The Role of Accreditation in the Regulation* of Quality and Safety of Care

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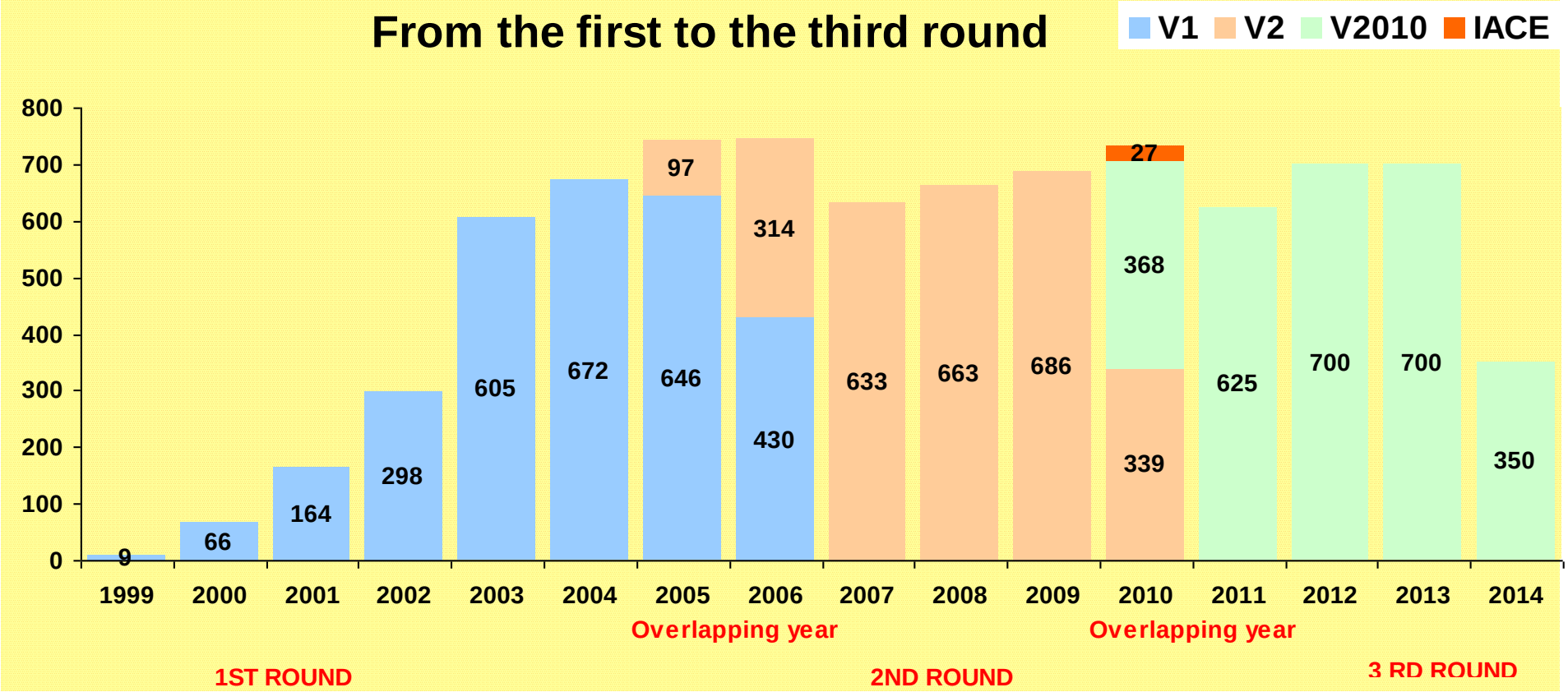
***A sustained and focused control exercised by a public agency over activities valued by a community (P Selznick)**

THE FRENCH ACCREDITATION PROGRAM

1. A program mandated by law (1996)
2. A primary objective of improvement in quality and safety of care through the generation of sustained changes in practices
3. An objective of accountability and of information of the public
4. An increasing role in the contractualisation process (Law on the reform of hospitals in relation to patients, health and territories, July 21, 2009)

