HIV Learning Network

The **CQUIN** Project for Differentiated Service Delivery

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Case Management for Service Delivery Across the HIV Care Cascade

A CQUIN Webinar

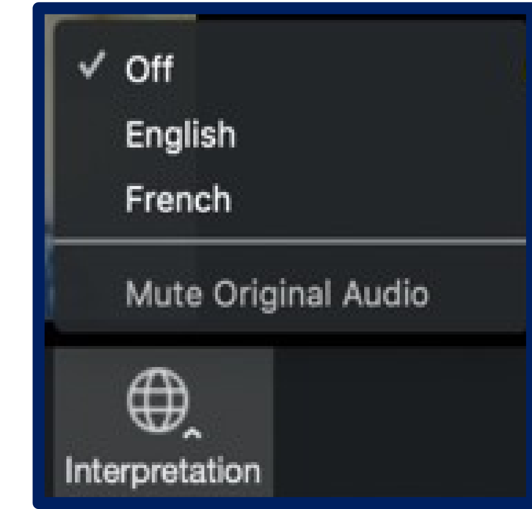
Tuesday, April 2, 2024

HIV **Coverage, Quality, and Impact Network**

Welcome/ Bienvenue

Peter Preko
CQUIN PI/Project Director
ICAP at Columbia University

- Be sure you have selected the language of your choice using the "Interpretation" menu on the bottom of your screen.
- Assurez-vous d'avoir sélectionné la langue de votre choix à l'aide du menu <<Interprétation>> en bas de votre écran Zoom.



Housekeeping

- 90-minute webinar with framing presentations followed by a panel discussion with Q&A
- Slides and recording will be available on the CQUIN website (www.cquin.icap.columbia.edu)
- Please type questions in the Q&A box located on the toolbar at the bottom of your screen
- If you would prefer to speak, please use the "raise hand" function on the toolbar and we will unmute you so that you have control of your microphone
- If you are a French or English speaker, please ask your question in your language of choice and the interpreters will translate as needed

Agenda

Timing	Run of Show
10 Minutes	**Welcome/Introductions/Housekeeping** Peter Preko, PI/Project Director, ICAP at Columbia University
15 Minutes	**Findings from the CDC Case Management Survey** Caitlin Biedron, Medical Officer, CDC Atlanta
15 Minutes	**Case Study – Linkage Case Management, Eswatini** Harriet Mamba, Community Linkages Coordinator, MOH Eswatini
15 Minutes	**Case Study – Use of Case management across the treatment cascade, Nigeria** Eleen Ekanem, DSD Coordinator, MOH Nigeria
10 Minutes	**Case Study – Coach Mpilo Project, South Africa** Thulani Grenville-Grey, Matchboxology, South Africa
20 Minutes	**Panel discussion & moderated Q&A session** Co-Moderators: Peter Preko & Maureen Syowai, ICAP at Columbia University **Panelists:** Caitlin Biedron (CDC Atlanta), Harriet Mamba (MOH Eswatini), Eleen Ekanem (MOH Nigeria), Thulani Grenville-Grey (MatchBoxology, ZA), Sabelo Phungwayo (Coach Mpilo, ZA)
5 Minutes	Wrap up and Next Steps

CDC Case Management Survey Findings

Caitlin Biedron

Medical Officer

HIV Care & Treatment Branch

U.S. Centers for Disease
Control & Prevention

Case Management Questionnaire: Results and Key Findings

April 2, 2024

CQUIN Case Management Webinar

Caitlin Biedron, MD, MSc
Michelle Williams Sherlock, MPH
HIV Care & Treatment Branch
Division of Global HIV & TB (DGHT)
CDC-Atlanta

Presentation Outline

- **Background and guidance on case management**

- **CM Questionnaire: Part 1 – Survey participant characteristics**
  - Role and type of organization
  - Country

- **CM Questionnaire: Part 2 – Client eligibility and intensity of CM services**
  - Client Eligibility
  - Risk Stratification Approach

- **CM Questionnaire: Part 3 – CM staffing models**
  - Staffing models
  - Types of cadres involved in CMT approach

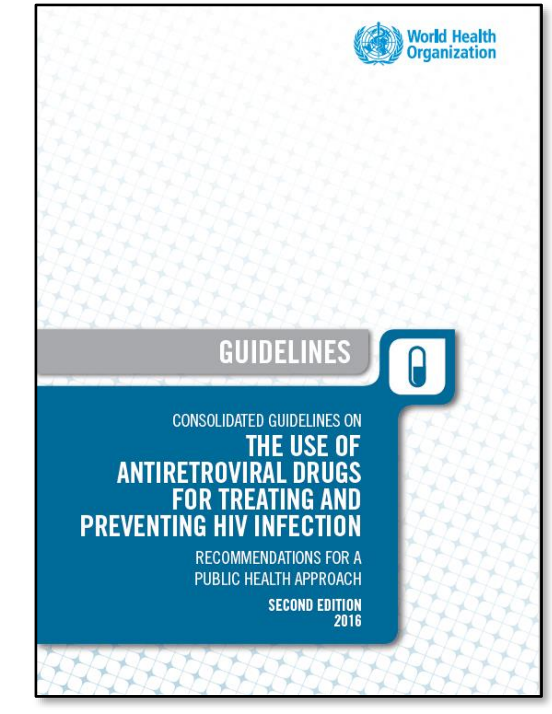
- **CM Questionnaire: Part 4 – CM functions, delivery modalities, and graduation criteria**
  - CM daily functions and activities
  - Service delivery modalities
  - Graduation criteria

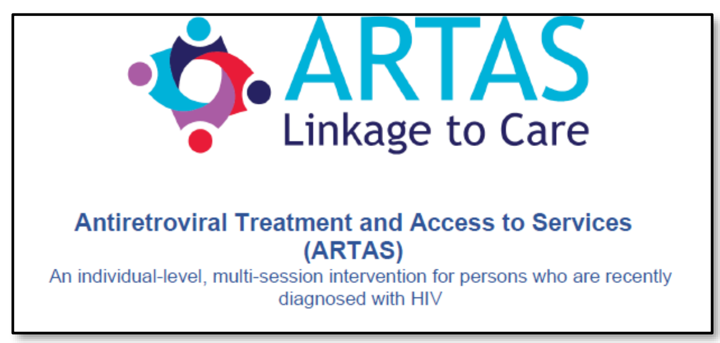
Background & Relevant Guidance on Case Management

Case Management Guidance: WHO Guidelines (2016) & IAPAC Guidelines (2015)

- **WHO HIV Consolidated Guidelines (2016):**
  - HIV case management is defined as the personalized, one-to-one relationship between individuals seeking HIV-related clinical services and those providing support (i.e., case managers).
  - Case management was recommended by WHO as an intervention to support **linkage to treatment.**

- **International Association of Providers of AIDS Care (IAPAC) (2015):**
  - The **ARTAS and ARTAS-II studies**, taken together, showed increased rates of linkage to care with intensive strengths-based case management compared to standard procedures (78 to 79% versus 60% within 6 months).
  - This led to the IAPAC recommendation to use strengths-based case management for improving **linkage to care**.
  - Additionally, using case management to **retain PLHIV** and to locate and **re-engage clients** following an interruption was also recommended by IAPAC.





Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach – second edition. Geneva: World Health Organization; 2016 (https://www.who.int/hiv/pub/arv/arv-2016/en).

Zuniga, JM, et al. IAPAC Guidelines for Optimizing the HIV Care Continuum for Adults and Adolescents. International Advisory Panel on HIV Care Continuum Optimization. .Journal of the International Association of Providers of AIDS Care. 2015, Vol. 14 (Supplement 1) S3–S34

Case Management Functions & Services

Case manager functions:

- Roles of case managers may differ across settings, but the overarching goal is to provide individualized assistance to clients to improve their health outcomes (Kelly et al, 2019).
- Functions may include client advocacy, care coordination, needs assessment and case monitoring, community engagement, education, administration activities, psychosocial support, and service navigation (Kelly et al, 2019).
- Depending on the context, the scope of work of a case manager could be performed by one or several cadres, such as linkage officer, case officer, peer counselor, peer coach, treatment navigator, clinician, or other staff member.

Case manager terminology:

- For the purposes of this presentation, the term "***case manager"*** refers to the cadre or cadres responsible for assisting clients with navigating HIV care and treatment services.
- Services provided by case managers are **context-specific** and may differ based on national guidelines and/or implementing partner program design.
- In general, ***case management programs*** often include the following services: conducting a baseline barrier or risk assessment, strengthening health literacy, assisting with treatment navigation, providing referral services and psychosocial support, supporting retention & adherence, and facilitating the transition to DSD models.

Kelly KJ, Doucet S, Luke A. Exploring the roles, functions, and background of patient navigators and case managers: a scoping review. Int J Nurs Stud 2019; 98: 27 – 47.

Case Management Guidance: WHO HIV Service Delivery Guidelines (2021)

- **Strategies to support same-day ART initiation**
  - Improve ART counseling content and delivery
  - Promote shared decision-making
  - Provide navigation during ART initiation session
- **Strategies to support post-ART initiation**
  - Appointment reminders
  - Intensified post-ART counseling
  - Ongoing navigation and support
- **Psychosocial interventions for adolescents and young adults living with HIV**
  - Interventions based on peer support and social networks, which are peer-driven.
  - Motivational interviewing, a client-centered counselling style.
- **Interventions to trace people who have disengaged from care and provide support for re-engagement**
  - Such as reminders, economic interventions, case management, or policy interventions

Table 1. Evidence-informed approaches to supporting same-day ART initiation at the level of the client, provider and health system

Strategies targeting clients		Strategies targeting health-care providers	Strategies targeting the health system
Pre-ART initiation	Reduce administrative requirements to initiate ART	Provider training on rapid ART initiation	Reduce the number of pre-ART sessions
	Reduce pre-ART psychosocial requirements	Provider training on counselling	First ART counselling on the day of HIV testing
	Aim to improve pre-ART counselling content and delivery	Provider supervision, coaching and mentorship	Increase the duration of pre-ART sessions
	Promote shared decision-making	Provider performance feedback	Expedite the scheduling of appointments to initiate ART
	Increase duration of pre-ART sessions	Provide standard operating procedures and guidance documents	Provide ART first starter pack immediately with no pharmacy waiting time
	Navigation during ART initiation visit	Provide decision support tool (checklist or algorithm)	Point-of-care CD4, TB testing and diagnosis
	Incentives		
Post-ART initiation	Appointment reminders		
	Short-term ongoing navigation and support		
	Intensified post-ART counselling		
	Increased duration post-ART initiation clinical visit		
	Incentive to attend post-ART initiation visits		

Updated recommendations on service delivery for the treatment and care of people living with HIV. Geneva: World Health Organization; 2021.

Case Management Guidance: Challenges & Unresolved Issues

- **Many national HIV programs now use case management to support HIV service delivery across the cascade** of HIV testing, linkage, ART initiation, and retention, with the goal of assisting clients in achieving viral suppression.
- **However, ambiguity remains regarding what core services are most critical to CM programs**.
- **Specific roles and responsibilities of case managers also remain unclear** along the HIV cascade, and how such roles overlap or intersect with roles of peer navigators, peer coaches, adherence counselors, and other providers.
- **Clearer operational definitions for case management** – which are adaptable based on setting and context – may be helpful in reaching a shared understanding for clinical & programmatic implementation.
- **Language and terminology matters**
  - *'Words have power: they bestow or remove dignity, build or break stigma, and divide or unite the HIV response… through words we choose to use at IAS, we acknowledge that a person is so much more than a condition; we promote inclusivity, dialogue, and equality.'* -International AIDS Society (2024)

"People-first" language puts the person before their condition

Do…

Don't…

use:	label people as:
people or person living with HIV; person or people with COVID-19; person or people with TB; person or people living with HIV and TB; healthcare seekers or clients.	HIV-infected; infected; co-infected; cases; carriers; victims; patients; sufferers.

Language Matters: People-first language and the HIV response. International AIDS Society; 2024. Language matters | International AIDS Society (IAS) (iasociety.org)

Part 1 – Survey Description & Participant Characteristics

PEPFAR Continuity of Treatment COOP – Case Management Workstream

Case Management Workstream Objectives:

1. Compile findings and conduct analyses to inform COP case management guidance for PEPFAR programs.

2. Disseminate best practice tools such as CM SOPs, job aids, and checklists to the broader PEPFAR community.

3. Identify core components for case management packages to facilitate transition to governments, as programs move towards sustainability and develop sustainability roadmaps.

Additional Challenges and Key Issues:

- **Impact Assessment**:
  - Impact of CM services: What evidence base already exists in the literature?
  - Are there additional examples from country programs in which the impact of case management services on patient outcomes has been assessed, using site level or patient level data?

- **Transition to MOH-led models**
  - What will CM look like as HIV activities and programs continue to be transitioned to MOH/national governments?
  - What are the core services that should be maintained and for whom?
  - Can MoH-supported clinic staff provide these services or are other cadres needed? (e.g., CHW, PLHIV peer counselors, etc)

Case Management Survey: Objectives and Dissemination

Objectives and Overview of Survey:

- Overall aim: To better understand the landscape of case management (CM) services offered by different national programs, sub-national programs, and implementing partners.
- Information obtained to be used to compile the core components of such programs and to share current CM best practices and innovative approaches.
- All responses will be confidential, and only aggregate results to be shared.

