

Hospital Management Training

New ways to improve services in Indonesia



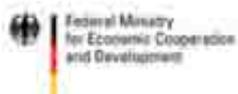


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New ways to improve services in Indonesia



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UNIVERSITAS GADJAH MADA
FACULTY OF MEDICINE

FOREWORD

Since the year of 2000, GTZ has already established a close collaboration with Faculty of Medicine, Universitas Gadjah Mada in the areas of teaching and learning process, research and consultation. The Principal Advisor of GTZ at that time, Dr. Paul Rueckert, visited our university as a guest lecturer and gave lecture at the International Programme of Medical Education in the Faculty of Medicine, Universitas Gadjah Mada. When Dr. Rueckert was replaced by Dr. Gertrud Schmidt-Ehry, the existing collaboration was then enhanced not only in the area of consultation on Health Financing, but also in the field of hospital management.

In year 2004, Dr. Gertrud Schmidt-Ehry from GTZ came to Yogyakarta to visit the hospital management master program at the Public Health graduate program in our Faculty. During this visit, ideas and idealisms were expressed from both sides and this became the starting point of the Hospital Management Training (HMT) program in Nusa Tenggara Barat (NTB) province of Indonesia. Two years later (2006), training needs assessment labelled as Rapid Assessment Procedure in Hospital Management, was carried out in Nusa Tenggara Barat and Nusa Tenggara Timur provinces. Following intensive dialogues between the stakeholders involved, HMT finally embarked on January 2008 with 18 training participants were participating from three public hospitals in Lombok island, NTB province.

This course was developed jointly with the hospital management master program, building on the current courses offered. Being part of the Faculty of Medicine with rich innovation in medical education, the hospital management curriculum also reflects a dynamic and continuous process of searching innovative strategies most appropriate for the education of hospital managers. With adaptations to meet the local needs of hospitals in NTB province, HMT course renews and implements the spirit of patient safety in hospital services by putting the patient first, reinforced by better clinical performance management, creating a well-functioning hospital and building linkages between hospitals and the health care system. This is achieved through the four main learning blocks in HMT, starting from patient safety and customer-focused services, clinical management system, functional management system and strategic management and leadership.



Through partnership with GTZ, SEAMEO TROPMED, University of Mataram and particularly hospitals in NTB province, this training has given mutual benefit. For UGM, not only the current curriculum in hospital management is strengthened, but also the overall training model that includes triangulation approach, integration of quality improvement action into the training, and comprehensive training evaluation methods strengthens the efforts to contribute in improving competence of hospital managers and human resources in health in general. We realize that HMT course will not cover all the menu needed for hospital managers to improve the hospital services. We do hope, however, that the course enlightens the hospital team work, motivates the team and hospital to update and apply their knowledge, and leads the way to sustain continuous quality improvement culture.

Finally, I would like to express my appreciation to NTB province and the hospitals, and to congratulate all stakeholders that have been involved in the efforts to develop human resource capacity of those engaged in managing hospitals. In this book, lessons learnt from the training process and key concepts applied in HMT are documented with the intention to further encourage other provinces as well as regions outside Indonesia to apply and adapt this training model in the pathway to improve management of hospitals for the benefit of the community at large.



Prof. Ali Ghufroon Mukti, M.D., MSc, PhD

Dean,
Faculty of Medicine
Universitas Gadjah Mada



SOUTHEAST ASIA MINISTERS OF EDUCATION ORGANIZATION

FOREWORD

The human resource is considered to be the most important resource of the health care system. The performance of the health care system is greatly influenced by the knowledge, skills and motivation of the human resource delivering the services. The quality and quantity of the health workforce determines to a great extent the success of a reformed health sector. Within the hospital setting, the same requirement exists. The quality of the services is influenced by the technical and managerial skills of the hospital team. The Hospital Management Training, developed and implemented within the context of GTZ and the Ministry of Health of Indonesia collaborative health projects, aims to improve the management skills of the hospital teams by focusing on behavioral change and internalization of the culture of quality improvement. The approach utilized in the training can be shared with other provinces within Indonesia and can be adapted to suit conditions in other countries in the region. This course is very timely to address the different challenges faced by the hospital and its staff especially in a decentralized state of health care like Indonesia.

As in any training program, continuous monitoring of the process of implementation of the training, and the utilization of the skills gained are prerequisites to its effectiveness. Furthermore, it should be underscored that the mainstreaming of the quality improvement concept is crucial in achieving a patient-oriented hospital services. SEAMEO TROPED Network's participation in the development, implementation and evaluation of this course is consistent with the mission of the Network and its mandate on the human resource development. A similar partnership was implemented in the 2 projects of GTZ in Cambodia.

Prof. Dr. Pratap Singhasivanon

Secretary General/Coordinator
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Tropical Medicine and Public Health Network



PEMERINTAH PROVINSI NUSA TENGGARA BARAT
DINAS KESEHATAN

FOREWORD

All praises to God Almighty for His permission and blessings that a book on Hospital Management Training (HMT) has been finalized. I also would like to appreciate the team who has prepared the book since November 2008. HMT planning was started with a workshop on 4 - 5 May 2007 in Jakarta, as a follow up of a Rapid Assessment Survey on Hospital Management (RAP-HoMe) conducted in all public general hospitals in Nusa Tenggara Barat (NTB) and Nusa Tenggara Timur (NTT) by GTZ Siskes/HRD, Gadjah Mada University (UGM) and Provincial Health Office NTB and NTT in 2006. The results of the RAP-HoMe showed that there is a need for training on Hospital Quality Management in order to improve service management of public general hospitals in both NTB province and NTT province.

GTZ Siskes/HRD, UGM and SEAMEO TropMed as well as NTB Provincial Health Office have collaborated involving also the Ministry of Health of the Republic of Indonesia for the hospital management training course development and implementation, including also Mataram University (UNRAM), Mataram Health Polytechnic (Poltekkes) and Nursing Department in Bima to organize HMT activities: in class training, workplace assignment, and QI Action at hospitals. The HMT book and toolkit have been implemented in two batches of training in NTB. The first batch was conducted in January to December 2008 for three hospital teams; NTB Provincial Hospital, Praya District Hospital and Selong District Hospital. The second batch extended from March to November 2009 involving the four remaining public hospital teams in NTB, namely RSUD Bima District Hospital, Dompu District Hospital, Sumbawa District Hospital, and Tripat District Hospital of Lombok Barat District.

This book is published in order to convey to all relevant stakeholders the importance of continuous hospital management improvement based on quality management with the hope that the model – which involves all relevant staff and use a team approach – can be adopted for future Hospital Management Training elsewhere.

This book is a product of experts from Indonesian universities as well as national and international experts. However, readers' constructive



criticisms and suggestions are most welcome in case of unintended mistakes. May this book and the HMT Toolkit HMT be useful for Indonesian people at large!



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DISTRICT HEALTH SYSTEM SUPPORT IN NTT AND NTB PROVINCE

FOREWORD

Focus on Primary Health Care, as revitalized by WHO in its 2008 Annual Report, is an important way to improve the health status of communities, to increase their own health responsibilities and to bring services close to the population. However, this is not sufficient. In case of emergencies the health system must also provide appropriate secondary level services to save lives. In this context the quality of services in hospitals is crucial to improve health indicators of the population.

Since 1973 I have gained a lot of experience by working on health systems and working in and with hospitals throughout Africa and Asia. In Togo, for example, we could show clear impact on maternal mortality by focusing on hospital improvement, decreasing the maternal mortality ratio from 400 to 62 per 100,000 live births within 6 years (1987-1993) in a defined district in the capital Lome. We proved that the remaining death cases at hospital level were mainly linked to managerial failures within the hospital and its supporting services. That is one of the many reasons why the focus of my work has always included hospitals and their management.

In Cambodia I continued my experience by involving hospital improvement in the overall health systems development. Poor infrastructure and lack of equipment was the initial big problem, but this was followed very soon showings gaps in skills and management.

Indonesia has fewer problems regarding infrastructure and equipment of hospitals and has a large capacity of skilled specialists and medical teams. Nevertheless, good human resources are not equally distributed across the country, and despite improvement in health indicators, the eastern provinces still show high mortality rates and alarming human development index scores. Evaluating hospital performance found that management problems are part of the challenges to overcome.



Strong leadership is one of the main assets for change and ongoing quality improvement. However, this alone is not enough, and it has proved to be unsustainable as leaders are frequently moved around. The Quality Improvement process requires a team, and to make QI a culture requires a critical mass. This has led me to rethink training approaches and to focus on team training rather than individuals. This includes immediate application of lessons learnt through practical exercises, enhancing peer exchange and using coaching in addition to classroom training. This approach was developed and implemented initially in Cambodia under the National Institute of Public Health, where I worked from 1995 – 2003, with assistance from teams from the SEAMEO TROPED network in Bangkok and Manila. The Cambodian Ministry of Health defined Quality Improvement as one of its priority areas of work for the period 2003-2007 and created a special unit at the MoH to develop specific strategies. Training in Cambodia is now implemented through the National Institute of Public Health (NIPH) and envisages covering all provinces and districts of the country.

Based on this past experience and despite large differences between countries, it was still useful to develop a hospital management training course in Indonesia using an approach similar to that in Cambodia but with different content. I am particularly grateful for the collaboration of Gadjah Mada University, and particularly Dr. Adi Utarini of that team, for contributing very new concepts and focusing on patient safety from different perspectives within the hospital and the health system, thereby bringing patient rights to the forefront and enriching the curriculum.

My gratitude goes as well to all of our Indonesian partners and stakeholders, especially the Ministry of Health in Jakarta, local decision makers, Provincial Health Offices, the local universities and training and education institutions, and especially the hospital teams. We count on them to take full ownership of the QI process and to make the current Course Book available to other provinces to share their experience and to continue advocacy for ongoing QI process and hospital management training.

SEAMEO TROPED was once more an important partner in the realization of the course development in Indonesia, and we count on them to further promote this course book to other interested countries through their network.



My special thanks go also to Peter S Hill, Associate Professor, International Health Policy, Australian Centre for International and Tropical Health who once again assisted in the final editing and improvement of this book.

My thanks also goes to the German (BMZ) and British (DFID) governments for making funds available so that the training could be developed and conducted. They are also invited to further promote this book.



Dr. Gertrud Schmidt-Ehry, MPH,

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GTZ principal advisor for SISKES
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INTRODUCTION TO THE COURSE CONCEPT & CONTENT

Inspiring hospital teams
for quality services through
hospital management training

Authors and acknowledgement:

Dr. Adi Utarini, director of Master of Hospital Management Program, UGM – Yogyakarta Indonesia; Dr. Gertrud Schmidt-Ehry, principal advisor for the two projects SISKES and HRD, GTZ Indonesia.

The course content was modified and further developed from the existing master program in Hospital Management, Postgraduate Program in Public Health, Faculty of Medicine, Universitas Gadjah Mada.

Overview of chapter:

This chapter explains how the hospital management training course was developed, why this approach was used, how the process was perceived and how implementation worked and what lessons were learned to improve subsequent courses. This first course implementation has been undertaken as a pilot, with errors expected, and adjusted for the second course.

The chapter should be helpful for those who wish to implement this course elsewhere in Indonesia, or in other countries. For participants, it gives a better understanding of the context of the course, before getting into the content of the modules.

CONTENT

A. BACKGROUND INFORMATION ON THE COURSE DEVELOPMENT

The Hospital Management Training (HMT) course was developed in the context of two projects financed by the German and British Government and implemented through GTZ and the Indonesian Ministry of Health and its local representatives. The overall objective of the Improvement of the District Health System in Nusa Tenggara Timur/Nusa Tenggara Barat (SISKES) project is that the population in the provinces of Nusa Tenggara Timur (NTT) and Nusa Tenggara Barat (NTB), especially the poor, women and children, use quality health care services. The objective of the Human Resources Development (HRD) project is that personnel management of appropriately qualified health personnel in NTT and NTB meets local requirements and national guidelines. Thus both have quality of services and quality of health staff as a common point of intervention. Each of the projects uses a multilevel approach and is aligned to national policies and provides feed back from local experiences to the policy development level. SISKES places a priority on maternal and neonatal deaths through enhancing systematic maternal auditing on cases of maternal death, and draws attention to how we can learn from medical errors in hospitals. Through training of hospital management teams, focusing on behavioural change, staff can become increasingly patient oriented and introduce changes such as the reporting of medical errors. The team training approach is aimed at behavioural change. Small quality improvement action projects focus on immediate implementation of newly acquired skills. Poor management, as well as poor clinical skills and missing or poorly maintained equipment and materials contribute significantly to patient deaths. Despite the impact that improving quality services in hospitals can

have on maternal and neonatal death, few international donors provide support for hospitals in their projects. With the available resources, in the context of our project, it was possible to develop a new training course approach and to pilot test it, before drawing conclusions and preparing broader use of it. A similar concept had been initiated by the present principal advisor of the two Indonesian projects in Cambodia in 2000 for district/provincial management teams, and in 2003 for hospital teams in the National Institute of Public Health (NIPH) involving SEAMEO TROPMED (South-East Asian Ministries of Education, Tropical Medicine). The hospital assessment in Indonesia showed similar problems in the quality of the hospital management, motivating replication of the project here.

