

STEP 1: DESIGNATE KEY PROJECT TEAM MEMBERS

Please provide the contact information for the following key project team members:

- Day to Day Leader (i.e. key contact person), who is responsible for the day-to-day management of the project
- Senior Leader (i.e. project sponsor)
- Physician Champion
- Nursing Champion
- Data Contact
- Patient / Family Member

NOTE: Because this project involves combined maternal and infant teams, you will be asked to designate both a “Maternal” and an “Infant” Senior Leader, Physician Champion, and Nursing Champion.

Ideally, the roles listed above are filled by different individuals from your facility.

If the same individual will be responsible for multiple roles on your project team, please provide all their contact information in the first role there are listed under below. After that, please re-list their First and Last Names in subsequent roles, and then specify “same” for the rest of their contact information.

IMPORTANT: By agreeing to being listed, the individual acknowledges their expected participation in this project.

Facility Details:

Name of facility:

Hospital type:

☐ Count/District ☐ University ☐ Non Profit ☐ For Profit ☐ Tribal

Teaching facility?

☐ No ☐ Yes

Urbanization level:

☐ Rural ☐ Urban ☐ Unknown

Annual delivery volume:

AAP NICU level:

- ☐ Level 1: Well Newborn Nursery
☐ Level 2: Special Care Nursery
☐ Level 3: Neonatal Intensive-care Unit (NICU)
☐ Level 4: Regional Neonatal Intensive-care Unit (Regional NICU)
☐ Unknown

Percentage Medicaid:

Day to Day Leader:

First Name:	Last Name:
Nickname / Preferred first name:	Degrees:
Title:	Phone number - primary:
Email address – primary:	Email address – secondary (if desired):

MATERNAL Senior Leader:

First Name:	Last Name:
Nickname / Preferred first name:	Degrees:
Title:	Phone number - primary:
Email address – primary:	Email address – secondary (if desired):

INFANT Senior Leader:

First Name:	Last Name:
Nickname / Preferred first name:	Degrees:
Title:	Phone number - primary:
Email address – primary:	Email address – secondary (if desired):

MATERNAL Physician Champion:

First Name:	Last Name:
Nickname / Preferred first name:	Degrees:
Title:	
Email address – primary:	Email address – secondary (if desired):

INFANT Physician Champion:

First Name:	Last Name:
Nickname / Preferred first name:	Degrees:
Title:	
Email address – primary:	Email address – secondary (if desired):

MATERNAL Nursing Champion:

First Name:	Last Name:
Nickname / Preferred first name:	Degrees:
Title:	
Email address – primary:	Email address – secondary (if desired):

INFANT Nursing Champion:

First Name:	Last Name:
Nickname / Preferred first name:	Degrees:
Title:	
Email address – primary:	Email address – secondary (if desired):

Data Contact:

First Name:	Last Name:
Nickname / Preferred first name:	Degrees:
Title:	
Email address – primary:	Email address – secondary (if desired):

Patient/Family Member:

First Name:	Last Name:
Nickname / Preferred first name:	Degrees:
Title:	
Email address – primary:	Email address – secondary (if desired):

STEP 2: DESIGNATE DATA ACCESS RIGHTS

To facilitate quantitative, data-driven improvement, this project will utilize an instance of a web-based data entry system called REDCap. Three groups of REDCap end-users must be identified for your facility:

- 1) personnel authorized to enter project data,
- 2) personnel authorized to receive/generate standardized reports of your project data, and
- 3) personnel authorized to request/receive downloads of your project data.

Please read the following carefully and then indicate (in the tables below) which team members should be granted which REDCap access rights related to data entry, reports, and data downloads. IMPORTANT: your facility will be responsible for contacting TIPQC promptly for any required changes to the listed personnel and/or their REDCap access rights.

1) Data entry: Individuals granted data entry access rights will be able to not only capture new records in REDCap, but also edit any data captured in existing records. Individuals granted access to generate reports of project data but not data entry access will not be able to capture new records in REDCap. Nor will they be able to edit any data captured in existing records. They will have read only access to all of project data.

