RAPIDLY EXPANDING COVERAGE OF CARE FOR CHILDREN AND ADULTS WITH CEREBRAL PALSY IN RURAL KZN: LESSONS LEARNED

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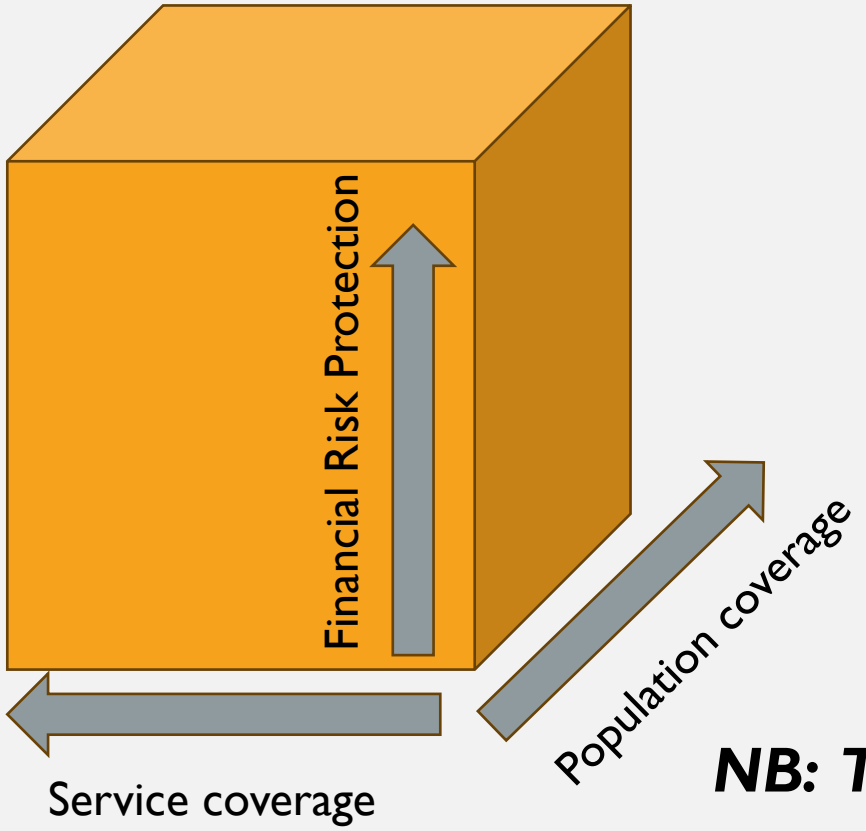
UNIVERSAL HEALTH COVERAGE: SERVICE DELIVERY STRATEGY



‘UHC’ as a:

- Financing model
- Principle guiding service delivery strategy
  - accessibility
  - affordability
  - acceptability

Vertical Equity

NB: Targeted, monitored strategies needed for vulnerable groups experiencing inequities in access and outcomes

DISABILITY & REHABILITATION

Access to Care (coverage)

- Multiple barriers in access specific to PwD
- Current analyses do not routinely measure inequities in access to healthcare for PwD

Financial Risk Protection

- PwD pay more out of pocket to access healthcare (transport, assistance)
- People with disabilities have more complex health needs and greater unmet need
- Current analyses do not stratify for disability when considering FRP measures

