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With this edition of *Building Quality in Health Care* you will be able to cover a large variety of experiences from all over the world. I would like to highlight the project undertaken by the Organization for Economic Co-operation and Development (OECD) using standardized indicators to promote the improvement of quality of care across borders (http://www.oecd-ilibrary.org/social-issues-migration-health/improving-value-in-health-care_9789264094819-en).

In October 2010, during the health ministerial conference, the OECD published the results of an ongoing work started in 2003. The results summarized in this issue are an eye opener for all those who believe that quality is a local approach. Having the possibility to compare at the international level allows every one to move toward achieving the best results. Of course such an initiative is not safe from criticisms. Any indicator can always be challenged either because it is a proxy measure which may not be the most relevant to describe the phenomenon, either because the information system is not fully reliable or because variations between countries may affect the interpretation of results. All these concerns have to be taken seriously on board but none of them can hide the benefit of having such measures to highlight differences that must be explained.

Providing international benchmarks is obliging governments to consider the outcome measures more seriously but there is a risk. The result obtained should never be looked at like a grading process with blaming and shaming practices for those at the bottom-end and praises for those on the top-end... The results are there to engage the decision makers to understand why they have reached these scores and what needs to be revised to make sure that they will perform better next time.

Although such a message is obvious for all those involved into quality improvement processes, it has not been repeated enough to both the media and to the politicians. When any of them use just the result as a short cut for supporting an argument, they may serve an immediate purpose but they certainly do not support an effective quality improvement process.

For this reason we are strongly committed in the International Hospital Federation to more transparency and to a continuous follow up of the quality improvement indicators. What is important is not the snapshot of the results but how they evolve over time.

The Core Measure Solution Exchange, an initiative from the Joint Commission is fully in accordance with such a concern and it allows moving from a policy perspective to a practitioner’s approach.

I will also recommend the articles from Hong Kong, Belgium and Italy which all have in common the correlation between quality improvement and accreditation. This is a subject open for discussion but more and more evidence is showing a positive association between accreditation and quality improvement while a few years ago skepticism was dominating the debate.

The purpose of quality of care is first and foremost to serve the patients. It is important to learn from Australia how they manage to take on board this component. This article echoes one published in April 2009 in the World Health Organization (Bull WHO, 2009;87:271-278) in which the authors were showing that patient opinion was not a good indicator for quality of care. If there are limitations in factoring in the patients opinion we should definitely seek ways to better assess them rather than to consider that they are of minor relevance.

I wish you a fruitful reading and take the opportunity to also wish all of you the best for the New Year, and for the continuous improvement of healthcare.

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Chief Executive Officer
International Hospital Federation
Improving value in health care

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Abstract

The Health Care Quality Indicator (HCQI) which is run by the Office for Economic Cooperation and Development (OECD), was formally launched 2003. The HCQI work builds on two earlier initiatives by the Commonwealth Fund and the Nordic Council of Ministers. The goal of the HCQI project is to coordinate the publication of health-care quality indicators that can be used for international comparison purposes. This article describes the OECD HCQI work and provides a summary of the international experience relating to health-care quality improvement. The quality improvement experience that has been accumulated via the HCQI work is pitched at health system level that said, it is evident that much of the learning has practical applications for hospital management also.

The requirement for robust international health care quality comparators is pressing. International studies have time and again demonstrated that there are serious and ongoing quality failures that cause harm and death to tens of thousands of patients every year.

For example, the landmark report by the Institute of Medicine (IOM), To Err is Human: Building a Safer Health System, estimated that in the United States alone medical errors kill more people than traffic accidents (Kohn and Donaldson, 2000). Data from the Nordic countries show that over 12% of hospitalized patients experience adverse events, 70% of which were preventable and over half of which lead to disability and increased length of stay (Soop et al, 2009). In addition, a study from England shows that around 1.9 million hospital emergency admissions, would have been avoidable if better primary care had been provided (Purdy et al, 2009).

These few examples serve to illustrate both the scale of the problem and the scope for improvement. Aside from the catastrophic impact on patients and their families, quality failures damage institutional reputation and erode public confidence. They result in wasted health-care resources at a time when money is tight and place unnecessary burdens on health-care systems that are already under strain to meet increased health demands in an increasingly complex care environment.

Despite the problems that have been highlighted, there is evidence that many countries are making significant health-care quality gains. The HCQI Project indicators for acute hospital care illustrate both the progress that has made in providing health-care quality improvements.
data for better policy decisions and, the work that remains. Although it should be noted that for a number of countries above, the confidence intervals overlap – indicating no statistical difference, the overall trend is positive and is indicative of improved AMI survival prospects. It is also encouraging to note that similar improvement patterns are observed for stroke fatality rates.

While the overall trends illustrated here are favourable it is noteworthy that differences in performance across OECD countries remain substantial. For example case fatality rates between the upper and lower tails of the distribution remain around threefold. While it is not possible to exclude the possibility that some of these differences are caused by data issues rather than actual quality variations, the findings suggest that there are opportunities for cross-country learning with a view to ensuring that improvement potential is optimized. Better availability of comparable process indicators would facilitate this learning process, because these types of measures can provide information on how countries achieve their results.

**How can quality indicators be used for health system improvement?**

This section describes how quality indicators can be used to improve health system performance. Ensuring that quality indicators relate meaningfully to policy imperatives aimed at improving quality is central to achieving this. In broad terms, there are four policy touch points in health systems that can influence the quality of care: health system inputs, health system design, monitoring mechanisms and improvement systems (see Table 1).

**Health system inputs**

Competent clinicians, high-performing hospitals and safe technologies are crucial health system inputs. All OECD countries have implemented various mechanisms to assure the quality of health-care professionals. Examples include; mandatory continuous (medical) education (CME), peer-review programmes and regular assessment of the performance of individual professionals. These mechanisms are related to regulation through licensing and credentialing.

**Health system design**

Health system design determines the responsibilities of various stakeholders in delivering quality. Roles and responsibilities for delivering quality can be assigned to professionals, management, payers (for example insurers or municipalities), governmental bodies, patients and the public. Irrespective of the nature or type of health-care system, responsibilities for quality need to be allocated and performance relative to agreed quality thresholds must be transparent.

**Health system and services monitoring**

Quality monitoring needs to be based on a well-functioning national information infrastructure. Though not impossible, international experience demonstrates that assembly of such infrastructure is complex and costly. The internet is increasingly used as an effective tool for the

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Table 1: Types of health system policy that influence health care quality

<table>
<thead>
<tr>
<th>Policy type</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health system input (professionals, organizations, technologies)</td>
<td>Accreditation and certification of health care institutes</td>
</tr>
<tr>
<td>Health system design (allocation of responsibilities)</td>
<td>Health system design (allocation of responsibilities)</td>
</tr>
<tr>
<td>Monitoring (standards and information systems)</td>
<td>Monitoring (standards and information systems)</td>
</tr>
<tr>
<td>Improvement (incentive structures and [national] programmes)</td>
<td>Improvement (incentive structures and [national] programmes)</td>
</tr>
</tbody>
</table>
Box 1: Documenting and improving quality in health care – an example from Denmark

The aim of the Danish National Indicator Project is to document and develop patient quality of care. The other objectives of the project are to enhance: quality comparisons (benchmarking); quality judgments; options for priority setting; support for accountability; transparency of quality in health care. The initiative has been implemented in all clinical departments in Denmark. Participation is mandatory.

The Danish National Indicator Project was established in 2000 as a concerted action between the Ministry of Health, the National Board of Health, the Danish regions, the Danish Medical Association, the Danish Nursing Association, the Scientific Societies, the Association of Physiotherapists, and the Danish Association of Occupational Therapists. So far these organisations have prioritised eight diseases on the basis of most heavy DRG values (incidence and expenditure) in the Danish hospital services. The eight diseases are: Stroke, diabetes, hip fracture, schizophrenia, acute intestinal surgery, heart failure, chronic obstructive lung disease (COLD) and lung cancer.

From 2000 to 2008 evidence-based disease-specific quality indicators have been developed by multi-professional clinicians appointed by the respective scientific societies.

To secure the comparability of data, prognostic factors are used to adjust for case mix. It is thereby possible to evaluate whether favourable or unfavourable outcomes are due to the health care system or due to conditions over which the health care system has no influence. Clinicians and managers received continuous feedback of results after a professional process of analysis, interpretation, and evaluation, the data are released publicly.

The experiences from 2000 to 2008 indicate that the quality of care related to the areas covered improve over time and that performance and outcome measurement can be used to drive quality improvement.

