

Healthcare Quality in Thailand

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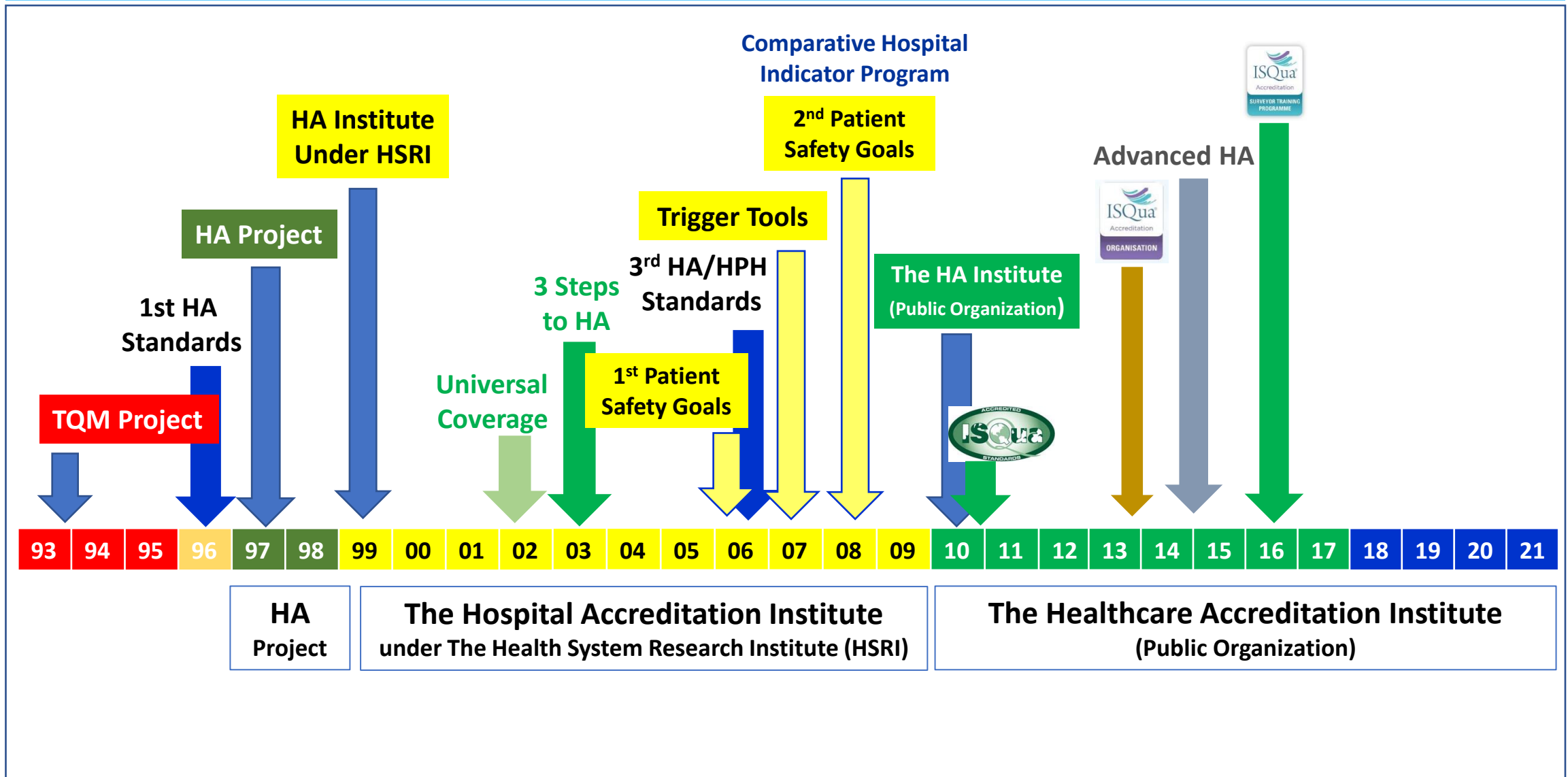
Former CEO The Healthcare Accreditation Institute, Thailand

