



ALLIANCE FOR INNOVATION  
ON MATERNAL HEALTH

## **Video Transcript: Leveraging System Strengths to Solve Capacity Gaps in Limited-Resource Environments Community of Learning**

**Allison Finkenbinder** [00:00:01] All right, we're gonna get started. Welcome to the first session of this community of learning, leveraging system strengths to solve capacity gaps in limited resource environments. Today's session explores how leadership exists across every level of an organization and serves as the primary engine for sustainable systems change. We'll be exploring how supporting leaders at all levels is essential for successfully implementing AIM patient safety bundles, particularly within limited resource settings.

**Allison Finkenbinder** [00:00:34] And this community of learning is hosted by the Alliance for Innovation on Maternal Health Technical Assistance Center, or the AIM-TA Center. You'll hear us refer it as. AIM is a quality improvement initiative to support best practices that make birth safer, improve maternal health outcomes, and save lives. The AIM TA Center is managed by JSI Research and Training Institute, a nonprofit public health consulting organization that works both internationally and across all 50 states. We are dedicated to improving lives through better health and education outcomes for individuals and communities. The AIM TA Center is supported by a cooperative agreement with the Health and Resources Services Administration of the U.S. Department of Health and Human Services. The contents in this webinar today are of the authors and they may not reflect the policies of HRSA, HHS, or the U.S. Government. Our goal for today is that this session supports you all and your organization in your work around implementing the AIM patient safety bundles and maternal health initiatives. Our hope is that by the end of the session, participants will be able to reframe that role of solo champion as a systems leadership position, and you'll be able identify where your sphere of influence is across the structures you work in and across relationships and goals. We hope you'll be able to apply strategies to build capacity and support even in low resource environments, for patient safety bundle implementation, and that you'll leave with a sense of how to leverage networks and partnerships in your organization and community to reduce isolation and increase the impact of the patient safety bundle. So before I introduce our speakers, I do wanna touch on a couple of housekeeping items. I'd like to introduce myself. My name's Allison Finkenbinder. I'm a TA specialist with the TA Center. Welcome to today. We do wanna let you know the webinar is being recorded and this will be available and on our website in the next two weeks. We will have time for question and answers at the end, but you don't have to wait to submit your questions. You can submit them anytime using the chat function. We also would love to see your faces. So please come off camera if you're able. And if you have a question and would like to come off mute to ask it later, it would be helpful if you have access to the raise hand function so we know that you have a question. Additionally, if you have a need for any technical support, you can use the chat feature to message any of the hosts directly. Look for those of us with this purple AIM background. And lastly, we welcome your feedback. It's really how we get better. We take it seriously, everything you tell us. So we're gonna share a link to the evaluation in the chat now, and we invite you to open it up and fill it out as we go along. And then we'll remind you about it again at the end of our time today. There we go, sorry about that. So I'm excited to introduce our speakers for today. First, I welcome to Tajan Braithwaite Renderos who is an ICF professional certified coach, leadership development trainer, and public health leader

with over 15 years of experience helping organizations strengthen leadership, communication, and team effectiveness. She specializes in supporting managers and senior leaders, many of whom were promoted without formal people management training and helps them develop practical, human-centered leadership skills that improve team culture and performance. She holds a Master of Public Health from Yale University and brings a unique blend of systems thinking, organizational development, and coaching expertise to her work. And I also welcome Patsy Welch, who is the Nursing Director of the Labor and Delivery Unit at Our Lady of the Angels Hospital in Bogalusa, Louisiana. With over three decades of healthcare experience, she has mainly focused on maternal child services. And since opening the Our Lady of the Angels Hospital Labor and Delivery Unit in 2008, Patsy's leadership has helped the unit achieve honors, such as gift designation, birth ready plus designation, the Catholic Healthcare Association Award for breastfeeding improvements, and the Making a Difference Award from the Gift Breastfeeding Collaborative. As a mother of five and grandmother to six, she deeply values nursing's impact on maternal care and consistently advocates for both patients and the community. So welcome Tajan and Patsy. And I will hand it over to you, Tajan, thank you.

**Tajan Braithwaite Renderos** [00:05:15] Thank you so much for the warm welcome, Allison. It's great to be with you all this afternoon. So we're gonna start off with a Zoom poll right away to make this as interactive as it can be, even though we're virtual. So I'm wondering if you all can think of a challenge that you're dealing with right now in AIM implementation. And I want you to be honest, like reflect on like what you really would do, not what you would ideally do, but what would you really do here? What's your instinct? Is your instinct to... a Challenge comes across your desk, fix the issue quickly, or do you tend to step back and look at the system? And just go ahead and provide your answer to that question in the poll that just launched.

