Why It Matters
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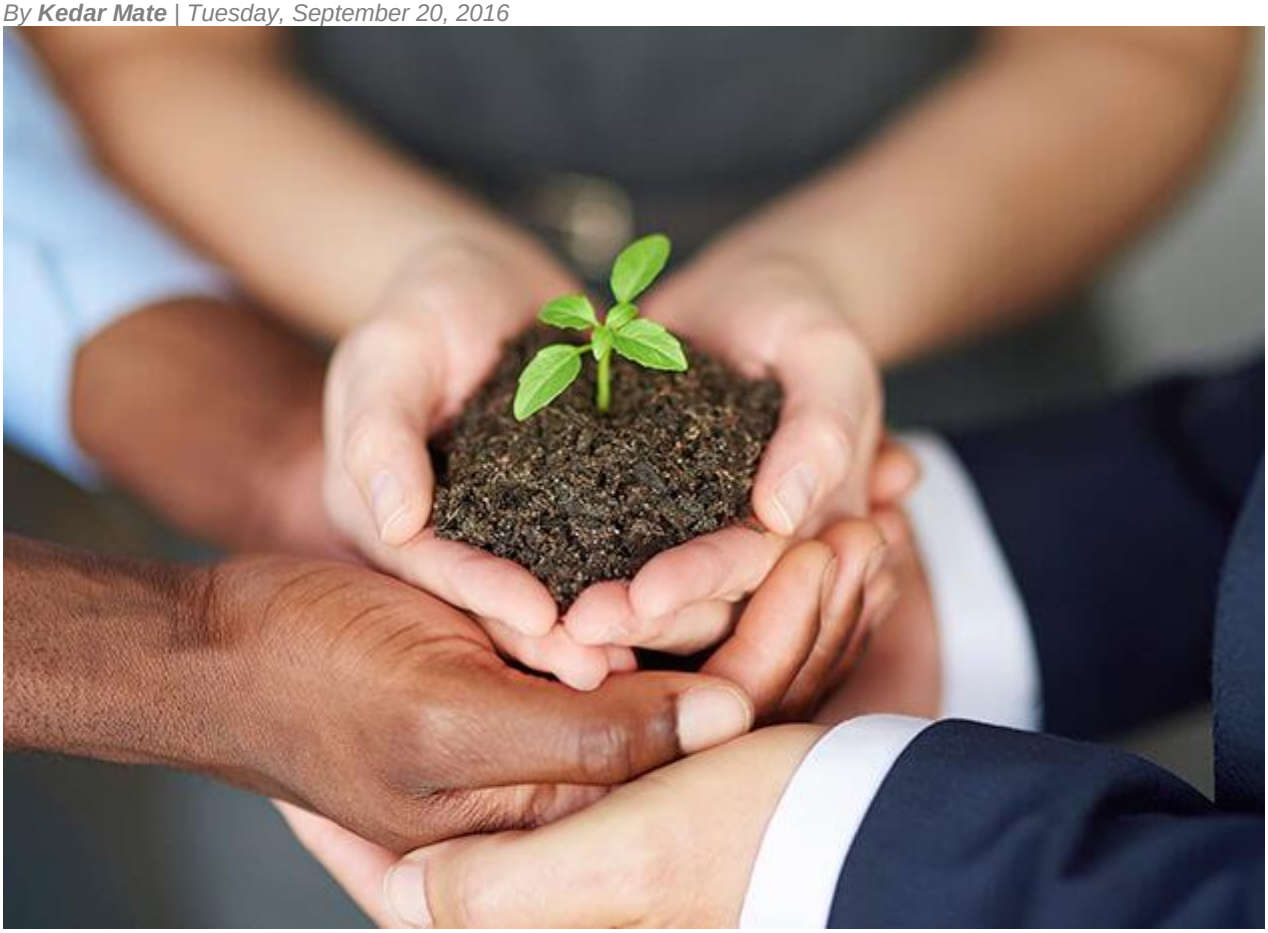
Tips for Sustaining Your Hard-Won Improvements

*By **Kedar Mate** | Tuesday, September 20, 2016*



At IHI, we've focused for years on quality improvement — how to use scientific tools and methods to systematically improve your performance.

But how do you sustain the gains, once you've made them? A new IHI white paper, Sustaining Improvement*, offers a framework and case*

studies to help. We recently sat down with Kedar Mate, MD, IHI's Chief Innovation and Education Officer, to learn more.

Do health systems focus too much on QI and not enough on sustaining improvement?

To my mind, they go together, hand in hand. I am a true believer in the notion of continuously improving, but it's also important to make sure we embed the improvements we create into the way we do our work to continue to produce results. It's not enough to have a systematic approach to improving care. Once we've made an improvement, we need to maintain a high level of performance in our system. In other words, we need to make the system better *and* maintain the system's new level of performance.

