Quality Assurance and Improvement in Primary and Secondary Health Care

PALESTINIAN HEALTH SECTOR REFORM AND DEVELOPMENT PROJECT (THE FLAGSHIP PROJECT)

SHORT-TERM TECHNICAL ASSISTANCE REPORT (FINAL)

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ACRONYMS

IDP	Institutional Development Plan
MoH	Ministry of Health
PHC	Primary Health Care
QA	Quality Assurance
QC	Quality Coordinators
QI	Quality Improvement
QA/QI	Quality Assurance and Improvement
SHC	Secondary Health Care
USAID	United States Agency for International Development

SECTION I: INTRODUCTION

The Flagship Project is a five-year initiative funded by the U.S. Agency of International Development (USAID), designed, and implemented in close collaboration with the Palestine Ministry of Health (MoH). The Project's main objective is to support the MoH, selected non-governmental organizations, and selected educational and professional institutions in strengthening their institutional capacities and performance to support a functional and democratic Palestinian health sector able to meet its priority public health needs. The Project works to achieve this goal through three components: (1) supporting health sector reform and management, (2) strengthening clinical and community-based health, and (3) supporting procurement of health and humanitarian assistance commodities.

Strengthening and defining quality of care has been identified by the MoH, during its self assessment in 2008, as an important element of reform. To assure the clinical quality of health services, health systems must define, communicate, and monitor national evidence based standards, which represent an ideal of how clinical care should be implemented and reviewed. The MoH, with support from the Flagship Project, has developed an institutional development plan (IDP) module and action plan to improve the quality aspects of care in the West Bank/Gaza. A first step of quality assurance (QA) is to develop a plan to support the establishment of a quality assurance approach and systems in both the primary and secondary health care facilities. Initial drafts, based on quality assurance and improvement situation analyses, have been developed by Flagship long-term staff.

This report contributes to Flagship Project Component 1, Objective 1.1 (Improve good governance and management practices), and Tasks 1.1.1 (Strengthen the capacity of the Ministry of Health to implement reforms needed for improved quality, sustainability, and equity in the Palestinian health sector) of the Flagship Project; Task 2.1.1 (Strengthen the Capacity of Palestinian Health Institutions to Deliver a Quality Package of Essential Primary Care Services); and Task 2.1.2 (Strengthen Quality Improvement Systems within Palestinian Health Institutions to Deliver Better Secondary Health Care Services). It contributes to the following Flagship Project Workplan Deliverables:

- 1.1.1.3 Health Administration and Management Program for the Public Sector; Deliverable
- 2.1.1.4: Integrated Quality Improvement Program for Delivery of the Essential Package of Primary Health Care Services; and
- 2.1.2.3 Integrated Quality Improvement Program for Delivery of Hospital Services.

This consultancy also contributed to the MoH IDP module numbers 11: improve the quality of clinical services in the Palestinian MoH primary care system, and 12: improve the quality of clinical services in the Palestinian MoH hospital system.

Section II: Activities Conducted

The Consultant was tasked with developing draft implementation and action plans for improving quality assurance at the primary health care and hospital levels. To develop these plans, the consultant worked with Flagship Project staff to identify a process for improving quality at the primary and secondary health levels, including identifying the knowledge, skills, and competencies required to implement quality processes and systems, tools and approaches, and best practices, procedures, job aids and patient education materials. See Annex B for a list of meetings and site visits conducted to inform development of the plans.

The implementation and action plans for strengthened quality assurance at primary and secondary health care levels are included in Annex E of this report. These plans will be finalized following review by the Ministry of Health.

SECTION III: FINDINGS, RECOMMENDATIONS, AND NEXT STEPS

Below are the consultant's findings, recommendations and next steps:

A. Findings

Strengths/Opportunities:

1) The General Director for Primary Healthcare and the General Director for Hospital or Secondary Care are committed to the concept of improving the quality of care/services.

2) The Director of Quality Improvement for Hospitals was appointed on October 27th by the General Director. He is interested and committed to support the QA/QI initiative. This is a very positive move by the MoH and also demonstrates the Director's interest and support. He responded immediately to the request of the Flagship Project staff for such a focal point.

3) The Minister of Health has decided that the USAID Flagship Project will have the shepherding role with the MoH. This provides a real opportunity to effect change. The Minister also appointed a focal person for quality of care within the central level MoH.

4) QA/QI processes are cross-cutting and are already being addressed by multiple components of the USAID Flagship Project such as health information systems, updating clinical guidelines and protocols, infection control and waste management, obtaining community and patient perspectives through client exit interviews and mystery patients, and the training program.

5) The opportunity to create a center of excellence through the Palestine Medical Complex as a model for the public sector.

Challenges:

1) The current organizational structure within the MoH does not provide the authority for the QA unit to implement quality measures because of its location below the level of the Directorates for Primary and Secondary care. It is located within the Directorate for Planning and Health Policy, which is on the same level as the Directorates for PHC and Secondary care.

2) Both of the Directorates for PHC and Secondary care have responsibilities for quality assurance. These positions were not filled at the beginning of my visit but the QA/QI focal person for the Secondary Care Directorate was appointed this week (10/27/09). The Director for Primary Care has also appointed a focal person for the Lab QA activities which will enable the initiation of activities.

3) There is no staff currently in place within the QA unit under the Health Policy and Planning Directorate, therefore no counterpart at this level for the Flagship Project QA focal person. This poses a challenge to sustainability but the topic could be introduced at a strategic point later on as the Flagship Project progresses.

4) Among some members of the MoH leadership there is an apparent "quality fatigue" (for lack of a better term) and a sense of resignation that it is very difficult to introduce the notion of quality of care in the current context.

B. Recommendations

1) Take adequate time in the initial phase to obtain and build high level leadership support for a sustainable QA/QI initiative. This may appear to be a slow start, but is crucial to long term effectiveness and sustainability.

2) Once this high level support is obtained, plan a visible launch of the QA/QI initiative so that the users of health care are aware of this initiative.

3) Since the Director of the Primary Care Directorate has voiced a desire to see QA instituted in primary care labs, this could be an opportunity for a "quick win" and might also contribute to gaining his support for the broader primary health care QA/QI approach that is needed. The short term technical assistance of a laboratory specialist will be needed to support the project QA specialist for this process.

4) Given the fact that the Flagship Project is already intervening to address many areas identified by the MoH to enhance the quality of care, the Project should use every opportunity to integrate the QA/QI concepts into ongoing trainings to create broad-based understanding of and support for the concepts of QA/QI in health care.

5) Design QA/QI systems that are simple and doable for busy clinicians and other staff and that build on or integrate activities they are already doing. For example, use supervisors as quality coordinators and build their skills to provide supportive supervision. Select clinical conditions to monitor that are already important to the MoH and for which clinical guidelines exist. Build the QA/QI monitoring system around existing indicators. Do not duplicate and add to staff work load unnecessarily.

6) Design systems that actually improve the work environment for health workers so that they can see the impact of QA/QI activities for their own morale and working conditions.

7) Maintain a focus on the client and listen to the communities being served. Incorporate patient's perceptions and exit interviews into the design of the system.

C. Next Steps

The above recommendations are built into the draft implementation plans for primary and secondary care and the detailed work plans for 2010 submitted with this report. These documents are intended as drafts to be re-worked and finalized in discussion with the Ministry of Health.

ANNEX A: SCOPE OF WORK

Palestinian Health Sector Reform and Development (Flagship) Project
Scope of Work

Position: Quality Assurance Technical Advisor

Consultant: Sharon Arscott-Mills

General Project Overview:

The Flagship Project is a five-year initiative funded by the U.S. Agency of International Development (USAID), and designed in close collaboration with the Palestinian Ministry of Health (MoH). The Project's main objective is to support the MoH, select non-governmental organizations, and select educational and professional institutions in strengthening their institutional capacities and performance to support a functional, democratic Palestinian health sector able to meet its priority public health needs. The project works to achieve this goal through three components: (1) supporting health sector reform and management, (2) strengthening clinical and community-based health, and (3) supporting procurement of health and humanitarian assistance commodities.

The Flagship Project will support the MoH in implementing health sector reforms needed for quality, sustainability, and equity in the health sector. By addressing key issues in governance, health finance, human resources, health service delivery, pharmaceutical management, and health information systems, the Ministry will strengthen its dual role as a regulator and main health service provider. The Flagship Project will also focus on improving the health status of Palestinians in priority areas to the Ministry and public, including mother and child health, chronic diseases, injury prevention, safe hygiene and water use, and breast cancer screening for women.

According to the MoH's self assessment, quality of health care has been on the national agenda since 1994, and the MoH has established a central unit for quality improvement, which has contributed to the development of outpatient clinic operation protocols, surgical department operation protocols and clinical protocols.

Background:

Strengthening and defining quality of care has been identified by the MoH, during its self assessment in 2008, as an important element of reform. To assure the clinical quality of health services, health systems must define, communicate, and monitor national evidence-based standards, which represent an ideal of how clinical care should be implemented and reviewed. The MoH, with support from the Flagship Project, has developed an institutional development plan (IDP) module and action plan to improve the quality aspects of care in the West Bank/Gaza. A first step of QA is to develop a plan to support the establishment of a quality assurance approach and systems in both the primary and secondary health care facilities. Initial drafts, based on QA/QI situation analyses, have been developed by Flagship long-term staff.

Specific Tasks:

The purpose of the trip will be:

1. Work with Flagship staff, Ministry of Health counterparts, representatives of other institutions to develop policies and standards for a national quality assurance system.
2. Work with the Quality Assurance Specialist in identifying tools and approaches and plan a process for improving quality at the primary and secondary health care levels and hospitals.
3. Assist the Quality Assurance Specialist in identifying tools and approaches to build MoH capacity to develop a multiyear implementation plan which works toward nation-wide adoption of quality assurance systems.
4. Assist Quality Assurance Specialist in assessing the current capacities and needs of the MoH to strengthen the *Quality Unit* including a plan about its location, structure, functions, staffing and financial support;
5. Coordinate QA planning with the Continuing Education and Accreditation Policy Advisor;
6. Assist Quality Assurance Specialist in identifying best practices, procedures, job aids and patient education materials that comply with national clinical standards and protocols;
7. Assist Quality Assurance specialist in outlining the knowledge, skills, and competencies required to implement quality processes and systems**;**
8. Review, adapt and finalize the draft QA/QI workplan for primary care facilities;
9. Review, adapt and finalize the draft QA/QI workplan for hospitals.

