

# Clinical Systems Mentorship

Draft Version 1.1



## The ICAP Guide to Site Support



**ICAP**

International Center for AIDS  
Care and Treatment Programs

MAILMAN SCHOOL OF PUBLIC HEALTH  
Columbia University

# DRAFT

## Clinical Systems Mentorship

The ICAP Guide to Site Support

A Product of the ICAP Clinical Unit

The International Center for AIDS Care and Treatment Programs (ICAP), at Columbia University's Mailman School of Public Health in New York City, USA, supports HIV-related service delivery, training, and research around the world. ICAP works with host countries and other organizations, principally in sub-Saharan Africa, to build capacity for family-focused HIV/AIDS prevention, care, and treatment programs. In support of HIV clinical programs, ICAP produces an array of resources for clinicians in resource-limited settings. ICAP programs are funded by a variety of sources, including United States government agencies and foundations.



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## **DRAFT Glossary (incomplete)**

Cadre	Professional category based on education and training
Capacity Building	Transfer of expertise and infrastructure to the site level with the ultimate goal of independence
Clinical Mentorship	One-to-one, or one-to-small group approach to teaching clinical skills, supporting professional development and growth as well as providing collegial support to clinicians
Clinical Mentorship Initiative	Structured and intensive approach to building Clinical Systems Mentorship in and across ICAP supported sites
Competency	Fundamental knowledge, ability, or expertise in a specific subject area or skill set
Comprehensive Care	Care that considers and takes into account all aspects of the patient's life, not just clinical care
Cross training	On-site training of personnel to develop overlapping expertise
Cross Cadre Training	Development of skills within a team where one cadre trains another non-traditional cadre in some of their tasks so as to ensure maximum coverage at the clinic
CSM	Clinical Systems Mentorship. Clinical mentorship approach expanded and applied to focus on the whole health system
Family Focused Care	Care that focuses on the family as a foundation of care

ICAP	International Center for AIDS Care and Treatment Programs
ICAP Model of Care	Comprehensive, integrated and continuous delivery of HIV care and treatment characterized by a focus on the family as a foundation of care; a multi-disciplinary team of providers; an emphasis on adherence and prevention; strong linkages across clinical services; and strong linkages with community resources
MTCT-Plus	Comprehensive treatment services for women throughout pregnancy and postpartum, with the understanding that HIV is a family disease, and that all members of the family should be included in care and treatment. Thus, all HIV services, including antiretroviral therapy (ART), are extended to each mother's HIV-infected children, partners, and other family members
Multidisciplinary Care	Care which incorporates aspects of many different areas of expertise
Multidisciplinary Team (MDT)	Team where members represent many areas of expertise which complement each other
On-Site Team	Team of staff working at the site level
PIHCT	Provider Initiated HIV Counseling and Testing
PLWHA	Person Living With HIV/AIDS
Precepting	Approach to teaching in which an expert or a specialist observes a junior provider in a clinical encounter and then offers feedback and suggestions for improvement

Quality Improvement	A process that seeks to evaluate and improve upon services or programs through continually measuring, analyzing, and structuring interventions to address problems.
Site Support Team (SST)	Central, regional or district level team deployed to individual sites for the purpose of lending expertise, site building, trouble shooting, and providing general clinic and programmatic support
SOC (Standard of Care)	Framework for measuring the delivery of components of care, assessing the adequacy of the care delivery, and developing guided activities to remediate inadequacies
Supportive Supervision	An approach to supervision which uses techniques such as self-assessment, peer assessment and feedback
Task Shifting	Process of shifting tasks from one cadre of health care worker to another to meet specific health care goals

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## Chapter 1

### Introduction to Clinical Systems Mentorship

ICAP supports the initiation and ongoing provision of comprehensive, multidisciplinary, family-focused HIV care and treatment in resource limited settings. Since 2002, we have supported programs at over 200 sites in Africa and Asia. These sites are diverse in culture, geography, population, and setting.

One of the biggest challenges we have had in working with these varied sites has been in accommodating and balancing the objectives of site support:

1. to rapidly enroll patients into care;
2. to ensure high quality comprehensive care; and
3. to foster site growth and sustainability.

The challenges faced by sites and site support teams in meeting these objectives are complex and often overwhelming. This guide has been created to compile these common challenges and suggest approaches to managing them.

Our concept of site support is built upon the process of **Clinical Systems Mentorship**, a re-conceptualization of traditional clinical mentorship. Clinical systems mentorship (CSM) is a unified set of approaches and activities used by the site support team to focus on the broader health environment, or system. This includes multiple levels of players and influences: the individual health care provider, the health care team, and the local site (in the context of the larger health care system and the community). With this broader focus, CSM moves beyond traditional mentorship, which has been geared toward promoting and enhancing the competency of providers with little attention to the work of other on-site providers (the team) or the external context (the site).

This document begins with an elaboration of a model for high quality HIV care, which is characterized by comprehensive continuity care, a focus on the family, and coordination of services within a health facility. As sites begin to employ this model, national, regional, or district site support teams may be deployed to assist with start up and provide ongoing support. Over time, the site support team may build local capacity such that sites become increasingly able to address challenges with decreasing need for external technical assistance. This manual details this trajectory from the perspective of site support teams, and provides a resource for them.

Every chapter of this document includes text and case studies from the field, as well as accompanying tools and materials. The cases illustrate the need to place the concepts in this guide into the specific, local context and also the need to continuously foster local ownership of site development. Site support teams, and ultimately site-level teams, should be involved in tailoring materials to meet specific needs.

## **Chapter 2**

### **The ICAP Model of HIV Care**

The ICAP model of HIV care defines the minimum package of services needed to provide high quality HIV care. The model of care also explicitly defines the model of service delivery to be comprehensive, family focused, and continuous. The model is further characterized by:

- A focus on the family as the foundation of care
- Optimizing use of a multidisciplinary team of providers, lab and pharmacy staff, and administrative support staff
- An emphasis on adherence and prevention
- Strong linkages across various clinical services
- Strong linkages with community resources and organizations

#### **Minimum package of HIV care**

The ICAP model of care consists of several clinical areas, which together define a minimum package for comprehensive HIV care. These include:

- Care of HIV Infected non-pregnant adults
  - CD4 testing within one month of enrollment and every six months thereafter
  - WHO staging at every visit
  - Assessment of weight, interim history and clinical condition at every visit
  - Focused and rapid assessment of patients with specific complaints
  - ART for eligible patients
  - Monitoring and management of medication toxicity in patients on ART
  - Monitoring and management of treatment failure in patients on ART
  - CTX for eligible patients
  - STI and OI assessment and management
  - Assessment and enrollment of family members
- Care of HIV-exposed and infected infants
  - CTX for HIV exposed infants starting at 4-6 weeks of age until final HIV status determined ; continuing if child is HIV infected
  - Growth monitoring of HIV exposed infants
  - DNA PCR testing of HIV exposed infants at 6-8 weeks of age
  - Final infection status testing for HIV exposed children at 18 months of age or 6 weeks post weaning
  - Neuro-developmental screening for HIV infected children every six months
  - CD4 testing for HIV infected children every six months
  - ART for HIV infected children meeting eligibility criteria
  - Visits every three months for children on ART to evaluate clinical status, weight, and dosing

- Visits every three-six months for eligibility reevaluation for ART-ineligible HIV infected infants and children, respectively
- Bed nets for malaria prevention in malaria endemic areas
- Assessment and enrollment of family members
- TB/HIV integrated care and treatment
  - Screening for TB at enrollment into HIV care and every six months thereafter
  - Prompt evaluation of TB suspects
  - Early HIV testing for TB patients of unknown HIV status
  - Enrollment of co-infected patients into HIV care and treatment
  - CTX for co-infected patients
  - Assessment and enrollment of family members
- pMTCT and care of HIV-infected pregnant women
  - HIV counseling and testing with results given at first ANC visit
  - Prompt CD4 testing of HIV positive pregnant women
  - Counseling about safe infant feeding practices
  - HAART for pregnant women with CD4<250-350 (depending on national guideline)
  - PMTCT prophylaxis for ART-ineligible HIV positive pregnant women
  - PMTCT prophylaxis for exposed infants
  - HIV counseling and testing in maternity for pregnant women of unknown HIV status (and prophylaxis if determined to be HIV infected)
  - CTX for HIV exposed infants starting at 4-6 weeks of age
  - Growth monitoring of HIV exposed infants
  - Bed nets for malaria prevention in malaria endemic areas
  - Assessment and enrollment of family members
- Psychosocial and adherence support
  - Baseline psychosocial evaluation
  - ART readiness counseling and evaluation for ART eligible patients
  - Adherence assessment at every visit
  - Adherence counseling at every visit
  - Support group referrals
  - Encouragement of treatment buddy selection
  - Patient tracking and follow-up for patients who miss appointments
  - Assessment and enrollment of family members
- Prevention
  - Transmission and prevention counseling
  - Disclosure counseling
  - Condom demonstration and distribution
  - STI screening and management at every visit
  - Family planning referral
  - Post exposure prophylaxis
  - Assessment and enrollment of family members

In addition to these clinical components, the ICAP model of care includes incorporation of non-clinic based service areas such as administrative infrastructure,

pharmacy services, laboratory services, and appropriate documentation, monitoring, and evaluation of key information at each patient visit.

### The process of continuity care

HIV is a chronic condition. Patients may remain healthy for years prior to showing any evidence of infection. Once on treatment, patients may also enjoy periods of wellness. To adequately address the differences in patients' needs during different phases of illness and health, to ensure early intervention, and to prevent illness whenever possible, a continuity care model must be adopted by sites.

Continuity care does not simply mean that the patient returns for repeated scheduled episodic care visits. Rather, there are changes that must occur at the levels of the provider, the team, and the site such that long term care and follow-up are feasible. Table 1 below details these differences. CSM emphasizes the necessity of transforming service provision to a continuity model of care .

**Table 1. Essential Differences: Acute vs. Continuity Care Models**

Service Component	Episodic/Acute	Continuity
Provider-content of patient encounter	Management of presenting illness	Prevention Health maintenance Interim history
Provider- process of patient encounter	Consultation with a single provider	Therapeutic alliances, family focused, multiple providers
Documentation	Items relevant to acute management only	Complete clinical assessment, understanding of long term importance of accurately documenting encounter- quality of care depends on past documentation
Clinical context of patient	Patient as an individual	Patient in sociocultural context
Clinical status	Discrete	Continuous
Perspective on patient	Cross-sectional	Longitudinal
Role of patient	Reporting symptoms	Self monitoring, adherence, healthy living, patient-centered care
Attitude	Reactive	Proactive
Team	Does not exist	Multidisciplinary, frequent communication, collaboration in patient management
Site- Record keeping	Items relevant to acute management	Longitudinal charting, clinical information systems, use of patient-level data to inform quality improvement
Site- Management and Organization	Self contained, task oriented, short term planning only	HR development, strategic planning, attention to trends
Site- External relations	Self contained	Community interaction and involvement

## **Who delivers this care? An on-site multidisciplinary team**

No single provider can deliver the diverse services needed by patients with HIV infection. While sites may be optimally staffed with a team of providers to deliver services, human resources may also be constrained. Certain cadres might be unavailable to be part of the site level team, or the number of staff may be limited. For example, at the health center level, nurses alone may staff sites; they then become responsible for tasks often associated with doctors or counselors. Cross-training, in which members of one cadre are trained to conduct tasks traditionally assumed by another cadre, may be required at sites to ensure delivery of the minimum package of care. Unlike the commonly understood definition of task shifting (down-shifting of tasks), cross shifting of tasks across cadres is encouraged when allowable by law, when feasible and as needed.

In this spirit, it is resource-wise to consider the traditional concept of cadre as defined by professional certification, as limiting; provision of care can be enhanced by expanding and making the roles of each cadre more fluid. In this model, people are fit to tasks, rather than vice versa. A successful multidisciplinary team is one that divides tasks appropriately and performs them competently.

## **Family-Focused Care**

Family-focused care has two implications: first, that family members of any patient are ascertained and invited into care; second, that programs offer, or can refer to, an array of HIV services that meet the needs of all family members. In this model, the program treats the patient as a member of a household rather than as an individual, recognizing that the health of one family member impacts on all others.

Implementing family focused programs requires:

- Understanding typical and specific family power dynamics and working with these to engage families in ongoing care
- Understanding typical family structure and creating programs that are “friendly” to this structure
- Offering coordinated services for all family members (visit schedules, medication pick ups, home visits, etc), optimally conducted in the same place;
- Counseling and testing all family members and inquiring about the health of other family members at each encounter;
- Including family information in each patient record;
- Developing a cohesive self-care plan for the family, rather than creating individual, uncoordinated plans, e.g., aligning adherence strategies so all family members take medication together;

**How does the site support team know that the model is being implemented?**

Each of the above elements of care has associated with it a set of necessary prerequisites, which include minimum logistical/infrastructural resources as well as minimum competency levels. Comprehensive checklists, as well as a Model of Care Assessment Checklist are provided in the appendix so that the site support team can ensure the minimum resources are in place for each component of care. Once these minimum criteria have been met, each element of care can be assessed quantitatively so efforts at improvement can be made. A framework for this process, and the roles of the on-site team, are detailed in Chapter 5 of this Manual.

## Chapter 3

### The Site Support Team and Site Development

This chapter begins to explore the site support team in the context of CSM. It suggests team members, goals, objectives, roles, and activities, and outlines methods for preparing, orienting, and evaluating the team. It introduces the concept of stages of site development as a guide for selecting appropriate activities. Tools and materials are included in the appendix which may facilitate and structure these efforts. Chapter 4 continues the discussion focusing on the skills of the site support team, and chapters 5-7 explore each stage of site development.

#### Definition: The Site Support Team

The site support team is a central, regional, or district level team working at individual sites to lend expertise, develop site function, help to address challenges, and provide general clinical and programmatic support. The site support team is also responsible for ensuring that activities at the site are executed acceptably, and that quality care is delivered. The site support team will over time, transfer leadership roles to on-site personnel, to facilitate program sustainability.

The site support team will work with the site at three levels: the provider level; the team level; and the site level. Figure 1 illustrates these interactions, and includes major activities of the site support team at each level. These activities are more fully described in the next chapter under macroskills.

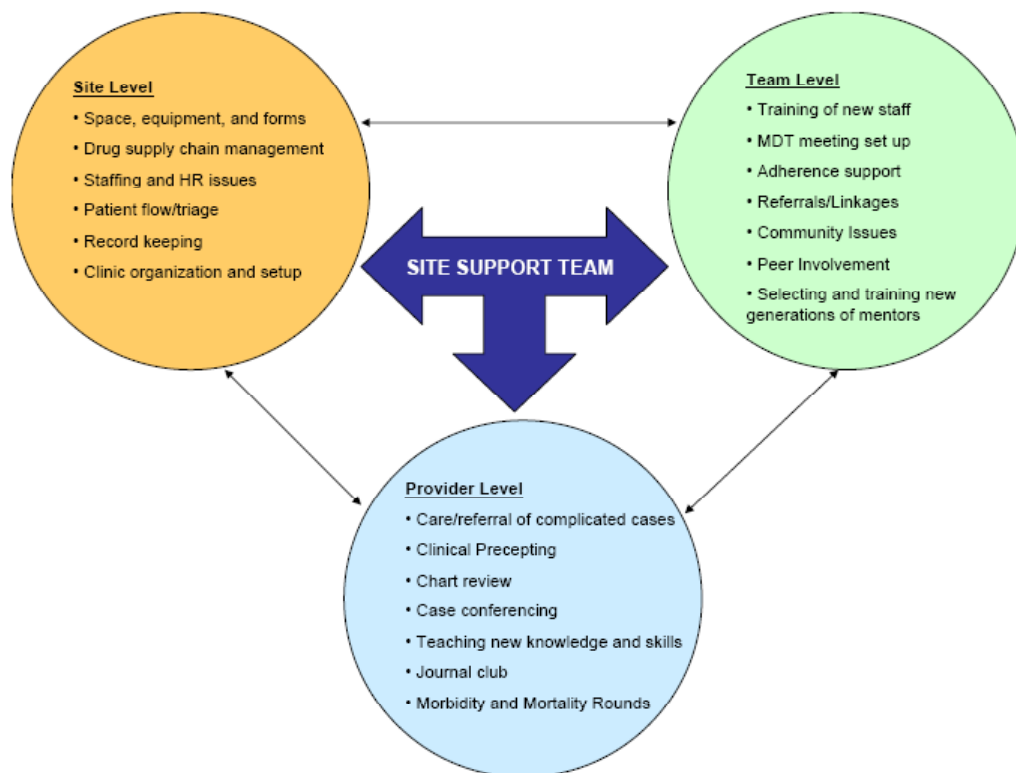


Figure 1. Areas of Attention for the Site Support Team

## Goals and Objectives of the Site Support Team

The site support team has two major goals:

1. To successfully transition sites to a continuity care model: providing high quality, comprehensive, family focused HIV care and treatment services.
2. To build local capacity to sustain this model.

Objectives for each of these goals, on the provider, team, and site levels, are shown in table 2, below.

