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Improving Utilization of Routine Viral Load Data: A Quality Improvement Collaborative in Western Kenya

Dr. Maureen Syowai
Regional Technical Advisor, ICAP Kenya
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Improving HIV Services for People on ART with Unsuppressed Viral Load

- People on ART with unsuppressed VL are at high risk of disease progression
- Swift identification and management is critical
- Because routine VL monitoring is relatively new, the emphasis has been on scale-up and coverage
- Systems to foster effective utilization of VL results have not yet been optimized
Routine VL Monitoring in Kenya

• Kenya launched routine VL monitoring in 2014
• A network of 9 labs provides services to 2000 health facilities – approximately 1.6M viral load tests are targeted for FY18
• **Coverage** is expanding rapidly, but **utilization** of tests remains a challenge
• National guidelines recommend
  – Swift identification of people w/ unsuppressed VL
  – Provision of three enhanced adherence counseling sessions, first within one month of VL test
  – Repeat VL within three months
  – Action on results!
• Siaya County performed 9,132 VL tests on specimens from 133 sites
• 2,811 tests (31%) had > 1,000 copies/mL
Utilization of VL Results

• With support from NASCOP, CDC and HRSA, ICAP conducted a rapid baseline assessment at 30 high-volume sites in Siaya County

• Used NASCOP VL website to identify all patients with routine VL test (October 2015 – October 2016)

• Reviewed registers and patient files for patients with unsuppressed VL (> 1,000 copies/mL)

• Data are still preliminary
Key Findings from Baseline Assessment

• Only 50% of patients with unsuppressed VL received even one enhanced adherence counseling session
• Only 35% had a repeat VL
  – Systems and strategies to identify and prioritize patients with unsuppressed VL are inadequate
  – There are important missed opportunities to provide recommended interventions
• There is a “know-do” gap that is likely amenable to quality improvement methodology
ICAP’s Quality Improvement Approach

ICAP builds the capacity of partner countries to improve the effectiveness, efficiency, safety, accessibility and equity of health services by supporting quality improvement (QI) programs, with an emphasis on the QI collaborative methodology and the Model for Improvement.

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The QI Collaborative Approach
Adapted from IHI Breakthrough Series

Select Improvement Aim
- Convene expert meeting
- Identify best practices
- Develop aim statement, Indicators, data SOPs

Select/prepare sites

Learning Session 1
- Action Period 1
- PLAN
- ACT
- DO
- STUDY

Learning Session 2
- Action Period 2
- PLAN
- ACT
- DO
- STUDY

Learning Session 3
- Action Period 3
- PLAN
- ACT
- DO
- STUDY

Learning Session 4

Scale up and spread
- “Harvest” of successful interventions, tools, resources
VL Utilization Collaborative

• Launched in Q1 2017
• QI teams at each of the sites are working to achieve the same goals:
  – To increase the proportion of clients with high VL who receive 3 EAC within four months from 18% to 90% by February 2018
  – To increase the proportion of clients with repeated high VL who are switched to 2\textsuperscript{nd} line ART within four months from 36% to 90% by February 2018
30 High-Volume Facilities in Siaya County
VL Utilization Collaborative

Early change ideas being tested:

- Piloting a longitudinal tracking register for clients with high VL
- Designating a VL focal person to download and file VL results from the NASCOP website
- Developing SOPs for filing VL results and notifying providers
- Storing files of clients w/high VL separately from those of other clients
- Recalling clients for timely interventions
- Special clinics for clients with high VL
- Appointment of case managers/adherence support systems
- Convening weekly multidisciplinary team meetings
Early Data are Promising, but the QIC is Just Starting...
Conclusions

Based on early results and prior experience with QI Collaboratives, we hope this approach will:

• Improve the QI skills of facility-level teams
• Identify systems and strategies to improve utilization of VL results towards attaining the “third 90” and contributing to epidemic control
• Generate feasible, practical strategies that can be taken to scale
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• NASCOP
• CDC / PEPFAR
• The staff and clients of the 30 participating health facilities