ETHEKWINI DISTRICT QI PROJECT FOR HIV-VL AND DRUG RESISTANCE MONITORING

ANNUAL WORKSHOP IN ADVANCED CLINICAL CARE (AWACC-2017

07/09/2017

Dr.Henry Sunpath -

Research /Clinical Director- (MEDICATE -AIDS :NPC)

Consultant : Ethekwini Health District Office &

CAPRISA Advanced Clinical care program

And Mr.Selvan Pillay

PROGRAM MANAGER :REVAMP STUDY

WHAT IS THE MOST EFFECTIVE WAY TO MAKE VL MONITORING ROUTINE IN AN ART CLINIC

1. INCREASE DEMAND BY PT EDUCATION AND HCW EDUCATION
2. INSTITUTE VL ANIVERSARY CONCEPT
3. IMPLEMENT GATE KEEPING NOT TO ISSUE REPEAT SCRIPTS WITHOUT VL RESULTS
4. ENHANCED ADHERENCE COUNSELLING
5. ALL OF THE ABOVE

IN PILOT SITE STUDIES ,HOW MANY PATIENTS WITH HIGH VL HAVE A REPEAT VL AFTER EAC 1 AND EAC 2

1. 60 %
2. 10 %
3. 30 %
4. 50 %

The commonest cause of sample rejection from the NHLS is

1. Clotted /haemolysed specimen
2. Incorrect blood tubes used
3. Forms filled incorrectly
4. Vl done at inappropriate time line

In a viral load priority clinic , what combination of staff is the most effective in managing high VL

1. Doctor , NIMART nurse
2. Doctor ,EAC counsellor ,social worker, psychologist
3. NIMART nurse ,EAC counsellor ,social worker
4. EAC counsellor, social worker, psychologist
5. Doctor ,EAC counsellor

What percentage of patients have a VL at 6 months in Ethekwini- approximately

1. 70 %
2. 40%
3. 25%
4. 50 %

Which statement is correct, according to the DOH guidelines

1. First Vl result is due at 6 months on ART and then 12 months if the 6 month Vl is undectable and then annually if the 12 month Vl is undectectable
2. First Vl result is due at 6 months on ART and thereafter one year later if the 6 month Vl is undectectable
3. First Vl result is due at month 6 on ART and then at month 12 if the Vl is > 1000.

Fast Track 90-90-90

ETHEKWINI HEALTH DISTRICT
Mrs P.Msimango ,Mr.S.Yose ;
Dr.Sewlal ,Mr.Gabela ,HAST team
,QA/IPC Teams

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

20 YEARS OF FREEDOM

eThekwini: Third 90 key activities and support

Dr.Aarthi Ramkissoon
Dr Kevi Naidu
Dr.Gugu Mkhulusi
Ms.Thoko Ngwenya

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SOUTH AFRICANS AND AMERICANS IN PARTNERSHIP TO FIGHT HIV/AIDS

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Health
PROVINCE OF KWAZULU-NATAL

MatCH
Maternal, Adolescent and Child Health Systems
School of Public Health
Faculty of Health Sciences
University of the Witwatersrand

CAPRISA
CENTRE FOR THE AIDS PROGRAMME OF RESEARCH IN SOUTH AFRICA

UNAIDS
CAPRISA is the UNAIDS Collaborating Centre for HIV Research and Policy

FILE AND FACILITY AUDIT –CAPRISA ACC PROJECT

Dr. Kogie Naidoo, Dr. Rochelle Adams.Santhana Gengiah
The Epicentre team led by Cherie Cawood
The 11 facilities that participated in the File and Facility Audit
The CAPRISA ACC Statistics & Data Management Team
Dr Henry Sunpath (eThekwini District Specialist Clinical Team Leader)

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PROVINCE OF KWAZULU-NATAL
ISIFUNDAZWE SAKWAZULU-NATALI

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

CAPRISA
CENTRE FOR THE AIDS PROGRAMME OF RESEARCH IN SOUTH AFRICA

MEDICATE –AIDS NPC & ACADEMIC PARTNERS

- Harvard Medical School – Mark Seidner ,Raj Gandhi,Kevin Ard
- Emory University- VC.Marconi , D.Kuritzkes
- REVAMP team – MYS Moosa , J.Brijkumar, Eseza Nambassi,Selvan Pillay and study team
- SA HIV clinicians Society -
- MSF
-

Quality improvement model

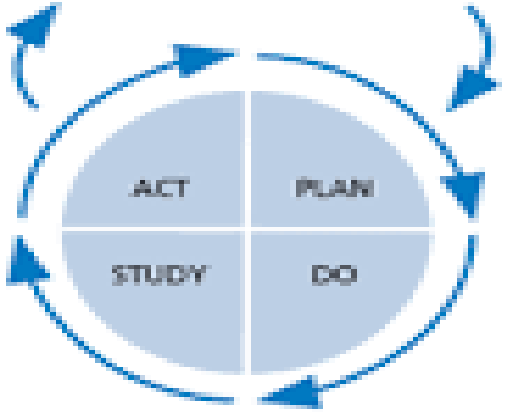
Root cause analysis (SIMS) → Stakeholder strategy → Ongoing education and development

AIM → What are we trying to accomplish?

MEASURE → How will we know if a change is an improvement?

CHANGE → What changes can we make that will result in improvement?

RAPID CYCLE IMPROVEMENT →



Adult with Viral load completion (VLD) rate (HIV -8)

Definition:

- Proportion of adults in the 12 month cohort, still on treatment who had Viral load test done in the last year

Numerator:

- Adult viral load done (VLD) at 12 months

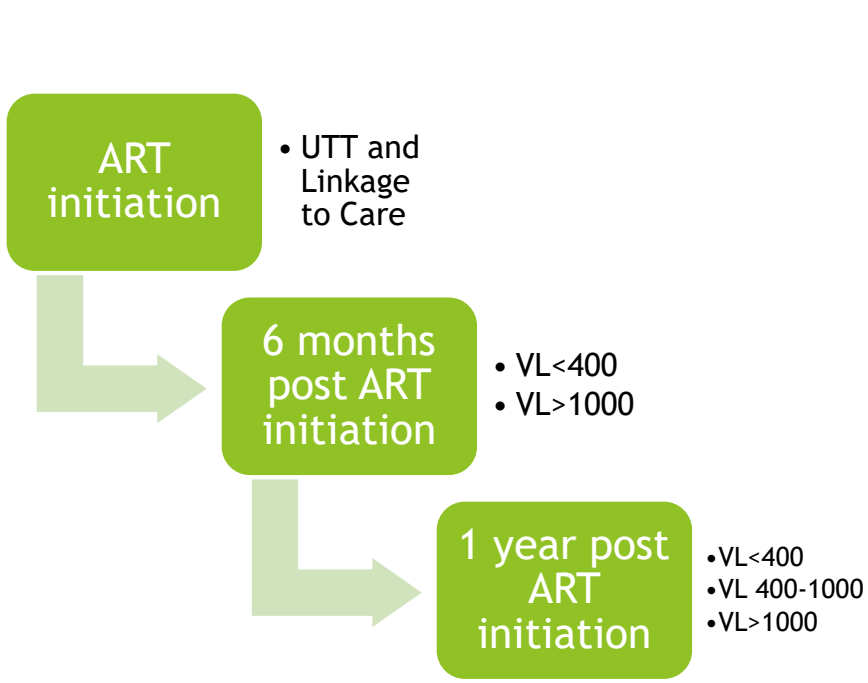
Denominator:

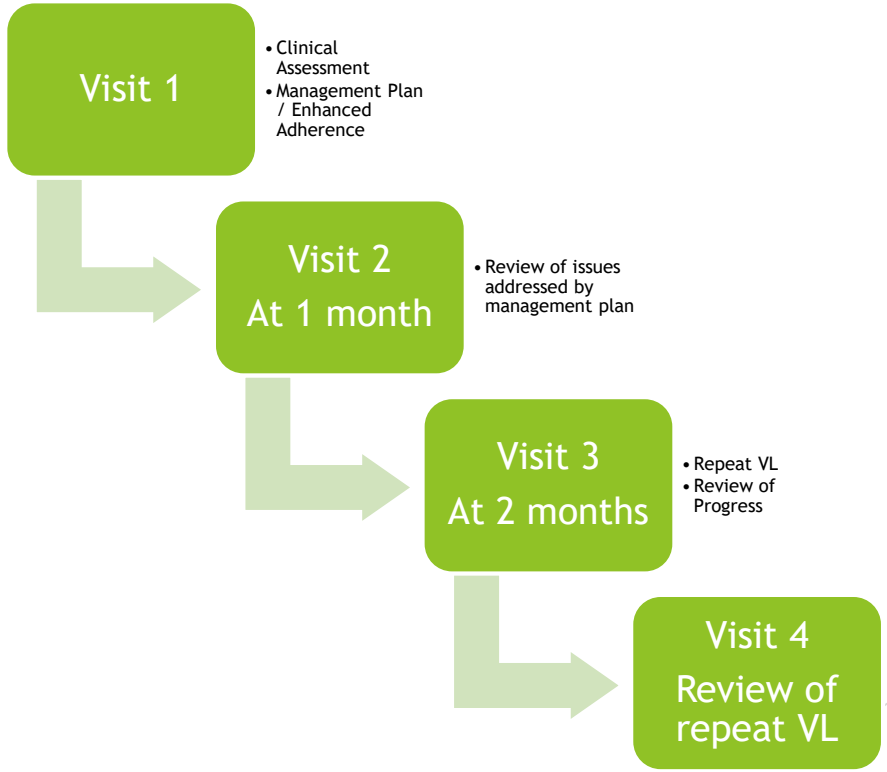
- Adult first line regimen + Adult second line regimen at intervals in 12 month cohort

2016/17 Target (Proposed):

- **80 % VLD** rate at 12 months

Key clinical contact points –ensure activity



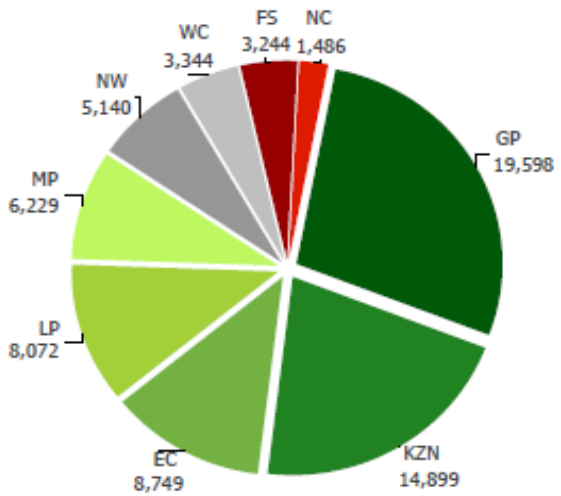


Analysis of various sources of VL data-

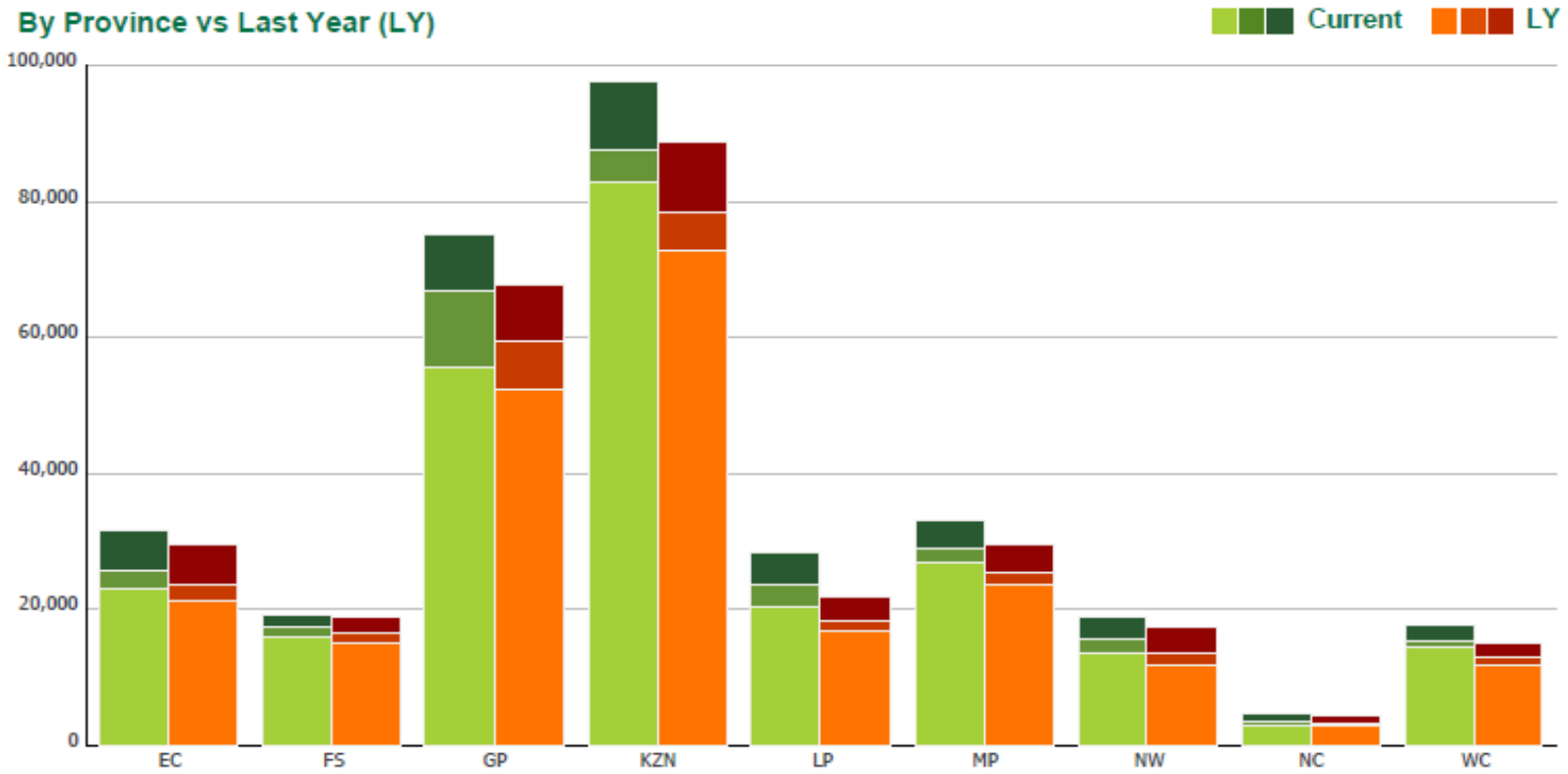
- Very large numbers of Vl tests done monthly –are they appropriately done and acted upon
- Vl suppression rates good on those samples tested
- Is there consistency with NHLS reports , records in clinical charts and entry into tier.net?
- NHLS unable to report on VL completion rates
- Does tier ,net accurately and completely report on VL completion rates?
- What is the best way to assess the VL completion rates ?
- Are repeat VL being done and acted upon after VF and adherence intervention?
- Need to triangulate data between NHLS database – Tier.net – clinical charts
- Aim for completion of exercise to ensure that data on Vl monitoring in accurate and complete

Viral Load Testing in SA for the Month of Jan 2017 vs Jan 2016

Total by Province VL > 1,000



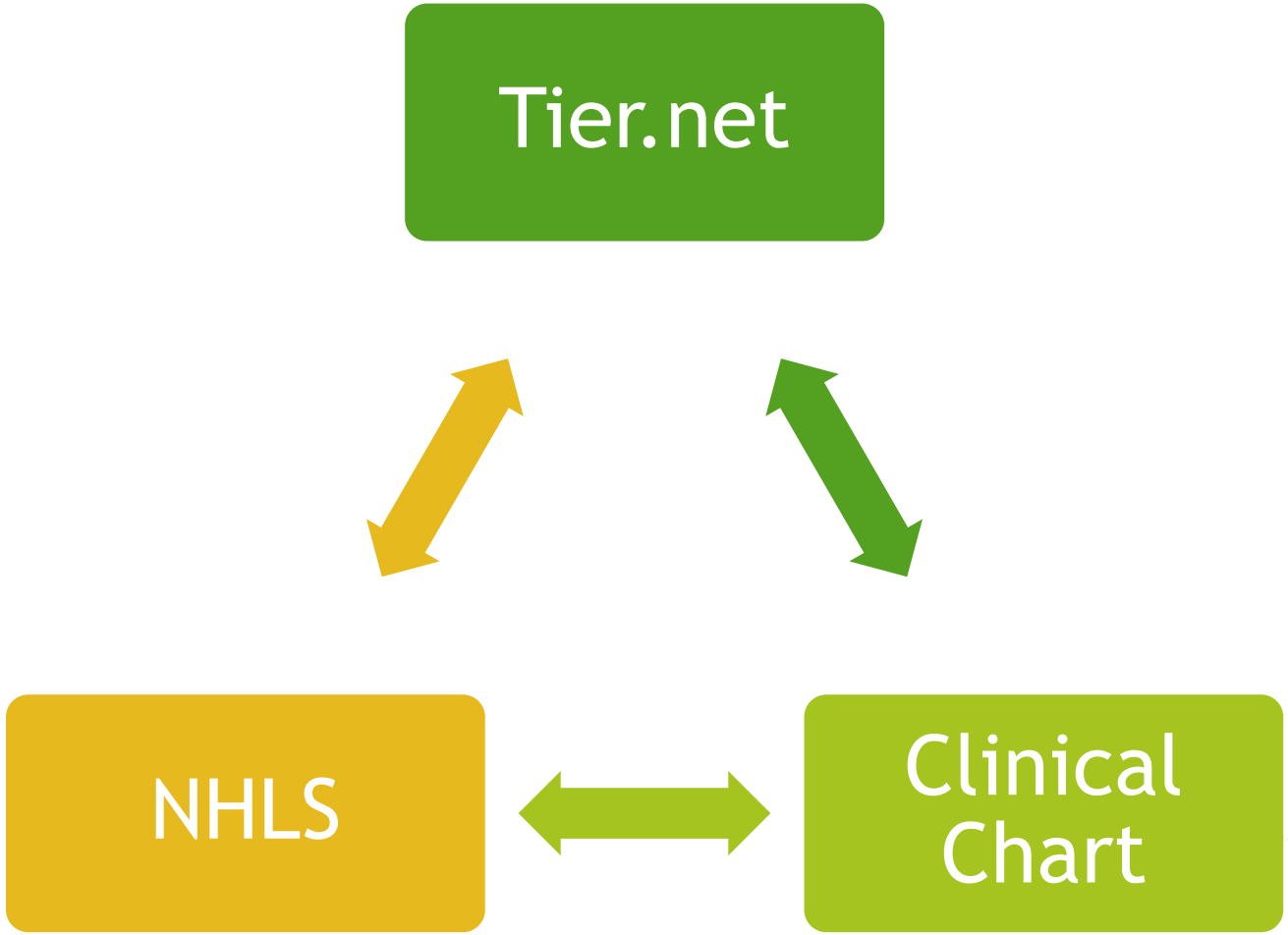
By Province vs Last Year (LY)



Results by Range by Province vs Last Year (LY)

