Quality Standards for Less-Intensive Differentiated ART Models

The CQUIN Quality & Quality Improvement Community of Practice

August 2019

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HIV LEARNING NETWORK

The CQUIN Project for Differentiated Service Delivery

INTRODUCTION

Recognizing that there is a gap in defining quality standards for differentiated ART (DART) models, the CQUIN *Quality & Quality Improvement Community of Practice* worked together to co-create a quality standards framework for DART models. The community of practice includes representatives of ministries of health, implementing partners, civil society, people living with HIV, donors, and academics from 10 countries.

The initial framework focuses on less-intensive DART models designed for "stable" recipients of care. Of note, the group did not attempt to craft "CQUIN standards" but to synthesize existing standards and fill gaps where standards have not yet been articulated. Following a literature review, the group worked together via email and at virtual meetings and calls to develop an initial draft. This draft was presented to CQUIN network members from 11 countries at a CQUIN workshop in Nairobi in June 2019. Feedback was incorporated and the document was finalized in late July. The framework is envisioned to be a living document, and feedback and suggested edits/additions are always welcome.

SECTION I: CROSS-CUTTING STANDARDS

General quality principles for ART programs

- Everyone enrolled in DART services should be treated with respect with regard to their human rights, ethics, privacy and confidentiality, informed consent and choice, autonomy, and dignity (adapted from WHO 2004).
- All DART models should be delivered in a way that acknowledges specific barriers identified by recipients of care and that empowers them to manage their needs with the support of the health system (adapted from Uganda's 2017 *Differentiated Service Delivery Guide*).
- All DART services should be evidence-based, contextually appropriate, and consistent with national guidelines.
- All DART models should meet standards for recipient of care satisfaction.
- All DART models should demonstrate excellent retention and viral suppression rates.

Cross-cutting standards for DART eligibility and enrollment

- There are written protocols for DART eligibility criteria according to national guidelines (adapted from WHO 2004).
- All people on ART are assessed for DART eligibility at the interval recommended by national guidelines.
- Everyone eligible for DART receives information about their DART options.
- Everyone eligible for DART has the opportunity to opt-in to their preferred DART model or to remain in a more-intensive "conventional" model.
- Eligibility is reassessed on a regular basis for people in DART models according to national guidelines.
- Recipients of care enrolled in less-intensive DART models who develop issues requiring more intensive services are promptly identified, assessed by health care workers, and transferred to an appropriate, more-intensive DART model. If/when they become eligible for less-intensive services, they are offered the option of re-enrolling in a less-intensive DART model.
- Key information about people in DART models is accurately and completely recorded in health facility records/DSD registers for monitoring and follow-up.

Cross-cutting standards for DART package of services

- There should be clearly defined standard operating protocols (SOPs) for each DART model.
- Everyone in all DART models should receive:
    - ART as per national guidelines
    - Screening for TB, cervical cancer, and other opportunistic infections (OI) at the interval recommended by national guidelines
    - TB preventive treatment (TPT) as per national guidelines
    - OI prophylaxis and treatment as per national guidelines
    - Access to family planning services, including condoms
    - Regular adherence assessment and support
    - Viral load testing, CD4 testing, other lab monitoring, and clinical examination at the intervals recommended by national guidelines
    - Services provided in a healthy and safe environment (*e.g.,* clean, well-ventilated, private)
    - Integrated services for other health conditions (*e.g.,* non-communicable diseases) when consistent with national guidelines
    - Reminders about next appointment dates (for drugs/clinic/labs)
    - Referrals to needed support services (facility- and/or community-based)
    - Easy access to medical services to address unanticipated problems or concerns that arise between regularly scheduled medical visits
- Monitoring and evaluation systems should capture key information irrespective of where services are delivered.
    - Data from community DART sites (*e.g.,* outreach, community pickup, CAGs, other) should be swiftly entered into facility-based M&E systems (*e.g.,* TASO SOPs specify within 72 hours).
    - Data from all DART models should routinely be reviewed at facility level (and higher) in order to improve quality of services provided.
- Systems should include:
    - Systems to identify and respond to missed appointments
    - Systems to ensure efficient flow of people and data at health facilities

