quality Improvement Department reviews 100% of all vacuum deliveries.	□ **Met** □ **Not Met**	Quality metrics
Alternative labor strategies to rest between pushes or open glottis pushing are adopted as common practice and education is provided to all clinicians in L&D on management of second stage of labor in accordance with AWHONN algorithm.	□ **Met** □ **Not Met**	Second Stage of Labor Policy/protocol Nursing staff roster Evidence of participation by all staff reflected in dated sign-in sheets
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**	Vacuum Policy
Informed consent is documented to include the risks, benefits, and alternatives of applying a vacuum during delivery.	□ **Met** □ **Not Met**	Medical record review
Estimated fetal weight is documented in the medical record.	□ **Met** □ **Not Met**	Medical record review
Fetal position and station are documented in the medical record.	□ **Met** □ **Not Met**	Medical record review
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**	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

TIER 2

Venous Thromboembolism (VTE) Bundle

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

Requirement	Goal	Validation
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 https://safehealthcareforeverywoman.org/	□ **Met** □ **Not Met**	VTE risk assessment tool review
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 *See resources contained in BETA's Perinatal Toolkit*	□ **Met** □ **Not Met**	VTE policy and procedure review
All staff in L&D, antepartum and postpartum must complete training and education on prevention, diagnosis, and management of VTE. All staff in L&D, antepartum and postpartum are oriented to the VTE protocol. *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 2021-2022

The (name of hospital) _____

intends to accomplish: (This usually contains an overarching statement describing what you intend to do i.e.: reduced birth injury to zero)

_____

_____

_____

_____

_____

by: Time frame, i.e., month/year by which you intend to accomplish improvement-unless for some reason you have another start date, recommend July 1, 2021 and end May 1, 2022.

_____

Our goals include: These are goals for your measures. Your measures for this project should of course align with your Quest for Zero components. See Quest for Zero Guideline.

-
-
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-
-
-

Our Stakeholders include: (These are the people involved with and affected by your process and improvement initiative. The success of your improvement initiative often depends on the inclusion and involvement of multiple stakeholders.)

-
-
-

NOTES

BETA Healthcare Group (BETA) is focused on improving reliability and reducing risk in emergency medicine. As your partner in patient safety, BETA provides its members and insureds a tiered approach to receive premium credit while enhancing safety. BETA organizations that provide emergency services are eligible to participate on an annual basis in our Quest for Zero: Excellence in ED initiative, which introduces key concepts designed to enhance the quality of care in this high-risk clinical setting.

Menu Selection:

BETA offers an education platform through Relias. The personal learning module, which measures a clinician's knowledge and judgment in diagnostic treatment and/or care delivery, and the personalized learning path (red and yellow zones) must be completed by all providers and nurses practicing in the ED in order to qualify for Tier 1. Note: the assessment component includes a performance improvement measure for individuals taking a re-assessment of Relias Platform that must be met to achieve compliance in Tier 1.

If Tier 1 is met, members and insureds receive additional benefits for implementing optional Tier 2 strategies customized to meet the individual member's risk profile needs. A description of each strategy, subcomponents, and the associated metrics are contained within this ED Guideline applicable to the 2022 contract year (7/1/2021-6/30/2022) or 2022 policy year (1/01/2022 – 12/31/2022), whichever applies.

Value of Participation:

Tier 1 is valued at 2% of your emergency department premium. There is further opportunity to gain additional credits by choosing up to two additional options per year in Tier 2, each worth an additional 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: ED Guideline carefully. Utilize the tools and resources contained in our emergency medicine Toolkit, as the tools contained therein represent best practice models. 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 emergency 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 Quest please contact Al Duke, Manager, Risk Management and Patient Safety at al.duke@betahg.com or at 818-549-9479.

DEMOGRAPHIC

Date of Validation Assessment: _____

Facility Name:_____

BETA Risk Director: _____

ED Director: _____

Facility Leadership

Chief Executive Officer: _____

Chief Financial Officer: _____

Chief Nursing Officer: _____

Chair of Emergency Medicine: _____

Nursing Leadership

Director: _____ Manager:_____

Clinical Nurse Specialist: _____

Broker: _____ Date Notified: _____

Licensed Beds

Critical Beds: _____ Acute Beds: _____ Fast Track: _____ Hall Beds: _____

Urgent Care: _____ Internal Waiting Room: _____ Hold Beds: _____

Trauma Level: I II III

Stroke Accreditation: _____ Level _____

Cardiac Accreditation: _____ Level _____

Collaborative Involvement

CHPSO	□Y □ N
Regional Hospital Association	□Y □ N
Emergency Nurses Association	□Y □ N
American College of Emergency Physicians	□Y □ N

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TIER 1
ANNUAL PERSONAL PROFICIENCY MODULE

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
The Relias Platform Personal Learning Module is completed by all Physicians, Residents, Physician Assistants, Nurse Practitioners covered by BETA 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	Staff roster is due to BETA on date of validation survey. Produce Relias report to demonstrate completion of assessment.
All nursing staff, to include travelers and registry must complete the Relias Platform Personal Learning assessment 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. Produce Relias report to demonstrate completion of assessment.
Based on the Relias Platform Personal Learning module, the participant must complete all designated “Red & Yellow Zones” *no later than 60 days before policy/contract renewal* *HealthPro insureds must meet the requirement within their annual policy period	❑ Met ❑ Not Met	Evidence of Personalized Learning module and confirmation of completion(s)
ED Units performing a reassessment of Relias Platform Personal Learning module must show a combined average score improvement of 1.5% in the knowledge domain a. a. A provider and nurse unit average in the upper 25th percentile need only maintain that upper quartile.	❑ Met ❑ Not Met	Produce Relias analytics report demonstrating an overall increase in knowledge domain scores of 1.5% (or scores in upper quartile).

QUEST FOR ZERO ED SEPSIS COLLABORATIVE

Management of sepsis is a complicated clinical challenge requiring early recognition and management of infection, hemodynamic state, and organ dysfunction. This year, BETA Healthcare Group is developing a Sepsis Collaborative and invite you to join us in fighting the tragic effects of sepsis. The Sepsis Collaborative is a two-year process designed to develop, implement, and improve your department's response to patients exhibiting signs or symptoms of the sepsis syndrome.

Requirement	Findings	Validation Process
Implement the Severe Sepsis Bundle recommended in the 2018 International Guidelines for Management of Severe Sepsis and Septic Shock. Implementation to include quality oversight and must be in effect for a minimum of one year prior to qualifying for this option. 1. Develop a protocol for treating patients with sepsis-induced tissue hypoperfusion, defined as hypotension persisting after an initial fluid challenge or blood lactate concentration ≥4. The protocol must include: a. A screening tool to be used by nursing for prompt identification of patients likely to require the implementation of the Sepsis Protocol. b. Measurement of lactate level promptly upon patient's arrival. c. When possible, obtain blood cultures as well as cultures from other likely sources of infection (urine, cerebrospinal fluid, wounds, respiratory secretions) prior to administration of antibiotics. If > than 45 minutes to obtain cultures, do not delay antibiotic therapy. d. Administer broad-spectrum antibiotics within one hour of presentation. e. Administer 30ml/kg isotonic fluid bolus. f. If the patient is hypotensive or has lactate ≥4, administer a bolus of crystalloid at 30ml/kg within the first hour. And, if indicated, within the first hour: g. Administer vasopressors if hypotension is not responsive to initial fluid resuscitation to maintain mean arterial pressure ≥ 65mm Hg	❑ Met ❑ Not Met	Copy of sepsis protocol *submitted to BETA 60 days prior to policy/contract renewal* for review to ensure it meets the evidence-based recommendations.

Requirement	Findings	Validation Process
(Norepinephrine is identified as the drug of choice in septic shock). h. Remeasure lactate level if initially elevated.		
2. Develop screening tool for early identification of patients presenting with sepsis and provide training. The screening tool shall include: a. A clear definition of when the use of a screening tool is indicated b. A trigger to capture the need for the use of the screening tool if using EMR c. Training 100% of ED staff on the use of the tool	❑ Met ❑ Not Met	Provide a copy of the screening tool, ED nursing roster, and sign-in sheet as evidence that training was completed. Medical record review of five patient records with diagnosis of sepsis.
3. Compliance with the sepsis protocol and proper use will be introduced through the quality review process and include: a. Quality review to be performed at minimum, monthly. b. Individual coaching of ED staff to include both positive feedback on compliance as well as any identified opportunities for improvement. c. The findings of physicians, PA's and NP's are delivered to the Medical Director. The results are shared (positive feedback and opportunities for improvement) with the individual providers. d. Reports of compliance with the Sepsis Protocol are presented at the Emergency Department Committee and Medical Staff Quality Committee meetings. The report(s) is evidenced by and reflected in the meeting minutes. e. When barriers are identified, action plans are developed and implemented to address the issues	❑ Met ❑ Not Met	Provide a copy of the monthly quality improvement report addressing compliance with the Sepsis Protocol and evidence of individual feedback provided to staff and physicians. Access to Emergency Department and Medical Staff Quality Committee meeting minutes addressing the following: • reporting of sepsis bundle compliance that reflects at a minimum 60% compliance with the use of the screening tool • evidence of timely tests and treatment which is defined as completion within the recommended timeframes.
4. All registered nurses practicing in the Emergency Department must complete the Relias Platform Personal Learning module on Sepsis.	❑ Met ❑ Not Met	The facility will provide the required documents to BETA 60 days before policy renewal. Review current staff roster

