GPs contracting with the NDoH: The Role in Context

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Wits Centre for Rural Health
Technical Advisor to the National Technical Task Team
5 June 2014

"Contracting in": Duties of the GP

- **These include:**

- provision of promotive and preventive services as per PHC package: services **taking into consideration the burden of disease of the community being served by the clinic**
- Use of clinical algorithms as per **PC101 Clinical Guidelines** for the management of chronic NCDs and of chronic communicable diseases such as HIV/AIDS and TB
- Give **in-service training and support to nurses** employed in the health facility
- Compliance with, and support of, clinical governance requirements, such as **appropriate record keeping and referral**
- GPs shall be required to **attend training and orientation** (especially as it relates to new guidelines)

“Where is it at...”

- Health Professionals Contracting National Technical Task team (since April 2013 – includes NHI Project Managers)
- NDoH: HP Contract Management Unit established
- Claims and Payment Administration outsourced
- GPs: National Contract plus a Service Level Agreement
- Approximately 60 GPs contracted by mid–Oct 2013); 130 to date
- Most: Tshwane (>30), least: OR Tambo (0)

The challenges

1. Recruitment in the context of the DHS (e.g. Vhembe and Pixley
2. Matching district/community need with GP preference
3. Sustainability past the pilots and ideal clinics
4. Rates: limited by the DPSA framework
5. Performance of the PHC team, not just GPs
6. Management and supervision
   - operational managers? DCSTs?

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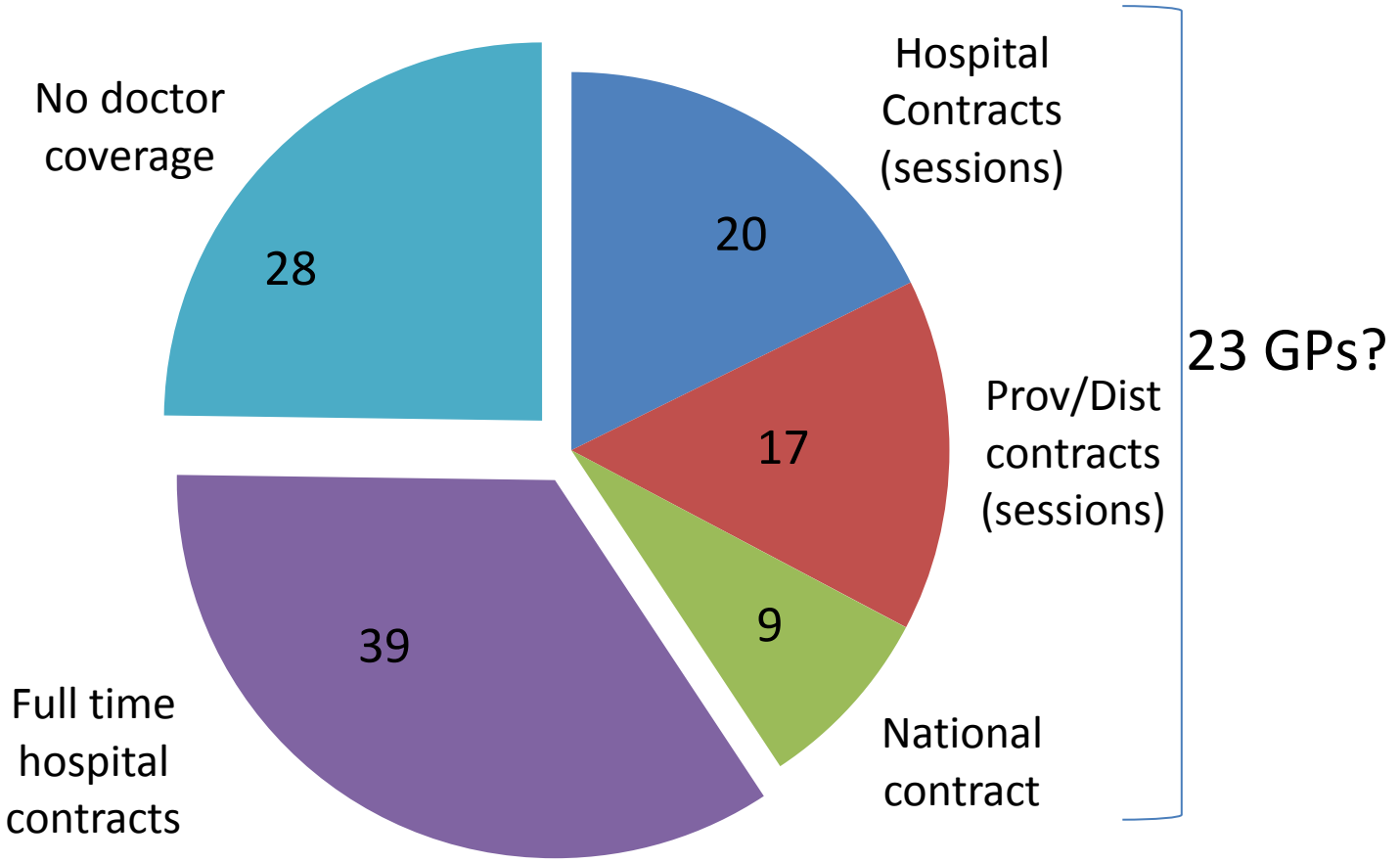
Of Vhembe's 113 clinics...



Source: CMU GP database

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Pixley Ka Seme

Emthanjeni LM

Clinic name	Doctors	Employment	Distance from home
Britstown	Drs K, K, W and D all live in De Aar	Full-time employed by Province, working at Central Karoo Hospital	**50 kms from De Aar**
De Aar			**In De Aar**
De Aar Town			
Kholekile Edward T			
Montana			
Hanover	Dr V lives in De Aar	Private GP (district session)	**60 kms from De Aar**

Kareeberg LM

Clinic Name			
Carnarvan	Dr VZ lives in Victoria West	**GP (national contract)**	**110 kms from Victoria West**
Vanwyksvlei			**40 kms from Carnarvan (gravel)**

Rates: coal face quotes

1. *The rate is far too low, and we won't be covering overheads if doing DoH clinic sessions (SAMA GPPP sub-committee)*
2. *"Basically it (higher sessional rates) would send the message that the career MO at the rural district hospital is the real bottom feeder" (Medical Officer Umgungundlovu)*
3. *"they cannot pay more than that otherwise there will be an exodus of doctors out of the hospitals to the clinics" (DH Clinical Manager OR Tambo)*
4. *"Maybe an exodus of doctors out of hospitals to clinics is just what we need!" (Wits Centre for Rural Health Family Physician)*

DCSTs managing GP clinical performance?

- Not a burden, rather utilise GPs as an “arm of clinical governance” on-site (not just seeing patients off the bench)
- Win-Win “colleagial relationship”
- DCST team approach to performance management – No doctors; Dr-Nurse heirachies
- Supervise performance of PHC team, not just GPs
- Start with DCST involvement with inductions

