Reducing Cesarean Deliveries for Low-Risk Pregnancies: Overcoming Resistance to Change: Be the Change Leader!

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Director of Perinatal Clinical Practice

January 22, 2019
Women’s and Children’s Clinical Excellence Council/Perinatal Patient Safety Initiative Co-leads

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Co-Lead of the Trinity Health Perinatal Patient Safety Initiative

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Perinatal Medical Director
Co-Lead of the Trinity Health Perinatal Patient Safety Initiative
Objectives

1) Define transformational change and common responses.

2) Identify 2 strategies to approach AIM Safely Reducing C-section Bundle

3) Describe leadership tools that reduce resistance to change.
Disclaimer

• What this is not…

• What this is…. 

Change Behaviors
Trinity Health Birth Volume
CY 2017: 67,456, 1.71% of country total
## PPSI Project History and Plan

### Rev. 1/18/19

<table>
<thead>
<tr>
<th>PPSI Projects</th>
<th>West/Midwest Implementation (24)</th>
<th>W/MW &amp; East Synergy Implementation (34)</th>
<th>40 Ministry Implementation</th>
</tr>
</thead>
</table>

### Risk Reduction: Cost/Claim, SRE
1. **System-wide Guidelines/Practices:**
   - Trial of Labor After Cesarean (VBAC)
   - Induction Augmentation
   - EFM (2 policies)
   - Second Stage Labor
   - Cervical Ripening
   - Mag Sulfate (4 Policies)
   - Preeclampsia Management (OB Hypertension Bundle)
   - OB Triage: Maternal Fetal Triage Index
   - Shoulder Dystocia Management

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2014</th>
<th>2018</th>
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<tbody>
<tr>
<td>VBAC</td>
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<td>2017-19</td>
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<td>Induction Augmentation</td>
<td>2009</td>
<td>2015</td>
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<td>EFM</td>
<td>2010</td>
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<td>2017-19</td>
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<tr>
<td>Second Stage Labor</td>
<td>2011</td>
<td>2015-16</td>
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<td>Cervical Ripening</td>
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<tr>
<td>Shoulder Dystocia</td>
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</tbody>
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2. **Validation of Competency/Practice**
   - Perinatal Risk Site Assessments
   - Premium Impact Audit Program (annual)
   - Electronic Fetal Monitoring Certification
   - AWHONN 2011 Staffing Guidelines

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<thead>
<tr>
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<tbody>
<tr>
<td>Perinatal Risk Site Assessments</td>
<td></td>
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<td>2017 current</td>
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<tr>
<td>Premium Impact Audit Program</td>
<td>2010</td>
<td>2014</td>
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<tr>
<td>Electronic Fetal Monitoring Certification</td>
<td>2012</td>
<td>2015</td>
<td>2019</td>
</tr>
</tbody>
</table>

3. **Maternal and Perinatal Morbidity/Mortality Reduction**
   - Elective Delivery <39 weeks (PC-01)
   - Baby Friendly/Exclusive Breast Milk Feeding (PC-05)
   - OB Hemorrhage Education Program
   - Reducing Primary C-section/Supporting Intended Vaginal Deliveries (PC-02)
   - March of Dimes Preterm Labor Assessment Toolkit (PC-03)
   - OB Sepsis/ Maternal Early Warning Criteria
   - Zika Exposure Screening
   - Custom OB Packs

<table>
<thead>
<tr>
<th></th>
<th>2009</th>
<th>2014</th>
<th>2017</th>
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<tbody>
<tr>
<td>Elective Delivery</td>
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<td>Baby Friendly</td>
<td>2012-2014</td>
<td>2013 – 2018</td>
<td>QBL 2018</td>
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<tr>
<td>Reducing Primary C-section</td>
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<td></td>
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<tr>
<td>March of Dimes</td>
<td></td>
<td>2016 - 2017</td>
<td></td>
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<tr>
<td>OB Sepsis/ Maternal Early Warning Criteria</td>
<td></td>
<td></td>
<td>2018</td>
</tr>
<tr>
<td>Zika Exposure Screening</td>
<td></td>
<td></td>
<td>2018</td>
</tr>
<tr>
<td>Custom OB Packs</td>
<td>2016-17</td>
<td></td>
<td>2017- current</td>
</tr>
</tbody>
</table>

4. **Experience of Care (HCAHPS)**
Types of Change

- **Developmental**: simplest - improves what you are currently doing, e.g. switching from manual driving to using cruise control in your car.

