PREMIER

Sustainability - Making Change Last!

GaPQC AIM Webinar – April 2, 2019

Objectives

1. Share the fundamentals of systems thinking as it applies to sustainability and organizational change.
2. Provide resources to help healthcare practitioners understand the key factors that impact the successful spread and sustainability of quality improvement.
3. Understand how to develop your own “Theory of Success” for sustaining organizational change.

About Premier

PREMIER

FOR IMMEDIATE RELEASE

Premier Inc. Launches Nationwide Bundle of Joy™ Campaign to Scale Advancements in Maternal Healthcare throughout the U.S.

Bundle of Joy™ campaign to raise the bar on the quality, safety and cost of care for mothers and babies; mobilizes Premier's alliance of 4,000+ hospitals and health systems, 100B data points, vast array of industry partnerships and history of proven best practices

CHARLOTTE, N.C. (April 2, 2019) — Premier Inc. (NASDAQ: PINC), a leading healthcare improvement company, has launched the *Bundle of Joy™* campaign to raise the bar on the quality, safety and cost of care for mothers and babies across the U.S. Premier aims to build and deploy new care delivery models using evidence-based guidelines and best practices from around the nation, ultimately scaling proven advancements across the industry.

"Every new mother and child deserves the best beginning possible, at the most affordable price point," said Susan DeVore, President and CEO of Premier. "Our goal for the *Bundle of Joy* campaign is to ensure mothers and babies are always at the center of care and supported by the latest evidence, the best doctors and the most successful practices. We're building on our years of work as well as our expertise in syndicating innovative ideas and data from our powerful footprint of health system, physician and industry partners to measure, monitor and scale industry advancements."

Maternal health is a national priority. Mothers are at higher risk of dying during childbirth in the U.S. than in any other industrialized nation. America is also the only developed nation with an increasing maternal mortality rate. However, more than 60 percent of pregnancy-related deaths in the U.S. are preventable. The *Bundle of Joy* campaign is a multi-year effort to collaboratively assess, build, implement and broadly share the tools and best practices that are needed to ensure every birth is a safe, healthy and joyful journey for mothers and their babies.

The *Bundle of Joy* campaign ignites efforts to improve maternal and infant health by:

- Evaluating the current state and pinpointing specific improvement opportunities using Premier's robust database, which houses information on more than 45 percent of all U.S. hospital discharges, 100 billion data points and 1.2 million annual births.
- Connecting providers through data-driven, collaborative, performance improvement work that aligns frontline clinicians to best practices and evidence-based reliability guidelines.
- Engaging brilliant industry minds to find the solutions that work and scale them across Premier's national alliance of more than 4,000 hospitals and health systems.
- Researching specific therapeutic interventions and tools and assessing their clinical efficacy over time.
- Linking clinical quality and performance from primary care to hospital to post-acute care.
- Designing and implementing a 12-month optimal care model that includes pregnancy, labor and delivery, and post-partum care.
- Transparently sharing the progress being made across the nation and the best practices achieving those results.

$18 billion

Total member savings of nearly **$18 billion** through our QUEST® Collaborative alone.

200,000 lives saved

Using insight from our collaboratives and member health systems, thousands of lives are being saved.

4,000

A network of approximately **4,000 member hospitals and health systems.**

Why Change?

“Why do we need to change?”

Preventable Deaths In Hospitals

- 1999: We learned that 98,000 people were dying every year from preventable errors in hospitals
- 2013: Estimated that more than 400,000 people per year die from preventable harm in hospitals
- 2013: Preventable medical errors ranks 3rd highest killer in U.S. only to heart disease and cancer
- 2011: “More than a third of the pregnancy-related deaths were determined to have had a good-to-strong chance of being prevented.”
- 2018: Over 60 – 70% of pregnancy-related deaths in the U.S. were preventable.
- 2019: “85% of Tennessee maternal deaths preventable”
- Georgia leads the nation in maternal deaths ~ how many were preventable?

2013 Journal of Patient Safety: A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care

Preventable Deaths

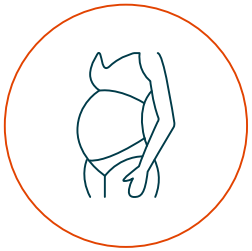
"We are burying a population the size of Miami every year from medical errors that can be prevented" ~ The Leapfrog Group 2013

The Statistics

Maternal death rates **are 2X** higher and harm **100% higher** than the past[1, 5]

60% of all maternal deaths **could be prevented**[2]

$19.5B in estimated costs of preventable harm[3]



Maternal deaths are **4X** more common in African Americans[1] and **64% higher** in rural areas[4]

1 Dina Fine Maron (2015, June 8). Has Maternal Mortality Really Doubled in the U.S.? (article) Retrieved from, https://www.scientificamerican.com/article/has-maternal-mortality-really-doubled-in-the-u-s/

2. Report From Nine Maternal Mortality Review Committees (2018). CDC Foundation (report). Retrieved from, https://www.cdcfoundation.org/building-us-capacity-review-and-prevent-maternal-deaths

3. Sophia Bernazzani. (2017, Oct 5). Tallying the High Cost of Preventable Harm (article). Retrieved from, http://costsofcare.org/tallying-the-high-cost-of-preventable-harm/

4. CDC Severe Maternal Morbidity in the U.S. Retrieved from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html

Distribution of Preventability

“60 - 70% of Maternal Deaths Were Found to be Preventable”

Overall	Cardiovascular and Coronary Conditions	Hemorrhage
33.5% Not Preventable	27.3% Not Preventable	25.0% Not Preventable
63.2% Preventable	68.2% Preventable	70.0% Preventable
3.2% Unable to Determine	4.6% Unable to Determine	5.0% Unable to Determine

Report From Nine Maternal Mortality Review Committees (2018). CDC Foundation (report). Retrieved from, https://www.cdcfoundation.org/building-us-capacity review-and-prevent-maternal-deaths

Council on Patient Safety in Women's Health Care

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE

safe health care for every woman

American Association of Nurse Anesthetists

American Board of Obstetrics and Gynecology

American College of Nurse Midwives

American Academy of Family Physicians

American College of Osteopathic Obstetricians and Gynecologists

American College of Obstetricians and Gynecologists

American Society of Anesthesiologists

American Society for Reproductive Medicine

American Urogynecologic Society

Association of Women's Health Obstetric and Neonatal Nurses

National Association of Nurse Practitioners in Women's Health

Pulse of New York

Society of Gynecologic Oncology

Society for Maternal Fetal Medicine

Society for Obstetric Anesthesia and Perinatology

Society of OB/GYN Hospitalists

Society for Reproductive Endocrinology and Fertility

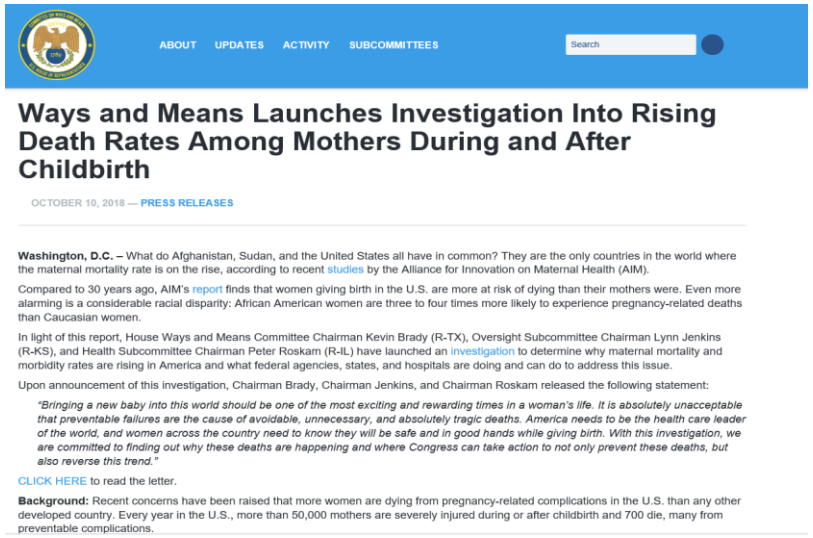
SafeHealthcareForEveryWoman.org

Hospitals and Headlines

USA Today, Deadly Deliveries

https://www.usatoday.com/series/deadlydeliveries/

Federal Action – State and Hospital Focused



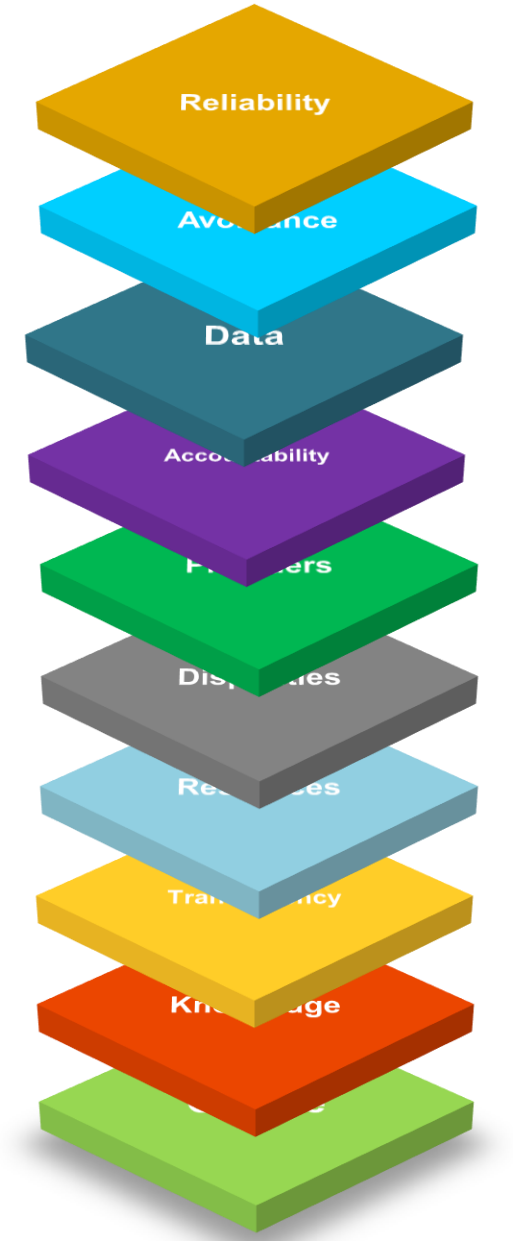
H.R.1318 Preventing Maternal Deaths Act and H.R.315 Improving Access to Maternity Care Act became law 12/18