Requirement	Findings	Validation Process
Based on the individualized Relias Platform Personal Learning module, participants must complete all designated "red and yellow zones," no later than 60 days before policy/contract renewal. Physicians and midlevel providers must complete one hour of sepsis specific education.		Review Certificates of Completion for 100% of registered nurses. Review roster of provider education Review education syllabus/outline
Year 2: 1. Achieve 90% compliance with the bundle one-hour goal 2. Illustrate process improvement. 3. There is evidence of cross-departmental collaboration where sepsis patients may be transferred to assure continuity of Care. Areas of focus may include: a. Formalized handoff b. Evidence of ongoing progress toward completion of the sepsis bundle elements Registered nurses and providers complete the required Relias GNOSIS Personal Proficiency Module on Sepsis* *Physicians and midlevel providers must complete one hour of sepsis specific education. Based on the individualized GNOSIS Learning Path, participants must complete all designated "Red, and Yellow," no later than 60 days before policy/contract renewal.	❑ Met ❑ Not Met	Review each of the following: 1. Performance Improvement Plan 2. Formalized handoff tool or process 3. Medical record review 4. Review Performance Improvement Plan 5. Review Handoff tool usage compliance Review Certificates of Completion for 100% of registered nurses and providers. *The facility shall provide the required documents to BETA 60 days before policy renewal.*

TIER 2
PARTICIPATION ON THE ED COLLABORATIVE

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

Requirement	Findings	Verification Process
• Identify two emergency department leaders to represent your facility on the ED Collaborative o Team to include a physician leader and a nurse leader, and Risk Manager/ Director, or Quality representative. 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 by the deadline set by ED Collaborative.

• Attend a minimum of two full-day in-person ED Collaborative meetings as outlined in the ED Collaborative Timeline
  o Team participation must be a minimum of 100% of all scheduled meetings and calls.
  o Representation means at least one member of the facility designated team will be in attendance
	❑ **Met**
	❑ **Not Met**
		Sign in rosters will be used to determine attendance at in-person meetings. Rollcall will be taken during all scheduled phone meetings and webinars.

• Lead or co-lead a subgroup as assigned by the ED Collaborative. • Complete all assignments by the agreed-upon deadline. • Participate in initial research, craft recommended practices, establish outcome measures, pilot recommendations and provide feedback as outlined by the ED Collaborative Memo of Understanding.	❑ **Met** ❑ **Not Met**	Although participation is subjective, a fair and objective assessment of participation will be done, and BETA will make the final determination regarding participation.

TIER 2
ORGANIZATION-WIDE MANAGEMENT OF EMERGENCY DEPARTMENT PATIENT SURGE CAPACITY

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

Requirement	Findings	Validation Process
Emergency medical groups and members must review and implement the strategies as outlined in the BETA Toolkit, "Organization-wide Management of Emergency Department Patient Surge Capacity" The policy/procedure or plan reflects the following elements 1. Cross-references the Patient Surge Capacity Plan if a separate document 2. Glossary of key terms defined by the organization. To include: a. Against Medical Advice b. Boarding c. Capacity d. Early Warning System e. Left without Being Seen f. Time "Seen by Provider" g. Patient Surge h. Throughput 3. Identifies which validated, objective overcrowding tool the Emergency Department uses. Examples include: National Emergency Department Overcrowding Scale (NEDOCS) or Community Emergency Department Overcrowding Scale (CEDOCS). 4. Outlines the process for triggering the Organization-wide Plan when ED activity reaches "Extremely busy but not yet overcrowded" through "Severely overcrowded" 5. Identifies for each of the tiered levels, the response to be taken by all units and departments to help prevent overcrowding from escalating 6. The Plan specifies a position responsible each shift to monitor ED activity at regular intervals to assess necessity for plan activation including: a. Once per shift b. After any rapid influx or surges of patients presenting to the ED	❑ Met ❑ Not Met	The process must be in place a minimum of 6 months before qualifying for consideration to meet Tier 2. Review Organization-wide Management of Emergency Department Patient Surge Capacity policy(s) *Review: ED Central Log for the previous six months.* *Review of log used to document ED activity levels and actions taken for the previous six months.* *Documentation must evidence ongoing compliance with the Plan*

Requirement	Findings	Validation Process
c. One to two hours before routine reduction of treatment area beds in the ED 7. Specifies the process used to document shift activity when assessed and actions taken 8. Requires orientation and competency verification of float and registry staff		*The facility will provide the required documents to BETA 60 days before policy renewal.*
If the organization currently has an active organization-wide plan for management of patient surge capacity in the ED, conduct a Gap Analysis utilizing the Tool provided in the BETA Healthcare Group Toolkit. If no plan currently exists or if current plan is not implemented organization-wide; utilize the "Building an Organization-wide Management of ED Patient Surge Capacity Plan Development Guide & Worksheet" provided in BETA's Toolkit.	❑ Met ❑ Not Met	Review completed Gap Analysis Tool with assigned action items, target dates to bridge any gaps Review the Plan Development Guide and Worksheet.
Conduct a formal plan launch to include a. Dissemination of Plan strategies b. Role of each department c. Review of Job Action Sheets (or similar tool) for each position d. Verify that all staff in every department/unit throughout the organization are aware of the Plan and their expected response	❑ Met ❑ Not Met	Review materials used to disseminate Plan expectations Review roster of names of individuals with assigned roles and corresponding sign-off sheet of receipt of training for Plan implementation.
Verify staff competency with Plan implementation. a. Conduct simulation and drills on each shift and on various days of the week to include weekends	❑ Met ❑ Not Met	Provide evidence of scenario used for simulation (may be activation level) and documentation reflecting that those with assigned roles are provided timely feedback and acted upon according to the level of the activation.

Requirement	Findings	Validation Process
Provide float and registry staff with unit orientation and verify competencies prior to making patient assignments during patient surges. (Note: best practice is to cross-train and orient float staff to the ED during quiet periods when staff are able to better respond to questions and provide guidance.)	❑ Met ❑ Not Met	Review of tools/checklists used for unit orientation of float and registry staff Review tool used to verify competency Review roster of individuals floating to the ED in the previous six-months Review the personnel files of ten random float and registry nurses to verify presence of completed competency checklist and unit orientation checklist
Measuring Plan effectiveness Post-Surge debriefs will be conducted to determine opportunities for improvement in communication and with Plan compliance. The debriefs will be documented according to a formal process and will include action items, assigned individuals and target dates for completion as indicated. Develop a performance improvement metric using the number of times a code activation was indicated each day as the denominator with the number of actual activations as the numerator. These numbers should be reported through the quality committees of the organization and include any barriers that are identified and addressed.	❑ Met ❑ Not Met	Review copy of the completed tool used for debriefing after a patient surge capacity activation. Review performance Improvement data by month for the previous six-months.

TIER 2
MANAGEMENT OF MENTAL HEALTH PATIENTS IN THE ED

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

Requirement	Findings	Validation Process
Emergency medical groups must review and implement the strategies as outlined in the BETA Toolkit, "Management of Mental Health Patients in the ED" Implementaition is formalized in policy. The policy and/or procedure reflects the following elements 1. Determination of primary and secondary locations best suited to keep agitated patients and those at risk of harming self or others safe. 2. Requires use of a formal tool or checklist to ensure treatment area is properly vetted for safety prior to patient placement. a. Use of secondary review when treatment space is not commonly used for this patient population 3. Contains or cross-references a policy and procedure for conducting patient searches. a. Includes criteria for when searches are warranted b. Guidance of what to look for c. Management of weapons & contraband, including marijuana d. Securing patient belongings e. Documentation 4. Use of trained sitters or cross-references a separate policy and procedure addressing the use of sitters. a. Defines levels of observation and when 1:1 observation is indicated b. Scope of duties c. Oversight d. Training and Competency e. Use of trained mental health peer supporters or cross-trained ED/psych techs	❑ Met ❑ Not Met	The process must be in place a minimum of 6 months before qualifying for consideration to meet Tier 2. Review Management of Mental Health Patient policy(s) Review tool or checklist utilized for environmental safety check Review ten medical records, randomly selected, for evidence that tool or checklist is utilized for all agitated patients and those who are at risk of harm to self or others. *Review Patient Search policy* *Review ten medical records, randomly selected, for evidence of documentation of rational for patient searches, findings, and shows evidence of how belongings were secured. [May require review of Care of Patient Belongings & Valuables policy]* *Review roster of staff providing Sitter Services in the ED over the past twelve months.* *Review Use of Sitters policy if a separate policy* *Review a copy of the educational materials used for sitter training* *Review of Competency Checklist and Sitter Observation Records* *Examine five trained sitter's personnel files for evidence of completion of formal training and demonstrated competency*

Requirement	Findings	Validation Process
f. Requires use of formal tool to evidence ongoing observations 5. Recognizes that different mental health issues require varied approaches in management. a. Importance of determining patient's decision-making capacity b. Determining patient's risk of suicide and elopement c. Meeting the patient's needs for reassurance and control 6. Details objective criteria for patient detainment, transfer and discharge a. Provides guidance for use of 5150 and 1799.111 b. Utilizes objective criteria for when patient should be stopped from leaving the department vs. allowing to elope and notifying law enforcement c. Patient's willingness for voluntary in-patient treatment if indicated 7. Provides a list of local outpatient mental health clinics and resources specific to common presentations a. Requires review of information and updating on an annual basis 8. Requires ED staff huddle when high-risk patient is placed in the ED treatment area so that all are aware of the risks		*Review ten medical records, randomly selected, of patients requiring 1:1 observation for appropriate use of observation documentation form according to policy* *Observation record confirming compliance with huddle requirement* *The facility will provide the required documents to BETA 60 days before policy renewal.*
All ED providers and staff (including techs and registration personnel) will receive training on the management of *agitated individuals*. Education will include: a. Importance of mindfulness and early intervention b. Verbal de-escalation techniques c. Identifying and attempting to meet perceived needs d. Pre and post test e. Nurses will additionally receive education on Assessment of Agitation using an evidence-based tool such as	❑ Met ❑ Not Met	Review copy of educational materials used for "Management of Agitated Individuals", "Triage and Placement of Individuals Presenting with Mental Health Conditions", and "Assessment and Treatment of Patients Presenting with Mental Health Conditions"; along with pre and post-tests. Review of documented evidence of education. medical providers and staff signatures reflecting receipt of the education ex. sign-in sheets, logs, etc.

