Kingdom of Cambodia

Nation Religion King

Ministry of Health

Standard Operating Procedures for Clinical Mentoring within Pediatric AIDS Care Services

May 2012

National Center for HIV/AIDS Dermatology and STD

Forward

In 2011 the National Centre for HIV/AIDS, Dermatology and STDs (NCHADS) and partners joined together to develop this Standard Operating Procedure for Clinical Mentoring at Pediatric AIDS Care (PAC) sites in Cambodia. In recent years the national program has achieved high levels of treatment coverage. More than 5,500 HIV-infected children were enrolled in PAC and among these 4439 children were on ART by the end of 2011, representing nearly 90% of children estimated to be in need of ART in that year.

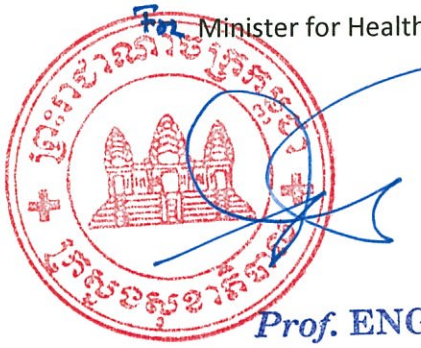
Now that the rapid scale up phase is nearing an end the program is transitioning to focus more attention on quality of patient care to address issues such as drug toxicity and treatment failure among the pediatric cohort. Many PAC sites have very small cohorts and limited experience addressing the diverse clinical needs of the pediatric cohort, especially uncommon cases or complex issues which require special expertise to assess and treat. Few pediatric sites around the country have the experience and capacity to address these complex clinical issues in their patients. Furthermore, clinicians with the experience necessary to manage such cases tend to be clustered at a small number of pediatric sites.

The aim of this SOP is to facilitate improved experience sharing and support for clinicians facing challenging cases every day. This SOP describes the structured mechanism through which experienced clinicians can share their expertise in managing clinical issues of the pediatric ART cohort with sites that may have less capacity to manage complex cases. Clinical mentoring will further provide a means of providing regular support for clinicians to ensure that patients receive appropriate care and will also facilitate the professional development of clinicians responsible for Pediatric AIDS Care throughout Cambodia.

This mentoring initiative will provide invaluable support for clinicians responsible for Pediatric AIDS Care in Cambodia and create a path for NCHADS and partners to ensure improved quality of patient care for the entire ART cohort.

Phnom Penh, 13 / June / 2012

For Minister for Health



Prof. ENG HUOT

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Phnom Penh, 24 / May / 2012

Director of National Pediatric Hospital

Prof. Chhour Y Meng

Director of National Center for HIV/AIDS Dermatology and STD

Dr. Mean Chhi Vun

List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral drug
CD4	T-CD4+ Lymphocyte
CHAI	Clinton Health Access Initiative
CoC	Continuum of Care
CQI	Continuous Quality Improvement
D4T	Stavudine
Hb	Hemoglobin
HEI	HIV-Exposed Infant
LR	Linked Response
MCH	Maternal and Child Health
NCHADS	National Centre for HIV/AIDS, Dermatology and STDs
NMCHC	National Maternal and Child Health Centre
NPH	National Pediatric Hospital
NGO	Non-Governmental Organization
OD	Operational District
OI	Opportunistic Infection

PAC	**Pediatric AIDS Care**
PASP	**Provincial AIDS and STI Programme**
SRH	**Sexual and Reproductive Health**
TWG	**Technical Working Group**
TB	**Tuberculosis**
UNICEF	**United Nations Children's Fund**
VL	**Viral Load**
WHO	**World Health Organization**

Contents

1. Introduction and background

1.1 HIV Program Context

As the HIV treatment cohort in Cambodia matures the national priority has evolved from scale-up of AIDS Care services to improving the quality of care and treatment. HIV care and treatment services have rapidly expanded during the last five years and there are currently 33 functioning and 3 not yet active Pediatric AIDS Care (PAC) sites in Cambodia, providing ART and pre-ART care to more than 5,500 children across the country. Some treatment sites are well established, have experienced clinicians, and high patient volumes. Other sites are newly established or have lower patient volumes and may have clinicians with less practical experience. Furthermore, the national program recently shortened the duration of the didactic component of its HIV clinical care training program.

The clinical mentoring strategy will support the capacity development of clinicians in newly established, lower volume, or weak sites while fostering professional support relationships and referral networks between expert and less-experienced clinicians. The strategy will support regional referrals between PAC sites to ensure treatment and care or complex cases. The strategy will align with Cambodia's vision for achieving the goals of zero new HIV infections, zero AIDS related deaths, and zero HIV-related stigma. It specifically supports elimination of new HIV infections among children and elimination of mortality among HIV-exposed and HIV-infected children.

1.2 Clinical Mentoring in the context of HIV care quality improvement strategies

In Cambodia, there are a number of national activities and approaches which support quality improvement. These strategies include Supportive Supervision to address program management issues, Continuous Quality Improvement (CQI) to monitor and improve quality of care indicators, and training and network meetings to build clinical competency. Clinical mentoring is distinct from these in that it focuses on clinical competency.

As new initiatives, approaches and guidelines are established there is a need to provide ongoing support to OI/ART and PAC teams to promote clinical skills development and high quality implementation of national treatment protocols. Continuum of Care Coordinating Committees (COCCC) meet every two months to coordinate activities and contribute to quality improvement. Clinical Mentoring will compliment other existing strategies in strengthening the

quality of care. Table 1 presents the roles, functions and frequency of the quality improvement mechanisms with the HIV program.

