GP Care Cell Partner Meeting Consensus Report

Margot Uys
Chris Visser

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1 Executive Summary

The SA National Department of Health (NDOH) has set ambitious targets relating to the 90-90-90 goals for HIV epidemic control by 2020. To achieve these targets models to contract private General Practitioners (GPs) to initiate and manage patients decanted from the public sector need to be piloted. CDC and USAID, convened a district support partner's (DSP) meeting on August 15, 2016 to discuss the viability of experimenting with models to utilize private practitioners in the new strategy to reach the 90-90-90 targets. The experience of different partners in the implementation of several equivalent models played an important role in the discussions.

The key questions that the meeting considered were:
i) Identification of appropriate General Practitioners (GPs).
ii) The service delivery model.
iii) Tariff standardisation.
iv) Access to drugs and laboratory services.
v) Recording and reporting requirements.
vi) Long term sustainability.

The outcome of the meeting resulted in clear criteria and requirements to be met in ensuring cost efficiency and quality of GP HIV care treatment services. While fulfilling the SAGs aims, the approach must also be commercially viable for the private sector, or there would be scant participation.

This consensus document should guide efforts by DSPs to organise private practitioners for the provision of integrated patient-focused quality care services. It includes:
- **Defined Benefit package:** includes HIV/TB care including basic and acute care modalities; plus other defined chronic and co-morbid conditions (in compliance with the criteria set out in this document)
- A proposed **remuneration** mechanism.

All DSPs were invited to attend the meeting and participation is reflected in the attached attendance list (See Appendix A).

2 Introduction

In order to achieve HIV epidemic control and reach the ambitious 90-90-90 targets set by the NDOH models to supplement the public sector by drawing on the capacity of the private sector could be a crucial intervention.

A variety of models of General Practitioner (GP) based care have been explored in the past, with a wide range of costing models. Discussions with the NDOH regarding using PEPFAR funding to explore the potential of developing cost efficient and patient-friendly care models in the private sector was held by USAID and CDC in recent months, resulting in PEPFAR giving a commitment to explore such models through the District Support Partners (DSP). The intention is that all DSPs will implement pilot programmes starting in the new budget year (1 October 2016).

The model of care should take into account:

- The initiation of new patients and the decanting of stable patients to private GP care for ongoing management.
- Provision of care for the estimated 20% of HIV positive patients with other chronic co-morbidities and acute diagnoses require specialized care than can be best provided at a Primary Health Care (PHC) facility. Involving care for co-morbidities at GP level would simultaneously address the 2nd and 3rd 90.
- Address the need to care for key populations, e.g. adolescents with a high rate of early pregnancies; and improving the enrolment and compliance of working men
- Alignment with the South African Government (SAG) policy which is mandatory, including data systems integration with current National Department of Health (NDoH) information systems.

The idea of the GP care cell originated in the HIV Think Tank and PEPFAR environment where, in the past, various partners implemented different service models using GPs. The cost varied considerably - between R1800 to R6500/annum depending on the content of the service delivery model. Based on past experience DSPs mentioned a number of challenges that originated with past GP contracting models that would need to be addressed in any new model. These included:

- Models for referral of patients into the public sector who have complex disease presentations
- Long laboratory turn-around times (TAT)

The purpose of the meeting was to develop consensus amongst DSPs and funders around a model of care for utilizing private GPs in the care and treatment of HIV positive uninsured (public sector) patients. The model should address the following areas:

- Enrolment and management of suitable GPS for the service
- Definition of the role of the GP in the care of stable patients, acute care and patients with co-morbidities within a defined benefit package.
- Standardisation of tariff to provide clear cost-benefit.
- Standardisation of treatment algorithms including access to medication and laboratory services within the framework of NDOH SCM.
- Linkages between the network GPs and the DoH systems for the movement of patients, supplies and information.

- Adaptation of standardised and effective information systems that have interoperability with SAG systems to provide required reports and information to both NDOH and funders.
- Financial sustainability defined within the framework of set timeframes.