Requirement	Findings	Validation Process
The Behavioral Activity Rating Scale (BARS) (Note: Provider education may be delivered through the provision of a Verbal De-escalation Fact Sheet with a sign-off sheet indicating the provider's review and understanding of the information). Nursing staff will receive additional education to include: a. Triage of patients with mental health complaints b. Proper placement of patients with acute exacerbations of mental health conditions c. Management of specific mental health conditions commonly presenting to the ED a. Bipolar disorder b. Major depression c. Schizophrenia d. Anxiety e. Borderline personality disorder f. Delirium g. Psychosis h. Malingering behaviors d. Pre and Post tests will be provided to measure knowledge acquisition		BETA Hospitals: provide a copy of the ED nursing roster to BETA, including dates of hire Medical Groups: Return an updated roster, reflective of current providers to BETA *within 60 days of receipt of the roster from BETA.*
The organization has a formal Workplace Violence Prevention Plan compliant with current Cal/OSHA Standards. The plan is reviewed and updated as necessary on an annual basis.	❑ Met ❑ Not Met	Review copy of the organization's Workplace Violence Prevention Plan
Measuring Quality and Performance Improvement. Focused chart review of patients presenting to the ED with Mental Health complaints is conducted monthly. The review should include at minimum: a. Timeliness of triage b. Patient placement c. Complete and accurate suicidal risk assessment with appropriate interventions	❑ Met ❑ Not Met	Review copy of the completed tool used for conducting quality and performance improvement checks. Review to include the number of patients presenting with mental health issues and those arriving with agitation each month for previous six-month period.

Requirement	Findings	Validation Process
d. Presence of complete Sitter Observation documentation when sitter was used e. Use of objective terms when describing patient behaviors f. Measures taken to identify and meet the patient's perceived needs g. Timeliness of verbal de-escalation h. Timeliness of initiating stabilizing treatment i. Timeliness of psychiatric consultation j. Method of detainment used: 5150 vs. 1799.111 k. Engagement of patient's family in treatment plan Chart review should consist of 30% of the patient volume if greater than 30 patients, or 100% if less than 30 patients BETA Healthcare Group's "Management of Mental Health Patients in the ED" Toolkit is available at: https://www.betahg.com/risk-management-and-safety/beta-rm-ed/beta-ed-toolkit/ Additional tools are available through the California Hospital Association's Emergency Department Toolkit at: https://www.calhospital.org/emergency-department-toolkit		

TIER 2
HIGH-RISK PATIENT CALLBACK PROGRAM

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
Develop a policy for the emergency department that at a minimum addresses the following: 1. Callback purpose a. This should include the goals, outcomes, and expectations of the callback program. 2. Define which patients should be included in the callback process a. Minimum callback criteria should include high-risk presentations, patients that have identified follow-up challenges, complicated discharge instructions, and identified concerns of the caregiver team. 3. Define the procedures for the callbacks to include: a. An individual responsible for direct oversight b. The individual responsible to conduct the call-back c. The steps to take should the patient be unreachable d. Escalation triggers (i.e., not improving, inability to secure a follow-up appointment, medication reactions). e. A defined process to manage escalation triggers f. Established method to document and record contact g. Log for communication and actions taken 4. PI process a. A list of criteria to identify quality review actions, i.e.: i. Tracking and trending ii. Patient not improving iii. Patient hospitalization after discharge iv. Patient complaints received during the callback v. Adverse events identified during the callback	❑ Met ❑ Not Met	Review ED callback policy. Review Call Log for completion in accordance with organization's procedure.

Requirement	Findings	Validation Process
b. Any event identified in the policy that would trigger quality review are presented in the Medical Staff Quality Committee and sent through the appropriate PI paths, including risk management.		
Callback Communication Log A log tracks all calls made, and include: a. Date/time b. Reason for call c. Individual(s) involved in the communication d. Method of communication e. Resolution Ideally, the log should be electronic, allowing access to ED provider, ED Leadership, and the risk manager.	❑ Met ❑ Not Met	A redacted copy of the current Callback Communication Log provided to BETA for review 60 days before policy renewal. ***Note:*** *Names and patient identifiers shall be redacted. All email communications should be sent by secure email with encryption.*

TIER 2
PEDIATRIC READINESS

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
There is a designated physician/nurse team who serve in the role of pediatric care coordinator. Their role includes: 1. Serve as the resource for pediatric Care for the respective disciplines and work together to develop education, formulate policy recommendation, and provide recommendations for general hospital emergency care 2. Serve as liaison to coordinate care recommendations with the respective hospital-wide committees to ensure continuity of Care through the spectrum.	❑ Met ❑ Not Met	Discussion with the designated pediatric care coordinators. Review appropriate committee minutes verifying participation. Review appropriate committee meeting minutes reflecting coordination of Care.
Ensure that the hospital meets the minimum equipment recommendations set out in the AAP/ACEP/ENA Joint Position Statement	❑ Met ❑ Not Met	A copy of the policy, procedure, and protocol submitted to BETA. Walkthrough and observation within ED reveal availability of minimum equipment recommendations
Emergency department staff receive continuing education in pediatric emergency care. All physicians shall complete and maintain current recognition in one of the following courses: a. AHA-AAP Pediatric Advanced Life Support (PALS) course or b. ACEP-AAP Advanced Pediatric Life Support (APLS) or equivalent. All full- or part-time emergency physicians shall have evidence of completion of a minimum of two hours of continuing medical education (AMA Category I or II) in pediatric emergency topics within a two-year period. All Advanced Practice Providers (APPs) shall complete and maintain current recognition in one of the following courses: a. AHA-AAP Pediatric Advanced Life Support (PALS) course	❑ Met ❑ Not Met	Review staffing roster and education files for evidence of completion

Requirement	Findings	Validation Process
https://cpr.heart.org/en/cpr-courses-and-kits/healthcare-professional/pediatric or b. ACEP-AAP Advanced Pediatric Life Support (APLS) course https://www.aap.org/en-us/continuing-medical-education/life-support/APLS-The-Pediatric-Emergency-Medicine-Resource/Pages/APLS-The-Pediatric-Emergency-Medicine-Resource.aspx or c. ENA Emergency Nursing Pediatric Course (ENPC) https://www.ena.org/education/enpc . All full- or part-time advanced practice providers (nurse practitioners and physician assistants) shall have evidence of completion of a minimum of two hours of approved continuing education units (AMA category I) in pediatric emergency topics within a 2-year period. Credit for CME shall be approved by: a. Accreditation Council on Continuing Medical Education (ACCME) or b. American Osteopathic Association Council on Continuing Medical Education (AOCCME) or c. American Academy of Family Physicians (AAFP) or d. American Academy of Physicians Assistants (AAPA). Registered Nurses All emergency department nurses shall maintain current certification in AHA-AAP Pediatric Advanced Life Support (PALS) course. t These requirements must be met within 12 months of employment. Continuing Education All nurses assigned to the emergency department shall have evidence of completion of a minimum of two hours of		

Requirement	Findings	Validation Process
pediatric emergency/critical Care continuing education hours within a two-year period. Continuing education may include, but is not limited to: a. PALS b. APLS c. ENPC d. CEU offerings; e. Case presentations f. Competency testing g. Teaching courses related to pediatrics or h. Contributing author to a publication The continuing education hours can be integrated with other existing continuing education requirements, provided the content is pediatric specific. All staff caring for children in the emergency department take part in at least two pediatric mock scenarios annually. Simulation Scenarios are available in the ED Quest Toolkit.		Review of documentation of mock pediatric scenarios including list of participants
Ensure the emergency department policies evidence the following ACEP/ AAP/ ENA Joint position statement standards on pediatric Care. Policies include: a. Kilogram based weights b. Triage of pediatric patients c. Transfers of pediatric patients d. Admission of pediatric patients e. Pediatric medication formulary	❑ Met ❑ Not Met	A copy of the policy, procedure, and protocol submitted to and reviewed by BETA.
The following activities are undertaken by a multidisciplinary Quality Committee: a. Pediatric emergency medical care shall be included in the emergency department "Dashboard" or Performance Improvement (PI) program and reported to the hospital Quality committee. b. The Pediatric Dashboard shall consist of, but is not limited to, the review and tracking of all pediatric emergency department deaths, resuscitations, child	❑ Met ❑ Not Met	Review Emergency Department Committee meeting minutes

Requirement	Findings	Validation Process
abuse, and neglect cases and interfacility (outbound or incoming) transfers. ~~c.~~ The Quality Committee includes EMS representation ~~d.~~ Multidisciplinary PI activities are established and include measures of effectiveness that address pediatric Care within the emergency department. Monitoring includes identified clinical indicators and outcomes of Care for children from birth to 18 years of age. e. There is evidence of criteria-based review and follow-up of sample pediatric emergency department visits. f. There is evidence of pre-hospital provider transported pediatric cases that includes a feedback mechanism to the EMS System Coordinator.		
The organization must participate in the Pediatric Readiness Project https://www.pedsready.org/	❑ Met ❑ Not Met	Review documentation of participation.

