Lebanese Society for Quality and Safety in Health Care

الجمعية اللبنانية للجودة والسلامة الصحية

5TH ANNUAL CONGRESS

Bridging the gap for a safer care

SEPTEMBER 8TH AND 9TH 2017

ESA BUSINESS SCHOOL - BEIRUT, LEBANON

What changing in accreditation process to bridge the gap for safer care ?

Pr René Amalberti, HAS, France

Beyrouth 2017

A brief look at…

FEEDBACK FROM ACCREDITATION

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Results as perceived by professionals (IPSOS survey 2012)

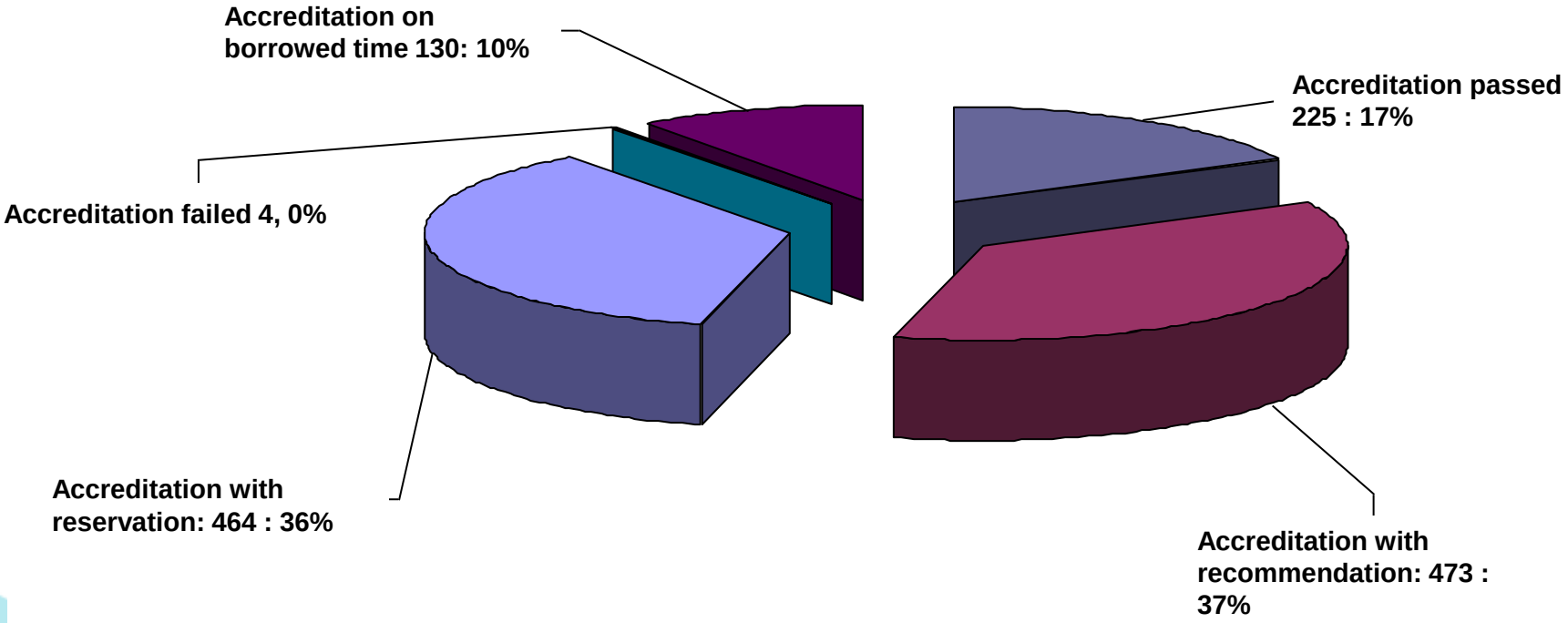
- Positive points
  - Recognition of a leverage effect for quality of care
  - An institutionalisation of quality structures and processes
  - The development of transversality between professionals
  - A marked interest for the evaluation of clinical practice