3 GP Care Cell Model Criteria

3.1 Enrolment and management of GPs

Private GPs need to be contracted either through existing network management companies or directly by the DSP. Once convened in a network the network manager will:

- Provide technical support, oversight and management of GPs to enable them to fulfil the mandate.
- Will continually monitor service provision and adherence to Service Level Agreement (SLA).
- Manage the relationship with NDoH, drug supply chain, public sector referral facilities, and community structures as required.
- Engage with public sector district management to streamline referral and linkages to and from public sector facilities.
- Liaise with DSPs
- Select GPs according to an accreditation criteria including but not limited to the following:
    - Qualifications.
    - Training, experience in HIV/TB medicine.
    - Capacity to manage the required number of patients.
    - Compliance with data minimum requirements, data analysis and confidentiality protection.
    - Facility review including staff and drug storage availability.
    - Monitor feedback from patients to ensure adherence to quality standards

3.2 Definition of the role of the GP in the care of stable patients, acute care and patients with co-morbidities within a defined benefit package.

3.2.1 Provision of a GP managed integrated package of services (one-stop-shop concept)

The provision of an integrated package of services (a one-stop-shop) was considered as crucial for promoting adherence and reducing loss to follow-up thereby ensuring successful viral load suppression. Care and treatment will need to be provided for stable patients on ART, (decanted patients), for newly diagnosed HIV positive patients presenting for ART initiation, as well as the care and treatment of cases with specified co-morbidities, and the package of care will also include identified acute conditions.

Benefit Package detail: The benefit package design details will need require further exploration however a number of partners have been using the Therapy Edge electronic medical record system that can be accessed to provide data and input on identifying the conditions to be included in the service offering (see 3.2.6).

Clinical standards will be achieved by a variety of approaches including:

- Protocol driven treatment criteria that align with NDOH criteria.
- Mentoring and training for all GPs in TB/HIV care and management

- Developing the capacity of GPs to provide services that meet the need of key populations, men and adolescents.

3.2.2 Practice Team composition:

GP practices will need to establish a team of professional and lay staff that are geared to providing a costs effective and comprehensive service. This could include nursing staff (to be accredited on PC101 accreditation – included in the accreditation criteria), staff to manage adherence clubs (AC), should the private providers see value in this approach and counsellors to increase HCT in the practice.

3.2.3 Adherence and defaulter management

Experience has shown that electronic case management systems when used in a private practice environment ensures that there is very limited loss to follow-up. Nonetheless, local community assets including Ward Based Outreach Teams (WBOTs), CBOs, NGOs can be used, as necessary, to limit loss to follow-up (LTFU).

3.2.4 Psycho-social support

The *Network* manager will ensure that GP Practices have access to such services.

3.2.5 Referrals

The link from GP to public sector clinics/hospitals and vice versa for “specialised” care must be established and defined in this model. The *Network manager* and/or DSP should manage this.

3.2.6 Care for adolescents, unstable patients and paediatrics

A system of referrals for complex cases is to be established between the network GPs and the public sector facilities *(**Action: Right to Care to provide some statistics from Therapy Edge to allow better quantification of this issue**.)*

3.3 Standardised tariff system for Services

3.3.1 Payment model

There is consensus that Fee for Service (FFS) remuneration is not suitable for this project because it leads to over-servicing and ignores clinical outcomes. However crude capitation often used by medical schemes to contract chronic care, is also problematic in that complex patients may be either underserved or compromise the commercial viability of the contract. The proposed formulation for the capitation model proposed for this project thus encompasses the severity of individual risk so the aggregate capitation fairly reflects the composite risk of the enrolees. In this model the various factors that characterise varying need / risk are independently accounted for so the final monthly capitation amount then reflects the aggregate risk. The model envisages a base per patient capitation amount that is supplemented with add-on amount payments based on achievements of specific quality targets. This will link success in meeting the projects outcomes to a financial incentive. One

of these quality measures that carries rewards will include patient's experience of the service i.e. an "Uber" feedback approach. *See Appendix B for an illustration of the model.*

3.4 Provision of medication to GPs from DoH (SCM) & Laboratory support

3.4.1 Provision of Drugs

CCMDD paved the way for a different model of engagement with private sector (e.g. pharmacies, GPs etc.). GPs are currently included in the CCMDD project as a potential Pick-up Point. The Network Manager/DSP will be responsible for ensuring the provision of medication to GPs via the NDoH procurement system. This includes a limited formulary of drugs for the treatment of the conditions included in the Benefit Package i.e. for co-morbid conditions such as TB, diabetes, hypertension, hyperlipidaemia and some acute conditions such as chest infection and UTI.

