Proposal for the Effective Rationalization of Support Services

POST-CODIV=19

NHI UNIT
Belize Social Security Board

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Introduction:

Since the launch of NHI on the Southside Belize City, the objective to provide quality Primary Care services at an affordable and sustainable manner continues to be the main focus. While the demand for Primary Care Services covered by NHI has expanded significantly with now 4 of the main PCPs having fully reached their capacity, the budget assigned for this purpose has not. It is therefore imperative that all stakeholders adopt practices that effectively rationalize the over-utilization of key support services without compromising the quality of care.

Current utilization trends pointed initially to the escalation of pharmacy services. Corrective measures were implemented to address the prescription patterns in particular as it pertained to patients with non-communicable chronic diseases. One such measure was the introduction of revised protocols for the management of these conditions. Additional protocols are also being developed for the other most common illnesses noted.

Besides the protocol revisions, PCPs were assigned to pharmacy providers to minimize possible auto-referrals. This reduced expenditures but not significantly. Later a cap was implemented to further curtail over prescription of medications. These combined approaches resulted in a reduction of expenditures in this area. However, since then there has been an unprecedented escalation of utilization of laboratory and imaging services. The trend was so alarmingly high that immediate measures had to be taken to avoid the depletion of the budget assigned for this purpose. Once again a cap has been introduced for these services which has since then been distributed for the 12 month contract period. Clinics now have the direct responsibility of managing these caps.

In spite of this however, PCPS continue to on a whole, exceed their budgets calling for a further assessment of the situation and approaches to address the concerns.

Actions Taken:

The NHI Unit with support of a PAHO representative met initially to propose possible solutions. Keeping in mind that the one constant is the set budget which will not increase and avoiding possible cuts in the package of Primary Care services, the team conducted research on trends, chronic case distribution at PCP levels, most common laboratory and imaging test ordered, as well as the most current guidelines on both preventative cancer screening, general physical examinations and NCD management.

Based on this data the following policy measures are being considered for future implementation.

Annual Physical Exam:

As it pertains to the Annual Physical Exam and supporting laboratory testing, it was noted that the list of tests for this purpose is too extensive and not necessarily recommended. As a result, it is proposed that although the physical examination and revision of systems can take place annually, the corresponding lab analysis do not need to be repeated if the initial results are normal.

Prior to COVID-19:

Annual Physical exams should be done as per date or registration at the clinic and not as a blanket policy on a specified month of the year regardless of date of initial registration.

Post COVID:

Routine Physical exams will be put on hold and requested on a need basis ONLY.

The proposed panel of laboratory tests that will be covered as part of the physical exam include:

1st visit (if normal repeat every 2 years)

1. HB
2. FBS
3. Lipid Panel (not recommended for persons after 80)
4. Creatinine
5. Occult blood (50 yrs)

Next step: Negotiate cost for panel.

High Risk: Metabolic Syndrome/ Obesity

High Risk:

For Suspected Diabetics: Confirm diagnosis with 2 consecutive FBS or HbA1c.

Gestational Diabetes: O'Soullivan Test approved.

Initial Visit: Diabetes/Patient: the following laboratory tests are to be done as per the Diabetes Protocol.

1. FBS (if not done prior)
2. Creatinine (if not done prior)
3. HbA1c (baseline)
4. Hb if not done prior
5. Microalbumin
6. Lipid Profile (if not done prior)
7. Urinalysis (if not done prior)

If the following results are found repeat as indicated below:

1. HbA1c (normal range; patient controlled and compliant with meds; repeat every six months)
2. HbA1c (abnormal; patient uncontrolled; repeat every 3 months. After repeating this test a second time and there is no further improvement; refer to specialist) During COVID- every 6 months.

3. Microalbumin:

Type 1 Diabetics: No need to test till 5 years from date of initial diagnosis. Thereafter, test once annually.

Type 2 Diabetics: test annually from the date of initial diagnosis.

If micro-albumin is abnormal in any of these cases, repeat after 3 months. (6 months during COVID-19)

Correlate findings with GFR screening order as required.

4. **Lipid Profile:** If the lipid profile is abnormal repeat in **6 months.**
5. **Urinalysis:** if proteins are found in the UA, follow with a micro-albumin test.

For Hypertensive Patients: Initial Visit should include the following as per the protocol.

1. Hb if not done prior
2. Microalbumin
3. Lipid Profile if not done prior
4. Urinalysis if not done prior
5. Uric Acid (baseline)
6. Electrolytes: (Na+ and K+ recommended only for patients on diuretics).

Frequency of testing is the same as described for Diabetes.

Target Organ Damage:

1. **Kidney: Micro Albumin is the preferred method.**
2. **Eye Dilated Exam for DM/HTN (This is to be done annually)**
3. **Heart EKG /Chest Xray by age:**

   If there is no risk factors present; do a Chest Xray annually.

   EKG: a baseline can be done at 40 years. If normal and there are no known risk factors present repeat every 5 years unless symptoms develop.

   If abnormal repeat annually.

4. **Foot Exam (This is to be done annually)**

Policies to be implemented:

1. Annual Exam should be based on date of registration and not calendar year.
2. ATB's prescription valid x 3 days
3. Confirmed /suspected non-compliant after 3 mos. not covered.
4. Clients must bring meds to refill prescription

Screening Tests

1. **Pap Smear**

   If sexually active (start 3 years after the first sexual intercourse)

   If 3 consecutive annual screenings are found normal thereafter, screen every three years.

   If patient has never been sexually active: No screening required

   If sexually active after age 20 and are at low risk:

   Cervical cancer screening (testing) should begin at age 21.

