

ALLIANCE FOR INNOVATION
ON MATERNAL HEALTH

# 2025 AIM Sustainability Community of Learning (COL)

Friday March 21, 2025 3:00PM-4:30PM (EST)



The Alliance for Innovation on Maternal Health is a national, cross-sector commitment designed to support best practices that make birth safer, improve maternal health outcomes, and save lives.

You can find more information at saferbirth.org.

This program is supported by a cooperative agreement with the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UC4MC49476, Alliance for Innovation on Maternal Health Technical Assistance Center. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.



- ▶ You are **muted** upon entry to the call.
- You will have the ability to unmute yourself during Q&A times.
- ► We encourage participants to **remain muted** to reduce background noise.
- ▶ If you are experiencing technical difficulties, please chat an AIM staff member or email aimdatasupport@acog.org

This presentation will be recorded.

Both the slides and recording will be available on the AIM Sustainability COL Webpage and shared in the Monthly Digest newsletter.



01 02 03 04 05 Q/A & Closing **Upcoming Speaker** Welcome & **Breakout Introductions Presentation:** Sessions Session **Planning for QI Initiatives** with **Sustainability** in Mind



### **Meet the AIM Data Team**



Izzy Taylor Senior Manager, AIM Data Program



Sadie Shireman Program Manager Evaluation



Inderveer Saini Program Data Analyst II



**Rekha Karki** Program Data Analyst



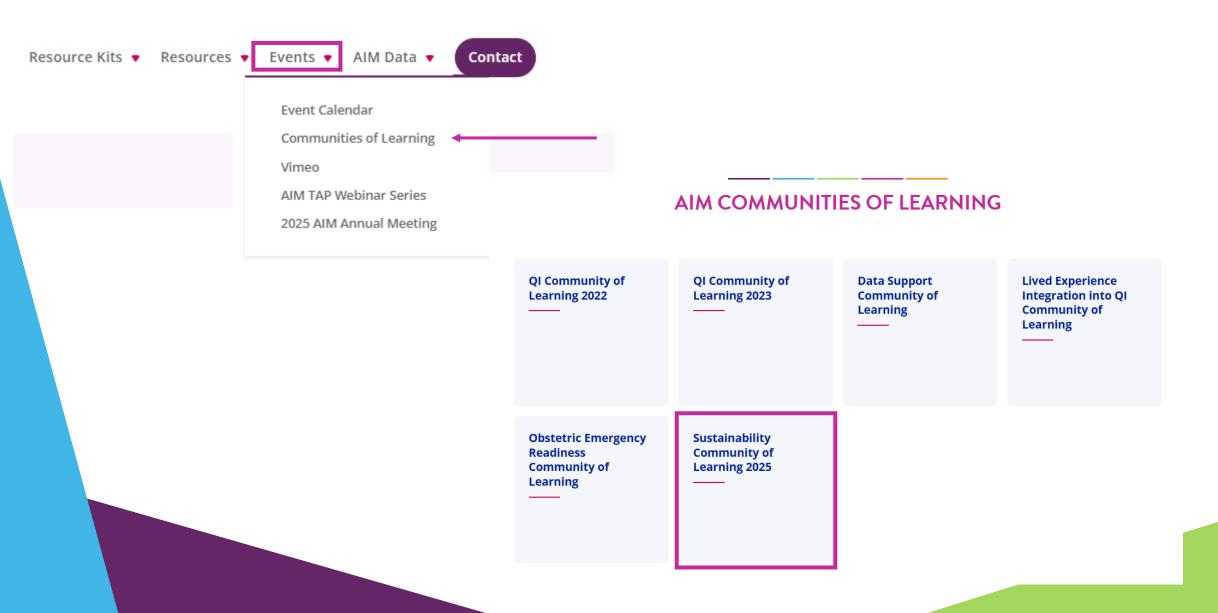
David
Laflamme
Epidemiology
Contractor



# **Upcoming Sessions**



#### Visit: saferbirth.org







Ronald E Iverson, MD, MPH

Massachusetts General

Hospital



Audra Summers, MSN, RN, CPHQ
Women, Children, and Families
Commission, Indiana Department
of Health

