

ISQua OPINION PAPER

**Three challenges for external
evaluation: Ensuring relevance
and preparing for the 2030's**

The IEAA Accreditation Council
and ISQua's Innovation and
Systems Change Working Group

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An Ageing, technologically advanced world

Between 1960 and 2015 the global population grew from 3.0 billion to 7.3 billion and is projected to reach 8.0 billion by 2025. In developed countries, people aged over 60 today make up more than 20% of the population. This group will approach or exceed 30% by the 2030s and in some countries, such as Japan and Switzerland, 40%. While approximately 15% of the populations of low- and middle-income countries are in this older age group today, significant demographic change is imminent. By the 2030s, 27% of Chinese will be aged over 60, rising to 40% by the 2050s, making China one of the world's oldest societies by the mid-21st Century.

Given the co-morbidities, complex medical histories and the chronic conditions associated with ageing, these very large, older cohorts present significant planning and budgetary challenges across acute, primary and aged care. We are simultaneously facing a revolution in treatment modalities, often spreading from wealthier to less wealthy communities as new things become widely available. Sophisticated rehabilitation protocols, early testing and diagnosis, and the progressive replacement of aggressive treatments with oral prescriptions or less invasive techniques, are facilitating the shift of care out of acute settings and into primary, community or homebased care. Over the past 30 years the average length of hospitalisation has been decreasing. By the 2030s the proportion of patients requiring lengthy hospitalisation will contract even further, and more care will be provided entirely outside of hospitals.

Taken from the 2016 White Paper - Health systems and their sustainability: Dealing with the impending pressures of ageing, chronic and complex conditions, technology and resource constraints; ISQua's Innovation and Systems Change Working Group

Since its origin, accreditation and certification programs (collectively, external evaluation) have been anchored on four pillars: first, a priority given to acute medicine, short term outcomes, and process driven approach; second, a priority given to evaluation of individual medical organizations/facilities; third, a priority given to 'one size fits all', with the same requirements and standards for all hospitals at the National level; and fourth, and last but not least, a logic of 'reach for excellence' or 'reach for improvement'.

With these four pillars, while their impact on outcomes remains challenged, external evaluation programs have proven their value and relevance. They do improve quality of care (incrementally), identify risk and enable improvement.

How ever, the recent and fast-growing occurrence of tremendous social changes impacting health and care (massive ageing, growing regional disparities, lack of medical resources, digital revolution) coupled with many tremendous technical changes already existing or soon coming (e.g. day surgery, personalized medicine, big data, artificial intelligence) lead one to question if the above approach is sustainable. Does it offer the most appropriate external evaluation approach to assess quality of health and social care, to meet public and governmental expectations, and will it mitigate future risks in the 2030's?

This opinion paper, co-authored by the members of the ISQua External Evaluation Association Accreditation Council, and the Innovation and Systems Change Working group of ISQua, is a first attempt to define the extent of the challenge, and tentatively show what type of (r)evolution is required to address evaluation in the 2030's.

The context: Healthcare under pressure: the end of the 'quality improvement' vision?

Massive ageing is – or will soon be - a problem for all developed countries, with a growing number of fragile patients with both physical and psychological impairments. More patients, more fragility, more complex care requirements and more dependency comes at a greater cost and amplifies the interaction and effects between quality ambitions and the demands on resources.

While the goal is to provide care according to current evidence, the quality improvement, 'stretch to improve' model, may simply no longer be tenable owing to a lack of resources, particularly human resources. The crisis originates from capacities of health and medicine to do far more than society is willing to fund, the rise of technology must be paid for, a vision of a healthcare system built in the period of great hope in the developed world, a degradation of the social appeal of medical professions in Western countries, and a series of formidable sociological changes with both massive ageing, changing demographics, massive reallocation and industrial changes in regions, with deindustrialization in many parts of economies.

Doctors are becoming a diminishing resource in many countries, especially GPs in isolated or socially or industrially deprived or isolated parts of countries (e.g., Canada, Australia, US, France, and most LMICs). In the reality, the medical workforce is increasingly maldistributed in Western countries, and it is even worse in LMICs countries suffering from a cumulation of an insufficient number of professionals entering into training and a growing emigration of those licensed.