- Negative points
  - Confusion of objectives that are not clearly perceived (assistance Vs regulation)
  - A need to balance control and incitation
  - Signs of demobilisation after the survey
  - A need for a more integrated process
  - A need for simplification and articulation
  - A demand to demonstrate value and impact

Result of French Hospital Accreditation

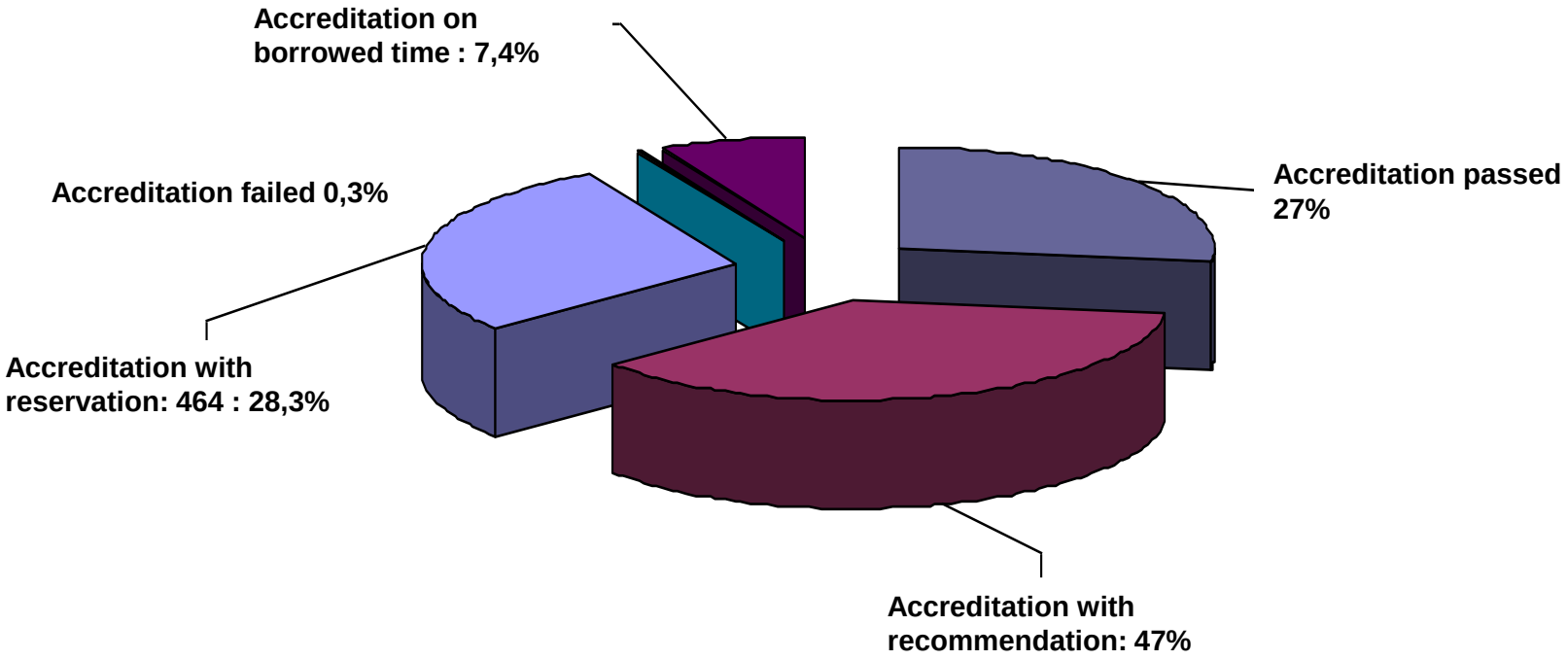
(Initial accreditation visit, HAS 2010-2014)

Sample of 1296 Hospitals, public and private



Living with non compliance is tolerated (and even the norm)

Result of French Hospital Accreditation (after a support period of 3 to 18 months)



