



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

JUL 28 2020

ADMINISTRATIVE ORDER

No. 2020- 0034

SUBJECT: Revised Guidelines on the Implementation of Continuous Quality Improvement (CQI) Program in Health Facilities in Support of Quality Access for Universal Health Care

I. BACKGROUND AND RATIONALE

Quality of care is one of the central themes of the Universal Health Care (UHC) Act, or Republic Act No. 11223, which seeks to ensure equitable access to quality and affordable health care. The National Quality Framework (NQF) in Health concretizes this theme in all initiatives related to the strategic management of the Department of Health's FOURmula One Plus for Health, which implements provisions of the UHC Law. Continuous Quality Improvement (CQI) thereby remains to be a relevant framework for DOH's plans, policies and programs in the development of health facilities towards UHC.

CQI was institutionalized with the issuance of Administrative Order No. 2006-0002, which directed all DOH hospitals to establish the CQI program and committee. The program was strengthened by Executive Order No. 605, series of 2007, which directed the institutionalization of the government quality management process and prescribed other provisions to effect improvements in public governance. In 2018, the program was adopted as a licensing requirement through the Department Circular No. 2018-0131, "Revised Licensing Assessment Tools for Hospitals".

In tune with the accelerating implementation of the UHC law, the guidelines of the CQI program need to be revisited and revised towards expanding its scope to encompass all health facilities, and emphasize the program's role as the performance management arm of the NQF in Health.

II. OBJECTIVE

This Order shall provide the revised guidelines for the establishment and/or implementation of the CQI Program in all health facilities.

III. SCOPE AND COVERAGE

This Order shall apply to all government and private health facilities nationwide. It shall cover the structure, process, functions, and monitoring for the operationalization of the CQI Program.

IV. DEFINITION OF TERMS

Continuous Quality Improvement (CQI) – refers to a process through which the level of quality is defined, pursued, achieved and continuously improved through the establishment of formal mechanisms / systems and structure within the organization. It is a strategic approach to provide the best health care possible for all. It is also a preventive strategy that uses constant innovation to improve work processes and systems by reducing time-consuming and low-value activities.

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2. **Culture of Quality** – refers to an organizational environment which promotes and values avenues for sharing of ideas, good practices, research and learning for the improvement of quality of care where blame is used exceptionally.
3. **Quality Improvement** – refers to an organizational strategy that formally involves the analysis of process and outcomes data and the application of systematic efforts to improve performance.
4. **Quality Management System** – refers to a set of interrelated or interacting elements of an organization relating to the establishment of quality processes which includes policies, objectives, planning, assurance and improvements.
5. **Quality of Care** – refers to the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

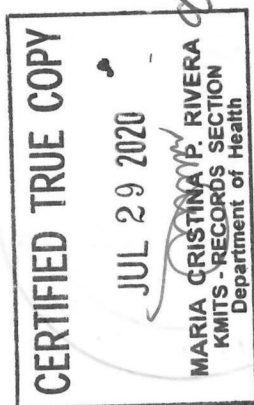
V. GENERAL GUIDELINES

- A. CQI shall be planned and identified as a priority of all health facilities along with the identified priorities of Universal Health Care of access, coverage and financial protection.
- B. All health facilities shall implement a CQI Program at all levels of care.
- C. CQI shall be sustained by following a number of steps and principles applied namely transparency, people centeredness, measurement, generation of information and investing on the workforce, all underpinned by leadership and supportive culture.
- D. A Quality Improvement (QI) Team/Unit shall be organized and shall serve as an advisory body to the head of the health facility. The roles and responsibilities of the QI Team/Unit are listed in (ANNEX A).

VI. SPECIFIC GUIDELINES

A. CQI Program Structure

1. The health facility shall have a unit that will oversee the implementation of the planned activities of the program. Pending approval of the Department of Budget and Management (DBM) on the Proposed Staffing Standard, the unit shall be headed by a healthcare worker trained in CQI. Support staff with CQI experience shall be provided by the health facility. The CQI committee as mandated by Department Circular No. 2018-0131 or the Revised Licensing Assessment Tools for Hospitals, and Administrative Order No. 2012-0012 or the Rules and Regulation Governing the new Classification of Hospitals and other Health facilities in the Philippines, shall work with the unit to ensure facility-wide implementation. In a local government setting, a unit shall be designated to oversee the activities in all the health facilities under its jurisdiction.
2. Continuous Quality Improvement shall be institutionalized in the policies, systems and process of the health facility or in the LGU unit governing the health care facilities.
3. Adequate and appropriate qualified staff shall be maintained. Continuous capacity building programs shall be in place in line with the development plan of the health facility.
4. Training to capacitate all staff on CQI shall be continuously scheduled in coordination with the Professional Education, Training and Research Unit (PETRU) or its equivalent.
5. Conduct Annual Operational Planning shall be reflected in their respective Work and Financial Plan (WFP) or as the case maybe. Funds shall be allocated for CQI activities. The provision and maintenance of quality healthcare services need not be expensive and/or dependent on the capability of the facility.



