FPQC
Florida Perinatal Quality Collaborative

Promoting Primary Vaginal Deliveries Initiative

Overcoming Resistance to Change

PROVIDE Collaborative Session Webinar

Partnering to Improve Health Care Quality
for Mothers and Babies

Welcome!

- **Please join by telephone to enter your Audio PIN on your phone or we will be unable to un-mute you for discussion.**
- If you have a question, please enter it in the Question box or Raise your hand to be un-muted.
- This webinar is being recorded.
- Please provide feedback on our post-webinar survey.

Webinar Agenda
February 8, 2018

- PROVIDE Announcements
- Overcoming Resistance to Change: Be the Change Leader!
  - Sue Garpiel, Trinity Health
- Questions/Comments

Announcements

- Data Collection or Submission Questions?
  - Estefania Rubio, Data Analyst erubio1@health.usf.edu
- Upcoming Webinars: 2nd Thursdays of every month at 12 PM EST (unless otherwise noted)

FPQC 2018
ANNUAL
CONFERENCE

CALL FOR POSTER ABSTRACTS

DUE MARCH 9, 2018

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Overcoming Resistance to Change: Be the Change Leader!

Susan Garpiel, RN, MSN, CNS, C-EFM
Director of Perinatal Clinical Practice

February 8, 2018

Perinatal Patient Safety Initiative Co-leads

Susan J. Garpiel, RN, MSN, CNS, C-EFM
Director of Perinatal Clinical Practice
Co-Lead of the Trinity Health
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Perinatal Medical Director
Co-Lead of the Trinity Health
Perinatal Patient Safety Initiative

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Objectives

1) Define transformational change and common responses.
2) Describe leadership tools that reduce resistance to change.
3) Apply tools to strategies for improving clinician engagement and commitment to the AIM Bundle: Safely Reducing the C-section.

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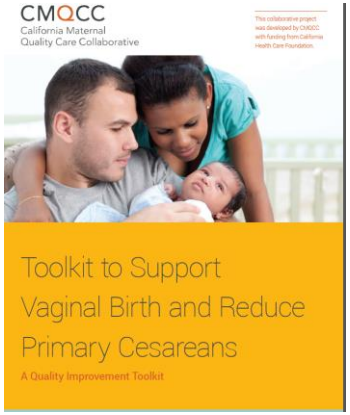
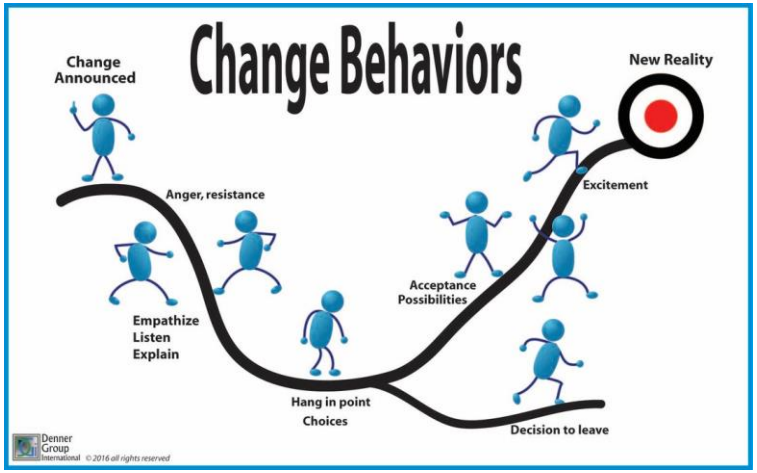
Disclaimer

- What this is not…



- What this is….



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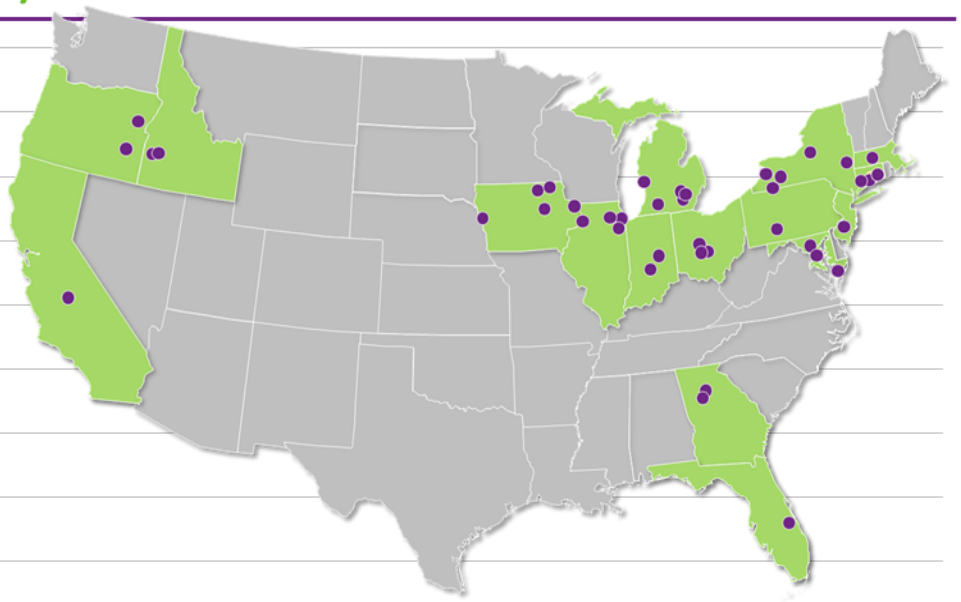
Trinity Health Volume of Total Deliveries

(CY 2016: 68,560 births, 1.72% of country total)



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PPSI Project History and Plan Rev. 1/19/18

PPSI Projects	West/Midwest Implementation (24)	W/MW & East Synergy Implementation(34)	40 Ministry Implementation
Risk Reduction: Cost/Claim, SRE			
1. System-wide Guidelines/Practices:			
• **Trial of Labor After Cesarean (VBAC)**	2009	2014	**2018**
• **Induction Augmentation**	2009	---	**2017-18**
• **EFM (2 policies)**	2010	2015	**2017-18**
• **Second Stage Labor**	2011	**2015-16**	**2017-18**
• **Cervical Ripening**	2012	---	**2017-18**
• **Mag Sulfate (4 Policies)**	2013	---	**2017-18**
• **Preeclampsia Management (OB Hypertension Bundle)**	-------	---	**2017-18**
• **OB Triage: Maternal Fetal Triage Index**	------	**2016-18**	**2017-18**
• **Shoulder Dystocia Management**	-------	---	**2018**
2. Validation of Competency /Practice			
• Perinatal Risk Site Assessments	2009-2013	2014-2016	2016-2017
• Premium Impact Audit Program (annual)	2010	2014	**2017**
• NCC Electronic Fetal Monitoring Certification	2012	2015	**2017**
• AWHONN 2011 Staffing Guidelines	2012	2014 - current	**2017-18**
3. Maternal and Perinatal Morbidity/Mortality Reduction			
• Elective Delivery <39 weeks (PC-01)	2009	2014	**2017**
• **Baby Friendly/Exclusive Breast Milk Feeding (PC-05)**	2012-2014	2013 – 2018	**2018**
• OB Hemorrhage Education Program	2013 - 2015	2015 - 2017	**QBL 2018**
• **Reducing Primary C-section/Supporting Intended Vaginal Deliveries (PC-02)**	--------	--------	**2017-18**
• March of Dimes Preterm Labor Assessment Toolkit (PC-03)	--------	2016 - 2017	**2018**
• OB Sepsis/ Maternal Early Warning Criteria	_____	_____	**2018**
• Zika Exposure Screening		2016	-------
4. Experience of Care (HCAHPS)		**2016-17**	**2017 -2018**

Types of Change

- **Developmental**: *simplest* - improves what you are currently doing, e.g new technique in labor support

- **Transitional**: replaces “what is” with something completely new. Designing/implementing a “new state.” No radical change in workflows or cultural change. e.g. method of cervical ripening/induction based upon bishop score and parity.

- **Transformational**: *difficult* -future state is so radically different than the current state that the people and culture must change to implement it successfully. New mindsets and behaviors are required.

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Transforming Maternity Care

CHILDBIRTH CONNECTION
a program of the national partnership for women & families

http://transform.childbirthconnection.org/

Maternity care quality is squarely on the national agenda.

After years of inadequate and poorly coordinated attention by policy makers and others, maternity care quality has become a priority in health care reform efforts, and public and private partners are working together more than ever before.

Learn more at **jointhetransformation.org**

CMQCC: Transforming Maternity Care

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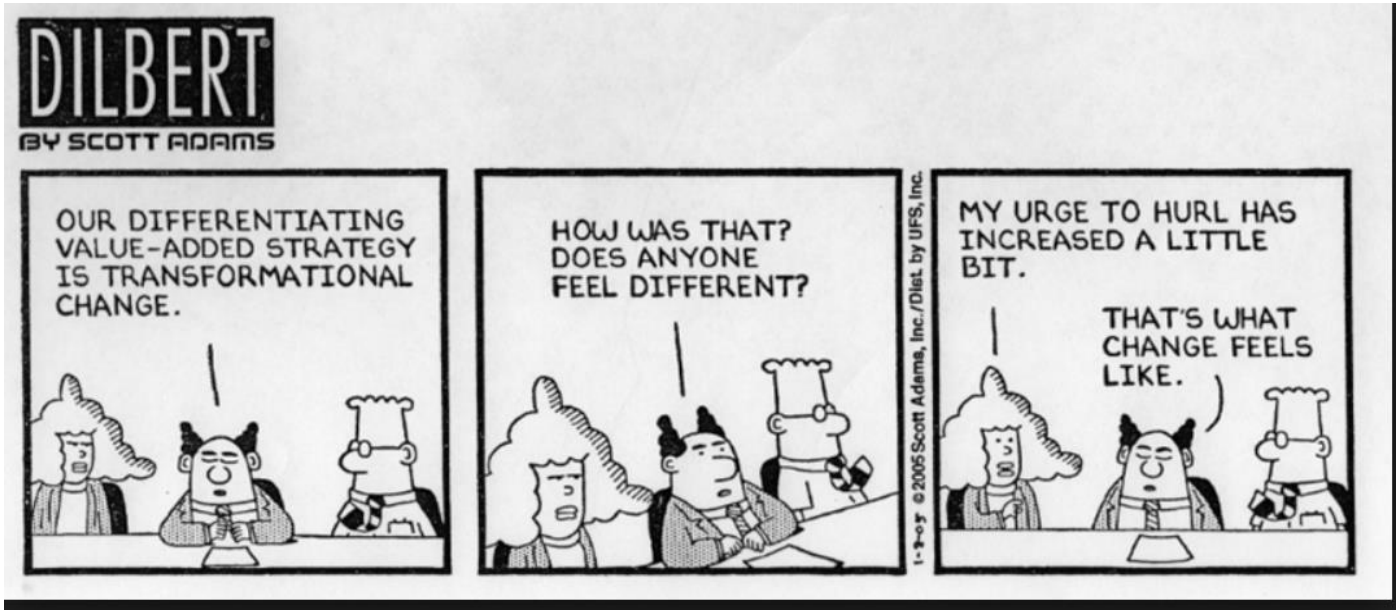
Responses to Transformational Change



