PROMOTING EVIDENCE-BASED PRIMARY HEALTHCARE ACCREDITATION POLICIES

A SELF-ASSESSMENT IN A PRIMARY HEALTHCARE CENTER

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BACKGROUND: PRIMARY HEALTH CARE & THE ACCREDITATION PROJECT IN LEBANON

During the Lebanese civil war period, Non-Governmental Organizations (NGO) invested in primary health care (PHC) services to compensate for the absence of the public sector and to respond to the population needs. Dispensaries and PHC centers were able to operate through the support of the Ministry of Social Affairs, international donations and the collection of fee-for-service.[1]

Upon the end of the civil war in 1991, and in line with its health system reform endeavor, the Lebanese Ministry of Public Health (MoPH) initiated a PHC restructuring initiative. Inspired by "Health for All" Alma-Ata declaration[2], the MoPH aimed to develop national policies, strategies and plans to guide PHC sustainability within a national comprehensive health system. Consequently, a Lebanese national PHC strategy was shaped based on a national conference and series of meetings with different stakeholders[3]. From that end, the MoPH embarked on the establishment of a PHC network through contractual agreement with NGOs and municipalities. Through this partnership, the MoPH provides the centers in the network with essential resources including free vaccines, medications and technical support. In addition, these centers benefit from the joint YMCA-MoPH chronic disease medication program.[4]

Initially, the network started with the involvement of 29 centers in 1996 and expended to 130 centers in 2012. Having this network in place, the MoPH launched in 2009 the PHC accreditation project in collaboration with *Accreditation Canada* aiming to raise the quality of PHC service provided in Lebanon. In fact, accreditation systems in developing countries are used by governments as a regulatory tool to promote quality healthcare services, ensure patient safety and enhance efficient use of resources[5]. Originally, most of the accreditation programs focused on tertiary care. Lately, however, there is a shift towards accreditation in primary health care due to the attention of population based medicine and funders' interest in community care.[6]

The MoPH- *Accreditation Canada* project is considered as a first step towards a national PHC accreditation system in Lebanon. Paving the way for this system started with the development of the first version of accreditation standards for Lebanon. A national multidisciplinary task force combining experts and academicians was responsible for drafting the standards. Afterward, on consultancy basis, *Accreditation Canada* updated and finalized the first version of the Lebanese PHC standards. Subsequently, during August 2010, representatives from sixteen PHC centers participated in a training to be introduced to quality/ accreditation concepts and the planed accreditation process. During the three days training, tools assisting the centers to improve the quality of care provided as well as the steps that the centers will go through were presented. Then, three pilot PHC centers were selected to be pilots and pioneers in embarking on the accreditation process. The selected centers were responsible for performing a self assessment based on the developed standards and identify areas of strength and areas for improvement in their practices. During November 2010, the three centers prepared for an evaluation survey performed by *Accreditation Canada* that tested the applicability of the standards. The evaluation survey results shaped the ministry's vision and strategy for the development and implementation of the accreditation process and its generalization on the entire PHC network. Most recently, and building on the success of the first phase, the Ministry opted to expand the project through inclusion of more centers in the accreditation cycle.

PROJECT OBJECTIVES & RATIONAL

The project involved an internal assessment in a primary care center other than the centers externally audited by *Accreditation Canada*. The internal assessment in the additional center built on the external assessment of the three pilot centers performed by *Accreditation Canada* to expand the MoPH insight on the applicability of the developed standards. Further, this project enabled an early preparation of the selected center for the accreditation process.

PROJECT SITE

The center established in 1987 is situated in the suburb area of Beirut serving a catchment area of around 250,000 to 300,000 individuals. The services provided at the center range from basic public health, primary care and medical services to radiology and social services.

METHODOLOGY

Initially, multiple visits were performed to the center so that the investigator gets introduced to the services offered and the daily operations. Then, in consultation with the center's director a multidisciplinary taskforce responsible for the accreditation process was convened. The investigator led the self assessment process through regular meetings with the taskforce and multiple mock tracers in the center. Tracer methodology was used extensively to evaluate priority processes during the on-site self-assessment surveys. The investigator, accompanied with members of the self-assessment taskforce, traced the path of clinical and administrative processes to gather evidence about the center's compliance with the standards.

