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MANAGING UNCERTAINTY: Piloting Supportive Supervision in Georgia

Europe and Eurasia Regional Family Planning Activity and
Healthy Women in Georgia Program

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John Snow, Inc. implements the Europe and Eurasia Regional Family Planning Activity.

The healthy Women in Georgia Program, also funded by USAID, seeks to improve women's health in Georgia through increased provision and use of quality health services. The Healthy Women in Georgia Program targets health facilities at regional and district levels.

JSI Research & Training Institute Inc., implements the Healthy Women in Georgia program in collaboration with Save the Children, Hera, and Curatio International Foundation.

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1 The Context

In RESPONSE to collective need identified during country-level situational analyses, USAID's Europe and Eurasia Regional Family Planning Activity (Regional Activity) piloted a supportive supervision system and training package for possible adaptation and use in the region. Georgia implemented the pilot through USAID's Healthy Women in Georgia (HWG) project, a large-scale women's health program already introducing many elements of quality family planning programming, including some aspects of supportive supervision, into health services. Healthy Women in Georgia, the project hosting the pilot, assists its 500 sites—including all supportive supervision pilot sites—with quarterly follow-up visits, on-the-job training, and family planning data collection and analysis, as needed.

This case study documents pilot supportive supervision effort, which achieved notable—and, in many ways, unexpected—successes. Originally designed as a family planning services improvement effort, the program is evolving, at least in pilot areas, into a comprehensive supportive supervision system for managing both quality and the substantial changes brought about by the ongoing privatization of most primary health care services in Georgia.

Creating team-based approaches to quality improvement

Supportive supervision is an evidence-driven approach to performance improvement that combines elements of tool-based assessment, training, quality assurance, teambuilding, and joint problem solving.

The pilot program in Georgia used a team-based approach that included:

Leadership Team: senior health program managers and trainers that led the planning, implementation, assessment, and planned institutionalization of the pilot

External Supervisors: regional master trainers in family medicine who trained and supervised staff in the pilot sites and led regular facility assessment and problem-solving visits with each site's Internal Team

Internal Quality Improvement Teams: multidisciplinary teams at each pilot site and one regional team in Imereti that each met regularly for joint data review and problem solving

2 The Supportive Supervision Pilot Program

2.1 Development of a Pilot System, Curriculum, and Toolbox

To design a model with potential application throughout the region, Regional Activity developed a pilot system and training package, based on state-of-the-art materials and best practices from around the world. Georgian program leadership adapted both the system and curricula at several points to meet local need: before it was introduced to senior managers, before training Internal Teams in pilot sites, and after the assessment of the pilot phase.

Contents of the training package

- Evidence-based approaches to effective supervision
- Defining quality for health care and family planning programs
- External supervisors and facility-based quality improvement teams
- Team building and team work
- Communication skills for external supervisors
- Using data for monitoring and supportive supervision
- Approaches for improving quality and performance
- Practice site visits
- Leadership skills
- The Toolbox: Job aids, self assessments, and practical client- or clinic-focused tools

Those interested can access the Georgian version of the training package and toolbox, in both English and Georgian, at www.jsi.ge

2.2 Training of Master Trainers and Senior Managers

The pilot system and training package were launched at a three-day national training in February 2008. Participants included senior managers from regulatory and programmatic branches within the Ministry of Labor, Health, and Social Affairs (MoLHSA), state and private insurance companies, the National Reproductive Health Council, as well as the health minister from the breakaway region of Abkhazia, and managers and master trainers from regional Family Medicine Training Centers.

An important outcome of the workshop, in addition to orientation to the proposed system and training package,

was to discuss and develop the national Supportive Supervision Leadership Team, whose function would be to coordinate, monitor progress, and set the stage for sustainable implementation of successful elements of the pilot. Participants concluded that a state health regulatory unit such as the Center of Health Care Regulation within the MoLHSA should logically lead this team.

In practice, regional family medicine master trainers—both trainers and External Supervisors in the pilot—emerged as the highly functional Leadership Team during the pilot. The inclusion in the launch workshop of senior managers from general health care and various insurance schemes was a key factor in the pilot's almost immediate evolution to a systems approach covering primary health care, rather than family planning alone, and both public and insurance-supported services in the pilot areas.

