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Developing and Implementing an Accreditation Program in Egypt

January 2006

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Order No TE 085



Mission

Partners for Health Reformplus is USAID's flagship project for health policy and health system strengthening in developing and transitional countries. The five-year project (2000-2005) builds on the predecessor Partnerships for Health Reform Project, continuing PHR's focus on health policy, financing, and organization, with new emphasis on community participation, infectious disease surveillance, and information systems that support the management and delivery of appropriate health services. PHRplus will focus on the following results:

- ▲ *Implementation of appropriate health system reform.*
- ▲ *Generation of new financing for health care, as well as more effective use of existing funds.*
- ▲ *Design and implementation of health information systems for disease surveillance.*
- ▲ *Delivery of quality services by health workers.*
- ▲ *Availability and appropriate use of health commodities.*

January 2006

Recommended Citation

Rafeh, Nadwa, Thomas Schwark. January 2006. *Developing and Implementing an Accreditation Program in Egypt*. Bethesda, MD: The Partners for Health Reformplus Project, Abt Associates Inc.

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Contract/Project No.: HRN-C-00-00-00019-00

Submitted to: USAID/Cairo

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Abstract

In 2003, the Egyptian Minister of Health and Population launched a national accreditation program through a ministerial decree calling for the establishment of a National Accreditation Board (NAB). PHR*plus* provided technical assistance to develop and test accreditation standards and build the institutional capacity for the program. Consensus was rapidly reached that for the accreditation initiative to be successful, the program had to be accountable, credible, applicable, consistent, transparent, objective, and impartial of oversight. This report describes steps completed in the design of the program including: the development of the NAB to direct and oversee all accreditation programs, the training of Egyptian surveyors and identification of those qualified to become trainers of future surveyors, the development of a training curriculum to be used to train future surveyors, the development of hospital standards tested for their validity and applicability in selected secondary and tertiary hospitals, and the revision of primary health care standards to mirror hospital standards such that standards apply in all applicable settings. The primary goal of the accreditation program under PHR*plus* was to create the framework for a national health care facility accreditation program to foster a culture of improvement in health care that would be sustained and grow after donor support was terminated.

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Acronyms

GOE	Government of Egypt
MOHP	Ministry of Health and Population
NAB	National Accreditation Board
PHC	Primary Health Care
PHR	Partnership for Health Reform Project
PHR<i>plus</i>	Partners for Health Reform <i>plus</i>
QI	Quality Improvement
QID	Quality Improvement Department

Acknowledgments

This report documents the approaches, methods and steps taken by *PHRplus* and the Ministry of Health and Population (MOHP) to develop the accreditation program in Egypt. Key *PHRplus* staff and consultants contributed to the preparation and review of this document. Thomas Schwark is the key technical consultant and author. Nadwa Rafeh, *PHRplus* Chief of Party in Egypt, assisted in the design and provided internal technical review of the report.

The authors wish to acknowledge the valuable participation and insightful contribution of many partners within and outside the MOHP. The Quality Improvement Directorate (QID) of the MOHP has been a valuable partner and played an important role in the development process. Thanks are due to Dr. Bassiouni Salem, QID Director and his team for their efforts. The *PHRplus* project would also like to express appreciation to Dr. Emam Mousa, Head of the MOHP Central Administration for Technical Support and Projects and his staff for their support. The authors also acknowledge with gratitude the contribution made by all surveyors, experts, university professors and directors and teams of the five pilot hospitals of Manshiet El-Bakri, Sadr El-Abbasiya, El-Galaa Teaching Hospital, El-Shourouk, and Ain Shams OB-GYN Teaching Hospital, in testing and implementing the standards.

Executive Summary

Since 1997, Egypt has engaged in a health sector reform program with quality improvement as a key goal of the reform program strategy. Over several years, the U.S. Agency for International Development (USAID)-funded Partnership for Health Reform Project (PHR) and later, the Partners for Health Reform *plus* (PHR*plus*) project, provided technical assistance to the Ministry of Health and Population (MOHP) in the design and pilot testing of the reform model. The initial PHR project was operational from 1997 to 2000, and the follow-on project, PHR*plus*, from 2003 to 2005.

At the beginning of the reform program, the emphasis was on the development of an infrastructure within the MOHP that would support a systematic approach to quality improvement, particularly at the primary health care (PHC) facility level. A parallel effort entailed developing standards for the purpose of accrediting PHC facilities. However, after several years of implementation, one of the critical lessons learned was that efforts to improve the delivery of health care services including standards development and implementation, use of clinical guidelines, and development of quality improvement systems, must encompass the full spectrum of health care delivery systems. Health care is a continuum and patients move back and forth from one level of the system to another. There were several incidences where patients who had received quite good care at the PHC level received substandard care at the hospital level and physicians expressed concerns about the quality of such care for their referred patients.

Therefore, it quickly became apparent that the concept of standards against which a health care facility could be judged as part of an accreditation program had to be integrated across the full spectrum of facilities and not be limited to one sector such as PHC. Although PHC is of crucial importance, it is obvious that patients who require hospitalization represent the highest risk population.

In 2003, the Minister of Health and Population launched a national accreditation program through a Ministerial Decree (no. 271). The decree called for the establishment of a National Accreditation Board (NAB) and an Executive Committee. PHR*plus* provided technical assistance to develop and test accreditation standards and build the institutional capacity for the program.

Several important steps were completed in the design of the program: 1) developed and defined the role and responsibilities of an organizational structure (the NAB) that would direct and oversee all accreditation programs, 2) trained the original group of Egyptian surveyors and identified those qualified to be certified surveyors and those qualified to become trainers of future surveyors, 3) developed a training curriculum to be used to train future surveyors, 4) developed hospital standards and tested their validity and applicability in selected secondary and tertiary hospitals, and 5) revised the PHC standards to mirror hospital standards such that standards apply in all applicable settings.

This report presents two important pieces of the facility accreditation program in Egypt. The first part describes the organizational structure and capacity building of the program, and the second part presents the technical work including developing and testing of standards.

1. Introduction

During the 1990s, the concept of standards against which the performance of health care organizations should be evaluated gained widespread international acceptance. The logical sequel to evaluating health care organizations against specific standards was the desire to provide some formal recognition of those organizations that were successful. This recognition takes the form of accreditation. Several countries have embarked on developing national accreditation programs including Brazil, Spain, and France.

In multiple countries, accreditation has proved to have many benefits. It is an organized process to monitor quality of services and influence the behavior and functions of health care providers to ensure compliance with quality standards. It reduces the variability in quality from one organization to another, it can serve to assist in rationalizing the mechanisms for financing health care, it increases public confidence in care received, and it is an agent for change in the culture and practice of health care. Accreditation is also found to play an important role in strengthening regulation in the area of quality improvement.

