Central and Eastern European Society
CEESTAHC 2014
of Technology Assessment in Health Care

IX Międzynarodowe Sympozjum
9th International Symposium
Evidence-Based Health Care

HTA for Healthcare Quality Assurance

"How to bring policy into practice - Are we missing something?"

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Bourek Ales, How to bring policy into practice - Are we missing something?, EBHC Conference, CEESTAHC, Krakow, December 2014 (www.bourek.eu)

POLICY

- “policy” can be interpreted as a course or principle of action adopted or proposed by the government, party, business, or individual. Terms close to policy are plan, strategy, stratagem, approach, code, system, guideline
- A policy is a principle or protocol to guide decisions and achieve rational outcomes.
- A policy is a statement of intent and is implemented as a procedure or protocol.
- Policies can assist in both subjective and objective decision making.

BACKGROUND EXPERIENCE

ODBORNÉ FÓRUM
pro tvorbu standardů péče a koncentraci vybrané vysoce specializované péče

IGA, No. 10650-3

IMPROHEALTH

SIMPATIE

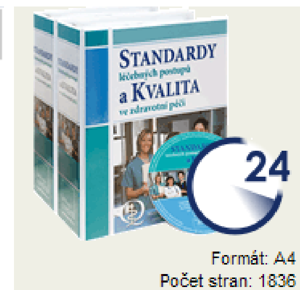
CEEQNET

riche

Programy kvality a standardy léčebných postupů | 3/2.3.4
díl 2, Teoretické minimum | str. 1

3/8
Týmová spolupráce

3/2.3.4
Health Technology Assessment (HTA) – kritické vyhodnocování zdravotnických technologií



European Health Futures Forum

IGA MZ NO/6236-3 "Aplikace standardů efektivní léčebné péče v praxi a jejich využití k zavedení systemu měření výkonnosti a ekonomické efektivity do vybraných oblastí zdravotní péče"

IMPLEMENTING RECOMMENDATIONS FOR SAFER HOSPITALS IN EUROPE:
SANITAS PROJECT

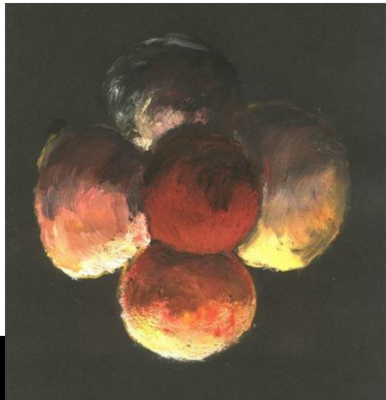
EFQM

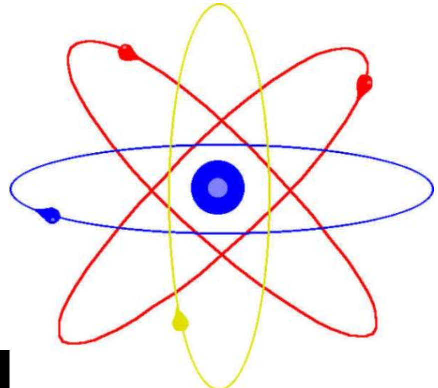
Central and Eastern European Society
CEESTAHC
of Technology Assessment in Health Care

