The CQUIN Learning Network

The Science & Practice of Scale Up

eThekwini ART Resistance & VL Monitoring Project

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CAPRISA

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The Kingdom of Eswatini

CAPRISA
CENTRE FOR THE AIDS PROGRAMME OF RESEARCH IN SOUTH AFRICA

HIV LEARNING NETWORK
The CQUIN Project for Differentiated Service Delivery

The Science & Practice of SCALE-UP

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

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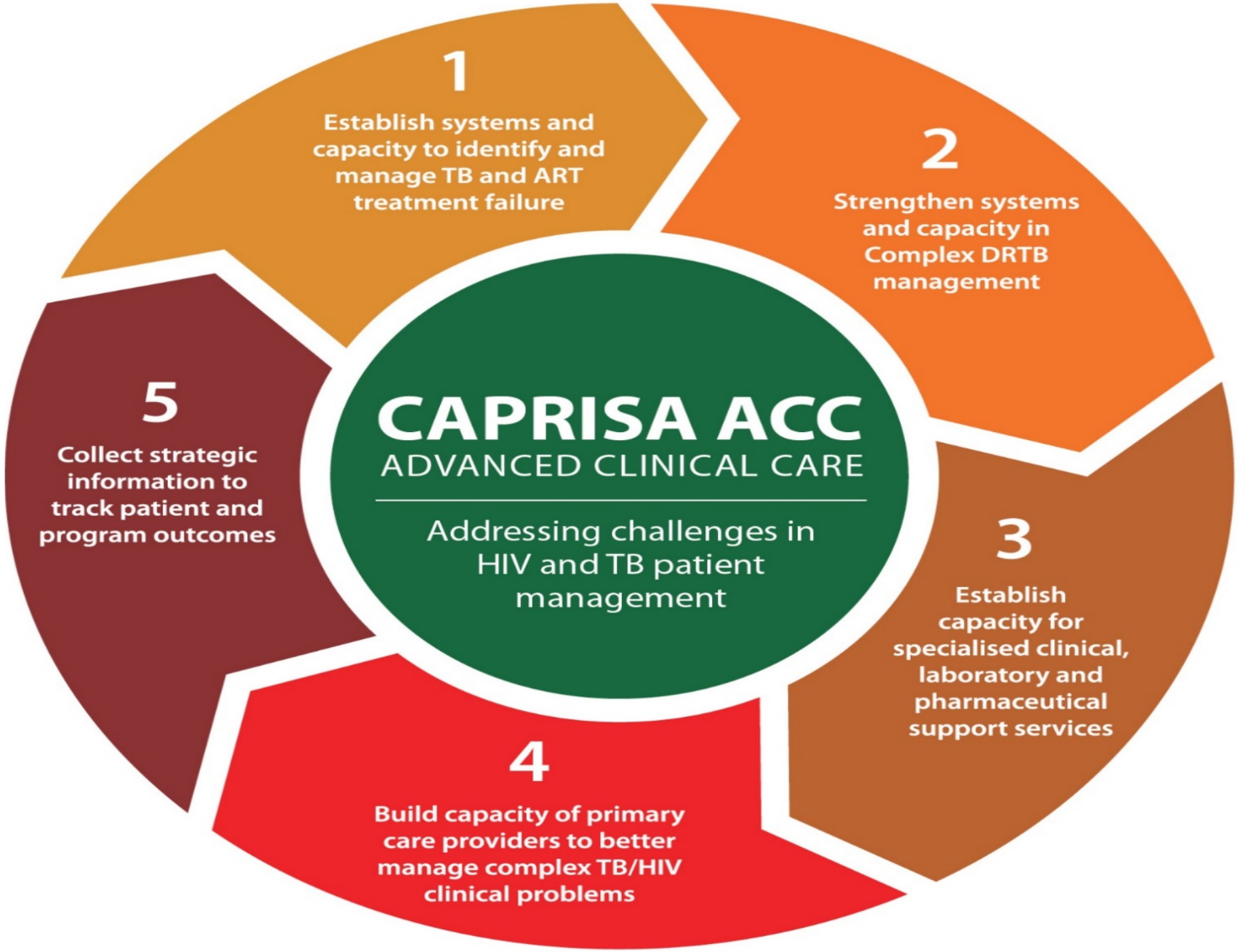
Empowering Health for 15 years ICAP
Columbia University Mailman School of Public Health