Table 1 presents national quality improvement activities

	Activity	Purpose	Frequency	Format	Facilitator / Recipient
1	Supervision	To address management challenges	Quarterly	Site visit	National program staff to OI/ART or PAC sites
2	CQI	To address and improve performance at the COC level	Semi-annually or quarterly	Workshop	National Program to OD level COC teams
3	Clinical Training	Build knowledge of health staff	Once at the start of work	Didactic and practical training	National to OI/ART and PAC teams
4	Clinical Refresher Training	Deliver updates on new information and reinforce key messages	Periodic	Didactic training	National to OI/ART and PAC teams
5	Network Meetings	To provide clinical updates through peer case review format and national program presentations	Semi-annually	Large group meeting	Nationally facilitated regional meeting for OI/ART teams; Nationally facilitated meeting for PAC teams
6	COC Coordinating Committee Meeting at OD level	To identify problems and find solutions to support strong implementation and good collaboration of COC components	Once every two months	Meeting at OD level	Coordinated at by the OD or Province depending on context
7	Clinical Mentoring	To develop clinical competency of OI/ART and PAC teams	As needed	One-on-one/ Mentor-to-mentee	Regional to OI/ART or PAC sites

2. Objectives of clinical mentoring strategy

Clinical mentoring will be used to strengthen the clinical competency of PAC teams. The objectives of the clinical mentoring strategy are:

- To provide competency based clinical mentoring to health staff working in Pediatric AIDS Care services.
- To reinforce training provided by the national program to health staff working in Pediatric AIDS Care services.

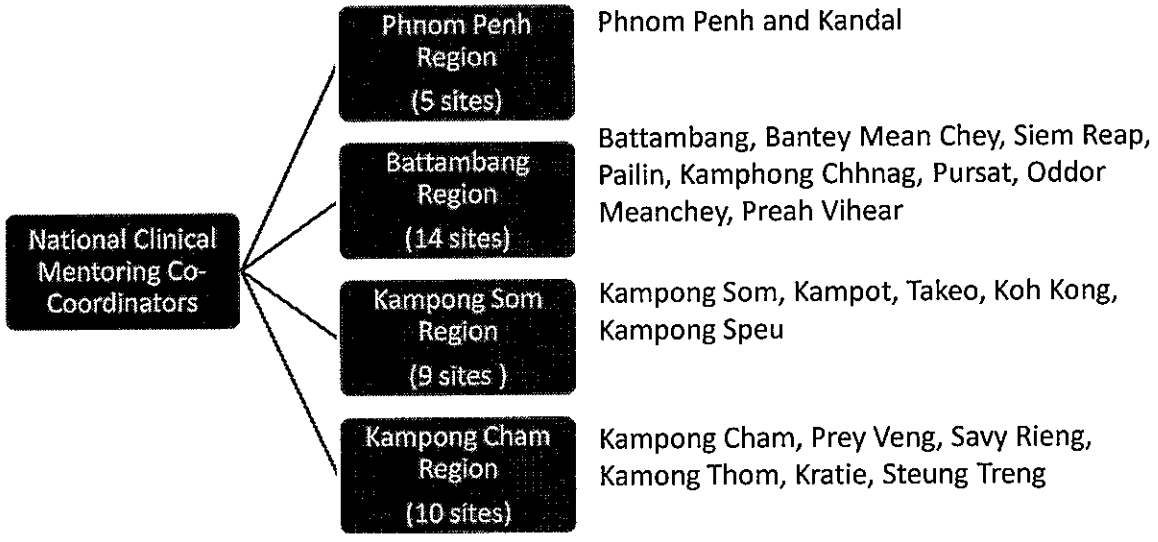
- To strengthen the implementation of clinical guidelines and SOPs.
- To support regional clinical referrals between PAC sites.
- To develop a national cadre of clinical mentors and to build the skills of mentors.

3. Clinical Mentoring Approach

3.1 Regional Structure

The clinical mentoring approach will establish a regional support mechanism to deliver professional skills development to clinicians working at PAC sites. The mechanism will support regional exchange between assigned mentors and mentees and will support clinical referrals within regions. Cambodia's PAC sites will be divided into four regions for the purpose of clinical mentoring; the Phnom Penh region, the Battambang Region, the Kampong Cham Region, and the Kampong Som Region. Figure 1, below, presents the regional groupings. Activities in each region will be supported by specifically assigned "national mentors" and the activities of all regions will be coordinated by two "National Mentoring Co-Coordinators" who will be identified with the National Pediatric Hospital and the National Center for HIV/AIDS Dermatology and STD.

Figure 1: Provincial groups form the clinical mentoring regions



3.2 Regional Mentoring Activities

Clinical mentors will be active in each region. These clinical mentors will come from established sites with large cohorts. Mentors will provide clinical mentoring to sites/clinicians within their respective region or may be assigned to support another region depending on the human resource availability. PAC clinicians will receive mentoring from experienced clinicians within their region.

Mentors and mentees will meet for mentoring at least semi-annually. Throughout the mentoring relationship medical records of patients will be reviewed by mentors at each site. Common challenges and weaknesses around diagnosis and management of side effects, diagnosis and management of treatment failure, and exposed infant care will be identified. Emphasis will be placed on re-enforcing implementation of the newly revised guidelines and strengthening documentation of patient care. This will allow problems in clinical management to be corrected. For example, if a child has indications for workup for treatment failure, the mentor will note this in chart, prompting the appropriate evaluation of a patient at the next visit.

At the OD or provincial level two mentoring modalities are proposed. These modalities include:

1. "Mature site" physicians can do routine visits to newer sites regularly for the first three months to provide on-the-job training and support. A schedule should be developed based on need, human resource availability, and funding. Visits may be monthly, quarterly or as mutually agreed between the mentor and mentee.
2. Newly trained site physicians will visit their mentors at more mature, experienced, high patient volume sites for on the job clinical training (especially at the beginning of the mentorship arrangement).

