HEALTHQUAL
Organizational Quality Assessment Tool

Healthqual

UCSF

UCSF Institute for
Global Health Sciences

Purpose

Sustained improvement requires attention to the organizational Quality Management Program (QMP), in which structures, processes and functions support measurement and improvement activities. Development, implementation and spread of sustainable QI requires an organizational commitment to quality management. Organizational structure is fundamental to QI success, and involves a receptive health care organization, sustained leadership, staff training and support, time for teams to meet, and data systems for tracking outcomes. This structure supports quality initiatives that apply process improvement including: reliable measurement, root cause analysis and finding solutions for the most important causes identified.

Implementation

The OA is implemented in two ways: 1) by an expert QI coach or 2) as a self evaluation. Before beginning the assessment process, the reviewer should identify the entity that is being assessed; the entire organization (hospital, health center) or a subset of the organization (the HIV/AIDS Program). The team that is brought together for the assessment should reflect the entity being assessed.

The leader should be identified as the leader for the entire organization or for the smaller program being assessed.

For small centers with few staff, a formal committee or project team may not be necessary to complete the functions described in this assessment. In these organizations, the entire staff should be considered the "committee" or the "team" that is involved in improvement activities.

Scoring

Whether performed by a QI coach or applied as a self evaluation, key leadership and staff should be involved in the assessment process to ensure that all key stakeholders have an opportunity to provide important information related to the scoring. This assessment identifies the important elements associated with a sustainable QMP. Scores from 0 to 5 are defined to identify gaps in the QMP and to set organizational improvement priorities. The scoring structure evaluates program performance in specific domains along the spectrum of improvement implementation. When assigning a score of 0 to 5 for individual components, select the number that most accurately reflects achievement in that area. **You must meet all elements associated with a particular number to receive that score.** If all of the boxes are not checked within one particular score section, then the score should be the number preceding that one. To score "2" for example, each box for the elements corresponding to that score section must be checked. If there is any uncertainty in assessing whether performance is closer to the statement in the next higher or next lower range, **choose the lower score**. Applied annually, this assessment will help a program evaluate its progress and guide the development of goals and objectives. Note that you may decide to check boxes for criteria in some of the higher scores and use that information to address gaps in the program that will help you meet the higher score.

Results

The results are ideally used to develop a workplan for each element with specific action steps and timelines guiding the planning process: to focus on priorities, set direction and ensure that resources are allocated for the QMP. Results of the OA should be communicated to internal key stakeholders, leadership and staff. Engagement of organizational leadership and staff is critical to ensure buy-in across departments, and essential for translating results into improvement practice.

Improvement activities should be aligned with National Quality Management strategies and frameworks, where applicable.

Please note: before applying the OA, it is important to determine the scope of the program for which this tool will be used. For example, is it the HIV program only or the entire institution? Does the "leader" represent the entire organization or is it limited to a specific program? These decisions will inform the context for each domain.

A. Quality Management

GOAL: To assess how the organizational Quality Management Plan supports a systematic process with identified leadership, accountability and dedicated resources.

Three components form the backbone of a strong sustainable QMP: Leadership, Quality Planning and a Quality Committee.

Leadership

Senior leadership staff are defined by each organization since titles and roles vary among organizations. Clinical programs should include a clinical leader and an administrative leader. Larger programs may include additional leadership positions. There may be other informal leaders in the organization that support quality activities, but these are not included in this section. When reviewing the criteria for each score, consider the clinical or administrative leader who is responsible for the quality management program or is most closely associated with it if there is no one officially designated for this function. Ideally, this person should be a hospital or health center senior leader who has the authority to convene committees and approve actions that are important to implement the quality management program.

Leaders establish a unity of purpose and direction for the organization and work to engage all staff, patients and external stakeholders in meeting organizational goals and objectives, this includes motivation that promotes shared responsibility and accountability with a focus on teamwork and individual performance. Organizational leaders should prioritize quality goals and improvement initiatives for the year and establish accountability for performance at all organizational levels. The benefits of strong leadership include clear communication of goals and objectives, where evaluation, alignment and implementation of activities are fully integrated.

