# INTEGRATED CHRONIC DISEASE MANAGEMENT

## Manual

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Department:
Health
REPUBLIC OF SOUTH AFRICA

The Department of Health would like to acknowledge the following individuals for their contribution to the development of the manual:

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# INTEGRATED CHRONIC DISEASE MANAGEMENT

## A STEP-BY-STEP MANUAL TO GUIDE IMPLEMENTATION

# >> Preamble

The National Department of Health (NDoH) with the support of the US President's Emergency Plan for AIDS relief (PEPFAR) has developed an Integrated Chronic Disease Management (ICDM) model based on the building blocks set out in the World Health Organisation (WHO) document *Innovative Care for Chronic Conditions: Building Blocks for Action.* The conceptualisation, development and translation of this ICDM model at health and community level has been initiated by Dr Shaidah Asmall, Senior Technical Advisor to the National Departmentof Health (NDoH) and Dr Ozayr Mahomed of the Discipline of Public Health Medicine at the University of KwaZulu-Natal.

The initiation of the ICDM commenced in April 2011 in the Dr Kenneth Kaunda District in the North West Province, West Rand Health District in Gauteng and Bushbuckridge sub-district in the Ehlanzeni District of Mpumalanga. It was implemented at 42 selected primary healthcare (PHC) facilities in a phased approach across the three districts. The lessons learnt during this pilot phase have been used to refine the tools and the methodology employed to ease implementation of the model at all PHC facilities.

This manual has been developed to support the provincial programme managers, district programme managers, PHC supervisors, local area managers and PHC facility managers in improving the quality of PHC services rendered through the implementation of the ICDM and in ensuring sustainability of the ICDM. The manual is written as a step-by-step guide, although many aspects of the implementation may occur simultaneously.

The manual aims to assist facility operational managers in ensuring compliance and in implementing the six priority areas of the National Core Quality Standards for Health Establishments, namely improving staff values and attitudes, waiting times, cleanliness, patient safety and security, infection prevention and control, and the availability of medicines and supplies.

**THE ICDM AND THE PRIORITY CORE STANDARDS ARE INTRINSICALLY LINKED AS SHOWN BELOW:**

- Improving the values and attitudes of staff, waiting times and cleanliness are addressed through **the facility re-organisation component of the ICDM model.**
- Patient safety and security and infection prevention and control are addressed through **the clinical management component of the ICDM model.**
- The availability of medicines and supplies is addressed through **the system strengthening component of the ICDM model.**

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# >> List of acronyms

| | |
|---|---|
| **ABN** | ABNORMAL |
| **AIDS** | ACQUIRED IMMUNE DEFICIENCY SYNDROME |
| **ART** | ANTIRETROVIRAL TREATMENT |
| **BMI** | BODY MASS INDEX |
| **CANSA** | CANCER ASSOCIATION OF SOUTH AFRICA |
| **CCMT** | COMPREHENSIVE CARE, TREATMENT AND MANAGEMENT |
| **CHC** | COMMUNITY HEALTHCARE CENTRES |
| **COPD** | CHRONIC OBSTRUCTIVE PULMONARY DISEASES |
| **DCST** | DISTRICT CLINICAL SPECIALIST TEAM |
| **DHIS** | DISTRICT HEALTH INFORMATION SYSTEM |
| **DHS** | DISTRICT HEALTH SERVICES |
| **HCW** | HEALTHCARE WORKERS |
| **HIV** | HUMAN IMMUNE DEFICIENCY VIRUS |
| **ICDM** | INTEGRATED CHRONIC DISEASE MANAGEMENT |
| **IPT** | ISONIAZID PROPHYLACTIC THERAPY |
| **ISHP** | INTEGRATED SCHOOL HEALTH PROGRAMME |
| **ISHT** | INTEGRATED SCHOOL HEALTH TEAM |
| **MDR-TB** | MULTI-DRUG RESISTANT TB |
| **NAD** | NO ABNORMALITY DETECTED |

| | |
|---|---|
| **NCD** | NON-COMMUNICABLE DISEASES |
| **NDoH** | NATIONAL DEPARTMENT OF HEALTH |
| **NGO** | NON-GOVERNMENTAL ORGANISATION |
| **NIMART** | NURSE INITIATED MANAGEMENT OF ANTIRETROVIRAL TREATMENT |
| **PC 101** | PRIMARY CARE 101 |
| **PALSA Plus** | PRACTICAL APPROACH TO LUNG HEALTH IN HIGH-HIV PREVALENCE COUNTRIES |
| **PEPFAR** | US PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF |
| **PICT** | PROVIDER INITIATED COUNSELLING AND TESTING |
| **PHC** | PRIMARY HEALTHCARE |
| **PLHIV** | PEOPLE LIVING WITH HIV AND AIDS |
| **PMDS** | PERFORMANCE MANAGEMENT DEVELOPMENT SYSTEM |
| **PMTCT** | PREVENTION OF MOTHER-TO-CHILD TRANSMISSION |
| **QA** | QUALITY ASSURANCE |
| **RTC** | REGIONAL TRAINING CENTRES |
| **TB** | TUBERCULOSIS |
| **U&E** | UREA AND ELECTROLYTES |
| **WBOT** | WARD-BASED PHC OUTREACH TEAMS |
| **WRHI** | WITS REPRODUCTIVE HEALTH AND HIV INSTITUTE |
| **WHO** | WORLD HEALTH ORGANISATION |

** Local Area Manager: refers to a PHC supervisor or manager who is responsible for PHC services across 6-8 clinics, including a CHC.*

# >> Outline of the manual

This manual provides a step-by-step guide for the implementation of ICDM by facilities without external service provider support. This comprehensive user manual has been developed to support health service ownership, accountability and sustainability in the implementation of the ICDM model. In addition, it aims to foster a common understanding and strong team work in the provision of quality services to patients with all chronic illnesses.

| | |
|---|---|
| **SECTION 1** This section provides a contextual overview of the ICDM model, linkages with the PHC re-engineering framework, and the roles and responsibilities of the various stakeholders within the health system. | **SECTION 5** Discusses the tools available and their application in improving the clinical care of patients with chronic diseases. |
| **SECTION 2** Outlines the pre-implementation tasks and activities to be conducted by the various stakeholders at provincial, district, sub-district and facility level in order to create an enabling environment for change and to implement the ICDM model. | **SECTION 6** Provides the procedure for down referral of a stable chronic patient to the ward-based outreach team for management, and the role of the community health worker in assisting the patient in managing their chronic illness. |
| **SECTION 3** Details the data that are required, the process to obtain the data, and how to conduct the data analysis so that the information can be used to prepare the ICDM implementation action plan. | **SECTION 7** Details the health system support that is required to ensure the sustainability and the effective and efficient implementation of the ICDM model. |
| **SECTION 4** Describes the key steps involved in conducting a baseline analysis at the facility level (waiting time, patient process flow and data analysis) and the practical application of the findings in re-organising the facility. | **SECTION 8** Closes the action planning cycle by providing a tool for the monitoring of ICDM at a sub-district level, as well as an overall programme monitoring tool for application at district and provincial levels. |

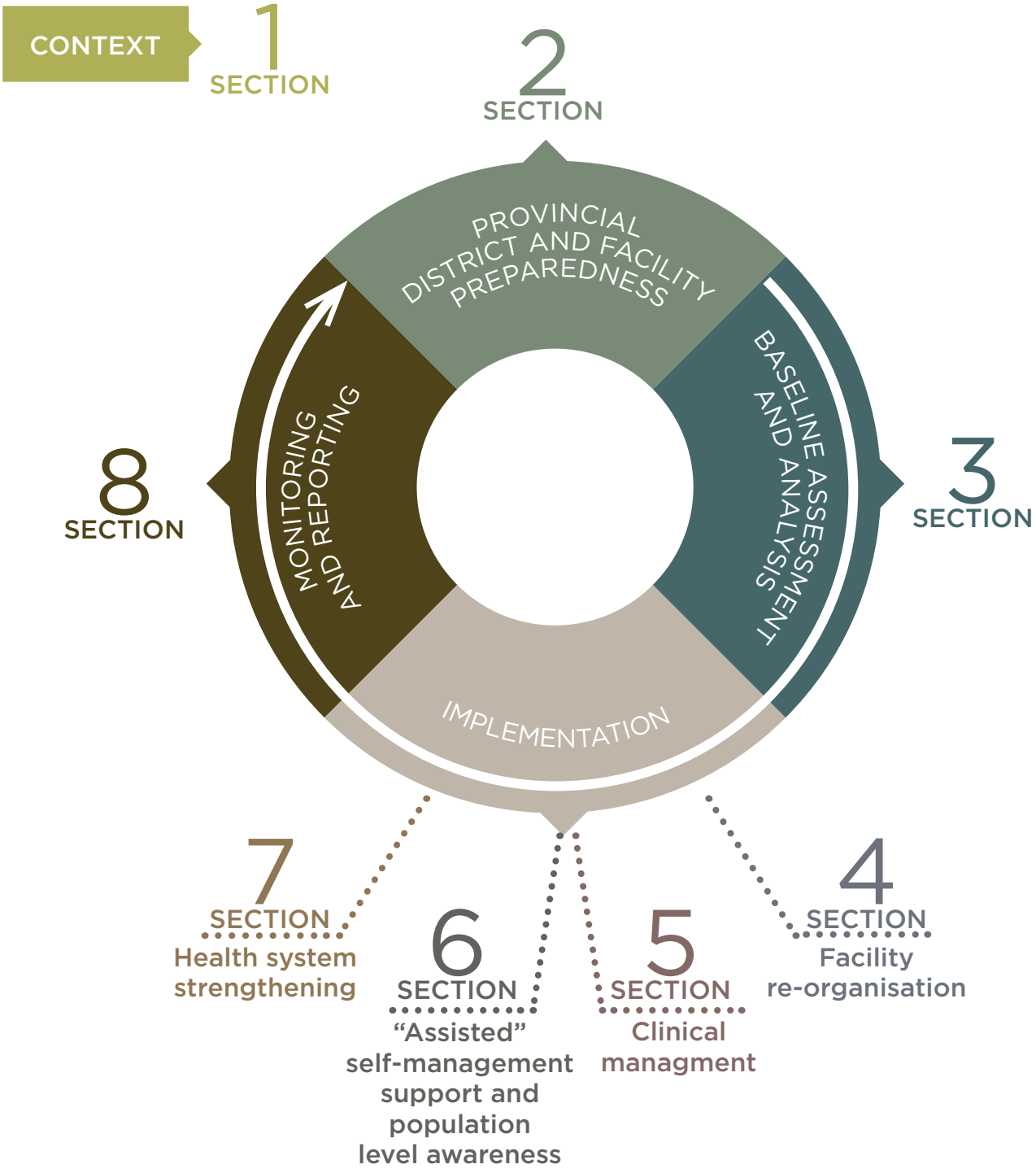



**FIGURE 1:** MANUAL OUTLINE AND ICDM APPROACH

### ▶ icon key

The following icons are used throughout the manual to identify different levels within the health system.

| PROVINCIAL | DISTRICT | SUB-DISTRICT | FACILITY | COMMUNITY | POPULATION |
|---|---|---|---|---|---|
| | | | | | |

Section One

01

# ICDM
## CONTEXT FOR DEVELOPMENT AND IMPLEMENTATION

**CONTEXT**

- Integrated Chronic Disease Management
- Chronic diseases included in the ICDM
- Link with the PHC Re-engineering Framework
- Key role players
- The Approach

# 1. What is Integrated Chronic Disease Management?

Integrated Chronic Disease Management (ICDM) is a model of managed care that provides for integrated prevention, treatment and care of chronic patients at primary healthcare level (PHC) to ensure a seamless transition to "assisted" self-management within the community.

The aim of ICDM is to achieve optimal clinical outcomes for patients with chronic communicable and non-communicable diseases (NCDs) using the health system building blocks approach.

ICDM adopts a diagonal approach to health system strengthening, i.e. technical interventions that improve the quality of care for chronic patients coupled with the strengthening of the support systems and structures to enhance the health system.

ICDM uses a health systems approach to chronic diseases (communicable and NCDs) through the strengthening of the various building blocks of the health system. The ICDM consists of four inter-related phases that are dependent on overarching strong stewardship and ownership at all levels of the health system.

### THE FOUR INTER-RELATED PHASES INCLUDE:

- Facility re-organisation to improve service efficiency
- Clinical supportive management to improve quality of clinical care
- "Assisted" self-support and management of patients through the PHC ward-based outreach teams (WBOT) to empower individuals to take responsibility for managing their own conditions and increasing awareness of chronic diseases at the population level
- Strengthening of support systems and structures outside the health facility to ensure a fully functional and responsive health system.

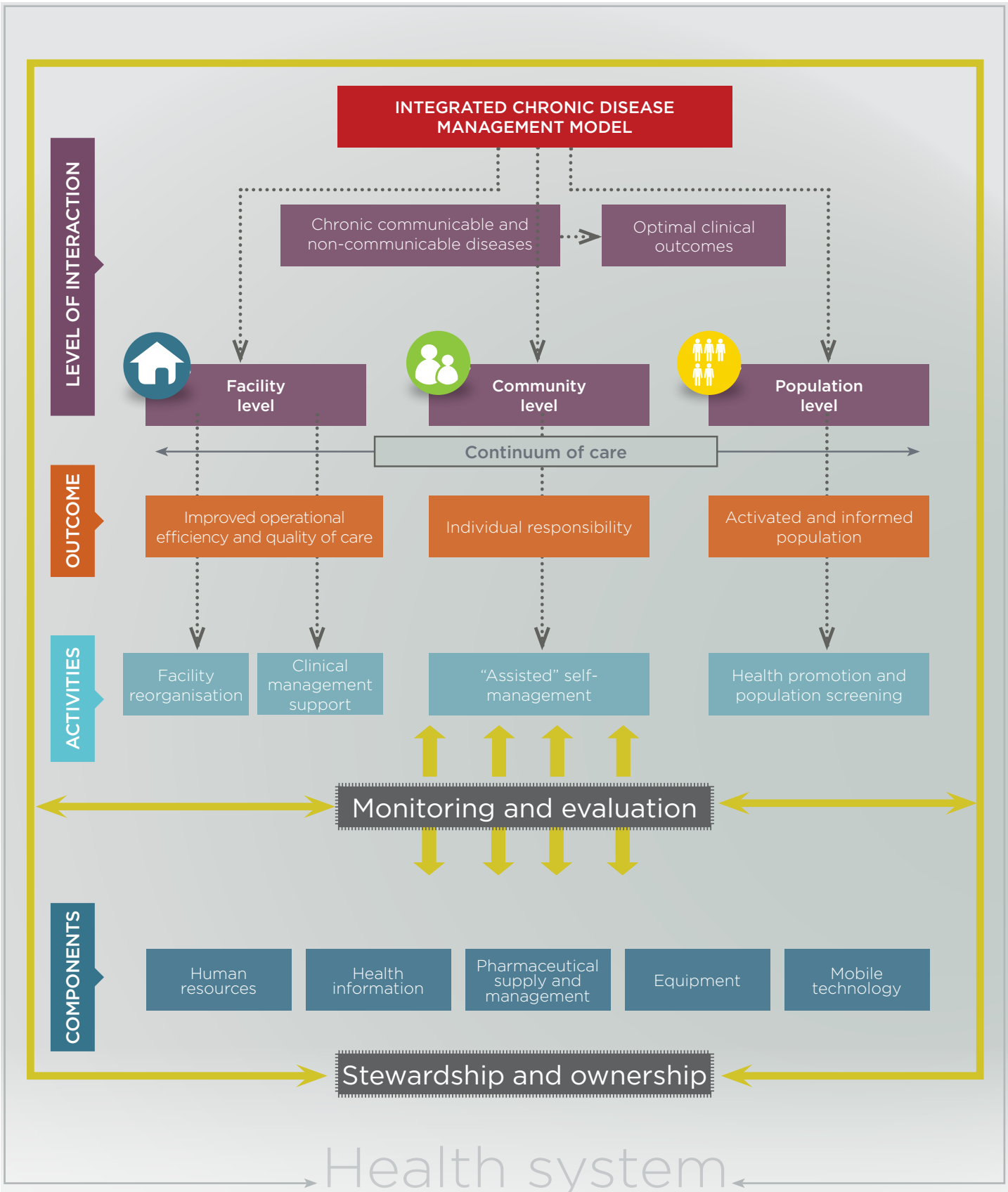



**FIGURE 2:** ICDM MODEL

The ICDM model is based on a Public Health approach to empower the individual to take responsibility for their own health, whilst simultaneously intervening at a community/population and health service level.

This approach adopts a systems perspective and addresses interventions across the spectrum of continuity of care that includes:

- primary prevention through health promotion, early detection, appropriate screening and surveillance,
- secondary prevention by providing appropriate treatment and care,
- and tertiary prevention through rehabilitation, and palliative care at the various stages of the disease pathway.

The main aim is to ensure early detection and appropriate management of high-risks patients.

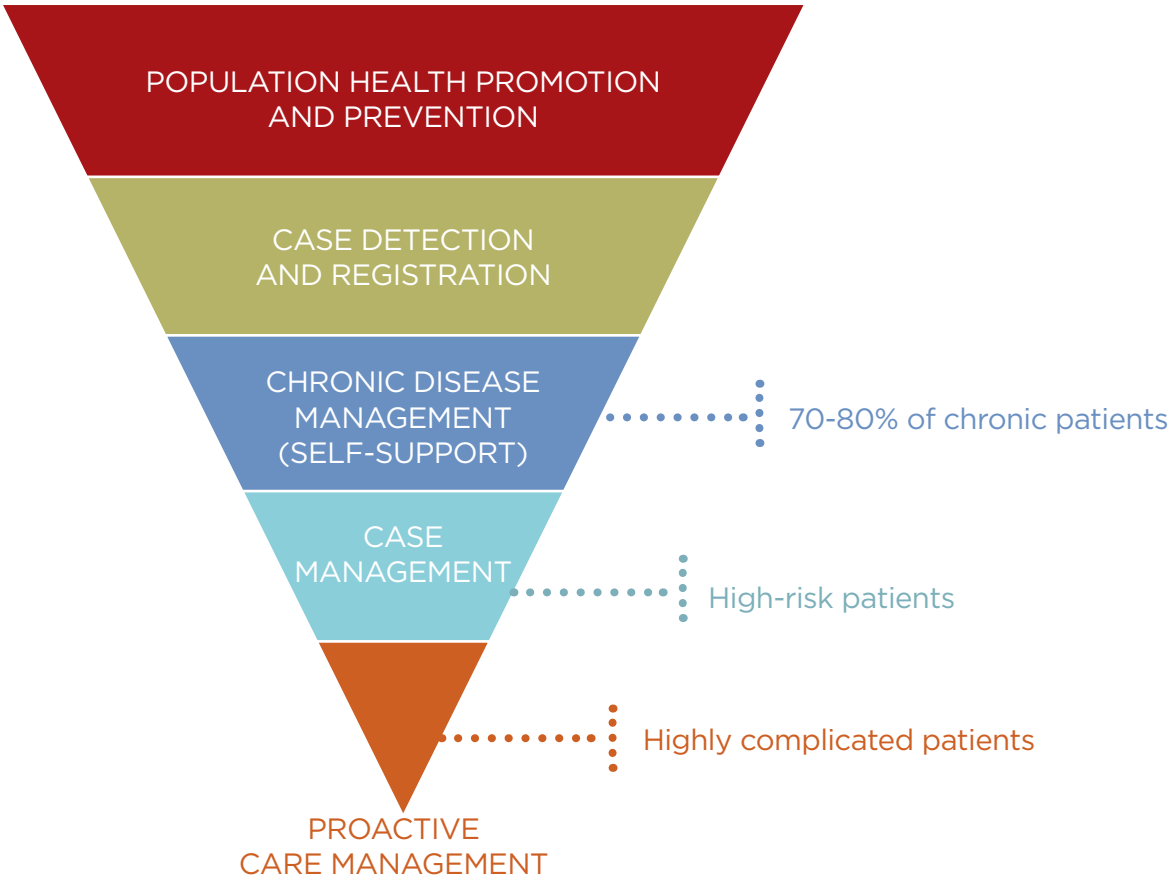



**FIGURE 3:** PUBLIC HEALTH PERSPECTIVE ON MANAGEMENT OF CHRONIC DISEASES

### PRIMARY PREVENTION

- Health education and health promotion at household level via the PHC outreach team and integrated school health teams (ISHTs)
- Identification of high-risk individuals within the community with an appropriate referral mechanism for confirmation of diagnosis and management.

### SECONDARY PREVENTION (TREATMENT AND CARE)

- A clear pathway of management that involves scheduled facility visits
- The application of evidence-based clinical guidelines for optimal clinical outcomes
- An inter-disciplinary approach to the care and management of patients
- Early identification of risk factors for disease complications and appropriate referral to a higher level of care
- Health education and promotion for at-risk individuals to prevent complications that are costly for the health system.

### TERTIARY PREVENTION

- The appropriate referral and management of patients with disabilities and complications by allied health workers, such as occupational therapist and physiotherapist.

### AN EMPOWERED INDIVIDUAL

- Who takes responsibility for self-management and control of disease
- "Assisted" self-management within the community through point of care testing and medication supply via the community health workers (CHWs).

### POPULATION LEVEL

- Strengthening of the implementation of health policies addressing the social determinants of health
- Health promotion campaigns addressing risk factors
- Population-based screening during health awareness campaigns.

## ICDM WILL BE ACHIEVED THROUGH:

- Strong stewardship and ownership at all levels of the health system
- Health service re-organisation at facility level
- Clinical management support at facility level
- "Assisted" self-management support at community level
- Strengthening of support systems and structures within the health system.

The ICDM model addresses the six priority areas of the National Core Quality Standards for Health Establishments, namely improving staff values and attitudes, waiting times, cleanliness, patient safety and security, infection prevention and control, and the availability of medicines and supplies.

**FACILITY RE-ORGANISATION**

Patient rights

- Improving staff values and attitudes
- Waiting times
- Cleanliness

**CLINICAL MANAGEMENT SUPPORT**

Patient safety, security, clinical governance and care

- Patient safety and security
- Infection prevention and control

**SYSTEM STRENGTHENING AND SUPPORT**

Clinical support services

- Availability of medicines and supplies

**FIGURE 4:** LINK BETWEEN ICDM AND SIX PRIORITY AREAS OF THE NATIONAL CORE STANDARDS

# 2. Chronic diseases included in the ICDM

**'Chronic' refers to a condition that continues or persists and will require management over an extended period of time.**

The current focus of the ICDM model is adult patients over the age of 15 years. However, the following categories of children can be included in ICDM:

- Children who are on the prevention of mother-to-child transmission (PMTCT) programme should be seen with the mothers to ensure seamless service delivery.
- Children with NCDs are usually managed at a district or regional facility. However, those that have been down-referred to the PHC should be included.
- Children > 5 years that have been diagnosed with chronic conditions at PHC facilities and are managed at primary care level through appropriate doctor support.

## The ICDM model addresses the following disease categories:

### Chronic communicable diseases

- People living with HIV and AIDS (PLHIV)
  - Pre-antiretroviral treatment (ART), or
  - on ART
- All patients with Tuberculosis (TB) receiving medication
- Down referred Multi-Drug Resistant TB (MDR-TB) patients
- Mothers that have commenced with ART during the antenatal period
- Children on the PMTCT programme attending with mothers.

### Chronic NCDs immediately on diagnosis

- Hypertension
- Diabetes
- Chronic Obstructive Pulmonary Disease (COPD)
- Asthma
- Epilepsy
- Mental Health Illnesses that are to be managed at PHC level.

# 3. Link with the PHC Re-engineering Framework

**THE PHC RE-ENGINEERING APPROACH CONSISTS OF THREE STREAMS, NAMELY:**

- A District Clinical Specialist Team (DCST)
- A ward based outreach team (WBOT) consisting of professional nurses, enrolled nurses and community health workers (CHWs) across the country
- An integrated school health programme (ISHP).

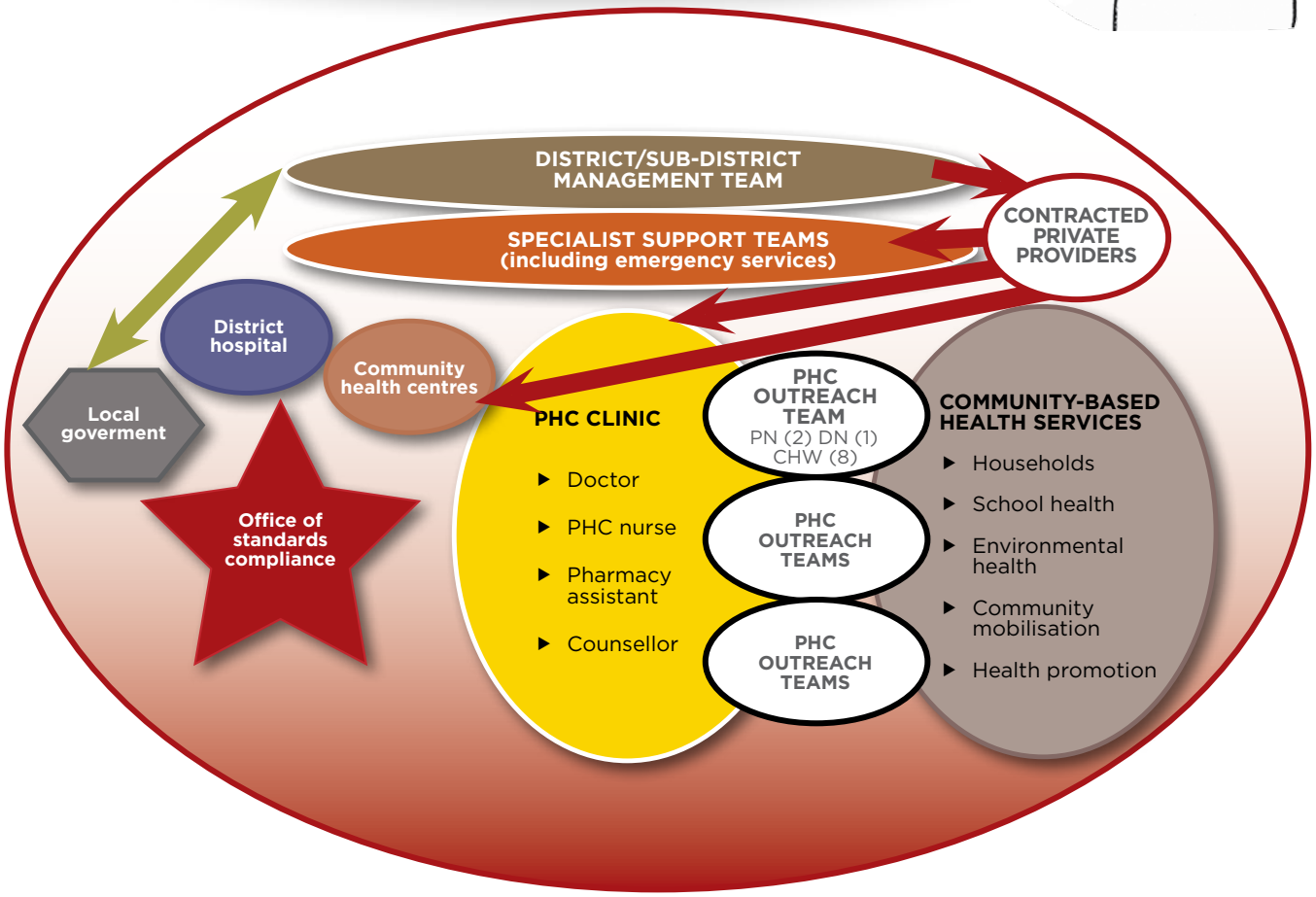



**FIGURE 5:** PHC RE-ENGINEERING FRAMEWORK BASED ON THE DISTRICT HEALTH MODEL

The ICDM model will integrate and work synergistically with all three spheres of the PHC Re-engineering framework in the following manner:

**WBOT**
Ward-based PHC outreach teams

- The WBOT will form an integral part in ensuring continuity of care by interacting directly with the community. The WBOT will furthermore conduct health education campaigns as well as primary prevention through screening of high-risk individuals at a population level.

**CHW**
Community health worker

- The CHWs will form the backbone of the "assisted" self-management component of the ICDM model by supporting at-risk households through regular visits to emphasise adherence, to do secondary health promotion, and to identify complications that require referral to a PHC facility.

**CHW**
Community health worker

- The vast majority of patients are poverty stricken and lack resources and the required education to conduct their own monitoring at home. This increases the patient load at the clinics. Therefore, the CHWs will also assist the patients by performing basic point of care testing, recording of these findings and explaining the implications of the results to the patient.

**DCST**
District clinical specialist team

- The District Clinical Specialist Team (DCST) will exercise oversight over the quality of care by mentoring and supervising the process of care provided and by undertaking clinical audits of the professional healthcare workers' services. The DCST will serve to strengthen the referral mechanism between PHC clinics and referral hospitals.

**ISHT**
Integrated school health team

- Integrated school health teams (ISHTs) will primarily conduct health education and awareness campaigns at school level and provide screening services to assist with the early detection of chronic diseases and the appropriate referral of these high-risk patients.

**DMT**
District management team

- The District Management Team (DMT) will perform an oversight and stewardship role in monitoring the implementation of the ICDM model and in addressing systemic challenges that impede the implementation process and service delivery as a whole.

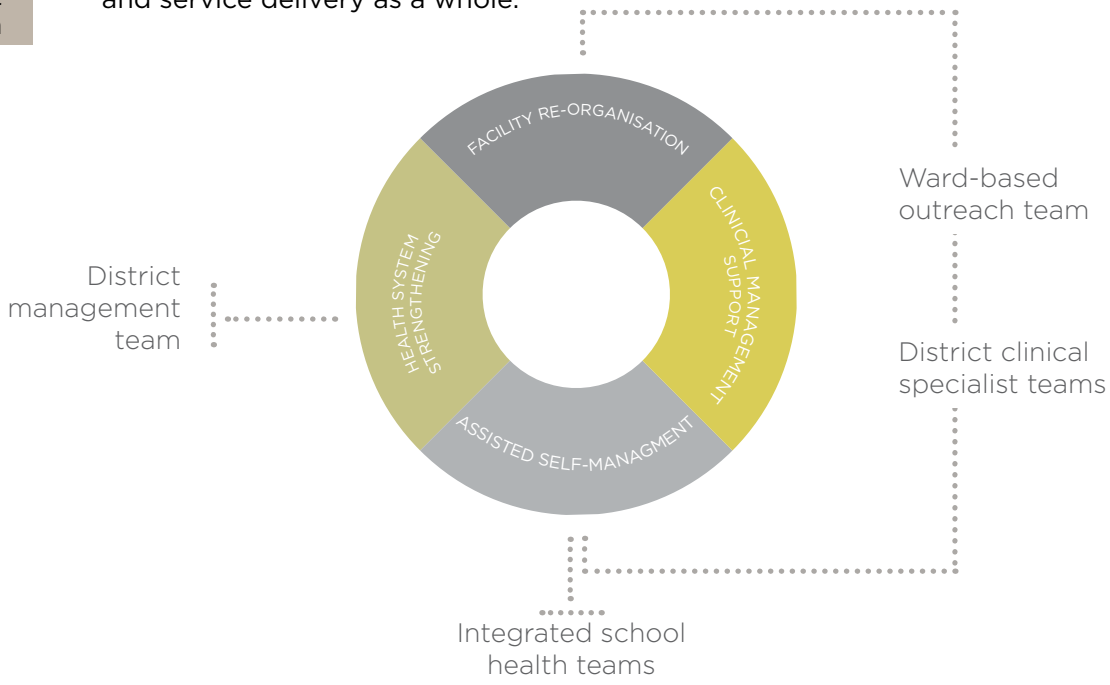



**FIGURE 6:** ICDM LINK WITH PHC RE-ENGINEERING FRAMEWORK

# 4. Key role players in the implementation of the ICDM model

The figure below sets out the roles of the various stakeholders that are an integral part of the implementation of the ICDM model.

## Provincial level

| | | | |
|---|---|---|---|
| Adoption of the ICDM model | Development of district engagement plan | Establishment of ICDM task team and active participation | Leadership and oversight |

## District level

| DISTRICT MANAGEMENT | DISTRICT PHARMACIST | DISTRICT CLINICAL SPECIALIST TEAM | REGIONAL TRAINING CENTRE | DISTRICT SUPPLY CHAIN |
|---|---|---|---|---|
| ↘ Adopt ICDM as a strategy for the improvement of the quality of care at PHC level<br>↘ Ensure that the district annual performance plan and district health budgets are aligned to cater for ICDM<br>↘ Monitor the implementation of ICDM during district meeting | ↘ Review stock levels at each facility<br>↘ Updating of minimum stock levels<br>↘ Ensure good pharmacy practice at facilities | ↘ Mentoring of professional nurses and doctors<br>↘ Clinical audits<br>↘ Primary point of referral for complicated cases | ↘ Development of PC 101 training plan<br>↘ Capacitation of facility trainers on PC 101<br>↘ Supporting of facility trainers to conduct mop up training | ↘ Procurement of equipment as per the essential equipment list for each facility<br>↘ Procurement of pre-dispensing bags and labels for patients |

## Sub-district/local area manager/PHC supervisor

| | | |
|---|---|---|
| Supporting the operational manager in implementing ICDM | Escalating systemic challenges that impede ICDM implementation to district | Progress monitoring and reporting of ICDM implementation on a quarterly basis |

**FIGURE 7:** KEY ROLE PLAYERS IN ICDM IMPLEMENTATION AND THEIR ROLES

## Facility level

### OPERATIONAL MANAGER

- Overall responsibility at facility level for implementing the all activities of ICDM
- Briefing and capacitation of the professional nurses and support staff at the facility on changes in delivery of service
- Engage with the community on changes through the clinic committee, ward councillors and traditional leaders

### ICDM CHAMPIONS

- In most instances will be the PC 101 facility trainer
- The go-to person who solves facility based ICDM challenges
- Provides updates on the project's development and issues upwards to management and downwards to staff
- Maintains a harmonious relationship between the project team and its stakeholders

### MEDICAL PRACTITIONERS

- Consultation of referred patients
- Mentoring of professional nurses
- Review of patients with multiple conditions at 6 month intervals

## Community level

### WARD BASED OUTREACH TEAM (WBOT)

- Serve as a link between the facility and the community
- Provide health education and promotion with respect to reducing the risk factors to chronic diseases as well as preventing complications
- Offer point of care screening for at risk clients during the home visits
- Serve as a medicine courier in certain circumstances
- Tracing of patients that have been lost to follow up and/or defaulted

### SUPPORT GROUPS

- Adherence clubs
- Social networks
- Education groups
- Provide moral support and platform for exchange of information for patients

### CLINIC HEALTH COMMITTEES

- Serve as liaison with the community

## Population Level

- **Integrated school health team –** Providing health education, screening and risk screening for adolescents
- **WBOT**- Health education and awareness campaigns
- Conduct joint screening campaigns

# 5. The approach

The following diagram depicts the approach in the implementation of the ICDM model.

**STEP 1: PREPAREDNESS AT PROVINCIAL, DISTRICT AND FACILITY LEVEL** 1

**STEP 2: BASELINE ASSESSMENT AND ANALYSIS** 2

**STEP 3: ICDM IMPLEMENTATION CONSISTS OF FOUR PHASES:** 3

- Phase 1 - facility re-organisation
- Phase 2 - clinical management support
- Phase 3 - "assisted" self-management through the down referral of patients to the WBOT
- Phase 4 - health system support and strengthening

**STEP 4: QUARTERLY MONITORING AND REVIEW OF PROGRESS.** 4

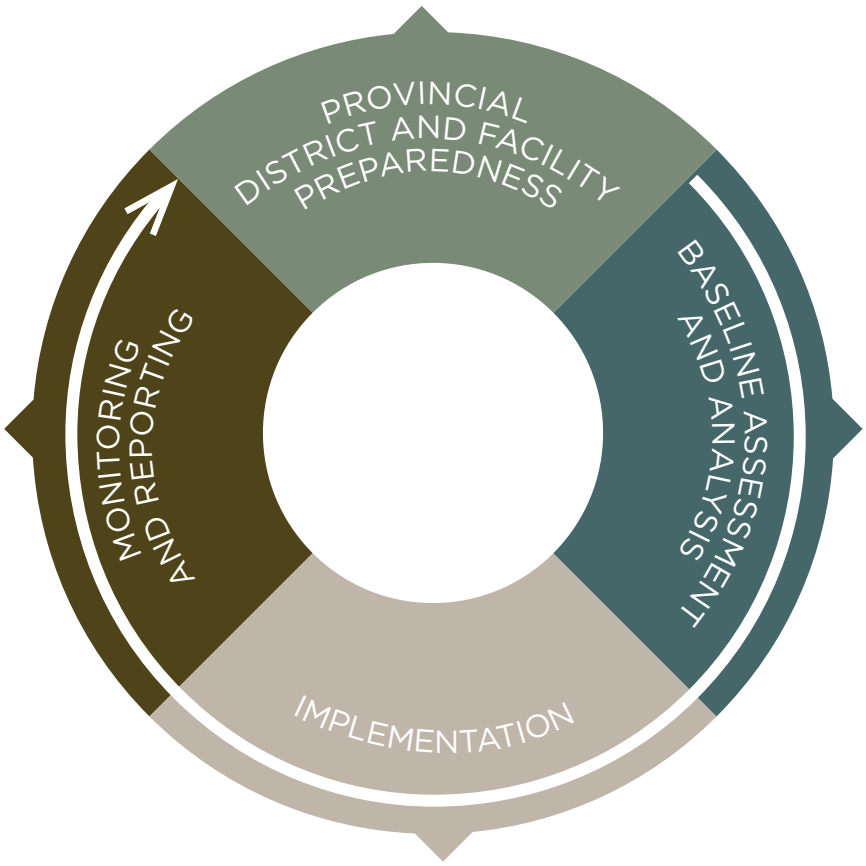



**FIGURE 8:** ICDM IMPLEMENTATION APPROACH

The table below provides an overview of the contents of the manual in each chapter and the key role players that the chapters are directed at.

## MANUAL CONTENTS AND ITS APPLICATION TO THE VARIOUS ICDM ROLE PLAYERS

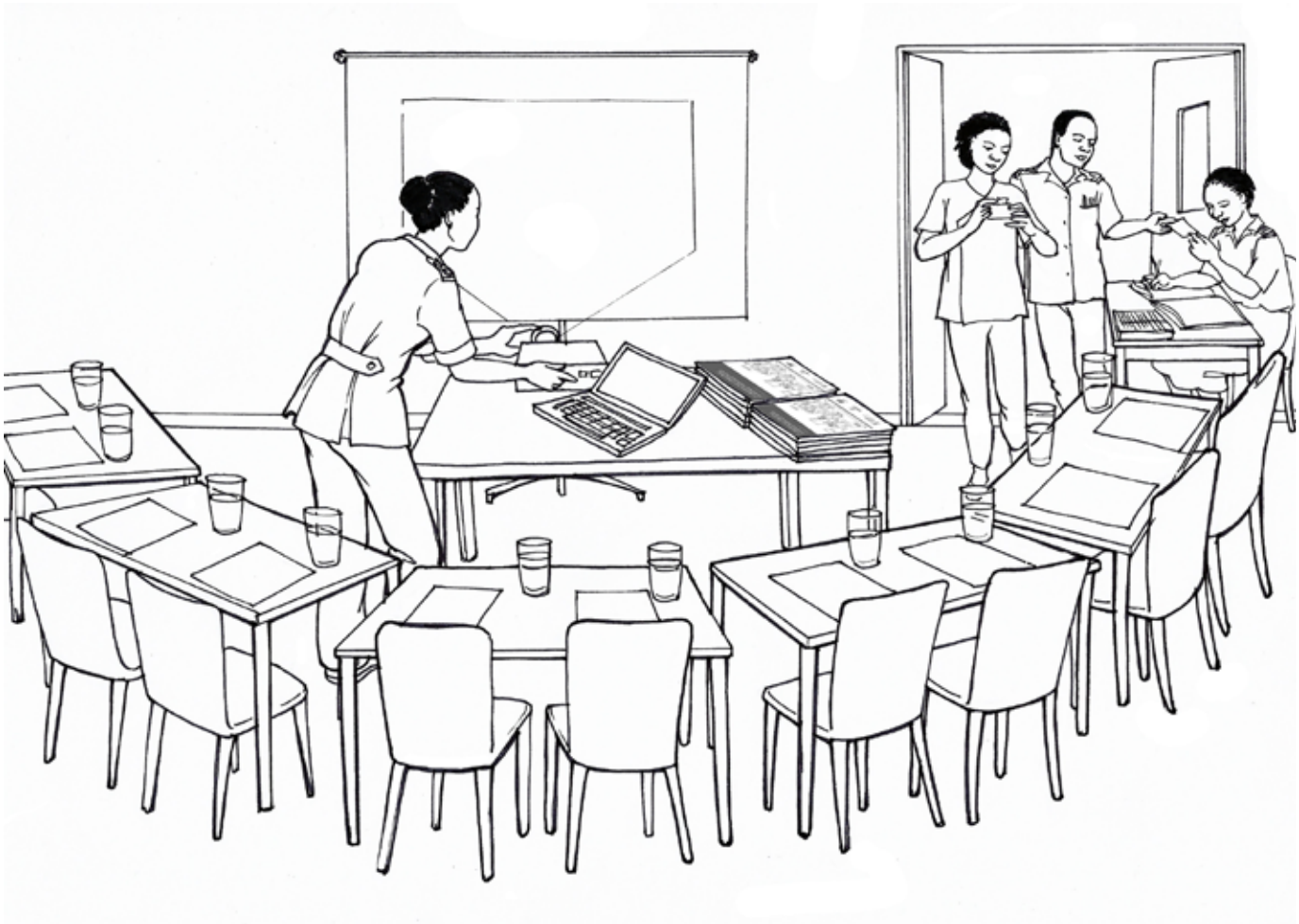
| SECTION OF THE MANUAL | DESCRIPTION OF CONTENT | ROLE PLAYERS |
|---|---|---|
| **SECTION 1: CONTEXT** | This section provides contextual background to the ICDM model and its steps for implementation | ↘ Provincial managers<br>↘ District managers<br>↘ DCST<br>↘ Local area managers<br>↘ Facility operational managers<br>↘ ICDM champions<br>↘ Regional Training Centre (RTC) managers |
| **SECTION 2: PRE-IMPLEMENTATION PREPAREDNESS** | This section details the activities to be conducted at provincial, district, facility and community Level in preparation for ICDM implementation | ↘ Provincial managers<br>↘ District managers<br>↘ DCST<br>↘ Local area managers<br>↘ Facility operational managers |
| **SECTION 3: BASELINE ASSESSMENT AND ANALYSIS** | This section provides details of the data required and the procedure to conduct a baseline analysis so that the information required for implementing ICDM activities are available | ↘ Local area managers<br>↘ Facility operational managers<br>↘ ICDM champions |
| **SECTION 4: HEALTH SERVICE RE-ORGANISATION** | This section provides a step-by-step guide to the various activities required for re-organising the facility | ↘ District task team members<br>↘ Local area managers<br>↘ Facility operational managers<br>↘ ICDM champions<br>↘ WBOT |

| SECTION OF THE MANUAL | DESCRIPTION OF CONTENT | ROLE PLAYERS |
|---|---|---|
| **SECTION 5: CLINICAL MANAGEMENT SUPPORT** | This section provides an overview of the chronic patient follow up record, as well as the Primary Care (PC) 101 training | ↘ DCST<br>↘ Local area managers<br>↘ Facility operational managers<br>↘ ICDM champions<br>↘ Quality assurance manager<br>↘ Regional training centre managers |
| **SECTION 6: "ASSISTED" SELF-MANAGEMENT AND POPULATION LEVEL AWARENESS** | This section describes the procedures to be followed in down referring a stable chronic patient to the PHC WBOT and the awareness and education at population level | ↘ District task team members<br>↘ Local area managers<br>↘ Facility operational managers<br>↘ ICDM champions<br>↘ WBOT |
| **SECTION 7: HEALTH SYSTEM STRENGTHENING AND SUPPORT** | This section describes the important health system strengthening components that are critical for the implementation of the ICDM model | ↘ Provincial managers<br>↘ District managers, including supply chain and pharmaceuticals<br>↘ Local area managers<br>↘ Operational managers<br>↘ Quality Assurance (QA) managers<br>↘ RTC managers / trainers |
| **SECTION 8: MONITORING AND REPORTING** | This section provides a tool for the PHC supervisors to monitor and report on the progress and challenges in implementing ICDM.<br><br>It also contains a section for District managers and Provincial managers to monitor and report on the overall implementation of the ICDM model. | ↘ Local area managers<br>↘ Provincial managers<br>↘ District managers |

Section Two

02

# PRE-IMPLEMENTATION PREPAREDNESS



Leadership, ownership and accountability are three essential ingredients for the success of any programme. The success of the ICDM model is highly dependent on active participation and ownership of the process by the provincial Departments of Health, the district management team, the facility and the community. This chapter discusses the preliminary steps that are required at provincial, district and facility level prior to implementing the ICDM model.

