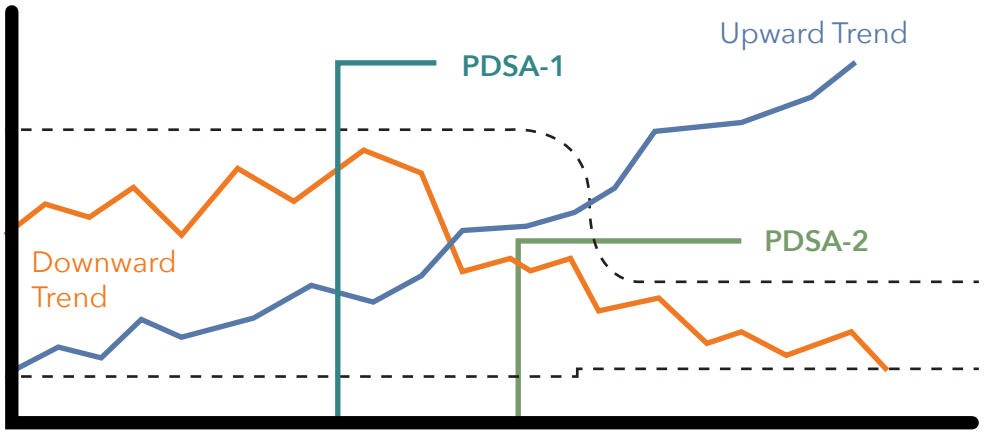
COMMUNITY

CHEKA IMPILO

IDEAS

SPOTLIGHTS COMPENDIUM

RUN CHART

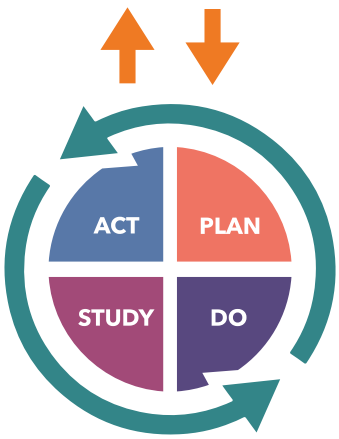


MODEL OF IMPROVEMENT

What are we trying to accomplish?

What change can we make that will result in improvement?

How will we know that a change is an improvement?



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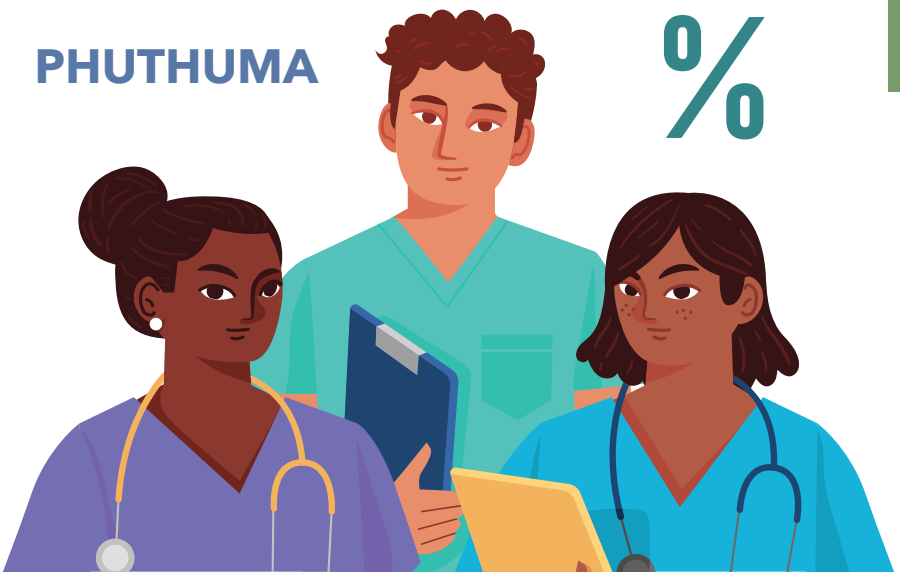

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UCSF Institute for Global Health Sciences | OPIQ Optimizing Performance by Improving Quality in HIV and HIV/TB Programs

ACKNOWLEDGEMENTS

This compendium of spotlights was developed by the University of California, San Francisco under the project Optimizing Performance by Improving Quality (OPIQ) in HIV and HIV/TB Programs in the Republic of South Africa under the President's Emergency Plan for AIDS Relief (PEPFAR). This project was a collaboration with the district support partners: Health Systems Trust, The Aurum Institute, TB HIV Care, and Wits Reproductive Health and HIV Institute.

Specific acknowledgment goes to the following:

The OPIQ Packaging Working Group:

Dr. Hloniphile Mabuza, Lara Miller, Shannon Fuller, Dr. Joseph Murungu, Siphokazi Mngcozelo, Admire Chiguvare, and Dr. Hlolisile Chiya.

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DISTRICT SUPPORT PARTNERS

HEALTH SYSTEMS TRUST

THE AURUM INSTITUTE

TBHIVCARE

University of the Witwatersrand WITS RHI

PEPFAR U.S. President's Emergency Plan for AIDS Relief

GLOSSARY AND ABBREVIATIONS

A
AC - Adherence Club
Airtime - Cell phone voice minutes
ALHIV - Adolescents living with HIV
ART - Antiretroviral therapy
ANC - Antenatal care

C
CA - Campaign Agent
CCMDD - Central chronic medicines dispensing and distribution
CHC - Community Health Centre
CHW - Community Health Worker
CM - Case Manager
CO - Case Officer
cPUP - Clinician-led pick-up point

D
DC - Data Capturer
Decanting - Enrolling into differentiated models of care (also see DMOC)
DHIS - District Health Information System
DMOC - Differentiated models of care (also see Decanting)
DoH - Department of Health
DQO - Data Quality Officer

E
eLabs - Electronic laboratory services
EMA - Early missed appointment (7–28 days)
ENA - Enrolled Nursing Assistant
EN - Enrolled Nurse
EPI - Expanded Programme on Immunization
Ex-PUP - External pick-up point

F
Fac-PUP - Facility pick-up point
FBL - Facility booking list
FC - Filing Clerk
FOM - Facility Operational Manager

H
HIV - Human Immunodeficiency Virus
HPRN - Health Patient Record Number
HPRS - Health Patient Registration System
HTS - HIV Testing Services

I
ICS - Ideal clinic standards
ICSM - Integrated Clinical Services Management

L
LC - Lay Counsellor
LO - Linkage Officer
LMA - Late missed appointment (29 – 90 days)
LTFU - Lost to follow-up
Loud hailer - A megaphone

N
NC - Nurse Clinician
NCM - Nurse Case Manager
NDoH - National Department of Health
NICD - National Institute for Communicable Diseases

0
OM - Operational Manager
OTL - Outreach Team Lead

P
PHC - Primary Health Care
PN - Professional Nurse
PUP - Pick-up point

Q
QI - Quality improvement

S
SOP - Standard operating procedure
SyNCH - Synchronized national communication in health (a database for patients enrolled into DMOC)

T
TB - Tuberculosis
TIER.Net - Three interlinked electronic registers (eectronic patient management system)
TLD - Tenofovir, Lamivudine, and Dolutegravir (HIV anti-viral medication)
TROA - Total remaining on ART
TVET Colleges - Technical and Vocational Education and Training colleges

U
uLTFU - Unconfirmed lost to follow-up (missed more than 90 days)

V
VL - Viral load
VMMC - Voluntary Medical Male Circumcision
VS - Virally suppressed

W
WBOT - Ward-based outreach team
WBPHCOT - Ward-based primary health care outreach team

Y
YCC - Youth Care Club

SPOTLIGHTS OVERVIEW

1 - Limpopo
2 - North West
3 - Gauteng
4 - Mpumalanga
5 - Northern Cape
6 - Free State
7 - Kwazulu-Natal
8 - Eastern Cape
9 - Western Cape

- Case Finding
- Decanting
- Records Management
- Retention
- TLD Transition
- Tuberculosis
- Viral Load Coverage

Ngaka Modiri Molema Spotlight:

After-Hours Tracing

Tshwane Spotlight:

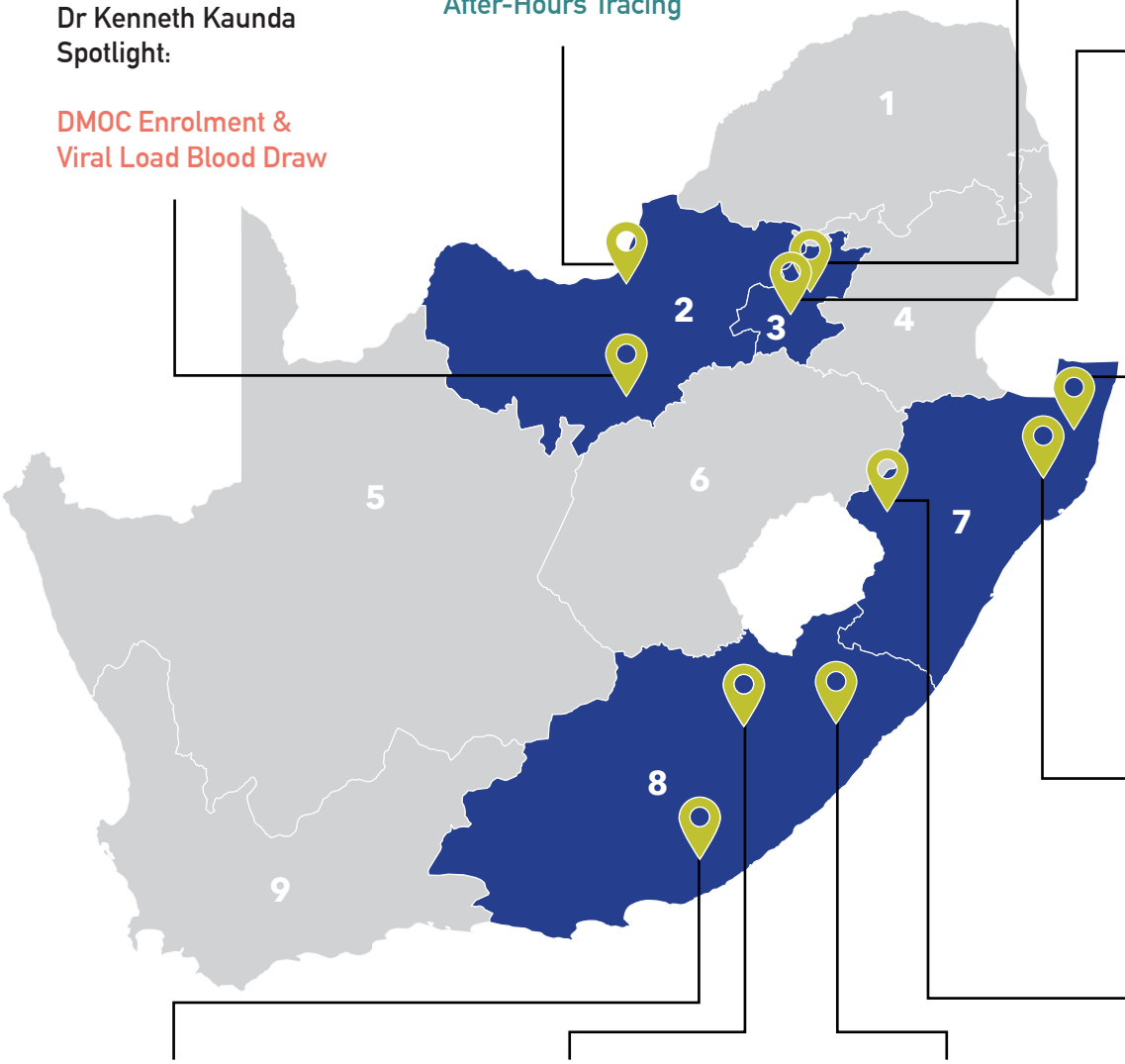
WhatsApp & Youth Care Clubs

Dr Kenneth Kaunda Spotlight:

DMOC Enrolment &
Viral Load Blood Draw

Ekurhuleni Spotlights:

Charge Out Cards
Nurse Case Management
Paediatric TB Screening
TIER.Net to Retrieve Files



uMgungundlovu Spotlights:

Clinician-Led
Pick-Up Point
Night Duty Clinical
Support Officer

uThukela Spotlights:

Community-Based
ART Delivery
Extended Clinic Hours

Amathole Spotlights:

DMOC Implementation
Early Telephonic Outreach

Chris Hani Spotlights:

DMOC Implementation
SMS Reminders
Supply & Demand

OR Tambo Spotlights:

Filing Room Organization
Physical Tracing During Lockdown
TLD Implementation

Zululand Spotlight:

Men's Health Initative

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SPOTLIGHTS ON CASE FINDING

EXTENDED CLINIC HOURS

SPOTLIGHT ON CASE FINDING

uThukela | Alfred Duma Sub-District | Sigweje Clinic | PHC
Average Monthly Headcount: 4100

IMPROVEMENT AREA & AIM

Normal clinic hours at Sigweje Clinic were from 07:00 to 17:00, Monday to Friday, with appointments ceasing at 1630. These hours, however, were problematic for the working population who were unable to attend clinic during normal operational hours. This, in turn, limited their ability to access HIV testing services which affected the overall facility HIV case-finding rate.

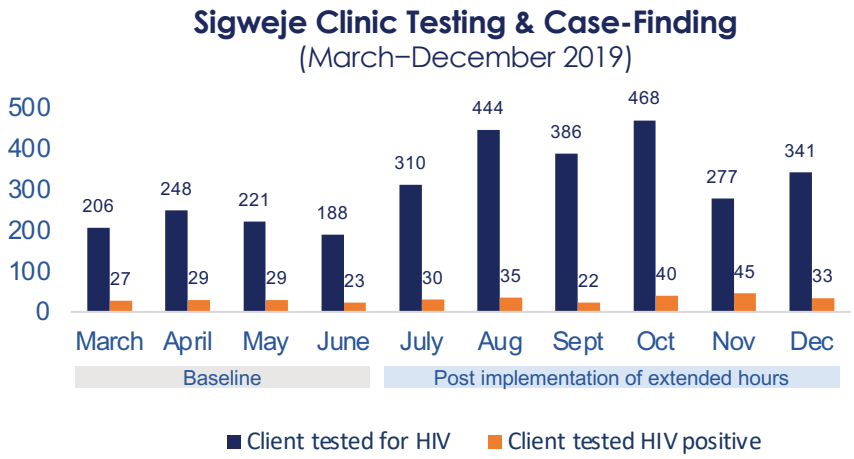
The aim was to improve the HIV case-finding median from 28 to at least 30 newly identified patients per month by targeting working patients.

DESCRIPTION

To accommodate patients unable to visit the clinic during normal operating hours, we tested the extension of facility service hours to include at least 1 weekend day and extended weekday operating times by 2 hours in the evening (from 1700 to 1900). During the extended hours, limited clinical services were available, including HIV testing.

OUTCOMES

After introducing extended hours, Sigweje Clinic's overall HIV testing numbers increased from a baseline median of 214 per month to a median of 364 per month. Case-finding numbers also improved from a baseline median of 28 per month (March –June 2019) to a post-implementation median of 34 per month. As a result of this performance, Sigweje Clinic was recognised as being among the top 10 CDC-supported Siyenza (now POPS – PEPFAR Operation Phuthuma Support) facilities in the country for HIV case-finding and linkage.



STEPS TO IMPLEMENT

PRE-IMPLEMENTATION

- ❑ Operational Manager (OM) orients all HIV care staff to the extended hours QI project.
- ❑ OM requests volunteers to work during extended hours, offering compensatory time off in exchange for after-hours service.
- ❑ Lay Counsellors (LC) and Community Caregivers (CCGs) raise awareness about the extended hours through health talks at the clinic and community forums. Also, emphasize the importance of knowing one's HIV status.

PATIENT ARRIVES AT THE CLINIC

- ❑ LC triages patient seeking an HIV test.
- ❑ Filing Clerk opens a file for new patients.
- ❑ LC conducts the test.
- ❑ If an HIV-positive case is identified, a Nurse Clinician (NC) will offer the patient same-day ART initiation.
- ❑ If the test result is negative, the patient is encouraged to return for retesting in 6 weeks.

