INTRODUCTION TO QUALITY AND OVERVIEW OF NQAP

Dr.Sushant Agrawal
Consultant QI
NHSRC

AGENDA?

- WHAT IS QUALITY
  -The definitions

- PRINICIPLES OF QUALITY
  -The concepts, Models and Approaches of Quality Improvement.

- INTRODUCTION TO NATIONAL QA PROGRAM
  -Vision of Quality Healthcare for All

WHAT IS QUALITY
in your own words.

Quality Defined

Quality is Meeting and Surpassing the Customer Expectation

Who are our customers-
External
Patients
Target Population/Beneficiaries
Community
Internal –
Employees
Health departments

Perspectives of Quality

What Patients want ?

- **Availability of Services**
- **Accessibility of Services**
- **Affordable Care**
- **Prompt Services**
- **Courteous Behavior**
- **Privacy & Dignity**
- **Informed Treatment & Cure**

Perspectives of Quality

What Government/Health Administrators wants.

IMPROVED HEALTH OUTCOMES

OPTIMAL &RATIONAL UTLIZATION OF RESOURCES.

ALL COMPONENTS OF HEALTH PROGRAMS DELIVERED

COMPLIANCE TO STG & PROTOCOLS

Ministry of Health and Family Welfare

National Health Mission

Quality is the degree of adherence to predetermined standards

Quality is Minimizing variations

QUALITY IS STANDARDIZATION

Dr. Sushant Agrawal

QUALITY IS DOING RIGHT THINGS IN RIGHT WAY FIRST TIME & EVERYTIME

Dr. Sushant Agrawal

Quality is a Lousy Idea-

If it's Only an Idea

WHY QUALITY?

WHY QUALITY IN PUBLIC HEALTH?

WHY QUALITY NOW?

WHY QUALITY?

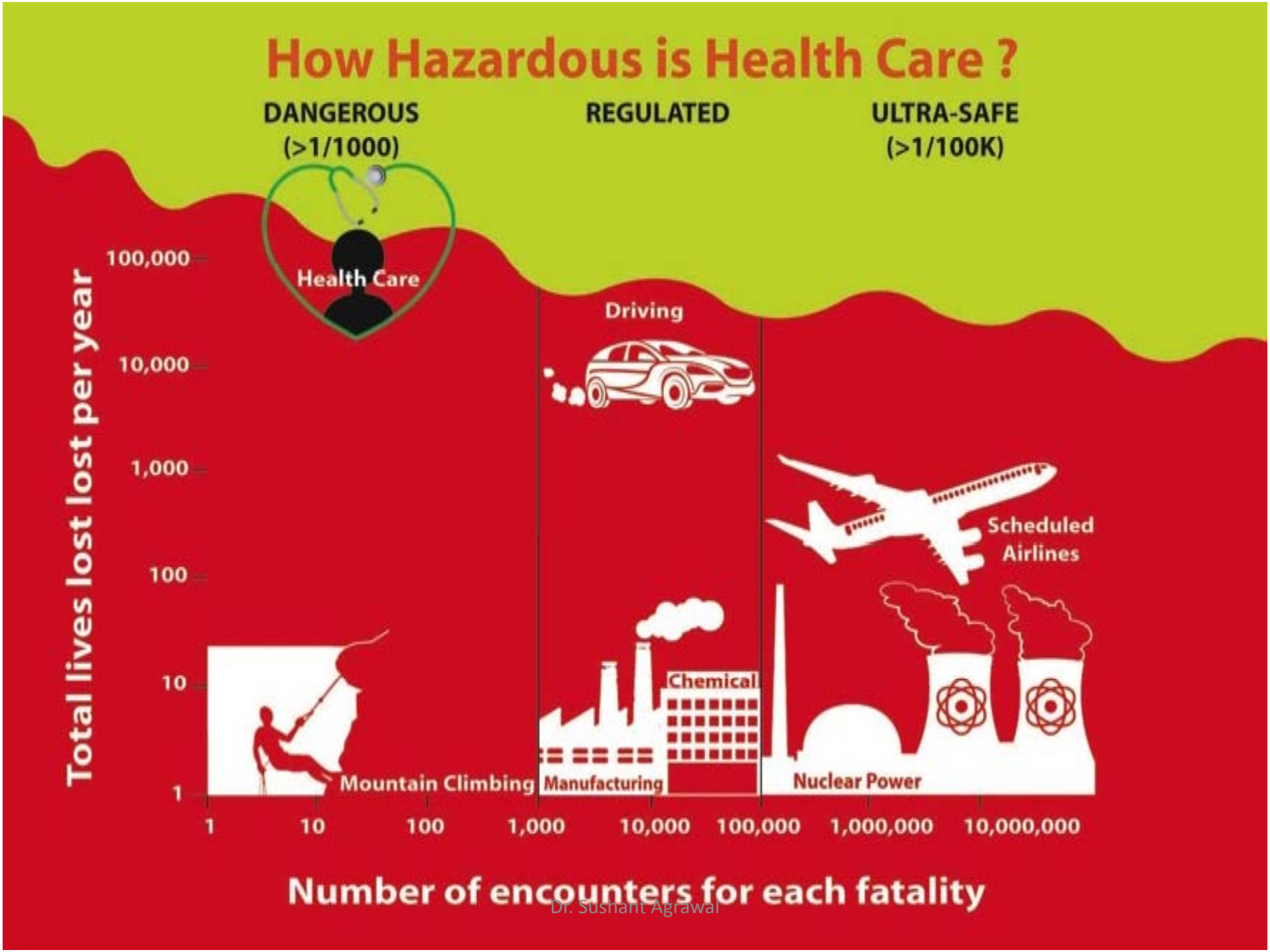
Because Safety is a major concern in Healthcare.

Simple Times: The Practice of Medicine

Earlier: Simple, less-effective but safe

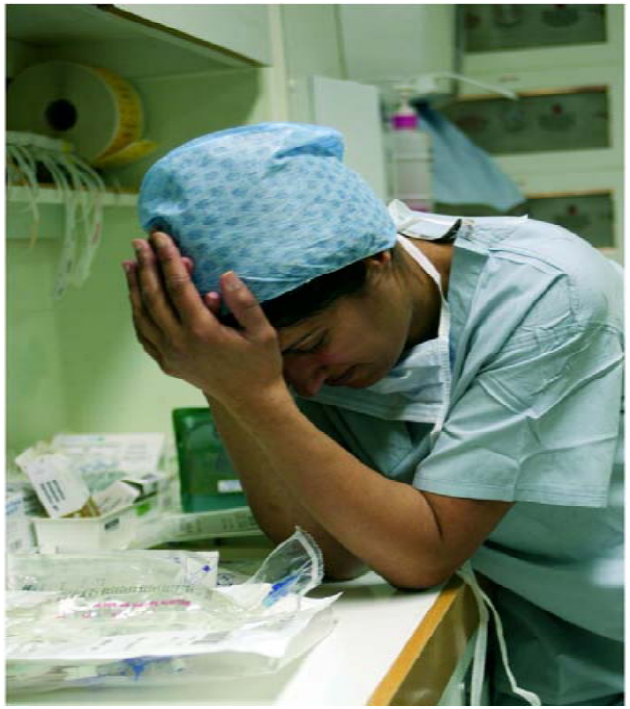
Today's healthcare is an organizational system with *complex* embedded processes to deliver care

Now: Complex, more Effective but Unsafe!



Simple mistakes, dangerous consequences

- Potentially deadly medication errors are so common that a typical 300-bed hospital experiences 40 every day, according to a new report.



We are not safety conscious

In Europe - Every 10th patient experiences preventable harm or adverse events in hospital, causing suffering and loss for the patient, their families and health care providers.

In INDIA ……..

Indian Scenario

- In India around 5.2 million injuries occur due to medical errors
- Resulting in around 3 million preventable deaths every year.
- This makes medical errors one of the major causes of death.
- For every 100 Hospitalization average 12.7 adverse event occurs.