6. Implementation of CQI shall be harmonized with ongoing initiatives to pursue Quality Management System. However, certification or accreditation from third parties (e.g. PGS, ISO and other international accreditation bodies) is optional for facilities that do not have existing requirement for such.

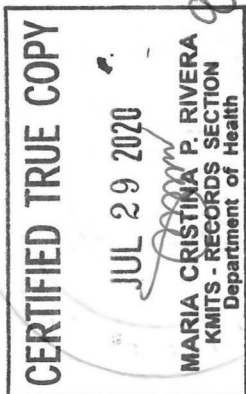
B. CQI Process

1. The systems and processes of the health facilities shall adhere to the elements of Quality (ANNEX B).
2. Health facilities shall:
 - a. Implement a computerized integrated health information and management system;
 - b. Benchmark with the standards and policies published by the DOH including the programs such as, but not limited to, Patient Safety, Infection Control, People Centeredness and the 12 Manuals on the Standard of Operations issued by the Health Facility Development Bureau.
3. The program shall document CQI activities for future best practice reference, and report outputs and outcomes as tool for monitoring and evaluation.

C. Output Monitoring:

This is the monitoring of the immediate results after the institutionalization of the program utilizing the set of indicators in the Monitoring Tool.

1. Periodic monitoring of deliverables as indicated in the plans of each unit in the facility shall be done and included in the monthly accomplishment of each unit.
2. The program shall develop a facility-based Monitoring Tool based on the indicators identified or improvement projects submitted by each area/department/unit as approved by the Head of the facility.
3. The QI/Team shall:
 - a. Monitor compliance to both regulatory and quality standards, policies and programs:
 - i. Established integrated health information system compliant with DOH Standards;
 - ii. Compliance to Patient Safety and Infection Prevention and Control Standards;
 - iii. Compliance to Bed Allocation, Occupancy Rate, Provision and Utilization of Health Services;
 - iv. Established a system of monitoring compliance to CPGs/Clinical Pathways;
 - v. Compliance to health care waste management standards.
 - b. Ensure that the hospitals shall utilize self-monitoring tools as provided in the different hospital manuals published or the Self-Assessment Tool of the Integrated Hospital Operations and Management Program (IHOMP).
 - c. Periodic implementation of the Plan-Do-Study-Act Cycle (ANNEX C) and utilizing other standard tools for evaluation and assessment (ANNEX D).
 - d. Encourage conduct of research or innovations to improve quality.
4. Conduct of periodic Performance Implementation Review of CQI program, in the facility level or in the regional level.



D. Outcome Monitoring:

This is the monitoring of the mid-term results of all the strategies which provide impact to the facility-wide service improvement.

Health facilities shall:

1. Monitor the impact of improvements on the patients and demonstrate the end result of improvement work and whether it has ultimately achieved the aims set.

2. Conduct evaluation of the responsiveness of health facilities as discussed in Administrative Order No. 2020-0003 or the Strategic Framework on the Adoption of Integrated People-Centered Health Services in All Health Facilities.
3. Ensure culture of safety through the following:
 - a. Annual assessment of adverse and sentinel events;
 - b. Monitoring of Healthcare-associated Infection Rate.
4. Measure impact of corresponding CQI indicator/s on identified clinical outcomes.

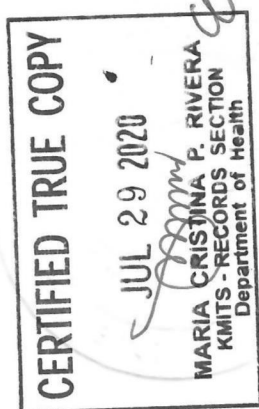
E. Rewards and Incentives

The following incentive schemes for Quality improvement shall be considered for motivation and sustainability:

1. Rewards and recognition given by the health facility such as Program on Awards and Incentives for Service Excellence (PRAISE);
2. Non-monetary rewards such as training opportunities and career development;
3. Incentive scheme from PhilHealth based on their rating system. (UHC IRR, Rule VII, Section 27.1)
4. Accreditation of local or International Agencies such as PGS, ISO, JCI;
5. Recognition from PCAHO, PHA and other societies.