- Process for reviewing pregnancy-related deaths
- Establish and sustain a maternal mortality review committee
- Ensure that the state department has a plan for ongoing provider education to improve the quality of maternal care, disseminate findings, and implement recommendations
- Provide for public disclosure of information

S.3392 - MOMS Act and H.R.5761 - Ending Maternal Mortality Act introduced 2018

- Pregnancy and postpartum safety and monitoring practices and maternal mortality and morbidity prevention
- To collect and analyze data related to process structure and patient outcomes to drive continuous quality improvement in the implementation of the maternal safety bundles
- Address specific issues relating to maternal mortality and SMM such as public awareness, at-risk populations and disparities, and quality of care

Contributing Causes



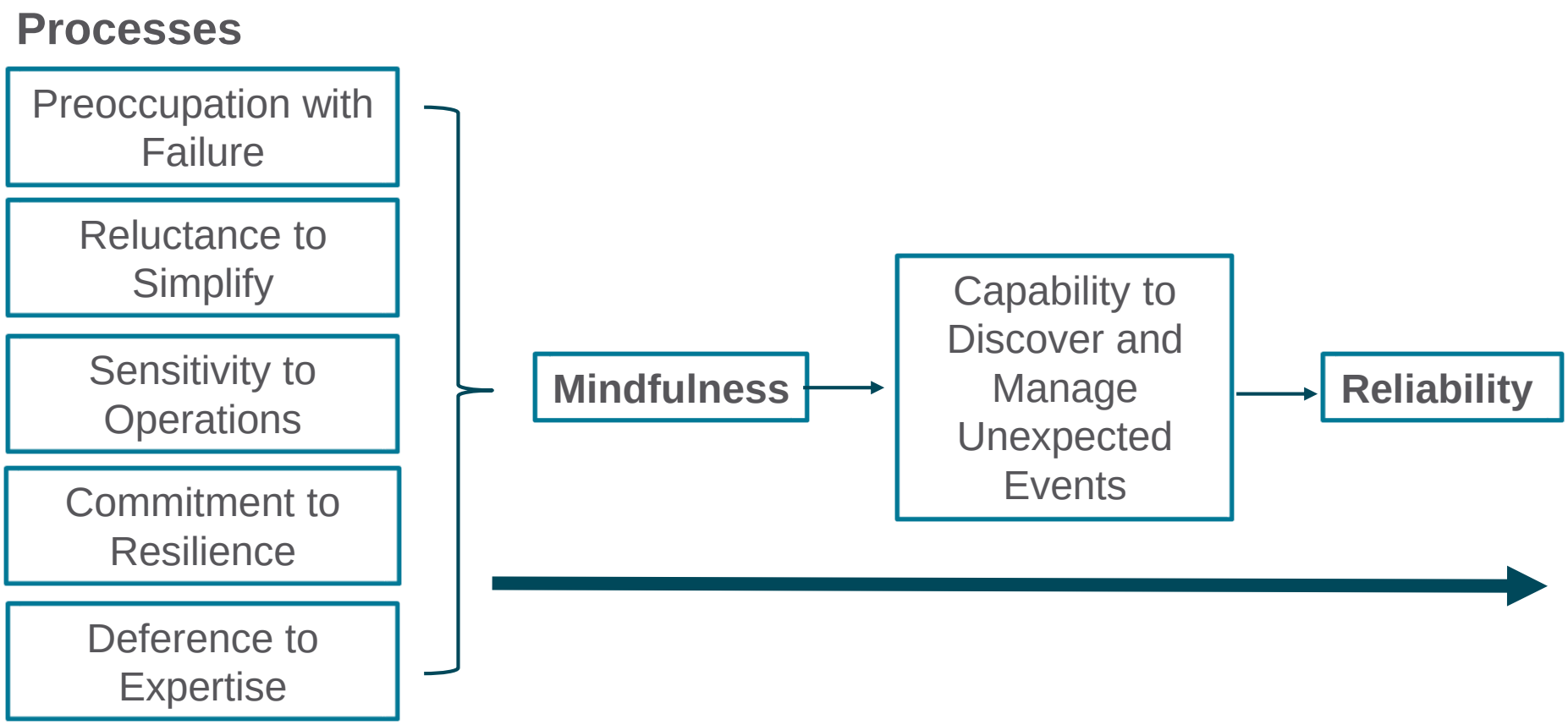
- Variation in care
- Obstetric risk is too expensive
- National-level data are often nonexistent
- Accountability for preventable maternal death and harm
- Overburdening or a complete absence of obstetric providers
- Disparities, racial, income, age, location - leading indicators
- Resource-poor, hospitals, states and patients
- Free, uninhibited sharing of information
- Necessary knowledge and preparation for safe practice
- Evolution, Culture, and the Obstetrical Dilemma

What is the Answer?

Culture of High Reliability

Principles of a Highly Reliable Organization's

Mindful Infrastructure



High Reliability

Hospitals?

Implementing Sustainable Change

“How do we implement sustainable change?”

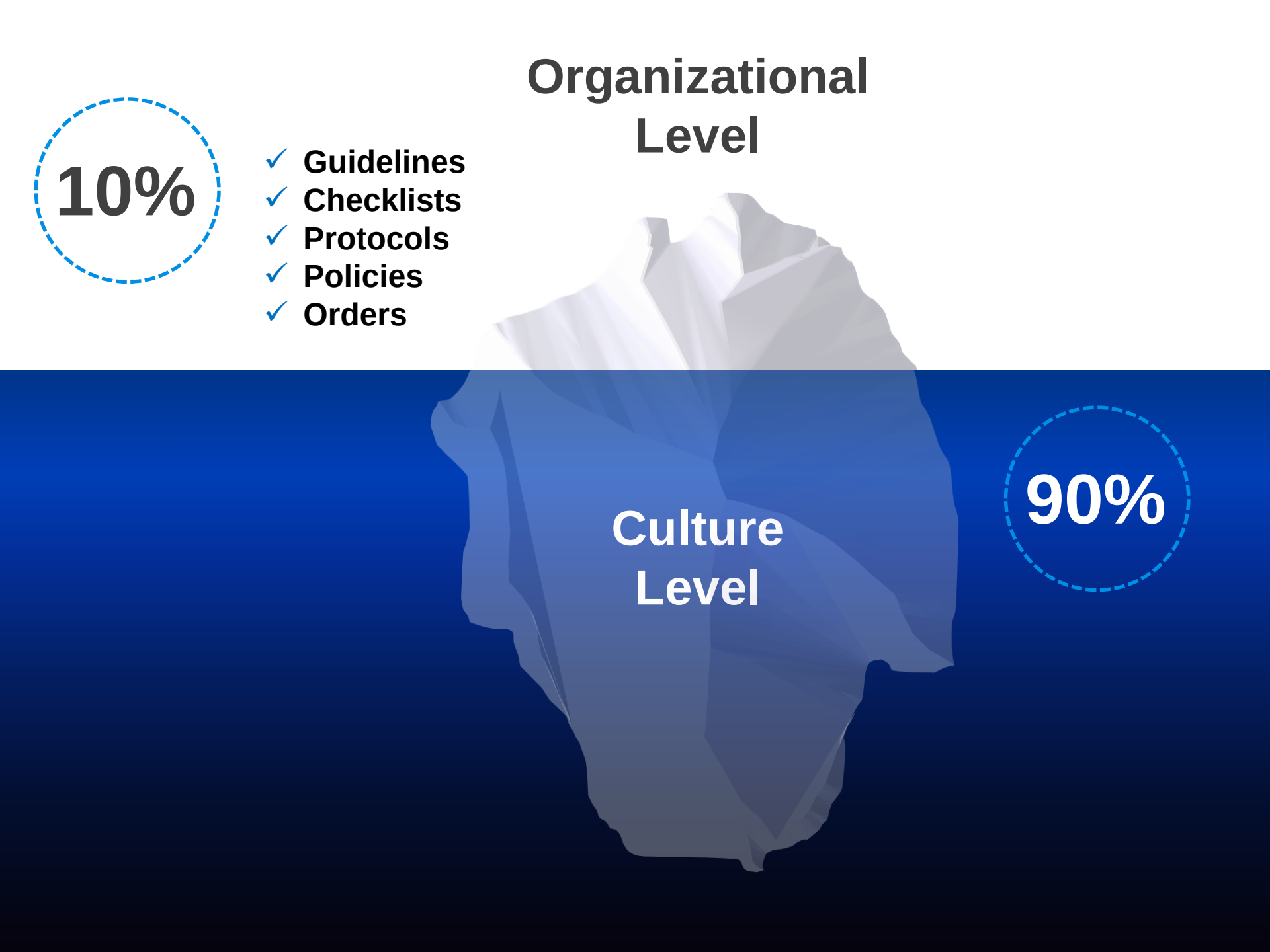
Foundation ~ Developing a Safety Culture

Safety culture is the sum of what an organization **is** and **does** in the pursuit of safety.