TIER 2
CARE FOR THE CAREGIVER (PEER SUPPORT)

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
Care for the ED Caregiver Executive Champion, and Team lead(s) are identified for an active role in program development which includes nursing and physician leaders.	❑ Met ❑ Not Met	Executive leadership champion has been designated and is this is reflected in committee meeting minutes. There is department leadership represented on the committee.
The department has assessed its current infrastructure and human resources to support the development of a Care for the Caregiver program. The use of the CANDOR or BETA HEART toolkit may be helpful in identifying the elements needed for a successful program.	❑ Met ❑ Not Met	Review of Emergency Department needs assessment. ED needs assessment can be accomplished through a review of culture survey data, incident reporting data and evaluating available resources, local needs and assets.
Care for the ED Caregiver Committee is created to drive the program development forward. Recommended members include: a. Department Directors b. Physician champion(s) c. Nursing champion(s) d. Ancillary champions(s) e. Resident(s) f. Advanced Practice Providers g. Social Work h. Employee Health i. Pastoral Care	❑ Met ❑ Not Met	Review the roster for Care for the Caregiver Committee members.
A policy is in place that specifies: 1. The expectations for the peer supporter response (time of event through investigation and possible litigation) that includes: a. 24/7 b. Intervention c. Follow-up	❑ Met ❑ Not Met	Review of department policies as they pertain to adverse events, staff support program, and any other supporting material. Interviews with staff

Requirement	Findings	Validation Process
2. Determines the criteria for activation of the response. At a minimum, this should include any event or series of events that result in an increase of emotional stress in the department, for example: a. Family or co-worker dies in the department b. Pediatric death c. Failure to rescue d. First death experience e. Unanticipated change in patient condition f. Patient harm (whether an error was made or not) g. Multiple patient traumatic events or deaths within a short period 3. Policy includes criteria to determine the need for team debrief (makeup of the team is determined by event) 4. Staff is aware that peer support is available		
A process is in place for the identification and training of Peer Supporters. The requirements include: 1. Peer Supporters sign a formal agreement defining their role and indicating their commitment to complete required training, be available to staff and maintain the confidentiality of discussions. 2. The organization provides formalized training regarding resilience, burnout, fatigue and stress debriefing, crisis intervention, active listening, situational awareness, and recognition of signs and symptoms that a colleague may benefit from peer support	❑ Met ❑ Not Met	Review signed peer supporter agreements. Review training materials and peer supporter sign-in sheets.

Requirement	Findings	Validation Process
3. All unit supervisors, charge nurses, and other departmental leaders will attend the full training 4. Formalized training is ongoing		
Care for the ED Caregiver policy requires trained Peer Supporters to be embedded within the department and available on all shifts and days of the week. The policy contains a mechanism for a Peer Supporter to be available to emotionally traumatized staff within the department immediately after the event. 1. A department Peer Supporter is available for each shift and day of the week 2. The policy allows for a Peer Supporter's routine responsibilities to be managed when assistance is needed for staff support	❑ Met ❑ Not Met	Review Care for the ED Caregiver policy (this requirement may be substituted for the organization-wide Care for the Caregiver policy). Review Peer Supporter Agreement Forms.
A process is in place for evaluating the C4C program. The C4C committee meets on a regular basis and reviews feedback provided by peer supporters (through encounter logs or other means) to evaluate the effectiveness of the C4C program	❑ Met ❑ Not Met	Review committee meeting minutes
A process for referring clinicians needing a higher level of support is in place and includes guideline criteria and mechanism for obtaining expedited access 1. Referral Network includes resources available both locally as well as separate from the organization such as: a. Chaplain Services b. Social Workers c. Clinical Psychologist and d. Employee Assistance Program, etc.	❑ Met ❑ Not Met	Review process and user feedback surveys.

Requirement	Findings	Validation Process
A process is in place to evaluate the effectiveness and staff satisfaction with the Care for the ED Caregiver program. 1. User survey	❑ Met ❑ Not Met	Review user surveys and evaluation tool.
A measurement strategy is identified, implemented, and is captured on the Department Dashboard. Sample measures include: 1. # of Care for the Caregiver calls activated (peer to peer interactions) per month 2. # of Care for the Caregiver interactions 3. Types of referrals made (clinician self-referral/supervisor/RM/other) 4. Effectiveness and timeliness of response (User survey) 5. Timely access to a higher level of support (User survey) 6. Staff retention rates	❑ Met ❑ Not Met	Review Department Dashboard metrics for measures of effectiveness of the program.

TIER 2
EMERGENCY DEPARTMENT RISK ASSESSMENT

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
Emergency Department Risk Assessment is scheduled with a BETA Risk Director no later than six months before the end of the policy period.	❑ Met ❑ Not Met	Emergency Department Risk Assessment scheduled
Requested policies and forms must be submitted to BETA at least two weeks before the assessment date: 1. See Emergency Department Risk Assessment for requested policies and forms	❑ Met ❑ Not Met	Submit policies and forms to BETA Risk Director.
Requested interviews will be scheduled at least two weeks before the assessment.	❑ Met ❑ Not Met	Interview schedule sent to BETA Risk Director.
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 Director: 1. Establish measurable goals or matrix for use in determining the effectiveness of process improvement 2. Goals must be objective, clearly defined and measurable 3. Review plan and modify as indicated to achieve the goal 4. Plans should be developed no later than 90 days before the policy renewal period. The performance improvement (PI) plans must be submitted to appropriate medical staff and quality committees for review	❑ Met ❑ Not Met	Review the Performance Improvement Plan(s) with all required components and ensure that the plans were submitted to appropriate medical staff and quality committees for review.
One plan must be completed by May 1 with evidence of measurable outcomes. Results should be submitted to medical staff and quality committees for review.	❑ Met ❑ Not Met	Review Performance Improvement Plan with evidence of data collection by May 1st or within 60 days of policy renewal.

TIER 2
FRACTURE MANAGEMENT AND FOLLOW-UP CARE

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
Develop a Radiology Policy for the emergency department that at a minimum addresses the following: 1. Radiology overread process 2. Criteria outlining which films should be read immediately vs. those that can be reviewed later (time to be defined). 3. What constitutes a critical result 4. Communication process for overread to include: a. Responsible person to contact the patient b. Follow-up plan with the patient c. Communication of anticipated plan for the patient 5. Mechanism for documenting communication and action(s) taken (i.e. logs, medical record tracking) 6. Quality review process for misreads	❑ Met ❑ Not Met	Radiology policy review
Overread Communication Log: 1. Tracking log is developed and maintained for review. 2. Log should track all overreads, and include: a. Date/Time b. Findings c. Individual involved in the communication d. Method of communication e. Resolution 3. The log should be electronic allowing access to both ED provider, radiologist, and quality coordinator.	❑ Met ❑ Not Met	Review redacted copy of the current Overread Communication Log will be provided to BETA for review 60 days before policy renewal. ***Note:*** *Names and patient identifiers should be redacted. All email communications should be sent by secure email with encryption.*
A mechanism for quality oversight Includes: 1. Misreads are presented in Medical Staff Quality Committee and sent through the appropriate quality improvement and/ or risk management pathways. 2. Misreads are tracked by the provider and become a part of Ongoing Physician Performance Evaluation (OPPE)	❑ Met ❑ Not Met	a. Review OPPE b. Review Quality Committee meeting minutes

Requirement	Findings	Validation Process
Patient follow-up: 1. Develop a formalized process for patient follow-up for both inpatient and outpatient reads.	❑ Met ❑ Not Met	Site Visit Review a. Review follow-up process log

TIER 2
EMERGENCY DEPARTMENT MEDICATION SAFETY #1

Must complete ALL (#1, #2, #3, #4, #5) Emergency Department Medication Safety Measure

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
A medication safety "quiet zone" designed to provide a designated area for medication retrieval without distraction is implemented. *ISMP, 2016; IHI 2014*	❑ Met ❑ Not Met	Observation
The safety zone requires staff to identify themselves through some distinguishing feature.	❑ Met ❑ Not Met	Observation
Compliance with this safety strategy is monitored monthly via observation of practice	❑ Met ❑ Not Met	Performance improvement statistics
Various structure standards for safe use of four common medications administered in the emergency department are in place, and 100% compliance is evident with these structure standards for the following: 1. Propofol 2. Narcotics 3. Heparin/ Low Molecular Weight Heparin 4. Electrolytes	❑ Met ❑ Not Met	Compliance with all structure standards contained in #1-5.