This section of the manual provides the process and tools for engaging with the relevant stakeholders.

These steps have been designed to assist managers in the implementation of the ICDM model and to ensure ownership and sustainability of ICDM.

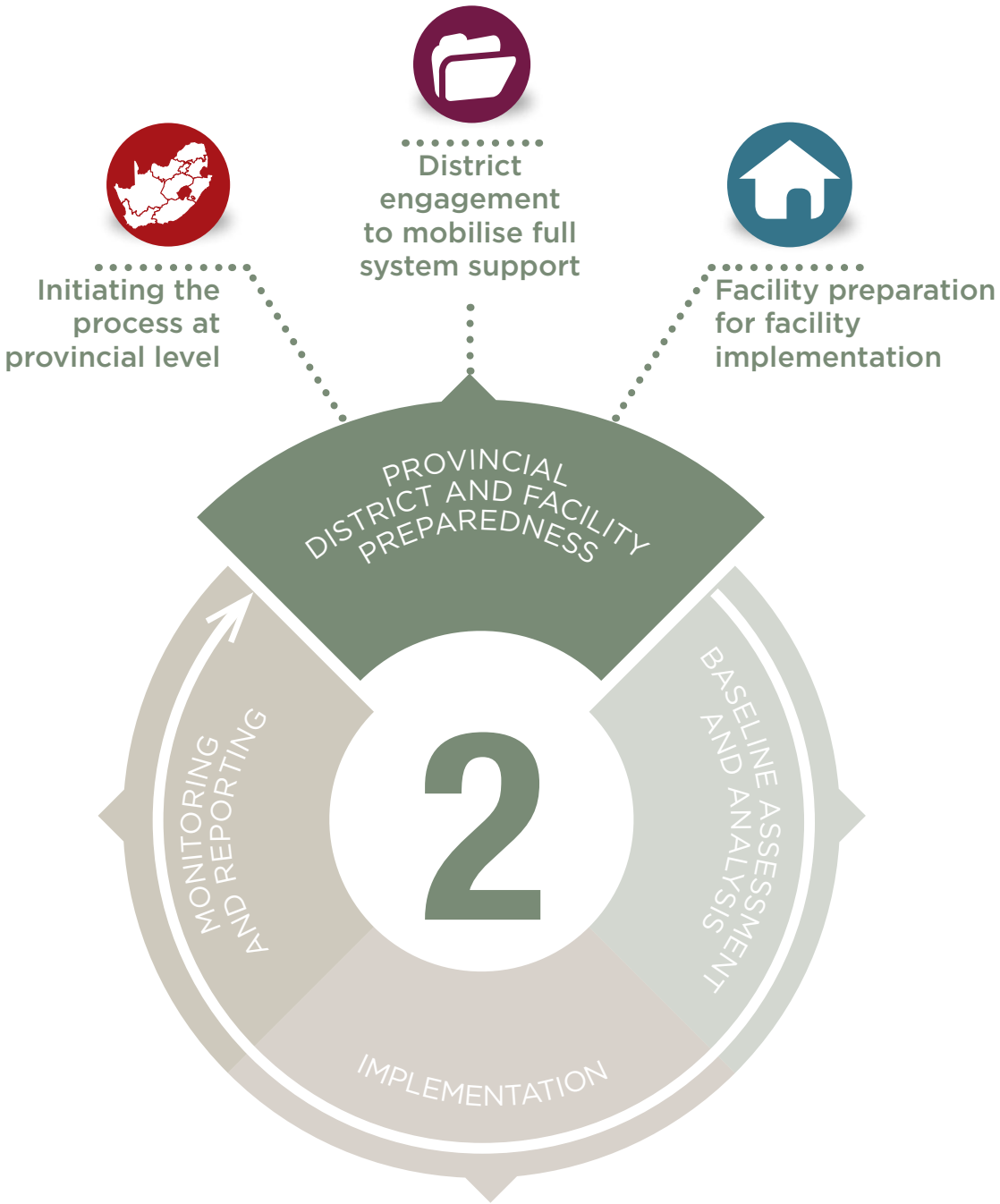



**FIGURE 9:** ICDM IMPLEMENTATION APPROACH

## THIS SECTION OF THE MANUAL COVERS THE FOLLOWING:

- Initiating the process at provincial level
- District engagement to mobilise full system support
- Facility preparation for facility implementation.

**PROVINCIAL LEVEL**

Initiation of process at provincial level

- ESTABLISHMENT OF PROVINCIAL ICDM TASK TEAM
- IDENTIFICATION OF DISTRICTS THAT WILL COMMENCE WITH ICDM
- DISTRICT ENGAGEMENT PLAN

**DISTRICT LEVEL**

District ICDM engagement

- ESTABLISHMENT OF DISTRICT ICDM TEAM
- DEVELOPMENT OF DISTRICT IMPLEMENTATION PLAN
- DEVELOPMENT OF A FACILITY ENGAGEMENT PLAN WITH CLEAR ROLES AND RESPONSIBILITIES

**FACILITY LEVEL**

Facility preparation

- BRIEFING OF OPERATIONAL MANAGERS ABOUT THE ICDM
- TO DETAIL THE ICDM IMPLEMENTATION STEPS
- TO INFORM THE OPERATIONAL MANAGERS ABOUT THE REQUIREMENTS FOR THE NEXT MEETING
- TO DEFINE THE CHARACTERISTICS AND THE ROLE OF THE ICDM CHAMPION

**FIGURE 10:** PREPAREDNESS FOR ICDM

# 1. Initiating the process at a provincial level

- The ICDM model should be initiated by the provincial senior management team and should be led by the District Health Services (DHS) directorate in conjunction with the HIV and AIDS and NCD directorates
- The provincial senior management team should invite the relevant provincial directorates to form part of the ICDM Task Team (refer to Figure 11).

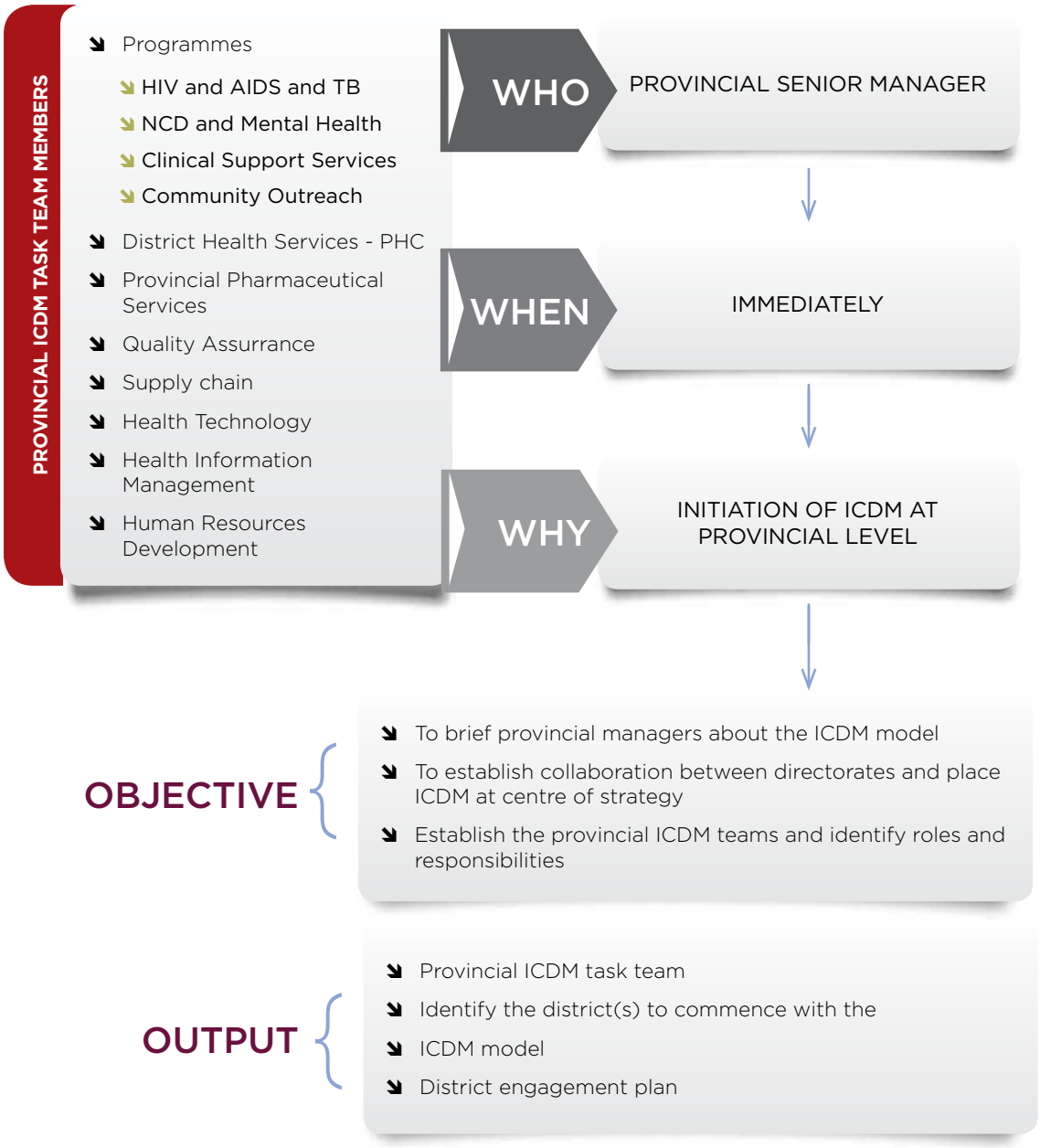



**FIGURE 11:** PROVINCIAL ICDM INITIATION

The three steps in the provincial initiation process are depicted below (Figure 12) and described in detail in the text that follows.

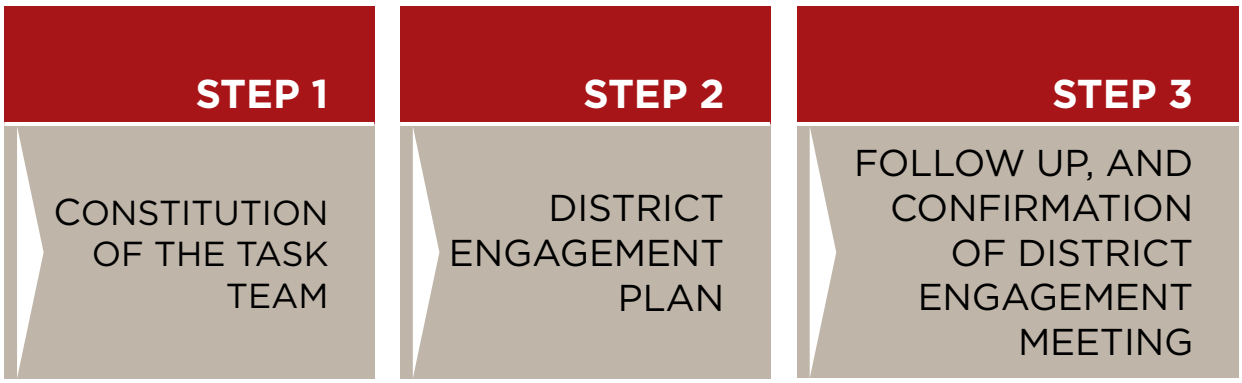



**FIGURE 12:** THREE STEPS FOR INITIATING ICDM AT PROVINCIAL LEVEL

### Role of the provincial ICDM task team

- Responsible for oversight and leadership in the implementation of the ICDM in the province
- Development of the district engagement plans
- Key members of the district ICDM teams
- Assist districts in escalating systemic challenges for attention at the provincial office.

## STEP 1: CONSTITUTION OF THE TASK TEAM

1

A provincial ICDM task team should be constituted to provide oversight and leadership in the implementation of the ICDM model across the districts.

- The provincial task team members should be formally appointed through a letter from the head of department (HoD), and the implementation of the ICDM model should form part of their performance management development system (PMDS).
- A senior manager should be delegated to oversee the implementation of ICDM across all districts in the province.
- The senior manager should be held accountable for facilitation of the process and be responsible for reporting to the senior management team.
- The senior manager or designated task team leader should brief the provincial task team on the ICDM model and their roles and responsibilities.
- Members should familiarise themselves with the implementation steps of ICDM and their roles as champions of the process.

## STEP 2: DEVELOPING AN ICDM ENGAGEMENT PLAN

2

- Provincial task team leader and members should brief all their respective directorates about the ICDM model during their internal directorate meetings.
- A district ICDM engagement plan should be formulated with clearly demarcated roles and responsibilities.
- The designated provincial ICDM task team leader should engage with the districts to identify the readiness and willingness of each district to initiate the process. This could be based on information obtained from the health programme managers regarding the performance of the districts in terms of patient load and patient outcomes (either best performing or worst performing).
- Depending on available capacity, the province may decide to roll out the programme across the entire province simultaneously or identify a single district to initiate the process and a phased roll out across the entire province.

## STEP 3: FOLLOW UP AND CONFIRMATION OF DISTRICT ENGAGEMENT MEETING

3

- Provincial task team leader should follow up with the District Manager to ensure that the district has received and timeously carried out all the steps identified in the memo.
- Confirmation of the meeting should be obtained electronically in writing.

TOOL 1

## Template for district engagement plan

| ACTIVITY | TIMEFRAME | RESPONSIBLE PERSON |
|---|---|---|
| Review of overall district performance data for NCDs and HIV | | |
| Determine the district that will commence with ICDM | | |
| Contact the district to arrange an information and briefing session | | |
| Send a memo (Tool 2) to the district with an agenda and a list of the personnel who are required to attend the initiation meeting | | |
| Follow up and confirmation of the district initiation meeting | | |
| Send out the meeting agenda (Tool 3) | | |
| Prepare the presentations for the meeting using the information provided plus the information boxes (Tool 4) | | |

TOOL 2

## Memo for district engagement

The provincial Department of Health will be strengthening the management of chronic diseases (NCDs and HIV) through the Integrated Chronic Disease Management (ICDM) Model. Your district *(insert name here)* has been selected for the implementation according to the provincial implementation plan.

1. In order to initiate the process, the Provincial ICDM task team would like to convene a meeting on the (*proposed date*) in your district
2. The meeting should be scheduled for approximately *4 hours*
3. It would be highly appreciated if the following key role players are in attendance:
    a. District manager
    b. District procurement and supply chain manager
    c. District PHC manager
    d. District human resource manager
    e. District regional training centre manager
    f. District NCD and mental health coordinator(s)
    g. District HIV and AIDS and TB manager
    h. District pharmaceutical manager(s)
    i. District health information manager
    j. District quality assurance manager
    k. All sub-district local area managers/PHC supervisors
4. Please arrange a suitable venue that caters for 25-30 people.

Your participation and co-operation will be highly appreciated.

Thanking you

Yours faithfully

ICDM provincial task team leader

TOOL 3

## Agenda for the district engagement meeting

### Meeting for district facilitationof ICDM implementation

**Date/Time:**

**Location**:

**Objectives:**

Initiation of the ICDM for the district health management team through a meeting with designated provincial managers.

**Agenda:**

| TIME | DESCRIPTION |
|---|---|
| | 1. Welcome and introduction<br>2. Purpose of the meeting<br>a Briefing on the ICDM<br>b District initiation process<br>c Nomination and appointment of district managers to serve as district task team members<br>d The identification of facilities that will initiate the ICDM (if phased approach used)<br>3. Briefing on the ICDM<br>a. What is the ICDM?<br>b. ICDM implementation steps<br>Discussion and feedback from district managers<br>4. District initiation process<br>a. Roles and responsibilities of the district ICDM team<br>b. Nomination of members to the district ICDM team<br>c. Nomination of District ICDM coordinator<br>d. Identification of the initiation facilities (1st phase) and subsequent facility scale up<br>e. Date for facility initiation<br>f. Responsibility for sending out invitations to facilities (who and when) and arranging logistics for venue and transport<br>g. Discussion and feedback from district managers<br>5. Responsibility for development of district implementation plan |

TOOL 4

## Presentation at district engagement meeting

### INFORMATION BOX 1: PRESENTATION GUIDE

- To present an overview of the ICDM, use the information provided
- PowerPoint slides available in tools section of the manual.

### INFORMATION BOX 2: THE ROLE OF THE DISTRICT TASK TEAM

- Championing of the project
- Interacting with key officials in the service delivery chain
- Conducting the situational analysis visits
- Working with the operational managers in developing quality improvement plans
- Adopting a facility and providing monitoring and supportive supervision
- Report back and attendance at task team meetings

### INFORMATION BOX 3: IDENTIFICATION OF FACILITIES/SUB-DISTRICTS TO COMMENCE WITH ICDM

- The number of facilities that will commence with the ICDM activities is dependent on the district's capacity and health system challenges
- Ideally, the plan will to be to initiate the programme in one sub-district or local area followed by saturation across all sub-districts
- A catchment area that has a community healthcare centre (CHC) and five referring PHC clinics should be selected for each sub-district or local area, and these facilities will act as the initiation sites.

### THE DISTRICT TASK TEAM MEMBERS

- District PHC manager
- District NCD and mental health coordinator
- District HIV and AIDS and TB manager
- District pharmaceutical managers
- District quality assurance manager
- Sub-district local area managers
- Operational managers/project managers from selected facilities

# 2. District engagement

This section of the manual focuses on district preparation for ICDM implementation.

**FIGURE 13:** PREPAREDNESS FOR ICDM IMPLEMENTATION

The district ICDM task team coordinator should convene a meeting of the district task team within 14 days of the provincial meeting.

The aim of this meeting is to develop a district implementation plan and a facility engagement plan with clear roles and responsibilities.

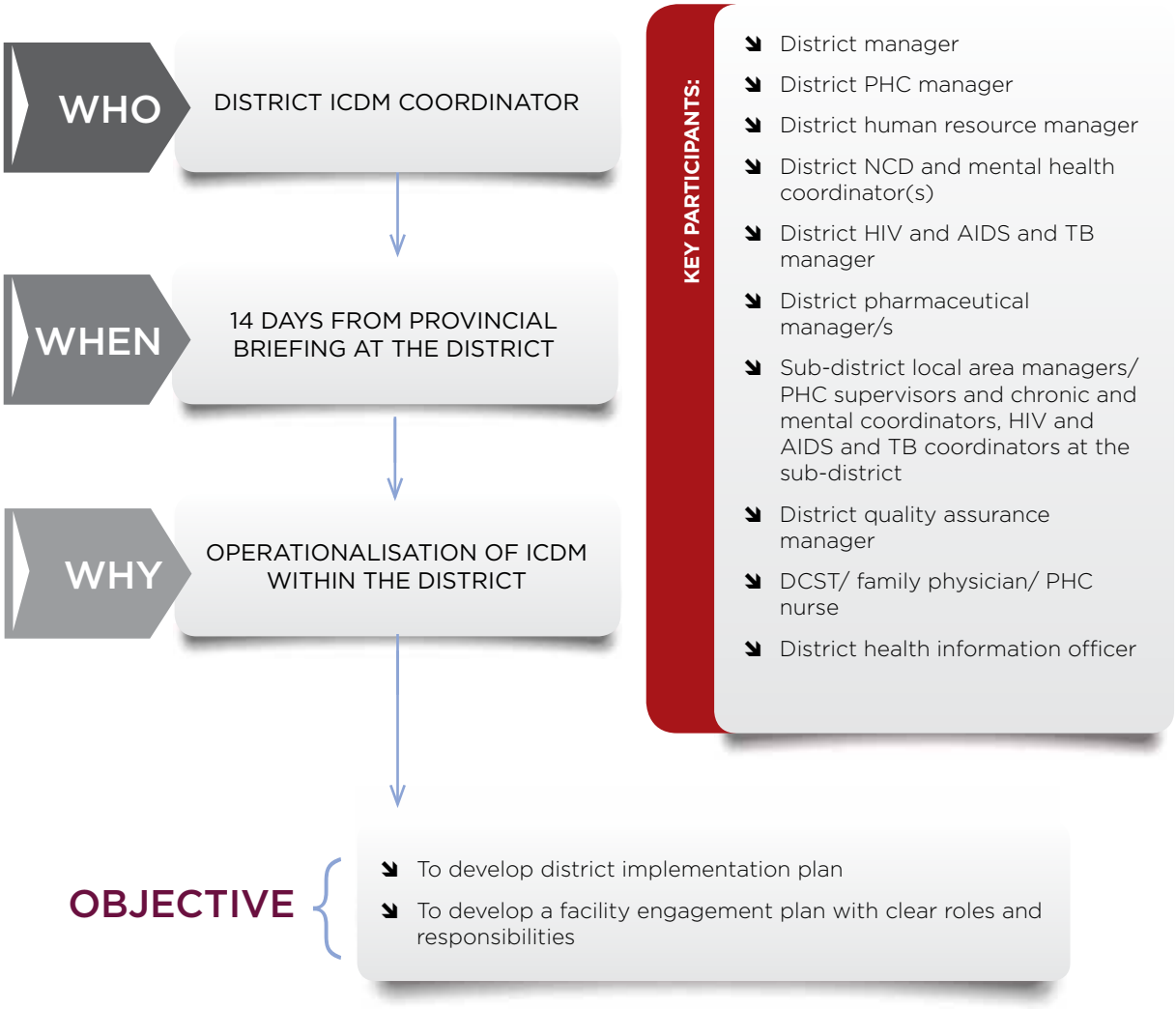



**FIGURE 14:** ICDM OPERATIONALISATION AT DISTRICT LEVEL

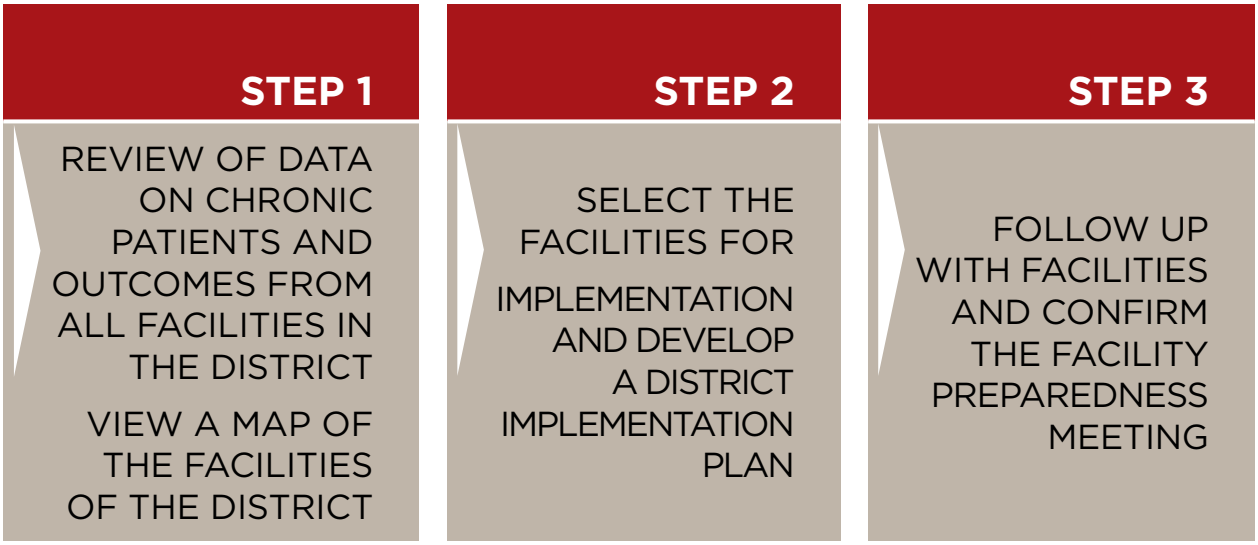



**FIGURE 15:** DISTRICT ENGAGEMENT ACTIVITIES

## 1 STEP 1: REVIEW THE CHRONIC PATIENT DATA FROM ALL FACILITIES

- The district health information manager should produce a print out of the following data for the preceding quarter :
  - Total PHC headcount
  - Total PHC headcount for patients > 5 years
  - Number of HIV patients on ART
  - Total number of NCD patients followed up
- This data should then be graphically displayed during the meeting for each facility in the district
- The district task team should view a map of all the facilities in the district and correlate the information with the facilities.

## 2 STEP 2: SELECTION OF THE FACILITIES TO IMPLEMENT THE ICDM MODEL

- Depending on available capacity, the district may decide to roll out the programme across the entire district simultaneously or identify local areas to initiate the process followed by a phased roll out across the entire district.
- Ideally, the plan will to be to initiate the programme in one sub-district or local area followed by saturation across all sub-districts.
- A catchment area that has a community healthcare centre (CHC) and five referring PHC clinics should ideally be selected for each sub-district or local area, and these will act as the initiation sites.
- A district implementation plan should be developed (Tool 6).

TOOL 5

## District ICDM implementation plan

| ICDM IMPLEMENTATION PLAN ACROSS THE DISTRICT | | | | |
|---|---|---|---|---|
| Total number of public health facilities in the district (CHC +PHC) | | Modify to be per sub-district | | |
| Number of sub-districts (local areas) | | | | |
| Number of district hospitals | | | | |
| Number of community health centres | | | | |
| Number of primary health care clinics | | | | |
| **PHASE 1** | **PHASE 2** | **PHASE 3** | **PHASE 4** | **PHASE 5** |
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# 3. Facility preparation

This section of the manual focuses on the facility preparation for ICDM implementation.

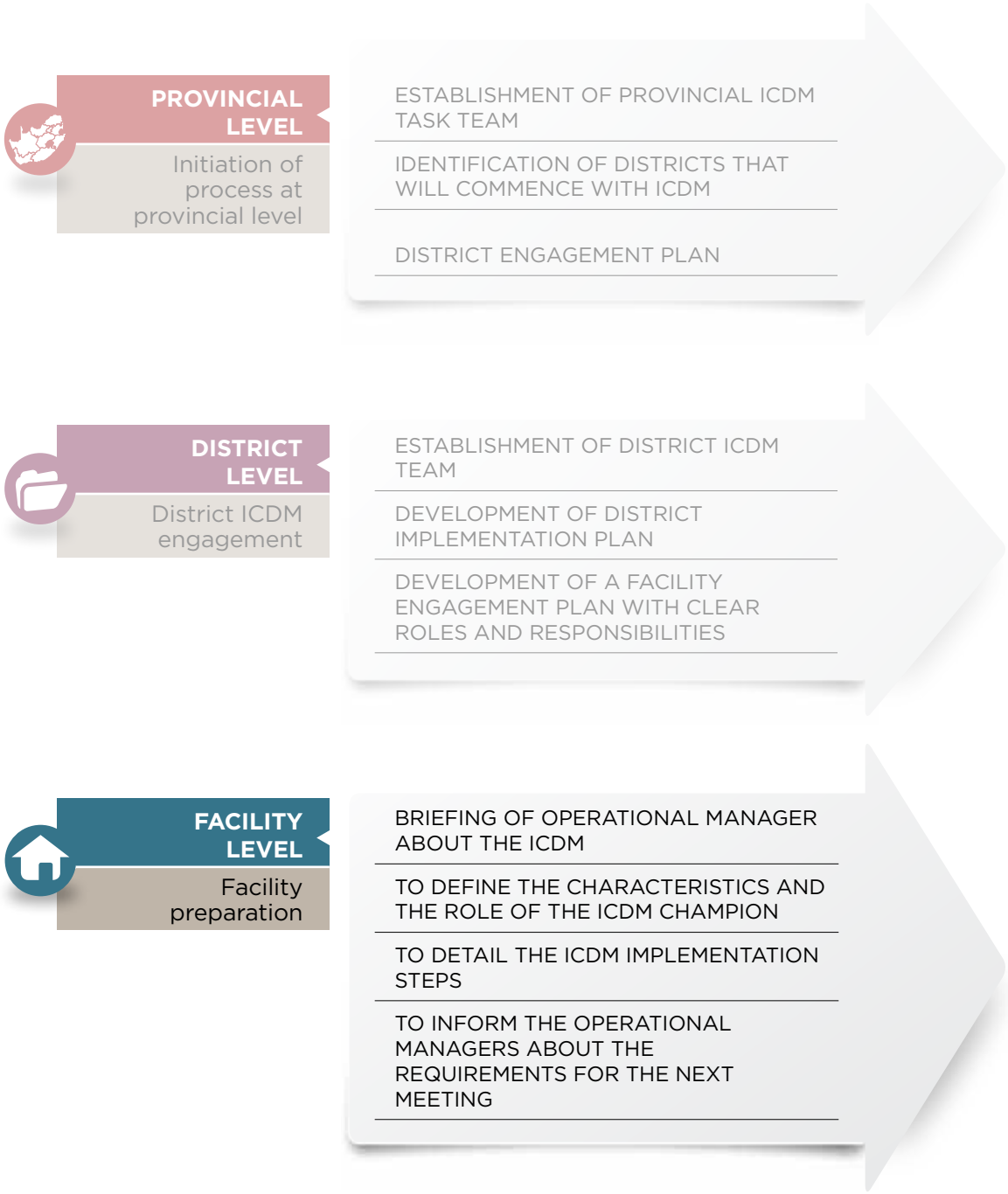



**FIGURE 16:** PREPAREDNESS FOR ICDM IMPLEMENTATION

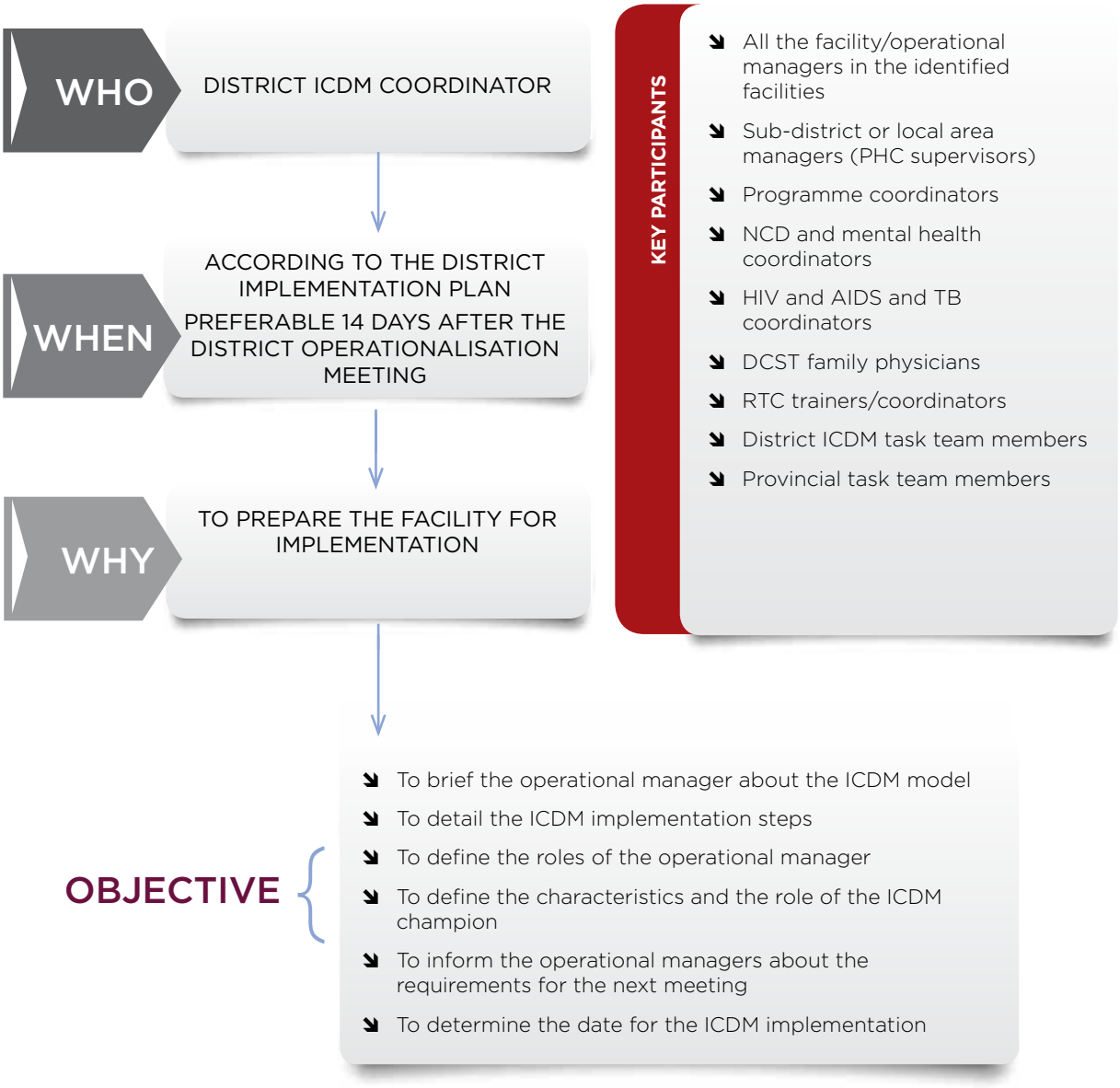



**FIGURE 17:** ICDM FACILITY INITIATION

**FIGURE 18:** FACILITY INITIATION ACTIVITIES

## 1 STEP 1: CONVENE THE FACILITY ICDM INITIATION MEETING

- The district ICDM task team leader should convene a meeting of the facilities identified for ICDM initiation at that point and time within 14 days of the district initiation.
- Complete Tool 6: Facility engagement plan.
- Key participants:
  - All the facility/operational managers
  - Comprehensive care, treatment and management (CCMT) project managers (where applicable)
  - Sub-district or local area managers (PHC supervisors)
  - Programme coordinators:
    - NCD and mental health coordinators
    - HIV and AIDS and TB coordinators
  - DCST family physicians
  - Training coordinators
  - District ICDM task team members
  - Provincial task team members.
- Send out the memo and agenda.

## 2 STEP 2: ENSURE THE LOGISTICAL ARRANGEMENTS ARE IN PLACE

- A suitable venue either at the district office or sub-district office that caters for the number of participants should be booked in advance.
- The agenda and the briefing document for operational/facility managers should be printed for each participant.
- An attendance register should be maintained.
- All logistical arrangements such as transport should be made well in advance for operational and project managers from the facility.
- Ensure that there is sufficient staff available at the facility to cover for staff attending meeting.

## STEP 3: FOLLOW UP AND CONFIRMATION OF FACILITY PREPARATION MEETING 3

- District task team leader should follow up with the local area managers to ensure that the facilities have received the memo timeously and all logistical arrangements are in place for the facility teams to attend.
- Update the facility engagement plan.

TOOL 6

### Facility engagement plan

| ACTIVITY | TIMEFRAME | RESPONSIBLE PERSON | PROGRESS |
|---|---|---|---|
| Contact the sub-district and facilities to arrange an information and briefing session | | | |
| Send a memo (Tool 2) to the sub-district and facilities with an agenda and a list of personnel that are required to attend the initiation meeting | | | |
| Follow up and confirmation of the initiation meeting | | | |
| Send out the meeting agenda (Tool 3) | | | |
| Prepare the presentations for the meeting using the information provided (Tool 4) | | | |
| Ensure that transport arrangements are made and that staff at the clinic are able to stand in for those who are away | | | |
| Contact the community representatives and arrange a meeting | | | |

TOOL 7

## Memo for facility ICDM initiation meeting

The provincial Department of Health in collaboration with the District will be strengthening the management of chronic diseases (NCDs and HIV) through the Integrated Chronic Disease Management (ICDM) Model. Your facility *(insert name here)* has been selected for the implementation according to the provincial implementation plan.

1. In order to initiate the process, the provincial ICDM task team and district management would like to convene a meeting on the (*proposed date*)
2. The meeting should be scheduled for approximately *4 hours*
3. We will appreciate it if the following key role players are in attendance:
    a. All the facility/operational managers
    b. CCMT project managers (where applicable)
    c. Sub-district or local area managers (PHC supervisors)
    d. Programme coordinators
    e. NCD and mental health coordinators
    f. HIV and AIDS and TB coordinators
    g. DCST
    h. Family physicians
    i. Training coordinators
    j. District ICDM task team members
    k. Provincial task team members
4. The venue for the meeting will be at (*Insert details here*)
5. Transport arrangements are as follows:

Your participation and co-operation will be highly appreciated.

Thanking you

Yours faithfully

District manager

TOOL 8

## Agenda for facility ICDM preparedness meeting

### Meeting for District Facilitationof ICDM Implementation

**Date:**

**Venue:**

**Time: 09h30-12h30**

**Objective:**

Initiation of the ICDM for the district task team and facility managers

**Agenda items:**

1. Welcome and introduction
2. Purpose of the meeting
3. What is the ICDM?
4. Key steps in implementation process
5. Responsibility of the operational manager
6. Identification of facility ICDM champions
7. Informing stakeholders
8. Date for orientation meeting
9. Data required for next meeting
10. Date for ICDM
11. Closure

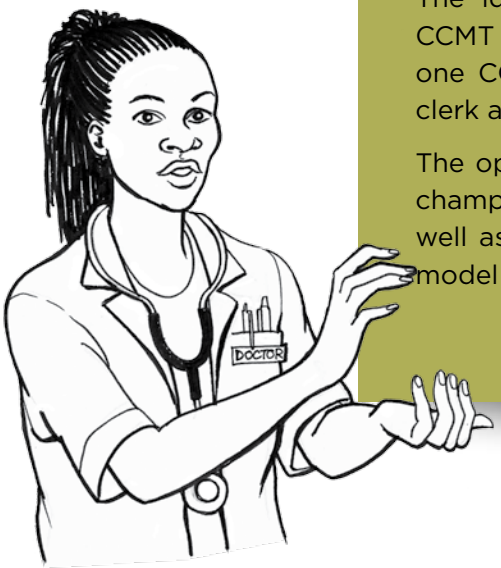
## RESPONSIBILITIES OF OPERATIONAL (FACILITY) MANAGER

The operational (facility) manager is a part of the district implementation team and the facility leader for the ICDM and has the following responsibilities:

- Convening a staff meeting at the facility with all category of personnel including the medical practitioners, professional nurses, enrolled nurses, enrolled nursing assistants, data capturer, administrative clerks, pharmaceutical assistants, general assistants, security guards, lay counsellors and any other additional category of staff
- Briefing the staff on the ICDM and its benefits (see the information boxes in Tool 10)
- Briefing the staff on the implementation steps and the requirement for each staff member to participate when called upon
- Establishing a facility ICDM team that will be responsible for implementation of the activities within the facility
- Identify an ICDM champion for the facility

The ideal facility team will include: operational manager, CCMT project manager, one PHC trained professional nurse, one CCMT nurse, pharmacy assistant, data capturer/admin clerk and medical practitioner if available at the facility

The operational manager together with the identified ICDM champion will need to engage with the clinic committee as well as community leaders to inform them about the ICDM model and its impact on the patients.



TOOL 9

## Presentation at ICDM facility initiation meeting

### PRESENTATION GUIDE

- To present an overview of the ICDM, use the information provided
- PowerPoint slides available in tools section of the manual

### PURPOSE OF THE FACILITY ICDM INITIATION MEETING:

- To brief the operational managers about the ICDM
- To clarify the roles of the operational managers
- To define the characteristics of the ICDM champion
- To set timeframes for ICDM implementation activities

### IDENTIFYING AN ICDM CHAMPION

- The ICDM champion is someone who will advocate for ICDM at all times, and who will always act as if the project is "his/her baby"
- The ICDM champion should be an individual of considerable importance in the clinic and should be diplomatic, have good communication skills, and should be the "proactive type" (meaning he should ask about the status of the project rather than be told about the status of the project).

### ROLES AND RESPONSIBILITIES OF THE ICDM CHAMPION

- Coordinator and mentor for ICDM
- Ensures stakeholder satisfaction and engagement from conception to completion
- Addresses the various obstacles with respect to ICDM
- Makes decisions or plans the steps that will make the project move forward.
- Constantly raises the project's profile, be a fierce supporter and praise its benefits to the stakeholders.
- Liaison between the facility and the district management team and external stakeholders
- Maintains a harmonious relationship between the ICDM team and its stakeholders
- Provides suggestions for solutions to the stakeholders who will then pick the best option
- Facility trainer for PC 101, if possible
- Communicates dates on the project's development and issues to upper management
- Communicates messages from the stakeholders to the facility ICDM team in case they have any concerns, requests in a change of direction or simply questions about the project's status and progress

Read more: *The Responsibilities of a Project Champion*
eHow.com http://www.ehow.com/info_8470180_responsibilities-project-champion.html#ixzz27THxoWWk

TOOL 10

## INFORMING STAKEHOLDERS

*THIS PROCESS SHOULD COMMENCE 4-6 WEEKS PRIOR TO THE COMMENCEMENT DATE*

Immediately after the briefing of the facility manager should convene a meeting with:

- All the staff at the clinic - doctors, nurses, pharmacy assistants, administrative clerks, data capturers, counsellors, general assistants, security guards and any other
- Clinic committee, local chiefs and traditional healers
- Patients - the facility manager and/or ICDM champion should address the patients daily as a collective after the morning prayers and inform them of the impending changes

The professional nurses should inform patients individually after their consultations about the impending changes

The health promoters should also brief the patients about the impending changes during their health promotion sessions conducted at various stages during the day

PHC re-engineering is the selected mechanism for overhauling the health system and improving patient outcomes. At the same time a renewed focus has been placed on improved management for patients with long-term conditions.

## SERVICE DELIVERY RE-DESIGN

Chronic patients will be seen according to an appointment system schedule

- Chronic patients' files will be retrieved prior to the appointment
- The waiting area will be separated
- A separate vital sign station will be provided for chronic patients
- Designated consulting rooms will be allocated for chronic patients
- Medication will be pre-dispensed
- Stable chronic patients will be dispensed with medication for 2-3 months depending on stock levels
- When the PHC WBOT is available for your area, the team will visit the patient monthly to assist with monitoring, health promotion and delivery of medication
- At six-monthly intervals the patient will receive a comprehensive medical examination and investigations as per the protocol of management

## WHAT WILL WE BE DOING TO IMPROVE PATIENT CARE AND MANAGEMENT?

- **Integration of care:** All chronic patients (requiring long-term medication) irrespective of whether communicable or non- communicable diseases will be consulted together.

TOOL 11

## Template for planning facility ICDM preparedness

| OBJECTIVE | ACTIVITY | TIMEFRAME | RESPONSIBLE PERSON |
|---|---|---|---|
| To initiate ICDM in your facility | Invite all personnel for a briefing session | | |
| To facilitate a briefing session with staff | Orientation and briefing of staff | | |
| To sketch the floor plan for the facility | Drawing of the facility floor plan | | |
| To conduct a process flow analysis | Conducting a patient flow analysis through the facility | | |
| To obtain the data from the facility information officer<br><br>Waiting time<br><br>HR | Print out of data from District Health Information System (DHIS) and PERSAL | | |
| To use the selection criteria provided to identify a facility champion | Identification of facility champion | | |
| To engage with programme co-ordinators and PHC supervisors | Engagement with programme coordinators and PHC supervisors | | |
| To brief the community leaders and the clinic health committee to obtain their buy-in for ICDM | Briefing the community via the clinic health committees and community leaders | | |

# 4. Facility ICDM implementation training

This section of the manual provides an overview of the Facility ICDM implementation training. The details of each of the steps are provided in the sections that follow.

