

# Guiding Principles for Improving Black Maternal Health

Through Community Collaboration

Report  
[ihi.org](https://www.ihi.org)

## Author

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# Introduction

Seeking to improve outcomes for all people who birth in the United States and their babies and to reduce the stark inequities in maternal health, the Institute for Healthcare Improvement (IHI) engaged in a three-year (April 2018 to October 2021), large-scale project called Better Maternal Outcomes, funded with generous support from Merck for Mothers.

As part of the work of Better Maternal Outcomes, the Redesigning Systems with Black Women project aimed to facilitate locally-driven, co-designed, rapid improvements in four US communities – Atlanta, Detroit, New Orleans, and Washington, DC – targeting the interface of health care delivery, the experience of Black people who birth, and community support systems. The initiative aimed to improve equity, dignity, and safety while reducing racial inequities in maternal outcomes for Black people who birth.

During the project, through observation and ongoing learning and feedback, IHI identified eight guiding principles for improving black maternal health through community collaboration that contributed to the four communities' success. This report describes the eight principles, shares the experiences of participating communities, identifies key themes that emerged, provides recommendations for others seeking to engage in this work, and discusses lessons learned and implications for future locally-driven, co-designed, rapid improvement projects.

## Project Design

The Better Maternal Outcomes: Redesigning Systems with Black Women project ran from April 2019 to April 2021 and used an Equity Action Lab model to guide the work (see Figure 1). An Equity Action Lab is a flexible model using the Community of Solutions Framework<sup>1</sup> to guide participants through a structured set of activities in an equitable co-design process to set a health equity goal that is important to the participants. After setting a goal, Equity Action Lab participants develop ideas to test and then act during an Action Phase over a short period of time (generally 100 days) to make progress toward that goal. Between Action Phases, Equity Action Lab participants convene in a Momentum Lab to share successes and challenges and plan for the next phase of work.

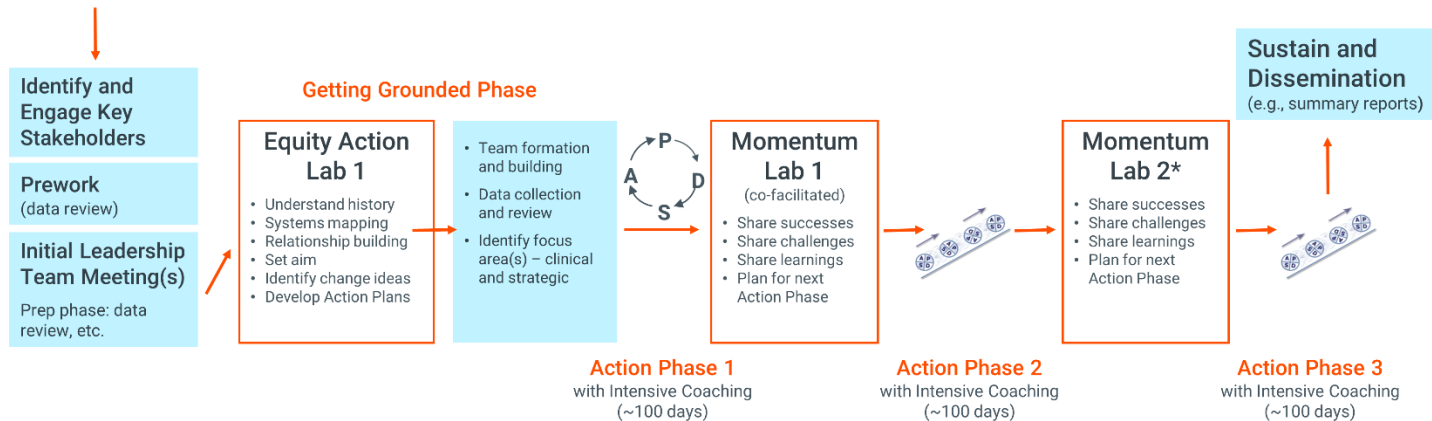
Equity Action Labs always involve people with lived experience and frontline staff in authentic co-design throughout this process. The Equity Action Lab model supported teams of disparate stakeholders to collaborate and develop ideas for improvement and then test these ideas in Detroit. It is important for readers who are interested in a similar approach to review the improvement ideas in this document through the lens of their own community's context and to test ideas on a small scale before deciding to implement more broadly.

Learn more about the specific ideas that the four communities tested in the summary reports.<sup>2</sup>

**Figure 1. Better Maternal Outcomes: Redesigning Systems with Black Women Project Model (18 to 24 Months)**

**Participants: 4 communities, each with 3 design teams (high-volume delivery centers)**

IHI Team: Select communities, partners, leads, faculty; environmental scan; identify measures (PROM)



**Supports**

Expert faculty; group facilitation/site visits; quality improvement methods; 2x monthly coaching calls during Action Phase; cross-community calls; key design principle assessments; 1:1 support (e.g., data, relationship building/management; leadership, managing up); monthly design progress check-ins; IHI Improvement Coach Program; IHI Psychology of Change Framework coaching

\*Some communities held 3 to 4 Momentum Labs; IHI facilitated the Equity Action Lab and first Momentum Lab; communities facilitated subsequent Momentum Labs

**Glossary of Terms**

- **Authentic co-design:** Health care staff, people with lived experience, and community-based organizations working together to design a new system or improve an existing system, making full use of each other’s knowledge, resources, and contributions to achieve better outcomes.
- **Context expert:** Sometimes referred to as a person with lived experience, a context expert is someone who has lived (or is currently living) with inequities and/or the issues that the community is focusing on and may also have insights about the system as it is experienced by consumers. In this project, context experts included Black people who were pregnant, had previously been pregnant, or have given birth.
- **Plan-Do-Study-Act (PDSA) cycle:**<sup>3</sup> An important component of the Model for Improvement, a PDSA cycle is a structured process for testing a change by developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the consequences (Study), and determining what modifications should be made to the test (Act).

