



DRAFT - NOVEMBER 22ND, 2014

REPUBLIC OF SOUTH AFRICA



Ideal Clinic Realisation and Maintenance

Waiting Times

Lab Report

Contents: Waiting Times

- **Context and case for change**

- Aspiration

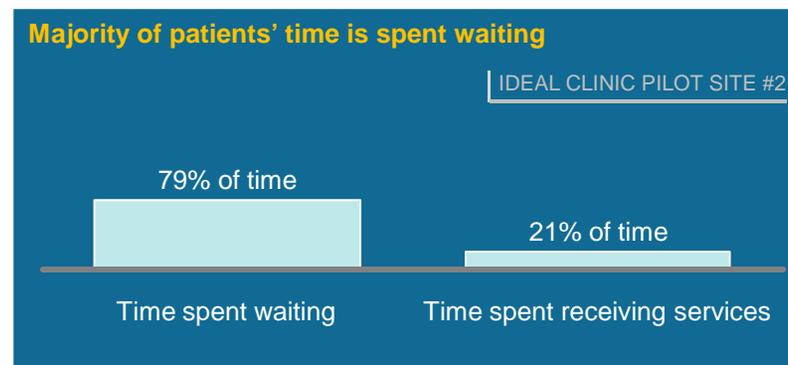
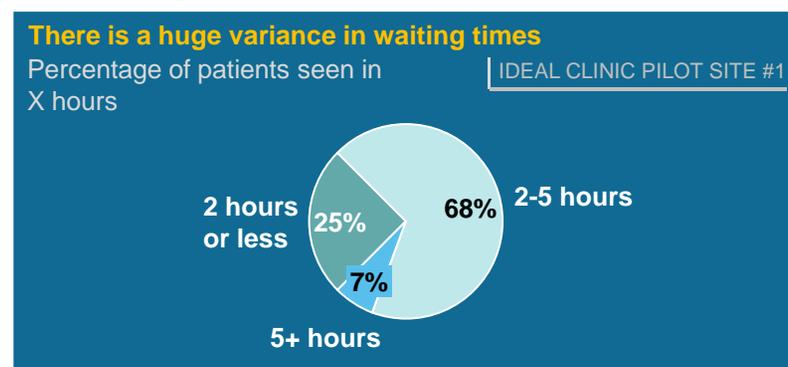
- Issues and root causes

- Initiatives

- Budget requirements

There is a significant opportunity to improve the overall patient experience of care, with a particular emphasis on long waiting times

EXAMPLES FROM
IDEAL CLINIC PILOT

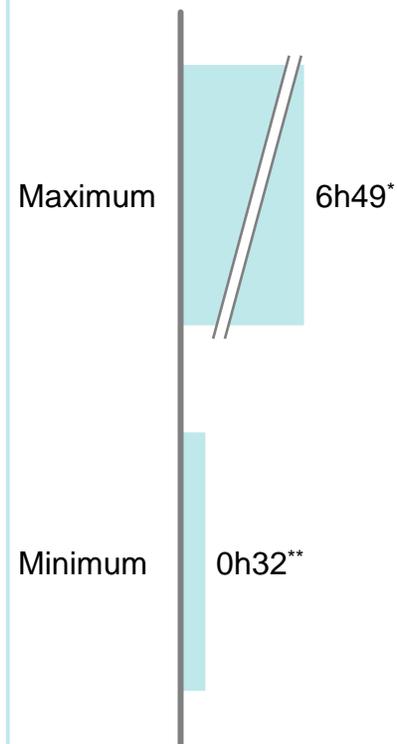


SOURCE: Public Service Commission, July 2011, Citizens Talk: A Citizen Satisfaction Survey Report; Lean Diagnostic in Ideal Clinic Pilot Sites; Lab Analysis

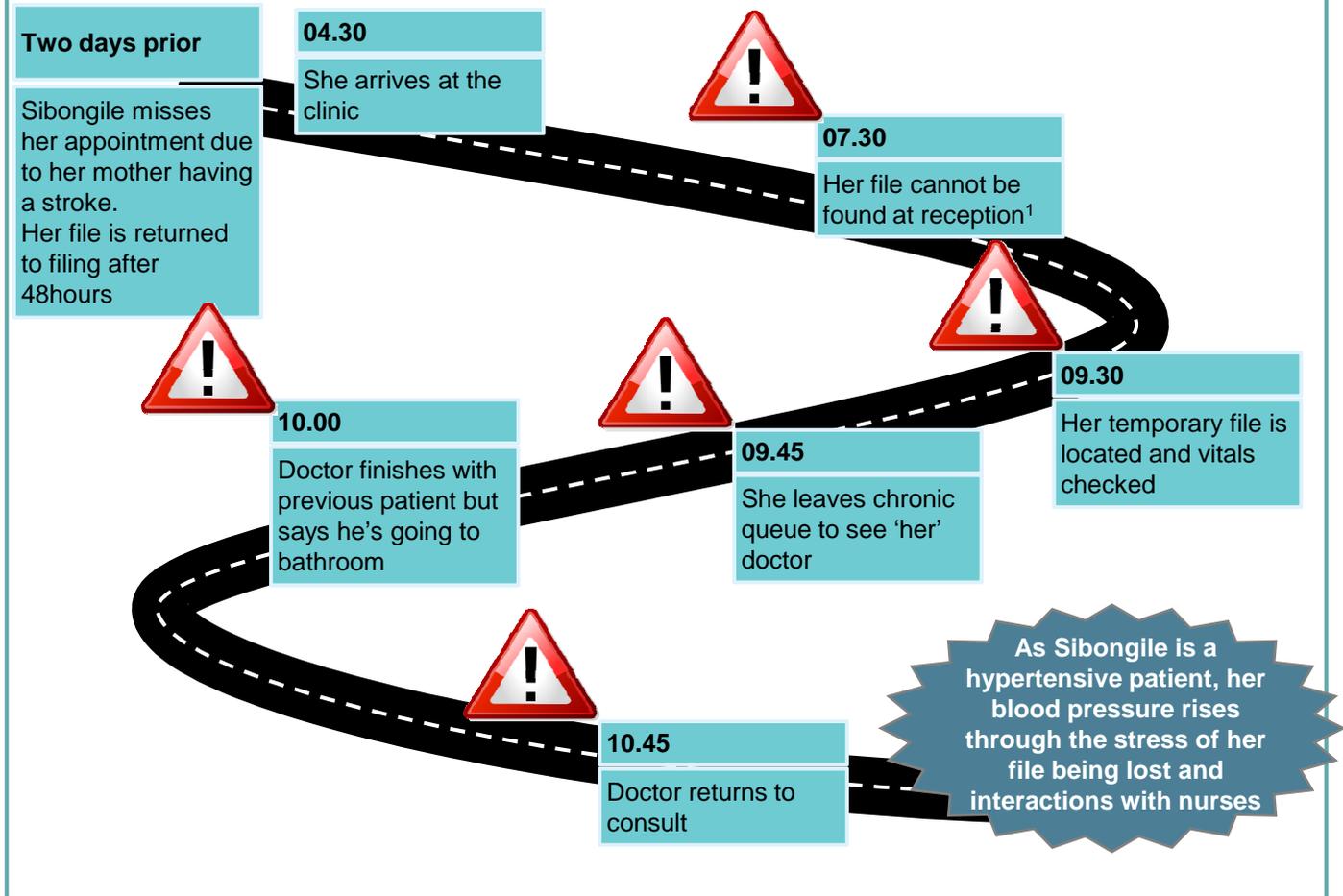
There is a large variance in patient experience, with some patients spending almost 7hrs in the clinic

Variance in time patient spends in facility total

Time spent in clinic
Number of hours



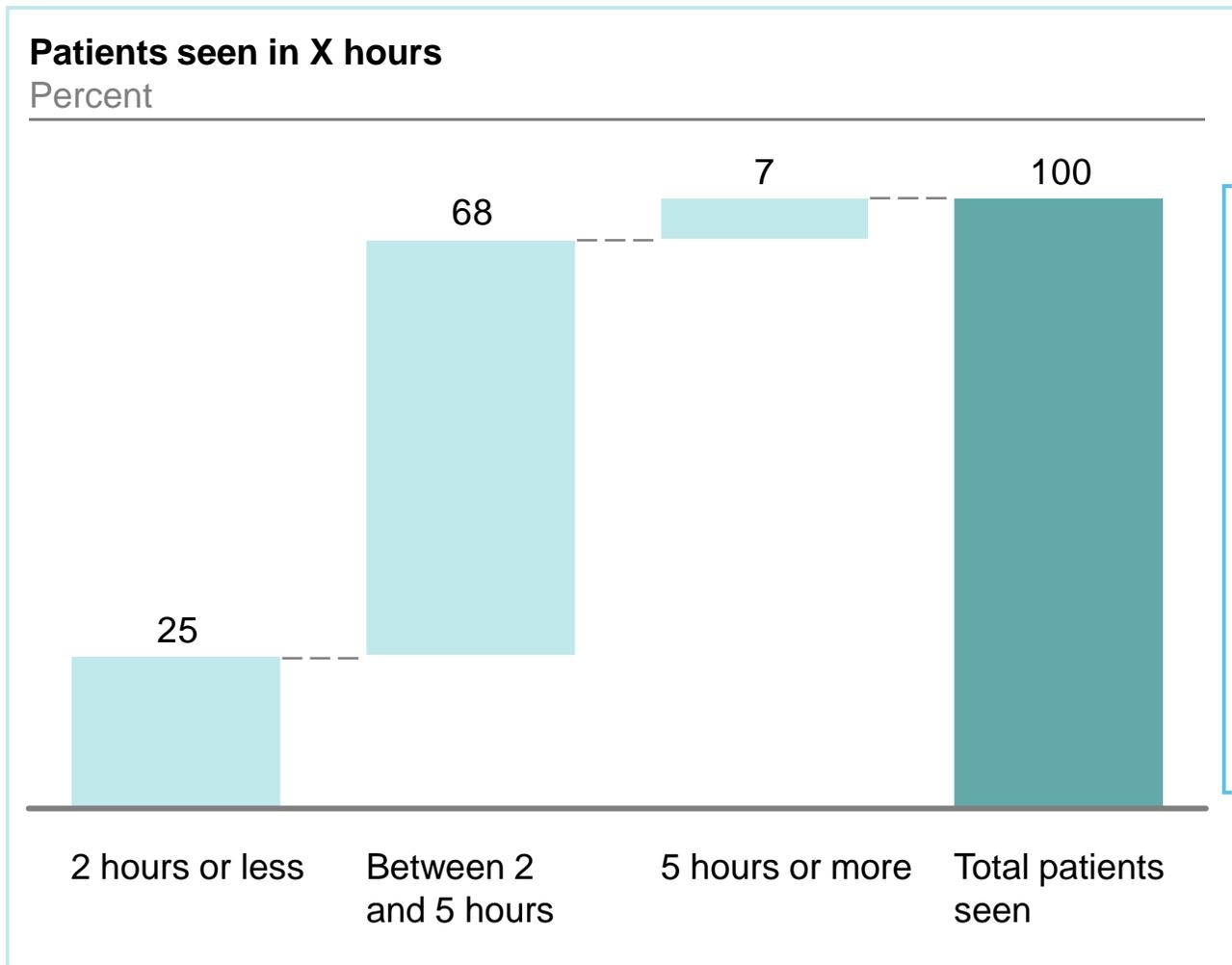
patient journeys



* Chronic patient file lost
** Chronic patient picks up meds

Average waiting times can be misleading given high variability – For instance, in one clinic only 25% of patients spent under two hours waiting in the facility

Clinic 4 EXAMPLE



- Just 25% of patients were seen within the two hour target
- High variance in patient experience: 4% of patients leave the clinic in under one hour, while 7% take over 5 hours to serve
- All patients seen in under one hour entered the clinic after 8:20

SOURCE: Clinic 4 June – September

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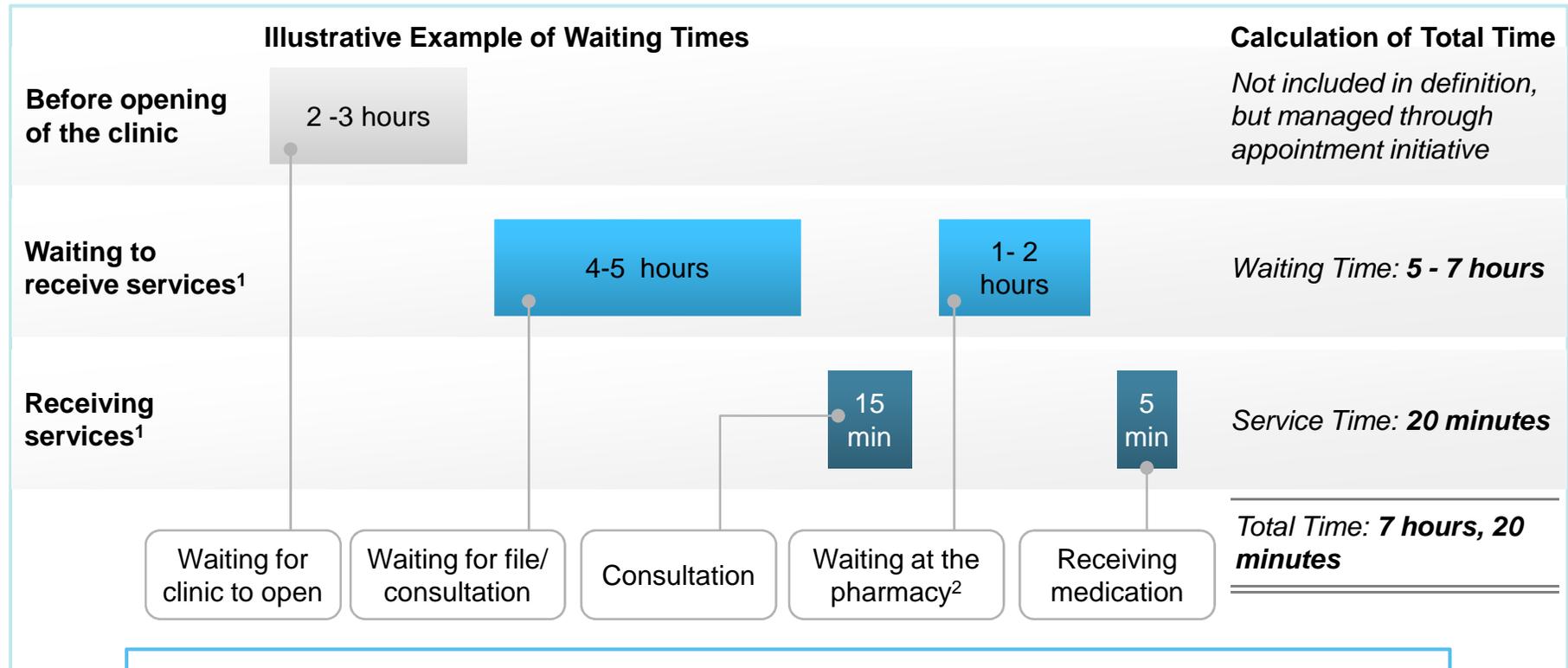
WAITING TIMES

Our aspiration is to reduce waiting times dramatically while improving the overall patient experience of care

	<u>Aspiration</u>	<u>Target</u>	
Waiting Times	<ul style="list-style-type: none">▪ Patients will wait less time before and in-between receiving services▪ Patients will spend less time in total at the clinic	<ul style="list-style-type: none">▪ 2 hours maximum by 30 Oct 2017▪ 3 hours maximum by 30 Oct 2017	
Patient Experience of Care	<ul style="list-style-type: none">▪ Patients will be satisfied with waiting times in a PHC facility▪ Patients will report a positive experience of care	<ul style="list-style-type: none">▪ 90% of patients by 30 Oct 2017▪ 80% of patients by 30 Oct 2017	<p>“Positive Experience of Care” defined along the six ministerial priority areas</p>

Our aspirations are based on a precise definition for both Waiting Time and Total Time spent in a clinic

ILLUSTRATIVE EXAMPLE



Definitions

Total Time: The time spent from the point at which the patient enters the clinic, until the final intervention²

Waiting Time: Same as the total time, but *excluding time spent receiving services*¹

1 "Receiving services" defined as receiving services from a clinical professional (including nurses, doctors, counselors, etc.), but not administrative activities (i.e., waiting for a file)

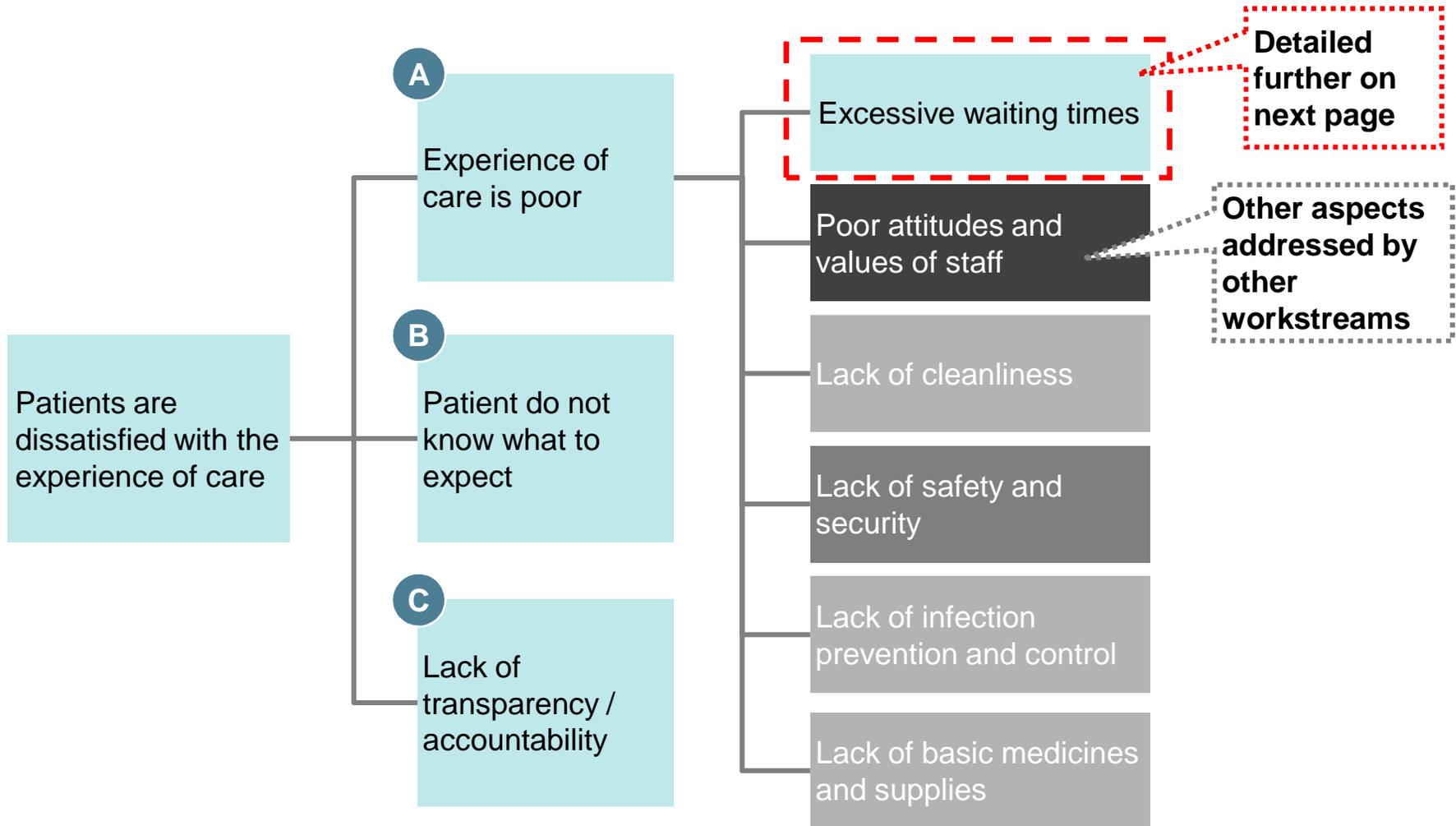
2 Note that this definition excludes time spent waiting for EMS services. While time spent waiting for EMS is not part of this definition, the Service Delivery team is working to address the issue of EMS waiting times