- **Transitional**: replaces “what is” with something completely new. Designing/implementing a “new state.” No radical change in workflows or cultural change. e.g. using the backup camera feature in the car.

- **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. e.g. purchasing a driverless car.
Responses to Transformational Change

[Comic strip with Dilbert cartoon showing responses to transformational change)

- Our differentiating value-added strategy is transformational change.
- How was that? Does anyone feel different?
- My urge to hurl has increased a little bit.
- That's what change feels like.

[Photo of man with wide eyes and text: 'Fear Change → Change Fear ←']
9 Stages of Transformational Change

1. Status Quo
2. Denial
3. Righteous Resistance
4. Pleading
5. Despair or Skepticism
6. Tolerance
7. Acceptance
8. Agreement
9. Advocacy

Grief → Growth
Objectives

1) Define transformational change and common responses.

2) Identify 2 strategies to approach AIM Safely Reducing C-section Bundle

3) Describe leadership tools that reduce resistance to change.
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
Safe Reduction of Primary Cesarean Births

RESPONSE

To Every Labor Challenge

- Have available an in-house maternity care provider or alternative coverage which guarantees timely and effective responses to labor problems.
- Uphold standardized induction scheduling to ensure proper selection and preparation of women undergoing induction.
- Utilize standardized evidence-based labor algorithms, policies, and techniques, which allow for prompt recognition and treatment of dystocia.
- Adopt policies that outline standard responses to abnormal fetal heart rate patterns and uterine activity.
- Make available special expertise and techniques to lessen the need for abdominal delivery, such as breech version, instrumented delivery, and twin delivery protocols.

REPORTING/SYSTEMS LEARNING

Every birth facility

- Track and report labor and cesarean measures in sufficient detail to: 1) compare to similar institutions, 2) conduct case review and system analysis to drive care improvement, and 3) assess individual provider performance.
- Track appropriate metrics and balancing measures, which assess maternal and newborn outcomes resulting from changes in labor management strategies to ensure safety.
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.”
### Table 7. Barriers to Supporting Intended Vaginal Birth

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

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

<table>
<thead>
<tr>
<th>Maternal Conditions</th>
<th>Pregnancy</th>
<th>Labor</th>
<th>Fetal Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active substance use</td>
<td>Cholestasis</td>
<td>Chorioamnionitis</td>
<td>IUGR</td>
</tr>
<tr>
<td>Chronic HTN</td>
<td>Hypertension/Pre-eclampsia</td>
<td>Epidural anesthesia</td>
<td>Known congenital anomaly</td>
</tr>
<tr>
<td>SLE/antiphospholipid syndrome</td>
<td>Multiple pregnancy</td>
<td>Meconium</td>
<td></td>
</tr>
<tr>
<td>Thyroid disease, uncontrolled</td>
<td>Oligohydramnios/Polyhydramnios</td>
<td>Pitoecin administration</td>
<td>Red cell alloimmunization in presence of erythroblastosis</td>
</tr>
<tr>
<td>Diabetes: pre-gestational; uncontrolled gestational; GDM on medications</td>
<td>Prematurity (less than 36 weeks)</td>
<td>Vaginal bleeding, other than bloody show</td>
<td></td>
</tr>
<tr>
<td>Previous Cesarean birth</td>
<td>Preterm premature ROM &lt;36 weeks</td>
<td>Misoprostol administration</td>
<td></td>
</tr>
<tr>
<td>History of IUFD</td>
<td>&gt;41 weeks gestation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

Algorithm B: Management of Category II FHR Tracings

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]
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.
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.
Objectives

1) Define transformational change and common responses.
2) Identify 2 strategies to approach AIM Safely Reducing C-section Bundle
3) Describe leadership tools that reduce resistance to change
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.
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.

