DSD 2.0- THE FUTURE OF DIFFERENTIATED SERVICE DELIVERY

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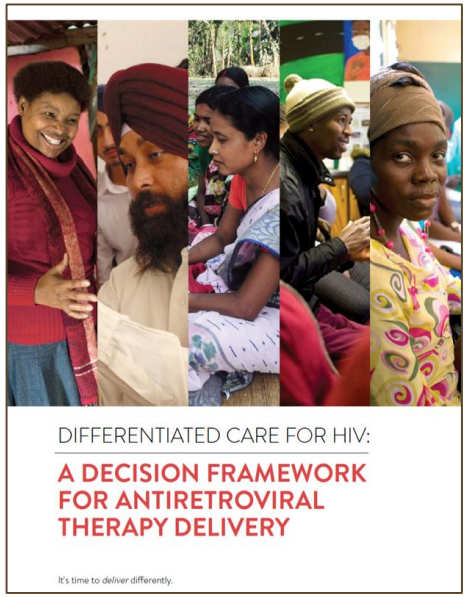
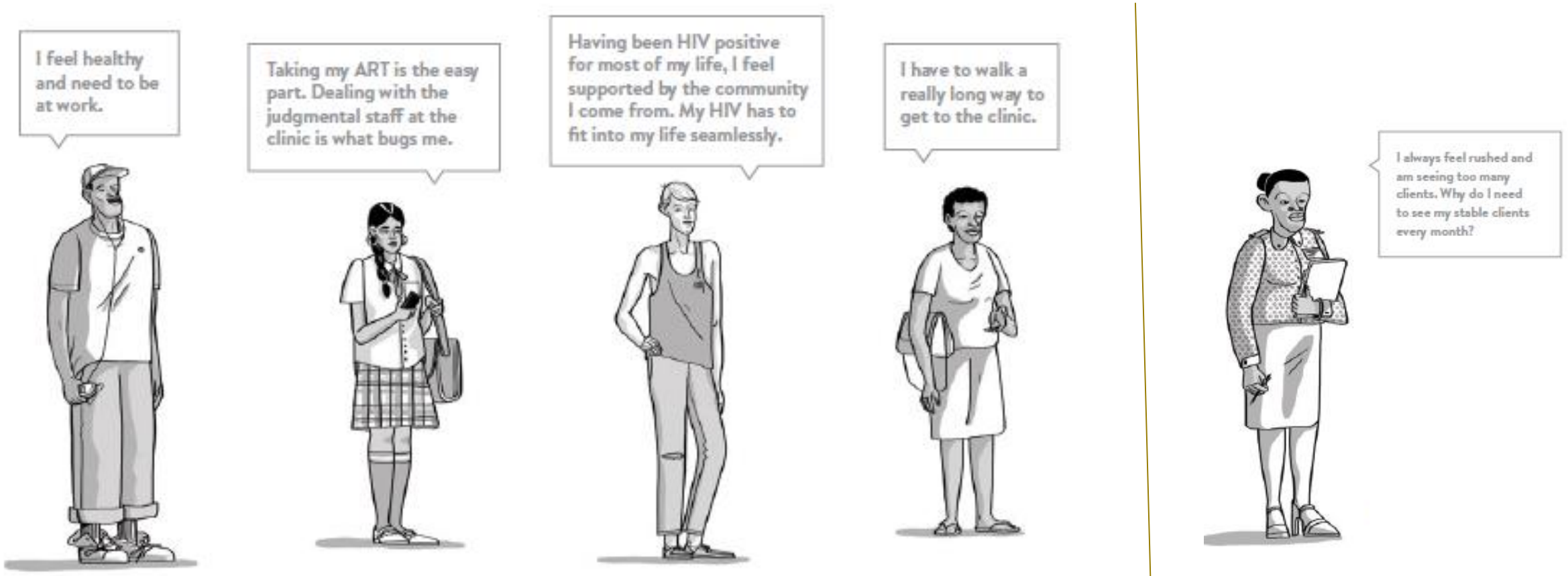
13 November 2019

Differentiated service delivery is a **client-centred** approach that simplifies and adapts HIV services **across the cascade** to reflect the preferences and expectations of various groups of people living with HIV (PLHIV) while **reducing unnecessary burdens on the health system**.



