SCUBY case study

Forum on scaling up - GACD 2019, Bankgok
Josefien van Olmen
Perspectives on designing and monitoring scale-up interventions
Specifications of the research call

**Challenges**

- implementation of control strategies / interventions, and tools and information

  eg lack of:
  - info on cost and financing of the intervention
  - provider training
  - availability of resources
  - integration into healthcare systems
  - delivery to vulnerable or difficult-to-reach populations
  - monitoring the quality of delivery

**Requirements**

- Identify, develop, test, evaluate and/or refine strategies for **scale-up of evidence-based practice**

- Overcome barriers to the adoption, adaptation, integration, scale-up

- Be aligned with existing policies, programme management, monitoring and evaluation processes
  - Align with (planned) commitments
  - Closely collaborate with policy-makers/authorities
  - Pay and provide the intervention
a. Conceptualization of scale up and operationalizing in our project
b. Our research questions
c. Evaluation of implementation and program fidelity
Comprehensive scale-up concept: 3 dimensions

1. Provided to more people in each country
2. To cover all five interventions
3. Incorporated into:
   • the **structural** elements & procedures of the health system
   • integrated at the **operational** level of health services, communities & patients
1. innovation
2. individuals or institutions facilitating the scale-up of the innovation
3. users of the innovation
4. strategies for S-U
5. the context
## Types of S-U strategies

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Horizontal strategy to increase population coverage</strong></td>
<td>expansion to different geographical sites or larger or new categories of population</td>
</tr>
<tr>
<td><strong>Vertical strategy to increase integration</strong></td>
<td>top-down process: central level decides to implement on a (sub)national level and institutionalizes through planning, policy changes or legal action</td>
</tr>
<tr>
<td><strong>Diversification strategy to expanding the integrated care package</strong></td>
<td>adding new elements to an existing intervention, broadening the scope</td>
</tr>
</tbody>
</table>

### Organisational processes

- Stakeholder engagement
- Cost & resource mobilisation
- Monitoring & Evaluation
<table>
<thead>
<tr>
<th>EXPAND elements</th>
<th>Meaning in the SCUBY project</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Innovation</td>
<td>ICP</td>
</tr>
</tbody>
</table>
| 2) Resource organisations | Different possibilities in each country, depending on the existing scale-up initiatives.  
• decentralised movement and local initiatives (Belgium): local actors and networks.  
• decided by government (Cambodia): government and partner organisations that facilitate  
• developed by local organisation, but scale-up decision is centrally taken: both organisations (Slovenia). |
| 3) User organisation | Different possibilities:  
• Health care facilities, community and patient organisations, who implement the integrated care package  
• Decision-makers at regional and local level who expand the integrated care package in their region or change regulations/data management/financing to facilitate integration |
| 4) Scale-up strategy and roadmap | Actions. Examples:  
• Protocols and flow charts, education materials, self-management support tools  
• Involvement of patients, informal care givers and community groups  
• Training  
• Task shifting; improving referral pathways  
• Monitoring of patients and at organisational level  
• Redesigning financing structures |
| 5) Context |  
• progress in implementation of integrated care package  
• current initiative in scale-up of integrated care package |
Integrated care package (ICP)

- Facility-based identification of patients with HT and/or T2D
- Health education & counselling to T2D and HT patients by non-physician care providers
- Treatment of T2D & HT by primary care providers using standardised protocols, including medications
- Self-management support to patients & their informal caregivers with tools for adherence and monitoring
- Structured collaboration between health care workers, community actors and patients and their caregivers

Step 2) What do you want to s-u?
How did we choose our research questions?

Step 2) Objectives

1. To analyse the **organisational capacity** to scale-up ICP for HT & T2D & to assess contextual **barriers and facilitators**

2. To **develop and implement roadmaps for a national** scale-up

3. To **evaluate the impact** on health outcomes and efficiency of care through the scale-up of the integrated care package.

4. To generate lessons **across contexts**
Step 3) Design and timing

Year 1

**Situation analysis**

- **Context: Cambodia**
  - Resource organisations
  - User organisations

- **Context: Slovenia**
  - Resource organisations
  - User organisations

- **Context: Belgium**
  - Resource organisations
  - User organisations

**Scale-up**

**Evaluation**
Step 4) Workpackages and RQ (tasks)

WP 2.
2.1 In-depth analysis of implementation sites (meso and micro level)
2.2 Stakeholder mapping and analysis of the current strategy
2.3 Context analysis (macro-level)

WP 3.
3.1. Rapid facility-based survey
3.2. A baseline population-based survey
3.3. Financing system analysis
3.4. Costing scale-up scenarios
3.5. Cost evaluation of scale-up

WP 4.
4.1 Assessment of existing data collection systems
4.2 Assessment of existing data collected in implementation sites
4.3 Building a minimum data set for monitoring in the scale-up phase
4.4 Data management

WP 5.
5.1 Identification of best practices and potential for change
5.2. Organization of policy dialogue in each country
5.3 Implementation roadmaps
5.4 Monitoring & support to roadmap implementation

WP 6.
6.1. To evaluate the process of the scale-up strategies and roadmaps
6.2. To evaluate the progress of implementation in the country along three dimensions of scale-up
6.3. To evaluate the impact of the scale-up strategies on health outcomes of T2D and HT patients.
Umbrella protocol

Step 1/Level1: Indepth analysis of implementation sites (meso)
1.1 Different models of ICP
1.2 Implementation assessment
1.3 Organisational context (WP2)
1.4 Cost from provider perspective (WP3)

Step 2/Level2 (micro): Effectiveness ICP
2.1 Effects of an (partially) implemented ICP? (WP4)
2.2 Core indicator set (WP4, WP6)
2.3 Cost for patient (WP3)

