INTEGRATED CLINICAL SYSTEMS MANAGEMENT

QUALITY IMPROVEMENT OF CARE OF PLWHA

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CAPE TOWN

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Why -PHC re-engineering?

•The health system needs to find its focus

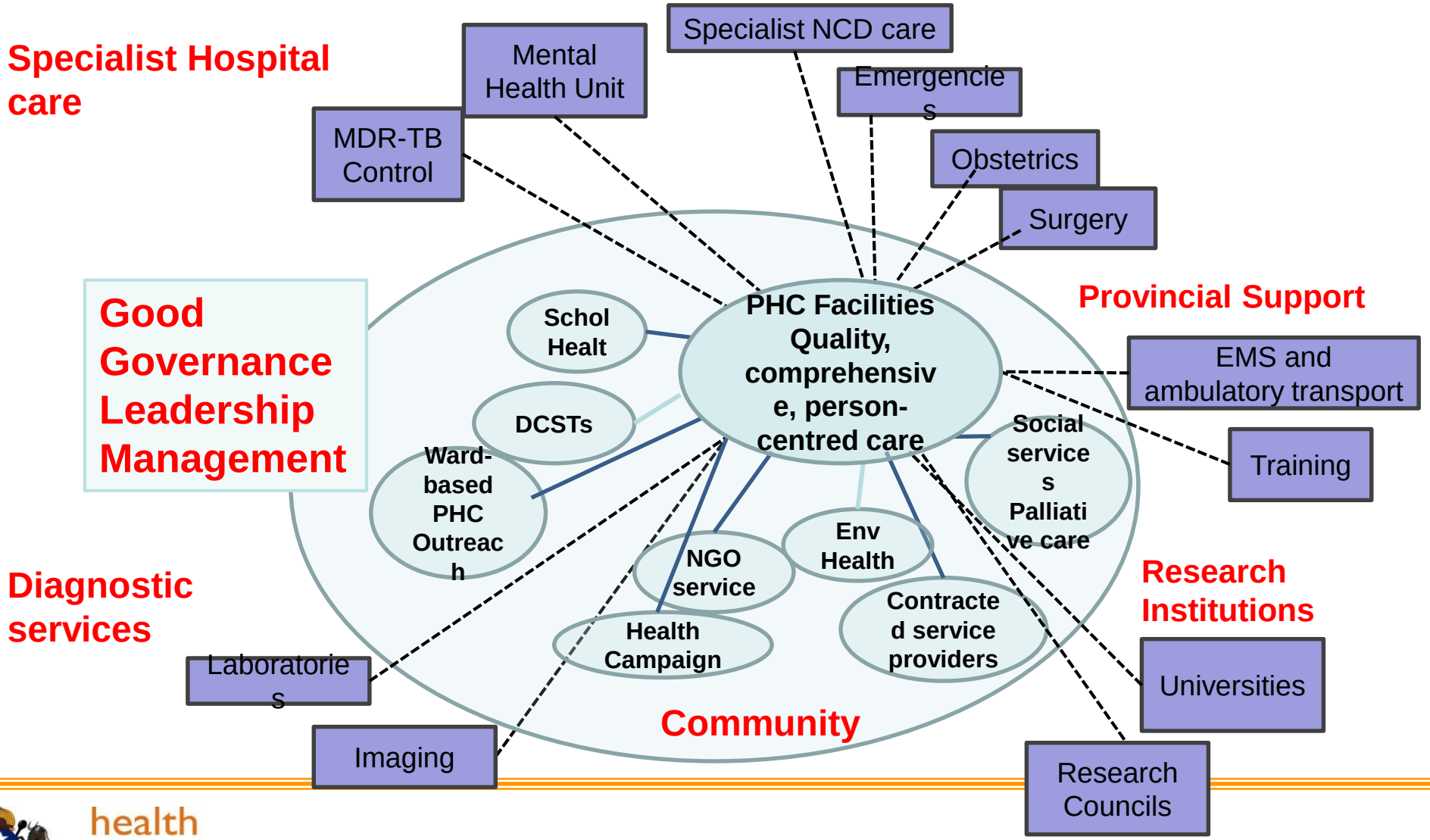
Outwards as service-related organisation to take services to the people to improve and maintain health in all aspects, of communities and individuals;

Inwards to create a motivated, enthusiastic committed health workforce in sufficient numbers and appropriately skilled to achieve this.