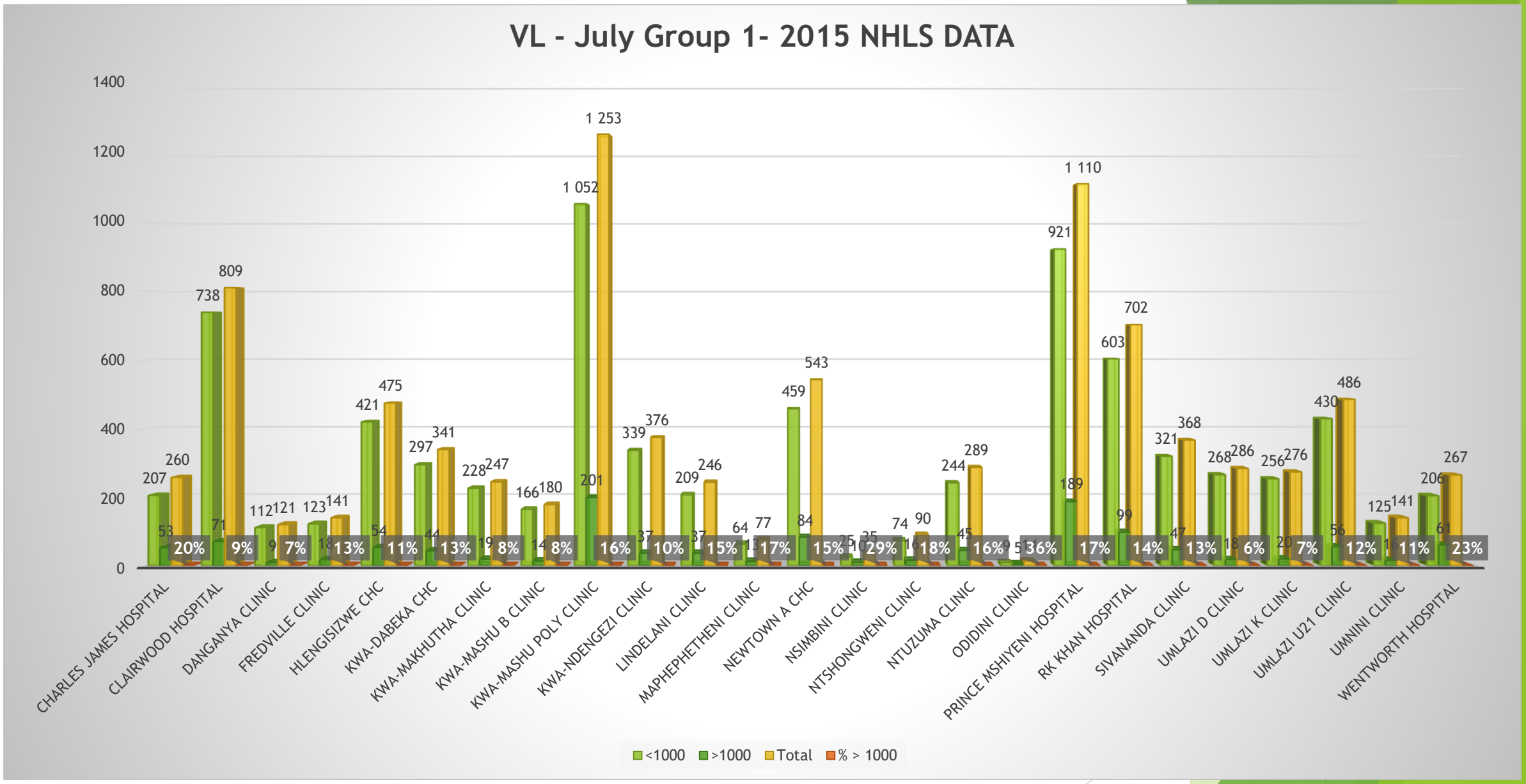
		Total		<= 1,000 (log 3)				> 1,000 (log 3) <= 10,000 (log 4)				> 10,000 (log 4)				Average (log)	
Province		Current	LY	Current	%	LY	% LY	Current	%	LY	% LY	Current	%	LY	% LY	Current	LY
Eastern Cape	EC	31,857	29,666	23,108	72.5%	21,236	71.6%	2,828	8.9%	2,519	8.5%	5,921	18.6%	5,911	19.9%	3.25	3.47
Free State	FS	19,294	18,804	16,050	83.2%	15,033	79.9%	1,326	6.9%	1,392	7.4%	1,918	9.9%	2,379	12.7%	3.64	3.73
Gauteng	GP	75,313	67,771	55,715	74.0%	52,093	76.9%	10,988	14.6%	7,449	11.0%	8,610	11.4%	8,229	12.1%	3.10	3.00
KwaZulu-Natal	KZN	97,683	88,674	82,784	84.7%	72,825	82.1%	4,932	5.0%	5,638	6.4%	9,967	10.2%	10,211	11.5%	3.14	3.23
Limpopo	LP	28,334	21,822	20,262	71.5%	16,619	76.2%	3,459	12.2%	1,528	7.0%	4,613	16.3%	3,675	16.8%	3.22	3.30
Mpumalanga	MP	33,116	29,554	26,887	81.2%	23,565	79.7%	1,903	5.7%	1,835	6.2%	4,326	13.1%	4,154	14.1%	3.26	3.13
North West	NW	18,847	17,347	13,707	72.7%	11,930	68.8%	1,872	9.9%	1,744	10.1%	3,268	17.3%	3,673	21.2%	3.62	3.61
Northern Cape	NC	4,501	4,311	3,015	67.0%	2,850	66.1%	457	10.2%	436	10.1%	1,029	22.9%	1,025	23.8%	4.01	4.07
Western Cape	WC	17,637	15,004	14,293	81.0%	11,756	78.4%	1,142	6.5%	1,118	7.5%	2,202	12.5%	2,130	14.2%	3.27	3.27

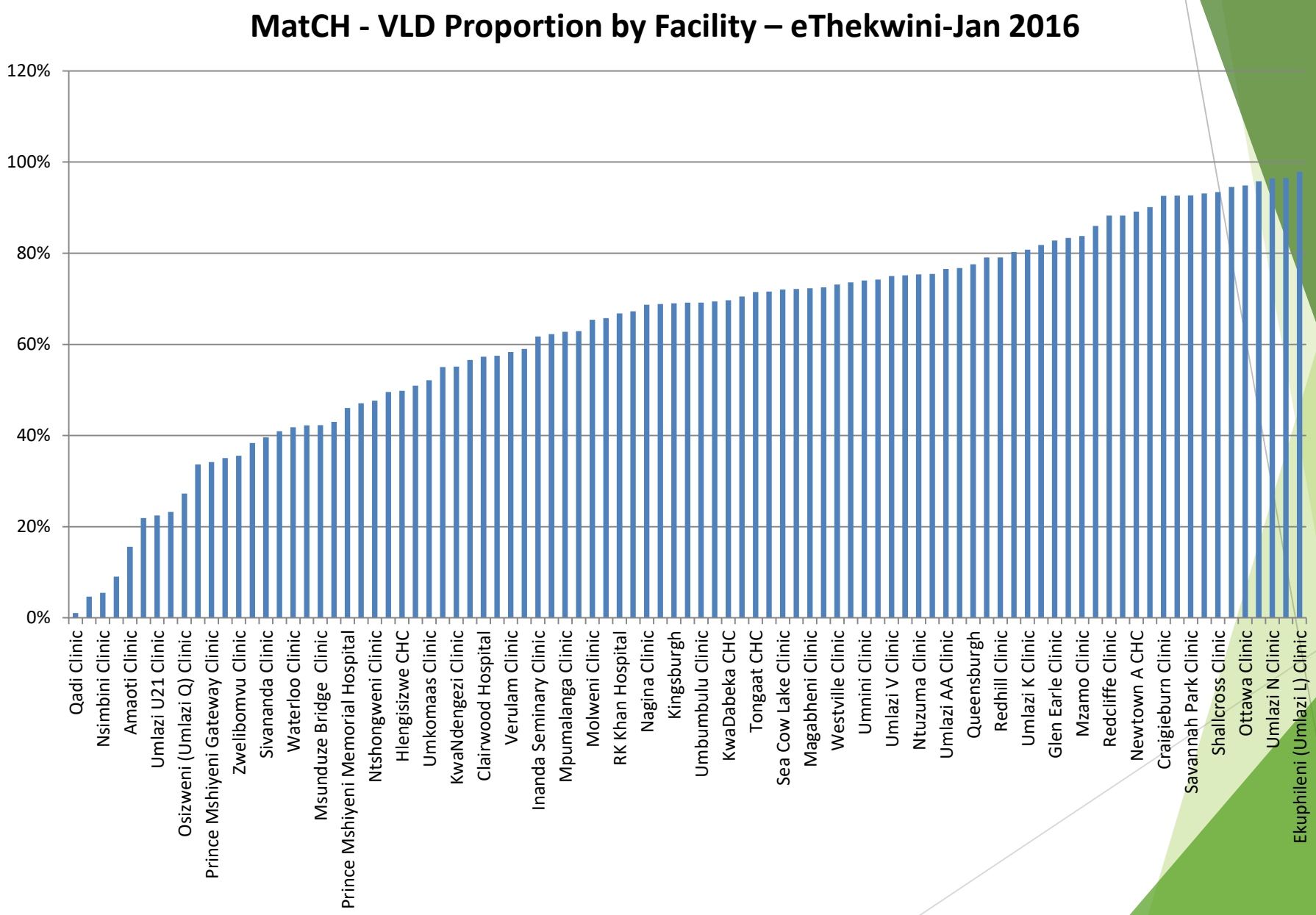
VL Health Information Systems



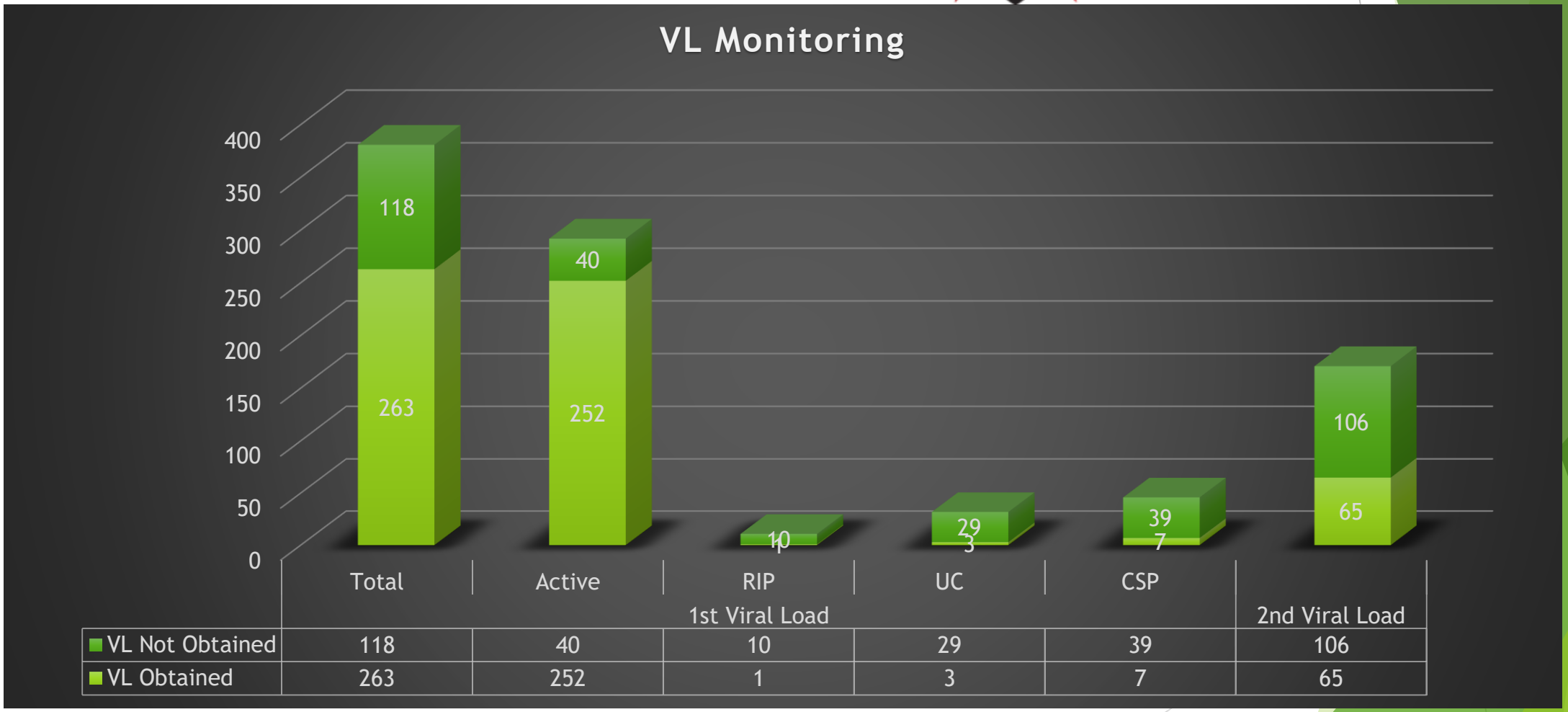
NDOH- Adult with Viral load completion rate at 6 months

District	NDoH Target FY 2014/15	FY 2011/12	FY 2012/13	FY 2013/14	Progress Q3	VLD at 6m FY 2013/14
Amajuba District Municipality	**80**	54.0	47.9	48.4		11,678
eThekwini Metropolitan Municipality	**80**	64.6	64.4	67.4		4,872
Harry Gwala District Municipality	**80**	65.1	55.3	44.1		1,148
iLembe District Municipality	**80**	50.2	44.0	42.6		23,041
Ugu District Municipality	**80**	38.6	36.2	32.4		1,178
uMgungundlovu District Municipality	**80**	26.5	30.6	29.6		4,888
Umkhanyakude District Municipality	**80**	41.4	39.4	35.4		1,888
Umzinyathi District Municipality	**80**	33.0	43.8	0.0		0
Uthukela District Municipality	**80**	37.7	42.9	53.4		4,318
Uthungulu District Municipality	**80**	38.6	35.2	28.4		1,083
Zululand District Municipality	**80**	43.4	37.6	32.0		2,064
KwaZulu-Natal	**80**	**17.4**	**15.4**	**19.3**		**397**


VL - July Group 1- 2015 NHLS DATA
1400
1200
1000
800
600
400
200
0
CHARLES JAMES HOSPITAL 207 53 260 20%
CLAIRWOOD HOSPITAL 738 71 809 9%
DANGANYA CLINIC 112 9 121 7%
FREDVILLE CLINIC 123 18 141 13%
HLENGISIZWE CHC 421 54 475 11%
KWA-DABEKA CHC 297 44 341 13%
KWA-MAKHUTHA CLINIC 228 19 247 8%
KWA-MASHU B CLINIC 166 14 180 8%
KWA-MASHU POLY CLINIC 1 052 201 1 253 16%
KWA-NDENGEZI CLINIC 339 37 376 10%
LINDELANI CLINIC 209 37 246 15%
MAPHEPHETHENI CLINIC 64 13 77 17%
NEWTOWN A CHC 459 84 543 15%
NSIMBINI CLINIC 25 10 35 29%
NTSHONGWENI CLINIC 74 16 90 18%
NTUZUMA CLINIC 244 45 289 16%
ODIDINI CLINIC 9 5 14 36%
PRINCE MSHIYENI HOSPITAL 921 189 1 110 17%
RK KHAN HOSPITAL 603 99 702 14%
SIVANANDA CLINIC 321 47 368 13%
UMLAZI D CLINIC 268 18 286 6%
UMLAZI K CLINIC 256 20 276 7%
UMLAZI U21 CLINIC 430 56 486 12%
UMNINI CLINIC 125 16 141 11%
WENTWORTH HOSPITAL 206 61 267 23%
<1000
>1000
Total
% > 1000


MatCH - VLD Proportion by Facility – eThekwini-Jan 2016
120%
100%
80%
60%
40%
20%
0%
Qadi Clinic
Nsimbini Clinic
Amaoti Clinic
Umlazi U21 Clinic
Osizweni (Umlazi Q) Clinic
Prince Mshiyeni Gateway Clinic
Zwelibomvu Clinic
Sivananda Clinic
Waterloo Clinic
Msunduze Bridge Clinic
Prince Mshiyeni Memorial Hospital
Ntshongweni Clinic
Hlengisizwe CHC
Umkomaas Clinic
KwaNdengezi Clinic
Clairwood Hospital
Verulam Clinic
Inanda Seminary Clinic
Mpumalanga Clinic
Molweni Clinic
RK Khan Hospital
Nagina Clinic
Kingsburgh
Umbumbulu Clinic
KwaDabeka CHC
Tongaat CHC
Sea Cow Lake Clinic
Magabheni Clinic
Westville Clinic
Umnini Clinic
Umlazi V Clinic
Ntuzuma Clinic
Umlazi AA Clinic
Queensburgh
Redhill Clinic
Umlazi K Clinic
Glen Earle Clinic
Mzamo Clinic
Redcliffe Clinic
Newtown A CHC
Craigieburn Clinic
Savannah Park Clinic
Shallcross Clinic
Ottawa Clinic
Umlazi N Clinic
Ekuphileni (Umlazi L) Clinic

Project Status on Viral load monitoring –May 2016
KwaZulu-Natal HIV Drug Resistance Surveillance Study Sites –RKKhan and Mkhuze CHC (file audit and trak care)



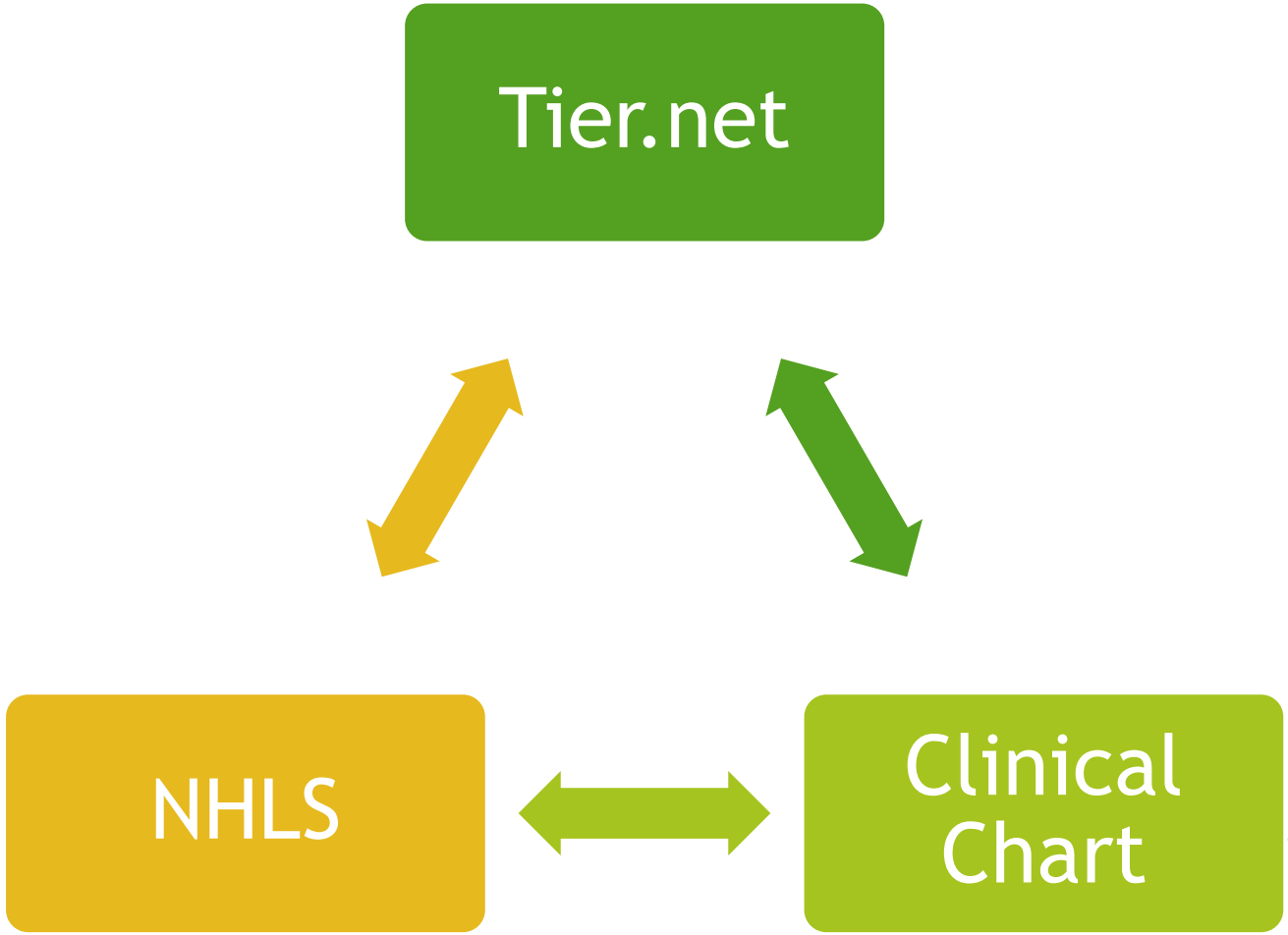
	Total	Active	RIP	UC	CSP	2nd Viral Load
VL Not Obtained	118	40	10	29	39	106
VL Obtained	263	252	1	3	7	65