### Alliance for Innovation in Maternal Health Sustainability Community of Learning

# Quality Improvement with Sustainability in (Front of) Mind

March 21, 2025

Audra Summers MSN, RN, CPHQ

Clinical Coordinator: Women, Children, and Families Commission, Indiana Department of Health

Ronald Iverson, MD, MPH

Co-Chair, Perinatal Neonatal Quality Improvement Network, Massachusetts

# How do we keep this project moving forward?

Creating a path for Sustainability



#### **Disclosures**

- The presenters have no financial relationships to disclose
- The presenters will not discuss any off-label or investigational use of medications in this lecture

### **Learning Objectives**

**Define sustainability** 

Identify key elements for sustaining QI initiatives

Develop a process to ensure improvement and leadership teams can bring new interventions to care when appropriate and identify when projects are not meeting desired goals

### What is sustainability?

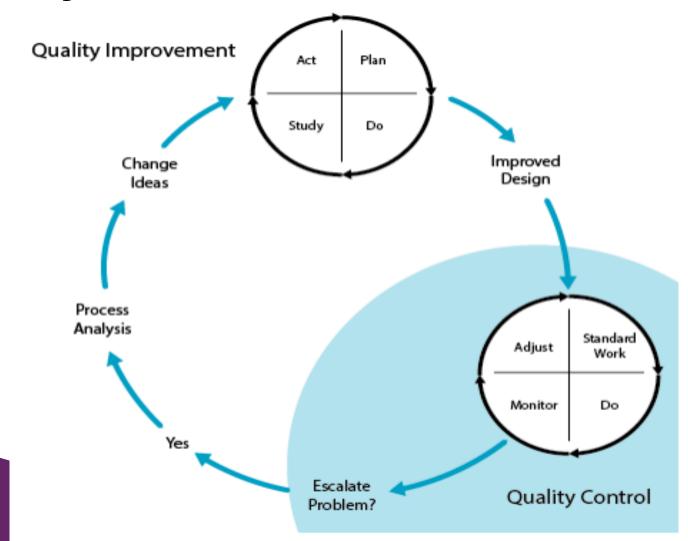
- "Ensuring gains (outcomes) are maintained beyond the life of the project, or the institutionalization or routinization of programs into ongoing organizations systems"\*
- Why did we do this project in the beginning?
- Is that still a goal?
- Sustainability is not "keeping things as they are." It is continuing to understand the outcome/goal we want and evolving the processes.

\*https://www.ahrq.gov/hai/tools/ambulatory-surgery/sections/sustainability/training-tools/slides.html

# Why is sustaining improvement so important – and so difficult?

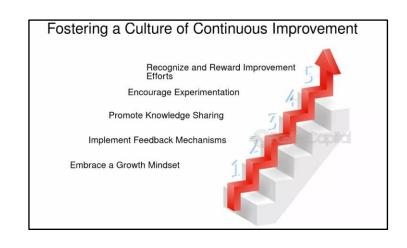


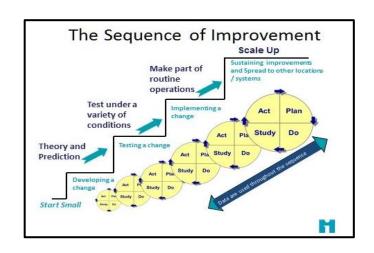
This is the cycle that we're going to think about today