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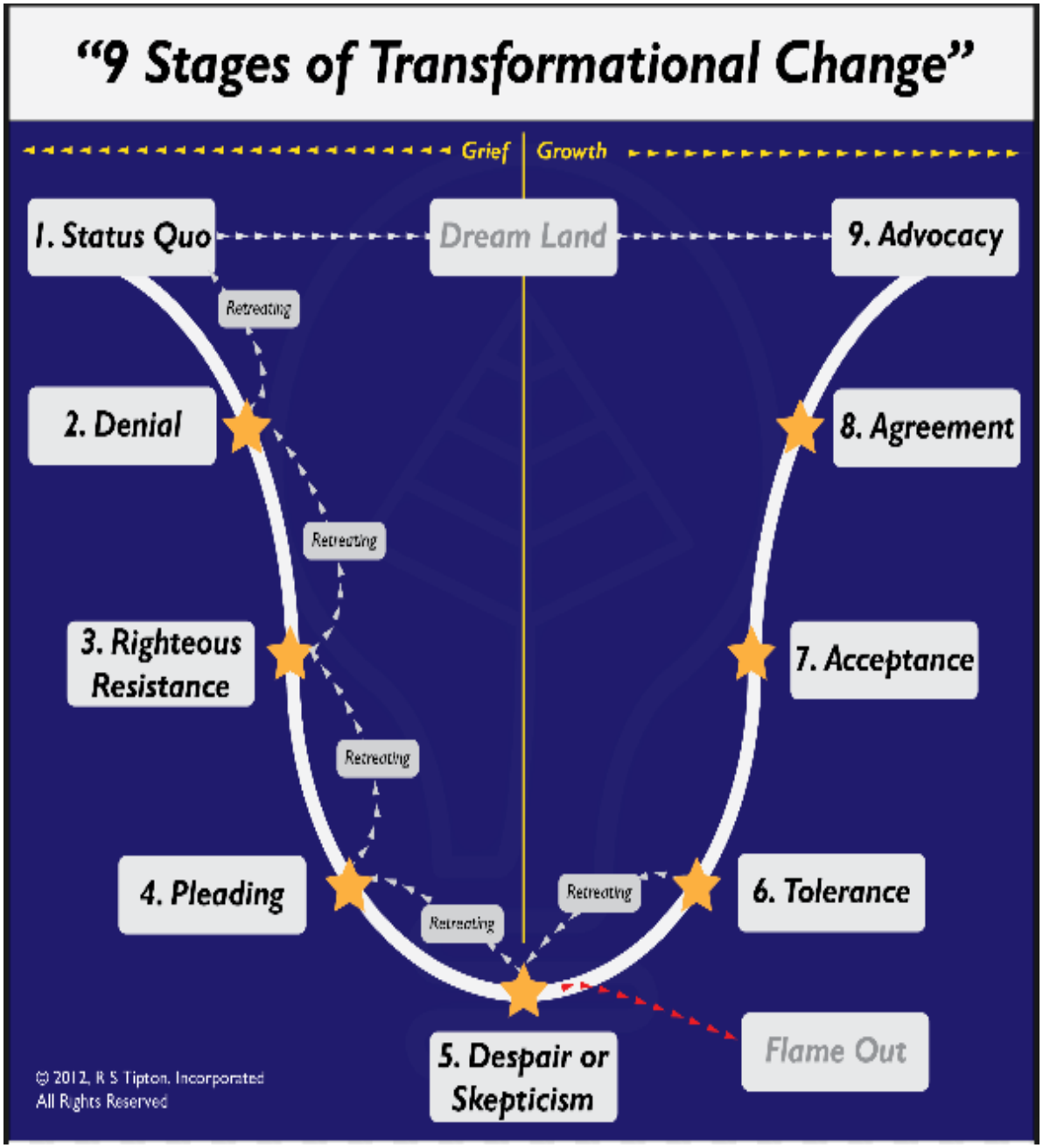

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Objectives

1) Define transformational change and common responses.
2) *Describe 2 leadership tools that reduce resistance to change.*
3) *Apply tools to strategies for improving clinician engagement and commitment to the AIM Bundle: Safely Reducing the C-section.*

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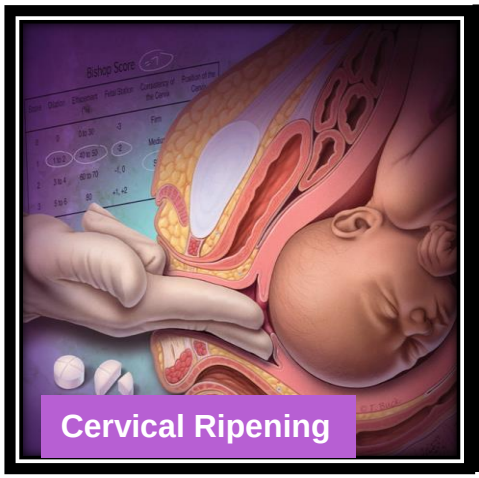
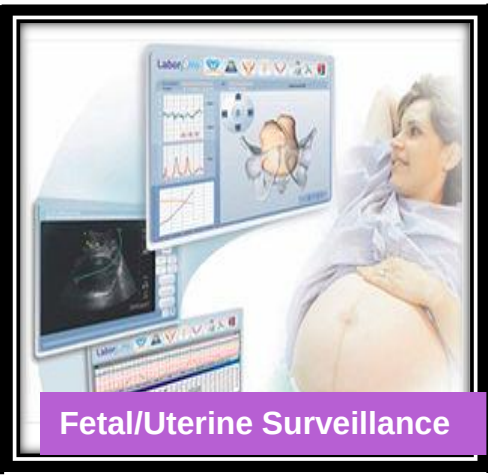
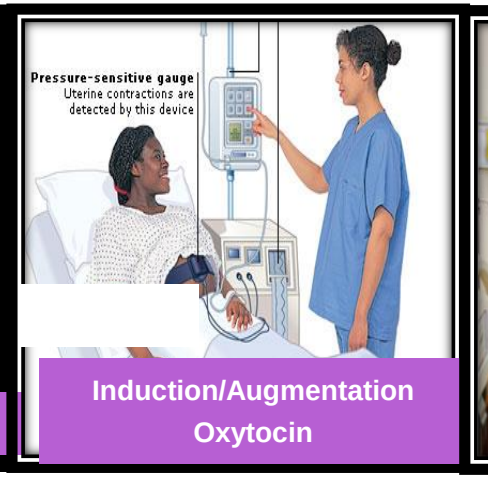
Trinity Health Journey: Safely Reducing C-section Workgroups

- Purpose: Design key strategies to support intended vaginal births, safely reduce the primary cesarean rate to improve mother and baby outcomes and the woman's satisfaction with her birth experience.







- Clarification of Goal: To prevent cesareans **is not to prevent cesarean births at all costs.**
  - Support Intended Vaginal Births
  - Care for Low-Risk Women – Redesigning Maternity care - the “New Normal”
  - “Understanding what is normal is fundamental to the judicious use of interventions during labor and birth.”

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Barriers to Supporting Intended Vaginal Births

Table 7. Barriers to Supporting Intended Vaginal Birth

Recognition and Prevention: Barriers to Supporting Intended Vaginal Birth
1. Lack of institutional support for the safe reduction of routine obstetric interventions
2. Admission in latent (early) labor without a medical indication
3. Inadequate labor support
4. Few choices to manage pain and improve coping during labor
5. Overuse of continuous fetal monitoring in low-risk women
6. Underutilization of the current treatment and prevention guidelines for potentially modifiable conditions (e.g. breech presentation and recurrent genital herpes simplex virus)

Smith H, Peterson N, Lagrew D, Main E. 2016. Toolkit to Support Vaginal Birth and Reduce Primary Cesareans: A Quality Improvement Toolkit. Stanford, CA: California Maternal Quality Care Collaborative. p. 39

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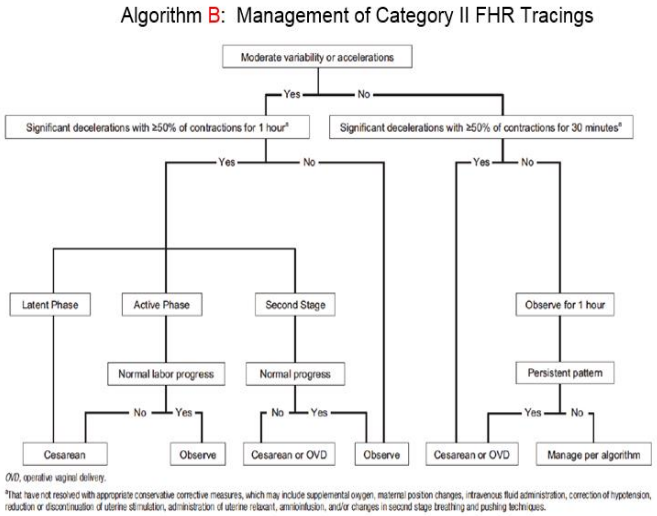
First Experiment: Revise existing electronic fetal monitoring system guideline to incorporate intermittent auscultation in low risk women, and expand management of category II tracing algorithm

Table C-1: Examples of High Risk Conditions/Indications for considering continuous Electronic Fetal Monitoring

Maternal Conditions	Pregnancy	Labor	Fetal Conditions
Active substance use	Cholestasis	Chorioamnionitis	IUGR
Chronic HTN	Hypertension/Pre-eclampsia	Epidural anesthesia	Known congenital anomaly
SLE/antiphospholipid syndrome	Multiple pregnancy	Meconium	
Thyroid disease, uncontrolled	Oligohydramnios/Polyhydramnios	Pitocin administration Cervidil administration	Red cell alloimmunization in presence of erythroblastosis
Diabetes: pre-gestational; uncontrolled gestational; GDM on medications	Prematurity (less than 36 weeks)	Vaginal bleeding, other than bloody show	
Previous Cesarean birth	Preterm premature ROM <36 weeks >41 weeks gestation	Misoprostol administration	
History of IUFD			
Not exclusions to intermittent auscultation: narcotic administration, ROM at term with clear fluid regardless of duration			

NOTE: This is not an all-inclusive list of high-risk conditions. Additional high risk conditions are determined by the OB Provider in collaboration with the perinatal team.