3.4.2 Laboratory

The network manager/DSP will pursue the most efficient logistic solution for cost-efficient service delivery regarding laboratory:

- At this stage NHLS is the preferred provider.
- Thus a courier service is required for the pick-up of blood specimens from the GP for delivery to the nearest NHLS depot. TAT will be a factor in the reward measures.
- The network manager/DSP will facilitate that their GPs are able to access NHLS laboratory results.

3.5 Data recording and Reporting: Information systems and linkages

While the TIER system is currently utilised by the NDoH for information on all HIV positive patients, it is recognised that it is only an electronic register with limited management functionalities. The Network Manager/DSP will need to deploy an IT system which minimum standards include:

- Interoperability with South African government (SAG) systems, especially SCM and DHIS and Tier.net
- Be user friendly in the GP environment and have reliable connectivity
- Provide guidance on management of adverse side effects. (The HIV Hotline, PEPFAR sponsored and run by UCT, is providing this service currently)
- Collect all relevant information on patient data for registers and clinical management, and maintain confidentiality
- Administrative and Clinical support to the GPs including quality of care monitoring
- Reporting to funders and SAG including performance indicators, patient level and clinician level

4 Sustainability

Sustainability will be enhanced by:

- Defined milestones for sustainability including the successful integration of the GP networks with the NHLS and the availability of SAG drugs

- Contract periods will be sufficiently long to mature but will be reviewed and tenders reopened regularly to ensure constant improvement. As stated above, patient feedback is important before contracts are renewed, as are LTFU and other success measures.

5 Summary of Recommendations

- To introduce suitable GP Networks to decant HIV + patients from the public to the private sector.
- Benefit Package to include both new patients and stable patients, including common co-morbid conditions and acute illnesses.
- The Tariff will be a refined capitation system, sensitive to the risk / need of the enrolee patients; plus, an additional ‘tiered’ component for excellence in the achievement of the projects goals. This measures of success will include hard outcomes such as viral load suppression and soft outcomes including patient subjective experience of the service.
- SCM in regard to drug supply and laboratory investigations will be provided by the *Network* and procurement through SAG and NHLS.
- An IT system for recording and reporting must be deployed and the data be provided for the relevant SAG databases including in the TIER system and to the SAG DHIS. Data will also be used for feedback to the funding bodies and SAG. The systems should aid the GPs clinically and administratively.
- Interactions with the local SAG facilities are stipulated and must be expedited.
- Funding is envisaged for the next 7 years, therefore must make provision for scale up on ART as well as attention to key populations, i.e. adolescents, men.
- Sustainability of the model must be built in through buy-in and providing a service that is affordable for the SAG and the provinces working towards elimination of the epidemic.

6 Way Forward

DSPs to incorporate GP Contracting models based on this consensus model in their work plans for the next financial year.

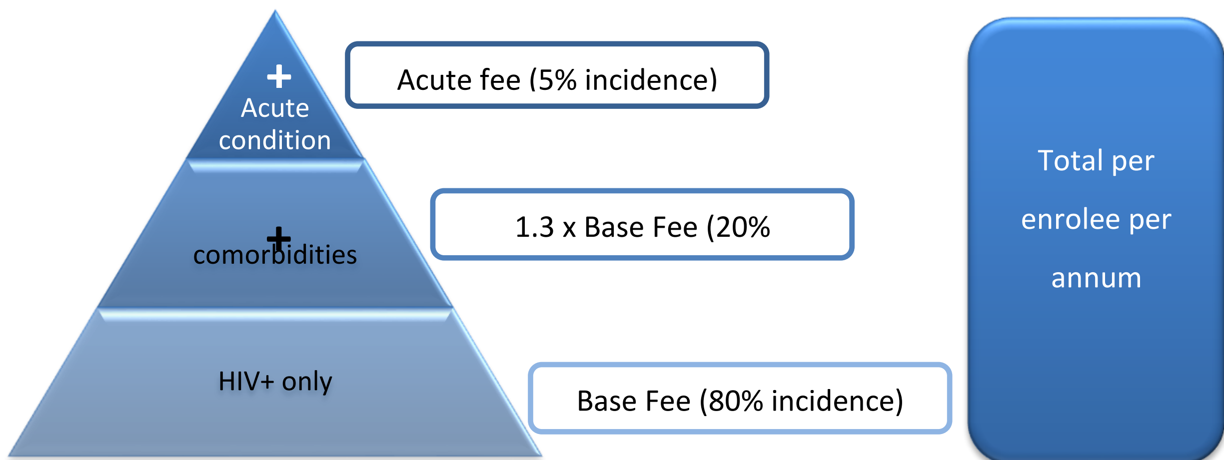
Appendix A. Test and Treat Programme: Proposed Financial Arrangements