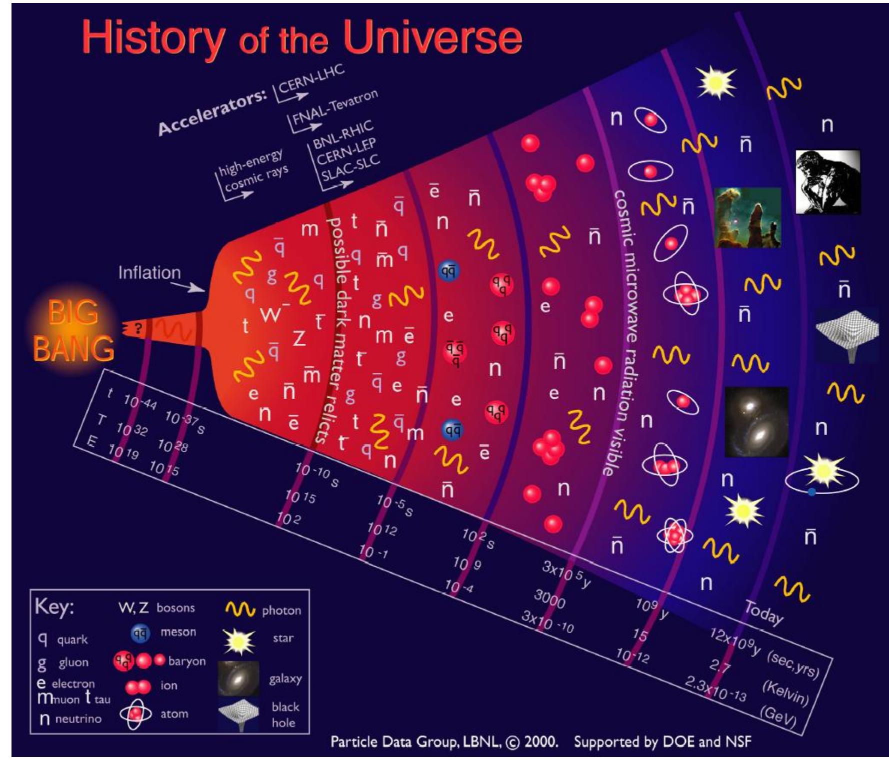
ESQH

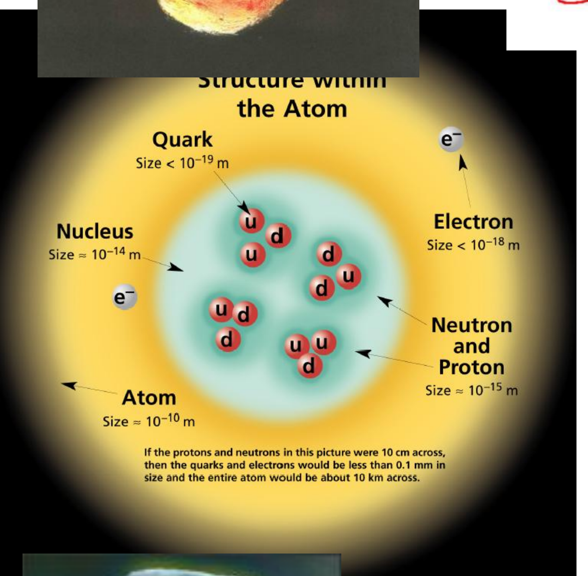
ENQual questionnaire National Quality Policy

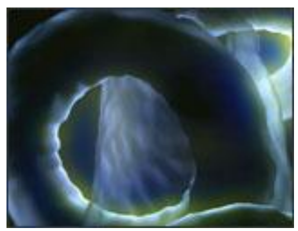
INCREASINGLY BETTER MODELS – POSSIBLY BETTER UNDERSTANDING