In addition to SEAMEO TROPMED a team from Cambodia was involved in the final review of training impact 6 months after completion. This gave the opportunity to exchange experiences and learn from each other, especially seeing Cambodia's experience during a longer period of time



and how the culture of quality improvement was maintained in a broader context. There will be a short chapter from Cambodia based on their experience and analysing especially aspects of sustainability of the HMT impact on an ongoing quality improvement process.

b) Training concepts

The demand for developing hospital management training in Indonesia is a combination of the number and growth of hospitals, the continuous need to produce competent hospital managers, and the availability of competent educational institutions capable of delivering such training. The choices for candidates seeking hospital management training may vary from overseas' master degrees in hospital management, in-country master programs in hospital management offered by public and private universities in Indonesia, and training programs or short courses organized and delivered by hospital and health care associations, Ministry of Health, and other institutions.

These choices for hospital management training have several strengths and limitations. Overseas master courses on hospital management training lead to high qualifications at the expense of the participants' absence from work for a period of 1-2 years. On the other hand, they have opportunities to exchange experience with participants from other countries, being exposed to a different environment, and gaining more international perspectives and new ideas to be taken home. This opportunity may not be accessible for those who work in remote provinces and those with limited English language skills. In-country master courses on hospital management are more accessible for hospital managers. However, they still require full or partial work leave, ranging from 3 weeks to 3 months each time. On returning to their workplace, participants may lack the support and understanding that would enable them to implement what they have learned and it is certainly difficult to start a process of change from only one individual. The remaining options are limited to short-courses or training programs which do not lead to formal qualifications, and are rarely accredited by recognized institutions. The topics offered vary, with the consequence that many institutions offer similar topics (such as BLU¹ – Public Enterprise Hospital, unit cost etc.), resulting in duplication of content in different short courses, or a situation where topics needed by participants are not offered in the training programs. In-house training program is another possibility, given adequate financial and human resources.

NTB suffers from a high staff turnover, limited resources, and less individual power to start change processes, as do other provinces in Indonesia. On the other hand, NTB province has one of the lowest Human Development Index in Indonesia and urgent improvement, especially in the health sector, is needed. In the past the many fragmented training courses or sessions have been offered - often also linked to projects.

¹ BLU is defined in Chapter 1 Law No. 1/2004 on State Treasury and Governmental institution and offers hospitals to keep their income and manage it at the hospital. It is established to serve people/public in terms of commercial goods and/or service without prioritizing on profit and is based on efficiency and productivity principles in its implementation. BLU gives an opportunity for public hospitals to change into a better management system. Its final objectives are to (1) improve health service quality, (2) increase efficiency, and (3) ensure access equity to health services. There are substantial, technical, and administrative requirements to be fulfilled in achieving BLU status.

These have had little or no ownership from the local teams, and have been unsupported by decision makers and politicians. As is the experience in other similar situations, they have not resulted in the desired improvements, with staff not motivated to implement change. Based on these experiences, an innovative concept for hospital management training that addresses these issues has been developed. The main concepts of the HMT, as piloted in NTB are the following:

- a. The training materials have been developed in a modular form
- b. The training has been accredited by a university or training institution, and the modules provide credit towards other degree programs
- c. An articulation pathway has been developed to allow participants to continue their training to complete a Masters degree. The pathway maps the content of the training modules and quality improvement action plan and implementation, against the curriculum of the Masters program, identifying the additional coursework, research and thesis writing needed to complete the Masters degree
- d. Successful participants who meet University enrolment criteria are rewarded with the opportunity to continue their training in order to get a Master's degree. This takes into account existing credits accumulated through their training in this course, and undertaking the required additional courses.
- e. The training provides a basis for advocacy for objective educational criteria for posting, such as requiring a Masters degree for leaders such as hospital directors in the health system. Where the training is shown to be of practical use, it provides a rationale for recommending graduates for higher level positions after successful training
- f. The demonstrated benefits of the training have been used to negotiate with employers to maintain staff in their positions for longer periods, in order not to disrupt change and improvement processes

In order to develop these concepts into a concrete training plan, several institutions were first identified and their potentials were listed. There are five main institutions that have played significant roles in this training. These are:

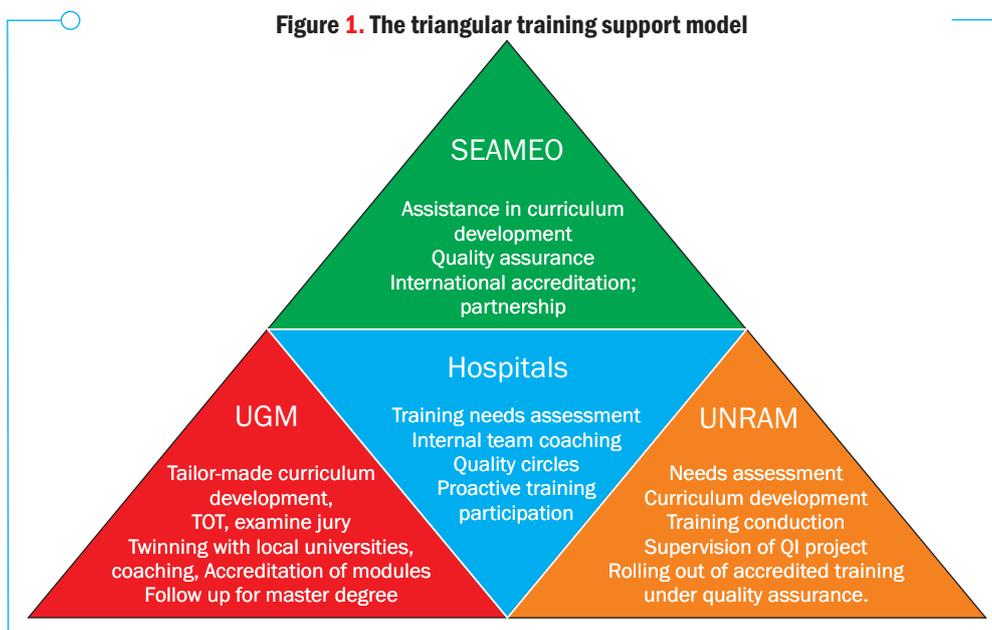
- a. SEAMEO TROPMED network, with international experience and accreditation, and a known history of building up capacity overseas in neighbouring countries, e.g. Cambodia, Laos and Vietnam
- b. UGM (Universitas Gadjah Mada), with an existing master course in hospital management and high commitment to quality education and training
- c. UNRAM (Universitas Mataram), a public university in Mataram that has a good knowledge of local context and is able to organize training courses
- d. HOSPITALS in NTB province, that have started with some quality improvement activities and are keen on going for BLU, some equipped with staff who already have Master's degrees and can assist as internal coaches for the team
- e. GTZ project staff, bringing in broad international experience in practical hospital management, its problems and possibilities for change and having initiated a similar training course concept before



A triangular training support model between SEAMEO TROPMED-UGM-UNRAM has been developed and their roles were further elaborated (Figure 1). SEAMEO TROPMED shared their experience from other countries in South-East-Asia, being in charge of organising and accompanying the benchmark

visit of stakeholders in neighbour countries, accompanying the course development during important milestones and being involved in the Hospital evaluation 6 months after course implementation. Through this they have a role in quality assurance and can provide international accreditation. UGM developed the tailor-made curriculum based on the

hospital needs assessment described later (Rapid Assessment Procedure in Hospital Management or RAP-HoMe), undertook preparatory workshops reflecting these needs, and developed the current curriculum of the hospital management master degree. They conducted training of trainers, were involved in selecting the participants; seeking accreditation of training modules; delivering training sessions; supervising quality improvement projects and implementing the final examination; and developing continuation plans for a Master's degree. UNRAM was involved in the needs assessment, curriculum development, training process, coaching and assisting in quality improvement action project and the final examination and organized the delivery of training under quality assurance. GTZ project staff were involved in all important concept development steps and in the implementation of the second training course covering all remaining public hospitals in NTB province.



Previous experience in training activities has revealed the importance of ensuring an appropriate atmosphere beyond the training itself, and winning the support from local government has to be seen as crucial to successful training. For this training, the following cycle represents critical steps leading to optimum achievement.

First, advocacy for quality management: Advocacy was carried out with local decision makers in several stages and activities to secure their interest, commitment and support for the concept of quality management. A hospital benchmarking activity involving stakeholders from local governments,

ADVOCACY FOR QUALITY MANAGEMENT

hospitals, facilitated by GTZ and SEAMEO TROPED, was organized prior to training activities. This gave hospital managers and politicians an opportunity to see quality management working out in other countries, and what that could mean for their respective hospitals. A written commitment from the local government and hospitals was required during the selection process in order to maintain the staff in their current positions and to demonstrate their commitment towards change and quality improvement.

Second, training content should be based on local needs and developed according to national and international standards. This principle was applied

TRAINING CONTENT SHOULD BE BASED ON LOCAL NEEDS

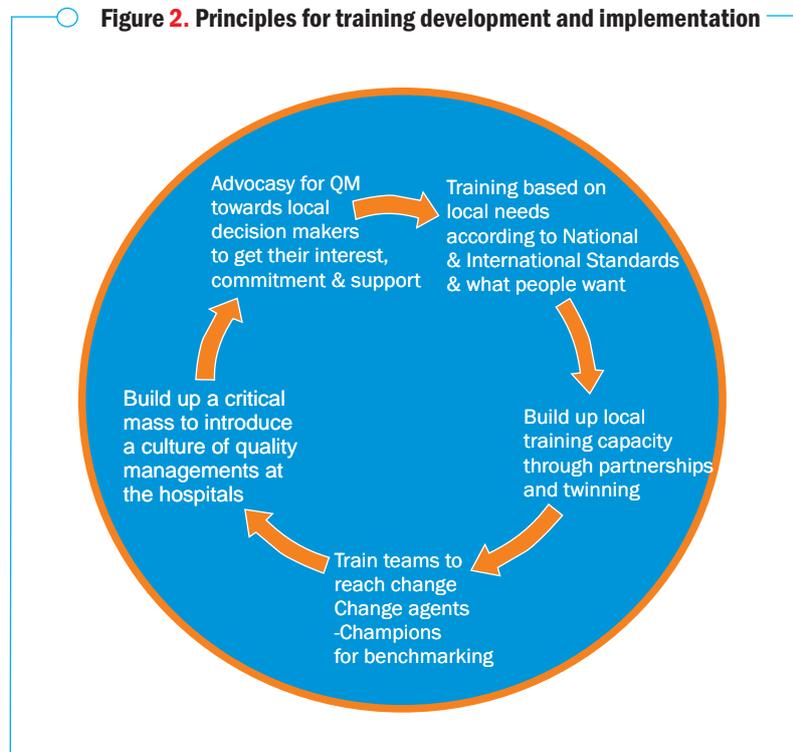
in this HMT through a training needs assessment (RAP-HoMe) conducted in 18 hospitals in NTB and NTT provinces. The main instruments used for the assessment were the hospital licensing requirements, the European Foundation for Quality Management self-assessment, hospital performance indicators and felt-need training assessment. Each hospital was visited by 3-4 surveyors (consisting of combined UGM and local surveyors) for 2-3 days. For measuring hospital inputs, the Ministry of Health (MOH) standard was applied as this is mandatory for all public-private general hospitals. Among the 18 hospitals reviewed only 66.4% and 63.8% of the hospital licensing requirements were met. Out of the four components in the hospital licensing standard, the lowest compliance was in the areas of governance and management (Utarini & Jasri, 2006). The findings were presented in several occasions and discussed in follow-up workshops organized in NTB and NTT provinces.

BUILD CAPACITY THROUGH LOCAL PARTNERSHIP

Third, build local capacity through partnership and twinning between a well recognized national university (UGM) and the local university (UNRAM). The local university has been involved throughout all processes from



Fourth, train the hospital teams as change agents with the main intention to plan and initiate improvements in the hospital.



During the HMT, the hospital teams were given an opportunity to apply what was learnt in their training through a quality improvement action project. The purpose was for the teams to experience the complete process of problem analysis, planning, through to evaluating the change, and to build up a critical mass to introduce a culture of quality management at the hospitals. This is carried out through a structured interaction between the hospital teams, hospital staff, tutor, trainers and stakeholders at the end of each training block and quality improvement action project (see training design below).

A roadmap for HMT was then prepared in reference to the above principles for training development and implementation. The roadmap consists of the following activities which will be described in subsequent subheadings:

1. Advocacy at the local level

2. Curriculum development
3. Orientation of Stakeholders and Training of Trainers
4. Implementation of first training batch, including team building measures and the QI action project
5. Training Evaluation, final examination and accreditation
6. Impact assessment 6-12 months after training completion
7. Review of the first training, lessons learned and the way forward

The overall training objective and expected outputs had been defined when the planning for the training started and the first ideas on a possible concept were further elaborated.