The table below shows the results related to evidence-based stroke indicators in the Danish National Indicator Project. Improvements are seen for all indicators in the period 2003-08.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2000</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of patients admitted to a stroke unit</td>
<td>91 (90-91)</td>
<td>77 (76-78)</td>
</tr>
<tr>
<td>Antiplatelet therapy: Proportion of patients with acute ischemic stroke without atrial fibrillation, where platelet inhibitor treatment is not contraindicated, treated with platelet inhibitor</td>
<td>87 (86-88)</td>
<td>69 (68-71)</td>
</tr>
<tr>
<td>Oral anticoagulant therapy: Proportion of patients treated with anticoagulants</td>
<td>73 (70-76)</td>
<td>15 (12-19)</td>
</tr>
<tr>
<td>Proportion of patients who undergo a CT/MRI scan</td>
<td>67 (66-68)</td>
<td>13 (11-11)</td>
</tr>
<tr>
<td>Proportion of patients assessed by a physiotherapist</td>
<td>73 (72-73)</td>
<td>42 (40-43)</td>
</tr>
<tr>
<td>Proportion of patients assessed by an occupational therapist</td>
<td>70 (69-71)</td>
<td>35 (34-36)</td>
</tr>
<tr>
<td>Proportion of patients who have their nutritional status evaluated</td>
<td>68 (67-69)</td>
<td>43 (41-44)</td>
</tr>
<tr>
<td>30-days mortality</td>
<td>10 (10-11)</td>
<td>12 (11-12)</td>
</tr>
</tbody>
</table>

Figure A describes a dose response correlation between proportion of interventions that patients with stroke have received and 30-day mortality rate (2003-07) in the Danish National Indicator Project.
public release of information on quality of care. These public information portals are often part of an overall accountability and transparency agenda in countries that tend more towards market oriented health care systems aimed at increasing patient choice. Although evidence of the impact of this type of approach on patient choice is scare, public reporting of performance on quality does have “reputational” impact on professionals and institutions and, as such, can have an impact on the improvement of performance (Bevan et al, 2010).

Health system improvement

Targets for improving the quality of care are increasingly used by countries. Apart from non-monetary incentives such as, the reputation of the provider, monetary incentives such as Pay-for-Performance schemes are used in the United States, United Kingdom and Korea. National initiatives such as patient safety or quality improvement programmes are also examples of system-wide approach to improve quality. Many of these initiatives have been inspired by the US Institute for Health Care Improvement and safety programmes instigated by the WHO Mail Web site (www.who.int/patientsafety/en/). National safety programmes are currently running in Australia, New Zealand, Germany, France, the United Kingdom and the United States.

Safety programmes can initiate new and important quality-related information collections e.g. risk registers and adverse event reporting. While these data are sensitive in nature, they are integral to gaining a comprehensive understanding of quality and, as such, should not be seen as separate or special. This also applies to secondary use of data, where disparate information streams can for example be linked together for purposes other than their original intended use i.e. quality monitoring. Important privacy and confidentiality issues arise from such applications. However, a sensible balance must also be struck between protecting the public interest on the one hand while ensuring that quality is robustly measured and improved on the other.

Box 1 describes how in Denmark quality strategies are based on an information infrastructure that links performance data on micro, meso and macro level.

Conclusions

Hospital administrators today face significant challenges: complex care needs and care processes, increased health care demand. Added to that money is now tighter than ever before. Whilst it may be the case in some countries the economic consequences of the downturn have not yet been fully felt, the real impact cannot be far off. Ultimately health-care services around the world will have to achieve more for less. Improving quality in health care cannot solve these challenges but it can help mitigate some of the negative impacts.

In their recent report “Improving Value in Health Care: Measuring Quality”, the OECD has drawn together a series of inter-related recommendations aimed at improving health-care quality and thereby value for money.

The report draws attention to the need for reliable and valid information for quality-led governance and the need to more fully exploit existing national data sets such as national registries and administrative databases for quality monitoring purposes. Attention is also drawn to the requirement to implement the electronic health records and to establish national systems to collect longitudinal information on patient experience.

The report recommends the use of common indicators sets that are linked coherently across and between quality improvement policies. Finally, the importance of learning from international experience is underlined.

The recommendations are not intended as a one size fits all solution to quality improvement, they do however provide a template drawn from a wide body of international experience and as such are likely to be applicable in disparate health-system settings.

Bibliography


Improving Value in Health Care: Measuring Quality OECD 2010
Quality is in the eye of the user: building public trust in the safety of vaccines

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Abstract

This commentary focuses on consumer concerns about the quality and safety of childhood vaccines and argues that: 1) measures of quality and safety need to be defined and addressed from multiple perspectives, but must include an understanding of how health consumers assess quality and safety; 2) concerns about the safety and quality of vaccines are driven by a number of factors – many are contextual, therefore assessments of quality and safety must be viewed in context and over time; and, 3) whether or not public concerns about safety and quality seem reasonable or accurate, they need to be addressed.

While there are many ways we can define metrics to measure the quality and safety of health care and health-care interventions, at the end of the day, health-care consumers will have their own perceptions of the quality and safety which may or may not align with institutional or scientific measures of quality and safety. This commentary focuses on the consumer concerns about the quality and safety of childhood vaccines and argues that: 1) measures of quality and safety need to be defined and addressed from multiple perspectives, but must include an understanding of how health consumers assess quality and safety; 2) concerns about the safety and quality of vaccines are driven by a number of factors – many are contextual, but many are historic and some immediate, therefore assessments of quality and safety must be viewed in context and over time; and, 3) whether or not public concerns about safety and quality seem reasonable or accurate, they need to be addressed.

1) How health consumers assess quality and safety
The example of waning public trust in vaccines is a poignant example of a gap between perceptions of safety among parents and care givers who make the decisions on whether to vaccinate their child, and those who produce, regulate and provide or administer vaccines.

As described in a systematic review of parental decision-making on MMR vaccination, despite extensive vaccine safety measures, “vaccine-declining parents believe that vaccines are unsafe and ineffective and that the diseases they are given to prevent are mild and uncommon; they mistrust their health professionals, Government and officially-endorsed vaccine research but trust media and non-official information sources and resent perceived pressure to risk their own child’s safety for public health benefit.”

In another systematic review of qualitative studies on parental beliefs and attitudes toward childhood vaccination, they similarly point distrust in the medical community and poor quality experience with health staff as influencing their attitudes towards vaccination: “We identified that parents, in many of the studies, held beliefs that vaccines cause ill health. They expressed specific concerns about both the short- and long-term adverse effects associated with vaccination. Parents also expressed a substantial level of distrust in the medical community, and identified several problems with access that impeded vaccination. Many parents also reported poor communication with health-care staff, unpleasant staff, and being unaware of the vaccination schedule.”

Another analysis of parental fears of vaccines concludes that, “attributions of harm (related to vaccination) are not so much linked to the science of the causal association but reflect societal attributes….there is too often an assumption that resistance to vaccination is a result of scientific illiteracy and public ignorance…This reflects a failure to recognize both the complex and deeply embedded nature of vaccine resistance.”

In short, health consumers – including parents and care givers making decisions regarding vaccinating their children – do not assess quality and safety merely based on the intervention itself, but on various contextual factors that influence their trust levels.

In short, health consumers – including parents and care givers making decisions regarding vaccinating their children – do not assess quality and safety merely based on the intervention itself, but on various contextual factors that influence their trust levels.
limited acceptance without trusting health consumers. One study from the environmental risk communication literature identifies three determinants of trust that can provide valuable cues for building trust in health care. These determinants are: knowledge and expertise; openness and honesty; and concern and care.

2) Quality and safety are not static and context matters

In short, the analyses above all point to the importance of contextual factors that influence the consumers’ notion of quality and safety. History also matters. A number of episodes of public distrust in vaccines have antecedents that have already seeded grains of distrust, such as around the management and inadequate transparency of BSE in the UK which later undermined the public’s trust around the safety of MMR vaccine when new, albeit faulty, research suggested links between MMR, bowel disease and autism. Alternatively, positive experiences with the health provider or policy maker can build trust which enables more acceptance and trust in the quality of health interventions.

As described above, there are multiple contextual and historical – and often complex – factors which influence consumers’ perceptions of quality and safety. The increasing scale of public concerns around the quality and safety of vaccines, though, points to a new trend of increasingly demanding consumerism that has implications for quality and safety questioning around a realm of health interventions beyond vaccines.

Some of the contributing factors to the changed trust environment around vaccines include the following:

- there has been a dramatic increase in the number of vaccines available and recommended for use;
- vaccine preventable diseases are much less visible leading to changed perceptions of disease risk;
- increased consumerism exists with more demand for information and ownership of health decision-making;
- information technology has dramatically increased the extent and speed of access to and the spread of both accurate and inaccurate information;
- the internet and new social media has also facilitated the growth of self-organized groups who question the safety and relevance of vaccines; and
- there is a broader climate of distrust in both public and private institutions prompted by dishonesty exposed in the business/corporate sector, politics and government, religious groups, and the media;
- And, finally, the public in general has become more risk-averse.

Many of these factors (namely items 3–7) which have contributed to less public trust in vaccines can equally contribute to questioning of safety and quality around other health interventions.