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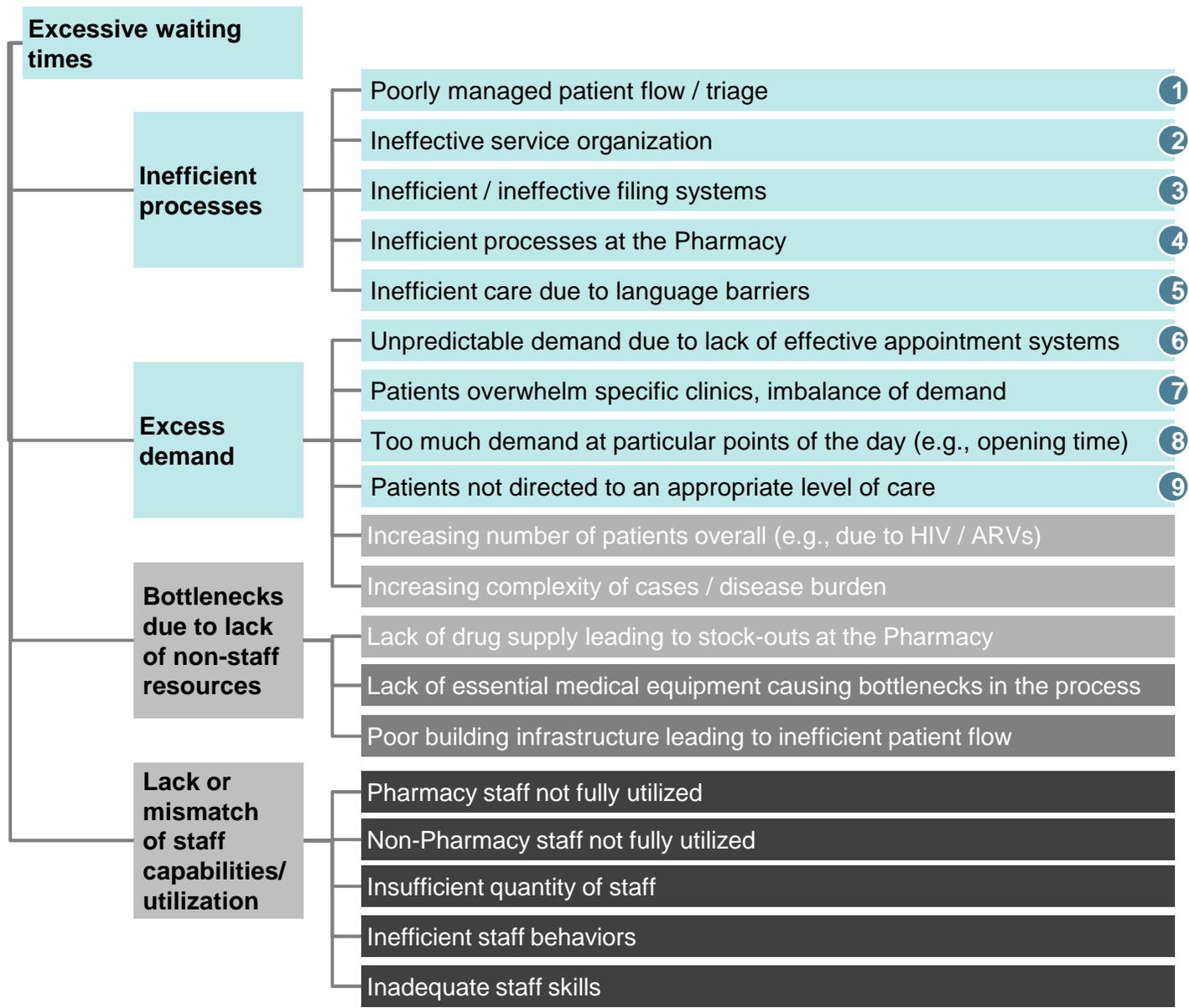
Within scope of Waiting Times	Infrastructure
Human Resources for Health	Service Delivery

There are three primary issues causing patient dissatisfaction



Within scope of Waiting Times	Infrastructure
Human Resources for Health	Service Delivery

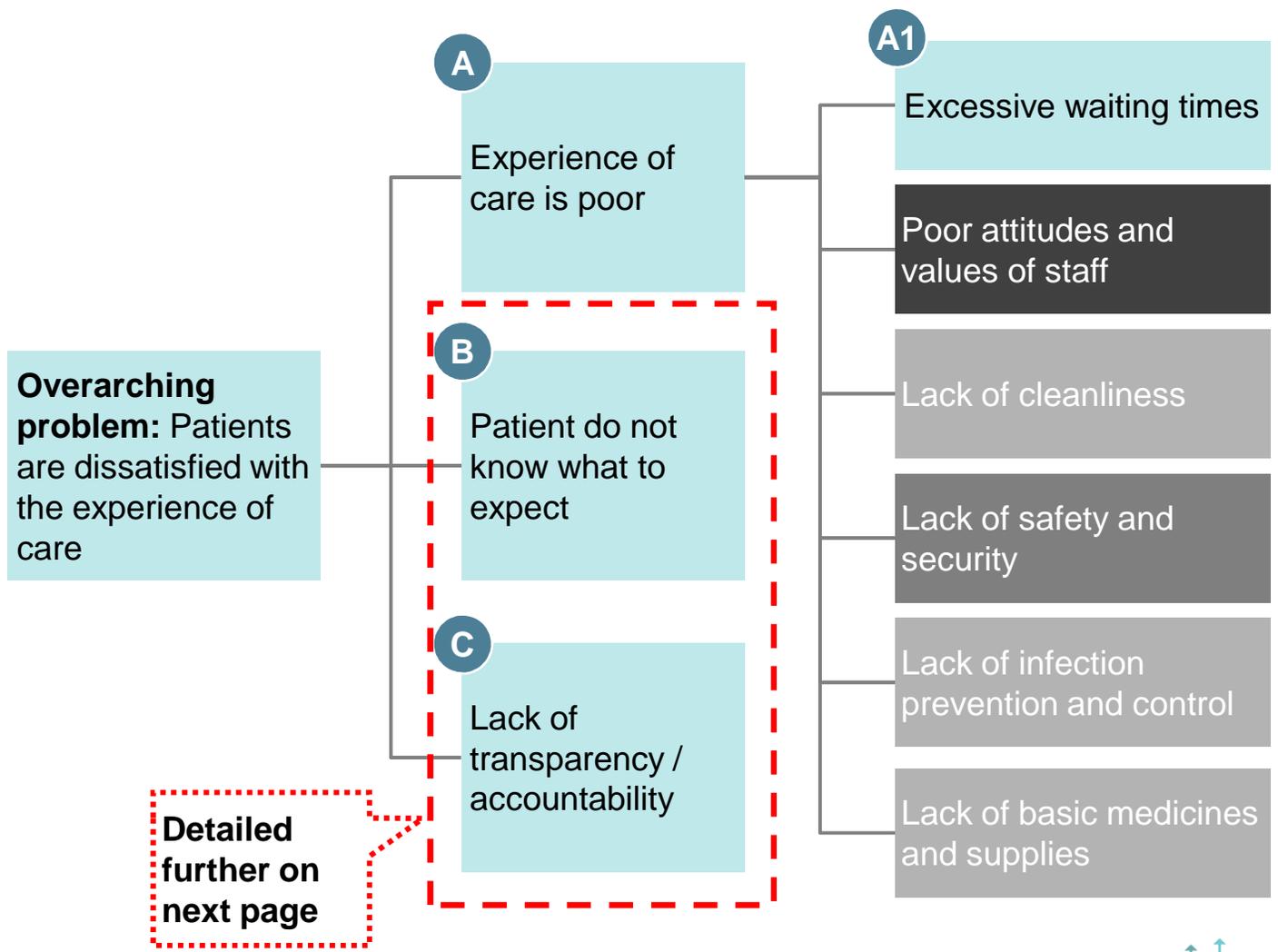
There are several root causes of long waiting times



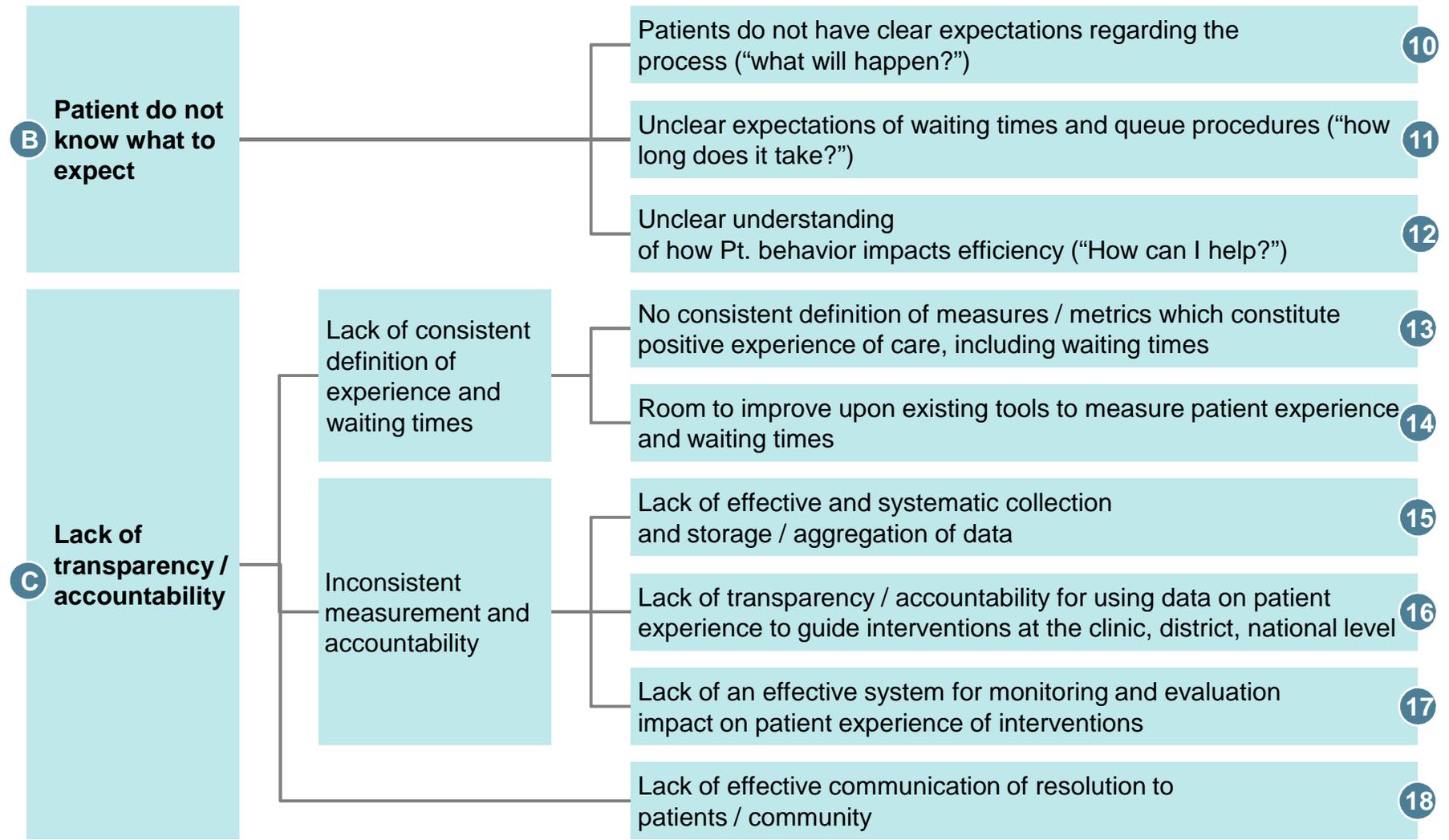
- There are **numerous root causes of waiting times**, including changing population dynamics (e.g., increase in number of HIV patients)
- The **focus of this work stream is on quick wins** – streamlining processes and managing demand in the short term (e.g., through appointments)
- Other work streams will address longer-term issues**, such as how to manage increasing NCDs and Chronic infectious diseases in the general population

Within scope of Waiting Times	Infrastructure
Human Resources for Health	Service Delivery

In addition to the poor experience rendered to the patient today, there is a lack of clear expectations and transparency/accountability

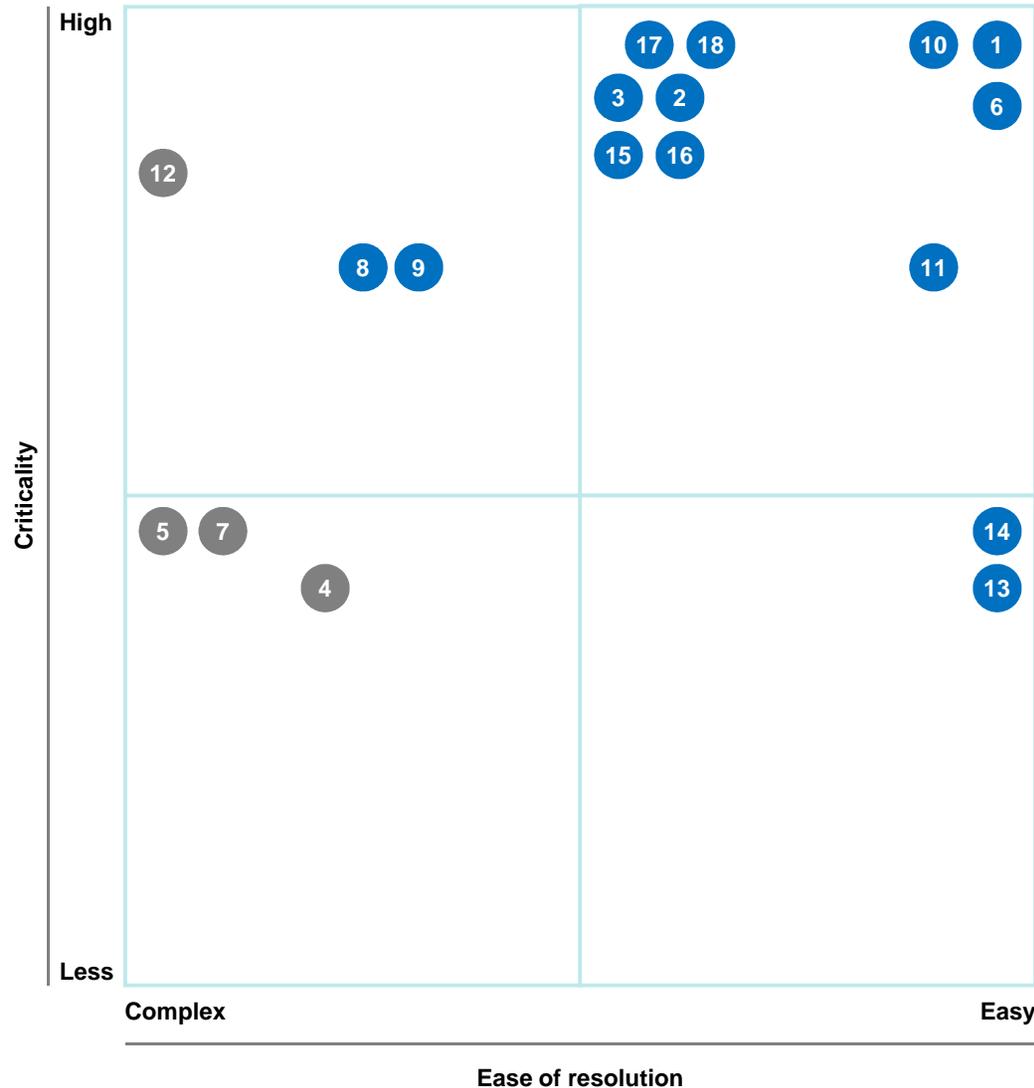


In addition to the poor experience rendered to the patient today, there is a lack of clear expectations and transparency/accountability



These issues have been prioritized on the basis of ease of resolution and criticality

● Prioritized ● De-prioritized



- 1 Poorly managed patient flow / triage
- 2 Ineffective service organization
- 3 Inefficient / ineffective filing systems
- 4 Inefficient processes at the Pharmacy
- 5 Inefficient care due to language barriers
- 6 Unpredictable demand due to lack of effective appointment systems
- 7 Patients overwhelm specific clinics, imbalance of demand
- 8 Too much demand at particular points of the day (e.g., opening time)
- 9 Patients not directed to an appropriate level of care
- 10 Patients do not have clear expectations regarding the process (“what will happen?”)
- 11 Unclear expectations of waiting times and queue procedures (“how long does it take?”)
- 12 Unclear understanding of how Pt. behavior impacts efficiency (“How can I help?”)
- 13 No consistent definition of measures / metrics constitute a “positive experience of care”, including waiting times
- 14 Room to improve upon existing tools to measure patient experience and waiting times
- 15 Lack of effective and systematic collection and storage / aggregation of data
- 16 Lack of transparency / accountability for using data on patient experience to guide interventions at the clinic, district, national level
- 17 Lack of an effective system for monitoring and evaluation impact on patient experience of interventions
- 18 Lack of effective communication of resolution to patients / community

Prioritised issues (1/4)

	Description	Impact of the issue	
1	Poorly managed patient flow / triage	<ul style="list-style-type: none"> ▪ Patient flow is not as efficiently managed as it could be – For instance, some patients cause bottlenecks at steps which are not strictly necessary (e.g., taking vitals for stable chronic patients) 	<ul style="list-style-type: none"> ▪ Long waiting times ▪ Safety of patients compromised ▪ Negative patient experiences ▪ Complications and death while waiting ▪ Demoralization of staff ▪ Delays referral to other levels of care ▪ Cross infections ▪ Human errors (staff & patients) ▪ Patient conflict
2	Ineffective service organization	<ul style="list-style-type: none"> ▪ Reorganizing services relieves pressure in specific areas or service points that have been identified to be experiencing bottlenecks allowing easy flow of patients translating to positive appraisal of services. 	<ul style="list-style-type: none"> ▪ See “Poorly managed patient flow / triage”
3	Inefficient / ineffective filing systems	<ul style="list-style-type: none"> ▪ Filing systems are inefficient, with patient records being stored in multiple folders for different conditions, and take an excessive amount of time to retrieve when the patient arrives in the clinic 	<ul style="list-style-type: none"> ▪ Excessively long waiting times ▪ Multiple files/records for individual patients ▪ Patient dissatisfaction ▪ Wastage in the system ▪ Poor time management and low productivity ▪ Creation of bottlenecks ▪ Abuse of staff by the service users
6	Unpredictable demand due to lack of effective appointment systems	<ul style="list-style-type: none"> ▪ Appointments are not widely used to balance demand throughout the day and week ▪ Patients do not adhere to their appointment dates since they are not given a choice ▪ Dates are given for appointments but not times 	<ul style="list-style-type: none"> ▪ Overcrowding of facilities ▪ Long waiting times ▪ Uncertainty and anxiety of patients

Prioritised issues (2/4)

	Description	Impact of the issue
8	<p>Too much demand at particular points of the day (e.g., opening time)</p> <ul style="list-style-type: none"> In one study done in Western Cape, 80% of patients arrived before the clinic opened, and in the ideal clinic sites studied, 60% of patients arrived before or within the first hour of the clinic opening 	<ul style="list-style-type: none"> Long waiting times for patients who arrive early Congestion in facilities
9	<p>Patients not directed to an appropriate level of care</p> <ul style="list-style-type: none"> Many patients come to clinic with issues which could be addressed outside a clinical setting (i.e., clarifying side effects of medication) 	<ul style="list-style-type: none"> Congestion in facilities, and long waiting times for other patients
10	<p>Patients do not have clear expectations regarding the process (“what will happen?”)</p> <ul style="list-style-type: none"> Lack of process understanding on clinic arrangements 	<ul style="list-style-type: none"> Patients confused and frustrated Patients spend unnecessary time in wrong queues Perception of a generally inefficient and ineffective health system General patient dissatisfaction Poor publicity for the public health system
11	<p>Unclear expectations of waiting times and queue procedures (“how long does it take?”)</p> <ul style="list-style-type: none"> Lack of clear waiting time expectations 	<ul style="list-style-type: none"> Frustrated and angry patients Rise in patient complaints Altercations between health care providers and patients

Prioritised issues (3/4)

	Description	Impact of the issue
<p>13</p> <p>No consistent definition of measures / metrics constitute a “positive experience of care”, including waiting times</p>	<ul style="list-style-type: none"> ▪ No consistent definition of what is a positive patient experience of care (PEC) ▪ No consistent definition of what is a positive waiting time experience (WT) 	<ul style="list-style-type: none"> ▪ It is impossible to measure consistently without an agreed definition of PEC & therefore impossible to make improvements
<p>14</p> <p>Room to improve upon existing tools to measure patient experience and waiting times</p>	<ul style="list-style-type: none"> ▪ We have no appropriate, robust and consistent tools for measuring patient of care or waiting times 	<ul style="list-style-type: none"> ▪ There are several tools across the country that makes it difficult to choose the appropriate ones. ▪ We are not using the same tools to measure PEC and WT and there are inconsistent implementation so we cannot compare across facilities
<p>15</p> <p>Lack of effective and systematic collection and storage / aggregation of data</p>	<ul style="list-style-type: none"> ▪ No national system for collecting and analyzing data on patient experience of care and waiting times 	<ul style="list-style-type: none"> ▪ No consistent perspective across South Africa on how PHC facilities are performing in regards to waiting times and PEC

Prioritised issues (4/4)

	Description	Impact of the issue
16	<p>Lack of transparency / accountability for using data on patient experience to guide interventions at the clinic, district, national level</p> <ul style="list-style-type: none"> In part because data is not readily available, lack of transparency and accountability for using data on PEC and Waiting Times to guide improvements 	<ul style="list-style-type: none"> Lack of accountability which leads to poor performance
17	<p>Lack of an effective system for monitoring and evaluation of impact on patient experience of interventions</p> <ul style="list-style-type: none"> Lack of a consistently effective system in place to monitor and evaluate the impact of initiatives on PEC and Waiting Times 	<ul style="list-style-type: none"> No consistent perspective across South Africa on how PHC facilities have been able to address issues of PEC and Waiting Times
18	<p>Lack of effective communication of resolution to patients / community</p> <ul style="list-style-type: none"> No communication which consistently and systematically engages patients as individuals and the communities on results and progress of quality improvement initiatives 	<ul style="list-style-type: none"> Patient left feeling despondent, like government does not care about their input and nothing is being done to improve circumstances Patients confused by recent changes Loss of confidence in public health care system resulting in either giving up or seeking better more costly alternatives which cannot be sustained General patient dissatisfaction

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WAITING TIMES

Our initiatives will improve the entire end-to-end patient experience of care, including waiting times

-  Breakthrough
-  Major Delivery Fix
-  Quick win

Proactively manage demand



-  1 Use appointments to manage demand and direct patients to appropriate level of care
-  2 Expand existing public call centre services to direct patients to the appropriate level of care
-  3 Roll out SMS-based platform for communicating individualized patient information (e.g., reminder system for appointments and medications)

Improve efficiency and patient experience within the clinic



-  4 Improve efficiency of patient flow
-  5 Standardize paper filing processes at the clinics for ease of retrieval
-  6 Support clinics to adjust hours / days of operation to increase accessibility and reduce waiting times
-  7 Implement electronic queue management systems

