



**USAID**  
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HEALTH CARE  
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PROJECT

## PROCEEDINGS

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# Technical Advisory Group Meeting

## *Washington, DC, May 18, 2009*

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JULY 2009

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This report was prepared by University Research Co., LLC (URC) for review by the United States Agency for International Development (USAID). It summarizes the discussions and conclusions of the Technical Advisory Group convened by USAID on May 18, 2009, to advise on the Health Care Improvement (HCI) Project, which is made possible by the support of the American people through USAID.

PROCEEDINGS

# **Technical Advisory Group Meeting**

*Washington, DC, May 18, 2009*

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**DISCLAIMER**

The views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

**Acknowledgements:** This compilation of the proceedings of the Technical Advisory Group Meeting for the USAID Health Care Improvement (HCI) Project was prepared by HCI Project staff. The HCI Project is funded by the American people through USAID's Bureau for Global Health, Office of Health, Infectious Diseases and Nutrition. The project is managed by University Research Co., LLC (URC) under the terms of Contract Number GHN-I-01-07-00003-00. URC's subcontractors for the HCI Project include EnCompass LLC, Family Health International, Initiatives Inc., Johns Hopkins University Center for Communication Programs, and Management Systems International.

**Recommended citation:** USAID Health Care Improvement Project. 2009. Technical Advisory Group Meeting, Washington, DC, May 18, 2009. Proceedings. Published by the USAID Health Care Improvement Project. Bethesda, MD: University Research Co., LLC (URC).

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## Abbreviations

AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired immunodeficiency syndrome
AMTSL	Active management of the third stage of labor
ART	Antiretroviral therapy
CDC	Centers for Disease Control and Prevention
CHW	Community health worker
COTR	Contracting Officer's Technical Representative
EONC	Essential Obstetric and Newborn Care
HCI	Health Care Improvement Project
HIV	Human immunodeficiency virus
HR	Human resources
HRSA	Health Resources and Services Administration
IHI	Institute for Healthcare Improvement
IQC	Indefinite Quantity Contract
MARP	Most at-risk population
MGH	Massachusetts General Hospital
MGPO	Massachusetts General Physicians Organization
MOH	Ministry of Health
NACHC	National Association of Community Health Centers
NGO	Non-governmental organization
OVC	Orphans and vulnerable children
PDSA	Plan-Do-Study-Act
PEPFAR	President's Emergency Fund for AIDS Relief
PHC	Primary Health Care
PLWHA	Persons living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission of HIV
PRICOR	Primary Health Care Operations Research Project
PVO	Private voluntary organization
QI	Quality improvement
TAG	Technical Advisory Group
TB	Tuberculosis
UN	United Nations
URC	University Research Co., LLC
US	United States
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing for HIV
WHO	World Health Organization



## Executive Summary

Leading health care improvement experts gathered in Washington, DC on May 18, 2009 to serve as the Technical Advisory Group (TAG) for the Health Care Improvement (HCI) Project, USAID's global initiative to expand the use of modern improvement methods in health care in developing countries. Launched in October 2007 as a three-year Task Order to University Research Co., LLC (URC), the project is at its mid-point. The TAG, comprised of experts in HCI's statement of work, met to review the project's progress to date and provide guidance for its direction in the second half of the task order.

Members of the HCI Technical Advisory Group included: Dr. Bruce Agins of the New York State Department of Health AIDS Institute and Director, HIVQUAL International; Ms. Katie Coleman of the MacColl Institute for Healthcare Innovation; Mr. Göran Henriks of Qulturum, Jönköping County Council (Sweden); Dr. Gregg S. Meyer, Center for Quality and Safety, Massachusetts General Hospital; Mr. Lloyd Provost of Associates in Process Improvement and the Institute for Healthcare Improvement; and Dr. David M. Stevens of the National Association of Community Health Centers.

The panelists were welcomed by Ms. Gloria Steele, Acting Administrator for Global Health at USAID, and Ms. Barbara Turner, President, URC. Dr. James Heiby, USAID Cognizant Technical Officer for the HCI Project, began the meeting with a brief review of the evolution of USAID's program in quality improvement that has culminated in the Health Care Improvement Project. Dr. M. Rashad Massoud, HCI Director, followed with a brief overview of the project's objectives and key activities.



*HCI TAG members, from right to left: Katie Coleman, David M. Stevens, Göran Henriks, Gregg S. Meyer, Lloyd Provost, and Bruce Agins.*

The meeting addressed five topic areas critical to the HCI statement of work: strengthening health systems, health workforce development, spread/institutionalization, quality improvement (QI) methods, and global learning/knowledge management. HCI staff opened each topic with brief presentations on project strategies and results and then posed a specific question for discussion by the TAG panelists.

### **Question #1. Applying quality improvement to strengthen health systems: How can we continue to build capacity in applying QI to strengthen health systems at different levels?**

HCI's approach to health systems strengthening includes: focus on districts, service integration, capacity building, strengthening information systems, accountability, and adoption of the innovative care for chronic conditions model.

#### Recommendations by TAG panelists:

- Design care for chronic diseases to offer patients pre-packaged bundles of self-care interventions.
- Other elements of the Chronic Care Model that you should build in are clinical information systems (ways to facilitate timely individual patient care and identify and target subpopulations for health interventions) and self-management support (working with patients to support their efforts to manage their health and health care).
- Align measures of improvement across all levels of the health system and with the information system, and build in ways to allow all levels to hold each other accountable.
- Make it explicit who is tasked with measuring and reporting on quality on an ongoing basis.
- Engage civil society actors and patients in improvement; while this is the hardest to achieve, it provides the biggest returns.

#### **Question #2. Health workforce development: *What are your thoughts about our approach to engaging or supporting the human element of health care?***

HCI's approach to applying QI to health workforce issues is focused on improving health worker productivity, retention, and engagement.

#### Recommendations by TAG panelists:

- Measure patient experience—it is an important outcome measure for staff satisfaction.
- If high turnover of staff is inevitable, plan for it. Since remuneration is low, staff often leaves for professional advancement; it is important to identify professional development incentives for staff.
- The ability to receive feedback is an important skill to learn; improvement efforts should prepare staff for giving and receiving feedback.

#### **Question #3. Spread and institutionalization: *Where we can best focus our efforts to strengthen institutionalization and spread improvements?***

HCI's definition of institutionalization emphasizes establishing and maintaining QI as an integral, sustainable part of a health system or organization—making quality service delivery and QI the “default” response of the health system.

#### Recommendations by TAG panelists:

- Demonstrate the business case for QI: Is it cost-effective? Design deliberate communication strategies to share what works and convince stakeholders in new places what could work for them.
- Continue to build the evidence base for improvement methods.
- Create standards and expectations for each level of the health system and define what capacity building is needed to support these roles.
- When moving to spread, keep in mind that the key components for sustained improvement are relationship building, communication and coaching. In addition to sharing the tools that come out of the initial collaborative, HCI needs to find ways to institutionalize the idea behind “learning sessions” to create mechanisms for ongoing learning and sharing. Tools also need to be integrated or “hard-wired” into the health system so that they become a permanent part of the way things are done.

#### **Question #4. New directions in quality improvement: *What are frameworks to consider?***

HCI's experience in applying new frameworks range from cultural adaptation for reducing home births in Nicaragua to, a framework to improve care for patients on ART, to phasing-in high-impact maternal newborn interventions at the district level in Afghanistan.

#### Recommendations by TAG panelists:

- Make greater use of positive deviance analysis—when things go really well, look in depth at the positive outliers to better understand why things went incredibly well.
- Build in how you're going to learn, so when adverse events occur, you'll have a way to review that. Build in a system to learn from failures.
- Apply the collaborative approach to address other environmental factors that cause underperformance, such as leadership and fiscal issues.
- Use patient safety as a lever and a wedge issue into QI. People understand safety as an issue. Measure safety awareness in the country before beginning the work—document how comfortable people are speaking up, etc. and measure progress in this awareness as a result of QI activities.
- Look at other QI methodologies, like “lean process improvement,” which is trying to systematically take waste out of processes.
- Develop measures that show how well the continuum of care is working, as a whole.

#### **Question #5. Partnerships for global learning: *What additional strategies can you suggest to strengthen global and regional communities of practice for improvement?***

HCI's global learning strategy is to develop an open-access, database-driven website for global knowledge management in QI that will provide a systematic way for storing the knowledge generated in the field and making it available to users worldwide through an easy-to-use search function.

#### Recommendations by TAG panelists:

- “Steal shamelessly; share senselessly.”
- Develop social networking features to help people identify and connect with QI practitioners or groups in their area.
- Stay in a learning mode, and don't forget the importance of creativity and its role in QI.
- Website can be a way to reach patients to find out more about the patient experience. Connect QI methods to patients and build their capacity (and that of providers) to address patient safety issues. Package QI concepts into materials for consumers, so that patients are more involved in their own health.
- Partner with major quality organizations to link them to your website to pull in their communities and explore linking with universities, both in the US and other countries.

#### **Concluding remarks**

The panelists all expressed support for the project's goals and ambitious work program and interest in convening again to follow further achievements of the project. Dr. Meyer recognized the leading edge nature of the work and commended USAID for its continued investment in quality improvement: “The American people would be pretty happy if they knew more about these programs done in their name. There's a lot to be proud of here,” he said.





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## Technical Advisory Group Meeting Agenda

**May 18, 2009**

Rotunda Room, Ronald Reagan Building  
1300 Pennsylvania Avenue, Washington, DC

### **AGENDA**

9:00-9:15	Arrival and Registration
9:15-9:45	Breakfast Reception
10:00-11:00	Welcome, Introductions and Project Overview
11:00-12:30	TAG Discussion
12:30-1:30	Lunch: Hosted in the Rotunda Room
1:30-2:30	TAG Discussion
2:45-3:00	Break
3:00-3:30	TAG Discussion
3:30-4:00	TAG Closing Remarks
4:00	Departure

## Technical Advisory Group Members

### **BRUCE D. AGINS MD, MPH**

**Medical Director, New York State Department of Health AIDS Institute**  
**Principal Investigator, HEALTHQUAL International; HIVQUAL-US;**  
**National Quality Center, New York, New York, US**



#### **Professional Experience:**

Dr. Agins is a board-certified infectious diseases specialist who oversaw the development of Designated AIDS Center Programs at Nassau County Medical Center and North Shore University Hospital at the height of the HIV epidemic in the late 1980s. He joined the Office of the Medical Director at the AIDS Institute with the assignment of designing a quality management program for the statewide HIV care delivery system based on the principles of quality improvement. This program was implemented in 1992 and became the basis for the US quality improvement program, HIVQUAL, which was launched in 1995, and HIVQUAL-International which was first implemented in Thailand in 2003 through support from HRSA and the CDC Global AIDS Program before becoming funded by PEPFAR through HRSA as the International Quality Center. Currently this program is operational in Uganda, Mozambique, Namibia, Nigeria, Haiti, Rwanda, Guyana and Kenya.