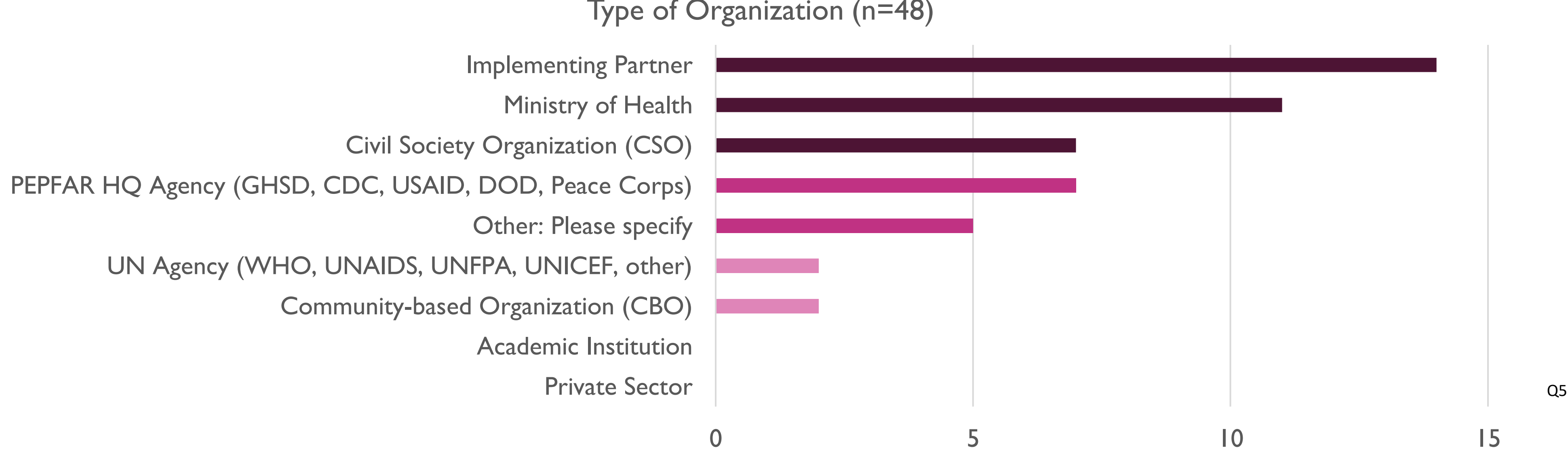
Survey Dissemination:

- Survey dissemination during occurred during the CQUIN 7th Annual Meeting (November 2023)
- All participants at the CQUIN Annual Meeting (~250) were sent the link to the CM survey via email.
- Survey was programmed on Qualtrics and was available in both English and French.
- Overall, 69 participants started the survey.
- 48 of 69 respondents are included in this analysis.
- 21 respondents provided demographic details only, and were excluded from this analysis given that they did not provide a response to at least one CM question.

Part 1 – Survey Participant Characteristics (1)

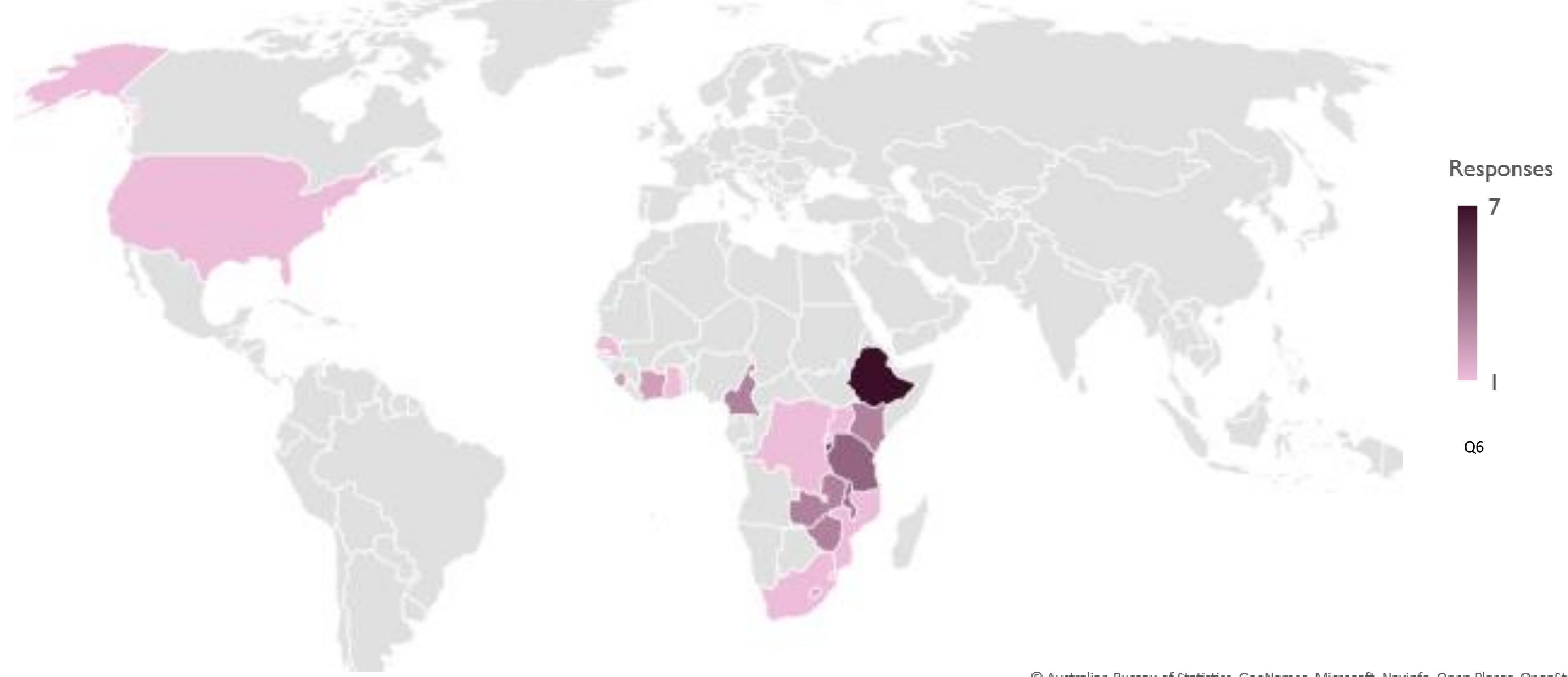
- **Role of respondent**
  - *Program manager* was the most heavily represented role (44% of respondents)
  - Followed by other (22%), HCW (10%), policy maker (10%)

- **Type of organization**
  - *Implementing partner* was the most heavily represented organization type (29% of respondents)
  - Followed by MOH (23%), Civil Society Organization (15%), and PEPFAR HQ agency (15%)



Part 1 – Survey Participant Characteristics (2)

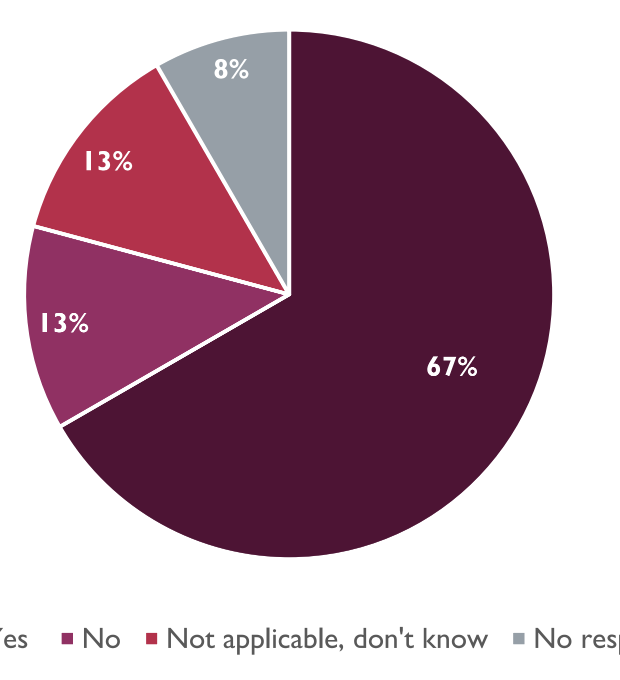
- **Country representation**:
  - 48 responses are included in this analysis.
  - 20 countries are represented by the 48 respondents.
  - Some countries are more heavily represented (Burundi n=6, Ethiopia n=7), while others less heavily represented (n=1 for most countries).



Part 2 – Client eligibility and intensity of CM services

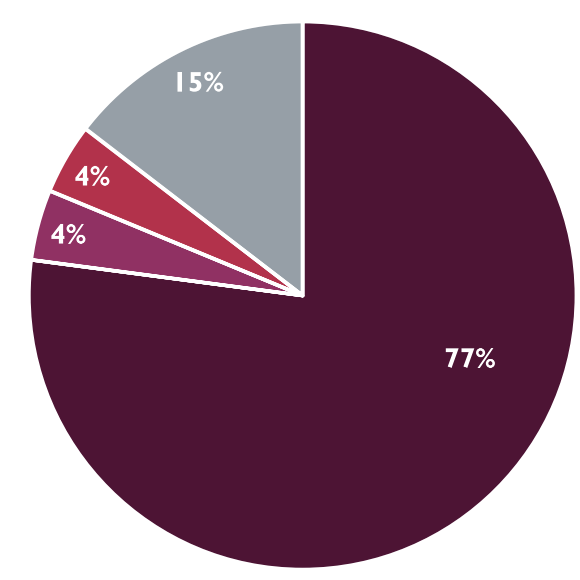
Part 2 – Client eligibility and intensity of CM services (1)

Most respondents (67%) indicated that **all PLHIV clients** are provided CM services.



Q8

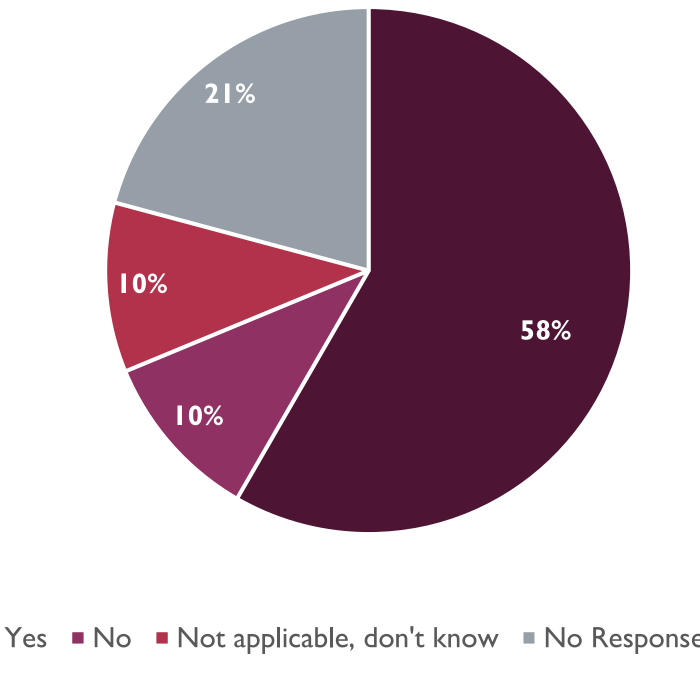
However, most respondents (77%) also indicated that **different CM services** were provided to different clients, depending on their clinical/social/ demographic characteristics.



- Different CM services provided to different groups of people depending on clinical, social, or demographic characteristics
- Everyone receives the same (or very similar) CM services
- Not applicable, don't know
- No Response

Q10

Furthermore, 58% of respondents report using a **risk stratification** approach to provide different intensity levels of CM services, depending on client characteristics.



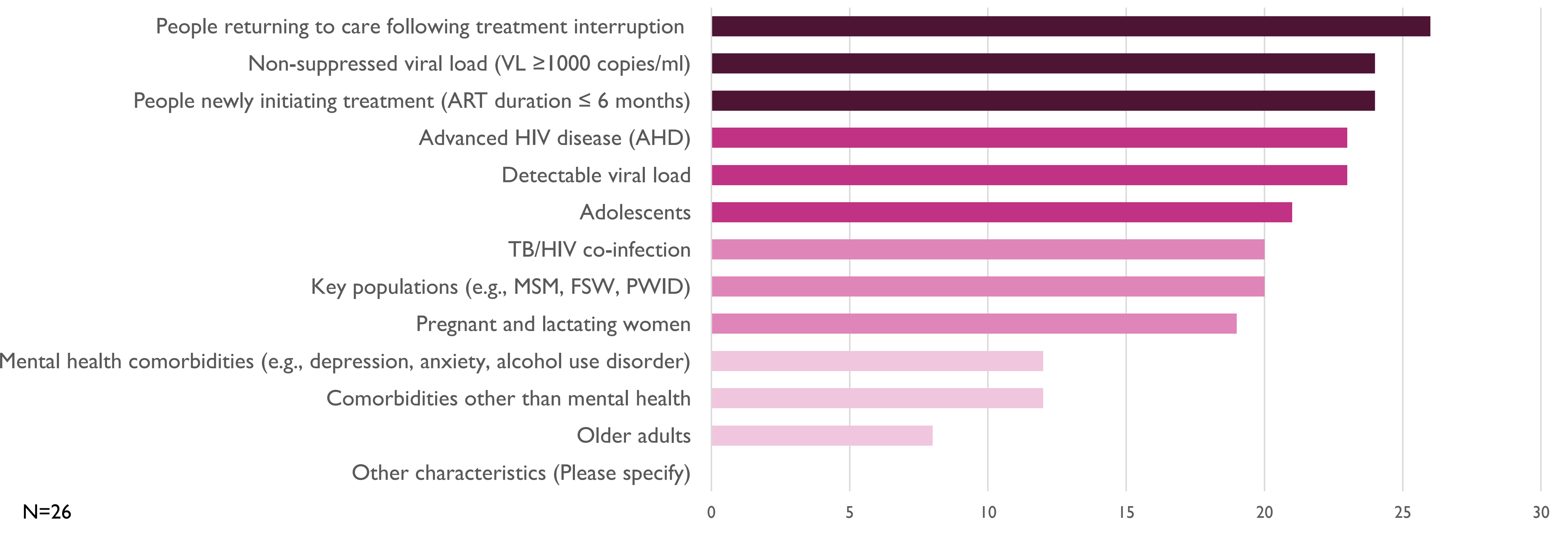
Q11

Part 2 – Client eligibility and intensity of CM services (2)

Risk Stratification: Key Findings

- Among the 28 respondents who noted using **risk stratification for CM services**, 26 provided further details on which client characteristics are considered.