MAINTENANCE

- ❑ Quality improvement (QI) team meets weekly to review performance on testing, case-finding, and linkage.
- ❑ LCs and CCGs continually raise awareness about extended hours and the importance of HIV testing at clinic and community forums.

FACILITATORS

- Offered compensatory time to staff working during extra operating hours.
- Made sure to understand the needs of the patient population and found ways to accommodate them (e.g., adjusted hours of service as much as possible to align with patient preferences).

CHALLENGES & ADAPTATIONS

- A few clients declined to initiate into care → A social worker provided psychosocial support to these clients.
- Burnout with staff working extra hours → Communication between staff and management ensured shared burden and equitable distribution of shifts.

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ABBREVIATIONS

- ✓ CCG – community caregivers
- ✓ LC – lay counsellor
- ✓ NC – nurse clinician
- ✓ OM – operational manager
- ✓ QI – quality improvement

OTHER FACILITY ADAPTATIONS

- ✓ Other facilities embraced this approach, varying the operating hours and days to suit the needs of the clinic and population.
- ✓ Some settings preferred adding an additional weekend day rather than longer hours on weekdays.
- ✓ Others expanded community-based testing efforts as an alternative for improving case-finding.

RESOURCES

No additional human resources were needed. Staff who worked extra hours were given compensatory time off during the week as an incentive.

LESSONS LEARNED

It is important to know when your patients can come to the facility, when and how community programmes may be effective, and how to best accommodate patient needs.

MEN'S HEALTH INITIATIVE

SPOTLIGHT ON CASE FINDING

KwaZulu-Natal | Zululand | Queen Nolonolo Clinic | PHC
Average Monthly Headcount: 7000

IMPROVEMENT AREA & AIM

At Queen Nolonolo only 20% of people tested for HIV in 2018 were men. In addition, more men were presenting with advanced HIV disease compared with women; e.g., 9% of newly diagnosed men presented with tuberculosis (TB) disease compared with only 2% of newly diagnosed women.

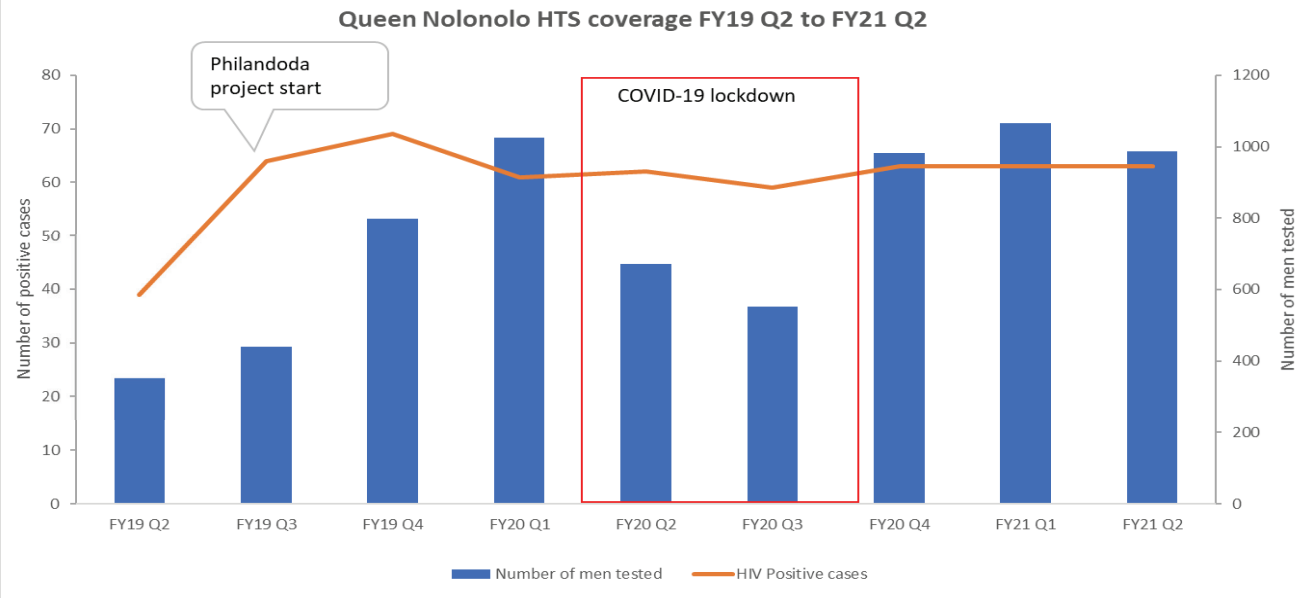
The aim of the Philandoda project was to increase the number of men tested for HIV per quarter from 352 from fiscal year 2019 (FY19) quarter 2 (Q2) (January – March 2019) to 700 by FY20 Q2 (January – March 2020).

DESCRIPTION

A men's clinic was set up in July 2019 at the taxi rank. The clinic was run by a male Professional Nurse (PN) and male Lay Counsellor (LC). The staff visited surrounding shops and Technical and Vocational Education and Training colleges to mobilize the community and raise awareness about the services offered. The clinic initially ran 3 days a week then expanded to 5 as demand increased. Services offered included: HIV testing, antiretroviral therapy (ART) initiation, screening and treatment for sexually transmitted infections (STIs), TB, and non-communicable diseases, and mobilization for Voluntary Medical Male Circumcision (VMMC).

OUTCOMES

A total of 2,933 men were tested between April 2019 to March 2020. The median number of men tested per quarter ***more than doubled*** from 352 before the Philandoda project to 733 by the end of the project implementation. This was sustained above 800 tests per quarter by March 2021. Similarly, case detection improved from a baseline of 39 cases in FY19 Q2 to a peak of 69 cases in FY19 Q3, and this was maintained at above 60 cases per quarter. Following the success, the intervention has been institutionalized.



STEPS TO IMPLEMENT

PRE-IMPLEMENTATION

- ❑ Lay Counsellor (LC) and Professional Nurse (NC) engage with community leaders and male representatives.
- ❑ LC & PN identify male service providers.
- ❑ LC & PN set up mobile services at the taxi rank.

IMPLEMENTATION

- ❑ LC engages community using loud hailers and pamphlets at the taxi rank and in colleges.
- ❑ LC & PN provide comprehensive services at the taxi rank.
- ❑ Data Capturer (DC) links captured data to Queen Nolonolo data system.
- ❑ DC conducts monthly data reviews.

FACILITATORS

- Services delivered by all male team.
- Services delivered in a place where men already congregate.
- Mobilised community through loud hailers by male driver mobiliser.
- Achieved community engagement and buy-in.

CHALLENGES

- Inadequate human resources to provide services on weekends and after hours.
- Interruption of services when the male staff took leave.

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ABBREVIATIONS

- ✓ ART – antiretroviral therapy
- ✓ DC – data capturer
- ✓ HTS – HIV testing services
- ✓ IEC – information, education, and communication
- ✓ FY – fiscal year
- ✓ LC – lay counsellor
- ✓ PN – professional nurse
- ✓ Q – quarter
- ✓ STI – sexually transmitted infections
- ✓ TB – tuberculosis
- ✓ VMMC – voluntary medical male circumcision

RESOURCES

- ✓ Mobile Van
- ✓ IEC material
- ✓ Loud hailer
- ✓ Clinical chart
- ✓ Pharmaceutical supply

STAFFING

- ✓ 1 Male Professional Nurse
- ✓ 1 Male Community Driver Mobiliser/ Lay Counsellor

IDEA INSPIRATION

The idea for this change idea came from the MSF men-friendly clinic that was implemented at eShowe taxi rank.

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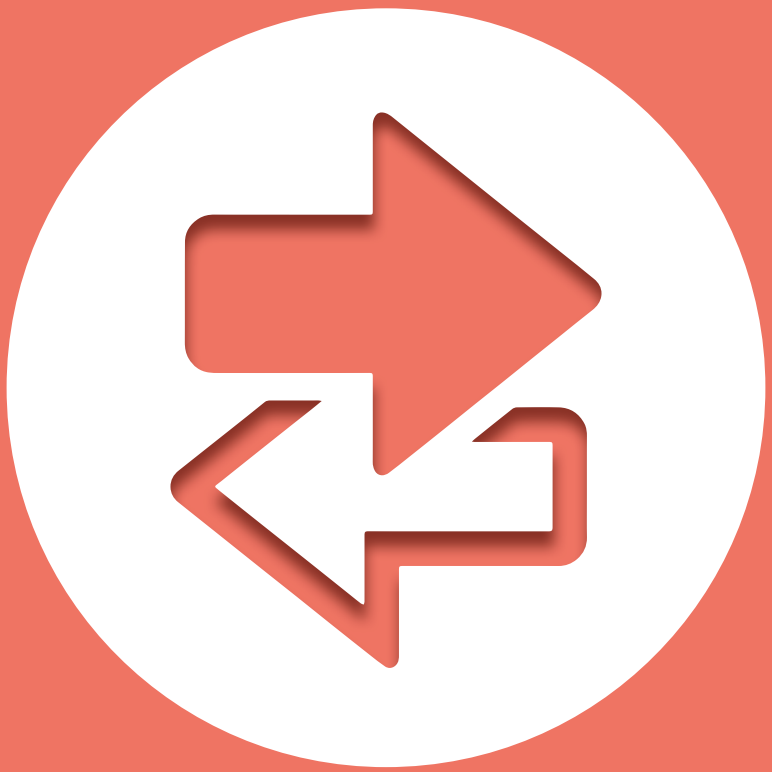
SPOTLIGHTS ON DECANTING



DMOC ENROLMENT & VIRAL LOAD BLOOD DRAW

SPOTLIGHT ON DECANTING

North West | Dr Kenneth Kaunda | Park Street Clinic | PHC
Average Monthly Headcount: 3400

IMPROVEMENT AREA & AIM

According to the National Adherence Guidelines of March 2020 at least 90% of eligible antiretroviral therapy (ART) patients must be decanted into differentiated models of care (DMOC). At Park Street Clinic a high number of eligible ART patients were not decanted due to failure to return for viral load (VL) results on time.

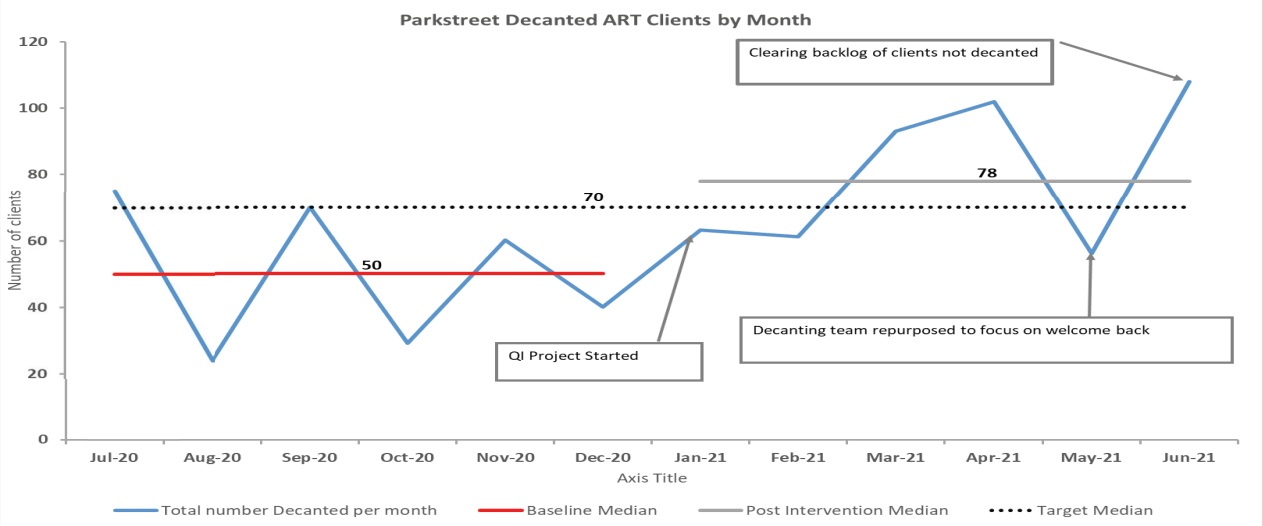
The aim of this project was to improve the number of eligible ART patients decanted from a baseline median of 50 per month (July to December 2020) to a post intervention median of 70 per month by June 2021.

DESCRIPTION

The Data Capturer (DC) generated an appointment list and flagged patients who were due for their VL blood draw. The Nurse Clinician (NC) saw patients for their blood draw and discussed DMOC. If the patient consented, the NC enrolled them in the programme (SyNCH) immediately and gave them a 6- or 12-month appointment date (depending on patients' duration on ART). When results came back, if the patient was virally suppressed (VS), they remained in the programme. If the patient was not VS, they would receive a call explaining the results, be deactivated from the programme, and a follow-up appointment would be scheduled for two months.

OUTCOMES

After implementing this project, there was an improvement in the number of patients decanted into DMOC programs from a baseline median of 50 per month in the period July to December 2020 to 78 per month between January and June 2021, surpassing the target of 70 per month.



STEPS TO IMPLEMENT

- ❑ DC generates appointment list.
- ❑ Filing Clerk (FC) retrieves files.
- ❑ FC flags patients on list due for VL blood draw.
- ❑ FC calls the patients to remind them of appointment and VL blood draw.
- ❑ NC sees all patients due for VL blood draw and offers them DMOC.
- ❑ NC explains the procedure to the patient and emphasizes that should VL be detectable, then the patient will be contacted telephonically and deactivated from DMOC.
- ❑ If patient consents to DMOC, they choose the preferred modality.
- ❑ NC draws blood for VL test, issues 2-months' ART supply and enrols patient on DMOC using SyNCH.
- ❑ After 24 hours, NC accesses VL results via eLabs.
- ❑ If VL is not suppressed, the patient is informed about the results and is deactivated from DMOC and given a 2-month review date.

FACILITATORS

- Support from the facility Operational Manager (OM).
- Commitment from the staff.
- One-stop model of service delivery combining blood draws and enrolment into DMOC.
- Used virtual communication with patients to remind them about their VL appointments and to give them updates on the results if they were not suppressed.

CHALLENGES & ADAPTATIONS

- Sporadic power cuts affecting patient registration on SyNCH → Patients' information on SyNCH was updated when the power was restored.
- Some patients missing appointments despite receiving telephonic reminders → Physical tracing was done.

ABBREVIATIONS

- ✓ ART – antiretroviral therapy
- ✓ DC – data capturer
- ✓ eLabs – electronic laboratory services
- ✓ FC – filing clerk
- ✓ NC – nurse clinician
- ✓ DMOC – differentiated models of care
- ✓ OM – operational manager
- ✓ VL – viral load

RESOURCES

- ✓ Computer/laptop
- ✓ Printer
- ✓ Paper
- ✓ Phone for eLabs
- ✓ Phone for tracing
- ✓ Toner and cartridge

STAFFING

- ✓ Filing Clerk
- ✓ Data Capturer
- ✓ Clinician
- ✓ Adherence and Retention Counsellor
- ✓ Tracer
- ✓ Operational Manager

LESSONS LEARNED

- ✓ The majority of patients face difficulties negotiating time away from work for clinic visits with their employer.
- ✓ Decanting on the spot has proven to work and is attractive to patients.

OTHER FACILITY SPREAD

- ✓ Potchefstroom Town Clinic
- ✓ Boiki Tlhapi CHC
- ✓ Grace Mokgomo CHC

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DMOC IMPLEMENTATION

SPOTLIGHT ON DECANTING

Amathole | Mbashe Sub-District | Willowvale | CHC

Average Monthly Headcount: 3738

IMPROVEMENT AREA & AIM

Willowvale Community Health Centres (CHC) had a low decanting rate of 61% of total patients remaining on antiretroviral therapy (ART) (TROA) compared to the national target of 80% due to a backlog in the capture of viral load (VL) results and missed appointments by some patients who were eligible for decanting.