Dr. Agins has participated as faculty in several national HIV quality improvement collaboratives, and chaired the faculty of the national HIV QI Collaborative for state HIV agencies. He is a graduate of Haverford College (1975) and Case Western Reserve School of Medicine, (1980) and received his MPH from the Mailman School of Public Health at Columbia University in 1994. He oversees guidelines development, the HIV Quality of Care Program and educational programs at the AIDS Institute.

Dr. Agins is honored to be participating in the work of HCI and has collaborated closely with URC since standing at his poster at the International AIDS Conference next to Neeraj Kak, where they quickly discovered that they were presenting similar approaches to quality management. This meeting led to what has been an enjoyable and fruitful working relationship, including consultation in Rwanda, Russia and South Africa. In Uganda, and in areas of policy work, the collaboration between HIVQUAL and HCI has been cited positively as a unique relationship between colleagues working in the same area and an all-too-rare demonstration of coordination within the world of PEPFAR.

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### **KATIE COLEMAN, MSPH**

**Research Associate, MacColl Institute for Healthcare Innovation,**  
**Seattle, Washington, US**

#### **Professional Experience:**

Ms. Coleman is a Research Associate at the MacColl Institute for Healthcare Innovation in Group Health's Center for Health Studies, where she works with Dr. Ed Wagner to implement and evaluate the Chronic Care Model in physician and nurse-led practices throughout the US. She also works with the MacColl



team to consult with states and international partners on policies to support improved chronic illness care.

Prior to joining the MacColl Institute, Ms. Coleman managed the strategic planning and development portfolio for Access Community Health Network, the nation's largest network of community health centers.

Ms. Coleman holds a Master of Science in Public Health with a concentration in health care financing from the University of North Carolina at Chapel Hill.

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## **GÖRAN HENRIKS, MA**

**Chief Executive of Learning and Innovation  
Jönköping County Council, Jönköping**

### **Professional Experience:**

Göran Henriks is Chief Executive of Learning and Innovation at the Qulturum in the County Council of Jönköping, Sweden. The Qulturum is a center for quality, leadership and management development for the employees in the County and also for the Swedish health care system at the regional and national levels. Mr. Henriks took up his appointment at the founding of Qulturum in 1998. He has over twenty years of management experience in the Swedish health care system.

Göran Henrik is also a member of the Jönköping County Council Strategic Group. He has been Jönköping's Project Director for the *Pursuing Perfection* Initiative over the last four years and is a senior fellow of the Institute for Healthcare Improvement, Cambridge, Massachusetts.

In addition, he is part of the Strategic Committee of the International Quality Forum organized by the British Medical Journal and the Institute for Healthcare Improvement.



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## **GREGG S. MEYER, MD, MS**

**Senior Vice President, Center for Quality and Safety  
Massachusetts General Hospital, Boston, Massachusetts**

### **Professional Experience:**

Gregg S. Meyer, MD, MS, was named the first Senior Vice President for the Edward P. Lawrence Center for Quality and Safety at the Massachusetts General Hospital (MGH) and Massachusetts General Physicians Organization (MGPO) in December 2006. A national leader in the area of quality and safety, Dr. Meyer leads the multi-faceted efforts of the MGH/MGPO in quality and safety.

Prior to that Dr. Meyer served as the Medical Director of the MGPO, the largest physician group practice in New England. There Dr. Meyer, a practicing internist, provided leadership to the MGPO's medical management efforts.

Dr. Meyer was previously the Director of the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality (AHRQ). There he was responsible for conducting and supporting research on the measurement, improvement, and reporting of health care quality including clinical performance measurement, patient safety issues, and consumer surveys. He took the lead position in articulating the Department of Health and Human Service's quality and safety agenda, and coordinating activity with other federal and non-governmental entities. He has served on numerous key committees related to quality and safety including the Joint Commission's Board of Commissioners, National Committee for Quality Assurance's Committee on Performance Measurement, the World Health Organization's Scientific Peer Review Group on Health Systems Performance Assessment, Institute of Medicine panels, the Advisory Committee to the Massachusetts Health Care Cost and Quality Council, and the Medical Policy Board of the National Aeronautics and Space Administration.

Before his tenure at AHRQ, Dr. Meyer was an Associate Professor at the Uniformed Services University of the Health Sciences, where he served as Division Director for General Medicine, coordinated the design and analysis of the Department of Defense's National Quality Management Project, and developed curricula for senior military medical leaders in quality improvement. He also served as an active duty Medical Corps officer and Colonel in the United States Air Force.

Dr. Meyer is a Phi Beta Kappa and *summa cum laude* graduate of Union College and *magna cum laude* graduate of Albany Medical College. He earned a Masters degree at Oxford University where he was a Rhodes Scholar. In addition, he holds a masters degree from the Department of Health Policy and Management from the Harvard School of Public Health. Dr. Meyer served as a fellow in the US Senate Labor and Human Resources Committee's health office and on President Clinton's Healthcare Reform Taskforce. He has authored over 100 articles, editorials, chapters and monographs and is board certified in Internal Medicine.

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## **LLOYD P. PROVOST, MS**

**Improvement Advisor, Associates in Process Improvement  
Austin, Texas, US  
Senior Fellow, Institute for Healthcare Improvement**

### **Professional Experience:**

Lloyd Provost is a statistician, consultant, teacher, and author who helps organizations make improvements and foster continuous learning and improvement. His experience includes consulting in planning, management



systems, planned experimentation, measurement, and other methods for improvement of quality and productivity. Mr. Provost is a co-founder of Associates in Process Improvement (API). Since 1984, API has assisted organizations in all aspects of improvement.

Ten years ago, API developed a partnership with the Institute of Healthcare (IHI), and since then, Mr. Provost has spent half his time supporting IHI programs as a Senior Fellow. He was responsible for the improvement framework and the measurement strategies in the IHI collaborative improvement initiatives called the "Breakthrough Series." He currently works with IHI on their "Improvement Advisor Development Program", the leadership component of the IMPACT program, and with the IHI Developing Countries program, currently active in South Africa, Malawi, and Ghana.

Mr. Provost has BS in Statistics from the University of Tennessee and an MS in Statistics from the University of Florida. He is the author of several papers relating to quality and measurement and co-author of books on planned experimentation (*Quality Improvement Through Planned Experimentation*, 2<sup>nd</sup> edition McGraw-Hill, 1998) and the science of improvement (*The Improvement Guide: A Practical Approach to Enhancing Organizational Performance*, Jossey-Bass Publishers, 1996). Previous work experience was with the US Department of Agriculture and Radian Corporation.

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## **DAVID M. STEVENS, MD**

**Director of the Quality Center and Associate Medical Director of the National Association of Community Health Centers, Bethesda, Maryland, US**

**Research Professor: Department of Health Policy, George Washington University School of Public Health and Health Services**

### **Professional Experiences:**

Before assuming his current positions, Dr. Stevens was senior medical officer for quality improvement in the Agency for Healthcare Research and Quality (AHRQ) and its Center for Quality Improvement and Patient Safety. While at AHRQ he provided major leadership in AHRQ's mission to translate research into action. Major initiatives include a AHRQ/Robert Wood Foundation sponsored learning collaborative to reduce health disparities with nine major national health plans; a care management improvement project with seventeen state Medicaid agencies; a partnership with the CDC to develop interventions for the prevention of type II Diabetes Mellitus; an improvement collaborative with End Stage Renal Disease providers; and contributor to the National Health Quality Reports.

Before coming to AHRQ, Dr. Stevens as chief medical officer was responsible for national clinical leadership of the Health Resources and Services Administration (HRSA) Community and Migrant Health Center Program and for leadership of the HRSA/Bureau of Primary Health Care initiative on eliminating health disparities in underserved and minority populations. This landmark program, the Health Disparities Collaboratives, transformed preventive and chronic care and generated major positive clinical outcomes as documented in peer reviewed scientific literature.

With the CDC and the Institute of Healthcare Improvement, he initiated a landmark pilot demonstration on translating research for the prevention of diabetes into practice as well as a pilot on cancer prevention with the National Cancer Institute.



Dr. Stevens also established national quality improvement policies for clinical programs in health centers, including the opportunity for JCAHO accreditation. With the CDC, he also implemented a major immunization quality improvement initiative, increasing immunization rates by 50% in 9 states in over 100 health centers, affecting 150,000 underserved infants and children each year.

He was a practicing family physician and medical director for over seven years at community health centers in the South Bronx and in Brooklyn, New York. Dr. Stevens continues to provide clinical care at a federally qualified health center, Greater Baden Health Services, which serves Prince Georges County and Southern Maryland.

Dr. Stevens was a member of a Department of Health and Human Services (DHHS) work group which completed the DHHS Strategic Plan for Asthma and a member of the DHHS Work Group on reducing health disparities for diabetes.

A member of the commissioned corps of the US Public Health Service, he has received numerous awards, including the commissioned corps meritorious service medal, the DHHS Award for Distinguished Service and the Arthur S. Fleming Award, a private-sector award for outstanding federal employees who have made extraordinary contributions to government.

# HCI Technical Advisory Group Meeting Notes

## A. Opening Remarks

Welcome by Gloria Steele, Acting Administrator for Global Health, USAID.

Welcome by Barbara Turner, President, University Research Co., LLC.

Opening remarks on the evolution of the USAID program in quality improvement (QI) by James Heiby, MD, MPH, Medical Officer and HCI Contracting Officer's Technical Representative (COTR), USAID, describing the focus on health systems and understanding key health care processes introduced by the Primary Health Care



*Gloria Steele and Barbara Turner*

Operations Research (PRICOR) Project, the application of quality management and continuous quality improvement approaches supported under Quality Assurance I and II, and the adaptation of the IHI Breakthrough Collaborative approach under Quality Assurance/Workforce Development and its emphasis on more rapid improvements and spread. He noted the additional challenges for HCI of expanding documentation and the evidence base for QI approaches, making improvement knowledge more widely available, and applying improvement methods to new issues.

Overview of the USAID Health Care Improvement Project by M. Rashad Massoud, MD, MPH, FACP, Director, HCI Project, summarizing the goal and objectives of the HCI Contract, its worldwide program of technical assistance, and some of the critical health care issues HCI is addressing, illustrated with results from Niger, Nicaragua, and Tanzania.

## B. Initial Reflections from the Panelists

Gregg Meyer:

- Have only heard what has gone well, am interested to also know what didn't work well and what did you learn from that? What are the factors for your success? Although multiple factors contribute, are there certain factors that stand out as reasons for the successes you've seen?
- Presentations suggest that QI methods used in the US work even better in developing countries.
- Recommends greater use of positive deviance analysis—when things go really well, look in depth at the positive outliers to better understand why things went incredibly well.

