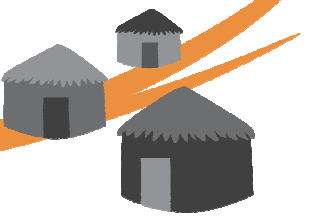
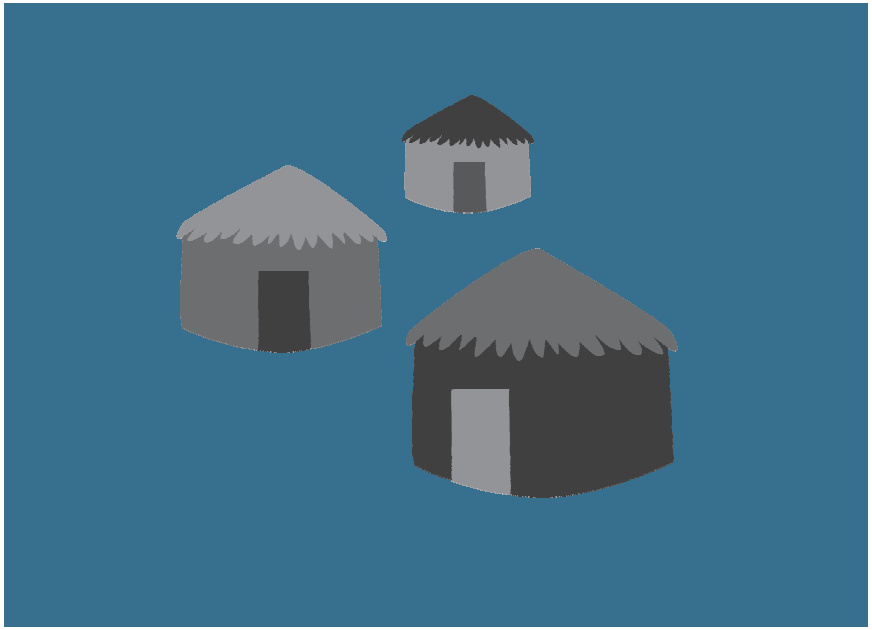
# Institutionalizing Community Health Conference



27-30 March 2017 | Johannesburg, South Africa



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# CARE:
## CONTINUITY ACROSS REMOTE ENVIRONMENTS

LAST MILE HEALTH

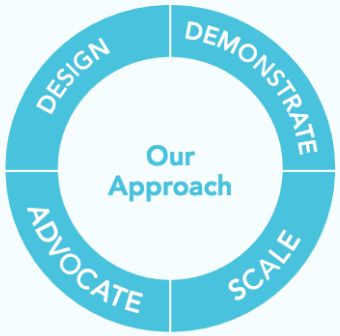
LASTMILEHEALTH.ORG

MALLIKA RAGHAVAN, MPH
DIRECTOR- NATIONAL COMMUNITY HEALTH SYSTEMS

# Last Mile Health: Who We Are

All people deserve access to health care, no matter where they live. Yet those who have the greatest need for primary health care are often the least likely to access it.

Over the last nine years, Last Mile Health has trained Community Health Workers (CHWs) to deliver care in Liberia's last mile, in partnership with the government. Today, Last Mile Health is supporting the Liberia Ministry of Health (MOH) and its partners to implement the National Community Health Assistant (CHA) Program that will serve the 29% of Liberians who live more than 5 kilometers from the nearest health center.




**Design** an evidence-based and replicable model for delivering health care to the world's most remote communities.

**Demonstrate** that community health professionals can have a dramatic impact.

**Scale** public sector community health programs in partnership with government through the provision of technical support, advancement of community health policy, and the allocation of resources.