**Table 2: Goals and objectives of site support team by level of function**

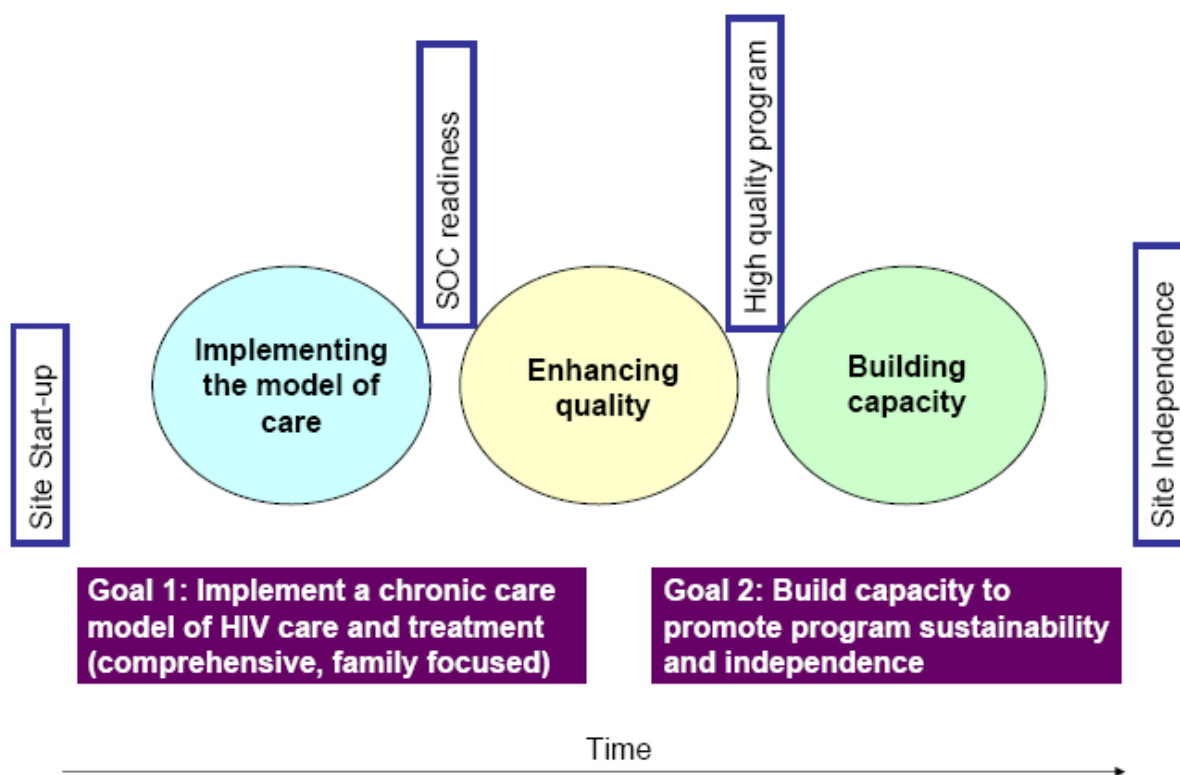
	<b>Transition sites to a continuity care model of HIV services (comprehensive, high quality, family-focused)</b>	<b>Build local capacity to sustain this model</b>
<b>Provider</b>	<ul style="list-style-type: none"> <li>• Fundamental clinical skills</li> <li>• Topic areas of HIV Care and treatment</li> <li>• Application of chronic care processes (FF, longitudinal, comprehensive, etc)</li> <li>• Enhance provider competencies</li> <li>• Provide opportunities for continuing education</li> <li>• Enhancing documentation skills</li> </ul>	<ul style="list-style-type: none"> <li>• Build provider skills in mentoring junior colleagues</li> <li>• Build skills in self education</li> </ul>
<b>Team</b>	<ul style="list-style-type: none"> <li>• Team building</li> <li>• Team maintenance</li> <li>• Team accountability</li> <li>• Team protocols and communication</li> <li>• Discussion and assessment of routinely collected data for quality improvement</li> </ul>	<ul style="list-style-type: none"> <li>• Cross training</li> <li>• Expanding the team</li> <li>• Critical assessment and improvement planning</li> </ul>
<b>Site</b>	<ul style="list-style-type: none"> <li>• Referrals and linkages</li> <li>• Patient tracking systems</li> <li>• Logistical infrastructure</li> <li>• Supervisory infrastructure</li> <li>• Community involvement</li> </ul>	<ul style="list-style-type: none"> <li>• Input systems for data analysis and feedback for quality improvement</li> <li>• HR development</li> <li>• Leadership development</li> <li>• Advocacy and fundraising</li> <li>• Mentoring mentors</li> <li>• Continuous quality improvement</li> </ul>

### Stage of site development guides the work of the site support team

It is important for the site support team to understand that meeting these goals and objectives occurs gradually over time as the site matures. For example, meeting Goal 1 is essential before moving to Goal 2. Certain objectives may be more critical during the start up phase, with decreasing importance as site functioning becomes more routine. Figure 2, below, illustrates the progression of goals and objectives over time.

Three rough stages of site development can be identified for this purpose. These stages are not defined by time but rather by capacity at the site to act at increasingly higher levels of independence. In stage 1, the site is starting up, and is facing a great number of logistical issues. The clinical components of the program are also being implemented during this stage and attention is placed on the elements of the model of care. These tasks require high levels of external support. Stage 2 begins when key programmatic elements have been fully implemented at the site. At this stage, care is provided routinely and the site is able to consider the quality of services offered. Quality is assessed quantitatively, and poor quality is addressed with focused interventions. In stage 3, the site is now providing high quality services, and is relying much less on external assistance. The alignment of site support team goals with these stages of development is also illustrated in the figure below.

Figure 2. Stages of site development model



## **CSM has a beginning, middle, and end**

An extension of the above model is that CSM has a beginning, middle and end. Ultimately, the goal of CSM is to prepare sites for decreasing levels of external support. The process over time must be carefully implemented, so support is not withdrawn prematurely. This finite nature of the relationship is consistent with most mentorship relationships.

## **Members of the Site Support Team**

Whenever possible, the composition of the site support team should mirror that of the on-site team. The members of the site support team, like the members of the on-site team, must be willing to fulfill many functions, and need to be cross-trained in other areas so that they can make a maximum contribution. The fewer the members of the site support team, the more cross-training necessary. In some cases, assembling a full team might be impossible; in extreme cases, site level mentorship may be successfully conducted by a single well-prepared mentor.

*Team Leader.* The team leader may be of any cadre, but must be committed to maintaining the site support team, and optimizing dialogue across team members. The leader takes responsibility for executive decision-making when necessary, and facilitates the work of the team through division of labor. Finally, the team leader is in a position to foster an innovative environment, so that the site support team may offer creative ways of coping with unusual challenges.

*Clinical Advisors/Officers:* Clinical advisors may be doctors, nurses, health officers, clinical officers, or nutritionists. They are primarily responsible for enhancing on-site clinical competency and supporting the development of a functioning multidisciplinary team.

*Psychosocial Advisors:* Psychosocial advisors may belong to many cadres including nurses, social workers, nutritionists, psychologists, and counselors. Their primary responsibility is to strengthen onsite capacity to provide accurate information to patients and facilitate the behavior change process. Psychosocial advisors work within local systems to create patient support infrastructures and to emphasize coordination of services, adherence to care and medication, patient education, involvement of family members, and patient follow-up.

*Monitoring & Evaluation (M&E) Staff:* M&E team members focus on data collection at the site level. They train on-site healthcare staff on proper completion of patient records and/or registers. They work with data clerks to compile monthly data reports and conduct data entry. They also collaborate with clinical and counseling staff to ensure good documentation and the use of data-based feedback to improve program quality.

*Lab Advisors:* Lab advisors are responsible for ensuring the structural and functional integrity of the lab as well as promoting the idea that the lab and on-site lab personnel

are vital members of the multidisciplinary team. Thus, they cannot work separate and apart from the site support team, nor can other team members neglect their role in supporting the lab. The site support team, working in close collaboration with the lab advisors, is able to model the value of including lab staff in the onsite multidisciplinary team. This integration departs from the traditional understanding of the lab as merely a support service.

*Pharmacy Advisors/Procurement Officers:* Similar to lab staff, pharmacy staff cannot and must not be isolated from the rest of the multidisciplinary team. The pharmacy advisor supports the development and maintenance of a fully functioning pharmacy and works with on site pharmacy staff to implement an effective dispensing, reporting, and procurement mechanism. At sites where pharmacy staff are responsible for adherence monitoring and counseling, the pharmacy advisors can work in collaboration with the psychosocial advisors to strengthen onsite capacity to assess adherence and provide support and counseling. In addition, the pharmacy advisor is key in encouraging full integration of pharmacy staff in the multidisciplinary team.

### **Orientation and training of the site support team**

The site support team must be trained in the ICAP model of care and in clinical systems mentorship skills (see next chapter). The site support team must further understand a systems and program perspective, including:

- Components of the continuity care model
- Coordination of services
- Task shifting and cross training
- Situation analysis
- Assessment of site level infrastructure
- Assessment of issues in delivery of various service components
- Use of tools and materials which can be used to structure, facilitate, quantify, evaluate, and improve activities.

Site support team preparation should begin with a self-assessment, and may continue with workshops, manuals, one-to-one coaching, or detailed orientation. It is important that site support teams understand their specific duties and expectations of them, and have tools and materials to facilitate, structure, and evaluate their efforts. Curricula and agendas for site support team training are presented in the appendix. Self assessment tools and integrated site visit checklists are also attached. These tools will enable the site support teams to track their efficiency and effectiveness, as well as organize their highly complex, multi-level work at each site. In addition, the site support team can use these tools at each visit to identify and prioritize areas needing special attention.

In July 2006, a pilot workshop was held in Kampala, Uganda by our MTCT-Plus Program to assess the feasibility of training four experienced teams of HIV care providers to train other site support teams in this holistic approach. Four MDTs (internist, pediatrician, nurse, counselor, laboratorian, peer educator) participated in this workshop, which included:

- Understanding the need to relate content of care to process of caregiving, all in the context of site setting and circumstances
- Skills honing for team building, cross training, and task shifting when possible, through objective definition, training in mentoring skills, role plays, and case presentations
- Tools development, including defining and quantifying provider competencies, curricular checklists, and others
- Understanding the need for data-based monitoring of program quality and provider performance

Teams completed the workshop with enhanced site support skills, a compendium of tools and materials, and a commitment to disseminating the ICAP model of care using this approach.

### **Evaluation of the site support team**

Site support team members may be evaluated quantitatively and qualitatively. Quantitative methods include assessing lists of activities performed, workplans created, and changes in on-site provider competency and site function and development over time. Mentorship skills checklists may also be used. Qualitative methods include sites' assessments of their mentors, collegial assessments, and supervisor assessments. Instruments for this process are included in the appendix.

### **Maintaining the site support team**

The site support team has a difficult and often frustrating job, and will need ongoing feedback, recognition, education and stimulation. Workshops, seminars, experience sharing, psychosocial support, educational opportunities, and opportunities for professional development should be made available at intervals during the year.

The South-to-South team holds quarterly staff retreats of all cadres involved in mentoring – precepting the health teams that come for training in S2S paediatric HIV treatment programme. The retreats focus on mentorship – precepting concepts and skills – and provide the luxury of time to reflect on work in a safe environment.

## **Chapter 4**

# **Skills Required for Clinical Systems Mentorship**

### **Clinical Systems Mentorship – History and Meaning**

Mentorship describes a relationship between people that promotes and enhances personal and professional development over time. Mentorship processes have been applied in a range of contexts, industry and commerce, health and human service professions, politics and education. In the health setting, mentorship has typically followed a one-to-one or one mentor-to-small group approach and has variously focused on teaching clinical skills, supporting professional development and growth, and providing collegial support to clinicians.

In the context of high quality HIV care, clinical systems mentorship (CSM) takes on an expanded meaning, which adds to this already complex process. CSM goes beyond the mentor's traditional emphasis on the individual provider, to consider the team of providers and the whole health system. CSM seeks to foster and support the development of a model of health care through a focus on skills, methods, processes, and systems at the level of the provider, the health care team, and the site.

It should be noted that like traditional mentorship relationships, CSM is characterized a beginning, middle, and end, as dictated by the stage of site development and by the solidity of the work done by the site support team and the site. Thus, support should theoretically be tapered over time. On a practical level, however, the site needs to demonstrate that sufficient skills have been transferred so that a reduction in support can be tolerated.

The relational nature of CSM requires that site support teams have extended and frequent periods of direct interaction with on-site teams. This deviates from the traditional training model, which is characterized by central, off-site trainings for clinic staff.

### **Traditional Training and CSM: Conceptual and Practical Considerations**

It has become clear that off-site, cadre-specific training of site-level personnel in HIV care and treatment, conducted by a training specialist, is of limited value in assisting a resource-limited site with organizing itself to deliver high quality HIV care. Several reasons exist for this limited value:

- Lack of practical, hands-on support: knowledge of a skill and use of a skill require different abilities, and traditional training focuses on the former.
- Lack of on-site systems to support new practice: if there are no supervisory or monitoring systems in place at the site level, new practice goes unassessed, if it occurs at all.

- Lack of available cadre-specific staff on site: In resource-limited settings, tasks may be performed by non-traditional cadres because of lack of available staff. Thus, training traditional cadres in their traditional tasks does not necessarily affect site level care and may leave gaps in services.
- Lack of alignment between personal goals and site level goals: Traditional training methods target skills of the individual provider rather than overall functioning of the site.

In contrast, when a site support team is sent to the site for a prolonged visit (days, as opposed to hours), a collegial on-site alliance may be established. The site may be assessed in a coordinated fashion. Multidisciplinary care may be modeled. Presence of resources and provider competency may be ascertained. Quality of care may be assessed and plans for enhancement made. Teaching and training may be done in context. Table 3 depicts the contrasts between traditional training and the ICAP CSM approach.

**Table 3: Traditional and ICAP Approaches to Training and Site Support** adapted from Engender Health's Whole Site Training approach

<b>Traditional Approach</b>	<b>ICAP Team-to-Team Site Support</b>
Training is centralized	Training is done on site
Training is knowledge and skills based	Training is a mixture of informational, practical, and motivational
Scanty follow-up	Continuous follow-up
Individuals practice solitarily	The team practices together
Training is cadre oriented	Team members are cross trained
Training content is standardized	Content is tailored to setting
Setting, content, and process are separated	Setting, content, and process are integrated
Site services are disrupted for training	Training occurs during service provision
Only trainees are involved in the training	All relevant site level personnel are considered potential trainees
PLWHA viewed as receivers of services	PLWHA are givers and receivers of services

The relationship between a site support team and the on-site team is intimate, and is built on trust and commitment to good patient outcomes. Developing this relationship and sustaining it involves an intense investment of time, and rests upon the use of two complex sets of skills by the site support team.

## Skill Sets

Mentorship, whether traditional or CSM, is rooted in two sets of skills, microskills (cross cutting, interpersonal) and macroskills (technical). Microskills rest on a foundation of particular values and personal qualities of the mentors in the site support team. To illustrate by example, consider the following vignette:

A mature HIV doctor from a traditional clinical background is the site support mentor helping a health facility to develop an HIV health care team. The health facility has several very experienced HIV care nurses (all women) and one new male doctor with no HIV experience. What role might gender attitudes play in this scenario? What role may attitudes regarding doctors versus nurses play? Who do you guess might be chosen to be the on-site team leader? Why?

The foundation for mentorship spans the domains of gender, race, and age attitudes, respect for diversity including cultural differences, flexibility and openness, and the ability to be genuine with others. Whereas micro and macroskills can be learned, these fundamental personal qualities and values are either present or not; in some cases they warrant challenge and/or confrontation, and at the very least a degree of personal awareness. They can be developed rather than simply learned as one would a technical skill. This process requires ongoing coaching, insight, and a desire to change.

## Microskills

Microskills improve interpersonal communication, enable leadership, improve teaching, enhance relationships and are fundamental to the work of the mentor. The set of microskills includes:

- Counseling and communication skills
- Interpersonal and people management skills
- Cultural competence
- Non-verbal communication
- A desire to empower others and provide opportunities for growth
- Flexibility and openness to new ideas
- Ability to coach or convey information to others
- Leadership qualities
- Self-awareness of values and limitations
- Ability to provide constructive non-judgmental feedback
- Ability to clarify
- Attention to details

In the Eastern Region of Ethiopia, the workday is structured unusually, with clinics primarily open in the mornings and providers gathered informally off-site in the afternoons. This pattern severely limited the amount of time the site support team had with providers during a visit. In response to this, the site support team joined the providers at their off-site gathering. Clinical and organizational issues were discussed, albeit less formally. With this innovative effort, the site support team has allied with and motivated the providers, who in turn are attentive to a range of clinical and organizational details that might have escaped their attention previously.

Training and exercises for development of CSM microskills are under development, and will be available in the next version of this manual.

## Macroskills

Macroskills are a set of technical approaches that are specific to the level (provider, team or site) at which the mentor is working. For example, working at the provider level, mentors use precepting, case discussion, and chart review to build the skills of the provider and achieve long-term learning goals. Working at the team level involves team building and maintenance, encouraging cross-cadre work, delegation of tasks, and facilitation of meetings. Finally, at the site level, the mentor works to choose and nurture a leader, address administrative issues, and evaluate quality of care. Clearly, successful execution of macroskills at all levels rests on a solidly built foundation of microskills.

### Working at the Provider Level: Enhancing Clinical Competency

Provider competency is critical for the provision of high quality HIV care and treatment services. Mentorship focuses on enhancing quality of care of the patient and his/her family members by building provider competency, skills, and knowledge. This can be achieved through *observed clinical encounters (precepting), provider feedback, chart review, and case based learning*.

### **Observed Clinical Encounters (Precepting)**

Structured observed clinical encounters (precepting) are a key strategy for assessing and building provider competency. In this approach, a mentor is silently present as the provider conducts the patient encounter. The mentor observes the interaction from the perspective of provider competencies, provides feedback, offers opportunities for improvement, monitors change over time in competency, and provides ongoing coaching.

Fundamental to structuring this macroskill is delineating specific provider competencies. Competency has been defined as the ability to do something according to a required standard. Thus, relevant areas must be selected, and internal decisions about

standards in specific areas need to be made. Specific areas might include knowledge, clinical and other patient- and self- care related activities, as well as processes such as patient assessment, clinical reasoning, awareness of limitations, and documentation.