These pressures have had considerable impact on external evaluation systems designed for developed countries during more progressive and stable times. Many people in healthcare realize that the solution is not (as most would have said 30-40 years ago) to find the resources we need. They feel squeezed between a rhetoric saying that healthcare must deliver the best possible care to everyone and a reality, where costs for drugs and “technology” are consistently, but not openly acknowledged, prioritized over time for care and interaction, accompanied by newspeak by politicians and top managers that with good leadership and management you can accomplish anything with what resources you happen to have. All of this leads to staff burnout, or as some prefer to call it, moral injury.

Accreditation and evaluation designed at the time of the quality improvement movement coming to the fore now face this new landscape of challenged resources. Unsurprisingly, evaluations based on an ambitious vision of quality and safety have produced disappointing results. More and more isolated hospitals and clinics are challenged to provide quality health and social care.

One immediate potential solution is centralization of resources—to consolidate clinical activity in large healthcare centers and those centers severely compromised by lack of resources. However, this is often impossible because of widely distributed populations with varied needs, and general resistance to a centralization model. However, a decentralized system with stretched resources and poorer service levels outside large metropolitan centres is a very significant problem—little more than ‘better than nothing’.

Challenges and responses

These changes pose multiple challenges for the current forms and systems of standards assessment and external evaluation processes. We suggest three key response areas of focus: adaptation; assessing the patient journey; and preparing for the digital future.

Response 1. Adapting to and reflecting a world of scarce resources and declining standards of care

One response to current pressures is to maintain the quality improvement approach, continuing to enable/focus on improvement in quality and safety on the premise that any impending crisis is temporary, that we need to focus on improvement in order to effectively cope. This belief encapsulates the idea that the continuous improvement model is appropriate to stimulate and enable health care organizations to improve and to demonstrate and assure citizens about the commitment to quality of care.

Among associated challenges, many relate to the growing goal of improving quality, while some are more human focused, for example most health care professionals still see the process as an 'add on' not part of their daily job. Therefore, if the logic is to continue to ask for improvement within accreditation programs, we should continue to tolerate partial or intermittent non-compliance, and therefore, perhaps, as challenges increase, we should adopt stronger more realistic assessment programs over time. In short, if we stay the course we will arrive at where we have been heading for several decades. True enough, if a facility / organization does not meet the basic standards over time or declines in performance (e.g., to safely deliver a newborn), the facility should be closed, or the program terminated. However, the question always to be asked is, "is the availability of this facility better than nothing at all"? Should governments and society continue to take such risks?

Alternatively, we can evolve from the current quality improvement (reach for excellence) system, and make evaluation more context-dependent, region-specific, with flexible standards and varying levels of achievement depending on the context—that is, flexing to the resources, services and complexity of the organization or services being assessed. In that case, we might turn assessment from the 'vision stretch/improvement' model to a 'vision of basic levels of care' model with a set of contractual 'no go' criteria under which the activity must be stopped and/or transferred. This new approach to external evaluation could assure the patient and stakeholders of the safest contextual access to care with the best risk/benefit ratio according to the context, day, and place. Needless to say, this adaption from the current approach will require great transparency for patients and citizens so that they understand the tradeoffs and choices being made.

Response 2: The new and inescapable focus on the patient journey

Increasingly, evidence suggests that patients recover faster and with fewer complications when discharged as soon as possible from the facility to their home, with fewer iatrogenic diseases. Over the past 20 years, health care organizations aiming to achieve better outcomes, control costs and optimize resources have been enabling rapid discharge from acute hospitals and this has resulted in shorter hospital stays. A growing number of patients are transferred from hospitals to rehabilitation centers, primary care, and into the home, and hospital stays have become a fraction of what they once were. This reality creates a myriad of challenges and dilemmas, not the least of which is to external assessment.

Should we continue to focus accreditation on individual structures, e.g. hospitals and clinics as we do mostly around the world at this time or should we make a pivotal change and adopt the patient's journey as the focus and pathway for assessment purposes? We suggest that such a refocus would require two components. First, focus accreditation on transitions and the person's health journey. Second, incorporate end users' input and judgement in the assessment and caring process since the patients, their families and careers will be those who are most familiar with the journey and most able to judge it. The standards should reflect that the patient journey is not always a series of sharp transitions, therefore promoting the notion of a team around the patient, and including the patient, where team members sometimes step forward, sometimes retract to the background, yet remain part of the team (metaphorically like a soccer player, playing the ball to some other player, rather than like "I have finished my job, now you do yours").

