Integrating Quality in HIV Services: Experience From the Field

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Outline

- Background
- Rationale for Integration of quality improvement in HIV services
- Building capacity of LGA's and Health facilities to carry out QI activities
- Examples of successful Quality Improvement projects
- Challenges of building QI culture in HIV services
- Recommendations

Background

- Globally, 8 million deaths due to manageable disease
    - 60% due to poor quality of care
- Global HIV elimination Goals by 2020 and 2030
- Tanzania HIV Impact Survey: Only 61% of Tanzanians who are HIV + know their status. Of those who knew their status, 94% were receiving ART and 87% had Viral Suppression (THIS 2017-18)
- Efforts to increase identification of PLHIV have been put in place: index contact tracing, focused PITC and on scale
- Despite increased enrollment into HIV care, access to quality HIV services is low, there is a high Net loss of 7% (PEPFAR T) due to disengament to care from various reasons including death

Rationale for Integration of Quality into HIV Services

- Global targets for HIV and TB by 2030 need ongoing quality services to ensure we are on track
- At patient level poor quality of care is associated with poor health outcomes e.g. delayed HIV (and TB) diagnosis/linkage to ART/TB treatment and lack of viral suppression, treatment failures, Drug resistance etc.
- Constrained Health systems in Tanzania if unchecked, lead to service interruption ; hence need for ongoing measurement of service outcomes e.g. HRH shortage, staff turnover, suboptimal laboratory services and supply chain systems, poor utilisation of data for service monitoring etc.
- The HIV epidemic dynamic nature requires constant adaptation of new scientific evidence that needs to be translated to service delivery
- Ensure users satisfaction for adequate service utilisation

Quality Improvements Strategies …1

Analyze routine data

Identify gaps in practice

Analyze possible causes

Implement Quality Improvement activity

Monitor changes due to QI activity

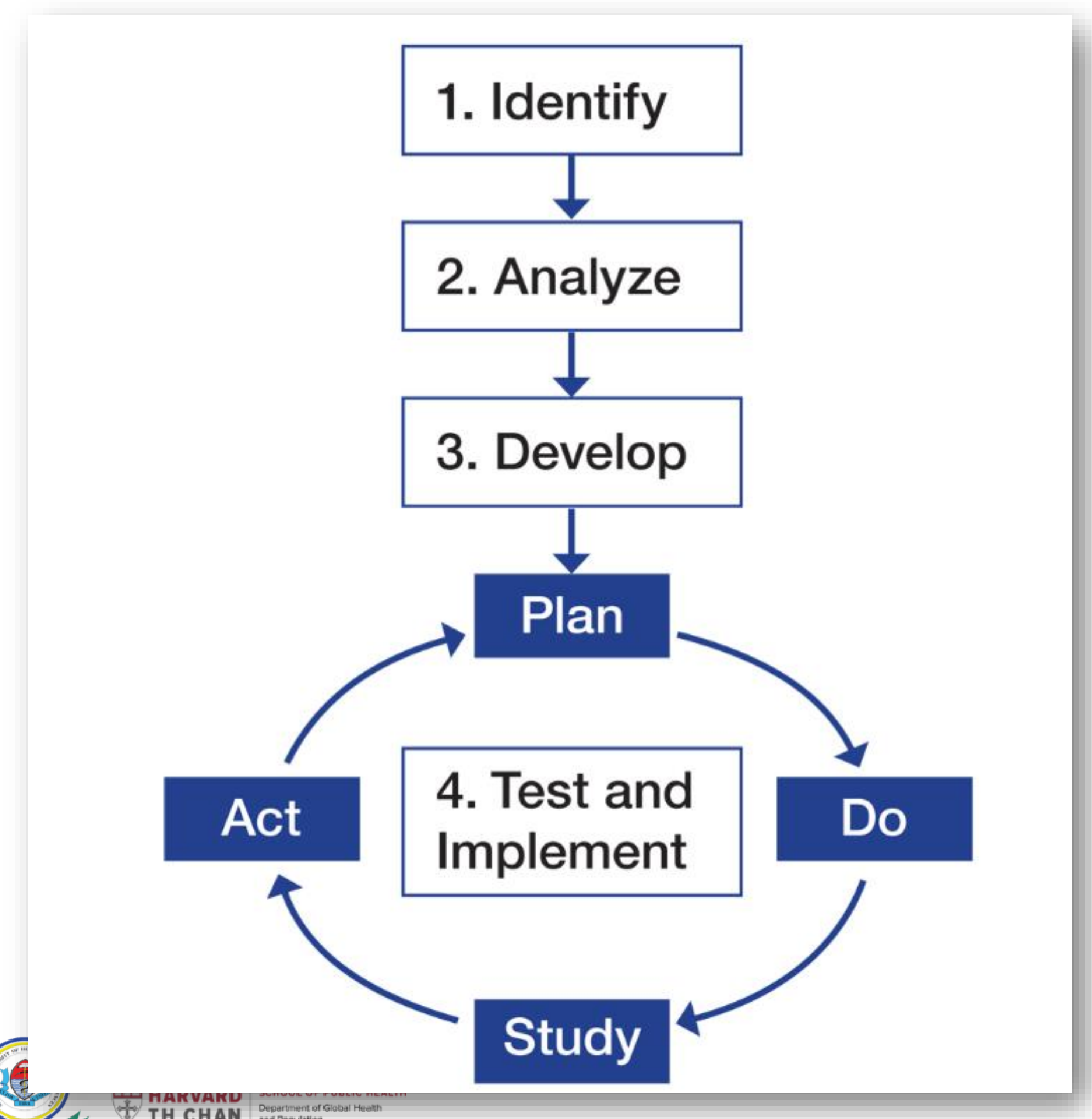
Quality Improvements Strategies …2

- Focusing on the needs of the patient
- Implementing an improvement model that includes measuring- testing change - re-measuring, and applying change
- Providing ongoing leadership support to improve the system of care
- Provide avenues for sharing and scaling up best practices e.g. PE as transport agents for HVL scale up; TDM initiative for PLHIV identification