# Guiding Principles for Improving Black Maternal Health

Approximately six months after the start of the Better Maternal Outcomes: Redesigning Systems with Black Women project, IHI identified eight principles that guided the work and contributed to the four communities' success.

## Guiding Principles for Improving Black Maternal Health Through Community Collaboration

- Affirm a Commitment to Health Equity
- Approach the Work with Humility
- Commit to Co-Design with People with Lived Experience
- Build Awareness of Historical Context and Willingness to Acknowledge and Address Institutional Racism
- Navigate Various Stakeholder Relationships
- Build Quality Improvement Capability
- Provide Dedicated Project Management Support
- Foster Shared Leadership

These principles are based on IHI's observation of and learning from community design teams during the first round of Equity Action Labs and Action Phases. Continuous feedback from the communities on the eight principles was obtained through coaching calls, Momentum Labs, an online survey, and 18 key informant interviews (14 design team members from the communities, 4 IHI team members) conducted between November 2020 and July 2021.

This section of the report describes the eight principles and findings from the interviews, including key themes that emerged from the communities' experiences and recommendations for others seeking to engage in this work.

## Affirm a Commitment to Health Equity

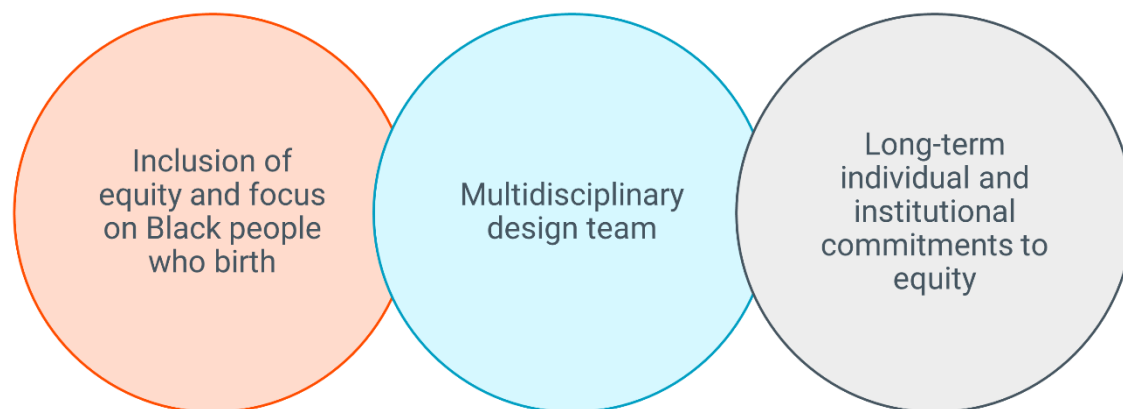
### Definition

Both individuals and institutions affirm their commitment to understanding and addressing health equity, and commit to integrating equity into how the work is designed and implemented.

### Themes

Design team members from the Better Maternal Outcomes: Redesigning Systems with Black Women project and the IHI team provided insights on how this principle influenced their work. Key themes for this principle emerged from the project and guided the work (see Figure 2), including the focus of the project on Black people who birth, engaging with people with lived experience (context experts), creating a multidisciplinary design team (e.g., Black people who birth, health care systems, and community-based organizations), and recognizing that this work requires long-term individual and institutional commitments to equity.

Figure 2. Themes for the Principle: Affirm a Commitment to Health Equity



Design team members described how their commitment to equity determined the focus of the project. As a result, the project explicitly focused on Black birthing people because they are disproportionately impacted by maternal mortality in the US. Understanding and addressing these inequities as well as their root causes (e.g., institutional racism) was embedded in the design and throughout activities led by IHI (e.g., Equity and Momentum Labs, coaching calls).

“We had to say for this project we’ve made the decision to focus on Black people who birth, because the data shows us that across the board that’s where the challenges are. That commitment to equity, a commitment to look at your data and what it’s telling you and be willing to commit to creating equitable outcomes based on what your data is telling you, that’s where that came from. And we found that’s important because, otherwise, you can get on all kinds of tangents – you know it’s not having that commitment to equity.”

—IHI Team Member

“The facilitators on those coaching calls always asked the question about equity. They made sure to always keep us grounded in equity and made sure that they asked the question if they didn’t hear it in the design or in the work.”

—Design Team Member

One key way to demonstrate a commitment to equity was through engaging context experts in the work and on multidisciplinary design teams. Design team members described two primary types of interactions with context experts: listening and uplifting their voices and ideas, and co-designing with them in the planning and implementation of design team activities. Many quality improvement (QI) projects do not routinely include context experts or community-based organizations.

Lastly, design team members and IHI discussed the importance of their own individual commitments to equity as well as the commitments (or lack thereof) of the health systems participating in the project.

“Commitment to equity is... an individual project and it also has to be tackled on a systemic level. We’re all on our own individual journeys, and that work has to happen on a daily basis.”

—Design Team Member

## Recommendations

Based on their experiences and feedback, the design teams and the IHI team shared recommendations for this principle.

- The focus and design of the quality improvement project needs to be data-informed and target groups disproportionately impacted by adverse health outcomes.
- Those leading and engaging in quality improvement projects need to make long-term individual as well as institutional commitments to understanding and addressing the root causes of health inequities (e.g., institutional racism).
- Develop diverse design teams that are inclusive of people from different backgrounds and disciplines (e.g., people with lived experience, community-based organizations, clinicians, academic institutions).
- Recognize power dynamics and establish processes that create an equitable and inclusive team dynamic.