**Tajan Braithwaite Renderos** [00:06:12] All right, we're going to give it a couple seconds more. And now we can close that poll and share back results here. Right. So 68% of you are saying that you tend to step back and look at the system and 32% of you are mentioning that you tend to fix the issue quickly. Now, even if most of you have the tendency to step and look back at the system in general in our modern society we're often trained to fix problems quickly especially in clinical settings where speed really matters. Right? But many of the challenges that we deal with in AIM are complex, they're dynamic, they're much like this visual bird murmuration image that you're seeing on the slide versus like fixing a car that just needs a new carburetor. Right? They're not mechanical problems, they are system problems. And systems don't respond to quick fixes the same way machines do. Right? So. You may not be using the language of systems thinking regularly but if you've ever navigated competing priorities, if you ever tried to influence folks across departments related to AIM work or adapted a bundle to your setting, you're already doing systems work. So today's about learning to see the system differently because when you see it differently, you can lead differently, you're already doing systems work. The webinar in part is really intended to help you name that work, strengthen that work and lead it more intentionally as you plan and implement and sustain AIM bundles, right? So I wanna make sure that we have a shared definition of what we mean by systems thinking here today. And at its core, it's really the ability to understand how different parts of a system interact and how that is shaping outcomes. But let's make this even more practical. It's pretty much this shift. So without systems thinking, if an issue comes across your desk, you're fixing the immediate challenge that presented itself. With a systems thinking approach, you are diagnosing the pattern that you've observed related to this this year, last year, five years ago. Patterns that other folks may be even seeing in PQCs in different states, right? Without systems thinking, you're adding more work. You're focusing on checking off the

boxes on your checklist. With a system thinking approach you're thinking about redesigning workflows, you're using evidence rather than your checklist. To inform strategic use of limited resources. Without systems thinking you might be focusing on individuals. Who do I need? Who do I have here? Who can do a thing? With systems thinking, you're not just looking at individuals to fulfill specific functional roles. You're looking at the nature of interactions and relationships between people in your system. So it's the difference between working hard and working more strategically. Now, one of the most helpful frameworks I've seen for really thinking about this work and applying it comes from Anna Birney. She's a director of the School of Systems Change. I encourage you to read more about her work. And what her work does, it really helps us answer a really important leadership question, and that is, where should I focus my effort to actually create change? And so Birney shows us that systems change is happening across three nested levels that you're seeing here on the slide. Level one is structures and flows. This is the visible part of your system. Think protocols, staffing, data systems. This is where your AIM bundles most naturally live, right? But here's a key insight. When things aren't working well at this level, it's often a signal that something deeper is happening. So level two gets at relationships and ways of organizing. This is all about how people work together. So at this level, when we're intervening here, we're actually intervening on things like trust, communication, power dynamics, shared understanding. And in many cases, what looks like a technical problem is actually a relationship problem, right? And then level three, which is our whole system goals. This big question here is, what is our system actually here to transform? And it's not that teams aren't thoughtful about work in this area, but how the goal is framed and how the framing of that goal shifts over time is gonna shape what gets prioritized, how decisions are made and what gets sustained. Now, at the bottom of the slide, you'll see the paradigm shift. This level is the accumulated result of the first three levels done well. This is the long-run change that we expect to see in assumptions, narratives. So in maternal health, a paradigm shift might sound like moving from, for example, maternal safety is a clinical issue handled by mostly obstetric experts to maternal health is equity-centered shared responsibility and reflects a system that depends on respectful care, learning and coordinated action. Across diverse settings. So to recap, systems change happens across these nested levels, structures and flows, relationships and ways of organizing, whole system goals and ultimately paradigms. So just to dive deeper here across each level, at level two, this is where systems thinking is really deepening, because change doesn't happen through structures alone, it does happen through people. And so the core question when you're designing interventions or experiments at this level is how are people working together, right? And so at this number, you're looking at shifting power dynamics, building trust where there is low trust. You're thinking about experimenting, changing ways of organizing, and new ways of working together. Right? Now, in order to do that, it requires a particular set of leadership behaviors, right? It requires that folks who are leading the systems change, build shared purpose, practice systems thinking, practice thinking at this level regularly. And that looks like engaging in collective learning, dialogue, ongoing reflection, right? So those are things that are just required behaviors in order to do this work well. And then if we take a deeper dive on whole system goals. At this level, we're really asking, what is the system actually there to transform? And Birney gives a wonderful reference that's an illustrative example of this, right? Which is, she looks at the education system as an example here and she says, okay, if the goal of the education system is to transform children so that they can participate in our society, you'll get a certain set of outcomes results from that. But if our goal is to foster their capacity to learn and question, we're gonna get an entirely different system, right? Just based on that alone, all right? And so what we're doing at this level is we're stepping back even further. And so when you think about this from maternal health, if the focus is narrowly on implementing specific practices, then that's gonna shape how the