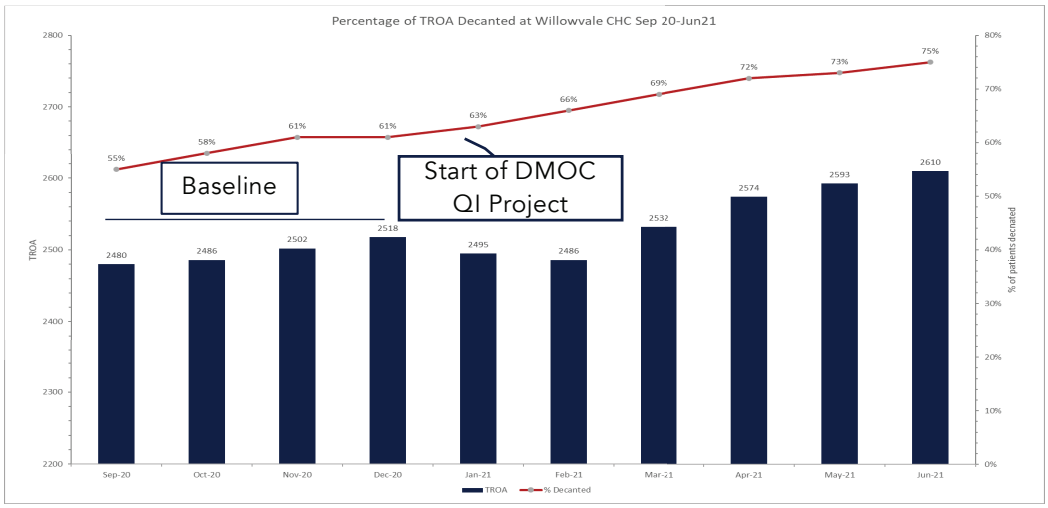
We aimed to improve decanting from a baseline of 61% of TROA in December 2020 to 80% by the end of June 2021.

DESCRIPTION

On a weekly basis, the Data Capturer (DC) completed bulk capturing of VL blood results on TIER.Net and flagged patients eligible for decanting using the NDOH criteria. The DC pulled the files of all patients eligible and shared the info with the Nurse Clinician (NC) for verification of eligibility. The decanting list was then given to the Case Officer (CO) to remind patients about their scheduled appointment dates and when they were due for a VL blood draw.

OUTCOMES

After 6 months of project implementation, the decanting rate at Willowvale CHC increased from 61% of TROA at baseline in December 2020 to 75% by June 2021. The facility started to become decongested resulting in reduced wait times which increased satisfaction among both patients and facility staff. There was also an improvement in the number of ART patients honouring their clinical appointments.



STEPS TO IMPLEMENT

- ❑ Data Capturer (DC) captures blood results on TIER.Net.
- ❑ DC flags patients eligible for decanting based on VL result.
- ❑ DC shares VL results with NC who transcribes blood results on patient folders.
- ❑ On Fridays, DC generates list of eligible patients due for a visit the following week and retrieves their folders for the NC to verify eligibility for decanting.
- ❑ NC puts stickers on the outside cover of all eligible patients' files.
- ❑ DC shares list of eligible patients with the CO.
- ❑ CO calls patients a week before their appointment as a reminder and to emphasize the importance of in-person consultation (rather than sending a friend or relative).
- ❑ Upon arrival at the facility, the patient alerts the CO.
- ❑ The CO escorts patient to the NC who then explains decanting in detail.
- ❑ The patient selects the decanting modality of choice.
- ❑ NC decants patient to modality of choice and documents in the clinical chart and SyNCH.
- ❑ DC captures clinic visit on TIER.Net.

FACILITATORS

- Facility provided an extra computer to support SyNCH.
- A NC was assigned as a champion to lead and monitor decanting activities.
- A dedicated CO was assigned as a Clinic Navigator, responsible for all patients eligible for decanting.
- A quality improvement (QI) team consisting of the DC, CO, NC and with support from the Operational Manager met to implement and monitor change.

CHALLENGES & ADAPTATIONS

- VL results not captured in patient folders → Patient folders were audited for completeness.
- Clinical chart was incomplete → Charts were sent back to Clinicians for documentation of VL results.
- Backlog in capturing of VL results → Blood results were captured daily to avoid backlog.
- Some patients not reached telephonically during the day → Patients were called after hours.

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ABBREVIATIONS

- ✓ DMOC – differentiated models of care
- ✓ DC – data capturer
- ✓ NC – nurse clinician
- ✓ CO – case officer
- ✓ CHC – community health centre
- ✓ NDoH – national department of health
- ✓ QI – quality improvement
- ✓ VL – viral load

OTHER FACILITY ADAPTATIONS

- ✓ The differentiated model of care (DMOC) Policy implementation QI project was replicated in other DSD facilities.

RESOURCES

- ✓ TIER.Net
- ✓ SyNCH
- ✓ Decanting SOP
- ✓ Decanting appointment cards
- ✓ Stickers

LESSONS LEARNED

- ✓ A lot can be achieved through teamwork.
- ✓ Near real-time capturing of VL results facilitates decanting eligible patients.

DMOC IMPLEMENTATION

SPOTLIGHT ON DECANTING

Chris Hani District | Sakhisizwe SD | Thembelihle Clinic | PHC
Average Monthly Headcount: 1700

IMPROVEMENT AREA & AIM

At Thembelihle clinic, patients experienced long wait times for their scheduled appointments due to facility congestion. To reduce congestion, we enrolled more patients into a differentiated model of care (DMOC), also called 'decanting'.

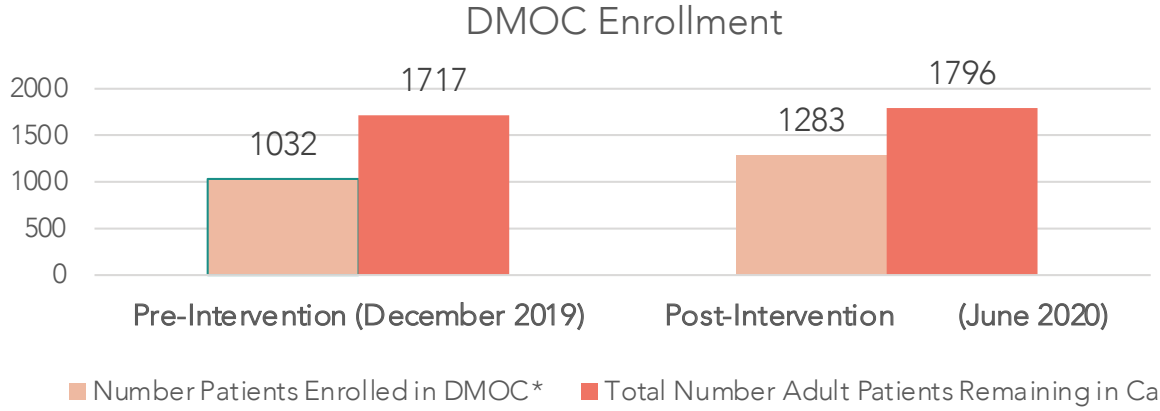
We aimed to increase the percentage of decanted patients from 60% of total retained on ART (TROA) in December 2019 to 70% by June 2020.

DESCRIPTION

Patients who had been virally suppressed (VS) for at least 6 months were offered enrolment in a differentiated model of care (DMOC) programme where medications and limited clinical care could be accessed at convenient locations within their communities (external pick-up points) or at a facility pick-up point. This same cohort of patients was also eligible for transition to Tenofovir, Lamivudine, and Dolutegravir (TLD) regimen. TLD was offered to patients at the same time as enrolment in a DMOC.

OUTCOMES

Enrolment in DMOC increased from 60% of TROA in December 2019 to 71% in June 2020, and remained stable from June–September 2020. As a result, the facility became less congested, with shorter wait times for clinical appointments. Once enrolled, patients were motivated to continue the programme because they spent less time traveling to appointments. Nurses also appreciated the extra time that became available to attend to patients with complex needs.



*Does not include patients receiving home delivery of medicines during the COVID-19 pandemic.

STEPS TO IMPLEMENT

- ❑ At the beginning of the week, the Data Capturer (DC) pulls a list from TIER.Net of patients virally suppressed (VS) for at least 6 months.
- ❑ DC retrieves patient files for patients on the VS list.
- ❑ DC gives report to Nurse Clinician (NC).
- ❑ CO calls patients and offers enrolment in the programme.
- ❑ NC gives list of eligible patients to the Case Officer (CO).
- ❑ NC determines if patient meets DMOC eligibility criteria (per Department of Health Standard Operating Procedures).
- ❑ If patient consents, they are asked to come to the facility for orientation and education about the DMOC programme and to select a convenient external or internal pick-up point (PUP).

FACILITATORS

- Expanded eligibility criteria to include patients who have been suppressed for 6 months (previously a 12-month requirement) which further decongested the facility and decreased wait time for patients (In 2020, this was done in response to the COVID-19 pandemic).
- Support and buy-in from leadership and staff.
- Designation of a Project Champion
- Patients were more motivated because once enrolled, they spent less time traveling and waiting for appointments.

CHALLENGES & ADAPTATIONS

Patients were asked to come to the clinic to join the DMOC programme (i.e., 'decanted') for orientation, but not all patients were able to make this trip due to COVID-19 travel restrictions.
→ Those unable to come to the clinic received temporary home delivery of medication (up to 3-months supply).

RECOMMENDATIONS

- Know the DoH guidelines and SOPs around DMOC programmes, specifically eligibility criteria.
- Patients still need to come to the clinic for viral load (VL) blood draws at standard intervals as per national guidelines.
- Active monitoring is critical: have systems in place in advance to monitor patient interactions with the PUPs. Many patients thought to be 'lost' to care were in fact in DMOC.
- Entering data about DMOC patients into both TIER.Net and SYNCH is essential for accurate record-keeping.

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ABBREVIATIONS

- ✓ DMOC – Differentiated model of care
- ✓ DoH – Department of Health
- ✓ NICD – National Institute For Communicable Diseases
- ✓ PUP – Pick-up point
- ✓ VL – Viral load
- ✓ VS – Virally suppressed
- ✓ TROA – total retained on ART
- ✓ TLD – Tenofovir, Lamivudine, and Dolutegravir

OTHER FACILITY ADAPTATTIONS

Other facilities in the region went on to adopt this and included other stable patients with other chronic conditions such as hypertension and epilepsy.

EXTERNAL PUP

Each external PUP needed to have: an air conditioner, a clean and secure room, windows, shelves, electricity, a computer, a stable internet connection, and the ability to scan medication parcels.

STAFFING

- ✓ 4 nurses (including 1 CCMDD champion)
- ✓ Data Capturer
- ✓ Case Officer for tracing and outreach to patients

NURSE CASE MANAGEMENT

SPOTLIGHT ON DECANTING

Gauteng | Ekurhuleni South | Germiston City Clinic | PHC
Average Monthly Headcount: 4338

IMPROVEMENT AREA & AIM

The National Adherence Guidelines of 2020 expanded the eligibility criteria for decanting stable antiretroviral therapy (ART) patients to include those who had received at least 6 months of ART and are virally suppressed. Germiston City Clinic had a low rate of decanting at 6 months due to over scripting and poor data systems among Nurse Clinicians.

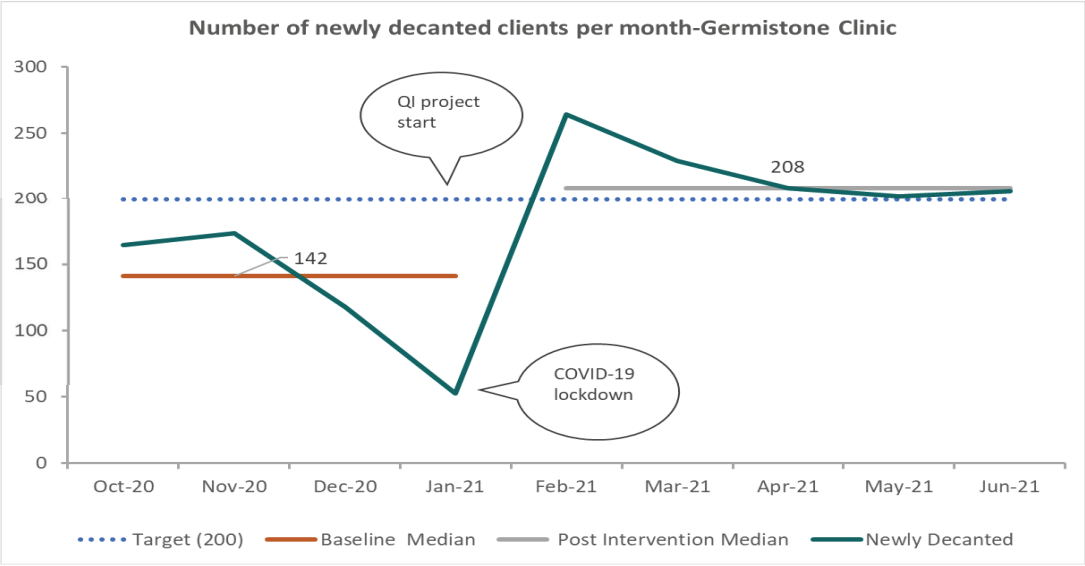
The aim of this project was to improve the number of patients decanted at 6 months after ART initiation from a baseline median of 142 per month, October 2020 to January 2021, to median of 200 per month by February to June 2021.

DESCRIPTION

All patients newly enrolled on ART were assigned a nurse initiated and managed antiretroviral therapy (NIMART) Nurse Case Manager (NCM) and became part of a 6-month case management (CM) programme. Patients saw the same NCM throughout the programme who provided ongoing counselling, adherence support, and general management, including blood draws, which helped to build a strong rapport. At 6 months, following results from VL tests, the NCM offered decanting to all virally suppressed patients according to national guidelines. Once decanted, patients graduated from the case management (CM) programme.

OUTCOMES

After implementing this project at Germiston City Clinic, the number of decanted ART patients improved from a baseline median of 142 patients per month, in the period October 2020 to January 2021, to a post intervention median of 208 patients per month during the follow-up period from February to June 2021. Patients appreciated the continuity of seeing the same clinician for the first 6 months of treatment. The NCM improved VL testing at 6-months and this improved enrolment into differentiated models of care (DMOC).



STEPS TO IMPLEMENT

- ❑ All newly enrolled patients are referred to the NCM.
- ❑ Filing Clerk (FC) records room number of NCM on patient-held appointment card for ease of navigation by FC when patient comes to the clinic.
- ❑ FC retrieves files for all patients on the day of the visit and takes these to the NCM consulting room.
- ❑ FC escorts patients on CM to NCM's consulting room.
- ❑ NCM continues to follow and see patients on CM until they complete 6 months of ART.
- ❑ NCM introduces the concept of DMOC and provides adherence support to the patients during each visit.
- ❑ At 6 months, the NCM performs VL testing and other needed tests.
- ❑ After 2 weeks, patient returns for VL result and decisions about decanting are made.
- ❑ Consenting eligible ART patients are decanted into modality of choice, and NCM registers them on SyNCH and issues a 6-months repeat script.
- ❑ NCM dispenses 2-months supply of ART.
- ❑ NCM also issues a new patient held card (the Dablap medication card) with dates for collection at pick-up point and clinic review.
- ❑ Patient graduates from case management programme.

FACILITATORS

- Rotated Nurse Clinicians through the NCM role.
- Facility management buy-in.
- Memorandum on decanting at 6 months distributed to staff by the OM.
- Having a designated Primary Nurse seeing patients for 6 months built trust and rapport.

CHALLENGES & ADAPTATIONS

- VL blood results delayed from lab and without results patients cannot be decanted.
- VL blood samples rejected by the lab so patients have to return for repeat blood draw.
- Unsuppressed VL → This led to delays in decanting some patients, but the numbers were usually very small.

