

Quality Surveillance Manual

Manual and instructions for quality accreditation and
surveillance at the polyclinics of Caja Nacional de
Salud in La Paz, Bolivia

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CONCEPTUAL FRAMEWORK

Quality health care is a multi-dimensional and multi-faceted concept, based on scientific principles, however, it interacts with value judgments, beliefs and perspectives concerning good or bad quality health care. This lack of uniformity as regards the explanations and visions, explains the existing great number of definitions of quality concepts as well as the different approaches proposed to measure quality.

Therefore, quality measurement constitutes a polemic multi-directional process as well as an action-oriented perspective that is directly linked to the methodology and approach that could be used to evaluate different services.

It could generally be said that two schools have grouped the existing different approaches to measure quality. On one hand the approach developed taking health sciences as a basis, and on the other hand the approach developed from a managerial standpoint or based on management sciences. Each one succeeded in establishing methodologies and techniques that are used in a similar manner in health services.

THE HEALTH SCIENCES APPROACH

In the nineteenth century, Florence Nightingale, launched a process of reforms aimed at improving the quality of health care at the hospital level. These measures included: cleaning, basic sanitation, improving the quality of the food as well as the appropriate handling thereof, and the establishment of strict disciplinary regulations and the organization of hospital routine. This simple approach, constituted a true revolution at the time which led to a drastic drop in the mortality rate in different hospitals.

Years later, the United States was the first country that institutionalized its interest in improving the quality of health care. In 1917 the American College of Surgeons institutionalized the first set of national quality standards and in 1951 the “Joint Commission” for hospital accreditation was founded.

A more analytical quality concept was developed later in a series of documents and proposals by Sheps (1955); Donabedian (1966); Dror (1968) and De Geyndt (1970). It could be said that conceptual development was very intense during the fifties and sixties, while during the seventies and eighties concrete quality approaches were put into practice. Avedis Donabedian can be mentioned among the authors that clearly led this practical approach to measure the quality of health services.

Donabedian developed a conceptual proposal based on three elements: Structure, Process and Result. Each of these elements formed part of a core organizer of indicators, practical evaluation guides and measurement and performance standards.

“Structure”, is defined as concrete and quantifiable inputs used in buildings, equipment, medications, medical supplies, vehicles, personnel, money and organizational systems. All of them necessary, but not sufficient to provide adequate quality care. It encompasses concrete, measurable and often visible attributes.

“Process” is defined as everything that is actually done to provide adequate services to the patient. The care process could be considered a key element of quality assurance. Assuming that there are minimum adequate conditions, medications, equipment and inputs, it is highly likely that an adequate care “Process” will produce satisfactory Results.

“Result” is defined as an adequate culmination of the patient care process, using the required time and inputs. Results are usually measured based on mortality and morbidity indicators and the functional ability or disability produced by the different diseases. However, favorable indicators could be affected by factors that are not directly controlled by health professionals and workers. Cultural factors, the availability of homes equipped with basic sanitation facilities and running water, a balanced diet, environmental, genetic and other factors, constitute external conditions that are directly related to adequate results and an optimal quality of life and health. Therefore, the success of an adequate care process is not clearly or unequivocally related to the actions of health professionals and workers.

These constitute the reasons why in order to ensure an adequate measurement of the care process it is considered more effective to continuously improve the provision of health care services and guarantee the availability of critical inputs.

Donabedian is careful in his definition of the three previously described elements not as “attributes” of an adequate quality of care but rather as approaches that allow for the acquisition of information regarding the presence of attributes that constitute or define quality.

The approach that Donabedian made popular, was nurtured by other authors, who include a clear distinction between what could be considered “technical quality” and “human quality within the

“Technical quality” is construed as health care provided by health personnel, based on adequate knowledge and fair judgment used to identify strategies and diagnosis and implement them. Generally “technical quality” is directly measurable, such as for example, the efficiency or effectiveness of a specific technology, the effectiveness of a medication, the specificity of a laboratory test, or the precision of a surgical procedure. Some other aspects of technical quality are measured with greater difficulty or indirectly, such as the use of a surgical procedure instead of

another medical procedure, or certain cardiovascular conditions evaluated at different altitudes above sea level.

