Case management and support for patients on decentralized drug distribution and multi-month dispensing

Decentralized Drug Distribution (DDD) Learning Collaborative

June 17, 2021

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EpiC
Meeting Targets and Maintaining Epidemic Control

Session 14: Learning Collaborative Agenda (7-8:30 am EDT)

- **Changes to Health Worker Roles in the Context of MMD/DDD**
  Jerilyn Hoover, Health Science Specialist, Health Workforce Development Advisor | *USAID*
  Lauren Bailey, Multi-Month Dispensing (MMD) Advisor | *USAID*
- **FHI 360's Framework for Virtual Case Management**
  Shanthi Noriega, Going Online HIV Services Consultant | *FHI 360*
- **QuickRes: Supporting Virtual Case Management (VCM) in Namibia**
  Abrahim Simmonds, Going Online HIV Services Consultant | *FHI 360*
- **HIV Case Management in a Federally Qualified Health Center: Benefits & Challenges**
  Kristen Jarvis, Manager of Medical Adherence Nursing | *Whitman-Walker Health*
- **Using Different Tools to Support Patients on MMD and DDD**
  Pius Nwaokoro, Director/Technical Lead | *FHI 360 (SIDHAS project)*
  Phillip Imohi, Associate Director, Prevention, Care & Treatment | *FHI 360 (SIDHAS project)*

PANELISTS

Lauren Bailey
MMD Advisor, USAID

Shanthi Noriega
Going Online Consultant, FHI 360

Abrahim Simmonds
Going Online Consultant, FHI 360

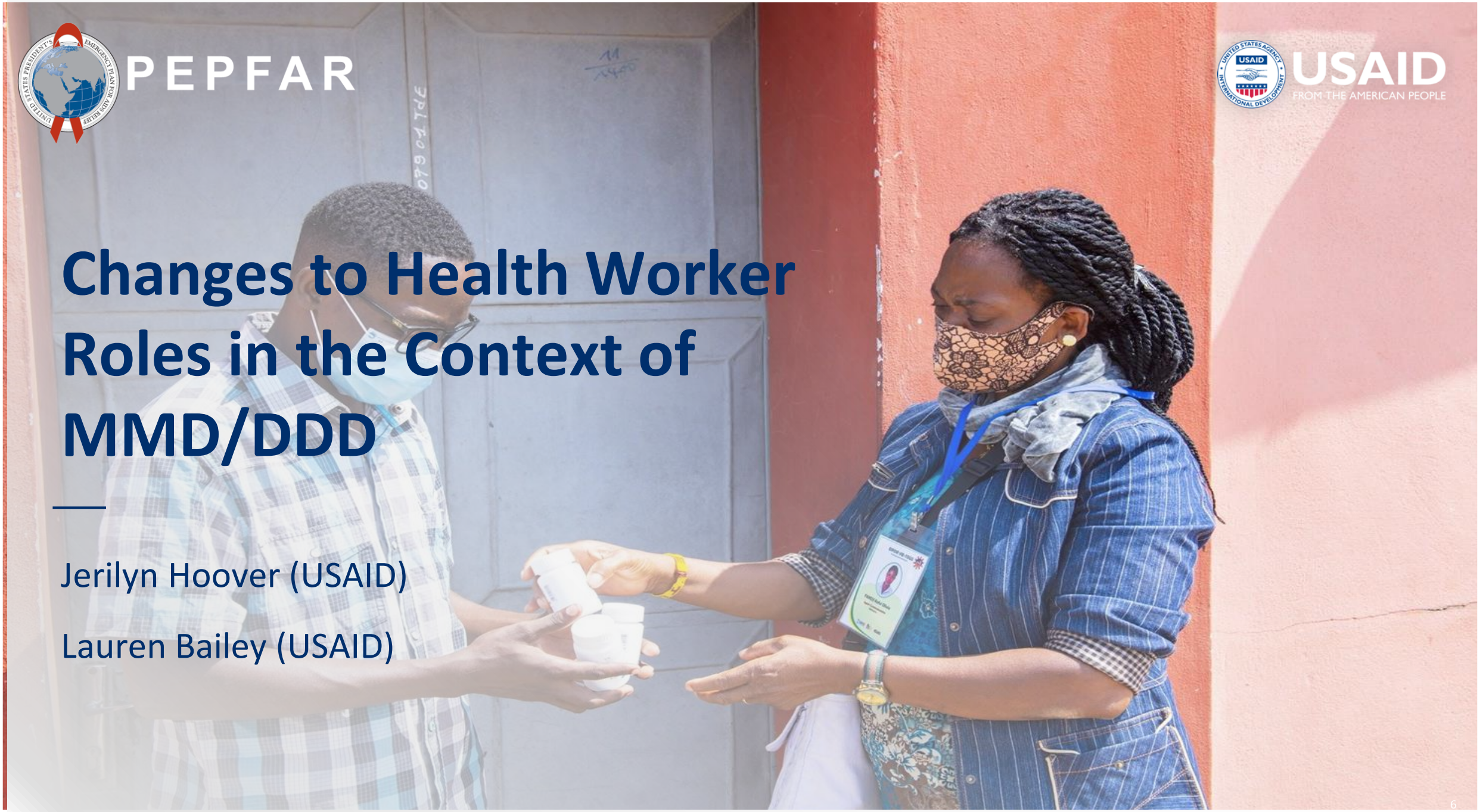
Kristen Jarvis
Manager of Medical Adherence Nursing, Whitman-Walker Health

Pius Nwaokoro
Director/Technical Lead, SIDHAS project, FHI 360

Phillip Imohi
Associate Director, SIDHAS project, FHI 360

FACILITATOR + PANELIST

Jerilyn Hoover
Health Science Specialist, Health Workforce Development Advisor, USAID



Changes to Health Worker Roles in the Context of MMD/DDD

Jerilyn Hoover (USAID)

Lauren Bailey (USAID)