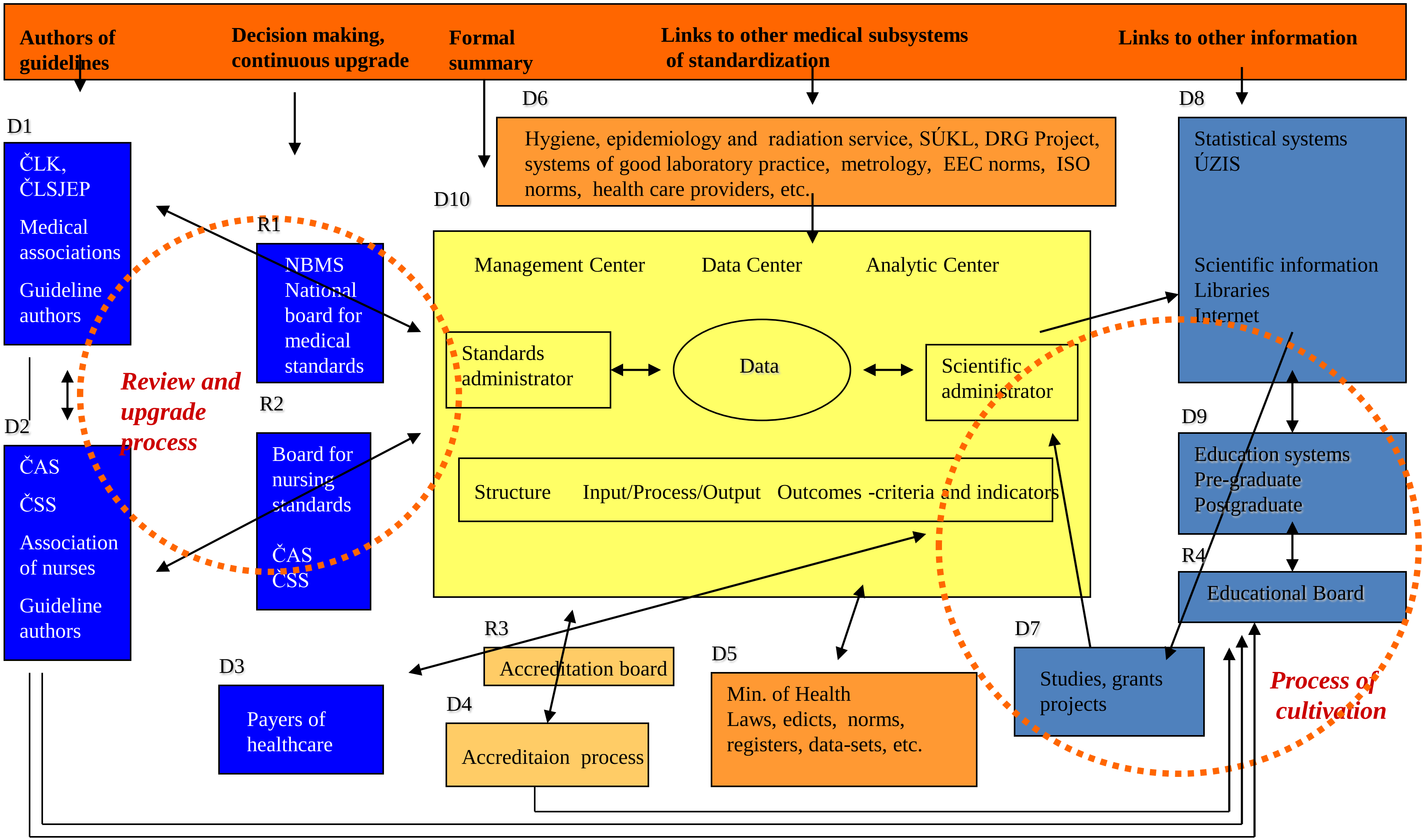




Greater dimensions It all started when superstring theory, hyperspace and dark matter made physicists realize that the three dimensions we thought described the Universe weren't enough. There are actually 11 dimensions. By the time they had finished they'd come to the conclusion that our Universe is just one bubble among an infinite number of membranous bubbles which ripple as they wobble through the eleventh dimension.

A creative touch Now imagine what might happen if two such bubble universes touched. Neil Turok from Cambridge, Burt Ovrut from the University of Pennsylvania and Paul Steinhardt from Princeton believe that has happened. The result? A very big bang indeed and a new universe was born - our Universe. The idea has shocked the scientific community; it turns the conventional Big Bang theory on its head. It may well be that the Big Bang wasn't really the beginning of everything after all. Time and space all existed before it. In fact Big Bangs may happen all the time.

HEALTHCARE SYSTEM COMPLEXITY– CZECH DOMAINS



THE HEALTHCARE ENVIRONMENT

– Understand – gather – digest – utilize – exploit

– No silly activities – no nonsense – don’t reinvent

– RT(F)Ms – use intelligent guides

SURPRISES ?

ECRI Institute's Top 10 Patient Safety Concerns for 2014

ECRI Institute's Top 10 Patient Safety Concerns for 2014

1. Data integrity failures with health information technology systems*
2. Poor care coordination with patient's next level of care
3. Test results reporting errors
4. Drug shortages
5. Failure to adequately manage behavioral health patients in acute care settings
6. Mislabeled specimens
7. Retained devices and unretrieved fragments*
8. Patient falls while toileting
9. Inadequate monitoring for respiratory depression in patients taking opioids
10. Inadequate reprocessing of endoscopes and surgical instruments*