However, there are serious measurement problems when it comes to evaluating “human quality”. It is more difficult to measure personal empathy, confidence, the sense of security inspired by the physician throughout his interaction with the patient, than other more clearly visible actions. Therefore, human quality could be defined as the interpersonal, two-way relationship that exists between the patient and the health professional or worker, which is in turn the vehicle that allows the efficient implementation of technical quality, but which is more difficult to identify and evaluate.

THE ACCREDITATION OF HEALTH SERVICES AS WELL AS THE PRACTICAL APPROACH TO HEALTH.

Based on the first standards created by the American College of Surgeons, for its “minimum standardization” program in 1917, a “national hospital standardization program” was developed. In 1951 a non-profit organization, denominated “Joint Commission for the Accreditation of Hospitals”, was founded with the aim of developing an institutional systematization that would provide quality standards for hospitals. The expansion of its voluntary “accreditation” of hospital support services, mental health, home care, nursing and outpatient care, led to a change of name to the current “Joint Commission for the Accreditation of Health Care”. Under this modality, standards and indicators were developed to measure the quality of the services provided within the health care process.

Accreditation became one of the pillars for the evaluation of services and it sought to “ensure” the basic conditions required to provide adequate quality care through different operational methodologies.

THE ADMINISTRATION'S APPROACH: QUALITY MANAGEMENT OR CONTINUOUS HEALTH CARE QUALITY IMPROVEMENT.

Used as synonyms, total quality management or continuous quality improvement, is probably the most important process developed in the past few years to evaluate and produce quality care. It emerges as a process aimed originally at the productive sector and it is later applied to the service sector. Since W.E. Deming and J. Juran, and the continuous quality improvement process (CQI) after the war, Japan became fascinated by the proposal to apply Deming's ideas and his “fourteen points” to the industrial sector, and it began using them to transform the Japanese industry. After almost 30 years Total Quality returns to its original birthplace in the United States and in the eighties its application to industrial firms begins. By the end of the decade, the health sector begins to apply it.

Deming's approach to quality seeks to “anticipate, become familiar and meet the clients' needs and expectations”. It involves four main processes:

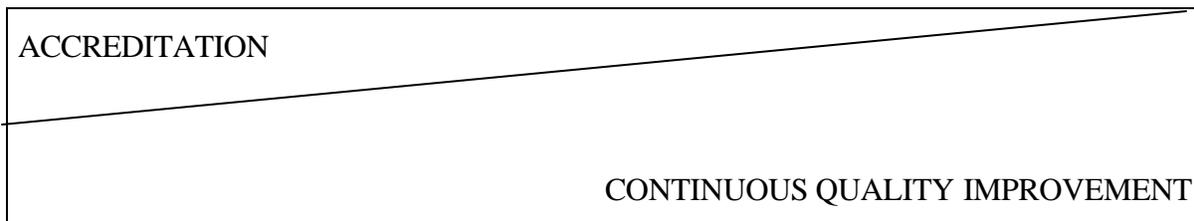
- a) Transform organizational culture from a product-oriented philosophy, to one that is wholly focused on client satisfaction.
- b) Empower employees at all levels, to improve the organizational process.
- c) Integrate administrative support systems and methodology to motivate and reward employees based on quality and productivity.
- d) Engage high and mid level managers in this cultural transformation, decentralization of the decision making process, empowerment of employees and systems to improve organizational change.

The first experiment at the national level that applied continuous quality improvement to the health sector was carried out in Boston in 1987, (Berwick). Under this study which comprised a large number of hospitals, HMOs, independent professionals and others, it was concluded that continuous quality improvement has to do mainly with improving the efficiency and therefore the costs. It was thus established, that continuous quality improvement constitutes one of the main tools for competitiveness.

With regard to the working areas described by Donabedian, continuous quality improvement emphasizes the analysis of processes: diagnostic strategies, medical treatments, waiting times and others. The main objective of continuous quality improvement is to achieve user satisfaction, through the adequate quality of technical and human processes.

DIFFERENCES BETWEEN QUALITY ASSURANCE (ACCREDITATION) AND CONTINUOUS QUALITY IMPROVEMENT.

