Training Agenda

- Welcome & Introductions
- Plan of Action and Objectives
- Training Expectations
- Review of TT Tracker Training
  - Project Development Overview
  - TT Tracker Summary
  - Review of Key Concepts
  - TT Tracker Form Overview and Use
    - Open/End Sessions
    - Register/Evaluate Patient
    - Record Surgery
    - Follow-up
    - Group Activities
  - Discuss surgical outreach—how will the TT Tracker be used in the camp
  - Discussion / conclusion of training
Objectives

- Understand the purpose of the TT Tracker
- Learn about the overall functionality of the TT Patient Tracker and how it fits into your surgical activities
- Be aware of the reports produced using the TT Tracker
- Review and understand all forms and questions within the TT Tracker
- Discuss and agree upon the approach for using the TT Tracker for surgical outreach
- Practice and feel comfortable entering patient data into the TT Tracker
• List expectations as a group
International commitment to eliminate Trachoma as a public health problem

Includes reducing the level of TT to <1 cases per 1000 population

Many TT initiatives working at scale

We have a responsibility to monitor the quality of the service

This responsibility is shared by surgeons, supervisors, MoH, supporting partners (NGOs), donors and WHO
The Need

• Challenges in TT outreach
  • Ensuring patient follow-up, especially at 3-6 months
  • Helping surgeons understand their strengths and weaknesses, and optimize performance
  • Thorough and timely reporting from field activities
• Partners were building various technology tools to track TT surgeries, but:
  • Designing and building technology is expensive
  • No one tool tracked the patient from registration through follow-up
  • Tools began overlapping geographically, complicating work for field staff
At a consultation coordinated by WHO in 2015, it was decided that the global community needed one application that would:

- Be available on a smartphone/tablet
- Track the patient from registration through follow-up
- Ensure patient follow-up
- Optimize surgeon performance
- Support timely reporting

The cost of development, use, and hosting would be free to countries; country programs would cover the related implementation costs.
Development of the TT Tracker

• Initial assessments were done in Malawi and Ethiopia where feedback was collected on:
  • How to effectively incorporate the application into program activities
  • Wording and order of data fields
  • What reports would be needed and by whom for program activities
  • How much time/effort is needed in each country to manage the application-related activities
• Pilot activities then conducted in Nigeria and Tanzania and additional modifications made to the TT Tracker.

The initial iteration of the app did not offer a structure for longitudinal tracking of patients. The decision was made to develop an application using the CommCare platform, which includes patient tracking functionality.
• Mobile data collection software that allows for tracking a patient through care and follow-up

• Can be used off-line when no network is available on GPS-enabled Android devices.

• Form-based
Definitions & Concepts
Key Concepts to Know

- Mobile Worker, Forms, Case/Record
- Coverage area
- Syncing
- Session
• Mobile workers are people who enter information into the phones—could be surgeon, surgical assistant, etc.

• Only mobile workers with usernames and passwords can enter and access information on the TT Tracker

• Patient Case / Record is the collation of all of the forms completed for a patient (similar to paper forms, there is a form for Registration, Screening/Evaluation, Surgery, and Follow-up)
Coverage Area

• Set of locations assigned to a mobile worker.
• Gives access to patient records within the designated location.
• Mobile workers can be assigned limited districts or an entire zone, region, or country, depending on program needs.
### Coverage area and access demonstrated

<table>
<thead>
<tr>
<th>Surgeon assigned to</th>
<th>Can see/modify</th>
</tr>
</thead>
<tbody>
<tr>
<td>District 1 and District 3</td>
<td></td>
</tr>
<tr>
<td>District 5</td>
<td></td>
</tr>
<tr>
<td>District 2, District 4 and District 6</td>
<td></td>
</tr>
</tbody>
</table>

![Map of Region A with districts and personnel assigned](image)
Regardless of who entered the information, all mobile workers within the coverage area will have access to the patients information. It is not required that a surgeon/assistant enter the patient information to be able to see the information entered.

<table>
<thead>
<tr>
<th>Surgeon assigned to</th>
<th>Can see/modify</th>
</tr>
</thead>
<tbody>
<tr>
<td>District 1 and District 3</td>
<td>Patients: P42, P32, P3</td>
</tr>
<tr>
<td>District 5</td>
<td>Patients: P19, P20, P30, P54</td>
</tr>
<tr>
<td>District 2, District 4 and District 6</td>
<td>Patients: P12, P22, P34, P2</td>
</tr>
</tbody>
</table>
How do records sync in the TT Tracker?

New forms and edits are uploaded by mobile workers. They are then combined with all other forms and edits submitted by mobile workers in the coverage area. The complete set of forms is then downloaded to each mobile worker’s phone so they have the most up-to-date records.
Activity: Who Can See It?