MS14086

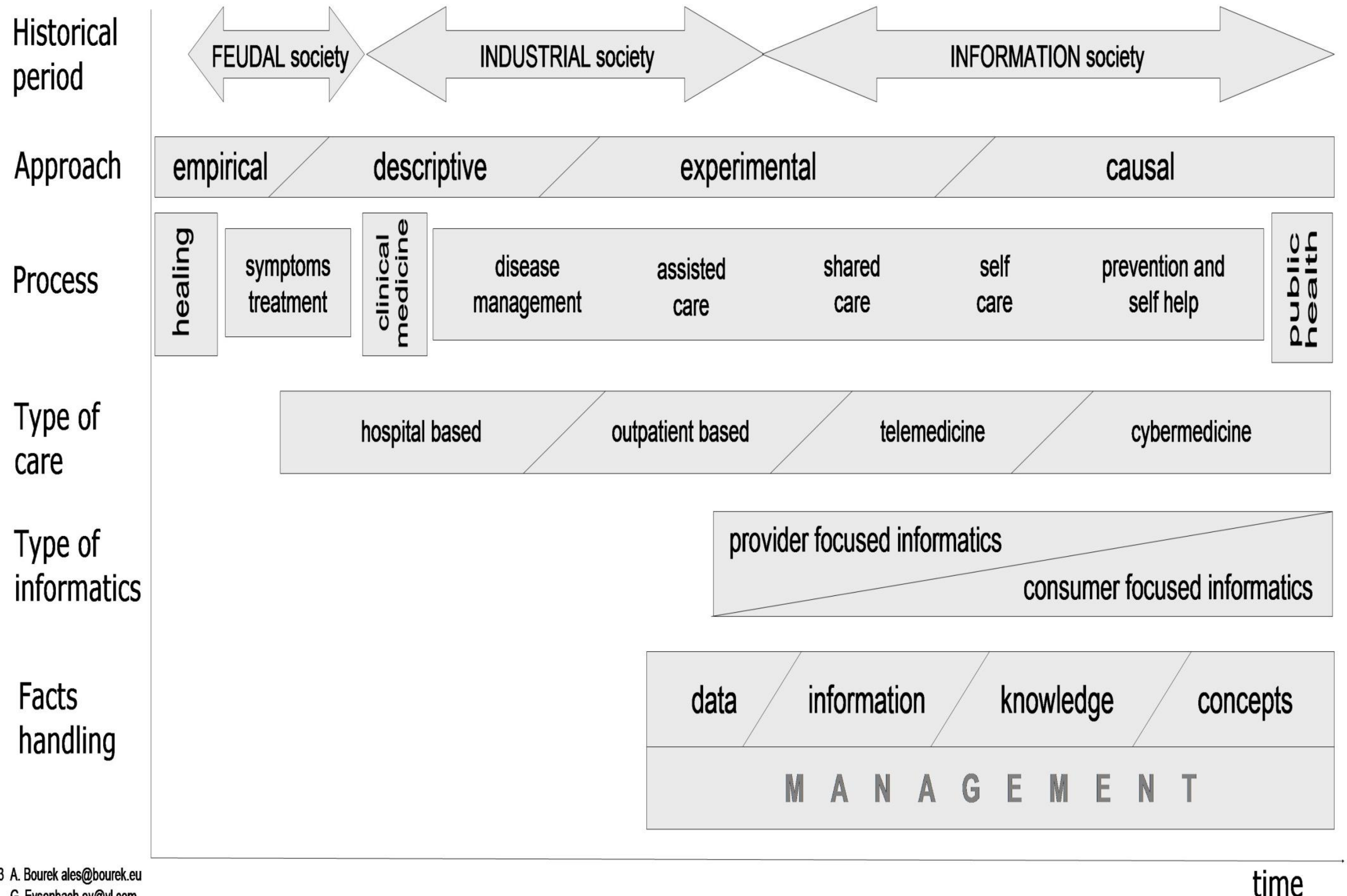
* Also included in ECRI Institute's list of the top 10 health technology hazards for 2014.
For information on strategies to address these hazards, refer to the publicly available abridged version of the report *Top 10 Health Technology Hazards for 2014*, available online at https://www.ecri.org/2014hazards, and to the full article, published in the November 2013 issue of ECRI Institute's journal *Health Devices*.

ECRI Institute 2014 Top 10 Health Technology Hazards

THE LIST FOR 2014

1. Alarm hazards
2. Infusion pump medication errors
3. CT radiation exposures in pediatric patients
4. Data integrity failures in EHRs and other health IT systems
5. Occupational radiation hazards in hybrid ORs
6. Inadequate reprocessing of endoscopes and surgical instruments
7. Neglecting change management for networked devices and systems
8. Risks to pediatric patients from “adult” technologies
9. Robotic surgery complications due to insufficient training
10. Retained devices and unretrieved fragments