(Ashsih Jha, BMJ Quality & Safety, Sept 2013)

As a patient what quality level would you accept from your healthcare provider?

- 50%
- 60%
- 70%
- 80%
- 90%
- 99.9%

IF 99.9% IS ACCEPTABLE TO YOU, THEN…

- YOUR HEART FAILS TO BEAT 32,000 TIMES EACH YEAR
- 500 SURGICAL OPERATIONS ARE PERFORMED

Because even 99.9% is not good enough!!!!

- BIRTH

DOCTOR BHAGWAN KA DOOSRA ROOP????

Caring and healing, up the slippery-slope of modern medicine

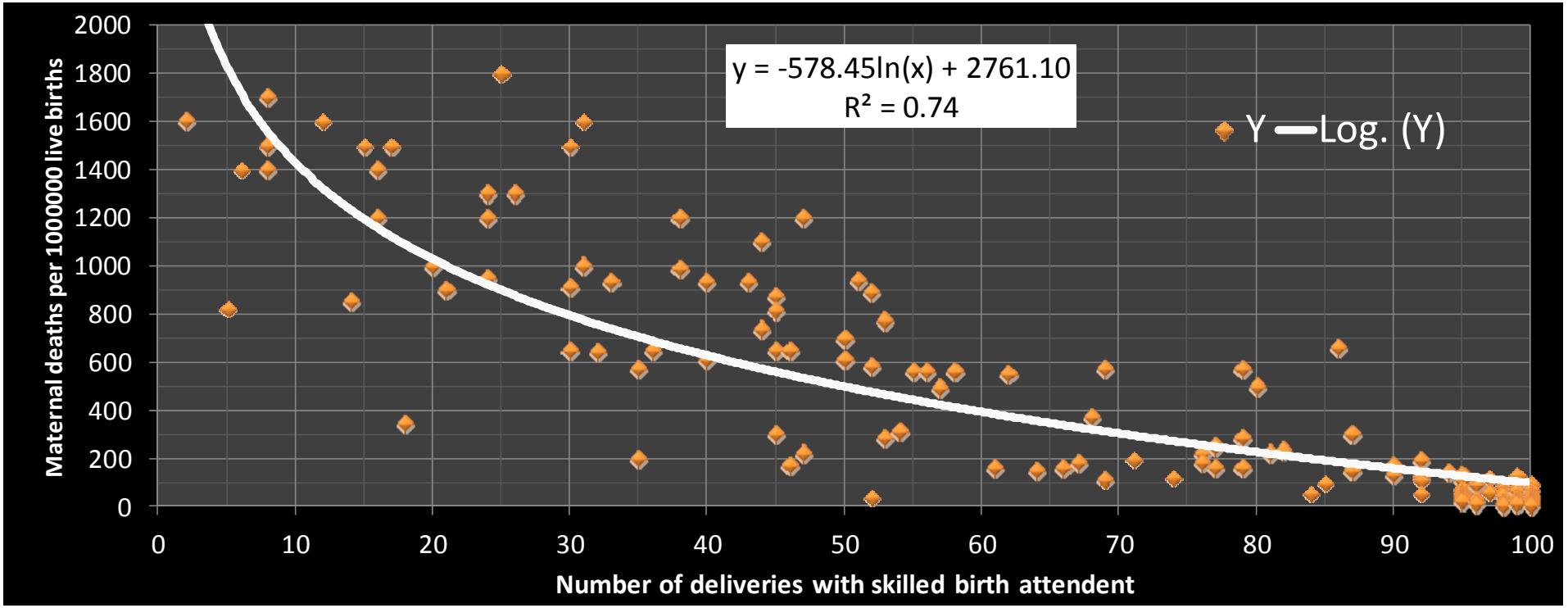
Because the sacred DOCTOR-PATIENT relationship is being challenged……

Dr. Sushant Agrawal

WHY QUALITY IN PUBLIC HEALTH?

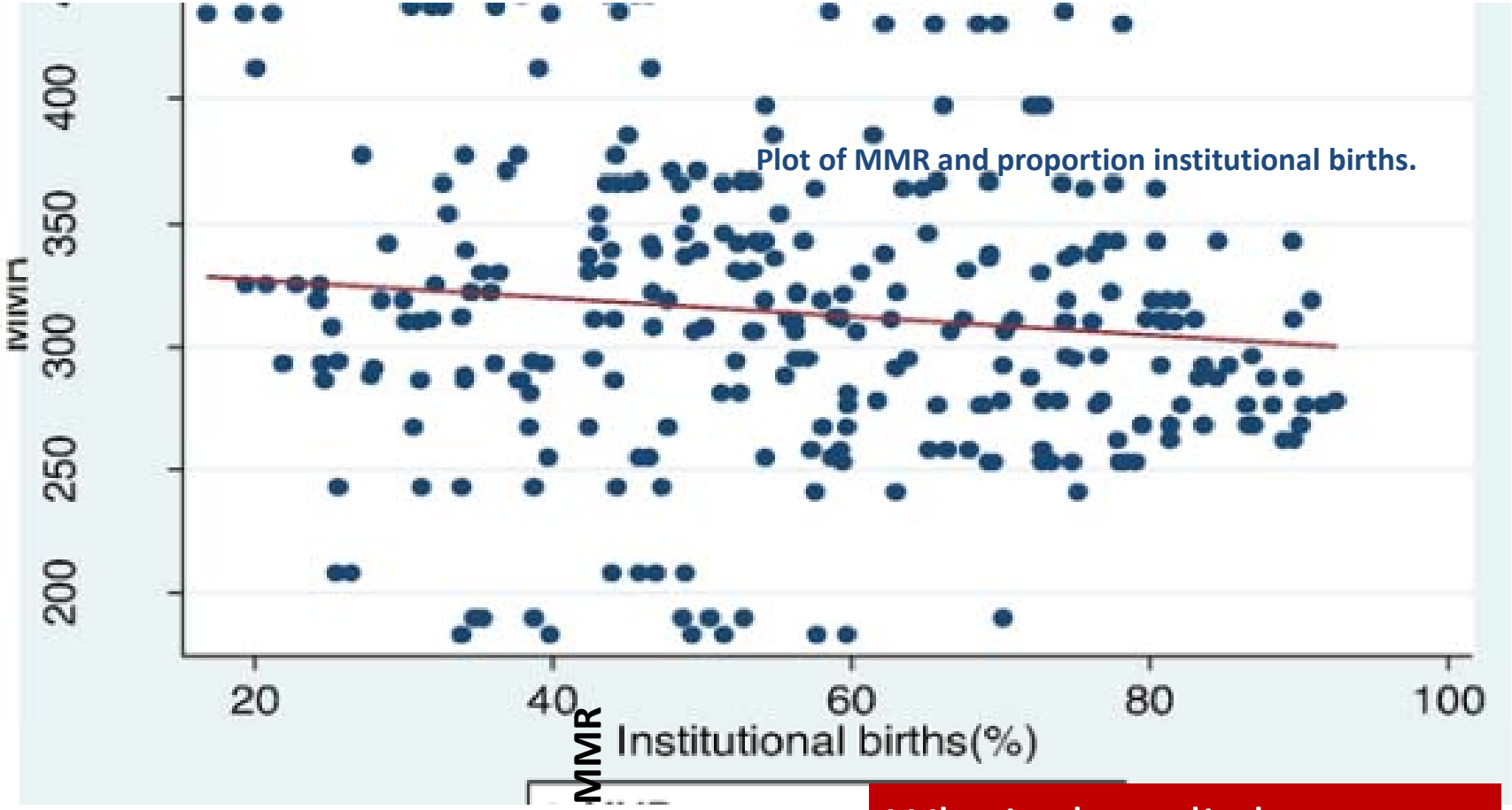
Because RESULTS don't match the NUMBERS.

ROLE OF ACCESS IN REDUCING MMR:
What does the global evidence tell us?