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ABBREVIATIONS

- ✓ ART – antiretroviral therapy
- ✓ CM – case management
- ✓ DMOC – differentiated models of care
- ✓ NIMART – nurse initiated and managed antiretroviral therapy
- ✓ NCM – nurse case manager
- ✓ OM – operational manager
- ✓ VL – viral load

STAFFING

- ✓ NIMART Nurse
- ✓ Filing Clerk

RESOURCES

- ✓ SyNCH computer
- ✓ Patient held cards
- ✓ Clinical Chart

LESSONS LEARNED

- ✓ One Nurse Case Manager for 6 months -strengthens rapport with patients and improves continuity of treatment
- ✓ Change idea improves VL testing and management of results
- ✓ One-stop shop is convenient for patients

UCSF Institute for Global Health Sciences | OPIQ
Optimizing Performance by Improving Quality in HIV and HIV/TB Programs

SPOTLIGHTS ON RECORDS MANAGEMENT

CHARGE OUT CARDS

SPOTLIGHT ON RECORDS MANAGEMENT

Gauteng | Ekurhuleni | North | Tembisa Health Care Centre | CHC
Average Monthly Headcount: 5300

IMPROVEMENT AREA & AIM

File maintenance is important to ensuring information is available to providers during clinical visits. At THCC, patient files were not always refiled and therefore could not be found at the next patient visit. This caused significant delays and file duplication. According to the Department of Health Ideal Clinic Standards (ICS), all patient files must be refiled daily after data are captured in TIER.Net.

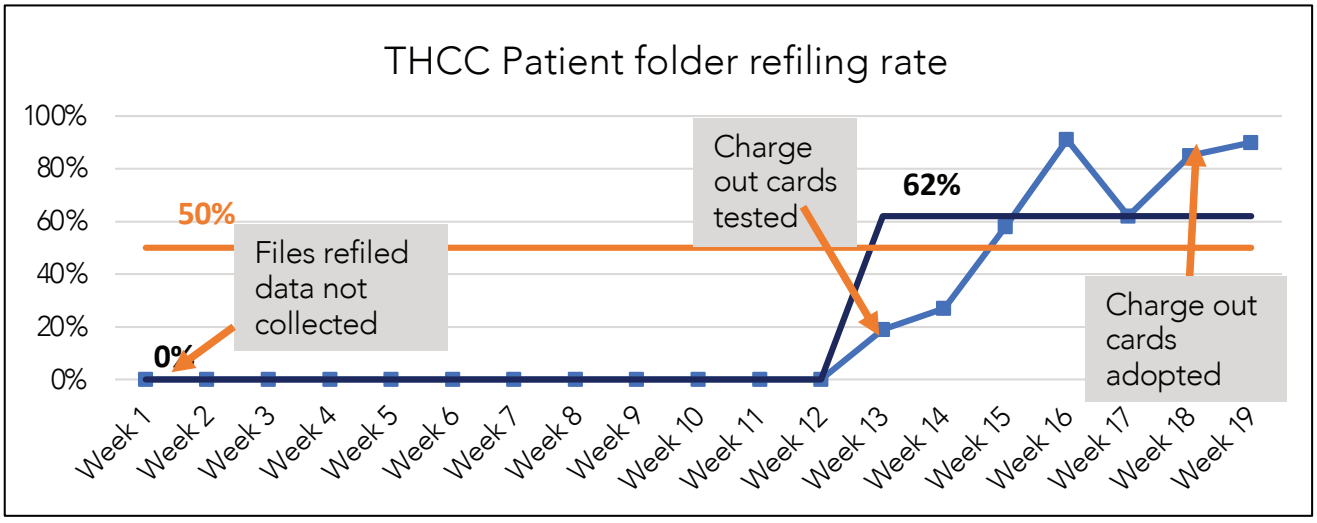
Our aim was to refile files retrieved weekly from 0% in April 2019 to 50% in July 2019.

DESCRIPTION

'Charge out cards' made of laminated A4 coloured paper were used as placeholders for files that had been retrieved from the filing cabinets for the daily patients. Different coloured cards were used for different days or services in the facilities: orange for Monday, yellow for Tuesday, red for Wednesday, etc., and white for tracing, green for consultation, etc. The patient's name, date of birth, service received, and date retrieved were written on the charge out cards in dry-erase marker.

OUTCOMES

The rate of files returned weekly improved from 0% to 62% in 7 weeks. The facility team expressed how the coloured cards served as a visual marker for files that had still not been refiled, resulting in a smoother and more efficient process.



STEPS TO IMPLEMENT

PRE-IMPLEMENTATION

- ❑ Decide on colour coding system such as orange for Monday, yellow for Tuesday, and red for Wednesday, white for tracing, and green for consultation.
- ❑ Create a key for the colour coding system.
- ❑ Hang key in filing room where it can be easily seen.
- ❑ Create charge-out cards by laminating A4 paper in different colours.

IMPLEMENTATION

- ❑ Retrieves patient file.
- ❑ Retrieves the appropriate coloured card and marks patient details on the card (name, date of birth, service given, and date retrieved).
- ❑ Replaces patient file with charge-out card to signify that a file is out.
- ❑ Collects all files and returns them to the reception area.
- ❑ Refiles patient files by replacing the charge-out card with the corresponding file.

FACILITATORS

- Made a training video to demonstrate the ease and quick pace of refiling using the charge-out cards to achieve staff buy-in.
- Pairing Filing Clerks with a QI support team member helped FCs take more ownership.
- Collected files from different facility service points to ensure they were all returned to the filing space.

CHALLENGES & ADAPTATIONS

- The coloured A4 charge-out cards ran out for a few days hampering the implementation of the change → An average daily headcount was calculated according to streams which enabled the facility to have an idea of how many A4 coloured sheets are required to sustain the change.
- Initially Filing Clerks viewed this idea as extra administrative work and resisted participation. → To save time, the coloured paper was inserted in the cabinets without writing patient details.

ABBREVIATIONS

- ✓ ICS – Ideal clinic standards
- ✓ QI – Quality improvement
- ✓ THCC - Tembisa Health Care Centre

RESOURCES

- ✓ Different coloured A4 papers
- ✓ Laminator
- ✓ White board markers

STAFFING

- ✓ Filing Clerks
- ✓ Operational Manager

RECOMMENDATIONS & LESSONS LEARNED

This is a very simple and easy change, but requires good planning and communication to be successful.

IDEA INSPIRATION

The idea for this change idea came from the library loan programme. The library cards list who borrowed the book, on which date, and when it was expected to be returned.

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FILING ROOM ORGANIZATION

SPOTLIGHT ON RECORDS MANAGEMENT

O.R. Tambo | Ingquza | Holy Cross | PHC

Average Monthly Headcount: 1100

IMPROVEMENT AREA & AIM

Many records were kept in systems that lack a coherent organizational structure which led to lost records, record duplications, and wasted materials. In turn, this led to increased work for health-records officers as well as increased wait time for patients and delays in clinical care.

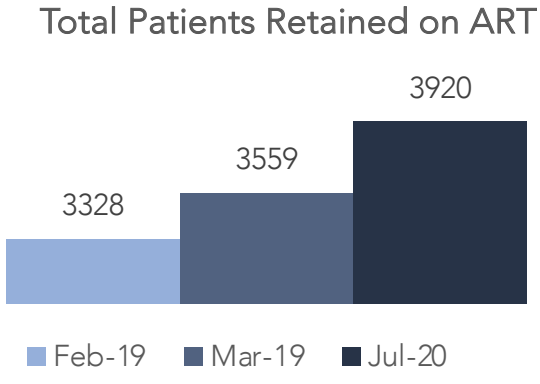
Our aim was to improve records management through a more organized record room and record management system.

DESCRIPTION

The records room organization was accomplished through archiving inactive files, bringing in new materials to organize active files, and implementing systems and protocols for standardization. The records management system was crafted as a health patient registration system (HPRS) centred around a health patient record number (HPRN) for each patient in the system.

OUTCOMES

The new management system facilitated timely retrieval of patient files, which reduced patient wait time, and ensured information contained in patient files was complete and up-to-date. This served as a prerequisite for improvements in patient management, linkage to care, and improving adherence and retention. Facility staff responded positively to the changes saying that their work-load was decreased and decanting eligibility was made clearer.



STEPS TO IMPLEMENT

ORGANIZE FILING SYSTEM

- ❑ Differentiate between active and dormant files (a patient has not come to the facility in 2+ years).
- ❑ Archive dormant files from 2–5 years in boxes on site, archive dormant files from 5+ years to off-site archives.
- ❑ Identify duplicate files and merge into one.
- ❑ Introduce an organized file numbering system.
- ❑ Label shelves to indicate number ranges.
- ❑ Place file dividers between files to keep them in place.
- ❑ Use filing boxes to separate bundles of files.

IMPROVE ACCURACY IN PATIENT FILES

- ❑ Mentor Clerks to complete file information at registration for every visit (update phone and address as needed).
- ❑ Test out-call numbers while the patient is still at the facility.
- ❑ Open health patient registration system (HPRS) record on every patient.
- ❑ Establish process to review files for completeness and updated information.
- ❑ Ensure that the HPRS computer is connected to the internet, at least periodically, to synchronize information.
- ❑ File laboratory reports as they arrive in the correct patient files.

PRE-RETRIEVE AND SORT FILES

Filing Clerks (FC):

- ❑ Assign responsibility for generating a list of appointments and for pulling files.
- ❑ Refile all sorted files daily.
- ❑ Place a note card in the space where a file was removed and note who has taken the file for easy refiling.
- ❑ Retrieve files from service points throughout the day.
- ❑ Create a single centralized drop-off point for patient files for refiling.
- ❑ Maintain a file control sheet showing the files retrieved and returned to the file room.
- ❑ Place files of patients who missed appointments in a box for follow-up and tracing.

MAINTAIN FILING SYSTEM

- ❑ Linkage Officer (LO) calls patient who missed appointments and uses the track and trace tool.
- ❑ LO separates patients who were misclassified as missed appointments and hands to a Clinician to correct the information.
- ❑ Data Capturer (DC) captures file in TIER.Net.
- ❑ FC sends/takes file to the filing room for immediate refiling.

FACILITATORS

- Involved the district management team from the beginning—had the acting Manager participate in the quality improvement (QI) meeting.
- Set up daily feedback sessions on data retrieval with Clinicians and DCs.
- Extended patient hours from 16:00 to 18:00.
- Used appointment books as a backup when a patient file could not be traced.
- Worked together with the Clinicians, appointed a Data Manager (DM) each month to oversee office file management.
- Rotated the DM every month.
- Promoted the positive impact of the change to facilitate staff buy-in.

CHALLENGES & ADAPTATIONS

Initial resistance from DC → Introduced pulling patient records once a day in advance. So, during the day, most files were ready, except for walk-in patients.

ABBREVIATIONS

- ✓ ART – antiretroviral therapy
- ✓ DC – data capturer
- ✓ DM – data manager
- ✓ FC – filing clerk
- ✓ HPRS - health patient registration system
- ✓ HPRN – health patient record number
- ✓ LO – linkage officer
- ✓ QI – quality improvement
- ✓ TROA – total remaining on ART

STORAGE ROOM

- ✓ Security gate
- ✓ Fire-proof door and roof
- ✓ Fire extinguisher
- ✓ Not near water pipes
- ✓ Small windows or dark blinds
- ✓ Shelves or cabinets made of coated metal
- ✓ Lowest shelf at least 100 mm off the floor
- ✓ Top of the shelving should not be less than 320 mm from the ceiling
- ✓ Aisles and shelves labelled
- ✓ Counter and/or a sorting table
- ✓ Proper lighting
- ✓ Ensure that the temperature is 20 degrees Celsius or below
- ✓ Clean and dust free
- ✓ Free of rodents and other pests

REGISTRATION SYSTEM

Generate a unique registration number for each patient record using:

- ✓ surname of patient
- ✓ identity document number or date of birth of patient
- ✓ a set of numbers or alphabet letters or a combination of the two

NIGHT DUTY CLINICAL SUPPORT OFFICER

SPOTLIGHT ON RECORDS MANAGEMENT

uMgungundlovu | Msunduzi | Caluza | PHC

Average Monthly Headcount 8000

IMPROVEMENT AREA & AIM

Without a Clinical Support Officer (CSO) on night duty, patient files were not retrieved and patients were not registered with Health Patient Registration System (HPRS). This resulted in the morning shift focusing on clearing the filing backlog from the previous night, long wait times for patients (both day and night shifts), and patients leaving before being seen.

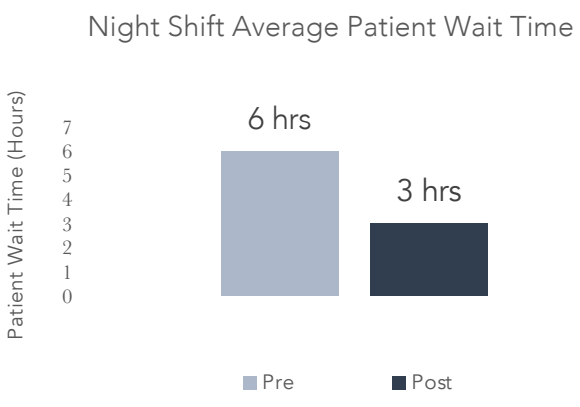
The aim of the project was to reduce patient wait time from an average of 6 hours to a maximum of 90 minutes and improve file retrieval and refiling after patients have been seen.

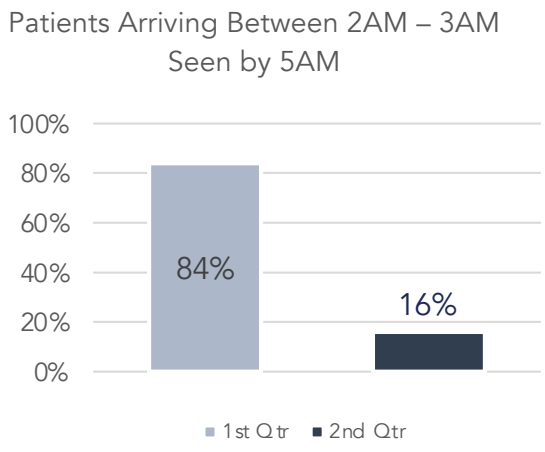
DESCRIPTION

Two CSOs were moved from day shifts to night shifts, with one on duty each night. During the night shift, CSOs: retrieved files and entered patients into HPRS for patients seen at night, organized files from earlier in the day that were unable to be re-filed due to work loads, and prepared files for patients with morning appointments.

OUTCOMES

This intervention resulted in decreased patient wait time (during the day and night shifts), improved job satisfaction for night shift workers, and decongested the day shifts.





STEPS TO IMPLEMENT

PRE-IMPLEMENTATION

- ❑ Operational Manager (OM) convenes a meeting with all Clinical Support Officers (CSOs).
- ❑ OM explains the change idea to the CSO emphasizing the reduced wait times and increased productivity.
- ❑ OM asks for volunteers (2) to change from day shift to night shift.
- ❑ OM ensures all CSOs have access to patient file cabinets during the night shift.

DURING THE NIGHT SHIFT

CSO :

- ❑ Registers patients in HPRS.
- ❑ Retrieves patient files for night and the following day.
- ❑ Files back files from patients seen in the afternoon by day staff.
- ❑ Files blood results.
- ❑ Merges duplicate files.

FACILITATORS

- Having the OM explain the problem and ask for volunteers to change from day shift to night shift led to early buy-in from CSO staff.
- Buy-in and support from Facility Operations Manager.
- Specific job responsibilities for night CSO were made clear.
- CSOs saw immediate positive impact from the change which reinforced buy-in.

CHALLENGES & ADAPTATIONS

- No EN to do observations/take vitals after hours
- No proper handover for CSOs because day CSO finishes at 1600 and night duty CSO starts at 1800
- Shortage of RX because there are no lockable cabinets → Day staff left medications for the night staff in boxes in locked consulting rooms.

