Program Quality and Efficiency in DC Implementation

Maureen A. Inimah, MPH
QI Coordinator NASCOP
25th June 2019

ICAP
Empowering Health
Columbia University
Mailman School of Public Health

HIV LEARNING NETWORK
The CQUIN Project for Differentiated Service Delivery

Outline

- Background
- Progress
- Tested changes
- Results
- Lessons learnt

Background

- Differentiated care approach first introduced in the guidelines in 2016

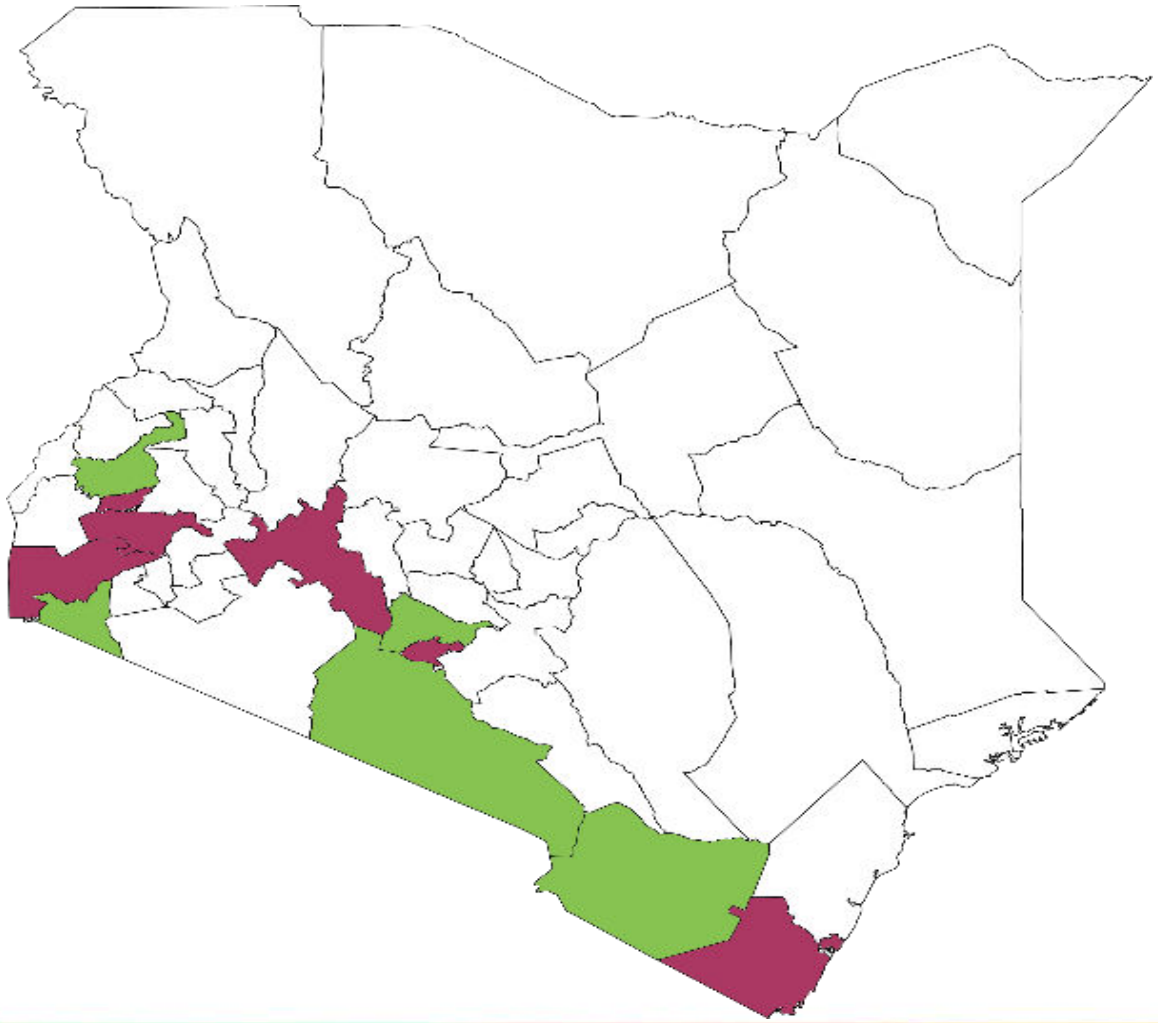
- DC toolkit developed in 2017 to facilitate implementation
  - (ART guidelines, Differentiated Care Operational Guide, Practical Handbook on DC)

