Resource May 11, 2012

Tanzania Human Resources for Health Collaborative

Date improvement activities began: October, 2010

Aims/objectives:

This work builds in the HCI-supported Human Resources Collaborative in Niger and utilizes a modified change package from that project. The specific objectives were:

-To improve selected areas of ART and PMTCT Care in 12 facilities in Tandahimba District, Mtwara Region, Tanzania

-To improve performance management at these facilities, including clarifying tasks, improving competencies, and increasing staff engagement

-To test an approach which combines quality improvement (QI) methods in combination with performance management improvement approaches

Implementation package/interventions:

HCI worked with the Ministry of Health and Social Welfare (MOHSW) to develop interventions that, when applied in combination with improvements to the process of care, will positively improve the ability

of staff to carry out the work effectively. The group identified the following seven priority areas such that all health workers have:

1. Achievable workloads, clear expectations, and measurable objectives

2. The knowledge and skills necessary to accomplish the required tasks

3. Frequent feedback on their performance according to defined expectations

4. Fair evaluations, with clear and specific evaluation criteria based on expectations

5. Recognition and rewards for high performance and consequences for lack of performance that were clearly articulated and understood by the workers

6. Opportunities to develop and grow in their careers and

7. Effective and efficient work environments which enable staff to perform their duties

Achievable workload with clear expectations

The QI teams began by working on Objective 1 - workers have an achievable workload with clear expectations and measureable objectives. Teams first developed process maps, which outlined the current care processes at their facility and the provider responsible for each step. The team then analyzed where problems and delays occurred and discussed ways to improve care by reorganizing and redistributing tasks across providers. The objective was to increase the efficiency of services.

Teams tested their proposed changes to determine whether they would result in improvement. The next step was to develop a new process map reflecting the changes in process and responsibility for tasks. This process resulted in simultaneous improvement in the delivery of care, in addition to the clarification and rationalization of tasks between providers.

Based on the improved process of care and distribution of tasks, each health care worker prepared a job model. This elaborated on each individual's tasks across different care processes, including defining the scope of work and goals. Based on the job models, teams prepared job descriptions in line with the Government of Tanzania format. All 57 HWs involved in the initiative now have job descriptions for their HIV and PMTCT related tasks, as compared to 2 at baseline.

Adequate Competencies

Once Objective 1 was completed, teams focused on Objective 2: Ensure that workers have the competencies to accomplish the required tasks as specified in job requirements and are able to build new skills on the job for future tasks. Coaches supported all HWs in designing a competency model for his/her specific post/tasks as elaborated in his/her job model. These competency models define the knowledge and skills health care workers need to perform each task, and enables them to identify competency development needs.

The competency models can now assist the staff member and supervisor in looking for targeted ways to build the competencies needed through self-directed learning, mentoring, on the job training, outside training or other means. Staff members will be testing the development of learning plans that describe competency development goals and strategies to meet their needs.

Feedback Mechanisms

QI teams began to address Objective 3: Ensure that workers receive frequent feedback on their performance according to expectations. To improve feedback mechanisms, supervisory feedback and the sharing of successes and challenges among workers in regards to providing care was incorporated into monthly facility-level QI meetings. QI teams developed and agreed upon a standardized format, which is currently used in all health facilities for reporting purposes. Teams will be developing and testing ways in which they can give each other more frequent one-to-one feedback on their performance.

Measurement:

There were seven indicators measured during this project:

HR Indicators:

-% of staff who have job descriptions

Clinical process indicators:

1. Percent of pregnant women attending ANC who tested position for HIV and enrolled into CTC per month

2. Percent of exposed children under 18 months receiving daily Cotrimoxazole treatment per month

3. Percent of HIV positive patients on ART that are lost to follow up per month

4. Percent of HIV positive patients that are assessed for active TB at every visit

5. Percent of HIV positive patients from CTC receiving CD4 test once every 6 months

Spread strategy:

After the first year of implementation, the lessons learned from the original 12 sites were introduced to an ongoing ART/PMTCT collaborative for Mtwara Region. An additional 8 sites began in February 2012 to clarify and organize tasks, develop job descriptions and workplans, determine individual competency needs, and develop feedback mechanisms within the facility.

Number of sites/coverage:

1 district hospital, 3 health centers and 8 dispensaries (HIV and PMTCT services/clinics only) located in one district (Tandahimba) in Mtwara Region.

Coaching:

Coaches were selected from Regional Health Management Team and Council Health Management Team staff who were also coaches of an ART/PMTCT QI collaborative in Mtwara Region. The role of a QI coach is to support QI teams in implementing QI activities and provide training, often on the job, in areas such as QI, HR, and clinical practice. These staff included district health secretary (DHS) who had a background in human resources; two QI team members from Tandahimba hospital were also selected as coaches to foster local ownership and project sustainability.

The team members were trained on the HRH change package at project launch. They received ongoing capacity building, guided by the HCI technical officer. The overall roles and responsibilities of the coaching team, articulated in a coaching guide, were to provide regular technical assistance to QI teams, including assessing the functionality of the QI team; reviewing QI team progress, and providing support in overcoming barriers; assessing the QI team understanding of clinical and HRH indicators,; supporting the team in documenting progress, using data for measuring progress; supporting documentation and testing changes; discussing next steps in QI teamwork; and assisting the teams in developing action plans to implement the change package.