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ABBREVIATIONS

- ✓ ART – Antiretroviral therapy
- ✓ CSO – Clinical Support Officer
- ✓ EN – Enrolled Nurse
- ✓ HPRS - Health Patient Registration System
- ✓ HPRN – Health Patient Record Number
- ✓ OM – Operational manager
- ✓ TROA – Total remaining on ART

STORAGE ROOM

- ✓ Security gate
- ✓ Fire-proof door and roof
- ✓ Fire extinguisher
- ✓ Not near water pipes
- ✓ Small windows or dark blinds
- ✓ Shelves or cabinets made of coated metal
- ✓ Lowest shelf at least 100 mm off the floor
- ✓ Top of the shelving should not be less than 320 mm from the ceiling
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- ✓ Proper lighting
- ✓ Ensure that the temperature is 20 degrees Celsius or below
- ✓ Clean and dust free
- ✓ Free of rodents and other pests

REGISTRATION SYSTEM

Generate a unique registration number for each patient record using:

- ✓ surname of patient
- ✓ identity document number or date of birth of patient
- ✓ a set of numbers or alphabet letters or a combination of the two

TIER.NET TO RETRIEVE FILES

SPOTLIGHT ON RECORDS MANAGEMENT

Gauteng | Ekurhuleni | North | Tembisa Health Care Centre | CHC
Average Monthly Headcount: 5300

IMPROVEMENT AREA & AIM

Previously, the Facility Booking List (FBL) was used as a reference to pre-retrieve patient files for all upcoming appointments. However, antiretroviral therapy (ART) patient appointments were booked with the Clinician in the consultation room and not recorded in the FBL. This was done to avoid disclosure of HIV status, but as a result, ART patient files were not pre-retrieved resulting in significant delays.

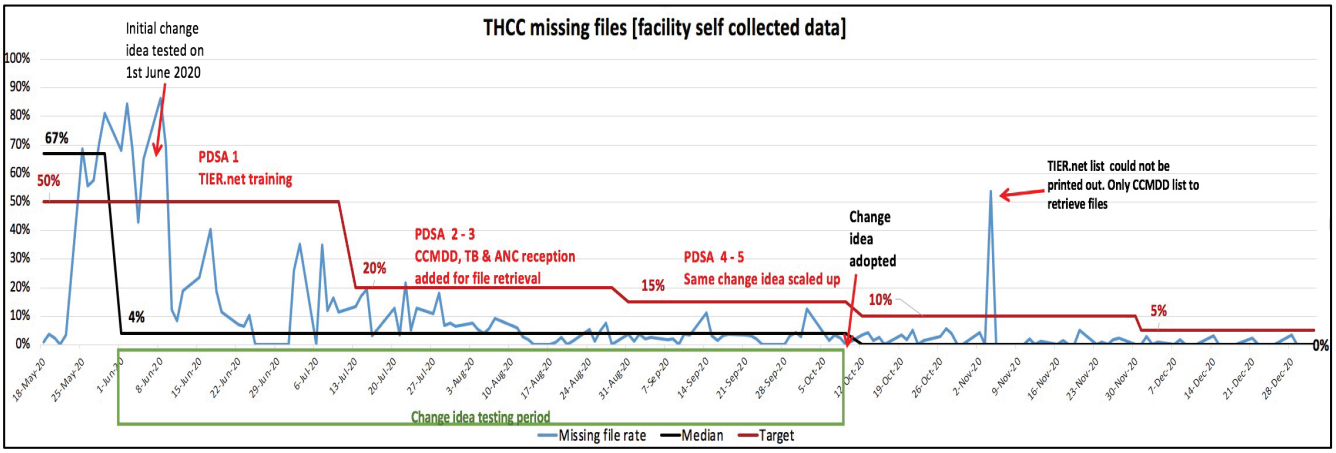
The aim of this change idea was to reduce the rate of un-retrieved ART patient files from 67% to 5% from June to November 2020.

DESCRIPTION

To ensure that the Filing Clerks (FC) had the most accurate and up-to-date lists of upcoming ART patient appointments, the Data Capturers downloaded appointment reports directly from TIER.Net. The list was then printed for the FCs on Mondays. The FCs then pulled all the files for the upcoming week and placed them in an easy-to-access drawer.

OUTCOMES

This new process increased the accuracy of retrieval lists, allowed patients to continue their desired confidential practice of booking appointments directly with their Clinicians, decreased patient wait times, improved staff morale, and motivated staff to implement more improvement projects.



Abbreviations: ANC (antenatal care), CCMDD (centralized chronic medication dispending and distribution), PDSA (plan, do, study, act), TB (tuberculosis)

STEPS TO IMPLEMENT

PRE-IMPLEMENTATION

- ❑ Train Data Capturer (DC) to download the appointment list from TIER.Net.
- ❑ Allocate responsibilities to FCs and ensure that they share the pre-retrieval responsibilities in different reception areas.
- ❑ Allocate an easy-to-access space for storage of patient files for the upcoming week.

WEEKLY TASKS

- ❑ DC downloads the appointment list for the upcoming week from TIER.Net (every Monday).
- ❑ DC allocates responsibilities to the FCs.
- ❑ FC retrieves the files on the list from the main filing room.
- ❑ FC searches for missing files in the consulting rooms.
- ❑ FC places the pre-retrieved files in the designated storage area for easy access during the upcoming week.

FACILITATORS

- Briefed all staff so everyone was aware of the changes being implemented.
- One FC trained the other to cover work the days they were out.
- Assigned pre-retrieval of files to a specific time each day.
- Added the procedures to the facility standing operating procedure (SOP) which promoted sustained adoption.

CHALLENGES & ADAPTATIONS

- The FBL system was phased out over time to allow for FC to adjust gradually to the new system.
- Data Capturers struggled with downloading the booking list report from TIER.Net → Comprehensive training was provided by the Aurum team.

OTHER FACILITY ADAPTATIONS

- A large print sign was added to remind patients to book their next appointment before exiting.
- In smaller facilities, only one Data Clerk pre-retrieved files, one day in advance, rather than once a week.
- Files were pre-retrieved at the same time each day and monitored by the OM.
- The help desk was placed at the main entrance/exit for booking and staffed by an allocated Clerk or Navigator.

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ABBREVIATIONS

- ✓ ANC – antenatal care
- ✓ ART – antiretroviral therapy
- ✓ CCMDD – centralized chronic medication dispending and distribution
- ✓ FBL – facility booking list
- ✓ HIV – human immunodeficiency virus
- ✓ OM – Operational Manager
- ✓ PDSA – plan, do, study, act
- ✓ SOP – standard operating procedures
- ✓ TB – tuberculosis)

QI PROCESS

A Root Cause Analysis addressed long wait times for ART patients. Through the use of a Cause and Effect diagram it was identified that 67% of ART patient files were not being pre-retrieved.

STAFFING & RESOURCES

- ✓ EPI Nurses
- ✓ Filing Clerks
- ✓ Data Capturers
- ✓ No additional resources were required.

SPOTLIGHTS ON RETENTION

AFTER-HOURS TRACING

SPOTLIGHT ON RETENTION

North-West NMM | Lonely Park | Montshioa Town | Unit 9 CHC

Average monthly head count 2400

IMPROVEMENT AREA & AIM

Telephonic outreach is one of the tools used to track and trace antiretroviral therapy (ART) patients who missed their clinic appointments, however, in these three facilities it was found that 40% of the patients contacted telephonically could not be reached during the day because they were either at work or at school and their phones were off.

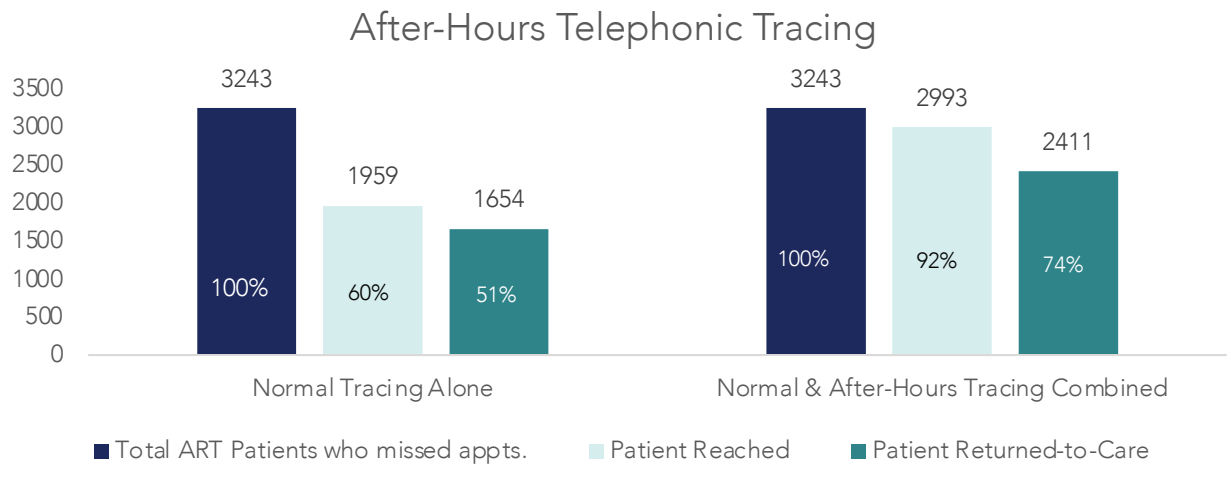
Our aim was to improve the number of ART patients reached through telephonic tracing from a baseline of 60% using daytime calls only to 80% when combined with after-hours calls.

DESCRIPTION

After-hours tracing was established to find patients who were not reachable during the day. After generating the list of patients not reachable, the tracers made follow-up calls from 16:30 to 19:00 using their work cell phones. The outcome of each call was then recorded by the Data Capturer the next morning. Patients' files were updated by the Clinician to reflect the outcome.

OUTCOMES

After implementing after-hours calls from May to July 2021, the percentage of ART patients reached through telephonic tracing improved from 60% using daytime calls only to 92% when combined with after-hours calls, exceeding our goal of 80%. Similarly, the percentage of patients who returned-to-care improved from 51% to 74%.



STEPS TO IMPLEMENT

MORNING

- ❑ Data Capturer (DC) creates a list of early missed appointments (EMA), late missed appointments (LMA), unconfirmed lost to follow-up (ULTFs) from TIER.Net.
- ❑ Patient files are retrieved and audited.

DURING THE DAY

- ❑ Department of Health (DOH) Tracers call patients who missed their appointments.
- ❑ Names and numbers of people not reached are recorded separately.

AFTER HOURS from 1630 to 1900

- ❑ DOH Tracers call all the numbers that were on voicemail or unanswered during the day.

THE FOLLOWING MORNING

- ❑ DOH Tracers record and capture feedback from after-hours tracing.

FACILITATORS

- Involved DOH Tracers, Community Health Workers (CHWs) and Outreach Team Leads (OTLs) to ensure entire team was engaged in process.
- Clinician made time to see returning patients.

CHALLENGES & ADAPTATIONS

- Shortage of airtime → R250 worth of airtime was uploaded every week.
- Some patients were still not reachable after hours → Allocated list of those not reached to CHWs and OTLs for home tracing and updated contact details.

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ABBREVIATIONS

- ✓ DC – data capturer
- ✓ EMA – early missed appointments
- ✓ LMA – late missed appointments
- ✓ ULTF – unconfirmed lost to follow-up
- ✓ CHWs – community health workers
- ✓ OTL – outreach team lead
- ✓ DOH – department of health

RESOURCES

- ✓ Computer
- ✓ Cell phones
- ✓ Airtime
- ✓ Pen and flash book

STAFFING

- ✓ Tracers
- ✓ Community Health Workers
- ✓ Data Capturers
- ✓ Filing Clerk

LESSONS LEARNED

- ✓ Some of the patients who are employed or at school during the day switch off their cell phones or are unable to answer.
- ✓ Patients should be asked during counselling about the best time to be contacted.
- ✓ Some patients do not have personal phones and rely on next-of-kin's cell phones.

CLINICIAN-LED PICK-UP POINT

SPOTLIGHT ON RETENTION

uMgungundlovu | Msunduzi | Impilwenhle | PHC
Average Monthly Headcount: 4500

IMPROVEMENT AREA & AIM

Many patients have been unable to attend clinic appointments due to late working schedules, living far from the facility, and/or lacking the funds necessary for transportation. This resulted in interruptions in treatment, increasing rates of patients lost to follow-up (LTFU), and declining total retained on ART (TROA) rates.

We aimed to increase retention through clinician-lead pick-up point (cPUP) programmes.

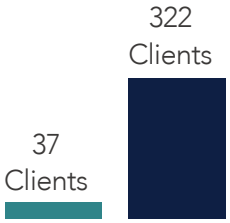
DESCRIPTION

Medication PUPs are an already established method of decanting; non-clinicians distribute medications in the community to patients who are unable to come to the facility. Historically, in order to participate, patients must have been virally suppressed for at least 12 months. A cPUP, by contrast, broadens the population of patients able to receive medications within their community by deploying a Nurse Clinician (NC) to attend to the basic clinical needs of the patient, allowing patients at varying stages of viral suppression to participate.

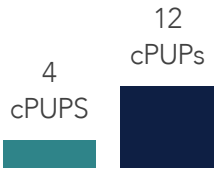
OUTCOMES

The cPUP positively impacted retention, reduced patient congestion at the facility (particularly relevant during the coronavirus pandemic), and was embraced enthusiastically by the patients who no longer needed to travel to receive their medications. Since opening the cPUP, other communities within the facility catchment area have requested similar programmes.

TROA



Clients Using cPUPs



cPUPs in Catchment Area

Abbreviations: cPUP – ART – antiretroviral therapy, clinician-led pick-up points, TROA – total retained on ART

STEPS TO IMPLEMENT

- ❑ Data capturer (DC) identifies ART patients who have not been coming to the clinic for care and medication pick-up.
- ❑ DC captures demographic data of said patients in the Community Outreach Register to help identify reasons for non-attendance.
- ❑ From the list, DC identifies those who live in close proximity to each other (using their addresses or word of mouth) and clusters them into a group.
- ❑ DC shares the list with a NC.
- ❑ NC calls patients to recruit into cPUP programme.
- ❑ NC starts a cPUP when there are more than 10 patients in close proximity interested in community-based care management.
- ❑ NC identifies a convenient location for pick-up within the community, e.g., a mobile clinic, someone's house, a place of work, etc.
- ❑ NC seeks permission from local authority figures and community health workers (CHWs) to confirm appropriate use of identified location.
- ❑ NC develops a schedule of visits — how often depends on the community and availability of medication at that time, but is typically between 1 – 3 months.
- ❑ NC visits the cPUP at agreed upon intervals.

FACILITATORS

- Engaged early and consistently with local campaign agents (CHWs, community leadership, etc.).
- NCs kept appointment dates with patients.
- CPUP built upon previous projects using mobile units and clinical teams.

CHALLENGES & ADAPTATIONS

- Farm employers were refusing to allow patients time away from work to attend the community clinic → cPUP members engaged the farm owners and educated them on the critical necessity of consistent care for their workers.
- Some community members expected mobile clinics to deliver the full public health centre (PHC) spectrum of services including vaccinations and antenatal care → cPUP members conducted community education and sensitization campaigns to explain the limited scope of services for this programme and encouraged alternative approaches to accessing the care they needed.
- Clients preferred to be seen by certain Clinicians whom they already knew → The cPUP programme made a consistent effort to avoid rotation of staff allowing for continuity in care whenever possible.

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ABBREVIATIONS

- ✓ ART – antiretroviral therapy
- ✓ cPUP – clinician-lead pick-up place
- ✓ DC – data capturer
- ✓ DoH -- department of health
- ✓ CHW – community health worker
- ✓ HIV – human immunodeficiency virus
- ✓ LTFU – lost to follow-up
- ✓ NC – nurse clinician
- ✓ PHC – public health centre
- ✓ PUP – pick-up place
- ✓ TROA – total retrained on ART

RECOMMENDATIONS

Blood specimen transport needs to be negotiated with the facility and a protocol put in place before beginning the cPUP programme, otherwise you risk rendering the specimens unsuitable for testing.

RESOURCES NEEDED

- ✓ Mobile clinic
- ✓ Test kits
- ✓ Essential drug list medications
- ✓ Registers
- ✓ Patient files
- ✓ Biospecimen transport case per department of health (DoH) guidelines

COMMUNITY-BASED ART DELIVERY

SPOTLIGHT ON RETENTION

uThukela | Alfred Duma Sub-District | Sigweje Clinic | PHC
Average Monthly Headcount: 4100

IMPROVEMENT AREA & AIM

Due to COVID-19 fears, many patients were not picking up their HIV medications from the clinic, resulting in a long list of missed appointments. This had a negative effect on the 28-day TROA (total patients remaining on antiretroviral therapy). The Center for Disease Control and Prevention (CDC) target for appointments missed by 29–90 days ('late') is less than 1% of TROA.