## Approach the Work with Humility

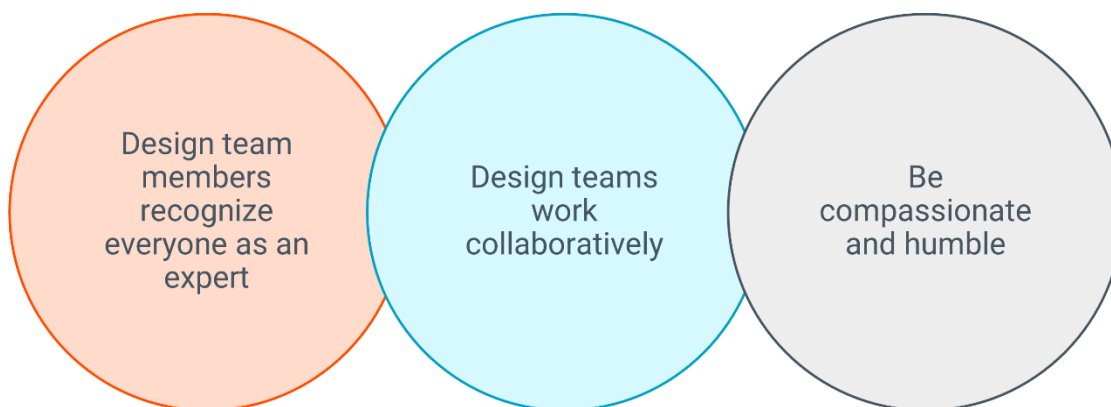
### Definition

Recognize that no single individual has all the answers; we all hold a piece of the puzzle, especially people with lived experience, and need each other’s knowledge and experience to identify and implement successful solutions, seeing the value in *all* people.

### Themes

Design team members from the Better Maternal Outcomes: Redesigning Systems with Black Women project and the IHI team provided insights on how this principle influenced their work. Key themes for this principle emerged from the project and guided the work (see Figure 3). Many responses affirmed the presence of this principle in design teams, reflective in members recognizing everyone as an expert and being compassionate and humble. Approaching the work with humility resulted in design teams being able to collaborate more effectively.

Figure 3. Themes for the Principle: Approach the Work with Humility



Design teams consisted of clinical and non-clinical members from academic institutions, community-based organizations, governmental agencies, hospital systems, payers, state and local health departments, and people with lived experience. As a result, design team members acknowledged that they did not have all the answers and stated the importance of recognizing everyone as an expert. This is key to addressing the inequities faced by Black birthing people. This expertise came not only from their professional experiences, but also from their lived experiences.

“Approaching the work with humility, I think we do that. I think we understand that, but there is this desire that when we don’t have the answers... we are just going to keep at it. We’re not going to give up, and [we’re] being fully [committed] to the charge that’s in front of us.”  
—Design Team Member

“I would hope that the communities would feel that approach to work with humility. We really tried to always lean back on the idea that we didn’t have the answers. The teams were going to be bringing the solutions to us, and we would help them figure out how they can put that into practice.”  
—Design Team Member

Approaching the work with humility also required design team members to be compassionate and humble. This encompassed meeting other design team members where they were regardless of their backgrounds or level of readiness to implement improvement projects, being open to learning, and believing the experiences of birthing persons.

“For everyone, but primarily for the hospital systems and providers and the community-based organizations, to come into this work with a humble posture of learning – that they wanted to be able to hear, listen, believe the experiences of persons who birth and be willing to lead, and just go in and do the work together.”

—Design Team Member

“Even when you’re not in a clinical setting there is respect. But they’re just realizing that you have to approach this [with] humility... This power gradient is real, whether you want it to be there or not. And the only way to navigate around it is the tincture of time and being humble and helping them have some wins and outcomes.”

—Design Team Member

This approach also resulted in design teams collaborating more effectively, including multiple design team members working in partnership to plan and implement activities.

“Yes, I think that we were able to do this as well. I don’t feel like there was ever a time when one person took over the planning and didn’t allow others to give their input. I actually think it was the opposite.”

—Design Team Member

“I think what really mattered was hearing from both groups and having them contribute equally to the design work, to the administrative work. I think that those partnerships wouldn’t have worked as well, if not for working together in partnership with each other.”

—Design Team Member

## Recommendations

Based on their experiences and feedback, the design teams and the IHI team shared recommendations for this principle.

- Recognize everyone on the design team as an expert, especially given the potential power dynamics between clinical and non-clinical members.
- Be compassionate and humble in your interactions with other design team members.

## Commit to Co-Design with People with Lived Experience

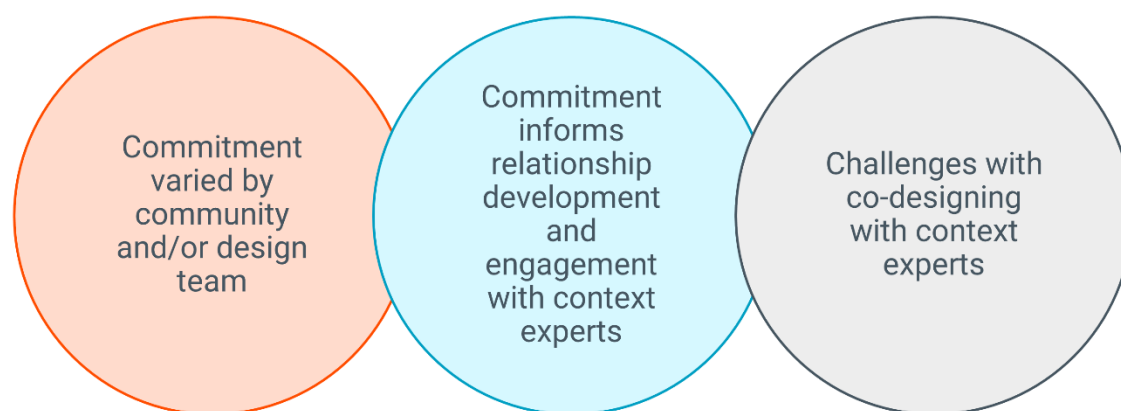
### Definition

Communities are more likely to make equitable change as they build trust, relationships, and interconnectedness through collaboration with people with lived experience (context experts).