Region 1
District A, B, C, D, E

Region 2
District F, G, H

Mobile Worker W
Coverage Area: District B, F, H

Mobile Worker X
Coverage Area: Region 1

Mobile Worker Y
Coverage Area: District B, C

Mobile Worker Z
Coverage Area: Region 2
Mobile worker W enters information in District A, and everyone syncs.
Mobile Y enters information for Patient in District F, and everyone syncs.
Mobile Worker Y enters information into District C, only he syncs.
Session = specific surgical outreach event

- E.g. a surgical campaign taking place over multiple days.
- Patient registration and surgeries will be submitted under a designated session so that activities can be tracked to the location of the activity if needed.

**Example A:**
Camp Wollo School (Surgical camp)
Outreach dates: 4-6 October

- Open session (by 4 October)
  - Surgeon A and B

- Close session (by 6 October)
  - Surgeon A and B

Creating sessions will automatically calculate:
Open: 4 October  Close: 6 October
Number of eye care workers: 2
Total number of days in session: 3
Total number of surgeries during session: 44
Average number of surgeries per surgeon per day: 7.3

**Example B:**
Chamwino Health Centre (Static site)
Outreach dates: 1-31 October

- October
  - Sun  Mon  Tue  Wed  Thu  Fri  Sat
  - 1    2    3    4    5    6    7
  - 8    9    10   11   12   13   14
  - 15   16   17   18   19   20   21
  - 22   23   24   25   26   27   28
  - 29   30   31

Creating sessions will automatically calculate:
Open: 1 October  Close: 31 October
Number of eye care workers: 1
Total number of days in session: 31
Total number of surgeries during session: 5
Mobile data collection software that allows for tracking a patient through care and follow-up.

- Can be used offline when no network is available on GPS-enabled Android devices.

Form-based CommCare TT Tracker Processes

**TT Tracker Processes**
Surgical Activity Documentation

- Steps/information taken for new TT suspect at TT surgical outreach camp:
  - Record patient demographic and residence information
  - Record patient screening information
  - Record surgery information
  - Record follow-up
**Registration**: Record name, age, village of residence, etc.

**Evaluation/Screening**: Record number of eyelashes touching the eye, evidence of conjunctival scarring, etc.

**Surgery**: Record operating surgeon, type of operative method and suture used, surgical complications, etc.

**Follow-up**: Record 24 hour, 7-14 day, or 3-6 months outcome assessment (surgical outcomes, post-operative care, etc.)
• Allows programs to collect patient information at different intervention time points

• Includes timely follow-up lists, surgeon performance reports, and activity reports

• Gives surgeons access to patient information within their designated coverage area
Though the TT Tracker does require data entry into the phone, which is different from current practices, most of the activities added to the phone are already existing activities required by the program.

- **Register Patient, Record Patient Surgery, Document Follow-up, and reports and follow-up lists** are all current activities in all programs. The TT Tracker will make the documentation of those activities easier due to ease and speed of reporting.
- **Open a session** and **Close a session** are new, though not frequently required, and assist with calculation of surgical outputs by individual outreach activities.
### New Forms, Known Questions

- Name
- Age & Sex
- District & Village of Residence
- # lashes touching the eye
- Evidence of epilation
- Date of Surgery
- Type of operation and suture
- Surgical complications
New Forms, Known Questions

- Name
- Age & Sex
- District & Village of Residence
- # lashes touching the eye
- Evidence of epilation
- Date of Surgery
- Type of operation and suture
- Surgical complications

**SAMPLE SESSION A**

Name of patient's district

**RECORD SURGERY**

What material was used for suture for eyes operated on?
- Absorbable (vicryl)
- Non-Absorbable (silk)

**SAMPLE SESSION A**

Is there evidence of epilation of inturned right upper lid eyelashes?
- Yes
- No

**RECORD SURGERY**

On the left upper eyelid, what type of operation was performed?
- Bilamellar tarsal rotation (clamp)
- Bilamellar tarsal rotation (no clamp)
- Trabut (Posterior lamellar tarsal rotation)
- Tarsal advance and rotation (modified Trabut)
We have aimed to build a system that can address some of the complex needs but easy enough for users:

- Similar to paper forms
- Logical progression
- Skip logic
- Multiple choice
- Instructions throughout
• Follow-up Lists
• Surgical Outcome and Output Reports
• Patient Records/Line Lists
• Activity Summaries
Due for Follow-up Lists

**Phone**
- One list per time period
- Can be searched by specific patient or district

**Email**
- Sent to designated officials responsible for follow-up planning
- Lists are broken down by district and can be used as needed