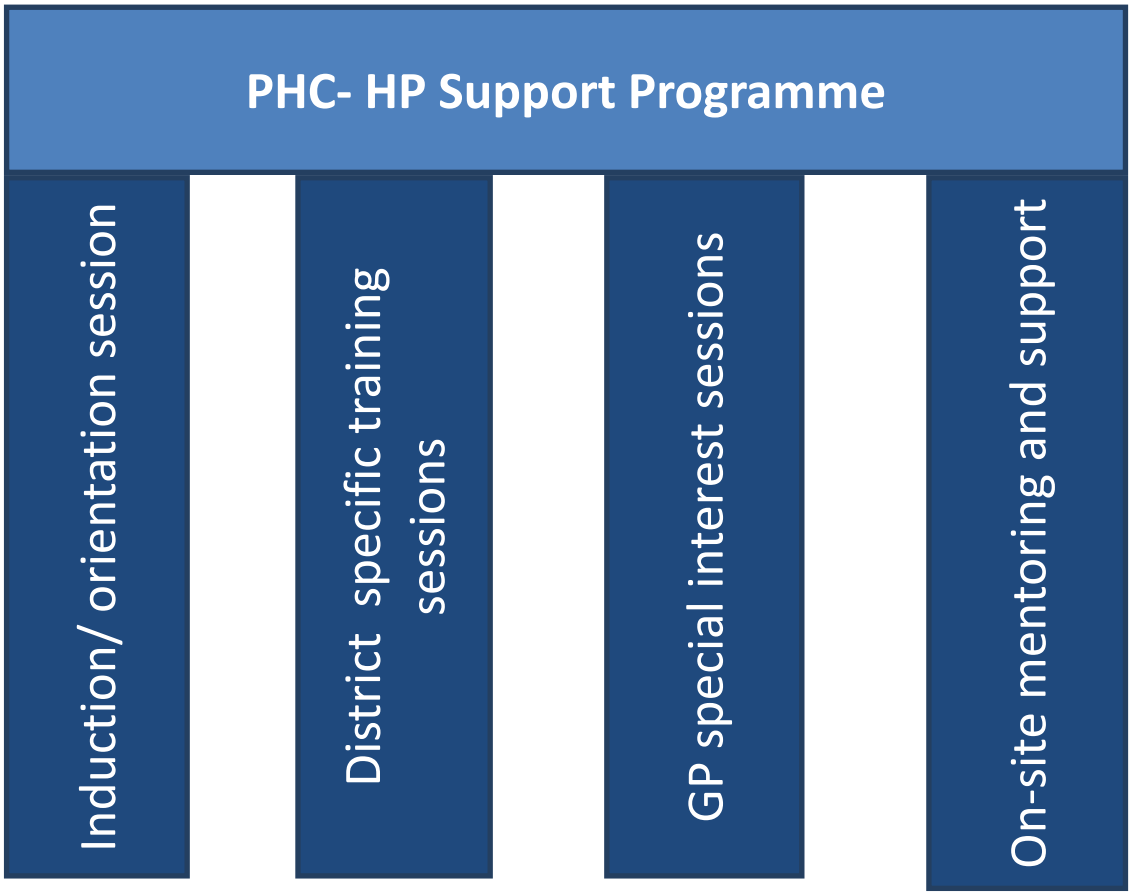
NDoH – praiseworthy intent

1. **National Technical Task Team: Terms of Reference**
2. **HP Contracting Research Forum**
3. **PHC-HP Support Framework**
4. "Hybrid" contracting model of sessions in Hospitals and Clinics
5. Rate paid at highest DPSA bracket
6. Travel time paid to clinics paid at the sessional rate
7. Attendance by GPs at induction programme is paid at the sessional rate
8. Ideal Clinics – policy meets implementation

NTTT Terms of Reference

- **Ensure** that the exercise of GP contracting is guided by a rational and costed plan
- **Pilot** the provision of packages of services
- **Pilot** the implementation of novel service configurations
- Ensure the **mitigation of negative risks** through the development of a monitoring system that provides early warnings.
- Commission an **annual independent evaluation** of the functioning and result of GP contracting. Include in the evaluation report positive and negative lessons learned and how these lessons will inform the design of future interventions

4 pillars of the PHC-HP Support Framework



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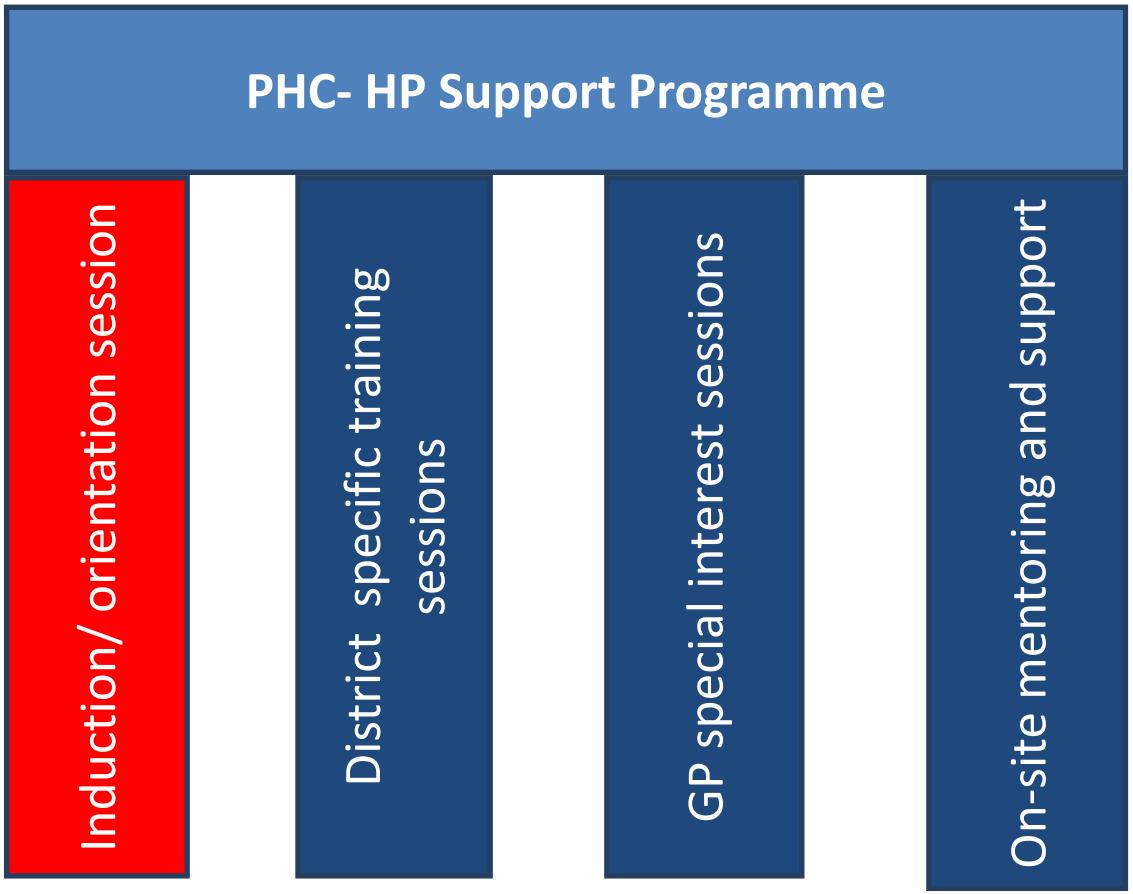
4 pillars of the PHC-HP Support Framework



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Gert Sibande

Induction Session

Primary Health Care - Health Professionals' Support Framework (PHC-HP)

30th May 2014

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Supported by the **European Union**

Task 1: Plenary Report Back - district profile

Each group is to identify the 3 most important inputs:

- 3 most important priorities
- 3 biggest challenges to address
- 3 greatest successes to harness
- 3 most effective actions to implement

Please refer to electronic resource pack!

