Quality Health Services: A holistic view

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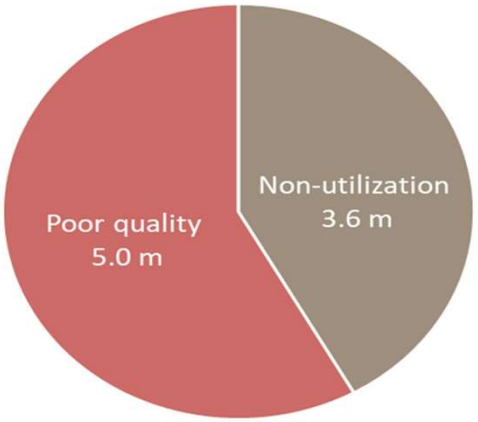
Significant body of knowledge

Three Reports in 2018:
Building the evidence and responding to the call for a UHC with Quality

World Health Organization

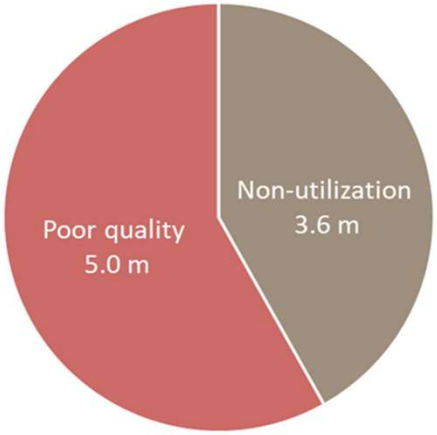
Deaths due to poor quality of care

- **8.6 million** deaths per year (UI 8.5-8.8) in 137 LMICs are due to inadequate access to quality care.
- Of these, **3.6 million** (UI 3.5-3.7) are people who did not access the health system.
- Whereas, **5.0 million** (UI 4.9-5.2) are people who sought care but received poor quality care.



COVID-19 – Access and Quality

- Need intentional focus on quality
  - Care for patients with COVID-19
  - Maintaining essential health services
- Likely increase in deaths related both to access & quality in Covid-19 pandemic – not clear which will have greatest effect
- Two sides of the same coin and should be addressed together!



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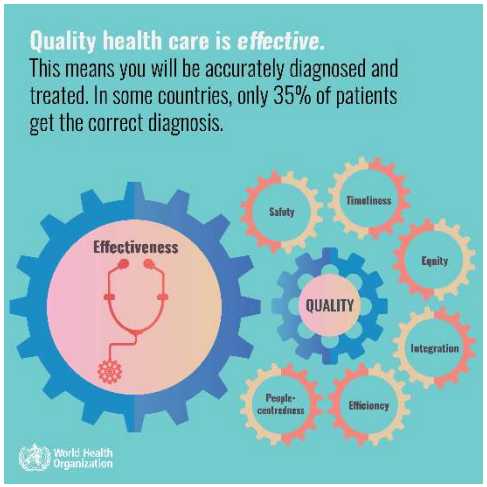
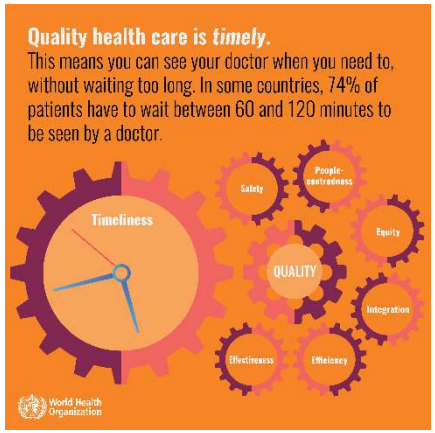
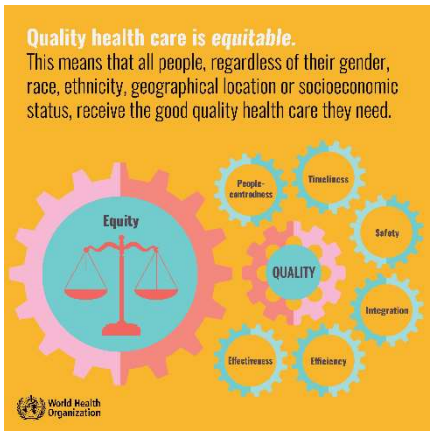
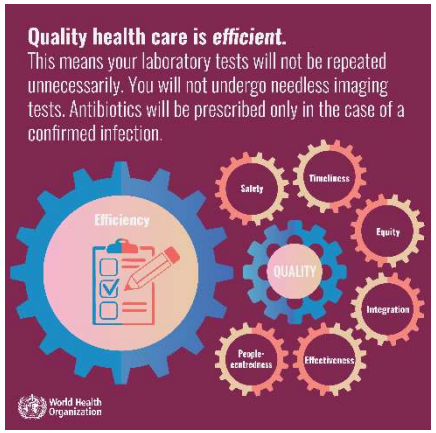
Thinking through quality…









