Improving Quality of Care in Guyana: A Case Study of Clinical Mentoring and Supportive Supervision

Introduction

In 2005, the World Health Organisation (WHO) released guidance on the importance of clinical mentoring and supportive supervision in fostering ongoing professional development and building successful networks of trained HIV-specialized health care workers in HIV care and treatment. Moreover, WHO recommended this as an effective strategy in the scale-up of anti-retroviral therapy (ART) programmes for sustainable, high-quality clinical care outcomes.

Guyana recognised that the increased CD4 threshold for initiating patients on antiretroviral therapy required a paradigm shift—from a monitoring to a mentoring approach—in addressing quality of care. It also clearly understood that this investment in the HIV workforce was a sustainable approach that would lead to desired treatment outcomes. In 2014, Guyana implemented its clinical mentoring and supportive supervision programme.

More recently, the Caribbean has endorsed the WHO Treat All strategy, and several countries have commenced implementation with implications for financial, human, and other resources. This case study will be valuable to national AIDS programmes (NAPs) in the Caribbean in understanding the role of clinical mentoring and supportive supervision for sustainable high-quality treatment outcomes in scaling up ART programmes.

This case study is intended for policymakers at Ministries of Health, technical officers (such as Chief Medical Officers), NAP managers responsible for the scale-up of ART programmes and the implementation of Treat All, directors of TB and other technical programmes, and clinicians involved in coaching and mentoring.

Background

In 2001, Guyana started offering treatment with ART at a single clinical site. It has since expanded, with 4,905 patients receiving treatment at 22 HIV treatment sites across its 10 administrative regions at the end of 2016.[1] The National AIDS Programme (NAP) leads the coordination of the treatment response, and over time, a treatment coordination model evolved with the overall objective of coordinating the delivery of high-quality care for people living with HIV and AIDS (PLHIV). Under this model, the National HIV Care and Treatment Steering Committee (NHCTSC) led by the National AIDS Programme Secretariat (NAPS) is responsible for coordinating and providing technical oversight to the HIV treatment programme. In response to new developments in HIV treatment, several sub-committees were established to provide oversight and technical guidance to specific aspects of HIV treatment. In that regard, Quality of Care (QoC) several successful quality initiatives—Health-qual, client satisfaction survey, and a collection of early warning indicators—were implemented.

In 2014, the NHCTSC endorsed guidelines that shifted ART initiation from a CD4 threshold of 350 to 500. Several challenges were encountered in the roll of the new guidelines, particularly related to the capacity of the clinical teams in low-volume primary health care and hinterland sites. The NHCTSC recognised that clinicians assigned to these sites on a two-year rotational basis are often inexperienced in HIV management. Additionally, the HIV patient load at these sites is generally very small and limits the scope of clinical practice in relation to the number of patients and complexity of cases. This is further complicated with resource limitations, particularly regarding laboratory and other diagnostic capabilities.

[1] (NAPS, 2017)

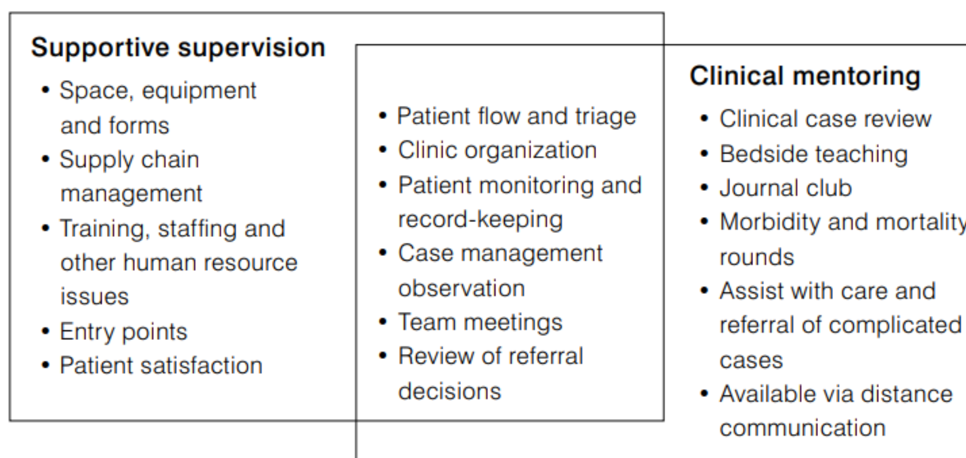
To address these challenges, bridge this gap, and enhance QoC, the NHCTSC, in 2014, established the clinical mentoring and supportive supervision technical working group (TWG) to provide ongoing capacity building of HIV practitioners and ensure the effective functioning of HIV treatment sites. A core group of mentors with more than ten years' experience in clinical management and a willingness to coach and mentor younger and less experienced physicians led this initiative. A blended approach of face-to-face and virtual clinical mentoring was implemented.