David Stevens:

- Who decides what to work on? Is there a menu? Is it the country that identifies the problem/issue or does HCI presents a list of the work you do to the country? If there are different answers, have you looked at correlations between who decides and your results?
- "Steal shamelessly; share senselessly."
- How do you bring up to speed teams that are lagging? With Community Health Centers in the US, we have found there were often core capability issues behind team performance. QI is most

successful when teams use it as a tool and not an end in itself. QI is not a strategy—it is a means to an end. Need to focus on how to achieve the end.

James Heiby (moderator):

- USAID usually follows congressional directives as to what areas should have priority. Additionally, the Strategic Element Groups at USAID have specific requests. In general, the major sources of morbidity and mortality are focused. The work is always within the confines of our contract and also focus on the priorities of the country; the USAID's focus within the country; the area of the work is also very unique to the QI teams and thus locally based to address local issues.

Bruce Agins:

- Sustainability of the work – how do you organize your work going forward to increase the likelihood that QI efforts are sustained?
- Are there common themes across countries that we can pull out and use as general lessons learned to inform improvement work more globally?
- How can we talk about the work to engage others?
- A lot more is happening than is in the data. How do we capture cultural changes which are needed to effect positive outcomes?



Lloyd Provost:

- There are always a few groups in a collaborative that don't really produce. Your results show aggregated data – don't show the variability across sites. Is there great variability? When high compliance is achieved, how do you sustain it? Does it suggest sustainability if results are consistent across sites?
- Have you considered doing some studies to show the impact of QI on measures of morbidity/mortality?

Göran Henriks:

- How do you lose the project mentality and think in terms of system level changes? It is important to understand the contextual situation in which improvement activities are carried out.

Troy Jacobs (audience):

- Is there a way to translate developed countries work to developing countries in QI?
- There is a tendency to focus on problem areas where we think we can be more successful and not on the more problematic areas (e.g., community level services). How can we reach the 'hardest-to-reach' areas?

Maina Boucar (addressing Lloyd's Question):

- The collaborative itself helps all teams, teams feel that they don't want to leave anyone behind and are motivated by seeing other teams' successes.

David Stevens:

- It's the group's ethic/value to not leave anyone behind – "Mission is more important than competition."

Gregg Meyer:

- QI collaborative can also address other environmental factors that cause underperformance (i.e., leadership; fiscal issues)

Katie Coleman:

- Who are on these QI "teams"?

HCI: Usually a team consists of 5-7 members at the facility level.

### C. Session #1: Applying Quality Improvement to Strengthen Health Systems

Presentations:

Neeraj Kak, PhD: Applying QI to Strengthen Health Systems

Donna Jacobs-Jokhan, MD: South Africa District-based Model

Victor Boguslavsky, MD: HIV/AIDS Treatment, Care and Support Collaborative in Russia

Nigel Livesley, MD, MPH: Applying the Chronic Care Model Design to Care for PLWHA

Neeraj Kak explained HCI's approach to health systems strengthening, consistent with the WHO Systems Strengthening Framework: Focus on districts, service integration, building capacity of district managers and frontline health workers through mentoring and on-the-job support, strengthening information systems, accountability, and adoption of a chronic care model. Donna Jacobs described how this approach has been implemented in South Africa to



*Maina Boucar*



*Neeraj Kak and Donna Jacobs-Jokhan*

strengthen the district level delivery of hospital and primary care services in 26% of districts in the country. Victor Boguslavsky described achievements in Russia to institutionalize improvements in HIV/AIDS treatment, care and support and TB-HIV integration through orders and decisions issued by health authorities in the two regions supported by HCI. Nigel Livesley described the fundamental shift in system focus from acute to chronic care and how HCI is introducing a chronic care model for HIV treatment in Uganda.

**Question 1: What are your reactions and ideas on how to continue to build capacity in applying QI to strengthen health systems at different levels?**

Reflections from the panel:

Katie Coleman:

- Chronic care model lessons – have not yet had success in being able to take lessons from a single disease specific approach and apply them to other disease areas.
- Essential to embed QI at the facility level and sustain this work, not just at a higher level.
- Define who is tasked with measuring and reporting on quality on an ongoing basis.
- Sustainability – Who should be targeted and how?

David Stevens:

- Aim: Change from not just focusing on the diseases to building up the health system: use a more deliberate approach to build up the health system through support for the different diseases.
- A good primary health care system is the way to go: we need to address what that system would look like (define your strategies), how we can get there and what long term infrastructure may be needed.
- What is it to support the teams over time?
- Important to demonstrate the business case for QI – is it cost-effective? What are the savings over time?
- Important to have a communication strategy to share what works and to convince stakeholders in new places what could work for them.
- Need to work with leadership to engage them in the process and sustain their involvement in improvement.

Gregg Meyer:

- How to align measures across all levels and have all levels hold each other accountable?
- How to make doing the right thing the easy thing to do (i.e., the default) and how to make it meaningful to all levels?
- Moving to a strategic method as you work through the different levels.

Göran Henriks:

- Recognizes the common struggles faced within the developed countries and our work in developing countries.



- How to design the next generation of care? For chronic care, chronic diseases are treated at home, but we lack the infrastructure/design to be able to treat them. Ikea is a great example of the approach health systems need to adopt. Ikea offers a great variety of household furnishings to meet a wide range of needs and tastes. Customers go to Ikea, see the items they need, and take home nicely pre-packaged bundles that they assemble at home. Health care for chronic diseases needs to offer patients pre-packaged bundles of interventions they can choose from to meet their needs and then implement at home.

Bruce Agins:

- Information systems side – aligning the improvement work with the information systems.
- Infrastructure – engagement of all staff is critical and of civil society; while this is the hardest to achieve, it provides the biggest results/return.

Lloyd Provost:

- What are our tools? What do we (QI) bring to address health system weaknesses?

Victor Boguslavsky:

- In Russia, we started with a system analysis to point out the main system problems for HIV/AIDS patients: access to care, patient participation in care, and integrating and coordinating different care services.

David Stevens:

- Need to define our target.

Göran Henriks:

- Should be “patients-focused” not “patient focused”, understand their perspective and have them be part of the process.

## **D. Session #2: Health Workforce Development**

Presentations:

Lauren Crigler, BA: Health Workforce Development

Maina Boucar, MD, MPH: Human Resources Collaborative, Niger

Lauren Crigler described HCI’s approach to applying QI to health workforce issues, such as overburdened, demoralized health workers and high turnover of qualified staff, through a focus on increasing health worker engagement. She described the framework guiding the human resources collaborative being implemented by HCI in Niger and the drivers of health worker engagement: belief in job and organization; belief in ability to succeed; good relations with supervisor and team; opportunities for professional advancement; recognition and reward; and influence in decision-making about work. Maina Boucar presented the results of the baseline assessment of employee engagement in the Tahoua Region of Niger and described the start-up of the Human Resources (HR) Collaborative with district and provincial managers and site teams.

***Question #2: What thoughts can you share about our approach to engaging or supporting the human element of health care?***

Reflections from the panel:

Bruce Agins:

- Very thoughtful application of the collaborative approach to a critical area—“this is really ground-breaking.”

- Like the mix of strategies, multi-pronged approach.
- High turnover of staff is inevitable, so our approach should not be too hung up on retention. When remuneration is very low, often staff leave for professional advancement—not necessarily something to discourage. It is important to identify professional development incentives for staff.
- One barrier that might be a challenge to address is the hierarchical structure of the health system in many countries.

Lauren Crigler: In response to the hierarchy barrier: In Niger it is less of a problem. All levels of hierarchy are involved in the process. We made sure to involve everyone from the beginning. We've actually seen that because they recognize their lack of capacity in HR within their organizations, they have really received the collaborative positively. The greater obstacle is the ability to manage care.

Lloyd Provost:

- What are the outcome measures that we can show results in within the near future? Need to be thinking of this from the beginning and measuring from the beginning.
- Good resource: Dartmouth Microsystems.
- Who are the coaches? Need to support, mentor and coach them.
- Be careful to not export poor HR practices from the developed world to the developing world.

Katie Coleman:

- Good opportunity to work together and develop the team ethic, don't need to necessarily recreate infrastructure, but use this opportunity to develop a new team approach.
- QI at its core is about engaged employees.
- The extent to which we can use teams to address issues of productivity and task-shifting to be more effective is better.
- We're going to need to have good teams to work together to change over to chronic care; roles and tasks of different health workers change as they move from acute to chronic care.

Göran Henriks:

- Hesitant about talking about productivity and health – it's not the people that are wrong but the circumstances that we created for them to work in.
- Also concerned that increasing productivity of health workers could lead to overuse of medical care.

Gregg Meyer:

- Cultural/human piece is the hardest part, not the technical piece. How do you get everyone to feel that improvement is part of their work? Everyone essentially has 2 jobs – their work and then how to improve their work.
- Culture is the key to sustainability – what we leave behind; while leaders are important, the culture is ultimately what is left behind. Need to be able to transcend simply depending on charismatic leaders.
- Need to measure safety awareness in the country before beginning the work- how comfortable people are speaking up etc.
- The team and workforce include patients, how can we engage them?
- Three things we need to answer:
  1. Am I treated with dignity and respect everyday?
  2. Am I given the resources to do my job?
  3. Does anyone notice if I do my job well?

David Stevens:

- Jessica Graber and her colleagues at the University of Chicago studied staff morale in the Health Disparities Collaboratives—a large quality improvement initiative in community health centers. She found a high correlation between positive staff morale and positive quality of care outcomes. Anecdotally, I also observed that reduced patient waiting times and increased contact time with health providers, improved provider satisfaction.
- The ability to receive feedback is an important skill to learn; need to prepare staff for giving and receiving feedback.
- Measuring patient experience is an important outcome measure for staff satisfaction.
- Should assume turnover of staff (signifies professional advancement) and plan for it.
- Social determinants for health and education of community – How can we make health a career in the community to make the community grow? Need to develop career paths in health for community members.

Lauren Crigler:

- Can apply these ideas to functional CHW.
- How to count and analyze role of CHW and their productivity?
- CHW requires the same thing as traditional health workers (incentives, supervision, etc.).
- Will hope to apply lessons learned from the HR collaborative to the CHW initiative.

Göran Henriks:

- Questions from the road map they use in Sweden: What is the purpose of what we are doing? How do we measure that purpose? How do we meet the patient's process? How do we link different things to each other?
- Patient microsystems are the real micro system – we have to build in degree of flexibility to teams—patients able to be a part of many teams, the most important thing is that the teams have the same language.

## E. Session #3: Spread and Institutionalization

Presentations:

Lynne Franco, ScD: Institutionalization and Spread

Jorge Hermida, MD: Implementation Experiences in the Latin American Region

Lynne Franco posed two key research questions for HCI: How do we make improvements stick? How do we get them to scale? She noted that HCI's definition of institutionalization refers to establishing and maintaining QI as an integral, sustainable part of a health system or organization—making quality service delivery and QI the “default” response of the health system. Jorge Hermida described how following a demonstration collaborative, there is need to synthesize and consolidate what has been learned about how to improve a particular aspect of health care and gather the tools developed that can make future improvement more efficient. To facilitate institutionalization, the idea is to transform existing processes into better ones and create accountability at different levels of the health system.