![Dissatisfaction/Data x Vision x First Steps > Resistance](image)
Formula for Change
Building the Case for Change

D x V x F > R

Dissatisfaction/Data  Vision  First Steps  Resistance

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.
Common Reasons for Resistance to Changing practice?
Example: Reduce 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.”
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”).
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?
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

<table>
<thead>
<tr>
<th>Region</th>
<th>Ministry</th>
<th>Cesarean Delivery (NTSV)</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>Fresno</td>
<td>24.5%</td>
</tr>
<tr>
<td>Oregon–Idaho</td>
<td>Boise, Nampa, Ontario, Baker City</td>
<td>20.0%, 11.1%, 44.4%</td>
</tr>
<tr>
<td>Iowa–Nebraska</td>
<td>Clinton, Dubuque, Mason City, Sioux City</td>
<td>23.5%, 21.0%, 35.0%</td>
</tr>
<tr>
<td>Illinois–LUHS</td>
<td>Gottlieb Memorial Hospital, Loyola University Medical Center</td>
<td>28.5%</td>
</tr>
<tr>
<td>Illinois – Mercy</td>
<td>Mercy Chicago</td>
<td>25.5%</td>
</tr>
<tr>
<td>Indiana</td>
<td>Mishawaka, Plymouth</td>
<td>3.7%, 47.1%</td>
</tr>
<tr>
<td>West Michigan</td>
<td>Grand Rapids, Holland &amp; Muskegon</td>
<td>32.6%, 36.7%</td>
</tr>
<tr>
<td>Southeast Michigan</td>
<td>Ann Arbor, Livonia, Oakland</td>
<td>23.5%, 22.2%</td>
</tr>
<tr>
<td>Ohio</td>
<td>Mt. Carmel–East, Mt. Carmel–West, St. Ann’s</td>
<td>16.3%, 13.6%, 24.1%</td>
</tr>
<tr>
<td>Maryland</td>
<td>Silver Spring, Germantown</td>
<td>31.5%, 16.4%</td>
</tr>
<tr>
<td>Northeast</td>
<td>St. Peter’s Mercy Hospital – Buffalo, Sisters of Charity, Mount St. Mary’s – Buffalo</td>
<td>16.3%, 26.4%, 25.4%, 35.9%</td>
</tr>
<tr>
<td>Springfield</td>
<td>Mercy Medical Center</td>
<td>36.5%</td>
</tr>
<tr>
<td>Mid-Atlantic</td>
<td>Lourdes–Camden, Saint Francis–Wilmingham</td>
<td>30.0%, 37.5%</td>
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<tr>
<td>Langhorne</td>
<td>St. Mary Medical Center</td>
<td>28.5%</td>
</tr>
<tr>
<td>Southeast</td>
<td>Holy Cross Hospital, St. Mary’s Hospital</td>
<td>46.4%, 25.4%</td>
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<td>Syracuse</td>
<td>St. Joseph Health</td>
<td>33.8%</td>
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<tr>
<td>Hartford</td>
<td>St. Francis Hospital</td>
<td>36.8%</td>
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</tbody>
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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

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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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 B. 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
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.
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
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.
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.
<table>
<thead>
<tr>
<th>Activity</th>
<th>Guideline</th>
<th>Order Sets</th>
<th>EMR doc</th>
<th>Education</th>
<th>Status</th>
<th>Implementation Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Ripening</td>
<td>Outpatient Balloon Cervical Ripening - <em>Draft</em></td>
<td>Changes TBD</td>
<td>Evaluate</td>
<td>OB Provider and RN: Use OB Summit?</td>
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<td>FALL 2019</td>
</tr>
<tr>
<td>Data Collection Tool <em>Draft</em> [AIM Structure and Process measure]</td>
<td>N/A</td>
<td>N/A</td>
<td>? Abstract in report</td>
<td>To be determined</td>
<td></td>
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</tbody>
</table>
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.
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.