Sharing with the CAHO Advisory Board

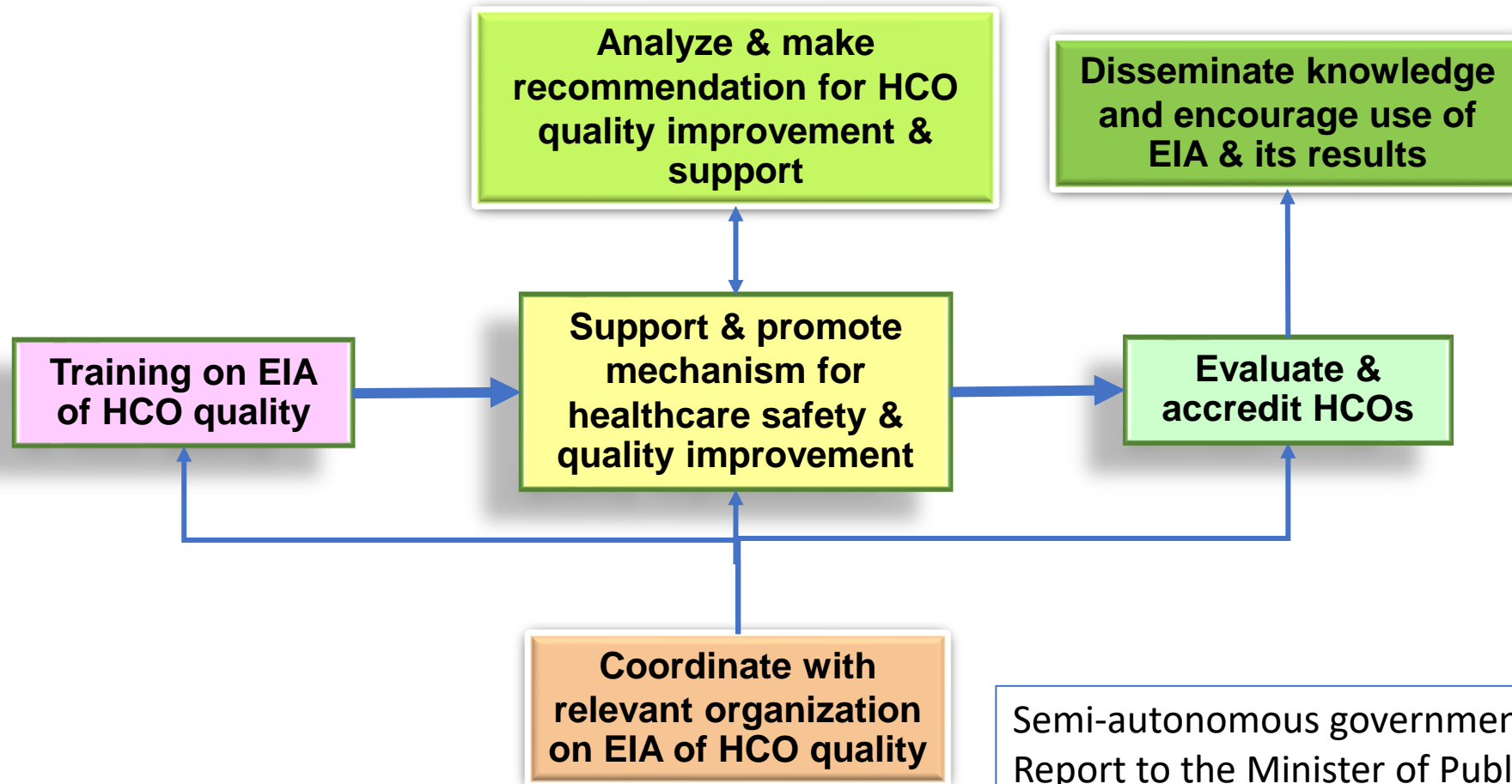
January 12, 2022

**The Healthcare Accreditation Institute
(HAI)**

Thailand Healthcare Accreditation Journey



Functions of the HAI

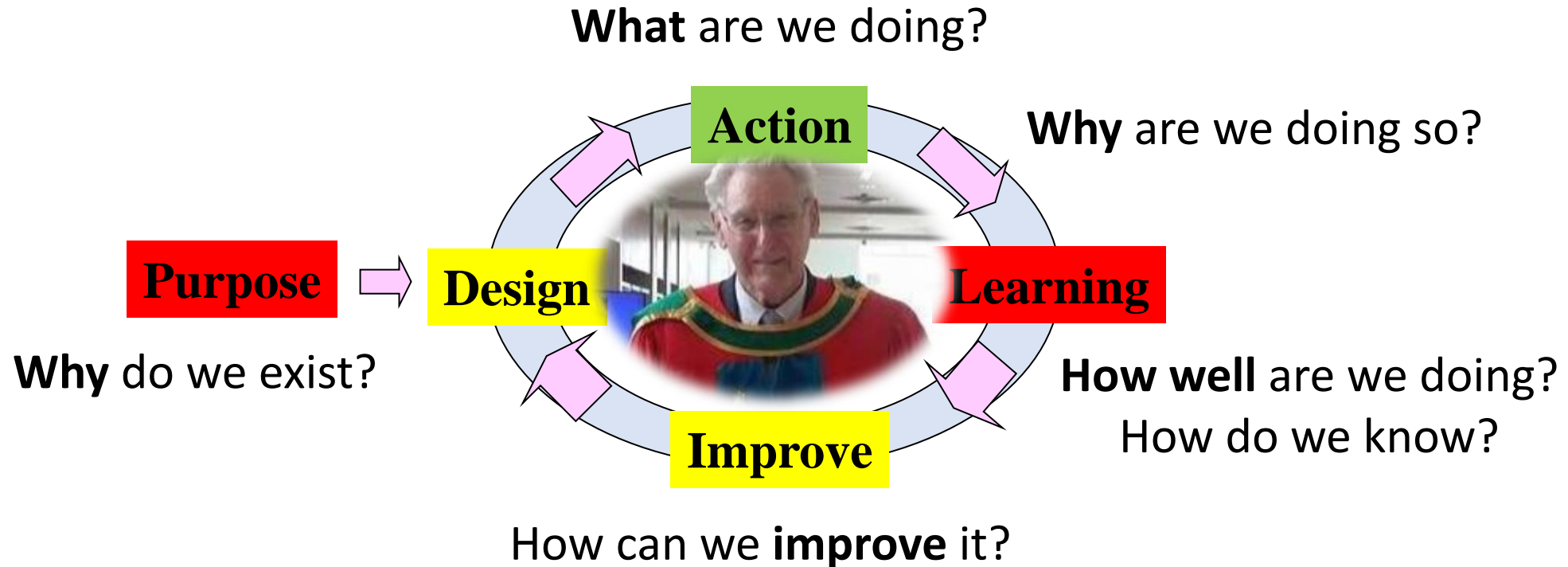


EIA=Evaluation, Improvement, & Accreditation
HCO=Healthcare Organization

Semi-autonomous government agency
Report to the Minister of Public Health
Partially funded by the government

The Essence of Accreditation

HA is an Educational Process, Not an Inspection!



Essence of Accreditation

Safety & Quality of Patient Care

Self Improvement

Educational Process

External Evaluation

Self Assessment

Recognition

The real essence of accreditation is external peer assist & review for self improvement

Voluntary
External peer review
Using standards
Not an inspection

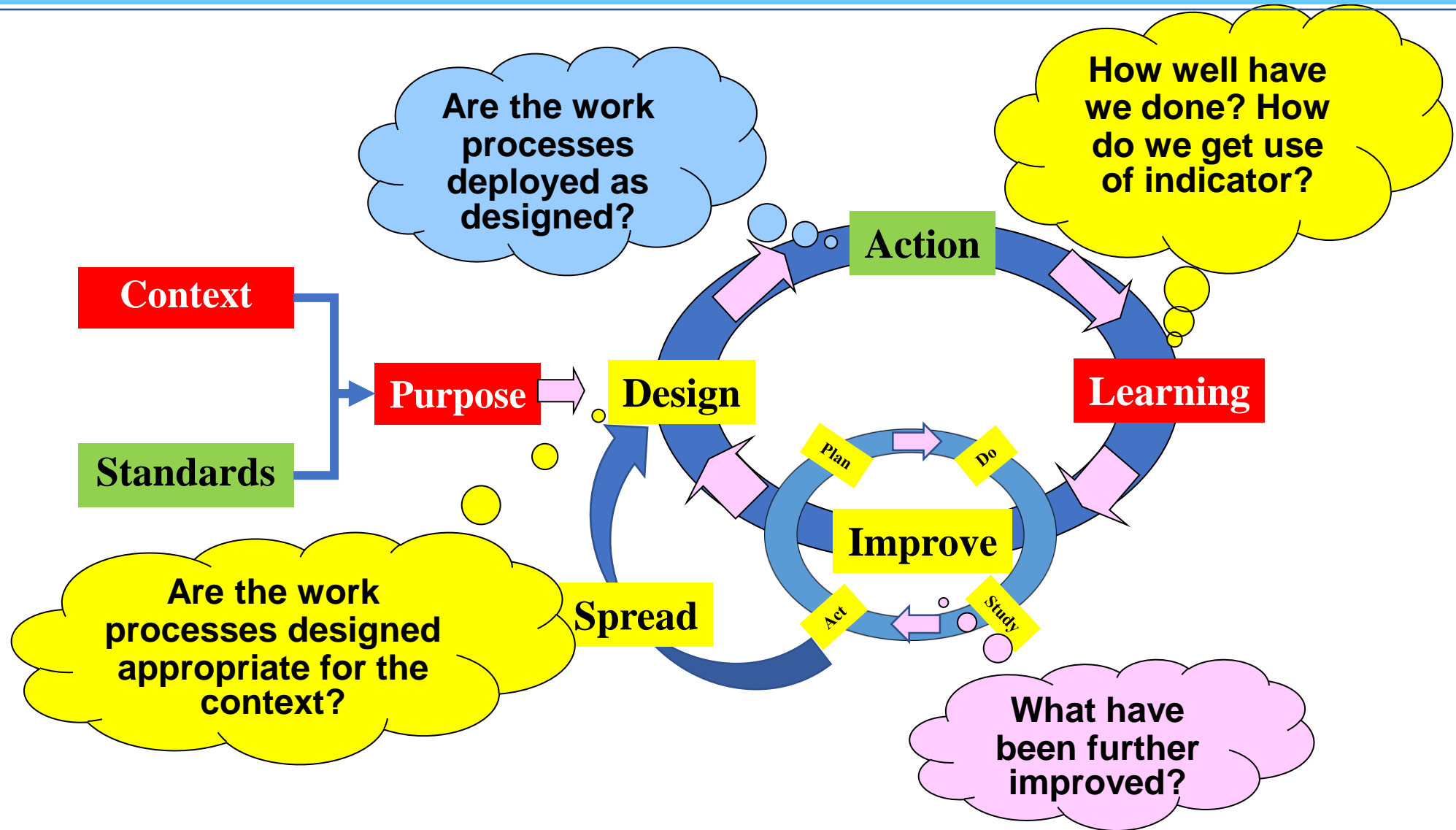
Peer Assist:

Local healthcare networks
Professional organizations

Peer Review:

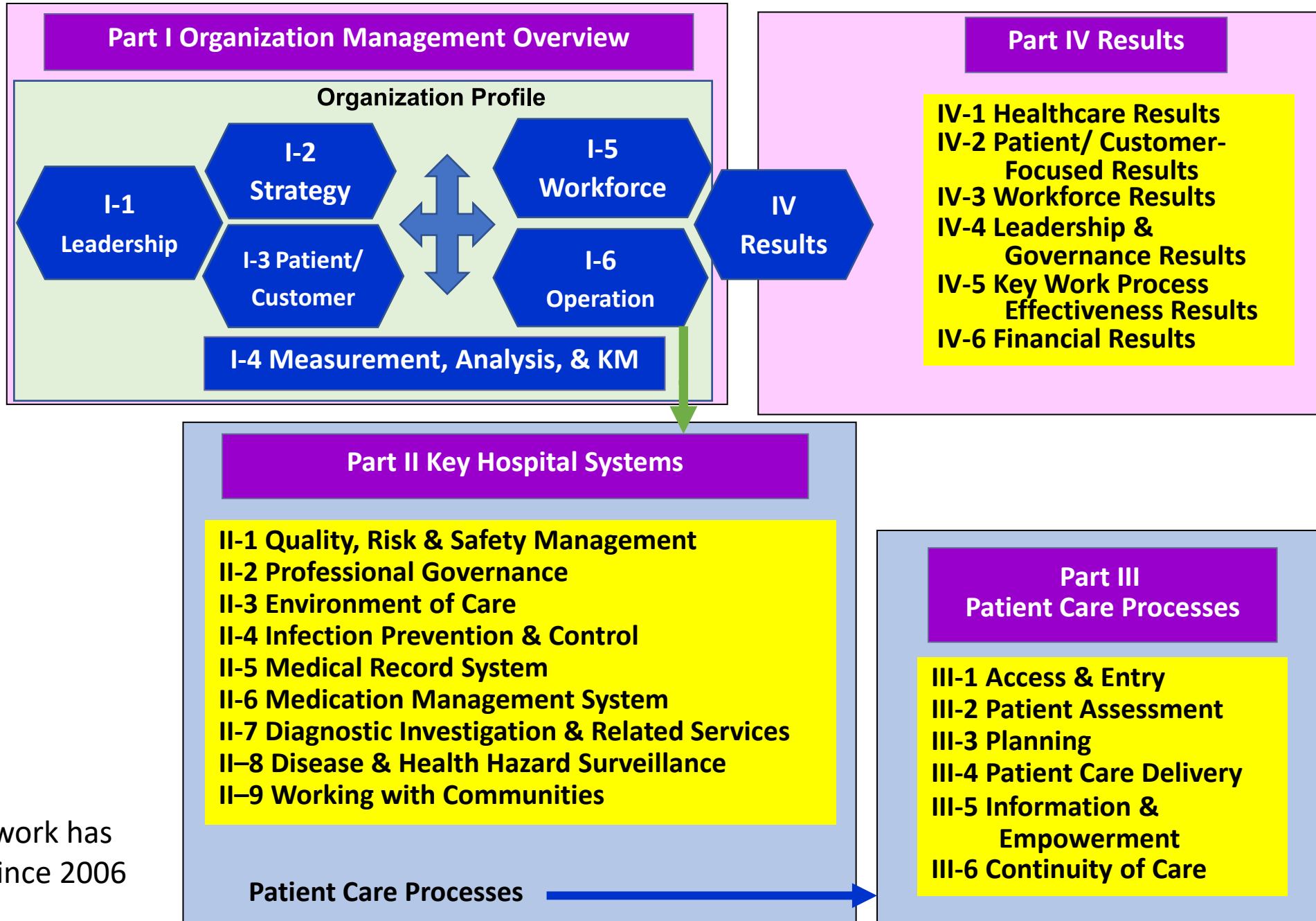
The accreditation body

Basic Questions for Assessment



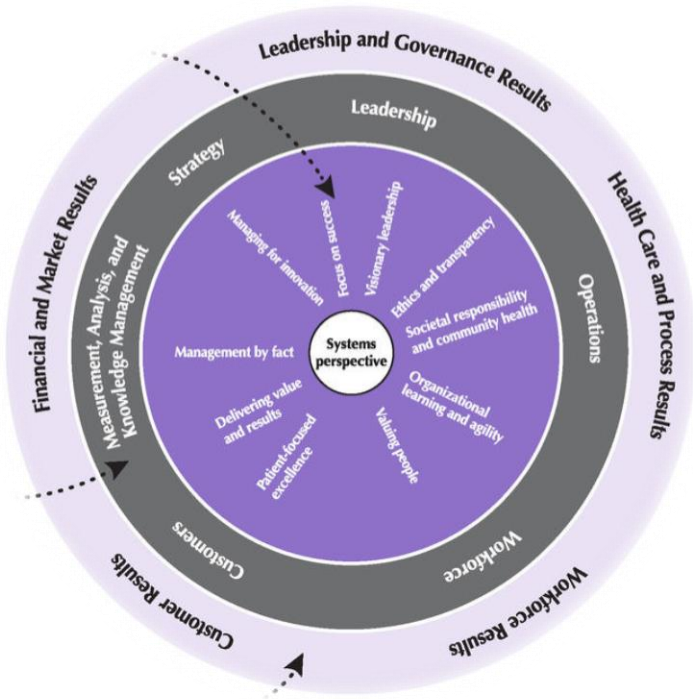
Hospital and Healthcare Standards, 5th Edition