DSD 1.0: PRIMARY CHALLENGE WAS SIMPLIFYING CARE FOR STABLE PLHIV AND EASING BURDEN ON HCWS

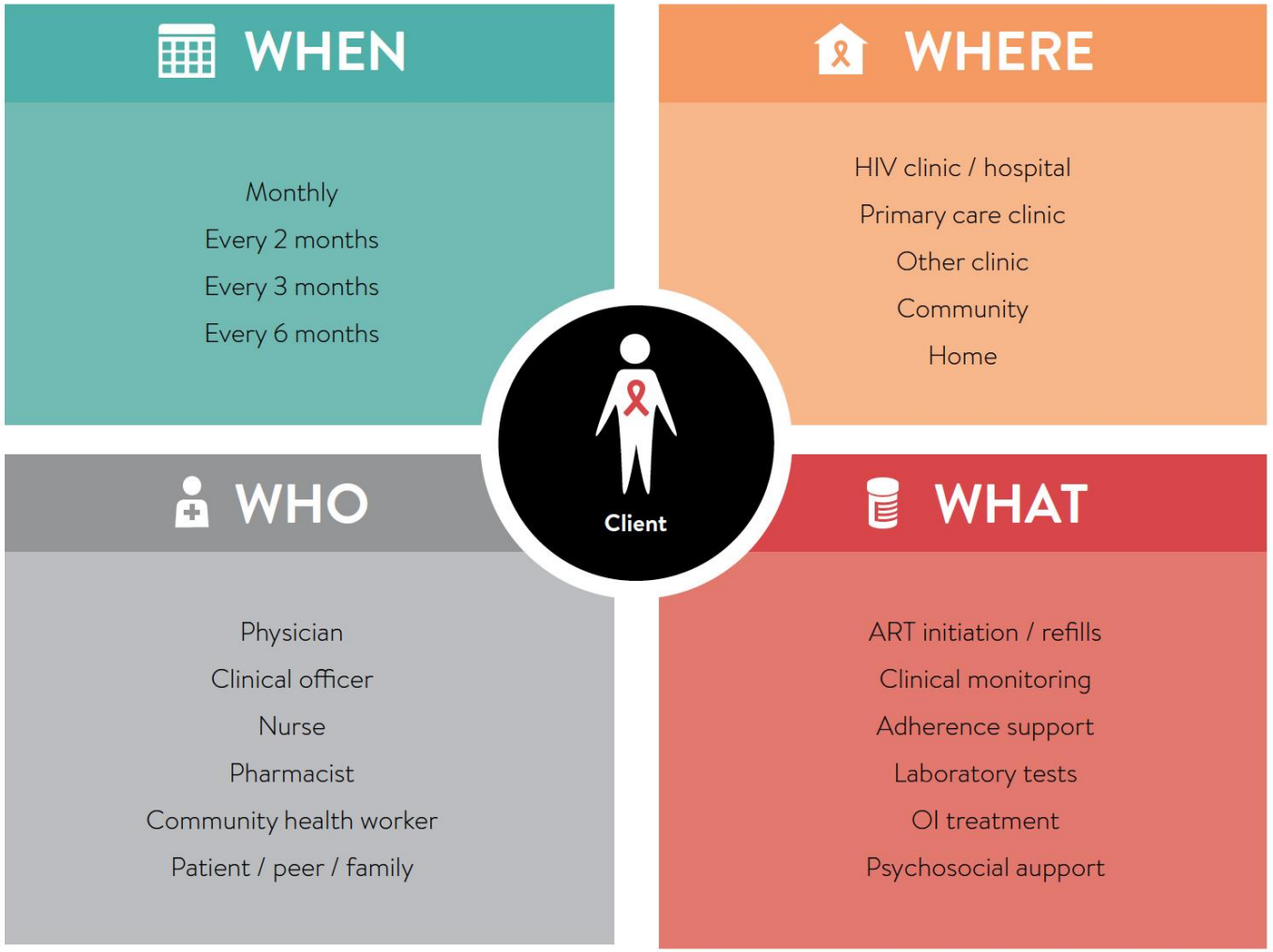


These are some of the common challenges of people living with HIV that can be addressed through differentiated care. **It's time to *deliver* differently.**