Transitional Change?

- Replace “what is” [existing guideline with something completely new.]
- Design/implement a “new state.” [intermittent auscultation for low risk women]
- No radical change in workflows or cultural change [RNs have been trained and we have the equipment]

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Rules of Engagement – Lessons learned

Physician Resistance!

- This is not what we do.
- We know from the literature that this is safe, but still want the option to do continuous fetal monitoring for low risk women.
- Are we going to miss something with intermittent?
- Bottom line: Physicians had no training or experience about intermittent auscultation in labor, and not comfortable with not having a visual tracing.

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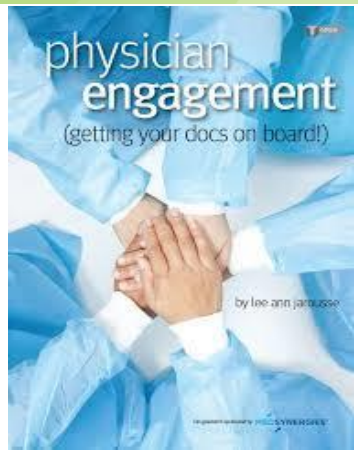
Rules of Engagement – Lessons learned



Strategies:

- Survey distributed regarding current practices: 8% almost always used intermittent auscultation in low risk women; predominately in hospitals with CNMs doing births
- Plan education for physicians regarding intermittent auscultation in low risk women.
- Have a backup plan: Explore wireless, beltless fetal monitoring.

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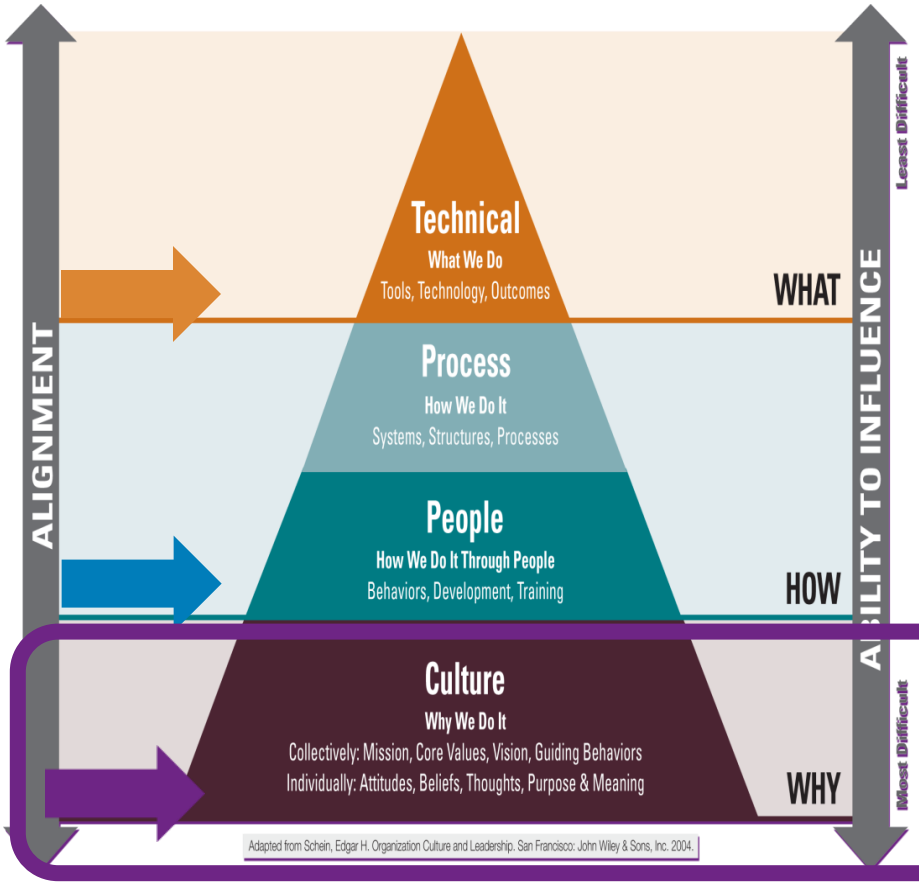
Change Pyramid – Shifting to improving the culture to recognize the value of vaginal birth



(SMFM/ACOG 2014) Dystocia Checklists/ induction algorithms in EHR
Shared decision-making aids for women regarding birth planning

Order sets supporting low intervention (IA, no routine IV fluids etc)
Standardized policy/guideline for labor support, freedom of movement, IA etc

Professional education about normal physiologic birth, labor support, IA, etc

Safely reduce C-section/support vaginal birth, reduce maternal morbidity, improve birth experience.

Although no ONE person or team owns all four levels of the Change Pyramid, integrating all four levels is EVERYONE'S responsibility.

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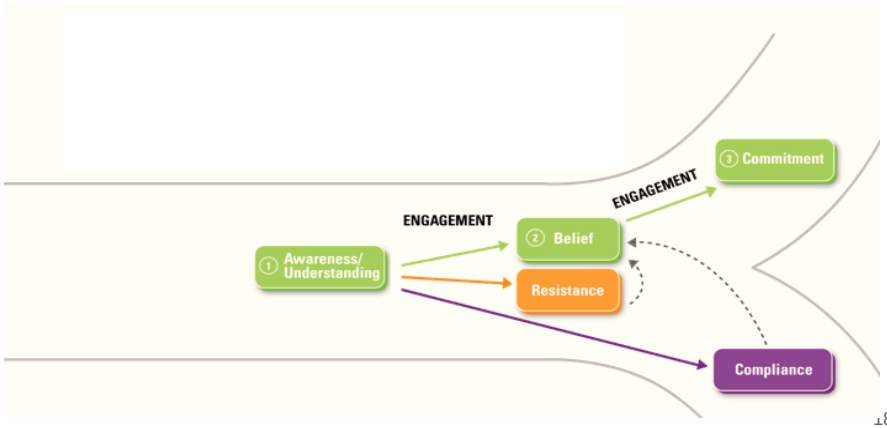
Change Leadership Tools

DVF>R

- Builds the case for change to overcome resistance
- Formula for success

Path to Commitment

- Helps change leaders understand the people side of change
- Increases the likelihood that stakeholders will fully commit to effecting and sustaining change.



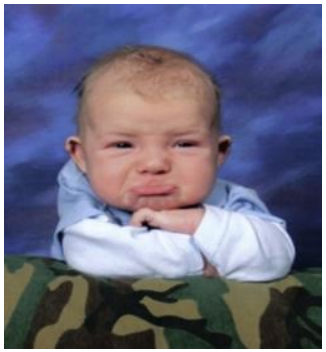
Formula for Change

Building the Case for Change

D x **V** x **F** > **R**

Dissatisfaction/Data **Vision** **First Steps** **Resistance**

Beckhard, Richard and Harris, Reuben, Organizational Transitions: Managing Complex Change, 2nd edition, Addison Wesley, Reading, MA, 1987



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R = Resistance

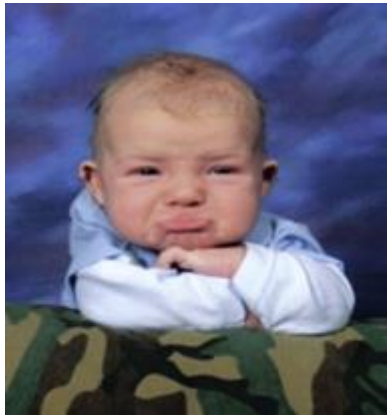
RESISTANCE to change

In order that the product of Desire, Vision and First Steps is greater than the Resistance to change, it is important to have a method of gauging the degree and nature of resistance.
Organizations do not resist change — people do. And although they resist change for highly personal reasons, there are some general principles. People resist change when they...

- believe they will lose something of value in the change (status, belonging, competence)
- lack trust in those promoting or driving the change
- feel they have insufficient knowledge about the proposed change and its implications;
- fear they will not be able to adapt to the change and will not have a place in the organization;
- believe the change is not in the best interests of the organization;
- believe they have been provided insufficient time to understand and commit to the change.

It's not that people resist change; it's just that they resist "being changed."

By far the most effective method of dealing with resistance is to engage stakeholders in shaping the elements on the left side of the change equation. By involving stakeholders in assessing the need for change (Dissatisfaction) creating a Vision of a preferred future, and determining First Steps toward achieving the vision, the system not only becomes richer in wisdom and passion, but many real or potential concerns about the change will be addressed.



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Common Reasons for ***Resistance*** to Changing practice? POLL

Example: Avoid elective inductions < 41 weeks

- "Our routine - This is the way we have always done it."
- "This is the way I learned it."
- "We are more likely to be sued by NOT doing a C-section."
- "Do not want anyone to tell them how to practice with their patients. – Don't tell me what to do."
- "Taking away autonomy. Now you are pushing it. Increase in perinatal risks."
- "Does not work with office schedule – limited time."
- "This is what the patient's want. Need to do this to improve patient's satisfaction."

