ALLIANCE FOR INNOVATION ON MATERNAL HEALTH

Video Transcript: How Whole System Quality Can Improve the AIM for Safer Birth

Naomi Clemmons [00:00:00] We are so happy to have you join us for today's webinar, How Whole System Quality Can Improve the AIM for Safer Birth. We're gonna wait for a couple more seconds before we dive in. But as you join, if you'd be willing to share your name and where you're coming from, it's always fun for us to know. And in a minute, Cora is going to be chatting out a question for you to contemplate and hopefully answer. And when the question comes, answer the question.

Naomi Clemmons [00:00:36] So I'm going to begin. My name is Naomi Clemmons. I'm a TA specialist with the AIM TA Center. It's really exciting topic today. This webinar is hosted by the Alliance for Innovation on Maternal Health Technical Assistance Center or the AIM TA Center. 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 non-profit 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 Health and Resources Service Administration of the U.S. Department of Health and Human Services. The content in this webinar today are of the authors and may not reflect the policies of HRSA, HHS, or the U.S. Government. Before I introduce our speakers, I do want to touch base on a couple of housekeeping items. The webinar today is being recorded. The webinar recording will be available and posted to the website in the next two weeks. We will have time for questions and answers at the end, but you don't have to wait to ask your questions. You can submit them any time using the chat function. We'd love to see your faces so please come off camera if available. And if you have questions and would like to come off mute, it would be helpful if you raised your hand or use the raise your hand function. Additionally, if you do need any technical support, you can use the chat feature to message any of us who have the AIM background on. Lastly, we welcome your feedback. It's how we get better. Cora is going to share the link to the evaluation. We'd love for you to fill that out in real time. And I will remind you about this one more time at the end of our session today. We really do take your feedback seriously. I am very pleased to introduce today's presenters, Jesse McCall and Dr. Debra Bingham. Jesse McCall is a Senior Director and Improvement Advisor at the Institute for Healthcare Improvement and an instructor in Health Policy and Management at the Harvard T.H. Chan School of Public Health. He works with healthcare leaders, organizations and organizations to identify strategic improvement strategies, build operational systems that support execution. And develop the capability needed to achieve measurable results. His work spans the development and delivery of improvement programs, collaboratives and educational initiatives across the U.S. And internationally. Welcome, Jesse. Dr. Debra Bingham is the Chief Executive Officer for the Institute for Perinatal Quality Improvement, a perinatal consultant and professor. Dr. Bingham is working to expand the utilization of implementation science and improvement science theories, frameworks and methods and tools to eliminate preventable perinatal morbidity and mortality. Dr. Bingham provides

consultation to organizations including state health departments, the Institute for Healthcare Improvement, schools of nursing and the March of Dimes. Welcome Dr. Bingham. And now I'm going to turn it over to Jessie.

Jesse McCall [00:04:34] Thank you so much for the warm welcome, Naomi, and the rest of the AIM team, and Debra, as always. Good to be sharing facilitation duties with you. Good day, everyone. Thanks so much, for joining us. Really exciting to see where you're all joining from come through in the chat. Great representation across the country. And I swear, I do have more than just blue shirts. But I always like it when my pic lines up with what I'm actually wearing. So we've got that going for us today. Um along with our objectives for the session what you've all come to to really hear about and so in today's session Debra and I are going to kind of go back and forth as we define whole system quality, what that means, both the leadership principles and management practices, what you lead and how you lead it. So we'll talk about sort of the whole body of work around whole system quality. The three main components of that are three different kind of phases, approaches, or areas of tools in your quality toolbox, quality planning, quality control, quality improvement, how those work together, reinforce each other to really be enable you to prioritize things that matter to your organizations, to the patients you serve, to your staff, to do dedicated improvement work in areas that matter based on that effective prioritization and to use quality control principles to promote sustainability and to make sure that you are not losing sight of the the critical improvement work that you've done and then it slides back to where it was. So we'll talk about those three phases. And finally, you know, scattered throughout, really looking towards practical application of these tools that you can walk away with, things you can try in your organization, hopefully different ways that you can think about organizing quality, engaging your communities, be it patients, staff, or broader than that, around shared goals. So that's what we're going to do today, all in the next 50 minutes. So we better get going. We're going to start by defining whole system quality, as I said, and this is around two areas of work, the management practices, what we lead in our system. So processes, organizational activities that support quality. That support learning in a transparent environment across the work that we do. And then there's leadership principles. And this really speaks to the culture that we create in organizations, how we lead the things that we're leading, how we're encouraging engagement, shared decision-making, really that culture that enables effective quality work. So we're gonna spend a little bit of time at the end talking about leadership principles, there is no shortage of writing and education around different ways to lead and experiences in doing that. But I think we've got kind of a unique approach in this whole system, quality thinking, the management practices, what we lead that, that really build a system for whole system quality. And why we've found this approach to be effective. So we've worked in what we call whole system quality for, geez, about 15 or 20 years now under different names. And this thinking expands way further back than that to original quality pioneers around W. Edwards Deming, Joseph Juran, on original. Creators of quality methodology tools and approaches that were used in industry and brought over to health care by early IHI founders and others. The main idea is to move out of this reactive state that we are so often caught in. We see a problem, we fix that problem, there's not a larger overarching strategy where it's kind of a whack-a-mole approach, that there's no North Star we're leading towards. We're not using data to drive where we're focusing our improvements. There's fires that we're trying to put out. It can leave staff disconnected from the mission vision values of the organization and really lead to a piecemeal approach to improvement where we are scattering our resources around. So this interplay between planning improvement and control can really move us into a proactive state because we're prioritizing things that matter based on data and we're using the right approach to solve problems that we're seeing and raising kind of before they

