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Are we there yet?
Using data to map our journey through *Person-Centered Services*

Bill Reidy, PhD, MPH

ICAP at Columbia University

CQUIN 8th Annual Meeting | December 9-13, 2024 – Johannesburg, South Africa

“It's not the destination, it's the journey”

Image created in ChatGPT

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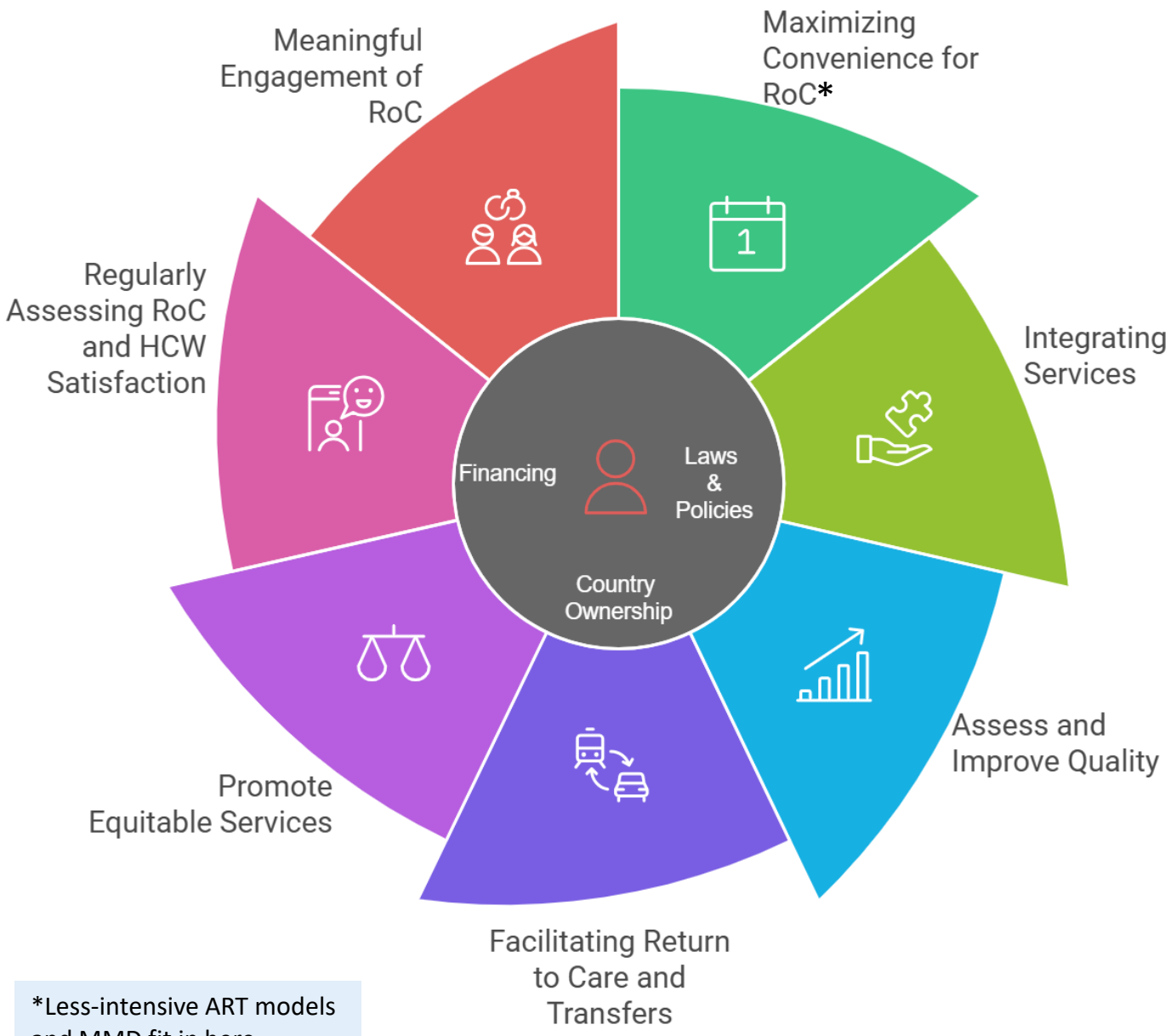


*Less-intensive ART models and MMD fit in here

ROC: recipients of care

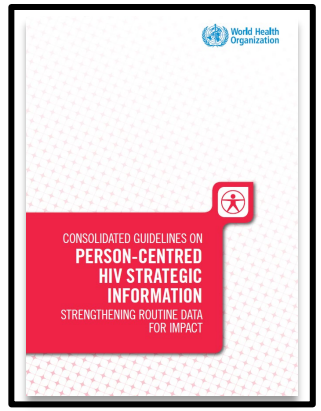
A working definition of person-centered services (PCS) for CQUIN

7 interrelated, mutually-reinforcing components of PCS

How does **data for decision-making** fit in here?

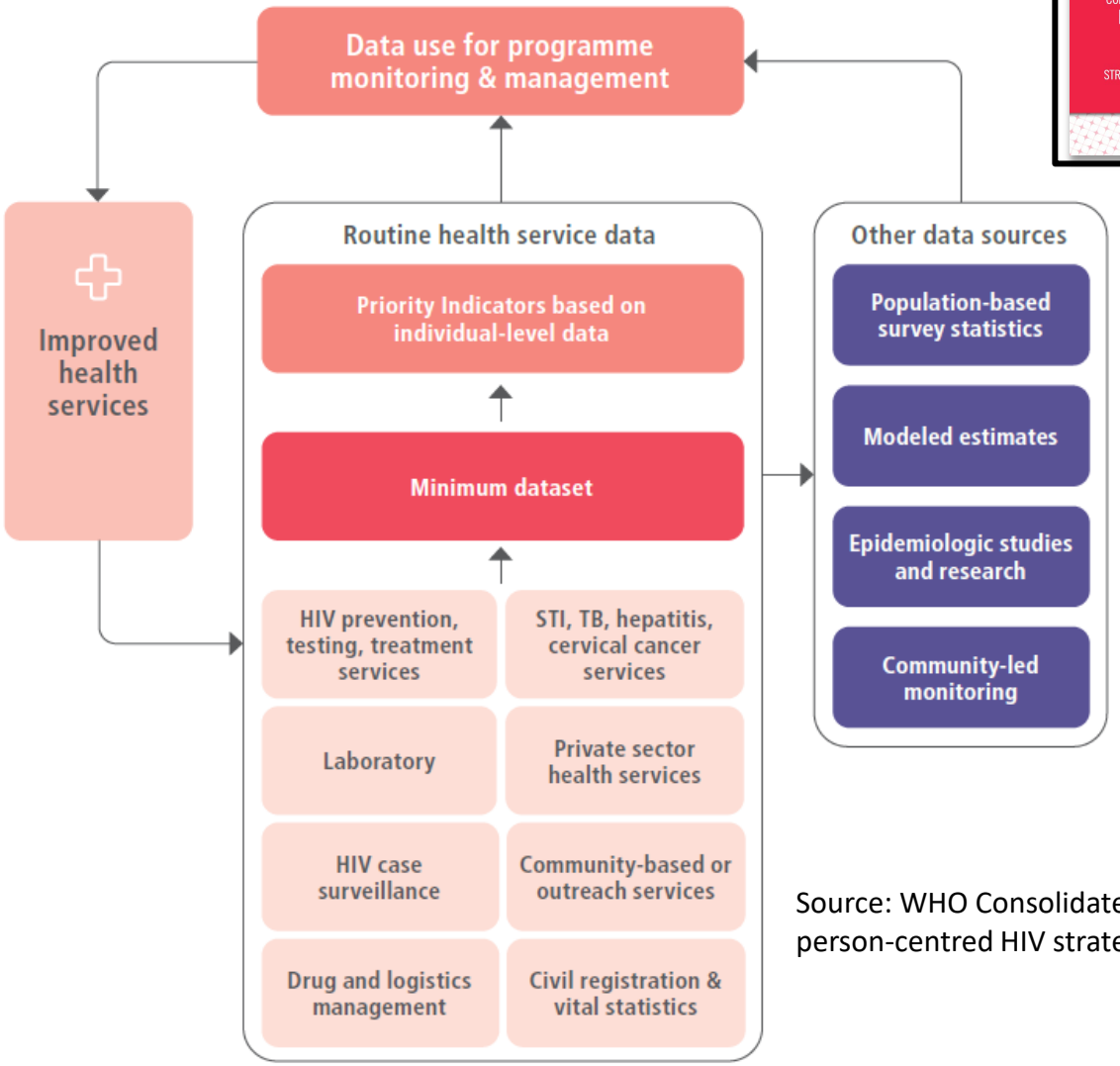
How can systems and processes **document, support, and measure** our progress towards the **sufficient implementation** of these 7 PCS components?

WHO: Person-centered strategic information



- Shift from siloed and aggregated data to electronic person-level, longitudinal data linked and utilized across points of care and locations
- More granular and more accurate
- Align with the broader health information system
- However *person-centered SI* utilizing clinical record information is only part of the picture

Fig. 1.2 Integrated data system architecture



Source: WHO Consolidated guidelines on person-centred HIV strategic information

Strategic information for person-centered services

Routinely-collected data*:

1. Person-centered health services data
2. Facility service quality assessments
3. Community-led monitoring

Other data sources:

- Population-based surveys & surveillance
- Modeled estimates
- Epidemiologic research

Process and outcome indicators

'Live' national data dashboards
MOH reporting indicators
UNAIDS Global AIDS Monitoring
Health equity measures**

Ongoing data use for program improvement

*Includes routine assessments of recipient of care and health care worker satisfaction, community engagement, and data from quality improvement initiatives
**Assesses disparities by location, age, sex, key populations group, socioeconomic factors, and other relevant dimensions

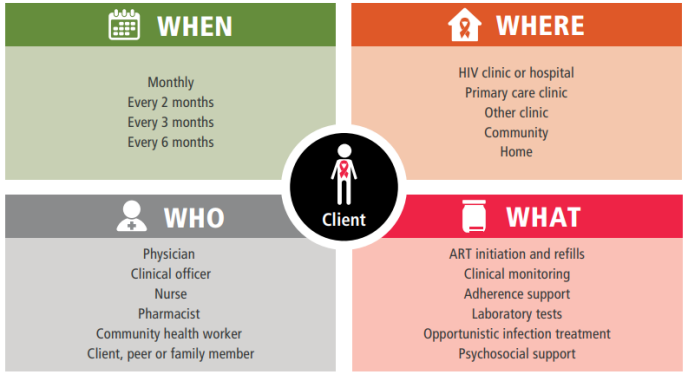
(Adapted from WHO *Consolidated guidelines on person-centred HIV strategic information* (2022))

PCS components:

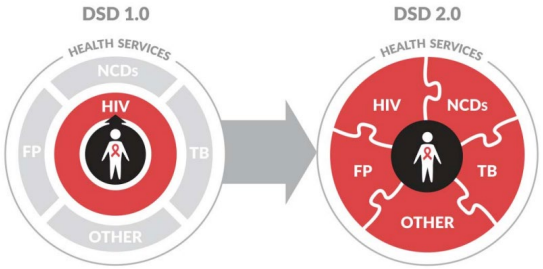
Maximizing convenience for recipients of care