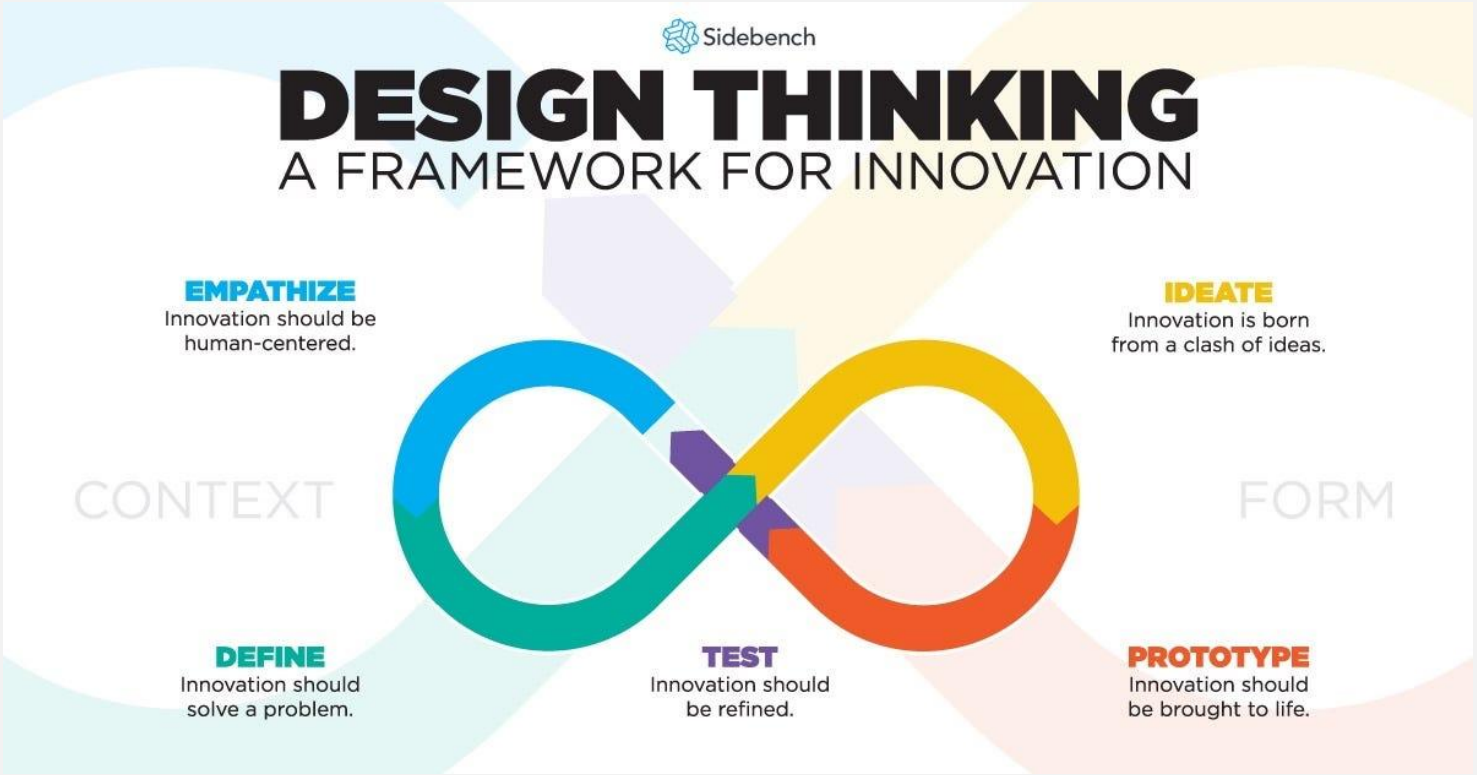
Quality of care

- Acceptability, service design & desired outcomes (for whom)

How much do our own systems perpetuate inequality in access and outcomes?

CONTEXT MATTERS WITH DISABILITY

System design and service delivery can worsen health outcomes, poverty and inequality……. or address it



WHY DOES IT MATTER TO ME

- **Public Health & Health Economics**
  - Inclusive clinical guideline development
  - Monitoring UHC progress as it relates to coverage of care and financial risk protection in SA: methodological shortcomings and lack of sub-group analysis relating to disability
  - Health financing incl. Basket of Care, HTA and contracting
- **Health Service Management**
  - HR: training, distribution and mix
  - D&R as a cross cutting program
  - Improved M&E for performance and outcomes
- **Health workers**
  - Contracting: Capitation? P4P? Block contracts?
  - Using service data strategically
  - Improving coverage and retention in care
  - Collaborating with end users to work smarter