# Why is sustainability so hard? First, it's not as interesting as improvement

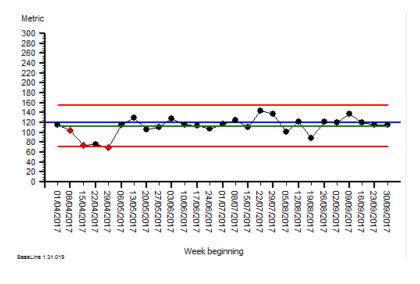










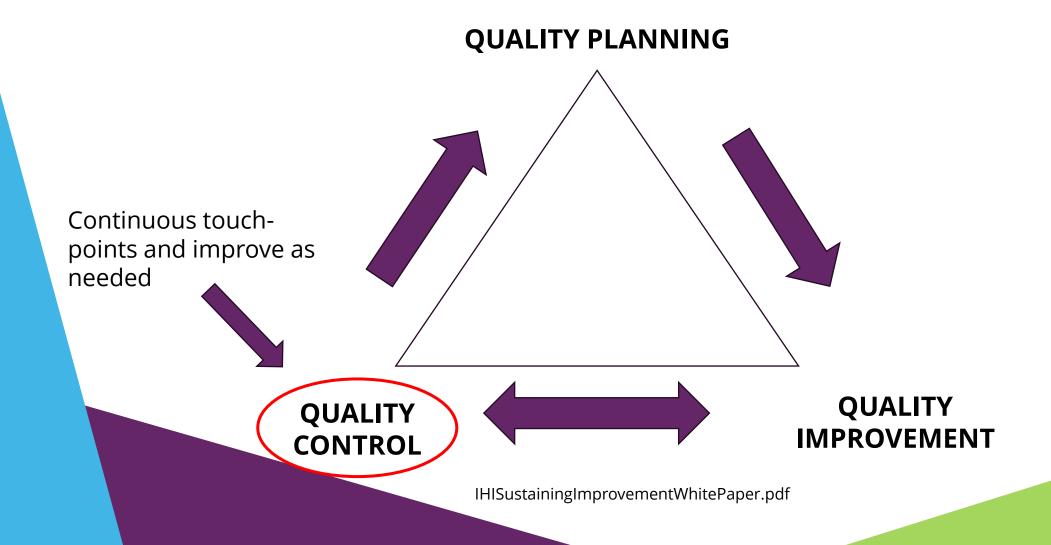


#### There are other reasons as well...

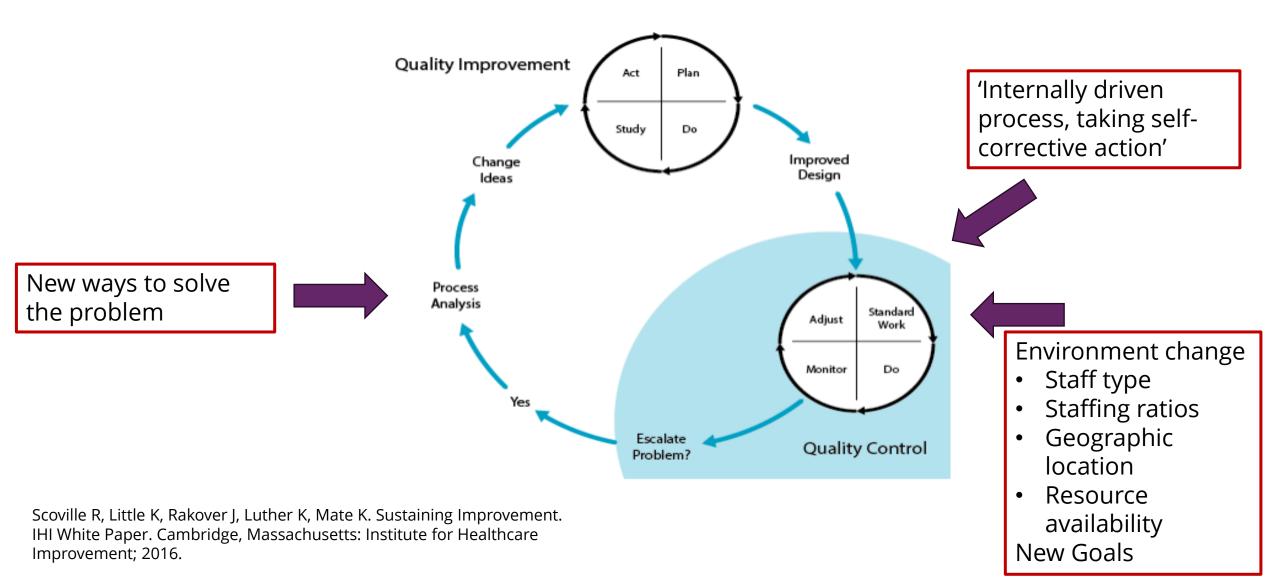
- ►We want to get this done now
- ►We might not know what is the key process or outcome measure
- ►We can't quite get the measure from our system
- ►We don't really know what we're going to do during this project
  - ► Especially if we are learning/developing new processes along the way
- ► Full implementation seems so far away
- ►The people who will need to keep this going are not at the table
- ►No-one is asking for a sustainability plan