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Quality is not a given. It takes vision, planning, investment, compassion, meticulous execution, and rigorous monitoring, from the national level to the smallest, remotest clinic.

Dr Tedros Adhanom Ghebreyesus
WHO Director-General

How could health care be anything other than high quality?

https://www.thelancet.com/action/showPdf?pii=S2214-109X%2818%2930394-2

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Box 6.1 **High-level actions by key constituencies for quality in health care**

All governments should:

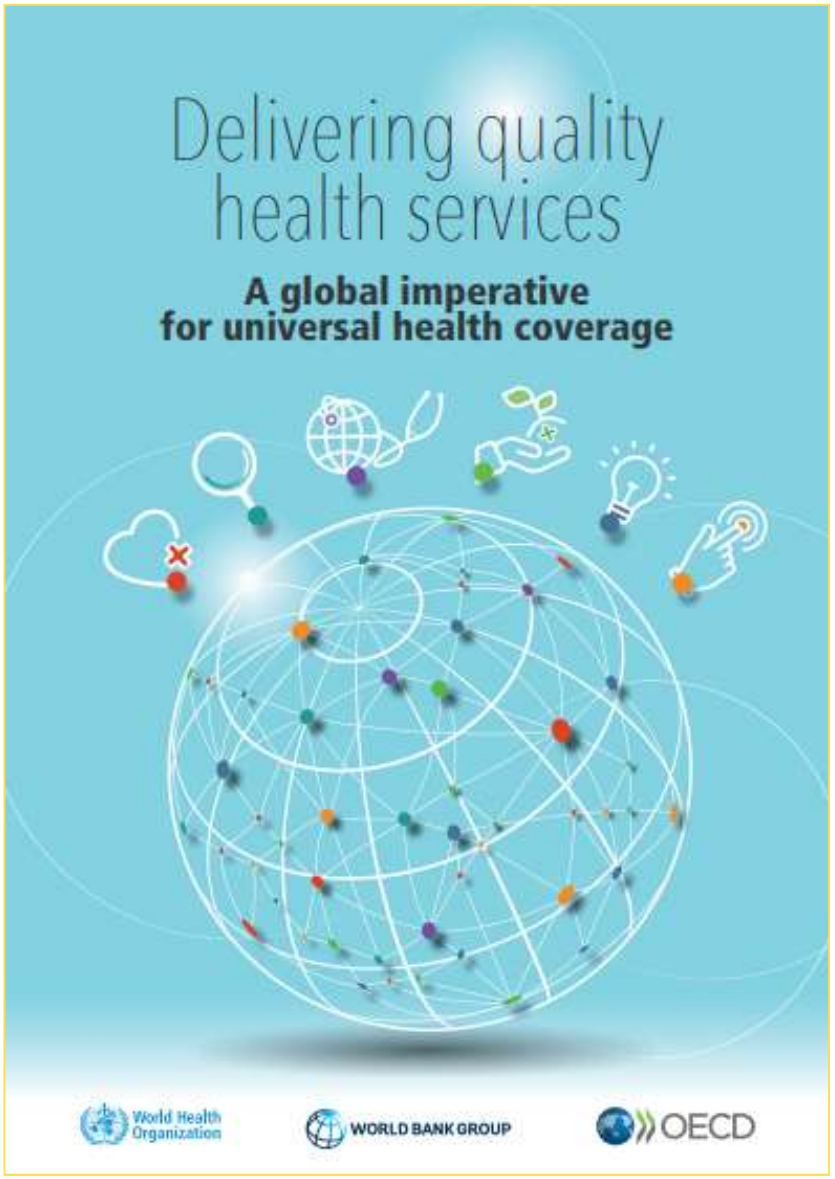
- have a national quality policy and strategy;
- demonstrate accountability for delivering a safe high-quality service;
- ensure that reforms driven by the goal of universal health coverage build quality into the foundation of their care systems;
- ensure that health systems have an infrastructure of information and information technology capable of measuring and reporting the quality of care;
- close the gap between actual and achievable performance in quality;
- strengthen the partnerships between health providers and health users that drive quality in care;
- establish and sustain a health professional workforce with the capacity and capability to meet the demands and needs of the population for high-quality care;
- purchase, fund and commission based on the principle of value;
- finance quality improvement research.