TIER 2
MEDICATION MANAGEMENT IN THE ED #2 OF 5
SAFE USE OF PROPOFOL

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
Pharmacy prepares or purchases standardized premixed concentration.	❑ Met ❑ Not Met	Observation Pharmacy procedure
Dose concentrations are separated in the Automated Dispensing Machine (ADM) in separate bins/cabinets etc. Each bin/cabinet containing a high-risk medication is labeled as a High-Risk Medication.	❑ Met ❑ Not Met	Observation
The High-alert and Hazardous Medication policy designates Propofol as a high-alert medication and requires a double-check. TJC-MM.01.01.03	❑ Met ❑ Not Met	Review High-alert and Hazardous Medication policy.
Procedural Sedation policy addresses the use of Propofol and reflects: 1. ACEP sedation guidelines 2. ASA Sedation guidelines 3. Staffing necessary for the administration 4. Credentialing of those privileged to administer Propofol for procedural sedation 5. 100% of procedural sedation cases occurring in the emergency department undergo quality review for compliance with policy requirements	❑ Met ❑ Not Met	Review Procedural Sedation policy Performance measures are recorded and submitted through the Quality Committee. Action plan(s) are developed for those in non-compliance

TIER 2
MEDICATION MANAGEMENT IN THE ED #3 OF 5
SAFE USE OF NARCOTICS

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
A well-defined Opioid Management policy is in place that, at a minimum, includes the following items: 1. Frequency of monitoring and vital signs 2. Protocols for the use of reversal agents 3. Expectation for the usage of smart pumps 4. Establish acceptable high and low limits for each medication administered via a smart pump 5. Avoid the use of overrides in the emergency department 6. Standardized concentrations available in the emergency department	❑ Met ❑ Not Met	Review Opioid Management policy Observation
Work with the pharmacy to develop standardized concentrations that meet the needs of the patient population. Develop a re-evaluation schedule to adjust the formulary and concentrations needed in the emergency department.	❑ Met ❑ Not Met	Review committee meeting minutes
Develop a fall prevention protocol for patients receiving narcotics/opioids in the emergency department to include: 1. Staff education 2. Patient education 3. Monitoring 4. Observation and assistance in ambulation/ toileting 5. Environmental safety measures	❑ Met ❑ Not Met	Review Opioid Management, Narcotics Management policy or other policy that reflects fall prevention strategies for patients receiving these high risk medications Observation

TIER 2
MEDICATION MANAGEMENT IN THE ED #4 OF 5
SAFE USE OF HEPARIN AND LOW MOLECULAR WEIGHT HEPARIN (LOVENOX)

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
Heparin ten thousand (10,000) units/mL will be stored in a separate bin/cabinet and labeled as a high-risk medication on the outside of bin as well as on the medication container.	❑ Met ❑ Not Met	Observation
Heparin one thousand (1,000) units/mL will be stored in a separate bin/cabinet and labeled as a high-risk medication on the outside of bin as well as on the medication container.	❑ Met ❑ Not Met	Observation
Heparin one hundred (100) units/mL doses will be stored in a separate bin/cabinet and labeled as a high-risk medication on the outside of bin as well as on the medication container.	❑ Met ❑ Not Met	Observation
A double-check process by Pharmacist/Pharmacy Technician is in place during refill of the Automated Dispensing Machine (ADM). The Tech Check system is written as a formal pharmacy procedure.	❑ Met ❑ Not Met	A copy of the pharmacy procedure that addresses the requirement of double-check by pharmacy personnel (Tech-check-Tech) when re-stocking high-risk medications will be provided to BETA no later than 60 days before the policy renewal period.
The ADM drawer is labeled with a high-risk sticker.	❑ Met ❑ Not Met	Observation
Heparin/Low molecular weight heparin is designated as a high-alert medication and requires independent double-check before administration. This process is defined in the policy.	❑ Met ❑ Not Met	Review High-alert and Hazardous Medication policy
Smart pumps with built-in high and low dose limits are used when infusing high-risk medications. Smart pumps have the ability to be programmed for the administration of bolus doses without the need to draw from a vial.	❑ Met ❑ Not Met	Observation
When heparin solution is necessary to flush IV lines, the premixed solution is supplied by	❑ Met ❑ Not Met	Review Anticoagulation policy, pharmacy procedure

Requirement	Findings	Validation Process
the pharmacy and not mixed by nurses on the unit.		
Low molecular weight heparin is obtained from the pharmacy.	❑ Met ❑ Not Met	Review Anticoagulation policy Review pharmacy procedure
Lab values (APTT) are double-checked by two nurses before adjusting IV dose heparin per the formalized protocol. Acceptable values are specified in the protocol and defined in Policy.	❑ Met ❑ Not Met	Review Anticoagulation policy
Implement standardized weight-based dosing following evidence-based standards using preprinted orders or computerized order sets.	❑ Met ❑ Not Met	Review anticoagulation policy Observation

TIER 2
MEDICATION MANAGEMENT IN THE ED #5 OF 5
SAFE USE OF ELECTROLYTES

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
Develop a policy on administration of electrolyte solutions to include: 1. Potassium Chloride 2. Magnesium Sulfate 3. Hypertonic Sodium Chloride 4. Calcium Chloride/Calcium Carbonate	❑ Met ❑ Not Met	Review Electrolyte Management policy
The pharmacy provides standardized premixed concentration for a loading dose of electrolytes in 50 mL or 100 mL volume solution. Policy & practice restrict drawing bolus doses of electrolytes from the main IV infusion.	❑ Met ❑ Not Met	Review Electrolyte Management policy Observation of practice
The pharmacy provides standardized premixed concentration for a maintenance dose of electrolytes in 250 mL or 500 mL volume solution.	❑ Met ❑ Not Met	Review Electrolyte Management policy Observation
Electrolytes are designated as high-alert medication requiring an independent double-check prior to administration. This process is formally defined in the policy.	❑ Met ❑ Not Met	Review High-Alert and hazardous Medication policy
Nurse to patient ratio is 1:1 during the loading phase of electrolytes.	❑ Met ❑ Not Met	Review Electrolyte Management policy

TIER 2
FALL PREVENTION PROGRAM IN THE ED

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
A baseline evaluation of the current state of fall prevention strategies must be administered by month six of the policy year. Goals for improvement are based on findings.	❑ Met ❑ Not Met	Performance Improvement Committee minutes reflect review of current state of fall prevention strategies.
Unit-specific information regarding staff perceptions of fall safety across the emergency department is gathered utilizing a survey instrument.	❑ Met ❑ Not Met	Completion of Fall Perception Knowledge Test by 100% of ED staff.
A policy is in place on Fall Management. To include at a minimum: 1. Universal fall precautions 2. Fall Scale(s) utilized 3. Criteria for utilization of Fall Scale 4. Prevention/interventions 5. Post fall management 6. Communication/documentation 7. Ongoing Fall Program Evaluation	❑ Met ❑ Not Met	Review Fall Management policy
A clinical pathway is developed using a validated fall assessment tool and the policy indicates the level(s) of intervention required based on scoring criteria. Flarity, K., Pate, T., & Finch, H. (2013). Development and Implementation of the Memorial Emergency Department Fall Risk Assessment Tool. Advanced Emergency Nursing Journal January/March, 35(1), 57-66. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=ovftn&AN=01261775-201301000-00008 McErlean, D. R., & Hughes, J. A. (2017). Who falls in an adult emergency department and why—A retrospective review. Australasian Emergency Nursing Journal, 20(1), 12-16. doi:https://doi.org/10.1016/j.aenj.2016.11.001 Terrell, K. M., Weaver, C. S., Giles, B. K., & Ross, M. J. (2009). ED Patient Falls and Resulting Injuries. Journal of Emergency	❑ Met ❑ Not Met	Observation Review clinical pathway

Requirement	Findings	Validation Process
Nursing, 35(2), 89-92. doi:https://doi.org/10.1016/j.jen.2008.01.004		
Department-specific event trends (incident reports/QRR's/ Chart Audits) are shared and discussed quarterly (at a minimum) at medical staff quality committee and nursing staff meetings to identify trends; the trends are addressed as evidenced by the development of solutions. Fall measures are adopted as a formal quality improvement metric, are monitored through quality, and compliance is reported to the appropriate medical staff committee.	❑ Met ❑ Not Met	Review committee meeting minutes Review staff meeting minutes Review Dashboard where falls are tracked and trended

TIER 2
TEAM TRAINING TECHNIQUES

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
A unit-based agreement to deploy TeamSTEPPs principles and a baseline readiness assessment is conducted and reviewed by senior leadership. Senior leadership supports the pursuit of team training in the emergency department setting, as evidenced by the attestation of the baseline assessment.	❑ Met ❑ Not Met	Evidence of baseline readiness assessment findings and signed attestation of senior leadership's support of the principles.
Develop in-house staff as certified trainers utilizing the train the trainer methodology to deploy Team STEPPs training or other CRM training techniques. For more information about the content, please contact Al Duke at al.duke@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 emergency department area is trained in TeamSTEPPS principles utilizing an interdisciplinary model of training. This includes all medical and nursing staff.	❑ Met ❑ Not Met	Evidence of participation by all staff is reflected in dated sign-in sheets.
The CAT's model of observation is deployed to measure performance and confirm the adoption of CRM principles. Observations shall occur starting after the training. You may use the TeamSTEPPS observation tool provided with the toolkit.	❑ Met ❑ Not Met	Evidence of documented observations and results shall be provided *60 days before policy renewal.*

TIER 2
SIMULATION AND DRILLS

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
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 through a simulation center may be utilized.	❑ Met ❑ Not Met	Evidence of active participation by all required providers and staff as reflected in the facility/group's roster to be provided to BETA.
Team members who respond to the specified emergency will be identified and included in the simulation/drill exercise. This may include anesthesia, obstetrics, neonatal team members, trauma, cardiology, 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 breed familiarity with clinical management. This may include: 1. Inadvertent deep sedation 2. STEMI 3. Stroke 4. Newborn delivery 5. Septic shock 6. Multiple critical patients requiring triage of resources	❑ Met ❑ Not Met	The scenario utilized shall be produced on the day of validation.
A debriefing process is in place, and there is documented evidence of the debriefs preferably written by staff, identifying individual learning.	❑ Met ❑ Not Met	Debrief summary of each simulation/drill scenario with an action plan as indicated with completion dates.
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 the day of validation.

