



## **NJHA Institute for Quality and Patient Safety Collaborative To Improve Perinatal Care**

### **Collaborative Charter**

#### **Introduction**

Welcome to the New Jersey Hospital Association Institute for Quality and Patient Safety (Institute) Perinatal Collaborative. This section of the Pre-work Handbook will give you some general information about the collaborative experience. The second section will provide you with more specific guidance about preparing for the project.

Some preliminaries about collaborative structure and methodology: The NJHA collaborative will involve many teams working intensely together for approximately 12 months. During the collaborative term, participants will engage in three Learning Sessions, and maintain continual contact with other registered teams and faculty members via site visits, webinars, conference calls, a dedicated Internet website, listserv, and e-mail. A **Change Packet**, defined as a collection of evidence-based ideas and tools supported by medical and nursing literature, will be developed and given to all participating organizations.

#### **Collaborative Expectations**

- Provide education on the latest and best subject matter application and research, as well as tools and interventions for process improvement, both during and between Learning Sessions;
- Coach teams and organizations;
- Assess participants' progress on a monthly basis and provide feedback to each organization regarding its progress

#### **Participating organizations are expected to:**

- Connect the goals of the collaborative work to a strategic initiative in their organization
- Provide a senior leader to sponsor and actively support the team and champion the spread of improvements within the facility
- Provide the resources to support the team, including resources necessary for Learning Sessions and staff time to devote to this effort
- Provide expert staff from key support units in the organization to support the team as needed
- Perform tests of change leading to process improvements within the organization
- Communicate regularly with their partners in other health care settings
- Share information with the collaborative, including details of changes made and data to support these changes, both during and between Learning Sessions.

#### **Collaborative Leadership:**

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## Problem Statement

Despite spending more of the U. S. gross national product on healthcare than any other industrialized country, currently we rank 17 in the world in perinatal mortality rate, outcomes that according to the World Health Organization are largely due to obstetric causes. In September, 2007, the National Quality Forum (NQF) appointed a steering committee to develop consensus standards in this area, noting “pregnancy and childbirth is the second most common reason for admission to a hospital, with 4.2 million childbirth-related hospital stays recorded in 2005 nationally.” Pregnancy and childbirth related procedures accounted for the five most common procedures performed on patients ages 18-44 and the most common procedures performed on infants were those associated with birth. There has been significant mortality and morbidity associated with pregnancy and childbirth, and poor quality of care during the last trimester, labor and delivery and postpartum leads to unnecessary complications, prolonged lengths of stay, costly NICU admissions and anxiety and suffering for patients and families.<sup>1</sup> Hoping to focus more quality improvement efforts on perinatal hospital performance, the NQF released its 17 national consensus standards for perinatal care in October, 2008.

In issuing its opinion statement on Late-Term Infants, The American College of Obstetricians and Gynecologists note that during the past decade the proportion of all U.S. births that were late-preterm births (defined as birth between 34 and 36 weeks) increased by 16 percent. These late term babies are often considered to be as physiologically and metabolically mature as full term babies, but recent work done by the American Academy of Pediatrics has noted that these babies are at higher risk of developing medical complications. Their published guidelines contain the following information:<sup>2</sup>

“During the initial birth hospitalization, late-preterm infants are four times more likely than term infants to have at least one medical condition diagnosed and three and a half times more likely to have two or more conditions diagnosed. Late-preterm infants are more likely than term infants to be diagnosed during the birth hospitalization with temperature instability, hypoglycemia, respiratory distress, apnea, jaundice and feeding difficulties. During the first month after birth, late-preterm infants are also more likely than term infants to develop hyper-bilirubinemia and to be readmitted for hyper-bilirubinemia and non-jaundice-related diagnoses such as feeding difficulties and rule out sepsis.”

The Academy goes on to say that these late-preterm infants have higher mortality rates, immature respiratory function and apnea, structural and functional immaturity of their cardiovascular system, and are more susceptible to difficulties with maintaining normal temperature. Their recommendation is that because of these increases in rates of morbidity and mortality, preterm deliver should only occur when an accepted maternal or fetal indication for delivery exists.

The New Jersey Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) Late Preterm Initiative, launched in 2005 as a multi-year endeavor, addresses the special needs of infants born between 34 and 36 weeks of gestation. Goals include increasing healthcare provider and consumer awareness of the risks associated with late preterm birth. Also, ensuring evidence-based educational resources are available for nurses and healthcare providers to provide appropriate assessment and care for these vulnerable newborns.

New Professional resources, released in 2007, include Late Preterm (Near-Term) Infant Assessment Guide and Optimizing Health for the Late Preterm Infant Presentation Package. AWHONN began a national multi-year research-based practice project in the late 2007.