- **Gap:** indicators, measurement, and structured continuous improvement within DC were limited

Background cont…

- **Opportunity:** Use of data to identify practices that result in the best outcomes for differentiated care
- **Plan:** Program Quality and Efficiency Initiative in DC implementation introduced in June 2017
- A technical support unit was established within NASCOP
- **Goal:** To produce evidence that differentiated care can lead to efficiencies when implemented in a quality improvement environment

Program Quality and Efficiency in DC Implementation



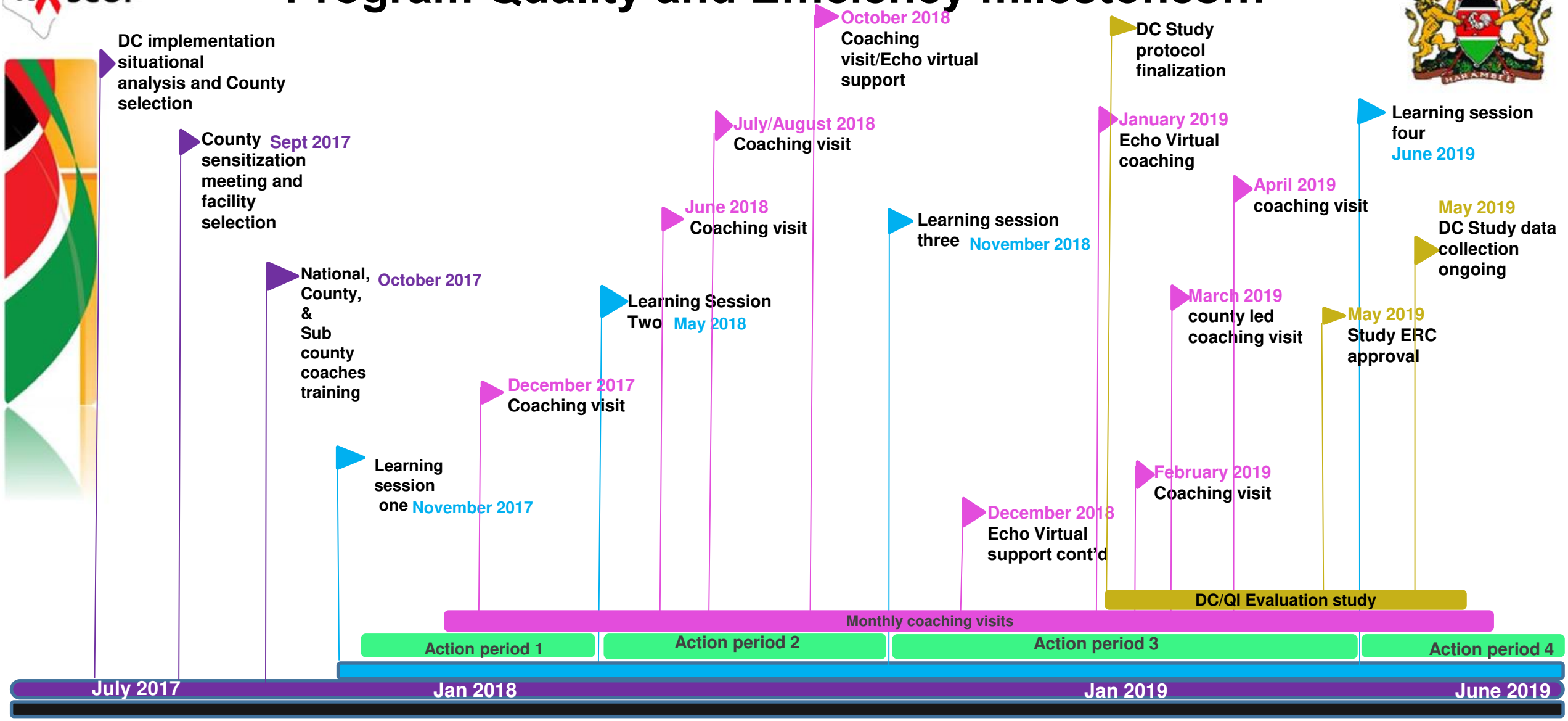
Intervention Counties: Homa Bay, Mombasa, Kwale, Vihiga, Kisumu, Nakuru, Nairobi