Learning sessions & communication among teams:

HCI conducted four three-day learning sessions, one every four–six months, with QI team members—chosen to represent their team—from all facilities. The first three learning sessions averaged 34 participants. Knowledge acquired during learning sessions would then be shared with other team members during the monthly team meetings. The first learning session introduced the change package,.

Learning sessions provided a forum for the teams to share their progress and lessons learned in implementing the change package and for airing ideas for improvements. The learning sessions were also used to identify best practices generated in one facility that should be replicated in others, capacity building to coaching teams to address the challenges in implementing change package and developing action plans for implementing the remaining parts of change package.

Results:

Performance indicators were collected on a monthly basis between July 2010 – February 2012, and data were used regularly by teams to inform further improvement. A qualitative evaluation was conducted in December 2011 [1]. Performance indicators will continue to be monitored as teams continue to improve performance management systems and HIV care.

Improvements in care delivery by December 2011

• Percentage of pregnant women attending ANC who tested positive for HIV and enrolled into CTC per month increased from 80% to 100%

• Percentage of HIV-positive patients assessed for active TB increased from 35% to 99%

• Percentage of exposed children under 18 months receiving daily co-trimoxazole prophylaxis per month increased from 13% to 94 %

In order to achieve these results, teams made changes such as reallocating tasks, including tasks for outreach workers, reorganizing the care delivery steps, and improving record keeping. (See graph inserts for more information.)

Improvements in performance management indicators

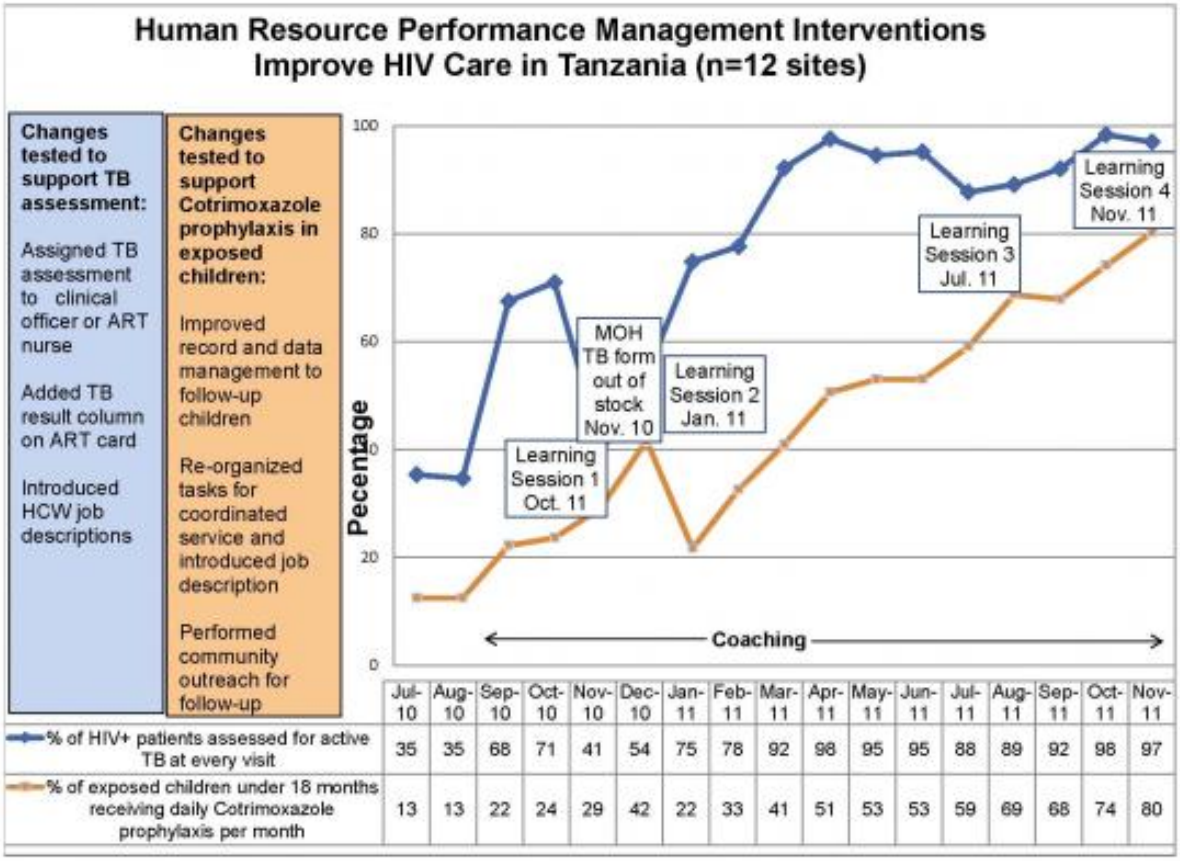
o Team members reported having clear roles and expectations for their work, better teamwork and more involvement in decision making.

o 88% of staff said they were highly motivated compared to 67% at baseline.

o All 57 health workers now have job descriptions compared to 2 at a baseline.

Best practices/conclusions:

Combining quality improvement methods and performance management interventions improves HIV care, along with the motivation and commitment of individual health care providers. This is accomplished by clarifying roles and expectations and empowering them to take ownership and control over the care they provide.



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