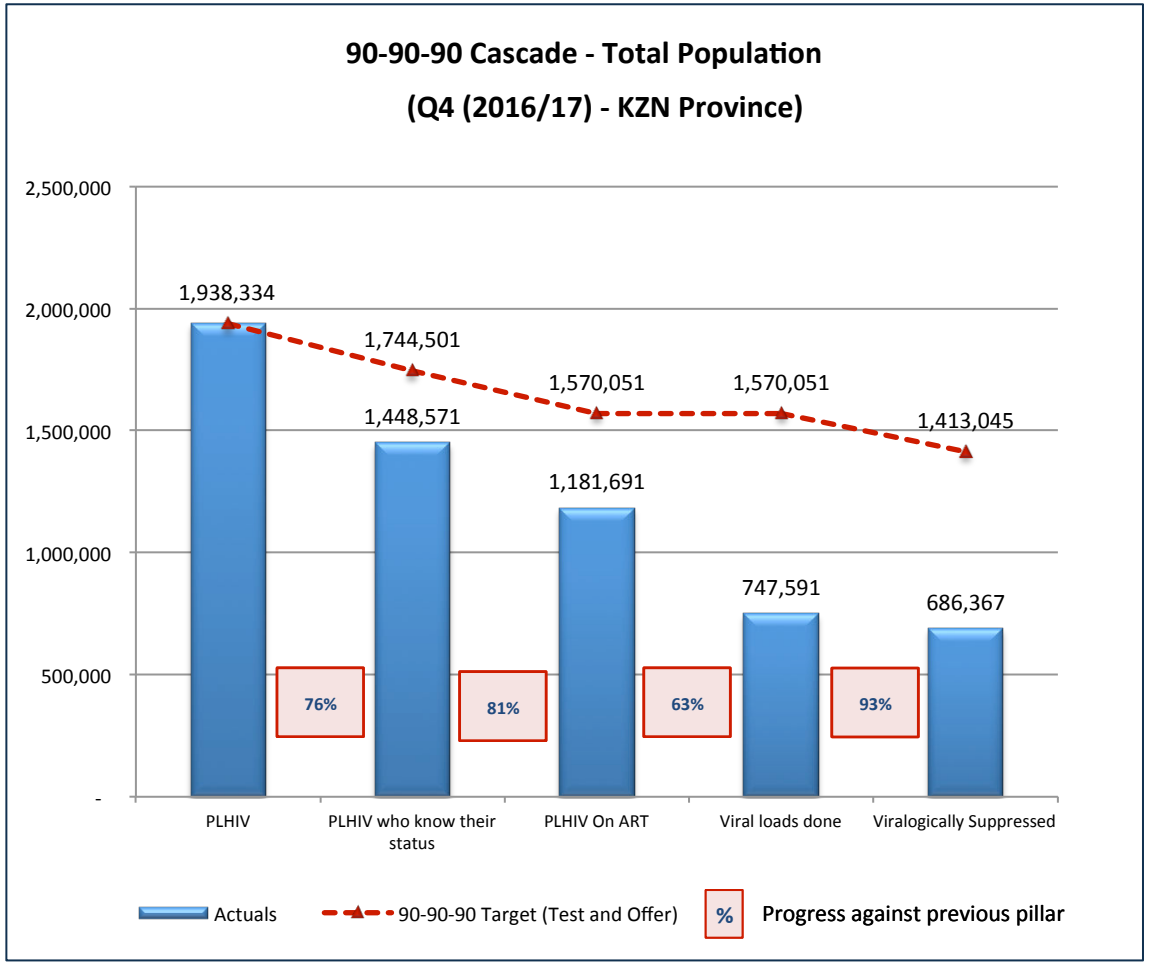
Presentation Outline

- Advanced Clinical Care (ACC) Program Overview
- Background
- Problem statement
- Intervention: Viral Priority Clinics
- 5 Step Plan
- Implementation of Viral Load Priority Clinic
- Performance 12 months post intervention
- Lessons Learnt and recommendations


1
Establish systems and capacity to identify and manage TB and ART treatment failure
2
Strengthen systems and capacity in Complex DRTB management
3
Establish capacity for specialised clinical, laboratory and pharmaceutical support services
4
Build capacity of primary care providers to better manage complex TB/HIV clinical problems
5
Collect strategic information to track patient and program outcomes
CAPRISA ACC
ADVANCED CLINICAL CARE
Addressing challenges in HIV and TB patient management