### Patients Due for 3 - 6 Month Follow Up

<table>
<thead>
<tr>
<th>Overdue?</th>
<th>Name</th>
<th>Age</th>
<th>Sex</th>
<th>Patient District</th>
<th>Patient Village</th>
<th>Phone</th>
<th>Owner of</th>
<th>Surgery Date</th>
<th>Session Name</th>
<th>Session ID</th>
<th>Surgeon Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adam Test</td>
<td>90</td>
<td>male</td>
<td>Alpha One</td>
<td>Villagename</td>
<td>555555</td>
<td>clinic</td>
<td>2017-10-13</td>
<td>clinic south</td>
<td>AA-TT-2</td>
<td>Carol Burnett</td>
</tr>
<tr>
<td></td>
<td>Adam Test</td>
<td>90</td>
<td>male</td>
<td>Alpha One</td>
<td>Villagename</td>
<td>555555</td>
<td>clinic</td>
<td>2017-10-13</td>
<td>clinic south</td>
<td>AA-TT-2</td>
<td>Carol Burnett</td>
</tr>
<tr>
<td></td>
<td>Leah M</td>
<td>58</td>
<td>female</td>
<td>Alpha One</td>
<td>Reyn</td>
<td></td>
<td></td>
<td>2017-07-21</td>
<td>Surgeon Region</td>
<td>AA-CR-5</td>
<td>Carol Burnett</td>
</tr>
<tr>
<td></td>
<td>Mariana K</td>
<td>55</td>
<td>female</td>
<td>Alpha One</td>
<td>Gambella</td>
<td>22222222</td>
<td></td>
<td>2017-07-02</td>
<td>home12</td>
<td>AA-CR-4</td>
<td>Floyd DeBarbour</td>
</tr>
</tbody>
</table>
Surgeon reports and performance

- Surgeons will receive a monthly email (if they are actively doing surgeries) showing their contribution and how many of those individuals completed a follow-up.

- Designated supervisors will received a report of surgical outcomes to assess what issues and surgical complications need to be addressed, if any.
Surgical Outcome Reports

- Surgical Outcome Reports can be emailed monthly to designated supervisors to see surgical outcomes by surgeon.
- Report includes number of surgeries completed and surgical successes and/or complications for surgeries with outcome assessment completed.

<table>
<thead>
<tr>
<th>Region</th>
<th>Surgeon</th>
<th># of surgeries this month</th>
<th># of surgeries YTD</th>
<th># of surgeries with 7-14 day follow-up</th>
<th>Complication %</th>
<th>Over-correction %</th>
<th>Granuloma %</th>
<th>Contour-abnormality %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha</td>
<td>Carol Burnett</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td>0%</td>
</tr>
<tr>
<td>Alpha, Beta</td>
<td>Chris Chross</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Beta</td>
<td>Dennis Duffy</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Alpha, Beta</td>
<td>Dr Drew Baird</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Surgeon</th>
<th># of surgeries with 3-6 month follow-up</th>
<th>Complication %</th>
<th>Over-correction %</th>
<th>Granuloma %</th>
<th>Contour-abnormality %</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td>0%</td>
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</tbody>
</table>
Basic Phone Elements: Logging in

• CommCare has been downloaded to the phones.
• Each phone will have a UserID and password. This should only be shared with those who need to use that phone.
• For the training, username and password will be different from field work.
  • Training
    – [_____#]
    – [_____#]
  • Field
    – [______#]
    – [______#]
Basic Phone Elements: TT Tracker Menu

- Start
- Sync
- Log out of CommCare
- Update App
Basic Phone Elements: Moving Between Screens

Move forward and back

Exit the form without saving

Required Questions

Complete/Submit
• **TT Tracker is form-based**—electronic forms mirror existing paper forms

  - **Patient Registration**: Each patient that comes to a camp for screening for TT should be registered.
  - **Patient Treatment Management**: includes all other forms needed tracking a patient (evaluation, surgery, follow-up)
  - **Due for follow-up**: Provides summary lists of those patients that fall within a follow-up timeframe
  - **Session Management**: Opening, updating, and closing Sessions (outreach activities)
Basic Phone Elements: Forms 2

- Forms based on existing paper forms
- Organized to support the sequential order of the camp
- There are some sub-folders housed within main folders

Patient Treatment Management
- Update Patient Info
- Record Evaluation
- Record Surgery
- Follow-up(s)
- Close out Patient
## Basic Phone Elements: Patient Line List

### TT TRACKER
- Patient Registration
- Patient Treatment Management
- Due for Day One Follow Up
- Due for 7-14 Day Follow Up
- Due for 3-6 Month Follow Up
- Session Management

### PATIENT TREATMENT MANAGEMENT

<table>
<thead>
<tr>
<th>ID</th>
<th>NAME</th>
<th>R/L</th>
<th>DSS</th>
</tr>
</thead>
<tbody>
<tr>
<td>AATT17</td>
<td>Sample Patient 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AACR9</td>
<td>Surgeon Region Tester</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AATT16</td>
<td>Test Patient 1</td>
<td>/E</td>
<td></td>
</tr>
<tr>
<td>AATT18</td>
<td>Test Patient 2</td>
<td>S/E</td>
<td>29</td>
</tr>
<tr>
<td>AATT18</td>
<td>Test Patient 2</td>
<td>redo</td>
<td>2</td>
</tr>
<tr>
<td>AATT26</td>
<td>William Amana</td>
<td></td>
<td>X/-</td>
</tr>
</tbody>
</table>
**Data Use: Patient List**