2.3 Implementation in Pilot Sites

2.3.1. Pilot sites

The original pilot sites included

- 2 Regional Family Medicine Training Centers
- 5 public sector ambulatory (primary health care) clinics
- 1 private insurance company clinic (Aldagi BCI's "My Family Clinic")
- 2 clinics for internally displaced persons (IDP)

The variety of pilot sites offered a range of service provision modes for testing the approach. The regional family medicine training centers in Imereti and Adjara train family doctors in family planning and other primary health care topics. These centers also provide secondary-level health care services and have mixed financing from the state and insurance schemes. Pilot ambulatory clinics provide a rural primary health care perspective and have referral and supervisory links to the regional centers. The largest private health insurance company in Georgia—Aldagi BCI—operates the private "My Family Clinic" in Batumi. The IDP clinics in Zugdidi and Tbilisi provide experience with specialized populations of relevance in Georgia and the breakaway regions of Abkhazia and South Ossetia. As expected, in the end, neither the facility type nor size mattered as much as the commitment of management and the quality of supervisory and team relationships.

Key tools in the family planning assessment and monitoring toolkit

In addition to various job aids and self-assessment tools, the original supportive supervision toolkit centered on the following instruments:

- Red Flag List of Critical Problems
- Facility Review with Checklist (monthly)
- Performance Assessment of Counseling and General Family Planning Skills
- Client Exit Interview Questionnaire
- Facility Audit with Checklist (quarterly)



*External Supervisors and JSI staff
left to right: A. Orjonikidze, K. Jugeli, K. Kajaia, T. Mkhatvari, L. Umikashvili, I. Ruseishvili*

As the pilot began to evolve, private insurance companies were immediately drawn to its data-driven approaches to quality and cost containment. It was agreed to add the three Tbilisi clinics of Aldagi BCI, (the managers of “My Family Clinic”), and two Peoples’ Insurance clinics to the pilot. Although at least one hospital, the Batumi Maternity, received limited assistance in supportive supervision during the pilot, it was difficult, in this first phase, to include tertiary facilities effectively.

2.3.2 Team formation and goal-setting

Given their normal clinical, training, and supervisory roles, the master trainers from the two Family Medicine Training Centers became the logical External Supervisors in the new system. The Aldagi BCI Clinical Manager also became an External Supervisor when three more of the insurance company’s clinics were added. As family medicine master trainers, the External Supervisors were able to easily expand the scope of the pilot from family planning to primary health care systems. Because they themselves found the supportive supervision concepts and tools challenging, the trainers plan to incorporate supportive supervision concepts and tools gradually into the family doctor continuing education curriculum. In their supervisory role, they can build on this knowledge and skill base over time.

External Supervisors introduced the pilot structure and concepts, organized and trained the Internal Teams, and monitored and supported the supportive supervision systems in the pilot facilities. **The master trainers serving as External Supervisors already had a highly functional and cooperative training team skilled in joint problem solving. Their dedication and cooperation were key factors in the pilot’s achievements.**

As the External Supervisors prepared the package of training materials and tools for rollout to the pilot sites, they both assessed and gradually internalized the content to the point that they emerged as the pilot’s functional Leadership Team, guiding and shaping all pilot activities. They initially found the many inter-related tools in the package complex and challenging to understand.

“I did an Internet search to validate these supervision approaches and found so many good examples of how services improved, I got really intrigued.”

“I taught this twice before I really understood it. And then it was like a light bulb went off. You have to just start using one or two [tools] and then you start to realize how all the pieces relate to each other.”

External supervisors conducted facility-based training in the pilot sites and assisted each to form an Internal Quality Improvement Team. Each Internal Team typically included at least one senior manager, family doctor, clinical specialist, nursing staff, and administrative and data management staff, depending on the size of the facility. In smaller facilities, all staff participated. Internal Teams typically met once per week, with External Supervisors participating once a month and checking in more frequently by e-mail or phone.