3) Public concerns need to be heard

In conclusion, whether or not public concerns about safety and quality seem reasonable or accurate, they need to be addressed. One of the drivers of distrust is the health consumers’ sense that their concerns are not being heard. A critical, and often underestimated, element of quality in health care is listening. Not listening, or listening too late, can cost not only health programme disruptions, and vaccine refusals, but lives. Poignant examples include: the recent government suspension of an HPV vaccine project in India following months of unanswered appeals from citizen groups to address their concerns; the belatedly addressed distrust in the safety of polio vaccines in northern Nigeria that lead to the rumour-driven state boycotts of polio vaccination and sparked outbreaks of polio across Africa as far as Indonesia, including in countries that had been declared polio free; and the all too long and severe impacts of the faulty research by Andrew Wakefield that lead to widespread distrust in and refusals of the MMR vaccine and consequent vaccine preventable disease outbreaks.

The issue of citizens questioning the safety and relevance of vaccines is not new, neither is the importance of listening. In 1902, in a hearing on opposition to smallpox vaccination, WT Sedgwick wrote:

“It is not always well to pay attention, of course, to everything that is said or done in this world. There is a great deal of talk that is not worth heeding...I do believe that it is worthwhile to listen to the arguments of honest objectors and endeavour, if possible, to meet the arguments.”

The need to listen and to “meet the arguments” has only become more pressing.

Dr Heidi Larson currently leads a team at the London School for Hygiene and Tropical Medicine studying issues around public trust in vaccines and the implications for immunization programmes and policies.

She previously headed Global Communication for Immunization at UNICEF and Chaired the Advocacy Task Force for the Global Alliance for Vaccines and Immunization (GAVI). Her research specializes in the analysis and evaluation of health and development programmes with particular attention to social and political factors which can affect policies and programmes. Her particular focus is on risk and rumour management in health programmes and technologies, especially vaccines — from clinical trials to delivery — and building public trust. Publications include “Public Health Response to Influenza A(H1N1) as an Opportunity to Build Public Trust” in JAMA (January 2010) and Protecting Public Trust in Immunization in Pediatrics (2008).

Dr Larson is also a Research Associate at the Harvard Center for Population and Development Studies and a Fellow at the Chatham House Centre on Global Health Security.
The forgotten tenet: client focus and quality improvement in health care

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Abstract

Health-care organizations have focused on most of the tenets of quality improvement in the drive to improve quality of care, however, “client-focussed” has typically proven more difficult. The history of the evolution of modern hospitals sheds some light on this lack of focus on the customers of care services. Listening to patients, valuing their experience and engaging patients and families in the quest to improve care delivery has lead to a range of outcome benefits for health-care organizations committed to a client focus.

 Whilst health-care service organizations recognize the importance of “patient-centredness” – endorsed as a dimension of quality in its own right by the IOM – many are struggling with how to move beyond the rhetoric towards improving patient care. Organizations are finding it difficult to involve patients and learn from their experience. While many health-care organizations have taken up some of the guiding principles of quality improvement, such as teamwork, systems and processes and measurement, the improvement tenet of “client-focused” is not always given the same degree of attention.

 Customer needs and expectations in most industries serve to drive development of services and associated processes. Health-care processes are often designed to meet the needs of providers (e.g. admitting and outpatient registration processes) rather than the customers (i.e. the users of health-care services). Many health-care services do not consult with the “customers” during the design and development stages of new services or updated processes. This general lack of customer engagement in health-care services has been paralleled in the approach to quality improvement in health care. Robert Jablonski stated in Healthcare Financial Management in 1992.

“Improvement efforts that do not identify customer satisfaction as their primary objective fail the basic litmus test of quality. If there is no perceived increase in value to the customer, there has been no quality improvement.”

Gladiators, pilgrims and lepers

The history of health-care services – particularly in the acute setting – sheds some light on the lack of customer engagement in health care improvement. The forerunners of modern hospitals may be traced back to about 100 BC when the Romans established hospitals (valetudinaria) for the gladiators, slaves and sick and injured soldiers. These “service users” were important to the Rome Empire, particularly the soldiers as the integrity of the legions formed the power base of Rome. The approach to care however may have focused mostly on “patch them up and get them back out there.” Archaeological excavations of valetudinaria indicate a hospital design not dissimilar to our modern day “ward” arrangement. Terminology attributable to a military model of health-care delivery is still used today in common clinical language (eg “discharge” and “triage”).

In 325 AD the Christian Church urged the Roman state to expand care to the poor, sick, widows and strangers. By the Middle Ages, hospitals served as hostels for pilgrims and almshouses for the poor. Hospitals in this era were largely religious communities, some with a single disease focus (eg for lepers). By the 18th Century, modern hospitals emerged to form our current model typically involving a teaching role, research centres, and the widespread commencement of disease-focused specialization. Consideration of the original “customers” of hospitals – soldiers, strangers, the poor and pilgrims – may provide insight into a history of neglecting client engagement that appears to have carried forward to modern health care settings.

Divergence in language in this field also provides some insight. The term “hospital” derives from the Latin hospes, meaning a stranger or foreigner, and therefore a guest. Another derivation of this term – hospitium - came to signify “hospitality” – the relationship between guest and shelterer. Historically, therefore, “hospital” means “a place of hospitality”. The word “hotel” is also a derivation of hospes and modern hotels are more...
commonly recognised as being in the hospitality industry focused on responding to client needs and preferences.

**Listening and responding to patients**

Listening to customers to improve service provision implies that a service values feedback about the customer’s experience. In 1999, Pine and Gilmore proposed a new theory that has lead to a move away from the industrial economy view of the “product” as the service outcome to a modern view that what a customer receives at the end of a service encounter is “the experience.” This theory suggests that organizations should create engaging, personal and memorable experiences for “customers.”

“Experience Economy” theory has potential to be applied to the health-care sector through the integration of patient care experience as an important indicator of quality of care.

What is it that patients value in a good health-care experience? Internationally studies consistently indicate the following areas are the aspects that patients value most: being treated with dignity and respect; having confidence and trust in providers; courtesy and availability of staff; continuity and transitions; coordination of care; pain management and physical comfort; respect for preferences; and emotional support. While health-care services increasingly gain feedback from patients about their experience of care through surveys, care experience scores can present a limited picture. Detailed information about specific aspects of patients’ experiences are likely to be more useful for monitoring performance of hospital departments and wards. Listening to patient narrative stories about care experiences can often provide insight into expectations of care in a more engaging manner than quantitative data. At the centre of really understanding patient values and preferences is establishing a healing relationship between clinicians and patients and patients’ families grounded in strong communication and trust.

**Better for all**

Demonstrating the link between patient care experience and “hard-edged” metrics can be used to promote the importance of valuing client feedback as a quality improvement driver. A growing body of evidence supports that a patient-centred approach not only improves patient care experience but also results in clinical and operational-level benefits. Impact on clinical outcomes includes: decreases in mortality, rates of hospital-acquired infection, surgical complications, and improvements in patient functional status and higher quality clinical care.

In a study of 1800 patients at a Veteran’s Administration Medical Centre in the USA, patients who reported receiving high level patient-centred care had a significantly lower mortality one year after being treated for acute myocardial infarction. This statistically significantly difference in survival was noted even after controlling for patient socio-demographic characteristics, clinical condition and history, technical quality of care and admission process characteristics. Similarly, higher positive patient ratings of involvement in care has been associated with significantly fewer cardiovascular symptoms 6-10 weeks post discharge for acute myocardial infarction. In a study of 927 US hospitals, Isaac et al. noted strong relationships with between patient experiences and technical measures of quality and safety, including better patient experiences being associated with lower infections due to medical care.

Research has demonstrated that positive staff experience is associated with positive patient experience. The association is positive for witnessing and reporting of errors and negative for working extra hours and stress. Consequently, improving patient experience through patient-centred approaches increases employee satisfaction, and improves employee retention rates.

Gradually, a business-case for patient-centred care is being built indicating an association with decreased malpractice claims, decreased staff turn-over reduced operating costs and increased market share.

**Engaging patients in the drive for higher quality care**

While many hospitals have attempted refocusing care to become more “patient-centred,” the outcome is often isolated pockets of excellence. A more comprehensive, organization-wide approach, fundamentally linked to organizational success, may be required. Within this approach, patients and family have also been identified as “an invaluable asset and resource for improving patient safety.”

Strategies for engaging patients in health-care improvement range from listening to individual patient stories, patient rounding, patient representation on governance and committees through to experience-based co-design of new processes and facilities. “Patients as Teachers” provides one such model that incorporates patient experience into service design and professional education. Internationally, programmes are emerging to support patient engagement in health-care improvement, such as Patients Accelerating Change (NHSC Clinical Governance Support Team, UK), The Point of Care Programme (The Kings Fund, UK) and Partnering With Patients (Clinical Excellence Commission, Australia).

Leading health-care services provide exemplars for patient engagement – such as Bronson Methodist Hospital, Griffin Hospital, MCG Health Inc – whilst organizations such as the Planetree Alliance aim to facilitate patient-centred care through forming healing environments in a collaborative community of health-care organizations.

