Job Aide for Clinicians

Implementation of National Adherence Guidelines SOP 9:

RE-ENGAGEMENT IN CARE

Support facility-level AGL SOP 9 implementation

Set out facility specific re-engaging patient visit flow

Guide facility staff on roles and responsibilities

Improve retention of patients re-engaging in care

SOP 9 RE-ENGAGEMENT THREE KEY PRINCIPLES

1

For returning patients, the *first return visit experience* is critical

Welcoming, supportive and empathetic

Clear facility visit flow focused on a positive patient experience

2

***Not all patients* late for scheduled appointments are re-engaging patients**

Only if they are **>14 days** after scheduled appointment
OR
silent transfer from another facility

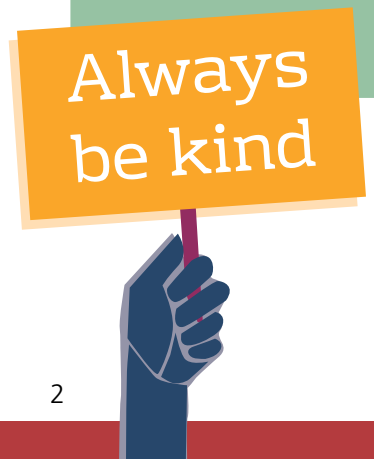
3

All re-engaging patients *DO NOT have* the same service delivery needs

Easier access to treatment

Psychosocial support

Clinical management



WHO IS A RE-ENGAGING PATIENT?

Assess all patients returning after scheduled appointment date

≤14 days

14 days or less after scheduled appointment

Routine care patient

Patient receives care according to scheduled appointment plan

>14 days

More than 14 days after scheduled appointment or silent transfer

RE-ENGAGING (RE) patient

AGL SOP 9: Re-engagement

Clinical assessment + differentiated follow-up plan

RETURNING ROUTINE CARE PATIENTS

No or very short interruption

- No need to worry unless patient unwell/red flag symptoms
- No need to delay patient
- No need for additional service provision
- If not on TLD → Offer TLD when patient has a scheduled clinical consultation

No change to visit plan

- If due to see clinician → See clinician
- If due to collect ART from pharmacy or facility-based RPCs (facility pick-up point or facility adherence club) → Collect from this service point
- Only attend additional service at patient request

If enrolled in Community Repeat Prescription Collection Strategies (RPCs/DMOC)

- If was due to pick up ART refill at out-of-facility RPCs (external pick-up point or community adhrence club), explain benefits of continuing collection at community RPCs to avoid script cancellation → Refer to out-of-facility RPCs
- If patient chooses to rather collect at facility → RPCs (Decanting/CCMDD) rescript immediately
- Capture ART visit on TIER.Net

SOP 9: RE-ENGAGEMENT STAFF ROLES & RESPONSIBILITIES

Batho Pele principles: Courteous, open, supportive and empathetic. Focus on positive patient return visit experience.

MAIN SOP 9 ACTIVITY	DETAILED SOP 9 ACTIVITIES	PERSON/S DESIGNATED IN SPECIFIC FACILITY TO BE INDICATED
Direct to facility reception	• Navigate to reception • **Do not turn any client away at facility entrance**	All Staff (also entrance security):
Identify re-engaging patient	• Identify a re-engaging patient • Mark on folder tracking tool indicating ≤ or >14 days • Insert SOP 9 RE-ENGAGE form in patient folder	Admin clerk/s:
Navigate to correct clinician	• Support navigation to appropriate clinician queue	Admin clerk/s or counsellor or Retention officer:
Prepare folder for clinician assessment	• Find patient folder/open duplicate	Admin or data clerks:
	• Print/document missing lab results and place in folder	Admin or data clerks or counsellor or retention officer:
Conduct clinical assessment	• Conduct re-engagement clinical assessment	Assigned re-engagement clinician/s or all clinicians:
Determine SOP 9 follow-up plan for RE patient	• Determine and carry out SOP 9 follow-up plan (+/-AHD package) • Script ART • Complete SOP 9 RE-ENGAGE form	Assigned re-engagement clinician/s or all clinicians:
Provide counselling (+case management)	• Provide FTIC combined sessions 3 and 4 or EAC session 1 • Provide low/high risk case management approach	Counsellor or retention officer:
Collect ART refill	• Dispense ART refill as directed • Confirm next place of ART refill collection with patient • Manage CCMDD script submission	Pharmacy/clinical staff:

CLINICAL APPROACH TO SOP 9

STEP 1: Conduct clinical assessment

Step 1: Create safe supportive space for positive patient interaction

"Good to see you today" *"I hope you didn't have to wait long. This is a supportive space for your return to care"*

Step 2: Check for any clinical concerns

"How are you feeling today?" *"Any worrying illness or symptoms recently?"*
Identify patient clinically unwell or with any red flag symptoms requiring clinical action