# Is there a secret to sustaining improvements? Sustaining improvement is not an on-off event



# Quality Improvement and Quality Control work together



### Ultimately, there are 3 main drivers for high

performing teams **Primary Drivers** Secondary Drivers \$1: Standardization: Processes to define and disseminate standard work (what to do, how to do it) \$2: Accountability: Process to review execution of standard work P1: Drive Quality Control (QC) S3: Visual Management: Process performance information is continuously available to synchronize staff attention and Management system is organized quide current activities to anticipate and detect defects, maintain stable operations, S4: Problem Solving: Methods for surfacing and addressing Aim, Outcomes: problems solvable at the front line, and for developing respond to abnormalities Tier 1 (unit) managers improvement capability create the conditions and \$5: Escalation: Frontline staff scope issues and escalate effectively oversee Quality those that require management action to resolve (e.g., Control and Quality requiring cross-department coordination) Improvement initiatives P2: Manage Quality \$6: Integration: Goals, standard work, and QI project aims that maintain and improve are integrated across organizational levels and coordinated Improvement (QI) system performance among units and departments Management system mounts coordinated projects to improve \$7: Prioritization: Processes to help prioritize frontline process capability improvement projects based on organizational goals S8: Assimilation: QI projects are integrated into daily work Impact: Frontline service delivery unit provides care that P3: Establish a Culture of High-\$9: Implementation: Frontline teams have support to move is reliably safe, timely, Performance Management from QI back to QC, integrating results of QI efforts into effective, efficient, standard processes Positive trust relationship equitable, and patientencourages and sustains frontline \$10: Policy: HR policies support engagement, transparency, centered staff engagement in QC and QI staff initiative (e.g., incentives, recognition, etc.) \$11: Feedback: Provided on patient outcomes, with details linked to process abnormalities, utilized in root cause analysis \$12: Transparency: System-focused analytical inquiry into Scoville R, Little K, Rakover J, Luther K, Mate K. Sustaining Improvement. causes of process abnormalities ("Why?", not "Who?") IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare

Improvement; 2016. (

\$13: Trust: Through regular, consistent execution of

standard work at all levels

# Consider primary drivers of high-performing systems

#### Drive Quality Control (Operations)

 Management system is organized to anticipate and detect defects, maintain stable operations, respond to abnormalities

#### Manage Quality Improvement (System Change)

Management system mounts coordinated projects to improve process capability

#### Establish a Culture of High-Performance Management

 Positive trust relationship encouraged and sustains frontline staff engagement in QC and QI

©2003 Institute for Healthcare Improvement https://www.ihi.org/sites/default/files/IHISustainingImprovementWhitePaper.pdf

# There are 4 groups to consider when thinking of quality

- **▶Patients** experience the system
- **►Working team** interprets and puts the system into action
- ► Management provides resources, assists in direction
- ► Leadership sets priorities, helps initiate and maintain quality and safety

### It takes a coordination and trust between management, leadership and the working team

Work Team/QI

design and test solutions

Leadership prioritize, suggests aim, resources



**Patients** 

Experience /influence the system

**Management** 

process and outcomes



What tools have you used?



### MOCHA is an efficient way to think about sustainability

Measurement

**O**wnership

**C**ommunication and Training

Hardwiring the Change

Assessment of Workload

https://www.ihi.org/sites/default/files/2023-11/IHITool\_Sustainability-Planning-Worksheet.pdf

### Measurement is core to monitor the process and outcome



IHISustainingImprovementWhitePaper.pdf

What will we display publicly?

What will we *continue to measure*?

Who collects it and how often is it to be reviewed? By who?

What will we stop measuring once the QI is complete?

What will the team do if they see a *negative signal*?

### Ownership of the process needs to be clear



IHISustainingImprovementWhitePaper.pdf

Where do patients go to when we don't meet the standard?

Who *owns* the new work standard (usually leadership)?

Who will *respond* to the process and outcome data?