happen. So it's around preventing fires rather than putting them out. And it comes down to reducing variation. That's really what it all comes down to when we think about it, being able to run a process or run a care experience and have expected outcomes at the end of that, trying to reduce the variation and how we're producing those outcomes. Through our work in whole system quality, and this includes diagnostic visits, direct technical support in establishing these systems in healthcare organizations and systems across the U.S., we see three main types of variations, strategic variation, operational variation, and clinical variation. So we often go right to the point of clinical variation, use our quality improvement tools, maybe fix a problem, again, that very reactive state. And then we go about our business. And then a year down the line, that same problem comes up again. I'll say because we haven't set up our operations to be able to support that improvement over the longterm, nor we have we gone back to what our strategic vision is to really help us prioritize where we're focusing those improvement efforts. So when we think about how do we mitigate the strategic variation that we're seeing, the operational variation across different service lines in our organization, these all build on each other to kind of as a cascading waterfall of variation in your organization. And to call on back to Deming, one of our improvement founders again, if he had to reduce his message of this broad, broad area of work around quality has to do with reducing variation, again, being able to expect anticipate those outcomes that your systems are producing time and time again. So we have those ideas of variation, those three levels of variation and I'll say planning control improvement are our antidotes to those types of variation that we see. So as strategic variation happens at the board, the executive level where they're setting organizational strategy, or even you can boil that down to service line strategy or team strategy, having strategic variation, leaders that don't agree, different priorities, not having a space for them to come together and say, here's what we wanna focus on as an organization, how we're gonna invest those critical improvement resources. Quality planning, and we'll look at this in more detail, brings that those people together to have a unified front and a unified strategy. When we think about operational variation, how we're using huddles, support structures within our organization, visual management to keep things moving, quality control principles can really help us tend to that operational variation and smooth things across different service areas. And then finally, quality improvement to really address that clinical variation, thinking about standardization, having a method to approach making improvement in our organizations. So we're gonna dig into, again, quality planning, quality control, and quality improvement. But before we break that down, I want Debra to come in and talk to us, again, how to apply this in our perinatal maternal health sphere of work here. So Debra, come on in.

Debra Bingham [00:12:21] Yeah, thanks, Jesse. Nice to be with all of you and see people from all over the country today and talk about this important topic. So I'm going to use a perinatal example. We know from national data, if we look at that strategic variation or the quality planning piece, we have a lot of data, state and national data that tells us that hypertension is a leading cause of preventable maternal deaths and morbidity. And so setting that as a priority across the system would be one way in which we would have whole quality improvement, whole quality safety. Anyway, operational variation or the surface and solve the problems. So this is where we get to that proactively making system level changes. And so thinking about... For example, implementing a maternal fetal triage index, not only in labor and delivery, but in the emergency department and creating this referral and transfer policies throughout the system and also how you would work with other hospitals throughout your state or in your region to be able to get women and newborns to the best places where they would have the best outcomes. And then moving to the clinical variation within those systems is important. So let me just go over a case with you to kind of talk this through. I'm going to talk about Shondra Johnson. And you

