Healthcare Worker Orientation Package on the Differentiated Care Operational Guide

Facilitator's Manual

January 2017

Ministry of Health

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Introduction

i. Goal of the Orientation Package

To sensitize healthcare workers on the Differentiated Care Operational Guide so they can plan, implement, and evaluate differentiated HIV care in Kenya.

ii. Learning Objectives

By the end of the training, participants will be able to:

1. Define differentiated care
2. Describe the criteria for categorizing patients for differentiated care
3. Outline the differentiated packages for clients in different categories
4. Assess for and manage patients who change categories
5. Describe the models of ART distribution for stable patients
6. Coordinate and conduct health talks on ART distribution for stable patients
7. Chair community or facility-based ART group meetings
8. Complete the reporting tools for differentiated ART distribution
9. Describe the data flow processes for monitoring differentiated ART distribution
10. Develop a work plan for implementing differentiated care
11. Assess the quality of differentiated services being offered at a health facility

iii. Target Audience

This package is targeted towards healthcare workers, health facility leadership, and County and Sub-County Health Management Teams.

iv. Training Resource Materials

The training package for HCWs includes:

- PowerPoint slides to provide an overview of the Differentiated Care Operational Guide
- Facilitator's Manual, containing:
    - Cases, questions, and role-plays
    - Expected responses and key points to reinforce during discussions
- Participant's Workbook, containing:
    - Cases and questions
    - Role plays

This training package should be used in conjunction with the following related resource material:

- Differentiated Care Operational Guide (2017)
- Improving the Quality and Efficiency of Health Services in Kenya: A Practical Handbook for HIV Managers and Service Providers on Differentiated Care (2016)
- Guidelines on Use of Antiretroviral Drugs for Treating and Preventing HIV Infection in Kenya (2016)
- Differentiated Care IEC Material (2017)

All of this material should be available to use during the training, including additional copies of the reporting tools to use during the practical exercises.

v. Methodology

This orientation package is case-based (with just a brief introductory PowerPoint presentation) and thus intended to be interactive through facility-based case discussions, case studies, role-plays, and practical exercises. Participants should receive the Participant's Workbook, which contains cases and questions. Facilitators will lead case discussions from the orientation package. The material is intended to take one day to cover completely, and should be included as an extra day as part of the 2016 ARV Guidelines orientation when possible. The material can also be delivered through several facility-based Continuous Medical Education sessions.

vi. Instructions to Facilitators

- All participants must complete the entire orientation package
- Participant's Workbooks should be distributed in advance along with hardcopies of the Differentiated Care Operational Guide (2017), so participants can work through the cases before the face-to-face sessions with facilitators
- It is expected that participants should take about 5-15 minutes per case and cover all cases in the package
- During group discussions, facilitators should give ample time for participants to respond to cases and ask for clarification on anything they read in advance
- Facilitators should refer participants to the relevant tables, figures, and sections of the Differentiated Care Operational Guide and other resource documents for each case, encouraging them to open their own copies of the Operational Guide to respond to the questions in the Participant's Workbook
- At the end of each case discussion, facilitators should summarize the responses and emphasize key recommendations using the notes in the Facilitator's Manual
- Each case has many possible discussion points so it is easy for the discussions to go in many directions. The facilitator must keep the group focused on the learning objectives and the key learning points listed in the Facilitator's Manual. Remember, this package is meant to orient healthcare workers on key issues

vii. Sample Training Time Table

Time	Session	Facilitator
8:00-8:30	Arrivals and Registration	
8:30-9:00	• Introductions • Climate Setting • Review of Training Table	
9:00-10:00	Part 1: Introduction to the Differentiated Care Operational Guide (ppt)	
10:00-10:30	Tea Break	
10:30-12:30	Part 2: Case Discussions	
12:30-1:00	Part 3: Case Study	
1:00-2:00	Lunch Break	
2:00-3:30	Part 4: Role-Plays	
3:30-4:15	Part 5: Work Plan Development	
4:15-4:30	Tea Break and Departure	

Part 1: PowerPoint Presentation

After introductions, climate setting, and review of the training timetable, conduct the PowerPoint Presentation (file name: *HCW DC Training Slides*). You do not need to go into detail about each point in the slides, since this is meant to be a brief overview that will be expanded on during the group work.

Allow brief discussion/questions, but remind participants that they will have an opportunity to get into the detailed content during the case discussions, case study, role-plays, and practical exercises.