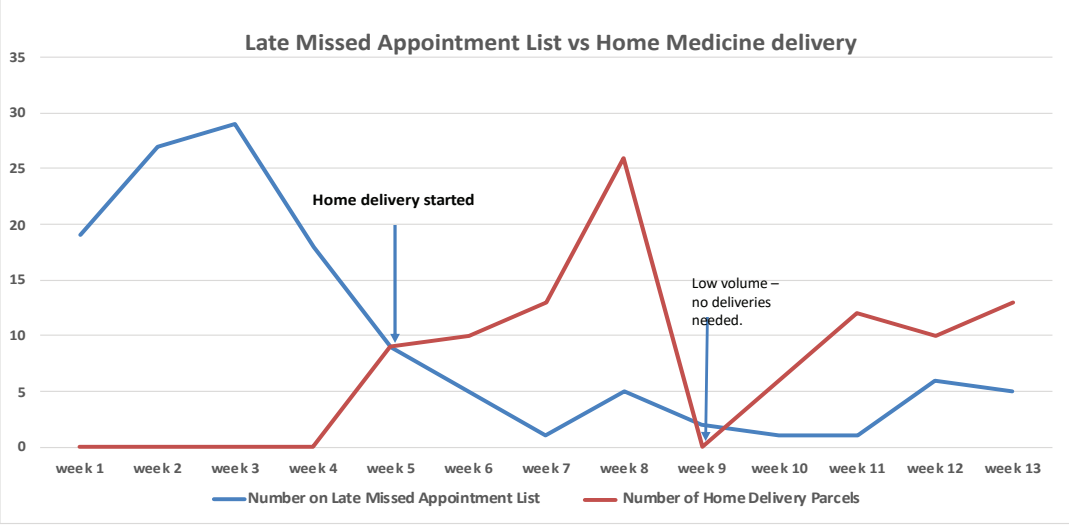
Our aim was to decrease the number of patients on the late appointments list from 1.2% of TROA in March 2020 to less than 1% by May 2020, using home medication delivery.

DESCRIPTION

Community-based Campaign Agents (CAs) were allocated a set of patients grouped by location from the late appointments list. Patients were then contacted telephonically to arrange a date and time for home delivery of their medication, and the CA delivered the drugs to the patient's home. The CA then reported back to the Nurse Clinician (NC) after each home delivery. The information was documented in the patient's clinical chart and sent to the Data Capturer for recording on TIER.Net.

OUTCOMES

After introducing home delivery of medicine, patient numbers on the late appointments list dropped to 0.2% by the end of May 2020. Patients appreciated receiving medicine parcels at home during the COVID-19 pandemic. The clinic staff hope to continue offering home delivery as part of standard practice for reaching patients on the late appointments list. The chart below shows how the number of patients on this list decreased as home delivery expanded.



STEPS TO IMPLEMENT

- ❑ Data capturer (DC) identifies ART patients who have not been coming to the clinic for care and medication pick-up.
- ❑ DC captures demographic data of said patients in the Community Outreach Register to help identify reasons for non-attendance.
- ❑ From the list, DC identifies those who live in close proximity to each other (using their addresses or word of mouth) and clusters them into a group.
- ❑ DC shares the list with a NC.
- ❑ NC calls patients to recruit into cPUP programme.
- ❑ NC starts a cPUP when there are more than 10 patients in close proximity interested in community-based care management.
- ❑ NC identifies a convenient location for pick-up within the community, e.g., a mobile clinic, someone's house, a place of work, etc.
- ❑ NC seeks permission from local authority figures and community health workers (CHWs) to confirm appropriate use of identified location.
- ❑ NC develops a schedule of visits — how often depends on the community and availability of medication at that time, but is typically between 1 – 3 months.
- ❑ NC visits the cPUP at agreed upon intervals.

FACILITATORS

- Engaged early and consistently with local campaign agents (CHWs, community leadership, etc.).
- NCs kept appointment dates with patients.
- CPUP built upon previous projects using mobile units and clinical teams.

CHALLENGES & ADAPTATIONS

- Farm employers were refusing to allow patients time away from work to attend the community clinic → cPUP members engaged the farm owners and educated them on the critical necessity of consistent care for their workers.
- Some community members expected mobile clinics to deliver the full public health centre (PHC) spectrum of services including vaccinations and antenatal care → cPUP members conducted community education and sensitization campaigns to explain the limited scope of services for this programme and encouraged alternative approaches to accessing the care they needed.
- Clients preferred to be seen by certain Clinicians whom they already knew → The cPUP programme made a consistent effort to avoid rotation of staff allowing for continuity in care whenever possible.

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ABBREVIATIONS

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- ✓ cPUP – clinician-lead pick-up place
- ✓ DC – data capturer
- ✓ DoH -- department of health
- ✓ CHW – community health worker
- ✓ HIV – human immunodeficiency virus
- ✓ LTFU – lost to follow-up
- ✓ NC – nurse clinician
- ✓ PHC – public health centre
- ✓ PUP – pick-up place
- ✓ TROA – total retrained on ART

RECOMMENDATIONS

Blood specimen transport needs to be negotiated with the facility and a protocol put in place before beginning the cPUP programme, otherwise you risk rendering the specimens unsuitable for testing.

RESOURCES NEEDED

- ✓ Mobile clinic
- ✓ Test kits
- ✓ Essential drug list medications
- ✓ Registers
- ✓ Patient files
- ✓ Biospecimen transport case per department of health (DoH) guidelines

EARLY TELEPHONIC OUTREACH

SPOTLIGHT ON RETENTION

Amathole District | Mbhashe | Xhora Community Health Centre | PHC
Average Monthly Headcount: 1738

IMPROVEMENT AREA & AIM

At Xhora Community Health Centre (CHC), previous outreach attempts following missed appointments were not done consistently. Many patients who missed appointments were not contacted until they had been out of care for so long they were no longer considered part of the facility's total retained on antiretroviral therapy (TROA).

This project aimed to reduce unconfirmed loss to follow up at Xhora CHC from 248 in September 2018 to 50 by March 2019 through reaching out to patients within a day when they appeared on the 'early missed appointment' (EMA) list described in more detail below.

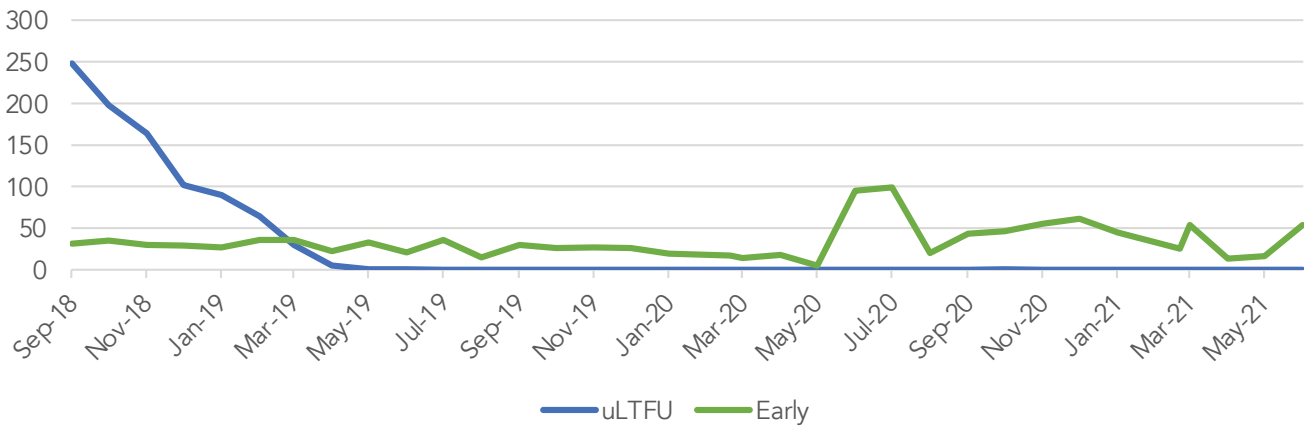
DESCRIPTION

If patients do not pick up medication within 7–28 days, TIER.Net will classify them as an 'early missed appointment'. Patients were called within one day of appearing on the early missed appointment list. Patients who were not reachable telephonically received home visits (physical tracing) from Case Officers on a dedicated weekend outreach day.

OUTCOMES

The unconfirmed-lost-to-follow-up (uLTFU) (patient is more than 89 days late in picking up medication) dropped from 248 to 0 and has remained at 0 (as of April 2021). Following up with patients led to correctly classifying them as remaining on ART. Some patients did not actually miss appointments, but the appointment had been misclassified in TIER.Net.

Changes in uLTFU, Early and Late Missed Lists



STEPS TO IMPLEMENT

- ❑ Case Officers (COs) review folders every day for ART patients who have missed their appointments.
- ❑ COs and Data Capturers (DCs) check folders and cross reference on TIER.Net to verify that the appointment was truly missed by patient.
- ❑ COs call patients during the week and weekend evenings to remind them of their overdue appointments.
- ❑ Record the reason for the patient's missed appointment in their folder (optional).
- ❑ Record the call time and date and repeat the process until it appears the patient cannot be reached telephonically.
- ❑ COs conduct home visits for patients who are not reachable by phone on a designated tracing day (early mornings or weekends).
- ❑ Clinician updates patient folder immediately after visit so change is reflected in TIER.Net.

FACILITATORS

- Coordinated efforts across team members — e.g., conducted home visits on the way to the clinic or with patients who live nearby to limit additional travel time, and staff covered each others' patients as needed so that the team could be more efficient.
- Conducted home visits during the weekends, when the clinic was only open for emergency visits, to protect routine clinic time .

CHALLENGES & ADAPTATIONS

- Reaching patients by phone was not always possible → Physical tracing was used to locate patients when phone outreach failed.
- Supporting staff to take on additional work → Staff deployed on weekends for home visits received a weekday off.
- Integrated medication delivery with home visits by having a nurse prepare the day before the medications for the scheduled home visits.
- HIV counsellors joined home visits to test family members of the patient, allowing for index case tracing.

ABBREVIATIONS

- ✓ **ART** – antiretroviral therapy
- ✓ CO – case officer
- ✓ CHC – community health centre
- ✓ DC – data capturer
- ✓ EMA – early missed appointment
- ✓ **LTFU** – lost to follow up
- ✓ TROA – total retained on ART
- ✓ **uLTFU** – unconfirmed lost to follow-up

PATIENT CATEGORIZATION

- ✓ **Early missed appointment** – patient is 7-28 days late in picking up medication
- ✓ **Late missed appointment** – patient is 2-89 days late in picking up medication
- ✓ **uLTFU** – unconfirmed-lost-to-follow-up, patient is more than 89 days late in picking up medication

RESOURCES NEEDED

- ✓ Phone
- ✓ Staff time for outreach
- ✓ Transportation and driver for home visits

RECOMMENDATIONS

Confirm that missed appointments are truly missed by checking patient folders and cross-referencing the missed appointment list with the list of decanted patients.

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PHYSICAL TRACING DURING LOCKDOWN

SPOTLIGHT ON RETENTION

O.R. Tambo | Ingquza Sub-District | Flagstaff | PHC

Average Monthly Headcount: 6700

IMPROVEMENT AREA & AIM

The second 95 of the 95-95-95 strategy aims to have 95% of all people diagnosed with HIV infection receiving sustained antiretroviral therapy. Due to the COVID-19 lockdown restrictions and fear of contracting the corona virus, many antiretroviral therapy (ART) patients missed their clinical appointments. This led to disruptions in continuity of treatment and a drop in total number of patients remaining on ART (TROA).

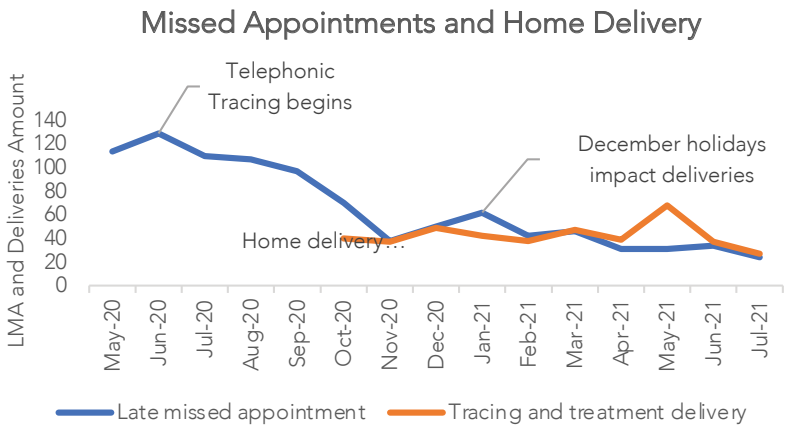
This project aimed to increase the number of patients remaining on ART from 5,065 in September 2020 to 5,600 by July 2021.

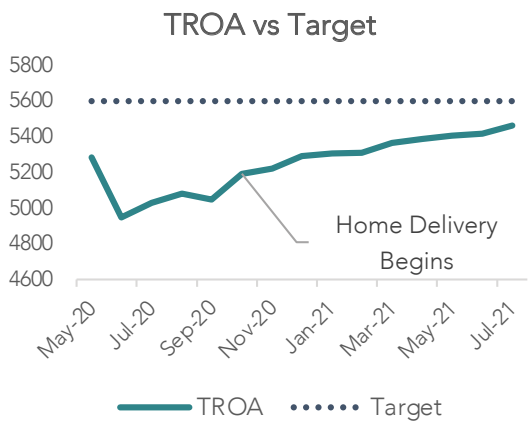
DESCRIPTION

During telephonic tracing of patients on the late-missed-appointment list (LMA), Case Officers (COs) offered home delivery of treatment to patients who were unable to visit the facility. Patients consenting to home delivery were clustered according to their areas of residence. Patients who were unreachable by phone, and who needed physical tracing, were also included on this list. Home delivery was offered to patients the day they are successfully traced.

OUTCOMES

The number of ART patients who missed their clinical appointments started to decrease which resulted in an increase in TROA from 5,065 patients in September 2020 to 5,463 by July 2021. Patients appreciated having medication delivered to their home, so they were motivated to provide correct contact details. Correct contact details made it easier to remind patients about their next appointment.





STEPS TO IMPLEMENT

- ❑ Case Officer (CO) lists the names of patients who consented to home delivery during telephonic tracing according to areas of residence (clustering).
- ❑ CO lists the names of patients unreachable by phone who need to be physically traced, according to areas of residence as documented in patient's file.
- ❑ The day before home delivery, the CO records names of patients (consented and not consented) in the treatment delivery register and requests Data Capturers (DCs) retrieve files of those patients.
- ❑ DC gives files to Nurse Clinician (NC) who requests the treatment pre-packs from pharmacy.
- ❑ On the day of home visit, the team collects treatment from pharmacy and proceeds to deliver treatment in the community.
- ❑ When meeting with patients who have not yet consented, the Enrolled Nurse Assistant (ENA) offers home delivery and gets patient consent.
- ❑ After issuing medication, the ENA updates the date of next appointment on the patient carrier card, and the patient signs the treatment delivery register as proof they received treatment.
- ❑ At the clinic, ENA gives the completed treatment delivery register, with patient signatures, to the NC who updates clinical records.
- ❑ NC gives updated folders to DC for capturing and refiling.

FACILITATORS

- Standard operating procedures (SOPs) for community ART delivery gave guidance on the implementation of home treatment delivery.
- Pre-existing physical tracing teams assisted in pairing treatment delivery with tracing.
- Home delivery improved patient provider relationship because patients understood the purpose of giving correct details for future contact.

CHALLENGES & ADAPTATIONS

- Unclear or lack of detailed demographics resulted in spending more time tracing the patient → Upon finding the patient, the demographics were captured correctly.
- Pharmacy department wanted to only issue treatment when it is recorded on the patient folder → Treatment delivery register was shared with them as a tool to monitor successful treatment delivery.