The product of **individual** and **group** beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's **commitment** to quality and patient safety.

"Collective Mindfulness"

Joint Commission, 11 Tenants of a Safety Culture


Organizational Level
10%
✓ Guidelines
✓ Checklists
✓ Protocols
✓ Policies
✓ Orders
Culture Level
90%

Quality Improvement

Quality Assurance	Quality Improvement
Individual focused	Systems focused
Perfection myth	Fallibility recognized
Solo practitioners	Teamwork
Peer review ignored	Peer review valued
Errors punished	Errors seen as opportunities to learn

Quality Improvement's key principles:

1. QI work as systems and processes
2. Focus on patients
3. Focus on being part of the team
4. Focus on use of the data

QI Methodologies and Tools: Framework for Change

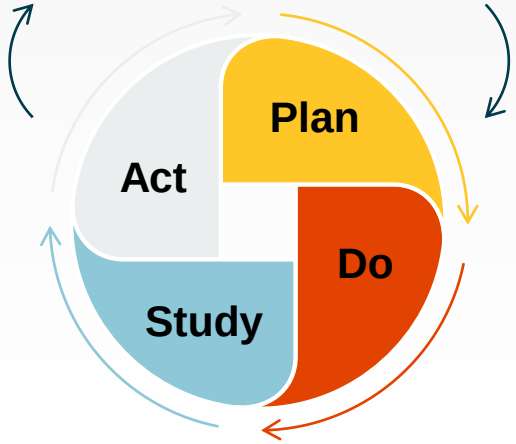
Form the Team → Set Aims → Establish Measures → Test Change → Implement Change → Spread Change → Sustain Change

IHI Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement

What change can we make that will result in improvement?



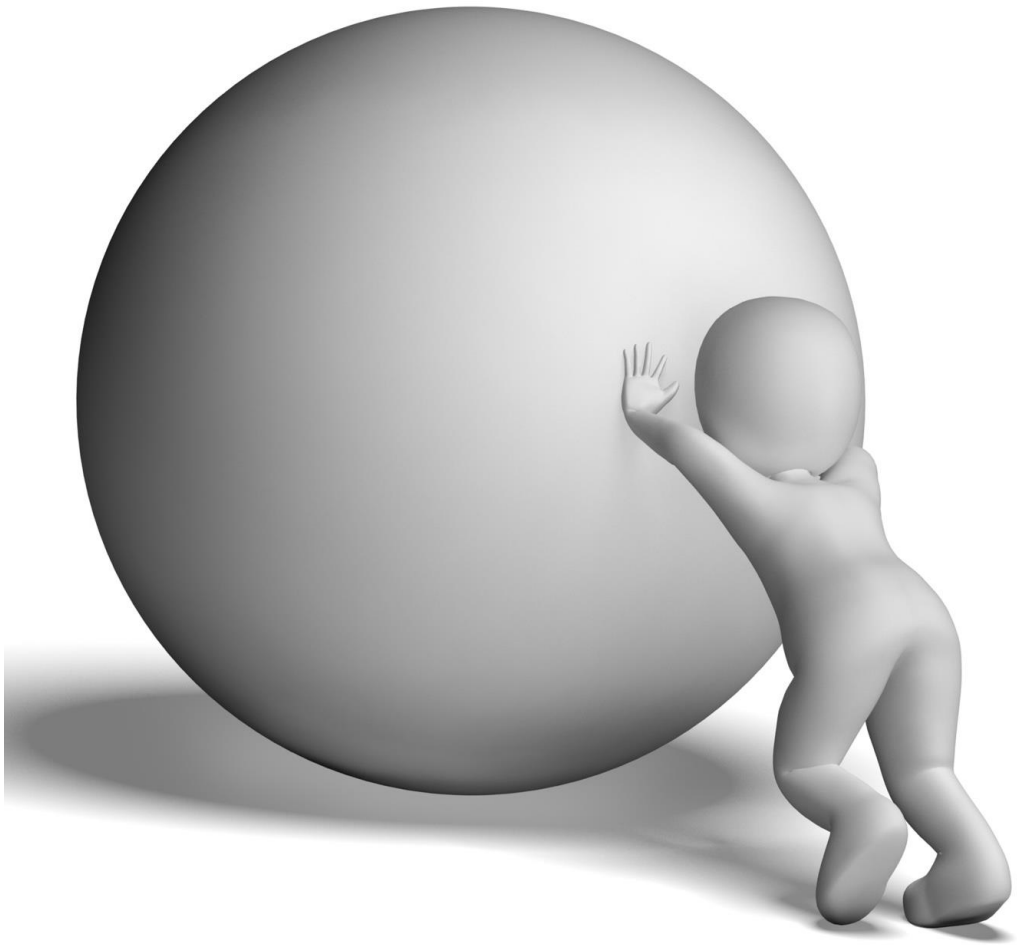
Lean Principles

Six Sigma

The Team Approach

Form the Team | Set Aims | Establish Measures | Test Change | Implement Change | Spread Change | Sustain Change

N of 1



The Importance of Leadership Support

Highly Reliable Teams

Collective Mindfulness

"Everyone who works in the organization, both individually and together, is acutely aware that even small failures in safety protocols or processes can lead to catastrophic adverse outcomes."

Setting the "AIM": Develop an Action Plan

Form the Team → **Set Aims** → Establish Measures → Test Change → Implement Change → Spread Change → Sustain Change

COUNCIL ON PATIENT SAFETY IN WOMEN'S HEALTH CARE
safe health care for every woman

PATIENT SAFETY BUNDLE

Obstetric Hemorrhage

READINESS

Every unit

- Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compressions stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Establish a response team - who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)
- Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched)
- Unit education on protocols, unit-based drills (with post-drill debriefs)

RECOGNITION & PREVENTION

Every patient

- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (formal, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

RESPONSE

Every hemorrhage

- Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists
- Support program for patients, families, and staff for all significant hemorrhages

REPORTING/SYSTEMS LEARNING

Every unit

- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

Standardization of health care processes and reduced variation has been shown to improve outcomes and quality of care. The Council on Patient Safety in Women's Health Care disseminates patient safety bundles to help facilitate the standardization process. This bundle reflects emerging clinical, scientific, and patient safety 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. Although the components of a particular bundle may be adapted to local resources, standardization within an institution is strongly encouraged.

The Council on Patient Safety in Women's Health Care is a broad consortium of organizations across the spectrum of women's health for the promotion of safe health care for every woman.

May 2015

For more information visit the Council's website at www.safehealthcareforeverywoman.org

Workgroup:

Organization Name:
Initiative Name: Obstetric Hemorrhage Initiative
Last Saved:

Project Start Month: April 1, 2019
Project End Month: March 31, 2020

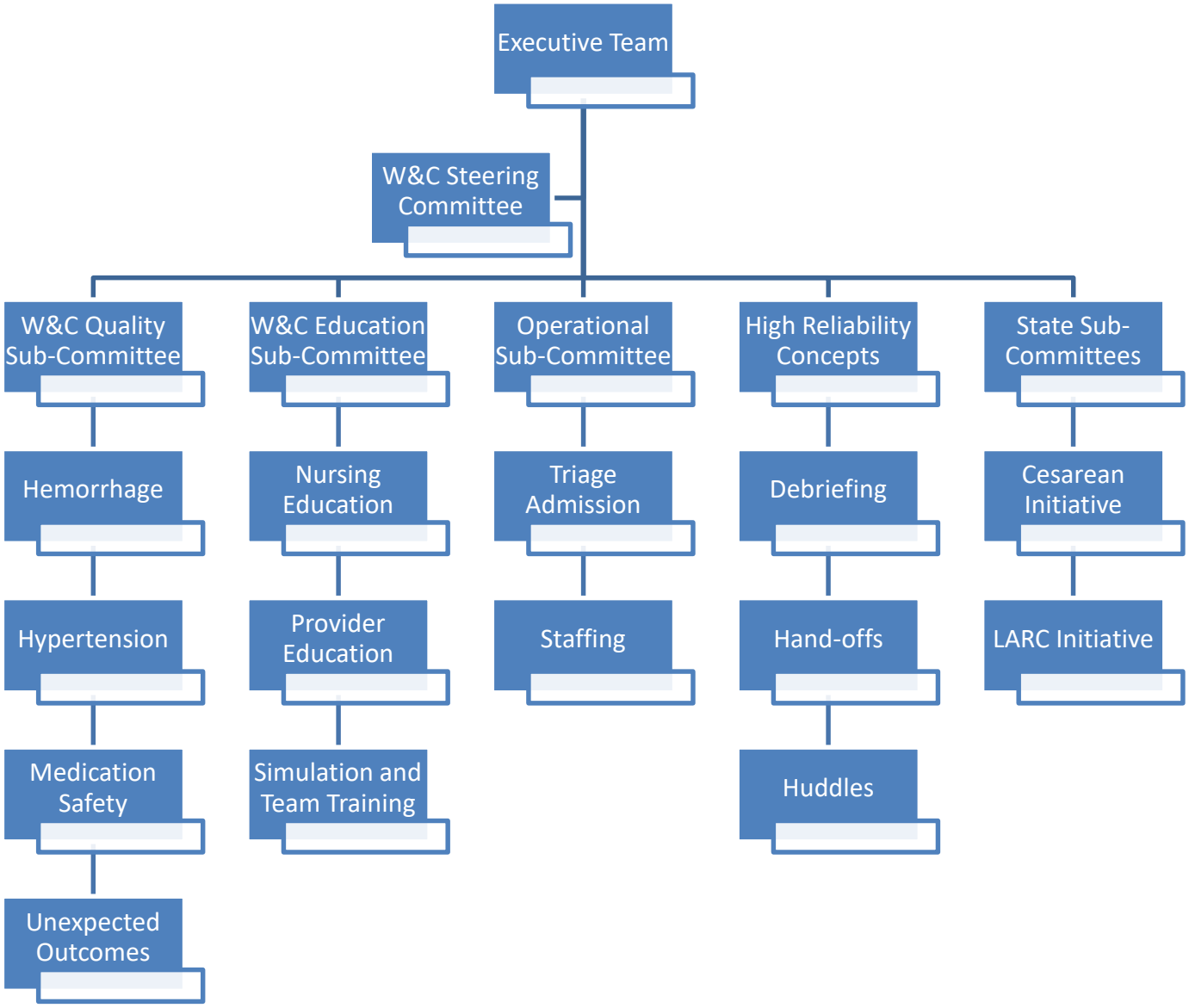
Not started (5) · Complete (4) · On track (3) · At risk (2) · Action required (1)