2) Report generation: Standardized periodic reports for this project will be available on-demand by authorized personnel at your facility using a secure link through the REDCap interface, or they may be sent to authorized personnel through a secure system *depending on the type of report*. The various types of periodic reports utilized may include:

- A report consisting of only your local facility's data. You will not be able to download or see other participating facility's local reports, nor will other participating facilities have access to your local report. You will use this report to present your facility's performance at each monthly huddle.
- A report comparing the performance of your local facility to the performance of the other participating teams. The other participating teams will be de-identified in this report.
- A report consisting of aggregate data from the collaborative as a whole. The TIPQC state leaders will present this report at each monthly huddle to share the overall performance of all of the participating facilities. This report will only be available to TIPQC state leaders.
- A confidential report that compares the overall performance of all of the participating teams. The participating teams will be identified in this report and thus will contain sensitive content. This report will only be made available to the TIPQC state leaders for coaching and improvement purposes.

The core contents of the periodic reports will be determined by group consensus, but flexibility is available to modify reports as needed in the future.

Potentially better practices to consider for managing QI project data and reports:

- Include at least two people who are authorized to both enter data and review reports. Some data entry error warnings can only be generated in the report. Investigating and correcting this type of data error is easier if the end-user is authorized to enter data and generate reports.
- Grant report generation authorization to senior leaders or executive champions to allow closer monitoring and to facilitate ownership of the outcome of the improvement effort.
- Review authorized personnel periodically as some may have left the project, or your facility and continued access may no longer be appropriate.

Any external requests to TIPQC for reports where your facility is individually identifiable will be referred to your facility's authorized representative listed above.

3) Data download: From time to time, TIPQC has received requests to provide downloads of a participating facility's project data. As your facility considers whether to authorize this option, we would like to emphasize several critical limitations of this potentially valuable feature.

- Your facility is responsible for the security of the authentication credentials, the device requesting the data download, and for any and all subsequent use, storage and/or transmission of the data. Your responsibility includes continued compliance with the TDH/TIPQC DUA, the HIPAA/HITECH Act and other Federal regulations as well as local policy and guidelines for the downloaded material.
- Neither TDH, nor personnel working under the TIPQC contract can be responsible for the proper handling, security, or usage of your downloaded data.

Data downloads are only to be completed when one of the authorized personnel indicated contacts TIPQC and request a one-time data download. (Note this does not preclude multiple requests over time, but a request must be made for each individual download event.)

Any requests made to TIPQC for direct access to your data as part of a legal, judicial or regulatory action will be referred to the Tennessee Department of Health.

Designation of rights – key project team members:

Please indicate the REDCap access rights (if any) that should be granted to the following key project team members already designated in this application.

If the same team member will be responsible for multiple key roles, please indicate their REDCap access rights for the first role they are listed under. After that, feel free to leave the REDCap access rights blank.

Project Team Member	REDCap Access Rights		
	Data Entry	Report Generation	Data Download
Day to Day Leader	☐	☐	☐
MATERNAL Senior Leader	☐	☐	☐
INFANT Senior Leader			
MATERNAL Physician Champion	☐	☐	☐
INFANT Physician Champion			
MATERNAL Nurse Champion	☐	☐	☐
INFANT Nurse Champion			
Data Contact	☐	☐	☐

STEP 3: DESIGNATE ADDITIONAL PROJECT TEAM MEMBERS

Please indicate the name, email address, and clinical role of any additional project team members. Please also indicate the REDCap data access rights (*if any*) that should be granted to any of the additional project team members specified.

NOTE: Not all team members must have REDCap access.

First & Last Name	Email Address (Primary)	Clinical Role NU = Nurse PM = Physician/Midwife NC = Not Clinical	REDCap Access Rights		
			Data Entry	Report Generation	Data Download
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐
		☐ NU ☐ PM ☐ NC	☐	☐	☐

(Feel free to add more rows to table if needed)

STEP 4: OBTAIN NECESSARY SIGNATURES

Please collect the signatures from the specific project team members as detailed on the following pages.