All health systems should:

- implement evidence-based interventions that demonstrate improvement;
- benchmark against similar systems that are delivering best performance;
- ensure that all people with chronic disease are enabled to minimize its impact on the quality of their lives;
- promote the culture systems and practices that will reduce harm to patients;
- build resilience to enable prevention, detection and response to health security threats through focused attention on quality;
- put in place the infrastructure for learning;
- provide technical assistance and knowledge management for improvement.

All citizens and patients should:

- be empowered to actively engage in care to optimize their health status;
- play a leading role in the design of new models of care to meet the needs of the local community;



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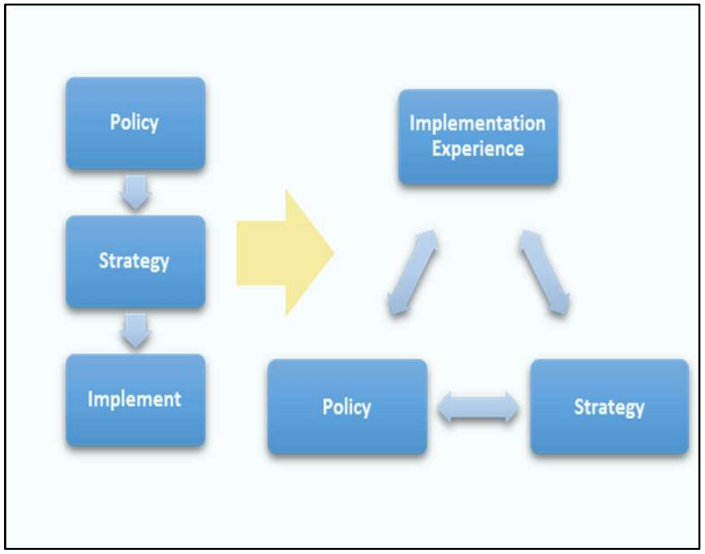
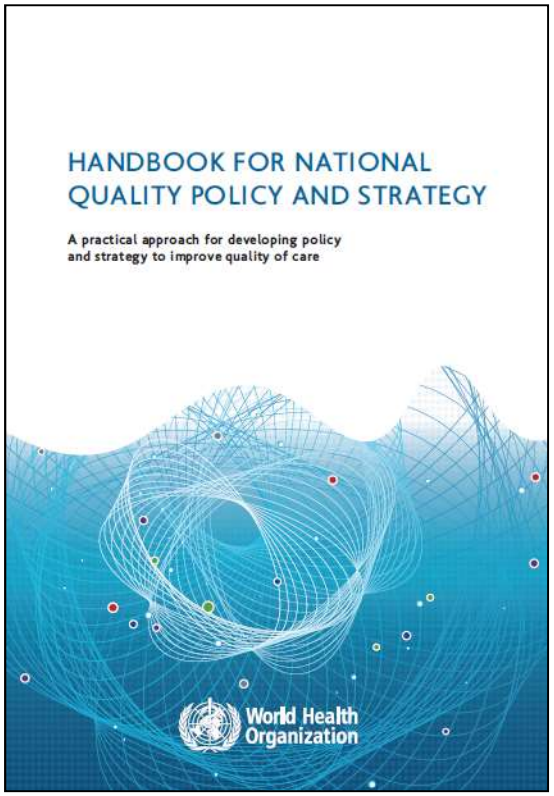
Where does quality policy & strategy meet implementation?

