***Sample Referral Protocol***

## Step 5. Referral Protocols and Procedures

Step 5 has four separate tools: 1) the design for the workshop on developing referral protocols, 2) Guide Questions for plenary discussions during the workshop, 3) the prototype or sample referral protocols, and 4) sample of LGU referral protocol

This tool shows the **sample referral protocols/guidelines.**

**SAMPLE OF LOCAL DOTS NETWORK PROTOCOLS AND PROCEDURES**

### I. Participation in the TB DOTS Referral Network

1. The following can become members of the DOTS network:
    a. Public Health Facilities
        - Rural health units or health centers
        - MDR-TB Treatment Centers
        - Satellite treatment centers (MDR-TB)

    b. Other public facilities.
        - Public hospitals and laboratories
        - Jails and prisons
        - Public schools (DepEd)
        - Military barracks and clinics
        - Day Care Centers (DSWD)
        - Residential homes (DSWD)
        - Government workplaces (TB in workplace)

    c. Private health facilities.
        - Private hospitals and diagnostic centers
        - Private clinics /Private PPMD clinics
        - Referring private physicians (stand-alone)
        - Private companies (TB in workplace)
        - Private schools
        - Private pharmacies
        - NGO-run DOTS clinics

    d. Community partners.
        - Community-based organizations
        - TB task forces
        - Community Health Teams

2. Engagement of participating facilities shall be spearheaded by the local Multisector Coordinating Committee (MSCC) in collaboration with partners. The MSCC shall determine the strategic direction in engagement of other private or public partners.

3. TB service providers who express interest in being part of the DOTS Network should be trained or oriented on basic DOTS and the NTP Manual of Procedures (MOP). The training course should be determined and provided by the local government unit (LGU) in coordination with DOH.

4. Participation in the local DOTS Network should be formalized through a letter of agreement or a memorandum of understanding (MOU) between the LGU (Municipality/Province/City) and the participating facilities.

## II. Referral Procedures

1. Facilities may refer to other facilities for any of the following reasons:
    a. Diagnosis
    b. Registration and initiation of treatment
    c. Continuation of treatment
    d. Management of serious side effects and complications
    e. Screening for MDRTB/ DRTB
    f. Screening of TB among PLHIV

2. Identify the DOTS facility where client will be referred using the national DOTS or local DOTS Network directory, and mutually agree with the client where he/she will be referred.

3. A referring facility should accomplish an NTP referral form *(Form 7)*. Attach other pertinent documents when available, such as results of laboratory or x-rays and NTP records. The referral form and pertinent documents should be brought by the client to the receiving facility. Whenever feasible, the referring facility should inform the receiving facility about the referral.

4. For referring individuals/groups, a duly-recognized local referral form that has been agreed upon with the LGU may be used.

5. All receiving facilities should accommodate the referral and assess the needs of the client. In cases where the referral form is not clear, and the patient is unable to provide details of the referral, efforts should be exerted to contact the referring facility for clarification.

6. The receiving facility should record the referral in the institutional NTP records, as applicable (e.g., Form 1. Presumptive TB masterlist; Form 3. NTP Laboratory Register; Form 6a. Drugs Susceptible TB Register; Form 6b. DR-TB Register; Form 9. Hospital TB Referral Logbook). It is best to indicate the specific name of the referring facility.

7. The receiving facility should provide feedback to the referring facility through any of the following means:

    a. Return slip of the referral form

b. Call (via telephone)
c. SMS/ text message
d. Email
e. Other modalities

8. Once feedback is received, the referring facility should update his/her records on the outcome of the referral.

9. It will be the responsibility of the Provincial/City Health Office to communicate to all TB service providers within the network. In cases wherein the referred client is from outside the catchment area of the receiving facility, clarify with the client or the referring facility the reason for the referral (e.g., nearby workplace, residing in the boundary of the LGU but nearer the receiving facility, services not available within catchment area). Patient should still be accommodated by the receiving facility after agreement with the client on his/her responsibilities and tracing mechanisms.

## III. Recording and Reporting

1. Standard NTP recording and reporting forms shall be used by all participating public and private TB service providers as prescribed by the DOH-NTP.

2. For non-health facilities/individuals/groups, a recording system duly recognized by the LGU (e.g., recording logbook or alternative referral form) shall be maintained as an alternative to the presumptive TB Masterlist or NTP referral form, respectively.