In addition, to be optimally useful, this approach needs to be conducted systematically, objectively, and sensitively. The mentor needs to allocate time for observation; while it might be cumbersome to conduct observations frequently, when they are conducted they should not be rushed. Precepting checklists are an excellent way to structure the observation. Precepting checklists are tailored to include the breadth and depth of competencies needed to conduct a high quality patient encounter. Four precepting checklists are included in the appendix of this manual. The four demonstrate how these competency checklists can be modified to be used both in medical, support (in this case, laboratory), and counseling areas. Several items from a precepting checklist for medical providers are shown here.

**ART Provider Precepting Checklist**

Patient:	Age: _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> New	<input type="checkbox"/> Follow-up	
5: Outstanding	4: Above Average	3: Average	2: Below Average	1: Poor		
1.	Medical Interviewing: Process-----	1	2	3	4	5
2.	Medical Interviewing: Content-----	1	2	3	4	5
3.	Physical Examination-----	1	2	3	4	5
4.	Progression of Symptoms/Signs-----	1	2	3	4	5

The process of giving feedback is detailed under microskills, above. Fundamental to good mentorship is using this information and offering feedback in a way that encourages and directs the provider to improve competency. Precepting checklists may be used over time to objectively measure this improvement.

**Chart Review**

Good documentation is central to ensuring multidisciplinary quality of care over time. The patient chart and HIV/ART card is the easiest and most obvious place to ensure adequate multidisciplinary communication. Further, it is impossible to achieve longitudinal continuity care without adequate documentation of visits and plans.

Chart review forms should reflect the purpose of charting. Thus, they may have a variety of emphases. For example, if health centers are responsible for reporting certain data, these elements could be covered in a chart review form, with assessment

of data accuracy and completion being the objectives of the review. More globally, a health care provider must be invested in charting as a prerequisite to quality care. To emphasize this purpose, a chart review form could include elements such as date, weight, clinical status, adherence, patient education, and future goals of care including referrals and linkages to other services. A small piece of a sample chart review form is shown here.

#### ICAP Clinical Mentorship Initiative Chart Review Form

	Yes (√)	No (√)	Comments
1. Intake Form Complete			
2. Follow Up Form Complete			
3. Progress Note (On Hospital Card)			

The appendix includes chart review forms that can be adapted to meet the specific objectives of the site support team and local setting. Site support teams may use these forms as a basis for providing feedback to providers as a way for providers to improve their competency in recording data for reporting as well as for quality of care purposes. This feedback process is parallel to that used in the observed clinical encounter described above.

### Case-Based Learning

Case-based learning engages providers in appreciating the complexity of real-world situations, and absorbing real and feasible approaches to case interpretation and management. This method is learner-centered, and involves intense interaction across participants, and between participants and mentors. Much of case-based learning involves learners striving to resolve questions that have no single right answer.

In the context of HIV care provision in resource-limited settings, case-based learning may be orchestrated based on a curriculum that reflects the minimum care package described in chapter 2. The mentor may assign case presentations to site-level providers based on the curriculum or based on complicated cases that have presented recently. A curriculum checklist for case based learning can be found in the appendix.

Case templates and libraries may be used to standardize case presentations across providers, in turn facilitating communication, enhancing multidisciplinary input and care, and developing a case-based site history. Challenges in using case based learning with different cadres include the propensity of differently trained individuals to pay attention to different details, to have different patterns of expression, and to have varying abilities to understand a presentation. Use of a standardized case template addresses some of these issues, and also enables easy compilation of cases. A case template is included in the appendix.

## Working at the Team Level: Building and Sustaining the Multidisciplinary Team

The multidisciplinary care team is the foundation of an effective and sustainable program. As transition occurs to the continuity care model, the care plan must be designed so that it can continue at home between clinic visits. Thus, the on-site team must include the diverse clinic-based members, as well as the patient, family, and community.

### **Assumptions about teams**

As a group of people with a presumed shared vision and common goals, teams are also assumed to have a desire to work together and be eager to share a sense of success and disappointment. In the multidisciplinary context, the members should represent many cadres, the assumption is that each member contributes a range of expertise that overlaps with others but has unique aspects. The final assumption is that the combined expertise of all members is greater than the sum of the parts. While honorable, this vision does not always play out in real life.

Indeed, teams are not always natural, motivated, straightforward entities. Interpersonal problems can interfere with teamwork. Pre-existing attitudes may lead to inequality amongst team members. Team members may be disinterested in their tasks. Available on-site staff may be very few in number and representative of only a limited number of cadres (one or two nurses are the only staff, for example).

The role of the site support team is crucial in helping on-site staff build and institutionalize a functional multidisciplinary team. To mentor and support teams effectively, site support teams must be aware of pre-existing attitudes of on-site team members, and must have analyzed and understood the setting and its strengths and limitations. Site support teams are also well positioned to model the value of multidisciplinary communication and teamwork. Onsite teams uncomfortable with the idea of equal contributions of all cadres may benefit from observing the site support team relying on this approach to maximize their efficiency and effectiveness.

If possible, a team leader may be chosen. Ideally, this person will possess spirit and vision, excellent communication skills, and trustworthiness. This person will be optimally effective if (s)he can draw out and motivate all team members, and manage conflict directly and constructively.

### **Approaches to supporting teams**

Several structured approaches can be helpful in supporting teams, including: *team building and motivation; strengthening communication and team work in the clinic; team training and cross training of cadres; involvement of PLWHA; recognizing and building community linkages; and strengthening accountability.*

Team Building and Motivation: A critical role of the site support team is building and motivating the on-site team. This may be accomplished in several ways:

- Aligning personal and programmatic goals. Staff members individually, and programs on the aggregate level all want patients to have good outcomes. This natural alignment of goals and commitment should be reinforced frequently. Team member self assessments may be used to identify the goals, vision, and commitment of team members.
- Engendering a sense of ownership over the care that is delivered in the clinic. Standards of care and a framework for assessing quality using data and intervening to improve services are extremely useful for this. The standards of care and framework are detailed in chapter 6.
- Engendering a sense of contributing to a larger whole. Site staff, though perhaps extremely geographically isolated, should be reminded that their experience can contribute to the world's knowledge base in HIV care and treatment. One effective approach for doing this is through creation of a case library. Site staff should be encouraged to write up cases and contribute them to this library, and they in turn should have access to the library for their own learning purposes. A simple case template is in the appendix to facilitate this endeavor.
- Building in mechanisms for recognition. Again, using the framework for the standards of care is useful for this. If an intervention is planned based on the standards, and is successful, it will be detected in the next round of measuring the standards. This is detailed fully in Chapter 6. Recognizing these achievements in a meeting or other form is important for building team spirit and maintaining motivation.
- Imparting regular appreciation and recognition. Site support teams should be especially sensitive to this, and should offer praise freely and regularly.
- Providing opportunities for personal and professional growth, including provision of constructive feedback, educational opportunities, problem solving sessions, and experience sharing.

In the Southern Region of Ethiopia, the Regional Director has organized a seminar for the ten teams in the region. These teams will come together (on a weekend) for case presentation and discussion, experience sharing and trouble shooting. A great deal of excitement surrounds this event.

Strengthening communication and teamwork in the clinic: Two prerequisites for strong communication and effective teamwork are trust and clarity. Trust can be built in the team by fostering non-judgmental responses to ideas or presentations, cultivating good listening skills, ensuring global participation of team members, and ensuring frequent regular interaction of team members.

Team Meetings should ideally be organized by the on-site team leader, but at the beginning may need to be organized by the site support team. They should be regular, attendance-required meetings that have an agenda, time constraint, and records of the proceedings. Content should focus on more than administrative frustrations; specifically, case discussion, educational presentations, and workplanning should take

place. A template for team meeting agendas and minutes may be found in the appendix.

Workplanning is the process of organizing a strategy for work to be conducted towards a specific outcome. This time sensitive plan lists the tasks that need to be accomplished in order to meet the objective. The person responsible for each task and the time frame for completion will also be included.

An illustrative workplan is shown in table 4. A blank template may be found in the appendix.

**Table 4**

	<b>Method</b>	<b>Person (s)</b>	<b>Timeframe</b>	<b>Evaluation</b>
<b>Precepting</b>	<i>1. Observe three patient encounters weekly with same day feedback sessions</i>	<i>Clinical advisors</i>	<i>3 months</i>	<ol style="list-style-type: none"> <li><i># Encounters observed</i></li> <li><i># same day feedback sessions</i></li> </ol>
	<i>2. Work with provider to identify strategies for change</i>	<i>Clinical advisors</i>	<i>3 months</i>	<ol style="list-style-type: none"> <li><i>Provider competency over time</i></li> <li><i>Percent of patients appropriately managed</i></li> </ol>
	<i>3. Review charts with providers to discuss cases and ensure accurate patient information recording</i>	<i>Clinical advisors</i>	<i>3 months</i>	<ol style="list-style-type: none"> <li><i># charts reviewed</i></li> </ol>

**Cross training of cadres:** Cross training is an approach that creates flexibility within a limited human resource pool and may allow more patients to receive services or more services to be provided. It may be viewed as a precursor to task-shifting, and must be done within legal limitations of licensure. Cross training involves on-site training of personnel to develop overlapping expertise, such that if one staff member is unable to perform a task, another can do so, avoiding interruption of work and expanding the skill pool of the team.

Cross training begins to build mentorship skills within the team, as staff trains staff. It also builds training and educational incentives into work, as staff are not only permitted but encouraged to learn new skills in a safe environment.

Techniques for cross training include the site support team and/or team leaders helping providers cross train, and on-site staff accompanying and learning from one another with supervision.

Cross training is not a solution to the human resource crisis but at the level of an individual site it may help avoid gaps in services due to personnel shortages. Questions that arise when considering cross training involve the challenge of broadening job descriptions, the question of who trains, how, and to what level of expertise, as well as anticipating sensitivities around salary, territoriality, pride, and historical training differences. While it is beyond the scope of this manual to answer these questions, they must be considered carefully and in context before embarking on cross training initiatives.

Involvement of persons living with HIV: Continuity care implies a shift in the role of the patient from care receiver to care giver and receiver. Strategies for encouraging this shift are detailed in the first Special Issues chapter.

Recognizing and building community linkages: Community mapping has proven to be immensely valuable in understanding the dynamics of a community. The site support team should be involved in creating the map so that they can fully understand the context of the clinic. This mapping exercise will locate key voices in the community with which linkages need to be made.

Standing committees and/or HIV community advisory boards (CABs) are a natural outgrowth of this mapping exercise. They provide a forum for information, education, ongoing communication, cross-referral, and advocacy. CABs are discussed in more detail in chapter 5.

Strengthening accountability: Workplans are useful in documenting accountability, as are team meeting minutes (see appendix). However, despite documentation, it is not unusual for accountability not to be enforced. Thus, the team leader (as modeled by the site support team) must make accountability an ethic of the team.

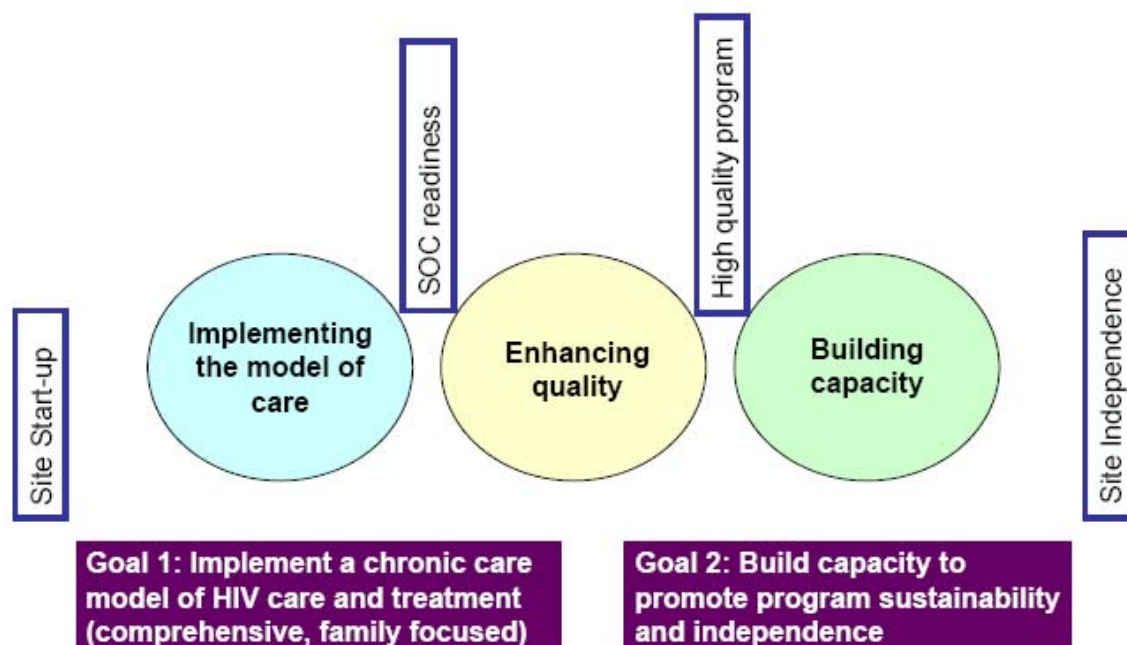
#### Working at the Site level: Establishing program infrastructure, developing leadership and building capacity

Site level infrastructure and staffing are critical components of program implementation and the ability to deliver comprehensive services in both the short term and the long term. The nature of site-level work by the site support team is particularly sensitive to the developmental stage of the site. Figure 2 is repeated below for convenience:

At site start-up, site support teams may help *improve system functioning and logistics*; as function becomes more routine, the site support team may *ensure implementation of the model of care and foster and support quality improvement efforts*; and as the site reaches maturity and is delivering high quality care, the site support team may *cultivate on-site leadership, mentor regional and district health teams to be mentors, and institutionalize quality improvement processes as a means of capacity building*.

During site start-up, a site's logistical needs might be overwhelming and urgent, necessitating the full attention of the site support team. During this phase, the site support team will benefit greatly from staying organized; comprehensive checklists (see appendix) can be very helpful as a way of prioritizing issues. Patient flow analyses and communication logs (see appendix) are also helpful in keeping progress organized.

**Figure 2: Stages of site development model**



As the site matures, the site support team needs to broaden its focus to ensure that all minimum pieces are in place to ensure delivery of the HIV care model. Integrated checklists, such as ICAP's model of care assessment detailed in chapter 5, contain logistics and infrastructure components as well as including the elements of care and other programmatic components. In addition to the integrated checklists used at the site level, the site support team is also working at the provider and team level to build competency. Thus, multiple tools from these levels (such as precepting checklists) will already be in use.

Once minimum pieces are assessed to be in place by using the model of care assessment, the site is mature enough to consider measuring elements of care and embarking on developing specific interventions to improve care. Measuring each element of care using standards provides a framework for interpreting measures, developing interventions to address problems, and assessing the effectiveness of the interventions.

Capacity building, a term often used vaguely, describes the transfer of expertise and infrastructure from external advisors to the site level with the ultimate goal of independence. For the site support team, this involves nurturing site supervisors and team leaders, in some settings mentoring regional or district health teams to continue supervisory work and on-site mentorship, propagating a common vision, and ensuring the on-site team has the necessary tools and expertise to identify problems, self-correct, advocate and perform well.

The on-site supervisor or team leader will need the following in order to successfully accept this transfer of responsibility:

- an understanding of the responsibility
- time to devote to supervision
- technical skills and expertise
- excellent microskills
- an interest in developing macroskills

The site support team may foster this growth of the on-site supervisor or team leader by conducting explicit teaching in microskills and macroskills. Mentorship skills checklists (see appendix) are useful for documenting this process.

The on-site team's involvement in, and ownership of, clinic processes must increase over time as well. Specifically, the on-site team must:

- understand what constitutes good quality care
- independently identify problem areas and plan/evaluate interventions
- work as a team

Plans for continuing education and development of the on-site team need to be made as capacity building and sustainability become the priority of the site support team. These efforts can generate from within the site, or from external sources. Table 5 depicts some options.