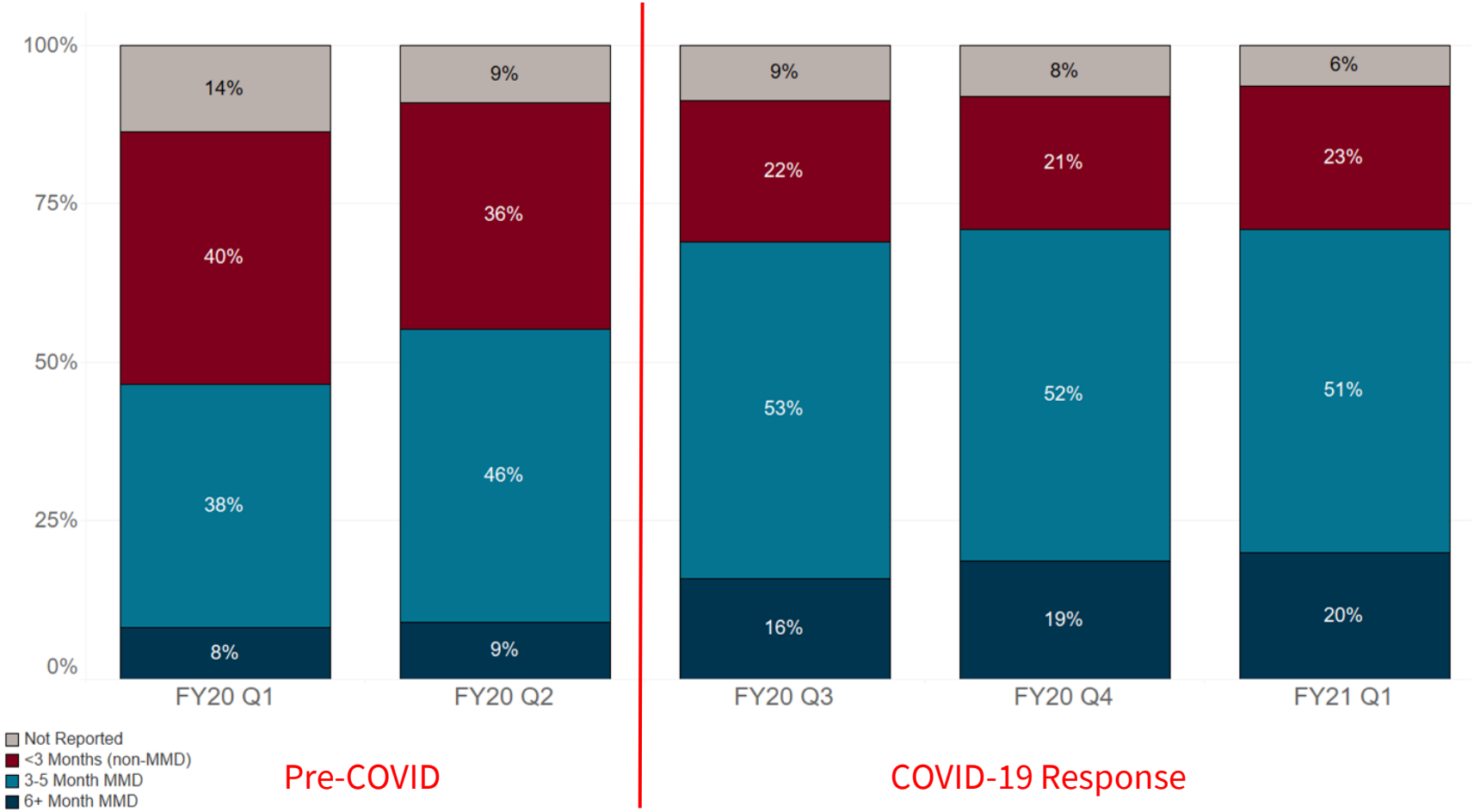
Background

Country-level policy largely permits 3 & 6MMD globally

Countries	3MMD Given	6MMD Given	Comments
El Salvador, Panama, Honduras	No	No	No policy exists (El Salvador, Panama) Honduras only permits 3MMD during COVID
Angola, India, Indonesia, Ukraine, Vietnam	✔	No	Policies in these countries do not formally permit MMD > 3 months
Botswana, Guatemala, Kenya, South Africa, Zimbabwe	✔	Some-times	6MMD is not formally approved and largely at the discretion of the clinician involved
Burkina Faso, Burma, Burundi, Cameroon, Côte d'Ivoire, DRC, Dominican Republic, Eswatini, Ethiopia, Ghana, Haiti, Jamaica, Laos, Lesotho, Liberia, Malawi, Mali, Mozambique, Namibia, Nepal, Nigeria, Papua New Guinea, Rwanda, Senegal, South Sudan, Tanzania, Thailand, Togo, Uganda, Zambia	✔	✔	There are no policy impediments in these countries, but implementation barriers may exist

And several countries temporarily amended MMD policy during the COVID response to permit extended dispensing intervals and expanded eligibility criteria.

PEPFAR has added over 4 million clients to MMD since FY20 Q1

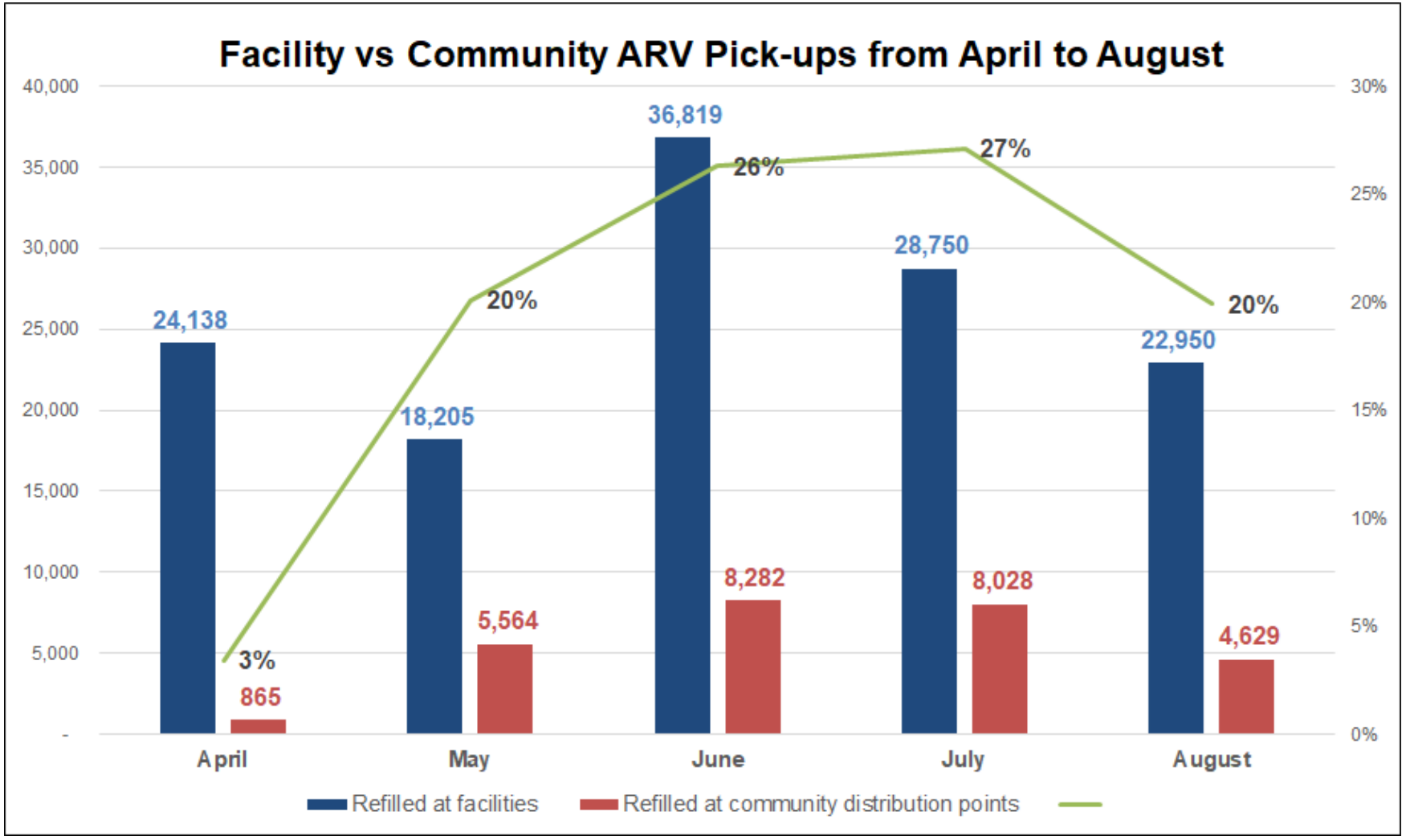


PEPFAR began collecting and reporting MMD data in FY20. Over the last five quarters, PEPFAR partners increased the provision of 3 and 6MMD across OUs; particularly in the immediate months of the COVID-19 response.

As of FY21 Q1, 71% of all clients on treatment (9 million!) are accessing at least 3 months of ART at a time.

Data do not include South Africa

COVID also facilitated an increase in DDD in select OUs



In Eswatini, the proportion of clients picking up ARVs in the community increased in the immediate months of the COVID response.

Distribution points included schools, neighborhood care points, churches, open community spaces, retail locations, etc.