SIGNATURE PAGES

Name of facility: _____ Day to Day Leader: _____

IRB / QUALITY COUNCIL APPROVAL

--- Please have the Day to Day Leader read and complete this section ---NOTE: Approval from your local IRB or Quality Council is required prior to review of this Project Application.

Which governance model is used in your facility:

- ☐ Our facility's IRB
- ☐ Our facility's Quality Council or similar QI governance entity
- ☐ Other – specify: _____

By checking this box,

☐ I confirm

1. This project has been reviewed in compliance with local policies and procedures for the governance of QI projects.
2. The team has received approval to participate in the project at our facility.
3. Documentation of local review and approval will be maintained in our facility throughout our participation in the project, and for at least one year after the project concludes.

Signature of *Day to Day Leader* : _____ Date: _____

LOCAL MEDICAL OVERSIGHT

--- Please have the MATERNAL & INFANT Physician Champions read and complete this section ---

This project seeks to effectively and efficiently implement evidence-based practice in an active clinical care setting. QI tests of change that introduce new processes or modify existing processes require assurance of local medical oversight of the work of the improvement team. This application requires identification of the physician champion who will be responsible for medical oversight of your facility's implementation of this project. The Physician Champion is also responsible for gaining approval from the Medical Director, Service Chief, Chief of the Medical Staff, or Chief Medical Office (as appropriate) at your facility for participation in this project.

By checking these boxes,

I agree to provide medical oversight for the work of the improvement team in my facility.

I have gained approval from the Medical Director, Service Chief, Chief of the Medical Staff, or Chief Medical Office (as appropriate) for participation in this project.

Physician Champion	
MATERNAL	INFANT
☐	☐
☐	☐

Signature of *MATERNAL Physician Champion*: _____ Date: _____Signature of *INFANT Physician Champion*: _____ Date: _____

SIGNATURE PAGES - continued

SENIOR LEADERSHIP SUPPORT

--- Please have the MATERNAL & INFANT Senior Leaders read and complete this section ---

I. General support

By checking this box,
I agree to support the team and will work with them to remove any barriers and/or
provide the resources necessary for them to achieve success.

Senior Leader	
MATERNAL	INFANT
☐	☐

Signature of *MATERNAL Senior Leader*: _____ Date: _____

Signature of *INFANT Senior Leader*: _____ Date: _____

II. TennesseeAIM

TIPQC has teamed up with the American College of Obstetricians and Gynecologists' (ACOG's) Alliance for Innovation on Maternal Health (AIM, <https://safehealthcareforeverywoman.org/>) program to carry out this project. AIM is a national data-driven maternal safety and quality improvement initiative based on interdisciplinary consensus-based practices to improve maternal safety and outcomes. The program provides implementation and data support for the adoption of evidence-based patient safety bundles - collections of best practices that have been vetted by experts in practice. TIPQC has put together a team of experts to guide the implementation of the relevant AIM maternal safety bundle for this project throughout Tennessee, with the goal of moving established guidelines into practice with a standard approach.

Hospital level data will be shared with AIM to track the progress of the maternal safety bundle implementation and outcomes. Some of this data will be collected and shared directly by the participating hospitals. Other data will be calculated and shared (on behalf of the participating hospitals) by the Tennessee Hospital Association (THA) using UB-04 claims data.

By checking these boxes,
This hospital grants permission for the THA to use UB-04 claims data to calculate and
report required measures for participation in this project. THA, as a partner to the TIPQC
project, has permission to submit data quarterly to the ACOG AIM national database on
behalf of the hospital. Hospitals are identified by name in the dataset. Project leaders
from THA, TIPQC and ACOG will have access to view the data reports.