Evidence of leadership support and engagement includes establishment of clear goals and objectives, communication of program/organizational vision, creating and sustaining shared values, and providing resources for implementation.

Quality Committee

A quality committee drives implementation of the quality plan and provides high-level comprehensive oversight of the quality program. This involves reviewing performance measures, developing workplans, chartering project teams and overseeing progress. Teams should be multidisciplinary and include a patient when feasible. The committee should meet monthly, document their activities and share meeting notes with committee members and other organizational staff and key stakeholders. For smaller organizations, the entire staff may be the QI committee and should be considered in that way since they perform all of the functions of the Quality Management Program.

Quality Plan

A quality management plan documents programmatic structure and annual quality program goals. The quality plan should serve as a roadmap to guide improvement efforts, and include a corresponding workplan to track activities, monitor progress and signify achievement of milestones.

A.1. To what extent does senior leadership create an environment that supports a focus on improving the quality of care in the organization?		
Getting Started	0	☐ Senior leaders are not visibly engaged in the quality of care program
Planning and initiation	1	Leaders are: ☐ Primarily focused only on reporting requirements ☐ Inconsistent in use of data to identify opportunities for improvement ☐ Not involved in improvement efforts ☐ Not involved in quality meetings ☐ Not supporting provision of resources for QI activities, including dedicated time for improvement
Beginning implementation	2	Leaders are: ☐ Engaged in quality of care with focus on use of data to identify opportunities for improvement ☐ Somewhat involved in improvement efforts ☐ Somewhat involved in quality meetings ☐ Supporting resources for QI activities but not yet at optimal levels to support improvement
Implementation	3	Leaders are: ☐ Providing routine leadership to support the quality management program ☐ Providing routine and consistent allocation of staff or staff time for QI (depending on organization size) ☐ Engaged in QI planning and evaluation ☐ Managing/leading quality committee meetings ☐ Clearly communicating quality goals and objectives to all staff ☐ Recognizing and supporting staff involved in QI ☐ Routinely reviewing performance measures and patient outcomes to inform program priorities and data use for improvement. ☐ Attentive to national health care trends/priorities that pertain to the program
Progress toward systematic approach to quality	4	Leaders are: ☐ Supporting development of a culture of QI across the program through provision of resources for staff participation in QI learning opportunities, seminars, professional conferences, and development of QI story boards. ☐ Supporting prioritization of quality goals based on data, and critical areas of care ☐ Promoting patient-centered care and patient involvement through the QMP ☐ Routinely engaged in QI planning and evaluation ☐ Routinely providing input and feedback to QI teams
Full systematic approach to quality management in place	5	Leaders are: ☐ Actively engaged in the implementation and shaping of a culture of QI across the program through the provision of resources for staff participation in QI learning opportunities, seminars, professional conferences, QI story boards ☐ Encouraging open communication about improvement measurement through routine team meetings and dedicated time for staff feedback ☐ Actively and consistently engaged in QI planning and evaluation ☐ Actively and consistently providing input and feedback to QI teams ☐ Visibly communicating to the entire organization about improvement work, performance measurement and priorities for quality goals ☐ Encouraging staff innovation through QI awards and incentives ☐ Directly linking QI activities back to institutional strategic plans and initiatives
Opportunities/Gaps:		