Higher proportion of deliveries attended by skilled attendant → Lower maternal mortality ratio

India: Outcome of increased institutional deliveries



Randive B, Diwan V, De Costa A (2013) India's Conditional Cash Transfer Programme (the JSY) to Promote Institutional Birth: Is There an Association between Institutional Birth Proportion and Maternal Mortality?. PLoS ONE 8(6): e67452. doi:10.1371/journal.pone.0067452 http://www.plosone.org/article/info:doi/10.1371/journal.pone.0067452

Dr. Sushant Agrawa

Why is there little association between institutional delivery and MMR in India???

Because POOR QUALITY ruins image of Public Health System.

More infant deaths taint for Malda hospital: 24 die in 6 days

Sagarnil Mukherjee
letters@hindustantimes.com

MALDA: With the death of five infants at Malda Medical College and Hospital (MMCH), it appears the scourge of infant deaths has returned to haunt the hospital, where close to 80 such deaths have occurred since 2011.

As many as 24 infants have died at the facility in the last six days and the condition of several others is said to be critical.

An official of the hospital, on the condition of anonymity, said that there are 30 beds in the neo-natal ward, 22 in the Special Newborn Care Unit and 46 beds in the children ward. But at present, 156 babies are admitted in the children ward alone. The deaths in the past 24 hours have been attributed to "several ailments".

Afroza Bibi, a resident of Malda-Kaliachak, said, "I brought my 22-day-old son here with the hope that he would receive good treatment. He was suffering from breathlessness and high fever. But a doctor visited him only twice. My baby died here without any treatment yesterday night."

DEATH TRAPS

April, 2012: 13 deaths at Malda Medical Hospital in the space of 72 hours

January, 2012: 18 infants died in Malda District Hospital

November 10, 2011: 6 infants died in Malda District Hospital

October 28, 2011: 12 infants died in Burdwan Hospital

October 26, 2011: 11 infants died in BC Roy Hospital, Kolkata

June 2011: 18 infants died at BC Roy Hospital, Kolkata

Nov 2006: 14 babies died at BC Roy Hospital, Kolkata

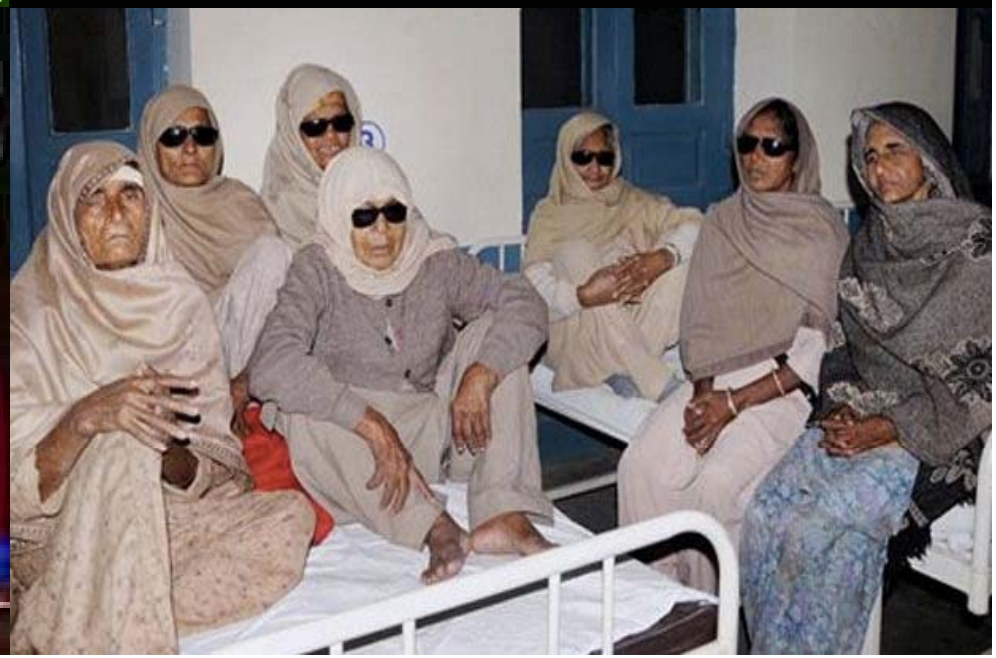
Aug 2002: 22 infants died BC Roy Hospital, Kolkata

A senior doctor of the hospital said that after the Malda district hospital was upgraded as the MMCH, the patient rush has increased. Patients from neighbouring states and districts were coming to the hospital for treatment.

Principal MMCH Uchhal Bhadra said, "So many babies were referred to this hospital in a critical state and doctors could do little to save them. Besides, child mortality is high in all hospitals during winters. The figure of deaths appears high because the admissions exceed our bed capacity." She didn't, however, divulge the number of infant deaths.

Badra said most of the dead infants were under weight (below 2.5kg) and some of them couldn't "fight the chill".

She said the high number of admissions was spreading infection among the infants fast, forcing the administration to restrict movement of people and canceling leaves of all doctors.



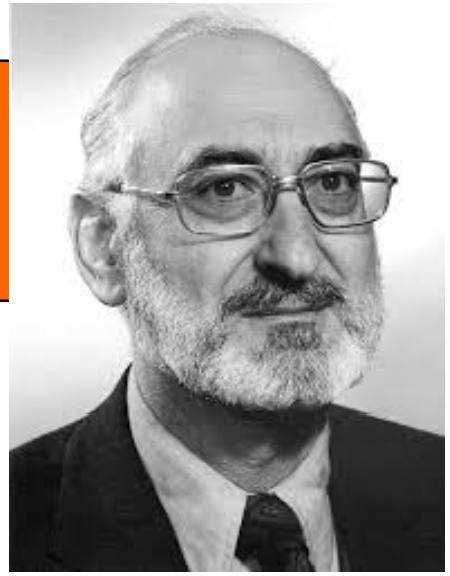
WHY NOW?

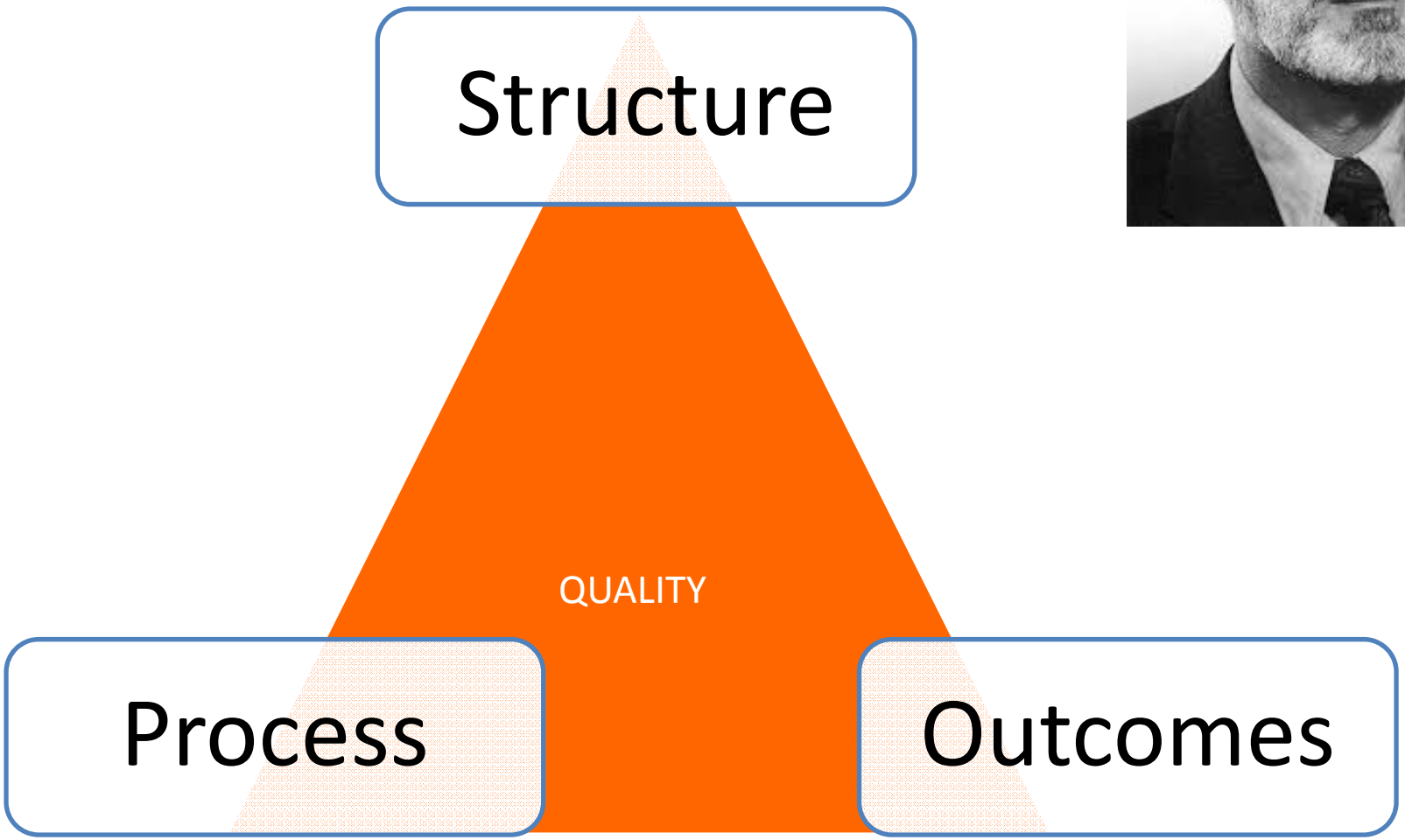
BECAUSE QUALITY IS NOW FOREMOST PRIORITY OF GOVERNMENT