Clinical Mentoring and Supportive Supervision

The WHO defines clinical mentoring as a "systematic process of practical training and consultations that fosters ongoing professional development to yield sustainable high-quality clinical care outcomes."[2] Clinical mentoring emphasizes capacity building for HIV practitioners and clinical teams using multiple approaches, from bedside teaching to clinical case review. This can be done face to face or virtually.

Supportive supervision is designed to improve the quality of care and service delivery (treatment) through joint observation, discussion, direct problem-solving, mentoring, and learning. It requires regular follow-up with staff to ensure that new tasks are being implemented correctly.[3] Supportive supervision focuses on ensuring that critical health systems components such as human resources, health information systems, supply chain management, and others are adequately supporting HIV treatment.

WHO distinguishes the key elements of supportive supervision and clinical mentoring, highlights the significant overlap and complementary aspects of these two approaches, and underscores the importance of the two systems to work together to maximize effectiveness and reduce duplication.[3]



Adapted from WHO Recommendations for Clinical Mentoring to Support Scale-Up of HIV Care, Antiretroviral Therapy and Prevention in Resource-Constrained Settings.

Guyana's Clinical Mentoring and Supportive Supervision Model

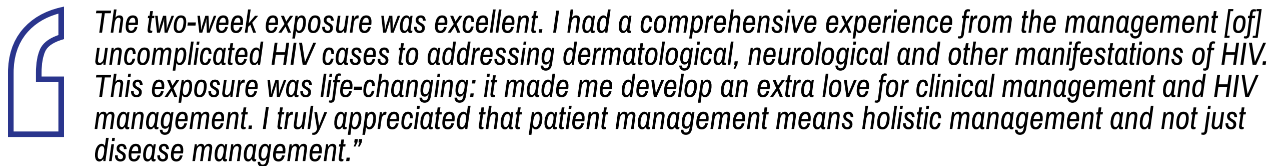
Guyana's clinical mentoring and supportive supervision model utilizes a multipronged approach that is interdependent and collaborative.

Intensive two-week face-to-face clinical mentoring

Face-to-face clinical mentoring is a process through which physicians with limited experience (mentees) are trained and supervised by experienced HIV clinicians (mentors) at a specialized HIV treatment site. It is led by mentors who possess extensive HIV management experience: more than five years of clinical management at high-volume HIV treatment sites. Mentoring is delivered over two weeks through a 12-module curriculum. A

[2] (WHO, 2006)
[3] (WHO, Training for MidLevel Managers: Module 4- Supportive Supervision., 2008)

dual-approach methodology of hands-on clinical consultations and didactic classroom sessions is employed to deliver the modules. The modules address all aspects of managing of an HIV patient, including the use of antiretroviral therapy, monitoring of patients on treatment, and diagnosing and treating opportunistic infections and co-morbid conditions. In Guyana, the face-to-face clinical mentoring programme is delivered at two HIV specialized sites, National Care and Treatment Center (NCTC) and St. Joseph Mercy Hospital (SJMH), that account for the management of more than 70% of all HIV cases.



The two-week exposure was excellent. I had a comprehensive experience from the management [of] uncomplicated HIV cases to addressing dermatological, neurological and other manifestations of HIV. This exposure was life-changing: it made me develop an extra love for clinical management and HIV management. I truly appreciated that patient management means holistic management and not just disease management."

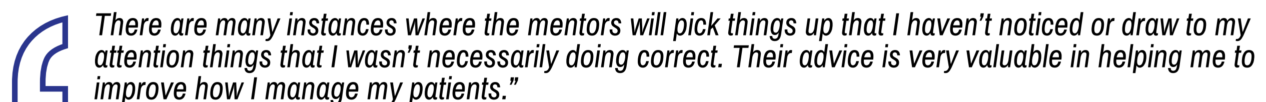
- Dr. Haygar Mohamed, Rosignol Health Center HIV treatment site

Clinical mentoring during HIV site visit

Mentoring continues beyond the initial two-week intensive. Semiannually, mentors visit their assigned sites and mentees to provide clinical guidance and supportive supervision. This includes joint clinical consultations and chart reviews.