3.3 Regional Clinical Mentoring Linkages, Referral Networks and Coordination

Mentoring and Referral Networks

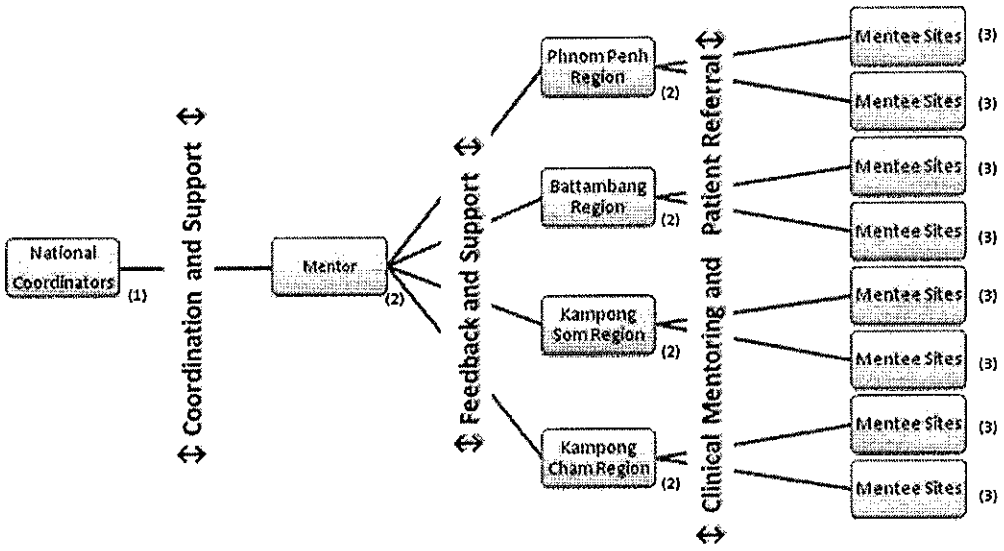
Facility links within regions and clinical referrals between PAC facilities will be strengthened through the clinical mentoring approach. When clinicians are faced with challenging, unfamiliar or complex cases they will be encouraged to contact a mentor and receive remote support by telephone or to refer patients to a mentor facility. In addition to in-person support, experienced clinicians will be available to consult with mentees by phone. To facilitate this arrangement a contact list will be created and maintained within each region and nationally. When appropriate care for complex cases cannot be delivered at a mentee site, patients will receive an assisted referral to a mentor site for diagnosis and treatment. Home-based care teams will support the transportation component of the referral.

Coordination

At the regional level Clinical Mentoring activities will be coordinated in part through *Mentor Feedback Meetings* and or *Regional/National Clinician Network Meetings*. Regional/National Clinician Network Meetings have been operational since 2006 and take place semi annually. To facilitate the exchange of information and learning across sites clinical mentoring activities will be linked to these existing network meetings. Mentor Feedback Meetings will provide an opportunity for mentors to compile data, exchange ideas about challenges and gaps and to propose solutions for consideration by the national program.

While clinical mentoring will be a regionally organized activity the national program will play a coordinating and supportive role. The national program will identify mentoring priorities, both geographic and clinical and communicate with mentors to ensure focus clinical mentorship around defined national priorities. NCHADS will organize periodic National Clinical Mentoring Meetings and ensure mentor participation in national clinical TWG meetings including ART TWG and PAC TWG. Finally, NCHADS will consolidate feedback and data from mentors and mentees, and liaise between mentors and mentees to ensure activities and visits are occurring as planned.

Figure 2: Mentor and Mentee Site Linkages



National Level (1)

- National coordination and support for mentors is offered through national mentoring coordinator and NCHADS
- National mentoring meetings allow for feedback and exchange
- Budget planned and is disbursed through AOCP process
- Data is compiled , analyzed and fed back to regional mentors

Regional Level (2)

- Mentors travel to PAC sites to deliver mentoring
- Chief mentors coordinates clinical mentoring and support activities
- Large T site receive patients with complex clinical presentations
- Regional mentoring meetings for feedback and exchange
- Data is compiled and submitted to NCHADS

PAC Site (3)

- Mentees receive coaching and support to build clinical skills
- Mentors travel to mentee sits and mentees travel to mentor sites for bedside learning
- Patients receive referral to larger facilities for clinical issues that cannot be addressed at smaller sites

3.4 Integration of Clinical Mentoring Within the National Program

The Clinical Mentoring strategy will be aligned with national program priorities and activities and plans.

The clinical mentorship strategy will:

- Compliment other quality improvement activities including supportive supervision, CQI, clinical trainings, orientations, workshops, and network meetings;
- Build on existing national and regional network meetings whenever possible to minimize costs and maximize efficiencies;
- Be delivered in a manner which is well coordinated at the national, provincial and district levels.

To ensure coordination clinical mentors will:

- Participate in relevant regularly scheduled national technical working groups (PAC TWG);
- Ensure that mentoring reinforces clinical care priorities that are in line with the national program;

- Participate in the leadership and preparation of network meetings;
- Liaise with the National Clinical Mentorship coordinator;
- Attend periodic mentor meetings.

Mentoring will focus on building clinical competency. While mentorship will be tailored to the needs of each clinician, key areas of national priority will be addressed to ensure that the mentoring approach supports the overall efforts of the national program. Mentors will ensure that mentees are updated on emerging national guidance including clinical guidelines, memorandum, and standard operating procures.

The NCHADS will interface with mentors in order focus clinical mentorship activities around one to three annually defined national priorities. In 2012 these include:

- Diagnosis of toxicity and appropriate switching to alternative first line regimens.
- Diagnosis of treatment failure through appropriate use of viral load testing.
- Care of the HIV-exposed infant and early diagnosis and treatment of HIV infected infants.

3.5 Roles and Responsibilities

Clinical mentors in each region will be drawn from mature PAC sites as well as from and partner organizations. As noted above, mentors will be grouped by region. At the launch of the strategy mentors will be assigned to one mentee site. Expansion to multiple mentee sites will be considered after the relationship is well established, or after the first six months.

Mentors will be selected based on experience. Mentors will have at least three years of clinical practice experience and will be affiliated with PAC sites that have ART cohorts of more 100 individuals. Mentors will show demonstrated interest in contributing to national program activities.

