

WHO-EM/HCD/128/E

Summary report on the
**Regional meeting on
tools and standards
to assess and improve
quality of care at the
primary care level**

Amman, Jordan
30 May–1 June 2016



**World Health
Organization**

Regional Office for the Eastern Mediterranean

Summary report on the

**Regional meeting on tools and
standards to assess and improve
quality of care at the primary care
level**

Amman, Jordan
30 May–1 June 2016



**World Health
Organization**

Regional Office for the Eastern Mediterranean

© World Health Organization 2016
All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement. The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Publications of the World Health Organization can be obtained from Knowledge Sharing and Production, World Health Organization, Regional Office for the Eastern Mediterranean, PO Box 7608, Nasr City, Cairo 11371, Egypt (tel: +202 2670 2535, fax: +202 2670 2492; email: emrgoksp@who.int). Requests for permission to reproduce, in part or in whole, or to translate publications of WHO Regional Office for the Eastern Mediterranean – whether for sale or for noncommercial distribution – should be addressed to WHO Regional Office for the Eastern Mediterranean, at the above address: email: emrgoegp@who.int.

Contents

1.	Introduction.....	1
2.	Summary of discussions	2
3.	Recommendations.....	10

1. Introduction

The WHO Regional Office for the Eastern Mediterranean has developed a set of quality indicators for primary care, through in-depth desk review, DELPHI study and a range of consultations with experts in the area of quality of care and patient safety during 2015. The draft indicators were refined through methodical pilot testing, a technical meeting with experts in Cairo (Egypt) in May 2015, and active engagement with country focal points for quality and safety in a meeting held in Tunis in June 2015. In total 34 core indicators were shortlisted that fall under six well established quality domains: access/equity, safety, efficiency, effectiveness, patient centredness and timeline. The indicators were piloted in ten facilities from each of the following four countries: the Islamic Republic of Iran, Jordan, Oman and Tunisia.

Preliminary test results of the pilot study indicate that there are numerous opportunities to scale up assessment and improvement of quality care at the primary care level within the Eastern Mediterranean Region. It is against this background that the WHO Regional Office for the Eastern Mediterranean held a regional meeting on tools and standards to assess and improve quality care at the primary care level in Amman, Jordan, from 30 May to 1 June 2016.

The meeting aimed to assist Member States in generating a roadmap to assess and improve quality care at the primary care level and raise awareness among the national quality and safety focal points on patient engagement and empowerment. Objectives were to:

- Discuss the situation of the quality of care at the primary care level and identify challenges across the Region;

- Share the quality framework for primary care developed by WHO and the experiences of piloting it in the four countries;
- Review and finalize the quality framework for primary care and its relevant indicators;
- Raise awareness among the national quality and safety focal points engagement and empowerment.

The meeting was attended by primary health care, quality of care, and patient safety focal points from ministries of health of 19 countries across the Region. Also in attendance were global and regional experts invited to present evidence and best practices related to quality of care at the primary care level. The meeting focused on four technical sessions, across the three days, related to the development and implementation of core indicators to assess and improve quality of care at the primary care level, and how to successfully utilize patient and community engagement in reaching this goal.

2. Summary of discussions

Quality in primary care

A strong and sustainable primary care system is undoubtedly the most crucial and integral part of any health care services. However, it is often undermined as the ‘weakest link’ in the system. The Region faces crucial challenges in chronic disease management, health promotion and prevention, refugee health and ensuring safe care in conflicts. These challenges, alongside the growing number of noncommunicable diseases, mean the case for change is stronger now than ever. A system that is able to measure these changing needs and quality gaps with adaptive management to respond is crucial for the system to overcome and address the challenges. However, measuring quality is not enough; the data need to be accurate and reliable, and

must be fed back to the community, health professionals and policy-makers in order to optimize system preparedness. Particular focus must be put on service delivery and patient safety as it is critical to the level of quality provided and its impact. When finalizing quality indicators, context matters, as shown from the results of pilot testing, intracountry variation must be taken into consideration, as well as socioeconomic norms. The final indicators must therefore be ‘adapted and adopted’ to feed into the country context. Strong leadership and a multidisciplinary approach are crucial in the implementation of these indicators.

WHO framework on integrated people-centred health services

Primary health care must be centred on the needs of the people, to deliver the most efficient and effective care possible. WHO has developed a global framework on integrated people-centred health services, to support this people-centred vision. The framework pushes for equal access to quality health services that are co-produced in a way that meets their life course needs and respects their preferences. Services should be coordinated across the continuum of care and be comprehensive, safe, effective, timely, efficient and acceptable. All carers should be motivated, skilled and operate in a supportive environment. The framework is focused around four strategic directions: empowering and engaging people; strengthening governance and accountability; reorienting the model of care; and coordinating services within and across sectors. Reorienting health systems toward strong primary health care is a key strategy to achieving integrated people-centred health services. Performance assessment and quality improvement can be entry points to strengthen primary health care. With granular, actionable and routine data, along with partnership and the alignment of stakeholders, primary care

systems can successfully produce the outputs and results expected to support the growth of primary health care in the Region.