The GP's role as part of a collective in improving the DHS

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Malnutrition

Task 2: Roles, responsibilities and processes towards strengthening the PHC team

Focus on Quality Improvement

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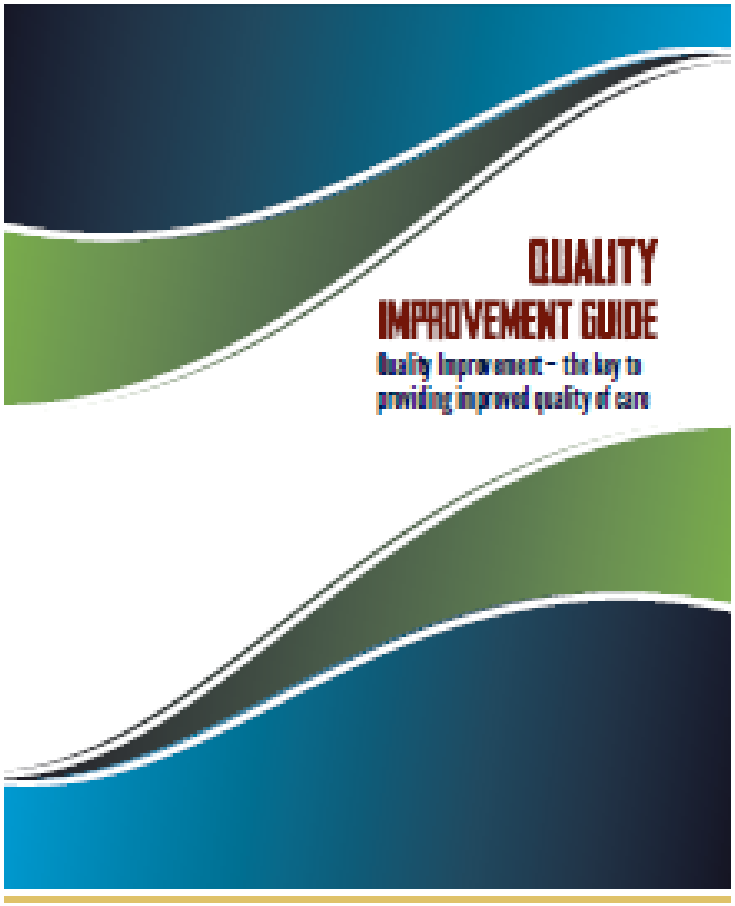
QI Guidelines



1. Context and NCS
2. 5 foundation stones
3. Practical application
4. QI tools and methods
5. PDSA – Plan, Do , Study, Act
6. Scaling up and sustaining change

Clinical Guidelines and policies Gert Sibande

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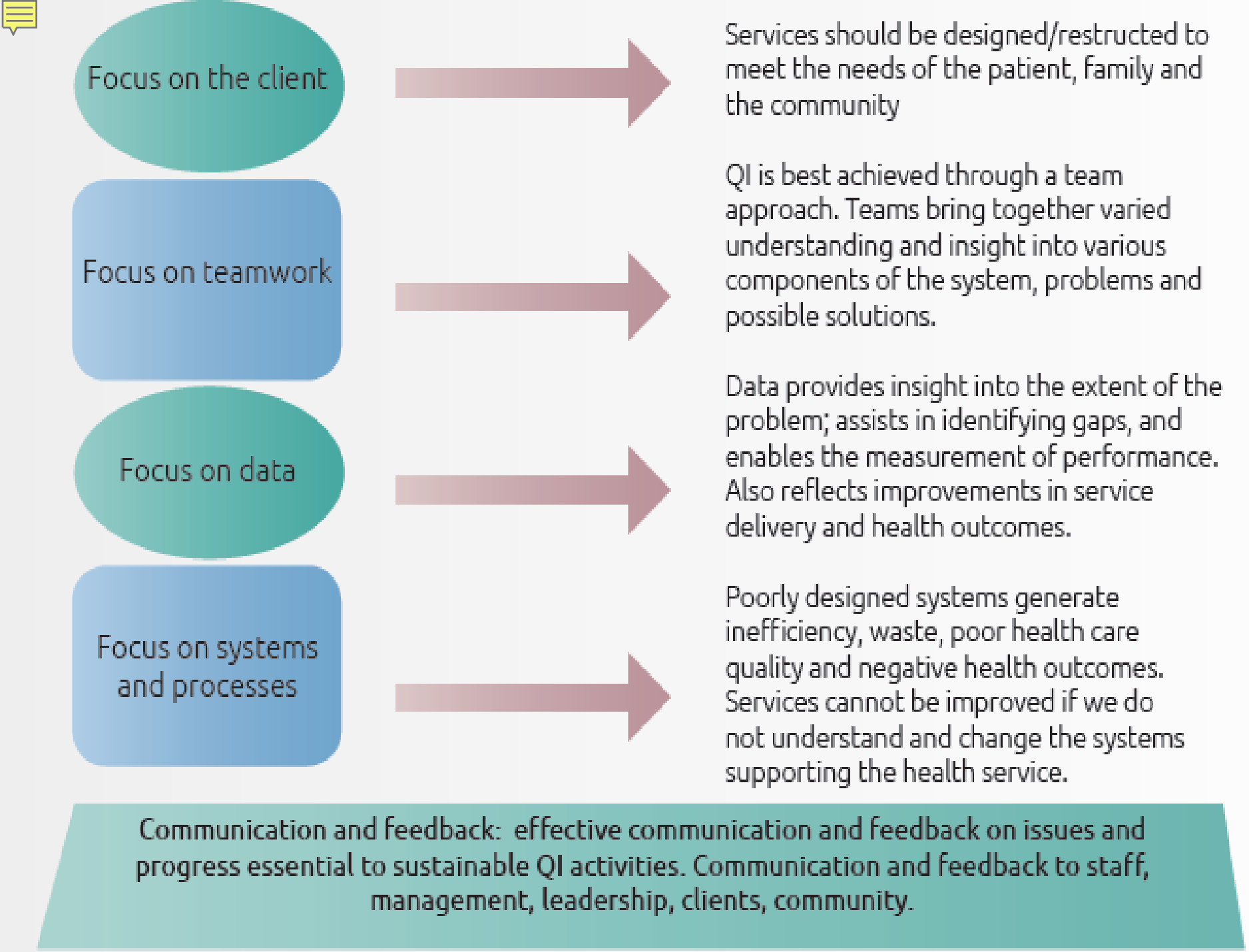
Focus on the client
Services should be designed/restructed to meet the needs of the patient, family and the community
Focus on teamwork
QI is best achieved through a team approach. Teams bring together varied understanding and insight into various components of the system, problems and possible solutions.
Focus on data
Data provides insight into the extent of the problem; assists in identifying gaps, and enables the measurement of performance. Also reflects improvements in service delivery and health outcomes.
Focus on systems and processes
Poorly designed systems generate inefficiency, waste, poor health care quality and negative health outcomes. Services cannot be improved if we do not understand and change the systems supporting the health service.
Communication and feedback: effective communication and feedback on issues and progress essential to sustainable QI activities. Communication and feedback to staff, management, leadership, clients, community.

Meet Nondumiso

A 2 year 3 month old girl called Nondumiso is brought in by her mother, with a cough for 4 days. The mother was worried that the child is so small and has discussed this with a Community Care Giver during a home visit, who referred her to the clinic for this consultation.

Mother and child live in an informal settlement. The mother is HIV+ on ARVs. Nodumiso tested PCR- for HIV at 6 weeks. She was fed with formula milk.

In your groups:

1. What are their (N and her mother) needs/expectations concerning the visit that you (PHC team) will need to meet?
2. Who is involved in Nondumiso's management and how are they involved? (teamwork/conflict)
3. Identify the data recording points in the patient process flow. What information needs to be reported?
4. What kind of possible challenges arise with regard to our existing systems and processes when managing her?
5. What communication and feedback issues do we need to be aware of?

1hr duration. Please refer to your electronic resources!