Figure 3. The overall objective for the training course and expected outputs

Objectives	Expectations	Measurement
Objective of the Training Course	Improve managerial skills and attitudes towards quality management at the hospitals in NTB & NTT to reach BLU status and based on international standards.	<ul style="list-style-type: none"> ✓ # of successful candidates ✓ Cost per succesful training ✓ Reaching the targets of the SPM's ✓ Patient satisfaction and health outcome ✓ Reaching BLU status: full accreditation.
Direct expected results	Appropriate knowledge and skills to implement quality improvement measures in the hospitals.	<ul style="list-style-type: none"> ✓ Post-test for each Module, final examination, ✓ Implementation of QI measures ✓ Differences between pre- and post-test will measure the ability of the trainers and the concept.
Expected Outputs/ Products	<ul style="list-style-type: none"> ✓ Training tool kit containing Modules, concept and process developed ✓ Improved organization and management of hospitals ✓ Successful implementation of quality improvement project. 	<ul style="list-style-type: none"> ✓ Tool kit available and disseminated ✓ Survey to assess management performance difference before and after training & one year later ✓ Evidence on quality improvement based on defined indicators.

1. ADVOCACY FOR HMT

In a decentralized health care system, the local government has the authority to designate and deploy human resources. This can be problematic if job placement is carried out based on political considerations rather than competence. Therefore, the commitment of local stakeholders to retain HMT participants in their hospitals for at least a certain period of time (3 years) is critical for the training to have an impact on improving hospital services. The strategy applied for advocacy was to organize a benchmark visit to neighboring countries, participated by a team of local government officials, hospital directors, assisted by GTZ staff members.

The general objective of this benchmark visit was to provide technical support and give inputs based on the international experience from ASEAN countries through the SEAMEO TROPED network in the development and implementation of HMT. The specific objectives were:

1. To expose decision makers to hospital performance using ongoing quality improvement approaches in Thailand and the Philippines.
2. To give them a chance to discuss with important stakeholders from the countries visited issues regarding health human resources policy and management, and the development and sustainability of good quality in hospital services.
3. To obtain commitment from the benchmarking delegates subsequently to support HMT and the quality improvement project, to mobilize local funds for the next training batches, and most importantly to have their commitment to sustain HMT participants in their hospitals after training.

With adequate support and a well-programmed benchmark visit, this tool for advocacy has brought some new perspectives to the delegates. New

ideas and innovations for better health services gained from the visit, and supported by current knowledge of the health systems in Indonesia has been a strong motivating factor for the delegates to commit to improving the hospital services. Those letters have been signed by the assistant Bupati (assistant to local head of government), Bappeda (Planning Department) and Hospital directors. Given the fact that elections were ongoing during the training and that the agreement did not include the maintenance of hospital directors in their positions, careful monitoring was needed to track the extent to which the commitments were fulfilled, despite these changes. In the advocacy tour which was conducted in preparation for the second training batch, we also requested that the province retain the hospital director in their position. This second advocacy tour covered all remaining districts in the province. The tour included the UGM team, PHO representatives, the GTZ team, as well as the hospital director from the provincial hospital together with one former HMT participant. As a result, we were able to gain interest and commitment from all hospital directors and local political leaders and parliamentarians.



During the implementation of the HMT course, a film was made based on a patient story, told by the sister of the patient, as a narrative focus throughout the film. Although the story finished with the death of the patient, it has been powerful in demonstrating in concrete terms how the training could address some of the

problems causing delay in the management of the case, and showing what the teams have learned and started to implement that will improve the situation. This film will be useful for further advocacy with decision makers, hospital directors, and also with the broader population, so that they can see that the hospital teams take what happens seriously. This could form the start for a new dialogue between the hospital, the patients and the community.

○ **Box 1**

“He was a real village person, a horse-cart driver. He was quite a naive sort of guy, couldn't really do much else. When he felt ill we both stayed one night and afterwards I took him to the hospital. Around this time we brought him to the hospital, we waited so long in the emergency ward of the hospital, waiting for blood and other things. We had to buy 3 bags of blood, but we did not have any money so I went home again to borrow money, I borrowed Rp. 400.000 to buy blood.

At first when it started to get worse, he came to me and I brought him to the Puskesmas. But first we had to organize a letter for free healthcare. To get this letter we had to wait for hours and hours, and I had to go back and forth several times between the Puskesmas and my house to get all sorts of things. And in the meantime my brother-in-law was bleeding to death in the hospital...

[And the administrative procedure?] To organize things I had to walk up and down from the 3 floor about 5 or 6 times. When one nurse gave a letter, the other nurse upstairs said it was the wrong one, why are you giving me this he said? I said I don't know this is what they gave to me downstairs.

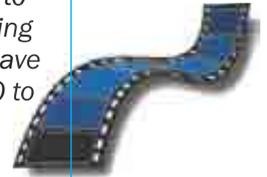
[How long did it take before your brother in law was treated?] Waa, very long, the doctors were busy phoning left and right, my brother in law was in bad pain, he was urinating blood.

[Wasn't he treated?] There were lots of doctors, but also lots of patients. In the emergency room that was where we waited for such a long time.

[But after giving about half a bag of blood he already died. And the blood was still frozen you said?] Yes, they had to warm it up first, it couldn't be used instantly, it was still frozen, came right out of the freezer. [And he was bleeding heavily?] Yes and this young doctor was asking all sort of things like: how long has he been like this? I answered already quite long but never as bad as this.

[And in the end he died?] Yes, I went home for a shower and got a phone call that he had died.

But what really surprised me is that when he was in so much pain it didn't show on him, even when he died he looked so peaceful. His face looked so normal, just a little pale that's all.”



2. CURRICULUM DEVELOPMENT

The curriculum for this training adopts the conceptual framework applied in the new curriculum of the hospital management master program in UGM. In the new curriculum, the conventional approach of management as commonly structured in business schools was no longer applied. One cannot find subjects such as human resource management, marketing management, information management etc. as subjects in the curriculum. Here, the curriculum is not structured according to the perspective of hospital managers (i.e. based on managerial functions), but from the patient perspectives.

The two main resources that have contributed significantly during the conceptual phase in developing the curriculum for the hospital management master program were Mintzberg (2004) and Berwick (2002). Mintzberg (2004) clearly points out the general mis-match in the business school curriculum, what is actually needed to enable managers to learn as part of their personal and organizational growth and development, and how can it be designed and delivered in a positive learning atmosphere. Eight basic propositions for management education are proposed by Mintzberg (2004) and the key messages are the following:

- Restricting management education to practicing managers
- Gaining learning experiences and feeding them back continuously to the workplace
- Solving problems in a thoughtful way
- Reflecting managers' experiences in the light of conceptual ideas
- Sharing competencies to raise managers' consciousness about their practice
- Stimulating further learning through reviewing its impact on the organization

- Blending together all learning elements into a process of experienced reflection
- Creating an educational program with flexible facilitating

The second concept was the 'chain of effect' in improving health care quality developed by Berwick (2002) in the Institution of Healthcare Improvement, USA. This chain takes patients' experiences further to be the fundamental source of definition and improvement of quality. The inter-linkages between the patients' experiences and the health care system is described under four levels of interest: the experience of patients and communities; the functioning of the operational units of care delivery (or called microsystems); the functioning of the organizations to support the microsystem; and the environment of policy, payment, regulation and other factors that shapes the organizations. Each level interacts, and changes at the higher level are necessary to produce satisfactory outcomes with the final intention to tie quality issues more closely to patients' and communities' experiences.

Figure 4: The chain of effect in Improving Health Care Quality (Source: Berwick, 2002)



Using the resulting UGM curriculum of the Master's in Hospital Management, further adjustments to improve its relevance to the local context for hospitals in NTB province were made. Several inputs were then incorporated in the final HMT curriculum. These were the findings in the RAP-HoMe carried out in 2006, feedback from curriculum review workshops involving the participating hospitals and key institutions in the triangular model, and discussions with UGM and UNRAM trainers.

2.1 Training Competence

At the end of training, the team should have the following competences:

- a. Understand and apply hospital safety in order to identify and measure safety issues
- b. Design and improve processes at the micro level care delivery system
- c. Understand organizational factors and identify the need for changes at the organizational level
- d. Increase the need to have leadership attributes and improve managerial skills to enable the hospital teams to plan, implement and evaluate changes
- e. Be able to involve the higher management of the hospital in the overall training process
- f. Act as change agents and implement quality improvement actions



2.2 The training curriculum

The curriculum places the patient (and community) at the centre of hospital management, in the HMT curriculum. It addresses hospital management topics at each different level within the hospital, using the patient's experience as the logical basis for improvements in operational units that deliver care. It then links those experiences to organizational issues and the broader environment in order to facilitate change at the operational level. This allows participants to deal with the same topics several times, but from different points of view.

The learning blocks in the curriculum start with putting the patient and community first, in a block named 'Patient Safety and Customer-focused Services'. This block integrates the concept of patient safety and customer-focused services into the everyday life of the HMT team. Participants are

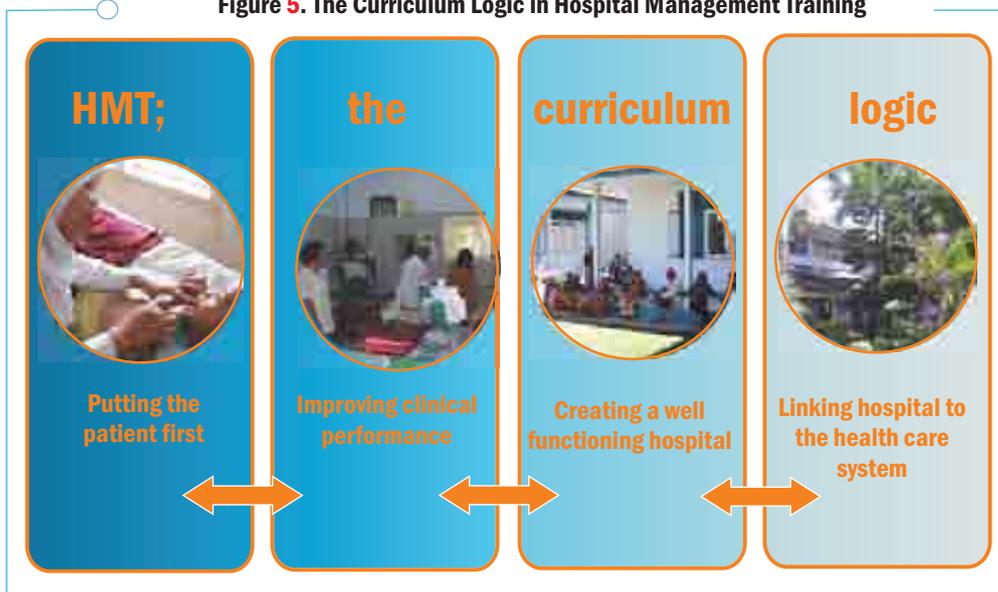
expected to comprehend the complexity of hospitals and the competition they face, and to identify dynamic changes faced by their hospitals. The concept of patient safety and customer-focused services should be internalized and communicated to the organizations and their implications for managing the hospital at the operational and organizational level discussed.

The principles of patient safety and customer-focused services are then applied at the unit or service level, whereby smaller operational units in hospitals deliver the actual care to the patients (or known as the 'microsystem' level). Through the clinical management system, hospital staff make direct personal exchanges with patients in different units. Patients may obtain services at the outpatient unit, emergency unit, inpatient unit, laboratory unit, radiology unit, pharmacy unit, and many others. If successful, this exchange produces the desired feelings of satisfaction, positive experiences, trust and loyalty of patients and patients' families to the hospitals. Outcome of care and costs associated with delivery of care are thus determined by performance at this level, which is in fact the core business of hospitals.



Improving clinical performance is the key message given in this second learning block. In this block, participants are exposed to complexity in problems related to management, service and risks in order to design managerial and service processes at the microsystem level. The ability to implement, monitor and evaluate managerial processes and services are critical for managing risks and improving quality of clinical services. Various concepts in the area of clinical governance, service quality management, patient rights and professional ethics, clinical information systems, logistics, human resources, nursing management, managerial economics, finance, are discussed during this learning block, and supported by the development of adequate managerial skills. In addition, interdependency between the service-unit level and the organizational level is also explored.

Figure 5. The Curriculum Logic in Hospital Management Training



Logically, the next learning block exposes the participants at the organizational level to issues concerning performance and functional management systems. The scope of learning covers marketing management, financial management, production and operation, human resources and accounting, all applicable at the hospital level. In this third learning block, participants are expected to use the principles of business and management to solve problems for increasing hospital performance and to improve professional behavior that will support good governance in hospital.

The survival of hospitals does not only depend on their performance in business and functional management systems, but is also affected by their external environment. The focus of the final learning block (block 4) is linking the hospital to the health care system, referral between the different levels, interference caused by these linkages and factors in the external environment affecting their customers. In this block, participants are required to analyze the hospital business environment (external and internal) in order to formulate a strategic plan and a business plan to increase the hospital performance. The scope of learning consists of three main areas, i.e. hospital environmental analysis (i.e. changes of hospital funding and regulation), strategic management (consisting of strategic

management process, formulation of strategy and evaluation of strategic plan) and a business plan for a public service institution (called Badan Layanan Umum in Indonesia).

2.3 Training modules, case studies and assignments

The curriculum and modules were adapted from the Master program in Hospital Management in UGM. In response to inputs from stakeholders as discussed in the curriculum workshop, the following modifications were made for this training:

- Curriculum: the original curriculum consisted of 6 blocks. For the purpose of HMT, the final learning block of research method and statistics was completely omitted as this was geared toward academic exercises for the thesis requirement. In addition, learning block 5 (leadership and managing change) was integrated into the previous block on strategic management and leadership.
- Sessions and modules: After adjustments in the curriculum were agreed by the core team and other stakeholders, the number of sessions and modules were adapted accordingly. The number of sessions was reduced in each learning block without affecting the overall understanding and coverage of the learning block. Modules were rewritten partly or fully from the existing modules to increase readability of the text and the ease of comprehension of the content in order to suit the needs of HMT participants better.

