HEADQUARTERS OFFICE
EMPLOYEES' STATE INSURANCE CORPORATION
(ISO 9001-2008 CERTIFIED)
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Subject: "ESIC decisions on medical services - July, 2014" taken by the ESI Corporation at its 162nd meeting held on 31.07.2014, for overall improvement in delivery of medical care under the ESI Scheme,

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Decisions on the above mentioned subject, taken by the ESI Corporation at its 162nd Meeting held on 31.07.2014 are enclosed herewith. These may be called **"ESIC DECISIONS ON MEDICAL SERVICES - JULY, 2014"**

Encl: As above

29/08/14

(Dr. S.K. Raju)
DMC (MS)

To,

Chairman/Vice-Chairman & Members of the ESI Corporation.

Copy to:-

1. All the Secretaries, State Govts.
2. All the Directors, ESI Scheme
3. All the SSMCs/SMCs, ESI Corporation
4. All the Regional Directors/Joint Directors (I/C), ESI Corporation
5. All Medical Superintendents, ESIC/ESI Hospitals

"ESIC DECISIONS ON MEDICAL SERVICES - JULY, 2014" TAKEN BY THE ESI CORPORATION AT ITS 162ND MEETING HELD ON 31.07.2014, FOR OVERALL IMPROVEMENT IN DELIVERY OF MEDICAL CARE UNDER THE ESI SCHEME,

For overall improvement in the delivery of Medical Care under the ESI Scheme, the ESI Corporation at its 162nd Meeting held on 31.07.2014 has taken the following decisions:

1. PRIMARY MEDICAL CARE

1.1 Insurance Medical Practitioner (IMP)

1.1.1 Capitation Fee, i.e., Package Remuneration per IP family per annum is enhanced to minimum Rs.300/-, which includes primary health services, minimum Rs.25/- for investigation facilities of Urine (albumin & sugar) Haemoglobin and Blood Sugar and cost of engaging support staff.

1.1.2 Each IMP is allowed to enrol up to 2000 IP family.

1.1.3 The IMP shall collect specified medicines from the designated nearest ESIS Dispensary for supplying the same to the beneficiaries.

1.1.4 The facility of investigations and medicine to be dispensed shall be displayed on a sign board by IMP.

1.1.5 IMP is required to maintain following records:-

a) Basic case record of beneficiaries in a register showing the ailment for which patient attended the IMP clinic.
b) Stock register, showing receipt and consumption of medicines.

1.1.6 IMP to submit following reports:

a) A monthly statement in r/o treated beneficiaries and stock position of medicines to DIMS with a copy to SSMC/SMC. If the report is not sent regularly for three months, IMP would be issued a notice.

b) If report is not received for another three months, the payment to IMP is to be stopped and inspection is to be done by a team constituted by the Chairman State Executive Committee which shall recommend further action.

1.1.7 Empanelment of IMP

a) Maximum age at the time of empanelment shall not be more than 50 yrs. This age limit for ESIC/Govt. retired doctors would be 65 yrs.

b) Maximum age of IMP during empanelment shall not exceed 70 yrs.

c) Contract period of IMP shall be for one year, renewable every year, for a maximum period of three years. In exceptional cases, this may be extended to five years. Regular dispensary should be set up within the maximum period of five years.

d) It is essential for IMP to have computer system with internet facility to verify the eligibility of the IP/beneficiary and for other online transactions concerning their work. For this purpose an additional amount of Rs.10,000/- per year shall be provided to the IMP.

e) Wherever feasible, a panel of IMPs shall be prepared, so that, if the selected IMP is not working satisfactorily, the IMP next in the panel could be assigned the duty.

f) IMP shall make alternative arrangement whenever he goes on leave.

g) A Standard Contract shall be signed with IMPs.

1.1.8 Inspection & Control of IMPs by Local Committee:

a. Local Committee: The local Committee constituted under Regulation 10 A of the ESI (General) Regulation would monitor functioning of IMPs by carrying out Surprise inspection of IMPs to check:

i) Whether records are being maintained properly

ii) Whether medicines are being dispensed in accordance with the prescribed norms/instructions

iii) Annually review performance of the IMPs and the report of the same shall be submitted to State Executive Committee.

b. If the IMP is continuing for more than 3 years, then the Local Committee will need to review the entire system in the area and make its recommendations for further action to the State Executive Committee.