Source: PEPFAR Eswatini FY20 Q3 POART

Health Worker Challenges during COVID-19

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Health Worker Actions during the COVID-19 Pandemic

- Health and care workers have worked under extremely difficult conditions to maintain safe provision of HIV services while responding to the new prevention, case identification, and treatment needs of the COVID-19 pandemic.

- Steep learning curve and rapidly evolving knowledge base for health workers learning about the COVID-19 virus and adapting to new clinical and IPC guidelines.[1]

- Health workers' dedication and commitment accommodated rapid change in HIV service delivery methods (including increasing the use of telehealth and virtual services) and in some cases were asked to work in unfamiliar clinical areas.

- All this done in the context of a pre-existing health worker shortage of up to 18 million by 2030, particularly in LMICs.[1]

PEPFAR Technical Guidance in the Context of the COVID-19 Pandemic (PEPFAR FAQ)

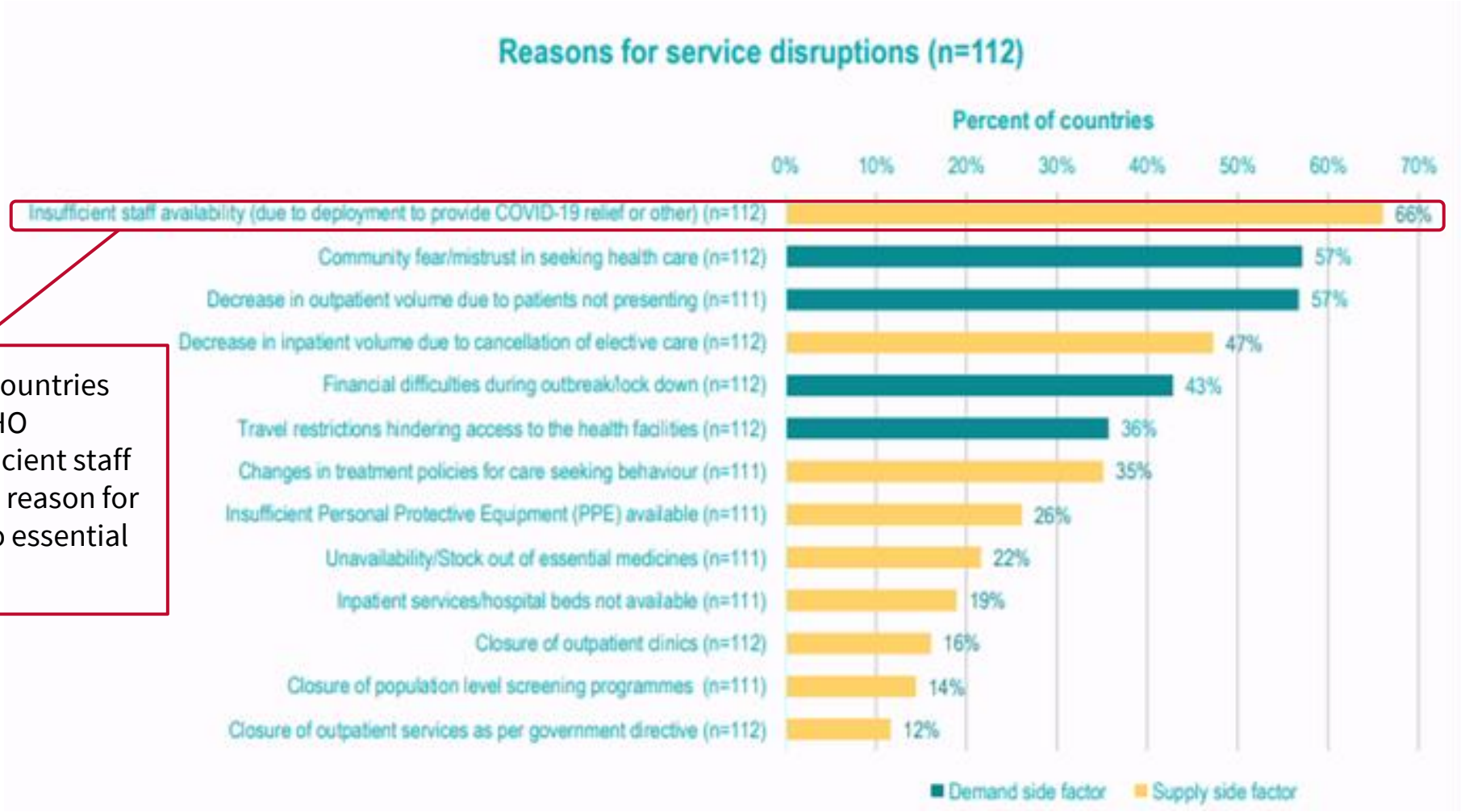
- *"Working in a prolonged COVID-19 response environment can negatively impact the wellness and mental health of PEPFAR supported staff." - PEPFAR FAQ*

- This guidance has been updated regularly throughout the pandemic and includes the following themes:
  - Staffing shifts throughout different phases of the pandemic
  - Protecting health workers
  - Identifying and managing COVID-19 risk among staff
  - Importance of sufficient PPE and effective training
  - Wellness and mental health of health workers

- *3-6 month MMD of ART and decentralized distribution are highlighted as critical interventions for all programs/individuals in response to COVID-19.*

The updated PEPFAR FAQ can be accessed at the bottom of this webpage: www.state.gov/pepfar/coronavirus

Countries are feeling impact from lack of sufficient health workers



Nearly 70% of countries surveyed by WHO reported insufficient staff availability as a reason for interruptions to essential health services

Second round of the national pulse survey on continuity of essential health services during the COVID-19 pandemic, WHO. (April 2021)

Health Workers Under Pressure

- *"When health systems are under pressure, so too are the professionals working within them. The safety of patients is intricately linked to the safety of health workers"* - *Paul Kadetz, Abebe Bekele, Agnes Binagwaho, University of Global Health Equity* [3]

- Inadequate availability of staff
- Increased workload and work hours to respond to COVID-19 in addition to providing regular services leading to fatigue and stress [1,4]
- Long work hours associated with increased risk of clinical errors [5]
- 84 countries reported labor disputes and health worker strikes since the beginning of COVID-19 due to indecent work conditions and inadequate PPE [6]

Psychosocial support officer offering counseling on adherence to treatment in Tete, Mozambique.

Personal Impact of COVID-19 on Health Workers

- Health workers are at higher COVID-19 risk than the general population - 1.29 million health workers known cases by January 2021 (data limited) [7-8]
- Working within a prolonged COVID-19 response has taken a toll on physical and emotional well-being
  - A review found a 23% prevalence of depression and anxiety, and 39% prevalence of insomnia among health workers during COVID-19 [9]
  - International Council of Nurses reported significant concerns of pandemic-associated burnout [4]
  - Other studies have noted depression, anxiety, distress, and difficulty sleeping [10-11]
  - Fears of transmitting COVID-19 to family and friends [1]

Higher Risk of COVID-19

Health workers are 2-3 % of global population but have made up 14% of reported cases to WHO

Negative Impact on Physical and Emotional Well-being

Fear of Transmitting COVID-19

Global Examples of Interventions

Protect	Support
- Ensuring sufficient PPE is available to protect health workers [12] - Monitor infection prevention and control practices for consistency with guidelines [12] - Providing transportation assistance and in some cases accommodation for health workers [13] - Identifying health workers at high risk for complications of COVID-19 and shifting those staff to telehealth / less patient facing activities [14] - Prioritizing health workers for COVID-19 vaccination [15]	- COVID-19 related leave [12] - Offer childcare / caregiving support [13] - Provide mental health and psychosocial support services for health workers [16] - Ensure health workers are paid consistently and on time[12] - Additional monetary and non-monetary incentives in some cases [12]