PARADIGM CHANGE – RESPECT THE CURENT ENVIRONMENT



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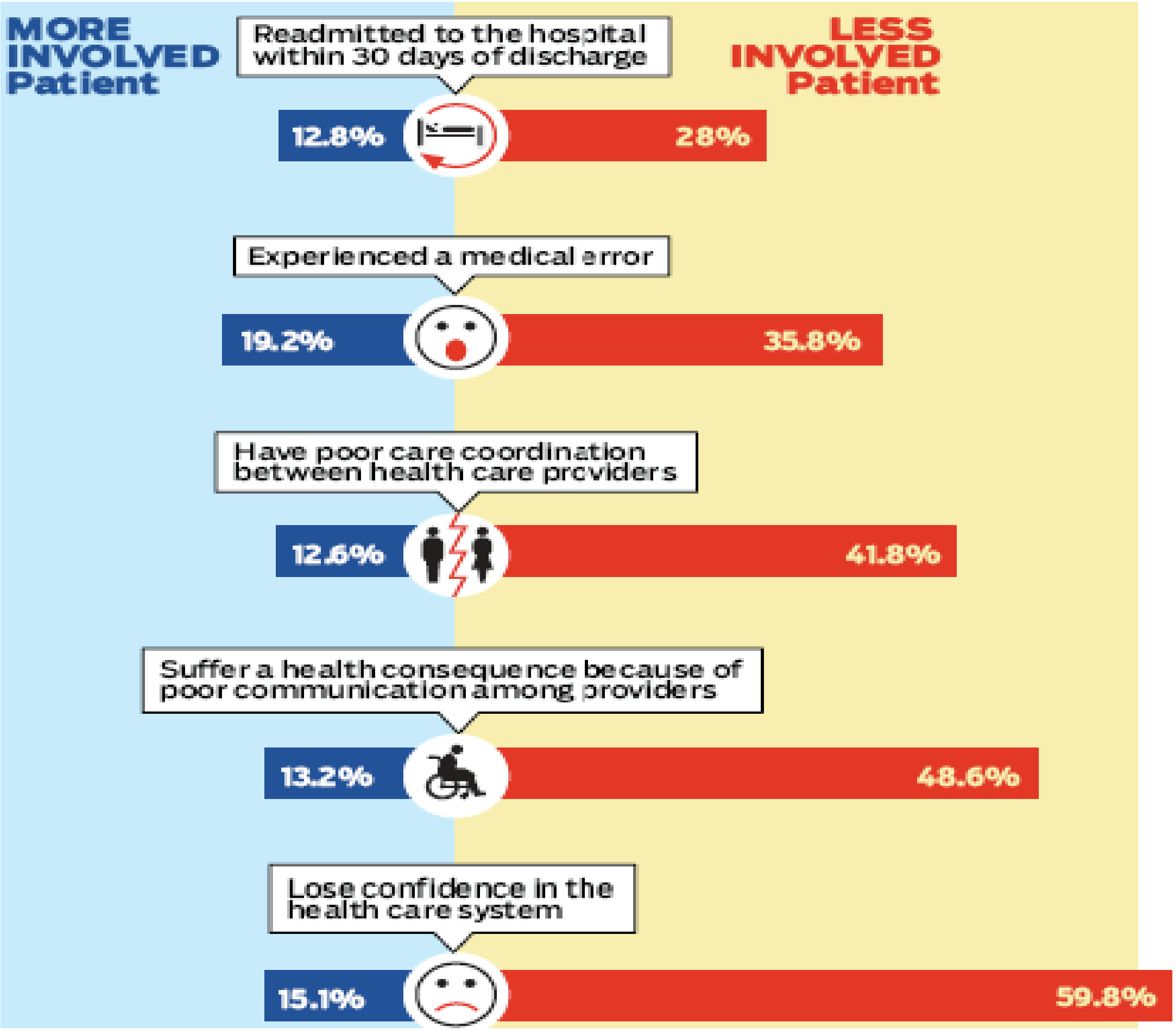
THE NEW PATIENT

Why is this important?

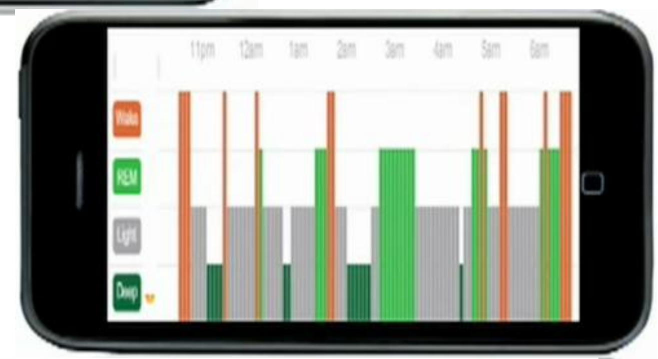


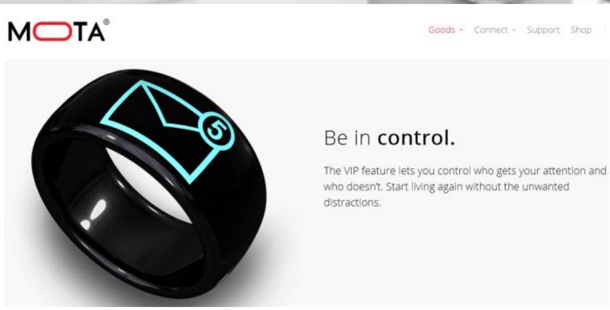
Source: AARP Public Policy Institute, Chronic Care: A Call to Action for Health Reform, Beyond 50.09. Study population age 50+ with at least one chronic condition. N=2,453
'More Involved'=Levels 3 & 4, Less Involved=Levels 1 & 2

BRIDGING THE GAP

Kyoh.org.uk

WIRELESS & HANDHELD





Human-computer interaction in healthcare

- requirements engineering
- usability studies

Value of IT in healthcare

- entrepreneurship
- business models & cases
- economic aspects
- assessment methods