TIER.NET Challenges

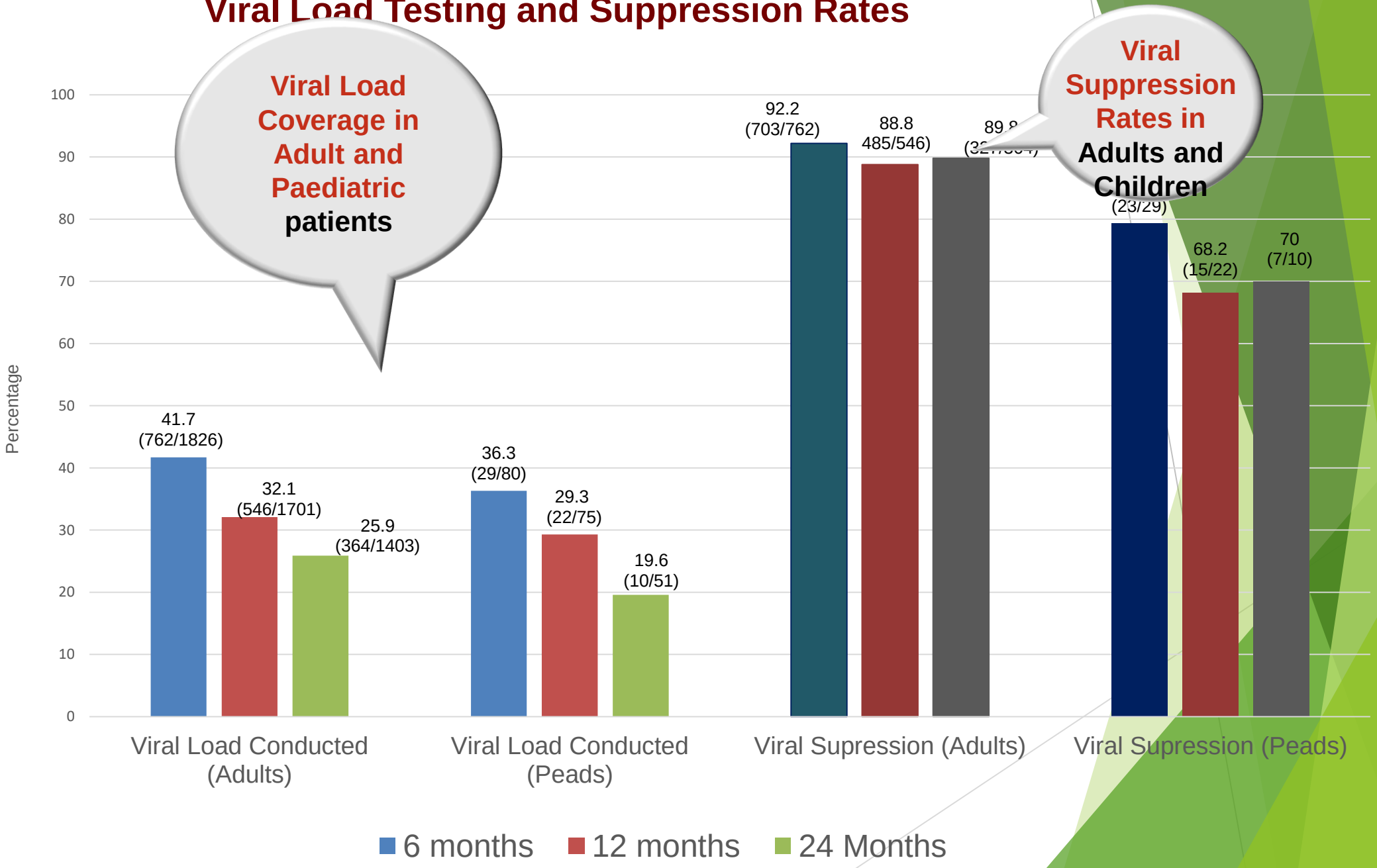
Challenges in facilities are as follows:

1. Poor clinical information recording on clinical charts.
2. Facility Data Captures not working as much as they are supposed to.
3. Backlogs-There is a big number of files in backlog resulting in the increased number of defaulters.
4. Blood results not being recorded on clinical charts which affects our VL completion as well as suppression rate.
5. Broken Computers in our facilities. (Technicians takes too long to respond to facilities whenever they report broken computers)
6. Although we do not cover all facilities currently because of the shortage of staff, but we are monitoring their data on monthly basis and we always send Data Captures whenever there is a need.

VL Health Information Systems



CAPRISA : FILE &FACILITY AUDIT (2015-16)
Viral Load Testing and Suppression Rates



CAPRISA - Summary of Findings

Viral Load Testing Coverage and Suppression

- Adults
  - Coverage: 32% and 26% at 12 and 24 months
  - Suppression: 90% at12 and 24 months
- Children
  - Coverage 29% and 20% at 12 and 24 months
  - Suppression 68 and 70% at 12 and 24 months
- Compared to NHLS reported suppression rates of 75%

Retention in care

- ± 50% of patients miss scheduled visits
- **Late presentation for visits among 67%**
- Vast majority of reasons for missed visits are not documented
- No evidence of action taken for missed visits
- Implementation of Retention Strategies urgently required

Fast Track 90-90-90

ETHEKWINI HEALTH DISTRICT
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,Mr.Gabela ,HAST team ,QA/IPC Teams
Dr.H.Sunpath (chair TWG)

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20 YEARS OF FREEDOM

Root cause analysis –summary- PHC

- **LOW stats reported for VLD due to**

Poor Vl completion in all sites (heterogenous) due to

Missed appointments ,delayed reporting to clinics, lack of blood draws due to

Poor patient education and health worker investment due to

Due to high volume clinics and poor role differentiation of staff due to

Lack of ownership of responsibility for Vl monitoring

Lack of awareness of SOC among junior staff/NIMART

- **Poor data management due to**

Incomplete entry of data onto clinical charts

HR issues and equipment issues

Poor understanding and implementation of SOP

- **Acting on results not according to SOC due to**

No dedicated persons and systems to engage pts with high VL due to

Lack of staff orientation to protocols due to

Lack of training and supervision of NIMART nurses and junior doctors

Training and Mentorship Model

Capacity development and onsite mentorship

Didactic central training program

TRAINING DONE / ONGOING

DOH QA TRAINING UNIT : DOH QA teams= TRAIN QA teams at all hospitals/CHCs and PHCs to assess VL outcomes by Dec 2017 and sustain the program

MEDICATE –AIDS NPC

ANNUAL WORKSHOP IN ADVANCED CLINICAL CARE –AWACC : updates to doctors, nurses and pharmacists on HIV VL and DR monitoring strategy with ID unit at UKZN and research partners and NGOs (key funder CAPRISA)

MatCH

- MatCH

TRAINING IN THE DIP AND DOP –MatCH of all PHC managers and district program managers.

Facilities grouped into 6 clusters according to mother Hospitals and referral pathway. 201 DoH Provincial OM's, 90/90/90 Champions, HAST and MCWH OM's trained

Training of nurses , counsellors, and teams in Enhanced adherence counselling

CAPRISA

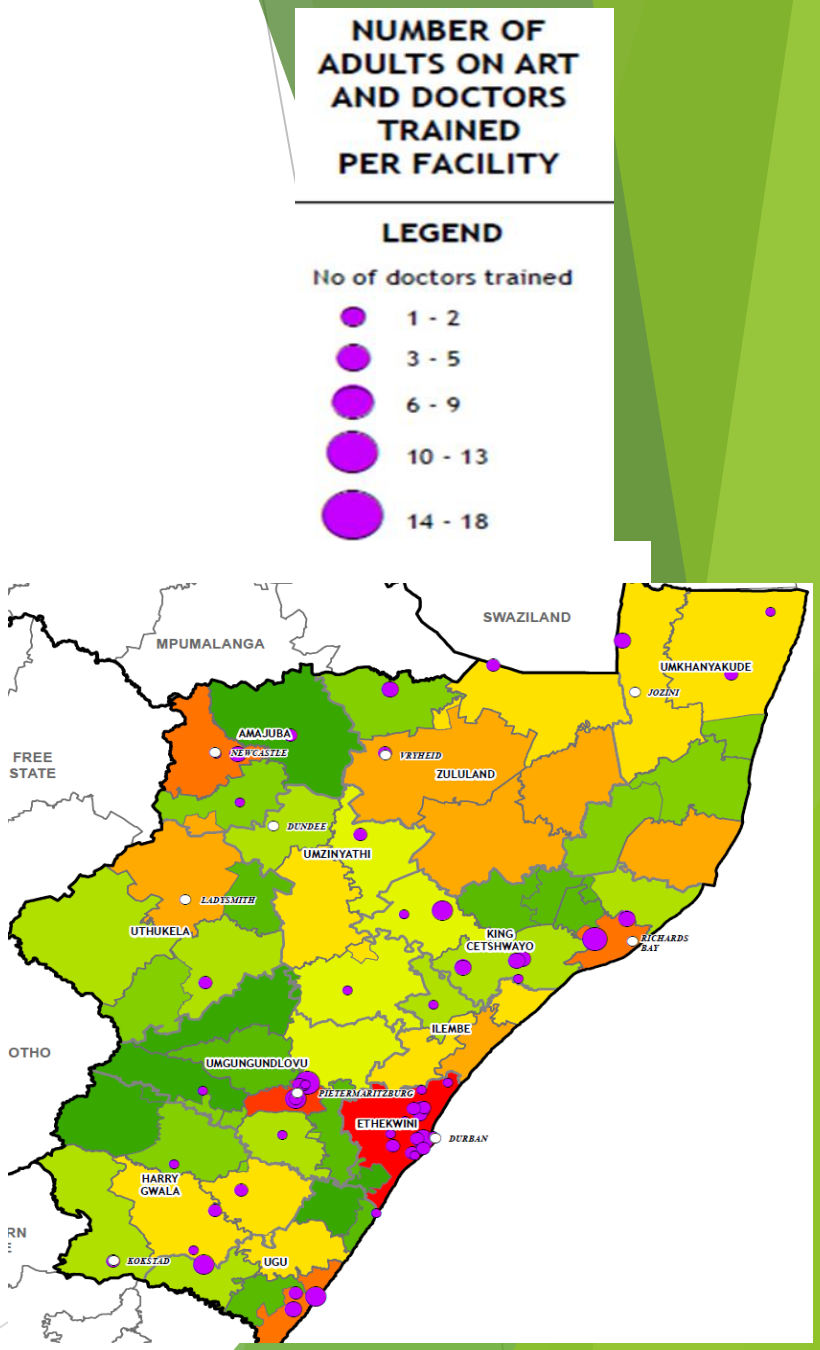
- CAPRISA

Advanced clinical care training conducted for key senior doctors in all facilities over 2 years ,that included HIV DR and DRTB

CAPRISA ACC –UKZN ID UNIT training by in-reach of doctors who will work as clinical advisors to a network of ART clinical sites for ACC and DR testing

CAPRISA ACC Didactic Training Programme

Category of Staff	Training Duration	PHC	CHC	District Hospital	Regional Hospital	Quaternary Hospital	Specialized Hospital	District Office	NGO/ Other	Total
Doctors	1 Day	8	28	46	47	2	15	10	17	173
	2 Day	13	40	132	98	4	41	24	71	423
	Total	**21**	**68**	**178**	**145**	**6**	**56**	**34**	**88**	**596**
Pharmacists	1 Day	1	13	22	16	0	5	3	2	62
	2 Day	2	21	75	30	0	7	16	10	161
	Total	**3**	**34**	**97**	**46**	**0**	**12**	**19**	**12**	**223**
Nursing Staff	1 Day	35	16	40	13	0	14	4	4	126
	2 Day	43	56	71	20	0	16	11	28	245
	Total	**78**	**72**	**111**	**33**	**0**	**30**	**15**	**32**	**371**
Program Managers	1 Day	1	3	2	0	0	0	10	1	17
	2 Day	0	1	4	0	0	0	11	6	22
	Total	**1**	**4**	**6**	**0**	**0**	**0**	**21**	**7**	**39**
TOTAL		**103**	**178**	**392**	**224**	**6**	**98**	**89**	**139**	**1229**



Capacity Building: In-reach Training Outputs

Name of Facility	Type of Facility	No of doctors mentored over 4 week period
MaTCH	DSP	3
Ithemba Labantu Hospital	NGO	1
CatoManor CHC	CHC	1
Wentworth Hospital	District Hospital	1
King Dinuzulu Hospital	District Hospital	2
Addington Hospital	Regional Hospital	1
Clairwood Hospital	Specialised Hospital	1
	Total Number Trained	10

· ACC trained Doctors selected for in-reach training by facility management
· 4 - 6 days of in-reach training with Adult IDU

Topics Covered

- Anti-retroviral treatment toxicities
- Drug induced liver injury
- Complicated tuberculosis incl (MOTT)
- HIV treatment failure
- Hepatitis B and C virus infection
- HIV assoc hematologic abnormalities
- ART Drug Resistance
- Completion of genotype request forms
- Interpretation of Stanford scoring

Knowledge Area Impacted	Pre Mentorship Median %	Post Mentorship Median %	Improvement Margin (%)
Liver Injury	30.8	84.6	53.8
ART Resistance	46.2	76.9	30.7
TB Molecular Tests	57.1	85.7	28.6
Hepatitis B co-infection	33.3	66.7	33.4

Quality improvement model

Root cause analysis (SIMS) → **Stakeholder strategy** → Ongoing education and development

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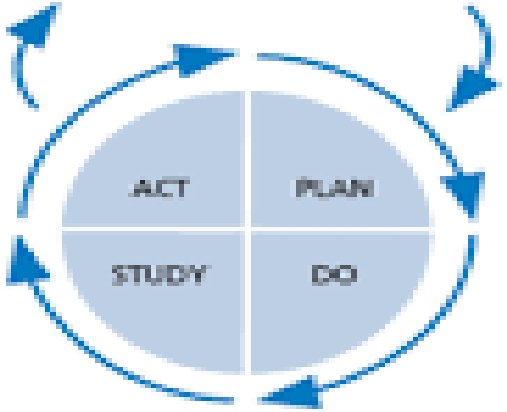

Fast Track 90-90-90

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20 YEARS OF FREEDOM
south africa 1994 - 2014

TWG 90/90/90 MANDATE –ETHEKWINI D/O- Sept 2016

Adult with viral load completion (VLD) rate	**Proper updating and use of Tier.net** **Implement VL registers where needed**
	Monitor VL suppression data, monthly
	Work with current partners QIP plans and integrate into DIP DEVELOP STRATEGY FOR SOP DEVELOPMENT

1. Know your indicator, track your response, accountability	**2. Target setting and targeting**	**3. Data management**	**4. Communication** (ACSM, demand creation strategy)
Quality of care	**6 Infrastructure, medicines, equipment, lab services**	**7. Human resources (quantity, capacity and skills)**	**8. Service delivery platforms (incl WBOT's and mobile services)**
9. Demand: Service delivery related	**10. Cascades and pathways** (continuum of care)	**11. Demand: Client related**	**12. Inter-sectoral coordination** (social development, private sector, schools)

12. Inter-sectoral and partner coordination- KEY intervention by CAPRISA –ACC and MEDICATE –AIDS -NPC

- What contribution can partners provide?
- CLEAR ROLE DEFINITION /DELIVERABLES …documentation available
- What contribution can the resident clinic staff make to ensure sustainability ?
- How can the district office team coordinate the project to ensure that indicators are achieved?
- How to conduct a pilot site intervention to develop a SOP ?
- How to scale up the efforts form the pilot sites

CHAIR –QI HAST PROJECT

Engage with CEOs ,medical /clinical managers and district managers to ensure mentorship of staff and appropriate referral pathways develop

Coordinate training plan and mentorship of staff for VL and HIV DR with all partners through resident HAST clinical managers /medical managers

Strategic planning team - DOH

- 1. Dr.H.Sunpath – District Specialist /Consultant QA HAST program
- 2. Ms.S.Ntuli and Ms.L.Mthethwa –QA managers DOH
- 3. Dr. J.Brijkumar – DOH consultant
- 4. HAST managers –Mr. P.Bhengu / Mr. X.Mbangata
- 5. M& E – Mr.Martin Gabela
- 6. KZN HAST UNIT – Ms.L.Dlamini
- 7. District management –Ms.P.Msimango ,Mr. S. Yose and Ms. S.Mbambo

- Start with 3 HAST pilot sites . (CWH/WWH/KDH) and repeat audit 31/08/17
- **Finalise SOP for VL monitoring to improve VLD over 12 months from 43% to >80 %**
- Begin with 11 ACC pilot sites (CWH and 10 0thers)- implement SOP and audit by 31/12/17
- Get all pts on second line with VF that are eligible for DRT processed immediately.
- Engage with all Ethekwini ART facilities to scale up project WITH QUICK WINS ?date

- CAPRISA – ACC team
  - Dr.K.Naidoo
  - Dr. R. Adams
  - Ms.S.Gengiah
- Epicenter team

- Site supervisors-REVAMP(pilot sites)
  - S.Pillay
  - S.Pertab
  - A.Singh

UKZN Infectious diseases Unit

Paediatrics – Dr. Sibusiso Khubeka/ Dr.M.Archary

Adults –Prof Moosa /Dr.Manickchund /Dr.Gosnell

NHLS

Viral load testing – Ms.R.Bridgemohan

Drug resistance testing –Dr.P.Moodley / R.Parboosingh

Business unit –Ms.Daphne Dlamini

NHLS managers

MatCH

Dr. Kevi Naidu –chief clinical program manager

Facility support team leaders – clinical advisors

M&E manager and Tier.net support team

Team leaders – DOH FACILITIES :HAST CLINICAL MANAGERS and VL CHAMP

FACILITY TEAM -PHC

- ONM / VL CHAMP
- QA REPS
- DATA TEAM
- LOCAL GOVT /MUNICIPAL CLINIC STAFF
- NGOs

FACILITY TEAM-HOSPITALS/CHC

- DR –MEDICAL MANAGER/HAST CLINICAL MANAGER
- VIRAL LOAD CHAMP
- M&E and QA MANAGER
- EAC TEAM –SW/HIV COUNSELLOR
- DATA CAPTURER

NHLS	
➢ Review operational plan	DW D.Dlamini on 24/11/16
➢ Look at business plan - improve on logistics	No reduction in capacity
➢ Daphne to speak to Kevi to coordinate with National NHLS IT	NDOH DASHBOARD – available at pilot sites… to provide access to all sites
➢ Enable fast track of genotype resistance tests for all second line failures	Meet with Ds Samuel /P.Moodley -
➢ Get patient linked reports at pilot sites	National dashboard – Kevi –follow up report to follow. Weekly facility VL results.
➢ Identify Vl time lines and under /over servicing	Clarify and correct time lines for VL blood draws and follow up
➢ Sample rejection reports	Site specific reports
➢ Explore unique identifier	Jointly

Quality improvement model

Root cause analysis (SIMS)

Stakeholder strategy

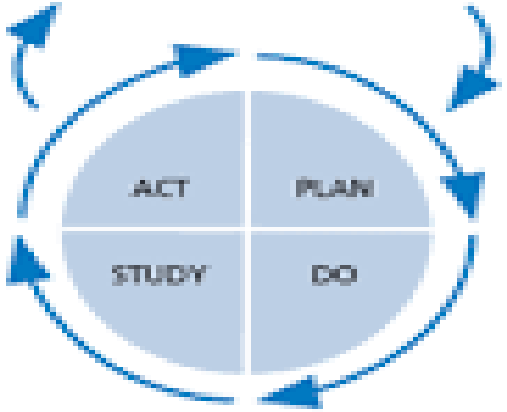
Ongoing education and development

AIM → What are we trying to accomplish?