Why is it so hard to sustain improvement?

Sustaining improvement can be challenging because there are a lot of pressures on systems today to rapidly evolve, change, and transform. Systems are cycling through these changes quickly.

People are distracted. That's part of the reason we find sustaining change difficult. They're busy. They're constantly being told to focus on another new thing. Frontline management teams can feel like they're given a new improvement priority every couple of weeks.

In the white paper, you devote a lot of time to the roles of frontline clinical managers. Why are these leaders so important to sustaining improvement?

The frontline is where clinical improvement takes place. Fundamentally, it's where we meet our patients. If we can't make improvements where we meet our patients, then we're going to have trouble with improving overall system performance.

Frontline clinical managers lead the staff members who work most closely with patients, who are involved on a day-to-day basis in making the system better. This is typically a nursing leader — whether it's an inpatient care unit or a primary care clinic — in charge of the

performance of their service delivery unit and also maintaining the best practices that the unit is using.

We studied 10 high-performing improvement systems in the US for the IHI *Sustaining Improvement*white paper. All of them worked with frontline clinical leaders as the focal point for how to sustain change in the unit in question.

What should frontline clinical leaders do to sustain improvement?

At the frontline a clinical service level, we need:

- Standardization — job descriptions with clear sets of roles and accountabilities. We need standard work to meet the specifications of what we're hoping a system will do to care for patients.
- Accountability — ways to keep the team accountable to the standard work. We should all know what we're supposed to do and our nurse leader or supervisor should keep us accountable.
- A visual management system — it's often a board mounted on the wall in wards or clinics. The visual display helps people understand their unit's performance over time on measures that matter to the staff and to the patients.
- Daily communication — teams often use huddles multiple times a day as a communication system that keeps everyone informed of the unit's progress.
- A problem-solving technique — units rely on a process for escalating and addressing problems when there's an issue with the performance of the unit that can't be immediately solved.

What are the first steps in trying to implement a high-performance management system? Who is in charge of leading this work?

A system has to make a choice to be high performing. It's a conscious choice to improve and maintain the improved level of performance. It's not an accident. It's not something that just happens to the system. It's something that becomes part of the business strategy of the

organization. That means top level leadership in the organization has to make the choice that this is the way we're going to do our work.

Once that decision is made, typically senior leadership will choose a service unit that's representative of the system. It could be a small microsystem, like a unit or ward. If it's an outpatient service, it could be one clinic day. Whatever the unit, it becomes what John Toussaint calls a "model cell." It becomes the place to start building the model for the high performing system. That unit typically has a strong clinical leader or a frontline leadership team that is willing to make changes. It has a relatively stable staff so you can teach and learn together. The unit also has to be interested in change. It should be willing to test, learn, innovate, and create.

If you can find a place like that in your system — and almost every system has a place like this within it somewhere — that's where to go. Start there. Pick an achievable end, whether it's standardizing your current work, setting up a visual management system, or building a daily communication system. Start with something small to build the kind of standardization you need to maintain or sustain changes in your system.

Can you share an example of an organization that's implementing such a system?

We're working on this with a number of different ambulatory surgery centers around the country through a relationship with the Health Research & Educational Trust (HRET). These are high-functioning, fast turnover microsystems. They are busy ambulatory surgery centers, and they make improvements all the time.

They're trying to improve their surgical performance in general and one of the major changes they're making right now is implementing the surgical safety checklist. They're using this high-performance management system to embed the checklist into the operations of the surgical centers. They're starting with visual management — using whiteboards — to help understand the performance of the system over time.

They're also using huddles, for five minutes every morning and at each shift change. They work to understand the level of performance at the clinic, and to address any anticipated challenges they'll face in the next seven to eight hours. Then, they make plans to solve the problems they foresee.

How do quality improvement and sustaining improvement — also known as quality control in the Juran Trilogy — work together?

They're bedfellows. This is the Juran Trilogy: you improve a system, make it perform better than when you originally started, and then you use the techniques of quality control to measure, stabilize operations in that system, and ensure that the system doesn't fall out of control again. If it does, there's a problem. If management decides that there's a new level of performance they'd like to reach, you then reactivate the quality improvement aspect of the organization.

I think of this as a virtuous cycle. To complete the trilogy, Juran would say you've got to have a customer-driven quality plan that would shape the overall trajectory of the efforts. In my mind, these things work together.

You may also be interested in:

IHI's Sustaining Improvement white paper

Sustaining Improvement on the Frontlines: The Story of Intermountain Healthcare