Senior Leader	
MATERNAL	INFANT
☐	☐

This hospital grants permission for TIPQC to aggregate data they capture in TIPQC's
instance of REDCap, maintained by the Tennessee Department of Health. TIPQC has
permission to submit data quarterly to the ACOG AIM national database on behalf of the
hospital. Hospitals are identified by name in the data set. THA and TIPQC will use the
same hospital identifiers. Project leaders from TIPQC and ACOG will have access to view
the data reports.

☐	☐
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Signature of *MATERNAL Senior Leader*: _____ Date: _____

Signature of *INFANT Senior Leader*: _____ Date: _____

SIGNATURE PAGES - continued**PROJECT DATA AND REPORTING**

--- Please have the Data Contact read and complete this section ---

I. Security Assurance

This project will be completed under your facility's DUA with TIPQC. Data and QI reports will be transmitted, analyzed and stored using hardware and software maintained by the Tennessee Department of Health who will be responsible for the security and maintenance of the systems as outlined in the DUA.

Your facility is responsible for maintaining the safety and security of all systems and software that are used in your facility and by your team members. Additionally, your facility is responsible for ensuring that local handling of quality improvement data and reports for this project are in compliance with the DUA and all federal and state regulations.

Additionally, your facility agrees to collect and report the agreed upon data for this project, including future collaborative wide modifications that may become necessary as the project moves forward. All data will be submitted for purposes of quality improvement, and all participants agree no data or information obtained during this project will be used for promotional or marketing purposes. The capture of Private Health Information (PHI) in any TIPQC QI project is always kept to the minimum extent possible consistent with efficiently and effectively achieving the projects stated Aim. In some projects, aggregated patient counts are captured instead of patient level data, thus concealing any potential PHI.

Data entry and report generation training will be conducted as part of the project kick-off. The responsibility for ensuring the quality and accuracy of the data reported to TIPQC as part of this project resides solely with the individual participating facility. Validation of data and correction of potential data errors that may become apparent during subsequent analysis is likewise the responsibility of the individual participating facility. Questions about data entry, report generation, and data error notifications for this project should be directed to TIPQC.

Should communication regarding specific data records be necessary, this communication will be based on the unique TIPQC record identification number or the assigned date of entry of the field in question. Participating facilities specifically agree they will not provide patient or provider level information to TIPQC when communicating about specific records that could potentially identify any patients, providers, or provider groups that have been de-identified as part of the project data collection and reporting plan outlined in the project toolkit.

By checking this box,

☐ I confirm that I have read, understand, and agree to abide by the provisions of this section.

Signature of *Data Contact*: _____ Date: _____

SIGNATURE PAGES - continued**II. Use and Release of Project Data and Reports**

Local project reports based on your local data are prepared by TIPQC for your facility's improvement work on this project. Sharing the results, (data, analysis, intervention, and implementation strategy) from local PDSA cycles is essential in order to harness the power of a collaborative approach to data-driven quality improvement. However, local reports where the local facility is identifiable will only be prepared for the identified facility. Thus, the decision to share your results in an identifiable fashion *within the collaborative* project is left to your institution's change team.

Using your TIPQC analyses or data for purposes other than collaborative quality improvement, specifically using TIPQC analyses or data for contracting, marketing, or promotional purposes, is prohibited by the TDH/TIPQC DUA, and you and your facility's agreement to be bound by this prohibition is confirmed by completion of this agreement.

State level reports will be prepared and distributed by TIPQC and represent a collaborative patient safety and/or quality improvement work product and are the intellectual property of TIPQC. State reports may include statewide and regional aggregate analyses. Local facilities will be provided with their facility identification code in order to compare their performance to other de-identified participants within the state when de-identified facility comparisons are prepared. *Release of your facility's comparative performance is not permitted, and participants hereby expressly agree they will not use comparative analyses or data for contracting, marketing or promotional purposes.*

In summary, local facility reports are provided by TIPQC for the internal use of the individual facility and can only be released or published in any form with the written consent of the individual facility (owner of the individual facility's data,) *and* the written consent of TIPQC (convener or the collaborative and owner of the aggregate data.)

