

Eight years of experience with family medicine accreditation

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INTRODUCTION

The Health Care Accreditation Authority under the Ministry of Health of the Republic of Lithuania is a governmental body with the mission to ensure patient safety through regulatory mechanisms. According to the law, its main functions are licensing of health care organizations (HCO) and health care professionals, market surveillance for medical devices, accreditation of health care organizations, and supervision of the quality of health care services and patient rights.

Lithuania has a well-developed primary health care system, and family physicians have a key role in managing patients' health. Family medicine services in Lithuania are provided by a wide spectrum of either municipality-owned or private facilities: practices of family physicians, primary health care centres, providing only family medicine services and city Polyclinics providing diverse professional ambulatory services including family medicine. Facilities receive an age and sex-adjusted capitation rate, activity- or output-based payments for a list of specific services, and a result-based payment based on the list of performance indicators. Family physicians work in teams with nurses and other healthcare professionals. Patients have to register with a gatekeeping family physician.

AIM

Accreditation of family medicine in Lithuania was launched in 2016 on a participatory voluntary approach. It was the first time an accreditation was introduced on the national level. The main goal of the accreditation was to strengthen family medicine while promoting quality improvement and introducing patient-centered family medicine.

METHOD

The accreditation program was developed by the Health Care Accreditation Authority in collaboration with professional organizations of family medicine physicians and University Clinics with the consultancy of Accreditation Canada. As a result, the handbook of the accreditation program describing standards, survey procedures, and auxiliary material was published. Necessary legal acts were adopted to facilitate the implementation of the program as well as financial incentives for HCO to voluntary participation.

A communication campaign was launched with key information about standards and survey procedures through meetings with family physicians and articles in professional weekly. After pilot voluntary accreditation of 6 HCO program of family medicine accreditation started.

After the first and second accreditation cycles, a survey of the management of accredited organizations and peer surveyors was performed to evaluate the attitude of accredited organizations to accreditation and its influence on the quality of services. E-mails were sent to the participants asking them to comment on the benefits and challenges the organization experienced meeting accreditation standards, the impact of the accreditation process on the quality of services and their improvement as well as suggestions for future improvement of the accreditation program.

RESULTS

Preparation for accreditation took HCO from six months to a year depending on organizational culture, management commitment, and intrinsic motivation of family physicians. A central idea behind most of the standards was not to prescribe the exact activities to be implemented but to inspire practices to engage in improvement activities. Self-assessment was necessary to prepare for accreditation.

Since 2016 accreditation underwent two four-year cycles.

The accreditation survey process was carried out by a team of surveyors composed of the representatives of the Health Care Accreditation Authority, family physicians, and nurses from accredited organizations. The tracer method was used for the assessment. The surveyors reviewed policies and procedures, during an onsite evaluation observed practice, interviewed personnel and patients, and reviewed medical records.

Clinics received oral feedback as part of the survey and a written report. A survey report with recommendations was submitted to the Accreditation Committee composed of the representatives of the Health Care Accreditation Authority, professional organizations of family physicians, patient organizations, and payers). The Committee reviewed the survey report and made an accreditation decision. Organizations were accredited for 4 years.

Currently accredited HCOs provide family medicine services to one-third of Lithuanian citizens.

National quality indicators for family medicine clinics (e.g., avoidable hospital admissions for chronic conditions, cancer screening) of accredited HCOs were monitored and compared with those of non-accredited organizations. Accredited organizations achieved better quality indicators comparing with non-accredited ones. All accredited organizations had developed quality improvement plans for the accreditation period and yearly plans.

Responses about accreditation from 32 accredited organizations and 13 peer surveyors were received. The majority of respondents indicated that accreditation helped organizations to evaluate the organizational side of services as well as to know better the needs and preferences of patients becoming more active participants in their health care. It was difficult for some organizations to understand the requirements of accreditation being different from regulation (regulatory compliance to minimal standards vs. continuous quality improvement) nevertheless the accreditation was voluntary. Though representatives from family medicine were involved in standard development from the very beginning there were difficulties in understanding and implementing some standard indicators. All respondents appreciated the use of peer surveyors, and discussions with them sharing the best practice of family medicine.

CONCLUSIONS

Our experience shows that accreditation is an effective tool to promote quality improvement in family medicine and introduce patient-centered care.

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