Increase transparency and accountability



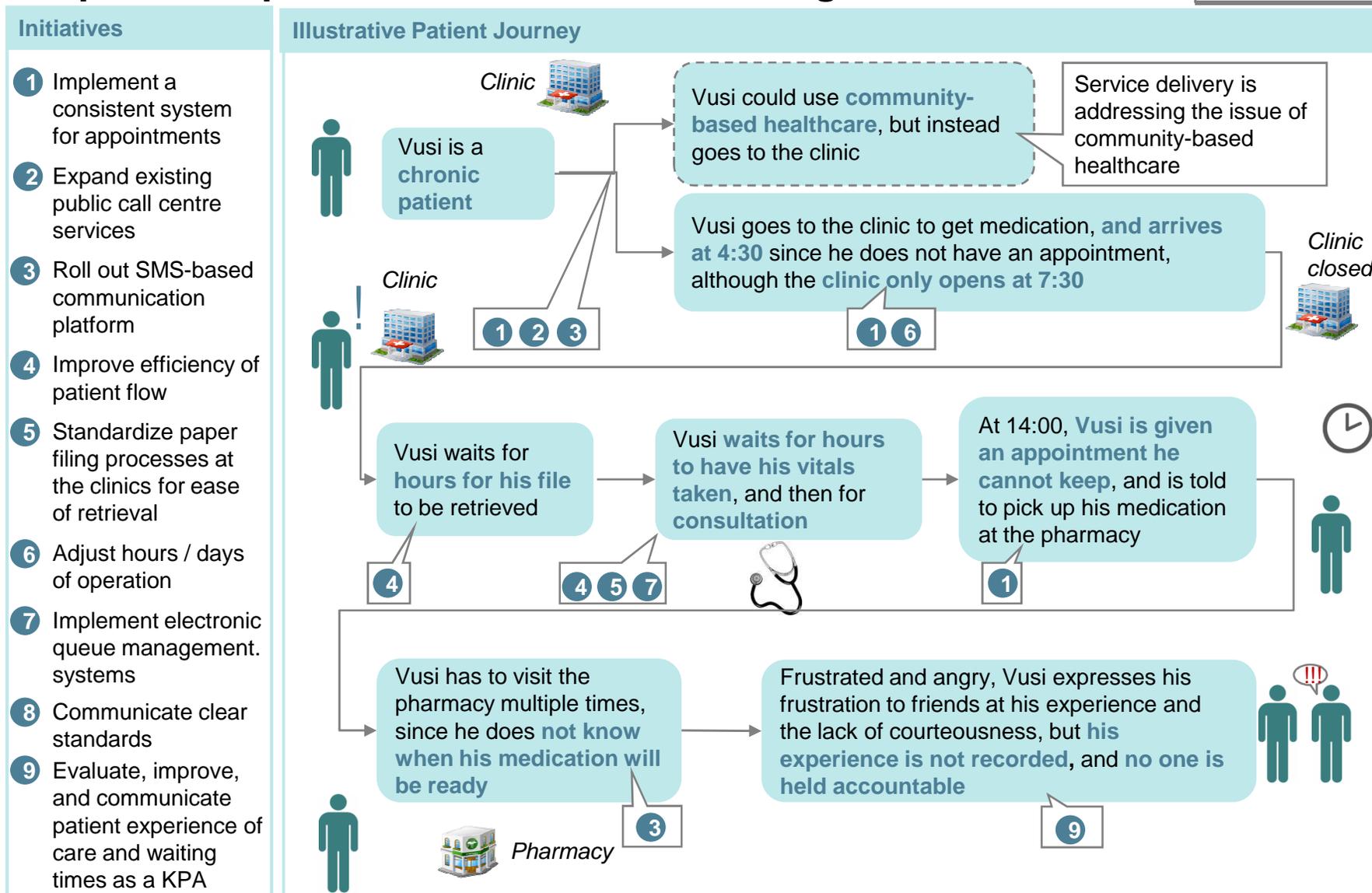
-  8 Communicate clear expectations for Waiting Times and process of care
-  9 Implement a country-wide system for evaluating, improving, and communicating patient experience of care and waiting times as a Key Performance Area (KPA)

These initiatives address the issues identified by the waiting times work stream

<p>1 Use appointments to manage demand and direct patients to appropriate level of care</p>	<p>5 Standardize paper filing processes at the clinics for ease of retrieval</p>	<p>9 Implement a country-wide system for evaluating, improving and communicating patient experience of care and waiting times as a Key Performance Area (KPA)</p>
<p>6 Unpredictable demand due to lack of effective appointment systems</p> <p>8 Too much demand at particular points of the day (e.g., opening time)</p>	<p>3 Inefficient / ineffective filing systems</p>	<p>13 No consistent definition of measures / metrics constitute a “positive experience of care”, including waiting times</p>
<p>2 Expand existing public call centre services to direct patients to the appropriate level of care</p> <p>9 Patients not directed to an appropriate level of care</p>	<p>6 Support clinics to adjust hours / days of operation and staff schedules to increase accessibility and reduce waiting times</p> <p>8 Too much demand at particular points of the day (e.g., opening time)</p>	<p>14 Room to improve upon existing tools to measure patient experience and waiting times</p> <p>15 Lack of effective and systematic collection and storage / aggregation of data</p>
<p>3 Roll out SMS-based platform for communicating individualized patient information (e.g., reminder system for appointments and medications)</p> <p>6 Unpredictable demand due to lack of effective appointment systems</p> <p>9 Patients not directed to an appropriate level of care</p>	<p>7 Implement electronic queue management systems</p> <p>1 Poorly managed patient flow / triage</p>	<p>16 Lack of transparency / accountability for using data on patient experience to guide interventions at the clinic, district, national level</p>
<p>4 Improve efficiency of patient flow</p> <p>1 Poorly managed patient flow / triage</p> <p>2 Ineffective service organization</p>	<p>8 Communicate clear expectations for Waiting Times and process of care</p> <p>10 Patients do not have clear expectations regarding the process (“what will happen?”)</p> <p>11 Unclear expectations of waiting times and queue procedures (“how long does it take?”)</p> <p>18 Lack of effective communication of resolution to patients / community</p>	<p>17 Lack of an effective system for monitoring and evaluation impact on patient experience of interventions</p>

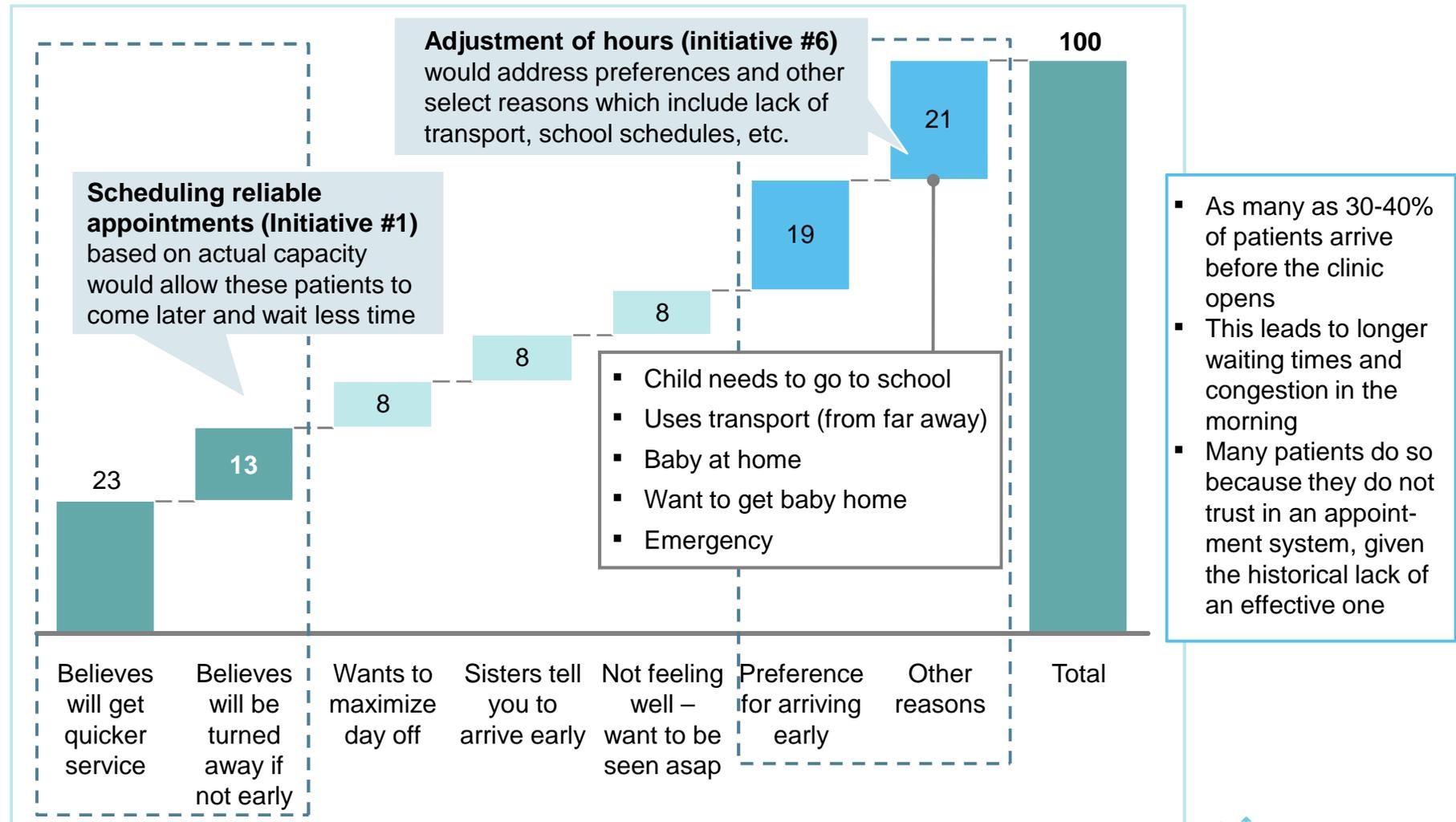
The Waiting Times work stream has taken responsibility for the end-to-end patient experience, not limited to waiting in the clinic

ILLUSTRATIVE



These initiatives address the root causes of critical issues with the patient experience today, such as waiting outside the clinic before it opens

Response to question, “Why did you arrive early this morning?”, %



SOURCE: Patient Interviews (Clinic 4); team analysis

1 Appointments will be used to manage patient volumes based on the capacity of the clinic, while improving overall patient experience

What happens today?	How will we change that?	Impact on the patient experience	
		From...	...to
Patients are given multiple, uncoordinated appointments by multiple nurses	A single, centralized appointment system for each clinic	Vusi has an appointment on Nov 4 th for chronic medication, and on Nov 6 th for an immunization	Vusi has an appointment on Nov 4 th for both of his needs
Patients are given no choice or flexibility in their appointments	Appointments will be negotiated with patients , and based on capacity to ensure that everyone can be seen	Vusi is told “come back on Nov 28 th ” but knows he cannot make that date	Vusi is given the chance to negotiate, and is able to arrive at the clinic knowing he’ll be seen
Patients are given no specific time to arrive at the clinic	Appointments will be given for specific times , and based on capacity	Mary shows up at the clinic at 4:30am despite having an appointment	Mary can arrive at 12pm and know that she and her son will be seen
Patients need to come to the clinic to get their medication	Appointments are given for picking up medication at the site of choice , and only utilize clinic when necessary	Vusi regularly comes to the clinic to get his medication and has to wait several hours	Vusi is given an appointment to pick up his medication at a community site

By giving appointments based on actual capacity, clinics can both manage patient volumes to address waiting times as well as improve the overall patient experience

1 Our revised model of appointment scheduling (1/2)

	How the new model will work	Why this is different from the current model
<p>1 Categorizing and streaming of patients who will require appointments</p>	<ul style="list-style-type: none"> ▪ Patient will be booked according to the three identified clinical streams. 	<ul style="list-style-type: none"> ▪ More than one return date result in patient defaulting their appointment and lead to influx .Follow ups for reviews, further diagnostic tests, repeat chronic medication, Maternal and Child Health visits should be scheduled on the same date for same patient
<p>2 Patient and nurse schedule appointment</p>	<ul style="list-style-type: none"> ▪ Patient negotiates the appointment date with the registered nurse within predetermined dates spreading over 2 weeks, based on actual capacity available in the clinic 	<ul style="list-style-type: none"> ▪ Today, there is no centralized system - appointment are booked in consulting rooms by individual nurses and doctors, leading to high variability in demand throughout the week and skewed spread of workload leading to long waiting times
<p>3 Determine the appointment date</p>	<ul style="list-style-type: none"> ▪ Negotiate with the patient regarding the appointment date and time to reduce non-adherence and defaulter rate ▪ Depending on the patient's condition and reason for the appointment (review, repeat medication or repeat/further tests) a determination to be made whether to return monthly, every 3months or at 6monthly intervals or specific day informed by Turn Around Time for Results 	<ul style="list-style-type: none"> ▪ Patients are given appointment according to service days and not according to patients convenient resulting in miss appointment Appointment are done without patient preference date and time. ▪ Patients have shown varying levels of non-adherence to their appointments e.g.35% of MNCWH and 10% of chronic patients miss their appointment (Lean Diagnostic of Four Ideal Clinics)
<p>4 Determining daily targets</p>	<ul style="list-style-type: none"> ▪ Determine targets for each date and time informed by patients conditions and needs as well as staff capacity per day. (Off duty rosters and leave plans used to pre-determine staff capacity per day. ▪ To balance patient influx and staff workload under the new process, each clinic will have a well-structured appointment booking system where nurses will have numbers of the maximum patients they can book per day. Patients will have to make a choice on the days that will be provided. This choice of the dates will be accommodated by providing dates straddling over 2 weeks 	<ul style="list-style-type: none"> ▪ Currently patients are booked without any predetermined target considerations. Little regulation of number of appointment per day due to poor training and lack of ownership by all clinic staff. Too few staff members are trained on determining appropriate numbers per day, resulting in influx of patients on some days

1 Our revised model of appointment scheduling (2/2)

5 Filing for easy retrieval

How the new model will work

- The new model will identify the patients according to their ID numbers as they cannot be duplicated like the same surnames, and will then reduce bottlenecks and waiting times

6 Pre-appointment retrieval of records

- Administrative clerk checks appointment book 48-72hrs before next appointments
Retrieves all files booked for that date and ticks off on the appointment book.
- Patient who have not turned up for their appointment their files will be kept for a maximum of 5 days, If patient arrived within 5 days will be seen after all booked patient have been seen for that day. Patient not arrived after 5 days, files will be returned to filling rooms and medications to pharmacy and inquiry lodged with WBOT
- Retrieves all results that may have come after last visits and puts in patient file
Keeps the files at reception. Files not found highlighted in red or any colour and remedial measures done

7 Pre-dispensing of treatment for patients collecting Chronic medication

- Pre-packed of medication before the appointment date will reduce waiting time as patient will receive their medication on the date of appointment

8 Patient complicating or defaulting at community site

- Complicated and defaulting patient will be referred back to the clinic with the written note on the file for further management
- Patient will be advised that their appointment will be done in the clinic till further noticed

Why this is different from the current model

- Currently there is no filling systems in place which result in patient waiting too long before receiving the clinical care
- Patients' files are retrieved on the appointment day and this result in long waiting times and, occasionally, lost files or patients not being seen on the day
- Pre-dispensing of chronic medication still not practised consistently throughout the country due shortage of pharmacy staff to do pre-packing
- Currently there is no structured way of managing and following on defaulting patients. They come whenever they want to.

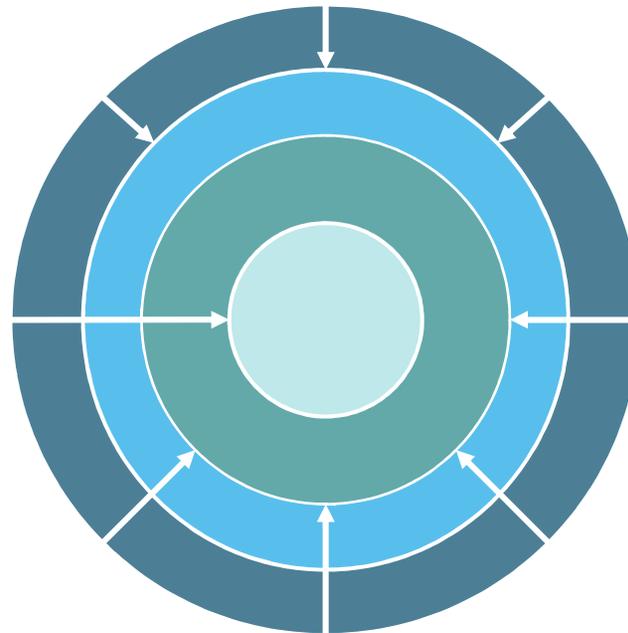
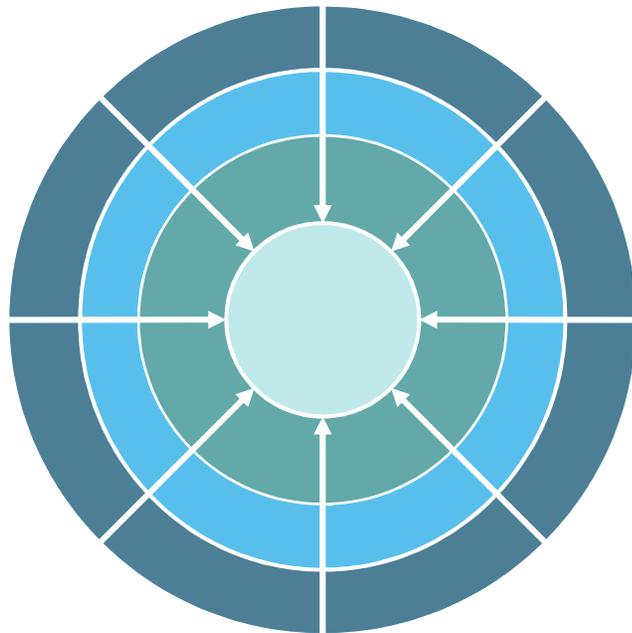
Breakthrough Ideas – Initiative #1: Use appointments to manage demand and direct patients

1 Appointments will be used to direct patients to community-level care, reducing waiting times due to influx of HIV or other chronic patients

- Clinic
- Ward based outreach
- Multi-purpose centres
- Other community-based care

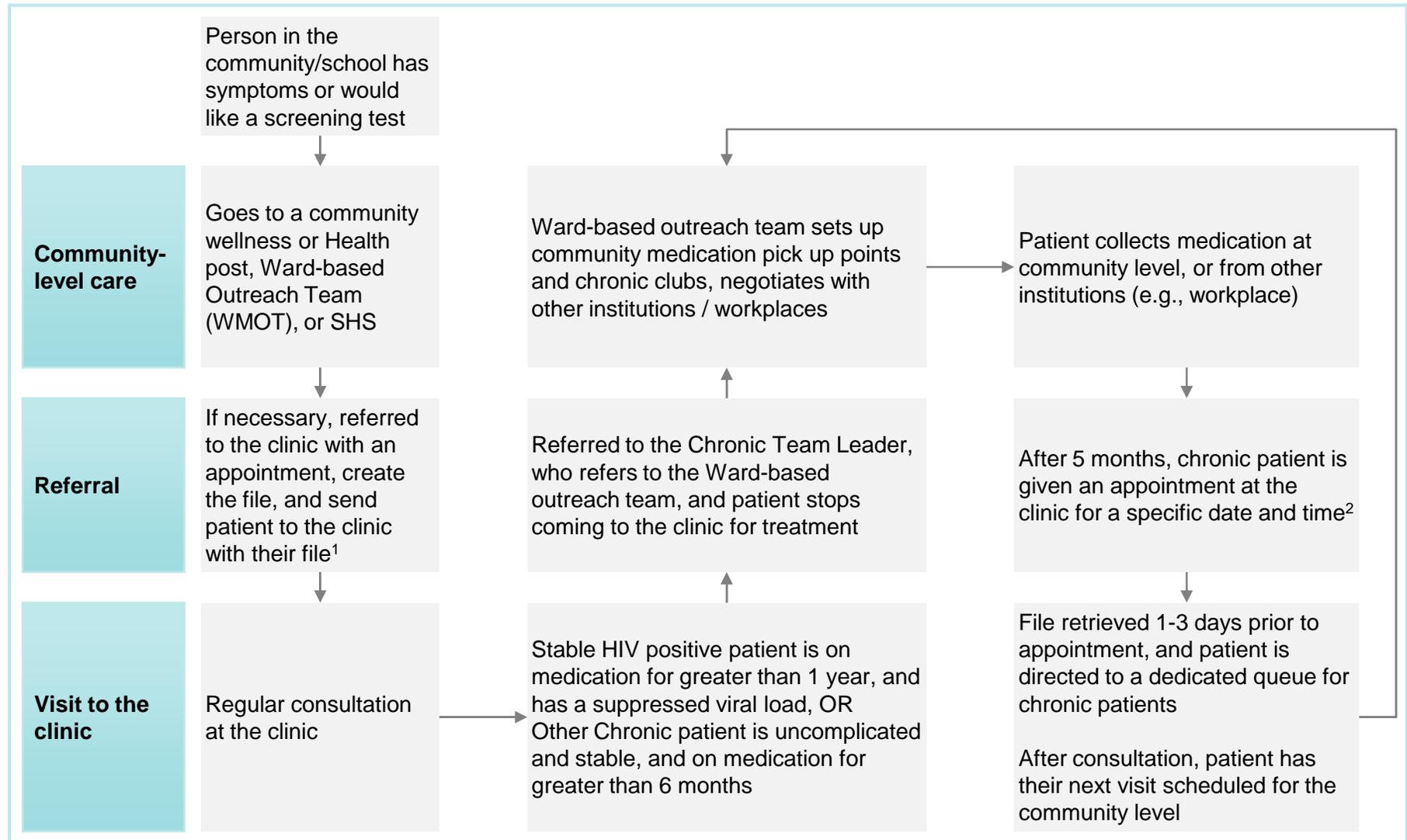
Before

After



- Currently, many patients come straight to the clinic
- An effective appointment system is one of several mechanisms to refer patients to community-based care

1 Appointments will be used to direct patients to community-level care, reducing waiting times due to influx of HIV or other chronic patients