A.2. To what extent does the organizational program have an effective quality committee to oversee, guide, assess, and improve the quality of services?		
Getting Started	0	☐ A quality committee has not yet been developed or formalized or is not currently meeting regularly to provide effective oversight for the quality program
Planning and initiation	1	The quality committee: ☐ May review data triggered by an event or problem, or generated by donor or Ministry of Health urging ☐ Has not yet developed a systematic process for data use to identify and prioritize annual goals ☐ Has not yet defined roles and responsibilities for participating individuals
Beginning implementation	2	The quality committee: ☐ Has plans to hold regular meetings, but meetings may not occur regularly and/or do not focus on performance data ☐ Has been formalized, representing most institutional departments ☐ Has identified roles and responsibilities for participating individuals including the QI focal person ☐ Has not yet implemented a structured process to review data for improvement
Implementation	3	The quality committee: ☐ Is formally established and led by the organization's director or manager as chair ☐ Represents most departments and disciplines ☐ Has established annual calendar of meeting dates ☐ Has defined roles and responsibilities as codified in the quality plan including the QI focal person ☐ Reviews performance data at each meeting ☐ Discusses QI progress and redirects teams as appropriate ☐ Introduces early stages of ground rule management and efficiency tools during meetings
Progress toward systematic approach to quality	4	The quality committee: ☐ Is formally established and led by an organizational director or manager as chair who actively oversees the work of the quality program with established annual meeting dates ☐ Represents all departments and disciplines ☐ Has established a performance review process to regularly evaluate clinical measures and respond to results as appropriate, including staff and patient satisfaction ☐ Communicates with non-members through distribution of minutes and discussion in regular staff meetings ☐ Actively utilizes a workplan to closely monitor progress of quality activities and team projects
Full systematic approach to quality management in place	5	The quality committee: ☐ Is a formal entity led by the organizational director or manager or by an individual as designated by the organization ☐ Represents all departments and disciplines ☐ Has defined roles and responsibilities as codified in the quality plan including a QI focal person ☐ Has established a systematic performance and review process, including structure, and process and outcomes measures. ☐ Is responsive to changes in treatment guidelines and external/national priorities, which are considered in development of indicators and choosing improvement initiatives ☐ Has fully engaged senior leadership who lead discussions during committee meetings ☐ Effectively communicates activities, annual goals, performance results and progress on improvement initiatives to all stakeholders, including staff and patients
Opportunities/Gaps:		

A.3. To what degree does the organization have a comprehensive quality plan that is actively utilized to oversee quality improvement activities?		
Getting Started	0	☐ A quality plan, including elements necessary to guide the administration of a quality program has not been developed
Planning and initiation	1	The quality plan: ☐ Is written but does not include the essential components necessary to direct an effective quality program (see level 3)
Beginning Implementation	2	The quality plan: ☐ Is written for the HIV program only, and contains some of the essential components (see level 3) ☐ Is under review for approval by senior leadership, and includes steps for implementation ☐ Includes a designated point of contact to manage QM program communication within the organization and with the national program
Implementation	3	The quality plan: ☐ Is complete, defining all essential QI components. This includes goals and objectives, quality committee roles, responsibilities and logistics, performance measurement and review processes, annual goal identification and prioritization processes, QI methodology, communication strategy, patient involvement, and a program evaluation procedure. ☐ Includes a workplan/timeline outlining key activities of the quality program and improvement initiatives, including individuals accountable for each. The timeline is reviewed regularly by the quality committee and modified as necessary to achieve the identified goals. ☐ Includes an organogram visually depicting the organizational quality management structure
Progress toward systematic approach to quality	4	The quality plan: ☐ Has been implemented and regularly used by the quality committee to direct the quality program ☐ Includes annual goals identified based on data generated through internal and external reviews, and engagement of the quality committee and staff to elicit priorities ☐ Includes a workplan/timeline outlining key activities in place and routinely used to track progress of performance measures and improvement initiatives, and is modified as needed to achieve annual goals ☐ Is routinely communicated to most stakeholders, including staff, patients, board members and the parent organizations, if appropriate ☐ Is evaluated annually by the quality committee to ensure that the needs of all stakeholders are met
Full systematic approach to quality management in place	5	The quality plan: ☐ Is written, implemented and regularly utilized by the quality committee to direct the quality program and includes all necessary components (see level 3) ☐ Includes regularly updated annual goals that were identified by the quality committee using data based on internal performance measures and externally required indicators through engagement of the quality committee and staff to identify priorities for improvement ☐ Includes the workplan/timeline outlining key activities in place ☐ Is routinely used to track progress on performance measures and improvement initiatives, and modified as needed to achieve annual goals ☐ Is communicated broadly to all stakeholders, including separate staff, patients, board members and the parent organizations, as appropriate ☐ Is evaluated annually by the quality committee and revised as needed to ensure that the needs of all stakeholders are met. ☐ Is adapted to changes in national policies and to ensure that the program continues to meet the changing needs of the patient as the evidence base and guidelines evolve
Opportunity/Gaps		

B. Workforce Engagement in the quality program

GOAL: To assess awareness, interest and engagement of staff in quality improvement activities.