THE (PUBLIC) SECTOR REALITY

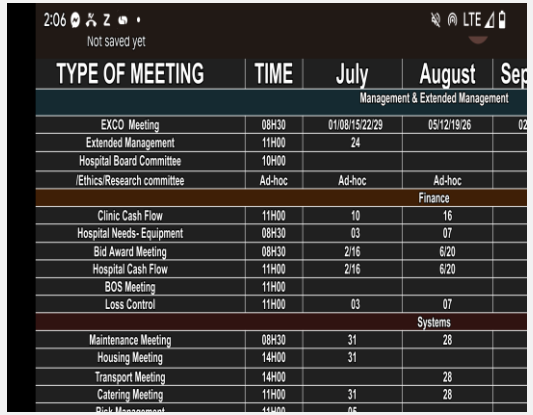
Coordinating rosters
Vehicle space/availability

Lack of end user
consultation & involvement

Fragmented records &
lack of M&E culture

SDH & transport

Health & professional silos



TYPE OF MEETING	TIME	July	August	Sep
		Management & Extended Management		
EXCO Meeting	08H30	01/08/15/22/29	05/12/19/26	02
Extended Management	11H00	24		
Hospital Board Committee	10H00			
/Ethics/Research committee	Ad-hoc	Ad-hoc	Ad-hoc	
			Finance	
Clinic Cash Flow	11H00	10	16	
Hospital Needs- Equipment	08H30	03	07	
Bid Award Meeting	08H30	2/16	6/20	
Hospital Cash Flow	11H00	2/16	6/20	
BOS Meeting	11H00			
Loss Control	11H00	03	07	
			Systems	
Maintenance Meeting	08H30	31	28	
Housing Meeting	14H00	31		
Transport Meeting	14H00		28	
Catering Meeting	11H00	31	28	

Case management meetings??

BASIC CONCEPTS

General:

- Functional HRB program with active surveillance
- Integration of rehab into PHC

CP program:

- Decent clinical rehabilitation service at hospital and clinic level
- No active surveillance or indicators
- Clinic level: single profession dominated
- Lack of data integration with other programs & professions
- No end user involvement in service delivery

Population coverage	2018
# Children & adults with CP 'on the books'	72
# Children & adults with CP 'regular' 6/12ly follow up	36
Estimated* population coverage rate CP: 0-5 years old	58%
Known pts wheelchair coverage rate CP: 0-5yr olds 6-12yr olds	32% 73%

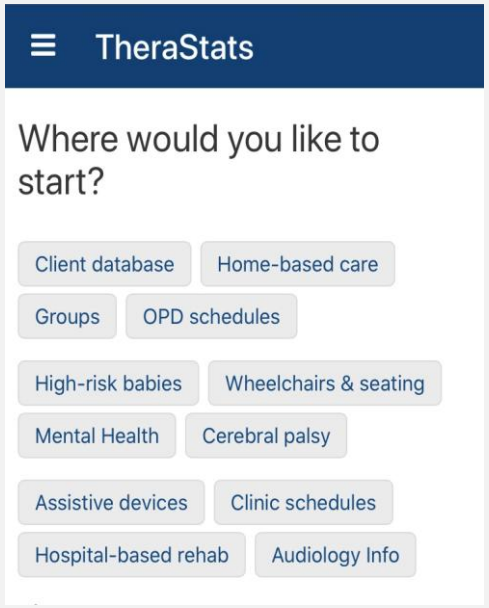
Service coverage	2018
Average # rehab sessions in 6 months: 0-5yr 6-12yr	1.3 0.7
Annual wheelchair seating review rate: 0-5yr 6-12yr	0% 17%
Twice annual wheelchair seating review rate: 0-5yr 6-12yr	0% 0%
Average CP home visits per month	0

‘NEVER WASTE A GOOD CRISIS’

Increased home visits

Added parent facilitators

Data reform & teamwork



Also

HOUSEHOLD, TAXI AND GRANT INFORMATION COLLECTED & ANALYSED

IMPACT OF MGZ CP SERVICE REFORMS

Population coverage	**2018**	**2021**	**2023**
# Children %& adults with CP receiving regular 6/12 follow up	104	140	166
Wheelchair coverage rate CP: 0-5yr olds 6-12yr olds	32% 73%	83% 95%	93% 99%
Service coverage	**2018**	**2021**	**2023**
Average # rehab sessions in 6 months: 0-5yr 6-12yr	1.3 0.7	6 4	6 3.3
Annual wheelchair seating review rate: 0-5yr 6-12yr	0% 17%	80% 84%	86% 92%
6/12ly wheelchair seating review rate: 0-5yr 6-12yr	0% 0%	64% 76%	63% 63%