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<sup>1</sup> Accessed National Quality Forum website ([www.qualityforum.org](http://www.qualityforum.org)) 12/29/08.

<sup>2</sup> Engle WA, Tomashed KM, Wallman C. “Late preterm” infants: a population at risk. *Committee on Fetus and Newborn. Pediatrics* 2007; 120:1390-1401.



In the fall of 2007, staff from the New Jersey Hospital Association, the New Jersey Department of Health and Senior Services (NJDHSS), the NJ chapter of the American College of Obstetrics and Gynecology, the New Jersey Obstetrical and Gynecological Society, the NJ chapter of the American College of Nurse Midwives and New Jersey Association of Women's Health, Obstetric and Neonatal Nurses met several times to discuss New Jersey's high rate of caesarean section and ways it might be addressed. Substantial data from the electronic birth certificate was shared by Dr. C. Denk and his staff from the NJDHSS focusing on c-sections and inductions of labor prior to week 39, looking at possible explanations. In general, he found that both primary and repeat cesareans in most categories increased at similar rates; cesareans without a trial of labor showed the fastest growth; and cesareans without any recorded medical reasons are rising. Similar increases were noted for inductions.

The importance of culture, teamwork, communication and a focus on patient centric care has been demonstrated in improving patient safety. The Institute for Healthcare Improvement incorporated these concepts in their *100,000 Lives* and *5 Million Lives from Harm* campaigns. Like in intensive care units, things can go wrong in seconds in pregnancy related care, and the ability to communicate effectively and work in well-coordinated teams is critical to achieving a positive outcome for mother and baby.

In 2004 The Joint Commission issued a sentinel alert advisory on preventing infant death and injury during delivery. While the absence of early and regular prenatal care is a leading contributor to the risk of infant death or morbidity, review of The Joint Commission's sentinel alert cases reveals that in all sentinel alert cases, communication issues topped the list of identified root causes (72 percent), with more than one half of the organizations citing organization culture as a barrier to effective communication and teamwork, i.e. hierarchy and intimidation, failure to function as a team and failure to follow the chain of communication. Other identified root causes include: staff competency (47 percent), orientation and training process (40 percent), inadequate fetal monitoring (34 percent), unavailable monitoring equipment and/or drugs (30 percent), credentialing/privileging/suspension issues for physicians and nurse midwives, staffing and lack of prenatal information.

### **Mission**

In this collaborative, the mission of the NJHA Institute for Quality and Patient Safety (Institute) and participating acute care hospitals is to achieve -- within 12 months -- breakthrough improvement in the teamwork and communication for all perinatal patients. The mission also includes developing a means to spread the initial learning and improvement more widely within the participating organizations.

Our goals are to close the gap between what is known and what is practiced and to establish new systems of care that will produce: better clinical outcomes, fewer adverse events, much higher levels of patient and family satisfaction, lower costs, better coordination of care, and enhanced communication among multiple healthcare providers. This will be achieved by implementing a system-wide model of care, one that includes establishing a culture of safety within the facilities and developing and maintaining a skilled, coordinated and collaborative care team that focuses on reducing perinatal harm.

Healthcare organizations with a positive safety culture are characterized by facile communication, mutual trust, shared belief of the importance of safety and by confidence in the efficacy of preventive measures. Improvements to care will be effected by implementing system-wide changes, which focus on the safe delivery of uniform processes and procedures, supported by medical evidence and in a highly reliable fashion.

### **Methods**

Each organization is expected to develop an aim statement that includes specific goals relating to improving perinatal care in their units.



Both process and outcome measurement strategies will be used to assess organizational progress toward achieving collaborative goals. Organizations will learn an improvement strategy that includes breakthrough goals and a method to develop, test and implement changes to their systems. Organizations will be expected to collect well-defined data that relate to their aim at least monthly and plot them over time for the duration of the collaborative. An annotated time series will be used to assess the impact of changes.

NJHA, the collaborative co-chairs and faculty will provide guidance to participating organizations in testing and implementing best practices. Participating organizations will capitalize on mastering process improvement from these focused projects by developing a method for disseminating the system redesign to other units in the organization. Such dissemination will require active involvement from the senior leaders of each organization.

**Learning Sessions** are the major integrative events of the collaborative. Through plenary sessions, small group discussions and team meetings, attendees have the opportunity to:

- Learn from faculty and colleagues
- Receive individual coaching from faculty members
- Gather new knowledge on the subject matter and process improvement
- Share experiences and build collaboration on improvement plans.

The time between Learning Sessions is called an **Action Period**. During Action Periods, collaborative participants work within their organizations towards major breakthrough improvement. Although participants focus on their own organizations, they remain in continuous contact with other collaborative participants and faculty. In addition, collaborative participants share the results of their improvement efforts in monthly reports. We encourage and expect the participation of your other team members in Action Period activities.