Group Work

After the PowerPoint presentation, divide the class into groups of 5-7 participants. The groups will work through the Participant's Workbook (with a trained facilitator in each group) for the rest of the day, until the work-planning session at the end of the day.

Note: If the participants have just completed the 3-day training on Guidelines Orientation there will be some overlap with a few of the cases/questions; these can still be reviewed quickly in the order presented in the Differentiated Care workbook to reinforce the key learning points.

Part 2: Case Discussions

Each facilitator can lead the group through the following case discussions, keeping the group focused on the key learning points (as per the answers in this facilitators manual), and keeping them moving forward as per the timetable.

Case 1 (Patient Who Presents Well)

Maria is a 26-year-old lady who was diagnosed with HIV an hour ago and brought to the CCC by a patient escort. Her HIV status is confirmed and she is fast-tracked for enrollment. She has no complaints, her LMP was 2 weeks ago and her physical examination is normal. She undergoes treatment preparation counseling and the ART Readiness Assessment, but she requests to return after 1 week for ART initiation. Laboratory samples are drawn and she is booked for a 1-week follow-up appointment.

A week later she returns to clinic as scheduled. Her CD4 count is 728 cells/mm^3 and the other laboratory parameters are normal. She has identified a treatment buddy and feels ready to start ART.

Question 1: Which differentiated care category would you classify Maria in, and why?

Refer to the Differentiated Care Operational Guide, Table 2 (Differentiated Care Based on Initial Patient Presentation)

Expected Response

Maria should be categorized as "Well", because she meets the following criteria:

- New/recent enrolment, less than 12 months on current ARV regimen (so doesn't qualify as stable yet)
- WHO stage 1 **and** CD4 > 200 (so not advanced disease)

Question 2: Describe your differentiated approach to managing Maria

Refer to the Differentiated Care Operational Guide, Table 2 (Differentiated Care Based on Initial Patient Presentation)

Expected Response:

· Package of Care:
- Standard package of care

· Location of Services:
- Any ART service delivery point

· Focus of Treatment Preparation Counselling:
- ART is the most important treatment to maintain good health
- Starting ART soon will decrease the risk of developing wasting and illness

· Frequency of Follow-up:
- Weekly until ART initiation, then at week 2 and 4 after ART initiation, then monthly until confirmed viral suppression
- Additional visits as needed for medical/psychosocial reasons

Case 2 (Patient Presents with Advanced Disease)

Andrew is a 34-year-old banker. He was diagnosed with pulmonary TB 3 weeks ago and is on anti-TBs, but had refused HIV testing until now. Upon testing he is positive (on all 4 of the RTKs before enrollment, as per the new HTS algorithm). He undergoes treatment preparation counseling and the ART Readiness Assessment. Laboratory samples are drawn for baseline investigations. He is initiated on standard 1st line ART (TDF/3TC/EFV) on the same day, and returns in 1 week for follow-up and review of laboratory results. His CD4 count is 450 cells/mm^3, and he has a microcytic hypochromic anaemia (Hb of 8.3 g/dl).

Question 1: Which differentiated care category would you classify Andrew in, and why?

Refer to the Differentiated Care Operational Guide, Table 2 (Differentiated Care Based on Initial Patient Presentation)

Expected Response

Andrew should be categorized as "Advanced Disease", because:

- New/recent enrolment, less than 12 months on current ARV regimen (so doesn't qualify as stable/unstable yet)
- WHO stage 3 (because of pTB)

- For a patient to be classified as Advanced Disease, they either need to meet CD4 criteria **or** WHO staging criteria. Andrew meets CD4 criteria for "well", but since his WHO stage is 3 he is considered to have advanced disease

Question 2: Describe your differentiated approach to managing Andrew

Refer to the Differentiated Care Operational Guide, Table 2 (Differentiated Care Based on Initial Patient Presentation)

Expected Response:

Package of Care:

-Standard package of care
-Management of presenting illnesses (including his anaemia)
-Priority for identification/management of OIs
-Priority of ART initiation
-Close monitoring for IRIS

· Location of Services:

-Any ART service delivery point but more likely to require consultations/referral to stabilize

· Focus of Treatment Preparation Counselling:

-ART is required to prevent further damage to the immune system
-Starting ART soon will decrease the risk of disease progression
-ART is the most important treatment to restore health

· Frequency of Follow-up:

-Weekly until ART initiation, then at week 2 and 4 after ART initiation, then monthly until confirmed viral suppression
-Additional visits as needed for medical/psychosocial reasons

Case 2, continued (Patient with Advanced Disease Who Becomes Stable)

Andrew has now been on ART for 3 years. He completed TB treatment, was asymptomatic and went on to complete 6 months of IPT. He has come to the CCC for routine follow up. He does not have any complaint today and reports that he has been adherent to his medication. His BMI is 23 kg/m^2. He has not missed any clinic appointment in the past 12 months. Physical examination is unremarkable. Andrew's latest viral load test done 2 months ago was < 1,000 copies/mL.