F. Roles and Responsibilities

1. The **Health Facility Development Bureau (HFDB)** shall:
 - a. Provide technical assistance to health facilities in the establishment/ sustainability of the CQI Program;
 - b. Monitor the overall implementation of the program and this policy in coordination with the Health Facility Development Unit (HFDU);
 - c. Develop standard Monitoring and Evaluation (M&E) and Reporting Tools;
 - d. Collaborate with Health Promotion and Communication Service (HPCS) in the development of a communication plan;
 - e. Conduct or support research initiatives geared towards improving quality in health facilities;
 - f. Conduct proof of concept in the LGU implementation and primary health facilities.
2. The **Field Implementation and Coordination Team (FICT)** shall:
 - a. Advocate the implementation of this policy in all health facilities;
 - b. Include the adherence of all health facilities in the CQI program in their regular management review of Center for Health Development (CHD) and DOH hospitals.
3. The **Health Facility Service Regulatory Bureau (HFSRB)** shall:
 - a. Ensure that all regulated health facilities shall have policies and plans for CQI and must have proof of its implementation.
4. The **Health Promotion and Communication Service (HPCS)** shall:
 - a. Develop a communication plan in collaboration with the HFDB;
 - b. Provide leadership in the Advocacy, Communication (IE & BCC) and Social Mobilization (ACSM) for the implementation of the CQI Program.
5. **Center for Health Development (CHD)**, through the HFDU shall:
 - a. Provide technical assistance to the health facilities for the establishment of the CQI Program;
 - b. Monitor the implementation of the CQI Program in all health facilities and identify best practices;
 - c. Include CQI Program in the regular PIR of health facilities;
 - d. Submit status reports related to CQI Program implementation to the HFDB semi-annually.



6. **The Local Government Units (LGUs) shall:**

- a. Pass, through their Local Health Board, a resolution adopting the establishment and implementation of the CQI Program in all health facilities within their Health Care Provider Network (HCPN);
- b. Provide management and logistics support for the implementation of the CQI Program.

7. **All Health facilities shall:**

- a. Adhere with the HFSRB licensing requirements and the PhilHealth accreditation;
- b. Establish and/or implement and sustain the CQI Program in accordance to this Administrative Order;
- c. Ensure that necessary reports are submitted quarterly to CHDs for DOH health facilities, while for the LGU and other government and private-owned health facilities, to the Provincial/City Health Office (Health Service Delivery Division) and furnish copy to CHDs-HFDU.

8. **The Philippine Health Insurance Corporation (PhilHealth) shall:**

- a. Provide the DOH with the required statistics based on the data submitted by the health facilities for CQI program review, evaluation, and conduct of research;
- b. Develop guidelines on incentives mechanism for Quality Improvement practice.

VII. MONITORING

The Health Facility Development Bureau shall conduct policy evaluation and review after three (3) years to ensure consistency with other relevant laws and issuances.

VIII. PENALTY CLAUSE

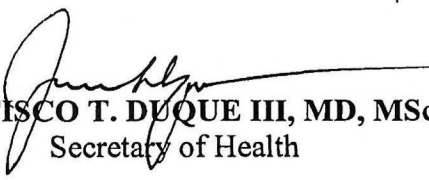
In case of non-compliance to the provisions of this Order, the concerned health facility shall not be issued license to operate or whatever applicable sanctions to be imposed by the Health Facilities and Services Regulatory Bureau.

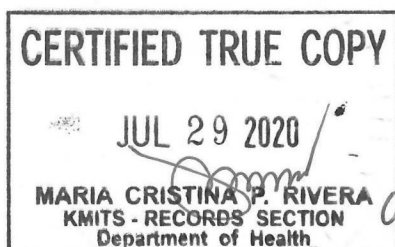
IX. REPEALING CLAUSE

Provisions of Administrative Order No. 2006-0002 dated January 23, 2006 entitled "Establishment of the CQI Program and Committee in DOH Hospitals" and all other issuances inconsistent or contrary to the provisions of this AO are hereby repealed.

X. EFFECTIVITY

This Order shall take effect fifteen (15) days after its publication in a newspaper of general circulation and upon filing with the University of the Philippines Law Center - Office of the National Administrative Register.