QI Strategies – What we do in the Field

- Use program data and SS visits to identify gaps at HF level, district, or in the region
- Work with health care providers and managers to develop improvements objectives and actions to address the gaps
- Develop QI plans/projects with facility QI teams
- Work with RHMT's/CHMTs, support implementation of QI plans
- Coach and mentor (IPs, R/CHMTs, NACP etc)
- Document and share best practices

QI Strategies model



Achievements in Continuous Quality Improvement (CQI) by LGAs

- Development of facility-based QI teams with QI focal persons and functional WITs
- Systematic documentation of QI projects using national tools
- Monthly WIT and QI team meetings held and documented
- Presence of harmonized QI guidelines and training materials
- Assessment of QI projects is part of routine supervision by CHMTs, RHMTs and IPs
- Increased awareness for QI at all levels of health system by providing opportunity to share successes and challenges

Examples of successful Quality Improvement projects by LGAs at HFs in Kigoma and Pwani

1st 95: Identification of PLHIV through sexual and biological index contact tracing: Uvinza HC

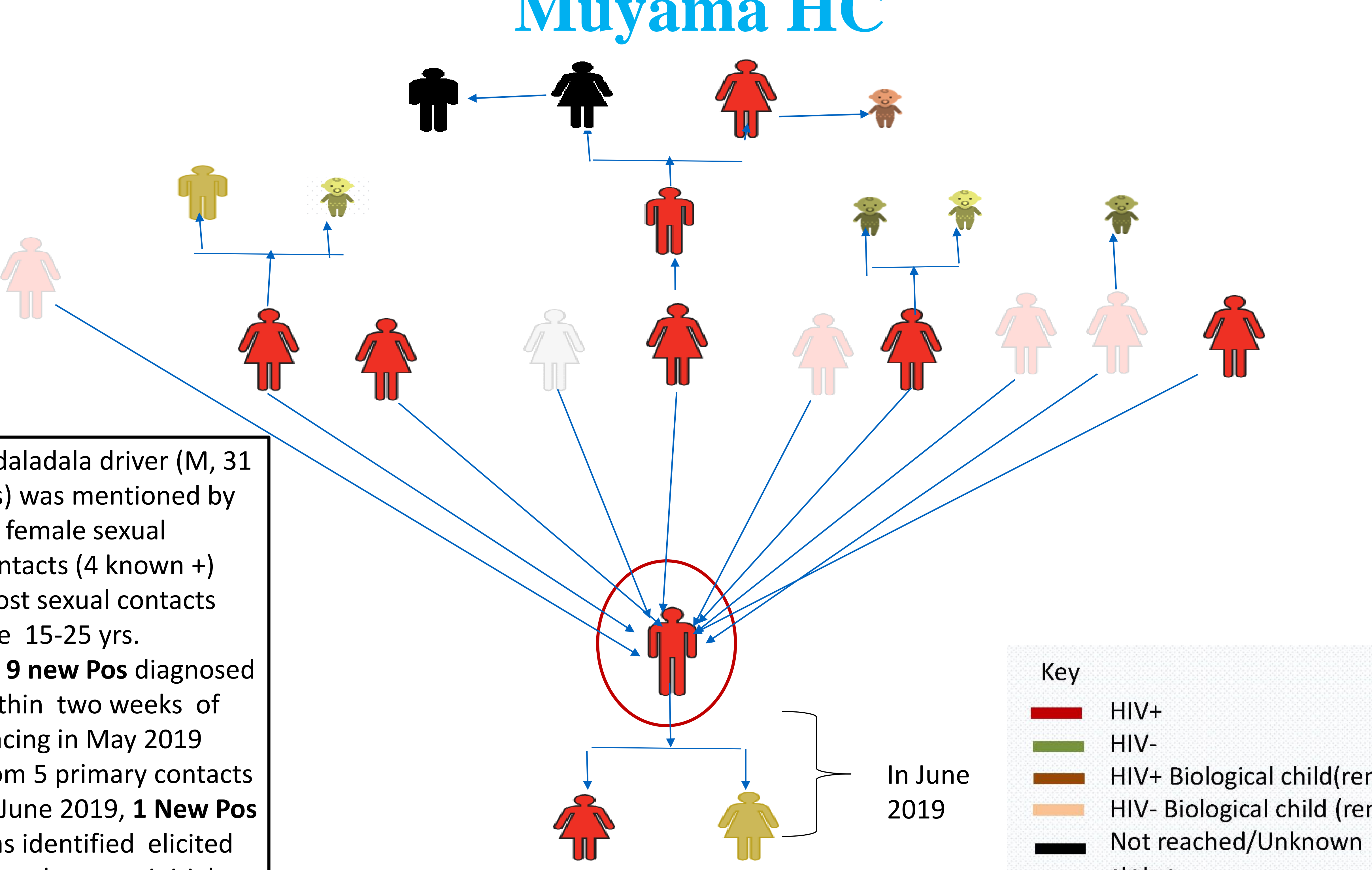
HIV+ Index client

1:1:2:6:2 → **5 new POS, 3 known HIV+**

Key:
- HIV+
- HIV-
- HIV+ Biological child(ren)
- HIV- Biological child (ren)
- Not reached/Unknown HIV status
- Known case

