2022 CLA CASE COMPETITION

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Case Title:

Unlocking the Functionality of the Health Referral System in Batangas, Philippines

Heads and representatives of healthcare organizations in Batangas during the signing of the referral network's Service Providers' Agreement in August 2016. Credit: Glenn Bede Benablo/RTI International

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Summary:

In 2015, Batangas, Philippines, had 86 maternal deaths per 100,000 live births. This high maternal mortality ratio (MMR), along with uncoordinated referral practices, characterized the province's fragmented local health system. This prompted the province to address gaps within its health system performance, beginning with operationalizing a province-wide referral system (PRS). Batangas had previously sought to strengthen care coordination within districts and between hospitals; however, failure to unite stakeholders' visions and maintain collaboration stagnated initiatives. With U.S. Agency for International Development (USAID) support and using collaborating, adapting, and learning (CLA) approaches, in 2016, Batangas used lessons learned from these experiences to restart operationalizing their PRS.

To overcome jurisdictional barriers, we secured the participation of health facilities at different levels in all municipalities and cities and avoided overwhelming stakeholders with tasks by using maternal and child health (MCH) as a tracer program. We created a learning environment that ensured common understanding of service delivery challenges and secured stakeholders' commitment to collaborate against challenges. Through consultations and workshops, we formed a service delivery network (SDN) comprising 67 public and private health care institutions to coordinate delivery of health services. We also installed a PRS monitoring and evaluation (M&E) system to ensure continuous learning and stakeholder engagement in instituting reforms. Since establishing the PRS, referral practices in Batangas have improved, coordinated referrals increased, and MMR significantly decreased. Moreover, M&E data generated local government support to upgrade the capacity of health facilities and make the local health system resilient.

Which two subcomponents of the Collaborating, Learning & Adapting (CLA) Framework are most reflected in your case? Please reference them in your submission.

- Internal Collaboration
- External Collaboration
- Technical Evidence Base
- Theories of Change
- Scenario Planning
- M&E for Learning
- Pause & Reflect
- Adaptive Management
- Openness
- Relationships & Networks
- Continuous Learning & Improvement
- Knowledge Management
- Institutional Memory
- Decision-Making
- Mission Resources
- CLA in Implementing Mechanisms

1. WHAT: What is the general context in which the case takes place? What organizational or development challenge(s) prompted you to collaborate, learn, and/or adapt?

Historically, obtaining timely and appropriate health services was a challenge for the people of Batangas, Philippines. Uncoordinated referral practices and delayed transfer of critical cases across facilities persistently hindered efficient health service delivery. In 2015, the province recorded an MMR of 86. This indicator of a fragmented health care system prompted an overhaul of the entire local health system through unified, collaborative efforts of local health executives, health care institutions, and external organizations.

Batangas, one of the biggest provinces in the Philippines, is composed of 30 municipalities and four cities. Each local government has a health office performing public health service delivery and program management. Some also either own a community hospital or host a hospital operated by the provincial or national government. Additionally, many of the localities have private health facilities with diverse capacities. Although different levels in health facilities—from primary to tertiary care—facilitate complementation in care, variations in health facility ownership have inevitably led to differences in service delivery mechanisms and programming protocols, and caused persistent fragmentation in the province-wide health system. Fragmentation was characterized by weak care coordination among health facilities (e.g., referral forms lacked vital information on initial work-up and management, patient transfers weren't prefaced by phone), which led to conflicts between service providers, some health workers' discomfort with or even fear of accompanying patients during referral, and reduced compliance with referral protocols. Moreover, differing health governance priorities induced health system performance and patient experience being inconsistent across localities.

Addressing these fragmentations required (1) progressively strengthening collaboration among health care organizations and local governments, starting with PRS establishment, (2) continuous learning and improvement through systematic M&E of the PRS, and (3) scaling up and adapting PRS strategies to address emerging problems and situational changes.

2. WHY: Why did you decide to use a CLA approach? Why was CLA considered helpful for addressing your organizational or development challenge(s)?

We applied CLA in Batangas to harness the lessons learned from the province's gains and shortfalls in previous efforts to strengthen referral processes.