Box 1: Clinical Mentoring Roles and Responsibilities

Mentee Role

- Participate in joint assessment and establishment of joint priorities for work with the mentor
- Be willing to work with a mentor .
- Be willing to diligently and accurately complete patient file forms

- *Mentor Role* Report to the National Mentor Co-Coordinators
- Conduct site assessment and establish priorities for work with the mentee site

- Evaluate competency of mentees using the clinical assessment checklist, including: 1) chart review with special attention to common challenges including identifying and dealing with side effects and diagnosis of treatment failure, 2) direct observation of clinical practice, 3) asking questions, and 4) working through case studies
- Provide practical training at the mentor site *(this activity will take place at the mentor site)*
- Provide on-the-job training support for mentee sites, at least semi-annually *(this activity will take place at the mentee site*
- Record experience and progress of mentee sites using the forms included in Annex I
- Deliver necessary follow-up, in person or over the phone to mentees
- Participate in skills building and mentorship training on how to provide constructive support to mentees
- Assist with accurate data collection and entry / medical note taking
- Prepare for and lead select activities at Paediatric Network Meetings and trainings

National Mentoring Co-Coordinator Role (Shared responsibility of NPH and NCHADS)

- Report to the Sub-Working Group on Paediatric AIDS Care
- Coordinate mentor feedback and liaise with the Sub-Working Group on Paediatric AIDS Care
- Prepare for and lead select activities at Paediatric Network Meetings and other trainings
- Develop, compile and submit annual and quarterly mentoring plans and reports to the national program
- Coordinate national clinical mentoring activities
- Ensure that mentors have access to and ART and Pre-ART Facility reports for the sites they are supporting
- Ensure that mentoring activities are implemented according to the Mentoring Workplan
- Communicate plans with mentors
- Support and facilitate mentor attendance at Sub Working Group
- Support professional development for mentors
- Maintain and disseminate a database of mentors with up-to-date contact information
- Work with partners to maintain an electronic library of reference material for mentors

4. Practical Implementation of Clinical Mentoring

4.1 National Launching of Clinical Mentoring

National launching of clinical mentoring will included the following practical steps:

1. Pediatric AIDS Care sites will be divided into four regions; Phnom Penh, Kampong Cham, Battambang, and Kampong Som. (Regional assignments appear in Annex 1)
2. Mentor and mentors sites will be identified within each of the four regions. A series of criteria will be used to identify mentor sites. Mentors and Mentor sites will:
    a) Have experienced clinicians who are available and willing to participate in mentoring;
    b) Be geographically accessible to mentee sites;
    c) Have higher patient volumes to ensure exposure to more complex clinical presentations.
3. Mentors will receive orientation to ensure they understand their roles and responsibilities.
4. Clinical mentor sites in each region will be paired with mentee sites within the respective regions.
5. Clinical mentoring activities will be included in the Annual Operational Comprehensive Planning process.
6. OI/ART sites in each region will be assessed. Those determined most in need of support will receive priority status.
7. Annual Regional Mentoring Plans will be developed with support from the national program. Budget for these plans will be included in the AOCP and MoH AOP.
8. As needed, national and international clinical experts will be requested to participate. NCHADS may request this support from multilateral, bilateral, and NGO partners.

4.2 Practical Implementation of Clinical Mentoring at the PAC Site Level

Clinical mentors will be paired with a limited number mentee sites. Mentors must be able to maintain their clinical responsibilities while providing support to others. Initially, it is suggested that mentors begin with one or two mentee sites. Box 2 presents the practical steps each mentor will take as he or she supports mentees. Clinical mentors will use the Clinical Mentorship Tools described in section 5.2 to support and document their work.

Box 2. Practical Implementation of Clinical Mentoring at the Regional Level

1. **National Orientation Workshop** – Clinical mentors and will be oriented to the mentoring strategy concept at a national meeting. Attendees will include: physicians, counsellors, PHD and OD directors, hospital directors, PASP Officers, and OD HIV and STI Coordinators.

2. **Regional Planning Workshop** - Sensitization and planning meetings will take place following the national orientation. Within each region, mentors will work with the national program to prioritize sites and PAC clinicians in need of mentoring and plan mentoring activities. ART and Pre-ART Facility Reports and anecdotal information will be used to inform site prioritization. Newly trained clinicians, newly opened sites, and sites with higher rates of loss to follow-up and death will be prioritized.
3. **Preparation** – Mentors will prepare for mentoring by reviewing mentee site program data and assembling a *Mentoring Kit*. See Annex III, *Practical Advice for Beginning Mentoring for details*. The national program with partners will ensure mentor access to necessary facility data and materials.
4. **Placement of Clinical Mentors** - The national program will support mentors as they are placed at mentee sites. The national program may assist mentors as they lead site assessments. The national program will assist in sensitization around the clinical mentoring concept.
5. **Assessment of the Mentee and Site** - Mentors will assess the mentee's clinical capabilities and develop a mentoring plan using the *Clinical Mentoring Tools.* This will include completion of the *Clinical Mentee Self-Assessment* and the *Clinical Mentor Assessment* forms. The process will include
    - chart review
    - direct observation of clinical practice
    - asking questions
    - working through case studies

    In addition, mentors determine whether there are basic tools and clinical instruments needed at the mentee site are available to the mentee clinician. The national program will assist mentors in identifying and filling medical supply gaps at mentee sites. Needed items might include drugs, diagnostics, or clinical instruments like scales, stethoscopes and othoscopes, and equipment such as refrigerators and filing systems.
6. **Mentorship Planning** - Using the *Clinical Mentorship Plan* form described in section 5.2 the mentor and mentee will agree and outline a basic plan for the mentorship. Mentor, Mentee, and the Mentee's supervisor will agree to and sign the form. This plan will be developed *after* the mentor and mentee complete the assessment process.
7. **Mentoring Visits** - Mentors will visit mentee sites, and mentees will visit mentor sites. Mentoring may also occur by telephone or e-mail. Mentors will use the Clinical Mentor Assessment Tool to document the mentees' skill building progress and competency throughout the mentoring relationship. Mentors and mentees will document their travel and communication for the purpose of program reporting and reimbursement. Following mentoring feedback meetings, patients will be called back so that inadequate care can be corrected. For example, if a child has indications for workup for failure, a note would be left in the chart so that the patient can be evaluated properly the next visit. This will reinforce guidelines and good documentation of clinical care while facilitating better care for patients with problems.
8. **Mentor Feedback Meetings** – Regional Mentor Feedback meetings will facilitate regular exchange. A review of patient medical records at mentee sites will be conducted and

common challenges in PAC will be identified. These meetings will also provide a venue for preparation for Clinical Network and Sub-Technical Working Group meetings. Feedback meetings may be held at the regional or national level. Mentors are encouraged to invite the national program and partners to attend feedback meetings.