**Question #3: What does institutionalized improvement look like at different levels of the health system? What are your thoughts about where we can best focus our efforts to strengthen institutionalization and spread improvements?**

Reflections from the panel:

David Stevens:

- View quality improvement as a political act; needs to be a very intentional strategy from the very beginning, starting with raising awareness.

- Each step of the quality improvement initiative should have spread and institutionalization built into it:

- Determine who is interested in this work? How can we get people to care?
- Determine the funding source for this work
- Determine who this work will affect
- Keep in mind to communicate differently with health personnel versus communication with legislators
- Determine 'Who are the stakeholders?'
  - Also, who would be in favor, and who would disrupt / oppose this work – keep this in mind when developing strategies
  - Also determine, who's support is needed from the beginning
  - And who do you want to keep at bay early on until you have some results to help gain consensus before moving forward?
- When developing a strategy, keep in mind various stakeholders
  - Donors, government health priorities, local government leaders, community interest, profession interests (doctors / nurses), business community (those doing the employing)
  - Think about what are their values, and how can we appeal to them?



*Lynne Franco and David Stevens*

#### Gregg Meyer:

- Shifting from opportunistic to strategic planning.
- What is the HCI strategy? (Question posed by panel) What are the strategies for the various levers? How can we hardwire the system to do QI?
- Which systems or processes can we leapfrog when institutionalizing? For example, skipping the step of landlines to cell phones.
- HCI already has the ingredients for institutionalization, but we need a strategy and different tactics (depending on the audience).
- Make this strategy appealing to policy makers and political leaders – making the business case for QI – getting in the door and building an evidence base is a good approach.

#### Göran Henriks:

- Leadership is based on trust and reliability. Spread starts with – how do I change myself as a leader?
- Capacity building is the foundation for spread: need to ensure that there are shared values, principles, and methods; these lead to shared results.
- When these exist in a system, spread is easier.
- Instead of starting with redesigning the process, then working on the structure, then finally developing a strategy – (this is the wrong way to solve a quality problem)
  - First define what are the strategic challenges? (dilemmas to solve)
  - Then look at what structure is needed to address these challenges

- What sort of processes (or how to modify current processes) to adopt this structure to avert these dilemmas
- This means that we also need the customer’s perspective in order to make improvements.

Lloyd Provost:

- It is always best to tap into existing systems, structures, and processes. How do we integrate QI into the systems that already exist? This is the most important aspect (work with existing committees, structures, etc).
- We also need to work with someone who has a deep understanding of how the health system works, MOH, etc.
- To institutionalize QI, need to building into a strategic planning process, sit down with the MOH, and decide what they want to address in the next coming years (health priorities). THEN, see how to use QI to address these issues and identify those measures associated with achieving these priorities. The best way to make QI permanent or institutionalize QI is to build in quality measures that are related to strategic priorities. A balanced cascade of measures, dashboard, balanced scorecard. What measures (indicators) can/does the MOH use that will tell us how we are doing?

Bruce Agins:

- Leadership is key, but we are talking about a public health government strategy.
- Create standards and expectations for each level of the health system and define what capacity building is needed to support these roles.
- What does institutionalization look like? Ultimately, success would be that we don’t need to be there anymore (complete structures are in place so QI activities continue without our presence).

James Heiby and M. Rashad Massoud response to the question posed, “What is HCI’s strategy?”

- We want to have positive influence on the health systems.
- By being asked to work on HIV/AIDS (for example) – we will try to see what influence we can have overall on all levels of the health system.



*James Heiby and M. Rashad Massoud*

- We cannot define an independent strategy; we have to work with the objectives and strategies of USAID, in country USAID Mission, donors, MOH, etc.
- We pursue evidence-based QI (show results that quality has improved).
- All stakeholders are responsive to evidence (results that prove our approach has worked).
- Ecuador – an example of successful institutionalization. Proof is that QI is in place at all levels and even at sites that Jorge’s team never worked with.
- Ultimately, we would want to create evidence for QI methods (an archive) of success stories.

Example of an HCI ‘strategy’: QI work in OVC and HIV (Marie-Eve Hammink)

- We received a mandate to develop standards with regards OVC programs.
- We have been working on tracking evidence of how having these standards has led to improvements in quality (that the standards make a difference for children).
- To address quality of OVC programs, we need to work in collaboration with all stakeholders (the MOH, donors, implementing partners, etc.).
- This is an improvement collaborative working at the point of service delivery (partially clinical services, partially social services).
  - Track organizational changes and impact on outcome (outcomes of interest – such as days of schools missed by child).
  - Tracking evidence on the work the NGO and PVOs are working on, and seeing if we are making an improvement to the outcome of interest.
  - Are we improving children’s wellbeing?
  - Share these results with 16 other countries also participating in collaboratives.

Gregg Meyer:

- Importance of building evidence base for improvement methods.

David Stevens:

- Interdisciplinary study of ‘QI’ – difficult to study – there is no research framework – what you are doing is creating a discipline for looking at this.
- Institutionalization studies should not be studies of QI but rather studies of institutionalizing changes in care. What we want to study is not actually QI methodology, but of health systems change: How does this happen, what factors need to be in place?
- For example: Model from Canada (Canadian Health Services Research Foundation)
  - The Foundation brings researchers and decision makers together to improve the health of the people of Canada. This means bridging the culture and aims of both groups to collaborate and to influence each other’s work. This leads to identifying the best evidence how to improve the healthcare system, identifying and addressing gaps in knowledge through funding research and evaluation and supporting policymakers and managers to develop their culture and skills to use evidence to improve health care services.
  - This forum is a good model for other countries, and a potential future model for countries under HCI.

Göran Henriks:

- What do different levels of health systems look like if QI was institutionalized? Identifying the key question is very important (what quality issue do we need to answer); this ‘question’ is the jumping off point for the quality improvement work.

Katie Coleman:

- The synthesis and consolidation of learning at the end of a collaborative is something we have struggled with over the past 15 years. Synthesis is important from the original collaborative to create this ‘change package’ (capture the tools and the strategies).

- However, when moving to spread, keep in mind that instead of just focusing on spreading tools, that a key component to improvement is about the relationship building, communication and coaching (How can we keep this aspect during spread?) – it’s not just about methods and tools.
- She gave the example of 600-page ‘change package’ for chronic care that in and of itself is not sufficient to create improvements.
- How to institutionalize the ‘Learning Session’ idea in addition to sharing the tools that come out of the initial collaborative?
- Tools should be made permanent; integrate them into the health system.



Katie Coleman

## F. Session #4: New Directions in Quality Improvement

Presentations:

Oscar Nuñez, MD: Cultural Adaptation of EONC in Nicaragua

Ibrahim Maroof, MD, MPH and Kathleen Hill, MD: Reducing Maternal and Neonatal Mortality in Afghanistan

Oscar Nuñez recounted HCI’s experience in Nicaragua working with health workers and patients to identify changes to introduce in maternal care that respect and recognize women’s cultural differences with respect to delivery and the results these efforts have had on increasing hospital deliveries (reducing home births). Ibrahim Maroof and Kathleen Hill described HCI’s new work in Afghanistan to build Ministry of Health capacity in health care improvement by applying lessons from EONC work in Niger to phase in high-impact maternal newborn interventions at a district level in two provinces and two districts in Kabul.

**Question #4: We would like your thoughts and ideas on methods, approaches and frameworks that we should consider and adapt in order to tackle the priorities in improving health care in the contexts we are working in?**

Reflections from the panel:

Gregg Meyer:

- It’s not difficult to provide a menu of services able to be provided; the key piece is the assessment into what fits the most. The upfront analysis is key, not only from a technical standpoint but also to address cultural competency.

- “Mass customization” allows you to efficiently develop a small set of service packages that are easily customizable to meet user needs.
- Look at other methodologies like, “lean process improvement” which is trying to systematically take waste out of processes.



*Kathleen Hill, Ibrahim Maroof, and Oscar Nuñez*

David Stevens:

- I would ask community members how they might design the system and maybe that could be helpful.
- What’s the role of risk assessment? Can you identify who’s at risk? Therefore to be able to anticipate – to help women at risk understand they may be at risk.
- In flow example, I would add “inter-conceptual care” – what might you be doing in that period, i.e., raising awareness.

Bruce Agins:

- QI methods not new, just the context in which they are being applied.
- It is important to map out the process of care and introduce measures that show how well the system or care process is working as a whole. I challenge you to develop a simple way to present the whole continuum of care with the data showing how well care is working, as a whole.

Lloyd Provost:

- In Malawi getting women to deliver wasn’t too difficult but sometimes the environment wouldn’t allow for it (we know what to do just can’t do it).
- Baby-friendly care – if you don’t have basic components of system working yet then who cares “how” they deliver, need to have a fully functioning basic health system before presenting attractive care.
- Traditional birth attendants can teach quality improvement.
- Visits across facilities were valuable in Malawi – taking midwives and have them spend a day in another health center, hospital.

Katie Coleman:

- Chronic care model has 6 elements demonstrated to be effective: delivery system design, decision support, linkage to community, etc., however, I didn’t hear you talk as much about:
  - Clinical information systems – need to have a way to identify the patient population with needs
  - Self-management support – working with patients themselves to identify their needs.

David Stevens:

- Building in how you’re going to learn, so when adverse events occur you’ll have a way to review that. Build a system to learn from failures.

- In some communities, identify the women who are highly respected can be a good resource for knowledge sharing, while using a mechanism already functioning in the community.

Göran Henriks:

- Schools are more important than health care, so they often work with schools, i.e., nursing schools, for example, have doctors visiting the schools.
- Through that dialogue they develop local knowledge for identifying the risk group.

## G. Session #5: Partnerships for Global Learning

Presentations:

Lani Marquez, MHS: HCI Strategies for Global Learning and Partnerships for QI

Dorcias Amolo, MA: Quality Improvement Initiative for OVC Programs

Lani Marquez described HCI's global learning strategy of developing an open-access, database-driven web site linked with the project's QI documentation and evaluation processes. The knowledge management website will provide a systematic way for storing the knowledge generated in the field and making it available to users worldwide through an easy-to-use search function. Dorcias Amolo described HCI's efforts to develop a regional community of practice for improvement of services for orphans and vulnerable children (OVC) through training events, monthly conference calls, web site, and virtual and on-site technical assistance.

**Question #5: What additional strategies and mechanisms can you suggest that will build on these efforts and allow us to strengthen global and regional communities of practice for improvement?**

Reflections from the panel:

Lloyd Provost:

- Where is the data from the example [www.maternoinfantil.org web page] going into the data system?
- Who are the primary customers/target audience for the website? Who are the secondary customers?

