2022 CLA CASE COMPETITION

COLLABORATE • LEARN • ADAPT

Case Title:

Adaptive Management and Learning in Complex Programming: Health System Strengthening in Ukraine

Name: Allen Tullos

Organization: USAID/UK Aid Health Reform Support

In September 2019, HRS supported hands-on training on performing opthalmoscopies for physicians from Selidove Primary Health Care Center in Donetsk. Credit: Vadym Vys

Summary:

In 2017, Ukraine began a series of reforms to overhaul its corrupt Soviet-style healthcare system, which failed to deliver high quality patient-centered care. USAID designed the Health Reform Support (HRS) activity to support the Government of Ukraine to implement these reforms, which would change the way healthcare was financed and delivered. HRS brought together a large multidisciplinary team to provide holistic support in health system governance, finance, health workforce, health information technology, and service delivery.

The center of HRS' CLA approach was its flexible activity design process, which allowed the team to prioritize the most important interventions given HRS' wide scope. The process led the team to prioritize improving the service delivery and operations of healthcare facilities. HRS used a pilot and scaling approach to test innovations in patient-centered care at 15 healthcare facilities before expanding best practices to the rest of Ukraine's nearly 2,000 public healthcare facilities. Within these 'Centers of Excellence,' HRS empowered local leaders by co-designing interventions alongside healthcare providers and used performance indicators to improve integrated care teams. HRS piloted other innovations, like e-tools for financial planning and supervisory boards for local oversight of healthcare facilities, which were eventually revised based on counterpart feedback and scaled. Patient satisfaction surveys at the Centers of Excellence found that 95% of patients who visited a Center were satisfied with their experience, compared to the national average of 73%. Centers of Excellence continue to model patient-centered care to other facilities.

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?

The 2014 Revolution of Dignity sparked a mass movement of Ukrainian citizens to protest systemic corruption and call for European-style reforms. Reformers set their sights on the Ukrainian healthcare system, a Soviet relic plagued by widespread corruption, an inefficient hospital network, and poor service delivery.
Ukraine began a series of health reforms beginning in 2017, which established a new national single-payer agency for health care, turning healthcare facilities into not-for-profit enterprises, transforming health financing, and standing up an electronic health (eHealth) system. The USAID Health Reform Support (HRS) activity, co-funded by UK Aid and implemented by Deloitte Consulting LLP, aimed to support the government of Ukraine (GOU) to build a transparent, accountable, and effective healthcare system that could meet the needs of the Ukrainian people. One of HRS' target beneficiaries were healthcare facilities, which include nearly 2,000 hospitals, private clinics, and outpatient centers serving 44 million people.

The healthcare facilities had significant service delivery challenges. They lacked modern approaches to deliver high quality care and quality management systems to continuously improve. Hospitals had vertical hierarchies that were resistant to change. The health workforce lacked modern skills, and there was a lack of transparency within the human resource departments that increased the potential for corruption. Authorities within local government had a mandate to oversee the facilities within their jurisdiction, but they lacked the capacity to conduct proper financial and performance monitoring. Healthcare facilities' administrators lacked the capacity to develop and implement strategic financial plans, which was a necessity now that the facilities had been transformed into non-profit enterprises.
Throughout implementation, political turnover within the Ministry of Health and National Health Service of Ukraine created a leadership vacuum that impeded implementation and reduced counterpart bandwidth. Russian aggression in Eastern Ukraine strained local resources, and eventually the invasion overwhelmed the healthcare system.

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

CLA in the Program Cycle combined with CLA Enabling Conditions were key to solving a variety of issues. During implementation, the Government of Ukraine would frequently request additional activities from HRS, some of which deviated from what USAID and HRS considered health reform priorities. HRS used its activity design process to discern which requests were and were not implementation priorities and justify those decisions. An adaptive management approach helped HRS find solutions to implement many of these requests. HRS also made course corrections to overcome activity implementation challenges caused by frequent leadership turnover within the MOH and barriers that health care facilities encountered.