In Egypt, health care leaders and members of the lay public recognized that health care needed to be improved and that, absent some catalyst for change in the status quo, meaningful improvements would be difficult. Without a national program, although some individual hospitals might embrace change and an improvement process, it would be unlikely that this would occur on a nation-wide basis.

Recognizing that accreditation has been a successful change agent in many countries, the decision was taken in Egypt to embark on a national health care organization accreditation program with the support of the United States Agency for International Development (USAID). This led to the Partners for Health Reform *plus* Project (PHR *plus*) accreditation program.

Building on the work that was accomplished during the initial Partnership for Health Reform Project (PHR) project, the PHR *plus* accreditation program for Egypt began in 2003-2005. During this period, efforts focused on expanding the focus of the accreditation program in Egypt from PHC facilities to include hospital facilities. More importantly, the work of PHR *plus* focused on assisting the Ministry of Health and Population (MOHP) establish an institutional base for a national accreditation program responsible for implementing and overseeing the program. This document presents a description of the Facility Accreditation Program in Egypt and is divided into three sections:

- ▲ An overview of the accreditation program outlining the main objectives, characteristics, and structure of the program
- ▲ An overview of the development and refinement of the technical standards and accreditation survey instruments
- ▲ A description of the hospital pilot activities and main findings

2. Overview of the Accreditation Program in Egypt

2.1 Rationale for Accreditation of Health Care Facilities in Egypt

Between 1997 and 2000, the USAID-funded PHR project provided technical assistance to the MOHP in the design and pilot testing of health sector reforms. As part of the 15-20 year reform strategy, quality improvement constituted a cornerstone of the Health Sector Reform Program. Without improvements in the quality of care, prospects for reforming the health sector are limited. To this end, the MOHP, with assistance from PHR, developed a strategy for building a Quality Improvement (QI) program. The strategy identified four key objectives: 1) build an organizational structure for QI in the MOHP (this resulted in the establishment of the QI Directorate at the MOHP), 2) build capacity for QI at the central and governorate levels, 3) set and disseminate standards of care and clinical practice guidelines for basic services, and 4) develop a systematic process for monitoring and improving the quality of care which resulted in the first PHC accreditation program.

Over the three-year period, PHR worked with the MOHP to achieve the objectives listed above. While building capacity for QI, an initial set of standards for PHC facilities was developed. Similarly, an accreditation survey tool was developed and automated in a computerized software. A curriculum for training in the principles and practice of QI, including tools and techniques, was developed and implemented. Training was provided to members of the MOHP and to selected representatives of primary health care (PHC) facilities.

For several years, the PHC accreditation program was used by the MOHP to screen facilities lacking minimum qualifications or structure from delivering medical services in the reform facilities. Moreover, the accreditation program set the ground for a performance-based reimbursement system under the reform. The program was tested and implemented in five reform facilities in the governorate of Alexandria and then expanded to cover 350 PHC facilities by the year 2005.

After several years of testing and implementing the PHC initiative, it became evident that the program had several limitations. First, accreditation activities remained linked to the few PHC clinics under the reform program and were not expanded to include the majority of other non-reform clinics in Egypt. Second, there was a gradual realization within the project and the MOHP that the concept of QI, measurable standards, and accreditation should not be limited to PHC. Since health care is a continuum and many patients move from one level to another during an episode of care (outpatient clinic to hospital and vice versa), standards and accreditation should encompass the full spectrum of health care facilities from primary to secondary to tertiary care. Third, there was no formal oversight structure responsible for program implementation and for expanding it at the national level. These observations and concerns led the MOHP, with technical assistance from PHR*plus*, to focus on developing a national program with an independent accreditation oversight body, targeting all facilities from the different sectors, revising the PHC standards and scoring methodology, and developing hospital standards.

2.2 Goals and Objectives of the Accreditation Program

The primary goal of the accreditation program under *PHRplus* was to create the framework for a national health care facility accreditation program to foster a culture of improvement in health care that would be sustained and grow after donor support is terminated.

To accomplish this goal, specific objectives were established. Each of these objectives is described in subsequent sections of this report. In summary, they are listed below:

- ▲ Establish an oversight organization with membership, roles and responsibilities, and organizational structure. Currently, this is the National Accreditation Board (NAB)
- ▲ Work with the NAB to formalize the accreditation program, perhaps by a presidential decree
- ▲ Develop and gain broad consensus on hospital standards and the survey process
- ▲ Update and gain broad consensus on revised PHC standards and the survey process
- ▲ Develop selection criteria for surveyors
- ▲ Train surveyors who can continue the process without technical support
- ▲ Develop a training curriculum for surveyor training
- ▲ Identify surveyors who are highly qualified to be trainers of future surveyors (train the trainers)
- ▲ Develop a process for certification of qualified surveyors
- ▲ Test the validity and applicability of the hospital standards in selected pilot hospitals representing all the hospital sectors in Egypt (MOHP, university, teaching, specialty, and private) and modify the standards when needed based on the result of the test
- ▲ Develop a scoring methodology to make the accreditation decision process uniform across all types of health care facilities

3. Development of National Accreditation Program for Egypt

3.1 Key Principles for Success of Program Development

During the entire program development, a consensus was rapidly reached that certain principle elements must be present for the program to succeed. For the accreditation initiative to be successful, the program had to be accountable, credible, applicable, consistent, transparent, objective, and impartial of oversight.

Accountability: For a national program to succeed and be self-maintaining there must be accountability. Accountability starts with an oversight organization that is accountable/responsible for the conduct, maintenance, and integrity of the program. Accountability also resides at the level of the health care facility director who is to be held accountable for ensuring that his or her facility meets and continues to meet the accreditation standards. Accountability then follows to the individual providers and staff who are held accountable for their part in meeting and maintaining compliance with the standards.

Leadership: Leadership must start at the national level with a commitment to make accreditation an integral part of a process to improve the quality of health care nation-wide. Leadership then is partially delegated to a national accreditation board and office to provide direction and guidance by taking the lead role in selecting, training, and certifying surveyors and overseeing the integrity of the survey process and the granting or denial of accreditation. Finally, and perhaps most importantly, is the leadership at the individual health care facility. Since meeting accreditation standards requires change in customary modes of behavior and since most people follow the direction of their leaders, facility leaders can make or break the process in their area of responsibility.