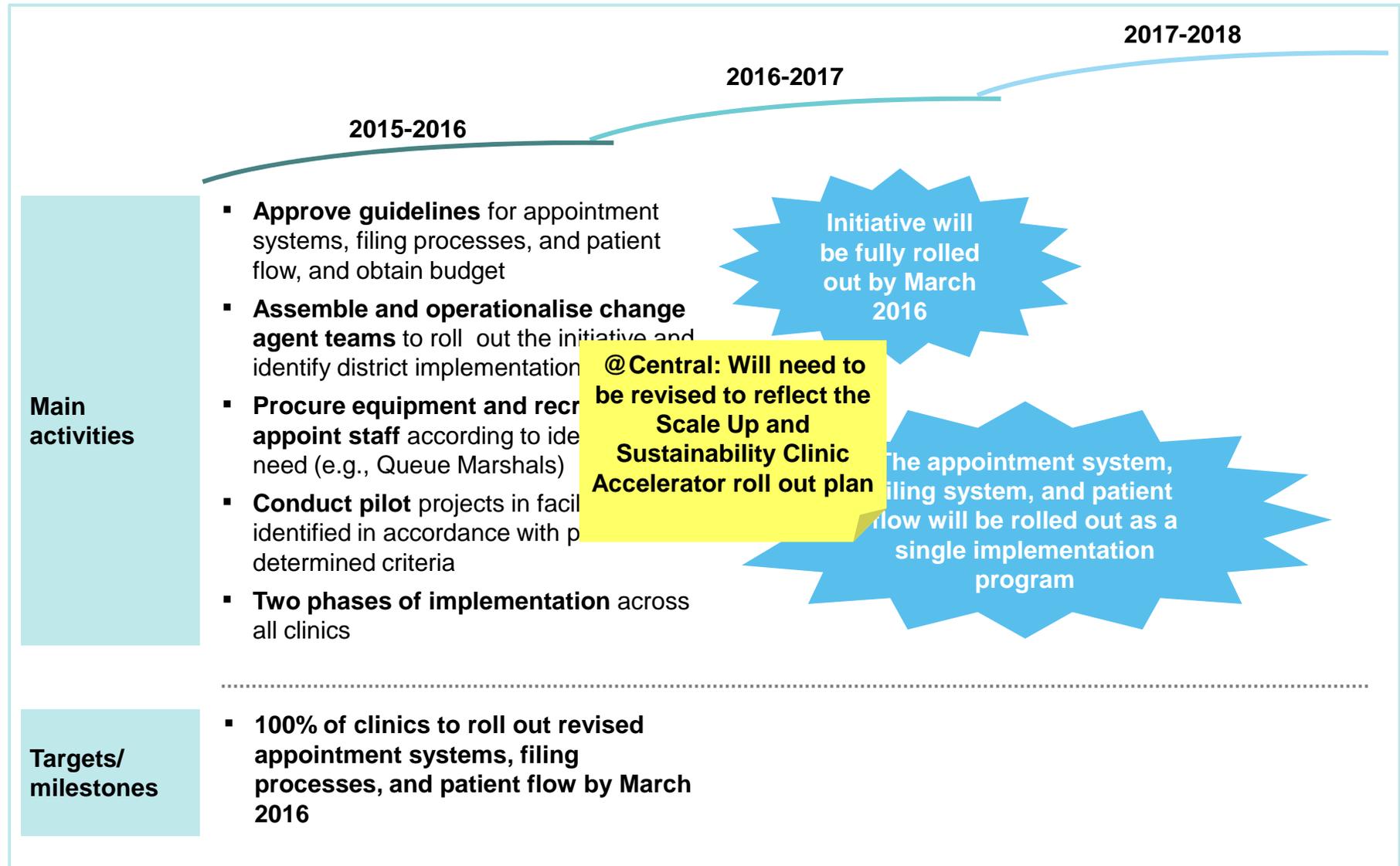


1 Note that doctors / nurses in the Ward Based Outreach Teams can also refer patients directly to the hospital if necessary

2 For HIV+ patients, WBOT nurse takes bloods, transports to clinic, and puts the results in the file in advance

1 Key activities for Initiative #1: Appointment Scheduling

1000-foot plan



2 Expand existing public call centre services

Initiative concept/details/highlights:

This initiative will implement the following

Partnerships with existing call centers.

- Every municipality and district is required by law to have a public emergency and communications center for calls by the public – currently centers exist in all provinces.
- Centers are already providing non emergency services.
- We will expand the available services through these centers, which are already linked to volunteer and full-time medical professionals who provide advice to the public
- These centers include EMS call centers – district and provincial level, as well as local government call centers and 10177 centers (local, district and metropolitan)

Provision of health-related advice and information, such as:

- Guidance on whether or not to visit a clinic.
- Clarifying side effects of chronic medication
- Provides information on the location of PHC facilities
- Provides information on health preventive measures

This will reduce the unnecessary burden of patients visiting facilities with questions that can be resolved over the phone.

Owner

- National and Provincial Department of Health.

Key stakeholders identified

- District and sub district Management
- Local Government
- Governance Structures
- NGOs
- Government Communications Departments

Required resources

- Minimal incremental infrastructure spend, and some additional cost for staff

Level of implementation

- District/ sub district level
- Provincial level

Implementation timeframe

- Start date: April 2015
- End Date: March 2017

2 There are existing public emergency communication centers in place which we would build upon



WALLY THE MASCOT
Wally 107 is our mascot who currently travels throughout the City of Cape Town area to educate children on the use of the 107 emergency number.
For more information on Wally and feedback on the 107 service please call 021 487 2745 or 021 487 2749.

POLICE • FIRE • AMBULANCE • TRAFFIC

CITY OF CAPE TOWN | IZINDO SAKHAKA | IZINDO KAPETOWN
THIS CITY WORKS FOR YOU

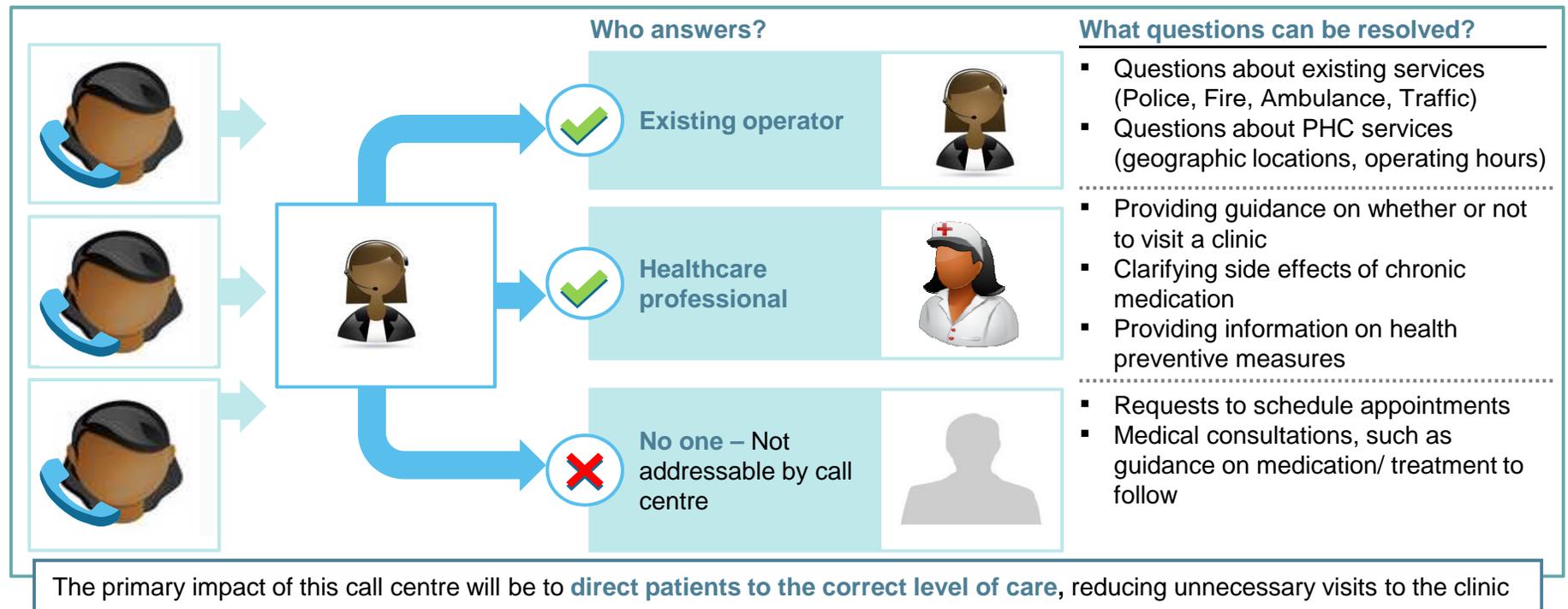
HELP!
107

Public Emergency
Communication Centre
www.capetown.gov.za/107/en/emergencyservices

- **Every municipality and district is required by law to have a public emergency and communications center for calls by the public**
- **We will expand the available services through these centers, which are already linked to volunteer and full-time medical professionals who provide advice to the public**
- **These centers include EMS call centers – district and provincial level, as well as local government call centers and 10177 centers (local, district and metropolitan)**

2 The call centre will not give medical consultation, but will give guidance on whether or not to visit the clinic through healthcare professionals

What it is ... 	What it is NOT ... 	What it could be... 
<p>A centre to provide basic guidance on...</p> <ul style="list-style-type: none"> Whether or not to visit a clinic (i.e., “Where can I get an HIV test?”) Side effects of chronic medication (i.e., “I’m on TB treatment and my urine is a deep orange, should I go to the clinic?”) Health preventive measures Location and operating hours of PHC facilities 	<p>An alternative to in-person consultation...</p> <ul style="list-style-type: none"> Providing medical consultation (i.e., “I have a cough, what should I do?”) 	<p>In the long-term, this could include</p> <ul style="list-style-type: none"> Expanded services to include scheduling of appointments and emergency medical advice (e.g., stabilizing a trauma victim while waiting for EMS) Expanded geographic coverage through virtual call lines (e.g., using metropolitan centres to serves rural areas)



NOTE: Community will be informed of medico legal implications

2 There are existing public emergency communication centres in place which we would build upon

The City of Cape Town 107 Centre was established in terms of the National Emergency Telephone Service Act of 1993¹

It is a multidisciplinary call centre which handles emergency and non-emergency calls.

For non emergency calls the centre has a separate and dedicated line with dedicated staff, including a drug dependency service (0800-helpforyou) and a service to the homeless



Existing Call Centres to be part of roll out

- City of Cape Town 107 Centre - WC
- Buffalo City Municipality – EC
- City of Johannesburg – GP
- City of Tshwane – GP
- Ekurhuleni Municipality - GP
- eThekweni Municipality - KZN
- Mangaung Municipality - FS
- Nelson Mandela Bay – EC
- Polokwane - LP
- Krugersdorp – GP
- *Other municipal centers exist, but not at the same scale*

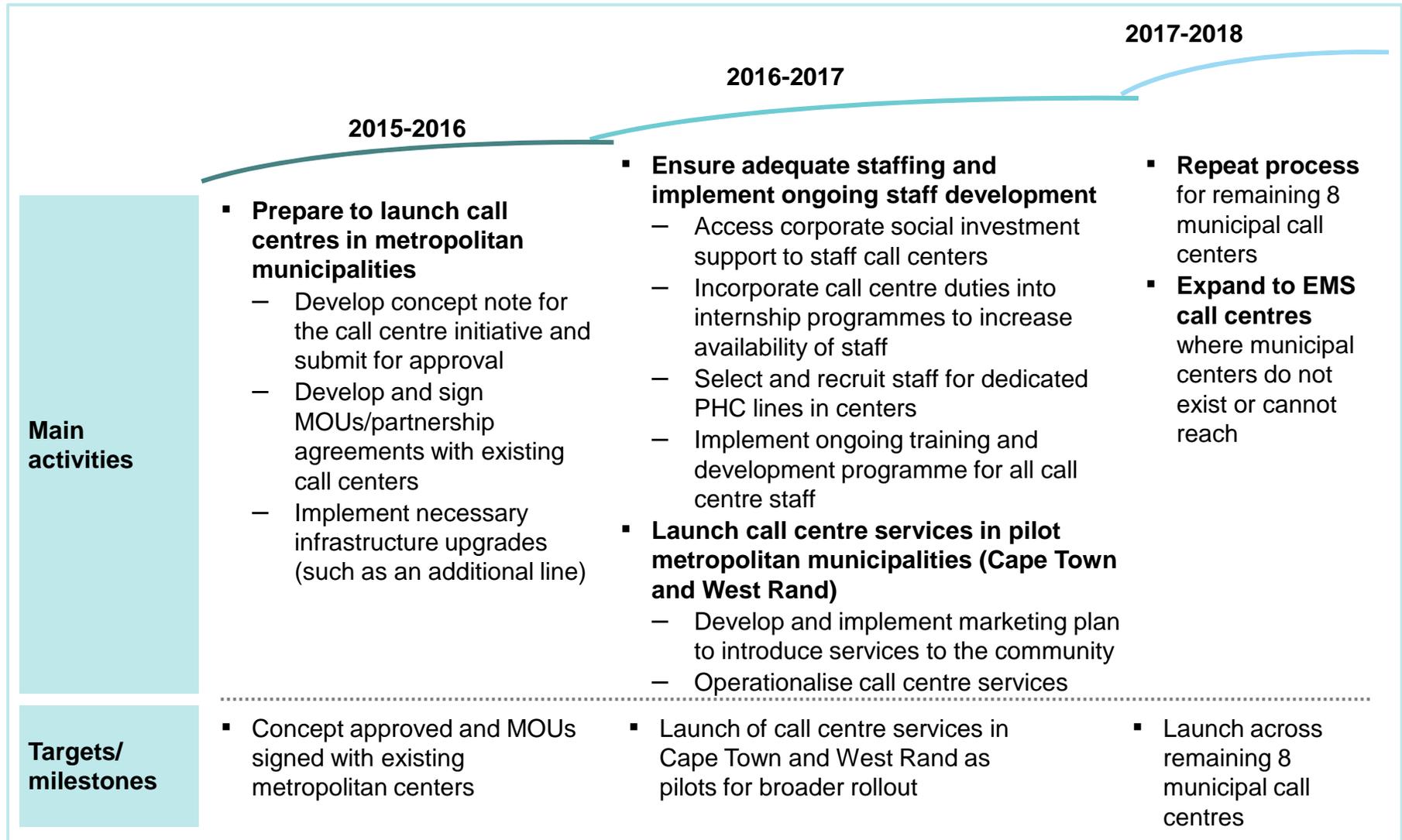
Implications

- This initiative would require **minimal additional infrastructure costs beyond an incremental phone line** as technological capacity already exists in centre.
- Medical volunteers already exist, and other sources (Corporate Social Investment, medical students doing community service as part of their internships) could present a **low-cost opportunity for additional capacity** beyond hiring full-time staff
- For **areas where municipal call centers do not exist, expanded geographic coverage is possible** through virtual call lines (e.g., using metropolitan centres to serves rural areas)

¹ The City of Cape Town 107 Centre operates on a Telkom line with no three digit number available for mobile phone users, despite the fact that there is provision made for a three digit number in terms of legislation for 112 Centres which was promulgated in the government gazette volume 508 number 30385 – 2007, but never implemented. Support from the Steering Committee in implementing this provision would greatly aid the implementation of this initiative

2 Key activities for Initiative #2: Call Centre

1000-feet plan



Major delivery fix – Initiative #3: Roll out SMS-based platform for individualized patient information

3 An SMS-based communication platform will enable the communication of individualized patient information, such as appointment reminders

Concept Overview

- The SMS systems should be able to **send short health messages, including individualized messages**
 - Status of medication for pickup
 - Reminders of appointments
 - General information such as health calendar days, importance of screenings, and advice for health problems and other health promotion messages
- **Each facility will have an SMS patient register** with patient personal details, health condition, and signature for patient consent for receiving SMS messages

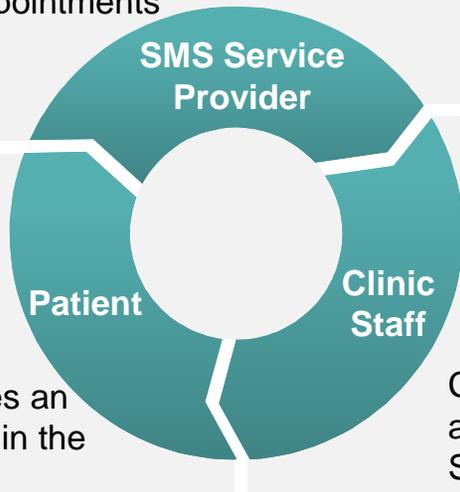


Patient receives SMS reminders of their appointments



Patient

Patient makes an appointment in the clinic



Clinic Staff

Clinic staff record appointment in the SMS system

Implementation plan

Action	Date
Establish project steering committee	Feb 2015
Conduct feasibility study	Apr 2015
Conduct pilot with suitable service provider	Jun – Aug 2015
Formulate policy on SMS communication	Oct 2015
Develop SMS communication roll-out strategy and approve budget	Dec 2015
Select service provider/s for upscaling and roll out to all clinics	Mar 2016
Full roll out of SMS system through change agent teams	Jun 2016

3 Roll out SMS-based platform for individualized patient information

Initiative concept/details/highlights:

This initiative will require the roll-out of the SMS patient communication platform to communicate individualized information to patients, including appointment reminders which will manage and balance the workload at the clinic, thus assisting to manage waiting times whilst reducing the defaulter rate for booked appointments

The SMS platform will consist of the following

- The SMS systems should be able to send short health messages, including individualized messages such as status of medication for pickup, reminders of appointments, and general informations such as health calendar days ; important of screenings and advice for health problems
- Each facility will have an SMS patient reminder register with patient personal details , health condition, and signature for patient consent for receiving SMS messages
- The systems should cater for all eleven languages but will especially cover languages used in the area
- SMS systems should provide feedback mechanism from patients about quality of care and essential message transfer, such as inability to honor appointment
- The systems should be able to monitor number of patients connected at any given time though it should seek to cover all follow up patients
- The systems should have an opt out option
- Patient will receive a reminder for their appointment 3 days before their actual appointment

In order to roll this SMS platform out, we will need to do the following

- A network service provider will be contracted to provide network connectivity for all PHC clinics
- All staff should be trained on registration of patient on the systems
- On registration all patients will be required to bring their cell phone numbers
- Cell number of the patient will be registered on the system and connected to a network
- Patient will be advised to update their cell numbers as when and required for continued communication

Owner

- NDOH

Key stakeholders identified

- Clinicians
- Administrative staff
- Patients/ Communities
- Governance structures
- ICT/ Infrastructure

Required resources

- ICT investment in the overall technology platform being developed across PHC Clinics

Level of implementation

- Province

Implementation timeframe

- Start date: February 2015
- End Date: December 2016

Impact: Whilst enabling the facility to rationalize the limited human resources, performance/working standards creating a fair working environment and mitigating the space limitations, the added impact will be the perceived as fair and human by patients as it considers their views on recommended clinic visits, visits are fairly managed and they have self-determined time to carry out their personal activities

3 In order to implement, we will need to follow the steps below

	Description	What is different and why
<p>1 Assess feasibility through piloting</p>	<ul style="list-style-type: none"> Conduct feasibility study to pilot SMS communication system at selected clinics 	<ul style="list-style-type: none"> Currently there is no SMS system. SMS systems will be used to remind patient for their appointment and prevent an influx
<p>2 Training of staff to register patient to the system</p>	<ul style="list-style-type: none"> All staff will be trained regarding the registration of patients during the clinic visits 	<ul style="list-style-type: none"> Training of staff will assist in registration of more patient in an efficiency and effective way
<p>3 Registering of patient into the systems</p>	<ul style="list-style-type: none"> Patient will be registered by trained staff and be advice to informed the staff if and when they changed their contact details changed 	<ul style="list-style-type: none"> Patients will benefit by receiving reminders, health calendar events and personal related health information The system will also allow patients to inform healthcare providers of the inability to keep the appointment allowing appropriate intervention
<p>4 Linking up patient in the network systems</p>	<ul style="list-style-type: none"> All registered patients will be given the option to opt out. The systems should allow patient to give feedback on the quality of the services and also if they are able to keep the appointment. 	<ul style="list-style-type: none"> Currently the systems is not yet in place.
<p>5 Establishing SMS register in all clinics across the country</p>	<ul style="list-style-type: none"> All PHC clinics will have a register for follow up patients on the system with the consent forms attached. 	<ul style="list-style-type: none"> The register will be updated and monitored regularly. Patients will be giving the staff permission to contact her/him according to arrangements Consent forms necessary for upholding patient privacy and human rights.