The differences between these two concepts have led many authors to refer to accreditation and continuous quality improvement, as the two faces of the same coin. Both processes support each other. The following graph explains the features and the existing relationship between them. As a matter of fact, to initiate a transformation process at the health services level, it is recommendable to begin the same with accreditation. Once the problems are identified it is more feasible to solve them through the continuous quality improvement process.



It is, therefore, ideal to begin an accreditation process simultaneously with a continuous quality improvement process, since both nurture on the efforts of the other, but, at the same time, the synergy generated by them, enhances the “conviction” that their common objective is quality and

On the other hand, even when the approaches are complementary between each other and can become part of an arsenal of health care instruments to improve the quality of the services, with the aim of better identifying their differences, the following table is included to present the various existing options for both perspectives.

Differences between quality assurance and continuous quality improvement.

	Quality assurance	Continuous quality improvement
Legitimacy	Legal mandate. Professional Authority	Collective responsibility Client satisfaction Staff empowerment
Motivation	A useful tool Accreditation Regulator as consumer	A way of thinking, a philosophy that fosters competition and excellence.
Source of error	The employee	Processes, systems.
Attitude	Reserved, defensive, external pose.	Proactive, aimed at providing internal orientation.
Expectations	Elaborate standards Inspect and repair	Know the performance expectations. Prevent
Approach	“bad apples” clinical results	Common and special causes Processes
Action spectrum	Selected professional specialty departments.	Total organization. All work-oriented processes

Source: Modified from Leebov and Ersov.

Within the “continuous quality improvement” process that was initiated in the policlinics of Caja Nacional de Salud through a cooperative agreement between the National Sexual and Reproductive Health Program of CNS and the Family Planning Management Development Project from MSH, both approaches were understood, emphasizing that a Surveillance Manual had been designed, based on the quality assurance perspective, but strongly client-oriented, and simultaneously an active continuous quality improvement process was launched, based on accreditation, which detected the initial flaws as well as the first challenges for the quality improvement teams at the Policlinics.

QUALITY SURVEILLANCE GUIDE FOR THE POLICLINICS OF CAJA NACIONAL DE SALUD IN BOLIVIA

BACKGROUND

It was based on a process launched by the directors and staff of Caja Nacional de Salud (CNS) and specifically the Sexual and Reproductive Health Program (PSR), motivated by the need to begin a quality improvement process that would allow the CNS to compete with other public health care providers in Bolivia, within a context of legislative changes and the decentralization of health services. With the financial and technical support of the mission in Bolivia the United States Agency for International Development, “USAID” and the Family Planning Management Development Project from the cooperation agency Management Sciences for Health, “MSH”, the Sexual and Reproductive Health Program of the CNS began a number of specific interventions in 1996 to improve the quality of care.

USAID/Bolivia in close coordination with the officers of the Sexual and Reproductive Health Program of CNS, the advisors of the cooperation agency Management Sciences for Health (MSH), introduced in 1996 the methodology of the Continuous Quality Improvement Process to the seven policlinics run by CNS in the city of La Paz. In 1997, the Head of the Sexual and Reproductive Health Program (PSR) of CNS, the advisors from MSH and the directors of the policlinics, refined in a joint effort the quality indicators/standards and sub-standards for the policlinics in La Paz, which were measured through the application of the instrument based on the model designed by the Integrated Health Services Project (Programa Integrado de Servicios de Salud - PROISS), funded by the World Bank.

In August 1997 the authorities of CNS and the Ministry of Health and Social Welfare were changed, and the newly appointed officers showed interest in developing national quality standards for the institution’s accreditation by the Accreditation Committee of the current Ministry of Health and Social Welfare. Based on the first instrument that had been previously developed, a Manual was prepared by a team of professionals from CNS (a Unit of the Sexual and Reproductive Health Program and the directors of the Policlinics), USAID/ BOLIVIA and MSH/FPMD.

The most important experiences used for the guide, were the previous accreditation models developed by different authors for secondary care hospitals. Donabedian, Deming, Sheps, De Geynedt, Dror, Baranchuck and other American, European and Latin American authors, were reviewed to support the conceptualization and design.