MEASURE → How will we know if a change is an improvement?

CHANGE → What changes can we make that will result in improvement?

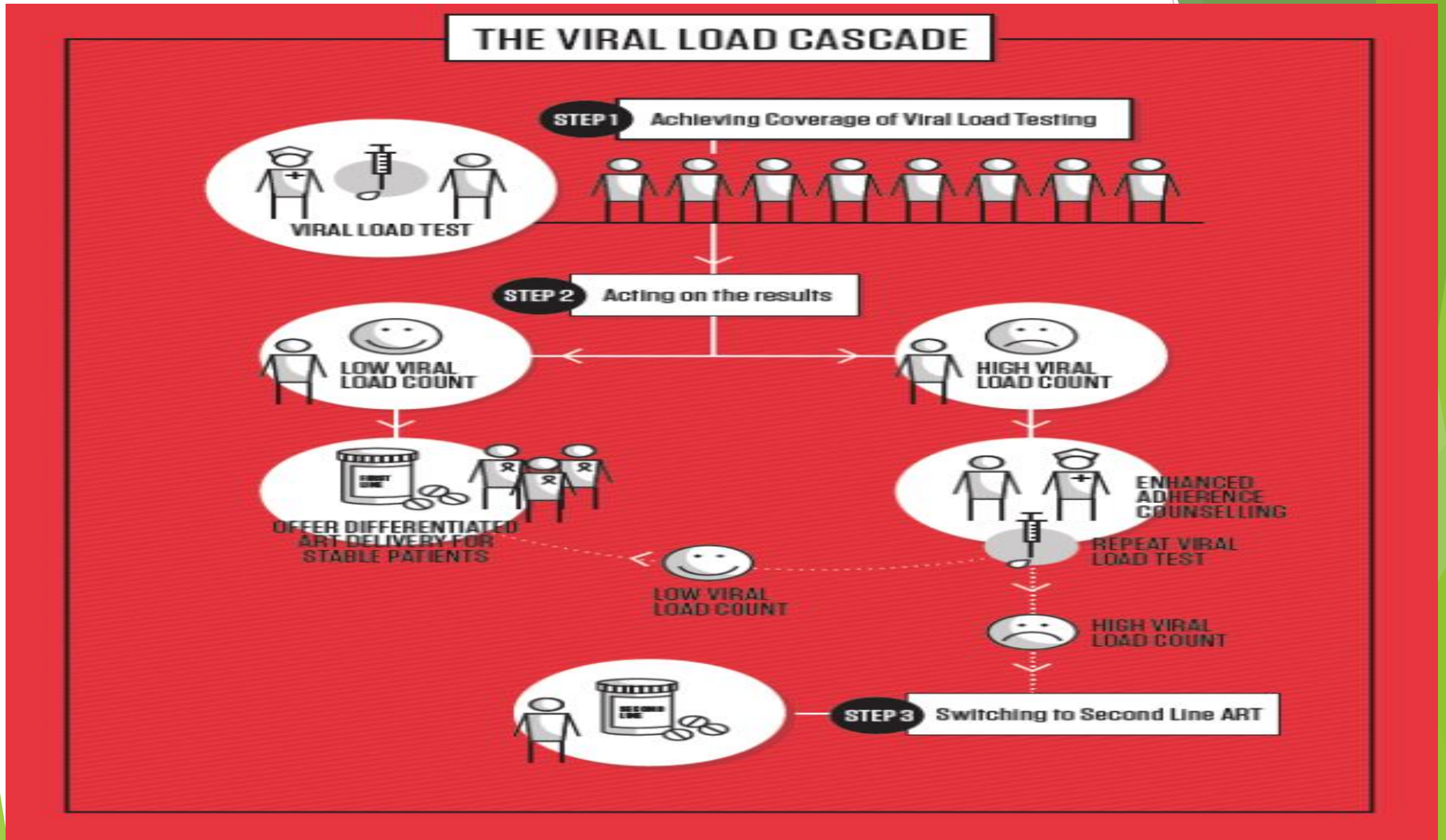
RAPID CYCLE IMPROVEMENT →



DISTRICT QI HAST SERVICES briefing MEETING HIV –VL AND DR MONITORING

ETHEKWINI HAST DISTRICT OFFCE – PARTNERS AND LOCAL GOVT

10 APRIL 2017


THE VIRAL LOAD CASCADE
STEP 1
Achieving Coverage of Viral Load Testing
VIRAL LOAD TEST
STEP 2
Acting on the results
LOW VIRAL LOAD COUNT
HIGH VIRAL LOAD COUNT
OFFER DIFFERENTIATED ART DELIVERY FOR STABLE PATIENTS
ENHANCED ADHERENCE COUNSELLING
REPEAT VIRAL LOAD TEST
LOW VIRAL LOAD COUNT
HIGH VIRAL LOAD COUNT
STEP 3
Switching to Second Line ART

STEPS TO ACHIEVE THE IDEAL HIV-VL&DR MONITORING PROGRAM -ART CLINIC LEVEL

1. HAST CLINICAL MANAGER AND VL CHAMP in each CHC/hospital and VLC in each ART site	**Terms of reference identified for overall supervision of process Responsible for facility reports to DOH Manage exit plan with partners in 2018**
2. MAKE VIRAL LOAD MONITORING ROUTINE	1. INCREASE DEMAND BY PT EDUCATION AND HCW EDUCATION 2. INSTITUTE VL ANIVERSARY CONCEPT 3. IMPLEMENT GATE KEEPING NOT TO ISSUE REPEAT SCRIPTS WITHOUT VL RESULTS
3. SYNERGISE DATA SOURCES SO THAT TIER.NET IS OPTIMALLY FUNCTIONAL AND TOTALLY RELIABLE	1. **CREATE A HIGH VL REGISTER FOR IST AND 2 ND LINE ART FROM ALL DATA SOURCES -ROUTINE CLINIC VL RECORDS , NHLS WEEKLY DASHBOARD, TIER.NET RECORDS, PHARMACY RECORDS , COMPLETE FILE AUDIT OF ALL ACTIVE PATIENTS** 2. CLEAN AND UPDATE TIER.NET FOR RECORDING AND REPORTING -WILL IMPROVE AFTER CATCH UP PHASE 3. CATCH UP PHASE TO ACCOUNT FOR EVERY PATIENT EVER SEEN IN CLINIC AND NOT ACCOUNTED FOR ON TIER.NET
4. START VL PRIORITY CLINIC ON SPECEFIC DAY/ DEDICATED TEAM WORKING DAILY	1. Trained EAC team work with trained doctor to manage complex VF in first line and all second line VF 2. Ensure that all patients receive care by a MDT
5. SUPPORT PHCs in the area	1. VLC in each PHC to be mentored and supported by local CHC/hospital .Manage all first line VF and refer all second line VF 2. Standardise referral forms for VF and data required for 3RD line ART

KEY IMPLEMENTATION STRATEGIES TO MAKE VIRAL LOAD ROUTINE

- A VL focal person dedicated to identifying those in of need of VL and enhanced adherence counselling - greatly facilitates uptake at all steps of the VL cascade.
- Systems to flag patients in need of VL using paper based and electronic medical records improved
- A patient triage system, clinic flow and tools (EAC register and high VL form) adapted to identify patients in need of VL and enhanced adherence counselling- will improve uptake.
- Investing in patient education and demand creation for viral load should be at the foundation of any VL scale up strategy.

1.ACHIEVING COVERAGE OF VL TESTING

Are HCWs aware of VL cascade and importance
How are the current VL systems working
Is there Facility leadership and Ownership
What Training and Mentoring takes place per site
Does the Facility have and SOP or use a District SOP
How accurate and reliable are the VL reports on Tier.net
Are there back up systems through registers in the clinic
Have the clinics establish ways in which all High VL can be accounted for ?high VL registers
Is there a process that triangulates charts, Tier.net and NHLS data? Composite data for every patient in the clinic ?use of prospective VL registers from file audits

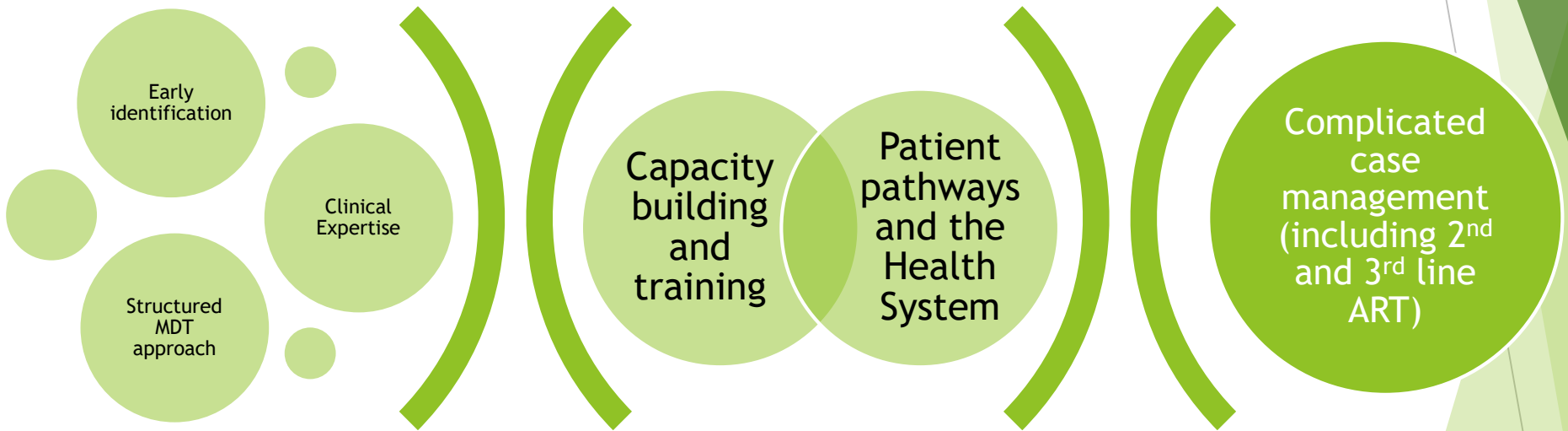
2. ACTING ON RESULTS

- The Clinic Lab Interface (MatCH)
- Early Identification Systems
- Risk of Treatment Failure
- Acting on High VL
- Enhanced Adherence Counselling
- Clinical Assessment and Management Plan

Role of MDT in Enhanced Counselling

- **Administrative staff** – Get and review results, can flag the patient's file, enter results/data on Tier.net
- **Counsellor** – Offer standardised adherence messages and motivate patient. Facilitate support groups
- **Nurse/ Doctor** – Standardised adherence support, clinical support, viral load monitoring and correct regimen choice.
- **Social Worker**- Address psychosocial Issues

Sustained Third 90 activities – unstable client management systems



DIFFERENT APPROACHES FOR HIGH AND LOW VOLUME SITES

LOW VOLUME SITES

- 1.WORK WITH FILING ALL VL RESULTS DAILY - IDENTIFY FILES WITH HIGH VL FOR ACTION DAILY
- 2.USE VL ANIVERSARY TO PROMPT BLOOD DRAWS
- 3. RECONCILE MISSED APPOINTMENTS WEEKLY/MONTHLY – KEEP FILES SEPARATELY AND CALL PTS FOR THREE MONTHS
- 4.GET REPORTS FROM TIER OF VL DUE MONTHLY FOR AUDIT
- 5.USE WEEKLY NHLS DASHBOARD OF HIGH VL TO PULL OUT PT FILES
- 6. ENUSRE TIER .NET ENTRY DAILY FROM CLINICAL CHART

ROTF patient flow algorithm- PHC model

Done before patient's clinical visit

Files of patient's with VL > 400 copies/ml are flagged with 'high viral load' tags

Done at screening area/reception

On arrival at the clinic, patients with tagged files are sent to ROTF counsellor

Done in a predetermined area in the clinic to allow sufficient space and seating

High viral load support group session

Counsellor

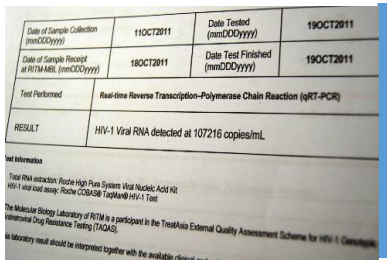
DIFFERENT APPROACHES FOR HIGH AND LOW VOLUME SITES

HIGH VOLUME SITES

- MANAGE ALL PTS WITH HIGH VL USING A HIGH VL REGISTER
- USE VL ANIVERSARY TO PROMPT BLOOD DRAWS
- SOURCE OF DATA –INITIALLY COMPLETE FILE AUDIT IN REGISTRY
- FILE ALL RESULTS DAILY OR PRINT AS PT COMES IN FOR CONSULTATION AND ENTER ONTO CLINICAL FILE –DATA ENTRY DAILY ONTO TIER.NET
- ONCE FILE AUDIT COMPLETE AND TIER DATA RECONCILED – USE NHLS DATA BASE FOR HIGH VL REGISTER

NHLS Track Care

Data Capturer



VL Result Printout

Data Capturer

File in Patient Chart

Doctor

HAST Flow Sheet in Patient Chart

Data Capturer

Tier.Net

Tier.Net

IALH

Sample Log

Nurse or delegate or counselor

Nurse or Phlebotomist

Email Weekly List of High VL to Clinic Manager

High VL Register

Patient Navigator

First Line

Patient Navigator (Adherence Counselor)

Nurse for Care (Viral Load Champ)

Adherence Counseling

Unsuppressed to Doctor

Suppressed Follow Up

Second Line

Clinical Manager or ARV Clinic Director

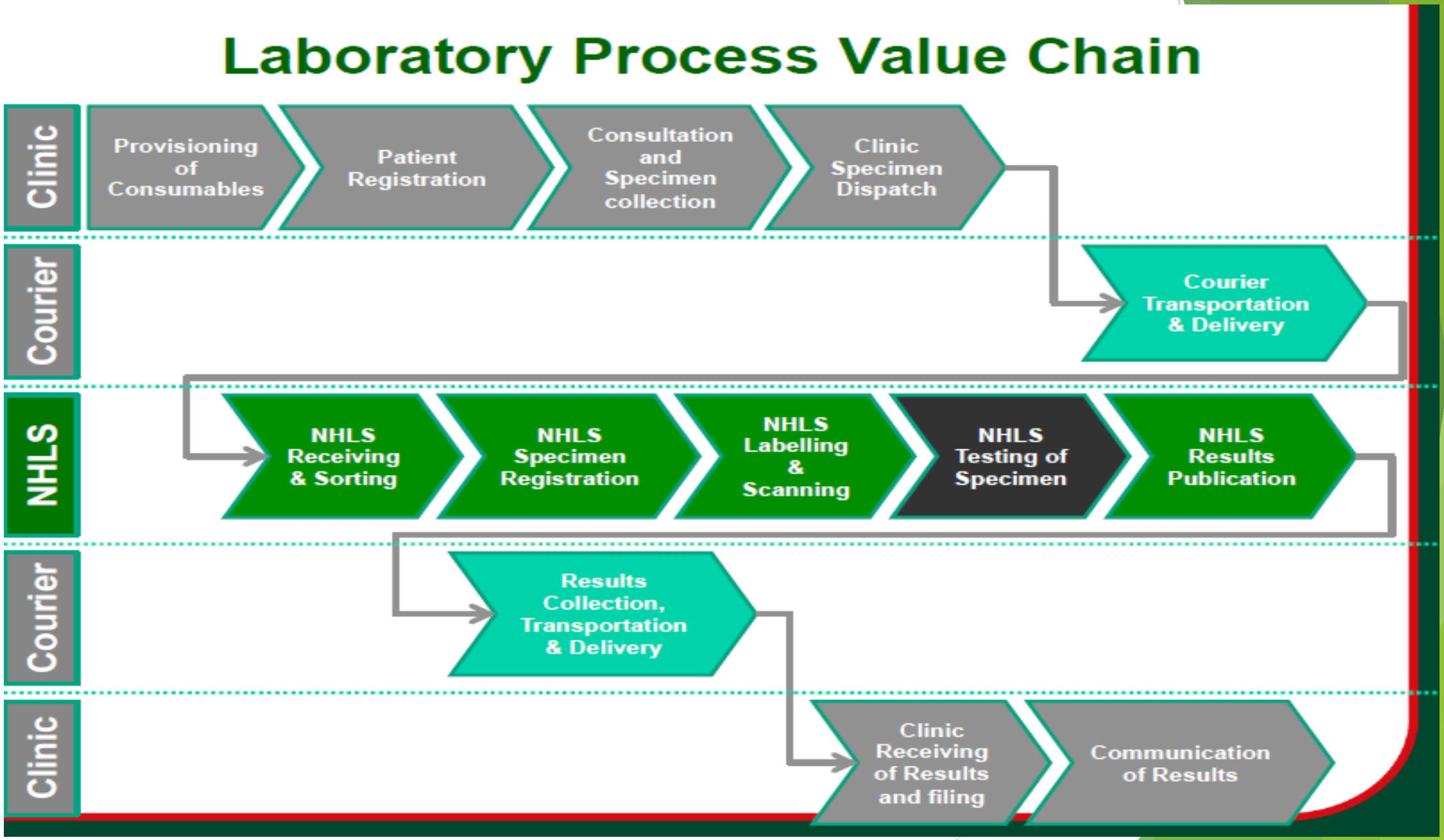
Weekly Group Session

Daily Individual Session

High VL Register

Clinic File No	Patient Name	ID No	Age	Contact Number 1	Contact Number 2	Contact Number 3	Hi VL result	Hi VL Date	Action	Action Date	Date Follow up visit EAC 1	Date Follow up visit EAC 2	Repeat VL	Date Repeat VL	Date check VL result & Manage	Date Continue 1st Line	Date COR (Change of regimen)
									Patient called								
									Patient booked								
									Patient Came in								
									Patient did not come in								

Laboratory Process Value Chain



WORK DONE AND PRELIMINARY REPORTS AT PILOT SITES

Commenced October 2016- December 2016 Preparatory Meetings DOH –CAPRISA-MatCH-NHLS

Site preparation – Jan –February 2017

Pilot site intervention with final SOP 01/03/2017

Review date ? 31/08/2017

REVIEWED = 31/10/17 ONWARDS

FOR FILE AUDITS

1. ROLES .pdf

TASK ON SITE LED BY VL CHAMP	Immediately by CM and VLC
➢Create and maintain a VL register of all VL done daily -review weekly /monthly -	• Ensure the use of the new VL register with bar codes and assign clinic staff to enter results from TRAK CARE regularly- • MatCH staff to check weekly and update register • Provide list of high viral loads from Vl register to RV staff • DO THE VL AFTER NEW RX INITIATION AT MONTH 5 • CALL PT IN AT MONTH 6 • NEVER ISSUE A PC WITHOUT A VL RESULT-PHARMACY TO DO GATEKEEPING!
➢Create a high Vl register and follow up with EAC team and doctor	• RV staff to create database on high VL register and present weekly to VLC. • VLC / RV study nurse to engage EAC team and ensure follow up with nurse clinician on specific dates • Refer to doctor in clinic or RV doctor all pats who do not suppress for second line – anyday /specific days • Plan towards a dedicated VL priority clinic /consultative team
➢Create a prospective Vl register.- - complete audit of all clinic files over 6 months	• Staff with guidance of filing clerks pull out by 1 pm .Create a list of files with names and file numbers for that date • VL champ and Clinic nurses to audit files and fill data sheet to identify next VL due date. • UKZN RV team to create data base weekly and monthly for different cohorts and assign VL anniversary dates

VL Register

Date	Name & ID Number	Barcodes	Results & Date	Follow-up VL result & Date	Comments

Prospective VL Register

Viral Load – Prospective Database

CLINIC FILE NO	PATIENT NAME	ID NO	Date of Initiation	Regimen	Last VL	Last VL Date	Next VL Date

2nd Line

CONTACT NO	LAST VL	DATE OF LAST VL RESULT	VL 1	VL1 DATE	ACTION	VL 2	VL 2 DATE	ACTION	VL 3	VL 3 DATE	ACTION	DATE OF NEXT APPOINTMENT

Pilot site 1

- 183 SLART patient files have been reviewed and 164 deemed eligible for analysis.
- Twenty-five per cent (41/164) of patients had an unsuppressed VL.
- Sixty-six per cent (27/41) patients had 2 or more consecutive unsuppressed viral load on file and of these 59% (n=16/27) had a third consecutive unsuppressed VL.
- Genotypic testing conducted in 19% (5/27) of patients, detected resistance
- Systems for identification and improved management of viral failure in SLART patients requires strengthening.
- Unsuppressed viral load is not acted on, and genotypic testing under-utilized.
- Chart audits contribute valuable patient level information about quality of service and completeness in guideline implementation, and should be done routinely.