PREMIER

In progress / Not complete · At Risk · Action Required · Complete

	Work Breakdown Structure / Activities / Tasks	Start Date	Completion Date	Responsible Lead	Task Lead	Additional Organization Resource (s)	Status	Notes & Assumptions	Engagement Weekly Timeline: 1-Apr	May-19	Jun-19	Jul-19
	Overall Plan								PRE	1	2	3
I.	**Identification of Problem and Current State**											
	• Assessment of current practices against guidelines											
	• Assessment of hemorrhage events											
	• Benchmarking data to peer											
	• Share benchmarking, data, opportunities identified with staff											
	• In situ simulation to identify opportunities											
II.	**SIH Hemorrhage Standardized Care Bundle**											
	• Establish a standardized reliable method for the multidisciplinary team to follow that is consistent and leads to improved processes and patient outcomes											
	• Develop Evidenced Based (AIM) Hemorrhage Bundle (see elements below in section III)											
	• Development of SIH Hemorrhage Protocol Olderset											
	• Approval of SIH Hemorrhage Protocol by OB Committee P&T (24) and EPIC (17)											
	• EPIC STORK Training of Clinical staff and Physicians											
	• Advertising Change Process: Email Screen Shots/Posting on Unit											
	• Provider Education OB Mini Thrive 22 January;											
	• Staff Education (Just in time training; AIMeModule; TXA; Elsevier)											
	• Go Live Hemorrhage Bundle Date											
III.	**Implement SIH Hemorrhage Care Bundle Key Elements**											
	Readiness											
	• Hemorrhage cart / box with supplies located in L&D and Mother Baby Units											
	• Immediate Access to hemorrhage Medications											
	• Establish a response team – who to call when help is needed (blood bank, advanced gynecologic surgery, other support and tertiary services)											
	• Establish massive and emergency release transfusion protocols (type-O negative/uncrossmatched											
	• Unit education on protocols, unit-based drills (with post-drill debriefs)											
	Recognition and Prevention											
	• Ongoing Hemorrhage Risk Assessment											
	• Quantified Measurement of Blood Loss											
	• Active management of the 3rd stage of labor (department wide protocol)											
	Response											
	• Unit standard, stage-based, obstetric hemorrhage emergency management plan with checklists											
	• Support program for patients, families, and staff for all significant hemorrhages											
	Reporting and System Learning											
	• Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities											
	• Multidisciplinary review of serious hemorrhages for systems issues											
	• Monitor outcomes and process metrics in perinatal quality improvement (QI) committee											
IV.	**Education and Accountability: Sustain Successful Processes**											
	• Hemorrhage Bundle Implementation Improvements—First Test of Change											
	• Ongoing In Situ Simulation Training											
	• Daily rounds on the frontlines directly observing the work that is being done in the oper											
	• Standardized multidisciplinary onboarding education											
V.	**Monitoring Results and Process**											
	Multidisciplanary Simulation and Team Training											
	RN Participation in On Line Education - Readiness											
	RN Participation in Hemorrhage Drills - Readiness											
	Provider Participation in Hemorrhage Drills - Readiness											
	Admission Hemorrhage Risk Assessment - Recognition											
	Post delivery Hemorrhage Risk Assessment - Recognition											
	Quantified Blood Loss - Recognition											
	Postpartum Hemorrhage protocol in place –Reviewed and updated annually											
	Ongoing measurement of Transfusion Per 1000 Births OE											
	Ongoing measurement of outcome data and adverse events											

Project Plan Structure

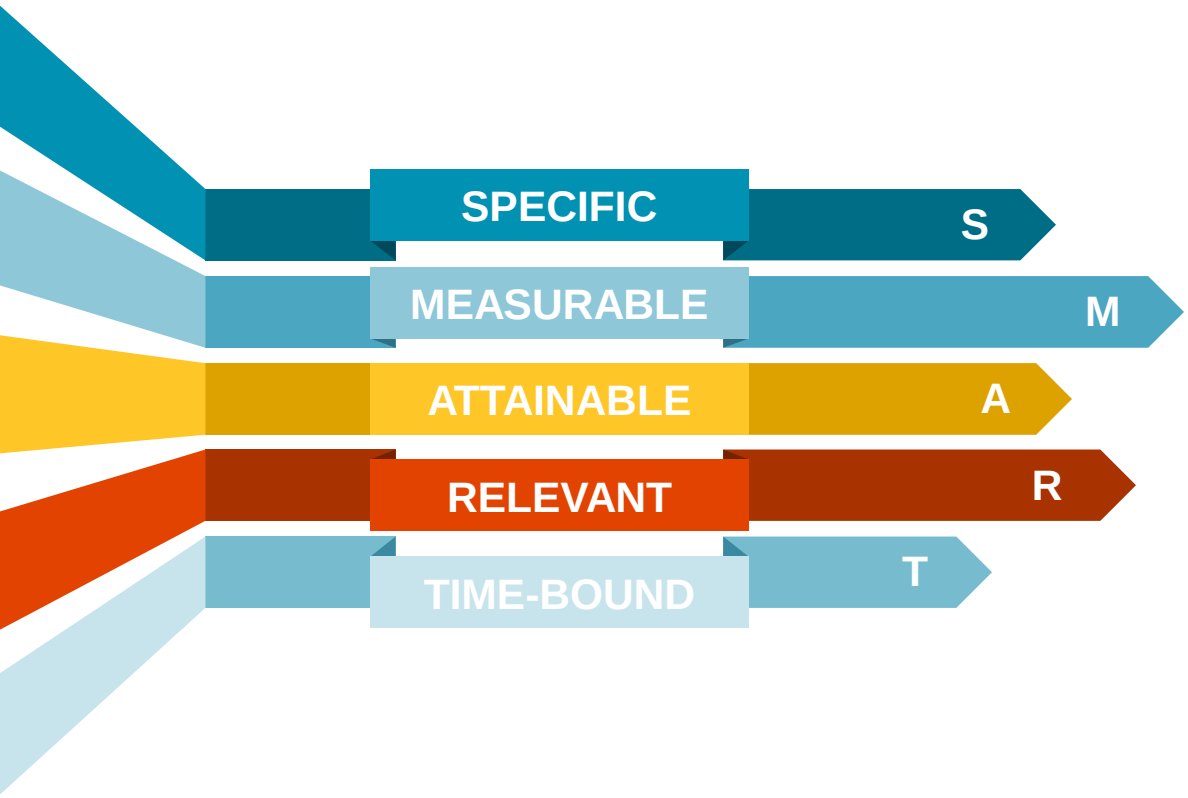


Setting the “AIM”: Assessment of Current State

1. Assess all perinatal service areas
2. Interview leadership, physicians, nursing and supportive staff
3. Review of clinical processes, procedures, orders
4. Team Culture of Safety

Setting the “AIM”: SMART Goals

Reducing Obstetrical Hemorrhage



SPECIFIC
Precisely define where you want to end up

MEASURABLE
Must have specific criteria in order to measure progress towards goal

ATTAINABLE
Goals should be challenging but not unrealistic

RELEVANT
In-line with current efforts and needs of the team and the organization

TIME-BOUND
Has clearly defined timeframe, including start date and target end date

Defining and Tracking Quality Measures

Form the Team | Set Aims | **Establish Measures** | Test Change | Implement Change | Spread Change | Sustain Change

- Tracking of progress and *re-adjust* the plan
- Analyze data and present results to clinical teams
- Review steps and when necessary, revise implemented tactics to ensure sustainable results

Types of Quality Measures

1. Structure: The characteristics of the setting where the care is provided
2. Process: What the organization does
3. Outcome: The change in the patient's health status as a result of the care received
4. Balancing: Ensures that if changes are made to one part of the health care system, it doesn't cause problems for another part of the system