Unauthorized public release of a TIPQC report where a facility is identified may be actionable by the individual facility that is identified, by the other non-identified facilities that contributed to the aggregated data, and/or by TIPQC.

By checking this box,

☐ I confirm that I have read, understand, and agree to abide by the provisions of this section.

Signature of *Data Contact*: _____ Date: _____

III. Publication and Presentation of Results

Publication or presentation of results and/or experiences derived from this project may be valuable to others who face similar challenges in implementation of evidence-based Potentially Better Practices. Any contemplated release of data or presentation of collaborative experience should conform to the principles of data ownership and collaborative sharing as outlined herein. Written permission for data release must be obtained from the data's respective owner(s) before the data is released in any public forum. Specifically, publication of any identifiable facility data requires written permission from that potentially identified facility and publication of any aggregate data requires written permission from TIPQC. As this project is by design a facility collaborative effort, authorship of any publication would ideally reflect the collaborative contribution of each facility, each facility's project leader, other significant contributors as designated by each facility's project leader, and TIPQC. For this collaborative project, authorship will minimally include the primary author of the report.

SIGNATURE PAGES - continued

TIPQC project data is not to be used for contracting, advertising, publicity, or marketing campaigns by any participating hospital.

By checking this box,

☐ I confirm that I have read, understand, and agree to abide by the provisions of this section.

Signature of *Data Contact*: _____ Date: _____

TEAM PARTICIPATION REQUIREMENTS

--- Please have the Day to Day Leader read and complete this section ---

I. General

Your completion of this project application serves as authorization to list your facility as a participant in this TIPQC project and a contributor to the aggregate result. Such listing may occur in conjunction with data presentations, on the TIPQC website, and when TIPQC is queried about which facilities are participating in a given project.

Continued listing as a participant requires timely data entry for monthly summary statistics. This provides TIPQC with sufficient time to analyze the data and prepare reports for each collaborative meeting. Likewise, accurate data entry (prompt resolution and correction of any automated data checks) is essential and must be completed by the data entry deadline each month. This helps ensure that aggregate reports prepared by TIPQC for all participants are both up-to date and representative.

Failure to maintain the timeliness and accuracy of your data may result in temporary or permanent removal of your local data from the TIPQC project, as well as removal of your facility's name as a participant in this project at the discretion of TIPQC's Medical Director.

In addition to keeping up to date on data collection and resolution of potential data entry errors in the TIPQC/TDH REDCap system, teams are expected to

1. Conduct frequent (consider weekly, but at least monthly) team meetings.
2. Use the Institute for Healthcare Improvement's (IHI) Model for Improvement to guide your QI efforts for this project, including testing implementing changes using Plan-Do-Study-Act (PDSA) cycles.
 - For more information, see <https://tipqc.org/qi/>.
3. Participate in project huddles, Learning Sessions, and other engagement opportunities including coaching calls and site visits.

By checking this box,

☐ I confirm that I have read, understand, and agree to abide by the provisions of this section.

Signature of *Day to Day Leader*: _____ Date: _____

SIGNATURE PAGES - continued**II. Tennessee AIM**

As mentioned in the Senior Leadership Report section, hospital level data will be shared with AIM to track the progress of the maternal safety bundle implementation and outcomes. Some data will be calculated and shared (on behalf of the participating hospitals) by THA and submitted to AIM by TIPQC. Other data will be collected and submitted quarterly directly by the participating hospitals. Submission of the required measures to the AIM Data Center is required for participation in this project.

The AIM Data Center is a secure online system used to capture data from every state participating in any of the AIM maternal safety bundles. One individual from each participating hospital will be granted access to the Data Center. The identity of each participating hospital is masked in the Data Center – only TIPQC and each participating hospital will know the identity of each masked hospital. Each participating hospital will be able to generate any number of reports in the Data Center on their data.

By checking this box,

- ☐ I confirm that I have read, understand, and agree to abide by the provisions of this section.
- ☐ I agree to granted access to the AIM Data Center and enter my hospital's measures as required.

Signature of *Day to Day Leader*: _____ Date: _____