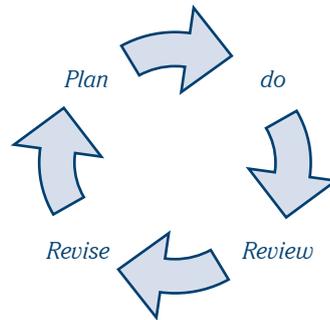
The Internal Teams used the quality improvement categories from the assessment tools to set preliminary goals, such as providing care that meets established quality standards, improving accessibility and affordability of services, or improving community outreach and involvement.

Facility-based trainings in pilot sites



Goal setting immediately led the teams to the revision or development of data collection and analysis tools and processes so they could measure progress towards an upward spiral on the performance improvement cycle.

The performance management cycle



3 Results of the Pilot

The MOST important achievement of the pilot was the incorporation of systematic data collection, analysis, and use into ongoing team-based performance improvement activities.

Some examples of how teams improved data tools and processes

- To clarify performance expectations, the two Family Medicine Training Centers jointly developed job descriptions and linked these to employment contracts, as did the IDP clinics
- All sites regularly assessed client satisfaction through suggestion boxes, exit questionnaires, direct queries of clients, and/or telephone surveys
- The Imereti training center and “My Family Clinic” used their own funding to include new data management personnel in their central management team
- Some sites linked provider bonus payments to timely and accurate completion of records as a first step to improved data collection

The clinics that benefited most from the supportive supervision system completely changed the way they use data, developing their own tools and review systems for tracking referral patterns, client waiting time, and other indicators of interest to them. Internal Teams began to check in more frequently and more efficiently with each other and with supervisors. One site developed a shared folder on its intranet where staff could post problems and suggested solutions. These were reviewed in a daily “fiveminute check in” of the Internal Team, in addition to their weekly, more in-depth team meetings.

“Rereading the curriculum session on data for decision making, I suddenly realized, ‘This is something we can really use. Data can be our friend.’ That was it for me. Now, I decide to do something because the data tell me to. It has to be objective. It has to be countable.”

From the beginning, the teams saw supportive supervision, although piloted to improve family planning services, as a systems approach that covered all services and referral links. In the Imereti region, the system eventually reached from the Family Medicine Training Center to cover all its dependent polyclinics and ambulatory clinics.

“Client satisfaction is the most important: that is how we will survive.”

The private insurance “My Family Clinic” in Batumi, in operation only 11 months when it introduced supportive supervision, is experiencing explosive growth due to its reputation for high-quality staff and services.

The managerial, clinical, and administrative staff on the Internal Supportive Supervision Team together use data to systematically assess and address quality at all levels. At weekly team meetings, the clinic manager presents data analyses on key quality and cost indicators including patient load per provider, referral patterns, and waiting time. Clinic staff regularly conduct exit and telephone surveys to monitor client satisfaction.



Observation visit in Aldagi BCI “My Family Clinic” Senior staff from USAID and JSI HWG program, and local internal quality improvement team

The clinic has achieved extraordinary results. Between May 2008 and March 2009, the clinic income rose over 400 percent from its baseline level (indicated as 0 percent in the figure below). In the first four months of the pilot alone, the patient load increased 74 percent.

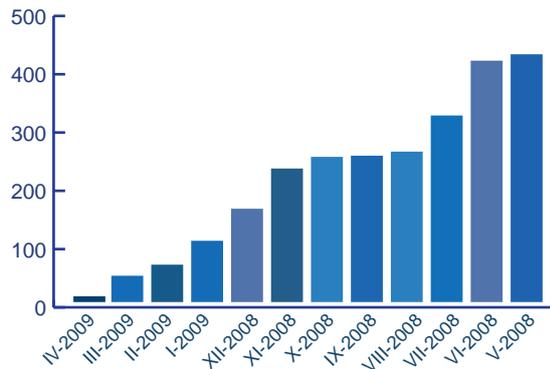


Figure 1: Cumulative Monthly Increase in Income From May 2008 Baseline

“We didn’t have any other way to look at quality. These tools came exactly when we needed them.”

To manage this growth, the Internal Team has integrated supportive supervision quality improvement techniques into problem solving at every level, including the most mundane. For example, when a client collapsed in the waiting area and the staff reacted in a disorganized way, they assessed the incident, developed a protocol, and re-assessed the protocol and results in two subsequent incidents.

The team continuously addresses the key threat to client satisfaction and provider burnout: waiting time.