Control Counties: Migori, Kakamega, Kiambu, Taita Taveta, Kajiado

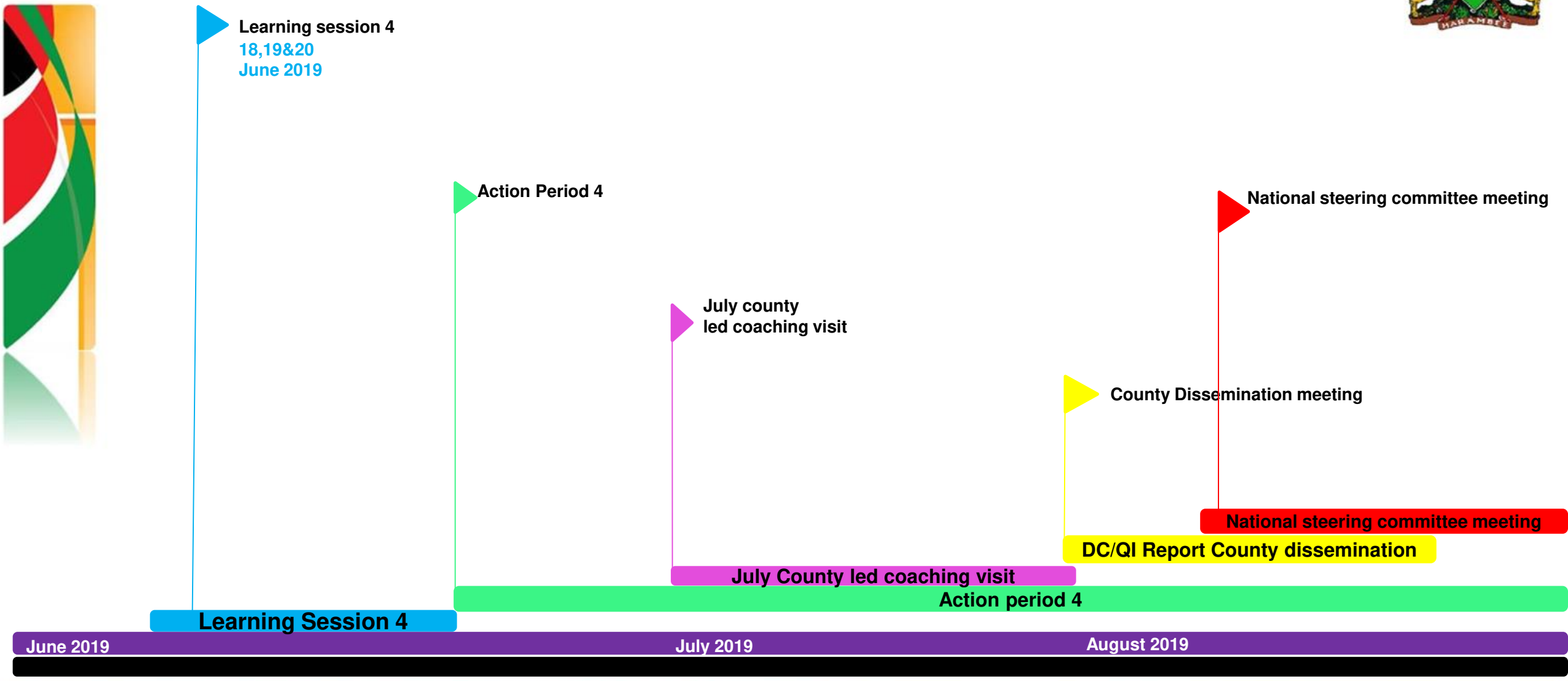
Cost evaluation of QI

- Time Driven Activity Based Costing study (TDABC study) - To demonstrate Program Quality and Efficiency.
- **Work packages:**
  - Processes of care and program efficiency
  - Costing: Estimating the patient and provider costs of care
  - Patient health outcomes and satisfaction
- **Study progress status:**
  - Data collection ending **25th June 2019.**
  - Data analysis and results to be shared in **August 2019**