**Advocate** for the health and development needs of last mile communities.

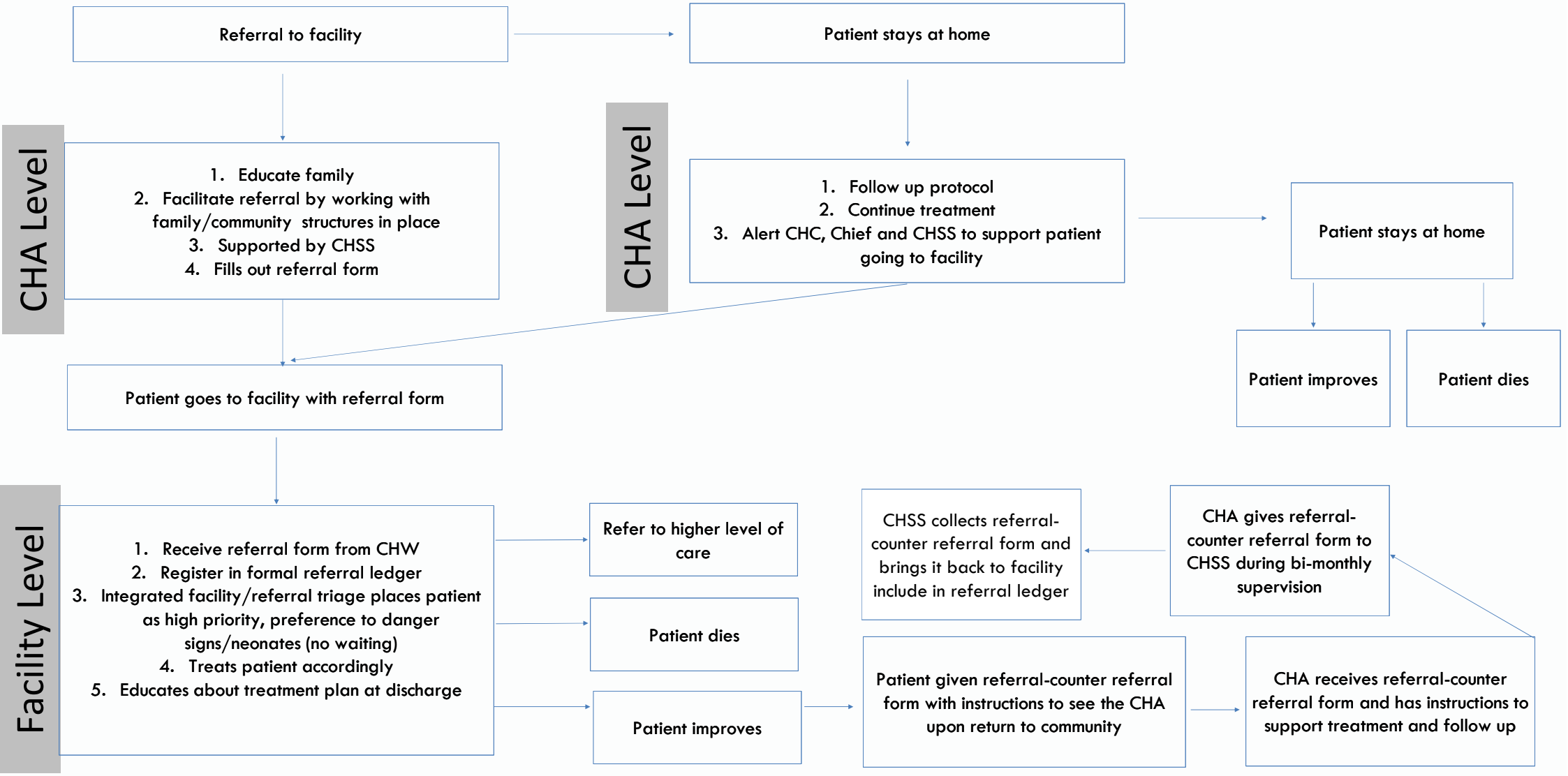

## Last Mile Health…

- Supports 322 Community Health Assistants as part of the National CHA Program in Remote Liberia
- Serves approximately 50k people living in 288 remote communities across 2.5 million acres of forest – every day
- Supports the Liberian Ministry of Health as a Community Health Technical Advisor for National Scale


Nearly 1.2 million Liberians live outside the reach of any health facility (beyond 5km)


# The Referral Pathway in Remote Liberia

# The Ideal Referral Pathway



# Referral- Counter Referral Pilot Project

- Breakdowns in the referral system were identified through on-going analysis using data from supervision reports, CHA records and patient outcomes
- A joint assessment was implemented by County Health Teams/Last Mile Health to explore enabling and inhibiting factors affecting referrals between the community and facility levels
- Our M&E and Programs teams set out to pilot the process for community involvement in patient referral and counter-referral systems
- Specifically, this initiative aimed to enhance areas of community engagement and governance of the National CHA Program, as well as improving the continuum of care from community to facility level