TIER 2
EMERGENCY NURSE CERTIFICATION (CEN) CREDENTIAL
CERTIFIED PEDIATRIC EMERGENCY NURSE (CPEN) CREDENTIAL

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
All eligible staff in the emergency department will sit for the CEN or CPEN exam by one month prior to policy renewal. Those eligible are defined as: 1. Those currently licensed in the U.S. 2. Two years of experience in the emergency department. Eligibility details can be found at the following links: CEN: https://bcen.org/cen/eligibility/ CPEN: https://bcen.org/cpen/eligibility/ *RMRF's may be utilized to offset the costs of the exam* Evidence of current certification; enrollment and participation in the exam is required to meet this goal. Evidence of pass/fail is not required.	❑ Met ❑ Not Met	Nursing staff roster provided on day of validation to include evidence of staff having greater than 2 years' experience in clinical specialty, and if indicated 1000 hours of practice time in a pediatric emergency department. Review of certificates of completion

TIER 2
CULTURE OF SAFETY

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
Unit-specific information regarding staff perceptions of patient safety 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 Safe & Reliable Healthcare • Pascal HealthBench Safety Attitudes Questionnaire (SAQ) • Agency for Healthcare Research & Quality (AHRQ) *RMRF's may be used to offset the cost of the survey.*	❑ Met ❑ Not Met	*The facility will provide the required documents to BETA 60 days before policy renewal.* Review of the evidence-based culture of safety assessment tool used to conduct the assessment and results.
A baseline survey must be administered by month six of the policy year. Goals for improvement are based on findings. There is evidence that an annual survey is conducted to measure performance.	❑ Met ❑ Not Met	As above
The culture survey results have been debriefed with nursing and medical staff to understand common themes in response to the results. *See questions that shall be addressed during debrief contained in Toolkit.* Sexton, J. B., Paine, L. A., Manfuso, J., Holzmueller, C. G., Martinez, E. A., Moore, D., . . . Pronovost, P. J. (2007). A Check-up for Safety Culture in "My Patient Care Area". The Joint Commission Journal on Quality and Patient Safety, 33(11), 699-703. doi:https://doi.org/10.1016/S1553-7250(07)33081-X	❑ Met ❑ Not Met	Evidence of participation by a minimum of 80% of staff as evidenced by number of staff totaled from each debriefing.
Evidence that the culture survey results and PI actions developed as a result of unit level debriefings were shared and discussed at	❑ Met ❑ Not Met	ED Committee meeting minutes

Requirement	Findings	Validation Process
the ED Committee and medical staff committee meetings. Evidence of discussion is contained in meeting minutes.		
To raise staff awareness of safety concerns, at a minimum, four case study presentations or M&M rounds are conducted, to discuss error and near-miss activity	❑ Met ❑ Not Met	Evidence of participation by all staff reflected in dated sign-in sheets.
Department-specific event trends (incident reports/QRR's) are shared and discussed quarterly (at a minimum), at medical staff committee and nursing staff meetings to identify trends and develop potential solutions.	❑ Met ❑ Not Met	Evidence of participation by all staff reflected in dated sign-in sheets, staff education documentation or other method to ensure staff receive the information. Review of committee minutes
Leadership Walk Rounds 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. For more information about Leadership Walkrounds, access BETA's ED Toolkit. http://www.ihi.org/resources/Pages/Tools/PatientSafetyLeadershipWalkRounds.aspx Sexton, J. B., Adair, K. C., Leonard, M. W., Frankel, T. C., Proulx, J., Watson, S. R., . . . Frankel, A. S. (2018). Providing feedback following Leadership WalkRounds is associated with better patient safety culture, higher employee engagement and lower burnout. BMJ Quality & Safety, 27(4), 261-270. doi:10.1136/bmjqs-2016-006399	❑ Met ❑ Not Met	Activity sheets are collected and signed by the CEO, CNE, CMO or other leaders conducting that specific WalkRound.

TIER 2
TRIAGE EDUCATION

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
All registered nurses and advanced practice providers who triage and who hold ED privileges and professional liability coverage through BETA Healthcare Group or HealthPro must complete the required Relias Platform Personal Learning module on Triage. Based on the Relias Platform Personal Learning module, participants must complete all designated "Red, Yellow," *no later than 60 days before policy/contract renewal.*	❑ Met ❑ Not Met	*The facility will provide the required documents to BETA 60 days before policy renewal.* *Review current staff roster* *Review Certificates of Completion for 100% of registered nurses.* *Review Certificates of Completion for advanced practice providers conducting triage and who are covered by BETA Healthcare Group or HealthPro to confirm evidence of successful completion.*
New hires and newly credentialed practitioners may use certificates of completion for the required Relias Platform Personal Learning module taken elsewhere if completed within the previous two years of the policy renewal.	❑ Met ❑ Not Met	Verified by documents above
Audit documentation of triage process of 5 charts per nurse/PA/NP who are covered by BETA Healthcare Group or HealthPro and perform triage. Audit will be conducted twice a year to verify the accuracy of severity index and compliance with Triage Policy and protocols. Providers will receive feedback on audit findings and can review the record for educational purposes. This process will be documented.	❑ Met ❑ Not Met	Review Triage policy Review of audit results Review meeting minutes or other data documenting the feedback mechanism taken

TIER 2
SAFER SIGN-OUT

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

Requirement	Findings	Validation Process
Emergency medical groups must complete the sections of the Emergency Medicine Patient Safety Signout (EMPSF) initiative required of all providers (physicians, nurse practitioners, physician assistants) The process must be in place a minimum of 6 months before qualifying for consideration to meet Tier 2 . The policy and/or procedure reflects Safer Sign-Out concepts as the authorized hand-off process for use by physicians, PA's, and NP's in the emergency department and require the following elements: 9. Use of a recordable form containing all elements on the official Safer Sign-Out tool (at a minimum) 10. Pre-rounding with patients by the off-going provider to update Sign-Out report a. Identify patient b. Critical details c. Follow-up items 11. Require joint focus on the available data (labs, imaging) 12. Sign out occurs at the computer terminal between the oncoming and off-going physicians/providers 13. Require joint rounding at the bedside a. Introduce on-coming provider b. Update the patient on his/her status c. Ask if the patient has any questions 14. Require the oncoming physician to update the nursing staff assigned to the patient of the patient's current status and provide the opportunity for the nurse to ask questions and provide input 15. Require nursing staff to conduct their SBAR or similar formalized hand-off process between the off-going and on-coming nurse 16. Form used during the nursing hand-off must contain a place for both	❑ Met ❑ Not Met	Review Handoff policy(s) Review tool or instrument utilized for Safer Sign-Out Observation of handoffs *The facility will provide the required documents to BETA 60 days before policy renewal.*

Requirement	Findings	Validation Process
nurses to sign attesting that the hand-off occurred at the patient's bedside and that the on-coming nurse was allowed the opportunity to ask questions.		
Evidence of education pertaining to the process of Safer Sign-Out provided to all clinicians practicing in the ED. Birmingham, P., Buffum, M. D., Blegen, M. A., & Lyndon, A. (2015). Handoffs and Patient Safety: Grasping the Story and Painting a Full Picture. Western journal of nursing research, 37(11), 1458-1478. doi:10.1177/0193945914539052 Starmer, Keohane, McSweeney, EY, C., Yoon, Lipsitz, … Skaret MM. (n.d.). Handoffs and Signouts. Retrieved from https://www.psnet.ahrq.gov/primer/handoffs-and-signouts. Wilson, E.M. (2018). Patient Transfer and Handoff. Emergency Nurses Association. Des Plaines. IL. Retrieved from: https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/patienthandofftransfer.pdf?sfvrsn=e2c42cb6_10	❑ Met ❑ Not Met	Review documentation ofmedical providers and staff signatures reflecting education of policy's expectations. BETA Hospitals: provide a copy of the ED nursing roster to BETA, including dates of hire Medical Groups: Return an updated roster, reflective of current providers to BETA *within 60 days of receipt of the roster from BETA.*

TIER 2
PATIENT AND FAMILY-CENTERED CARE

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
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. See Readiness Assessment in BETA's Emergency Medicine Toolkit.	❑ Met ❑ Not Met	Evidence of executed Readiness Assessment
A policy is in place in the emergency department that includes patients on improvement teams. This may be accomplished through the formation of a Patient & Family Advisory Council, which includes emergency services.	❑ Met ❑ Not Met	Patient & Family Advisory Council policy and/or procedure
In partnership with a patient partner, identify three areas of improvement to enhance the patient experience in your emergency department. 1. Develop an action plan with reasonable target dates for completion 2. Monitor changes for sustained implementation Provide update to the Emergency Medicine Committee and medical staff committee as evidenced in the meeting minutes.	❑ Met ❑ Not Met	Staff meeting minutes and medical staff committee meeting minutes 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. Emergency Department satisfaction scores reflect performance in the 90th percentile at minimum or marked improvement toward that goal.	❑ Met ❑ Not Met	HCAHPS, Press Ganey scores