Continued Attention to PEPFAR-supported staff in COP21

- ***"The COVID 19 pandemic has brought additional challenges to the health and social service workforce in PEPFAR-supported countries. PEPFAR-programs must prioritize the safety and well-being of the workforce, and revive some of the 'care for the caretaker' practices that were essential to supporting the workforce in the early days of the HIV pandemic to support the resilience of the workforce as they face twin pandemics." - COP21 Guidance*** [19]

  Related to caring for staff, PEPFAR programs should focus on:
  - Building health workers' resilience
  - Ensuring a safe working environment and the safety and well-being of the health and social service workforce
  - Routine wellness checks on health workers
  - Ensuring staff have access to and are encouraged to use mental health services

  COP21 Guidance p. 458

Changes to Health Worker Roles and Types of Staff Engaged as a Result of DDD/MMD Expansion

DDD/MMD Models Can Reduce Burden on Health Workers

- Health workers faced significant challenges as they continue to deliver essential services during the COVID-19 pandemic.
- DDD/MMD models are being used by PEPFAR-supported partners in partnership with governments and private sector and leverage staff such as CHWs, pharmacists, and peer navigators.
- These models can be beneficial to both clients and health workers and are valuable tools to alleviate workload burden on staff and shift tasks between types of health workers.
- Increase in use of DDD/MMD models can:
  - Protect staff by reducing exposure to clients in person
  - Reduce the frequency of medication pickup / workload for dispensing medications
  - Reduce the numbers of clients in health facilities/pharmacies
  - Shift tasks for dispensing medication from facility to community staff
  - Shifting medication dispensing workload to private pharmacy workers

MMD/DDD helps health workers provide more client-centered care

A growing body of literature indicates a provider preference for extended dispensing intervals

- Zambia, Interval Trial: The majority of providers reported that 3 and 6MMD **reduced provider workload** and **decongested facilities**
- Malawi, Interval Trial: Nearly all providers interviewed chose a 6-month interval as the ideal ART supply, citing reasons including **reduced congestion of clinics**, **reduced provider workload**, and i**mproved ability to care for clients who are newly initiated and unstable/ ill.**

"You know we have got a lot of clients here, about 10,000 plus now … With the coming of the six-month dispensing of drugs, it has helped us reduce the number of clients we see so that **we individualise the care of the clients**."
- Clinical Officer, Zambia

Phiri, Khumbo, et al.
Hubbard, Julie, et al.

Facility-based health workers can see clients less often

Clients receiving MMD/DDD have the opportunity to minimize facility visits

- With increased ART dispensing intervals of 3- 6 months, patients may not need to come to the facility/pharmacy at all between consults
- Clients on 6MMD were found to have less healthcare system interactions compared to the standard of care and clients on 3MMD in a cluster-randomized noninferiority trial in Zimbabwe and Lesotho
  - However, the number of *actual* interactions exceeded the *intended* interactions, signaling a need to optimize MMD

Model	Total intended interactions/year	Total actual interactions/year
Zimbabwe		
Conventional care	4	3.3
3-month CARG	5-6	7.4
6-month CARG	3-4	3.5
Lesotho		
Conventional care	4	4.7
3-month CAG	4	5.7
6-month community dispensing	2	2.7

Fatti et al., JAIDS 2020; Tukei et al., JAIDS 2020

Diversity of staff engaged and leveraged for DDD/MMD

- Many MMD/DDD models use community health workers or similar staff to create more flexible services for clients outside of facilities.
  - Home delivery of medications by **community workers** for individuals or groups

- Can leverage new types of staff who were not previously involved in medication dispensing/delivery, expanding options for clients.
  - **Private pharmacy staff** - pharmacists and pharmacy technicians
  - **Postal / other delivery service workers** can extend the reach of medication delivery options for clients

Photo from GHSC Ethiopia

How can healthcare workers support a client's MMD/DDD journey?

Optimizing MMD/DDD

- To reap the full benefits of MMD/DDD and ease burden on providers/clients, client interactions with the healthcare system need to be aligned
  - Streamlining MMD schedules with clinical visits where possible/makes sense
  - Synchronizing MMD schedules or ART pickups across household members

Improving patient education to ensure adherence and health seeking behavior

- EpiC, RISE and ACHIEVE developed MMD literacy materials and job aids to improve patient/client/caretaker engagement on MMD

Job aid in English

Client brochure in French

How can healthcare workers support a client's MMD/DDD journey?

Supporting new types of client follow-up practices to ensure treatment adherence and treatment continuity while on MMD/DDD

- Since facility-based staff see clients less often through DDD/MMD service delivery models, it's important to consider how to check in with and support clients effectively outside of face-to-face facility visits. This can include things like:
  - Comprehensive adherence counseling so clients are equipped to know what to do if they miss doses, etc.
  - Remote check-ins between visits or home visits
- Community staff who interact with clients between visits or to deliver drugs can assess how clients are doing and identify any needs/issues that may need attention.
- Linkages can be made between private pharmacy workers and facility staff to share information on the status of medication pickups (where agreements exist)

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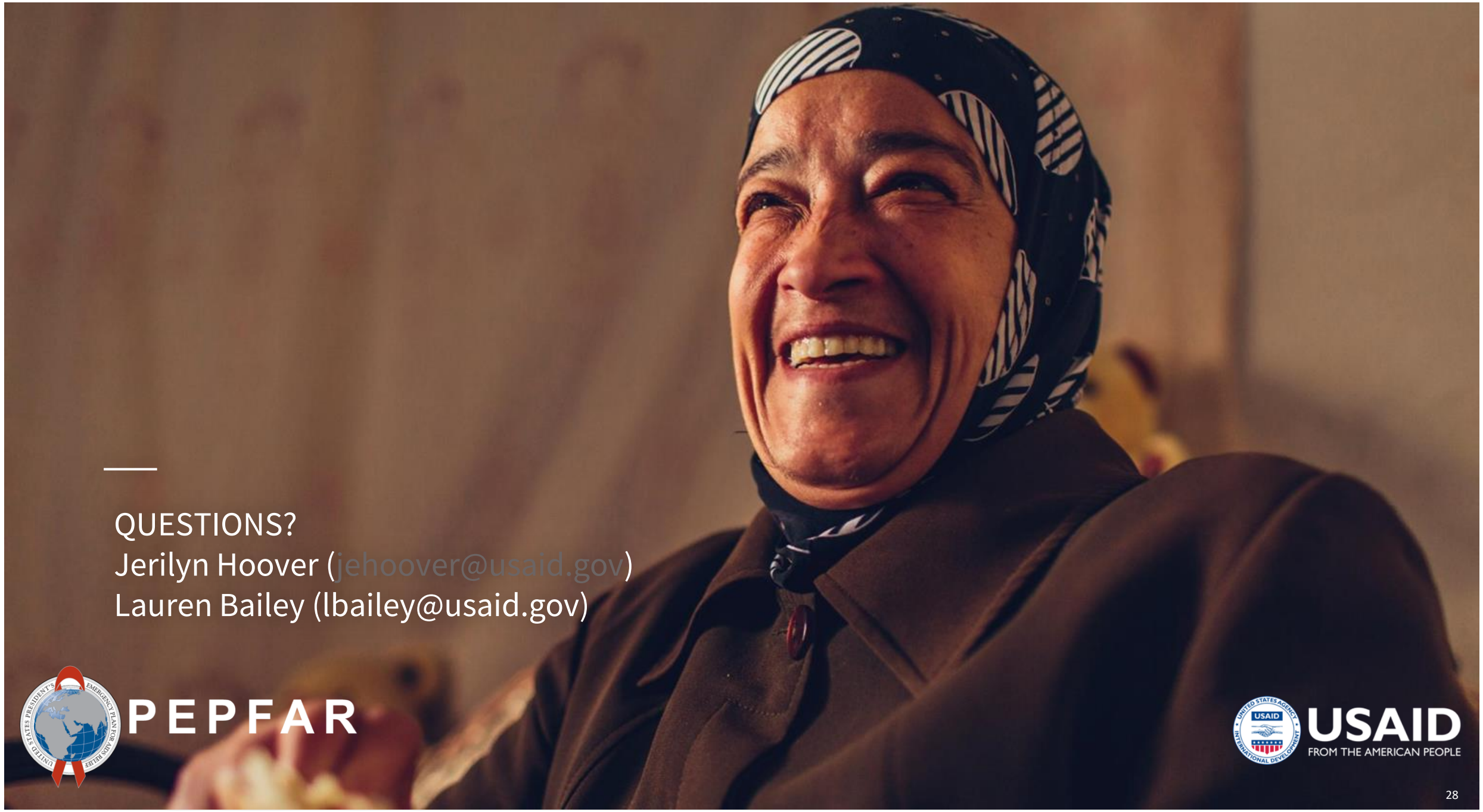

QUESTIONS?