Baldrige
Excellence
Framework

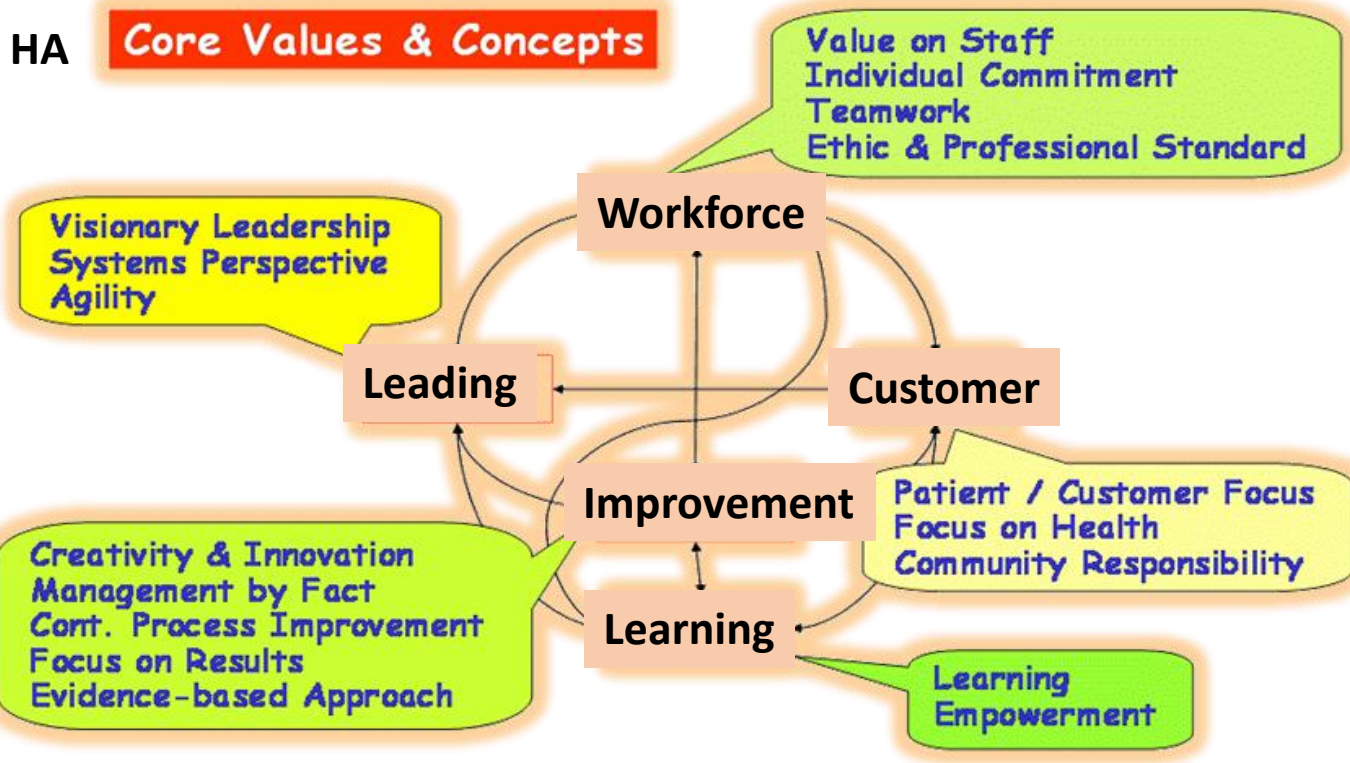


This framework has
been used since 2006

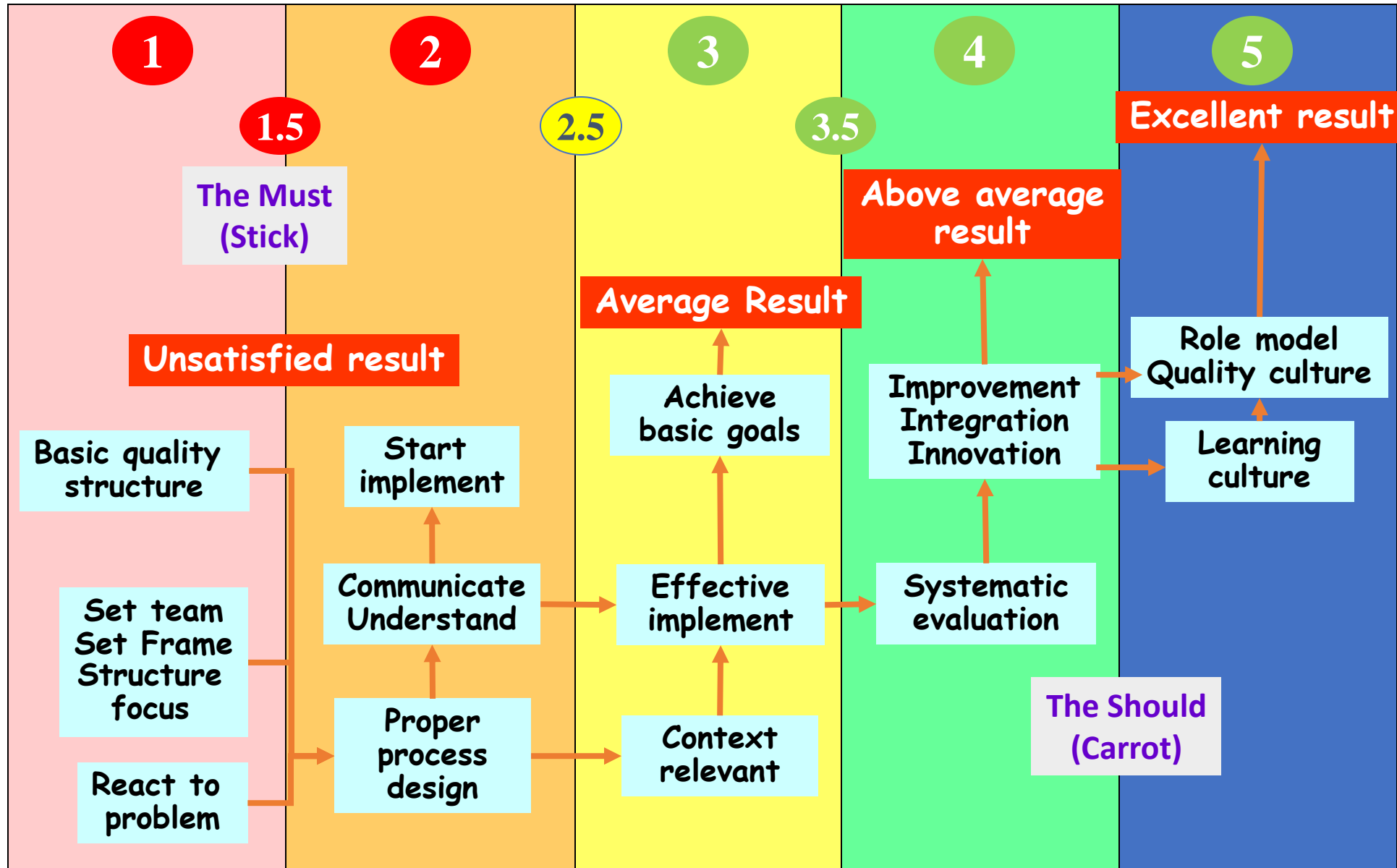
HA Core Values & Concepts



Baldrige Core Values & Concepts



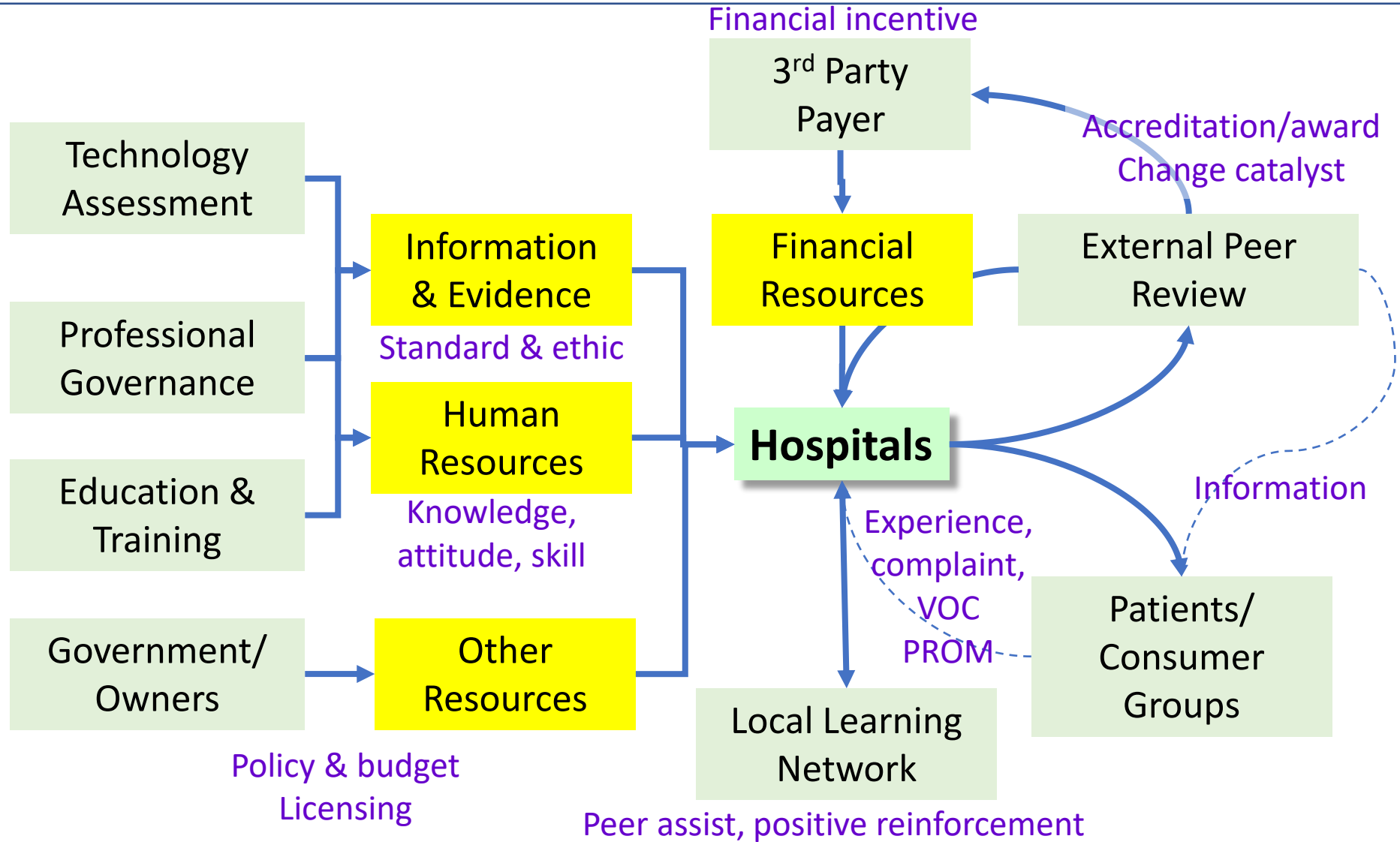
Scoring Guideline: For Continuous Improvement to Excellence



Special Focus of the Thai Healthcare Accreditation Program

- Emphasis accreditation as an **educational process**, not an inspection, aim for empowerment evaluation
- **Balance of improvement** based on quality system, spirituality, science & knowledge
- **Integration** of all relevant concepts, standards, and criteria for the purpose of quality & safety
- Offer multiple **models of recognition**, including stepwise recognition
- Comply with the **ISQua IAP**
- **Promote quality improvement**
 - Local quality learning networks