1296 Hospitals, public and private

A brief look at…

CONTEXTUAL CHANGE

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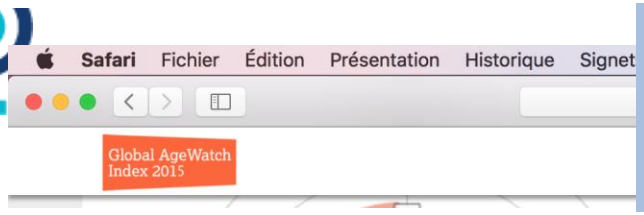
Worldwide context



LEBANON

Source Global Age Watch, accessed March 17
http://www.helpage.org/global-agewatch/population-ageing-data/country-ageing-data/?country=Lebanon

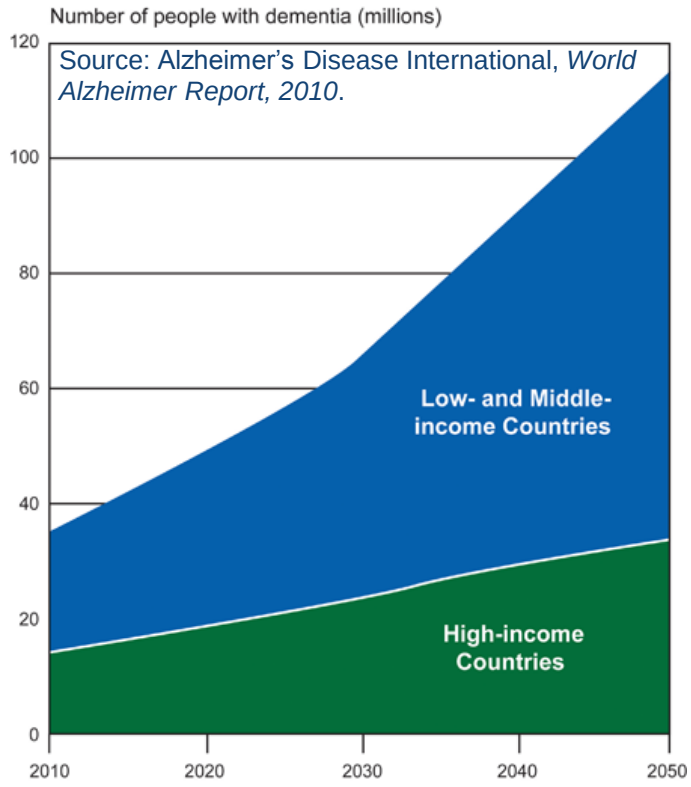
- Increasing population
- ‘baby boomers’
- A generation of peace time
- Improved living conditions
- More access to care
- Reduced infant mortality
- Biomedical science

The domino effect

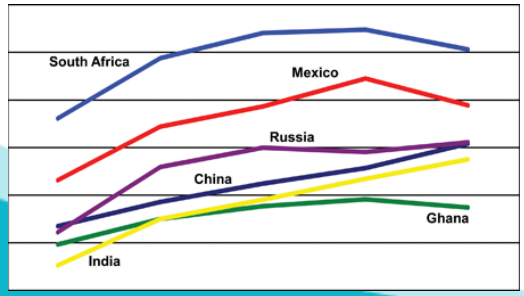
- Patients now surviving critical illnesses (that were once time life threatening) for longer than 10 or even 30 years
- Many more patients (up to 20% average in western countries compare to the 90's), more chronic, complex care and comorbidities, and people wanting to age well
- End of life and frailty patients could represent over 40% of healthcare expenditures, with a peak possibly reaching 50% in the 2030's with the massive growth in required end of life care for baby boomers including 10 to 15% seniors with dementia in the 50's
- Incredible additional cost for healthcare expanditures (1 to 5% of GDP depending on the situation)
- Massive effects, happening all over the world

