US FULBRIGHT PROFESSIONAL EXCELLENCE TEACHING SCHOLAR PROGRAM

Fulbright-Nehru Project Title of the Academic Scholar program

Enhancing Quality and Improving Patient Safety (EQuIP) Program in Healthcare

EXECUTIVE SUMMARY

Project Director : Prof. JUZAR ALI MD FRCP FCCP, CMO LSU HEALTH, NEW ORLEANS ,USA

Physician Champion (INDIA) : Paltial Palat MD, Associate Professor ,NHL Municipal Medical College, Ahmedabad,Gujerat

BASE SITE: NHL Municipal Medical College , Ellisbridge, Ahmedabad ,INDIA

Background

The challenge of Health Care Delivery within the global prism of Quality Care, efforts at enhancing wellbeing of the population and /or treating acute and chronic conditions is universal in all countries. The only difference is the priority and focus each system gives or can afford to give to this challenge. The response to this challenge is based on the demands on the systems and the resources available.

Imparting Education and Increasing awareness of these challenges to the trainees, health care professionals and providers of care has its own limitations and can be clouded by the inherent bias and constraints within this group, no matter where one practices in the world.

Health Care in India remains a dichotomy, that is not unique in developing and resource challenged countries. The public sector health care in India suffers from an imbalance of demand/capacity and available or identified resources. Attempts to improve delivery of services in public services with preventive and public health initiatives have been partially successful, but with no documented impact. It is also acknowledged that mere investment of resources and monies is not the answer to the improving health care of the population. The private sector, where most Indians seek healthcare, varies greatly in regulation, quality, efficiency and patient centeredness. Costs are generally covered by out of pocket means. In either of these settings it is not clear whether the population is always getting quality standardized care across the board, and if they are, how is this being monitored and evaluated.

**The within-country range of quality of doctors may be 10 times as great as the between-country range. Such wide variation strongly suggests that efforts to improve health status must involve policies that change the quality of clinical care. The process of providing care in developing countries is often poor and varies widely. A large body of evidence from industrial countries consistently shows variations in process, and these findings have transformed how quality of care is perceived (McGlynn and others 2003). A 2002 study found that physicians complied with evidence-based guidelines for at least 80 percent of patients in only 8 of 306 U.S. hospital regions (Wennberg, Fisher, and Skinner 2002). It is important to note that these variations appear to be independent of access to care or cost of care: Neither greater supply nor higher spending resulted in better care or better survival. Studies from developing countries show similar results.

This brings us to the core question. Do all systems and patients in diverse geographical and socio-cultural settings deserve some basic standardized quality of care imparted with conscientious considerations of safety, value and service? The answer to me is unequivocally yes. The practical question, however, is how to do this, given the constraints of matching demand to capacity of service.

In my mind the common denominator in this dilemma and the overarching theme is to establish increased awareness of and imparting enhanced education to providers of care , that emphasizes the chiasms of Quality of Care across the board , no matter whether one is dealing with an acute infectious disease case, managing a chronic medical condition or dealing with a high intensity rescue condition or managing a surgical emergency, and no matter if it is in a urban high resource setting or a semi –urban or rural area and irrespective of payer mix , types of patients/clients

To improve and enhance awareness of Quality and Patient safety requires structural and process enhancement and measurement of outcomes. Structural resources either in the form of manpower and or supplies and facilities play a part, but that will not be enough nor will that be an acceptable approach in resource challenged settings. There are too many demands on resources. However Process Improvement definitely can play a role in enhancing quality and patient safety and outcomes unrelated to disease and disease severity or morbidity. Processes that lead to standardization of care, patient /healthcare provider engagement and accountability and patient experience satisfaction can be more measurable and meaningful. The framework established by IOM's in its landmark report, *crossing the Quality Chiasm* focuses on 6 aims: Patient safety, effective care, patient centeredness, timeliness of care efficiency in care and equity of care and these form part of the core curriculum

The proposed EQuiP academic scholar program will create a template of this curriculum, then topicalize it to the system and venue in India it is applying to, and seek comparably uniform outcomes from the patient and provider perspective. This can be achieved by defining quality, establishing processes with buy in and incentives and measure outcomes. It is not intended to regulate or seek legal oversight but to impart education and increase awareness to enhance the "culture of care"