 - Involvement of professional organization
 - Comparative indicator program
 - HA National Forum

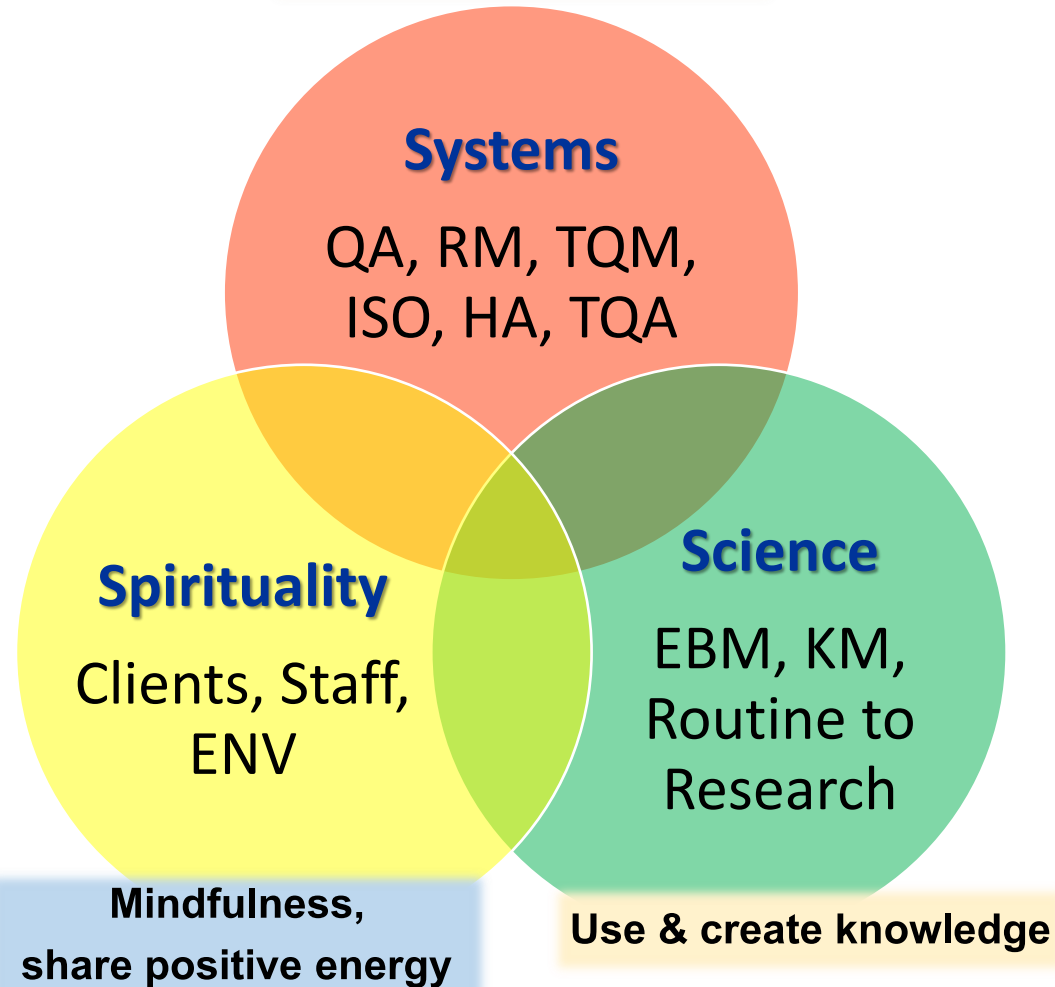
HA as a part of the Whole System



Balance of Improvement

Balance of Quality Movement

Creative quality system



Hospital staff:

- to recognize other efforts
- to balance their capacity

HA Surveyor:

- to promote balance of quality movement

HAI:

- to keep alignment & work with all partners

Spirituality



To ourself	New consciousness, mindfulness, peace of mind
To our friends	Deep listening & productive communication
To our patients	Humanized healthcare, respect, response to spiritual needs
To our organization	Living organization
To our health service system	Lean & seamless healthcare
To our environment	Healing environment
To our society, planet, humanity	Societal responsibility Systems approach Flexible & sustainable Beauty in diversity