Credibility: To ensure credibility certain factors were considered to be of paramount importance. First, the standards should specifically reflect Egypt's cultural and religious mandates. In other words, to simply adopt standards from another country or another area would not work. Second, while reflecting Egypt's unique culture, the standards should as closely as possible, reflect international norms and standards. In the future, an accredited hospital and its patients should be able to know that by being accredited in Egypt, the health care facility has demonstrated that it meets the intent of standards that would be expected of a hospital anywhere in the world. Third, many standards should require effort to be achieved. To simply adopt standards that reflect current practices would be of little value. A health care facility should be required to change and improve. Early in the development of standards there was a tendency to state that a proposed standard should not apply since "that is not how we do it here." However, commendably, these views were quickly overwhelmed by the majority of participants who responded "Yes, we know how we do it now. But how *should* we do it?" Fourth, the surveyors must be viewed as true experts who are impartial and free from personal or political agendas.

Applicability: Consensus was quickly achieved that the standards should apply equally to all health care sectors. Particularly for hospital standards, it was agreed that they should apply equally to MOHP, teaching, university, specialty, and private hospitals. The PHC standards also should be applicable in all PHC facilities, including any private clinics that in the future might seek accreditation. Although *individual* standards might not be applicable in some facilities based on the services they provide and the types of patients they serve, the bulk of standards should apply in all settings.

Consistency: The standards must be consistently interpreted and applied. Personal opinion about the standard must be reduced or eliminated. Based on the experience in many countries, it was recognized that surveyors might interpret standards differently, and thus the consistency from one surveyor to another, or from one survey team to another, might vary significantly. To address this need, a surveyor guide was developed that identifies for each standard what the surveyor should look for to demonstrate compliance and a uniform requirement for how to score each standard. Although the surveyors may be free to offer *advice* about how the standard might be better met, they are limited to scoring the standard in accordance with the survey guide. The scoring methodology is discussed later in this report.

Impartiality of Oversight: Oversight for the program should not reside in only one sector. To ensure that the program is free from potential, or perceived, conflicts of interest, the oversight of the program should be vested in a broadly based independent agency with representation from all the health care sectors, non-health care government and private agencies and entities, and representatives of health care consumers. The concept of an independent National Accreditation Board in Egypt is under discussion and several steps were taken to legislate the independence of the program.

Transparency: For the program to succeed and gain credibility among health providers, the standards, survey process, scoring, and accreditation decision should be transparent. All facilities must know in advance what is required, how they will be surveyed, how they will be scored, and how and by whom the accreditation decision will be made.

Objectivity: The survey process and accreditation decisions must be insulated from any implication of bias or political influence. The accreditation decision process must be the same for all facilities, and must be based on objective and quantifiable factors.

Furthermore, the selection and certification of surveyors must be uniform and based on objective evidence of their knowledge and direct observation of their surveying skills.

3.2 Characteristics of the Accreditation Program

3.2.1 Eligibility and Scope of Program

The accreditation program in Egypt is designed to accredit all levels of health facilities in all sectors. This will include PHC facilities and secondary and tertiary care hospitals in both the private and public sectors. It is imperative that the program should oversee all health care facilities (PHC and hospital). Since health care is a continuum, and should not be viewed as a series of isolated events dependent exclusively on the physical location of the care, accreditation and its oversight should encompass all types of health care facilities.

While all facilities are eligible for accreditation, many facilities may require significant efforts to prepare for accreditation such as instituting a patient record system or a quality improvement program.

3.2.2 Type of Program: Voluntary or Mandatory?

One of the issues that is still being discussed in Egypt is whether participation in the accreditation program should be voluntary or mandatory for health facilities. Several key questions are raised when addressing this issue: If voluntary, what is the incentive for a facility to participate? If mandatory, should the mandate be to participate or to succeed? Should there be recognition only for success, or also for efforts even if not yet successful?

In most developed countries with a mature health care accreditation program, accreditation is voluntary. However, in these countries there are federal and local laws and regulations that ensure oversight of the quality of the care and the facility even if it is not accredited. In fact, in many countries much of the health care regulatory structure is modeled on the accreditation standards. Therefore, even if a health care facility chooses not to seek accreditation, they are not free from some form of regulatory oversight. Thus, the incentive for becoming accredited is both philosophical (a desire to be measured and receive the recognition of meeting a rigid set of standards) and pragmatic (by being accredited some or all governmental inspections are eliminated). However, in developing countries, this formal and universally applied government regulatory oversight does not exist. Therefore, except perhaps for private facilities that view accreditation as a “market advantage,” there is little incentive to participate in a voluntary program.

Since the overall goal of the project in Egypt is to create a self-sustaining culture of improvement in health care, voluntary participation may well allow many facilities to cling to the status quo and deny that improvement is needed. The risk of the program being voluntary is that it will be embraced by only a few facilities and nation-wide improvement and change in culture and practice would not occur. For example, should a university or teaching hospital choose not to participate, then future generations of health care professionals trained there will continue to behave and practice in the “old” way and nation-wide improvement will be significantly delayed, potentially for many years. If, on the other hand, accreditation were made mandatory, all health care facilities would be required to participate. This approach would eliminate the question of incentives since it would be a requirement and the facility director would not have the opportunity of electing not to participate. However, not all health care facilities may now have the resources to meet all standards. In this case, the accreditation program may be introduced gradually and in stages. It may be advisable in the early stage of the program to provide a different level of recognition other than full accreditation to those facilities that are meeting the standards as best they can within the constraints of their resources. However, full accreditation should be reserved for those facilities that *fully* meet the accreditation standards. Patients should have the right to understand the accreditation status of the facility where they receive care.

For all the factors listed above, making participation in the accreditation process mandatory may be the preferable option. To accomplish this, several steps have been taken towards achieving legislation that will mandate accreditation for all health care facilities in the future.

3.2.3 Financing the Accreditation Program

In countries with a national program, the initial or “start-up” funding has come either through government subsidies, grants from non-government professional organizations (such as the American College of Surgeons and the Canadian Medical Association) or grants from other non-government organizations (the Donabedian Foundation in Spain). However, after initial funding and once the program is established, it must become financially self-sustaining and cannot rely on long term subsidies. Today, the majority of countries fund their program through fees charged to facilities to undergo an accreditation survey. The fee serves to support the cost of the accreditation program. Additional funds may be generated by tuition charges for sponsored accreditation training courses and by development of publications for purchase.

In Egypt, initial funding for the development of PHC accreditation (1997-2000) and later for the development of the hospital accreditation (2003-2005) has been with assistance from USAID. However, several steps have been taken to prepare for the future financial sustainability of the program. To start with, *PHRplus* conducted a costing study to determine the cost of an accreditation program in Egypt over a period of 15 years. The study projects costs in five-year stages to ensure gradual phasing in of funding sources with initial phases including government support followed by gradual application of a facility-based accreditation fee structure.

3.3 Organizational Structure of the Accreditation Program

The accreditation program in Egypt is designed as a “quasi-public” model. This indicates that the program is an independent government program with representatives from all sectors (public and private) as well as from the community. The government of Egypt (GOE) has the authority to implement the program. However, as indicated earlier, for the program to be successful, the oversight body responsible for enforcing the program should be impartial.