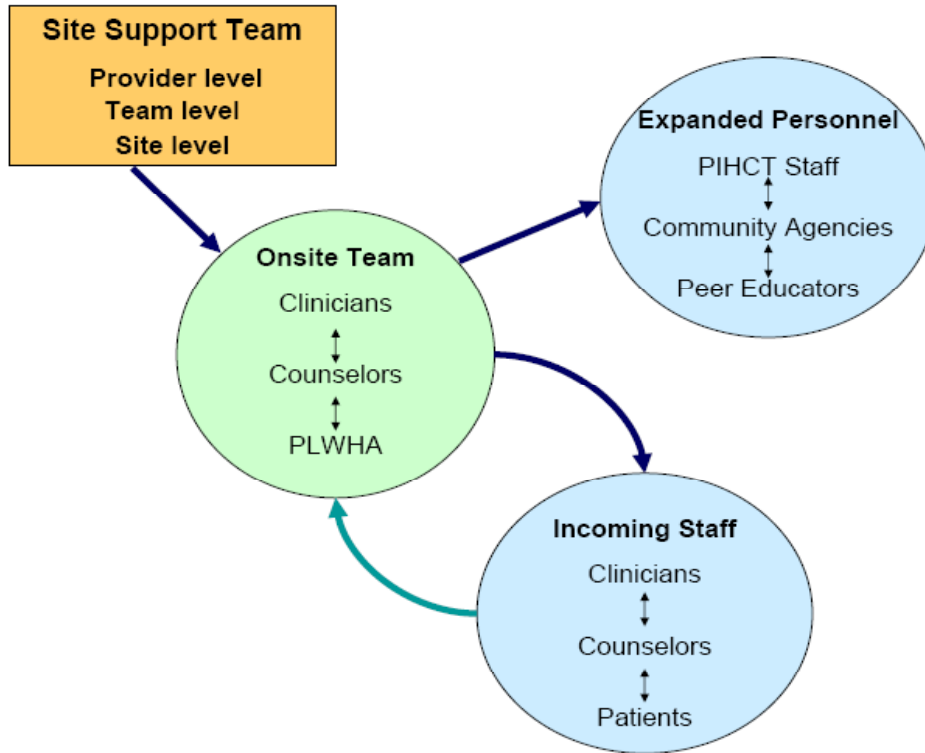
**Table 5: Options for continuing education and team development**

<b>Internal</b>	<b>External</b>
-case presentations	-educational presentations
-mortality and morbidity conferences	-off-site conferences
-local experience sharing	-regional experience sharing
-journal clubs	-cross site visitation

As CSM is institutionalized at a mature site, additional capacity building begins to occur spontaneously. In one scenario, incoming (new) staff are trained and oriented by the existing on-site staff. With this process, roles change as existing on-site staff practice CSM. A second scenario in which this is visible is when the on-site team expands, for example, to accommodate provider initiated HIV counseling and testing (PIHCT). Again, existing members of the on-site team may act as mentors for the new PIHCT providers. Figure 3 depicts the cyclic and expanding nature of this. Additional aspects

of capacity building will be discussed in Chapter 7 of this Manual. Working with regional and district health teams will be explored in the second Special Issues Chapter.

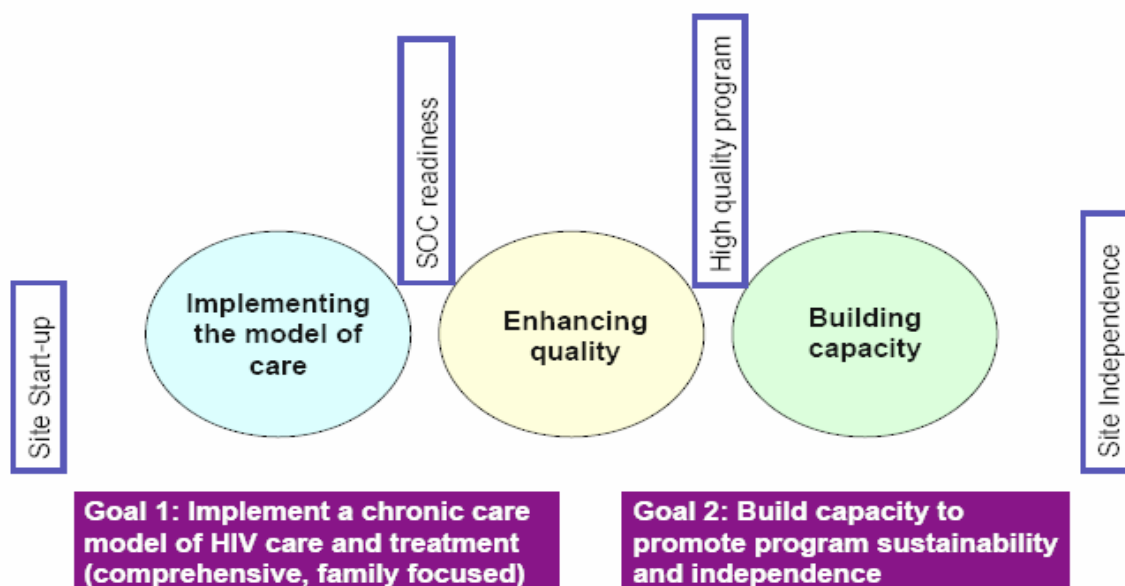
Figure 3. Clinical Systems Mentorship Process



## Part 2: Applying Clinical Systems Mentorship to Site Development and Support

A site that has been identified to provide HIV care and treatment services will pass through predictable stages of development as services are introduced and developed over time. These stages are not defined by time but rather by capacity at the site to act at increasingly higher levels of independence. The site support team has as a primary responsibility to understand the stage of development of the site and consequently the needs of the site. The diagram below identifies the three general stages of site development relative to the goals and activities of the site support team.

**Figure 2: Stages of site development model**



The next four chapters discuss each stage in detail. Common challenges faced by site support teams are discussed, and strategies and support tools for site support teams are described. It is important to note that sites exist on a continuum with stages often overlapping. The purpose of separating and naming these stages is to recognize the variety of needs of the site and shifting roles of the site support team. This can be especially helpful for site support teams who often feel overwhelmed by the extensive array of competing issues at a site.

The tools and assessments in this manual may help ensure that certain critical aspects of each stage are met before embarking on strategies appropriate for later stages. It can be unproductive or even counter-productive for a site support team to conduct activities that are more advanced than is appropriate for the site's reality.

Finally, it must be appreciated that site development takes time. Many years of support may be necessary before a site has institutionalized the model of care and is prepared to direct the work needed to sustain the delivery of high quality HIV care.

**Table 6: Site Support Team Approaches by Stages of Site Development**

<b>Stage 1: Establishing pre-requisites for care delivery and implementing the model of care</b>
Partner survey and communication
Community mapping and CAB formation
Site needs assessment
Comprehensive checklists
Infrastructure
Provider needs assessment
MOC assessment
Team building
Identifying a supervisor
<b>Stage 2: Strengthening the model of care and initiating quality improvement</b>
Provider level CSM
Precepting checklists
Chart review
Case based learning
Team level CSM
Team meetings and work planning
PLWHA activities
Site level CSM
Introducing the SOCs
Fostering political will
Strengthening linkages
Nurturing the team leader and site supervisor
<b>Stage 3: Building capacity and fostering independence</b>
Provider, team, and site level CSM activities continuing
Site driven SOC activities
Explicit transfer of mentorship skills
Capacity assessment
Building Networks

## **Chapter 5**

### **Stage 1: Establishing Pre-Requisites for Care Delivery and Implementing the Model of Care**

The first goal of site support is implementation of the continuity HIV care and treatment model at the site. The ICAP model of care details the specific clinical services that comprise this model. This chapter discusses the major components of this initial start-up stage, and presents some of these tools and activities that site support teams have used in the past in supporting implementation of the model of care.

#### **Pre-Implementation**

To prepare for implementation of a program, it is important to meet with local health authorities and NGOs to share the mission and planned activities for the region. This communication provides an occasion to solicit inputs and buy-in from site-level partners and collect information about local systems and tools already in place at the site. Introductions early on provide a wealth of information for follow-up and give everyone a chance to adjust to new aspects of HIV care in the region.

Coordinating activities of site-level funding partners has the dual benefit of helping to link various areas of service delivery and maximizing the use of available resources. Additionally, the effects of coordination at the regional or national level may positively influence how site personnel collaborate. Even when services are not obviously linked to HIV care and treatment, good coordination can reveal unforeseen opportunities to identify and enroll new patients infected with HIV and optimize the care of HIV-infected patients. Coordination can identify service gaps and enable partners to advocate for funding priorities.

Taking the time to create a forum for communication that will continuously channel information, ideas, and opinions between implementing partners, the community, and the clinic is paramount to appropriate initiation and continuation of services. Ideally, this sort of communication begins during the pre-implementation needs assessment, when local health authorities, NGOs and other implementing partners, community leaders, groups and individuals are consulted. Once established, a cooperative relationship between partners and the community enables interaction through on-going communication.

Tools for pre-implementation needs assessment, as well as surveys for ascertaining relevant agencies and partners, are in the appendix.

## Working with the Community

Before the program begins offering services or soon after start-up, key community members should be invited into a discussion with clinic leadership. These discussions should introduce planned activities and encourage a discussion of community needs, experiences with existing HIV services, and suggestions. The community perspective is crucial to developing outreach and care retention strategies that respond to the needs of patients living in the community. Time spent in discussions with the community will foster good relations, help establish credibility and contribute to improvements in service delivery and uptake.

Standing committees or HIV community advisory boards (CABs) are a natural outgrowth of initial meetings between the site and local stakeholders. These groups provide a forum for information, education and communication, where participants often organize community resources to advocate for services and funding. Committee participation is a commitment that extends beyond pre-implementation needs assessment, so selecting membership should be done thoughtfully. If an HIV care and treatment committee already exists, every effort should be made to work with the existing group. Below are some of the assumptions, or preconditions for an effective CAB, as well as some of their functions.

**Table 7: Community Advisory Board**

<b>CAB Preconditions</b>	<b>CAB Functions</b>
Diverse/representative membership – members of HIV affected community	Observe and report information about the community as well as share information about HIV services with the community
Commitment and interest in learning; willingness to share	Serve as representatives of the community – share concerns and perspectives with HIV service providers
Ongoing and sufficient support	Build trust and acceptance of HIV services
Clear mechanisms for information exchange	Promote access to HIV care
Meeting accessibility, e.g. location, transportation, child care	Advise on appropriate/culturally sensitive HIV information and activities
Sense of civic responsibility/volunteerism	Monitor ethical issues and patient rights
Recognition by community represented and institutions that are advised	Advocate for HIV services and funding

In settings where HIV services are being introduced for the first time, a community launch of planned services in collaboration with local stakeholders will help increase community awareness and demonstrate acceptance and buy-in from important opinion leaders. Creating an early opportunity to publicize the program cannot be underestimated, as the community will be naturally curious about new services, and interested to see how stakeholders have been involved. A community launch is a great activity to carry out with a stakeholder committee and a memorable accomplishment that can serve to inspire ongoing collaboration. Waiting months until the program is well underway may be more convenient for staff, but will garner less interest and support

from a community that may be focused on other priorities or worse, feel slighted by a less transparent initiation of services. Efforts to celebrate the new program can demonstrate progress, prevent skepticism, and revitalize the community. No matter what the circumstance, a new program cannot afford to neglect the one-time chance to spotlight services and publicly seal a partnership with the community.

### **Working within Existing Facilities/Institutions**

Facility-level and institutional management are typically preexisting, and introduction of a new program requires explicitly engaging with key players including the Medical Director, Administrator, and representatives of partner NGOs with an on-site presence. All of these leaders should be involved and oriented as early on as possible, and it is important to have repeated contacts to clarify vision, state program challenges and needs, engage in problem solving, and reaffirm commitment.

The commitment needed from the existing leadership may take the concrete form of dedicating supervisory time from a facility staff person, to the more abstract form of acknowledging that the program will inevitably place demands on facility/institutional resources, to the most long term understanding that running this program will affect change in certain policies and procedures. Site support and program staff need to know that their efforts to provide high quality HIV care and treatment services will be supported.

Table 8 illustrates strategies and information to be presented in fostering a relationship with key personnel.

**Table 8: Steps in Information Sharing (Adapted from Engender Health COPE Handbook p. 20)**

<p>Discussion of site strengths          Discussion of site philosophy especially with regard to quality          Program overview including funder obligations          Program needs (i.e., dedicated time for a supervisor)          Stages and steps (workplan)          Shared attitude and commitment: enabling quality improvement efforts and team decision making and responsibility          Acknowledging the difficulty of change          Plan for regular conversations/meetings          Appointment of a liaison</p>
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### **Initial Needs Assessments**

An initial needs assessment should be conducted at the site to evaluate the physical resources and constraints as well as the human resource capacity existing at the site. This assessment is critical in structuring the preliminary workplan, outlining reasonable targets, and planning for future program costs and needs. This assessment will also

help guide a staffing process by identifying the greatest human resource needs. The assessment should consider but is not limited to the following areas:

- Physical Layout and Service Organization
  - Where is the ART clinic located and how much space is available?
  - What is the proximity to key service referrals (TB, STI, PMTCT, Nutrition, Counseling, Pharmacy, Lab, etc...)
  - Counseling – is there a private room for one to one and group counseling sessions, proximity to linked services?
  - Testing – is there space in the clinic for testing? Does the facility have a separate VCT area? Is testing conducted only at the laboratory?
  - Laboratory – Is there a lab on-site? What are the capabilities of this lab? Where are specimens collected and processed? How are lab supplies, equipment, and reagent coordinated and ordered? Are there QA protocols? How are results reported to the clinic? Is there sufficient staffing to handle the lab demands of an HIV clinic?
  - Is there a nearby reference lab? What are the capabilities of this facility? How is storage, transportation, and results reporting coordinated?
  - Pharmacy – Is there a pharmacy? Is there sufficient storage space and security? Who dispenses medications? What are the tracking and procurement procedures? Can medications be dispensed at individual clinics or only centrally?
  - Equipment- Is there necessary equipment in all of the areas of the clinic?
  - Supplies- Are there sufficient supplies for providing comprehensive services? Are there frequent stockouts of supplies?
  - Documentation- What facility and patient held tools are currently available? What type of filing system is used? How are patients identified?
  
- Staffing
  - Is there a doctor in the ART clinic? How often is this doctor available?
  - Is there a nurse? How many? What training have these nurses had? What (if anything) are these nurses allowed to prescribe?
  - Are there psychosocial support staff members in the clinic? What is their training/areas of specialty?
  - Is there administrative support? Data recording support?
  - Is there sufficient staffing in the pharmacy and laboratory to support the clinic?
  - Are there other staffing needs?
  - What is the overall competency of the staff at the clinic? Does the staff have HIV care and treatment experience? How much training is needed?

This is not a comprehensive needs assessment, but outlines some of the key issues that should be considered in conducting a preliminary site assessment. Examples of preliminary needs assessments can be found in the appendix.

### **First Plan for Implementation**

These discussions and agreements should be used to compile a preliminary workplan detailing the first months of program implementation. This first plan will include addressing essential logistical concerns and challenges identified in the needs assessment, as well as preliminary efforts at forming a multidisciplinary team and training the onsite staff in the model of care. The beginning stages of implementation can be very overwhelming so making shorter, targeted workplans aimed at addressing a few issues at a time can be helpful in making the start up months more manageable. Table 9 depicts how this might look.

Table 9: Start-up workplan example

### Start-up workplan- ICAP Site A Jul-07

Support Category		Activity	Start Date	Completion Date	Who	Comments
Space	Clinic organization	Create nurses station for patient vital signs. Reorganize waiting room and create constant flow from intake to pharmacy.	Aug-07	2 months	Clinical advisor, supervisor	Discuss clinic organization in team meeting before making changes
Preparatory meetings		Meet with CAB to discuss history of HIV activities in community and what they see as most pressing need	Aug-07	Aug-07	Country director, clinical advisor	meeting held at CU office
Create Team		Meet with hospital management to select supervisor. Discuss need for	Jul-07	1 month	Program officer	need main point of contact, supervisor, and community liaison; invite
Staff needs		assess any immediate staff needs	Jul-07	1 month	Clinical advisor	Discuss plans for new hires with hospital management
Equipment		Assess any equipment needs in clinic, laboratory, and pharmacy	Jul-07	2 months	Program officer	Discuss needs with ICAP office and hospital management
Other needs	Lab transport	Create plan for transporting lab specimens while waiting for lab renovations to be completed	Jul-07	1 month	Program officer, lab director	ICAP can provide transport costs, lab must coordinate
Team training		Conduct training needs assessment of all team members	Aug-07	2 months	Clinical advisor, supervisor	Create follow-up training plan based on results
ARV	Pharmacy	Quantify ARV needs for 3 months based upon first line therapy algorithm, create procurement and ordering	Aug-07	2 months	Program officer, pharmacist	Need for constant supply of adult and pediatric ARVs, importance of no stock outs
OI & other drugs	Pharmacy	Train pharmacist on quantifying, strengthening ordering mechanism and stock	Aug-07	2 months	Program officer, pharmacist	Importance of constant CTX stock
Laboratory	CD4	Develop system for lab reporting of results	Jul-07	2 months	Laboratory advisor	
	other exams	discuss availability of basic lab tests during lab renovation with management	Jul-07	2 months	Laboratory advisor	
	HIV rapid test	Arrange ordering from MoH, obtain supply for clinic	Jul-07	2 months	Laboratory advisor	Discuss the need for HIV rapid test with Hospital management
M & E / patient tracking	Records	Create a record filing system and link with appointment book	Aug-07	2 months	Clinical advisor, supervisor, program officer, M&E advisor	Coordinate to discuss at a team meeting, solicit team input
Home visit and community outreach		Include place on chart for patient approval of home visit, create system for structuring visits	Aug-07	2 months	Community advisor	Develop plan with team to follow up patients at home based on anticipated needs and

## Implementation: Site Start-Up and Program Function

Several key areas beyond logistics must be considered and systematically approached before basic adult and pediatric HIV care and treatment can be delivered, assessed and enhanced on an ongoing basis during care provision.

- A. Systems and infrastructure
  - Supplies and equipment
  - Patient flow
  - Pharmacy services
  - Appointment system and patient tracking
  - Patient records system
  - Laboratory services
- B. Clinical skills and components of care
  - Provider skills
  - Continuity care model
  - Coordination of services and family focused care
- C. Leadership and management
  - Supervisory structures with accountability
  - Sufficient staff to meet program demands
- D. Multidisciplinary team formation and function
  - Members (including PLWHA)
  - Orientation
  - Task Shifting
  - Team Building
- E. Internal and external linkages
  - Within site, other programs/clinics (e.g., ANC, L&D, TB)
  - Home care programs
  - Community organizations
  - Professional associations
  - PLWHA organizations

Prioritizing these issues is challenging, especially in early stages of program implementation when often all areas need simultaneous attention. Coordination and planning within the site support team is of utmost importance in order for efforts to be maximized rather than duplicated. Although the rush to address multiple needs may make it seem more efficient to have the site support team fix problems, it is beneficial in the long term to involve at least one site member in arranging logistic and programmatic pieces so that knowledge of these systems is held not only by the site support team but also by the onsite team.