Case studies (short and long cases) were also integrated into the training materials. Cases and assignments were used in different ways to enhance learning. The learning block on patient safety and customer-focused services applies short-cases derived from the news, articles or participants' experiences as trigger discussions for sensitization of patient safety problems. These cases were included in the trainer's presentations. The assignments further deepen the participants' awareness of patient safety issues in their own hospitals. Participants were asked to select a certain unit (e.g. emergency, pharmacy, laboratory, inpatient etc), to communicate patient safety and customer-focused services for that particular unit, and

finally to identify and analyze patient safety problems with the unit staff. In learning block 2 (clinical management system), a long case was specially developed for this training which illustrates the complexity of hospital operations in delivering care to patients. This case was presented in the beginning of learning block 2, as it also demonstrates the need to appreciate and comprehend the broad range of issues relevant to managing the clinical service. For illustration purposes, the case summary is presented below:

○ **Box 2**

Satiti, a pregnant woman of 25 years of age was brought by her sister to the emergency department at 6.45am with vaginal discharge and bleeding. During antenatal care with a midwife, she was told that she has twin in this first pregnancy. She was encouraged to deliver the babies in the hospital. Upon arrival at the emergency, Satiti waited for about half an hour before a nurse came to ask few questions. She was then taken with an old screechy patient carrier to the labor room, which is quite far from the emergency room.

WHAT WENT WRONG?

Arriving at the labor room, again she had to wait for half an hour due to shift rotation (at around 7.30am). Finally, a midwife came to examine her. Without wearing gloves, the midwife did vaginal toucher and said that she had 1-2 cm cervical dilatation. After examination by an obstetrician, Satiti was allowed to have a normal delivery as both the mother and the babies (with normal weight and presentation) were in good conditions. There was no indication for cesarean section.

WHY DID SHE DIE?

WHAT PROBLEMS CAN BE IDENTIFIED?

Around 2.20pm, the babies were born, weighted 3200 gram each. Soon, Satiti experienced heavy bleeding and the doctor orders IV line insertion and gives 10 unit oxytocin injection.

HOW COULD HER DEATH BE AVOIDED?

Bleeding continued. External and internal bimanual compression did not help. Finally, a hysterectomy was planned and the family was urged to look for blood donors. The hospital gave 1 blood bag and the family bought two more bags at 6pm and another one at around 830pm.

WHAT ARE THE MANAGERIAL PROBLEMS?

Preparation of the operating theater took 2 hours. An operating surgery in the emergency room was not available. The hospital already proposed this to the local government, but only 10% of the budget was available. The surgery was performed from 7.15pm to 8.15pm. Satiti was immediately transferred to the ICU before she finally passed away at 6am the following day.



At the end of this second learning block, an assignment was given to enable the participants to describe aspects related to the clinical management system. These are, for example, client experience, identification of needs and expectations, outcome of services, and many others. Participants are allowed to choose a unit providing direct services to the patients. Conclusion and recommendations were then given by the participants to improve the current services at a dedicated unit of the hospital.

Cases in the functional management system learning block were applied differently. The content of this block was designed according to the managerial functions performed in hospitals, such as human resource management, marketing management, finance, accounting, quality management, hospital information system, and physical asset management. Therefore, cases (long and short cases), exercises and assignments were developed referring to certain managerial functions. Two long case studies were developed by the local partner (i.e. University of Mataram) to give more emphasis to local situations. One case was developed on consumer behaviour (marketing case study) and another case was written on the insensitivity of staff (human resource case study). In addition to these case studies, short cases were also used during classroom teaching for the purpose of brainstorming the problem and exploring concepts that needed to be learnt. Examples of the short cases are as follows:

Box 3

A woman aged 40 years old was scheduled to have surgery for her kidney stone problem. The patient was taken to the operating theatre. After waiting for one hour, a nurse approached the family and gave them a prescription. The family had to go outside the hospital because the drug was out of stock in the hospital. Due to this problem, the surgery was further postponed.

WHAT'S WRONG?

HOW COULD THIS OCCUR?

Why did the patient have to wait in the operating theatre? How could the hospital run out of stock for that drug?

A hospital decided to buy an expensive item of medical equipment. After a while, it was found that the equipment was underutilized.

For the final learning block on strategic management and leadership, short cases were used to illustrate the steps in developing a hospital strategic plan. In the assignment, the HMT team was then asked to choose between developing-revising a hospital strategic plan or developing a business plan. The format for a strategic plan and a business plan was given to the participants.

Overall, the following materials are available for HMT participants:

- Course plan
- Training modules and session plan
- Case studies
- Assignments
- Trainer's presentations

3. Orientation of Stakeholders and Training of Trainers

Before the training starts, a meeting with all hospital directors and other important stakeholders needs to be held to remind them again of their commitment. It also provides an opportunity to reiterate the message that not only the participants profit from the training, but that all hospital staff will be involved in improving quality through implementation of what has been learned and that this should lead to start an ongoing process of quality improvement. Hospital directors need to keep informed and to support the process; if not it will be difficult to reach a critical mass that will ensure sustainable change. This should not be a problem as hospitals were already committed to quality improvement and had commenced change activities, even before the HMT course started.

Increasing the capacity of local universities is important for rolling out of training and further training and/or education development that use new approaches and content. Twinning lecturers from UNRAM with lecturers from UGM was another important way to transfer knowledge and approaches, and have an impact on local institutions. But their participation is not without challenge, as they may not see the usefulness of taking up new approaches without immediate benefit and due to their high workload with other routine programs may not be able to meet their commitments.



For the Training of Trainers or initiation of the local university lecturers, specific attention to the training content, as well as the training methodology, is required. Clear delegation of tasks and responsibilities

needs to be agreed upon. All modules should be completed before training commences, with the lesson plans and methodology worked out together. The local university trainers have an important role in the follow up of the hospital teams in the implementation of homework assignments, and in ongoing coaching for participants who need to practice their newly gained skills. This opportunity can also be used to clarify any issues not well understood during the training, to deepen theoretical knowledge and to link it to their daily work. UGM could then use ad hoc visits to assess the quality of the coaching and give advice for improvement. Team training requires particular attention and careful preparation, as universities conventionally construct education programs with a focus on individual, rather than team learning. Shortening the Training of Trainers and the attention that can be given to them because of time constraints may result in later inefficiencies and a loss of quality.



4. Training process and implementation

4.1 Team approach

The training activities should be part of a larger effort to ensure real improvements to the advantage of patients seeking care in hospitals. Their benefit should go beyond the impact on increasing individual competence, as commonly experienced in training targeted to individuals. There is often a lack of monitoring and supervision to support practice of the knowledge and skills gained in the students' work setting, and a mismatch between competence and job description in the organization. These factors, as well as high staff turnover, further contribute to the limited impact of training on increasing staff performance.

Applying a team approach, there is a better chance to stimulate the organization by sharing of learning experiences continuously throughout the training process. Specifically, intensive communications between HMT teams and their colleagues in the hospitals occur during assignments at the end of each learning block, presentations of the results to hospital staff in each hospital, and finally during the quality improvement action project.

Team composition also needs thoughtful consideration. Its composition should reflect the complexity of the problems faced and ensure that there is sufficient decision making capacity within the team to solve problems. If their structural positions are too low in the hierarchy, their capacity to make decisions is more limited. Similarly, if the team members consist of those in charge of clinical services only, problems related to finance, logistics etc. may not be familiar to them. Therefore, the team should represent key functions in the organization, such as clinical services, finance, logistics and functional staff (medical doctors, nurses etc.). The size should neither be too little nor too large, i.e. between 5-6 persons per hospital and no larger

than a team of ten. The team size should not affect the current functioning of services in the hospital.

4.2 Hospital and team selection

This training is targeted at hospital management teams at the level of senior to middle managers, composed of health professionals (medical doctor, nurse or other allied health professionals), management teams in charge of medical services and accounting or logistics. Participants may either already hold positions within the management structure or be considered as future managers. The training also provides women an equal opportunity to move up in the hierarchy, once they have successfully completed the training.

The selection of public hospitals is the first step in the selection process, consistent with the priority of aiming to improve services for the public. Selection criteria were developed to select both the hospitals and the participants. For selecting the hospitals, the criteria were:

- Letter of intent, consisting of: description of improvements undertaken in five areas assessed in Rap-HoMe (i.e. input requirement, performance, staff satisfaction, patient satisfaction and finance), list of proposed participants (6-8 persons, 40% female)
- Commitment letter from the local government to retain the participants to work at the hospital for at least 3 years post-training
- Commitment letter signed by the proposed participants and hospital directors to participate in the training
- Completion of form for each proposed training participant



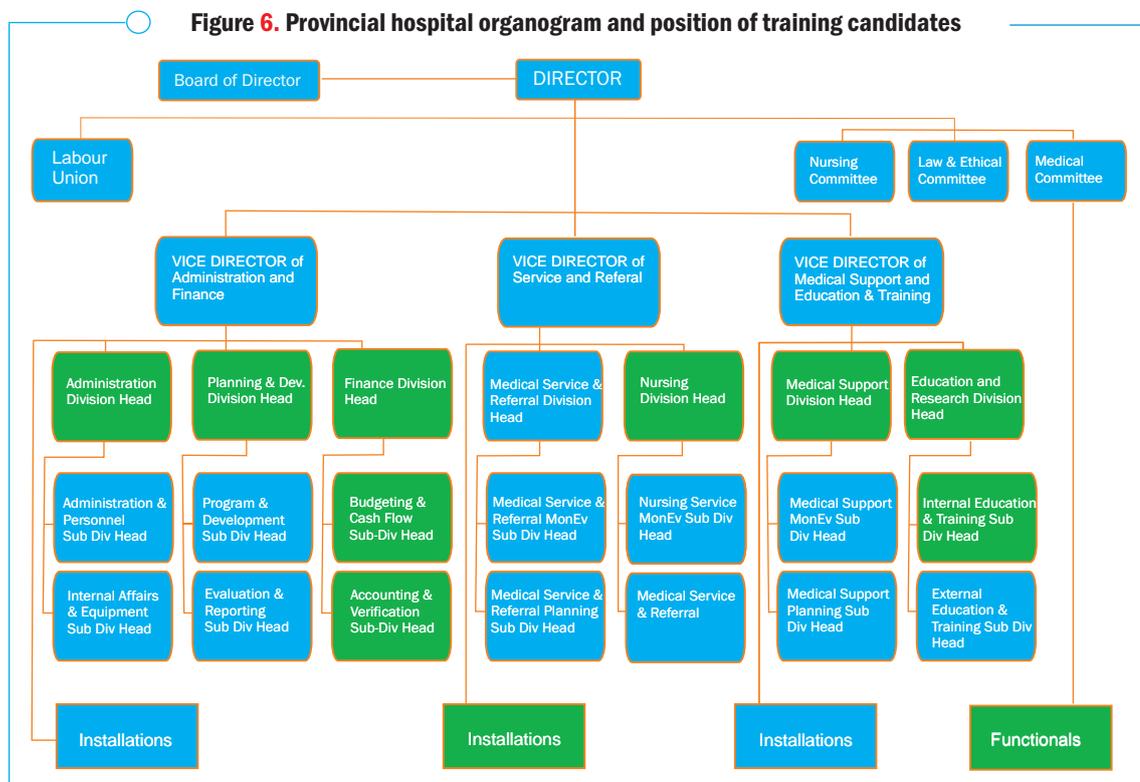


Figure 6. provides an example of the possible distribution of candidates for training within the hospital organogram (marked in green), though other combinations are possible. Once the hospital has been selected, the proposed participants are invited to nominate for the selection process.

Proposed participants should meet the following criteria to be eligible:

- Have at least two years of working experience
- Age below 50 years
- Completed diploma or undergraduate level of education.
- Have managerial positions at the middle level or work as professional staff (medical doctor, nurse, midwife or allied health professionals)

Meeting the above requirements, the candidates then take the selection tests, consisting of both a written examination and a panel interview. The written examination covers not only aspects related to knowledge

concerning local health policy and hospital management, but also tests their ability to work as a team, and ability to identify and solve problems using a case study. The interview is conducted by a panel of four examiners, consisting of representatives from the Provincial Health Office, the international support organization (GTZ) and universities (UGM and UNRAM). The interview explores the participant's motivation, awareness of health problems and policies set by the Provincial Health Office, and basic understanding of management and hospital managerial problems.

Applying the above selection processes for the hospitals and participant candidates, 3 out of 6 public hospitals and 18 out of 28 candidates were selected as HMT participants for the first batch of training. They were all from Lombok Island, which made the organization of the training easier.



During the first batch, the fact that some staff were not selected had a negative impact on the team work. Staff who were not selected did not feel concerned for the later change processes, and selection created divisions and jealousy within the staff. To deal with this, the selection criteria need to be communicated to the staff and be applied by hospital managers, and the trainer team may decline proposed selections and ask for new considerations to be made, if the team mix is not appropriate. As it may be necessary to include staff with lower qualifications as part of the team,

accreditation may need to be reconsidered and may not be possible for all participants.