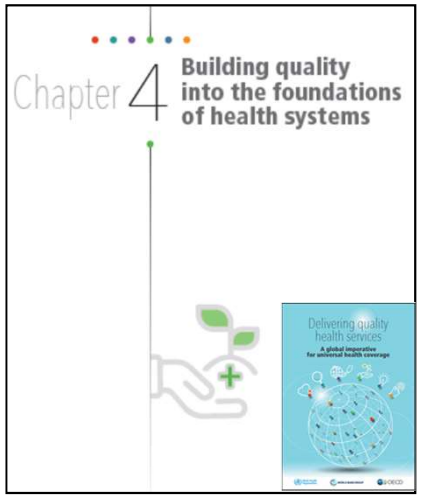




Access here:
http://www.who.int/servicedeliverysafety/areas/qhc/nqps_handbook/en/

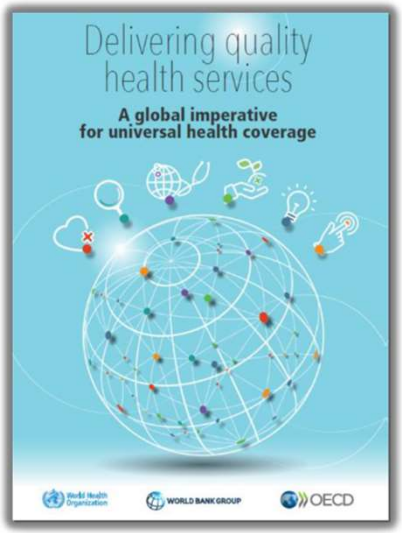
Building quality into the foundations of health systems

1. Health care **workers** that are motivated & supported to provide quality care;
2. Accessible & well equipped health care **facilities**;
3. **Medicines, devices & technologies** that are safe in design & use;
4. **Information systems** that continuously monitor and drive better care;
5. **Financing** mechanisms that enable & encourage quality care.



A culture shift to enhance safety and quality

- "…Establishing **standards for care** is part of quality improvement, but, for the standards to be reliably implemented, **additional actions are needed,** such as training and supervision, monitoring for compliance and feedback to health care providers".



- " The process of standard setting alone, without these other **supporting and interdependent actions**, is of limited value…"

Quality Improvement & Clinical Audit

"The action of every person working to implement iterative measurable changes to make health services more effective, safe and people-centred."

CLINICAL AUDIT
A pathway to quality improvement

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Illustrative quality interventions

Category	Interventions
System environment	• **Registration and licensing** of doctors and other health professionals, as well as health organizations, is often considered a key determinant and foundation of a well performing health system. • **External evaluation and accreditation** is the public recognition, by an external body (public sector, non-profit or for-profit), of an organization's level of performance across a core set of prespecified standards. • **Clinical governance** is a concept used to improve management, accountability and the provision of quality health care. It incorporates clinical audit; clinical risk management; patient or service user involvement; professional education and development; clinical effectiveness research and development; use of information systems; and institutional clinical governance committees. • **Public reporting and comparative benchmarking** is a strategy often used to increase transparency and accountability on issues of quality and cost in the health care system by providing consumers, payers, health care organizations and providers with comparative information on performance. • **Performance-based financing and contracting** is a broad term for the payment of health providers based on some set of performance measures and is increasingly used as a quality lever. The amount contingent on performance is often a subcomponent of the full payment, which may be based on a range of financing modalities. • **Training and supervision of the workforce** are among the most common interventions to improve the quality of health care in low- and middle-income countries. • **Medicines regulation** to ensure quality-assured, safe and effective medicines, vaccines and medical devices is fundamental to a functioning health system. Regulation, including post-marketing surveillance, is needed to eliminate substandard and falsified medicines based on international norms and standards.
Improvement in clinical care	• **Clinical decision support tools** provide knowledge and patient-specific information (automated or paper based) at appropriate times to enhance front-line health care delivery. • **Clinical standards, pathways and protocols** are tools used to guide evidence-based health care that have been implemented internationally for decades. Clinical pathways are increasingly used to improve care for diverse high-volume conditions. • **Clinical audit and feedback** is a strategy to improve patient care through tracking adherence to explicit standards and guidelines coupled with provision of actionable feedback on clinical practice. • **Morbidity and mortality reviews** provide a collaborative learning mechanism and transparent review process for clinicians to examine their practice and identify areas of improvement, such as patient outcomes and adverse events, without fear of blame. • **Collaborative and team-based improvement cycles** are a formalized method for hospitals or clinics to work together on improvement around a focused topic area over a fixed period of time with shared learning mechanisms.
Reducing harm	• **Inspection of institutions for minimum safety standards** can be used as a mechanism to ensure there is a baseline capacity and resources to maintain a safe clinical environment. • **Safety protocols**, such as those for hand hygiene, address many avoidable risks that threaten the well-being of patients and cause suffering and harm. • **Safety checklists**, such as the WHO Surgical Safety Checklist and Trauma Care Checklist, can have a positive impact on reducing both clinical complications and mortality. • **Adverse event reporting** documents an unwanted medical occurrence in a patient resulting from specific health services or during patient medical encounters in a medical care setting and should be linked to a learning system.
Patient, family and community engagement and empowerment	• **Formalized community engagement and empowerment** refers to the active and intentional contribution of community members to the health of a community's population and the performance of the health delivery system, and can function as an additional accountability mechanism. • **Health literacy** is the capacity to obtain and understand basic health information required to make appropriate health decisions on the part of patients, families and wider communities consistently, and is intimately linked with quality of care. • **Shared decision-making** is often employed to more appropriately tailor care to patient needs and preferences, with the goal of improving patient adherence and minimizing unnecessary future care. • **Peer support and expert patient groups** link people living with similar clinical conditions in order to share knowledge and experiences. It creates the emotional, social and practical support for improving clinical care.