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.
Table 2. The 5 Ps Second-Stage of Labor Process Results

<table>
<thead>
<tr>
<th>5 Ps Process Metrics (Aspects of Care)</th>
<th>Baseline ((n = 1,278))</th>
<th>4 Months Post-implementation ((n = 2,158))</th>
<th>(p) Value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENCE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Pushing is delayed until the urge to push or fetal head at the introitus.</td>
<td>939 (73%)</td>
<td>1,858 (86%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>2. Pushed immediately without indication of abnormal fetal tracing.</td>
<td>326 (26%)</td>
<td>231 (11%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>3. Method of pushing is to support mother’s spontaneous pushing efforts.</td>
<td>875 (68%)</td>
<td>1,810 (84%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>4. Active directive pushing used without clinical indication.</td>
<td>366 (29%)</td>
<td>274 (13%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>5. Active directive pushing technique appropriate.</td>
<td>252 (81%)</td>
<td>460 (91%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>POSITIONING</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Second-stage position changes occur every 30 min.</td>
<td>216 (62%)</td>
<td>770 (76%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>2. Nonsupine lithotomy position used for birth.</td>
<td>964 (80%)</td>
<td>1,908 (90%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>PHYSIOLOGIC RESUSCITATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Modified pushing with category II or III FHR tracings.</td>
<td>736 (58%)</td>
<td>1,491 (69%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>2. Tachysystole (if present) is managed appropriately.</td>
<td>68 (45%)</td>
<td>139 (68%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>PROGRESS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Progress (fetal descent and/or rotation) is documented if delayed pushing &gt; 2 hours.</td>
<td>41 (71%)</td>
<td>118 (92%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td><strong>PREVENT URINARY INJURY</strong> (For Women with Epidurals)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Indwelling urinary catheter present.</td>
<td>560 (44%)</td>
<td>429 (20%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>2. Indwelling urinary catheter was indicated.</td>
<td>175 (59%)</td>
<td>123 (80%)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>3. Indwelling catheter removed prior to pushing.</td>
<td>411 (73%)</td>
<td>315 (73%)</td>
<td>0.4</td>
</tr>
</tbody>
</table>
### Second Stage Balancing and Outcome Metrics: Pre and 4 months post-implementation

**Table 3.** The 5 Ps Second-Stage of Labor Balancing and Outcome Metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Baseline (n = 6,012)</th>
<th>4 Months Postimplementation (n = 11,223)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Morbidity</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Chorioamnionitis</td>
<td>106 (1.76%)</td>
<td>236 (2.10%)</td>
<td>p = 0.13</td>
</tr>
<tr>
<td>● Postpartum hemorrhage</td>
<td>228 (3.8%)</td>
<td>411 (3.7%)</td>
<td>p = 0.67</td>
</tr>
<tr>
<td>Birth Outcomes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Assisted birth (forceps/vacuum)</td>
<td>372 (6.1%)</td>
<td>642 (5.7%)</td>
<td>p = 0.21</td>
</tr>
<tr>
<td>● Shoulder dystocia</td>
<td>168 (2.8%)</td>
<td>285 (2.5%)</td>
<td>p = 0.32</td>
</tr>
<tr>
<td>Cesarean Birth (Joint Commission PC-02 NTSV)</td>
<td>1,713 (28.5%)</td>
<td>2,805 (25%)</td>
<td>p = 0.02</td>
</tr>
<tr>
<td>Newborn Birth Trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● All singleton term births</td>
<td>43 (0.7%)</td>
<td>65 (0.46%)</td>
<td>p = 0.05</td>
</tr>
<tr>
<td>● Singleton vaginal births</td>
<td>38 (2.4%)</td>
<td>58 (2.3%)</td>
<td>p = 0.07</td>
</tr>
<tr>
<td>Term Newborn with Complications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● All singleton term births</td>
<td>247 (3.9%)</td>
<td>265 (2.7%)</td>
<td>p &lt; 0.001</td>
</tr>
<tr>
<td>● Singleton vaginal births</td>
<td>146 (3.2%)</td>
<td>404 (2.9%)</td>
<td>p = 0.05</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric</th>
<th>Baseline (n = 4,500)</th>
<th>4 Months Postimplementation (n = 9,500)</th>
<th>p Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Singleton Term Vaginal Births</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Newborn Birth Trauma</td>
<td>38 (2.4%)</td>
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<td>● Term Newborn with Complications</td>
<td>146 (3.2%)</td>
<td>404 (2.9%)</td>
<td>p = 0.05</td>
</tr>
</tbody>
</table>
Thank you to all of the Trinity Health Ministry Second Stage leaders for their hard work!!!