If risk stratification is being used to determine the level of intensity of CM services, which of the following characteristics or demographics are considered? [Select all that apply]

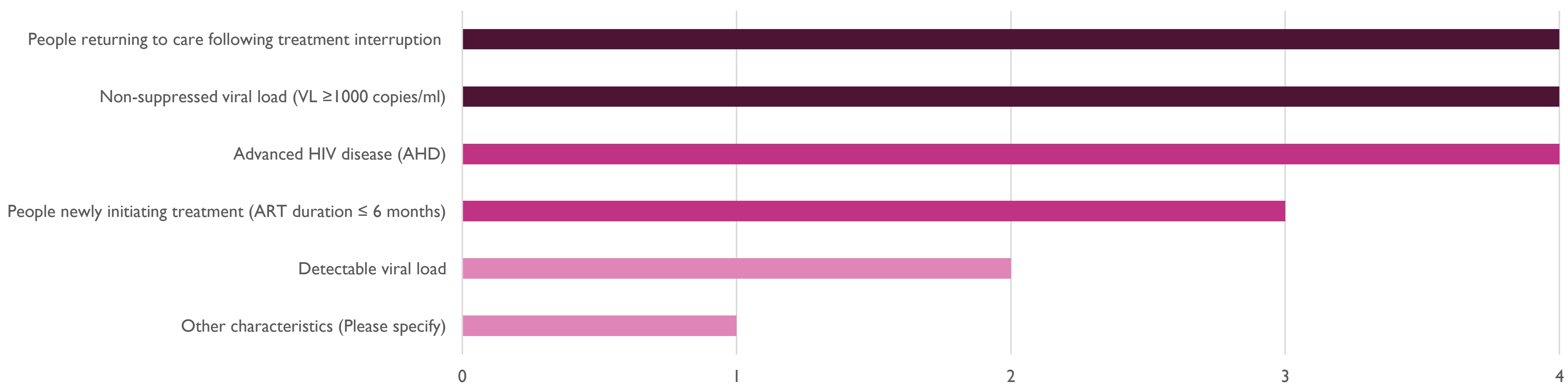


Q12 Follow on from Q11

Part 2 – Client eligibility and intensity of CM services (3)

- **Client eligibility criteria: Key Findings**
  - Among those respondents who indicated that **not all clients** are provided CM services (n=6, 14% of total respondents), 4 respondents reported on the **eligibility criteria** to determine who should receive CM services.
  - The most commonly reported eligibility criteria include:
    - Clients RTC following missed appointment or treatment interruption
    - Non-suppressed VL (VL ≥1000 copies/ml)
    - Advanced HIV disease (AHD)

If CM services are not offered to all people on treatment, which eligibility criteria is your program using to determine who should receive CM services? [select all that apply]



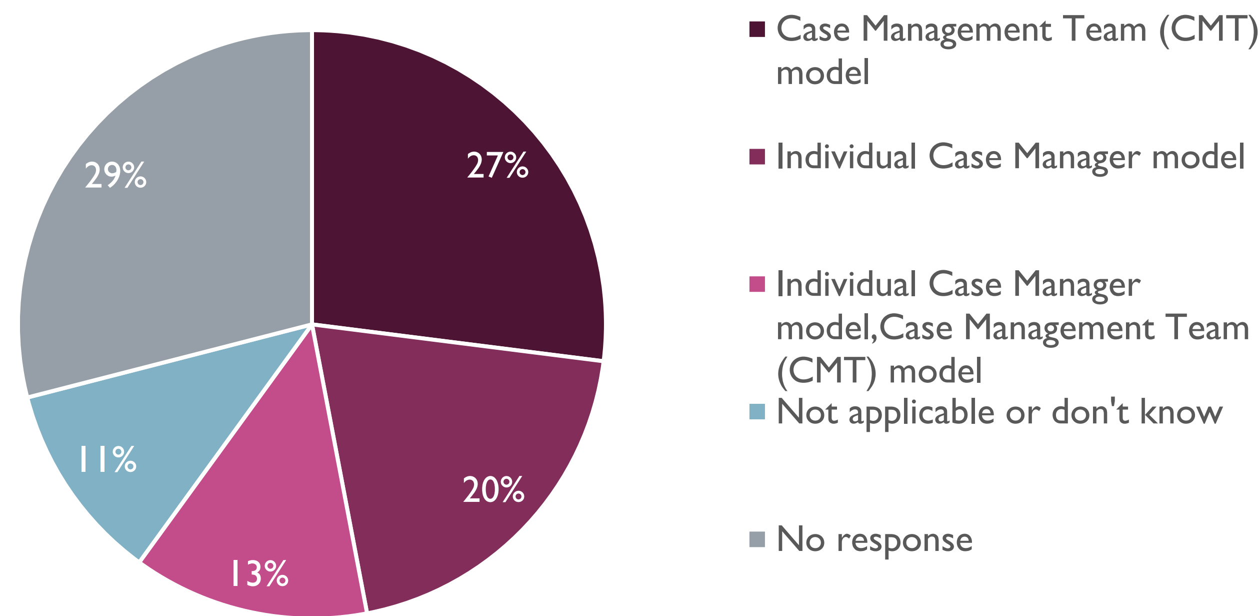
Q9 Follow on from Q8

Part 3 – CM Staffing Models and Cadres

Part 3 – CM Staffing Models and Cadres (1)

- **CM Staffing Models: Key Findings**
  - For this survey, a *Case Management Team (CMT)* refers to a multidisciplinary team which shares the responsibility of providing case management services.
  - 27% of respondents indicated that their program uses a **case manager team (CMT)** approach
  - 20% of respondents reported their program uses an **individual case manager approach**
  - 13% of respondents reported their program uses a **combination of the two approaches**

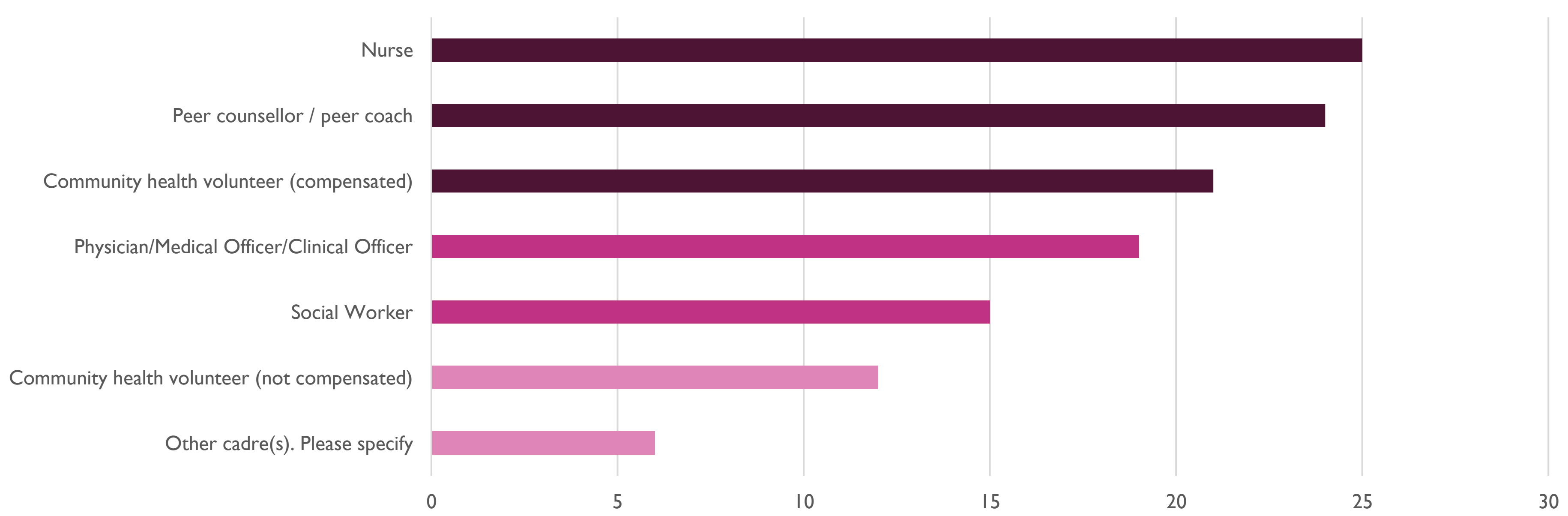
CM approach: Does your program have individual case managers or use a CM Team (CMT) model?



Part 3 – CM Staffing Models and Cadres (2)

- **Staffing Cadres: Key Findings**
  - **The most common cadres** that were reported to be included in CMTs included nurses, peer counsellors/peer coaches, and community health volunteers (compensated).
  - **Less frequently reported cadres** included physicians/medical officers, social workers, and community health volunteers (non-compensated).

If a CMT model is being used, which staff cadres are included in the CMT? [select all that apply]



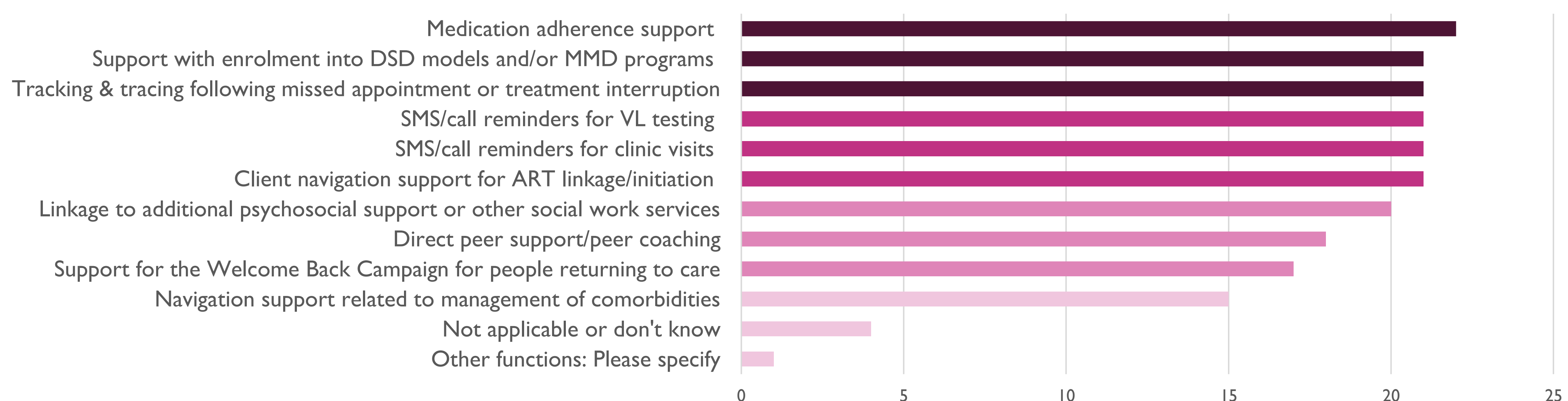
N=29/48

Q17 Follow on from Q16

Part 4 – CM Functions, Delivery Modalities, and Graduation Criteria

Part 4 – Case Management Functions & Activities

- **CM Functions: Key Findings**
  - 27/48 (56%) respondents reported on this question and noted that the **daily activities undertaken by CM** include a number of functions, which encompass tasks extending across the cascade of HIV care.
  - Most commonly reported task was **medication adherence support**
  - Other commonly reported tasks include navigation for ART initiation, SMS/call reminders, support for enrolment into a DSD or MMD program, and tracking & tracing following treatment interruption.