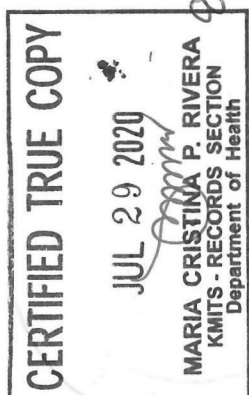

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Secretary of Health



ANNEX A. Roles and Responsibilities of the Quality Improvement Team/ Unit

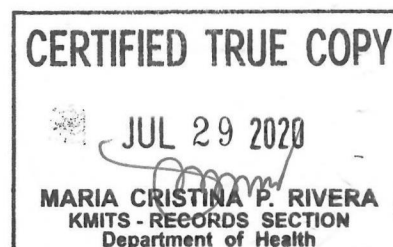
All health facilities shall designate, if possible, a multidisciplinary QI Team or Unit to implement the program. In a local government setting, a unit shall be designated to oversee the activities in all the health facilities under its jurisdiction. The QI Team or Unit shall report directly to the Head or Chief of the health facility and ensure management support to the program.

- a. Instill and adopt CQI in all the units of the health facility;
- b. Initiate the conduct of a structured, cyclical process for developing and implementing change and improvement through Plan-Do-Study-Act (PDSA) Model;
- c. Integrate all strategic initiatives to ensure attainment of the breakthrough goals of the healthcare facility;
- d. Conduct of institution-wide periodic Monitoring & Evaluation (M&E) of quality plans, monitor the offices' deliverables to ensure continuous conformance to quality standard requirements (e.g. Hospital Services Manual of Standards issued by the DOH-Health Facility Development Bureau); make feedback and necessary recommendation to the Head of the facility;
- e. Ensure compliance to reporting requirements;
- f. Maintain a quality recording of all data gathered during the monitoring;
- g. Analyze, evaluate and submit a comprehensive periodic report to the Head of the facility;
- h. Submit quarterly approved reports using standard reporting tools to the Center for Health Development (CHD) through the Health Facility Development Unit (HFDU) on a quarterly basis.
- i. Drive service improvements through continuous and repeated cycles of changes that are guided by standards:
 - i.1. patient's rights and organizational ethics;
 - i.2. access to quality care;
 - i.3. inpatient admission and outpatient registration;
 - i.4. assessment and quality care of patients;
 - i.5. medication management;
 - i.6. surgical and anesthesia care;
 - i.7. human resource and mobilization management;
 - i.8. using data to identify areas for action, develop and test strategies, and implement service redesign;
 - i.9. information and communication management;
 - i.10. leadership and management;
 - i.11. safe practice and environment;
 - i.12. performance improvement.
- j. Work alongside accreditation, governance, monitoring and evaluation to improve health care and outcomes.



