Essential actions to foster stakeholder's engagement and the establishment of supportive collaboration and mutual learning networks in the area of quality of care

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ABSTRACT

Minimising quality gaps in healthcare systems remains a global healthcare challenge. Clinicians and policy-makers optimally seek to pursue effective healthcare through improving and establishing a standardised quality of care measure across various healthcare institutions both at home and abroad.

Therefore, building cross-border mutual learning networks becomes crucial for collaboration to enable effective multi-culturally relevant and sustainable healthcare delivery. The Institute of Healthcare Improvement presents a model to foster stakeholder involvement and the establishment of supportive collaboration using the concept of mutual learning networks.

INTRODUCTION

Closing quality gaps remains an open and ongoing challenge for health systems across the globe. As we continue to pursue the mission of improving health and healthcare worldwide, with a view to ensure the best possible health and care for all, building networks of impact that collaborate towards better health and care at sustainable costs (the Triple Aim) remains a top priority. We welcome the opportunity to reflect upon some of the networks we have built in partnership with many across the globe over the last decade, including those with clear vision but without numerically quantifiable aims, and those with clear time bound aims. We acknowledge that there are many other types of networks and have decided that for the purposes of this meeting, we will focus on the two types described.

DESCRIPTION OF GOOD PRACTICE

A network with clear vision and intent: IHI's Health Improvement Alliance Europe

Nurturing networks is an art, not a science. In our experience, there are some fundamental design features for networks to drive change and be sustainable over time. These include:

1. Defining the 'why' of the network: belonging that is driven by shared purpose tends to stand the test of time.
2. Co-designing the network's vision, working principles, and values.
3. Defining a network's activities to translate the vision into reality.
4. Articulating the network's benefits for members.
5. Setting the network's priorities as a collective.
6. Leveraging the collective voice of the network.
7. Adapting and renewing the network systematically – for instance, every year.

AN EXAMPLE

The following example illustrates the potential of networks in health and healthcare to drive shared leaning and improvement.

In 2015, the Institute for Healthcare Improvement co-created the IHI Health Improvement Alliance Europe (HIAE) with four core strategic partners including East London Foundation Trust, Jonkoping County Council's Qulturum, the Scottish Government, and Royal Free NHS Foundation Trust. Members of the HIAE co-create systemic improvements (in conjunction with staff and users in their regions) with a vision to co-design and co-produce health and care better than we have ever known, at a cost we can all afford for every person, every time. Through an "all teach, all learn" network, the HIAE is comprised of leaders who are focused on improvement, willing to both share

and test innovations and improvements in new systems and eager to spread successful learning locally and nationally. Member organisations include over 30 providers of primary and secondary care, governments, improvement organisations, hospital associations, and integrated care systems. HIAE has been active since its launch in September 2015 on an annual schedule and is open to new members each year (September-August). 70% of members have been members since 2015. Activities include three, in person, intensive 1.5 days meetings each year hosted by members across Europe, and monthly webinars on priority topics. Three priority topics are selected annually by members for HIAE – and in 2021 these include equity, health and care across systems, and sustainability (environment). These priorities generate work-streams for HIAE, and members are able to invite individuals with a special interest in these sub-groups to attend any and all virtual HIAE activities. In person activities tend to be limited to 3-5 members per participating organisation. The group's learning opportunities are driven by and for members, with a focus on innovations relevant to their local system challenges.

Members agreed on clear working principles reviewed annually that guide everything done by HIAE:

- Accept and encourage messiness: The pathway to health care improvement is challenging; to progress we must accept that the way forward will be messy and encourage bold new ideas that add to the messiness.

- Share assets and ideas: Everyone has something to share, and when we share freely and openly, we accelerate the pace of testing, change, and improvement.

- Radiate authenticity: This is a safe space for you to be your authentic self, in the spirit of well-being.

- Build strong relationships: We are more generative, impactful, and bold when we work together, across silos, and between regions.

- Practice "all teach, all learn": We are all willing to teach and be taught, drawing upon the collective knowledge and experience we share as an alliance. We learn across cultures and share knowledge across all health systems, leveraging our collective cultural identities and regional differences.

- Centre on Equity: Continually practice our equity guidelines as we work to advance equity as individual leaders, within our member organisations, and in partnership with local communities. Benefits for members include direct access to each other (leading health and healthcare organisations); opportunities to develop networks within the context of Alliance meetings, and beyond with member organisations; unlimited organisational participation in collaborative harvesting, designing, and testing; unlimited organisational participation in virtual meetings and on HIAE virtual platforms; permission to use HIAE Member badge on social media, email signatures, and other relevant resources.

EVIDENCE OF IMPACT

Some of the results of HIAE members over time include:

- The sustainability of the network over time
- Protected space to reflect together on shared priorities.
- Presentations at global events on shared interest topics.
- A British Medical Journal (BMJ) publication on equity and population health improvement.[1]
- The start of a global kindness in healthcare network.
- Agreed HIAE equity guidelines.
- Several learning partnerships between teams (diabetes, equity, population health, etc.) and organisations (board to board, etc.).
- Capacity to galvanise local leaders when hosting HIAE meetings.

Learning and action networks with quantifiable aims

Learning and action networks (LANs) that bring together health and healthcare teams seeking to achieve a commonly agreed aim or set of aims through structured learning activities over a defined period are commonplace.