9. **Network Meetings and Trainings** – Mentors will facilitate at Network Meetings. Mentors will ensure that the content to Network Meetings will address common gaps and weaknesses identified my mentors in the field. Mentees will routinely participate in the Network Meetings.
10. **Evaluation** – After the period of one year, mentee skills will be evaluated using the *Clinical Mentor Assessment* records which have been maintained throughout the mentoring. The mentees, mentors and NCHADS AIDS Care Unit and partners will jointly determine whether mentoring should continue at the same frequency, be reduced, or conclude.
11. **Awards** – Mentors and mentees will be recognized with award certificates.

4.3 Support and Motivation for Clinical Mentorship

Mentors and mentees will be supported in the following manner:

- **Mentors** will be compensated for their travel for telephone and electronic communications costs.
- **Mentors** will receive opportunities for professional development including support for attendance at international scientific meetings. clinical practices, exchange visit
- **Mentors** will have access to an electronic library of information which is maintained by the national program. This "drop-box" will contain guidelines, SOPs, recent relevant papers from the international literature, and job aids.
- **Mentors** will have the opportunity to receive in-service training at national and international training venues.
- **Mentees** will be compensated for their travel and communication costs.
- **Mentees** will receive awards of recognition for successful completion of the mentoring program.

5. Monitoring and Evaluation

5.1 Monitoring and Evaluation Approach

The Clinical Mentoring strategy will monitored through the routine review of selected existing HIV program indicators as well as collection and review of clinical mentoring specific process indicators. Clinical mentoring data including the number of mentees, sites, and mentoring visits

conducted will be collected by each mentor and reported to the Co-Coordinators on a quarterly basis. Clinical competency and skills of mentees will be evaluated and monitored using the tools described in section 5.2.

5.2 Clinical Mentoring Tools

A series of paper based tools will be used by mentor and mentee to document and report on mentoring activities. Mentors will maintain records of their work and use these records to report to NCHADS and funding partners on a quarterly basis. Table 2 outlines the content and purpose of each tool.

Table 2. Overview of clinical mentoring tools.

Tool Name	Description	Purpose
Clinical Mentee Self Assessment	Comprehensive checklist of clinical competencies to be completed by the mentee (Identical to Mentor Assessment)	To facilitate comprehensive self assessment of mentee's own clinical skills
Clinical Mentor Assessment	Comprehensive checklist of clinical competencies to be completed by the mentor about (Identical to Mentee Self Assessment)	To facilitate comprehensive assessment of clinical skills by mentor of mentee
Clinical Mentorship Plan	Clinical mentorship work plan template	To plan and document mentoring visits
Clinical Mentorship Report	Reporting form to support financial disbursement and program coordination.	To outline and account for mentor and mentee responsibilities and identify key challenges
Regional Clinical Mentoring Report	Regional activity report form	To provide quarterly activity updates to the national program

5.3 Monitoring Indicators

The clinical mentoring strategy will monitored in part through the routine collection and review of strategy specific indicators. The following indicators will be collected through the Regional Clinical Mentoring Report. The report will be collected on a quarterly basis.

Number of mentee clinicians receiving clinical mentorship

Data source: Clinical Mentoring Report

Reference: Concept for HIV Care Quality Improvement Through Clinical Mentoring

Number of PAC sites receiving mentorship

Data source: Clinical Mentoring Report

Reference: Concept for HIV Care Quality Improvement Through Clinical Mentoring

Number of active clinical mentors

Data source: Clinical Mentoring Report

Reference: Concept for HIV Care Quality Improvement Through Clinical Mentoring

Number of mentorship visits conducted

Data source: Clinical Mentoring Report

Reference: Concept for HIV Care Quality Improvement Through Clinical Mentoring

The following service access indicators will be collected on a quarterly basis:

Number and percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth

Numerator = Number of infants born to HIV-infected mothers started on CTX prophylaxis within two months of birth

Denominator = Estimated number of HIV infected pregnant women in Cambodia

Note: For the purpose of Clinical Mentoring monitoring and evaluation the denominator should

be adjusted for the OI/ART catchment in question.

Reference: National Guidelines for the Prevention of Mother-to-Child Transmission of HIV, 2011

Number of children on ART died

Numerator = Number of children on ART died
Denominator = Number of children on ART

Reference: ART Facility Report

Number of children on Pre ART died

Numerator = Number of children on Pre ART died
Denominator = Number of children on Pre ART