Cross-cutting standards for DART medication management

- Medication management should always include:
    - Receipt of the correct amount of ARVs and other medications, with special attention to quantification and packaging for those receiving multi-month prescriptions
    - Dispensing medications in discreet and convenient packaging
    - Appropriate instructions and education about medication side effects, storage and security
    - Standards and procedures for replacing lost medication

- Health facility processes should include the following (tailored to model):
    - Effective ART quantification, forecasting, and requisition protocols
    - Sufficient storage capacity and security for ARVs and other medications
    - Clear and structured systems for pre-packing medications when needed
    - Model-adapted systems to identify and respond to missed medication pick-ups
    - Pharmacovigilance systems (active or passive depending on national guidelines)
    - Accurate and efficient data management and reporting systems

SECTION II: MODEL-SPECIFIC STANDARDS

Facility-based Individual Models

Fast Track Visits

- In addition to the cross-cutting package of services above, recipients of care should receive:
  - Efficient visits with minimal wait time (*e.g.,* Zimbabwe guidelines specify < 30 minutes)
  - Triage to see if clinical assessment and/or other referrals are indicated/desired

Facility-based Group Models

ART Clubs

- In addition to the cross-cutting package of services above, recipients of care should receive:
  - Orientation to the roles and responsibilities of club members, including expectations about confidentiality and mutual/psychosocial support
  - Club meetings at the appropriate intervals
- Necessary model-specific health facility processes include:
  - Staff trained in group dynamics and club protocols
  - Systems to ensure that records, drugs, and supplies (*e.g.,* condoms) are assembled and in place before each meeting
  - Systems for referral to other departments
  - A place/room assigned for services

For teen clubs:

  - Systems to transition members to adult care when recipient of care is ready
  - System to ensure meeting between health care worker team and caregiver (*e.g.,* parent/guardian) at least once every three or six months

Community-based Individual Models

Outreach Model / Community Drug Distribution Points

- In addition to the cross-cutting package of services above, recipients of care should receive:
  - Orientation to outreach model procedures and schedules
  - Community sensitization and engagement, including possible provision of space for the service
  - "Up referral" to health facilities when needed
- Necessary model-specific processes include:
  - Staff trained in community-based services
  - Transportation and human resources
  - Systems to track recipients of care and to facilitate "up referral" to health facilities as needed
  - Systems to ensure data from outreach services are swiftly entered into the facility M&E system (*e.g.,* TASO guidelines specify within 72 hours)

PODI Model

- In addition to the cross-cutting package of services above, recipients of care should receive:
  - Orientation to the PODI model procedures and schedule
  - Community sensitization and engagement, including possible provision of space for the service
  - "Up referral" to health facilities when needed
- Necessary model-specific processes include:
  - Peers trained in community-based services, screening, documentation, and drug dispensing
  - Systems to track recipients of care and to facilitate "up referral" to health facilities as needed
  - Space for PODI activities
  - Systems to ensure data from PODI services are swiftly entered into the facility M&E system

Community-based Group Models

Community-based ART Groups (CAGs)

- In addition to the cross-cutting package of services above, recipients of care should receive:
  - Access to self-forming CAGs
  - Access to CAGs of the appropriate size (as per national guidelines)
  - Access to CAGs with trained leaders
  - Orientation to the roles and responsibilities of CAG members, including expectations about confidentiality and mutual support
  - Training on how to provide screening (*e.g.,* for OI symptoms) and monitor and support adherence and retention
  - CAG meetings at the appropriate intervals (every 1 to 3 months, depending on country)
- Necessary model-specific processes include:
  - Systems for supporting self-forming CAG groups
  - Ability to train and support CAG leaders
  - Systems for 'up referral' from CAGs to health facility
  - Systems to ensure data from CAGs are swiftly entered into the facility M&E system