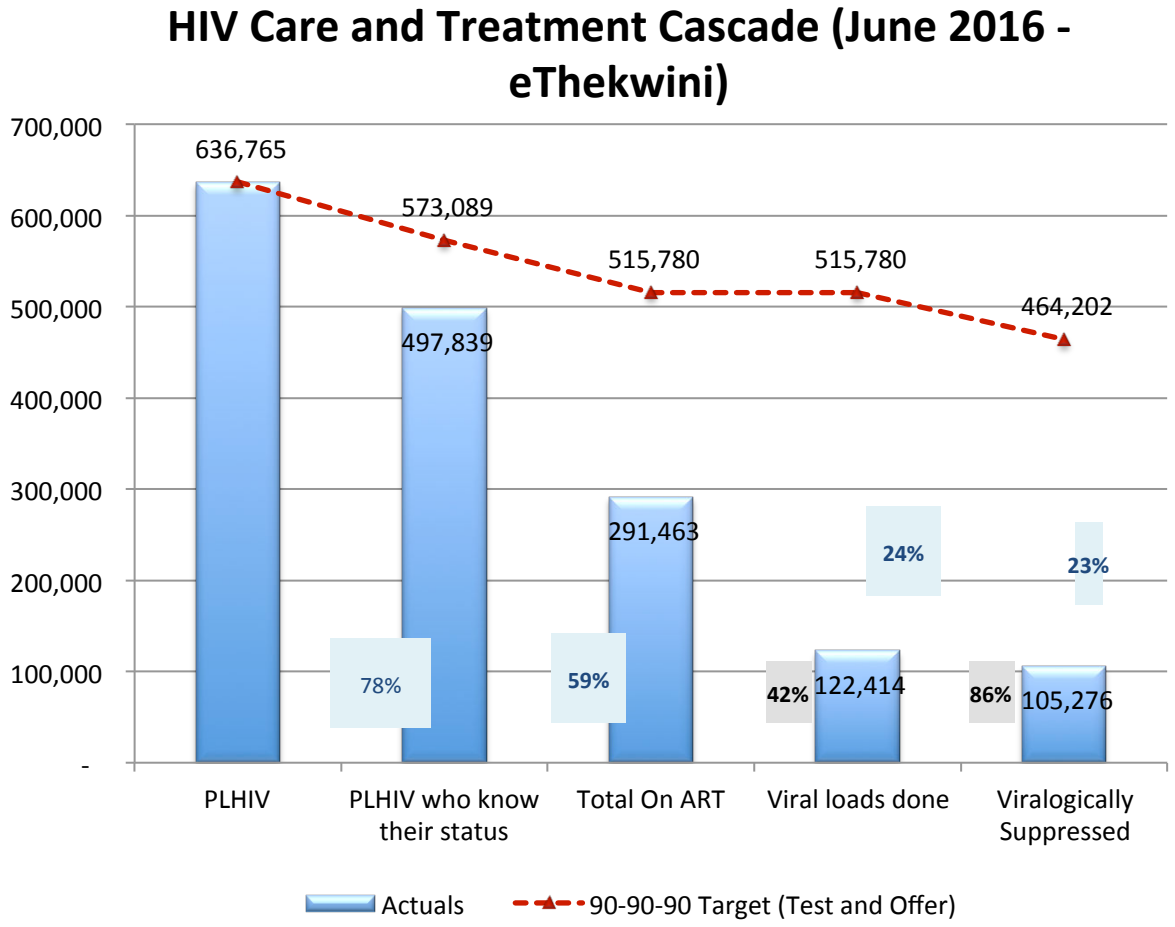
Background: ART Program in KZN

Total remaining on ART (KZN): 1 232 595
One third of ART patients in eThekwini
HIV positivity rate : 17%
TB /HIV co-infected on ART : 88.3%



Source: Ms Linda Dlamini , KZN HAST Manager , 28 May 2018

Poor VL Coverage
Poor identification of Virologic Failure with delayed switching to appropriate regimen