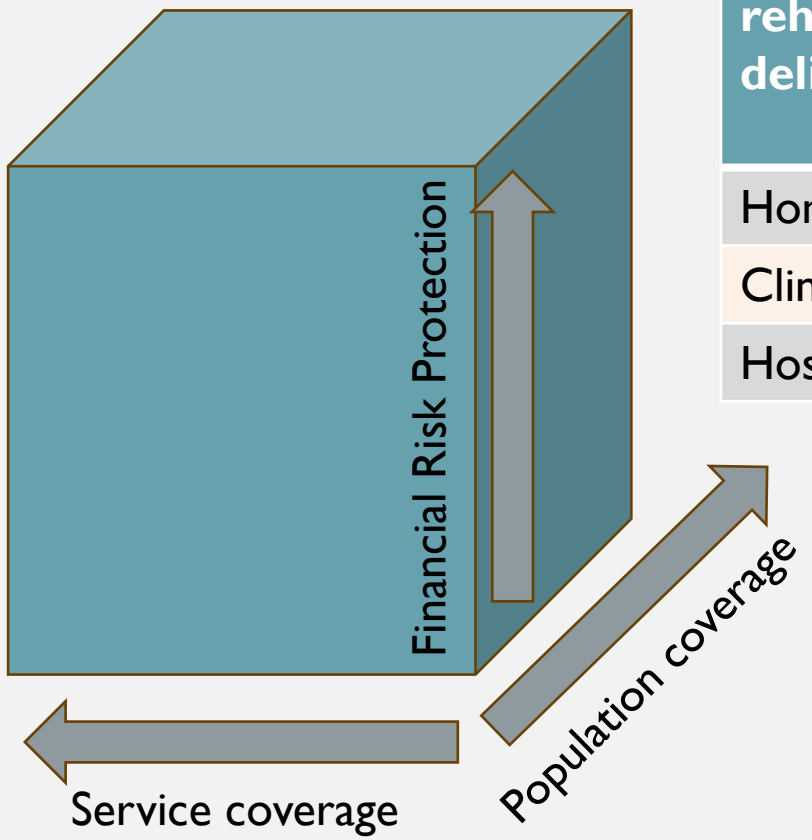
**sessions exclude groups and parent facilitator sessions*

*** in MDT sessions, each profession logs a session (workload)*

AFFORDABILITY, ACCEPTABILITY, ACCESSIBILITY

Shifting case management and cost from patient to provider

WHY DECENTRALIZE?



Predominant rehab service delivery strategy	Proportion 82 x CP households experiencing CHE at 10% threshold in 8 months attending rehab
Home based model	8%
Clinic based model	18%
Hospital based model	49%

Catastrophic Health Expenditure estimated 5-12% at a 10% threshold for general population SA

(Koch and Setshegetso 2019)

WHY PARENT FACILITATORS

Relatable
Approachable
Committed

- Improve population coverage rapidly
- Increase rehab contact time and check-ups (home)
- Address psychosocial issues relating to buy-in/retention in care
- Hold therapists accountable, improve early referrals
- Strengthen patient networks
- Provide sustainability to a program

SHIFTING RESPONSIBILITY & COST: BUILDING & INTEGRATING SYSTEMS

Data system requirements:

- Relational database with high level of functionality including automated and customizable scheduling functions required for grassroots services to plan and manage services and individual care as well as track devices and program performance

Indicators:

- Workload & output (DHIS)
- Program performance (coverage, proxy quality of care indicators, outcomes)

Team requirements:

- Data literacy
- M&E culture
- Management and governance

Beyond rehab: UNMET NEED

Unmet medical needs	
25%	38/150 had unmet medication needs (comorbidities not addressed)
8%	12/150 had not had chronic prescriptions reviewed in over a year
Unmet audiology needs	
92%	66/72 no previous recollection of seeing audio
33%	24/72 wax/infection prevented OAE screening
35%	17/48 failed 1st OAE screening
Unmet dietary needs	
53%	79/150 had never seen a dietician
21%	31/150 SAM, with 20/31 previously unknown to dietetics
10%	15/150 MAM, with only 5/15 being previously known to dietetics
Unmet dental needs	
70%	101/145 never seen a dentist
22%	32/145 saw one more than a year ago
46%	67/145 required dental interventions/further assessment
36%	24/67 required extraction

AND NOW WHAT?