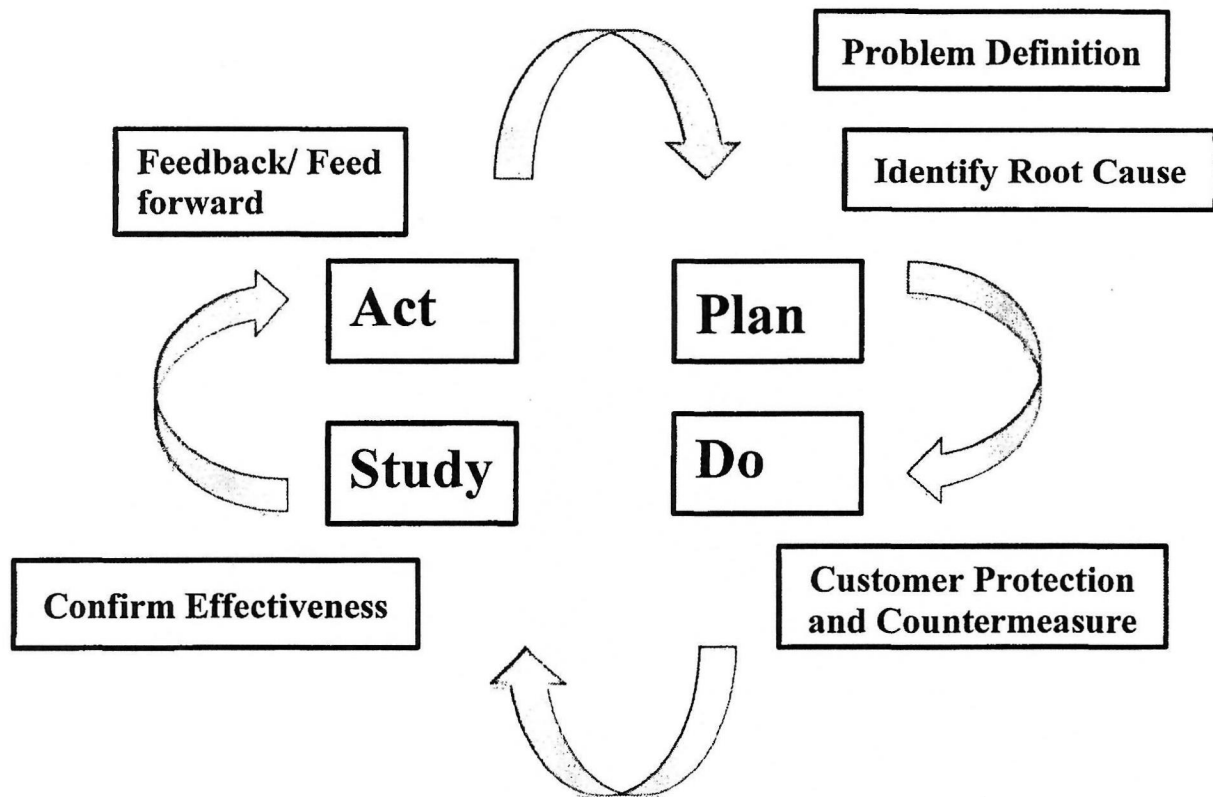
ANNEX B. Elements of CQI Program

1. **People-Centeredness.** “An approach to care that focuses on what is valued by the client, individuals, families, and communities, and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in holistic and humane ways” (WHO, 2016) as discussed in Administrative Order No. 2020-0003.
2. **Effectiveness.** Delivering health care and products that improve health outcomes for individuals and communities, based on need as supported by evidence-based knowledge.
3. **Safety.** Delivering health care and products which minimize risk and harm to service and medical product users; health care and products that ensure that the patients and staff do not suffer undue harm from the treatment itself and from the manner it was given. Thus, institutionalization of the Patient Safety Program as mandated by the Administrative Order No. 2020-0007 shall be embraced among all healthcare facilities at all levels and networks.
4. **Efficiency.** Delivering health care and products in a manner which maximizes resources use and avoid waste (technical efficiency); resources are used appropriately to ensure optimum benefits for patients and the population (allocative efficiency).
5. **Equity.** The extent to which a health system does not vary in quality and deals fairly with the distribution of health care and its benefits to the people regardless of socio-economic status, religion, gender, race, ethnicity, political inclination, or geographical location. Further, equity implies considerations of fairness so that in some circumstances, individuals will receive more care than others to reflect differences in their ability to benefit or in their particular needs.
6. **Access.** Ability of the people to obtain health care and products that are timely, geographically and financially reasonable, socio-culturally sensitive and provided in a setting where skills and resources are appropriate to medical need.
7. **Appropriateness.** Defined as that care is effective (based on valid evidence); efficient (cost-effectiveness); and consistent with the ethical principles and preferences of the relevant individual, community or society. The priority given to each of these dimensions vary in different populations. Appropriateness contains a judgment regarding care at different decision levels (such as health care delivery, and research and development) that summarizes clinical, public health, economic, social, ethical and legal considerations. It is therefore important to consider who makes the judgment, on what evidence and following which process of consultation.



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ANNEX C. Plan-Do-Study-Act (PDSA) Cycle



Benefits of PDSA Cycle

- Scientific approach to improvement
- Rapid identification of effective solutions
- Small scale testing to reduce waste in resources
- Structured and organized improvement process
- Systematic documentation to facilitate learning and dissemination of ideas

The PDSA Cycle - Step by Step

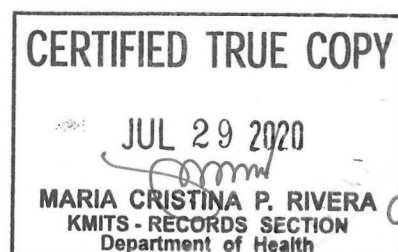
PLAN: *Define the Problem and Identify the Root cause*

Step 1: Identify area for improvement.

- ☐ Identify the area, problem, or opportunity for improvement.
- ☐ Estimate and commit the needed resources.

Step 2: Assemble a team.

- ☐ Identify and assemble team members.
- ☐ Specify team member roles and responsibilities.
- ☐ Specify meeting frequency and structure.
- ☐ Develop SMART aim.



Step 3: Identify current process.