Example: Quality Scorecard Snapshot

PREMIER

AEIX Perinatal Dashboard

Select View: ○ Collaborative ◉ System Svstem B ○ Facility

Maternal Outcomes

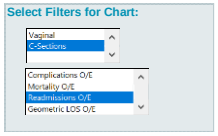
Vaginal

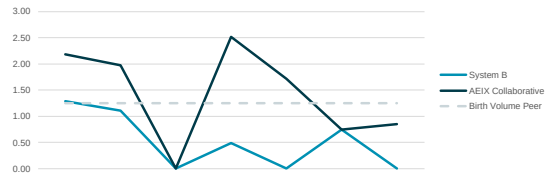
Outcome	Baseline 2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	Collaborative Timeline 2019 Q2	2019 Q3	2019 Q4	2020 Q1	Slope Rolling 4 Quarters	Benchmark Birth Volume Peer	Collaborative 2018 Q4
Complications O/E	2.46	2.17	1.62	2.74	1.19	0.00	0.00						↘	1.61	2.16
Mortality O/E	0.00	0.00	0.00	0.00	0.00	0.00	0.00						→	0.55	0.00
Readmissions O/E	0.53	0.00	1.10	0.00	1.38	0.00	0.00						↘	1.17	1.11
Geometric LOS O/E	0.96	1.06	1.12	1.10	1.02	0.00	0.00						↘	1.09	1.05

C-Sections

Outcome	Baseline 2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	Collaborative Timeline 2019 Q2	2019 Q3	2019 Q4	2020 Q1	Slope Rolling 4 Quarters	Benchmark Birth Volume Peer	Collaborative 2018 Q4
Complications O/E	3.15	2.55	1.36	0.27	1.17	3.18	0.00						↗	1.44	0.94
Mortality O/E	0.00	0.00	0.00	0.00	0.00	0.00	0.00						→	8.78	0.00
Readmissions O/E	1.29	1.11	0.00	0.49	0.00	0.74	0.00						↘	1.25	0.85
Geometric LOS O/E	1.04	1.00	1.11	1.00	0.99	1.11	0.00						↘	1.06	1.22

Select Filters for Chart:





Back to Top

PREMIER

AEIX Perinatal Dashboard

Select View: ○ Collaborative ◉ System Svstem B ○ Facility

Neonatal Outcomes

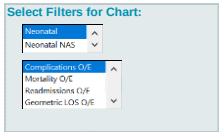
Neonatal

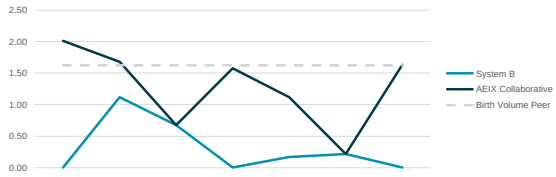
Outcome	Baseline 2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	Collaborative Timeline 2019 Q2	2019 Q3	2019 Q4	2020 Q1	Slope Rolling 4 Quarters	Benchmark Birth Volume Peer	Collaborative 2018 Q4
Complications O/E	0.00	1.12	0.67	0.00	0.16	0.21	0.00						→	1.63	1.63
NQI 02 - Mortality	0.00	0.00	0.00	0.00	2.20	0.00	0.00						↘	0.00	1.40
Readmissions O/E	0.00	0.00	0.00	0.00	0.00	0.00	0.00						→	0.00	0.00
Geometric LOS O/E	0.00	1.03	1.17	0.00	1.00	1.07	0.00						↗	1.08	1.13

Neonatal NAS

Outcome	Baseline 2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	Collaborative Timeline 2019 Q2	2019 Q3	2019 Q4	2020 Q1	Slope Rolling 4 Quarters	Benchmark Birth Volume Peer	Collaborative 2018 Q4
Complications O/E	0.00	0.00	0.00	0.00	0.00	0.00	14.77						↗	2.13	3.75
Mortality O/E	0.00	0.00	0.00	0.00	0.00	0.00	0.00						→	1.02	0.00
Readmissions O/E	0.00	0.00	0.00	0.00	0.00	0.00	0.00						→	0.47	0.00
Geometric LOS O/E	1.56	0.00	1.03	0.00	0.00	2.57	1.68						↗	1.51	1.94

Select Filters for Chart:





Back to Top

PREMIER

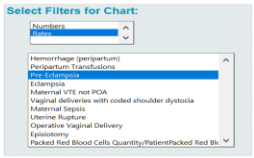
AEIX Perinatal Dashboard

Select View: ○ Collaborative ◉ System Svstem B ○ Facility

Maternal Complications

Complication Measure	Baseline 2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	Collaborative Timeline 2019 Q2	2019 Q3	2019 Q4	2020 Q1	Slope Rolling 4 Quarters	Benchmark Birth Volume Peer	Collaborative 2018 Q4
Hemorrhage (peripartum)	39 4.3%	18 3.7%	17 3.7%	21 4.4%	23 5.1%	26 5.5%	15 3.0%						→	5.9%	173 5.6%
Peripartum Transfusions	9 1.0%	6 1.2%	5 1.1%	1 0.2%	4 0.9%	5 1.1%	6 1.2%						→	1.2%	39 1.3%
Pre-Eclampsia	33 3.7%	11 2.3%	19 4.2%	19 4.0%	17 3.8%	11 2.3%	13 2.6%						↘	5.4%	174 5.7%
Eclampsia	0 0.0%	0 0.0%	0 0.0%	0 0.0%	1 0.2%	0 0.0%	0 0.0%						→	0.0%	3 0.1%
Maternal VTE not POA	1 0.1%	1 0.2%	0 0.0%	0 0.0%	0 0.0%	1 0.2%	0 0.0%						→	0.0%	1 0.0%
Vaginal Deliveries With Coded Shoulder Dystocia	19 2.1%	7 1.4%	11 2.4%	2 0.4%	8 1.8%	7 1.5%	7 1.4%						→	1.6%	55 1.8%
Maternal Sepsis	1 0.1%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%						→	0.0%	- 0.0%
Uterine Rupture	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%						→	0.0%	2 0.1%
Operative Vaginal Delivery	62 6.9%	33 6.8%	24 5.3%	33 6.9%	31 6.9%	39 8.3%	36 7.2%						→	5.5%	152 4.9%
Episiotomy	80 12.6%	26 7.7%	25 8.4%	42 13.0%	29 8.9%	37 11.1%	29 8.8%						↘	9.1%	104 4.8%
Packed Red Blood Cells Quantity/Patient	1.8	1.5	2.0	1.5	1.6	1.7	2.1						↗	2.40	2
Packed Red Blood Cells % Use	1.2%	1.2%	1.1%	0.7%	1.5%	1.9%	1.4%						→	1.8%	1.5%

Select Filters for Chart:



Back to Top

PREMIER

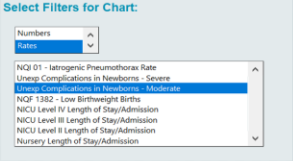
AEIX Perinatal Dashboard

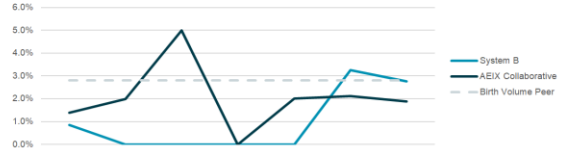
Select View: ○ Collaborative ◉ System Svstem B ○ Facility

Neonatal Complications

Complication Measure	Baseline 2017 Q2	2017 Q3	2017 Q4	2018 Q1	2018 Q2	2018 Q3	2018 Q4	2019 Q1	Collaborative Timeline 2019 Q2	2019 Q3	2019 Q4	2020 Q1	Slope Rolling 4 Quarters	Benchmark Birth Volume Peer	Collaborative 2018 Q4
NQI 01 - Iatrogenic Pneumothorax Rate	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%						→	0.0%	0 0.0%
Unexp Complications in Newborns - Severe	89 4.7%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	11 3.0%	31 2.8%						↗	5.6%	145 3.2%
Unexp Complications in Newborns - Moderate	16 0.8%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	12 3.2%	30 2.8%						↗	2.8%	85 1.9%
NQF 1382 - Low Birthweight Births	0 0.0%	24 171.4%	29 5.8%	0 0.0%	15 1.1%	10 2.0%	0 0.0%						→	4.6%	119 5.1%
NICU Level IV Length of Stay/Admission	-	-	-	-	-	-	-						→	0.0	17
NICU Level III Length of Stay/Admission	8.0	9.7	8.2	2.7	4.8	3.1	9.0						↗	8.2	7
NICU Level II Length of Stay/Admission	5.7	4.2	9.6	5.3	1.8	3.3	3.1						↘	4.2	5
Nursery Length of Stay/Admission	1.9	2.0	2.0	2.0	2.0	2.0	2.0						→	2.0	2

Select Filters for Chart:

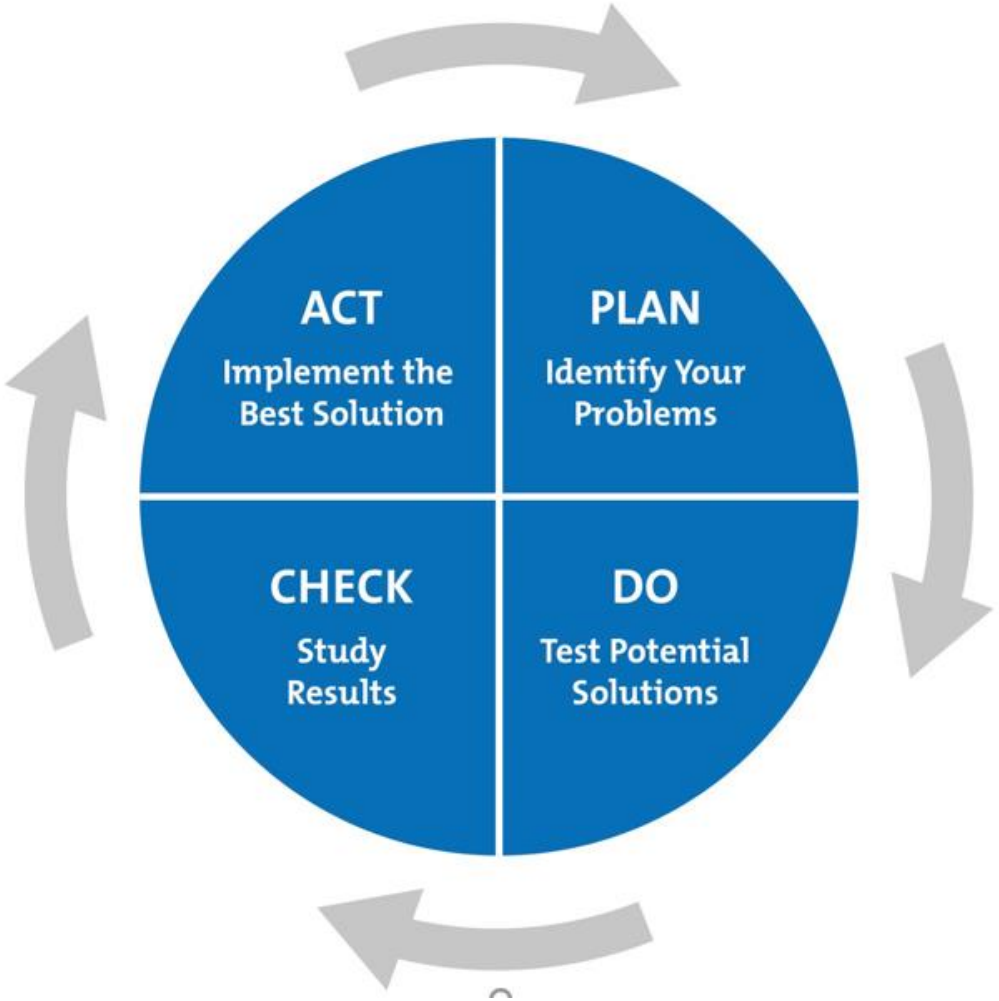




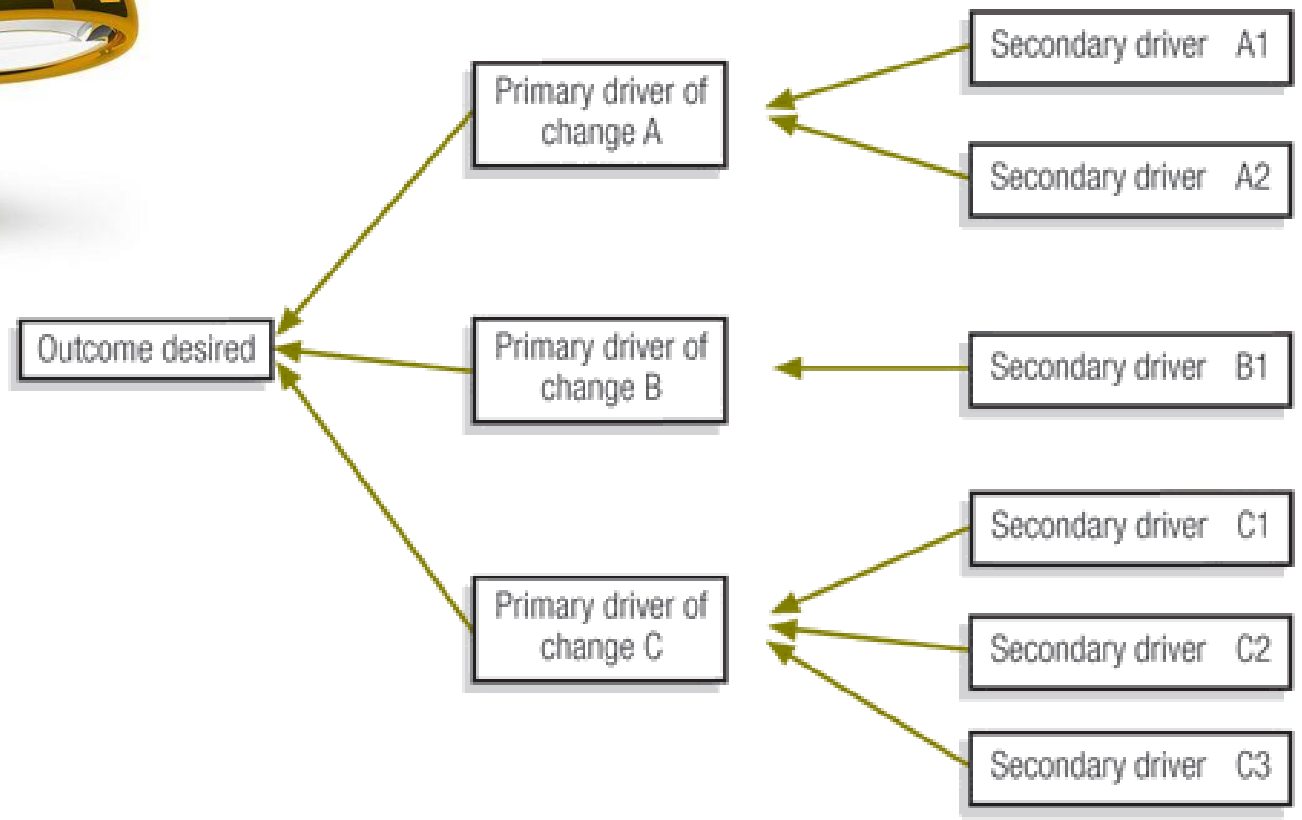
Back to Top

Testing Change: PDSA Cycles

Form the Team | Set Aims | Establish Measures | **Test Change** | Implement Change | Spread Change | Sustain Change



Designing Driver Diagrams and Test of Change



Why Test Change Prior to Implementation?

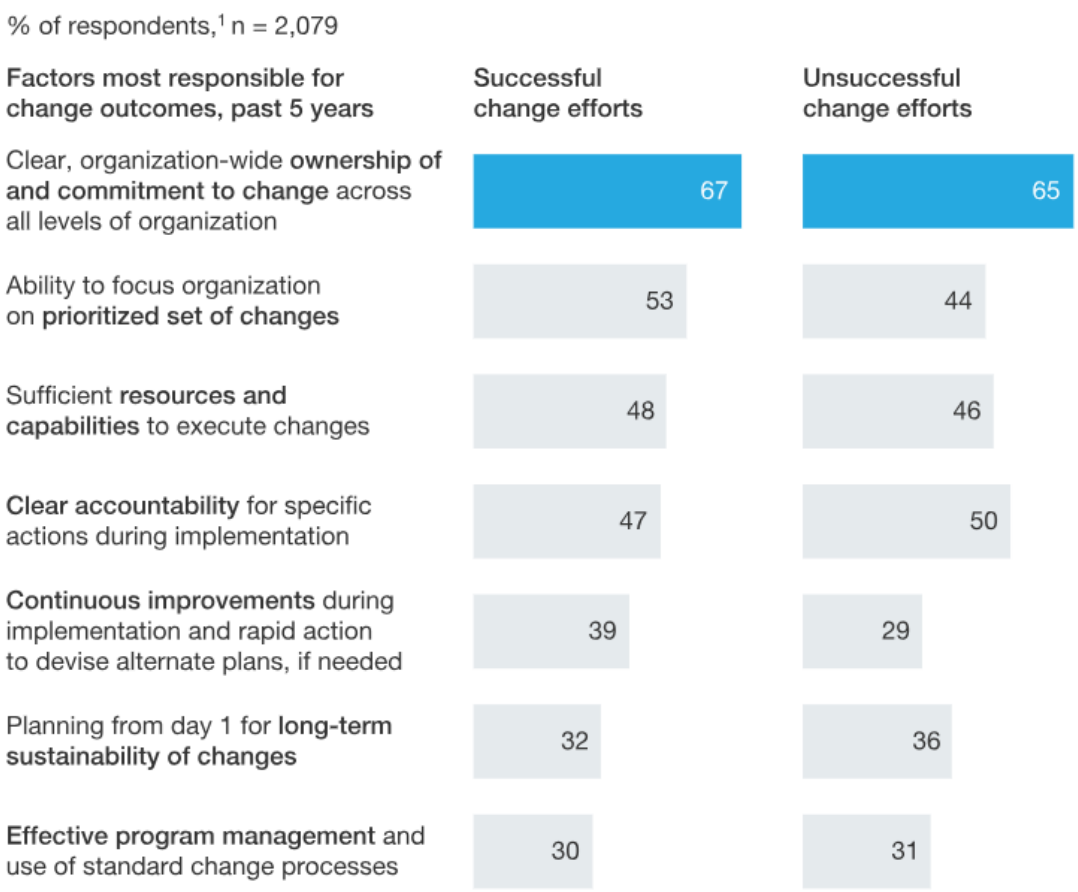
- ✓ Involves less time, money, and risk
- ✓ A powerful tool for learning; from both ideas that work and those that don't
- ✓ Less disruptive for patients and staff
- ✓ Less resistance to change

Implementing Change: Putting Practices into Operation

Form the Team | Set Aims | Establish Measures | Test Change | **Implement Change** | Spread Change | Sustain Change

Secrets of Successful Change Implementation

The greatest impact on a major change effort's outcome comes from ownership of and commitment to change.