TIER 2
DATA VISIBILITY & TRANSPARENCY

Must complete criteria in Tier 1 each year before credit may be earned for Tier 2 options

Requirement	Findings	Validation Process
The organization participates in one formal or informal performance improvement projects on an annual basis (at minimum) to include: IHI, Regional Projects, ED Collaborative, etc.	❑ Met ❑ Not Met	Evidence of participation & performance.
The organization studies outcomes utilizing evidence-based Trigger Tool screening mechanisms. See BETA's Emergency Medicine Toolkit for examples.	❑ Met ❑ Not Met	Trigger Tool metrics
The organization provides incident report trends to the medical staff committee and nursing staff. A minimum of two trends are analyzed, and performance improvement activities are implemented to address these trends and reported to the hospital's Quality Committee.	❑ Met ❑ Not Met	Medical staff committee minutes Nursing staff meeting minutes Quality committee meeting minutes and medical staff meeting minutes
The unit has adopted a one-page *unit-specific* scorecard designed to provide feedback on performance over time. This scorecard is shared on a quarterly basis (at a minimum) with staff and may include metrics such as: 1. Incident report trends 2. Trigger tool trends 3. Claims frequency data 4. Patient satisfaction metrics 5. Culture survey data 6. Nurse turnover rates 7. Leadership Walk Round performance (open/completed items) See BETA's Emergency Medicine Toolkit for examples.	❑ Met ❑ Not Met	Most recent scorecard
A "White Board" designed to address current progress toward the goal is visible in the unit with the purpose of providing ongoing feedback on performance to staff and providers. A digital, interactive learning board to enhance visibility may be found at Safe & Reliable Healthcare: LENS Safe & Reliable or access the Emergency Medicine toolkit for other examples	❑ Met ❑ Not Met	Observation

PROJECT PLANNING WORKSHEET 2021-2022

(Name of hospital) _____

intends to accomplish: (This usually contains an overarching statement describing what you intend to do i.e.: Reduction in Falls to zero)

_____

_____

_____

_____

_____

by: (time frame, i.e., month/year by which you intend to accomplish improvement)

_____

Our goals include: These are goals for your measures. Your measures for this project should, of course, align with your Quest for Zero components. See Quest for Zero current Guideline.

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Our Stakeholders include: (These are the people involved with and affected by your process and improvement initiative. The success of your improvement initiative often depends on the inclusion and involvement of multiple stakeholders).

-
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For clarification, questions, or consultation regarding the
Quest for Zero: Excellence in ED contact:
Al Duke, RN, M.B.A., B.S.N., CEN, CPPS, CPHRM
Manager, Risk Management and Patient Safety
Al.duke@betahg.com (818) 549-9479

Governance Quality Assessment

HARRY WEIS

MAY - 2021

Category 2 – Keep Me Safe: Safe Care

Core Board Measure:

Board annually reviews management's summary of the financial impact of poor quality on payments and liability costs

This process leads to a:

Board that understands the financial costs of poor safety performance

Current Actions: Safe Care

- Monitor administrative adjustments by department on Care Complaints. Report biannually to Board of Directors.

- Monitor and report Medical Malpractice costs

Future Actions: Safe Care

- Evaluate the opportunity to capture the following costs related to care:
  - Hospital Acquired Conditions for inpatient stays
  - Unexpected Outcomes for inpatient services
  - Readmissions with same diagnosis
  - Increase length of stay or increase outpatients services do to delay or less than optimal care.

Category 4 – Treat me with respect: equitable and patient-centered care

Core Board Process

Board ensures that all patient populations, especially the most vulnerable, are provided effective care by evaluating variations in care outcomes for key conditions or service lines based on race, gender, ethnicity, language, socioeconomic status/payer type, and age.

This process leads to a:

Board that holds senior leaders accountable for health equity (making sure all patients receive the same quality of care) and prioritizes closing the gaps in outcomes that are identified as disparities in care.

Current Actions: Equitable and Patient-Centered Care

- All hospital patients evaluated for discharge planning needs
  - Interdisciplinary rounds to allow the entire healthcare team to have input
  - Involvement of the patient and the significant others and family to participate
  - All discharge plans are patient-centered through patient goals and medical healthcare wishes per federal regulation
  - Discharge Assessment includes:
    - Housing
    - Food
    - Transport
    - Economic/healthcare insecurities
    - Caregiver needs
    - Referral and resources are coordinated as indicated

Current Actions: Equitable and Patient-Centered Care

- Risk assessment for social determinants on admission along with risk of readmission – high risk patients followed for 30 days post discharge
- The medically complex or socioeconomic needs are referred to the outpatient Care Coordination team to navigate their healthcare needs.
  - Added Spanish speaking Care Coordinator to the team in 2021
  - Care Coordinator accompanies patient physician office
- Care Coordination services include populations for complex medical and social, elderly, behavioral health, COVID-19, pediatric, high-risk perinatal, orthopedic and total joint and neuro/trauma (FY22).
- All patients are accepted into the programs with appropriate referral regardless of insurance status or ability to pay.

Future Actions: Equitable and Patient-Centered Care

- Ongoing development of care coordination to cover specialty areas beyond:
  - Orthopedics
  - Urology
  - Obstetrics
  - Behavioral Health
  - Pediatrics
  - Complex and Transitional Primary Care Patients
- Evaluate unexpected outcomes, readmissions and hospital acquired conditions for disparities.
- Evaluate longevity by ethnicity or zip code

Category 5 – Help me navigate my care: timely and efficient care

Core Board Process

Board reviews metrics related to access to care at all points in the system (e.g., hospital, clinics, behavioral health, nursing home, home care, dental) and ensures that access is equitable and timely for all patients

This process leads to a:

Board oversees senior leadership's strategy to improve care access (e.g., time and ability to get an appointment, wait time for test results, delays) for all patients

Current Actions: Timely and Efficient Care

- Addition to provider services that includes physicians, physician assistants, nurse practitioners in the areas of Primary Care, Behavioral Health, Ophthalmology, Neurology
  - Increased access to care in both primary care and specialty areas
  - Expansion of service lines (orthopedics, stroke, trauma)
  - Comprehensive services provided through the Rural Heath Clinics
  - Risk stratification of complex patient care and follow up with ongoing Care Coordination
  - Integration of support services (medication assisted program, behavioral health, care coordination) into primary care clinics that address social determinants and referral systems that allow for more efficient and appropriate care

Future Actions: Timely and Efficient Care

- Evaluate ongoing opportunities to improve care access:
  - Consider adding Mobile Rural Health Clinic that services to disparate areas and people for care.
  - Develop report on access to care that includes first available appointments.
  - Expand Urgent Care service locations

Category 6 – HELP ME STAY WELL: COMMUNITY & POPULATION HEATH & WELLNESS

Core Board Process

Board evaluates approach to integration and continuity of care for behavioral health patients.

This process leads to a:

Board that holds senior leaders accountable for integrating care and tracking care coordination data to support screening, access, and follow-up

Current Actions: Behavioral Health Integration

- Added Primary Care Physician (PCP) assessments for the evaluation of behavioral health issues in the primary care departments
- Integrated behavioral health intensivist that streamline the referral process from the PCP to a behavioral health provider
- The behavioral health team evaluates patients need for:
  - Medication management services
  - Counseling services
  - Psychiatric Services
  - Programming
  - Follow up

Current Actions: Behavioral Health Integration

- RHC integration that will allow for both PCP and Behavioral Health visit on the same day
- Regular huddles with shared communication between the Behavioral Health Team and the PCP
- Continuous monitoring of our data through Quality Incentive Program (former PRIME) measures as well as our quality dashboards
- Ongoing grant submissions that support Behavioral Health and the integration of services within the RHC and PCP practices

Future Actions: Behavioral Health Integration

- Master Planning to increase space available for Behavioral Health Services
- Monitor resource needs and increase as space permits
- Evaluate need for outpatient telehealth
- Ongoing grant opportunities that support growth in Behavioral Health

TFHD Care Compare Quality Metrics

April 2021

Define	Measure
Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and Total Knee Arthroplasty (TKA)	COMP-HIP-KNEE is the metric identifier with CMS. This metric was identified on the April 2021 Star Rating
Hospital-Level 30-Day All-Cause Risk- Standardized Readmission Rate (RSRR) Following Elective Total Hip Arthroplasty (THA)/Total Knee Arthroplasty (TKA)	READM-30-Hip-Knee is the metric identifier with CMS. This metric was identified on the April 2021 Star Rating
Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	OP-35 ED is the metric identifier with CMS. This metric was identified on the April 2021 Star Rating Report.
Clostridium Difficile (C.difficile)	HAI-6 is the metric identifier with CMS. This metric was identified on the April 2021 Star Rating Report.
HWR Hospital-Wide All-Cause Unplanned Readmission	READM-30-HOSP-WIDE is the metric identifier with CMS. This metric was identified on the April 2021 Star Rating Report.

Define	Measure
Admit Decision Time to ED Departure Time for Admitted Patients	ED-2b is the metric identifier with CMS. This metric was identified on the April 2021 Star Rating Report.
Abdomen CT Use of Contrast Material	OP-10 is the metric identifier with CMS. This metric was identified on the April 2021 Star Rating Report.
Admissions for Patients Receiving Outpatient Chemotherapy	OP-35 ADM is the metric identifier with CMS. This metric was identified on the April 2021 Star Rating Report.