work unfolds. But when the goal starts expanding to something, to a bigger goal, right? Like safe, equitable, respectful maternal care across the entire journey. Then that's gonna change priorities, decision-making and sustainability, right? And that work really aligns with what Michael Lu, Dr. Michael Lu calls a whole person, whole community systems approach, okay? And so we've been talking, you know, translating Birney's framework in theory. But what I want to do now is turn back over to Patsy, who's actually gonna talk about how systems thinking happens in the real world in AIM settings to make this much more tangible. So with that, I'll turn over to Patsy.

**Allison Finkenbinder** [00:15:25] And I think we were working to make sure that Patsy can see the slides. Any luck, Patsy?

**Patsy Welch** [00:15:32] Um, I'm just going to let you advance them. I pulled them up.

**Allison Finkenbinder** [00:15:36] Um, okay.

**Patsy Welch** [00:15:37] And we'll just work from there.

**Allison Finkenbinder** [00:15:39] Okay.

**Patsy Welch** [00:15:41] All right. One second. Let me get there. Hi, I'm Patsy Welch. I'm from Our Lady of the Angels Hospital in Bogalusa, Louisiana. As you can see on this slide, we're in the toe of the boot and we opened this unit in 2008 after we did not deliver obstetrical services in the parish for a 10-year period. So when I came to work here, it was stale walls. It was a highly impoverished population. I had to hire 23 nurses, put all those skill sets together. So there was many challenges that I faced as I was implementing this and learning the patient population that we had. It was huge opportunity to do the work in our community. So we surely embraced it. We have a level one nursery. We deliver about 240 babies a year. You can go to the next slide. So when I came to work here, I realized that you didn't have the tools and the resources of a big hospital. I had come from a big hospital. So right away, I learned that I was in charge of my own data. I was also in charge my own education. I would teach also NRP. I would also teach fetal monitor courses for the staff. I would have to be staff sometimes. I would have to come stay the night when we were short and later on as I started growing our work in a community then I began presenting out into the community and then throughout the state I became the chairman of the board of the directors of the Southeast Louisiana Pregnancy Center for Women and Children that we decided to partner with the hospital. And just a lot of work, a lot hats to wear. If you're from a rural hospital, then you do understand what that work looks like. So a pivotal moment in my career here at Our Lady of the Angels was we were invited to New Orleans to attend a conference by the governor of Louisiana and the cause of the meeting was the morbidity and mortality rate in the state of Louisiana was one of the highest in the nation and the leading cause of death that was determined at that point was hemorrhage and hypertension, cardiovascular disease. At a panel of many families that's the mothers had died and the majority of these calls was the hemorrhage and hypertension. And it was a very moving and a very touching conference that I attended. It really moved me into action that if it wouldn't be when, but if this would happen to us, if we did not put things into place to mitigate the severe hypertension, hemorrhage, and the outlying causes of a primary C-section rate and the risk factors that go along with that. And at first, honestly, I did not think I had a problem with hypertension management. I was like, we did great with that, but we're going to go ahead and review these charts and kind of see where we are. And as I was reviewing the charts, I discovered, oh no, we really don't manage severe hypertension very well. And then I would look at those charts and there would be patients