Mentors work with their mentees to schedule visits on days when HIV patients are seeking care, as many of the smaller HIV sites do not conduct daily clinics. They also work collaboratively with the site clinical team to schedule difficult cases who could benefit from an expert consultation. Generally, these include cases of poor response to treatment, suspected treatment failure, switching therapy, management of severe adverse events, and significant comorbidities.

During the visit, mentors review patient charts to determine compliance with the national HIV treatment guidelines and defined standards of care. Chart review is conducted for all paediatric cases. For low-volume sites (<20 patients), all charts are reviewed; for high-volume sites, a random sample is taken. Chart reviews are done jointly with the mentee and focus on key parameters of QoC, such as ART initiation, laboratory monitoring, patient follow-up, management of co-infections (particularly TB/HIV), and management of comorbidities. Specific attention is paid to ensuring alignment with the HIV treatment guidelines for HIV- and -exposed adults and children.



There are many instances where the mentors will pick things up that I haven't noticed or draw to my attention things that I wasn't necessarily doing correct. Their advice is very valuable in helping me to improve how I manage my patients."

- Dr. Suresh Suerattan, Suddie HIV treatment site

Mentors also conduct supportive supervision with the entire clinical team in addressing issues related to the clinic environment, such as physical infrastructure and availability of equipment (e.g., blood pressure monitor, scale, etc.). Supply chain issues are also discussed, especially around the consistent availability of ARVs, other pharmaceuticals, and access to laboratory testing. Staff issues are discussed and recommendations are made for task-shifting, training, and advocacy for additional staff. Feedback on the site visit is provided to the entire clinical team and collaborative recommendations are made for improvement. Generally, solutions to many of the issues are beyond the scope of the site, so mentors serve as advocates in lobbying the regional health authorities and the national programme.

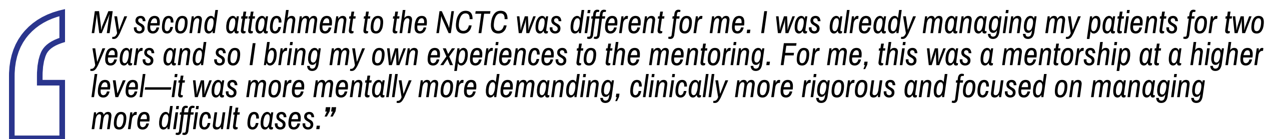
To ensure that the onsite face-to-face mentoring and supportive supervision is systematic and standardized across all HIV treatment sites, an HIV Treatment Oversight Visit Form is used to document the visit findings and outcomes.

Clinical mentoring after HIV site visit

Refresher face-to-face clinical mentoring

Refresher mentoring is a second two-week intensive process during which mentees benefit from more focused interactions with their mentors, based on identified areas of weakness.

Depending on the mentee's performance, mentors determine the need for refresher mentoring. If it is needed, it takes place at the specialized HIV sites and is generally more hands-on, with a greater focus on addressing the mentee's weaknesses and conducting clinical consultations of challenging cases.



My second attachment to the NCTC was different for me. I was already managing my patients for two years and so I bring my own experiences to the mentoring. For me, this was a mentorship at a higher level—it was more mentally more demanding, clinically more rigorous and focused on managing more difficult cases."

- Dr. Suresh Suerattan, HIV clinician and mentee, Suddie HIV treatment site

Mentees also connect and network with their mentors and other HIV practitioners from across the country at meetings such as the quarterly National Care and Treatment feedback meeting. At these meetings, clinical mentoring is ongoing through the discussion of difficult, interesting, and unique cases from the various HIV treatment sites.

Ongoing virtual clinical mentoring

Through virtual clinical mentoring, mentor clinicians provide guidance and support to their mentees using a variety of distance communication platforms. Virtual clinical mentoring is generally initiated by mentees through phone calls, WhatsApp messaging, and radio communication (as in the case of the hinterland regions) when they experience challenges in clinical management. This offsite mentoring strengthens the relationship established during the face-to-face mentoring and fosters greater technical independence and confidence.