**PATIENT TREATMENT MANAGEMENT**

<table>
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<td></td>
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<td>AACR9</td>
<td>Surgeon Region Tester</td>
<td>-/-</td>
<td></td>
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<td>2</td>
</tr>
<tr>
<td>AATT26</td>
<td>William Amana</td>
<td>X/-</td>
<td></td>
</tr>
</tbody>
</table>

Supporting summary documentation has been included to assist users in viewing patient record information from the main patient list:

- **R/L**: Right/Left (eye)
  - **S**: Surgery
  - **E**: Epilation
  - **R**: Referral
  - **X**: Refusal
  - **O**: Other management
- **DSS**: Days since surgery
Patient summaries allow users to see all information entered for the patient in one place, selecting the specific tab to review the information entered on that form: Registration, Evaluation/Screening, Surgery, Follow-up (24-hour, 7-14 day, 3-6 month)
Activity: Find the Patient

- Who is Patient AAAZ2?
- Where does he/she live?
- When were they evaluated for TT?
- What was the recommended treatment for patient AAAZ2?
  - Why and to where?
Activity: Find the Patient

- Esteli Davidi Mtuli
  - How old is she?
  - What eye(s) did she have operated?
  - How many days has it been since surgery?
  - Who conducted the 7-14 day follow-up?
  - Were there any complications observed during surgery?
  - What follow-ups were completed for Esteli? Are any follow-ups missing?
  - Where does she live?
Correct the information
- Ariet Malisa: Patient ID AAAZ2
- 10+ eyehashes touching the eye
- LE no conjunctival scarring
- LE lower lid trichiasis
- Both eyes were recommended for operation
- Received surgery 7 days ago
Hands on Data Entry
Step 1: Session Management

Session = specific surgical outreach event
- Can be a surgical campaign taking place over multiple days, or all surgical activities that take place at a static health center over one month.
- Patient registration and surgeries will be submitted under a designated session so that activities can be tracked to the location of the activity if needed.

Example A:
Camp Wollo School (Surgical camp)
Outreach dates: 4-6 October

Example B:
Chamwino Health Centre (Static site)
Outreach dates: 1-31 October

Creating sessions will automatically calculate:
Open: 4 October  Close: 6 October
Number of eye care workers: 2
Total number of days in session: 3
Total number of surgeries during session: 44
Average number of surgeries per surgeon per day: 7.3

Creating sessions will automatically calculate:
Open: 1 October  Close: 31 October
Number of eye care workers: 1
Total number of days in session: 31
Total number of surgeries during session: 5
In order to register patients and record surgeries during outreach, there must be an open Session to assign patients.
Session Management

Open Session: Should be started before the specific outreach activity, so patients can be registered and linked to the Session.

Close Session: Should be ended after the specific outreach activity, removing it from the phones so no other patients can be newly registered to the Session.

Update Session: Used to correct any errors to open sessions. Once the session is ended, it cannot be updated.
**Open Session**

- One session started for a specific outreach activity
- One person starts/ends the session
- ALL individuals should be informed of the Session ID and name opened and sync their phones
Name of Site/Session should be descriptive and recognizable by all users—it will be how the Session appears on the list for all users.
The designated person will start the session when there is network available.

Session start most likely will be done in advance of the outreach so GPS will **NOT** be taken during Open Session

- **Update Session** can be used in the field to capture the GPS coordinates after Session is open
Type of outreach activity will be selected. If “Other” is selected, type of session will be entered in space provided.

Session will be assigned a unique Session ID. All mobile workers working in that camp/session should be informed of Session Name AND Session ID.

This Session ID is "AA-TT-14".
Open Session Practice

In pairs, create a new Session for outreach. Use your name in the Session name so it can be recognized.
Session List

Three ways to view open Sessions: Update Session, Close Session, Patient Registration

Can you find your Session?
Update Session

- Used to correct errors in Session information
- Can only be used for Sessions that are open
- Helpful if GPS still needs to be captured (if applicable)
## Update Session

### Session Management
- Open Session
- **Update Session**
- Close Session

### Update Session

<table>
<thead>
<tr>
<th>ID</th>
<th>Name</th>
<th>Start</th>
</tr>
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<tbody>
<tr>
<td>AA-TT-13</td>
<td>Beta Primary School</td>
<td>2018-06-01</td>
</tr>
<tr>
<td>AA-TT-10</td>
<td>Sample Session A</td>
<td>2018-04-01</td>
</tr>
<tr>
<td>AA-CR-5</td>
<td>September Static Site Beta One</td>
<td>2017-09-01</td>
</tr>
<tr>
<td>AA-TT-11</td>
<td>Temporary Session</td>
<td>2018-05-01</td>
</tr>
</tbody>
</table>