**FIGURE 19:** PREPAREDNESS FOR ICDM IMPLEMENTATION

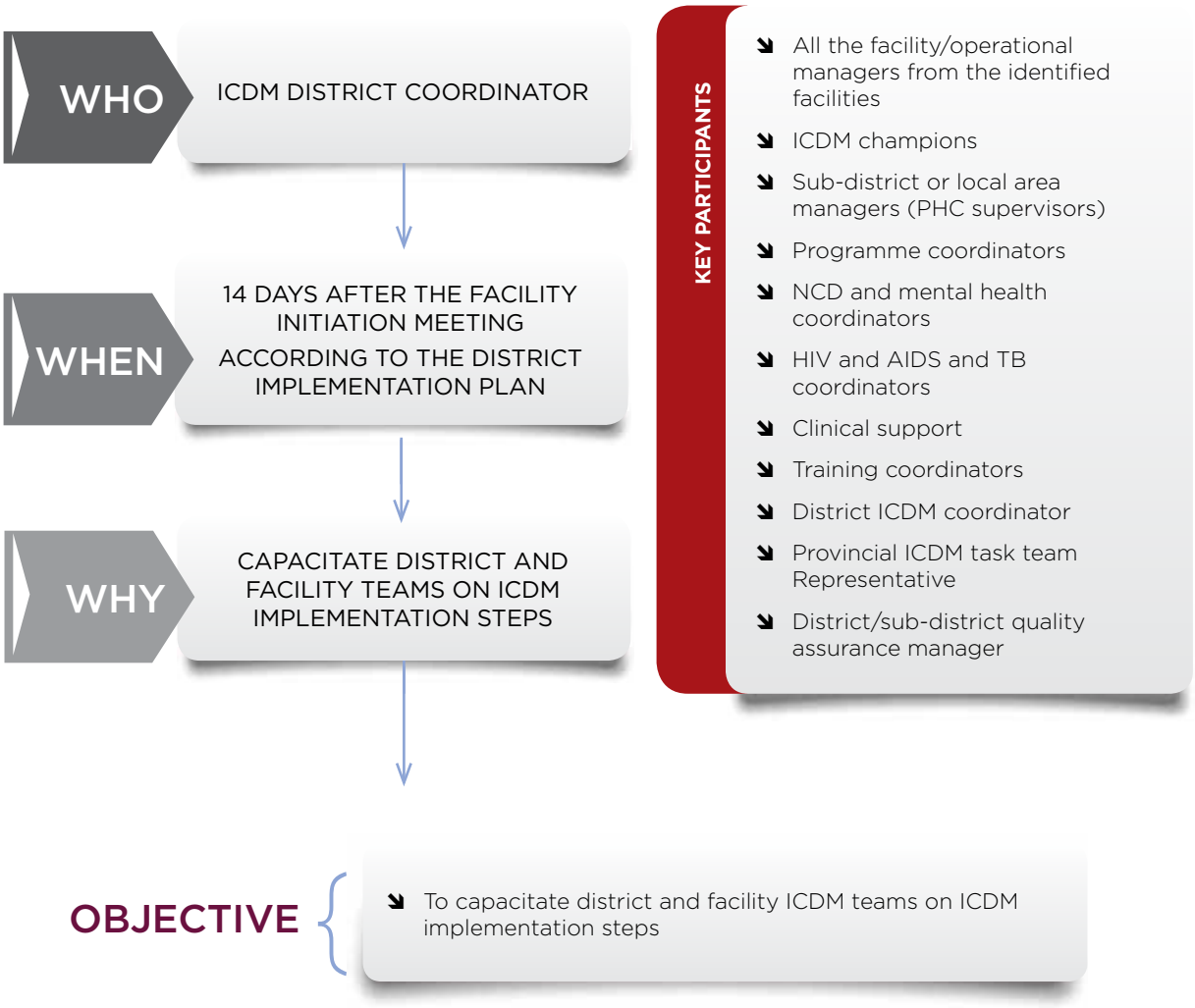



**FIGURE 20:** FACILITY ICDM IMPLEMENTATION TRAINING

**FIGURE 21:** FACILITY IMPLEMENTATION TRAINING ACTIVITIES

## 1 STEP 1: CONVENE THE DISTRICT AND FACILITY ICDM IMPLEMENTATION TRAINING WORKSHOP

- The district ICDM task team leader should convene a meeting of the facilities identified for ICDM initiation at that point and time on the date identified during the district initiation meeting.
- The training workshop should be scheduled for an entire day.
- The following key stakeholders should be invited to attend:
  - All the facility/operational managers
  - ICDM champions
  - Sub-district or local area managers (PHC supervisors)
  - Programme coordinators
  - NCD and mental health coordinators
  - HIV and AIDS and TB coordinators
  - DCST
  - Training coordinators
  - District ICDM task team members
  - Provincial task team members.
- Send out the memo and agenda.

## 2 STEP 2: CONFIRM THE MEETING AND ENSURE THE LOGISTICAL ARRANGEMENTS ARE IN PLACE

- A suitable venue either at the district office or sub-district office that caters for the number of participants should be booked in advance.
- The agenda and the briefing document for operational/facility managers should be printed for each participant.
- The facility implementation plan should be printed for each facility.
- An attendance register should be maintained.
- All logistical arrangements such as transport should be made well in advance for operational and project managers from the facility.
- Ensure that there is sufficient staff available at the facility to cover for staff attending meeting.
- Flip chart paper and pens must be available.

## 3 STEP 3: FOLLOW UP AND CONFIRMATION OF FACILITY TRAINING MEETING

- District task team leader should follow up with the Local area managers to ensure that the facilities have received the memo timeously and all the required information for the meeting has been collected and all logistical arrangements are in place for the facility teams to attend.

TOOL 12

## Memo for district and facility implementation training

The provincial Department of Health in collaboration with the District will be strengthening the management of chronic diseases (NCDs and HIV) through the Integrated Chronic Disease Management (ICDM) model. Your facility (*insert name here*) has been selected for the implementation according to the provincial implementation plan.

1. In order to initiate the process, the provincial ICDM task team and district management would like to convene an implementation training workshop on the (*proposed date)*
2. The meeting would last an entire day so please arrange adequate staff cover to provide services at the facility
3. We will appreciate it if the following key role players are in attendance:
    a. All the facility/operational managers
    b. ICDM champions
    c. Sub-district or local area managers (PHC supervisors)
    d. Programme coordinators
        i NCD and mental health coordinators
        ii HIV and AIDS and TB coordinators
        iii Clinical support coordinators
    e. Training coordinators
    f. District ICDM task team members
    g. Provincial task team members
4. A detailed memo highlighting the information you are required to bring with you to the training is enclosed
5. The venue for the meeting will be at (*Insert details here*)
6. Transport arrangements are as follows:

Your participation and co-operation will be highly appreciated.

Thanking you

Yours faithfully

District manager

TOOL 13

## Agenda for the district and facility implementation training workshop

### DISTRICT AND FACILITY IMPLEMENTATION TRAINING WORKSHOP

**Date:**

**Venue:**

**Time: 09h30-12h30**

**Objective:**

To capacitate the operational manager and/or the ICDM champion on the implementation steps for the ICDM model at facility level.

At the end of the meeting ensure that you have achieved the following:

1. Know how to re-organise your facility
2. Addressed the six priority areas of the National Core Standards
3. RTC to develop a plan for PC 101 and ICDM training

**Agenda items:**

1. Welcome and introduction
2. Purpose of the meeting
3. What is the ICDM?
4. Key steps in implementation process:
    a. Baseline analysis
    b. Process flow and waiting time analysis
    c. Human resource data
    d. Facility data
    e. Implementation activities
    f. Selection of a start date
    g. Data collection for ICDM
    h. Monitoring of the ICDM model
5. Closure - development of a facility specific implementation plan

TOOL 14

## Detailed memo highlighting information required

### INVITATION TO A TRAINING WORKSHOP ON THE IMPLEMENTATION OF THE INTEGRATED CHRONIC DISEASE MANAGEMENT (ICDM) MODEL

Integrated Chronic Disease Management (ICDM) is a model of managed care that provides for integrated prevention, treatment and care of chronic patients at primary healthcare level (PHC) to ensure a seamless transition to "assisted" self-management within the community.

The aim of ICDM is to achieve optimal clinical outcomes for patients with chronic communicable and non-communicable diseases using the health system building blocks approach.

The ICDM consists of four inter-related phases:

1. Facility re-organisation
2. Clinical supportive management
3. "Assisted" self-support and management of patients through the PHC ward based outreach teams (WBOT); and
4. Support systems and structure strengthening outside the facility.

The ICDM is aligned to PHC Re-engineering and is a component of the NCD Strategy and forms part of the Annual Performance Plan of the National Department of Health in supporting the NSDA goals of increasing life expectancy and improving health system effectiveness.

Please find attached an annexure with details of the expected participants and the data and documentation that are required for the workshop.

TOOL 14 (CNTD)

*Detailed memo highlighting information required*

The following key stakeholders are invited to attend this training workshop:

- All the facility/operational managers
- Sub-district or local area managers (PHC supervisors)
- District and sub-district programme coordinators (NCD and mental health coordinators, HIV and AIDS and TB coordinators)
- District Clinical Specialist Team
- District training coordinators
- District ICDM task team members.

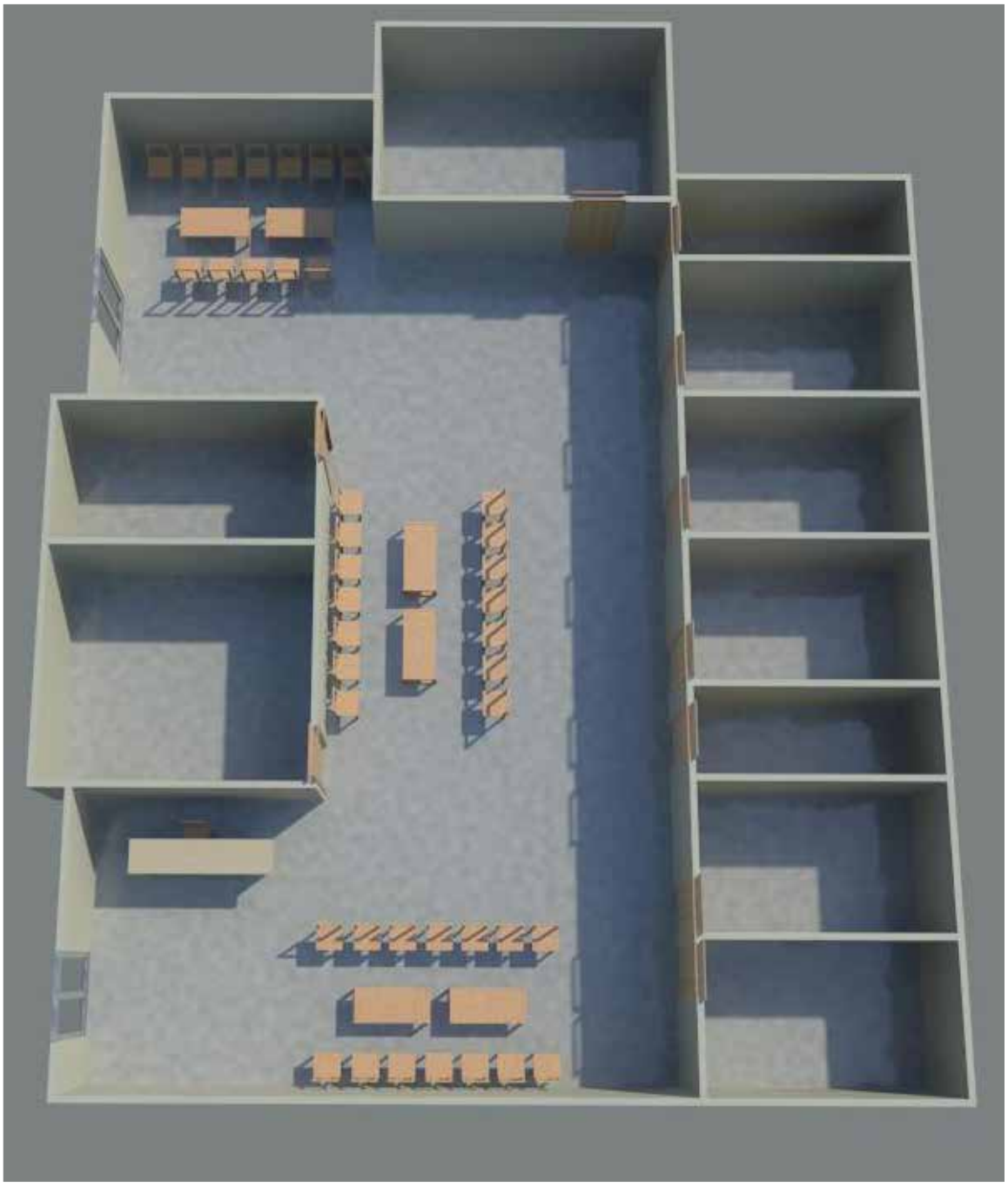
To achieve the maximum effect the following information should be brought to the workshop by each facility:

1. Previous waiting time survey conducted in the last quarter
2. Facility floor plan - a sketch plan of the facility indicating all the service points:
   - Reception
   - Consulting rooms
   - Waiting areas
   - Toilets
   - Park homes and external structures.
3. The sketch should indicate the various services delivered at each of the consultation rooms.
4. A patient flow diagram should be superimposed on the sketch in a different colour. Example of a process flow in a typical clinic is provided below.

TOOL 14 (CNTD)

*Detailed memo highlighting information required*

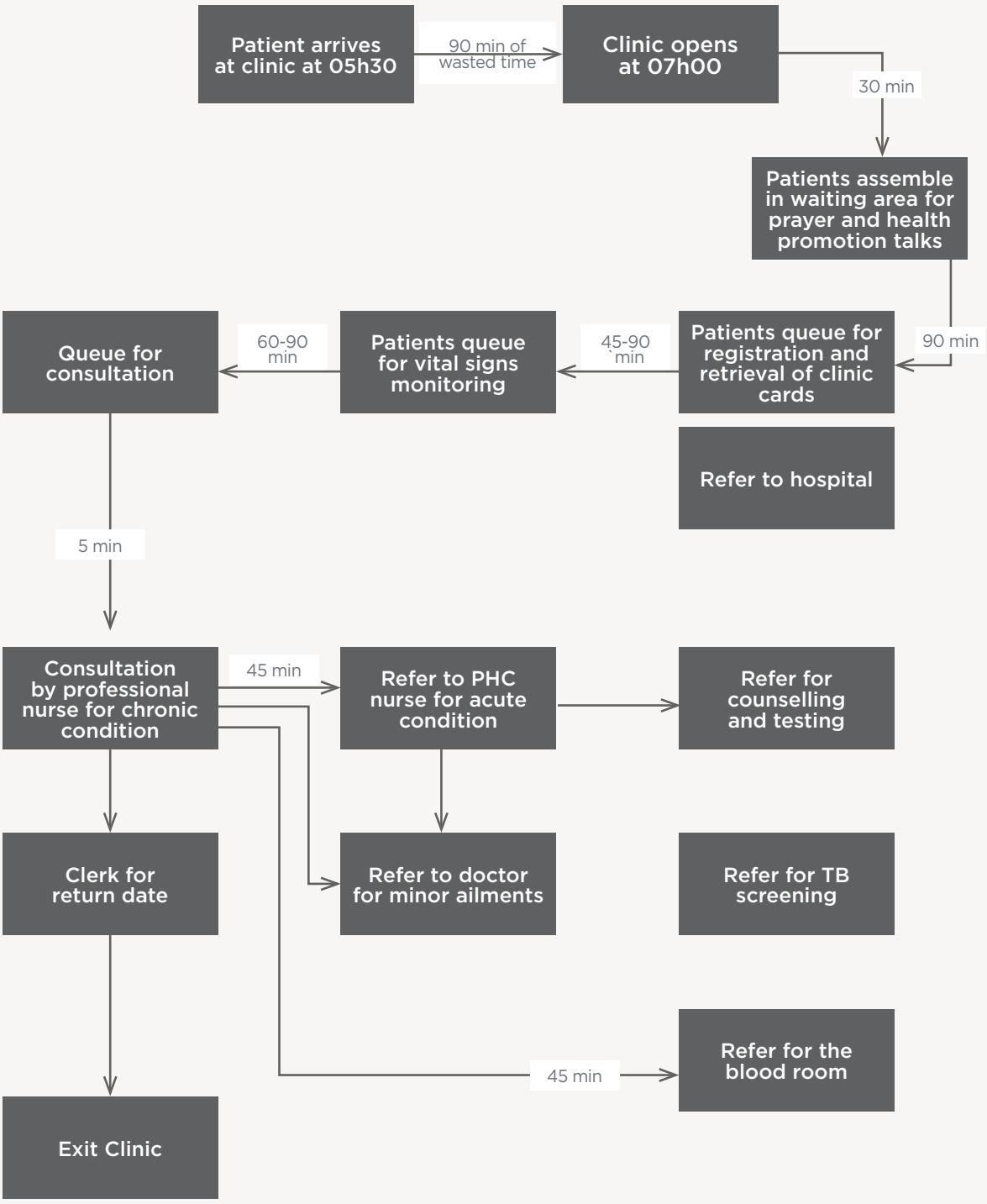
## EXAMPLE OF A FACILITY FLOOR PLAN



TOOL 14 (CNTD)

*Detailed memo highlighting information required*

## EXAMPLE OF PATIENT PROCESS FLOW



TOOL 14 (CNTD)

*Detailed memo highlighting information required*

| | |
|---|---|
| **HUMAN RESOURCES** | |
| Total number of human resources employed at the facility | |
| **INDICATE NUMBER OF STAFF IN THE FOLLOWING CATEGORIES** | |
| Operational managers | |
| Project managers/deputy manager | |
| Professional nurses | |
| Enrolled nurses | |
| Enrolled nursing assistants | |
| Health promoters | |
| HCT counsellors | |
| Admin clerks | |
| Data capturers | |
| Pharmacist assistants | |
| General assistants | |
| Full time medical doctors | |
| Sessional medical doctors | |
| Dentist/dental therapist | |
| **STAFF DEVELOPMENT** | |
| No. of P/N that are PHC trained | |
| No. of P/N that are NIMART trained | |
| No. of P/N that are PC 101 trained (both master and at facility level) | |

TOOL 14 (CNTD)

*Detailed memo highlighting information required*

| HEALTH INFORMATION FOR THE LAST QUARTER | QUARTER: |
|---|---|
| PHC headcount ( < 5 years + > 5 years) | |
| PHC headcount > 5 years | |
| Number of HIV patients currently on art new | |
| Total number of HIV patients remaining on art | |
| Number of patients on pre-art | |
| Number of TB patients > 8 years receiving monthly medication | |
| Number of TB MDR confirmed patients initiated on treatment | |
| Total number of chronic NCD patients new and follow up (to arrive at this total- sum up the six (6) indicators below) | |
| Hypertension case load - number of patients with HPT > 5 years visiting the clinic | |
| Diabetes case load - number of patients with diabetes > 5 years visiting the clinic | |
| Epilepsy case load - number of patients with epilepsy > 5 years visiting the clinic | |
| Asthma case load - number of patients with asthma > 5 years visiting the clinic | |
| Chronic obstructive airway disease (COPD) case load - number of patients with COPD > 5 years visiting the clinic | |
| Mental health case load - number of patients with mental health > 5 years visiting the clinic | |

TOOL 15

## Template for planning ICDM implementation at facility level

| OBJECTIVE | ACTIVITY | TIMEFRAME | RESPONSIBLE PERSON | PROGRESS ACHIEVED |
|---|---|---|---|---|
| Sorting and shining | Walk through the facility and remove unwanted items from walls and desks and ensure cleanliness | | | |
| To introduce the patient scheduling system | Application of an appointment scheduling system | | | |
| To integrate patient records | Review of patient records and combine and integrate records | | | |
| Introduction of chronic patient record | Training of all staff on application of chronic patient record | | | |
| To re-organise facility | Designated chronic consulting rooms<br><br>An additional vital signs station<br><br>Designated waiting area for chronic patients | | | |
| To introduce a staff rotation schedule for consulting chronic patients | Audit of staff training<br><br>Development of a roster for staff | | | |
| To pre-retrieve patient records prior to appointments | Pre-retrieval of patient records | | | |
| To pre-dispense patient medication | Pre-appointment dispensing and storage of patient medication | | | |
| Down referral of stable chronic patients | Consultation with PHC outreach team | | | |
| To implement data collection tools for chronic patients | Capacitation of all staff on use of daily tally sheet and data collection tools | | | |
| Ensure availability of essential equipment for each consulting room | Equipment audit and ordering of appropriate equipment | | | |
| Ensure the availability of medication for 2-3 month supply | Adjustment of medication stock levels | | | |
| Ensure that all staff are trained on evidence-based guidelines | PC 101 training at facility level for all staff | | | |

Section Three

03

# BASELINE ASSESSMENT AND ANALYSIS

The baseline assessment represents the first stage of the continuous quality improvement cycle. The purpose of conducting a baseline assessment is:

- To have a snapshot picture of what is happening at the facility
- To identify areas of wastage and inefficiency
- To allow the staff to be involved and to share their experiences.

The findings from the baseline assessment will form the basis for the quality improvement programme design.

**FIGURE 22:** ICDM IMPLEMENTATION APPROACH

# 1. Theoretical framework

In order to provide good quality of clinical care, it is essential that the inputs, processes and outcomes of care conform to desired standards and are continually monitored and improved[2].

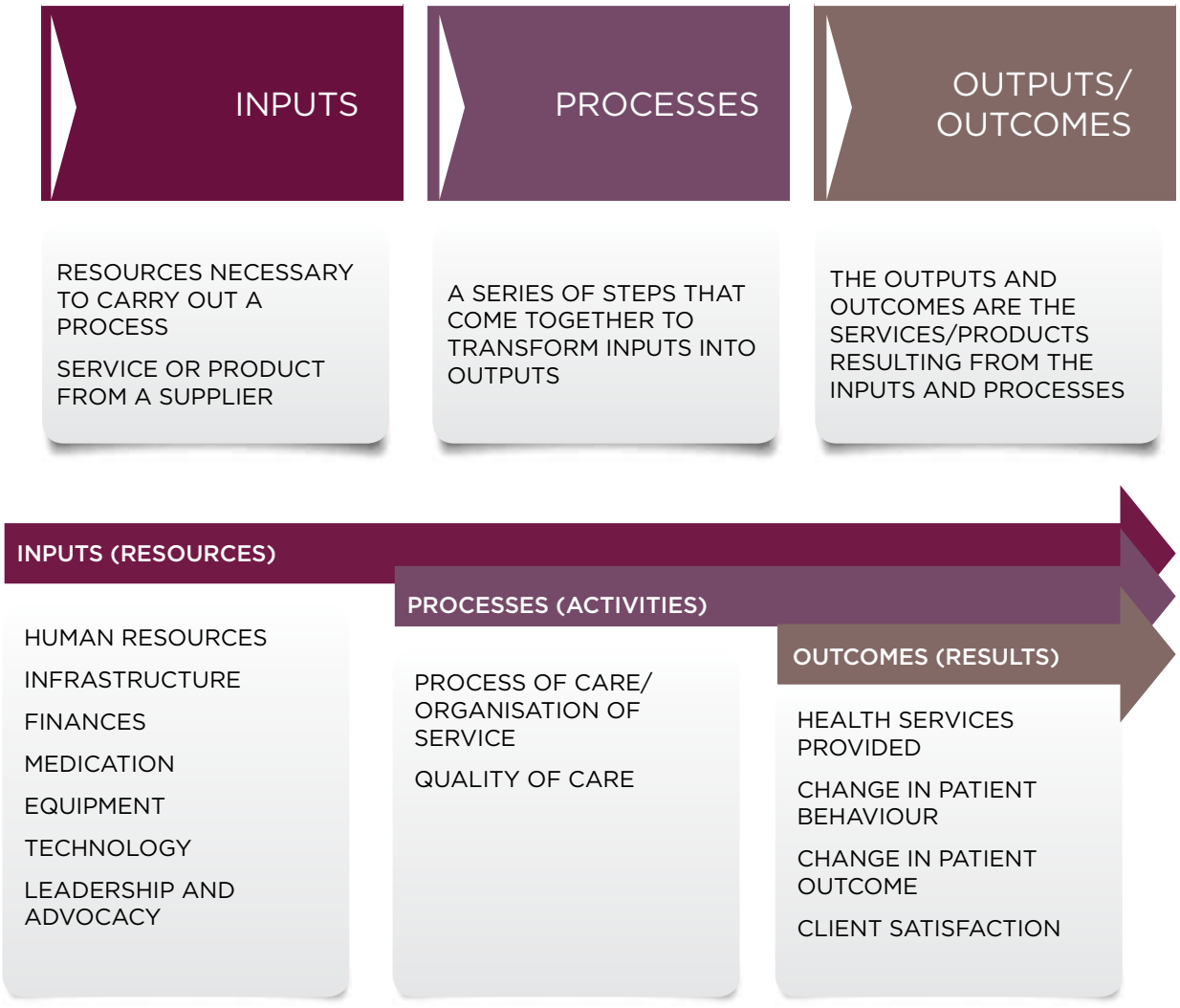



**FIGURE 23:** MODIFIED SYSTEMS FRAMEWORK FOR HEALTH SERVICE DELIVERY

## 2. The baseline assessment for ICDM involves:

- Conducting a waiting time survey or review of previous waiting time survey to determine the baseline for future comparisons
- Patient flow analysis - this will be used to identify areas of bottleneck within the healthcare process
- Reviewing the last quarter facility health information to determine the number of chronic patients to schedule for daily to achieve an even distribution of patients
- Reviewing of human resource data in order to plan the training programme based on the service requirements.

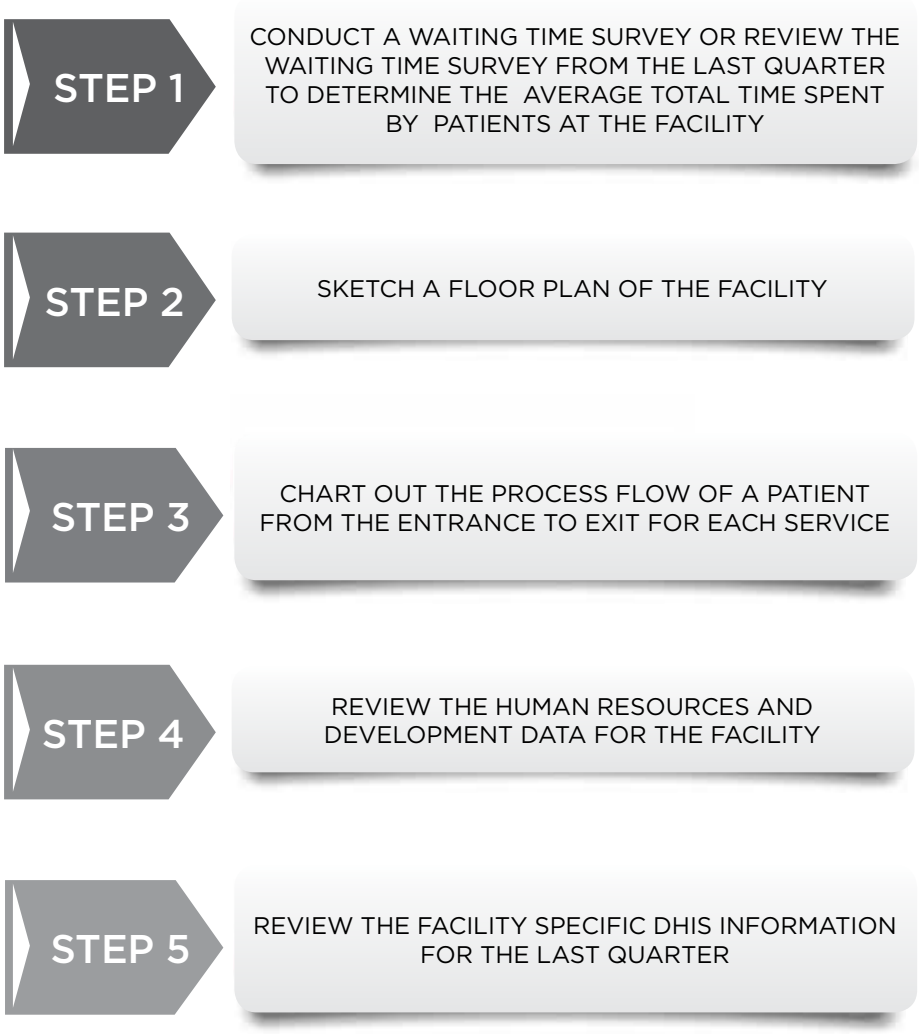



**FIGURE 24:** ACTIVITY STEPS FOR BASELINE ASSESSMENT

# 1 STEP 1: CONDUCT A WAITING TIME SURVEY OR REVIEW THE LAST QUARTER'S WAITING TIME SURVEY RESULTS

- **If available,** obtain a copy of the results of the waiting time survey for the last quarter from the appointed facility quality assurance officer
- **If not, then conduct a waiting time survey as follows:**

The waiting time survey consists of two sections:

1. Facility specific data summary sheet - to collect data on the availability of staff at the facility on the survey date as well as the total number of patients consulted on that day.
2. Waiting time survey tool - to collect data on patient waiting times.

**FACILITY SPECIFIC**

Data summary sheet

ON THE DAY OF THE SURVEY

1. The operational manager will complete the facility-specific data summary sheet by indicating the date(s) that the survey was conducted.
2. On the morning of the survey, use the information from the staff attendance register to fill in how many professional nurses are on duty. This is only for primary healthcare and not labour/delivery services (MOU), but must include the nurses doing antenatal care.
3. Indicate the number of enrolled nurses/enrolled nursing assistants on duty.
4. Indicate the number of clerks on duty for the day.

**TOOL 16**

## Facility-specific data summary sheet for waiting time survey

| | |
|---|---|
| Name of facility | |
| Date(s) of survey | |
| Total number of patients seen for the day/s at the facility | |
| Total number of professional nurses on duty for the day(s) (outpatient services only) | |
| Total number of enrolled nursing assistants/ enrolled nurses on duty for the day(s) (outpatient services only) | |
| Total number of admin clerks/data capturers on duty for the day(s) | |

## Waiting time survey methodology

1. All facilities involved in the ICDM project within the district should conduct the survey **during the same week with the same start date.**
2. A total of 100 patients should be sampled per facility.

**FACILITY SPECIFIC**

The survey

THE SURVEY

1. The **1st 100 patients** attending the facility, irrespective of diagnosis, should be surveyed using the waiting time survey tool.
2. **ROW 1** the queue marshal/enrolled nurse should enter the time that each patient enters the clinic.
3. **ROW 2** the administrative clerk registering the patient should complete the time after he/she completes the patient registration.
4. **ROW 3** the enrolled nurse/enrolled nursing assistant at the vital sign station should complete the time after the vital signs have been completed.
5. **ROW 4** the professional nurse should indicate at what time the patient entered the consulting room
6. **ROW 5** the professional nurse should enter time after he/she completes the consultation.
7. The professional nurse should also complete the diagnostic information of the patient
8. **ROW 6** if the patient is referred to another professional nurse or to another service point, for example to receive medication, then the service provider must fill in the time the patient enters the second consultation room.
9. **ROW 7** when the patient departs the second consultation area, this will be completed.
10. **ROW 8** the form should be collected by the queue marshal/ professional nurse and the time that the patient departs the facility should be indicated.

TOOL 17

## Waiting time survey tool

| | CONDITION FOR WHICH PATIENT ATTENDING | Immunisation | ART | Acute minor illness (Adult) | Chronic-NCD | Family planning |
|---|---|---|---|---|---|---|
| | | ANC | TB | Well baby clinic | Child health curative | Dressings/ injections |
| 1 | Time the patient enters the clinic | | | | | |
| 2 | Time the patient is registered / allocated card | | | | | |
| 3 | Time the patient completed vital signs | | | | | |
| 4 | Time the patient starts 1st consultation | | | | | |
| 5 | Time patient completed 1st consultation | | | | | |
| 6 | Time the patient started 2nd consultation<br><br>(if referred to another service) | | | | | |
| 7 | Time the patient completed 2nd consultation (if referred) | | | | | |
| 8 | Time patient departs clinic | | | | | |

**FACILITY SPECIFIC**

After the survey

AFTER THE SURVEY

1. If all 100 patients surveyed are completed in a single day, use the register to provide the total number of outpatients seen for that day and enter this on Tool 15
2. If the 100 patients surveyed are done on sequential days, then add the total number of patients consulted over the period of days on which the survey was done and also indicate the dates.
3. The data should then be forwarded to the facility Information officer for entry into Microsoft Excel.

## STEP 2: DRAW THE ACTUAL FLOOR PLAN OF THE FACILITY - AN ARCHITECTURAL SKETCH

2

- The operational manager and the ICDM champion should sketch the layout of the actual facility
- Each area in the floor plan should be labelled and described in terms of the activity that takes place in that area.

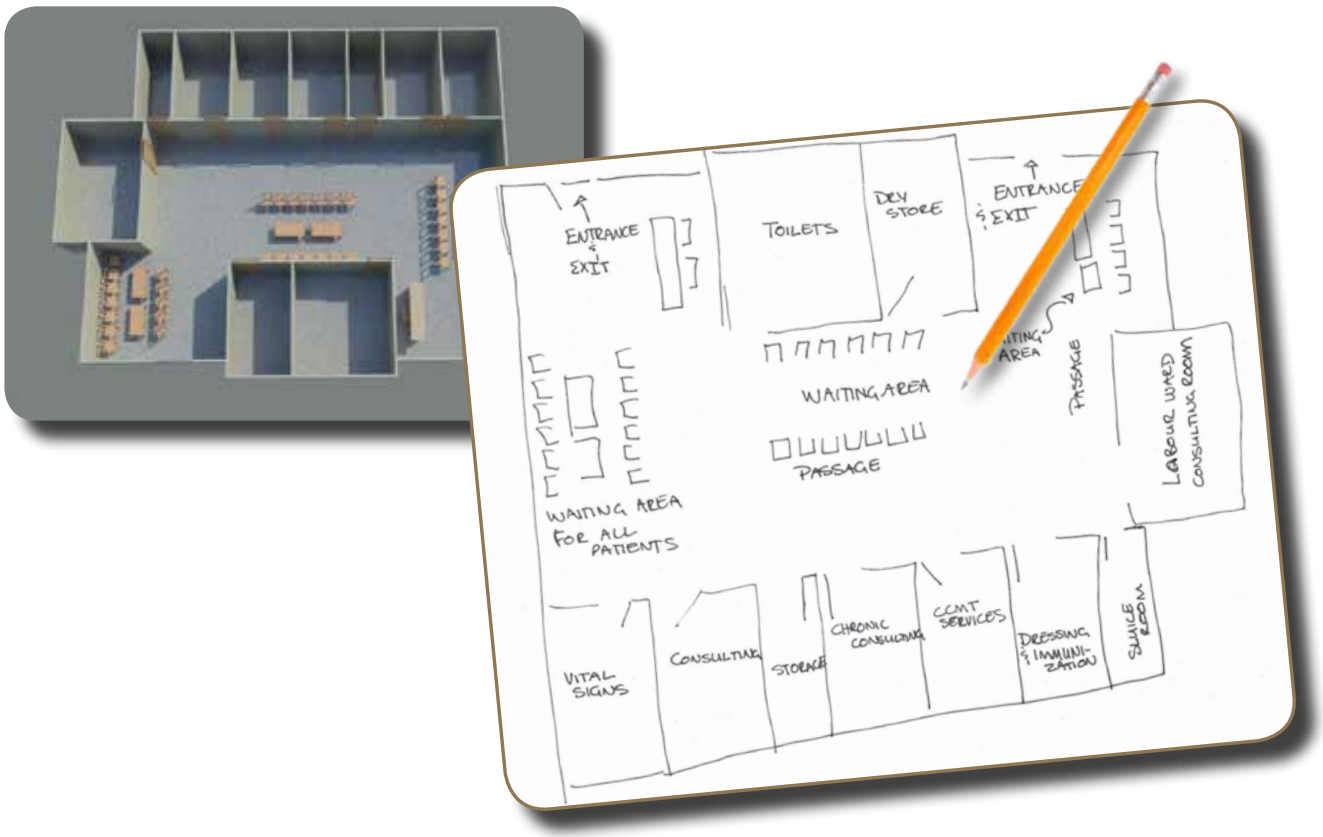



**FIGURE 25:** EXAMPLE OF A SKETCHED FLOOR PLAN

## 3 STEP 3: CHART OUT THE PROCESS FLOW

*(For a detailed discussion on what a process flow entails and its application, refer to the Quality Improvement guide developed by the Office of National Standards Compliance of the National Department of Health)*

a. Decide on the beginning and ending points of the process using a patient's perspective
b. There can be more than one starting or ending point
c. Identify each step of the process
d. Describe the activities of the process
e. Correlate each step with the waiting time obtained from the previous survey
f. Chart the process in A3 paper (example of process map below)
g. Plot the process as is, even if not ideal
h. Use common symbols such as the ones given below.

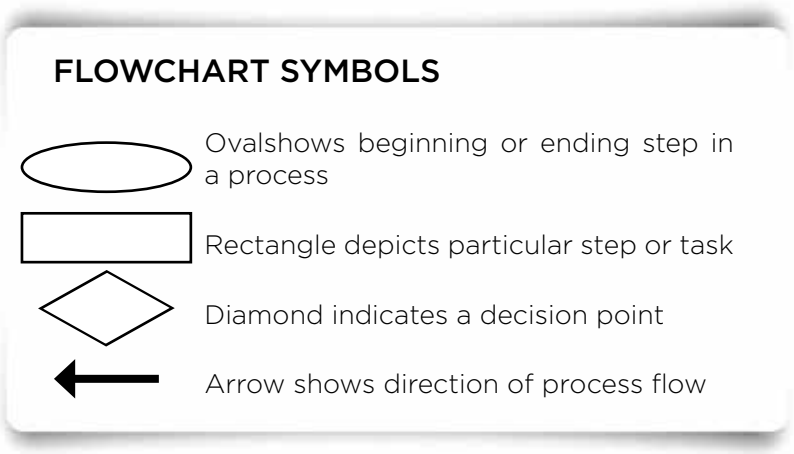



**FIGURE 26:** FLOWCHART SYMBOLS TO BE USED FOR DEPICTING PROCESS FLOW

The diagram below is an example of a process flow in a typical clinic.

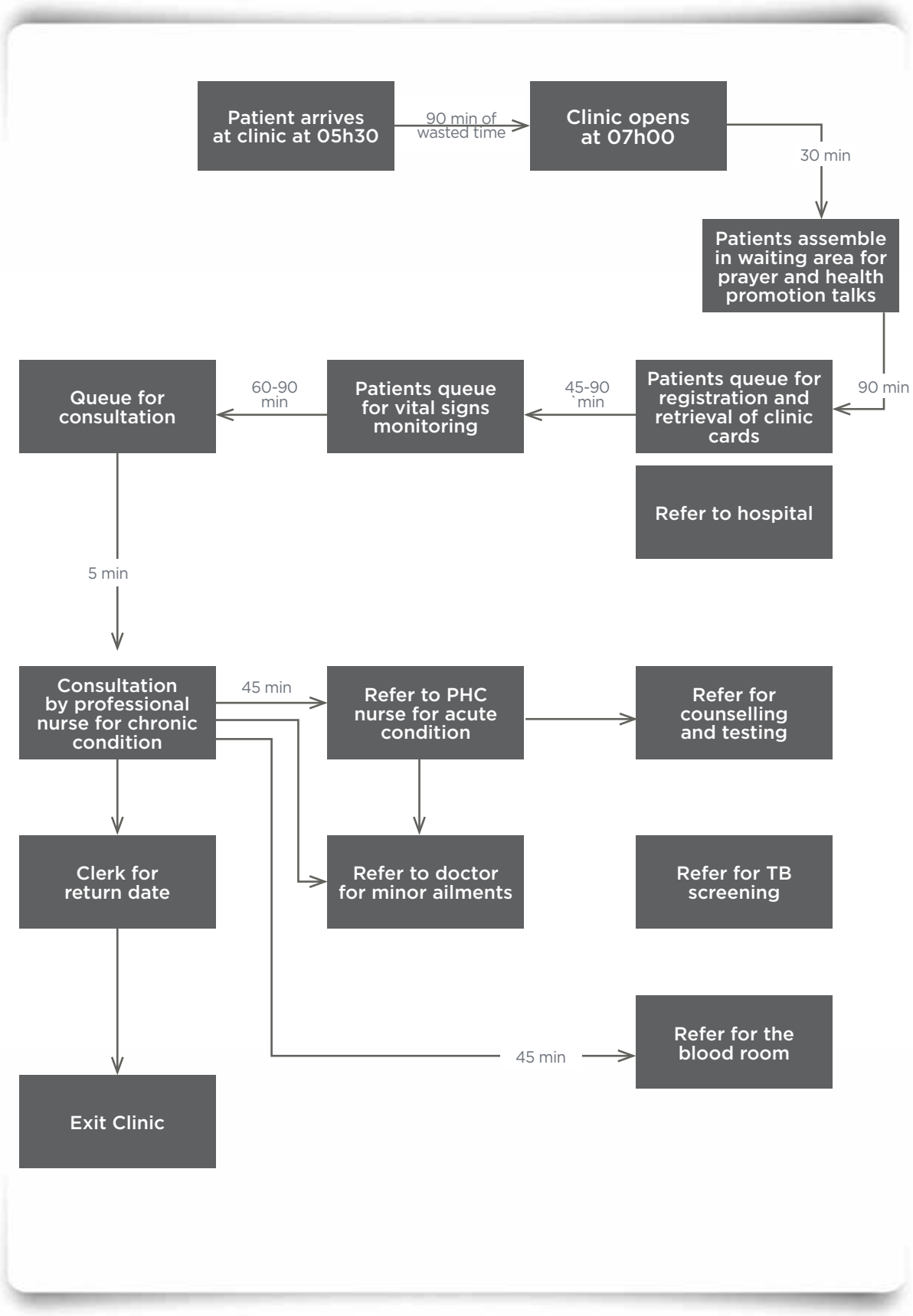



**FIGURE 27:** EXAMPLE OF A PROCESS FLOW PLAN

## STEP 3: REVIEW THE HUMAN RESOURCES DATA

For each professional nurse employed at the facility, obtain the following information and conduct a detailed analysis:

TOOL 18

### Staff development needs assessment

| | | TRAINING COMPLETED | | | | | |
|---|---|---|---|---|---|---|---|
| **NAME OF PROFESSIONAL NURSE** | South african nursing council registration number | Primary healthcare | Palsa plus | Nurse initiated art (NIMART) | Mental health | Advanced midwifery | PC 101 |
| | | | | | | | |
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## STEP 4: REVIEW THE FACILITY DHIS INFORMATION FOR THE LAST QUARTER

TOOL 19

### Summary sheet for DHIS data for the last quarter

| HEALTH INFORMATION FOR THE LAST QUARTER | QUARTER: |
|---|---|
| PHC headcount ( < 5 years + > 5 years) | |
| PHC headcount > 5 years | |
| Number of HIV patients currently on ART new | |
| Total number of HIV patients remaining on ART | |
| Number of patients on pre-ART | |
| Number of TB patients > 8 years receiving monthly medication | |
| Number of TB MDR confirmed patients initiated on treatment | |
| Total number of chronic NCD patients new and follow up (to arrive at this total- sum up the six (6) indicators below) | |
| Hypertension case load - number of patients with HPT > 5 years visiting the clinic | |
| Diabetes case load - number of patients with diabetes > 5 years visiting the clinic | |
| Epilepsy case load - number of patients with epilepsy > 5 years visiting the clinic | |
| Asthma case load - number of patients with asthma > 5 years visiting the clinic | |
| Chronic obstructive airway disease (COPD) case load - number of patients with COPD > 5 years visiting the clinic | |
| Mental health case load - number of patients with mental health > 5 years visiting the clinic | |

# 3. Baseline analysis

**FIGURE 28:** BASELINE ANALYSIS ACTIVITIES

## 1 STEP 1: WAITING TIME ANALYSIS

- Assess the following information from the survey:
  - Nurse to patient ratio - total number of professional nurses on duty on date of survey / total number of patients consulted at facility on the date of the survey
  - Total median time spent by all patients at the facility
  - Total median waiting time spent by chronic (HIV and NCD) patients
  - Total median waiting time between clinic entry and registration
  - Total median waiting time between registration and vital signs completion
  - Total median waiting time between vital signs completion and consultation

**This information can be obtained automatically by appropriately inserting the formulas in the Excel package and should be in the competence of the facility information officer.**

## STEP 2: PROCESS FLOW ANALYSIS

2

After completing the mapping exercise the team should sit in a meeting room and pin the map on a board.

The following question should be answered in analysing the information and for each symptom the question why should be posed to generate possible solutions.