For years, the province sought different methods to address local health system fragmentations. They implemented top-down activities to standardize service delivery processes, which assessments found inadequate for harmonizing health facility processes and fully ensuring their compliance to standards. In the 2000s, guided by the Department of Health (DOH), the province established inter-local health zones (ILHZs) to strengthen complementation in care among neighboring localities and promote collaboration in implementing health programs. However, this strategy did not fully address the poor referral practices, especially among health facilities across different ILHZs. After some time, differences in the ILHZs' operations appeared; some remained functional, while others deteriorated. In 2014, to address poor referral practices among hospitals across the province, the PHO spearheaded the development of a PRS for hospitals, which did not sustain momentum due to the lack of continuous M&E, and gradually weakened when confronted with coordination problems among primary care facilities. These experiences catalyzed the intentional application of CLA in 2016, when USAID began supporting the province in health system integration, starting with operationalizing the PRS. With support from USAID's LuzonHealth and ReachHealth projects, CLA approaches, such as pause-and-reflect sessions and inclusive program reviews, were applied to help stakeholders generate and use lessons from past experiences. It made them realize that to ensure genuine and lasting collaboration among localities, they must overcome jurisdictional boundaries; establish partnerships among as many health care organizations as possible, including public and private facilities; and avoid backsliding of stakeholders through continuous M&E, even when the health system intervention (in this case, operationalizing a PRS) becomes fully institutionalized.

3. How: Tell us the story of how you used a collaborating, learning and/or adapting approach to address the organizational or development challenge described in Question 2.

The establishment of a PRS in Batangas commenced with gathering support from potential stakeholders in the province by establishing a collective understanding of health service delivery challenges. Their commitment to come together to address these challenges was secured through a formal Service Providers' Agreement. This effort was a product of the joint action among various stakeholders, including primary care facilities and public and private hospitals, through the leadership of the PHO and the Batangas Medical Center (BatMC, the apex referral hospital of the province) with support from local government chief executives, DOH, and USAID. These stakeholders believed that a system needs genuine collaboration to work.

Through consultation meetings with health service providers (HSPs) from different health facilities and local health leaders, the PHO and BatMC directed stakeholders' attention to their past experiences in PRS strengthening and the challenges and shortfalls that caused their efforts to stagnate. ReachHealth facilitated co-developing plans to operationalize a PRS that uses the group's past lessons. To avoid overwhelming the stakeholders with too many tasks, we started with a tracer program, MCH, to track progress, which was chosen because Batangas had a high MMR. Collaboration in PRS establishment took the following forms:

(a) Active involvement of member facilities in the development of protocols and tools. HSPs were consulted and also participated in writing the referral guidelines of the network.
(b) A multi-level referral committee with representatives from various groups of health facilities, organized by the SDN. This team spearheaded the development and pilot-testing of a comprehensive, localized referral guideline.
(c) The PHO, BatMC, and clinical and management experts from the network reviewed, validated, enhanced, and ensured clinical standard adherence of the PRS operative documents.
(d) Coaching and mentoring of HSPs on various aspects of health service delivery by the PHO, BatMC, and clinical experts in the SDN.
(e) Cost- and resource-sharing among stakeholders (e.g., commodity transfer from one facility to another, co-funding of workshops, meetings, and capacity-building activities).

Immediately after standardizing referral protocols and tools, the province installed its M&E system for the referral network. The M&E system, which was initially designed to determine the effectiveness of the newly installed referral system, promotes continuous learning and implementation of evidence-based responses to gaps and challenges. It assesses the functionality and performance and identifies areas for improvement of the PRS to enable the network to serve its clients better. Its indicators include utilization of the system, technical soundness, administrative feasibility, and political acceptance of referral practices. Through regular and rigorous implementation of M&E activities, the network and its partners have generated quantitative and qualitative data on the gains and gaps of the PRS. Findings from M&E were used in the development and implementation of the adaptive solutions below to the challenges encountered by the network.

(a) Installing additional telecommunication lines in hospitals for referral.
(b) The provincial government hiring additional staff for local government hospitals.
(c) Training HSPs in basic emergency maternal obstetrics and newborn care, family planning (FP) services, and similar practices.
(d) Partnering between the provincial government and private hospitals for diagnostic services that local government hospitals cannot provide.
(e) Revising and enhancing the referral guidelines.

The M&E system also created a space for resolving conflicts between and among HSPs. We developed an official incident reporting process for this purpose, wherein complaints filed officially trigger action from the referral committee. This (1) provides appropriate conflict settlement, (2) allows identification and resolution of the root causes of conflicts, which usually include unclear protocols and miscommunication, and (3) enables application of improvements based on lessons learned.

4. ORGANIZATIONAL IMPACT: How has collaborating, learning and adapting affected your team and/or organization? If it's too early to tell, what effects do you expect to see in the future?