### Case Detail

<table>
<thead>
<tr>
<th>Case</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Session Id</td>
<td>AA-TT-13</td>
</tr>
<tr>
<td>Site Type</td>
<td>Camp</td>
</tr>
<tr>
<td>Site Name</td>
<td>Beta Primary School</td>
</tr>
<tr>
<td>Start Date</td>
<td>2018-06-01</td>
</tr>
<tr>
<td>Village</td>
<td>Beta Village</td>
</tr>
<tr>
<td>District Name</td>
<td>Beta One</td>
</tr>
</tbody>
</table>
Use Update Session form to capture GPS if Session was opened when not located at Session

- Questions will appear pre-filled with the responses given on the Open Session form
- Any information that must be updated can be edited. All correct information should remain unchanged
Use Update Session form to capture GPS if Session was opened when not located at Session

- Questions will appear pre-filled with the responses given on the Open Session form
- Any information that must be updated can be edited. All correct information should remain unchanged
Close Session

- Used to correct errors in Session information
- Can only be used for Sessions that are open
- Helpful if GPS still needs to be captured (if applicable)
### Close Session

**SESSION MANAGEMENT**

- Open Session
- Update Session
- Close Session

**Search**

<table>
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<tbody>
<tr>
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**Case Detail**

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<tr>
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<tr>
<td>District Name</td>
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</tr>
</tbody>
</table>

**CHECK SUMMARY BEFORE CLOSING**
If Session should be closed, but needs to be saved (patient records registered to Session)

If Session had NO records registered to it, was created in error and should be DELETED

The most likely option: Close because Activity Ended
If Session had NO records registered to it and was created in error, it will be flagged to be DELETED.

Why is this session being closed:
- Activity ended ✔
- Erroneous/duplicate data

You have selected to permanently remove the Session from the records. To confirm select next.

Confirm before submitting
Close Session—Activity Ended

Practice: Close Session

Why is this session being closed

- Activity ended
- Erroneous/duplicate

End date of outreach

Number of men presented (total men registered, with and without TT)

Number of women presented (total women registered, with and without TT)

Are you currently located at the site?
- Yes
- No

Only asked if GPS has not yet been captured
### Session List

#### Update Session

<table>
<thead>
<tr>
<th>ID</th>
<th>Name</th>
<th>Start</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA-TT-13</td>
<td>Beta Primary School</td>
<td>2018-06-01</td>
</tr>
<tr>
<td>AA-TT-10</td>
<td>Sample Session A</td>
<td>2018-04-01</td>
</tr>
<tr>
<td>AA-CR-5</td>
<td>September Static Site</td>
<td>2017-09-01</td>
</tr>
<tr>
<td>AA-TT-11</td>
<td>Temporary Session</td>
<td>2018-05-01</td>
</tr>
</tbody>
</table>

#### Close Session

<table>
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<tr>
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</tr>
<tr>
<td>AA-CR-6</td>
<td>Test Site Beta</td>
<td></td>
</tr>
<tr>
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<td>Sample Session A</td>
<td></td>
</tr>
<tr>
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#### Patient Registration

<table>
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<tr>
<th>ID</th>
<th>Site</th>
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<tbody>
<tr>
<td>AA-CR-5</td>
<td>September Static Site Beta One</td>
</tr>
<tr>
<td>AA-CR-6</td>
<td>Test Site Beta</td>
</tr>
<tr>
<td>AA-TT-10</td>
<td>Sample Session A</td>
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<td>Temporary Session</td>
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<td>Beta Primary School</td>
</tr>
</tbody>
</table>

Three ways to view open Sessions: Update Session, Close Session, Patient Registration

Can you find your Session?
When a patient comes to a camp/outreach site for evaluation and treatment, he/she must be registered.

When registering a patient, he/she will be assigned to a Session—the outreach site.
No: If patient does not have an existing ID, the TT Tracker will randomly assign a unique Patient ID

- Most patients will not have existing Patient IDs
- Attention will be mainly dedicated to registering patients with no Patient IDs
Record demographic information
• All information is what is collected on paper forms
Patient Registration

Select patient region and district
• Only districts within the selected region appear

If Other is selected, the name of the region/district can be manually entered

After region and district are selected, patient village can be manually entered
If a phone number is available, select the owner of the phone and record the phone number.

If the phone owner is “other”, first enter the owner of the phone and record the phone number.
Once a patient is registered, he/she will be given a patient ID number which will be UNIQUE to him/her.

- Write this number on any written materials, including paper surgery records, patient follow-up cards, etc.