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ABBREVIATIONS

- ✓ CHW – Community Health Workers
- ✓ ENA – Enrolled Nursing Assistant
- ✓ LMA – Late missed appointment
- ✓ SOP – Standard operating procedure
- ✓ TROA – Total remaining on ART
- ✓ WBOT – Ward-base outreach team

RESOURCES

- ✓ Treatment delivery register
- ✓ Treatment delivery SOP
- ✓ Pre-pack envelopes
- ✓ Marker
- ✓ Cooler box
- ✓ Vehicle

STAFFING

- ✓ Data Capturer
- ✓ Pharmacist Assistants
- ✓ Enrolled Nurse Assistant
- ✓ Case Officers
- ✓ Nurse Clinician

RECOMMENDATIONS

- ✓ Explain to the patient that the intervention is temporary.
- ✓ Engage WBOT team leaders in order to use CHWs as another resource for treatment delivery.

IDEA INSPIRATION

This change idea came from primary healthcare (PHC) re-engineering (back to basics) taking services to the patients.

WHATSAPP PRE-REMINDERS & YOUTH CARE CLUBS

SPOTLIGHT ON RETENTION

Gauteng | Tshwane | 22 Siyenza (POPS) Sites

IMPROVEMENT AREA & AIM

Restrictive COVID-19 regulations prevented adolescents and youth living with HIV (AYLHIV) from accessing Youth Care Clubs (YCCs) activities which led to a decline in care retention. When open, the YCCs offered a group-based clinical and psychosocial HIV management approach, a mix of newly initiated, virally suppressed, and unsuppressed AYLHIV.

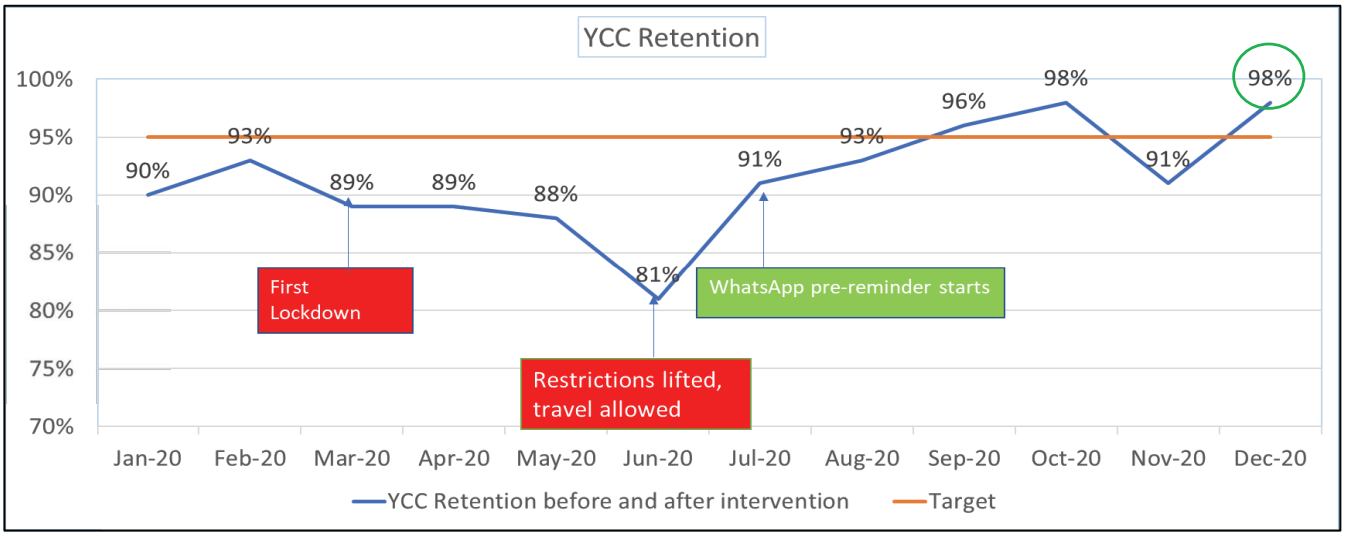
The aim was to increase retention of AYLHIV among YCC members from a baseline of 81% in June 2020 to 95% by December 2020 and to foster peer learning.

DESCRIPTION

A WhatsApp group pre-reminder system was created to strengthen access to care and treatment for AYLHIV during the COVID pandemic. The groups were established by YCC facilitators and split by age (12–15, 16–19, and 20–24 years). Participants received a standardized WhatsApp message 2–3 days before their YCC visit and were required to respond confirming attendance. Calls were made to those who did not respond or had undelivered messages to trace missing participants. For those who confirmed attendance, their patient files were then pre-retrieved for their clinic visit. During the implementation period, multi-month scripting was also used to decrease visit frequency.

OUTCOMES

The WhatsApp pre-reminder system was put in place and by July 2020, the retention rate started to steadily increase to 91%. By October 2020, the retention rate had peaked to 98% surpassing the target of 95%. Social cohesion and clinical discussions with facilitators and clinicians proved beneficial. The approach enabled a sense of belonging and peer support for the AYLHIV.



STEPS TO IMPLEMENT

PRE-IMPLEMENTATION

- ❑ YCC Facilitator obtains consent according to age (12–17 years: caregiver, 18–24 years: self).
- ❑ YCC Facilitator creates WhatsApp groups.
- ❑ The YCC team designs pre-reminder texts.

IMPLEMENTATION

2–3 days before clinic visit, the YCC Facilitator:

- ❑ Pre-retrieves files for all booked YCC members.
- ❑ Sends pre-reminder texts to members regarding appointment.
- ❑ Member confirms attendance using a "hands up emoji." 🙋🏾‍♀️ 🙋🏾‍♂️
- ❑ If member is unable to make it, will respond with a 👎🏾 and arrangements will be made with the Facilitator for a more convenient date for the member.
- ❑ Follows-up with those who did not respond to the text telephonically.
- ❑ YCC Facilitator informs Clinician of those who have confirmed their appointments.

After the clinic visit:

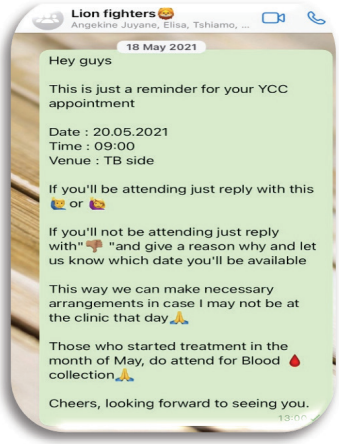
- ❑ YYC Facilitator makes 3 follow-up calls to those who confirmed but did not come (within the 5-day grace period, as per integrated clinical services management (ICSM).
- ❑ WBPHCOT physically trace YCC members who could not be reached through telephonic tracing.

FACILITATORS

- YCC Facilitators and Love Life Facilitators worked in tandem.
- Buy-in and support from Department of Health Clinician, facility staff, and WBPHCOT streamlined patient flow.

CHALLENGES & ADAPTATIONS

- Facility ownership (YCC facilitation, clinical support) → It was a challenge to get buy-in from Counsellors, especially in relation to YCC facilitation which is a major enabler to implementation.
- Network coverage and access to mobile data → This was a challenge for the patients, especially those who were residing in informal settlements. Data costs were also a challenge.



ABBREVIATIONS

- ✓ AYLHIV– adolescent and youth living with HIV
- ✓ ICSM – integrated clinical services management
- ✓ POPS – Pepfar Operation Phuthuma Support
- ✓ WBPHCOT – ward-based primary health care outreach team
- ✓ YCC – youth care club

RESOURCES

- ✓ Smartphones
- ✓ Airtime/Data
- ✓ YCC Register
- ✓ Process measure Tools

STAFFING

- ✓ YCC Facilitator
- ✓ Clinician

RECOMMENDATION

It is recommended that process measures be monitored effectively. This can be done through development of a monitoring and evaluation plan with clear indicators before implementation to enable monitoring of the intervention impact.

IDEA INSPIRATION

The idea was a collaborative effort that involved YCC clients clearly articulating their needs and the AYFS Team responding.

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SPOTLIGHT ON TLD TRANSITION

TLD IMPLEMENTATION

SPOTLIGHT ON TLD TRANSITION

O.R. Tambo | Ingquza | St. Elizabeth Gateway | PHC

Average Monthly Headcount: 3300

IMPROVEMENT AREA & AIM

Certain facilities were more successful than others in implementing widespread Tenofovir, Lamivudine, and Dolutegravir (TLD) policy.

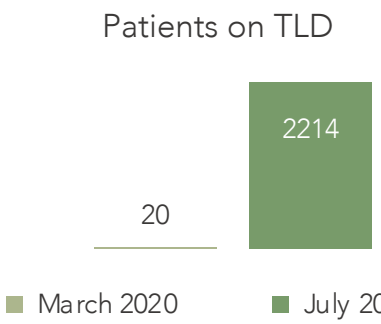
With the COVID-19 pandemic, there is an additional aim to quickly decant stable patients (not just those who transitioned to TLD) to community-based medication management programs.

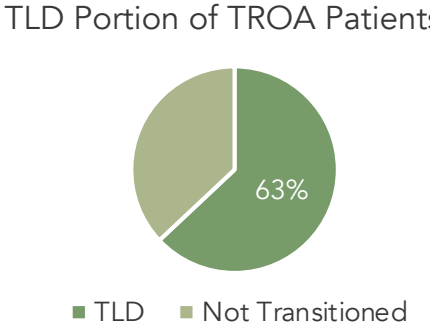
DESCRIPTION

Patients were offered TLD and preferred it because it is taken in the morning (rather than at night) and has fewer side effects. TLD drug availability allowed patients, who were not yet eligible to be decanted, to get multiple-month prescriptions which increased retention. Many patients who were eligible to switch were also eligible to be decanted which helped to decongest the facility and led to deceased COVID-19 risk for antiretroviral therapy (ART) patients.

OUTCOMES

Here we highlight the success of St. Elizabeth Gateway in the O.R. Tambo region in achieving a 63% TLD transition since the policy implementation in March 2020.





Abbreviations: ART – antiretroviral therapy, TLD – tenofovir, lamivudine, dolutegravir, TROA – total retained on ART

STEPS TO IMPLEMENT

PRE-IMPLEMENTATION

- ❑ Data Capturer (DC) filters in TIER.Net patients who are virally suppressed and patients due for a viral load (VL) blood draw.
- ❑ DC sends TIER.Net Excel export to quality improvement (QI) Coordinator/Mentor.
- ❑ DC filters and identifies those eligible.
- ❑ Case Officer (CO) contacts patients telephonically to ask them to come in person.
- ❑ Filing Clerk retrieves files out of cabinets, labelled for TLD transition, and others labelled for VL blood draw (so that Clinician knows immediately what type of management is needed).
- ❑ Clinician explains benefits of TLD transition to patient and offers option to transition to TLD.

EVERY AFTERNOON

Data Capturer:

- ❑ Checks whether all the patients eligible for TLD attended appointments and were transitioned.
- ❑ Ensures those successfully transitioned are captured correctly by checking number of clinical records against TIER.Net.

FACILITATORS

- Gained autonomy for facility to execute policy with phone guidance from TB HIV Care.
- Gained buy-in and guidance from Department of Health (DOH) staff with detailed SOP.
- Provided continuous feedback to Facility Operational Manager (FOM) on number of patients found to be eligible, number successfully decanted, and number captured on TIER.Net.
- Centralized chronic medication dispending and distribution (CCMDD) re-scripted patient and sent SMS to patient to continue collecting meds at external pick-up point without coming to facility.
- Revised CCMDD standard operating procedure (SOPs) so that only one suppressed VL needed to transition and decant patient.
- Stable patients were able to get 12-month prescription instead of 6-month.

CHALLENGES & ADAPTATIONS

- Concerns about switching patients to TLD, particularly women of childbearing age, led to delays in this population → We educated patients on new understanding of minimal risk to pregnant women.
- Patients were reluctant to transition because they did not want to sign a consent form and it made them feel like they were putting their lives at risk → We no longer required written consent forms from patients.
- Incorrect capturing of TLD on TIER.Net (system automates to second-line treatment which can be fixed but requires attention) resulted in reporting lower than actual numbers → We held trainings on correct method of entering data into TIER.Net.

ABBREVIATIONS

- ✓ **ART** – antiretroviral therapy
- ✓ **CO – case officer**
- ✓ **CCMDD** – Centralized chronic medication dispending and distribution
- ✓ DC – data capturer
- ✓ **DOH** – department of health
- ✓ **DQO** – data quality officer
- ✓ **FOM** – facility operational manager
- ✓ **SOP** – standard operating procedures
- ✓ **TLD** - tenofovir, lamivudine, and dolutegravir
- ✓ **TROA** – total remaining on ART
- ✓ **VL** – viral load

STAFF NEEDS

- ✓ 5 Professional Nurses
- ✓ 3 Enrolled Nurse Assistants
- ✓ 5 Data Capturers
- ✓ 3 Pharmacy Assistants
- ✓ 1 FOM

RESOURCES NEEDED

- ✓ TLD drug supply
- ✓ Resources for VL blood monitoring needed (blood draw forms)

SPOTLIGHT ON TUBERCULOSIS

PAEDIATRIC TB SCREENING

SPOTLIGHT ON TUBERCULOSIS

Gauteng | Ekurhuleni | North | Edenvale Clinic | PHC
Average Monthly Headcount: 3000

IMPROVEMENT AREA & AIM

Tuberculosis (TB) symptom screening was previously centralized at the facility vital-signs station at Edenvale Clinic. Paediatric patients, however, do not go through the vital-signs station and therefore were not routinely screened for TB. In addition, paediatric nurses were unaware of the importance of screening children under 5 years for TB symptoms.

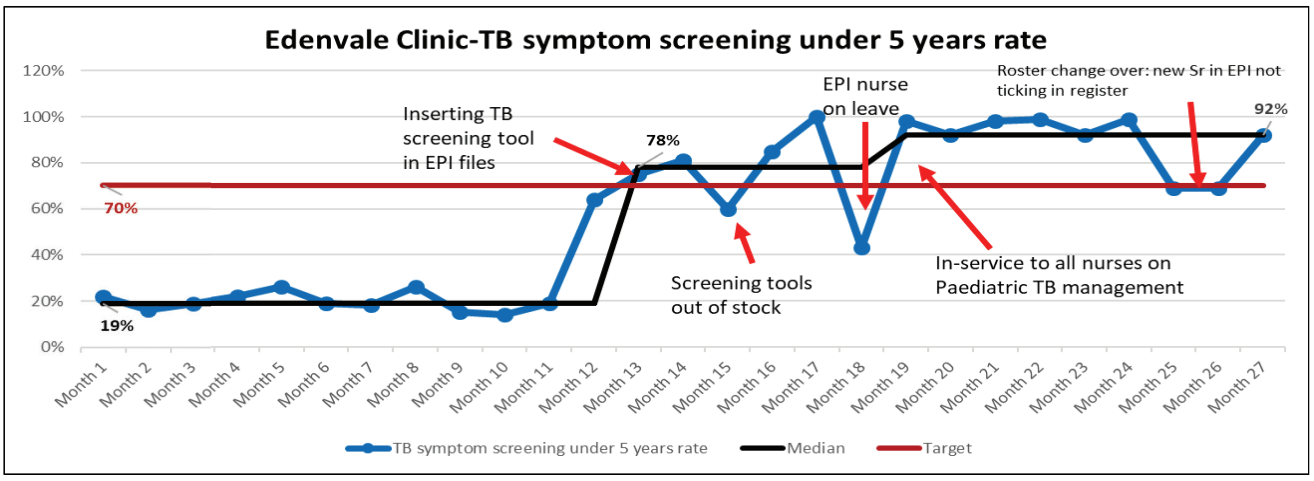
Our aim was to increase the TB symptom screening rate for patients under 5 years from a baseline of 19% in March 2018 to 70% by May 2018.