Although the quantity rather than quality of health services has been the focus historically in developing countries, ample evidence suggests that quality of care (or the lack of it) must be at the center of every discussion about better health. These deficiencies in quality of care represent neither the failure of professional compassion nor necessarily a lack of resources (Institute of Medicine 2001). Rather, they result from gaps in knowledge, inappropriate applications of available technology (Murray and Frank 2000), or the inability of organizations to change (Berwick 1989). Local health care systems may have failed to align practitioner incentives and objectives, to measure clinical practice, or to link quality improvement to better health outcomes and an increased awareness and “culture” change is needed. The basics of aiming for the Quality Chiasm cannot be compromised even when given the constraints of resources. Only the methodology needs to be modified.

A literature review of the system via the Medical Council Of India data reveals that whereas there may be pockets of excellence in clinical practices in certain centers like All India Institutes of Medical Science, the emphasis on and in established conventional medical curriculum and processes and pathways focusing globally on Quality of care /Performance matrices and Patient safety is acutely lacking. Verbal communication with opinion leaders in India in the practicing medical fields over the year that I have had the opportunity to discuss confirms the lack of such structured programs and endeavors

The answer therefore lies in creating awareness of quality of care, standardized evidence based protocols and programs of care emphasizing the basic dictum of patient safety both at the public and private health facilities independently. This must go further with a premise that such a program is as important in treating a rural based patient under the public sector as it is in a facility based unit catering to privately funded patient. Understanding that such two systems may well be within a city block and not necessarily miles apart , patients in both these systems deserve the Quality and Patient safety programs to give cost effective care and improve outcomes . Further, pharmaceutical drug costs account for a substantial expense in health care and additional non -regulation of prescribing processes potentially further adds to overuse and misuse of medicines and directly and indirectly impacts treatment outcomes and increased chances of failed treatment and drug resistant disorders. This unique combination of core medical expertise performing in this ambience makes India the right substrate for such a program.

In those areas, it is not regulatory or legal mandates that work because there is always a work around. What works in the concept of professional buy in, establishing comparative analysis and the culture to do the right thing? My academic curriculum plan as envisaged with a right blend of data, processes, experience, and passion and yes, some cynicism, will try to impart that education across the landscape. I know I can be more effective in introducing this concept of Quality of Care with all its domains, knowing the challenges of resources and demands on capacity first hand.

Hypothesis:

Inspired by the existing framework of *Quality Chiasm of* Patient safety, Effective care, Patient centeredness, Timeliness of care, Efficiency in care and Equity of care, this Enhanced Quality Improvement and Patient Safety (EQuIP) program in resource limited health care and delivery environment will use standardized modules. Dr Juzar Ali with the local leadership proposes to establish a collaborative regionally sensitive program in partnership with local leaders in pilot health care settings in Gujarat, India. He will strive to augment patient and provider perspective and increase awareness among medical colleagues to enhance the "culture" of safe and quality oriented patient care across the board.

Specific Aims

At the end of the project/program, the participants will have

1. Increased Awareness of the Quality Improvement and Patient Safety programs in their unique clinical settings
2. Developed topically suited Process Improvement Methodologies based on specific needs assessments in their clinical settings
3. Establish protocols and checklists to enhance the framework of the *Quality Chiasm* of Patient Safety , Effective Care, Patient Centeredness, Timeliness of Care, Efficiency in Care and Equity of Care

Locales and Venues

Under the banner of the team of the Project Director and the Physician Champion, the following 4 sites in the Ahmedabad area will act as a clinical base substrate and focused on:

1. Academic Clinical setting NHL /VS hospital
2. Private Hospital ---TBD with consultation of NHL team
3. Multi-disciplinary Ambulatory Surgical Center- TBD with Consultation of NHL team
4. Semi urban –rural ground level clinic –TBD with Consultation of NHL team

Each site will have an identified Liaison/Coordinator/Champion depending upon organizational structure

Invited Participants in each venue

1. MD Leadership and Faculty
2. Students and trainees
3. Medical and paramedical staff
4. Patient Representative/Advocates if available and applicable