- Analysis of referral data led to the engagement of several clinical specialists, reducing cost, inconvenience to clients of external referrals, and overload to clinic staff
- Patients can now book an appointment on the phone or in person, although they still tend to show up hours ahead, as they get used to this new system

Although these efforts decreased waiting time by 40 percent, another outcome is even more clients, either insured or willing to pay out of pocket for the clinic’s high quality standards. Available space and staffing constrain what the Internal Quality Team can do to address the problem further, requiring a corporate decision about expansion. The corporate Clinical Director, the pilot’s External Supervisor, is addressing this encouraging problem at headquarters.

Client satisfaction is the most important

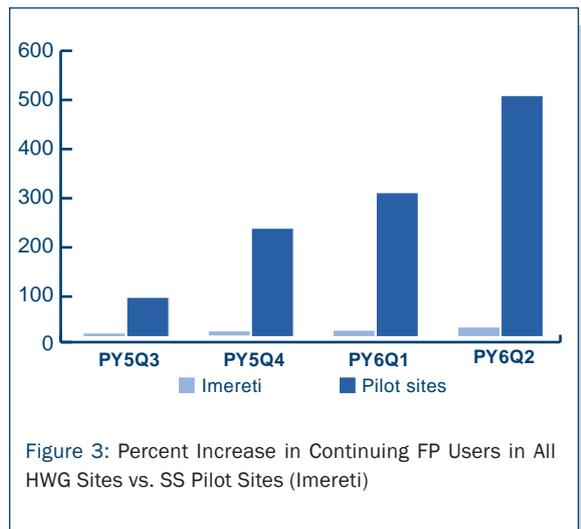
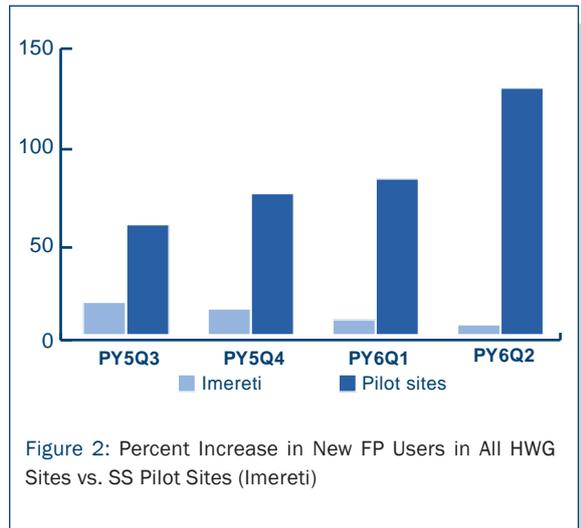


3.1. Family Planning

Five rural ambulatory clinics served as pilot sites in Imereti region: three in Tskaltubo and two in Bagdadi rayons (districts). Imereti region has 11 rayons and 148 medical facilities served by the HWG project. The following data compare the five pilot sites with results from all HWG sites in Imereti.

3.1.1. Family planning users in pilot and other HWG sites

In the year following the launch of the supportive supervision intervention, the number of new and continuing contraceptive users in the five pilot HWG ambulatory clinics in Imereti far outpaced the number in regular HWG-supported sites in the same region. This may be partially due to the fresh energy given in the pilot sites to improving family planning promotion and services.