Jerilyn Hoover (jehoover@usaid.gov)
Lauren Bailey (lbailey@usaid.gov)

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17 JUNE 2021

Virtual Case Management

FHI 360'S FRAMEWORK AND CASES

Shanthi Noriega Minichiello, Going Online Consultant

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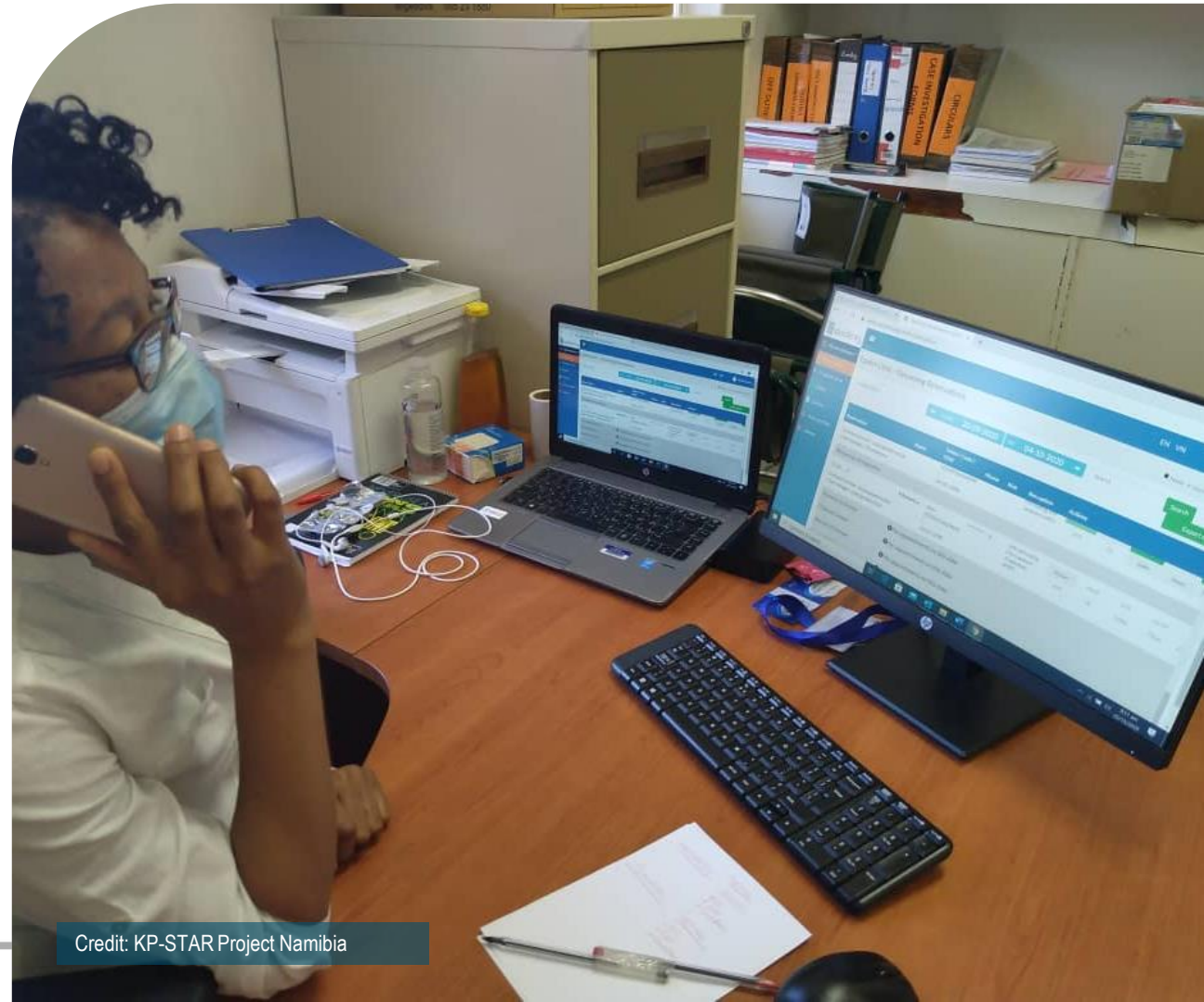
EpiC Meeting Targets and Maintaining Epidemic Control

What is virtual case management?

- Virtual HIV case management is like traditional case management in that it is an individual relationship between case managers and clients where the case manager helps clients achieve their prevention and treatment goals along the HIV service cascade.
- Case management becomes virtual when support is provided partially or entirely through virtual tools and platforms.



Defining characteristics

For client support to be considered “virtual case management” the support must follow 5 criteria:

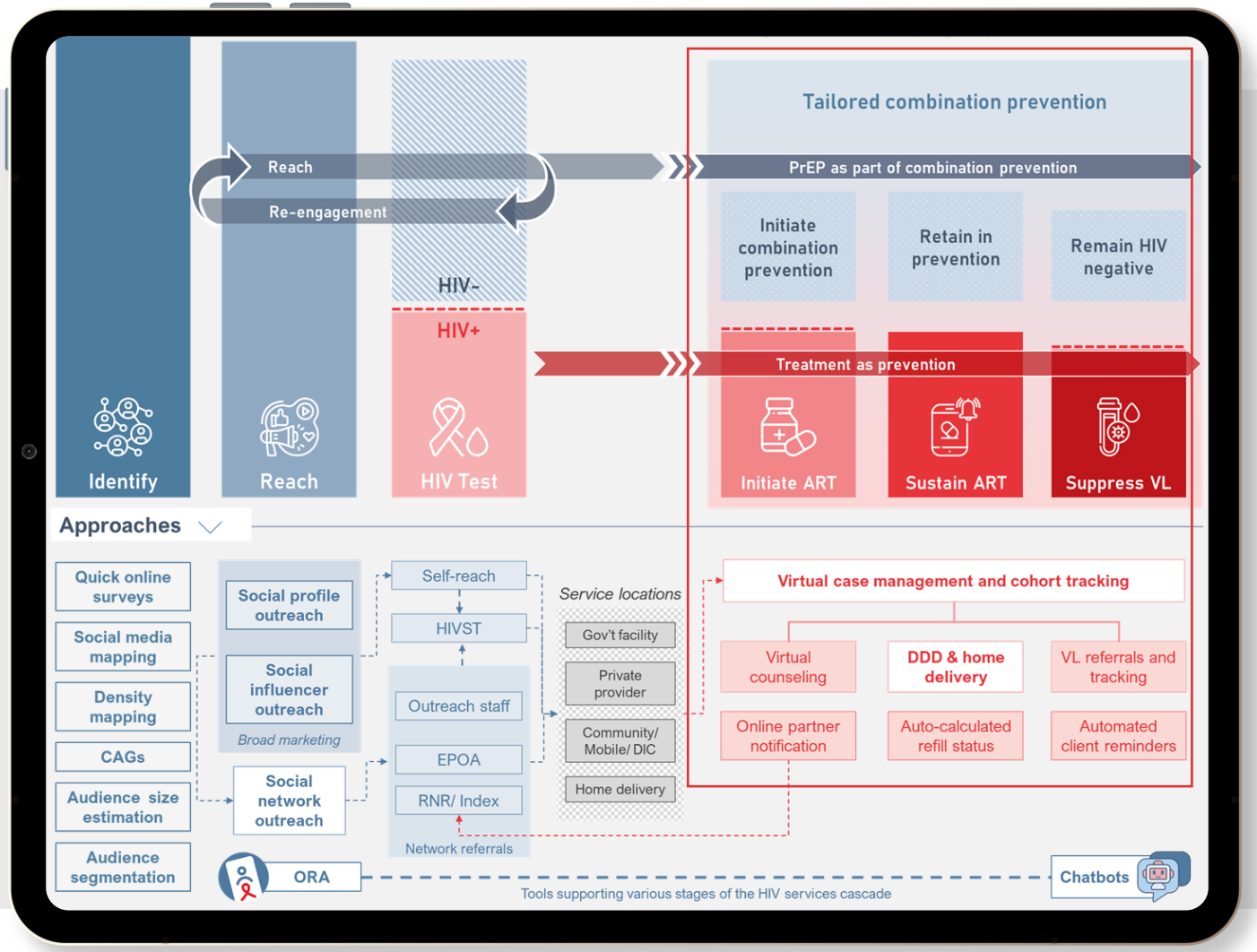
- Virtual
- Tracked
- One-on-one
- Tailored
- Coordinated