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D = Dissatisfaction with Current State or Data

DISSATISFACTION with the status quo

All change begins with (a) dissatisfaction with the current state based on a recognition that the pain of not changing is likely to be greater than the uncertainty of change, and, (b) a willingness to search for alternatives. The combination of these two elements creates desire for change. Organizational leaders should never take for granted that the rest of the enterprise will see the need for change as clearly as they do (see "the Marathon effect, below).

Why?
Why now?

3 Questions: Be Prepared to Build the Case for Change

1. WIIFM: Positives and Negatives
   - Will the changes I have to make threaten my job, autonomy, status, workload?
   - Will the changes I have to make help me be a better clinician?
2. Is it good for my hospital, team, and patients?
   - Will the final change help us provide better care?
   - Will the final change help us to be more effective, efficient and reach our goals?
3. Do we have what we need to be successful?
   - Do we have resources (e.g. time, people, equipment, technology)?
   - Do we have the will, and the discipline?

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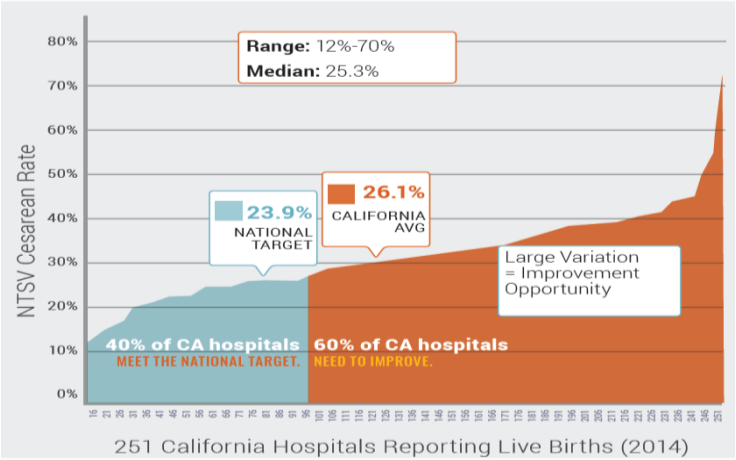
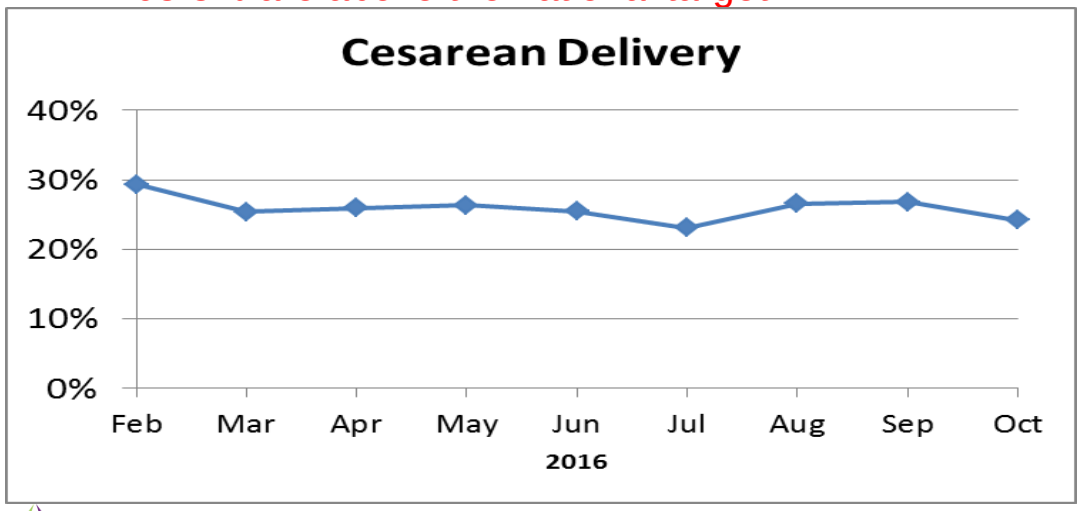
Goal: Healthy People 2020 target rate of 23.9%



- Trinity Health: PC-02 - 26% (32 HMs)
- 68.8% are above the national target.



Jun 2016 - Nov 2016

Region	Ministry	Cesarean Delivery (NTSV) JC PC-02
California	Fresno	24.1%
Oregon-Idaho	Boise	20.0%
	Nampa	--
	Ontario	11.1%
	Baker City	44.4%
Iowa- Nebraska	Clinton	23.3%
	Dubuque	21.0%
	Mason City	35.0%
	Sioux City	--
Illinois-LUHS	Gottlieb Memorial Hospital	38.5%
	Loyola University Medical Ctr	27.6%
Illinois - Mercy	Mercy Chicago	25.1%
Indiana	Mishawaka	9.7%
	Plymouth	47.1%
West Michigan	Grand Rapids	32.8%
	Hackley & Muskegon	36.7%
Southeast Michigan	Ann Arbor	23.5%
	Livonia	--
	Oakland	22.2%
Ohio	Mt. Carmel - East	16.3%
	Mt. Carmel - West	13.0%
	St. Ann's	24.1%
Maryland	Silver Spring	31.5%
	Germantown	16.4%
Northeast	St. Peter's	18.3%
	Mercy Hospital - Buffalo	26.4%
	Sisters of Charity	25.4%
	Mount St. Mary's - Buffalo	35.9%
Springfield	Mercy Medical Center	36.1%
Mid-Atlantic	Lourdes-Camden	30.0%
	Saint Francis-Wilmington	37.5%
Langhorne	St. Mary Medical Center	28.5%
Southeast	Holy Cross Hospital	46.4%
	St. Mary's Hospital	25.4%
Syracuse	St. Joseph Health	33.8%
Hartford	St. Francis Hospital	36.9%
Trinity Health		26.0%

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Future of C-section Rate Transparency

Patient Engagement ACOs Population Health Legal & Regulatory Compensation Payer Issues Opi

Infection Control & Clinical Quality

Yelp adds C-section delivery rates, other statistics for California hospitals providing maternity care

Written by Alyssa Rege | July 27, 2017 | Print | Email

1 Share Tweet 0 Share G+

Yelp added a maternity care rating feature for select hospitals in California July 26, *TechCrunch* reports.

The rollout is part of a collaboration with ProPublica to insure users have better access to medical information about health facilities in their area.

To determine each hospital's rating, Yelp pulled self-reported statistics from 250 California hospitals aggregated by state and nonprofit organizations such as the California Health Care Foundation and Cal Hospital Compare on a variety of maternity care issues. Users in the state can obtain information on the number of C-sections performed at each hospital, breastfeeding success rates and episiotomies, among other procedures.

While the feature is only available at hospitals in California that offer maternity care, Yelp officials said they will continue to work with state and federal officials to gather information about hospitals and health systems nationwide and intend to roll out the feature in other states.

More articles on quality:
12-state Salmonella outbreak linked to papayas
CDC updates Zika testing guidance for pregnant women
NAHQ: 10k professionals now certified in healthcare quality

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Professional Practice Guidelines & Opinions

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Society for Maternal-Fetal Medicine

OBSTETRIC CARE CONSENSUS

Number 1 • March 2014

Safe Prevention of the Primary Cesarean Delivery

New National Guidelines for Defining Labor Abnormalities and Management Options

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION

Number 687 • February 2017

Committee on Obstetric Practice

The American College of Nurse–Midwives and the Association of Women's Health, Obstetric and Neonatal Nurses endorse this document. This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice, in collaboration with American College of Nurse–Midwives' liaison member Tekoa L. King, CNM, MPH, and College committee members Kurt R. Wharton, MD, Jeffrey L. Ecker, MD, and Joseph R. Wax, MD.

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Approaches to Limit Intervention During Labor and Birth

ABSTRACT: Obstetrician–gynecologists, in collaboration with midwives, nurses, patients, and those who support them in labor, can help women meet their goals for labor and birth by using techniques that are associated with minimal interventions and high rates of patient satisfaction. Many common obstetric practices are of limited or uncertain benefit for low-risk women in spontaneous labor. For women who are in latent labor and are not admitted, a process of shared decision making is recommended. Admission during the latent phase of labor may be necessary for a variety of reasons. A pregnant woman with term premature rupture of membranes (also known as prelabor rupture of membranes) should be assessed, and the woman and her obstetrician–gynecologist or other obstetric care provider should make a plan for expectant management versus admission and induction. Data suggest that in women with normally progressing labor and no evidence of fetal compromise, routine amniotomy is not necessary. The widespread use of continuous electronic fetal heart-rate monitoring has not improved

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Women's Perceptions

"Few women benefit from low-tech supportive care practices that help them safely cope with the demands of pregnancy, labor, and birth."

Facts:

- >60% of mothers agreed that "giving birth is a process that should not be interfered with unless medically necessary,"
- "Most women said they were not allowed to drink, were confined to bed once admitted to the hospital and in "active" labor, and gave birth lying on their backs ."
- 2% of women experienced a set of 5 evidence-based supportive care practices that benefit mothers and babies:
  - 1) Labor begins on its own
  - 2) Woman has the freedom to move and change positions
  - 3) Woman has continuous labor support from a partner, family member, or doula
  - 4) Woman does not give birth on her back
  - 5) Mother and baby are not separated after birth.

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Brianna’s Birth Experience

Lauren was born at 8 33 pm on December 16th 2016 10 lbs 6 Oz and 21 inches

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Moving from the WIIFM to People-Centered Approach: Put yourself in the place of the woman.

- If you had a choice for this elective intervention, knowing the potential risks would you choose?

- Is there shared decision-making: Are risks, benefits and alternatives discussed?