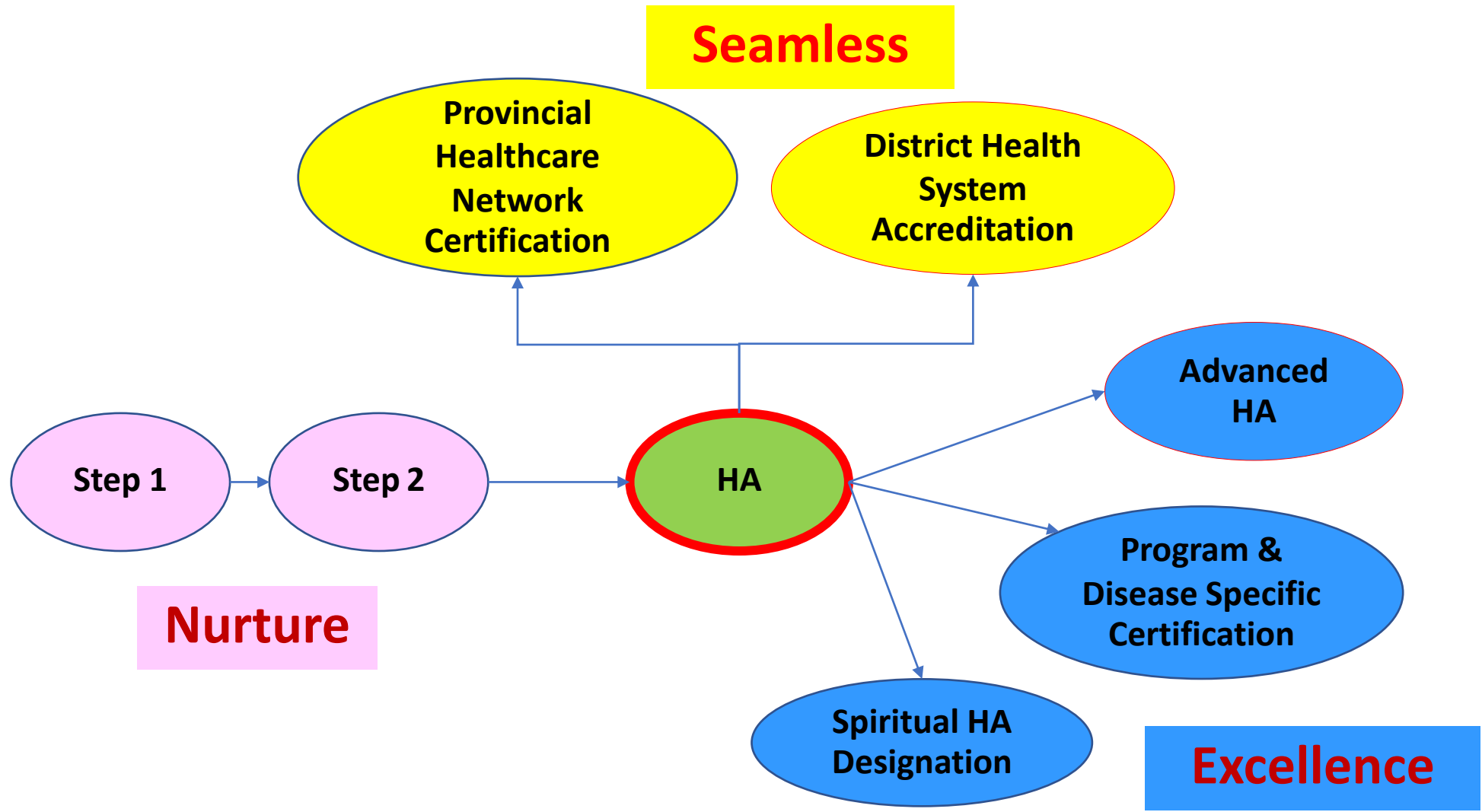
Spiritual Health

Happiness that comes from

- understanding and realization of **truth, value and meaning** of one's own, others, the world and life; both truth in daily life and the ultimate truth;
 - a **peaceful mind**;
 - seeing a **connection** between self and others / nature;
 - respect and harmonization with diversity;
- which will contribute to a supportive and resilience society

A Variety of Recognition

HA Recognition Program



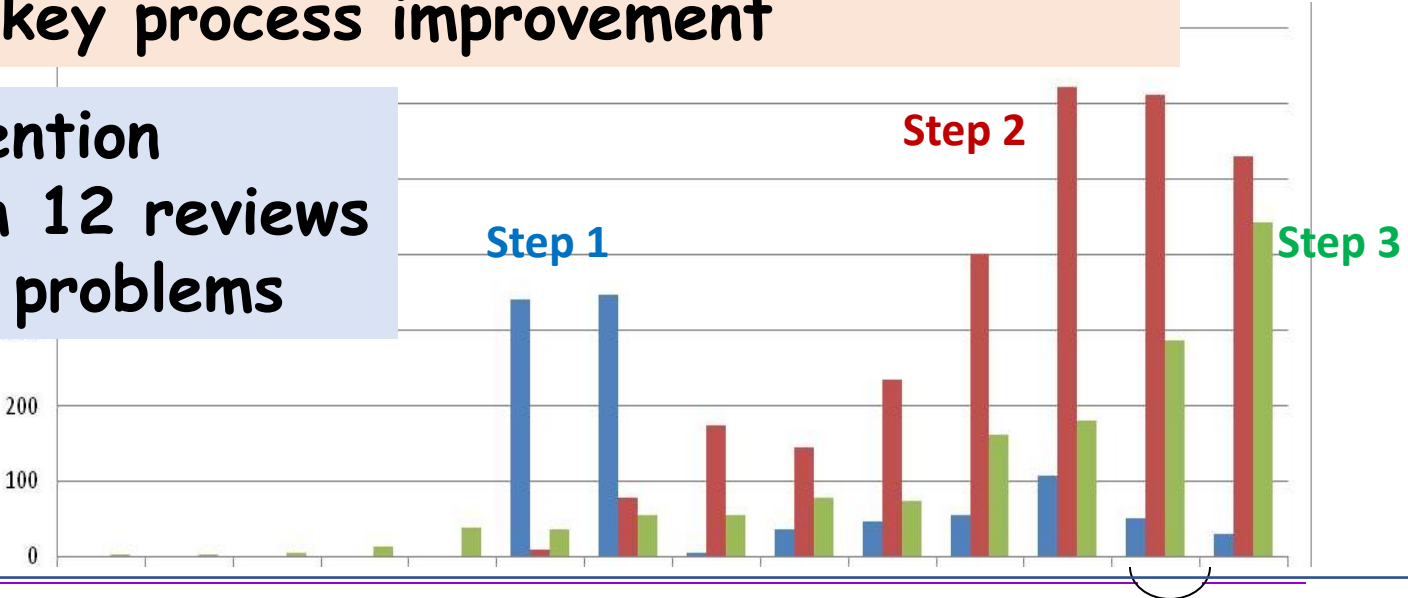
Stepwise Recognition

A strategy to gain acceptance and expand coverage

Step 3: Quality Culture
Identify OFI from standards
Focus on integration, learning, result

Step 2: Quality Assurance & Improvement
Identify OFI from goals & objectives of units
Focus on key process improvement