- Additional notes/comments can be recorded on any of the forms
  - If an issue arises with the patient record, a note can be added for data managers/supervisors.
  - If there are no issues, this can be left blank
If the user is ready to enter the evaluation information (number of eyelashes touching the eye, evidence of epilation, etc.), it is possible to go directly to the evaluation form.

If user is not ready to enter the evaluation, the form can be closed the evaluation form can be accessed later.
Work in pairs or small groups to create 2 patient registrations. Each person will be the patient for the other who is completing the registration form.

Once a patient registration has been submitted, confirm that the information has been submitted by accessing the Patient Case Summary Form.

- Select the “Reg” tab to review the information recorded for the registration.
- All other forms in the Case Detail will remain blank until completed.

Do not begin Evaluation.
Once a patient registration has been submitted, the information is available on the patient summary form. Select the “Reg” tab to review the information recorded for the registration. All other forms in the Case Detail will remain blank until completed.
• Once a patient has been registered, they can be evaluated / screened for TT
• Two ways to record the evaluation form
  • Continue directly after completing registration form
  • Access Evaluation form through Patient Treatment Management
Record Evaluation

- Once a patient has been registered, they can be evaluated / screened for TT
- Two ways to record the evaluation form
  - Continue directly after completing registration form
  - Access Evaluation form through Patient Treatment Management
Record Evaluation

- Questions are asked of each eye individually
- If eye is NOT suspected of TT, questions are skipped
- If the eye is suspected of TT, follow-up questions will be asked

Is the right eye suspected of TT?
- Yes
- No

How many right upper lid eyelashes touch the eyeball?
- None
- 1-2
- 3-4
- 5-6
- 7-9
- 10+

Is there evidence of epilation of inturned right upper lid eyelashes?
- Yes
- No
### Record Evaluation

#### Question asked only if patient had surgery before

<table>
<thead>
<tr>
<th>RECORD EVALUATION</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Has this patient had lid surgery before on the right eye?</td>
<td>When you evert the eyelid, is there obvious scarring of the right upper tarsal conjunctiva?</td>
<td>Is there a scar consistent with a previous operation for upper right lid trichiasis?</td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>RECORD EVALUATION</th>
<th>RECORD EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there trichiasis of the right lower eyelid?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
Based on the evaluation, a recommended action will be selected for each eye

- Follow-up questions may be asked, depending on the action selected
  - **Surgery (accepted):** Consent and date of surgery
  - **Surgery (refused):** Reason for refusal
  - **Epilation:** Trained to epilate & forceps given
  - **Referral:** Reason and location of referral
  - **Other:** Description of other management
  - **No Management:** Reason for no management
Record Evaluation: Action Required

Surgery (accepted): Record whether patient accepts to surgery and if surgery will happen today
• If surgery will not happen today, describe why.

Surgery (refused): Record reason for refusal

Questions will be asked for at the end of evaluation, for ANY eyes accepting / refusing surgery
If epilation was required, record whether patient and/or family were trained to epilate and if epilation forceps were given to patient.

Questions will be asked for at the end of evaluation, for ANY eyes needed epilation.
If patient was referred, describe the reason for the referral and to where the patient was referred.

Questions will be asked immediately after EACH eye that is referred.
If patient required **other management**, describe what management was required.

- This may be due to trichiasis caused by other issues, etc.

If **no management** is required, describe what no management was required.
- This may be due to trichiasis caused by other issues, etc.

Questions will be asked immediately after EACH eye.
• Use the patient you registered during the Registration practice to create an evaluation for the patient
• Each person will be given two cards that will determine what action is required for the patient—they will need to create the rest of the evaluation on their own
Use the patient summary list to review the information you just entered for the patient.

- **R/L**: Action recommended for each eye
  - S: Surgery
  - E: Epilation
  - R: Referral
  - X: Refusal
- **DSS**: Days since surgery (after surgery form has been completed)
In pairs, complete a combined registration and evaluation form for a new patient.

Each person in the group should enter one patient from Registration through Evaluation:
- The participant not entering the information is the patient providing the personal information (name, age, etc).
- The participant entering the information is the surgeon/screener and will assess the patient for the diagnosis.
The process to complete patient forms is the same until form selection is made.
Record Surgery

What was the date of the activity?

The default date selected will be the current date. If the operation did not happen on the day the form was completed, select the correct date.
Record operating surgeon for ANY/ALL treated eyes
- If surgeon’s name is not listed, select Unknown / Not listed and enter Surgeon Name
- If surgeon’s name is unknown, select Unknown / Not listed and leave surgeon name blank

Please enter the name of the surgeon. If unknown, leave empty and press next.
• If eye was not recommended for surgery, a warning message will appear to remind user that eye wasn’t recommended/accepted for surgery
• If eye was recommended for surgery, TT Tracker will ask to confirm that surgery was done on that eye
• If eye was NOT operated, surgical questions for that eye are skipped
If operation was performed on eye, operation type is asked.