1.2 Dispensaries

1.2.1 All dispensaries to maintain uniform timings of 7.30 AM to 7.30 PM. Timings to be displayed on a notice board in the registration area.

1.2.2 Dispensaries working in single shift/split duty hours, the timings shall be such that IPs working in both morning and evening shifts can avail of services.

1.2.3 Heavy dispensaries (OPD attendance of 200 patients/day or more) shall have facility for carrying out essential lab investigations like blood sugar, urine analysis, simpler Biochemistry investigations like KFT, LFT etc. and CBCT, & ECG.

1.2.4 A semi automatic analyzer shall be installed in all such dispensaries. A suitable lab technician shall have to be posted in such dispensaries.

1.2.5 State Governments shall ensure availability of drugs in the dispensary.

1.2.6 Patients suffering from chronic ailments shall be issued medicines from dispensary for one month at a time.

1.2.7 Dispensary shall maintain re-order level and indent medicine on monthly basis.

1.2.8 For medicines not available in the State/Central Store, local chemist shall be empanelled on the basis of discount offered for branded and generic medicine.

1.2.9 IMO In-charge of dispensary may be given financial powers for reimbursement of medical bills upto Rs.1,000/- per case subject to maximum of total imprest money of Rs.10,000/- per month.

1.2.10 The Dispensary shall have the following infrastructure -

a) Dispensary shall have facility for toilet, drinking water for patients, power back up, adequate furniture, IT hardware and telephone.

b) Heavy dispensaries (>200 patients/day) should install token vending machines to manage the queue.

c) Heavy dispensaries (>200 patients/day) shall have a separate registration counter for Senior Citizens.

d) Dispensaries shall have proper sign boards in local languages.

1.3 STATE EXECUTIVE COMMITTEE:

1.3.1 For monitoring the performance of all ESIS Hospitals and Dispensaries in the State, a State Executive Committee shall be constituted as under :

i	Principal Secretary/ Secretary Labour/Health looking after ESI Scheme.	Chairman
ii.	Officers from other State Departments (PWD, Finance etc.) to be co-opted by Chairman	Member
iii.	State Health Commissioner/Director Health Services	Member
iv.	ESI Corporation Members belonging to that State	Member
v.	MS of ESIS Hospital to be nominated by DIMS on rotational basis	Member
vi.	Two Employer Representatives to be nominated by the Chairman Regional Board from amongst employers' Representative included in the Regional Board	Member
vii.	The representatives of the two Central Trade Union Organisations having the highest membership in the State, with due approval of the Chairman, Regional Board.	Member
iii.	Regional Director of ESIC of State.	Member
ix.	SSMC/SMCs	Member
x.	DIMS/Administrative Head of State Directorate	Member Secretary
xi.	In addition to above, for resolving IT related issues the following officers shall also attend the meeting – a) State IT Nodal Officer nominated by DIMS b) WIPRO Representative c) Any member co-opted by the Chairman	

1.3.2 The State Executive Committee shall have the following powers/functions :

i. It shall meet once in three months.
ii. To ensure availability of medical and paramedical man power.
iii. To ensure availability of drugs.
iv. To monitor functioning of IMPs. through periodic review of the reports of the Local Committees as well as independent inspections.
v. To monitor Super Specialty Treatment bills.

vi. To approve empanelment, de-empanelment, blacklisting etc. of tie-up hospitals for secondary care. (No referrals or pre-approvals for patients being referred to tie-up hospitals for secondary care would be routed through SMC for any reasons whatsoever).

vii. To approve empanelment, de-empanelment and blacklisting of hospitals for Super Specialty Treatment based on the proposal submitted by SSMC/SMC as per the approved policy of the ESI Corporation.

viii. To monitor payment of bills of hospitals having tie-up for secondary treatment.

ix. To monitor implementation of IT Roll-out under Project Panchdeep in the State, including power back-up issue.

x. To monitor training of ESIS officials.

xi. To monitor infrastructural issues and execution of repair work; i.e. to monitor timely survey of all the ESIS building and getting proposals for repair, reviewing of rented premises of ESIS dispensaries.

xii. To submit reports/returns and/or any proposals to National Level Committee headed by DG, ESIC for further action/consideration.

xiii. For Special Repairs & annual Repair & Maintenance the following financial powers are delegated to the State Executive Committee:-