Step 3/Level3: National analysis (macro):
3.1 Health and financing system (WP3)
3.2 Stakeholder analysis (WP2)

Step 4: Scale-up roadmaps
4.1 Policy dialogues
4.2 Action roadmap (WP3, WP4, WP5)

Step 5: Support scale-up
5.1 Strengthen capacity (WP5)
5.2 Costing scenarios (WP3)
5.3 Monitoring (WP4)

Step 6: Support scale-up

Step 7: Progress evaluation along 3 axes (WP6):
- increase in horizontal coverage (units; people)
- new components added
- integration: macro-system level (grading scale)
  meso-operational level (normalisation)

Step 8: Cost evaluation (WP3)

Step 9: Impact evaluation (WP6)
<table>
<thead>
<tr>
<th>#</th>
<th>Substudy</th>
<th>RQ- Data - indicators</th>
<th>Data collect tool</th>
<th>Way of data collection</th>
<th>Informed Consent (IC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>In-depth analysis in implementation sites</td>
<td></td>
<td></td>
<td>Two researchers fill in the grade separately, at the end of the visit. Collect from multiple sources: Interviews with health care staff, Interviews with patients (aged 40 and over) who utilize the service. Observation of processes with checklist, random check of data management system</td>
<td>asked from the person in charge of the health facility/unit of analysis, before the visit, so that it can be discussed within the team and be announced to patients visiting that day. Patients or health care workers who wish not to take part are informed that they have the option to refuse.</td>
</tr>
<tr>
<td>1.2</td>
<td>Implementation of ICP</td>
<td>WP2</td>
<td>ICP Grid (tool B)</td>
<td>Two researchers fill in the grade separately, at the end of the visit. Collect from multiple sources: Interviews with health care staff, Interviews with patients (aged 40 and over) who utilize the service. Observation of processes with checklist, random check of data management system</td>
<td>asked from the person in charge of the health facility/unit of analysis, before the visit, so that it can be discussed within the team and be announced to patients visiting that day. Patients or health care workers who wish not to take part are informed that they have the option to refuse.</td>
</tr>
<tr>
<td>1.3</td>
<td>Organisational context</td>
<td>WP2</td>
<td>Focus group guide (tool C)</td>
<td>Guided discussion, audiorecording and transcribing</td>
<td>All participants will be asked informed consent before the start.</td>
</tr>
<tr>
<td>1.4</td>
<td>Cost from provider perspective</td>
<td>WP3</td>
<td>Costing tool (tool F)</td>
<td>national health accounts, existing lit, complemented with focus group/key informant interviews and (in Cam) a rapid health facility survey</td>
<td>This will be part of IC in step 1.2 and 1.3</td>
</tr>
<tr>
<td>2</td>
<td>Effectiveness</td>
<td></td>
<td></td>
<td>household survey</td>
<td>Cam: IC form in survey; Bel/Slov: encrypted/anonymous. If primary data collection will be done, additional tool and IC</td>
</tr>
<tr>
<td>2.1</td>
<td>Effects of ICP on different outputs/outcomes of care</td>
<td>WP4</td>
<td>Cascades of care T2D (tool D) and HT (tool E)</td>
<td>national data anonymised through third party encryption</td>
<td>Cam: IC form in survey; Bel/Slov: encrypted/anonymous. If primary data collection will be done, additional tool and IC</td>
</tr>
<tr>
<td>2.3</td>
<td>Cost and barriers patient</td>
<td>WP3</td>
<td>Demand side costing tool (tool G)</td>
<td>household survey</td>
<td>Cam: IC form in survey; Bel/Slov: separate IC</td>
</tr>
<tr>
<td>3</td>
<td>Macro-level analysis</td>
<td>WP3</td>
<td>Additional questions for particular key informants (addition in tool H)</td>
<td>Document review, complemented with focus group/key informant interviews</td>
<td>Separate IC form</td>
</tr>
<tr>
<td>3.1</td>
<td>Health financing system</td>
<td>WP3</td>
<td>Additional questions for particular key informants (addition in tool H)</td>
<td>Document review, complemented with focus group/key informant interviews</td>
<td>Separate IC form</td>
</tr>
<tr>
<td>3.2</td>
<td>Stakeholder analysis</td>
<td>WP2</td>
<td>Interview guide (tool H)</td>
<td>Selection of stakeholders based upon preliminary mapping</td>
<td>Separate IC form</td>
</tr>
</tbody>
</table>
How do we measure implementation and ensure fidelity....

Discuss: Theory of Change for each country.
Tools for verification (WP5)

Step 4: Scale-up roadmaps
4.1 Policy-dialogues
4.2 Action roadmap (WP3,4,5)

Step 5: Support scale-up
5.1 Strengthen capacity (WP5)
5.2 Costing scenarios (WP3)
5.3 Monitoring (WP4)

Step 6: Progress evaluation along 3 axes (WP6):
- Increase in horizontal coverage (units; people)
- New components added
- Integration: macro-system level (grading scale)
  meso-operational level (normalisation)

Step 7: Cost evaluation (WP3)

Step 8: Impact evaluation (WP6)
Monitoring and Evaluation

Elements

• To evaluate the **process** of the scale-up strategies and roadmaps
  • Fidelity framework: reach, acceptability & feasibility, adaptation, fidelity and costs

• To evaluate the **implementation** of the ICP along the three dimensions:
  • The population coverage
  • Expansion of the intervention package
  • Integration of the intervention into the larger health system

• To evaluate the **impact**

Tools

Measure organisational structure: ICP scoring grid

Outcomes: Cascade of Care
Take-home: Work step-wise

From concept

To intervention

To objectives

To organisation of work

To research questions (smaller units)

To tools and measuring