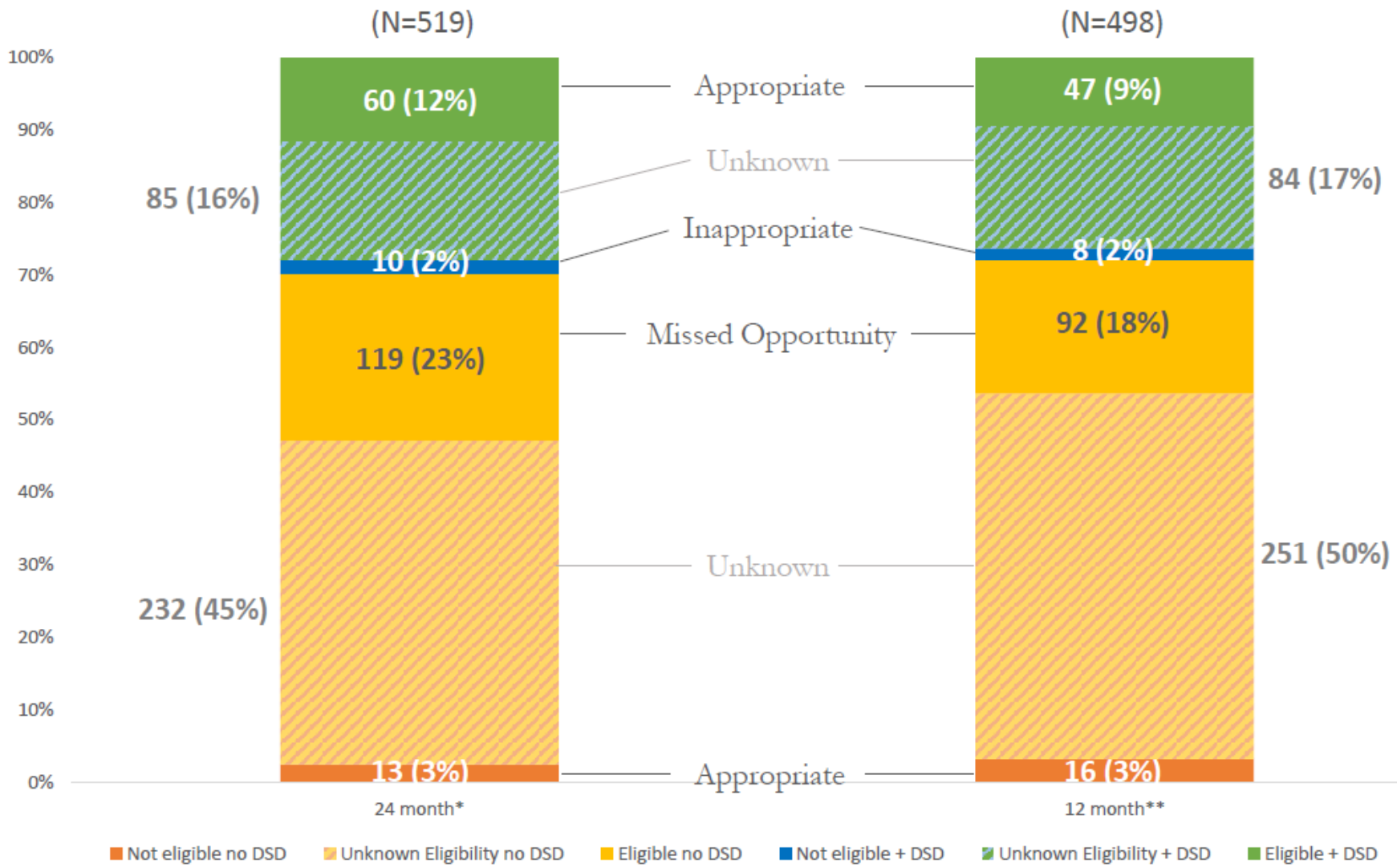
DSD 1.0: MULTIPLE INNOVATIONS IN MODELS OF SERVICE DELIVERY

- Appointment spacing, Fast track
- Community pharmacy pickups, outreaches, home delivery, drop-in centers
- Adherence clubs, teen clubs
- Community adherence groups