DESCRIPTION

The Administrative Clerk (AC) inserted a TB screening tool into each paediatric patient chart at reception. This 4-question paper form was used to screen for TB and determine which children needed to be sent for a confirmatory X-ray. All Nurses were oriented to the new protocol. Additional blank patient files with TB screening tools were also placed in the paediatric exam rooms to accommodate any patients who were missed at the vital-signs station.

OUTCOMES

The TB symptom screening rate for children under 5 years was improved from 19% to 78% within the testing period (May - November 2018) and sustained at 92% after the change idea was adopted (December 2018 - July 2019). The outcome uplifted staff morale and motivated more quality improvement (QI) projects.



Abbreviations: TB – tuberculosis, EPI – expanded programme immunisation

STEPS TO IMPLEMENT

- ❑ Conduct an in-service training for all paediatric Nurses on TB screening tool, confirmatory tests, and management guidelines.
- ❑ Hold training sessions for ACs on inserting TB screening tool into paediatric patient files (both acute and chronic).
- ❑ AC inserts screening tools into patient charts at vital-signs station.
- ❑ Paediatric Nurse takes patient files with them into paediatric exam room.
- ❑ Paediatric Nurses screen each patient for TB.
- ❑ Paediatric Nurses refer patients who screen positive for chest X-rays.
- ❑ Data Capturer collects patients' charts at the end of the day and inputs data from TB screening tools into district health information software (DHIS) system.

FACILITATORS

- Routinely offered in-service training for new staff on the TB screening process and protocols.
- Ensured screening tools were available—assigned a paediatric Clinician to check stock weekly.
- Monitored data continuously by using run charts to observe any cause variations.
- Spot checked and audited files to ensure that documentation was complete and comprehensive.

CHALLENGES & ADAPTATIONS

- When Nurses were rotated to the paediatric stream, screening did not happen as planned → All new Nurses were oriented.
- Some patients made their way to the EPI (Expanded Programme on Immunization) rooms without files → A few blank files and TB screening tools were placed in the EPI room for the Nurses.

ABBREVIATIONS

- ✓ AC – administrative clerks
- ✓ DHIS – district health information software
- ✓ EPI – expanded programme on immunization
- ✓ PHC – primary health care
- ✓ QI – quality improvement
- ✓ TB - tuberculosis

QI PROCESS

The project was carried out as part of the NDoH TB quality improvement (QI) collaborative and this facility was in one of the pilot districts.

CONFOUNDERS

During the testing period, a new comprehensive screening tool was introduced that allowed for both children and adults to be screened on the same form. This reduced the challenge of using individual tools that had to be inserted separately in the patients' files.

RESOURCES NEEDED

No additional resources needed.

STAFFING NEEDS

- ✓ EPI Nurses
- ✓ Administrative Clerks
- ✓ Data Capturers

SPOTLIGHTS ON VIRAL LOAD COVERAGE

SMS REMINDERS

SPOTLIGHT ON VIRAL LOAD COVERAGE

Chris Hani District | Sakhisizwe SD | Thembelihle Clinic | PHC
Average Monthly Headcount:1700

IMPROVEMENT AREA & AIM

At Thembelihle clinic there were no systems in place to remind facility staff to collect viral loads (VL) and record the results in TIER.Net, or for patients to come to the facility for their 6-month VL appointments post-antiretroviral therapy (ART) initiation. As a result, patients were often missed and the VL monitoring rate was low.

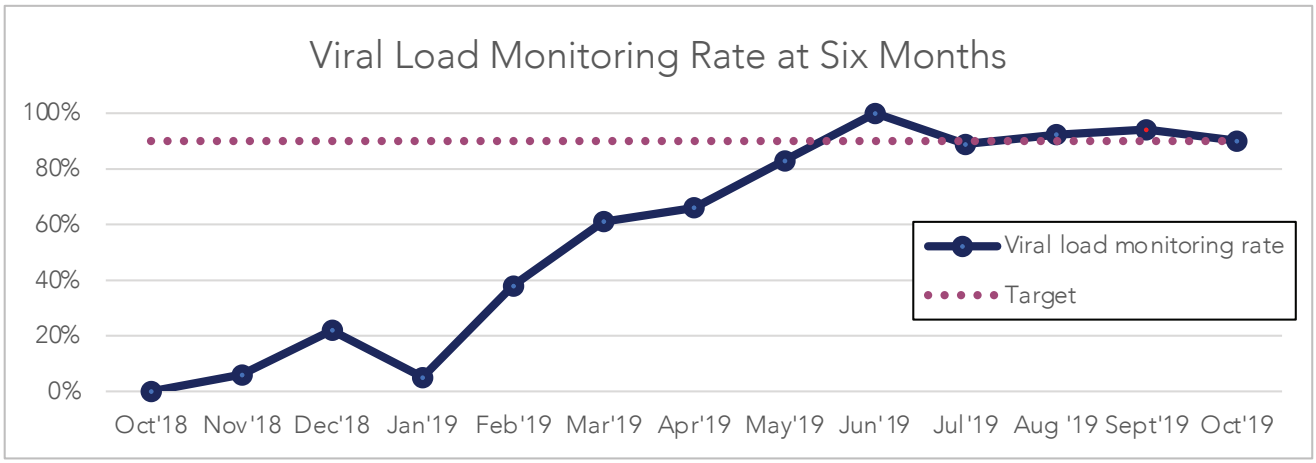
Our aim was to increase the VL monitoring rate at 6 months from a baseline median of 14% (October 2018 – March 2019) to 90% by 30 June 2019.

DESCRIPTION

Lists of patients due for VL at 6 months were generated monthly by the Data Capturers (DC). A Case Officer (CO) was then assigned to send patients cell phone SMS reminders that they were due for a VL blood draw. Additionally, the DCs placed paper notes in the patient files to remind Clinicians about blood draws. A VL Professional Nurse (PN) champion at the facility was assigned to be responsible for daily auditing of the patient files and overseeing the CO and DC VL duties.

OUTCOMES

Viral load monitoring at 6 months improved from the baseline median of 14% to 100% by June 2019. Qualitative findings showed an improvement in retention as patients became better informed about treatment efficacy and VL results. Patients who were found to be virally suppressed at 6 months were given longer-term prescriptions (at least 2 months*), resulting in facility decongestion and more time to focus on each patient. *[Note that this was pre-COVID-19. Patients are now enrolled in differentiated models of care (DMOC) for 6 months.]



STEPS TO IMPLEMENT

- ❑ At the beginning of the month, the DC pulls a list of patients from TIER.Net who are due for a 6-month clinic visit and VL blood draw the following month.
- ❑ DC gives the list and phone contact information to the CO.
- ❑ Patient comes to the clinic for their appointment.
- ❑ DC keeps another copy of the list and inserts a visual reminder in the patient's file for the Clinicians to complete a blood draw.
- ❑ CO sends a cell phone SMS message to the patient reminding them to come to the facility for their 6-month appointment.
- ❑ PN conducts a blood draw and marks it in the patient file.
- ❑ Blood sample is sent to the laboratory for VL test.
- ❑ Clinician records VL test result in the patient's file.
- ❑ DC captures VL test results in TIER.Net.

FACILITATORS

- Held weekly meetings with everyone to remind the Clinicians to watch for patients in need of 6-month follow up appointments.
- A quarterly review of performance for all facilities, including the operational manager (OM) from each facility, helped to monitor progress and encourage further improvement.
- A VL champion helped oversee the process and provide motivation for staff.
- Decanting opportunity encouraged patients to complete VL testing.
- Decanting opportunity was an incentive for Clinicians to monitor patients to determine which patients were eligible for decanting.

CHALLENGES & ADAPTATIONS

- Patients would sometimes give the wrong phone number or address so as not to reveal that their true address is outside of the facility catchment area → Most people with same surname reside in the same area; therefore, we used LabTrack and HPRS to identify their true locations.
- Providers did not always see or process the visual reminders in the patient files → Facility meetings were held to remind providers to look for the reminders.
- Initially, SMS reminders told patients that they would not have to wait when they came to the facility, but that was not always accurate as patients could not be fast tracked until they had been receiving care for 12 months → We learned to manage expectations in our SMS text communications.

ABBREVIATIONS

- ✓ ART – antiretroviral treatment
- ✓ CO – case officer
- ✓ DC – data capturer
- ✓ DMOC – differentiated model of care
- ✓ OM – operational manager
- ✓ PN – professional nurse
- ✓ VL – viral load

OTHER FACILITY ADAPTATIONS

- ✓ Some facilities used stickers in patient files, while others wrote directly on the file to indicate patients due for blood draws.
- ✓ Some facilities also began with monthly review but realized that weekly was less burdensome and allowed for closer monitoring of patients.

RECOMMENDATIONS

We recommend including everyone in VL management, not only the clinicians, but also data and administrative staff. Routine data monitoring and quality improvement (QI) processes were key to the success of this change idea.

Disclaimer: *This Spotlight was developed and implemented by TB HIV Care and DoH staff, with support from OPIQ South Africa. This resource can be freely used and distributed, with acknowledgement of TB HIV Care and DoH, so long as it does not result in commercial gain. The findings and conclusions in this Spotlight are those of the authors and do not necessarily represent the official position of the funding agencies: this project has been supported by the President's Emergency Plan for AIDS Relief (PEPFAR) through the Centers for the Disease Control and Prevention (CDC) under the terms of grant number: 6 NU2GGH002227.*

SUPPLY AND DEMAND

SPOTLIGHT ON VIRAL LOAD COVERAGE

Chris Hani I Ngcobo I All Saints Gateway Clinic I PHC
Average Monthly Headcount: 2300

IMPROVEMENT AREA & AIM

According to the national consolidated guidelines for HIV Management 2020, all patients initiated on antiretroviral therapy (ART) must have a viral load (VL) taken 6 months after treatment initiation. All Saints Gateway clinic had low 6-month VL coverage due to clinical management challenges and patients' missing appointments.

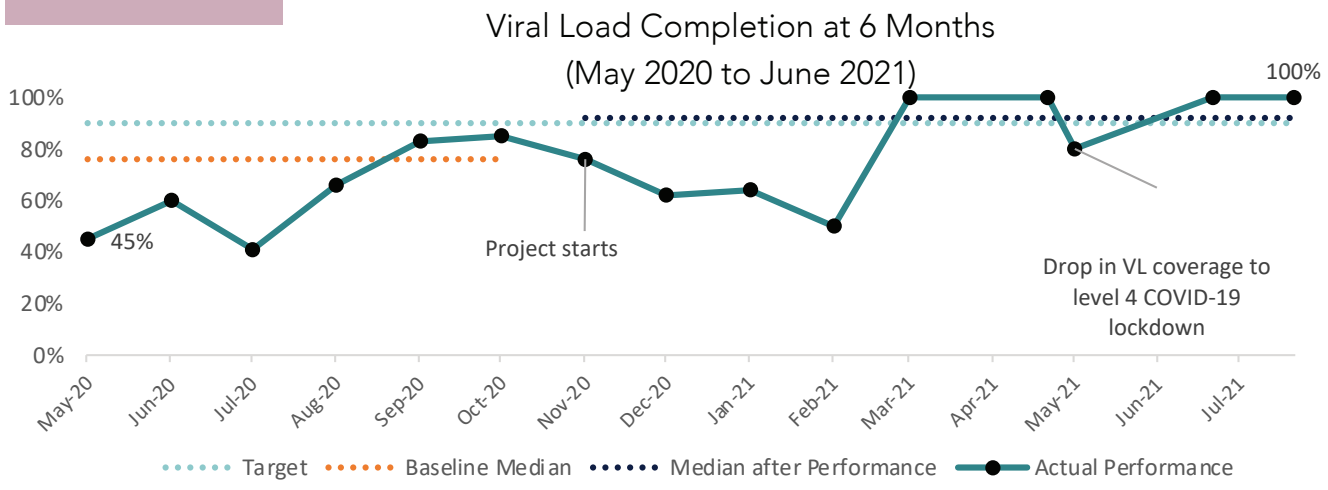
This project aimed to increase the percentage of VL coverage at 6 months from a baseline median of 76% (May - October 2020) to a median of 90% (November 2020 - July 2021).

DESCRIPTION

The Data Capturers (DCs) generated a VL blood draw list weekly from TIER.Net. Patient records were retrieved and the laboratory request form was inserted into the record by the Nurse Clinician (NC). Case Officers (CO) telephonically reminded all patients due for VL draws and appointments. The quality improvement (QI) team cross referenced the list of blood results on eLabs with those captured in TIER.Net.

OUTCOMES

VL coverage improved from a baseline median of 76% (May – October 2020) to median VL coverage of 92% (November 2020 - July 2021).



Abbreviations: VL – viral load

STEPS TO IMPLEMENT

- ❑ Data Capturer (DC) generates viral load (VL) blood draw list from TIER.Net every week.
- ❑ Every Friday, NC identifies patients who will be visiting the following week and retrieves patient records with laboratory request forms inserted.
- ❑ COs telephonically remind patients to come in person for VL blood draws.
- ❑ NC records patients' blood draws in the specimen register.
- ❑ Every morning, CO reviews the specimen register to check list of patients who have come for their VL blood draw and calls those who have not honoured their appointments.
- ❑ DC captures VL stickers from patient folder in order to do bulk capturing when results come back.
- ❑ Every Friday, quality improvement (QI) team cross references the list of blood results on eLabs with those captured in TIER.Net.

FACILITATORS

- Appointed a VL Champion to facilitate the process.
- Allocated responsibilities to different team members.
- Gained willingness and buy-in from the facility team.
- Operational Manager audited files weekly.

CHALLENGES & ADAPTATIONS

- Consultation of patients without patients' records → Patient files were retrieved for every consultation.
- Outdated patient information made it difficult to track and trace → Patient information was updated in HPRS and folder at every visit.
- Low patient adherence → Patients were counselled by the team.
- Long wait times → Appointment system and decanting were improved.
- Unavailability of the Phlebotomist to fast-track blood samples.

ABBREVIATIONS

- ✓ ART – antiretroviral therapy
- ✓ DC – data capturer
- ✓ CO – case officer
- ✓ NC – nurse clinician
- ✓ QI – quality improvement
- ✓ VL – viral load

RESOURCES

- ✓ TIER.Net
- ✓ HPRS
- ✓ ELabs
- ✓ Patient Folders
- ✓ Specimen request forms and register

LESSONS LEARNED

- ✓ Teamwork has improved accountability and program ownership at All Saints Gateway Clinic following QI approach initiative.
- ✓ QI approach can be replicated by other facilities to enhance program efficiency.
- ✓ Updating patient demographics is important.
- ✓ Implementation of an effective appointment system improved resource allocation.

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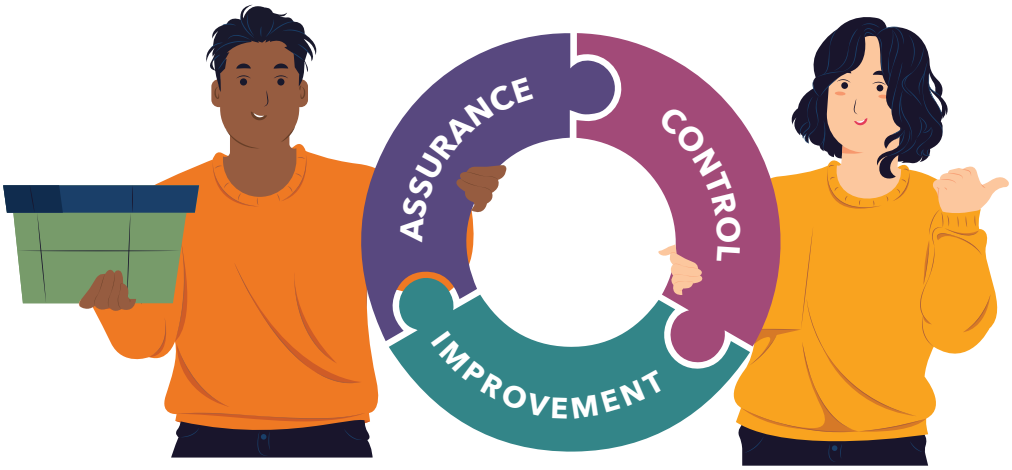
TEAMWORK



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