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TRAINER'S GUIDE

Collaboratives for Quality Improvement in Healthcare

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DISCLAIMER
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Introduction

The improvement collaborative is a major new approach for rapidly improving the quality and efficiency of healthcare. A collaborative focuses on a single technical area (for example, prevention of mother-to-child transmission of HIV) and seeks to rapidly spread existing knowledge or best practices related to that technical topic to multiple settings, through systematic improvement efforts of a large number of teams. A collaborative is a time-limited improvement strategy, usually lasting from 12 to 24 months. An improvement collaborative is made up of any number of teams (usually 15 to 40) from different organizations or geographic regions, that are all focused on making rapid incremental improvements in a single technical area and committed to working and learning together intensively.

Teams participating in a collaborative typically are located in healthcare facilities in different geographic areas and may even work for different organizations. The collaborative engages the teams in working out the operational details in implementing a set of identified best practices in the focus area of the collaborative in their respective settings. The collaborative facilitates active sharing of strategies and ideas for improvement among participating teams, so that teams learn from each other and can quickly benefit from successful changes implemented by other teams.

Collaboratives are designed to achieve dramatic improvements in the quality and outcomes of care in a short period of time by fostering active learning among improvement teams and by regularly tracking and communicating results of the improvement efforts. Teams within a collaborative use a common set of core measurement indicators—usually five to 10 key indicators—that relate to the desired outcomes of the collaborative. Each team collects data for its facility on the indicators and reports these data, usually on a monthly basis, to the other teams. Frequent monitoring and sharing of results helps to spur the pace of improvements, creating a sense of friendly competition among teams to see which team can achieve the best results. The network of shared learning results in rapid development and testing of innovations and solutions to problems, rapid dissemination of effective changes, and rapid development of effective models of care.

Another distinguishing feature of the improvement collaborative approach is that it seeks to spread improvements beyond the participating teams, to be applied throughout the organization(s) participating in the collaborative. Typically, a collaborative on a new topic area may conclude with the development of a package of interventions that have been field tested and proven to yield results in a particular setting. The initial collaborative—sometimes called a demonstration collaborative—may then be followed by a second phase, often known as an expansion, or *spread*, collaborative, that provides a framework for spreading the improvements from the initial or demonstration sites to the rest of the parent health system. This emphasis on intentional spread of the improvements achieved distinguishes collaboratives from other quality improvement approaches and makes collaboratives an attractive scale-up strategy.

Origins of the collaborative approach

The Institute for Healthcare Improvement (www.ihi.org) developed the improvement collaborative approach in the mid-1990s in the United States. Since then, IHI has supported over 1000 teams applying this methodology, addressing diverse healthcare processes and clinical content areas. Healthcare organizations in many other countries have since implemented

improvement collaboratives in hospital and clinical practice settings, demonstrating excellent results.

The Quality Assurance Project began to work with the improvement collaborative approach as part of the project's technical assistance in the Russian Federation in 1998. QAP work with two Russian oblasts to develop and pilot test improved models of care for the management of pregnancy-induced hypertension, adult arterial hypertension, and neonatal respiratory distress syndrome. QAP worked with teams in a small number of health facilities in Tver and Tula Oblasts to update local clinical guidelines and then introduce a series of changes. After 24 months, teams had succeeded in putting in place new models of care that had demonstrated results in the Russian healthcare setting. Following the initial demonstration collaborative, the models of care were scaled up to the rest of the healthcare facilities in the two oblasts over a 12-monthy period. Thereafter, QAP assisted the Ministry of Health of the Russian Federation to start five national improvement collaboratives involving 23 Russian territories in the spread of the improved systems of care that had been developed in Tula and Tver as well as new collaboratives in HIV Care and Support.

QAP also began to apply the improvement collaborative approach in other countries and to new clinical areas, such as essential obstetric care and HIV/AIDS. In 2003, QAP started improvement collaboratives in Rwanda (one on PMTCT-VCT and a second collaborative on child malaria), Ecuador (essential obstetric care), Nicaragua (one on essential obstetric care and a second collaborative on pediatric care in hospitals), Honduras (essential obstetric care), Eritrea (pediatric hospital care), Niger (pediatric hospital care), and Tanzania (infection prevention). In 2004, QAP launched new improvement collaboratives in Rwanda (antiretroviral therapy), Malawi (pediatric hospital care), the Russian Federation (HIV/AIDS care, treatment and support), Tanzania (one on pediatric hospital care, with a focus on pediatric AIDS, and another on family planning), and Benin (essential obstetric care). In 2005, QAP began developing an essential obstetric and newborn collaborative in Niger, building on the scale-up of the Pediatric Hospital Improvement (PHI) collaborative in that country, and developed a national ART/quality of HIV/AIDS care collaborative with the MOH of Uganda starting in one facility in all districts of the country. The Niger EONC collaborative and Uganda HIV/AIDS collaborative were launched early in 2006. Also in 2006 in Russia, a new family planning collaborative for PLWHA was started, and the HIV/AIDS treatment, care and support collaborative moved from a demonstration phase to a spread phase in all 19 districts of St. Petersburg City and three cities in Orenburg Oblast. In 2007, QAP is initiating two new collaboratives: a TB-DOTS collaborative in three departments of Bolivia and a TB-HIV integration collaborative in Vietnam.

Purpose of this Guide

As a result of the successes to be had using collaboratives, there are many organizations in developing country settings that would like to use the adapted methodology.

This manual is intended to serve as a guide for the trainer(s) leading an orientation on how to design and implement a healthcare improvement collaborative for participants with or without prior quality improvement or collaborative experience.

Planning a collaborative is an iterative process. During this workshop, participants will be led through structured exercises designed to help them think through the process. Accordingly, participants will spend most of their time doing exercises with mini-lectures providing the need-

to-know facts.

There is no "one best way" to design a collaborative. There are many factors influencing the available choices. This course will stimulate participants to identify the key questions for designing the "right" collaborative for their setting and organization.

Course Overview

Audience and Participant Selection Criteria

The course is designed for senior and/or middle-level managers who will be in charge of planning and implementing collaboratives for improving quality of care. They may come from government, NGO or private sectors, and may be responsible for these activities at national, regional, programmatic, or institutional levels, including:

- NGO managers
- Host country MOH staff
- Donor or technical assistance organizations that want to support improvement collaboratives
- Those who are considering whether a collaborative is appropriate for their needs

Course goal

- This course is designed to prepare participants for planning and implementing improvement collaboratives in developing country settings.

Prerequisites

- Conducting a collaborative will require certain skills in quality improvement which are not included in this course. These skills include: indicator development; data collection, use, and display; systems analysis; coaching; and working in teams.

Course Content and Duration

The course is designed to be conducted as a three- or three-and-a-half-day workshop. Also, the first section can be modified for use with senior leaders.

There is an optional half-day session at the beginning called "What is Quality Improvement?" that serves as an introduction to the role of quality improvement and teams in healthcare collaboratives.

Next is an introduction to improvement collaboratives that can be used separately as an overview for senior leaders and managers to help them decide whether the improvement collaborative represents the best model for their needs. That is followed by the remainder of the workshop that focuses on the planning and implementing stages of a collaborative.

Methods of Evaluation

- Trainer observation of participant discussion and exercises
- Participant feedback form

Components of the Training Package

This course consists of the following components:

A **Trainer's Guide** containing the same material as the participant manual, plus material for the trainer, including exercises and guidance on how to conduct the sessions.

A **Participant Manual** containing an overview of the course, examples of tools and instruments used by improvement collaboratives, and copies of the PowerPoint presentations used in the course.

Training / Learning Methods

This course is designed to be interactive and participatory, with time for discussion. There will be large and small group exercises to give participants an opportunity to think about and grapple with the types of decisions that they will have to make in planning their own collaborative. There is a minimum of lecture.

Using the Training Package

This course should be led by persons with appropriate facilitation and training skills. The course materials will provide guidance in how to plan and implement a collaborative after the training. It is not expected that participants will design the collaborative during the course.

Adapting the Materials for Different Users

Because the course may be used by a variety of users or organizations, it should be adapted to suit the needs of the user. Some decisions may be made prior to the course that will obviate the need for certain modules; for example, participating sites may have already been selected in advance.

The optional module, "What is Quality?" can be used when the audience includes participants who have not worked in Quality Improvement (QI), or to establish a common understanding of QI.

The module, "What is an improvement collaborative?" can be used as a stand-alone, high-level briefing module for those who are seeking evidence and information to help them make a decision whether to implement a collaborative.

If the implementing organization does not already possess the other technical skills needed (e.g., working in teams/teambuilding, coaching, quality improvement), the Quality Assurance Project (QAP) has training courses that can be downloaded from the QAP website at www.QAProject.org /training.html.

Improvement Collaboratives

The improvement collaborative is a major new approach for rapidly improving the quality and

efficiency of health care. The Institute for Healthcare Improvement (IHI, www.ihi.org) in Boston developed this approach in the mid-1990s to address situations in which there is a big gap between the existing situation and the desired quality of care or outcomes or when evidence exists for a standard of care but it is not practiced. IHI has supported over 1000 teams from various health care organizations in applying this methodology in the U.S. Since then, USAID's Quality Assurance Project has adapted and applied the improvement collaborative methodology in developing and middle-income countries.

Improvement collaboratives seek to adapt and spread existing knowledge (e.g., best practices, evidence-based guidelines) to multiple settings. An improvement collaborative is made up of a number of teams from different geographic regions or from different organizations or units that are all working toward making improvements in a single technical area around a common technical area and common quality improvement goals. The typical collaborative may last from 18 to 24 months. The teams work out the best ways to implement the new practices and overcome barriers in their settings. Then they share their solutions with each other so that none has to reinvent the wheel. A collaborative can achieve dramatic improvements in the quality and outcomes of care in a short period of time by testing change and monthly tracking of how well their improvements are working and then sharing strategies for improvement among participating teams. A collaborative is often followed by a second phase, often known as a spread, or expansion, collaborative, to spread the strategies for improvement from the initial or demonstration sites to the rest of the health system.

How an Improvement Collaborative Works

There are three basic phases in a collaborative: preparation, roll-out, and closure. The preparation phase usually lasts several months, but in extreme cases may last up to one year, depending on the time needed to develop local consensus about the scope and objectives of the collaborative and the complexity of the technical area. The roll-out phase of a collaborative is divided into three to five time periods. Each period begins with a Learning Session followed by an Action Period. Ideally, each Action Period will last from one to six months. Learning Sessions provide updates or training in clinical knowledge and skills and quality improvement knowledge and skills, and provide guidance for improving performance in the area of focus. Learning Sessions also provide teams an opportunity to report on their activities, methods, results, and lessons learned, determine common future actions, and, most important, share best practices in implementing a change. Such sharing among teams enables rapid learning, social support, and encouragement for making further changes. During an Action Period, each team independently engages in planning, implementing, and assessing strategies to implement new practices that will improve their system of care. Support is provided by coaches through visits and (where feasible, conference calls, e-mail listservs) and consultations with each other as well as with technical experts who manage the collaborative. At the end of a collaborative, a conference is often held to share results with members and stakeholders outside the collaborative. If a spread phase is planned, it may begin at that time so that persons new to the collaborative can attend. Members of the collaborative can become change agents and advisors for the spread phase.

Glossary of Terms

Action period	The time between learning sessions when teams work on improvement at their facility, supported by visits (and sometimes calls) from coaches.
Best practices	Evidenced-based (in multiple settings) tools, materials, models of care, organizational arrangements, practices that facilitate compliance with evidence-based norms and standards.
Change package	A collection of changes that when implemented will improve quality. All the sites use the same package. Not all collaboratives use this term. The changes can be an evidence-based best practices, guidelines, or redesign of a process.
Demonstration collaborative	An improvement collaborative that aims to test/implement the change package, and ends with a clearer better defined package; it is frequently followed by a planned spread phase.
Improved change package	The result of work done in a demonstration (initial implementation phase) collaborative in which best practices and possibly modifications in essential norms have been added to the "change package" before its extension to other sites.
Improvement collaborative	A short- to medium-term (12- to 24-month) initiative that functions as process for refining, adapting and making improvements. A collaborative brings together a number of teams from multiple sites (from the same organization or different organizations) where they work alongside experts on a regular, periodic basis to learn and share improved methods for providing care. The collaborative model is expected to facilitate more rapid spread of evidence-based improvements. Collaboratives can also be used to scale up new improvements and knowledge using a spread strategy.
Improvement Objectives	Statements of the improvements that the collaborative seeks to achieve.
Innovations	Quality improvement teams generate, discover, and test solutions (innovations) that help them overcome barriers to implementing guidelines and norms. These innovations do not yet have substantial evidence but are backed by results at least a single site, and can be shared and then tested or improvement objectives until they cannot be improved substantially by other teams. .

Quality indicators	An agreed-upon process or outcome measure that is used to determine degree of adherence to a standard or the level of quality achieved; a measurable variable (or characteristic), usually expressed as numbers (counts), averages, and ratios (proportion or rate).
Learning session	A meeting for selected team members and technical and quality improvement experts to learn key changes in the topic area, quality improvement techniques, and share their successful experiences implementing changes and overcoming obstacles. Teams bring knowledge and materials from these meetings back to their fellow team members to start making changes.
Measurement strategy	A blueprint that describes the collection and management of data that will be used to measure progress and achievement s of improvement in selected areas. It usually includes agreement on a few common indicators related to the desirable outcomes of the change package, a format for collecting data, a plan for data analysis, and an agreement on reporting this data (e.g., run charts) .
PDSA or Plan-Do-Study-Act Cycle	A method used in quality improvement to test changes to see if they have the desired effect.
Promising practices	Innovations or solutions that have been tried in several sites, but have not yet been tested sufficiently or need some tweaking before incorporating into a modified or improved change package. .
Quality improvement	In healthcare, the process of intentionally making care better in some way (e.g., effectiveness, efficiency, etc.), with the ultimate goal of improving the outcomes for healthcare clients.
Scope of a collaborative	The breadth or narrowness of the defined area for improvement, e.g.,: one process of care (AMTSL) vs. a larger system (Essential Obstetric Care).
Spread (or scale-up)	The intentional and methodical expansion of the number and type of people, facilities, or organizations who use the improvements. The theory and application of spread comes from the literature on diffusion of innovation.
Spread collaborative	A collaborative in which there is an intent to expand ("spread") the number of facilities, organizations, or other units using the improvements.
Stakeholder	One who has a share or an interest in the collaborative.
Topic	The area of healthcare improvement.

	Session 1: What is Quality?
	Purpose The purpose of this module is to introduce the concept of Quality and Quality Improvement in healthcare, the basis for improvement collaboratives. **Objectives** Participants will: ❑ Recognize / acknowledge the value of Quality and Quality Improvement
Welcome/ Preview Introductions *10 min*	Welcome the participants and provide general information regarding the facilities such as location of phones, bathrooms, and lunch plans. Present the purpose, objectives and an overview of the content, including a preview of the learning activities to be used. Describe purpose of the workshop and high-level overview of the workshop. For most of the group exercises, participants will ideally be at round tables of 4 to 7 persons, if possible.
Optional Icebreaker *10 min*	If the participants do not already know each other, conduct an activity to introduce each participant. The object is to develop a rapport with the group and "break the ice." Preferably the activity is fun as well as having a relationship to the topic. Ask participants to pair up and take turns interviewing each other about any experience they have had in the past as part of something resembling a community of practice (often abbreviated as CoP). *Define CoP as follows*: A group of "professionals, informally bound to one another through exposure to a common class of problems, common pursuit of solutions, and thereby themselves embodying a store of knowledge." (McKinsey & Co., www.ichnet.org/glossary.htm). It has also been defined as an "informal network or forum where tips are exchanged and ideas generated" (Thomas A. Stewart) The organizational development (OD) concept of a CoP refers to the process of social learning that occurs when people who have a common interest in some subject or problem collaborate to share ideas, find solutions, and build innovations. (en.wikipedia.org/wiki/Community_of_practice)
Discussion *15-20 min*	At the conclusion of the introductions and icebreaker, you may tailor an introductory discussion to participants' organization: ❑ The vision of this organization ❑ Why is quality important to our organization and what is the context of quality improvement in the work of our organization or project?

	❑ Our current level of quality (if data exist) ❑ What work is ahead of us
Presentation: *30-45 min*	**Introduction to QI** This is a section that must not be rushed, as these are the concepts of quality that participants will build on for the rest of the training. Do not expect all participants to understand all concepts by the end, but probe to make sure most participants understand each concept. During the group work, both participants and facilitators will help to clarify concepts of quality that related to the case study. **Show the PowerPoints 1-22 on quality prior to the case study** *Slides 15-21*: These slides elaborate on two concepts from slide 14: focus on systems and processes and QI teams. *Slide 15:* First ask, "What are systems and processes?" and "Why focus on them? Changing systems or processes is more demanding than solving the immediate problem, but leads to more long-lasting solutions. *Slides 16-17:* These two example flowcharts are used in each of the case study options for Session 1 and serve as a preview. Make sure participants understand the basic flowchart shapes and how to read the flowchart.
Q&A on QA	Allow participants to ask questions on basic QA concepts covered so far.

<table>
<tr><td></td><td>What is Quality? Case Study Exercise</td></tr>
<tr><td>CASE STUDY AND EXERCISES

Approxi-mately 4 hours</td><td>Case Study Exercise

The idea of this case study is to put the participants in the shoes of a QI team so that they experience what a team does and see examples of the various elements and principles of QI that the facilitator will emphasize in the plenary debriefing. This is of critical importance if participants do not have experience doing QI.

You may select one of the two prepared case study options, but it is better to develop one that is related to your collaborative topic, if you have one. For an audience composed of mostly non-clinical participants, there is a community malaria case study. For an audience with participants with greater clinical background, there is an Essential Obstetric Care case study. The latter could also be attempted if sufficient clinical background is given to prepare participants. Provide any relevant clinical standards to participants.

Divide the participants into groups of four to six. If you have a mixed group of clinicians and non-clinicians with a variety of backgrounds, split them up so that the groups are heterogeneous.

Advise the groups that they will play the members of a QA team at the health centre (facility) level.

Assign or ask each group to assign the roles of Team Leader (ensures exercises completed and that all participate), Recorder/Reporter (reports to plenary on group findings), and Timekeeper. Distribute the case and questions. For clarity it is good to have one person read the case aloud and make sure everyone understands it. Ask groups to begin working on the case study. Assure that each group is facilitated.

Facilitators should:
• pay attention to the groups and guide them if they go too far off track.
• check to see if groups need help to prepare for the presentation of their work.</td></tr>
<tr><td>GROUP PRESENTA TIONS</td><td>Plenary presentations by the groups. Begin with a different group for each question or set of related questions. Have one group present on a point. Let each groups add where they have something new.</td></tr>
<tr><td>DEBRIEF</td><td>Conduct a discussion on the following points from the case study and follow up using the PowerPoints.
• Quality – the Quality triangle: define quality, measure quality, improve quality.
• The model of improvement.
• The four principles of quality: customer, team work, process/system,</td></tr>
</table>

	data/scientific method. It is important to emphasize the elements in the case study to explain what implementing quality using a facility level QI team might look like. The case study employs following elements of quality: flowcharts, teams, standards, monitoring with indicators, PDSA, analysis of processes, customers (internal and external). The facilitator must provide these links from the case to the principals. This can be a good opportunity to bring in slides 19-21, which explains how people involved with the different steps of the process to be improved should be involved in the QI team. This debrief/discussion will be allow for a more productive focused conversation.
FOCUSED CONVER-SATION GROUP DISCUS-SION **10-15 min**	Discussion, Slides 23 and 24 The discussion outlined in Slides 23 and 24 is based on the ORID facilitation method.1 The objective is to help participants process the information they just heard and read and discuss what they can do as individuals and as an organization to bring quality into their organization or workplace. Other facilitation methods can be used as long as you debrief the previous activity and tie the case study to the future work. Slide 25 is a reprise of Slide 5 and is included for participants to be able to identify what quality methods are currently used in their workplace

[1]Stanfield RB, ed. The Art of Focused Conversation. Toronto: The Canadian Institute of Cultural Affairs (ICA Canada); 1997.

What is Quality?

Option 1: Maternity Clinic Case Study

Concepts of Quality Assurance/Quality Improvement

Description of the situation:

In the NAOURI district, the Zogbokabo maternity clinic conducts activities of pre- and post-natal care, Prevention of Mother to Child Transmission of HIV (PMTCT), vaccination and delivery. Any serious or complicated cases are referred to the maternity doctor who decides action to carry out including referral to the zonal hospital.

Raissa lives in the town of Zogbokabo. This is her fifth pregnancy. For this pregnancy, which is at term, she has completed all the recommended antenatal visits. As soon as she felt the 1st signs of labor, Raissa went to the maternity clinic. Upon her arrival, she is directed towards the office of the midwife. The midwife examines her and gives the instructions. Raissa is then taken to the labor ward which is adjacent the delivery room. In the labor ward, she is supervised by a nurse's aide who comes in from time to time to check dilation. When dilation is advanced, she is moved to the delivery table. Raisa's companion is forbidden to accompany her into the delivery room. During labor, the midwife asks Raissa to push continuously, sometimes pressing down on her abdomen to help. After the baby is delivered, the midwife cuts the cord, gives the baby to the nurse's aide and fills out the partograph hastily. The newborn is wrapped in a cloth and given to Raissa's companion who gives him his first bath immediately. The midwife waits until the placenta is expelled and gives it to Raissa's companion in a container that the family brought for this purpose. Raissa has no tearing in the perineum, but if she had, the nurse would have been called to suture her. But to the great surprise of the midwife, Raissa starts to bleed abundantly. The midwife panics and calls the doctor. The doctor assessed Raissa's clinical history and declared that she should be referred to the District hospital. He was afraid he could not manage the problem. The doctor inserted an IV and telephoned at the District hospital to inform them of the transfer. The emergency room team, after the phone call, made all the provisions for Raissa's arrival. However, upon arrival, after one hour of transport, Raissa, at 36 years of age, had already died.

Exercise 1: Concepts of QA/QI (Trainer's version contains potential answers filled in.)

1. What are the facts in the case?

- *The maternity clinic conducts prenatal, postnatal, PMTCT, vaccination and delivery services;*
- *The patient is an adult multiparous woman who had all the recommended antenatal visits;*
- *The patient decides to go to the maternity clinic at the first signs of labor;*
- *Registering, examination and instructions done by the midwife;*
- *The labor and delivery ward are separate but adjacent;*
- *Monitoring of labor by a nurse's aide;*
- *Instructions to push until delivery;*
- *Midwife put pressure on the abdomen to help;*
- *Partograph hastily filled after delivery;*
- *Newborn was bathed immediately after birth;*
- *Waiting passively for the delivery of the placenta;*
- *Massive hemorrhage;*
- *Up to the nurse to suture;*
- *Panic by the midwife at the hemorrhage;*
- *Decision of the doctor to refer the woman to the district hospital;*
- *Placement of an IV prior to referral;*
- *Telephoned hospital before the transfer;*
- *Emergency services prepared and on standby for the referred woman;*
- *One hour of travel to reach the district hospital;*
- *Death of the woman during transport.*

2. What surprised you about this case?

Depends on the opinion of each participant. Nevertheless, the incapacity to prevent and address hemorrhage at a delivery in a maternity staffed by a midwife and a doctor surprises us much.

3. What examples of good practices (i.e. in favor of quality) that should be encouraged did you read about in this case study?

- *The maternity clinic does prenatal, postnatal, PMTCT, vaccination and delivery; the patient had all her antenatal visits;*
- *the patient decides to go to the maternity clinic at the first signs of labor;*
- *Recording, examination and instructions by the midwife;*
- *Labor room contiguous to delivery room;*
- *Inserting an IV prior to referral;*
- *Telephone before the transporting the patient;*

- *The hospital's advance preparation prior to the referred patient's arrival*

4. What are the examples of opportunities to improve current practices in this case study (i.e., not good quality)?

- *Monitoring of labor by a nurse's aide;*
- *Instructions to push until delivery;*
- *Abdominal pressure to help;*
- *Partograph hastily filled after delivery;*
- *Bathing the newborn minutes after the birth;*
- *Passively waiting for delivery of the placenta;*
- *Leaving it to a nurse to suture perineum tears;*
- *Panic of the midwife faced with the hemorrhage;*
- *No examination or attempt by the doctor to control the hemorrhage before the referral.*
- *Lack of immediate post-partum monitoring (for uterine atony, hemorrhage)*

5. What is your judgment on the quality found in this maternity clinic?

It is up to the participant to answer, but we can say that the services of delivery in this maternity are of an insufficient quality.