Primary health care performance initiative

The primary health care performance initiative will help countries achieve the health-related Sustainable Development Goals (SDGs) and universal health coverage by catalysing improvements in primary health care systems through improved measurement, and sharing of best practices and practical tools to manage and improve delivery of essential health services. High-performing primary health care systems are central to reaching global and country-specific goals, achieving universal health coverage, and advancing gains against infectious diseases, maternal and child morbidity and mortality and noncommunicable diseases. The founding partners of the initiative aim to support countries in accelerating progress towards the achievement of the health-related SDGs through better performance measurement, knowledge-sharing of best practices between countries, and the joint development of practical tools to manage and improve delivery of primary health care services. The Initiative will build on existing data and generate new data where needed to support countries in focusing on how to improve the performance of their primary health care systems.

Development of the core quality indicators

The 34 core quality indicators tool developed by the Regional Office responds to the previous lack of information on quality and safety of the health care services within primary health care. The core indicators are to be used by primary care facilities to assess, report on and monitor the quality of care at primary health care level. When

developing the tool, universal health coverage was seen as the overarching goal, taking into consideration regional priorities.

The methodology of the indicators included literature review, candidate indicators, DELPHI survey, pilot test, second review by experts (May 2015) and validation of the refined list with national focal points from 19 countries. The initial list of indicators that was shared with the participants during the meeting includes 34. The meeting offered the opportunity to gather additional feedback from the experts and participants on the importance, the amenability to intervention and the feasibility of these indicators. This exercise allowed further refinement of the initial list of indicators and so some of these indicators were reformulated while others were dropped from the list to avoid any overlap with others. The final list includes 32 indicators.

During the discussion particular focus was put on the ‘scaling up’ of indicators and on their sustainability. It was emphasized that WHO must work with countries to integrate these indicators into their current efforts.

Pilot implementation of quality indicators in four countries

The quality tool was pilot tested through a five-step implementation process in four countries: the Islamic Republic of Iran, Jordan, Oman and Tunisia. First, four experts were identified in each country (quality of care and primary care). Second, ten pilot sites for implementation were nominated. The third step was clarification and support through consultation with experts on the quality tool, metadata and deliverables. The last steps were follow-up and the compilation and analysis of the reports. Through the pilot implementation process came the identification of key challenges and important lessons learnt,

all crucial for the successful roll-out of the core indicators across the Region. All four countries gave a brief summary of their experience and methods used to implement the quality indicators.

Overcoming challenges within the Region

It was reiterated that indicators must be adapted and adopted into existing country contexts, and the challenges within these countries must be recognized as a factor when rolling out the core indicators. Lack of supervision and commitment, as well as lack of systematic governance and restrictions on human resources, were also discussed as hindrances and barriers to implementation. Conflicts and wars within the region were also mentioned as a key factor preventing many countries from implementing fully all of the core indicators. The discussion focused around ‘doing what you can’ to adopt these core indicators, depending on the intra-country situation, some indicators may be easier to adopt than others, and some may need to be adapted to the country context.

International experience and best practice

The United Kingdom implemented the Quality Outcome Framework (QOF) in April 2004, aimed at increasing performance at the primary care level. QOF was based around a number of indicators, each indicator was allocated points, and each point earns a practice a certain income. In 2004 QOF covered 11 clinical domains, and a further seven were added in 2006, including depression, dementia, obesity and palliative care.

The initial impact of QOF was vast; there was improved morale among general practitioners, measured through better recruitment and retention of workforce. There was greater organization around chronic

disease management and secondary prevention, and all-cause and cause-specific mortality rates declined over the study period. However, despite the higher reported achievements under QOF, there was no evidence to suggest reduced incidence of premature death in the population. There are plans to redesign QOF with new models of care, in order to prevent the implications of using an outdated model.

There is a lot to learn from the results and outcomes of QOF, specifically on the importance of the sustainability and impact of quality indicators. Results suggest that to be able to create meaningful and lasting changes to the system, multi-disciplinary action must be taken. Patient safety was also a running theme throughout the discussion, and it was recognized that patient and community engagement must come into play as an integral factor when rolling out these indicators in the Region.

Keys actions needed to roll out the quality framework

The existing health system must support the current strategy at national level. Information systems and resources also need to be assessed in the preparatory phase. Leadership roles should be defined according to the country context. For the process to be sustainable, the rationale behind the indicators needs to be clear in each country context (e.g. link the indicators to disease burden and national and international strategy). Key strategies were outlined for implementation: pilot study (start where you may likely succeed); data analysis; adapting the indicators; expand planning; and regulation and supervision system.

The participants also suggested that a steering group should be set up with clear roles and clearly defined terms of reference. The frequency of collection must be regulated and data must be reviewed and

validated by trained staff. A multidisciplinary team should also be set up at the facility level to facilitate the implementation process. This process should be reviewed early on before starting to scale up the implementation. WHO will be needed in support of these processes to monitor progress, for technical support and to support advocacy efforts.