Deliverables:

1. Specific activities for 2010 Quality Assurance workplan outlined.
2. Trip report.
3. Complete draft of QA/QI workplan for primary care facilities.
4. Complete draft of QA/QI workplan for hospitals.

Reporting:

The consultant will report to Dr. Maha Al-Saheb, Quality Assurance Specialist on Flagship Project

Qualifications:

Please list any specific qualifications that you would like the consultant to have, including:

1. Physician, RN or graduate degree in public health or a related field.
2. A minimum of 5 years direct experience developing health quality assurance systems.
3. Knowledge and experience in developing health services in developing countries.
4. Excellent oral and written communication skills.
5. Ability to work with and communicate with a wide variety of people.
6. Excellent writing and communication skills in English.

Timing: October 11 – 31, 2009

Total LOE Days (including travel): Approximately 25 days

ANNEX B: MEETINGS AND SITE VISITS

- Flagship Project staff, general
- Dr. Anan Al Masri, Deputy Minister of Health.
- Site visit to Level III clinic, Howarrah Clinic
- Mr. Amar Sbouh at the Nablus Health Directorate.
- Dr. Intisar Al-Alem, Director, Surveillance and Research for Non- Communicable Diseases
- Site visits to Primary Care Level IV in Nablus.
- Meeting with Dr. Khaled G. Qadri, Nablus General Directorate for Primary Care.
- Site visit: Augusta Victoria Hospital, Dr. Tawfiq Nasser, Chief Executive Officer of the Lutheran World Federation, Augusta Victoria Hospital in East Jerusalem.
- Meeting with Dr. Assad Ramlawi and Mr. Mohamed Shahwan at the Primary Health Care Directorate, Ramallah
- Flagship Technical Team meeting with Dr. Naim Sabra, Director General of Secondary Care.

ANNEX C: CONSULTANT CV

SHARON ARSCOTT-MILLS

Mailing Address: 6 Marchmont Court, Durham, NC 27705
Phone: Home: 336-501-3112 Office: 919-433-5718
Email: sarscott-mills@intrahealth.org
Citizenship: United States

I was born and grew up in rural Zambia where I was exposed to public health and development issues. This exposure shaped my desire to pursue nursing as a career and later, international public health. I also have experience as a computer programmer/systems analyst and have combined this background with my international public health training and nursing experience in the area of health information systems development, injury surveillance, health research, program monitoring and evaluation, performance improvement and program management. During my tenure in the Ministry of Health, Jamaica, I implemented a national injury surveillance system, conducted injury surveillance data analysis and reporting, strengthened the national health information system and initiated the national HIV and AIDS monitoring and evaluation system. For the last seven years, prior to joining IntraHealth International, I worked within the United States Agency for International Development as a Senior Technical Advisor for maternal and child health and family planning programs as well as HIV and AIDS both in Washington D.C. and Nepal. As Senior Public Health Advisor and HIV and AIDS Team Leader, USAID/Nepal, I was responsible for technical oversight of a broad range of research projects, and HIV and AIDS, maternal and child health, and family planning programs. I have experience in a multi-sectoral approach to problem solving and in coordinating with multiple donor agencies, government, non government and implementing partners. I have also had broad project management experience and bring cross-cultural sensitivity, versatility, attention to detail, excellent communication skills, commitment and maturity to my work.

Professional Experience:
Senior Technical Advisor and Team Leader for Clinical Services — May 09 to present
IntraHealth International, Chapel Hill, NC

- Ensures technical quality and clinical excellence of IntraHealth's program design and implementation in maternal, newborn, and child health, malaria and family planning
- Builds staff and organizational capacity in high quality clinical care and service delivery
- Leads IntraHealth International's quality assurance and performance improvement initiatives
- Increases the visibility of IntraHealth's clinical services work in global health community

Senior Public Health Advisor, Office of Health and Family Planning — May 07 to April 09
U. S. Agency for International Development (USAID), Nepal

- Ensured technical quality of implementing partners' programs in maternal and child health, family planning and reproductive health, and HIV and AIDS
- Used quality assurance and performance improvement approaches to monitor key clinical components of USAID funded maternal, child and HIV/AIDS programs
- Provided technical oversight to health research projects implemented with USAID funding such as the Nepal Demographic and Health Survey (2006), the National HIV and AIDS Integrated Bio- behavioral Surveillance and the Nepal Maternal Mortality and Morbidity study, 2008.
- Ensured quality and timely reporting of strategic information for the US government HIV and AIDS, maternal and child health and family planning program in Nepal
- Continued all roles and responsibilities identified below

Senior Technical Advisor for HIV and AIDS (04/05) — April 2005 to May 2007
& Team Leader (11/06), Office of Health and Family Planning,
USAID, Nepal

- Assumed role of team leader for HIV/AIDS in November 2006 and mentor and supervise 5 team members

- Ensure technical quality and stat of the art of implementing partners' programs in HIV and AIDS
- Serve as USAID representative for donor coordination for HIV and AIDS and Global Fund implementation
- Provide technical leadership on a range of national technical task forces, including the National HIV/AIDS Strategic Information Technical Working Group
- Ensure quality and timely reporting of HIV and AIDS strategic information
- Led and coordinated the application of sustainability measurement tool to USAID supported health programming

Senior Technical Advisor to the Child Survival and Health Grants Program (CSHGP), Bureau for Global Health, USAID, Washington, DC — October 1, 2002-April 2005

- Provided technical leadership and oversight for the quality and direction of the CSHGP
- Monitored and advised on implementation of over 35 child and maternal health and nutrition, HIV and AIDS and Tuberculosis projects internationally in resource poor settings implemented by international non government organizations
- Provided technical review of a wide range of program guidelines and tools
- Provided technical leadership in technical working groups and task forces including: HIV/AIDS, Safe Motherhood/Reproductive Health, Monitoring and Evaluation technical working groups of the Collaborations and Resources (CORE) Group and the Knowledge Practices and Coverage Survey Task Force, and Orphans and Vulnerable Children Task Force
- Functioned as Jamaica Country Coodinator for Global Health Bureau, USAID, Washington.

HIV/AIDS Monitoring & Evaluation and Health Information System Consultant, World Bank, Washington, D.C. and Ministry of Health, Jamaica — September 2001- September 2002

- Played a key role in developing health information systems and monitoring and evaluation component of National HIV and AIDS Prevention and Control Program for Jamaica.
- Provided expert advice for the development and implementation of the national Prevention of Mother to Child Transmission Program (PMTCT)
- Developed Obstetric and peri-natal surveillance system to enable improved monitoring of PMTCT of HIV/AIDS and causes of maternal mortality and morbidity

Project Director and Health Information Systems Development Specialist, Academy for Educational Development (AED), Washington, D.C. and Ministry of Health, Jamaica contracted by USAID. — September 2000 – September 2001

- Provided overall management of health information systems strengthening project including financial and technical reports
- Provided technical assistance to the Jamaican Ministry of Health to strengthen the existing Management Information System through a computer-based Patient Administration system in 11 hospitals and 2 clinics island-wide.
- Provided technical assistance to key units within the Ministry of Health to re-organize and streamline data collection processes
- Trained various levels of staff in data management, data quality assessment, data interpretation and report generation
- Developed training tools, information system procedure manuals and database user manuals
- Represented the contractor in relations with donors and stakeholders

Project Director for Injury Surveillance System, U.S. Centers for Disease Control and Ministry of — June 1, 1999 - February 27, 2000

Health, Jamaica contracted by the Inter-American

Development Bank

- Provided technical support from Division of Violence Prevention, U.S. Centers for Disease Control to Ministry of Health, Jamaica for project implementation
- Led numerous stakeholders in finalizing the design and full implementation, quality assurance and evaluation of computer-based injury surveillance system in five hospitals
- Developed an all-injury surveillance training manual and conducted training workshops for 140 staff members at five hospitals
- Directed an 8 member team in an evaluation of emergency room data collection systems in 13 hospitals across Jamaica
- Initiated and maintained a reliable financial accounting system for project
- Designed an interpersonal injury survey instrument and conducted original research at the Women's Crisis Centre in Kingston, Jamaica on intimate partner violence

Cross-cultural Program Director, Reciprocal Ministries International, Jamaica. January 1991-January 1998

- Designed and implemented a cross-cultural community-based cooperative exchange program between Jamaica and the United States for Reciprocal Ministries International (RMI)
- Developed cross-cultural negotiation skills
- Developed an orientation program and training materials for international visitors and local groups
- Trained and supervised staff
- Developed administrative and accounting systems for managing and implementing the exchange program
- Collaborated in the development of several micro-enterprises and community-based projects in rural and urban Jamaica

Staff nurse, Intermediate Intensive Care, May 1987-December 1990

High Point Regional Hospital, High Point, NC

Senior Computer Programmer, Agathos April 1983-December 1986

Systems Ltd., Reading, England

PRESENTATIONS:

- "Beyond the Borders: Innovations for international excellence in nurse education" June 13, 2009, keynote address, Royal College of Nursing Joint Education Forums' 2nd International Conference, Glasgow, Scotland.
- Public-Private Partnerships and Collaborative Approaches for Supply Chain Management in a Concentrated Epidemic: oral presentation at the HIV Implementer's Conference, Kigali, Rwanda, June 2007.
- Injury Surveillance in Jamaica: February 2000, presentation to the Division of Violence Prevention, National Center for Injury Prevention and Control, US Centers for Disease Control and Prevention, Atlanta, GA and at the Rollins School of Public Health, Emory University, Atlanta, GA, March 2000.
- Intimate Partner Violence in Jamaica: Presentation to the Caribbean Health Research Council Conference, April 27, 2001. Abstract published in the West Indian Medical Journal Supplement, 2001: 50 (Suppl. 2): 32.
- Comparative evaluation of different modes of a national accident and emergency department-based injury surveillance system-Jamaican experience: Poster presentation at the Caribbean Health Research Council Conference, April 25-28, 2001. Abstract published in the West Indian Medical Journal Supplement, 2001:50 (Suppl. 2): 63.