Lani Marquez: Care-specific sections of the database—and this is a manual task, not an automated one. Primary audience: Counterparts and partners in the countries we work (albeit ones with access to the Internet) in and other implementing agencies funded by USAID, other partnering agencies with other funders, and also national (local) agencies. Secondary customers are others working in health care improvement in any country.



Lloyd Provost

Göran Henriks:

- Website can be a way to reach patients to find out more about the patient experience. Connect QI methods to the patients and build their capacity as well as the providers' capacity in issues related to patient safety.

Gregg Meyer:

- The target audience of the website is fine but how do you pull people in? There needs to be a blend of pull and push strategies to encourage to use the website. It's important to know your audience and think through how to partner with major organizations to link them to your website.
- Another strategy you should explore is linking with universities, both in the US and other countries. This is a terrific tool to reach college students who are just getting into the field. We're not all going to be around forever and we need people to replace us.

Bruce Agins:

- It will be important for this website to be seen as larger than HCI—make it a global resource. The challenge is to make sure that major stakeholders (CDC, United Nations agencies) are aware of it and can also contribute to it. This is something that the UN family can use as well. This is larger than HCI; that's why it's important. One good website is enough. Hopefully USAID can direct other partners to use this as the central website in QI.

David Stevens:

- Is it possible for countries/country programs to build their own websites for knowledge management and can these be linked to the main site?
- It would also be nice to have a social networking feature, to help people identify QI practitioners or groups in their area.

Victor Boguslavsky: In Russia, we are making the information available to people outside the collaborative. There will be open and closed parts (for the general public and collaborative members respectively).

Katie Coleman:

- Can this website foster regional QI initiatives—sharing data and results?
- Consumer engagement – How do you package QI concepts into materials for consumers, so that patients are more involved in their own health? What additional strategies do you have for regional quality improvement?

Göran Henriks:

- I was in Singapore at the Alexandra hospital, a colonial era hospital. Employees had started to build a garden around the facility. They had different aims, but one aim was to put in a variety of trees and bushes so that they would have at least 100 different types of butterflies in the garden. When they succeeded, they added a new aim of attracting at least 100 types of birds. This was all being done for patients. The point is, they were thinking of the delivery system as a whole, organic system, not just a collection of isolated processes.
- We need to think beyond our current thinking.

## H. Concluding Remarks from Panelists

Lloyd Provost:

- Data quality – At IHI, we have had to invest a lot of resources in strengthening data systems. Data are often inaccurate, incomplete, and so on. IHI has had to divert resources to data collection. Plan future projects to take this into account early. The reality is that in developing country settings, facility staff often collect data and send in their data but they never hear anything back. There's no feedback.
- Until resources are readily available it is not always effective to work on quality improvement. Unless we are willing to do something about resources, QI alone will not be enough to be able to do it all.

Gregg Meyer:

- “The American people would be pretty happy if they knew more about these programs done in their name. There's a lot to be proud of here.”
- Use patient safety as a lever and a wedge issue into QI. People understand safety as an issue. Tools can be simple and ideas are well understood.
- People vs. Programs – Where do you invest your money? What do you do with the next dollar? What is HCl's strategy to invest in future health leaders?
- Health vs. Health Care Delivery – Where would we get the most impact?

Katie Coleman:

- “I'm really optimistic. What HCl is doing is really on the forefront globally. Key to this is building learning communities—expand the evidence base but also increase people's skills to solve the next problem.”

David Stevens:

- If QI is answer, what is the question?
- What's another effective method? Community governance. How does community fit into QI? Leverage communities as a political force by tapping into their willingness to work on their own health needs. We often ignore this.

Göran Henriks:

- Stay in a learning mode. How can an infrastructure help with that mindset? We haven't talked about creativity and its role in QI. Another story: There was a facility where people were staying too long at the hospital. The solution? Decrease the number of beds! If there's a bed, someone will be lying in it. Get the care you need and nothing more. 3.5% of the people are using 60% of the health care system's capacity.
- Using your old eyes in a new way rather than creating a new landscape.

Bruce Agins:

- “The depth and breadth of the work is impressive. The spirit of enlarging this activity beyond URC is to be admired.”

## PowerPoint Presentations

James Heiby

M. Rashad Massoud

Neeraj Kak

Donna Jacobs

Victor Boguslavsky

Nigel Livesley

Lauren Crigler

Maina Boucar

Lynne Miller Franco

Oscar Nuñez

Kathleen Hill and Ibrahim Maroof

Lani Marquez and Dorcas Amolo


**USAID** HEALTH CARE IMPROVEMENT PROJECT  
 FROM THE AMERICAN PEOPLE

## Technical Advisory Group Conference

**May 18, 2009**  
**Washington, DC**


**USAID** HEALTH CARE IMPROVEMENT PROJECT  
 FROM THE AMERICAN PEOPLE

### Technical Advisory Group Members

- **Bruce Agins, MD, MPH**
  - New York State Department of Health AIDS Institute
- **Katie Coleman, MSPH**
  - MacColl Institute for Healthcare Innovation
- **Göran Henriks, MA**
  - Jönköping County Council, Sweden
- **Gregg S. Meyer, MD, MS**
  - Massachusetts General Hospital
- **Lloyd P. Provost, MS**
  - Institute for Healthcare Improvement
- **David M. Stevens, MD, FAFPM**
  - National Association of Community Healthcare Centers


**USAID**  
 FROM THE AMERICAN PEOPLE

## Evolution of the USAID Program in Quality Improvement

James Heiby  
 Medical Officer  
 Global Health Bureau  
 jheiby@usaid.gov


**USAID**  
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### Primary Health Care Operations Research, 1985-90

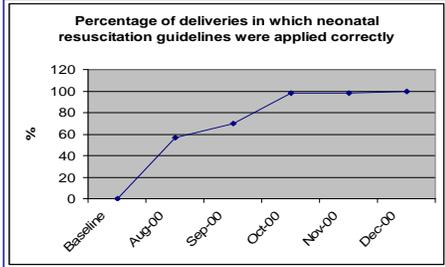
- Focus: Understanding health care processes
- A health systems view:
  - Inputs: training, drugs, basic service packages, policies, evaluations, expert advisors
  - Processes: evidence-based guidelines (new), supervision, standard operating procedures, clinical records
  - Outcomes: mortality, case fatality, child immunization coverage (surveys)
- Examples of clinical process measures:
  - Screen diarrhea patient for dysentery: 22% (Philippines)
  - Correct dose of malaria drug: 48% (Zaire)
  - Advice on immunization return visit: 35% (Senegal)


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### Quality Assurance I & II (1990-2002)

- Focus: Can the new quality management/continuous quality improvement approaches work in developing countries?
- Conclusions:
  - Many successful applications
  - Zambia evaluation revealed important weaknesses after external support ended:
    - Support by policymakers limited
    - Large scale program, but teams working in isolation
    - Low level of improvement activities
    - Technical problems with implementing CQI

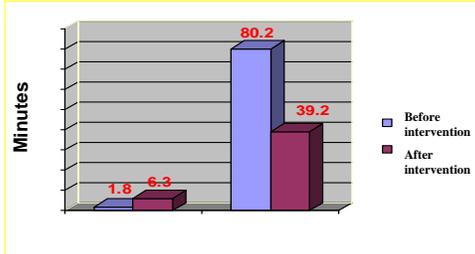
**QI Objective: All Standards for Neonatal Resuscitation will be Applied at Each Delivery**



**Percentage of deliveries in which neonatal resuscitation guidelines were applied correctly**

Month	Percentage (%)
Baseline	0
Aug-00	60
Sep-00	70
Oct-00	100
Nov-00	100
Dec-00	100

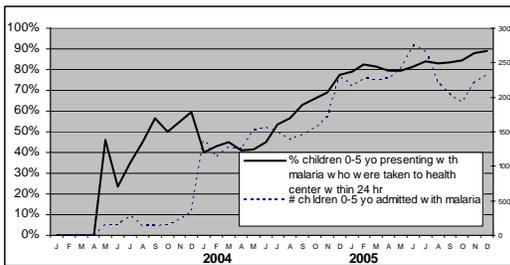
**Results Increased Contact Time and Decreased Waiting (Kenya)**



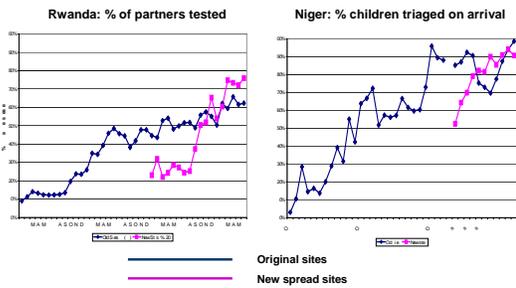
**Quality Assurance/Workforce Development (2002-2007)**

- Focus: Adapt IHI Breakthrough Collaborative approach to give CQI teams more support
  - Multiple CQI teams working on the same area
  - Policy maker sponsorship
  - Support from technical experts
  - Monitoring common quantitative indicators
- Outcomes:
  - More rapid quantitative improvements
  - More consistent performance across teams
  - Visibility from multiple facilities
  - Peer-to-peer spread of improved practices

**Rwanda Malaria Collaborative: Improvements in Care-seeking by Mothers (19 Health Centers)**



**Rapid Improvements in Spread Sites**



**Health Care Improvement (2007-2012): Challenges**

- Expand documentation of QI activities and results
- Develop QI evidence bases for advocacy with global health leaders and country level decision makers
- Increase the cost-effectiveness of QI
  - Make improvement knowledge available to those that can apply it
  - Research and evaluation focused on QI programs—including spread, KM
- Apply improvement methods to additional issues
  - Human resources management
  - District level management
  - Efficiency and productivity
  - Links with financing; pay-for-performance
  - Chronic care model, including AIDS
- Respond to USAID mission improvement needs
- Structure assistance to support institutionalization of improvement as an integral part of health care

**The USAID Health Care Improvement Project**

M. Rashad Massoud, MD, MPH, FACP

Director, USAID Health Care Improvement Project  
Senior Vice President, Quality and Performance Institute  
University Research Co. LLC

## HCI Project Goal and Overall Objective

### Goal:

Achieve and document measurable improvements in 1) the quality of health care in USAID-assisted countries and 2) the quality of human resources planning and management, including HR strategies traditionally linked to quality of care, such as supervision and training.