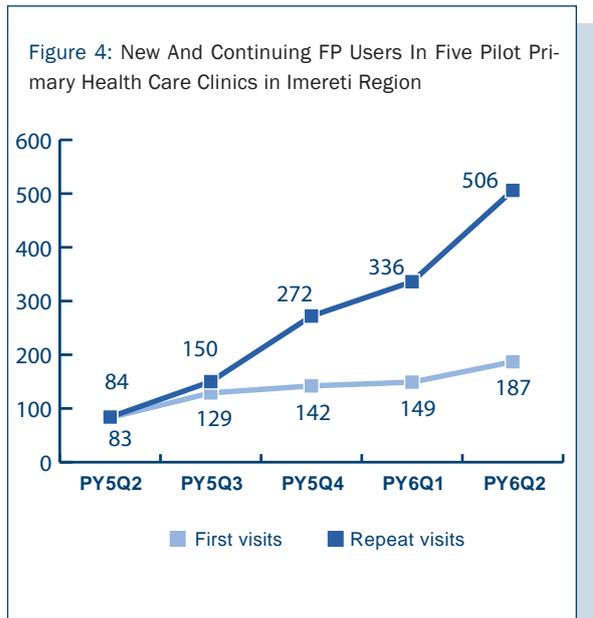


HWG has been active in Imereti since 2005 and maintains a steady level of both new and continuing clients in their sites, as might be expected in a mature program. Results in Figures 2 and 3 below show that the pace of attracting new and continuing clients may be greatly enhanced by adding supportive supervision to basic support to family planning services.

3.1.2. New and continuing users

Figure 4 shows quarterly trends in the number of new and continuing family planning users in the five pilot ambulatory clinics of Tskaltubo and Bagdadi. Supportive Supervision (SS) training had been conducted and internal group formation was completed in these facilities in June–July 2008. Increased numbers of both first and repeat family planning visits can be observed in pilot facilities.

The five pilot ambulatory clinics in Imereti Region show the same pattern, individually and collectively: a steady rate of new users and an accelerating increase in continuing users (with the lowest individual clinic increase in return visits 2.5 and the highest 13.8). Both rates are a measure of general client satisfaction with services.



3.1.3. Contraceptive method mix

Contraceptive method mix became more even in all five rural ambulatory pilot clinics as well as the secondary-level Regional Family Medicine Center. This is an indication that family doctors who previously lacked confidence to provide a broad range of methods were effectively providing a wider range of family planning services, possibly

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Figure 5: Contraceptive Method Mix Among New FP Users in Imereti Family Medicine Center Before SS Intervention (September 2008)

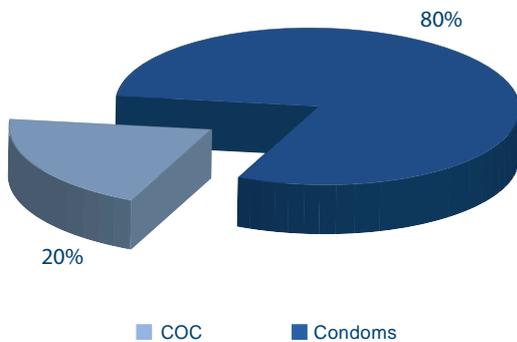
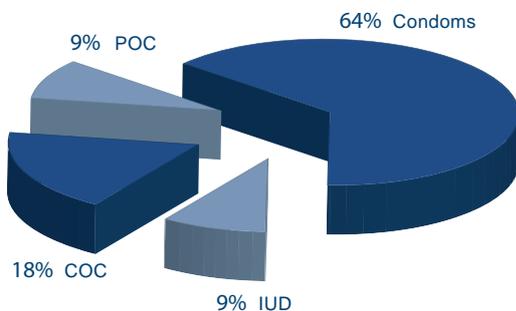


Figure 6: Contraceptive Method Mix Among New FP Users in Imereti Family Medicine Center After SS intervention (March 2009)

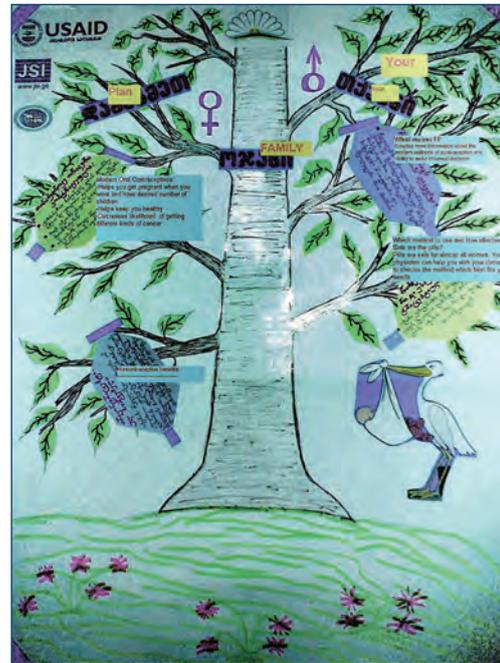


3.2. Managing Uncertainty

Internal Teams in the pilot sites repeatedly pointed to supportive supervision assessment tools and team-based approaches as practical ways to manage uncertainty. To create a team with a common purpose, management and at least some staff need to be committed and adaptable. The sites that had already undergone a significant change, such as changing from a polyclinic to a family medicine center or launching a new center, were both the most receptive and the most successful in adopting supportive supervision techniques. Motivated Internal Teams tended to “spiral upward”, with success breeding success. Those who saw little incentive—either personal or for the increasingly immediate viability of the clinic—stagnated.