Item.	Description of Powers	Extent of Powers
1.	To sanction Special Repair Works of ESI buildings being used by the State Governments. To have the Special Repair Works executed by CPWD or an agency of the State Government, duly approved by the State Finance Department by a general or specific order.	Dispensaries# Upto a ceiling of Rs. 50,00,000/-* (Fifty Lakh) in 5 years period** per dispensary. Hospitals# (i) Upto 200 beds – up to a ceiling of Rs. 3,00,00,000/-* (Three Crore) in 5 years period**. (ii) More than 200 beds – Up to a ceiling of Rs. 5,00,00,000/-* (Five Crore) in 5 years period**.
2.	To sanction Annual Repair & Maintenance, including operation and maintenance of essential services.	As per CPWD Plinth Area Rates, within the overall budgetary allocation given by ESIC under the ARM head for that State.

** Estimated amount for Special Repairs, in one or more phases, shall not exceed the total prescribed ceiling amount during the entire 5 year period. 5 years period is to be counted from the financial year succeeding the date of sanction in a particular financial year.

***** Proposals of Special Repairs beyond the prescribed financial limit may be sent to ESIC Hqrs.

Proposals of Special Repairs of Staff Quarters attached to Dispensaries / Hospitals shall be dealt by RD/SSMC within their delegated powers and those requiring expenditures above the delegated powers need to be sent to ESIC Hqrs as per extant instructions.

2. SECONDARY MEDICAL CARE

2.1 Referral from Dispensary

2.1.1 'Kahin Bhi Kabhi Bhi' is to be restricted for emergency situation only. The I.P. shall have a parent dispensary for himself and his family. IP may choose separate dispensary for his family. If referral for secondary care is required, IP shall be referred on a prescribed proforma from the parent dispensary to the hospital. Patients would be given repeat medicines only from home dispensary. As far as possible Dhanwantri Module shall be utilized for referral.

2.1.2 Patients discharged from the hospital could be issued medicines from the hospital for the period prescribed or maximum for one month, whichever is shorter.

2.2 Continuing Medical Education (CME)

2.2.1 Dispensary doctors are to be trained in family medicine by posting them in hospital for 15 days on rotational basis.

2.2.2 CME programmes for doctors shall be held in ESIC Hospitals once in a month. It shall be mandatory for dispensary (attached to the hospital or falling within 25 kms.) doctors to attend minimum three CME programme in a year. Other dispensary doctors are also welcome to attend.

2.2.3 Doctors are entitled to two conferences in two years, one with Conference fee, TA & DA and other without TA & DA but, Conference fee and leave shall be sanctioned.

2.3 Mentoring

Each of the ESIC-PGIMSRs shall provide mentoring to other ESI hospitals in respective specialties. The specialities assigned to PGIMSRs are as under:-

a. PGIMSR-Basaidarapur: Orthopedics, Obstetrics & Gynaecology, Dermatology, Anesthesia and Pulmonary Medicine.

b. PGIMSR-Rajajinagar: Paediatrics, Surgery, Microbiology, Medicine and Radio-diagnosis.

c. PGIMSR- K.K. Nagar: Biochemistry and Pathology.

d. PGIMSR-Joka: Shall provide support in Obstetrics & Gynaecology to Basaidarapur.

e. PGIMSR-Andheri: Laparoscopic surgery, they will provide support to Rajajinagar in Neonatology and to Basaidarapur in Obstetrics & Gynaecology.

f. PGIMSR-Rajajinagar: shall provide support in Paediatric surgery to ESIC Super Specialty hospital Sanath Nagar.

2.3.1 The mentoring institutions would take up multi-centre research.

2.3.2 They would conduct at least 2 CMEs per department per year through video-conferencing for specialists of the ESI hospitals. Live demonstrations of some special procedures/surgeries would be part of CME.

2.3.3 They would be the reference point for taking stock of the facilities in the ESIC/ESIS hospitals in that discipline and would contribute towards effective development of that discipline.

2.3.4 They may also initiate an ESIC Journal in the relevant discipline.

2.3.5 They would draw up an implementation plan to increase use of telemedicine and tele-conferencing.

2.4 Measures to overcome shortage of man power.

2.4.1 Each authority (MS, SMC, RD) would send vacancy position to HQ office, once in a year, in a prescribed month every year.