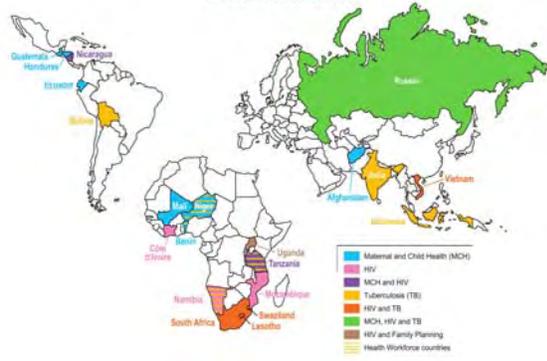
### Overall Objective of the IQC:

Develop the capacity of host country health systems to apply modern with a focus on adapting modern quality improvement (QI) approaches to the needs of USAID-assisted countries.

## Eight HCI Objectives

- 1 Document the interventions supported by this task order to improve the quality of health care, how quality was measured, and the impact of these interventions
- 2 Institutionalize modern quality improvement approaches as an integral part of health care in USAID-assisted countries
- 3 Expand the evidence base for the application of QI to human resources (HR) planning and management
- 4 Expand experience with the improvement collaborative approach in USAID-assisted countries
- 5 Expand experience with the spread collaborative approach in USAID-assisted countries
- 6 Expand the experience base for other specific QI approaches
- 7 Improve the cost-effectiveness of QI in USAID-assisted countries
- 8 Provide global technical leadership for QI in USAID-assisted countries

## USAID Health Care Improvement Project FY2009 Activities



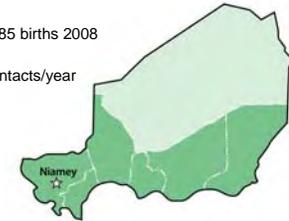
## Program Coverage: Niger

HCI is assisting MOH in 48 MOH sites in 7 of 8 regions

### Maternal Newborn Care

- AMTSL/Essential Newborn Care
- 33 MOH sites; 64% districts; 31,085 births 2008
- Pre-eclampsia/Eclampsia
- 31 MOH sites; 119,045 patient contacts/year

- Child Health
- IMCI and Malnutrition
- 15 MOH sites

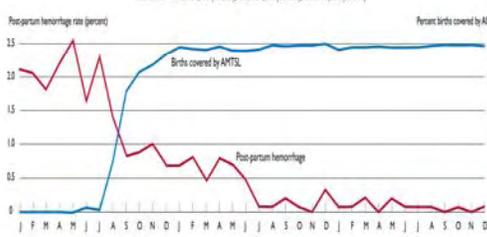


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## Program Impact: Niger Reduction in Post-partum Hemorrhage

### AMTSL coverage and post-partum hemorrhage rates in targeted facilities, January 2006 – December 2008

Total births — 2006: 24,785 (28 sites); 2007: 31,073 (33 sites); 2008: 31,085 (33 sites)

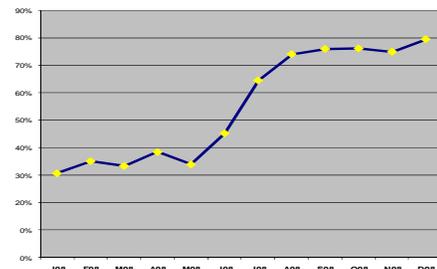


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## Program Impact: Niger Improving pre-eclampsia/eclampsia care

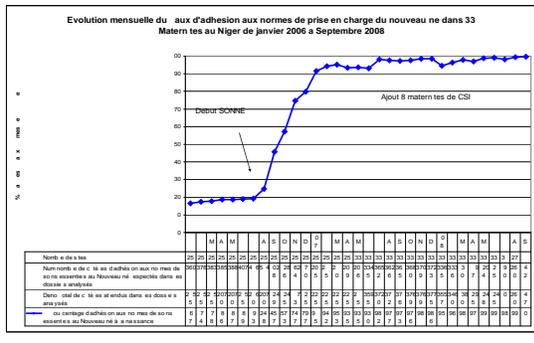
### Percentage of pre-eclampsia and eclampsia case management standards achieved

Jan-Dec 2008, average of 120 cases analyzed per month  
Based on detection in 120,000 patient contacts at 31 MOH facilities

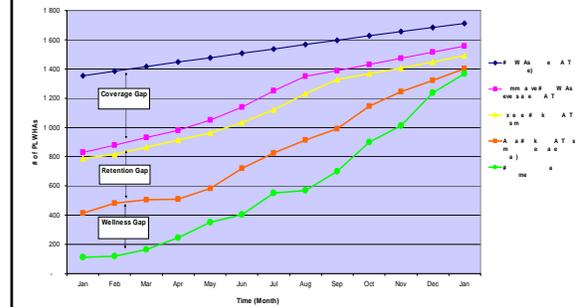


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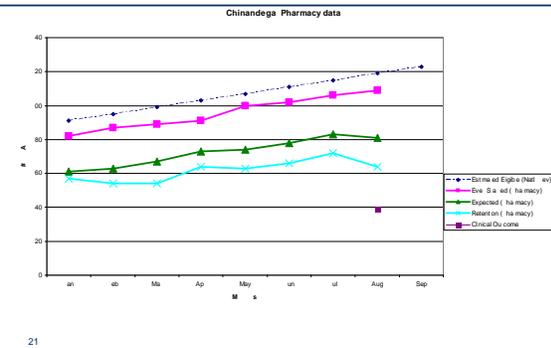
### Program Impact Niger: Improving Compliance with Essential Newborn Care Standards Jan 06- Sep 08, 33 MOH sites



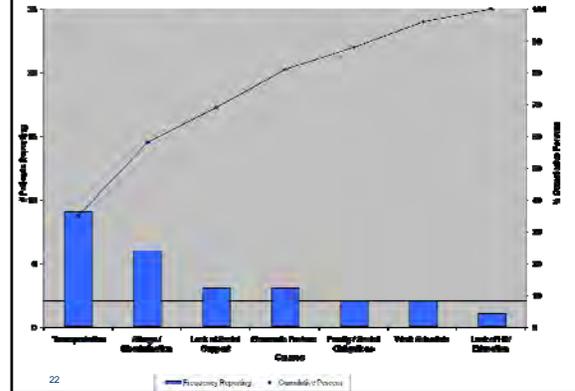
### Framework for Improving Care for Patients on ARTs



### Results: ART Framework data from Nicaragua



### Common Reported by ART Patients for Missing Clinic Visits (n=32) Sebaseba Health Center for Tanzania, April 2009



### Patient Interviews and PDSA's from Sebaseba Health center, Morogoro, Tanzania

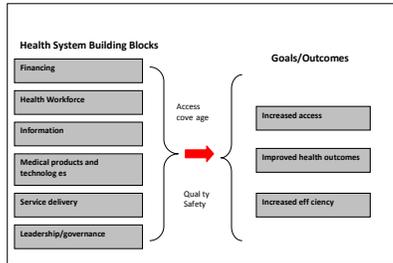
Reason for missing appointment	Change to prevent recurrence	How would we know if the test is successful?
Forgot	Share appointments schedule with someone who lives closely	Monitor if same or other patients continue to forget and if sharing appointments schedule helped
Needed to tend to a sick relative on day of appointment	Have a relative pick up treatment on patient's behalf	Monitor relatives picking up treatment for this reason
Conflict with work schedule	Present in advance of appointment	Monitor conflict with work as a reason for missing appointments
	Pick up a 2 month supply of treatment in advance	Monitor conflict with work as a reason for missing appointments
	Wife picks up treatment on behalf of patient	Monitor conflict with work as a reason for missing appointments
Having treatment beyond appointment date	Still needs to come for appointment on time leaving a few days of reserve treatment just in case. Need to check for missed doses	Monitor treatment beyond appointment date as a reason for missing appointments
ART finishes 5/7 but next appointment is 5/15	Come on or before 5/7. Rule: If treatment is finishing – come before next appointment	Check to see if patient returns on or before 5/7



## Applying QI to Strengthen Health Systems

**Neeraj Kak, PhD**  
Associate HCI Project Director for Asia and the Near East  
Vice President, University Research Co. LLC.,

## Framework for Systems Strengthening (WHO)



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## HCI Approach to Systems Strengthening

- Focus on districts
- Integration of services
- Health worker capacity building
- Information system strengthening
- Mentoring and on the job support
- Strengthening policy frameworks
- Advocacy for accountability
- Chronic conditions and care framework

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## South Africa – District-based Model

Donna Jacobs, MD  
HCI Chief of Party, South Africa

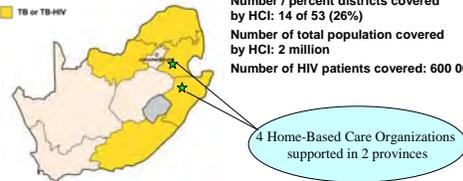


**Goal:** Improve the quality of HIV prevention, care and treatment services & expand linkages between communities and facilities through work with home-based care organizations

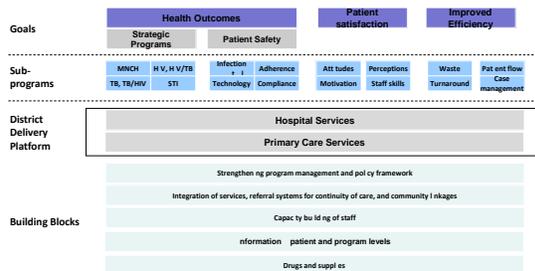
**Geographic focus:**

5 out of 9 provinces, 214 facilities (9% of all PHC facilities in 5 provinces)

Number / percent districts covered by HCI: 14 of 53 (26%)  
Number of total population covered by HCI: 2 million  
Number of HIV patients covered: 600 000



## HCI Model for Systems Strengthening in South Africa



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## HIV/AIDS Treatment, Care and Support Collaborative in Russia

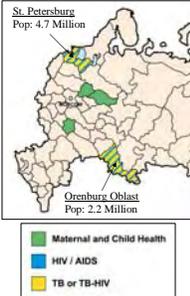
Victor Boguslavsky, MD  
Associate HCI Project Director for Europe and Eurasia

## Russia/HIV/AIDS Treatment, Care and Support

### What we are trying to accomplish

#### St. Petersburg and Orenburg

- Increase coverage of HIV patients with basic care medical follow-up, TB testing and ART
- Improve skills of providers in VCT
  - all 18 districts in St. Petersburg plus 2 out of 17 districts of Leningrad Oblast
  - entire city of Orenburg and 3 cities of Eastern Zone of Orenburg Oblast:



#### St. Petersburg

- Expand access to substance abuse treatment and rehabilitation for MARPs and for patients with HIV
  - 3 districts out of 18 districts of St. Petersburg
- Institutionalize models of municipal social services for HIV infected families
  - 9 districts out of 18 districts of St. Petersburg

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## Institutionalization of Results

- May 15, 2007 - Orenburg Oblast MOH issued an Order N666 "On improving TB screening and TB preventive therapy among HIV patients".
- October 9, 2007 - Decision N529-r by the City's Health Care Committee "On improving provision of medical care for HIV infected patients at ambulatory-polyclinic settings". The Decision requires heads of polyclinics to employ infectious disease doctors and nurses to provide medical follow on HIV patients including those on ART.
- April 6, 2009 - Decision N201-r "On early detection of Tuberculosis in patients with HIV" was issued by the City Committee of St Petersburg. The Decision requires heads of polyclinics to organize and implement TB testing through X-ray, tuberculin skin test, microscopy.