### Themes

Design team members from the Better Maternal Outcomes: Redesigning Systems with Black Women project and the IHI team provided insights on how this principle influenced their work. Key themes for this principle emerged from the project and guided the work (see Figure 4). Responses included the varying levels of commitment demonstrated by different communities and design teams, how their commitment informed developing relationships and engaging with context experts, and challenges with co-designing with context experts.

Figure 4. Themes for the Principle: Commit to Co-Design with People with Lived Experience



Although the project encouraged communities to co-design with context experts, design team members shared that there were varying levels of commitment from communities and design teams. For example, a few team members shared that only one of three design teams in their communities co-designed with context experts. Existing relationships or the development of new relationships with context experts throughout the project was also mentioned as a factor that impacted co-design.

“A young lady that [a design team member] probably recruited, she might’ve been engaged for the first hour and that was it. We didn’t have [co-design] on that team... The only place that we have women with lived experience [engaged in co-design] has been on [one] team.”

—Design Team Member

“We really tried to set it up so that context experts felt like they were centered and their voices were being valued in the work, not just as an additional input but as primary. That worked itself out differently in different communities. Some communities started with really strong relationships with context experts, and so it was very easy for their teams to be led by context experts and have deep interactions. Other teams had to build relationships with context experts as the work progressed.”

—IHI Team Member

Relationships with context experts included consistent communication, learning from them, and working side-by-side in the planning and implementation of design activities. This extended beyond just receiving their input.

“I’m like, ‘Here’s my phone number. Call me whenever, we’ll figure it out.’ I have an hour commute from work, so the first few months I would talk to [context expert] every day about this project and we’d brainstorm and so on.”

—Design Team Member

“I think that our team did certainly commit to working alongside [context experts]... We wanted to really learn from those who we were speaking with and we were sharing with. So, yes, definitely, there was a commitment to the experts... up until the pandemic caused us to have to be apart.”

—Design Team Member

However, some design team members shared challenges with being able to build trust, develop relationships, and collaborate with context experts. One team member shared how context experts had to balance multiple responsibilities while attending meetings as well as having to accommodate providers’ schedules. Another team member made the distinction between co-designing and having context experts provide input on something that was already designed.

“I don’t know that trust, that true trust, was ever built [with] people with lived experience — the people who are showing up often with two or three kids yelling in the background, often calling from their phones while they were going to pick someone up from school. And to show up on those phone conversations and not see the other parts of your design team, like continually having to reschedule meetings around the schedules of providers, I think really was a barrier to building trust and relationships.”

—Design Team Member

“The postpartum support group was really successfully co-designed with context experts. They were able to put in their input — but that’s why I keep saying ‘put in their input.’ Is that co-designing, or is that ‘it’s already been designed and now we’re making changes’? I don’t know about that one. I’m sure there’s an idea that you want to have that commitment to co-design, but I don’t know if that’s always achieved.”

—Design Team Member

## Recommendations

Based on their experiences and feedback, the design teams and the IHI team shared recommendations for this principle.

- Attempt to understand and address context experts’ needs and wants to better facilitate participation.
- Identify and address barriers to co-designing with context experts early in the design.
- Provide explicit expectations on what it means to co-design with context experts.

## Build Awareness of Historical Context and Willingness to Acknowledge and Address Institutional Racism

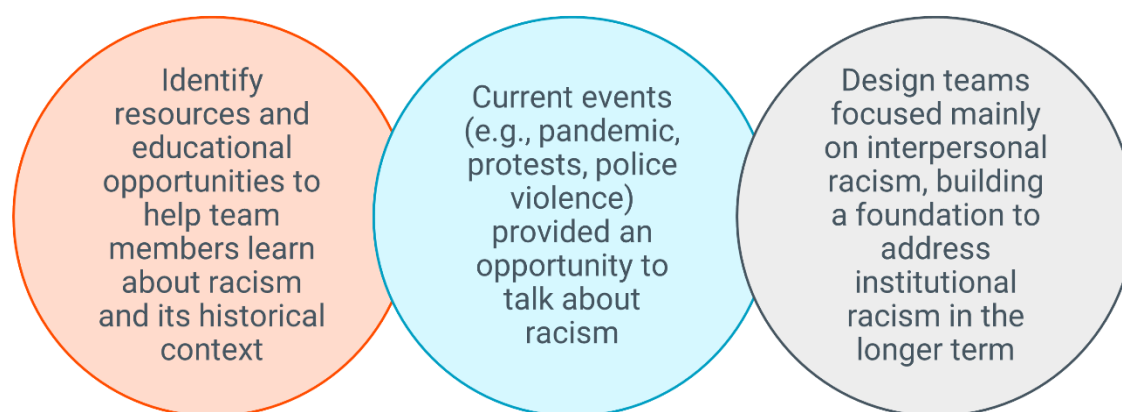
### Definition

To address current inequities, it is necessary to be aware of and understand the historical context of how systemic and structural racism has manifested in communities as design teams work together to unravel and build new systems rooted in equity.

