The doctor reads the slides and adds few examples

I'm sorry for any mistake In advance

……
……

***Three Steps of the Quality Control Process**

1. The criterion or standard is determined.
2. Information is collected to determine whether the standard has been met.
3. Educational or corrective action Is taken If the criterion has not been met

***Steps of the Quality Control Process In details**

- Establish control criteria
- Identify the Information relevant to the criteria.
- Determine ways to collect the Information.
- Collect and analyze the Information.
- Compare collected Information with the established criteria.
- Make a judgment about quality.
- Provide Information and, if necessary, take corrective action regarding findings to appropriate sources.
- Re-evaluation

***Standards**

- Predetermined level of excellence that serves as a guide for practice.
- Must be objective, measurable, and achievable.
  For example: It is not right to aim for “low rates of infections” as a criterion; because “low” by itself can’t be measured or identified; it differs from one person to another that’s why we have to set a number for this criterion to be measurable & achievable, for example: “we want to achieve a rate of infections < 6%”.
  Bottom Line: I don't want the description as a criterion “low”, I want It as number “< 6%” which can be measured so that I can make a decision
- No one set of standards fits all organizations.
  The standards of the Hospital X differ from the standards of the hospital Y ,, and the standards of the hospitals differ from the standards of the clinics
- Organizational standards are found In policy and procedure manual which help us to achieve these standards,

We said last time, that policies & procedures will tell us the guidelines, and also they will standardize the following procedures we are about to do,
For example: We want all the Drs to deal with the patients following one procedure, not every Dr in his own way.

- American Medical Association has played a critical role in developing standards for the medical profession.

***Clinical Practice Guidelines**

- In 1970s there was a shortage In physicians so there was a necessary for using the junior physicians to deal directly with the patients, and for this a guideline was created for diagnosis & treatment, which those juniors must follow, because they have little experience, and we don't want the medical service to be delayed, until the specialist is free.
- Provide diagnosis-based step-by-step Interventions for providers to follow in an effort to promote quality care.
- Also called standardized clinical guidelines.
- Should reflect evidence-based practice (EBP); that Is, they should be based on cutting-edge research and best practices.

***Standards of Practice**

1. Assessment
2. Diagnosis
3. Outcomes Identification
4. Planning
5. Implementation
6. Evaluation
7. Quality of practice
8. Education
9. Professional practice evaluation
10. Collegiality
11. COLLABORATION (with the patient, family,
1. and others)
12. Ethics
13. Research
14. Resource utilization
15. Leadership

-how can I collect data? Through using something called "audit"

***Audits as a Quality Control Tool**

- An audit Is a systematic and official examination of a record, process, structure, environment, or account to evaluate performance

- three types of audit

1. Retrospective audits: when is it performed? After happening/occurrence of things, such as after administering the drug or after the operation and this type is dangerous because the thing happens then I want to know why. Example: the patient died and after that I want to know why by reviewing his file and see what medications he was taking.
2. Concurrent audits: are performed while the patient is receiving the service.
3. Prospective audits: attempt to identify how future performance will be affected by current Interventions. (before the service is provided)

- The audit should be done for :
    - Structure
    - Process
    - Outcome

Structure audits: assume that a relationship exists between quality care and appropriate structure. (Components of the structure is Input)

Process audits: the relationships between the Input elements

Outcomes: the end results which I plan to achieve

- While outcomes are an important measure of quality care, it is dangerous to use them as the only criterion for quality measurement.

***Quality Assurance vs. Quality Improvement**

- Quality assurance models seek to ensure that quality currently exists Ex: X hospital tries to Assure the quality , It tries to find the falling down ,Infection rates … It has standards and measures by them
- Quality Improvement models assume that the process is ongoing and that quality can always be improved. (It Is better than the Quality Assurance)… Now, It isn't acceptable just to have assurance, their must be improvement too.

*Total Quality Management Principles: one of the models that teaches how to gain the quality (قراءة ذاتية، غير مطلوب)

*HCAC –Health Care Accreditation Counsel in Jordan-, National Quality & Safety Goals2010, Jordan (للاطلاع)

First goal: before starter of any procedure, full identification is a must (not only the name).

**Second goal: if there is no good administration of high alert medications (like: insulin), the patient might die.

**Third goal: for example: a patient is about to have nephrectomy, the site (right or left) must be marked be4 going to the OR.