Social implications

- ethical aspects
- cultural aspects
- digital divide between regions and ages

General topics

Security issues in health networks

- privacy
- legal aspects
- secure data exchange

Standardization and conformity

- internationalization
- health services research guidelines
- standardization

Education, training and dissemination

- organization of medical and organizational knowledge base
- e-learning

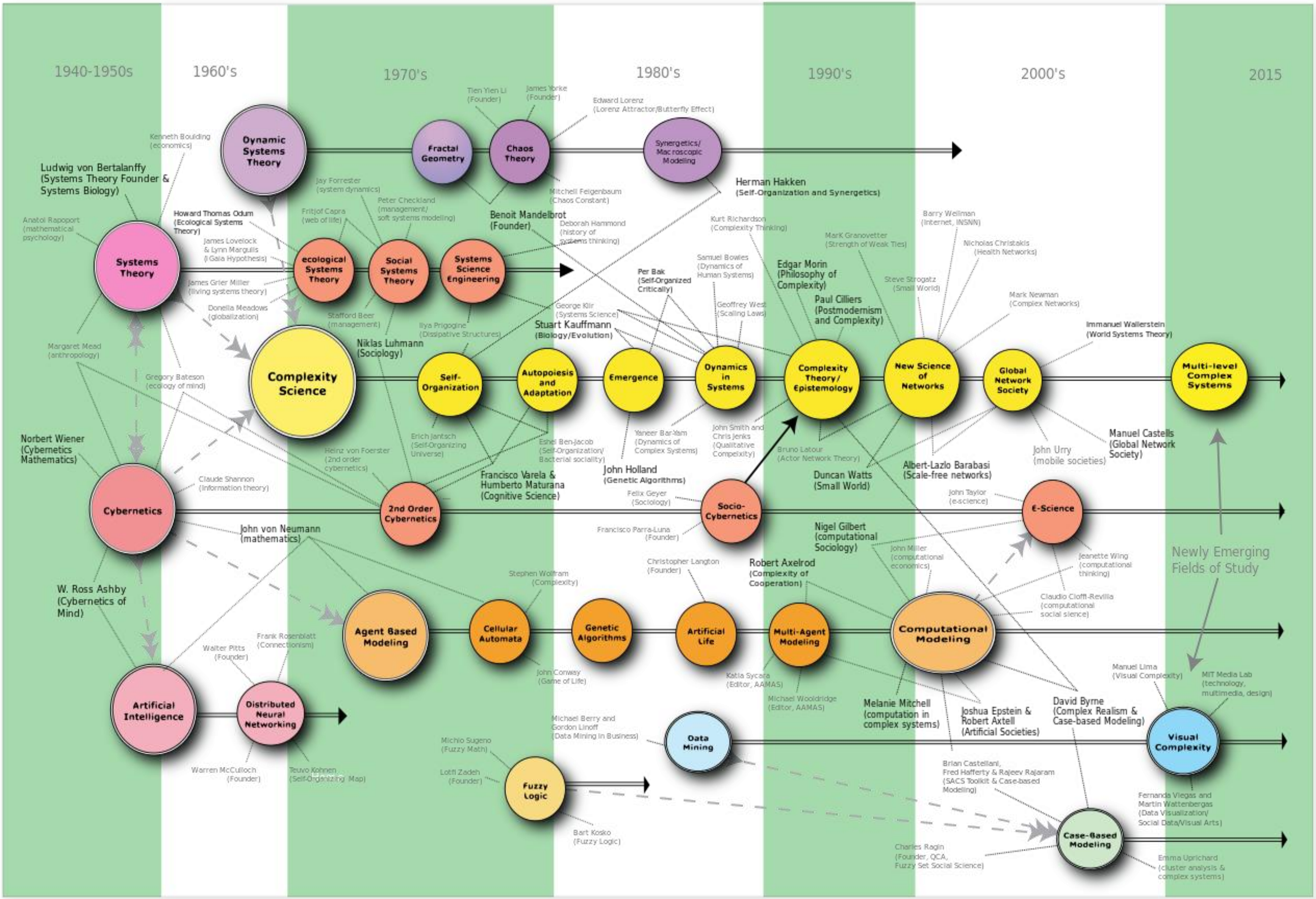
GOALS of a good POLICY

- „change the system in a way that lets ordinary people do extraordinary things instead of taking extraordinary people and getting very ordinary results from it“