were emailed this case ahead of time for you to be able to think about this. I'm not going to go in all detail in the case. But we'll tell you that. Just some of the highlighted and what actually happened in the case is on the bottom line. So basically she sees she's 30 weeks. She's got edema and she's got just a lot, you know, not feeling well, has a headache periodically. She goes to a regular doctor and for prenatal visit. She doesn't realize that this might be a warning sign. She hasn't received the education to know that that's a problem. So that gets to that state public health leadership, getting those messages out. If we think whole system quality rights, so we can include all kinds of not think only at the hospital level, but the community and what are the messages. And then she she was told by the doctor, she isn't told what her blood pressure is, but is told that she needs to urgently get to the hospital. Now, she isn't sent by ambulance, she's just sent to the hospital. She doesn't actually, she's 30 weeks, so she hadn't actually known exactly where to go. And she goes to the emergency room. Now the emergency room hasn't gone through training on how to do maternal fetal triage. They, she waits a little while. They then realize she's pregnant and then they say, oh, well, can you walk to labor and delivery? Oh, and also say is like the parking lot was like several blocks away. So she had to walk from the parking lot. By this time, her headache's even worse. She walks up to labor and delivery and the person at the desk just sees her and thinks, oh, she's not in labor, she is not very important, of course it's a busy day and they have her sit down and wait. So all of that leads her to then the nurse, when the nurse comes to see her like several I'll talk to you all in a little bit. I'll see you all minutes later. She is asked to change into a gown and put into a bed where she has a seizure. So all of that is like the maternal fetal triage index was created to to be a way in which like she's triaged in a very systematic way, both the mother and the baby when they arrive. Other options would be, as you can see in this flow chart is is to actually have sent her to the hospital via ambulance, or in this case, where she had severe range blood pressures, is to send her directly from a level, not to the level one hospital, but to go straight to her tertiary center. In this case she has her seizures, she's stabilized, they send her up to the referral hospital and transfer her there where she does give birth. So that's just an example of how all these pieces keep happening over and over in our country. As we look at these cases, this is not a unique case. This is happening in every state across the country. And so we do need to, as perinatal leaders, take this whole system approach to quality and think about ways in which we can eliminate denial and delays within our system. And think about the benefits and the challenges. And so that the perinatal cases aren't just isolated and everybody's reviewing them themselves, but that we bring in other leaders within the organization for this broader perspective and operational changes. So we can eliminate these preventable morbidity and mortality, but we do need to do this proactive whole system quality approach to this work. All right. I'm going to turn it back to Jesse.

Jesse McCall [00:18:09] Thanks, Debra. I do want to pause just a moment to ask for a couple of reflections on those reflection or dialogue questions that are in here. Any thoughts around? I mean, you had reinforced why a systems-based approach is important. But. What are the benefits of it? And in all of your work, what are some of the challenges that you encounter? So maybe we'll start with some of that, the benefits. Do you see strength in the systems based approach? And I'll give you around 30 seconds to think of something and put it in the chat and then we'll see what results come in there.

Debra Bingham [00:18:44] Oh, Dominique has a really good point about it helps us with being sure that we treat all patients based on their clinical presentation and help eliminate and identify bias too, right? So it may in order to eliminate that bias, we first need to identify it. So thanks, Dominique, for putting that in there. Yeah. And then there's consistency every patient, every time, regardless of clinician. Thank you, Terry. And let's

see. Yeah, the patient, yeah, Jenica doesn't rely on the patient. The patient doesn't have to be the expert here. I love that you pointed that out. Jesse, you wanna call on, point out anything else?

Jesse McCall [00:19:31] I was just going to pick up on standard standardization, decreasing that clinician mental load, having some repeatable known actions, helping to ease some of those decisions. And I'm not talking about cookbook medicine by any means, but to help people make the right decisions and to have tools that enable that. And just a quick hi, Terry. Good to see you. Thanks for thanks for joining us. I know Terry from other other IHI work. So let's pivot and think about, we all know these are some of the right things to do to take this systems-based approach to think about these. Yet, it is really challenging. What are some of the challenges that you all come up against as you think about engaging other departments or other pieces of your system that you know have shared goals or are trying to put the patient at the center across your silos? What are the challenges there?

Debra Bingham [00:20:21] Yeah, Geneva puts that as difficult as it relies on coordination and buy-in from different sites, ambulatory and hospital, oftentimes need to establish trust. And they probably have some of their own priorities too, right? I would think some competing priorities. Jamie, you said the amount of people to educate, it does make it a more complex project. But that's why you need that. CEO like executive buy-in, understanding that this is an important strategic initiative. Oh, and boundary pushback or workflow friction. Yeah. Yeah, there could be some of that as well.