For the second batch the selection process was changed as hospitals in more remote districts/islands do not have sufficient qualified staff to enable a real choice and the focus was to cover all remaining general public hospitals of NTB province. As a result, there was no competition for selection between hospitals, though they still had to fulfill the same criteria. The hospital directors were give the criteria and they had to provide a list,

which was critically analyzed, and if not conforming to the criteria, had to be revised.

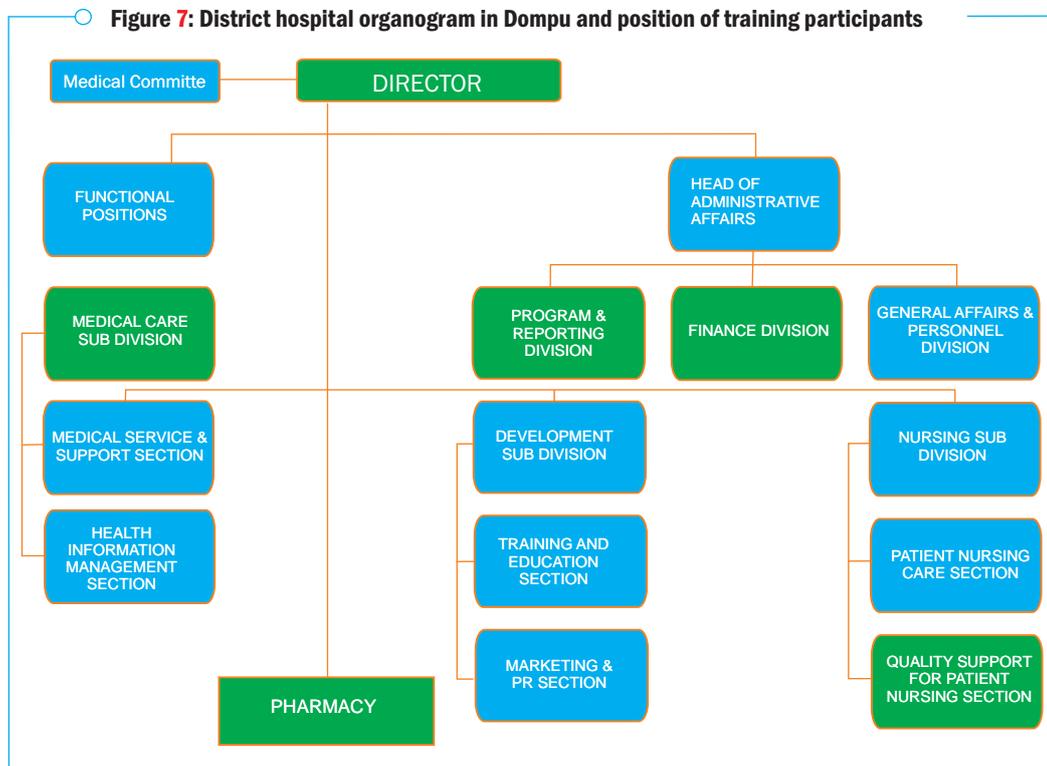
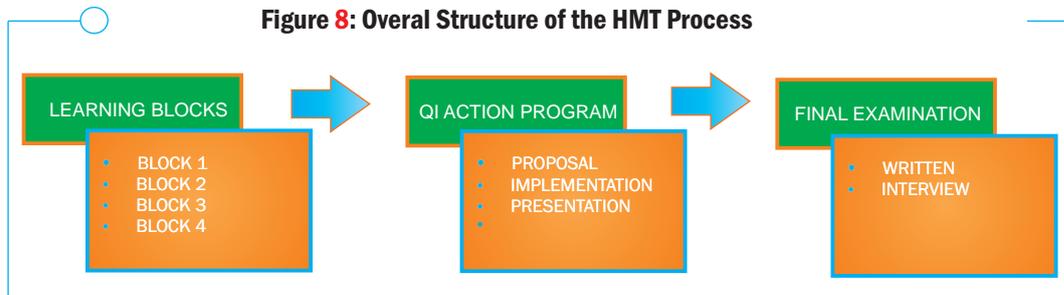


Figure 7. shows an example of participants distribution in the second batch is seen in the Organogram from Dompu district, where the hospital director also participates.

4.3 Training process

Overall, the HMT process is divided into three main components: the four learning blocks, the Quality Improvement (QI) action project and the final course examination. In total, the learning blocks take approximately 6 months, including assignments carried out in their own work settings at the end of each block. To enhance the application of concepts learned into practice, participants organize block presentations to other staff in their own hospitals. The results are then used to select priority problems in hospital management and to identify feasible interventions to be implemented within a 2 month period for the QI action project. Afterwards, the findings are presented in a seminar, inviting key stakeholders from

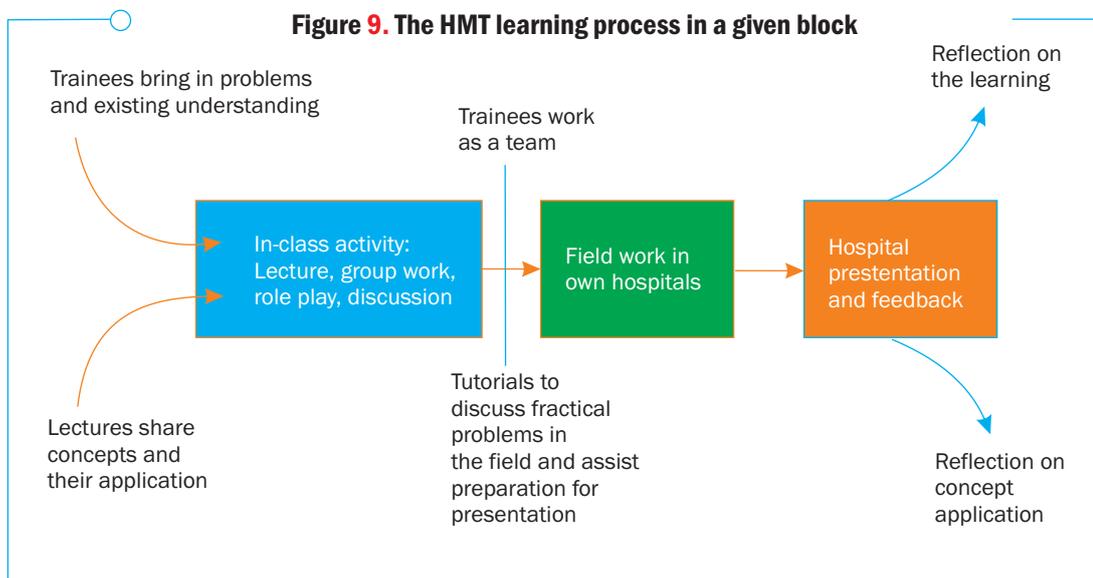
within the hospital, district/provincial health offices, universities and GTZ as the international organization involved. The final activity in the HMT is the final examination of the course.



The learning blocks were delivered over two full-days in a week (Friday and Saturday). In this approach, training is not conducted in isolation from their current duties. Participants have the ability to perform their normal duty and concurrently, concepts delivered during HMT can be related directly to actual situations in the hospital. Since participants come from the same island, within reasonable distance of the training, this design is easier to apply. For other situations, where participants are from different islands, regions or provinces, different strategies should be applied.

For the second training course, which was held in Sumbawa Island and distances between the hospitals were quite significant, the learning blocks were delivered over a one-week duration, twice a month throughout the training period. Each presentation of assignments after each block moved to a different hospital, as it was not possible to go to all of them every time. There was also a longer introduction especially focusing on problem analysis, which was felt necessary after the first training course experience.

The method used in this training is a participatory and active learning approach. Within each block, the learning process is designed as shown in figure 9.



Within each learning block, the process starts with giving an overview of the module and its learning objectives, delivered by the block coordinators. Lecturers are encouraged to give ample illustrations of real situations or pose a trigger problem relevant to the topics to be delivered. In this way, the learning is contextual and participants are motivated to take an active role in the learning process. Afterwards, experiences and thoughts expressed by the participants are linked to theoretical concepts. A typical session of 1.5 hours duration is divided into 5-10 minutes of introduction, 30-45 minutes of lecture and the remaining time available is used for discussion, practical-group exercises, role-play and a brief summary at the end of session. Each block has developed its own learning strategies in order to bring the concepts closer to the reality.

4.4 Coaching and Peer-Review

During homework assignments after each block, trainers assist in the homework and provide supplementary inputs in order to translate the theory into practice, and to clarify theoretical aspects which may not have been completely assimilated during the training sessions. The coaching is done on a regular base through the local university. Ideally, coaching should be done at the work place of the respective hospital teams and not in a class room, with agreed upon time schedules. Each team should have their own

coach, to be assigned in the beginning of the training. During the first training course, the principles of coaching were not well understood, and these concepts were not strictly followed. For the second training batch this has been changed. Coaches were appointed for each hospital and they participated in all training sessions. UGM was involved to ensure the quality of the coaching process. Participants present their results in front of their peers and the higher management colleagues from other hospitals. The valuable comments given and important questions asked for clarification provide important opportunities for feed-back and further learning. This creates an atmosphere of additional competition and encourages each hospital team to improve their work for each presentation.

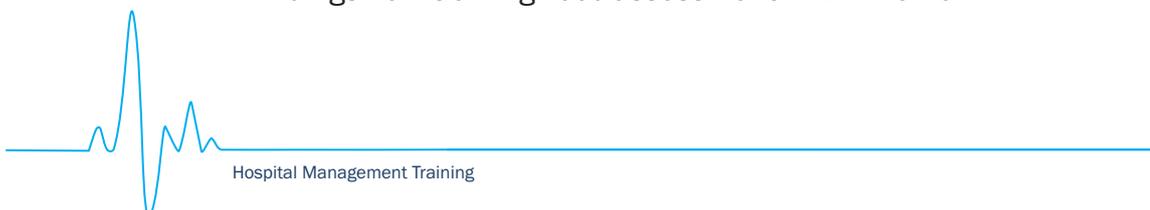
4.5 Quality Improvement action project

“Think big, start small, act now”. The QI action project is dedicated to improving current services and management practices in the hospital, demonstrating the direct benefit of HMT to the hospitals. The objectives of QI action project are three-fold:

1. To apply concepts learnt in HMT learning blocks 1-4 to diagnose priority problems and develop quality improvement action plan;
2. To implement and evaluate quality improvement actions; and
3. To share reflections on learning and the application of concepts.

In selecting priority problems, participants are encouraged to make use of information presented at the end of each block (hospital presentations) and to refer to priority problems in NTB province. In addition, the following considerations can be taken into account when selecting the priority problem:

- Impact on reduction of maternal and neonatal mortality ratio (focusing on death occurring in the hospital)
- Preparation toward reaching BLU status and hospital accreditation
- Findings from training need assessment in RAP-HoMe



- Main concepts referred on the curriculum concept (European Foundation for Quality Management, chain of improvement), and last but not least
- Hospital commitment and current planned activities

The QI action project can be used as an opportunity for the HMT team to strengthen existing interventions already underway in each hospital, to initiate new changes or to modify existing practices. Referring to Berwick's (2001) chain of improvement model, the intervention can be targeted at different



levels within the hospital, from the patient, services or unit, organization up to environment level. The learning blocks in HMT are linked to this chain, i.e. block 1 for the patient level, block 2 for the service/unit level and block 3-4 for organizational level. Action to increase patient awareness or participation in safety issues illustrates intervention at the patient level. Efforts to decrease health-care associated infections in the delivery room and to improve safety at the emergency unit are an illustration of interventions carried out at a service/unit level. Examples of organizational interventions include setting up of patient safety systems, modification of current hospital billing systems, strengthening the quality management system etc.

It is suggested that QI activities implemented as part of the HMT should focus on an issue whose results are achievable within the time frame of the training. The team can focus on a bigger issue but work on achievable activities/preparatory/first set of activities that will lead to the resolution of the bigger issue.

The preparation for the QI action project proposal should involve the director and other leading staff from the hospital. The process could start during the first block and be further developed throughout the course. It is

important to identify the core problem and analyze carefully the causes based on data and information gained, to apply what was learned during the course and then agree on one sub-problem. The problem should be examined to determine what quantitative indicators are possible for the measurement of change. This initial situation provides a baseline from which an improvement can be proposed and a strategic approach developed. Series of simple activities are then outlined to achieve the planned objective. Participants need to describe their hypothesis for change, explaining how these activities will bring about an improvement in the situation. The steps need to be clearly stated and the risks identified and strategies to minimize risks should be discussed. The QI action project should rely on available manpower and other resources, with a focus on small 'achievable' improvements within the more complex picture. In this situation, risks should not play a major role. A small grant has been part of the training implementation; nevertheless it is important that the concrete action plan is part of a broader picture and vision and can be used as a starting point for continuous improvement.