There are some challenges that may impede the adoption of implementation of the indicators such as the shortage of resources, resistance at facility level, logistic issues, lack of skills, and the difficulty in reaching a consensus at national level.

Patient, family and community engagement and empowerment

For primary health care facilities to deliver safe quality care, patients and families must be placed at the centre. Engaging patients, families and communities is a mechanism to facilitate and foster collaboration between patients, families, communities, health care providers and policy-makers. It allows for the opportunity to empower and build capacity for patients and families, as informed and knowledgeable health care partners.

The patient, family and community engagement interventions aim to move beyond the financial commitments of universal health coverage and focus on delivering safe quality care for people that recognizes responsibilities, values and cultures. Community engagement is extremely important as it focuses on the societal structure as a whole, not just health services.

Within primary care, open communication between patient and doctor is vital. Focusing on patient and family engagement builds this partnership and allows for open disclosure and shared responsibility.

Often families are the direct care givers or those who give consent, they should not be overlooked as a powerful influence that can help strengthen the system as a whole.

The group discussions highlighted that in the current situation, patient and family rights are an integral part of the accreditation process and this is something all health care professionals should be aware of. Current initiatives included: campaigns in shopping malls, health initiatives in communities and villages, and the involvement of patient groups. Community members should be members of accreditation boards and patients should play an important role in the development and use of safety checklists.

The participants indicated that it was a challenge to provide what the community needed due to lack of commitment to the community and regular changes in policies and leaders. There should be a balance between community expectations versus national capacity and resources; political turnover, competing priorities; lack of preparation of the community (health literacy, knowledge, attitudes and practices, knowledge about rights and entitlements). The proposed solutions to overcome these barriers include education and structural training programmes, as well as campaigns and sharing experiences. Stakeholders include families, schools, media and social media groups, and community and religious leaders. It was suggested that a workshop should be organized to raise awareness, in which media, community, civil society and accreditation all should participate. It was also suggested that more importance should be placed on incorporating community and civil society engagement in the formation of accreditation standards. Quality and safety policy should be improved to include patient engagement, and a more representative committee should be formed.

3. Recommendations

To Member States

1. Establish or use an existing steering committee or available high-level structure (with defined terms of reference) chaired by a senior official at the Ministry of Health and with the membership of all priority programme managers to plan and oversee assessment and improvement of quality of care at primary care level and report progress of work to the Ministry on a regular basis. [June and July 2016]
2. Build on the existing relevant activities and programmes, review ongoing quality of care activities and interventions at the country level (conduct rapid situation analysis), identifying major challenges, opportunities and priorities to implement phase 1 of the WHO framework for assessment and improvement for quality of care at primary care level. [July and August 2016]
3. As part of the responsibilities of the above-mentioned national steering committee, strengthen coordination, partnership and alignment with major stakeholders and different care providers at the national and subnational level including the private sector, other public health care providers, nongovernmental organizations, patients and communities etc. [September 2016]
4. Adapt the WHO framework for assessment and improvement of quality of care at primary care level based on the health system infrastructure, national and local capacities, community needs and priorities, cost effectiveness and burden of disease. [October 2016]
5. Prepare for the implementation phase, i.e. collecting tools to be used during implementation phase, building qualified teams at different levels to oversee and manage the assessment, integration and improvement of quality of care at primary health care facility

- level, planning for capacity building activities (managers and care providers) and updating guidelines, standards and protocols for service delivery at primary care level. [November and December 2016]
6. Decide on the first phase implementation areas with defined criteria and train the target area stakeholders including care providers. [December 2016]
 7. Collect and analyse data, identify gaps in delivery of quality primary health care services and identify local interventions that can improve quality of care at structure, process and outcome level related to: access and equity, safety, efficiency, effectiveness, people centredness and timeline domains. [January 2017 to March 2018]
 8. Plan for continuous monitoring, supportive supervision and corrective actions based on findings, documentation and evidence. [continuous process]
 9. Prepare a report on outcomes of the implementation of the programme in the first phase area/s and present the outcomes, achievements and lessons learnt to national and subnational policy-makers and stakeholders and plan for scaling-up of quality at primary health care facilities. [April and May 2018]
 10. Facilitate exchange of experiences between different facilities. [continuous process]

To WHO

11. Develop an expanded list of indicators for those countries that want more detail. [June–July 2016]
12. Take an active convening role in briefing policy-makers and coordinating with partners at the regional and national level based on country needs and priorities. [continuous process]

13. Provide technical support for national and subnational capacity-building activities using the available expertise in the Region. [as per country request]
14. Facilitate exchange of experience between countries and establish a website or platform for uploading tools, standards and guidelines that can assist Member States in moving forward their national plan. [continuous process]
15. Facilitate intercountry collaboration within and outside Region on improving quality of care at primary care level. [June 2017]
16. Monitor implementation, collect progress reports and prepare for developing a technical paper to be presented at the 65th session of the Regional Committee. [October 2018]



World Health Organization
Regional Office for the Eastern Mediterranean
P.O. Box 7608, Nasr City 11371
Cairo, Egypt
www.emro.who.int