… mostly for “stable” RoCs

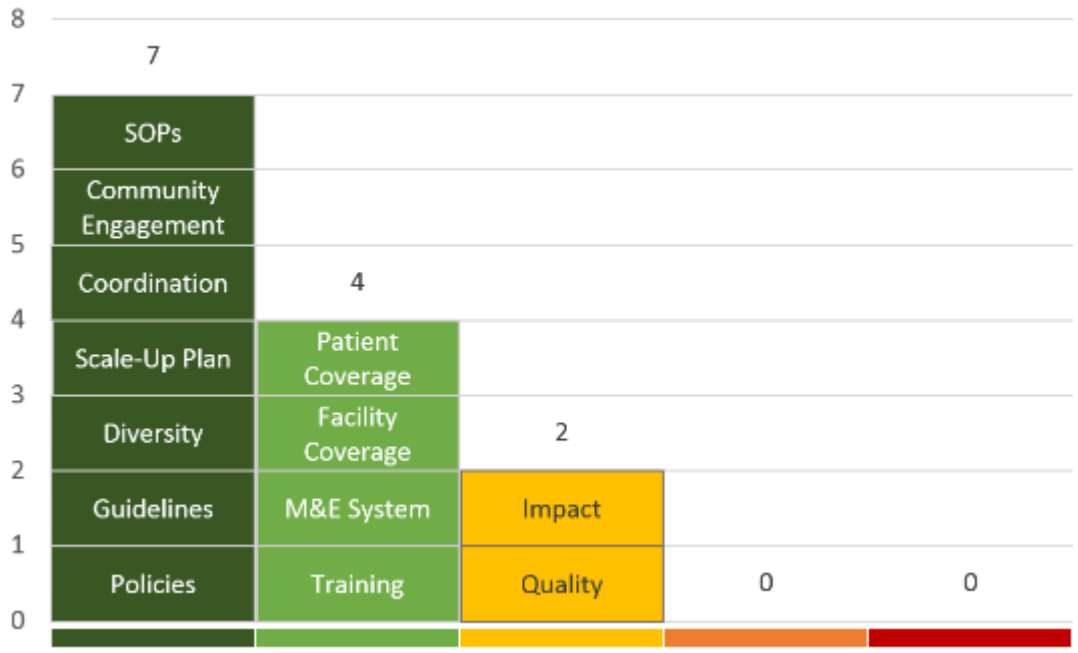


DSD 1.0: INCREASING ATTEMPTS TO ACTIVELY DIFFERENTIATE ROC BASED ON THEIR NEEDS

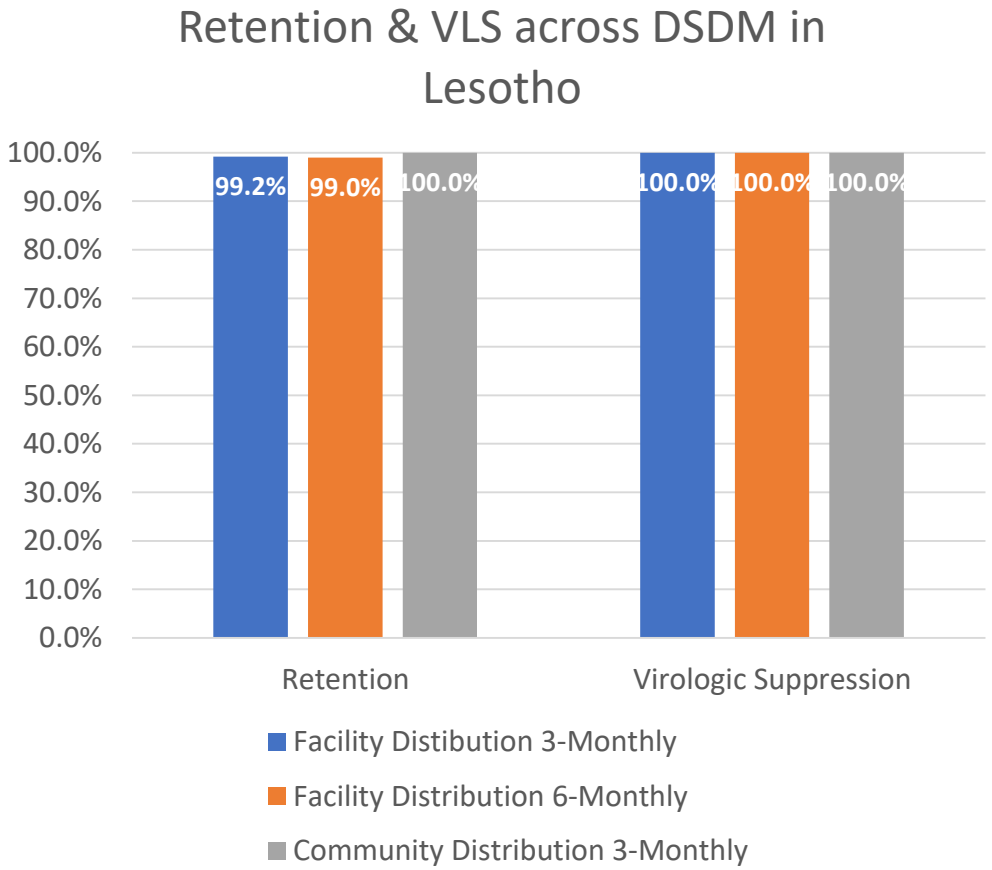


DSD 1.0: SUCCESS OF DSD MEASURED MOSTLY THROUGH PROCESS AND CLINICAL OUTCOMES

Monitoring process milestones to promote scale up



Evaluating different models to ensure non-inferior clinical outcomes



Sources: CQUIN 2019; EQUIP Lesotho program data, August 2018.

REMARKABLE PROGRESS, BUT IS RIGHT TIME TO LOOK FORWARD TO DSD 2.0

1. What are the critical trends that will effect ART delivery?
2. Recheck: Who is DSD intended for?
3. Recheck: What models should be prioritized– stable and “unstable”
4. What could be done better in DSD 2.0?
5. In DSD 2.0, how will we measure success?

1. WHAT ARE THE CRITICAL TRENDS THAT WILL EFFECT ART DELIVERY?

- Increasing numbers of PLHIV who will require lifelong treatment within the same infrastructure and resource envelopes
- Increasing attempts to differentiate people to appropriate models of care based on their needs
- Increasing recognition of the number of PLHIV who will require longitudinal care for other health needs (HTN, DM, family planning, TPT)
- Expectation that “sustainability” for HIV services may require some integration with other health services, but little country experience with to how to accomplish this objective

2. RECHECK: WHO (AND WHAT) IS DSD INTENDED FOR?

I've been virally suppressed on 2nd line treatment for 1 year now, but no one considers me stable.

It's great to get 3M of ART at a time, but do the nurses know that I still have to come every 2 months for my FP shot?