During the Action Periods, there will be monthly conference calls for teams from all participating organizations with faculty and co-directors of the collaborative. Site visits to participating organizations may also be utilized if needed to work with team members more closely and provide more education and support.

To prepare your organization for the first Learning Session, we will expect each team to complete the following tasks:

### **1. Identify Leadership and Assemble a Team**

The Perinatal Collaborative requires change in an organization's culture and infrastructure as well as specific changes in aspects of patient care. A number of different individuals are required to effectively adopt and implement these changes. The first step for each participant is to assemble a team committed to accomplishing the goals and objectives. About three to five members of this intra-organization team should plan to attend the first Learning Session on March 5.

- Your team members will be adapting and implementing changes to improve care in each setting. Teams will be actively involved for the duration of the collaborative. Having appropriate and effective teams focusing on a specific problem is a key component of successful improvement. Choose your team members based on their knowledge of and involvement in the goal, and also by their work in the processes that will be affected.

Your own project team should be larger than just the individuals who attend the Learning Sessions, but not so large as to make it difficult to get work done. A team of 5-6 individuals is about right. The team should have representation from administrative leadership, clinical/technical expertise and day-to-day



unit leadership and staff. Team members should include physicians, midwives, nursing and maybe coding staff.

The *system leader* is someone with sufficient authority in the organization to institute change and to allocate the time and resources necessary to achieve the team's goal. Significantly, the leader must have authority over all areas to be affected by the change. Examples of an appropriate leader in a hospital include a vice president for patient services, chief of obstetrics and gynecology or service line director. This person is on the project team, but may also be part of senior management. Often the system leader is the senior leader who "adopts" this team.

A *clinical expert* is one who knows the subject intimately and who understands the processes of care. It is beneficial to have at least one physician champion on the team, but could also be a clinical nurse specialist, midwife or nurse. This champion should have a good working relationship with colleagues and with the day-to-day leader(s) and should be interested in driving change in the system.

A *day-to-day leader* is the key point person for the project, assuring compliance with necessary assessments, interventions, and data collection. This person understands all the details of the process and the effects of change once made. This leader also needs to be able to work effectively with the clinical technical expert. The day-to-day person will be NJHA's "key contact" at your organization for the purpose of this project and will be responsible for coordinating communications between and among the onsite and partner team and the collaborative staff. The responsibilities of the day-to-day leader also include:

- Telephonic communication and meeting facilitation
- Orchestration of team activities
- Overseeing preparation of reports and presentations
- Assuring timelines are met
- Acting as the official team data collector, recorder, and ensuring correct and thorough project documentation.
- Participates as a full fledge team member.

## 2. Who should attend Learning Sessions?

Your organization should choose up to five individuals who can work together effectively, learn the methodology and plan for action on return to the facility. The same individuals should attend each learning session if at all possible.

## 3. Get Started on Improvement: Defining an Aim

You will be asked to set a goal for your team. We will review this with you during our first set of monthly conference calls. An aim is an explicit statement summarizing what your organization hopes to achieve during the collaborative. You could use the results of perinatal trigger tool to determine what you want to focus on. For example, an aim might be to reduce your organization's incidence of inductions prior to week 39. The approach to improvement we will be using in the collaborative is based on three fundamental questions:

- (1) What are we trying to accomplish?
- (2) How will we know that a change is an improvement?
- (3) What changes can we make that will result in improvement?

In setting your aim(s), be sure to do the following:

- Involve senior leaders – leadership must align the aim with strategic goals of the organization.



- Base your aim on data – do you know what your current data shows?
- State the aim clearly and use numerical goals – teams make better progress when they have unambiguous, specific aims. Setting numerical targets clarifies the aim, helps to create tension for change and directs measurement. For example, an aim to decrease elective inductions prior to week 39 by 10 percent will be more effective than the aim to “reduce the elective induction rate.”

#### **Example of Aim:**

Aim: To redesign the care systems of your facility in order to reduce harm and improve outcomes for patients using the following goals:

- Implement the use of SBAR as a communication tool by some date.
- Reduce the incidence of elective inductions prior to week 39.

#### **4. Assess Your Organization**

This collaborative is about improvement in care, not just measurement. But measurement will play a number of important roles throughout the collaborative. Assessment and measurement of the quality of care and patient safety is an important ongoing component of a health care organization serious about the care it provides its patients. Measurement is required to assure that all staff members stay aware of changes in level of care and safety.

