Trinidad and Tobago HEARTS Initiative (TTHI) Implementation Plan Matrix (National)

NIDAD AND TOBAGO HEARTS INITIATIVE (TTHI) IMPLEMENTATION - (FOR STRENGTHENING CVD MANAGEMENT AND CONTROL IN PRIMARY CARE)

GOAL: By 2025, reduce the burden of preventable mortality (before the age of 70) due to NCDs by 25%

Purpose: To strengthen CVD management (targeting hypertension and diabetes) in primary health care in T&T

Specific Objectives	Activities	Targets and KPIs	**Resources (Human/Equipment/Financial)**	Timeline	Key Stakeholders
1. Position the TTHI on the agenda for all key stakeholders	1.1 Obtain approval for the implementation of the Global HEARTS Initiative in Trinidad and Tobago (TTO), as a mechanism to strengthen CVD management, tratment and control	1.1.1 GLOBAL HEARTS Initiative approved for implementation by MOH 1.1.2 PAHO accepts TTO into Global HEARTS Initiative 1.1.4 National TTHI Governance Mechanism and Team established	MOH Executive Management , PAHO TRT Office, Global HEARTS Team	By end July 2018	MOH Executive Management, NCD Oversight Committee; PAHO TRT Office, Global HEARTS Team
	1.2 Obtain commitment from RHAs for implementation of TTHI in primary care centres and identify demonstration sites TTHI	1.2.1 Regional and local TTHI Focal Points identified 1.2.2 Demonstration sites TTHI in RHAs identified 1.2.3 Site assessment completed	MOH HEARTS Team, PAHO TRT, Seed Funds from PAHO/WHO Global HEARTS	By end Sept 2018	Chair HEARTS Sub Committee of the NCD Oversight Committee, CEOs RHAs, Director Health Education Division, Regional TTHI Focal Points, PAHO TRT,
	1.3 Complete TTHI Work Plan	1.3.1 TTHI Site Assessment submited 1.3.2 TTHI Workplan developed and approved	MOH HEARTS Team, PAHO TRT, Seed Funds from PAHO/WHO Global HEARTS	By end October 2018	HEARTS Sub Committee of the NCD Oversight Committee, CEOs RHAs, Director Health Education Division, Regional TTHI Focal Points, PAHO TRT,

	1.4 Adopt HEARTS Technical Guidelines for Treament of Hypertension and Diabetes and adapt to develop National Guidelines for Treatment of Hypertension and Diabetes in primary care settings	1.4.1 Trinidad and Tobago National Guidelines for Managing Diabetes and Hypertension in primary care established. 1.4.3 National National Guidelines for Treatment of Diabetes and Hypertension conducted	MOH HEARTS Sub Committee, PMO, PAHO TRT, Funding from PAHO/WHO Global HEARTS Initiative/HSSP	By 4th Quarter 2019	MOH Management Executive, MOH HEARTS Sub Committee, CMO, PAHO TRT, WHO Global HEARTS, PMO, Clinicians, PCNMs, CEOs, GM Primary Care, CMOsH
	1.5 Adapt/Customise the Global HEARTS Packages for the TTO context (Healthy Lifestyle; Evidence Based Protocols; Access to Medicines/Technologies; Risk-based Management; Team Based Care; SYstem for Monitoring). Establisha consultancy to produce the TTO Protocol for Evidence based diabetes and hypertension	1.5.1 HEARTS Packages slected and customised for implementation in TTO context	MOH HEARTS Sub Committee, PMO, PAHO TRT, Funding from PAHO/WHO Global HEARTS Initiative/HSSP	By 4th Quarter 2019	HEARTS Sub Committee, CMO, PMO, PAHO TRT, WHO Global HEARTS, GM Primary Care, CMOsH
	1.6 Official launch of TTHI	1.6.1 National TTHI Symposium conducted 1.6.2 Trinidad and Tobago National Guidelines for Managing Diabetes and Hypertension in primary care printed and circulated 1.6.3 Training of master trainers completed for protocols	MOH HEARTS Sub Committee, PMO, PAHO TRT, Funding from PAHO/WHO Global HEARTS Initiative/HSSP	By end 2019	MOH Management Executive, MOH HEARTS Sub Committee, CMO, PAHO TRT, PAHO TRT, WHO Global HEARTS, Corporate Communications, CMOsH, PCNM, CEO, GM Primary Care, NGOs, Clients, Support Group leaders, Village Councils, Dieticians

2. Strengthen/Create registries for hypertension and diabetes	2.1 Develop minimum data sets for diabetes and hypertension for TTO using HEARTS guidelines 2.2 Training of Trainers and staff at Demonstration sites in TTHI Treatment and Surveillance protocls completed 2.3 Minimum Data Set disseminated, and staff at demonstration sites, trained in use of new protocol 2.4. Establish mechanism for NCD Surveillance beginning with data capture from HEARTS Sites	2.1.1 Standardised minimum data set established beginning with paper based forms (to scale up/migrate to IT Platform) 2.2.2 Cadre of Master Trainers in the Minimum Data Set protocol 2.2.3 Minimum Data Capture Forms approved by MOH 2.2.3 At least 5 training workshops conducted for staff in use of Min Data Set protocol 2.2.4 Demonstration sites establish hypertension register and diabetes registers establish and report Minimum Data Sets to MOH Monthly	MOH HEARTS Sub Committee, PMO, PAHO TRT, Funding from PAHO/WHO Global HEARTS Initiative/HSSP, Dedicated trained staff/local Health Teams, Material: Forms etc Equipment: Computers etc,	By end 2019	Surveillance team, clinicians, clerks, DHVs, medical records staff, PMO and CMOsH, HPRP, nurses, UWI, NSU MOH, PHO/Surveillance Teams RHAs