### Themes

Design team members from the Better Maternal Outcomes: Redesigning Systems with Black Women project and the IHI team provided insights on how this principle influenced their work. Key themes for this principle emerged from the project and guided the work (see Figure 5). Many team members affirmed the presence of this principle in relation to the work they did, both professionally and personally.

**Figure 5. Themes for the Principle: Build Awareness of Historical Context and Willingness to Acknowledge and Address Institutional Racism**



Many design team members had an awareness of the historical impact of racism in the US, while others had to increase their awareness through videos, reading, and presentations by thought leaders, advocates, and researchers who are advancing birth equity and reproductive justice in maternal health (e.g., Dr. Joia Crear-Perry, Dr. Fleda Mask Jackson). Some books that team members noted include *Battling Over Birth: Black Women and the Maternal Health Care Crisis*; *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*; and *Stamped from the Beginning: The Definitive History of Racist Ideas in America*.

“I thought it was very helpful bringing people in from an educational perspective, especially at the beginning, to address, talk about racism, use different videos to educate. It kind of level-set. Didn’t assume that we all knew about racism, what it was, but it did assume that we needed to address it. So, let’s get some historical background on racism — and that was done very early [in the project].”  
—Design Team Member

Several design team members shared their teams’ willingness to acknowledge and even address institutional racism, given the national attention to and impact of several public health

crises disproportionately impacting Black, Indigenous, and people of color (i.e., maternal mortality, police violence, COVID-19 pandemic).

“You couldn’t help but talk about these sorts of things, especially this year, because not only did we have the pandemic – which just highlighted the differences and the experiences and outcomes among different racial and ethnic populations – but you [also] had what was going on with George Floyd, Breonna Taylor, Ahmaud Arbery, [and] how many more?... It was just interesting that you had the opportunity because it was right there in the news. It wasn’t like we were just pulling on it just because. It was there for us refer to and say, ‘Hey, this is going on, too.’”

—Design Team Member

“In [Washington,] DC, with the protests and police brutality and just a highlight on COVID-19 disparities, I think there is definitely right now a willingness to acknowledge institutional racism and acknowledge it in different institutions, like the police system or like our council or different institutions that are rooted in inequity. And there’s definitely a push to have people address that, or people acknowledge that.”

—Design Team Member

Despite the acknowledgment of how racism contributes to maternal health inequities, many design teams were unable to address it on an institutional or structural level (e.g., transforming policies or funding). Design teams tested activities that primarily focused on reducing racism’s impact on an interpersonal level and sought to improve the interaction between providers and patients, such as with implicit bias trainings and bias checklists for providers. Nevertheless, these activities provide the foundation for more long-term efforts to address institutional and structural racism within health systems.

“You have to acknowledge it and do it, or you can’t do the work. Otherwise you’ll keep making missteps. Especially you can’t [do the work] if you don’t acknowledge that history of racism when you see the patient – you typically want to blame them and put all of the elements on them, instead of realizing that our systems are messed up and we need to fix how we do things, not how they come to seek care.”

—IHI Team Member

## Recommendations

Based on their experiences and feedback, the design teams and the IHI team shared recommendations for this principle.

- Provide training and resources on the different types of racism (e.g., internalized, interpersonal, institutional, structural), how racism impacts quality of care received as well as adverse health outcomes, and anti-racist interventions in health care settings.
- Targeting institutional racism requires addressing the policies, practices, and customs codified in health systems that negatively impact the quality of care and health outcomes experienced by Black women and birthing people. Encourage design teams to focus their efforts on these instead of interpersonal interactions.

## Navigate Various Stakeholder Relationships

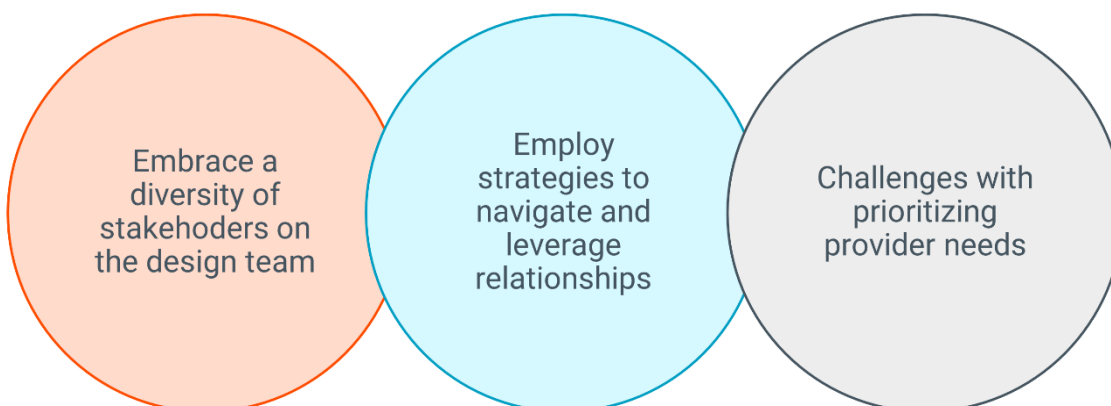
### Definition

For many teams, this project may be the first time to co-design and co-implement efforts with people with lived experience; teams must be able to “meet people where they are” and understand what matters to them.

### Themes

Design team members from the Better Maternal Outcomes: Redesigning Systems with Black Women project and the IHI team provided insights on how this principle influenced their work. Key themes for this principle emerged from the project and guided the work (see Figure 6). Responses included the importance of embracing a diversity of stakeholders on the design team, employing strategies such as problem-solving to navigate relationships, and challenges with prioritizing provider needs.