- **5 new Pos were** identified from 1 index client at Uvinza HC
- Index tracking done for 10 days May 2019

Sexual Index Contacts Network at Muyama HC



- A daladala driver (M, 31 yrs) was mentioned by 10 female sexual contacts (4 known +)
- Most sexual contacts age 15-25 yrs.
- All **9 new Pos** diagnosed within two weeks of tracing in May 2019 from 5 primary contacts
- In June 2019, **1 New Pos** was identified elicited from the same initial client (zero index)

2nd 95: Linkage and retention to ART and Care

Improved Adherence and early Retention among newly diagnosed PLHIV (Tx-New) Maweni RR Hospital:July- Sept 2019

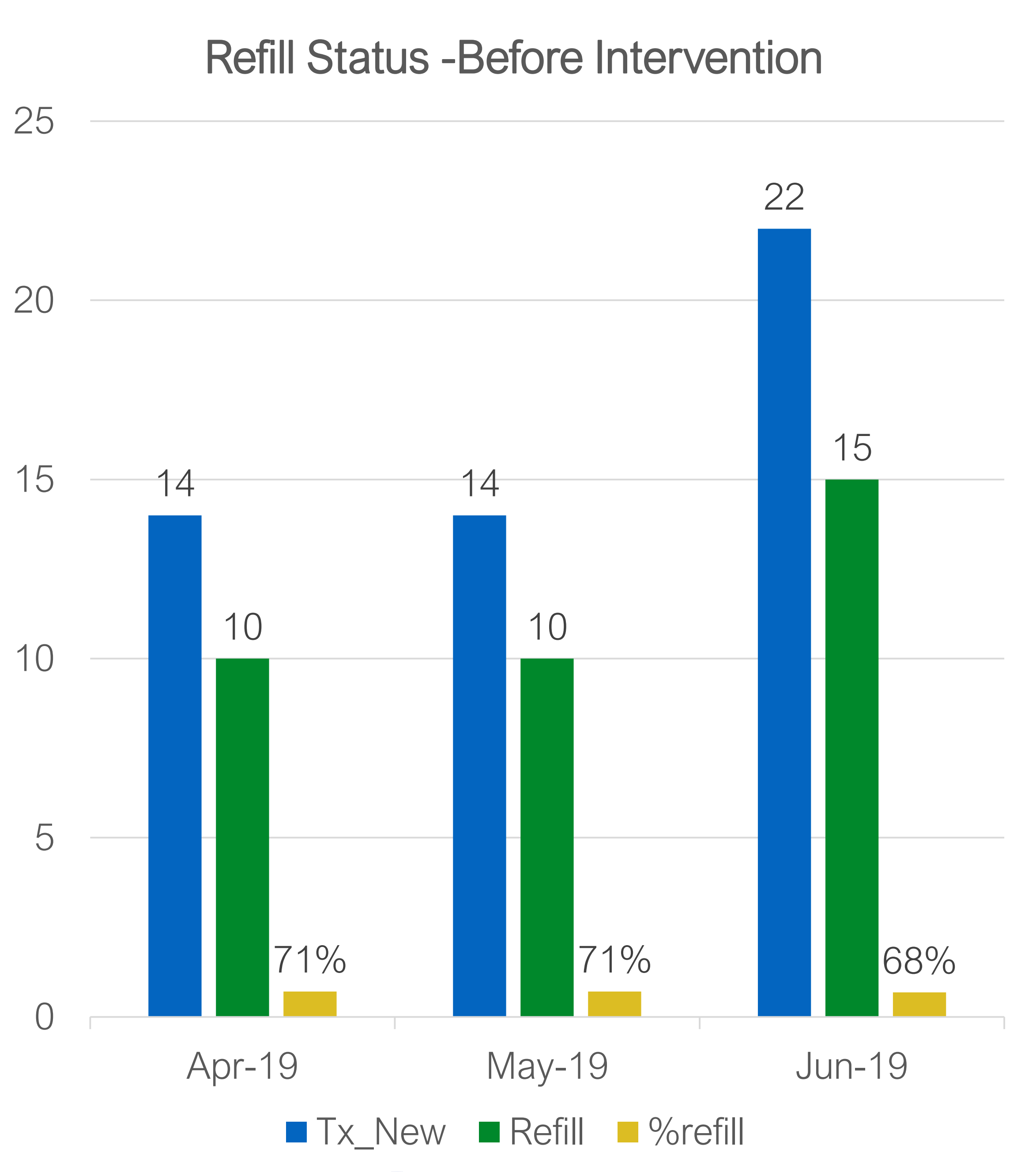
Background Information

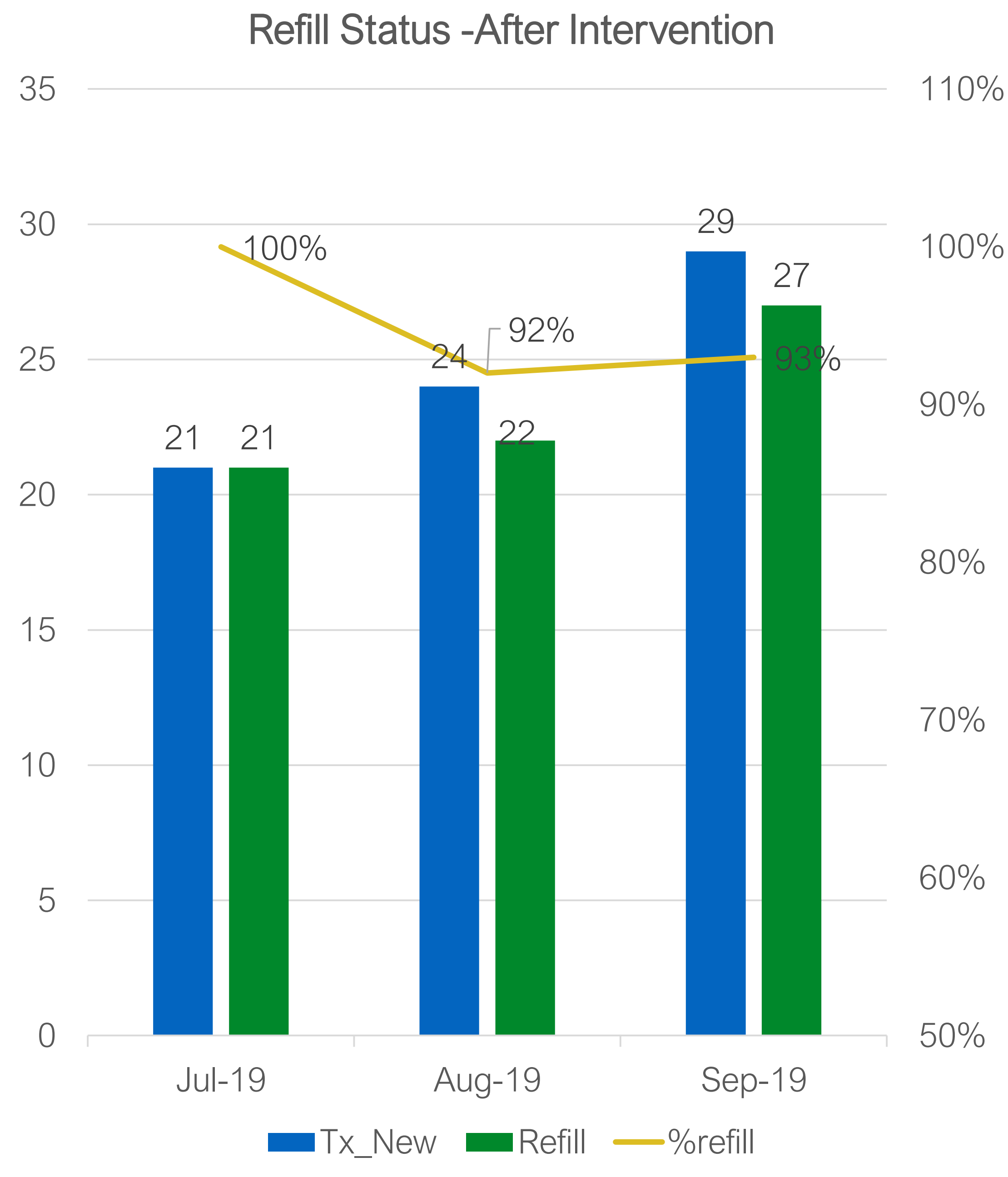
- Retaining clients on HIV care and treatment is more challenging to new diagnosed clients compared to long term clients.
- Only 70% of newly diagnosed client refilled for the quarter of April- June 19 which is below the set target of 95% at the RRH.

What was done

- Effective Pre & Post counselling, treatment preparation, continuous follow up and support within 45 days after diagnoses provided at OPD and CTC clinic (LCM).
- Appointment reminders one day before scheduled clinic visit & day of appointment.
- Confirming clients mobile no by calling in front of client.
- Effective use of three boxes approach, use of tracking registers and Mapcue.
- Committed BCPE staff, trackers and PEs at OPD and CTC depts

Results: 1st ART Refill status
April – June 2019 & July – Sept 2019





Lessons Learnt

Results

- A remarkable progress in retaining clients on care and treatment for the newly diagnosed clients from 71.6% to 97% in 3 months as a result of close monitoring at Kigoma RRH