Incredible medical impact

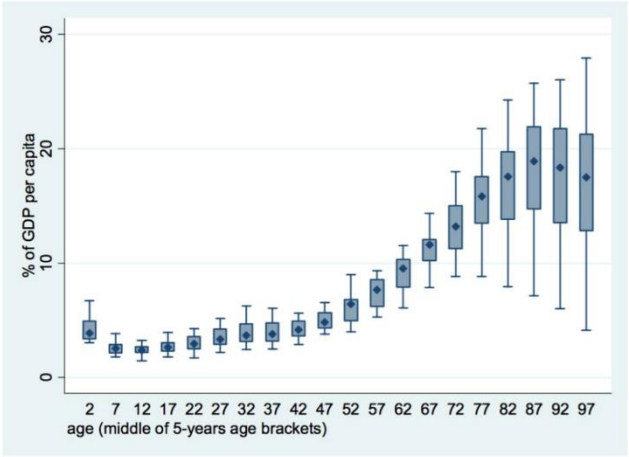
- Incredible Medical impact
  - Multi-morbidity
  - Greater number of surgeries: Healthy ageing = 2 to 6 prosthesis at age 75 (dental, eyes, ears, hip, knee…)
  - Loss of autonomy, growing number of frail patients
  - Significant proportion of the population (around 10 to 15%?) cognitively impaired in the 30's



Disparity of the world's population with three risk factors above 60



Public health care expenditure by age groups (per cent of GDP per capita). Source: Maisonneuve and Martins (2013).



Domino effect on healthcare organizations

- More patients, more co-morbid patients, more care needed

- Changing treatment modalities
  - Patients spending less and less time in acute care settings, thanks to scientific and technological advances such as minimally invasive surgery, early testing and diagnosis, rapid discharge, and sophisticated rehabilitation protocols
- The number and type of hospitals and other healthcare organisations will be affected.
  - Early discharge and massive transfer of post-acute — and now new chronic patients — to primary care
  - Moving from a provider and diagnosis-centred approach to a person-centred approach
  - Multiple implications for quality and safety

A brief look at…

THREE MAJOR CHANGES TO BRIDGE THE GAP FOR SAFER CARE

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Strategies for change

Primary care	→	Day and community care
Treating sickness	→	Encouraging ‘wellness’
Provider-centric	→	Person-centred care
Fragmented	→	Integrated

1 VISIT FOLLOW UP
ASK FOR PLAN A & PLAN B

MAX BAR
OPTIMAL

1: REFERENCE/ PLAN A

ACCEPTABLE

BAR +

2: COMPENSATIONS TO MAINTAIN OPTIMAL SAFETY DESPITE NON ADHERENCE TO THE MAX BAR

Area of full compensation

RISK MANAGEMENT PLAN B

ACCEPTABLE

BAR -

3: END OF FULL COMPENSATION

Growing risk
Partial compensation

MIN BAR
High risk

Ask for PLAN A / return to compliance within X months +Immediate PLAN B / contractual risk management to leave with Identified weakenesses

Optimisation strategies

Ensure that best practices in prevention are in place and being implemented
Encourage compliance
Build and update best standards
Build capacities and resources

Optimize Human and Organizational factors

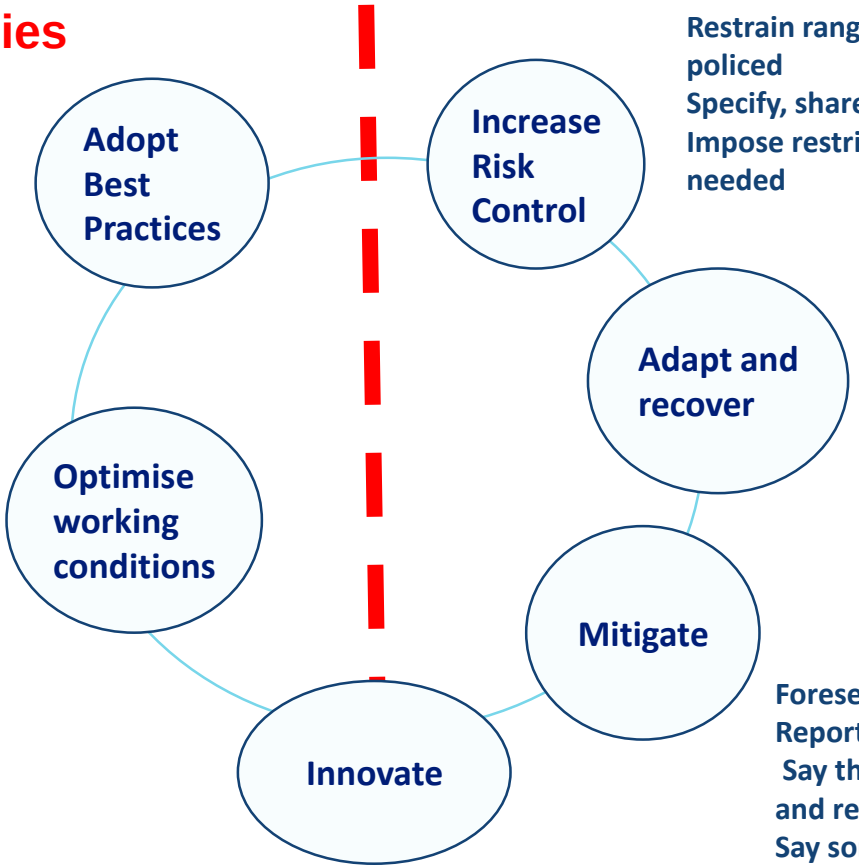
Improved style of Leadership
Improved working hours
Improved utilization of skills
Share values among the team
Improved working conditions