Doctors

- in-serviced on KZN CP guidelines, received summarized medical guidelines
- Assessed 9 children at Disability center

Speech & Audio:

- Joined home visits for baseline screening, committed to 'follow up visits'

Dietician:

- Mobilized province and nutritional advisors on the ground
- Required child to present to clinic every 3/12 for OSP

Dental:

- Saw clients for theatre who arrived for extractions
- Assessed 9 children at disability center

IMPACT SIX MONTHS LATER?

- **Dietician**
  - 41/45 malnutrition cases seen and entered into OSP, 15 default almost immediately
- **Dental:**

  6/24 requiring extractions received extractions, no other up referrals arrived
- **Doctors:**

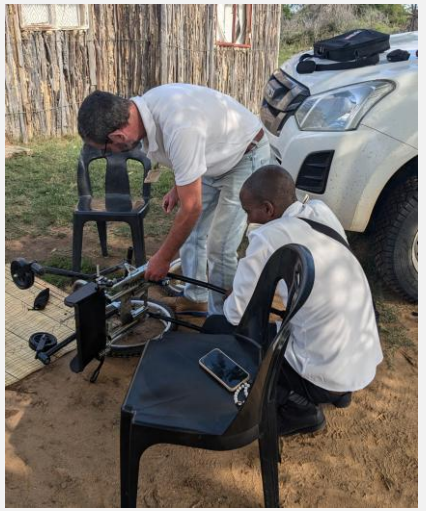
  9 children at care center had pink cards with chronic meds on
- **Audiology**

  None of 41 screened at home & referred for follow up at clinic/home were seen again
- **Speech:**

  9/11 requiring thick n easy had not been followed up, none on repeat prescriptions

Listen & address	Allay individual managers fears
Effort & positivity	Be the champion. …and make that first day out really epic
Help a lot	Be prepared to spoon feed prep and data
Specialist support	Make sure specialist help is on the end of a call
Interpret & Advocate	Use the outreach to explain barriers and address attitudes

