

# PQCNC Initiative Participation Agreement

## INTRODUCTION

Medicaid considers us their 'perinatal quality improvement arm' and that is both an honor and a responsibility that we take seriously, and in doing so must exemplify the best that quality improvement science has to offer in improving the care of the perinatal population. Medicaid expects us to share with them what works, what doesn't, and what's needed to help inform their policies and decisions, something we can only do by adhering to the best of quality improvement science.

The Agency for Healthcare Research and Quality in a report entitled *Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies* undertaken to determine the effects of 'quality improvement strategies' on promoting adherence to interventions (categorized as) clinician education, patient education, audit and feedback, clinician reminders, and after looking at numerous hospital projects around CLABSI, SSI, CAUTI, HAI, and VAP, found no evidence to "consistently demonstrate the effectiveness of any specific strategy"

Education, policies, and reminders are not sufficient to move the needle, nor is one or two people working alone. Don Berwick - former president and CEO of the Institute for Healthcare Improvement (IHI) and led the organization's 100,000 Lives Campaign. Former administrator of the Centers for Medicare & Medicaid Services (CMS) who has served on the faculty for Harvard Medical School and Harvard School of Public Health – puts it this way:

*"I think clinicians do feel they're doing their best because they are doing their best. They're really, they're normal human beings, flawed, frail people, in difficult context, trying as hard as they can. The quality improvement science says trying harder is the wrong plan. It can't work. You're already trying as hard as you can. The problem is you're in a context which doesn't allow you to be reliable.*

*Most injuries to patients like most hazards in any situation are systemic. They're built into the way that the things flow. And this myth that somehow it all depends on the individual is a hard myth to break because I was trained in modern approaches to improvement systems thinking and ways to think about interdependency. I became able to see the problem of patient safety as a systemic issue, which can only be fixed through systemic changes. Those are very hard to achieve, but it's the only route.*

*And so, the trick is to learn to think systemically, for clinicians to understand that they are citizens in complex environments, much bigger than themselves. And only when we get involved in... working in those interdependencies with the support of leaders can we make progress. It's really frustrating to try to be a hero all the time. It doesn't work."*

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Clearly you need more than policies and education and a single person doing their best. We know that too many things are lumped together as 'quality improvement,' resulting only in 'old wine in new bottles' - actions and mindsets that will not get us where we want to go. We know what doesn't work, and we've known for quite some time.

We know what does work – you need a team and adherence to good QI methodology to make the systemic change necessary to improve patient outcomes. Don Berwick again:

*“I think also, adhering to the science. (T)here are scientific foundations for making things better. Understanding systems and working at a systemic level, instead of, as I said, individual heroism, using data properly. We misuse data all the time in healthcare. We don't use it to help illuminate variation and how things are going. Information can really help unleash knowledge. And that's part of the plan. Part of it is learning to cooperate. (Y)ou can't improve patient journeys without high levels of respect and cooperation across many, many boundaries.*

*And then, we refer to in our field, PDSA, Plan-Do-Study-Act. It's a mnemonic to help remember that you improve by trying things, you improve by getting... you learn to ride a bicycle by getting on the bicycle and healthy organizations are always, always trying new things, reflect on what they've learned from it. Everyone's involved. This is what I call the science of improvement. And it involves leadership who understand it and then allow it to thrive. That's probably the biggest problem is leadership focused on improvement.”*

Building a team that can work across silos to address systems, talking to the population you're serving (nothing about me without me), mapping your current processes, devising SMART goals, devising PDSAs with rapid iteration, collecting and analyzing data to confirm improvement, and working to 'hardwire those improvements' – **this** is how improvement gets done.

Teams will be enrolled' and 'auditing' teams, based on organizational maturity (your ability to work across silos, have an effective team, deploy proven QI techniques during an initiative), ability to complete prerequisites and manage the work, and have a sense of urgency in improving patient care.

In this context, urgency refers to that fact that all 'hands on deck' working hard for a short period of time can really make an impact. Your team may not have the same urgency around this issue and this population, something you'll need to decide among yourselves.

While you and the patient populations you serve will get the most out of being an enrolled participant, there is much to be gained from auditing including: access to resources, newsletters, learning session content, potential best practices, and occasional coaching calls.



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But there is also much you will miss out on including intensive hands-on mentoring on the latest tools/techniques, technical assistance calls with leading experts, and more as we continue to develop new resources for enrolled teams.

Not quite ready as an institution, or unsure how to address the issues that are preventing you from enrolling? Rest assured, we can, and will, help you with any of the issues that are preventing you from becoming enrolled - it's why we're here!

We are committed to having every facility that wants to provide the best possible care for their patients to join us as an enrolled team - it's the path to making North Carolina the best place to give birth and be born.

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## **REQUIREMENTS**

***Your hospital will need to agree to the following requirements for participation as an enrolled team in the Perinatal Quality Collaborative of North Carolina (PQCNC) initiative:***

### **PREWORK**

- Team full roster submitted prior to kickoff
- Snapshot completed prior to kickoff
- Pework Data completed prior to kickoff

### **MEETINGS**

- Learning Sessions - Enrolled teams should bring their entire team, but will have at least two members in attendance for **all** Learning Sessions
- Enrolled teams will meet at minimum once a month following the start of the initiative to evaluate and move forward their work.
- Enrolled teams will meet at minimum with a PQCNC Clinical Initiative Manager once a quarter to review progress, discuss challenges, and receive support in accessing resources.
- Enrolled teams will provide relevant data and reports for discussion during all meetings

### **QUALITY IMPROVEMENT**

- Enrolled teams will complete the PQCNC Quality Improvement Plan with the help and support of the PQCNC team during the January Kickoff,
- Enrolled teams will update the status of this plan throughout the duration of the initiative on the PQCNC Monthly Leadership Report.
- Enrolled teams will submit the updated PQCNC Monthly Leadership Report each month throughout the duration of the initiative.

### **DATA**

- Enrolled teams will submit required initiative data to DELPHI throughout the duration of the initiative, within 60 days of the end of each month.
- If an enrolled team falls behind in their data submission, they will meet with a PQCNC Clinical Initiative Manager to create an action plan to bring submissions current.

***“Quality without science and research is absurd. You can't make inferences that something works when you have 60 percent missing data.”***

*– Peter Pronovost, world-renowned patient safety champion, innovator, critical care physician, a prolific researcher (publishing over 800 peer review publications)*