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QUALITY HEALTH SERVICES

URC

Transitioning the Cambodian health system to self-reliance: URC's contribution 2002-2019

BUILDING THE FOUNDATIONS FOR QUALITY SERVICES:

STRUCTURES, SYSTEMS, SKILLS AND CULTURE

Sustainable improvements to the quality of health care can only be achieved through a system-wide approach that strengthens structures, systems, skills, culture, and leadership. Health workers need clinical skills as well as capacity in data analysis and adaptive management. Institutionalizing quality improvement also requires clear guidelines and performance standards, inclusion of quality improvement in job descriptions, and access to reliable data. None of this is possible without the commitment of the leadership to quality improvement and a culture of teamwork, problem-solving, and learning.

In many countries, these supply-side strategies to improve quality of care are complemented by demand-side incentives where health providers are, at least partly, paid on the basis of their performance. Performance-based financing can be also designed to address quality of care by paying providers based on performance on quality indicators.[1]

University Research Co. LLC (URC) supported the Royal Government of Cambodia (RGC) to strengthen the health system through four USAID projects:

- Health Systems Strengthening in Cambodia (HSSC), 2002-2008
- Better Health Services Project (BHS), 2009-2013
- Quality Health Services Project (QHS), 2014-2019
- Social Health Protection Project (SHP), 2014-2019

Through these projects, USAID sought to support the RGC improve the quality of primary care and hospital services, increase demand for health services and reduce financial barriers to access, and build provincial and operational district (OD) capacity to manage services and social protection programs.

Since 2002, University Research Co. LLC (URC) has worked with the Cambodian Ministry of Cambodia (MOH) to improve the quality of health services through both supply- and demand-side mechanisms. Building on the MOH's strong commitment to quality improvement, URC used a health-systems approach to build capacity and strengthen the foundations for quality improvement.

CONTEXT

During the last two decades, the MOH's Quality Assurance Office (QAO) has led efforts to develop and implement national plans for quality improvement and worked with development partners to identify and scale-up effective approaches. A particular challenge has been expanding responsibility for quality beyond the QAO to be a shared priority across health departments and facilities at all levels, as well as across vertical programs (maternal and child health, HIV/AIDS, tuberculosis etc.). The traditionally top-down, physician-dominated system has discouraged constructive criticism and improvement and dampened teamwork and learning.

Cambodia has also sought to identify strategies for sustainable health financing while ensuring that services remain accessible to the poor. The introduction of user fees in 1996 spurred the development of the national pro-poor health financing scheme, the Health Equity Funds (HEF). The growth of the HEF program provided a unique opportunity to complement the supply-side quality improvement efforts with demand-side incentives: HEF reimbursements to providers and facilities were linked with the quality of care they provide to poor patients.

[1] For further information, see https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5493453/

KEY INTERVENTIONS

LEVEL 1 QUALITY ASSESSMENTS: STRUCTURAL QUALITY

Under the USAID HSSC Project, URC collaborated with the QAO to develop a system of regular monitoring of quality of services. Because the essential elements of assessing quality were not in place, URC and the MOH realized that work on quality assurance would need to begin at a very basic level and progress step by step to a more sophisticated review of clinical care using clinical practice guidelines.

The Level 1 Quality Assessments, launched in 2005, provide information primarily on structural elements of quality: equipment, staff, recordkeeping etc. The focus reflected the large investments made by the MOH to improve the structural quality of the health system by building health facilities to expand coverage, providing essential equipment and supplies, and training and placement of medical providers.

As a result of participation in the assessment process and review of the findings, facility staff gained a clearer sense of the standards of practice expected from them and began making improvements. At the national level, the tools enlightened managers about the real conditions at the facility level, and dispelled assumptions about how facilities have been functioning. The assessments also highlighted the need for standard operating procedures for each function in the hospital or health center, spurring action to develop the much-needed performance standards and guidelines.

NATIONAL POLICIES AND GUIDELINES

Recognizing the need for better clinical guidelines and protocols, URC supported the MOH under the BHS and QHS projects to develop and update key national documents. During the past three decades, these have included: the Complementary Package of Activities for referral hospitals (CPA) and Minimum Package of Activities for health centers (MPA), Safe Motherhood Protocols, nursing and midwifery protocols, infection control guidelines, and hundreds of clinical practice guidelines on topics such as post-partum hemorrhage, severe acute malnutrition, neonatal sepsis, diarrhea, respiratory infections, neonatal sepsis, pneumonia and acute gastrointestinal tract infection (pediatric), and pneumonia and asthma (adult), among others.