In 2003, the Minister of Health and Population launched the accreditation program through Ministerial Decree number 271. The decree establishes a National Accreditation Board (NAB) consisting of 22 members representing all health care sectors – public and private – as well as non-health care representatives. The NAB is chaired by the Minister of Health.

The current structure of the board is still in its transitional phase and several efforts are underway to pass a law that establishes an independent body responsible for overseeing and implementing a national accreditation program. The MOHP, which initiated and facilitates the development phase of the program, will continue to be an important partner in the future independent program.

The current structure of the accreditation program consists of three important organizational entities:

1. An accreditation board as the main oversight body
2. An accreditation management office responsible for the day-to-day operation and coordination of the program
3. A team of surveyors

3.3.1 Structure of the National Accreditation Board

The NAB has been established according to the decree mentioned above. When fully functional, the board should have a formal structure including:

- ▲ Chairperson
- ▲ Secretary
- ▲ Executive committee
- ▲ Subcommittees such as:
 - △ Standards development/revision to judge, approve, reject, or modify suggested changes by the accreditation management office
 - △ Survey process to review the results of survey and surveyors performance and recommend modifications to the process as needed based on experience
 - △ Accreditation decision to approve, modify, or reject recommendations of the accreditation management office
 - △ Budget/Finance to approve fees and other financial fiduciary responsibilities

3.3.2 Roles and Responsibilities of the National Accreditation Board

The main responsibility of the NAB is to oversee all health care accreditation programs and ensure the integrity and credibility of the accreditation process. To accomplish this, it should have the final authority on:

- ▲ Accreditation decisions and authority to grant or deny accreditation to a health care facility
- ▲ Selection and certification of surveyors
- ▲ Approval of new or modified standards
- ▲ Interpretation of standards
- ▲ Scoring methodology
- ▲ Weighting of individual standards
- ▲ Determining the importance of individual standards as critical, core, or non-core (this is discussed in more detail later in this report)
- ▲ Overseeing the accreditation management office
- ▲ Ensuring that the accreditation is mandatory and truly national by working with the GOE to formulate the required legislation and administrative rules

3.3.3 Accreditation Management Office

Since the board itself may not have the technical skill or professional knowledge to accomplish all these responsibilities, it should establish a formal accreditation management office. This office should have a full-time director reporting to the board and a support staff sufficient to fulfill the following functions:

- ▲ Provide administrative support to the NAB
- ▲ Manage the daily operations of the accreditation program
- ▲ Provide ongoing review of standards and proposed updating when needed
- ▲ Ensure quality control of survey reports. This involves reviewing the draft reports submitted by the survey team to ensure that they are complete and that all standards scored by the survey team as not fully met have adequate documented evidence to support this conclusion
- ▲ Make recommendations to the NAB about the proposed accreditation decision for surveyed organizations
- ▲ Formulate official interpretation of standards in response to questions from surveyors or health care facilities
- ▲ Train surveyors and recommend to the NAB those qualified to be certified
- ▲ Process applications for surveys
- ▲ Schedule surveys and determine duration of survey process
- ▲ Recommend to the NAB the fees for accreditation surveys, training courses, and publications
- ▲ Provide proposed annual budgets to the NAB
- ▲ Provide logistic support (travel and accommodations) to survey teams
- ▲ Provide and/or support training courses, including the preparation of printed materials for staff of health care facilities to learn about the standards and the accreditation process

4. Development of Accreditation Standards

4.1 Development and Consensus Building for Hospital Standards

The staff of the Quality Improvement Department (QID) of the MOHP had begun to develop a draft of hospital standards using a “checklist” approach. An initial rough draft of hospital standards was completed by late spring of 2004. Development of these draft standards included the participation of a group of experts from the various sectors.

During the later part of July and into early August 2004, PHRplus facilitated a series of meetings in the QID offices. These meetings were attended by representatives from multiple departments in the MOHP as well as by representatives from all the hospital sectors. At the meetings, the initial draft of the hospital standards was reviewed and the decision to make them adhere as closely as possible to international standards was confirmed. At the conclusion of these meetings, occurring over a two-week period, there was broad consensus on the standards for hospitals. One of the key principles of credibility was agreement that the Egyptian standards should closely mirror international standards. After final consensus on the Egyptian standards, a side-by-side comparison demonstrated that the Egyptian standards met the intent, although not necessarily the specific language, of the *Joint Commission International Accreditation Standards for Hospitals, Second Edition*.¹

4.2 Types of Standards and Weighting

Rather than using a checklist approach, the standards were organized into a total of 14 chapters that represent a mix of department-specific standards and standards that defined processes that are organization-wide. The chapters and their content are:

1. Patient Rights
2. Access and Continuity of Care
3. Assessment of Patients
 - a. General Assessment
 - b. Laboratory
 - c. Radiology
 - d. Pain
4. Care of Patients

¹ *Joint Commission International. 2002. Joint Commission International Accreditation Standards for Hospitals, Second Edition. Oak Brook, IL.*

- a. Surgery
 - b. Anesthesia/Sedation
 - c. Medication Use and Pharmacy Services
 - d. Blood Bank
 - e. Emergency Care
 - f. Newborn Care
5. Clinical Safety
 - a. Infection Control
 - b. Sterilization
 - c. Employee Health
 6. Environmental Safety
 7. Support Services
 - a. Housekeeping
 - b. Kitchen and Food Services
 - c. Laundry
 8. Quality Improvement and Patient Safety
 9. Medical Records
 10. Management of Information
 11. Human Resources
 12. Management and Leadership
 13. Medical Staff
 14. Nursing Services

4.2.1 Types of Standards

Consensus was reached on dividing the standards into three categories: critical, core, and non-core.

Critical standards are those that were considered so important to quality of care and the correct functioning of a hospital that no hospital could be accredited unless 100 percent of these standards were fully met.

Core standards are those that were considered to be of great value, but that a hospital would not be expected to have to fully meet all of them to become accredited.

Non-core standards are those that represent laudable goals for the future, but that may take considerable time and gradual change in traditional approaches to reach. In other words, the non-core standards were “stretch” standards.

Because it was recognized that every one of the core and non-core standards was not of equal importance, each was assigned a numerical weight from 1-5 with 5 being the most important and 1 being the least important.

As discussed in the next section of this report, the categorization of standards into critical, core, and non-core and the assigning of a numerical weight to each, supported the development of a scoring system that will guide the accreditation decision process.