Staff engagement in the quality management program at all organizational levels is central to the success of improvement activities. Engagement includes development and promotion of staff knowledge around organizational systems and processes to build sustainable quality management programs, such as internal management processes, operational challenges, patient interaction, and successful strategies and barriers to QI implementation.

Ongoing training and retraining in QI methodology and practical skills reinforces knowledge and the building of workforce expertise around improvement. As staff progress along the continuum of QI sophistication, improvement is slowly integrated into routine work and practice, enhancing staff engagement in the process. Immediate access to improvement data for example, empowers staff to focus on key areas of care and build consensus around QI activities to improve patient outcomes.

As QI becomes part of the institutional culture and team work progresses, staff embrace their respective roles and responsibilities, acquiring a sense of ownership and deeper involvement in improvement work.

B.1. To what extent are clinicians and staff routinely engaged in quality improvement activities and provided training to enhance knowledge, skills and methodology needed to fully implement QI work on an ongoing basis?		
Getting Started	0	☐ All of the staff (clinical and non-clinical) are not routinely engaged in QI activities and are not provided training to enhance skills, knowledge, theory or methodology or encouragement to identify opportunities for improvement and develop effective solutions
Planning and initiation	1	Engagement of core staff in QI (clinical and non-clinical): ☐ Is under development and includes training in QI methods and opportunities to attend meetings where QI projects are discussed
Beginning Implementation	2	Engagement of core staff in QI (clinical and non-clinical): ☐ Is underway and some staff have been trained in QI methodology ☐ Includes QI meetings attended by some designated staff
Implementation	3	Engagement of core staff in QI (clinical and non-clinical): ☐ Includes attendance in at least one training in QI methodology. Staff members are generally aware of Program QI activities (quality plan/priorities) ☐ Includes involvement in QI projects, project selection and participation in a QI committee ☐ Includes QI project development, where projects are discussed and reviewed during staff meetings ☐ Includes defined roles and responsibilities related to QI. Clinicians and staff are aware of the organizational quality management plan and priorities for improvement. ☐ Includes a formal process for regularly recognizing staff performance in QI via performance appraisals, public recognition during staff meetings, etc.
Progress toward systematic approach to quality	4	Engagement of core staff in QI (clinical and non-clinical): ☐ Is demonstrated by evidence that staff members are engaged and encouraged to use those skills to identify QI opportunities and develop solutions ☐ Involves a shared language regarding quality, which is evidenced in routine discussion ☐ Is described in the annual quality plan, and includes staff training and roles and responsibilities regarding staff involvement in QI activities ☐ Includes a formal process for recognizing staff performance internally. QI teams are provided opportunities to present successful projects to all staff and leadership.
Full systematic approach to quality management in place	5	Engagement of core staff in QI (clinical and non-clinical): ☐ Is defined by staff awareness of the importance of quality and continuous improvement, and their participation in identifying QI issues, developing strategies for improvement and implementing strategies ☐ Is evidenced by regular and continuous QI education and training in QI methodology ☐ Is reinforced by leadership who encourages all staff to make needed changes and improve systems for sustainable improvement including the necessary data to support decisions ☐ Involves formal and informal discussions where teamwork is openly encouraged and leadership shapes teamwork behavior ☐ Incorporates routine communication about new developments in QI, including promotion of QI projects both internally (e.g., quality conferences) and externally (e.g., national meetings) ☐ Includes a formal process for recognizing staff performance internally. QI teams are provided opportunities to present successful projects to all staff and leadership ☐ Includes opportunities for abstract development and submission to relevant professional conferences and authorship of related publications about development and implementation of institutional QM programs ☐ Involves clearly defined roles and responsibilities which are utilized to assess staff performance
Opportunity/Gaps		

C. Measurement, Analysis and Use of Data to Improve Program Performance

GOAL: To assess how the organization uses data and information to identify opportunities for improvement, develops measures to evaluate the success of change initiatives, aligns initiatives with national priorities, and monitors results; and to ensure that accurate, timely data and information are available to stakeholders throughout the organization to drive effective decision making.