Programmatic follow-up after HIV site visits

The HIV Treatment Oversight Visit Form used to document visit findings and outcomes is completed by the mentors and serves as the report submitted to the NAP. The report makes recommendations applicable to the treatment site, as well as the regional and national levels. The NAPS reviews the findings to understand the delivery of treatment and care services across all treatment sites. The recommendations are used to provide support to each individual site, the mentees, and their clinical team to enhance the functioning of their site and delivery of care to their patients. Selected findings are shared with other technical programmes in the Ministry of Public Health (MOPH)—for example, issues around tuberculin skin testing such as availability and access, health care worker technical capacity, and return rates for read-off are discussed with the National Tuberculosis Control Programme (NTP). Similarly, findings related to CD4, viral load, and other testing are shared with the National Public Health Reference Laboratory (NPHRL) and other laboratories directly linked to the treatment site.

Findings are also discussed with the clinical mentoring and supportive supervision TWG and National HIV Care and Treatment Steering Committee. Recommendations are fed back to the community of HIV practitioners at quarterly meetings and are used to enhance ongoing clinical mentoring and supportive supervision.

Facilitating Clinical Mentoring and Supportive Supervision

National MOPH leadership

MOPH leadership understood the value of the treatment programme and clinical mentoring and supportive supervision in enhancing quality of life for PLHIV and preventing new infections. This has facilitated implementation on many fronts. For example, the director of regional health services expedited the release of clinicians to participate in the two-week intensive mentoring and coordinated with the regional health administration to facilitate site visits and implement relevant recommendations arising from supportive supervision.

NAP leadership

As the custodian of the national HIV response, the NAP provided administrative and technical support to the mentoring and supervision processes via the treatment coordination model. The NAP engagement with policy makers and technical personnel at the MOPH, department heads, HIV clinicians and clinical teams, and other stakeholders was critical to the successful implementation of the initiative.

The National AIDS Programme building in Georgetown, Guyana.

HIV treatment coordination

The National HIV Care and Treatment Steering Committee (NHCTSC) acknowledged that a comprehensive approach to ensuring QoC was necessary to successfully scale up ART. Moreover, it recognised that existing QoC initiatives were limiting and should be expanded to include capacity building for clinical practitioners. With this, the NHCTSC led the development of the mentoring and supervision initiative, defined its scope of work, selected appropriate members, and convened the Clinical Mentoring and Supportive Supervision Working Group (TWG).

The TWG comprised primarily mentors and receives administrative support from the NAP. This group convened after each round of site visits to debrief, analyze findings, and make recommendations for improvement in HIV care delivery. The group also provided feedback to the NHCTSC to enable information exchange with other quality initiatives such as Health-Qual, thereby embracing a more holistic approach to improving QoC. The TWG also led discussions at national quarterly HIV clinical practitioner feedback meetings of on the impact of their clinical management on the quality of care delivered nationally.

Inter-departmental engagement

Collaboration between the NAP and other MOPH technical departments are provided the opportunity for addressing QoC in a multidimensional and comprehensive manner. This inter-departmental engagement was fostered at the level of the National Care and Treatment Oversight Committee as well through direct communication with the NAP. For example, issues raised on TB-HIV co-management were addressed with the NTP. Similarly, issues related to availability of laboratory testing consumables and supplies and ART were addressed with representatives from the NPHRL and procurement department.

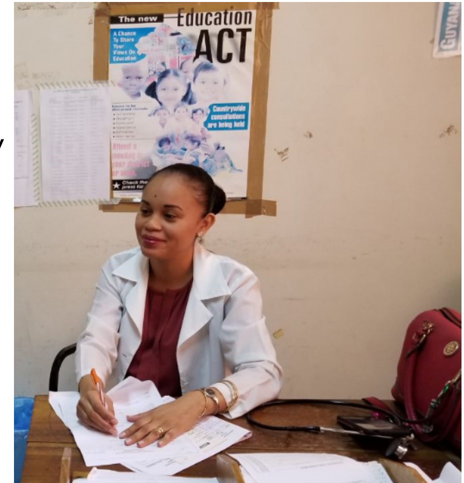
Availability of effective mentors

Clinical mentoring, both onsite and virtual, is driven by mentors. To effectively implement the clinical mentoring and supportive supervision initiative, an experience cored of HIV clinicians was required. Mentors had more than 10 years' experience in clinical management and were attached to high-volume HIV treatment sites that managed routine patients as well as complicated cases on a daily basis. They were assigned specific sites and mentees; over time, they developed professional and respectful working relationships with their mentees and

clinical teams. This augured well for mentees in reaching out to their mentors for follow-up ongoing virtual mentoring.