3. Chronic Care Model for mangement and control of NCDs in primary care implemented through TTHI in selected health facilities	3.1 Identify and sensitise HEARTS Local Teams in each RHA 3.2 Select HEARTS Packages for implementation by each site 3.2 Conduct needs assessment at Demonstration sites and review procurement issues, stock outs, and communication between C40 and stakeholders to ensure access and availability of medicines, medical technologies etc 3.3 Calculate cost of TTHI using the WHO Hearts costing tool.	3.1.1 Costing exercise completed and budget developed 3.1.2 Demonstration sites provided with necessary technology, access to medication, trained staff to implement the HEARTS Packages 3.1.3 No. of persons treated who are controlled for hypertension and diabetes 3.1.5 Bi-monthly HEARTS NCD Surveillance Report produced and circulated	Regional and Local HEARTS Teams, PAHO TRT, Dedicated trained staff/local Health Teams, Funding from PAHO/WHO Global HEARTS Initiative/HSSP for provision of site specific needs (Material: Forms etc Technogy: Point of Care Testing equipmwnt, Computers etc, Training)	By End 2019	Surveillance team, clinicians, clerks, DHVs, medical records staff, NSU, HEARTS Sub Committee, PAHO, UWI
4. Build capacity at different levels and on different areas to effectively implement the TTHI	5.1 Conduct training needs assessment 5.2 Develop Training plan 5.3 Conduct training of staff at each Demonstration site 5.4 Conduct training of staff at each Demonstration site	5.1.1 Training plan developed 5.1.2 Training materials developed, printed 5.1.3 Number trained by category of staff.		By End of 2019	
5. Revise formulary of drugs for treatment of hypertension and ensure availability and accessibility of essential medicines at the primary health care level	Review current medications for treatment of Diabetes and Htn and ensure alignment with TT National Treatment Guidelines	(i) core sets of medication available at each site (ii) basic health technology to facilitate implementation available at each site		By end 2020	
	Review procurement issues, stock outs, and communication between C40 and stakeholders to ensure access and availability	(i) procurement issues identified and mechanism to correct gaps developed (ii) availability of core sets of medications (hypertension/ diabetes mellitus drugs)		By End of 2019	

5. Strengthen NCD self management programme	5.1 Review access to Patient Education and Patient Support programs/services, ensuring to document and share lessons learned from existing relationships. 5.2 Build alliances with NGOs and Civil Society Groups related to NCD management 5.3 Develop tools/programs to strengthen patient education and self management, guided by HEARTS Healthy Lifestyle and Team Based care Modules 5.4 Develop a communications plan that engages a whole of government and whole of society approach to support patient education and self mamagement 5.3 Review and facilitate integration for the use of the Health Passport and other self monitoring tools. 5.5 Conduct relevant training for Lay persons in Self Management and support establishment of NCD Support Groups 5.5 Document and share lessons learned from innovations in self management	5.1.1 Communication plan developed 5.1.2 TTO Healthy Lifestyle Module customised from the HEARTS Package 5.1.3 Health passport revised and integrated for use in primary healthcare 5.1.4 At least one forum for best practice sharing implemented 5.1.5 Best practices for patient education and patient support documented 5.1.6 No. Clients achieve targeted control of BP and Blood Sugar		By End of 2019	

6. Strengthen CVD management in primary health care	6.1 Develop Clinical Management tools to ensure adherence to the application of the Guidelines. (treatment guidelines poster/algorithm/pocket reference for hypertension and diabetes) 6.2 Procure medicines and technology based on the needs assessment conducted Conduct needs assessment (CVD medicine and technology, procurement, distribution, management and handling of supplies at facility level) 6.3 Review utilisation of CVD Risk Assessment Tools in management of CVD in primary care settings	6.1.1 Treatment algorithms for hypertension developed 6.1.2 Treatment algorithms for diabetes developed 6.1.3 Treatment algorithms in use in all facilities within the program 6.1.4 Availability of core sets of medications (hypertension/ diabetes mellitus drugs) 6.1.5 CVD risk management guidelines developed and disseminated 6.1.6 CVD risk management being used at 100% sites		By End of 2020	
7. Build/strengthen multi-sectoral partnerships through communications and advocacy	7.1 Build alliances with NGOs and Civil Society Groups related to NCD management 7.2 Conduct relevant training for Lay persons in Self Management and support establishment of NCD Support Groups 7.3 Develop a communications plan that engages a whole of government and whole of society approach 7.4 Review and facilitate integration for the use of the Health Passport and other self monitoring tools. 7.5 Review access to Patient Education and Patient Support programs/services 7.6 document and share lessons learned from innovations in self management			By End of 2019	

8. Measure the impact of the implementation of TTHI on CVD/diabetes	8.1 Select Indicators (Core and Optional). 8.2 Development M&E Plan for TTHI. 8.3 Establishment of current baselines (prevalence data) 8.4 Conduct monitoring and evaluation of TTHI Establish targets, indicators of success, and the M&E framework (including reporting framework) 8.5 Engage with policy makers and academic institutions to document, findings after the first year of implementation	8.1.1 Targets and indicators selected and agreed on 8.1.2 monitoring framework established and used evaluation team identified 8.1..3 Evaluation conducted 1 year after the program 8.1.4 Articles and research papers on TTHI written 8.1.5 At least one article published in a peer reviewed journal 8.1.6 public forum to share the results of the program conducted after 1 year		By End of 2021