Reference: Pre-ART Facility Report

Annex I: Clinical Mentoring Sites, Adult and Pediatric Mentors by Region

Region	*Site name*	*RH Name*	*Mentor name*
Kampong Cham	Kampong Cham	1- RH Kampongcham	Dr Lun Tripatric
		2- RH Tbongkhmum	
	Prey Veng	3- RH Preyveng	
		4- RH Nakloung	
		5- RH Pearaing	
	Svay Reing	6- RH Svay Rieng	
		7- RH Romeas Hek	
	Kampong Thom	8- RH Kampong Thom	
	Kratie	9- RH Kratie	
	Stung Streng	10- RH Stung Treng	
Phnom Penh	Phnom Penh	11- NPH	Drs Ung Vibol, Hout Chann Teany, Chann Bunthy, Pich Boren, Srey Sokhunn, Sam Sophann
		12- SHC	Dr Bun Vannary
		13- Khmer Soviet	Dr Siek Meng
	Kandal	14- RH Chey Chum Neak	
		15- RH Kok Thom	
Sihanoukville	Sihanoukville	16- RH Sihanouk Vill	Dr Ouk Phirin
	Kok khong	17- RH Smach MeanChey	Dr Noun Sangvath
		18- RH Sre Ambel	
	Kampot	19- RH Kampot	
		20- RH Kampong Trach	
	Kampong Speu	21- RH Kampong Speu	
	Takeo	22- RH Don Keo	Dr Phat Vuth
		23- RH Kirivong	
		24- RH Angroka	
Battambang	Battam bong	25- RH Battambong	Dr Chea Pov
		26- RH Mong Russey	
		27- RH SamPoa Lounn	
	Bantey Mean Chey	28- RH Mong Kul Borey	Dr Chee Vicheat
		29- RH Serey Sophoan	
		30- RH Poi Pet	Opening in 2012
	Pailin	31- RH Pailin	
	Siem Riep	32- RH komar Angkor	
		33- RH Sotnikum	
		34- RH Kralagn	
	Phreavihea	35- RH Phreavihea	
	Odar Meanchey	36- RH Odarmeanchey	
	Pursat	37- RH Pursat	
	Kampong Chhnang	38- RH kampong chhnang	

Annex II: Clinical Mentoring Tools

Tool I. Clinical Competency Assessment / Mentee Self –Assessment
To be completed by: Mentee
Submitted to: Clinical Mentor
Frequency: At beginning and end of mentoring attachment
Purpose: For the mentee to complete a self-assessment of their own specific clinical competencies.

Clinical Competency Assessment: Mentee Self-Assessment			
Name:		**Date:**	
Directions for Mentee: The following tasks ask how confident you feel about your ability to do specific HIV related clinical skills. Put the number in the box that you feel best shows how confident you are at the following tasks:			
1	I am not at all confident: I do not know how to do this task		
2	I am somewhat confident: I can perform the task with support		
3	I am extremely confident: I am capable of doing this task and consider myself competent / proficient		
4	I consider myself to have expertise and can teach this task to others		
		Task/Competency	**1-4**
All Care	**1**	Obtain a comprehensive health history in adults, children and pregnant women	
	2	Perform a complete physical exam of adults and children (heart rate, respiratory rate, weight, height, blood pressure, etc.)	
	3	Properly document history and physical exam in patient record	
	4	Weigh and measure child and calculate Z score	
	5	Treats patients with empathy, dignity, and respect using language terms the patient understands	
	6	Carry out clinical review of patients and present the patient cases in a clinical review forum	
Comprehensive Care of Children	**7**	Educate patients on HIV/AIDS disease progression, including modes of transmission and prevention	
	8	Educate patients on the proper and consistent use of male and female condoms	
	9	Educate patients on the signs and symptoms of HIV infection, including opportunistic infections	
	10	Correctly counsel and diagnose HIV in adults, infants and children with the understanding of the role of antibody vs. virologic HIV tests	
	11	Describe the relationship between HIV and TB and how to diagnose TB	
	12	Order and interpret lab tests according to clinical assessment and with respect to current HIV protocols: rapid and confirmatory HIV antibody tests, DNA-PCR, Hb/Hct, rapid pregnancy test, RPR or other rapid syphilis test, creatinine (calculate), white blood cell count, liver enzymes (ALT, AST), lipids, glucose, CD4 count, viral load, sputum microscopy for AFB, sputum culture, stool exam for ova and parasites, urine dipstick	
	13	Diagnose and manage (treatment/referral) common and severe respiratory diseases: pneumonia, tuberculosis, Pneumocystis Carinii Pneumonia (PCP)	
	14	Screen all patients for TB and provide Isoniazid Preventive Therapy (IPT) as necessary	
	15	Prescribe the correct TB drugs at the correct dose and monitor patients according to National TB Guidelines	
	16	Suspect and manage/refer TB treatment failure	
	17	Diagnose and manage peripheral neuropathy	
	18	Diagnose and manage gastrointestinal diseases and dehydration: acute diarrhoea, persistent diarrhea, dysentery, etc.	
	19	Diagnose and manage oral candidiasis, esophageal candidiasis, gum/mouth ulcers, oral hairy leukoplakia, oral malignancies	
	20	Recognize and provide appropriate therapy/referral for skin diseases: impetigo, folliculitis, herpes simplex, tinea, varicella zoster, scabies, seborrhea, pruritic popular eruption, drug reactions, kaposi's sarcoma, anogenital ulcers, warts, herpes	
	21	Recognize and provide appropriate therapy/referral for neurological diseases: toxoplasma brain abscess, neurosyphilis, cryptococcal meningitis, TB meningitis, progressive multifocal leucoencephalopathy (PML), malignancies, etc.	
	22	Diagnose and manage psychological disorders (treatment/referral), including depression	
	23	Initiate and manage cotrimoxazole at the correct dose at the correct clinical stage, managing adverse reactions and know when to discontinue	
	24	Initiate and manage secondary fluconazole prophylaxis at the correct dose and know when to discontinue	