Step 3: Check last scheduled visit and discuss reasons for missing visit

"When was your last scheduled visit?"
"Can you tell me what made it difficult for you to attend?"
Document last visit date on SOP RE-ENGAGE form
Document any **critical** reasons for missing scheduled visit relevant to assessment

Step 4: Discuss any concerns about returning to care

"Did you have any worries about coming back to us?"
"Do you have any concerns about being able to continue your care and treatment at this facility"
"Anything else you are worried about"

Step 5: Check previous history of disengagements using an open, non-judgemental approach

"Have you been off treatment before?"
"Tell me about these times and any worries you had at the time"
Check file for previous history of disengagement

Step 6: Check VL history

Review most recent VL result
Review previous VL result history
Review NCD lab history (if applicable)
Document on SOP RE-ENGAGE form

Step 7: Ask patient self-report on treatment interruption

"Did you have enough treatment" If no - *"When did you run out"*
Document on SOP 9 RE-ENGAGE form

Step 8: Decide re-engagement clinical assessment outcome

Make your assessment

1. Clinically unwell:
☐ YES or ☐ NO

2. Likely interruption took place:
☐ YES or ☐ NO

Determine SOP 9 follow-up plan

☐ interruption unlikely + VLS<6m
☐ interruption unlikely + no VL<6m
☐ interruption + well (no clinical concerns) with VLS/no VL
☐ clinical concerns/uncontrolled NCD/VL>50

Document on SOP 9 ENGAGE form
Follow SOP 9 colour coded follow-up plan

Step 2: Determine and provide SOP 9 colour-coded follow-up plan

No interruption

Suppressed VL, controlled HbA1c in last 6 months or BP <140/90

1. Offer enrolment/re-enrolment in RPCs available at your facility
2. Immediately rescript according to patient choice

No recent VL or HbA1c

1. Immediately rescript
2. Take VL or HbA1c if due/ overdue

Interruption

Previous suppressed VL or controlled HbA1c or BP <140/90 and no side effects

1. Immediately restart treatment on same regimen
2. Offer adherence counselling if wanted by patient (**FTIC session 3+4 combined**)
3. Explain next assessment in 3 months + offer multi-month treatment supply until next assessment + rescript accordingly
4. Explain if next assessment is normal, will be able to offer RPCs options for easier treatment collection

Clinical concerns

VL >50 copies/ml, HbA1c >7% or BP >140/90 or side effects or ill

1. Follow clinical guidelines management
2. Refer for **EAC session 1** (unless clinician not concerned about adherence)
3. Explain next assessment in 3 months
4. Explain after next assessment:
   IF NORMAL: can offer RPCs enrolment
   IF ABNORMAL: will consider treatment regimen switch and refer for **EAC session 2**

RPCs = Repeat prescription collection strategies (DMOC)

DARK GREEN: Interruption unlikely + VL suppression (VLS) result within 6 months

Re-engagement visit procedure

Step 1: Offer TLD and RPCs

Offer TLD if not already on TLD

Explain and offer RPCs options

Step 2: Assess for TPT

If person has not completed TPT, assess for and initiate TPT

Step 3: Script for ART (and TPT)

If RPCs offer accepted: Complete 6-month script (Decanting/CCMDD) with **THREE** months ART (and TPT) refills

Explain first scripted 3-month ART (and TPT) refill to be collected from health facility pharmacy.

Record on SOP 9 RE-ENGAGE form any reason why 3-month refill could not be scripted

Visit schedule

Re-engagement visit ONLY

See detailed steps above – **take VL** at next clinical consult/rescript visit in **6 months time**

LIGHT GREEN: Interruption unlikely + no VL result within 6 months

Re-engagement visit procedure

Step 1: Take VL today (as overdue and did not interrupt treatment)

Explain VL again and if VL suppression: Qualify for longer refills and RPCs options → Take VL

Step 2: Assess for TPT

If person has not completed TPT, assess for and initiate TPT

Step 3: Explain patient return visit schedule

Explain visit schedule (see below) – need to return for VL result in 1 month.
If VL is suppressed can immediately get 3-month ART refills and access to RPCs options

Step 4: Script for ART (and TPT)

Rescript same ART regimen for **ONE** month ART (and TPT) refill

Visit schedule

Re-engagement visit
See detailed steps above

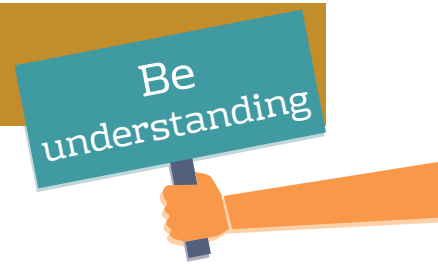
→

RE month 1 visit
Check and communicate VL result

If VL>50 copies/ml
Switch to SOP 9 Brown follow-up plan including following ART guidelines