Having an organizational culture that is strongly supportive of change and learning is central for re-orientating patient-centred care delivery. Learning organisations have systems, mechanisms and processes in place that are used to continually enhance the capabilities of those who work with it or for it, and are open to learning from past failures and customer experience. Tragic events can cause an organisation to examine its own values and its processes for promoting safety and quality improvement. Listening to patients and involving patients and families in improving care delivery is a positive response to these tragedies. This necessitates greater engagement of patients and family in open disclosure processes and review of adverse events.
To move beyond the rhetoric of “patient-centred care” requires revisiting the original tenets of quality improvement and ensuring they are applied in totality to health care, including “patient-focussed”. Revisiting the origin of hospitals may help us to be mindful of the need to take a new approach to the design of health-care delivery whilst retaining the “hospitality” in healing. The foundation of improving patient-centred care is to listen and learn from patient experience and to actively partner with patients, families and carers in driving improvement in the quality of health care.

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The Core Measure Solution Exchange: expanding the quality improvement community

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Abstract

In order to stimulate quality improvement activities among lower performing hospitals, The Joint Commission has developed an innovative new tool: The Core Measure Solution Exchange. The Exchange is designed to expand the peer network of health-care professionals by facilitating their access to a community of over 4,000 accredited hospitals. The Exchange, scheduled to formally launch in January 2011, will expose professionals to quality improvement experiences that have produced positive results in the “real-world.”

Change can be hard. It can be difficult even when the need to change is clear and the basic path to improvement appears obvious. As evidence of this statement, one need look no further than the health-care system to provide numerous examples. We know, for example, that hand washing compliance rates among health-care providers often fall below 50%, and that only 40% of health-care professionals are annually vaccinated to prevent the spread of influenza. Yet the evidence for a positive impact on health and health outcomes in both cases is abundantly clear.

This should come as no great surprise to most readers. In 2001, the Institute of Medicine’s landmark report, Crossing the Quality Chasm, clearly identified the need to improve health care effectiveness through the consistent provision of services that are based on current scientific knowledge. While this goal seems obvious, it has often taken years for research findings to impact training and clinical practice.

Currently, most medical research is disseminated through the time-honored scientific tradition of peer-reviewed publication and presentation at scientific conferences. This approach to the dissemination of innovation is well summarized by Shojania and Grimshaw as an optimistic, albeit passive, approach to dissemination (“If you publish it, they will come”). Following the publication of landmark research, dissemination efforts are often expanded to include a similarly optimistic and passive approach – the establishment of treatment guidelines and systematic reviews (aka: “If you read it for them, they will come”). The shortcomings of these dissemination efforts are well established, most notably by Balas and Boren who reported a 17-year average for health care research evidence to reach clinical practice.

Of course, the pace of quality improvement need not be so slow. Considerable work has been done to explore barriers to effective dissemination and implementation and to study effective solutions. One such body of work is alternately referred to as “knowledge translation research”, “implementation research” or “diffusion research”.

Diffusion research, an outgrowth of sociology, was first used to understand how agricultural innovations spread from farmer to farmer. Beginning in the 1940s, the first diffusion researchers sought to explain why one farmer would know about and adopt a certain innovation while his neighbor did not. Since the 1960’s diffusion research has been applied to a wide variety of disciplines most notably communications, organizational theory, agricultural economics, education, public health, marketing, geography and general sociology. More recently, the model has been discussed as an important mechanism for the diffusion of health care innovations.

Traditional dissemination efforts are typically focused on establishing and increasing a population’s awareness of an innovation. While such efforts are obviously important, they are often insufficient if the ultimate goal is to create behaviour change. To bring about change, especially voluntary change, a few key ingredients must be present. First, potential adoptees must perceive the change as advantageous (which is also related to complexity, compatibility, trialability and observability). Second, the communication network must be trusted and credible. Third, change must be sensitive to the social system into which it is introduced.

How might these principals be applied to accelerate quality improvement efforts? Fittingly, it is the rapid adoption of another recent innovation – the internet – which may provide quality improvement advocates with an unprecedented opportunity to implement the lessons of diffusion research and accelerate the adoption of health care innovations. To test this concept, The Joint Commission has recently developed an application that is designed around these principals for the purpose of improving hospital performance on measures that address...
Since 2002, The Joint Commission has required its more than 4,000 accredited hospitals to measure and report compliance on evidence-based measures of care that are related to the treatment of high risk and/or high volume patient populations (e.g., acute myocardial infarction, health failure, pneumonia, surgical care). While performance measure rates, on average, have steadily improved, an unacceptably high number of hospitals still fail to consistently achieve high rates. As part of the ongoing effort to address this quality gap, The Joint Commission has developed the “Core Measure Solution Exchange.” The Exchange is a web-based application that is built around the principals of diffusion research and it is designed to take advantage of two key environmental opportunities:

1) nationally standardized performance measures now make it possible to identify hospitals that have made significant improvements, as well as hospitals that still need to improve;
2) The Joint Commission, by virtue of its role as an accrediting body, has an established communication channel that can be accessed by thousands of hospitals.

The Core Measure Solution Exchange is organized around a simple concept – to accelerate quality improvement, it is important to: 1) Expand health-care providers’ peer network by facilitating their access to the entire community of accredited hospitals, and 2) Expose health-care providers in lower performing organizations to multiple examples of quality improvement experiences that have produced positive results in the “real-world”. We know, based upon decades of diffusion research (as well as our own personal experience), that peer-to-peer sharing of experiences (e.g., neighbour-to-neighbour, farmer-to-farmer) plays a critical role in our ability to evaluate the potential advantages of an innovation. By exchanging information and stories with peers (i.e., trusted friends, respected colleagues, or even dozens of online reviewers), we draw conclusions about our own potential experience with an innovation, and we form attitudes that influence our decisions to adopt or reject an innovation.

The Core Measure Solution Exchange initially focuses on improving hospital performance on eight measures of surgical care are based upon a strong foundation of research, accurately represent the care being delivered, address processes of care that are proximate to desired outcomes, and are constructed in a manner that reduces the possibility of unintended consequences (See Table 1). In order to find hospitals that might serve as real-world examples of dramatic quality improvement, The Joint Commission analyzed three years of performance measure data to search for hospitals that achieved three milestones: 1) Statistically significant improvement in performance on at least one measure; 2) Improvement that resulted in measure rates that met or exceeded national targets for the measure (typically rates that exceeded 90%) and 3)...

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**Table 1: Surgical care performance measures - percentage of hospitals with rates below 90%**

<table>
<thead>
<tr>
<th>Measure</th>
<th>% of hospitals with rates below 90%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotics within one hour before the first surgical cut</td>
<td>9.2%</td>
</tr>
<tr>
<td>Appropriate prophylactic antibiotics stopping antibiotics within 24 hours</td>
<td>3.3%</td>
</tr>
<tr>
<td>Stopping antibiotics within 24 hours</td>
<td>21.4%</td>
</tr>
<tr>
<td>Cardiac patient with 6 a.m. postoperative blood glucose</td>
<td>25.3%</td>
</tr>
<tr>
<td>Patients with appropriate hair removal</td>
<td>1.7%</td>
</tr>
<tr>
<td>Beta-blocker patients who received beta-blocker perioperatively</td>
<td>33.0%</td>
</tr>
<tr>
<td>Prescribing VTE medicine/treatment</td>
<td>34.8%</td>
</tr>
<tr>
<td>Receiving VTE medicine/treatment</td>
<td>24.2%</td>
</tr>
</tbody>
</table>

Rates based upon 2009 data reported in The Joint Commission’s Annual Report on Quality and Safety. For additional information on the Surgical Care measures, including detailed calculation specifications, please refer to the Specifications Manual for National Hospital Quality Measures.
Improvement sustained for at least 6 months. A total of 225 hospitals met all three criteria. The Joint Commission sent a letter to the Chief Executive Officer of each organization to encourage them to describe their quality improvement experience using the Exchange website.

Solutions posted to the Exchange are submitted using a structured form that requires hospitals to define the problem they faced, explain how they analyzed the problem, describe the quality improvement solution they implemented, and highlight the challenges they faced along the way (See Figure 1). High performing hospitals are also able to upload additional documents and materials that they are willing to share with peers. Hospitals seeking solutions may filter content by both individual measure and a range of hospital characteristics. Such filtering allows them to find solutions that are related to their specific improvement needs which may have been implemented by organizations that are structurally similar to their own (see Figure 2).

The website is designed to promote interaction among participants. Inspired by the interactive content of pioneering commercial websites, such as Amazon.com, iStockphoto, or Digg.com, users of the Exchange can post comments, ask questions, and submit ratings of the solutions based upon their perceived transferability (ie, How likely is it that this solution could be implemented in my organization?). Hospitals that attempt to implement or adapt solutions can also post their own quality improvement experiences (See Figure 3). Finally, in order to stay connected, users can subscribe to e-mail notifications that update them whenever content is added or changed.