	25	Explain mechanism of action of ARVs, goals of treatment, and describe what drug resistance means and how it develops	
	26	Identify drug-drug interactions in commonly co-administered medications	
	27	Identify common and serious side effects of each ARV, including laboratory studies used in assessment, and manage/refer appropriately	
	28	Prepare patients for ARVs, including develop of a treatment plan (including anticipating ARV supply needs) and an adherence plan	
	29	Recognize and provide appropriate therapy/referral for immune reconstitution inflammatory syndrome (IRS)	
	30	Identify treatment failure clinically, virologically, and hematologically	
	31	Make appropriate switches to alternative first-line ARV regimens in appropriate circumstances	
	32	Correctly provide syndromic management of STIs	
	33	Provide PEP in case of sexual assault and occupational exposure	
	34	Determine WHO clinical stage of adults, including calculation of BMI	
	35	Prescribe the correct ARVs for the first line regimen in adults, including pregnant women according to national guidelines	
	36	Prescribe the correct drugs for TB/HIV co-treatment in adults, including pregnant women according to the national guidelines	
Care Specific to Women	37	Counsel mother on benefits and risks of breastfeeding vs. replacement feeding, including the role of nevirapine prophylaxis in reducing HIV transmission through breastfeeding	
	38	Explain post-partum package of care and follow-up schedule for HIV positive women and their newborns	
Care Specific to Children	39	Monitor growth, accurately play weight, height, and head circumference on a growth chart on every visit	
	40	Demonstrate knowledge of immunization schedule in HIV positive children	
	41	Determine HIV status of HIV-exposed children,.including DNA-PCR (dry blood spot)	
	42	Describe how, when, and why cotrimoxazole prophylaxis is given to HIV-exposed children	
	43	Determine WHO clinical stage of children, including calculation of percent weight loss and weight gain	
	44	Recognize and interpret developmental abnormalities in children	
	45	Diagnose and manage (treatment/referral) common and severe respiratory diseases in addition to those listed above: lymphocytic interstitial pneumonitis	
	46	Counsel caregivers to disclose HIV status to children	
	47	Prescribe the correct ARVs in the correct doses for the first line regimens in infants and children according to national guidelines	
	48	Prescribe the correct ARVs in the correct doses for second line regimens for children according to national guidelines	
	49	Prescribe the correct drugs for TB/HIV co-treatment in infants and children according to national guidelines	

Tool II. Clinical Competency Assessment / Mentor Assessment
To be completed by: Mentor
Submitted to: Facility Manager
Frequency: To be used throughout mentoring attachment
Purpose: To assess the specific clinical competencies of the mentee.

Clinical Competency Assessment: Mentor Assessment			
Name:		**Date:**	
Directions for the Clinical Mentor: Through observation, assess the specific clinical competencies of the individual whom you are mentoring (mentee). Put the number in the box that you feel best shows how competent s/he is as follows:			
1	S/he is not at all capable; requires both didactic and clinical training		
2	S/he has knowledge on the task topic but cannot independently make a clinical decision regarding patient care		
3	S/he is competent and able to independently make a clinical decision regarding patient care		
4	S/he has expertise and can teach others this task		
		Task/Competency	**1-4**
All Care	1	Obtain a comprehensive health history in adults, children and pregnant women	
	2	Perform a complete physical exam of adults and children (heart rate, respiratory rate, weight, height, blood pressure, etc.)	
	3	Properly document history and physical exam in patient record	
	4	Weigh and measure child and calculate Z score	
	5	Treats patients with empathy, dignity, and respect using language terms the patient understands	
	6	Carry out clinical review of patients and present the patient cases in a clinical review forum	
Comprehensive Care of Children	7	Educate patients on HIV/AIDS disease progression, including modes of transmission and prevention	
	8	Educate patients on the proper and consistent use of male and female condoms	
	9	Educate patients on the signs and symptoms of HIV infection, including opportunistic infections	
	10	Correctly counsel and diagnose HIV in adults, infants and children with the understanding of the role of antibody vs. virologic HIV tests	
	11	Describe the relationship between HIV and TB and how to diagnose TB	
	12	Order and interpret lab tests according to clinical assessment and with respect to current HIV protocols: rapid and confirmatory HIV antibody tests, DNA-PCR, Hb/Hct, rapid pregnancy test, RPR or other rapid syphilis test, creatinine (calculate), white blood cell count, liver enzymes (ALT, AST), lipids, glucose, CD4 count, viral load, sputum microscopy for AFB, sputum culture, stool exam for ova and parasites, urine dipstick	
	13	Diagnose and manage (treatment/referral) common and severe respiratory diseases: pneumonia, tuberculosis, Pneumocystis Carinii Pneumonia (PCP)	
	14	Screen all patients for TB and provide Isoniazid Preventive Therapy (IPT) as necessary	
	15	Prescribe the correct TB drugs at the correct dose and monitor patients according to National TB Guidelines	
	16	Suspect and manage/refer TB treatment failure	
	17	Diagnose and manage peripheral neuropathy	
	18	Diagnose and manage gastrointestinal diseases and dehydration: acute diarrhoea, persistent diarrhea, dysentery, etc.	
	19	Diagnose and manage oral candidiasis, esophageal candidiasis, gum/mouth ulcers, oral hairy leukoplakia, oral malignancies	
	20	Recognize and provide appropriate therapy/referral for skin diseases: impetigo, folliculitis, herpes simplex, tinea, varicella zoster, scabies, seborrhea, pruritic popular eruption, drug reactions, kaposi's sarcoma, anogenital ulcers, warts, herpes	
	21	Recognize and provide appropriate therapy/referral for neurological diseases: toxoplasma brain abscess, neurosyphilis, cryptococcal meningitis, TB meningitis, progressive multifocal leucoencephalopathy (PML), malignancies, etc.	
	22	Diagnose and manage psychological disorders (treatment/referral), including depression	
	23	Initiate and manage cotrimoxazole at the correct dose at the correct clinical stage, managing adverse reactions and know when to discontinue	
	24	Initiate and manage secondary fluconazole prophylaxis at the correct dose and know when to discontinue	
	25	Explain mechanism of action of ARVs, goals of treatment, and describe what drug resistance means and how it develops	
	26	Identify drug-drug interactions in commonly co-administered medications	