Create an environment where all available resources are used (including academia & private sector with all its human resources e.g. doctors, pharmacists)

•The time is right and the necessary political will is strong

DISTRICT HEALTH SYSTEM



Ideal Clinic model

- **Ideal clinic** –refers to a facility (clinic) which has been developed to a perfect/ ultimate model to be used as an example for other facilities to benchmark.
- An "ideal clinic", according to a prototype developed by the health department, consists of 10 domains, which in turn consist of 10 components and 185 subcomponents.

Components of the Ideal Clinic

Administration	ICDM/ICSM	Medicines, supplies & lab services	Staffing & professional standards
Availability of a doctor	Communication	Health Information Management	Infrastructure & Support services
	District Health Support Systems	Partners & stakeholders	

Sustainability Of the Project

- Real involvement at facility by district, province and national level
- Engaging in interventions at PHC clinic level alongside the clinic, district and provincial management to **determine the causes of bottlenecks and how best to address these**
- Documenting decisions and process flows pertaining to **effective and efficient solutions to ensure sustainable improvements**
- Compile decisions and process flows into a manual for creating and maintaining an ideal clinic
- **Provide training on the ideal clinic manual**

Organise patient flow in a way that minimises the exposure of non-infectious to infectious AND reduces waiting times

Challenges for the SA health system

- **BoD from HIV & AIDS and NCDs**
- A **weak** health system due to:
  - Lack of leadership at various levels
  - Lack of innovation and uptake of innovations
  - Lack of and poor financial resource allocation & spending
  - **Operational inefficiencies**
  - Lack of devolution of authority
  - Low health worker morale
  - **Poor quality of care**
  - Inability to prevent new and emerging epidemics(MDR-TB),
  - **Inadequate HR** (numbers and **properly trained**)

Integrated clinical services

- WHO defined integrated service delivery as
  - “the organization and management of health services so that people get the care they need, when they need it, in ways that are user friendly, achieve the desired results and provide value for money”.

Clinical Services Integration

- Service integration means blending either some of the elements of, or all aspects of one service into the regular functioning of another service.

Integrated Chronic Disease Management Model

Chronic-care system 'to transform healthcare'

PRINESHA NAIDOO
Contributing Writer

LIFE for patients treated for chronic diseases in public health facilities is expected to become much easier with the roll-out of a new management system in April next year.

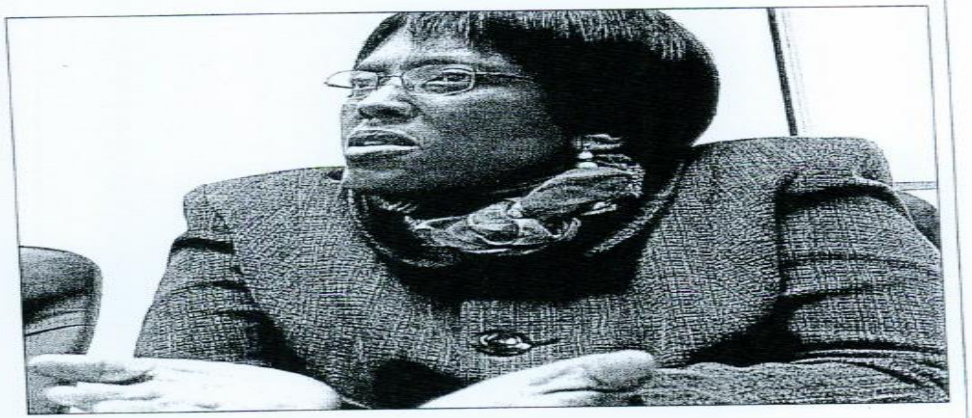
The integrated chronic-care model will not only ease the burden for chronic patients, but also make space in public healthcare facilities for patients with acute conditions, Malebona Matsoso, director-general in the Department of Health, said yesterday.