Assessing this process in an objective and systematic way helps to highlight successes as well as identify ongoing challenges. Involving onsite staff in this process builds critical thinking skills and engages staff in analyzing current conditions at the clinic. A tool such as the model of care (MOC) assessment, found in the appendix, is unique in that it integrates logistical, clinical, and team-related areas of function as they specifically relate to programmatic objectives. It is a structured way to conduct this implementation assessment.

**Table 10: Model of Care (MOC) Assessment example**

Element of Care	Implementation Questions	Yes/No? Comments
pMTCT and care of HIV infected pregnant women		
HIV counseling and testing with results given at first ANC visit	Are test kits available in the ANC?	
	Is a staff member trained to conduct T&C? Who does HIV testing?	
	Is there ANC staff 'buy-in'?	
	Are there fees for testing?	
	Is there a private room for individual post test counseling?	
	Are there serious issues with community stigma that prevent women from testing?	
	Are there cultural issues that prevent women from testing?	
	Are there time constraints?	
	Is there a comprehensive ANC register containing PMTCT information?	
	Does an ANC/PMTCT register exist? Are registers being completed properly?	
	PMTCT prophylaxis for ART-ineligible HIV positive pregnant women	Is AZT available? NVP tablets?
Where is AZT and NVP kept (ANC or Pharmacy)?		
Are nurses allowed to give AZT?		
Is the lab equipped to measure Hb?		
What is the turn around time for Hb test?		
Is PMTCT register/patient record being completed properly		

The assessment includes an accompanying toolkit (see below for a small example and appendix for complete toolkit) that identifies helpful activities and tools to address issues raised during the assessment process. Taken as a whole, this is a constructive, rather than evaluative process that can guide the site support team in working along with the onsite team to implement the model of care.

Table 11: Support Tools Table example

Element of Care	Questions to consider in evaluating implementation of element	Strategies for Improving	Support Tools
Pregnant women should receive HIV counseling and testing and same day HIV test results at first ANC visit	<ul style="list-style-type: none"> <li>• Are test kits available in the ANC?</li> <li>• Is a staff member trained to conduct C&amp;T? Who does HIV testing?</li> <li>• Is there ANC staff 'buy-in'?</li> <li>• Are there fees for testing?</li> <li>• Is there a private room for individual post test counseling?</li> <li>• Are there serious issues with community stigma that prevent women from testing?</li> <li>• Are there cultural issues that prevent women from testing?</li> <li>• Are there time constraints?</li> <li>• Is there a comprehensive ANC register containing PMTCT information?</li> <li>• Does an ANC/PMTCT register exist?</li> <li>• Are registers being completed properly?</li> </ul>	<ul style="list-style-type: none"> <li>• Group education and pretest counseling</li> <li>• Opt out testing</li> <li>• POS testing</li> <li>• Partner testing and invitation</li> <li>• Train nurses on proper register completion</li> </ul>	<ul style="list-style-type: none"> <li>• Counseling and testing script-CDC</li> <li>• Testing module</li> <li>• Checklist for pretest education</li> <li>• Checklist for posttest counseling</li> <li>• Patient poster and brochure about why to test and what services are offered</li> <li>• Flip charts- CDC</li> <li>• Partner disclosure counseling materials</li> <li>• Integrated PMTCT/VCT training curriculum</li> <li>• Patient flow algorithms</li> </ul>
HIV-positive pregnant women should receive AZT + sd-NVP to prevent MTCT	<ul style="list-style-type: none"> <li>• Is AZT available? NVP tablets?</li> <li>• Where is AZT and NVP kept (ANC or Pharmacy)?</li> <li>• Are nurses allowed to give AZT?</li> <li>• Is the lab equipped to measure Hb?</li> <li>• What is the turn around time for Hb test?</li> <li>• Is PMTCT register/patient record being completed properly</li> </ul>	<ul style="list-style-type: none"> <li>• Train nurses to give AZT</li> <li>• Arrange to store AZT and NVP at ANC</li> <li>• Give NVP at 28 weeks (start of 3<sup>rd</sup> trimester)</li> <li>• Hemoglobinometer if turn around time is &gt; 2 weeks</li> <li>• Train nurses on register completion</li> </ul>	<ul style="list-style-type: none"> <li>• PMTCT curriculum</li> <li>• Job aid for eligibility criteria</li> <li>• Patient education pamphlet</li> <li>• Patient flow algorithms</li> </ul>

The MOC assessment can also be supplemented or preceded by comprehensive checklists for each component. These comprehensive checklists are of greatest use during program start-up, but are often too lengthy and cumbersome to use on a regular, ongoing basis.

### Attending to Logistics and Strengthening Infrastructure

Often logistical and system level challenges require the most attention in early stages of implementation. Structural challenges often prohibit patient care and therefore need to be addressed even before the program begins offering services. Some of the major system level concerns that need attention are:

- Supplies and equipment: The clinic needs to be equipped for service provision. This includes basic materials such as furniture, lighting, water, private rooms; medical equipment such as scales, stethoscopes, and syringes; and basic supplies such as rubber gloves, soap, and bandages. A complete list of supplies and equipment can be found in the appendix.
- Pharmacy- Introducing HIV care and treatment services to a clinic requires an extension of the current pharmacy duties. Continuity care patients have a predictable need for medication and this must be factored into current procurement mechanisms. The supply of ART and cotrimoxazole must be assured and anticipated. New patients must be accounted for in these procurement plans. In addition, medications for the management of opportunistic infections may need to be ordered and stocked. A system for patient tracking needs to be put in place so that patients who do not return for medication refills are identified.
- Laboratory- The ART clinic will require extensive laboratory support in order to monitor HIV positive patients. The lab will be responsible for regular monitoring of patient's liver function tests and hematology profiles, as well as CD4 count and in some cases DNA PCR for early infant diagnosis. Laboratories not equipped to conduct these test will need to create a system for sending samples to referral labs, receiving results, and reporting these to the ART clinic. Sites with equipped labs need to develop a mechanism for phlebotomy and sending samples to the lab as well as results reporting. The lab will also need a procurement system for reagents and a plan for machine maintenance.
- Patient records- Continuity care requires regular patient contact and follow-up. Robust medical records are a critical component of this model of care. The site support team must attend to this issue early on in program start-up. The onsite team must understand the importance of documentation and record keeping so that providers can identify longitudinal issues in care.
- Appointment and tracking systems- Patients should be given a return date at every visit for follow-up. Depending on the patient's clinical condition, the length of time for follow-up varies. However, a mechanism must be created so that these return dates are tracked and patient's who do not return can be followed-up. In addition, a system for identifying patients using unique ID numbers or a similar strategy is important for keeping track of individuals. There are many ways to organize these systems. ICAP has a repository of systems used in current programs.
- Patient flow and space management- The clinic must work to maximize available space. Analysis of patient flow is important to ensure the most efficient use of time and space for both patients and providers. Shadowing patients and mapping the clinic are helpful activities for gathering information. A team meeting where this information is discussed and analyzed can be helpful for identifying changes that need to be made.

Managing logistics in early stages of program start-up can be overwhelming and time consuming. It is important to think critically about how services are being provided with attention to changes that can improve clinic function and enable meeting care objectives. Attention to details and an awareness of day to day function are important for this. When the site support team is unable to spend large amounts of time at the site,

the role of the supervisor in analyzing and critically thinking about the clinic as a system is increased. The site support team needs to coach the supervisor in systems-level thinking and build a relationship so that the supervisor can refer to the site support team for help when large problems arise.

### **Clinical Skills and Components of Care**

All on-site staff should be introduced to the model of care and trained in its individual components. Gauging onsite clinical skills and knowledge can be done through provider self assessment and clinical precepting, as described in Chapter 4. It is important to have realistic expectations for the time needed to build clinical skills. A one-week off site training will not suffice to produce a team of skilled HIV providers. Ongoing site support requires providing information, mentoring and supporting providers in acquiring skills, and providing ongoing feedback and encouragement as providers grow in their roles as HIV clinicians.

The ICAP Clinical Manual is a good resource for fundamental HIV clinical information and clinical algorithms.

### **Building Leadership and Management**

In addition to acting as a program liaison and coordinator, the site support team might function in a supervisory role to on-site staff during the early stages of implementation. However, over time, on-site personnel should be assigned to these roles. The site supervisor has a broad range of tasks including fostering team ethic, monitoring program function, and providing support and guidance to team members. Table 12 summarizes the main roles of the site supervisor.

Table 12

#### **Roles of Program Managers**

- Supervision of program staff
- Team building
- Monitoring Program Function
- Liaison with Facility/Institutional Management
- Coordination of services and partners
- Expanding PLWHA roles

Identifying the site supervisor may be the role of the site support team or the clinic director. If the site support team is permitted to select a supervisor, it is wise to select someone with analytical and critical thinking skills who is familiar with HIV care and treatment as well as linked with the community. Excellent clinical skills are not necessarily the highest priority for this position, rather the supervisor should be a leader who can motivate and unite the on-site team to build up the program and address key challenges. An ability to think critically about program function and components are crucial.

After the supervisor is selected, it is important that discussions with key clinic leadership are held to ensure that a significant portion of the new supervisor's time can be allocated for program management duties. The site support team is then able to work with the supervisor to enhance program management skills. Working with the supervisor to address logistical, programmatic, managerial, and infrastructure issues will prepare the supervisor to eventually assume full responsibility.

### **The Multidisciplinary Team (MDT)**

Team formation and building often require hands-on involvement of the site support team. Additionally, working with a team to provide clinical services may be a new and somewhat unnatural process for many onsite providers. Frequent reinforcement of the process including inter-team referrals, case discussions, and regular meetings can be done by the site support team.

The on-site supervisor may also act in the role of team leader. The leader will in turn take on the role of facilitating communication in the clinic, ensuring regular organized meetings, organizing discussions around challenging cases, and building team unity and spirit. Specific strategies and tools for team building and maintenance, including the role of multidisciplinary team meetings, were presented in chapter 4.

The site-level multidisciplinary team should include as many as possible of the personnel listed below. Some sites may have small teams in which tasks traditionally associated with one cadre are performed by another. This is an example of task-shifting, and illustrates why it is important to cross train MDT members.

**Clinicians** include doctors, nurses, health officers, tecnicos, and other staff empowered to provide medical care and treatment. Their primary responsibility is the provision of family-focused medical care and treatment and appropriate documentation of the services they provide.

**Counselors and Adjunct Staff** include both counselors at the ART clinic, as well as hospital or health center staff involved in VCT or PIHCT at points of entry into care, e.g., ANC Clinic, Medical Clinic, Pediatrics Clinic Hospital Inpatient Wards, and Labor Wards. Of note, these latter counselors might be nurses by cadre, but they function as counselors on the multidisciplinary team. They are charged with providing educational counseling, practical and appropriate behavior change communication, psychosocial support, adherence support, household recruitment, and ensuring appropriate linkage of the patient and family to medical care and treatment.

**Data Staff** supervise and coordinate site level forms completion, collation, and organization of data. This activity involves intensive communication and interaction with clinicians and counselors, as well as aggregation of available data for feedback to the team.

**Lab Staff** are charged with doing accurate laboratory work and providing timely results. Their responsibilities may also include phlebotomy as well as other types of specimen collection. Lab personnel are fundamental to accurate and respectful diagnosis and management of patients and as members of the care team have an opportunity to interact with patients, to observe them, and to reinforce the model of care. Lab personnel are an integral part of the multidisciplinary team and ongoing communication between lab and clinical staff is critical to implementation of the model of care and smooth functioning of the staff. The appendix contains a tool for supporting lab staff in this integrated fashion.

**Pharmacy Staff** are charged with medication stocking and anticipating need for restocking, distribution of medicines to patients, discussing regimens with patients including adherence and side effects, and documenting and monitoring medication pick-up as a means of monitoring adherence. Effective provision of the latter tasks in particular requires extensive communication with other members of the multidisciplinary team.

**Administrative Staff** are in a unique position to appreciate the overview of clinic function, including interactions across staff and services. They are thus essential to the multidisciplinary team in enhancing linkages, facilitation communication, identifying opportunities for improvement of function, and bridging gaps in team function.

**Peer Educators and “Expert Patients”** can play an integral role in implementing programs, serving as service linkage coordinators, community liaisons, and direct supporters of patient adherence. They also play a key role in linking patients with psychosocial support and establishing/leading support groups at the facility or in the community. Specific aspects of integrating PLWHAs into the care team are discussed in the first Special Issues chapter of this Manual.

**Patients** are an essential component of the multidisciplinary team. Not only are patients ultimately responsible for their own adherence with HIV care and treatment, living positively, and preventing new infections, they are also the most direct and appropriate route of referral into care for their partners and family members. Patients who become actively involved in their own care and treatment often have better health outcomes, become advocates, peer educators, or treatment partners for new patients.

### **Forming Internal and External Linkages**

Creating linkages between services in the care site is a defining aspect of high quality HIV care. The relationship the ART clinic forms with other services such as antenatal care (ANC), TB clinic, laboratory, inpatient ward, and other outpatient clinics is key in providing comprehensive services for patients with HIV. Providing continuity care requires recognizing the inevitability of a patient needing other medical services throughout life, and coordinating with these services to optimize the outcome. If these

linkages are created early in the program, the ART clinic will be built into the existing health care delivery system. Forming relationships with key leaders at other service delivery sites and developing systems to strengthen sharing of information and referral of patients will help build these linkages.

In Ethiopia, two-part referral forms are used when patients are referred across services within the clinic. The first part of the form describes the patient's history and reason for referral. The second part describes the care and treatment of the patient at the service to which the patient was referred. This part of the form is returned to the point of origin of the referral. In addition to providing this mechanism of cross-communication, PLWHAs have volunteered to escort patients between services, assist patients in navigating the system, and providing affirmation in terms of the sequence of services for the patient and family.

### **Community and Other Partnerships**

Forming relationships with community organizations and other partners early on is also crucial in ensuring the program is integrated into the existing infrastructure.

Collaborators should include:

- other government and NGO agencies
- community agencies
- PLWHA organizations
- traditional birth attendant groups
- professional associations
- colleges and professional schools/associations
- community churches or religious associations

These relationships are important for facilitating comprehensive care for patients as well as identifying resources that are available and cannot be provided by the program. Community organizations can provide support and home based care for patients. In addition, these organizations are key partners and informants for the program on key community issues and concerns. Other NGOs as well as professional associations help strengthen the onsite team and link staff with other providers working with similar challenges and situations. Partnerships with all of these organizations strengthen the connections that the program has with its surroundings. This helps in entrenching the program in the community and building sustainability.

## **Chapter 6**

### **Stage 2: Strengthening the Model of Care and Initiating Quality Improvement**

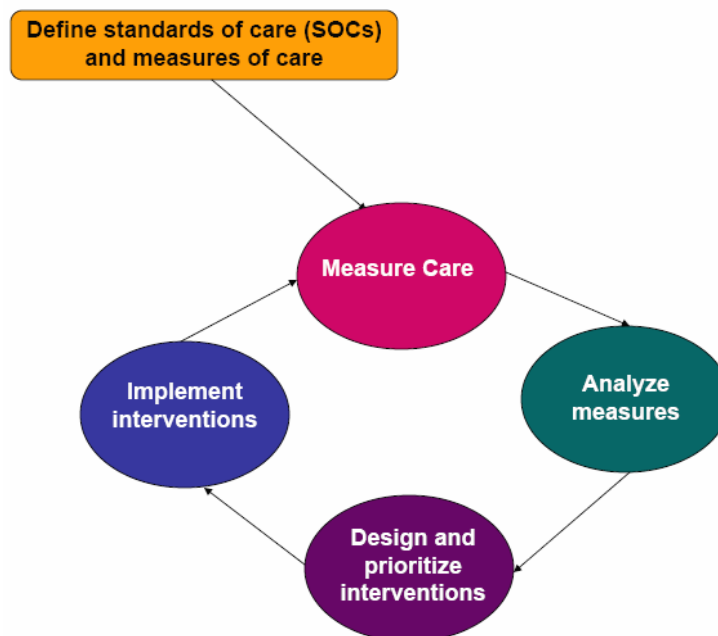
In this stage, the site has experienced successful start-up, has conducted the MOC assessment, and the elements of care are being implemented. The site is now ready to progress to the next stage, where the question becomes, “how well?” The on-site teams learn how to critically think about performance and quality, to assume ownership of their program and performance, and to address issues and challenges in quality increasingly independently. In this chapter, a framework for this work is identified. At the beginning, the site support team may lead the effort. Ultimately, on-site teams take responsibility for the process.

#### **Summary of Framework**

The MOC assessment tool used in the previous stage is the basis for a framework for measuring the delivery of components of care in the model, assessing the quality of the care delivery, and developing guided activities to improve upon inadequacies. This framework is called standards of care (SOCs). As the goal of the site support team moves from ensuring that each element of care is implemented, ensuring quality becomes paramount. For ease of use, the SOCs are outlined in the same structure as the elements of care in the MOC assessment. The difference is that a quantitative standard is applied to each component. For example, “TB screening at enrollment into HIV care” becomes “All HIV care enrollees should be screened for TB at enrollment”.

The SOC framework begins with the site choosing measures for each element of care based on available data sources. These measures are then assessed using information from the clinic and the results are analyzed. The team discusses the results and works to develop priority interventions when services are inadequate. Finally, the measure is reevaluated to determine effectiveness of the intervention.

Figure 4 illustrates this process, and the rest of this chapter details each of the steps.