GP role in building a client focus, teamwork and communication, use of information, and quality improvement

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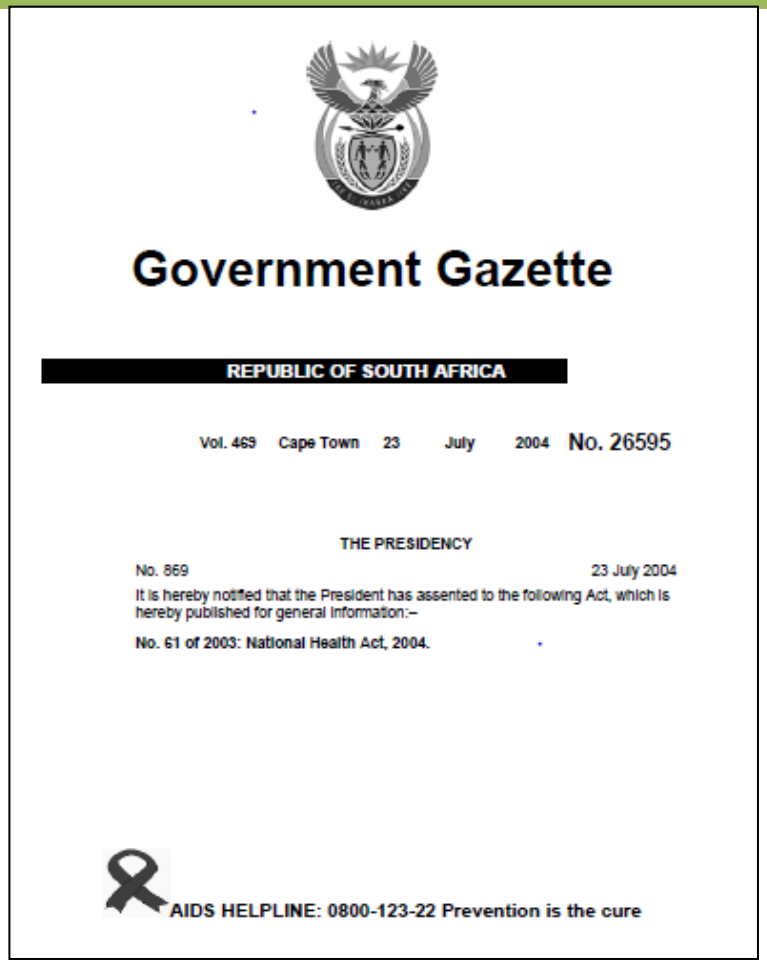
National Health Act



Government Gazette

REPUBLIC OF SOUTH AFRICA

Vol. 469 Cape Town 23 July 2004 No. 26595

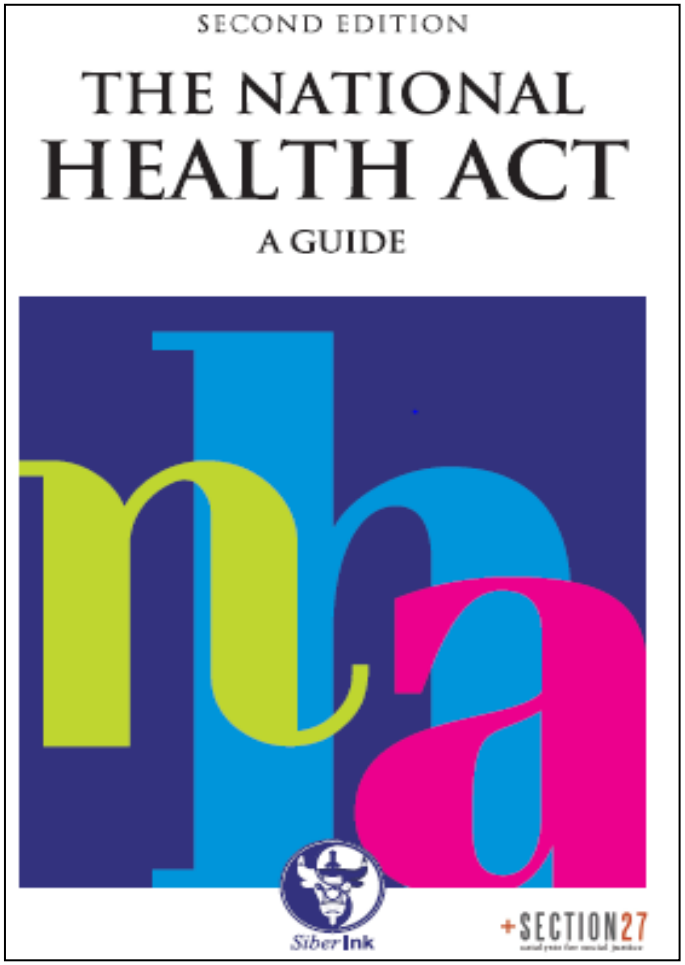
THE PRESIDENCY

No. 869 23 July 2004

It is hereby notified that the President has assented to the following Act, which is hereby published for general information:–

No. 61 of 2003: National Health Act, 2004.

AIDS HELPLINE: 0800-123-22 Prevention is the cure



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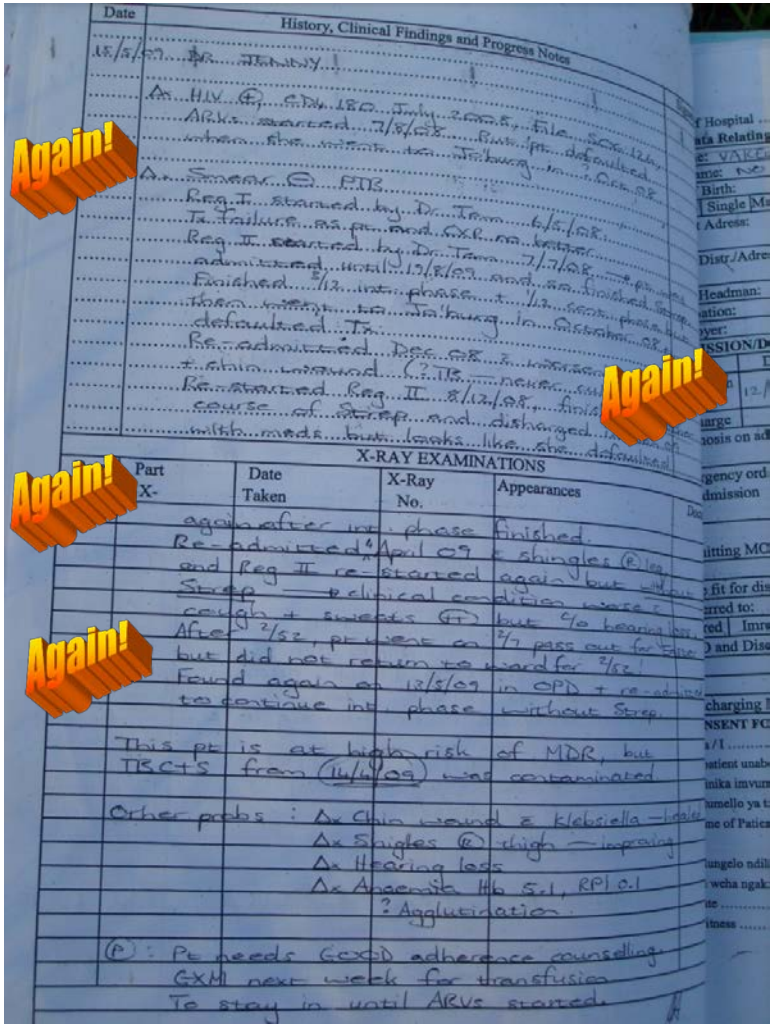
Patients Rights Charter

1. HEALTHY AND SAFE ENVIRONMENT
2. PARTICIPATION IN DECISION-MAKING
3. ACCESS TO HEALTH CARE
4. KNOWLEDGE OF ONE'S HEALTH INSURANCE/MEDICAL AID SCHEME
5. CHOICE OF HEALTH SERVICES
6. TREATED BY A NAMED HEALTH CARE PROVIDER
7. CONFIDENTIALITY AND PRIVACY
8. INFORMED CONSENT
9. REFUSAL OF TREATMENT
10. A SECOND OPINION
11. CONTINUITY OF CARE
12. COMPLAINTS ABOUT HEALTH SERVICES



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Complaints management

Complaint: dissatisfaction/ displeasure/disapproval/ discontent expressed verbally or in writing by any person about the actual health services being rendered and/ or care being provided within the public health sector

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National Core Standards and six priorities

National core standards

1.Patient rights

2. Safety, clinical risk

3.Clinical support services.