Test and Treat Programme: Proposed Financial Arrangements

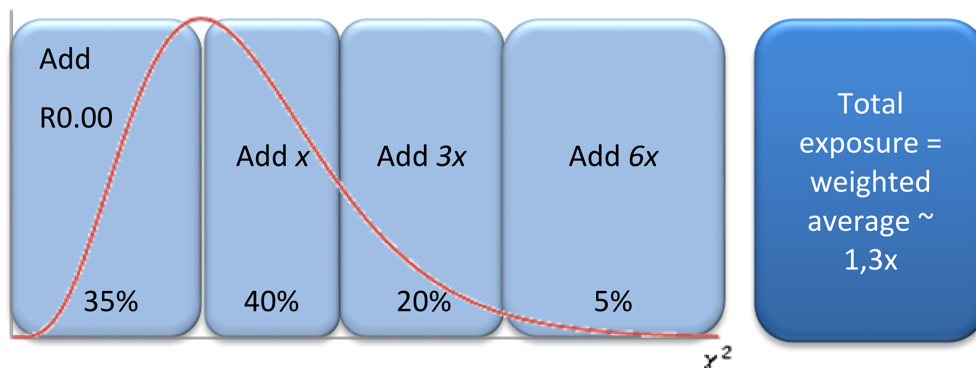
The contract proposal is for a modified capitation formula that reflects both the patient population complexity and an appropriate balance between quality and production cost outcomes.

The formula has 2 components:

1. A Team Fee
   a. that reflects the reasonable costs of delivering the services included in the benefit schedule per patient
   b. that recognises the variable complexity of treating patients' clinical problems
   c. the composite monthly fee is based on aggregating the 2 above factors as per the graphic:



2. A Value Linked Fee based on the performance that the service is routinely producing for the contracted patients i.e. reflecting the relative successful in meeting the programmes aims:
   a. Factors include:
      i. compliance with visits and medication adherence
      ii. viral load suppression
      iii. successful retention (vs. lost to follow up or back to the District)
      iv. measured patient experience (ala Uber)
   b. The higher the composite score, the higher the additional fee the provider can bill:



Appendix B: Attendance List

GP Model – PEPFAR Partner Workshop

Monday, 15 August 2016

Title	Name	Surname	Company
Dr	Rochelle	Adams	CAPRISA
Ms	Ranahnah	Afriye-Matuba	USAID
Ms	Ulenta	Chetty	CAPRISA
Dr	Cephas	Chikanda	Pulse Health Solutions
Dr	Raymond	Chimatira	CDC
Dr	Dave	Clark	CEO: SA Region Aurum Institute
Ms	Suraya	Dawad	Health
Dr	Ashraf	Grimwood	Khethimpilo
Dr	Nelis	Grobbelaar	Anova
Mr	Bulelani	Kuwane	Aurum Institute
Dr	Gloria	Maimela	Wits RHI
Dr	Thapelo	Maotoe	Right to Care
Mr	Mpho	Maraisane	Aurum Institute
Ms	Nomea	Masihleho	USAID
Dr	Mazvita	Mberi	Wits RHI
Ms	Jenny	McLoughlin	TBHIV Care
Ms.	Tiwonga	Mkandawire	USAID
Dr	Kevi	Naidu	Match
Dr	Olarotimi	Oladoyinbo	USAID
Ms	Wendy	Ovens	Right to Care
Mr	Francois	Pretorius	BroadReach
Ms	Pam	Qavile	Beyond Zero
Mr	Shuabe	Rajap	BroadReach
Ms	Elsie	Raphela	Health
Ms	Andronica	Ratshefola	Health
Mr	Brian	Ruff	PPO Serve
Miss	Sibongile	Shezi	Health Systems Trsut (HST)
Dr	Helen	Struthers	Anova
Dr	Margot	Uys	FPD
Dr	Chris	Visser	FPD
Dr	Gustaaf	Wolvaardt	FPD