6. What are some of the changes one would have to make to avoid such situations?

- *Regular monitoring of labor and delivery using a partograph filled by a qualified person;*
- *Assistance at delivery according to standards;*
- *Active Management of Third Stage Labor (AMTSL);*
- *Checking the uterus for retained products of conception (e.g., placenta fragments);*
- *Staff training on the essential standards of the AMTSL and care of the new-born baby,*
- *Regular supervision of providers*
- *Systematic immediate post-partum monitoring (uterine atony, bleeding, BP, temperature)*
- *Administration of stabilizing interventions at first sign of hemorrhage (uterotonic, uterine massage, etc.)*

Exercise 2: Improving processes

1. **From looking at this situation in the maternity ward of Zogbokabo, what are the improvement priorities?**

- *Regular monitoring of labor with a partograph; include systematic immediate post-partum monitoring*
- *Use of AMTSL*
- *Systematic care of the newborn*

2. **Write two improvement objectives for these priority areas and their indicators.**

   a) *Introduce AMTSL into the daily practices of labor and delivery;*

   % of vaginal births for which AMTSL was applied

   b) *Improve neonatal essential care*

   % of newborns cared for according to standard

3. **In Table 1. below, for each of the major stages or steps, list the persons involved.**

Table 1: Personnel involved

Steps	**Person involved**
1. Reception, Registration	• *Reception Personnel* • *Patient* • *Companion/caregiver*
2. Registration and initial exam	• *Midwife in charge* • *Patient*
3. Monitoring in labor ward	• *Matron* • *Patient*
4. Delivery	• *Midwife* • *Nurses* • *Doctor* • *Patient in labor* • *Patient's caregiver*
5. Care of the newborn	• *Midwife* • *Patient's caregiver* • *Baby*

6. Referral	• *Midwife* • *Doctor* • *Patient* • *Patient's caregiver*

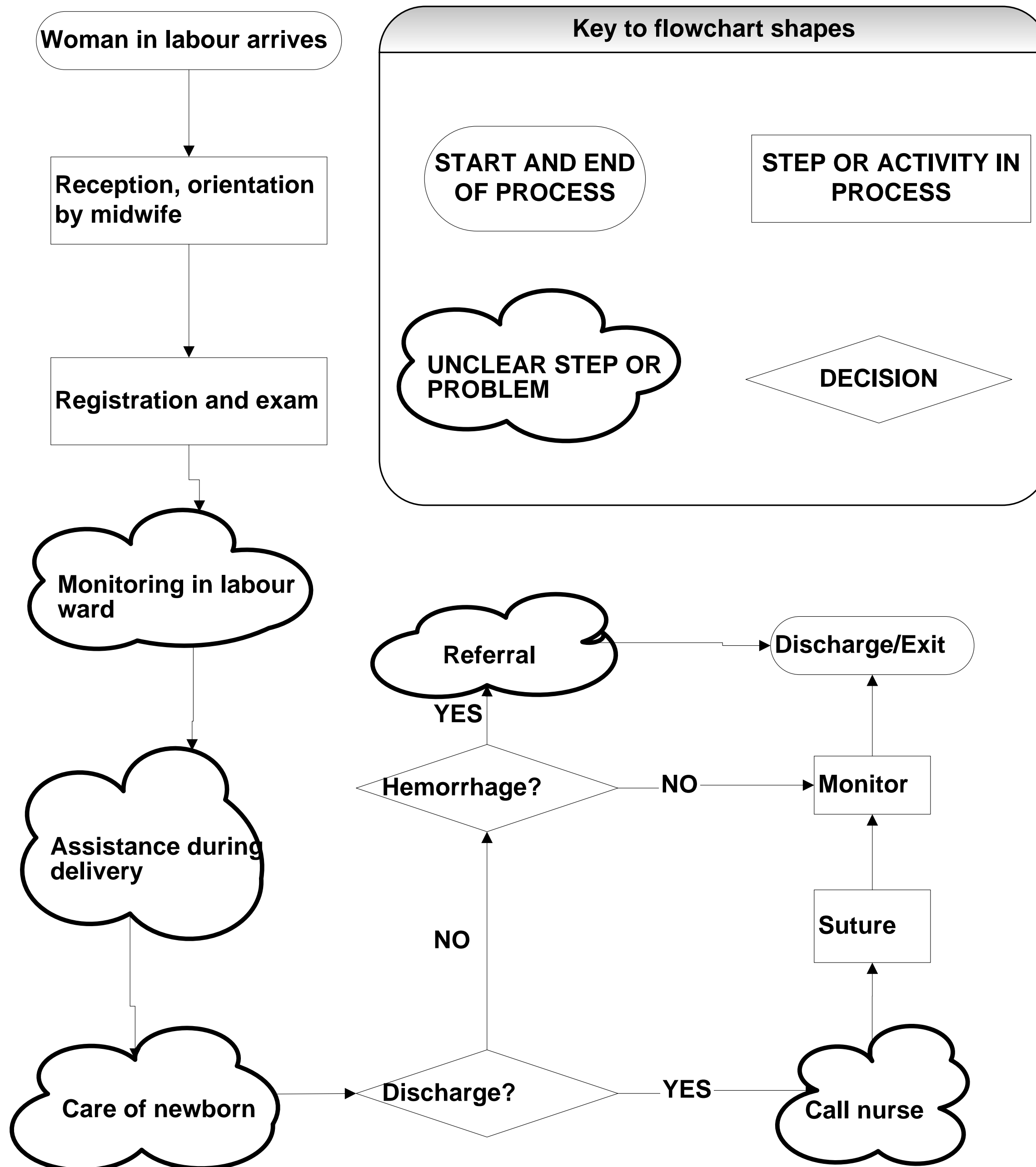
4a. Upon whom will solutions to improve the quality of care issues (outlined in Question 6 in Exercise 1) depend? Who will benefit from these solutions?

The solutions depend on all people listed above, i.e., the people involved in the various stages of the process. The beneficiaries of the improvements from question 6 are also the health staff and women and their babies.

4b. Propose membership for a quality improvement team to take charge of the improvements for the maternity clinic of Zogbokabo.

Doctor, midwife, nurse, nurse's aide, plus one representative of the local health center management committee.

Figure1: Simplified Flow Chart Diagram of the process of women coming to give birth at the Zogbokabo Maternity Clinic.



4c. Based on an analysis of the process flowchart's cloudy steps (bottlenecks or problems), fill in the table below with the actual practice at the Zogbokabo Maternity Clinic (ZMC) and the changes that must occur to achieve the improvements laid out in Question 2 and that would effect the desired improvement in the indicators.

Table 2: Analyze the process

Cloudy Step	What the standard says	Actual practice at ZMC	Changes to support improvement
Assistance at delivery	- Prepare the materials and drugs - Prepare woman psychologically - Perform Infection Prevention measures - Assist labor without abdominal pressure - Inject 10 IU oxytocin IM during the minute immediately following birth - - Perform controlled cord traction - - Perform uterine massage - - Provide immediate postpartum care to the mother and child - - Monitor the mother and the child	- *No psychological preparation of the patient* - *Abdominal pressure during labor (this is contraindicated)* - *No ocytocin in the minute following birth* - *No controlled cord traction* - *No uterine massage* - *No immediate post-partum care to newborn* - *Child bathed immediately following delivery* - *No immediate post-partum monitoring*	- *Systematic application of AMTSL at the maternity clinic* - *Application of essential newborn care* - *Infection prevention measures* - *-Post-partum monitoring*

4d. Choose one improvement from the table above, and describe how you are going to put it into practice by filling in Table 3.

Table 3: Plan and measure the change. Application of AMTSL is the example.

Describe the change to be introduced	*All deliveries in the Zogbokabo maternity should have the three essential features of AMTSL (Administration of oxytocin, controlled cord traction and uterine massage)*
How?	- *Ensure availability of oxytocin (essential element of AMTSL)* - *Train maternity staff on essential standards of AMTSL* - *Provide job aids to be posted in delivery room* - *Ensure adequate materials and supplies for Infection prevention* - *Systematically apply three features of AMTSL at every birth*
When?	- *Following implementation, every week during the team meeting*
Process Indicators	- Availability of oxytocin (% of days oxytocin is available in maternity) - % of midwives trained in AMTSL - % of vaginal deliveries in which AMTSL is performed by trained midwives
Outcome Indicators	- % of vaginal deliveries with post-partum hemorrhage (per month)

What is Quality? Option 2: community-based malaria case study

Description of the situation

In the health zone of Zodji, the district health centre (CSA in French) of Massaka and provides both curative and preventive care services. Serious or complicated malaria cases should be referred to the larger health center, called "CSC."

Akouavi, a 24 year old woman, lives in Sissa with her husband, their two children, and her mother-in-law. The eldest child is very small, ever since he had "tchikéchi" (fever). A few months ago, he has been pale for a few months. But this Monday, it is the younger, an eleven-month-old daughter, who has a fever and who does not want to eat. In the afternoon, Akouavi tries to give her milk and an infusion of leaves. The child refuses it.

The following day, Akouavi sees that the child is not improving, she still has a fever. She won't drink much, despite her attempts to give her some tablets she bought from the drug vendor on the corner. That evening when her husband returns home, he and Akouavi discuss what they should do if the child does not improve by morning. Akouavi decides to go to the CSA, but her husband says that that is not worth the trouble because, as he says, "the center is too far away and the journey is expensive."

During the night, the child has two convulsions. The mother-in-law says that it is a sign of witchcraft, and the family brings the child to the traditional healer who performs a ceremony and gives her a dark drink.

The next morning, the child has a very high fever and remains lethargic. Akouavi and her husband decide to go to the CSA with both children. The trip takes two hours, the family arrives at 9:00 a.m., and waits almost three hours before being received.

Akouavi explains that her daughter has a fever and has not eaten well for 3 days (but does not mention the convulsions).

A blood test confirms malaria. The nurse tells them that the child has malaria and gives them 8 chloroquine tablets, and explains to give her two tablets per day for 4 days. The family returns to the house, and at night, the child dies.

<u>Exercise 1: Concepts of Quality</u> (Trainer's version contains some potential answers filled in below.)

1. What are the significant facts in this case study?

2. What has surprised you in this case study?

Depends on each participant

3. What examples of good practices (i.e. in favor of quality) did you read about in this case study that should be encouraged?

- *Mother recognized the fever quickly and sought care quickly also.*
- *Mother encouraged the child to drink and eat.*
- *Mother accessed care in the community.*
- *Mother brought the sick child to trained providers for care (but late)*
- *Counseling was correct for telling mother how to give the drug.*
- *Norse took history*
- *Blood test*
- *Couple discussed what to do*

4. What are the examples of opportunities to improve current practices in this case study (i.e., not good quality)?

- *Delay in seeking care (the parents don't agree to go to the CSA)*
- *Mother did not understand that malaria requires immediate and complete treatment with a suitable antimalarial*
- *Mother didn't recognize the danger signs of malaria (lethargy, refusal to eat or nurse or drink, convulsions) which need immediate follow-up*
- *Mother doesn't have access to immediate care (cost, distance, perception of bad quality)*
- *Informal sector (drug vendor) didn't provide adequate care and/or referral*
- *Inadequate treatment by the provider at CSA*
- *Family had to wait a long time with a sick child before being received, lack of triage system*
- *Missed the opportunity to check on the other child with problems (not examined).*
- *Missed opportunity to promote insecticide-impregnated mosquito nets*
- *Neglected to give follow-up counseling information.*
- *Nurse gave pills but child wasn't eating or drinking.*
- *Mother didn't mention convulsions.*

5. What is your judgment of the care and treatment of malaria in this community?

One could say that aside from not recognizing malaria danger signs and not taking the child to the CSA immediately, the mother cared for the child adequately at home. The various agents in the community she made recourse to (drug seller, healer, CSA) all provided inadequate care.

6. What could one do to avoid such situations?

Things that must be improved

1) **the promotion of health and recognition of the danger signs**
2) **case management at the community level**
3) **case management at the health center**

Community

1. *Prevention*
   - *promotion of insecticide-treated bednets at the community level*
   - *promotion of prevention at the community level*
2. *Promote the recognition of danger signs at community level among various groups :*
   - *Traditional healers*
   - *Drug vendors*
   - *Women's groups*
   - *Leaders, etc.*
   - *Health centers*
3. *Reduce the delay before seeking care for urgent cases*
   - *Allow moms (women) to make health care decisions for their children*
   - *Have funds for mothers to use for care*
   - *Facilitate transport for serious cases at community level*
4. *Introduce standards for Community IMCI*
5. *Train community health promoters in Community IMCI*
6. *Assure the provision of essential drugs and other resources (e.g.. COARTEM = artemisinin combination therapy (ACT) and mosquito nets) at community level*

Facility/health centre

- *Ensure the adequate supply of essential drugs at the health center*
- *Train providers in clinical IMCI*
- *Regular supervision of the performance of service providers to ensure of the quality of care*

- *Monitor competency of service providers in prevention and counseling for follow-up to avoid missed opportunities. l*

Exercise 2: Improving the process

4. What are the improvement priorities?
   - Promote to mothers the seeking of care early at health centre
   - Promote to mothers methods for prevention of childhood diseases (breast feeding, care of the newborn, hygiene and the use of ITNs (insecticide-treated bednets)
   - To improve the case management of sick children at health facilities via application of clinical IMCI.
   - Improve the case management of sick children and early care-seeking via application of community IMCI.

Focus on malaria

- To improve the quality of the care for children of less than 5 years with malaria at health facilities
- To improve community case management of malaria by mothers of children under 5 years

5. Develop two improvement objectives for the priority health issues and their indicators

a) *To promote the appropriate management of malaria/ IMCI for children under 5 years in the target communities*
   - *% of communities who have COARTEM available (define adequate stock) and who have not experienced a stockout*
   - *% of communities with community health promoter trained in IMCI, treatment of malaria at home or % of community health promoters trained in IMCI or home care of malaria*
   - *% of community health promoters who can demonstrate good case management of children <5 with fever.*
   - *% mothers whose child <5 years had fever in the past 2 weeks and who sought care at the health centre within 24 hours*
   - *# of children seen by the community health promoter for fever in the previous month (percentage if census of all children available)*

b) *To increase the proportion of households using an impregnated bed net / To increase the proportion of mothers and children under 5 who sleep under an impregnated bed net.*
   - *% of communities with trained health promoter trained in promotion of impregnated bednets. or % of health promoter trained in promotion of use of impregnated bednets.*
   - *# / % of households who receive an impregnated bed net*
   - *% of mothers who report using a ITN the previous night (if supervision and F/U of households to whom beds are distributed)*

3. In the table below, for each of the major stages or steps specific to this case, list the persons involved.

Table 1:

Steps	**People involved**
• Prevention of malaria at home	• *Family members mother, father, grandparents, mothers/fathers-in-law* • *Community members (health promoter, GP, leaders, vendors, teachers, church leaders, etc)*
• Early awareness of symptoms	• *Family members* • *Community members (health promoter, GP, leaders, vendors, teachers, church leaders, etc)*
• Decision to seek care early	• *Child's mother* • *Child's father* • *Mother in law*
• Care at home	• *Family members : mothers/fathers/ grandparents, mothers/fathers-in-law*
• Care at informal service provider (vendor and healer)	• *Traditional healers* • *Drug vendor/pharmacist* • *Vendors*
• Care at formal service provider	• *Nurse* • *Doctor,* • *Midwives* • *Nurses' aide*
• Caretaker complies with appropriate treatment and referral	• *Nurse* • *Doctor,* • *Midwives* • *Nurses' aide* • *Mothers/fathers/in-laws/grandparents*
• Referral facility Health centre/hospital provides adequate care	• *Head doctor/ hospital director* • *MOH* • *Nurse* • *Doctor* • *Midwife*

4. Who do the improvement solutions depend on?

The solutions depend on everyone listed above—in other words, the persons involved at each of the different steps of the process.

5. Who benefits when things function well?

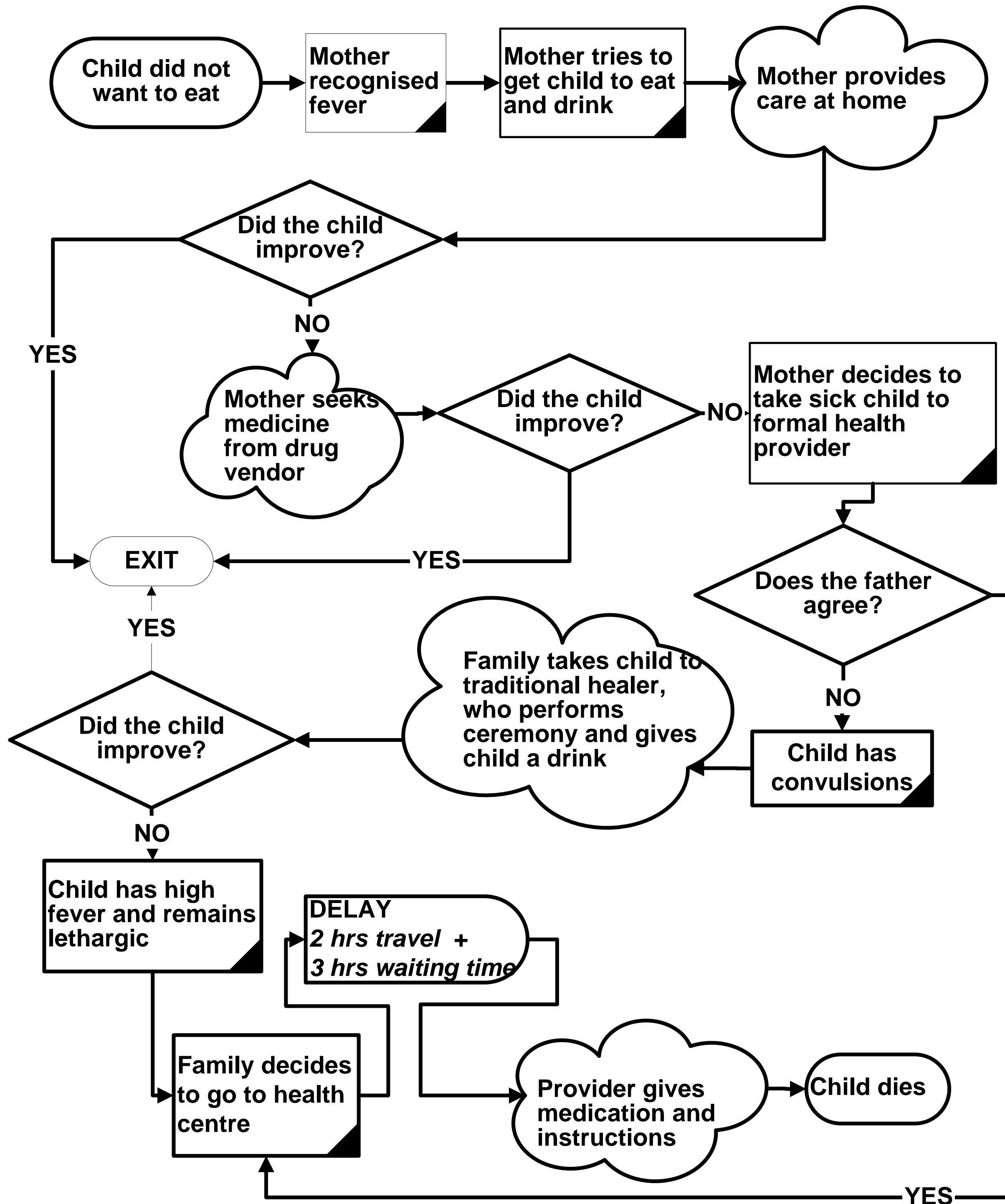
The beneficiaries are the service providers (internal clients) and the families and their children (external clients).

6. Propose a quality improvement team for case management of the children in this community.

Representative of the mothers (women's groups), health promoters, leaders, taxi drivers, schools, representatives of other health-related groups such as IMCI, malaria, etc. Representatives of health facility (if nearby).

Health facility: doctor, midwife, nurse, nurse aide, counselor, representative of Community Management Committee, women's groups and other groups (such as IMCI), representative of community QI team.

Figure1: Diagram of the original process of case management of children with malaria in the community



8. **Based on the cloudy steps, fill in the table that analyzes the process diagram with the actual practices of the Zodji community and the changes that should be made in order to improve the indicators.**

Table 1: Analysis of Process Flow Chart

Cloudy steps	**What the norms/standards of care say:**	**Actual practices in Massaka**	**Changes for improving the care**
Appropriate home care	The mother should • Prevent malaria by using an impregnated bednet • Learn how to treat fever • Know the danger signs of malaria • Seek antimalarial within 24 hours of symptoms • If the child does not improve during the first 48 hours, seek care at the health center	• Mothers recognize fever but they don't recognize danger signs • The mother doesn't know to seek for effective antimalarial during the first 24 hours • Effective treatment with an antimalarial is not available at the community level (people are not trained, the medicines are not available)	• Ensure the availability of treatment with COARTEM at the community level • Promote the recognition of danger signs and the need to seek care in case of malaria • Ensure the transport of emergency cases • Have trained persons at the community level to provide case management for sick children
Good case management at the health facility	• Provide good welcome/reception • Health providers must be able to perform a o good evaluation o good classification o good treatment according to the standards for the case • referral or complete local case management o fever without complications COARTEM at home, go to health center within 24 hours if no improvement o With complications (danger	• Poor evaluation? • Evaluated and treated as simple, but complicated malaria • Child should have been admitted • Poor counseling. No instruction to mother on how to administer medication or when to return to facility or other aspects of prevention • No attention to	• Improve quality of case management • Triage

	signs – lethargy, cannot eat or drink, convulsions, anemia) treatment pre-referral and referral to hospital o Give treatment with correct dosage and duration o Explain to mother when to return immediately o Give counseling on nutrition (eat a little at a time), pay attention to other problems o Pay attention if other members of the family are sick	remainder of family • No triage • No rehydration	

8. **Choose an improvement and describe how you are going to put it into practice by filling in Table 3.** .

Table 3. Plan and study the change

Describe the change introduced	*Community level care: All children who present with a fever are going to receive appropriate case management (They receive an effective antimalarial drug at home).*
How?	*Train drug vendors*
When?	
Process Indicators	
Outcome indicators	

	Session 2: What is an Improvement Collaborative?
	Purpose The purpose of this module is to introduce the concept of improvement collaboratives in the context of developing countries and healthcare quality. **Objectives** Participants will recognize / acknowledge the value of improvement collaboratives; and, given a case study: • Discuss the scope of the improvement objectives –the breadth or narrowness – and associated issues; • Discuss the issues related to site selection and the relation to later spread and the implication it will have for resources; • Describe what a change package can consist of • Describe the issues to consider in developing indicators and setting up a monitoring system • Describe the organizational structure and the roles and tasks of the various players, e.g., leaders; managers; technical experts; trainers; coaches; and teams. • Identify activities that teams undertake in learning sessions and action periods • Discuss how the improvement collaborative might have been implemented differently or in another country or setting; • Identify the factors that supported or hindered the teams in their work • Identify the factors that would support and hinder implementing an improvement collaborative in their organization
Welcome/ Preview Introductions *10 min*	Orient participants with the overview of the day, including purpose, objectives (e.g., can present on flipchart or use Slide #2), and structure of the day. Emphasize that this session is an overview of collaboratives, while details will be covered in Sessions 3-13. (Note: this session can be used independently for high level and senior leaders to help them make an informed decision about whether to embark on an improvement collaborative.) Optional: allow participants a Q&A session before initiating orientation.
Presentation: Overview of Improvement	Select from the Power Points 3-20 those you wish to use for your presentation.