MORE INTENSE SERVICES INTENDED TO HELP PEOPLE MAY ACTUALLY DRIVE SOME OF THEM AWAY

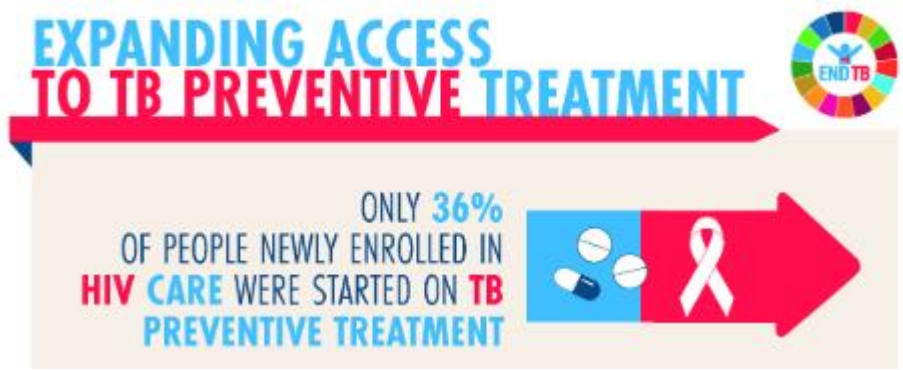
- Some people **newly initiating ART** or with **high VL** have trouble returning to clinic monthly due to jobs, distance, stigma, etc

- Many people on **2nd line ART** are very clinically stable. As are pregnant women, PLHIV on TB continuation phase treatment, children with active guradians, etc.

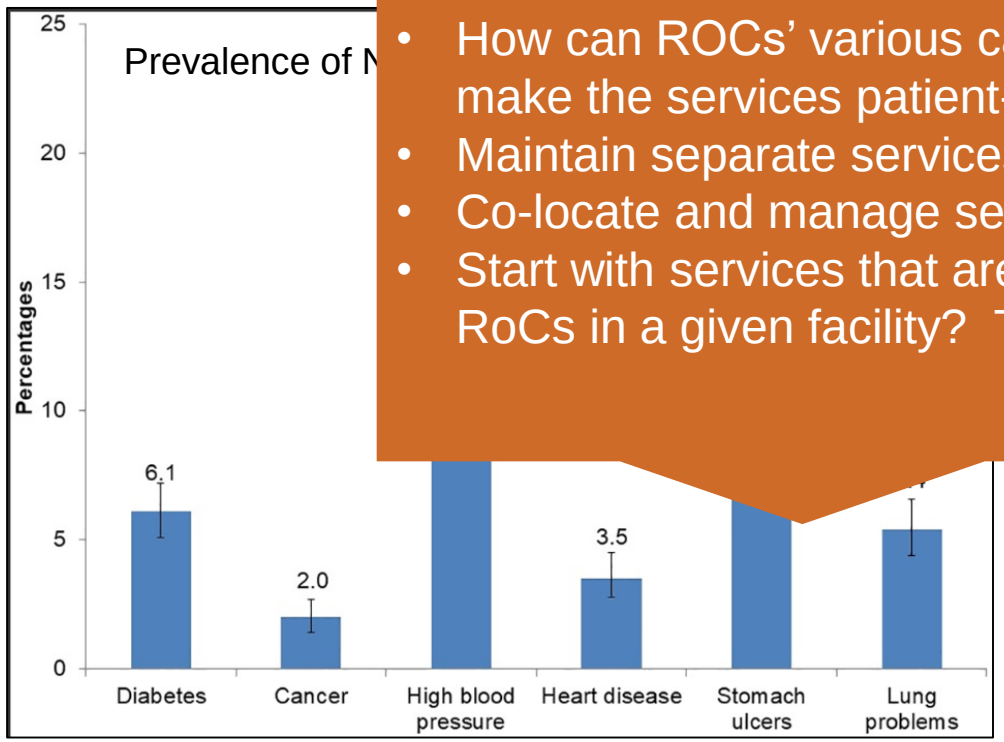
Can we be innovative about ways to stay in touch with these people that will set them up for success? Revise policies? Replace in person visits with regular SMS or phone check ins? Offer them longer refills or participation in community adherence groups?