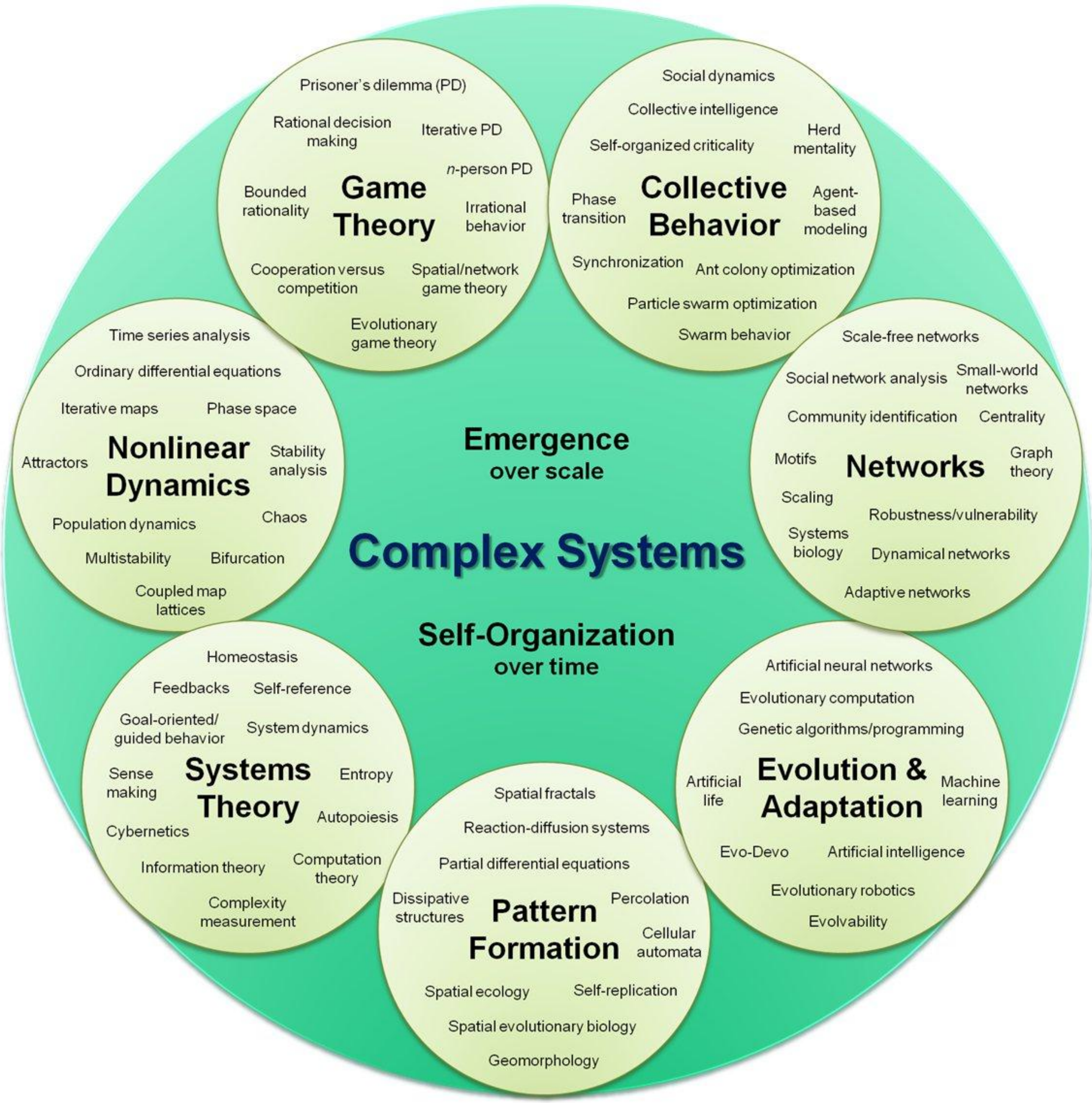
CHANGE

Thinking		Values	
Self presentation	**Integration**	**Self presentation**	**Integration**
Rational	**Intuitive**	**Expansion**	**Conservation**
Analysis	**Synthesis**	**Competition**	**Collaboration**
Reductionalism	**Holism**	**Quantity**	**Quality**
Linear	**Non-linear**	**Dominance**	**Partnership**

Systems Theory + Cybernetics = COMPLEXITY SCIENCE



COMPLEX SYSTEMS properties & behavior



RESPECT COMMON PRINCIPLES

Lesson #1

A living social system is a self-generating network of communications. The aliveness of an organization resides in its informal networks, or communities of practice. Bringing life into human organizations means empowering their communities of practice.

Lesson #2

You can never direct a social system; you can only disturb it. A living network chooses which disturbances to notice and how to respond. A message will get through to people in a community of practice when it is meaningful to them.

Lesson #3

The creativity and adaptability of life expresses itself through the spontaneous emergence of novelty at critical points of instability. Every human organization contains both designed and emergent structures. The challenge is to find the right balance between the creativity of emergence and the stability of design.

Lesson #4

In addition to holding a clear vision, leadership involves facilitating the emergence of novelty by building and nurturing networks of communications; creating a learning culture in which questioning is encouraged and innovation is rewarded; creating a climate of trust and mutual support; and recognizing viable novelty when it emerges, while allowing the freedom to make mistakes.