At which point do patient wait the longest and why?

For a detailed discussion on '*process flow*' and its application, refer to the Quality Improvement guide developed by the Office of National Standards Compliance of the National Department of Health

TOOL 20

### Process flow and waiting time analysis template

| SERVICE DELIVERY POINT | SYMPTOM: LONG WAITING TIME |
|---|---|
| Area A – e.g. between entry and registration | Why?<br><br>Batching - all patients arriving at a single point together, e.g. all patients arrive at the clinic at 06h30 when the clinic opens at 07h00.<br><br>Over-processing - patient having to go through a process that can be avoided<br><br>People - availability of the correct type of human resources<br><br>Equipment - availability of equipment |
| Between registration and vital signs | |
| Between vital signs and consultation | |
| Between consultation and additional service points | |
| Between consultation and departure from clinic | |

## 3 STEP 3: HUMAN RESOURCE DATA ANALYSIS

Summarise the human resource data using the table below to identify the number of staff that require further development and the number of staff that can be scheduled to consult chronic patients.

TOOL 21

### Summary of human resource data

| | NUMBER |
|---|---|
| Total number of professional nurses employed at the facility | |
| Total number of enrolled nurses employed at the facility | |
| Number of professional nurses PHC trained | |
| Number of professional nurses PALSA Plus trained | |
| Number of professional nurses NIMART trained | |
| Number of professional nurses PC 101 trained | |
| | |
| **STAFF DEVELOPMENT** | |
| Number of professional nurses that require to be trained | |
| PHC | |
| NIMART | |
| PC 101 | |

## STEP 4: ANALYSE THE FACILITY SPECIFIC DHIS INFORMATION 4

TOOL 22

### Analysis of DHIS information for the facility

| INDICATORS | NUMBER/% | FORMULA |
|---|---|---|
| Total PHC headcount | | |
| Proportion of patients > 5 years | | (PHC headcount > 5 years / total PHC headcount) |
| Total number of NCD patients | | (hypertension case load + diabetes case load + epilepsy case load + asthma case load + chronic obstructive pulmonary disease case load + mental health case load) |
| HIV patients on ART case load | | (number of new patients on ART + total number remaining on ART) |
| Pre-ART HIV patients | | |
| TB patients > 8 years receiving monthly medication | | |
| Number of TB MDR confirmed patients initiated on treatment | | |
| Total chronic patient case load | | (total number of NCD patients + HIV patients on ART case load + pre-ART HIV patients + TB patients > 8 years receiving monthly medication + number of MDR TB patients initiated on treatment) |

**This information that you have will now make it possible for you to develop the ICDM implementation plan.**

Section Four

04

# HEALTH SERVICE RE-ORGANISATION

# 1. ICDM implementation activities

The purpose of this section of the manual is to provide the provincial, district and facility ICDM teams a step-by-step guide on the process to implement the health service re-organisation component of the ICDM model.

**Although this manual presents the implementation steps sequentially, the practical application of each of these steps may occur simultaneously.**

**Facility re-organisation**

- Re-organisation of patient flow
- Appointment scheduling
- Pre-appointment retrieval of clinical records
- Designated consultation area
- Single administrative point
- Integration of care
- Pre-dispensing of medication

**FIGURE 29:** ICDM IMPLEMENTATION APPROACH

## 2. Selection of the start date

- It is important to work backwards from a target
- All the facilities within the sub-district or those identified to initiate the ICDM model should commence within the same period
- All facilities should commence with implementation of the various components of the ICDM on the 1st Monday of a new month, 6 –8 weeks after the facility implementation and training workshop.

**START DATE:**
**1ST MONDAY OF A NEW MONTH**
6 – 8 WEEKS AFTER FACILITY TRAINING
AND IMPLEMENTATION WORKSHOP

**Example**:
Facility Training and Implementation Workshop
18th April 2013

**Commencement Date:** 3rd June 2013

## 3. Facility re-organisation

Prior to addressing the components of the ICDM model that will eliminate waste, it is important to address the facility environment.

**STEP 1:** **IMPLEMENT THE 'FIVE S's OF THE LEAN THINKING PRINCIPLES'**
**As detailed by the quality improvement guidelines prepared by national department of health office of national standards compliance.**

1

**FIGURE 30:** LEAN THINKING PRINCIPLES

TOOL 23

## Lean thinking principles

| | |
|---|---|
| Sorting | Remove unnecessary items from consulting rooms and any unused items from the workspace |
| Set-in order/straighten | Organise the process flow and ensure all the necessary items are in the correct place for easy access and efficient service provision |
| Shine | Maintain a clean environment |
| Standardise | Set up, sort and shine at all work stations |
| Sustain | Reinforce the importance |

### Organising the process flow:

The process flow at the facility should be organised into three clearly designated areas that make it easy for patients to access and exit without any cross over. These areas should have different colour markings painted as footmarks on the floor or lines on the wall to appropriately direct patients.

1. The area for acute/minor ailments should be marked as **red/orange**.
2. The area leading to preventive services including maternal, women and child health should be marked as **green**.
3. The area for chronic patients on ICDM should be marked as **blue**.

2

## STEP 2: NUMBER OF PATIENTS TO BE SCHEDULED DAILY

1. Use a 20-day-per-month cycle to determine the number of patients to be consulted (20 days are used to cater for pension days, public holidays as well as weekends).
2. The booking is determined on a Monday-Friday basis and can be modified for 24 hour facilities and those facilities that are open on weekends.
3. Use the data from Tool 19 - DHIS Summary sheet for chronic case load (total number of NCD patients + HIV patients on ART case load + pre-ART HIV patients + TB patients > 8 years receiving monthly medication + Number of MDR TB patients initiated on treatment) and divide this value by 20 days.
4. Ensure that there is an equal mix of patients with chronic non-communicable diseases and chronic communicable diseases scheduled daily and not a predominance of one condition only.

TOOL 24

## Formula for calculating number of patients to be scheduled daily

Total number of NCD patients + HIV patients on ART case load + pre-ART HIV patients + TB patients > 8 years receiving monthly medication + number of MDR TB patients initiated on treatment

### EXAMPLE:

| Indicators | Number/% | Formula |
|---|---|---|
| Total number of NCD patients | 580 | (hypertension case load + diabetes case load + epilepsy case load + asthma case load + chronic obstructive pulmonary disease case load + mental health case load) |
| HIV patients on ART case load | 760 | (number of new patients on ART + total number remaining on ART) |
| Pre-ART HIV patients | 120 | |
| TB patients > 8 years receiving monthly medication | 80 | |
| Number of TB MDR confirmed patients initiated on treatment | 5 | |
| Chronic patients case load | 1545 | (total number of NCD patients + HIV patients on ART case load + pre-ART HIV patients + TB patients > 8 years receiving monthly medication + number of MDR TB patients initiated on treatment) |
| Number of patients to be scheduled daily | | = Chronic case load/20<br>= 1545/20<br>= 77,25 **= 77 patients/day** |

## 3 STEP 3: DETERMINING THE NUMBER OF CONSULTING ROOMS AND NUMBER OF NURSES TO CONSULT CHRONIC PATIENTS

The current national norm is that a professional nurse should consult 40 patients per day. Use a conservative value of 40 patients to be booked per consulting room requiring a single professional nurse to be allocated.

### DETERMINING THE NUMBER OF CHRONIC CONSULTATION ROOMS TO BE USED

| NUMBER OF PATIENTS SCHEDULED/DAY | NUMBER OF CONSULTING ROOMS TO BE USED | NUMBER OF NURSES TO CONSULT CHRONIC PATIENTS |
|---|---|---|
| 40 | 1 | 1 |
| 41-80 | 2 | 2 |
| 81-120 | 3 | 3 |
| 121-160 | 4 | 4 |

**Using the example above, the facility will need to use two consulting rooms and schedule two nurses for consulting patients.**

## STEP 4: IMPROVING PATIENT FLOW FOR CHRONIC PATIENTS

4

- **The scheduled patients *do not need to report* to the main reception for registration and headcount.**

  - The headcount can be obtained from the appointment scheduling tool - refer to section on appointment scheduling
  - The pre-retrieved patient file should be stored at a dedicated area chronic patient reception station or at the chronic vital signs station or in the chronic consultation room

When the patient arrives for the appointment, a tick should be placed in the column against the patient's name on the appointment scheduling tool (Tool 25 and 26). This should be completed at the point where the patient retrieves the file.

The patient file should be retrieved at dedicated area chronic patient reception station or at the chronic vital signs station or in the chronic consultation room.

- **Designated waiting area for chronic patients**
  - A clearly marked and designated waiting area should be arranged for chronic patients.
  - The allocation of this area may vary dependant on the design of the facility and the availability of space at each facility.
  - Ideally, if a separate entrance and exit is available the chronic waiting area should be positioned near the chronic consulting room and separate from the acute clinical services.
  - Where space is limited, the main waiting area should be divided to cater for chronic patients. A single row or multiple rows clearly marked or with different coloured chairs should be placed in such a manner that it would facilitate easy patient flow to chronic consultation rooms.

- **An additional vital signs station for chronic patients**
  - An additional vital signs monitoring station should be established for chronic patients.
  - This vital sign station should be conveniently located between the chronic patient waiting area and consulting room.
  - At facilities where less than 30 patients are booked as chronic patients per day, and there is sufficient equipment available, the blood pressure and blood glucose could be monitored in the consulting room.

### EQUIPMENT FOR VITAL SIGN STATION

- Desk
- Two chairs
- Medical record stationary
- Body mass index scale
- Sphygmomanometer
- Blood glucometer
- Urine dipsticks and urine specimen jars
- Thermometer
- Stethoscope

### Triaging of chronic patients

**AFTER COMPLETING THE VITAL SIGNS, THE PATIENTS SHOULD BE FURTHER TRIAGED INTO THE FOLLOWING CATEGORIES AND DIRECTED APPROPRIATELY:**

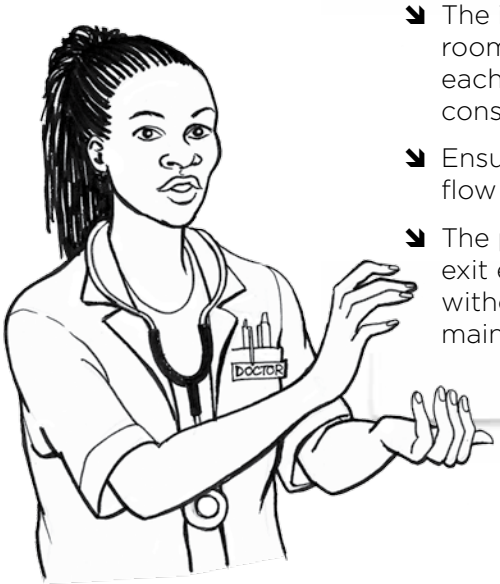
- Repeat medication with normal vital signs
- Repeat medication with abnormal vital signs
- Six month full examination
- Doctor referral.

### Designation of chronic consulting rooms

- After calculating the number of consulting rooms required to consult chronic patients, it is important to identify the most suitable consulting rooms for chronic patients.

**CRITERIA FOR CHRONIC CONSULTING ROOM**

- The ideal is to allocate consulting rooms that are adjacent to each other if more than one consulting room is to be used.
- Ensure that there is no cross flow between patients.
- The patients should be able to exit easily after consultation without having to re-enter the main clinic area.



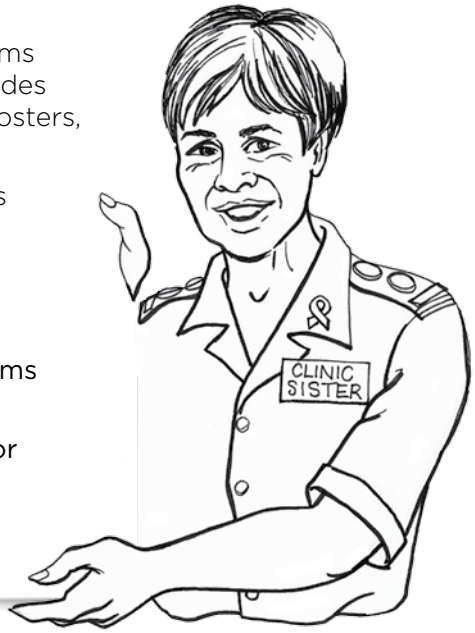
- **The chronic consultation room should:**
  - Be well ventilated
  - Have a hand washing basin in the room or adjacent to it
  - Have a desk with a lock up drawer and three chairs
  - Have a lock up cabinet for storage of patient medication
  - Contain three colour-coded waste containers.

## EQUIPMENT FOR CHRONIC CONSULTING ROOM

- Basic diagnostic set - ophthalmoscope and otoscope
- Thermometer
- Stethoscope
- Urine dipsticks
- Blood glucometer
- Sphygmomanometer
- Peak flow meter
- Patella hammer
- An appropriate medical consulting bed
- A mobile examination lamp

## STATIONARY FOR CHRONIC CONSULTING ROOM

- Clinical support tools for provider (clinical algorithms (PC101)), drug dosing guides (EDL), desktop guides, posters, textbooks, etc.)
- Patient education posters
- Other forms:
  - Laboratory requests
  - Prescription forms
  - Transfer or referral forms
  - Reporting forms
  - Continuation sheets for clinical records



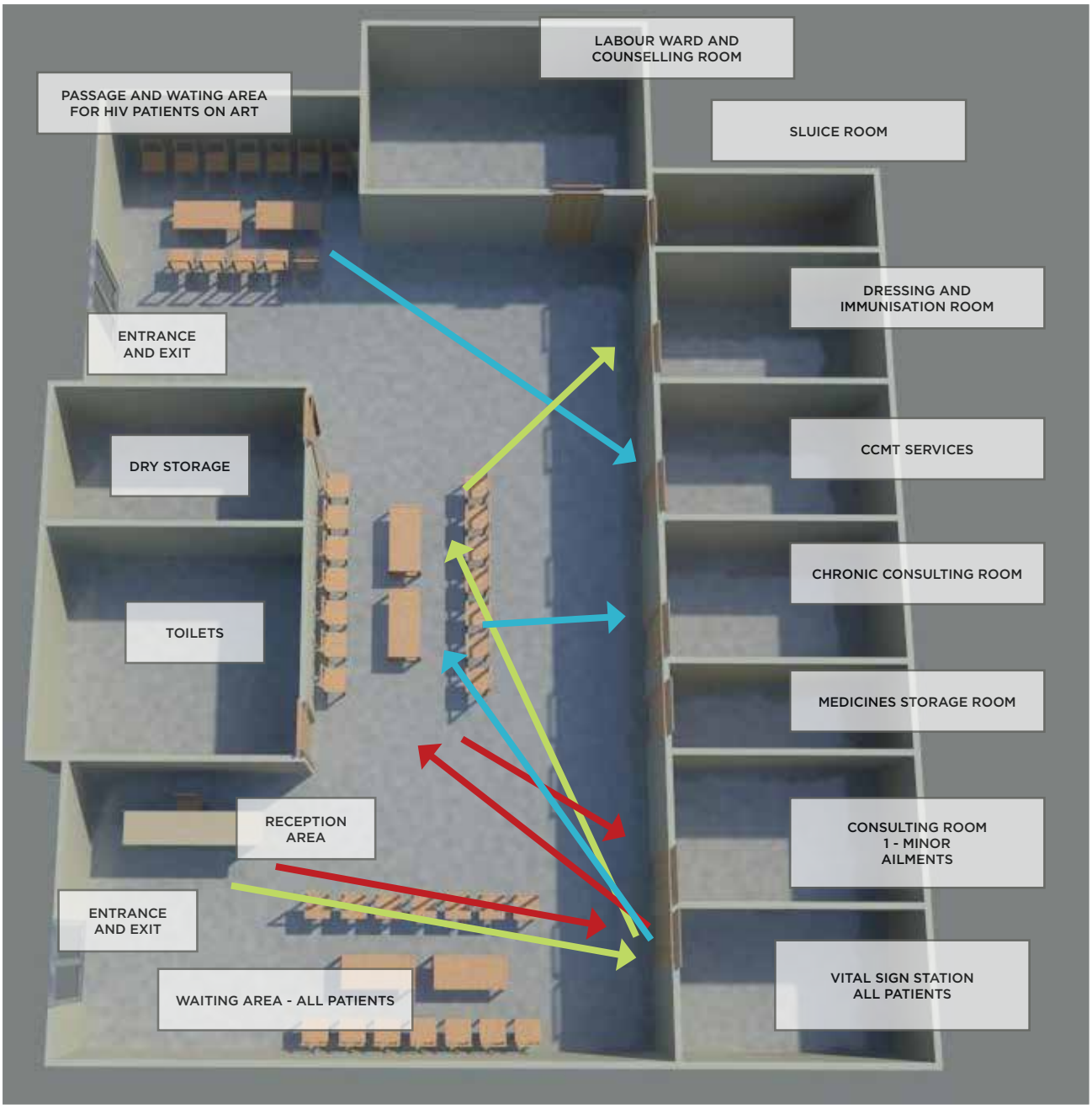



**FIGURE 31:** TYPICAL PATIENT FLOW IN A CLINIC

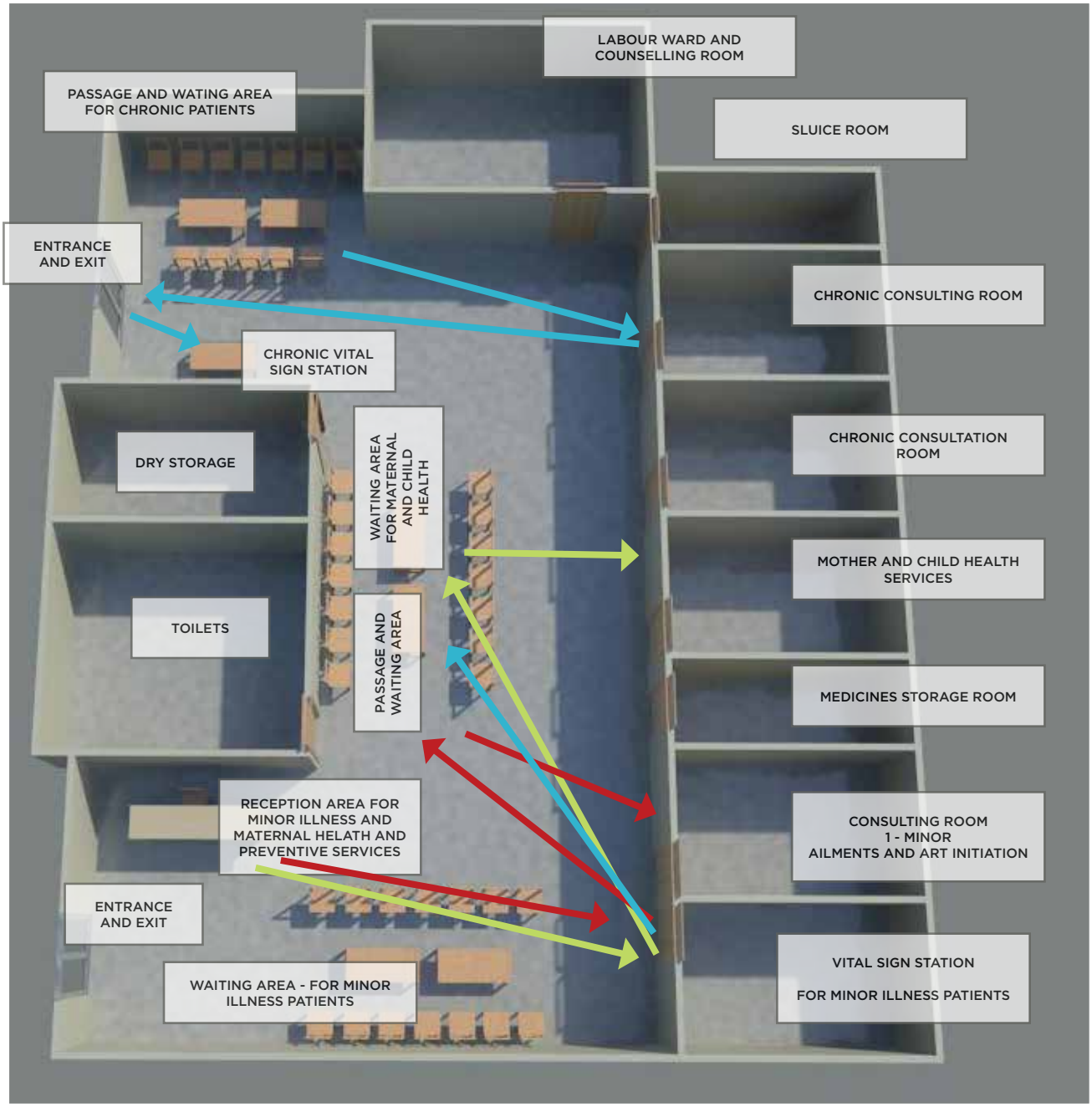



**FIGURE 32:** EXAMPLE OF A RE-ORGANISED PATIENT FLOW

- **Pre-appointment retrieval of patient records**
  - Between 48 and 72 hours prior to the patient's appointment, the chronic professional nurse should provide the administrative clerk (where available) or support staff with a copy of the appointment schedule.
  - The administrative clerk or support staff should retrieve the patient's record and tick off in the scheduling book after the record has been retrieved.
  - The professional nurse/administrative clerk should retrieve any outstanding results for laboratory investigations conducted during previous visits and place the results in the records.
  - After updating the records, the records should be kept in a box at the chronic reception, vital sign station or consulting room depending on facility arrangement.

# 4. Appointment scheduling process

Once the start date for consulting patients according to a scheduling system has been determined, the scheduling of patients should commence.

- The scheduling of patients should be done by the *professional nurse in the consulting room* if a single consultation room is used for consulting chronic patients.
- If more than one consulting room is being used, a number of options could be considered:
  - Each professional nurse should be allocated a maximum number of patients that could be booked per day within the respective week and the professional nurse could transcribe them on the scheduling book
  - An administrative clerk could be stationed in a convenient area and schedule the patients according to the information provided by the professional nurse on the chronic patient record.

### Determining the appointment date

Depending on the patient's condition and availability of medication at the facility, the patient will either return on:

- A monthly basis if unstable or complicated patient
- Every 2nd or 3rd month for a repeat prescription if the patient is clinically stable
- After six months if the patient has been down referred to the PHC outreach team.

### Scheduling the appointment

- The maximum number of patients that should be consulted daily is pre-determined per facility usage.
- At the beginning of each week, the professional nurses should determine and provide a five day period during which returning patients should be scheduled.
- This should be calculated between 25 and 30 days after the current date.
- All patients should then be given a choice as to the exact date that they would like to return within this period. *The date should not be imposed on the patient.*
- An appointment file or register needs to be completed using the format described below.

  - Patients that are to be initiated on ART should be scheduled for afternoon sessions when NIMART trained or PALSA plus trained nurses will be available to provide them a dedicated service.

TOOL 25

## Appointment scheduling format - no time slots

| DATE OF APPOINTMENT | | | | | | |
|---|---|---|---|---|---|---|
| CALENDAR DAY | | | | | | |
| NO | PATIENT FILE NUMBER | SURNAME AND INITIALS OF PATIENT | DIAGNOSTIC CONDITION | COMMENTS | FILE RETRIEVED (Y/N) | PATIENT ATTENDED (Y/N) |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |
| 11 | | | | | | |
| 12 | | | | | | |
| 13 | | | | | | |
| 14 | | | | | | |
| 15 | | | | | | |
| 16 | | | | | | |
| 17 | | | | | | |
| 18 | | | | | | |
| 19 | | | | | | |
| 20 | | | | | | |
| 21 | | | | | | |
| 22 | | | | | | |
| 23 | | | | | | |
| 24 | | | | | | |
| 25 | | | | | | |
| 26 | | | | | | |
| 27 | | | | | | |
| 28 | | | | | | |
| 29 | | | | | | |
| 30 | | | | | | |
| NON-SCHEDULED PATIENTS | | | | | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |

### Date of appointment

This refers to a calendar date. To facilitate the smooth running of the appointment dates you should label all the dates in the forms to cater for operating calendar days for the facility for the year, e.g. 9th April 2012, 10th April 2012.

### No.

Number refers to the numerical order in ascending order. This will guide you as to when you reach your target appointments for the respective date, e.g. 32 per day.

### Calendar day

Refers to the day of the week - Monday to Friday, and Saturday and Sunday in some instances.

### Patient file number

This refers to the patient file number as indicated on the patient record. This will facilitate easy retrieval of the patient record prior to the appointment.

### Surname and initials

This should be as reflected in patient's identity documents and /or patient records.

### Diagnostic condition

This refers to the chronic condition for which the patient is booked for, e.g. hypertension, diabetes, epilepsy, asthma, COPD, ART.

### Comments

This column should contain comments that will assist in triaging the patients as well as monitoring the patient in the process, for example:

- Patient defaulted-referred for tracing - you can add address and health tracers name
- Doctor appointment
- Six month appointment
- Repeat prescription and collection of medication
- Referred to ophthalmologist/ophthalmic nurse
- Referred to social worker.

### File retrieved

Pre-appointment retrieval of patient records needs to be done 1-3 days prior to the appointment. When the administrative clerk retrieves the patient's file, a tick should be made in this column to indicate the file has been retrieved. A cross should be made in red pen if the file is not found and this should be attended to.

### Patient attended

When the patient arrives for the appointment, then a tick should be placed in the column against the patient's name.

NOTE: A cross should be placed to indicate non-adherence to appointment.

### Non-scheduled appointments

Patients may default on the original appointment and arrive within the appointment grace period. The patient's details should be recorded in the relevant section. The original appointment date should be noted in the comments section.

### What happens if a patient misses a scheduled appointment?

- The pre-dispensed medication will only be kept in the consulting room for a further five working days.
- The patient's record will be filed back in the main filing area after five working days.
- Should the patients come within five working days after their scheduled date, the patient will be consulted after all the patients allocated to that time slot have been consulted even if they arrive first. The patient will be placed at the back of the chronic queue.
- Should the patient arrive after five working days, the patient will need to follow the normal process of retrieving their files, wait for the vital signs and be consulted after all the chronic patients have been completed.
  - Defaulter tracing
  - After five working days the patient details should be provided to the WBOT who should trace the patient and refer to the facility.
  - When the patient arrives at the facility the patient should be referred for adherence counselling.

### Time scheduling of the appointments

- In order to avoid the batching of patients and prolonging the waiting times, patients should be offered time slots for attending the appointment.
- Patient's requiring six month appointments should be distributed equally across the time slots or scheduled in a specific time slot to avoid prolonging the waiting times for other patients.
- The time slots should be per two hour session with 10-12 patients scheduled per two hour session.

TOOL 26

## Appointment scheduling format - time slots

| DATE OF APPOINTMENT | | | | | | |
|---|---|---|---|---|---|---|
| CALENDAR DAY | | | | | | |
| NO | PATIENT FILE NUMBER | SURNAME and INITIALS OF PATIENT | DIAGNOSTIC CONDITION | COMMENTS | FILE RETRIEVED (Y/N) | PATIENT ATTENDED (Y/N) |
| TIME SLOT: 07H00-09H00 | | | | | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |
| TIME SLOT: 09H00-11H00 | | | | | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |
| TIME SLOT: 11H00-13H00 | | | | | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |
| TIME SLOT: 13H00-16H00 | | | | | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |

# 5. Pre-dispensing of chronic medication

- Two days prior to the patient's appointment, the patient's clinical records and scheduling list should be provided to the allocated professional nurse for chronic patients or the pharmacy assistant, where available.
- The designated professional should pre-dispense the chronic medication according to the prescription.
- The medication should be pre-packed in a brown bag or clear opaque plastic bag, where available.
- A sticker with the patient's name and file number should be placed on the external part of the bag.
- The bag should not be closed as to validate the medication on dispensing to the patient.
- Where plastic bags are not available the facility should adopt innovative measures to pre-dispense the medication
- Once the medication has been pre-dispensed, depending on the allocation of the patient, the medication should then be placed in the medication cupboard according to alphabetical order in the respective consultation rooms, or kept in the pharmacy if it is to be dispensed by a pharmacist assistant.

# 6. Integration of clinical records

- Each patient (except active TB patients) should have a single file for acute and chronic records.
- The facility should have a single system for filing and storing all patients' clinical records.
- The records should not be stored per diagnostic condition but rather by the first three letters of the patient surname and date of birth, or address e.g. ASM600108 or as per provincial/district filing protocol.
- In order to identify a chronic patient's record a colour coded sticker (blue) should be affixed to the front cover.

## Organisation of the chronic record

- **The front cover of the clinical record should display the following:**

**Patient's name and surname**

**Physical address**

**Identity number**

**File number**

**Colour coded sticker.**

## ▸ INSIDE FRONT COVER:

In order to link the chronic patient with a specific national register, the table depicted below should be affixed to the inside of the front cover.

The register number or file number allocated to the patient in the respective registers should be completed in the appropriate row. This is for ease of entry into national registers.

TOOL 27

### Patient record identification

| REGISTER | FILE/REGISTER NUMBER |
|---|---|
| IMMUNISATION | |
| CHRONIC | |
| MENTAL HEALTH | |
| ANC | |
| PMTCT | |
| PRE-ART | |
| ART | |
| IPT | |
| TB | |
| FAMILY PLANNING | |

## Contents of the record

▶ Each chronic patient file should contain the following sections:

**Chronic patient follow up records**

**Continuation sheets**

**Additional national stationery such as ART stationary for relevant patients**

**Section for laboratory investigations**

**Repeat prescriptions.**

# 7. Scheduling of professional nurses

- The professional nurses allocated to consulting chronic patients should be preferably PC 101 trained or primary care trained.
- In the interim period, whilst all the professional nurses are being trained on PC 101, nurses with additional PHC and/or PALSA Plus or NIMART training should be scheduled to consult chronic patients.
- The roster system should be designed for a monthly, two-monthly or quarterly rotation dependent on the number of trained professional nurses available and the number of chronic consultation rooms required for the patient load at that facility.

TOOL 28

## Nurse scheduling format

| NAME OF PROFESSIONAL NURSE | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
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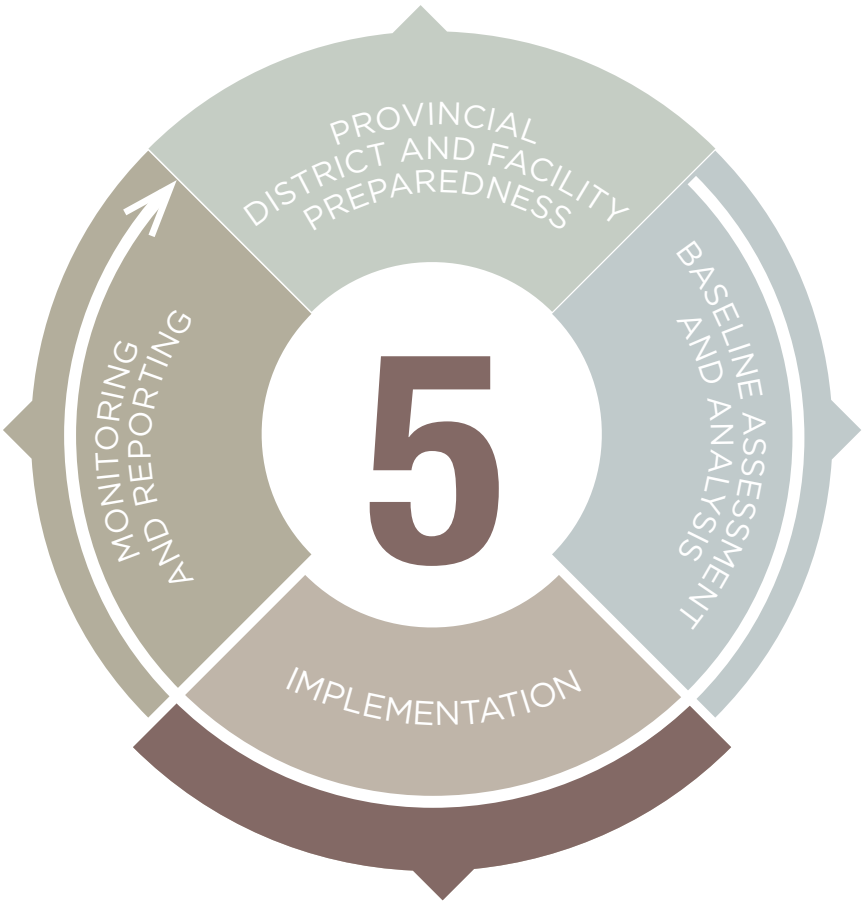
Section five

05

# CLINICAL MANAGEMENT SUPPORT

This section discusses the tools available for clinical management and their application in improving the care of patients with chronic diseases.

- The purpose of the clinical management support is to:
  - Assist professional nurses and other health care professionals at PHC level to provide holistic care to patients in accordance with best practices and following evidence-based guidelines
  - Improve the quality of care provided to patients with chronic diseases
  - To achieve optimal clinical stability of the disease condition
- Clinical management support consists of the following:
  - Clinical care and support:
    - Evidence-based clinical guidelines (PC101)
    - Health promotion compendium and guidelines(*in development* )
  - Chronic patient record (to supplement clinical ART stationary)
  - District Clinical Specialist Team (DCST) to provide mentoring and supervision.




**Clinical management support**

- Chronic patient follow up record
- PC101 training and application of algorithmic based guidelines
- Health promotion compendium
- Supportive supervision by district clinical specialist teams

**FIGURE 33:** ICDM IMPLEMENTATION APPROACH

# 1. Chronic patient record

The chronic patient record is primarily a checklist to ensure that patients attending the primary care facility for chronic disease management over a 12 month period are reviewed systematically and comprehensively at each visit and the appropriate laboratory investigations are conducted.

- This chronic patient record does not serve to replace the requirement for a comprehensive patient record.
- The chronic patient record is to be used as an adjunct together with the ART stationery for patients that are on ART.

## APPLICATIONS OF THE CHRONIC PATIENT RECORD:

- Primarily for use for patients attending for chronic care (communicable and non-communicable).
- To be used in conjunction with pre-existing National Patient record tools for HIV, ART and TB.
- Should form part of the records for all patients included in ICDM.

# 2. Procedure for the completion of the chronic patient record

## Part A: Diagnostic condition

- Complete the diagnosis for which the patient is enrolled on the ICDM programme by placing a cross in the column adjacent to the diagnostic condition.
- For example, if the patient enrolled on the ICDM programme is an epileptic than make a cross against the diagnostic condition (as demonstrated in the table below with an orange cross).
- If a patient has co-morbidity, such as a patient receiving ART and is hypertensive, then make crosses in the columns adjacent to both conditions (as demonstrated in the table below with a green cross).

In the column adjacent to the diagnosis write the date on which the condition was diagnosed.

| DIAGNOSTIC CONDITION | ASTHMA/ COPD | | DIABETES | | HPT | 20/06/2001 |
|---|---|---|---|---|---|---|
| | TB | | EPILEPSY | **13/10/07** | HIV-ART | |
| | MENTAL ILLNESS | | OTHER - FOR E.G. | | HIV NOT YET ON ART | **18/08/2010** |

## Part B: Patient details

Complete the following details for the patient in the space provided:

- Name and surname as is contained in the patients identity book
- Clinic file number is the number that appears on the main folder and is the unique identifier for the patient's record
- Circle the gender of the patient using M = male and F = female
- Allergies - please ask the patient specifically about medication allergies and record in the appropriate space, e.g. penicillin, sulphur
- If the patient's identity document is available, then complete the patients identity number in the space provided
- If the patient is a foreign citizen or the identity number is not available, then record the patient's date of birth or passport number in the space provided
- The height of the patient should be measured on the 1st and 7th consultations and should be recorded in the space provided.

| | | | | | | |
|---|---|---|---|---|---|---|
| NAME and SURNAME | | | | | | |
| CLINIC FILE NUMBER | | GENDER | M | F | ALLERGIES | |
| IDENTITY NUMBER OR DATE OF BIRTH | | | | | HEIGHT | BMI |

The patient's body mass index (BMI) should be calculated on the 1st and 7th month using the formulae (Weight/height$^2$) and should be recorded in the space provided.

## Part C: Patient visit details

- The top row refers to the calendar month and should be completed as follows:
  a. The month of the visit should be indicated next to the numbers in the top row, for example, if the chart is being used for the 1st time in July, then July will be written adjacent to the number 1, as in the example below
  b. In the subsequent columns the subsequent calendar months should be recorded.

| MONTH | 1 - JULY | 2 - AUGUST | 3 - SEPTEMBER | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| DATE CONSULTED | 01 July 2012 | 2 Month | TREATMENT PROVIDED | | | |

- The date consulted indicates the exact date of the patient's consultation
- When the patient is provided with 2-3 monthly appointments, then the following should be written under month 2 and or month 3 -"**2 or 3 months treatment provided".**

## Part D: Vital signs

- The patient's weight should be measured at every appointment and recorded in the first row in line with the corresponding month.
- The patient's blood pressure should be measured at every appointment and recorded in the second row in line with the corresponding month.
- The patient's blood sugar should be measured according to the appropriate guidelines and recorded in the third row in line with the corresponding month.
- Urine dipstick results will be performed according to the appropriate guidelines and recorded in the fourth row in line with the month in which it was conducted, if not done routinely at every visit. For the urine dipstick the results should be recorded as NAD if no abnormalities detected. If any of the components are positive this should be recorded as in the example.
- The pulse reading should be recorded in the column. The rhythm should be noted. Abnormalities should be recorded in case records.

| VITAL SIGNS | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| WEIGHT | 78,6 | 79 | Patient | provided | | |
| BLOOD PRESSURE | 130/90 | 130/90 | medication | for | | |
| BLOOD SUGAR | 7.1 | 6.5 | 2 months | | | |
| URINE | ++ leuc | NAD | | | | |
| PULSE | 70 REGULAR | | | | | |

## Part E: History

| SYMPTOMS | 1 | 2 |
|---|---|---|
| ANY ACUTE EPISODES OR SYMPTOMS? | YES | NO |

The first row should indicate whether the patient has experienced any acute episodes (especially for asthma, COPD, epilepsy or mental illness) or has experienced any symptoms of illness or complications over the past month or three months depending on appointment schedule. It should be completed as follows:

- This should be indicated by either by YES or NO
- The details should be recorded in the patients chart for NCDs
- For HIV patients on ART the details should be recorded in the appropriate portion of the ART stationary
- For TB patients the details should be recorded in the appropriate portion of the TB stationary.

The symptoms that should be probed for include but are not restricted to the following: **Refer to PC 101 for details of symptoms.**

| ASTHMA | COPD | DIABETES | EPILEPSY | HYPERTENSION | MENTAL ILLNESS |
|---|---|---|---|---|---|
| DAY TIME COUGH | PRODUCTIVE COUGH WITH YELLOW SPUTUM | ANY CHEST PAINS, BLURRING OF VISION, PINS AND NEEDLES IN THE LEG, CONSTIPATION | ANY SEIZURES IN THE LAST MONTH | CHEST PAINS, DIFFICULTY BREATHING | DEPRESSED MOOD, FATIGUE, LACK OF PLEASURE |
| TIGHT CHEST | TIGHT CHEST | FREQUENCY OF URINATION | BLURRING OF VISION | BLURRING OF VISION | DECREASED CONCENTRATION, DISTURBED SLEEP, DECREASED APPETITE |
| DIFFICULTY BREATHING > 2 TIMES PER WEEK | DIFFICULTY BREATHING > 2 TIMES PER WEEK | HEADACHES, PALPITATIONS, DIZZINESS WEAKNESS, TIREDNESS | | HEADACHES, PALPITATIONS, DIZZINESS, WEAKNESS, TIREDNESS | TENSE, NERVOUS, WORRIED |
| | | | | | HEARING VOICES, SEEING VISIONS, DELUSIONS |

- The patient should be asked about the effect of the condition on their ability to conduct their normal activities. This should be graded as mild, moderate or severe and reflected accordingly in the appropriate column, for example:
  a. Do you experience any difficulty with strenuous activities like climbing up stairs? (Mild)
  b. Do you experience any difficulty walking at normal pace? (Moderate)
  c. Do you experience any difficulty with activities of daily living like dressing? (Severe)

| ANY LIMITATION OF ACTIVITY? | MILD | MODERATE | SEVERE |
|---|---|---|---|

| NIGHT SYMPTOMS? | YES | NO |
|---|---|---|

- The patient should be asked whether they experience any symptoms at night that causes them to awake from their sleep.

**↘ Positive findings should be recorded in the check sheet and details should be recorded in case notes.**

- The patient should be asked whether they visited the General Practitioner or other health facilities during the period before the current visit, or was hospitalised during this period.

| HOSPITALISATION OR DOCTOR VISITS? | YES | NO |
|---|---|---|

**↘ Positive findings should be recorded in the check sheet and details should be recorded in case notes.**

- A pill count should be conducted or the patient should be asked how often they take their medication and what medication they take.

| | | |
|---|---|---|
| ADHERENCE TO MEDS- PILL COUNT? | YES | NO |

> ↘ **Positive findings should be recorded in the check sheet and details should be recorded in case notes**.

- The patient should be asked specifically about any side–effects while taking medication.

| | | |
|---|---|---|
| SIDE-EFFECTS TO MEDS | YES | NO |

> ↘ **Positive findings should be recorded in the check sheet and details should be recorded in case notes**.

- The patient should be asked if they use any additional medication except the chronic medication and this should be completed in the appropriate column.

| | |
|---|---|
| ADDITIONAL MEDICATION | AMOXICILLIN |

> ↘ **Positive findings should be recorded in the check sheet and details should be recorded in case notes**.

- An enquiry should be made regarding the following :
  a. whether the patient smokes cigarettes,
  b. consumes alcohol ,or
  c. uses snuff.

| | | |
|---|---|---|
| TOBACCO / ALCOHOL / SNUFF USE | YES SMOKES | YES ALCOHOL |

> ↘ **Positive findings should be recorded in the check sheet and details should be recorded in case notes**.

## Part F: Examination - refer to PC 101 for detail

The patient should be fully examined with a view to detecting worsening clinical condition(s) or complications, especially cardiac failures.

| EXAMINATION | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| PULSE | | | | | | |
| PEDAL OEDEMA | | | | | | |
| CHEST | | | | | | |
| CARDIOVASCULAR | | | | | | |
| ABDOMEN | | | | | | |
| MENTAL STATE | | | | | | |
| ADDITIONAL INVESTIGATION | | | | | | |
| | | | | | | |

- **Pedal oedema:** The patient's feet above the ankle should be pressed firmly with the thumb to look for any indentation. This should be recorded as positive or negative.
- **Chest:** The lungs should be auscultated for any wheezes or fine crackles at the bases.
- **Cardiovascular:** The jugular vein in the neck should be examined to observe for any engorgement reflecting right ventricular failure. The heart sound should be auscultated.
- **Abdomen:** The abdomen should be examined for Ascites or any right-sided epigastric tenderness.
- **Mental state examination:** Determine whether the patient displays any sign of depression, anxiety or is delusional.
- **Additional investigations:** This refers to any additional investigations conducted on the visit date that is not within the guidelines for chronic patients.

## Part G: Prescribed medication

The patient's medication should be transcribed in this section.

- In the column adjacent to the name of the medication, the number of tablets issued to the patient should be recorded.
- The medication that has been changed should have a line drawn across the six months and the word 'stopped' should be written across the columns.
- The changed medication should be recorded in a vacant row and the medication dispensed against this item will be reflected in the corresponding months from which the medication was issued.

| PRESCRIPTION (MONTH 0) | 1 | 2 | 3 | 4 | 5 | 6 |
|---|---|---|---|---|---|---|
| METFORMIN 500MG | ~~28~~ | ~~28~~ | ~~Stop~~ | | | |
| COVERSYL PLUS 4 MG | 28 | 28 | | | | |
| ASPIRIN | 28 | 28 | | | | |
| METFORMIN 850MG<br>ED | | | 56 | | | |
| | | | | | | |

## Part H: Health education / promotion

- Specify what aspect of health promotion / education was provided at each visit, for example:
  a. Lifestyle modification with goal setting at each visit - diet, exercise, alcohol, tobacco
  b. Drug compliance
  c. Disease-specific education
  d. Cancer screening, e.g. breast examination, cervical smears, prostate cancer screening
  e. Sexual and reproductive health
  f. Education about HIV and PICT.

| HEALTH EDUCATION / PROMOTION | | |
|---|---|---|

## Part I: Healthcare practitioner administrative details

| | | | | | | |
|---|---|---|---|---|---|---|
| REFERRALS | | | | | | |
| DATE OF NEXT VISIT | | | | | | |
| HCP NAME | | | | | | |
| HCP SIGNATURE | | | | | | |
| DR SIGNATURE | | | | | | |

Record if any external referrals have been made. Indicate hospital or doctor and provide details in case records.