If VL Suppression AND well:
- TLD and RPCs offer
- If RPCs offer accepted: 6-month script (Decanting/ CCMDD) with **THREE** months ART (and TPT) refills

GOLD: Interrupted treatment + well (no clinical concerns) with VL suppression result or no VL result within 6 months



AHD = Advanced HIV Disease
VLS = VL suppression

Re-engagement visit procedure

Step 1: Take CD4 count IF interrupted ART>90 days

Take CD4 count to identify AHD for AHD package provision

Unless CD4<200 in last 6 months, then switch to SOP 9 Brown follow-up plan

IF CRAG+ RESULT RECEIVED BY FACILITY URGENTLY RECALL

Step 2: Assess for TPT

If person has not completed TPT, assess for and initiate TPT

Explain visit schedule (see below) - return in 3 months, then 1 month later for VL result and if VLS, will offer RPCs options.

Step 3: Restart ART immediately

If NO VLS within 6 months:
rescript same ART regimen for **THREE** months ART (and TPT) refill

If VLS within 6 months:
offer TLD and script for **THREE** months ART (and TPT) refill

Record on SOP 9 form any reason 3-month ART refill could not be scripted

Step 4: Explain important to see counsellor and what counsellor will provide

Where clinician is of the view that patient will benefit from counselling review and VL education:
explain importance of seeing counsellor

At facility with case management:
explain counsellor will also offer case management support

Refer to counsellor for Fast Track Initiation and Counselling combined session 3 and 4 combined and low risk CM offer

Visit schedule

Re-engagement visit

See detailed steps above

RE month 3 visit

If CD4<200 and **not already recalled for action** – provide AHD package and switch to SOP 9 Brown follow-up plan including following ART guidelines

Explain VL again and RPCs options

Take VL

1 month script + refill

RE month 4 visit

Check and communicate VL result

If VL>50 copies/ml:
Switch to SOP 9 Brown follow-up plan including following ART guidelines

If VLS AND well:

- TLD and RPCs offer
- If RPCs offer accepted: 6-month script (Decanting/ CCMDD) with **THREE** months ART (and TPT) refills
  Stop low risk case management

Facilities with case management (CM) only:
Provide low risk CM support if patient accepted

BROWN: Clinical concerns or uncontrolled hypertension or diabetes and/or interrupted treatment with VL>50 copies/ml

Be caring

AHD = Advanced HIV Disease
VLS = VL suppression

Re-engagement visit procedure

Step 1: Clinically manage presentation

Follow ART clinical guidelines

Follow PHC guidelines for uncontrolled DM/HPT

Step 2: Take CD4 count

Take CD4 count to identify AHD for AHD package delivery next visit

***Unless** CD4<200 in last 6 months, then immediately proceed with AHD package provision.*

Step 3: Assess for TPT

If person has not completed TPT, assess for and initiate TPT

Step 4: Explain patient return visit schedule

Explain visit schedule (see below) to provide clinical management and adherence support until viral load at 3rd month

If VL is suppressed can immediately get 3-month ART refill and access to RPCs.

Explain return visit in one month very important for:
1) CD4 results
2) If CD4<200 other clinical support package to prevent opportunistic infections
3) Clinical follow-up

Step 5: Restart ART immediately

If NO VLS within 6 months:
rescript same ART regimen for **ONE** month ART (and TPT) refill

If VLS within 6 months:
offer TLD and script for **ONE** month ART (and TPT) refill

Step 6: Explain important to see counsellor and what counsellor will provide

Where clinician is of the view that patient will benefit from adherence counselling:
explain importance of seeing counsellor who will provide adherence counselling, more information on viral load and RPCs

At facility with case management:
explain counsellor will also offer case management support

Refer to counsellor for EAC session 1 and high risk case management offer

Visit schedule

Re-engagement visit

See detailed steps above

RE month 1 visit

- Check and communicate CD4 result
- **CD4<200:** follow AHD package provision
- ART clinical guidelines follow-up
- **If uncontrolled DM/HPT:** PHC clinical guidelines follow-up
- **If CD4<200 or continued close clinical management required:** ONE month script + refill
- **If CD4>200 and clinically well now :** TWO months script + refill

RE month 2 visit

- AHD/ART clinical guidelines follow-up
- If uncontrolled DM/HPT: PHC clinical guide-lines follow-up
- Reminder VL next month and what this means
- 1 month script + refill

RE month 3 visit

- AHD/ART clinical guidelines follow-up
- Explain VL again and RPCs options
- Take VL
- 1 month script + refill

RE month 4 visit

- Check and communicate VL result
- **If VL>50 copies/ml:**
  Follow ART switch guidelines
  Continue high risk case management
- **If VLS AND well:**
  - TLD and RPCs offer
  - If RPCs offer accepted: 6-month script (Decanting/CCMDD) with **THREE** months ART (and TPT) refills
  - Stop high risk CM

Facilities with case management (CM) only: High risk CM support if patient accepted