Question 3: Which differentiated care category would you classify Andrew in, and why?

Refer to the Differentiated Care Operational Guide, Table 3 (Differentiated Follow-up of Patients Beyond the First Year in Care)

Expected Response
Andrew should now be categorized as "Stable", because he meets **all** of the following criteria:

- On his current ART regimen for ≥ 12 months
- No active OIs (including TB) in the past 6 months
- Adherent to scheduled clinic visits for the past 6 months
- Most recent VL < 1,000 copies/mL
- Has completed 6 months of IPT
- Non-pregnant/not breastfeeding
- BMI ≥ 18.5
- Age ≥ 20 years
- Healthcare team does not have concerns about providing longer follow-up intervals for the patient (such as mental illness, alcohol or substance abuse, unstable comorbid conditions, inadequate support systems)

Question 2: What is the recommended appointment frequency for Andrew?

Refer to the Differentiated Care Operational Guide, Table 3 (Differentiated Follow-up of Patients Beyond the First Year in Care)

Expected Response
Andrew should be given longer intervals (3-6 months) between facility-based clinical visits with additional visits as required to address any emerging medical or psychosocial concerns. His ART should only be dispensed for up to 3 months at a time, with a prescription refill provided through a fast-tracked process between clinical visits (either at the facility or through community-based ART distribution)

Question 3: Regarding stable patients, how would you go about dispensing and distributing ART between the facility-based clinical evaluation appointments, under the following settings?

a) Facility-based ART refill distribution

Refer to the Differentiated Care Operations Guide, Section 2.4.1 (Facility-based Fast Track System for ART Refills) and to the ART Guidelines (2016) Table 3.7 (Facility-based ART refill distribution for stable patients)

Expected Response

- Fast-tracked process to minimize patient waiting times, preferably with medications pre-packed and patient-labeled in advance (using the Appointment Diary for ART Refills to determine which patients are expected)
- The ART Distribution Form (which includes a review for "danger signs") should be completed and signed for each patient before giving the patient their ART, and if there are any danger signs the patient should be referred for clinical evaluation
- If any patient misses their ART refill (using the Appointment Diary for ART Refills) they should be entered into the facility's missed appointments/defaulter register for tracing, and no longer meet criteria as "stable"
- Each facility must clearly define its fast track process and communicate this to staff and patients; the process should be reviewed quarterly for quality (waiting times, patient satisfaction, compliance to criteria (follow-up intervals; unstable patients are not fast-tracked), etc.)
- The fast-track refill pick-up may operate during normal hours as well as on designated out-of-hours times/days (e.g. early mornings, weekends)
- If the patient has any concerns they should be encouraged to call the facility or come for an unscheduled visit

b) Community-based ART refill distribution

Refer to the Differentiated Care Operations Guide, Sections 2.4.2-2.4.4 and to the ART Guidelines (2016) Table 3.8 (Community-based ART refill distribution for stable patients)

Expected Response

- Patient must voluntarily enroll into any community-based refill distribution program
- Community-based ART distribution models include: Community ART Groups (CAGs, which can be peer-led or HCW-led); Community ART Distribution Points, and; Individual Patient ART Distribution in the Community
- ART can be distributed every 1-3 months between the biannual clinical review appointments at the health facility; the ART may be picked up from the health facility and distributed by a HCW or lay health worker (including CAG members)
- The ART Distribution Form (which includes a review for "danger signs") should be completed and signed for each patient before giving the patient their ART,

and if there are any danger signs the patient should be referred for clinical evaluation
- If any patient misses their ART refill (using the Appointment Diary for ART Refills) they should be entered into the facility's missed appointments/defaulter register for tracing, and no longer meet criteria as "stable"
- If patient has any concerns they should be encouraged to call the facility or come for an unscheduled visit
- A system for communication between the distributor and facility must be clearly defined (e.g. reporting any problems identified during distribution, failure to deliver the ART, etc.)