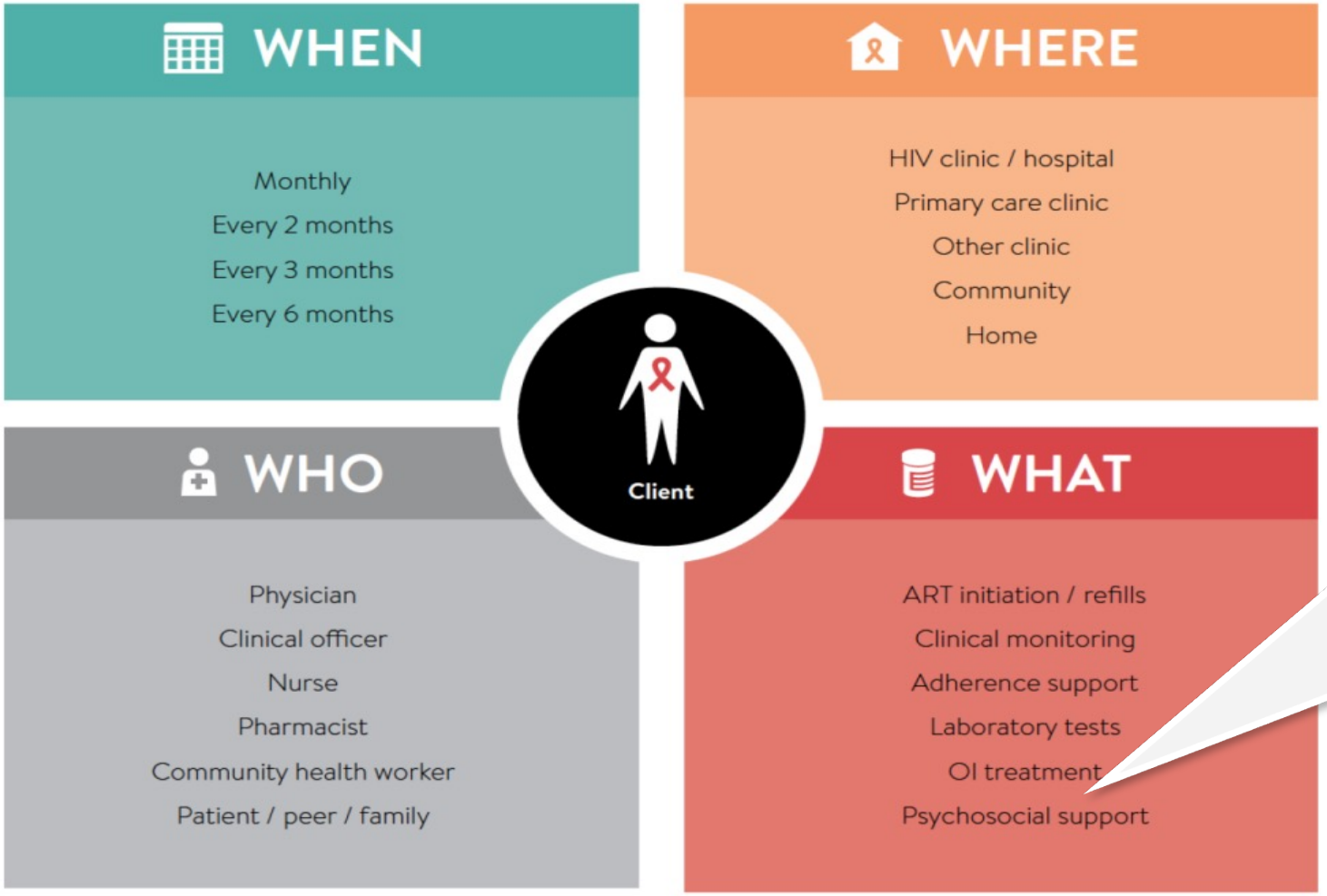


Source: Mr K. Naidu, MATCh Senior Program Manager, February 2017

Intervention-Viral Load Priority Clinics

- Initiative between **CAPRISA ACC**, **eThekwini District Management team** , **MatCH** (DSP), **UKZN REVAMP and UKZN Infectious Disease Unit**
- Selected 3 medium to high volume; poorly performing Hospital ART sites
- **Objectives:**
  - **Improve VL coverage & suppression rates**
  - Improve identification and triage of patients requiring differentiated viral load services (Failing First line ART with co-morbidity, failing Second Line ART)

Differentiated Service Delivery for High Viral Loads and co-occurring co-morbidities



Key Interventions to Improve Quality of services for better Viral Load completion & re-suppression of failing patients

5 Step Plan

1. Establishing a VL CHAMP
2. Make Viral Load Monitoring Routine
3. Optimize use of Data Sources
4. Dedicated Viral Failure Clinics
5. Cascade and Support PHCs to do same

Strategies to Improve Performance

Step One: Achieving Coverage of VL testing

- VL Clinical Manager and VL Champion
- Making VL monitoring routine (VL Anniversary, Pharmacy gatekeeping)

Step two: Acting on results

- TIER VL reports, NHLS RFA reports, triangulation
- Maintain high VL register

Step three: Switching Failing Regimens

- VL priority clinic (EAC)
- Support PHCs in cluster for advanced clinical care and referral

Need for Viral Load Priority Clinic

- **ID specialist to HIV + patient ratio in KZN= *1: > 400 000***
- **Required task shifting and decentralization of identification and management of Second Line ART (SLART) Failure**
- **Steps to achieve this:**