Figure 6. Themes for the Principle: Navigate Various Stakeholder Relationships



Although people with lived experience are key stakeholders in this work, team members also described a range of other important stakeholders to engage. In addition to including stakeholders on the design team, one team member shared how they were able to effectively work together despite differing interests, while another team member shared how this diversity resulted in greater impact of the work.

“Thinking through all of the different groups that were represented on our team, we definitely worked well together and played to each other’s strengths, and we were able to make sure that there weren’t any conflicts of interest or conflicts of agendas.”

—Design Team Member

“I think that really contributed... the breadth of their experiences that they spoke from, and that also contributed to the design teams themselves... having a wide range of involved participants, which would then lead to more impactful strategies and more change across different groups.”

—Design Team Member

“The groups were not afraid to bring in other agencies and other stakeholders, even if they weren’t with the core team. Even me, from a personal perspective, bringing in subject matter experts from [a

health care organization] where I thought that their expertise was needed and would benefit the overall outcomes.”

—Design Team Member

Design team members also shared how they navigated and leveraged relationships with stakeholders. This included communication, problem-solving, and using their positions to design and test activities.

“Just the relationships on the design teams — they’re very willing to connect you to other people, very willing to leverage their positions in their organizations to help co-design and implement things. That’s one thing that’s been really good.”

—Design Team Member

“I think all of those things helped strengthen the relationships... talking through a lot of real-time problem-solving and navigation. In some of our coaching calls, it wasn’t much about QI; it was about how do we navigate the different stakeholders here.”

—IHI Team Member

However, there were several challenges that arose. Several design team members shared the frustration with having to meet providers where they were, but not having this reciprocated.

“I think just as much as the providers, I struggled with meeting the context experts and the community partners where they were at. It was also hard for us to really understand the hospital themselves. I don’t want to say that it was just one-sided. I think that [one community-based organization] really struggled to understand the concept of having to package this information in a certain way to even get a foot in the door, to even get providers to consider doing some of this work.”

—Design Team Member

“I can’t say that it was not without challenges. Trying to match lived experiences or the experiences with community-based doulas with the meet-and-greet that we had — how we would go about it and the language that was preferred for clinicians to hear so that they don’t feel ostracized was heavily a part of how we designed the meet-and-greet.”

—Design Team Member

## Recommendations

Based on their experiences and feedback, the design teams and the IHI team shared recommendations for this principle.

- Embrace a range of stakeholders, especially those with lived experience, on design teams.
- Build in time for relationship/partnership development in the project design.
- Provide design teams with tools and resources on effectively communicating, collaborating, and problem-solving.
- Make accommodations for both clinical and non-clinical design team members.



## Build Quality Improvement Capability

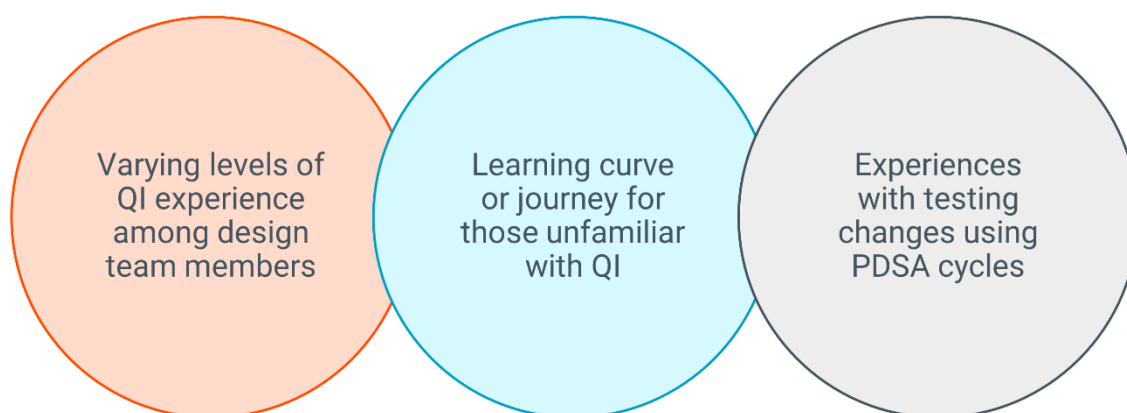
### Definition

Knowledge of quality improvement (QI) methods and how to use them, along with readiness to do so, is an important component of the work.

### Themes

Design team members from the Better Maternal Outcomes: Redesigning Systems with Black Women project and the IHI team provided insights on how this principle influenced their work. Key themes for this principle emerged from the project and guided the work (see Figure 7). Responses included the varying levels of QI experience among design team members, the learning curve or journey that occurred among design team members who were unfamiliar with QI, and experiences with testing changes using the Plan-Do-Study-Act (PDSA) cycle.

Figure 7. Themes for the Principle: Build Quality Improvement Capability



Design team members discussed the differing levels of QI experience among team members. Some team members, particularly those currently working in clinical settings, were more familiar with QI methodology while others were unfamiliar with it. Those with more QI experience were able to support other design team members.

“Fortunately, because IHI is QI and I do QI in a clinical setting, it helped keep us anchored because most of these stakeholders don’t really know what [QI] is. They hear it in theory, but doing [QI], they’re not [familiar with it].”

—Design Team Member

“There were some people who came into this [project] with a high level of [QI] skill... I had done QI before, and it was really embedding those principles. Then there were other groups where we were sort of coming alongside in terms of being able to help them use the principles. So, we did things like a little PDSA booster session. I sat with all the community organizations by the end of the work [and] talked about measurement.”