3 In order to implement, we will need to follow the steps below

	Description	What is different and why
6 Integrating health messages in the systems	<ul style="list-style-type: none"> The system will be utilized for other important health promotion messages Patient will be informed about health messages such as TB months, signs and symptom of TB, Vaccines campaigns, and other health threats e.g., status of Ebola in SA 	<ul style="list-style-type: none"> The initiative will help build a health literate citizenry Patients will have an opportunity to learn more about their health and other conditions that can affect their health
7 SMS process	<ul style="list-style-type: none"> Identify service provider e.g. : Vodacom, mtn, Telkom The central place where the system will be based or communicated from.E.G :national, province, district or PHC level 	<ul style="list-style-type: none"> The department shall have to do cost benefit analysis to identify the service from which it will derive the greatest value for money Understanding the equipment shall inform the resource mobilization process
8 The programming of specifications needed	<ul style="list-style-type: none"> The appointments will be collected at the end of the day It will be entered in to the PC so that the reminder can be auto generated according to the system and should be 48 to 72 hours before the appointment date The system should make provision for the patient to respond “yes the appointment will be honored” by punching a certain number or “no I cant honor the appointment” by punching another number This information is retrieved by the data capturer who makes the appropriate intervention; either confirming the appointment for file retrieval or calling the patient to understand the challenge and reschedule appointment 	<ul style="list-style-type: none"> The process shall be centrally operated allowing effective utilization of the system promoting reliability and accountability It will enhance other processes associated with the appointment systems e.g. file retrieval This is a two way system that strengthens provider-patient relationship, making a patient an equal partner in the health service provision equation and building trust in the system It reduces defaulter rate

3 In order to implement, we will need to follow the steps below

9 Level of accountability

Description

Role of national

- Approval of plan
- Approval and allocation of budget
- Management of service provider contract
- Policy

Role of province

- Support in terms of putting systems in place and play oversight in terms of monitoring, to the districts on implementation of the policy
- Marketing of the system to the other stakeholders ensuring training on the system

Role of the district

- Implementation of the system at sub-district and facility level
- Support the marketing of the system at community level

Role at sub-district/ facility

- Ownership and buy-in at ground level
- Implementation at the ground level
- Monitoring and evaluation of the system through surveys

Role of the community

- Active participation of the community through community mobilization structures, IMBIZOS, Ward Meetings

What is different and why

- This will lead to the legitimization of the project
- Enhance resource mobilization
- Will enhance the roll-out of the system
- Will guide the relationship between the service provider and the department

- Will legitimize the project at provincial level
- Will lead to buy in to the system by different stakeholders accentuating the efficiency and effectiveness of the implementation of the system

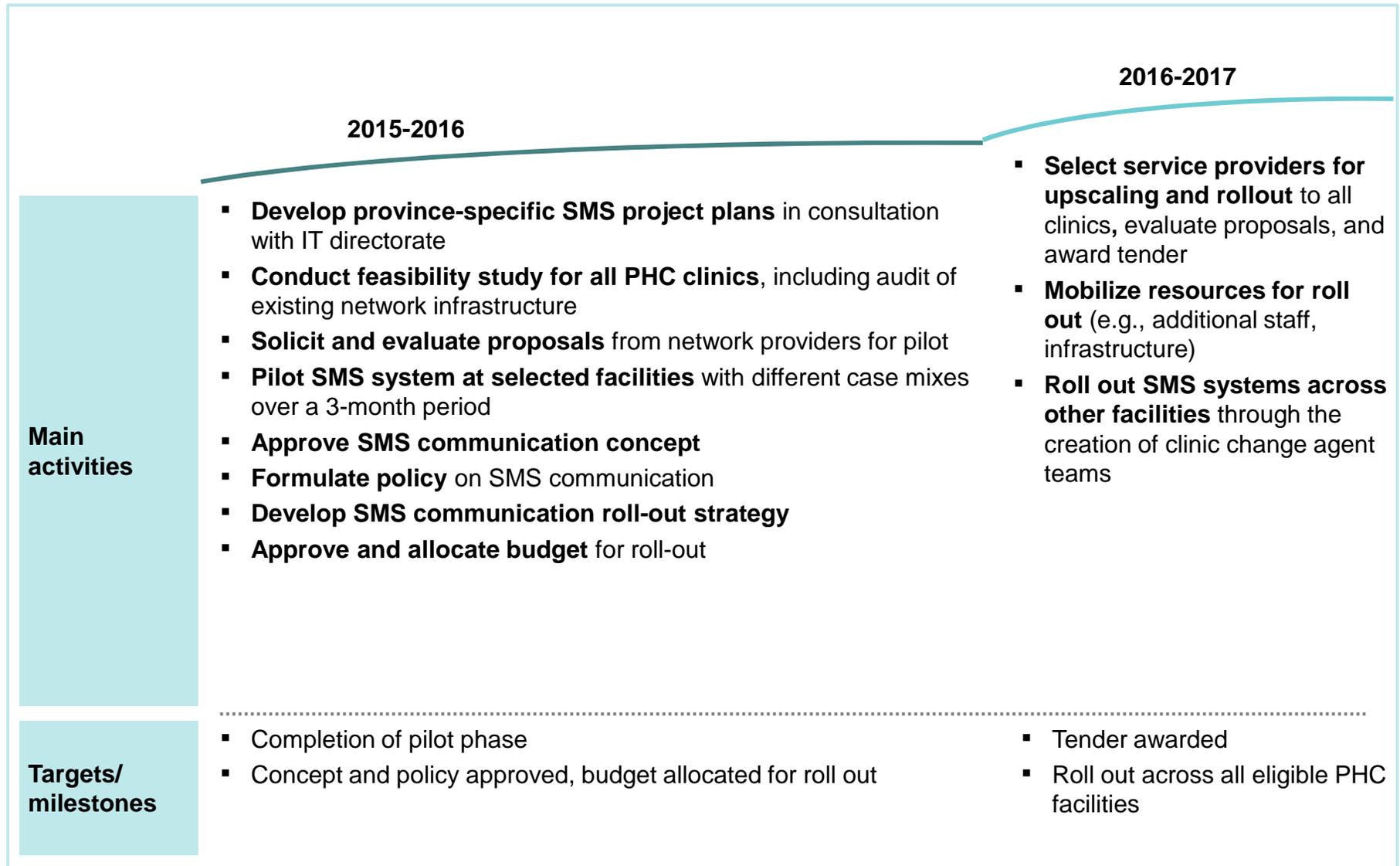
- Ensure effective organizational design to enhance project implementation.
- Establish sound community relations to promote community participation

- Solicit commitment from frontline workers to enhance the effective implementation of the system
- To measure and maintain the quality of the experience of care

- To acquire buy-in and ownership at community level to promote participation in the system by patients
- To solicit oversight at community level by community structures

3 Key activities for Initiative #3: SMS-based communication platform

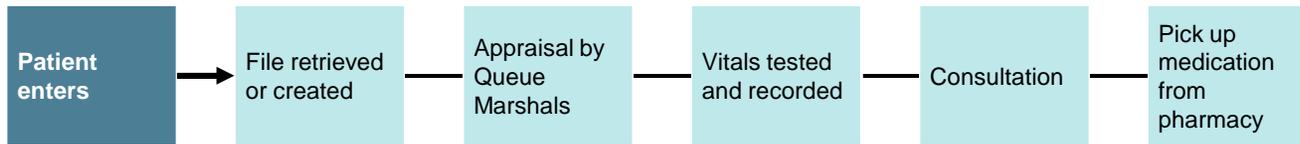
1000-feet plan



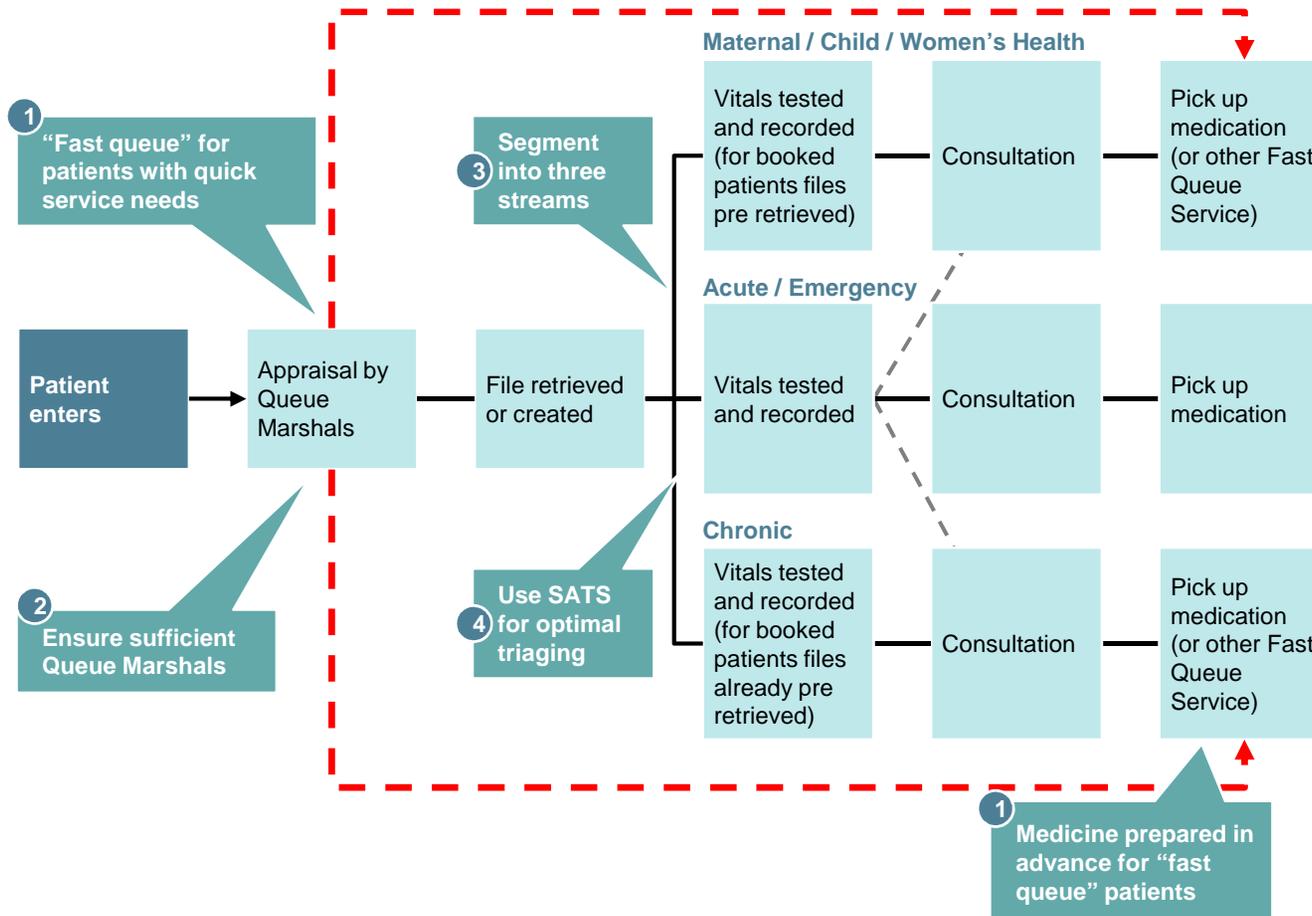
Major delivery fix – Initiative #4: Improve efficiency of patient flow

4 Chronic patients will be able to pick up medicines without waiting for their files or vitals to be taken, among other changes to patient flow

Status quo – All patients



Revised flow



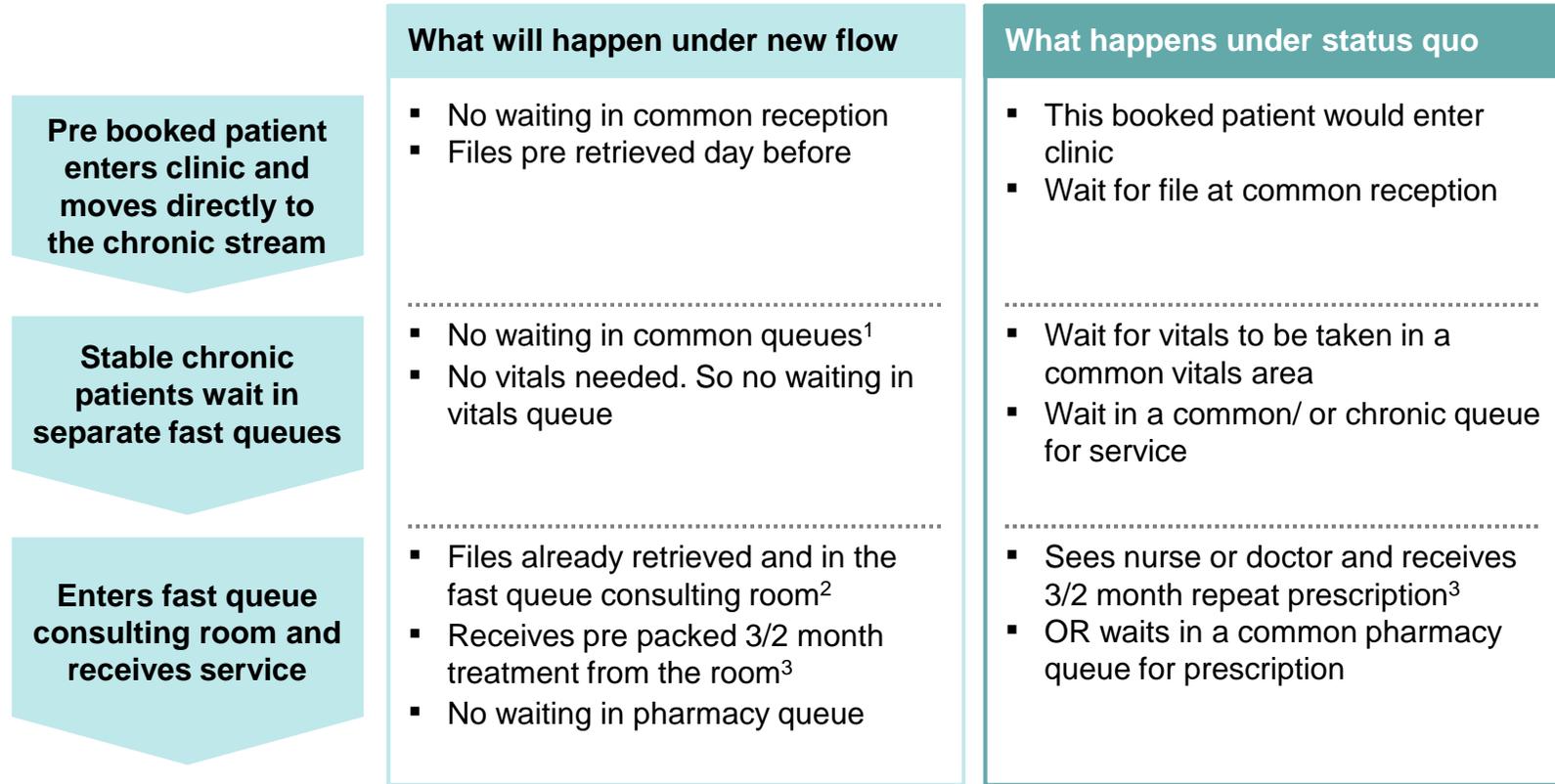
Interventions:

- 1 Create a queue to fast-track patients with quick service needs** (e.g., chronic patients, family planning, and immunizations) through the implementation of "Fast Queues"
- 2 Ensure that prescribed number of Queue Marshals are appointed** to streamline patients efficiently and manage queues
- 3 Implement three separate queues and streams of care** across all PHC facilities, which has been shown to reduce waiting times overall by segmenting patients with chronic, acute, and maternal / child health needs
- 4 Support facilities to implement a triage system**, specifically the South African Triage Score (SATS), which has been shown to reduce under- and over-triaging

Impact

Though significant variability exists, ICDM pilot sites were able to **decrease the median total time spent by chronic patients by ~30%** through a sub-set of these interventions

4 In the example of a chronic stabilized patient, unnecessary steps in the process are eliminated or streamlined to reduce waiting times¹



1 The other chronic stream consulting rooms now see un-stabilised NCDs, HIV and TB patients
 2 The fast queue consulting room within the chronic stream sees stabilised chronic patients with NCDs, HIV and TB. Patients seen here spend no more than 5 minutes.
 3 If systems in place, these patients would not have to even come to the clinic for their 3/2 month repeat prescriptions, but would receive it outside (CCMDD or home delivery through WBOT)

4 These interventions will lead to more efficient patient flow and shorter waiting times

	From	To
1 SATS Triageing	<ul style="list-style-type: none"> ▪ Seriously sick patients wait in queues ▪ Adverse events happening whilst waiting for service 	<ul style="list-style-type: none"> ▪ Sick patients are put first in the queue ▪ SATS triaging system ensuring that complications due to waiting in queues are reduced
2 Queue marshals	<ul style="list-style-type: none"> ▪ Patients getting lost in PHC and wandering about ▪ Disruptions of service due to such patients being at the wrong service point 	<ul style="list-style-type: none"> ▪ Queue Marshalls directing patients where to go
3 Three streams of care	<ul style="list-style-type: none"> ▪ Patients with multiple conditions having to visit different service points in the same facility causing increased total waiting time ▪ The same patient having to have multiple visitations a month to the facility for various services ▪ Patient do not know if services will be received ▪ Bottle necks at a single reception, vital signs area and consultation rooms ▪ Overcrowding due to multiple visitations 	<ul style="list-style-type: none"> ▪ Such patients will go to only one service point and get all services there ▪ No reason for multiple visitations for different services ▪ Patients receiving all services in one day ▪ Reduced bottlenecks by patients streamlined to their respective 3 areas ▪ Single visits by such patients reducing the overall crowding
4 Fast queues	<ul style="list-style-type: none"> ▪ Stable patients (e.g. stabilised chronic patients, family planning, and maternal and child care) having to wait long in usual queues ▪ Overcrowding in the clinics with stable patients waiting in queues 	<ul style="list-style-type: none"> ▪ Such patients in a 'fast queue' service point not having to wait for their quick service needs ▪ Designated waiting and consulting areas for stable patients

4 South African Triage Score – Overview

What is triaging, and why is it so important?

Triaging is the process of determining the priority of patients' treatments based on the severity of their condition and is essential in all healthcare facilities

The characteristics of an ideal triage system include the following:

- Primarily identifies patients with life-threatening conditions
- Requires minimal training
- Should be easy to use
- Able to process many patients quickly
- Provides information regarding services and waiting times
- Decreases waiting area congestion

The South Africa Triage Score (SATS) has been validated in public, private health care setting as well as pre-hospital (PHCs).

Why consider implementing SATS over other triaging systems?

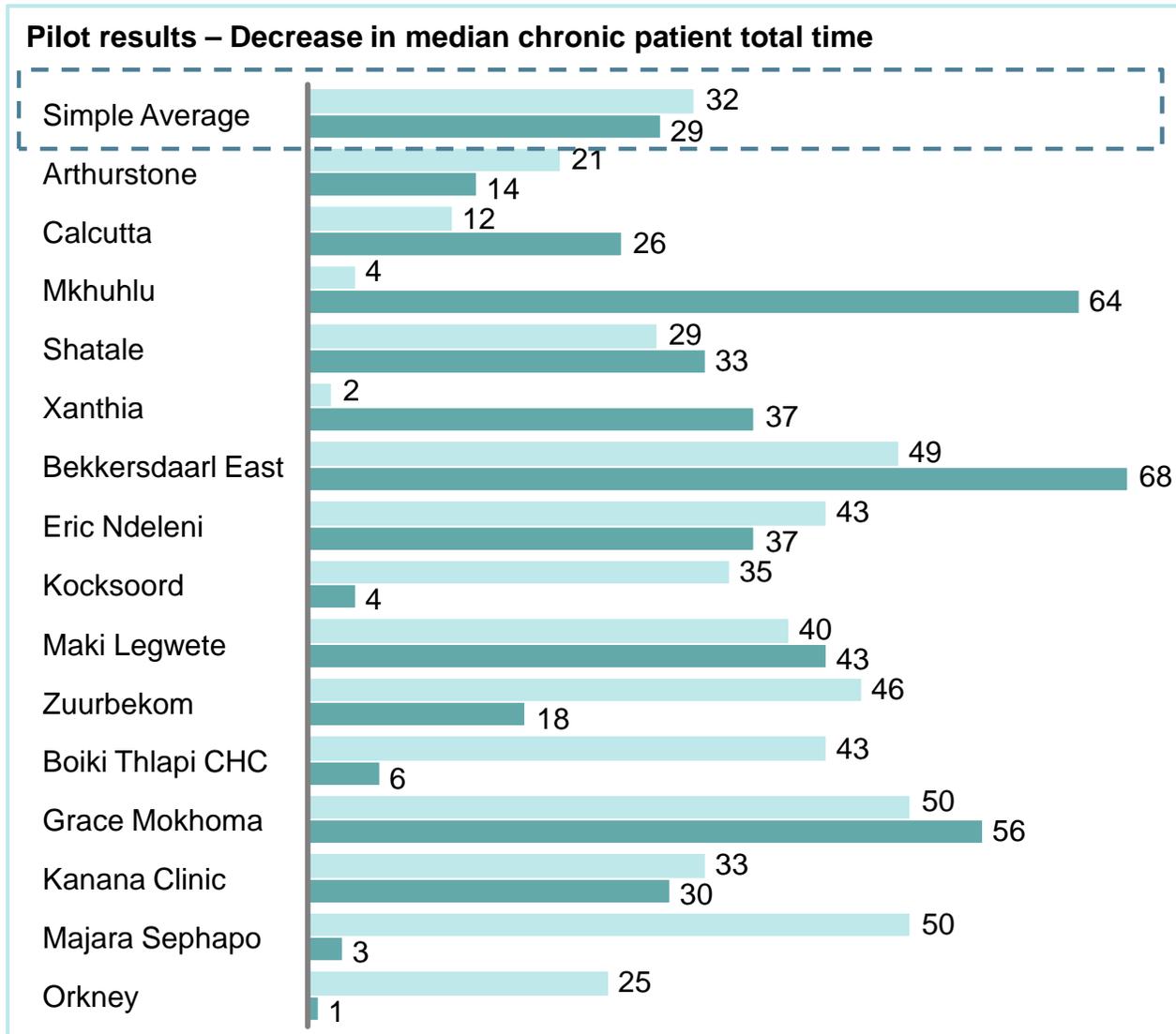
An argument for using the SATS in South Africa was that it would avoid the extensive training required to implement other triage systems such as the Manchester Triage, Canadian Triage Assessment Scale and Australian Triage Score. In this study, it was shown to be more effective in terms of under triaging as compared to other triaging systems. Over triaging did happen using SATS (although within the acceptable range of 50% as per American College of Surgeons Committee on Trauma (ACSCOT) guidelines). This is a pitfall considering the high rate of chronically unwell patients in South Africa (due to HIV/TB). However, in this study, it compared better to other triage systems in terms of over triaging.

The study concluded that a 'senior health care professional's discretion' is essential, not only to ensure adherence but also to oversee correct patient endpoints, particularly to downgrade priority levels in chronic disease.