Hospital accreditation in France
From V1 to V2010



« Mandatory priority practices »

1. Policy and organisation of professional practice appraisal
2. Management of adverse events
3. Control of infection risk
4. Management system of patients'complaints and claims
5. Pain management
6. Patient care at the end of life
7. Management of the patient medical record
8. Patient access to his medical record
9. Patient identification at all stages
10. Quality improvement of medication management
11. Management of emergencies and non elective care
12. Organisation of the operating room

National indicators

- Infection control
- Proper use of antibiotics
- Pain management
- Patient medical record
- Nutritional disorder
- Medication management
- Patient discharge process

Advantages of a mandatory system

- **Mandatory systems are arguably more effective :**
  - Equity and national coverage
  - Coherence with national strategies and integration into other regulatory mechanisms
  - Achieving a commanding position to drive quality and safety in national health systems

- **Mandatory systems are arguably more mature:**
  - More emphasis on outcomes
  - Greater weight of decisions
  - Greater involvement of all stakeholders

Results as perceived by professionals (IPSOS survey 2007)

1. Positive points

1. Recognition of a leverage effect for quality of care
2. An institutionalisation of quality structures and processes
3. The development of transversality between professionals
4. A marked interest for the evaluation of clinical practices
5. Ratcheting of levels of requirements

2. Negative points

1. Confusion of objectives that are not clearly perceived
2. A need to balance control and incitation
3. Signs of demobilisation after the survey
4. A need for a more integrated process
5. A need for simplification and articulation
6. A demand to demonstrate value and impact

Rising expectations and demands for regulation

1. Awareness of issues related to safety and quality of care
2. Demands for accountability and transparency
3. An expansion of patient rights to include quality and safety of care
4. Doubts on the eficacy of self-regulation
5. Search for efficiency, cost of low quality and financial pressures

The international regulatory landscape

Canadian Council on Health Services Accreditation

Conseil canadien d'agrément des services de santé

www.cchsa-ccass.ca

Healthcare Commission

NCQA
Measuring quality. Improving health care.