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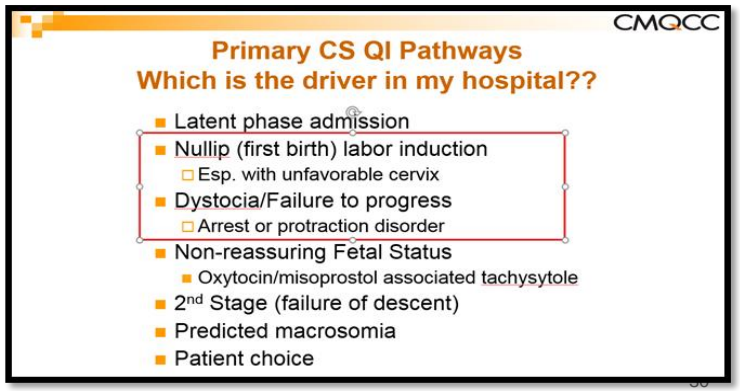
Summary: **Data** to Establish the Case for Change

- Goal: to provide information for identifying case for change, decision-making, and prioritizing initiatives?
- Sources for "What we know"
  - PC-02 NTSV rates against the HP2020 goal
  - Individual clinician rates: OB Providers and RNs
  - Birth Experience Scores – May 2017: 79% Target 86.3%-90.5%
  - Professional organization position papers: ACOG, AWHONN, ACNM
- What else do we need to know?
  - Multidisciplinary audits
  - Coded data



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V = Vision

a VISION for change

When individuals or groups desire change, but cannot identify a "way out," the result is anger, depression, frustration, anxiety and/or apathy. Whatever the reaction, it is seldom positive. Mobilizing the energy generated by a desire for change requires a Vision. At its simplest, a shared vision is the answer to the question, “What do we want to create or achieve—together?"

Although it is not particularly important where in the organization the Vision originated, it is critical that the Vision be communicated in such a way that organizational members are encouraged -- not mandated -- to share the vision.

V = Vision

- Avoid unnecessary interventions that interfere with normal hormonal childbirth physiology and birth experience.
- Avoid unnecessary procedures that may create perinatal harm.
- Balance - Improve birth outcomes and prevent OB professional liability.
- Increase woman's satisfaction with her birth experience
- Implement evidence-based standards of care
- Improve the culture of care, awareness, and education to recognizing the value of vaginal birth

F = First Steps

FIRST STEPS

While Dissatisfaction without Vision often leads to despair, Vision without Action is no more than a "castle in the air", a great idea without a roadmap. This too can create frustration and feelings of helplessness, feelings which often result in apathy and/or cynicism.

When engaging organizational members in the process of change, they must have the opportunity to describe their own reality, influence the shaping of a new vision for the future, and to participate in developing action plans (First Steps) for making the Vision a reality.

What?
Who?

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First Steps

- Examined baseline practice data to determine which areas that many hospitals were on the path vs. had not started
- Used CMQCC toolkit to align the top 10 drivers with action steps.
- Each group prioritized the steps in terms of what they felt would have the highest impact, and be able to manage the resistance.

CMQCC
California Maternal Quality Care Collaborative

TOP 10 DRIVER DIAGRAM

Aim	Primary Drivers	Top Ten First Steps (not to downplay other activities!)
Improve Support for Intended Vaginal Birth and Reduce Primary Cesareans Target: NTSV* CS rate <24% With continued good outcomes for infant and perineal measures *NTSV= Nulliparous, Term, Singleton Vertex	Readiness: Build a provider and maternity unit culture that values, promotes, and supports intended vaginal birth and optimally engages patients and families	• Create a team of providers (e.g. obstetricians, midwives, family practitioners, and anesthesia providers), staff and administrators to lead the effort and cultivate maternity unit buy-in
		• Develop program for ongoing staff training for labor support techniques including caring for women regional anesthesia
		• Develop a program with positive messaging to women and their families about intended vaginal birth strategies for use throughout pregnancy and birth
	Recognition and Prevention: Develop unit-standard approaches for admission, labor support, pain management and freedom of movement	• Implement protocols and support tools for women who present in latent (early) labor to safely encourage early labor at home
		• Implement Policies and protocols for encouraging movement in labor and intermittent monitoring for low-risk women
	Response: Develop unit-standard approaches for prompt identification and treatment of abnormal conditions	• Implement standard criteria for diagnosis and treatment of labor dystocia, arrest disorders and failed induction
		• Implement training/procedures for identification and appropriate interventions for malpositions (e.g. OP/OT)
	Reporting and Systems Learning: Utilize local data and case reviews to present feedback and benchmarking for providers and to guide unit progress	• Share provider level measures with department (may start with blinded data but quickly move to open release)
		• Perform monthly case reviews to identify consistency with dystocia and induction checklists (derived from the ACOG/SMFM guidelines)
		• Establish a project communications plan (at least monthly education and progress updates

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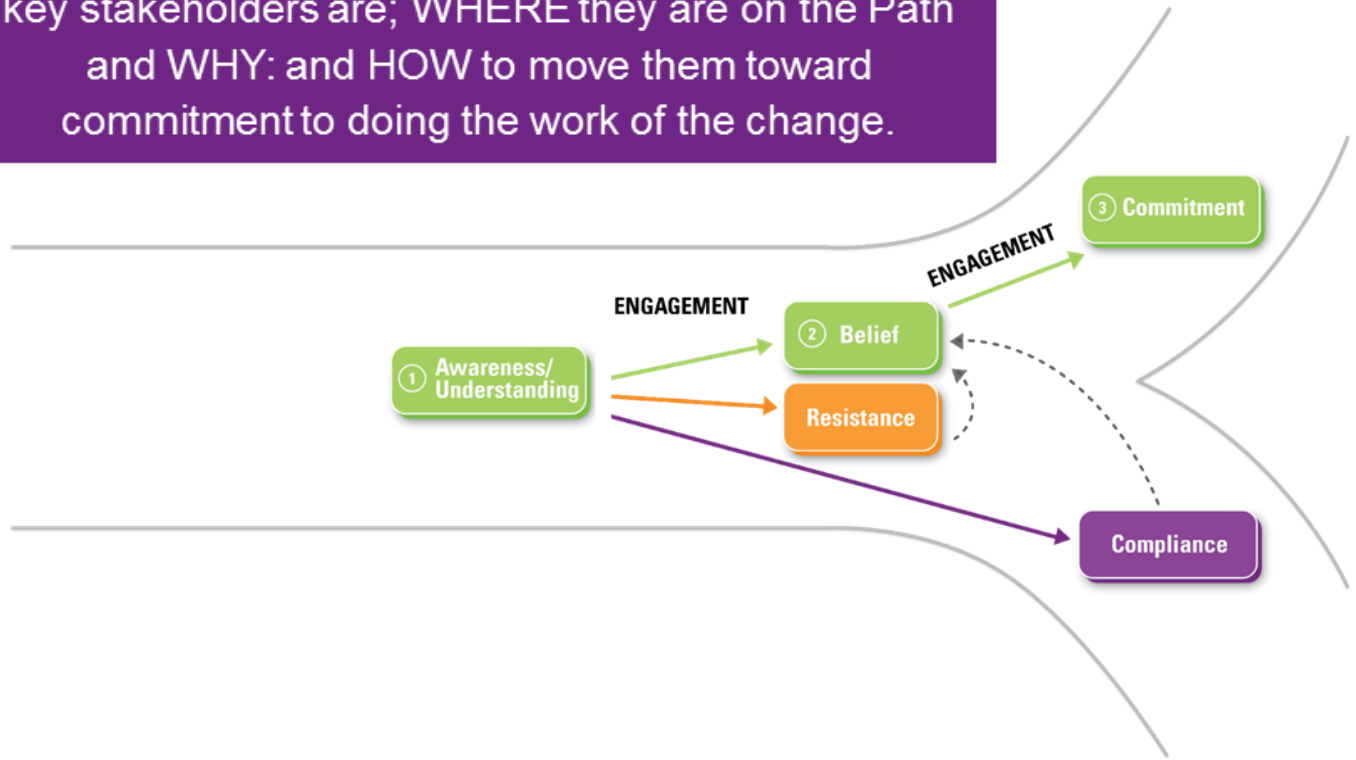
Pathway to Commitment: Working model of an individual journey that starts with awareness and understanding and ends at full commitment to make change happen.

The Change Leader's role is to understand WHO the key stakeholders are; WHERE they are on the Path and WHY: and HOW to move them toward commitment to doing the work of the change.



"Capturing the Head, Hearts and Hands of People to Effect Change: The Road to Commitment," Roland Loup and Ron Koller, OD Journal, Fall 2005.

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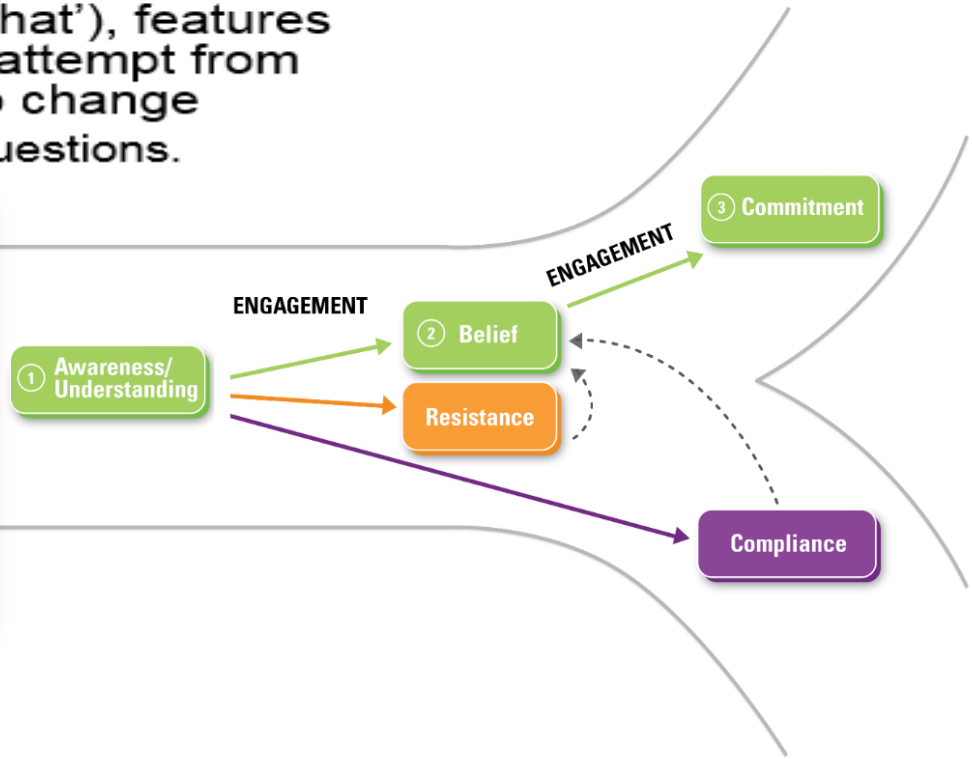
The PATH to Commitment

- Awareness and Understanding: Critical mass understands case for change – reasons, intended results, actions and WIIFM (Be able to answer 'why' and 'what'), features that distinguish this attempt from previous attempts to change
  - "What" and "Why" questions.