Source: Zanolini A, PLoS Med, 2018

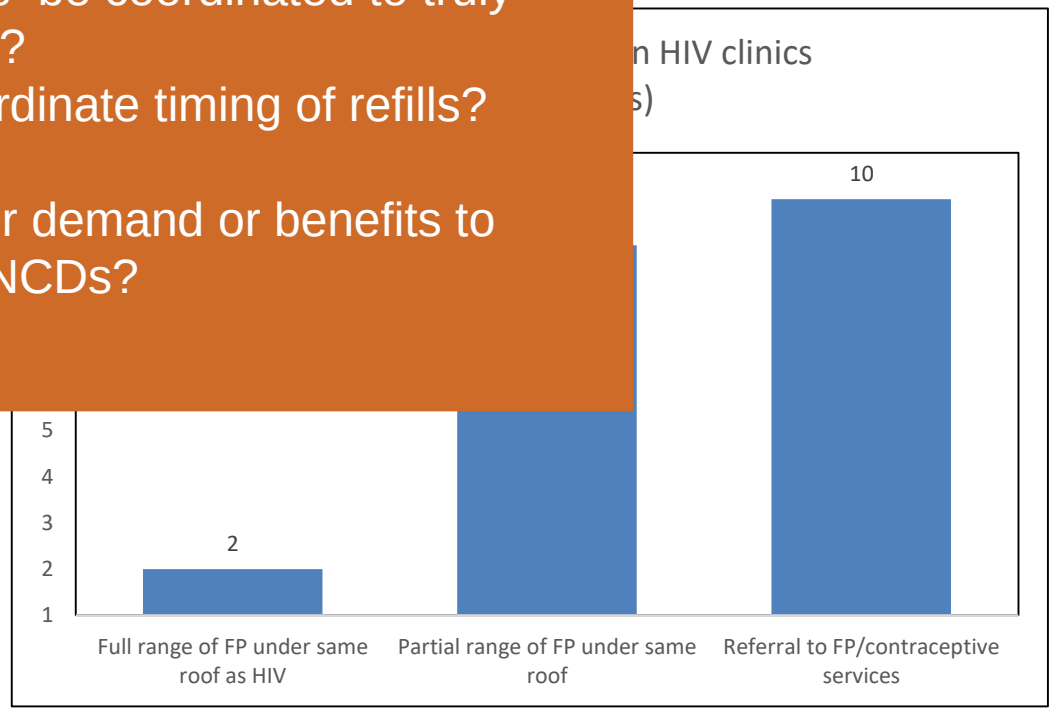
IF DSD ONLY ADDRESSES HIV, IT IS NOT PATIENT-CENTERED CARE



- How can ROCs' various care needs be coordinated to truly make the services patient-centered?
- Maintain separate services but coordinate timing of refills?
- Co-locate and manage services?
- Start with services that are of higher demand or benefits to RoCs in a given facility? TPT, FP, NCDs?



Zungu, Plos One, 2019



WHO, 2019- Survey on HIV and FP integration

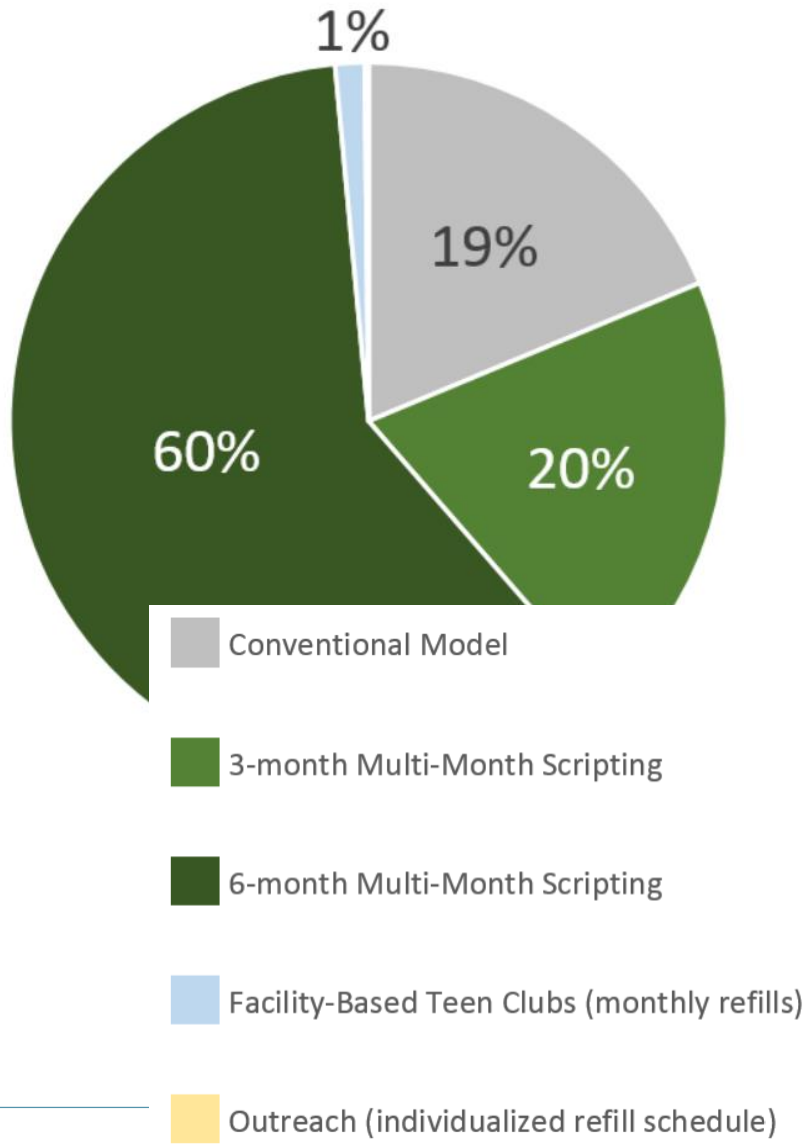
3. RECHECK: WHAT MODELS OF DSD WILL BE PRIORITIZED?