Major delivery fix – Initiative #4: Improve efficiency of patient flow

4 The implementation of some of these guidelines, at ICSM pilot sites, has demonstrated potential to reduce median total times for chronic patients

Percentage change from May 2014
 Percentage change from baseline

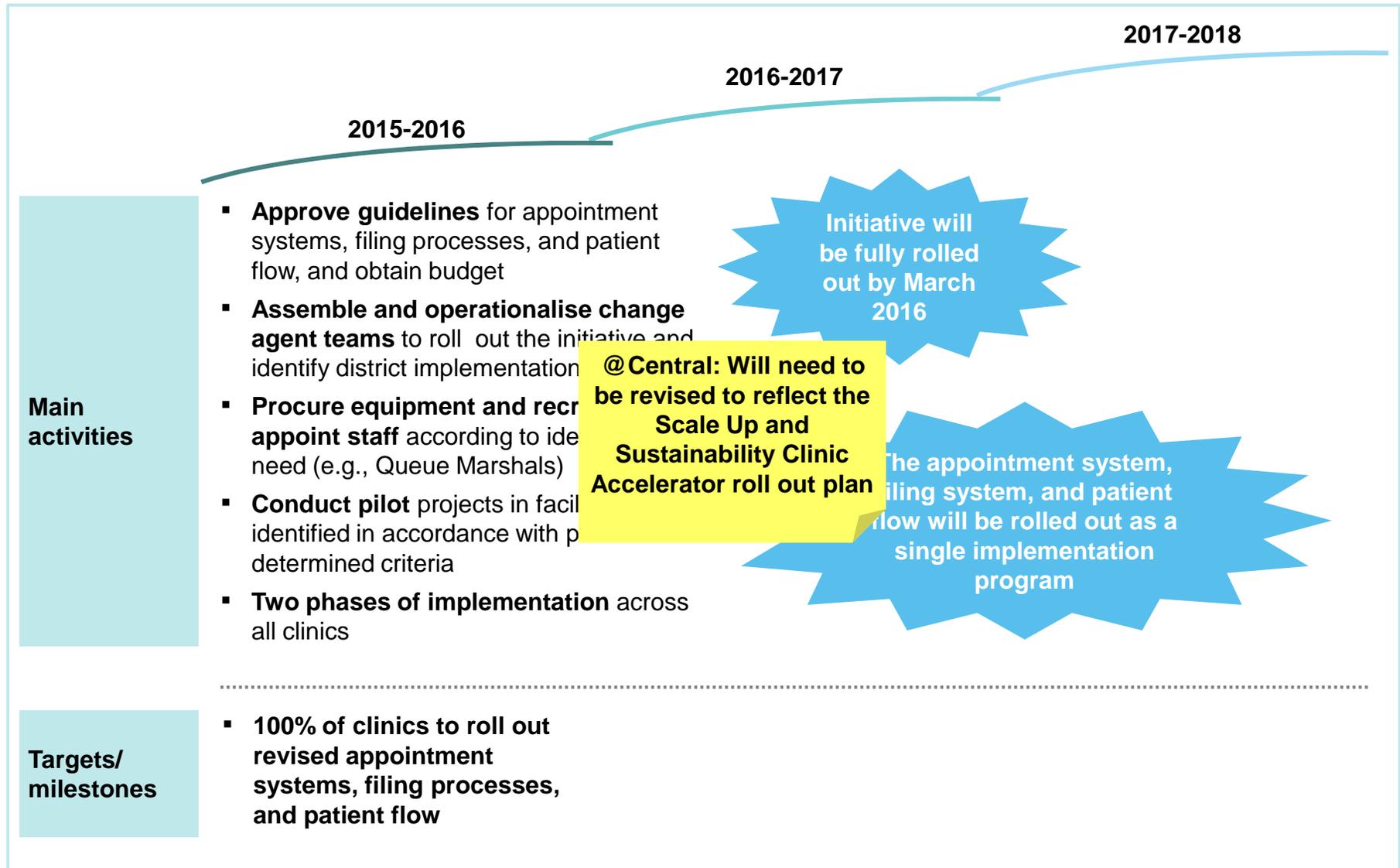


Takeaways
 Though significant variability exists, ICDM pilot sites were able to decrease the median total time spent by chronic patients by ~30%.

SOURCE: GAUTENG QA

4 Key activities for Initiative #4: Improve efficiency of patient flow

1000-foot plan



Major delivery fix – Initiative #5: Standardize paper filing processes at the clinics for ease of retrieval

5 Standardizing the paper filing processes will have both a short- and a long-term impact on patient experience and waiting times

Concept Overview

“Reset the system” - Reorganize and streamline the existing filing system

Selected steps

- **Consolidate all records** for each patient into a single file, instead of the multiple records
- **Thereafter, transfer data from multiple records to a single patient record**, and file by month of birth, ID number, Passport and Asylum letter.
- **Review existing records to identify dormant files** which can be archived to decongest the filing area
- **If necessary, install additional filing infrastructure** (e.g., cabinets) and roll out use of standardized patient folder
- **Arrange shelves** by calendar month and include color codes **for easy retrieval**

“Change the process” - Implement redesigned filing processes

- **File by month of birth and ID number**
- **Begin to use Home Affairs ID numbers on files**, creating a unique identifier which will ease migration to electronic database¹
- **Enforce guidelines on re-filing** immediately after appointments
- **Retrieve files for those with appointments 1-3 days prior** to their appointment

Impact

- **Short-term impact**
 - Implementing a selection of these steps at four of the ideal clinic pilot sites reduced waiting times for files by ~50%
- **Long term impact**
 - By consolidating paper records, this initiative will enable the long-term shift to electronic filing



¹ Note that access will not be denied to those patients without, or having challenges with, some form of identification.

Major delivery fix – Initiative #5: Standardize paper filing processes at the clinics for ease of retrieval

5 The current state of filing is disorganized and congested, causing significant bottlenecks in reception

Space inside the filing room is extremely limited (extremely difficult to walk between shelves)



“I waited from 4:30 [am] and was fourth in line [when the clinic opened at 7:30] but they only gave me my file at 9”
-Patient interview¹

Space inside the filing room is extremely limited (extremely difficult to walk between shelves)



“We have 88 000 patient files. Nine people work in these two rooms [roughly ~20m²]”
- Admin assistant interview¹

Space inside the filing room is extremely limited (extremely difficult to walk between shelves)



“My back hurts by the end of the day – it takes too long to find these files”
-Admin assistant interview¹

¹ Translated

SOURCE: Clinic visits

Major delivery fix – Initiative #5: Standardize paper filing processes at the clinics for ease of retrieval

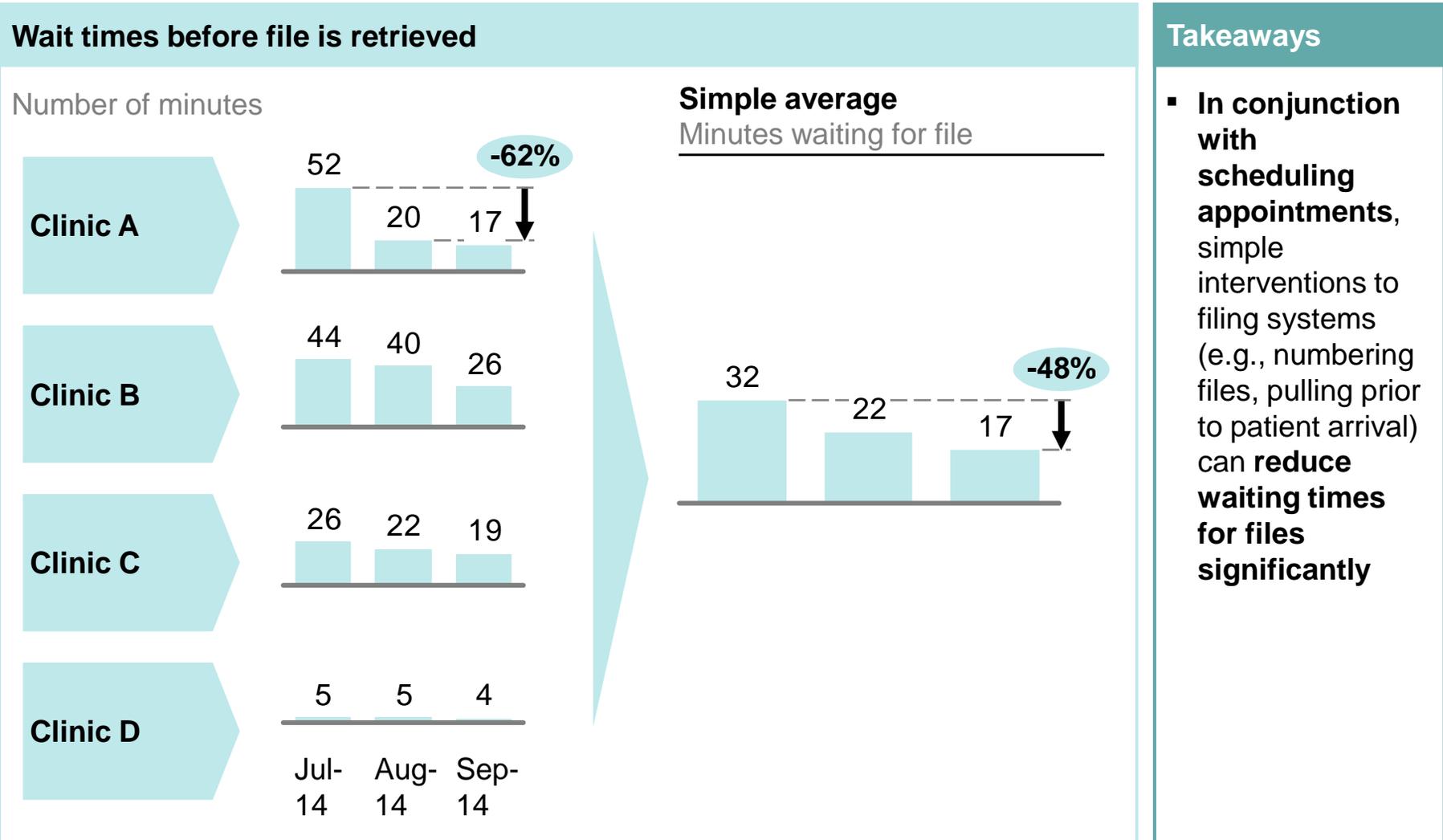
5 There are many root causes of the disorganized and congested filing system today



<u>Root cause</u>	<u>Description</u>
1 Multiple files for each patient	<ul style="list-style-type: none">▪ Staff duplicating files due to difficulty of accessing existing files▪ New files created for each visit of the patient based on their condition▪ More Information and documents needed to open a file▪ Patients give wrong information leading to duplication of files▪ No “just in time” filing in place, so files get lost and need to be duplicated
2 Poor labelling leading to delays in retrieval	<ul style="list-style-type: none">▪ The use of first 3 letter and surname in communities where that does not provide a unique identifier (due to many common last names)
3 Lack of proper archiving	<ul style="list-style-type: none">▪ Archiving process requires an investment of time, though it saves time in the long run▪ Staff do not all understand the means by which they can archive files per policy▪ Lack of provision of information on deceased patients whose files should be dormant

Major delivery fix – Initiative #5: Standardize paper filing processes at the clinics for ease of retrieval

5 Based on the impact achieved in a lean diagnostic at four of the ideal clinic pilot sites, these simple interventions to filing and appointments can reduce waiting times for files by ~50%



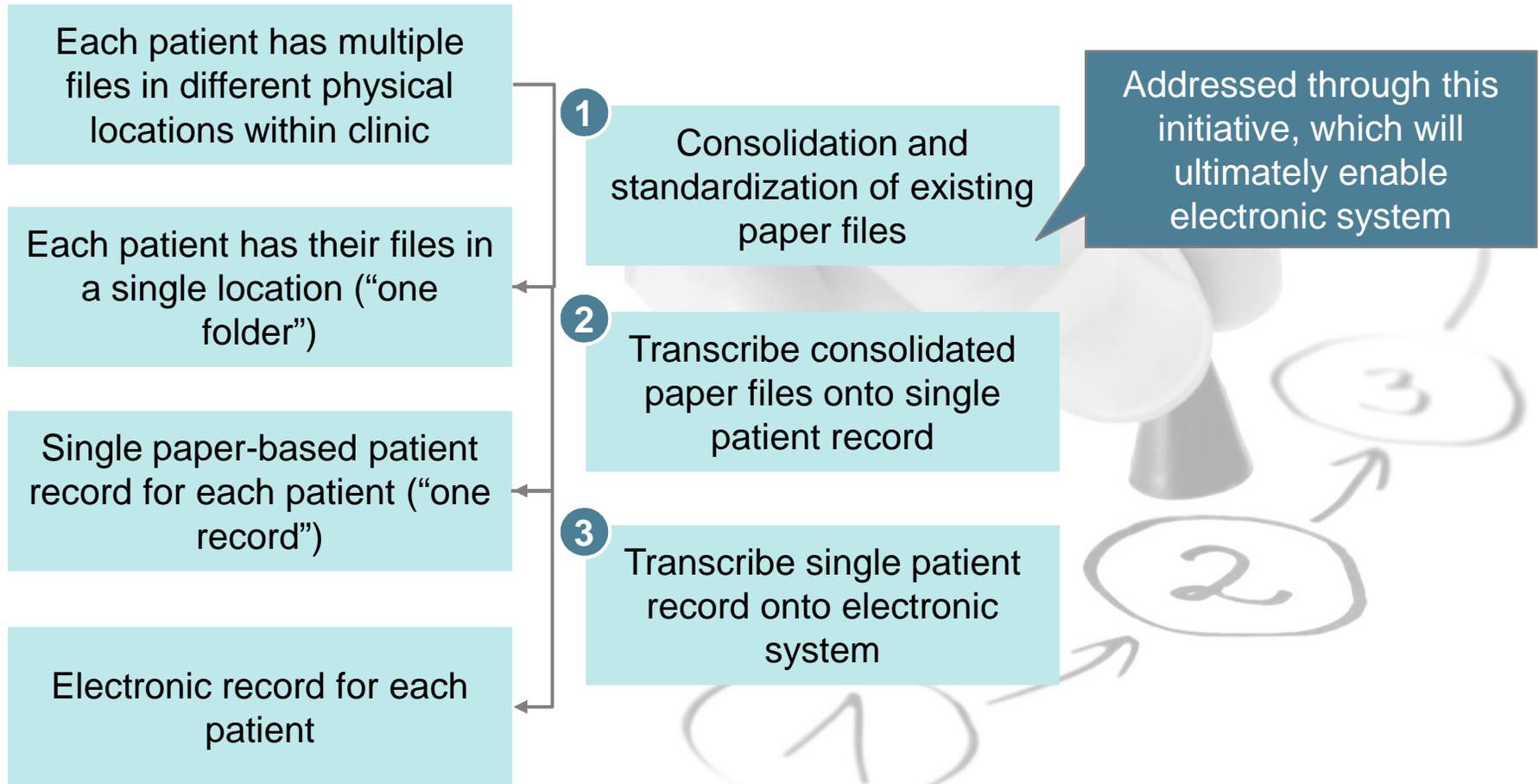
SOURCE: Gauteng Health Quality Assurance data, team analysis

Major delivery fix – Initiative #5: Standardize paper filing processes at the clinics for ease of retrieval

5 In addition to having an impact in the short-term, this initiative will enable the longer-term solution of electronic filing

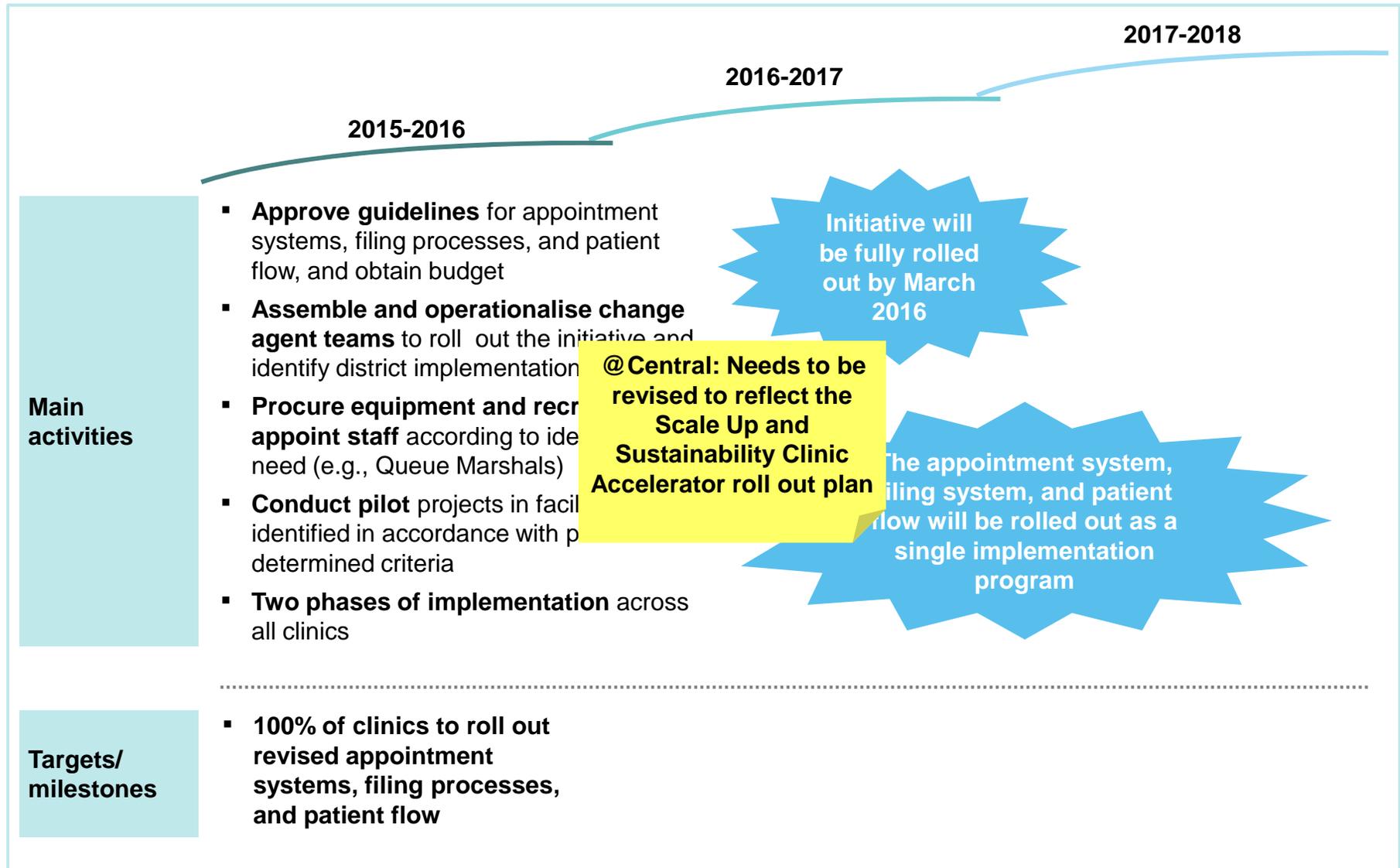
Stage of transition

Action required



5 Key activities for Initiative #5: Standardize filing process

1000-foot plan



6 Support clinics to adjust hours / days of operation to increase accessibility and reduce waiting times

Objective – To adjust operating hours / days and staff shifts at PHC facilities to improve patient experience

Key Actions

1 Conduct rapid baseline assessment of demand “hotspots”:

Use existing data (including clinic service utilization / headcounts through DHIS and geographic archetypes (e.g., CBDs)) to identify priority “hot spots”. Follow up with 1-month baseline assessment of patient needs at clinics in “hot spots” to identify specific clinics which require adjustments in operating hours / days and staff shifts

National negotiations to establish a common understanding should begin in parallel

Completed by May 2015



2 Negotiate extended hours / days or adjustment of staff shifts:

Once national negotiations are concluded, district-level discussions will occur between district / province officials and labor organizations and staff, to come to a decision on clinic-by-clinic solutions, through reviewing the results of assessment

Discussions with lab members suggest that, **once started, these negotiations could feasibly be completed within 4-6 months**

Completed by November 2015



3 Market the new hours to the public:

Communicate the revised hours to patients using clinic committees and other local governance structures