- Injury Surveillance in Jamaica: Analysis of data from December 1999 through May 2000, University of the West Indies Medical Alumni Conference, St. Kitts, W.I., November 9, 2001.
- Use of Volunteer Community-based Health Workers: Lessons learned. Presentation to the National Refugee Program Consultation, October 10, 2003, Washington, DC.
- Childhood Injury Prevention: September 13, 2004, Presentation to the FY 2005 Child Survival and Health Grants Program RFA Conference, Ronald Reagan Building, Washington, DC.

PUBLICATIONS:

1. Arscott-Mills S. Intimate Partner Violence in Jamaica: A descriptive study of women who access the Women's Crisis Centre. Violence Against Women, November 2001.
2. Arscott-Mills S, Holder Y, Gordon G, McDonald A. A profile of injuries in Jamaica. Injury Control and Safety Promotion, 2002. Vol.9, No.4, pp. 227-234
3. Arscott-Mills S, Holder Y, Gordon G, Ashley D. A comparative evaluation of different modes of the Jamaican accident and emergency department based injury surveillance system. Injury Control and Safety Promotion, 2002. Vol.9, No.4, pp. 235-239
4. Ward E, Arscott-Mills S, Gordon G, Ashley D and the JISS working group. The establishment of the Jamaica Injury Surveillance System. Injury Control and Safety Promotion, 2002. Vol.9, No.4, pp. 219-225
5. Sarriot E, Ricca J, Ryan L, Basnet J, Arscott-Mills S. Measuring sustainability as a programming tool for health sector investments—report from a pilot sustainability assessment in five Nepalese health districts. Int J Health Plann Mgmt 23:1-25. Published online in Wiley InterScience (www.interscience.wiley.com) DOI: 10.1002/hpm.932.2008

TRAINING, EDUCATION, HONORS and AWARDS:

- Global HIV/AIDS Surveillance meeting, Bangkok, Thailand, March 2009
- Certificate of Appreciation, U.S Embassy, Kathmandu, Nepal, June 2008
- Certificate of Appreciation, U.S Embassy, Kathmandu, Nepal, May 2007
- Joint UNAIDS/PEPFAR Strategic Information training, Bangkok, Thailand, July 2006
- PEPFAR Country Operational Plan training, Bangkok, Thailand, July 2006
- Population Leadership Program, Leadership Retreat and training, June 2006
- Acquisition Management for Cognizant Technical Officers (CTOs), USAID Learning and Support Division, Bureau for Management, May 2006
- Routine Health Information Systems (RHINO) workshop, Chiang Rai, Thailand, January 2006
- 2004 Superior Service to the Field Award for assistance to the USAID Jamaica Mission.
- Assistance Management for CTO's, USAID Learning and Support Division, Bureau for Management, November 2004
- Standard Days Method Training of Trainers, Washington, DC. September 2004
- Knowledge, Practices and Coverage Survey Training of Survey Trainers, Kampala, Uganda, August 2004
- Meritorious Group Award, Child Survival and Health Grants Team, Bureau for Global Health, US Agency for International Development, November 2003
- Role and Function of NGOs in Public Health Programs, Johns Hopkins University, January 2003
- MPH, Rollins School of Public Health, Emory University, Atlanta, May 2000
- Delta Omega Honorary Society in Public Health membership, April 2000
- American Schools of Public Health internship program, June-August, 1999
- B.Sc., Nursing, magna cum laude, Rutgers, The State University of New Jersey, College of Nursing, and Ella V. Stonsby Award for outstanding academic achievement, May 1971

VOLUNTEER ACTIVITIES:

- Member, Christian Connections for International Health (CCIH), current.
- Volunteer in local children's home, Kathmandu, Nepal
- Board member, Woman Inc., Women's Crisis Centre, Kingston, Jamaica,1999-2002
- Collaborated in establishing a community-based vocational training center and clinic in Devon, Manchester, Jamaica (1992-1993)

- Board member of the Devon Community Vocational Training Center and Clinic, Jamaica (1992-1997)
- Collaborated in the development of youth sports and recreational centers in inner-city Kingston and rural Jamaica (1992-1997)

LANGUAGES:
French, Portuguese and Spanish understood but refresher needed to regain fluency.

LICENSURE:
Current licensure as a registered professional nurse in Georgia (inactive status), North Carolina (inactive status)

REFERENCES:
Sheila Lutjens, Deputy Mission Director, USAID, Zambia. Phone: +260-1-254303/6
Email: slutjens@usaid.gov
Anne Peniston, Director, Office of Health and Family Planning, USAID, Nepal. Phone: 977-1-400-7200 ext. 4260, Email: apeniston@usaid.gov
Susan Youll, President's Malaria Initiative, formerly Program Manager, Child Survival and Health Grants Program, Office of Health, Infectious Disease and Nutrition, Bureau for Global Health, USAID, 1300 Pennsylvania Ave., Washington, DC 20523. Phone: 202-712-1444 Email: syoull@usaid.gov
Glenn Strachan, formerly with Academy for Educational Development, 1875 Connecticut Ave., NW, Washington, DC. Currently freelance consultant. Phone: 202-884-8108
Email: glenn@glennstrachan.com
Dr. Deanna Ashley, formerly director of Health Promotion, Ministry of Health, 2 King St., Kingston, Jamaica (now retired) phone: 876-924-2781 email: deanna_ashley@hotmail.com

ANNEX D: BIBLIOGRAPHY OF DOCUMENTS COLLECTED AND REVIEWED

Ministry of Health Institutional Development Plan, Palestinian Health Sector Reform and Development Project: The Flagship Project/USAID, 2009.

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Agha, Sohail. July 2009. The Impact of a Quality Improvement Package on the Quality of Reproductive Health Services Delivered by Private Providers in Uganda. Bethesda, MD: Private Sector Partnerships-One Project, Abt Associates Inc.

Bouchet, B, Francisco, M, Ovretveit, J. The Zambia Quality Assurance Program: successes and challenges. International Journal for Quality in Health Care 2002; Volume 14, Supplement 1:89-95

Ovretveit J. What are the best strategies for ensuring quality in hospitals? Health Evidence Network, World Health Organization. November 2003.

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Quality Assurance in the Jordan Primary Health Care System: Best Practices. Primary Health Care Initiatives. USAID. 2004.

Collaboratives: A Feasible Improvement Strategy for Less Developed Countries. Health Care Improvement Project. USAID. March 2009.

ANNEX E: LIST AND COPY OF MATERIALS UTILIZED DURING ASSIGNMENT

E1:

STRENGTHENING QUALITY ASSURANCE
IN PRIMARY HEALTH CARE
IN THE PALESTINIAN HEALTH SECTOR

Implementation Plan

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Implementation Plan for Quality Assurance/Quality Improvement
Primary Health Care
Ministry of Health
Palestinian Health Sector

Introduction

This implementation plan represents the combined input of the Ministry of Health (MoH) and the Flagship Project and includes detailed planning on how to revitalize, implement and sustain a nationwide quality assurance and quality improvement (QA/QI) system overseen by the Ministry of Health to improve the quality of services provided in primary health care (PHC) facilities.

The MoH will take the leadership and ownership of this initiative through a commitment to rejuvenate the QA/QI program and to assure all necessary conditions to maintain the QA/QI system for both Primary and Secondary care in the Palestinian Health Sector. This document focuses on the Primary Care plan.

The USAID Flagship Project will perform a supporting role in the activities outlined in this document with major input in capacity building of and technical support for the implementers. It is intended to be a "living" document that will be amended to reflect on-the-ground lessons learned as training is completed and implementation begins. Refer to Appendix A for the overall QA/QI Strategy that provides the policy background for this implementation plan.

Actions Necessary from the MoH to Ensure Sustainability of the Quality Improvement System