Patients treated for chronic diseases such as diabetes and hypertension have to visit a clinic or hospital on more than one day to obtain various services.

"We cannot have someone who presents on a Wednesday for hypertension come back on a Thursday to be seen for diabetes and yet come back again on a Friday to be treated for HIV," Ms Matsoso said.

Speaking on the sidelines of the Interacademy Medical Panel Conference on the Changing Patterns of Non-Communicable Diseases, she said the new system — successfully piloted in the North West province, Mpumalanga and on Gauteng's West Rand — would allow patients to receive treatment for a host of ailments and chronic diseases during a single session on a single day, rather than in multiple sessions on different days.

Ms Matsoso said the results of the pilot programme had given the department hope of integrating services and improving healthcare. "We have to ensure that our health system performs and we have to ensure that human resources in our health facilities are appropriately addressed, including training, recruitment and retention."



SERVICE: **Malebona Matsoso says SA's integrated chronic-care model will ensure better healthcare for patients.** Picture: DAILY DISPATCH

She also announced that the department was partnering with the World Health Organisation to assess its workforce in terms of its workload and skills base. She said the quality of services offered at 4,000 public sector health facilities had been audited and necessary corrective measures were being considered.

Ms Matsoso said that as part of the integrated chronic-care model, the department would be working with the private sector to assist patients to collect their medication. Instead of having to queue at state facilities on specified days, patients would be able to collect their medication from selected facilities and pharmacies.

Ms Matsoso said the department had finished mapping suitable facilities and pharmacies across SA.

South African Pharmacy Council CEO Amos Masango said yesterday the proposed integrated care model was good for patients. "If all the pharmacies in the country can be utilised to assist in the distribution of medicines, it is better — long queues can be reduced."

Mr Masango said there are 5,000 registered public and private sector pharmacies in SA.

Ms Matsoso said the department was now placing emphasis on evidence, and districts were being used as planning units.

"In each district, we can tell you what the burden of a disease is in that district, we can tell you what the socioeconomic indicators that need to be tracked are, we can tell you what the performance of the health system in each district is, and we can also tell you what the service delivery outputs are," she said.

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Barclays said yesterday chief financial officer **Chris Lucas** would resign tomorrow, six months earlier than planned
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What is the ICDM model?

- A health **system strengthening** model
- Builds on the **strengths of the HIV** programme
- To deliver **integrated care** to patients with **chronic diseases**
- Takes a **patient-centric view** that encompasses the full value chain of **continuum of care and support**

What is the ICDM?

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 by taking a ***patient-centric view***
- that encompasses the full value chain of **continuum of care and support.**

Purpose of the ICDM

- To achieve **optimal clinical outcomes** for patients with chronic diseases (communicable and non-communicable) by:
  - Ensuring the coordination of care and transitioning to self-management at a community level
  - Using the health system building block framework, to improve the efficiency and decrease the strain on the health care system
  - Maintaining the economic and social productivity of the patient
  - By developing an individual's sense of responsibility for their own health

Why do we need ICDM?

- South Africa has **poor health indicators** and outcomes despite spending more on health than any other African country.
- **Two significant contributors** to the poor health outcomes:
  - The **burden of disease**
  - The health system **challenges**

Burden of chronic diseases

- **Non communicable diseases** - the highest contributor to the mortality (40.8%) and to the DALYs (33%) and the 3rd most significant contributor to YLL (22.8%)- BOD 2000
- **Number of patients receiving ART** increased
  - **47 500** (95% CI 42 900 – 51 800) middle of 2004
  - to **1.79 million** (95% CI 1.65 - 1.93 million) end of June 2011.
  - CURRENTLY close to 2 million

What are the implications for patients ?