Trend: 3-6 months refill models > CAGs, Clubs, etc

Active differentiation of all HIV ROCs based on:

1. **Clinical stability** (especially VL)
   - New initiation → Conventional model (???)
   - Suppressed VL → MMS for stable adult RoCs
   - Unsuppressed VL or other advanced disease
     → Viremia clinics or other appropriate care
2. **Demographic group**
   - Teen clubs
   - KP programs
   - Residents of rural v urban areas

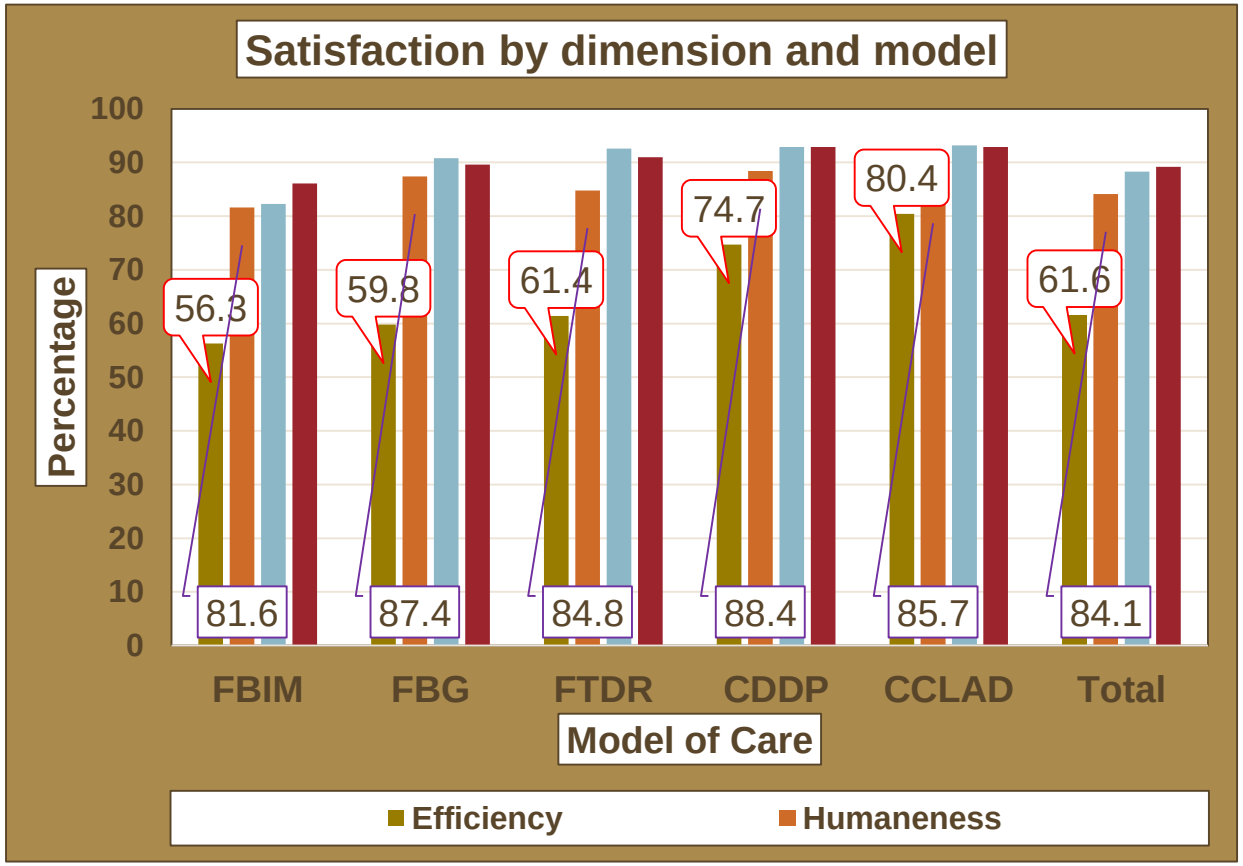
RoCs should and could move between models as their circumstances change.



4. RECHECK: HOW WILL SUCCESS BE MEASURED?

- Continue with process and clinical outcomes measurements
- Add indicators for TPT uptake, FP uptake, NCDs care among PLHIV?
- Add:
  - ROC experience
  - HCW experience
  - Efficiency measures

Makerere University Key Preliminary Results – ROC Satisfaction



Facility based models had lower satisfaction level than community models. FBIM had lowest level of satisfaction