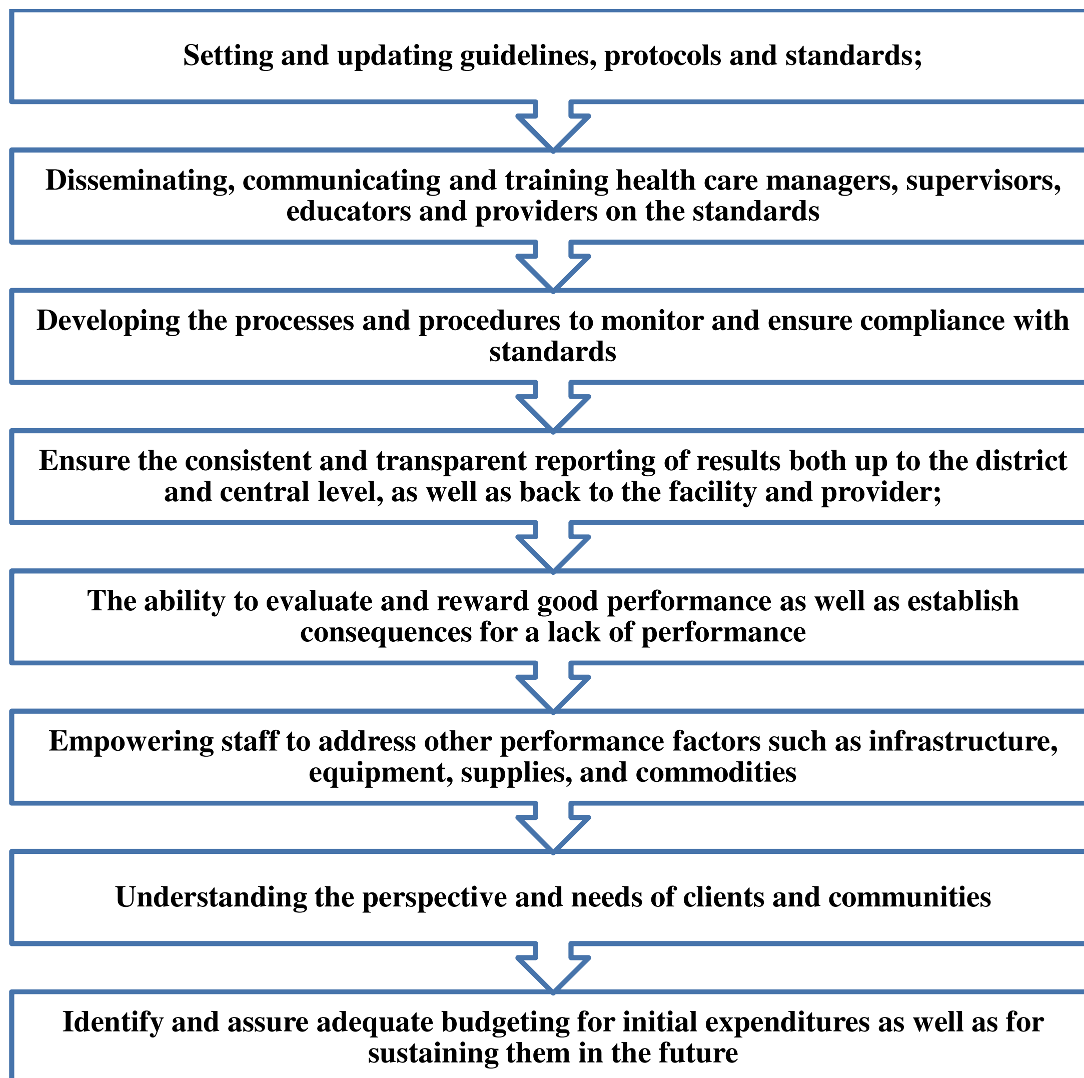
- Establishment of a "home" for QA/QI at the Central (MoH) level:
  - Initially, it will be necessary that 2 persons, currently in supervisory roles at the MoH, be assigned part-time as focal points for quality at the operational level within the Primary Health Care Directorate.
  - By the end of year three (October 2011) of the USAID Flagship Project, it is recommended that the structural and organizational issues regarding the location of the Department of Quality and Planning within the General Directorate for Planning and Health Policies within the MoH are addressed. This will entail revisiting the current structure as the health reform process progresses and making a decision as to the placement and terms of reference for this unit. If it is to be re-activated it will be necessary to assign appropriately-trained and empowered staff with clear terms of reference to be responsible for oversight, implementation and sustainability of the QA/QI program
  -
- Make provisions and allocate adequate resources and targeted funds to ensure implementation and sustainability of QA/QI processes.
- Support for the creation and functioning of the district level Quality Assurance/Quality Improvement Committees and staff to lead and support QA/QI processes at the district level.
- Continuous support for the data collection and monitoring of quality indicators in the new Health Information System (HIS).
- Participate in review and selection of QA/QI Coordinators using the criteria in this plan and participate in the QA/QI Coordinators' training.
- Incorporate QA\QI concepts and techniques\tools with supportive supervision culture and practices, as well as pre-service and Continuing Health Care Education curricula.

- Set up a mechanism to support incentives for QA/QI Coordinators to perform their role of maintaining the functionality of the established QA/QI mechanisms.

1. Systematic Sustainability

Implementing a nationwide quality assurance and quality improvement (QA/QI) program requires 1) high level commitment and ownership by the central (MoH) and district health directorate levels to support the implementation of a QA/QI process; 2) trained staff to implement the program; 3) developing sustainable and effective processes including the adoption of tools and techniques that monitor quality.

A systematic implementation approach includes the following steps:



Understanding the cross-cutting nature of quality assurance and quality improvement, the USAID Flagship Project has already worked with the MoH to identify key areas for strengthening quality of care in primary care. Multiple activities have been designed and are already being implemented in each of the above areas which will impact the delivery of quality services. As these activities are implemented, each area will be re-visited and further needs assessed and addressed.

1.1. Central Level Quality Assurance/Quality Improvement Department and Committees

The first step to ensure these systems are developed is to strengthen and re-invigorate the QA/QI Department within the MoH to oversee and manage the development and implementation of the different aspects of quality assurance and quality improvement. It is envisioned that QA/QI committees will be re-invigorated or established at three levels – one at the Central level within the Primary Healthcare Directorate; a QA/QI Committee for each district; and a QA/QI committee at each PHC facility. Implementation should be flexible to adapt to the local situation. As an example, Level IV PHCs might establish QA/QI committees with representatives from different departments whereas smaller PHCs could involve all staff on the QA/QI committee. Ideally, district level Quality Coordinators, which may be supervisors, should be responsible for supervising and supporting no more than 5 PHCs.

The central level QA/QI committee at the PHC General Directory level will take the leadership in:
(1) Establishing and maintaining standards of care;
(2) Systemizing and requiring transparent reporting mechanisms;
(3) Monitoring the compliance of providers and facilities according to the established standards;
(4) Developing a fair and equitable incentive scheme;
(5)Providing remedial actions when targets are not met;
(6) Ensuring that funds are available at the district and facility levels to enable implementation of these QA/QI processes.

The USAID/Flagship Project will support the MoH during the initial implementation phase of the QA/QI system but it is envisioned that in the long term the structures will become permanent and institutionalized within the MoH so that the QA/QI system becomes sustainable. Several activities related to instituting quality assurance and quality improvement have already been initiated or are in process within the MoH with assistance from the USAID Flagship Project. These include, but are not limited to, updating national standards for evidenced-based medicine, revising guidelines and training on infection control, and addressing laboratory quality assurance.

In discussion with senior MoH leadership for Primary Care, laboratory quality assurance was identified as an opportunity for a highly visible, focused, rapid and catalytic improvement in primary care. A meeting is planned for early November with laboratory specialists and the MoH leadership to explore opportunities to support the MoH to improve quality assurance in this technical area. Specific steps for implementing a laboratory QA plan will be identified during and after that meeting but will follow the general steps laid out below.

1.2. Immediate first steps and tasks for the MoH and Flagship (1-6 months)

1.2.1. Ministerial approval of QA/QI Primary Health Care Strategy and Implementation plan (Jan 2010)
1.2.2. Formal establishment of the QA/QI committee at PHC General Directorate level with recommendations for membership and responsibilities (Nov 2009).
1.2.3. Assess training needs and conduct initial workshop with QA/QI Committee at General Directorate to review QA/QI principles and finalize PHC QA/QI implementation plan. (Dec 2009)
1.2.4. Ministerial approval of QA/QI package including quality tools, processes and training curricula (April 2010).
1.2.5. Support district health departments in selected districts to establish a QA/QI Committees that will oversee and monitor the implementation of quality processes and address gaps through supervision and reporting of progress at the facility level.(Mar 2010)
1.2.6. Review and rationalize current reporting mechanisms to ensure they include data for quality monitoring and feedback.
1.2.7. Develop a process for continuous review and updating of clinical protocols and Job Aids according to evidence-based practices. (On-going and linked to Module 8)

1.2.8. Approve and assure dissemination and training on priority clinical protocols and job aids. (On-going and linked to Module 8)
1.2.9. Review and finalize 2 training curricula for QA/QI Coordinators and for PHC facilities' officers. (Jan-Mar 2010)
1.2.10. Study tour to Armenia for 6-8 Quality Coordinators and Flagship focal point for QA to observe QA/QI PHC implementation process. (Mar 2010)

1.3. Next steps (7-12 months)

1.3.1. Under the leadership of MoH QA/QI Coordinators conduct QA/QI trainings of PHC facility staff in Nablus district (April 2010)
1.3.2. Quality Coordinators provide technical support to PHC facility staff to implement QI tools through conduct of supportive visits to PHC facilities. (on going after April 2010)
1.3.3. Flagship provides technical support to Quality Coordinators during the facility training and supportive visits. (on-going)
1.3.4. Under MoH leadership, develop plan for rolling out to additional districts (Aug-Sept 2010)

2. Implementation Plan

2.1. Communication Plan

It is important for the Ministry of Health to communicate its intentions to make quality of care for all PHC facilities a priority for the Palestinian Health Sector. The following steps are recommended to be incorporated in the launch:

1) **National-level Launch** meeting to announce and describe the revitalization of QA/QI initiatives, including selected indicators and tools.
2) A written **communication** from the MoH to all PHC facilities describing the initiative and including clear expectations of all health staff on the importance of quality in health care service delivery.
3) A **poster** with an official Quality Statement should be hung in the entrance to all PHC facilities to communicate the initiative to patients and to highlight their role in quality by providing feedback.

2.2. Setting Standards by Revising/Updating and Ensuring Use of Protocols and Job Aids

It is recommended that the MoH establish sustainable mechanisms to ensure development and continuous updating of standards, guidelines and protocols for primary health care in the Palestinian Health Sector.

Although medical guidelines exist, there is a recognized need to update these and develop concise, easy-to-follow, step-by-step practical protocols/job aids for PHC providers to use on a daily basis in their practice. These will serve as a basis to monitor quality of care, specifically in reviewing medical records/cases for the management of common diseases and conditions that are managed at the primary care level. The USAID/Flagship Project is currently supporting the MoH in conducting a review and updating priority health protocols and job aids. The following protocols and job aids for PHC providers are currently under revision or development:

- Hypertension
- Diabetes Mellitus
- Basic Life Support
- Infection control
- Breast Cancer screening
- Integrated Management of Childhood Illness
- Referral and counter referral mechanisms

The MoH will assume the responsibility for approval of these clinical standards, protocols and job aids, as well as for future development, standardization, continuous updating, and clear communication and training to health care providers. Inclusion of clinical standards in postgraduate continuing health care education (CHCE) requirements will be important for the institutionalization of their use and this is also already integrated into the USAID Flagship implementation plan. In addition, it is recommended that a one hour introduction to QA/QI principles be incorporated, where possible, in other health care training courses so that the cross-cutting nature of QA/QI becomes well understood and accepted by all health care workers.

2.3. Training Strategy: District Level and PHC Facilities

The lead trainer/implementer from the District Directorate will be known as the **Quality Coordinator**. A job description for this position (please see Appendix B) includes responsibility for the following areas:

- On the job training for PHC facility level staff in quality and the use of QA/QI tools;
- Working on a regular basis with facility staff to solve performance gaps and mobilize resources, whether equipment, commodities, supplies or financial;
- Reviewing and interpreting data for tracking progress on quality performance indicators and reporting these data up the system as well as back to the facility level.