- Indicate the date for the next visit. This should be indicated in weeks (3/52, 4/52 or 8/52) so that the person making the appointment can discuss a suitable date with the patient.
- Complete your name-professional or doctor who undertakes initial consultation.
- Sign the check list as well.
- The doctor's signature is required if patient consulted a doctor at clinic on same day as part of a referral from the professional nurse.

## Part J: Additional examination

Column 7 lists ANY additional examination that needs to be performed six monthly or annually on patients according to the protocols (PC 101). These include physical examinations and laboratory investigations.

- **Foot Examination:** This should be performed on diagnosis and annually if no symptoms and signs of peripheral neuropathy or peripheral vascular diseases:
  a. Indicate the date on which this examination was conducted
  b. Under results indicate NAD or abnormal (ABN). If abnormal, describe details in case records.
- **Eye:** An annual ophthalmic examination is required for diabetics:
  a. Indicate the date on which this was conducted by the ophthalmic nurse and indicate results
  b. Under results indicate NAD or ABN. If abnormal, describe details in case records.
- **Urea and Electrolytes (U&E):** This is required for diabetic and hypertension patients annually:
  a. Indicate the date on which this was conducted
  b. Under results indicate NAD or ABN. If abnormal, describe details in case records.
- **$HBA_{1C}$:** This is required for diabetic patients annually if stable and after 3 months if treatment is changed:
  a. Indicate the date that this was conducted
  b. Under results, record the results.
- **Cholesterol:** Required at diagnosis:
  a. Indicate the date that this was conducted
  b. Under results, record the results.
- **Cervical smear:** This is required as per protocol or high risk groups:
  a. Indicate the date on which this was conducted
  b. If smear was done at 6 months then in next 6 months record date only
  c. Under results indicate NAD or ABN. If abnormal, describe details in case records and next steps.

TOOL 29

## Chronic patient record

THE PATIENT SHOULD NOT BE GIVEN A 2 MONTH APPOINTMENT ON THE 5TH MONTH AS THE PRESCRIPTION WILL NEED TO BE REVIEWED.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **DIAGNOSTIC CONDITION** | ASTHMA/ COPD | | DIABETES | | | HPT | |
| | TB | | EPILEPSY | | | HIV-ART | |
| | MENTAL ILLNESS | | OTHER | | | HIV NOT YET ON ARV | |
| **NAME & SURNAME** | | | | | | | |
| **CLINIC FILE NUMBER** | | | **GENDER** | M | F | **ALLERGIES** | |
| **IDENTITY NUMBER OF DATE OF BIRTH** | | | | | | **HEIGHT** | **BMI** |
| **MONTH OF VISIT** | **1** | **2** | **3** | **4** | **5** | 6 | **ADDITIONAL EXAMS** |
| Date consulted | | | | | | | |
| Vital signs | | | | | | | **FOOT** |
| Weight | | | | | | | Date Conducted |
| Blood pressure | | | | | | | |
| Blood sugar | | | | | | | Results |
| Urine | | | | | | | |
| Pulse | | | | | | | |
| **HISTORY** | **1** | **2** | **3** | **4** | **5** | 6 | **EYE** |
| Any acute episodes or symptoms? | | | | | | | Date Conducted |
| Any limitation of activity? | | | | | | | |
| Night symptoms? | | | | | | | Results |
| Hospitalisation or doctor visits? | | | | | | | **U&E** |
| Adherence to meds pill count? | | | | | | | |
| Side effects of meds | | | | | | | Date Conducted |
| Additional medication | | | | | | | |
| Tobacco/alcohol/snuff use/illicit drugs | | | | | | | Results |
| **EXAMINATION** | **1** | **2** | **3** | **4** | **5** | 6 | |
| Pedal oedema | | | | | | | **HBA1C** |
| Chest | | | | | | | Date Conducted |
| Cardiovascular | | | | | | | |
| Abdomen | | | | | | | Results |
| Mental state | | | | | | | |
| Investigations ordered | | | | | | | **CHOLESTROL** |
| | | | | | | | Date Conducted |
| **PATIENTS MEDICATION** | **1** | **2** | **3** | **4** | **5** | 6 | |
| | | | | | | | Results |
| | | | | | | | **CERVICAL SMEAR**** |
| | | | | | | | Date Conducted |
| | | | | | | | Results |
| **HEALTH EDUCATION/PROMOTION** | **1** | **2** | **3** | **4** | **5** | 6 | |
| **REFERRALS** | | | | | | | |
| **DATE OF NEXT VISIT** | | | | | | | |
| **HCP NAME** | | | | | | | |
| **HCP SIGNATURE** | | | | | | | |
| **DR'S SIGNATURE** | | | | | | | |

TOOL 29 (CNTD)

## *Chronic patient record*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **DIAGNOSTIC CONDITION** | ASTHMA/ COPD | | DIABETES | | | HPT | |
| | TB | | EPILEPSY | | | HIV-ART | |
| | MENTAL ILLNESS | | OTHER | | | HIV NOT YET ON ARV | |
| **NAME & SURNAME** | | | | | | | |
| **CLINIC FILE NUMBER** | | | **GENDER** | M | F | **ALLERGIES** | |
| **IDENTITY NUMBER OF DATE OF BIRTH** | | | | | | **HEIGHT** | **BMI** |
| **MONTH OF VISIT** | **7** | **8** | **9** | **10** | **11** | 12 | **ADDITIONAL EXAMS** |
| Date consulted | | | | | | | |
| Vital signs | | | | | | | **FOOT** |
| Weight | | | | | | | Date Conducted |
| Blood pressure | | | | | | | |
| Blood sugar | | | | | | | Results |
| Urine | | | | | | | |
| Pulse | | | | | | | |
| **HISTORY** | **7** | **8** | **9** | **10** | **11** | 12 | **EYE** |
| Any acute episodes or symptoms? | | | | | | | Date Conducted |
| Any limitation of activity? | | | | | | | |
| Night symptoms? | | | | | | | Results |
| Hospitalisation or doctor visits? | | | | | | | **U&E** |
| Adherence to meds pill count? | | | | | | | |
| Side effects of meds | | | | | | | Date Conducted |
| Additional medication | | | | | | | |
| Tobacco/alcohol/snuff use/illicit drugs | | | | | | | Results |
| **EXAMINATION** | **7** | **8** | **9** | **10** | **11** | 12 | |
| Pedal oedema | | | | | | | **HBA1C** |
| Chest | | | | | | | Date Conducted |
| Cardiovascular | | | | | | | |
| Abdomen | | | | | | | Results |
| Mental state | | | | | | | |
| Investigations ordered | | | | | | | **CHOLESTROL** |
| | | | | | | | Date Conducted |
| **PATIENTS MEDICATION** | **7** | **8** | **9** | **10** | **11** | 12 | |
| | | | | | | | Results |
| | | | | | | | **CERVICAL SMEAR**** |
| | | | | | | | Date Conducted |
| | | | | | | | Results |
| **HEALTH EDUCATION/PROMOTION** | **7** | **8** | **9** | **10** | **11** | 12 | |
| **REFERRALS** | | | | | | | |
| **DATE OF NEXT VISIT** | | | | | | | |
| **HCP NAME** | | | | | | | |
| **HCP SIGNATURE** | | | | | | | |
| **DR'S SIGNATURE** | | | | | | | |

# 3. Health promotion and wellness management

Tobacco use, unhealthy diet, physical inactivity, the excessive use of alcohol and the use of illicit drugs are common risk factors for the four priority NCDs as demonstrated in Figure 34 below.

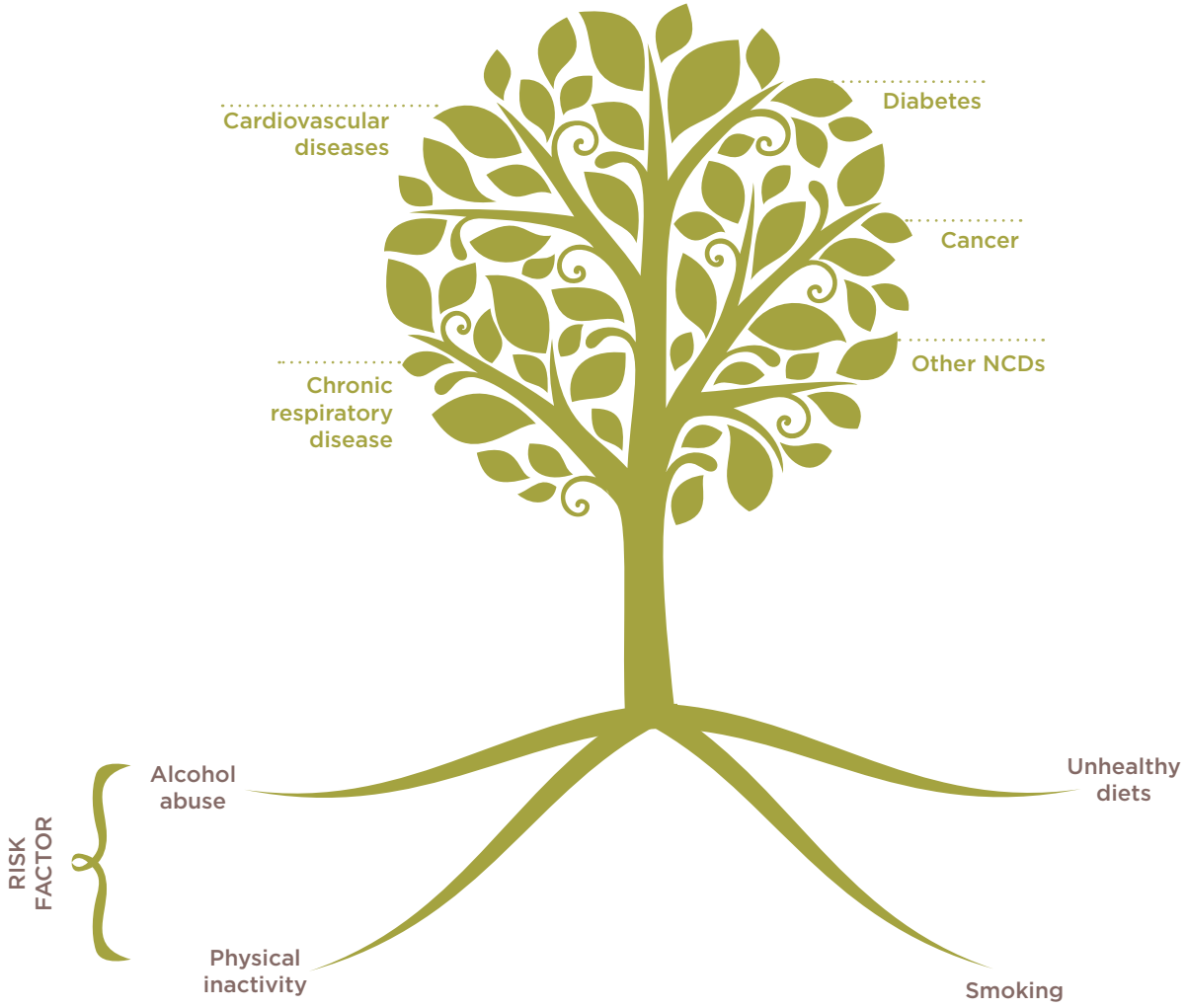



**FIGURE 34:** COMMON RISK FACTORS FOR NCDS

- **Risk factors for TB** : Generally, persons at high risk for developing TB disease fall into two categories:
  - Persons who have been recently infected with TB bacteria
  - Persons with medical conditions that weaken the immune system.

## Persons who have been recently infected with TB bacteria

- This includes:
  - Close contacts of a person with infectious TB disease
  - Persons who have immigrated from areas of the world with high rates of TB

- Children less than five years of age who have a positive TB test
- Groups with high rates of TB transmission, such as homeless persons, injection drug users, and persons with HIV infection
- Persons who work or reside with people who are at high risk for TB in facilities or institutions such as hospitals, homeless shelters, correctional facilities, nursing homes, and residential homes for those with HIV.

## Persons with medical conditions that weaken the immune system

Babies and young children often have weak immune systems. Other people can have weak immune systems, too, especially people with any of these conditions:

- HIV infection (the virus that causes AIDS)
- Substance abuse
- Silicosis
- Diabetes mellitus
- Severe kidney disease
- Low body weight
- Organ transplants
- Head and neck cancer
- Medical treatments such as corticosteroids or organ transplant
- Specialised treatment for rheumatoid arthritis or Crohn's disease.

## Risk factor for HIV infection

Certain behaviour can increase your HIV risk. These are some of the most common HIV risk factors:

- Having unprotected vaginal, anal or oral sex with someone who is infected with HIV or whose HIV status you don't know
- Having many sexual partners
- Sharing needles, syringes or equipment used to prepare or inject drugs with someone who is HIV infected
- Babies of mothers who are HIV infected
- People who have another STI, especially STIs that cause open sores or ulcers such as herpes, chancroid or syphilis
- Haemophiliacs and other people who frequently receive blood products (this risk is now very much diminished, but there are still countries where blood is not adequately screened)
- Healthcare workers, where precautions are neglected or fail (for example through not wearing gloves or accidental needle injuries).

A combination of methods can be used to target the at risk population:

- Individual approaches: May involve counselling, patient education, health risk assessment, and dietary assessments.

> ↘ Refer to the compendium on health promotion for more details-in development.

- Group approaches: May involve lectures, seminars, skills training, peer education, role play and simulation, support groups and adherence clubs.
- Population approaches: May involve mass media campaigns, social marketing, advertising etc.
- Non-governmental organisations (NGOs) such as the Cancer Association of South Africa (CANSA), Heart Foundation, Diabetes Association, Depression and Anxiety Association and Quadriplegic Association of South Africa (QUALSA) all play a critical role in health promotion and supporting patients with NCDs.
- The South African National Tuberculosis Association (SANTA) provides support for patients with TB.
- Soul City and other local support groups provide patient information and education.

> ↘ Refer to the compendium for health promotion for the appropriate messages to be provided at an individual or group level-this is in development.

# 4. Evidence-based clinical guidelines

Primary Care 101 is a 101-page clinical guideline which covers the management of all common symptoms and conditions seen in adults (15 years and above) who seek care from PHC facilities. The guideline has been expanded from PALSA Plus to address 40 common presenting symptoms and 20 chronic conditions in adults. It retains many aspects of PALSA PLUS, including the symptom-based approach and the standardised format for routine care of a chronic condition. The treatment guides in PC 101 is fully compliant with the national standard treatment guidelines for PHC facilities.

- Chronic conditions covered by the guideline include:
  - Chronic diseases of lifestyle (hypertension, diabetes, cardiovascular risk and disease)
  - Communicable diseases (TB, HIV, STIs)
  - Chronic respiratory diseases (asthma, COPD)
  - Mental health conditions (depression, anxiety, substance abuse)
  - Women's health and reproductive health (antenatal care, contraception)
  - Others (musculoskeletal conditions, epilepsy, skin conditions).
- Clinical support:
  a. Each facility will receive copies of the PC 101 Clinical Guidelines for use by professional nurses whilst consulting chronic patients
  b. At each facility, a single facility trainer will be capacitated on the methodology to train all professional nurses at the facility
  c. All professional nurses and support staff will be trained on the application of the PC 101 in the management of chronic patients by the facility trainer over the course of eight to twelve weeks to be followed by a maintenance programme to ensure strengthening of clinical care by service providers.

**For details on training methods and application of guidelines refer to the PC 101 Master Trainers Training Manual and/or PC101 Facility Trainers Manual.**

# 5. District clinical specialist teams (DCSTs)

According to the recommendations of the ministerial task team on DCSTs for South Africa, the focus of the DCSTs' activities must be on facilitation, integration and coordination of staff, services, programmes and packages of care as well as surveillance, monitoring and evaluation. The primary role of the district clinical specialist is thus supportive supervision and clinical governance and not the direct delivery of clinical services.

## ICDM ROLES FOR DCST

- Supervision and mentoring of professional nurses, PHC nurses in management of chronic diseases
- Conducting clinical audits
- Primary referral for complicated cases
- Strengthening the referral mechanism to district and regional Hospitals
- Monitoring patient clinical outcomes

## Notes

Section Six

06

# "ASSISTED" SELF-MANAGEMENT

# 1. Building the capacity of patients and communities

The focus of the "assisted" self-management component is to utilise the PHC ward based outreach team (WBOT) to support and capacitate patients and communities to take responsibility for their own health and well-being.

The aim of the self-management component of the ICDM model is to empower chronic patients to take responsibility to manage their illness through understanding the necessary preventive and promotive actions required to decrease complications and multiple encounters with the health system.

The expected outcome is to create an informed, motivated and adherent patient.

This will be achieved through:

- Primary identification of high-risk patients within families and referral to PHC facility
- Support to stable chronic patients already well-established on treatment and down-referred to PHC ward based outreach team through the following:
  - point of care testing (blood pressure and blood sugar monitoring assistance) by CHWs at the patient's home
  - medication delivery to the patient (via a courier system, NGOs or CHWs).
- Health promotion and education by the WBOT at the individual, family and community level
- Establishment of age appropriate support groups for a specific or a combination of chronic diseases to maintain and strengthen patient's control of their condition and health.

**This section of the manual describes the roles of the community health workers and provides an explanation of the steps to be followed in down referring the patient from the PHC facility to the CHW and the tasks to be fulfilled by the CHWs.**

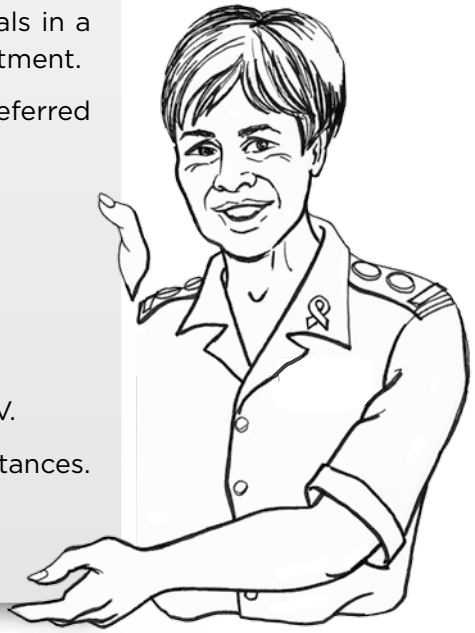
**Assisted self-management**

- Health promotion and education at community level
- Identification of at risk patients within the household by point of care screening
- Point of care testing and screening
- Support groups and adherence clubs
- Medication delivery

**FIGURE 35:** ICDM IMPLEMENTATION APPROACH

ROLE OF THE COMMUNITY HEALTH WORKERS

- The CHW is part of the PHC ward based outreach team.
- The CHW will serve as a **link** between the PHC facility and the community.
- The CHW will provide **health education and promotion** with respect to reducing the risk factors for developing chronic diseases and to prevent complications from the existing disease condition(s). This will include, but is not limited to:
  - Healthy eating habits
  - Active living through appropriate exercises
  - Reduction in tobacco and snuff use
  - Decrease in alcohol intake
  - Reduction in salt intake
  - Reduction of risk taking behaviour for sexual activity
- The CHW will conduct screening of all high-risk individuals in a family and early referral of patients for diagnosis and treatment.
- The CHW will offer point of care testing for stable down-referred patients during home visit. This will include:
  - Blood pressure measurements
  - Blood sugar screening.
- The CHW will also:
  - Screen for symptoms of TB
  - Perform provider and client initiated counselling for HIV.
- The CHW will serve as a medicine courier in certain circumstances.



## STEPS TO BE FOLLOWED IN DOWN REFERRING A PATIENT TO THE CHW

- **Once the patient is classified as stable:**
  - The patient's name, address and file number should be entered into the down referral diary
  - The patients address should be mapped with the PHC ward based outreach team leader and specifically the responsible CHW allocated to cover that locality
  - Ideally, the patient should be introduced to the CHW at the facility, so that a communication channel can be opened, but if this is not possible, then the patient should be provided with the CHW's name and contact details
  - The patient should be asked about the most convenient time and day for the CHW to visit
  - The latest date that the patient should receive a refill of medication should be entered into the diary
  - The patient should be provided with the clinic number and contact numbers for any emergencies.

### DAILY ROUTINE FOR CHWS

- Depending on the internal arrangements, the CHWs should report daily either to the clinic or to the WBOT team leader
- During this meeting the CHWs should provide a brief report of the previous day's work and also provide the records of all patients/households visited to the PHC nurse
- The PHC nurse should provide the CHWs with the pre-dispensed medication for the patients on the list for visits on that day, as well as relevant recording tools.

TOOL 30

## Down referral diary format/Patient down referral to CHW

| NAME AND SURNAME | PHYSICAL ADDRESS | CONTACT NUMBER | CONVENIENT TIME FOR CHW TO VISIT | LAST DATE BY WHICH MEDICATION SHOULD BE DELIVERED | COMMUNITY HEALTH WORKER ALLOCATED |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

### CHW's activities with respect to ICDM

- The CHW should proceed with the schedule for the day.
- The CHW should complete the patient's record during the visit to the patient's home.
- The CHW should provide point of care testing of blood pressure and blood glucose, where necessary.
- Should any of the readings be abnormal, the CHW should repeat the measurement after 10 minutes.
- If it is still abnormal, then the patient should be referred to the WBOT leader or to the facility and this should be recorded in the chart.
- If all the measurements are normal and the patient has no complications, the pre-dispensed medication package should be opened and the patient should check the medication against the prescription and sign the acknowledgement of receipt attached to the packet.

TOOL 31

## Tool for acknowledging receipt of medication by patient

| | | | | | |
|---|---|---|---|---|---|
| NAME and SURNAME | | | | | |
| CLINIC FILE NUMBER | | | | | |
| IDENTITY NUMBER OR DATE OF BIRTH | | | | | |
| MONTH IN SCHEDULE | | | | | |
| DATE OF MEDICATION DELIVERY | | | | | |
| DISPENSER'S SIGNATURE (TO BE COMPLETED AFTER CHECKING, PLACING LABEL AND SEALING PACKET) | | | | | |
| CHWS SIGNATURE ON RECEIPT OF MEDICATION (SEALED BAG) | | | | | |
| PATIENTS SIGNATURE ON OPENING OF SEALED BAG AND CHECKING MEDICATION | | | | | |
| MEDICATION NOT DELIVERED | | | | | |

### Completion of the chronic patient record by the CHW

- A summary patient record to ensure continuity of care has been designed for completion by the CHW.
- Medication list should be completed at facility level and the CHW will tick against the medication provided to the patient.

TOOL 32

## Chronic patient record for use by CHWs

| | | | | | | |
|---|---|---|---|---|---|---|
| NAME AND SURNAME | | | | | | |
| CLINIC FILE NUMBER | | | | MALE | | FEMALE |
| IDENTITY NUMBER OR DATE OF BIRTH | | | | | | |
| **MONTH OF VISIT** | **1** | **2** | **3** | **4** | **5** | **6** |
| Date consulted | | | | | | |
| **Vital signs** | **1** | **2** | **3** | **4** | **5** | **6** |
| Weight | | | | | | |
| Blood pressure | | | | | | |
| Blood sugar | | | | | | |
| Urine | | | | | | |
| **SYMPTOMS** | **1** | **2** | **3** | **4** | **5** | **6** |
| Any complaints | | | | | | |
| Any limitation of activity | | | | | | |
| Adherence to meds – pill count | | | | | | |
| Any side-effects | | | | | | |
| **HEALTH EDUCATION / PROMOTION** | **1** | **2** | **3** | **4** | **5** | **6** |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| REFERRALS | | | | | | |
| DATE OF NEXT VISIT | | | | | | |
| CHW NAME | | | | | | |
| CHW SIGNATURE | | | | | | |
| PATIENT'S SIGNATURE ON RECEIPT OF MEDICATION | | | | | | |

- Demographic details of the patient and should already be completed at the clinic prior to the down referral.
- Date of Consultation
- Vital signs readings

**TO BE COMPLETED BY CHW**

- Record yes or no to the questions. Details in patient folder
- Record of any referrals
- Record the nature of health promotion/education provided
- The CHW should tahen indicate date for next visit and sign the record.
- This record will then be handed over to the professional nurse and then facility/ pharmacy for dispensing of medication for next month visit.

# 2. Population level awareness and screening

The WBOTs should play a critical role in raising the level of awareness of chronic diseases at a population level.

Primary prevention is most successful if be conducted at a population level to increase awareness about the social determinants of health and their direct impact on the development of chronic diseases.

This can only be achieved through the participation of the WBOTs in awareness campaigns that may be organised to co-incide with specific events within the health calendar.

Social marketing should be used at sports and religious events to raise awareness about chronic conditions.

Screening services should be provided during special events or at strategic points to identify asymptomatic patients or to identify at risk individuals and refer them appropriately.

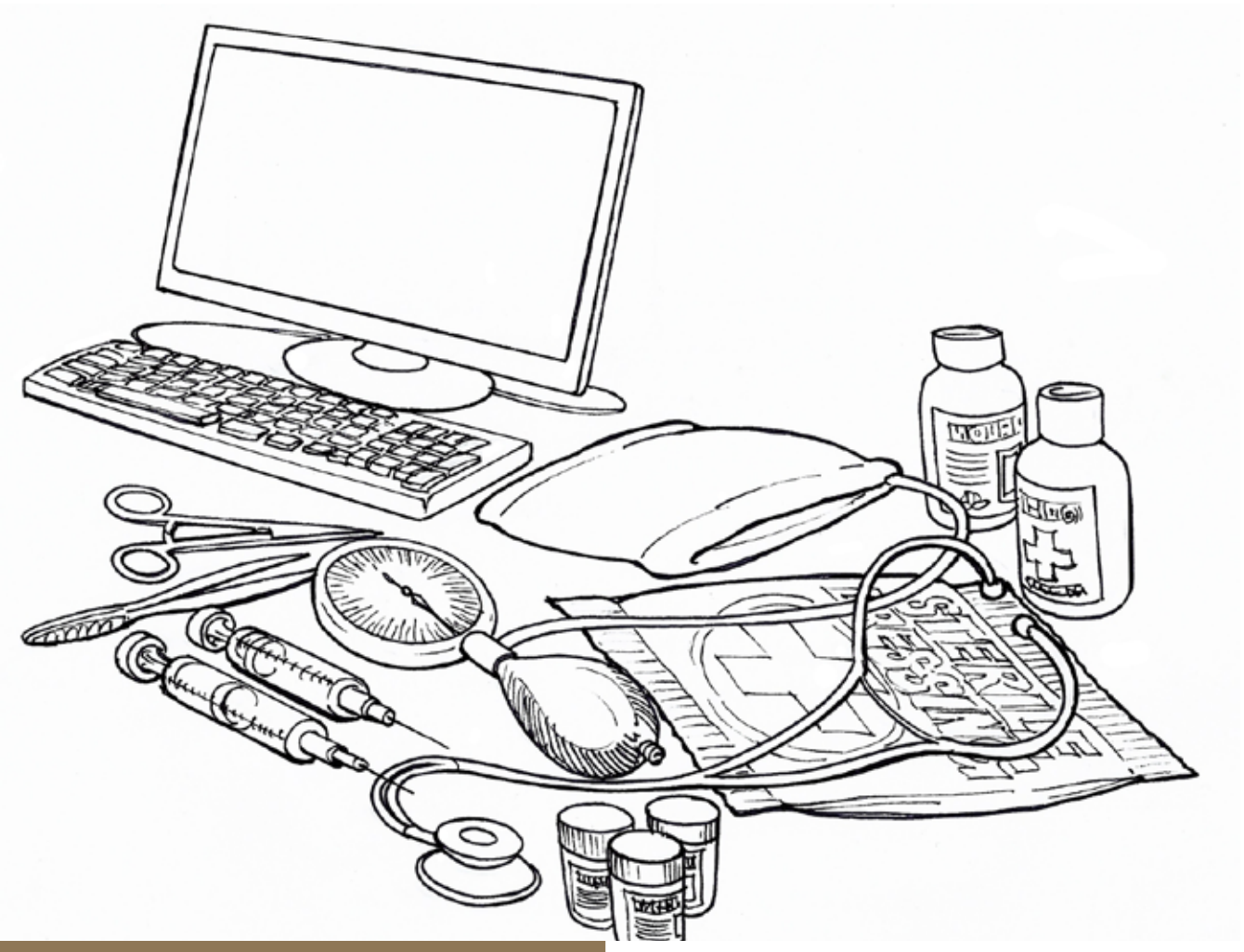
ISHTs will primarily conduct health education and awareness campaigns at school level and provide screening services to assist with the early detection of chronic diseases and the appropriate referral of these high-risk patients.

## Notes

Section Seven

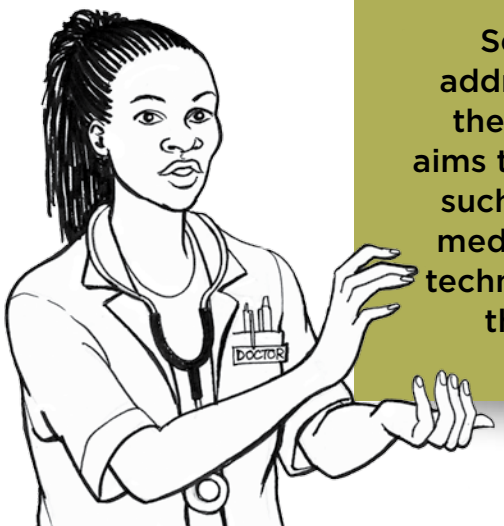
07

# SYSTEM STRENGTHENING AND SUPPORT



The ICDM model adopts a diagonal approach to health system strengthening, i.e. technical interventions that improve the quality of care for chronic patients coupled with the strengthening of the external support systems and structures to enhance the functioning of the health system as a whole.

**FIGURE 36:** ICDM IMPLEMENTATION APPROACH




**Section 3, 4, 5 and 6 of the manual have addressed the service delivery component of the ICDM model. This section of the manual aims to address the health system strengthening such as human resources, health information, medicines supply and availability, Equipment, technology and advocacy that are essential for the implementation of the ICDM model.**

**FIGURE 37:** HEALTH SYSTEM BUILDING BLOCKS

# 1. Human resources

**THE PURPOSE OF STRENGTHENING THE WORKFORCE IN IMPLEMENTING THE ICDM MODEL IS:**

- To create a competent calibre of professional nurses and medical practitioners for the optimal management of patients with chronic diseases
- To optimise the utilisation of professional health workers.

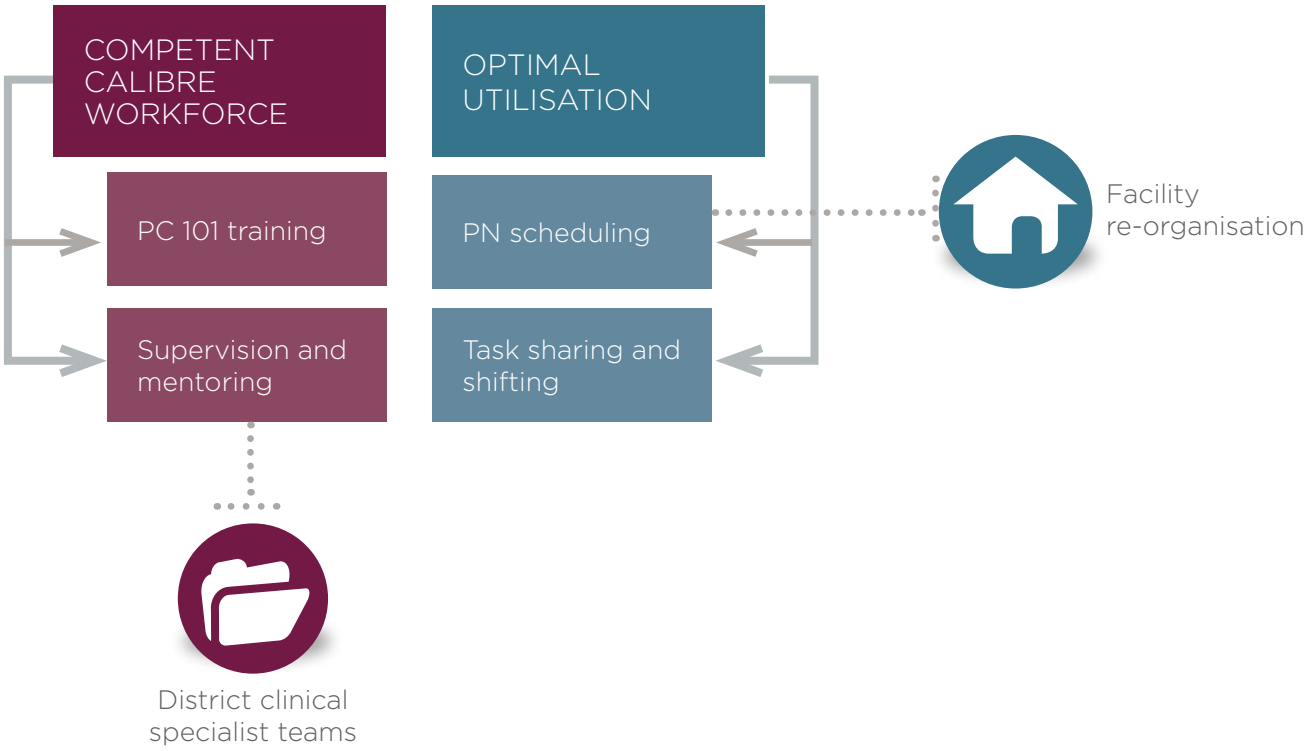



**FIGURE 38:** WORKFORCE STRENGTHENING

The following key ICDM activities will be implemented to achieve the above stated objectives:

- Scheduling of professional nurses as discussed under facility re-organisation.
- Capacitation of all professional staff on the algorithmic management of chronic diseases (communicable and non-communicable) using a symptoms-based approach.
- Task sharing and shifting such that non-clinical work is performed by an appropriate cadre of staff and the delegation of some activities to a lower level cadre. This will release the burden often placed on professional staff to render patient care services.
- Mentoring and supervision through the district clinical specialist team as discussed under clinical management support.

### ▶ Primary Care 101 training

Primary Care 101 is a 101-page clinical guideline which covers the management of all common symptoms and conditions seen in adults who seek care at primary health care level.

PC 101 training is the accompanying training programme where all primary care staff are trained during short training sessions at the primary care facility over a prolonged period. This form of on-site training, known as **educational outreach**, is delivered by **facility trainers** who are nurses drawn from the system. **Master trainers** are trained to train and support these facility trainers and track implementation of the training programme.

Primary Care 101 aims to:

- Empower nurses to change the management of all chronic diseases.
- Build on the NIMART approach, where nurses were equipped to manage HIV&AIDS using clear guidelines and with ongoing mentorship and support.

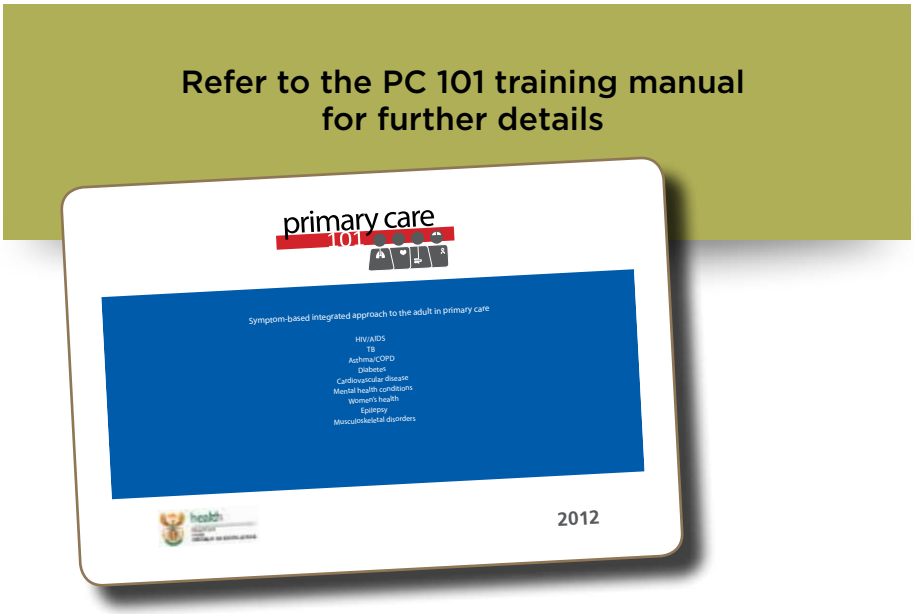


**FIGURE 38:** PC 101 PRINCIPLES

**FIGURE 39:** PC 101 CASCADE MODEL

### Task shifting and sharing

Task shifting is defined as the rational redistribution of tasks among health workforce teams[10]. When feasible, healthcare tasks are shifted from higher-trained health workers to less highly trained health workers in order to maximise the efficient use of health workforce resources. The four main cadres of workers among whom tasks can be shifted are:

- Medical doctors
- Medical assistants
- Nurses
- Community health workers.

Task sharing adopts a team approach whereby different cadres of the health workforce work together to achieve the stated objectives.

Task shifting has already been introduced at the PHC level through the ART programme. The ICDM model builds on this approach by adopting a task shifting and sharing approach where tasks will be shifted from higher trained workers such as medical practitioners to professional nurses and to CHWs who will now work as a team and share the responsibility for delivering care for chronic patients.

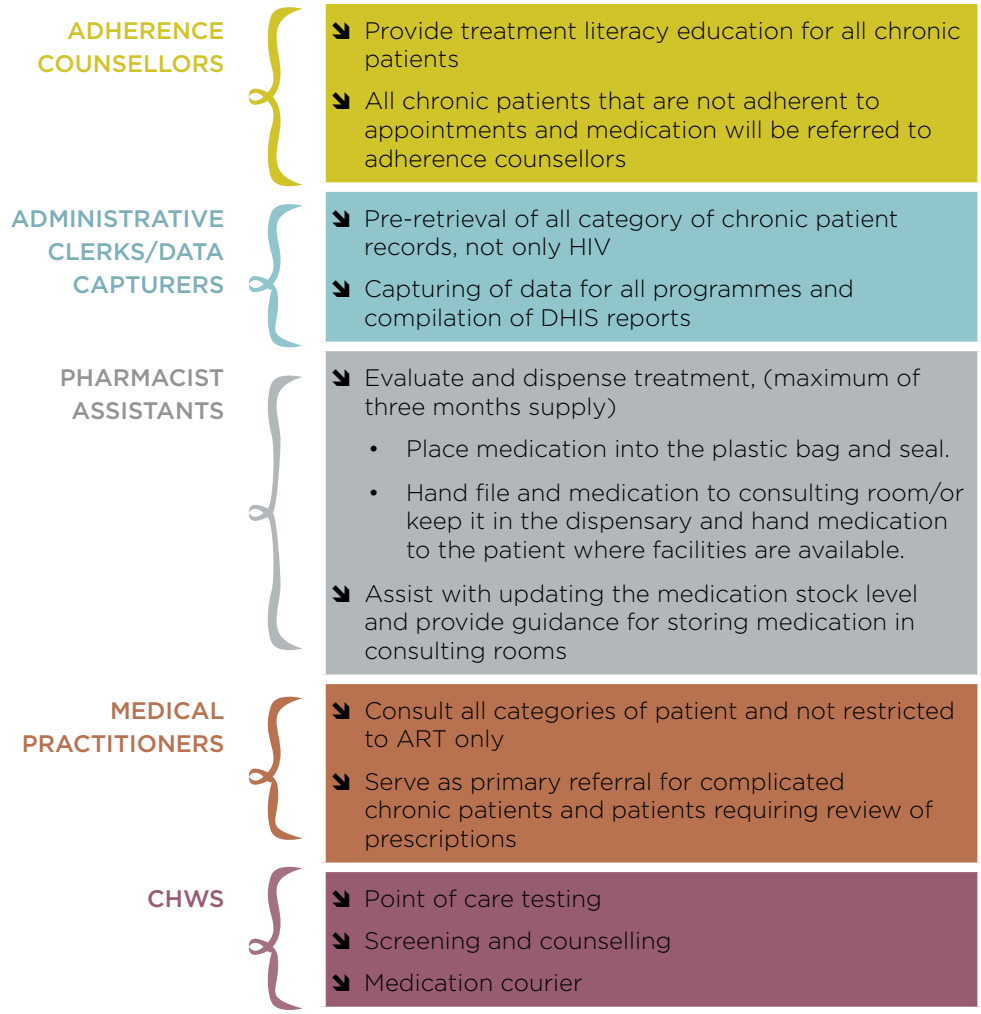



**FIGURE 40:** TASK SHIFTING AND SHARING FOR ICDM

# 2. Health information

The district health information system (DHIS) is the primary vehicle through which data is routinely collected from facilities.

The purpose of implementing a data collection tool in the ICDM model is to ensure that the chronic programme is viewed comprehensively and to facilitate the collection of outcome data that would improve the quality of chronic care.

Many of the identified data items are **already routinely collected** at the facility as a part of the DHIS. There are no new data elements for any of the programmes. This data collection should not interfere with the routine data collection for the DHIS.