- Antiretroviral treatment (**ART**) has transformed HIV & AIDS into a chronic disease,
- People with HIV are **living longer** and ageing,
- Developing **non-HIV-related** chronic conditions similar to the rest of the population.
- Some **non-communicable diseases** are related to HIV infection itself and to the side effects of some of the medicines used to treat HIV infection

Implication of the increased chronic disease burden on health system?

- Provision of **affordable** and **effective care** to increasing number of people
- The health system will be **overburdened**
- Chronic patients require **frequent visits** to healthcare facilities for constant care
- Attention will be required over **a long period of time**

What do we mean by chronic disease?

- **Chronic** refers to a condition that continues or persists and will require management over an extended period of time (usually more than 6 months)
- **WHO defintion:**
  - **Long duration** and generally **slow progression**

Conditions included as Chronic Diseases

- Non-communicable Diseases
  Diabetes,Hypertension,IHD,COPD,Asthma
- Persistent Communicable Diseases
  HIV(Pre-ART & on ART),TB
- Long term Mental Illness
  Depression,Anxiety
- Persistent Physical Impairments
  Strokes, Cerebral Palsy

Pillars of the ICDM

- Primary prevention- identification of high risk individuals at community and facility level and appropriate interventions
- Secondary prevention through planned, optimal evidence based clinical care using an interdisciplinary approach
- Cultivate a sense of individual responsibility through assisted self-management at community level
- These 3 pillars are supported through a sustained, strengthened and integrated health system.

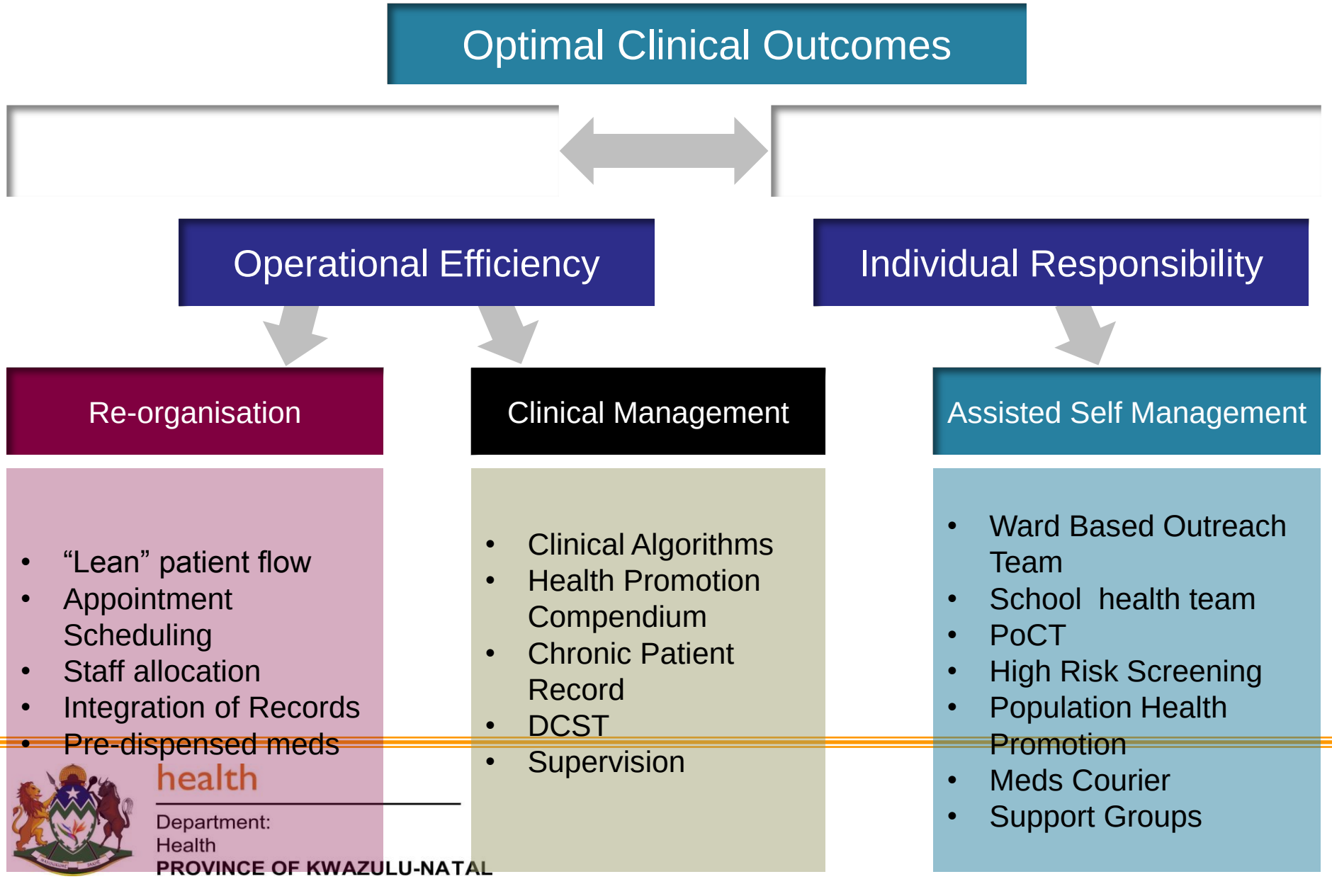
What do we need?