that were not treated properly. And then 100% of the time, they would be re-admitted to the hospital. So, about 2018, we began the work with LAPQC, and they introduced us to these fantastic AIM bundles and ASIM education that we started using to put this work in place. We developed algorithms, protocols. The algorithm that we developed, we had it laminated and placed at the nurses station. We started educating the residents, the nurses, all the staff that had something to do with labor and delivery. You can go to the next slide. And during this process of education, one of the residents approached me about a patient that presented to the ED that was post-partum and she went over the whole case from then. She said, I just don't think we treated this patient right. She had hypertension, and we sent her home and told her to follow up with a doctor. So right then I knew that we did need to spread this work beyond the four walls of our L&D unit. And so we started educating the doctors and the nurses in the ED. And then later it became an annual training in the ICU and the med surge units. But at that point though, we knew that, well, we did have a patient population that was falling through the cracks that were presented into the ED. You can go to the next slide. So not long after we started this work, we had this 26 year old gravida five, para five, that is post vaginal delivery seven days and she presented to the ED because after she had a syncopal episode it had a worsening headache after percocet treatment and she could not recall the incidents that occurred before her arrival. Her initial blood pressure is 123 over 78 respirations 18 sats 97. She's sensitive to light and sounds as she had blurry vision and what kind of clouded the picture a little bit was that she had a wet tap seven days prior that she was treated for and that kind of like convoluted the picture a little bit that she still had the problems from the epidural. A call was placed to the OB physician per protocol that we had developed and the OB physicians said go on ahead and get her over to labor and delivery. She continued to have the same complaints but at this point her pressures were systolic 170s. Her platelets and liver enzymes were within normal limits. The UA with signs of protein urea, LDH was mildly elevated. UA with mild evidence of a UTI. So she was given Keflex in the ED. We decided to treat this patient with a hydralazine. She got a five milligram IV dose for the pressures and give her a load of magnesium milligrams. And due to the the lethargy and the loss of memory and the continued headache, the physician obtained a CT and a CRNA was consulted for possible blood patch procedure through the suspicion of the spinal headache. Well... To our shock, it came back that this patient had a subarachnoid bleed, she has cerebral edema, she had posterior reversible encephalopathy syndrome and hyponatremia . So because we were a level one facility, we quickly got Tulane Medical Center on the phone and got her transferred over to neurosurgery. Well... I called the ED director over and I said, I want you to look at this chart and he goes, oh God, what did we do wrong this time? I said no, I just wanted you to look at it and give me your opinion. And he said, well, honestly, I think that we would have sent this patient home from the emergency department because of her blood pressures were not in the range that we thought they should be treated. So that let me know the work that we were doing was much needed and we were able to mitigate the terrible would have possibly been a terrible outcome. You can go to the next slide. Thank you.

**Allison Finkenbinder** [00:24:34] I think we're going to pause here. I'm going to hand it back to you Tajan for just a second.

**Tajan Braithwaite Renderos** [00:24:38] Thanks. Thank you so much, Patsy, for sharing your work with the ED and on this hypertension bundle. So we just wanted to do a quick audience check-in. Before Patsy was speaking, we talked about the different systems change levels, right? Level one being your structures and flows, level two being repatterning relationships and ways of organizing and level three whole system goals. Based on what you've heard from Patsy so far, as it relates to this particular case of the

work expanding beyond her four walls into the ED, what levels of systems change are you seeing at work here? And I'd love if you could just drop your responses in the chat or raise a hand and just jump off mute, but what have you noticed? So far. And you can chat to everyone. You can chat privately to me as a presenter, or just raise a hand and jump off mute, or just jump off. All right. So Molly, you're saying that you're seeing level two. Might you be able to just jump off mute and expand on what you're noticing at level two here?

**Molly** [00:26:07] Sure. Can you hear me?

**Tajan Braithwaite Renderos** [00:26:09] Yes, we can.

**Molly** [00:26:10] OK. I have bad internet connection, so I'm leaving my camera off. I guess I was thinking of the interactions with the ED, so kind of two departments working together wasn't quite at the level of level three, but leading there, so that's what let me think, level two.

**Tajan Braithwaite Renderos** [00:26:33] Absolutely. And I want to elevate some other responses in the chat. Thank you, Molly. Rebecca, you mentioned all of them. It probably started in level one and two, but then now three as well. Can you just expand on what makes you say that?

**Rebecca** [00:26:51] Hello, everyone. I really appreciate the story, Patsy. That was incredible. I guess I'm hearing that you were working on this process for a long time, that you did have a lot of protocols and plans, especially well-developed with your OB department, but then this patient showed up in the ED, and so that sounds like a level two relationship building. And then now, as you're that final chart review and discussion with everyone. You're realizing, you know, with the low pressures, that first initial vital sign check, it was like 120s over 80s, still sounded pretty good. So it could have been missed. She could have been sent home. I'm so glad she wasn't. But yeah, I think you're working on all three.

**Tajan Braithwaite Renderos** [00:27:35] Exactly. Anybody else have anything else? Any other nuance that you all picked up that hasn't been mentioned as yet? Whether you can drop that in the chat or just jump off mute. And Lynette, if you were seeing something different or wanting to expand on what you chatted out here, feel free to jump off mute too.