<table>
<tr><td>Collaboratives
30-45 min

Essential Features handout</td><td>

• Slide 4 (equivalent to Slide 5 from Session 1): Review the difference between the collaborative approach relative to other QI efforts and discuss the added value of a collaborative above either traditional interventions and even doing Quality Assurance and Quality Improvement alone
• Slide 5: Discuss reasons to use the Improvement Collaborative Approach.
– Model of Care or Best Practice is not in current guidelines
– Guidelines not well known or accepted
– No guidelines exist in this area
– Evidence-based effective models of care exist in country but are not practiced
– Effective models exist elsewhere but never or rarely used in country
– There is a big gap between existing situation and desired quality of care or outcomes or both.
• Slides 6-14: Show examples of what collaboratives have achieved—most of the slides included relate one of the two Session 1 (QA) case studies, so that the link is made between problem identification and collaborative improvement as a method to address the problem. Speaker notes for Rwanda collaborative indicators have information on the improvement changes that teams employed (best practices).
• Slides 15-20: Present the nine essential features of a collaborative (hand out), and explain both the preparatory and implementation phases of the collaborative, explaining how these will be covered for the rest of the training session. As there are new terms introduced, provide handouts of the glossary for participants.</td></tr>
<tr><td>GROUP EXERCISE
Case Study

2 hours</td><td>Ask the participants to assign the following roles at their table for this small group exercise: timekeeper, discussion leader, secretary/reporter. Tell participants how long they have for this exercise.

Hand out the case study and questions sheets to each participant. Ask them to read the case study and answer the questions.</td></tr>
<tr><td>Debrief and discuss case
60 minutes</td><td>Call on each group to answer each question. Let a different group answer first for each question and then ask other groups if they have something new to add. It is not necessary for each group to report on each question.

Lead a plenary discussion and ask deeper questions on identifying what are the most important issues that promote or hinder the success of improvement collaboratives or discuss special issues about their organization.</td></tr>
</table>

Handout

Essential features (or elements) of an Improvement Collaborative, defined

Improvement objectives

Improvement objectives are statements of the "improvements" one seeks to achieve. They represent both an engagement/commitment to results and a guide for all collaborative planning and implementation. The improvement objectives should be based on documented problems in the quality of care or outcomes related to priority health issues. They should be defined through a collaborative process with key stakeholders. The improvement objectives will define the scope of the collaborative, depending on whether they take on a broad area of improvement like pediatric hospital care or a more narrow focus like improvement of triage and emergency pediatric hospital cases.

Organizational structures

Organizational structures provide the frame through which the collaborative activities will be managed. There are several key roles to be played in a collaborative, and these roles can be distributed over a variety of structures:

1) leadership/strategic direction: this role includes ensuring that collaborative is continuing to work towards its improvement objectives, providing moral and other support needed to keep it running, motivating participating teams and stakeholders to keep involved and active, and facilitating the links between collaborative activities and policy work.

2) ongoing management: a collaborative requires ongoing planning and implementation of activities, management of collaborative data, organizing coaching and learning sessions, etc. This role is critical for the success of the collaborative and requires good monitoring of teams and results in order to adjust collaborative activities to the reality.

3) content and QA expertise: collaboratives are built on an evidence-based "change package" and strong quality improvement teams. Content expertise is critical in the preparatory phases in developing the change package and the indicators for monitoring improvement, but also during the roll-out as well, providing content support to teams and content at learning sessions. QA expertise is critical for providing QI teams the support they need, in the beginning as they are forming teams, and ongoing to help with norms, organization, monitoring, improvement methods, and teamwork.

4) quality improvement teams: these are described in more detail later, but are the heart of the collaborative. The other roles mentioned above are primarily in support of what the QI teams are doing on the ground, as it is they who will be implementing and testing the strategies to improve quality and achieve collaborative improvement objectives.

Although a collaborative is not a "permanent" entity, many of these roles continue even after the collaborative. Thus, conceptualization of an organizational structure should keep in mind the institutionalization and sustainability of key collaborative features, such as coaching, quality improvement teams, opportunities for sharing, and monitoring of results. This is best achieved by grafting the collaborative roles onto existing structures when possible. Often, these organizational structures include a small managerial group, an "expert" group, and a "director"

or "coordinator" in the Ministry of Health. Often collaboratives have made use of management structures at decentralized levels to support collaborative activities.

Initial Change Package

A "change package" defines what all sites participating in the collaborative will be implementing. The change package lays out a set of evidence-based changes that stakeholders and experts agree will facilitate achieving the improvement objectives of the collaborative. Depending on what already exists in the situation and the current level of problems with quality, what a change package might include is described below:

1) where no norms or consensus on "proper" practice exists, the change package may be a new set of norms

2) where norms exist but they are out-of-date, the change package may be an updated set of norms

3) where up-to-date norms exist, but are not well implemented, the change package might be a set of "essential norms" that focus on the most important tasks needed to achieve improvement objectives, or a "service delivery model" or "model of care" that would more effectively ensure that norms are implemented and patients receive what they need

4) where up-to-date norms and a model of care exist but neither is well implemented, the change package may be a series of organizational changes that can facilitate their implementation.

In all cases, the change package should be based on evidence of what works. This evidence can come from the international literature or from local well-documented experiences.

Spread strategy

As a collaborative is, by definition, a mechanism for ensuring rapid spread of norms, service delivery models, organizational changes and best practices, a spread strategy is a crucial feature of a collaborative. A spread strategy is a strategy that defines where one wants to go (spread to whom?) and how one plans to get there. Normally, a collaborative can be thought of as having a series of phases: a preparatory phase where improvement objectives, the change package and indicators are developed. Then there is a first roll-out phase, often called a demonstration collaborative. This phase involves an initial set of teams who, through their efforts, come up with the first set of "improvements" on the change package and best practices for its implementation. This "improved" package is then rolled out in a third phase, often called a spread collaborative, where additional sites are added and continued refinements are made to the change package and best practices. In this "spread" phase, often initial site teams provide support to new team. There is often a fourth phase, which can be called a scale-up phase, in which the refined package is then expanded to all remaining sites where one expects the norms to be implemented.

In each successive phase, the roles and responsibilities and the organizational structures may need to be modified to ensure adequate support to an increasing number of sites. This calls for ever-increasing responsibility of existing structures for management of health services.

Qualified and functional quality improvement teams

Quality improvement teams are the pillar of all collaboratives. Without these teams working at facility level, there would be no collaborative. Quality improvement can be defined as the process of intentionally making care better in some way (e.g., effectiveness, efficiency, etc.), with the ultimate goal of improving the outcomes for healthcare clients. These teams are made up of key individuals involved in the processes behind the change package. They work as a team to understand their clients, analyze their process, monitor results, and plan, implement and study changes or innovations to improve performance. These teams then come together as a network with other teams to share results, innovations, and issues, and to learn from one another. To ensure that QI teams are able to function optimally, the collaborative will need to ensure their knowledge and skills related to both the "change package" and to quality assurance techniques, and the minimal supplies and equipment needed to implement the change package.

Monitoring system for quality of process and results

A collaborative bases its identified best practices on continuously collected data. Thus, monitoring is an essential feature of a collaborative. Monitoring involves developing a limited set of key indicators that will reflect progress towards improvement objectives, developing systems for collecting and compiling data (including baseline data if it is not already available), and mechanisms for analysis and interpretation of that data, both at quality improvement team level and aggregated at the collaborative level. Indicators should include, where possible, measures of process (compliance with standards related to quality of care, QI team functioning, input availability) and outcomes/impact. These indicators are measured regularly (often monthly) and used by teams to determine how they are doing. Self-collected indicator data are also shared with other teams during learning sessions or other opportunities for sharing information (such as on-line communities, etc). Evaluation of these data becomes a Generally the data collection and compilation is done by the teams themselves (self-monitoring). Thus, it is crucial to ensure systems for checking the validity of the data because the results of the collaborative will be used to determine spread of best practices and an improved change package to other sites. Wherever possible, data should come from existing sources and not from a separate data collection system. Occasionally, existing health information collection systems may be slightly modified to capture essential information (for example a column might be added to a register, or a stamp inserted into a medical record).

Regular support to quality improvement teams (coaching)

Experience in developing countries has shown that quality improvement team need additional assistance to be able to carry out their QI tasks. This assistance is provided through "coaching," a process by which someone with additional knowledge and skills in quality improvement provides technical and moral support to team in order to improve the team's performance. A coach will help the team carry out its work and will assist the team leader to guide the team to carry out its work effectively, working towards self-sufficiency over time using the tools available to teams. Coaching provides a structure to help team functioning, provide on-the-job training in content and QA, verify monitoring data and provide support to the monitoring process, and help the team to see other opportunities to improve how they do things.

Opportunities to share experiences and results (learning sessions, etc)

Collaboratives include a strong notion of "collaboration," and an essential feature of a collaborative is structured opportunities for sharing experiences, results, and promising practices across teams. These opportunities generally include learning sessions, but may also involve the use of an "extranet" (private website on the internet) where data and experiences are posted, telephone calls, smaller meetings, and other mechanisms. The most common method, the "Learning Session," generally bring representatives from all sites together (or all sites in a region if the learning sessions are decentralized) to strengthen their skills in the content areas and in QI (as needed), to share their results and changes, to identify innovations and promising practices, and to plan their work for the interim period until the next learning session. Learning sessions are attended by selected site-team members and technical and quality improvement experts. The site teams bring knowledge and materials from these meetings back to their fellow team members to start making changes. When they see and bring back innovations that have been tested by other teams, adoption of these identified effective changes is accelerated. Generally, during any one phase of a collaborative, there may be three to six learning sessions, followed by a "final" conference where final modifications in the change package and best practices are identified, for expansion in the next phase.

Tested change package and best practices

Collaboratives have as their overall goal to provide an improved set of norms, models of care and/or best practices in an organization for carrying out norms, that can be rapidly spread to other sites. Collaboratives provide a mechanism for resolving the operational barriers or obstacles around implementing any set of norms. Thus, a key feature of a collaborative is to arrive at a tested and refined "change package" and/or a set of best practices related to its implementation. Depending on the initial situation and the type of change package, it may take more than one "roll-out" phase to achieve what is needed for broad scale-up – there may need to be more than one spread phase before full scale-up.

Collaboratives Case Study Exercise

Prevention of Mother To Child Transmission/Volunteer Counseling and Testing Improvement Collaborative, "Euphorbia" (fictitious country)

Background

In 2001, with a population of eight to nine million, nearly nine percent of the inhabitants of Euphorbia was infected with HIV. With 20% of HIV infections in Euphorbia occurring during pregnancy or childbirth, programs to prevent mother-to-child transmission (PMTCT) were key to lowering HIV prevalence. In April 2003, only 34 sites in Euphorbia offered PMTCT services. Nevirapine, the drug then used to decrease vertical transmission, was not yet supplied by the MOH except at the national hospital, and these sites received private funding. Most sites saw only 10 clients per day. However, the MOH was developing national norms for PMTCT, and the number of PMTCT sites was set to increase to 160 by 2006.

Faced with this rapid expansion of PMTCT service delivery sites across the country, the Euphorbia Ministry of Health (MOH) recognized the importance of strengthening the existing PMTCT delivery model to assure the quality of services before launching additional sites. USAID/Euphorbia discussed with the Euphorbia MOH the opportunity to receive funding to develop a PMTCT delivery model. They agreed, and USAID asked the Quality Assurance Project (QAP), with its prior experience in training Euphorbian health providers in quality improvement approaches, to launch the PMTCT Improvement Collaborative.

A series of leaders meetings starting in November 2002 brought together MOH representatives, including the Center for HIV/AIDS Research and Treatment (CHART), the Division of Quality Health Services (DQHS), and PMTCT partners. During these meetings, participants made key decisions in planning the collaborative, such as agreeing on a preliminary model of care, defining key improvement objectives and indicators, and selecting initial sites. By April 2003, teams from various sites across the country would begin to collaborate in making shared improvements for better efficiency and knowledge sharing.

Organizational Structure and leadership

CHART, as the agency providing oversight over PMTCT services, sponsored the collaborative, and served as key decision maker during the preparatory phase of the collaborative. The MOH's Division of Quality Health Services (DQHS), with its previous expertise in quality working with QAP, helped to conduct learning sessions, while QAP managed the day-to-day organization and provided technical support to the collaborative. The collaborative built on and complemented the work of numerous PMTCT partners working at the same sites as the collaborative teams, who provided support in the form of clinic and lab renovation, supplies, equipment, clinical training and supervision. A secretariat of these donors included representatives from QAP, other collaborating agencies, WHO, and UNICEF.

With little to no exposure to quality improvement or collaboratives, CHART was initially skeptical about the value of the exercise. DQHS and CHART also had little experience working together. After the exchange of information, joint planning for the learning sessions, and some initial results on the ground, CHART become more engaged and worked collaboratively with DQHS.

Site and team selection

The participants of the leaders meeting identified at least one site (health center or hospital) from each of the 12 country provinces to participate in the collaborative, with the vision of spreading PMTCT to the entire country. Health centers and hospitals from all provinces joined, totaling 18 health centers and hospitals. Site directors selected two people to attend the first learning session (LS1), during which they were encouraged to form a site QI team of people who were involved in the PMTCT process. This might include higher-level staff, such as the health center or training directors, nurses, lab techs, as well as community members, including PLWAs. The team composition and size varied over time, however. As core team members focused on specific issues (e.g., lab testing, or HIV testing of the child of the HIV+ mother), staff working the related service were invited to the team. In addition, team attrition due to staff being transferred to other posts or attending trainings, was a large problem.

Learning sessions and action periods

Table 1: Learning sessions and action periods

Event	Date	Description
Learning Session 1 *2 days*	6/ 03	Site and district representatives from each site participated in workshops on: • principles of quality, the collaborative model, and the role of leaders at their sites. • brainstorming session to identify improvement changes • how to develop process flow charts • proposed key indicators for the collaborative
Action Period 1 *3 mo.*	6-8/03	Site representatives then returned to their sites, formed teams and led the team in conducting: • a baseline assessment, by measuring a subset of the improvement indicators • flow chart of the flow of current PMTCT services
Learning Session 2 *3 days*	8/03	Team reps presented their PMTCT flowcharts, identified problems, developed a list of improvement changes, and refined the common improvement objectives accordingly (see Table 2) They also presented site data on the rate of client return for HIV tests. Teams learned that sites with the longest turnaround times for obtaining HIV results (one to three days) also experienced the lowest rates of clients returning for their results. Teams also received a refresher on case management of HIV/AIDS from CHART and training on rapid problem solving. Finally, they wrote action plans in which they identified the changes they were going to implement in the second action period.
Action Period 2 *3 mo.*	8-11/03	***Solution testing and improvement monitoring**:* Teams implemented solutions and monitored indicators to see if there were improvements in problem areas
Learning Session 3 *2 days*	12/03	Teams shared results and improvement changes leading to these results. Developed work plans for next action period
Action Period 3 *3 mos.*	1-3/04	***Solution testing and improvement monitoring**:* Teams implemented solutions and monitored indicators.

Learning Session 4 *2 days*	4/04	Reported indicator data and developed work plans for further solutions

Learning sessions As shown in Table 1, during learning sessions, team representatives gained technical expertise in quality improvement and PMTCT and developed action plans, which they then transmitted to site team members during action periods, when teams implemented changes in their local systems of care to address improvement objectives. For many team members, learning sessions were the first time they had the opportunity to work with colleagues outside their own facility. It was also an opportunity for teams to interact with CHART, who could address any concerns or confusion about national PMTCT norms and policies.

Action periods. During action periods, teams implemented action plans set during the learning sessions, which normally consisted of implementing a change in their PMTCT care system. Each site could choose to implement any changes--either those developed by other teams that were discussed during learning session or those they developed themselves. Improvement changes sometimes focused on inputs but mostly aimed at processes, internal reorganization of services, and ways to involve the community. To monitor the effect of the changes they implemented, teams monitored indicator data monthly. Coaches either gathered data during the site visit, collected by telephone, or had the teams hand deliver.

Table 2: Improvement Objectives and Indicators

Improvement Objectives	Indicators for Measuring Quality and Improvements
All pregnant women in the catchment area come to prenatal care	% of pregnant women in catchment area who attend a prenatal visit
All prenatal clients: ▪ are counseled and tested ▪ receive their HIV test results on the same day they are tested	% of pregnant women attending prenatal visit who are tested for HIV % of tested pregnant women who return for the HIV test results
All partners of prenatal clients are tested for HIV	% of partners of HIV+ women who are tested for HIV
All women who test HIV+ in the PMTCT program: ▪ receive NVP to take home on the same day they are tested ▪ swallow their NVP at the beginning of labor ▪ deliver at the maternity	% HIV+ women who took nevirapine (NVP) at home % seropositive women who gave birth at a PMTCT facility % seropositive women who received NVP 48 to 72 hours after giving birth
All children born of HIV+ women: ▪ swallow NVP syrup within 72 hours after delivery ▪ are monitored monthly until the 18th month	% of children born to HIV+ women who are monitored % of children born to HIV+ women who are tested at 15 months

▪ are tested for HIV between the 15th-18th month	

Coaching Few teams were familiar with quality improvement methods at the beginning of the collaborative. The tasks of data collection and correctly calculating indicators and working in teams were challenging, particularly dividing the responsibilities among team members. A monthly site visit by a coach was critical in addressing capacity and team-building issues. Coaches were typically drawn from DQHS but, as these professionals were typically less experienced in HIV/AIDS than CHART, CHART was enlisted to assist with coaching support.

During the site visits, coaches reviewed the team's progress and constraints. They validated monitoring data and offered technical assistance where needed. With these site visits, the teams' mastery of PMTCT delivery and monitoring increased. Coaching visits were highly motivating for some teams in continuing in the collaborative.

Results

Of the various changes, only two indicators are shown below.

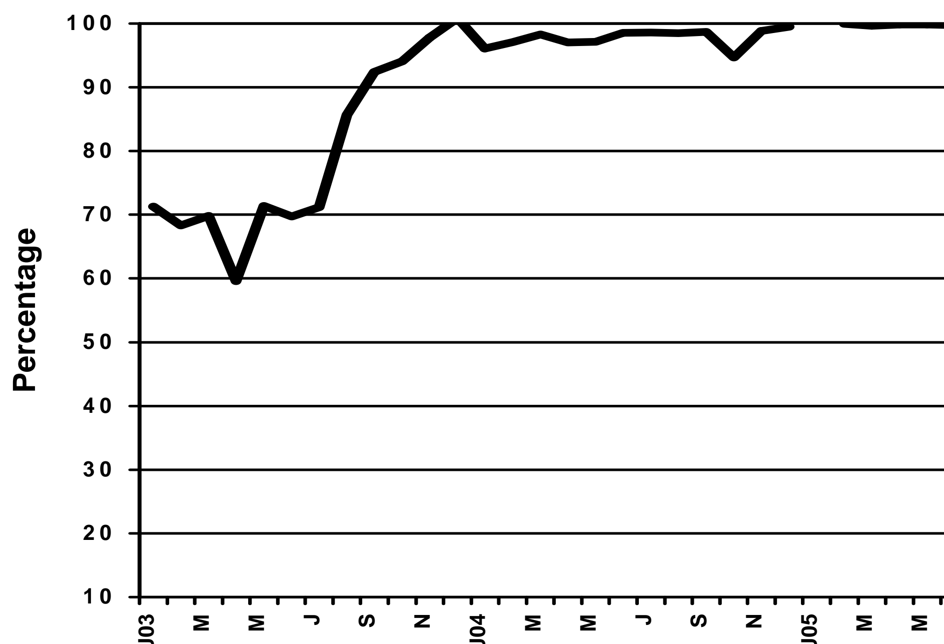
Over time, collaborative managers compiled a list of changes introduced by teams that the collaborative believed led to have greatest impact in results, as measured by indicators. Results of two indicators are presented below, along with the key improvement changes that the collaborative implemented.

Improvement objective: All prenatal clients who are counseled receive their test results. As mentioned earlier, collaborative teams found early on that women who were taking the HIV test often did not receive their results. Some of the key changes teams implemented were:

- Increase # of ANC sessions per week to receive fewer clients per session to increase length of counseling session per client
- Send HIV test blood samples to lab as soon as they are taken rather than in batches later
- Analyze HIV test blood samples as they arrive in lab
- Reduce staff lunch time to snack break (so that all clients receive post-test counseling that day)

The early gains in this indicator were achieved largely due to the implementation of changes in 2003 that allowed women to receive their HIV test results on the same day, a strategy QAP first tested that was then implemented nationally. As clearly shown in this graph, these levels have been maintained in both old and new sites.

Figure 1: Percentage of women who took the HIV test who received their results



Improvement objective: All partners of prenatal clients are tested for HIV. Partner testing is a particular challenge for PMTCT programs in most countries. In Euphorbia, changes were implemented to the support system, process and interpersonal relations.

Support systems

- Sent written invitations to the partners of women who have been tested so that they accompany their partner to the next prenatal visit.

Process

- Assured staff permanence during weekends and holidays.
- Kept ANC *carnet* and/or liaison card at health centre and invite partners to retrieve them. This was an opportunity to sensitize partners to be tested.

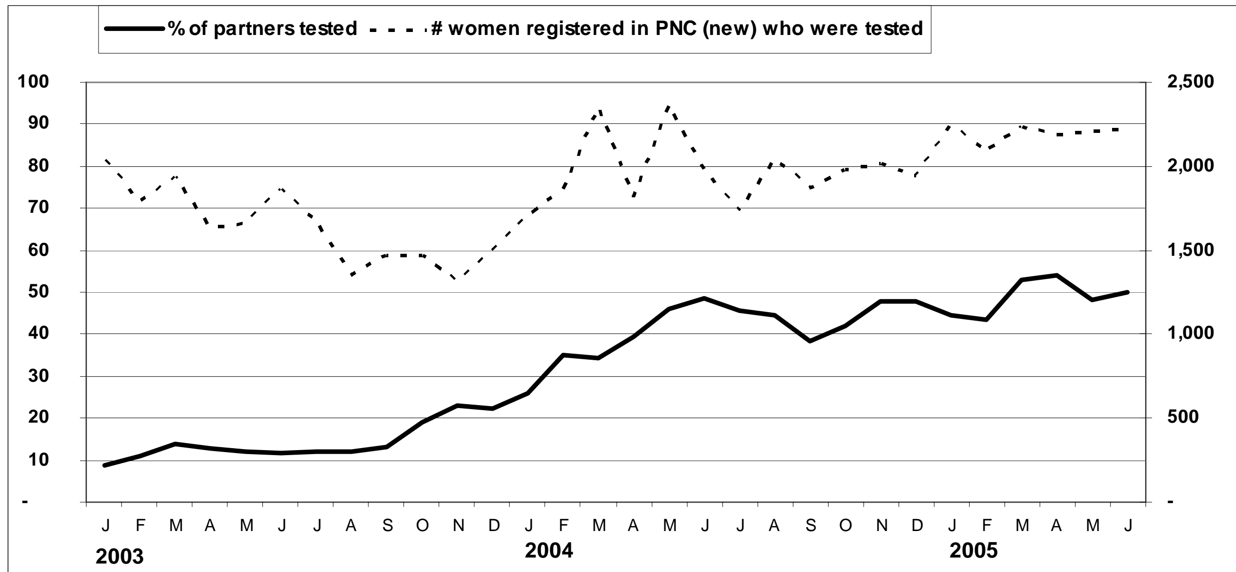
Interpersonal relations

- Involved local authorities in the success of the program while taking advantage of community meetings to pass on the message re: the importance of partner testing.
- Sensitized partners to accompany women to the first ANC visit.

As a result, the rate of partner testing increased from an initial average monthly rate of less than 15% to 43%, with some sites testing more than 90% of partners. Data cumulated for 14 of the 18 sites are presented in Figure 2 below.

This indicator showed great improvement, especially at new sites. For the last quarter of the reporting period, the partner testing was over 60% for old sites and over 70% for new sites, compared to 33% reported for all PMTCT sites in Euphorbia. Upon learning that staff at Kabgayi had tested the strategy of inviting partners to get tested, collaborative sites adopted this strategy and found it to be very effective. In addition, the Muhura site was the first to involve local authorities in motivating both men and women to get tested, including by having local officials get tested during community meetings. This strategy was later adopted throughout the collaborative.