4. Public health

5. Leadership & corporate governance

6. Operational management

7. Facilities & infrastructure

6 Priorities

Patient Rights:

1.Values and attitudes
2. Waiting times
3. Cleanliness

Patient Safety, Clinical Governance & Care:

4. Patient safety
5. Infection prevention and control

Facilities & infrastructure

3. Cleanliness/infection control
4.Patient safety and security
(e.g maintenance, waste management

Clinical Support Services:

6. Availability of medicines and supplies

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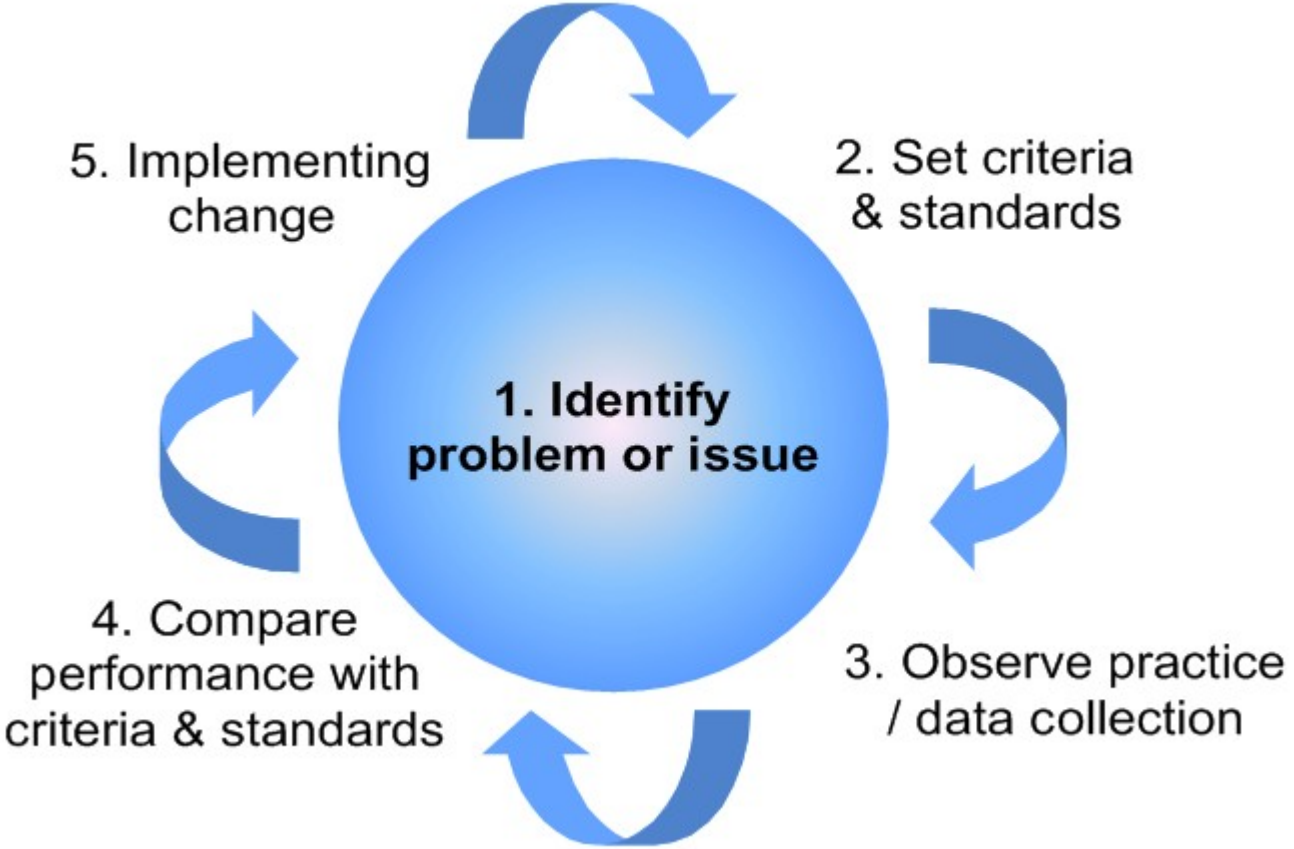
Recording keeping, data sets and reporting

- Audit tools for keeping of clinical records and registers
- Data sets: NIDS, DHIS and others
- Cascades/Dashboards of Indicators
- Electronic versus paper records

Operation Sakhume Sakhe KZN.docx

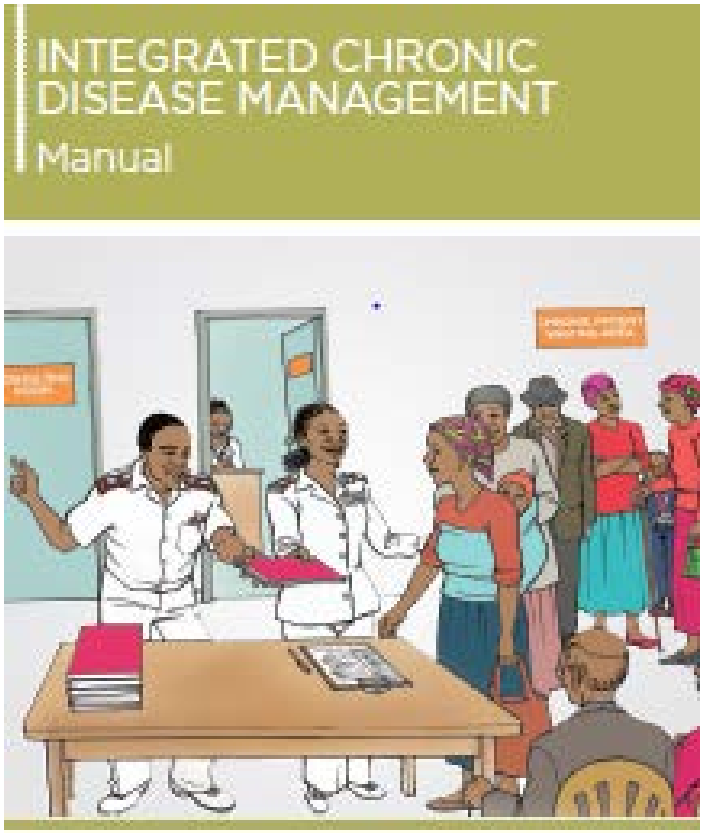
Quality Improvement Cycle



IDEAL CLINIC INITIATIVE

10 FOCUS AREAS	
Administration	Infrastructure and (bulk) support services
Implementation of clinical guidelines and ICSM	Health Information Management
Management of medicines, supplies and laboratory services	Communications
Staffing and Professional standards	District Health Systems
Availability of a doctor	Engagement with partners and stakeholders

ICDM / ICSM



[Clinical Guidelines and policies Gert Sibande]

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Task 3: Clinical Management Group discussion

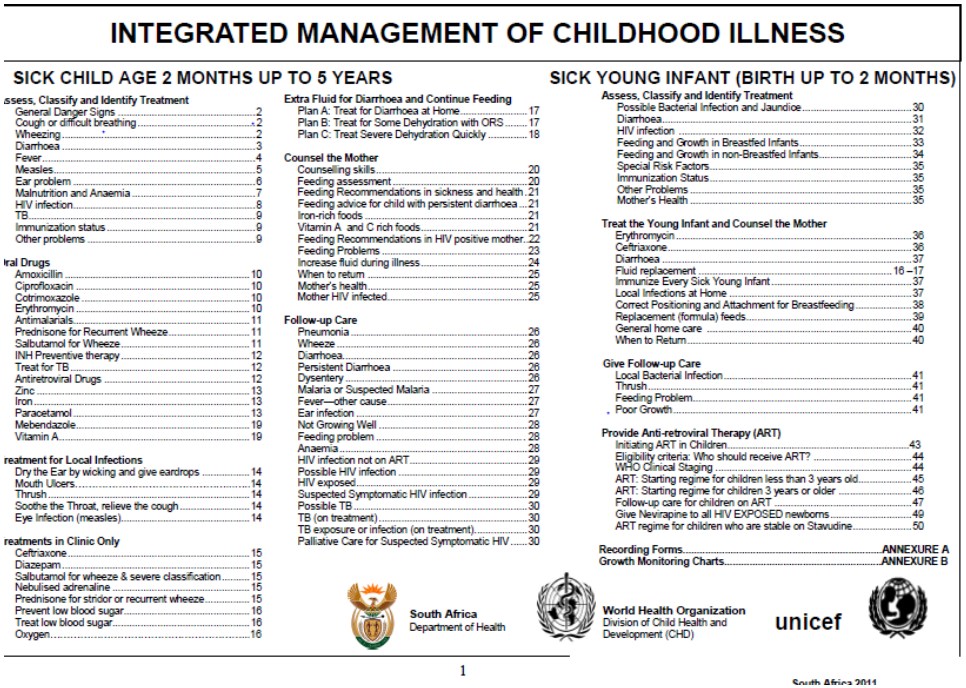
Your case study patient has arrived at the clinic.