Credit: Alexandra Iammerink on Unsplash

Why should HIV programs use VCM?

- Why case management?
  - Offers clients tailored, systematic, and quality follow up
  - Data-oriented approach to ART/PrEP support (transparency and accountability)
- Why virtual?
  - Better connect with growing user base of online and mobile platforms
  - Meet client preferences for more private and convenient engagement
  - Builds resilience in programs to maintain engagement during and after COVID-19

Going Online Across the Cascade



For more information on this model, see "Going Online: A Budgeting and Programming Aid for Virtual HIV Interventions"

Models of virtual case management

The virtual case management model can be adapted to the context of HIV programs and target audiences based on several variables including…

Team format	Support structure	Channel
Community	Dual	Virtual only
Hybrid	Staggered	Partially virtual
Clinic	Layered	Client dependent
	Singular	

01 Who provides virtual case management services?

02 What is the scope of services provided, when is hand-off made?

03 How do clients stay in contact with their virtual case manager?

Results from Nepal and Indonesia

- Efficiency and speed of moving case management services virtually
  - VCM moved virtual in less than a month
  - Costs range from $2-8 per PLHIV supported per month
- Client clinical outcomes maintained with virtual support and during C19
  - 1-2% IIT maintained during VCM implementation and C19 lockdown
  - VL suppression maintained at 94-95% in Nepal and 91-92% in Indonesia
  - VL coverage maintained or increased (Nepal)

Credit: EpiC Nepal Project

Going Online

17 JUNE 2021

VCM with QuickRes in Namibia

SUPPORTING VIRTUAL CASE MANAGEMENT WITH QUICKRES.ORG IN NAMIBIA

Abrahim Simmonds, Going Online Consultant, FHI 360

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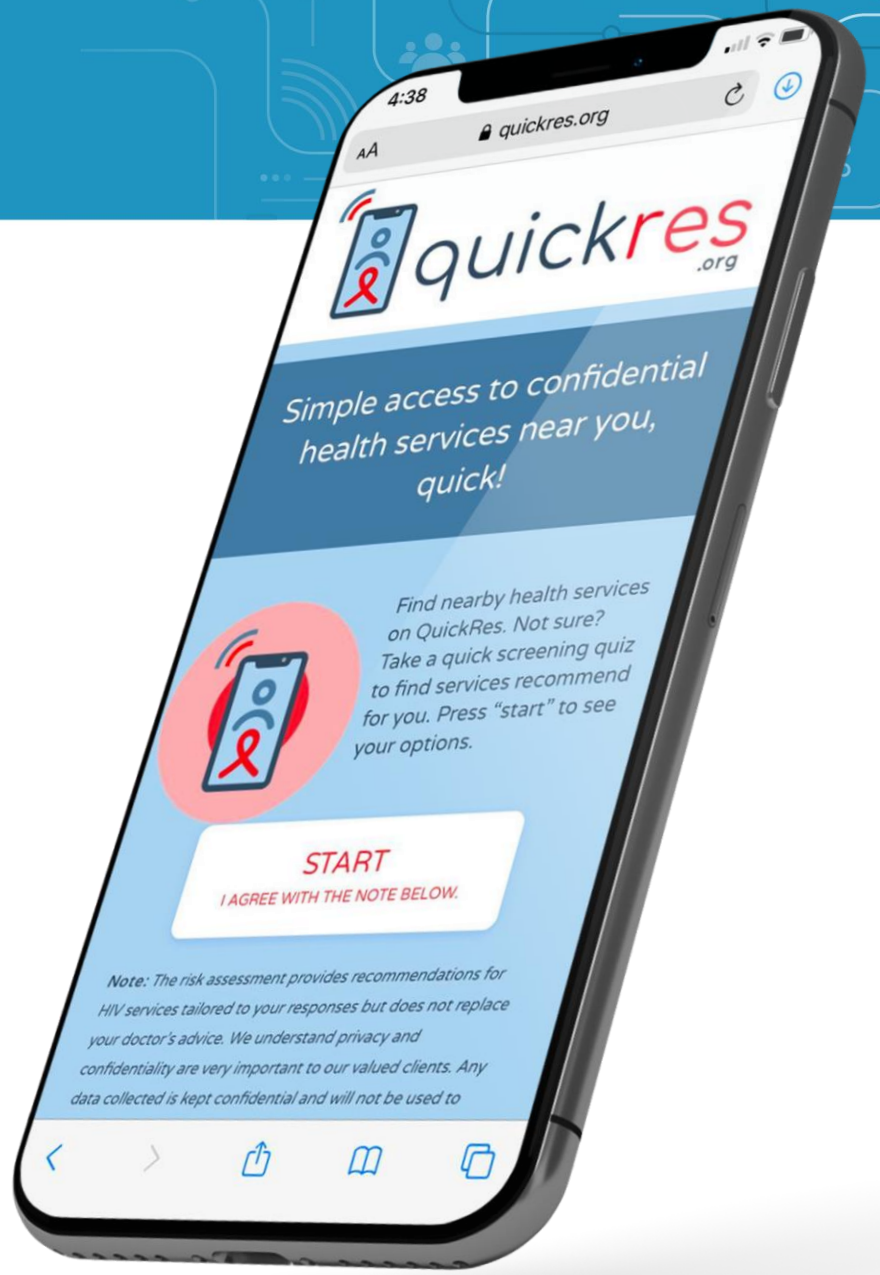
EpiC Meeting Targets and Maintaining Epidemic Control