England's healthcare watchdog

The Joint Commission

HAS
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audit commission

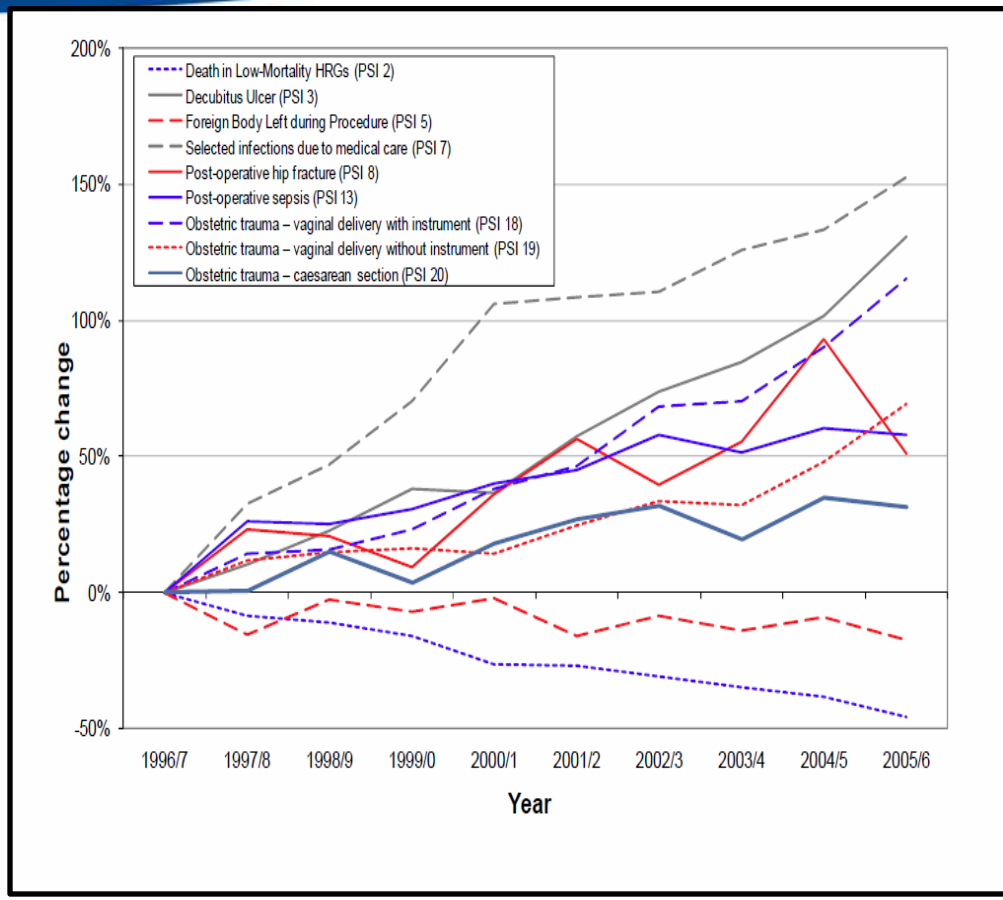
STAATSTOEZICHT OP DE VOLKSGEZONDHEID
INSPECTIE VOOR DE GEZONDHEIDSZORG

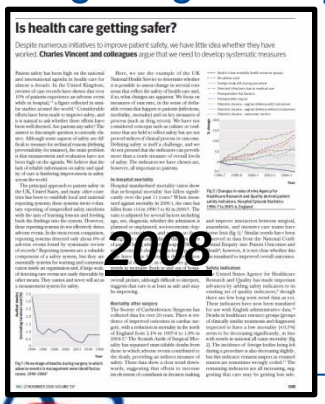
Limits of strategies of “vertical” regulation

1. Accumulation of rules, controls and demands for external reports
2. Loss of visibility of objectives
3. Energy focused on external demands that are not necessarily linked to the functioning of their organisation

Is health care getting Safer?

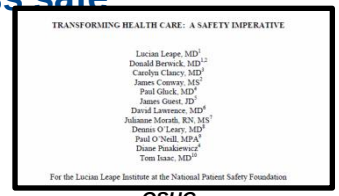
1. The Agency for Healthcare Research and Quality (US) has defined safety indicators and generated measurement initiatives over the last 10 years.
2. In UK, rates are actually increasing in all but two of the nine indicators measured.
3. “Deaths in low mortalty Healthcare Resource Groups” appear to be decreasing significantly.
4. “Foreign Body Left during Procedure” is decreasing slightly.
5. The remaining indicators suggest that care is getting steadily less safe




Is health care getting safer?

Despite numerous initiatives to improve patient safety, we have little idea whether they have worked. **Charles Vincent and colleagues** argue that we need to develop systematic measures

2008


TRANSFORMING HEALTH CARE: A SAFETY IMPERATIVE

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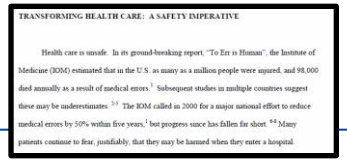
QSHC

2009


TRANSFORMING HEALTH CARE: A SAFETY IMPERATIVE

Health care is unsafe. In its ground-breaking report, “To Err is Human”, the Institute of Medicine (IOM) estimated that in the U.S. as many as a million people were injured, and 98,000 died annually as a result of medical errors.[1] Subsequent studies in multiple countries suggest these may be underestimates.[2-5] The IOM called in 2000 for a major national effort to reduce medical errors by 50% within five years,[1] but progress since has fallen far short.[4-6] Many patients continue to fear, justifiably, that they may be harmed when they enter a hospital.