Program Quality and Efficiency milestones…



Planned activities



Tested changes

QI projects	Facilities testing change idea	Summary of change ideas
Categorization process	**(28%) 18/70**	• Clinical prompts eg. flagging of files for patients due for categorization using colored stickers; inserting categorization checklists in patients files; • Establishment of viraemic clinics; Appointing of focal persons to support VL process; Listing of patients due for VL; Line listing and contact tracing of defaulters; • Call reminders for missed appointments; • EMR set up for categorization; clinical mentorship on categorization; • Prompt VL uptake to complete stable/unstable categorization process; • CME for health workers to address knowledge gap; • Centralized booking of clients; • Whole blood sample collection for VL testing;
VL uptake process	**20% (13/70)**	• SMS reminders prior to appointment; • shorter clinic appointments; • Introduction of tracking log for results received; • Appointment of a VL focal person; • Linelisting of patients due for VL; • Decentralization of VL sample collection to the CCC; • synchronizing appointment dates; • Sample networking • Increased sample collection days and hours

Tested changes

QI projects	Facilities testing change idea	Summary of change ideas
VL Suppression	**12% (8/70)**	• Enhanced Adherence counselling; • Establishment of viraemia clinics; • issuing shorter client appointments; • Conducting literacy classes; case management; • linelisting of patients eligible for VL; contacting eligible clients for VL; Enhanced file identification systems eg color coding; color coding of files for patients due for VL testing;
Linkage to care process	**6% (4/70)**	• Appointment of Linkage officer; • use of referral forms at testing points to enrollment points • Phone calls at testing points to confirm enrollment;
HIV positivity	**3% (2/70)**	• PNS; testing during hospital visiting hours; Targeted out of facility testing; Strengthened index client contact testing;
Case identification	**5% (3/70)**	• Line listing of eligible HIV exposed Infants for testing as per the guidelines and linking them to HTS officer for routine testing;
Retention	**17% (11/70)**	• Use of community support groups; sms and phone call reminders; Enhanced adherence counselling sessions; Use of appointment diary to identify missed appointments; Reduced waiting time during clinic days; Updating patients contact information during clinical visit; ART Literacy classes; Enhanced adherence counselling; Use of mentor mothers to escort clients; Enhanced defaulter tracing systems;
Adolescent Viral suppression	**3% (2/70)**	• Age specific appointment systems; Establishment of adolescent's specific support groups; Linkage of adolescents to school programs that support adherence; Pediatrics and adolescents clubs;
Pediatric Viral suppression	**2% (1/70)**	• Adolescents weekend clinics • Enhanced adherence counselling sessions • Line listing and contact tracing

CATEGORIZATION OF PATIENTS ON CARE & TREATMENT AT K2SCH

Diana Odock, Millicent Nyakowa, Mary Nzamalu, Everlyn Muthoni, Peter Gituthu, Ambrose Opere, Mary Muli, Susan Naliaka, Lydia Obiero, Rosemary Wanjiru, Phillomena Adhiambo

PLAN

Identification of opportunities and plan for improvement

Background information

Kayole ii is a level 2 hospital serving a population of 78002 overally with the ccc/Pmtct serving 1552 clients to date.
Currently the staff working at the ccc/Pmtct are 10 and serving 1552 clients as May 2019.
Our QI project is to improve categorization of clients and our WIT meet monthly to look at our progress.
The issues being addressed are poor categorization, unclear process for identifying eligible patients for VL uptake and poor patient retention at 12 months. This problems have resulted to increased workload and reduced quality of care in the clinic and enrollment into DSD models.

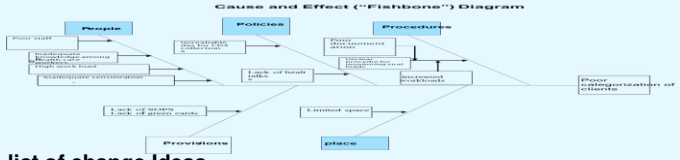
a) Problem statement

After baseline data collection and validation(June-Nov 2017 data),it was realized that the categorization process was poor hence the clinic could not establish different patient categories. It was also difficult to identify patients with different needs and the workload in the clinic was increased and hence implementation of DC was not well demonstrated

a) Aim statement

To improve categorization of patients from 0% to 90% from May 2018 to Dec 2018 in Kayole 2 sub county hospital.