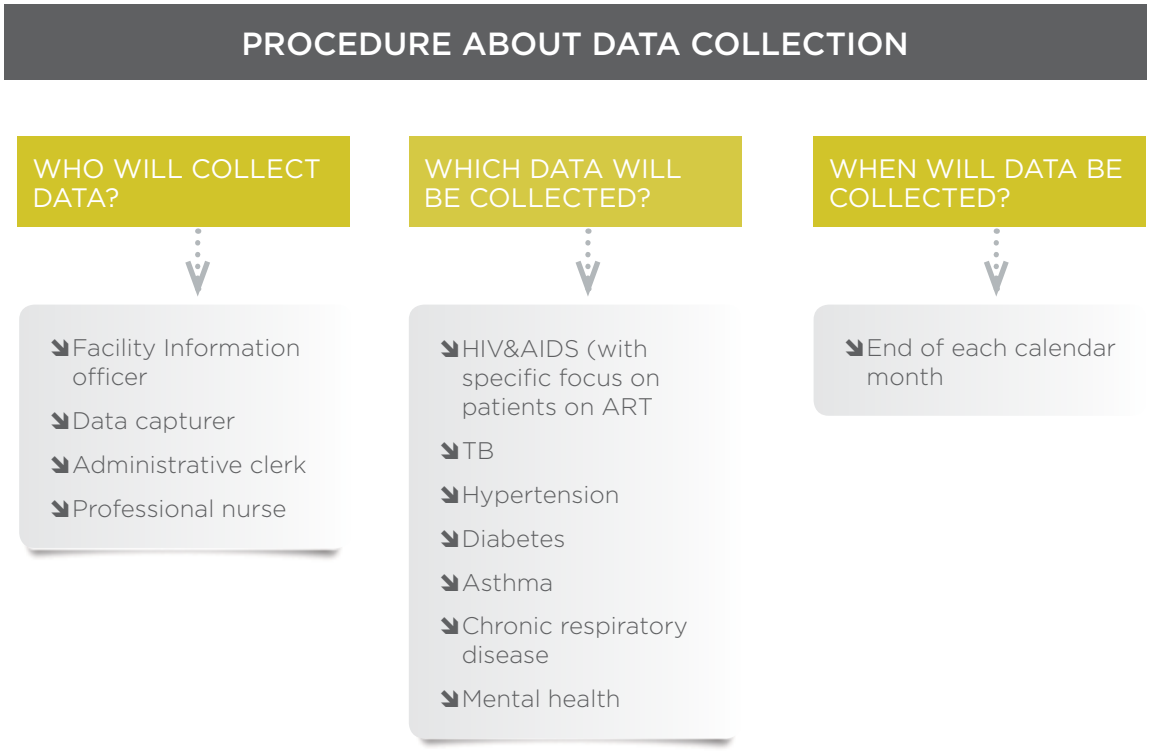



**FIGURE 41:** DATA COLLECTION FOR ICDM

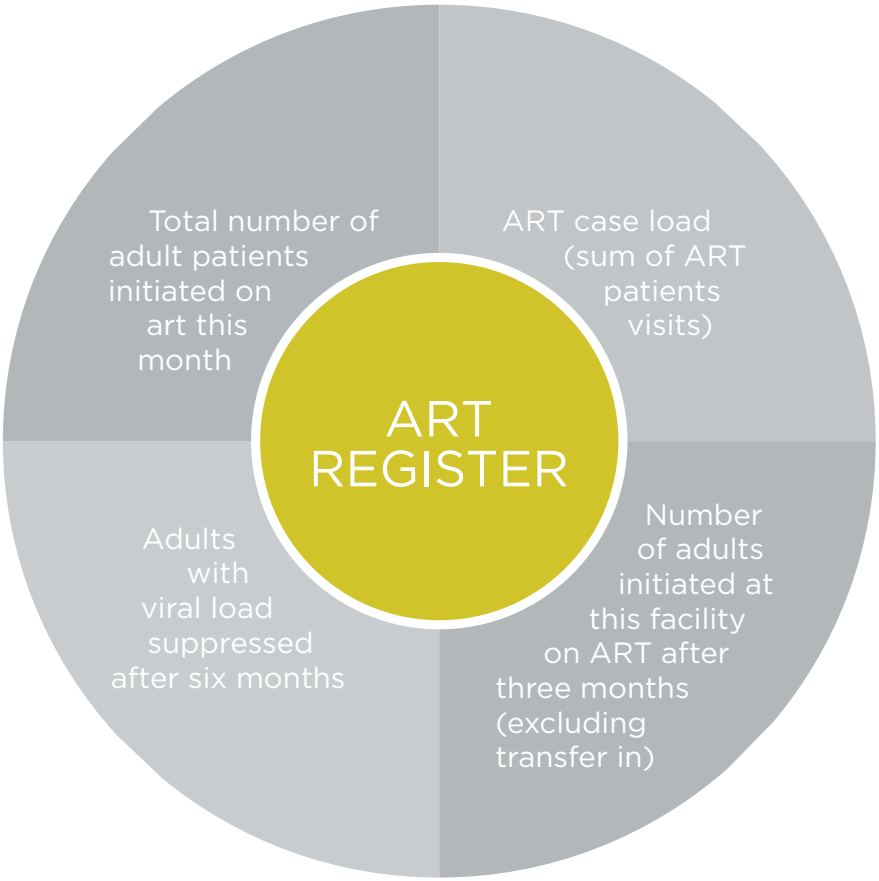



**FIGURE 42:** ART DATA FOR ICDM

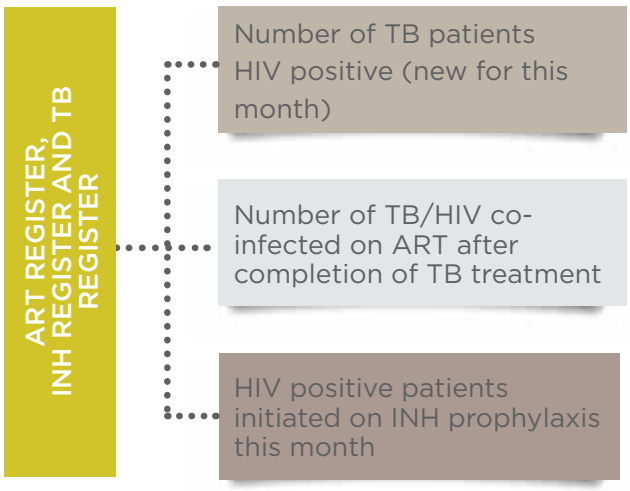



**FIGURE 43:** TB DATA FOR ICDM

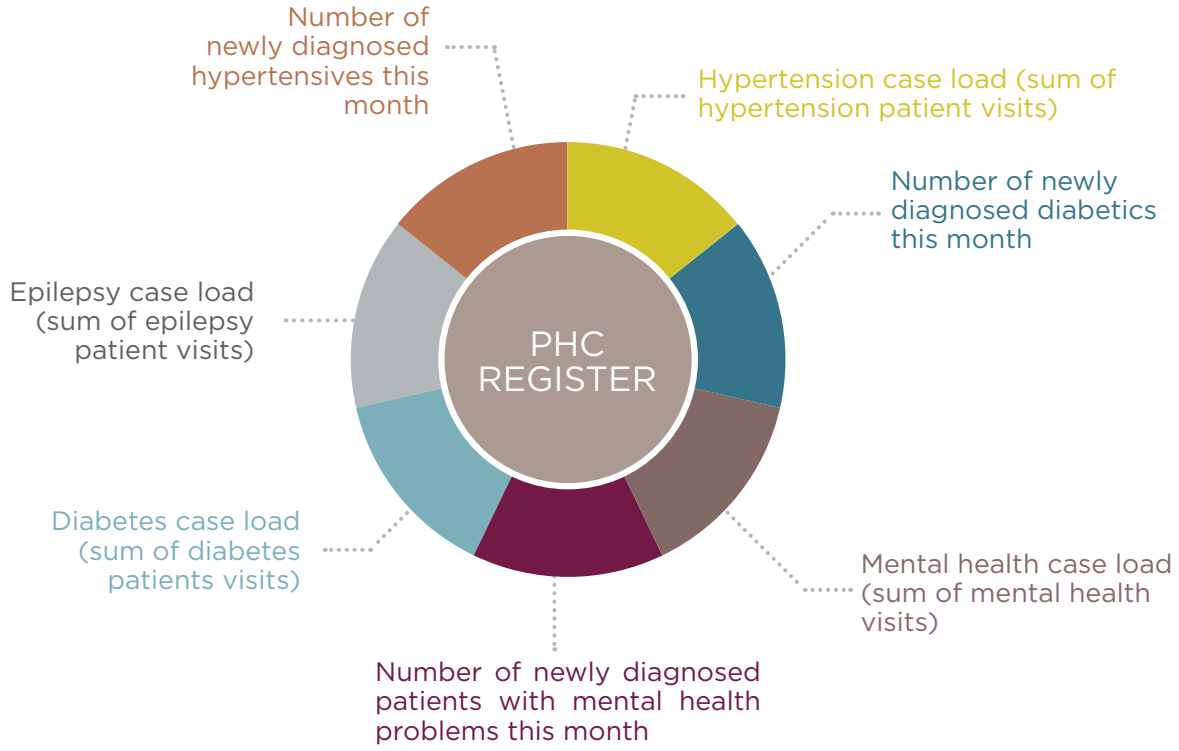



**FIGURE 44:** NCD DATA FOR ICDM

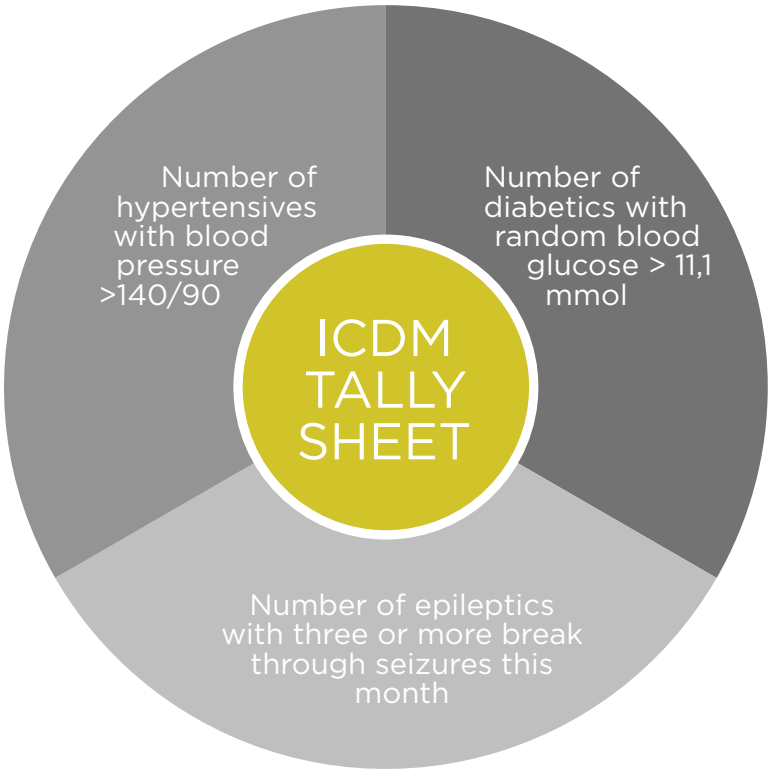



**FIGURE 45:** OUTCOME DATA FOR ICDM

TOOL 33

## Monthly data collection tool for ICDM

| **NAME OF CLINIC** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **DATASET** | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH 9 |
| **ANTIRETROVIRAL TREATMENT-ADULT** | | | | | | | | | |
| TOTAL NUMBER OF ADULT PATIENTS INITIATED ON ART THIS MONTH | | | | | | | | | |
| ART CASE LOAD (SUM OF ART PATIENTS VISITS) | | | | | | | | | |
| NUMBER OF ADULTS INITIATED AT THIS FACILITY ON ART AFTER 3 MONTHS (THIS DOES NOT INCLUDE TRANSFER IN ) | | | | | | | | | |
| ADULTS WITH VIRAL LOAD SUPPRESSED AFTER 6 MONTHS | | | | | | | | | |
| HIV AND TB CO-INFECTION | | | | | | | | | |
| NUMBER OF TB PATIENTS HIV POSITIVE (NEW FOR THIS MONTH) | | | | | | | | | |
| NUMBER OF TB/HIV CO-INFECTED ON ART AFTER COMPLETION OF TB TREATMENT | | | | | | | | | |
| HIV POSITIVE PATIENTS INITIATED ON INH PROPHYLAXIS THIS MONTH | | | | | | | | | |
| TOTAL NUMBER OF HIV POSITIVE PATIENTS ON INH PROHYLAXIS | | | | | | | | | |
| HYPERTENSION | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH 9 |
| NUMBER OF NEWLY DIAGNOSED HYPERTENSIVES THIS MONTH | | | | | | | | | |
| HYPERTENSION CASE LOAD (SUM OF HYPERTENSION PATIENT VISITS) | | | | | | | | | |
| NUMBER OF HYPERTENSIVES WITH BLOOD PRESSURE >140/90 | | | | | | | | | |
| DIABETES MELLITUS | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH 9 |
| NUMBER OF NEWLY DIAGNOSED DIABETICS THIS MONTH | | | | | | | | | |
| DIABETES CASE LOAD (SUM OF DIABETES PATIENTS VISITS) | | | | | | | | | |

*Monthly data collection tool for ICDM*

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| NUMBER OF DIABETICS WITH RANDOM BLOOD GLUCOSE > 11,1 MMOL | | | | | | | | | |
| | | | | | | | | | |
| ASTHMA/COPD | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH 9 |
| NUMBER OF NEWLY DIAGNOSED ASTHMATICS/COPD CONSULTED THIS MONTH | | | | | | | | | |
| CHRONIC PULMONARY DISEASE CASELOAD (SUM OF ASTHMA + COPD VISITS) | | | | | | | | | |
| EPILEPSY | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH 9 |
| NUMBER OF NEWLY DIAGNOSED EPILEPSY PATIENTS THIS MONTH | | | | | | | | | |
| EPILEPSY CASE LOAD ( SUM OF EPILEPSY PATIENT VISITS) | | | | | | | | | |
| NUMBER OF EPILEPTICS WITH 3 OR MORE BREAKTHROUGH SEIZURES THIS MONTH | | | | | | | | | |
| MENTAL HEALTH | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH 9 |
| NUMBER OF NEWLY DIAGNOSED PATIENTS WITH MENTAL HEALTH PROBLEMS THIS MONTH | | | | | | | | | |
| MENTAL HEALTH CASE LOAD (SUM OF MENTAL HEALTH VISITS) | | | | | | | | | |
| CERVICAL SMEAR | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH 9 |
| CERVICAL SMEAR SCREENING RATE (NUMBER OF FEMALES > 30 YEARS ON WHOM CERVICAL SMEAR OR VIA CONDUCTED THIS MONTH) | | | | | | | | | |

## DAILY TALLY SHEET

**Purpose:** To facilitate the ease with which data is collected and to improve the accuracy of data on chronic patients enrolled within the ICDM programme.

**The tool will be useful for the following data elements:**

1. Number of hypertensive patients with blood pressure >140/90.
2. Number of diabetics with random blood glucose > 11,1 mmol.
3. Number of epileptics with three or more break breakthrough seizures in the past month.

**Who will complete the daily tally sheet?**

The data will be completed daily by the professional nurse(s) consulting chronic patients in conjunction with the administrative clerk/data capturer responsible for collating the daily PHC tally sheets from the nurses.

**Completion of the daily tally sheet:**

a. The professional nurse(s) will scan the patient's chronic record charts after consulting all the chronic patients.

b. The professional nurse will identify the patients with blood pressure >140/90; random blood glucose > 11,1 mmol; and epileptics with three or more breakthrough seizures in the past month.

c. The numbers for each of these categories will be tallied and recorded against the appropriate date.

**What should be done with the tally sheet at the end of the month?**

a. At the end of the calendar month the totals should be collated.

b. This value should then be entered into the ICDM data collection sheet.

c. The tally sheet should be filed and stored appropriately.

## ICDM tally sheet

**DATA COLLECTION TALLY SHEET FOR ICDM OUTCOME INDICATORS**

| **MONTH** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **NAME OF FACILITY** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DATE | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | TOT |
| HYPERTENSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NUMBER OF HYPERTENSIVES WITH BLOOD PRESSURE >140/90 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DIABETES MELLITUS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NUMBER OF DIABETICS WITH RANDOM BLOOD GLUCOSE > 11,1 MMOL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EPILEPSY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NUMBER OF EPILEPTICS WITH THREE OR MORE BREAKTHROUGH SEIZURES THIS MONTH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

# 3. Medicine supply and management

Medication supply is the backbone to achieving optimal management of chronic patients. The consequences of medication stock shortages are detrimental to the patients' health outcomes as well as resulting in a loss in confidence in the health sector. It also leads to healthcare workers becoming demotivated.

For this reason, an effective stock management system for medicine is important at all levels of the healthcare system.

Although the supply of medication and appropriate storage are critical factors in the process, they are beyond the scope of this manual.

Refer to World Health Organisation's *Management of Drugs at Healthcare Level* training manual available at *www.who.int/medicinedocs/en/d/Js7919e/5.4.html*

▶ **The critical areas that are reinforced by this manual are:**

- Stock card management
- Re-order levels

## Stock card management

### STOCK CARDS ARE:

- Small record-keeping cards made from cardboard
- Kept on the same shelf as the medication
- Completed by the dispensary or clinic staff
- Information recorded at the time of each stock movement
- One stock card per item (separate stock card is created for each item, in each pack size and strength).

### STOCK MOVEMENTS OCCUR WHEN:

- Stock is received from the provincial stores or hospital or depot which supplies the facility
- Stock is issued from the "closed" stock area to the patient care or dispensing areas within a facility
- Expired stock is removed for disposal or return.

TOOL 35

## Stock card template

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **NAME OF FACILITY** | | | | | | **FACILITY CODE** | | | |
| **ITEM DESCRIPTION** | | | | | | **ITEM CODE** | | | |
| **RE-ORDER LEVEL** | | | | | | **UNIT OF ISSUE** | | | |
| Date | Requisition/ order No: | Received from / issued to: | Batch no. | Expiry date | Quantity ordered | Quantity received | Quantity issued | Stock balance | Signature |
| | | | | | | | | | |
| | | | | | | | | | |
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## Re-order level

The type and quantity of drugs to be ordered will depend on the following:

- The disease pattern of the area served by the health centre
- The quantity of medicines (for each item and dosage strength) previously consumed, when drugs were not out of stock
- The period for which the new stock is to serve
- The number of patients.

### DETERMINING THE QUANTITY TO BE REQUESTED

- Consider the lead or delivery time.
- Consider the number of patients to be treated (using national treatment guidelines).
- Consider epidemics or seasonal changes in disease pattern.
- Look through all the stock cards in a systematic manner and compare the re-order level with the current stock balances.
- Request only those items where the stock balance approaches the re-order level, equals the re-order level or is below the re-order level.

### DETERMINE MONTHLY CONSUMPTION

**THE FIRST METHOD:**

- (Quantity of drugs [beginning of a period] + quantity of drugs received during that same period) **less** quantity of drugs remaining at the end of the period.

**A second method:**

- Add quantity of consumption on a monthly basis / period of time.

### RE-ORDER LEVEL

- A minimum of three months drug supply for each item should be kept in stock.
- In order to calculate the re-order quantity, perform the following calculation:
- (3 x average monthly consumption) - (quantity of remaining stock) = (re-order quantity)

### ▶ Medication storage in medicines room

The Pharmacy Act 53 of 1974 issued rules that established the Good Pharmacy Practice Guidelines [12]. Section 1.6 of the Act has direct bearing on the storage of medication at PHC level.

#### DESIGNATION OF DISPENSARY OR MEDICINE ROOM

▶ **In a PHC clinic where:**

- The services are provided by a pharmacist's assistant, there must be a suitable room assigned for use as a dispensary
- The services are provided by a licensed dispenser in the consulting rooms in the PHC clinic there must be a suitable room designated as a medicine room for use as a storage area for medicine.

**THE FOLLOWING STANDARDS MUST BE OBSERVED IN SUCH A FACILITY:**

- The dispensing must be done in the consulting room(s) and not in the medicine room
- No medicine may be stored in the consulting room(s) except in situations where there is an air-conditioner installed and the temperature is controlled
- Where medicine is stored only in the medicine room, medicines or scheduled substances must be transported to the consulting room(s) on a daily basis in, for example, a lockable medicine trolley or tray
- Control of access to the medicine room and the consulting room(s) (as applicable) must be of such a nature that only licensed dispensers have direct access to medicines.

#### CONDITION OF A DISPENSARY OR MEDICINE ROOM

▶ **The walls, floors, windows, ceiling, woodwork and all other parts of the dispensary or medicine room must:**

- Be kept clean; and kept in such good order, repair and condition as to enable them to be effectively cleaned and to prevent, as far as is reasonably practicable, any risk of infestation by insects, birds or rodents
- Countertops, shelves and walls must be finished in a smooth, washable and impermeable material which is easy to maintain in a hygienic condition
- Light conditions, temperature and humidity within the dispensary or medicine room must comply with the requirements for the storage of medicine, other pharmaceutical products, and packaging materials

- The dispensary, its fittings and equipment must be adequate and suitable for the purpose of dispensing
- The working surface area in a dispensary must be sufficient for the volume of prescriptions dispensed
- The temperature in the dispensary/medicine room must be below 25°C.

### ▶ The dispensary/medicine room must have the following fixtures/fittings:

- An air-conditioner in good working order; a refrigerator in good working order; a wash hand basin with hot and cold water.

## STORAGE AREAS IN A DISPENSARY OR MEDICINES ROOM

- Storage areas must have sufficient shelving constructed from smooth, washable and impermeable material, which is easy to maintain in a hygienic condition.
- No medicines may be stored on the floor.
- Storage areas for medicines must be self-contained and secure.
- Storage areas must be large enough to allow orderly arrangement of stock and proper stock rotation.

### ▶ Control of access to dispensary or medicine room

- The pharmacist's assistant or licensed dispenser in charge must ensure that every key, key card or other device, or the combination of any device, which allows access to a dispensary/medicine room when it is locked, is kept only on his/her person or the person of a pharmacist's assistant at a post-basic level licensed dispenser or a pharmacist (as applicable) at all times.
- Control of access to the dispensary, medicine room and/or consulting room(s) (as applicable) must be of such a nature that only authorised personnel have direct access to medicines.

# 4. Equipment supply and management

The availability of appropriate medical devices is critical for the optimal management of patients and has implications for the prevention of disease, disability and death.

- Devices should be necessary to the implementation of a cost-effective health intervention.
- Devices should be **effective**.
- Devices should be **safe**.

The following essential equipment list is proposed for a CHC/clinic with specific reference to the ICDM model.

## RECEPTION

- Safe
- Wheelchair
- Patient trolley
- Bench
- Table (magazines)
- Bin, wastepaper
- Chairs
- Filing cabinet

## VITAL SIGNS STATION

- Desk
- Chairs
- Scale (adult, weight/ height)
- Scale (baby)
- Stethoscope
- Bin
- Kick about bucket (stainless steel)
- HB meter
- Glucometer
- Electronic BP machines, mobile with pulse oximetry and temperature
- Sphygmomanometer cuff size XL
- Sphygmomanometer cuff size pd
- Urine specimen jar

## CONSULTING ROOM

- Desk
- Chair (patient)
- Examination couch
- Baumanometer (portable)
- Baumanometer (wall mounted)
- Steps (bed)
- Dressing trolley
- Examination lamp
- Stethoscope
- Bin
- HB meter
- Diagnostic set, wall mounted
- Suture set
- Diagnostic sets, portable
- Patella hammer
- Doctor's torch
- Medicine cupboard or trolley

### RESUSCITATION ROOM

- X-ray viewer
- ECG machine
- Defibrillator
- Emergency trolley and accessories
- Resuscitation set
- Laryngoscope set
- Examination couch
- Oxygen cylinder stand
- Oxygen regulator
- Pulse oximeter
- Ear syringe
- Electric BP machines, mobile with pulse oximetry and temperature
- Bin

### MEDICINES ROOM

- Refrigerator
- Desk
- Chair
- Computer
- Containers for transport of goods to wards
- Water distiller
- Trolley
- Medicine cabinet
- Scheduled drugs cabinet
- Shelving

## 5. Mobile technology

M-Health (mobile health) is a general term for the use of mobile phones and other wireless technology in medical care.

The implementation of the ICDM model of care provides us an ideal opportunity to explore the use of mobile technology at health facility and community level in the chronic health care programme.

The mobile technology will firstly be piloted, and based on the evidence obtained could be rolled out during ICDM implementation.

It is envisaged that this innovative aspect in the implementation of the ICDM will be used at facility level in order to have a continuous patient record as well as provide instant patient information, at community level to allow for health promotion messages and treatment reminders to be broadcast to patients. It will also be used for management purposes to allow for the tracking of information and for planning.

For further details refer to the M-Health for ICDM manual.

# 6. Partners

Externally funded partners were leveraged to ensure and sustain the roll out of ART across PHC facilities in South Africa. These partners have assisted with human resources, innovative technology and systems support.

In order to ensure seamless integration and the sustainability of the ICDM model it is important that the externally funded partners do not view ICDM as a threat. Therefore, it is important that partners are briefed and play an integral role in the implementation and sustainability of the ICDM model.

Partners should be invited for all ICDM meetings and their staff appointed at the facilities need to be an integral part of the ICDM teams. The medical practitioners and data capturers should be integrated into the ICDM programme and should not function vertically. Where externally funded pharmacy assistants are available, they should be informed of the need to pre-dispense all chronic medication and not only ART.

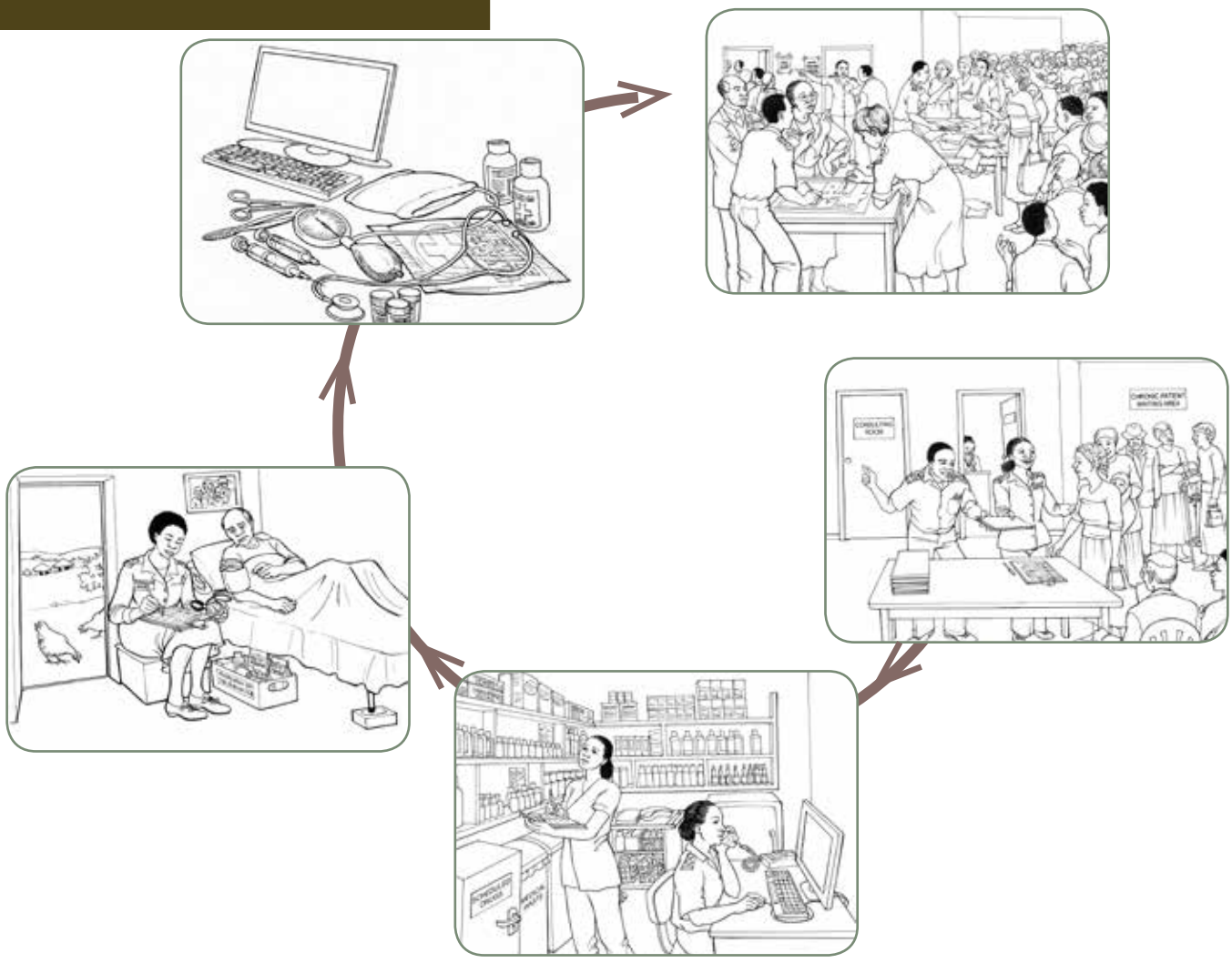
Furthermore,partners can support the process tremendously by proving holistic mentorship and health system strengthening support.

Partners should be leveraged to assist with the supply of equipment and the development of infrastructure.

Section Eight

08

# MONITORING AND REPORTING



# 1. Introduction

This section of the manual provides the tools that should be used from a management perspective to monitor the implementation of the ICDM model.

The findings from the monitoring tools should be used to develop quality improvement strategies to continually improve the implementation of ICDM.

**FIGURE 46:** ICDM IMPLEMENTATION APPROACH

# 2. Monitoring from a provincial programme level

The appointed Provincial ICDM task team coordinator is ultimately responsible for reporting progress in the implementation of the ICDM model to the senior management team. Therefore, it is important that key indicators of the implementation process are collected and reported.

The following table provides an overview of the key data elements that are to be collected for monitoring ICDM implementation. Tool 37 provides a format for collecting and recording the data.

TOOL 36

## Performance monitoring indicators at district and provincial level

| ITEM | INDICATOR | SOURCE OF DATA | DATA ELEMENTS |
|---|---|---|---|
| **INPUT** | Percentage of professional nurses fully PC 101 trained across the district | Training register and PERSAL data | Number of professional nurses PC 101 trained |
| | Percentage of PHC facilities with appointed WBOT | PERSAL data | Number of WBOTs deployed per facility |
| | Percentage of CHWs trained to manage chronic diseases | Training registers | Number of CHWs that attended additional training to manage chronic diseases |
| **PROCESS** | Percentage of districts with fully constituted ICDM teams | | Number of districts with ICDM teams |
| | Percentage of facilities that have commenced patient scheduling | PHC supervisor monitoring report | Number of facilities with scheduling system |
| | Percentage of facilities with integrated clinical records | PHC supervisor monitoring report | Number of facilities with integrated filing system |
| | Percentage of facilities with additional vital signs station for chronic patients | PHC supervisor monitoring report | Number of facilities with vital sign station for chronic patients |
| | Percentage of facilities that have commenced with pre-dispensing of medication | PHC supervisor monitoring report | Number of facilities that have commenced with pre-dispensing medication |
| | Down referral rate | DHIS | Number of stable patients referred to the outreach team |
| | Percentage of facilities with chronic medication stock out | PHC supervisor monitoring report | |
| **OUTPUT** | Percentage of PHC/CHC implementing both the facility and community component of the ICDM model | PHC supervisor monitoring report | Number of PHC facilities that have completed facility re-organisation and have started down referring patients to the CHWs |
| **OUTCOME** | Percentage of hypertension patients that poorly controlled | ICDM data collection sheet | Number of hypertensive patients with blood pressure > 140/90 |
| | Percentage of diabetes patients that are poorly controlled | ICDM data collection sheet | Number of diabetes patients with random blood sugar > 11.1 mmol |

TOOL 36 (CNTD)

*Performance monitoring indicators at district and provincial level*

| ITEM | INDICATOR | QUARTER 1 | QUARTER 2 | QUARTER 3 | QUARTER 4 |
|---|---|---|---|---|---|
| **INPUT** | Percentage of professional nurses fully PC 101 trained across the district | | | | |
| | Percentage of PHC facilities with appointed WBOT | | | | |
| | Percentage of CHWs trained to manage chronic diseases | | | | |
| **PROCESS** | Percentage of districts with fully constituted ICDM teams | | | | |
| | Percentage of facilities that have commenced patient scheduling | | | | |
| | Percentage of facilities with integrated clinical records | | | | |
| | Percentage of facilities with additional vital signs station for chronic patients | | | | |
| | Percentage of facilities that have commenced with pre-dispensing of medication | | | | |
| | Down referral rate | | | | |
| | Percentage of facilities with chronic medication stock out | | | | |
| **OUTPUT** | Percentage of PHC/CHC implementing both the facility and community component of the ICDM model | | | | |
| **OUTCOME** | Percentage of hypertension patients that poorly controlled | | | | |
| | Percentage of diabetes patients that are poorly controlled | | | | |

# 3. Monitoring template for PHC supervisor

**FIGURE 47:** FLOW CHART FOR QUARTERLY ICDM MONITORING

## Quarterly progress monitoring tool

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NAME OF FACILITY** | | | | | | | | |
| **NAME OF THE CLINIC SUPERVISOR** | | | | | | | | |
| **QUARTER** | QUARTER 1: APRIL-JUNE | | QUARTER 2: JULY-SEPT | | QUARTER 3: OCT-DEC | | QUARTER 4: JAN-MARCH | |
| **DATE OF FACILITY VISIT** | | | | | | | | |
| | | | | | | | | |
| **GENERAL- INFRASTRUCTURE** | ***CIRCLE/TICK THE APPLICABLE CHOICE*** | | | | | | | |
| 1. **STATE OF THE BUILDING** | SERIOUS REPAIRS (BROKEN WINDOWS and CEILINGS) | | SERIOUS REPAIRS (BROKEN WINDOWS and CEILINGS) | | SERIOUS REPAIRS (BROKEN WINDOWS and CEILINGS) | | SERIOUS REPAIRS (BROKEN WINDOWS and CEILINGS) | |
| | MINOR REPAIRS (PAINTING, TAPS TOILETS, AIRCONDITIONERS, FANS and PLUGS) | | MINOR REPAIRS (PAINTING, TAPS TOILETS, AIRCONDITIONERS, FANS and PLUGS) | | MINOR REPAIRS (PAINTING, TAPS, TOILETS, AIRCONDITIONERS, FANS and PLUGS) | | MINOR REPAIRS (PAINTING, TAPS, TOILETS, AIRCONDITIONERS, FANS and PLUGS) | |
| | NO IMMEDIATE REPAIRS | | NO IMMEDIATE REPAIRS | | NO IMMEDIATE REPAIRS | | NO IMMEDIATE REPAIRS | |
| 2. **CLEANLINESS** | | | | | | | | |
| WALLS | DIRTY WALLS WITH TATTERED POSTERS | | DIRTY WALLS WITH TATTERED POSTERS | | DIRTY WALLS WITH TATTERED POSTERS | | DIRTY WALLS WITH TATTERED POSTERS | |
| | CLEAN | | CLEAN | | CLEAN | | CLEAN | |
| FLOORS | FLOORS ARE DIRTY | | FLOORS ARE DIRTY | | FLOORS ARE DIRTY | | FLOORS ARE DIRTY | |
| | CLEAN | | CLEAN | | CLEAN | | CLEAN | |
| 3. **BULK SERVICES –TYPE and AVAILABILITY** | | | | | | | | |
| WATER SUPPLY | | | | | | | | |
| SANITATION | | | | | | | | |
| DOMESTICE WASTE REFUSE | | | | | | | | |
| TELECOMMUNICATION | | | | | | | | |
| 4. **INFECTION CONTROL** | | | | | | | | |
| **DOES THE FACILITY HAVE** | | | | | | | | |
| SHARPS CONTAINERS | YES | NO | YES | NO | YES | NO | YES | NO |
| COLOUR CODED DISPOSABLE BAGS | YES | NO | YES | NO | YES | NO | YES | NO |
| MEDICAL WASTE BOXES | YES | NO | YES | NO | YES | NO | YES | NO |
| ELBOW HEIGHT HAND WASHING BASINS IN OR ADJACENT TO CONSULTING ROOMS | YES | NO | YES | NO | YES | NO | YES | NO |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AVAILABILITY OF HAND WASHING SOAP OR DISINFECTANT SPRAY | YES | NO | YES | NO | YES | NO | YES | NO |
| 5. **SPACE** | | | | | | | | |
| HOW MANY CONSULTING ROOMS ARE AVAILABLE AT THE FACILITY? | | | | | | | | |
| DOES EACH PROFESSIONAL NURSE HAVE AN INDEPENDENT ROOM FOR CONSULTING PATIENTS? | YES | NO | YES | NO | YES | NO | YES | NO |
| DO CONSULTATION ROOMS HAVE PRIVACY? | YES | NO | YES | NO | YES | NO | YES | NO |
| 6. **HUMAN RESOURCES** | | | | | | | | |
| TOTAL NUMBER OF HUMAN RESOURCES EMPLOYED AT THE FACILITY | | | | | | | | |
| 6.1. **INDICATE NUMBER OF STAFF IN THE FOLLOWING CATEGORIES** | | | | | | | | |
| PROFESSIONAL NURSES | | | | | | | | |
| AUXILLARY HEALTHCARE WORKERS | | | | | | | | |
| ADMIN SUPPORT | | | | | | | | |
| PHARMACY ASSISTANTS | | | | | | | | |
| GENERAL ASSISTANTS | | | | | | | | |
| FULL TIME MEDICAL DOCTORS | | | | | | | | |
| SESSIONAL MEDICAL DOCTORS | | | | | | | | |
| 6.2. **PROFESSIONAL NURSES- STAFF DEVELOPMENT** | | | | | | | | |
| NO. PHC TRAINED P/N? | | | | | | | | |
| NO. OF P/N NIMART TRAINING? | | | | | | | | |
| NO. OF P/N THAT HAVE BEEN COMPLETELY TRAINED ON PC 101 | | | | | | | | |
| 7. **EQUIPMENT** | | | | | | | | |
| DOES THE FACILITY HAVE A FULLY EQUIPPED EMERGENCY TROLLEY? | YES | NO | YES | NO | YES | NO | YES | NO |
| NUMBER OF FUNCTIONAL BLOOD PRESSURE MACHINES | | | | | | | | |
| NUMBER OF FUNCTIONAL GLUCOMETERS | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|
| NUMBER OF DIAGNOSTIC SETS FOR EYE and EAR EXAMINATIONS | | | | | | | | |
| NUMBER OF CONSULTING ROOMS WITH APPROPRIATE EXAMINATION COUCHES | | | | | | | | |
| DOES EACH CONSULTING ROOM HAVE AN EXAMINATION COUCH? | | | | | | | | |
| TYPE OF SCALES USED TO WEIGH PATIENTS | BATHROOM SCALE | BMI SCALE | BATHROOM SCALE | BMI SCALE | BATHROOM SCALE | BMI SCALE | BATHROOM SCALE | BMI SCALE |
| AVAILABILITY OF BODY MASS INDEX CHARTS | | | | | | | | |
| 8. **ICDM COMPONENTS** | | | | | | | | |
| **PATIENT FLOW** | | | | | | | | |
| 8.1. **WAITING AREA** | | | | | | | | |
| DOES THE WAITING AREA HAVE SUFFICIENT SPACE? | YES | NO | YES | NO | YES | NO | YES | NO |
| HAS THE WAITING AREA BEEN SEPARATED AND IS THERE CLEARLY MARKED SPACE FOR ACUTE AND CHRONIC SERVICES? | YES | NO | YES | NO | YES | NO | YES | NO |
| IF NOT, WHAT ARE THE CHALLENGES IN SEPARATION OF WAITING AREA? | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 8.2. **CONSULTATION AREA FOR ICDM** | | | | | | | | |
| HOW MANY ROOMS HAVE BEEN DESIGNATED FOR CHRONIC PATIENTS? | | | | | | | | |
| 8.3. **VITAL SIGNS STATION** | | | | | | | | |
| IS THERE A DESIGNATED VITAL SIGNS STATION FOR CHRONIC PATIENTS? | YES | NO | YES | NO | YES | NO | YES | NO |
| IF NOT, WHAT ARE THE CHALLENGES? | | | | | | | | |
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| 8.4. **PATIENT APPOINTMENT SCHEDULING** | | | | | | | | |
| HAS THE FACILITY COMMENCED WITH USING AN APPROPRIATE PATIENT SCHEDULING SYSTEM IN LINE WITH THE RECOMMENDATIONS OF THE NDOH? | YES | NO | YES | NO | YES | NO | YES | NO |
| IF NOT, WHAT IS THE REASON FOR NON-COMPLIANCE? | | | | | | | | |
| WHO IS RESPONSIBLE FOR PROVIDING THE PATIENTS WITH THEIR RETURN APPOINTMENT DATES? | PROFESSIONAL NURSES | | PROFESSIONAL NURSES | | PROFESSIONAL NURSES | | PROFESSIONAL NURSES | |
| | ADMIN CLERKS | | ADMIN CLERKS | | ADMIN CLERKS | | ADMIN CLERKS | |
| HAS THE FACILITY COMMENCED WITH 2-3 MONTH APPOINTMENT SCHEDULING? | YES | NO | YES | NO | YES | NO | YES | NO |
| ARE THE PATIENTS ATTENDING THE FACILITY FOR HIV-ART INCLUDED IN THE SCHEDULING SYSTEM? | YES | NO | YES | NO | YES | NO | YES | NO |
| ARE THE PATIENTS ATTENDING THE FACILITY FOR PRE-ART INCLUDED IN THE SCHEDULING SYSTEM? | YES | NO | YES | NO | YES | NO | YES | NO |
| 8.5. **PATIENT CLINICAL RECORDS** | | | | | | | | |
| CATEGORY OF PATIENTS THAT HAVE CLINICAL RECORDS AVAILABLE AT THE FACILITY | CHRONIC PATIENTS ONLY | | CHRONIC PATIENTS ONLY | | CHRONIC PATIENTS ONLY | | CHRONIC PATIENTS ONLY | |
| | MINOR AILMENTS ONLY | | MINOR AILMENTS ONLY | | MINOR AILMENTS ONLY | | MINOR AILMENTS ONLY | |
| | HIV-ART PATIENTS | | HIV-ART PATIENTS | | HIV-ART PATIENTS | | HIV-ART PATIENTS | |
| | TUBERCULOSIS | | TUBERCULOSIS | | TUBERCULOSIS | | TUBERCULOSIS | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | ANTENATAL CARE | | ANTENATAL CARE | | ANTENATAL CARE | | ANTENATAL CARE | |
| | ALL PATIENTS | | ALL PATIENTS | | ALL PATIENTS | | ALL PATIENTS | |
| ARE ALL PATIENT RECORDS (ACUTE/CHRONIC/HIV-ART/TB) STORED IN A SINGLE AREA? | YES | NO | YES | NO | YES | NO | YES | NO |
| WHAT SYSTEM IS USED TO FILE THE PATIENTS' RECORDS? | DATE OF BIRTH | | DATE OF BIRTH | | DATE OF BIRTH | | DATE OF BIRTH | |
| | SURNAMES | | SURNAMES | | SURNAMES | | SURNAMES | |
| | ADDRESSES | | ADDRESSES | | ADDRESSES | | ADDRESSES | |
| ARE THE CHRONIC PATIENT FILES RETRIEVED A DAY OR MORE PRIOR TO THE SCHEDULED APPOINTMENT? | YES | NO | YES | NO | YES | NO | YES | NO |
| WHERE DO PATIENTS WITH APPOINTMENTS RECEIVE THEIR FILES ON THE DATE OF APPOINTMENT? | | | | | | | | |
| HAS THE FACILITY COMMENCED WITH USING A STANDARD FORMAT FOR RECORDING CLINICAL NOTES FOR PATIENTS WITH CHRONIC CONDITIONS? | | | | | | | | |
| 8.6. **NURSE SCHEDULING FOR ICDM** | | | | | | | | |
| HAS THE FACILITY COMMENCED WITH A SCHEDULING SYSTEM TO ROTATE APPROPRITELY TRAINED NURSES TO CONSULT CHRONIC PATIENTS? | YES | NO | YES | NO | YES | NO | YES | NO |
| HOW MANY NURSES ARE SCHEDULED TO CONSULT CHRONIC PATIENTS DAILY? | | | | | | | | |
| HOW OFTEN ARE THE PROFESSIONAL NURSES THAT CONSULT CHRONIC PATIENTS ROTATED ACROSS THE FACILITY? | WEEKLY | | WEEKLY | | WEEKLY | | WEEKLY | |
| | MONTHLY | | MONTHLY | | MONTHLY | | MONTHLY | |
| | 3 MONTHLY | | 3 MONTHLY | | 3 MONTHLY | | 3 MONTHLY | |
| 9. **MEDICATION SUPPLY** | | | | | | | | |
| HOW OFTEN DOES THE FACILITY RECEIVE THE STOCK OF MEDICATION, INCLUDING ART MEDICATION? | FORTHNIGHTLY | MONTHLY | FORTHNIGHTLY | MONTHLY | FORTHNIGHTLY | MONTHLY | FORTHNIGHTLY | MONTHLY |
| DOES THE FACILITY HAVE SUFFICIENT CHRONIC MEDICATION SUPPLY TO PROVIDE MEDICATION FOR PATIENTS FOR 2 MONTHS? | YES | NO | YES | NO | YES | NO | YES | NO |
| HAS THE FACILITY COMMENCED WITH THE PRE-DISPENSING and PACKAGING OF MEDICATION FOR CHRONIC PATIENTS? | YES | NO | YES | NO | YES | NO | YES | NO |

## TOOL 37 (CNTD)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| WHO IS REPSONSIBLE FOR PRE-PACKING OF PATIENT MEDICATION AT THE FACILITY? | PROFESSIONAL NURSE | | PROFESSIONAL NURSE | | PROFESSIONAL NURSE | | PROFESSIONAL NURSE | |
| | PHARMACY ASSISTANT | | PHARMACY ASSISTANT | | PHARMACY ASSISTANT | | PHARMACY ASSISTANT | |
| | OTHER | | OTHER | | OTHER | | OTHER | |
| WHEN THE MEDICATION IS PRE-DISPENSED, WHERE IS IT STORED? | BOXES | | BOXES | | BOXES | | BOXES | |
| | CUPBOARD | | CUPBOARD | | CUPBOARD | | CUPBOARD | |
| HOW IS THE MEDICATION STORED IN THE BOXES/ CUPBOARDS IN THE CONSULTING ROOM? | HAPHAZARDLY | ALPHABETICALLY | HAPHAZARDLY | ALPHABETI-CALLY | HAPHAZARDLY | ALPHABETICALLY | HAPHAZARDLY | ALPHABET-ICALLY |
| ARE PHC MEDICATION KEPT IN THE CHRONIC CONSULTING ROOM? | YES | NO | YES | NO | YES | NO | YES | NO |
| HAS ANY STOCK OUT OF CHRONIC MEDICATION (NCDS) BEEN EXPERIENCED IN THE LAST 2 MONTHS? | YES | NO | YES | NO | YES | NO | YES | NO |
| IF STOCK OUT HAS BEEN EXPERIENCED, WHAT MEDICATION HAS BEEN OUT OF STOCK? | | | | | | | | |
| HAS THERE BEEN ANY STOCK OUT OF ART MEDICATION IN THE LAST 2 MONTHS? | YES | NO | YES | NO | YES | NO | YES | NO |
| IF STOCK OUT HAS BEEN EXPERIENCED, WHAT MEDICATION HAS BEEN OUT OF STOCK? | | | | | | | | |
| 10. **HEALTH PROMOTION** | | | | | | | | |
| DOES THE FACILITY HAVE THE SERVICES OF A HEALTH PROMOTER? | YES | NO | YES | NO | YES | NO | YES | NO |
| IF NO, WHO CONDUCTS HEALTH PROMOTION AT THE FACILITY? | | | | | | | | |
| WHERE IS HEALTH EDUCATION and HEALTH PROMOTION PROVIDED TO PATIENTS? | WAITING AREA | | WAITING AREA | | WAITING AREA | | WAITING AREA | |
| | CONSULTING ROOM | | CONSULTING ROOM | | CONSULTING ROOM | | CONSULTING ROOM | |
| DOES THE FACILITY HAVE HEALTH EDUCATION MATERIAL FOR PATIENTS WITH DISEASES OF LIFESTYLE? | YES | | YES | | YES | | YES | |
| | NO | | NO | | NO | | NO | |
| | LIMITED | | LIMITED | | LIMITED | | LIMITED | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | OLD | | OLD | | OLD | | OLD | |
| DOES THE FACILITY HAVE SUPPORT GROUPS FOR PATIENTS WITH CHRONIC DISEASES (COMMUNICABLE and NON-COMMUNICABLE)? | YES | NO | YES | NO | YES | NO | YES | NO |
| HOW OFTEN DO THESE SUPPORT GROUPS MEET? | WEEKLY | | WEEKLY | | WEEKLY | | WEEKLY | |
| | FORTHNIGHTLY | | FORTHNIGHTLY | | FORTHNIGHTLY | | FORTHNIGHTLY | |
| | MONTHLY | | MONTHLY | | MONTHLY | | MONTHLY | |
| WHAT TYPE OF ACTIVITIES ARE CONDUCTED BY THE SUPPORT GROUPS? | | | | | | | | |
| 11. **CERVICAL SMEAR SCREENING** | | | | | | | | |
| HOW OFTEN DOES THE FACITY OFFER CERVICAL SCREENING SERVICES? | DAILY | | | | | | | |
| | WEEKLY | | | | | | | |
| | NOT OFFERED | | | | | | | |
| WHO CONDUCTS THE CERVICAL SCREENING AT THE FACILITY? | ALL NURSES | | | | | | | |
| | DESIGNATED NURSES | | | | | | | |
| | DOCTORS | | | | | | | |
| IS THE CERVICAL SMEARS OFFERED ON | APPOINTMENT BASIS | | | | | | | |
| | PER PATIENT REQUEST | | | | | | | |
| HOW MANY SPECULUMS DOES THE FACILITY HAVE? | | | | | | | | |
| HOW MANY ANGLEPOISE LAMPS DOES THE FACILITY HAVE? | | | | | | | | |
| DOES THE FACILITY HAVE SUFFICIENT SLIDES FOR SMEARS? | YES | NO | YES | NO | YES | NO | YES | NO |
| DOES THE FACILITY HAVE FIXATIVES FOR THE SMEARS? | YES | NO | YES | NO | YES | NO | YES | NO |

## TOOL 37 (CNTD)

| | | | | |
|---|---|---|---|---|
| 12.**COMMUNITY WARD BASED PHC OUTREACH TEAM** | | | | |
| HOW MANY PHC OUTREACH TEAMS HAVE BEEN APPOINTED FOR YOUR FACILITY? | | | | |
| HAS THE PROFESSIONAL NURSE THAT WILL LEAD THE PHC OUTREACH TEAM FOR THE WARD BEEN IDENTIFIED? | | | | |
| HOW MANY COMMUNITY HEALTHCARE WORKERS HAVE BEEN IDENTIFIED FOR THE FACILITY? | | | | |
| HAVE THE COMMUNITY HEALTHCARE WORKERS COMPLETED THEIR TRAINING? | | | | |
| HAVE THE COMMUNITY HEALTHCARE WORKERS BEEN TRAINED ON MONITORING OF CHRONIC PATIENTS? | | | | |
| HAS THE FACILITY COMMENCED WITH DOWN REFERRING PATIENTS TO THE PHC OUTREACH TEAM? | | | | |
| HOW MANY CHRONIC PATIENTS HAVE BEEN DOWN REFERRED TO THE PHC OUTREACH TEAM? | | | | |

# 4. Action planning template

At the end of each quarter, after analysing the results achieved through the application of the Quarterly progress monitoring tool (tool35), the PHC supervisor, operational manager and ICDM champion should develop an action plan to address the problems identified with clear roles, responsibilities and time periods for addressing the challenges/problems noted. Issues that are beyond the capability of the facility to address should be raised with the sub-district, district and province as a key responsibility of the PHC supervisor who must provide the wider systems link and "unblocking "support to the facility staff.