- Questions are eye specific
- If “other” is selected, describe the method that was used

On the right upper eyelid, what type of operation was performed?

- Bilamellar tarsal rotation (clamp)
- Bilamellar tarsal rotation (no clamp)
- Trabut (Posterior lamellar tarsal rotation)
- Tarsal advance and rotation (modified Trabut)
- Other
For EACH operated eye, document any complications that occurred during surgery.

Was the right eyelid margin fragment severed?
- Yes
- No

Was there excessive bleeding?
- Yes
- No

Was there any other complication on the right eye?
- Yes
- No

Describe other complications
For **ALL** operated eyes, questions are asked that are relevant to either/both eyes that have been operated.

- **Suture material and antibiotics given are only asked once—after surgery activity has been recorded for either/both eyes operated**
Each person in the group should complete one of the surgery records for the patient that already evaluated.
Make sure to READ and use the information provided from the evaluation in order to properly document the surgery
When complete, as a group review the information on the Case Summary forms

<table>
<thead>
<tr>
<th>Case Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>REG</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>Eyes Operated</td>
</tr>
<tr>
<td>Eyes Epilated</td>
</tr>
<tr>
<td>Surgery Date</td>
</tr>
<tr>
<td>Days Since</td>
</tr>
<tr>
<td>LE Operation</td>
</tr>
<tr>
<td>LE EMF Severed</td>
</tr>
<tr>
<td>LE Bleeding</td>
</tr>
<tr>
<td>Suture Used</td>
</tr>
</tbody>
</table>
• Each person in the group should a paper copy for a patient record.
• Once complete, switch with your partner—each partner will use the paper to enter the information into the phone.
• The information may be located in a different order.
Most forms completed for a patient can be edited if an error was submitted.

- Patient Info (Registration)
- Evaluation
- Surgery
- Follow-up
Update Patient Forms

- Select the patient record to be updated
- Select the form to be edited

If a form has already been completed for the patient, a warning message will appear.
• All information entered previously will be filled in.
• Information can be changed and saved to the record
Update Patient Forms

- If questions result in follow-up questions, the changes made to the form will affect all follow-up questions as well
  - Epilation → trained to epilate?
  - Surgery → patient consent; date of surgery

<table>
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</thead>
<tbody>
<tr>
<td>How many right upper lid eyelashes touch the eyeball?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For the right eye, what have you recommended to the patient?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery (patient accepted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery (patient refused)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No management</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the patient consent to have surgery performed on eyes needing surgery?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- Each person will be given a problem with a record that they need to fix. Participant must determine the correct form where the information is housed and change the information.
- Discuss as a group how/what each person/pair did correct the form(s)
All initial questions for every follow-up timepoint (24-hour, 7-14 day, 3-6 months) are identical
**Record Follow-up**

**24 Hour Follow-up**

- Right eye was recommended for surgery.

  - Looking at the eye, was there surgery performed on the right eye 1-3 days ago?
    - Yes
    - No

  How many right upper lid eyelashes touch the eyeball?
  - None
  - 1-2
  - 3-4
  - 5-6
  - 7-9
  - 10+

- Is there any sign of bleeding in the right eye?
  - Yes
  - No

- Are there any signs of infection in the right eye?
  - Yes
  - No

- Is there a lid contour abnormality in the right eye?
  - Yes
  - No

**TT Tracker** reminds surgeon what was recommended for patient:

- If eye was recommended for surgery, message will to confirm scar is consistent with surgery
- If surgery is confirmed, follow-up questions are asked
- If surgery is not confirmed, follow-up questions are skipped
Follow-up questions will be asked, conditional on the response of the previous question:
- If no undercorrection is observed, question for excessive overcorrection will be asked.
- If no excessive overcorrection is observed, question for desired overcorrection will be asked.
Record Follow-up: 24-hour

What actions were required for right eye?

- Re-do surgery
- Epilation
- Other management
- No action required

Actions required are specific to the eye being assessed.

Did you inform patient of the 7-14 day follow-up?

What other action was required for right eye?

Additional notes/comments

If no additional comments, select Next
TT Tracker will provide a message informing surgeon of the action that was recommended for the action.

- Though message may appear stating that surgery was NOT recommended, surgery question will still be asked to confirm that all information has been recorded accurately.
- If **NO** surgery was completed, epilation will be asked.
- If surgery **WAS** conducted, epilation questions will be skipped
Right eye was recommended for surgery.

Looking at the eye, was there surgery performed on the right eye 7-14 days ago?

- Yes
- No

How many right upper lid eyelashes touch the eyeball?

- None
- 1-2
- 3-4
- 5-6
- 7-9
- 10+

Is there granuloma (or several granulomata) of the right upper eyelid?

- Yes
- No

Is there a contour abnormality of the right upper eyelid?