Figure 2. Percentage of partners of women in prenatal care who are also tested for HIV.



Next, we will discuss scaling up.

Scale up

The results obtained by the collaborative teams by mid 2005 were so encouraging – in particular, increases in the a) number of women being tested and receiving same-day test results, b) partners being tested, and c) children tested at 15-18 months, that 21 new sites were added to the PMTCT collaborative in September 2005.

The expansion phase teams, using best practices identified from the first phase of teams, could quickly implement the best practices of demonstration phase sites and therefore obtained results in a shorter time period. To support the new teams, QAP and DQHS trained a new cadre of coaches selected among collaborative participants from the site-, district- and national-level that were "champions" of the PMTCT QI process in the first phase.

Euphorbia Case Study Questions

Read the case study. Then, in your small group, discuss answers to these questions. Keep the answers simple.

A) Overall

1. Identify each of the nine essential collaborative elements presented in this case study.

➔ Are there any elements that were not in the case study?

B) Preparation for the collaborative

1. Who were the key stakeholders that participated in the collaborative and what was their contribution?
2. Are there other key stakeholders that could have participated in this process? *(FBOs, ,general community women's groups)*
3. What topic was chosen for the improvement? How was it chosen? *(MOH decided)* Why?
4. Did you think the scope of the improvement objectives was too broad or narrow? *(depends on whether they select a number of indicators)*
5. What was the source of the evidence-based guidelines? Did they exist prior? If so, were they up-to-date?
6. How was the roll-out of the collaborative affected by the fact that the national PMTCT norms and guidelines had not yet been developed in the country?

C) Collaborative organization

1. Who were the main managers and implementers involved in this collaborative, and what were their roles?
2. Who were the main partners/stakeholders encouraging improvement in this area? How were the partners/stakeholders involved?
3. What was the role of district or provincial level MOH staff?

D) Improvement activities

1. How did the teams share learning among the different sites?
2. Describe the monitoring system. What indicators / measurements were chosen to measure improvement?
3. What results were achieved?

4. What were some of the changes that the teams introduced to achieve improvements?

5. What challenges could teams have faced when implementing the changes? How could these challenges be addressed?

6. What lessons can you identify from this case for repeating this collaborative in another environment? More stakeholders, discuss what happens when norms are updated, buy-in is important, bring in technical people right away, lesson using high-profile people to get tested, keep a card/carnet at center, have focused objectives)

7. If your organization was going to implement the same changes that this collaborative did, what factors would support or hinder you in doing the work?

E) Sustainability

1. Three years after the collaborative initiated in Euphorbia, the USAID funding for the PMTCT collaborative ended. How could this collaborative have been implemented differently to maximize the sustainability of the PMTCT work? (ex. Coaching strategy, learning sessions [content, national vs. regional])

	Session 3: Preparation for the collaborative: Overview
	Purpose The purpose of this session is to begin talking about the actual preparation and implementation of a collaborative – the iterative nature, overall steps, and finally, the selection of an overall improvement aim and set of specific improvement objectives. **Objective** Participants will: – Recognize the steps in the preparatory phase and implementation phase
Overview of the activities in the preparation phase 15 minutes	Show the PowerPoints that list some of the main steps in the **preparation** phase and the **implementation** phase of a collaborative. Tell the participants that this is an iterative process and does not always happen in a linear manner. It will be necessary to revisit earlier decisions as the collaborative unfolds. **Steps in the Preparatory Phase** ❑ Involve and meet with key actors and stakeholders ❑ May need to narrow the focus (using baseline data if necessary) if the topic area is broad; set improvement objectives. ❑ Develop an organizational structure for the collaborative ❑ Review evidence-based standards with an expert group and agree on adaptation to country setting ❑ Review evidence and create a consensus on the change package and indicators ❑ Determine capacity building and resource needs to implement change package ❑ Choose initial sites with spread in mind, if spread is a goal ❑ Develop a spread and sustainability strategy ❑ Develop collaborative implementation plan and timeline ❑ Develop and test the system for monitoring process and results indicators ❑ Define communication and sharing mechanisms that can be used ❑ Develop the tools for QI team support: content training, CQI training, monitoring, coaching, job aids, etc. **Steps in Implementation Phase** ❑ Form QI teams and prepare them to carry out their tasks ❑ Ensure needed competencies: clinical competencies for health workers, QA for teams and coaches, etc.

	❑ Ensure the basic resources needed to implement norms ❑ Organize the content, methods, and roll-out of learning sessions ❑ Develop and implement a plan for regular coaching for QI teams ❑ Ensure the validity of monitoring data ❑ Determine the appropriate moment to synthesize best practices and move on to spread.

	Session 4: Focusing topic area and identifying improvement objectives
Slide 1	**Purpose:** To be able to focus an appropriate topic for an improvement collaborative (not too wide or narrow) and derive improvement objectives **Learning Objectives** – Discuss challenges in tackling broad topic areas – Discuss how to identify improvement objectives and their relationship to the measurement strategy and the change package
Introduction: **Topic and Improvement Objectives** *5-10 min*	*Optional:* Discuss how current workshop participants have come to be future implementers of a collaborative. Who identified the topic area? How was it decided that the work would be implemented using the collaborative methodology? What would be examples of narrow and broad scale and scope?
Presentation and Discussion *30-45 min*	Present PowerPoints *Slides 1-15*: Discuss these concepts by referring to a potential collaborative topic area, for example essential obstetric care. *Slide 3: Note on demonstrating need for focus on quality of topic area by conducting a baseline study:* QAP has found that involving country national and regional MOH staff as well as facility staff in conducting quality of care assessments has been an effective method of raising awareness and engaging key stakeholders in the collaborative process. *Slide 4:* Explain to participants that if there is no country level consensus on clinical terminology, the implementing agency can help to facilitate this process, which can simultaneously engage key stakeholders in the collaborative. For instance when the Nicaragua EOC started, each of the main partners working in obstetric care already had its own obstetric care initiative and clinical definition: UNICEF had Safe Motherhood, UNFPA had emergency obstetric care (EmOC), and PAHO had essential obstetric care. Once they achieved agreement, they approached the MOH with a unified definition of EOC and a joint strategy for the collaborative, which made it very easy for the MOH to accept. It is possible to proceed with collaborative work before national standards are officially approved and published, as has been the case for many QAP collaboratives. In all cases, broad consensus with country experts and

officials was sought and obtained, making it more difficult to argue against their use. In one case, in which the development of country standards was ongoing but slow, the diplomatic approach was to frame the collaborative as pilot testing the application of the standards. In another case, collaborative indicators were published without specifying clinical standards (e.g., % of obstetric medical records complying with EOC standards).

Slide 5: Explain that in practice, one way to focus the scope of a topic is by defining improvement objectives. During the preparatory stage, one often starts with a broad topic area for improvement and then defines it more narrowly to take account for time, money and human resource implications. QAP experience has found that a topic area that is defined more narrowly (i.e., fewer improvement objectives) allows teams time to learn QI, and topic area can always be broadened at a later date (i.e., within the same collaborative or a even a new collaborative). Alternatively, a comprehensive set of objectives and indicators can be defined, and teams can work on a subset of those objectives, broadening the list once improvements have been achieved with the initial objectives.

Is there existing data to advocate for improvement in the quality of care of the selected topic and to define priority improvement areas? Will a baseline study be necessary?

Where do these objectives come from? Ask, "How do improvement objectives come to be identified?" Explain that often they can be identified according to:

- MOH priorities,
- international public health entities (e.g., WHO) priorities,
- donors' priorities,
- country data reflecting health system needs, etc.

Systems approach: From these, it is helpful to broaden the conceptual framework of the topic area before deciding on a final list of improvement objectives. To do this, one may use a systems perspective by:

- flowcharting processes that represent the topic area to identify where system might be lacking;
- identify inputs, processes, and outcomes for the system
- in the case of a new service, derive objectives on the main new interventions to be implemented (e.g., ETAT in PHI, slide 10).

Slide 7: This slide explains the role of improvement objectives in setting the framework for the measurement strategy and change package.

Slide 8: Explain evidence-based medicine and that the experts group are key stakeholders in defining and focusing the topic area, developing clinical standards (if this has not been done at the national level), defining improvement objectives and the change package. The experts group includes

	both clinical experts and MOH officials in charge of the topic area. *Slides 10-19:* Examples of topics, improvement objectives and measurement strategy. After presenting the three examples, explain to participants how in Rwanda, change packages for the two collaboratives were not formally defined, so the improvement objectives were defined in much more detail than in the Pediatric Healthcare Improvement (PHI) collaborative (first example).
EXERCISE 30 minutes	Provide the Handout on Topics and Improvement Objectives. Divide class up into small groups. Ask each group to review one (of the three) country examples that is most suited to your group as a whole and answer the questions listed (post questions on flipchart): ❑ What are the health problems/priorities? How are the improvement topics defined? ❑ What contributed to the challenges of narrowing down a focus area of the topic? ❑ What are some ways collaborative managers defined and narrowed the scope of the topic? If not described in text, how could they have narrowed the scope? ❑ What do you think of their solutions? Debrief in plenary by calling on one group to answer each question, letting other groups add when they have something different.

Handout

Topics and Improvement Objectives -– Three examples

What are some strategies collaborative managers used to better define and narrow the scope of the topic for the following collaboratives? "Scope" refers to the breadth or narrowness of the defined area for improvement.

Example 1

LAC: Essential Obstetric Care (EOC) Improvement

Maternal mortality ratios in the Latin America and Caribbean (LAC) region remain a major health priority at 190 deaths per 100,000 live births. Direct obstetric causes account for more than 70% of these maternal deaths, many of which are preventable. In August 2003, the LAC regional Maternal Mortality Reduction Initiative (MMRI) launched the Essential Obstetric Care Improvement Collaborative in three countries (Nicaragua, Ecuador and Honduras) to strengthen the entire continuum of maternal care by building local, integrated EOC systems designed to provide high quality maternal and perinatal care and engage communities in expanding access to EOC and utilization of skilled attendance at birth. *To impact the entire continuum of care with an integrated EOC system would require far more resources and coordination of effort than was realistically possible.*

To focus on achievable improvements, the QI teams identified four priority areas needed to reduce maternal mortality: (1) continuous improvement of the quality of facility-based services; (2) clinical EOC training, especially in active management of the third stage of labor and the management of obstetric complications; (3) community level activities to increase access and demand; and (4) adapting services to the cultural needs of delivering women and their families. Clinically, the most effective way to reduce maternal mortality is to ensure consistent application of certain basic procedures and management strategies in delivering essential obstetric and newborn care (EONC). These include the use of the partograph, infection prevention (very much neglected in many countries), eclampsia management, sepsis management, and hemorrhage management. Postpartum procedures included active management of the third stage of labor (AMTSL), prompt treatment of maternal hemorrhage, treatment of maternal and newborn infections, essential newborn care, newborn resuscitation, and care of low birth weight (LBW) infant. The strategy was to gradually extend the package of EOC improvement strategies (e.g., orientation to standards, training in use of partograph and other perinatal technologies, participation in EOC learning sessions, etc.) to all participating sites to eventually achieve an average of 80% to 90% rate of compliance with standards of obstetric and newborn care. In addition to the improvement of clinical care processes, the complete change package also involved clinical training, cultural adaptation and community promotion to address the social, economic and cultural barriers to timely and appropriate care for obstetric complications.

<u>Challenge:</u> The EOC collaborative is one example of how national priorities can influence the selection of a topic that is often so broad in scope that it would involve multiple levels of the health care system and require resources well beyond what is realistically available to make an impact.

Example 2

Pediatric Hospital Improvement Collaborative (PHI)

In 2003, QAP launched a multi-country effort in Eritrea, Nicaragua, and Niger to improve the quality of care for hospitalized children, based on the evidence-based standards in WHO's *Management of the Child with a Serious Infection or Severe Malnutrition: Guidelines for care at the first-referral level in developing countries.* In 2004, Guatemala, Malawi and Tanzania joined the effort. In each country, QAP worked with MOH counterparts to adapt the WHO Guidelines, identify technical advisory groups and coordinating bodies for the PHI, agree upon the common indicators to measure progress, and organize pediatric improvement teams in each participating hospital. Baseline assessments conducted in Niger, Nicaragua and Malawi revealed critical gaps in care in almost every aspect of pediatric hospital case management. For example, in Niger, emergency care and triage were found to be most in need of improvement followed by diarrheal disease, malnutrition, fever, and acute respiratory illness. Indeed, in most hospitals evaluated during the baseline assessment, there was effectively no triage system or urgent care provision. *Faced with this daunting list of critical needs, it was difficult to know where to start and what to prioritize.*

The first step that was taken was to convene a group of content experts and key stakeholders in reviewing and adapting the WHO guidelines to fit the local conditions by defining clear, concise and concrete standards of care. This provided a foundation on which to make improvements in standards of care and for monitoring quality of pediatric care. The baseline results were also used by planning groups to identify priorities and focus the improvement strategies. For example, the Niger planning group selected three aspects of pediatric care to address: 1) emergency triage assessment and treatment (ETAT); 2) case management of malaria, dehydration, and pneumonia; and 3) newborn care. These areas were addressed in a series of phased cycles, each cycle focusing on a specific management area and building on the work of the previous cycle. Other areas of improvement selected by other countries include staff training and development of job aides to increase adherence with standards of care, reduction of stock out of essential drugs and emergency equipment/supplies, better integration of laboratory services and improved patient monitoring and nutritional support in hospital. By June 2004, most participating hospitals were able to document improvement in the common indicators measured over time and reductions in hospital fatality rates in some cases.

Challenge: The early PHI sites struggled with the scope of the topic and the magnitude of the need. "The data really woke us up. When I saw the baseline data results, I was humiliated. My head was down between my feet – I felt like a dog that had just bit his owner. Before, our consciousness slept with our habits. I had never realized that all those children died in the first 24 hours at the hospital." —Urban District Health Director in Niger.

Example 3

Uganda: HIV/AIDS

Following initial discussions between QAP, USAID and the MOH, a collaborative to improve the quality of HIV/AIDS care for adults and children was established in November 2005 under the aegis of the National HIV/AIDS Quality of Care (QoC) Initiative. Its main objective was to develop a sustainable quality improvement system for HIV/AIDS service delivery at both national and sub-national levels. In the first year of the project, 57 health facilities, including national and regional referral hospitals, district hospitals, and health centers, were selected for participation in the antiretroviral treatment (ART) improvement collaborative. The intent was to increase the number of sites in subsequent years to include all facilities providing ART in the country. Quality improvement had never been implemented on such a large scale before in Uganda, nor in this manner that seeks to build capacity at all levels within the MOH to sustain quality assurance activities. *Both the geographic spread, number of sites and scope of the topic presented an enormous challenge for QAP staff and their partners.*

In order to adequately address this challenge, QAP devoted most of its efforts in the first year to facilitating the creation of a leadership and technical structure to support quality improvement activities in the districts. A Steering Committee for the Initiative was established with members from the MOH, USAID, the Regional Center for Quality in Health Care (RCQHC), and QAP-Uganda. A core technical team made up of technical staff from the MOH, the private sector, other HIV/AIDS providers, and local QAP staff was also created and received quality improvement training to be able to provide technical leadership for the QoC Initiative. The Core Technical Team was also responsible for building the capacity of regional coordination teams to support treatment facilities. The value of this leadership structure was not only in the implementation of the collaborative on a national scale, but in gaining buy-in at all levels of the health care system for the collaborative approach to quality improvement in HIV/AIDS care. This leadership structure, in particular the Core Technical Team, took the main responsibility for defining the collaborative's improvement objectives, which they linked to 27 improvement indicators in five categories: patient assessment and screening; patient treatment with ART; prevention of opportunistic infections, referral and follow-up of patients; and health facility preparedness. To reduce the burden on improvement teams, sites were asked to monitor only one indicator per category, with the stipulation that adherence to ART be included for all sites. Thus each treatment facility was able to define its own focus for improvement at an agency level, based on baseline results and local priorities. This allowed for flexibility at the local level while keeping the broader national perspective on the front burner. The indicators chosen by the treatment facilities also served as a proxy for identifying the priorities at the facility level. Members of the core and regional teams visited teams to help clarify and reinforce indicator definitions and validate data collected. The preliminary results were encouraging in showing improvements in the percentage of eligible patients started on ART and a drop in death rates from 5% to about 1% of patients on ART.

<u>Challenge:</u> Both the national scale of the collaborative and the wide scope of the topic presented an enormous challenge to the QAP managers and their partners.

Solutions for exercise on scope of topic and improvement objectives

Example 1 LAC: Essential Obstetric Care (EOC) Improvement

Strategic solutions: In an attempt to better define and focus the topic for improvement, a number of strategies were employed including:

- Implementing simple low-cost procedures at scale that have a direct impact on outcome (e.g., use of partograph);
- Focusing on a limited set of prioritized activities (i.e., provision of basic EONC services);
- Use a graduated approach in extending the change package to participating sites in order to adequately support and sustain the improvements in clinical care

Example 2 Pediatric Hospital Improvement Collaborative (PHI)

Strategic solutions:

- Convening meetings of key stakeholders and experts to clarify and adapt the WHO guidelines to local conditions, and to establish clear, concrete criteria for standards of care to serve as a foundation for identifying areas for improvement
- Use of baseline data to identify critical gaps in care to guide planning and implementation of improvement strategies
- Using a phased approach to focusing on specific areas with each cycle building on the work of the previous cycle
- Empowering local actors to define, select and negotiate the boundaries of the topic based on local realities and priorities

Example 3 Uganda: HIV/AIDS

Strategic solutions:

- Considerable effort in the first year was devoted to facilitating the establishment of a leadership and coordinating structure to guide, support and sustain the collaborative. The participatory approach used in establishing the leadership structure also helped to develop a common understanding of the improvement objectives.
- Although 27 quality indicators in five categories were identified by the Core Technical Team, participating sites were able to select five indicators (one from each category) to focus on for improvement activities to start, with the idea that, eventually, over time, all teams would focus efforts on all 27 indicators.
- Ongoing support and coaching were provided to the site teams in further refining the improvement indicators and in data collection to ensure quality data.

Strategies for defining, clarifying and focusing the topic for improvement:

- Convene key stakeholders and experts to clarify and adapt international standards to local conditions and establish clear, concrete criteria for standards of care.
- Use baseline data to identify critical gaps in care to guide choice of improvement objectives and planning and implementation of improvement strategies.
- Target simple, low-cost interventions focusing on a limited set of prioritized activities.
- Monitor and analyze quality improvement processes and outcomes to further refine areas for improvement
- Empower local actors to define, select and negotiate the boundaries of the topic based on local realities and priorities
- Support the national agenda by linking local topics to national standards of care

	Session 5: Organizational Structure and Roles in Managing a Collaborative
	Objectives Participants will: – Identify the main roles needed in a collaborative and the main responsibilities for each role – Discuss which preparatory and implementation tasks are best suited for each collaborative role.
Presentation: **Organizational structure and roles** *30 min*	*Please note that Notes Pages in the PowerPoint files include explanations of slides* *Slides 1-6*: Present each organizational structure function (leadership, management, content expertise, QI expertise, QI team) and after each slide, ask participants to brainstorm what actors might be included/invited to play each role. Write these down on a flipchart page with each role as a heading. Tape them to walls as participants should be able to refer to all roles simultaneously. *Slides 7-11*: Show examples. Point out that graphical representations are very helpful to conceptualize organizational structures, as they can show both existing and proposed structures and the relationships between them. Different style figures can be used emphasize functions, technical support, regional organizational structure, etc. Please refer to notes section of PowerPoints for explanations.
Group exercise *20-30 min*	*Slides 12- 15*: Make sure slide 13 is clear before going on the group exercise. Show slide #13 again and ask if someone can explain it in order to identify areas that need clarification. Answer any questions, and then move on to actual exercise. Ask participants to refer to their glossaries for additional explanations. Divide participants into groups of 3-6. Using the example of the collaborative participants will implement, ask each group to complete the exercises on slides 14 – 16. Ask each group to discuss and come to consensus on which groups should be involved with each activity in the preparatory and implementation stages (mark with an X in the table on each slide). If participants will implement more than one collaborative, have separate groups complete the exercise separately. In plenary, have one group per collaborative present its results and then facilitate discussion of areas of disagreement with other groups. This is an exercise to start participants thinking about how the collaborative will be implemented, as well as to clarify the different tasks at each stage.

	If material is available (e.g., from collaborative evaluations at www.qaproject.org website), it might also be helpful to provide descriptions of the organizational structure of existing collaboratives so that participants can compare how differently collaboratives can be organized.

	Session 6: Key stakeholders, partners, experts
	Objectives Participants will: ❑ Identify partners who would participate in the collaborative, e.g., MOH, funding agency, other organizations ❑ Identify the roles played by partners and other local and/or NGO groups ❑ Identify how to access content specialists (experts in topic) who could assist with both the technical improvement topic and the facilitation / training of collaborative teams
Key stakeholders, partners, experts 15-20 minutes	NOTE: Depending on where the participants' organization is in its preparation, they may already have identified most or all key partners. This session may also be presented **before** Session 5 (Organizational Structure and Roles). Lead a discussion on identifying possible partners, such as NGOs, MOH, international, donor, community, civil society, academia, agriculture, professional societies, etc., and how they might help you and what roles they might take (e.g., planning, permission granting, implementation, provide content experts, monitoring and oversight). Explore nontraditional partners outside of health, such as in the private sector or local government. Differentiate between partners needed for political / reasons and partners in implementation and monitoring. Discuss the roles each can play relative to the other; e.g., an NGO may be able to provide content experts and an MOH may respond to politically hot health issues. Refer to **Handout on the Use of Experts.** Discuss who are content experts and why you need them. Note the need for input early on in planning for ensuring that the changes you are about to make are based on the most accurate and up-to-date evidence. Note the recurring nature of their input, for example, whenever questions of clinical content arise or the teams need new technical information, skills or techniques, and updating. Ask participants to identify where experts could come from, relative to the audience (academia, MOH, professional society, etc.) Discuss how to orient them to the objectives and approach of the collaborative so they are informed and aligned with the activity.

PARTNERS EXERCISE *30 min*	Using the handout on the following page, ask group to first brainstorm and record ideas on who they might recruit to help with the collaborative. Remind participants that they can refer to the earlier handout on experts to see how other collaboratives have used experts.

Handout

Use of Experts – "Notes" Section

Who are the "experts"?

Clinical, technical content experts and officers from relevant MOH departments (central, regional and district levels).

- Directors and experts from national programs (e.g., National HIV/AIDS Secretariat, National Malaria Control Program, etc.).
- Technical experts from international organizations and donors (USAID, UNICEF, WHO, CDC, PAHO, UNFPA, UNAIDS, The Global Fund, etc.).
- Experts from partner organizations (EngenderHealth, John Snow, Inc., DELIVER, etc.).
- Professional groups (physicians, nurses, midwives, counselors, clinicians, epidemiologist, other specialists).
- Officials, opinion leaders and key representatives from stakeholder groups (professional groups, civil society, NGOs, etc.).
- Academic and research groups.

When and how were they used?

Initial preparatory phase

- Review, introduce and reinforce evidence-based standards of care
- Development of national standards of care adapted from WHO or other international guidelines
- Define, focus and clarify the improvement topic
- Developing the change package and the indicators for monitoring improvement
- Inform key stakeholders and obtain buy-in and commitment to collaborative objectives and methodologies
- Assist in the planning on the roll-out and elaboration of the improvement objectives
- Selection of sites

Ongoing technical support and capacity building

- Provide ongoing technical training and assist in the planning and delivery of technical content in the learning sessions
- Ongoing technical support to teams
- Coaching of teams
- Targeted training in specific technical areas
- Participate in innovative capacity-building strategies (e.g., competitive learning events)
- Revise indicators as needed and improve data collection system
- Training of trainers in clinical skills

Scale-up and Spread

- Assess preparedness for scale up and readiness of new sites (Russia HIV/AIDS).
- Provide technical guidance to new sites (Rwanda Malaria).

How do experts contribute to collaboratives?