Effects of an Interdisciplinary Practice Bundle for Second-Stage Labor on Clinical Outcomes

Susan J. Garpiel, MSN, RN, CNS, C-EFM

Abstract
Background: There is renewed interest in second-stage labor practices as recent evidence has challenged historical perspectives on safe duration of second-stage labor. Traditional practices and routine interventions during second-stage have uncertain benefit for low-risk women and may result in cesarean birth.
Purpose: The purpose of this quality improvement project was to implement an interdisciplinary second-stage practice bundle to promote safe outcomes including method of birth and women’s birth experience.
Methods: Standardized second-stage labor evidence-based practice recommendations structured into a 5 Ps practice bundle (patience, positioning, physiologic resuscitation, progress, preventing urinary harm) were implemented across 34 birthing hospitals in Trinity Health system.
Results: Significant improvements were observed in second-stage practices. Association of Women’s Health, Obstetric and Neonatal Nurses’ perinatal nursing care quality measure Second-Stage of Labor: Mother-Initiated Spontaneous Pushing significantly improved [pre-implementation 43% (510/1,195), post-implementation 76% (1,541/2,028), p < .0001]. Joint Commission Perinatal Care-02: nulliparous, term, singleton, vertex cesarean rate significantly decreased (p = 0.02) with no differences in maternal morbidity, or negative newborn birth outcomes. Unexpected complications in term births significant specific maximum length of time spent in second-stage of labor beyond which all women should undergo operative birth has not been identified” (ACOG & SMFM, p. 9). In 2017, ACOG suggested that clinicians use low-interventional approaches for labor management to help women meet their labor and birth goals and to improve birth satisfaction.
Several experts have expressed concern that maternal and fetal safety evidence for lengthening second-stage is not robust (Leveno, Nelson, & McIntire, 2016). Laughon et al. (2014) reported increased risk of maternal and neonatal morbidity associated with prolonged second-stage from a large retrospective cohort. Grobman et al. (2016) ana-

https://journals.lww.com/mcnjournal/Abstract/publishahead/Effects_of_an_Interdisciplinary_Practice_Bundle.99854.aspx
• 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!
The PATH to Commitment

1. Awareness/Understanding
2. Belief
3. Resistance
4. Commitment

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

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

1. **Awareness/Understanding**
2. **Belief**
3. **Commitment**
4. **Resistance**
5. **Compliance**

**Engagement**
Summary of Strategies to Improve Commitment to Safely Reducing C-section Bundle

• Recognize the stage of transformational change and commitment of all major decision-makers. – Use a practice survey to determine early adopters who can be your advocates, and select your low hanging fruit. A win leads to “Belief” along the path to commitment.

• Engage stakeholders through entire process: Group and Individual
  - Ask for where they are on pathway to commitment? We use polling. Anyone who does not respond, we ask for them to voice their opinion or express concern verbally.
  - SurveyMonkeys for feedback during design process
  - Organizational commitment occurs by winning over each stakeholder until you have a critical mass!

• Perform DVF>R for EVERY strategy: Avoid assuming that change will be simple.

• 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 on calls.

• Provide positive feedback to your early adopters and celebrate success!
Final Words and Advice

Be the Change Winner! Not the Change Whiner.
The PATH to Commitment: Use intermittent auscultation for low risk women to improve freedom of movement

- **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.

- **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!

- **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.

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

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


• Center for Ethical Leadership. The Tipping Point: Assessing Readiness with DVF>R http://www.valuebasedmanagement.net/methods_beckhard_change_model.html

• Loop, R. and R. Koller (2005) The road to commitment: Capturing the head, hearts and hands of people to effect change. Organizational Development Journal. 23(3) 73-81.


• Mayfield, Shaun, "The Formula for Change: [D x V x F x CL > R]," http://www.shaunmayfield.com/1/post/2011/06/the-formula-for-change-dxvxfxclgtr.html
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.