After every interaction with my mentor, I feel that I have learned more. The visit is always completed with me having more knowledge and more equipped to manage my patients. Not only is my mentor knowledgeable and experienced, she is also very patient, calm and not easily flustered in dealing with difficult patients. I learn a lot from her."

- Dr. Jillian Apple Jardine, HIV clinician and mentee, Bartica HIV treatment site



Lessons Learned and Recommendations

1. Leadership and upper-level management engagement at the MOPH facilitated the development, maintenance, and expansion of the clinical mentoring and supportive initiative**. National programmes scaling up ART and embarking on a clinical mentoring and supportive supervision initiative should invest in advocacy with the leadership of the Ministry of Health to ensure a greater understanding of its impact on delivering high-quality services to PLHIV. For programmes already in place, the NAP should continue to engage MOH leadership in providing regular updates, including scale-up plans and implementation successes and bottlenecks.**

2. The coordination model led by the NHCTSC has provided effective technical leadership to the diverse aspects of the HIV treatment programme. This model facilitated greater accountability for QoC initiatives and effectively created a space for the clinical mentoring and supportive supervision TWG to interface with other related TWGs, such as the Health-Qual Steering Committee, thereby fostering a comprehensive understanding of QoC. **In scaling up ART programmes, it is recommended that clinical mentoring and supportive supervision initiatives be framed within the broader context of the overall HIV treatment programme, so that they benefit from strong coordination and technical leadership and are integrated with other QoC initiatives.**

3. The selection of mentors based on their technical competence and clinical experience was important in ensuring that mentees benefited from high-quality expertise. Candidates' readiness and willingness to serve as mentors was also significantly weighted during the selection process. This was important in nurturing a mentor-mentee relationship that was trusting, respectful, and professional. **It is recommended that in addition to technical competence, characteristics of a good mentor should be defined and used to select mentors.**

"Serving as a mentor has been a learning experience. It has provided me with an intrinsic sense of deep satisfaction knowing that I can transform my knowledge to benefit patients beyond the confines of my clinic. It has helped me personally to develop as a better practitioner, provide objective and constructive feedback to my mentees, develop my coaching skills and force me to stay up to date with technical knowledge and skills. Through this process, I also reflect on and improve on my own practice. This is a win-win initiative for both mentors and mentees, with patients living with HIV the ultimate winners."

- Dr. Ruth Ramos, Director, National Care and Treatment Center

4 The assignment of clinical mentors to specific HIV sites was intended to facilitate the creation of a "safe space" for patients to have open discussions with their site's mentor, reducing anxiety around breach of confidentiality. However, the pool of clinical mentors remained relatively small, often affecting scheduled site visits because of other priorities. This resulted in mentors conducting visits to sites that were not assigned to them, conflicting with the original goal of creating trust between the clinical team and patients. **The development of a structured capacity-building plan for new mentors is recommended for the sustainability of this initiative.**

5 The two-year rotation schedule for hinterland and primary health care clinicians coupled with the intensive two-week face-to-face onsite clinical mentoring resulted in increased HIV management competencies among a large number of clinical practitioners. However, many of these are currently not in active HIV practice. **It is recommended that NAPs develop a mechanism to consolidate this expertise and facilitate HIV knowledge sharing and learning among clinicians. For example, NAPs should establish a virtual community of practice for all clinicians trained in HIV management.**

6 After the two-week intensive mentoring, mentees were required to manage patients independently and received ongoing virtual support from their mentors. The virtual mentoring was beneficial for addressing clinical challenges and instrumental in nurturing the mentor-mentee relationship; however, it was not systematically structured, but rather dependent on the mentee reaching out to the mentor for assistance as needed. **It is recommended that the mentor and mentee develop a structured follow-up plan post the initial two-week intensive mentoring.**

7 Despite WHO recommendations that clinical mentoring and supportive supervision should be conducted by distinct teams, Guyana demonstrated that they can be effectively combined in an environment with limited resources. This could be attributed to the high level of professionalism among the mentors, who were non-judgmental and focused on improving the knowledge and skills of the clinical team at their assigned HIV treatment site. **It is recommended that NAPs in similar contexts explore the nuances of merging clinical mentoring and supportive supervision.**

For more information on Guyana's clinical mentoring and supportive supervision initiative, please contact Dr. Rhonda Moore, Director, National AIDS Programme Secretariat, Ministry of Public Health at rhondamoore2512@yahoo.com.

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