- Bring credibility and validity to the application of evidence-based improvement strategies.
- Assist in the definition and articulation of the improvement topic and selection of improvement indicators for monitoring.
- Facilitate the development of national standards of care, adapted from published international standards.
- Create enthusiasm and buy-in among key stakeholders, MOH and other partners
- Assist in the planning and roll-out of collaboratives.
- Assist in site selection and assess readiness for scale-up and spread.
- Provide ongoing technical support, coaching and mentoring for site teams.
- Participate in the planning and delivery of learning sessions.
- Provide expert advise and training on specialty areas.
- Build technical capacity of local health care systems including the training of trainers.
- Act as "champions" of the collaborative approach.
- Contribute to the sustainability of quality improvement collaboratives through the engagement of national and local experts in both the public and private sectors.

Lessons Learned

- Involving specialists from the beginning created a critical mass of experts who understood and could communicate the new norms and standards of care. These individuals have played an active role in training, coaching and learning sessions, and have been great advocates both at their sites and in general for the quality improvement efforts.
- Engage experts early on and continue to make use of them throughout the collaborative by involving them directly in baseline assessments, norms and indicators validation and modification over time, training of trainers, coaching, organization of learning sessions, and most importantly, provide opportunities for them to participate directly on a QI team at one of the sites.
- The sharing of experiences and best practices through the use of experts led to rapid expansion of innovations and strengthened the community of professionals involved in a common area of interest.
- Utilization of local expertise is a cost-effective way to increase the efficiency and effectiveness of quality improvement collaboratives in developing countries.

Handout on Use of Experts (Table section)

COLLAB-ORATIVE	ACTIVITY	WHO	OUTCOME/BENEFITS
LAC EOC	• The Expert's Meeting was held to assess the draft charter, the change package and the measurement strategy for the regional collaborative and suggest solutions for potential obstacles and review the latest evidence on the topic of EOC	Seventeen experts from various Latin American countries and international agencies participated, including members of Ecuador's MOH.	Recommendations were made on: Community component Institutional component Indicators/measurement strategy
Nicaragua/PHI	• To stimulate each PHI hospital to actively ensure that its personnel were familiar with these new pediatric care standards, QAP introduced the "Prize for Knowledge" competition, which was judged by experts.	Expert judges from the Ministry of Health, UNICEF, USAID, the Nicaraguan Society for Pediatrics, the Nicasalud Federation, and QAP	Supported an innovative capacity building strategy
Nicaragua/PHI	• In introducing evidence-based standards of care, a group of national experts were brought together to review the WHO norms, suggest changes, and to review the evidence basis for a variety of pediatric conditions including pneumonia, severe dehydration due to diarrhea and severe malnutrition, which were priority conditions in Nicaragua.	The expert group included representatives from USAID, UNICEF, PAHO, Nicasalud, the national children's hospital, the Ministry of Health (Hospitals and IMCI directors) and the Nicaraguan Pediatric Society.	The review process led to modifications in the WHO norms and a document that was adopted as the Ministry of Health Norm, and is referred to as AIEPI Hospitalario.
Nicaragua/EOC	• In Nicaragua, the TAG group (composed of MINSA officials in charge of the topic area of interest, key specialists in the country, representatives of the SILAIS and facility level, and NGOs and other partners) reviewed the EBM literature together.	MINSA officials in charge of the topic area of interest, key specialists in the country, representatives of the SILAIS and facility level, and NGOs and other partners	The involvement of leading clinical specialists proved to be very important to obtaining buy-in at the hospital level.

COLLAB-ORATIVE	ACTIVITY	WHO	OUTCOME/BENEFITS
Benin/EOC	• The collaborative was launched in February 2005 with a one-day national awareness workshop to sensitize key stakeholders on the methodology's value and implementation experiences in Africa and Latin America. An expert meeting was convened to discuss and finalize key collaborative documents, including the statement of improvement objectives, quality indicators, and change package.	The expert group included National University lecturers, other national experts on EOC, MOH staff, and technical staff from other cooperating agencies (UNFPA, UNICEF, EngenderHealth/ACQUIRE Project, and the Projet Socio-Sanitaire/Coopération Suisse [PSS]).	Informed key stakeholders of the collaborative objectives and methodologies, and got agreement on final collaborative documents
Niger/EONC	• 36 EONC experts (10 obstetricians, two pediatricians, and 24 midwives) participated in a training of trainers to prepare them as national expert trainers. These 36 EONC expert trainers in turn trained 121 EONC providers from all 28 collaborative sites in seven of Niger's eight regions.	36 national EONC trainers (10 obstetricians, two pediatricians, and 24 midwives	Implementation of a focused training strategy to provide technical training in two large regional maternity hospitals
Niger/EONC	• A national expert meeting was convened in December 2005 to introduce the EONC collaborative at national and regional levels and was attended by national MOH DSR authorities, leading obstetricians, and midwifery experts. • After the initial experts meeting, QAP and selected members of the Experts Group were tasked to do an inventory of existing norms and standards, and where they were out-of-date or missing, to propose norms and indicators to be used for the EONC collaborative. Where norms were needed, the team used current evidence (Lancet, 2005) and WHO, and modeled on norms that were in use in other countries, such as Benin's norms and Save the Children's *Care of the Newborn*.	Regional MOH pediatrics, obstetrics, and midwifery experts	The participants reviewed and debated these norms and indicators and approved a final set.

COLLAB-ORATIVE	ACTIVITY	WHO	OUTCOME/BENEFITS
	• These norms and indicators were then presented at a Validation workshop held in March 2006, and attended by 37 key stakeholders.	Stakeholders included: : representatives from the Reproductive Health Directorate in the MOH, the Regional Health Offices, pediatricians and obstetricians from around the country, midwives from many of the proposed sites, representatives of the professional training institutions.	
Niger/PHI	• The Niger/PHI Experts Group's responsibilities include adapting norms, participating in the PHI baseline survey, developing strategies for IMCI at hospital level, developing indicators for PHI monitoring and evaluation, and providing training in both IMCI and quality, and selecting initial PHI sites was with spread in mind. • They play an active role in coaching, reviewing agendas for learning sessions, and assisting with clinical training and learning sessions.	The Experts group was initially quite large, including most all public sector pediatric specialists in the country and IMCI trainers. As the initial activities were completed, a smaller subset of experts continued participation.	Initial and ongoing technical support for the planning and implementation of the collaborative
	Specific Tasks: • Before the rollout of the collaborative, an Experts Group of 32 individuals used the WHO guidelines to adapt norms to ensure the ETAT manual reflected the availability of medicines and the terminology used in Niger.	District medical officers (district health directors); other MOH representatives, including those in the IMCI division, National Malaria Control Program, the Nutrition division, and the planning unit; pediatricians from around the country	The process of adapting this manual permitted extensive discussions among the various pediatric specialists coming from different schools to come to consensus on the norms for Niger.

COLLAB-ORATIVE	ACTIVITY	WHO	OUTCOME/BENEFITS
	• PHI facilitated a meeting in October 2003 where WHO experts were available to answer specific questions Nigerien specialists had about some of the standards, including needs for different classification for health center level and for referral hospitals.	• PHI Expert Group and WHO experts	• Facilitated the adaptations of WHO standards to Nigerian context
	• A second session with the Expert Group only was held in February 2004 to adapt the ETAT manual. Adaptations included language used to describe equipment and certain tasks, as well as modification of drugs proposed according to their availability in Nigerien hospitals.	• Expert Group	• Facilitated the adaptation of the ETAT manual to Niger
	• Coaching has been a central and critical feature of the QAP/Niger collaborative strategy since its inception for supporting local facilities to engage in specific improvement objectives. Coaching services have been delivered on-site by a combined external expert team of Ministry of Health and QAP/Niger staff. External coaches were selected for their ability to support the team's functioning. They included members of the DRSP/MOH, Experts Group, and other sites. For MOH supervisors, coaching and supervision are intertwined activities. QAP coaches accompanied regional DRSP in every coaching visit.	• Members of the DRSP/MOH, Experts Group, and other sites	• Coaches conducted 6 site visits per Phase I PHI site in 13 mo (2003-4); visits focused on monitoring and supporting for QI team functioning, reinforcing QI principles and changes, providing specific clinical content training, and reviewing medical records and data collection on PHI indicators.
	• During 2004 and 2005, Expert Group worked with the QAP/Niger staff to simplify and condense the set of indicators and data sources for monitoring of PHI; reduce the number of medical records to review (to reduce the burden and make it feasible), and modify the way that process indicators are calculated.	Expert Group and QAP/Niger staff	• Development of a simplified data collection system with indicators that focus on essential elements of care.

COLLAB-ORATIVE	ACTIVITY	WHO	OUTCOME/BENEFITS
Uganda/ART	• A core technical team made up of technical staff from the MOH, the private sector, other HIV/AIDS providers, and QAP/Uganda was created and received quality improvement training to be able to provide technical leadership for the QoC Initiative. This team developed key monitoring indicators to be used in the collaborative and has been also been responsible for building capacity of regional coordination teams and supporting them in coaching facility teams.	Technical staff from the MOH, the private sector, other HIV/AIDS providers, and QAP/Uganda	The Core Technical Team played a central role in the planning, development and implementation of the collaborative
Rwanda/Malaria	• In September 2005, QAP trained a team of 25 local experts to serve as coaches/mentors to two or three new sites. These local experts were asked to visit newer sites at least once or twice a month to provide encouragement and technical guidance in quality improvement.	Staff from the original sites in the PMTCT and malaria collaboratives who best mastered the QA process and methods	The use of local experts helped to teach health personnel at all levels to improve on their own performance.
Russia/HIVAIDS	• QAP and AIHA hosted a three-day planning meeting in St. Petersburg at the beginning of 2005, bringing together key national and international experts/stakeholders with, disparate views. The purpose was two-fold: to facilitate the development of a shared vision and integrated models for effectively providing care, treatment, and support services to people living with HIV/AIDS, and to promote continuity and synergy between various organizations and extant programs.	Key Russian healthcare policymakers; experts from WHO, the Global Fund, UNAIDS, UNICEF, USAID, and other international organizations; and clinicians, epidemiologists, and service providers from Russia and the United States	Four global topics emerged as primary areas for improvement: *access and patient retention, care coordination, patient management and adherence,* and *coordinated HIV and TB detection and treatment.*

COLLAB-ORATIVE	ACTIVITY	WHO	OUTCOME/BENEFITS
Russia/HIVAIDS	• In October 2005, QAP conducted a two-day round table in Moscow on coordinating HIV and TB co-infection detection and treatment for members of the inter-disciplinary HIV-TB teams in the project sites. The purpose of the round table was to provide for an exchange of ideas on HIV-TB detection and treatment between the project sites; to receive advice, feedback and answers from experts on the teams' work; to update participants on the current situation in HIV-TB co-infection in Russia, major federal regulations and efforts regarding care delivery to patients with HIV-TB; and to share relevant international experiences and identify best practices to adapt. Experts offered presentations on rates of HIV-TB co-infection in Russia, efforts to deliver services, and implementation of federal regulations. • In December 2005, the third learning session was held in St. Petersburg. . Dr. Oleg Yurin, Deputy Head of the Federal AIDS Center, updated participants on MOHSD plans for ART roll-out in 2006-2007. He also served as an expert for the teams advising them on key elements that should constitute such organizational plans. This and other presentations by national and international experts were followed by facilitated Question & Answer sections, in which experts shared their experience and personal vision regarding different issues, such as ART inclusion criteria, strategies to improve adherence, and recruitment of active intravenous drug users (IDUs) into ART.	Leading international and national TB/HIV experts Dr. Oleg Yurin, Deputy Head of the Federal AIDS Center and –other national and international experts	Provided a forum for exchange of ideas and information on HIV/TB detection and treatment Each of the four multidisciplinary teams agreed on a unified ideal readiness plan, tailored it to their local environments, identified local needs and possible resources, and developed concrete action plans and timelines.

Handout for exercise on identifying potential partners (trainer's guide with some suggested partners filled in)

Partner/Stakeholder	**You need this partner because:**	**What's in it for them?**	**What would it take to get the commitment of a partner you have identified or to find a partner?**
Government Ministry (Health? Other?)	.		
Senior health officials			
Medical association			
Nursing associations			
Community or consumer groups			
NGO			
International public health entities (e.g., WHO, UNICEF)			
Other			

	Session 7: Change Package and Measurement Strategy
	Objective Participants will: ❑ Discuss how the improvement objectives, "change package", and measurement strategy are developed ❑ Discuss common challenges in data collection
From improvement objectives to change package and measurement strategy *30 min*	*Slides 1-16:* Using these slides, explain the relationship between improvement objectives, the change package and measurement strategy. Slides 11-16 present an example from topic area to results data..
Exercise *30-45 min*	*Slides 17-32:* Plenary exercise to construct a change package and monitoring plan Ask participants to design a change package and monitoring plan for a single Improvement Objective from a QAP Essential Obstetric Care Collaborative using as a setting: Francophone West Africa, with very high maternal mortality rate, mostly due to post-partum hemorrhage. Use the remainder of the PowerPoint to summarize after the exercise.

	# Session 8 Site Selection
	Objective Participants will be able to: ❑ Discuss how to select the sites participating in the collaborative based upon the scope of improvement selected (i.e., national, regional, local; mix of public/private), and ❑ Discuss how site selection is affected when spread is an eventual goal.
Presentation/ discussion Site selection 30 minutes	*Slide 1*: Start by asking participants to describe potential sites. In a health-based collaborative in the public health system in a developing country, it might be hospitals or health centers where the quality of care of the topic area will be improved through the collaborative. A site could also be a regional/local health system, as has been the case in the QAP run EOC collaborative in Nicaragua.[2] Ask and discuss what might be the advantages of defining a site in such a manner. *Slide 3*: First, ask participants why these three are related. After discussion, explain that the decision of what sites to select for collaborative implementation will depend on: 1) whether there will be a spread collaborative following the demonstration collaborative, and if so, what will be the **spread strategy**? How will sites for the spread collaborative will be selected? 2) what the **coaching strategy** will be, i.e., who will be the coaches, taking into consideration the feasibility of coaching visits to sites, both in the demonstration and spread collaboratives. In other words, the strategy for all three activities will depend on the other two and should not be designed independently. In addition, both the coaching and the spread strategy may change as the collaborative rolls out, as planned strategies may prove to be less feasible than alternatives once they are tested. Thus this is an iterative process. *Slide 4*: Facilitate a brainstorming session to elicit ideas from participants for site selection criteria. Jot down the ideas on a flipchart page or equivalent.

[2] each site is a SILAIS, or *Sistema Local de Atencion Integral de Salud*, which is a referral hospital and the primary health care units that refer to it.

	Slide 5: Ask participants to classify the criteria into the four main categories.
	Then discuss any of the issues described in the outline below that may not have been included in the brainstormed list. Alternatively, distribute the outline below as a handout at this point and ask participants to identify what criteria were not included in the brainstormed list.

Outline of Criteria (May use as handout)

1) **Need**
   A) **Health statistics**- facilities that see many cases of condition of interest ➔ *should target facilities with highest need?*
2) **Factors that increase probability of success**
   General guideline: success (measurable results, champions) paves the way for spread collaborative
   A) **Geography**
      1. Accessibility, especially for coaches

      Comment: Russia and Rwanda strategy of having one site per province may provide an experienced site per province that might serve as reference in each province. *However*, this strategy also proved to be costly, especially in Russia
   B) **Background experience (i.e., flatten learning curve)**
      1. already working in target clinical area (especially when target area is new to system)
      2. Previous experience with QA
   C) **Support for team**
      1. presence of partners (*why?*)
      2. commitment and/or agreement of senior and local managers and others (they can free up resources or access to resources like phone/computer to help team, allow for time for teams to work and meet)
      3. if working with community, presence of community leadership or history of good community liaison
   D) **a site that carries out relevant care/service, places where this can work realistically**

3) **Factors that strengthen health system**
   A) what is a referral unit? (i.e., referral hospital and sites that refer to it) –this would strengthen referral links (e.g., docent centers in Nicaragua/Ecuador)
4) **Variety/homogeneity of sites (representativeness)**
   A) *geography*
   B) *levels*: hospital, primary care, national, regional, local, NGO
   C) *other*: public/private, religious/NGO/public

Handout	Provide the **Site Selection Handout** for reference so that participants can see the different ways in which sites have been selected. The text selected have been excerpted from full evaluation documents so that clarification details (e.g., who was on the steering committee that selected the sites in each country) may be in the full report.
Group exercise	*Slide 6*: Allow participants this opportunity to make recommendations on the site selection criteria to use. The results of this exercise can be presented to collaborative decision makers.

Handout on Site Selection

1) **Ecuador EOC collaborative**

In June of 2003, the national steering group in Ecuador identified the geographical area that would participate in the collaborative. The geographical area to be selected needed to include a provincial level secondary care hospital, and the primary care facilities of its catchment area, which together would constitute a local "EOC system" (i.e., SICOE in Spanish), with an estimated coverage of a population of 500,000[3]. The criteria for selection included:[4]

- Districts where Management Committees of Local Solidarity Health Funds (MCLSHF) existed
- Epidemiological data showing high maternal and infant mortality
- Previous QA work
- A collaborative relationship between QAP and the local MOH facilities

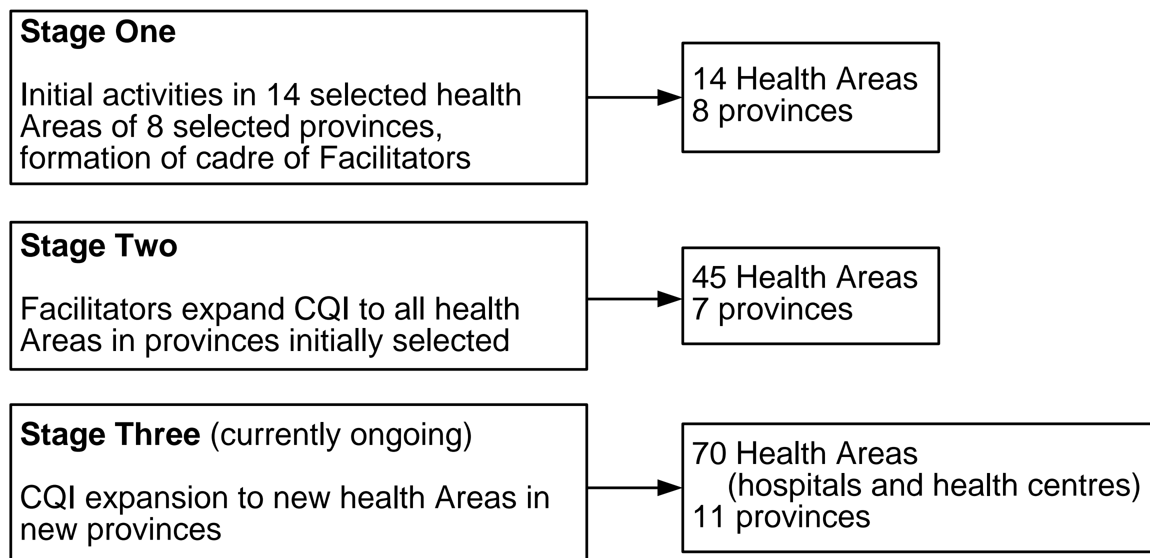
Among the country's 22 provinces, the Ecuador group chose the Tungurahua province, which had been an active participant in the prior LAMM initiative. While the collaborative approach eventually spread to the become the approach for spreading CQI under the Free Maternity Law, Tungurahua benefited from being the first province to officially enter the EOC collaborative. Because the QAP did not have the budget to support all interventions throughout the country, Tungurahua became, in effect, a pilot for the collaborative interventions in CQI, clinical training, cultural adaptation of birth that later have expanded to other sites. Because active management of the third stage of labor (AMTSL) was not part of the country's maternal health norms, the MOH gave permission to the Tungurahua Provincial Health Directorate to implement AMTSL in the collaborative.

Over time, the eight provinces and 14 Health Areas that received CQI training for implementing quality into maternal health care under LFMC became folded under the collaborative. The selection of the 14 areas had included an additional criterion: the existence of Management Committees of Local Solidarity Funds at the municipal level, the committees in charge of channeling the funds from the EULFMC to healthcare units. In the collaborative's second stage (October 2003 to December 2004), new health areas of the initial provinces were added to the initiative, covering some provinces entirely. In the third stage (Feb 2004 to July 2005), new provinces were added, mostly on the basis of their high rates of maternal mortality.

[3] Guidelines for Monitoring the Availability and Use of Obstetric Services, UNICEF, NY, 1997.

[4] Scaling Up and Institutionalizing CQI in the Free Maternity and Child Care Program in Ecuador

Figure 1 The three stages of expansion of EOC collaborative[5]



2) **Niger Pediatric Hospital Improvement Collaborative**

The initial selection of PHI sites was done by the Expert Group, with spread in mind. The original 14 sites included two (Niamey and Zinder) of the three national hospitals, four regional hospitals, and two district hospitals in each of the four regions already represented. Geographic access was the main reason for limiting the initial sites to four regions. Selection of districts was based on accessibility, having received IMCI training, possible other partners, and dynamism of the district health team.

After the baseline survey indicated problems in quality for neonates as well, the three national maternities joined the collaborative (Niamey, Tahoua and Zinder), raising the number of sites to 17.

In Phase II, which expanded the number of sites from 17 sites to 32 sites, two more regions were added, including their regional hospitals, and two more districts in every region (selected by the Regional Health Office). However, two participating regions had only three districts total and the Regional Health offices asked to have them all involved. There is one remaining region that is yet untouched by the collaborative: Agadez. This region did not send any representatives to the National Conference. In addition, Agadez comprises two districts, one which houses only private hospitals managed by the Uranium mines, and the other is basically inaccessible much of the year.

[5] Hermida J. et al. Scaling up and institutionalizing continuous quality improvement in the Free Maternity and Child Care Program in Ecuador. P. 7.

3) **Tanzania Family Planning Collaborative**

The initial five sites were selected by MOH and the RMO of Dar es Salaam, in consultation with USAID/TZ, based on level of interest and likelihood for success in the demonstration phase of the collaborative. The epidemiology of HIV/AIDS within Tanzania was also taken into consideration in selecting sites. In the last year, twelve new sites in the Northern regions were selected and funded by MOH for participation in the collaborative. Spread to future sites in the Southern regions are being considered as well.

It was clear in the three PHI facilities the evaluation team visited (Temeke, Tumbi and Morogoro) that the senior management staff (the Medical Officer in Charge and the Head Matron) provided strong institutional support for the program. Involvement of senior management staff in the learning sessions may have been critical to both increasing their understanding of the collaborative process, but also in obtaining their buy-in and support. Both the Directors of the Temeke and Tumbi Hospitals expressed an interest in seeing the introduction of quality improvement methods to other departments and clinical services.

4) **Uganda HIV/AIDS Quality of Care (QoC) Initative Collaborative**

Site selection was done primarily by the Regional Coordination Team with support from the Core Technical Team and based on criteria developed by the Steering Committee. The criteria were established to ensure participation of different levels of health facilities in the first phase of the QoC Initiative. In addition, participating sites had to have been delivering ART services for at least six months. In each region, sites were selected to provide the following mix:

- One site per district
- One regional referral hospital
- At least one Health Center IV
- One district hospital
- One private NGO

A total of 57 sites were selected from 51 districts in 11 regions, including 25 district hospitals, eight NGO hospitals, 13 health centers IV, and 11 regional hospitals.

5) Nicaragua Pediatric Hospital Improvement collaborative

The initial six hospital sites for this collaborative were chosen by the Director of Hospitals at the Ministry of Health, Dr. Roberto Jimenez, in consultation with the QAP team. The criteria he used for selection were 1) areas where regional staff had good leadership qualities and had potential to learn and apply the methods; 2) mortality rates (national IMR for 2002 was 20); and 3) existence of other programs, such as UNICEF, CARE, PAHO, active in the areas so that complimentary support could be provided. Of Nicaragua's 22 hospitals, six hospitals were chosen.

Participating Hospitals in the PHI Collaborative in Nicaragua -- 2003

Infant Mortality Rate	Region	Hospital
25.8	Matagalpa Region	Hospital Casar Amador Molina
19.4	Jinotega Region	Hospital Victoria Mott
19.1	Chinandega Region	Hospital Mauricio Abdalah
17.8	Esteli Region	Hospital San Juan de Dios
27.3	Madriz Region	Hospital Juan Brenes
17.2	Bluefields Region	Hospital Ernesto Sequiera

In 2004, four sites were added, and in 2005 three additional hospitals were added and two more in 2006, bringing the number of hospitals to a total of 16 of 22 hospitals. Thus, national coverage is achieved.