**Figure 4: Working with Quality**

### Standards of Care

The standards of care for each HIV care and treatment program area are included in the appendix. Table 13 shows an example of these SOC's for HIV-exposed infants. As described above, the process of assessing and improving care involves four key steps: measuring care, analyzing and interpreting the data, prioritizing key issues that emerge from the information, and intervening to improve care. This process is cyclical and is most effective when completed at set time intervals by the onsite multidisciplinary team.

When working with the SOC's the site support team must recognize that sites may be overwhelmed by the nature of this task. The final section of this chapter discusses how site support teams may introduce the process thoughtfully, to maximize site-level uptake.

**Table 13 Sample of Pediatric SOCs**

ICAP Standards of Care (SOC) for Pediatrics	
<b>1a</b>	All HIV-exposed infants should have growth monitoring
<b>1b</b>	All HIV-exposed infants should be started on cotrimoxazole preventive therapy (CPT) by 4-6 weeks of age
<b>1c</b>	All HIV-exposed infants should get DNA PCR done by 6-8 weeks of age
<b>1d</b>	All HIV-exposed infants should have a final infection status by 18 months of age or by 6 weeks post weaning

**Step 1: Measure Care**

Each SOC can be assessed through a measure of care that corresponds to the clinical service that the SOC represents. Each of these measures establish surrogate markers that reflect the sources of data present at the site. Table 14 shows the measures of care that accompany the exposed infant SOCs and their accompanying markers as well as potential data sources.

**Table 14: Sample of pediatric SOCs, measures of care, and potential data sources**

ICAP Standards of Care (SOC) for Pediatrics		Quarterly Measure of Care	Numerator Denominator	Possible Source of information
<b>1a</b>	All HIV-exposed infants should have growth monitoring	Proportion of HIV-exposed infants who have accurately plotted growth measurements	# of HIV-exposed infants with complete, accurately plotted growth measurements # of charts reviewed	Chart review of random sample of 20% of HIV-exposed infant charts on a quarterly basis*
<b>1b</b>	All HIV-exposed infants should be started on cotrimoxazole preventive therapy (CPT) by 4-6 weeks of age	Proportion of HIV-exposed infants who received CPT by 6 weeks of age	# of HIV-exposed infants on CTX at 6 weeks of age # of HIV-exposed infants > 6 weeks of age	Chart review of random sample of 20% of HIV-exposed infant charts on a quarterly basis*
<b>1c</b>	All HIV-exposed infants should get DNA PCR done by 6-8 weeks of age	Proportion of HIV-exposed infants who get DNA PCR	# of HIV-exposed infants with virologic tests done by 8 weeks of age # of HIV-exposed infants > 8 weeks of age	Random sample of 20% infants from the HIV-exposed infant register/ exposed infant chart or RTHC card*
<b>1d</b>	All HIV-exposed infants should have a final infection status by 18 months of age or by 6 weeks post weaning	Proportion of HIV-exposed infants with a final infection status by 18 months of age or by 6 weeks post weaning.	# of HIV-exposed infants with a documented final infection status # of HIV-exposed infants charts reviewed	Random sample of 20% infants from the HIV-exposed infant register*

## Sources of data

As Table 14 shows, there are many places from where relevant data may be abstracted so that SOCs can be measured. These include:

- Registers: Paper based or electronic registers
- Chart review: random selection of charts and review accuracy of completion. Generally sample of 10% is sufficient if the clinic sees a large volume of patients.
- Patient interviews or focus group discussions
- Pharmacy records
- Lab records
- Referral forms
- Program monthly reporting forms including Ministry of Health reports.
- Local benchmarks such as national surveys of behavior, sentinel surveillance

## Step 2: Analyze Measures

Once the data are abstracted and measures calculated, service areas that require attention will be easily identified. Table 15 shows how results of measures may be considered.

**Table 15: Sample of Pediatric SOCs with evaluation results and possible actions**

ICAP Standards of Care (SOC) for Pediatrics		Quarterly Measure of SOC	Numerator	Possible Source of information	Evaluation of Program Quality		
			Denominator		Result of Quarterly measure of SOC Possible Actions		
1a	All HIV-exposed infants should have growth monitoring	Proportion of HIV-exposed infants who have accurately plotted growth measurements	# of HIV-exposed infants with complete, accurately plotted growth measurements	Chart review of random sample of 20% of HIV-exposed infant charts on a quarterly basis*	<80%	80-94%	≥95%
			# of charts reviewed		Evaluate this month	Prioritize and evaluate next quarter	On target
1b	All HIV-exposed infants should be started on cotrimoxazole preventive therapy (CPT) by 4-6 weeks of age	Proportion of HIV-exposed infants who received CPT by 6 weeks of age	# of HIV-exposed infants on CTX at 6 weeks of age	Chart review of random sample of 20% of HIV-exposed infant charts on a quarterly basis*	<75%	75-94%	≥95%
			# of HIV-exposed infants > 6 weeks of age		Evaluate this month	Prioritize and evaluate next quarter	On target
1c	All HIV-exposed infants should get DNA PCR	Proportion of HIV-exposed infants who get DNA	# of HIV-exposed infants with virologic tests done by 8 weeks of age	Random sample of 20% infants from the HIV-	<80%	80-94%	≥95%

	done by 6-8 weeks of age	PCR	# of HIV-exposed infants > 8 weeks of age	exposed infant register/ exposed infant chart or RTHC card*	Evaluate this month	Prioritize and evaluate next quarter	On target
1d	All HIV-exposed infants should have a final infection status by 18 months of age or by 6 weeks post weaning	Proportion of HIV-exposed infants with a final infection status by 18 months of age or by 6 weeks post weaning.	# of HIV-exposed infants with a documented final infection status	Random sample of 20% infants from the HIV-exposed infant register*	<60%	60-94%	≥95%
			# of HIV- exposed infants charts reviewed		Evaluate this month	Prioritize and evaluate next quarter	On target

For areas in deficit, the multi-disciplinary team needs to take action to determine why this is the case. The simplest way to begin this process is to ask a systematic series of questions asking “Why?” until the root cause of the problem is discovered.<sup>1</sup> Team discussion of the SOC results provides a forum for instant feedback about service provision within the site. Table 16 illustrates this process.

**Table 16: Analyzing SOC Data**

<p><b>SOC:</b> All pregnant women should be tested for HIV at first ANC visit  <b>Measure:</b> Proportion of pregnant women who are tested at intake visit  <b>Outcome</b> at Site: 67%</p>
<p><u>Question:</u> Are women tested with rapid tests at ANC?  <u>Answer:</u> No  <b>WHY?</b>  <u>Answer:</u> Because they are tested with ELISA at the lab  <b>WHY?</b>  <u>Answer:</u> Because we don't have rapid test kits  <b>WHY?</b>  <u>Answer:</u> Because there is no one who is responsible for ordering them</p>

**Step 3: Prioritize Issues and Design Interventions**

As core issues are uncovered, strategies for improvement may be developed. Table 17 is a tool that has been developed to assist in targeted design of interventions by posing leading questions. These questions are the same as the questions in the MOC assessment. By involving the site in this process, the site support team transfers not only quality assessment skills but also the analytical skills necessary to analyze the clinic's pressing issues and overcome challenges. The accompanying toolkit also suggests possible strategies for addressing common challenges in implementing the specific service. Finally, it lists tools available to support intervention.

<sup>1</sup> Engender Health

Table 17: Pediatric SOC Tool Kit Sample

SOC	Questions to consider in evaluating SOC Outcomes	Strategies for Achieving SOC	Support Tools
1a. All HIV-exposed infants should have growth monitoring	<ul style="list-style-type: none"> <li>Are growth charts available</li> <li>Are there scales, measuring tapes and a stadiometer</li> <li>Is staff trained to measure and plot growth</li> <li>Do infants come for follow-up</li> </ul>	<ul style="list-style-type: none"> <li>Weigh/measure children before seeing doctor</li> <li>Have training in plotting growth charts</li> <li>Nurses can plot charts before patients are seen</li> </ul>	<ul style="list-style-type: none"> <li><i>Growth charts WHO and CDC</i></li> <li>Scales, measuring tapes, stadiometer</li> <li>Job aid on how to plot</li> <li><i>Training module- pediatric growth monitoring</i></li> </ul>
1b. All HIV-exposed infants should be started on cotrimoxazole preventive therapy (CPT) by 4-6 weeks of age	<ul style="list-style-type: none"> <li>Is a pediatric formulation available?</li> <li>Are exposed babies identified</li> <li>Who prescribes?</li> <li>Is the prescriber trained? Available?</li> </ul>	<ul style="list-style-type: none"> <li>Train team to administer and agree on a system for implementing</li> <li>Identify counselor or CHW to work with moms</li> <li>Procure CPT, make available at HIV pharmacy</li> <li>Strengthen linkage with ANC</li> </ul>	<ul style="list-style-type: none"> <li><i>Training module- CPT</i></li> <li><i>CTX job aid</i></li> <li>Patient brochure including how to crush and mix tablets</li> </ul>
1c. All HIV-exposed infants should get DNA PCR done by 6-8 weeks of age	<ul style="list-style-type: none"> <li>Are virologic tests available?</li> <li>Is the lab capable of doing DBS and reporting results</li> <li>Is staff trained to collect blood</li> <li>Do patients return for testing/results?</li> <li>Are there issues with blood letting?</li> </ul>	<ul style="list-style-type: none"> <li>Strengthen linkage with ANC</li> <li>Establish peer educators to work with families on infant diagnosis process</li> <li>Procure test kits</li> <li>Liaise with lab and secure transport</li> </ul>	<ul style="list-style-type: none"> <li><i>Training module- Infant diagnosis</i></li> <li><i>Training module- DBS</i></li> <li>DBS test kits</li> <li>Patient brochure</li> <li>Job aid/poster with Infant Diagnosis Algorithm</li> </ul>
1d. All HIV-exposed infants should have a final infection status by 18 months of age or by 6 weeks post weaning	<ul style="list-style-type: none"> <li>Are exposed infants followed in the same place for 18 months?</li> <li>What systems are in place to decrease lost to follow-up?</li> </ul>	<ul style="list-style-type: none"> <li>Strengthen follow-up and tracking defaulters</li> <li>Identify CHW to track defaulters</li> <li>Strengthen linkage with care and treatment</li> </ul>	<ul style="list-style-type: none"> <li><i>Training module- Infant diagnosis</i></li> <li>Job aid/poster with algorithm</li> <li><i>Exposed infant tracking form and records</i></li> </ul>

This exercise works best when conducted at set intervals to assess the effect of interventions on quality, as well as the level of improvement over time.

#### Step 4: Implement Interventions

The team now has objective information for assessing program quality, identifying gaps in quality, and discovering core underlying problems. Using this, they can design interventions to remedy problems.

There are three fundamental parts of this process:

- Each challenge will likely require a specific targeted intervention. Rarely, an intervention may be designed that addresses multiple issues.
- As many members of the team as possible should participate in designing interventions. A broad range of staff and cadres will expand the possibilities for effective and efficient interventions, and will promote ownership and investment in outcome
- Once interventions are identified, a clear work plan must be developed and agreed upon that specifies time frame and person responsible for overseeing the intervention. Table 18 illustrates this approach.
- Progress on the workplan should be revisited regularly so that timely adjustments can be made if needed.

**Table 18: Intervening for Improvement**

*Intervention:* Ensure constant supply of rapid test kits in ANC

Action Step	Person(s)	Time Line (Months)				Necessary Resources or Support
		1	2	3	4	
Identify person responsible (procurer) for ordering test kits	Matron MDT representatives (e.g. ANC nurse, laboratorian, ART doctor)	Week 1				
Communicate with regional or national procurement centers to introduce the new person and explain the new plan for rapid testing	Matron Procurer	Week 1				
Use ANC register to estimate the amount of kits needed	Procurer ANC nurse	Week 2				
Order kits	Procurer	Week 2				
Arrange for kit storage and set up testing room	ANC staff	Week 4				
Receive kits and ensure appropriate stocking of test room	Procurer					
Use rapid tests to test women at first ANC visit	ANC staff					
Re-evaluate proportion or women receiving testing at first ANC visit	MDT					

**Step 5/1: Assessing Interventions/ Measure Care**

After implementing an intervention, the impact may be assessed by re-measuring the SOC. Thus, the process begins again. Additional assessment can be employed to look at broader impacts of the project or evaluate cost-effectiveness.

- Cost effectiveness- The site may choose to assess the cost of each intervention as it relates to its impact, and in comparison to other interventions. A very expensive intervention with a small outcome is less sustainable than an inexpensive intervention leading to significant improvements in quality.
- Program level impacts- It is useful to look at changes in program performance across indicators other than the SOC that was receiving the intervention. Often effects will extend beyond the targeted service area. While it is rewarding and exciting if other areas of care improved as a result of this intervention, it is more crucial to ensure that no service areas were weakened by attention placed on a specific SOC.
  - For example, if extensive time was devoted to testing women in ANC, but as a result very few women received infant feeding counseling, then the intervention may not have had an overall positive outcome.

### **Implementing the SOCs at the Site Level**

The following steps may ease the acceptance of the SOC framework, and ease the transition to local ownership.

- Understand the focus of the SOCs.
  - The SOCs are as much about process as they are about outcome. Of course, the standards should be met as closely as possible at all sites; yet institutionalizing the on-site process of problem identification and resolution is an important feature of capacity building.
  - The SOCs are not for external parties and should not be pirated by external parties for site evaluation. The SOCs are for the site level team themselves so that they can improve the quality of their care.
  - The SOCs can and should be introduced slowly, at first with the site support team doing and guiding the work, only over time handed over to the on-site team.
- Take time to introduce the SOC's to the on-site team, with an emphasis on the above three points and a full description of the process.
- Begin with either SOCs from a single priority area (such as pMTCT or TB/HIV for example) or with 1-2 SOCs from each area. This way the work will not be overwhelming as a routine is developed.
- Identify routinely collected data sources that can act as measures of SOCs in order to minimize workload.
- Measure SOCs optimally quarterly, so that site level teams can see the benefits of their interventions.
- Experiment with turning over associated tasks to the on-site team as the process becomes familiar.
- Tailor the SOCs to sites or regions as appropriate. If one or more are inapplicable, do not use them. If sources of data are not ideal, be creative.

Assessing and improving quality using the SOC process is an important bridge between implementing the model of care and building capacity. The site support team should make efforts to involve onsite staff in this process so that it is not an evaluative activity. Emphasis must continually be placed on the importance of using data to improve programs and site staff must integrate this attitude into day to day activities. SOC uptake at the site level indicates site maturity and readiness for more advanced activities that promote independence.

## **Chapter 7**

### **Stage 3: Building Capacity and Fostering Local Independence**

Site support teams, as primary providers of technical assistance, are charged with ensuring effective and high quality program implementation and with fostering local capacity. Capacity building is defined as “an approach to the development of sustainable skills, organizational structures, resources, and commitment to health improvement in health and other sectors to prolong and multiply health gains many times over.”<sup>2</sup> This is achieved through multiple modalities at the intersection of education, clinical mentorship and supportive supervision, and through ongoing skills building around program operation and maintenance.

Capacity building activities are the logical extension of quality promoting activities in the context of the continuity care model. Thus, the site support team must first work to ensure the site understands the model of care and the need for quality. As the site becomes increasingly self-reliant, and is able to identify and solve its own problems frequently, onsite staff build an awareness of what makes for good quality care, what areas of clinic function need attention, and which strategies are useful for improving quality. Technical assistance now focuses on solidifying and institutionalizing the knowledge, skills, and systems at the site to preserve program function in the long term. Working to build site independence requires site level teams to stay motivated, understand the role for continuing education, and be capable of passing expertise to others with less experience. As described in Chapters 1-4, CSM has a beginning, middle and end. Moving through this trajectory may take years.

#### **Readiness**

Sites that have taken responsibility for assessing and improving quality in stage 2 have naturally begun the process of capacity building. Having perfect SOC results does not necessarily mean a site is ready to move toward capacity building. Rather site ownership and involvement in program implementation is a stronger indicator of readiness. As the site support team is able to take a decreasing role and the site becomes more actively involved in program management and improvement, the site support team can begin assessing readiness for explicit capacity building efforts. Assessment can be informal or formal; the former is a natural outgrowth of the intimate site support team/on site team intimacy, the latter can be accomplished using a checklist (see page 59 for a small example and appendix for complete checklist).

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<sup>2</sup> Hawe et al, 1999

## Objectives for Capacity Building

Specific objectives for providers, teams, and sites are helpful in structuring and developing interventions for building capacity. Table 19 lists these key objectives.

**Table 19: Objectives for Building Local Capacity**

Providers	<ul style="list-style-type: none"> <li>• Build provider skills in mentoring junior colleagues</li> <li>• Build skills in self education</li> <li>• Develop skills in identifying necessary referrals and collaboration with other providers on difficult cases</li> </ul>
Teams	<ul style="list-style-type: none"> <li>• Cross training</li> <li>• Expanding the team</li> <li>• Critical assessment and improvement planning</li> <li>• Communication and case presentation/group discussion skills</li> </ul>
Sites	<ul style="list-style-type: none"> <li>• Input systems for data analysis and feedback for quality improvement/CQI</li> <li>• HR development</li> <li>• Leadership development</li> <li>• Advocacy, fundraising, networking</li> <li>• Supporting District Health Teams (Mentoring mentors)</li> <li>• Logistics management</li> <li>• Patient flow, appointment systems, and patient tracking mechanisms</li> <li>• Forming networks</li> </ul>

## Strategies for Capacity Building

A variety of approaches and activities may be used to build local program capacity. Depending on the specific needs of the site, site support teams can structure their strategy to address key areas. It is important to be aware of the breadth of activities, detailed below, encompassing both clinical and administrative duties that must be assumed by site level personnel for the site to be maintained in the long term.