Question 4: What documentation is essential during facility and/or community-based ART distribution to stable patients?

Refer to the Differentiated Care Operations Guide, Section 3.2 (Monitoring and Evaluation Tools) and Annexes 7, 8, 9,

Expected Response
- ART Dispensing Tool (current FCDRR)
- Appointment Diary for ART Refills (which can be a modification of the standard appointment diary, as described in Annex 8 of the Operational Guide)
- ART Refill Register (Annex 9)
- ART Distribution Form (Annex 7)
- HIV Care and Treatment Daily Activity Register (current tool already in use) (Annex 11)
- Differentiated Care Facility Aggregation Form (Annex 12)

Case 2, continued (Stable Patient Who Becomes Unstable)

Andrew has been receiving ART through a fast-tracked process at the facility. He comes to the clinic to pick up his drugs at the pharmacy, and is noted to be 10 days late for his drug pick-up.

Question 5: Complete the ART Distribution Form for Andrew, and outline your next step.

Expected Response
- ART Distribution Form should be completed with the following points in mind:
  -Show that Andrew has missed doses of his ART
  -Specify how many doses he has missed
  -Note that he has been referred to the clinic
  -Specify the date he should be seen by the clinician (preferably same day)

- Andrew has missed doses of ARVs so, as per the ART Distribution Form, should be referred to the clinician for further evaluation
- Show participants the instructions on the form: action to take if any symptoms
- Remind participants that if a patient does not meet any of the criteria for "stable" then they should move to "unstable" management

Question 6: Complete the ART Refill Register and Appointment Diary for ART Refills using the information available for Andrew.

Expected Response

- Lead participants through a practical exercise completing the Differentiated Care tools

Question 7: Describe your differentiated approach to managing Andrew now

Refer to the Differentiated Care Operational Guide, Table 3 (Differentiated Follow-up of Patients Beyond the First Year in Care)

Expected Response:

Andrew is no longer "stable", so should be reclassified as "unstable" and managed as per that patient category, including:

· Package of Care:
  -Standard package of care
  -Case management to address the reason he is no longer "stable"

· Location of Services:
  -Any ART service delivery point, with consultation/referral as needed

· Focus of Treatment Preparation Counselling:
  -ART is the most important treatment to improve health
  -Targeted counseling to address the reason/s he is no longer "stable"

· Frequency of Follow-up:
  -Every 1-3 months, based on clinical judgment and specific reason for not being "stable"
  -Additional visits as needed for medical/psychosocial reasons

Part 3: Case Study

Staying in the same groups, go through a case study of how a facility has implemented differentiated care:

Refer to *"Improving the Quality and Efficiency of Health Services in Kenya: A Practical Handbook for HIV Managers and Service Providers on Differentiated Care, 2016"*.

Read Example 14, on page 66.

Question 1: What was the stated problem at Homa Bay County Referral Hospital? Did the intervention in Homa Bay County Referral Hospital address the problem?

Expected Response

- The stated problem was workload greater than staffing capacity
- The data presented does not mention how workload changed as a result of the intervention so we cannot be clear it addressed the problem, but based on the uptake of the intervention (almost ¼ of patients enrolled into the fast-track program) there was probably a reduction in workload

Question 2: Based on the preliminary results presented, do you think this intervention improved patient outcomes (such as retention in care, mortality, or viral suppression)?

Expected Response

- We cannot assess whether patient outcomes improved because no data from a comparison group was presented
- If these patients qualified as "stable" upon entry (meaning virally suppressed and not missing appointments) we would expect better retention than 86% at 6 months

Question 3: How else could you evaluate outcomes for this intervention using routine program data?

Expected Response

- Comparison between "stable" patients in mainstream care and "stable" patients in fast-tracked care
- Use additional indicators from KHQIF (viral suppression; retention; mortality)

Question 4: What strategies could you use to improve outcomes for this intervention?

Expected Response

- Health talks (using standardized IEC materials) to increase patient awareness
- Appointment reminders before drug refill pick-up and before clinical evaluation appointments (phone calls, SMS reminder system, home visits, etc.)
- Integrate an SMS reminder system into the program so reminders are sent automatically
- Orientation/training of all HCWs to improve buy-in
- Utilization of patient feedback systems, such as a suggestion box, patient satisfactions surveys, and community dialogue initiatives

Question 5: What systems should be in place to ensure ongoing assessment is performed and action is taken on any gaps to address quality of care? What is your role in ensuring continuous quality improvement?