Gaps in Hospital Discharge Planning and Transitional Care

Base: Adults with any chronic condition who were hospitalized in past 2 years

Percent	AUS	CAN	FR	GER	NETH	NZ	UK	US
Did *not* receive instructions about symptoms and when to seek further care	25	20	37	29	24	28	26	12
Did *not* know who to contact for questions about condition or treatment	15	11	16	11	13	14	17	8
Hospital did *not* provide written plan for care after discharge	43	29	39	40	37	31	32	9
Hospital did *not* make arrangements for follow-up visits with any doctor	38	32	40	35	21	32	27	28
Any of the above discharge gaps	61	50	71	61	51	53	50	38

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Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults

Patient Engagement in Care

Base: Adults with any chronic condition who have regular doctor or place of care

Regular doctor or doctor at usual place of care *always*: (%)	AUS	CAN	FR	GER	NETH	NZ	UK	US
Encourages you to ask questions	52	53	39	42	42	56	47	56
Tells you about treatment options and involves you in decisions	58	56	43	56	63	62	51	53
Gives you clear instructions about symptoms and when to seek care	59	58	44	61	60	67	52	59

Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults

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What is Safety….?
A land of ambiguities

GOOD ACCESS TO CARE — *Improving ?*

REDUCTION OF DISEASE COMPLICATIONS — *Improving +++*

REDUCTION OF CARE RELATED COMPLICATIONS — *Improving +*

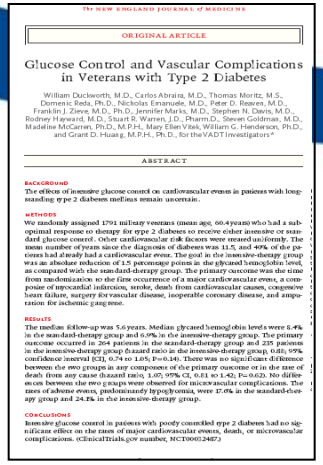
REDUCTION OF UNACCEPTABLE ERRORS — *Worsening ?*

PATIENT'S ADHERENCE AND COMPREHENSION OF RISKS — *Stable Or Worsening ?*

Physicians' perception of Quality

1. **The first rationale for system change (healthcare improvement) is innovation, not quality**
   1. Promises of better effectiveness
   2. Increase patients' recruitment (elderly… disabled)
2. **Quality helps to improve the effectiveness of Innovation**
   1. Adapt the system to innovation
   2. Optimize innovation, reduce undesirable side effects (disease complications, care related complications and errors) and promote cost-effectiveness

Innovation is creating both hope and confusion in Quality and Safety



THE NEW ENGLAND JOURNAL of MEDICINE

ORIGINAL ARTICLE

Glucose Control and Vascular Complications in Veterans with Type 2 Diabetes

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ABSTRACT

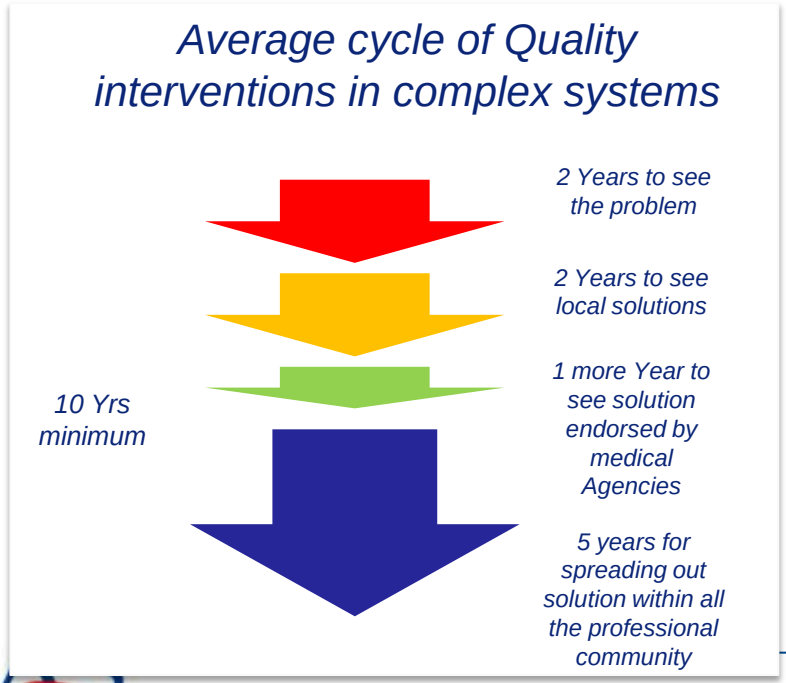
BACKGROUND
The effects of intensive glucose control on cardiovascular events in patients with long-standing type 2 diabetes mellitus remain uncertain.