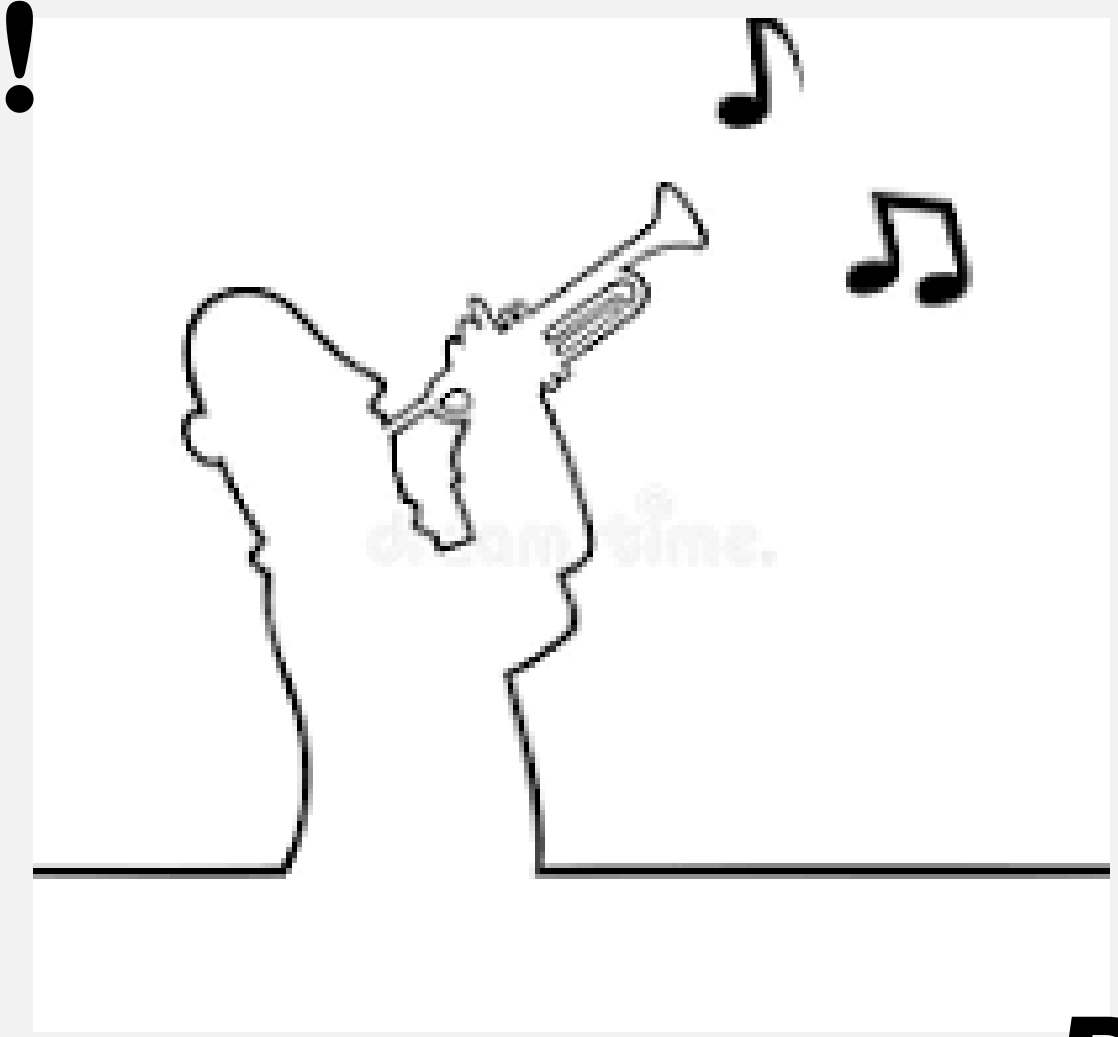
REVIEW THE DATA AND PITCH IT AGAIN!



Building trust….

with families, in each other, in ourselves, in the team, in the system

YAY!!!!!!!!



But……..