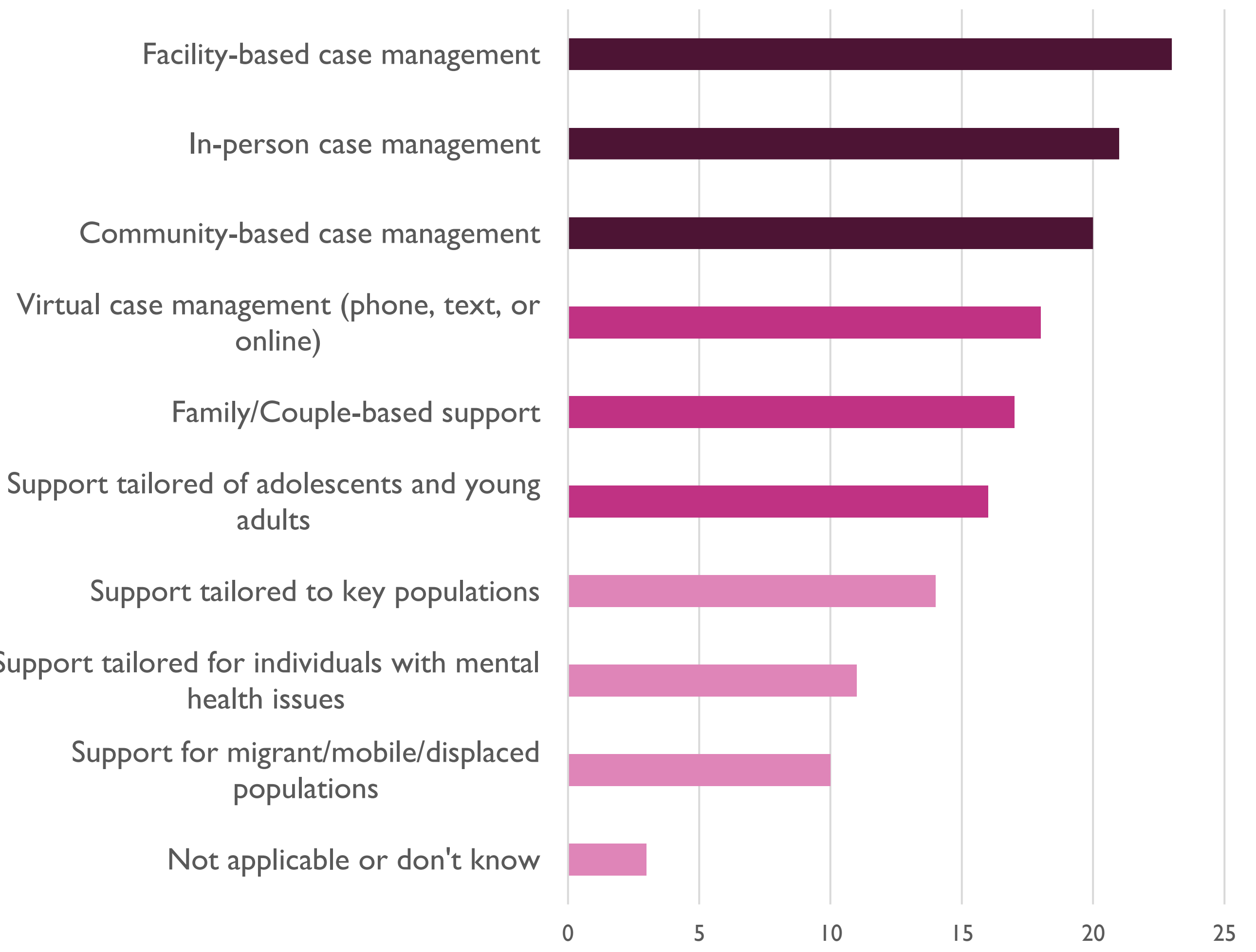
Q21

N=27/48

Part 4 – Case Management Service Delivery Modalities

Service Delivery Modalities: Key Findings

- Variety of service delivery modalities were **commonly reported** by respondents (>75%)
  - Facility-based CM
  - In-person CM
  - Community-based CM
- **Less commonly reported** service delivery modalities:
  - Virtual CM
  - Family/couple-based CM support
  - CM support tailored for adolescents/young adults, PLHIV with mental health comorbidities, and mobile populations



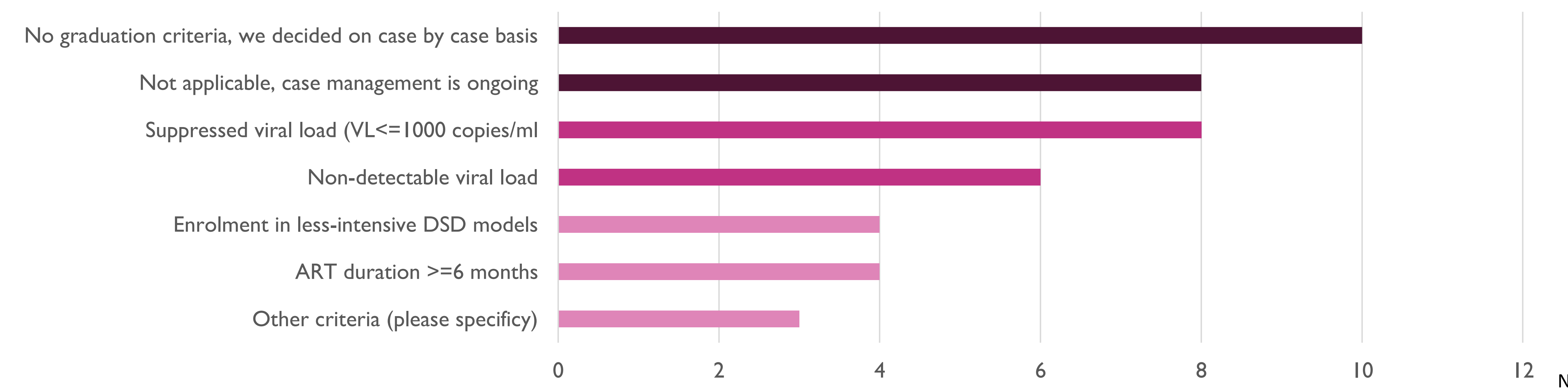
N=27/48

Q22

Part 4 – Case Management Graduation Criteria

CM Graduation Criteria: **Key Findings**

- Nearly half of respondents (45%) reported that they do not use graduation criteria, and instead decide on an individual basis when to end CM.
- Additionally, 36% of respondents reported that CM services are ongoing.
- Among those respondents who did report graduation criteria were used, the most common criteria was suppressed viral load (VL <1000 copies/ml)

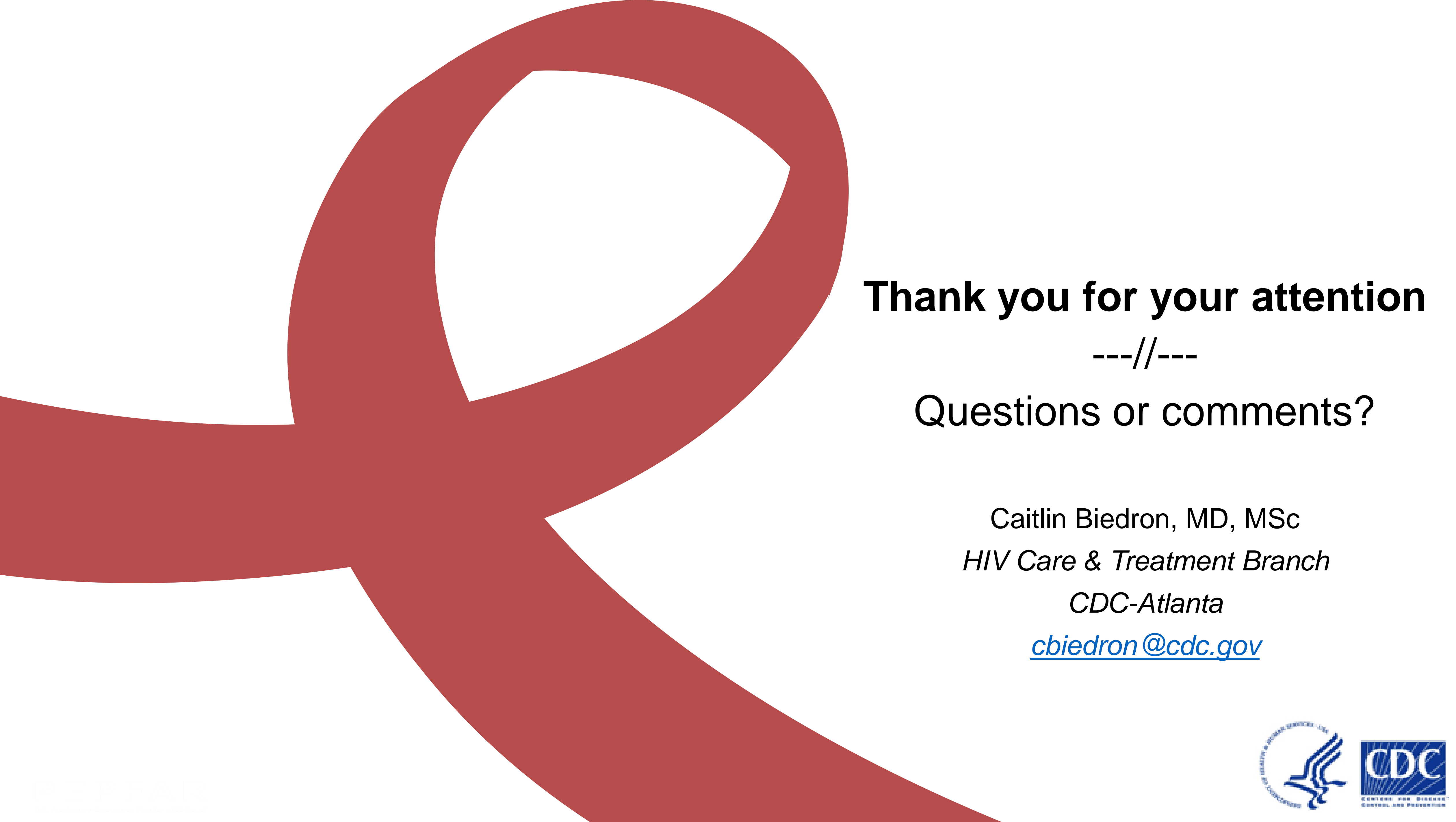


Q22

Guiding Questions for Panelists & Discussion

- **Guiding questions for speakers, panelists, and discussion**:
  - **Risk stratification**: Is a risk stratification approach being used by your program to provide different intensity levels of CM services, depending on client characteristics.?
  - **Impact assessment**: Are there examples from country programs where impact of case management services on patient outcomes has been assessed?
  - **Core components**: As HIV programmatic activities continue to transition to MOH/national programs, what are the core services that you feel should be maintained and for whom?

- **Additional perspectives from speakers and panelists**:
  - Are there examples of where **virtual case management** has been used, either in a stand-alone fashion or in combination with in-person case management?
  - What are some of the benefits / challenges of **peer coaching programs** that have been implemented?
    - What innovative approaches have been implemented by peer coaches to strengthen retention or adherence?
    - How do the responsibilities of peer coaches intersect with the duties of adherence nurses, clinicians, and other staff?
  - What steps are being taken to ensure **capacity building efforts** are occurring between implementing partners and MOH-supported staff?



Thank you for your attention
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Questions or comments?
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CDC

Case Study Speakers

Harriet Mamba

HIV Linkages Program Coordinator

Ministry of Health, Eswatini

Chinyere Eleen Ekanem

DSD Coordinator

Ministry of Health, Nigeria

Thulani Grenville-Grey

Human-Centered Design Practitioner

& Trainer

Matchboxology, South Africa

Implementation of Linkages Case Management in Eswatini

Harriet Mamba
Clara Nyapokoto

HIV Coverage, Quality, and Impact Network

Background - What was the problem?

- HIV prevalence among 15-49years 27%→23.7%
- Before 2015, only 37% of PLHIV identified at community were linking to care within 6 months of diagnosis
- Men 15–29 years were lagging behind in HIV testing
- Test and start was introduced in November 2016
- 2nd 95 in 2018 was at 87%
- PLHIV with CD4 < 350 were at 43.3% for the rural population while the urban was at 31.9%

The Intervention – Why Linkage Case Management (LCM)?

- To help improve early HIV diagnosis and ART initiation in Eswatini implemented a community-based HIV testing and peer-delivered, linkage case management recommended by WHO
- To help diagnose and initiate antiretroviral therapy (ART) for 95% of all persons living with HIV (PLHIV), the World Health Organization (WHO) LCM
- Weak community to facility referrals

CommLink Implementation

Partnerships

- Piloted by Population Services International (PSI) in collaboration with the Eswatini Ministry of Health & CDC Eswatini

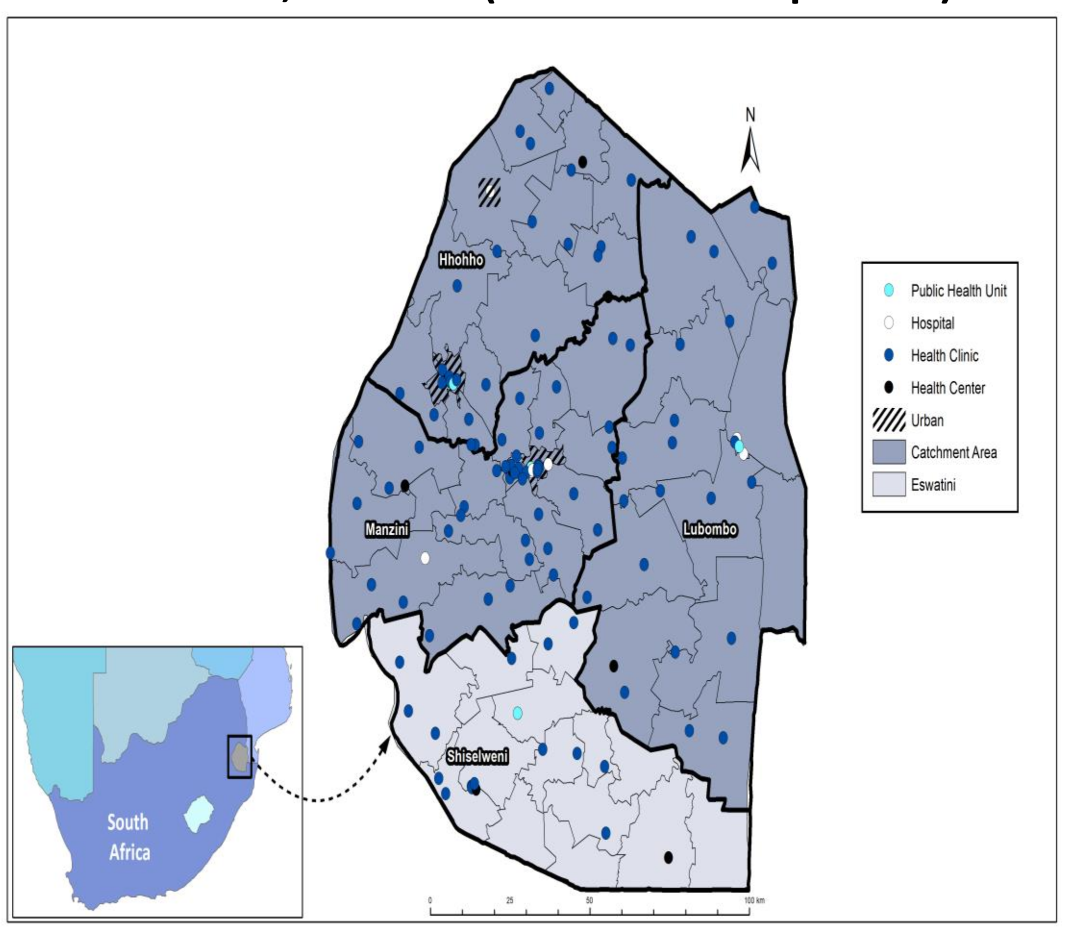
Phases

- Phase I (June 2015 - March 2017): two regions, 2 mobile-unit teams each of 3 EC counselors and 1 nurse, and ~2-4 HTS counselors
- Phase II (April 2017 - Sept 2018): three regions, 4 mobile-unit teams