Risk management strategies

Restrain range of activity to than can be properly policed
Specify, share and respect 'no go'
Impose restriction of at-risk activities when needed

Accept intelligent adaptation to context
- Share situation awareness and risks in the team
- Detect and recover errors
- Improve failure to rescue and team decision making
- Adopt a context adapted safety culture (Ultra safe, HRO, Adaptive)

Foresee and mitigate consequences of flaws
Report incidents and accidents
Say thank you to acknowledge team effort and recovery
Say sorry to clients
Invest on a just culture blameless



- Adopt new solutions redefining boundaries of playability, quality and safety
- Analyse risk associated with innovative solutions

CHANGE AND REDUCE THE 'BUREAUCRACY' OF ACCREDITATION

2 Unannounced versus announced hospital surveys

- **Ehlers L., Simonsen K., Jensen M ., Rasmussen G., Olesen A., Unannounced versus announced hospital surveys: a nationwide cluster-randomized controlled trial,** *International Journal for Quality in Health Care*, Volume 29, Issue 3, 1 June 2017, Pages 406-411

Research

JAMA Internal Medicine | Original Investigation | HEALTH CARE POLICY AND LAW

Patient Mortality During Unannounced Accreditation Surveys at US Hospitals

Michael L. Barnett, MD; Andrew R. Olenski, BS; Anupam B. Jena, MD, PhD

Supplemental content

IMPORTANCE In the United States, hospitals receive accreditation through unannounced on-site inspections (ie, surveys) by The Joint Commission (TJC), which are high-pressure periods to demonstrate compliance with best practices. No research has addressed whether the potential changes in behavior and heightened vigilance during a TJC survey are associated with changes in patient outcomes.

OBJECTIVE To assess whether heightened vigilance during survey weeks is associated with improved patient outcomes compared with nonsurvey weeks, particularly in major teaching hospitals.

DESIGN, SETTING, AND PARTICIPANTS Quasi-randomized analysis of Medicare admissions at 1984 surveyed hospitals from calendar year 2008 through 2012 in the period from 3 weeks before to 3 weeks after surveys. Outcomes between surveys and surrounding weeks were compared, adjusting for beneficiaries' sociodemographic and clinical characteristics, with subanalyses for major teaching hospitals. Data analysis was conducted from January 1 to September 1, 2016.

EXPOSURES Hospitalization during a TJC survey week vs nonsurvey weeks.

MAIN OUTCOMES AND MEASURES The primary outcome was 30-day mortality. Secondary outcomes were rates of *Clostridium difficile* infections, in-hospital cardiac arrest mortality, and Patient Safety Indicators (PSI) 90 and PSI 4 measure events.