Conclusion

While the primary goal of the Exchange is to create an environment that facilitates the sharing of experiences among colleagues, it is also designed to highlight the everyday achievements of health care professionals who are working to improve patient care. By making these stories available – enabling front-line staff from a broad range of hospital types and environments to tell their stories in their own words – it may be easier for health-care professional in lower performing hospitals to visualize their own potential success.

The Exchange is currently a work-in-progress. Pilot testing began in November 2010 and high performing hospitals, invited to post solutions, have taken the first step. During just the first 14 days of operation, 22 solutions (targeting 6 of the 8 measures) have been submitted by 19 hospitals. Those hospitals have been both rural and urban, ranging from fewer than 50 beds to more than 500. It is a promising start, but only time will tell if the Exchange is capable of fulfilling its promise. The Core Measure Solution Exchange will be made available to all accredited hospitals in December 2010, and it will be formally launched in January 2011. By spring, we should know if the community of health care professionals has embraced this innovation and helped it to take root and blossom, or if like so many other innovations, it fails to engage the community in a way that meets their needs.

Dr Scott Williams oversees the Center for Quality, Patient Safety and Innovation Research within The Joint Commission’s Division of Healthcare Quality Evaluation. He is primarily responsible for the development and coordination of externally funded research projects within the Division. Most recently, he has pursued the development of web-based applications that apply social networking and diffusion tools to facilitate the dissemination of health care quality improvement strategies. His work has been published in the New England Journal of Medicine, Circulation, International Journal on Quality in Health Care, Psychological Reports and other peer-reviewed journals on issues related to health care performance measurement. In his 13 years at the Joint Commission, he has directed the pilot testing of nationally standardized performance measures and coordinated the Joint Commission’s measurement system vendor auditing process. He holds a doctorate in counseling psychology from the University of Northern Colorado and a Masters degree in counseling psychology from the University of Denver. Dr Williams is licensed as a Marriage and Family Therapist in Illinois.
References


Working in quality

Abstract

Working in quality: this is now the imperative for every company, especially when its primary function concerns the provision of benefits which (directly involve) the public, such as health benefits. It is also what we are asked by citizens themselves.

But what exactly does this mean? What is required?

Work as a means to internalize the concept that a good outcome for the patient is achieved through the synergistic work of various professionals, considering the totality of the person and not just the clinical situation of the moment, with the ability and willingness on the part of everyone regardless of their business function, to enter the various organizational processes critically and working jointly with the aim of improving them.

The growing tendency towards continuous improvement of quality in recent years is very noticeable in Humanitas Gavazzeni.

The programme on the management and continuous improvement of service quality adopted by the structure has the objective of improving care processes, management and results by promoting convergence between the health needs of the patient and the services available, the coordination of benefits paid, the reduction of risks for both patients and practitioners and the dissemination of a culture of safety and quality. The reference model adopted by Humanitas Gavazzeni since 2004 for methods, purpose and content, is the system of accreditation for excellence Joint Commission International, favoured over other methods as more responsive to a hospital. All staff – both technical, managerial and clinical care – were involved to meet the requirements, and, in particular, training courses were organized. Improvement groups on specific topics, made up of different professionals, were established with the aim of deepening the JCI standards and to integrate them in the processes and procedures of Humanitas Gavazzeni.

Working in Quality is not just making the correct diagnosis, to identify the best treatment and set a treatment plan and follow-up. It is not just being able to customize clinical or nursing plans, or to properly apply the interdisciplinary protocols. It is not simply to provide all the necessary tools for the staff who must deliver the activities, with the right staffing and best technologies, to the different business functions of organizational support. It is not simply organizing the cleaning and catering, to prevent accidents and incidents and maintain safe.

Work as a means to internalize the concept that a good outcome for the patient is achieved through the synergistic work of various professionals, considering the totality of the person and not just the clinical situation of the moment, with the ability and willingness on the part of everyone regardless of their business function, to enter the various organizational processes critically and working jointly with the aim of improving them.

In literature one can find many definitions of quality and safety, and many methods are proposed. We do not enter into the merits of this content, but we stress that all reporting leads back to common elements such as the precise determination and commitment of all professionals to pursue them and adopt a reference model as a guide to the different actions.

The growing tendency towards continuous improvement of quality in recent years is very noticeable in Humanitas Gavazzeni; experienced seriously and attended by staff it is a direct derivation of its Mission, which aims to:

- Ensure the effectiveness of treatments, combining skilled clinical care responsibilities and modern technologies in validated diagnostic and therapeutic processes;
- Effective use of available resources, involving staff in the responsible management of the economic factors of the service;
- Ensure the humane care and the centrality of the patient as a person, through the motivation and training of all staff and the creation of structures on a human scale.
The programme on the management and continuous improvement of service quality adopted by the structure has the objective of improving care processes, management and results by promoting convergence between the health needs of the patient and the services available, the coordination of benefits paid, the reduction of risks for both patients and practitioners and the dissemination of a culture of safety and quality. The reference model adopted by Humanitas Gavazzeni since 2004 for methods, purpose and content, is the system of accreditation for excellence. Joint Commission International, which was favoured over other methods as being more responsive to a hospital.

In particular, the advantages of this approach by the focus on the following main aspects:
- spreading the “culture of quality”;
- interdisciplinary;
- uniformity of care and stimulates continuous improvement in patient care;
- improvement of security strategies for patients and operators;
- improvement of communication between operators;
- direct feedback from customers;
- corporate image.

It also encourages an objective assessment of the quality of the structure because it is based on internationally accepted standards - set of predefined performance expectations - and on principles of validity, acceptability and objectivity.

Quality and security are rooted in the daily work of individual health professionals and hospital staff in general. JCI helps us in focusing effectively on the areas of attention, on which to focus improvement efforts for both patients and operators. According to this approach, continuous quality improvement presents the development of a virtuous circle which pursues the satisfaction of patients and staff, safety in the building, the safety of provided procedures, the operational and managerial efficiency and is achieved through the following methodological steps:
- analysis of the quality system in use;
- evaluation of business documents;
- visits to clinical units/departments and interviews with operators to determine the degree of adhesion of the JCI standards;
- identifying critical areas to design improvement activities and plan the necessary training sessions (detailed plan of action “who-does-what”: quality plan).

All staff – both technical, managerial and clinical care – was involved to meet the requirements, and, in particular, training courses were organized. Improvement groups on specific topics, made up of different professionals, were established with the aim of deepening the JCI standards and integrating them in the processes and procedures of Humanitas Gavazzeni.

Here are some results obtained from these synergies:
- Correct identification of the patient before each procedure and before the administration of drugs and other therapies: each patient will be asked name, surname and date of birth, and the data are then compared with clinical documentation; if patients are hospitalized, the data are instead compared with those in the bracelet.
- Integration and continuity of clinical care: we established the figure of the referring physician, who is a constant reference point throughout the process of patient care, responsible for managing the care plan as well as main contact for information both for the patient and his family.

All clinical documentation has been revised and integrated medical records have been created to foster communication among different health professionals (doctors, nurses and technicians) and for a better use of information.

Plans have been prepared to inform and educate patients and their families, questionnaires and defined processes that identify the needs of each person and encourage understanding of proposed treatments, the potential benefits or risks of the possible paths after discharge.

Specific guides for each clinical specialty containing valuable information in view of admission were prepared and distributed prior to admission itself.
- Reduction of pain and control thereof in the processes of care: the Committee “pain-free hospital” was established and clinics have been opened for the management of acute and chronic pain.
- Improved safety of clinical-care processes: the process of medication management within the facility has been revised throughout.

A procedure defining the checks to be carried out before a surgery or a complicated procedure has been prepared, known as Time Out and Check List of Operating Room.

Procedures have been defined and paths implemented to increase safety of patients admitted through a system of assessment and reassessment of fall risk, with the identification and implementation of preventive measures.
- Reducing the risk of healthcare associated infections: we made a programme of awareness and training on proper hand hygiene and the use of disinfectant gel. Specific information boards on the proper cleaning of hands have been prepared and placed both in operational areas and at the points of greatest influx of patients and visitors. A monitoring programme has been put in place in the various operating units.

The overall approach to quality improvement and patient safety promotes not only the definition of preventive, improvement and corrective actions, but also allows the collection of a series of data on specific activities provided (indicators), especially for certain processes, and encourages constant monitoring by the professionals themselves and managers. The business decisions that lead to the design, construction and publication of indicators follows a validation path shared
among different professionals and managers responsible for the phenomena to study. In particular, the decision to start or stop the collection or publication of an indicator is in view of a number of factors, including: the magnitude and trend over time of a phenomenon that has a significant impact on the quality of service and management in the broadest sense, the feasibility of detection, the validity and understanding and interpretation of the measure found, the effectiveness of the indicator in function of the improvement, or the real ability to guide action and monitor the results; the comparison with the outside world, which may propose reference models and standards as well as specific tools and areas for improvement (e.g. local health authorities, national or regional bodies, JCI itself, other bodies scientific and professional), the internal comparison between professional groups to promote consistent behaviour. The new processes should definitely be monitored in order to be able to quickly highlight any negative trends, facilitating a rapid redesign. The indicators collected in Humanitas Gavazzeni can be grouped into three main categories:

- Indicators of patient satisfaction: issues relating to the satisfaction of care received. These data, in particular, are drawn from specific questionnaires that patients are requested to submit before leaving the hospital, after performing outpatient services or hospitalization. It analyzes several areas, including the level of care and quality of care received from medical and nursing staff, the quality of information received, the level of confidentiality and privacy, the quality of hotel services, including meals and housekeeping, and administrative services. These data are particularly important for business improvement, especially when patients leave feedback, comments or suggestions.