- In July – September 2019, 70 clients out of 74 (95%) Tx New) came for their 1st ART refill
- The remaining 4 (5%) had other valid documented reasons (death and confirmed referral).

Lesson Learnt

- Availability of trackers and facility mobile phones facilitated appointment reminders to clients and calling all those who missed their set appointments.
- Effective use of 3 boxes approach, use of tracking registers and Map cue also contributed to this success.
- Staff dedication

Improving Early Retention- Uvinza HC

Problem Statement

- Low rate of Early retention of 14% in May 2019 of new clients enrolled to care
- There were very few clients returned to care for 1st ART REFILL
- This was contributed by:-
  - ✓ Inadequate follow up of by Providers, Peer educators and lay counsellors
  - ✓ Incomplete documentation of clients demographic information and mapcue
  - ✓ Lack of disclosure of clients
  - ✓ Long distance to the facility for refill

Indicator of interest	Data Sources	Frequency of collection
Increasing percent of clients receiving 1st ART Refill from 14% in May 2019 to 100% in September 2019	Data collection and review from CTC 2 Data base	Monthly data review through collaborative WIT meetings

Action Taken

- QI project was initiated for improving percent of clients received 1st ART refill

  GOAL: Increasing percent of clients receiving 1st ART REFILL from 14% in May 2019 to 100% in September 2019

- **Numerator:**
  - ➢ Number of clients returned to care after ART initiation(received 1st ART refill) among clients started ART in the prior month
- **Denominator**:
  - ➢ Number of clients who started ART in the prior month