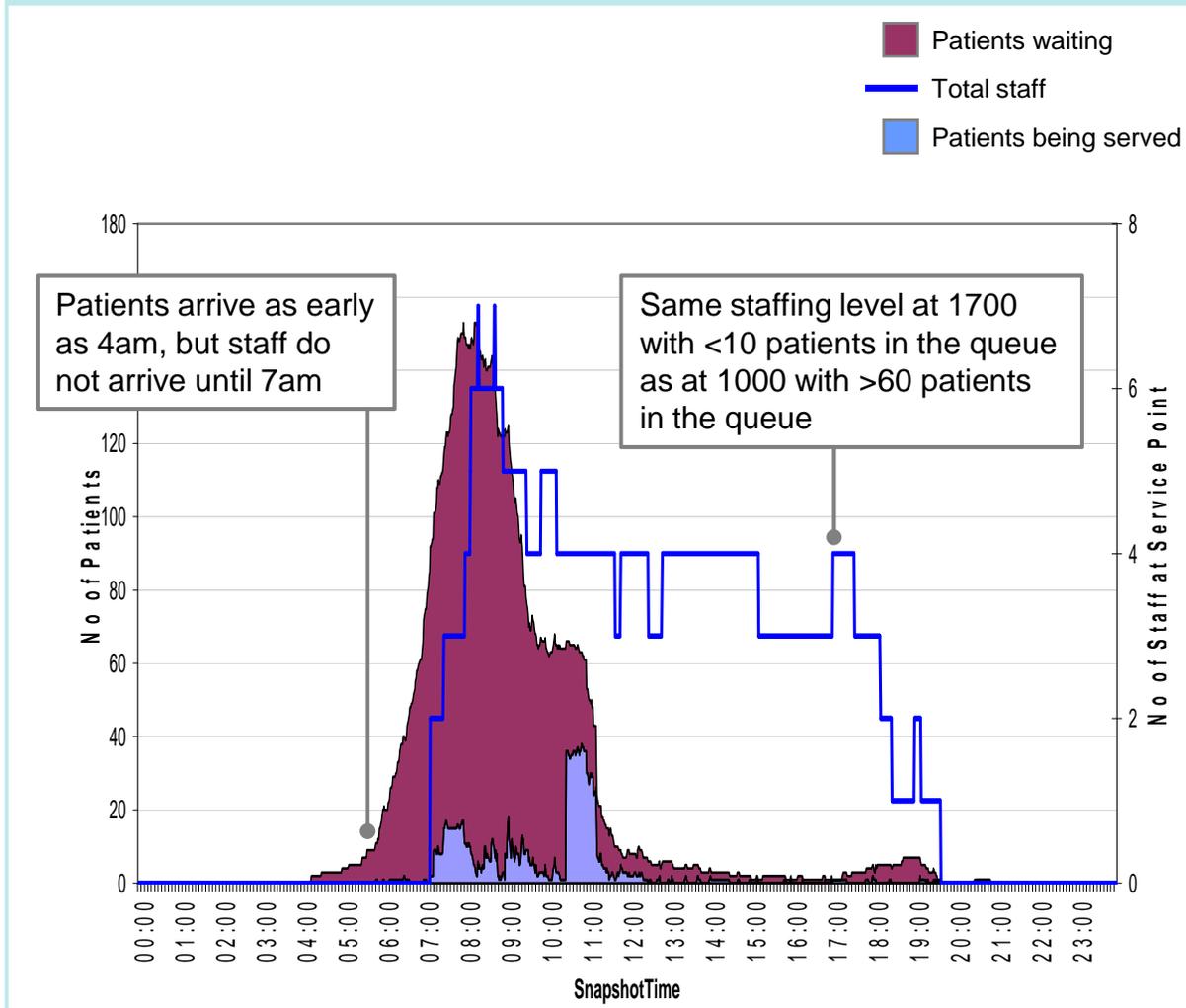
Completed by December 2015

Impact

- In one study done in Western Cape, **80% of patients arrived before clinics open, and in four of the ideal clinic pilot sites, 60% of patients arrive before or within the first hour of the clinic opening.**
- This initiative will help districts **rapidly assess demand and adjust hours / days to work for patients, to improve the patient experience and decongest clinics** in the mornings

6 Many patients need different operating hours and staffing levels to accommodate their needs

Mismatch in patient arrival times and staffing levels / operating hours

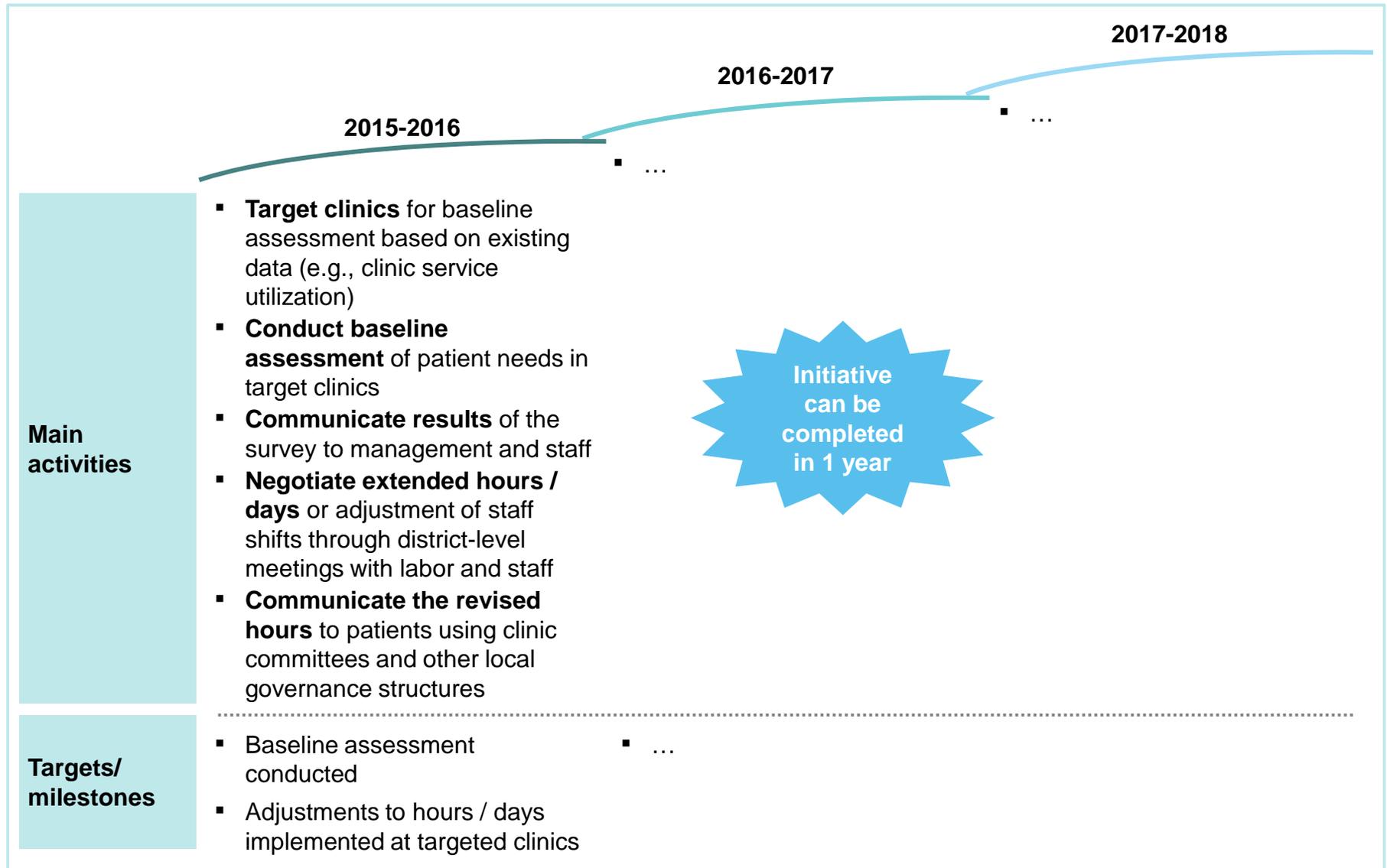


Key issues

- **Operating hours:** Traditional operating hours do not always work for patients, due to
 - Lack of transport at other times
 - Patients with day jobs or who are scholars, and need to receive care before the day begins
- **Staffing levels:** Further, staffing levels are not always adjusted to accommodate patient loads, especially in the morning
- **Staff utilization:** Furthermore, staff are not always available to serve patients starting at the official opening time, and can take significant breaks

6 Key activities for Initiative #6: Adjust hours / days of operation

1000-foot plan



7 Implement electronic queue management systems

Concept Overview

- When patients arrive, they **check-in at a terminal which assigns them to a queue** based on their stream of care, and gives them a number for their place in the queue
- **Numbers are then displayed on a screen and called on a PA system** when the service provider is ready for the next patient
- Patients can see the current number being served, and **adjust their expectations of waiting times**



Implementation Overview

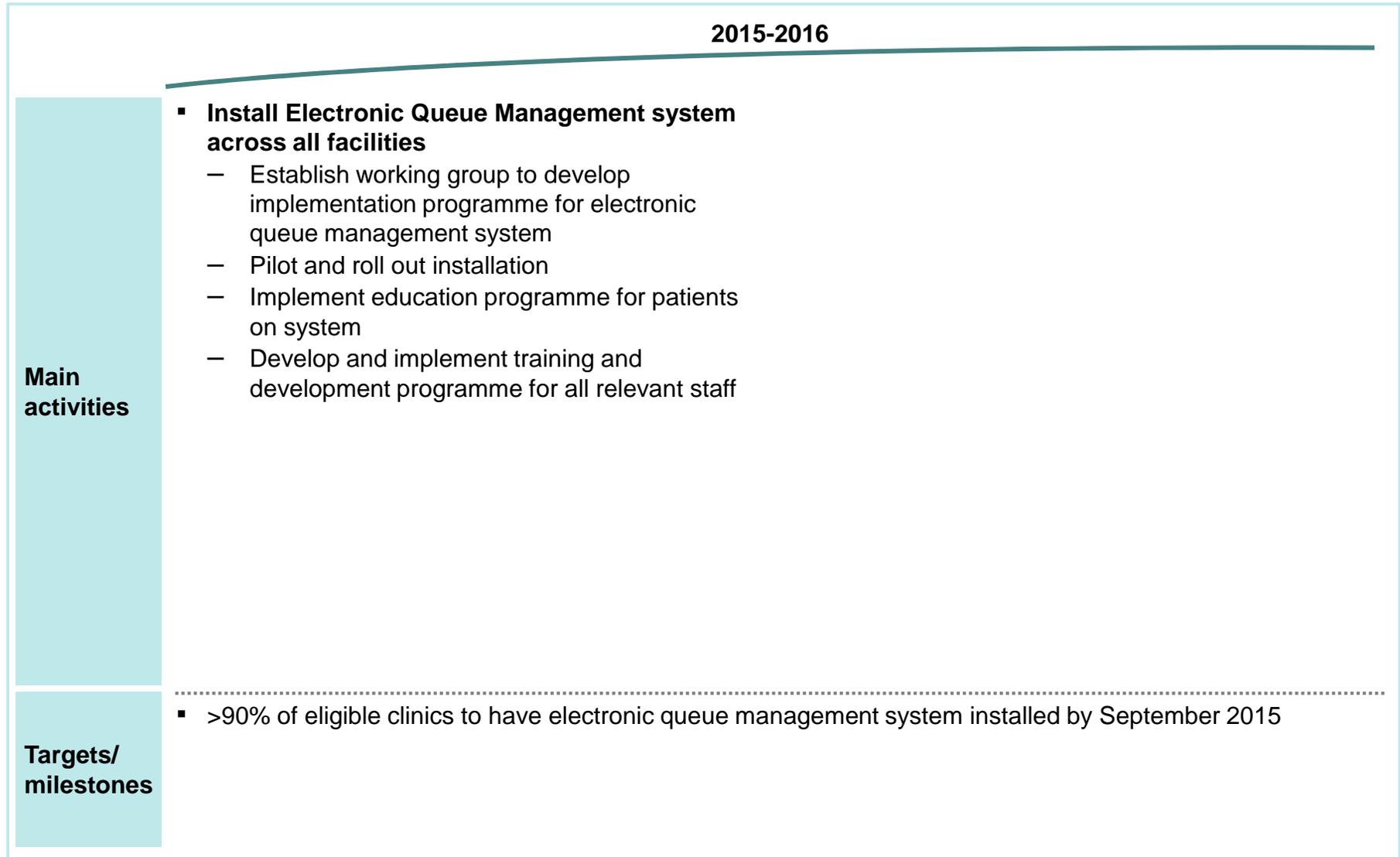
- **Pilot will be conducted in a small number (~10) of high-volume clinics** to refine implementation plan and criteria for roll out
- **System will then be rolled out to high-volume clinics** (e.g., clinics with >4000 patients per month) incorporating lessons from the pilot

Case Example



7 Implement electronic queue management systems

1000-feet plan

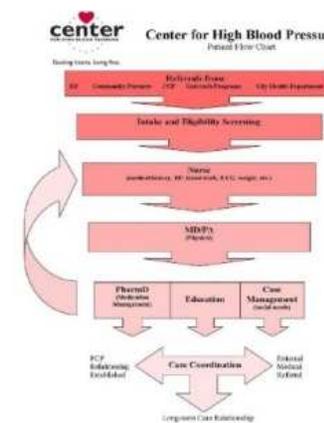


8 Communicate clear expectations for Waiting Times and process of care

This initiative will roll out several visible changes within PHC clinics to help communicate clear expectations to patients

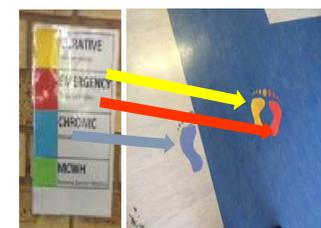
Checklist of care

- Patients will receive a clear checklist, as part of their appointment card, which outlines the visits required for their condition and **what care they should expect to receive** at each visit
- By having their own checklist, the patient is empowered as a partner in the care process **to speak up for their own care**, and prompt discussions with medical professionals when those expectations are not met.
- These checklists will dramatically **improve the patient experience for chronic patients in particular**, to help them take ownership of the process of their care, as well as increase adherence to appointments and treatment



Clearly displayed standards and signage

- All clinics will have clearly displayed signage explaining:
 - Waiting time expectations** for each service point
 - Patient flow** and separate queues
 - Opening and closing times**



This initiative will include the rollout of a general communications campaign, including messages such as:

- Educating patients on the operating hours, service agreements (e.g., waiting times) and core values of public service and PHC
- Encouraging patients to utilize channels of expressing their (dis)satisfaction (e.g., rate my clinic, complaints / suggestions procedure)

Quick Wins – Initiative #8: Communicate clear expectations to the patient and community

8 For example, the following checklist of care for a new HIV positive patient clearly explains their process of care over several visits

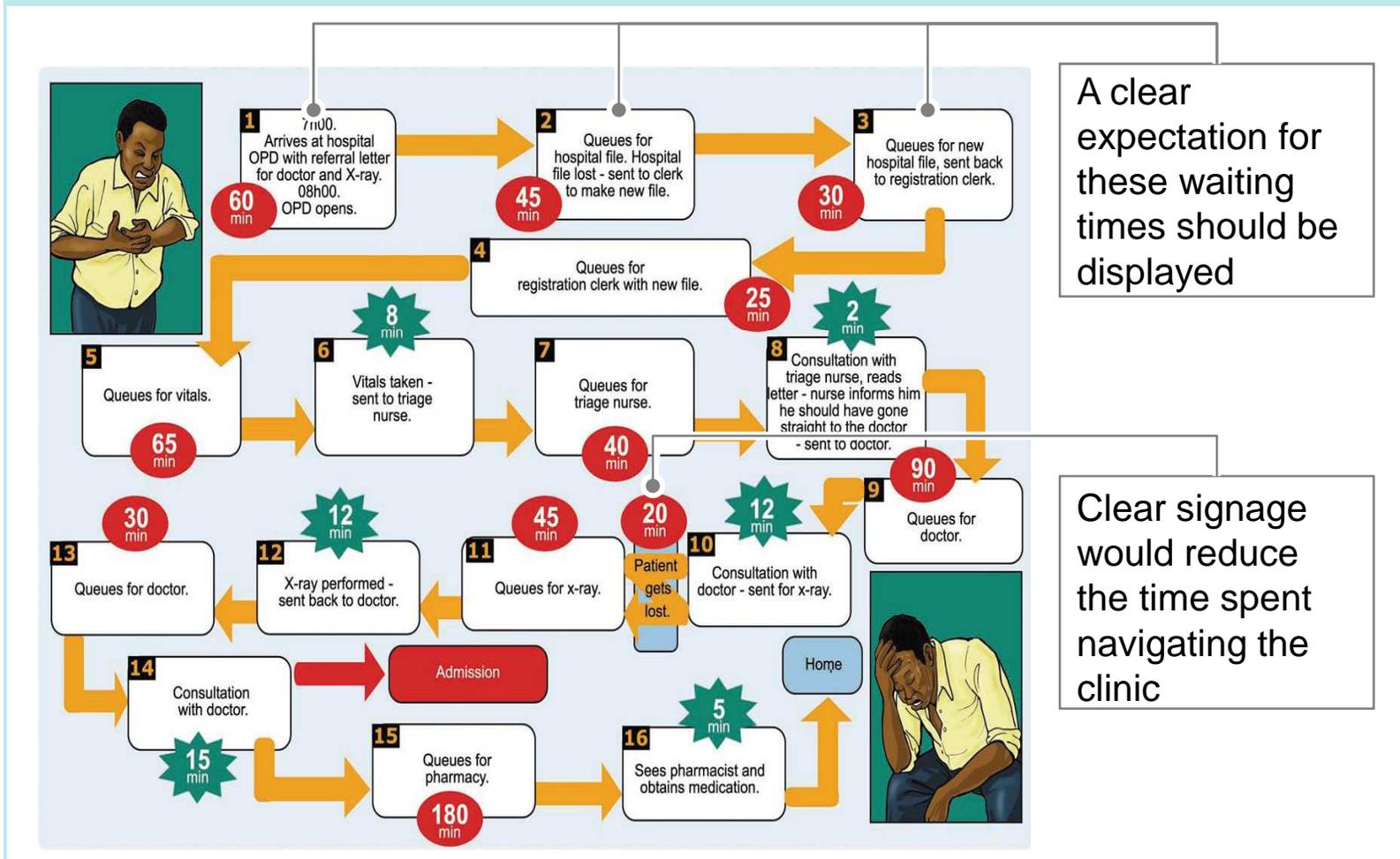
Patient Held Appointment and Process of Care Card									
Patient Name			Appointment Date/Venue/Time						
File number		24.11.15/Bester Clinic/13h00							
Clinic name									
First Visit:				Second Visit:Date&Time			Third Visit:Date&Time		
What	Why	Done (Y/N)	If N, Reason	What	Why	DoneY/N	What	Why	
Screening Test	Early diagnosis								
Counselling	Reassurance			Counselling	Adherence		Counselling	Reassurance	
Physical Exam				Physical ExamWHO Staging			Physical Exam	Physical Exam	
Baseline Bloods	To determine treatment course			Blood Results	Interpretation				
Treatment				Adjust	CD4 count < 350		Continue Rx	Continue Rx	

See appendix for example appointment card

Quick Wins – Initiative #8: Communicate clear expectations to the patient and community

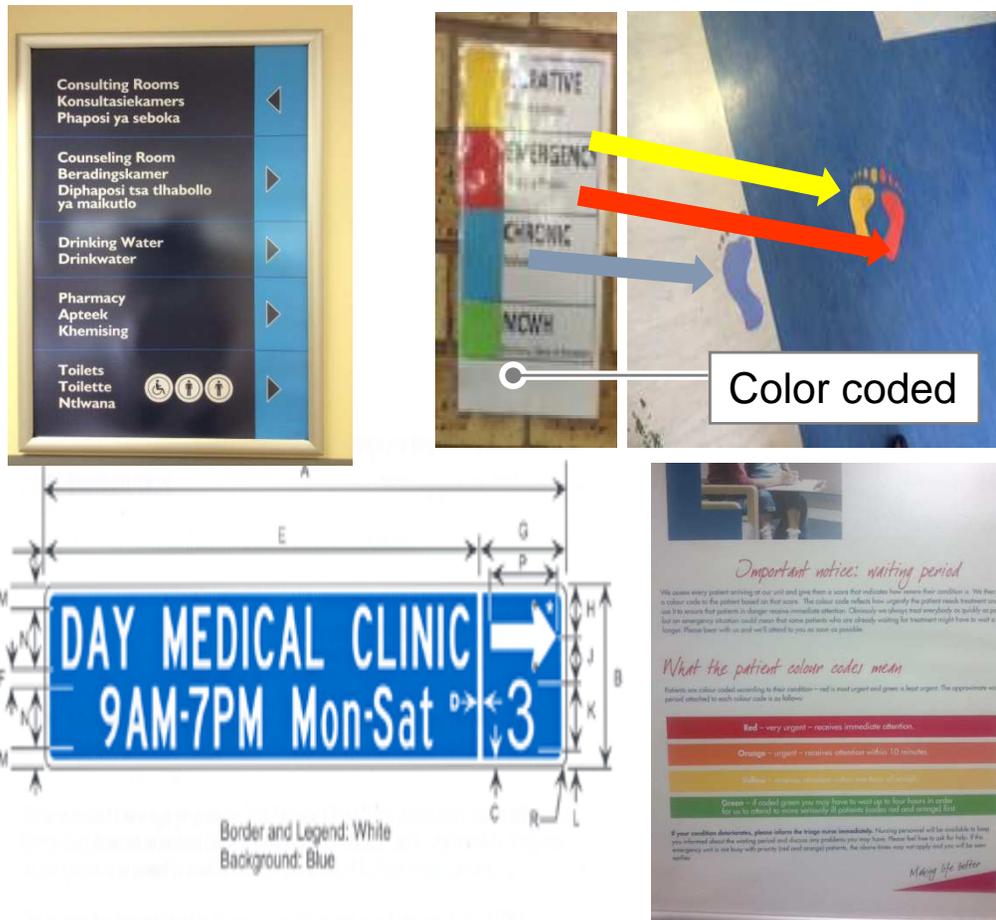
8 Clear internal signage is critical - even if patients experience long waiting times, it is still helpful to display the waiting time expectation

Illustrative example



8 Each clinic will have clear signage within all service points ...

Example



Description

- All clinics will have signage explaining
 - Opening and closing times
 - Patient flow and separate queues
 - Waiting time expectations for each service point
- In addition, queue marshals and help desks will help relay these messages

8 Our communications campaign will communicate several key messages

	What to communicate	Audience	Rationale
1	<ul style="list-style-type: none"> “Go to the clinic first, not the hospital” 	<ul style="list-style-type: none"> Patients & community members and other partners in the communities e.g. CBO, etc. 	<ul style="list-style-type: none"> Decongest level 2 & 3 health facilities Ensure appropriate and effective utilization of facilities
2	<ul style="list-style-type: none"> Encouraging patients to utilize channels of expressing their (dis)satisfaction (e.g., rate my clinic, complaints / suggestions procedure) 	<ul style="list-style-type: none"> Clients & community members and structures e.g. clinic committees 	<ul style="list-style-type: none"> Patient satisfaction and empowerment
3	<ul style="list-style-type: none"> Information about health conditions through open days and campaigns 	<ul style="list-style-type: none"> Clients & community members and structures e.g. clinic committees 	<ul style="list-style-type: none"> Knowledgeable society Decreased disease burden
4	<ul style="list-style-type: none"> Educate patients on the operating hours, service agreements (e.g., waiting times expectation) and core values of public service and PHC 	<ul style="list-style-type: none"> Patients & community members and other partners in the communities e.g. CBO’s, Organised Labour etc. 	<ul style="list-style-type: none"> Ensure appropriate and effective utilization of facilities – e.g. patients presenting themselves at the clinic at the right time.
5	<ul style="list-style-type: none"> Prominent events of health calendar 	<ul style="list-style-type: none"> Patients & community members and other partners in the communities e.g. CBO’s, Organized Labor etc. 	<ul style="list-style-type: none"> Increased awareness of health conditions Promote a health conscious society

8 Therefore the impact is ...

- **Patient and wider community will be informed** of waiting times, patient experiences and expectations
- **District management, facility management, staff and other governance structures will be committed** to clear communications
- **Community members will participate and be involved** in the management of their disease conditions
- **PHC facilities will be decongested of clients** that might be better managed at their home
- **Members of the community encouraged to use other available health facilities** or institutions



8 Key activities for Initiative #8: Communications

1000-feet plan

2015-2016	
Main activities	<ul style="list-style-type: none">▪ Launch condition process flow map roll out<ul style="list-style-type: none">– Design and develop process flow maps for chronic, emergency and minor/acute conditions– Develop and implement a staff training programme on process flow maps– Pilot process flow maps in select facilities– Roll out condition process flow maps in all PHC facilities▪ Implement standardised signage across all facilities<ul style="list-style-type: none">– Develop and implement plan to standardize signage with transformation teams– Develop and implement patient education programme on signage– Establish joint cost team with other departments to coordinate signage to reduce costs e.g. Dept. of Roads and Transport and Public Works– Fast-track procurement and installation of external signage with Public works and Dept of Roads and transport▪ Roll out communication campaign outlining clear service standards<ul style="list-style-type: none">– Appoint group to plan communication campaign– Contract media company to development communication campaign– Roll out communication campaign
Targets/ milestones	<ul style="list-style-type: none">▪ >90% of clinics to have condition process flow maps by end of October 2015▪ >95% of clinics to have standardized signage installed by July 2015▪ Launch national communications campaign by November 2015

9 The patient experience will be rigorously monitored through the use of an annual survey complemented by daily measures

What does it measure?