The Measurement, Analysis and Use of Data section assesses how the organizational program selects, gathers, analyzes and uses data to improve performance. This includes how leaders conduct performance reviews to ensure that actions are taken, when appropriate, to achieve the organization's program goals.

C.1. To what extent does the organization routinely measure performance and use data for improvement?		
Getting Started	0	Performance measures: ☐ Have not been identified
Planning and initiation	1	Performance measures: ☐ Have been identified to evaluate some components of the organization's program, but do not cover all significant aspects of service delivery
		Performance data: ☐ Collection is planned but has not been initiated
Beginning Implementation	2	Performance measures: ☐ Are defined and used by staff in all applicable service delivery areas
		Performance data: ☐ Analysis and interpretation of results on measures is in early stages of development and use ☐ Results are occasionally shared with staff and patients, but a structured process is not in place
Implementation	3	Performance measures: ☐ Are defined by the Ministry of Health or donor partner ☐ Are consistently used by staff in all applicable service delivery areas
		Performance data: ☐ Are longitudinally tracked, analyzed and reviewed with the frequency required to identify areas in need of improvement. A structured review process is used regularly by the leadership to identify and prioritize improvement needs and initiate action plans to ensure that goals are achieved. ☐ Are collected by staff with working knowledge of indicator definitions and their application ☐ Results and associated measures are routinely shared with staff and their input is elicited to make improvements ☐ Clinic has a process for checking the accuracy of its data occasionally but not systematically
Progress toward systematic approach to quality	4	Performance measures: ☐ Are tied to organizational goals and priorities ☐ Are defined and consistently used by staff in all applicable departments
		Performance data: ☐ Are reviewed for accuracy on all measures in all departments ☐ Are actively used to drive improvement activities ☐ Results and associated measures are frequently shared with staff to elicit their input and engage them in improvement processes aligned with organizational goals
Full systematic approach to quality management in place	5	Performance measures: ☐ Are selected using national/donor partner measures and organizational annual goals, with the intent to meet Ministry of Health requirements and the needs of stakeholders and patients ☐ Reflect organizational and patient priorities, in consideration of organizational & local issues ☐ Are defined for key component ☐ Are evaluated regularly to ensure that the program is able to respond effectively to internal and external changes quickly. ☐ Are linked to performance of key clinical outcomes
		Performance data: ☐ Are reviewed for accuracy on all measures in all applicable departments ☐ Visible or easily accessible to ensure data reporting transparency throughout the organization ☐ Are arrayed in formats that enable accurate interpretation, such as run charts or simple bar graphs ☐ Results and associated measures are systematically shared with all key stakeholders, including staff and patients ☐ Are systematically reviewed through a Formal Data Quality Assurance program
Opportunities/Gaps:		

D. Quality Improvement Initiatives

GOAL: To evaluate how the organization uses QI methodology and teamwork to achieve program goals and maintain high levels of performance over long periods of time.

The Quality Improvement Initiatives section examines how leadership and workforce use these methods and tools to conduct improvement initiatives with emphasis on identification of the exact causes of problems and designing effective solutions; determining program specific best practices and sustaining improvement over long periods of time. In high reliability organizations, robust process improvement methodology is routinely utilized for all identified problems and improvement opportunities to ensure consistency in approach by all staff members.