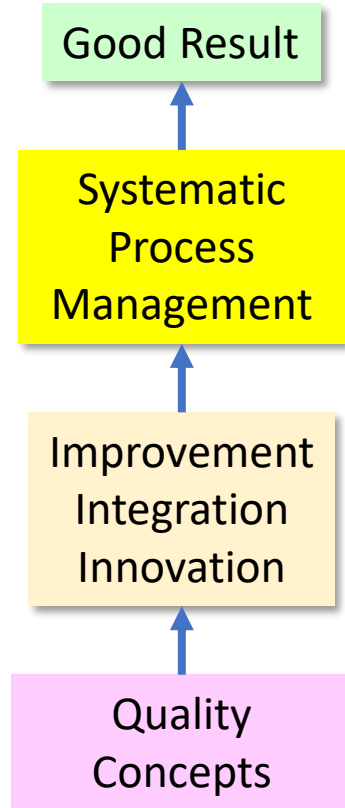
Step 1: Risk prevention
Identify OFI from 12 reviews
Focus on high risk problems



Advanced HA : From Process to Performance Evaluation

	Process Evaluation (HA)	Performance Evaluation (A-HA)
Question	How do we do our work?	How well, how effective?
Starting Point	Standard requirement Hospital context	What are our key issues? What are our goals? How to measure our achievement? Who will be the target groups? What method of evaluation?
Example	How do senior leaders communicate with the staff?	What is the effectiveness of the communication?

Program & Disease Specific Certification



- 1. Result** : good result with favorable trend or excellent result, comparison with challenged benchmark
- 2. Process management** : systematic process management for key processes for the whole value stream
- 3. Learning** : evaluation & Improvement, Integration, Innovation
- 4. Quality Concepts** : Lean / waste reduction, safety & risk management, evidence-based & professional standards, health promotion, spiritual dimension

Program & Disease Specific Certification

Stroke	18
HIV	11
DM	6
ER	4
Preterm	4
CA Colorectal	4
CA Breast	3
TKA	3
CA Cervix	2
Heart failure	2
Hip fracture	2
Liver transplant	2
Palliative care	2

Specific standards for stroke, HIV, ER

One organization for each program certification

ACL injury
AML
Asthma
CA lung
CA oral cavity
CAPD
CIED
Cleft lip & palate
Cerebral aneurysm
ECT
Gyn laparoscopy

Head injury
Hematopoietic transplant
Kidney transplant
Nephrology
Newborn hearing
OA knee
Poisoning
Refractive error
Retinal detachment
Thyroid
Trauma

Supporting Mechanisms

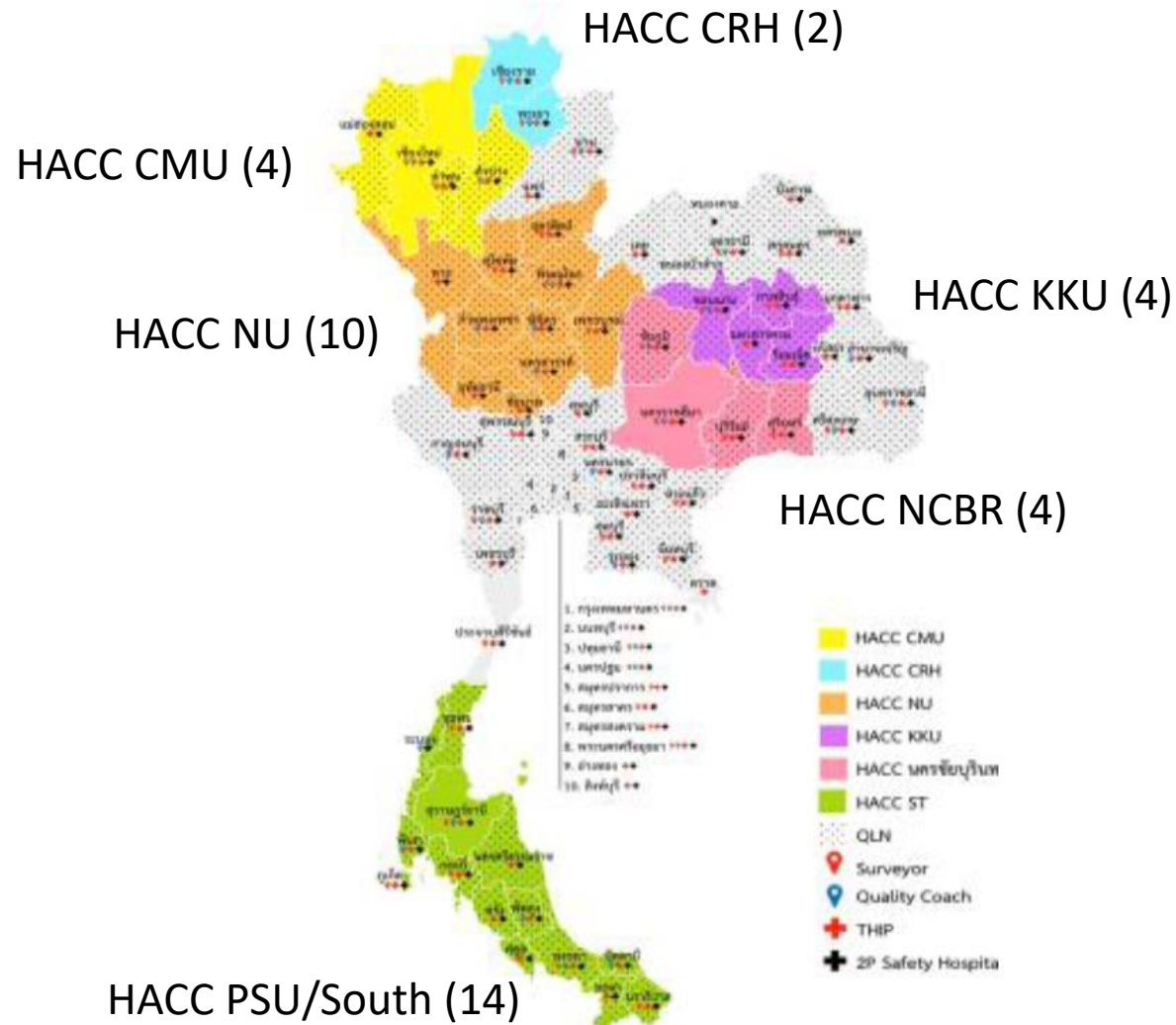
HA National Forum

- 1st (1999): Quality Improvement to Serve the Public
- 2nd (2000): Roadmap for a Learning Society in Healthcare
- 3rd (2002): Simplicity in a Complex System
- 4th (2003): Best Practices for Patient Safety
- 5th (2004): Knowledge Management for Balance of Quality
- 6th (2005): Systems Approach: A Holistic Way to Create Value
- 7th (2006): Innovate, Trace & Measure
- 8th (2007): Humanized Healthcare
- 9th (2008): Living Organization
- 10th (2009): Lean & Seamless Healthcare
- 11th (2010): Flexible & Sustainable Development
- 12th (2011): Beauty in Diversity
- 13th (2012): The Wholeness of Work & Life
- 14th (2013): High Reliability Organization (HRO)
- 15th (2014): Engagement for Quality
- 16th (2015): Imagination for Quality
- 17th (2016): Enjoy Quality Every Moment
- 18th (2017): Inner Power, Together We Can
- 19th (2018): Value, Quality, and Merit
- 20th (2019): Change & Collaboration for Sustainability
- 21st (2021): Enhancing Trust in Healthcare