- ☐ Examine the current approach or process flow.
- ☐ Obtain existing baseline data or create a plan to obtain needed baseline data.
- ☐ Obtain input from stakeholders.
- ☐ Determine root causes of the problem.

Step 4: Identify potential change strategies.

- ☐ Identify all potential change strategies based on root causes.
- ☐ Select change strategy (or strategies) most likely to achieve the SMART aim.

Step 5: Identify improvement theory. *NOTE: (Strategies should be evidenced-based thus, documentation/report requires the provision of corresponding journal articles.)*

- ☐ Develop a theory of change for the change strategy.
- ☐ Develop strategy to test the theory on a small scale (small number of participants).
- ☐ What is the strategy? Who will apply it? How will it be measured? What is success?

DO: *Customer Protection and Countermeasure*

Step 6: Test the theory.

- ☐ Carry out the test on a small scale.
- ☐ Collect, chart, and display data to determine the effectiveness of the change strategy.
- ☐ Monitor fidelity of implementation of the change strategy; document problems, unexpected observations, and unintended side effects.

STUDY: *Confirm effectiveness (Check is replaced with Study to put more emphasis on people understanding the results not just recording them)*

Step 7: Study the results.

- ☐ Was the improvement successful on a small scale?
- ☐ Did the results match the theory/prediction?
- ☐ Were there any unintended consequences?
- ☐ Describe and report what you learned.

ACT: *Feedback/ Feed forward*

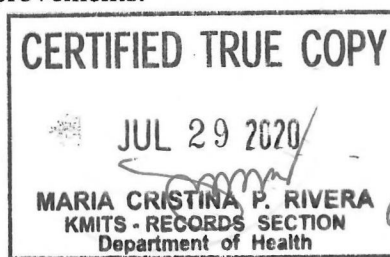
Three A's of Acting : 1. Adapt, 2. Adopt and 3. Abandon

Step 8: Scale up implementation.

- ☐ Scale up successful change strategies and continue testing until improvement is achieved.
- ☐ Develop and test new theories for unsuccessful changes.
- ☐ Standardize successful improvements.

Step 9: Establish future plans.

- ☐ Repeat the PDSA cycle, when needed.
- ☐ Take steps to preserve gains and sustain successes.
- ☐ Make long-term plan for additional improvements.
- ☐ Celebrate your successes.



The Measurement in PDSA Cycles

1. Process Measures

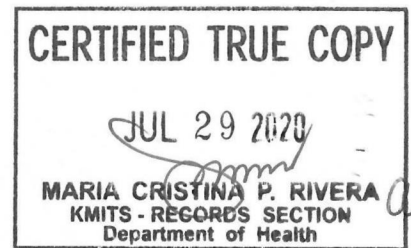
- ☐ Used to understand implementation of the change strategy.
- ☐ Help assess fidelity when testing a change strategy.
- ☐ Support scaling up.

2. Outcome Measures

- ☐ Used to determine if there is a change as a result of the change strategy tested.

3. Balancing Measures

- ☐ Used to identify unintended consequences of the change strategy.



ANNEX D. Standard Tools for Evaluation and Assessment

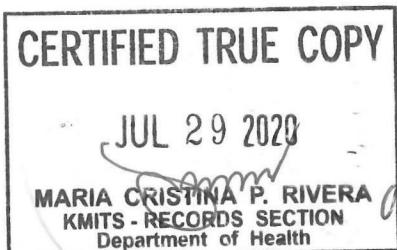
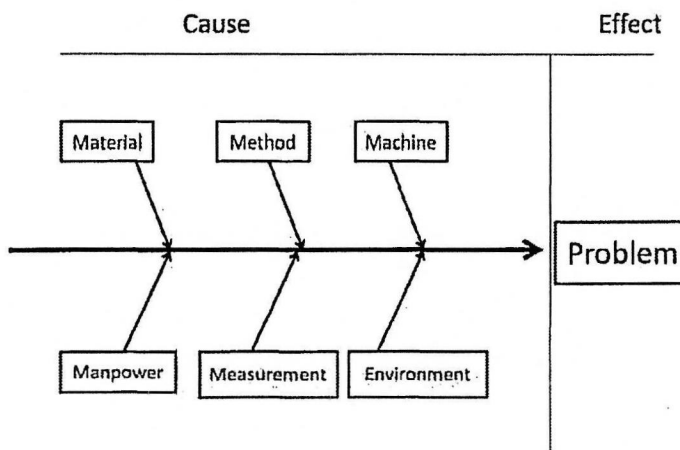
A. Problem Identification