2.4.2 All-out efforts shall be made to fill up the vacancies within next six months.

2.4.3 Whenever a post of specialist falls vacant or is likely to fall vacant within six months, it should be advertised. If regular specialist is not available even after advertising the post twice, full time contractual specialist may be engaged; failing which part time contractual specialist may be engaged. Wherever regular or contractual (full time/ part time) specialists/ super specialist are not available, they can be hired from private sector on market rate either on per case basis or fixed duration basis. Specific guidelines of engagement on market rate may be developed.

2.4.4 Senior Residents may be engaged as per provisions of the Central Residency Scheme or ESIC Residency Scheme. Their engagement beyond the period specified under Central Residency Scheme/ ESIC Residency Scheme can be done on annual contract basis, outside the Central Residency Scheme/ ESIC Residency Scheme.

2.4.5 If the Senior Residents are not available as mentioned above, the candidates eligible for Senior Residents can be engaged for 39 days extendable by another 39 days to tide over the immediate requirement.

2.4.6 Wherever a new facility like infertility clinic, dialysis unit, Nursery, ICU, ICCU etc. is required in a hospital, the proposal should be submitted to HQ Office along with requirement of staff.

2.5 Streamlining procurement of equipment

2.5.1 Specification bank for common equipment shall be developed and uploaded on ESIC website.

2.5.2 Standard tender document for procurement of equipment shall be prepared.

2.5.3 Major equipment must be purchased with 5 yrs Comprehensive Maintenance Contract (CMC). Equipment maintenance register shall be prepared and kept in the concerned department of the hospital.

2.5.4 The rate contract for Prosthesis and Aids/Appliances is prepared by the Central Stores, Director (Med.) Delhi. These specifications and rates can be shared with other ESIC/ESIS hospitals.

2.6 BENCH MARK FOR SPECIAL FACILITIES

2.6.1 Hospitals with 500 beds and above shall have a blood bank.

2.6.2 Hospitals with more than 200 beds shall have blood storage facility attached to nearest blood bank of ESIC/Govt./Red Cross/IMA.

2.6.3 It is mandatory for a hospital to have an ICU.

2.6.4 Hospital having labour room shall have NICU of appropriate size.

2.6.5 Hospitals with 500 beds & above, with minimum 70% bed occupancy may have facility of CT / MRI. Various options such as own setup, PPP model, outsourcing may be examined for this purpose.

2.6.6 To redress the grievances of ESI employees, a senior administrative officer (in addition to his administrative responsibility) is designated as grievance officer by the Medical Superintendent in every ESIC hospital. Similarly a Grievance officer shall be designated in ESIS hospitals also, if not in place. Regular meetings of Administration with the Staff of hospital should be an essential part of hospital management and record of such meetings shall be maintained.

2.6.7 The laboratories and Departments of a hospital shall make all-out efforts to get NABH/NABL, NABH Safe-i certification.

2.6.8 Separate registration counter and colour coding of prescription slip for senior citizen patients is to be introduced for easy identification for giving priority treatment.

3. PROCUREMENT AND DISTRIBUTION OF DRUGS AND DRESSINGS

3.1 E-tendering for procurement of drugs shall be followed.

3.2 Doctors shall prescribe the medicines available on ESIC Rate Contract/drug formulary. If a drug is required outside the rate-contract, the prescribing doctor would provide full justification to his/her controlling officer.

3.3 Protocols for local purchase of medicines shall be clearly defined.

3.4 Selection of drugs samples for quality check shall be made as under:-

a. Each month the total number of batches of medicines received during the period of last 30 days are to be uploaded in the computer system. More than 10% of the batches for each supplier shall be selected randomly by the computer software program which will be provided by the system division of ESIC Hqrs. Office. This exercise shall be conducted in the presence of committee constituted by the indenting officer (DMD/Medical Superintendents of the hospitals/ Directors of ESI Scheme).

The same committee shall collect the samples from the batches selected through software system, seal and submit for testing. In order to maintain the quality, the testing policy needs to be strictly adhered to. Till such software programme is developed, the committee shall manually select the batches for testing, and submit the same for testing to the approved laboratories. The records of such proceeding and testing report is to be maintained in the concerned offices. The reports of drugs not found of standard quality shall be submitted to DMC-RC Hqrs. Office.

4. SUPER-SPECIALITY SERVICES (SST)

SST could be provided through a mix of in-house facilities, PPP mode and 'Tie-up' with private/public hospitals, duly keeping in mind cost effectiveness and other relevant parameters.