3. Indicate in the NTP recording forms (i.e., presumptive TB masterlist, NTP Laboratory register, Drug-susceptible TB register, DRTB Register) the name of the source of the referral (e.g., names of private hospitals, government hospitals, pharmacies, private companies, schools, individuals, etc.). This can be in specific sections of the forms (as applicable) or under the Remarks column.

4. Indicate the source of the TB patient (from the DSTB register) in the NTP quarterly report on Case Finding (Report 3a).

5. NTP reports and other reports agreed upon by the network members should be submitted by the DOTS Network member-facility on a quarterly basis to the RHU/PHO/CHO depending on the agreement within the LGU.

6. Additional reports developed by the LGU as agreed with the health providers may include:

a. Report on number of referrals from pharmacies

b. Report on number of referrals from different community groups
c. Report on number of referrals from non-health facilities/ workplaces (whether public or private)
d. Report on number of TB cases that were referred from specific health providers (e.g., jails, public schools, private hospitals)

(Note: Other reports include the data collection forms developed by the MSCC/LGU to monitor the functionality and effectiveness of DOTS in SDN. Refer to the Monitoring and Evaluation section of this sample referral protocol to get an idea of the indicators and the additional data to be collected. You may need to update this section if the data collection forms are not ready by the time you draft this referral protocol.)

## IV. Logistics Management

1. All participating TB service providers formally engaged in the DOTS Network will be eligible to receive first-line, second-line anti TB drugs and laboratory supplies from the DOH through the LGU (Province, Municipality or City), if applicable. This will be subject to availability of drugs from the DOH.

2. DOTS facilities should submit a quarterly request for TB drugs using the standard NTP requisition form.

3. The LGU is responsible for ensuring availability of both standard reporting NTP forms and locally-recognized referral and recording forms for participating providers.

4. In cases of unforeseen stock-outs, the LGUs and PHIC-accredited DOTS facilities are encouraged to procure their own supply of anti-TB drugs but dispense these according to the NTP procedures.

5. Depending on the agreement with the Province/Municipality/City, anti-TB drugs may be provided to DOTS facilities in the following manner:

    a. In accordance with the NTP-MOP (i.e., 1 quarter supply and 1 quarter buffer) delivered every quarter
    b. Minimum buffer stocks maintained in the facility (e.g., 3-5 kits), request and delivery whenever stocks fall below the minimum

6. Drugs are to be picked-up by the facility from the LGU (Municipality/Province/City) on agreed dates and site.

7. The supply chain for anti-TB drugs will be consistent with the reporting flow (e.g., from facility to RHU to PHO).

## V. Monitoring and Evaluation (including Quality Assurance)

***Sample Referral Protocol***

1. Participating facilities will cooperate with the LGU (Municipality/ Province/City) and/or the MSCC in the conduct of technical monitoring of program implementation. Records and reports relevant to the program should be made available to the technical monitors.

2. Technical monitors can be the LGU TB program coordinators (Municipality/Province/City), MSCC members, DOH representatives or development partners.

3. The LGU (MHO/PHO/CHO will spearhead and coordinate the conduct of monitoring visits to the participating facilities. A monitoring and evaluation plan developed by the PHO/CHO and approved by the MSCC will be the basis for the conduct of M&E activities. The indicators to be used are as follows:
    a. Indicators for Inputs
        i. Percentage of engaged providers (DOTS network membership)
        ii. Functional MSCC
        iii. Availability of local policy support for the DOTS network
        iv. Availability of implementing guidelines/referral protocols
        v. Availability of budget for DOTS network
    b. Process Indicators
        i. Provision of services compliant with NTP policies
        ii. Implementation of M&E activities
    c. Indicators for Outputs
        i. Number of referrals per sectoral partner
        ii. Referral Acceptance Rate
    d. Indicators for Outcome
        i. Percentage contribution of community (15%)
        ii. Percentage contribution of private sector (30%)
        iii. Program turnaround time
        iv. Percent of patients who faced catastrophic cost (sold an asset or borrowed money)
        v. Diagnostic Delays
        vi. DSTB - 92% Case Detection Rate/Treatment Coverage Rate
        vii. DRTB – 90% Case Detection Rate/Treatment Coverage Rate
        viii. DSTB - 95% Treatment Success Rate
        ix. DRTB - 85% Treatment Success Rate

4. All monitoring findings will be relayed to the monitored facility and kept confidential. Assistance to improve program implementation will be discussed.

5. For participating TB microscopy laboratories, participation in the Quality Assurance System through quarterly selection and re-reading of a sample of slides will be conducted. This should be coordinated with the Provincial/City Quality Assurance Center (QA Center) under the LGU.