VCM model used in Namibia

- Team format: Hybrid
- Support structure: Layered
- Channel: Partially virtual

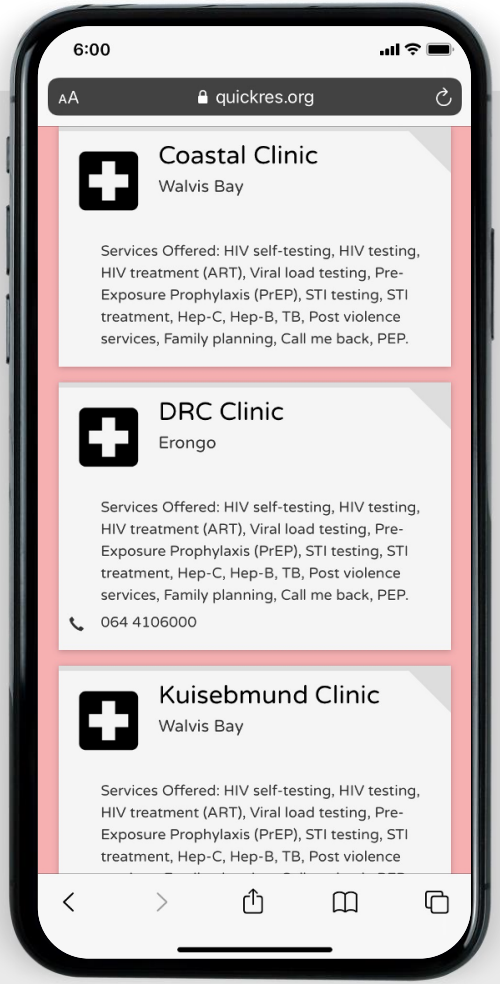


Explainer video of client-facing functions

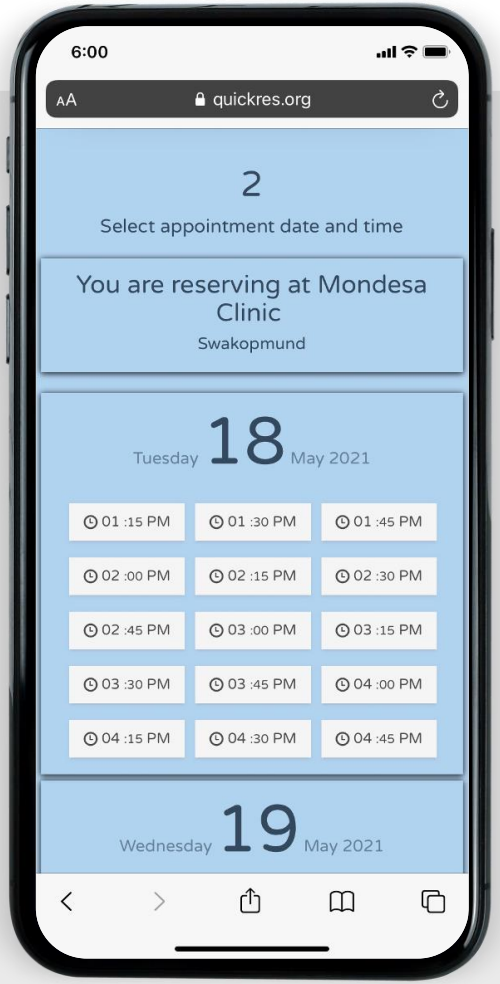
This 3-minute video describes the client-facing functions of QuickRes.

How does QuickRes work?