Tested Changes

Root Cause	Change Interventions selected	Planned start date	End date	Responsible staff	Remarks
Inadequate documentation of clients' demographic information	Ensuring clients demographic information are filled and updated routinely and every client visit	May 2019	Sep 2019	• CTC I/C • Linkage coordinator	Done, ongoing activity
Inadequate documentation of clients mapcue	Ensuring clients mapcue forms are documented and updated routinely and during every visit	May 2019	Sept 2019	• CTC I/C • Linkage coordinator	Done, ongoing activity
Inadequate adherence counselling	Ensuring enough adherence counselling (three adherence session) is provided to all new clients	May 2019	Sep 2019	• CTC I/C	Done, ongoing activity
Large number of 'never refill'	Weekly sharing of 'never refill' clients with community partner	June 2019	Sep 2019	• CTC IC • Clinical tracker	Done, ongoing activity
Large number of never refill clients	Attaching all new identified clients (Tx New) to respective health care providers and Peer educator/lay counsellors for close follow up (HCP-CLIENT TIE)	June 2019	Sep 2019	• CTC I/C	Done, Ongoing activity
Long distance to the facility for refill	Conducting Jointly facility Led community ART refill to distant clients	August 2019	Sep 2019	• CTC I/C • Clinical tracker	Done, ongoing activity

% 1st ART Refill

Month	% of clients returned for 1 st ART refill
May-19	14%
Jun-19	51%
Jul-19	76%
Aug-19	82%
Sep-19	93%

% 1st ART Refill

Results

- The percent of clients returned for 1st ART refill improved from 14% in May 2019 to 93% in Sept 2019

Lesson learnt

- Demographic information and mapcue documentation improve reachability of never refill clients
- HCP-client tie provided easy accessibility of clients and brought responsibility to tester and LC/PE
- Facility led community ART outreach bring ART service near to clients living distant to the facility (SDM- use nearby Tandala Disp)

Client assessment and documentation

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COMMUNITY ART REFILL CLIENTS REGISTRATION FORM

Date of Outreach 14|09|2019

AGE	SEX (M/F)	ADDRESS	CONTACTS	ART REGIME	DAYS DISPENSED	NEXT APPOINTMENT	FOLLOW UP STATUS PRIOR TO OUTREACH REFILL: TS	MISS APPS	LTF	ORIGIN REFERRAL CARE (F=F C=COM)

Registration form for Community ART refill

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3rd 95: Increasing HIV Viral Load Coverage at Kibondo DH

Problem Description:

- Low HIV viral load coverage in Kibondo DH (68%) by Oct 2018 among clients attending at clinic.
- Increased number of Treatment supporters (TS) who come for drug pick up.
- Inadequate documentation of HVL sample collection and results received
- Lack of HVL demand from the clients

Actions taken

- Increase in HVL Sample collection and follow-up of result
- Health education during CTC clinic on important of HVL
- Daily follow-up of clients eligible for HVL,
- Minimize TS drug pick up ensuring HVL samples are collected
- Improve documentation