- Process indicators, related to clinical care: they concern issues directly linked to care pathways and are collected directly by doctors, nurses and technicians. For example, we remind the monitoring data of patients undergoing deep sedation, collected by anesthetists, where adverse events are reported. After analyzing the data several drug protocols and some care processes have been revised to reduce the most common complaints such as nausea, vomiting or chills.

- Indicators of activity: covering more organizational and managerial aspects. Include data related to quality control programmes for equipment used, such as checks in Radiology and lab analysis, data management related to resource use and data related to demographic aspects of the patients.

The spread of the trend of the observed activities is facilitated by the use of a tool that collects all the indicators, called “Tableau de Bord of Quality” – a book of quality – sent periodically to the various corporate officers (doctors, nurses, technicians, management) for shared assessment. The head of each indicator provides instructions for the understanding of indicators and, periodically, demonstrates and shares with all colleagues the possible developments and projects.

The implementation of JCI methodology at all levels of the company has not been easy: as often happens, while recognizing the validity of content and methodology. It is always difficult to change the operating procedures and habits, especially when they are consolidated and “apparently” without serious errors. Aspects affecting the quality are often perceived as discounted items belonging to the normal rules and best practices. Plenty of time and patience were needed in order to make it clear to all operators that processes can be reviewed and small parts changed for the improvement of a result or the prevention of adverse events, without having to disrupt the good practices already in clinical use and not necessarily take much longer.

It takes less time to properly explain to the patient and family proceedings and to successfully build a plan of care, rather than chasing the missing parts or searching for interdisciplinarity.

It is of course important that professionals are supported in the process of change as much as possible. It is not just a matter of time, training and/or acquisition of behaviour. It is essential to envisage a process that certainly provides for:

- The total involvement of the “Top Management” and “Leadership”;
- identification of a coordination centre for quality, which is credible, competent and located in the heart of the organization (such as a Committee or the Quality Network, representative of the different business functions);
- the Organization’s definition of corporate quality;
- identification of objectives and priorities for action;
- defining the necessary resources (human, technological, structural);
- the direct involvement of staff in quality improvement activities;
- maximum information sharing at all levels;
- training and monitoring across the board.

Within six years after the first accreditation we are satisfied because we realize that – slowly and unconsciously, and sometimes painfully – the valuable insights provided by JCI methodology have become an integral part of our activities and a reference point.

Indeed, in some situations, in the provocative hypothesis to return to previous modes of operation or documentation of former formats, professionals themselves are resisting because they do not want to lose the new settings and philosophies met. This is an element of real satisfaction for us and let us understand that it’s important to continue the road taken with patience, passion and determination!

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Hospital accreditation from the perspective of a Belgian Academic Medical Centre

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Abstract
The Belgian health care system does not impose mandatory hospital accreditation. In this report, we explain why from our perspective, as the largest academic medical centre in the country, accreditation on a voluntary basis felt to be an essential aspect in legitimizing our mission. We also describe how we think the attention to patient safety in a continuous quality improvement process, ought to be complemented by pathology specific quality of care improvement measures.

Belgium is a federated state with approximately 10.5 million inhabitants and spends 10.2% of its gross domestic product on health care. Curative care is largely organized at the Belgian federal level, whereas preventive care is a regional competency.

Curative Belgian health care is in essence a social security based system. It is characterized by a very high degree of accessibility through the combination of a broad range of health-care providers and provisions without any form of gatekeeping or echelons, coupled to an extensive coverage of medical care for all citizens through the compulsory and centrally organized health insurance system.

Financing of hospital care is largely activity based, along two major roughly equivalent channels: one consists of an APR-DRG-based financing that is intended to cover the cost of the hospital services and the other consists of a fee-for-service reimbursement for medical services provided by the health-care professionals within the hospital, and is based on a uniform, centrally set tariff list. Co-financing of hospital activities from the clinician’s fees is legally embedded. The funding is the same for academic and non-academic hospitals, except for a small non-activity based additional lump sum for academic hospitals, as a compensation for the higher cost of the physicians employed by the hospital. In all other hospitals, clinicians are self-employed.

In terms of patient safety and quality of care in hospitals, Belgian legislation imposes a number of requirements which are largely structural, such as the minimally required bedside nursing staffing ratio. Compliance with this legislation is certified by the regional health-care administration. In doing so, they can impose additional requirements with regard to quality management. As yet, hospital accreditation is not mandatory, nor is the public reporting of patient outcome measures, albeit that the current administration is envisaging both options.

Overall patient satisfaction and perceived quality of care is high. However, international benchmarks would seem to indicate that this perception is based more on the fundamentals of the health-care organization (high accessibility and fee for service reimbursement resulting in a high service level with the virtual absence of waiting lists) rather than on measurable patient outcome parameters. The systematic collecting and reporting at country level of a broad, well defined set of validated patient outcome parameters other than mortality is lacking at present. However, the data that are available such as preventable years of life lost or cancer survival rates positions Belgium only approximately half way up the European ranking.

The University Hospital Leuven (UZLeuven) counts 1933 beds and is the largest academic medical centre (AMC) in the country (Table 1). As an AMC, its characteristic triple mission consists of delivering high quality (top referral) patient care, training health-care professionals and performing translational biomedical research, aimed at developing innovative care and care models that result in safer and better care. Passing on these innovative concepts to health-care professionals during their education and training, ensures their dissemination and should thus contribute to continuous quality improvement of overall health care in our society.

Numerous reports highlight that how well treated individual health-care professionals may be, achieving the goal of continuously providing better and safer care, clearly requires the implementation of a structured continuous quality improvement (CQI) process within health-care organizations. How to do so, and how to instil the appropriate CQI culture within an organization should therefore be an essential feature in the education and
training of health-care professionals. It is well known that education and training on aspects of patient safety cannot merely consist of a series of lectures in the formal curriculum. Students and residents also learn a “hidden” curriculum through interaction with staff in the hospital and by complying with hospital quality initiatives. Hence the need for an AMC to ascertain that patient safety measures and best practices are adopted in the clinical setting to which students and residents are daily exposed, not only from the patient care perspective, but also from a more educational perspective. With this purpose in mind, UZ Leuven has embarked on a dual process.

Approach in UZ Leuven

1. Hospital wide safety and quality

In terms of overall hospital-wide aspects of safety for patients, visitors and staff, UZ Leuven has sought accreditation on a voluntary basis through the Joint Commission International (JCI).

By subjecting the hospital to a survey by an external independent organization, we wished to ascertain that our CQI process meets international standards. In addition, given that an accreditation survey reveals points for improvement in an organization, both with regard to clinical processes as well as facility management aspects, this can help to stimulate and strengthen the quality culture within the organization.

The JCI accreditation process takes a very patient centred approach, starting from daily practice by tracing individual patients. This approach has been met with great enthusiasm and has involved commitment at all levels within the hospital. Numerous professionals of all clinical and non clinical departments volunteered to participate in working groups that prepared, rewrote or updated policies and procedures required in the standards on safety and quality, and then went on to implement them throughout the hospital. The large majority of these standards such as patient identification, correct site surgery, infection control or completeness of patient assessment were felt to reflect sound, well established practice in the organization. Aspects in a few standards such as primary source verification of the education of all clinical staff members or requirements with regard to ongoing professional practice evaluation (OPPE) were new to the Belgian health-care legislation and therefore needed to be introduced in the organization.

Preparing for the accreditation survey has also focused efforts to develop tools that further improve patient safety and allowed for a quicker implementation of new techniques and information technology that ought to improve quality outcomes.

Preparation for the accreditation survey was designed over an 18 month time period. The Accreditation status was obtained in June 2010.

By acknowledging the constant dedication, motivation and skill of our staff, obtaining accreditation had a positive impact on staff satisfaction and increased even further the motivation to reinforce the continuous quality improvement process within the organization.

2. Pathology specific quality of care

Attention to patient safety is an essential part of the CQI process within the hospital. However, it does not guarantee pathology specific optimal quality of care. It is therefore not surprising that the correlation between accreditation status and pathology specific patient outcome measures is inconsistent.

Separate from the accreditation survey, but related to the overall CQI process, we have therefore launched a second project that focuses on pathology specific quality of care. In this process we actively involve all the clinicians, as we are convinced that, as has been reported by others, hospital performance goes together with the level of physician involvement. We have started by delineating the portfolio of conditions that we treat or wish to treat within our hospital. We have then asked the clinicians to structure the care that we wish to provide in disease specific care programmes. To date, approximately 250 of these care programmes have been listed.