**Lynette** [00:28:04] I agree with the previous speaker there that I see that they started out really working hard level one in their area and then developed to level two, working hard with the ED, but now seeing how it affects everyone and all the patients. So I agree that they're moving to level 3 as well.

**Tajan Braithwaite Renderos** [00:28:30] Thank you, Lynette. So it's a fabulous case example of how this works in actual practice. And so Patsy's got more to share. So I'm gonna turn back over to Patsy and just keep your questions streaming in or comments as we go. We will be monitoring them. And I just wanna elevate before I transition that Rebecca mentioned, I guess level three, which also includes working with other hospitals because you needed to transfer her, et cetera. So yes, absolutely. So I will transition back to Patsy who's gonna talk a little bit more about their SUD initiatives.

**Patsy Welch** [00:29:14] Reference in the maternal health initiative substance use slide. In 2019, we began the work with patients that were identified with substance use disorder. But this work really went back to 2008, where we opened the unit and we suddenly

realized that we had a 30% positive substance use disorder population. And all of the nuances that come with that, like referral, how do you refer, who do you refer to? And also the treatment of the mother and the newborn. And we did not really seem to have a steady fast solution to the problem of these moms with substance use disorder. And we were seeing these moms losing their children, not one were able to keep them. Now, if it was THC, yeah, they took their baby home, But. As far as referencing opioids or meth or cocaine or whatever. We were seeing that these moms were not bringing their babies at home at all. And we were grappling with what solution that we could come up with to help these moms with the substance use disorder. Though we were approached by LAPQC to apply for a grant and initially, LAPQC, they turned us down for the grant and they came and met with me and I said, why didn't you give us the funding? Was it because of our volume? And they were like, yes, it was because of the volume. I said well, I have a plan. If you'll listen to me on how we can best treat these moms, if we can get this money for this grant. And I presented to them that we would identify these patients in the clinic with using the SBIRT process, the screening, brief intervention, referral, and treatment, and that we would get all of our residents trained on how to treat with a medication-assisted therapy, such as buprenorphine. And with that funding, we could send all those residents, OB doctors, family practice doctors, to training, because at that time, you had to be MAT trained to write those prescriptions, and I explained the problem that we were facing and the high substance use population that we did have. So they agreed to find me some funding from somewhere, which was great. They were very moved by our mission and vision, and we seemed to have a formalized plan on how we were going to proceed with the treatment of these patients. So we started this work, as I referenced, using the SBIRT process. We put together a team and this was all the stakeholders, the directors of the clinic, the directors of pediatrics, the social workers, and we all met and we decided how we were going to move forward. It was um a great deal of work. We met with our community stakeholders that we would be referring to and one of our big partners was DCFS and how we could gain the trust of DCFS and let them know that we want to put this plan in place and how we could best move forward well if a mom participated in treatment, that she could keep her baby if she had a suitable home for that child. So we began the work and it wasn't long after we started the work that we had a patient that you will see in the next slide. I'm not gonna ask her to go to the next slides yet, but you'll see her in the next slide. She came to us from St Tammany Parish Jail, a jail adjacent to Washington Parish. And she had... Had been using heroin for eight years. She was 18 weeks pregnant and we treated her with non-biased treatment. She expected, she was like, I was always told don't go to the, definitely don't go to doctor, they're going to take your baby away. And she said, I thought, well they would be standing there at my bed right away ready to take my baby away when I delivered. But nothing was further from the truth. She said I was mad with the physician. With a big bright smile on his face. And how are you doing today, Ms. Rachel? And we started her on buprenorphine. She went back to the jail and they released her prior to delivery. Even though she lived 45 minutes away, she came back to deliver with us because of the treatment that we had given her. And we actually had began a process of implementation of Eat, Sleep and Console. Actually, Tajan may be aware of this, but Eat, Sleep and Console was out of Yale. It's a treatment modality other than using the Finnegan Abstinence scoring system that if the baby can eat, sleep, and console, then we would not treat them with morphine. So we piloted the Eat, Sleep and Console with Rachel. And she was able to remain with her baby, and she was able to breastfeed and I think her baby ended up staying like seven days and they both went home together, which is a fabulous story. If you have the time, if you can go at the end of this presentation, there's some videos that you can look at. And we share that Rachel's story and how we did the work because it's very comprehensive. It would take probably an hour to talk about. But during this process, we taught our staff about bias. We trained them that words matter