The characteristics of LANs include:

1. A commonly agreed gap to be closed
2. Existence of evidence of 'what works' to close identified gaps
3. Clearly defined and commonly agreed 'how much, by when, for whom' aims
4. Willingness by participating institutions to translate such evidence into action locally, by adapting the evidence to the local context in partnership with those who do the daily work in those systems
5. An improvement toolkit to support teams to adapt theory into practice, and to learn regularly
6. Transparency of real time measurement, for shared learning and improvement
7. A learning tempo that includes clearly defined activities and their frequency

The following two examples summarised in Table 1 illustrate active or recent LANs in Mexico and Portugal. Figure 1

SUSTAINABILITY AND FEASIBILITY OF GOOD PRACTICE

When health and healthcare quality challenges are broad (i.e. new models of care, changing co-production paradigms, learning to work across boundaries, etc.) and solutions are not known nor well defined, a broader approach to co-designing networks with clear vision and sense of purpose can bring about positive changes, enhanced collaborative relationships, and increase the potential for the collective voice of the network to be amplified. When challenges are specific and solutions are well evidenced in some contexts, learning and action networks can bring about measurable results. We have provided key characteristics for both designs. Both designs have weaknesses and in our ever-changing health and healthcare quality context, we have an opportunity to continue to learn together in pursuit of best possible health and care at sustainable costs for (and with) all. A continuous iteration of learning that not only reacts but also predicts ambient healthcare needs would allow this approach to offer the next level of quality assurance moving forward.



HIAE MEMBERS

STOP Infeccao core partners



Colaborativa MAS core partners and supporters



FIGURE 1: Multi-organizational contributors, collaborative partnerships and core supporters associated with this initiative.

Table 1: Comparing two examples to illustrate active or recent LANs in Mexico and Portugal. [1-10]

Stop Infeccao Portugal https://gulbenkian.pt/noticias/apresentacao-do- estudo-stop-infecao-hospitalar/	**Colaborativa MAS in Mexico** https://global.stjude.org/en- us/colaborativamas.html
THE GAP In 2014, seven times more people died from infections acquired in hospitals than in car accidents, and the length of stay of patients with hospital infections was five times longer than the rest. Portugal recorded almost twice as many hospital infections as the average for European countries, with costs estimated at 300 to 400 million euros a year* *Multiple references from: https://gulbenkian.pt/noticias/apresentacao-do-estudo- stop-infecao-hospitalar/	**THE GAP** Paediatric cancer is the first cause of death among sick children 1-15 years old[1]. Estimated around 5,000-6,000 new paediatric cancer diagnoses/year[1] with approximately 50% survival rate[1,2,3] (international benchmark ~84%[4]). 12% - Infection-related mortality rate for children with cancer in Mexico [1,2,3] (international benchmark <2.5%) *Sources:* [1]Boletin CeNSIA 2015; [2]Jimenez-Hernandez et al., JGO 2015; [3]Gonzalez-Montalvo et al., Blood 2017; [4]Rodriguez-Galindo et al.,Curr Op Ped, 2013; [5]Aviles-Robles et al., Am J Infect Control 2014; [6]Caniza et al., Exp Rev of Hem 2015
KNOWN SOLUTIONS TO CLOSE GAPS  GLOBAL EFFORT By Carol Haraden and Jason Leitch Scotland's Successful National Approach To Improving Patient Safety In Acute Care	**KNOWN SOLUTIONS TO CLOSE GAP**  Blood Adv. 2018 Nov 30; 2(Suppl 1): 63–66. PMCID: PMC6438; Published online 2018 Nov 30. doi: 10.1182/bloodadvances.2018GS112240 PMID: 30504; The "Golden Hour": a capacity-building initiative to decrease life-threating complications related to neutropenic fever in patients with hematologic malignancies in low- and middle-income countries Mario Ornelas-Sánchez,[3†] Laura Nuño-Vázquez,[1] Adriana Loera-Reyna,[1] Dara Torres-Reyes,[1] Rebeca Rivera-Gómez,[1] Alicia Sánchez,[1] Mitzy Romano,[1] Miriam González,[2] Miguela A. Caniza,[2] and Paula Aristizabal[3,4,5]  ORIGINAL REPORTS | Pediatric Oncology The Golden Hour: Sustainability and Clinical Outcomes of Adequate Time to Antibiotic Administration in Children with Cancer and Febril Neutropenia in Northwestern Mexico Check for updates Miriam L. Gonzalez, MD, MSc[1]; Paula Aristizabal, MD, MAS[2,3,4]; Adriana Loe Reyna, MD[1]; Dara Torres, MD[1]; Mario Ornelas-Sánchez, MD[1]; Laura Nuño-Vázquez, M Show More

PARTICIPANTS 12 hospital systems (19 hospitals) were selected competitively to tackle four hospital acquired infections: the ones associated with urinary catheterization in general medical units (CAUTI); those related to the central vascular catheter in ICUs (CLABSI); those related to mechanical ventilation in ICUs (VAP); and those related to surgical wounds (SSIs)	**PARTICIPANTS** 23 public hospitals of Mexico
AIM To reduce by 50% CLABSIs, CAUTIs, VAPs and SSIs in pioneering units of each of the 19 participating hospitals in Portugal by May 2018	**AIM** To increase the percentage of febrile pediatric hematology-oncology patients presenting to the Emergency Department
RESULTS Est reductions: CLABSI: 56% CAUTIs: 51% VAPs: 51% SSIs (hip and knee): 55% SSIs (gallbladder): 52% SSIs (colorectal): 0%	**RESULTS** Est 87% increase percentage of febrile pediatric hematology-oncology patients presenting to the Emergency Department who receive the first dose of antibiotics within 60 minutes from the initial assessment Est 55% reduction of average time between Triage and Antibiotic Administration (TTA) among HOPf patients Est 80% reduction of infection-related mortality rate amongst HOPf patients who present to the ED

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We acknowledge the organisations presented in Figure 1.

Keywords: stakeholder engagement, mutual learning networks, supportive collaboration, quality of care

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