The practice of CLA in this project enabled the Batangas PHO to (1) increasingly address health care fragmentations by harnessing collaboration among varied stakeholders and using data when instituting reforms; (2) promptly adapt to situational changes by making the local health system resilient through strengthened collaborations, functional systems, and strong policy support for interventions; and (3) maintain stakeholder engagement and develop evidence-based interventions through continuous M&E. Meanwhile, it enabled USAID's ReachHealth Project to (1) develop strategies, activities, and tools for referral system establishment using actual experiences of local stakeholders; (2) determine effective ways to promote collaboration among stakeholders with varying priorities and capacities; (3) further build the capacity of the project in providing technical assistance to strengthen local health systems; (4) create M&E mechanisms on referral system functionality; and (5) strengthen partnerships with national and sub-national stakeholders for providing technical assistance to local governments.

Our success inspired other provinces. Our system's replicability, including processes and tools, enabled its implementation in other areas, leading to institutionalized changes within several local governments: Camarines Sur, Laguna, Manila, Oriental Mindoro, Pampanga, Rizal, and Sultan Kudarat. One of the system's most replicated features is the categorization of referrals: a guide that matches specific health conditions to appropriate facilities and prompts immediate transit interventions for specific cases. This unique practice, developed through learnings from existing clinical practice guidelines and collaboration among specialists within the network, has promoted appropriate and timely care. By making the local health system more responsive through stronger collaboration among health care organizations and local governments, Batangas has promptly adapted during disasters and health emergencies. When the COVID-19 pandemic happened, we were able to immediately establish a command center for COVID-19 facilities and install teleconsultation and tele-referral platforms.

5. DEVELOPMENT IMPACT: How has using a CLA approach contributed to your development outcomes? What evidence can you provide? If it's too early to tell, what effects do you expect to see in the future?

Continuous and intentional application of CLA helped the province maintain momentum in operationalizing and further improving their referral system. By using M&E data, the network was able to generate local government support for upgrading health facility capacities, specifically by hiring additional human resources, installing communication systems, and forging partnerships between public and private facilities for services with limited resources, such as diagnostics.

Since establishing a PRS, Batangas has seen improvements in referral practices. During meetings and forums, health facility representatives reported observed improvements, specifically increased respect, in the behaviors of both referring and accepting service providers. Moreover, M&E activities found that coordinated referrals increased from 28% in 2016 to 74% in 2020. A referral acceptance rate of 99% was recorded in 2020 compared to 85% in 2016. Furthermore, MMR decreased from 86 in 2015 to 16 in 2020.

The Batangas PRS is a story of transformation. Limited participation of local government hospitals expanded to involvement of primary care facilities and private hospitals. From the initial focus on MCH, referral protocols gradually covered service lines for other obstetrics-gynecology cases, pediatrics, medicine, and surgery. The PRS participants expanded coordination with facilities in neighboring provinces upon learning that there were several cases of uncoordinated referrals received from facilities outside the province. The network also branched out from referrals to addressing other health system issues, including financial, human resources, and capacity-building difficulties.

These achievements were guided by the principle "the client of one facility is a client of the entire network," which underscores collaboration and complementation in health care.

6. ENABLING CONDITIONS: How have enabling conditions - resources (time/money/staff), organizational culture, or business/work processes - influenced your results? How would you advise others to navigate any challenges you may have faced?

The operationalization of the Batangas PRS was made possible by three enabling factors: (1) collaborative leadership, (2) responsive local government, and (3) utilization of a tracer program. The Batangas SDN recommends that these be ensured when addressing fragmentations in health care.

The Batangas PHO has always assumed the main leadership role in the network. However, as interventions progressed, it found it imperative to share leadership with other collaborators, specifically BatMC. Although the PHO continued to lead policy and health system interventions, BatMC took the helm of clinical aspects, particularly leading the categorization of referrals and training HSPs in service delivery. Moreover, recognizing that promoting greater representation of HSPs and diversified perspectives in decision-making is vital in ensuring that network interventions respond to the actual needs of member facilities, leadership roles were further shared with a referral committee, which the network formed for that purpose. This sharing of decision-making power also helped address resistance to improvements in referral mechanisms.

The network considers collaboration among health care organizations as the main driver of our success, but we believe that local government support was also key to maintaining our momentum. Had the local governments not addressed the problems we found using M&E data, these problems might not have been addressed by anyone, risking health facilities dropping out of the network.

We wanted the PRS to be highly comprehensive from the beginning. However, this would have meant taking on too many tasks, which could have overwhelmed health facilities and caused them to backslide again. Hence, we decided to use a tracer program and gradually expand our efforts once reforms have taken root. This approach allowed us to progressively strengthen the province-wide health system and keep member facilities engaged and continuously growing.