The District level Quality Coordinators will be drawn from qualified or recently trained district level staff who already have jobs within the District Directorate. The district level Quality Coordinator will create a QA/QI team with whom to coordinate their activities drawn from the relevant departments at the district level.

Preparation of the District level Quality Coordinators is planned to be 5 days in total divided in two stages. Stage 1 will be 3 days in length, focused on: 1) concept of quality, 2) indicators, 3) QI tools (Self-assessment), and development of an action plan and problem-solving process; and 4) supportive supervision. The 4th and 5th days will be an opportunity to practice the material learned in order to prepare the PHC facility representatives. Stage 2 of preparation of the Quality Coordinators will take place approximately 4 months later (following the preparation of PHC facility representatives from the larger facilities). Stage 2 training will be 2 days in length and will focus on two quality assurance tools: 1) the Medical Chart Review along with clinical job aids and 2) Patient satisfaction. Refer to Appendix C for an overview of the two-stage training plan to prepare Quality Coordinators. These trainings and tool development will build on and integrate the recently updated national clinical protocols and indicators for primary care, whether for infection control or clinical diagnostic and treatment guidelines.

The above training plan for district Quality Coordinators will be applied in the district of Nablus as part of the integrated approach initially and then be rolled out across all other districts in a phased manner in ensuing years.

At the PHC facility level, one Facility Quality Coordinator (Nurse) will be identified in addition to the facility director to be responsible for oversight, managing and supporting the QA/QI process at that facility. At Level IV facilities the quality coordinator will be a doctor or nurse and the team should be composed of a representative from medical records, infection control and morbidity tracking. At Level I-III centers, the quality coordinator will most likely be a nurse and the team could be composed of all other staff depending on the number of staff at that location.

The training of PHC QA/QI facility representatives will be provided through a two-stage training process which will be conducted at the district level. The training plan will enable all to be trained but will ensure that only one trained staff member is away from a facility at one time. The training will focus on overview of the quality assurance initiative, including formation a quality improvement committee at each facility and learning about QA/QI tools and procedures. Each training course will be provided by a 2-person Quality Coordinator team with support from the Flagship Project. In total, 14 such training courses will be provided

nationwide. The USAID/Flagship Project will provide technical support to QA/QI teams for these trainings. The training of PHC facility representatives will be provided with a two-stage approach for the following reasons: it will give staff a chance to return to their facility after the stage-1 training course, form the committee, and practice using the newly acquired QA/QI tools and skills, and approximately 4 months later to take the stage-2 training course on the remaining QA/QI tools and methods. Stage 1 of the facility training is 2 days and stage 2 is 1 day in duration. Refer to Appendix D for draft outlines of Stage 1 and Stage 2 PHC facility representative training.

2.4. On-site practical support to implementation of QI Tools

Following the PHC facility trainings district level Quality Coordinators (QC) will provide ongoing technical support to all trained PHC facilities: one QC will be responsible for supportive visits to 4-5 facilities. During these visits they will meet with the facility QA/QI committees, provide support, review the use of QI tools, action plans, and help to resolve performance gaps. These staff will also be provided ongoing technical assistance and capacity building as needed by the USAID/Flagship Project.

3. Phased Roll-out Plan

3.1. Phase 1 Roll-out (PHC Facilities in Nablus)

It is recommended that the rollout of QA/QI activities concentrate initially on the Nablus district integrated initiative. There are 9 PHC facilities that have been identified as part of this initiative. The table below shows the estimated numbers to be trained by districts in the West Bank. Based on the updated Primary Health Care facility data (see Table 1 below), the West Bank has a total of 356 PHC facilities serving ~63.4% of the population who access care from the public/government sector.

Table 1. Number of PHC Facilities and Participants to be prepared as Quality Coordinators/District Level

District	# of Level II & III facilities	*# of QCs*	# of Level IV facilities	*# of QCs*	Totals to be trained by District
Nablus	9		*2*		
District Total					

The detailed work plan with timeline for Phase-One QA/QI Implementation Activities is in Section 6 of this document.

3.2. Phase 2 Roll-out: (PHC facilities in remaining districts)

One of the challenges of rolling out the QA/QI process nationwide is the configuration of QA/QI committees in smaller facilities that do not have sufficient physicians, nurses or direct supervisors to conduct quality reviews. This proposal suggests the following possibilities:

(1) Create QA/QI committees at Level II and III clinics incorporating all staff, where possible. These committees would be led by a permanent staff member, either a midwife or nurse. The doctor/s assigned to that PHC would be expected to join the committee when it meets.

(2) District level QA/QI coordinators would supervise and assist with quality reviews in Level II and III facilities.

(3) Schedule quarterly QA/QI collaborative one-day meetings, bringing together key staff from several Level II and III facilities to review, analyze, and share their performance challenges and solutions with others from similar facilities. This strategy has worked in some settings and not in others and should therefore be evaluated for beneficial results.

The specifics of the Phase two roll-out and training plan will depend on key decisions being made on the above issues by the MoH. Once these decisions are made the detailed training and implementation plan can be developed.

4. Sustainability and Development

A combination of implementing mechanisms and partners' clear roles and responsibilities will ensure the successful implementation of the proposed QA/QI process nationwide.

4.1. Ministry of Health

The MoH will take the lead in this initiative by establishing a Quality Assurance Quality Improvement committee for Primary Care at the central level Primary Health Care General Directory and committing to advance the policy-level issues raised in section one of this plan. Practical first steps include: reviewing and approving QA/QI tools and protocols, and ensuring that this process is followed by having approval from the central level that requires facilities to adopt the QA/QI process and tools. In addition, the Ministry of Health will identify one or more individuals who can work closely with the USAID/Flagship Project during all phases of the implementation to ensure that knowledge and lessons learned during implementation remain and become institutionalized within the MoH once the USAID/Flagship Project ends. All training and capacity building activities will be conducted with the involvement and participation of the MoH national trainers and staff, and/or with support from the USAID/Flagship Project. The MoH will allocate adequate resources and targeted funds to PHC facilities to ensure implementation and sustainability of QA/QI processes.

The MoH will also assure recognition and rewarding of PHC facilities that meet the established quality criteria. It is proposed that the quality achievement of selected PHC facilities be awarded with a recognition plaque for documented quality improvement. The process of recognition is proposed to be in 2-stages- stage 1 for having in place certain structures and processes and stage 2 – achievement/improvement of key indicators. Facility recognition for key achievements in quality of services could also be incorporated into the longer-term accreditation process.

4.2. District Health Departments

District Health Departments will be active in the process by creating district-level QA/QI committees and monitoring the QA/QI progress in their districts.

The active participation of the district health departments is required in the following areas:

1) Name prospective candidates; participate in selection and identifying qualified persons to serve as District Quality Coordinators,
2) Organize trainings at facilities in their district,
3) participate in review of data related to performance indicators,
4) Facilitate and track improvements in the indicators at each facility,
5) foster involvement of doctors and/or nurses as supportive supervisors to the QA/QI committees,
6) Provide feedback and be responsive to QA/QI committees when issues need to be resolved and when data are reported on a quarterly, semi-annual, or annual basis.

4.3. District Supervisors and Quality Coordinators

It is recommended that District Supervisors be among those individuals nominated to be trained as District level Quality Coordinators. They will be prepared to accomplish tasks according to the Job Description (see Appendix B) Facility Level Quality Assurance Quality Improvement Committees

Quality Assurance Quality Improvement Committees will be the key implementers of this activity and will be based and created in all Level IV PHC facilities. The Ministry of Health will establish a detailed description of the role and responsibilities of the QA/QI committees. The MoH will consider and make decisions on options for QA/QI structure in Level I-III facilities which will guide the phase two rollout plan.

4.4. Health Care Providers

Individual physicians, nurses and health workers are the frontline for this process and will require training and support in order to participate fully in the QA/QI process. Their training and support to implement the quality tools and approaches will primarily come from the Quality Coordinators. However, they will require individual training in the use of the QA/QI tools as well as new clinical protocols/job aids. The detailed nationwide training plan will be developed at a later stage.

4.5. USAID/Flagship Project

The USAID/Flagship Project will perform a supporting role in the activities outlined in this document with major responsibility and input as follows:

1. Develop two training curricula: a) to prepare Quality Coordinators and b) to train PHC facility representatives.
2. Provide technical support to the central and district QA/QI committees to be functional and implement their roles and responsibilities outlined in the approved regulations;
3. Prepare the Quality Coordinators,
4. Support the Quality Coordinators to train the PHC facility staff to use QI tools and resolve performance gaps, and
5. Support PHC facilities to review data collected at facility level in relation to performance indicators and develop key strategies to improve facility level performance.

5. Quality Tools and Monitoring Process

Through the process and activities described in this implementation plan, the Ministry of Health will establish uniform key indicators and standards for quality of care, QA/QI techniques and tools as a basis for the QA/QI initiative with support from the USAID/Flagship Project. The key indicators to monitor will be drawn from the priority health conditions managed at Level II-IV health facilities and will be based on the MoH Essential Package of Services. In order for the QI process to become sustainable, it will be necessary for the MoH to review and allocate targeted funds into PHC budgets to implement and sustain the QI process.

5.1. Roll-out Training for QA/QI Implementation in Remaining PHC Facilities

The detailed training plans and selection of priority PHC facilities will be developed in discussion with the MoH. It is envisaged that 2-3 staff from facilities will attend a district level two-day training that covers QA/QI tools/methods selected for the 1st stage of implementation (e.g. formation of facility QA/QI committees, conducting committee meetings, review of Quality Indicators and Self-assessment). Each training will be provided by a 2-person Quality Coordinator team. The USAID/Flagship Project will provide technical support to Quality Coordinator teams for 1 training for each team.

Following the above training there will be additional one-day trainings (Stage-2) of PHC facility staff (the same facilities as above) to review their experience with quality tools and "lessons learned" from Stage-1. Quality Coordinators then will introduce the remaining QI tools/methods: medical chart/case review with job aids and patient satisfaction feedback. Each training will be conducted by a 2-person Quality Coordinator team. USAID Flagship staff will provide technical support to QC teams as they train PHC staff.