CMS Overall Hospital Quality Star Rating

The Overall Hospital Quality Star rating (overall star rating) summarizes a variety of measures across 5 areas of quality into a single star rating for each hospital. Once reporting thresholds are met, a hospital's overall star rating is calculated using only those measures for which data are available. The average is about 37 measures. Hospitals report data to the Centers for Medicare & Medicaid Services through the Hospital Inpatient Quality Reporting (IQR) Program, Hospital Outpatient Quality Reporting (OQR) Program, Hospital Readmission Reduction Program (HRRP), Hospital-Acquired Condition (HAC) Reduction Program, and Hospital Value-Based Purchasing (VBP) Program. Overall star ratings aren't calculated for Veterans Health Administration (VHA) or Department of Defense (DoD) hospitals.

The new 2021 methodology uses a simple average of measure scores to calculate measure group scores and Z-score standardization to standardize measure group scores for these 5 measure groups

1. Mortality
2. Safety of Care
3. Readmission
4. Patient Experience
5. Timely & Effective Care

After estimating the group score for each hospital and each group, CMS calculates a weighted average to combine the 5 group scores into a single hospital summary score. If a hospital is missing a measure category or group, the weights are redistributed proportionally amongst the qualifying measure categories or groups

After summary score calculation, hospitals are assigned to one of 3 peer groups based on the number of measure groups for which they report at least three measures; three measure groups, four measure groups, or five measure groups.

Finally, hospitals are assigned to star ratings within each peer group using k-means clustering so that summary scores in one star rating category are more similar to each other and more different than summary scores in other star rating categories.

Only hospitals that have at least 3 measures within 3 measure groups with at least one of those groups being Mortality or Safety of Care, are eligible for an overall star rating. Not all hospitals report all measures. Therefore, some hospitals may not be eligible.

The comprehensive methodology report provides additional detail on the methodology used to calculate the Overall Hospital Quality Star Rating.

How measure categories are weighted

For each hospital, a hospital summary score is calculated by taking the weighted average of the hospital's scores for each measure group or category. The table below shows the weight applied to each measure category. The hospital summary score is then used to assign hospitals to star ratings using k-means clustering within each peer group.

Measure Category	Weight Used in Calculation
Mortality	22%
Safety	22%
Readmission	22%
Patient Experience	22%
Timely & Effective Care	12%

Note that these percentage weights are out of 100%. If a hospital has no measures in a certain measure category, the weight percentage is redistributed proportionally to the other measure groups.

For example, if a hospital had no measures in the timely & effective category, the 12% weight would be distributed as 25% for the mortality, safety of care, readmission and patient experience groups.

National distribution of the Overall Hospital Quality Star Rating

The following table shows the national distribution of the overall star rating based on April 2021 results.

Overall Rating	Number of Hospitals (N=4,586, %)
1 star	204 (6.06%)
2 stars	690 (20.57%)
3 stars	1,018 (30.34%)
4 stars	988 (29.45%)
5 stars	455 (13.56%)
N/A	1,181 (26.03%)

Additional information

The methodology for calculating the Overall Hospital Quality Star Rating was developed with input from stakeholders and members of the public and finalized in the Calendar Year (CY) 2021 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Proposed Rule (CMS-1736-P). Learn more about the methodology.

For general questions regarding the Overall Hospital Quality Star Rating, go to the QualityNet Q & A site.

Measures included by categories

The Overall star rating includes a variety of the more than 100 measures CMS publicly reports, divided into 5 measure groups or categories: Mortality, Safety of Care, Readmission, Patient Experience, and Timely & Effective Care. The table below lists all possible measures that could be included. It also lists, for each measure, the data collection period used to calculate the April 2021 overall star rating using October 2020 data. Once reporting thresholds are met, a hospital's overall star rating is calculated using only those measures for which data are available. A hospital may not be able to report data on all measures, due to the number or type of patients they treat

Measure Group	Measures	Data Collection Period	
		From	Through
Mortality (7)	Death rate for heart attack patients	7/1/2016	6/30/2019
	Death rate for coronary artery bypass graft (CABG) surgery patients	7/1/2016	6/30/2019

Measure Group	Measures	Data Collection Period	
		From	Through
	Death rate for chronic obstructive pulmonary disease (COPD) patients	7/1/2016	6/30/2019
	Death rate for heart failure patients	7/1/2016	6/30/2019
	Death rate for pneumonia patients	7/1/2016	6/30/2019
	Death rate for stroke patients	7/1/2016	6/30/2019
	Deaths among patients with serious treatable complications after surgery	7/1/2017	6/30/2019
Safety of Care (8)	Central line-associated bloodstream infections (CLABSI)	1/1/2019	12/31/2019

Measure Group	Measures	Data Collection Period	
		From	Through
	Catheter-associated urinary tract infections (CAUTI)	1/1/2019	12/31/2019
	Surgical site infections from colon surgery (SSI: Colon)	1/1/2019	12/31/2019
	Surgical site infections from abdominal hysterectomy (SSI: Hysterectomy)	1/1/2019	12/31/2019
	Methicillin-resistant Staphylococcus Aureus (MRSA) Blood Laboratory-identified Events (Bloodstream infections)	1/1/2019	12/31/2019
	Clostridium difficile (C.diff.) Laboratory-identified Events (Intestinal infections)	1/1/2019	12/31/2019

Measure Group	Measures	Data Collection Period	
		From	Through
	Rate of complications for hip/knee replacement patients	4/1/2016	3/31/2019
	Serious complications	7/1/2017	6/30/2019
Readmission (11)	Hospital return days for heart attack patients	7/1/2016	6/30/2019
	Rate of readmission for coronary artery bypass graft (CABG) surgery patients	7/1/2016	6/30/2019
	Rate of readmission for chronic obstructive pulmonary disease (COPD) patients	7/1/2016	6/30/2019
	Hospital return days for heart failure patients	7/1/2016	6/30/2019

Measure Group	Measures	Data Collection Period	
		From	Through
	Rate of readmission after hip/knee surgery	7/1/2016	6/30/2019
	Hospital return days for pneumonia patients	7/1/2016	6/30/2019
	Rate of readmission after discharge from hospital (hospital-wide)	7/1/2016	6/30/2019
	Rate of unplanned hospital visits after an outpatient colonoscopy	1/1/2016	12/31/2018
	Rate of unplanned hospital visits for patients receiving outpatient chemotherapy	1/1/2018	12/31/2018

Measure Group	Measures	Data Collection Period	
		From	Through
	Rate of emergency department (ED) visits for patients receiving outpatient chemotherapy	1/1/2018	12/31/2018
	Ratio of unplanned hospital visits after hospital outpatient surgery	1/1/2018	12/31/2018
Patient Experience (8)	Patients who reported that their nurses communicated well	1/1/2019	12/31/2019
	Patients who reported that their doctors communicated well	1/1/2019	12/31/2019
	Patients who reported that they received help as soon as they wanted	1/1/2019	12/31/2019

Measure Group	Measures	Data Collection Period	
		From	Through
	Patients who reported that staff explained about medicines before giving it to them	1/1/2019	12/31/2019
	Patients who reported that their room and bathroom were clean/ Patients who reported that the area around their room was quiet at night	1/1/2019	12/31/2019
	Patients who reported that they were given information about what to do during their recovery at home	1/1/2019	12/31/2019
	Patients who understood their care when they left the hospital	1/1/2019	12/31/2019
	Patients who gave their hospital a rating on a scale from 0 (lowest) to 10 (highest)/ Patients who would recommend the hospital to their friends and family	1/1/2019	12/31/2019
Timely and Effective Care (14)	Percentage of healthcare workers given influenza vaccination	10/1/2019	3/31/2020
	Percentage of patients who left the emergency department before being seen	1/1/2018	12/31/2018

Measure Group	Measures	Data Collection Period	
		From	Through
	Percentage of patients who came to the emergency department with stroke symptoms who received brain scan results within 45 minutes of arrival	1/1/2019	12/31/2019
	Percentage of patients receiving appropriate recommendation for follow-up screening colonoscopy	1/1/2018	12/31/2018
	Percentage of patients with history of polyps receiving follow-up colonoscopy in the appropriate timeframe	1/1/2018	12/31/2018
	Percentage of mothers whose deliveries were scheduled too early (1-2 weeks early), when a scheduled delivery was not medically necessary	1/1/2019	12/31/2019
	Percentage of patients who received appropriate care for severe sepsis and septic shock.	1/1/2019	12/31/2019
	Percentage of outpatients with chest pain or possible heart attack who got drugs to break up blood clots within 30 minutes of arrival	1/1/2019	12/31/2019
	Percentage of patients receiving appropriate radiation therapy for cancer that has spread to the bone	1/1/2018	12/31/2018

Measure Group	Measures	Data Collection Period	
		From	Through
	Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room	1/1/2019	12/31/2019
	Average (median) number of minutes before outpatients with chest pain or possible heart attack who needed specialized care were transferred to another hospital	1/1/2019	12/31/2019
	Average (median) time patients spent in the emergency department before leaving from the visit	1/1/2019	12/31/2019
	Percentage of outpatients with low-back pain who had an MRI without trying recommended treatments first, such as physical therapy	7/1/2018	6/30/2019
	Percentage of outpatient CT scans of the abdomen that were “combination” (double) scans	7/1/2018	6/30/2019
	Percentage of outpatients who got cardiac imaging stress tests before low-risk outpatient surgery	7/1/2018	6/30/2019