National Convention
on
Dr. Jagdish Prasad
Dr. Harsh Vardhan
Lov Verma
C.K. Mishra
कायाकल्प विजेताओं 2016–17
का राष्ट्रीय सम्मान
श्री जे पी नड्डा
द्वारा
National Felicitation of
Kayakalp Awardees 2016-17
by
Shri J.P. Nadda
Wednesday, 15 February 2017
Rejuvenating Public Healthcare Facilities
कायाकल्प

Dimensions of Quality

Dr Avedis Donabedian (1919-2000)





Focus shifting from Structure to Processes.

APPROACHES TO QUALITY

QUALITY CONTROL	QUALITY ASSURANCE	QUALITY IMPROVEMENT	CERTIFICATION ACCREDITATION
• Quality Control is the "detection of defects", (also referred to as Verification and Validation)	• *Quality Assurance* is the "prevention of defects", such as the deployment of a Quality Management System and preventive activities.	• Quality Improvement is a part of Quality Management, focussed on increasing the ability to fulfil quality requirements	• a formal process by which a recognized body, assesses and recognizes that a health care organization meets applicable pre-determined and published standards.

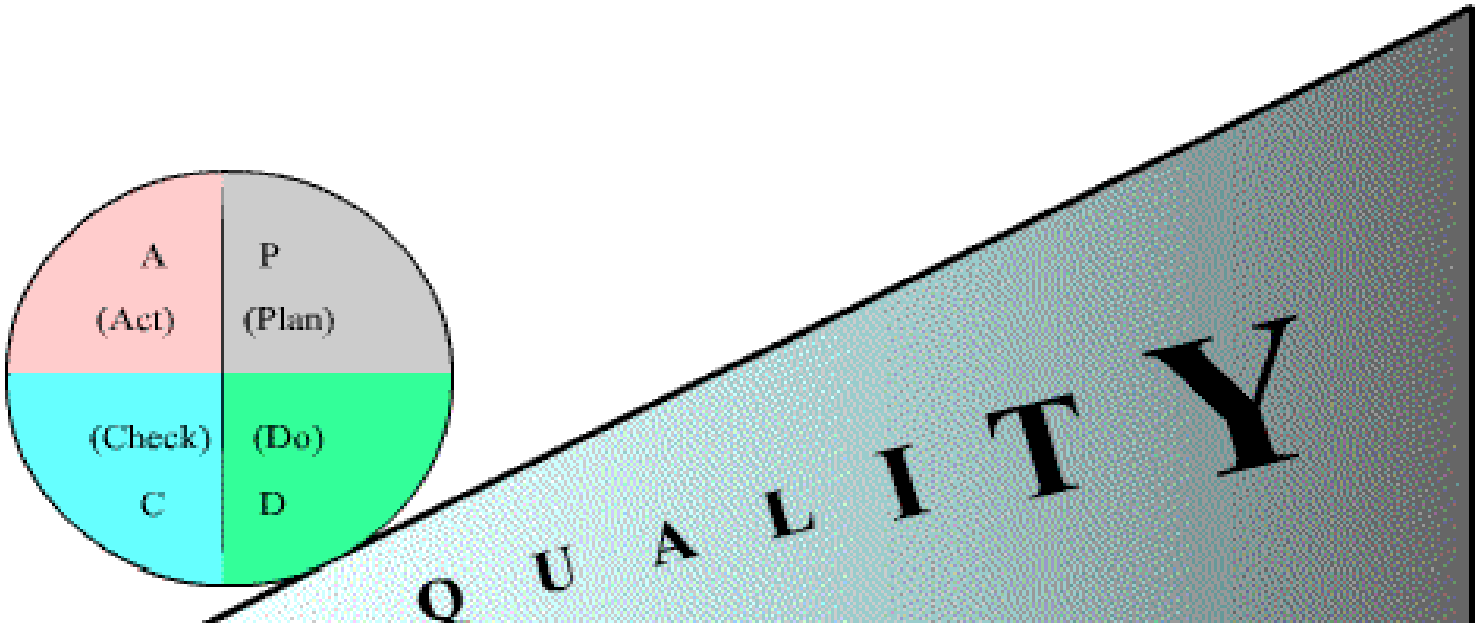
Model for Quality Improvement

PLAN A CHANGE
FORMLATE A PLAN FOR IMPROVEMENT-
SET GOLAS, TARGETS & METHODS FOR IMPROVEMENT

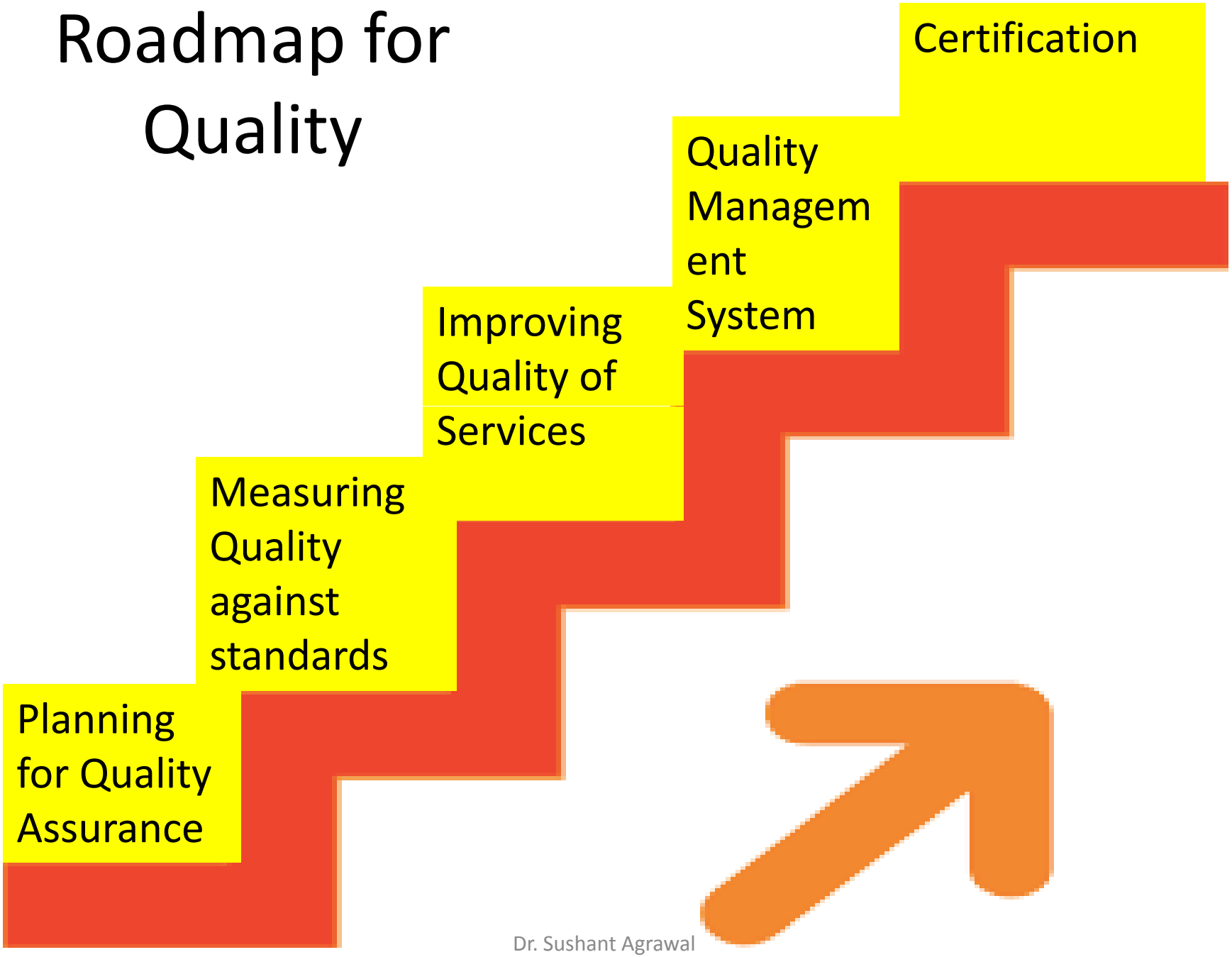
DO
IMPLIMENT THE PLAN
EDUCATE/TRAIN

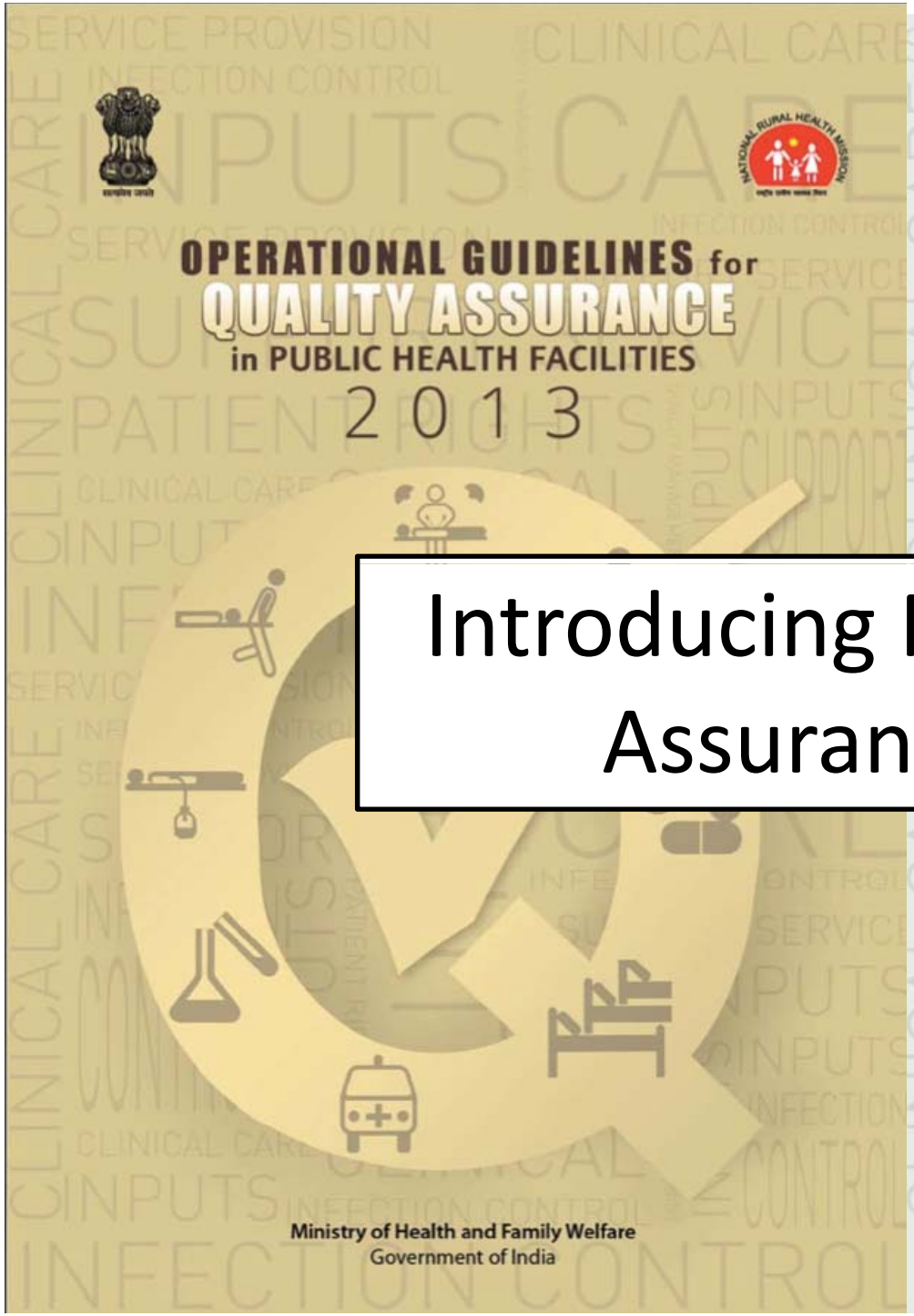
CHECK
EVALUATE RESULTS
MODIFICATIONS NEEDED

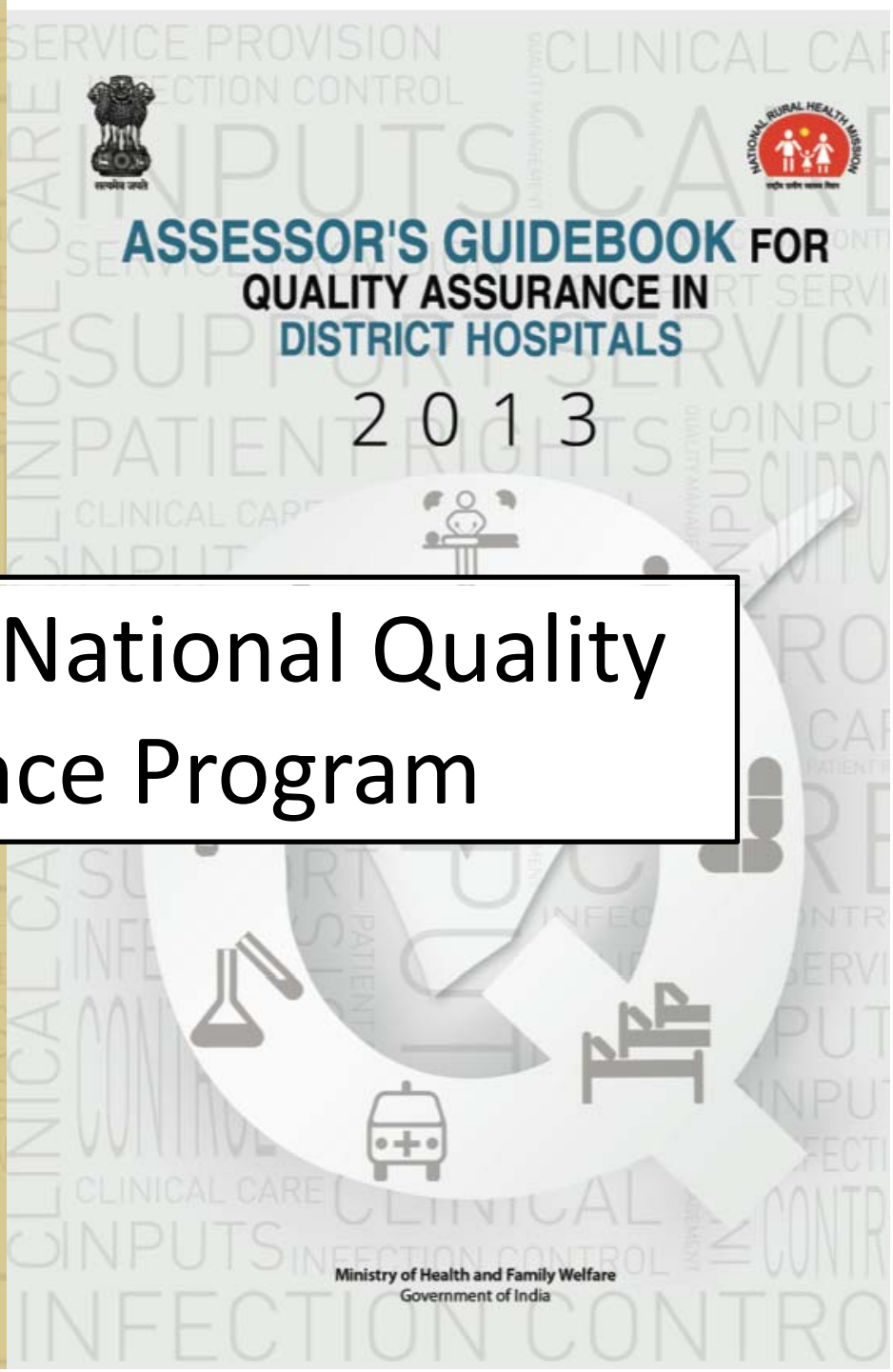
ACT
IMPLIMENT PLANNED CHANGES
NOT SUCCESSFUL, REWORK CYCLE