The project was also expanding its focus to include pediatric care and referral at the health center level. Work at the health center level was planned for 2006 in Rio San Juan, Managua, Chinandega, and Leon. Approximately five health centers will participate in each of these regions. The criteria for selection continue to be need, potential for success, and the presence of partners who can facilitate and complement QA activities.

6) Nicaragua EOC Collaborative

The first three SILAIS were identified by MINSA and Quality Assurance Project, with the collaboration of **UNICEF, PAHO and CARE** early on, based primarily on maternal mortality rates and presence of external assistance agency. MINSA identified municipalities in each SILAIS based on the following criteria:

- organizational, leadership
- maternal and perinatal mortality rates
- external assistance
- more than fifty percent of equipment for EOC complete
- links with local NGOs that support community network, type of health unit.

Additional SILAIS sites joined the collaborative throughout the following three years.

	Session 9: Planning for spread
	Objective Participants will: ❑ Describe several spread strategies and how to develop a strategy for spread, and discuss common activities undertaken to implement spread. ❑ Discuss how to determine closure, including discussion of what needs to be done to prepare for spread or next phase, if any ❑ Identify factors that will establish a supportive environment that will enable the organization to sustain/ maintain improvements/results over time; maintain the quality method of working and ongoing application of QI; and/or establish a Community of Practice
Spread Presentation *45 min*	Ask why this topic is addressed during planning. Include issues of initial site selection and implications for workforce (e.g., a larger number of teams means more coaching visits), and the budget. Lead a discussion on the factors that are considered necessary for spread and discuss how to evaluate readiness for spread. Discuss different models of spread strategies. Give examples of spread strategies (expanding from one to many facilities in an area, or from one area to many areas). Does this country or organization have an approach to spreading changes? If yes, how has that worked in the past? Describe a Community of Practice (CoP) that can emerge at any time but may be especially useful during the spread stage of a collaborative or the ending stage of a demonstration collaborative. Discuss how such a CoP can support sustained improvement over time Show PowerPoints on spread. Define "spread" and "spread strategy." Use PowerPoint to describe QAP experience of factors that support change, WHO and others' scale-up guidance, such as the Monograph, "Scaling up– from vision to large-scale change, a management framework for practitioners," by Management Systems International (MSI).

Handout

Planning for Spread

Approaches to Spread of improvements

A range of approaches can be used to spread improvements, innovations, best practices, etc. They include:

Spread Method	Focus	Comment
(Spontaneous) Diffusion	Not focused	Word of mouth
Dissemination and outreach	Raising awareness about the benefits of an intervention	
Training	Building technical competencies Creating a team among participants	Successful when the political will and system are
Supervision	Building technical competencies Encouragement and motivation	Important to have supervisors enforce compliance with standards in order for the change to be sustainable
Campaigns	Building commitment and political will	
Extension Agents	Coverage where there is no facility	One person going from place to place
Policy development	Increasing perceived legitimacy of the improved intervention	Important for building sustainability
Spread collaborative	Building technical competence Encouragement and motivation Building a community of practice	This is an integrated approach that covers several strategies. It is important for complex, high-priority areas

Organizing a Spread Collaborative

A spread collaborative can be organized in conjunction to other methods for spreading improved healthcare and quality improvement. If a decision has been made to organize a spread collaborative, here are some key considerations in planning a spread collaborative early on.

Establishing readiness and a foundation for Spread: Facilities develop a vision for the spread of the improvements from the early stages of the first phase of an improvement (demonstration) collaborative. At the start of a spread collaborative, the fundamental material for spread need to be ready in the form of a range of improved interventions that have been tested and accepted.

Developing a Spread Aim: Essential features of the improved processes to be spread should be clear. In addition, the intended improved outcomes should be clear, making sure the improved processes are presented as credible, observable, relevant to main problems, easy to adopt, in line

with existing values, and with clear advantages over existing practices[6],[7]. The number and type of facilities to which the interventions are to be spread should be agreed, including population coverage targets for spread activities; quantitative targets for numbers of providers complying with evidence-based guidelines, expected outcomes and timelines for achieving the expected targets.

Developing a Spread operational plan: An organizational framework for the spread collaborative should include the identification of the leading institution, and the appointment of a Coordinating Committee to lead and manage the spread collaborative. Working together with the national institutions, the operational plan should address at a minimum the following elements:

- How many "spread waves" will be needed to achieve the quantitative targets? How will the "spread waves" be organized?
- What roles need to be defined both at sub-national levels and within the main facilities?
- What mechanisms will be used for increasing perceived legitimacy of interventions to be spread (endorsement by widely recognized "champions" in the field, dissemination of evidence literature, results from CQI teams from improvement collaborative, policy decisions, international opinion)
- How will leaders identified in CQI teams from the Improvement Collaborative (first phase) become "change agents" and assist in the spread of interventions to the new target facilities?
- How will providers in the Spread Collaborative be trained both in the clinical content of the intervention, as well as in implementing the organizational changes needed for improved processes?
- What communication mechanisms will be established among participating facilities?
- How will the Spread Collaborative use our knowledge management approach as the core source of key knowledge on innovative interventions to overcome obstacles to evidence-based practices.
- What monitoring mechanisms will be put in practice to track compliance with improved practices and document improved outcomes?

In addition, other mechanisms for increase motivation of providers for spread activities, will be considered. These include: a) communication of the advantages of adopting the improved process; b) competition and rewards among facilities in terms of implementing improved practice; c) use of widely recognized "champions" to advocate for new improved practice; d) engagement of professional associations in advocacy for improved practice; e) engagement of users' organizations in such advocacy; f) supervision visits by managers when use of improved practice is less than expected; g) inclusion of improved practice within management agreements or similar mechanisms that define commitments between facilities and contractors/payers

Implementing and adjusting the Spread: The leading institution for the spread collaborative, such as the MOH, and the Coordinating Committee should establish mechanisms to oversee

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[6] Kohl, R. and Cooley, L. *Scaling Up - From Vision to Large-scale Change. A Management Framework for Practitioners*. Published by Management Systems International with funding from the MacArthur Foundation. 2005.

[7] Simmons, R. et. al. *Scaling up Reproductive Health Service Innovations: a conceptual framework*. 2002.

progress of the spread achieved over time, to discuss data coming from monitoring compliance and outcomes, to make decisions and adjust activities accordingly.

Organizing and implementing a Spread Collaborative to expand the use of Active Management of Third Stage of Labor (AMTSL) in Ecuador, 2007

Elements of the spread collaborative	How they were implemented in Ecuador
1. Defining a vision for the spread	- Every woman delivering a baby in every Ecuadorian hospital managed by the Ministry of Health should receive AMTSL.
2. Establishing population/facility coverage targets for spread	- Spread AMTSL to 58 additional hospitals in 11 additional provinces. The expansion will have an impact on 88,082 additional expected births in the new AMTSL facilities. At the end of the spread, QAP/MOH will have expanded AMTSL to cover 117,051 births annually.
3. Defining precisely what are the features of the improved process	- Improved birth care including practice of Active Management of Third Stage of Labor, in accordance to international and MOH guidelines. Evidence is conclusive about AMTSL reducing significantly postpartum hemorrhage and maternal mortality due to this cause.
4. Use of our knowledge management approach as the core source of key knowledge on implementing improved processes	- As a product of the knowledge and experiences of CQI teams in the first improvement collaborative phase, QAP/MOH developed and distributed a document[8] showing: 1) main operational obstacles faced by CQI teams to implement AMTSL; 2) main successful interventions put in practice by CQI teams to overcome such obstacles; 3) resources available at QAP and MOH offices to help teams implement successful interventions.
5. Establishing an organizational framework for the Spread Collaborative:	- The Maternal Health Division of the MOH is the leading organization - A Coordinating Group including three staff from the MOH and two from QAP was organized. - 58 additional hospitals were identified as targets

[8] *Experiences and lessons learned by the Ministry of Health and QAP in implementing AMTSL in the Improvement Collaborative, to be used for the expansion of AMTSL to every MOH hospital in Ecuador.* Quito, April 2007.

Elements of the spread collaborative	How they were implemented in Ecuador
	- Two "spread waves" were identified as necessary. In the first one, two professionals from each new hospital will be trained in AMTSL and CQI. In the second one, these professionals, with support from staff from original facilities will train every professional who attends deliveries in each hospital. - Roles of "facilitator for clinical content" and "facilitator for CQI contents" were identified. Specific MOH persons in each province were identified for these roles.
6. Increasing perceived legitimacy of interventions to be spread	- The most respected two ob-gyn's from the main six hospitals of Ecuador were proposed and accepted to act as local "champions" for AMTSL. They will promote AMTSL through specific activities to ob-gyn's from satellite hospitals in the regions. - The MOH issued a formal policy document endorsing AMTSL and launched it officially through institutional and media channels. - The MOH included spread of AMTSL to every Ecuadorian hospital as part of a national campaign to reduce hospital maternal mortality which will also include additional interventions.
7. Using leaders in CQI teams from the Improvement Collaborative (first phase) to assist in the spread	- In each province from the first phase Improvement Collaborative, leaders from CQI teams were identified and engaged to assist with new facilities.
8. Training providers in the additional facilities in the Spread Collaborative	- A one-day long curriculum for training on skills and knowledge for AMTSL, as well as in CQI, monitoring and reporting compliance with AMTSL was developed. It includes materials developed and tested in the first phase Improvement Collaborative, as well as POPPHI training materials. - A schedule for training providers in every new facility by champions and Facilitators was agreed.
9. Establishing communication mechanisms among facilities participating in the spread	- CQI teams delegates and provincial facilitators meet every quarter to review progress achieved in the spread collaborative.
10. Establishing monitoring mechanisms	- Every hospital measures monthly compliance

Elements of the spread collaborative	How they were implemented in Ecuador
	with use of oxytocin as part of AMTSL and reports the indicator to provincial MOH offices, which analyze the information and uses it to prioritize supervision visits. - Provincial offices report aggregates to national MOH. - Hospital Case-fatality rates for hemorrhage are examined periodically.
11. Evaluation of the collaboratives	
- The Coordinating Group, Maternal Division of the MOH and HCI will meet periodically and at the end of the Spread to monitor progress and evaluate the achievement of objectives and targets.	
12. Transition to long term sustainability of improvements (e.g. a community of practice)	- QAP and MOHwill support post-Spread periodic activities to monitor and foster implementation of improved processes. - QAP and MOH will conduct post-Spread assessments to evaluate long-term sustainability of improved processes spread.

	Session 10: Coaching teams
	Objectives Participants will be able to: ❑ Identify a strategy for managing and coaching the teams. ❑ Discuss the need to plan, develop, and conduct training for coaches.
Presentation and discussion: **Coaching collaborative**	*Slide 3*: Ask participants how coaching might be different from "traditional" supervision. Try to lead this conversation to the three points described below. *Answer*:

teams 20 minutes	*Traditional supervision*, in some instances, refers to supervision visits that are conducted like audits (e.g., to see if production levels or fiscal procedures are conducted correctly), with emphasis on negative feedback when expected results are not met. *Coaching* is a concept that originated in a sports context and is now used in business, industry, and personal development. In addition to performance monitoring, coaching implies the additional role of helping the teams perform better by ❑ providing technical feedback, ❑ helping to brainstorm and facilitate actions that might lead to better performance, and ❑ providing positive motivation. Explain that while coaching is similar to **supportive supervision**, it is very different from **traditional supervision**; therefore, people who have been supervisors must be open to the new role. *Slide 4-7***:** Given this general introduction to coaching, ask participants the questions in this slide to define the improvement collaborative coach role and responsibilities—i.e., in more detail than previously discussed. Allow participants to discuss this before moving on to the next slides. Explain that because the QI team does the actual improvement "work" of the collaborative, it is the coach that helps the inexperienced team to understand how to play this role. QAP's experience shows that appropriate coaching is critical to collaborative success. *Slide 8: Who Should Be a Coach?* Allow participants to answer questions marked in blue italics before proceeding discussion. District or regional-level supervisors can be well placed to be coaches, especially if they are supervisors and/or have reporting obligations for the collaborative clinical topic area. However, supervisors seldom have the needed skills. In addition to training, it is helpful for them to start by accompanying an experienced coach who can mentor them to acquire the needed skills and understanding of their role and collaborative work. A proven strategy QAP has employed has been to identify QA champions from among the team members and regional-level MOH staff from the demonstration phase experience who can then carry on coaching in a spread collaborative. This initial phase allows implementing agency coaches to identify individuals who understand QA and have the enthusiasm and respect from colleagues to carry on as coaches. This strategy allows for the identification of coaches that have a most important attribute: successful implementation of QI as specifically applied to the collaborative being implemented.

| **What skills do coaches need?**

20-30 minutes | *Slide 9*: Allow participants to answer questions marked in blue italics before proceeding discussion—write these down on a flipchart or equivalent and check off items as they are mentioned in the following slides.

Slide 10: Coaching Skills 1: Discuss the need for coaching skills in teambuilding. Coaches need to be able to assess the functionality of teams and how to address any problems. It is common for only one or two people to carry the burden of the work of the team. Individual team roles may be organized differently for each team (i.e., some teams may rotate roles; others might have permanent roles); coaches need to ensure the arrangement is functional.

Coaches help teams communicate with other collaborative sites.

Coaches help in cross-fertilization among teams of successful changes. Over the long run, if relationships are developed between sites, site-to-site learning could occur without the coach.

Discuss how coaches must also understand that they play a diplomatic, or promotional, role and should develop a positive relationship with site managers and directors as well as between the team and management. The sustainability of QI at the site will largely depend on the degree to which site managers understand and appropriate and see the benefits of QI.

It may also be helpful to identify local actors with whom to develop mutually beneficial relationships; i.e., those who may help in problem solving, financing, and community level efforts. Examples could include local governments, partners and civil society groups working with areas related to topic area (ex. women, children or health), community health agents, private sector, etc.

Slide 13: Coaching Goal: Explain that in a collaborative, the goal is for teams to gain experience in QI teamwork that will allow them to function independently.

The strategy of using internal coaches in Niger is described in the coaching handout. Training a cadre of coaches of various levels (local, regional and national) in the health system promotes sustainability.

Slide 14: Issues with QI Coaching

Costs: Transport is often a limiting factor in achieving regular coaching support. Options include sharing costs with or among central/regional/district/local MOH, partners, local governments and implementing agency.

Logistics Discuss the efficiency of piggybacking on existing management |

	structures facilitate regular coaching visits. Identify management systems that may need to be set up, such as site visit scheduling (e.g., to coordinate shared transportation), incorporating team meetings or discussion of indicators during existing meeting structures.[9] *Clinical knowledge* Coaches need some clinical knowledge to effectively conduct their role. If that is not possible, coaches can go out in pairs, with one of them being an expert in the clinical topic and one an expert in quality improvement. The coach or coaching team is more effective when they are able to both assess clinical performance and to answer questions in the clinical topic that come up. A coach's lack of clinical expertise may affect his or her credibility and effectiveness though, in QAP's experience, regional-level supervisors have gained credibility through their role as coaches. In one case, the previous lack of credibility may have been led by clinical specialists at hospitals who did not believe public health specialists (provincial supervisors) had anything to teach them. In another case, a nurse became a QA champion, who then became a coach to teams including doctors. *Plan to develop coaching skills* For efficiency, a basic level of coaching skills can be addressed using targeted training sessions, though they cannot replace the above-mentioned mentoring strategy. The latter, a proven strategy used by QAP, allows for experienced coaches to be paired with new coaches. New coaches first observe coaching visits, and over time lead coaching sessions, with experienced coaches providing mentoring. In QAP's Ecuador experience, coaches are provincial level supervisors who met at the national level several times a year. The first three workshops focused specifically on the tasks facilitators were to conduct at the provincial level immediately after each workshop (e.g., provide QI training, hold three learning sessions, conduct coaching visits to sites etc). Subsequent workshops allowed coaches to focus on common problems and solutions. *Slide 15: Coaching strategy* *Strategy:* Coaching strategy may change to adapt with collaborative coaching experience and spread strategy. At the practical level, the implementing agency may also want to shift its coaching strategy over time from an initial reliance on external coaches to coaches that are part of the existing MOH structure.

[9] Examples: results of indicator data and problem solving could be discussed during grand round equivalent meetings; teams could conduct a short debrief of quality issues in between staff shifts; team leader could include progress update of QI efforts in regular reports to hospital director; team meeting minutes could be included in official ward notebook.

	Organization: How often will coaches visit the teams? Visits can be of fixed periodicity or can focus on teams with the greatest need. Where feasible, telephone calls with the team leader can be used between coaching visits. *Skills development*: Coaching in pairs allows for new coaches to observe and be mentored in this new role.
Group exercise 1 hour	Divide group into groups of 3 to 5 people. Provide the Handout titled, Innovation in Coaching: Niger PHI Team Coaching and Support, and provide the exercise handout. Ask groups to assign a leader, recorder, reporter and timekeeper. In plenary, discuss issues in selecting, and developing coaches.

Handout

Innovation in Coaching: **Niger PHI Team Coaching and Support**

Coaching has been a central and critical feature of the URC Niger collaborative strategy since its inception. It is the primary collaborative mechanism for supporting local facilities to engage in specific improvement objectives. Coaching services have been delivered on-site by a combined external expert team of URC and Ministry of Health staff. URC developed a clear and detailed set of guidelines for the external coaching teams' use in planning and conducting site visits. These teams conducted six coaching site visits to all PHI sites between October 2003 to November 2004, which focused on monitoring activities, providing support for QI team functioning, reinforcing quality improvement principles and changes, providing specific clinical content training, and reviewing medical records and data collection on PHI indicators. External coaches received financial support from URC for travel costs to conduct coaching site visits.

URC has developed a structure for coaching and an impressive group of well-designed training materials, tools and job aids to guide the coaches in supporting optimal team functioning and strengthening quality assurance activities. These documents prepare the coaches to understand their roles, to plan and conduct coaching visits, to prepare documentation, including an action plan, and to conduct follow-up activities.

The strategy to engage the Ministry of Health regional staff as partners in coaching has contributed to a sense of ownership and commitment on the part of the MOH, and to building a more effective partnership in implementing the collaborative and to engaging in problem solving at the site level. QAP values this strategy for its contribution to sustainability of QA in the healthcare system in Niger. It is an essential input to supporting and strengthening teams and to improving quality of care and adherence to standards.

Evolution of Coaching: In March 2005, URC convened a national conference with key collaborators and partners to share the results of Phase 1 of PHI, identify best practices and determine strategies for expansion of the Collaborative. Conference participants made recommendations regarding coaching in the expansion to Phase 2, specifically to conduct coaching monthly for the first three months and then every two months for the remainder of 2005. Participants deemed coaching to be an important reinforcement for the QI teams. They acknowledged that new and established teams continue to need intensive ongoing technical support to initiate and sustain pediatric hospital care quality improvements. The support of teams on site and opportunities for shared learning were highly valued by teams for reinforcing capacity and quality improvement.

In March 2005, URC conducted a two-day training course for 19 new coaches focused on strengthening the competencies of the coaches, exploring their roles and the needs of QI teams, skills development, and next steps in supporting the existing and new QI teams. Participants included PHI experts in the system. From a review of agendas for Regional Learning Sessions implemented in 2005, it appears that external coaches are playing an increasing role in Regional Learning Sessions.

In late 2005, URC pioneered a strategy to develop a cadre of internal coaches throughout the

Niger health system in order to decentralize and expand the coaching function. This strategy was crucial for taking the QAP collaborative to scale in Niger with the level of support needed by the QI teams (QITs). URC designed a training program to develop internal coaches and conducted a five-day training workshop in each of three regions in January 2006. Of 101 coaches trained in this workshop, 60 were internal PHI coaches, 41 were those charged with statistical and information responsibilities and epidemiology, and nine were internal coaches specifically for SONNE.

Through the training, the role of the internal coaches was clearly defined and they were charged with these activities:

- Reproduce similar training workshops at sites
- Review the composition of teams
- Conduct a process analysis and construct a flow chart for care of sick children
- Help the team finalize the Action Plan developed in the training session
- Verify availability for data collection and use of tools for team functioning
- Elaborate an Action Plan for monitoring teams.

The training event also produced recommendations by participants to strengthen the integration of monitoring and coaching at the regional, site, and URC and national levels.

Best Practices in Coaching

Focus groups were conducted in which, among other things, coaches were asked to identify the best practices they had used or seen in coaching. The following response are summarized and presented in order of frequency.

- Calculate indicators with the team (4)
- Give advance notice of coaching visit with date and time (2)
- Demonstrate activity during on-the-job training with concrete case (2)
- Practice skill in on-the-job training
- Train on norms; place norms on walls
- Make site visits
- Ask QITs what they expect from coaching
- Prepare a framework or tool for coaching
- Provide information about performance; synthesize what you've seen with a focus on performance
- Review notion of teamwork
- Tell teams coach will be there with them to discuss any problems
- Explain or work out whatever is not clear during the coaching session
- Give feedback on strengths and weaknesses

Who Should be a Coach

Responses to this question included practically the entire health system, from supervisors to providers, to all specializations, levels off care, the administration, and those who have qualities of motivation, experience and availability. One respondent said, "for all the different domains where one wants to improve quality." These responses are a clear indication of the value attributed to the role of coaching in improving health care quality and results.

Summary on Coaching: The Niger team explained that there is not a culture of clinical supervision in Niger and that there is not a structure for administration of clinical supervision to support quality care. Coaching can play a useful role in growing a culture to support quality improvement. Coaching can also have an impact on integrating monitoring and supervision roles in the Ministry of Health.

"When we went to visit the first site after the baseline survey for PHI to follow up on the commitments the team had made during the initial on-site feedback session, they were so surprised that we actually came. Now the teams work between our visits because the coaches will really come." (Coach URC)

"Why did you wait so long to give us this information!?" (Trainee as an Internal Coach)

"The QITs work interactively – there is no 'boss.' The staff feel involved and want to work on solving the problems." (Regional coach)

Coaching exercise

Keeping in mind the collaborative that you will implement, discuss the following in your group. The idea is to generate as many viable ideas as possible.

1) **Who could be good coaches …**
   Consider :
   - Skills
   - Total number of sites

2) **How many coaches will be needed?**

Consider:
- Distances among the sites and the coaches' locations
- How many sites should one coach cover?
- What will the coaching demand be in the demonstration vs. expansion phase?

3) • **Who might be available as coaches?**

Consider:

- What personnel in the existing (public health) structure might be candidates?

4) **Coach development:[10] how will coaches be trained, mentored and supervised**
   A) Who will train coaches? Why did you select these trainers?

   B) Coaching in pairs – who will be the experienced coaches? Why did you select them?

5) **Organization of coaching**
   A) What are options for funding coaching visits?

   B) If examples of coaching tools are provided, select prototypes that might be appropriate to adapt from. Which tools did you select and why?

[10] The QAP course, "Coaching and Team-building" provides a good foundation of skills for coaching and the document, "Training Manager's Guide" provides how-to steps for assessing training needs and creating training. Identify what training a coach may need.

	Session 11: Communication and reporting plan
	Objectives Participants will: ❑ Discuss issues related to developing a plan for communications and reporting among improvement collaborative management and teams; identify factors that promote and hinder communication and reporting among collaborative mgmt and teams
Communica tion and reporting 60 Minutes	Present PowerPoint followed by discussion. Describe what such a plan should address. Who needs to be informed? What needs to be communicated? How frequently? Where does information have to travel from and to, and what are the conditions there? Are there already structures present that can be used - e.g., standing meetings, phone calls, email, intranet or extranet? Ask what types and frequencies of communication would be common to audience. • What is the optimum level of reporting – and what is the minimum level – from field to leader / manager / coach, or others? • Identify "who" and "what" in needs of senior/ upper level management information and communication. • Discuss factors that promote and block communication. • How is a communication plan influenced by the scope, scale and budget of the collaborative? (May or may not be as detailed or formal as a dissemination plan) • What are some factors that promote and block such communication? • Give examples from QAP experience of what has worked well, not so well. Include electronic / telephone / printed / observed information, and how communication within the improvement collaborative relates to routine supervisory communication.