Is leadership involved in the improvement planning?

Is leadership *on board* with the changes?

### Communication of the changes and ongoing training should be either added to present process or created



IHISustainingImprovementWhitePaper.pdf

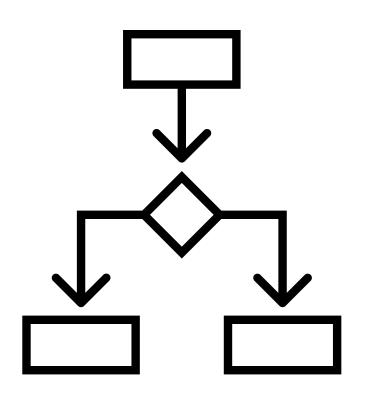
How will patients know what to expect?

How will we *communicate* about the standard to our team ongoing?

How will we *support* individuals in the new standard we have set?

What type of *training* will we use for our present and new colleagues?

#### **Hardwiring** the change is essential



IHISustainingImprovementWhitePaper.pdf

How will we make it difficult to do the wrong thing and easy to do the right thing?

Where is this updated process available to the teams?

How do we make sure that the change allows for modification as new ideas and tools become available?

How does patient feedback affect this hardwired process?

### <u>Assessment</u> of workload is necessary to keep the process possible and safe



IHISustainingImprovementWhitePaper.pdf

Do we need to *adjust the* workload over time?

How does this new process affect all the other workloads?

Do we need fewer or more work hours or effort at the time of this process?

### MOCHA is an efficient way to think about sustainability

#### Measurement

- What we will continue to measure
- What we will stop measuring
- What will we do if there is a negative signal

#### **O**wnership

- Who owns the new work standard
- Is s/he
   onboard with
   the changes

### **C**ommunication and Training

- Who will communicate the change?
- How will the change be communicated

### Hardwiring the Change

- How will we make it hard to do the wrong thing and easy to do the right thing?
- How will we standardize?

### Assessment of Workload

 Are our changes increasing the overall workload?

https://www.ihi.org/sites/default/files/2023-11/IHITool\_Sustainability-Planning-Worksheet.pdf

# An example: QI was done to initiate improved Postpartum Mental Health information for patients with discharge information and info magnets

The team went through problem identification, process improvement ideas, prioritization, PDSA testing, and measurement to know if the changes improved the outcomes.

#### Structure Measures

5/5 Structure
 measures
 reported as fully
 implemented

#### **Process Measures**

- 2/3 Process measures reported at 85% or greater for 3 consecutive quarters
- 1/3 process measures reported at 75% or greater x2 consecutive quarters
- Unit reviews conducted quarterly during day shifts

#### **Outcome Measures**

 >90% of patients going home with verbal, written information and magnets

### Let's use the MOCHA sustainability planning worksheet

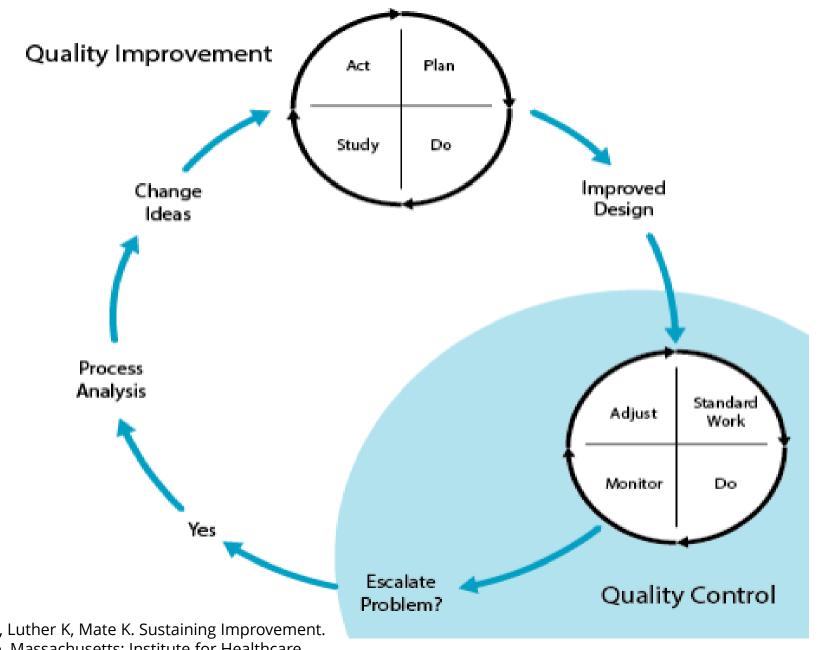
Areas for Consideration	Notes
What will we continue to measure?     What will we stop measuring?     What will we do if we see a negative signal (i.e., special cause variation)?	
Who will own the new standard work?     Is he or she engaged and onboard with the improvement?	
<ul> <li>Communication and Training</li> <li>How will we communicate about the change and who will be the messengers?</li> <li>How will we support individuals in the new "right way"?</li> <li>What type of training will we use?</li> </ul>	
Hardwiring the Change  How will we make it hard to do the wrong thing and easy to do the right thing?  Can we reduce reliance on human memory?  How will we standardize?  Do we need new documentation and resources?	
Are our changes increasing the overall workload to the system?  If so, how can we decrease the workload?  If not, how will we communicate about what is changing and not changing?	