TOOL 38

## Quarterly reporting and action planning tool

| QUARTERLY REPORT AND ACTION PLANNING | | | |
|---|---|---|---|
| REPORTING PERIOD | | | |
| CHALLENGES IDENTIFIED | ACTION PLANS | RESPONSIBILITY | TIMEFRAME |
| | | | |
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# 5. Chronic coordinator's monitoring visit checklist

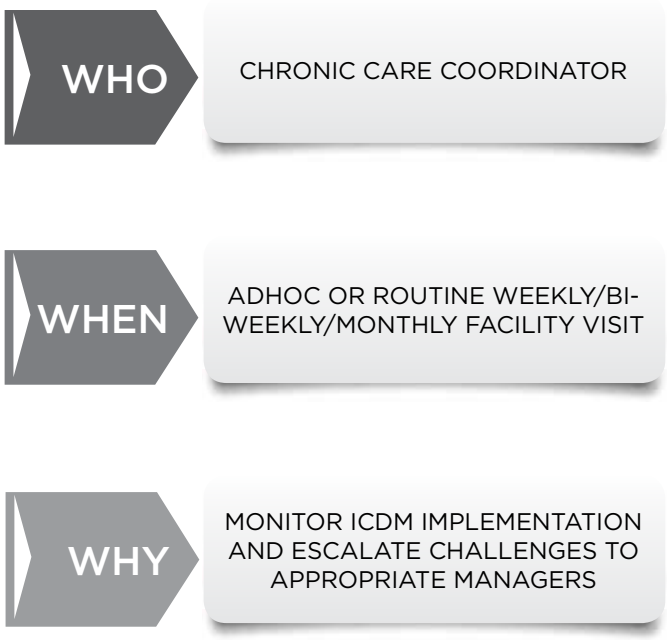


**FIGURE 48:** FLOW CHART FOR CHRONIC COORDINATOR ICDM MONITORING ACTIVITIES

The district/sub-district **chronic care coordinator** should use the following checklist when conducting ad hoc or routine facility visits in order to monitor the ICDM activities. This will assist the coordinator in identifying challenges and appropriately escalate them to the relevant managers.

TOOL 39

## Chronic coordinator facility checklist

| ICDM FACILITY VISIT CHECKLIST FOR CHRONIC COORDINATOR | | | |
|---|---|---|---|
| **NAME OF THE OPERATIONAL MANAGER** | | | |
| **NAME OF THE CLINIC SUPERVISOR** | | | |
| **DATE OF FACILITY VISIT** | | | |
| **1. FACILITY RE-ORGANISATION** | YES | NO | IF NO, WHY NOT? |
| ↘ HAS THE FACILITY BEEN RE-ORGANISED WITH DESIGNATED CONSULTING AREAS FOR ACUTE, CHRONIC AND PREVENTIVE SERVICES? | | | |
| ↘ DESIGNATED WAITING AREA FOR CHRONIC PATIENTS | | | |
| ↘ DESIGNATED VITAL SIGN STATIONS FOR CHRONIC PATIENTS | | | |
| ↘ INTEGRATION OF PATIENTS WITH HIV/TB/NCDs/MENTAL HEALTH | | | |
| ↘ ARE THERE DESIGNATED CONSULTING ROOMS FOR CHRONIC PATIENTS? | | | |
| **2. CLINICAL RECORDS** | | | |
| ↘ ARE ALL PATIENT RECORDS STORED IN A SINGLE LOCATION? | | | |
| ↘ HAVE ALL PATIENT FILES BEING INTEGRATED INTO A SINGLE FILE PER PATIENT? | | | |
| ↘ ARE THE RECORDS RETRIEVED PRIOR TO THE APPOINTMENT? | | | |
| **3. PRE-DISPENSING OF MEDICATION** | | | |
| ↘ HAS THE FACILITY COMMENCED WITH PRE-DISPENSING OF MEDICATION? | | | |
| **4. MEDICATION SUPPLY** | | | |
| ↘ DOES THE FACILITY HAVE SUFFICIENT STOCK TO DISPENSE MEDICATION FOR 2 MONTHS? | | | |
| **5. HUMAN RESOURCES SCHEDULING** | | | |
| ↘ HAS THE FACILITY COMMENCED WITH SCHEDULING OF PROFESSIONAL NURSES FOR CHRONIC PATIENT CONSULTATION? | | | |
| **6. CHRONIC CONSULTING ROOM** | | | |
| ↘ DOES EACH CHRONIC CONSULTING ROOM HAVE THE ESSENTIAL EQUIPMENT? | | | |
| **7. CLINICAL SUPPORT** | | | |

TOOL 39 (CNTD)

## *Chronic coordinator facility checklist*

| | | | |
|---|---|---|---|
| ↘ DOES THE FACILITY HAVE COPIES OF THE PC 101 GUIDELINES FOR EACH CHRONIC CONSULTING ROOM? | | | |
| ↘ HAS THE FACILITY IMPLEMENTED THE CHRONIC PATIENT RECORD? | | | |
| ↘ DOES THE DISTRICT CLINICAL SPECIALIST TEAM MENTOR THE PROFESSIONAL NURSES DURING SUPERVISORY VISITS? | | | |
| ↘ HAS THE DISTRICT CLINICAL SPECIALIST TEAM CONDUCTED ANY CLINICAL AUDITS? | | | |
| **8. "ASSISTED" SELF-SUPPORT MANAGEMENT** | | | |
| ↘ HAS THE WBOT TEAM FOR THE FACILITY BEEN EMPLOYED? | | | |
| ↘ HAVE THE CHWS BEEN TRAINED ON CHRONIC PATIENT MANAGEMENT AT THE HOUSEHOLD LEVEL? | | | |
| ↘ HAS THE FACILITY COMMENCED WITH DOWN REFERRAL OF PATIENTS TO THE WBOTs? | | | |
| ↘ NUMBER OF PATIENTS DOWN REFERRED TO WBOT | | | |
| **9. HUMAN RESOURCES** | | | |
| ↘ HAS PC 101 TRAINING COMMENCED AT THE FACILITY? | | | |
| ↘ NUMBER OF PROFESSIONAL NURSES FULLY TRAINED ON PC 101 | INSERT NUMBER | | |
| ↘ HOW MANY SESSIONS HAVE BEEN COMPLETED? | INSERT NUMBER | | |
| **10. HEALTH INFORMATION** | | | |
| ↘ IS THE DAILY TALLY SHEET BEING COMPLETED ACCORDING TO THE STANDARD OPERATING PROCEDURE? | | | |
| ↘ IS THE MONTHLY DHIS DATA SHEET BEING COMPLETED FOR CHRONIC CONDITIONS? | | | |
| **11. MEDICINE MANAGEMENT** | | | |
| ↘ ARE THE STOCK CARDS UPDATED? | | | |
| ↘ IS THE TEMPERATURE IN THE MEDICATION STORE ROOM APPROPRIATELY CONTROLLED? | | | |
| ↘ IS MEDICATION NEATLY STORED? | | | |
| **12. SUPPORT GROUPS** | | | |
| ↘ ARE THERE FACILITY-BASED SUPORT GROUPS FOR CHRONIC PATIENTS? | | | |

## Notes

# >> Conclusion

This step-by-step guide adopts a quality improvement approach and addresses the implementation of the ICDM model. The manual takes the reader through preparation from a provincial, district, facility and community level to the actual implementation of the facility and community components of the model. The manual also addresses the health system requirements to ensure that the model is sustainable and effective in achieving the outcomes.

You may have encountered many things you already knew in this guide, and you may do some things better than what we have described here. This manual is not prescriptive, but instead provides a platform for systemic thinking in order to address the huge burden of chronic diseases in an efficient manner.

We hope that this manual will inspire you and your team to work smarter and better and provide comprehensive and holistic care to the patients and to introduce preventive and curative measures that will assist it towards greater health and wellbeing .

We trust that you will go back to different chapters at different times and use them in your own creative way. If this booklet remains in a file, it is worthless; it must be used, tested, discussed, criticised, revised, and digested.

Lastly, we want to thank you for your hard work, commitment and persistence despite all the difficulties you may face at your facilities.

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# INTEGRATED CHRONIC DISEASE MANAGEMENT

## Toolkit

health

Department:
Health
REPUBLIC OF SOUTH AFRICA

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# TEMPLATE FOR DISTRICT ENGAGEMENT PLAN

1

| ACTIVITY | TIMEFRAME | RESPONSIBLE PERSON |
|---|---|---|
| Review of overall district performance data for NCDs and HIV | | |
| Determine the district that will commence with ICDM | | |
| Contact the district to arrange an information and briefing session | | |
| Send a memo (Tool 2) to the district with an agenda and a list of the personnel who are required to attend the initiation meeting | | |
| Follow up and confirmation of the district initiation meeting | | |
| Send out the meeting agenda (Tool 3) | | |
| Prepare the presentations for the meeting using the information provided plus the information boxes (Tool 4) | | |

# MEMO FOR DISTRICT ENGAGEMENT

2

The rovincial Department of Health will be strengthening the management of chronic diseases (NCDs and HIV) through the Integrated Chronic Disease Management (ICDM) Model. Your district *(insert name here)* has been selected for the implementation according to the provincial implementation plan.

1. In order to initiate the process, the provincial ICDM task team would like to convene a meeting on the (*proposed date*) in your district
2. The meeting should be scheduled for approximately *4 hours*
3. It would be highly appreciated if the following key role players are in attendance:
    a. District manager
    b. District procurement and supply chain manager
    c. District PHC manager
    d. District human resource manager
    e. District regional training centre manager
    f. District NCD and mental health coordinator(s)
    g. District HIV & AIDS & TB manager
    h. District pharmaceutical manager(s)
    i. District health information manager
    j. District quality assurance manager
    k. All sub-district local area managers/PHC supervisors
4. Please arrange a suitable venue that caters for 25-30 people.

Your participation and co-operation will be highly appreciated.

Thanking you

Yours faithfully

ICDM provincial task team leader

# AGENDA FOR THE DISTRICT ENGAGEMENT MEETING

3

**Meeting for district facilitationof ICDM implementation**

**Date/Time:**

**Location**:

**Objectives:**

Initiation of the ICDM for the district health management team through a meeting with designated provincial managers.

**Agenda:**

| TIME | DESCRIPTION |
|---|---|
| | 1. Welcome and introduction<br>2. Purpose of the meeting<br>a Briefing on the ICDM<br>b District initiation process<br>c Nomination and appointment of district managers to serve as district task team members<br>d The identification of facilities that will initiate the ICDM (if phased approach used)<br>3. Briefing on the ICDM<br>a. What is the ICDM?<br>b. ICDM implementation steps<br>Discussion and feedback from district managers<br>4. District initiation process<br>a. Roles and responsibilities of the district ICDM team<br>b. Nomination of members to the district ICDM team<br>c. Nomination of District ICDM coordinator<br>d. Identification of the initiation facilities (1st phase) and subsequent facility scale up<br>e. Date for facility initiation<br>f. Responsibility for sending out invitations to facilities (who and when) and arranging logistics for venue and transport<br>g. Discussion and feedback from district managers<br>5. Responsibility for development of district implementation plan |

# PRESENTATION AT DISTRICT ENGAGEMENT MEETING

4

### INFORMATION BOX 1: PRESENTATION GUIDE

- To present an overview of the ICDM, use the information provided
- PowerPoint slides available in tools section of the manual.

### INFORMATION BOX 2: THE ROLE OF THE DISTRICT TASK TEAM

- Championing of the project
- Interacting with key officials in the service delivery chain
- Conducting the situational analysis visits
- Working with the operational managers in developing quality improvement plans
- Adopting a facility and providing monitoring and supportive supervision
- Report back and attendance at task team meetings

### INFORMATION BOX 3: IDENTIFICATION OF FACILITIES/SUB-DISTRICTS TO COMMENCE WITH ICDM

- The number of facilities that will commence with the ICDM activities is dependent on the district's capacity and health system challenges
- Ideally, the plan will to be to initiate the programme in one sub-district or local area followed by saturation across all sub-districts
- A catchment area that has a community healthcare centre (CHC) and five referring PHC clinics should be selected for each sub-district or local area, and these facilities will act as the initiation sites.

### THE DISTRICT TASK TEAM MEMBERS

- District PHC manager
- District NCD and mental health coordinator
- District HIV & AIDS & TB manager
- District pharmaceutical managers
- District quality assurance manager
- Sub-district local area managers
- Operational managers/project managers from selected facilities

# DISTRICT ICDM IMPLEMENTATION PLAN

5

| ICDM IMPLEMENTATION PLAN ACROSS THE DISTRICT | |
|---|---|
| Total number of public health facilities in the district (CHC +PHC) | Modify to be per sub-district |
| Number of sub-districts (local areas) | |
| Number of district hospitals | |
| Number of community health centres | |
| Number of primary health care clinics | |

| PHASE 1 | PHASE 2 | PHASE 3 | PHASE 4 | PHASE 5 |
|---|---|---|---|---|
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# FACILITY ENGAGEMENT PLAN

6

| ACTIVITY | TIMEFRAME | RESPONSIBLE PERSON | PROGRESS |
|---|---|---|---|
| Contact the sub-district & facilities to arrange an information and briefing session | | | |
| Send a memo (Tool 2) to the sub-district & facilities with an agenda and a list of personnel that are required to attend the initiation meeting | | | |
| Follow up and confirmation of the initiation meeting | | | |
| Send out the meeting agenda (Tool 3) | | | |
| Prepare the Presentations for the meeting using the information provided (Tool 4) | | | |
| Ensure that transport arrangements are made and that staff at the clinic are able to stand in for those who are away | | | |
| Contact the community representatives and arrange a meeting | | | |

# MEMO FOR FACILITY ICDM INITIATION MEETING

7

The provincial Department of Health in collaboration with the District will be strengthening the management of chronic diseases (NCDs and HIV) through the Integrated Chronic Disease Management (ICDM) Model. Your facility *(insert name here*) has been selected for the implementation according to the provincial implementation plan.

1. In order to initiate the process, the provincial ICDM task team and district management would like to convene a meeting on the (*proposed date*)
2. The meeting should be scheduled for approximately *4 hours*
3. We will appreciate it if the following key role players are in attendance:
    a. All the facility/operational managers
    b. CCMT project managers (where applicable)
    c. Sub-district or local area managers (PHC supervisors)
    d. Programme coordinators
    e. NCD and mental health coordinators
    f. HIV & AIDS & TB coordinators
    g. DCST
    h. Family physicians
    i. Training coordinators
    j. District ICDM task team members
    k. Provincial task team members
4. The venue for the meeting will be at (*Insert details here*)
5. Transport arrangements are as follows:

Your participation and co-operation will be highly appreciated.

Thanking you
Yours faithfully

District manager

# AGENDA FOR FACILITY ICDM PREPAREDNESS MEETING

8

**Meeting for district facilitation of ICDM implementation**

**Date:**

**Venue:**

**Time: 09h30-12h30**

**Objective:**

Initiation of the ICDM for the district task team and facility managers

**Agenda items:**

1. Welcome and introduction
2. Purpose of the meeting
3. What is the ICDM?
4. Key steps in implementation process
5. Responsibility of the operational manager
6. Identification of facility ICDM champions
7. Informing stakeholders
8. Date for orientation meeting
9. Data required for next meeting
10. Date for ICDM
11. Closure

# PRESENTATION AT ICDM FACILITY INITIATION MEETING



## PRESENTATION GUIDE

- To present an overview of the ICDM, use the information provided
- PowerPoint slides available in tools section of the manual

## PURPOSE OF THE FACILITY ICDM INITIATION MEETING:

- To brief the operational managers about the ICDM
- To clarify the roles of the operational managers
- To define the characteristics of the ICDM champion
- To set timeframes for ICDM implementation activities

## IDENTIFYING AN ICDM CHAMPION

- The ICDM champion is someone who will advocate for ICDM at all times, and who will always act as if the project is "his/her baby"
- The ICDM champion should be an individual of considerable importance in the clinic and should be diplomatic, have good communication skills, and should be the "proactive type" (meaning he should ask about the status of the project rather than be told about the status of the project).

## ROLES AND RESPONSIBILITIES OF THE ICDM CHAMPION

- Coordinator and mentor for ICDM
- Ensures stakeholder satisfaction and engagement from conception to completion
- Addresses the various obstacles with respect to ICDM
- Makes decisions or plans the steps that will make the project move forward.
- Constantly raises the project's profile, be a fierce supporter and praise its benefits to the stakeholders.
- Liaison between the facility and the district management team and external stakeholders
- Maintains a harmonious relationship between the ICDM team and its stakeholders
- Provides suggestions for solutions to the stakeholders who will then pick the best option
- Facility trainer for PC 101, if possible
- Communicates dates on the project's development and issues to upper management
- Communicates messages from the stakeholders to the facility ICDM team in case they have any concerns, requests in a change of direction or simply questions about the project's status and progress

# PRESENTATION AT ICDM FACILITY INITIATION MEETING



## INFORMING STAKEHOLDERS

*THIS PROCESS SHOULD COMMENCE 4-6 WEEKS PRIOR TO THE COMMENCEMENT DATE*

Immediately after the briefing of the facility manager should convene a meeting with:

- All the staff at the clinic - doctors, nurses, pharmacy assistants, administrative clerks, data capturers, counsellors, general assistants, security guards and any other
- Clinic committee, local chiefs and traditional healers
- Patients - the facility manager and/or ICDM champion should address the patients daily as a collective after the morning prayers and inform them of the impending changes

The professional nurses should inform patients individually after their consultations about the impending changes

The health promoters should also brief the patients about the impending changes during their health promotion sessions conducted at various stages during the day

PHC re-engineering is the selected mechanism for overhauling the health system and improving patient outcomes. At the same time a renewed focus has been placed on improved management for patients with long-term conditions.

## SERVICE DELIVERY RE-DESIGN

Chronic patients will be seen according to an appointment system schedule

- Chronic patients' files will be retrieved prior to the appointment
- The waiting area will be separated
- A separate vital sign station will be provided for chronic patients
- Designated consulting rooms will be allocated for chronic patients
- Medication will be pre-dispensed
- Stable chronic patients will be dispensed with medication for 2-3 months depending on stock levels
- When the PHC WBOT is available for your area, the team will visit the patient monthly to assist with monitoring, health promotion and delivery of medication
- At six-monthly intervals the patient will receive a comprehensive medical examination and investigations as per the protocol of management

## WHAT WILL WE BE DOING TO IMPROVE PATIENT CARE AND MANAGEMENT?

- **Integration of care:** All chronic patients (requiring long-term medication) irrespective of whether communicable or non-communicable diseases will be consulted together.

# TEMPLATE FOR PLANNING FACILITY ICDM PREPAREDNESS



| OBJECTIVE | ACTIVITY | TIMEFRAME | RESPONSIBLE PERSON |
|---|---|---|---|
| To initiate ICDM in your facility | Invite all personnel for a briefing session | | |
| To facilitate a briefing session with staff | Orientation and briefing of staff | | |
| To sketch the floor plan for the facility | Drawing of the facility floor plan | | |
| To conduct a process flow analysis | Conducting a patient flow analysis through the facility | | |
| To obtain the data from the facility information officer<br><br>Waiting time<br><br>HR | Print out of data from District Health Information System (DHIS) and PERSAL | | |
| To use the selection criteria provided to identify a facility champion | Identification of facility champion | | |
| To engage with programme co-ordinators and PHC supervisors | Engagement with programme coordinators & PHC supervisors | | |
| To brief the community leaders and the clinic health committee to obtain their buy-in for ICDM | Briefing the community via the clinic health committees and community leaders | | |

# MEMO FOR DISTRICT AND FACILITY IMPLEMENTATION TRAINING

12

The provincial Department of Health in collaboration with the District will be strengthening the management of chronic diseases (NCDs and HIV) through the Integrated Chronic Disease Management (ICDM) model. Your facility (*insert name here*) has been selected for the implementation according to the provincial implementation plan.

1. In order to initiate the process, the provincial ICDM task team & district management would like to convene an implementation training workshop on the (*proposed date)*
2. The meeting would last an entire day so please arrange adequate staff cover to provide services at the facility
3. We will appreciate it if the following key role players are in attendance:
    a. All the facility/operational managers
    b. ICDM champions
    c. Sub-district or local area managers (PHC supervisors)
    d. Programme coordinators
        i NCD and mental health coordinators
        ii HIV & AIDS & TB coordinators
        iii Clinical support coordinators
    e. Training coordinators
    f. District ICDM task team members
    g. Provincial task team members
4. A detailed memo highlighting the information you are required to bring with you to the training is enclosed
5. The venue for the meeting will be at (*Insert details here*)
6. Transport arrangements are as follows:

Your participation and co-operation will be highly appreciated.

Thanking you

Yours faithfully

District manager

# AGENDA FOR THE DISTRICT AND FACILITY IMPLEMENTATION TRAINING WORKSHOP

13

## DISTRICT AND FACILITY IMPLEMENTATION TRAINING WORKSHOP

**Date:**

**Venue:**

**Time: 09h30-12h30**

**Objective:**

To capacitate the operational manager and/or the ICDM champion on the implementation steps for the ICDM model at facility level.

At the end of the meeting ensure that you have achieved the following:

1. Know how to re-organise your facility
2. Addressed the six priority areas of the National Core Standards
3. RTC to develop a plan for PC 101 & ICDM training

**Agenda items:**

1. Welcome and introduction
2. Purpose of the meeting
3. What is the ICDM?
4. Key steps in implementation process:
    a. Baseline analysis
    b. Process flow and waiting time analysis
    c. Human resource data
    d. Facility data
    e. Implementation activities
    f. Selection of a start date
    g. Data collection for ICDM
    h. Monitoring of the ICDM model
5. Closure - development of a facility specific implementation plan

# DETAILED MEMO HIGHLIGHTING INFORMATION REQUIRED



## INVITATION TO A TRAINING WORKSHOP ON THE IMPLEMENTATION OF THE INTEGRATED CHRONIC DISEASE MANAGEMENT (ICDM) MODEL

Integrated Chronic Disease Management (ICDM) is a model of managed care that provides for integrated prevention, treatment and care of chronic patients at primary healthcare level (PHC) to ensure a seamless transition to "assisted" self-management within the community.

The aim of ICDM is to achieve optimal clinical outcomes for patients with chronic communicable and non-communicable diseases using the health system building blocks approach.

The ICDM consists of four inter-related phases:

1. Facility re-organisation

2. Clinical supportive management

3. "Assisted" self-support and management of patients through the PHC ward based outreach teams (WBOT); and

4. Support systems and structure strengthening outside the facility.

The ICDM is aligned to PHC Re-engineering and is a component of the NCD Strategy and forms part of the Annual Performance Plan of the National Department of Health in supporting the NSDA goals of increasing life expectancy and improving health system effectiveness.

Please find attached an annexure with details of the expected participants and the data and documentation that are required for the workshop.

# DETAILED MEMO HIGHLIGHTING INFORMATION REQUIRED



The following key stakeholders are invited to attend this training workshop:

- All the facility/operational managers
- Sub-district or local area managers (PHC supervisors)
- District & sub-district programme coordinators (NCD and mental health coordinators, HIV & AIDS & TB coordinators)
- District clinical specialist team
- District training coordinators
- District ICDM task team members.

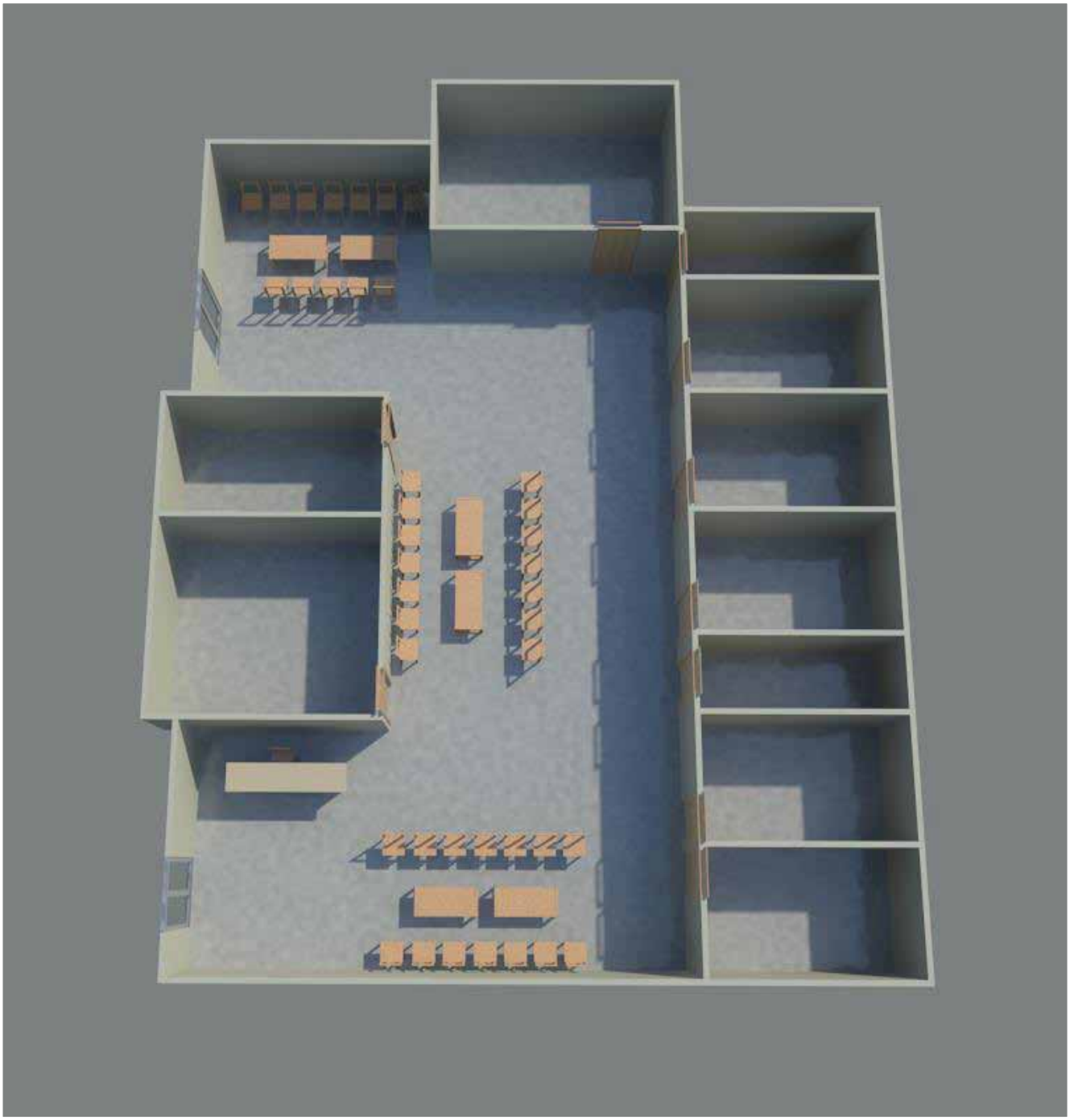
To achieve the maximum effect the following information should be brought to the workshop by each facility:

1. Previous waiting time survey conducted in the last quarter
2. Facility floor plan - a sketch plan of the facility indicating all the service points:
   - Reception
   - Consulting rooms
   - Waiting areas
   - Toilets
   - Park homes and external structures.
3. The sketch should indicate the various services delivered at each of the consultation rooms.
4. A patient flow diagram should be superimposed on the sketch in a different colour. Example of a process flow in a typical clinic is provided below.

# DETAILED MEMO HIGHLIGHTING INFORMATION REQUIRED



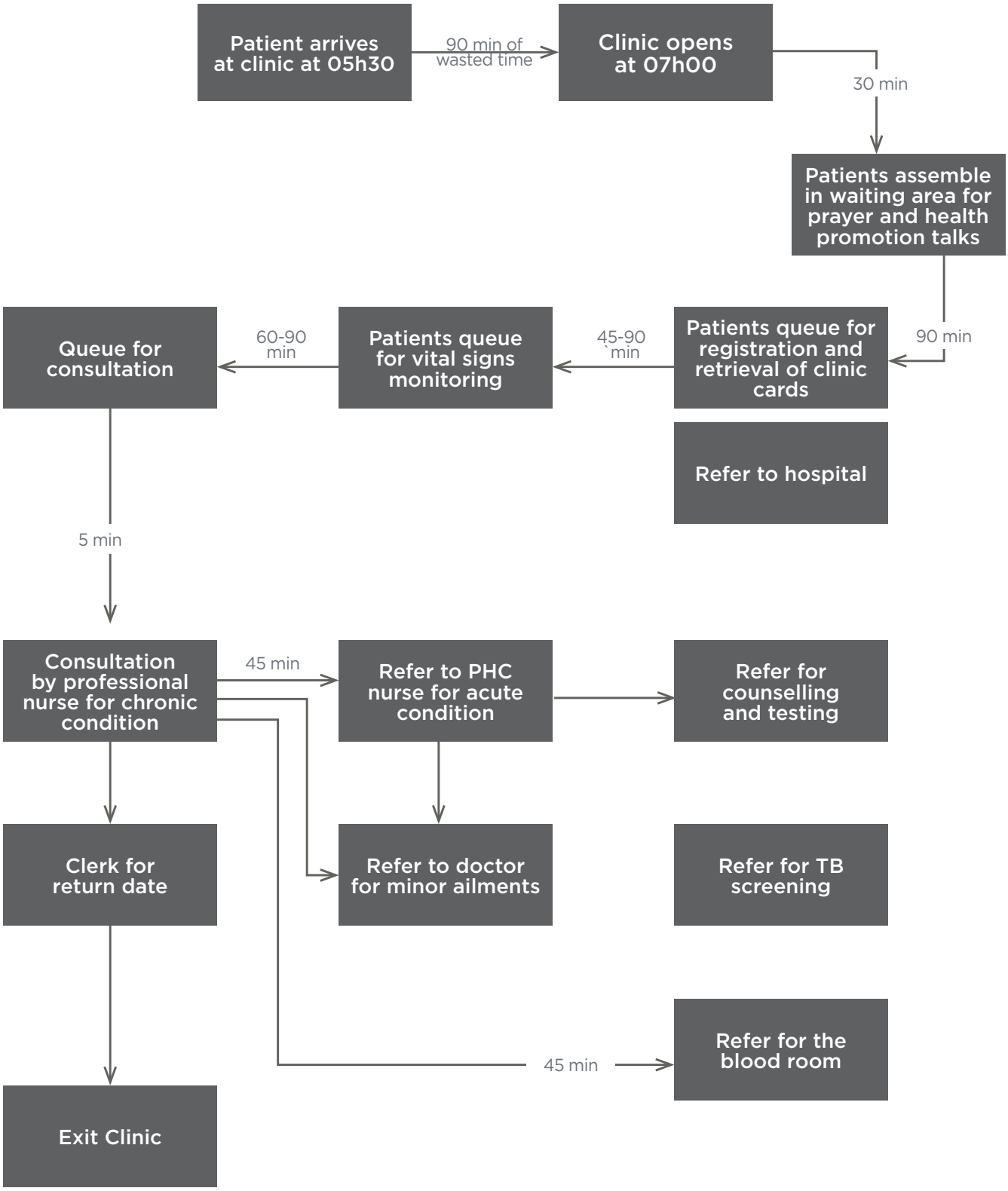
## EXAMPLE OF A FACILITY FLOOR PLAN



# DETAILED MEMO HIGHLIGHTING INFORMATION REQUIRED



## EXAMPLE OF PATIENT PROCESS FLOW



# DETAILED MEMO HIGHLIGHTING INFORMATION REQUIRED



| | |
|---|---|
| **HUMAN RESOURCE DATA** | |
| Total number of human resources employed at the facility | |
| **INDICATE NUMBER OF STAFF IN THE FOLLOWING CATEGORIES** | |
| Operational managers | |
| Project managers/deputy manager | |
| Professional nurses | |
| Enrolled nurses | |
| Enrolled nursing assistants | |
| Health promoters | |
| HCT counsellors | |
| Admin clerks | |
| Data capturers | |
| Pharmacist assistants | |
| General assistants | |
| Full time medical doctors | |
| Sessional medical doctors | |
| Dentist/dental therapist | |
| **STAFF DEVELOPMENT** | |
| No. of P/N that are PHC trained | |
| No. of P/N that are NIMART trained | |
| No. of P/N that are PC 101 trained (both master and at facility level) | |

# DETAILED MEMO HIGHLIGHTING INFORMATION REQUIRED



| HEALTH INFORMATION FROM THE DHIS FOR THE LAST QUARTER | QUARTER: |
|---|---|
| PHC headcount ( < 5 years + > 5 years) | |
| PHC headcount > 5 years | |
| Number of HIV patients currently on art new | |
| Total number of HIV patients remaining on ART | |
| Number of patients on pre-ART | |
| Number of tb patients > 8 years receiving monthly medication | |
| Number of TB MDR confirmed patients initiated on treatment | |
| Total number of chronic NCD patients new and follow up (to arrive at this total- sum up the six (6) indicators below) | |
| Hypertension case load - number of patients with HPT > 5 years visiting the clinic | |
| Diabetes case load - number of patients with diabetes > 5 years visiting the clinic | |
| Epilepsy case load - number of patients with epilepsy > 5 years visiting the clinic | |
| Asthma case load - number of patients with asthma > 5 years visiting the clinic | |
| Chronic obstructive airway disease (COPD) case load - number of patients with COPD > 5 years visiting the clinic | |
| Mental health case load - number of patients with mental health > 5 years visiting the clinic | |

# TEMPLATE FOR PLANNING ICDM IMPLEMENTATION AT FACILITY LEVEL



| OBJECTIVE | ACTIVITY | TIMEFRAME | RESPONSIBLE PERSON | PROGRESS ACHIEVED |
|---|---|---|---|---|
| Sorting and shining | Walk through the facility and remove unwanted items from walls and desks and ensure cleanliness | | | |
| To introduce the patient scheduling system | Application of an appointment scheduling system | | | |
| To integrate patient records | Review of patient records and combine and integrate records | | | |
| Introduction of chronic patient record | Training of all staff on application of chronic patient record | | | |
| To re-organise facility | Designated chronic consulting rooms<br><br>An additional vital signs station<br><br>Designated waiting area for chronic patients | | | |
| To introduce a staff rotation schedule for consulting chronic patients | Audit of staff training<br><br>Development of a roster for staff | | | |
| To pre-retrieve patient records prior to appointments | Pre-retrieval of patient records | | | |
| To pre-dispense patient medication | Pre-appointment dispensing and storage of patient medication | | | |
| Down referral of stable chronic patients | Consultation with outreach team | | | |
| To implement data collection tools for chronic patients | Capacitation of all staff on use of daily tally sheet and data collection tools | | | |
| Ensure availability of essential equipment for each consulting room | Equipment audit and ordering of appropriate equipment | | | |
| Ensure the availability of medication for 2-3 month supply | Adjustment of medication stock levels | | | |
| Ensure that all staff are trained on evidence-based guidelines | PC 101 training at facility level for all staff | | | |

# FACILITY-SPECIFIC DATA SUMMARY SHEET FOR WAITING TIME SURVEY

16

| | |
|---|---|
| Name of facility | |
| Date(s) of survey | |
| Total number of patients seen for the day(s) at the facility | |
| Total number of professional nurses on duty for the day(s) (outpatient services only) | |
| Total number of enrolled nursing assistants/enrolled nurses on duty for the day(s) (outpatient services only) | |
| Total number of admin clerks/data capturers on duty for the day(s) | |

# WAITING TIME SURVEY TOOL



| | CONDITION FOR WHICH PATIENT ATTENDING | Immunisation | ART | Acute minor illness (Adult) | Chronic-NCD | Family planning |
|---|---|---|---|---|---|---|
| | | ANC | TB | Well baby clinic | Child health curative | Dressings/ injections |
| 1 | Time the patient enters the clinic | | | | | |
| 2 | Time the patient is registered / allocated card | | | | | |
| 3 | Time the patient completed vital signs | | | | | |
| 4 | Time the patient starts 1st consultation | | | | | |
| 5 | Time patient completed 1st consultation | | | | | |
| 6 | Time the patient started 2nd consultation<br><br>(if referred to another service) | | | | | |
| 7 | Time the patient completed 2nd consultation (if referred) | | | | | |
| 8 | Time patient departs clinic | | | | | |

# STAFF DEVELOPMENT NEEDS ASSESSMENT



| | TRAINING COMPLETED | | | | | | |
|---|---|---|---|---|---|---|---|
| **NAME OF PROFESSIONAL NURSE** | South african nursing council registration number | Primary healthcare | Palsa plus | Nurse initiated art (NIMART) | Mental health | Advanced midwifery | Pc 101 |
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# SUMMARY SHEET FOR DHIS DATA FOR THE LAST QUARTER



| HEALTH INFORMATION FOR THE LAST QUARTER | QUARTER: |
|---|---|
| PHC headcount ( < 5 years + > 5 years) | |
| PHC headcount > 5 years | |
| Number of HIV patients currently on art new | |
| Total number of HIV patients remaining on ART | |
| Number of patients on pre-ART | |
| Number of tb patients > 8 years receiving monthly medication | |
| Number of TB MDR confirmed patients initiated on treatment | |
| Total number of chronic NCD patients new and follow up (to arrive at this total- sum up the six (6) indicators below) | |
| Hypertension case load - number of patients with HPT > 5 years visiting the clinic | |
| Diabetes case load - number of patients with diabetes > 5 years visiting the clinic | |
| Epilepsy case load - number of patients with epilepsy > 5 years visiting the clinic | |
| Asthma case load - number of patients with asthma > 5 years visiting the clinic | |
| Chronic obstructive airway disease (COPD) case load - number of patients with COPD > 5 years visiting the clinic | |
| Mental health case load - number of patients with mental health > 5 years visiting the clinic | |

# PROCESS FLOW AND WAITING TIME ANALYSIS TEMPLATE



| SERVICE DELIVERY POINT | SYMPTOM: LONG WAITING TIME |
|---|---|
| Area A – e.g. between entry and registration | Why?<br><br>Batching - all patients arriving at a single point together, e.g. all patients arrive at the clinic at 06h30 when the clinic opens at 07h00.<br><br>Over-processing - patient having to go through a process that can be avoided<br><br>People - availability of the correct type of human resources<br><br>Equipment - availability of equipment |
| Between registration and vital signs | |
| Between vital signs and consultation | |
| Between consultation and additional service points | |
| Between consultation and departure from clinic | |

# SUMMARY OF HUMAN RESOURCE DATA



| | NUMBER |
|---|---|
| Total number of professional nurses employed at the facility | |
| Total number of enrolled nurses employed at the facility | |
| Number of professional nurses PHC trained | |
| Number of professional nurses PALSA Plus trained | |
| Number of professional nurses NIMART trained | |
| Number of professional nurses PC 101 trained | |
| | |
| **STAFF DEVELOPMENT** | |
| Number of professional nurses that require to be trained | |
| PHC | |
| NIMART | |
| PC 101 | |