1. Problem identification methods (Quality Monitoring, Evaluation and Design)
 - a. Problem Analysis
 - b. Criteria Building
 - c. Study Design
 - d. Data Collection and Analysis
 - e. Intervention Design
 - f. Intervention Implementation
 - g. Reevaluation
2. Monitoring Quality with Control Charts
-Tools for continuous monitoring of indicators, analyzing variation

B. Methods for Problem Analysis

1. With or without data:
 - a. **Flowcharts** – Structured description of the sequence of activities and steps of a process. Most useful to understand organizational problems and sequential coordination of several tasks.
 - b. **Cause and Effect Diagram (Fish Bone Diagram or Ishikawa Diagram)**
A structured display of the possible causes of factors that contribute to the quality problem (effect) under analysis

Step 1: Identify the problem
Step 2: Identify the main categories
Step 3: Identify root causes
Step 4: Analyze



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c. 5 Whys Activity

Step 1: Identify the problem

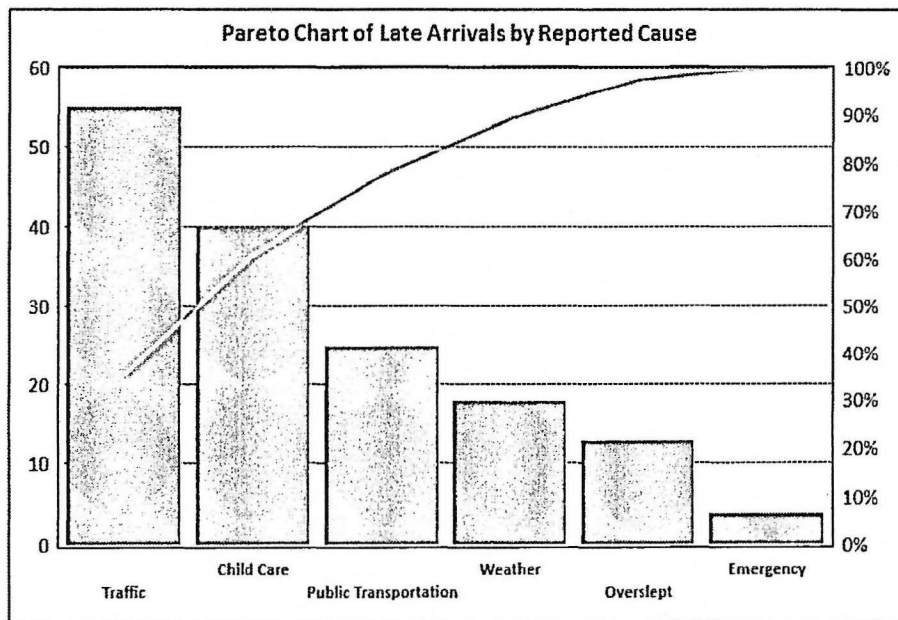
Step 2: Ask the first why question

Step 3: Walk the process backward, asking the next why question

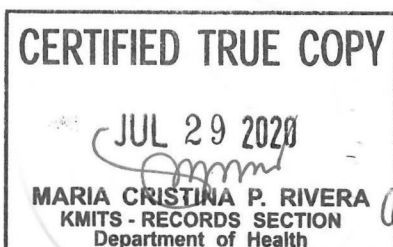
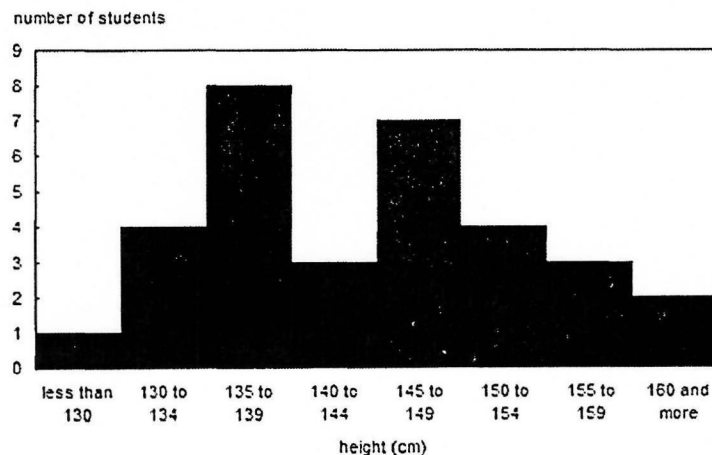
Step 4: Continue until asking the fifth why and arriving at the root cause

2. With Data:

- a. **Pareto Diagram or Charts** - contain bars in descending order for the values and line graph for the total. These are used to identify set of priorities to determine what parameters have the biggest impact on the specific area of concern.