D.1. To what extent does the organization identify and conduct quality improvement initiatives using QI methodology to ensure high levels of performance over long periods of time?		
Getting Started	0	☐ Formal quality improvement projects have not yet been initiated in the organizational program
Planning and initiation	1	QI initiatives: ☐ Focus on individual cases without assessment of organizational performance or system level analysis of data. Reviews primarily used for inspection. ☐ Are not team-based ☐ Do not use specific tools or methodology to understand causes and make effective changes
Beginning Implementation	2	QI initiatives: ☐ Are prioritized by the quality committee based on program goals, objectives and analysis of performance measurement data ☐ Involve team leaders and team members who are assigned by the quality committee or other leadership ☐ Begin to use specific tools or methodology to understand causes and make effective changes
Implementation	3	QI initiatives: ☐ Are ongoing based on analysis of performance data and other program information, including external reviews and assessments ☐ Focus on processes of care in which QI methodology is routinely utilized ☐ Are regularly documented and provided to the Quality Improvement Committee ☐ Involve staff on QI teams. Cross departmental/cross functional teams are developed depending on specific project needs. This would include laboratory, administrative and pharmacy staff where relevant.
Progress toward systematic approach to quality	4	QI initiatives: ☐ Are ongoing based on analysis of performance data and other program information, including external agency reviews and assessments ☐ Can be identified by any member of the program team through direct communication with program leadership ☐ Routinely and consistently reinforce and promote a culture of quality improvement throughout the program through shared accountability and responsibility of identified improvement priorities ☐ Are supported with appropriate resources, including people and time, to achieve effective and sustainable results ☐ Involve support of data collection with results routinely reported to QI project teams
Full systematic approach to quality management in place	5	QI initiatives: ☐ Are ongoing in core service categories ☐ Correspond with a structured process for prioritization based on analysis of performance data and other factors, such as patient surveys ☐ Are implemented by project teams. Further, physicians and staff can identify an improvement opportunity at any point in time and suggest a QI team be initiated ☐ Consistently and routinely utilize robust process improvement and multidisciplinary teams to identify actual causes of variation and apply effective, sustainable solutions ☐ Are guided by a team leader, and include all relevant staff depending on specific project needs ☐ Are regularly communicated to the Quality Committee, staff and patients ☐ Routinely involve patients on QI project teams ☐ Are presented in storyboard context or other formats and reported to the larger organization and/or placed in public areas for staff and patients (if relevant) ☐ Involve recognition of successful teamwork by senior leadership ☐ Are supported by development of sustainability or "spread" plans

Opportunities/Gaps:

E. Patient Involvement

Goal: This section assesses the extent to which patient involvement is formally integrated into the quality management program.

Patient involvement encompasses the diversity of individuals using the organization's services and can be achieved in multiple ways, including solicitation of patient perspectives through focus groups, key informant interviews and satisfaction surveys; a formal patient advisory board that is actively engaged in improvement work; including patients as members of organizational committees; conducting patient needs assessments and including patients in specific QI initiatives. Ideally patients have a venue to identify improvement concerns and are integrated into the process to find solutions and develop improvement strategies. Overall, patients are considered valued members of the program, where patient perspectives are solicited, information is used for performance improvement and feedback is provided to patients. Patient experience is considered an important dimension of quality that is considered in determining improvement priorities and included as an important component of the quality management plan.

E.1. To what extent are patients effectively engaged and involved in the HIV quality management program?		
Getting Started	0	☐ There is currently no process to involve patients in HIV quality management program activities
Planning and Initiation	1	Patient involvement is demonstrated by: ☐ Occasionally soliciting patient feedback, but no formal process is in place for ongoing and systematic participation in quality management program activities
Beginning Implementation	2	Patient involvement is demonstrated by: ☐ Soliciting patient feedback, with development of a formal process for ongoing and systematic participation in quality management program activities, such as through patient satisfaction surveys
Implementation	3	Patient involvement is demonstrated by: ☐ Engagement with patients to solicit perspectives and experiences related to quality of care ☐ Formal involvement in quality management program activities through a formal patient advisory committee, satisfaction surveys, interviews, focus groups, storytelling and/or patient training/skills building. However, the extent to which patients participate in quality management program activities is not documented or assessed.
Progress toward systematic approach to quality	4	Patient involvement is demonstrated by: ☐ A formal process for patients to participate in quality management program activities, including a formal patient advisory committee, surveys, interviews, focus groups and/or patient training/skills building ☐Three or more of the following activities: – Sharing of performance data and discussing quality during formal patient meetings – membership on the internal quality management team or committee – training in quality management principles and methodologies – engagement to make recommendations based on performance data results – increasing documentation of how recommendations by patients are used to implement quality improvement projects ☐ Use of documented information gathered through the above activities to improve the quality of care. However, staff does not review with patients how their involvement contributes to refinements in quality improvement activities.
Full systematic approach to quality management in place	5	Patient involvement is demonstrated by: ☐ A formal, well-documented process for patients to participate in HIV quality management program activities, including a patient advisory committee with regular meetings, patient surveys, interviews, focus groups and patient training/skills building ☐ Quality improvement activities that include at least four of the items bulleted in E1#4 (second bullet) ☐ Information gathered through the above noted activities being documented, assessed and used to drive QI projects and establish priorities for improvement ☐ Review of changes by patients with program staff based on recommendations received with opportunities to offer refinements for improvements. Information is gathered in this process and used to improve the quality of care. ☐ Involvement on at least an annual basis in the review by the quality management team/committee of successes and challenges of patient involvement in quality management program activities, with the goal of enhanced collaboration between patients and providers engaged in improvement
Opportunities/Gaps:		