Expected Response

- Work-improvement team (can be the MDT) using KHQIF indicators, but disaggregate between service delivery models (fast-track vs mainstream care, comparing patients in both groups who qualify as "stable")
- QI team should be in place to ensure KHQIF in being implemented

- *Encourage participants to discuss their individual role/s in CQI*

Part 4: Role Plays

The next part of the training is role-plays. Participants can remain in their current groups (or if the groups have 6 or more participants the groups can be divided in half).

Role-Play 1: Health Talks

In this role-play, each training participant will have the opportunity to use the Differentiated Care IEC Material to give a health talk focusing on stable patient management (how patients can qualify as stable, and what privileges and expectations come with being stable).

One training participant will play the role of the HCW giving the health talk, and the other training participants will play the role of being patients (listening to the health talk). After each practice health talk, the audience can give feedback, then the group rotates so a different participant practices giving the health talk.

- Provide the group with the IEC material for Stable Patient Management
- Each participant should be given 5 minutes to practice giving a health talk using the IEC material in front of their group members
- The scenario can be changed for each health talk practice, e.g.:
    - In the waiting bay
    - For a support group of "stable" patients already in differentiated care
    - At a Drop-In Centre for Female Sex Workers
    - At the pharmacy while dispensing ART
    - At the antenatal clinic
    - During a one-on-one encounter with an unstable patient
    - etc. (customize based on scenarios that are applicable for the individual participants' work settings)
- A timekeeper should give a 1-minute warning once the presenter has reached 4 minutes
- If the presenter takes longer than 5 minutes they should be cut off in order to receive feedback and move to the next participant
- After each practice health talk, the group members can be given 5 minutes to provide feedback:
    - How was the speed and organization of the presentation?
    - How was their voice projection?
    - Did they use the IEC material well?
    - Did they use simple language?
    - Was the material adapted to the target audience?
- All participants should be given an opportunity to practice leading a health talk

Role-Play 2: Chairing a Support Group Meeting

In this role-play, each training participant will have the opportunity to use the IEC material for Community ART Group (CAG) Standing Agenda to practice chairing a HCW-led CAG meeting (which could use a community meeting point or could meet at the health facility).

One training participant will play the role of the HCW chairing the meeting, and the other training participants will play the role of CAG members (attending the meeting). Training participants will provide feedback and rotate so they all have an opportunity to practice chairing the CAG meeting.

- Remind participants that they will be practicing chairing a Community ART Group (i.e. a support group comprised of "stable" patients who are receiving ART distributed in the community)
- Provide the group with the IEC material for Community ART Group Standing Agenda
- Each participant should be given 5 minutes to practice a specific scenario for chairing a support group meeting, then rotate to the next participant to lead the next scenario of a support group meeting
- The other participants will also need to take on roles as active support group members, and try to act out the scenario as realistically as possible to give the chair practice
- The scenarios of a support group meeting that should be covered include:
    - First Meeting (New CAG): Setting the ground rules
    - First Meeting (New CAG): Leading self-introductions
    - First Meeting (New CAG): Reviewing member expectations/motivation for joining
    - First Meeting (New CAG): Review a specific component of CAG operations
    - Follow-up Meeting: Leading group member updates since last meeting
    - Follow-up Meeting: Problem solving with group on follow-up plan for any members who did not attend the meeting
- If the chair takes longer than 5 minutes they should be cut off in order to receive feedback and move to the next participant
- All participants should be given an opportunity to practice chairing a support group meeting

Part 5: Work Plan Development

The last session of the training is for facilities to develop a work plan for implementation of differentiated care.

- Divide the participants into groups based on facility/county (may not be the same groups as the during the case discussions and role-plays)
- Provide each group with the work plan template (preferably soft-copy if each group has a laptop)
- Briefly explain each column in the template
- Encourage groups to focus on implementation of facility-based fast-track care for stable patients
- Remind them of the need to include the Facility/County Readiness Self-Assessments (Sections 1.1.1-1.1.2 of the Differentiated Care Operational Guide) as one of the first steps in the work plan
- Allow 30 min for group work, with a facilitator per group assisting them
- At the end of the 30 min, choose 1 group to present their progress (preferably choose the group with the best draft work plan, as an example for the other groups)
- Allow plenary discussion so other groups can highlight what might be different or unique about their implementation strategy
- The facilitators should take a copy of the work plan and send to the SCASCO/CASCO for follow-up