—Design Team Member

For those unfamiliar with QI, design team members described the learning curve or journey that occurred throughout the project.

“I’m a doer... someone tells me to design something, then I’m about designing it. And, of course, we got to test it and make sure it works. But sometimes you are tweaking it while you design it... this was a little different. So, I finally got it together and, it was funny, during one of our calls, everybody was excited because at first, I complained about it. I was like, ‘Oh, all these steps? This is too much work.’ But now I do understand Plan, Do, Study, Act, and this is good.”

—Design Team Member

“It was hard to understand, but I think that [a design team member] finally got it by the end. I think we all struggled with it because we were just like, ‘Let’s do this’ and ‘This is what we’re doing.’ There was this whole idea about testing the ideas [first].”

—Design Team Member

Although a range of QI methods were shared with design teams, members shared their specific experiences with PDSAs. However, one design team member shared their difficulties with utilizing PDSA cycles.

“We learned about PDSAs from IHI... and so we were able to use that to move the work forward and to be able to make changes quickly as opposed to waiting. There’s a PDSA, you set a timeframe... two weeks, three weeks, two months as opposed to those 90-day cycles that we had.”

—Design Team Member

“[An IHI team member] helped me design an assessment tool and I was able to show that this is what people know and this is what’s not happening, to make the case for a Postpartum Navigator. So, those PDSA cycles worked.”

—Design Team Member

“We had to shift the way that we do things so that we could report to IHI the way that they wanted to receive the report. And so, it really impacted our progress. I think we spent a lot of time trying to make things fit into this PDSA model versus giving us a method that was reflective of the way that we work best.”

—Design Team Member

## Recommendations

Based on their experiences and feedback, the design teams and the IHI team shared recommendations for this principle.

- Provide affordable opportunities for design team members to increase their knowledge of QI methods and tools.
- Partner QI methodology with the existing methodology used by community-based organizations.

## Provide Dedicated Project Management Support

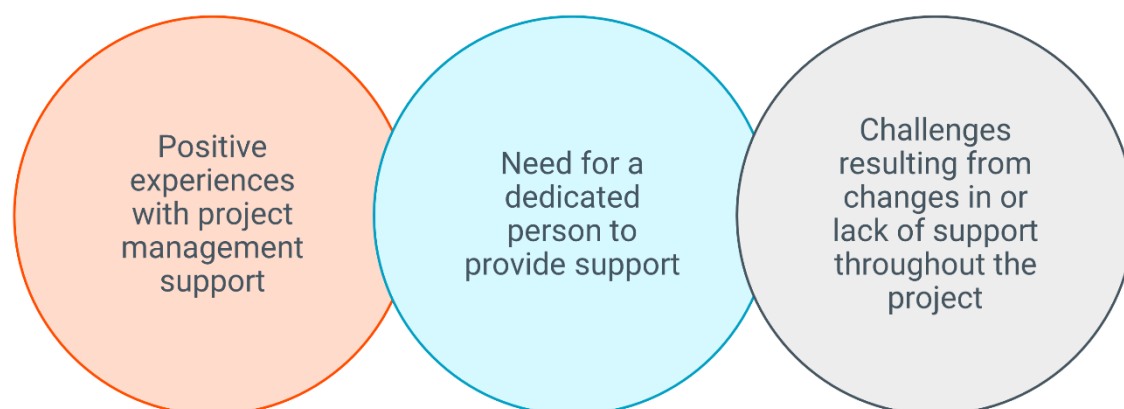
### Definition

It's critical to have people whose responsibility it is to ensure that the work keeps moving forward (stewards for the work).

### Themes

Design team members from the Better Maternal Outcomes: Redesigning Systems with Black Women project and the IHI team provided insights on how this principle influenced their work. Key themes for this principle emerged from the project and guided the work (see Figure 8). Responses included positive experiences with the project management support, the need for a dedicated person to provide project management support, and challenges resulting from changes in or lack of support throughout the project.

Figure 8. Themes for the Principle: Provide Dedicated Project Management Support



Many design team members shared positive experiences with the project management support they received throughout the project. This was often facilitated by the lead organization in the community, but team members also remarked on the support they received through IHI.

“[IHI] should write a book on it if you want to know how to manage a project. Take a page out of this [book] because there are some very specific indicators on how other teams can be successful using the tools and the resources and the blueprint that we used.”

—Design Team Member

“We had a wonderful team, and they still go above and beyond to help out where necessary. I feel like where someone may be lacking because of our lived experiences, they’re willing to step in and help out with that.”

—Design Team Member

“IHI definitely was helpful in providing us the support and encouragement, and what we needed to do to spur things along. There were moments where we hit some snags and tried to move forward, delays and people not being able to get back in time for whatever reason with information, things like that.”

—Design Team Member

Project management support was typically provided by a dedicated person on each design team, in addition to their current workload. This person moved the work forward by coordinating with IHI, maintaining relationships with context experts, scheduling meetings, responding to emails, coordinating weekly tasks, and coordinating report writing. This was key especially during the COVID-19 pandemic.

“We had a project coordinator who was our point person between IHI and the organizations... She did a phenomenal job at trying to keep everybody on task. At the very least, making sure that people turned in their reports on time and had something to report.”

—Design Team Member

“[Design team member]’s commitment to showing up was huge... especially during those dog days of the pandemic when there would be call after call, where there were very few people showing up other than the context experts and [our design team member]. I give her so much credit for that because I know her plate was full and she really carried the charge for this work.”

—Design Team Member

However, some design team members shared challenges resulting from changes in support or lack of support throughout the project.