- **Differentiated ART models**
  - Also differentiated HTS, prevention
- **Multi-month ART dispensation**
- Indicators in CQUIN DSD M&E framework and CMM
  - Facilitated by person-centered SI
- Links to other components:
  - ROC and provider satisfaction
  - Integration (via DSD 2.0)

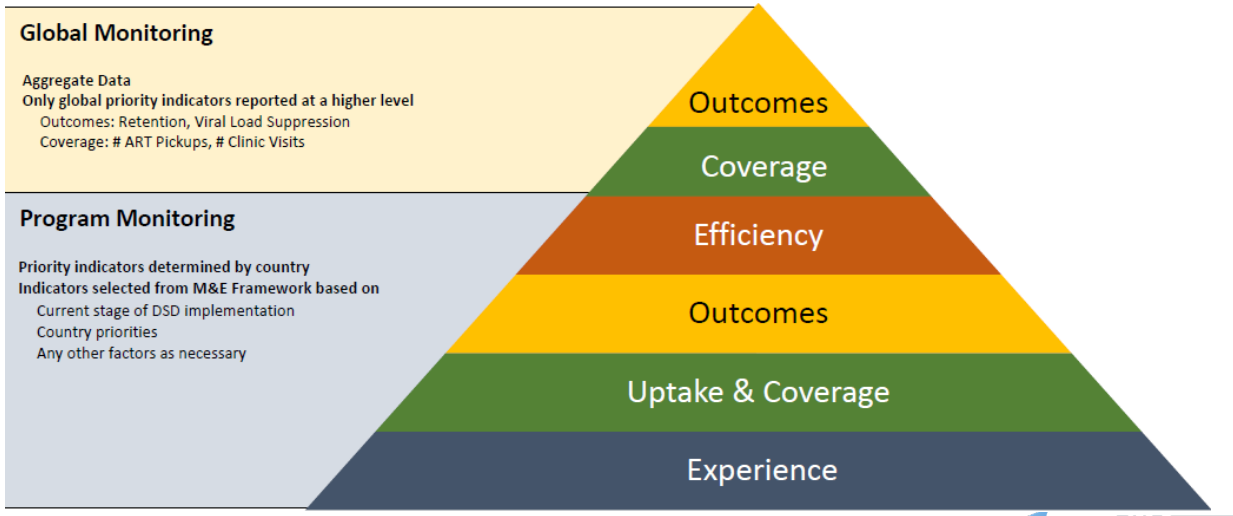
Fig. 7.1 The building blocks of differentiated service delivery for HIV treatment



(WHO Consolidated Guidelines 2021)



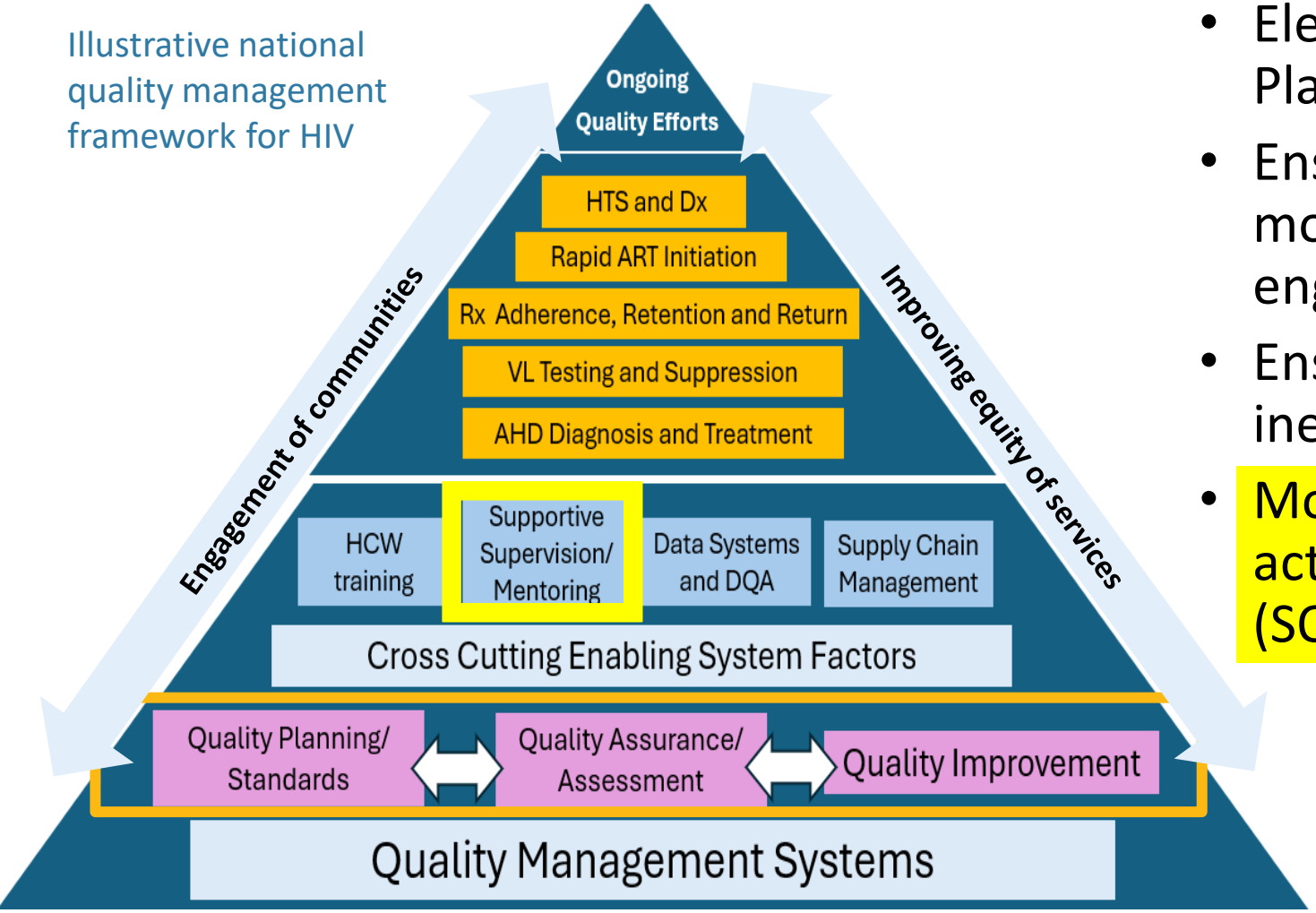
(Ehrenkranz et al, JAIDS 2021)



(CQUIN DSD M&E framework - Available on the CQUIN web site)

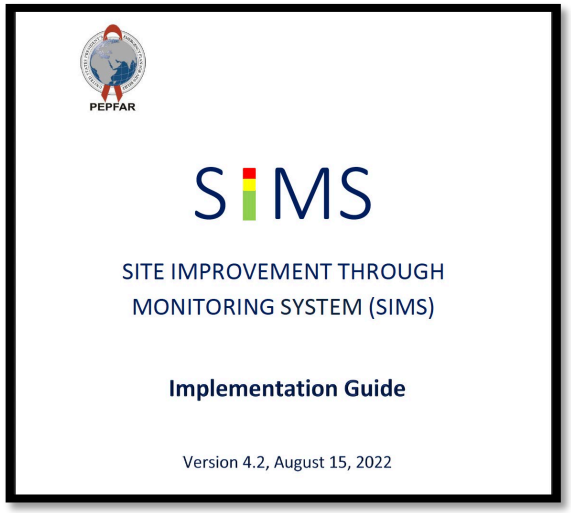
PCS components:
Ongoing efforts to assess and improve quality

Illustrative national quality management framework for HIV



- Elements of quality management systems: Planning/standards, QA, QI
- Ensure that planning, implementation, monitoring is done with community engagement
- Ensure that quality activities address inequities rather than amplify them
- Monitor quality-related infrastructure and activities via service quality assessments (SQAs)

A variety of SQA tools in use in CQUIN countries



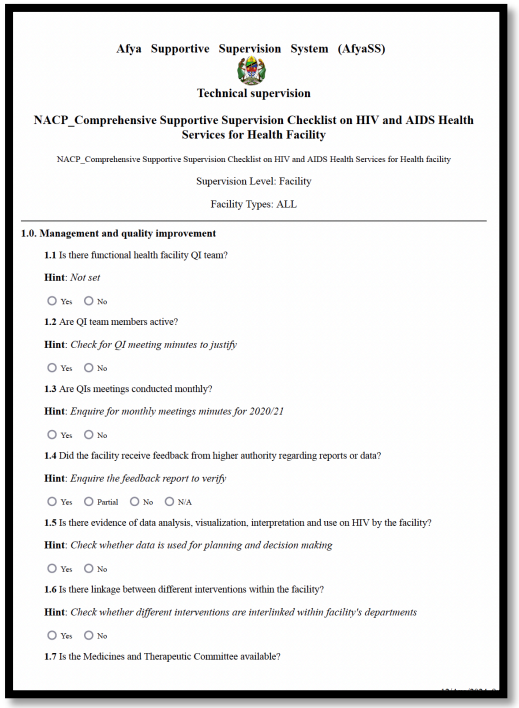
PEPFAR

SIMS

SITE IMPROVEMENT THROUGH MONITORING SYSTEM (SIMS)

Implementation Guide

Version 4.2, August 15, 2022



Afya Supportive Supervision System (AfyaSS)

Technical supervision

NACP_Comprehensive Supportive Supervision Checklist on HIV and AIDS Health Services for Health Facility

NACP_Comprehensive Supportive Supervision Checklist on HIV and AIDS Health Services for Health facility

Supervision Level: Facility

Facility Types: ALL

1.0. Management and quality improvement

1.1 Is there functional health facility QI team?

Hint: *Not set*

○ Yes ○ No

1.2 Are QI team members active?

Hint: *Check for QI meeting minutes to justify*

○ Yes ○ No

1.3 Are QIs meetings conducted monthly?

Hint: *Enquire for monthly meetings minutes for 2020/21*

○ Yes ○ No

1.4 Did the facility receive feedback from higher authority regarding reports or data?

Hint: *Enquire the feedback report to verify*

○ Yes ○ Partial ○ No ○ N/A

1.5 Is there evidence of data analysis, visualization, interpretation and use on HIV by the facility?

Hint: *Check whether data is used for planning and decision making*

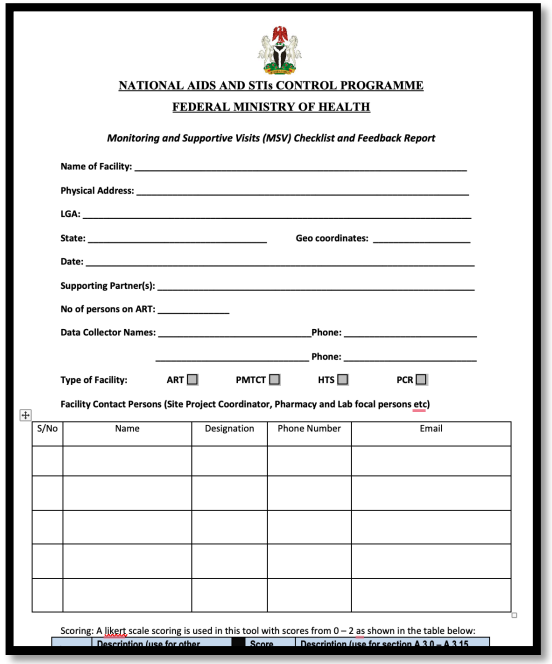
○ Yes ○ No

1.6 Is there linkage between different interventions within the facility?

Hint: *Check whether different interventions are interlinked within facility's departments*

