**TIPQC – Best For All (BFA) Quality Improvement Project**

**MONTHLY and QUARTERLY MEASURE DATA ENTRY**

**OUTCOME MEASURES – Reported monthly and quarterly**

**#1: Tennessee Birthing Hospitals will have 90% of all key Process and Structure measures (strategies) in place.**

* Cumulative proportion of implemented **Best For All (BFA) Strategies** defined in the tool kit as Structure and Process Measures. Teams will report in 10% increments (0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%). Each process and structure measure are defined in detail below.

**#2: Demonstrate improvement in Patient Reported Experience Measure (PREM) survey scores by 10% for ALL families during hospital delivery stay by 2026.**

* Utilizing PREM Survey, at the time of discharge patients will be asked to complete the survey as an opportunity to give feedback on their care experience.
* Hospitals will demonstrate a 10% increase in patient survey scores as demonstrated by a percent increase in the number of survey responses of ‘agree or strongly agree’.
	+ Surveys are distributed to all birthing people at discharge. Patients will be given a QR scan code and/or link to complete the survey via REDCap. Paper survey forms will be used as needed. Surveys will be provided in English, Spanish, Mandarin, French, Chinese and Arabic.
	+ REDCap survey responses will be aggregated, and *data entered into SimpleQI by TIPQC staff.*

Outcome measures will be stratified to report disaggregated race, preferred language, and payor status data as applicable.

**BALANCING MEASURES – Reported monthly**

**Balancing Measure #1: Percent of less-than-optimal patient experiences by analyzing the Patient Reported Experience Measure (PREM) survey responses of ‘disagree/strongly disagree.’**

* Utilizing the PREM Survey, at the time of discharge patients will be asked to complete the survey as an opportunity to give feedback on their care experience.
* Patient survey responses of ‘disagree and strongly disagree’ will be analyzed.
	+ Surveys are distributed to all birthing people at discharge. Patients will be given a QR scan code and/or link to complete the survey via REDCap. Paper survey forms will be used as needed. Surveys will be provided in English, Spanish, Mandarin, French, Chinese and Arabic.
	+ REDCap survey responses will be aggregated, and *data entered into SimpleQI by TIPQC staff.*

**PROCESS MEASURES – Reported quarterly**

The following process measures should be entered directly into SimpleQI by hospital teams.

**#1: Provider Education – Implicit Bias, Equity and Inclusion that includes unit-standard policy and procedure for addressing equity.**

* Report in 10% increments (0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Q3 2025 | Q4 2025 | Q1 2026 | Q2 2026 | Q3 2026 |
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**#2: Nursing Education - Implicit Bias, Equity and Inclusion that includes unit-standard policy and procedure for addressing equity.**

* Report in 10% increments (0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%)

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| Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Q3 2025 | Q4 2025 | Q1 2026 | Q2 2026 | Q3 2026 |
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**STRUCTURE MEASURES – Reported quarterly**

The following process measures should be entered directly into SimpleQI by hospital teams.

**#1: Hospital has implemented a protocol for collecting race and payor data for all birthing patients, collects self-reported data, and tracks and reviews missing data.**

* Report in 10% increments (0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%)

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| Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Q3 2025 | Q4 2025 | Q1 2026 | Q2 2026 | Q3 2026 |
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**#2: Hospital has implemented a protocol to review disaggregated race and payor data to identify disparities.**

* Report in 10% increments (0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%)

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| Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Q3 2025 | Q4 2025 | Q1 2026 | Q2 2026 | Q3 2026 |
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**#3: Each unit (OB, NICU, PP, Nursery) has implemented a protocol for collecting race and payor data for all birthing patients, collects self-reported data, and tracks and reviews missing data.**

* Report in 10% increments (0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Q3 2025 | Q4 2025 | Q1 2026 | Q2 2026 | Q3 2026 |
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**#4: Hospital has implemented standardized social determinants of health screening tools in the electronic record for all pregnant women during delivery admission to link patients to needed resources and services.**

* Report in 10% increments (0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%)

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| Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Q3 2025 | Q4 2025 | Q1 2026 | Q2 2026 | Q3 2026 |
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**#5: Hospital has implemented a process to monitor if patients received the needed services identified through screening.**

* Report in 10% increments (0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%)

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| Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Q3 2025 | Q4 2025 | Q1 2026 | Q2 2026 | Q3 2026 |
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**#6. Hospital has implemented a strategy for incorporating discussions of social determinants of health and discrimination as potential factors in hospital maternal morbidity reviews.**

* Report in 10% increments (0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%)

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| Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Q3 2025 | Q4 2025 | Q1 2026 | Q2 2026 | Q3 2026 |
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**#7. Hospital has implemented a strategy for sharing expected respectful care practices with delivery staff and patients including appropriately engaging support partners and/or doulas.**

* Report in 10% increments (0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Q3 2025 | Q4 2025 | Q1 2026 | Q2 2026 | Q3 2026 |
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**#8. Hospital has implemented a strategy to provide all patients the recommended postpartum safety patient education materials prior to hospital discharge, including infant patient safety and urgent maternal warning signs, and where patients call for immediate help with concerns, as well as scheduling early postpartum follow-up.**

* Report in 10% increments (0%, 10%, 20%, 30%, 40%, 50%, 60%, 70%, 80%, 90%, 100%)

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| Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Q3 2025 | Q4 2025 | Q1 2026 | Q2 2026 | Q3 2026 |
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