3. Root cause analysis



A list of change Ideas

1. Develop check list
2. Develop file stickers
3. CME/sensitization
4. OJTs to all ccc staffs
5. Improvise line list tool for documentation
6. Improvise DC model log/Register

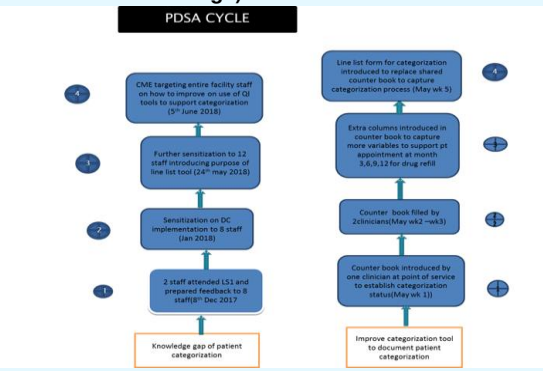
5. Tree and Matrix diagram

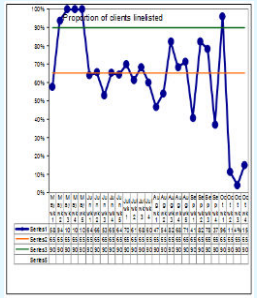
AIM	ROOT CAUSES	COUNTER MEASURES	FEASIBLE SCORES				
			Implementation	Ownership	Difficulty	Time	Resources
To improve patient categorization from 0% to 70% by Aug 2018.	Poor documentation on categorization	Develop checklist Develop file stickers	3	3	2	2	2
	Knowledge gap	On job training for all CCC staff	3	3	3	2	2
		CME's/ Sensitization	3	3	3	2	2
	Inability to task shift/defined JDs	Team work, task sharing and shifting	3	3	3	3	3
	Inadequate tools for documentation	Improvise tools for documentation Improvise DC Model log/ Register	3	3	3	3	2
	Staff attitude	CME's , OJT	3	3	2	2	2

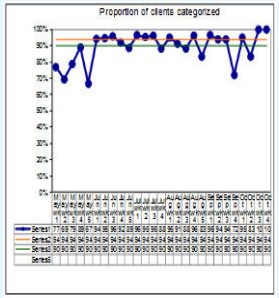
DO

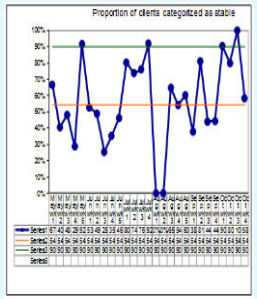
Test the theory for improvement

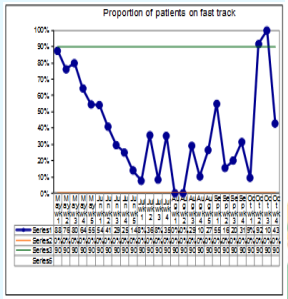
6. Test the Theory (Include small tests of change)







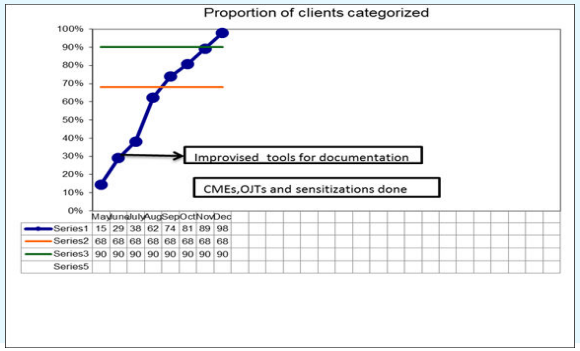




STUDY

Linking Outcomes to tested change

7. Linking outcomes to tested changes



ACT

standardize the improvement and establish future plans

8. Indicate whether change(s) were abandoned/adopted

Most of the change ideas implemented by the QI team had a positive impact in achieving the goal of the project, with evidence well demonstrated by use of process indicators and overall change seen from the outcome indicator. The lessons learnt through this project were informative and the team decided to adopt the change and sustain the concepts in future projects.

9. Recommendation

To capacity built all staff in our facility to adopt QI in implementing different projects in respective departments.

10. Acknowledgement

We take this opportunity to thank the CASCO Nairobi county, Dr Carol Ngunu, Nascop, Maureen Inimah and the entire team, SCASCO Embakasi West,Edwin Mwangi, County and Sub-county coaches, implementing partner (Afya jijini),kayole 2 staff and the QI team.

Preliminary Findings

The National program is currently collating findings from 70 sites to be presented at a later date.

Lessons Learnt

- DC implementation with QI Approach has supported strengthening the **entire health system** in the facilities
- Continuous mentorship of service providers and **treatment literacy for PLHIV of different DSD models** critical
- There is reluctance by some PLHIV to join DSD models due to stigma and fear of detachment from the health system.
- Integration of support supervision QI into existing logistic support for other programs.
- Involvement of stakeholders and leadership in QI implementation.
- Need for regular progress status updates with stakeholders

Thank you