The taskforce members consisting of both clinicians and administrators were introduced to concepts of quality, patient safety and accreditation. In fact, the process was new to the majority of the self assessment team since only the director attended the accreditation training organized by MoPH. As a result, the taskforce members tended to rate most of the standards as "In Place" since the process was erroneously regarded as an evaluation of the center's practices by the MoPH rather than an opportunity for improvement. Hence, the validity and reliability of the self assessment process was jeopardized. To deal with this issue, the investigator reinforced the objectives of the self assessment process and introduced the taskforce to quality and accreditation concepts backed up with material from the literature and the accreditation training. Through clarifying the intended objective behind the accreditation project and highlighting the importance of transparency as a prerequisite for the identification of areas for improvement in the center, the investigator managed to gain members' commitment. Afterwards, the self-assessment process was resumed with regular meetings to discuss, clarify and rate the standards. Based on the self-assessment results, areas of strength and areas for improvement was identified in the center and a quality improvement plan (QIP) was developed accordingly.

TOOL

Areas of strength and areas for improvement in the center were identified using the first version of the standards composed of a total of 25 standards enclosing the following themes (i) Building an Effective Primary Care Clinic (ii) Maintaining a Safe Primary Care Clinic (iii) Having the right People Together to Deliver Care (iv) Delivering and Coordinating Primary Health Care (v) Maintaining Accessible and Efficient Health Information Systems (vi) Monitoring Quality and Achieving Positive Outcomes.

Each of the standards has measures of quality elaborating on the standard that can be rated according to the following scale: N= Not in place (the requirement is not in place in the organization), D= In development (the requirement is not fully in place but the organization is in the process of developing activities, policies or process that will meet the requirement), I= In place (the requirement is fully implemented and understood by staff) and L= Leading practice (the requirement is in place and leads the field because it is creative and innovative; demonstrates efficiency in practice; is linked to the primary care standards; and is adaptable by other organizations).

PRODUCTS & RESULTS

Self assessment findings

Rating the 240 quality measures describing the 25 standards showed promising results (Table 1). Almost 48% of the 240 quality measures were "In Place", 34% were "Not

in place", 17% were "In development" and none was a "Leading practice" (Figure 1). It is worth mentioning that the majority of the met standards fell under the "Basic" and "Intermediate" categories, while the majority of the unmet standards were under the "Advanced" category according to *Accreditation Canada* classification of standards. Additionally, one quality measure related to malpractice insurance was not currently applicable to the Lebanese context.

Areas of strength

During the assessment, it was noted that the center (i) follows transparency in reporting to its funders and stakeholders (ii) clearly presents to the community the type, schedule and fees of services offered using an appropriate language (iii) has a good access to appropriate and timely diagnostic tests and has systematic process for informing clients and health care providers about critical tests results (iv) prepares and monitors its annual operating budget, according to recognized financial and legislative policies (v) carries out regular health education campaigns, using different health promoting models and interactive learning strategies (vi) provides education session for the staff to promote leadership, team work and cultural diversity (vii) has a systematic process for selecting medical equipments and has maintenance contracts with the equipments' suppliers (viii) confidentially stores medical files and has a clear process allowing patients to have access to their medical information.

Areas for improvement & the Quality Improvement Plan

Results for each theme of the standard (Table 1) highlighted "Monitoring quality and achieving positive outcomes" and "Having the right people work together" as priority areas for improvement in the center. A quality improvement plan (Table 2) was developed accordingly and included areas for improvement, related standards, critical actions to take, people to be involved, responsibilities and the goal behind each standard. The QIP adopted from *Accreditation Canada* framework highlighted crucial steps to drive improvement in the center practices in order to meet the accreditation standards.

RECOMMENDATIONS AND IMPLICATIONS

On the institutional level (The selected center)

To ensure optimal benefit from the upcoming accreditation system, the center ought to:

- Align the developed organization QIP with the center strategic plan and highlight quality improvement as a strategic priority.
- Develop departmental specific QIPs that are in line with the developed organization wide plan.
- Formalize the partnership with health care organization and providers (i.e. hospitals and specialists) to improve care coordination and enhance continuity of care.
- Promote better communication and collaboration between different providers in the center to enable team based approach while delivering care.
- Adopt and implement the MoPH standardised electronic health information system to replace the currently used fragmented system.
- Embrace a proactive approach while delivering care through focusing on outreach health promotion and disease prevention activities targeting the center catchment area.

On the National level (The MoPH)

Lebanon is considered a pioneer in developing and implementing hospital and PHC accreditation systems in the Middle East. Actually, Lebanon was the first in the region to adopt and implement a national hospital accreditation system in the year 2002[7]. Certainly, the PHC accreditation initiative is considered a major step towards proper rationing of health care services in Lebanon. Indeed, shifting from a reactive disease focused system to a proactive population based system has potential to promote healthier population and improve the Lebanese heath care system's efficiency, effectiveness and promote health equity on the national level. However, this is not an easy endeavor that requires good system's inputs and infrastructure. The following system level recommendations could help moving in the right direction.