Three additional points should be made in relation to this challenge.

First, there is significant pressure and expectation in the healthcare system to move external assessment from the traditional structure and process approach to that of including outcomes measurement. Patient judgements on quality and safety (PROMS, PREMS, PRIMS) are increasingly integrated as measurements into external evaluation programs and expected to become the leading quality indicators, or at least as important as others in the mix, over time. That being said, there must be a balance of structure, process and outcome measures. By the time an outcome measure alerts the health team to a problem, it may be too late. Structure and process measures enable tracking the progress of particular practices and identifying where system or process changes are required, before negative impact on outcomes.

Second, we need new quality and safety standards that reflect the individual's health journey: primary care, prevention and health promotion, rehospitalization, long term, transitions of care, community-based care, rehabilitation, social care, and the like. Even more-so, we may think that the main challenge will be to turn external evaluation of structures to accreditation of the patient journey however the real and most complex challenge may be to turn to regional accreditation, demonstrating to local populations that regional consistency in quality and safety of all healthcare services is achieved. In some provinces of Canada, this regional accreditation approach has been tested and found valuable over the last 15 years.

Third, and even more complex, we need to revise and reframe standards to become accessible and relevant for patients, families at home and communities. They need to be written for 'lay' users, with minimal use of jargon, acronyms and 'insider' language. We will need to increasingly incorporate patients into the visiting or surveyor teams and share a common language between expert 'healthcare professional' visitors and non 'expert' populations.

Response 3: The digital era and the exponential growth of complex biomarkers in healthcare

Information technology, artificial intelligence, tele-health and other developments are changing the way care is provided, the location of provision and the role of patients and families. In addition, new types of diagnosis and treatment will stretch the capacity, utility and viability of existing standards to the breaking point. The application of genomics, biomarkers and the move to personalized medicine will all require oversight and therefore new forms of external evaluation in the new more complex world of healthcare.

These innovations will clearly add new pressures and demands to external assessment organizations – to adapt and be relevant. Accreditation has been historically designed for evaluating static healthcare organizations such as laboratories, hospitals and ambulatory care clinics attached to hospitals. Healthcare is now increasingly delivered in a wider variety of settings, without healthcare professionals necessarily being present or even close by. Healthcare services may be situated in distant regions and linked by telemedicine or teleradiology, or even other countries (anatomopathological examination for example). External assessment programs will need to consider how conditions are effectively monitored and treated at a distance, providing quality health and social care and with consistent access to digital tools for all citizens in all places.

A role for ISQua and the ISQua External Evaluation Association (IEEA)

We could view future external evaluation as a simple continuation of the traditional accreditation model with some 'add-ons' for changing or distant care providers. In that case, the solution is to add new standards related to these realities, prove their relevance, and define how they counterbalance short term indicators in the final evaluation. This is largely predicated on our supposition stated within Response 1.

Alternatively, we might need to develop a new vision of external evaluation focused on quality of life instead of inpatient or institutional care or static models of accreditation.

The overarching effect of these perspectives challenges a need to consider the assessment not of organizations or services but health outcomes over a longer period of time, hence requiring a shift of the focus and value of evaluation and assessment to the same time scale. In other words, to move from directly assessing the quality of care to assessing the role of healthcare in providing quality of life and healing.

In that case, not only do we need new standards but also to rethink the fundamentals of evaluation. These new models of evaluation will need to consider how to turn process and outcomes thinking into evaluation via clinical registers. It will mean changing reporting systems, consider new accident analysis methods, and more. A shift to process and outcome evaluation and incorporating patients' judgments into assessment processes may be at the core of this new model, but need much further consideration as compared to present state of play.

In conclusion:

Most methods and underlying concepts of present external evaluation programs have been unchallenged for decades. They have focused on assessing quality and safety in organizations or services cross-sectionally, in the immediate short term, using the quality improvement focus, and have been proximal to the administration of care. Little - if any - thinking has refashioned external assessment in a new frame, shifting old, decades-long models of quality improvement accreditation to reflect the value of delivered health and care over medium (months) and/or long-term horizons and challenges (years).

Given the complexity of the challenges in rethinking external assessment, it is time for the ISQua to challenge and consider new models and propose directions for future external evaluation in healthcare.



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