AfIHQSA's

Model of Building Quality Resilient Health Facilities:

Strengthening Facility Health Systems for Quality Resilience

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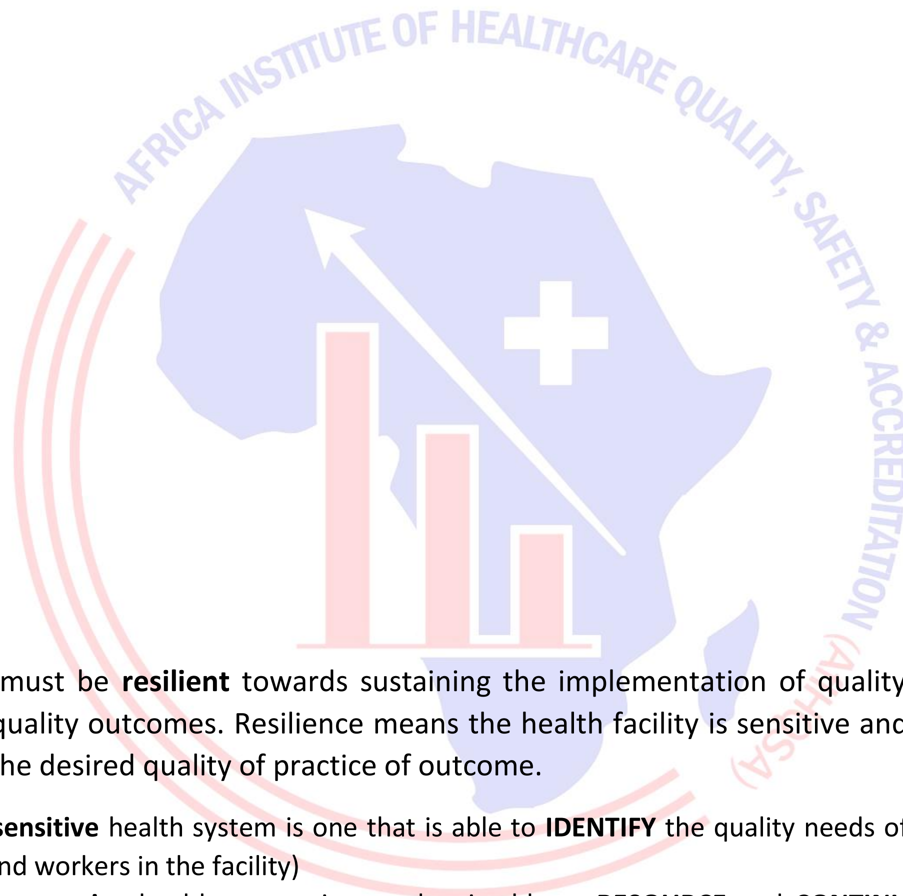

Introduction

A health facility must be **resilient** towards sustaining the implementation of quality practices and achievement of quality outcomes. Resilience means the health facility is sensitive and responsive to deviations from the desired quality of practice of outcome.

1. A **quality-sensitive** health system is one that is able to **IDENTIFY** the quality needs of the population (users of and workers in the facility)
2. **A quality-responsive** health system is one that is able to **RESOURCE** and **CONTINUOUSLY** execute quality improvement practices carried out in the facility

These two attributes of sensitivity and responsiveness are mutually reinforcing. An increasingly quality-sensitive health system becomes increasingly quality-responsive and the reverse is true as well.

The health system

A system is perfectly designed to produce the results it does

The health facility is recognised to have nine (9) health systems building blocks (WHO AFRO) each has to be designed to support the provision of quality within its mandate.

Table 1: The functions and outcomes of the nine (9) health systems building blocks