	Session 12: Training and capacity development
	Objectives ❑ Identify who will need new knowledge and skills ❑ Identify common topics that will likely need to be addressed by training and capacity development plans ❑ Discuss issues related to developing training plans or capacity development plans for those involved in the improvement collaborative ❑ Discuss various ways in which collaborative stakeholders can learn the skills they need outside of traditional training
Training and capacity development plans for technical training *30 min.*	In plenary, lead discussion to identify stakeholder groups who will need some type of capacity building. List groups on flipcharts as they are named. Break into small groups and split up the list among the groups. Ask each group to discuss and report back on 1) how they will determine learning needs; 2) what types of knowledge and skills do they think the groups will need (e.g., technical/clinical content, quality improvement, data and measurement, how to work in teams; coaching skills; how to conduct just-in-time training for teams); and 3) how these needs can be met. Ask them to think beyond traditional classroom training (e.g., job aids, mentoring, peer-to-peer, etc.). Have each group present the results of their small group discussion. Present PowerPoints as needed to reinforce discussion. Points to make if this does not come out in group report-backs: Make sure all who may need training have been mentioned, including site QI teams, team leaders, collaborative managers. Others? Coaches' training needs may have already been discussed in previous session. Discuss how to determine what training is needed - training needs assessment (task analysis, audience analysis, existing skills, gaps) . Not everyone needs all training. "Just-in-time" training is important during an improvement collaborative. For clinical knowledge and skills – is this a new area? Does it require practice to achieve competency? Can it be done in learning sessions? If so, how will the rest of the team be trained? Do you need separate "whole-site" training? Discuss the difference in training someone how to work in an improvement collaborative versus the new skills in technical content of the change package and how that needs to become part of in-service and orientation for new people and

	for updates. What technical training and orientation will be addressed through the improvement collaborative and what may be addressed through routine methods? For quality improvement skills – has there been any exposure to quality assurance or quality improvement? No exposure? How much do coaches know? How will QI skills taught to the teams in learning sessions be learned by the team members who don't attend? Discuss where to get existing training materials and identify what might need to be created. In which topic area/skills does your organization have content expertise? Your partners? If you do not have it in-house, where will you get it? Discuss where to obtain training resources on various topics (QAP's core courses) and what might need to be developed. How will you identify someone with skills capable of designing training? Refer to QAP's Training Managers Guide (http://www.qaproject.org/pubs/PDFs/M_TRAIN.PDF) for assistance in how to assess training needs, design, develop, and evaluate training. (When applicable) Give QAP examples of when technical training was done, for whom, how orientation and in-service were addressed. Show sample agendas and/or objectives from QAP collaboratives experience. Include training for "core team and other managers" if different.

	Session 13: Running a collaborative
	Objectives The participant will be able to: ❑ Identify topics (needs) commonly addressed in learning sessions ❑ Identify resources available to develop or adapt training materials and tools that can be used during learning sessions and action periods ❑ Review typical schedules/timelines for conducting the improvement collaborative
Presentation and discussion: **Preparing facilities and facility teams prior to Learning Session One**	Review steps in planning that will have already been carried out by management team. (15 min) Refer to Days 1 and 2, with the assumption that discussion today addresses the implementation of an improvement collaborative at a clinical facility level, among several facilities (could be at mixed or same level). Ask what planning steps would be completed by the time facility-level teams start working.
Presentation **Review of collaborative phases** ***2 hrs***	Present and discuss slides, prompting for questions at intervals. *Slide 3:* Review the overview of the life stages of a collaborative. Sessions 4 through 12 covered the preparatory stage of a collaborative, while the current session focuses on the implementation stage. *Slides 4-6*: Optional, depending on level of understanding participants have reached. If you do not use these, note that the preparatory stage normally takes 6-8 months. *Slide 7:* This is the overview of what happens in the implementation stage, which may last 18-24 months. The slides following elaborate on the topics on this slide that have not yet been discussed. *Slides 8-12*: These slides focus on learning sessions, where group training in QA usually occurs. *Slides 14:* Explain how to build clinical competency. Competency is about the ability to perform, not about actual performance on the job. Competency is necessary but not sufficient for good performance. This slide shows alternatives or complements to traditional training for ensuring

	clinical competency of providers. The Nicaragua Essential Obstetric Care collaborative's annual Knowledge Prize is a competition held among all EOC collaborative sites in Nicaragua in which a nurse and a doctor from each site are selected at random in an oral competition of knowledge of the EOC standards. Since until the selection date no one knows who will represent the site, it motivates all staff to study the norms. QAP's experience has found that both QA and clinical training are most effective, where possible, if they can be decentralized to the regional if not the site level. *Slides 15:* Data that teams submit may not reflect reality for two main reasons: errors in measurement and false data (intentional or unintentional). These can be due to lack of time (e.g., to follow the procedure for randomly selecting clinical records, to complete the partograph during the delivery etc), lack of understanding of the measurement tools or system, human error or other reasons. How to check data validity? One important way is to understand the data variables, how they relate to each other, and what quick checks can be done for internal consistency. For instance, do the data correspond with one's impression of the cohesiveness of the clinical staff or QI team? Do the numbers of cases of the particular topic area vary from month to month according to expectations? Are the data "too perfect"? Do percentages always end in 0 or 5? Do they consistently increase every single month (as opposed to the more usual fluctuation)? Unsophisticated data falsification can yield such results. In each of these cases, if there is reason to suspect that the data do not reflect reality, they should be checked by re-measuring. In addition, periodic spot-checking of data validity is also important. Consistent with coaching principles, data falsification should be viewed as a problem to be solved, not as an issue that warrants punishment.
Group review of collaborative implementation tool examples	*Preparation*: Select examples of tools used in the collaborative implementation stage (see Appendix) and select examples for teams to review (e.g., LS agendas, coaching tools, data collection tools etc). Classify the tools you selected, giving them a category name (e.g., coaching tools, LS tools, training tools, monitoring and evaluation tools etc). Divide participants into groups of at least three people. Allow each group to select a facilitator, reporter and recorder. Show everyone the categories of tools available for their review. Allow groups to select the categories of tools they will review by allowing each group to select their first choice from the list of available tools in turn until all categories are taken. The recorder will note both the choice of tools and the reasons for the choice. If there is time, the group can also discuss changes of the tool they might recommend. Have each group review a tool to understand how it works, and then select the

	ones they believe are the best prototypes for the collaborative they will implement. In plenary, have each group present their findings, including reasons for their recommendations. Collect group recommendations.

	Session 14: Putting It All Together: The Action Plan[1]
Objectives	The participant will: ❑ Organize participants into task groups who will implement the first phase of the collaborative ❑ Produce an action plan of activities for collaborative task groups: o Explain vision of the collaborative that will be implemented o List main tasks that will be performed by each group during the next 12 months, when each task will be done, and which groups will need to coordinate with each other o Describe each person's individual role in the collaborative and his/her next steps
Audience	This four-hour action plan session was written for participants who will implement a collaborative together after the collaborative training. However, some steps (e.g., Step VII) have been written as a demonstration step, with the expectation that participants will work through the step in more detail after the training. However, if there is time available, this session could also be expanded to a full-day workshop to help participants with more detailed planning to allow for more time, in particular, for Steps V-VII. If the training will consist of participants who do *not* plan to implement a collaborative together, you will need to conduct Session 14 using either 1) a hypothetical example (i.e.,. participants pretend they will work on a collaborative together that you define) or 2) the example of a collaborative that one of the participants will be implementing. In the latter case in particular, steps such as I-IV and VII should ensure that participant can apply the step and may take even less time than what is estimated.
Group Exercise	**Materials** • Sticky wall (5' x 12' nylon parachute fabric, 3M™ spray mount artists' adhesive) • 8" x 5" cards, of at least two different colors (half a sheet of paper) • Multi-colored markers • Flipchart
Preparation	Read through all sections first to prepare. Each step from II to VI will require advanced preparation, such as gathering information ahead of time or preparing a visual for group exercises. Find out in advance from group leader what action

[1] The exercise in Session 14 is adapted from the Institute Cultural Affairs' group facilitation methods.

	planning time frame would be most appropriate and relevant (shorter time periods would allow for more detailed planning and vice-versa).
Step I. Context *10-15 min*	1. *Preparation* On flipchart paper, prepare evidence (data from HMIS, data from existing studies, anecdotes, pictures, statements from clients/staff, any other evidence) that supports the need to implement this collaborative for substep 2 below. Also, if participants come from diverse organizations or otherwise might benefit from motivation to work together, prepare a collage of images and symbols that represent the past victories of the groups the participants represent to provide a reminder of the strengths of the group. 2. Explain to participants that the purpose of this last session is to create an action plan of all major activities that will need to take place in the next 6 to 12 months. Remind participants (possibly with the help of others who can speak on these topics with greater authority): • Of their strengths and prior successes to this point • Of the prior decisions that led to the implementation of this collaborative and any other prior decisions made • The importance of and purpose of implementing this collaborative (e.g., ask questions such as the following: What is the mandate? What is the need for improvement in this topic area? What are the consequences if this collaborative work is not implemented (i.e., increased morbidity/mortality?)? Provide rationale of the need. • Links between this work and other work of the organizations participants represent 3. Outline the timeframe for this session and explain the steps of this Action Planning method, noting how it differs from other planning processes. Emphasize that consensus will be reached during steps IV, VII and VIII.
Step II. Envisioning victory *10-15 min*	1. *Preparation* Draw a large circle on a flipchart paper and title it "Victory." 2. Ask participants to help you imagine and visualize the future final outcome of the collaborative work they will be implementing. "What do you see and hear?" "Who was involved?" "What was going on?" Go around the room once getting an image from each person and draw it simply, with different color markers, until the circle is filled with images. Translate abstract statements of vision into images that can be drawn, and keep words, if any, to a minimum. The objective is to give the group a sense of the final outcome in rich detail. This step is a high energy session and it may move rapidly if there is already a shared vision. If not, it will help participants to build one.
Step III. Current Reality *10-15 min*	1. *Preparation* Prepare a flipchart sheet as shown below:

	CURRENT REALITY Implementing group ↓ Project success ↓ Strengths | Benefits Weaknesses | Dangers 2. Divide participants into four groups and give each group a marker and flipchart paper. Referring to the flipchart figure shown above, explain that the vision needs to fit within the current reality of the strengths and weaknesses of the implementing group (i.e., participants and others that might be involved). Assign one group to brainstorm a list of group strengths, and another its weaknesses. Ask the third group to write a list of what benefits there will be if the project is successful, and the fourth to make a list of dangers. Each group posts these together in the room for all to see.
Step IV. Commitment *10-15 min*	This quick step is about forming consensus on the level of commitment for implementing the collaborative and in the process, participants develop ownership for the work. This is not a planning step, but it is the beginning of the process of developing of the scope of the collaborative. Point out to the group the gap between Step II and Step III and ask the group what are the implications for the imagined victory, given the current reality. Hold a short discussion with the group on the topic of what they are ready to commit to. *What are we promising the community?* Explain to the group that their statement of commitment will help inform the expert's group in defining the scope of the topic area and the development of improvement objectives. Show the group the evidence of the need for the collaborative to help in broadening their thoughts on areas of commitment. There are two main ways of articulating the commitment. You can ask the group to summarize its commitment as a list of key deliverables or concrete goals to achieve by a target date while you jot them on flipchart paper. The most time efficient way, however is to assign two people (or ask for volunteers) to convert the discussion general statement of commitment that includes description of the boundaries of the commitment. At a later stage, participants can modify the draft until the commitment statement centers on the groups'.
Step V. Key Actions	1. <u>*Preparation*</u>: Prepare the sticky mat with temporary column headings lined across the top (see Figure 1 below), using symbols. Also, prepare a stock of white and colored cards (**Note on task groups** explanation below). Participants will brainstorm

45-60 min

actions items and group them under these temporary headings. After they agree on task group titles, the temporary column headings will be replaced with title cards, which will be of a color different from the cards used for actions.

Note on task groups -- A task group is a subgroup of people who participate in the collaborative training who will take on a group of tasks to implement the collaborative immediately after the training. However, they do not necessarily correspond to the organizational structure roles covered in Session 5 (i.e., leadership, management, content expertise, etc).[2]

2. <u>*Brainstorm actions*</u> Ask participants to break up into groups of 4 to 6 members and for each group to write **___** (number)[3] cards, each stating an **action** that will need to be accomplished to implement the collaborative--by *any* collaborative actors.

In writing action items -- one idea per card; 3 to 7 words written large.

Explain that action items need to be phrased starting with a explicit verb ("*action")* and more specific than the 12 preparatory or 7 implementation (19 total) steps presented in Session 3. Alternatively, assign each group a different group of the 19 steps, and ask that each list specific action steps that will accomplish each step. Examples of action-oriented language:

What needs to be done	**Action oriented language**
Ensure basic resources needed to implement norms	Write up minimum resource list for sites Conduct site visits to assess resource needs
Develop tools (monitoring, coaching, job aids etc)	Conduct workshop to review examples and draft tools Send draft tools to key reviewers for feedback

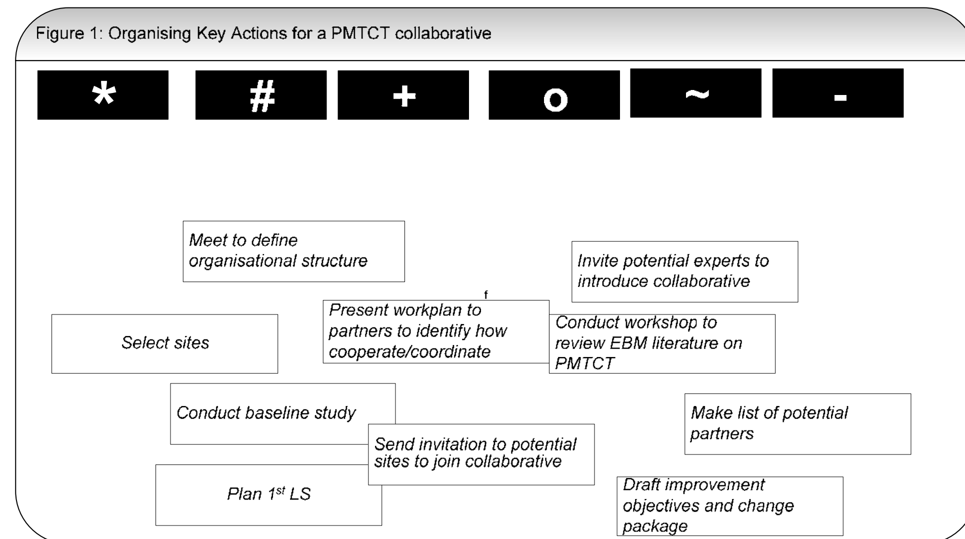
3. <u>*Share actions*</u> Ask each group for the 2 **clearest** (least ambiguous) action cards from each group, read each out loud, and stick to prepared sticky board in any order

---

[2] This is because task groups take in to account only the participants present, whereas in practice, the organizational structure of a collaborative needs to be designed and agreed upon by the main stakeholders (who may not be at the training), and also take into account existing structures and groups. For example, for a collaborative implemented within Ministry of Health facilities, the existing district health management office or team (DHMT) may be well suited in the implementation phase of a collaborative to conduct coaching and/or training. Similarly, for a collaborative on improving community knowledge and access of family planning, existing community women's associations organized by an NGO working on women's issues may be the natural initial QI team. In reality, neither DHMT or NGO representatives may be present at the training. On the other hand, tasks groups may naturally transition into a particular role in the organizational structure. For instance, the same group that implements a baseline study might serve well as coaches and QI team leaders. On the other hand, the task group that implements the baseline might also include clinical experts who may not participate in coaching or teams.

[3] You want to collect 35-45 cards total, so divide 35 by the number of groups for the approximate number of independent actions each group will write.

as shown in Figure 1. Ask the group if there are questions of clarity and, if so, clarify with the person who wrote the card. If there are actions that seem similar, ask group if they are the same—if they are, only one is necessary. The following is an example of what the process might look like at this stage, *before* classifying cards (substeps 5 and 6):



4. *<u>Classify actions</u>* Ask participants to group actions together logically that **should be executed by the same group of people** (i.e., task group). Allow participants to verify agreement of actions under each task group. If there is disagreement, allow for discussion and attempt to bring to consensus. If they are actions that do not clearly fall under a particular group, set these aside and reassess if a new task group needs to be formed. Line up action items of the same group under a different temporary symbol card.

5. *<u>Classify remaining cards and name task groups on colored title cards</u>*

a) Ask participants for the 2 action items that are **unique** or **most different** from each other. Repeat substeps 3 and 4. With each round, ask participants to name the task groups according to the actions listed under the title, replacing the temporary symbol headings with colored title cards. If no task group name comes quickly, just keep the temporary symbol title, and replace it when participants come up with a task group name.

b) Ask participants to place all remaining cards with actions not already represented on the board under the group they feel should be responsible for those actions. In plenary, allow participants to verify agreement. Adjust according to group consensus.

c) Ask participants to look at each list of items under each task group to see if there are any actions that are missing.

6. *<u>Self select task groups</u>* Ask participants to place their names on a blank card, and stick them on the mat under the task group they would like to work with. If group size is very unbalanced, ask for volunteers who can adjust. If there is a task area with no volunteers, ask if another group can take on these tasks. Explain that these task

groups will need to identify other people that should be in each group, with the help of key leadership in their organization, and invite them to participate.

In some cases, participation in task groups might be assigned by the main collaborative manager at this stage, or there may be logical reasons for assigning a pre-existing group to a particular task group. Keep in mind, however, that allowing participants to self select, typically results in greater ownership of the actions to be executed.

7. _Finalize and order actions_ Ask each task group to collect their actions and meet in a separate area of the room. Their job will be to look at all the tasks for the group, arrange them in sequential order, and then determine if additional actions need to be added. Then, each group will define what will be their contribution to the victory defined in Step II.

Step VI. Calendar

45-60 min

1. _Preparation_. Prepare a second sticky mat as shown in Figure 2. The number of months of planning should be between 6 to 12 months, keeping in mind that the preparatory stage of the collaborative is normally 6 to 8 months. Make sure the cards are spaced out so that action cards have enough room to fit on the board.

Figure 2: PMTCT Collaborative Action Calendar

	MAR	APR	MAY	JUN	JUL	AUG	...	Victory
Planners/oversight								
Clinical experts								
Baseline executers								
(… other task groups)								

2. Ask a representative of each task group to place their actions on the calendar in chronological order, according to the date the action is expected to be **completed** (rather than the date it is expected to be **done**). Some actions may need to be slightly reworded to correspond to an action that can be completed. Participant name cards can also be lined to the left of the task group name. This is a relatively quick step as adjustments will be done in Step VII.

Step VII. Coordination

10 min

1. Explain to participants that this step is the chance to check the rationale for the timeline of each group and synchronise the timing of actions from one group with that of another. Ask everyone to look at the calendar and ask questions such as:
- Does the timing of the activities of each group make sense with that of other groups? Adjust if necessary
- Are there activities that can be combined? Are there activities that more than one group should collaborate in?
- Some groups will be busier on certain months—can they help other groups during the months they are less busy?

	- Do the victories of each group reflect the group commitment? - Do initial budget projections call for adjustments? For the four-hour day that Session 14 has been allotted, simply allow the group to adjust a couple of actions as an example and move on. For a longer workshop, allow these details to be worked out. 2. If there is additional time, discuss implementation tracking questions, such as: - How will you keep everyone informed? - Will group representatives meet? How often? When will the larger group meet again? - How will you update the plan? How will you maintain momentum and motivation?
Step VIII. Resolve *30 min*	Facilitate a focused conversation with participants: Ask them to reflect on their current work, the collaborative planning they have done, and the implications it will have for each (adjust questions as appropriate): - **What exactly have we done here today?** - **What excites you about this? / What are you looking forward to?** - **What are you not looking forward to?** - **What does it mean / what are the implications for us and others?** - **What will be the main challenges in implementing this collaborative?** - **What are the next steps for the preparatory stage of the collaborative?** These should correspond to the calendar (or adjust the calendar) and everyone should agree on these. - **Make sure you establish in a concrete way how each person will receive a copy of the action plan within the next week.** The action plan will contain an overall planning map/timeline as well as a reminder of individual commitments. **Any questions?** This step may also lead to clarification questions on methodology, or general questions about implementation, especially if participants will not implement a collaborative together. Take the time to elicit and answer these questions in detail, as this is a crucial stage in the process.
Step IX. Individual next steps *30 min*	In this step, each participant will define his or her individual next steps in launching the preparatory stage of collaborative. Ask participants **What are the next steps for you**? Give everyone 10 minutes to write down what their next steps will be. Pair participants with someone who will work in the same task group; ask pairs to trade and read each others plans, and then give each other feedback. [4]

[4] If participants will not implement a collaborative together, they can still work on the first two questions of this step and then pair with someone who might implement a similar collaborative (e.g., related clinical areas) for feedback.