5.2. Planning for Supportive Visits to Remaining PHC Facilities

Following the Stage-1 trainings Quality Coordinators will provide ongoing technical support to all stage-1 trained PHC facilities: one QC will be responsible for supportive visits to 4-5 facilities. During these visits

they will meet with the newly formed facility quality committees, provide support, review completed self-assessment questionnaires, action plans, and help to resolve performance gaps at facilities. In the 1st month QCs will visit each facility twice (1visit every 2 weeks), and the 2nd and 3rd months – once per month. Flagship staff will participate in 1-2 mentoring visits together with the Quality Coordinators and provide them support as needed.

5.3. Roll-out Supportive Visits to Phase 2 PHC Facilities

Following the Phase-2 trainings QCs will continue ongoing technical support to all Stage-2 trained PHC facilities through supportive visits: one QC will be responsible for supportive visits to 4-5 facilities. During these visits they will provide support, review Medical Charts/Cases with Job Aids and patient satisfaction feedback, action plans, and help to resolve performance gaps at facilities. In the 1st month QCs will visit each facility twice (1 visit every 2 weeks), and the 2nd and 3rd months – once per month. USAID Flagship staff will participate in 1-2 mentoring visits together with the Quality Coordinators and provide them support as needed.

5.4. After September 2010 Nablus district PHC facilities work independently:

Nablus district PHCs implement and assure routine use of QA/QI tools and techniques within the facilities by engaging their staff, using their own capacity and resources. USAID Flagship Project team and District Quality Coordinators will provide technical assistance (consultation, advice, clarification) on an “as needed” basis.

5.5. Monitoring and Evaluation of Phase 1 QA/QI implementation

The data collection Tool for M&E of Quality Assurance will be developed in conjunction with the MoH with support from USAID/Flagship Project and STTA.

Focus of M&E Visits	**Purpose: review and evaluate use of QA/QI tool, meet with facility QA/QI committees and provide support.**	**Respon-sible: Quality Coordi-nators**	**May 2010**				**June 2010**				**July 2010**				**Aug 2010**				**Sept 2010**			
			Weeks				***Weeks***				***Weeks***				***Weeks***				***Weeks***			
M&E visits Nablus PHCs	9 PHC facilities	District QC and Flagship staff		Lvl IV	Grp 1			**Lvl IV**	Grp 2			**Lvl IV**	Grp 3			**Lvl IV**	**Grp 1**			**Lvl IV**	Grp 2	Grp 3

Group 1:
Group 2:
Group 3:

The detailed M&E plan for following up in all other districts after Phase two training will be developed based on the experience in Nablus and in coordination with the MoH.

Appendix A: QA/QI Strategic Plan: STRENGTHENING QUALITY ASSURANCE: OVERVIEW AND STRATEGY FOR THE PALESTINIAN HEALTH SECTOR

Definition and Dimensions of Quality

Quality assurance and improvement in healthcare include all the actions taken to make healthcare better.[1] It is based on the quality management principle that the process for improvement involves identifying gaps or shortcomings in actual service delivery or as perceived by clients, understanding the reasons for these gaps, designing interventions to address the gaps and determining whether quality improvement was achieved. Quality improvement integrates the content of care and the process of providing care. Although either could be addressed separately, both must be addressed to achieve optimal quality improvement. Improvement requires change but not every change is an improvement therefore changes must be studied and tested to be sure that the change achieved is an improvement.

The dimensions of quality[2]require that healthcare be:

- ***Effective,*** delivering health care that results in improved health outcomes for individuals and communities;
- ***Efficient,*** maximizing resource use;
- ***Accessible,*** delivering health care that is within reasonable geographic reach and available when needed;
- ***Acceptable and patient-centered*** taking into consideration preferences and cultures;
- ***Equitable,*** delivering health care that is of equal quality for all;
- ***Safe,*** minimizing risk and harm.

The following core principles for successful quality improvement are distilled from the global experience of implementing quality assurance and quality improvement:

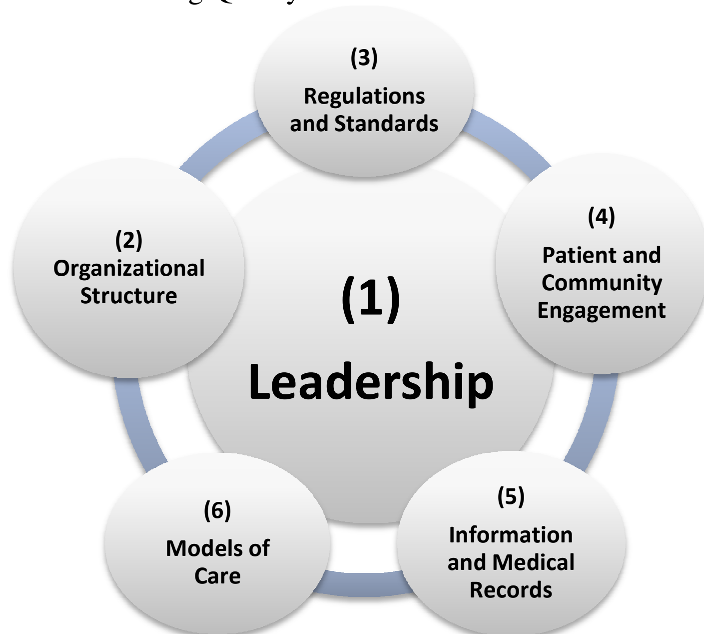
1) Organizational leadership commitment to the process
2) Client focus - services should be designed to meet the needs and expectations of clients
3) Use of evidenced-based standards to guide clinical practice
4) Health care processes and systems must be understood in order to improve them. The steps to clarifying the processes include:
    a. Conduct situation analysis
    b. Clear definition of the gap or problem
    c. Identify and choose realistic, feasible interventions
    d. Implement the interventions
    e. Monitor to track change/improvement over time
5) Teamwork is essential – a single individual cannot maintain and sustain systemic changes
6) Plan for sustainability and institutionalization of a QI process

The above steps follow a familiar, iterative public health planning process which begins with identifying and involving key stakeholders who will take ownership and propel the process, followed by situational

[1] *A Modern Paradigm for Improving the Quality of Healthcare*. The Quality Assurance Project. USAID. 2004. www.qap.org.
[2] WHO, 2006.

analysis; clear goal and/or gap identification; developing and implementing interventions; followed by monitoring and adjusting plans dependent on the findings and outcomes. The cycle can be simplified further to four steps of Plan, Do, Study, Act and repeat. The cycle can be applied at each level of the healthcare delivery system from primary care to hospital, medical center and national level with variations specific to the context.

The framework below (Diagram 1) can also be used as a guide for considering the different domains for introducing quality interventions and is intended as a simple prompt for decision-makers. It highlights the important role of committed leadership to effective implementation. The domains are as follows:
Diagram 1. Domains affecting Quality of Care



Over the last few decades, a wealth of research, knowledge and experience in assuring and enhancing the quality of health care has accumulated globally. In spite of this, the problem frequently faced by policy-makers everywhere is to know which strategies – complemented by and integrated with existing initiatives – will have the greatest impact on the health outcomes delivered by their health systems.[3] The rationale for consciously addressing quality from a health systems perspective is best summarized in a quotation from an Institute of Medicine (USA) report: "As medical science and technology has advanced at a rapid pace, the health care delivery system has floundered in its ability to provide consistently high quality care to all."[4]

The main arguments for promoting a focus on quality in health systems are:

- Quality remains a serious concern as evident by failure to achieve expected outcomes and by the wide variations in standards of health-care delivery within and between health-care systems even where health systems are well developed and resourced.
- The need to optimize resource use and expand population coverage particularly in developing countries.
- The process of improvement and scaling up needs to be based on sound local strategies for quality so that the best possible results are achieved from new investment.
- Integration of evidenced-based medicine and quality improvement has been tested in many countries and proven effective.

[3] *Quality of care: a process for making strategic choices in health systems*. World Health Organization, Geneva, Switzerland. 2006.
[4] *Crossing the Quality Chasm: A New Health System for the 21st Century*. Committee on Quality of Health Care in America, Institute of Medicine. Washington, DC, USA: National Academies Press; 2001

- A simple quality improvement methodology is the most effective and sustainable for most contexts.

However, increased know-how and resources do not automatically produce better quality of care or health outcomes. Adopting a systems approach to implementing high quality health care and health care service delivery is fundamental to achieving improved outcomes and meeting the expectations of clients. The over arching goal of the USAID Flagship Project is to assist the Palestinian Health Sector to achieve integrated health systems reform that will result in high quality health services provided to its people. Instituting a system of quality assurance is therefore fundamental and integral to the reform process.

Background of Quality Assurance and Quality Improvement in the Palestinian Health Sector
The subject of quality assurance is not new to the Ministry of Health. The first national effort toward quality improvement of health services in Palestine dates back to 1994 when the Palestinian Health Council established a central unit for quality improvement.

Those efforts were focused on understanding the concept of quality in health care and its influence on the well-being of the population. In 1996 the Ministry started implementation of quality improvement through the Health System Development Project (HSDP) funded by the World Bank to build national capacity in quality improvement. The first phase of the project focused on training of key team members on total quality management, improved team work, as well as prioritizing improvement processes in several primary and secondary health care facilities in both the West Bank and Gaza Strip. During the second phase of the project, many initiatives and improvement priorities were tackled including the production of nine diagnostic and management clinical guidelines for chronic diseases, training health professionals on drug rationalization, and diabetic protocols implementation. Standard operational procedures (SOPs) were drafted for primary health care interventions as well as for laboratory and clinical procedures. The drug interaction directory for doctors and pharmacists was also developed.

In 2005, as part of the MoH effort to institutionalize quality improvement, a ministerial decision was taken to establish a quality improvement department within the Policy and Planning Division. The quality improvement department then took the initiative to reinvigorate quality improvement processes and to disseminate lessons learned and exchange experiences and achievements in the following PHC and secondary health care (SHC) areas:

- Improve referral system between PHC and SHC
- Develop outpatient clinic operational protocols
- Develop surgical department operational protocols
- Develop clinical protocols from the guidelines and train health professionals in both primary and secondary health care.