- Yes
- No
Based on the evaluation, surgeon will select what action is required for that EYE.

- Multiple selections can be made (i.e. “remove sutures” and “remove granuloma” may both be recorded)
Record Follow-up: 7-14 day

Right eye was recommended for epilation.

Looking at the eye, was there surgery performed on the right eye 7-14 days ago?

- Yes
- No

Was the right eye epilated 7-14 days ago?

- Yes
- No

How many right upper lid eyelashes touch the eyeball?

- None
- 1-2
- 3-4
- 5-6
- 7-9
- 10+

Does the right eye need further action?

- Yes
- No

What action is required?

- Surgery
- Epilation
- Referral
- Other Management

Is there evidence of corneal opacity/ulcer(s) in the right eye?

- Yes
- No
- Unclear
Record Follow-up: 3-6 month

Right eye was recommended for surgery.

Is there a scar consistent with previous operation for right upper lid trichiasis 3-6 months ago?
- Yes
- No

How many lashes?
- None
- 1-2
- 3-4
- 5-6
- 7-9
- 10+

Is there granuloma (or several granulomata) of the right upper eyelid?
- Yes
- No

Was the right granuloma removed?
- Yes
- No

Location of lashes
- Inner
- Central
- Outer
Record Follow-up: 3-6 month

Is there a contour abnormality of the right upper eyelid?
- Yes
- No

Is there over-correction of the right upper eyelid?
- Yes
- No

Is there trichiasis of the right lower eyelid?
- Yes
- No
Based on the evaluation, surgeon will select what action is required for that EYE.

For the right eye, what actions are required based on the evaluation?

- Re-do Surgery
- Epilation
- Referral
- Other management
If a surgery needs to be re-done and will be done on site, a new patient registration and surgery form will be needed.

- This will ensure patient is properly followed up after next surgery.
Paper to Phone Practice

• Each pair should complete the relevant registration and evaluation information.
• Forms will be exchanged and pairs will enter the information completed by another group.
• Once completed, phones will be synced (or exchanged if no network) and the surgery form should be completed
  • Participants should REVIEW the evaluation information entered in order to correctly complete the surgery information.
• Once Surgery form is completed, phones will be synced (or exchanged if no network) and the 24-hour AND 7-14 day follow-up forms should be completed
  • Participants should REVIEW the evaluation and surgery information
• Once 24-hour and 7-14 day follow-up forms are completed, phones will be synced (or exchanged if no network) and the 3-6 month follow-up form should be completed
Due for Follow-up

If patients are due for a follow-up, they will appear on one of 3 lists:

- Due for Day one Follow Up
- Due for 7-14 Day Follow Up
- Due for 3-6 Month Follow Up

Based on the “Due for follow-up” list selected, that related follow-up form will appear after selecting the patient to follow-up.

If a patient is due for follow-up but does not appear on the list, access the correct follow-up form from the Patient Treatment Management menu.
Patient Registration: Temporary Session

If the correct Session cannot be found, register patient to Temporary Session. If Session where patient should be REASSIGNED is known, include it on the form.

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You've selected a temporary session. If the patient's session name or ID is known, enter it here.

Free response
Patient Registration: Register Patient with ID

- **Yes**: If a patient has an existing ID from a previous treatment, it can be manually entered and used to link the different treatments for the patient so all records can be visible in a list.
  - Demographic information may also be copied to save time.

Does patient already have a Patient ID?

- Yes
- No
Patient Registration: Register Patient with ID

If a patient has an existing ID, enter the ID (in all caps) in the space provided. Must be all capitalized.

- If the correct patient information is found, the demographic information can be copied for the new evaluation.
- Make sure to REVIEW the information.

If the patient already has a Patient ID?

- Yes
- No

Enter Patient ID: AATT15

Look Up Patient ID: AATT15?

- Yes

This patient registration information was found for patient ID entered; is this the patient information you would like to use to add another surgical intervention?

- Yes
- No
Patient Registration: Register Patient with ID

- If patient information is not found, a new Patient ID will be randomly assigned and all registration information must be entered again.

- The existing Patient ID can be entered into the Notes so Data Manager can modify patient records (if possible).
• **Patient Returning within 6 months for another treatment**
  • Imagine patient [_____] has come back for a new surgery.
  • Register the patient again. The Patient is supposed to be registered to Session [-----].
• **Patient Returning one year later for another treatment**
  • Imagine patient [_____] has come back for a new surgery.
  • Register the patient again. The Patient is supposed to be registered to Session [-----].
Group Work

- Discuss as a group about how the patient moves through the camp when they conduct outreach and who completes what information.
- Based on the feedback, in small groups, each person should complete the assigned activities in the camp
  - E.g.: Group member 1 completes the registration information. Group member 2 assesses the patient and completes the screening information. Group member “conducts” the surgery and completes the surgery form.
- Discuss how phones should be used in the field
Questions and discussion