## VI. Roles and Responsibilities

1. Multisectoral Coordinating Committee
   a. Initiate the development of local policies, guidelines and plan for the DOTS Network.
   b. Advocate for the passage of legislative policies, resolutions related to DOTS network.
   c. Advocate with local governments to support activities to sustain the DOTS Network.
   d. Lead resource mobilization for the DOTS Network activities.
   e. Identify capacity building needs and recommend to PHO/CHO for implementation.
   f. Regularly assess the notification processes and recommend ways to improve it.
   g. Conduct monitoring and evaluation of the DOTS Network.
   h. Develop mechanism to ensure access and minimize delays to diagnostic and treatment services and reduce out-of-pocket cost to patients.
   i. Receive feedback from participating partners and key affected populations and discuss/mediate interventions to address any problems.

2. Province/City/Municipal LGUs and HUCs
   a. Create policies to support the DOTS network and to institutionalize the membership of participating TB service providers.
   b. Lead the development and implementation of sustainability mechanisms of the DOTS Network.
   c. Allocate budget for activities related to the local implementation of RA 10767 and MSCC activities to maximize participation of members.
   d. Provide (Mobilize?) logistical support and other enablers for TB patients and other resources for the program.
   e. Assist in the mapping of participating and non-participating TB service providers (master list) and advocacy to participate.
   f. Disseminate the directory of participating TB service providers which shall be derived from the master list.
   g. Update annually the local directory to reflect new members of the network as well as potential attrition.
   h. Implement the referral and tracking mechanism for patients and biological specimens
   i. Provide anti-TB drugs, laboratory supplies and other commodities from DOH to DOTS facilities based on agreed modes of allocation and delivery.
   j. Initiate monitoring and evaluation activities, including monitoring visits to facilities and program implementation reviews.

3. Provincial/City Health Office

a. Act as secretariat to the MSCC and assist in the development of local policies, guidelines and plans for DOTS Network.
b. Coordinate with the DOH regional offices in the conduct of trainings and orientation for the network.
c. Coordinate the activities planned by the MSCC related to the DOTS Network.
d. Document all meetings and activities and maintain records.
e. Receive and analyze reports from DOTS facilities (as agreed within the local DOTS Network).
f. Submit regular NTP reports to the DOH RO and special reports agreed within the DOTS Network.
g. Plan the monitoring and evaluation of the DOTS Network
h. Conduct monitoring and technical supervision of the members of the DOTS Network.
i. Facilitate communication between and among MSCC and DOTS Network members.
j. Coordinate with the DOH regional office for the supply of anti-TB drugs, laboratory supplies and other commodities that may be required.
k. Provide feedback to participating facilities and MSCC about any problems encountered in implementation of DOTS Network.
l. Draft the referral protocol and procedures

4. TB Service Providers
   a. Comply and ensure adherence to the agreed referral protocols and procedures and forms.
   b. Support the sustainability mechanisms installed by their respective LGUs.
   c. Refer identified presumptive TB cases, biological specimens and diagnosed TB cases to other TB service providers, if necessary.
   d. Receive, accommodate and assess referrals from RHUs/HCs and other TB service providers
   e. Notify PHOs/CHOs of all diagnosed TB cases within one week of diagnosis.
   f. Provide feedback to referring facilities on outcome of referrals.
   g. Encourage the patient to continue consultation and follow-up with participating private physician while on treatment.
   h. Provide follow-up care for patients receiving treatment/TB drugs from private TB service providers.
   i. Provide data information for monitoring the functionality of the DOTS Network.
   j. Attend activities planned by the MSCC or PHO/CHO.
   k. Comply with Quality Assurance system for TB diagnostics.
   l. Coordinate with other TB service providers for tracking down referrals.
   m. Request, transport, store and use anti-TB drugs, laboratory supplies and other commodities in accordance with NTP policies and procedures and as agreed within the DOTS Network.
   n. Provide feedback to the MHO/PHO/CHO or MSCC about any problems encountered in implementation of DOTS Network.
   o. Participate in monitoring and program implementation reviews.

***Sample Referral Protocol***

5. DOTS Referring Facility/Individual/Group
   a. Identify and refer presumptive TB cases, biological specimens and diagnosed TB cases.
   b. Assist CHOs and MHOs in tracking patients, as applicable.
   c. Attend meetings and advocacy activities.
   d. Submit reports on referrals.
   e. Comply with the agreed DOTS Network protocol.