# ANALYSIS OF DHIS INFORMATION FOR THE FACILITY



| INDICATORS | NUMBER/% | FORMULA |
|---|---|---|
| Total PHC headcount | | |
| Proportion of patients > 5 years | | (PHC headcount > 5 years / total PHC headcount) |
| Total number of NCD patients | | (hypertension case load + diabetes case load + epilepsy case load + asthma case load + chronic obstructive pulmonary disease case load + mental health case load) |
| HIV patients on ART case load | | (number of new patients on ART + total number remaining on ART) |
| Pre-ART HIV patients | | |
| TB patients > 8 years receiving monthly medication | | |
| Number of TB MDR confirmed patients initiated on treatment | | |
| Total chronic patient case load | | (total number of NCD patients + HIV patients on ART case load + pre-ART HIV patients + TB patients > 8 years receiving monthly medication + number of MDR TB patients initiated on treatment) |

| | |
|---|---|
| Sorting | Remove unnecessary items from consulting rooms and any unused items from the workspace |
| Set-in order/ straighten | Organise the process flow and ensure all the necessary items are in the correct place for easy access and efficient service provision |
| Shine | Maintain a clean environment |
| Standardise | Set up, sort and shine at all work stations |
| Sustain | Reinforce the importance |

Total number of NCD patients + HIV patients on ART case load + pre-ART HIV patients + TB patients > 8 years receiving monthly medication + number of MDR TB patients initiated on treatment

# APPOINTMENT SCHEDULING FORMAT - NO TIME SLOTS



| DATE OF APPOINTMENT | | | | | | |
|---|---|---|---|---|---|---|
| CALENDAR DAY | | | | | | |
| NO | PATIENT FILE NUMBER | SURNAME & INITIALS OF PATIENT | DIAGNOSTIC CONDITION | COMMENTS | FILE RETRIEVED (Y/N) | PATIENT ATTENDED (Y/N) |
| 1 | | | | | | |
| 2 | | | | | | |
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| NON-SCHEDULED PATIENTS | | | | | | |
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| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |

# APPOINTMENT SCHEDULING FORMAT - TIME SLOTS



| DATE OF APPOINTMENT | | | | | | |
|---|---|---|---|---|---|---|
| CALENDAR DAY | | | | | | |
| NO | PATIENT FILE NUMBER | SURNAME & INITIALS OF PATIENT | DIAGNOSTIC CONDITION | COMMENTS | FILE RETRIEVED (Y/N) | PATIENT ATTENDED (Y/N) |
| TIME SLOT: 07H00-09H00 | | | | | | |
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| 9 | | | | | | |
| 10 | | | | | | |
| TIME SLOT: 09H00-11H00 | | | | | | |
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| 10 | | | | | | |
| TIME SLOT: 11H00-13H00 | | | | | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |
| TIME SLOT: 13H00-16H00 | | | | | | |
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |
| 7 | | | | | | |
| 8 | | | | | | |
| 9 | | | | | | |
| 10 | | | | | | |

# PATIENT RECORD IDENTIFICATION



| REGISTER | FILE/REGISTER NUMBER |
|---|---|
| IMMUNISATION | |
| CHRONIC | |
| MENTAL HEALTH | |
| ANC | |
| PMTCT | |
| PRE-ART | |
| ART | |
| IPT | |
| TB | |
| FAMILY PLANNING | |

# NURSE SCHEDULING FORMAT



| NAME OF PROFESSIONAL NURSE | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 |
|---|---|---|---|---|---|---|
| | | | | | | |
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# CHRONIC PATIENT RECORD



| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **DIAGNOSTIC CONDITION** | ASTHMA/ COPD | | DIABETES | | | HPT | |
| | TB | | EPILEPSY | | | HIV-ART | |
| | MENTAL ILLNESS | | OTHER | | | HIV NOT YET ON ARV | |
| **NAME & SURNAME** | | | | | | | |
| **CLINIC FILE NUMBER** | | | **GENDER** | M | F | **ALLERGIES** | |
| **IDENTITY NUMBER OF DATE OF BIRTH** | | | | | | **HEIGHT** | **BMI** |
| **MONTH OF VISIT** | **1** | **2** | **3** | **4** | **5** | 6 | **ADDITIONAL EXAMS** |
| Date consulted | | | | | | | |
| Vital signs | | | | | | | **FOOT** |
| Weight | | | | | | | Date Conducted |
| Blood pressure | | | | | | | |
| Blood sugar | | | | | | | Results |
| Urine | | | | | | | |
| Pulse | | | | | | | |
| **HISTORY** | **1** | **2** | **3** | **4** | **5** | 6 | **EYE** |
| Any acute episodes or symptoms? | | | | | | | Date Conducted |
| Any limitation of activity? | | | | | | | |
| Night symptoms? | | | | | | | Results |
| Hospitalisation or doctor visits? | | | | | | | **U&E** |
| Adherence to meds pill count? | | | | | | | |
| Side effects of meds | | | | | | | Date Conducted |
| Additional medication | | | | | | | |
| Tobacco/alcohol/snuff use/illicit drugs | | | | | | | Results |
| **EXAMINATION** | **1** | **2** | **3** | **4** | **5** | 6 | |
| Pedal oedema | | | | | | | **HBA1C** |
| Chest | | | | | | | Date Conducted |
| Cardiovascular | | | | | | | |
| Abdomen | | | | | | | Results |
| Mental state | | | | | | | |
| Investigations ordered | | | | | | | **CHOLESTROL** |
| | | | | | | | Date Conducted |
| **PATIENTS MEDICATION** | **1** | **2** | **3** | **4** | **5** | 6 | |
| | | | | | | | Results |
| | | | | | | | |
| | | | | | | | **CERVICAL SMEAR**** |
| | | | | | | | Date Conducted |
| | | | | | | | |
| | | | | | | | Results |
| | | | | | | | |
| | | | | | | | |
| **HEALTH EDUCATION/PROMOTION** | **1** | **2** | **3** | **4** | **5** | 6 | |
| **REFERRALS** | | | | | | | |
| **DATE OF NEXT VISIT** | | | | | | | |
| **HCP NAME** | | | | | | | |
| **HCP SIGNATURE** | | | | | | | |
| **DR'S SIGNATURE** | | | | | | | |

# CHRONIC PATIENT RECORD



| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **DIAGNOSTIC CONDITION** | ASTHMA/ COPD | | DIABETES | | | HPT | |
| | TB | | EPILEPSY | | | HIV-ART | |
| | MENTAL ILLNESS | | OTHER | | | HIV NOT YET ON ARV | |
| **NAME & SURNAME** | | | | | | | |
| **CLINIC FILE NUMBER** | | | **GENDER** | M | F | **ALLERGIES** | |
| **IDENTITY NUMBER OF DATE OF BIRTH** | | | | | | **HEIGHT** | **BMI** |
| **MONTH OF VISIT** | **7** | **8** | **9** | **10** | **11** | 12 | **ADDITIONAL EXAMS** |
| Date consulted | | | | | | | |
| Vital signs | | | | | | | **FOOT** |
| Weight | | | | | | | Date Conducted |
| Blood pressure | | | | | | | |
| Blood sugar | | | | | | | Results |
| Urine | | | | | | | |
| Pulse | | | | | | | |
| **HISTORY** | **7** | **8** | **9** | **10** | **11** | 12 | **EYE** |
| Any acute episodes or symptoms? | | | | | | | Date Conducted |
| Any limitation of activity? | | | | | | | |
| Night symptoms? | | | | | | | Results |
| Hospitalisation or doctor visits? | | | | | | | **U&E** |
| Adherence to meds pill count? | | | | | | | |
| Side effects of meds | | | | | | | Date Conducted |
| Additional medication | | | | | | | |
| Tobacco/alcohol/snuff use/illicit drugs | | | | | | | Results |
| **EXAMINATION** | **7** | **8** | **9** | **10** | **11** | 12 | |
| Pedal oedema | | | | | | | **HBA1C** |
| Chest | | | | | | | Date Conducted |
| Cardiovascular | | | | | | | |
| Abdomen | | | | | | | Results |
| Mental state | | | | | | | |
| Investigations ordered | | | | | | | **CHOLESTROL** |
| | | | | | | | Date Conducted |
| **PATIENTS MEDICATION** | **7** | **8** | **9** | **10** | **11** | 12 | |
| | | | | | | | Results |
| | | | | | | | |
| | | | | | | | **CERVICAL SMEAR**** |
| | | | | | | | Date Conducted |
| | | | | | | | |
| | | | | | | | Results |
| | | | | | | | |
| | | | | | | | |
| **HEALTH EDUCATION/PROMOTION** | **7** | **8** | **9** | **10** | **11** | 12 | |
| **REFERRALS** | | | | | | | |
| **DATE OF NEXT VISIT** | | | | | | | |
| **HCP NAME** | | | | | | | |
| **HCP SIGNATURE** | | | | | | | |
| **DR'S SIGNATURE** | | | | | | | |

# DOWN REFERRAL DIARY FORMAT/PATIENT DOWN REFERRAL TO CHW

| NAME & SURNAME | PHYSICAL ADDRESS | CONTACT NUMBER | CONVENIENT TIME FOR CHW TO VISIT | LAST DATE BY WHICH MEDICATION SHOULD BE DELIVERED | COMMUNITY HEALTH WORKER ALLOCATED |
|---|---|---|---|---|---|
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# TOOL FOR ACKNOWLEDGING RECEIPT OF MEDICATION BY PATIENT



| | | | | | |
|---|---|---|---|---|---|
| NAME & SURNAME | | | | | |
| CLINIC FILE NUMBER | | | | | |
| IDENTITY NUMBER OR DATE OF BIRTH | | | | | |
| MONTH IN SCHEDULE | | | | | |
| DATE OF MEDICATION DELIVERY | | | | | |
| DISPENSER'S SIGNATURE (TO BE COMPLETED AFTER CHECKING, PLACING LABEL AND SEALING PACKET) | | | | | |
| CHWS SIGNATURE ON RECEIPT OF MEDICATION (SEALED BAG) | | | | | |
| PATIENTS SIGNATURE ON OPENING OF SEALED BAG AND CHECKING MEDICATION | | | | | |
| MEDICATION NOT DELIVERED | | | | | |

# CHRONIC PATIENT RECORD FOR USE BY CHWS



| | | | | | | |
|---|---|---|---|---|---|---|
| NAME AND SURNAME | | | | | | |
| CLINIC FILE NUMBER | | | | MALE | | FEMALE |
| IDENTITY NUMBER OR DATE OF BIRTH | | | | | | |
| MONTH OF VISIT | 1 | 2 | 3 | 4 | 5 | 6 |
| Date consulted | | | | | | |
| Vital signs | 1 | 2 | 3 | 4 | 5 | 6 |
| Weight | | | | | | |
| Blood pressure | | | | | | |
| Blood sugar | | | | | | |
| Urine | | | | | | |
| SYMPTOMS | 1 | 2 | 3 | 4 | 5 | 6 |
| Any complaints | | | | | | |
| Any limitation of activity | | | | | | |
| Adherence to meds – pill count | | | | | | |
| Any side-effects | | | | | | |
| HEALTH EDUCATION / PROMOTION | 1 | 2 | 3 | 4 | 5 | 6 |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| REFERRALS | | | | | | |
| DATE OF NEXT VISIT | | | | | | |
| CHW NAME | | | | | | |
| CHW SIGNATURE | | | | | | |
| PATIENT'S SIGNATURE ON RECEIPT OF MEDICATION | | | | | | |

# CHRONIC PATIENT RECORD FOR USE BY CHWS



| | | | | | | |
|---|---|---|---|---|---|---|
| NAME AND SURNAME | | | | | | |
| CLINIC FILE NUMBER | | | | MALE | | FEMALE |
| IDENTITY NUMBER OR DATE OF BIRTH | | | | | | |
| MONTH OF VISIT | 7 | 8 | 9 | 10 | 11 | 12 |
| Date consulted | | | | | | |
| VITAL SIGNS | 7 | 8 | 9 | 10 | 11 | 12 |
| Weight | | | | | | |
| Blood pressure | | | | | | |
| Blood sugar | | | | | | |
| Urine | | | | | | |
| SYMPTOMS | 7 | 8 | 9 | 10 | 11 | 12 |
| Any complaints | | | | | | |
| Any limitation of activity | | | | | | |
| Adherence to meds – pill count | | | | | | |
| Any side-effects | | | | | | |
| HEALTH EDUCATION / PROMOTION | 7 | 8 | 9 | 10 | 11 | 12 |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| REFERRALS | | | | | | |
| DATE OF NEXT VISIT | | | | | | |
| CHW NAME | | | | | | |
| CHW SIGNATURE | | | | | | |
| PATIENT'S SIGNATURE ON RECEIPT OF MEDICATION | | | | | | |

# MONTHLY DATA COLLECTION TOOL FOR ICDM

| **NAME OF CLINIC** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **DATASET** | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH 9 |
| **ANTIRETROVIRAL TREATMENT-ADULT** | | | | | | | | | |
| TOTAL NUMBER OF ADULT PATIENTS INITIATED ON ART THIS MONTH | | | | | | | | | |
| ART CASE LOAD (SUM OF ART PATIENTS VISITS) | | | | | | | | | |
| NUMBER OF ADULTS INITIATED AT THIS FACILITY ON ART AFTER 3 MONTHS (THIS DOES NOT INCLUDE TRANSFER IN ) | | | | | | | | | |
| ADULTS WITH VIRAL LOAD SUPPRESSED AFTER 6 MONTHS | | | | | | | | | |
| HIV AND TB CO-INFECTION | | | | | | | | | |
| NUMBER OF TB PATIENTS HIV POSITIVE (NEW FOR THIS MONTH) | | | | | | | | | |
| NUMBER OF TB/HIV CO-INFECTED ON ART AFTER COMPLETION OF TB TREATMENT | | | | | | | | | |
| HIV POSITIVE PATIENTS INITIATED ON INH PROPHYLAXIS THIS MONTH | | | | | | | | | |
| TOTAL NUMBER OF HIV POSITIVE PATIENTS ON INH PROHYLAXIS | | | | | | | | | |
| HYPERTENSION | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH 9 |
| NUMBER OF NEWLY DIAGNOSED HYPERTENSIVES THIS MONTH | | | | | | | | | |
| HYPERTENSION CASE LOAD (SUM OF HYPERTENSION PATIENT VISITS) | | | | | | | | | |
| NUMBER OF HYPERTENSIVES WITH BLOOD PRESSURE >140/90 | | | | | | | | | |
| DIABETES MELLITUS | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH |

# MONTHLY DATA COLLECTION TOOL FOR ICDM

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| NUMBER OF NEWLY DIAGNOSED DIABETICS THIS MONTH | | | | | | | | | |
| DIABETES CASE LOAD (SUM OF DIABETES PATIENTS VISITS) | | | | | | | | | |
| NUMBER OF DIABETICS WITH RANDOM BLOOD GLUCOSE > 11,1 MMOL | | | | | | | | | |
| | | | | | | | | | |
| ASTHMA/COPD | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH 9 |
| NUMBER OF NEWLY DIAGNOSED ASTHMATICS/COPD CONSULTED THIS MONTH | | | | | | | | | |
| CHRONIC PULMONARY DISEASE CASELOAD (SUM OF ASTHMA + COPD VISITS) | | | | | | | | | |
| EPILEPSY | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH 9 |
| NUMBER OF NEWLY DIAGNOSED EPILEPSY PATIENTS THIS MONTH | | | | | | | | | |
| EPILEPSY CASE LOAD ( SUM OF EPILEPSY PATIENT VISITS) | | | | | | | | | |
| NUMBER OF EPILEPTICS WITH 3 OR MORE BREAKTHROUGH SEIZURES THIS MONTH | | | | | | | | | |
| MENTAL HEALTH | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH 9 |
| NUMBER OF NEWLY DIAGNOSED PATIENTS WITH MENTAL HEALTH PROBLEMS THIS MONTH | | | | | | | | | |
| MENTAL HEALTH CASE LOAD (SUM OF MENTAL HEALTH VISITS) | | | | | | | | | |
| CERVICAL SMEAR | MONTH 1 | MONTH 2 | MONTH 3 | MONTH 4 | MONTH 5 | MONTH 6 | MONTH 7 | MONTH 8 | MONTH 9 |
| CERVICAL SMEAR SCREENING RATE (NUMBER OF FEMALES > 30 YEARS ON WHOM CERVICAL SMEAR OR VIA CONDUCTED THIS MONTH) | | | | | | | | | |

# ICDM TALLY SHEET

| DATA COLLECTION TALLY SHEET FOR ICDM outcome indicators | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| MONTH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NAME OF FACILITY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DATE | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | TOT |
| HYPERTENSION | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NUMBER OF HYPERTENSIVES WITH BLOOD PRESSURE >140/90 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DIABETES MELLITUS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NUMBER OF DIABETICS WITH RANDOM BLOOD GLUCOSE > 11,1 MMOL | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| EPILEPSY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| NUMBER OF EPILEPTICS WITH 3 OR MORE BREAKTHROUGH SEIZURES THIS MONTH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

# STOCK CARD TEMPLATE

| Name of facility | | | | | | Facility Code | | | |
|---|---|---|---|---|---|---|---|---|---|
| Item Description | | | | | | Item Code | | | |
| Re-order Level | | | | | | Unit of Issue | | | |
| Date | Requisition/Order no: | Received from / issued to: | Batch no. | Expiry date | Quantity ordered | Quantity received | Quantity issued | Stock balance | Signature |
| | | | | | | | | | |

# PERFORMANCE MONITORING INDICATORS AT DISTRICT AND PROVINCIAL LEVEL



| ITEM | INDICATOR | SOURCE OF DATA | DATA ELEMENTS |
|---|---|---|---|
| **INPUT** | Percentage of professional nurses fully PC 101 trained across the district | Training register and PERSAL data | Number of professional nurses PC 101 trained |
| | Percentage of PHC facilities with appointed WBOT | PERSAL data | Number of WBOTs deployed per facility |
| | Percentage of CHWs trained to manage chronic diseases | Training registers | Number of CHWs that attended additional training to manage chronic diseases |
| **PROCESS** | Percentage of districts with fully constituted ICDM teams | | Number of districts with ICDM teams |
| | Percentage of facilities that have commenced patient scheduling | PHC supervisor monitoring report | Number of facilities with scheduling system |
| | Percentage of facilities with integrated clinical records | PHC supervisor monitoring report | Number of facilities with integrated filing system |
| | Percentage of facilities with additional vital signs station for chronic patients | PHC supervisor monitoring report | Number of facilities with vital sign station for chronic patients |
| | Percentage of facilities that have commenced with pre-dispensing of medication | PHC supervisor monitoring report | Number of facilities that have commenced with pre-dispensing medication |
| | Down referral rate | DHIS | Number of stable patients referred to the outreach team |
| | Percentage of facilities with chronic medication stock out | PHC supervisor monitoring report | |
| **OUTPUT** | Percentage of PHC/CHC implementing both the facility and community component of the ICDM model | PHC supervisor monitoring report | Number of PHC facilities that have completed facility re-organisation and have started down referring patients to the CHWs |
| **OUTCOME** | Percentage of hypertension patients that poorly controlled | ICDM data collection sheet | Number of hypertensive patients with blood pressure > 140/90 |
| | Percentage of diabetes patients that are poorly controlled | ICDM data collection sheet | Number of diabetes patients with random blood sugar > 11.1 mmol |

# PERFORMANCE MONITORING INDICATORS AT DISTRICT AND PROVINCIAL LEVEL



| ITEM | INDICATOR | QUARTER 1 | QUARTER 2 | QUARTER 3 | QUARTER 4 |
|---|---|---|---|---|---|
| **INPUT** | Percentage of professional nurses fully PC 101 trained across the district | | | | |
| | Percentage of PHC facilities with appointed WBOT | | | | |
| | Percentage of CHWs trained to manage chronic diseases | | | | |
| **PROCESS** | Percentage of districts with fully constituted ICDM teams | | | | |
| | Percentage of facilities that have commenced patient scheduling | | | | |
| | Percentage of facilities with integrated clinical records | | | | |
| | Percentage of facilities with additional vital signs station for chronic patients | | | | |
| | Percentage of facilities that have commenced with pre-dispensing of medication | | | | |
| | Down referral rate | | | | |
| | Percentage of facilities with chronic medication stock out | | | | |
| **OUTPUT** | Percentage of PHC/CHC implementing both the facility and community component of the ICDM model | | | | |
| **OUTCOME** | Percentage of hypertension patients that poorly controlled | | | | |
| | Percentage of diabetes patients that are poorly controlled | | | | |

# QUARTERLY PROGRESS MONITORING TOOL

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **NAME OF FACILITY** | | | | | | | | |
| **NAME OF THE CLINIC SUPERVISOR** | | | | | | | | |
| **QUARTER** | QUARTER 1: APRIL-JUNE | | QUARTER 2: JULY-SEPT | | QUARTER 3: OCT-DEC | | QUARTER 4: JAN-MARCH | |
| **DATE OF FACILITY VISIT** | | | | | | | | |
| | | | | | | | | |
| **GENERAL- INFRASTRUCTURE** | ***CIRCLE/TICK THE APPLICABLE CHOICE*** | | | | | | | |
| 1. **STATE OF THE BUILDING** | SERIOUS REPAIRS (BROKEN WINDOWS & CEILINGS) | | SERIOUS REPAIRS (BROKEN WINDOWS & CEILINGS) | | SERIOUS REPAIRS (BROKEN WINDOWS & CEILINGS) | | SERIOUS REPAIRS (BROKEN WINDOWS & CEILINGS) | |
| | MINOR REPAIRS (PAINTING, TAPS TOILETS, AIRCONDITIONERS, FANS & PLUGS) | | MINOR REPAIRS (PAINTING, TAPS TOILETS, AIRCONDITIONERS, FANS & PLUGS) | | MINOR REPAIRS (PAINTING, TAPS, TOILETS, AIRCONDITIONERS, FANS & PLUGS) | | MINOR REPAIRS (PAINTING, TAPS, TOILETS, AIRCONDITIONERS, FANS & PLUGS) | |
| | NO IMMEDIATE REPAIRS | | NO IMMEDIATE REPAIRS | | NO IMMEDIATE REPAIRS | | NO IMMEDIATE REPAIRS | |
| 2. **CLEANLINESS** | | | | | | | | |
| WALLS | DIRTY WALLS WITH TATTERED POSTERS | | DIRTY WALLS WITH TATTERED POSTERS | | DIRTY WALLS WITH TATTERED POSTERS | | DIRTY WALLS WITH TATTERED POSTERS | |
| | CLEAN | | CLEAN | | CLEAN | | CLEAN | |
| FLOORS | FLOORS ARE DIRTY | | FLOORS ARE DIRTY | | FLOORS ARE DIRTY | | FLOORS ARE DIRTY | |
| | CLEAN | | CLEAN | | CLEAN | | CLEAN | |
| 3. **BULK SERVICES –TYPE & AVAILABILITY** | | | | | | | | |
| WATER SUPPLY | | | | | | | | |
| SANITATION | | | | | | | | |
| DOMESTICE WASTE REFUSE | | | | | | | | |
| TELECOMMUNICATION | | | | | | | | |
| 4. **INFECTION CONTROL** | | | | | | | | |
| **DOES THE FACILITY HAVE** | | | | | | | | |
| SHARPS CONTAINERS | YES | NO | YES | NO | YES | NO | YES | NO |
| COLOUR CODED DISPOSABLE BAGS | YES | NO | YES | NO | YES | NO | YES | NO |
| MEDICAL WASTE BOXES | YES | NO | YES | NO | YES | NO | YES | NO |
| ELBOW HEIGHT HAND WASHING BASINS IN OR ADJACENT TO CONSULTING ROOMS | YES | NO | YES | NO | YES | NO | YES | NO |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AVAILABILITY OF HAND WASHING SOAP OR DISINFECTANT SPRAY | YES | NO | YES | NO | YES | NO | YES | NO |
| 5. **SPACE** | | | | | | | | |
| HOW MANY CONSULTING ROOMS ARE AVAILABLE AT THE FACILITY? | | | | | | | | |
| DOES EACH PROFESSIONAL NURSE HAVE AN INDEPENDENT ROOM FOR CONSULTING PATIENTS? | YES | NO | YES | NO | YES | NO | YES | NO |
| DO CONSULTATION ROOMS HAVE PRIVACY? | YES | NO | YES | NO | YES | NO | YES | NO |
| 6. **HUMAN RESOURCES** | | | | | | | | |
| TOTAL NUMBER OF HUMAN RESOURCES EMPLOYED AT THE FACILITY | | | | | | | | |
| 6.1. **INDICATE NUMBER OF STAFF IN THE FOLLOWING CATEGORIES** | | | | | | | | |
| PROFESSIONAL NURSES | | | | | | | | |
| AUXILLARY HEALTHCARE WORKERS | | | | | | | | |
| ADMIN SUPPORT | | | | | | | | |
| PHARMACY ASSISTANTS | | | | | | | | |
| GENERAL ASSISTANTS | | | | | | | | |
| FULL TIME MEDICAL DOCTORS | | | | | | | | |
| SESSIONAL MEDICAL DOCTORS | | | | | | | | |
| 6.2. **PROFESSIONAL NURSES- STAFF DEVELOPMENT** | | | | | | | | |
| NO. PHC TRAINED P/N? | | | | | | | | |
| NO. OF P/N NIMART TRAINING? | | | | | | | | |
| NO OF P/N THAT HAVE BEEN COMPLETELY TRAINED ON PC 101 | | | | | | | | |
| 7. **EQUIPMENT** | | | | | | | | |
| DOES THE FACILITY HAVE A FULLY EQUIPPED EMERGENCY TROLLEY? | YES | NO | YES | NO | YES | NO | YES | NO |
| NUMBER OF FUNCTIONAL BLOOD PRESSURE MACHINES | | | | | | | | |
| NUMBER OF FUNCTIONAL GLUCOMETERS | | | | | | | | |
| NUMBER OF DIAGNOSTIC SETS FOR EYE & EAR EXAMINATIONS | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| NUMBER OF CONSULTING ROOMS WITH APPROPRIATE EXAMINATION COUCHES | | | | | | | | |
| DOES EACH CONSULTING ROOM HAVE AN EXAMINATION COUCH? | | | | | | | | |
| TYPE OF SCALES USED TO WEIGH PATIENTS | BATHROOM SCALE | BMI SCALE | BATHROOM SCALE | BMI SCALE | BATHROOM SCALE | BMI SCALE | BATHROOM SCALE | BMI SCALE |
| AVAILABILITY OF BODY MASS INDEX CHARTS | | | | | | | | |
| 8. **ICDM COMPONENTS** | | | | | | | | |
| **PATIENT FLOW** | | | | | | | | |
| 8.1. **WAITING AREA** | | | | | | | | |
| DOES THE WAITING AREA HAVE SUFFICIENT SPACE? | YES | NO | YES | NO | YES | NO | YES | NO |
| HAS THE WAITING AREA BEEN SEPARATED AND CLEARLY MARKED SPACE FOR ACUTE AND CHRONIC SERVICES | YES | NO | YES | NO | YES | NO | YES | NO |
| IF NOT, WHAT ARE THE CHALLENGES IN SEPARATION OF WAITING AREA? | | | | | | | | |
| 8.2. **CONSULTATION AREA FOR ICDM** | | | | | | | | |
| HOW MANY ROOMS HAVE BEEN DESIGNATED FOR CHRONIC PATIENTS? | | | | | | | | |
| 1.3. **VITAL SIGNS STATION** | | | | | | | | |
| IS THERE A DESIGNATED VITAL SIGNS STATION FOR CHRONIC PATIENTS? | YES | NO | YES | NO | YES | NO | YES | NO |
| IF NOT, WHAT ARE THE CHALLENGES? | | | | | | | | |
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| 1.4. **PATIENT APPOINTMENT SCHEDULING** | | | | | | | | |
| HAS THE FACILITY COMMENCED WITH USING AN APPROPRIATE PATIENT SCHEDULING SYSTEM IN LINE WITH THE RECOMMENDATIONS OF THE NDOH? | YES | NO | YES | NO | YES | NO | YES | NO |
| IF NOT, WHAT IS THE REASON FOR NON-COMPLIANCE? | | | | | | | | |
| WHO IS RESPONSIBLE FOR PROVIDING THE PATIENTS WITH THEIR RETURN APPOINTMENT DATES? | PROFESSIONAL NURSES | | PROFESSIONAL NURSES | | PROFESSIONAL NURSES | | PROFESSIONAL NURSES | |
| | ADMIN CLERKS | | ADMIN CLERKS | | ADMIN CLERKS | | ADMIN CLERKS | |
| HAS THE FACILITY COMMENCED WITH 2-3 MONTH APPOINTMENT SCHEDULING? | YES | NO | YES | NO | YES | NO | YES | NO |
| ARE THE PATIENTS ATTENDING THE FACILITY FOR HIV-ARTINCLUDED IN THE SCHEDULING SYSTEM? | YES | NO | YES | NO | YES | NO | YES | NO |
| ARE THE PATIENTS ATTENDING THE FACILITY FOR PRE-ARTINCLUDED IN THE SCHEDULING SYSTEM? | YES | NO | YES | NO | YES | NO | YES | NO |
| 1.5. **PATIENT CLINICAL RECORDS** | | | | | | | | |
| CATEGORY OF PATIENTS THAT HAVE CLINICAL RECORDS AVAILABLE AT THE FACILITY | CHRONIC PATIENTS ONLY | | CHRONIC PATIENTS ONLY | | CHRONIC PATIENTS ONLY | | CHRONIC PATIENTS ONLY | |
| | MINOR AILMENTS ONLY | | MINOR AILMENTS ONLY | | MINOR AILMENTS ONLY | | MINOR AILMENTS ONLY | |
| | HIV-ART PATIENTS | | HIV-ART PATIENTS | | HIV-ART PATIENTS | | HIV-ART PATIENTS | |
| | TUBERCULOSIS | | TUBERCULOSIS | | TUBERCULOSIS | | TUBERCULOSIS | |

| | ANTENATAL CARE | | ANTENATAL CARE | | ANTENATAL CARE | | ANTENATAL CARE | |
|---|---|---|---|---|---|---|---|---|
| | ALL PATIENTS | | ALL PATIENTS | | ALL PATIENTS | | ALL PATIENTS | |
| ARE ALL PATIENT RECORDS (ACUTE/CHRONIC/HIV-ART/TB) STORED IN A SINGLE AREA? | YES | NO | YES | NO | YES | NO | YES | NO |
| WHAT SYSTEM IS USED TO FILE THE PATIENTS' RECORDS? | DATE OF BIRTH | | DATE OF BIRTH | | DATE OF BIRTH | | DATE OF BIRTH | |
| | SURNAMES | | SURNAMES | | SURNAMES | | SURNAMES | |
| | ADDRESSES | | ADDRESSES | | ADDRESSES | | ADDRESSES | |
| ARE THE CHRONIC PATIENT FILES RETRIEVED A DAY OR MORE PRIOR TO THE SCHEDULED APPOINTMENT? | YES | NO | YES | NO | YES | NO | YES | NO |
| WHERE DO PATIENTS WITH APPOINTMENTS RECEIVE THEIR FILES ON THE DATE OF APPOINTMENT? | | | | | | | | |
| HAS THE FACILITY COMMENCED WITH USING A STANDARD FORMAT FOR RECORDING CLINICAL NOTES FOR PATIENTS WITH CHRONIC CONDITIONS? | | | | | | | | |
| 1.6. **NURSE SCHEDULING FOR ICDM** | | | | | | | | |
| HAS THE FACILITY COMMENCED WITH A SCHEDULING SYSTEM TO ROTATE APPROPRITELY TRAINED NURSES TO CONSULT CHRONIC PATIENTS? | YES | NO | YES | NO | YES | NO | YES | NO |
| HOW MANY NURSES ARE SCHEDULED TO CONSULT CHRONIC PATIENTS DAILY? | | | | | | | | |
| HOW OFTEN ARE THE PROFESSIONAL NURSES THAT-CONSULT CHRONIC PATIENTS ROTATED ACROSS THE FACILITY? | WEEKLY | | WEEKLY | | WEEKLY | | WEEKLY | |
| | MONTHLY | | MONTHLY | | MONTHLY | | MONTHLY | |
| | 3 MONTHLY | | 3 MONTHLY | | 3 MONTHLY | | 3 MONTHLY | |
| 8. **MEDICATION SUPPLY** | | | | | | | | |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| HOW OFTEN DOES THE FACILITY RECEIVE THE STOCK OF MEDICATION, INCLUDING ART MEDICATION? | FORTHNIGHTLY | MONTHLY | FORTHNIGHT-LY | MONTHLY | FORTHNIGHT-LY | MONTHLY | FORTHNIGHT-LY | MONTHLY |
| DOES THE FACILITY HAVE SUFFICIENT CHRONIC MEDICATION SUPPLY TO PROVIDE MEDICATION FOR PATIENTS FOR 2 MONTHS? | YES | NO | YES | NO | YES | NO | YES | NO |
| HAS THE FACILITY COMMENCED WITH THE PRE-DIS-PENSING & PACKAGING OF MEDICATION FOR CHRONIC PATIENTS? | YES | NO | YES | NO | YES | NO | YES | NO |
| WHO IS REPSONSIBLE FOR PRE-PACKING OF PATIENT MEDICATION AT THE FACILITY? | PROFESSIONAL NURSE | | PROFESSIONAL NURSE | | PROFESSIONAL NURSE | | PROFESSIONAL NURSE | |
| | PHARMACY ASSISTANT | | PHARMACY ASSISTANT | | PHARMACY ASSISTANT | | PHARMACY ASSISTANT | |
| | OTHER | | OTHER | | OTHER | | OTHER | |
| WHEN THE MEDICATION IS PRE-DISPENSED, WHERE IS IT STORED? | BOXES | | BOXES | | BOXES | | BOXES | |
| | CUPBOARD | | CUPBOARD | | CUPBOARD | | CUPBOARD | |
| HOW IS THE MEDICATION STORED IN THE BOXES/CUP-BOARDS IN THE CONSULTING ROOM? | HAPHAZARDLY | ALPHABETI-CALLY | HAPHAZARD-LY | ALPHABETI-CALLY | HAPHAZARD-LY | ALPHABETI-CALLY | HAPHAZARD-LY | ALPHA-BETICALLY |
| ARE PHC MEDICATION KEPT IN THE CHRONIC CON-SULTING ROOM? | YES | NO | YES | NO | YES | NO | YES | NO |
| HAS ANY STOCK OUT OF CHRONIC MEDICATION (NCDS) BEEN EXPERIENCED IN THE LAST 2 MONTHS? | YES | NO | YES | NO | YES | NO | YES | NO |
| IF STOCK OUT HAS BEEN EXPERIENCED, WHAT MEDI-CATION HAS BEEN OUT OF STOCK? | | | | | | | | |
| HAS THERE BEEN ANY STOCK OUT OF ART MEDICA-TION IN THE LAST 2 MONTHS? | YES | NO | YES | NO | YES | NO | YES | NO |
| IF STOCK OUT HAS BEEN EXPERIENCED, WHAT MEDI-CATION HAS BEEN OUT OF STOCK? | | | | | | | | |

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| 9. **HEALTH PROMOTION** | | | | | | | | |
| DOES THE FACILITY HAVE THE SERVICES OF A HEALTH PROMOTER? | YES | NO | YES | NO | YES | NO | YES | NO |
| IF NO, WHO CONDUCTS HEALTH PROMOTION AT THE FACILITY? | | | | | | | | |
| WHERE IS HEALTH EDUCATION & HEALTH PROMOTION PROVIDED TO PATIENTS? | WAITING AREA | | WAITING AREA | | WAITING AREA | | WAITING AREA | |
| | CONSULTING ROOM | | CONSULTING ROOM | | CONSULTING ROOM | | CONSULTING ROOM | |
| DOES THE FACILITY HAVE HEALTH EDUCATION MATERIAL FOR PATIENTS WITH DISEASES OF LIFESTYLE? | YES | | YES | | YES | | YES | |
| | NO | | NO | | NO | | NO | |
| | LIMITED | | LIMITED | | LIMITED | | LIMITED | |
| | OLD | | OLD | | OLD | | OLD | |
| DOES THE FACILITY HAVE SUPPORT GROUPS FOR PATIENTS WITH CHRONIC DISEASES (COMMUNICABLE & NON-COMMUNICABLE)? | YES | NO | YES | NO | YES | NO | YES | NO |
| HOW OFTEN DO THESE SUPPORT GROUPS MEET? | WEEKLY | | WEEKLY | | WEEKLY | | WEEKLY | |
| | FORTHNIGHTLY | | FORTHNIGHTLY | | FORTHNIGHTLY | | FORTHNIGHTLY | |
| | MONTHLY | | MONTHLY | | MONTHLY | | MONTHLY | |
| WHAT TYPE OF ACTIVITIES ARE CONDUCTED BY THE SUPPORT GROUPS? | | | | | | | | |
| 10. **CERVICAL SMEAR SCREENING** | | | | | | | | |
| HOW OFTEN DOES THE FACITY OFFER CERVICAL SCREENING SERVICES? | DAILY | | | | | | | |
| | WEEKLY | | | | | | | |
| | NOT OFFERED | | | | | | | |
| WHO CONDUCTS THE CERVICAL SCREENING AT THE FACILITY? | ALL NURSES | | | | | | | |
| | DESIGNATED NURSES | | | | | | | |

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|---|---|---|---|---|---|---|---|---|
| | DOCTORS | | | | | | | |
| IS THE CERVICAL SMEARS OFFERED ON | APPOINTMENT BASIS | | | | | | | |
| | PER PATIENT REQUEST | | | | | | | |
| HOW MANY SPECULUMS DOES THE FACILITY HAVE? | | | | | | | | |
| HOW MANY ANGLEPOISE LAMPS DOES THE FACILITY HAVE? | | | | | | | | |
| DOES THE FACILITY HAVE SUFFICIENT SLIDES FOR SMEARS? | YES | NO | YES | NO | YES | NO | YES | NO |
| DOES THE FACILITY HAVE FIXATIVES FOR THE SMEARS? | YES | NO | YES | NO | YES | NO | YES | NO |
| | | | | | | | | |
| 11. **COMMUNITY WARD BASED PHC OUTREACH TEAM** | | | | | | | | |
| HOW MANY PHC OUTREACH TEAMS HAVE BEEN APPOINTED FOR YOUR FACILITY? | | | | | | | | |
| HAS THE PROFESSIONAL NURSE THAT WILL LEAD THE PHC OUTREACH TEAM FOR THE WARD BEEN IDENTIFIED? | | | | | | | | |
| HOW MANY COMMUNITY HEALTHCARE WORKERS HAVE BEEN IDENTIFIED FOR THE FACILITY? | | | | | | | | |
| HAVE THE COMMUNITY HEALTHCARE WORKERS COMPLETED THEIR TRAINING? | | | | | | | | |
| HAVE THE COMMUNITY HEALTHCARE WORKERS BEEN TRAINED ON MONITORING OF CHRONIC PATIENTS? | | | | | | | | |
| HAS THE FACILITY COMMENCED WITH DOWN REFERRING PATIENTS TO THE PHC OUTREACH TEAM? | | | | | | | | |
| HOW MANY CHRONIC PATIENTS HAVE BEEN DOWN REFERRED TO THE PHC OUTREACH TEAM? | | | | | | | | |

# QUARTERLY REPORTING AND ACTION PLANNING TOOL



| QUARTERLY REPORT AND ACTION PLANNING | | | |
|---|---|---|---|
| REPORTING PERIOD | | | |
| CHALLENGES IDENTIFIED | ACTION PLANS | RESPONSIBILITY | TIMEFRAME |
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# CHRONIC COORDINATOR FACILITY CHECKLIST



| ICDM FACILITY VISIT CHECKLIST FOR CHRONIC COORDINATOR | | | |
|---|---|---|---|
| NAME OF FACILITY | | | |
| NAME OF THE OPERATIONAL MANAGER | | | |
| NAME OF THE CLINIC SUPERVISOR | | | |
| DATE OF FACILITY VISIT | | | |
| **1. FACILITY RE-ORGANISATION** | YES | NO | IF NO, WHY NOT? |
| ↘ HAS THE FACILITY BEEN RE-ORGANISED WITH DESIGNATED CONSULTING AREAS FOR ACUTE, CHRONIC AND PREVENTIVE SERVICES? | | | |
| ↘ DESIGNATED WAITING AREA FOR CHRONIC PATIENTS | | | |
| ↘ DESIGNATED VITAL SIGN STATIONS FOR CHRONIC PATIENTS | | | |
| ↘ INTEGRATION OF PATIENTS WITH HIV/TB/NCDs/MENTAL HEALTH | | | |
| ↘ ARE THERE DESIGNATED CONSULTING ROOMS FOR CHRONIC PATIENTS? | | | |
| **2. CLINICAL RECORDS** | | | |
| ↘ ARE ALL PATIENT RECORDS STORED IN A SINGLE LOCATION? | | | |
| ↘ HAVE ALL PATIENT FILES BEING INTEGRATED INTO A SINGLE FILE PER PATIENT? | | | |
| ↘ ARE THE RECORDS RETRIEVED PRIOR TO THE APPOINTMENT? | | | |
| **3. PRE-DISPENSING OF MEDICATION** | | | |
| ↘ HAS THE FACILITY COMMENCED WITH PRE-DISPENSING OF MEDICATION? | | | |
| **4. MEDICATION SUPPLY** | | | |
| ↘ DOES THE FACILITY HAVE SUFFICIENT STOCK TO DISPENSE MEDICATION FOR 2 MONTHS? | | | |
| **5. HUMAN RESOURCES SCHEDULING** | | | |
| ↘ HAS THE FACILITY COMMENCED WITH SCHEDULING OF PROFESSIONAL NURSES FOR CHRONIC PATIENT CONSULTATION? | | | |
| **6. CHRONIC CONSULTING ROOM** | | | |
| ↘ DOES EACH CHRONIC CONSULTING ROOM HAVE THE ESSENTIAL EQUIPMENT? | | | |

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|---|---|---|---|
| **7. CLINICAL SUPPORT** | | | |
| ↘ DOES THE FACILITY HAVE COPIES OF THE PC 101 GUIDELINES FOR EACH CHRONIC CONSULTING ROOM? | | | |
| ↘ HAS THE FACILITY IMPLEMENTED THE CHRONIC PATIENT RECORD? | | | |
| ↘ DOES THE DISTRICT CLINICAL SPECIALIST TEAM MENTOR THE PROFESSIONAL NURSES DURING SUPERVISORY VISITS? | | | |
| ↘ HAS THE DISTRICT CLINICAL SPECIALIST TEAM CONDUCTED ANY CLINICAL AUDITS? | | | |
| **8. "ASSISTED" SELF-SUPPORT MANAGEMENT** | | | |
| ↘ HAS THE WBOT TEAM FOR THE FACILITY BEEN EMPLOYED? | | | |
| ↘ HAVE THE CHWS BEEN TRAINED ON CHRONIC PATIENT MANAGEMENT AT THE HOUSEHOLD LEVEL? | | | |
| ↘ HAS THE FACILITY COMMENCED WITH DOWN REFERRAL OF PATIENTS TO THE WBOTs? | | | |
| ↘ NUMBER OF PATIENTS DOWN REFERRED TO WBOT | | | |
| **9. HUMAN RESOURCES** | | | |
| ↘ HAS PC 101 TRAINING COMMENCED AT THE FACILITY? | | | |
| ↘ NUMBER OF PROFESSIONAL NURSES FULLY TRAINED ON PC 101 | INSERT NUMBER | | |
| ↘ HOW MANY SESSIONS HAVE BEEN COMPLETED? | INSERT NUMBER | | |
| **10. HEALTH INFORMATION** | | | |
| ↘ IS THE DAILY TALLY SHEET BEING COMPLETED ACCORDING TO THE STANDARD OPERATING PROCEDURE? | | | |
| ↘ IS THE MONTHLY DHIS DATA SHEET BEING COMPLETED FOR CHRONIC CONDITIONS? | | | |
| **11. MEDICINE MANAGEMENT** | | | |
| ↘ ARE THE STOCK CARDS UPDATED? | | | |
| ↘ IS THE TEMPERATURE IN THE MEDICATION STORE ROOM APPROPRIATELY CONTROLLED? | | | |
| ↘ IS MEDICATION NEATLY STORED? | | | |
| **12. SUPPORT GROUPS** | | | |
| ↘ ARE THERE FACILITY-BASED SUPORT GROUPS FOR CHRONIC PATIENTS? | | | |

## DEPARTMENT OF HEALTH

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CIVITAS BUILDING, CNR THABO SEHUME AND
STRUBEN STREETS, PRETORIA

PRIVATE BAG X828, PRETORIA, 0001

## WWW.DOH.GOV.ZA



health

Department:
Health
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FROM THE AMERICAN PEOPLE

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