4.3 Scoring Methodology and Accreditation Rules

Each individual standard is scored on a three-point scale of 0, 1, and 2 or not applicable. A score of zero means that there is no compliance with the standard. A score of 1 means there is partial compliance and a score of 2 means full compliance. If based on its services, a standard does not apply to a facility, it is listed as non-applicable and this standard does not reflect on the final score.

Each individual standard also has a weight from 1-5. Therefore, each standard has a maximum attainable score, which is the weight times two. At the conclusion of the survey, each standard will have been assigned a score by the survey team. This score times the weight of that standard is the actual score for that standard. Then, the aggregate total of the actual scores for all the core standards divided by the aggregate maximum attainable score for all the core standards becomes the aggregate percent score for the core standards. The exact same process is used for the non-core standards.

To be granted accreditation the facility must meet the following criteria:

- ▲ One hundred percent of all critical standards must be fully met (score 2).
- ▲ The aggregate score, as defined above, for the core standards must be 85 percent.
- ▲ The aggregate score for the non-core standards must be 40 percent.

This scoring methodology gives maximum flexibility to the NAB to foster continued improvement in health care facilities. For example, in the future, the NAB could determine that some current core standards should be moved into the critical category and some non-core standards should be moved into the core category. The NAB can also revise upward the weighting of standards. This flexibility allows the NAB to gradually “raise the bar” and make accreditation a progressively more valuable tool for fostering improvement and change in traditional patterns of practice.

In addition to the numerical scoring rules, for the initial survey the facility must demonstrate that it has been in compliance with the requisite percent of the standards for a minimum of the six months prior to the survey. The intent of this “track-record” requirement is to ensure that the facility maintains compliance and does not view it as a one-time effort. Accreditation will be granted for two years. As the program matures, the track-record requirement will be expanded to at least one year and the duration of accreditation lengthened to three years.

4.4 Surveyor Guide

One of the problems that plague accreditation programs around the world is lack of consistency between surveyors. Although it is clear that surveyors must exercise judgment, the consensus was that some method should be developed to reduce the variability in the surveyor's interpretation of whether a standard was fully met, partially met, or not met.

A guiding principle incorporated in the surveyor guide is that surveyors should look for actual evidence of compliance with standards and not be content to simply accept a description that it is present.

A surveyor guide was developed and reviewed with an expert committee from the MOHP and other sectors and consensus was reached on its format, content, and value.

The survey guide follows the chapter outline of the standards themselves. For each chapter there is an introduction describing the survey activities, such as interviews and observations as well as any documents that should be reviewed. To guide the surveyor in reaching conclusions about the status of compliance with each standard there is a description of what evidence the surveyor should look for and how this evidence can be obtained or found. Following the description of the process the surveyor should use to obtain evidence about compliance with a standard is a detailed description of what evidence must be present to score the standard as fully, partially, or not met. The adherence to the rules found in the survey guide will reduce the variability of interpretation between individual surveyors and will guide the accreditation office in quality control of the survey reports to ensure that survey findings accurately reflect the scoring rules (see Section 4.3).

The new hospital standards and survey guide have been published as separate documents by *PHRplus* and the MOHP.

4.5 Survey Tool and Report Template and Automation

Because facilities may require multiple consultative visits as they prepare for the actual accreditation survey, a survey tool and report format was developed for survey/consultation visits. During preparation visits to a health care facility, the surveyor/consultant team is expected to score the current status of each standard that is applicable to the facility. For each standard that is not fully met, i.e., scored as zero or one, the surveyor/consultant team must document the specific findings that led to this conclusion and provide recommendations on what the facility might do to correct the deficiency. The survey tool and report template is similar to the actual accreditation survey except that only findings must be documented and recommendations are not required.

The scoring of the standards and the aggregation to determine the percent that are fully met has been automated. *PHRplus* developed an Access-based computerized system for data entry, analysis, and reporting.

4.6 Revision and Consensus Building for PHC Standards

4.6.1 Process and Rationale for the Revision of the PHC Standards

The revision was intended to accomplish three objectives: 1) bring the PHC standards into a similar format with the hospital standards, 2) use the survey guide concept so that the “checklist” approach did not dominate, and 3) make the scoring methodology similar to hospitals, thereby eliminating the concern that a PHC facility could become accredited even if it was not performing a critical function.

The basic concept used was that although there are standards that logically apply only to hospitals and there are standards that logically apply only in a PHC setting, the bulk of standards relating to patient care processes should universally apply to all settings where patients are seen.

The approach to the revision of the PHC standards included:

- ▲ Reviewing the hospital standards and eliminating those standards not applicable to PHC facilities
- ▲ Editing of hospital standards that would be equally applicable (patient care processes) to PHC facilities to make the language for the standard PHC specific
- ▲ Reviewing the current PHC standards and adding those not covered by steps one and two
- ▲ Separating the standards from the survey guide (eliminating the checklist approach)
- ▲ Dividing the standards into the same three categories of critical, core, and non-core
- ▲ Assigning each standard, versus a chapter, a weight, thereby eliminating the possibility of a PHC facility becoming accredited even if it was not performing a critical function
- ▲ Using the same scoring methodology as for hospitals

The rationale for this approach included:

- ▲ Some standards are applicable only to PHC facilities. Other standards are applicable only to hospitals. However, the majority of standards relate to patient care processes that are independent of the setting where care is provided. The standards should focus on uniform care processes, not just on the setting of the care. If a standard is important for the care of patients, it should apply to any setting where care is provided.
- ▲ This is the same process being used to develop international standards for ambulatory care.
- ▲ The hospital standards are more current and more closely mirror international standards and were written in more measurable and objective terms.
- ▲ If the format and structure (for example chapters) and the basic content of the standards are similar, surveyors may be more easily trained to survey both hospital and PHC standards.
- ▲ It makes the accreditation decision process for the NAB similar for all programs since the

scoring methodology is the same.

Then, using the identical approach as for the hospital standards, a PHC survey guide was prepared.

The new PHC standards and survey guide have been published as separate documents by *PHRplus* and the MOHP.

4.6.2 Consensus Building for New PHC Standards

Two days of meetings were held with representatives from Cairo University, Ain Shams University, the Quality Improvement Directorate, the Blood Bank Department, the PHC Department, the Environmental Safety Department, the Maternal and Child Health Department and the Pharmacy Department of the MOHP. During these two days, the methodology and the rationale for the revisions were discussed. The draft revision of the PHC standards and the survey guide were reviewed in detail and modifications were made based on the input from the participants.

5. Selection, Training, and Certification of Surveyors

The survey is a key step in the accreditation program. It is an organized and structured mechanism to identify strengths and weaknesses of a health care facility. The survey process consists of a site visit to the facility conducted by a team of experts trained in the use of the accreditation survey instrument and tools. In addition to evaluating compliance with national standards, surveys are useful venues for exchanging skills and expertise between the survey team and facility staff.