and the appropriate words to use. We don't refer to our patients as the druggies or people that have a habit or... Abusers or any of those stigmatized words, and we just developed a culture here at Our Lady of the Angels that we would treat these patients and meet them where they are. And I would say today we have like a 50% success rate with these moms taking these babies home and that are participate in our program. You can go to the next slide. We started this work, like I told you, in 2019, and here we are. We're in 2026. We have met with community entities. Rachel has spoke. Louisiana has developed a Project Mom to combat opioid overdose being the number one cause of death in the pregnant population. Rachel went and spoke at this conference where we presented Project Mom to the state and now we are the catalyst site for Project Mom and the model that we have developed in the state is the model, or the model we have the developed here at the hospital is the model for the rest of the state. And it's just so moving. How just a little a small plan that we had developed just to treat our patients is is being so impactful and you don't know when you start this work how far reaching your work could actually be. We have made the front page of the Times Speaking Union which is the state newspaper, the Catholic Health Care Association and our local newspaper. We have allowed Rachel to tell her story. She has now been clean for five years. She is a peer counselor for Humana Health and she's doing very well, but we have more stories like Rachel and it's very rewarding work and it is very rewarding to see her be so successful and turn her life around. I'm gonna go to the next slide. So we've been sharing our data with the rest of the state. We're leading the way, of course. And just to... Go back to some of our prior implementations. Our NTSV rate, PCO2 has been 16% the last six months, and nationwide it's like 23%. Our severe hypertension management rate last year was 95% successful treatment. And for the helping, with the hemorrhage, we have implemented quantitative blood loss, and we're 92% on that across the vaginal and cesarean delivery. We have added patient advisors, which Rachel is one of our patient advisors. But we have two more. And we've also developed a community partnership where one of our patients and I are on the board together at the Pregnancy Center. And we have other key stakeholders from the hospital plus the community to form a partnership on that board to meet the needs of that community and help that client population. And thank you all for allowing me to present today. And if you have any questions, I think later on in the presentation, you'll be able to ask those.

**Tajan Braithwaite Renderos** [00:39:52] Actually, I'm wondering if we can just make some space for any clarifying questions that people may have for you now, Patsy. Are there any questions that people have after hearing all of that? Feel free to jump off mute or just drop your questions in the chat.

**Carrie Redman** [00:40:20] I'm going to jump off mute. I am Carrie Redman. I am the perinatal quality, one of the Initiative Improvement Advisors for the LAPQC. And I just want to tell you that Patsy is a one-woman show that has done a lot and is learning a lot more to spread her work and ask for help. But she has done so much work in her hospital. They also consistently are always reporting data, and they are doing so many things that are around our designations, as well as all of the many initiatives that the LAPQC falls under the umbrella LAPQC. And she also talked about some other initiatives in the state that are not part of the LAPQC, like being a catalyst site. Um, so. They do very important work and Patsy has been a key player in that. And I think if you are a smaller facility and you're thinking, how can I do this? Or how can do this work? Or how I can start small? Patsy has done that and started out, you know, again, she's told you her first story and now they are one of the greatest influence in our state. I could be a little verklempt over this because I just feel like she's done some amazing things along, you now, so many landscapes. And she actually has changed the culture within her hospital. And so they are a great leader of

quality improvement. So again, I know AIM is about collaboration and learning and you can learn a lot from Patsy and her team at Our Lady of the Angels, definitely.