○ Yes ○ No

1.7 Is the Medicines and Therapeutic Committee available?



NATIONAL AIDS AND STIs CONTROL PROGRAMME

FEDERAL MINISTRY OF HEALTH

Monitoring and Supportive Visits (MSV) Checklist and Feedback Report

Name of Facility: _____

Physical Address: _____

LGA: _____

State: _____ **Geo coordinates:** _____

Date: _____

Supporting Partner(s): _____

No of persons on ART: _____

Data Collector Names: _____ **Phone:** _____

_____ **Phone:** _____

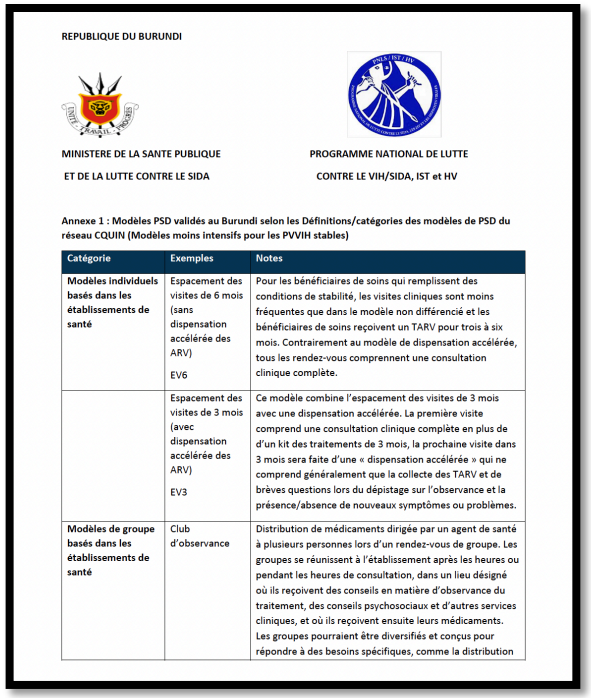
Type of Facility: **ART** ☐ **PMTCT** ☐ **HTS** ☐ **PCR** ☐

Facility Contact Persons (Site Project Coordinator, Pharmacy and Lab focal persons etc)

S/No	Name	Designation	Phone Number	Email

Scoring: A likert scale scoring is used in this tool with scores from 0 – 2 as shown in the table below:

	Description (use for other	Score	Description (use for section A 3.0 – A 3.15



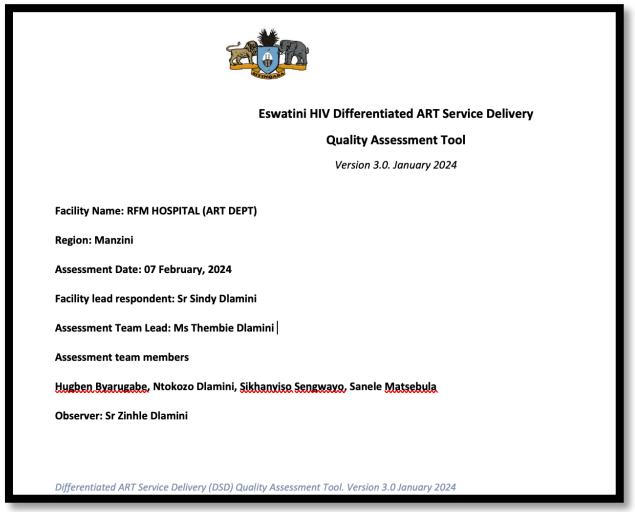
REPUBLIQUE DU BURUNDI

MINISTERE DE LA SANTE PUBLIQUE ET DE LA LUTTE CONTRE LE SIDA

PROGRAMME NATIONAL DE LUTTE CONTRE LE VIH/SIDA, IST et HV

Annexe 1 : Modèles PSD validés au Burundi selon les Définitions/catégories des modèles de PSD du réseau CQUIN (Modèles moins intensifs pour les PVVIH stables)

Catégorie	Exemples	Notes
Modèles individuels basés dans les établissements de santé	Espacement des visites de 6 mois (sans dispensation accélérée des ARV) EV6	Pour les bénéficiaires de soins qui remplissent des conditions de stabilité, les visites cliniques sont moins fréquentes que dans le modèle non différencié et les bénéficiaires de soins reçoivent un TARV pour trois à six mois. Contrairement au modèle de dispensation accélérée, tous les rendez-vous comprennent une consultation clinique complète.
	Espacement des visites de 3 mois (avec dispensation accélérée des ARV) EV3	Ce modèle combine l'espacement des visites de 3 mois avec une dispensation accélérée. La première visite comprend une consultation clinique complète en plus de d'un kit des traitements de 3 mois, la prochaine visite dans 3 mois sera faite d'une « dispensation accélérée » qui ne comprend généralement que la collecte des TARV et de brèves questions lors du dépistage sur l'observance et la présence/absence de nouveaux symptômes ou problèmes.
Modèles de groupe basés dans les établissements de santé	Club d'observance	Distribution de médicaments dirigée par un agent de santé à plusieurs personnes lors d'un rendez-vous de groupe. Les groupes se réunissent à l'établissement après les heures ou pendant les heures de consultation, dans un lieu désigné où ils reçoivent des conseils en matière d'observance du traitement, des conseils psychosociaux et d'autres services cliniques, et où ils reçoivent ensuite leurs médicaments. Les groupes pourraient être diversifiés et conçus pour répondre à des besoins spécifiques, comme la distribution



Eswatini HIV Differentiated ART Service Delivery

Quality Assessment Tool

Version 3.0. January 2024

Facility Name: RFM HOSPITAL (ART DEPT)

Region: Manzini

Assessment Date: 07 February, 2024

Facility lead respondent: Sr Sindy Dlamini

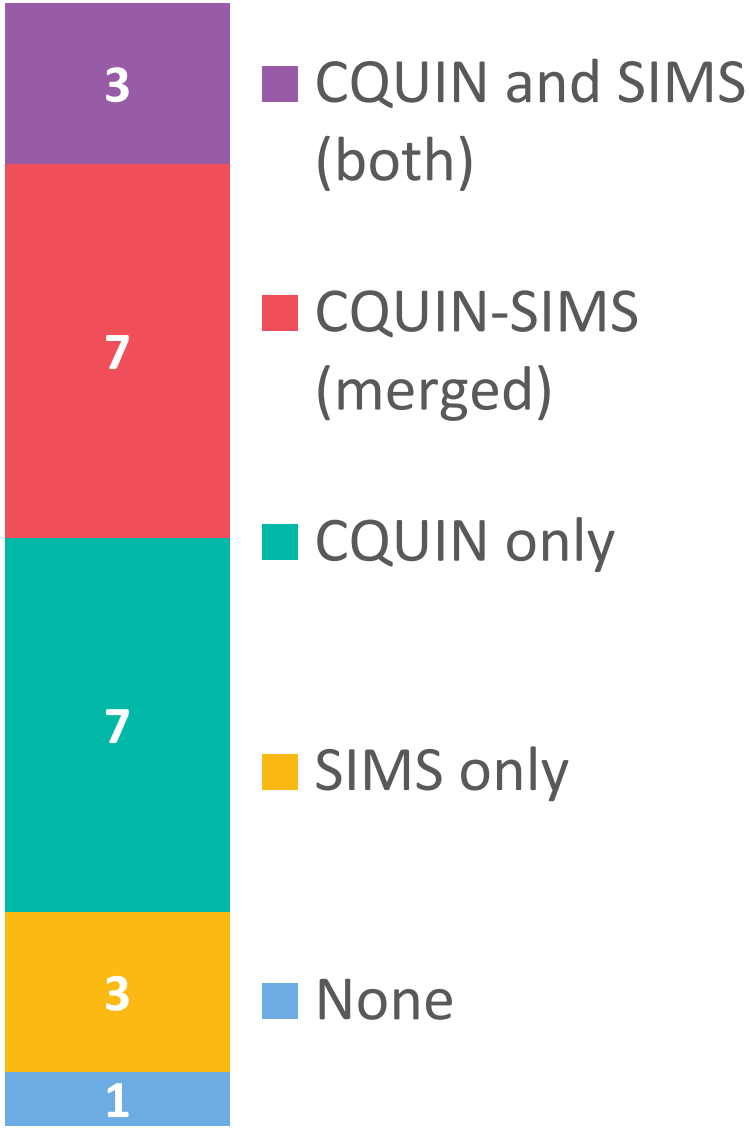
Assessment Team Lead: Ms Thembie Dlamini

Assessment team members

Hugben Byarugabe, Ntokozo Dlamini, Sikhanviso Sengwayo, Sanele Matsebula

Observer: Sr Zinhle Dlamini

Differentiated ART Service Delivery (DSD) Quality Assessment Tool. Version 3.0 January 2024



Innovative Approaches Towards Integration/Sustainability in Kenya

Before	Current
Siloed Data Quality Assurance/Service Quality Assurance for Programs (HTS, PMTCT, KP, C&T etc.)	One National Annual Integrated DQA/SQA (DSD Data & Quality Elements Included)
Fragmented Program Performance Review (QPR) (National, County, PEPFAR/IPs)	One Joint Quarterly Performance Review Meeting Includes all stakeholders including CLM

(Slide from Session 3 Kenya MOH presentation)

PCS components:
Integrating services

High level SI takeaways from 2024 CQUIN Integration Meeting:

- Keep in mind the scope of what is being integrated
    - Ensure that key elements of care, including outcomes, are documented as appropriate
    - Significant gaps in documentation noted for services integrated into HIV care
- Update M&E indicators to account for any unique needs of integrated services, such as disaggregations by HIV or ART status of RoC
- **Coordinate across clinical services areas to mutually plan and manage M&E**

Additional M&E considerations:

- Document characteristics and coverage of integrated services via SQAs
- Assess satisfaction of both ROC and health care workers

ART Treatment Card – Liberia

Limited information on hypertension services documented (not atypical!)