- First line ART= 1958
- Failure =242 (12.3%)

- Baseline VLD -42 %
- Awaiting tier report for VLD stats in August

PILOT SITE analysis

PILOT SITE 2

- FILE AUDIT -

SECOND LINE ART = 67

FAILURE =2 (2.9%)

FIRST LINE =1010

FAILURE =96 (9.5%)

- VL Done at baseline =43 %
- VLD rate at 21/08/17= 80%

NB VL due calculated from last VL done .

Have all high Vl been managed appropriately?

PILOT SITE 3 :

- STATS ETHEKWINI BASELINE AT 42%
- Progress : CWH baseline VLD at 61% now at 76% (6500 PTS ACTIVE) -4 Months
- Ongoing file audit

Second line = 765

Failure =187 (24.4%)

First line = 3724

Failure =161(5%)

- CRITERIA FOR REFERRAL OF PATIENTS TO A VIRAL LOAD PRIORITY CLINIC (VPC)
  - To be held on a specific day or on days when key staff are available.
  - Key staff component of the clinic:
  - 1. ARV Clinic Doctor/MatCH Doctor
  - 2. Enhanced Adherence Counselling (EAC) Social Worker
  - 3. HIV Counsellor- EAC Trained
  - 4. EAC Trained NIMART Nurse/Professional Nurse

- Criteria for referral to VPC
  - FIRST LINE virologic failures despite two months of counseling and viral loads > 1000 copies/ml
  - Multiple co-morbidities i.e. renal ,cardiac, liver pathology
  - On TB treatment or requiring TB treatment.
  - All patients with complex psychosocial problems that will benefit from trained EAC team.
  - Hepatitis B sAg positive patients that have renal failure for dose adjusted TDF treatment.

- Patients on second line treatment
  - Treatment failure high viral loads (>1000)
  - All patients with multiple co-morbidities
  - Drug toxicities
  - Drug interactions
  - All patients with complex psychosocial problems that will benefit from trained EAC team.
  - Hepatitis B sAg positive patients that have renal failure for dose adjusted TDF treatment.

- Criteria for contacting Infectious Diseases Specialist Unit
- Failing third line treatment
- Complex drug toxicities
- CALL TOLL FREE HELP-LINE FOR CONSULTATION ON ANY OTHER CLINICAL PROBLEM IN KZN 0800 111 740

ETHEKWINI DISTRICT QI PROJECT FOR HIV-VL AND DRUG RESISTANCE MONITORING

ANNUAL WORKSHOP IN ADVANCED CLINICAL CARE (AWACC-2017

07/09/2017

Dr.Henry Sunpath -

Research /Clinical Director- (MEDICATE -AIDS :NPC)

Consultant : Ethekwini Health District Office &

CAPRISA Advanced Clinical care program

And Mr.Selvan Pillay

PROGRAM MANAGER :REVAMP STUDY

Pilot site Follow up of High VL -Stats

USE OF NHLS DASHBOARD…

High VL Register

Clinic File No	Patient Name	ID No	Age	Contact Number 1	Contact Number 2	Contact Number 3	Hi VL result	Hi VL Date	Action	Action Date	Date Follow up visit EAC 1	Date Follow up visit EAC 2	Repeat VL	Date Repeat VL	Date check VL result & Manage	Date Continue 1st Line	Date COR (Change of regimen)
									Patient called								
									Patient booked								
									Patient Came in								
									Patient did not come in								

PILOT SITE A= High VL Stats

REVAMP

RESISTANCE TESTING VERSUS ADHERENCE SUPPORT FOR MANAGEMENT OF PATIENTS WITH VIROLOGIC FAILURE ON FIRST-LINE ANTIRETROVIRAL THERAPY IN SUB-SAHARAN AFRICA

VL Monitoring Report

AWACC 2017

Compiled & Presented By Selvan Pillay
selvan@kznhiv.org

NIH National Institute of Allergy and Infectious Diseases · HARVARD MEDICAL SCHOOL · MGH 1811 MASSACHUSETTS GENERAL HOSPITAL · EMORY UNIVERSITY · UNIVERSITY OF KWAZULU-NATAL INYUVESI YAKWAZULU-NATALI · health Department: Health PROVINCE OF KWAZULU-NATAL · HEARD · UNIVERSITY of ROCHESTER

REVAMP
RESISTANCE TESTING VERSUS ADHERENCE SUPPORT FOR MANAGEMENT OF PATIENTS WITH VIROLOGIC FAILURE ON FIRST-LINE ANTIRETROVIRAL THERAPY IN SUB-SAHARAN AFRICA

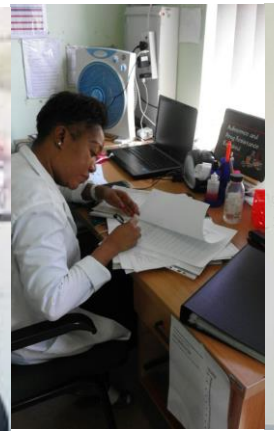
Overview

- Acknowledgements
- Monitoring of VL
  - Source of data
  - High VL Reg
  - Data collected & Basic Stats
  - NHLS Weekly High VL Report

REVAMP
RESISTANCE TESTING VERSUS ADHERENCE SUPPORT FOR MANAGEMENT OF PATIENTS WITH VIROLOGIC FAILURE ON FIRST-LINE ANTIRETROVIRAL THERAPY IN SUB-SAHARAN AFRICA

Research Team

- Study nurse, research assistants, data manager & quality manager
- High VL register
- Primary source of data - file audit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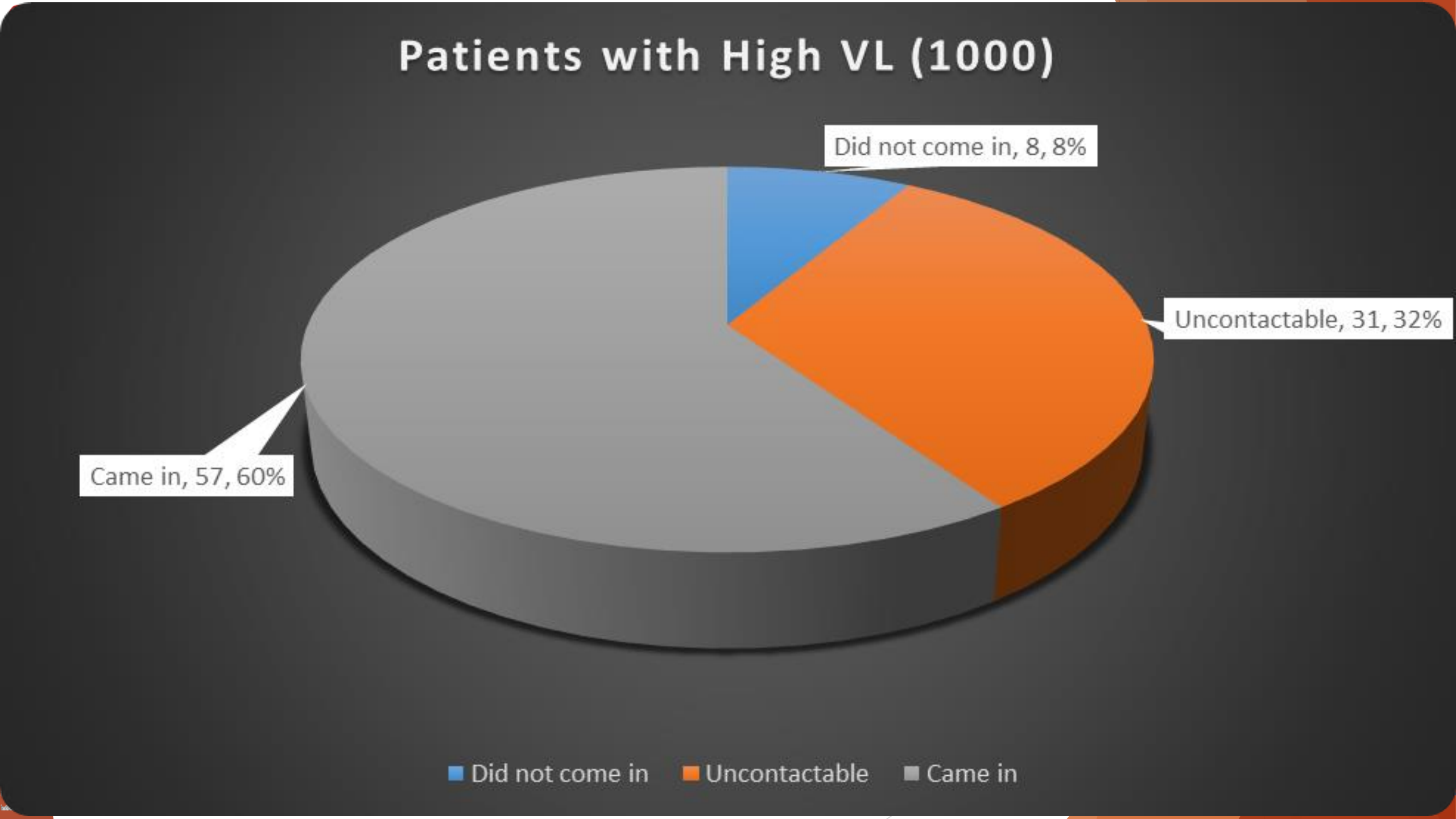
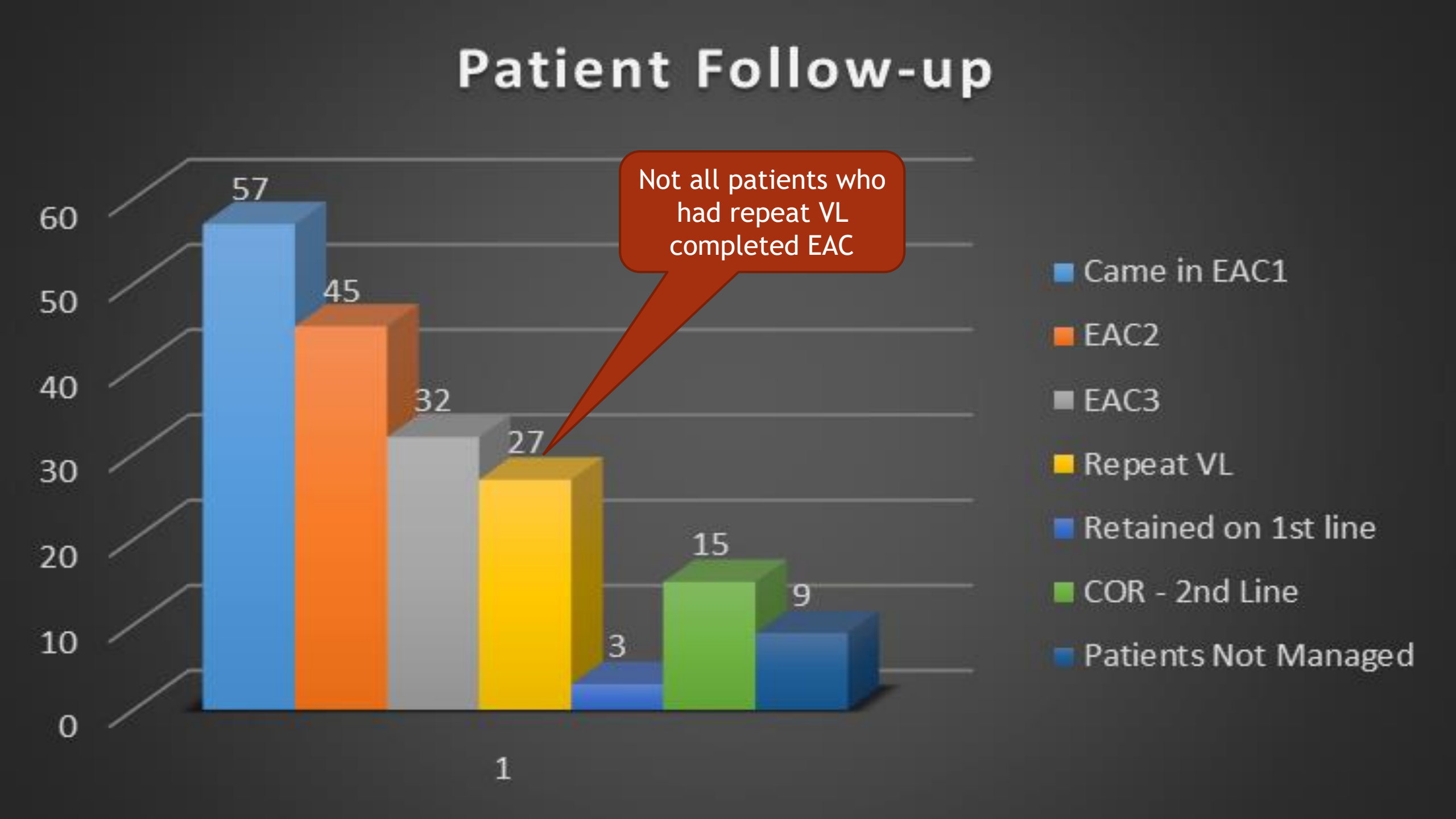
RESISTANCE TESTING VERSUS ADHERENCE SUPPORT FOR MANAGEMENT OF PATIENTS WITH VIROLOGIC FAILURE ON FIRST-LINE ANTIRETROVIRAL THERAPY IN SUB-SAHARAN AFRICA

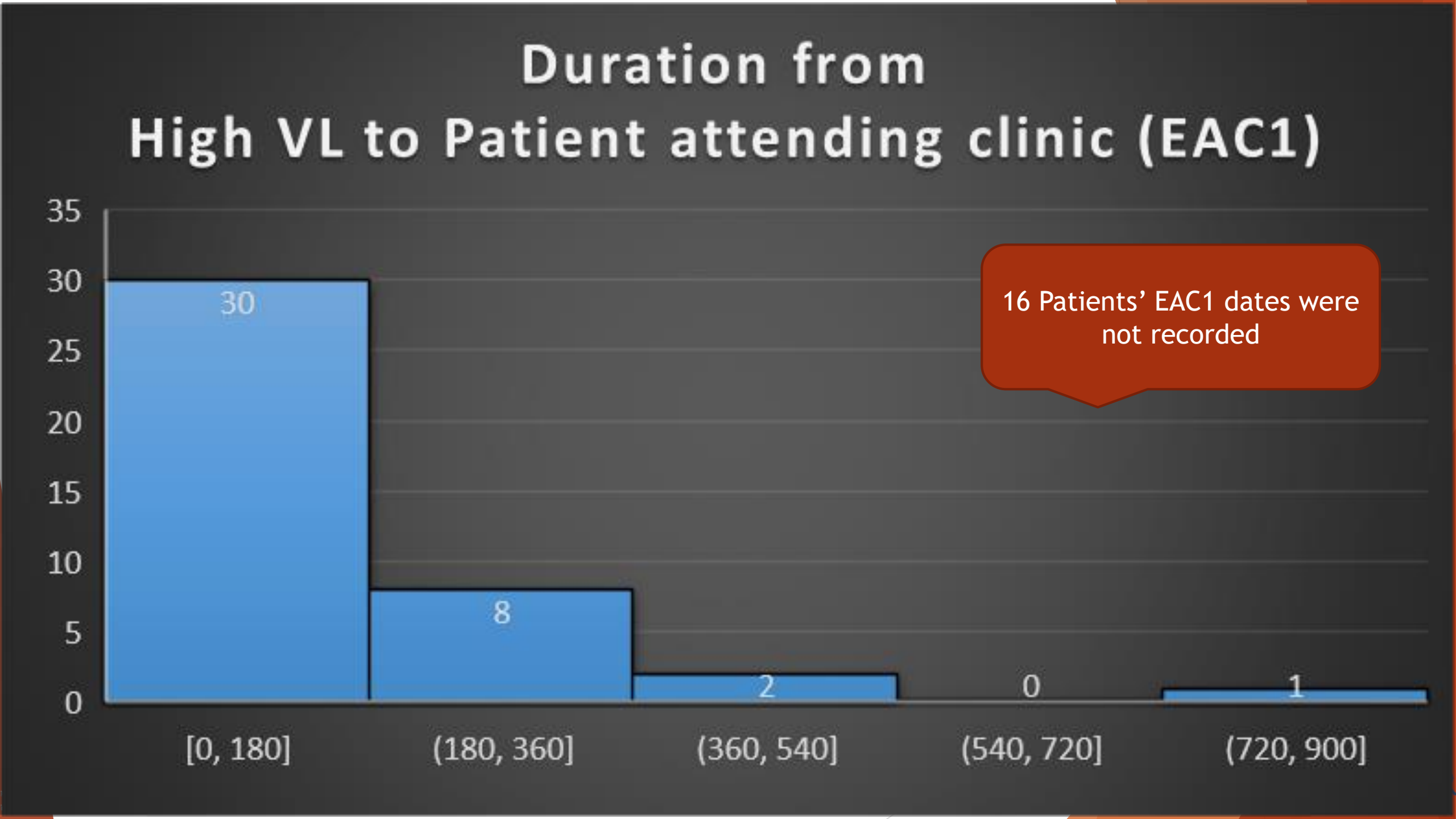
High VL Register

Clinic File No	Patient Name	ID Number	Age	Contact Number 1	Contact Number 2	Contact Number 3	Hi VL result	Hi VL Date	Action	Action Date	Date Follow up visit EAC 2	Date Follow up visit EAC 3	Repeat VL	Date Repeat VL	Date check VL result & Manage	Date Continue 1st Line	Date COR
									Patient called								
									Patient booked								
									Patient Came in								
									did not come in								