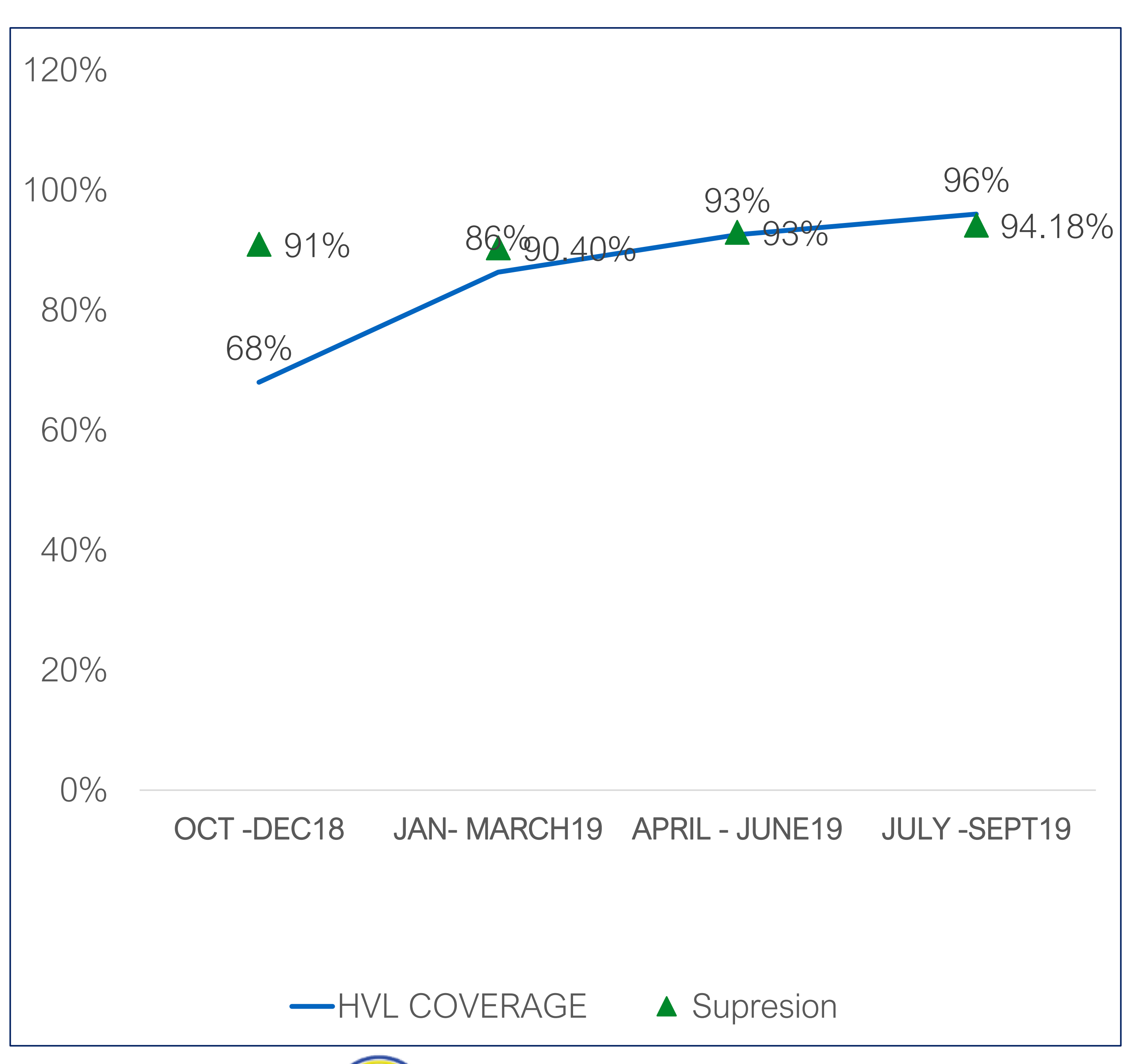
Follow up Indicators

Indicators	Methods	Frequency
Increase % of client who had sample taken for HVL from 68 % (Oct 2018) to 100% by Sept 2019.	Through data collection, review of HVL registers and using Data base .	Monthly data review trough collaborative WIT meetings

Tested Changes

Root cause Analysis	Change Interventions Selected	Planned Start date	End Data	Responsible Staff	Remarks
Inadequate knowledge and information about HVL test among Clients	Mentorship of PE on how to conduct HVL health education to the clients during CTC clinics.	Oct 2018	Dec 2018	CTC Clinicians	Done and ongoing
HVL sample not taken from eligible clients despite attending clinic.	Daily follow-up of clients eligible for HVL; ensure sample collection and documentation done properly.	Oct 2018	Sept 2019	Adherence nurse	Done and continues
Staff Issues: shortages, low/lack of commitment to HVL testing	Allocation of Lab staff and data clerk who ensures all eligible HVL samples are timely collected and updated in DB	Oct 2018	Sep 2019	Lab staff andData Clerk	Done and continues

Results



Outcome

- HVL coverage increased from 68 % (Oct –Dec 2018) to 96% 2019
- HVL suppression rates increased from 91% - 95% during the same period
- Demand creation, some of clients are demanding HVL testing incase of prolonged interval per algorithm.

Lessons learnt

- Utilization of data to actively follow up of HVL sample taken assists in monitoring progress towards target.
- Sensitization through Health education sessions empowers PLHIV to demand for services on visit day.
- Collaboration and ownership by CHMT and Facility staff on identification of eligible clients.

Using Adolescent Camp to improve Viral Suppression among Adolescents with High VL

Theme: ‘Afya yangu Mtaji Wangu’