Yellow Card - Adult Unique Code: _ _ - _ _ _ _ - _ _ - _ _ _ _ - _ _ In Date Facility Client #: Cohort # MM/YYYY

Patient / Guardian Information			Status at ART Initiation				Confirmatory HIV Test before ART Start		
Patient Name			HIV-related diseases				Site, HTS Serial No		
Sex, Birth Date	M F	DOB(dd/mmm/yy)	Urine LAM/ CrAg Result/Other	RPR HgB ALT HBV HCV M/S CrAg U-			Test Date		Rapid PCR
Detailed Physical Address			WHO Stage	1 2 3 4	TB Status at initiation	Never >2yrs Last 2yrs Curr	ART education done	N Y	Date
			CD4		[redacted]		TB Treatment	Reg No	Start
Guardian Name			CD4 Date		Pregnant / Breastfeeing	N Preg Bf	ART Regimens	Regimen	Start
Phone	Patient	Guardian	Height / Wgt	cm kg	Ever taken ARVs	N Y		Blood Pressure	sys dias
Agrees to FUP	N Y	Guardian Relation	Age at Initiation		Last ARVs (drug, date)				

Visit Date (dd mmm yy)	Weight (kg)	Pregnant/Breastfeed (Write child HCC no if Bf)	TB Status(Current)* Suspected (No Yes) / Confirmed (noRx Rx)	Side Effects (Specify in Notes)	Advanced HIV Disease (See codes)	Doses Missed	ART Regimen Code	ARVs Given (No. of tablets / To)	CPT/TPT Given (CPT Only / TPT Only / CPT + TPT / No. of tablets)	Stable? (Y/N) / DSD	Viral Load/CD4 (Sample taken / Result)	Next Appointment/ Outcome Date (dd mmm yy)	Outcome	Name of clinician
		Preg Bf	N Y C Rx	N Y				P G	C I CI		Bled / VL result / CD4 Result		D Def Stop TO	
		Preg Bf	N Y C Rx	N Y				P G	C I CI		Bled / VL result / CD4 Result		D Def Stop TO	
		Preg Bf	N Y C Rx	N Y				P G	C I CI		Bled / VL result / CD4 Result		D Def Stop TO	
		Preg Bf	N Y C Rx	N Y				P G	C I CI		Bled / VL result / CD4 Result		D Def Stop TO	
		Preg Bf	N Y C Rx	N Y				P G	C I CI		Bled / VL result / CD4 Result		D Def Stop TO	
		Preg Bf	N Y C Rx	N Y				P G	C I CI		Bled / VL result / CD4 Result		D Def Stop TO	
		Preg Bf	N Y C Rx	N Y				P G	C I CI		Bled / VL result / CD4 Result		D Def Stop TO	

Notes

Routine TB Screening Checklist*
1. Cough for any duration
2. Fever
3. Night sweats
4. Wt. loss / failure to thrive

Advanced HIV Disease (AHD)
1 - Cryptococcal Meningitis
2 - Toxoplasmosis
3 - Tuberculosis
4 - Pneumocystis Carinii (Jiroveci) Pneumonia(PCS)
5 - Cepsis
6. Kaposi Sarcoma
7. Cervical (pre) Cancer

TB Status Current
N - TB Not suspected
Y - TB sustected
C - TB confirmed not on TB Treatment
Rx - TB confirmed on TB Rx

ARVs Given
P - to patient
G - to Guardian

DSD Model
0 - Routine
1 - Fast-track ART(ART Facility)
2 - Family/Support group
3 - Teen Clubs
4 - Community/Home Delivery
5 - Pharmacy/Outlet Delivery
6 - Outreach Delivery

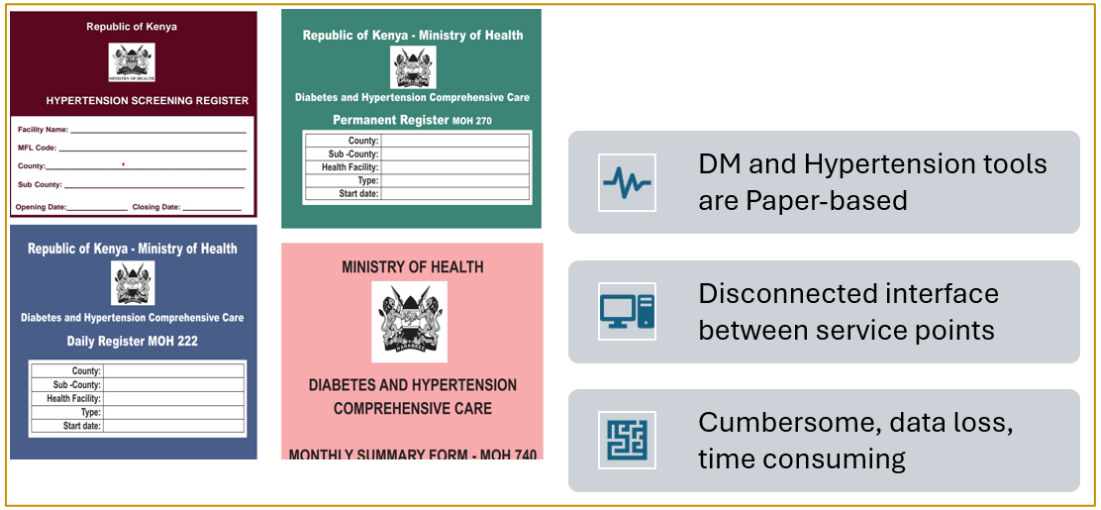
Outcome
D - Died
Def - Defaulted/LTFU
Stop - Client stopped medication
TO - Transferred out

ART Regimen (Adult)

1st Line	2nd Line
A1a - TDF + 3TC + DTG	A2a - AZT + 3TC + DTG
A1b - TDF + 3TC + EFV	A2b - AZT + 3TC + LPV/r
A1c - ABC + 3TC + DTG	A2c - AZT + 3TC + ATV/r
A1d - AZT + 3TC + EFV	A2d - TDF + 3TC + LPV/r
	A2e - TDF + 3TC + DRV/r

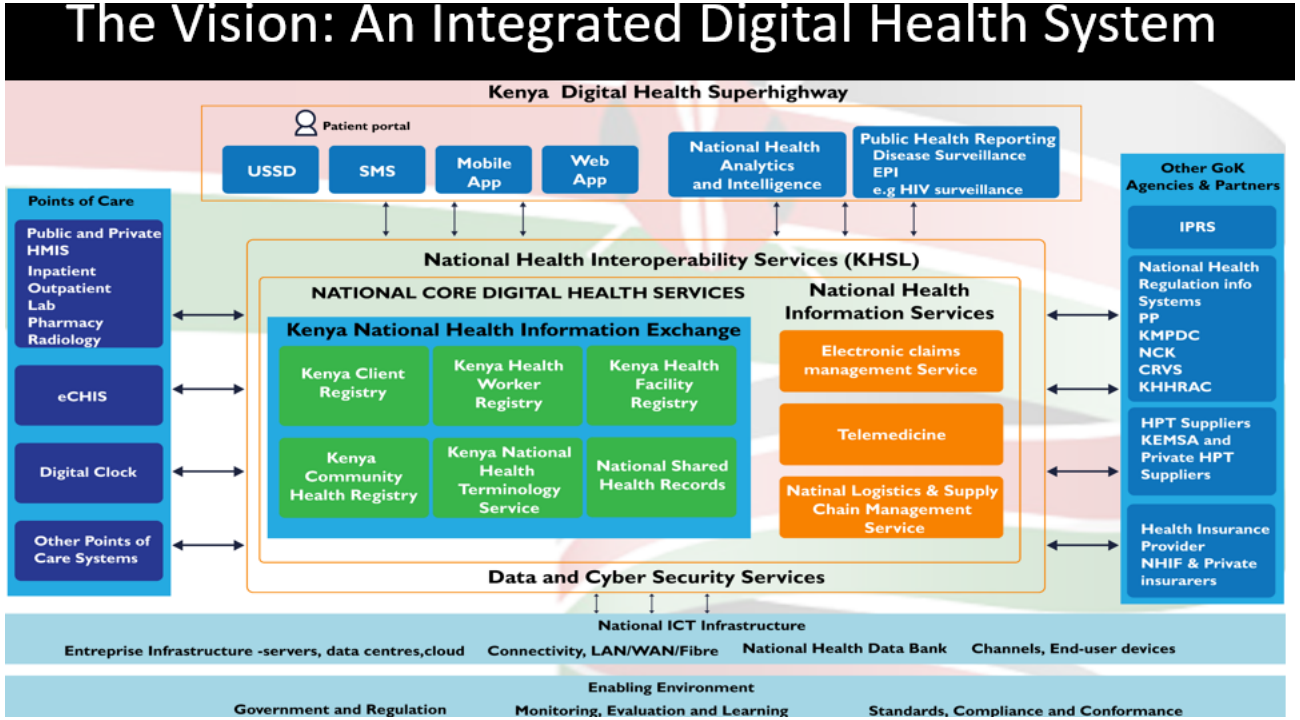
Source: COHIIN NCD COP meeting Nov 2024

Description of Integrated M&E for HIV/HTN & Other NCDs - Kenya



- DM and Hypertension tools are Paper-based
- Disconnected interface between service points
- Cumbersome, data loss, time consuming

- HIV service points are largely paperless
- Utilize the Kenya EMR system
- Hosts longitudinal data for>94% of ART clients
- Seamless end-to-end connection in all service points



❖ Currently the Country is rolling out facility wide EMRs; Ability to document and visualize and monitor data from all SDPs

Source: CQUIN NCD COP meeting Nov 2024

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PCS components:

Meaningful engagement of recipients of care

1. Community engagement: Policy, program, and community level indicators

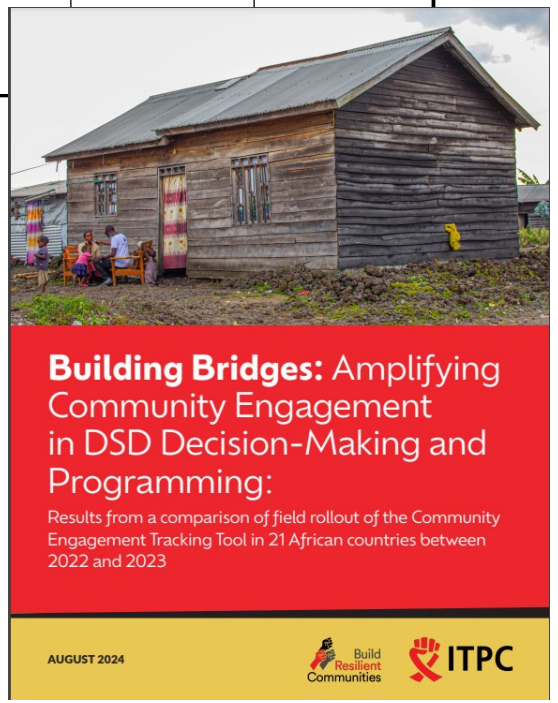
RoC participation in:

- ✓ TWG and task team meetings and online platforms
- ✓ Meetings focused on programme design
- ✓ Policy validation exercises
- ✓ M&E tools development meetings
- ✓ Health facility trainings (as planners, facilitators, and participants)
- ✓ Supportive supervision visits
- ✓ Sensitization/demand creation activities (led by or actively involving RoC/community members)
- ✓ Impact assessment/evaluations

Also tracking the extent of:

- ✓ Health facilities where RoC work as service providers
- ✓ Health facilities where community scorecards and/or RoC satisfaction surveys are implemented

0-20%	21-40%	41-60%	61-80%	81-100%
RoC are not involved in the DSD activity and there are currently no plans to engage these groups	RoC are not currently engaged in DSD activity, but engagement with RoC is planned or meetings and discussions with RoC are ongoing.	RoC are minimally engaged in the DSD activity	RoC are satisfactorly engaged in the DSD activity	RoC are meaningfully engaged in the DSD activity



2. Community-led monitoring

RAMBAU N ET AL. *Journal of the International AIDS Society* 2024, **27**:e26374
http://onlinelibrary.wiley.com/doi/10.1002/jia2.26374/full | https://doi.org/10.1002/jia2.26374

JIAS JOURNAL OF THE INTERNATIONAL AIDS SOCIETY

COMMENTARY

Power, data and social accountability: defining a community-led monitoring model for strengthened health service delivery