SUMMARY: THE EVOLUTION OF DSD 1.0 TO DSD 2.0

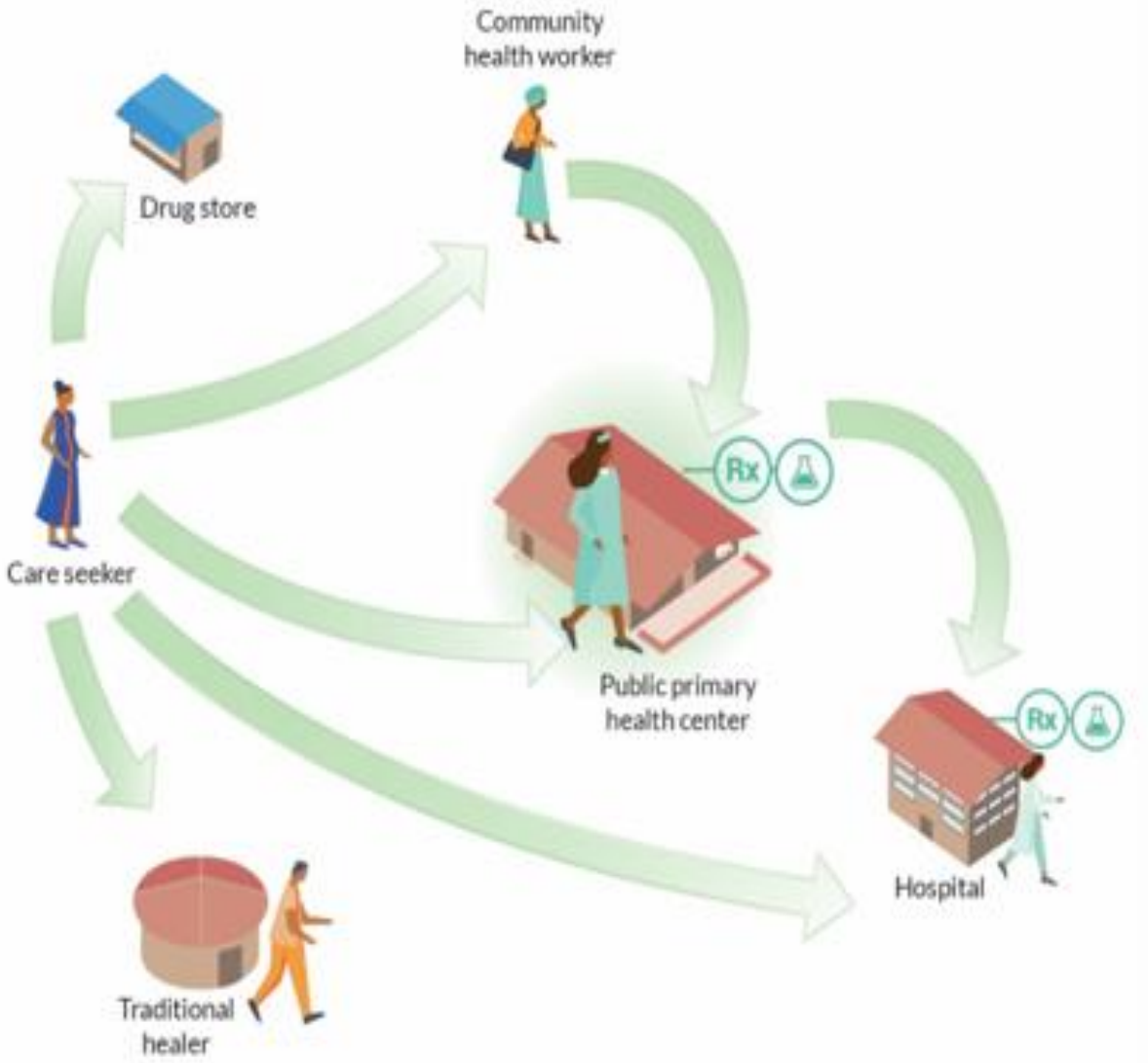
	DSD 1.0	DSD 2.0
Health services of interest	HIV	HIV, TB, SRH, NCDs…
RoCs of focus	Stable	Stable and "unstable," redefining "stability" and recognizing that RoCs shift between models
Diversity of models	Lots of experimentation	Narrowing to fewer more successful models, including advanced disease
Accuracy of differentiation	Variable	More accountability
Measure of success (RoC)	Less contact with health system	Positive experience of care
Measure of success (Health system)	Non-inferior HIV outcomes Current CQUIN dashboard focused on HIV Decongested facilities	Improved health outcomes (for more than HIV) Expanded CQUIN dashboard More efficient use of resources Positive HCW experience

CAN HIV DSD PROVIDE A PATHWAY FOR ALL HEALTH SERVICES?

Differentiated service delivery is a **client-centred** approach that simplifies and adapts ~~HIV~~ health services* **across the cascade** to reflect the preferences and expectations of various groups of people ~~living with HIV (PLHIV)~~ while **reducing unnecessary burdens on the health system**.

* Or at least those requiring care over time?

DSD IS LEADING THE SHIFT FROM THE PROVIDER AND FACILITY-CENTERED HEALTH SYSTEM OF TODAY…



TO A PATIENT-CENTERED HEALTH SYSTEM OF THE FUTURE