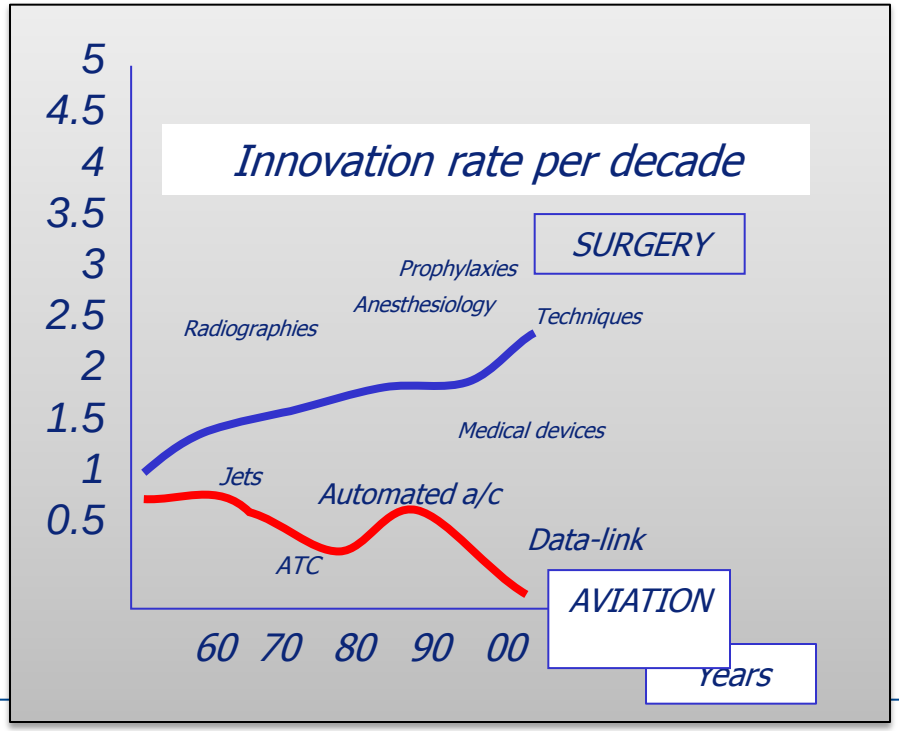
METHODS
We randomly assigned 1791 military veterans (mean age, 60.4 years) who had a suboptimal response to therapy for type 2 diabetes to receive either intensive or standard glucose control. Other cardiovascular risk factors were treated uniformly. The mean number of years since the diagnosis of diabetes was 11.5, and 40% of the patients had already had a cardiovascular event. The goal in the intensive-therapy group was an absolute reduction of 1.5 percentage points in the glycated hemoglobin level, as compared with the standard-therapy group. The primary outcome was the time from randomization to the first occurrence of a major cardiovascular event, a composite of myocardial infarction, stroke, death from cardiovascular causes, congestive heart failure, surgery for vascular disease, inoperable coronary disease, and amputation for ischemic gangrene.