Each of these care programmes is championed by a staff member, who describes, evidence based whenever possible, in a multidisciplinary approach with other colleagues involved, the diagnostic and therapeutic modules required for optimally treating a specific condition. The primary goal is to describe from a strict clinician’s perspective what the desired outcome of the medical process should be and how this quality aspect can be measured. A prerequisite for the design of these integrated clinical care programmes is a multidisciplinary approach that includes all other health-care professionals involved, thus further enhancing the quality of patient care. At the same time, from a more operational perspective, these detailed care programmes allow us to visualize the optimal use of diagnostic procedures and therapeutic approaches, avoiding both over- and underuse, and thus increasing the overall efficiency of the care process. Indeed, as described in the landmark report by the Institute of Medicine, key features of high quality care include not only safety and effectiveness but also, amongst other aspects, efficiency of the care process. It has been well established that these different aspects are not mutually exclusive and that initiatives to improve patient outcome can also increase the efficiency of care.

Through the electronic patient record, which is part of the overall hospital information system, patients can be labeled to specific care programmes, which in turn is linked to a number of possible applications such as a pre-programmed diagnostic work up for complex diseases or detailed clinical paths, primarily for elective surgery. As

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Table 1: Key figures University Hospital Leuven 2009

<table>
<thead>
<tr>
<th>Category</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of beds</td>
<td>1933</td>
</tr>
<tr>
<td>Total staff</td>
<td>6152 FTE</td>
</tr>
<tr>
<td>Medical staff members</td>
<td>484 FTE</td>
</tr>
<tr>
<td>Daily activities</td>
<td></td>
</tr>
<tr>
<td>Outpatient visits</td>
<td>2760</td>
</tr>
<tr>
<td>Admissions</td>
<td>247</td>
</tr>
<tr>
<td>Day care treatment</td>
<td>352</td>
</tr>
<tr>
<td>Surgical procedures</td>
<td>203</td>
</tr>
</tbody>
</table>
part of chronic disease management, we are also extending these care programmes in collaboration with general practitioners to ambulatory care. The care programme labeling also allows us to track the patient throughout his hospital stay at the different medical services and wards and thus to calculate the costs and revenues for each care programme. Linking these data to the well defined quality outcome measures should thus allow us in dialogue with the clinician to improve both patient outcome and efficiency at the level of the care program. We believe that this type of detailed and balanced care cost analysis appeals far more to the treating physician and thus is a better substrate to a continuous quality improvement reflection than more generalized overall quality data such as mortality figures, overall number of nosocomial infections or general trends in medication use.

Benchmarking in a hospital network
The data on patient safety and quality of care should ideally be complemented by an external benchmarking that would allow us to learn from other, potentially better practices. Reliable benchmarking is however frequently hampered by differences in methodology, exact outcome parameters or differences in data collection. To solve these shortcomings, we are building a balanced scorecard approach to hospital performance in a network of 19 hospitals throughout Flanders. These hospitals are all member of the Flemish Hospital Network KU Leuven. This is a network of independent organizations. Together, they make up for approximately 10 000 beds, which is roughly 40% of all hospital beds in Flanders. The primary purpose of the network is to build a trusted environment that allows for an open, transparent exchange of information. In doing so, the aim is to identify, show and learn from best practices within these hospitals, thus improving the level of hospital performance for all members of the network. As all aspects of hospital management are targeted, the balanced scorecard is to include indicators of financial performance, human resource management, but also and mainly indicators of patient safety and quality of medical care. All indicators are uniformly defined, and thus provide valid benchmarking as a tool for increasing the overall quality of health care in its various aspects throughout the different hospitals within the network.

Conclusion
Raising awareness as to the necessity of participating to structured CQI processes within health-care organisations has to be part of the education and training of health care professionals. This requires the active participation in and development of an innovative approach to CQI in academic medical centres. Internationally defined standards of patient safety can be of substantial use to stimulate a hospital wide CQI culture throughout various departments of the hospital, but this needs to be complemented by disease specific quality of care measures that have to be defined by the treating physicians. Benchmarking within a trusted network can have added value by defining and learning from best practices.

Professor Johan Kips MD is CEO of the University Hospitals Leuven, Belgium and is Faculty Member of the Department of Public Health at Lovain University.

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Raising awareness as to the necessity of participating to structured CQI processes within health-care organizations has to be part of the education and training of health-care professionals.
Leveraging on hospital accreditation for quality improvement in Hong Kong

Abstract

Hong Kong has embarked on a pilot scheme of hospital accreditation in collaboration with the Australian Council on Healthcare Standards. In this paper, we discuss the rationale behind the pursuit of accreditation as the territory-wide quality improvement programme for both public and private hospitals, outline the critical success factors for the pilot scheme and share the benefits derived and lessons learnt in implementing the pilot scheme.

Hong Kong is a modern city with 7 million inhabitants. Under its prevailing health-care policy, Hong Kong has a “safety net” public health-care system which ensures that no one is denied adequate medical treatment through lack of means. The majority of public health-care costs are funded by the government with very low fees for service. Despite its relatively low total health-care expenditure (at 5.0% of gross domestic product) compared with OECD countries, Hong Kong’s health indices are among the best in the world.

Hong Kong has a private and public health-care sector with separate funding and fee charging arrangements (Table 1). As in many advanced countries, Hong Kong’s health-care system is facing many challenges, such as rapidly ageing population, rising medical costs against finite manpower and resources and heightened expectations for quality and safety. To rise up to the challenges, there is imminent need to ensure sustainable development and continuous quality improvement in the Hong Kong health-care system.

Challenges to HA quality system

Since its establishment by statute as an independent organization accountable to the Government for the management and control of all public hospitals in 1990, the Hospital Authority (HA) has always strived to continually improve services and patient care quality. In its quality journey, HA has focused on various key components in the clinical governance loop, such as defining and setting quality standards / parameters, conducting quality diagnosis and review, implementing programmes and incentives to improve quality and monitor performance. In 2006, HA has established a Quality and Safety Division in its Head Office with the key aims of driving strategies and changes to enhance quality and patient safety in all public hospitals.

Over the years, HA has developed and refined a set of patient care standards to promote quality and safety as an integral part of its annual planning process. However, by adopting a self-assessment approach against its own preset standards instead of external peer review, the HA quality system is not perceived to be as robust or credible as other external hospital accreditation systems. In the wake of a spate of highly publicized medical incidents in recent years and in an endeavor to improve its quality system to one that is transparent and trusted by the community, HA had finally decided to go for external accreditation, after debating at length around the fundamental questions of “what are the incentives; staffing and resources requirements as well as benefits and challenges for public hospitals to undergo external hospital accreditation?”

Why accreditation?

Accreditation is well recognized as a proven tool for continuous quality improvement in the health-care setting. As shown in various literature, there is evidence of rapid growth in the number of health-care accreditation programmes globally as a key strategy in sustaining quality improvement. Most organizations or healthcare systems embark on external accreditation programs because of legislation, marketing and publicity, insurance, funding, or government policy requirements.

Hong Kong has embarked on a pilot scheme of hospital accreditation in collaboration with the Australian Council on Healthcare Standards. In this paper, we discuss the rationale behind the pursuit of accreditation as the territory-wide quality improvement programme for both public and private hospitals, outline the critical success factors for the pilot scheme and share the benefits derived and lessons learnt in implementing the pilot scheme.

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Despite the steady uptake of voluntary accreditation programmes in United States, Canada and Australia, it is interesting to note that not all accreditation programmes are thriving. Some countries have resorted to legislative means to implement national accreditation programmes. Others, such as Ireland and Portugal, have ceased their accreditation programmes because of policy or political considerations.

As part of public health-care system, HA’s key consideration is to be in line with government’s strategic directions and intent in pursuit of quality and safety. Given the various issues mentioned in the preceding paragraph, it was not certain whether our staff would recognize the value of or support the introduction of an external accreditation scheme as a new quality system. There was also the question as to whether it was feasible and practicable for an international accrediting body to implement an external accreditation system that would suit our local environment. In face of such uncertainties, HA has decided to introduce an external hospital accreditation scheme, with voluntary participation by a small number of public and private hospitals, on a pilot basis.

The pilot scheme of hospital accreditation

With the support and collaboration from the Government, Private Hospital Association and the Department of Health, HA launched the Pilot Scheme of Hospital Accreditation (Pilot Scheme) in 2009. Through open tendering process, an international accrediting agent, the Australian Council on Healthcare Standards (ACHS), was selected as our partner and the latest ACHS Evaluation and its Quality Improvement Program (EQaIP) was adopted for accrediting hospitals in Hong Kong. After discussion and consultation, five public and three private hospitals voluntarily joined the Pilot Scheme.

The key objectives of the Pilot Scheme are as follow:

- Establish the governance structure to steer and oversee the Pilot Scheme, set standards for evaluation and accreditation, and develop the HK surveyor system.
- Enhance capability of local hospitals in preparation of ACHS accreditation.
- Test the feasibility of implementing ACHS accreditation programme prior to formal survey.
- Enhance public-private collaboration in implementing hospital accreditation in Hong Kong.

