

Include Sustainment Plan at the Beginning

The strongest justification for building a sustainment plan into the design phase, rather than incorporating it after the intervention demonstrated improvement, comes from evidence that improvement decays predictably once the project stimulus is withdrawn, that most QI evaluations are too short to detect that decay, and that the determinants of sustainability differ from the determinants of successful implementation.[\[1\]\[2\]\[3\]\[4\]](#)

Evidence that gains decay ("improvement evaporation")

Rolnitsky and Bell - a perinatal-specific review stating that QI projects, like other organizational changes, show frequent decline after implementation, with sustained change dependent on leadership, system capacity and resources, change characteristics, and formal processes to maintain, evaluate, and communicate results.[\[1\]](#)

Fleiszer et al. - cites estimates that 33–70% of healthcare innovations are not sustained, framed as the "improvement evaporation effect," and notes that failed sustainment squanders resources and produces stakeholder disenchantment.[\[5\]](#)

Evidence that sustainment must be planned early, not retrospectively

Devi et al. - followed seven interventions from three QI projects; only three of seven were still running at follow-up. Influences on sustainment included ongoing outcome monitoring and regular check-ins, and continued communication. The authors conclude explicitly that sustainability is best addressed during implementation rather than treated as a separate downstream process, and that this should be built in at the commissioning.[\[2\]](#)

Jaladanki et al. - national multisite study of pediatric asthma care in community hospitals; notes that QI research has predominantly examined effects ≤ 1 year and that sustainability is a distinct, dynamic process requiring its own strategies. Promising strategies identified: dedicated local champions delivering reminders and ongoing education, and EHR tools/order sets that persist long term.[\[6\]](#)

Zurynski et al. - systematic integrative review of 124 studies. Only 29 (23.4%) reported sustainability beyond 5 years, and just over half of those defined sustainability. The most frequently cited barriers/facilitators were leadership/support (49.2%), training/supervision (43.5%), and staffing/turnover (40.3%), all modifiable by a sustainment plan.[\[7\]](#)

Lee and Chang - analysis of 123 hospital QI projects (2015–2023) categorized by duration of post-project effect. The strongest predictors of persistence were alignment with clinical needs (17.7%), substantial patient benefit (15.1%), team QI knowledge/skills (14.4%), degree of IT/EHR integration (10.3%), and improvement in work efficiency (10.3%). Notably, long-term (>3 year) persistence was rare in the sample.[\[8\]](#)

Bray et al. - after three chronic disease collaboratives ended, 12 of 13 practices had sustained the specific improvements, but 5 of 13 reported sustaining improvement was a challenge; practices that continued generating new QI had "institutionalized" their strategies, citing regular data review meetings, leadership

commitment, infrastructure/staff support, and pursuit of additional funding.^[9]

Structural/organizational requirements that support sustainment

The AAP Standards for Levels of Neonatal Care effectively mandate the infrastructure a sustainment plan relies on: a dashboard with defined quality measures, a defined data-update frequency, internal/external benchmarking, a multidisciplinary forum for dashboard review; a process for monitoring implementation of identified interventions; a designated multidisciplinary QI team with a team lead; and periodic review of guidelines and policies to keep them current and evidence-based.^[10] Dye et al. describe the operational plan in a large NICU: a QI dashboard aligning unit and hospital metrics, formal QI leader training, embedded QI coaches, and secure web-based data infrastructure, which supported sustained improvement over 5 years.^[11]

References

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