Phase II Index Client Testing

- Re-training on importance of disclosure and offering HTS to partners, biologic children, and adult family members
- Modified forms and expanded scope to include "associates" of clients
  - *Associates* are persons other than partners or family members who have defaulted from care or who might benefit from HTS
    - Examples include friends, neighbors, coworkers, etc.
    - *Sex partners of index patients who do not want to identify by name*

CommLink Phase I & II Operating Areas and ART Facilities, Eswatini (June 2015 – Sept 2018)



CommLink (Eswatini LCM) Model

Community-based HIV Testing Services
- Homesteads, high-traffic venues, bars, etc.
- All HTS clients informed about CommLink

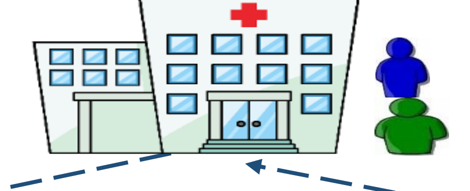
HIV+ Client Expert Client (EC)

LCM Session 1
- Explains role and scope of CommLink
- Discloses status, Tx history, and conveys importance of early enrollment and ART

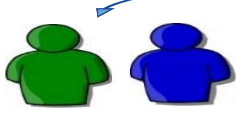
Nurse

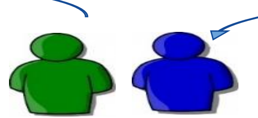
Point-of-diagnosis Clinical Services
- Medical assessment, WHO staging, CD4 testing, TB and STI screening, CTX

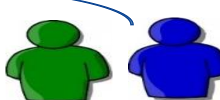
Appointed Treatment Navigation
- Call clients to ensure appointment are kept
- Orient clients to sequence and stations of care
- Stay with clients for the duration of the 1st visit to provide psychosocial and info. support



Transportation
- If requested and possible
- 1st visit only







LCM Sessions 4-5 (if needed)

LCM Session 3

LCM Session 2

Telephone-based Support
- Weekly to bi-weekly calls, often initiated by clients
- Immediate support to address emerging questions, fears, side effects, barriers
- Appointment reminders for treatment navigation and index testing

Follow-up LCM Sessions
- Sessions conducted at healthcare facilities, homes, or other locations
- Often occurred at facilities during medical appointments
- Provide psychosocial, informational, and ART adherence support

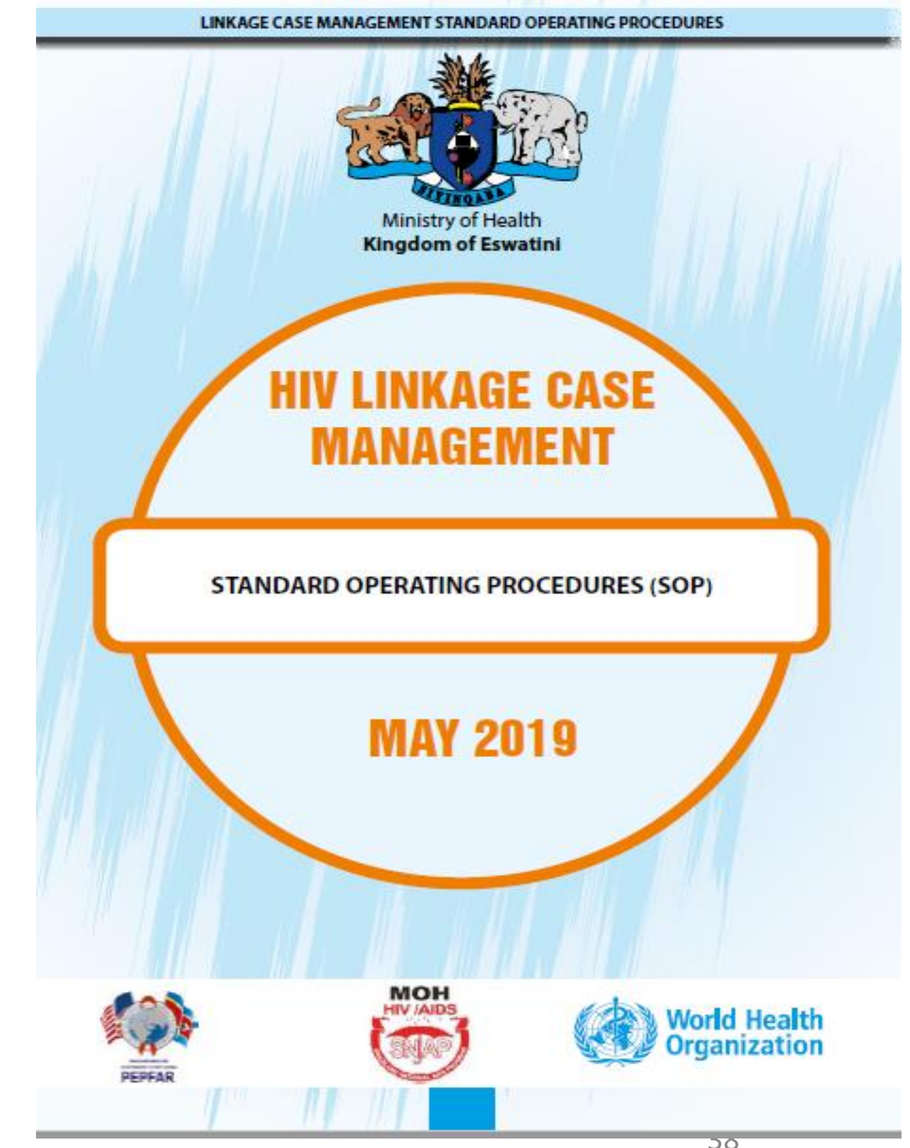
Follow-up LCM Sessions (Cont.)
- Encourage, plan, and facilitate disclosure
- Support index testing for partners, family members, and associates
- Identify, and mitigate or resolve barriers to enrollment and retention in care
- Support other ECs on challenging cases

Impact of CommLink

ART eligibility period and CommLink client characteristics	Total Clients n	Enrolled in HIV Care n (%)	Initiated on ART n (%)	Received $\geq$1 ARV Refills n (%)
Total	1,250	1,215 (97)	1,120 (90)	1,051 (94)
ART eligibility periods				
Jun 2015 - Nov 2015 (CD4≤350)	137	127 (93)	90 (66)	78 (87)
Dec 2015 - Sep 2016 (CD4<500)	289	285 (99)	235 (81)	214 (91)
Oct 2016 - Sep 2018 (test and treat)	824	803 (97)	795 (96)	759 (95)
Sex				
Male	699	676 (97)	623 (89)	576 (92)
Female	551	539 (98)	497 (90)	475 (96)
Age group (years)				
15-24	207	202 (98)	185 (89)	170 (92)
25-34	541	521 (96)	474 (88)	446 (94)
>34	502	492 (98)	461 (92)	435 (94)
Route of participation				
Outreach testing	1,040	1,012 (97)	920 (88)	855 (93)
Index client testing	210	203 (97)	200 (95)	196 (98)
Partner	64	64 (100)	62 (97)	61 (98)
Family member	67	65 (97)	65 (97)	63 (97)
Associate	79	74 (94)	73 (92)	72 (99)

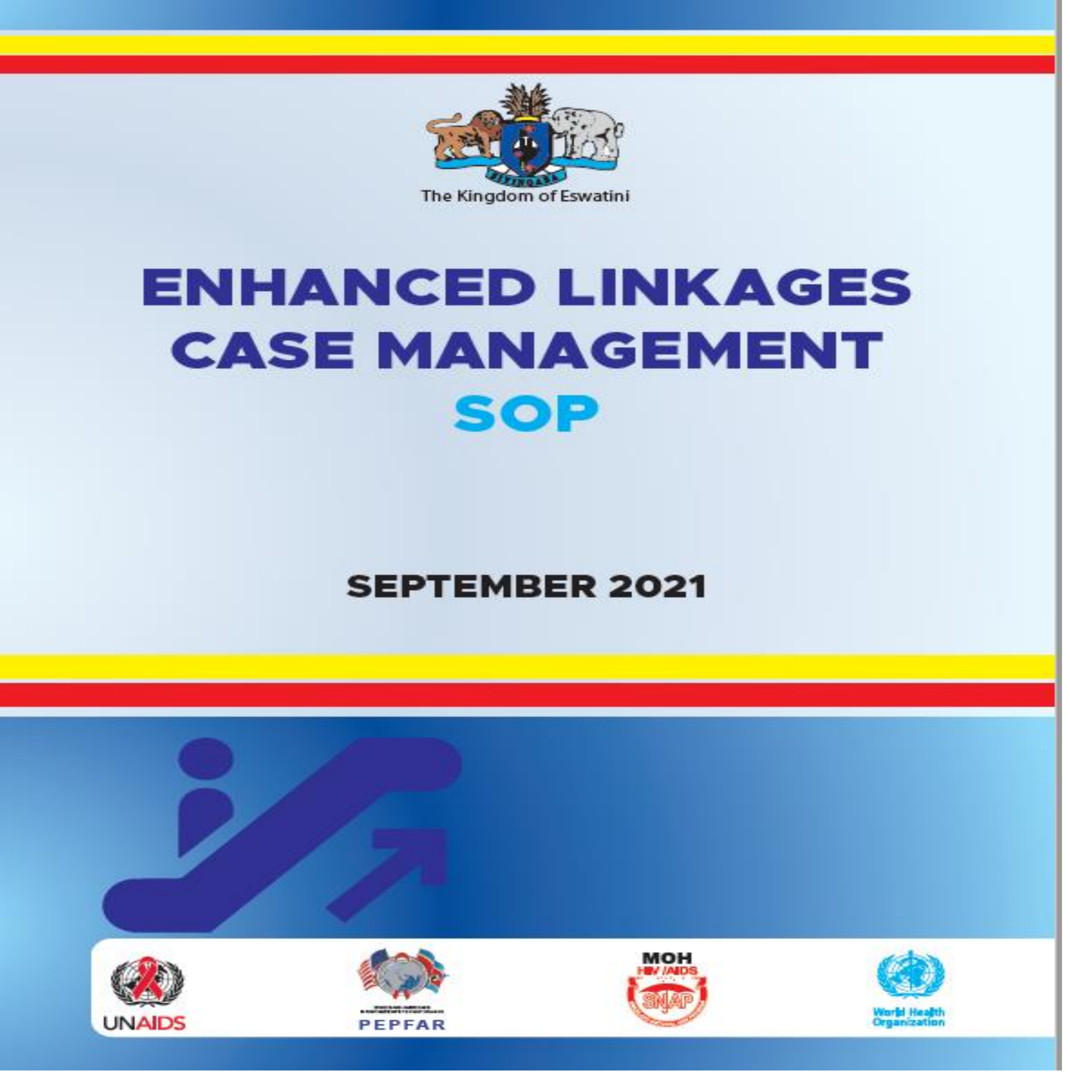
Policy Implication following CommLink Pilot

- Eswatini Ministry of Health approved peer-delivered, linkage case management in 2018 as a national standard of care for all newly diagnosed PLHIV
- LCM is implemented in all health facilities
- Services provided by peer supporters:
  - Index elicitation of consenting high risk associates, adult family members and biological children,
  - Individualised services(Telephone calls and psychosocial support),
  - Treatment navigation