Ket Tainhor, a midwife at Sla Health Center in Tbong Khmum Province, looks through a patient's Maternal Child Health Book

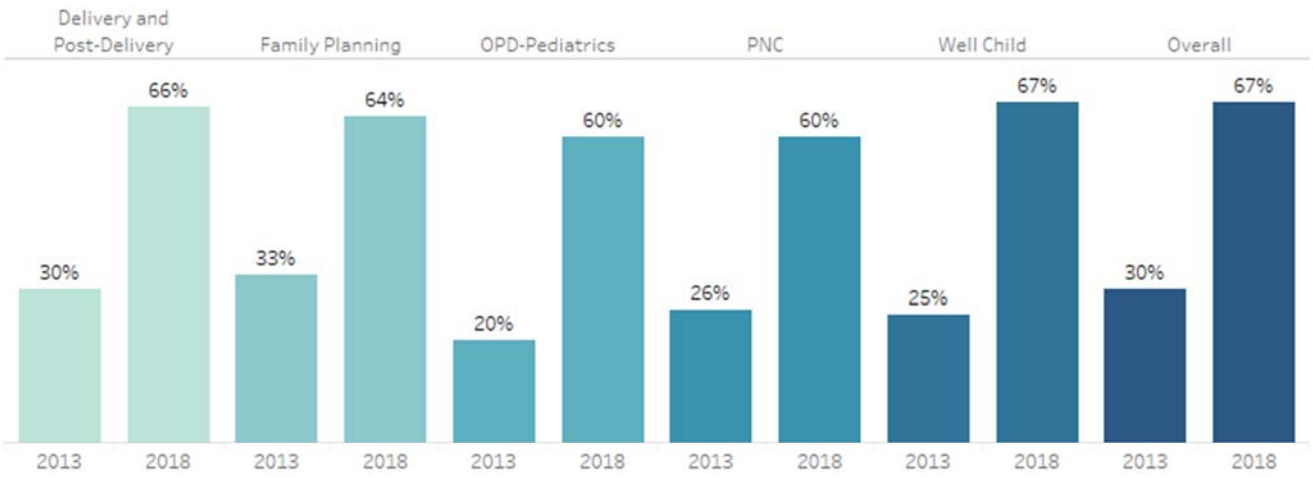
DEMAND-SIDE INCENTIVES TO QUALITY IMPROVEMENT

From the outset, URC strove to incentivize quality improvement by linking it with health equity funds (HEF). HEFs are a pro-poor health financing scheme that targets identified poor households in a given area and provides financial and social support so that these households can better access government health services *(see brief: From a health financing pilot to a national social health protection system)*. In the 2000s, the HSSC Project fully funded most of the HEF schemes, providing URC with the unique opportunity to link provision of HEF funds to facilities with objective measurable improvements in the quality of care.

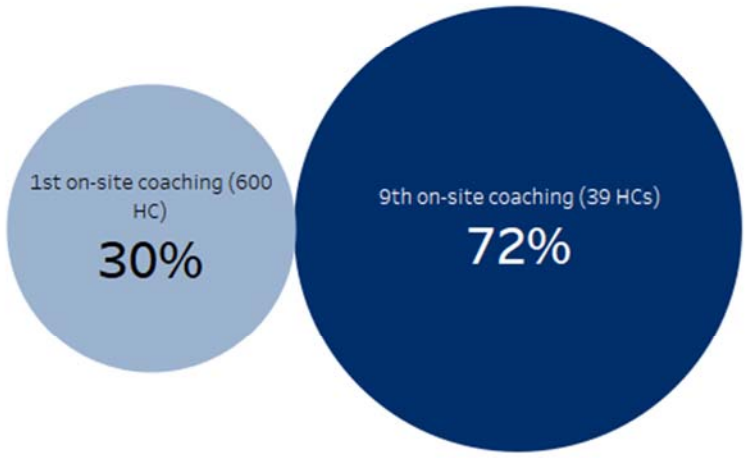
While the specific clauses of the HEF contracts with facilities have evolved over time, in order to be contracted for provision of services to the poor, a facility must have a minimum score on Level 1 Assessment. As a result, staff became well-motivated to achieve and maintain acceptable quality to avoid losing the HEF, which provides additional funds for incentives and facility improvements. Level 1 Assessments are now typically paid for by the provincial health departments and operational districts.

