**Multi-country Workshop
Development of Accreditation
Standards for Maternity Wards and
Neonatal Departments
Belgrade, September 15-16**

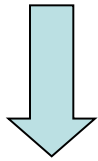# Quality Management systems: principles and open issues

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the "road to quality" in delivering maternal and neonatal care: not just quality management

HS components: managerial capacity, infrastructure, equipment, drugs and supplies, staff, training, norms and guidelines, information system, etc.

Regionalization/ referral system

QM approaches (external and internal assessment /reassessments, audits,etc.)
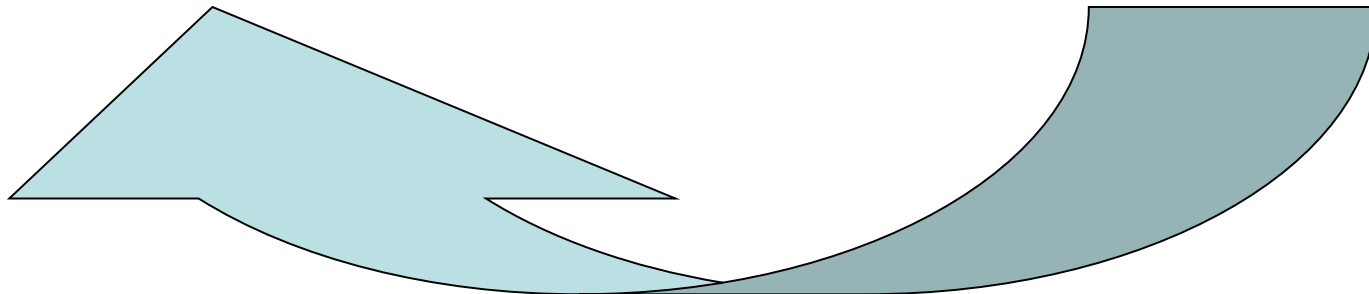
Provide the basic requisites for delivering quality care
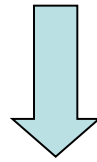
Ensure that at risk cases (mothers, newborn babies and sick children) are taken care of in the most appropriate place

Promote implementation of good practices, identify where and how to improve quality at local as well as at national level

Improving quality of care includes

- Ensuring the essential <u>health system requisites</u>

- Identifying and implementing, based on sensible and context-sensitive assessment, <u>Quality Management approaches and systems</u>

- Developing and implementing <u>demand generation</u> policies, with particular emphasis on health literacy

Quality management (QM) systems and approaches

- are based on different philosophies (control versus support)

- are context- sensitive, depending on level of care and objectives

- Require the building of national and local capacity

- Have advantages and disadvantages, and always imply costs, to be carefully assessed against likely benefits

Quality management strategies may address

- A specific "product" or service (e.g. promotion of breast feeding)

- A specific group of health services (e.g. maternal and neonatal health)

- A specific level of care (e.g. primary care, hospital care)

- A system component (e.g. data collection and use, referral system, continuous education)

Quality management approaches may be

- Internal, driven by the Hospital or Unit management (e.g. case reviews, perinatal audit)

- External, driven by health authorities, professional organizations, patients associations, others

- Combined (various combinations of the above)

- They usually imply a cycle: baseline assessment (analysis), identification of actions (plan), implementation (action), reassessment. They should also include rewarding systems.

In all cases, four essential components are needed for quality improvement

- Standards (practice guidelines, structural standards, training standards, etc.)

- Measurements (assessment tools and indicators)

- Strategies (how to motivate managers and health professionals)

- Driving forces (Ministries of Health, International Agencies, NGOs, Professional Societies)

Standards

- Structure , equipment and commodities*

- Access (financial and logistical)**

- Staffing (numbers and training requisites)*

- Service delivery modes (by levels and referral criteria)**

- Clinical practice guidelines*

- Continuity of care **

- Respectful care (not only patient satisfaction) **

*Most frequently considered   ** too often neglected

Measurements

- measuring structure is easy, may not require expertise, but structural requisites are just <u>one</u> of the many requisites for quality care

- measuring process is difficult, requires specific expertise but is crucial to assess <u>what</u> is going on, and understand <u>why</u>

- measuring outcome is easy if data available and valid, requires analytical skills; outcomes may not improve in the short term, e.g. mortality rates, or be reliably measurable and attributed to only one factor/ intervention

Strategies

- There is no quality management without a well defined strategy

- Strategies for quality improvement are essentially aimed at building **motivation** to change

- They are based on **incentives** (financial or professional , individual or facility based)

- They should maintain the quality cycle (analysis, plan, action, reassessment) by rewarding results

Professional incentives include

- ownership
- professional recognition and gratification
- career and training opportunities
- role and responsibilities

Sensible human resource management and supportive supervision are key requisites

Benchmarking and comparisons across units and facilities, if appropriately conducted, are very useful

Financial incentives include

- **Product-linked salary components**: % of salary linked to achievement of specific predefined activities/products, to be identified annually as a result of a shared process between managers and health professionals (usually head of units or departments or teams)

- **Pay for performance schemes**: % salary linked to the achievement of specific indicators (process or outcome)

- **Indirect** incentives (e.g. paid training stages , new equipment, etc.)