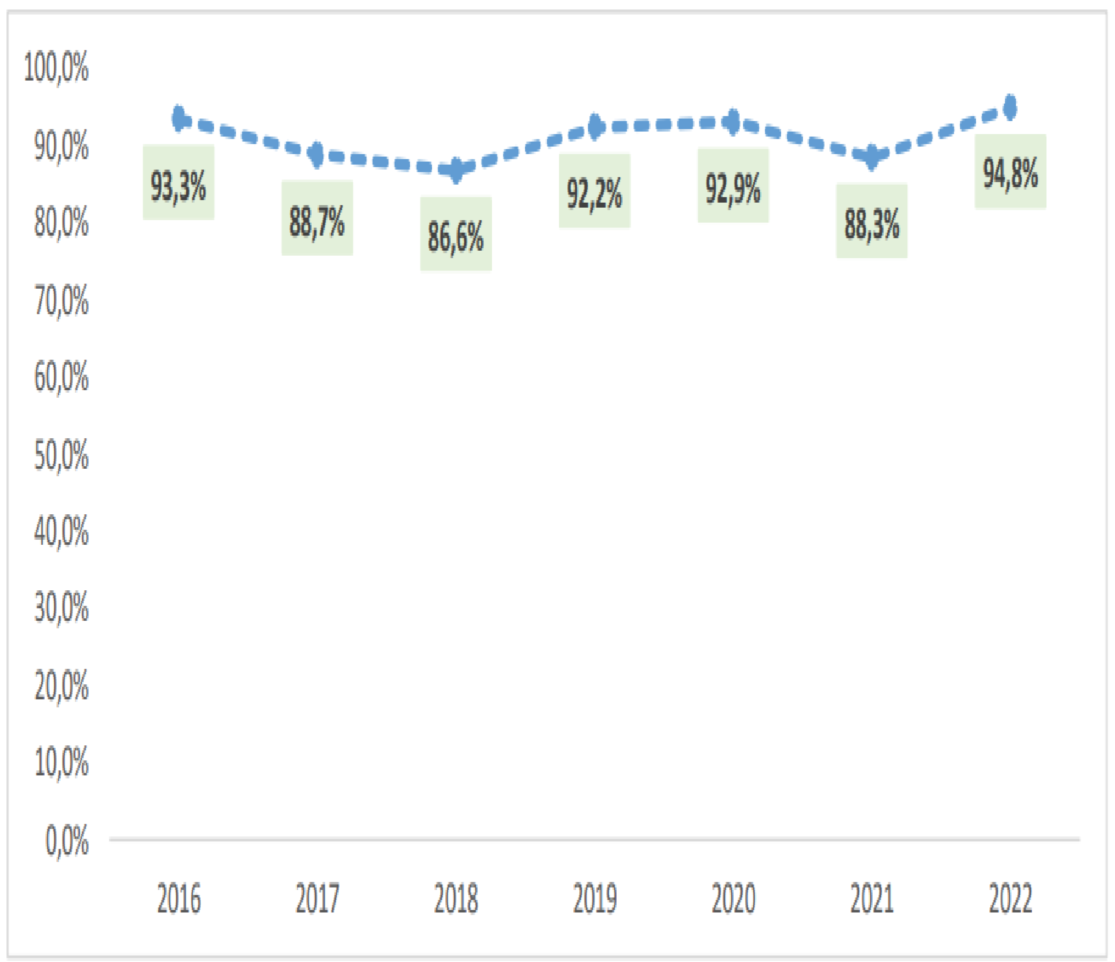


Progress since LCM policy adoption

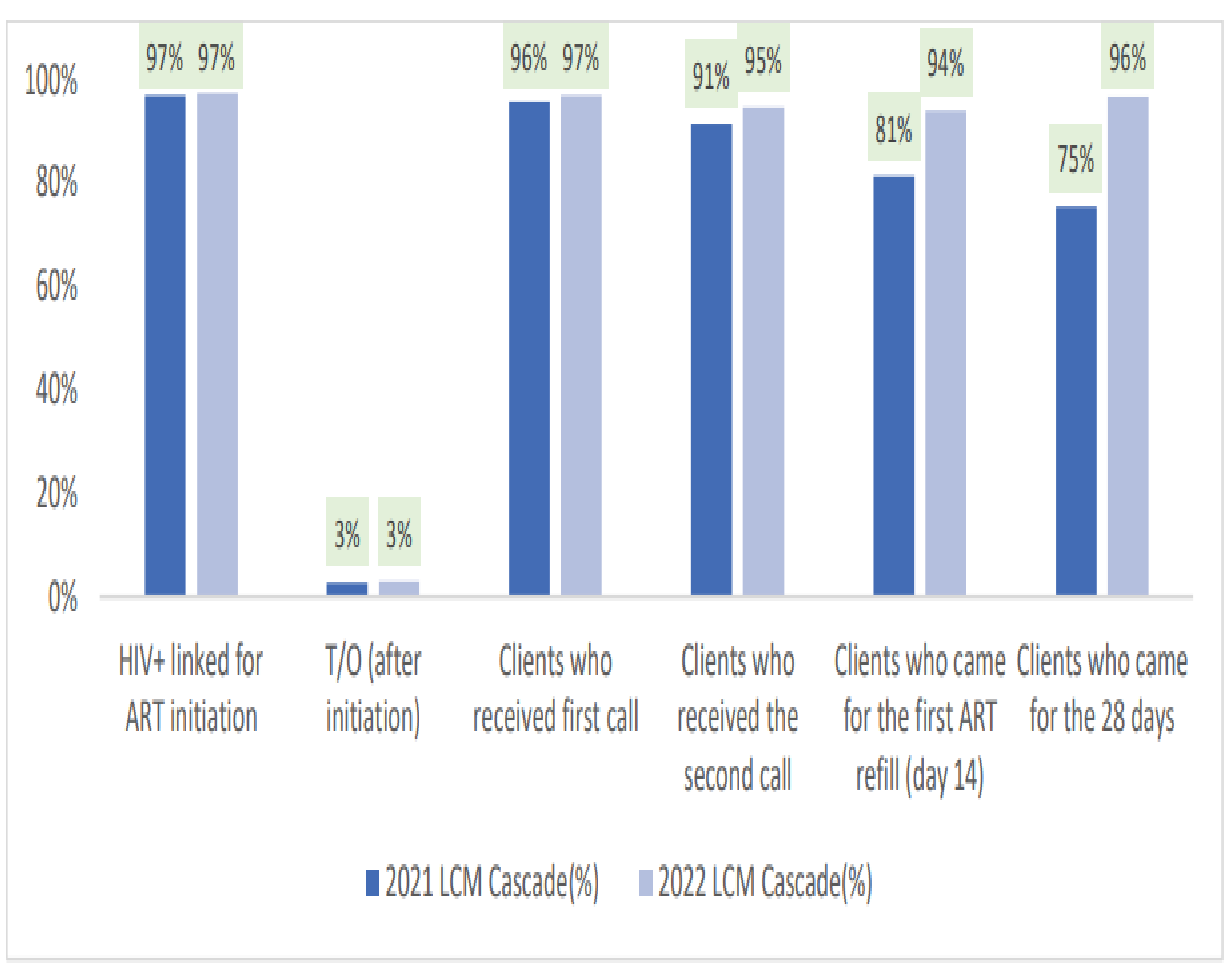
- Linkage case management SOPs updated in 2021
  - LCM extended to 6 months
- Implementation of collaborative meeting among facilities and community health care workers
- Appointment of focal persons at both facility and community level to improve linkages
- Tracking or returning to care indicators developed
- Provision of peer support for ART initiation and those returning to care to assist with psychosocial counselling, disclosure and follow up on index contacts
- Implementation of escalation counselling for clients not ready to be initiated
- Tracking of ELCM outcome and linkages to prevention services during MDT's and TWG meetings



Linkages and retention trends



Source: HMIS,2022



Source: HMIS. 2022

Direct linkage

	Tested HIV +	Initiated on ART	Same day initiation	Initiated within 7 days	Initiated within 14 days	Initiated within 1 month
Count	6352	5672	4579	5117	5330	5523
%		89.3%	80.7%	90.2%	94.0%	97.4%

Lesson Learned

- Use of electronic medical records system (EMR) and unique identifier improve data quality of the highly mobile clients.
- Capacity building on ECLM is critical
- Inadequate integration of prevention services in all entry points
- Line listing of clients delaying ART
- Escalation counselling of clients delaying ART initiation or have adherence/psychosocial issues
- MDT approach to provision of psychosocial support aids continuity in care
- Bi-directional linkages is important in eLCM implementation
- Collaboration between community partners and facilities is important for Community ART initiation
- Program for IIT returning to care

Challenges and Recommendations

Challenges	Recommendations
1. Linkage Gap -13% of men aged 25-34 - Late presentation - 13% of Tx_ new	➢ Provide comprehensive male friendly clinics ➢ Focus group discussion ➢ Collaborate with private sector ➢ Pretreatment viral load ➢ Engage private facilities
2. CMIS down time	➢ Offline version CMIS
3. Inadequate confidentiality with EMR	➢ Security measures in place
4. Inadequate deployment of psychologist in health facilities	➢ Train health care workers on psychological first aid

Acknowledgement

- Coordination

- TA
- Funding

- CommLink Study

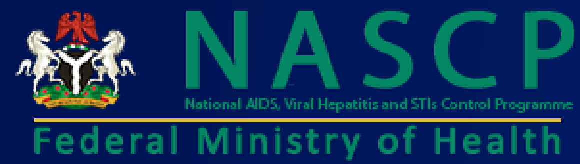
THANK YOU!

SIYABONGA

OBRIGADO

TATENDA

MERCI



Case Management for Service Delivery Across the HIV Care Cascade

Case study from Nigeria

National HIV/AIDS, Viral Hepatitis and STIs Control Program (NASCP)

Abuja, Nigeria

2nd April 2024

Outline

icap Global Health
THE CQUIN NETWORK

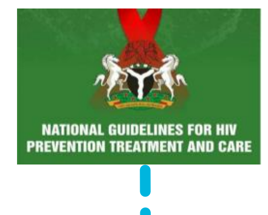
Country Profile

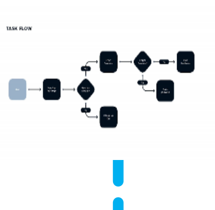
Estimated Population
226.2M
Nigerian Population Commission - Dec. 2023

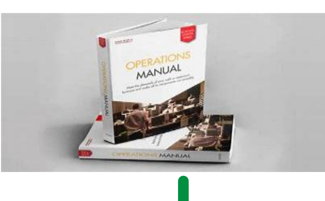
PLHIV Burden
2.0M

HIV Prevalence
1.3%
NAIIS 2018

Nigerians on ARV Treatment
1.74M
2023 Programmatic data







- **2016**: First Recommended DSD Packages of Care in the 2016 National Guidelines for HIV/AIDS Prev, Tx and Care
- **2018**: Conducted a Situational Analysis on DSD
- **2019**: Establishment of a Country DSD Task Team (now DSD Subcommittee)
- **2019-2021**: Development of DSD Operational Manual, Training Guides/Slides and Job Aids
- **Nov. 2021**: Nigeria Joined CQUIN
- **July 2021**: Finalization of DSD Operational Manual, Training Guides/Slides and Job Aids

Background-Case Management

- Case Management is a **collaborative process** deployed to **assess, plan, implement, co-ordinate, monitor and evaluate** recipients of care **options and services** required to **meet their health needs**
- Usually deployed as multifunctional teams – **Case management Teams (CMT)**
- **Case managers** play a pivotal role in the delivery of **tailored support and guidance** and **fosters a holistic approach to HIV care**, using **communication** and **available resources** to promote health, improve quality and cost-effective outcomes aimed at:
- Improving clients' experience of care
- Improving the health of populations
- Reducing per capita costs of health care.

Rationale for Case Management

- CMT is designed to address challenges along the HIV treatment continuum
    - Access treatment
    - Sustain good adherence
    - Be retained in treatment
    - Achieve viral suppression
    - Attain overall optimal health outcomes.

RATIONALE

- To improve program quality at site level
- Ensure accountability among site-level staff
- Ensure staff are motivated through performance-based monitoring and improvements
- Encourage teamwork and multi-tasking among staff

Case Management Team - Composition and roles

Model Case Management Team
1 CMT to 1000 clients

- ART Nurse/ Adherence Counselor — **CMT Lead**
  - Data Entry Assistant — **Data Quality Manager**
    - Linkage and Retention Officer — **Treatment Continuity**
    - Lay Adherence Counselor — **Adherence Counselling**
    - Viral Load Champion (VLC) — **VL Optimization**

Role	Responsibilities
CMT Lead	Coordinates & oversees day to day functions, provides technical and mentoring supports towards meeting CMT Targets Supervise and support clients follow-up / tracing activities in the facility
LAC	Ensures optimal adherence for all ART patients and document properly Facilitates the utilization of VL and EID results and ensures clients that qualify for EAC are enrolled and provided with quality EAC
LRO	Sends SMS reminders prior to the appointment date Calls missed appointments to reschedule visit date/ home visits
VLC	Ensures optimal adherence and document appropriately Facilitates the utilization of VL and EID results and Ensures clients are enrolled and provided with quality EAC
DEA	Responsible for documentation and data management for the team Ensure biometric verification and validation.