To prepare pilot hospitals for accreditation, ACHS was engaged to provide support, advice and assistance on staff engagement and education; adoption and harmonization of ACHS standards and guidelines for use in Hong Kong; training and development of local surveyors and surveyor system; consultancy surveys (gap analysis) to identify opportunities for improvement and preparation of pilot hospitals for eventual accreditation via the formal process of ACHS organization-wide survey (OWS).

Update on pilot scheme

By October 2010, 18 months after the launch of the Pilot Scheme, all eight pilot hospitals have completed the OWS successfully and were awarded or awaiting the award of full accreditation status. In addition, three hospitals not in the Pilot Scheme have completed the OWS and were awarded full accreditation status. By November, 2010, 30 health-care professionals and managers have been appointed ACHS (HK) surveyors after completion of full training.

Key success factors of the Pilot Scheme

The Pilot Scheme was considered a great success in
quality improvement for Hong Kong hospitals. We believe that the following are key success factors for the Pilot Scheme:

1) Partnering with an international accrediting organization

Hong Kong does not have its own accreditation system. Instead of undergoing lengthy consultation and development of local standards and accreditation programme from scratch, it was considered more practical and expedient to partner with an international accrediting body to ensure credibility, skill and knowledge transfer. By partnering with ACHS and adopting its EQuIP Standards which are accredited by the International Society for Quality in Healthcare (ISQua), we can derive the benefits of having a readymade and well proven accreditation scheme to align our practices with international standards and facilitate benchmarking and sharing of best practices.

2) Policy support and leadership

Policy support from the Government is of paramount importance. The Hong Kong Government has provided the needed stewardship and resources to support the implementation of an international hospital accreditation scheme as one of its key initiatives to improve the health of the community and ensure sustainability in the provision of quality healthcare services.

Besides the Government, there is also strong leadership and commitment by all major stakeholders to support the Pilot Scheme. At the governance level, the Steering Committee on Hospital Accreditation, comprising representatives from the Food and Health Bureau, Department of Health, HA and the Private Hospital Association, has been set up to oversee the Pilot Scheme (Figure 1). At the hospital level, clinician champions were empowered to lead the accreditation programme.

Support from leaders is pivotal. Leaders can create confidence, act as role model, show commitment, and allocate needed resources for training, facility enhancement and system redesign. In HA, additional resources have indeed been allocated to support implementation of various improvement initiatives to prepare pilot hospitals for final accreditation survey.

3) Stakeholders engagement and education

The ACHS Accreditation programme and standards are new to Hong Kong. Full understanding, engagement and support from all staff and major stakeholders are prerequisite to the successful implementation of the accreditation programme in pilot hospitals. The ACHS consultants have conducted various comprehensive training and engagement programmes for all levels of staff, such as advice and guidance in hospital visits, “master-classes” to engage clinician leaders, “preparatory and speciality workshops” on standards implementation, on-site support by the Australian quality managers as well as consultancy surveys (gap analysis) with recommendations on preparation for accreditation surveys. These comprehensive education programmes have contributed enormously to staff engagement and support which are vital to the successful implementation of the Pilot Scheme.

4) Harmonization with international standards

Given the differences between Australia and Hong Kong in local culture, practice, laws and regulations, it is imperative to ensure that the ACHS EQuIP 4 Standards and Guidelines are equally applicable in Hong Kong. By involving experts and inviting feedback from stakeholders as well as patient groups, we have conducted a thorough review of the EQuIP 4 Standards to assess their relevance, usefulness, feasibility and adaptability for local implementation. By incorporating local policies, laws and regulations, we have developed a Hong Kong version of EQuIP 4 Guide (HK Guide) to assist staff in the application of ACHS standards across hospitals. In the process of harmonizing and adapting the ACHS standards for local use, it has helped build consensus and spirit of cooperation among staff of both private and public hospitals in using the first uniform accreditation standards for all hospitals in Hong Kong.

5) Development of surveyor system

Trained and experienced surveyors and a robust surveyor system are key to all accreditation programmes. To implement the ACHS accreditation program successfully in Hong Kong, we believe in the importance of building up our local surveyor system, with a cadre of well trained and qualified surveyors who can eventually contribute to the development of a local accreditation scheme at par with other international accreditation programmes. By adopting a systematic surveyor training, evaluation and appointment programme in partnership with ACHS, we have to date successfully trained over 30 local surveyors who are given same recognition as ACHS surveyors. These trained surveyors, and others to be trained in the future, will help proactively contribute to the extension and sustainable development of the hospital accreditation programme in Hong Kong.

Outcome of pilot scheme

The Pilot Scheme was well received by staff as many improvement initiatives have been undertaken during the course of the Pilot Scheme as highlighted below:

1) Private/Public Collaboration

The rather compartmentalized private and public hospital sectors in Hong Kong have hitherto not been conducive to cooperation and collaboration. However, in the course of implementing the Pilot Scheme, there has been significant joint involvement of major stakeholders of both sectors in committee work (Steering Committee, Surveyors and Standards), selection of accreditation agent, training and
sharing, cross surveys of public and private hospitals, discussion and adoption of territory-wide surveyor system and standards. These have resulted in enhanced understanding and collaboration between the two sectors which will help galvanize future joint efforts in promoting quality and safety as well as provision of seamless care for the benefit of patients and community.

2) Quality culture and system

Through education and engagement, staff has gained a deep appreciation on the importance of quality culture and system. Most staff reported good experience throughout the Pilot Scheme because of the genuine commitment and passion on quality from all levels of the organization as well as improved team work and cohesiveness in CQI efforts. In preparation of accreditation survey, staffs have come up with many commendable and innovative initiatives and solutions to improve policies, practices or procedures in an effort to attain high standards in care and service delivery according to international benchmarks.

3) Opportunities for improvement

In the process of self assessment and consultancy surveys (gap analysis) to assess the readiness of pilot hospitals for formal accreditation survey, many issues, problems and opportunities for improvement have been identified pertaining to the corporate, clinical and support functions in the pilot hospitals. With concerted effort, over 100 quality improvement initiatives have been implemented at department, hospital and corporate level of HA. Some notable examples of key areas of improvement are shown in (Table 2).

Discussion

The key objective of the Pilot Scheme of Hospital Accreditation is to introduce an international accreditation system for Hong Kong hospitals. The emphasis of the Scheme is on voluntary participation and on the process of education, self-assessment, external survey and benchmarking for continuous improvement. The Scheme’s accreditation process provided the opportunity to identify what is being done well and what needs to be improved. The award of full accreditation status to all pilot hospitals in Hong Kong signified that our service delivery and quality systems are meeting international standards.

With the successful completion of the Pilot Scheme, formal evaluation of the Scheme by ACHS will follow. Also, independent studies are underway to evaluate staff and public acceptance on hospital accreditation. The Scheme has laid solid foundations and infrastructures, and has marked the first step towards Hong Kong’s vision of implementing future model for territory-wide external hospital accreditation. With the lessons learnt from the Pilot Scheme and support by staff in both private and public hospitals, we are optimistic that external hospital accreditation will be extended to more Hong Kong hospitals in 2011 and beyond.

Dr Leung began his career in 1985 in public health and administrative medicine. He was appointed Deputy Director of Food and Environmental Hygiene in 2000, Deputy Director of Health in 2002 and Controller of Centre for Health Protection in 2004. Dr Leung joined the Hong Kong Hospital Authority as Director of Quality and Safety in 2007 and is currently Chief Executive of the Hospital Authority responsible for 41 public hospitals and institutions and 57,000 staff.

Dr Lawrence Lai graduating in 1970, Dr Lai was appointed Consultant Physician in 1980 and Deputy Director of Hospital Services Department in 1989. Since joining the newly established Hospital Authority in 1991, Dr Lai has taken up various senior posts and is currently serving as Senior Advisor (Medical Affairs). Dr Lai has also been actively involved in the work of the Asian Hospital Federation and International Hospital Federation for many years.

Dr Pang is the Chief Manager of the Department of Quality and Standards of the Hong Kong Hospital Authority (HA). He is leading a pilot hospital accreditation program in HA in collaboration with private hospitals and the Hong Kong Government and overseeing the whole implementation. He is monitoring a set of HA Standards to facilitate quality services in public hospitals and planning to migrate to international standards adopted by hospital accreditation. He is also developing the strategies on access management in dealing with the waiting time issues specifically on Elective Surgery and Specialist Out-patient Services for all public hospitals in Hong Kong.

Ms Annie AU is the Manager of the Quality and Safety Division of Hospital Authority Head Office in Hong Kong. She assists the Quality and Standards Department in Quality Management and the Pilot Scheme of Hospital Accreditation which commenced in 2009. Ms Au is a registered physiotherapist and a Certified Professional in Healthcare Quality (CPHQ) of The Healthcare Quality Certification Board, National Association for Healthcare Quality (NAHQ), US since 2002.

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