“I know what it was [like] when we did have [project management support] versus when we don’t have it, and it’s so different. When we had someone who was dedicated to just manage the project and support, it was literally like grease on the wheels, like it was a moving train. We had meetings every week, we had tasks... [and the project manager would say], ‘Did you do it? Did you not do it? We’re going to be here. We’re going to be there.’ But now it’s just me trying to do that.”

—Design Team Member

“I knew very early on that I needed an admin to manage my meetings and hopefully my invites. That is 40-plus percent of the work. [Design team member], who I’ve gotten to know well and is now a friend, was serving in that role. But that was also not really her wheelhouse either, so I think other teams did struggle because we didn’t have that project management support as strong.”

—Design Team Member

## Recommendations

Based on their experiences and feedback, the design teams and the IHI team shared recommendations for this principle.

- Secure one to two dedicated people to provide project management support throughout the project.
- Provide funding to lead organizations for project management support (i.e., people, software, resources).
- Provide access to project management tools and resources to streamline activities and make tasks more efficient.

## Foster Shared Leadership

### Definition

To support the sustainability of the work, design team members must feel a sense of ownership and a commitment to see it through together.

### Themes

Design team members from the Better Maternal Outcomes: Redesigning Systems with Black Women project and the IHI team provided insights on how this principle influenced their work. Key themes for this principle emerged from the project and guided the work (see Figure 9). Responses included the importance of sharing input and workload among design team members, the differences that exist among teams within communities, and challenges with shared leadership.

Figure 9. Themes for the Principle: Foster Shared Leadership



Design team members described shared leadership in relation to team members being able to share their input and share the workload.

“I believe that my design team put their best efforts into trying to make sure that everybody did something, or at least everybody had an input.”

—Design Team Member

“I do feel like there was a sense of shared leadership, especially on the pregnancy team... We were all willing to take on what [was] needed in order to execute.”

—Design Team Member

However, shared leadership differed among communities. For example, in Atlanta there was a design team focused specifically on shared leadership.

“This is where it definitely was a little bit different [by] community... [A lead organization] might say that they feel like it was shared leadership. I don’t know if any other organization would agree with them, we only ever saw them. And so, it became hard to assess what true co-design looks like.”

—IHI Team Member

“Atlanta put that [shared leadership principle] into a design team – it hadn’t been that at first, but I think it morphed into that to acknowledge the specific importance. I think this really helped contribute to not only creating and designing something that would impact a lot more people, but also would be sustainable because you had leaders in hospitals who knew about this project and would hopefully see that running through in their future projects.”

–IHI Team Member

There were also challenges of sharing leadership with context experts, especially throughout the project, and some design team members were more interested in sole versus shared leadership.

“This is a great word, shared leadership... I know they know that they’re context experts, but I don’t know that they feel like they own this work.”

–Design Team Member

“In certain communities, the fact that we built the initial relationship with certain entities that had less power allowed them to build that shared leadership. That’s where we learned, too, that it really made a big difference who the relationship was with. We started out with an idea of having a leadership team and leadership team meetings, and that was something we didn’t really actively continue to facilitate as an IHI team.”

–IHI Team Member

“I think initially they did [want to share leadership]. I just think it was very hard to get it done.”

–Design Team Member

## Recommendations

Based on their experiences and feedback, the design teams and the IHI team shared recommendations for this principle.

- Provide design teams with information and resources on collaborative, democratic leadership styles to facilitate shared leadership. This should result in shared decision-making and the equitable distribution of the workload. This is key when co-designing with team members, especially context experts.
- Develop a common understanding of shared leadership that can be utilized by design teams.

# Conclusion

“There are so many places I go where people think of equity as one strategy and QI as another. There is no quality without equity. If only some people benefit from the improvements you make, how can you say you’re providing high-quality care?”<sup>4</sup>

—Dr. Joia Crear-Perry

The Better Maternal Outcomes: Redesigning Systems with Black Women project aimed to improve equity, dignity, and safety while reducing racial inequities in maternal outcomes for Black people who birth. With feedback and learning from design teams in Atlanta, Detroit, New Orleans, and Washington, DC, IHI identified eight guiding principles as critical to the success of this work.

Although the four communities implemented the principles with varying levels of success throughout the project, two principles in particular were central for all communities: the importance of centering and co-designing with Black people who birth, as well as their community support systems; and long-term individual and institutional commitments to addressing the root causes of health inequities (e.g., institutional racism).

Some core learnings were distilled from design teams’ feedback and recommendations.

## **Communities engaging in locally-driven, co-designed, rapid improvement projects are more successful when:**

- Teams are multidisciplinary
- Everyone on the team is recognized as an expert
- Design teams are led or co-led by people with lived experience
- Design teams address power dynamics and establish processes that create equitable and inclusive team dynamics
- Design team efforts target policies, practices, and customs codified in health systems that negatively impact the quality of care and health outcomes experienced by Black birthing people

Additionally, there were takeaways for IHI related to supporting design teams in communities engaged in locally-driven, co-designed, rapid improvement projects.

#### **IHI can better support design teams in communities by:**

- Incorporating more time for relationship/partnership development
- Translating or partnering QI methodology with existing methodologies that are more familiar to community-based organizations
- Providing free or affordable opportunities for design team members to gain knowledge about QI methods and tools
- Providing tools and resources on effectively communicating, collaborating, and problem-solving
- Providing information and resources on collaborative, democratic leadership styles to facilitate shared leadership

This report endeavors to inform future improvement efforts by sharing the learning and experiences from this project, and by encouraging others to build on these guiding principles to eliminate maternal health inequities in the US.

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