Task:

- Choose the appropriate protocol (s) or guideline(s) to follow in the clinical management of your patient.
- Discuss the clinical management of the patient based on the chosen clinical guideline

GP Role in providing top-quality clinical care
Reference point – evidence and research

Nondumiso



INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

SICK CHILD AGE 2 MONTHS UP TO 5 YEARS

SICK YOUNG INFANT (BIRTH UP TO 2 MONTHS)

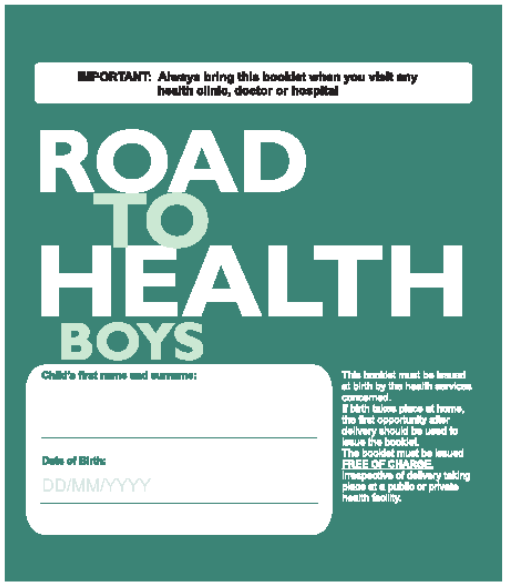
South Africa Department of Health

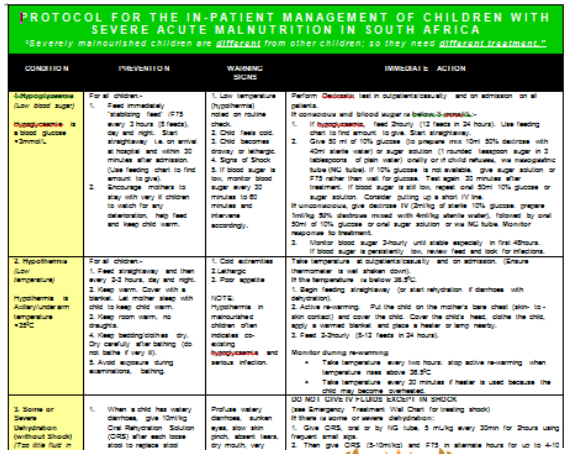
World Health Organization Division of Child Health and Development (CHD)

unicef

1

South Africa 2011





PROTOCOL FOR THE IN-PATIENT MANAGEMENT OF CHILDREN WITH SEVERE ACUTE MALNUTRITION IN SOUTH AFRICA

"Severely malnourished children are different from other children; so they need different treatment."

CONDITION	PREVENTION	WARNING SIGNS	IMMEDIATE ACTION
1. Hypoglycaemia (Low blood sugar) Hypoglycaemia is a blood glucose <3mmol/L	For all children:- 1. Feed immediately: 'stabilising feed' (F75 every 2 hours (6 feeds), day and night. Start straightaway. i.e. on arrival at hospital and within 30 minutes after admission. (Use feeding chart to find amount to give). 2. Encourage mothers to stay with very ill children to watch for any deterioration, help feed and keep child warm.	1. Low temperature (hypothermia) noted on routine check. 2. Child feels cold. 3. Child becomes drowsy or lethargic. 4. Signs of Shock 5. If blood sugar is low, monitor blood sugar every 30 minutes to 60 minutes and intervene accordingly.	Perform Dextrostix test in outpatients/casualty and on admission on all patients. If conscious and blood sugar is below 3 mmol/L:- 1. If hypoglycaemia, feed 2hourly (12 feeds in 24 hours). Use feeding chart to find amount to give. Start straightaway. 2. Give 50 ml of 10% glucose (to prepare mix 10ml 50% dextrose with 40ml sterile water) or sugar solution (1 rounded teaspoon sugar in 2 tablespoons of plain water) orally or if child refuses, via nasogastric tube (NG tube). If 10% glucose is not available, give sugar solution or F75 rather than wait for glucose. Test again 30 minutes after treatment. If blood sugar is still low, repeat one 50ml 10% glucose or sugar solution. Consider putting up a short IV line. If unconscious, give dextrose IV (2ml/kg of sterile 10% glucose: prepare 1ml/kg 50% dextrose mixed with 4ml/kg sterile water), followed by one/ 50ml of 10% glucose or oral sugar solution or via NG tube. Monitor response to treatment. 3. Monitor blood sugar 3-hourly until stable especially in first 48hours. If blood sugar is persistently low, review feed and look for infections.
2. Hypothermia (Low temperature) Hypothermia is Axillary/underarm temperature <35°C	For all children:- 1. Feed straightaway and then every 2-3 hours, day and night. 2. Keep warm. Cover with a blanket. Let mother sleep with child to keep child warm. 3. Keep room warm, no draughts. 4. Keep bedding/clothes dry. Dry carefully after bathing (do not bathe if very ill). 5. Avoid exposure during examinations, bathing.	1. Cold extremities 2.Lethargic 3. Poor appetite NOTE: Hypothermia in malnourished children often indicates co-existing hypoglycaemia and serious infection.	Take temperature at outpatients/casualty and on admission. (Ensure thermometer is well shaken down). If the temperature is below 35.5°C: 1. Begin feeding straightaway (or start rehydration if diarrhoea with dehydration). 2. Active re-warming. Put the child on the mother's bare chest (skin- to -skin contact) and cover the child. Cover the child's head, clothe the child, apply a warmed blanket, and place a heater or lamp nearby. 3. Feed 2-hourly (6-12 feeds in 24 hours). Monitor during re-warming • Take temperature every two hours, stop active re-warming when temperature rises above 36.5°C • Take temperature every 30 minutes if heater is used because the child may become overheated.
3. Some or Severe Dehydration (without Shock) (Too little fluid in	1. When a child has watery diarrhoea, give 10ml/kg Oral Rehydration Solution (ORS) after each loose stool to replace stool	Profuse watery diarrhoea, sunken eyes, slow skin pinch, absent tears, dry mouth, very	DO NOT GIVE IV FLUIDS EXCEPT IN SHOCK (see Emergency Treatment Wall Chart for treating shock) If there is some or severe dehydration: 1. Give ORS, oral or by NG tube, 5 mL/kg every 30min for 2hours using frequent small sips. 2. Then give ORS (5-10ml/kg) and F75 in alternate hours for up to 4-10