Roadmap for Quality







Introducing National Quality Assurance Program

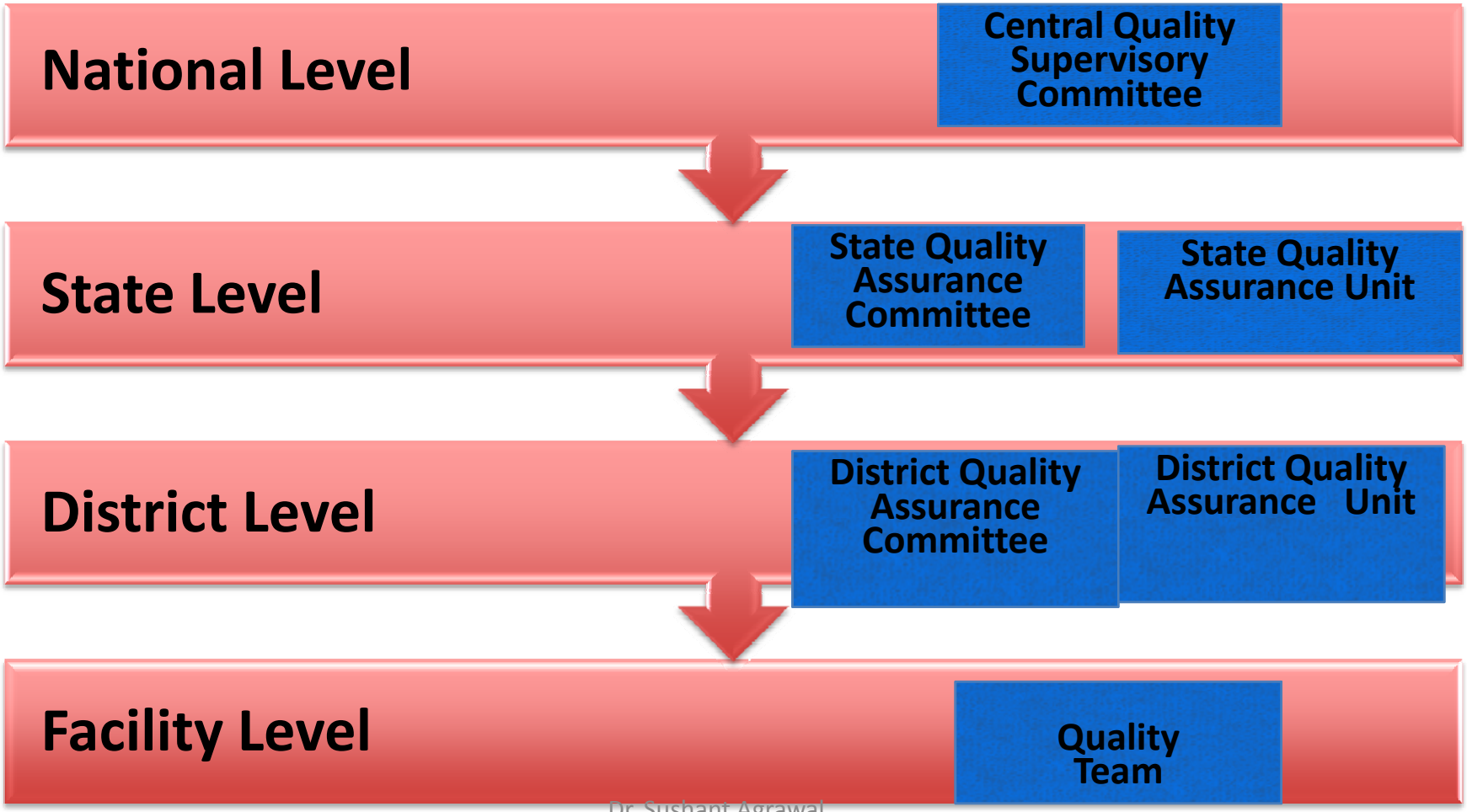
Brief History of Quality Assurance in NHM

2005	NRHM Launched Supreme court judgment leading to QAC for Family Planning
2007	Indian Public Health Standard were launched for District Hospital, Sub District Hospitals, PHC, CHC and Sub centers
2008	Taken 8 District Hospitals in EAG state for implementing Quality Management System
2011	Spread of certification program ISO-NABH
2012	74 Facilities get ISO Certification , 15 NABH Review of Currently going accreditation process
2013	Consultation for National Quality Assurance Standards started. Operational Guidelines launched
2014	Guidelines for PHC & CHCs, National Quality Convention Priority area for NHM

Key Features of QA Programme

1. Unified Org. Framework
2. Quality Assurance Standards
3. Continuous Assessment and scoring
4. Key Performance Indicators
5. Training & Capacity Building
6. Inbuilt Quality Improvement Model
7. Certification at State & National Level
8. Incentives & Sustenance

Quality Assurance Institutional Structure



Aligning Organizational Structure

- **All existing QA cells including Family Planning merged to proposed structure**
- **Notification for Constitution/Restructuring Committees**
- **Appointment of Nodal Person**
- **Recruitment of fulltime technical staff**

State Family Planning Indemnity Subcommittee

- Mission Director –NRHM (Chairperson).
- Director Family Welfare/Director Health Services/Director Public Health Equivalent (Convener).
- Additional/Joint Director (FW)/Deputy Director (FW)/Equivalent (Member Secretary).
- Empanelled Gynaecologist (from public institutions).
- Empanelled Surgeon (from public institutions).