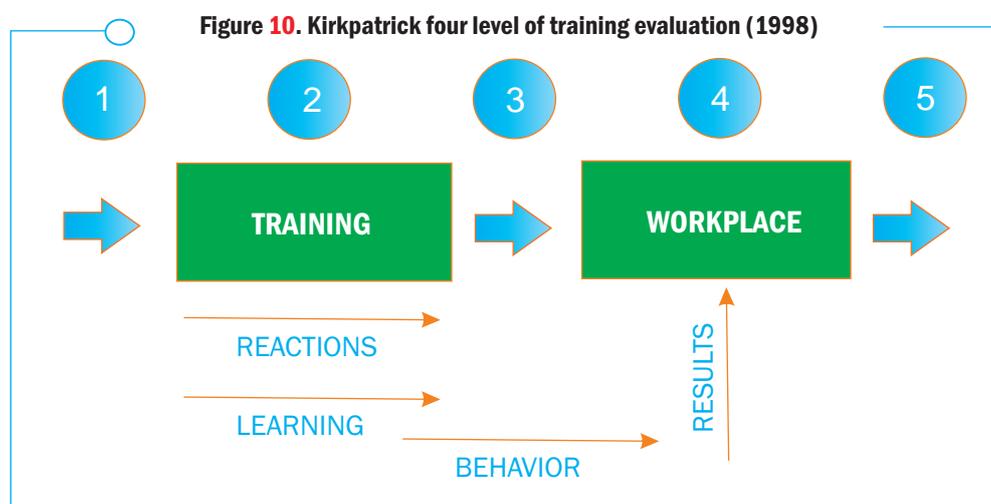
5. Training evaluation

The training evaluation has different facets to consider, each of them looking at quality output, relevance, applicability, and improvement, thus applying the principles of quality in its whole form:

- Training Process
- Feed-back to trainers
- Learning effect on participants
- Translation of theory into practice
- Ongoing accompanying monitoring and translation into improvement
- Participants assessment during course and final examine
- Impact on organizational change and improvement

5.1 Course evaluation

The training evaluation model from Kirkpatrick (1998) was used for evaluating this course. Donald Kirkpatrick's evaluation model, first published in 1959, has maintained its value, as it does not only look at newly achieved knowledge and skills, but goes far beyond this to include other aspects, focusing in particular on the impact of training in achieving quality improvement, but also on participants' perceptions of the training quality and process.



Systematic evaluation of organizational change is not usually part of the assessment of training, and funders of training courses rarely provide a budget for later post hoc evaluation of improvement of services or organizations. Especially in a decentralized environment, where the health sector has to compete with other sectors in budget allocation it is important to show local governments that investing in training can demonstrate evidence of improved public services and have an impact on patients.

In this training, four levels of training evaluation are applied. At the first level, the reactions of training participants to the session and learning blocks are documented through a simple check-list for each session of a given learning block. The check-list can be filled in at the end of session or at the end of the day. The second level (learning) is assessed through the comparison of questionnaires before and after each learning block. A pre and post test with multiple-choice question is developed for each learning block and the results are presented in terms of achievement of individual scores and average team scores. These first two levels are carried out during implementation of the learning blocks.

Questionnaire for participants' reactions to the session are filled in after each block to give feed-back to the trainers. The questionnaire can be seen on the next page.

PARTICIPANT REACTIONS TO THE SESSIONS

Block: _____

Topics of the session:

Session facilitator:

1. How relevant is this topic for you?
 - a. Not relevant
 - b. Partly relevant
 - c. Highly relevant

2. Balance between lecture and discussion:
 - a. Lecture dominates
 - b. Good balance
 - c. Discussion dominates

3. What do you think about the facilitator:

	Very good	Good	Neutral	Weak	Very weak
In describing the session objective					
In keeping the session attractive					
In communication					
In using audiovisual					

4. Overall, what do you think about the facilitator?
 - a. Excellent
 - b. Very good
 - c. Good
 - d. Adequate
 - e. Poor

5. Suggestions:



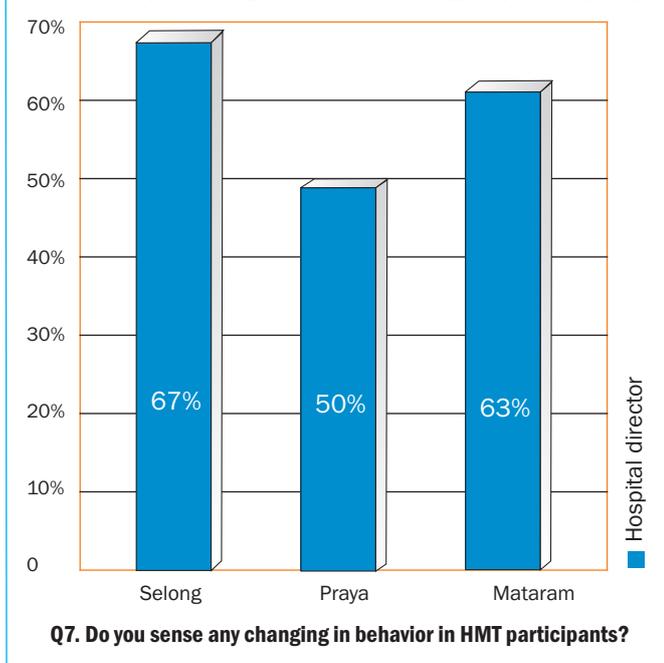
Level three and four (i.e. behavioral changes and result) are evaluated during the phase of implementing the QI action project. Behavioral changes are documented by asking the participants as well as their hospital management colleagues and supervisors. A survey of a total 41 respondents from three participating hospitals was carried out to identify different perceptions among stakeholders of HMT in West Nusa Tenggara province and to trigger further discussions for the lessons learnt workshop.

The respondents comprised HMT participants and hospital managers. In addition, trainers from UNRAM were also included in the interview. In this survey, changes or progress in relation to initiatives concerning patient safety, overall hospital management, human resource management, marketing and strategic planning were identified. Additional questions on the benefit of HMT to the hospital and training processes were also included and suggestions for improving HMT were sought. This survey was repeated later linked to the impact assessment (Rap-Home 2). The following results illustrate some of the findings from the first survey:

In addition to quantitative information, qualitative expressions were also

explored. For example, in one hospital with the lowest perception of managers toward behavioral changes of the participants, the reasons given were inability to judge the behavioral changes in few months after the learning blocks were completed. In contrast, those who perceived immediate changes stated “in advocating patient safety and during the revision of our strategic plan, HMT participants had lots of new ideas and inputs for the hospital. The team revised the strategic plan and it was approved by the local government”.

Figure 11: Change of behaviour of the participants as perceived by the hospital managers in West Nusa Tenggara province (n 38)



Some comments from a course participant taken from the film and linked to the problem as stated by the woman (page 9) nicely show the direct impact of the training on change:

○ **Box 4**

“We definitely feel the benefits of our information received by the HMT team in our hospital. In the emergency ward we have followed-up the recommendations and now things are running well. Before, the pharmacy for the emergency ward was too far away and the procedures for getting the drugs etc. were too long.

Starting from the 1st of July we supplied the Emergency Ward with its own stock of drugs and materials. By doing so patients will not have to go all the way to the pharmacy to get the drugs and come back here again“

Finally, the result of the training (level 4 evaluation) is captured by assessing the process and outcome of the QI action plan. These reflect the actual changes made in the hospital as a result of comprehensive mastering of hospital management content as well as managerial skills involved in a change process.

Unfortunately the QI action project had not shown immediate convincing results during the team presentation after two months, but gave a good understanding on the process and the initiative. But this was not felt as a problem, as the process went on and a follow up WS could correct this problem later.

5.2 Participants' assessment

The overall course assessment is designed to reflect the balance between individual and team performance. Individual performance consists of knowledge gained from the learning blocks, as shown by the pre-post test results and the final examination at the end of HMT, while team performance is composed of hospital presentations at the end of all blocks

and quality improvement action project process and achievements. The overall assessment was planned to have four parts as follows:

- 20% : Improved knowledge from pre and post tests in all blocks
- 20% : Final examination, consisting of written test and panel interview in equal proportion
- 30% : Hospital presentation at the end of all learning blocks
- 30% : Quality improvement action project

In reality, hospital presentations in each learning block were not calculated as part of the overall participants' performance assessment. Instead, those presentations are used as opportunities to give feedback on the presentation skills itself and to highlight key concepts delivered during the learning block. Therefore, the 30% initial proportion for hospital presentations at the end of learning blocks is redistributed to the other three components with equal weight.

The final examination takes two-days, one day each for the written test and panel interview. The written tests consist of 50 multiple-choice type of questions, 10 short-essay questions and one case study. Their proportions were weighted 40% for the multiple choice questions and 60% for essay questions and case study. Questions for the final examination were derived from the modules in the learning blocks as well as quality improvement action project. Overall, the maximum score for the written test was 100.

The panel interview covers four aspects. These are learning and individual action plan, behavioral changes, motivation and commitment, and career development plan. Each aspect was further developed into sub-aspects as the following:

- A. LEARNING AND INDIVIDUAL ACTION PLAN
 - a. Learning process
 - b. Understanding
 - c. Individual action plan



- B. BEHAVIORAL CHANGES
 - a. Participant's behavioral changes
 - b. Changes in the perception and behavior of hospital staff toward HMT participation

- C. MOTIVATION AND COMMITMENT
 - a. Commitment
 - b. Motivation

- D. CAREER PLANS
 - a. Changes in their job position/career during HMT
 - b. Career plans
 - c. Contribution of HMT and opportunities for higher education to their career plans.

For each aspect, 3-4 sample questions were developed (see box 5), from which the panelist was asked to select 1-2 questions. All four aspects were covered during this 30 minute interview. In total, there were 10 sub-aspects and each sub-aspect was scored 5. The scoring was carried out individually by the panelist, before interviewing the next HMT participants. If the individual score between the panelists for a particular sub-aspect exceeds 2, this was discussed and if necessary, the score was adjusted.

Box 5

B. Behavioural changes. Aspect 2: changes in perception and behaviour of hospital staff toward HMT participants

- a. Do hospital staff have different perception toward you during HMT?
- b. To what extent the hospital Director and staff treat you differently?
Are these positive changes?
- c. Do you feel that the hospital director and staff respect you better after participating in HMT?



Four groups of panelists are available and each panelist team is composed of the following stakeholders:

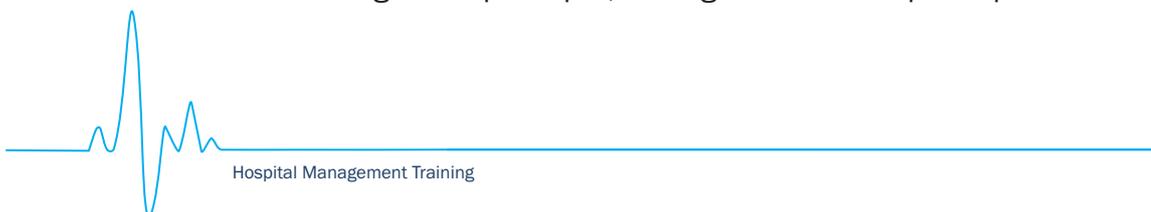
- Representatives of HMT core team members
- UGM
- UNRAM
- GTZ representative

5.3 Cost analysis and economic appraisal of the HMT

Quantifying the value gained through training, in order to do a cost-effectiveness analysis for HMT, is difficult, and little can be found in the literature on cost effectiveness analysis of training. Training is often perceived as an additional benefit for other interventions without a readily quantifiable value. One possibility for analyzing training costs could be to compare two different kinds of training and their respective consequences for patients.

The QI action project is focusing on concrete changes and results, such as reducing nosocomical infection rate often leading to re-surgery, to improve reporting on medical errors and thus being able to reduce them, would allow to link cost to changes and improvements.

Nevertheless, cost analysis of training is important, especially as resources are limited. The issue of sustainability is also significant - training cannot continue to be dependent on international organizations or donors, but must become a financially viable and beneficial option for local stakeholders to maintain. The analysis of cost linked to a defined output in the form of successful participants or something similar is not enough to convince local decision makers to invest in such training. Measurable improvements based on hospital indicators would be more convincing. As many other factors influence the real impact on outcomes such as decreased mortality ratios, it will be difficult to clearly show cost-effectiveness. Here as an initial step we are examining costs per input, linking these to the participant team and



calculating costs per individual participant. Further analysis can only be estimated, as there is need for a longer period to assess change or/and improvement or/and impact.

We have analyzed the cost according to the different inputs for the first training course. There were no additional costs for participants such as accommodation, as everybody could go home at night, but participants and trainers were provided with meals and snacks during the training session, and a small amount for transportation was paid (50.000 IDR² per day per participant), and is included in the training implementation calculation.

The preparation cost includes the selection process, the workshops and the trainers' and stakeholders' orientation and the official opening ceremony.

The implementation analyzes the cost for each Block and the training material, as well as the travel costs for trainers. It does not count the salary or lost time of the trainers or participants, only direct payments linked to the training.

The QI project includes the preparation the result and the evaluation. The additional costs which may occur in the hospital are not taken into consideration.

The Monitoring Workshops are the mechanisms planned for ongoing evaluation and analysis.

The course management includes all kinds of logistic costs as well as Human Resources for coordination.

Neither the benchmarking visit nor the involvement of SEAMEO TROPED network is included in the calculations.