A major outstanding challenge is to introduce nationwide quality standards for accrediting all health facilities and establishing re-licensure and continuing education requirements for all cadres of health personnel in the public and private sector. There are also challenges in the training and preparation of technical personnel to lead improvement processes and to build the capacity of health personnel in a range of managerial and technical areas to adopt quality improvement as an underlying approach to all healthcare delivery.

In addition to the quality assurance and quality improvement efforts described above, several other donor programs have focused on delivering quality services including USAID funded projects in the late 90's through 2008. These efforts primarily focused on primary care.

The MoH Institutional Development Plan, 2008-2010 identifies "Improve performance management" as a priority area. Module 12 of the 2011-2013 Institutional Development Plan focuses on improving the quality of clinical services in the Palestinian MoH Hospital System, linking this activity to multiple other modules demonstrating the integration and cross-cutting nature of quality assurance and quality improvement.

The Ministry of Health (MoH) has expressed a high level of political will, support, and enthusiasm for the goals and quality assurance approaches designed within the USAID Flagship Project (Palestinian Health Sector Reform and Development Project). The MoH recognizes the importance of building on past experience and continuing this important initiative and also experiences public pressure to continue to improve and strengthen the quality of primary and secondary care services. This convergence of political wills, donor funding and client expectation provides a prime opportunity and context to move this initiative forward.

This proposed implementation plan calls for strengthening quality assurance in primary and secondary care and have been drafted based on several widely accepted guidance in the health literature including the WHO publication, *Quality of care: a process for making strategic choices in health systems, 2006, and the following USAID project documents: A Modern Paradigm for Improving Healthcare Quality, and Stages, Steps and Tools for Performance Improvement*[5]**.**

The goal is to provide a basis for discussion to assist decision-makers and managers within the Palestinian Health Sector as a regulatory body and major provider of healthcare services to adopt a systematic process which will allow the design and implementation of simple yet effective and sustainable interventions to promote quality in healthcare management and service provision.
The focus on quality assurance and quality improvement is cross-cutting and underlies many of the stated priority areas of the Palestinian health reform process as identified with the Ministry of Health in conjunction with the USAID Flagship Project in the list below (from the MoH Institutional Development Plan, 2011-2013). See also Appendix A for complete list of Modules.

Module 2 – Health Information system (and medical records management)
Module 8 – Strengthening service delivery and clinical guidelines
Module 11 – Improve clinical primary care system
Module 12 – Improve the quality of clinical services in the Palestinian MoH hospital system
Module 17 – Improve medical waste management and infection control program

The following modules are also related indirectly to ensuring quality.

Module 3 – Health Insurance Program, relates to equity and access
Module 5 – Licensure program for health professionals, relates to ensuring appropriate qualifications and maintaining technical competence to deliver quality services
Module 6 – Health Facility Accreditation program- ensures that facilities and staff meet quality criteria to remain open to provide services
Module 10 – Commodity procurement – ensures that healthcare providers have the required equipment, drugs and supplies to be able to provide care.
Module 15 – High quality administration and management are key components to ensuring quality of services

The MoH has established a Department of Quality Planning within the General Directorate for Planning and Health Policies. Three staff positions were created within this unit; the director, performance and monitoring and evaluation officer, service provision improvement officer and management improvement officer. However, none of these positions are currently filled. Under the Primary Health Care General Directorate and the Hospitals General Directorate, quality development officer positions have been created but not filled. In addition, at the provincial level, quality development committees were established. It is unclear whether these function currently.

The Palestinian Health System Assessment Report identifies multiple opportunities for strengthening and improving health care delivery which are being addressed by the MoH with the support of the USAID Flagship Project. These include but are not limited to:

- Standardized administrative, operational and clinical guidelines and protocols

[5] *Performance Improvement: Stages, Steps and Tools*. The Prime II Project, USAID. 2005. www.prime2.org/sst

- Establish mechanisms to receive and process feedback from patients about the care they receive, including exit interviews and mystery patients
- Strengthen referral, counter-referral and discharge systems to ensure follow-up
- Installation of medical waste management systems
- Ensure effective infection control practices
- Installation of a health information system to improve management of patient records, appointments, aggregation and analysis of data, communication, HR financial management and procurement.

Proposed Strategy:
This draft implementation plan proposes a three-pronged and phased approach to addressing quality improvement in health care service delivery for the Palestinian Health Sector. The goal is to achieve an effective, straightforward and sustainable institutionalized system that has the support and commitment of healthcare workers at every level as well as the communities they serve. The three levels for consideration are:

1) Policy and Planning at the national level
2) Secondary Care level
3) Primary Care level

The implementation of quality assurance and performance improvement depend on the availability of standards, guidelines and protocols as well as addressing the underlying reasons why health workers practice or are unable to adhere to these guidelines. The USAID Flagship project is currently supporting the MoH to review, update and provide training on most clinical guidelines and protocols. It is strongly recommended that, where possible, a short module (one hour overview) on quality assurance and quality improvement principles be integrated into trainings on these guidelines and protocols to take advantage of all opportunities to highlight the cross-cutting nature of quality improvement and to institutionalize the concept.

This plan recommends that the quality assurance strategy at the primary and secondary care level be implemented first in the integrated sites in Nablus in phase one. During this phase the QA/QI teams will be established and the training materials developed and rolled out in 9 primary care sites and two hospitals. As lessons are learned through implementation in the Nablus integrated sites, the curriculum and process will be refined and rolled-out in a phased manner across the remaining districts in close coordination with priorities established by the MoH.

In discussion with MoH leadership, laboratory quality assurance for primary care settings was also identified as a priority area as well as one in which there is high level commitment to achieve change. Working with the MoH in this area initially to address the identified gaps and implement improvements could be an opportunity to demonstrate what can be accomplished. Specific technical assistance to address laboratory quality assurance systems may be needed to support the MoH in this process.

Policy and Planning Level:
Although the Department of Quality and Planning exists within the MoH, the current location of this Department within the MoH organizational structure may not provide the necessary authority over the secondary and primary care service delivery directorates. In this situation, the MoH has several options, identified as follows:

1) Elevate the Department of Quality and Planning in the organizational structure so that it is able to function with the required authority.

2) Maintain the current structure and focus on strengthening the quality development staff within the General Directorates for Primary and Secondary care and also at the provincial level with the long term goal of transferring key trained staff over to the Department of Quality and Planning.

3) Maintain the current structure and focus on strengthening the quality development staff within the General Directorates for primary and secondary care and also at the provincial level. Develop the Department of Quality and Planning as a unit with responsibility for policies and regulations for service provision and ensuring high quality management practices.

Given the complexity of changing the organizational structure and location of the Quality Department within the MoH, the recommendation is to begin activities by re-activating and re-energizing the quality focal persons within the directorates for primary and secondary care. A systematic team problem-solving approach is recommended. As these persons' capacity for ensuring quality service delivery and health worker performance improvement is built, a cadre of trained staff will become available. The MoH can decide at that point whether to re-invigorate the Department of Quality and Planning with some of these trained personnel.

Because quality assurance and performance improvement of health workers is cross-cutting and affected by so many factors, such as clear national guidelines and protocols, functioning infrastructure, medical records and health information systems, availability of commodities and supplies, waste management and infection control, staffing levels and motivational factors, the Quality Assurance team at the General Directorate level should ideally be composed of one focal person from each of the following modules, if possible:

Module 2 – Health Information system (and medical records management)
Module 8 – Strengthening service delivery and clinical guidelines
Module 11 – Improve clinical primary care system
Module 12 – Improve the quality of clinical services in the Palestinian MoH hospital system
Module 17 – Improve medical waste management and infection control program
Module 18- Introduce and implement a comprehensive M&E approach and system

Ideally, this structure should be mirrored at the provincial level with smaller teams at the hospital level and a smaller more feasible team structure for primary care which will depend on the specific situation and size of institution.

Two draft documents accompany this document for discussion and finalization with key leadership within the MoH:

- Draft/Strengthening Quality Assurance in Secondary Care in the Palestinian Health Sector, Implementation Plan

- Draft/Strengthening Quality Assurance in Primary Care in the Palestinian Health Sector, Implementation Plan

Appendix B. Modules for Palestinian Health Sector Reform Process

Module No.	USAID Flagship Project Module subject	Linkages with NHS sub objectives
1	Create a center of excellence at the Palestine Medical Complex	Strategic Objectives: 1.9, 3.2, 3.3, and 4.2.
2	Develop a health information system	Strategic Objective 1.10, 2.3, 5.3, and 5.4.
4	Design and implement a continuous education program for health professionals	Strategic Objective: 4.3
5	Create and implement a relicensing system for health professionals	Strategic Objective 5.2.
6	Design and implement a health facility accreditation program	Strategic Objective 5.2.
7	Improve performance management	Strategic Objectives 2.1, 2.3, 4.1, 4.2, 4.5, 5.1, 5.2, and 5.6.
8	Strengthen service delivery and clinical guidelines	1.4, 1.7, 4.1, and 5.3.
11	Improve clinical MoH primary care system	Strategic Objectives: 1.4, 1.7, 1.9, and 3.1.
12	Improve the quality of clinical services in the Palestinian MoH hospital system	Strategic Objectives: 1.7, 1.9, 3.2, and 5.6.
13	Improve health communications services	Strategic Objectives 1.1, 1.2, 1.3, 1.4, and 1.5.
14	Support MoH emergency departments and emergency preparedness	Strategic Objectives: 1.10, 3.3, 4.6, 5.3, and 5.7.
15	Training and fellowship program in health administration and management for the public sector	Strategic Objectives: 4.1 and 4.2.
16	Improve community-based health services	Strategic Objectives 1.1 and 1.2.
18	Introduce and implement a comprehensive M&E approach and system	Strategic Objectives 4.1, 5.2, and 5.4.

Appendix C. Scope of work / Job description for Quality Coordinators

JOB DESCRIPTION

Title: Quality Coordinator (QC)
Geographic Location: Health District Level, Palestinian Health Sector

PRIMARY RESPONSIBILITES

The Quality Coordinator is responsible for providing district level ongoing technical support to effective implementation of the Primary Health Care (PHC) Quality Assurance and Quality Improvement (QA/QI) systems in PHC facilities. The major areas of his/her responsibility include: 1) training PHC facility staff for the use of QA/QI tools; 2) working on a regular basis with facility staff to implement QA/QI tools and to solve quality performance issues; 3) reviewing of M&E data for tracking progress on quality indicators.