"Capturing the Head, Hearts and Hands of People to Effect Change: The Road to Commitment," Roland Loup and Ron Koller, OD Journal, Fall 2005.

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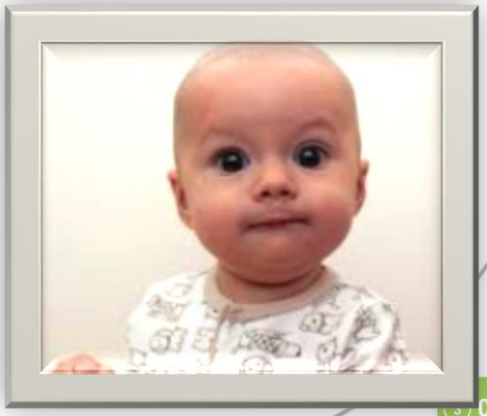
The PATH to Commitment

- **Belief:** Need to believe in at least one: Change is good, Good for me or We can change successfully. If not, will stall in compliance or resistance.



"Capturing the Head, Hearts and Hands of People to Effect Change: The Road to Commitment," Roland Loup and Ron Koller, OD Journal, Fall 2005.

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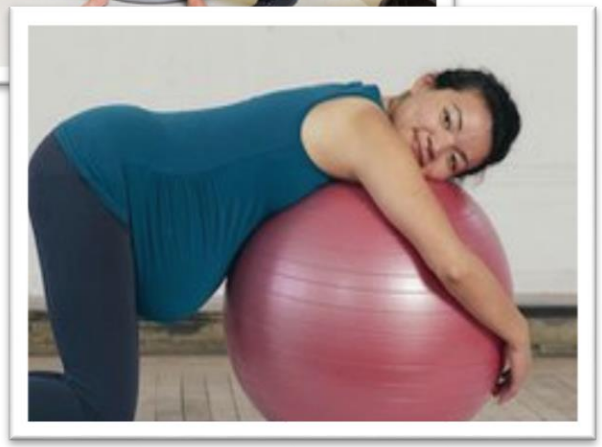
Implementing the Evidence for Safe Second Stage Labor Care Bundle (4 Ps)

Patience and
Positioning for
Physiologic
Progress



Second Stage Balancing and Outcome Metrics Presenting 4/18 ACOG Accepted for publication: The American Journal of Maternal Child Nursing

Women's Health and Perinatal Nursing Care Quality Measures

AWHONN
PROMOTING THE HEALTH OF WOMEN AND NEWBORNS

Measure 02: Second Stage of Labor: Mother-Initiated, Spontaneous Pushing

Description

Mother-initiated, spontaneous pushing in the second stage of labor begins at the time the patient feels the urge to push. Spontaneous pushing is defined as a mother's response to a natural urge to push or bearing down effort that comes and goes several times during each contraction. It does not involve timed breath holding or counting to 10.

Documentation in the medical record will reflect nursing education to the patient regarding the second stage of labor, patient's report of feeling pressure or the urge to push prior to initiation of active pushing, and evidence of nursing support during the second stage of labor. Nursing support during the second stage of labor will include: support/promotion of mother-initiated pushing and open-glottis pushing, assisting the patient into upright, gravity-neutral positions, and encouraging grunting, groaning, or vocalization during the push in response to contractions.

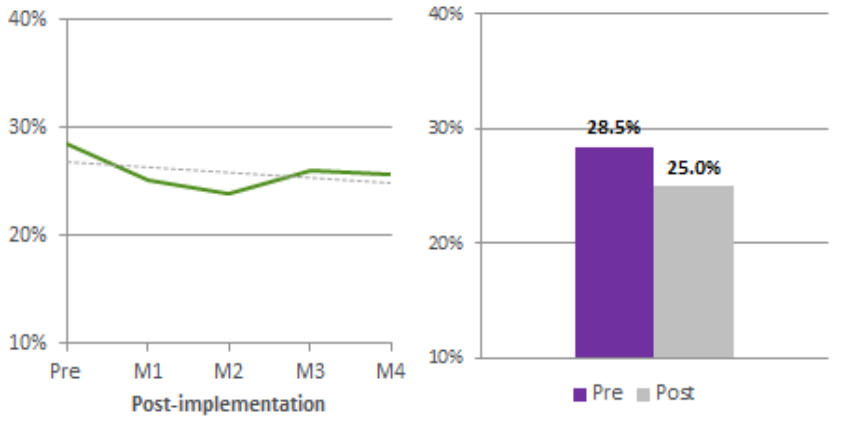
The goal is 100%.

Vaginal Deliveries: Numerator was those who answered "yes" to ***pushing delayed until urge AND support spontaneous pushing.***

Trinity Health Rate pre-implementation: **510/1195=43%**;
post-implementation: **1541/2028=76%**

Metric	Baseline (n =4,500)	4 months Post-implementation (n=9,950)	p Value
Maternal Morbidity			
• Chorioamnionitis	106 (1.76%)	236 (2.10%)	p=0.13
• Postpartum Hemorrhage	228 (3.8%)	411(3.7%)	p=0.67
Delivery Outcomes			
• Assisted Delivery (Forceps/Vacuum)	372 (6.1%)	642 (5.7%)	p=0.21
• Shoulder Dystocia	168 (2.8%)	285 (2.5%)	p=0.32
Newborn Trauma			
• Singleton vaginal Deliveries	38(2.4%)	58(2.3%)	p=.07

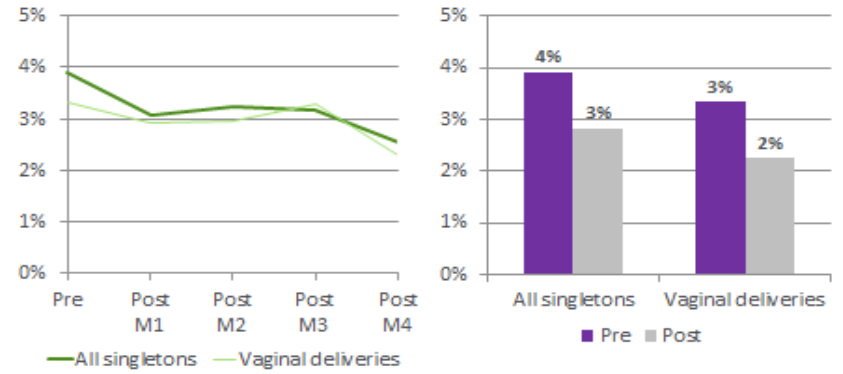
Outcome measures: PC-02



Significant decrease in PC-02 rates post-implementation compared to pre-implementation (p=0.02).

Note: "Pre" data is from April and May 2015

Outcome measures: Unexpected complications in term newborns



Significant decrease in unexpected complications in all term newborns post-implementation vs. pre-implementation (p-value < 0.001), and for vaginal births only (p = 0.03)

The PATH to Commitment

- Resistance: Think change is not a good idea or will not work and not ready to commit to action. Energy can be used to move to action!

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The PATH to Commitment

① Awareness/ Understanding

ENGAGEMENT

② Belief

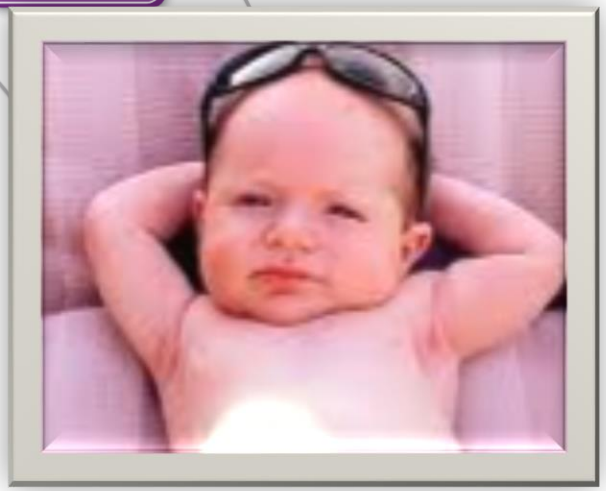
Resistance

ENGAGEMENT

③ Commitment

- Compliance: Go along, but heart not in it and little energy and effort. Conformity and waits to see what happens before making change.