HRS prioritized M&E for Learning because healthcare facilities had never implemented reforms before. Health care teams had to learn new ways of interacting with each other; facility administrators had to learn new ways of financing operations, accounting, and managing their facilities and service delivery teams.
With over 60 local staff working remotely due to COVID-19, HRS could have become a stovepipe organization that suppressed cross-Objective communication. However, HRS prioritized internal collaboration and supported a culture of continuous learning to make the most of its large team.

HRS prioritized external collaboration because of the large number of stakeholders involved. In addition to healthcare facilities, HRS was required to simultaneously support organizational and regulatory changes to governance bodies at the national, regional, and local levels. HRS also engaged patients' rights organizations in the design and implementation of key reforms to encourage higher utilization of preventive care.

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.

CLA helped HRS prioritize the most important interventions given the activity's wide scope. In its second year of implementation, HRS realized that the quality of healthcare facilities was highly uneven, and these facilities lacked models of how to improve their quality of care. HRS leadership overhauled its activity design process to improve the adaptive management capacity – including articulating discrete activity-level theories of change. The activity-level theories of change helped the HRS team to articulate how healthcare facilities should improve.

Because of the complexity of the reforms, HRS used a pilot and scaling approach that enabled HRS to learn best practices from a small group of healthcare facilities before expanding them to others. HRS selected 15 primary healthcare facilities to become Centers of Excellence (COEs) that would pilot innovative service delivery and operational approaches. As one part of this, HRS piloted Pay&Care, an e-tool to cost paid services, and InSight 2.0, an e-tool to help healthcare facility administrators to produce financial planning reports. HRS adapted and refined the tools based on their use in the COEs and distributed them to other healthcare facilities.

The activity design process required the HRS team to clearly define their external and internal collaborators. This step encouraged cross-project collaboration and consideration of outside experts and non-traditional partnerships. The multi-disciplinary makeup of the HRS team led to strong internal collaboration through a cross-pollination of ideas.

HRS prioritized stakeholder decision-making throughout implementation. For example, HRS worked with doctors and nurses to stand up quality teams within each COE that increased the role of nurses in delivering care and instituted an incentive system for teams that met specific targets (e.g., childhood vaccinations delivered, palliative patients treated, and patients treated with opioid substitution therapy). HRS used M&E for Learning by co-developing patient feedback surveys that used ratings and open-ended questions. Doctors and administrators analyzed feedback to improve individual performance and facility issues. The evidence-based improvements helped to break vertical management hierarchies and led to higher quality care. HRS selected the most highly motivated COE teams to become trainers and equipped these teams with training resources to lead educational events where they could share success stories and lessons learned based off their pilot experiences. HRS' work with the COEs gave it data on how health reforms worked in practice, and HRS shared those lessons learned with the Government of Ukraine and via a wide-reaching manual for health care facilities.

A few months after HRS completed its COE activity, the COVID-19 pandemic struck, which forced HRS to shift to remote work. HRS' activity design process helped the team to develop new activities asynchronously and quickly course correct. When designing activities, HRS team members would have a 'Plan B'. For example, when health care workers did not have bandwidth to participate in HRS-led activities due to surges in COVID-19, HRS moved in-person trainings online or worked with alternative participants.

HRS' adaptive management approach was tested two years later. In January 2022, HRS held internal Scenario Planning workshops and produced a technical brief in response to warnings that Russia was setting the stage for a large-scale invasion. The technical brief provided HRS and USAID with critical situational awareness of how to respond in the initial aftermath of an invasion. After the invasion, HRS engaged healthcare facilities, the Government of Ukraine, donors, and other partners to revise its work plan, which USAID approved within three weeks of the outbreak of the invasion. Because HRS had two years of experience in adaptive management in response to COVID-19, it was well prepared to flexibly respond to war-related health system needs.

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?

Defining activity-level theories of change and indicators brought about a mindset shift among HRS staff and healthcare facility stakeholders. Before the new activity design process was instituted, not all HRS team members understood the theory of change of activities. Elucidating these cause-and-effect relationships helping the HRS team articulate the impact and advocate for interventions to government counterparts and partners, who in turn appreciated HRS' strategic insight and advice on core health reform priorities.