Appendix 1 Examples of tools and other documents used by various country collaboratives

Sample country budget

Sample Agenda Learning Session 1 (Uganda)

Format for Teams' Presentations at Learning Session 2 (Uganda)

Coaches' Terms of Reference AP1 (Uganda)

Coaches' Site Visit Protocol (Tanzania)

Coaches' Site Visit Report Form AP1 (Uganda)

Site Team Functionality Form (Uganda)

Baseline Data Collection Form (Uganda)

M&E Draft Indicators Matrix (Uganda)

Effective Meetings (Uganda)

Meeting Minutes Format (French and English)

Job Aid for Writing Meeting Minutes (Uganda)

Site Decision Follow-Up Form (Uganda)

Worksheet for Testing Change (Uganda)

Team Action Interview Form (Rwanda)

Analysis of Flow Charts (Uganda)

Sample country budget

Budget for Scale-up of the Malawi PHI Collaborative June 2005- December 2006

Assessment and sensitization activities.			
Item	**Calculation**	**Sub-total MK**	108.00MK=1**US $**
Training for assessment over 4 days in Blantyre COM - 2px from 19 facilities for 4days @ MK4000	2*19*4*4000	608,000.00	5,629.63
Assessment teams: Accommodation 2 nights@ MK4000 per night for 38 people	2*19*2*4000	304,000.00	2,814.81
Costs of Mentors during the assessment – 4days @MK 1,300 for 6Registrars- They will move around the facilities(M&I)	Covered under monthly rate		-
Transportation assessment teams @ MK1,000/person	2 px per facility =19*2,	38,000.00	351.85
Transportation Mentors= 1002kms @ k30/km x 6	1002kms x K30 x 3 Reg	360,720.00	3,340.00
Cost of Materials-stationary, Photocopying of RCM and assessment tool, 2 boxes of pens	2 boxes of pens @ 1500	3,000.00	27.78
38 copies of RCM and 38 copies of assessment tool plus 6 copies of assessment tools for registrars = 82 copies		311,600.00	2,885.19
	Sub-Total	**1,625,320.00**	**15,049.26**

Learning session in LL			
Accommodation Participants 2 from the 19 new hospitals and 1 from 8 old hospitals			
46 participants @ MK5200	46plp x 5200 x 2dys	478,400.00	4,429.63
Transportation			

Fuel for 2 vehicles estimated 0ne at 1002kms @K30/km and one at 311km@K30/km(Hiring two minibuses)	1002 x 30 x 2	78,780.00	729.44
Fuel for 1 LL vehicles at K30/km	311 x 2 x 30	18,660.00	172.78
M&IE for 3 days			
Participants 46 x 1,300 x 4		239,200.00	2,214.81
Drivers x 27 districts x 1 COM at MK1,300		109,200.00	1,011.11
Refreshments at K250/person		42,500.00	393.52
46 participants, 27 drivers, 2 WHO, 2 USAID, 2 UNICEF, 2 LCH total 85			
Stationery & Photocopying			
writing pads, pens, flip charts, markers, masking tape, folders, resource materials x 10 pages @K10		100,000.00	925.93
Administration			
		24,000.00	222.22
Local Run fuel - administrative work		10,000.00	92.59
	Sub-Total for 1 learning session	**1,100,740.00**	**10,192.04**
	Sub-Total 5 Learning sessions	**5,503,700.00**	**50,960.19**

Action Period

Mentoring sessions, monitoring changes, data analysis and compilation of run charts

Item	Calculation	Sub-total MK	US $
Accommodation - Mentor makes two 1-day visits per month, 18 months, all 19 facilities visited twice each month.	Covered under monthly rate		-

mentors @ 4000			
Transportation mentors			
Vehicle Hire mileage at K30/km			
Fuel for vehs @ K…. each			
M&IE for 4 days			
Mentor makes two 1 day visits per month, 18 months, all 19 facilities visited twice each month.	Covered under monthly rate		
Cost of fuel from BT to all facilities estimated at 1002km @k30/km x 2 x 6reg	Covered under monthly rate		
Stationery & Photocopying			
Essential items cost for all facilities per action period for all the facilities	$19000/4 action periods	513,000.00	4750
Communication per action period for all facilities ($10 pre facility, 18 months, 27 facilities) divided by 4 action periods	$10*18*27/4	131,220.00	1215
	Sub-total for 1 Action Period	**644,220.00**	**5,965.00**
	Sub-Total for 4 Action Periods	**2,576,880.00**	**23,860.00**
	Training in ETAT - TOT		
Accommodation @ MK4000 x 19facilities x 2 x 4 days		608,000.00	5,629.63
Per-diem @ MK1,300 x 38pts x 4dys		197,600.00	1,829.63
Transportation of participants form 19 facilities (Hiring two minibuses)		78,780.00	729.44
Stationary			
writing pads, pens, flip charts, markers, masking tape, folders, ETAT partic manual, lead pencils 10 pages @K10		50,000.00	462.96
	Sub-Total for ETAT	**934,380.00**	**8,651.67**

Facilities to consist of Chitipa, Karonga, Rumphi, Mzimba, Nkhatabay, Kasungu, Mchinji, Lilongwe, Dedza, Ntchisi, Dowa, Nkhotakota, Salima, Mangochi, Nsanje, Balaka

Training in ETAT at district level – 3 training centers, 2 with 12participants each and the 3rd with 14 participants. Two registrars do training in one center.			
Per diem for Registrars (3 regs *2 days each@1300)	Covered under monthly rate		-
Transport for regs (2 regs conduct a session i.e., 3 sessions by 6 regs) Average distance to training center is Kms……..	1002kms x K30 x 6Reg	360,720.00	3,340.00
Per diem for trainees @MK1300	38ptrs x 2 daysx1300	98,800.00	914.81
Transportation for trainees (Hire of minibuses from the districts) estimated		100,000.00	925.93
Materials and stationary: flip charts, markers, writing pads, photocopying papers for resource materials, pens		50,000.00	462.96
Refreshments at K200/pts/day	200 x 180 x 2	72,000.00	666.67
	Sub-total	**681,520.00**	**6,310.37**

National Conference Dec 05 - Jan 06 in Lilongwe			
Accommodation			
54 participants @ MK5200	54ptcpts x 5200 x 2dys	561,600.00	5,200.00
3 COM @ 6800		40,800.00	377.78
Transportation			
Hire of two minibuses one from the south one from the north or use of public transport estimated		78,780.00	729.44
Fuel for COM I Vehicle estimated @ 311kms x 2 x 1 x K30/km	311 x 2 x 30	18,660.00	172.78

Item	Calculation	MK	USD
M&IE for 3 days			
Participants 50pts x 1,300 x 2dys	1300 x 50 pts x 2dys	130,000.00	1,203.70
Drivers x 2 minibuses from districts x 1 COM at MK1,300	1300 x3 pts x 2dys	7,800.00	72.22
Refreshments at K250/person			
50 participants, 27 drivers, 2 WHO, 2 USAID, 2 UNICEF, 2 LCH total 85	50 x 250 x 2	25,000.00	231.48
Stationery & Photocopying			
writing pads, pens, flip charts, markers, masking tape, folders, resource materials x 10 pages @K10		50,000.00	462.96
Administration			
Photocopying of resource material		50,000.00	462.96
Local Run fuel - administrative work		10,000.00	92.59
	Sub- Total	**972,640.00**	**9,005.93**
Total of all activities (Training for assessment, Assessment and TOT and district teams training, Learning sessions and Action periods, national conference		**12,294,440.00**	**113,837.41**
College of Medicine Personnel Costs			
Collaborative Directors costs (Prof. Molyneux		540,000.00	**$5,000.00**
Local Malawian Expert (To be recruited)		2,700,000.00	**$25,000.00**
Data management		216,000.00	**$2,000.00**
Registrar Remuneration (to cover per diem, travel,	$450x18x 6	5,250,258.00	**48,600.00**
Support for essential elements to all new districts	108000 x19 facilities x 4 action periods	8,208,000.00	**76,000.00**
Support for communication to all facilities	27dists x 108 x 18mths	524,880.00	**4,860.00**
	COM Sub-Total	**17,439,138.00**	**161,473.50**
Total of all activities Plus COM	**Total all cost**	**29,733,578.00**	**275,310.91**

COM Overhead	15%	**4,460,036.70**	**41,296.64**
Grand Total		**34,193,614.70**	**316,607.54**

SAMPLE AGENDA LEARNING SESSION 1 (UGANDA)

QUALITY OF CARE INITIATIVE IN HIV/AIDS
FIRST LEARNING SESSION

TIME	DAY ONE	FACILITATOR
Moderator:		**Dr. Herbert Kadama**
8.00	Welcome and Registration	QAP/MOH
8.30	Introductions and Expectations	Dr. Herbert Kadama
8.45	Opening remarks	District Director of Health Services
9.15	Review of HIV/AIDS and ART strategies in Uganda	Dr. Hudson Balidawa
10.45	**Break**	
11.00	Discussion	Dr. Herbert Kadama
11.30	Presentation by site in Region 1	Site Representatives
11.45	Presentation by site in Region 2	Site Representatives
12:00	Presentation by site in Region 3	Site Representatives
12:15	Discussion	Dr. Herbert Kadama
12.45	Introduction to the QoC Initiative	Dr. Eric Ikoona
1.15	**Lunch**	
2.15	Introduction to Principles of Quality Improvement	Dr. Herbert Kadama
3.30	Dimensions of Quality Improvement	Dr. Peter Masaba
4.30	**Break**	
4.45	Introduction to collaborative learning	Dr. Anthony Musisi
5:15	**END OF DAY 1**	
DAY TWO		
Moderator:		**Dr. Emmy Habyara**
8.15	Recap of Day 1	Participant
8.30	Quality Improvement Tool 1: Flow Chart	Dr. Eric Ikoona
10.00	**Break**	
10.45	Site Presentations	All Participants
11.45	Data Collection Methods and Sources	Dr. Rachel Jean-Baptiste
12.15	Improvement Objectives and baseline data collection	Dr. Hudson Balidawa
1.30	**Lunch**	
2.30	Exercise on baseline data collection	Dr. Eric Ikoona
3.30	Quality Improvement Tool 2: Trends Analysis	Dr. Bernie Ssebadduka
4.30	Steps in Quality	Dr. Hafsa Lukwata
6:00	**END OF DAY 2**	
DAY THREE		
Moderator:		**Dr. Masaba Peter**
8.15	Recap of Day 2	Participant
8:30	Site presentations of flow diagrams	All participants
9:30	The role of site teams	Dr. Bernie Ssebadduka
10.45	**Break**	
11:00	Leading the process of Quality Improvement	Dr. Anthony Musisi
12:00	Next steps: Work plans for Action Period 1	Dr. Emmy Habyara
1:00	**Lunch**	
2:00	Site presentations of Next Steps	Dr. Emmy Habyara
3:30	**Closing Remarks**	**Chief Administrative Officer Jinja**

FORMAT FOR SITE PRESENTATIONS FOR 2ND LEARNING SESSION

Quality of Care Initiative in HIV/AIDS

I. Name of health facility

II. Functionality of team
   a. Composition
   b. Established day and time of meetings
   c. # meetings held/meeting minutes available

III. Result of baseline assessment
   a. Objective 1 (run chart)
      i. Comment
   b. Objective 2 (run chart)
      i. Comment
   c. Objective 3 (run chart)
      i. Comment
   d. Objective 4 (run chart)
      i. Comment
   e. Objective 5 (run chart)
      i. Comment

IV. Difficulties/constraints

V. Next steps and Recommendations

COACHES' TERMS OF REFERENCE FOR SITE VISIT AP1 (UGANDA)

Quality of Care Initiative in HIV/AIDS

ACTION PERIOD: 1 (Feb 2006)

I. Goal: to help participating health facilities implement their action plan from learning session

II. Objectives:

1- Evaluate whether quality improvement teams have been established at the site;
- Composition of the team
- Regularity, day and time of the meeting
- Participation of members during team meetings
- Existence of minutes of the meetings and quality of the information written
- Archival/storage of team documents

2- Evaluate the level of completion of flow charts and system analysis;
- Updated flow charts initiated at LS
- Identification of steps that may need improvement (clouds) and written justification

3- Collection of baseline data
- Ensure that Comprehensive HIV care/ART cards and registers are being completed properly
- Provide clarification on chosen indicators
- Evaluate data collected so far

4- Identify and discuss difficulties and constraints encountered by the team in implementing their action plan to date (establishing teams, holding team meetings, collecting baseline data);
5- Share format for site presentations for LS 2; Identify and discuss technical assistance needed by the team in order to prepare their presentation for the next Learning session;
6- Provide additional relevant information to the team regarding how to hold effective meetings, how to write good minutes of the meetings, how to collect data for indicators and how to study and document lessons learned from data collected;
7- Build consensus on next steps (agreements by the site team members and agreements made by the visiting coaches)

III. Proposed method of work:

- Visit to health facility by one member of the Core Technical Team and one member of the Regional Coordination Team;
- Meet with team members and discuss on the above points;
- Provide on the spot training (may even demonstrate how to collect data);
- Verify the information gathered (data, team members, team functionality (do they meet? Are there meeting notes? Etc);
- Obtain copies of necessary documents.

IV. Useful Documents :

- Introductory letter
- Job Aide for holding effective team meetings;
- Form to follow-up the functionality of team;
- Job Aid for writing team meeting minutes;
- Table for follow-up of team meetings;
- Form for follow-up of decisions taken during team meeting;
- Format for site presentations for Learning Session 2
- Form for site visit reports

COACHES' SITE VISIT PROTOCOL (TANZANIA)

Dar FP Collaborative

QAP/ Quality Assurance Project, Tanzania

Site: ___________________________ Date: __________________________

Type of Contact: Site Visit, Phone, Email	Name of Site Visitor	Team Members/Changes to Team Members

1. Team Function:

Team Leader	Last Meeting Date	Meeting Agenda Reviewed	Meeting Notes Reviewed

2. Indicators Site Seeks to Improve:

#	Indicator	Most Recent Result	Data Source

3. Review of Changes:

Review of changes (cycles)	Potential Impact of Change Type of Change	Review of activities since the last visit and review plans for the next few weeks. Write Comments Here.
Indicator(s) # Date planning started ___/___/___ Describe change being applied: Date change implemented ___/___/___ Date testing began ___/___/___ Was there an improvement in the indicator? ____ Y/N If yes, was the improvement modest, moderate or significant? (Circle or highlight one)		
Indicator(s) # Date planning started ___/___/___ Describe change being applied: Date change implemented ___/___/___ Date testing began ___/___/___ Was there an improvement in the indicator? ____ Y/N If yes, was the improvement modest, moderate or significant? (Circle or highlight one)		

Indicator(s) # Date planning started ___/___/___ Describe change being applied: Date change implemented ___/___/___ Date testing began ___/___/___ Was there an improvement in the indicator? ____ Y/N If yes, was the improvement modest, moderate or significant? (Circle or highlight one)		
Indicator(s) # Date planning started ___/___/___ Describe change being applied: Date change implemented ___/___/___ Date testing began ___/___/___ Was there an improvement in the indicator? ____ Y/N If yes, was the improvement modest, moderate or significant? (Circle or highlight one)		

What costs have you (QI team) incurred? (Notebooks, forms, photocopies, local travel) Describe amount and reason.

Have you contacted other teams? List How (Telephone, email, meeting, other opportunity) Date, Reason, Result

List questions from site visit that arise during the review and answers or Technical Assistance given by Reviewer:

Question/Issue	Answer/Technical Assistance

Do you have any questions resulting from the last learning session?

FP update areas covered:

Possible probing questions for QI teams:

- What is the reception you are receiving by your "home" organization for your work in the collaborative?
    - i. What type of support exists and by whom?
    - ii. What are the major obstacles
    - iii. What strategies has the team used to address them?
    - iv. Is there anything else we should know that has an impact (positive or negative) on your collaborative work?

- What were the most useful lessons and skills developed in last learning session

- What was the most satisfying thing that happened to you or your team in the last period in your collaborative work?

- What was the most challenging thing that happened to you or your team in the last period in your collaborative work?

- ❑ What do you find helps you most in achieving the work you are doing in collaboratives? What additional skills or support would be most helpful to you?

Please indicate challenges you as QAP coach encountered and what you did:

Challenges	Response

COACHES' SITE VISIT REPORT FORM, ACTION PERIOD 1 (UGANDA)

Quality of Care Initiative in HIV/AIDS

GENERAL INFORMATION

Site Name, District and Region:____

Date: ___/___/_____

Name of Coaches: 1.____

2.____

3.____

Names of site personnel attending meeting with coaches:

____

____

____

____

Evaluation of Quality Improvement Team

Has QI team been established? [ ] Yes [ ] No

Composition of Team

	Name	**Job Function**	**Role in Team**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Established QI team meeting: DAY____________________ Time_______

Dates that meetings were held in February: ___/___/_____| ___/___/____| ___/___/___

Meeting minutes available? [ ]Y [ ]N | [ ]Y [ ]N | [ ]Y [ ]N

How participatory were team members? (attendance, participation at meetings, etc.)

____
____
____

Is there a folder for maintaining QI-related paperwork? [ ] Yes [ ] No

EVALUATION OF LEVEL OF COMPLETION OF FLOW CHARTS AND SYSTEM ANALYSIS

Have site team updated flow charts? [ ] Yes [ ] No

(ID all steps, steps with problems, etc…)

Advice given/suggestions made

____
____
____

COLLECTION OF BASELINE DATA

Are registers being completed properly? [ ] Yes [ ] No

IF NO, what are issues?

____
____
____

Is baseline data collection completed? [ ] Yes [ ] No

IF YES: Obtained copy of data to report? [ ] Yes [ ] No

Verify calculations? [ ] Yes [ ] No

(attach a copy of the data to report)

DIFFICULTIES AND CONSTRAINTS ENCOUNTERED BY TEAM TO DATE:

____
____
____
____
____
____
____

ADDITIONAL TECHNICAL ASSISTANCE NEEDED TO PREPARE FOR LS 2

____
____
____
____
____

NEXT STEPS

QI Site Team

1.______________________________________

2.______________________________________

3.______________________________________

4.______________________________________

5.______________________________________

6.______________________________________

7.______________________________________

Coaches

1. ______________________________________

2. ______________________________________

3. ______________________________________

4. ______________________________________

5. ______________________________________

6. ______________________________________

SITE TEAM FUNCTIONALITY FORM (Uganda)

Quality of Care Initiative in HIV/AIDS

SITE : --- YEAR : ------------------------------

Month	# meetings planned	# meetings held	% meetings planned and held	# Meetings w/notes	Average # of participants	# activities planned	# activities completed	% activities planned vs. accomplished	Observations
January									
February									
March									
April									
May									

M&E DRAFT INDICATORS MATRIX

Quality of Care Initiative in HIV/AIDS

OBJECTIVES AND INDICATORS FOR MONITORING HIVAIDS COMPREHENSIVE SERVICES, INCLUDING ART

Sample of selected objectives and indicators

ART Functional Category A: Patient Assessment and Screening					
Main Objective Related to the above Category	Indicator related to the main Objective	Definition: Narrative	Definition: Numerical		Means of Verification
			Numerator	Denominator	
1. 100% of HIV+ patients in general care have been assessed for ART	1. % of HIV+ patients in general care who have been assessed for ART.	HIV infected patients enrolled by the program, i.e. cumulative number of HIV+ patients enrolled by the program. Assessed is either through CD4 count, TLC, WHO Staging; - may be disaggregated by sex, age and pregnancy status	Number of patients receiving general care who are screened for ART	Total number of patients receiving in general care;	General comprehensive HIV/AIDS care register, HIV care/ART card and ART register
2. 100% of HIV+ women of reproductive are in general care are reviewed for pregnancy	2. % of HIV+ women of reproductive age in general care are reviewed for pregnancy	HIV+ Women of reproductive age (15 – 49 years) who are screened for pregnancy using MOH /Internationally recommended methods;	Number of HIV+ women of reproductive age who are receiving care and reviewed for	Total number of HIV+ women of reproductive age who are receiving care	General comprehensive HIV/AIDS care register, HIV care/ART card and ART register

		Such methods may include the following: -Urine test for pregnancy -Haematological test for pregnancy, -Pelvic ultrasonography	**pregnancy**		
3. Family planning options are discussed with 100% of HIV+ patients of reproductive age	**3. % of HIV+ patients of reproductive age with whom family planning options are discussed**	HIV+ patients of reproductive age who are receiving care at health facility; Patients of reproductive age refers to HIV+ men and women between the ages 15-49 This cohort includes both HIV+ patients on general care AND patients receiving ART	**Number of HIV+ patients of reproductive age receiving care or treatment at the health facility with whom family planning options are discussed**	**Total number of HIV+ patients receiving care or treatment at the health facility**	General comprehensive HIV/AIDS care register, HIV care/ART card and ART register
4. 100% of patients on ART are assessed for active TB	**4. % of patients on ART who are assessed for active TB**	HIV+ patients on ART who are assessed for TB using the following procedures: -Clinical assessment (coughing for more than 3 wks, blood in sputum, weight loss, night sweats) . This may be disaggregated by age, sex and pregnancy status	**Number of patients on ART who are assessed for active TB**	**Total number of patients on ART**	HIV care/ART card, ART register and TB register

BASELINE DATA COLLECTION FORM (UGANDA)

Quality of Care Initiative in HIV/AIDS

Site Name____

INDICATOR :
____
____
____

	Numerator	Denominator	Numerator/Denominator	%
June				
July				
Aug				
Sept				
Oct				
Nov				
Dec				

[Numerator/Denominator * 100 = percentage(%)]

Quality of Care Initiative in HIV/AIDS

Effective meetings

- Regular (1 x week in the beginning…)
- Pre-meeting work
  - Agenda developed and shared, specifying date, time, and topics for discussion
  - Pre-set time duration
- Work during the meeting
  - Respect the agenda and time
  - Review previous mtg report
  - Review and evaluate implementation of tasks previously assigned
  - Design new interventions to test
  - Take notes
- Post-meeting work
  - Write-up and share meeting notes
  - Implement recommended tasks, interventions
  - File all relevant meeting materials
  - Prepare for next meeting

MEETING MINUTES FORMAT (Niger)

Canevas de rédaction des PV de réunion des équipes d'amélioration de la qualité des soins : *(Meeting minutes of the of the quality improvement teams)*

(Les items suivants peuvent être un guide pour améliorer la qualité de vos PV)

(The following items can be a guide to improve your statement of quality)

- Date :
- Lieu : (*place*)
- Heure de début et heure de fin de la réunion : (*Time the meeting started and ended*)
- Objectif de la réunion : (*Objective of the meeting*)
- Points inscrits à l'ordre du jour : (*Agenda points*)
- Eléments essentiels discutés pour chaque point inscrit : *(Essential elements discussed for each point*)
- Décisions prises (en terme d'action à faire, par qui ? et quand ?) *(Decisions made in terms of action plan – by whom and when*)
- Recommandations faites : (*recommendations made*)
- Date de la prochaine réunion : (*date of the next meeting)*
- Points à discuter à la prochaine rencontre : *(points to be discussed at next meeting)*
- Nom, prénom et signature du rapporteur (*first and last name and signature of reporter)*

En Annexe : (*in annex*)

- Liste de présence (*List of persons present)*
    - indiquer les noms, prénoms, titre et poste de travail dans l'hôpital (*list first and last name, title, and job position)*
    - Mentionner entre parenthèse et en face du nom, le rôle joué dans la réunion (président, rapporteur, chronométreur) *(in parentheses opposite the name write the role played during the meeting; e.g., leader, reporter, timekeeper)*
- Autres documents produits lors de la réunion *(other documents produced during the meeting)*

Job Aid for Writing Meeting Minutes for Site Collaborative Improvement Teams (Uganda)

Quality of Care Initiative in HIV/AIDS

- Date :
- Place :
- Persons present (names, job function, unit work, role in team meeting)
- Time meeting started :
- Objective of meeting:
- Agenda/discussion points:
- Summary of each discussion point:
- Decisions taken (what needs to be done, when, and by whom ?)
- Recommendations made :
- Date and venue of next meeting:
- Draft agenda for next meeting:
- Time meeting ended
- Signature of secretary and the chair person

Attachments:

- Other documents discussed during the meeting

SITE DECISION FOLLOW-UP FORM ***for follow-up of decisions taken by the team during the team meetings***

Quality of Care Initiative in HIV/AIDS

Name of Health Facility____

Activities to be completed between ……/…..…/…….. and ………/………./………..

N[O]	**Planned Activities**	Responsible	In Process	Completed	Not completed	**Reasons for non-completion or delays**
1						
2						
3						
4						

Worksheet For Testing Change (Tanzania)

Aim: (Overall goal you would like to reach)

Every goal will require multiple smaller tests of change

Describe your first (or next) test of change	**Person Responsible**	**When to be done**	**Where to be done**

Plan

List the tasks needed to set up this test of change	**Person Responsible**	**When to be done**	**Where to be done**
1- 2- 3- 4- 5-			

Predict what will happen when the test is carried out	**Measures to determine if prediction succeeds**
1- 2- 3- 4-	

Do Describe what actually happened when you ran the test

Study Describe the measured results and how they compared to the predictions

Act Describe what modifications to the plan will be made for the next cycle from what you learned

TEAM ACTION INTERVIEW FORM (Rwanda)

Team/ Name: ________________________ Date: _________

Compiled by: ____________________ Location: ______________

For Period starting: __________________________

and ending: _________________ Team members: ____________________

Questions for Team	Score	Data Source
Actions in Action Period 2		______ Oriented others in the organization (facility, hospital, etc.) ______ Flowcharted additional processes in collaborative team topic ______ Developed data collection forms to measure activities in collaborative team topic ______ Collected some data in my collaborative team topic ______ Designed changes in the health care delivery process ______ Developed indicators to measure the changes I designed ______ Implemented changes in the health care delivery process ______ I have implemented some changes in the health care delivery process and have anecdotal evidences (stories) that demonstrate how it has worked

Questions for Team	Score	Data Source
		______ Implement changes in the health care delivery process and measured to check improvement in the indicators ______ No actions in Action Period 2 Evidence seen to demonstrate actions taken:
Supportive factors		______ Team is enthusiastic and committed to the collaboratives work ______ Team's organization's (facility/district, etc.) management supports the collaboratives work ______ Team has some skilled members who have the competencies to implement quality improvement in our topic area ______ Overall, team enjoys implementing quality improvement in my work ______ Morale is high in the team and organization about our ability to make improvements in our topic area Comments:

Questions for Team	**Score**	**Data Source**
Factors that hindered actions		______ Team members have changed and this made team lose momentum ______ Team's organization's management does not support the collaboratives work ______ Team has not found the time to fit the collaborative work in my regular schedule ______ Team has low competence for structuring improvements ______ Team has low competence to develop indicators ______ Team has low competence in measuring progress ______ Team prefers to provide care, and does not enjoy some of the quality improvement aspects of the work

Questions for Team	**Score**	**Data Source**
		Comments:

ANALYSIS OF FLOW CHARTS

Health Facility, District and Region:______________________________________

STEP/ACTIVITY	CONTENT/WHAT IS INVOLVED	DIFFICULTIES/PROBLEMS

Appendix 2: PowerPoint slides