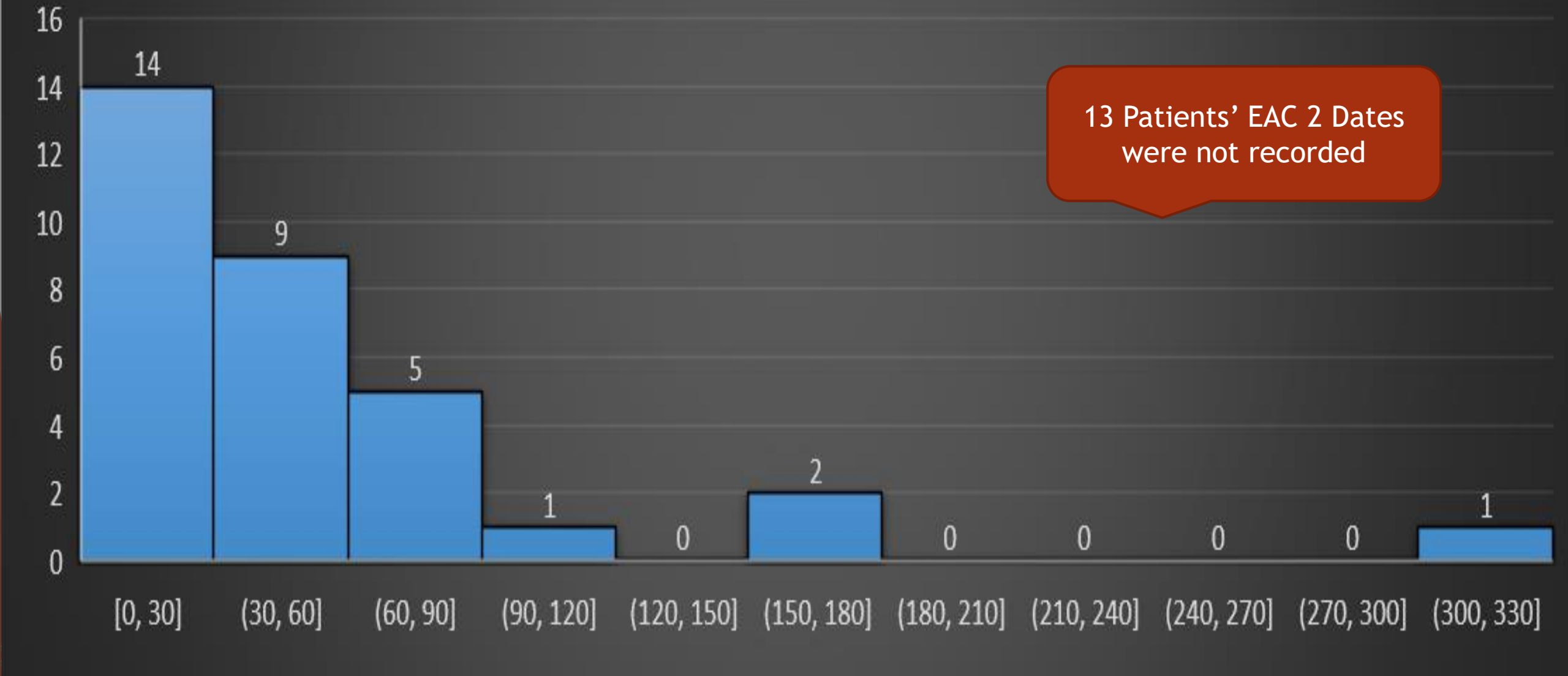

Patients with High VL (1000)
Did not come in, 8, 8%
Uncontactable, 31, 32%
Came in, 57, 60%
Did not come in
Uncontactable
Came in

Patient Follow-up



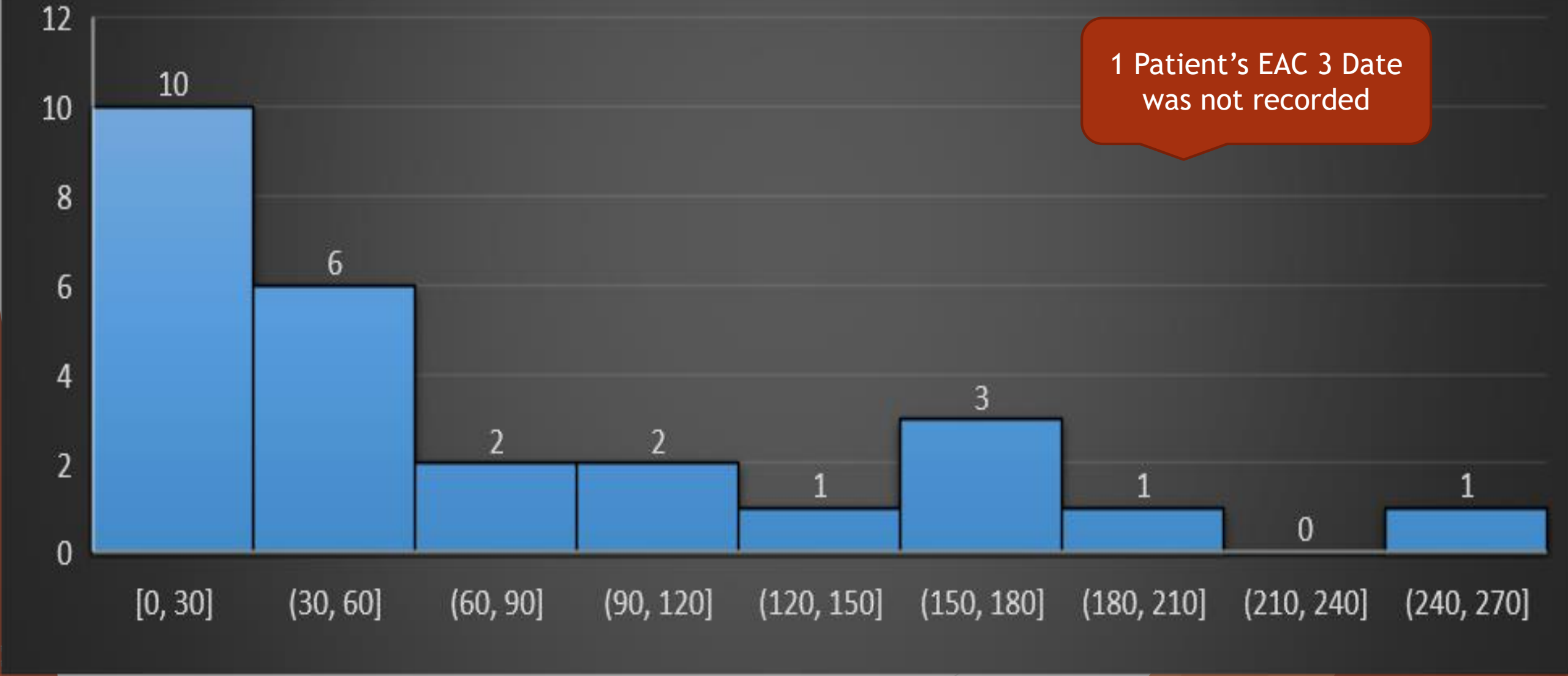

Duration from
High VL to Patient attending clinic (EAC1)
35
30
25
20
15
10
5
0
30
8
2
0
1
[0, 180]
(180, 360]
(360, 540]
(540, 720]
(720, 900]
16 Patients' EAC1 dates were not recorded

Duration from 1st EAC to 2nd EAC



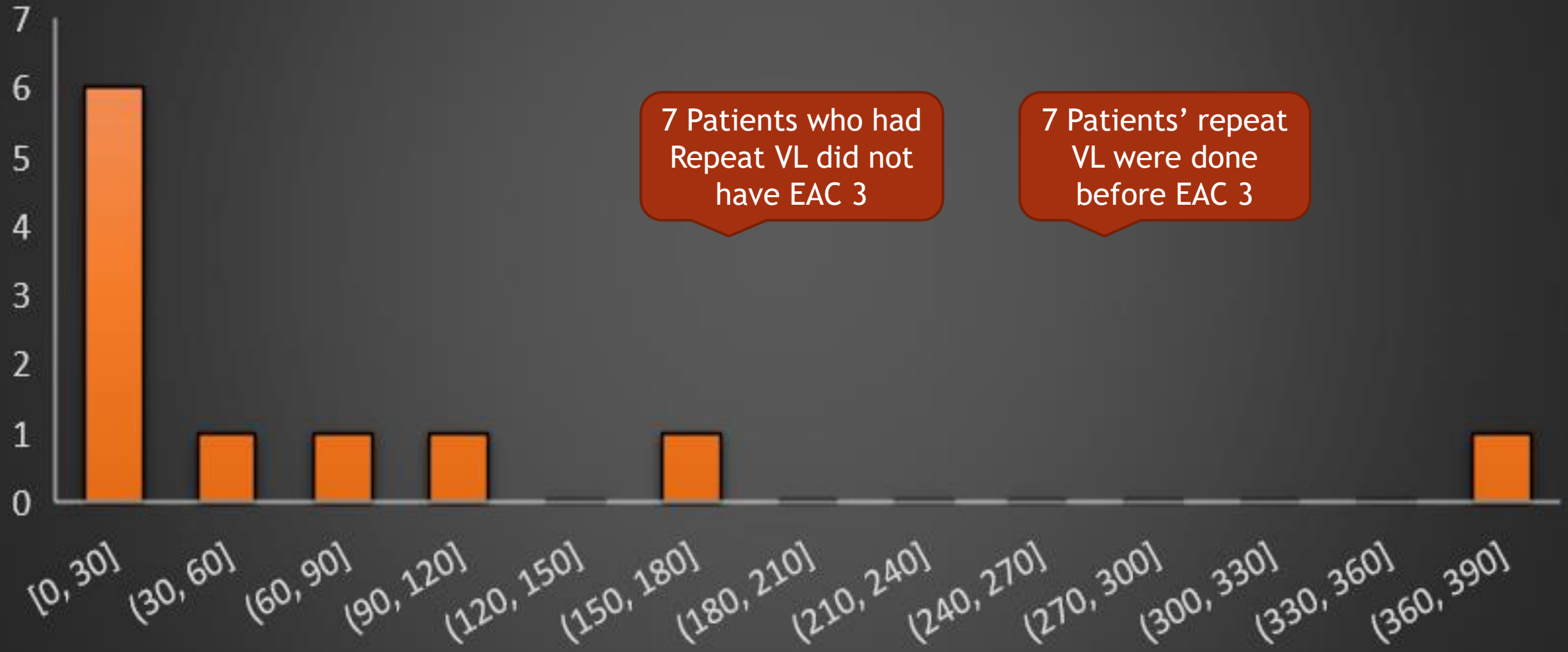
13 Patients' EAC 2 Dates were not recorded

Duration from 2nd EAC to 3rd EAC

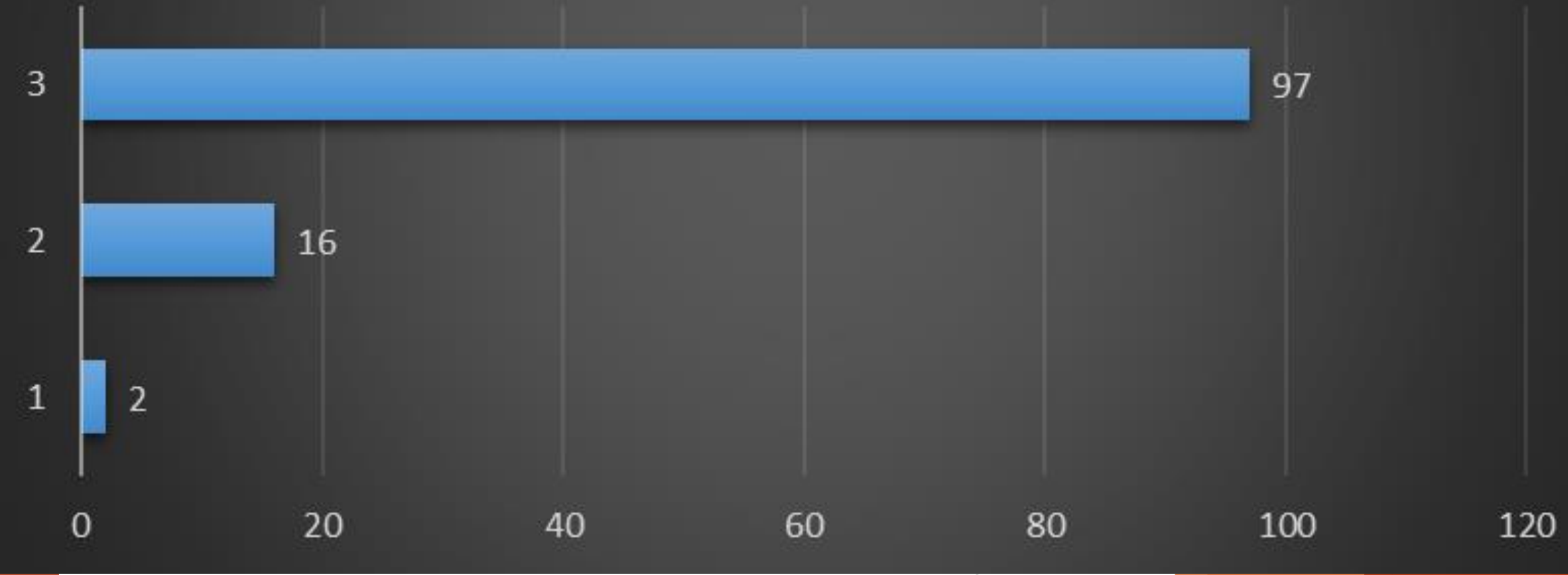


1 Patient's EAC 3 Date was not recorded

Duration from 3rd EAC to Repeat VL

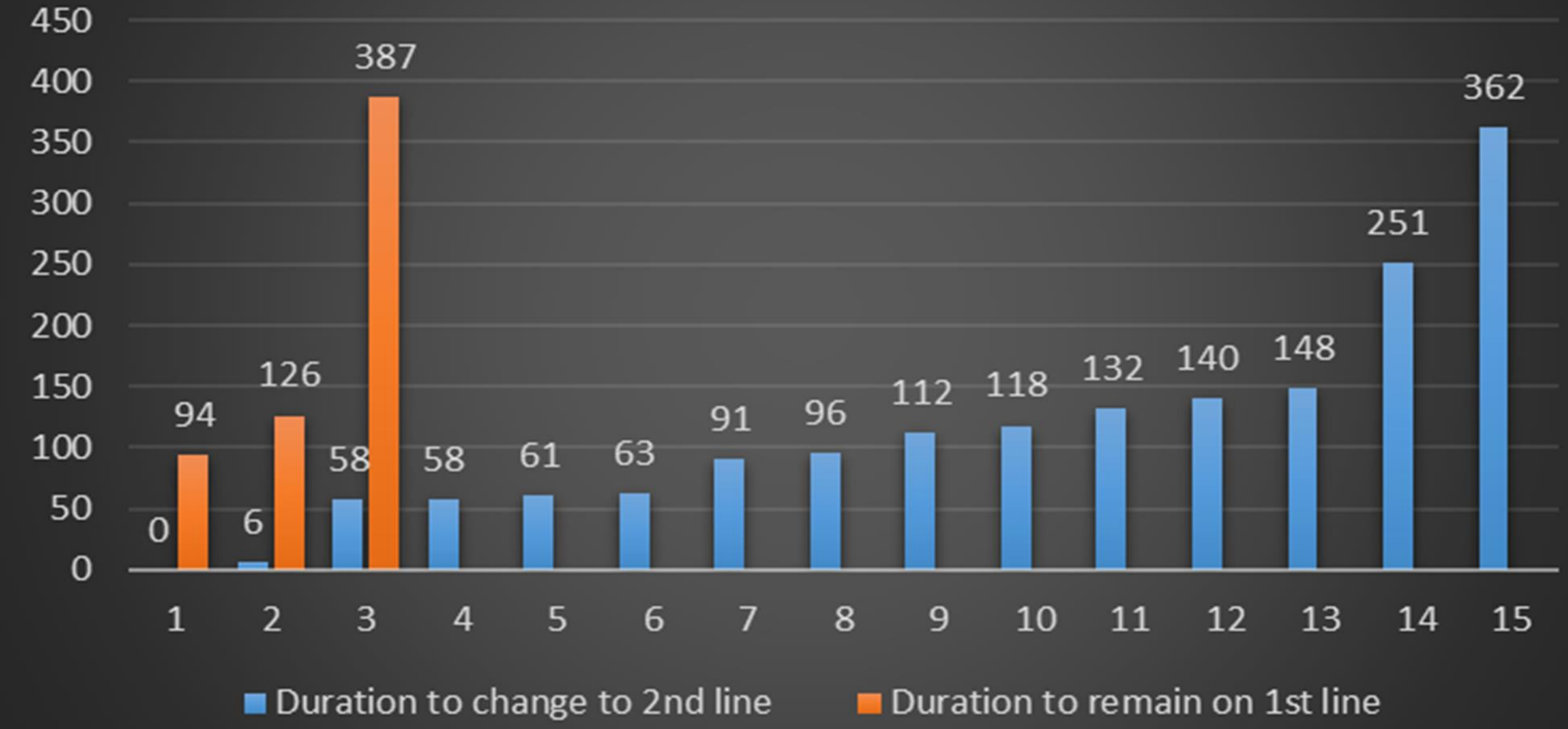


Duration from Repeat VL to Management (Retained on 1st Line)



Duration from Repeat VL to Management (COR - 2nd Line)

Duration from 1st discovering High VL to Management



We may have many challenges, BUT

REVAMP
RESISTANCE TESTING VERSUS ADHERENCE SUPPORT FOR MANAGEMENT OF PATIENTS WITH VIROLOGIC FAILURE ON FIRST-LINE ANTIRETROVIRAL THERAPY IN SUB-SAHARAN AFRICA

NHLS Weekly Data Report

- New data automation tool
- The NHLS weekly data report
- Access - NHLS website www.nhls.ac.za

National Health Laborato

nhls.ac.za

NATIONAL HEALTH LABORATORY SERVICE

NHLS's WCA number: **990000306648**

Login to Thusano Portal

Login to Proficiency Testing

Login to Lab Results

Thusano Portal

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Welcome to the NHLS

The National Health Laboratory Service (NHLS) is the largest diagnostic pathology service in South Africa with the responsibility of supporting the national and provincial health departments in the delivery of healthcare.

The NHLS provides laboratory and related public health services to over 80% of the population through a national network of laboratories.

Read More

We have 260+ Labs

Disease Outbreak News

https://cdwmicrostrategy.nhls.ac.za/MicroStrategy/asp/

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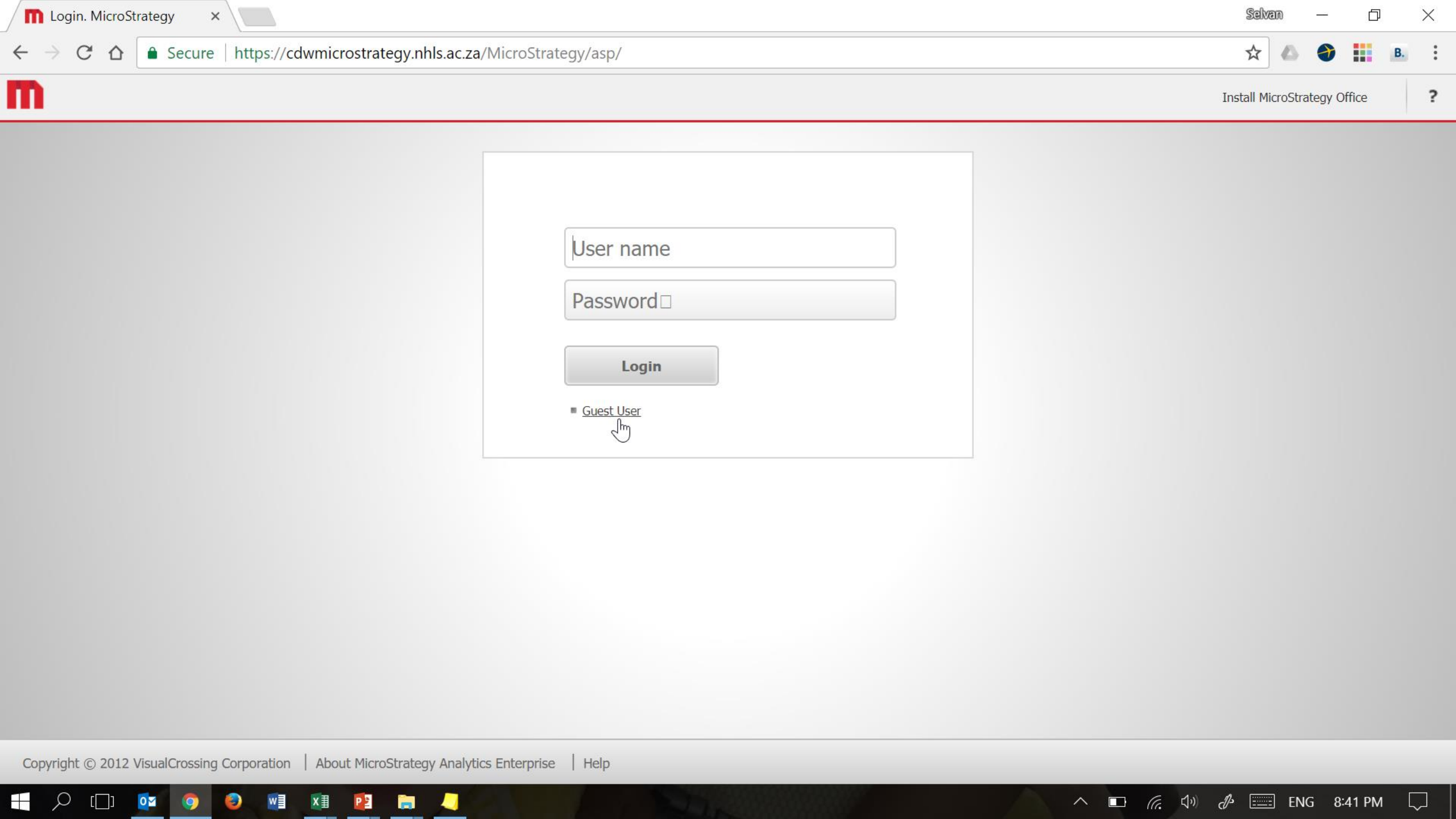
Login. MicroStrategy
Selvan
Secure
https://cdwmicrostrategy.nhls.ac.za/MicroStrategy/asp/
Install MicroStrategy Office
User name
Password
Login
Guest User
Copyright © 2012 VisualCrossing Corporation
About MicroStrategy Analytics Enterprise
Help
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WELCOME. MicroStrateg

Selvan

Secure | https://cdwmicrostrategy.nhls.ac.za/MicroStrategy/asp/Main.aspx?evt=3001&src=Main.aspx.3001&Port=0&

Install MicroStrategy Office

Welcome Guest User. (If you are not Guest User, click here .)