# Pilot Methods

- November- February 2017
- Using qualitative questionnaires and audits, the team conducted 22 focus groups in the two counties where Last Mile Health is implementing the NCHA program
- The pilot targeted health facility staff, clinical supervisors, referred patients/caregivers, CHAs and community members
- The geographical scope was a mix of small and large mining and non mining communities which raged from 5-30 km away from the nearest health facility

# What We Learned: The Current State of the Referral System

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| **CHA Level** | • CHAs are making referrals but not for all patients<br>• Mostly for ANC, delivery, vaccines but rarely danger signs<br>• Some referrals are verbal without any record<br>• Patients and CHAs say the paper referral form is used but often the documentation is not available to prove this |

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| **Community Level** | • Patients are (mostly) going to the facility<br>• Many challenges: road, transportation, money, lodging |

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| **Facility Level** | • Facility staff are newly educated about counter-referral process<br>• Varied referral tracking systems across each county<br>• Staffing at facility levels differ based on human resource availability |

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| **Counter Referral Form** | • Not used often- little training for facility staff on how to use the form<br>• CHA doesn't have good system for follow-up of referred patients once they return to the community<br>• Clinical supervisor doesn't always reach CHA on routine basis for follow up |

# What We Learned: Barriers to Successful Referrals

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| **Documentation & Communication** | • Lack of use of CHA program referral/counter-referral form<br>• Patient does not always bring form to facility<br>• Patients come in contact with multiple facility staff and not all are aware of how to complete counter-referral form |

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| **Logistics** | • Cost of transportation and few options in remote areas<br>• Poor road conditions: difficult for pregnant women and small children<br>• Rainy season lasting up to 8 months which severely hampers movements |

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| **Behaviors** | • Attitudes and treatment of patients by the health workers in the facilities<br>• Lack of integration between the facility and community levels creates less buy in for overall success of system |

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| **Other** | • Use of drugstore, herbalist or black bagger (local person selling medicines)<br>• Pregnant women afraid that husbands will leave them if they pursue their own plans to reach facility |

# What We Learned: Features that Lead to Successful Referrals

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| **Referral by the CHA** | • Community member knowledge of CHA presence and role<br>• Appropriate use of referral slip by CHA with community awareness of referrals each week |

| | |
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| **Community** | • Community support for transportation: ”susu fund”<br>• Community pressure/influence<br>• Physical/monetary support: flag down bike, carry in hammock, donate money<br>• Functional CHC collaborating with CHA to make decisions about referrals and logistics<br>• “Laws” or rules set by camp master in mining communities outlawing community delivery |

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| **Facility** | • Perception of timely, high-quality, free care at health facility due to referral<br>• Perception of being treated well by facility staff |

| | |
|---|---|
| **Counter Referral** | • Training facility staff on referral/ counter-referral slip during the same time clinical supervisors and CHAs are trained<br>• Availability of forms with frequent quality assurance on process |

# Planned Activities & Actions

1. Reinforce training on National CHA program referral/counter-referral forms with clear SOP on the flow of information from the community to the facility and back

2. Active tracking of referrals and counter-referrals through use of mobile phones and barcoded referral/counter-referral forms as well as maintenance of referral ledger at the primary health facility

3. Establish a practice of weekly discussion of community referral and counter-referral cases at the facility

4. Monthly review of summary referral/counter-referral data at the facility for its catchment area

5. Monthly mapping of referral data to highlight potential “hotspots” or areas in need of targeted interventions


1.3 Community Trigger & Referral Form

# Future Outcomes

1. Improved adherence to referral protocols

2. Improved fidelity of referral data

3. Ability to monitor referral data as proxy measure for CHA performance

4. Ability to use referral data to map potential outbreak ”hotspots” or areas in need of targeted interventions (i.e. disease outbreak, WASH, or transport support)

5. Improved patient continuity of care, leading to fewer instances of loss to follow-up for chronic conditions (i.e. malnutrition)