“We have so many problems. The main contribution [of supportive supervision] is that we can analyze and solve problems together. We are not alone.”

“It was exactly the right moment for us [to try supportive supervision]. We understand change.”



The tree of clients needs and expectations Poster designed by the health care provider for her village ambulatory

“How much will your insurance company pay us for a satisfied client?”

The Imereti Family Medicine Center used the data-driven supportive supervision approaches to make a proposition to key insurance companies in the country: “we will provide primary health care to the whole Imereti region and use these quality assessment tools and system to optimize services. How much will you pay us for a satisfied client?”

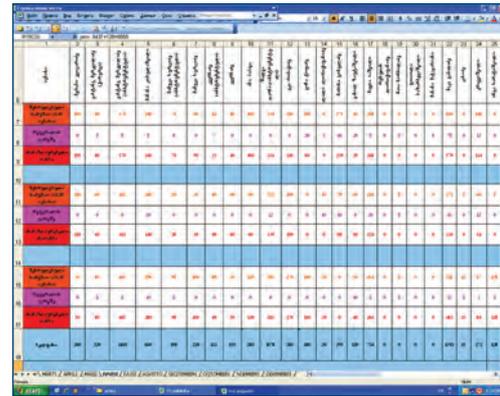
As a result of this bold question, the center is quickly developing an exclusive regional service network for a number of insurance companies and public-sector insurance schemes covering teachers and the poor. A bonus system that rewards providers financially for both patient load and the quality of services attracts the most highly qualified staff and provides clear motivation to comply with supportive supervision reporting and monitoring requirements. Nevertheless, it has been a cultural shift for some providers to have their clinical decisions, such as referral rates, reviewed and sometimes questioned by management.

The Internal Team’s regular review of referrals has led both to on-the-job training for providers referring inappropriately as well as to hiring needed specialists to address unmet need. For the first time, all district clinics in the system fall within defined standards for medically appropriate referrals.

“We’re just getting started with this: we want to track providers’ patient load, disease incidence and prevalence, and try to quantify how to deliver full services to clients.”

Every week, the Internal Team reviews and acts on data summaries prepared by a fulltime analyst, including review of randomly chosen client records. The largest private insurance company in the country likes the system so much it has adopted the supportive supervision and management forms developed by the center’s Internal Team. It plans to replicate the model throughout Georgia.

An even more compelling endorsement of this approach may be the expected July 2009 government deadline for primary care clinics to provide their own financing and cover staff salaries for most services.

A screenshot of a software application displaying a large data table. The table has many columns, some with headers in Georgian, and several rows of data. The data cells contain numbers and some text. The interface includes a menu bar at the top and a status bar at the bottom.

The Imereti Family Medicine Center developed its own forms and processes to review referrals across its regional system

3.3. Tools for a Competitive Climate

“How do you program for enthusiasm?”

At the program launch, participants thought that a regulatory unit in the MoLHSA should lead the activity. In fact, the family medicine training institutes and then the private sector enthusiastically picked the pilot effort up, with minimal government involvement.

State health agency priorities currently revolve around massive restructuring of the system, with little current attention to quality of services. On the contrary, with an expected July 2009 deadline for primary care clinics to be self-supporting for most services, the individual clinic must itself have a competitive self-interest to provide the best services possible in order to thrive.

“Those providers who don’t get it [adapting to change], they will just go home.”

This pilot has demonstrated that individual health facilities, and regional networks of health facilities, can proactively define, measure, and improve the quality of services they offer. The next challenge in Georgia is to engage government to address quality, perhaps through inclusion of supportive supervision concepts and tools in forthcoming national primary health care guidelines and ongoing health reform structures.

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