**We don't achieve the 5th and last goal unless the first goal is already achieved- the most important.

NEW TOPIC…

*fiscal planning

- Fiscal planning is not Intuitive; It Is a learned skill that Improves with time (practice).4 ex: the way you deal with your money differs by time.
- Fiscal planning requires vision, creativity, and a thorough knowledge of the political, social, and economic forces that shape health care. - It is very important on the level of the organization to look at everything in the country, including insurance companies.
  For example, the country can't simply allow all citizens to do their checkups in both private and governmental hospitals as they wish; because this will create overload pressure on private hospitals, and then changes in the structure and service are a must in these hospitals to acquire all this.
- Cost containment: effective and efficient delivery of services while generating needed revenues for continued organizational productivity - For example you want to buy shoes and the seller told you that Its price Is 20 dollar, now you negotiate the seller to get the shoes at less price 17 for example but the seller will tell you that if he goes below the last price, it won't be sufficient because he pays the cost of electricity and water from the 17 dollars, same thing with health care services; when a patient comes for a visit –مراجعة-, it'll cost him about 15 JDs, why not 12? Because we are paying for electricity, water, security men, etc from these 15 JDs so I must contain the price of the service and don't serve It with losing

- Cost effectiveness: the product is worth the price, cost doesn't always equal the quality In terms of health care.
  - for example you may go to a doctor and he spent an hour with you and you pay 20 JD and may go to another doctor and spent 10 minutes with you and you pay 20 JD … so the quality didn't equal the cost of the service *cost is never related to the level of health care provided
- Responsibility accounting: each of an organization's revenues, expenses, assets, and liabilities Is someone's responsibility
  - This mean that every dinar In the hospital there Is someone responsible for It … the manager has the money... he buy the tools and send them to the stores now Its responsibility of the officers In the stores >> the stores send the tools to the clinics now it's the clinics' responsibility, and the clinics use them for the patient and the patient pay to get these tools benefits..
  Meaning: The money paid by the manager to buy these tools, were back to the hospital when the patients pay… which means that everything in the hospital is the patient's responsibility; so, it isn't acceptable that u as a Dr, to take some medications with you from the hospital to home, because this is stealing, u r not paying for it, the hospital will lose. Our governmental health sector is losing due to this.
- Forecasting Involves making an educated budget estimate using historical data
  The budget Is estimated not real.
- Budget: a financial plan that estimates expenditures and revenues by an agent for a stated future period.
- Fiscal planning requires flexibility, ongoing evaluation, and revision.
  - If the budget of a hospital Is 12 million (1 million every month) and the hospital spent 2 million In one month, there is an error, so It should be flexible and It should do evaluation and revision to know why there Is an Increase In the expenditures and why what I planned doesn't appear In the right way

***Expenses Classifications:**

- Fixed expenses do not vary with volume, whereas variable expenses do. e.g.
  - fixed expenses: manager's salary
  - variable expenses: cost of supplies, ex.: cost of syringes.
- Controllable expenses can be controlled or varied by the manager, whereas noncontrollable expenses cannot. e.g.

- Controllable: the number of personnel working on a certain shift, ex.: only one Dr. is shifting, and this is controlled.
- Noncontrollable: overtime that occurs in response to an emergency. Ex: Today I need one doctor working overtime, but In the next day I need more than one because the cases of the patients are complicated

- Can Expenses be Fixed and Noncontrollable? No

- Can expense be fixed and controllable? Yes

***planning is a process contains: (Steps in the Budgetary Process)**

1. Assess what needs to be covered in the budget.
    - Input from all levels of the organizational hierarchy.
    - A composite of unit needs In terms of manor, equipment, and operating expenses can then be compiled to determine the organizational budget.
2. Develop a plan.
    - Fiscal-year budget can be broken down into monthly, quarterly, or semiannual periods.
    - Budget is predicted too far in advance → ↑error (will increase) - I can't make a budget for 3 or 5 years because the health care system Is changed daily
    - Budget is shortsighted, compensating for unexpected major expenses or purchasing capital equipment may be difficult. - Example when the H1N1 Infection appeared It was not Involved In the budget (because the budget Is estimated) so the tests for people was not free even for the workers themselves, we needed money to run the tests.
      *to have +5%, -5% on the budget can be handled, but +50% is totally unacceptable; this means that the whole estimate was wrong.