Jesse McCall [00:21:06] This hot potato mentality, it's not my area of expertise. Someone else is gonna fix that. Yeah, we've got different staff turning over. The education piece always comes up. I'll say education is necessary. Everyone has to know what to do. And. If we're really thinking about a systems based approach where we're trying to solution for the system so it is not up to an individual person to try and remember all those different little process steps that they have to do to try to make it easy for people. Thanks everybody for the for the great pause for dialogue really appreciate your thoughts insights and experience there so let's continue on and we are going to break down each of those main kind of. Areas of quality into a little bit more detail and we'll continue with our one-two act. I'll talk about it broadly and then Debra is going to bring us home with a perinatal maternal health example. So quality planning, remember it's that kind of antidote to strategic variation and this is really a process at the organizational level to get people together to look at your mission, vision, values, your North Star as an organization. What are your quality goals? Are you meeting those now? Do you have data that tells you if you are? And if not... What are you gonna do about it? What actions are you going to agree to as a leadership team that's going to meet the needs of the people you're serving more effectively? And that goes broadly to patients, staff, community. How are you are going to organize yourselves to address that? So that's the quality planning process. Within this, I think there are four milestones and these aren't distinct. Like you finish one, you move to two. Some of it's iterative or cyclative. There's some catch ball as you're kind of defining and looking at these priorities. But in a quality planning process, there's preparation, data gathering, kind of building some capability or some will in the people who are involved in this effort that blends in with communication. Why are we doing this? How do we look at data together? And then you get into refining and prioritizing, shaping your opportunities for improvement, looking at them in a similar way, trying to develop some theories for change. And then ultimately, a process to prioritize, a defined process to really evaluate objectively those opportunities for improvement based on data, make some decisions so that you can again invest your quality energy in places that matter most to the people that

you're serving. So let's look at each of these steps in a little bit more detail. Step one. Get your data together. You have an immense amount of data in your organization. If you are like any other health care organization that I have worked with, you have a ton of data. Most organizations aren't using that data to the fullest, nor are they blending together qualitative and quantitative data to get a real picture of what's happening. And are we meeting the expectations, both in experience and outcomes for the people that we're working with. So when we think about the patient level, we have complaint data, experience data, we have population needs assessments, community assessments, security reports, things that we already have that are from that patient perspective. We have the middle of our organizations. We have staff satisfaction, engagement, patient culture survey data, capability assessments, whatever you've used to understand how your staff function. And then. At the upper levels of an organization, we have our RCA's or our safety event reports, any organizational benchmarking, consultant accreditation reports, all data that exists that helps us know if we're meeting our goals, if we are meeting the expectations of the constituents, that broader community that we do serve. So you gather all that data together. And then I do think some preparation is needed for the folks that are involved in this quality planning exercise. They need to know what the organizational goals are, that North Star. They need see alignment between how their unit contributes to that North star. So if our goal as an organization is to reduce mortality, what's labor and delivery's piece in contributing to that larger organizational goal? There needs to be a discussion around how we're looking at data as an organization. Are we looking at data in, you know, over time in run or control charts? Are we understanding variation or are we just, you know, getting lucky or unlucky in how we are measuring and kind of misjudging the outcomes that we are achieving? And finally, orienting people to the process. Here's what a quality planning process looks like. We're gonna get together. Here's how we're gonna look at data. Here's where we expect this process to yield on the other side of it. So trying to get them to see the value in this connected, really process-oriented prioritization. So when it comes to having that quality strategy, that North Star, that quality framework in your organization, this is a fairly generic one. And I'm sure your organizations have something that looks like this. You have big measurable domains at the top, the patient safety, regulatory and accreditation needs, patient flow, clinical outcomes, patient or staff experience. Cross-cutting domains, thinking about access to care, and then further down into your system than that. But this is our guiding star. If we're intending to do well in safety, to meet regulatory needs, what are the measures that tell us how we're doing in that area and what needs attention or not based on what the data is telling us?

Jesse McCall [00:26:47] So. When you're evaluating different improvement opportunities, different gaps that might exist within your system, I think it's important to have a common way to view and analyze those opportunities as a group. You're making a collective decision on this being a priority or not. So there's just a couple of template slides here that you would use in a quality planning effort, a quality planning meeting, a long or short format to look at that opportunity. What have we done in this area before? How risky is this thing that we're evaluating? What's the impact of not doing anything about it? What's impact of patient experience, clinical outcomes, regulatory needs? How are we doing? I mentioned looking at data over time. How are doing in this particular measure, both process and outcome-wise? And then a second slide here that's kind of around history. How are defining this? What have we done in the past? Do we have a theory that might, that we think would bring about improvement in this area initially, and it might not always be as well developed as that. Do we have a team that might work on this already? So again, you put up all these different areas for opportunity, these different potential improvement projects, get together as a team and hold this event. You look at all of the