NHLS BI
NHLS BI (Production)
Server name NHLSGPAPP002

Self Service Portal
Self Service Portal
Server name NHLSGPAPP002

https://cdwmicrostrategy.nhls.ac.za/MicroStrategy/asp/Main.aspx?evt=3010&src=Main.aspx.3010&loginReq=true&Server=NHLSGPAPP002&ServerAlias=NHLSGPAPP002&Project=Self+Service+Portal&Port=0

ENG 8:41 PM

Home. MicroStrategy

Selvan

Secure | https://cdwmicrostrategy.nhls.ac.za/MicroStrategy/asp/Main.aspx

Self Service Portal > **Home**

Guest User

Recents

Shared Reports

Browse

Shared Reports

ENG 8:41 PM

Shared Reports. MicroStr

Selvan

Secure | https://cdwmicrostrategy.nhls.ac.za/MicroStrategy/asp/Main.aspx

Self Service Portal > **Shared Reports**

Guest User

Recents

Shared Reports

00 Transfer to Self Service Portal
Owner: Administrator
Modified:
14/11/16 17:48:37
undefined

01 Self Service Portal - Landing Page
Owner: Administrator
Modified:
30/03/17 12:42:03
undefined
Export

Self Service Portal > **Shared Reports**

https://cdwmicrostrategy.nhls.ac.za/MicroStrategy/asp/Main.aspx?evt=2048001&src=Main.aspx.2048001&documentID=0ECEE7CE45217271BCDF46AA51AEE5FE&currentViewMedia=1&visMode=0

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NATIONAL HEALTH LABORATORY SERVICE

Self-Service Portal

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES

What is the Self-Service Portal?

The Self Service Portal allows online registration of users to access Monitoring and Evaluation Reports for the purpose of improving outcomes in South Africa's Health Programs.

For the Health Programs in which they operate, users can register to receive

1) M&E Reports regularly distributed via email and/or
2) Online M&E Dashboards

New Users

NEW USER REGISTRATION

IMPORTANT: After completing the "New User Registration", use the buttons on the right to select "ADD ONLINE REPORTS" or "ADD REPORT DISTRIBUTIONS".

Existing Users

ADD REPORT DISTRIBUTIONS

ADD ONLINE REPORTS

MY PROFILE

Distributions - New Users

Selvan

Secure | https://cdwmicrostrategy.nhls.ac.za/MicroStrategy/asp/Main.aspx

Self Service Portal > Shared Reports > [...] > **Distributions - New Users**

Guest User

NATIONAL HEALTH LABORATORY SERVICE

Self-Service Portal

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES

New User Registrations

Back to Landing Page

Title *

First Name *

Last Name *

ID / Passport Number *

HPCSA/SANC Number

Work Phone Number

Mobile Number *

Email Address *

Organisation *

If other, specify

Occupation *

If other, specify

Terms & Conditions *

- I have read and agree to the Terms & Conditions
- I do not agree to the Terms & Conditions

Note:

Please ensure all mandatory fields are completed for registration.

Kindly read and accept Terms & Conditions relating to ethical use of reports.

At least one report category must be selected.

For a description, examples and user guides of available reports, **click here**

A valid HPCSA or SANC number is required for access to reports with patient identifying details.

Report Category 1 *

Report Category 2

Report Category 3

Report Category 4

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Discard Changes

* Compulsory Field(s)

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NATIONAL HEALTH LABORATORY SERVICE

Self-Service Portal

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES

What is the Self-Service Portal?

The Self Service Portal allows online registration of users to access Monitoring and Evaluation Reports for the purpose of improving outcomes in South Africa's Health Programs.

For the Health Programs in which they operate, users can register to receive

1) M&E Reports regularly distributed via email and/or
2) Online M&E Dashboards

New Users

NEW USER REGISTRATION

IMPORTANT: After completing the "New User Registration", use the buttons on the right to select "ADD ONLINE REPORTS" or "ADD REPORT DISTRIBUTIONS".

Existing Users

ADD REPORT DISTRIBUTIONS

ADD ONLINE REPORTS

MY PROFILE

Distributions - Registered

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Self Service Portal > Shared Reports > [...] > **Distributions - Registered Users**

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Self-Service Portal - Distribution Reports

NATIONAL INSTITUTE FOR COMMUNICABLE DISEASES

Registered User

<Back to Landing Page

Your Details

ID No.:	6104165148085
Name:	Henry
Surname:	Sunpath
Email Address:	selvan@kznhiv.org
Mobile No.:	0836264410
Organisation:	District DoH - eThekwini
(If Other):	
Occupation:	Healthcare Worker - Doctor
(If Other):	
HPCSA/SANC:	MP0328103

Current Distributions

For a description, examples and user guides of available reports, **click here**

Distribution Report	Province	District	Facility	Contact Email	Approved	Declined	Unsubscribed
RPT00001 - HIV VL RfA Report (All Ages) (Excel)	-	-	Bethesda Hospital°	HIV@nhls.ac.za	✓		
			Clairwood Hospital	HIV@nhls.ac.za	✓		
			Doh KZN: Jozini	HIV@nhls.ac.za	✓		
			Jozini Clinic	HIV@nhls.ac.za	✓		
			King Dinuzulu Hospital	HIV@nhls.ac.za	✓		
			Mkuze Clinic	HIV@nhls.ac.za	✓		
			RK Khan Hospital	HIV@nhls.ac.za	✓		
			Wentworth Hospital	HIV@nhls.ac.za	✓		

Add Reports by Province | Add Reports by District | Add Reports by Facility

Add Reports by Facility

Report Category	Report Type	Province	District
HIV M&E AD...	All Ages VL	KwaZulu-Natal	eThekwini Metro

Report Name	Province	District	Facility	Select
RPT00001 - HIV VL RfA Report (All Ages) (Excel)	KZN	eThekwini Metro	ADAMS MISSION CLINIC	☐
			ADDINGTON HOSPITAL	☑
			AMANZIMTOTI CLINIC	☐
			AMAOTI CLINIC	☐
			AMATIKWE (BHEKIMPILO) CLINIC [UMBILO]	☐
			AMATIKWE CLINIC [INANDA]	☐
			AMAWELE MOBILE CLINIC	☐
			ARYAN BENEVOLENT HOME	☐
			ASHERVILLE SATELITE CLINIC [DURBAN]	☐
			ATHLONE PARK CLINIC	☐
			AUSTERVILLE CLINIC	☐
			BAYVIEW CLINIC	☐
			BEATRICE STREET CLINIC	☐
			BEKIMPILO TRUST	☐
			BESTERS CLINIC	☐
			BHEKULWANDLE (BHEKIMPILO) CLINIC	☐

Submit

ENG 8:55 PM

RPT00001 - HIV VL RfA Report (All Ages) - Facility _ King Dinuzulu Hospital.xlsx - Excel

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A1 Strictly Confidential

Strictly Confidential

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1. The Recipient agrees to keep the Results secure and confidential at all times. Confidentiality includes, but is not limited to the properties, characteristics, content and composition of the Results. All information relating to the nature and processes of the Results in whatever form must also be treated as confidential. The identity and particulars of the Patient must be protected and kept confidential at all times. Any publications of the Results to third parties must not divulge any details of the Patient unless consent has been obtained for such use from the Patient. Third Parties mean a party other than any health practitioner involved in the treatment of the patient.

2. The Recipient shall use its reasonable endeavours to minimise the risk of unauthorised disclosure or use of the Results or identity and particulars of the Patient and undertakes to take proper care and all reasonable measures to protect the confidentiality of the Patient's information using a standard of care which is no less than that standard of care which it applies for the protection of its own Confidential Information.

3. The Recipient shall indemnify and hold NHLS and/or all of its directors, officers, employees and representatives harmless from and against any claim, demand, cause of action, liability, loss or expense arising:

   3.1. by reason of Recipient's actual or asserted failure to comply with any law, ordinance, regulation, rule or order in disclosing the Results or identity and particulars of the Patient to any third party. This includes, but not limited to, fines or penalties by government authorities;

   3.2. from injury to or from damage to or loss of property of the Patient arising directly or indirectly out of this unauthorized disclosure of the Results or identity and particulars of the Patient to third parties.

4. The Recipient's indemnity obligation shall include the duty to reimburse any attorney's fees and expenses incurred by NHLS for legal action to enforce or defend the Recipient's indemnity obligations.

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This e-report must be password protected when saving and distributing.
Non-compliance may lead to legal action.

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ENG 9:18 PM

HIV VL RfA Report (all ages)

Run Date: 3/20/2017 2:32:06 AM

Note: - In rare instances results can be updated on the laboratory information system and may therefore differ with the final report.
- 'CDW identifier': probabalistic linkage to match multiple tests to a single patient and is not 100% accurate.
- 'Previous VL>1000' worksheet: Previous patient VL results matched by a probabalistic linking algorithm. The presence or absence of a match is not 100% accurate.

Facility = King Dinuzulu Hospital

Total number of Viral Loads reported (period: last 7 days)	**109**
Number of VL results below 1000 cp/mL	**16**
Percentage VL results below 1000 cp/mL	**14.7**
Number of VL results above 1000 cp/mL	**25**
Percentage VL results above 1000 cp/mL	**22.9%**

Disclaimer:

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RPT00001 - HIV VL RfA Report (All Ages) - Facility _ King Dinuzulu Hospital.xlsx - Excel

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
1	Province	District	Sub District	Facility	Ward	Folder Number	Patient Surname	Patient Name	Patient DOB	Patient Address	Patient Tel No	Patient Age	Taken Date	Reviewed Date	Episode No	CDW Identifier	HIV VL Result (Detected VL)	Total No. of Previous Consecutive VL >1000		
2	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Ward I - Male Medical								11-MAR-2017	14-MAR-2017	BC01165165	115295741	3 556 652			
3	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Accident Unit								07-MAR-2017	12-MAR-2017	BC01161416	115295741	2 476 173			
4	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Khethimphilo Clinic (district)								10-MAR-2017	15-MAR-2017	BC01164823	111182657	1 400 000			
5	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Medical Opd								14-MAR-2017	17-MAR-2017	BC01166488	111182657	947 767			
6	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Ward I - Male Medical								14-MAR-2017	18-MAR-2017	BC01166495	116232655	361 723			
7	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Paediatric Opd								13-MAR-2017	16-MAR-2017	BC01165611	130889745	308 864			
8	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Khethimphilo Clinic (district)								15-MAR-2017	19-MAR-2017	BC01167751	27933264	149 954			
9	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Khethimphilo Clinic								10-MAR-2017	15-MAR-2017	BC01164827	28411745	108 000	3		
10	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Khethimpilo Clinic (mdr)								14-MAR-2017	17-MAR-2017	BC01166856	143357	96 549	3		
11	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Ms1 - Male Tb Medical								15-MAR-2017	19-MAR-2017	BC01167680	130135309	95 866	1		
12	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Khethimpilo Clinic (mdr)								14-MAR-2017	18-MAR-2017	BC01166899	107263030	90 194	1		
13	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Accident Unit								11-MAR-2017	14-MAR-2017	BC01165132	257165	57 470	1		

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RPT00001 - HIV VL RfA Report (All Ages) - Facility _ King Dinuzulu Hospital.xlsx - Excel

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Paste Cut Copy Format Painter | Arial 8 | Wrap Text | General | Conditional Formatting | Format as Table | Cell Styles | Insert | Delete | Format | AutoSum | Fill | Clear | Sort & Filter | Find & Select

Clipboard Font Alignment Number Styles Cells Editing

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
1	Province	District	Sub District	Facility	Ward	Folder Number	Patient Surname	Patient Name	Patient DOB	Patient Address	Patient Tel No	Patient Age	Taken Date	Reviewed Date	Episode No	CDW Identifier	Previous Consecutive VL >1000 Results			
2	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Ms1 - Male Tb Medical								14-NOV-2016	17-NOV-2016	BC01099133	143357	4 902			
3	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Ms1 - Male Tb Medical								28-AUG-2015	02-SEP-2015	BC00855633	143357	2 550 350			
4	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Mdr Tb Clinic								31-JUL-2015	05-AUG-2015	BC00841441	143357	2 282 115			
5	KwaZulu-Natal	eThekwini Metro	eThekwini	Ntshongweni Clinic	Not Applicable								06-APR-2016	10-APR-2016	CG02862991	257165	2 095			
6	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Ms3 - Female Tb Medical								21-DEC-2016	29-DEC-2016	BC01119174	1041168	61 005			
7	KwaZulu-Natal	iLembe	Kwadukuza	Stanger Hospital	Female Medical Annex								29-NOV-2016	02-DEC-2016	BH01738123	1041168	171 000			
8	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Khethimphilo Clinic (district)								05-JAN-2017	09-JAN-2017	BC01124088	2241112	12 887			
9	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Ms4 - Female Tb Medical								18-NOV-2016	23-NOV-2016	BC01102241	17618704	76 989			
10	KwaZulu-Natal	Harry Gwala	Ingwe	St Apollinaris Hospital	Ethembeni Clinic								28-AUG-2015	03-SEP-2015	EJ00232913	17618704	21 645			
11	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Khethimphilo Clinic (district)								20-JUL-2016	22-JUL-2016	BC01032163	25360520	119 000			
12	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Khethimphilo Clinic (district)								01-FEB-2016	05-FEB-2016	BC00938022	25360520	26 100			
13	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Khethimphilo Clinic (district)								19-OCT-2016	22-OCT-2016	BC01085114	28411745	2 609			
14	KwaZulu-Natal	eThekwini Metro	eThekwini	King Dinuzulu Hospital	Ward Not Stated								10-AUG-2016	14-AUG-2016	BC01042729	28411745	2 800			

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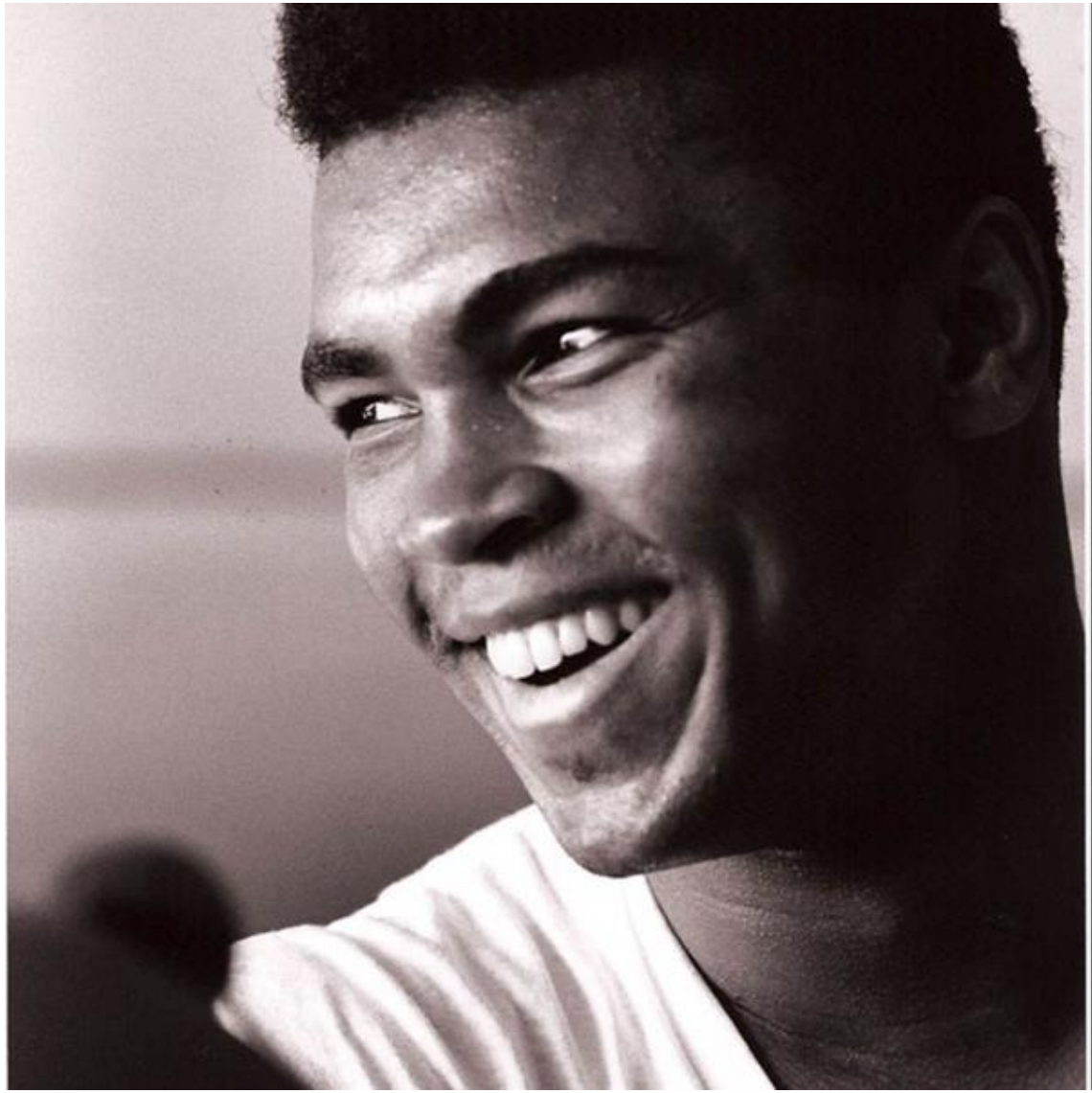
REVAMP
RESISTANCE TESTING VERSUS ADHERENCE SUPPORT FOR MANAGEMENT OF PATIENTS WITH VIROLOGIC FAILURE ON FIRST-LINE ANTIRETROVIRAL THERAPY IN SUB-SAHARAN AFRICA

High VL Register

Clinic File No	Patient Name	ID Number	Age	Contact Number 1	Contact Number 2	Contact Number 3	Hi VL result	Hi VL Date	Action	Action Date	Date Follow up visit EAC 2	Date Follow up visit EAC 3	Repeat VL	Date Repeat VL	Date check VL result & Manage	Date Continue 1st Line	Date COR
									Patient called								
									Patient booked								
									Patient Came in								
									did not come in								

REVAMP
RESISTANCE TESTING VERSUS ADHERENCE SUPPORT FOR MANAGEMENT OF PATIENTS WITH VIROLOGIC FAILURE ON FIRST-LINE ANTIRETROVIRAL THERAPY IN SUB-SAHARAN AFRICA



THE WILL MUST BE STRONGER THAN THE SKILL

MUHAMMAD ALI

Being challenged in life is inevitable, being defeated is optional.