**Patsy Welch** [00:42:05] Thank you, Carrie.

**Tajan Braithwaite Renderos** [00:42:06] Thank you Carrie. Just wanna elevate a few comments that came through to the chat in addition to all of the love that you got here, Patsy. But Megan mentioned, I love hearing how you did this. We currently partner with a community agency to support our moms with SUD. But to hear that your hospital or state is so accepting of this is incredible. Kudos to you. So lots of folks saying, giving you kudos and talking about the great job that you've done here. So I'm going to move along here and we're going to have, again, more time for questions. So Patsy has been talking a lot about how she's been doing the systems work at her local level. But when you go back to your desk, I want you to also be thinking about where you have opportunities to do systems change work. And the question that it begs is how do you know where and when to intervene? And so one of the most powerful ideas from Birney is that the system itself is going to signal to you where change is possible, right? So then your job isn't necessarily to push everywhere. That's overwhelming. But it's the notice where the system is already opening. The system itself is giving you cues in the form of data, in the saw. And so, here are some indicators on this slide that kind of show you where there are different entry points that you can have. So, for example, you may notice or you may ask yourself, where is the system exhibiting existing momentum or a clear urgency for change? That can be an entry point. Where are we not seeing information that we need to see or, you know, where is there some kind of information gap? That can be an entry point. Where are there emerging approaches, right? Where is new ways of working already starting to gain traction? Where is there already readiness for change? Where are people already kind of wanting to make change happen in a particular direction? Also, new partnerships. Where are new partnerships or innovative approaches being tested? When you see new partnerships forming, that's often a signal that the system itself is ready to move toward collective impact. And alignment, like where are goals or funding, even from disparate places, efforts already starting to align. All of these places are kind of potential entry points. Now there is a systems thinking diagnostic tool that we sent to you earlier on over email and that we're also going to drop in the chat that you can use to kind of go through this process of diagnosing where you can potentially be crafting a systems-thinking intervention, right, across whatever level. And at the bottom of the slide you'll see those same questions that we had flagged before, which can be used as stimulus for you to think of like, okay, where can you be intervening? Whether at the structures and flows level, the relationships and ways of organizing level, or the whole system goals level. What we want to do now is actually give you some time to pause and reflect on this, given your own setting. We're going to actually have you partially complete the systems diagnostic tool. And when I say partial completion, what I mean here is you're gonna think of one AIM-related challenge, and you wanting to think of where you could have a systems level intervention, right? What level is it really happening at? And how might you employ a systems thinking strategy to intervene? So if anything, you're thinking of completing just one row of this table, if you will. And what I'd like for you to do is just drop in the chat "done" when you're done with that exercise and then we're going to have a bit of time to debrief as a large group on it. Just drop "done" when your done in the chat and ask us any questions if you have any. I'll just play a little bit of music, give you all like three minutes to do this. All right, I'm noticing that there are a few "dones" in the chat. So I would love if anybody could just jump off mute and reflect on in at a high level around kind of what you reflected on and wrote about. Feel free to just jump off mute. And, you know, either

Regina, Audra, Faith, anybody who's dropped "done" in the chat, feel free to jump off mute just to share.

**Regina** [00:47:09] Yeah, this is Regina. So I'm thinking about a change. One of our measures is above benchmark, which is not a good thing. It's supposed to be the other way around. And we have some relationship building to do. And I think one of the strategies that we're working on or trying to do really is making sure we have champions in each of the different disciplines and trying to get kind of a cross disciplinary team together to have those conversations.

**Tajan Braithwaite Renderos** [00:47:41] Absolutely. So really what we're seeing is a lot of level one and level two work there in terms of relationships and different ways of organizing and different ways of building relationships across folks who are maybe in different silos. So thank you for sharing that, Regina. Is there anybody else that wants to just jump off mute and share kind of what experiment or intervention is occurring to you as a systems level experiment that you might wanna run?

**Audra** [00:48:17] Hey, it's Audra. I can share. One thing that we've been working on or I've been talking with facilities with regards to the SUD patient safety bundle is just around provider engagement. There's a lot of questions with regards to after we screen individuals and they screen positive, then what do we do? So. Provider engagement has just been a bit of a challenge in some of the facilities. So some thoughts around there is really looking at, do we have a provider champion who can really work with his or her colleagues to support this work? Some C-suite support, how does this initiative tie to the hospital's strategic goals? Use data to really illustrate what this what this problem looks like for these facilities. And I loved Patsy's examples of really using those patient engagement stories and having and inviting individuals with lived expertise share their experience to illustrate the impact of what evidence-based treatment and that support and guidance can do for them. So that's what I was thinking about.

**Tajan Braithwaite Renderos** [00:49:41] Thank you so much, Audra, for sharing that. And I wanna make sure we have time for questions. So I want to leave you with this. You don't necessarily have to change a system by pushing harder inside it, but you can change it by understanding how its parts are working together or not working together and then shifting it intentionally. So this systems diagnostic tool can be an instrument that you use in partnership with colleagues who are sitting in different places within your system. Start diagnosing the system and then thinking about how folks can collectively start running experiments to shift things. And so with that I know there are some questions that did come in the chat. So I'm going to transition back to Allison for some Q&A here.

**Allison Finkenbinder** [00:50:36] Thank you Tajan. Yeah, I wanna just call out one from Audra. This is for you, Patsy. Could you provide more insights regarding how you provided ASPR training to providers? Did you use a specific training module or share about that?