   Women between ages 21 and 29 should have a Pap test every 3 years. (HPV testing should *not* be used in this age group unless it is needed after an

abnormal Pap test result). (HPV testing will not be covered by NHI but if patient chooses to do so at their own expense the recommendation applies)

Women between the ages of 30 and 65 should have a Pap test plus an HPV test (called "co-testing") every 5 years. This is the preferred approach, but it is also OK to have a Pap test alone every 3 years.

Women over age 65 who have had regular cervical cancer testing with normal results should *not* be tested for cervical cancer. Once testing is stopped, it should not be started again. Women with a history of a serious cervical pre-cancer should continue to be tested for at least 20 years after that diagnosis, even if testing continues past age 65.

A woman who has had her uterus removed (and also her cervix) for reasons not related to cervical cancer and who has no history of cervical cancer or serious pre-cancer should *not* be tested.

A woman who has been vaccinated against HPV should still follow the screening recommendations for her age group.

Patients with compromised Immune systems (including HIV and auto-immune diseases should be screened annually regardless of age)

American Cancer Society Guidelines

2. **Mammogram**

Yearly mammograms are recommended starting at age 40 and continuing for as long as a woman is in good health

Clinical breast exam (CBE) about every 3 years for women in their 20s and 30s and every year for women 40 and over

Women should know how their breasts normally look and feel and report any breast change promptly to their health care provider. Breast self-exam (BSE) is an option for women starting in their 20s. (American cancer society)

3. **PSA:** The American Cancer Society recommends that men make an informed decision with their doctor about whether to be tested for prostate cancer. Research has not yet proven that the potential benefits of testing outweigh the harms of testing and treatment. The American Cancer Society believes that men should not be tested without learning about what we know and don't know about the risks and possible benefits of testing and treatment.

Starting at age 50, men should talk to a doctor about the pros and cons of testing so they can decide if testing is the right choice for them. If they are African American or have a father or brother who had prostate cancer before age 65, men should have this talk with a doctor starting at age 40. If men decide to be tested, they should have the PSA blood test with or without a rectal exam. How often they are tested will depend on their PSA level.

If PSA is normal without any history of risk, repeat every 4 years.

Any male after age of 50 should be screened with PSA every year.

If PSA is abnormal refer patient to a urologist. PSA levels 4 or higher should be referred to the urologist.

PSA should not be performed on males with a life expectancy of less than 10 years.

Digital Rectal Exam: is recommended at least once annually as of age 50 or when presenting with an abnormal PSA.

Ultrasounds: (Prenatal)

- ONE ultrasound recommended primarily in second trimester to Diagnose fetal malformation
    - Weeks 20-28 for congenital malformations
- Structural abnormalities
- Confirm multiple pregnancies
- Verify dates and growth
- Confirm intrauterine death
- Identify hydramnios or oligohydramnios – excessive or reduced levels of amniotic fluid
- Evaluation of fetal well-being

(American Pregnancy Association)

If the pregnancy is not considered high risk and is normal there is no need to repeat the ultrasound.

Risk Management:

One of the concerns related to the management of NCDs and in particular CVD is the holistic approach to determining the appropriate level of intervention and initiation of therapy. Currently the practice leans heavily towards the initiation of therapy as the first line of intervention with little consideration or emphasis on lifestyle modification and reduction of risk factors that contribute to the progression and prognosis of the disease.

WHO has proposed a guideline for assessment and management of cardiovascular risk which in turn defines the level of non-therapy and therapeutic measures called for once a threshold for intervention is established. Though this guideline has to now be adopted in future practice the current hypertension protocol does make an initial reference to this concept.

Table 4 on page 18 of the protocol defines the stratification of risk which in turn defines the level of intervention required as detailed in pg. 15 and 16 of the same.

Key to the risk assessment is the determination of the first course of action. When referring to the management of Hypertension according to the determination of risk detailed in table 4, persons who have Stage 1 hypertension but do not demonstrate any of the key risk factors (such as smoking, salt intake, obesity etc) and no history of CVD in the family are considered low risk. For these patients the recommended course of action is the introduction of lifestyle modification and re-assessment of blood pressure in 3 months. Treatment initiation in these cases is not the first option.

NHI will seek to adopt the new guidelines of risk assessment to minimize the over-reliance on treatment intervention at the expense of preventative measures that can provide positive outcomes to the

patient with less utilization of limited resources.

Compliance:

It is evident that effective clinical management when drug therapy is required is dependent on the client's compliance with the treatment regimen.

In an effort to reduce the overcrowding and burden to the clinic for refills, NHI approved the issuance of 2 months supply of medications for patients that show evidence of compliance. However the trends show that compliance is not been carefully assessed or documented resulting in an indiscriminate coverage of patients regardless of their compliance status.

This was documented in a recent visit to Mercy Clinic. It was disturbing to see the quantities of medications not utilized and wasted.

NHI is requiring clinics to closely monitor and report incidences of non-compliance. The criteria for refills will be as follows:

- Clients must bring all medications to the clinic prior to the issuance of a new prescription.
- If there is evidence of non-compliance and wastage of medications; clients are to be given a formal caution that this practice will result in discontinuing of services until compliance is achieved.
- Client's medication dosages should not be increased until there is evidence that the first course of treatment was ineffective thereby accounting for the need to re-adjust the course of treatment
- For these cases only a month supply should be issued at a time.
- If the patient still does not comply after the 3 month, patient is to be suspended from receiving a referral from NHI and should be referred to a specialist.
- Only on the advice of the specialist can the client resume treatment if the issue of compliance has been addressed

This policy applies for both Hypertension and Diabetes.

Referrals of antibiotics should be valid only for 1 week. Patients requesting these medications after the expiration date, must visit their provider to determine the relevance.