Ndivhuwo Rambau[1], Soeurette Policar[2], Alana R. Sharp[3,#], Elise Lankiewicz[4,§,#], Allan Nsubuga[5], Luke Chimhanda[6], Anele Yawa[1], Kenneth Mwehonge[7], Donald Denis Tobaiwa[8], Gérald Marie Alfred[9], Matthew M. Kavanagh[4,10], Asia Russell[11], Solange Baptiste[12], Onesmus Mlewa Kalama[13], Rodelyn M. Marte[14], Naïké Ledan[11], Brian Honermann[4], Krista Lauer[12], Nadia Rafif[12], Susan Perez[15], Gang Sun[16], Anna Grimsrud[17], Laurel Sprague[16] and Keith Mienies[15]

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The CLM cycle involves local community-led organizations (CLOs) and civil society leading a regular process of data collection, identifying issues, developing solutions, conducting advocacy and monitoring change to improve access and quality of services

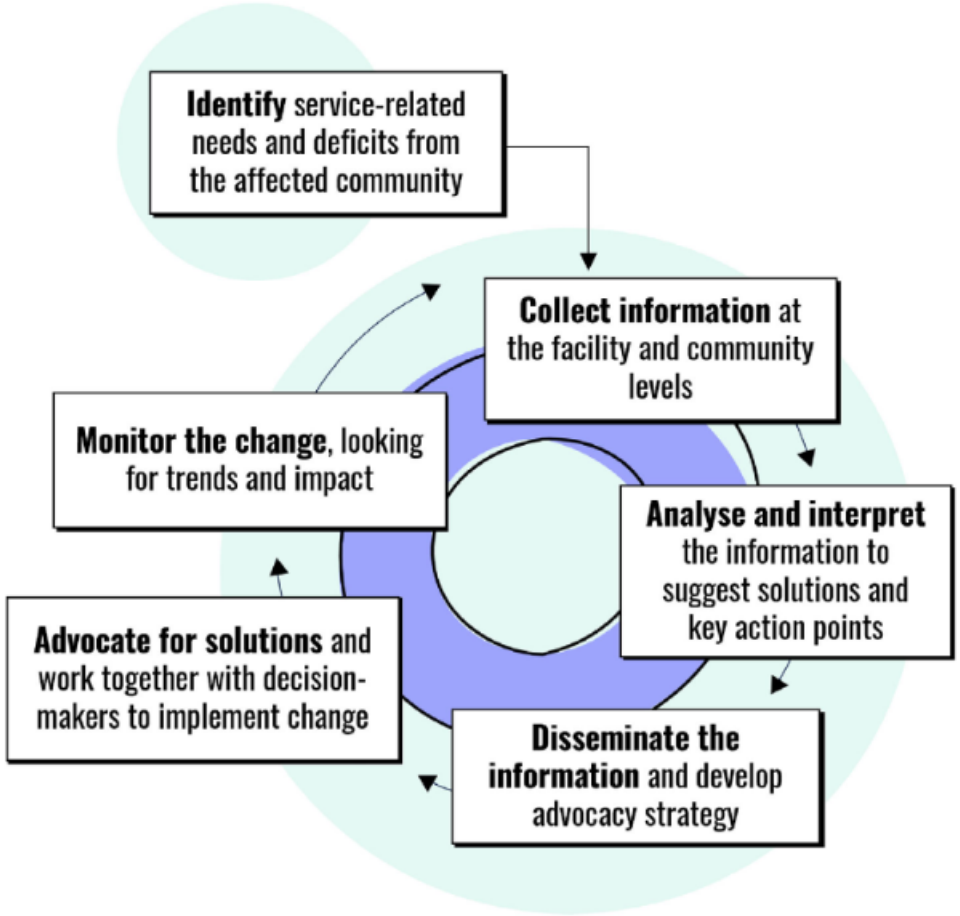


Figure 1. Phases of the CLM model. Integration of community-led monitoring into service review and improvement [9].

Expand use of community-led monitoring data

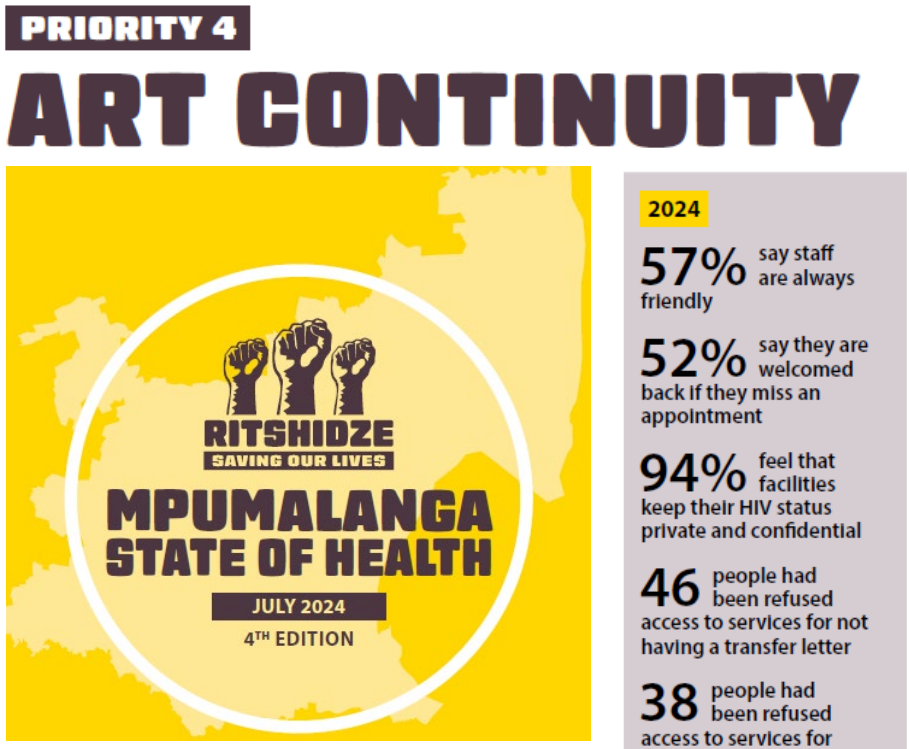
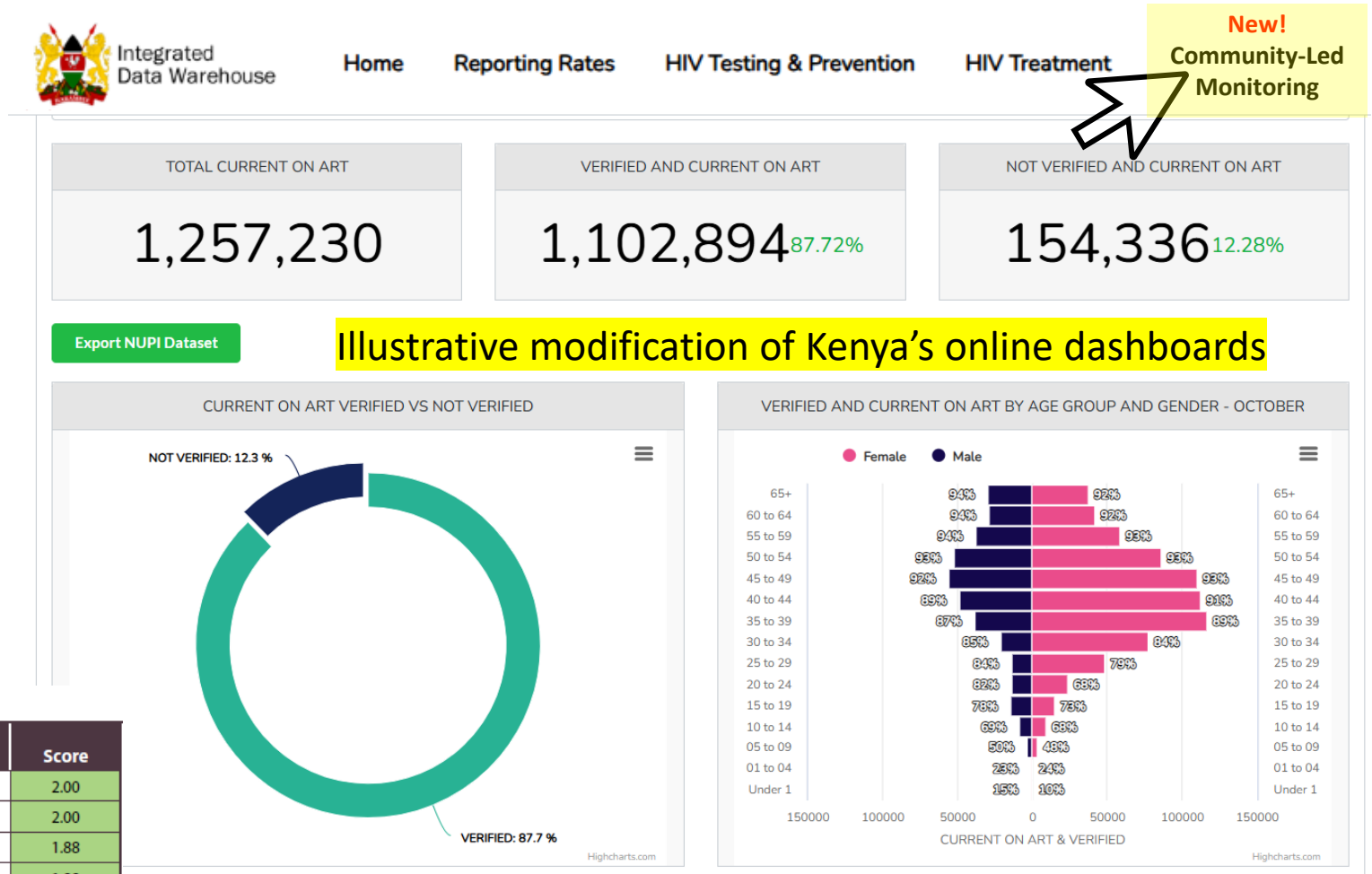


Table 11: Best performing facilities on staff attitudes (April to May 2024)

District	Facility	Surveys Completed	Yes	Sometimes	No	Score
Gert Sibande	Nhlazatshe 6 Clinic	50	50	0	0	2.00
Gert Sibande	Nhlazatshe Clinic	51	51	0	0	2.00
Gert Sibande	Thussiville (MN Cindi) Clinic	59	52	7	0	1.88
Ehlanzeni	Manzini Clinic	51	44	6	0	1.88
Ehlanzeni	Bhuga CHC	50	41	6	1	1.83
Gert Sibande	Mkhondo Town Clinic	54	44	10	0	1.81

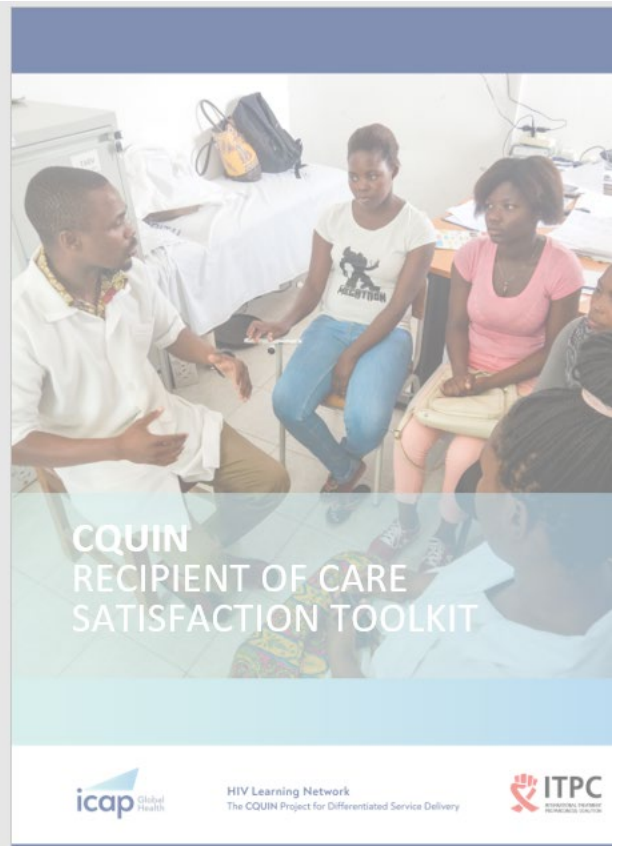


Screenshot of Kenya online Data Warehouse modified with New CLM tab for illustration

PCS components:

Assessing RoC and health care worker satisfaction

- Evidence suggests that ROC satisfaction affects outcomes across the cyclical HIV cascade—testing, linkage, treatment, retention, and re-engagement*
    - Lack of standardized approach and no routine use of satisfaction data
    - CQUIN ROC Satisfaction Toolkit was released in 2023; available at https://cquin.icap.columbia.edu/cquin-resources/
- Also similar gaps in assessing healthcare worker satisfaction



Slide adapted from Gillian Dougherty, ICAP-CQUIN, M&E/Quality CoP presentation 2023.