- The **changing disease patterns** require a **reorientation of the health system** so that it:
  - Provides a **comprehensive, effective and appropriate** service for chronic, long-term care
  - **Maintains and improves** the capacity of acute care services

Opportunity for change

- **International guiding principles** − shift towards integrated chronic disease management
- **Medium Term Strategic Framework** − 2009-14
- **Negotiated Service Delivery Agreement** (NSDA)
  - **Output 1**: **Increasing Life Expectancy**
  - **Output 2**: Decreasing Maternal and Child mortality
  - **Output 3**: Combating HIV and AIDS and decreasing the burden of disease from Tuberculosis
  - **Output 4**: **Strengthening Health System Effectiveness**
- **PHC Re-engineering Framework**

Integrated Chronic Disease Management



health

Department:
Health
PROVINCE OF KWAZULU-NATAL

ICSM

Integrated Clinical Services Management

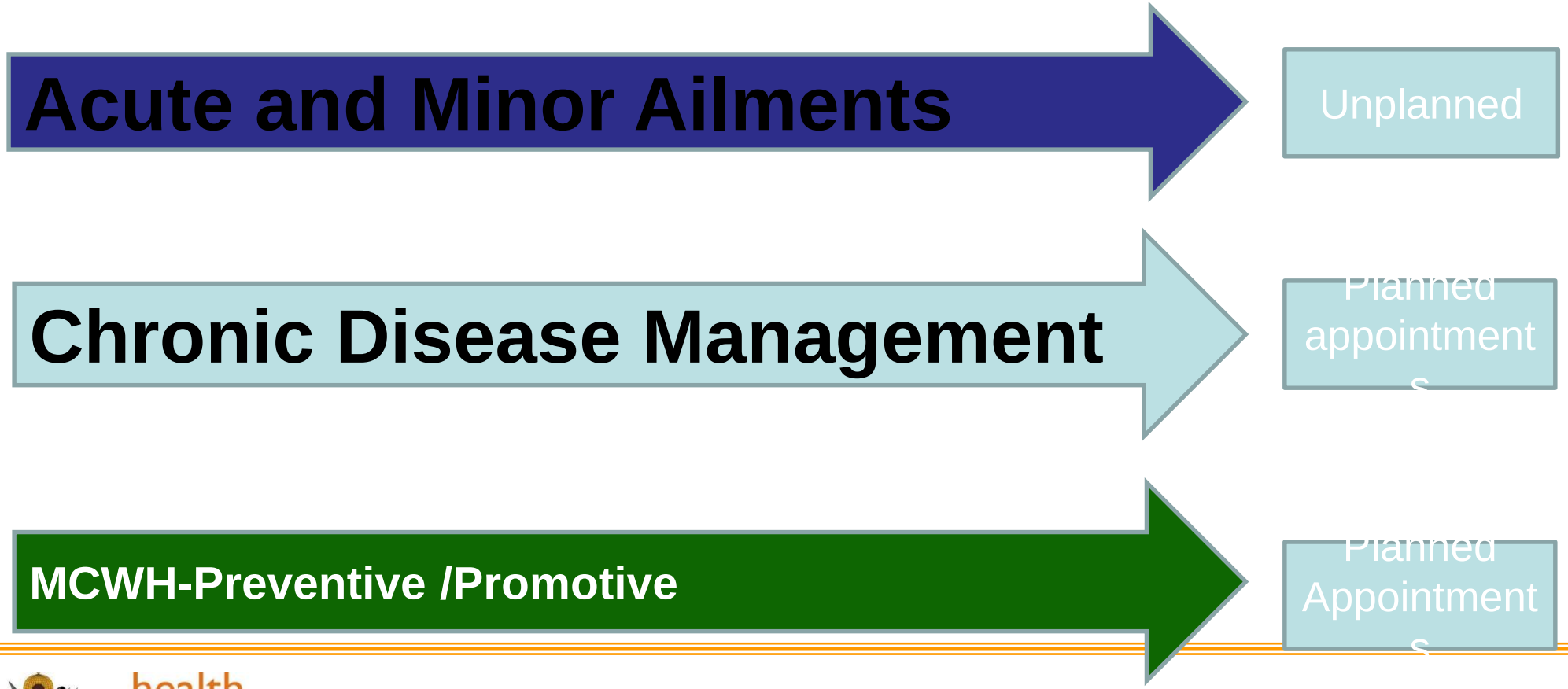


FIGURE 4: LINK BETWEEN ICDM AND SIX PRIORITY AREAS OF THE NATIONAL CORE STANDARDS

OBJECTIVES OF HIV/TB INTEGRATION

- Increase HCT amongst TB clients as an entry point to HIV care
- Diagnose TB disease earlier in HIV-infected persons
- Facilitate an integrated approach to the management of co-infected persons, creating a “one stop” service
- Increase service efficiency through more rational staff deployment and increased competence in the management of co-infected patients
- Improve cure rates for both co-infected and TB patients through a more patient- centred approach to adherence
- Benefit from the experience of the TB programme to standardise the approach and the monitoring of ARV patients

INTEGRATED TB/HIV CASE MANAGEMENT