SUPERVISOR: This position is accountable to the Ministry of Health Primary Health Care General Directorate Quality Coordinator and will work with the technical assistance of the USAID/Flagship Project Quality Assurance Officer.

ESSENTIAL FUNCTIONS

- Work with MoH Primary Health Care General Directory Quality Coordinator/team, USAID/Flagship, district health authorities and PHC facilities; provide technical and administrative assistance to ensure the implementation and sustainability of quality assurance plans at the district level PHC facilities.
- Organize and ensure the implementation of activities for quality assurance in PHC facilities, including QA/QI training courses and supportive visits.
- Conduct district level training (2 rounds of 1-day QI courses) for the assigned PHC facilities to prepare facility staff to implement the QI tools and methods and resolve quality gaps.
- Following each round of facility trainings provide ongoing technical support to the trained PHC facilities through supportive visits: meet with the staff, provide the needed support, review completed QA/QI tools and action plans, and help to resolve quality issues at facilities.
- Conduct “lessons learned” discussions to review experiences of PHC facilities with implementation of quality tools and methods; obtain feedback and suggest revisions if needed.
- Organize and ensure the monitoring and evaluation activities for PHC QA/QI implementation in the assigned PHC facilities, including M&E visits, data gathering, analysis and reporting.
- Establish effective communication and provide feedback to key stakeholders for identifying needs and addressing challenges in support of QI activities.
- Other functions as defined by the service contract.

EDUCATION AND EXPERIENCE

- A Master’s degree in medicine, Public Health or Health Management.
- Five or more years of clinical and/or healthcare administration/supervision experience in the field of primary health care.
- Demonstrated skills/ experience in training/teaching and/or supporting training.
- Availability and readiness (willingness) to assume additional responsibilities (functions, time, workload) in addition to the tasks that he/she is currently performing.

- Interest in the subject area of quality of care and quality improvement
- Good interpersonal and organizational skills.
- Good oral and written communication skills
- Ability to work and effectively communicate with a variety of people
- Ability to travel regularly outside his/her work/residence place.
- Knowledge of the structure of and major reforms in PHC system of the Palestinian Health Sector.
- Computer skills (MS Word, Excel, Power Point, internet) is an asset.
- Excellent Arabic. Knowledge of English is an asset.

WORKING CONDITIONS

- USAID/Flagship Project will assume responsibility for training/preparation of Quality Coordinators and providing technical support to Quality Coordinators as the implementation process is rolled out in PHC facilities.

Appendix D. Suggested Schedules for Training of Quality Coordinators to Use the QA/QI Package and Prepare PHC Facility Staff

Schedule for Stage-1 four-day Training of Quality Coordinators

Day 1 **9:00- 4:30 PM**	**Day 2** **9:00 AM- 4:15 PM**	**Day 3** **9:00 -4:00 PM**	**Day 4 (Practice Training for PHC Facility Reps)** **9:00 -4:00 PM**
Registration and pre-test: 9:00 ***Session 1***. Creating a Learning Environment: Introductions, Hopes and Concerns; Review of Schedule & Learning Objectives; participant materials (60 min) ***Session 2***. Why Is Quality Important in Primary Health Care? (40 minutes) **Break (15 min)** ***Session 3***. Implementing QI – Role of QIB. Introduction of Section I (QI Strategy) and Section II (QIBs) of QI Package. (55 min) ***Session 4***: PHC Quality Indicators – What are they and why important. (Section III of the QI Package). How the 6 indicators are calculated and reported. (75 min)	***Session 7***. Opening Circle (15 min) ***Session 8***. Problem solving process: Root Cause Analysis: *Reviewing the 5 Whys* (45 min) ***Session 9***. Problem solving process: *Fishbone Diagram* (45 min) **Break (15 min)** ***Session 10*** Problem solving process: *Classifying and Prioritizing Problems* (45 min) ***Session 11*** Developing Action Plan for PHC Facility/QI committees (60 min)	***Session 14:*** Opening Circle (15min) ***Session 15:*** Applying Tools in a PHC facility: *Working Together to Improve Quality* (100 min) **Break (15 min)** ***Session 16:*** Overview of 1-st stage PHC facility Training: *Planning and assignment of responsibilities for day 4* (60 min) ***Session 17:*** *Post-Test*	***Session 19:*** Practice training of QI tools & Procedures to be delivered by QCs: **Purpose**: Practice of Stage-1 training curriculum for PHC facilities: The assigned QCs introduce the following Stage-1 sessions to the rest of their colleagues in the group. ***Session 19.1*****:** Creating a Learning Environment: (30 min.). **Session 19.2** Why is Quality Important in PHC and Introduce PHC QI Strategy (30 min.) 60 ***Session 19.3*****:** Forming & Working with QIB (30 min.) Break: 15 minutes ***Session 19.4*****:** Performance Indicators (45 min.) 60 ***Session 19.5*****:** How to improve quality using Self-Assessment Questionnaire (90 min.) 135
Lunch (1:00 –1:45)	**Lunch (12:45 1:30)**	**Lunch (1:00 –1:45)**	**Lunch (1:00 –1:45)**
Session 5. QI Tool: Quality Self-Assessment Tool: Discussion of Dimensions of Quality, the structure and questions about the tool (1 hr.) **Break (15 min)** ***Session 6***. Practicing (completing and scoring) the Self-Assessment Tool (90 min)	***Session 12***. Traditional versus Supportive Supervision. (60 min) **Break (15 min)** ***Session 13:*** Roles/Responsibilities of Quality Coordinators and Effective Communication skills. (90 min)	***Session 18: In-class preparation for the next day practice of Stage-1 training of PHC facility representatives:*** - ***Participants work individually on their sessions.*** - ***Trainers are available to provide needed assistance, answer questions etc.*** (135 min)	***Session 19.6*****:** Problem solving process: *Root Cause Analysis (5 Whys), Fishbone Diagram, Classifying and Prioritizing Problems* (30 min.) 90 ***Session 19.7*****:** How to develop an action plan to resolve performance gaps (45 min.) 60 ***Session 19.8*****:** Practice leading QI committee meeting with PHC facility staff (45min.) 100 *Evaluation- Closing Circle* (15 min).

Schedule for Stage-2 two-day Training of Quality Coordinators

Day 1 **9:00- 4:00 PM**	**Day 2** **9:00 AM-3:30 PM**
Registration: 9:00 Review: Learnings from Stage 1 Trainings and Practice with PHC Facility Teams (60 minutes) ***Session 1A***. QI Tool: Medical Chart (MCR) /Case Review Introduction of MCR procedure, checklist, Job Aids, recording and reporting forms. (90 min) **Break (15 min)** ***Session 1B***. Practice MCR (90 min)	***Session 4***. Opening Circle (15 min) ***Session 5***.Practice training of QI tools & Procedures to be delivered by QCs: **Purpose**: Practice of Stage-2 one-day training curriculum for PHC facilities: The assigned QCs introduce the following Stage-2 sessions to the rest of their colleagues in the group. ***Session 5.1***. Medical Chart review and Job Aids (180 min)
Lunch (1:15 –2:00)	**Lunch (1:00 –1:45)**
Session 2A. QI Tool: Patient Satisfaction Feedback*:* (30 min) **Session 2B.** Practice Patient Satisfaction Tools (45 minutes) **Session 3**. Preparing to Practice Stage 2 Training: *Planning and assignment of responsibilities for the next day* (45 min)	***Session 5.2:*** Patient Satisfaction Feedback (90 minutes) *Evaluation- Closing Circle* (15 min).

Appendix E. Schedules for Stage-1 and Stage-2 Training of PHC facility staff by Quality Coordinators

<u>Stage-1</u> **two-day training of PHC facility staff**	
Day 1 9:00- 4:00 PM	**Day 2 9:00 AM- 4:00 PM**
Purpose: to prepare PHC facility representatives to introduce concept of quality, QIBs, quality indicators, Self-assessment tool and the overall problem-solving at their facility. **Registration and pre-test**: 9:00 ***Session 1:*** Creating a Learning Environment (45 min.) ***Session 2*****:** Why is quality important in PHC and introduce PHC QI Strategy (60 min.) **Break (15 min)** ***Session 3:*** Forming & Working with QIB (30 min.) ***Session 4:*** Performance Indicators: *How the 6 Indicators are calculated and reported* (60 min.)	***Session 6.*** Opening Circle (15 min.) ***Session 7:*** Problem solving process: *Root Cause Analysis (5 Whys), Fishbone Diagram, Classifying and Prioritizing Problems* (90 min.) **Break (15 min)** ***Session 8:*** How to develop an action plan to resolve performance gaps (120 min.)
Lunch (1:00–1:45)	**Lunch (1:00–1:45)**
Session 5: How to improve quality using Self-Assessment tool: *practice the self-assessment questionnaire and scoring* (135 min.)	***Session 9:*** Leading QIB meeting with PHC facility staff and to work with Quality Coordinators to resolve performance gaps (120 min.) ***Session 10:*** *Closing Circle (*15 min).

<u>Stage-2</u> **one-day training of PHC facility staff**
9:00 AM- 4:00 PM
Purpose: to prepare facility PHC representatives to introduce Medical Chart /Case Review and Patient Satisfaction Feedback tools at their facility. **Registration** 9:00 ***Session 1:*** Opening Circle to review: Learnings from Stage-1 work on quality at facilities. (60 minutes) ***Session 2A***. QI Tool: Medical Chart /Case Review (MCR). *Introduction of MCR procedure, checklist, Job Aids, recording and reporting forms.* (90 min) **Break (15 min)** ***Session 2B***. Practice MCR (90 min)
Lunch (1:00-1:45)
Session 3A. QI Tool: Patient Satisfaction Tools (30 min) ***Session 3B.*** Practice Patient Satisfaction Tools (45 minutes) ***Session 4***. Practice leading Facility board meeting with 2 new QI tools (60 minutes) ***Session 5***. *Closing Circle* (15 min)

E2:

STRENGTHENING QUALITY ASSURANCE IN SECONDARY CARE IN THE PALESTINIAN HEALTH SECTOR

Implementation Plan

October 2009

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