3. Implementation.
    - Ongoing monitoring and analysis.
    - Top-level managers must watch for and correct unrealistic budget.
4. Evaluation.
    - The budget must be reviled periodically and modified as needed throughout the fiscal year

***Types of Budgets**

1. <u>The Personnel Budget</u>

- The largest of the budget expenditures is the workforce or personnel budget because health care is labor Intensive.
  - the care of one patient require many workers (doctor, nurse, Laboratory technician) so the workforce In the hospitals Is large because they serve specialized different medical service
- A manager must monitor the personnel budget closely to prevent understaffing or overstaffing.
- Staffing mix: the mix (percentages) of licensed and unlicensed staff working at a given time.
- When shifting, a specialized Dr. will be more paid than a non-specialized Dr.
- The manager must be aware of the patient acuity, i.e: a patient in ER differs from a patient in hospital room, that's why seniors are sent to ER.
- The personnel budget Includes actual worked time (productive time or salary expense) and time the organization pays the employee for not working (nonproductive or benefit time).
  - For example the nonproductive time >> the yearly vacation and the motherhood vacation (the hospital pay for us while we are sitting In the house)

-The productive time >> is the actual workload of the worker

2. <u>The Operating Budget</u>

- The operating budget reflects expenses that change in response to the volume of service, such as daily expenses as the cost of electricity, repairs and maintenance, and supplies.
- Supplies are the second most significant component in the hospital budget next to personnel costs.

3. <u>The Capital Budget (which need big capital)</u>

- Capital budgets plan for the purchase of buildings or major equipment, which Include
  - A long life equipment (> 5-7)
  - Is not used In daily operations
  - Is more expensive than operating supplies.

Example: buying MRI Machine which is highly costing, 100/200 thousand JDs, isn't like buying 20,000 syringes or cotton swaps which cost 500-1000 JDs

- In addition to the original price cost, examine the costs of Implementation, Installation, upkeep, and technological updates.
  - When I buy a machine I try to buy long Warranty with It

How can I do the budget?

***Budgeting Methods**

1. Incremental Budgeting

- Multiplying current year expenses by a certain figure, usually the Inflation rate or consumer price Index, this method arrives at the budget for the coming year.
  - Example: If I want to make a budget for the coming year so –for example- If the price of the petrol Increase by 7% so the new budget Is /the current budget *7%/ and so on
  -ex. On inflation rate -حجم التضخم– :if the inflation rate in the country = 30%, the new budget is /the current budget *30%/
  - simple and quick
  - requires little budgeting expertise
  - no motivation to contain costs
  - no need to prioritize programs and services

2. Flexible Budgeting and New Performance Budgeting

- Are budgets that adjust automatically over the course of the year depending on variables such as volume, labor costs, and capital expenditures.
- Costs can be allocated on a volume basis.

***critical Pathways**

- Are predetermined courses of progress that patients should be making after admission for a specific diagnosis or after a specific surgery.
- They do provide some means of standardizing medical care.
- Difficulties In accounting for and accepting what are often justifiable differentiations between unique patients.
- Pathway documentation challenge.
- This pathway is similar to the clinical guidelines mentioned above.
- Ex.: a patient arrived with heart symptoms, we should walk along a defined protocol with him, NO trials shall be made on the patients.

***Health Care Reimbursement**

1. Fee for Service (FFS) … the patient pays to get the service

- Reimbursement was based on costs Incurred to provide the service plus profit.
- FFS reimbursement → clients' overtreatment → ↑ gross domestic product (GDP).

2. <u>The prospective payment system</u>
   - The patient pays before getting the service, for example: a patient has recurrent tonsillitis, and he wants to have tonsillectomy, he'll go to the Dr., which will tell him that if he goes to hospital X, he'll pay 200 JDs, while in Y, it's 300 JDs, when he goes to the hospital, while doing the admission, he'll pay the cost of the surgery –be4 having the surgery-.
   - Diagnosis related groups (DRGs) are predetermined payment schedules that reflected historical costs for treatment of specific patient conditions (approx. 550 DRGs). Meaning: set admission payments for heart failure patients, diabetic patients and so on.
   - As a result of the PPS and the need to contain costs, the length of stay for most hospital admissions has decreased greatly.
   - Effects on quality of care

3. <u>Capitation</u>: providers receive a fixed monthly payment regardless of services used by that patient during the month.
   - The provider may profit or suffer a loss.
   - May lead to patients' under-treatment.
   - Capitation means : عالراس:P
     Example to illustrate the meaning: you are a manager, you have 200 employees, and you have a deal with a hospital to pay 200,000 JDs per year –for their treatment-, ((if the employees became only 150, you'll pay to the hospital only 150,000)), the problem arises when an employee consumes the 200,000 JDs during his treatment, then the hospital will try to avoid losing the deal/contract with you, by under-treating the other patients from your company (yshalfeg el 3elaj).
     (The provider/hospital will suffer a loss when the number of patients from your company is high)