F. Quality Program Evaluation

GOAL: To assess how the organization evaluates the extent to which it is meeting the identified program goals related to quality improvement planning, priorities and implementation.

Quality program evaluation can occur at any point during the cycle of quality activities, but should occur annually at a minimum. The process of evaluation should be linked closely to the quality plan goals: to assess what worked and what did not, to determine ongoing improvement needs and to facilitate planning for the upcoming year. The evaluation examines the methodology, infrastructure and processes, and assesses whether or not these led to expected improvements and desired outcomes. At a minimum, the evaluation should assess access to data to drive improvements, success of QI project teams, and effectiveness of quality structure. The evaluation is most effectively performed by program leadership and the program's quality committee, optimally with some degree of patient involvement. Although external evaluations may be useful by peers or formal evaluators, the purpose of this assessment is focused on internal routine evaluation of the quality management program.

F.1. Is a process in place to evaluate the organization's quality management plan and related activities, and processes and systems to ensure attainment of quality goals, objective and outcomes?		
Getting Started	0	☐ No formal process is established to evaluate the quality program
Planning and Initiation	1	Quality program evaluation: ☐ To assess program processes and systems is exclusively external (national/donors/partners)
Beginning Implementation	2	Quality program evaluation: ☐ Is part of a formal process and is integrated into annual quality management plan development, but has not been consistently employed
Implementation	3	Quality program evaluation: ☐ Occurs annually, conducted by the quality committee, and includes QM plan and workplan updates and revisions ☐ Involves annual (at minimum) revision of quality goals and objectives to reflect current improvement needs ☐ Results are used to plan for future quality efforts ☐ Includes a summary of improvements and performance measurement trends to document and assess the success of QI projects ☐ Results, noted above, are shared with patients and other key stakeholders
Progress toward systematic approach to quality	4	Quality program evaluation: ☐ In addition to the elements listed in F1.3, findings are integrated into the annual quality plan and used to develop and revise program priorities ☐ Is reviewed during quality committee meetings to assess progress toward planning goals and objectives ☐ Includes review of performance data, which is used to inform decisions about potential changes to measures ☐ Is used to determine new performance measures based on new priorities if they are identified ☐ Includes analysis of QI interventions to inform changes in program policies and procedures to support sustainability
Full systematic approach to quality management in place	5	Quality program evaluation: ☐ In addition to the elements listed in F.1. 3 and 4, findings are integrated into routine program activities as part of a systematic process for assessing quality activities, outcomes and progress toward goals. Data and information from the evaluation are provided regularly to the quality committee. ☐ Is used by the quality committee to regularly assess the success of QI project work, successful interventions and other markers of improved care ☐ Includes data reflecting improvement initiatives, and is presented to ensure comprehensive analysis of all quality activities ☐ Uses a detailed assessment process. The results of this assessment are utilized to revise and update the annual quality plan; adjust organizational program priorities; and identify gaps in the program. ☐ Includes an analysis of progress towards goals and objectives and QI program successes and accomplishments ☐ Describes performance measurement trends which are used to inform future quality efforts
Opportunities/Gaps		

G. Achievement of outcomes

GOAL: To assess HIV program capability for achieving excellent results and outcomes in areas that are central to providing high quality HIV care.

To determine whether a program is achieving excellence in HIV care, a system for monitoring and assessing clinical outcomes should be in place. This system should include routine analysis of an appropriate set of measures; trending results over time; stratifying data by high-prevalence populations; and comparison of results to a larger aggregate data set* used for programmatic target setting. A set of appropriate measures may be externally developed (national government, PEPFAR, WHO/UNAIDS) and/or internally developed based on program goals. Examples of outcome measures include viral load suppression, retention in care, mother-to-child transmission rates, and late diagnosis of HIV as measured by either CD4<200 or AIDS diagnosis at time of testing. At least one of these measures should be incorporated into the program's set of clinical measures.

