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

Pr René Amalberti, HAS, France
A brief look at…

FEEDBACK FROM ACCREDITATION
Results as perceived by professionals (IPSOS survey 2012)

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

• Negative points
  – Confusion of objectives that are not clearly perceived (assistance Vs regulation)
  – A need to balance control and incitation
  – Signs of demobilisation after the survey
  – A need for a more integrated process
  – A need for simplification and articulation
  – A demand to demonstrate value and impact
Result of French Hospital Accreditation
(Initial accreditation visit, HAS 2010-2014)

Sample of 1296 Hospitals, public and private

Accreditation failed 4,0%
Accreditation on borrowed time 130: 10%
Accreditation with reservation: 464 : 36%
Accreditation with recommendation: 473 : 37%
Accreditation passed 225 : 17%

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

Beyrouth 2017
Result of French Hospital Accreditation
(after a support period of 3 to 18 months)

- Accreditation on borrowed time: 7.4%
- Accreditation failed: 0.3%
- Accreditation with reservation: 464 (28.3%)
- Accreditation with recommendation: 47.4%
- Accreditation passed: 27%

1296 Hospitals, public and private
Beyrouth 2017
A brief look at…

CONTEXTUAL CHANGE
Worldwide context

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

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

0.7 million people over 60

<table>
<thead>
<tr>
<th>Year</th>
<th>% of population over 60</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>11.5</td>
</tr>
<tr>
<td>2030</td>
<td>19.2</td>
</tr>
<tr>
<td>2050</td>
<td>30.8</td>
</tr>
</tbody>
</table>
The domino effect

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

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

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

Domino effect on healthcare organizations

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

• Changing treatment modalities
  – Patients spending less and less time in acute care settings, thanks to scientific and technological advances such as minimally invasive surgery, early testing and diagnosis, rapid discharge, and sophisticated rehabilitation protocols

• The number and type of hospitals and other healthcare organisations will be affected.
  ▪ Early discharge and massive transfer of post-acute — and now new chronic patients — to primary care
  ▪ Moving from a provider and diagnosis-centred approach to a person-centred approach
  ▪ Multiple implications for quality and safety

Beyrouth 2017
A brief look at…

THREE MAJOR CHANGES TO BRIDGE THE GAP FOR SAFER CARE

Beyrouth 2017
Strategies for change

Primary care → Day and community care
Treating sickness → Encouraging ‘wellness’
Provider-centric → Person-centred care
Fragmented → Integrated
VISIT FOLLOW UP
ASK FOR PLAN A & PLAN B

1: REFERENCE/ PLAN A

MAX BAR
OPTIMAL

ACCEPTABLE
BAR +

RISK MANAGEMENT PLAN B

1

MIN BAR
High risk

ACCEPTABLE
BAR -
Growing risk
Partial compensation

Area of full compensation

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

3: END OF FULL COMPENSATION

Beyrouth 2017
Ask for PLAN A / return to compliance within X months + Immediate PLAN B / contractual risk management to leave with Identified weaknesses

**Optimisation strategies**

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

- Optimize Human and Organizational factors
- Improved style of Leadership
- Improved working hours
- Improved utilization of skills
- Share values among the team
- Improved working conditions

**Risk management strategies**

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

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

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

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

Beyrouth 2017

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

Beyrouth 2017
WIDEN the scope of ACCREDITATION

ACCREDITATION /CERTIFICATION PATIENT JOURNEY

Chronic diseases

Medical Establishment

Wards

TEAM ORIENTED ACCREDITATION/CERTIFICATION

Teams

Traditional Quality management

In and out clinic

Operating theatre Maternity PATIENT TRACER

PATIENT TRACER

Beyrouth 2017