Gap: Viral suppression among adolescents attending care and treatment facilities

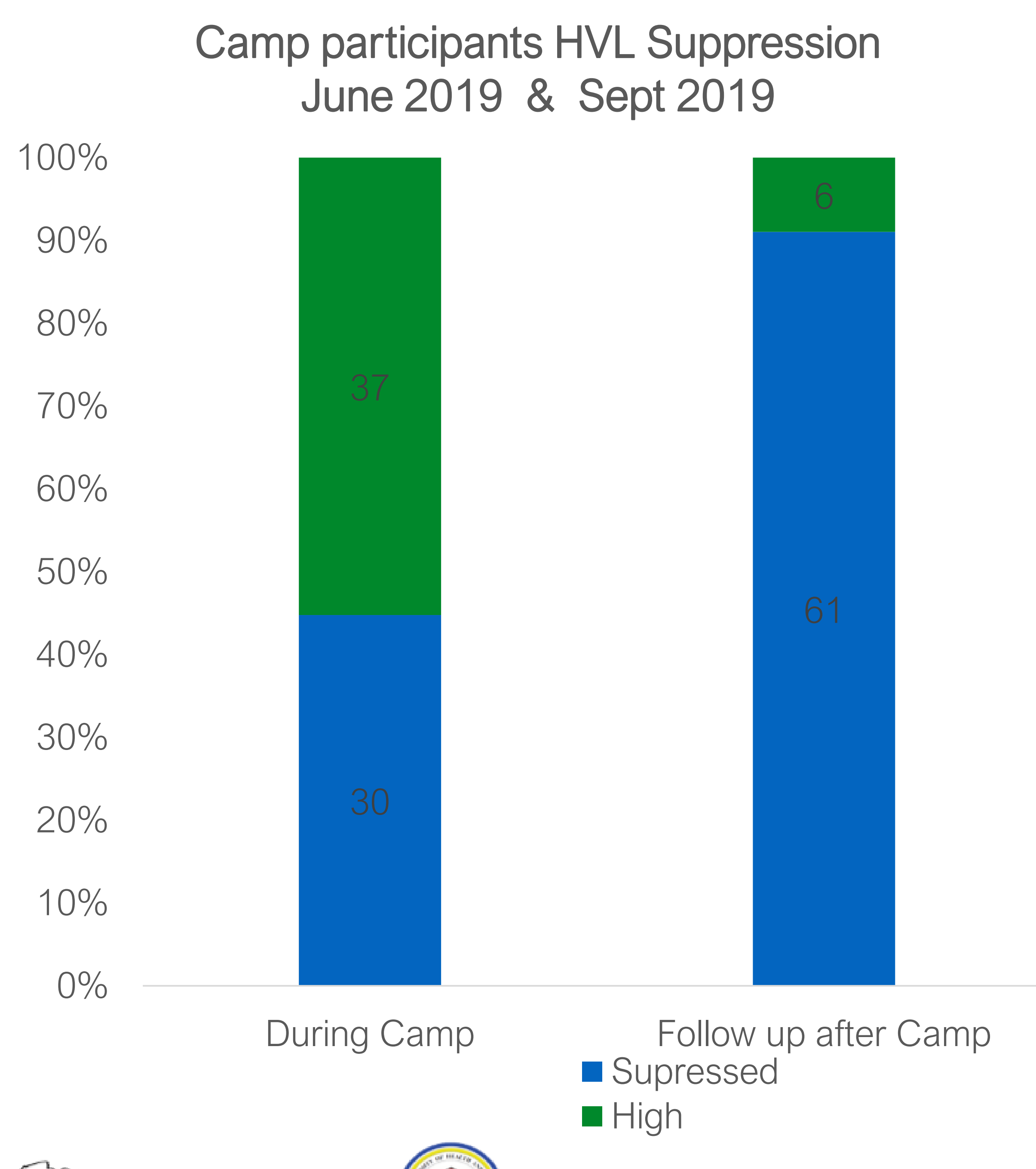
Challenges Noted

- Difficult for most of the adolescents to take the morning pills in time especially for those who are going to school.
- Poor nutrition in some families especially breakfast is the problem for adolescents taking ARVs in morning.
- Some adolescents were still engaged in high risk behaviors
- Missing HVL sample/results from 30 adolescents

What was done :

- THPS organized annual adolescent camp with the theme '*Afya Yangu Mtaji Wangu*'
- 97(15-24 years) Campers were selected based on, unsuppressed VL (80%) and suppressed VL (20%)
- The activities for *Afya Yangu Mtaji Wangu* included :
  - Testimonials from suppressed adolescents as motivators
  - Edutainment sessions (games , music and life skills sessions)
  - One to One counseling with Pediatrician (*Chat with your Dr session)*
  - Provider patient tie for follow up. Each Adol. with high VL tied to a specific HCP

Results: HVL Suppression among Adolescents June 2019 and Sept 2019: Pwani and Kigoma



Outcome:

- 67 out 97 **(69%)** camp participants HVL samples were taken and results documented during camp and at follow up (3 months later)
- 30 had recent HVL samples taken
- **37(55%)** had high viral load during camp
- **Only 6 (8.9%)** had high viral load after camp