RESULTS The study sample included 244 787 and 1 462 339 admissions during survey and nonsurvey weeks with similar patient characteristics, reason for admission, and in-hospital procedures across both groups. There were 811 598 (55.5%) women in the nonsurvey weeks (mean [SD] age, 72.84 [14.5] years) and 135 857 (55.5%) in the survey weeks (age, 72.76 [14.5] years). Overall, there was a significant reversible decrease in 30-day mortality for admissions during survey (7.03%) vs nonsurvey weeks (7.21%) (adjusted difference, −0.12%; 95% CI, −0.22% to −0.01%). This observed decrease was larger than 99.5% of mortality changes among 1000 random permutations of hospital survey date combinations, suggesting that observed mortality changes were not attributable to chance alone. Observed mortality reductions were largest in major teaching hospitals, where mortality fell from 6.41% to 5.93% during survey weeks (adjusted difference, −0.38%; 95% CI, −0.74% to −0.03%), a 5.9% relative decrease. We observed no significant differences in admission volume, length of stay, or secondary outcomes.

Author Affiliations: Department of Health Care Policy and Management, Harvard T. H. Chan School of Public Health, Boston, Massachusetts (Barnett); Division of General Internal Medicine and Primary Care, Department of Medicine, Brigham and Women's Hospital, Boston,

CONCLUSIONS AND RELEVANCE Patients admitted to hospitals during TJC survey weeks have significantly lower mortality than during nonsurvey weeks, particularly in major teaching hospitals. These results suggest that changes in practice occurring during periods of surveyor observation may meaningfully affect patient mortality.

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3 WIDEN the scope of ACCREDITATION

Chronic diseases

ACCREDITATION /CERTIFICATION PATIENT JOURNEY

In and out clinic

Medical Establishment

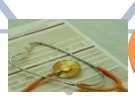
Traditional Quality management

Wards

Operating theatre
Maternity
PATIENT TRACER

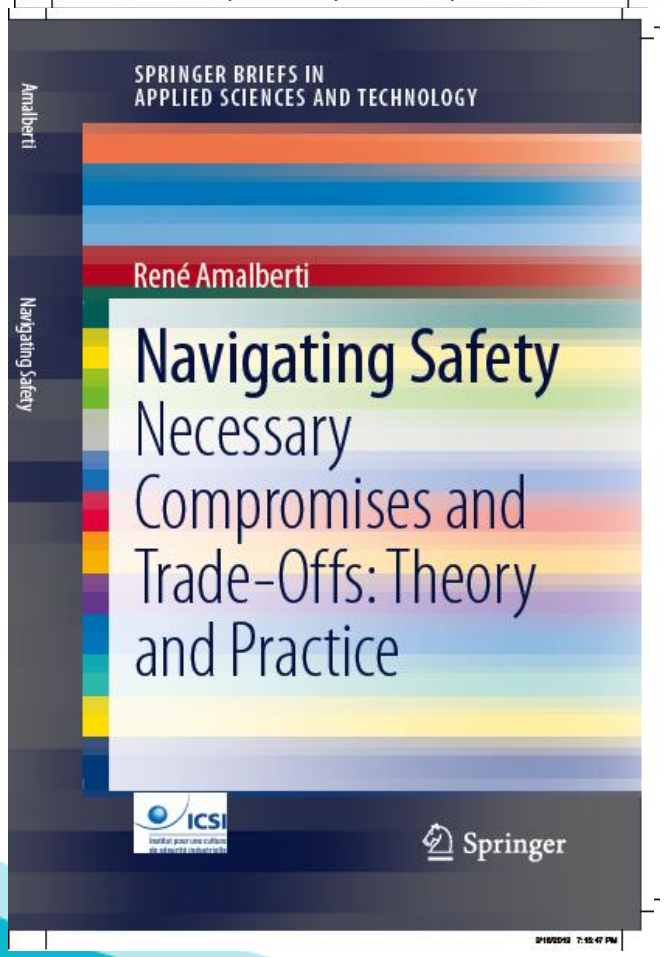
TEAM ORIENTED ACCREDITATION/CERTIFICATION

Teams



Teams

ALSO IN FRENCH, ITALIAN, SPANISH, PORTUGUESE



ALSO IN SPANISH, PORTUGUESE, JAPANESE, CHINESE

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