RESULTS
The median follow-up was 5.6 years. Median glycated hemoglobin levels were 8.4% in the standard-therapy group and 6.9% in the intensive-therapy group. The primary outcome occurred in 264 patients in the standard-therapy group and 235 patients in the intensive-therapy group (hazard ratio in the intensive-therapy group, 0.88; 95% confidence interval [CI], 0.74 to 1.05; P=0.14). There was no significant difference between the two groups in any component of the primary outcome or in the rate of death from any cause (hazard ratio, 1.07; 95% CI, 0.81 to 1.42; P=0.62). No differences between the two groups were observed for microvascular complications. The rates of adverse events, predominantly hypoglycemia, were 17.6% in the standard-therapy group and 24.8% in the intensive-therapy group.

CONCLUSIONS
Intensive glucose control in patients with poorly controlled type 2 diabetes had no significant effect on the rates of major cardiovascular events, death, or microvascular complications. (ClinicalTrials.gov number, NCT00032487.)

The power of newspapers
The need for actualisation of recommendations in quality and safety





Three horizon lines

The silo technical vision
Time continuity
Specialty dependant

The Integrated patient life's journey vision
Stats from end (AE) and look backwards on the evolution of the disease

AE

Consequence of AEs

Consequence of AEs

Surgery
General
Anesthesia

Primary care

Potential AE
Drug errors
Poor Strategy
Poor Compliance…

Good care recoveries

Admission

Good & bad care recoveries

Discharge

More or less effective rehabilitation

After events
Short term Mortality 30 or 60 days after discharge

long term Mortality
Amenable Mortality

Time horizon

Patient life's journey trough out the medical system

The patient 's medical episode vision
Consider a longer period of time
Analysis extended backward and forward to the previous and next transition of care

An alternative strategy to transform health care organisations

Based on 5 concepts :

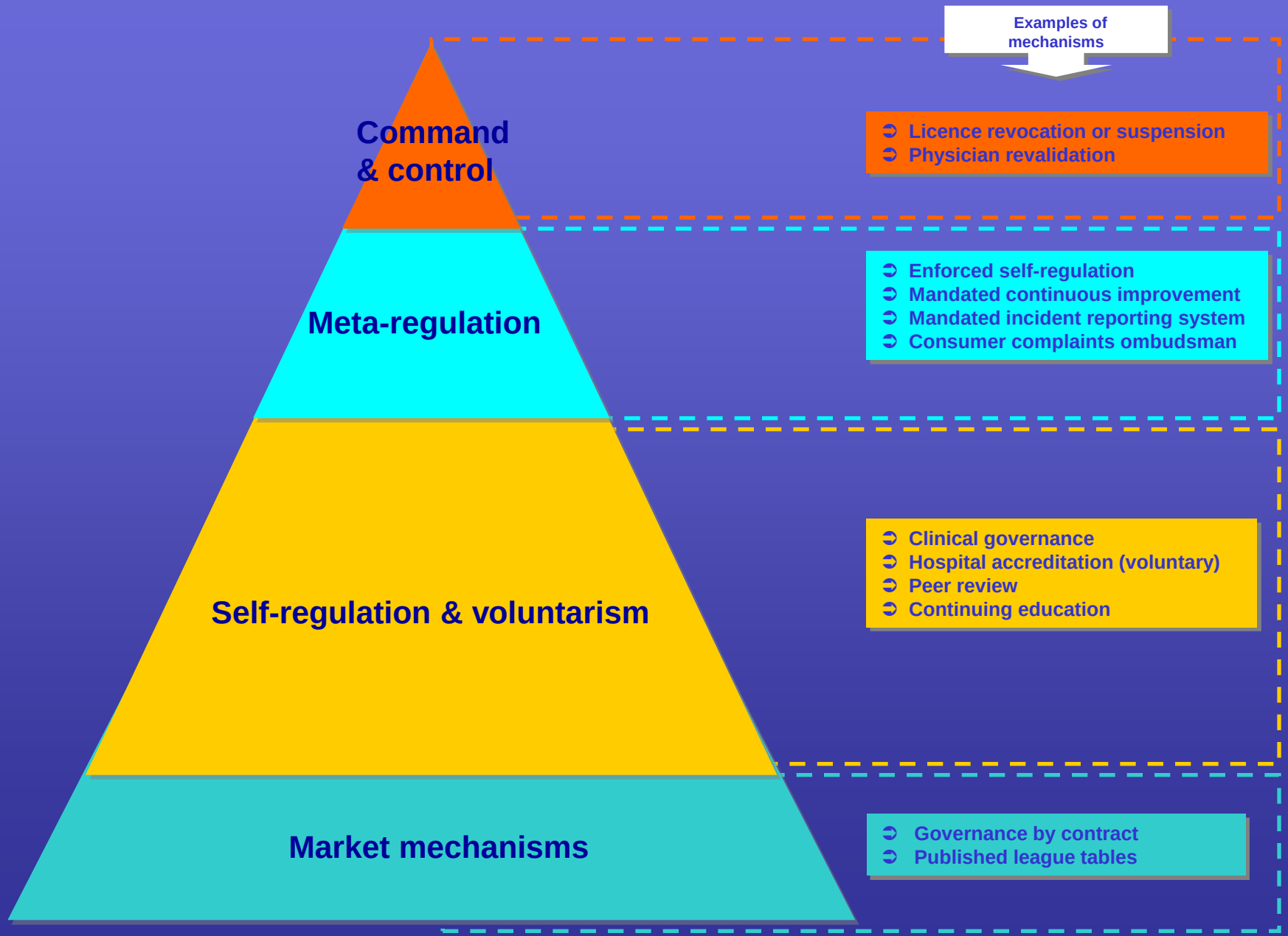
- **Transparency and promotion of a culture for patient safety**
- **Integrated patient care pathways**
- **Patients' participation and empowerment**
- **Quality of work life**
- **Education of health care professionals**