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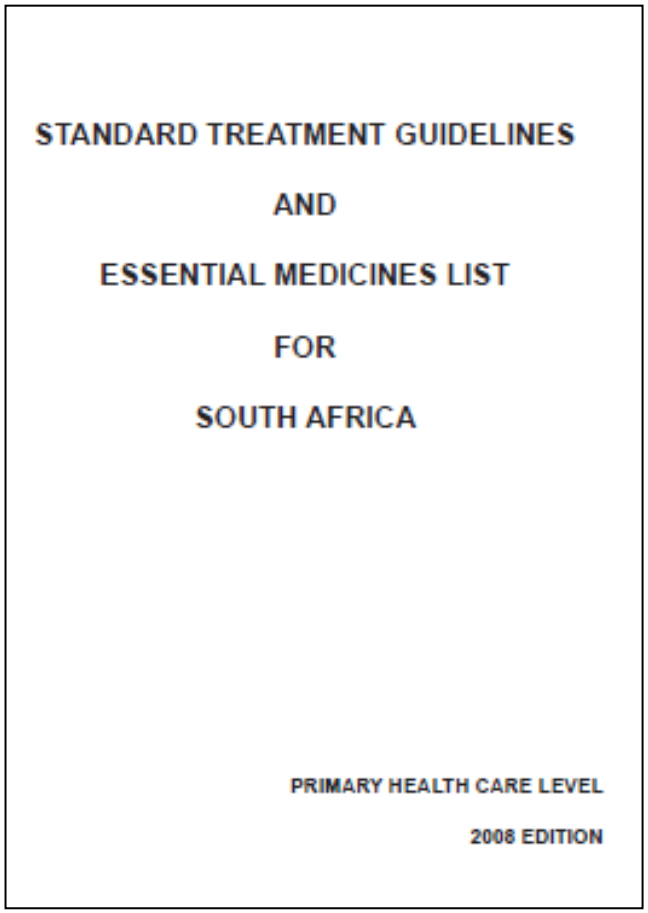

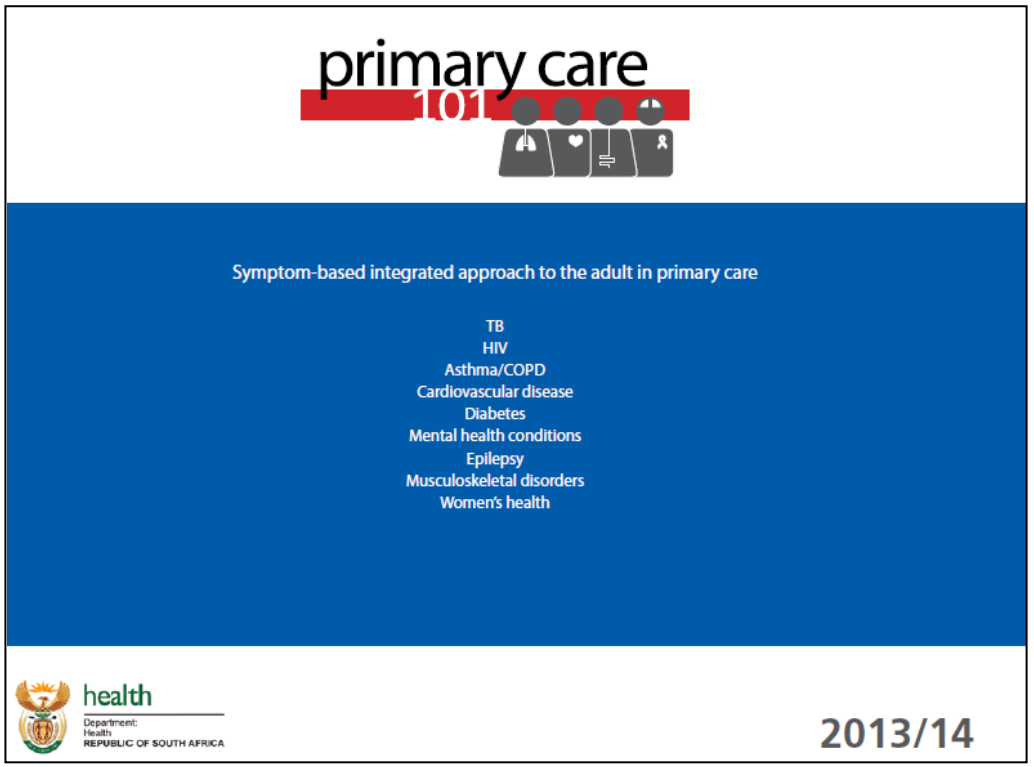

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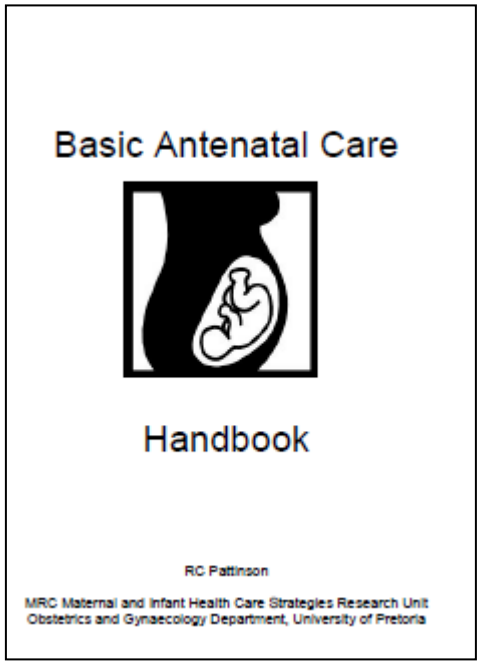