Through the Delphy method, a reflection process was initiated resorting to successive approaches and consultations with experts, which culminated with the development of a Methodological Guide as a matrix that was validated and became the first draft of the Quality Surveillance Guide or Manual at a number of workshops held with the Directors of the policlinics and managers of the

Sexual and Reproductive Health program of CNS. Later on, through consultations with international experts from MSH, the questionnaire was systematized and improved, and a field test was carried out to validate it.

6 CNS policlinics were targeted to receive technical support to initiate the accreditation process, with the aim of attaining a gradual improvement, that would promote and initiate a deep transformation thereof, aimed at strengthening the management, efficiency and competitiveness of their own structures, and at the same time, leading the internal process to offer renewed quality care. This would earn the CNS the acknowledgment of a quality health care services provider. Moreover, the accreditation process itself stimulates quality improvement and strengthens the managerial capabilities of the team at each policlinic.

The instrument destined to the evaluation of the policlinics of Caja Nacional de Salud, intends to carry out an analysis of its administrative aspects.

1. Its structure comprises 17 standards, focused on one administrative and/or management area, which are important for the policlinic's adequate operation, guaranteeing an impact on the target population's health. For this purpose, it is essential that the answers obtained in the survey reflect the actual status of the selected policlinic.
2. The questionnaire must be filled out by the external evaluator(s), in conjunction with the administrative team (management Unit). This participatory process must ensure a broad understanding of the diagnosis itself by all the participants, as well as an in-depth knowledge of the findings.
3. The questionnaire comprises 399 questions divided in three levels which correspond to three elements, i.e. structure, process and result, and these are in turn subdivided in technical-administrative quality and human quality. Each level represents an increasing complexity starting from the first scenario, which is the simplest and ending with level three, which reflects an optimal condition of the policlinic. Within the document's conceptual framework, the differences between structure, process and result are clearly established.
4. To answer the questions the respondent must choose one of two alternatives: affirmative (YES) or negative (NO), and there is a possibility to annul a question that will not be taken into consideration at the time the average score is obtained for the corresponding standard and sub-standard. This annulment will apply to questions that do not depict the reality of the policlinic, for example if the question refers to the existence of dentistry equipment in good operating conditions and the center does not offer dentistry services.
5. It is important to underline that the questions that are divided in two or more parts must be answered in their entirety, i.e. every part must coincide with the assigned answer.
6. To avoid the presence of different symbols in answer boxes, these will simply be marked with an "X", if the answer is affirmative (YES box) or negative (NO box) respectively.

7. This survey does not require more than 16 continuous hours, therefore we suggest this time period for the corresponding analysis.
8. In case of doubt concerning the answer to a given question, this must be answered negatively or the external evaluator should be consulted.
9. The external evaluator must ask control questions to certify affirmative answers. For example, the existence of plans or projects must be verified with the documents.
10. In the event there are doubts of a more general nature concerning the survey, these questions should be referred to the external evaluator.

SCORING CRITERIA

The success of the evaluation depends to a large extent on the modality used to assign scores. The evaluator must keep in mind, at the time he/she asks the questions contained in the questionnaire, certain criteria that will allow him/her to determine if an answer is affirmative (YES) or negative (NO). It is important to comply with these criteria to ensure that the results obtained reflect the policlinic's actual level of efficiency, thus avoiding a possible bias concerning the information or the determination of unrealistic development percentages.

CRITERIA USED TO DETERMINE IF THE ANSWER IS AFFIRMATIVE (YES)

The following aspects must be considered before classifying an answer as affirmative (YES):

1. Questions must be answered in their entirety, without leaving any pending items. For example question 11 concerning equipment "100% of the staff has been trained concerning the handling, appropriate use and adequate conservation of the equipment in his/her area", seeks to find out if the person is familiar with all aspects mentioned in the question.
2. For some questions it is advisable to carry out an additional control to support the affirmative score. Such as, for example, question 20 on Sexual and Reproductive Health "The policlinic estimated its coverage and input needs for the development of its sexual and reproductive health activities; including printed educational and audiovisual materials" that seeks to find out if there is a written order for inputs. The answer will be positive only if the additional control determines that the document verifies that there is really a requirement for such inputs according to the type of facility.