Available: https://www.who.int/servicedeliverysafety/quality-report/en/

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Clinical audit…

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Clinical Audit – the essence

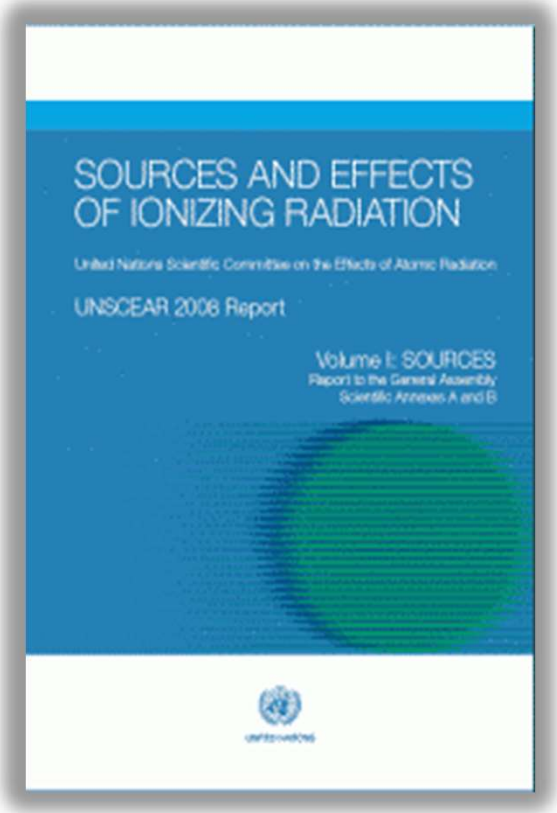
- Clinical audit is aimed at improving patient care and outcomes by:
  - **Assessing** whether healthcare is provided **in line with standards** through review against explicit criteria.
  - **Identifying** whether/where **changes** are necessary/ possible for quality improvement and proposing solutions.
  - **Implementing** changes and **monitoring** their impact on the quality of care (**audit cycle**)

Good medical practice encompasses radiation safety

- Quality health service delivery is the manifestation of health systems functionality (multiple building blocks).
- **Radiation safety** is embedded in health care quality and therefore needs to be integrated into quality improvement strategies (including use of clinical audits).