4.1 Non emergency referrals- The patients shall be recommended for referral by the Specialist for SST, by following specified clinical pathway/ specified guidelines in this regard. Such formats along with SOPs shall be prepared at HQ office and shall be circulated. If the nature of disease is such that the specialist concerned is not able to decide the procedure required, he/she would refer the patient to super specialist (if required in a tie up hospital) for specific opinion. After the opinion has been obtained, specific reference for SST is to be made, as far as practicable to a different tie up hospital i.e. to a different tie up hospital and not to the same tie up hospital from where super specialist opinion was sought in the first instance.

4.1.1 Patients for Super Specialty Treatment shall be referred for a specific/particular procedure. Sometimes, the tie-up hospitals undertake several other procedures that may or may not be related to procedure for which the patient was referred. In cases where additional procedures are required, the additional procedure shall have to be duly approved by the referring ESI hospital. With a view to ensure this, tie-up bills shall be paid only for those procedures for which patient was referred by the ESI hospital concerned either initially or by way of additional procedure approved subsequently.

4.2 Emergency referrals.

4.2.1 In case patient comes to an emergency ward of ESI Hospital outside normal working hours, emergency duty officer will assess and, if required, refer the patient for SST along with a detailed clinical note to be prepared as per specified guidelines. The emergency duty medical officer will submit the details of the case to the MS on the next day for review and follow up action, if any. MS may decide to send a team of doctors to the tie up hospital for verification. As far as possible, the patient in emergency shall be examined by the specialist concerned available at the emergency or on call. Further, the CMO/Senior resident available on emergency duty shall consult concerned Specialist/superiors over phone before making emergency referral for SST.

4.2.2 It shall be mandatory for the tie up hospital to send a report in respect of emergency referrals to the MS concerned on the same day or the very next working day on receipt of referral, giving details of the case and giving their specific opinion about the treatment to be given.

4.2.3 Cashless SST shall be provided to only those IPs/beneficiaries who have been referred to 'Tie-up' hospitals by ESIC/ESIS institutions following SOPs. Patients going to tie-up hospitals without being referred as such by the ESI system, may be provided SST services on reimbursement basis if found suitable. (This is as per the prevailing practice in Armed Forces Medical Services and Railways Medical Services.)

4.3 With a view to prevent too many referrals and /or those referrals being made to a particular hospital, all the referrals made in a month shall be reviewed in a meeting to be chaired by MS and attended to by all the Specialist doctors concerned. Among other

issues, the three important issues to be discussed in this committee shall be:-

a. The necessity of referral.
b. Prescribed procedure was followed or not.
c. Whether too many patients were referred to a particular hospital and whether it required monitoring.

4.4 As far as Cancer Chemotherapy is concerned, the anti cancer drugs available in Indian Pharmacopeia, British Pharmacopeia and US Pharmacopeia, shall only be reimbursed. The drugs which are not available in any of the standard Pharmacopeia will not be reimbursed. As far as possible, anti cancer medicine shall be issued by the referring ESI Hospital. In due course, it shall be made mandatory.

4.5 Revision of the eligibility criteria to prevent misuse:

4.5.1 The eligibility of patients for SST shall be determined from the date of registration of IP on IP portal.

4.6 Chemotherapy to be given in ESI hospital itself

4.6.1 Post of Medical Oncologist with support staff may be sanctioned for hospitals having bed strength of 300 beds and with average bed occupancy of 70% and above.

5. HIGH COST TREATMENT

5.1 Upper limit on the expenditure for procedures not covered under CGHS package rates would be Rs. 10 lac per beneficiaries per year.

5.2 Cases involving expenditure of more than Rs.10 Lac may be considered only as an exception and on reimbursement basis. The reimbursement proposal of such cases shall be submitted to Hqrs. Office for consideration and approval by ESI Corporation, on case to case basis.

5.3 In respect of children of IP, congenital diseases requiring referral to SST and genetic dis-orders would be eligible for coverage up to the ceiling mentioned earlier only in case the child is born after the IP had become eligible for SST.

5.4 In case of malignancy and chronic renal failure, pre-existing disease shall not be eligible for coverage, so as to prevent potential misuse of SST. In case during the course of treatment it is found that the disease was existing prior to person becoming an IP, the treatment shall be discontinued.

5.5 Dialysis has been brought back within the definition of SST. Therefore, the eligibility for dialysis shall be the same as that of SST.