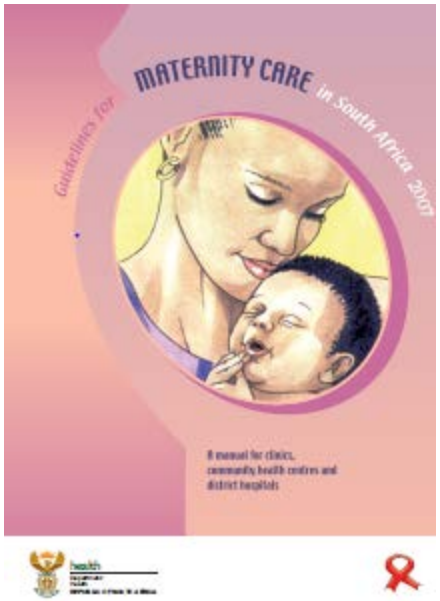

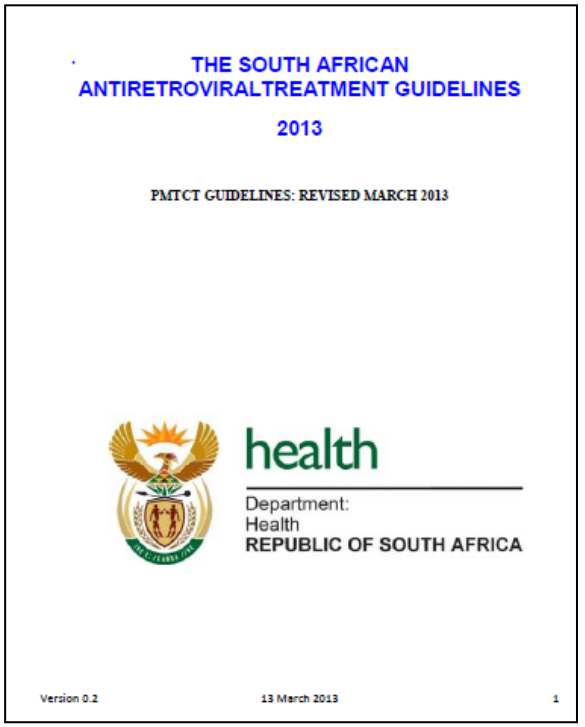

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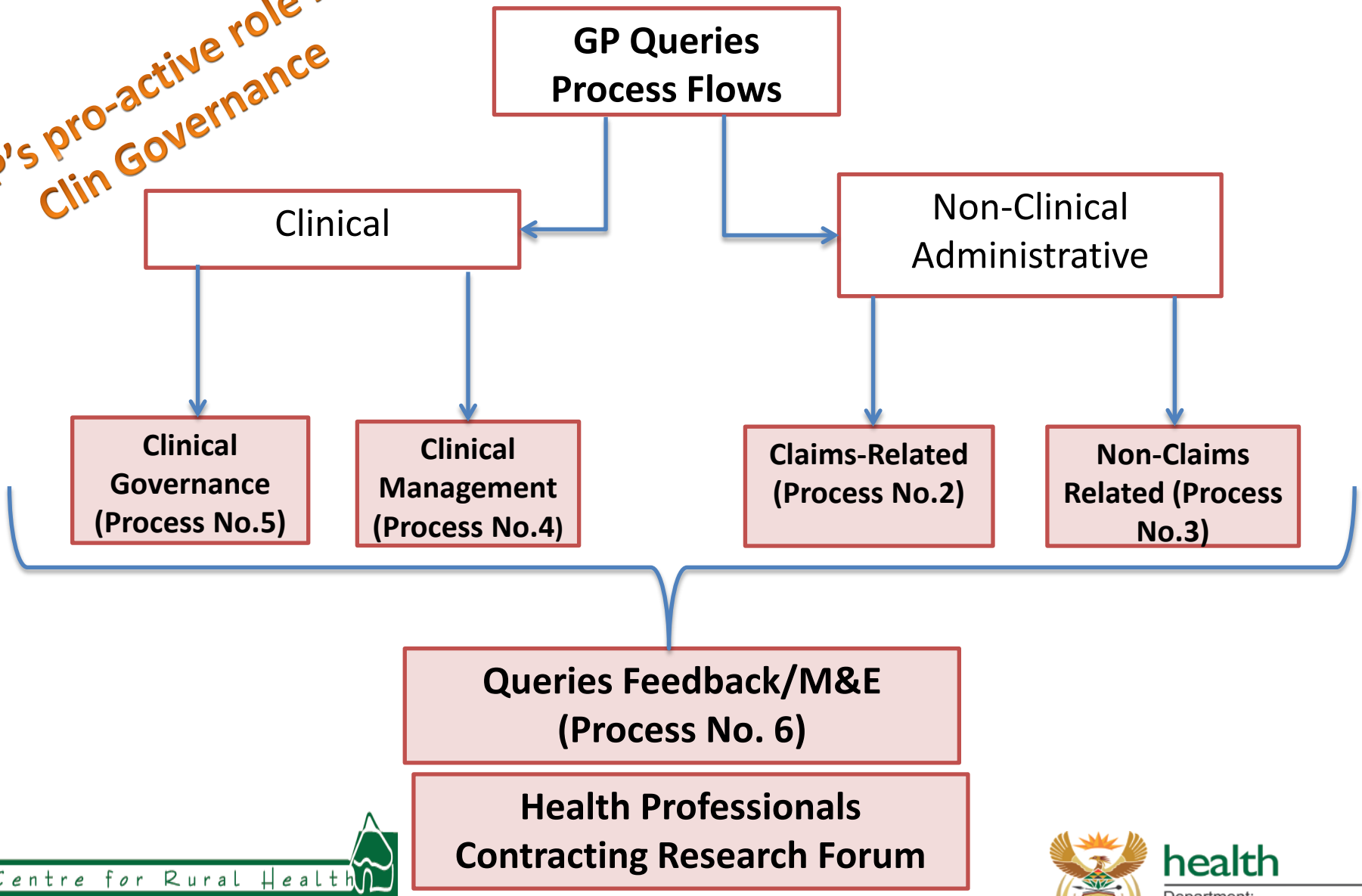
HP CONTRACTING PROCESSING OF QUERIES No. 1 0F 6

GP's pro-active role in Clin Governance



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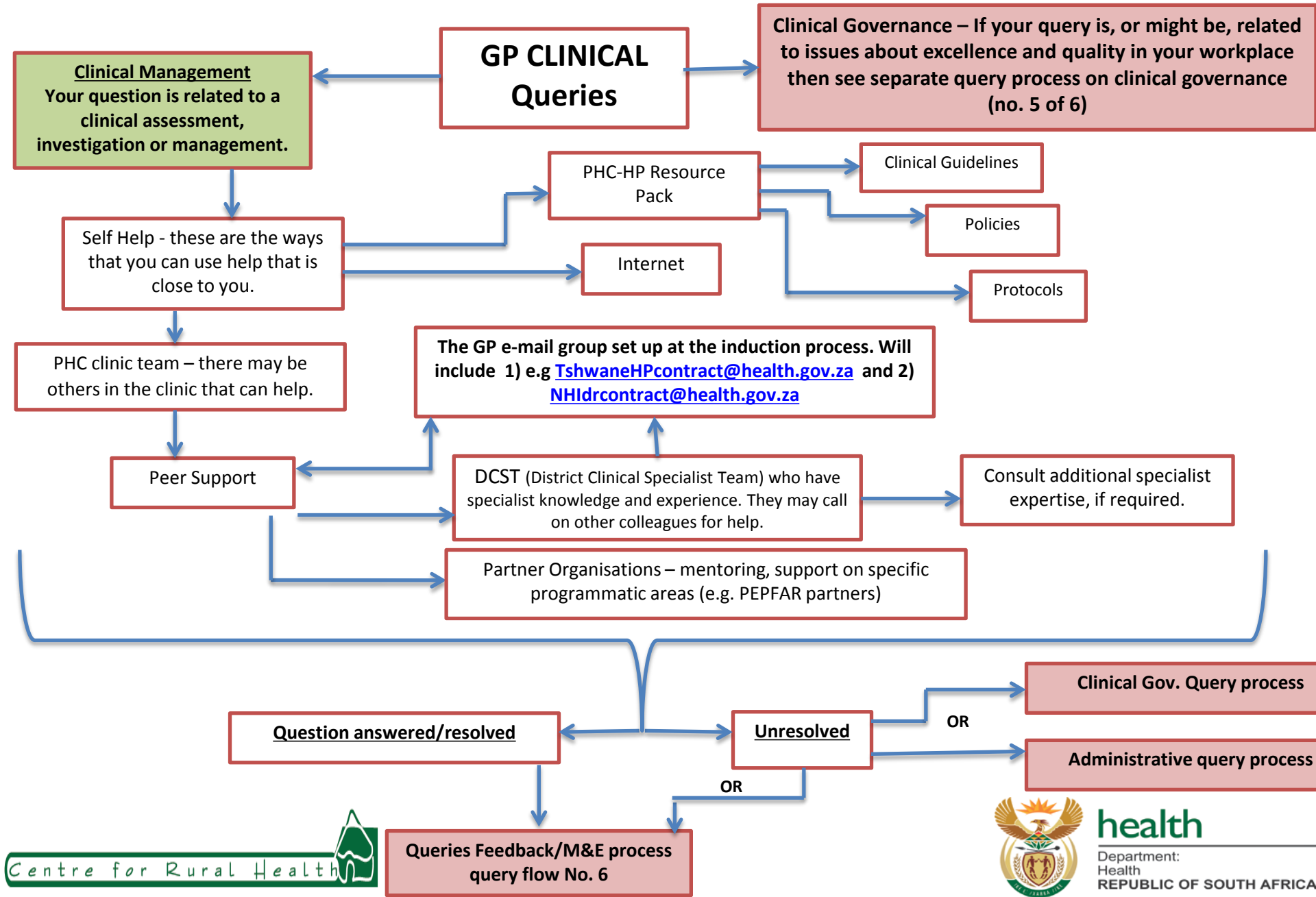
HP CONTRACTING QUERIES PROCESSES No. 4 0F 6



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HP CONTRACTING PROCESSING OF QUERIES No. 5 0F 6

Clinical Governance (CG) queries

- Clinical Audit
- Clinical effectiveness
- Research
- Openness
- Risk management
- Information Management
- Education and Training

The GP e-mail group set up at the induction process. Will include 1) e.g. TshwaneHPcontract@health.gov.za and 2) NHIdrcontract@health.gov.za

- DHMT
- NGO Partners and other stakeholders

Queries Feedback/M&E process query flow (No.6)

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Thank you

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