Appendix 1: CQUIN DSD Model Definitions/Categories - Models for "Stable" Recipients of Care

Category	Examples	Notes
More-intensive models		These are the models used for recipients of care who are: (a) not eligible for less-intensive differentiated service delivery models (DSDM); (b) have not yet been assessed for eligibility for less-intensive DSDM; or (c) who have chosen not to enroll immediately in a less-intensive DSDM. Uganda calls this the facility-based individual model (FBIM) and comprehensive clinical evaluation (CCE); Eswatini calls it "mainstream" ART; and Zimbabwe calls it the "conventional" model.
Facility-based individual models	Appointment spacing without fast track	For recipients of care who meet specified eligibility requirements, clinical visits are less frequent than in the undifferentiated model and recipients of care receive three to six months of ART at a time (multi-month scripting). Unlike the fast-track model, all appointments include a full clinical consultation. Examples: Ethiopia's six-month appointment spacing model (ASM) and Malawi's three-month appointment spacing model. *Note that it is not the exact visit interval that defines this model, but that it is available only to people who have been determined to meet specific "stability" criteria.*
	Fast track + appointment spacing	These models combine appointment spacing (with one to two clinical visits per year) with interim, "fast-track" visits, which generally involve only ART pickup and brief screening questions about adherence and the presence/absence of new symptoms or issues. The visit is designed mainly for swift ART drug pickup at the health facility and includes ART pick-ups that occur only at the pharmacy and/or during extended hours (early mornings, evenings, weekends). This is called "spaced and fast lane (SAFL)" in South Africa and "six monthly appointments (SMA)" in Kenya.
Facility-based group models	ART clubs	Health care worker-led ART distribution to multiple people at a group appointment. The groups meet at the facility either after hours or during clinic hours at a designated place where they receive group adherence counseling, psychosocial counseling, and other clinical services, and then receive their ARVs. The groups can be diverse or gender-specific or designed with specific needs in mind, such as those with both HIV and non-communicable diseases. This is called "facility adherence clubs" in Côte d'Ivoire and "urban adherence clubs" in Zambia.
	Facility-based teen clubs	Health care worker-led group ART distribution for adolescents living with HIV. Services often include group psychosocial support, adherence counseling, and ART refills, as well as sample blood draw/specimen collection for those who are due for routine viral load testing.

Community-based individual models (include clinical assessments every 6–12 months)	Outreach model	Health care worker-led community ART distribution + streamlined clinical services. For example, mobile ART distribution (Zambia), outreach ART (Eswatini), and outreach model (Zimbabwe).
	Community drug distribution	ART distribution only, no/minimal clinical services (*e.g.*, limited to TB screening, adherence review, and pregnancy status). Examples include: CCMDD[1] (South Africa and Zambia), CDDP[2] (Uganda), OFCAD[3] (Zimbabwe), Community retail pharmacy model (Zambia), Home ART delivery (Zambia), PODI *(Postes de distribution communautaire d'ARV)* model: Peer-led drop-in centers for ART distribution + adherence/symptom check.
Community-based group models (include clinic visits every 6–12 months)	Community ART groups (peer-led)	This is a peer-led model for small groups of individuals on ART (up to six in most cases), who meet regularly in the community every 1 to 3 months. One member of the group collects the drugs on behalf of the group from the health facility and the group members meet in the community to collect and sign for the ARVs. This model is called "CAG" (community ART group) or "CARG" in Zimbabwe, "GAAC" in Mozambique, or "CCLAD" (community client-led ART delivery) in Uganda.
	Family model	Recipients of care pick up ART in facilities and distribute to family members. This is called "family centered model" in Eswatini and "family ART group refill" in Zimbabwe.
	Community-based teen clubs (health care worker-led)	This is similar to facility-based teen clubs, except the meetings happen at a venue within the community.

[1] CCMDD = chronic centralized medication dispensing and distribution (South Africa and Zambia)
[2] CDDP = community drug distribution points (Uganda)
[3] OFCAD = out of facility community ART distribution (Zimbabwe)