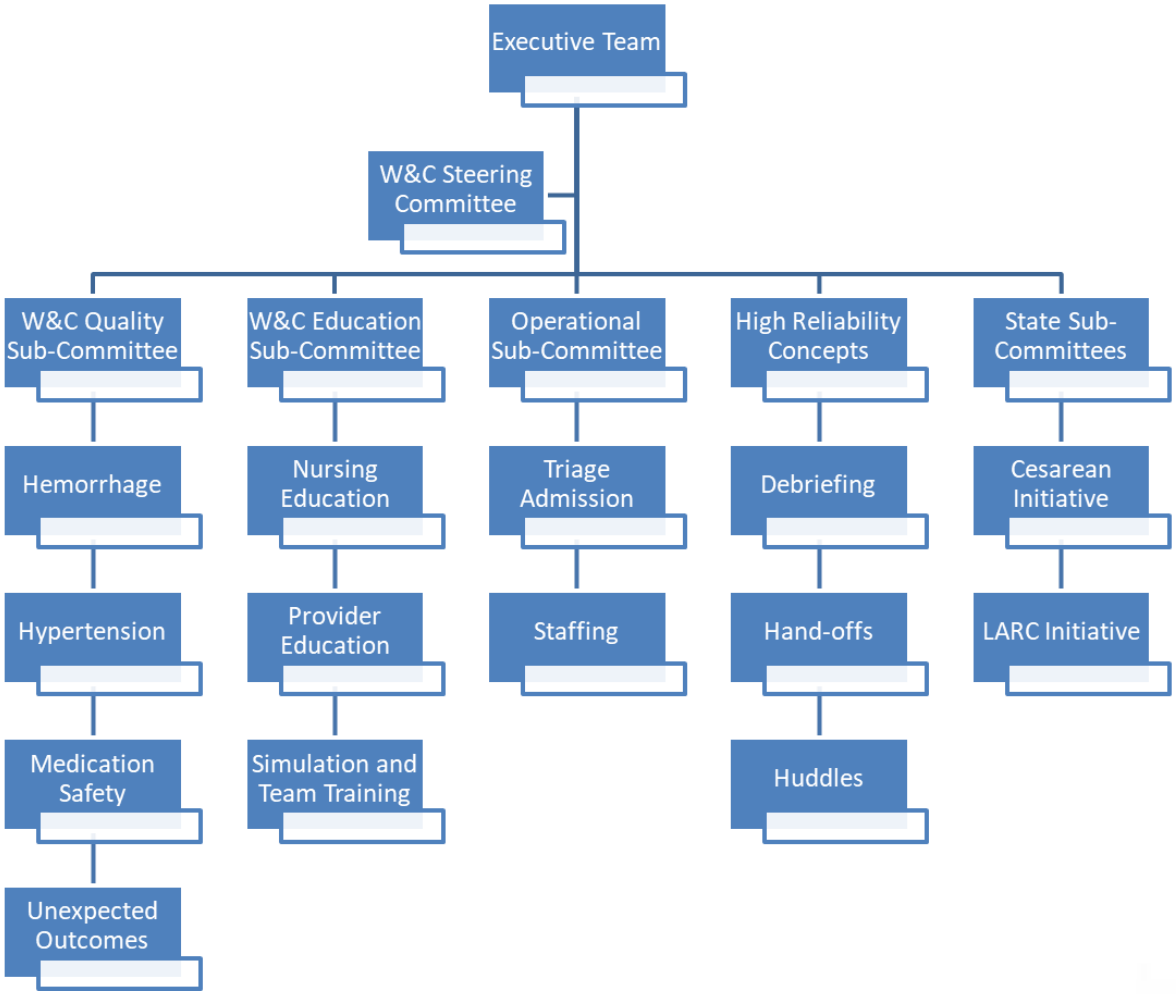
[1]Respondents who answered "don't know" are not shown.

McKinsey&Company

QI Methodologies and Tools: Kotter 8-STEP PROCESS

1. **Create a Sense of Urgency** - Identify the ‘why’ for change, and be prepared to speak to it
2. **Build a Guiding Coalition** - Collect representative leadership to guide the change
3. **Develop a strategic vision** and plan initiatives
4. **Enlist a Volunteer Army** - Gather staff who can put the plan into action
5. **Remove Barriers** or Obstacles to Change
6. **Generate Short Term Wins** - Begin change efforts and track progress
7. **Sustain Acceleration** - Ensure change is successful and sustainable
8. **Institute Change** - regularly to review and monitor successes, identify and address new challenges, and communicate progress transparently

Communication



Communication Strategies

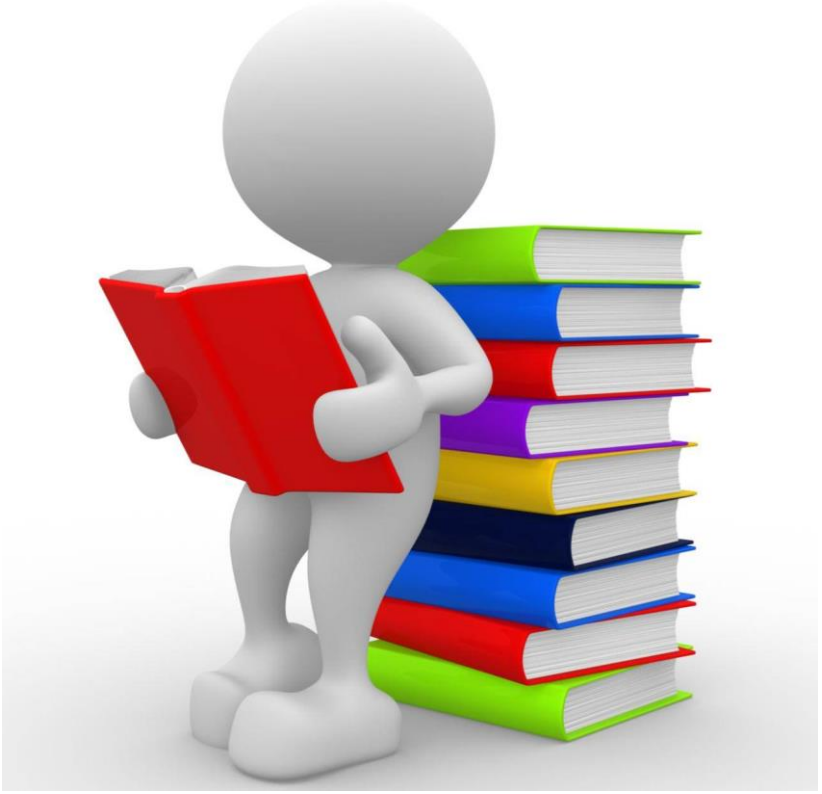
Buy-in and Engagement

Discussions cannot begin with talk of contracts and compensation but must focus instead on what is at stake for patients

1. **Discover a common purpose.**
2. Adopt an engaging style and talk about rewards
3. Reframe values and beliefs to turn physicians into partners, not customers
4. Segment the engagement plan and provide education.
5. Use “engaging” improvement methods by using evidence and data
6. Provide backup all the way to the board

Shared Knowledge

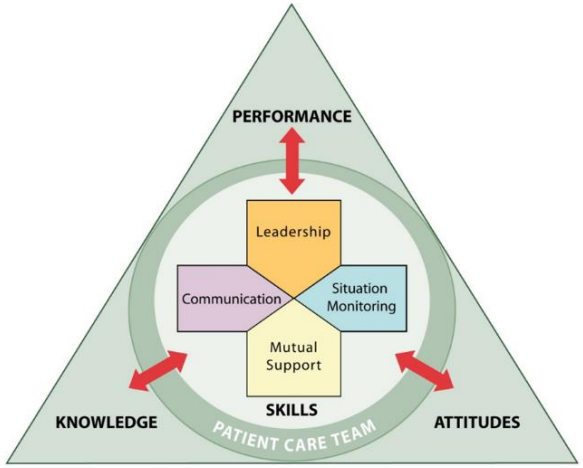
- Provide initial team communications about changes
- Develop collaborative training programs
- Prepare informational and resource documents
- Assess team readiness before the change
- Analyze impact
- Establish an ongoing training structure



Team Dynamics: Team Training and In-situ Simulation

Team Training

- Focus on communication and teamwork skills
- Optimize team safety, efficiency and effectiveness
- Common Labor and Delivery scenarios