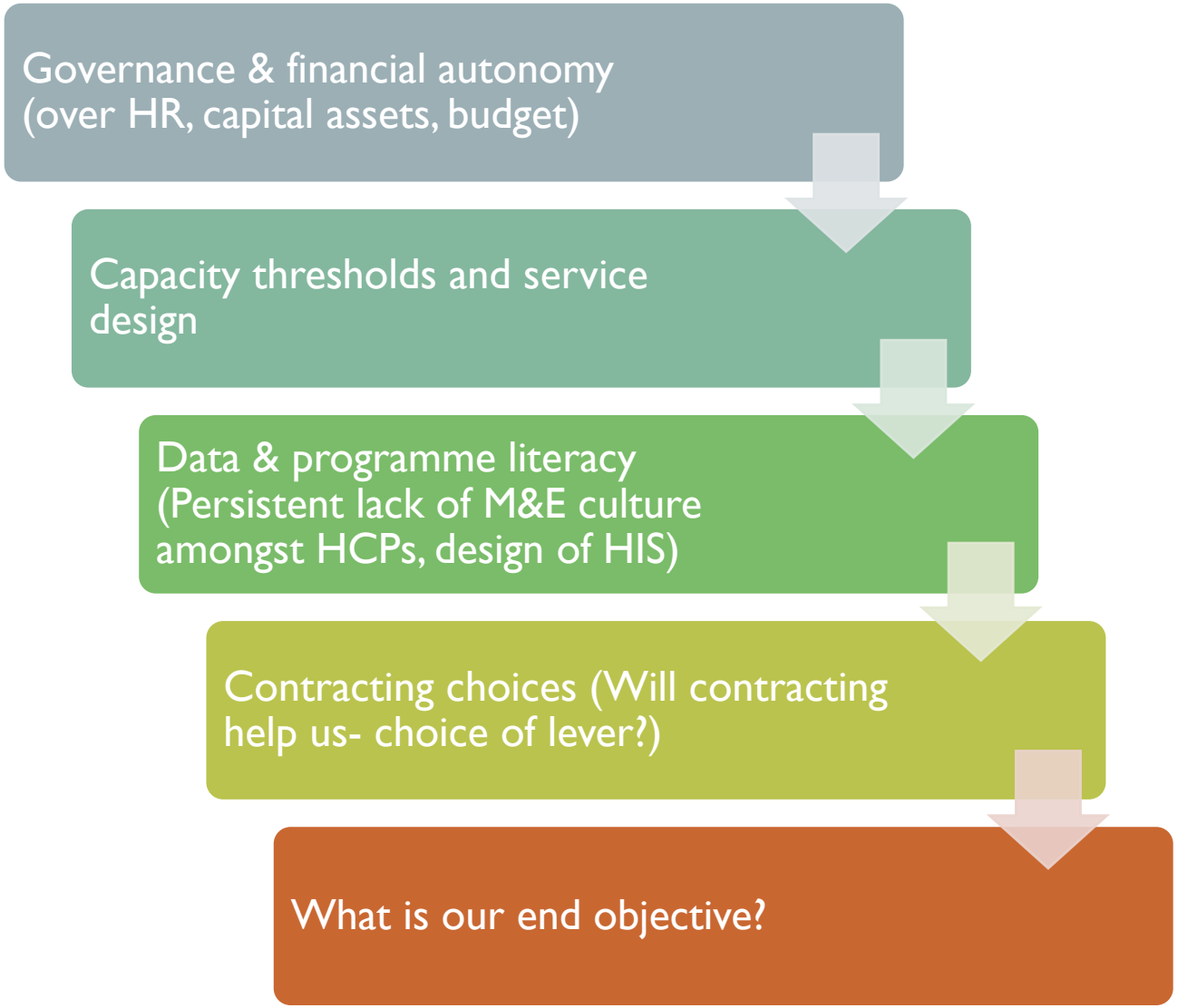
SYSTEMS ARE FRAGILE

Population coverage	**2023**	**2024**		**2025**	
Number of active CP cases managed by team	166	165	• 2 x maternity leave • CSO driving policy • Incr. 'out-of-area'	180	• 1 x maternity leave • WCS champion absent 3/12 • CSO driving policy • 'Out of area' persists
Wheelchair coverage rate CP: 0-5yr olds 6-12yr olds	93% 99%	100% 100%		100% 100%	
Service coverage	**2023**	**2024**		**2025**	
Average # rehab sessions in 6 months: 0-5yr 6-12yr	6 3.3	3.3 3.5	2.4h 2.6h	2.9 2	2.2h (PF: 8h ; group: 3h) 1.7h (PF: 6h)
Annual wheelchair seating review rate: 0-5yr 6-12yr	86% 92%	95% 100%		89% 94%	
6/12ly wheelchair seating review rate: 0-5yr 6-12yr	63% 63%	68% 77%		26% 53%	

CURRENT MEDICOLEGAL RECOMMENDATIONS: DOSAGE

Age	Recommended hrs of rehab per annum	We offer (rehab + parent facilitators)	If we added block therapy	Resource implications (2 x dedicated trained therapists, PPT, ?universality?)
Under 3 years	90-120 hours	20 hours	100 hours	16 X one week blocks (2 blocks pa)
4-7 years	70-90 hours	15 hours	95 hours	16 x one week blocks (2 blocks pa)
8-18 years	60-70 hours	16 - 26 hours	56-66 hours	5 x one week blocks (1 block pa)
19 years onwards	40-60 hours	27 hours	67 hours	9 x one week blocks (1 block pa)

IMPLICATIONS



BROADER PROGRAMME OBJECTIVES?

ECD & SCHOOLING

SKILLS TRAINING

EMPLOYMENT

COMMUNITY INTEGRATION

Photo by SIMON LEE on Unsplash

INDEPENDENT LIVING, RESIDENTIAL AND DAY CARE

JUSTICE

SPORTS AND RECREATION

ACCESSIBLE TRANSPORT & BUILT ENVIRONMENTS

CONTEXT MATTERS

System design and service delivery can worsen poverty and inequality or address it.