² 10.000 IDR are about 1 US\$ at the time of the training

Box 6: Cost analysis of HMT Training

1 EURO= 13,000 IDR

Item	Cost in IDR	Cost in EURO
Preparatory Phase	141,295,000	€10,869
Implementation Block 1-4	378,605,000	€29,123
QI action project	200,500,000	€15,423
Monitoring Workshops	65,405,000	€5,031
Course Management & Coordination	258,930,500	€19,918
Final Examen (estimation)	50,000,000	€3,846
Follow up survey on hospital competence (estimation)	260,000,000	€20,000
Total cost per course:	1,354,735,500	€104,210
Total cost per Hospital team:	451,578,500	€34,737
Cost per Trainee (18) course fee per Trainee enrolled in the UGM	75,263,083	€5,789
Master Degree course	95,449,000	€7,342

The cost per trainee or per successful trainee is still slightly cheaper than the participation in the Master Degree course. Nevertheless to weight the advantage and disadvantage and possible impact in improvement for patients through one kind of training against another is not possible and would need a complex study.

During a project evaluation early 2009 the following remarks have been made regarding cost-efficiency of HMT³:

³. Project Review report Dr. Susanne Pritze-Aliassime, February 2009

Box 7

“Cost-efficiency reflections as compared to scholarships for Master degree have to be considered against the training impact in change and improved patient safety. Tailor-made training courses are relatively expensive compared to Master courses in Hospital Administration. Yet, Master Courses can only be accessed with the required entry level, which many of the actual trainees do not have.

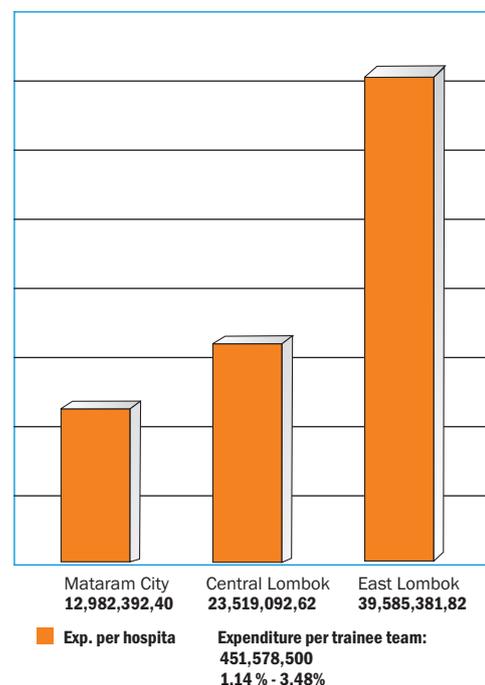
Coaching is an important method of teaching, but to institutionalize coaches and linking them to a local university is a too narrow concept. Experience indicates that a more open approach to coaching might be better without putting too many criteria. Actually, alumni from the UGM Master program are considered a possible option and are already involved in the second training cycle in Sumbawa island starting in February 2009.”

Nevertheless it is possible also to finance training through the hospital directly. If we look at what the three hospitals being enrolled in the first training had spent for overall hospital expenditure in 2008 and what percentage this would mean regarding the team being trained, it only represents 1-3.5%. That should be affordable if the value and impact on improvement through training could be clearly shown

5.4 Accreditation & course certification

Accreditation for the HMT has been given by the Provincial Health Office in NTB province⁴ and the Master of Hospital Management program at UGM.

Figure 12. Expenditure in 2008 for the 3 hospitals participating in the 1st training batch as analyze for the District Health Accounts in NTB.



Expenditure per hospital in 2008

⁴ As Indonesia is a decentralized country accreditation is given at provincial level and not at central level.

This accreditation enables the participants to obtain academic credits should they continue to a master's degree (see credit transferable units). Accreditation by the Provincial Health Office requires all training plans for each block to be submitted to the Provincial Health Office before implementation. In addition, the Ministry of Health has been involved as part of the core team and having participated in every important milestone. The overall evaluation is as follows:

Source of assessment	Component	Score	Proportion
Individual			40%
	Block pre-port test	100%	
	Final examination	100%	
Team			60%
	Block presentation	150%	
	QI Action	150%	
Total score		500%	100%

After successful completion of HMT, training certificates are given to the participants in two forms, i.e. certificate of attendance and course certificate. Certificate of attendance is given provided that participants complete at least 75% of all training activities, regardless of the achievement. While the course certificate is awarded under the conditions that 60% of individual score is achieved and 75% of team score is achieved.

5.5 Credit transferable units

For each learning block, we have compared the existing curriculum in the Master of Hospital Management program at UGM with the content of the HMT. Credit transferable units are calculated, taking into consideration the topics covered, number of sessions, in-class and field assignments, and overall study load. Overall, credit units gained from HMT is equivalent to 16 credits transferable to the master program with the total 35 credits,

excluding thesis writing. This will be applied as the basis for describing further learning activities to be completed in the master program and can be used until the latest two years after completion of HMT.

5.6 Scholarship award

The GTZ scholarship award is granted for the 2 best participants based on their performance in the course evaluation. It is only available for the first training batch as payment is linked to the duration of the projects. The award covers full payment of tuition fees, modules, research allowance, and living allowance up to graduation ceremony for a maximum of two years. Beyond this period, participants are responsible for their own cost. Participants will participate in the intensive track or distance learning track in the hospital management postgraduate program.

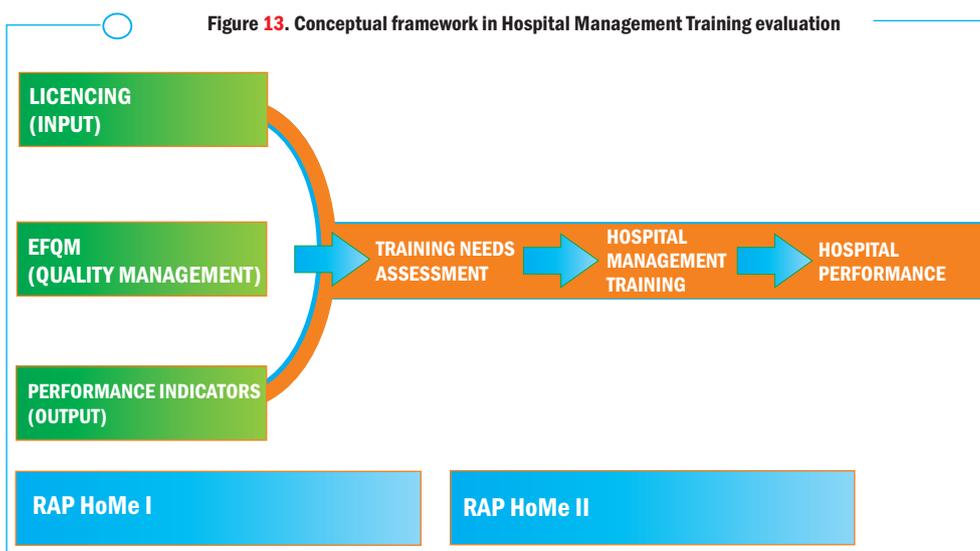
UGM in addition gave also 2 awards to the next best participants exempting payment for course fees for them.

6. Impact assessment 6 months after training completion

Efforts to evaluate the training course and its impact on hospital services have been planned since the preparatory of HMT as it is felt as a very important part to show changes and hopefully improvement.

The second survey was a comprehensive and systematic assessment of hospitals' input, process and outcome. To see changes the findings from RAP-HoMe surveys before and after HMT were done in order to analyze the impact of HMT batch 1 in 3 hospitals in Lombok Island.

The Conceptual Framework, as designed by UGM, is based on the logic of identifying needs, implementing tailor made training as action and assessing changes and impact. In the case of little positive or even negative changes, causes need to be analyzed especially linked to possible negative environmental changes, which may have intervened since 2006. It will be crucial to see if the former participants' team is able to enhance a prioritized process of action to overcome problems and if the hospital directors are committed and able to make the improvement process work



The initial RAP-HoMe was looking at aspects of hospital management from different perspectives, utilizing the existing Ministry of Health hospital licensing requirements and hospital performance indicators, EFQM self-assessment and felt-need training assessment. The tools capture different perspectives of hospital stakeholders, i.e. District/Provincial health office/Ministry of Health (through the licensing requirements), patient perspectives (as part of the performance indicators), health professional perspectives (as part of the performance indicators) and the hospital managers' perspectives. The RAP-HoMe survey before and after HMT follow the same protocol to enable comparisons, but with modifications and additional aspects covered in the second survey.

For illustration, in the first survey patient satisfaction was only measured in inpatient services. In the second survey, patient satisfaction was measured in several units (such as emergency, inpatient, outpatient, lab, pharmacy) in accordance to the minimum service standard (or Standar



Pelayanan Minimal Rumah Sakit) launched by MOH. The second survey also incorporates patient experiences in selected units relevant to the QI project (such as emergency unit in NTB province hospital, surgery ward in Praya hospital and obstetric ward in Selong hospital). An assessment of behavioral changes similar to the one undertaken after the QI project was also repeated in the second survey with some modifications. Another example of additional aspects covered in the second survey was related to SPM indicators, which consist of 96 indicators to measure 21 hospital services. Although it is impossible to cover all indicators, the second RAP-HoMe survey added 24 indicators to measure 15 services in the tools.

ASPECTS	FIRST RAP HoME SURVEY (2006)	SECOND RAP HoME SURVEY (2009)
Regulation	Hospital licensing standard	Hospital licensing standard
Quality Management	EFQM self-assessment	EFQM self-assessment
Hospital Performance	MoH hospital performance indicators	MoH minimum service standard (including previous hospital performance indicators)
Training assessment	Felt-need training assessment	Not carried out
Additional small scale study	Conducted but after QI	Included with additional questions

The following list shows part of the Minimum Service Standards for hospitals in Indonesia as defined by the Ministry of health that are included in the impact assessment:

Table 1. Hospital Minimum Service Standard - SPM

No	Service	Indicator	STANDARD
1	Emergency Room	Response time	5'
		Staff competency	100%
2	Outpatient	Service type	4 basic specialist
		Patient satisfaction	80%
3	Inpatient	Service type	4 basic specialist
		Patient satisfaction	80%
4	Obstetrics and Gynecology	Availability of CEONC team	Available
		Maternal mortality due to sepsis	Max 1.5%
		Maternal mortality due to eclampsia	Max 2%
5	Surgery	Waiting time for elective surgery	Max 2 days
6	Intensive Care	Staff competency	100%
7	Pharmacy	Waiting time	Max 30'
		Patient satisfaction	Min 80%

8	Laboratory	On time calibration	100%
		Patient satisfaction	Min 80%
9	Radiology	Expertise staff for radiology	100%
		Patient satisfaction	Min 80%
10	Nutrition	On time feeding time	Min 90%
12	Logistics & Maintenance	On time equipment maintenance	100%
13	Medical Record	Medical Record completeness	OP 100%
			IP 100%
14	Waste Management	Solid waste QC	BOD Max 75 COD Max 27 TSS Max 30 pH 6 - 9
15	Management	Number of staff training	36 hour
		Staff satisfaction	80%
		Cost recovery	60%

The assessment should include aspects to comment on the DAC criteria in relation to the hospital improvement and the role of the HMT training has in that:

- Relevance
- Effectiveness
- Impact
- Efficiency
- Sustainability

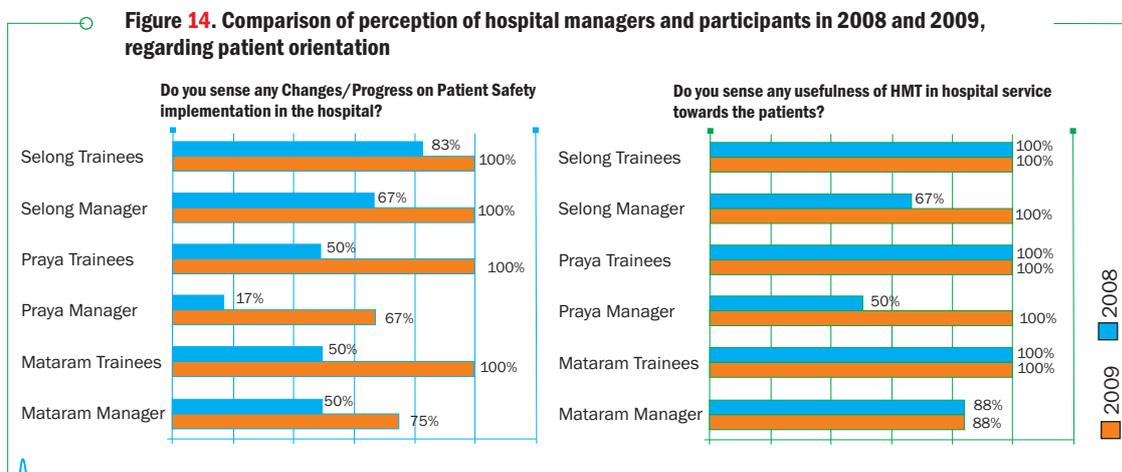
Relevance and effectiveness of HMT has been evaluated as part of level 1 and 2 training evaluation. Efficiency was not specifically assessed. However, data on cost and training outcome may be used to illustrate efficiency. Therefore, the focus of the second evaluation is on impact and sustainability.