To this end, one of the most critical factors in making the accreditation program credible is the quality and integrity of the surveyors. To ensure a highly qualified group of surveyors, the program should have the following:

- ▲ Selection criteria for “candidate surveyors”
- ▲ A training curriculum for surveyors
- ▲ A formal process for certification

Each of these is discussed below.

5.1 Selection Criteria

To be selected as a candidate for training as a surveyor, the individual should meet at least the following criteria:

- ▲ The individual should be a volunteer with interest in and enthusiastic support for the accreditation process. Surveying experience should not be a requirement of the job.
- ▲ The individual must have credible experience, such as at least 10 years of experience working in a hospital or PHC setting or both. If surveyors do not have actual “hands-on” experience, or experience was in the distant past, it becomes very difficult for them to relate to the “real world” of health care.
- ▲ Must have good interpersonal and interviewing skills.
- ▲ Must have demonstrated ability to be an effective teacher. A surveyor is not just an inspector. They must be able to instruct staff how to meet the standards and effectively gain the confidence of the hospital personnel.

In addition to these personal attributes, the selection of “candidate surveyors” should ensure representation from all health care sectors (university, teaching, specialty, private, MOHP, and PHC). The selection should ensure a broad representation of health care professionals and not just doctors.

5.2 Training of Surveyors

To ensure accountability of the program, PHR*plus* realized the need to have a rigorous surveyors' training program that includes several steps. Each "candidate surveyor" should go through the following training steps:

1. Attendance of formal didactic course on the standards, the survey process, the surveyor guide, and the scoring methodology
2. Observation of at least one practice survey conducted by an experienced surveyor
3. Conduct at least one (or more if needed) practice survey under the observation and tutoring of an experienced surveyor
4. Conduct one evaluation survey under the supervision of experienced consultants
5. Pass a final written exam on standards and the use of the survey guide

Evaluation of their practical survey skills is based on evaluation of the following factors:

- ▲ Ability to work cooperatively in a group situation
- ▲ Ability to actively participate
- ▲ Ability to listen without interrupting
- ▲ Ability to convey a positive and helpful attitude
- ▲ Knowledge and understanding of standards, survey process, and scoring rules
- ▲ Interviewing skills
- ▲ Correct interpretation of standards
- ▲ Ability to teach

5.3 Certification Process of Surveyors:

To receive NAB certification as a qualified surveyor, the following steps must be completed:

1. Successfully complete steps 1 – 3 (above) of the training curriculum.
2. Successfully pass a written test on the standards and the survey process. It may be possible for highly motivated individuals who do intense self-study to meet these criteria without attending a formal didactic course required by step 1.
3. Have the endorsement and recommendation of the supervising experienced surveyor.
4. Conduct one final evaluation survey.

5. Obtain final NAB approval.

The initial group of surveyors recommended for certification will be classified as either qualified surveyors and/or as qualified trainers for future surveyors. Yet to be determined is whether there should be a third category – those who are qualified only to assist health care facilities prepare for accreditation, but will not conduct actual accreditation surveys themselves.

6. Pilot Test Hospitals

6.1 Purpose

Early in the development of the hospital standards and survey guide, it was recognized that after the completion of the initial draft, the standards and survey process must be tested in hospitals. The purpose of this pilot test was to:

- ▲ Evaluate whether the standards could be applied to all types of hospitals in all health care sectors.
- ▲ Based on the results of the practical application of standards, identify those standards that should be eliminated (but never based only on the fact that they were hard to do), modified, or added.
- ▲ Develop an initial group of hospitals that have the experience in implementing the standards so they can serve as national resources to other hospitals as they start the accreditation preparation process.
- ▲ Provide practical “on-the-job” training for candidate surveyors (see Section 5.2).
- ▲ Provide assistance to the pilot test hospitals to prepare them to become accredited.

To achieve the objectives listed above, an initial group of five hospitals were selected. There were only two criteria for selection.

Criteria one: Selected hospitals should represent the different sectors in Egypt. One hospital from each of the five hospital sectors were selected, i.e., university, teaching, specialty, private, and MOHP. Although there were many hospitals within each sector as well as in various geographic locations that wished to participate, managing the logistics of the test dictated that it be limited to five and that the test be done in the Cairo area. This was the correct decision since adding more hospitals would have seriously diluted the value and the effort needed to carry out an adequate evaluation.

Criteria two: Commitment of hospital leadership. The hospital director should volunteer to participate and should be committed to the concept of quality improvement and to value standards against which the hospital would be measured, and have a belief in the accreditation process and be willing to devote the resources (staff time) to this project.

The five hospitals that were selected were:

1. Ain Shams University Obstetrics and Gynecology Hospital representing university hospitals
2. Al Galaa Teaching Hospital representing teaching hospitals

3. Abbassia Chest Disease Hospital representing specialty hospitals
4. El Sherouk Hospital representing the private sector
5. Monsheyet El Bakry Hospital representing MOHP hospitals

6.2 Approach

The overall approach in the pilot test hospitals involved a sequence of steps. These steps were:

1. Build leadership awareness in the concept of quality improvement and familiarize the leadership with the accreditation standards and survey guide
2. Perform a self-evaluation and development of an action plan for correction of any standards that the self-evaluation found to be less than fully met
3. Validate the accuracy of the self-evaluation and the effectiveness of the action plan (by PHR*plus* technical advisors)
4. Complete a full evaluation of compliance with the standards by external surveyors

Each of these steps is discussed below.

1. Familiarization of the leadership with the standards and the survey guide

Each hospital's director and senior staff was educated on the concepts of standards and accreditation, the organization of the standards, and how to use the survey guide. PHR*plus* provided them with access to the web-based Joint Commission International course on international standards and an e-learning course containing five modules on quality improvement.

2. Performance of a self-evaluation

Each hospital appointed a team of "internal surveyors." This group was led by one or more individuals who had attended a didactic course taught by PHR*plus* personnel on the standards and the survey process. To prevent the hospital from being overwhelmed by the self-evaluation task, the initial self-evaluation was limited to the critical standards. Once this was completed, each hospital was expected to continue with their self-evaluation by evaluating compliance with the core standards and then evaluate all standards chapter by chapter.

3. Development of an action plan for correction of any standards that the self-evaluation found to be less than fully met

Each hospital was provided with a template that was used to prepare an action plan. The template included a place to write the standard that was not fully met and the findings that led to this conclusion, the recommended action, the name of the individual who would assume responsibility for ensuring that the recommended action took place, the expected time frame for completion of the action, and a final column that allowed the hospital management to track the status of the corrective action. This action plan only needed to include those standards that the self-evaluation found not to be already fully met.