COORDINATION ⟷ COLLABORATION ⟷ TASK-SHIFTING

Client stratification and case management support

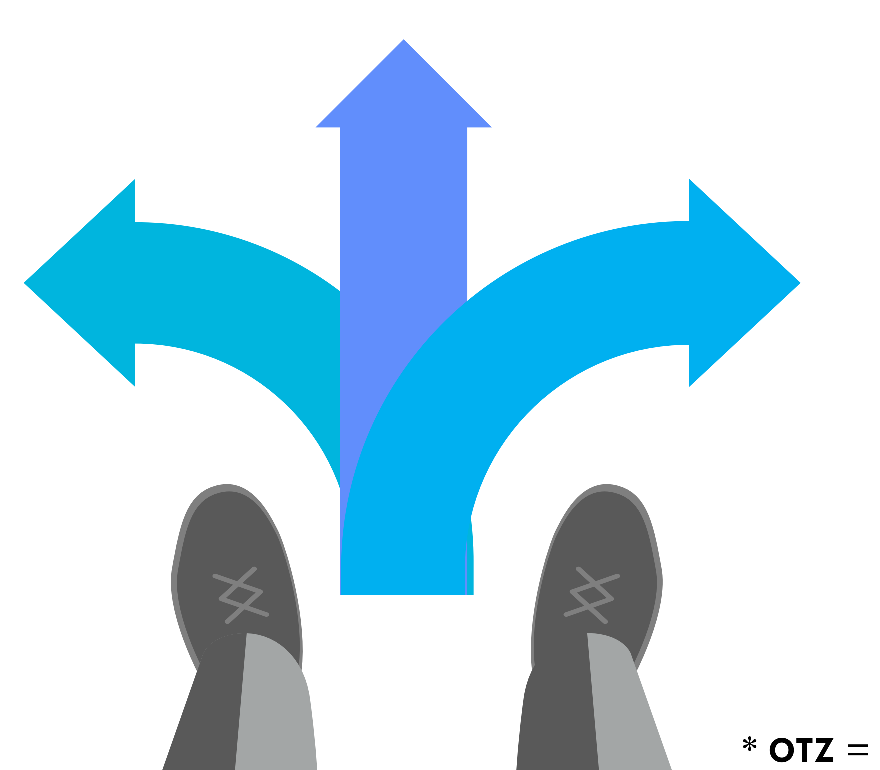
All Care recipients are assigned to Case Management Teams using a differentiated approach

Individualized care

Stable clients/ Virally suppressed / Devolved to DSD models

Based on specific needs/risks

- Newly Enrolled Clients < 6 months
- Clients with Advanced HIV disease
- Virally Unsuppressed clients
- Clients requiring Enhance Adherence Counselling.
- Clients with history of missed appointments/ interruptions
- HIV Co-morbidities
- Clients in security-challenged/ riverine areas who are difficult to reach.



Based on Prioritization

- Pediatrics – **Pediatric Case Managers**
- Adolescent and young persons - **OTZ champions**
- Pregnant & Mother Baby Dyad – **Mentor Mothers**
- Key population
- Men

* **OTZ** = Operation Triple Zero

Operationalization and Performance reviews

Tools to support CMT

- CMT Standard Operating Procedure (SOP)
- Terms of reference for Linkage and Retention Coordinators
- Client Tracking SOP
- CMT Service Flowchart
- CM Register – Newly Enrolled Clients
- Case Management Register – Previously IIT
- Client Consent Form, CM Form, Plan for action form

KPIs assessed at CMT, Facility and State levels
No of Teams with > 98% of their clients active
% of Teams with > 98% of their clients active in treatment
Number of facilities that had an IIT Rate of <2%
% of facilities with an IIT rate of <2%
No of Teams with > 95% of clients who interrupted treatment returned to care
% of Teams with > 95% of clients who interrupted treatment returned to care
Number of Teams with VL coverage of > 95%
% of Facilities with a 95% VLC Rate
Number of facilities who had a concurrence rate of 95% and above
% of Facilities with a 95% Concurrence Rate (EMR/NDR)

Differentiated approach to Case Management

WHAT	WHEN	WHERE	WHO
Case Finding/Testing Services Provide treatment education, adherence counselling and peer support to assigned clients following testing and linkage	At ART Initiation or at Next clinic visit	Community(support groups/club, outreaches) Facility(OPD, Adherence room, Service Delivery Point)	Case management Teams (Counsellor Testers,, Viral Load Champions, Adherence, HTS Counsellors)
Sensitize clients on the differentiated models of care: MMD 3 and 6 dispensing, Community Pharmacy refills, Home refills and Community ART Groups as options available to stable clients.	Next Clinic visit pending on ART mode of dispensing.	ART SDP in facilities (Medication dispensing at the Pharmacy) Community Pharmacy refills, home refills and community ART groups .	Case management Teams (Viral Load Champions, Adherence, HTS Counsellors)

Differentiated approach to Case Management -2

WHAT	WHEN	WHERE	WHO
Referral and linkage: Facilitate referrals of clients to treatment through escort service to needed services.	HIV testing Service/Service delivery Points.	Community(support groups/club, outreaches) Facility(OPD, Adherence room, Service Delivery Point)	Case management Teams (Mentor mothers, Treatment Champions, Viral Load Champions, Adherence Counsellors)
Support assigned health facilities with early identification, tracking and return to care of defaulting and lost to follow up clients.	Next Clinic visit	Community Facility	Case management Teams (Mentor mothers, Treatment Champions, Viral Load Champions, Adherence Counsellors)
Maintains a log of all assigned clients contacts (descriptive addresses and phone numbers) and interventions carried out to support their retention.	Facility(Records) Community(Support group attendance report	Community Facility	Case management Teams (Mentor mothers, Treatment Champions, Viral Load Champions, Adherence Counsellors)

Differentiated approach to Case Management - 3

WHAT	WHEN	WHERE	WHO
PMTCT Support positive pregnant women and mother-infant pair to ensure they keep all appointments through delivery and till outcome is determined.	At ANC/SDPs ,ART Initiation	Facility, Community(TBAs, Faith Based Homes, Outreaches, Private homes, Support groups, CBO's)	Case Managers(Mentor Mothers)Midwives, CHEWs, Nurses, Doctors.
Support health facility and community management of infected children and their families across supported sites.	At ANC/SDPs ,ART Initiation	Facility, Community(TBAs, Faith Based Homes, Outreaches, Private homes, Support groups, CBO's)	Case Managers(Mentor Mothers)Midwives, CHEWs, Nurses, Doctors

Implementation and Capacity Strengthening approaches

CM models implemented

In-person

Household contact tracing, pre-enrollment counselling, facility-based EAC, ADR monitoring, OVC home visits/OTZ clubs, Support group meetings

Virtual

Pre-appointment tracking, Back-to-care drive, Virtual EAC, medication assessment, health education, mortality surveillance

Peer coaching

Lay adherence counsellors, Mentor mothers, NEPWHAN, ASWHAN, KP CMs

DSD models

Leveraging on both Facility and Community based models

Capacity building efforts

SACA/SMoH

Weekly meetings, refresher trainings, routine performance review meetings with the GoN staff, and Clinical mentors for cross-learning and data review,

NEPWHAN/ASWHAN

Incorporation into the ECEWS SPEED mainstream - lay adherence counsellor, mentor mothers, KP CMs - beneficiaries of onsite training sessions by teams on TA visit

Community

Quarterly and need-driven review meetings with Gen pop CBO leadership and LACA managers to strengthen knowledge base, COPP team training

Facility

Routine trainings, CQI meetings, Switch committee, DTC meetings, onsite TA visit, Spice ECHO

Virtual case management approaches

Telemedicine

- Adopting teleservices to provide remote healthcare for HIV clients.
- Consult with healthcare providers, discuss their HIV management, receive adherence support, and provide feedback

Integrated health messages (IHMS)

Integrated messages to sexual contacts of index clients for convenient offering of index testing

Mobile Applications

Jolly 95 app - A self-service app that simplifies access to ART services:
Cool girl's app -provides a safe platform where AGYW can access knowledge on sexual behavior and communication change among AGYW

Remote Monitoring and Adherence Support

Remote monitoring technologies, such as WhatsApp platform and SMS-based reminders are employed to support adherence.

SMS WhatsApp Phone calls

Impact of Case Management on service delivery – IP Level

APIN - Impact on Treatment Continuity - Declining IIT Trend

	FY19 Q4	FY21 Q1	FY21 Q2	FY21 Q3	FY21 Q4	FY22 Q1	FY22 Q2	FY22 Q3
IIT	3.0%	3.9%	3.0%	3.0%	2.0%	1.6%	1.5%	1%

Impact of Case Management on service delivery – Case Study St. Gerald's Catholic Hospital, Kaduna (TX_CURR 3,246)

APIN - Impact on Treatment Continuity - Declining IIT Trend

101.0%
99.0%
97.0%
95.0%
93.0%
91.0%
89.0%
87.0%
85.0%

Improved linkage rates

Improved VL Suppression

Declining IIT rates

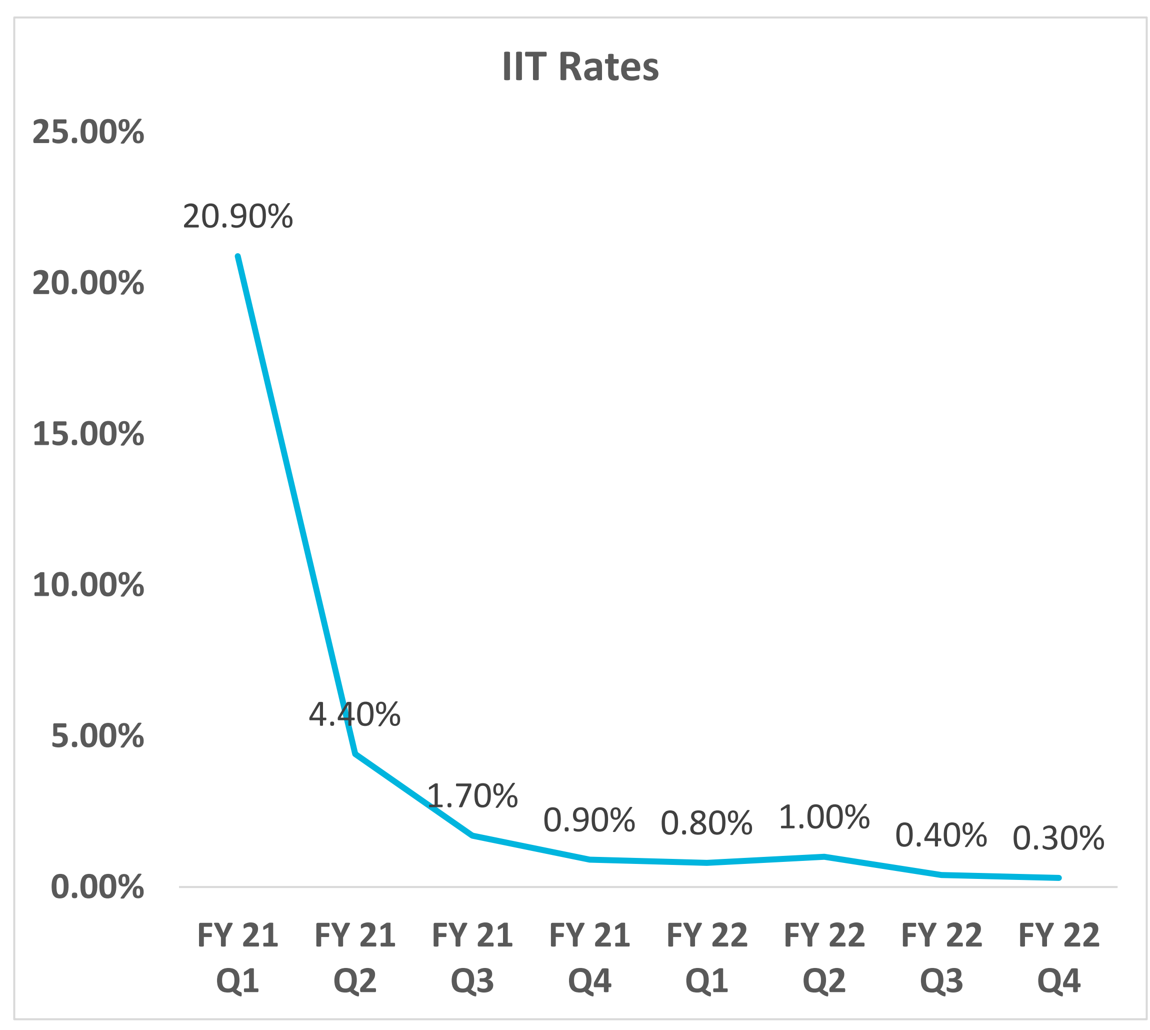
	FY23 Q2	FY23 Q3	FY23 Q4	FY24 Q1	FY24 Q2
Linkage rate (%)	93.0%	95.0%	100.0%	100.0%	100.0%
VL suppression 0-19yrs (%)	88.0%	91.0%	93.0%	94.0%	94.0%
IIT rate (%)	4.2%	4.4%	2.9%	2.6%	1.9%