HSB	Functions	Outcomes
Leadership and Governance	Stewardship, setting health system performance goals, developing strategic plans and managing operations and resources in line with regulatory frameworks.	Accountability, transparency, efficiency, effectiveness and synergy amongst the health system building blocks towards the achievement of health system performance goals.
Human Resources	Planning, managing and utilizing the numbers, quality and distribution of health staff.	Required health workforce to deliver quality health services is available, motivated, satisfied and functional.
Service Delivery	Provision of essential, accessible, affordable and integrated health services.	Availability and accessibility of health services
Financing	The mobilization, management and accountability of funds and resources.	Required inputs for services are available at the most competitive prices.
Technologies	Ensuring access to and appropriate utilization of medicines, vaccines, technologies and infrastructure.	Availability and use of scientifically sound and cost-effective technologies.
Health Information	Monitoring and Evaluation, the use, analysis and dissemination of reliable and timely information.	Reliable and timely information for evidence-based decision making.
Community Participation and Ownership	Engaging communities and their leadership in determining health activities and taking ownership for their own health.	Increased responsiveness to the health needs of the community and improved health seeking behavior of community members.
Partnership	Working with stakeholders in the context of mutual respect to fill in gaps within the health system and address them in a coordinated manner.	Improved collaboration and coordination among actors and increased efficiency and effectiveness in service delivery.
Research	Study and analyze system functioning.	Evidence-based, locally relevant system improvement interventions.

Health facility system quality readiness assessment

How resilient is the health facility towards quality? Is the facility fit o do quality? Is it prepared to do quality? Is it sensitive and responsive to deviations from quality? Here is where a health facility system quality readiness assessment is required. The simple question is “does the health facility have systems that are designed to and strong enough to deliver on quality of care?”

Exercise 1:

Choose a service that is being provided as a reference point. This will be used for all other exercises.
Table 2 Health system readiness assessment tool

Score each criterion 1 to 5. 1= no, 2=sometimes, 3=ost times, 4= very often, 5= yes.

No	System Block	Readiness criteria	Score
	Leadership and governance	Are we doing the right thing?	
		Are we doing the right thing, the right way?	
		Are we doing the right thing, the right way at the right time?	
		Are we doing the right thing, the right way at the right time all the time?	
		Average score	
2	Human Resource	Are we using the right people?	
		Are we using the right people, with the right skill?	
		Are we using the right people, with the right skill and right attitude?	
		Average score	
3	Service Delivery	Are we providing services that are meeting the needs and expectations of the users?	
		Are we proving services that are exceeding the needs and expectations of the users?	
		Are we providing services that are achieving the desired level of care outcomes?	
		Average score	
4	Information	Are we collecting information on the quality of care provided?	
		Are we using appropriate tools to collect the required information on the quality of care provided?	
		Are we using the information to improve the services we provide and care outcomes achieved?	
		Average score	
5	Technology	Are we using the right medicines?	
		Are we using the right equipment?	
		Are we using the right infrastructure?	

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		Are we using the right infrastructure?	
		Average score	
6	Financing	Are we providing care at the right cost?	
		Are we budgeting for quality improvement related interventions?	
		Are we making funds available for quality improvement related interventions	
		Average score	
7	Community Participation	Are we engaging the community to better manage their health?	
		Are we supporting the community to better manage their health?	
		Average score	
8	Partnership	Are we partnering with the right people or organizations to promote quality of care?	
9	Research	Are we finding new ways to improve the services we provide and the outcomes they achieve?	
		Average Score	
		Total Score (sum of all average scores)	
		Level of Readiness % (Total Score over 45 X 100)	

Exercise 2: Quality of Care status assessment:

Dimensions of quality

The question here is; to what extent are the services being provided meeting the quality of care outcomes. The quality of care provided is assessed by outcomes of care not outputs. They are qualitative in nature but can be quantitatively measured. We are not so much interested in the number of patients seen or the number of procedures carried out, rather we are interested in **what happened to them** when the service provider had finished attending to them?

1. **Safety** — Patients and workers are not harmed while respectively receiving or giving the care that is intended.
2. **Effective** — Scientifically proven evidence is the basis for care that is given for the achievement of optimal (desired) outcomes and avoidance of both underuse and misuse.
3. **Efficient** — Wastage of manpower, time, equipment, medicines and medical supplies, ideas and energy (utilities) and all other resources is at a minimum .
4. **Patient-centered** — Care delivery respects and responds to individual patient preferences, needs, expectations and values. Furthermore, these values guide all clinical decisions. All clinical stakeholders have a comprehensive view into each patients' entire medical history.
5. **Timely** — Wait times and potentially harmful delays for both those who receive and give care is at a minimum
6. **Equitable** — Care does not vary in quality because of personal characteristics, such as gender, ethnicity, age, geographic location and socioeconomic status.
7. Integrity -- The provision of care is devoid of collusion and corruption at all times
8. Integrated -- The provision of care is not fragmented. It is a 'one-stop shop' experience!