Pros and cons: professional incentives

pros

- Potentially the most powerful and sustainable approach
- May be contagious
- Promotes team cohesion
- Promotes internal leadership

cons

- Usually does not work for all
- May not work if salaries are very low
- Requires attitudes and skills for supportive and motivating work
- Requires a recognizably fair and independent career system

Pros and cons: financial incentives

pros

- May work also for those not motivated by professional incentives
- May be easier to manage on a large scale
- The "easy solution" very much liked by some Agencies

cons

- Evidence contradictory so far: may not work in all circumstances
- Requires independent assessment of results
- May require step up of incentives to maintain effectiveness

Pieter Van Herck et al. Systematic review: Effects, design choices, and context of pay-for-performance (P4P) in health care
BMC Health Services Research, 2010

- 128 studies reviewed
- P4P programs result in the full spectrum of possible effects for specific quality of care targets, from absent or negligible to strongly beneficial
- Less evidence on the impact on coordination, continuity, patient-centeredness and cost-effectiveness was found.
- Future P4P programs should
(1) select and define P4P targets on the basis of baseline room for improvement
(2) make use of process and (intermediary) outcome indicators as target measures
(3) involve stakeholders and communicate information about the programs thoroughly and directly

Stephen M. Campbell et al. Effects of Pay for Performance on the Quality of Primary Care in England
New England Journal of Medicine, 2009

- 42 family medicine practices, 3 conditions (diabetes, asthma, heart disease)
- Against a background of increases in the quality of care before the pay-for-performance scheme was introduced, the scheme accelerated improvements in quality for two of three chronic conditions in the short term.
- However, once targets were reached, the improvement in the quality of care for patients with these conditions slowed, and the quality of care declined for two conditions that had not been linked to incentives.
- Continuity of care was reduced after the introduction of the scheme.

Quality improvement strategies addressing directly health professionals, building on professional motivation

- Standard-based peer review assessment with identification of critical priority areas and action plans, as in the WHO EURO tool

- Periodical supervision and BTN approaches

- Critical events/mortality audits

Quality management externally driven mechanisms: definitions

- **Licensure** is a process by which a <u>governmental authority</u> grants permission to an individual practitioner or health care organization to operate or to engage in an occupation or profession.

- **Certification** is a process by which an <u>authorized body, either a governmental or non-governmental organization</u>, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements or criteria (standards).

- **Accreditation** is defined as process in which <u>trained external peer reviewers</u> evaluate a health care organization's compliance with pre-established performance standards. Accreditation addresses organizational, rather than individual practitioners capability or performance.

Accreditation

- Accreditation focuses on achievement of optimal quality standards, rather than adherence to minimal standards intended to assure public safety.

- An accreditation system includes agreed upon and published standards in order to ensure clear and shared expectations and to be able to measure compliance with standards.

- Funding needs to be available to ensure sustainability.

- Decision, methodology and rules need to be clear and fair and an accreditation database needs to be available.

- Field operations include mentoring and assessments and require different sets of skills.

Accreditation systems

- A health facility is accredited (to excellence) based on predefined standards and a process of externally driven assessments, usually a rather long process (e.g. Joint Commission International, USA, takes usually 2 years)

- It needs a national regulatory framework, including standards and methods for accreditation

- It requires an independent and professionally competent accreditation authority, otherwise it may result in a burocratic and politically biased system

Current accreditation systems: pros and cons

pros

- Systematic
- Authoritative
- External
- Indipendent
- May allow a step by step process

cons

- High Cost (direct and indirect)
- Labor-intensive
- Do not focus on users
- May not capture actual case management
- Usually do not involve enough and motivate health professionals and are seen as an external control administrative measure

Accreditation and continuous quality improvement (CQI): two different philosophies,

- Accreditation is usually given after a period of assessment and remains valid for a predetermined period of time (years), usually requires to be confirmed periodically, mainly <u>externally driven</u>

- CQI is a continuous process based on a cycle of assessments, analyses, and actions, which requires <u>internal participation and commitment</u>

- Accreditation and Continuous Quality Improvement strategies <u>should be combined</u>

Individual professional motivation, team motivation and institutional motivation should be combined with financial motivation. How?

- By linking accreditation with systems that involve health professionals, such as WHO BTN and systematic assessments

- By including a stepwise process where health facilities (or units, or districts) can gradually achieve excellence and are proportionally rewarded

- Result-based rewards can be attributed to facilities, units as well as to individuals and include both financial (direct and indirect) and professional rewarding mechanisms

Driving forces: who should care about quality of care?
what is missing in the Region?

1. For health managers, at both national and local level, quality of care should be one of their key objectives, but most of them were not trained on Quality Management nor they are assessed on the basis of quality indicators

2. For health professionals, quality of care is a crucial dimension of professional ethics, but health professionals organizations are weak throughout the Region, and they pay very little attention to QoC issues

3. For patients, it is a right, but patients lack awareness and information about their rights, and patients associations are weak or non-existent

Summary: key strategic issues in quality management

- Link QI initiatives in MNCH with national QM systems, including a solid and independent accreditation system

- Identify a comprehensive strategy to motivate managers and professionals, not limited to financial incentives

- Focus quality assessment and improvement on clinical management and not only on infrastructure, commodities, and administrative procedures

- Incorporate quality issues and QI methods in training curricula for both managers and health professionals

- Involve professional societies as well as users/patients associations