SQAU Composition

- SQAU is the working arm under SQAC
- **Composition:**
  - ❖ Additional/ Joint Director (FW)/Deputy Director (FW) / Equivalent, designated by the state government as the nodal officer for the Quality Assurance (QA) Unit (Member Secretary - SQAC).
  - ❖ State Nodal Officers of Programme Divisions;
  - ❖ State Consultant (Quality Assurance)
  - ❖ State Consultant(Public health)
  - ❖ State Consultant (Quality Monitoring)
  - ❖ Administrative-cum-Programme Assistant

Functions of DQAC

1. **Dissemination of QA policy and guidelines:**
2. **Ensuring Standards for Quality of Care**
3. **Review, report and process compensation claims**
4. **Capacity building of DQAU and DQT**
5. **Monitoring QA efforts in the district**
6. **Periodic Review of the progress of QA activities**
7. **Supporting QI Process**
8. **Co-ordination with State & Reporting**

District Family Planning Indemnity Subcommittee

- District Collector, (Chairperson)
- Chief Medical Officer/District Health Officer (convener)
- District Family Welfare Officer/RCHO/ ACMO/ equivalent (member secretary)
- Empanelled gynaecologist (from public institutions)
- Empanelled surgeon(from public institutions)

Composition of DQAU

Composition:

- District Family Welfare Officer/RCHO/ ACMO/ equivalent (Head of DQAU)
- One Clinician (Surgical/ Medical/ any other speciality)
- District Consultant (Quality Assurance)
- District Consultant (Public Health)
- District Consultant (Quality Monitoring)
- Administrative cum Programme Assistant

Quality Team (District Hospital)

- I/C Hospital/Medical Superintendent: Chairperson
- I/C Operation Theatre/Anaesthesia I/C, Surgeon
- I/C Obstetrics and Gynaecology
- I/C Lab services (Microbiologist/ Pathologist) : for enforcing IMEP & BMW protocols
- I/C Nursing
- I/C Ancillary Services
- I/C Transport
- I/C Stores
- I/C Records
- Hospital Manager

2

Explicit Measurement System

Implicit Vs. Explicit Measurement System

Implicit

- Easy to design
- Require more vigorous training
- Requires highly qualified assessors (Domain Expert)
- Scalability is limited
- More subjective
- Needs interpretations
- Less in Volume
- Reference to other guidelines

Explicit

- Hard to design
- Requires less vigorous training
- Do not require domain experts
- Easy to scale up
- More Objective
- Self explanatory
- Voluminous
- Reference is limited

National Quality Assurance Standards
(Areas of Concern)

Service Provision

Patient Rights

Inputs

Support Services

Clinical Care

Infection Control

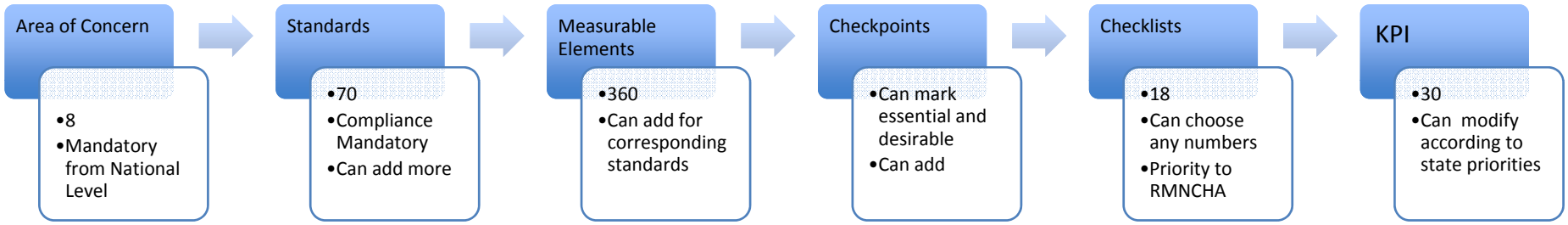
Quality Management

Outcome

3

Flexibility of adopting as per state's need

Customization as per State need



- Essential and and Desirable Components can be marked
- Prioritization of Areas for first phase
- Dissemination of final Quality Policy, Standards, and Checklists

4

Training & Capacity Building

Training & Capacity Building

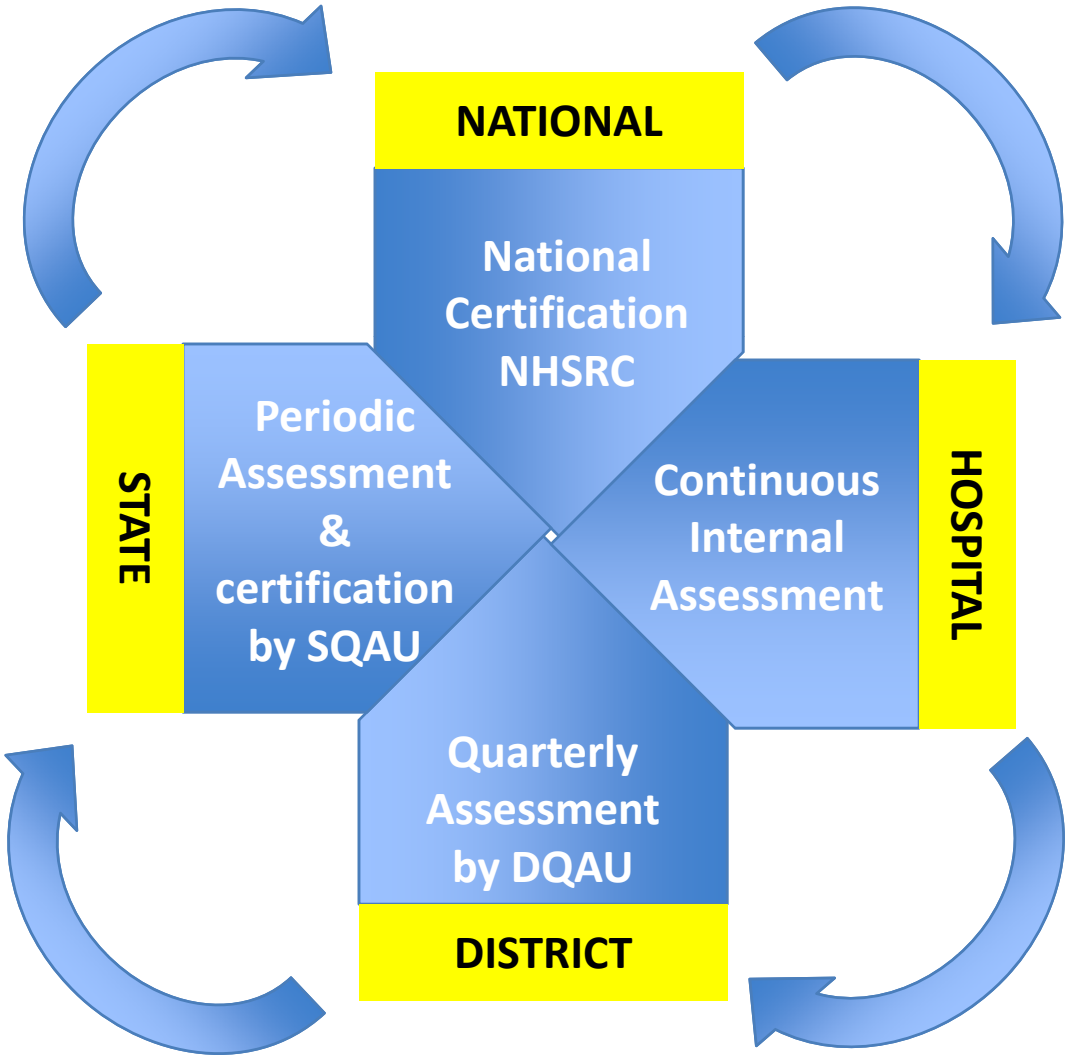
Training	Duration	Level	Participants	Scope
Awareness Workshop	1 day	State	SQAC, State level program officers, RPM units, Civil Surgeons/ CDMOs	To sensitize state level officials for quality assurance program and its steps
Internal Assessor Training	2 Day	State / Regional Level	SQAC/DQAC/DQT members	standards , measurable element, Internal assessment Methodology Filling up checklists and calculating scores Preparing action Plans
Service Provider training (For Implementation)	3 Day	Regional/ District Level	MS, Hospital Managers, Matrons, department I/C, DPM , other service providers	Basic concepts of quality Introduction to standards and measurement system Standard operating procedures Patient satisfaction programs , quality improvement tools
Ext. Assessor Training	5 Day	National/ State	Impaneled external national/state assessors	Detailed training on standards , measurable elements, assessment methodology, audit trail, code of conduct, filling formats and reporting