In-situ Simulation

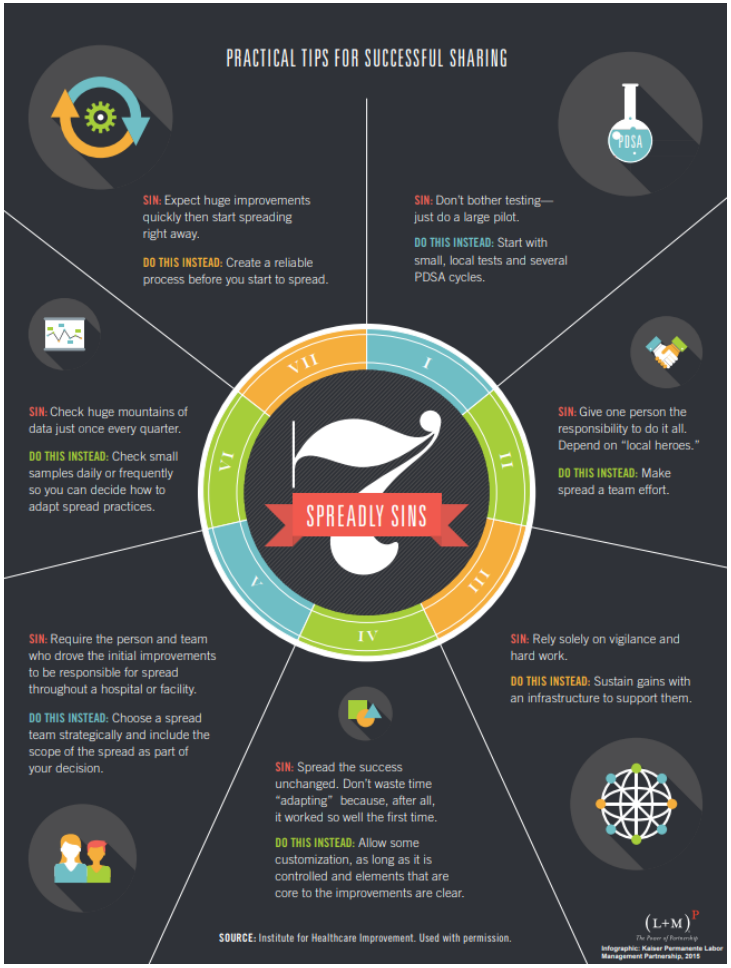
- Test of Change
- Common emergency
- Videotaped with constructive debriefings
- Knowledge sharing and analyzing team performance

Challenges and Barriers

Spreading Change - Diffusion of Innovation

Form the Team | Set Aims | Establish Measures | Test Change | Implement Change | **Spread Change** | Sustain Change

IHI Spreading Changes



Diffusion Key Attributes

- ✓ **Clear** advantage compared to current ways
- ✓ **Compatibility** with current systems and values
- ✓ **Simplicity** of change and its implementation
- ✓ **Ease of testing** before making a full commitment
- ✓ **Observability** of the change and its impact

Sustainability: Path to Improvement

Form the Team → Set Aims → Establish Measures → Test Change → Implement Change → Spread Change → **Sustain Change**

Using prioritized analytics

REPEAT

Steering council oversight throughout

- Assess Current State vs. Continuum of Care Pathways
- Identify gaps and facilitate practitioner-led redesign to close gaps
- Design and implement scorecards to ensure data-driven decision making
- Leverage small test of change (pilots) to validate the effect and feasibility
- Spread change to all pertinent areas across the care continuum
- Establish an infrastructure to ensure sustainability

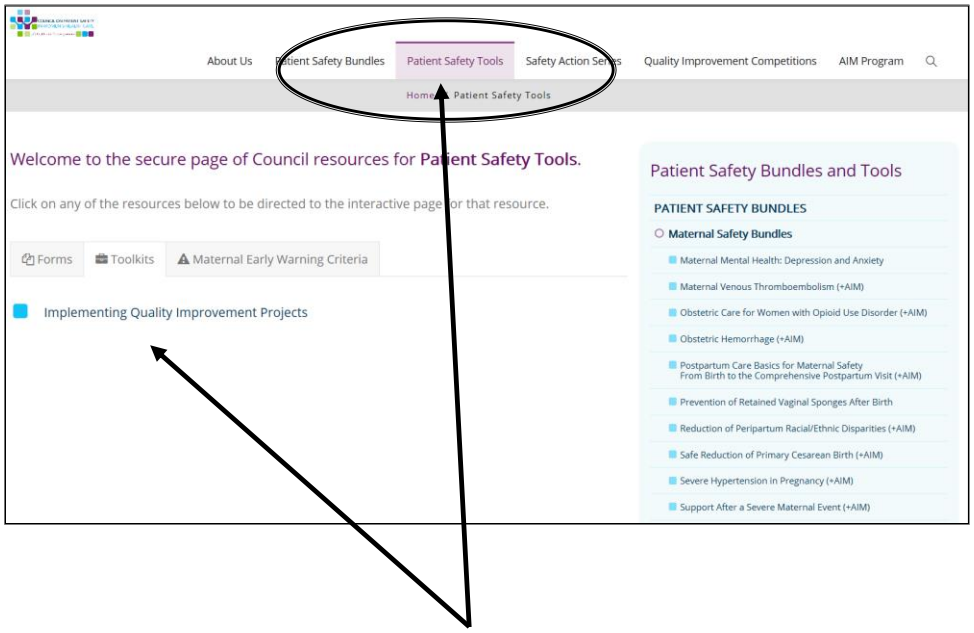
Sustainability

“Without continual growth and progress, such words as improvement, achievement, and success have no meaning.”

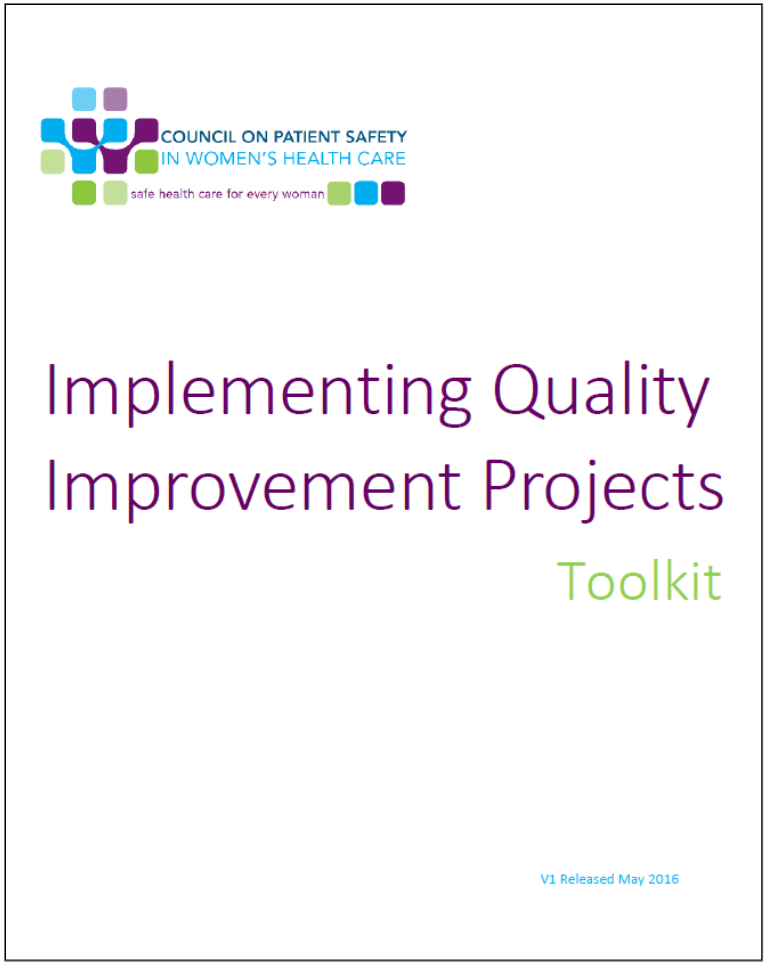
Celebrating Success

Implementation and Sustainability

Council on Patient Safety Resources



[Quality Improvement Toolkit]



Questions

Deb Kilday, MSN, RN
Premier Performance Partner Manager, Women and Infants
Deborah_Kilday@PremierInc.com

PREMIER

Thank You

References and Resources

Kotter's 8 step Model of Change – Management Study Guide

Lean Enterprise Institute

AHRQ High Reliability

AHRQ Toolkit for Improving Perinatal Safety

TJC High-Reliability Health Care: Getting There from Here

IHI uses the Model for Improvement

MindTools: Management Training and Leadership Training, Online

Council on Patient Safety in Women's Healthcare Quality Improvement Toolkit

IHI Prevent Obstetrical Adverse Events

Applying a Science-Based Method to Improve Perinatal Care: The Institute for Healthcare Improvement Perinatal Improvement Community

Making Sense of Implementation Theories, Models and Frameworks

References

Action For Better Healthcare: Premier Inc. Blog:
www.actionforbetterhealthcare.com/

Council on Patient Safety | Women & Mothers' Health Care:
https://safehealthcareforeverywoman.org/

The Global Burden of Disease Study:
https://www.thelancet.com/gbd

Severe Maternal Morbidity in the United States:
https://www.cdc.gov

USA Today, Deadly Deliveries:
https://www.usatoday.com/deadly-deliveries/interactive/how-hospitals-are-failing-new-moms-in-graphics/

National Network of Perinatal Quality Collaboratives:
https://www.cdc.gov/reproductivehealth/maternalinfanthealth/nnpqc.htm

Review to Action, Report From Nine Maternal Mortality Review Committees:
http://reviewtoaction.org/sites/default/files/national-portal-material/Report%20from%20Nine%20MMRCs%20final_0.pdf

