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Commitment to Collaborate: The Value of Establishing Multicenter Quality Improvement Collaboratives in Saudi Arabia

Abstract

Healthcare organizations around the globe are increasingly turning to multicenter quality improvement collaboratives (QICs) to improve patient care and outcomes. Despite the increase in demand and popularity of establishing multi-organizational QICs, there is limited evidence of these collaboratives in Saudi Arabia and in the Middle Eastern region. This article highlights the main components of successful QICs, recommendations to ensure successful QICs, and implications for establishing future collaboratives in Saudi Arabia.

Keywords: Collaborative, critical care, patient safety, quality improvement

Background

Recent global healthcare trends have proven that multicenter quality improvement collaboratives (QICs) bridge the gap between best practices and actual performance, which ultimately improve patient care and outcomes.^[1] When healthcare providers are engaged in these multiorganizational collaboratives, they work with experts and peers in a structured way to improve one preidentified area of care,^[2] some of which include and are not limited to infection rates, intensive care, medication errors, mortality rates, patient pain prevalence, asthma care, falls, pressure ulcers, cancer care, HIV/AIDS, mental health, patient throughput, and many others.

As a result, healthcare providers form multidisciplinary teams and meet frequently to learn about best practices, guide improvement practices within their organizations, and share the experiences of their local environments. This has been common practice adopted by healthcare leaders, policymakers, providers, research institutions, and sponsors in countries, such as the United States, Canada, Australia, the United Kingdom, and several countries in Europe.^[3] Numerous international collaboratives have been modeled after the Institute for Healthcare Improvement's Breakthrough Series model, the Agency for Healthcare Research and Quality's Learning

Collaborative, the United Kingdom's Academic Health Science Networks, and others, with the aim of sharing and translating knowledge into practice.^[4,5]

Despite the growing global interest of establishing multiorganizational QICs, there continues to be a lack of quality collaboratives in the Kingdom of Saudi Arabia and in the Middle Eastern region.

Components of Successful Quality Improvement Collaboratives

Quality improvement efforts housed in single organizations can be successful at achieving a desired goal, yet they struggle to maintain results over time. Evidence suggests that QICs succeed in achieving and sustaining quality care efforts. These QICs include the following key components which maximize the effectiveness of collaboratives and result in sustained change:^[2,3,5-7]

1. Developing and communicating a clear mission for the collaborative: the mission will aim to create a sense of urgency and common interest among the participants to collectively work toward reducing patient harm and achieving the desired goal
2. Establishing a structure and preliminary plan with the involvement of key stakeholders: this structure will set the expectations for the collaborative, identify project milestones, and

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Table 1: Recommendations for increasing the chances of successful spread of quality improvement through a collaborative^[1]

Recommendations for preparation and defining purpose	Choose the right type of subject Define objectives for taking part and assess your capacity to benefit from the collaborative Define roles and make clear what is expected Ensure team building and preparation by teams for the collaborative
Recommendations for collaborative learning meetings	Emphasize mutual learning rather than teaching Pay attention to motivating and empowering teams Ensure teams have measurable and achievable targets Equip and support teams to deal with data and change challenges
Recommendations for post-collaborative transition	Learn and plan for sustaining improvements, involving managers in this work Plan and learn for “spread”

define roles and responsibilities for individuals and organizations involved

- Engaging participants in prescheduled activities: these activities may include in-person learning sessions, team phone calls/webinars, data collection and reporting, and training in quality improvement methods and tools
- Building strong relationships among the teams: multidisciplinary quality improvement teams from various sites will be able to engage with others in a learning environment where success stories are shared and where challenges are addressed. Teams will also have the opportunity to benchmark their efforts with other participants in the collaborative.

Recommendations to Ensure Successful quality improvement collaboratives

Launching a collaborative is a challenging task. Moreover, lessons from previous collaboratives can be applied to ensure the success of future collaboratives. These recommendations have been described by Ovretveit *et al* [Table 1].^[1]

Implications for Future Collaboratives in Saudi Arabia

The notion of collectively organizing to improve patient care and build partnerships across various organizations in Saudi Arabia is promising. To the best of our knowledge, there are only two documented multiorganizational QICs in the region.^[8,9] In 2012, 18 Intensive Care Units (ICUs) in seven hospitals in Abu Dhabi, United Arab Emirates,

implemented a CUSP/CLABSI program that resulted in reducing central line-associated bloodstream infection rates by 38%.^[8] Moreover, in 2015, 17 ICUs in eight hospitals in the Kingdom of Saudi Arabia implemented the CUSP 4 MVP program in collaboration with 169 hospitals in the United States; this resulted in a reduction in ventilator-associated pneumonia rates.^[9]

Currently, plans are underway to launch NASAM – National Approach to Standardize And improve Mechanical ventilation – a national quality improvement collaborative to improve the care for mechanically ventilated patients in adult ICUs in the Kingdom of Saudi Arabia. The goal is to include 100 ICUs across the country for an 18 month period. The project integrates best practices in the science of patient safety and critical care and utilizes data to drive change.

Despite these efforts, there continues to be a need for establishing QICs in the region. The World Health Organization (WHO) recognizes the value of establishing multicenter quality improvement collaboratives through its efforts in implementing global and regional programs,^[10] such as the “Save lives: clean your hands,” “Safe surgery saves lives,” the Patient Safety Friendly Hospital Initiative, and the WHO Global Oral Health Programme. Given that multiorganizational QICs require access to resources, such as dedicated time and funding, it is essential that local healthcare leaders, senior executives, and policymakers encourage organizations to commit and collaborate to reduce patient harm.

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Conflicts of interest

There are no conflicts of interest.

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