Compliance



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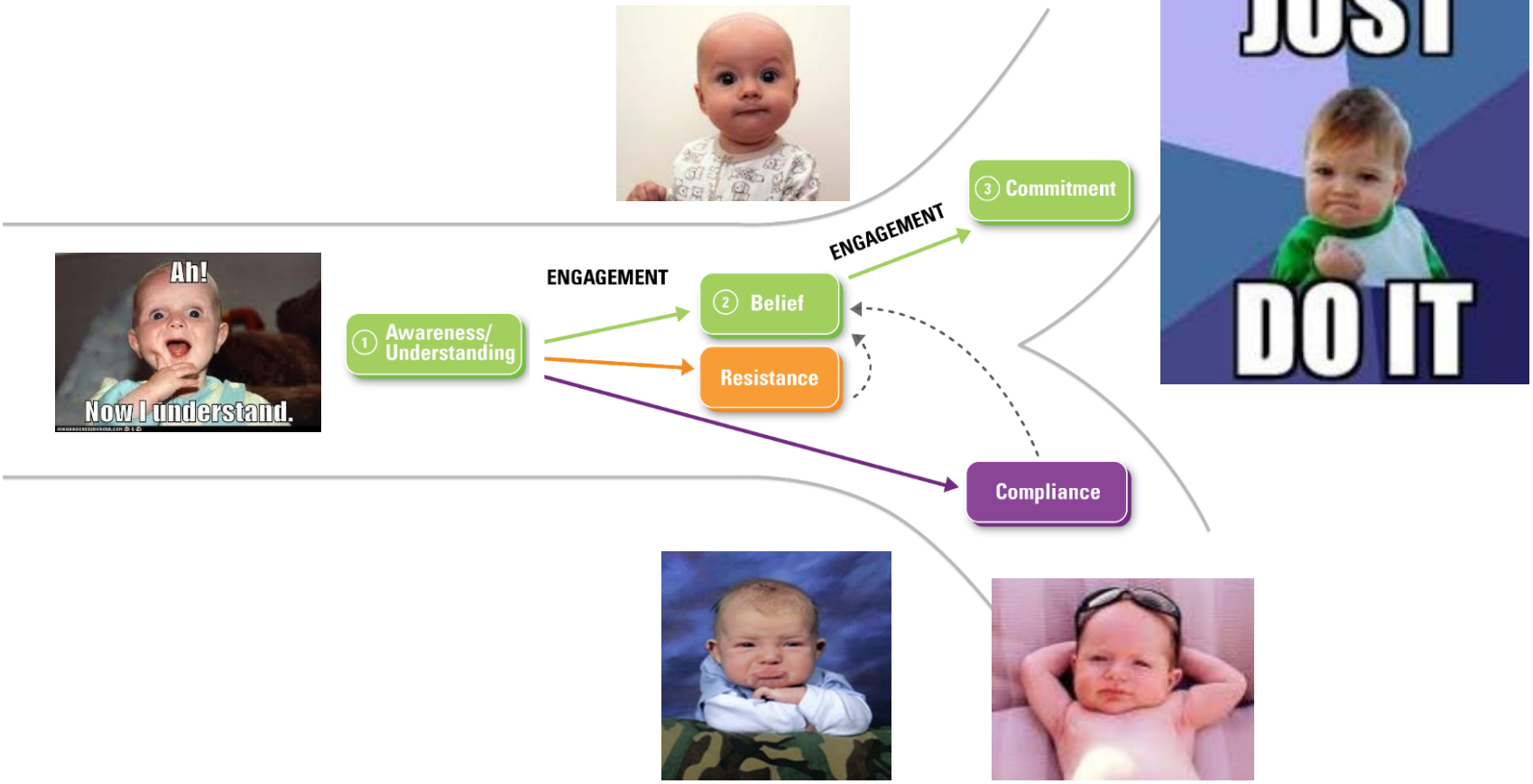
The PATH to Commitment

- Commitment: Critical mass take the necessary actions to make the change happen.



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Strategies to move to Commitment

- Engage stakeholders through **entire** process
- Perform DVF>R for EVERY strategy: Avoid assuming that change will be simple.
- Recognize the stage of transformational change and commitment of all major decision-makers.
- Moving from compliance to belief:
  - Use audits and other data sources to continue to monitor progress
  - Leverage the wins of early adopters. – Ask them to present their learning and success.
- Provide positive feedback to your early adopters and celebrate success!

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Changing Culture starts with vision and action

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Final Words and Advice

Be the Change Winner!

Not the Change Whiner.

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Questions?

Supplemental Materials

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9 Stages of Transformational Change Detail R. T. Tipton 2012

The “9 Stages of Transformational Change” curve shows a normal, predictable process. The fact that the whole thing can be represented as a process is comforting! They can “plot” themselves somewhere, and then they can see that there’s an eventual “WAY OUT” as well. Throughout the process, While we may only visit a stage for a blink of an eye related to some changes, we might get stuck for days, weeks, months or years in other stages depending upon the “bigness” of the transformational change we’re asked to make. My advice? Go through ALL the stages, but don’t get stuck “too long” in any of them. Additionally, you can see the word “retreating” for many of the stages. All the way up until Stage 7 (acceptance), we can go backwards through the curve — revisiting stages we’ve already seen. This is also normal – and typical. However, once we reach Stage 7, we don’t slip backward — at least related to “this” transformational change!

- Dreamland (Stage 1 to Stage 9) it’s the “fast path” we’d prefer — to avoid the “ickiness” of transformational change. We want to jump directly from stage 1 (status quo) to stage 9 (advocacy), but it doesn’t work very well. Therefore, I call it “Dreamland.” An example of a “dreamland” jump? A New Year’s resolution. Do you ever wonder why “resolutions” don’t actually create real, sustainable change? Because there’s no grief and no growth involved… In short, we never commit, really, to the change.
- Stage 1: Status Quo: simply what “is” at the beginning of the transformational change process. It is the known, the predictable, the safe, etc. And then — boom! Someone or something proposes a change, and we start “down” the transformational change curve. Next stop? Denial
- Stage 2: Denial: our first response to a change (and yes, this is exactly like Elizabeth Kubler-Ross’ grief and death cycle). This is when we find ourselves saying things like, “I can’t believe it.” For some, denial can be quick — while for others they can stay in denial for a LONG time — like forever.
- Stage 3: Righteous Resistance: A transformational change leader recognizes that anger is expected and rather than trying to “quash” the anger, they help people move through their anger..
- Stage 4: Pleading: After anger comes “pleading” or “bargaining” or “wishful thinking…” Listen for sentences starting with the words, “If Only…” and you’ll know you’re in the presence of pleading. Each time you hear, “If only” understand the person is living in the past and denying the present. Bargaining is normal — but it’s also temporary.
- Stage 5: Despair / Skepticism: At this stage can choose four things: •We can stay here, become an energy vampire (sucking it out of everyone around us), and live in despair or skepticism. •We can go backwards to “pleading” because maybe we feel better being there. •We can “Flame Out” — and give up on the change. •We can choose to move forward — to GROW, to CHOOSE the change that we’re part of.
- Stage 6: Tolerance: decided to move forward THROUGH the change. You say yes when someone like me asks you this question, “Can you live with it?” it’s possible to still harbor some negativity and move forward at the same time. Don’t wait until you feel 100% comfortable — have the courage to “live with it” even if you still have some negativity, and you can start the process of moving ahead.
- Stage 7: Acceptance: There’s no more “retreating” at this point. Why? Because at “acceptance” we are at least neutral about the change — our negativity has been resolved. We have made the choice to “take down” the rearview mirror completely and to move forward harboring no negative thoughts. This is a HUGE step in the transformational change process — and the sooner an entire group or organization reaches this stage, the better.
- Stage 8: Agreement: Beyond neutrality and actively positive. It’s OUR CHOICE to feel and believe this way, and our behavior reflects it. We are openly optimistic, we share our hope for a positive outcome, and we anticipate the benefits coming from the change process. It’s rare to have entire organizations reach the “agreement stage” — it’s more typical to have excellence in transformation look more like 80% in stage 8, and 20% in “some other” stage (many in stage 7, some in stage 6, and some holdouts remaining in stages 5, 4, 3 and even 2.)
- Stage 9: Advocacy: People are so positive that they become advocates for the change itself. They have CHOSEN to become infectious, contagious, passionate sales people for the change — there’s no buy-in, no convincing, no arm twisting, no “or-else” statements. Advocates are high-energy, positive agents for change and it’s WONDERFUL to be in their presence.
- The Leadership Lesson:
  - First — transformational change leaders (TCLs) recognize that their organizations “grieve then grow” behind them as changes are proposed and implemented. TCLs know this, plan for this, and manage the process associated with this.
  - Second — TCLs (using the advice from General George Patton) will occasionally “turn around” in their organizations and make sure there’s someone following them! In other words, a TCL won’t let the change get “too far ahead” of the organization. TCLs, by nature are forward-looking, strategic, positive people — but they also realize that change happens THROUGH people, not in spite of them.

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Announcement of Critical Drug Shortage

- Shortage: IV solutions, local anesthetics (lidocaine, ropivacaine, Marcaine), parenteral analgesics, heparin and Oxytocin
  - Are you aware? Are you feeling the impact?
- Bob Ripley, Pharmacy VP expects this to last through 2018.
  - Coming to Steering Team on 1/31 to discuss situation
- Consider: OB is the lowest risk patient in the hospital (except those with medical/obstetric clinical complications)
  - How can we leverage the strategies we are working on to safely reduce C-section to align with appropriate utilization of those drugs in shortage?

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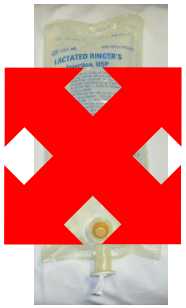
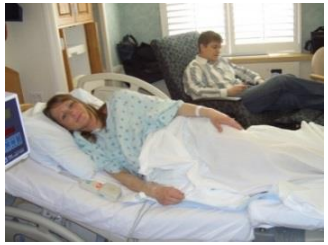
Cascade of Interventions Related to induction or augmentation of labor





IV

Bedrest

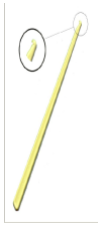
Continuous EFM

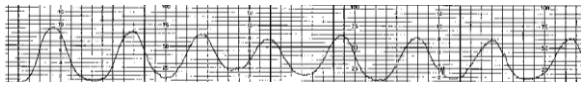
Amniotomy

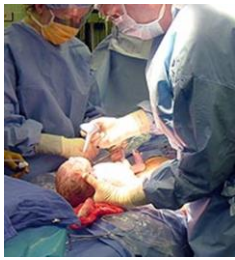
Significant discomfort

Epidural

Prolonged labor







Induction Cascade vs. Strategies to reduce C-sections

What happens (Induction Cascade)