IN TB FOCAL POINT

- **Diagnosis of TB in persons with HIV infection**,

✓ guidelines advise culture, CXR after 2 negative smears

- **Diagnosis and Management of HIV in TB cases**

✓ Need for HIV testing of all TB cases

✓ Initiation of ART, CTX, Drug/dose modifications, nutritional assessment, staging, management of OIs,

HIV FOCAL POINT

- **Initiation of ART**:

✓ CD4 count <350cells/mm 3 & in patients with TB

✓ All patients with MDR/XDR irrespective of CD4 (for fast track – ie within 2 weeks of being eligible

✓ First line standardised regimen for TB patients (excluding those on streptomycin) is TDF/3TC/EFV

- **If not eligible for ART**

✓ Initiate INH prophylaxis if asymptomatic for TB

✓ TB screening advised at every visit

✓ Timing of ART initiation

✓ Within 2-8 weeks of starting TB treatment.

MODEL OF SERVICE DELIVERY:

- **A practical guide for TB and HIV Service Integration at Primary Health Care Facilities (NDOH, 2010).**

✓ **One stop shop**'. TB and HIV services (Counselling and testing for HIV, ART, TB screening and treatment) are provided in the same room by the same staff

✓ Legislative framework for NIMART.

✓ Management structures, roles and responsibilities of CHW, facility, sub-district and district managers (TB and HAS/T).

✓ HIV wellness registers serves as an integration data tool for management of co infected patient.

BENEFITS OF TB/HIV SERVICE INTEGRATION

- **Early detection:**

✓ Less client will present with advance HIV

such as: disseminated TB and low CD4 count

through:

✓ CHW visits

✓ HCT campaign

✓ INH prophylaxis

✓ Early ART initiation

- No loss of patients in the system

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