7. Review of the training course

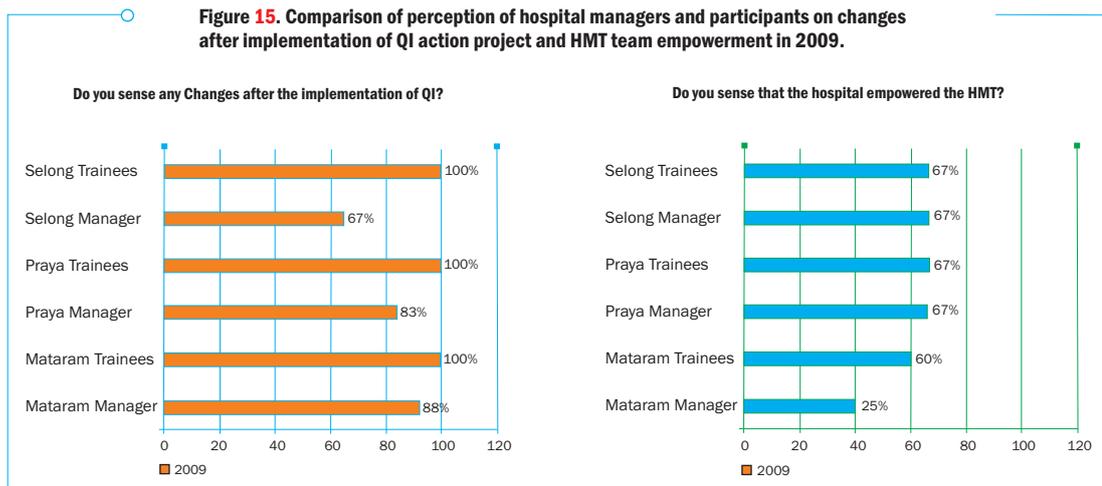
The HMT conforms to the slogan for quality management: “Do the right thing right at the right time and do it better tomorrow”. Ongoing feed-back and monitoring is important to permanently improve the process in order to establish a culture of quality improvement towards quality assurance.

7.1 Ongoing monitoring

Each training session and learning blocks were evaluated and participants' comments were translated into action for change. Course modules were also adapted during the course in order to accommodate the learning process. Before the QI action project started a first review was carried out in order to have a sense of the overall training process, knowing that it was too early to make substantial comments. But by doing so, there was still the possibility for correction and improvements. A small survey of the participants and the top management of the hospital was initiated with the objective of finding out the different perceptions among stakeholders of HMT in NTB and in order to trigger discussion for a lessons learnt workshop. The perceptions of the top manager and the participants were different on the extent of change and also on the perceived usefulness of the training. The results were then commented on by trainers. This survey was then repeated 6 months after completion of the training.



The findings were an important input in a first review workshop involving participants, trainers and the hospital directors, GTZ staff and consultants and the core team and representatives from SEAMEO TROPMED Bangkok. The second survey and the evolution on judgment was then an important input on the overall review and impact assessment workshop in July 2009.



7.2 Lessons learned

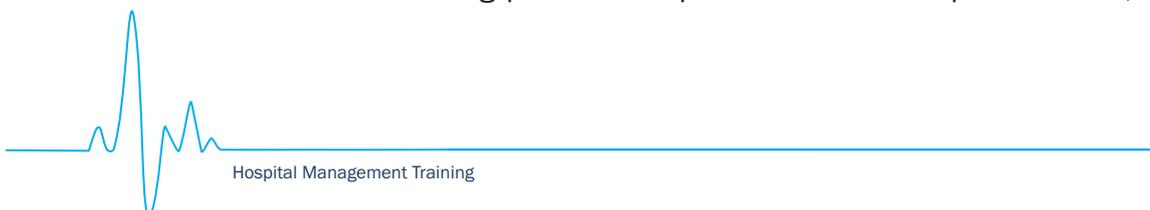
The approach of HMT was felt to be innovative, with a higher potential to achieve change for the betterment of the patients and the hospital than other training. The team approach can give greater synergies and makes problem solving easier. The process triggered open discussion on medical errors and how to reduce them, or even to avoid them. This has never been done in the past and can hopefully be maintained beyond the training. Many initiatives that had started before the HMT contributed to the positive change, but it now became more focused. The involvement of other hospital staff and the top management is considered a particular asset. This can lead to a cascade effect so that the training impact can extend far beyond the participant team. Peer-review directly increases efforts by participants as nobody want to feel weak in front of their peers. Advocacy has resulted in benefits for staff stability, as the planned rotation of one staff member was withdrawn, and one of the participants was promoted to vice-director. There have been improvements in gender equity, as women represented 44.4% of the participants in the first batch and 38% in the second batch.

The fact that for the first batch all participants came from the same Island (Lombok Island) made it easier to organize the training, as the most distant hospital was only about 1.5 hours drive away. This was changed for the second training batch where participants are from islands where driving distances may take up to 6 hours or air travel. It will be even more difficult if participants come from several Islands. This will influence the way the training is organized: only 2 days per week during Friday and Saturday will not be possible anymore. Sessions have to be regrouped in one week, which means also a longer absence from the workplace. This must be negotiated with the hospital director as it may also be a problem to have 6-8 persons absent at the same time and it may be needed to split them in 2 groups of 3/3 or if more of 4/4. To keep the team together there are common events as the starting and team building and the assignments in the hospital, which should be backstopped from the local trainers. The workload for the trainers may increase, not so much altogether (if not a parallel course has to be run), but occupy a more compact time schedule. This may increase the cost also.

Ongoing monitoring has been felt as a very important tool for ongoing improvement of the training conduction, to keep the stakeholders informed, to make the hospital teams critically question their impact and change process and to keep the ongoing quality improvement process alive. Learning from other countries and exchange of experiences and challenges encountered is another important way to start the process and culture of patient orientation and QI.

7.3 The way forward

Stakeholders involved in this HMT process have identified both strengths and weaknesses. The positive aspects of the HMT include: the training curriculum and process, incorporating trigger materials and case studies; the team approach as a way of solving hospital problems; the broader impact of HMT to the hospital organization beyond the trainees; peer-review mechanisms creating positive competition in trainees performance; and



recent knowledge in global health care system incorporated in the training materials (such as patient safety). Despite the positive features, challenges remain. These include: the course load; the need for completed training materials prior to the learning blocks; keeping the same level of enthusiasm throughout 11 months of training; effective mechanisms to engage more decision makers in hospital presentations; the need for a stronger structure for mentoring during assignment; and the need for the QI action project to link and reinforce messages delivered during the course; the delicate balance between personal and organizational benefit to be gained from participation in HMT; and the overall design for continuation to a master's degree at UGM. The training courses and the QI action project were not well integrated from the beginning of the first course. This led to insufficient depth of problem analysis in the QI action project, and less utilization of assignments in the previous learning blocks to contribute to the QI action project. To make full advantage of the learning blocks, it is recommended that the problem for the QI action project is defined from the beginning of the training. Problems can then be fine-tuned and analyzed during the learning blocks. Similarly, potential interventions may also be identified early. Preparation of the QI action program is focused on the detailed preparation and implementation of the selected intervention.

The following recommendations identify aspects to be considered for improving future implementation of the second batch and other courses.

This may also be useful for others in order to see problems encountered and the proposed solutions.

a) **Continuing advocacy**

Before training, a benchmarking visit and signed letter of commitment was carried out as part of advocacy with the local government. The advocacy needs to be reinforced during and after training activities, through sending the list of HMT participants who have succeeded in the training, keeping the local government informed of the key training process, and preventing changes in the position of hospital director. Similarly, the commitment of

hospital directors to promote and empower the team will sustain further efforts to continuously improve the services. It is equally important to keep the central level, MoH informed and involved along the way. They are the ones able to further spread the HMT course concept and give recommendations that other provinces can adapt and use it for their hospitals.

b) Selecting individuals with higher capacity

Despite the advantages of the team approach and the appropriate mix of individuals in the team, the effect of HMT may be greater where a team with higher capacity in the organization is selected.

c) Better alignment of human resources

With the intention for the training to impact on the organization, this HMT applies complex learning activities which occur for a period of nearly one year. Human resources from different organizations are engaged in HMT and they play different roles during HMT. Resources from a partner local university are mobilized for transfer of knowledge and skills. The provincial health office, as well as hospital managers, are invited to enrich the relevance to the local policy and practical problems faced. Hospital directors of the participating hospitals are also involved to facilitate sharing and communications to other hospital staff and to support the HMT team while introducing changes. Their roles also vary across the training period, acting as trainers, facilitators of discussion, tutors in tutorial sessions for discussing field assignments, supervisors and mentors during the QI action. To give a synergy in the learning process, these human resources need to be better prepared and aligned to optimize their capacity and roles.

d) Preparing the participants better

Prior to the learning blocks, the HMT team can be better prepared by incorporating sessions on problem analysis, how to search and use literature and how to read effectively. Distribution of training materials beforehand will also increase the preparedness of HMT participants.



e) **Building QI action from the start and mentoring system**

Problem identification for the QI action should be discussed early enough to enable proper justification and analysis as well as to take advantage of the learning and assignments from previous learning blocks. During the implementation of QI action, mechanisms for close supervision and mentoring are necessary to ensure timely and effective implementation of the changes. Resources from institutions such as Health Training Centre and GTZ project staff can be attached in this activity.

f) **Encouraging proactive behavior of trainees**

This type of training is demanding for the participants as they are expected not only to master the content, but also to share and communicate their learning to involve more hospital staff and to initiate changes throughout training period. This increases the course load considerably. Therefore, problems faced at any training stage need to be immediately discussed with peers, superiors or training facilitators. Keeping open dialogue with trainers, peers, hospital directors and others is important to maintain their spirit, motivation and commitment as a change agent for the organization.

g) **Possibilities for other countries to use a similar approach**

The wide dissemination of the present HMT course book through the SEAMEO TROP MED network may draw interest from other countries to use a similar approach as was considered during the SEAMEO TROP MED board meeting in 2008 by Laos and Vietnam. The Indonesian and Cambodia experiences could be used as an entry point.

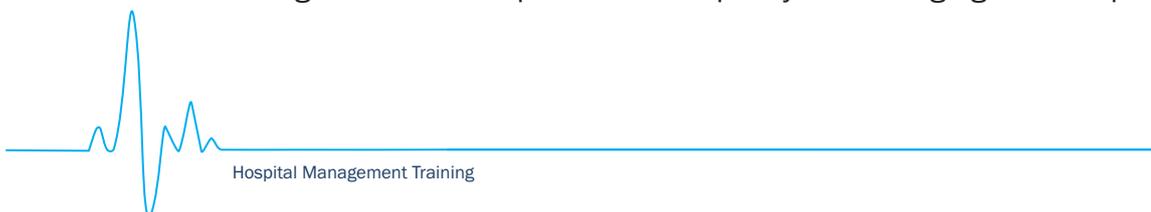
As expressed by Dr. Sandra Tempongko from SEAMEO TROP MED network during the final HMT impact evaluation workshop held in July 2009, the overall evaluation of the training content and methodology has been very positive. The course is very much appreciated by the participants and is perceived to have further enabled them to improve their performance in the hospital. The triangulated approach, detailed planning and monitoring as well as immediate utilization of the feedback gathered from different evaluation methodologies have been the strengths of the course. In

addition, the opportunity for the HMT team to make concrete quality improvement actions that is integrated in the training model is highly valued to demonstrate how improvements can be done. Internalization of quality improvement and patient safety culture, hence, is strengthened with the team and hopefully be sustained in the entire hospital level.

Implementation of HMT and QI action are not free from problems. These problems are also described and need to be best approached as challenges and lessons learnt. Having the triangulation model and strong involvement of all relevant stakeholders in identifying measures, problems are analyzed and recommendations for quality improvement of training implementation are already put in practice for the next batch of HMT.

Sustainability of HMT results and team empowerment depends upon many factors - most directly, the commitment of the hospital director, and hence, the hospital. In this regard, the role and level of participation of the hospital director in the HMT training is critical. It would be an ideal situation if the the hospital director can be a member of the HMT team. However, in some instances this is not possible. Therefore, alternative ways to involve the hospital director aside from direct participation should be explored, such as to arrange a short orientation seminar focusing on patient safety and quality improvement. In the second batch of HMT, open invitation to the hospital directors are sent.

Applicability of this course can be expanded to other provinces in Indonesia and to other countries in the region. The Cambodian and Indonesian experiences of HMT can together be models to be shared to other countries. Lessons learnt drawn from these two experiences and identification of potential areas to adapt this training should take into account the context of hospital development and setting of these provinces and countries in which HMT was initiated. Where access to university masters programs or training in hospital management is limited due to geographical remoteness or unavailability of training programs, limited human resources available with high needs to improve their capacity in managing the hospitals,



coupled with serious health burdens in the community such as in NTB province, this training model can be most effective and efficient.

Key references:

Berwick DM. A User's Manual for the IOM's 'Quality Chasm' Report. Health Affairs, 2002; 21(3): 80-90.

Kirkpatrick DL. (1998). Evaluating Training Programs: The Four Levels. San Francisco: Berrett-Koehler Publishers.

Mintzberg H. (2004). Managers not MBAs: a hard look at the soft practice of managing and management development. San Francisco: Berrett-Koehler Publishers, Inc.

Utarini A. and Jasri H. (2006). Final Report on Rapid Assessment Procedures in Hospital Management (RAP-HoMe) in West and East Nusa Tenggara Provinces. Universitas Gadjah Mada; Yogyakarta.

Waterman H, Tillen D, Dickson R, de Koning K. Action research: a systematic review and guidance for assessment. Health Technology Assessment, 2001; 5: 23.

World alliance for patient safety: WHO patient safety curriculum guide, for medical schools, 2008