5

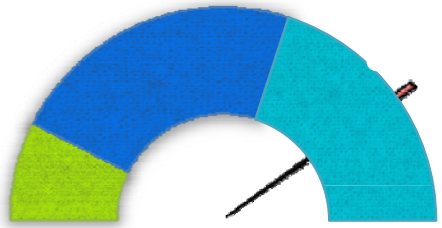
Assessment scoring & Performances Measurement

Dr. Sushant Agrawal

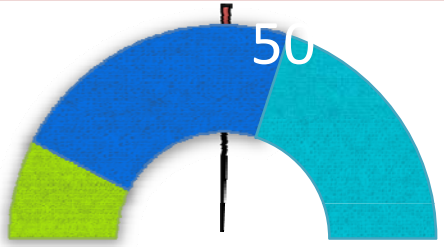
Continual Quality Improvement



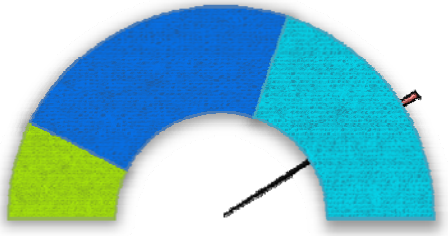
Key Performance Indicators



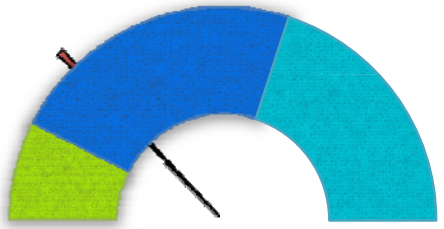
PRODUCTIVITY



EFFICIENCY



CLINICAL CARE/ SAFETY



SERVICE QUALITY

Reporting of Key Performance Indicators

Productivity

- Bed Occupancy Rate
- Lab Utilization Index
- Percentage of High Risk Pregnancy/ Obstetric Complications
- Percentage of Surgeries done at Night
- C- Section Rate

Efficiency

- Referral Rate
- Major Surgeries per Surgeon
- OPD per Doctor
- External Quality Assurance Score for Lab test
- Stock out percent of supplies for RMNCHA

Clinical Quality

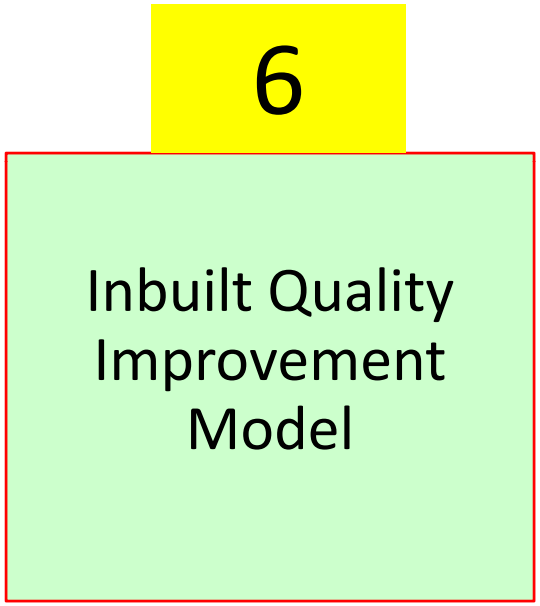
Maternal Death Rate
Neonatal Death Rate
Percentage Maternal Death Review done
Average Length of Stay
Surgical Site Infection Rate
SNCU Mortality Rate
No. of Sterilization Failures
No. of Sterilization Complications
No. of Sterilization Deaths
Blood unit replacement Rate
Partograph Recording Rate
Antibiotic use rate

Service Quality

LAMA Rate
Patient Satisfaction Score (IPD)
Patient Satisfaction Score (IPD)
Registration to Drug time
Percentage of JSY payment done before discharge
Percentage of women provided drop back after delivery

- .

Facility Level Quality Improvement

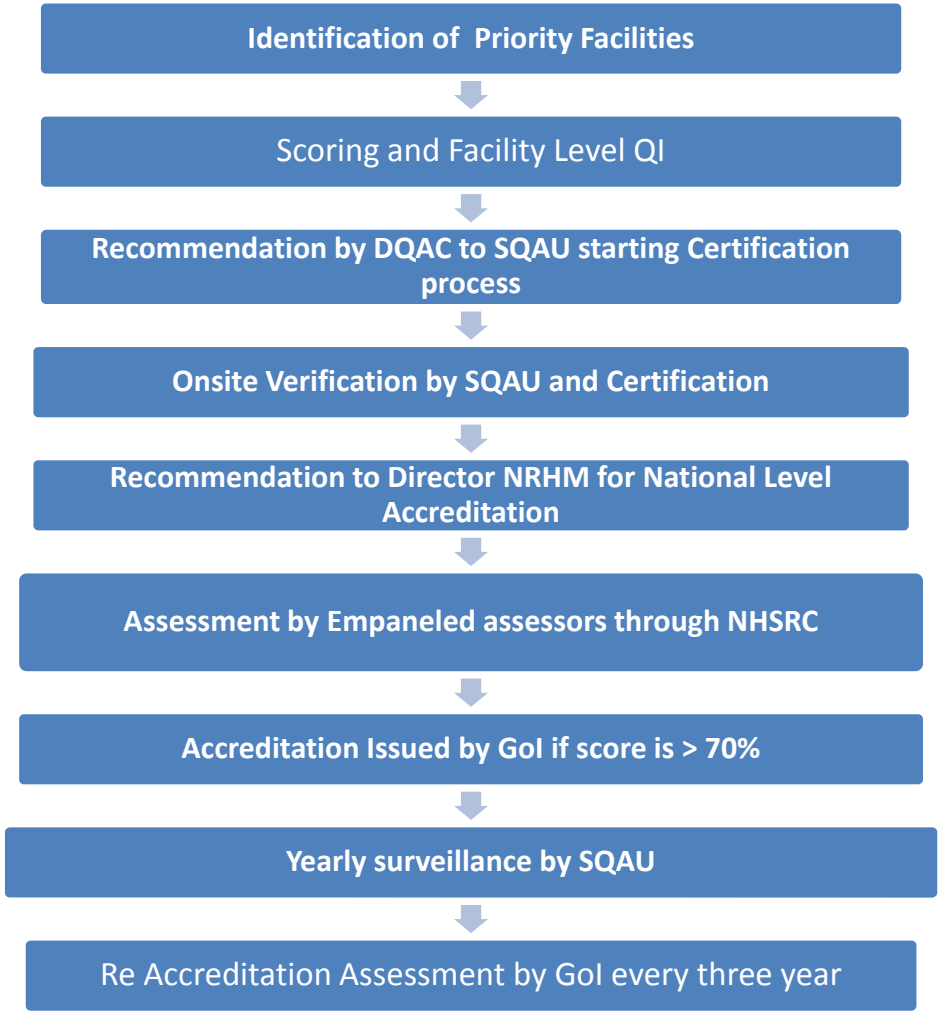


Facility Level Quality Improvement

7

Certification at State & National Level

Certification/Accreditation Process



Issue of Certificate & Incentives

Submission of Assessment Report

Recommendation for Certification

Assessment by external Assessor

Processing of Application and appointment of assessors

Application to Director, NHM, MoHFW, GoI

Internal Assessment and Quality Improvement

Recommendation for Certification

State Level Assessment & Certification

8

Incentives on Achievement & Sustenance

Incentives

Financial

- Rs. 5000 per Functional bed on National Accreditation
- 25% for Individual Incentives
  75% for Staff welfare and Improving Work environment
- Annual Incentives of Same Amount for maintaining the accreditation

Non Financial

- Facilitation at State Level
- Publication of Achievement in Media
- CMEs, Trainings , Short Courses for Staff
  Weightage during Appraisal

NHSRC Support

- Planning and PIP Formulation
- Customization of Checklists as per State Need
- Support in Base line Assessment of Selected Facilities
- Training of assessors and service providers
- Support for implementing monitoring system in place
- Handholding for Certification of Selected Facilities

The question is not , if India can afford to do it…

The question is can India afford not to do it…

Thanks