International Journal of Integrated Care ISSN 1568-4156

Volume 14, 8 December 2014
Publisher: Igitur publishing
URL: http://www.ijic.org
Cite this as: Int J Integr Care 2014; WCIC Conf Suppl; URN:NBN:NL:UI:10-1-116682

Conference Abstract

Implementation of an Integrated Chronic Disease Management Model in South Africa

Ozayr Mahomed, *University of KwaZulu Natal, South Africa*

Melvyn Freeman, *National Department of Health, South Africa*

Shaidah Asmall, *Senior Technical Advisor-National Department of Health, South Africa*

Correspondence to: ***Ozayr Mahomed,*** *University of KwaZulu Natal, South Africa, E-mail: ozayr411@gmail.com*

Abstract

Introduction: Whilst chronic disease management of non-communicable diseases and mental health within primary care is and has been provided in primary care for many years, in many instances the health system has put greater emphasis on the relief of acute symptoms to the detriment of prevention and optimal care of chronic conditions. Moreover chronic disease services are primarily run as disease specific entities and hence programmes treat specific diseases rather than the whole person.

Practice and context: An integrated chronic disease management (ICDM) model was proposed as a vehicle to improve the management of chronic conditions. The ICDM consists of four inter-related phases that are dependent on overarching strong stewardship and ownership at all levels of the health system (Figure 1). The four inter-related phases include:

• Facility re-organisation to improve service efficiency.

• Clinical supportive management to improve quality of clinical care.

• “Assisted “self-support and management of patients through the ward based outreach teams (WBOT) to empower individuals to take responsibility for managing their own conditions and increasing awareness of chronic diseases at the population level

• Health system strengthening

Aim of the intervention: The aim of the ICDM is to achieve optimal clinical outcomes for patients with chronic diseases and improve the operational efficiency of the PHC clinics. The model was implemented between April 2011 and February 2013, at 42 public health sector clinics in three districts

Approach: We used the clinical practice improvement model (CPI) for continuous quality improvement to implement components of the breakthrough series (BS) model

Results: Fourteen facilities have shown a decrease in the median total time spent by patients across all diagnostic conditions from the baseline in December 2011. The total median time that

chronic patients spent at the facilities in January 2013 decreased from both the baseline in December 2011 and intermediate measurement in May 2012 at 17 of the facilities. Fifty percent of the facilities have shown a decrease greater than 30% in the total time spent by chronic patients from the baseline in December 2011 and a decrease greater than 35% in the total time spent by chronic patients between May 2012 and January 2013.

Discussion: Key requirements for implementing and sustaining change are change management; project planning and the use of quality improvement tools and these together with health service ownership were the central themes that resonated throughout the implementation process.

Despite every effort to take cognisance of and address potential barriers, the implementation of the ICDM was dependent on the leadership capabilities of the operational managers. Cross messages from the various programme managers and the reluctance of the designated HIV/AIDS nurses that initiated and managed only HIV/AIDs patients created some organisational resistance. Systemic challenges inherent in the health system negatively impacted on the smooth implementation of the ICDM model. The lack of adequate essential equipment required at the facility posed a major challenge. The lack of financial resources and the procurement of poor quality equipment without a maintenance plan in place hindered the process.

The health services is still very focussed at a curative health service level, with inadequate emphasis on primary prevention, health promotion and empowering the communities and patients to take responsibility for their individual health.

Conclusion: The implementation of the ICDM is feasible at primary care in South Africa provided that systemic challenges and appropriate change management is not neglected.

Keywords

integrated care; quality improvement; non communicable diseases; health system strengthening

---

PowerPoint presentation

https://www.conftool.net/integratedcare2014/index.php?page=downloadPaper&form_id=243