5.6 Treatment in case of malignancy at tie up hospitals shall be eligible only for surgery/Chemotherapy/Radiotherapy. Any additional treatment/procedure shall require specific recommendation by Medical Board, duly constituted for the purpose by the ESI Hospital concerned.

5.7 The cost of artificial limbs is to be restricted to Rs.1.00 lac.

6. INCREASE IN CEILING ON MEDICAL EXPENDITURE

The ceiling on medical expenditure has been raised from Rs.1500/- per year to Rs.2000/- per IP per year. The increased ceiling will be effective from 1st April, 2014. The ceiling will include expenditure on primary and secondary medical care. Specific instances of some inclusions and all the exclusions, in this regard, are mentioned in paras 6.1and 6.2 below. However, no State Government would get less funds on this count from the ESIC than what they got in 2013-14 for the next five years starting from 2014-15.

6.1 Inclusions:

6.1.1. All expenditure incurred by SSMC on behalf of the State Government, such as rent on hiring of dispensaries on behalf of the State Government; expenditure on patients referred to tie up hospitals where no ESI Hospital is available within 25 Kms; payment made to part time Specialists engaged against vacant posts of specialists in ESIS hospitals, etc. Audit of expenditure / bills paid by SMC on behalf of State shall be responsibility of the respective State and reimbursement / settlement shall be subject to audit certificate by State AG. Arrangement of record keeping by States shall be such that it facilitates audit by State AG. The States would make arrangements for making such payments themselves, at the earliest.

6.1.2. Expenditure on other patients referred to tie- up hospitals for secondary care.

6.1.3 Expenditure on patients referred by ESIS dispensaries and hospitals to tie-up hospitals for SST.

6.2 Exclusions

6.2.1 Capital expenditure such as new construction, ARM / Special repairs, equipment, etc. The accounting of such expenditure would be governed by the extant instructions.

6.2.2 Specific incentives provided in the decisions of the Corporation, taken at its 162nd meeting.

6.2.3 Expenditure on ESIC institutions and SST/secondary care cases referred by ESIC Hospitals/ MDDCs.

6.3 The "Administrative cost" and "other costs, such as drugs, dressings, bills of tie up hospitals" will have sub-ceiling of Rs.1000/- and Rs.1000 respectively out of overall ceiling of Rs.2000/-.

6.4 The ceiling will be further increased by Rs.150/- per IP per year , each year for the next 5 years starting from 1st April, 2015.

6.5 All hospitals to be approved by the ESIC in future shall be run by the State Government concerned, with the proviso that each State shall have at least one ESIC Hospital.

6.6 With a view to facilitate expeditious implementation, the States may consider setting up State ESI (Medical Benefit) Corporation as Autonomous Bodies. Enabling provision for State ESI Corporation already exists under the ESI Act.

6.7 States may consider having a separate cadre of medical and paramedical personnel and other staff for ESI Scheme.

6.8 The States shall, as far as possible, provide man power under ESIS as per the ESIC norms. Necessary incentive scheme already exists for the purpose.

7. AYUSH/ISM

7.1 The following Norms /guidelines for strengthening /promotion of AYUSH services and for establishment of AYUSH units in ESIS hospitals/dispensaries, the data (OPD registration, admission and discharge etc.) available under the Dhanwantari module only would be used as the qualifying criteria mentioned in these norms.

7.1.1 ESIS hospital/dispensary having average OPD attendance of more than 200 patients/day during the previous six months may set up one AYUSH unit of their choice from among the 4 systems of medicines namely Ayurveda, Siddha, Unani and Homeopathy.

7.1.2 After setting up of new unit, the average OPD attendance of the AYUSH unit shall be at least 25 patients per day in the next financial year. The expenditure shall be treated as a part of the ESI expenditure only if this benchmark is achieved in the Financial Year subsequent to the Financial Year in which the said AYUSH Unit was set up. If this Bench mark is not achieved, either the unit shall be closed down or the expenditure will have to be borne by State Govt. outside ESI Scheme.

7.1.3 With a view to facilitate closing down of the unit in such circumstances, the AYUSH doctors and other staff for the said unit shall be recruited on contractual basis for one year, renewable every year for a total period not exceeding 3 years.