In case the person surveyed has doubts concerning any question, it is necessary to make some control questions to back up the score assigned. For example the following question "There is a SNIS registration system in place that is used in all examination rooms and shifts. The data are concentrated by one person who is responsible for information", and which seeks to find out the specific information concerning the health programs required for decision making; the control questions that would support the affirmative answer could include ¿What type of specific information is required for decision making?

information effectively support the decision making process? If all additional questions are satisfactorily answered, the answer to the question may be marked YES.

CRITERIA USED TO DETERMINE IF THE ANSWER IS NEGATIVE (NO).

The following criteria must be kept in mind to determine if an answer is negative (NO).

1. If the answer fails to include all the aspects mentioned in the question. Such as for example “There is a manual of cleaning procedures and functions, and the staff is familiar therewith”, which seeks to find out if specific written procedures have been established for the policlinic but fails to include administrative aspects, the answer will be negative because there are no written procedures for administrative functions.
2. If at the time the questions are asked these are supported by a additional control questions that show that there are no documents to support the answer, or if the control question shows that reality does not support the purpose, the answer will be negative.
3. The surveyor is advised to keep in mind the existing relationship among a number of fields. Once the questions in the guide or questionnaire are concluded, it is necessary to compare the answers with the questions that consider similar aspects, in the event there are contradictory answers or if these fail to coincide, both questions shall be marked negative.
4. After concluding the application of the instrument, the evaluating team will hold separate meetings with the representatives of each policlinic (for example. Directors, department heads, CQI teams) and the persons responsible for the Sexual and Reproductive Health Program of CNS, (PSR); who will hold meetings to analyze the survey’s data and findings.

SCORING CRITERIA

The structure of the “Quality Surveillance Map”, was developed following the same order of the working matrix which classifies each sub-standard in “Structure, Process and Result”. The questions are in turn classified in Technical and Administrative Quality and Human Quality and Comfort and these comprise three development levels (initial, intermediate and maturity). An example of the above may be observed in the “map”, which permits us to observe the layout and structure that was developed. This matrix offers a wide array of possibilities to analyze and review the results, because it allows us to go from a global vision, to specific observations according to the standard, level, structure and quality type.

Scoring is carried out by introducing the data into the information system, which has a specific screen for this purpose. Enter by pressing the tab labeled forms and making a double “click” on the “score” tab, this will automatically generate the evaluation template for all the policlinics of Caja Nacional de Salud in La Paz, and the answers must be introduced to this template in adherence to the Quality Surveillance Manual. Answers are introduced activating the check box

that corresponds to the answer, if check boxes are not clearly marked or if both are marked, the answer must be annulled marking the corresponding box on the screen.

Considering that each sub-standard that contains a positive answer is assigned a percentage and is classified in adherence to an organization matrix, a score can be determined for technical and administrative quality, human quality and comfort, or for the structure, processes and results obtained by the policlinic according to the requirements.

Scoring by standard is carried out based on the percentage of positive answers from the total number of questions asked for that standard, this means that the annulled answers, in the evaluation form, are not taken into consideration for the standard's score. To calculate the policlinic's global score an average of all standards must be found.

Accreditation scores

To accredit policlinics, a redistribution of percentages is performed, assigning 100 points to the total number of questions in the same level, the score obtained by each level corresponds to the percentage of positive answers at this level. The accreditation range for each level is as follows:

Accreditation table by levels

Level 1	Level 2	Level 3	Accredited:
100%	-	-	Level 1
90%	30%	-	Level 1
100%	100%	-	Level 1 and Level 2
100%	90%	30%	Level 1 and Level 2
100%	100%	-	Level 1 and Level 2
100%	100%	100%	Level 1, Level 2 and Level 3

Graphic reports

These data are included in the following Report forms:

1. Report by Standards: which shows the score by standard and the average thereof, which determines the policlinic's global evaluation.
2. The Standards chart corresponds to the preceding report plotted in a graph.

3. Development level chart, which shows the percentages attained by the policlinics at the different levels.
4. Structure, process and result chart, which shows the percentages attained by the policlinics according to the aforementioned grouping.
5. Technical and administrative quality chart and human quality and comfort chart, which show the percentages attained by the policlinic according to this grouping.

The graphic expression of the results, contained in software “outputs”, permits us to simply observe the situation of each policlinic that was evaluated. The accreditation by levels constitutes a simple way of determining the level of growth of an organization in particular.