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## Applying the Chronic Care Model Design to Care for PLWHA

Nigel Livesley, MD, MPH  
HCI Chief of Party, Uganda

## Acute vs Chronic Care

- | Acute Care   | Chronic Care   |
|--|--|
| • Patient comes to clinic with a specific complaint which occurred in the recent past.                     | • Patient is asked to come to the clinic by the clinician. She usually comes with no complaints. |
| • The provider makes a diagnosis.  | • For most visits there is no new diagnosis.   |
| • The provider fixes the problem or gives treatment that the patient will take for a short period of time. | • For most visits the treatment doesn't change.  |
|  | • The treatment is in the hands of the patient.  |

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## Phasing in a Chronic Care Model for HIV treatment

	Coverage	Retention	Outcomes
Phase I		Accreditation	
Phase II	Links with HCT Links with PMTCT Links with TB Triage system is present for pre-ART and ART patients (Task-shifting)	Appointment given at each visit Contact tracing recorded Community member on QI team	Information recorded at visit: Clinical status Weight Adherence TB assessment Cotrimoxazole TB infection control program
Phase III	Pre-ART assessed for eligibility at least once in past 6 months Stable patients seen every 3 months Identify main barriers to coverage Improvements made to top 2 causes of low coverage	Identify most common causes of missed visits Improvements made to top 2 causes of missed visits	Patients have a plan for self-management prior to starting ART improve patients' confidence in their ability to care for themselves o treatment next month identify causes of bad outcomes improvements made to top 2 causes of poor outcomes
Phase IV	Increase HIV testing in community Decentralize care	Continued improvement work	Self-management support done in community

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## Applying QI to Strengthen Health Systems

**Q#1: What are your reactions and ideas on how to continue to build capacity in applying QI to strengthen health systems at different levels**

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# Health Workforce Development

**Lauren Crigler, BA**  
 HCI Director for Health Workforce Development

## HCI's Health Workforce Development Challenge

- **Health workforce is in crisis:**
  - Disfunctional health systems
  - Overburdened, demoralized and dissatisfied workers
  - High turnover, particularly among qualified staff
- **HCI's challenge:**
  - Develop an approach that applies QI to problems of productivity and retention
  - Develop scalable ways to engage workers through team-based performance management
  - Extend this model to improve larger HR systems with lessons learned and successful interventions

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## Improving Health Outcomes Requires Engaged, Present, and Competent Workers

- Improved clinical processes are critical but depend on health workers
- Trained health workers are important but they often do not perform
- Increased numbers of health care providers are required but they do not stay
- Additional incentives are needed but are not sufficient
- Stronger supervision is required but often fails

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## Engaged Health Workers Produce Results

- Believe in their job and organization
- Believe in their ability to succeed
- Have good relations w/ supervisor and/or team
- Have a future in health care
- Feel recognized and rewarded
- Have influence in decisions about their work



1. Higher quality services
2. Improved productivity of health workers
3. Greater retention of staff

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Performance Systems	Health Worker Engagement	Results
<b>Performance Management</b> Setting objectives Feedback Incentives Capacity building Evaluation Professional advancement Environmental safety	 Belief in job/organization Belief in ability to succeed Good relations w/ supervisor and/or team Prof advancement Recognition/reward Influence in decision-making	<ol style="list-style-type: none"> <li>1. Higher quality services</li> <li>2. Improved productivity of health workers</li> <li>3. Greater retention of staff</li> </ol>
<b>Quality Improvement</b> Process of care Quality of care		

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## FRAMEWORK FOR HR COLLABORATIVE

<b>Performance Management</b> <ul style="list-style-type: none"> <li>• Setting objectives</li> <li>• Feedback</li> <li>• Incentives</li> <li>• Capacity building</li> <li>• Evaluation</li> <li>• Prof advancement</li> <li>• Environment and safety</li> </ul>	<b>HR Systems</b> <ul style="list-style-type: none"> <li>• Planning</li> <li>• Recruitment</li> <li>• Deployment</li> <li>• Compensation</li> <li>• Pre/ Inservice education</li> <li>• HRIS</li> </ul>	<b>Other Mgmt Systems</b> <ul style="list-style-type: none"> <li>• Licensing/accred</li> <li>• Protocols</li> <li>• Logistics</li> <li>• Supplies</li> <li>• Infrastructure</li> <li>• Quality assurance</li> </ul>	<b>Health Worker Engagement</b> <i>Belief in job and organization</i> <i>Belief in ability to succeed</i> <i>Good relations w/ supervisor and/or team</i> <i>Professional advancement</i> <i>Recognition and reward</i> <i>Influence in decision-making</i>	<ol style="list-style-type: none"> <li>1. Higher Retention</li> <li>2. Improved Productivity</li> <li>3. Better Quality of Care</li> </ol>
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**Improvement Objective #1**  
All workers have achievable workloads, clear expectations and measurable objectives.

1. **Setting objectives**
2. **Feedback**
3. **Incentives**
4. **Capacity building**
5. **Evaluation**
6. **Professional advancement**
7. **Environment & safety**

- **Change Concept**
  - Clarify expectations and set objectives
- **Specific Changes**
  - Articulate and align goals
  - Design jobs with performance objectives
- **Ideas for Changes/PDSAs**
  - Each director of unit works with colleagues to describe/define the different roles in his/her unit.
  - Two HWs in the same role (example: 2 nurses) sit together to describe what they think are their objectives of their daily job. Present to rest of team/supervisor for feedback. Run PDSA to determine if objectives are consistent.

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## Human Resources Collaborative - Niger

**Maina Boucar, MD, MPH**  
Associate HCI Project Director for West Africa

### Human Resources Collaborative – Niger

- **Launch the first HR collaborative to improve worker productivity, retention and quality of services**
- **Pilot phase of collaborative in Tahoua 15 facilities/ 8 districts**
- **Baseline assessment done in 15 facilities in Tahoua and 5 control facilities**

Controls: Tillabery (2 facilities), Maradi (3 facilities)

Tahoua

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### Baseline Assessment Objectives and Instruments

- Assess current state of HR systems from perspectives of MOH, Regional Mgmt (DRSP), District Mgmt (ECD), and health workers
- Assess current state of elements of performance management and support from all perspectives
- Measure employee engagement
- Assess productivity of health workers
- Assess retention factors

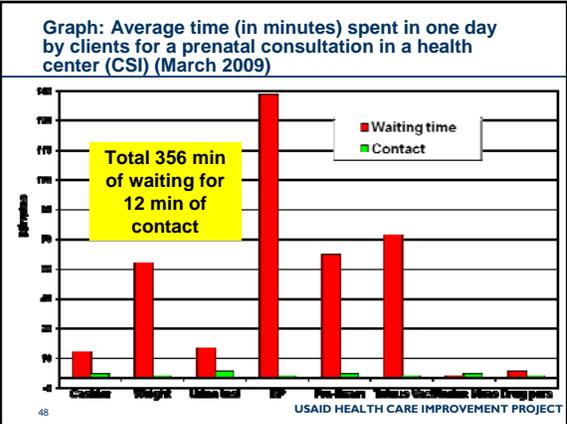
Tools	
Interviews DRSP	(34)
Interviews ECD	(44)
Interviews Maternités/CHR	(8)
Interviews health workers	(53)
Employee Engagement	147 literate/84 illiterate
Client Flow	(565)
Time Utilization of Personnel	(33)

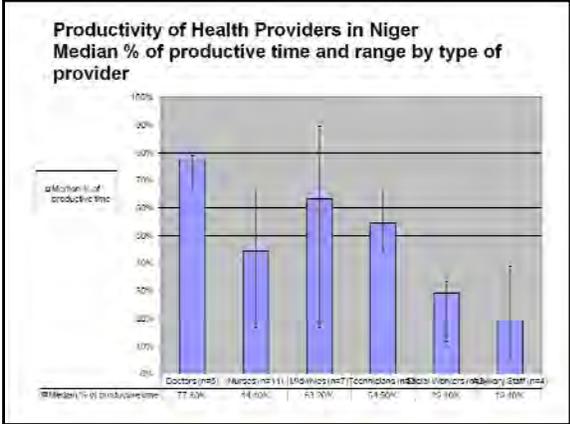
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### Some Relevant Findings

- **Job descriptions** : 4 of 53 said yes but couldn't produce it
- **Evaluation**: 3 of 53 believed an evaluation system existed (had not been evaluated)
- **Supervision**: 24/53 had at least one supervision visit in the last 12 months; only 10/53 had >1

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### Employee Engagement: Some Results (Avg)

Engaged 4-5    Not Engaged 3-4    Actively Disengaged < 3

Item	X/5
I believe that what I do at work is important.	4.6
I have the materials and supplies I need to do my job well.	<= 2
My supervisor knows when I work hard.	3.6
In the past 12 months, some has talked to me at work about my career.	2.6
I am evaluated fairly for my work.	3.3
This facility cares about my safety on the job.	2.6
People who perform their jobs well at the facility generally get rewarded for it.	2.2
I know what I need to do to advance in my career.	3.7
I don't really like to make decisions on my own because I am afraid of the consequences if I am wrong.(negative item)	3.8*

### Reactions from the Field

- Showed limited knowledge of health managers on the HR scope and their responsibilities
- Very enthusiastic on the new scope of HR, a new paradigm career and rotation management and link with real work (productivity, rewards, engagement)
- Told how many opportunities were missed by not knowing the right approach and tools (organization of services, waiting time, and teamwork)
- Exercise came at a right time as the "Public Service" is in a reform process
- First time that personnel are involved in HR management (employee engagement, interviews..)
- Saw the link between action plans and HR management

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### Actions from the Field

- The change package was introduced to in-country experts that enthusiastically validated its content and relevance to the Niger context
- QI teams discussed the first phase and developed detailed action plans and indicators
- A steering committee was formed, chaired by the MOH, to support field-level activities from the central level
- The Minister of Health was vocal in his support for this process, saying that this was the missing link needed to engage health care workers
- A first coaching visit held to support finalise action plan and test changes on Objective 1.