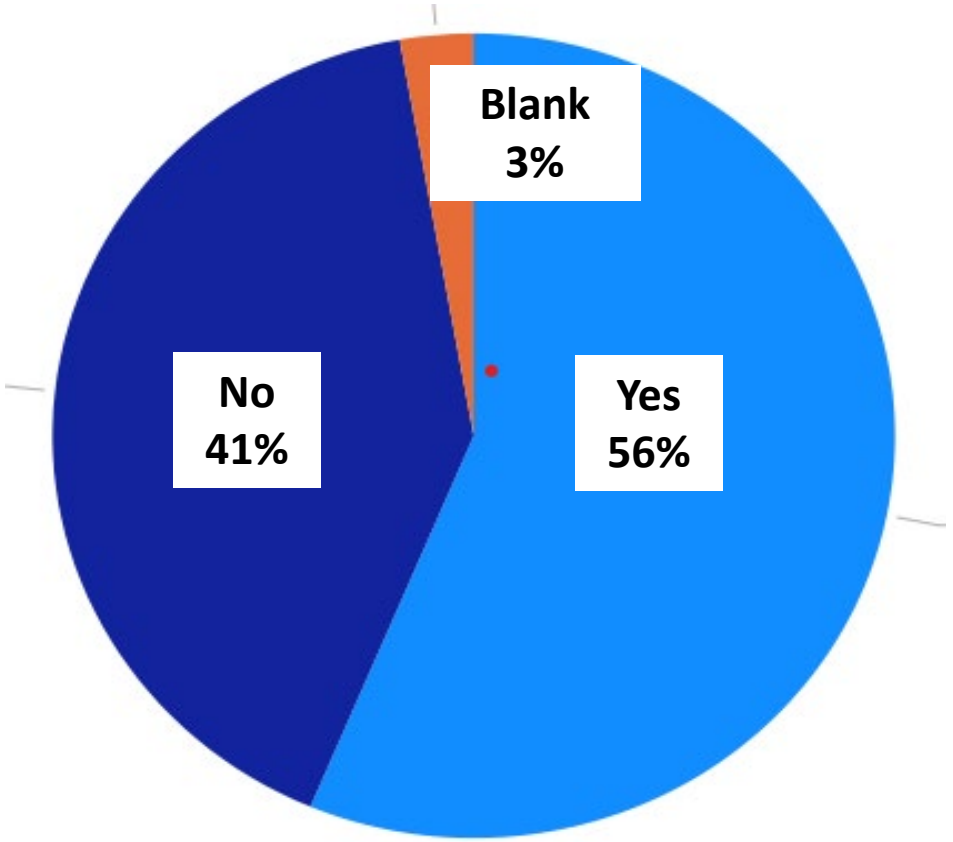
*Citations: Roberts 2004; Martinez *et al.,* 2012*;* Dang *et al.,* 2013 Somi et al, 2021; Leon et al, 2019; Nwabueze et al, 2011; Murray et al, 2018; Thornton *et al.,* 2012; Brincks et al, 2019; Hailemeskal et al, 2020; Chau et al, 2022.

Examples of satisfaction assessments in CQUIN countries

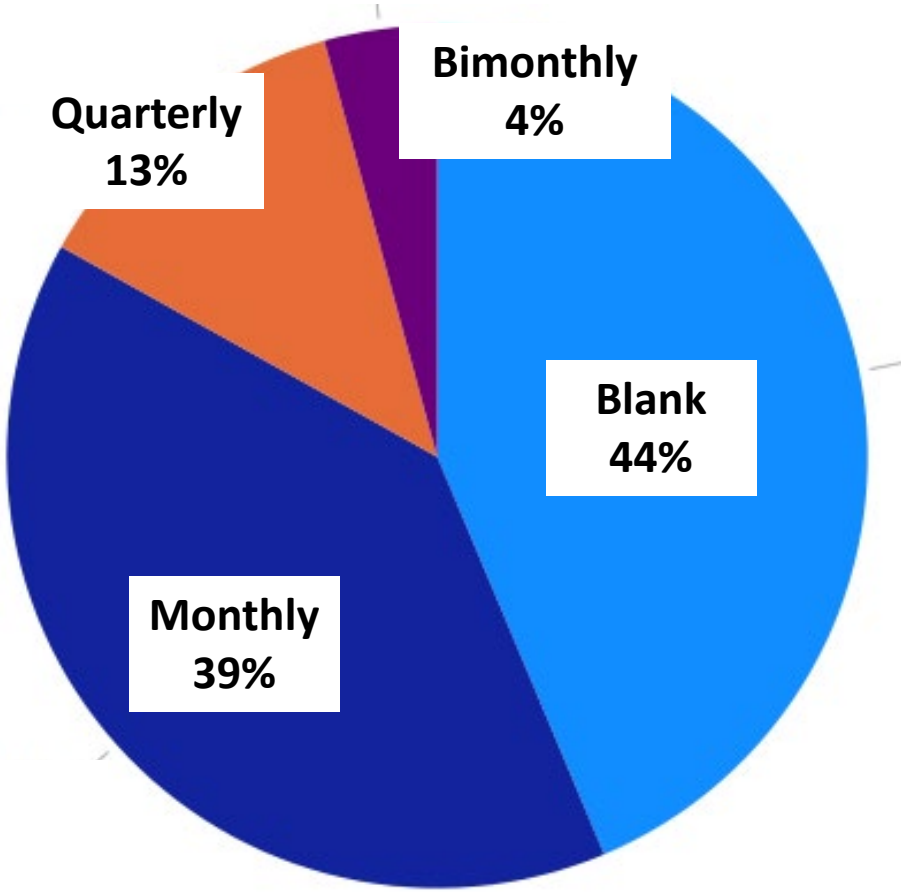
- In Zambia, a mobile exit survey has been used to assess satisfaction
- In Mozambique and Nigeria, satisfaction interviews were integrated into DSD performance reviews
- The Zimbabwe National Network of People Living with HIV (ZNNP+) leads a large-scale electronic client satisfaction survey-based assessment and improvement advocacy program

Tanzania Quality Indicators, HCW Satisfaction, DPR 2024

Health Facilities that perform HCW Satisfaction Surveys



HCW Satisfaction Survey Frequency



(Slide from G Dougherty session 9b presentation)

PCS components:
Ensuring equitable services

WHO: Health equity is the absence of unfair, avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically or by other dimensions of inequality (e.g. sex, gender, ethnicity, disability, or sexual orientation).

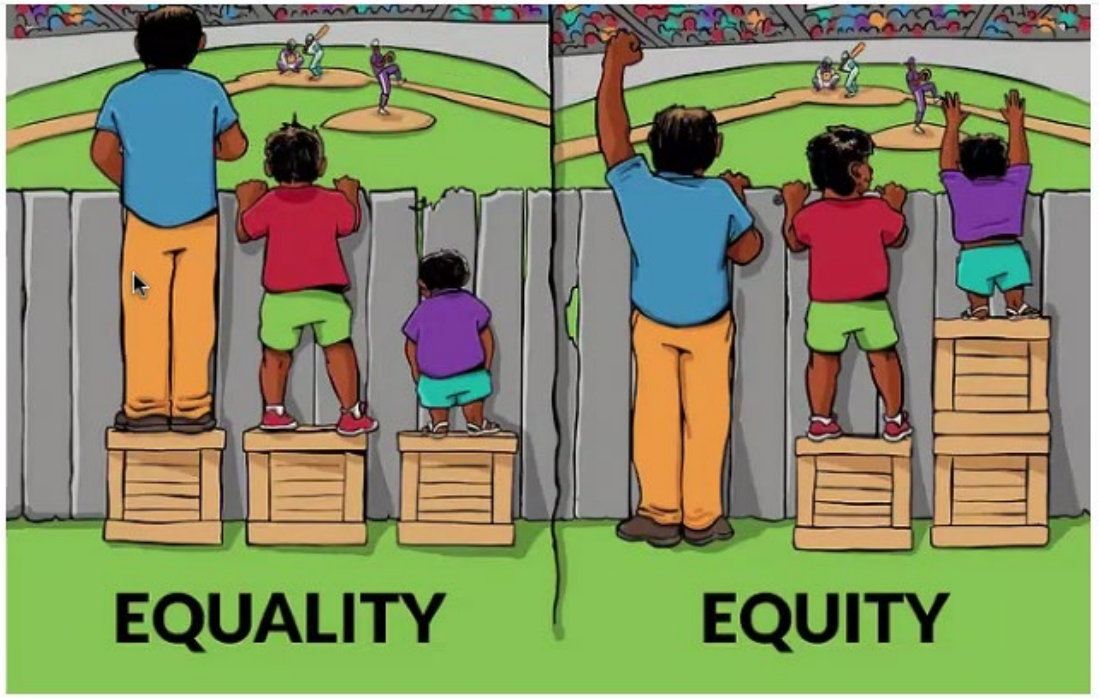
NO SUSTAINED HIV EPIDEMIC CONTROL WITHOUT EQUITY

HOW DO YOU MEASURE EQUITY IN HEALTH SERVICES?