*Possible data sets for comparison include national, provincial or partner network data sets.

G.1. To what extent does the HIV program monitor patient outcomes and utilize data to improve patient care?		
Getting Started	0	☐ No clinical performance results are routinely reviewed or used to monitor patient outcomes and guide improvement activities
Planning and Initiation	1	Data: ☐ A clinical database is used to routinely measure performance of care (EMR, database, register) ☐ Some measures are routinely reviewed and used to guide improvement activities ☐ Trends for some measures are reported to determine improvement over time
Beginning Implementation	2	Data: ☐ Results for most measures are routinely reviewed and used to guide improvement activities ☐ Trends for most measures are reported and many show improving trends over time
Implementation	3	Data: ☐ A listing of active patients is maintained and refreshed at least annually to remove those who have died, transferred or are lost to follow-up according to national definitions ☐ Results for all measures are routinely reviewed and used to guide improvement activities, including one of the following: viral load suppression (CD4 may be used as a proxy if viral load is not available), retention in care, late diagnosis, MTCT transmission rate ☐ Trends for all measures are reported and many show improving trends over time ☐ Results are compared to a larger aggregate data set for **at least one** outcome measure (see above) ☐ Comparison to a larger aggregate data set is used to set programmatic targets
Progress toward systematic approach to quality	4	Data: ☐ Results for all measures are routinely reviewed and used to guide improvement activities, including outcome measures ☐ Trends are reported for all measures and most show improving trends over time ☐ Results are compared to a larger aggregate data set for **two** outcome measures ☐ Comparison to a larger aggregate data set is used to set improvement goals which are met for at least 50% of measures
Full systematic approach to quality management in place	5	Data: ☐ Results for all measures are routinely reviewed and used to guide improvement activities, including outcome measures ☐ Trends are reported for all measures and most show sustained improvement over time in areas of importance aligned with organizational goals ☐ Results are compared to a larger aggregate data set for all core national prioritized outcomes measures (such as retention, viral load suppression, etc) ☐ Comparison to a larger aggregate data set is used to set programmatic goals which are met for at least 75% of measures ☐ Results for outcomes measures are above the 75th percentile of the comparative data set
Opportunities/Gaps		

What are the major findings from the Organizational Assessment?

What are the key recommendations and suggestions? What specific areas should be improved? What are specific improvement goals for the upcoming year?

Organizational Quality Assessment Tool

Hospital/Clinic name……

Rater team:

( ) Administrative/Hospital committee/hospital quality team

( ) HIV coordinator team/clinic team

( ) external survey/assessment

Organization Assessment	Score					
	0	1	2	3	4	5
A. Quality management						
A.1. To what extent does senior leadership create an environment that supports a focus on improving the quality of care in the hospital?						
A.2. To what extent does the hospital program have an effective quality committee to oversee, guide, assess, and improve the quality of hospital services?						
A.3. To what degree does the hospital have a comprehensive quality plan that is actively utilized to oversee quality improvement activities?						
B. Workforce engagement in the quality program						
B.1. To what extent are clinicians and staff routinely engaged in quality improvement activities and provided training to enhance knowledge, skills and methodology needed to fully implement QI work on an ongoing basis?						
C. Measurement, analysis and use of data to improve program performance						
C.1. To what extent does the Hospital routinely measure performance and use data for improvement?						
D. Quality improvement initiatives						
D.1. To what extent does the hospital identify and conduct quality improvement initiatives using QI methodology to assure high levels of performance over long periods of time?						
E. Patient involvement						
E.1. To what extent are patients effectively engaged and involved in the HIV quality management program?						
F. Quality program evaluation						
F.1. Is a process in place to evaluate the hospital's QMP and related activities, and processes and systems to ensure attainment of quality goals, objective and outcomes?						
G. **Achievement of outcomes**						
G.1. To what extent does the HIV program monitor patient outcomes and utilize data to improve patient care?						