(Fritjof Capra)

SUGESTIONS

- The **success of implemented strategies is** a function of the volatility of the environment where they are implemented and extremely **dependent on unexpected turning points.**
- Given the unpredictability of the impacts of introduced **systemic changes**, my suggestion to healthcare professionals in the position when they must interact with policy makers is to get across the fact, that even the best designed and implemented systemic change introduced into the complex existing health systems **may produce unexpected results.**
- One safeguard mechanism is to propose **gradual step-wise system change and readjust as quickly as possible** strategies based on feedback from the influenced system.
- In order to widely disseminate a policy, a **„cascade" system of implementation** has been found to be effective
- All proposed changes must **take into consideration the level of „literacy" of stakeholders** involved in the change process

- **WE MUST CONSIDER HAVING PEOPLE UNDERSTANDING COMPLEXITY AS A PART OF OUR HC QUALITY IMPLEMENTATION TEAMS**

Literacy

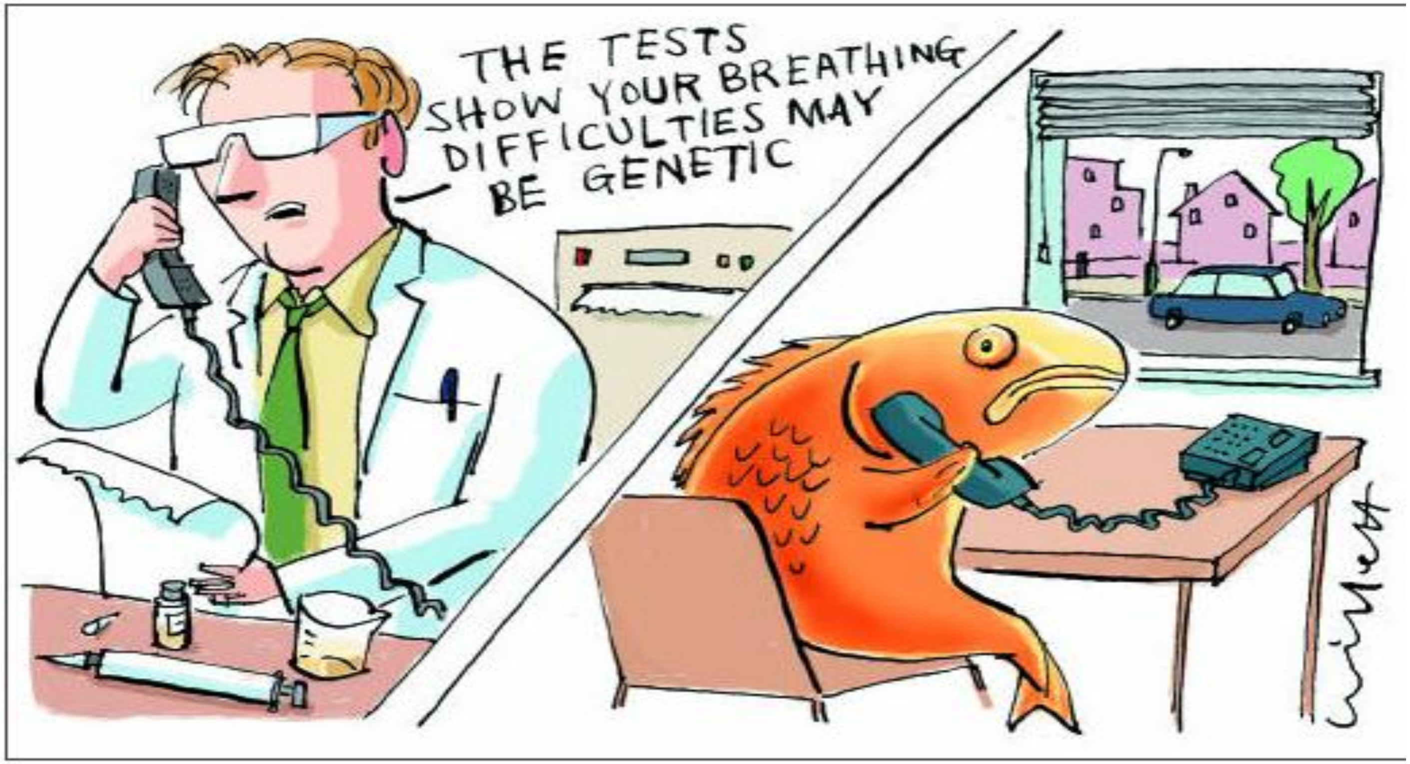


Figure 4

Some patients with long term health problems do not attend review appointments. This is a particular problem when the individual has multiple comorbidities. A patient with depression may not think it is worthwhile spending scarce health service resources on themselves because they have low self esteem, which is often associated with depression. Electronic patient records summarise health problems and, potentially, prompt when reviews have not been undertaken. Some services, like review of the patient's self monitoring, can be provided immediately. Others, such as retinopathy screening, may have to be scheduled for another date and place. An electronic health record shared between colleagues in different professions and parts of the health services makes scheduling easier.

How decision support tools help define clinical problems
BMJ. 2005 October 8;331(7520):831-833.

RIGHT INSTINCTS badly NEEDED !

THANK YOU FOR YOUR ATTENTION

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