Exercise 2

Score each dimension of quality 1 to 5. 1= no, 2=sometimes, 3=most times, 4= very often, 5= yes.

How are these dimensions of quality playing out in selected services?

Table 3 Service Quality Assessment

	Dimensions of Quality	Service:
1	Safe	
2	Effective (outcomes)	
3	Efficient	
4	Patient centered *	
5	Timely	
6	Equitable care	
7	Integrity	
8	Integrated	

Total Score	
Quality Score (%) (Total score over 40 X 100)	

*complete the patient centeredness assessment to generate the score for this

Pickers Eight (8) Principles of Patient Centered Care

1. **Respect for patient preferences, values and expressed needs:** involve the patient in decision making, treat them with dignity, respect and sensitivity
2. **Information, education and communication: give** information on clinical status, progress and prognosis; information on processes of care; information to facilitate autonomy, self-care and health promotion
3. **Coordination and integration of care and services:** coordinate clinical care, ancillary and support services and front-line patient care for care to be as seamless and uninterrupted as possible
4. **Emotional support: manage patient's** anxiety over physical status, treatment and prognosis; anxiety over the impact of the illness on themselves and family; anxiety over the financial impact of illness
5. **Physical comfort: provide** pain management; assistance with activities and daily living needs; hospital surroundings and environment
6. **Involvement of family and friends: support family by** providing accommodations for family and friends; involving family and close friends in decision making; supporting family members as caregivers; recognizing the needs of family and friends
7. **Continuity and transition: give** understandable, detailed information regarding medications, physical limitations, dietary needs, etc.; coordinate and plan ongoing treatment and services after discharge; provide information regarding access to clinical, social, physical and financial support on a continuing basis.
8. **Access to care and services: make it easy to** access the location of hospitals, clinics and physician offices; availability of transportation; ease of scheduling appointments; availability of appointments when needed; accessibility to specialists or specialty services when a referral is made; clear instructions provided on when and how to get referrals.

Table 3 Patient centeredness assessment score

Score each criterion 1 to 5. 1= no, 2=sometimes, 3=most times, 4= very often, 5= yes.

	Characteristics of Patient Centered Care	**Service:**
1	Patient preferences, values and expressed needs are respected	
2	Care is coordinated and integrated	
3	Information, education and communication to patients is carried out	
4	The physical comfort of the patient is attended to	
5	Emotional support is given to the patient	

6	The appropriate family and friends are involved in the care of the patient	
7	Care requiring different providers and at different time is continuous and the transition point smooth	
8	Access to care and services is easy	
	Total Score	
	Quality Score (%) (Total score over 40 X 100)	

Model for Institutional Transformation for Healthcare Quality, developed by AfIHQSA

The model is mindful of the need to develop team cohesion, individual capacity to innovate and initiate change, employee intrinsic motivation to achieve high levels of performance and commitment to quality. The model is grounded on the fact that ensuring leadership commitment and buy-in is the most important and critical success factor for achieving a high-quality performing organization. The following descriptions form the basis of the 6 steps:

1. Without leadership and management appreciation and commitment to an organisational culture towards quality, very little will be achieved.
2. The context in which quality is to be achieved is unique to each organisation thus knowledge of the current situation in the organisation is fundamental to initiating any form of intervention. In looking at the current situation, both the capacity of the health system to deliver quality outcomes and the level of quality are assessed.
3. The foundation of quality is a health system designed for quality as such the model strengthens the facility's health systems to better manage quality.
4. When the system is 'quality ready' quality improvement interventions are then initiated and executed to achieve improved service and care outcomes.
5. These interventions are at all times supported by iterative monitoring and evaluation to feedback and continuously improve intervention design and execution.
6. The facility is ready to attain the desired quality of care outcomes (and this could be through accreditation, certification, etc.). The facility can now be designed and redesigned for its systems to deliver the desired results, in a sustainable manner.

Employee involvement in the planning and execution of activities will be a critical component to the implementation of the activities described for respective objectives.

In addition, a coaching and mentorship approach is used to facilitate the achievement of sustainable attitudinal and behavioral changes that will support the institutionalization of quality practices and systems.

Use of appropriate existing organizational processes, procedures and structures are a default approach to the intervention. This is to ensure that, as much as possible, the proposed activities do not unduly disrupt services to clients in the organization.