**Patsy Welch** [00:50:54] Basically when we started the whole process of how we were going to implement treatment for substance use disorder, we all got together in a room and we discussed how we're going to screen the patient with screening tool we were gonna use and then go through the different ones that we were going use because we met and interviewed a lot of community resources including DCFS to decide who we're gonna use. And they were all part of that process. They were able to interview those community partners and that's what provided the best collaboration between us and the community because they had a face with the name and with the phone number and we all exchanged

cell phone numbers and like DCFS they had all the providers cell phone number so we were we developed a great collaboration between ourselves. And then the clinic, they'd give us some kickback about, well, doing this extra screening, how long it's gonna take. So we did time studies in the clinic too, to tell them how much longer it would take to do the screening. That was one of the PDSAs that we did do.

**Allison Finkenbinder** [00:52:08] Great, thank you. I invite others to come off mute or to drop your questions in the chat. I have a question for you, Patsy, while we're waiting for other questions to come in, but I was wondering if you could share how you handle extracting the data. You mentioned data a lot throughout for, you know, different initiatives. How do you handle extracting that data and the challenges with that?

**Patsy Welch** [00:52:46] We use Epic, that electronic medical record. We've struggled with the use of Epic. We can get some data out of Epic, but some of it has to be manually extracted. And I utilize staff to help me. I have sheets that I leave on the chart, and then when the patient's discharged, then they go through and they add the information that we would need. For the chart extraction and that kind of gives you a foot forward on that and those that you have to look at more deeply then you can go into that chart and I also have delegated to one of my nursing staff and I allocate like eight hours to her to help her review but I'm part of a hospital system and we all are plagued with the same problem. And they deliver a lot of errors way more than me. One of them is the top deliver in the state and we will have to do a lot of manual extraction unfortunately.

**Allison Finkenbinder** [00:53:51] All right, thank you. Again, if anyone has any questions, please come off mute. Or drop it in the chat. I have a question for you, Tajan. And it seems like this has kind of come out over some of the cases and through what you've shared with us. But when we're thinking about these levels, do we work at one level only? Are we trying to work across many levels at the same time? How do we do that? It seems like a lot. I'm just wondering if you could share thoughts on that.

**Tajan Braithwaite Renderos** [00:54:34] Or so I actually think one of the most important mindset shifts in systems thinking is realizing that you're almost never working at only one level, right? Like what usually happens is that we enter the work at one level. But sustainable change requires movement across the levels over time, right. So for example, many AIM teams might begin at the structures and flows because that's where the work is most visible. So you may implement a protocol, redesign an escalation pathway. But very quickly, you're gonna realize that a protocol only works if people trust each other enough to use it. Escalation only works if we have communication patterns to support that. That only matters if we're, if we share learning around it, right? And so that moves us into the second level, which is relationships and ways of organizing. So the levels aren't separate silos, they're nested and they're interacting. And a change in one level is almost gonna create pressure or opportunity or tension in another. Now, if we have solo champions who harness that opportunity, which is what we're seeing Patsy do, then you can be moving across the levels, right? And then over time, if enough change happens consistently, then the organization begins to rethink its larger purpose. Now it's not just only about my hospital, now it's about the state, now it is about, right. And so that's where whole systems goals start evolving and even paradigm shifts begin to emerge and move. So I think Birney's framework is especially helpful, because it's reminding us not to ask, what level should I work at, but rather what level am I entering through and what other levels need to move with that, right? So I'm hoping it helps.

**Allison Finkenbinder** [00:56:16] Yeah, thank you so much, Tajan. Well, we just have a minute left. So if you have questions, please put them in the chat or we also wanna share our speakers have graciously shared their contact information. So if you wanna reach out to them, they are good with that. If you could all help me just give a big round of applause to our speakers today. Thank you so for being here. If you'd like to learn more about the work on the substance use disorder for Pregnant and Postpartum Patients, that work that's happening in Louisiana, we're gonna put a link to those videos that the Louisiana PQC created. So that is in the chat. We also ask, back to our evaluation, please fill out that evaluation. Make sure you hit submit. And then lastly, we just invite you to join us at the final clinical refresher, which will focus on safe reduction of primary cesarean birth. That is a half hour webinar next Wednesday on May 27th. The registration link will be put in the chat. And our last, last thing is we invite you to join us at the AIM annual meeting. And that is in Arlington, Virginia, June 15th through the 17th. The deadline to register is May 29th. We still have spaces open and we invite you to come so we can continue these discussions together. Thank you all for joining and take care everyone. Bye-bye.