opportunities that have been surfaced. You have an opportunity for dialogue around them. Especially powerful to have patients or family members or community members in the room. They add such a valuable perspective to what really matters to them and where your focus might be as an organization. And you work through each of the opportunities and position them in different priority levels for improvement. Whether that is to say this is something that's so important, our entire system needs to focus on it. We are going to marshall some centralized resources from our quality team, the improvement teams are going to get a great amount of support as they undertake this. It's critically important across different services in our organization. There are local improvement priorities, labor and delivery. You've identified this problem. We think it exists and you have the capability to do that within your service line, go ahead and do it. Let us know what kind of support or resources you might need to really be able to address that problem. There's quality control. Yeah, this might not be the best, but we want to keep an eye on it. And we're going to assign a group to really be looking at that data over time, monitoring performance, and we might bring it back into our next quality planning cycle. There's things that come into a process like this that aren't able to be addressed by the people in the room. They might involve parking or different community organizations, things that you can delegate. And finally, I think this might be the most important category, deference. We don't know enough about this opportunity. We have other things that are more important that we need to address, and we can't do it all at once. I know it's tough to make those decisions, but we've got to. It's better to, I'll say, swing the bat all the way through on a couple of things that we know are important, than try and take a million swings and only hit a couple of the balls. So deference and an important category there. And then I'll say there is an amount of work that comes out of a quality planning process. There's thinking about a sequence to the work. So if you're doing this at the system or organizational level, ensuring that the emergency department doesn't end up with a stack of 15 different change ideas and interventions they've got to do over the next six months, that there's some sequencing, that there is organizational structure to support these improvement efforts. So that's what a quality planning process looks like, I think at the organizational level. Written a couple of different pieces on that that are available on the IHI website. So did you want more organizational examples? But again, I'll pull Debra in to talk about what quality planning looks like around this great example from California. So Debra, come on in again.

Debra Bingham [00:30:53] Yeah, so this goes back to in there to goes back 20 years ago when I was in California, I was the first executive director of the California Maternal Quality Care Collaborative. The collaborative was just getting formed and we were trying to set our priorities. We were given data to show that there was a rise in maternal deaths in the state of California. There was no review committee for the state. And we were just given that one piece of information. We didn't know what the rise was due to or why there was a rise. So we formed a committee. We got together people from around the state to start to review the deaths and start to identify the reasons for these deaths. In addition, we started telling people about this rise in maternal deaths and started asking questions across the state. We would have meetings all over the state with people asking them what were their quality and safety priorities. As we went around, we also identified people to help serve on committees. Now we had very little funding. There was a lot, it's a huge state, one in eight births occur in one of the eight, one out of every eight births in the United States occur in California. So that's a huge number of births in the U.S. occur in that state. In fact, a county in California has as many births as some of the states in the United States. So there was just a lot to try to figure out when our small budget, what would be these priorities of action. And one of the things we did, literally we did what Jesse just described. We got people together, we identified the leading causes of death, we divvied them up, we divided these causes of deaths among each other, and we then made a case, we then

came back and made a place for which would be the best cause of death to focus in on. And ultimately we decided that hemorrhage was the death that we would focus in, we would prioritize reducing eliminating preventable deaths from obstetric hemorrhage as our first out-of-the-gate topic. And part of it was, you know, there, it was really just trying to figure out what would make the biggest impact. And every death we reviewed that was related to hemorrhage had been identified by the committee to be preventable. So it made a lot of sense to focus in on this leading cause of death. And it also wasn't very controversial. But I will say, when we got together, we also, we had people disagreeing with, well, what should we do to reduce hemorrhage deaths, right? And so we then started thinking about what would be those different actions. And so one of the suggestions was we needed more interventional radiologists, for example. But when we would read the cases, as we reviewed the cases we realized that wasn't really going to give us the better outcomes, right? So that the people were dying because they weren't getting blood soon enough. So having more interventional radiologists, why, well, that wouldn't be a bad thing. It wouldn't also save lives. So that's what we started working on. We shared this composite case that you see posted here. This was an actual composite of different deaths that had occurred in California. And this exemplar, then changed the entire room's opinion of what would be the priority, right? So it was an exemplar of what we were reading in the case studies, in the Case Reviews, I should say. So that data, drilling it down, but then also not just jumping to the first idea, right, really understanding the problem deeply so that we actually are solving the problem and not just throwing spaghetti at the wall, thinking, okay, I'm doing something, so that's going to make a difference, but really deeply understanding the problem, setting the priorities for action.