  - ❑ **Clinician Capacity building –** Infectious disease mentorship
  - ❑ **Referral Criteria** for Viral Load Priority Clinic
  - ❑ **Identification of sites for decentralised SLART Failure management**
  - ❑ **Establish VF Clinic Day**
  - ❑ **System for identification of patients** – Viral load register/ Tier.net/ NHLS dashboard/follow-up
  - ❑ **System for booking patients**
  - ❑ **Ongoing clinician support** through onsite/virtual specialist mentorship
  - ❑ **Re-assess** after 6 months
  - ❑ **Cascade** to lower level facilities

Implementation of Viral Load Priority Clinic

Step One: Assembly of Viral Load Priority Clinic team

- **Facility leadership and ownership**
- **Doctor, NIMART nurse, Pharmacy representative, Social worker, Lay counsellor, admin staff, tracers**
- **Clearly defined of roles and responsibilities with accountability**

Step two: Capacitation for management of SLART failure

- Doctors
- ACC case based didactic training
- Infectious Disease mentorship
- Ongoing virtual support via ACC Helplines
- Enhanced Adherence Guideline Training for all staff

Step three: Systems for identification and management of patients

- Criteria of referral for patients to clinic
- Data cleanup and chart reviews to identify patients
- Dedicated day for clinic

Implementation of Viral Load Priority Clinic

Step One: Assembly of Viral Load Priority Clinic team

Step two: Capacitation for management of complex cases and SLART failure

- **Doctors**
- **ACC case based didactic training**
- **Infectious Disease mentorship**
- **Ongoing virtual support via ACC Helplines**
- **Enhanced Adherence Guideline Training for all staff**

Step three: Systems for identification and management of patients

- Criteria of referral for patients to clinic
- Data cleanup and chart reviews to identify patients
- Dedicated day for clinic

Implementation of Viral Load Priority Clinic

Step One: Assembly of Viral Load Priority Clinic team

- Doctor, NIMART nurse, Pharmacy representative
- Social worker, Lay counselor, admin staff and data
- Clearly defined of roles and responsibilities with accountability

Step two: Capacitation for management of SLART failure

- Doctors
- ACC case based didactic training
- Infectious Disease mentorship
- Ongoing virtual support via ACC Helplines
- Enhanced Adherence Guideline Training for all staff

Step three: Systems for identification and management of patients

- **Criteria of referral for patients to clinic**
- **Data cleanup and chart reviews to identify patients**
- **Dedicated day for clinic**

Pilot site performance 12 months after intervention

	Baseline Viral Load Coverage	Post-Intervention Viral Load Coverage	Baseline Viral Load suppression	Post-Intervention Viral Load Suppression
Facility 1	42%	97%	92%	93%
Facility 2	43%	90%	91%	92%
Facility 3	61%	83%	94%	94%

eThekwini District Manager scaled up quick wins to all CHC and Hospitals:

- VL Champ ; VL Anniversary; VL due reports;
- Chart audits to identify active and failing patients
- Clinicians registered for High VL reports from Lab
- High VL register from November 2017.

District VL coverage improved to 73% as at end March 2018

Summary

- **Collaborative activity for VL monitoring and triage of unsuppressed patients**
  - Collective team approach with R+R
  - Managers holding teams to account
  - addresses improved quality and coverage of HIV treatment services
  - Enhanced efficiency in treating complex patients
- **Need for decentralised ART failure services**
  - Establishment of systems for identification and improved management of VF patients by optimising data sources
- **Systems for ART failure management support:**
  - Helplines/mentorship
  - Streamlining systems for decentralised care

Lessons Learned

- Differentiated HIV service model need for SLART failure and complex patients in settings with scarce specialist resources
- Optimize VL success to sustain gains of ART rollout
- Monitoring of active interventions on unsuppressed VL are critical
- Barriers to quality care include severe staff shortages and turnover

Recommendations

- Dedicated staffing with specific roles, responsibilities and ownership
- Monitoring of program outcomes at facility level through optimisation of data sources
- Chart audits – standardized approach to improve quality of care

Acknowledgements

- **The CAPRISA ACC Staff**
- **eThekwini District Management and DOH**

  Facility staff
- **Department of Infectious Disease**

MatCH

Maternal and Adolescent Child Health

REVAMP
RESISTANCE TESTING VERSUS ADHERENCE SUPPORT FOR MANAGEMENT OF PATIENTS WITH VIROLOGIC FAILURE ON FIRST-LINE ANTIRETROVIRAL THERAPY IN SUB-SAHARAN AFRICA

Resistance testing Versus Adherence support for Management of Patients with virologic failure on a first-line antiretroviral therapy

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