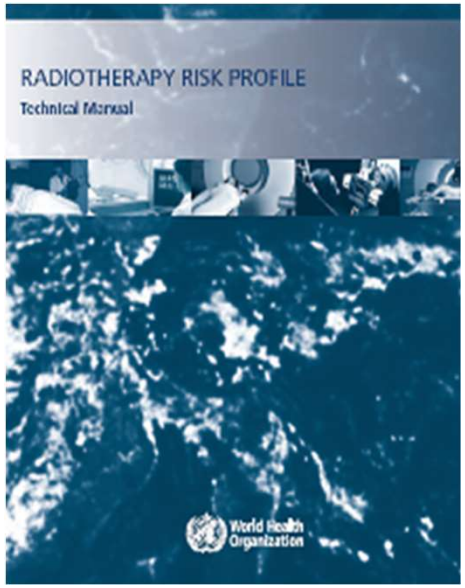
Radiation safety in health care: unintended and accidental exposures

- **UNSCEAR 2008 Report: *"Sources and effects of ionizing radiation"* Volume II**
  Annex C - Radiation exposures in accidents
  - UNSCEAR has reviewed radiation accidents within a period of >60 years (1945-2007);
  - A large number of fatalities (46) and high number of cases of acute injuries (623 cases) was due to accidents occurred during the use of radiation in health care.
  - Other accidents either not recognized or not reported may have occurred.

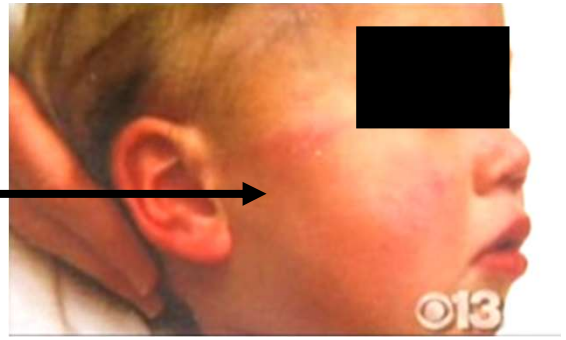


Radiotherapy

- Radiotherapy Risk Profile [WHO, 2008]
  - 3125 patients affected by radiotherapy incidents between 1976 and 2007.
  - About 1% (N=38) of the affected patients died due to radiation toxicity (overdose).
  - Only two reports estimated the number of deaths from under-dosage.
  - More than 4500 near misses (N=4616) were reported in the literature in the years 1992 to 2007.
  - Many more may have occurred and not reported



151 CT sequences over 65 minutes



Parents sue California hospital over pediatric CT radiation overdose

By Cynthia Keen
AuntMinnie.com staff writer
November 20, 2008

A rural California hospital is being sued by parents of a child who underwent a CT exam during an emergency department visit for a neck injury. The parents allege that their 23-month-old boy received radiation burns and has permanent chromosomal damage due to excessive radiation exposure from the CT scan, which took over an hour to perform.

The incident allegedly took place on January 23, 2008, at Mad River Community Hospital in Arcata, a rural town of 17,000 located 290 miles north of San Francisco. Television news anchorman Sam Shane of CBS 13 of Sacramento broke the story on October 30.

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California Department of Public Health spokesman Ken August told Tam that the state of California will determine whether any state or federal laws were violated. A hospital in violation can be fined up to $25,000, a fine that will increase to $100,000 in January 2009.

The lawsuit has a case management conference set for February 4, 2009. The hospital will not comment due to pending litigation, and the California Department of Public Health did not explain the six-month delay before suspending Knickerbocker's license to either CBS 13 or the *Times-Standard*.

Unintended exposures may also happen in nuclear medicine, interventional radiology, and diagnostic imaging !!

Education, training, safety culture, quality improvement (including CLINICAL AUDIT)

Standards, regulations, clinical governance…

- Radiation safety standards provide safety requirements for medical exposure (international and Euratom Radiation Basic Safety Standards / **BSS**).
  - **Radiological reviews** are referred in the international BSS and **clinical audits** are explicitly required in Art 58 Euratom BSS.
  - Implementation through national regulations needs concurrence/coordination between the radiation protection regulator (i.e. radiation safety) and the health authority (clinical governance, good medical practice)

Clinical audit as one of the quality interventions

- Improvement in clinical care
  - Clinical audit and feedback

IMPROVE PATIENT CARE

Adherence to standards and guidelines

Feedback on clinical practice
(identify areas needing improvement)

Justification and optimization
Intended outcomes – right dose

Thank You

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