Debra Bingham [00:35:36] So the priorities for action that were set were then we needed to do better risk assessment. We created the stages of hemorrhage. This is later was then. With permission from CMQCC when I was a vice president at AWOHNN, we then created it there as well and modified it. So this is showing the AWOHNN version. But just really defining stages of hemorrhage, there had not been a clear definition of what a hemorrhage was. One of the biggest changes, shifts in practice was needing to quantify blood loss. But we also found other things that would really help save lives. One was that there wasn't a lot of experience around B-Lynch suturing or other kinds of methods. Because in the cases we were reading, there was repeated trying to the people would get stuck on this. Trying to find if there's any retained placenta products. I'm doing that over and over this DNC during a hemorrhage. And so now we have in our country, many more resources and many more skills that clinicians have in order to help to address a hemorrhage that's happening. We also started talking something as simple as a calibrated underbuttock strake. So that people could visually see some of this hemorrhage loss as well as measuring it. So those became very practical solutions. And this and the obstetric hemorrhage initiative, then you see the results was this decrease in five years we reduced deaths by about 50%. We also at around that same few years later launched the elimination of elective deliveries prior to 39 weeks work. And we followed a similar process. And And I did include on some of those slides the reference so that if you wanted to look at, look up the paper where we wrote about it, you can be, feel free to do that. But it is showing this statewide approach, but each individual hospital then tailored the work that we shared with them to meet the needs of their system. They then took that and they looked at what were some of the major areas that they needed to work on in their areas, and then rolled it out for their systems and for their hospitals. So it became a whole system approach to quality. So thanks, Jesse.

Jesse McCall [00:38:20] Thank you, Deborah. I think a really helpful example because it boils it down to the essence of quality planning, a data driven approach to agree on what

the most impactful change or area to improve in is going to be to build the will and engage other people in addressing that problem together. I saw a comment come in that, yeah, this is. You know, our data here ends in 2013. Debra, I'm not sure if you're familiar with how it played out after that. I'm sure it's available somewhere, but we've got to keep moving. So.

Debra Bingham [00:38:55] We can dig into that another time, but yeah, there is national data to show that California still leads the country in having some of the lowest rates of maternal deaths. And we did not, I will say these data do not, we did reduce or eliminate disparities. And that became a later focus of mine because that's also not acceptable. Everybody's rates improved, but we didn't actually change the gap in disparity. So more on that at another time, like Jesse said, but that's just a quick snippet.

Jesse McCall [00:39:32] Thanks, Debra. So once we've prioritized, and I don't mean to say that's a simple activity to go through that prioritization approach, but then we can really, I think, use quality improvement effectively, get the people who need to be involved in an improvement effort really in it and supported to do the work that they know best. They know the care processes, they'll have ideas to improve them. How do we support them in actively doing that? So. There are a ton of improvement methodologies out there, whether you're a lean organization, a Six Sigma, a mesh of the two, or you're following the Toyota production system and methodology, which is really focused in on the workforce and honoring that expertise. Any improvement methodology, I think, can be sort of boiled down to the model for improvement that you see in the bottom right-hand corner of your screen here. Having an aim. What are we trying to accomplish? Having some measures that are going to tell you about how your system is functioning and if a change is an improvement or not. And then being able to make changes to your system. If we want to... Have different outcomes, we need to change the system that produced those outcomes. And this is all anchored by the PDSA, or plan, do, study, act cycle, a practical application of the scientific method, where we're intentional about making changes, studying the effect that they had before we implement them or scale them up across our organization. Not gonna spend too long in quality improvement. I think it is where a lot of attention has been placed. I'll just quickly mention what I think are six core components really effective quality improvement. Great manuscript just came out of IHI around each of these components with different templates and tools that are available. But it begins with system understanding and Debra, it's kind of quality planning to an element. Debra had talked about this in her work in California. What's happening in our system? What is happening in the context? What are the outcomes that we're producing? What's the environment we're reducing them in? And then to my points around the model for improvement, having an aim, how much by when, measurable, time bound. And then we have our measurement system. How, what are we measuring? How are we using those measures, those indicators to guide our performance and our learning about our system as a team? A content theory. What that is, it's a fancy way of saying. What changes are you going to make? What theory do you have that's going to bring about improvement in your system? What things can be done differently? Which interventions do you want to put in place? And the AIM bundles a great source and a representation of content theory across multiple areas of, uh, maternal and infant health work. Your execution theory. How is this project going to be done and what scale is it going to be done at, is this a national initiative? What kind of structure does that take? Is it just in your hospital? What structure does it take to support improvement teams at the local level? And then finally, dissemination communication. How might you tell others about the work that you've done, the learnings that you had, hopefully the improvement that you have achieved. So again, check out that manuscript a lot around quality improvement, but I don't want to spend much time there. I