7.2 The proposal for opening the first AYUSH unit and subsequent ones would require the approval of ESIC Hqrs. and shall fulfil following minimum criteria:

a. Opening of second AYUSH unit in a different stream of AYUSH, the minimum AYUSH OPD attendance shall be 40 patients per day in already functioning unit.

b. The minimum AYUSH OPD attendance in one system shall be 60 patients per day to be eligible for setting up of second AYUSH unit in the same system.

c. The 5 year period for reimbursement of full cost by ESIC, hospital- wise, will commence from the first April of the year subsequent to the year in which the first AYUSH unit was started.

7.3 All attempts shall be made for promoting AYUSH system at the hospital level wherever there is adequate demand.

7.4 Herbal Park may be established in all ESI hospitals.

7.5 Wherever AYUSH unit already exists or these are proposed to be opened as per norms mentioned above, it shall be supported by appropriate awareness creation activities.

8. DHANWANTRI

8.1 Capturing of home dispensary data in Pehchan Card must be mandatory.

8.2 Implementation of Dhanwantari at hospital and dispensary levels shall be monitored. Good performance shall be recognized both at individual and institutional level. Incentive shall be provided to both the Government as well as staff working at ESIS hospitals / dispensaries**.** Doctors/para medical staff whose performance is not satisfactory shall be informed about their performance through automated e-mails.

8.3 A joint team of representatives of SSMC, Wipro, and DIMS shall visit each dispensary wherever IT installation is yet to take place. They shall assess whether the existing accommodation in the building is adequate for installation of the IT infrastructure, including space for keeping DG set, diesel etc., depending upon the power shortages in that area. If required, they may negotiate increase in rent with landlord and make a recommendation in this regard to the SSMC. The Committee consisting of SSMC, DIMS and representative of the RD will finally approve any increase in rent. The upper ceiling of increasing of rent will be 15% of existing rent. Wherever it is felt that infrastructure at the existing dispensary premises is inadequate for installation of IT hardware, the committee shall recommend shifting of the dispensary.

8.4 Decision of shifting the dispensary and inviting fresh tender for the new premises is to be taken by committee headed by SMC, at the State level. The same process shall be followed in dispensaries wherever IT hardware is installed but not functional for lack of adequate space or power. Till a permanent solution is achieved, necessary action shall be taken so that at least registration is done online and certificates are issued online.

8.5 Regional Connect Meeting shall be held every month with the active participation of the SMC/RD/MS/ State Director/WIPRO.

8.6 Every State/UT DIMS/Directorate Office should have one State Nodal Officer for Dhanwantri and also one Nodal Officer in each location, i.e., (each dispensary and hospital), if the same is not already in place. The ESIS Directors/ State Nodal officers of those states where Dhanwantri Module has not been successfully implemented may visit other states which have successfully implemented the same such as Gujarat, Goa, and Delhi.

8.7 Monthly change management / soft skill sessions shall be held on attitude development particularly for staff where maximum resistance is observed.

8.8 A phased programme of adoption of different modules under Dhanwantari shall be adopted.

8.9 The consumables for implementation of Dhanwantari, shall be procured (for both hospitals and dispensaries) by DIMS/ESIS Directorate utilizing the funds of HDC under " Improvement Head".

8.10 The State Executive Committees shall hold meetings to handle/resolve IT issues concerning support from the State Governments and co-ordination with ESIC.

9. HOSPITAL DEVELOPMENT COMMITTEE (HDC)

9.1 The composition of HDC has been modified to the extent given below:

9.1.1 Two representatives each, representing Employers and Employees shall be nominated by DIMS of concerned State provisionally, for a period of six months at a time, till the nomination from State Govt. is received.

9.1.2 A representative from the office of SMC shall also be part of this committee.

9.1.3 Representative of State Labour Department shall be replaced with representative from DIMS.

9.2 There is a need for constituting a separate sub-committee of the HDC, comprising the following members to look into the issues of State run ESI dispensaries attached with ESIC hospitals regarding improvement activities and expenditure would be met and booked by SMCs:-

DIMS/JDIMS	Member
Dy. MS of Hospital	Convener
Representative of SSMC/SMC	Member
Dispensary in-charges concerned	Member

9.3 The SMCs shall allocate the budget allotted by Hqrs Office for ARM of the Hospitals & Dispensaries proportionately, among the HDCs in the State depending upon the size of the hospitals, number of attached dispensaries, staff quarters, etc, to ensure equitable distribution of budget.