A forum for

- Recognition
- Reward
- Sharing & Learning
- Inspiration
- Campaign
- Seeking new paradigm
- Networking
- Fun

HA Collaborating Center (HACC): Networks of Quality Coach



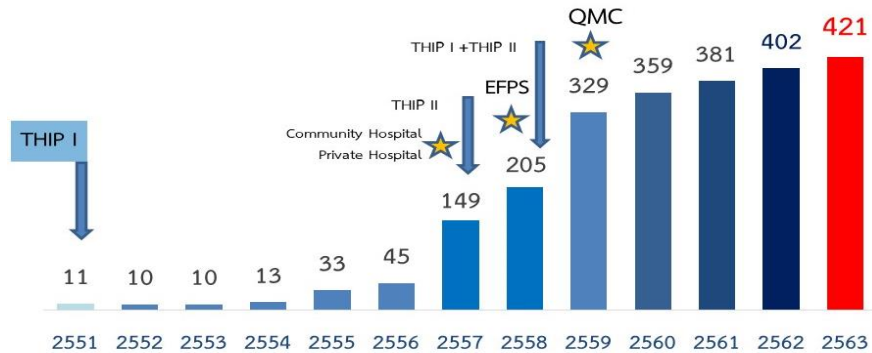
Roles of HACCs

- Education & training
- Consultation
- Knowledge management

Most HACCs are managed by university hospitals

Comparing Hospital Indicators (THIP: Thailand Hospital Indicator Program)

Number of member hospitals
(about 1/3 of all hospitals)

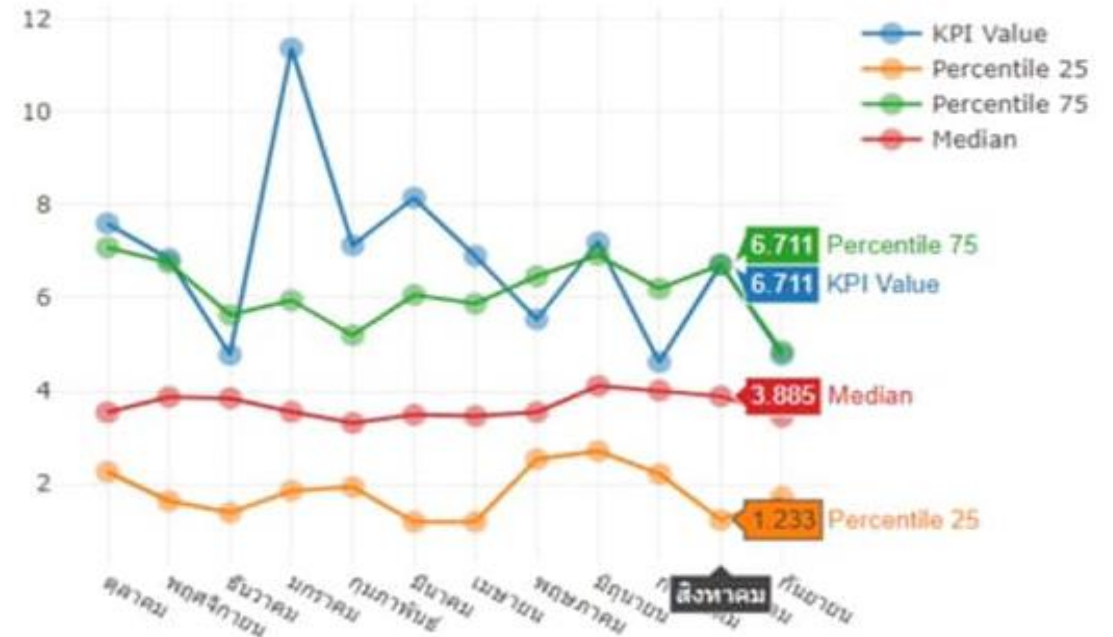


Type of hospital for comparison

- Public academic/tertiary care hospital
- Public general hospital
- Public community hospital
- Private hospital

Number of Indicators: 225

Ventilator Associated Pneumonia in ICU/1,000 vent. day



Patient and Personnel (2P) Safety Goals

Patient Safety Goals		Personnel Safety Goals	
S	S afe Surgery and Invasive Procedures	S	S ecurity and privacy of information and S ocial Media (communication)
I	I nfection Prevention and Control	I	I nfection and Exposure
M	M edication & Blood Safety	M	M ental Health and M ediation
P	P atient Care Processes	P	P rocess of work
L	L ine, Tube & Catheter, Device and L aboratory	L	L ane (ambulance), L egal Issues
E	E mergency Response	E	E nvironment & Working conditions

Patient Safety Goals : SIMPLE

Safe Surgery & Invasive Procedure



Surgical Safety Check list, SSI Prevention, Enhanced Recovery After Surgery, VTE Prevention , Safe Anesthesia, Safe Operating room (Safe Environment, Safe Surgical Instruments, Safe Surgical Process)

Infection Prevention & Control



Hand Hygiene, Prevention of HAI (CAUTI, VAP, CLABSI)
Isolation precaution, Control of MDRO

Medication & Blood Safety



Safe from ADE: Safe from High Alert Drug, Safe from Preventable Adverse Drug Reactions, Safe from Fatal Drug Interaction, Safe from Medication Error: LASA & Medication Names, Safe from Using Medication, Medication Reconciliation, Rational Drug Use, Blood Transfusion Safety

Patient Care Process



Patients Identification, Reduction of Diagnostic errors, Refer and transfer safety, Communication: Effective Communication, Communication during Patient Care Handovers, Communicating Critical Test Results, Verbal or Telephone Order, Abbreviations, Acronyms, Symbols, & Dose designation)
Preventing Common Complication: Pressure Sore, Fall, Pain Management: Pain Management in General, Acute Pain Management, Safe Prescribing Opioids for Chronic Non-Cancer Patients, Management for Cancer Pain and Palliative Care

Line, Tubing, Catheter and Laboratory



Catheter and Tubing Connection, and Flow Control, Right and Appropriate Laboratory Specimens and Testing

Emergency Response



Response to the Deteriorating Patient / RRT, Medical Emergency (Sepsis, Stroke, Acute Coronary Syndrome, Safety CPR), Stroke, Maternal & Neonatal Morbidity and Mortality (PPH, Safe labor at community hospitals Birth asphyxia), ER Safety

National Reporting & Learning System

Incident Type	E	F	G	H	I	รวม E-Up	รวม(ระดับ A-I)	ร้อยละ E-Up
Safe Surgery	972	475	35	40	34	1556	9172	16.96
Infection Prevention and Control	1118	439	10	3	50	1620	8850	18.31
Medication & Blood Safety	1479	206	3	21	21	1730	113277	1.53
Patient Care Processes	3274	797	62	219	272	4624	56073	8.25
Line, Tube, and Catheter & Laboratory	1448	144	5	32	11	1640	18227	9.00
Emergency Response	2257	737	112	623	837	4566	9528	47.92
Other (อื่นๆ ซึ่งไม่สามารถจัดเข้า SIMPLE ได้)	749	142	8	69	220	1188	15955	7.45
รวม	11297	2940	235	1007	1445	16924	231082	7.32

Thank You