Quality Improvement by the Numbers

The QHS project improved quality and provider competency in all care domains

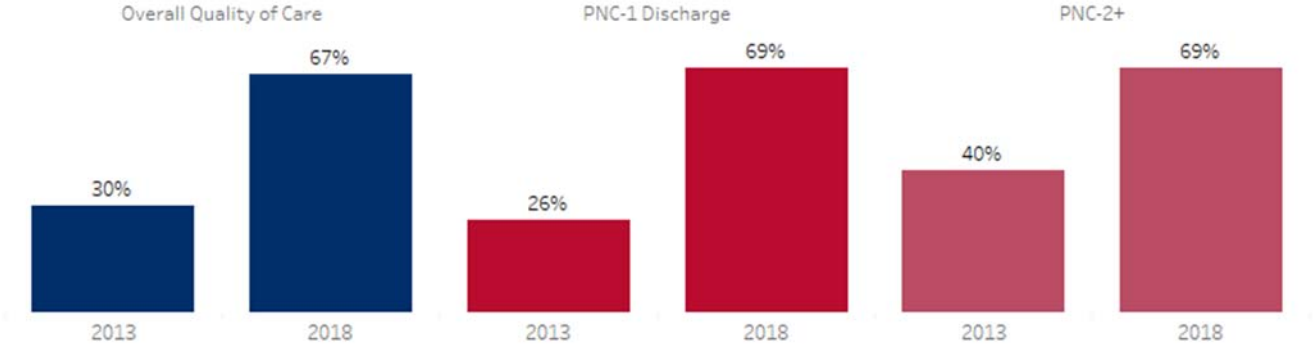


Health Center Quality Improvement (HCQI) was successful and led to improved provider competency at the health center level



QHS has provided on-site coaching to
all 600
health centers
in the nine target provinces, accounting for
more than half
of health centers nationwide

Level 2 Quality Assessment results support the results of the QHS project in improving quality of care



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LEVEL 2 QUALITY ASSESSMENTS – PROCESS OF CARE

As Cambodia's health system improved and many of the fundamental structures were put into place, the 2010 MOH Master Plan for Quality Improvement envisioned that the Level 1 tool would be followed by a Level 2 tool that focused on the process level of care. Between 2010 and 2013 the QAO, with support from URC through the USAID BHS Project, developed the Level 2 Quality Assurance tool and process that uses direct clinical observation, clinical vignettes, and document reviews. The Level 2 Assessment became the national standard in 2014. Level 2 Assessments are also linked with the HEF program.

The Level 2 Assessment covers five areas: routine clinical procedures, counseling, behavior of staff towards the patient, standard precautions and documentation, and compliance with clinical standards. Specific results related to a facility's services or cross-cutting components of care can be analyzed and used as a targeting mechanism for clinical training. Training topics can be prioritized and targeted to make better use of resources and maximize their effect on the measured quality of care. The effect of training can be tracked through subsequent Level 2 Quality Assessments.

CONTINUOUS QUALITY IMPROVEMENT AT HEALTH FACILITIES

The capacity of the health workforce is critical to quality improvement, not only in terms of delivering clinical services according to national standard, but also in improving performance through coaching, teamwork, problem-solving, and learning, skills not typically nurtured in medical education. Under the USAID BHS and QHS projects, URC introduced competency-based, hands-on, participatory training that was integrated into routine supervision systems in order to provide continuous, supportive feedback on performance and practical guidance on how to improve quality. Both the health center model called Health Center Quality Improvement (HCQI) and the hospital model called Clinical Skills Practice (CSP) use coaching and mentoring techniques on-site, and both rely on routine follow-up to ensure that the lessons learned continue to be practiced. Coaching visits review both clinical areas as well as management processes such as logistics management and record keeping. Teamwork is further enhanced through Midwifery and Pediatric Coordination Alliance Teams (MCAT and PCAT). The approaches have led to marked increases in provider competencies as measured with structured tools. (*see brief: Transforming the Health Workforce*).

CONCLUSIONS

During the past three decades, URC has assisted the MOH in putting in place the building blocks for quality health services in Cambodia: standards for quality performance, tools for measuring and monitoring quality, and approaches to increase health workforce capacity in the delivery of quality health services and their continuous improvement. The Level 1 and Level 2 Quality Assessments which cover all health programs at all levels, the growing culture of teamwork within and between facilities, as well as the incentives provided by the HEF program, have made quality a priority for everyone.

University Research Co., LLC
5404 Wisconsin Avenue, Suite 800
Chevy Chase, MD 20815 USA
www.urc-chs.com

For further information, please contact:
Dr. Neeraj Kak
Chief Innovation Officer, Senior Vice President
+1 (301) 941-8622 | nkak@urc-chs.com

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