9.4 State Govt. shall delegate concomitant power to their MSs of the respective hospitals. Procurements, etc as sanctioned by HDC, shall be made by the MS, following applicable procedures of GFR/Financial Rules.

9.5 Hospital having bed occupancy of 50% or more, based on statistical data of 2012-13 shall be provided with one time improvement fund for procurement of medical instruments and equipments as non sharable expenditure up to the amount of Rs. 10.00 lac for the year 2014-15 (extendable up to September, 2015). To draw this fund, the eligibility criteria shall be that the hospital shall have adopted the Dhanwantri module with online registration, admission and discharges which shall be certified by ESIC Hqrs, New Delhi.

9.6 ESI Dispensary shall be granted incentive for implementation of Dhanwantri Module for 3 years starting from 2014-2015 subject to fulfilling the following criteria:-

9.6.1 In the financial year 2014-2015 each dispensary having OPD attendance of at least 30 patients per day would be eligible to get Rs.10,000/-.

9.6.2 For the 2nd Year i.e. 2015-2016 the dispensary has to satisfy two conditions to get the grant of Rs. 10,000/-

I. It should have implemented the Dhanwantri Module; and,

II. Average OPD attendance as per Dhanwantri Module should be at least 45 patients per day.

9.6.3 In 2016-17 the dispensary has to satisfy the following two conditions for the grant of Rs. 10,000/-

I. It should have implemented the Dhanwantri Module; and,

II. Average OPD attendance as per Dhanwantri Module should be at least 60 patients per day.

9.7 The HDC meetings shall be held as per requirement but minimum of four meetings shall be held in a year. MS in-charge shall invite the members of HDC for participation in the Suvidha Samagam meetings being organised by RD/MS.

9.8 The Annual Repair Maintenance (ARM) works of buildings and services shall follow the norms & yardsticks of ARM activities as defined in CPWD Maintenance Manual for all such activities, including manpower required for day to day maintenance, frequency of painting, etc.

9.9 The cleaning services mentioned in the circular issued vide U - 16/18/186/07-Med-I dated 15.04.2010 is clarified as cleaning of external drains in the compounds, sewer lines, manholes inspection chambers, water sumps, overhead tanks, and periodic terrace cleaning before and after the onset of monsoon for both dispensaries and hospitals and the expenditure shall be met out from the "HDC-Repair & Maintenance of the Building Fund".

9.10 The cleaning/mopping of floors/circulation area inside the buildings/wards and compound is part of Housekeeping Services and hence to be treated as "administrative expenditure".

9.11 The ARM work of the staff quarters situated in the compound of ESI Hospitals/ Dispensaries shall be looked after by the HDC.

10. TRAINING OF MANPOWER IN ESIC/ESIS

10.1 Training funds shall be placed at the disposal of SMC. SMC shall make payments for training activities on the same pattern as for drugs and dressing through the revolving fund mechanism.

10.2 Training needs are to be identified by HDC and submitted to DIMS for approval and coordination. DIMS or an officer nominated by DIMS shall be Nodal Officer Training for ESIS. DIMS shall also develop Annual Plan/ Calendar for training of doctors and other staff during the year.

10.3 30% of training budget shall be utilized for training of paramedical and nursing staff. Due emphasis shall be given on training for improving of soft skills. For all the training programmes, about 15% of training time shall be devoted for soft skill training.

10.4 NTA shall develop modules for training of staff nurses, paramedical staff, etc in consultation with DIMSs, and standardize budget for training programme of different kinds. Feedback of DIMSs may be obtained on the existing training modules developed by NTA and based, on the feedback, the modules may be revised or new modules may be developed. NTA shall also monitor implementation of training activities in States.

10.5 NTA shall organise training for newly appointed SMC/DMS/MS for a period of 6 working days covering all the required aspects, essential for these posts. As far as possible, this training shall be organized before these doctors are posted to these administrative positions.

10.6 Doctors posted in dispensaries who are likely to be posted as SMC/ MS in near future should preferably be posted as OSD/DMS at hospitals at the same station or nearest location for familiarisation.

10.7 All newly recruited Revenue officers and doctors shall be provided with induction training of 3 to 5 days. This training shall be organized preferably within three months of their joining.

10.8 Each ESIC & ESIS hospital shall designate one of its medical officers, preferably Deputy MS, as Nodal Training Officer for hospital.

10.9 Doctors shall be given training in Hospital Administration after completing certain duration of service·

DMC (MS)