The action plan format is in table form as shown below:

Standard	Findings	Recommended Action	Responsible Person	Time Frame	Status

4. Validation of the accuracy of the self-evaluation and the effectiveness of the action plan by PHRplus technical advisors

During subsequent visits, the PHRplus technical advisors provided feedback and guidance to the hospital leadership. This was intended to accomplish two goals. The first was to assist the hospital in accurately identifying those areas that needed improvement. The second goal was to provide practical experience about how to do a survey by observing experienced international surveyors (PHRplus technical advisors) conducting a “mock” or practice survey.

5. Full evaluation of compliance with the standards by external surveyors

Once the self-evaluation process and the creation and implementation of corrective actions had been done, the next step was to have the hospital evaluated by external surveyors. The external surveyors were drawn from two groups: those who had participated in the self-evaluation in their own hospital and those who had completed the didactic course on the standards and survey process. The purpose of this step was two-fold. First, was to demonstrate the actual process a hospital would go through in becoming accredited. Typically, this involves three steps: self-evaluation, confirmation of the hospital’s self-evaluation by outside surveyors (as in step 4 above), and completion of the actual survey by external surveyors. Second, was to continue the training of surveyors as described in Section 5.2.

6.3 Evaluation Results

6.3.1 Hospitals

One of the purposes of using pilot test hospitals was to validate the accuracy and applicability of the standards to all types of hospitals. Of the approximately 700 standards, none were eliminated as not being valid or applicable, one standard was added, and approximately 15 were modified in some way.

The learning curve of how to do a self-evaluation was steep. The initial results were dependent on how the hospital director viewed the value of the process. Not surprisingly, this varied from a desire to convey that everything was already being done correctly to a desire to use the process to identify ways in which the hospital could improve its services. In general, the early efforts at self-evaluation tended to be rather superficial and did not delve deeply to determine if there was hard evidence that the standard was being met. There was also an early tendency to score the standard as met if there was agreement that it should be done rather than on whether it was actually being done. There was some initial confusion over what was meant by a standard being non-applicable. Some facilities were self-scoring standards as non-applicable because “we don’t do it that way,” rather than because they did not have that service or care for that type of patient.

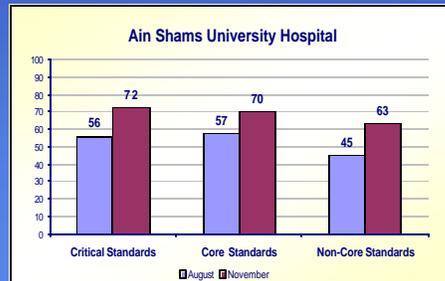
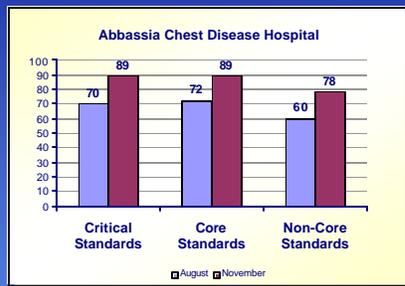
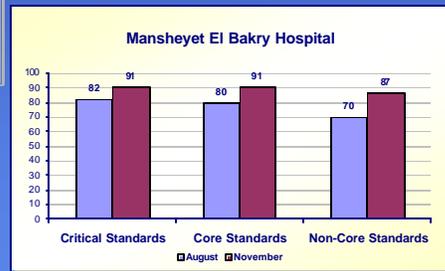
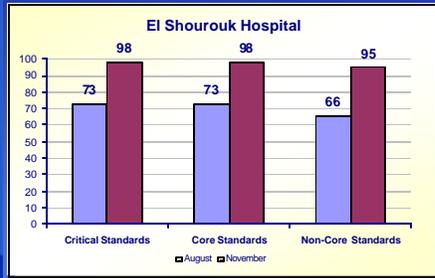
The most difficult standards for the hospitals to accept were the nursing standards, since they represent a significantly different role for nursing than has been traditionally permitted. These standards describe nursing processes that are taught to all Egyptian nurses during their training, even though in the hospital they have not traditionally been permitted to use these skills. However, by the time of the last technical assistance visit, all hospitals had started the process to implement these standards and one had succeeded in fully implementing them. The concept of an expanded role for nursing was being accepted, even by the physicians.

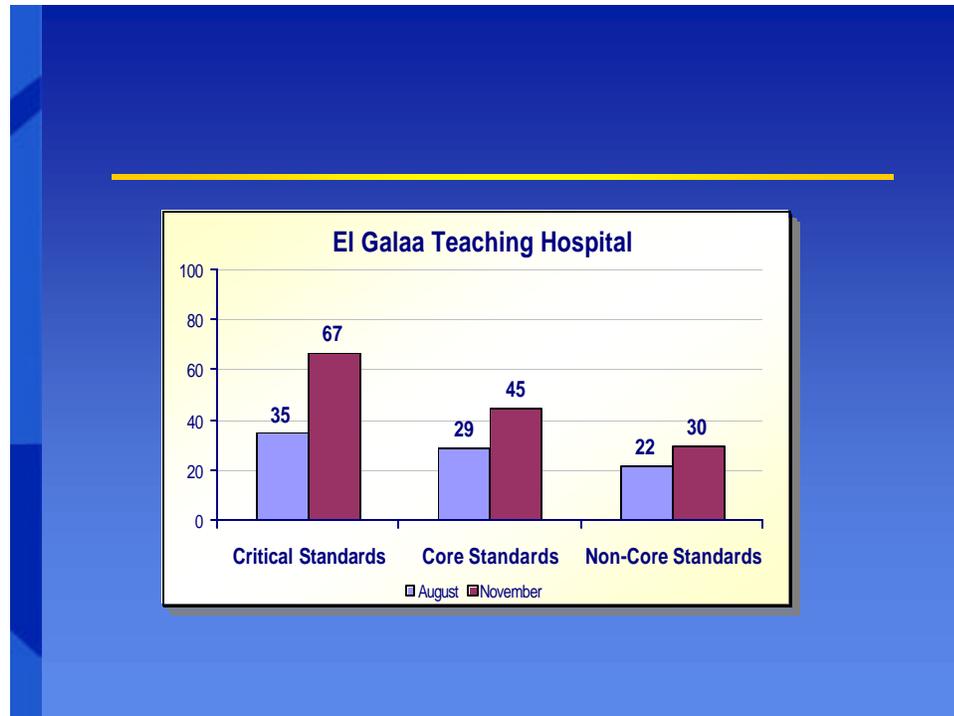
The second most difficult standards were those related to documentation of medical records. Although there was no disagreement over the need for accurate medical record documentation, customary practice needed to be changed and progress has been slow but steady.