Theme/Curriculum across the spectrum of 1. Access 2. Availability 3/. Value of care /4. Process Improvement/ 5. Patient Experience/ 6. Core Primary Care and 7. Specialty Measures/Disease specific Outcomes

A: Core Curriculum outlining elements of Quality of Care/Performance Measures

B: Role and limitations of regulatory and legal requirements if applicable

C: Elements of Quality with differentiation of structure, process and outcomes & Quality Improvement in Processes with PDSA/PDCA cycles and Root Cause Analysis , RCA processes and importance of SENTINEL EVENTS in practice and in hospitals

D. Importance of Disease specific Performance Measures

E: Population-Level Considerations

F: Establishing Peer Review processes, Incident, Focused and Ongoing Peer review components through Medical Staff engagement,

G. Structured Comprehensive Site Specific Quality Meetings

Specific methodologies

1. Medical Staff meetings & Brain storming
2. Trainee sessions : Didactic and small group discussions
3. M&M type Case Conferences with standardized and real life Clinical Vignettes
4. Data Analysis and Interpretation

General Methodologies

The design of the EQuIPS Teaching program will be geared towards

1. Discussion towards establishing a Quality/Patient Safety Curriculum at the medical college level
2. Creating processes and pathways for Performance measures in clinical venues of these medical colleges related to chronic conditions and standards of care practices
3. Expanding on existing infrastructure to design pathways of Ongoing and Focused Peer Reviews of practitioners within practices both in hospitals and in multidisciplinary ambulatory centers

4. Pioneering methodologies to review Incidents and sentinel events in the format of Root cause Analysis
5. Specific modules will include interactive course lectures, small group discussions and focused QI directed workshops.

EVALUATION & EXPECTED OUTCOMES

PROGRAM

The proposed pilot programs as above in the four settings will then generate additional interest and ripple effect with the buy in of the local leads

PATIENTS /POPULATION

Quality Health Care is the demand to be met for all populations with structured steps that depict processes of Quality Assurance /Performance measures

ENGAGED STAFF AND PROFESSIONALS

Awareness of the importance of these specific venue based Quality and Patient Safety based program will incorporate Self Evaluation and Continued Professional education by physicians

INSTITUTIONS

Once they adopt these culture changing game changing programs will find benefit from self-evaluation and self-improvement and structured quality ratings beyond the word of mouth of incidental anecdotes

SUSTAINABILITY OF THIS PROGRAM

This element is always considered important in any program. Rightly so. It is my plan that as I start increasing awareness and imparting educational tools at different venues, I will develop a core India team. The cadre of providers coming up the chain can then adapt to and adopt these programs on an ongoing basis. Remote ongoing tele-video communication will enable developing continuation modules of these programs with LSU beyond the duration of the grant program. Through the school /professorship funds and other allied grant funds, I have the support at LSU to engineer that and an ongoing academic collaboration between institutions and individuals in India and US can be developed and fostered.

CHALLENGES ANTICIPATED

1. “Selling” this concept
2. Buy in of local leads
3. Why should they do so?
4. What do they get out of it?
5. Convert the Passion to Cynicism (PC) ratio from infinity to 1; who cares?
6. Engage the administration of the health Care entities
7. Enhance the coordination between officials and private field leaders
8. Where do patients and patients advocates come in ?
9. Overcome the potential cynicism of Alternate Medicine pathway
10. Overcome the perception and potential danger of “once this is out of sight it is out of mind”

Requirements from Base Host Institutions
General Letter of support to cooperate and provide available infrastructure support
Direct Formal Letter of Affiliation through the US Fulbright – Nehru India Office and IIE
Logistical and Operational Details to be mutually decided with remote consultation face to face meeting

References and Reading Material and examples of curriculum/agenda on file and part of the consolidated dossier

Respectfully submitted

Juzar Ali, MD FRCP FCCP
Klein Endowed Professor of Medicine, Section of Pulmonary CC Med, LSUHSC
Chief Medical Office /Health Administration LSU HEALTH NETWORK
LSUHSC/School of Medicine
NEW ORLEANS, USA
Fulbright-Nehru Scholar Program Dec 2016- March 2017