(Paraphrased from UNAIDS/PEPFAR *Equity in the HIV response: Assessing progress and charting a way forward.)*

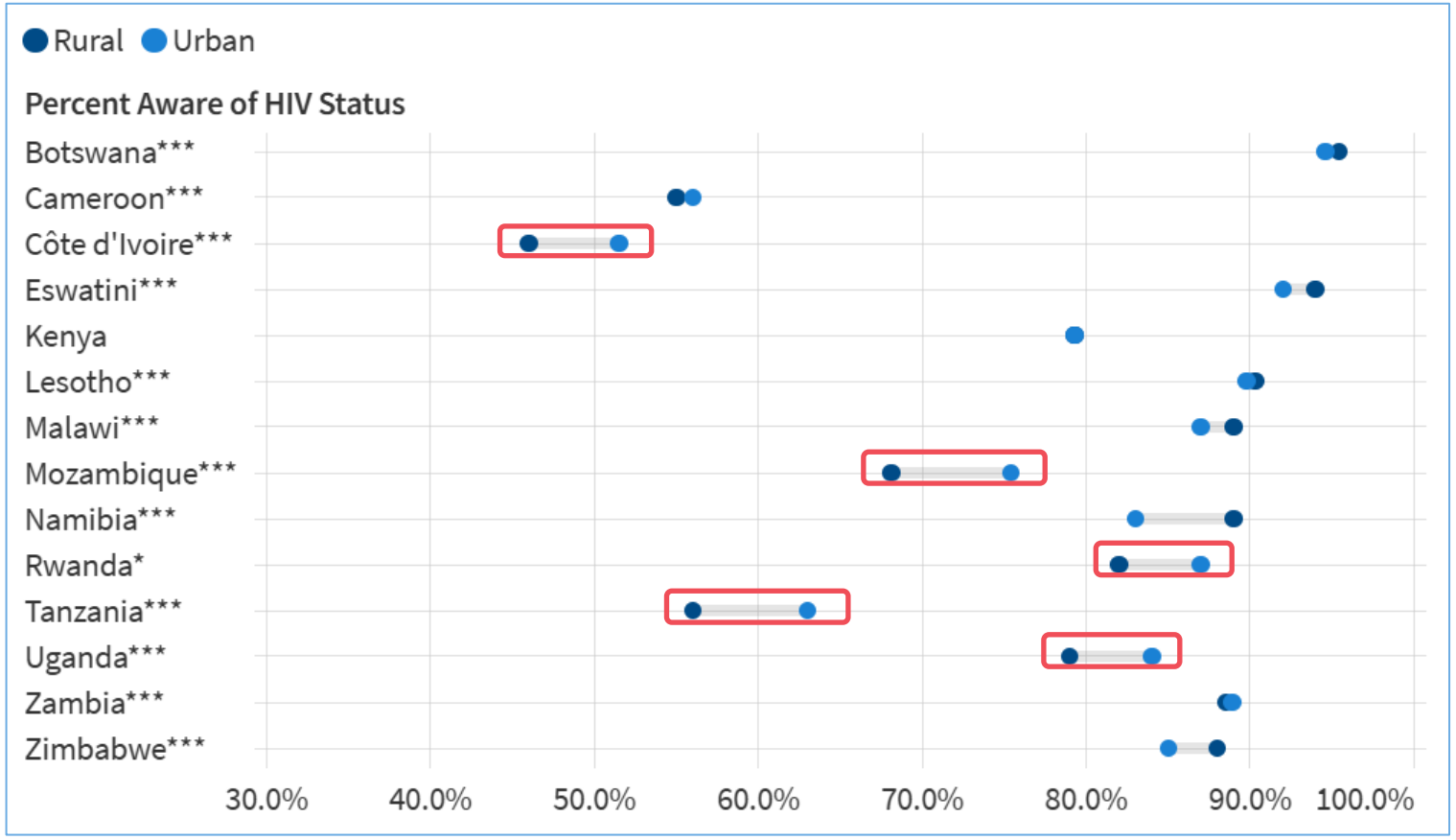
Assessing equity of HIV services

- Based on *need* (equity) rather than *quantity* (equality) of services
- Metrics of disparities in access, quality, outcomes
  - Comparisons of subpopulations
- Use of services data, spatial analyses, modeled estimates as denominators
- Routine use of these metrics
- **Creative ideas are needed…**



Assessing equity across locations

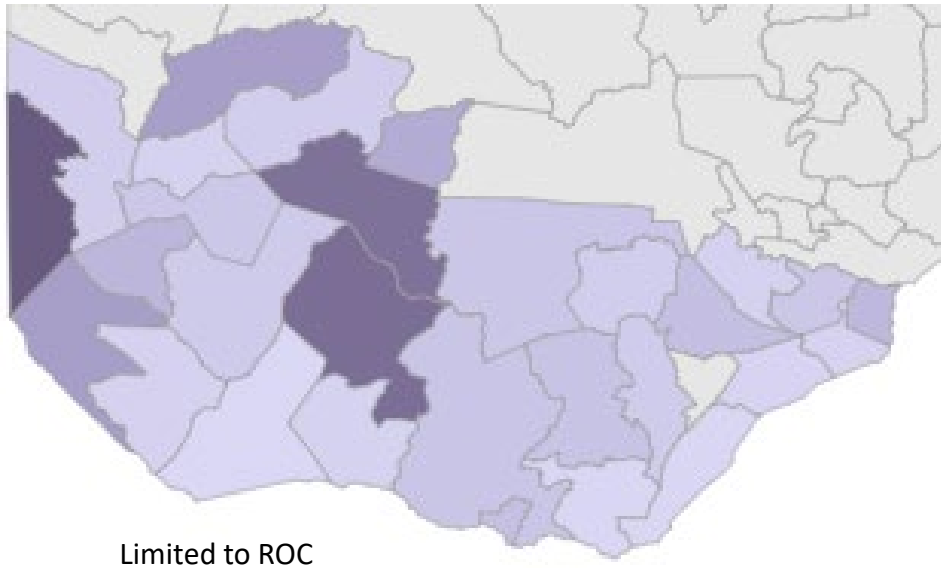
SURVEY DATA:



Source: PEPFAR/UNAIDS analysis of PHIA data

PROGRAM DATA:

Percent of ROC with CD4<200 at ART initiation, by district, ICAP supported HF, Southern and Western Provinces, Zambia, FY24 Q2:



Limited to ROC with CD4 results at ART initiation

Max | Mean | Min

Equity for key populations

SERVICE QUALITY ASSESSMENT DATA:

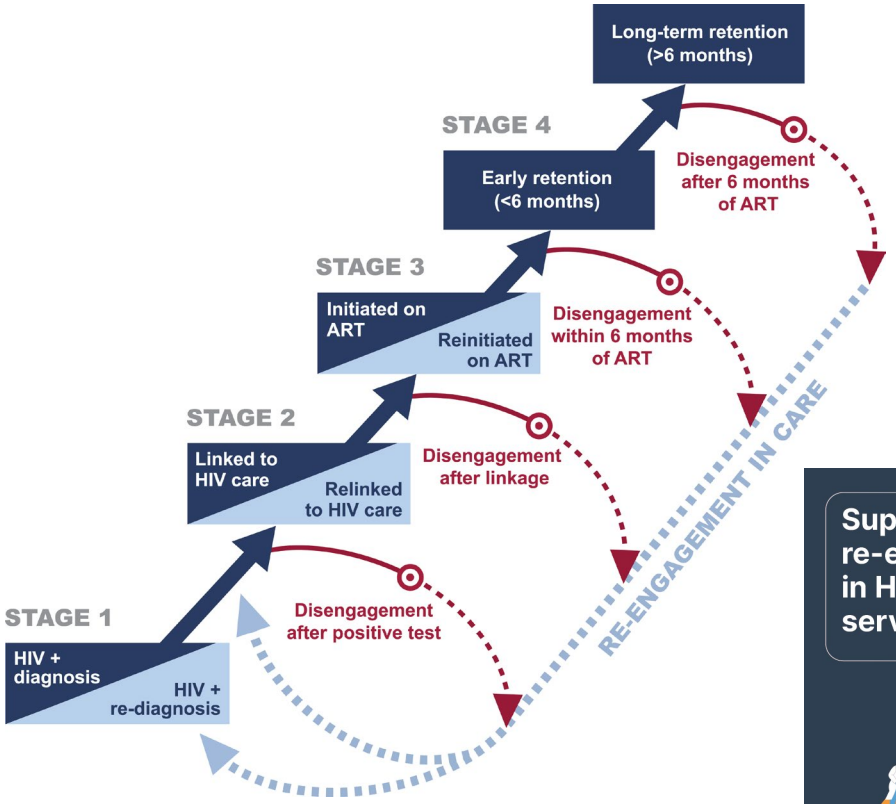
Societal enablers		
10-10-10 targets for removing societal and legal impediments to an enabling environment that limit access or utilization of HIV services.		
Less than 10% of countries have punitive legal and policy environments that deny or limit access to services.	Less than 10% of people living with HIV and key populations experience stigma and discrimination.	Less than 10% of women, girls, people living with HIV and key populations experience gender inequality and violence.

CQUIN Quality Standards for KP-Friendly Services

- Designed as a **practical resource** for HIV programs to improve care for KP
- Intended as just **one component of a broader effort** to improve KP services
- Focus on improving HIV-related services at **health facilities in the public sector**

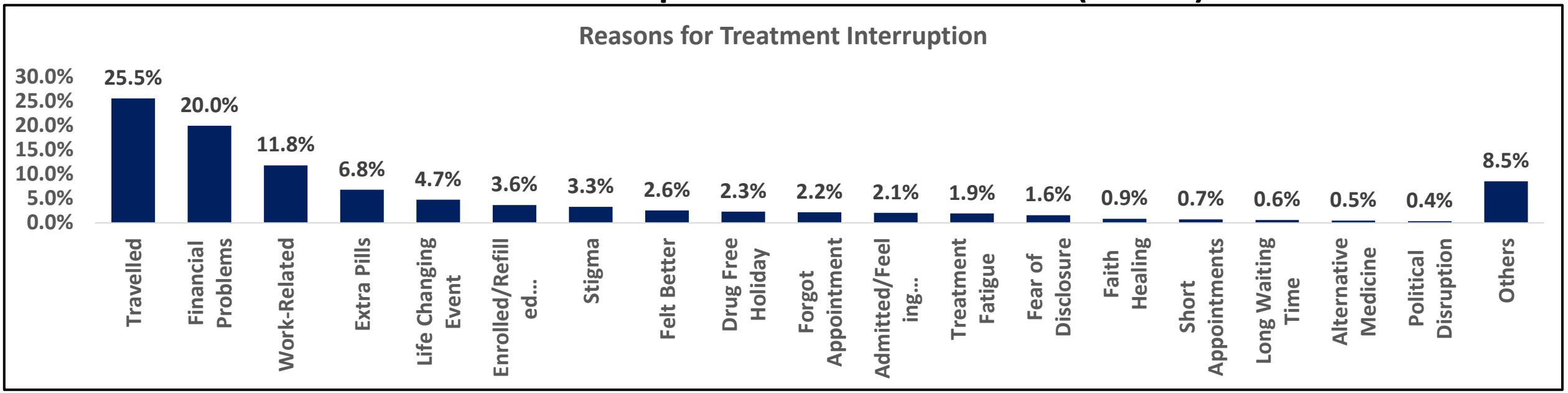
Quality Standard 13: Key population community members are actively engaged in providing health services.		
Process Indicators		
13.1	Are there members of key population groups (peers) engaged in providing services at the health facility? *If there are individuals who identify as members of key population groups (i.e. men who have sex with men, sex workers, transgender people and/or drug users) currently serving in any capacity within HIV programs (i.e. peer supporters, group leaders or expert clients), score = Y. If no individuals who identify as a key population member serve at the health facility, score = N.* *Partial: If there is evidence of involvement by members from some key population groups, but not all key population groups served by the facility.* *Data source = Staff logbooks, and key informants (e.g., talk to peers)*	Y P N Yes = Green Partial = Yellow No = Red