Notable results include:

- ▲ All had developed a formal process for improving medical records
- ▲ All had developed a quality improvement program including a committee that was active and at least beginning to collect data for improvement efforts
- ▲ All had either developed or improved their infection control programs
- ▲ All were continuing to develop and implement the required policies and had at least begun the process of educating staff and implementing the policies and procedures
- ▲ All had developed orientation programs for new employees
- ▲ All had begun the process of upgrading the role of nurses in the assessment and care planning for patients

The graphs below show the progress in meeting each category of standards. It is apparent that three of the five pilot test hospitals will be ready for accreditation early in 2006.





6.3.2 Training of Surveyors

The original plan was to train an initial group of 20-25 surveyors and that each would go through the sequential steps outlined in Section 5.2, i.e., attend a formal didactic course, observe a practice survey conducted by an experienced international surveyor, conduct at least one practice survey themselves under the mentoring of an experienced international surveyor, and complete the final written examination. This initial group was also to be the cadre that would assist the pilot test hospitals in starting their self-assessment. An initial group of 26 candidate surveyors received didactic training early in the program. In addition, each pilot test hospital developed a quality team that developed (with technical assistance) in-house knowledge of the standards and survey process. These teams varied in size from five to seven members.

While the criteria for selection (see criteria in Section 5.1) of this initial group were well defined, it became apparent that there were gaps in the selection process of the group, with less than half of the selected team being truly qualified. Therefore, a second course was held six months after the first training. Attending were 20 additional candidate surveyors, 19 of who were university medical school faculty members. The criteria for selection to be included in this second group were more rigidly adhered to.

However, this meant that there were now surveyors in training with varying experience. All had the basic knowledge from the didactic course and their self-study but only those from the initial course had observed practice surveys by the experienced PHR*plus* international surveyors and were ready to conduct a survey themselves under observation of the PHR*plus* surveyors. Others from the second group were observing a survey for the first time. In retrospect, more objective and less political consideration for the selection of the first group would have enhanced the training process of

the surveyors. However, the capability of the second group, drawn mostly from the university sector, was very high so ultimately, this did not present a significant obstacle and in fact, the second group proved to be among the best.

The PHR^{plus} international survey experts evaluated the performance of each candidate surveyor on a numerical scale for the following factors:

- ▲ Ability to work cooperatively in a group situation
- ▲ Ability to actively participate
- ▲ Ability to convey a positive and helpful attitude
- ▲ Knowledge and understanding of standards and survey process and scoring rules
- ▲ Interviewing skills
- ▲ Correct interpretation of standards
- ▲ Ability to teach

Of the total number of 53 candidate surveyors trained, 45 successfully completed all didactic and practical requirements and were certified in a ceremony hosted by the Minister of Health.

6.4 Lessons Learned

Lessons learned include:

1. The *single* most important lesson learned is that success is entirely dependent on the commitment and support of the hospital director as conveyed to his/her staff!
2. Incentives must be internal and based on a desire to improve. Financial incentives rapidly become perceived not as incentives, but as entitlements. The work for which the incentive was provided is quickly forgotten, but the expectation of the extra payment remains.
3. Using the concept of testing the standards and survey process in a variety of hospitals was valuable and has increased the credibility of the standards.
4. The credibility of the accreditation program is highly dependent on the quality of the surveyors. The criteria for selecting the surveyors, as well as the criteria for certifying them as qualified, must be objective and free from political manipulation.
5. Progress will be slow and not all facilities will succeed. Some may even intentionally elect not to.
6. The role and participation of university and teaching hospitals in accreditation is critical. If university or teaching hospitals do not actively participate and support the concept of standards and accreditation, including the concept of continuous improvement, another generation of health care professionals will be taught that the current status is acceptable and that there is no need for improvement.

7. Significant effort and political support is needed to ensure that a sustainable oversight body is present and functioning before the conclusion of the ongoing technical assistance.

7. Next Steps and Recommendations

7.1 National Accreditation Board

The following are short- and long-term recommendations for the NAB.

7.1.1 Short-term Recommendations

- ▲ The NAB should formally approve the certification criteria for surveyors as outlined in Section 5.3 and provide certification of the initial group of surveyors. To demonstrate the importance of certification, the certificates should be signed by the NAB chairman.
- ▲ The NAB should formally approve the criteria for accreditation of health care facilities (hospitals and PHC) as outlined in Section 4.3.
- ▲ The NAB should continue to work with the MOHP and the Parliament to gain approval of appropriate legislation that will formally establish an independent body to oversee the national accreditation program for both hospitals and PHC facilities.
- ▲ The NAB should quickly establish the basics of an accreditation management office. At a minimum, this should include the appointment of an executive director, at least two clerical assistants, and dedicated office space.

A funding mechanism will have to be determined. Potential options are discussed in Section 3.2. This will need to include a mechanism to compensate the surveyors who are not MOHP employees. If a funding mechanism for surveyors is not quickly developed and by default the surveyors are all MOHP employees, the integrity and credibility of the program will quickly be severely compromised.

7.1.2 Long-term Recommendations

- ▲ Under the direction of the accreditation management office, the certified surveyors should continue to work with the original five pilot test hospitals to continue their final preparation for the actual accreditation survey.
- ▲ The NAB should determine the time limitation on accreditation. Two years is recommended.
- ▲ The NAB should nominate additional hospitals to start the accreditation preparation process next year under the guidance of the certified surveyors. Because university and teaching hospitals are responsible for training the next generation of health care professionals, strong consideration should be given to inclusion of several in this group. Although it creates some logistical issues, equally strong consideration should be given to including facilities outside of the metropolitan Cairo area. At least one hospital operated by the national Health

Insurance Organization should be included.

7.2 Hospitals

The original five test hospitals should continue to refine their compliance with the standards with the aim that by no later than the end of 2006, all five are accredited. These hospitals should work collaboratively to develop a repository of “best practices” (under the auspices of the National Accreditation Office) including policies and procedures they developed as part of their accreditation preparation. They should also serve as a resource to other hospitals selected by the NAB to start the accreditation journey in 2006.

7.3 Surveyors

Although the initial group of 45 certified surveyors have demonstrated appropriate skills and knowledge, to become truly proficient they must have the opportunity to practice these skills. Teams should be scheduled to visit the five pilot test hospitals at least every two months to both assist the hospital in the final preparation for accreditation and to further gain surveying experience. The final accreditation survey will need to be done by surveyors who had not participated in the hospital’s preparation. The NAB needs to quickly develop a mechanism to compensate the surveyors for the time they spend.

7.4 Technical Assistance

For practical purposes, one hundred percent of the surveyors and the pilot test hospitals expressed the need for continued technical assistance for at least one more year. Although the surveyors have developed a certain skill level, most, if not all, still need ongoing mentoring until their skills are at a level of self-sustainability.