### Developing On-Site Supervision

Until an on-site supervisor is identified and trained, the site remains dependent on the site support team for overseeing implementation of goals, improving performance quality, coordinating staff and services, and identifying and solving problems. As supervisors are identified, they must be supported in developing necessary managerial skills as well as allocated the time and resources necessary to supervise the program and team. Thus, institutional commitment is required in order for capacity building to be successful.

Although the supervisor must not be the clinician with the highest skill level, it is important that the supervisor have well-developed clinical implementation skills. This means that the supervisor must be aware of key issues in HIV care and treatment and understand the implications for a program attending to the many needs of families. This requires a supervisor to have excellent analytical and critical thinking skills in addition to managerial and organization skills. Finally, the supervisor must have an understanding of his/her own limitations both clinically and managerially and be able to involve key people in handling issues beyond his/her scope of knowledge and skills.

Once a supervisor is identified, (s)he should be coached intensively by the site support team in the principles and strategies for effective supportive (facilitative) supervision and mentorship. The coaching is similar to the preparation of the site support team, described in chapter 2 of this manual. The areas for coaching should include:

- Philosophy and model of care
- Coordination of services – content and process
- Task shifting – content and process
- Situation analysis
- Assessment of site level infrastructure
- Assessment and enhancement of provider-specific competencies
- Assessment of issues in delivery of various service components and mechanisms for integration of services
- Team building skills
- Clinical mentorship skills
- Use of tools and materials that can be used to structure, facilitate, quantify, and evaluate activities.

### Staff Development: Enhancing Skills and Knowledge

#### *Educational Initiatives*

Education of onsite staff is an important responsibility of the site support team, and education and training initiatives can help solidify an ongoing supportive relationship. Provider education and skills building will optimally follow certain key principles in developing training programs:

- That all content must be made practical
- That supportive supervision provided in the clinic is crucial for ensuring accurate and effective implementation of services.
- That active participation in learning through group discussion around case studies permits the immediate application of learning objectives to realistic situations.
- That identifying specific skills and action steps are necessary for implementing services, and introducing effective job aids to be used throughout the training exercises supports these skills and facilitates long term programmatic change.

- That the mentorship role established during the hands-on component of the workshop must be sustained over time through active follow-up.

Educational needs of on-site staff can be assessed using a needs assessment tool (see appendix) that probes knowledge, skills, and attitudes. The identified gaps can be used to develop goals and objectives of educational programs and can help determine appropriate methodologies for meeting them. Common methodologies include:

- Didactic lectures
- Case studies presented by a teacher
- Case studies presented by a learner
- Preceptorship/ supportive supervision
- Role plays and demonstrations
- Multidisciplinary group discussions around specific issues
- Development of job aids by learners
- Journal clubs, morbidity and mortality (M&M) discussions, and topic presentations

Traditional training activities occurring offsite and using primarily didactic lectures have a place in capacity building. This can be an efficient way to expand the basic knowledge of staff. However, these activities cannot suffice to prepare a staff for their site-specific challenges. Educational initiatives and implementation workshops may be conjoined, as described below.

#### *Implementation Workshops*

Implementation workshops are on-site sessions aimed at improving the quality of services provided in one specific area of care. They are time limited, usually one afternoon, and can be conducted by the site support team or a senior member of the onsite team. These workshops generally have five components:

- Review of the clinical algorithm or basic medicine related to the topic
- Presentation of case studies to apply the algorithm/medicine to a realistic scenario
- Discussion of challenges in implementing the service
- Formulation of a plan to overcome some of these challenges
- Creation of a job aid or poster to be put in the clinic

#### Using the MOC Assessment and SOCs to Guide Workshop Content

Each component in the model of care can be converted into an implementation workshop if there is a problem with an area of care. Short workshops are inexpensive and easy to prepare; however, without a plan for follow-up they have limited effects. It is important after a workshop to decide on the follow-up plan and monitoring strategy with the team so that improvement can be tracked and ensured.

### *Provider Development*

Other activities that provide opportunities for personal and professional growth can include provision of constructive feedback, offsite educational opportunities, distance learning, problem solving sessions, and experience sharing. Systematic chart review also improves provider clinical skills while emphasizing the importance of accurate patient information records. A sample instrument for chart review is included in the appendix.

Provider development through all of these activities will never be sufficient to build a truly sustainable clinical team. Rather, the on-site team must be supported to build skills in seeking information, promoting continuing education, and prioritizing activities for professional development. The impetus for learning and developing new skills must come from the team members. The site support team can help build skills necessary to design learning initiatives, seek information, and promote continuous skill acquisition amongst team members. Once these two things have been achieved, the on-site team has the capacity to sustain the clinical skills of the program.

### Team Level Mentorship

*Team Motivation:* The site team must be motivated on an ongoing basis. This can be done through many activities.

- Aligning personal and programmatic goals. Staff members individually, and programs on the aggregate level, all want patients to have good outcomes. This natural alignment of goals and commitment should be reinforced frequently.
- Building staff confidence to acknowledge what has been learned and what is still unknown or unclear especially in the context of patient care or site improvement. Staff should be encouraged to express gaps in knowledge and skill, so that these gaps can be filled. Self-assessments are useful for this, and are included in the appendix. Similarly, staff should be encouraged to identify problems in service delivery, so that these can be addressed as well. Decisions about solutions should be made in a participatory fashion.
- Team incentives: Retreats, conferences, meals, excursions, and formal recognition ceremonies are good ways to sustain motivation, maintain team spirit, and ensure the team members feel valued.

### Data-based problem identification and program modification

Invaluable to an efficient and effective program is ongoing use of program data to evaluate and improve program components, as described in Chapter 6. The on-site team, with the leadership of the supervisor, should review the data frequently and meet together to discuss them. They should be used as points of action for program and provider improvement. Including the whole team in this process builds skills at the site to analyze and solve problems at the clinic, which is a key component of ensuring the program continues to provide high quality care over time. Additionally, supporting one

team member to build skills in leading this process will increase the likelihood that program assessment and improvement will continue in the long term.

### Managing Logistics

It is important that pertinent team members be included in efforts at addressing logistical challenges and developing on-site systems for program management. This will not only promote ownership of the program, but also develop a base of knowledge about program management at the site. Some examples of this are including the pharmacist in developing a procurement mechanism; working with laboratorians in building quality assurance measures and supply ordering systems; and including clinic supervisors in developing patient flow, appointment systems, and patient tracking mechanisms. It is important that staff understand the scope of logistical and program management needs, as well as the importance of attending to these regularly and systematically.

### Training New Generations of Mentors

For the program to sustain itself, site-level staff must become mentors to new incoming staff as well as HIV providers in other areas of the clinic. This process is essential to capacity building as the site level team (not just the supervisor) begins to mentor others with less experience. Solidifying this mentorship role among senior providers fosters local ownership of HIV care and treatment programs, recognizing that:

- members of the hospital-level HIV team will rapidly assume the role of mentors for providers and teams at the health center level, and that strengthening their mentorship skills will facilitate the network model.
- staff at the site level, especially in rural areas, tend to have rapid turn over. Institutionalizing these mentorship processes can help reduce the strain that is put on the clinic during these frequent changes in staffing.
- task-shifting among site-level clinicians via a cross-mentorship strategy (i.e., team members mentor one another in performing various tasks) is a vital and efficient way to transfer information and skills in resource limited settings.
- all providers at all points of entry into HIV care (not just those working in the ART clinic) are part of the multidisciplinary HIV team and should be trained and mentored as such.
- District Health Teams may assume a mentorship/supervisory role for sites. Site support teams may work mentoring these mentors to ensure a smooth transition. This is further detailed in the second Special Issues chapter of this Manual.

### **Measuring and Assessing Capacity**

Building a sustainable and independent program is a long process often built upon many years of external technical support. It is important early on in this process to define measures for assessing the program's capacity. These measures delineate long

term expectations for the program and facilitate intermediate evaluation of capacity building efforts. It can be helpful to identify a set interval of time at which a site will be assessed on these measures to gauge progress. These intervals should be relatively long, no shorter than 6 months, as it is difficult to detect any measurable change in a shorter length of time.

Providing comprehensive HIV services for families requires highly skilled providers, well functioning multidisciplinary teams, and well established systems for care provision. A capacity assessment of a program implementing the ICAP model of care should take into account:

- Clinical skills capacity and model of care
- Leadership and management
- Team function
- Systems and infrastructure
- Internal and external linkages

The appendix contains a capacity assessment tool, which includes indicators for each of the above areas. This tool may be adapted for each site, but the same assessment should be used at each site over time. Although many tools used during capacity building activities are useful in assessing a given area of program function, it is important to have a single tool that is used consistently over time so that progress can be measured on the same scale. The results of this periodic assessment can also inform work planning for capacity building activities to address the most pressing gaps at the site. The section of this tool that assesses leadership and management capacity is shown here.

<b>Leadership and Management</b>		
<b>Capacity Element</b>	<b>Yes/No</b>	<b>Comments</b>
Is there a supervisor at the site full time?		
Do the goals of this supervisor align with the clinic?		
Does the supervisor take a leadership role in motivating the team?		
Does the supervisor take a leadership role in helping the program to grow and improve?		
Is there a financial management system in place?		
Is there a designated person in charge of expense tracking, financial planning and fundraising?		
Does leadership mentor the clinic team?		

Site support teams can also use the following tools to assess progress within each component of the capacity assessment.

- *Clinical Skills Capacity.* Chart review, precepting checklists
- *Team Function.* MDT meeting logs and minutes, SOCs, observation of communication in the clinic, observation of team meeting
- *Leadership.* Supervisor precepting, assess workplans, assess patient flow
- *Systems and infrastructure.* Assess procurement, supplies and equipment, clinic organization, patient flow and workload, patient records, appointment books, etc.
- *Linkages with other areas of clinic.* Patient shadowing, follow-up on referrals, chart reviews
- *Linkages with community based organizations.* Staff and patient interviews

## Networks

As sites evolve and become increasingly self-sufficient, they become available to support newer sites. They are able to propose solutions to common challenges, mentor junior providers unfamiliar with HIV, and offer support and encouragement. Providers at mature sites can be part of a network of HIV experts within their country, and take on increasingly more responsibility formerly held by site support teams. Site support teams and sites should recognize the mutual benefits of sharing site successes. It is not only gratifying for a site support team, and for a site, to note progress in implementation and quality but these successes can be shared. Site visits, conferences, and cross-site case discussions can be instructive and serve the larger purpose of creating circles of contact for teams. The process of sharing experiences, successes, and challenges amongst providers in a country and subsequently forming a network creates a professional community that supports the sustainability of HIV programs as well as the professional development of its members.

These professional networks also create an avenue for advocacy, and a powerful voice for all people in the field. Fostering of networks is an important component of building program sustainability. As sites rely on support from colleagues in nearby clinics rather than external technical assistance, capacity within the health system to sustain programs and overcome challenges is generated with each country.

## **Special Issues: Patient Involvement: Adherence, Education, and Expert Patients**

Adherence and psychosocial support activities are crucial components of HIV/AIDS care and treatment programs. Such activities help patients, their families, and others in the patient's support network to ensure that care continues between visits, and patients maintain, and get maximum benefit from, their care and treatment.

This chapter outlines an approach to implementing adherence and psychosocial support, provides case studies highlighting strengths and challenges, and references tools for adaptation and use by site support teams.

### **Over-Arching Adherence and Psychosocial Support Goals**

Adherence and psychosocial activities aim to:

- Recognize the framework of patient education, support, and ownership over care.
- Recognize the patient as both a giver and receiver of care.
- Optimize patient adherence to care and treatment.
- Enhance staff support of patients through training and supervision.
- Provide support services which support adherence.
- Improve access to community and home-based care services and assistance.
- Mobilize community awareness of, and involvement in, HIV prevention, care, and treatment activities.
- Provide central support to Ministries of Health to encourage development and implementation of policies aimed to increase adherence and psychosocial support.
- Build capacity of local programs such that integrated, lifestyle-friendly care and treatment is offered.

Ultimately, patient adherence to care and treatment should be considered a very sensitive barometer of program quality.

### **Core Elements**

Core elements for adherence are:

- Patient education
- Psychosocial support
- Counseling by MDT and lay providers
- Adherence assessment, monitoring, and facilitation
- Support groups
- Community/facility linkages

Additionally, programs may also include these elements:

- Peer supporters
- Community based efforts

### **Specific Adherence and Psychosocial Support Activities**

The appendix contains a sample of the various adherence and psychosocial support activities that ICAP teams have used, sorted into thematic groups. The activities within these groups often address more than one of the common goals listed above. For example, the range of activities listed under 'peer education and support' certainly work to achieve optimal adherence to care and treatment but often also increase community awareness and involvement in HIV prevention, care, and treatment activities. Thus, there is often a synergy between goals and activities that enrich each activity beyond what may have been its most apparent goal. The specifics of country programs and their particular adherence and psychosocial support activities will be discussed in detail in the case studies later on in this chapter.

### **Key Considerations**

Two crucial components of ICAP adherence and psychosocial support programs are PLWHA involvement and monitoring and evaluation. The sections below detail these approaches.

#### **1. PLWHA Involvement**

The patient's role as expert caregiver and caretaker of self or family members is essential to good medical and psychosocial outcomes. Involvement of PLWHA in care and treatment activities, beyond the notion that PLWHA are simply recipients of services, may improve health outcomes and contribute to reduced stigma and discrimination of PLWHA in communities and among facility-based staff.

As participants in care themselves, PLWHA have invaluable first-hand knowledge of navigating health care systems, maintaining adherence (for themselves or for their children), and linking to community-based services. This may result in patients viewing PLWHA peer educators as having a degree of legitimacy in providing adherence counseling and support that patients do not perceive in counselors that are HIV-negative. Thus the peer educators may be uniquely well-equipped to engage patients in activities that increase adherence.

Greater involvement of PLWHA means:

- Recognizing the important contribution people infected or affected with HIV/AIDS can make in the response to the epidemic.

- Creating space within society for the involvement of people infected or affected with HIV/AIDS and active participation in all aspects of that response.
- Sharing decision-making about use of resources and program design with PLWHA.

The MTCT-Plus Initiative program at Makerere University's Johns Hopkins University (MU-JHU) clinic in Kampala, Uganda, has been providing HIV care and treatment to families since April 2003. The program was co-founded by the Director of the MU-JHU Clinic and the community outreach nurse. Together, they developed a peer support network with over 200 couples and their children involved in numerous activities and outreach programs. All patients are encouraged to attend monthly meetings and to join subcommittees such as:

Community Outreach	Loan Scheme Project
Discordant Couples Group	Mama/Papa Handicraft and Book Binding
Drummer Club	Organic Farming
Friend in Need	Pre/Post Test Club
Games and Sports Club	Young Generation Alive

Peer education or “expert patient” activities, when adequately planned and supervised, are a means to better involve PLWHA in the implementation of care and treatment programs and also to increase adherence to care and treatment among patients. ICAP has identified key steps to initiate and manage a successful HIV/AIDS peer education/expert patient program:

- Conduct a patient-centered needs assessment (with the assistance and guidance of facility staff and existing NGOs, CBOs, FBOs, and PLWHA groups).
- Develop peer educator and peer educator coordinator/case manager recruitment criteria and scopes of work.
- Develop and implement training and supervision plans.
- Develop a participatory curriculum to train peer educators and coordinators/case managers.
- Facilitate training of existing community-based peer educators, members of PLWHA groups, and community health workers.
- Create a national peer educator network and bring peer educators together annually to share experiences, problem-solve, and build solidarity.

Ongoing supportive supervision and training is critical to the success of peer educator/expert patient programs. The site support team should include staff able to provide mentoring to peer educators/expert patients. Non-clinical staff, such as counselors, should be included as part of the multi-disciplinary site support team and are ideal candidates to provide ongoing mentoring and support to this cadre. Retention strategies should be considered, and the notion that peer educators/experts patients will work for free should be discouraged.

ICAP-Swaziland is supporting Swaziland's Ministry of Health and Social Welfare to create a national cadre of expert patients, beginning with 52 PLWHA who were recruited by MDTs at the sites where they receive care. The expert patients will provide counseling and support to strengthen other patients' adherence to care and treatment; help pregnant women understand MTCT-Plus and access the services they need to keep themselves, their babies, and their families healthy; and initiate and run PLWHA support groups. Comprehensive training for the expert patients will begin in late 2007; future expanded trainings will focus on tracking patients lost to follow-up. ICAP-Swaziland will provide ongoing support and mentoring, ensuring expert patients' integration with MDTs.

It is critical to involve PLWHA as decision-makers and experts, not just as program recipients or implementers. Key first steps the site support teams and other ICAP staff can undertake to better involve PLWHA at these levels of policy and decision-making are to:

- Include PLWHA individuals and associations on national HIV/AIDS working groups and at the MOH.
- Adopt a national PLWHA involvement strategy.
- Develop the technical and programmatic capacity of national and regional PLWHA associations to implement HIV/AIDS activities and receive donor funding directly.
- Advocate for the recruitment and hiring of PLWHA as key supervisory staff at the national, regional, and site levels (including as part of the site support team), assuming they are qualified and able to perform the tasks of the job.
- Develop a national forum for sharing information and best practices related to PLWHA involvement.

## **2. Monitoring & Evaluation Systems**

As with all aspects of care and treatment programs, monitoring and evaluation is critical to the appropriate development of adherence program activities. Many programs gather basic count data to monitor the status of their activities. These data include the number of patients in care and treatment, number of patients attending counseling, number of home visits, and number of peer educators trained. Some programs also take these measures one step further and report either percentage measures or pre- and post-measures that add an evaluative component to monitoring efforts. For example, if the percentage of patients on ART being counseled is collected, this measure allows program managers to get a sense of what percentage still needs to be counseled. These data are often compiled periodically in monthly or quarterly reports that highlight progress, challenges, and next steps.