(L Leape, Transforming health care : a safety imperative, QHSC, 2009)

A strategy of adaptive or responsive regulation

- Flexible and sensitive to local conditions
- Participative and empowering the « regulee »
- Allowing for the rapid evolution of professional practices
- Addressing issues that generate change
- Giving a large role to the model of « meta-regulation »

Regulatory pyramid and health care safety and quality mechanisms



A national strategy for accreditation

- A balance between autonomy and standardisation
- An equilibrium between prescriptive strategies and those that promote culture changes
- A dialogue between « regulee » and regulator throughout a pluriannual accreditation cycle
- Activities of « portage »
- The measurement of impact

At the European level (1)

- A rise in expectations and a sharing of values
- Opportunities for exchange and learning
- The promotion or exernal evaluation/pressure mechanisms in Member States incorporating principles of the model of responsive regulation
- The inclusion of EU priorities into national programs, for example, specific guidelines related to cross border care

EUNetPaS: an EU network…

An EU-level platform for collaboration and networking between:

- 27 Member States
- International organisations
- Stakeholders in the field of Patient Safety (decision makers, healthcare professionals, patients, scientists)

And of National Networks

EUNetPaS Outcomes and Deliverables

Promote coherence at EU level through recommendations and proposition of common tools

- **Culture measurement tools** and links to performance
- Guidelines for **education and training**
- Virtual library of European **Reporting and Learning Systems**
- A mechanism for sharing **high priority PS issues and/or solutions** between all Member States
- Recommendations on **medication safety protocols**
- An EU community of hospitals involved in PS

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At the European level (2)

- **Informing MS and stakeholders of the external evaluation mechanisms in place in MS**

- **Informing MS and stakeholders of the results external evaluation mechanisms in place in MS**

- **Not putting emphasis on European standards which would not be adapted to the local context, would be only minimal and are not acceptable to Member States**