HRS leadership led team-wide workshops on adaptive management to empower Activity Managers and others to escalate ideas for course corrections and new activities. Over time, this created a flexible organizational culture capable of rapidly responding to health system needs created by the evolving health reform context, the COVID-19 pandemic, and later Russia's war against Ukraine.
HRS used bi-annual pause and reflect sessions to "look back, look up, and look forward." In looking back, the HRS team used rapid after-action reviews to reflect on their performance over the previous six months; in looking up, HRS leadership critically examined the logical framework and assumptions; and in looking forward, HRS leadership used the results of the rapid after-action reviews and refreshed theories of change to tweak implementation approaches or develop new activities. As an example, one of the pause and reflect sessions revealed a challenge posed by overreliance on certain government counterparts. Some counterparts were under-resourced and others had leadership vacuums, which led to implementation challenges and delays. After the pause and reflect sessions, HRS learned to broaden its local partners. As a result, HRS collaborated with Kernel, a major Ukrainian agrobusiness with community-level relationships to communicate health reform changes to local authorities. HRS also increased partnerships with other USAID and donor projects. Each pause and reflect session motivated the HRS team to expand their creativity.

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?

HRS implemented many activities, of which the Centers of Excellence was just one example. In total, HRS strengthened the capacity of 80% of public health care facilities and more than 400 local government institutions. HRS contributed to a critical health reform milestone: 96% of public healthcare facilities contracted with the government to provide state guaranteed medical services to Ukrainians, all without interrupting access to services. During that time, the level of informal payments (a type of petty corruption in health care) fell from 62% in 2018 to 21% in 2021, indicating that reforms to health financing had played a role in reducing corruption.

In the case of the Centers of Excellence, the combination of CLA approaches used during implementation led to empowered local leadership and improvements in patient-centered care. Patient satisfaction surveys at the COEs found that 95% of patients who visited a COE were satisfied with their experience, compared to the national average of 73%. One COE took a radically transparent approach by publishing all patient feedback online, including feedback for facility leadership. They demonstrated two-way trust that the public could play a role in health care improvements.

COEs successfully implemented many HRS-facilitated innovations that HRS later expanded to other facilities. For example, the COEs brought members of patients' rights and civil society organizations to participate in supervisory boards and oversaw the COE. HRS used the lessons learned from the COEs' experience to support the drafting of new legislation that would strengthen supervisory boards among all facilities. HRS continued to refine the financial planning e-tools that were piloted in the COEs and shared them with other facilities. HRS brought COE team members to mentor health care providers as part of an online course that reached 1,088 facilities, and COE team members contributed to a manual on facility management.

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?

USAID and leadership support were critical enabling factors. Recognizing the importance of CLA, the USAID Contracting Officer's Representative closely collaborated with HRS throughout the activity lifecycle, sharing valuable input on design, implementation, and evaluation. USAID also enabled HRS to continually adapt its activities through rolling Work Plan revisions. HRS leadership understood the long-term benefits of overhauling the activity design process and using pause-and-reflect sessions. They utilized a Learning Specialist to conduct a CLA Assessment and brought onboard a CLA Advisor to integrate CLA practices across the project. HRS leadership also prioritized empowering local decision-makers, which included mentorship, co-creating tools to access data, bringing non-traditional actors into decision-making (e.g., nurses), and amplifying local voices as role models.
Leadership within the COEs was another enabling factor. HRS selected COEs with progressive chief physicians and administrators that were eager to engage with CLA and improve their facilities. After the COE activity, HRS continued to spotlight those leaders in other activities.
HRS' large multi-disciplinary team was also an enabling factor, as diversity encouraged a culture of openness. Cross-objective collaboration led to innovation and stronger activities.
Lastly, the wide scope of the HRS activity provided flexibility for the HRS team to use data to understand the context and decide on health reform priorities. The wide scope enabled HRS to use adaptive management to pivot when the activity encountered obstacles.
Poor health care system data was an obstacle to leveraging data-driven decision-making. HRS mitigated this challenge by conducting studies and assessments itself. HRS conducted large-scale mixed-methods surveys to better understand informal payments and digital literacy of the health workforce. HRS used innovative data gathering approaches, including near-real-time location-based surveys, to learn how to tailor activities and machine learning software that analyzed Ukrainian social media to understand public sentiment on health reform and corruption.