Several programs have more complex systems for patient tracking and follow-up, which integrate programmatic data into a natural evaluative mechanism. Either electronic or

paper logs are used to highlight missed appointments, indicating the need for follow-up by telephone or home visit. This type of system seeks to reduce the number of patients lost to follow-up and gives staff a more tangible sense of a program's progress.

As the training components of adherence and psychosocial support interventions are not often evaluated, this is an area in which development of tools and other supportive materials is ongoing.

The MTCT-Plus Initiative programs in Abidjan, Cote d'Ivoire and Kampala, Uganda seem very different on the surface – the densely urban, hospital-based Abidjan program uses computers to track patient visits, while Kampala's less urban, non-hospital-based system does not. But both programs have very low lost-to-follow-up (LTFU) rates -- lower than those in some industrialized nations and rivaling those of clinical trials. These rates have been achieved through key components common to both programs:

- Careful notation of patient appointment dates with clues re: urgency (on ART or not)
- Daily review of the check-in registry to monitor who did not follow up in care
- Outreach workers (or community partners) that follow up with patients who did not follow up by the end of the week
- Review of the results of previous outreach efforts at every multidisciplinary meeting
- Routine information exchange with pharmacists re: patient adherence to care
- Designating one individual to monitor this system and be responsible for results
- Clinical team has comprehensive knowledge of each patient's unique psychosocial circumstances

### **Challenges Faced Across Adherence & Psychosocial Support Activities**

While there are clearly numerous challenges to implementing adherence and psychosocial support activities – from patient-level barriers to structural barriers to difficulties coordinating multiple community partners – strategies have been devised to deal with many of these implementation issues. Here are some examples:

- Large patient load and/or understaffing have caused many country programs to feel they are not providing patients with adequate psychosocial and adherence support. *This common challenge has been dealt with in a variety of ways. Some countries were able to hire or train additional staff in adherence counseling. Others prioritized patients who had previously had adherence challenges and reinforced group adherence counseling and the services of lay and peer counselors.*
- Difficulty in providing adequate training and supervision to all key staff. *Some countries have attempted to vary the times of trainings to coordinate with staff*

*schedules, while others have alleviated supervisors' burdens by involving staff directly in feedback and supervision mechanisms.*

Many challenges may be addressed through collaboration and sharing of tools between country sites. The appendix contains a list of commonly reported challenges and solutions.

## **Recommendations**

Site support teams may find it useful to keep the following recommendations in mind when developing strategies to address adherence challenges in their country programs:

- Coordination of adherence strategies across different areas of care is important in creating a consistent approach to adherence within a site.
- Programs should develop linkages with local organizations to create a network of complementary services (particularly home visits and nutritional support) to which patients can be referred for additional adherence support.
- The multidisciplinary team approach should be emphasized from the start of any adherence activity in order to prevent adherence and psychosocial support from becoming a marginalized or adjunct activity. Having dedicated adherence staff such as psychologists, social workers, or outreach staff who work as a part of this team is a viable method to accomplish this for many ICAP programs. Further, collaboration between monitoring and evaluation staff and adherence staff enables patient tracking to reduce loss to follow-up and improve adherence.
- From ART initiation, an integrated patient appointment and tracking system is paramount to successful adherence support across several programs.
- Integrating monitoring and evaluation data with adherence support implementation is a valuable way to improve program performance.
- Providing adherence counseling in the same location and at the same time that patients receive other care and services is recommended.

## Developing a Comprehensive Training Course

*Peer Education in HIV/AIDS Care and Treatment Programs: A Comprehensive Training Course for Facility-Based Peer Educators*, was designed jointly by staff at ICAP-Ethiopia and ICAP-NY to train PEs working at hospital-based HIV/AIDS care and treatment sites. The purpose of the training course is to empower and ensure greater involvement of PLWHA as active participants in care and treatment programs in order to increase treatment literacy, adherence, quality of services and demand for services.

The curriculum was developed based on existing peer education and care and treatment training materials, with an emphasis on building practical skills instead of knowledge alone. The curriculum was translated into Amharic and reviewed by members of the Association of Ethiopians Living with HIV/AIDS (AELWHA) Network and staff at RHBs.

The curriculum consists of 15 units to be conducted over eight theoretical and five practical days. Trainers were selected from the ICAP-Ethiopia Regional Office staff, as well as from the MDT at each site. The main task of the trainers is to facilitate the learning process and encourage interactive learning among participants, recognizing the enormous amount of knowledge PEs have as participants in the care and treatment programs. Lectures and trainer-led activities are minimized, in exchange for peer-led, participatory group activities, with the trainer supplementing information when needed. A practicum checklist was developed and preceptors identified and oriented to ensure that each participant was able to demonstrate the key skills needed to be an effective PE. All training takes place on-site at the hospitals, and involves the multidisciplinary teams and other key program stakeholders. CBO representatives are also invited to the training as guest speakers and resource people.

The average pre- and post-test scores at the four pilot sites were 84% and 94%, respectively. By the end of training, participants were able to:

- Provide basic counseling and practical strategies to patients on adherence to care and treatment, disclosure, positive living, and prevention.
- Assist patients and their families to access other services within the hospital, such as VCT, TB diagnosis and treatment, and pediatric care and treatment.
- Organize and lead support groups.
- Provide linkages to community-based care and support services to ensure a continuum of care.
- Assist in patient follow-up through linkages with community-based services and improved tracing mechanisms for patients lost to follow-up.
- Organize, and educate community members about, comprehensive HIV/AIDS prevention, care, treatment, and support services, and generate support for these services.
- Contribute to reduced stigma and discrimination by working as an integral part of the MDT and engaging communities in the fight against HIV/AIDS.

### **Adherence and Psychosocial Support: Developing a National Strategy**

The National Strategy for Psychosocial Support and Adherence was developed by the Ministry of Health, in collaboration with ICAP. The strategy includes five main areas:

- **Training:** Strategies for training health care teams in order to improve the quality of psychosocial support provided to PLWHA on ART, as well as their families and friends.
  - **IE/BCC:** Communication strategies that develop materials for patients and their caretakers and systems of support on the benefits of ART and the specifics of ART regimens.
  - **Social Issues:** Strategies for addressing structural barriers to adherence, such as lack of adequate food and low socioeconomic status of those living with HIV and on ART. These include identifying organizational partners that can provide nutritional support, income generation, and increased community involvement and social capital.
  - **Research/Evaluations:** Developing evaluations that can monitor the progress and assess the cost-effectiveness of adherence strategies.
  - **Health Facilities:** Strengthening health teams by providing development, better tools for monitoring adherence, improving loss to follow-up and providing care for caregivers.
- In addition to the development of these strategies, a permanent working group on adherence and psychosocial support was instituted at the MOH and is coordinated by ICAP. This group implements the recommendations and develops tools based on the strategy document.

### **Multidisciplinary Tracking System of Patient Adherence: A Case Study from Rwanda**

ICAP-Rwanda is implementing an integrated system for patient follow-up that helps to track patients who miss clinical or pharmacy appointments. The system relies on individual pharmacy records, health facility patient registers (for pre-ART and ART patients), patient appointment logs and the participation of clinicians, pharmacists, social workers and outreach workers.

- During the psychosocial assessment, the social worker asks the patient for detailed information about where they live, asks if they will accept home visits, and explains the importance and process of home visits.
  - New patients are added to the appropriate register (usually pre-ART register and then transferred to ART register), which includes information on dates and results of CD4 tests.
  - At the end of every month, the clinician gives the social worker a list of the patients who did not come for their CD4 results or for their scheduled follow-up CD4 exam during the last month.
  - The pharmacist completes an individual record for each patient on treatment, which includes appointment dates, attendance, and number of pills remaining at each visit.
  - The pharmacist is given a date book, in which s/he lists expected medication pick-up appointments for each patient. As patients return to the pharmacy, the pharmacist ticks off those who came and highlights those who did not come. At the end of every week, the pharmacist gives the social worker a list of the patients who did not pick up their medication.
  - The social worker schedules home visits with the outreach worker to visit those who did not return to pick up their ARV drugs. At least one outreach worker is available at every site to conduct home visits four days a week.
  - During the home visits, the outreach worker reminds the patient of the appointment, and discusses barriers and adherence challenges with patients. If there is a problem requiring immediate follow-up, s/he communicates it to the social worker and the team.
- Regular HIV team multidisciplinary staff meetings are a forum for discussing patient follow up and home visits for patients identified as missing an appointment. These meetings are encouraged by ICAP to assure that staff are communicating well and implementing the system.

### **Collaboration with Mothers-2-Mothers on Wellness Centers: A Case Study from South Africa**

ICAP has provided technical assistance to Eastern Cape Department of Health-supported HIV care programs at public health care facilities since 2004. Two rural areas include St Patrick's Hospital/Mbizana and Holy Cross Hospital/Flagstaff, along with associated primary health care clinics. Adherence and social support programs pioneered in these regions include wellness centers (WCs) developed at the hospital sites and co-located with ART clinics, promoting a "one stop shop" approach. These prefabricated structures include offices, a reception area and waiting room, VCT and pMTCT rooms, additional counseling and client resting rooms, a conference room, and other amenities. WC programs include:

- VCT and pMTCT
- Tracking of ART patients lost to follow-up
- CHBC and family education/counseling
- Adherence monitoring/support and ongoing counseling for PLWHA
- Group education
- PLWHA support groups: ART- and pMTCT-specific
- Nutrition counseling and supplementation
- Educational pamphlets and videos
- Promotion of linkages between other hospital wards and HIV care
- Community outreach education and services promotion
- Community advisory board

Daily operations of the WC are carried out through an ICAP sub-contractual agreement with Mothers-2-Mothers (M2M), a South African NGO with extensive pMTCT support operations throughout the country. ICAP focuses on overall infrastructure, linkages, and program direction to support the WC. M2M staff include a regional manager/trainer, WC site coordinators, field care givers (FCG), and peer educators.

### **Mozambique – 'Positive Teas': Creating Adherence Support with Limited Resources**

Through research conducted jointly by ICAP and the Ministry of Health, lack of social support was identified as a key obstacle to adherence to care and treatment for people living with HIV/AIDS in Mozambique. To address this barrier, in 2005, "Positive Teas" were launched in four sites in Maputo. "Positive Teas" are informal, monthly meetings that take place in the clinic and involve PLWHA receiving services, as well as their family, friends, and caregivers, both formal and informal. The meetings generally last for an hour, and are unstructured spaces where PLWHA can share their experiences, concerns, and questions regarding living with HIV/AIDS. Positive Teas can also act as a doorway for PLWHA to participate in or create other services, such as weekly support groups or peer education. While doctors, nurses, counselors and other staff are present, their role is not to deliver formal services, but to develop rapport with and reinforce their support for PLWHA receiving services. The keys to successful "Positive Teas" include consistency, collocation with services, and active participation of clinic staff. Currently, "Positive Teas" are held in all provinces where ICAP works, and will soon be implemented in all sites as a simple way to improve social support and adherence in low-resource settings.

## Tools for Initiating and Supporting Adherence Programs

The appendix contains an index of tools from various programs related to adherence and psychosocial support. These materials are also included in the appendix and may be useful for site support teams to share and adapt.

ICAP-Lesotho is working to build linkages to community-based organizations (CBOs) that provide psychosocial and adherence services and that could, in particular, help track women and children who do not return to health facilities for either their HIV or CD4 test results. To this end, the country team created a tool to inventory organizations that offer psychosocial and adherence support services to HIV-positive pregnant women and their families at ICAP-supported sites. Using the tool, Clinical Advisors worked with Public Health Nurses in five districts to inventory CBO services. ICAP-Lesotho's planned next step is to build linkages with the identified CBOs and enhance the limited psychosocial and adherence support services that are currently available to clients.

## Standards for Adherence Work

As adherence and psychosocial support activities expand, so too should the opportunities for exchange and collaboration on this critical aspect of care and treatment.

The model of care includes specific tasks associated with adherence work that need to be provided on site to ensure high quality care. These tasks may be surveyed for implementation, and then standards of care (SOCs) may be assessed as described in chapter 6. SOCs for adherence, as for other areas, operationalize agreed upon "best practices". The SOCs provide a critical benchmark against which improvements in program quality can be measured, and capacity built. A preliminary list of these standards can be found in the appendix.

## Special Issues: Supporting and Strengthening District Health Teams

As decentralization of VCT, pMTCT and HIV care and treatment services proceeds to the primary health care level, and as the number of sites increases dramatically, the external Site Support Team often will work in conjunction with the Ministry of Health and the District Health Teams to provide site support. A healthy, constructive relationship between the government-based site support teams and the external teams provided by implementing partners is essential to promote local ownership of the HIV services at a facility, and to make it more likely that support from the external partner can decrease over time. This process is facilitated when the complementary aspects of this relationship are identified early on, and when clear roles and systems for collaboration are explicitly anticipated.

It is important to note that the role of the District Health Teams (DHTs) must eventually expand beyond evaluative supervision to providing mentorship to sites in a meaningful way if local capacity is to continue to be built. Thus, the role of the external Site Support Team in this context becomes “mentoring of mentors”.

### Prerequisites for Collaboration

A clear vision, plan, and definition of roles over time are necessary foundations of the relationship. These may be discussed in detail, and delineated in a memorandum of understanding or similar document in writing.

Clarification of team members: Early clarification of team members is necessary for moving forward. The NGO and government offices may have different personnel structures. Aligning these systems and identifying the specific team members of each partner is necessary for commencing the programme.

Assurance of accountability: Once team members of the DHT are designated, the members must accept that they are collaborating. One way to ensure that all team members realize and practice collaboration is to pair each external team member with a DHT member. These pairs can support one another in working at the site level; further an increased awareness of reporting requirements, meetings, or performance based results can be fostered within a pair, as compared to a larger group.

Clarification of terms and duration of relationship: By definition, this collaborative relationship is finite. It will have a start and projected end time. Both teams need to be realistic about this, and prepare from the beginning to work together in a certain way, to meet certain goals (see next point), and to gradually taper and end the collaboration. A formal contracting process may be conducted during which these terms are specified in writing, as part of the memorandum of understanding.

Clarification of agendas and goals: Certainly, governmental and non-governmental teams will have different priorities and goals for site support. Facing this discrepancy honestly and explicitly can help teams agree on common goals and strategies, and on a way to handle discrepancies. A series of meetings should be conducted before initiating site level work to agree on overlapping goals, and to determine the extent to which mutually exclusive goals can be facilitated by the collaboration. For example, governmental teams might be interested in honing supervision at sites, while non-governmental teams might be interested in non-evaluative mentorship. Certain strategies can address both concerns and these should be the ones initiated first. Long term plans can be created once the governmental team takes on greater responsibility, and the collaboration decreases in intensity.

Clarification of roles and responsibilities: Again, it is important to clarify specific roles of both governmental and non-governmental teams. For example, will non-governmental teams be responsible for skills building, training, and mentoring the newer governmental mentor teams at the beginning of the collaboration? Will site visits be conducted together? Who will write the reports? How will results be discussed? Who will communicate recommendations to the sites? The answers to these questions will change over time, and the balance of responsibility will shift away from the non-governmental partner. A workplan with a timeline can help elaborate the details of how responsibilities will change over time.

### **Equilibration of Knowledge and Skills Base**

The District Health Team must be equipped with the knowledge and skills necessary to assume a mentorship/supervisory role for sites. Thus, the non-governmental Site Support Team, which usually has had more experience in supporting HIV care and treatment sites will often assume the role of “mentoring mentors”.

As described in the body of this manual, mentors need to teach and develop the skills of their mentees. This principle holds for the Site Support Team in relation to the District Health Team.

Training: Specific content-based information may be required by the District Health Team to deepen their understanding of clinical issues. The Site Support Team may take the responsibility of arranging content-based learning opportunities. Alternatively, the parent organization of the Site Support Team may include the District Health Team in training and mentoring activities that target the Site Support Team. Either way, a curriculum should be used to ensure that all topic areas are covered and well understood, and that gaps are addressed.

Mentorship and supervisory skills: The District Health Team will need to know how to implement the mentorship practices described in the body of this manual, both in terms of microskills and macroskills. These skills can be learned explicitly during pre-planned workshops or meetings, as well as on the job during joint visits as the Site Support

Team models mentorship skills. Again, a curriculum should be used to ensure full coverage. Site Support Teams relying on modeling of mentorship skills should plan opportunities for debriefing and discussing strategies used at the site.

### **Transfer of Roles**

As with all mentorship relationships, the one between the Site Support Team and the District Health Team must have a beginning, middle, and end. The contracting process described above will have made this explicit and will have assigned a projected end date. The process through which this is accomplished must not be abrupt. A gradual transfer of roles should be enforced as the District Health Team becomes more comfortable in their new roles as mentors and supervisors. This transfer should be conducted explicitly, with the site support team closely observing progress and using mentorship microskills such as feedback and confidence enhancement. Macroskills such as case based learning and observed encounters with providers and teams on site should be practiced routinely but less frequently as the process matures, though as below, there may continue to be a rationale for an ongoing role for the non-governmental Site Support Team.

### **Ongoing Relationships**

Whenever feasible, after the formal end of the relationship, plans should be in place for intermittent follow-up of District Health Teams by non-governmental Site Support Teams. Such follow-up may include occasional visits, conferences, and telephone or e-mail contact. Plans should also be in place for internal support of District Health Teams including debrief opportunities, experience sharing amongst several District Health Teams, and continuing education. The value of increasing the internal corps of mentors should not be lost, as District Health Teams over time will be enabled to mentor mentors and thus continue the cascade of capacity building.

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