Measurement will help you evaluate the impact of changes you make to improve care in your facility. Always remember that measurement should accelerate improvement, not slow it down. Your team needs just enough measurement to be convinced that the changes you are making are leading to improvement. We will not be comparing data across organizations – we are only asking that you measure to provide feedback to your team on how you are improving.

- **Do a Walk Through**

Your work in the collaborative will lead you to fundamental system change, but even with a strong aim, you may not know where to begin. One simple way to understand where major problems lie is to experience your system. We are strongly recommending that at least two members of your team do a “walk through” of your system prior to the First Learning Session.

- **Tips for Making the “Walk Through” Most Productive**

Determine with your team where the starting and ending points of your walk through should be taking into consideration issues of hand-offs, unclear communication, unclear roles, etc.

Set aside a reasonable amount of time (at least two hours) to conduct the walk-through. Make it real. Make a realistic paper trail of charts, lab reports, referrals, transfers, medications, etc. During the walk through, note both positive and negative experiences, as well as any surprises. Where was communication unclear? Where was the system so complex that the next step was difficult? When was needed information not available?

If possible, meet with your team and debrief them on what you did and what you learned.



## Collaborative Glossary

### Action Period

The period of time between Learning Sessions when facility team and partner teams work on improvement in their sponsoring organizations. Teams are supported by the Collaborative Leadership and Faculty, and are connected to other Collaborative Team Members.

### Aim

A written, measurable, and time sensitive statement of the expected results of an improvement process.

### Annotated Time Series

A line chart showing results of improvement efforts plotted over time. The changes made are also noted on the line chart at the time they occur. This allows the viewer to connect changes made with specific results.

### Change Concept

A general idea for changing a process. Change concepts are usually at a high level of abstraction, but evoke multiple ideas for specific processes. "Simplify," "reduce handoffs," "consider all parties as part of the same system," are all examples of change concepts.

### Collaborative

A time-limited effort (usually six to 12 months) of multiple organizations that come together with faculty to learn about and to create improved processes in a specific topic area. The expectation is that the teams share expertise and data with each other thus, "Everyone learns, everyone teaches."

### Collaborative Team

Involves all participants in the improvement effort.

### Cycle or PDSA Cycle

A structured trial of a process change. Drawn from the Shewhart cycle, this effort includes:

- Plan - a specific planning phase;
- Do - a time to try the change and observe what happens;
- Study - an analysis of the results of the trial; and
- Act - devising next steps based on the analysis.

This PDSA cycle will naturally lead to the Plan component of a subsequent cycle.

### Key Changes

The list of essential process changes that will help lead to breakthrough improvement, usually created by the Collaborative Chair and Faculty based on literature and their experiences.

### Learning Session

A one-day meeting during which team members from participating organizations meet with faculty and collaborate to learn key changes in the topic area including how to implement changes, an approach for accelerating improvement, and a method for overcoming obstacles to change. Teams leave these meetings with new knowledge, skills, and materials that prepare them to make immediate changes.

### Measure

An indicator of change. Key measures should be focused, clarify your team's aim, and be reportable. A measure is used to track the delivery of proven interventions to patients and to monitor progress over time.



### **Model for Improvement**

An approach to process improvement, developed by Associates in Process Improvement, which helps teams accelerate the adoption of proven and effective changes.

### **PDSA**

Another name for a cycle (structured trial) of a process change, which includes four phases: Plan, Do, Study, and Act. (See the definition of "Cycle" above.) Sometimes known as Plan, Do, Check, Act (PDCA).

### **Pre-work Period**

The time prior to the first Learning Session when teams prepare for their work in the collaborative by selecting team members, scheduling initial meetings, consulting with senior leaders, preparing their aim, and initiating data collection.

### **Process Change**

A specific change in a process in the organization. More focused and detailed than a change concept, a process change describes what specific changes should occur. "Institute a pain management protocol for patients with moderate to severe pain" is an example of a process change.

### **Run Chart**

A graphic representation of data over time, also known as a "time series graph" or "line graph." This type of data display is particularly effective for process improvement activities.

### **Sampling Plan**

A specific description of the data to be collected, the interval of data collection, and the subjects from whom the data will be collected. This is included on all Senior Leader reports. It emphasizes the importance of gathering samples of data and to obtain "just enough" information.

### **Senior Leader Report**

The standard reporting format for monthly progress updates in a collaborative. This concise one-page report includes a list of the changes made, and progress to date.

### **Team**

The group of individuals, usually from multiple disciplines, that participates in and drives the improvement process. A core team attends the Learning Sessions, but a larger team of six to eight people participates in the improvement process in the organization.

### **Test**

A small-scale trial of a new approach or a new process. A test is designed to learn if the change results in improvement and to fine-tune the change to fit the organization and patients. Tests are carried out using one or more PDSA cycles.