Who collects the data?

Tools employed

National Patient Experience of Care tool

- Annual survey of patient experience of care along the six ministerial priority areas

- Seasonal researchers use prescribed tool and guideline to conduct annually

Developed by members in the lab

National Waiting times monitoring tool

- Daily measurement of waiting times at each stage of the process

- Clinic staff complete form daily for all patients that comes to the facilities

PATIENT WAITING TIME MONITORING TOOL FOR PRIMARY HEALTHCARE FACILITIES.

Rate My Clinic tool

- Continuous feedback from patients on experience of care along the six ministerial priority areas

- Patients use SMS to report their experience via Unstructured Supplementary Service Data (USSD)

This initiative will impact patient experience of care through:

- Creating transparency for the public regarding overall patient experience of care and what is being done to address it, by publishing results and displaying results inside the clinic
- Establishing accountability through incorporating outcomes into Key Performance Areas of Facility Managers and District Managers

9 Initiative 9.1: Definition and tool for Patient Experience of Care

Objective: To Measure and act upon Patient Experience of Care results

Initiative concept/details/highlights:

This initiative will require us to define the patient experience of care and to develop a **standardized tool** that will be used country-wide in all Primary Health Care facilities to measure patient experience of care and inform service delivery improvement

To do this we require:

- A **standardized definition** of patient experience of care (**Done within the Lab**)
 - Review existing literature on definitions
 - Decide on the standardized definitions of Patient experience of care
- **Adapting a standardized tool** (**Done within the Lab**)
 - We reviewed accessible tools used country wide to measure patient experience of care in PHC facilities.
 - The decision on the best tool was based on guidance from experts and literature review
 - Determining the most acceptable tool from the accessed literature, the decision was based on its acceptability, feasibility, user-friendliness and explicit results that inform targeted service delivery improvement.
- **Get agreement from NDoH to make the tool universal**
 - We will identify mechanisms to test the validity of the tool.
 - We will consult with NDoH to ensure that this survey will be conducted annually.

Owner

- NDOH: PHC Branch and QA

Key stakeholders identified

Not Applicable

Required resources

- NDoH and research institutions to pilot the tool and guideline

Level of implementation

- PHC facilities

Implementation timeframe

- Start date: January 2015
- End Date: April 2015

Impact: The impact of this initiative is to give us a common measurement to track progress against our overall aspiration on waiting times and patient experience of care

9 There are number of tools which are currently in use, but no single tool is used consistently...

Tool	Pro	Con
1 Client Satisfaction survey tool 2000	<ul style="list-style-type: none"> It measures patient “satisfaction” of care 	<ul style="list-style-type: none"> Does not cover current priority health issues Questions are ambiguous The term “satisfaction” is more subjective and cannot be tested scientifically The tool is designed for hospitals not PHC facilities DHIS 1.4 software is not accessible to all managers
2 Infection Control Assessment Tool: A Standardized Approach for Improving Hospital Infection Control Practices. April 2012	<ul style="list-style-type: none"> Measured issues that are related to IPC and Cleanliness only 	<ul style="list-style-type: none"> Excludes all other factors that influence patient experience of care in SA
3 City of Johannesburg Patient satisfaction survey tool	<ul style="list-style-type: none"> Measures satisfaction with six Ministerial priority areas. The questionnaire takes a very short time (<5 minutes) for patients to complete 	<ul style="list-style-type: none"> Uses a three point Likert scale that is prone to central inclination. Some of the questions are ambiguous Not linked to DHIS software
4 National Patient Experience of Care: SA	<ul style="list-style-type: none"> The tool has been scientifically tested by HSRC. Measures priority factors that influence patient experience of care Tailor made to address PHC facility needs. Easy to apply and to allow for basic descriptive analysis approach Data analysis can be conducted using any data analysis software Comprehensive and includes both patient experience of care and waiting times It has an inbuilt automatic quality control mechanism 	<ul style="list-style-type: none"> Requires extensive resources to roll-out

9 Based on the aforementioned review we have selected and revised the National Patient Experience of Care tool to roll-out country-wide

Questions focused on the following

- Biographical data, including sex, age, and frequency of visit to the facility

1

Access to care

- Physical access for all, including persons with disabilities
- Information signs such as patient flow and services that are provided.

2

Availability of medicines

- On determining whether patients receive all their prescribed medicines on the day of their visit to the facility.

3

Patient safety

- Whether there are proactive measures available to ensure patient safety

4

Cleanliness and IPC

- Apart from general cleanliness of the facility, is there consistent availability of toilet paper and hand washing facilities in strategic areas.

5

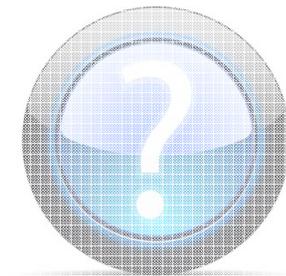
Values and attitudes

- To determine if patients are treated with courtesy and respect

6

Patient waiting time

- Whether or not patients feel that they wait too long for services



9 We aspire to attain 80% of patients reporting a positive experience of care

Dimension	Target %	Description
Access to care	100	To determine if all the patients have the required access to health care services
Availability of medicine	95	To determine the extent of availability of essential medicines
Patient safety	80	To determine the level of safety of care in the facility
Cleanliness and IPC	80	To determine status of cleanliness and IPC practices
Values and attitude	90	To determine staff attitude towards patients
Patient waiting time	90	To determine if the time the patient spends waiting for services is in line with the policy target

- If a patient answers “yes” to >80% of questions across all categories, they are considered to be reporting a “positive experience of care”
- Moreover, when results are analyzed by category, there is a target for each dimension

1 Percentage calculated on the basis of recommendations from the pilot study that was conducted NHI clinics by HSRC (2012) for the NDoH: QA Directorate.

9 Initiative 8.2: Definition and tool for Waiting Times

Objective: To Measure and act upon Waiting Times results

Initiative concept/details/highlights:

This initiative will require us to define Patients Waiting time and to develop a standardized tool that will be used country-wide in all Primary Health Care facilities to monitor patient waiting times and inform service delivery improvement

To do this we require:

- A **standardized definition** of Waiting Time (**Done within the Lab**)
 - Review existing literature on definitions
 - Decide on the standardized definition of Waiting Time
- **To adopt a standardized tool** (**Done within the Lab**)
 - We reviewed accessible tools used country wide to measure waiting times in PHC facilities.
 - The decision on the selected tool was based on guidance from experts that were consulted (Dr G Reagon: UWC and Prof N Faull: Lean Institute Africa).
 - In determining the most acceptable tool for measuring Patient Waiting Time, the following characteristics were considered: feasibility, user-friendliness and explicit (clear) results that inform targeted service delivery improvements.
- **To obtain an agreement from NDoH to make the tool universal**
 - We will identify mechanisms to test the validity and reliability of the tool.
 - We will consult with NDoH to pilot the tool and methodology in a wider audience prior to roll-out to all PHC facilities.

Owner

- NDOH PHC Branch and QA

Key stakeholders identified

- Not applicable

Required resources

- NDoH to partner with research Institutions to conduct the pilot and recommend the best approach to measure patient waiting time.

Level of implementation

- PHC facilities

Implementation timeframe

- Start date: January 2015
- End Date: April 2015

Impact: The impact of this initiative is improved waiting times that meets the needs of patients

9 There are number of tools which are currently in use for measuring patient waiting times, however no single tool is used consistently...

Tool	Pro	Con
1 Study on Out Patients' waiting time in hospital university Kebangsaan	<ul style="list-style-type: none"> Measured patient waiting time in a hospital 	<ul style="list-style-type: none"> Data elements are not applicable to SA PHC setting.
2 Gauteng monitoring of Patient waiting time tool	<ul style="list-style-type: none"> Measures patient flow and consultation time 	<ul style="list-style-type: none"> Waiting time not readily explicit in the tool therefore there is tendency to confuse consultation with actual waiting time.
3 Western Cape Conducting and interpreting waiting time survey	<ul style="list-style-type: none"> The tool is comprehensive in measuring patient waiting time. Data provides extensive factors that contribute to patient waiting time. It identifies areas requiring intervention. It uses open source that compares with any software e.g. DHIS. 	<ul style="list-style-type: none"> Requires further discussion with NDoH for consideration. Requires intensive training of all staff members to use. It has high cost implication. If adopted may require further national roll-out. Requires staff buy-in and behavioral change. Requires manual rather than built-in quality control measures.
4 National Waiting Time Monitoring tool	<ul style="list-style-type: none"> Describes aspired patient flow. Measures waiting, consultation and time spent in a facility. Determines waiting time per service area therefore objectively informs service delivery improvement. 	<ul style="list-style-type: none"> Requires national pilot on a larger scale and roll-out.
5 National Waiting time tool: SA	<ul style="list-style-type: none"> The tool has been scientifically tested by Lechoba Medicals and UKZN. Measures factors that influence patient waiting in all three streams of care. Tailor made to address PHC facility needs. Easy to apply and allows for basic descriptive analysis. Data analysis can be conducted using any data analysis software. It has an inbuilt automatic quality control mechanism. 	<ul style="list-style-type: none"> Requires extensive resources to roll-out.

9 Based on the aforementioned review we have selected and revised the National Waiting times monitoring tool to roll-out to all PHC facilities country-wide

Stage	Methodology	What is measured
Entering the facility at the door:	Patient is given a color-coded number with the entry time written on it on a sticker	The file can be used to calculate waiting times and determine bottlenecks.
At registry:	When the patient gets to the registry, the clerk writes the time of arrival at the door as appearing on the sticker and on the measuring form, as well as the time the file is issued	Waiting time is calculated at:
At all clinical service areas:	At every service point thereafter, the health professional records on the measuring form <ul style="list-style-type: none"> ▪ The time of arrival at the service point ▪ The time of departure from the service point 	<ul style="list-style-type: none"> ▪ Reception (door) ▪ Registry ▪ Screening and vital signs ▪ Consultation ▪ Other services ▪ Pharmacy ▪ Referral (where applicable)
Upon leaving facility	At the end of the visit, the file is collected from the last service point	

In the longer term, the tool will be made electronic to ease data capturing of patient waiting times.

9 We have defined targets across key dimensions

We aspire to attain overall patient satisfaction with patient waiting time.

Dimension	Target
Total Time spent in a facility:	Not more than 3 hours
Patient Waiting Time	Not more than 2 hours
Waiting for number in the queue at the door	2 minutes
Waiting for a file at registry	15 minutes
Waiting for screening (using SATS tool)	10 minutes
Waiting for clinical consultation (3 streams of care) and other service areas	45 minutes
Waiting for pharmaceuticals to take home (where applicable)	10 minutes
Time spent waiting for an ambulance ¹	Should be based on documented, approved EMS standards (15 minutes for urban, 40 minutes for rural)

¹ This is not measured as part of the clinic waiting time target of two hours, but will be measured separately

SOURCE: Team discussions of anecdotal experience; Peltzer K, 2009 Patient experiences and health system responsiveness in South Africa. BMC Health Services Research 9:117; Conducting and Interpreting Waiting Times Surveys: Reagon G.: School of Public Health - University of the Western Cape; Worley MM, Schommer JC. Pharmacist Patient Relationship: Influencing Quality and commitment. J Soc Admin Pharm 1999 ;(16):158; National Quality Seminar Resolutions: 2009; Cullinan K. Dying while waiting: South Africa. Health-e. 2009; Lean Institute Africa (LIA): Rustenburg Provincial Hospital Pharmacy 2009



8 Initiative 8.3: System to monitor Waiting Times and PEC

Objective: Implement Patient Experience of Care and Waiting Time measuring tools

Initiative concept/details/highlights:

This initiative will require us to

- **1. Implement the tools**
 - We will develop a guideline for conducting PEC and patient waiting time survey in PHC facilities.
 - We will use paper based data collection tool and electronic data capturing and analysis software.
 - We will detail mechanisms of integrating the collected data with existing routine health information systems (web-based DHIS).
 - We will outline a roll-out plan of implementation across the country with consecutive targets.
 - We will recommend that seasonal researchers be employed to conduct surveys so to promote objectivity.
 - We will use daily “Rate My Clinic” results and patient complaint trends to inform service delivery improvements on monthly basis.
- **2. Use of information to inform service delivery improvement.**
 - We will determine the process for dissemination of information to all levels of care up to facility levels.
 - We will determine the levels of accountability and responsibility.
 - We will recommend inclusion of survey results in service delivery improvement activities.
 - We will incorporate the program activities into KPAs of Facility and District Managers
 - We will determine feedback mechanisms to patients.
 - We will develop M&E strategy for PEC survey.

Owner

- NDOH together with PDOH, Local authorities & District Health Management

Key stakeholders identified

- PDOH PHC Directorate
- Local municipality health Dept authorities
- District & sub-district Management teams
- Facility management
- Stakeholders (Clinic committees, community organizations, NGOs, civic organizations)

Required resources

- Budget for seasonal employed researchers (data collectors, analyzers and report writers).

Level of implementation

- Provincial health department
- Districts (implement, account for results, facilitate improvements).
- PHC facilities (respond to results, demonstrate implemented service delivery improvements)

Implementation timeframe

- Start date: April 2015 for country-wide
- End Date: April 2016

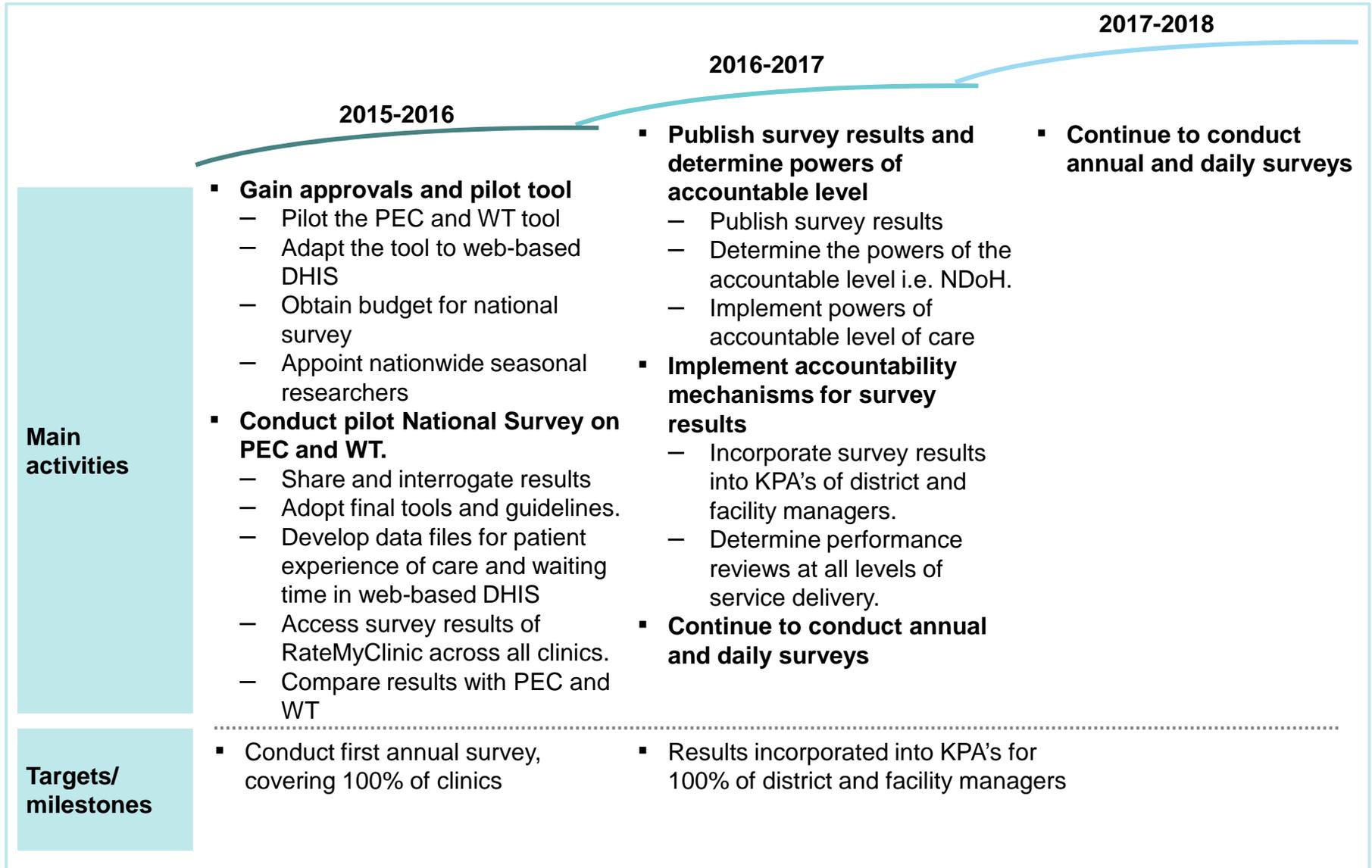
Impact: The impact of this initiative is to track progress against overall aspiration on waiting times and patient experience of care, and provide transparency to encourage good performance

9 We will measure Patient Experience of Care and Waiting Times through both an annual, continuous, and ad-hoc process

How often?	Which tool?	Who collects the data?	How is the data used?
Annual survey	1 National Patient Experience of Care	<ul style="list-style-type: none"> Seasonal researchers use prescribed tool and guideline to conduct annual survey Results are aggregated and entered in the DHIS2 	<ul style="list-style-type: none"> Reports given to facilities and district / sub-districts to inform service improvements Performance determined against KPA for facility managers and district managers Progress communicated to patients and other stakeholders
	Daily survey	2 National monitoring of Waiting Times tool	
3 Rate My Clinic tool		<ul style="list-style-type: none"> Patients report their experience via Telephonic Short Message Service (SMS) Results consolidated in central database of OHSC 	
Ad-hoc feedback	4 Form to lodge a complaint	<ul style="list-style-type: none"> Patients complete complaint forms and hand to facility manager, receive acknowledgement letter within 5 working days as stipulated in the National Complaint Management Protocol 	

9 Key activities for Initiative #8: System for measuring PEC and WT

1000-feet plan



Contents: Waiting Times

- Context and case for change
- Aspiration
- Issues and root causes
- Initiatives
- **Budget requirements**

Detailed initiative budget – Waiting Times

Total additional budget, R 1070 million

		2015/16		2016/17		2017/18		
Initiatives	Initiative Description	Capex/ Opex	Personnel & Training	Capex/ Opex	Personnel & Training	Capex/ Opex	Personnel & Training	TOTAL
1,5	1. Use appointments to manage demand and direct patients to appropriate level of care 5. Standardize paper filing processes at the clinics for ease of retrieval	R 235,027	R 346	R 1,500	0	R 1,500	0	R 238,372
2	2. Expand existing public call centre services to direct patients to the appropriate level of care	R 1,260	R 9,512	R 1,228	R 19,907	R 122	R 14,481	R 46,510
3, 4	3. Roll out SMS-based platform for communicating individualized patient information 4. Improve efficiency of patient flow	R 19,711	R 137,588	R 16,194	R 144,468	R 16,194	R 151,691	R 485,847
6	6. Support clinics to adjust hours / days of operation to increase accessibility and reduce waiting times	0	R 0	0	R 79,310	0	R 78,555	R 157,865
7	7. Implement electronic queue management systems	R 7,826	R 1,244	R 104,767	R 1,228	R 19,770	R 0	R 134,835
8, 9	8. Communicate clear expectations for Waiting Times and process of care, 9. Implement a country-wide system for evaluating, improving, and communicating patient experience of care and waiting times	R 3,000	R 221	R 1,500	0	R 1,500	0	R 6,221
		R 266,823	R 148,911	R 125,189	R 244,913	R 39,087	R 244,727	R 1,069,650

Note that several initiatives are grouped since they incur overlapping costs (e.g., SMS appointment system and patient flow both rely on hiring queue marshals to manage the queue as well as input appointments into the SMS system)

Budget overview – Waiting Times