Promote proper capacity building that leads towards a balanced human resources supply, an important input of any high performing health care system. In fact, General Practitioners in Lebanon are playing the role of Family Physicians. Developing proper system incentives for physician to specialise in family medicine could help in having more physicians choosing family medicine as a specialty. Further, it is recommended to integrate primary care concepts and training in medical and paramedical curricula. Within the same line, the centers in Lebanon need proper preparation and skills to board on the accreditation process. Through the investigator's experience in leading a self assessment taskforce at the selected center, it was remarked that the members didn't have sufficient proficiency to rate the standards and develop a QIP. Basically, integrating quality and accreditation concepts in the medical and paramedical curricula to equip future healthcare professional with fundamental improvement tools and skills is highly recommended. Meanwhile, it is recommended to deliver a more comprehensive and extended workshop where PHC centers representatives will have a better grasp of quality improvement tools for a smother embracement of the accreditation process.

Embed proper system's incentive for physician commitment to team based models for delivering primary care services in Lebanon. The current practices are based on a solo practice and often physicians work on part time basis in the PHC centers.

Develop standardized national PHC indicators that will constitute the measurement tool that enables performance reporting, benchmarking and ultimately driving improvement in the system.

Establish and implement a population based performance measurement and monitoring system that focuses on outcome and impact indicators within each center catchment area. Essentially, such a system has the potential to enhance transparency, commitment to quality and accountability for outcome in the primary health care system in Lebanon. This comprehensive monitoring system is recommended to build on the current system that focuses on structural indicators (i.e. Number of Human resources, Number of visits to the center, Number of vaccines delivered) through the centers' monthly report submitted to the MoPH.

Endorse a legislation that would grant the MoPH the authority for licensing dispensaries and health centers in Lebanon based on a predetermined criteria. The absence of such legislation can ease lenient regulations that do not ensure minimal safety standards in the system.

On a concluding note, working in a public sector in the unique Lebanese context is a considered a challenge in itself. The venture could be hindered by many factors that are politically rooted and tetchy. Nevertheless, the hassle of being over challenged is abolished by the potential national benefits implied by the work which are marvelously rewarding.

Table 1

Results for rating the 240 quality measures in the selected center

	Not applicable	Not in place	In development	In place	Leading practice	Total
Building an Effective Primary Care Clinic	0	8	12	28	0	**48**
Maintaining a Safe Primary Care Clinic	0	29	7	33	0	**70**
Having the right People Together to Deliver Care	1	10	7	9	0	**27**
Delivering and Coordinating Primary Health Care	0	18	8	29	0	**56**
Maintaining Accessible and Efficient Health Information Systems	0	2	4	16	0	**22**
Monitoring Quality and Achieving Positive Outcomes	0	14	2	1	0	**17**
Total	**(.5%)**	**81 (33%)**	**41 (17%)**	**116 (48%)**	**0 (0%)**	**240 (100%)**

Figure 1

Acknowledgement

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Table 2
Extracted example from the QIP for one of the priority areas for improvement in the selected center

Area for improvement	Critical Actions to Take	People Involved	Responsibility	Standard Related	Goal
Monitoring Quality and Achieving Positive Outcome	• Secure clinical staff access to computers and reliable evidence based health care sources (e.g. Cochrane Collaboration) • Develop training session and deliver frequent continuous education on the proper implementation and use of evidence based practices	Quality Improvement committee including: General Director, Family physician, Registered Nurse, Medical Lab technician	• Have access and to primary care best practice information and promote the use of chronic disease management guidelines and flow sheets to improve the quality of care provided in the center • Train the staff on how to properly use evidence based clinical guidelines and best care pathways	S.24 S.20 (20.6, 20.7)	Use best practice information to improve the quality of the service provided
	• Promote the culture of continuous improvement in the center • Assign a designated person responsible for Quality Improvement at the center (chairperson of the Quality Improvement Committee) • Identify process and outcome measures indicators at the center. Continuously measure and analyse the indicators and suggest recommendations for improvement shaped in annual quality improvement plan • Develop and review the QI Plan annually and flag unachieved goals for follow up	Quality Improvement committee including: General Director, Family physician, Registered Nurse, Medical Lab technician	• Develop educational sessions for the staff on Quality measurement and improvement concepts • Ensure and assign staff responsible for quality monitoring and improvement in the center who will chair the quality improvement committee • Promote commitment for quality improvement and accountability in the center	S25 (25.1, 25.2, 25..3, 25.5, 25.7, 25.10)	Have a process driving Quality Improvement at the center