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| **Evaluation Sheet – ENTREPOSE Administration****[Organization and Management]** | Sheet ID:**A-II** |
| 1. **Instructions**
 |
| * The evaluator is to fill this form based on:
	+ Review of the A-I forms filled by ENTREPOSE facilitators,
	+ Interviews with key staff members involved in ENTREPOSE facilitation and administration, and
	+ Review of existing registers and other documents.
* The coverage period of the facilitators’ activities (Part 1) is the past one month, counting back from yesterday.
 |
| 1. **General Information**
 |
| Facility: |  | Date of Evaluation (MM/DD/YY): |  | Coverage Period (one month): | (MM/DD/YY) | -- | (MM/DD/YY) |
| 1. **Evaluator Information**
 |
| Name: |  | Designation: |  |

**Part 1: Summary of Facilitators’ Activities during the Coverage Period**

|  | Facilitators | Program Orientation(# patients) | Number of Sessions Facilitated |
| --- | --- | --- | --- |
| CBT & CBT-E | PE | SHGM |
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**Part 2: Evaluation of ENTREPOSE Administration**

| **Evaluation Standards** | **Yes/No** | **Comments** |
| --- | --- | --- |
| 1. **Organizational Aspects**
 |
| 1. *Patients*
 |
|  | The facility’s own eligibility criteria for patients to participate in ENTREPOSE are established and implemented. | Yes No |  |
|  | Patients’ individual registers are developed and updated to keep their attendance to the ENTREPOSE sessions. | Yes No |  |
| 1. *Family Members*
 |
|  | Family members’ statuses of participation in the PE sessions are updated in the patients’ individual registers. | Yes No |  |
|  | Family members of more than 50% of all the eligible patients in their 5th and 6th month period of treatment have attended at least 6 PE sessions.  | Yes No |  |
| 1. *Scheduling*
 |
|  | Timetables of all the patient groups throughout the treatment period are available with the information of the scheduled ENTREPOSE sessions that satisfy the minimum requirements as follows:* PO-1, CBT-28, CBT-E-3, PE-12, SHGM-6, ICA-26
 | Yes No |  |
|  | A calendar with a schedule of the PE sessions meant for family members is available for the next three months and its copy is provided with them upon registration of the patients. | Yes No |  |
| 1. *Facilitators*
 |
|  | All the staff members facilitating sessions have attended a training program for ENTREPOSE facilitators. | Yes No |  |
|  | All the facilitators weekly record their activities in the Weekly Reporting Form for ENTREPOSE Facilitators. | Yes No |  |
|  | At least one peer-evaluation session per facilitator, using the evaluation forms, was conducted to ensure the facilitation quality of the CBT program during the last 6 months.  | Yes No |  |
| 1. *Environment*
 |
|  | Appropriate places are secured for the ENTREPOSE group sessions (e.g. not too noisy to conduct group sessions). | Yes No |  |
| 1. **ENTREPOSE Implementation Status during the past one month**(based on the facilitators’ activities during the coverage period)
 |
| 1. *Program Orientation*
 |
|  | Eligible patients attended an orientation program before entering ENTREPOSE groups. | Yes No |  |
| 1. *Cognitive Behavioral Therapy (CBT) & Cognitive Behavioral Therapy-Evaluation (CBT-E)*
 |
|  | Eligible patients attended CBT and CBT-E sessions according to the schedule. | Yes No |  |
|  | Copies of Patient’s Workbooks and Schedule Books were given to all the eligible patients. | Yes No |  |
|  | The group size was mostly less than 15 and did not exceed 20. | Yes No |  |
|  | A co-facilitator was assigned to the CBT sessions. | Yes No |  |
| 1. *Psycho-Education (PE)*
 |
|  | Eligible patients attended PE sessions according to the schedule. | Yes No |  |
|  | The group size was less than 50. | Yes No |  |
| 1. *Self-help Group Meeting (SHGM)*
 |
|  | Eligible patients attended SHGM sessions according to the schedule. | Yes No |  |
|  | The group size was mostly less than 12 and did not exceed 15. | Yes No |  |
|  | SHGM sessions were conducted without involving TRC staff members and led by chairpersons selected from patients. | Yes No |  |

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| *Overall comments and suggestions to the facilitator:* |

*Signature of Evaluator: Date:*