NIH National Institute of Allergy and Infectious Diseases
HARVARD MEDICAL SCHOOL
MGH 1811 MASSACHUSETTS GENERAL HOSPITAL
EMORY UNIVERSITY
UNIVERSITY OF KWAZULU-NATAL INYUVESI YAKWAZULU-NATALI
health Department: Health PROVINCE OF KWAZULU-NATAL
HEARD
UNIVERSITY of ROCHESTER

Challenges of managing high VL

- 1. Many do not turn up for first visit after VL result available
- 2.Time between EAC sessions not consistent
- 3. repeat Vl not done at EAC -3
- 4. Time to change regimen delayed
- 5. Many pts have several high Vl before action
- 6.Some patients refuse to change to regimen 2 and hence delay time lines

- 1.If pt does not come by next appointment –call immediately.
- If relative comes to fetch medication do not issue more than one month script till pt arrives for EAC1
- Each pt must be entered on a HIGH VL register and the lay counsellor follow up with calls regularly till three months
- Do baseline EAC assessment and emphasise the importance of month 5 VL,VL anniversary and need to change regimen as per guidelines

Quality improvement model

Root cause analysis (SIMS)

Stakeholder strategy

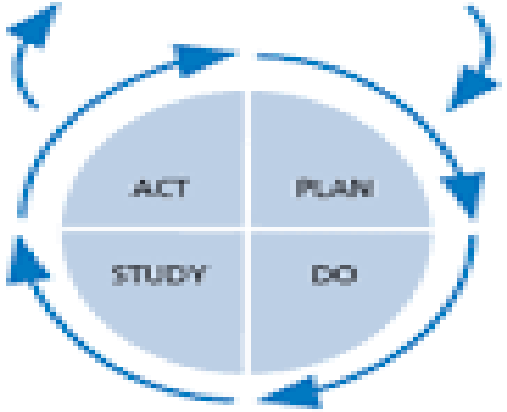
Ongoing education and development

AIM → What are we trying to accomplish?

MEASURE → How will we know if a change is an improvement?

CHANGE → What changes can we make that will result in improvement?

RAPID CYCLE IMPROVEMENT →



STEPS TO ACHIEVE THE IDEAL HIV-VL&DR MONITORING PROGRAM -ART CLINIC LEVEL

1. HAST CLINICAL MANAGER AND VL CHAMP in each CHC/hospital and VLC in each ART site	**Terms of reference identified for overall supervision of process** **Responsible for facility reports to DOH** **Manage exit plan with partners in 2018**
2. MAKE VIRAL LOAD MONITORING ROUTINE	1. INCREASE DEMAND BY PT EDUCATION AND HCW EDUCATION 2. INSTITUTE VL ANIVERSARY CONCEPT 3. IMPLEMENT GATE KEEPING NOT TO ISSUE REPEAT SCRIPTS WITHOUT VL RESULTS
3. SYNERGISE DATA SOURCES SO THAT TIER.NET IS OPTIMALLY FUNCTIONAL AND TOTALLY RELIABLE	1. **CREATE A HIGH VL REGISTER** FOR IST AND 2 ND LINE ART FROM ALL DATA SOURCES –ROUTINE CLINIC VL RECORDS , NHLS WEEKLY DASHBOARD, TIER.NET RECORDS, PHARMACY RECORDS , COMPLETE FILE AUDIT OF ALL ACTIVE PATIENTS 2. CLEAN AND UPDATE TIER.NET FOR RECORDING AND REPORTING –WILL IMPROVE AFTER CATCH UP PHASE 3. **CATCH UP PHASE TO ACCOUNT FOR EVERY PATIENT EVER SEEN IN CLINIC AND NOT ACCOUNTED FOR ON TIER.NET**
4. START VL PRIORITY CLINIC ON SPECEFIC DAY/ DEDICATED TEAM WORKING DAILY	1. Trained EAC team work with trained doctor to manage complex VF in first line and all second line VF 2. Ensure that all patients receive care by a MDT
5. SUPPORT PHCs in the area	1. VLC in each PHC to be mentored and supported by local CHC/hospital .Manage all first line VF and refer all second line VF 2. Standardise referral forms for VF and data required for 3RD line ART

SOP FOR RISK OF TREATMENT FAILURE – NIMART and /or VL PRIORITY CLINIC

5. ROTF.pdf

CRITERIA FOR REFERRAL OF PATIENTS TO A VIRAL LOAD PRIORITY CLINIC (VPC)

SPECIFIC DAY OR ALL DAYS WHEN THE KEY STAFF ARE AVAILABLE

1. ARV CLINIC DOCTOR /MatCH DOCTOR

2. EAC SOCIAL WORKER

3. HIV COUNSELLOR- EAC TRAINED

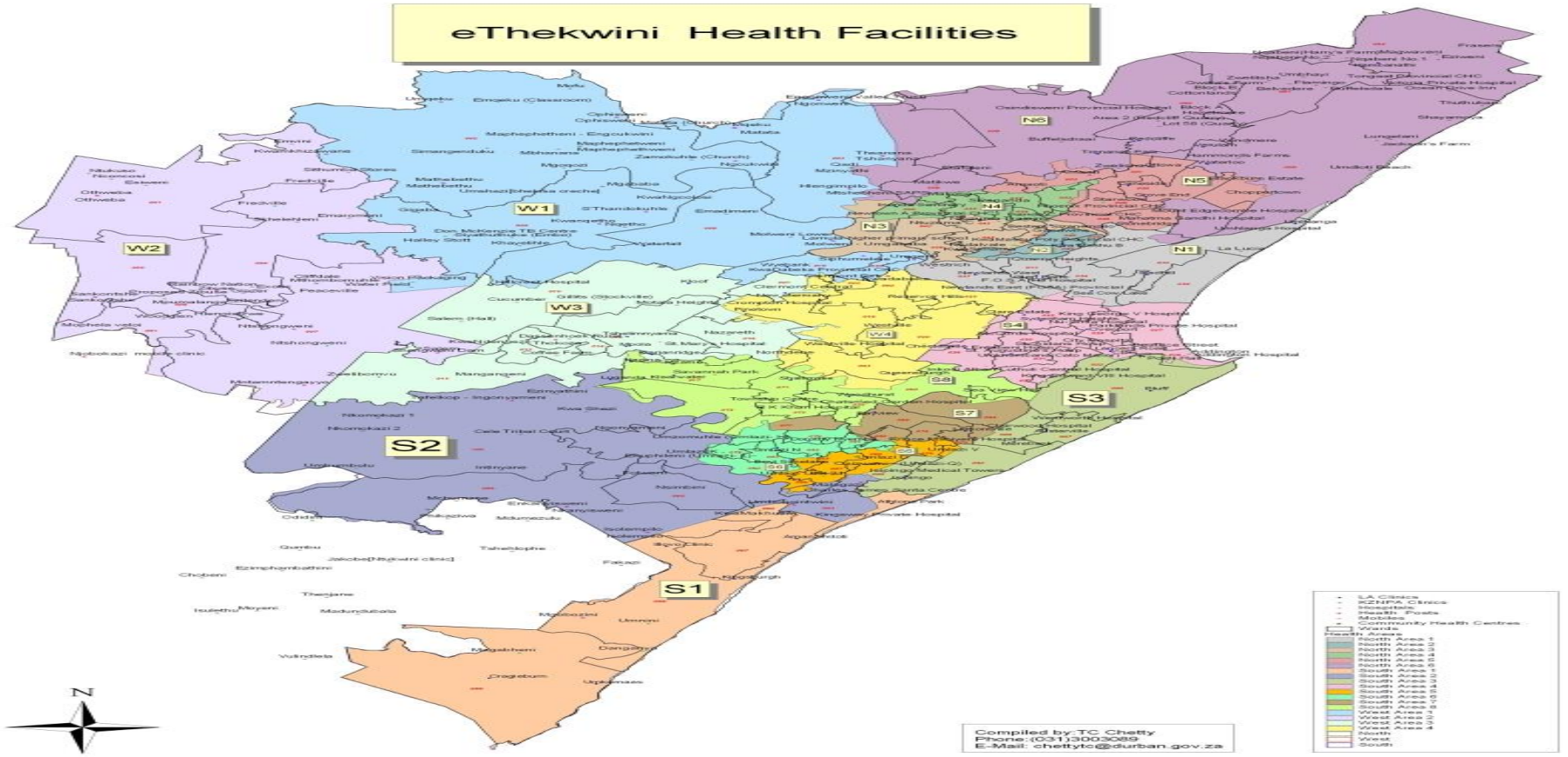
4. EAC TRAINED NIMART NURSE /PN

1. **FIRST LINE (virologic failure after counselling for two months and repeat VL 1000 copies/ml)**
a. Multiple co-morbidities i.e. renal ,cardiac, liver pathology
b. On TB treatment or requiring TB treatment.
c. All patients with complex psychosocial problems that need intervention by trained EAC teams
d. Hepatitis B SAg positive patients that have renal failure for dose adjusted TDF treatment.

2. On second line Treatment
a. Treatment failure high viral loads
b. All patients with multiple co-morbidities on second line
c. Drug toxicities
d. Drug interactions
e. All patients with complex psychosocial problems that need intervention by trained EAC teams
f. Hepatitis B SAg positive patients that have renal failure for dose adjusted TDF treatment.

NB.REFERRAL FORMS FROM ART CLINICS TO REFERRAL CENTRES AND FORM TO BE USED TO ORDER GRT WILL NEED TO BE FINALISED BY HAST UNIT AND NHLS with input from clinical specialists

The data in this DHP is broken down into 8 proposed sub-districts. The South sub-district has been divided into three functional areas: 1) South Central, 2) South West, 3) Umlazi/Engonyameni and 4) Lower South. The North/West is divided into 4 sub-districts namely: 1) North Central, 2) Greater Inanda/Tongaat Sub-District, 3) Inner West; and 4) Outer West Sub-Districts.
Population =3 442 361
ART sites =124
TROA = ?350 000



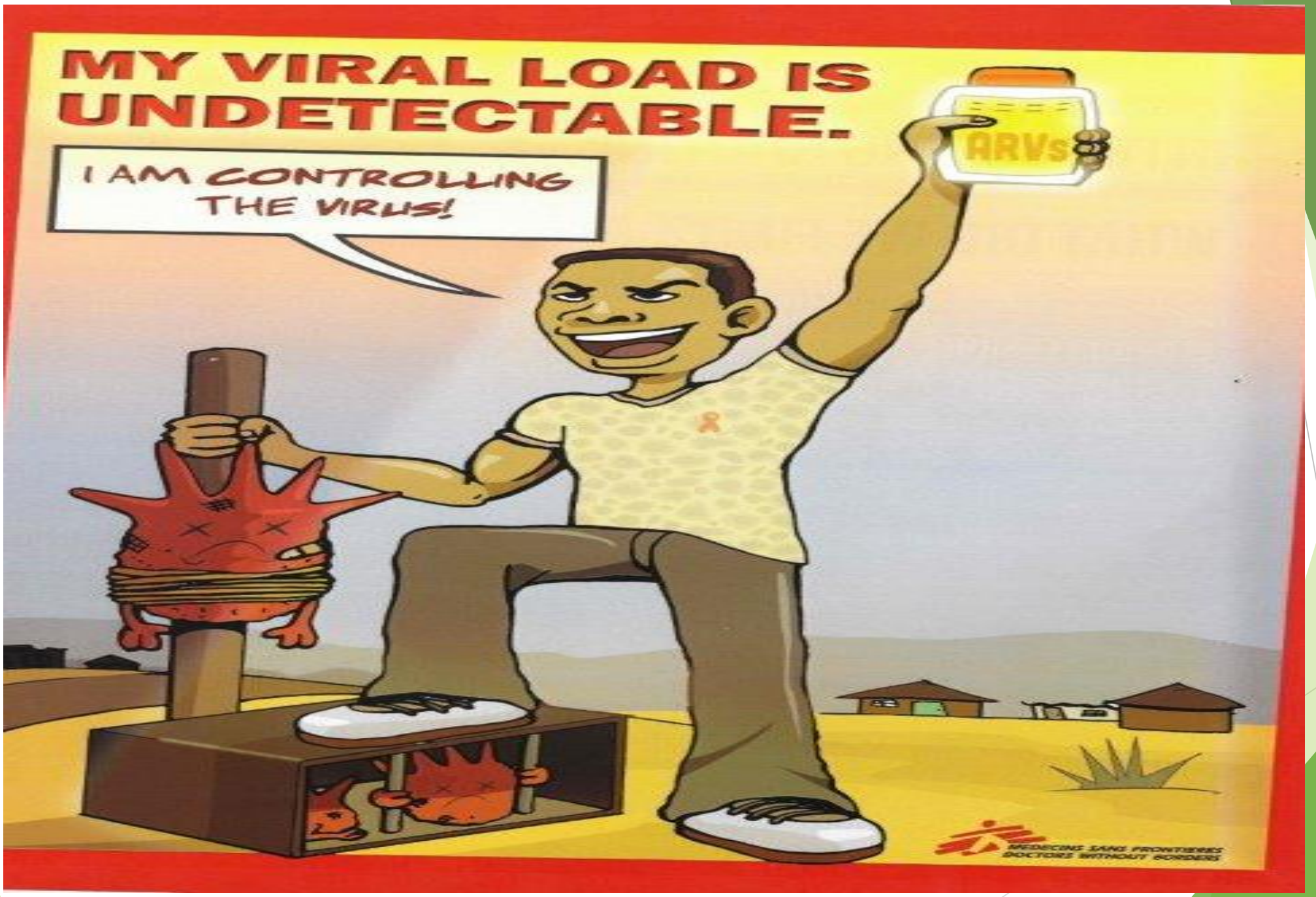
Draft referral pattern from PHC to CHC/hospital for PLHA that require GRT and ACC :

Doctor as Clinical Advisor at each geographical unit

King Edward hospital Prince Cryil Zulu CDC (LA) Queensburgh Clinic (LA) Lancers road **CATO MANOR**	King dinizulu hospital CLARE ESTATE(LA) OVERPORT (LA) SYDENHAM (LA) Westville –LA Claire Estate Clinic (LA) **KWA MASHU**	Hlengisizwe Marianridge Clinic Molweni Clinic Mpola Clinic (LA) Mpumalanga Clinic Msunduzi Clinic Mzamo Clinic (LA) Nagina Clinic (LA) New Germany Clinic (
Wentworth hospital Bluff Clinic (LA) Austerville Clinic (LA) Merebank Clinic (L/A) Illovo Clinic (LA) Isipingo Clinic (LA) Isipingo Hospital (LA) Kingsburgh Clinic(LA) Kingsway Hospital Cragieburn Clinic (LA) **CATO MANOR** **CLAIRWOOD**	RKKHAN RKK Hospital Shallcross Clinic (LA) Township Clinic (LA) Woodhurst Clinic (LA) Pinetown Clinic (LA) Bayview **ST MARYS** **KWA DABEKA** **HLENGISIZWE**	Clairwood hospital Clairwood Hospital Lamontville Clinic (LA Montclaire sea View (LA)
MGMH La Lucia Clinic (LA) Umhlanga **PHOENIX CHC**	PHOENIX CHC STARWOOD CANESIDE (LA) GROVE END (LA) STONE BRIDGE (LA)	Osindisweni hospit Oakford clinic **TONGAAT CHC**
Kwa MASHU CHC GOODWINS LINDELANI NTUZUMA KWAMASHU B BESTER SANDASONKE BHEK NEWLAND EAST (LA) NEWLANDS WEST GLEN EARL	Inanda CHC AMAOTI QADI SIVANANDA INANDA SEMINARY AMATHIKWE MISSION INANDA DAY HLENGIMPILO	Kwa DABEKA CLARMONT HALLEY STOTT KWANDENGEZI MOLWENI ZWELIBOMVU NGCOLOSI MAPHEPHETHENI Waterfall Clinic (LA) Waterloo Clinic (LA) Whyebank Clinic (LA
St MARYS hospital ?DEFINE CLINICS	DMH ??ART CLINCS NEARBY CJH ??ART CLINICS NEARBY PMMH –23 CLINICS	Newtown CHC Tongaat Chc /OSW Hambanati Ottawa (LA) Redcliff (LA) Terrance Park (LA) Tongaat CHC Verulam (LA)

DOCUMENTATION OF SOP

SOP DRAFT 1.pdf


MY VIRAL LOAD IS UNDETECTABLE.
I AM CONTROLLING THE VIRUS!
ARVs
MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

WHAT IS THE MOST EFFECTIVE WAY TO MAKE VL MONITORING ROUTINE IN AN ART CLINIC

1. INCREASE DEMAND BY PT EDUCATION AND HCW EDUCATION
2. INSTITUTE VL ANIVERSARY CONCEPT
3. IMPLEMENT GATE KEEPING NOT TO ISSUE REPEAT SCRIPTS WITHOUT VL RESULTS
4. ENHANCED ADHERENCE COUNSELLING
5. ALL OF THE ABOVE

IN PILOT SITE STUDIES ,HOW MANY PATIENTS WITH HIGH VL HAVE A REPEAT VL AFTER EAC 1 AND EAC 2

1. 60 %
2. 10 %
3. 30 %
4. 50 %

The commonest cause of sample rejection from the NHLS is

1. Clotted /haemolysed specimen
2. Incorrect blood tubes used
3. Forms filled incorrectly
4. Vl done at inappropriate time line

In a viral load priority clinic , what combination of staff is the most effective in managing high VL

1. Doctor , NIMART nurse
2. Doctor ,EAC counsellor ,social worker, psychologist
3. NIMART nurse ,EAC counsellor ,social worker
4. EAC counsellor, social worker, psychologist
5. Doctor ,EAC counsellor

What percentage of patients have a VL at 6 months in Ethekwini- approximately

1. 70 %
2. 40%
3. 25%
4. 50 %

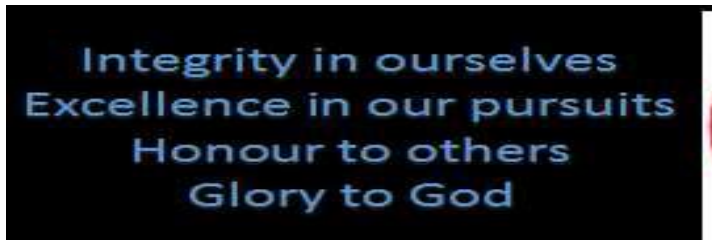
Which statement is correct, according to the DOH guidelines

1. First Vl result is due at 6 months on ART and then 12 months if the 6 month Vl is undectable and then annually if the 12 month Vl is undectectable
2. First Vl result is due at 6 months on ART and thereafter one year later if the 6 month Vl is undectectable
3. First Vl result is due at month 6 on ART and then at month 12 if the Vl is > 1000.

ACKNOWLEDGEMENTS

- ETHEKWNI HEALTH DISTRICT OFFICE
- CAPRISA –ACC
- MatCH
- HEALTH SYSTEMS TRUST
- LOCAL GOVT /MUNICIPAL CLINICS
- Harvard Medical School
- Emory University
- SA HIV clinicians Society –ART MONITORING GUIDELINES
- REVAMP STUDY TEAM
- Report Adapted from the Medecins Sans Frontieres (MSF) ROTF report and toolkit – Supporting adherence to Antiretroviral Treatment : A facility approach to reduce the Risk of Treatment failure. Khayelitsha 2012.

THANK YOU



THANK YOU