want to talk about quality control because I think this is really often a misunderstood element of this whole quality interlocking, quality phase process. So when I talk about quality control, this is really an internally driven process. They're internally driven tools that can help you surface and solve problems as they're happening, monitoring data, having prescribed actions for what happens when things start to go wrong within the processes or outcomes that you're monitoring. This is quite different, but I think often confused with quality assurance. Quality assurance. Are externally driven activities. That's our accreditors, that's an external body making sure everyone is up to a base level of operations. It's around fire exits, having documented policies. It's not necessary, and it's someone else saying that you're good enough or not. Quality control is our own internally driven process to assess our performance and say to us, to our patients, to our community, is that good enough, or not? Both of these can lead to quality improvement efforts, but they're different driving forces for the focus of what that improvement effort might be. Within quality control, and these are the practical applications of quality control. Folks mentioned in our earlier chat around standardization. Do we have standard workflows, protocols, that maternal fetal triage index? How robust is that in our organization? Does everyone know when to pull that out and when to use it? Plenty of opportunities exist around standardization in the right way in our organizations. Second piece is around visual management. Are we using visual management? Tons of us have whiteboards in our organization. A lot of them that I walk around are blank. Some of them are used effectively for team huddles, bringing together. Here's performance data in our organization. Here's priorities locally or organizationally. Here's things that we have completed or achieved as a team and why that's important. But a visual way to gather people together and talk about what your priorities are and how you're progressing towards those. Visual management and the final one, problem solving and escalation, often work hand in hand with huddles. And team meetings, but being able to have a culture that supports. Transparent, active dialog around safety issues that people might see, safety issues that haven't happened yet, concerns that are being raised. And are those either solved right when they're raised or does the team not have what they need to be able to do that? And it's escalated further up into a system and solved at a level and then communicated back to here's how you can work on this back at the front line where the problem or wherever the problem was raised from. So there are more different, more quality control principles. I think these three are most easily triable in your organization, especially visual management and having a huddle around that visual management or a huddled to debrief an event or to prep for an event, whatever it might be. And that's where I'll pull Debra in for here, thinking about standardized debriefs after different types of events. So Debra, I'll play you in again.

Debra Bingham [00:46:24] Yeah, so you want to do debriefs from both human and non-human systems approach and thinking about identifying what went well. You want to look at both the strategic operations and the clinical levels. So what are the things that we need? You're looking for opportunities for improvement or what went well that we don't, that was maybe by accident we want to keep replicating. When I have the checklist, sometimes makes it easier for these debriefs. And I've helped create several of them that are, and ACOG has some, and you can find examples of this. You may have some of your own. But it makes it quickly and easy to track what you learn in these conversations. And then you get insights from both the patient and the family. So that you have you're getting that input and believe me I've had so many insights come to me from the family things that my eyes did not see And then you share what is learned during the debrief as strategic operational and at the clinical levels. You don't want to keep that to yourselves. I also think it's important to share with each other across facilities. Why should we have everybody making the same mistakes in our country? So we want to share with each other. That's

why we're here today as well. And then identify those problems. And really identify the problem. Like don't do the, like I see people trying to fix a problem that isn't really the true problem. So really understanding what is the problem that you're trying to fixed and making sure you have the right problem that you are trying to solve, figure it out. Thanks, Jessie.

Jesse McCall [00:48:16] Thanks, Debra. Getting to the root cause. And that's why we test to make sure that our solutions are actually solving the right problem. So I'd like to end our sort of journey through these main phases, thinking about planning, control, improvement with a little poll for you all. I think this is an organizational journey. So many of us started thinking about, again, driven by quality assurance, an external organization saying, here's where we think you need to do better. And then leadership, having a command and control approach to say, yeah, emergency department, you're working on this, general wards, you are on that. What we wanna be moving towards, I think is what Debra and I described, where it's an organizationally driven process around quality planning, surfacing those opportunities for improvement, using improvement judiciously, and finally, control appropriately. As you begin to move away from this externally driven function, you may see a lot of quality improvement happening that's not necessarily connected. But if you are also attending to quality control principles, those huddle systems, visual management standardization. And you won't be solving the same problems over and again, using that quality, those quality improvement approaches. It promotes sustainability. Um, so as you think about your own organizations, one, two, three, or four, where would you say you are? Are you externally driven? Um, do you have a bunch of quality improvement activity happening? That's not necessarily really lined up and connected to larger organizational goals or are you kind of over an area four where everything's humming along working in concert nicely and I'll say there are a few organizations uh that that are at that four um but where are you right now one two three or four you can drop that number into the chat. Thanks, Jamie, 1.5. Starting to think about some of these other opportunities to define quality priorities. It's not a bad spot to be. Plenty of opportunity. All right, well, I encourage you all to reflect on where you are in this journey. Do you have a system either within your department or within your organization to surface and evaluate opportunities for improvement? How is improvement undertaken in your organization piecemeal or coordinated? And then finally, are you using some of those practical quality control principles that can help sustain the improvements that you've made or maintain focus on things that are important? So I said the whole system quality at the beginning was management practices, and that's where we've spent our time today. I want to close with just a little bit around the leadership principles to get you an idea of how those work in concert with the things that you lead these systems, these processes that Debra and I have talked about. So IHI has no shortage of writing on leadership all the way, you know, even earlier than these papers, but tons of different ways to approach leading people, organizations, processes. As we looked at these and we were thinking about whole system quality, it... They, again, really boil down to three elements and, you know, not planning quality control, but really around knowing what matters to the people that you're working with and the patients communities that you serve using data to know what's important, enabling what matters, building the culture in your organization, psychological safety, having learning and dialogue around safety events, data, root causes that enabling environment. And delivering what matters using planning improvement and control as quality management systems in your organization to hopefully deliver on those expectations of your communities, patients, staff aligned with that vision and strategy that you have as an organization. Lots of personal behaviors that sit within each of these, but I encourage you to think, do you know what's important to the staff that you work with, the patients and communities that you serve? What do you do to create that enabling