	27	Identify common and serious side effects of each ARV, including laboratory studies used in assessment, and manage/refer appropriately	
	28	Prepare patients for ARVs, including develop of a treatment plan (including anticipating ARV supply needs) and an adherence plan	
	29	Recognize and provide appropriate therapy/referral for immune reconstitution inflammatory syndrome (IRS)	
	30	Identify treatment failure clinically, virologically, and hematologically	
	31	Make appropriate switches to alternative first-line ARV regimens in appropriate circumstances	
	32	Correctly provide syndromic management of STIs and refer to STI Service	
	33	Provide PEP in case of sexual assault and occupational exposure	
	34	Determine WHO clinical stage of adults, including calculation of BMI	
	35	Prescribe the correct ARVs for the first line regimen in adults, including pregnant women according to national guidelines	
	36	Prescribe the correct drugs for TB/HIV co-treatment in adults, including pregnant women according to the national guidelines	
Care Specific to Women	37	Counsel mother on benefits and risks of breastfeeding vs. replacement feeding, including the role of nevirapine prophylaxis in reducing HIV transmission through breastfeeding	
	38	Explain post-partum package of care and follow-up schedule for HIV positive women and their newborns	
Care Specific to Children	39	Monitor growth, accurately play weight, height, and head circumference on a growth chart on every visit	
	40	Demonstrate knowledge of immunization schedule in HIV positive children	
	41	Determine HIV status of HIV-exposed children, including DNA-PCR (dry blood spot)	
	42	Describe how, when, and why cotrimoxazole prophylaxis is given to HIV-exposed children	
	43	Determine WHO clinical stage of children, including calculation of percent weight loss and weight gain	
	44	Recognize and interpret developmental abnormalities in children	
	45	Diagnose and manage (treatment/referral) common and severe respiratory diseases in addition to those listed above: lymphocytic interstitial pneumonitis	
	46	Counsel caregivers to disclose HIV status to children	
	47	Prescribe the correct ARVs in the correct doses for the first line regimens in infants and children according to national guidelines	
	48	Prescribe the correct ARVs in the correct doses for the second line regimens in infants and children according to national guidelines	
	49	Prescribe the correct drugs for TB/HIV co-treatment in infants and children according to national guidelines	

Tool iii. Workplan for Clinical Mentor
To be completed by: Clinical Mentor
Submitted to: Hospital Director & Mentoring Co-Coordinators
Frequency: Throughout the mentoring cycle
Purpose: Clinical mentor to indicate timelines to facility manager. Please enter date of completion of each item and any relevant comments.

Workplan for Clinical Mentor

Facility Name: _____

Name of Clinical Mentor: _____

Checklist for the Clinical Mentor	Date Planned	Date Completed	Comments
Approval obtained from District Manager and/or Facility Supervisor for proposed mentorship activities.			
Set up meeting schedule for clinical mentorship activities			
Complete mentor/mentee agreement form			
Complete baseline clinical competency assessment of each mentee			
Have mentees complete baseline self-assessment			
Develop a plan for clinical mentorship encounters			
After scoring 3-4's on the Clinical Competency Assessment Form, mentee is deemed competent			
Complete and distribute Clinical Mentorship Award			

Clinical Mentor's signature: _____ **Date:** _____

Facility Manager's signature: _____ **Date:** _____

Tool IV. Mentorship Reporting Tool
To be completed by: Clinical Mentor
Frequency: At each mentoring visit
Purpose: Outline and account for mentor and mentee responsibilities and identify key challenges.

Facility Name: _____

No.	Mentee Name	Position	Dates of Mentorship	Hospital Director Signature	Key Challenges	Plan to Address
1						
2						
3						
4						
5						
6						
7						

Tool V. Regional Mentoring Report
To be completed by: National Mentoring Coordinator
Frequency: Quarterly
Purpose: To report number and frequency of clinical mentoring visits

Regional Clinical Mentoring Report Form

	Region Name :	
a	Chief PAC Regional Mentor (name)	
b	Active PAC Mentors	
c	Mentor PAC Facilities	
d	Active PAC Mentee Facilities	
e	Active PAC Mentees	
f	PAC Mentor visits	
g	PAC Mentee visit	
h	TOTAL VISITS	f + g
i	PAC Mentor Feedback Meetings	
j	PAC Clinician Network Meetings	

Note: Attach supporting documentation when submitting this form to NCHADS

1) *Copies of Mentorship Reporting Tools*
2) *Travel documentation*

Annex III. Practical Advice for Beginning Mentoring

I. **Get permission to begin mentoring partnership**

II. **Make contact with the person you are going to meet and make a plan for your first visit**

III. **Prepare toolkit for mentoring including:**

- ✓ National guidelines
- ✓ PAC OI and ART Facility Report, Exposed Infant Report and Linked Response Report
- ✓ Mentoring tools (blank copies and relevant files)
- ✓ Measuring tapes and growth charts
- ✓ Example of good patient chart
- ✓ Othoscope & Stethoscope

IV. **Suggestions for the First Visit:**

1. Introduce yourself and the mentoring program to the hospital director
2. Visit with hospital staff to introduce the plan for next steps
   - ➢ OI/ART
   - ➢ PAC
   - ➢ Nutrition
   - ➢ EPI
   - ➢ Lab
   - ➢ PAC physicians to introduce the program and plan for next steps
3. Identify supply gaps (drugs & clinical instruments)
4. Establish a plan for the next visit
5. Debrief with the hospital director

V. **Suggestions for the Second Visit:**

1. Present yourself to the hospital director
2. Begin mentoring according to the goals established in the assessment process
3. Observe the clinician seeing patients
4. Discuss observations with mentee clinician
5. Review 5 patient charts and discuss strengths and gaps in chart completion with mentee
6. Discuss a difficult case with mentee
7. Debrief with team meeting: feedback, encourage team problem solving
8. Make a plan for independent work and set goals for the next visit

Annex IV: Facility Equipment and Supply Checklist

Suggested list:

- ☐ ARV drugs
- ☐ Othoscope
- ☐ Stethoscope
- ☐ Scales (infant and pediatric)
- ☐ Tape measure
- ☐ Height board
- ☐ Refrigerator
- ☐ Gloves
- ☐ Sharps disposal
- ☐ Filing system: folders, cabinet or shelf