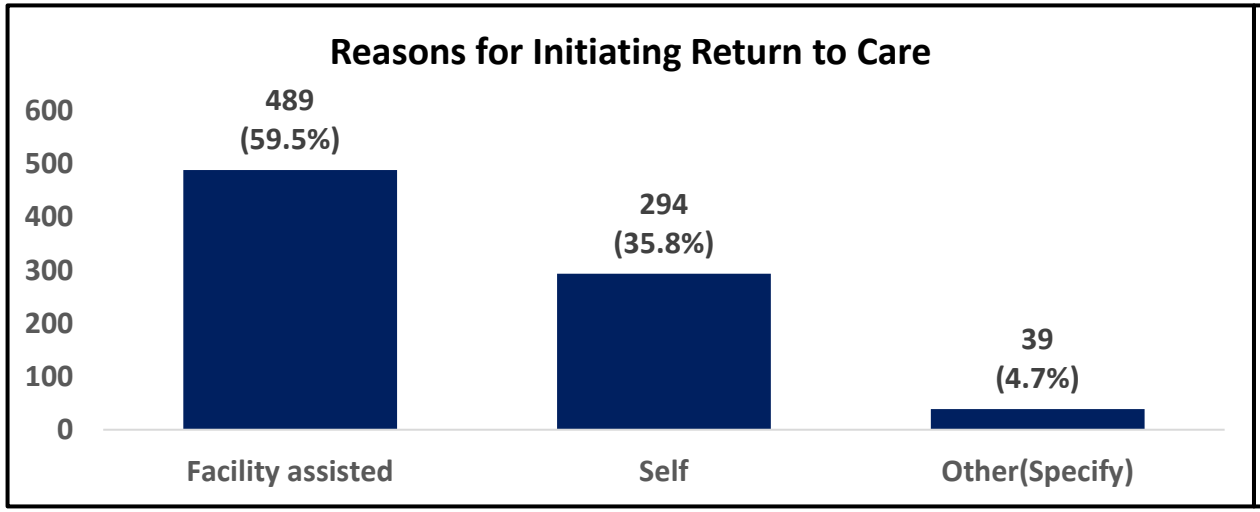
PCS components:
Facilitating returns to care and transfers

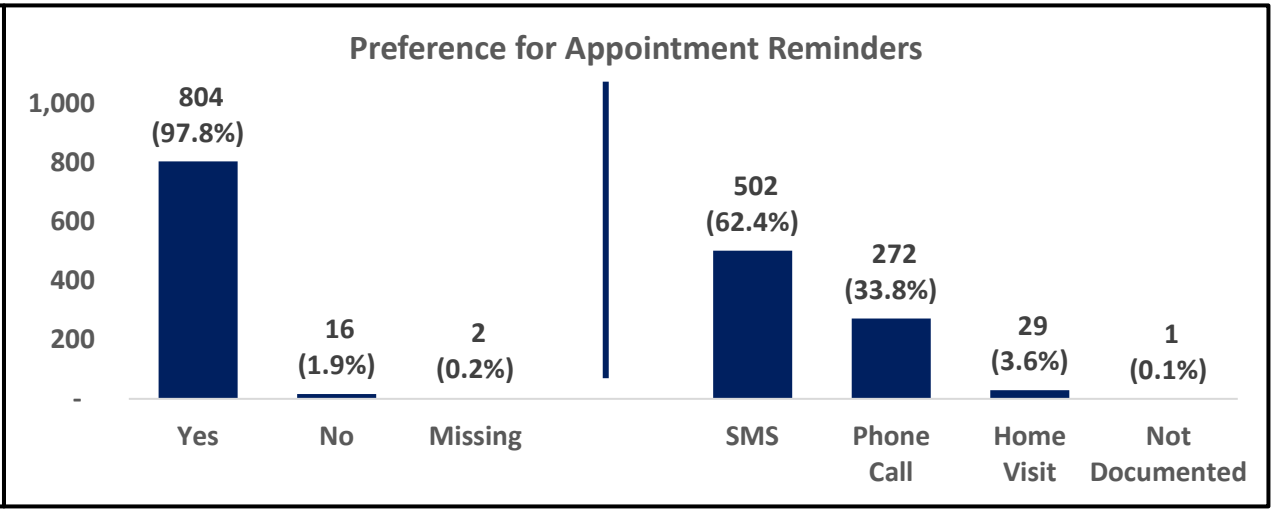


- Welcome back packages and re-engagement algorithms
- Policies and procedure for re-testing for re-engagement
- RoC support for successful transfers
- Systems to ensure timely and complete sharing of clinical documentation across sites
  - Person-centered strategic information
  - Continuity of care and accurate data in HMIS
  - Characterizing patterns of engagement over time

Using EMR P-Survey Solution to Understand Clients' Perspectives on Factors Associated with Treatment Interruption and Return to Care (N=822)



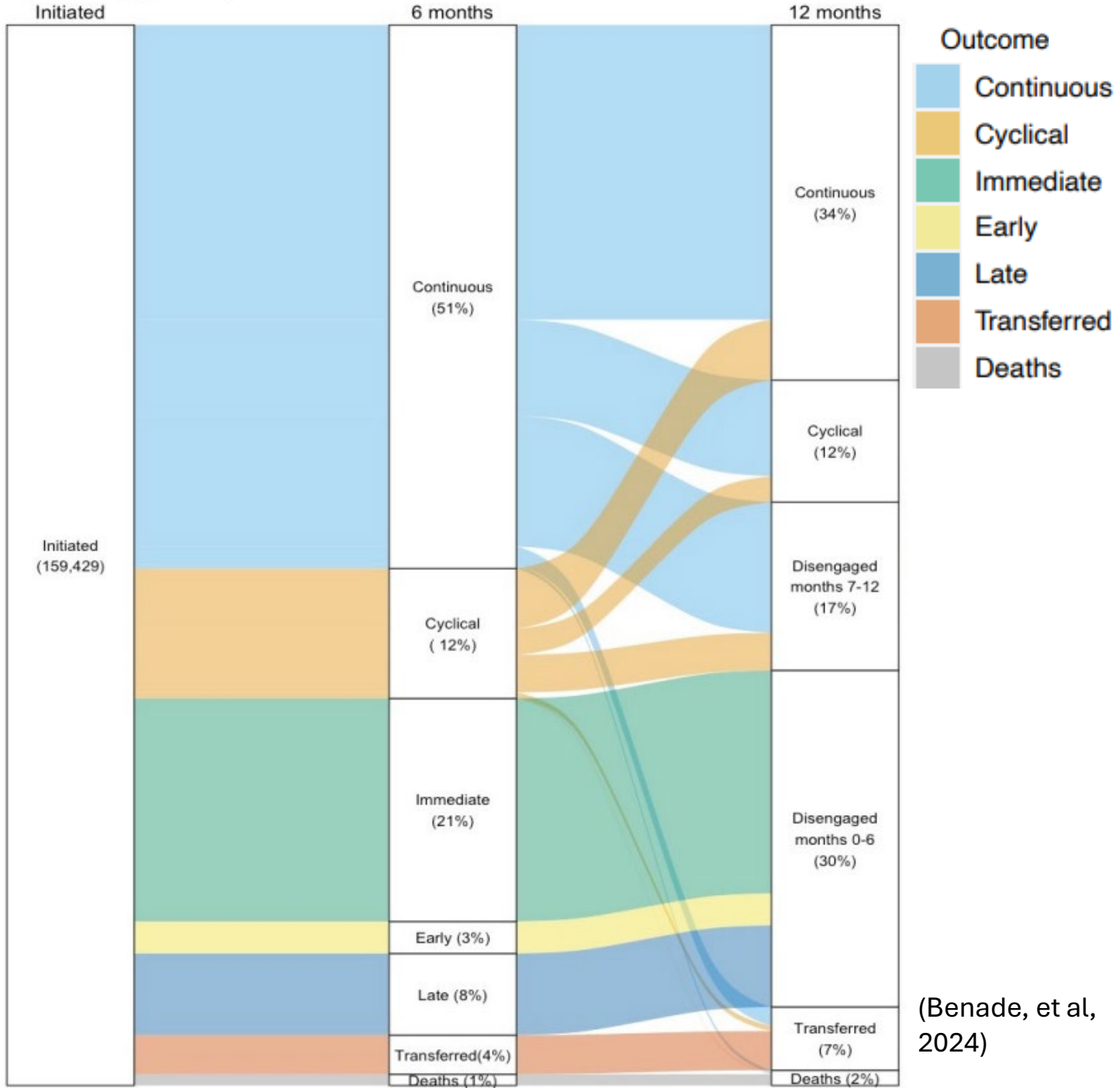




Slide presented by Kenya in M&E pre-meeting

Source: DWH

Figure 1. Engagement patterns at 6 and 12 months after ART initiation



(Benade, et al, 2024)

RETAIN6 results from Zambia SmartCare EMR

- **Example of using routine data to characterize interruptions, returns, and transfers longitudinally**

- Only 34% of RoC had continuous engagement
- 12% of clients at 6/12 mos demonstrated cyclical engagement
- More than 20% of initiators did not return after the initiation visit
- Half of all disengagement in the first year occurred within the first 3 months.

- **Future work of this type: Assess varying patterns and associations among subpopulations (geographic location, ART model/MMD, past disengagement, facility characteristics)**
  - **Use this information to intervene to reduce interruptions**

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South Africa 2023-24 DPR results – Highlights data quality gaps

Adherence, Retention and Re-engagement

M&E 101: Support high-quality data across service areas

Treatment literacy documented as "Done", "Ongoing", - Not specific what was taught to the clients	Patient adherence plan not available in clients' folders (less than 10 found across all districts)	High LTFU (migration, file duplications, missing files, treatment interruption)	Poor documentation of tracing outcomes, EAC, welcome back and re-engagement to care

Source: M&E CoP Meeting: South Africa's DPR Experience, Musa Manganye, Feb 2024

Strategic information for person-centered services

Routinely-collected data*:

1. Person-centered health services data
2. Facility service quality assessments
3. Community-led monitoring

Ensure data quality

Other data sources:

- Population-based surveys & surveillance
- Modeled estimates
- Epidemiologic research

Process and outcome indicators

'Live' national data dashboards
MOH reporting indicators
UNAIDS Global AIDS Monitoring
Health equity measures**

Ongoing data use for program improvement

*Includes routine assessments of recipient of care and health care worker satisfaction, community engagement, and data from quality improvement initiatives

**Assesses disparities by location, age, sex, key populations group, socioeconomic factors, and other relevant dimensions

(Adapted from WHO *Consolidated guidelines on person-centred HIV strategic information* (2022))

Key points: PCS and data for decision-making

- **Person-centered, longitudinal health services data** linked across locations and clinical service areas
- **Community engagement** across phases of M&E, and **community-led monitoring** results integrated with program M&E dashboard
- **Measures of equity** are critically needed; also equity should be a key consideration in all PCS elements (e.g., in prioritizing Quality efforts)
- Develop **process and outcome indicators for PCS priorities**
    - **Service quality assessments** can be used as a data source
- Routinize and utilize **assessments of ROC and health worker satisfaction**
- Use person-centered data to **characterize the cyclical cascade by subpopulation** and understand risk points for disengagement
- **We look forward to your input on this**

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Thank You!