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### Health Workforce Development

**Q#2: What thoughts can you share about our approach to engaging or supporting the human element of health care?**

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### Institutionalization and Spread

**Lynne Miller-Franco, Sc.D**  
HCI Director for Research and Evaluation

**Jorge Hermida, MD**  
Associate HCI Project Director for Latin America

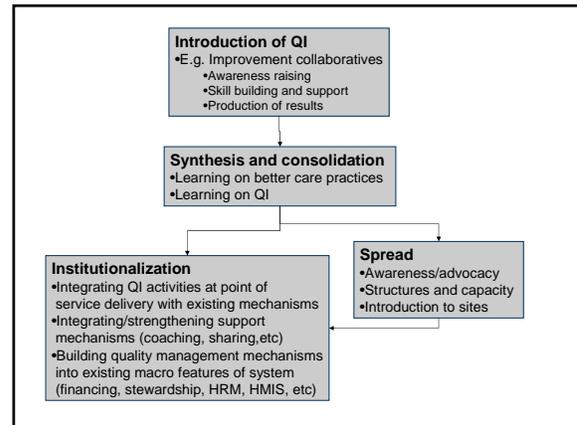
## How are we defining Institutionalization?

- Establishing and maintaining QI as an integral, sustainable part of a health system or organization, woven into the fabric of daily activities and routine

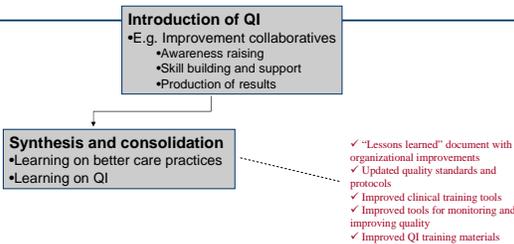
Franco LM et al. Sustaining quality of health care. Institutionalization of quality assurance. September 2002. Quality Assurance Project: Bethesda MD

- Maintaining gains in quality of care
- Managing quality at the point of service delivery
- Managing for quality at decentralized and central level

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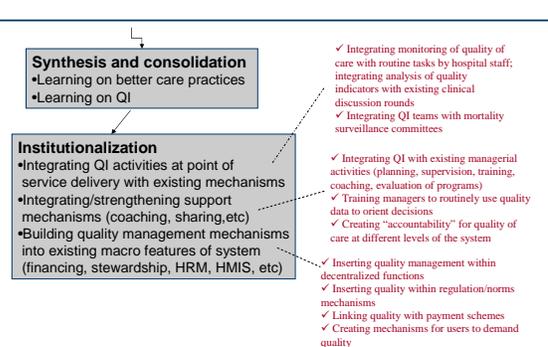


## Implementation experiences in the Latin American region



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## Implementation experiences in the Latin American region



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## What would we see if improvement were institutionalized?

LEVEL	ACTIONS/RESULTS
Care provided at the point of service delivery	
QI at the point of service	
QI support from decentralized levels	
QI support and framework from central level	

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## Institutionalization and Spread

**Q#3: What does institutionalized improvement look like at different levels of the health system?**

**What are your thoughts about where we can best focus our efforts to strengthen institutionalization and spread improvements?**

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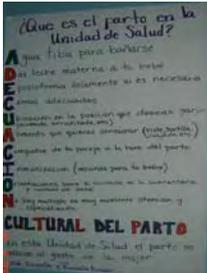
## New Directions in Quality Improvement


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## Cultural Adaptation of EONC in Nicaragua

**Oscar Nunez, MD**  
 HCI Country Director, Nicaragua

### Improving the Cultural Adequacy of Delivery Care in Nicaragua



Changes introduced:

- Advising pregnant women of choices in delivery position
- Allowing presence of family members
- Improved interpersonal treatment
- Privacy, availability of warm water for bathing
- Alternative food and drink

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### Quilali Health Center in Nueva Segovia Region, Nicaragua



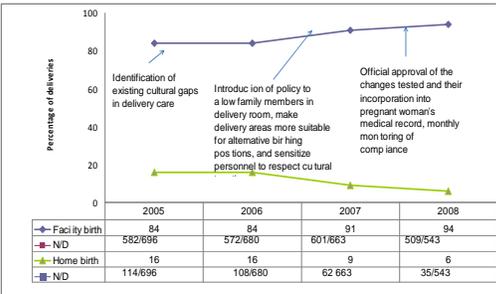
**Delivery in vertical position, accompanied by spouse**



**Delivery accompanied by family member**

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### Nicaragua: Impact of cultural adaptation of delivery care on institutional deliveries in the Quilali Health Center, Nueva Segovia SILAIS, 2005-November 2008



Identification of existing cultural gaps in delivery care (2005)  
 Introduction of policy to a low family members in delivery room, make delivery areas more suitable for alternative birthing positions, and sensitize personnel to respect cultural (2006)  
 Official approval of the changes tested and their incorporation into pregnant woman's medical record, monthly monitoring of compliance (2008)

	2005	2006	2007	2008
→ Facility birth	84	84	91	94
→ ND	582/696	572/680	601/663	509/543
→ Home birth	16	16	9	6
→ ND	114/696	108/680	62/663	35/543

See US State of the World report of the Millennium Development Goals  
 Population in 2005: 5.4 billion; 2008: 6.2 billion

OBJECT


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## Reducing Maternal and Neonatal Mortality in Afghanistan

**Kathleen Hill, MD**  
 HCI Senior QA Advisor for MNCH  
**Ibrahim Maroof, MD, MPH**  
 HCI Chief of Party, Afghanistan

## HCI - Afghanistan

### What we are trying to accomplish:

- To support MOPH in building capacity for health care improvement nationwide and institutionalize health care improvement in Afghanistan
- To demonstrate how specific improvements can be accomplished, initially on a demonstration-level scale in 3/34 selected provinces, with a focus on **reduction of maternal and neonatal deaths**
- In year one, the program will work in "slices of the system" in 2 districts in Balkh and Kunduz provinces, and in Malalai hospital and 2 districts in Kabul



Maternal and Child Health

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## Integrating and Phasing Maternal Newborn Improvement Work in Afghanistan

- Integrating district-level improvement work across distinct care continuums:
  - District service level continuum: household/community → primary care → hospital
  - Life-cycle continuum: prenatal → birth → post-partum
  - Maternal-Newborn continuum: integrating maternal and newborn care at every service delivery point
- Chronologic phasing of intervention content for maximal improvement

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## Phasing of High-Impact Technical Interventions in Demonstration Maternal and Newborn Collaborative

Service Type	Phase One	Phase Two
Community midwives, CHW's	ANC: Birth preparedness/complication readiness; Tetanus; Iron/Folate Post-partum: Essential Maternal and Newborn Care; Danger sign recognition and care seeking	ANC: Screening, stabilization and referral for complications (pre-eclampsia and other) Birth: Clean delivery; AMTSL (pending MOPH approval) Post-partum: Screening, stabilization, and treatment of maternal and newborn complications (sepsis, etc.)
BHC	ANC: Birth preparedness; Tetanus; Iron/Folate Birth: AMTSL/ENC; IP Post-partum: ENC; maternal/newborn monitoring; counseling	ANC: Screening and management of pre-eclampsia/eclampsia Birth: Partogram; early intervention for obstructed labor; IP (expanded) Post-partum: FP (LAM; progesterin-based oral contraceptives)
CHC	ANC: Birth preparedness; Tetanus; Iron/Folate Birth/post-partum: AMTSL/ENC; IP (basic); post-partum monitoring and discharge	ANC: Screening and management of pre-eclampsia/eclampsia Birth: Partogram; IP (expanded); complications management (hemorrhage, eclampsia, sepsis, newborn asphyxia and LBW) Post-partum: FP (LAM; progesterin-based oral contraceptives)
Hospital	ANC: NA Birth/Post-partum: AMTSL/ENC; IP (basic); post-partum monitoring and discharge	ANC: NA Birth: Partogram; IP (expanded); complications management (hemorrhage, eclampsia, sepsis, newborn asphyxia and LBW) Post-partum: FP; maternal and newborn sepsis; LBW
Community-to-Facility Linkages	ANC: Birth preparedness/complication readiness (facility and community services.)	ANC/Birth/Post-partum: Referral/counter-referral for maternal newborn complications

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## New Directions in Quality Improvement

**Q#4: We would like your thoughts and ideas on methods, approaches and frameworks that we should consider and adapt in order to tackle the priorities in improving health care in the contexts we are working in**

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## Partnerships for Global Learning

**Lani Marquez, M.H.S**  
HCI Director for Knowledge Management and Communications

**Dorcus Amolo, MA**  
HCI Regional Advisor for Orphans and Vulnerable Children, Kenya

## HCI Strategies for Global Learning and Partnerships for QI

Develop a global system for harvesting and sharing learning from QI teams and country experiences, accessible via the Web

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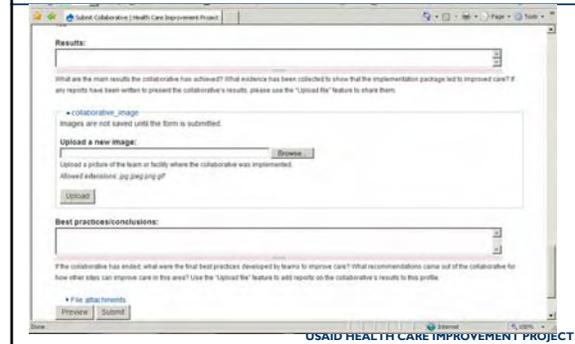
## A Global System for Learning and Documentation

- Learning from QI teams about improving specific areas of care
- Tools and best practices from collaboratives and other improvement experiences
- Information on QI methods
- Links to other resources for improving health care



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## Collaborative and Improvement Report Databases



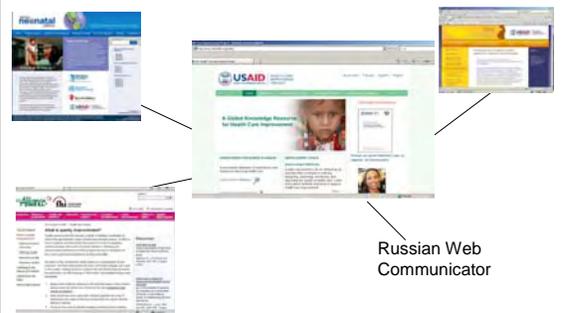
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## HCI Strategies for Global Learning and Partnerships for QI

- Develop a global system for harvesting and sharing learning from QI teams and country experiences, accessible via the Web
- Create “Sister” Web sites to support regional sharing in specific topic areas

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## Family of Web Sites to Support Regional and National Improvement in Specific Areas



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## www.maternoinfantil.org



## HCI Strategies for Global Learning and Partnerships for QI

- Develop a global system for harvesting and sharing learning from QI teams and country experiences, accessible via the Web
- Create “Sister” Web sites to support regional sharing in specific topic areas
- Regional communities of practice around specific topic areas
- Regional hubs of QI expertise

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### Quality Improvement Initiative for OVC Programs

- Regional training events helped build cadre of QI facilitators across Africa
- Monthly conference calls and web page to promote cross-country sharing
- Pilot south-to-south exchange
- Support for a regional institution to serve as the host for an African Partnership for OVC QI



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### Partnerships for Global Learning

**Q#5: What additional strategies and mechanisms can you suggest that will build on these efforts and allow us to strengthen global and regional communities of practice for improvement?**

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## Concluding Remarks

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