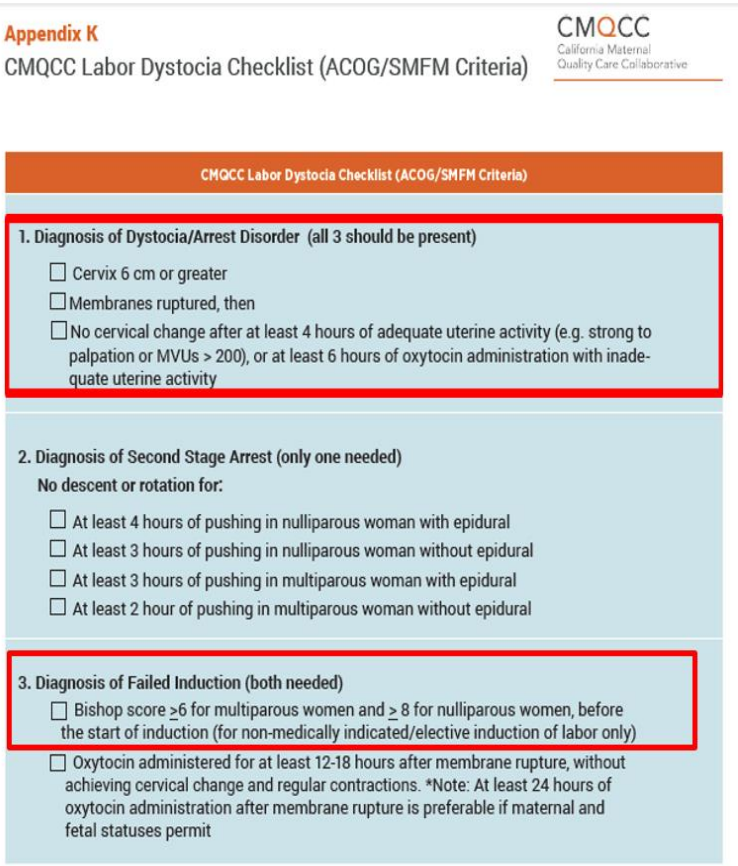
- IV
- Oxytocin
- Bedrest
- Continuous EFM
- Amniotomy
- Significant Discomfort
- Epidural
- Prolonged labor
- C-section: failure to progress

What we want to accomplish

- Appropriate use of IV, and oxytocin resources to conserve for medically necessary (fluid resuscitation, prevent PPH)
- Improve mobility/freedom of movement to support labor progress and fetal descent
- Limit interventions that may increase risk
- Conserve local anesthetics – use alternative strategies and labor support to improve coping in labor

Prioritizing Strategies to impact practice: Cervical Ripening Group

- __1__ Avoid elective inductions <40 6/7 weeks gestation
- __2__ Bishop scores to drive selection of cervical ripening/induction method(s)
- __3__ Utilize cost-effective, efficient inpt cervical ripening methods and processes that result in high value, high quality care.
- __2__ Outpatient balloon cervical ripening
- __4__ Hardwiring tools in practice (i.e. guidelines, order sets, checklists, algorithms, documentation) for clinical decision-making.



Appendix K

CMQCC Labor Dystocia Checklist (ACOG/SMFM Criteria)

CMQCC California Maternal Quality Care Collaborative

CMQCC Labor Dystocia Checklist (ACOG/SMFM Criteria)

1. Diagnosis of Dystocia/Arrest Disorder (all 3 should be present)

- ☐ Cervix 6 cm or greater
- ☐ Membranes ruptured, then
- ☐ No cervical change after at least 4 hours of adequate uterine activity (e.g. strong to palpation or MVUs > 200), or at least 6 hours of oxytocin administration with inadequate uterine activity

2. Diagnosis of Second Stage Arrest (only one needed)

No descent or rotation for:

- ☐ At least 4 hours of pushing in nulliparous woman with epidural
- ☐ At least 3 hours of pushing in nulliparous woman without epidural
- ☐ At least 3 hours of pushing in multiparous woman with epidural
- ☐ At least 2 hour of pushing in multiparous woman without epidural

3. Diagnosis of Failed Induction (both needed)

- ☐ Bishop score ≥6 for multiparous women and ≥ 8 for nulliparous women, before the start of induction (for non-medically indicated/elective induction of labor only)
- ☐ Oxytocin administered for at least 12-18 hours after membrane rupture, without achieving cervical change and regular contractions. *Note: At least 24 hours of oxytocin administration after membrane rupture is preferable if maternal and fetal statuses permit

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Prioritizing Strategies to impact practice: Induction/Augmentation with Oxytocin

- __2__ Standardize Oxytocin Use
  - Patient Selection – PreOxytocin Checklist
- __2__ Standardize diagnosis of dystocia / arrest disorder
- __2__ Standardize diagnosis of failed induction
- __1__ Early admissions in labor

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Labor Support Comprehensive Multidisciplinary Approach

_4__Ministry designed birth plan to assist woman in setting expectations [Structure Measure]

_1_ Review of standardized labor orders and policies to identify conflicts

_1__ Role of Physician in Labor Support program: *draft being presented by a physician from Mount Carmel Health System*

_2__Labor Support for Nurses program: *outline completed. Survey developed to identify resources and integration of content cross continuum under development*

_3__AIM Structure Measures: Unit-standard for labor support, in a guideline/policy/procedure revised in past 2-3 years for freedom of movement. *Sandi Michaels (Albany, St Peters) drafting a policy for system consideration*

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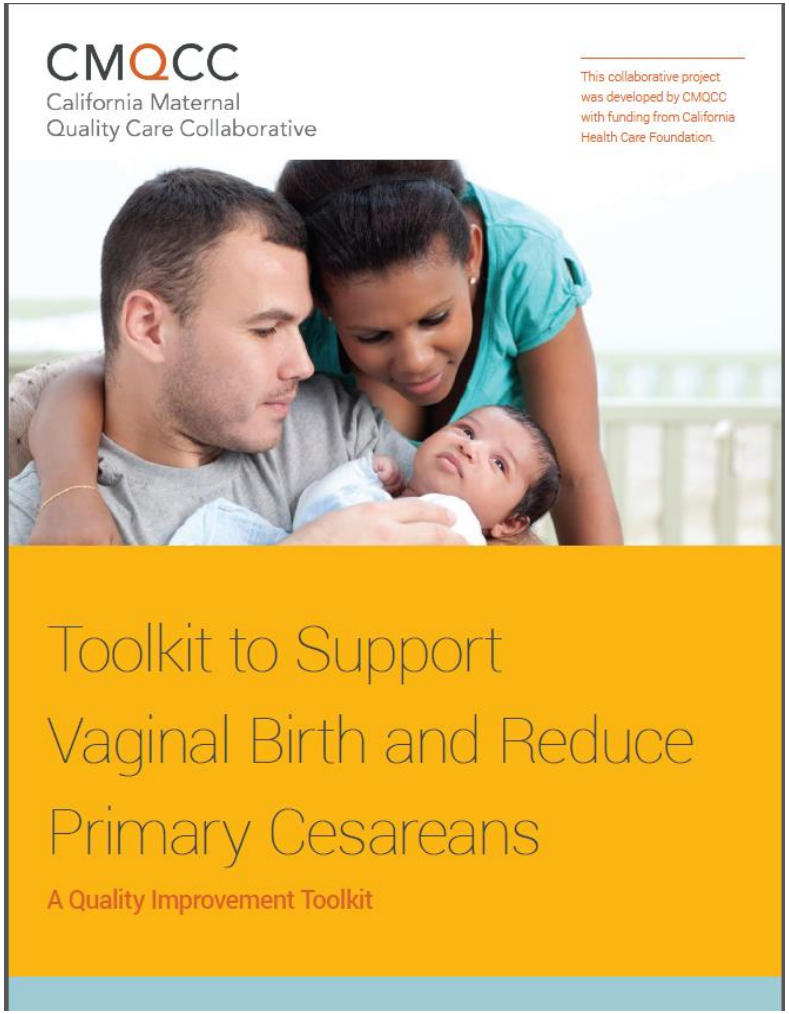

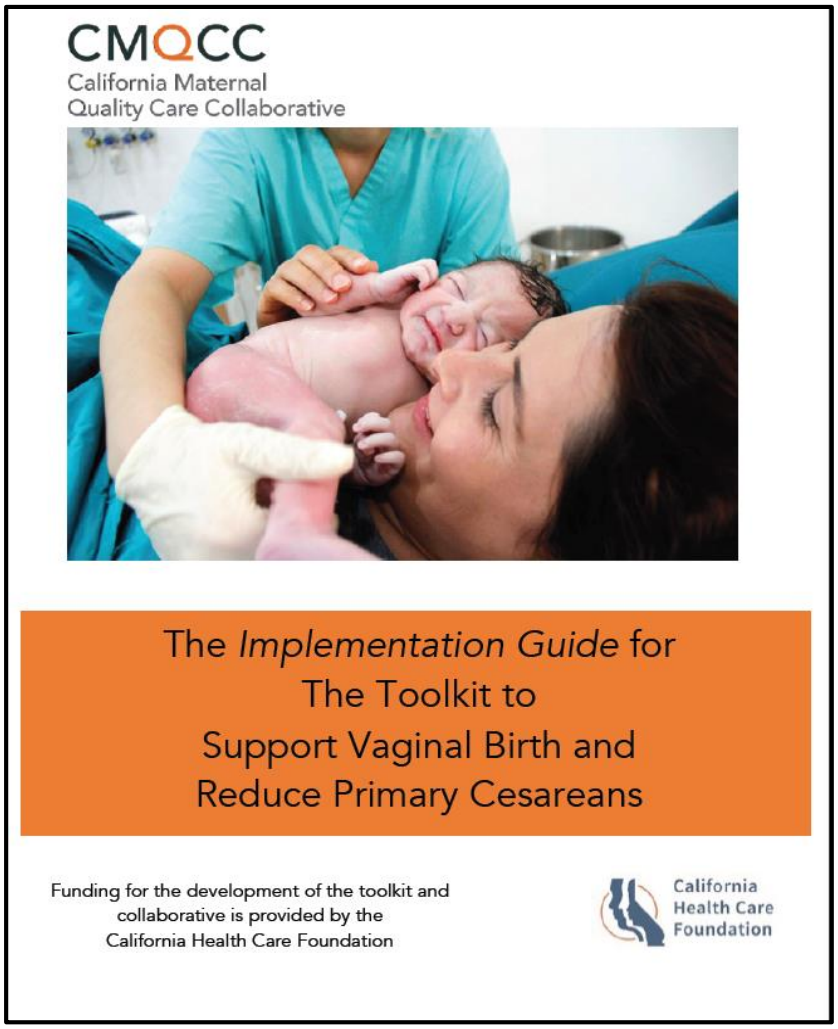

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