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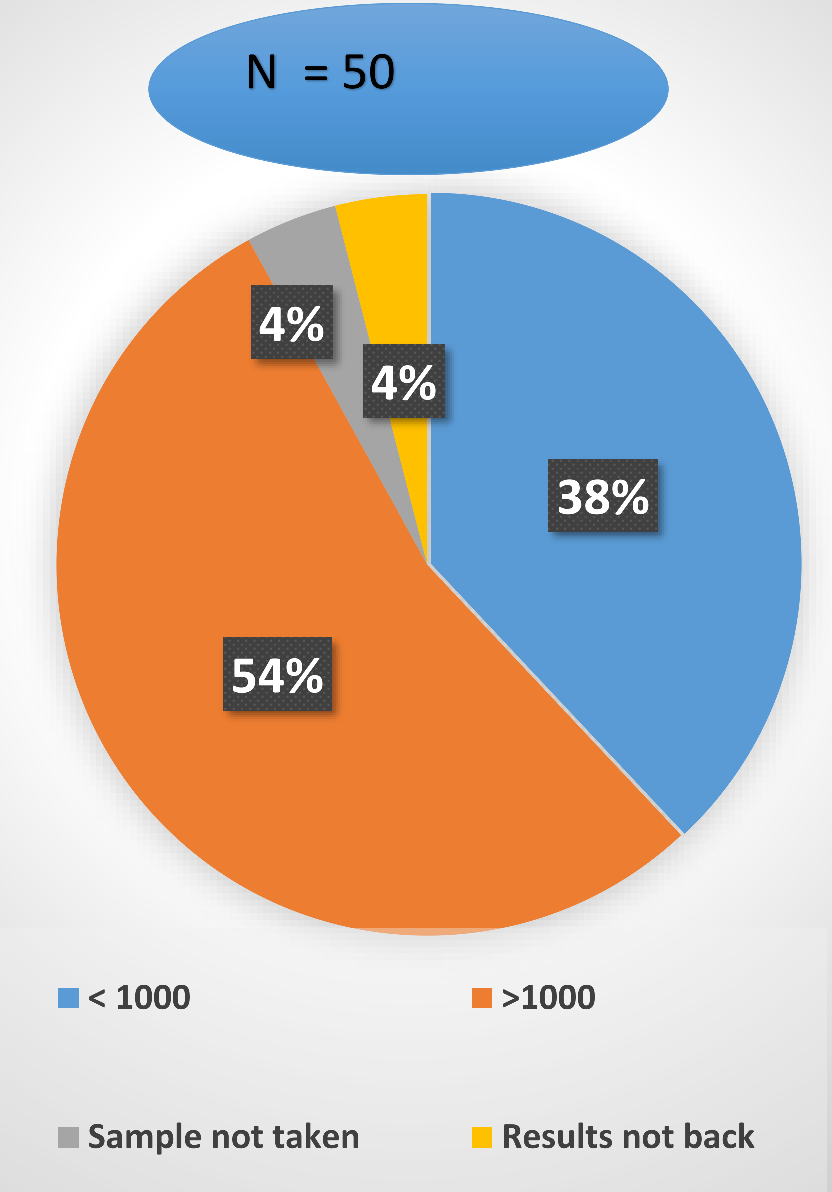
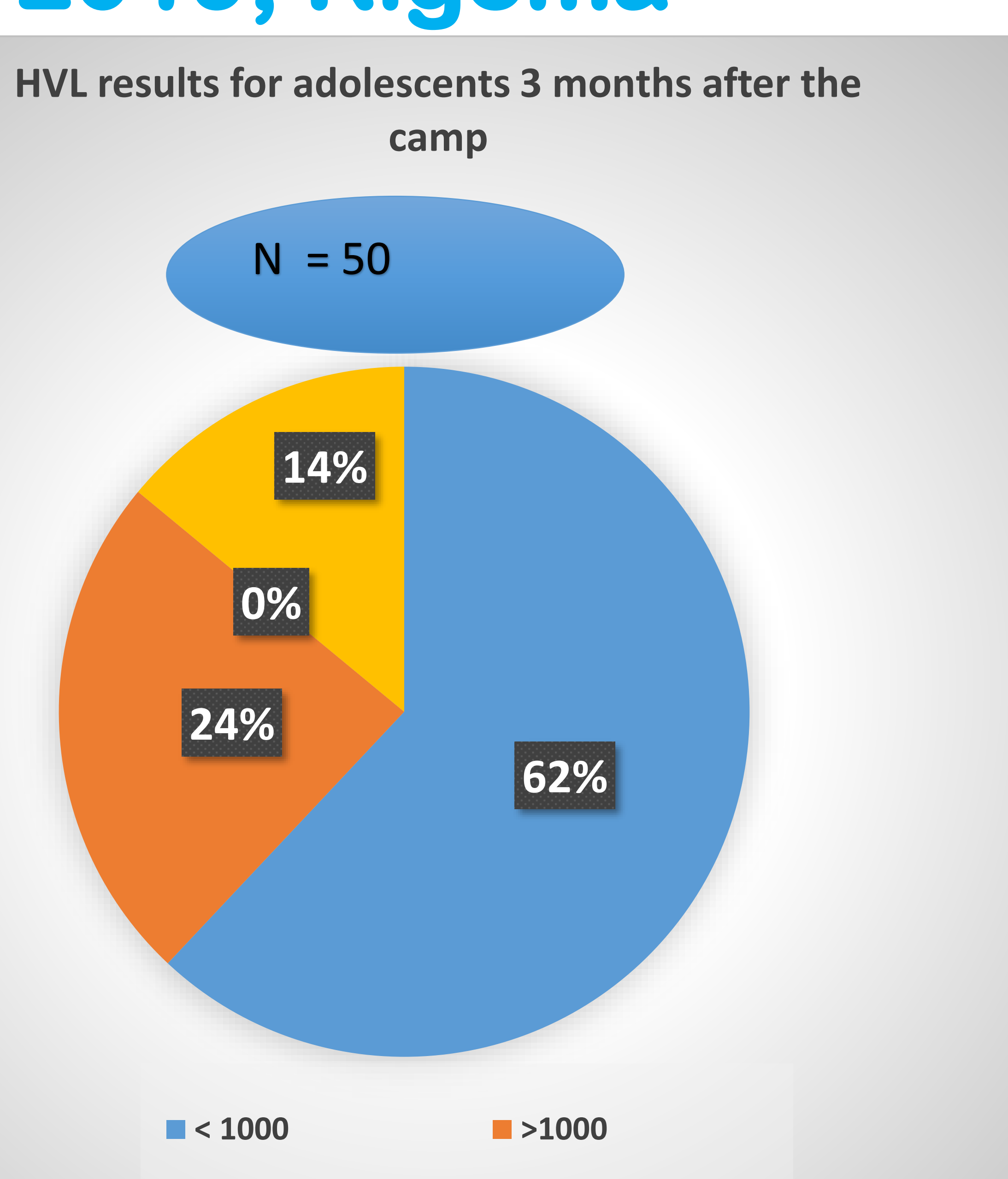
HIV VL suppression during and after Camp : June and September 2019, Kigoma



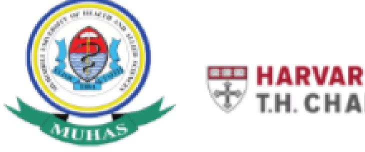


Lessons Learned

- Adolescents relate well, and perhaps best, to their peers
- Using adolescents with good clinical outcomes (HVL suppression) to provide peer education to those unsuppressed was effective
- Adolescent camps with a one-one Dr interaction provide a platform outside clinic settings to learn from each other and be open about their issues with clinician
- Interactive, fun activities — convey health messages, and facilitate learning, expression, discussions and disclosure.
- Parents and care giver involvement contributes to ART adherence hence HVL suppression (Family centered ART services)
- Use of adolescents PEs and CTC friendly services attracts them to care

Challenges of Implementing QI within LGA Settings

- Inadequate adherence to treatment protocols
- Lack of commitment among some service providers – e.g. seeking for allowance in order to hold QI meetings
- QI is viewed as a vertical program, and not part of the care and treatment program
- QI not budgeted in the CCHP
- Inadequate capacity of site level teams to analyse data, ongoing support from R/CHMTs and IPs is needed



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Recommendations

- Engagement of facility QI teams at each stage of CQI service initiatives enhances understanding and ownership
- To ensure sustainability council must include QI activities in the CCHP plans
- QI is an integral part of care and treatment for PLHIV, thus it should be incorporated in the care and treatment guideline with set indicators for monitoring.
- Need to encourage cross learning by providing forums to CHMTs and health providers to share their QI projects at quarterly progress review meetings, National Forums e.g. Symposium on QI and conferences
- This also serves as an incentive to continue and creates healthy competition.

ASANTE to all dedicated HCP, PEs, LCs, R/CHMTs & IP staff

Acknowledgements