### Complete the MOCHA worksheet with people leading and managing the project

Areas for Consideration	Notes
What will we continue to measure?     What will we stop measuring?     What will we do if we see a negative signal (i.e., special cause variation)?	If the patient's are using the Magnet post discharge - determine how to measure this - using MyChart survey Continue measuring Staff knowledge- Learning Management System
Who will own the new standard work?     Is he or she engaged and onboard with the improvement?	We have identified group which will meet monthly along with the monthly PNQIN webinars. Director s organizing the monthly meetings for the team.
<ul> <li>Communication and Training</li> <li>How will we communicate about the change and who will be the messengers?</li> <li>How will we support individuals in the new "right way"?</li> <li>What type of training will we use?</li> </ul>	Communication will be done through Staff Meetings, Friday Flash (newsletter), Huddles and emails. Chart reviews will determine if Staff are handing out the resources, Manager and Clinical Leader rounding will ask the patients if they understand the education given to them. Pretest and Posttest after Education given through the Learning Management system.
Hardwiring the Change     How will we make it hard to do the wrong thing and easy to do the right thing?     Can we reduce reliance on human memory?     How will we standardize?     Do we need new documentation and resources?  Assessment of Workload     Are our changes increasing the overall workload to the system?     If so, how can we decrease the workload?     If not, how will we communicate about what is changing and not	Having Champions on all units to continue to educate Discussing PPD is already part of our workflow- this is updated and provides a handout  Yes, we are in the process of working on the documentation piece within EPIC - we have created a work around while we await the change.  initially this will not be an increase to the workload of the nurse. If we move to utilizing the Edinburg in the postpartum period and on Pediatrics that will be a bigger undertaking.

# Sustainability Planning: Knowledge Pearls

- Clearly define your AIM
  - Has the AIM changed since you started your QI program implementation?
- Identify measures for sustainability as part of your QI program implementation
- Consider using IHI's MOCHA or another sustainability planning tool
  - Sustainability doesn't just happen you must plan for it!
- Develop a plan of action for when, not if, your data indicates a negative shift
  - Can you make minor corrections as part of your sustainability plan OR
  - Can you move the project back into a QI phase to address factors contributing to the negative shift
- How will you keep leaders and staff up to date on sustainability monitoring?



Scoville R, Little K, Rakover J, Luther K, Mate K. Sustaining Improvement. IHI White Paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2016.

# Breakout Session (20 minutes)

#### Evaluate a project for sustainability

Back to the basics: Choose a project

- What were you trying to improve?
  - What was your aim?
- What changes did you test?
  - Have your changes over time resulted in improvement?
  - Does your data reflect the changes you desire?
- How did you know a change was an improvement
  - What were you measuring?
- Did you keep up the processes and outcomes you wanted?
- Do you know who is monitoring the process?
- Extra points: have you kept variance low?

### Share what you learned

A-ha moments from break out groups

#### Call to action

- What QI projects do you have in flight?
- What is your sustainability plan for each QI project?