environment, that culture that supports? Achieving effective outcomes time and time again. And do you have an approach to quality management in your organization that's going to enable you to deliver on what's important or what you know to be important? So these pieces, as the arrows go around, are all connected, reinforcing, and they lead to that higher level of performance that we strive for as organizations.

Debra Bingham [00:53:11] That was one of my favorite slides. I'll just say I like that slide a lot.

Jesse McCall [00:53:16] I'll take that as a win. Our final chat exercise here, or I would even invite someone if they want to come on and talk it through, what elements in your system work really well? And I just posed this question to you. Where do you struggle? Do you feel like you know what matters, enable, and deliver? Or do you struggling with these? So I'll, I'll do it as one big chat waterfall. If you want to put in, you know, um, working well, uh, WW colon, here's what it is and struggling with colon. There's what it. You can just take them all in at once. So I give you a little bit to think of that. Uh, what are you doing well with? Where are you, where are you challenged? Yes, sustainability remains a challenge. I could launch into a whole session around sustainability tools, but I will stave myself, um, and, and just recognize that, that, yes, that that is a challenge because there's so many competing priorities as soon as we're done with one thing, it's onto the next, um and hopefully effective quality planning at least maintains, um some prioritization and enables us to focus on those things that are important.

Debra Bingham [00:54:27] Yeah. So then Jenica brought up that as a statewide leader, she struggles with enabling how to get individuals, hospitals, departments to work as their best selves. And then I think the follow-up of Shannon, it's kind of like, well, yeah, and then at the hospitals are struggling with staffing and turn around. So I think it's all kind of connected. We're all connected in all of this. Right. So. But I think those are good questions, Jenica, and we could have a whole nother session just on how to help engage people and help them do their work. So yeah, be their best selves. I love how you said that.

Jesse McCall [00:55:04] Thanks, Debra, and thanks everyone for your thoughts and comments around these challenges, competing priorities within and across organizations as we're thinking about this whole system. I will say, putting the patient at the center of that using storytelling, trying to have individual experiences then represented with larger data sets like Debra had shared with us allows us to see an individual experience and then recognize that's happening to more and more people. That can also go towards keeping your team involved and intrinsically motivated to keep on in improvement effort. I don't mean to make it sound that simple because it's certainly not, but one approach there.

Debra Bingham [00:55:53] Yeah, and we also used some modeling in this presentation where we showed, like, made it real, like not talk about the principles, but also include actual data and cases, like case exemplars. So yeah.

Jesse McCall [00:56:09] Well, thank you so much, Debra. I think as our participants have seen, it's certainly taken both of us to put this together. I really value your perspective, the work that you've done and the examples that you bring. It's just been a pleasure to work with you today. Hopefully you all found some value in this approach and can think about how you might strengthen elements of planning, control, improvement in your organization. If you have any feedback, of course, thank you for putting that feedback link in the chat. We're very interested in how you might apply this in your settings or any feedback for

Debra and I about how we're coaching and delivering this process. And I think I'll pass it back to Naomi to close us out. Thank you so much for having us today, Naomi.

Naomi Clemmons [00:56:58] Thank you, Jesse, and thank you, Dr. Bingham, for a fantastic presentation. That was great. A lot of content you covered, but just so smooth, and still time for conversation. So we really appreciate the dialogue that you created with the audience. And just one last reminder to everyone, please complete the evaluation, the link that Cora sent out. We really appreciate your feedback. It's important to us and it helps us improve. And I wish everyone a good rest of their day. Thank you. Thanks, everyone.

Debra Bingham [00:57:32] Everyone. Nice to be with you.