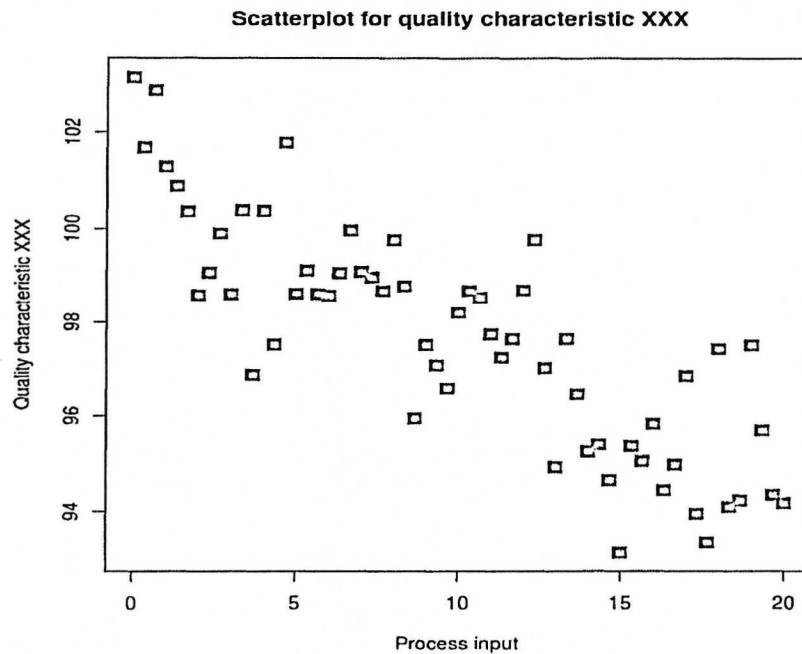


- b. **Histograms** - a chart with different columns representing the distribution by the mean. Are used to measure one thing against another and should always have a minimum of two variables.

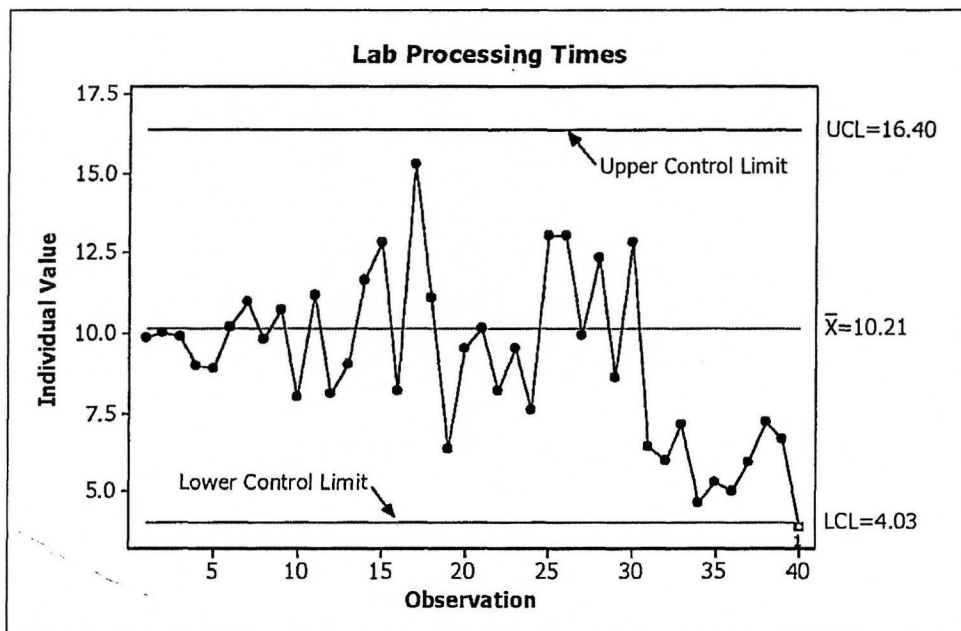


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- c. **Scatter Diagrams** – the best way to represent the value of two different variables. These present the relationship between the different variables and illustrate the results on a Cartesian plane. Then further analysis can be done on the values.



- d. **Control Charts** – a good tool for monitoring performance and can be used to monitor any process that relates to the function of an organization. These allow to identify the stability and predictability of the process and identify common causes of variation.



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