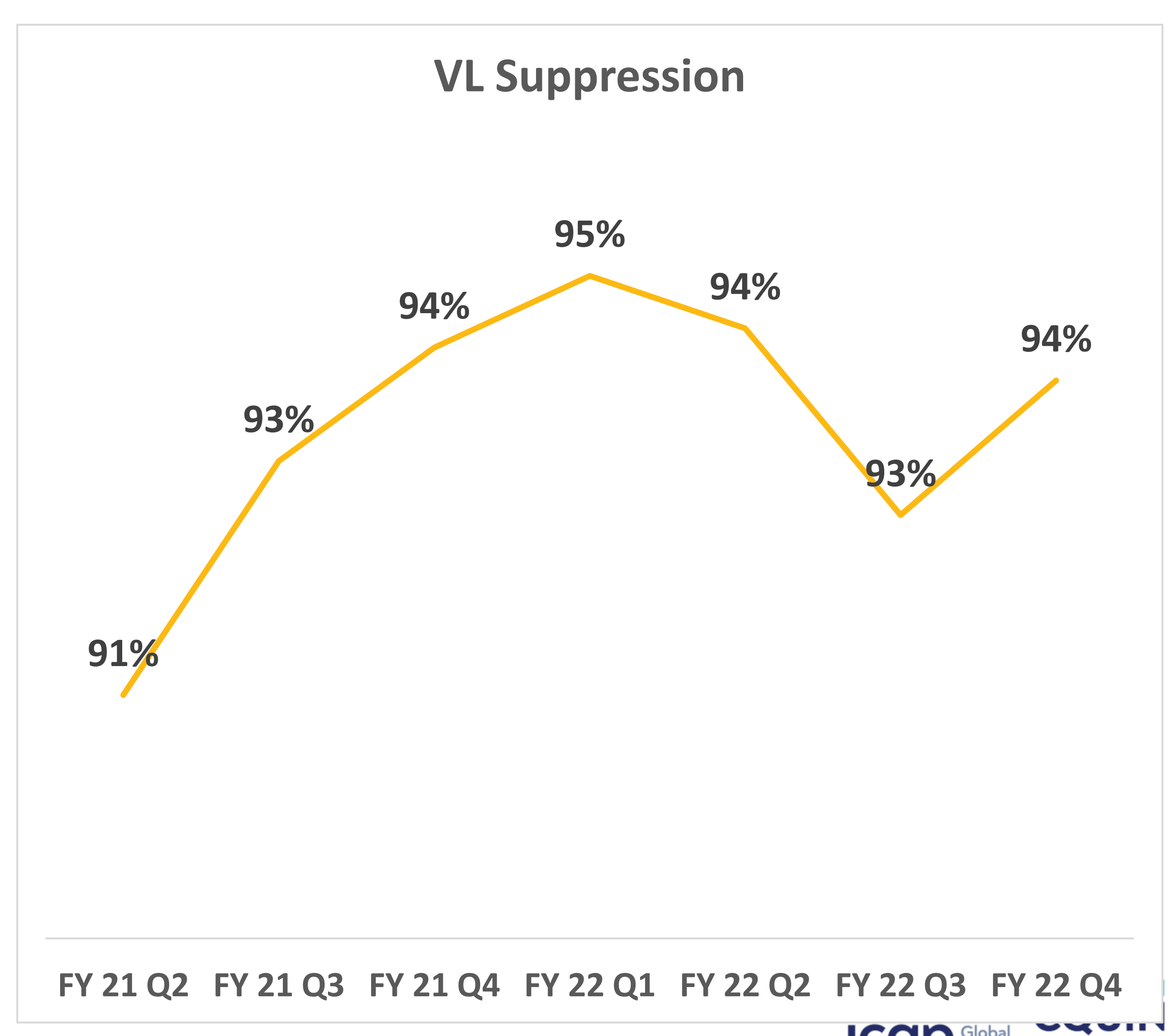
VL suppression (overall, %)

IIT rate %: 5.0% 4.5% 4.0% 3.5% 3.0% 2.5% 2.0% 1.5% 1.0% 0.5% 0.0%

- A site-level case study of an effective and impactful case management system
- 4 Case Management Teams - comprising of an adherence nurse(CMT lead), adherence counselor, viral load champion, data management officer, and retention navigator.

Impact of Case Management on service delivery – Case Study Improving Retention and Viral load suppression in Wuse District Hospital, Abuja.





Lessons Learned

- Case managers deliver care that is **personalized, targeted, effective** and **tailored** to the needs of each client.
- Case managers can **facilitate seamless transitions between different stages of care**, ensuring that clients receive consistent support over time.
- **Sufficient resource allocation is critical** for successful case management.
- **Continuous training and capacity building** ensure CM stay updated on best practices, emerging issues and deliver services aligned to the country's needs.
- **Integrating this critical human resource into government transition plans** should be given due consideration

Case Management and Sustainability of HIV programs:

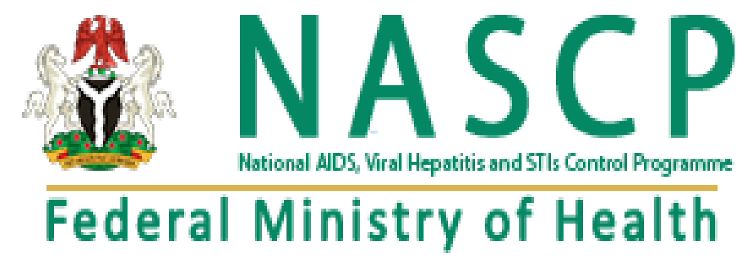
Challenges

- **Resource intensive** and mostly **donor driven** within dwindling resources
- **High attrition rates** necessitating training and retraining efforts
- Concerns around **sensitivity to cultural, social, and economic contexts** that influence their clients' lives
- Confidentiality/protection of medical data still a cause for concern for most clients

Recommended Adaptations

- **Partial /Full integration** of HIV services into routine healthcare delivery to optimize HRH.
- Scaling up self care interventions to transfer responsibilities of CMT to **informed** and **motivated** recipients of care.
- Matching trained case managers with in GoN human resource cadres and absorption.
- **Capacity strengthening efforts** for MoH healthcare workers - online resources, workshops, and conferences to update them on best practices/emerging issues in HIV care.

Acknowledgements



Thank you

References

https://www.unaids.org/sites/default/files/country/documents/NGA_2020_countryreport.pdf

National Guidelines for HIV Prevention, Treatment and Care, Federal Ministry of Health, Abuja Nigeria 2020

Coach Mpilo:

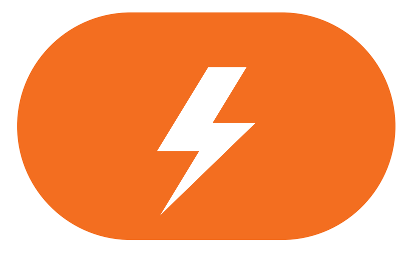
A peer-led case management model for men living with HIV

Thulani Grenville-Grey
Matchboxology

Men in South Africa are less likely to start and stay on treatment.

We talked with more than 2000 of them to find out why.

While we identified various barriers, we designed around three in particular:



HIV leaves many men anxious and afraid, not stubborn and indifferent. They need comfort and reassurance.

Many men do not believe that it is possible to live a long, healthy, happy, 'normal' life with HIV.

Most men are hungry for support in coping with HIV but see no sources that feel safe and relatable.

One solution generated through the design process was Coach Mpilo.

What it is

- A humanised case management model that trains and employs men living well with HIV (not just clinically but also socially and emotionally) as 'coaches' of newly diagnosed men and men who have disengaged from treatment.

Why it works

- Breaks through the fear and anxiety many men feel about HIV
- Provides living proof that a man with HIV can live a good life
- Gives men a source of support that feels safe and relatable

Other benefits

- **Rapid-response.** Coaches can be recruited in any community, trained in a week, and immediately deployed.
- **Low-cost.** Coaches are paid a modest salary and transport/data stipend and otherwise require minimal infrastructure or operational support.
- **Contextualised.** Because coaches come from the communities they serve, they understand the local language, culture, leadership, etc.
- **PLHIV-led.** The model puts PLHIV at the forefront of the response, taking seriously the principle of "*Nothing about us without us.*"

How does it work?

- Coaches are **recruited from within their communities**, via formal job advertisements as well as informal networks.
- Coaches **participate in a one-week, transformative training**, focused on giving them the skills and confidence to leverage their own story for building trust and rapport with men and helping them identify and overcome barriers to care.
- Each coach is **linked and introduced to a clinic**. Clinic staff then begin referring men to coaches and giving coaches the roster of men who have missed appointments. Coaches also connect with men through community outreach.
- The coach **engages one-on-one with each man** and supports him in addressing whatever barriers he is facing, generally for a period of six months. As men overcome their barriers, support tapers off, though coaches remain available.

The model is achieving **high levels of uptake, linkage, and retention.**

Pilot phase
(March-September 2020)

Reached	Linked	Retained
3848 men accepted the support of a coach	**3811 men (99%)** linked, returned or maintained on ART	**3653 men (96%)** retained on ART at pilot endline

- Piloted with 2 PEPFAR partners in South Africa
- Covering 3 districts in 2 provinces
- 63 coaches supporting 70 clinics
- Uptake, linkage and retention for the period of March-September 2020 (7 months)

Routine implementation phase
(April 2021-February 2024)

Reached	Linked	Retained
39,121 men accepted the support of a coach	**37,916 men (97%)** linked, returned or maintained on ART	**36,531 men (97%)** currently retained on ART

- Scaled by 7 PEPFAR partners in South Africa
- Covering 26 districts in all 9 provinces
- 364 coaches supporting 278 clinics
- Uptake, linkage and retention for the period of April 2021-February 2024 *(CDC partner data only)*

Our bottom line:
Men are not ‘hard to reach’ if we take the time to understand their barriers and needs and give them the right support!

Coach Mpilo resources and contact information

A Coach Mpilo ‘playbook’ to support partners on planning and roll-out of the model is available at www.coachmpilo.co.za

Interested stakeholders are also welcome to contact PSI and Matchboxology for advice and support:

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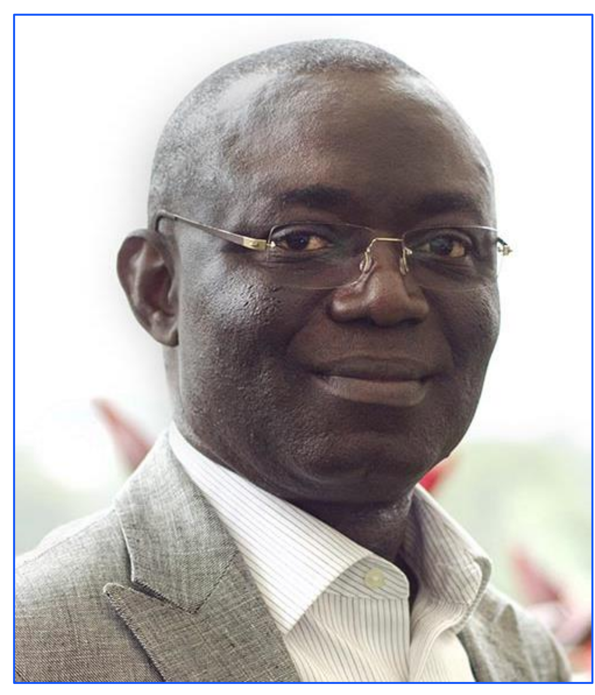
Thank you!

Moderators



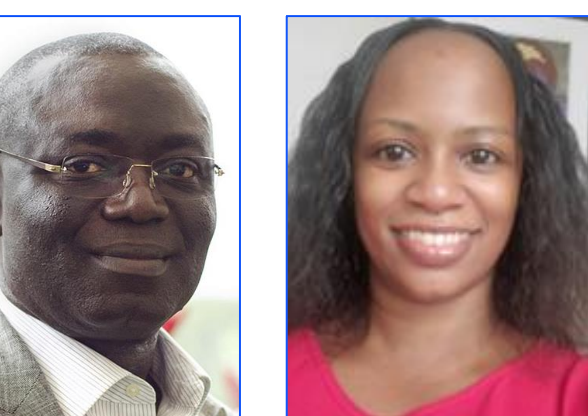
Peter Preko
CQUIN PI/Project Director
ICAP at Columbia University

Maureen Syowai
CQUIN Deputy Director, Technical
ICAP Kenya

Q&A Discussion

Moderators

Panelists & Discussants



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Ministry of Health, Nigeria

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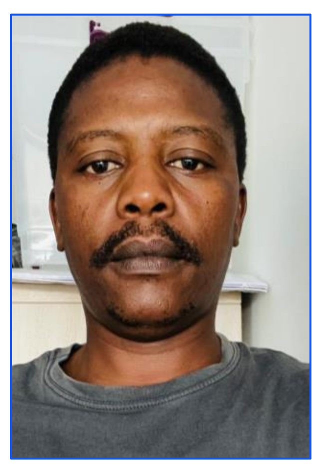
Human-Centered Design & Practitioner Matchboxology,

South Africa



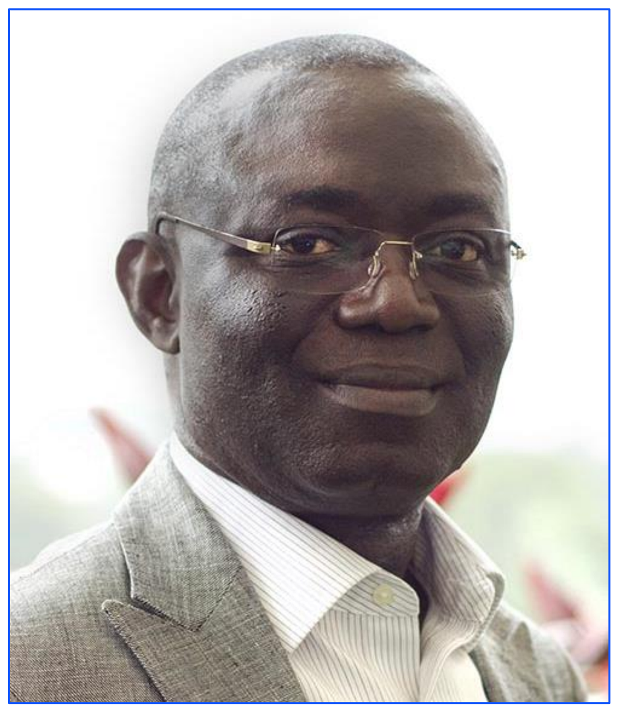
Sabelo Phungwayo

Squad Manager

Coach Mpilo

South Africa

Closing Remarks



Peter Preko
CQUIN PI/Project Director
ICAP at Columbia University

icap Global Health

Slides & recordings from this session will be available on the CQUIN Website

https://cquin.icap.columbia.edu/

The next webinar on HIV & Mental Health Integration will take place, on May 2nd, 2024

HIV **Coverage, Quality, and Impact Network**