Select a service or get help with your decision



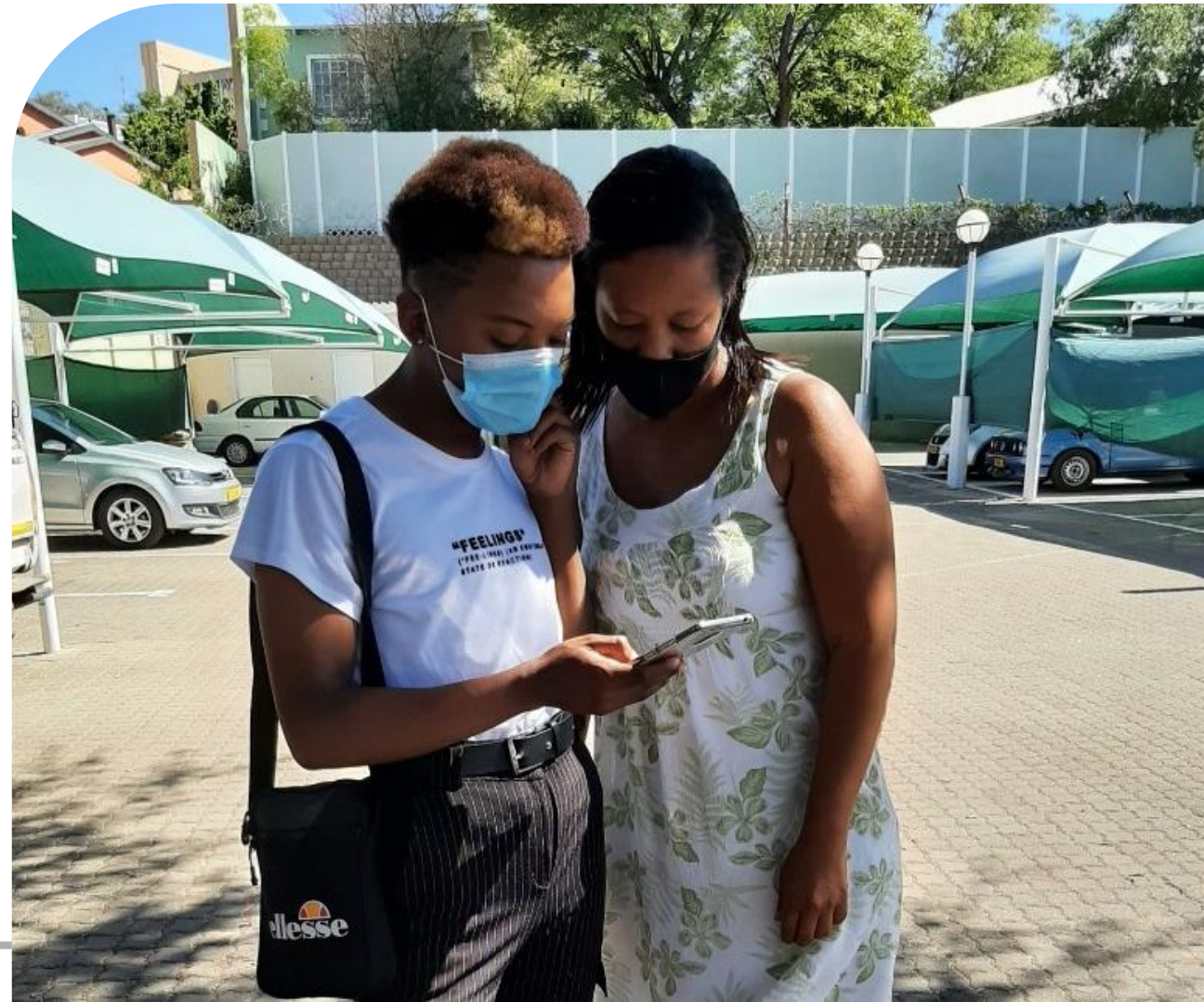
Select a nearby clinic



Select a date and time for your appointment

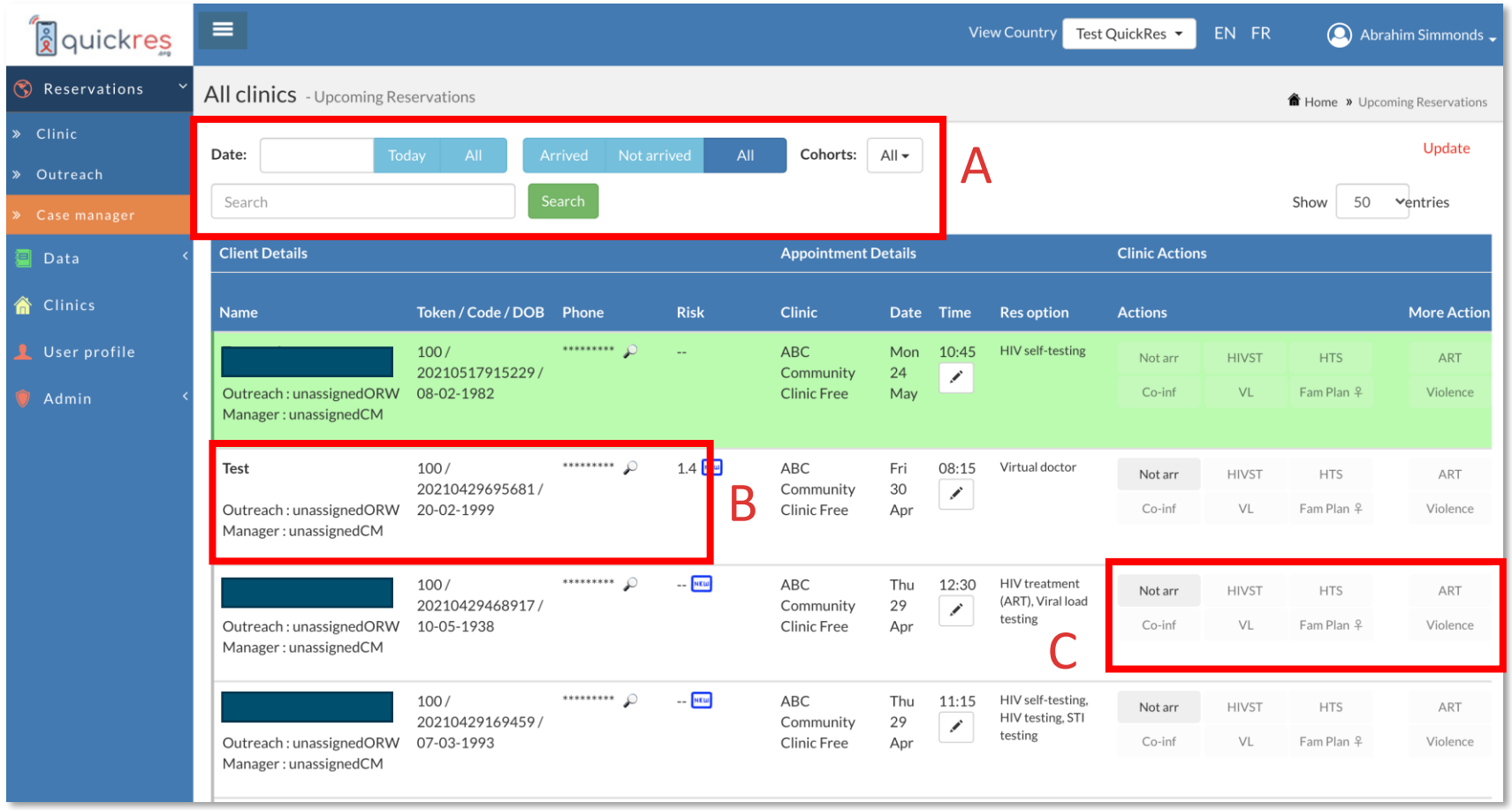
How do case managers use QuickRes?

- Support clients to book new appointments for ART and PrEP refills.
- Book routine HTS appointments for PrEP cohorts.
- Register service uptake and decentralized service referrals.
- Review upcoming appointments and give reminders in addition to system generated reminders.
- Provide phone-based counselling and support and make useful case notes.
- Report clients' quarterly ART/PrEP status.



Going Online

Case Management Functions on QuickRes

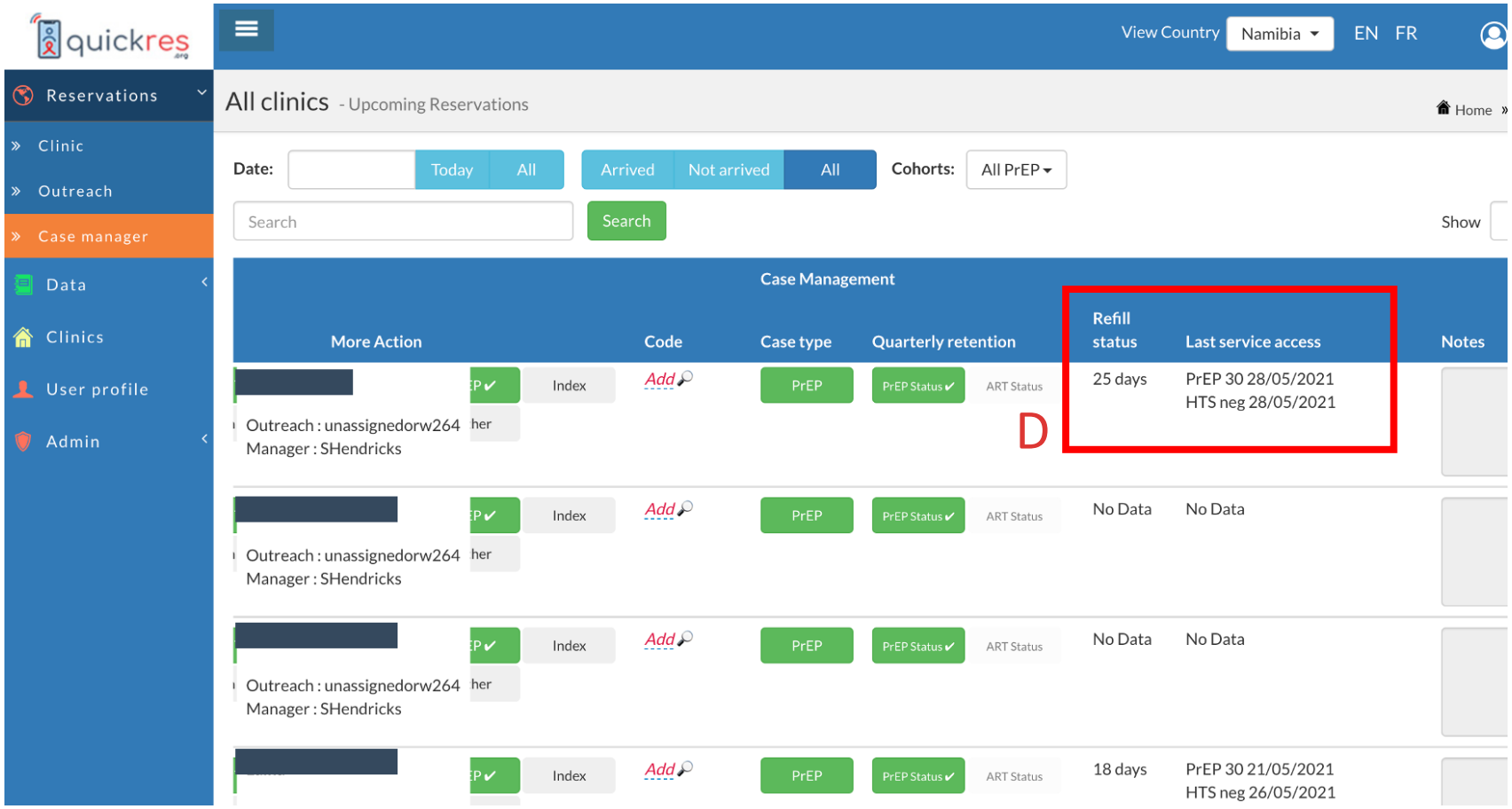


A. Filters that help CMs to navigate records for follow up and tracking.

B. CMs are automatically assigned based on Token used. Simple look-up also available.

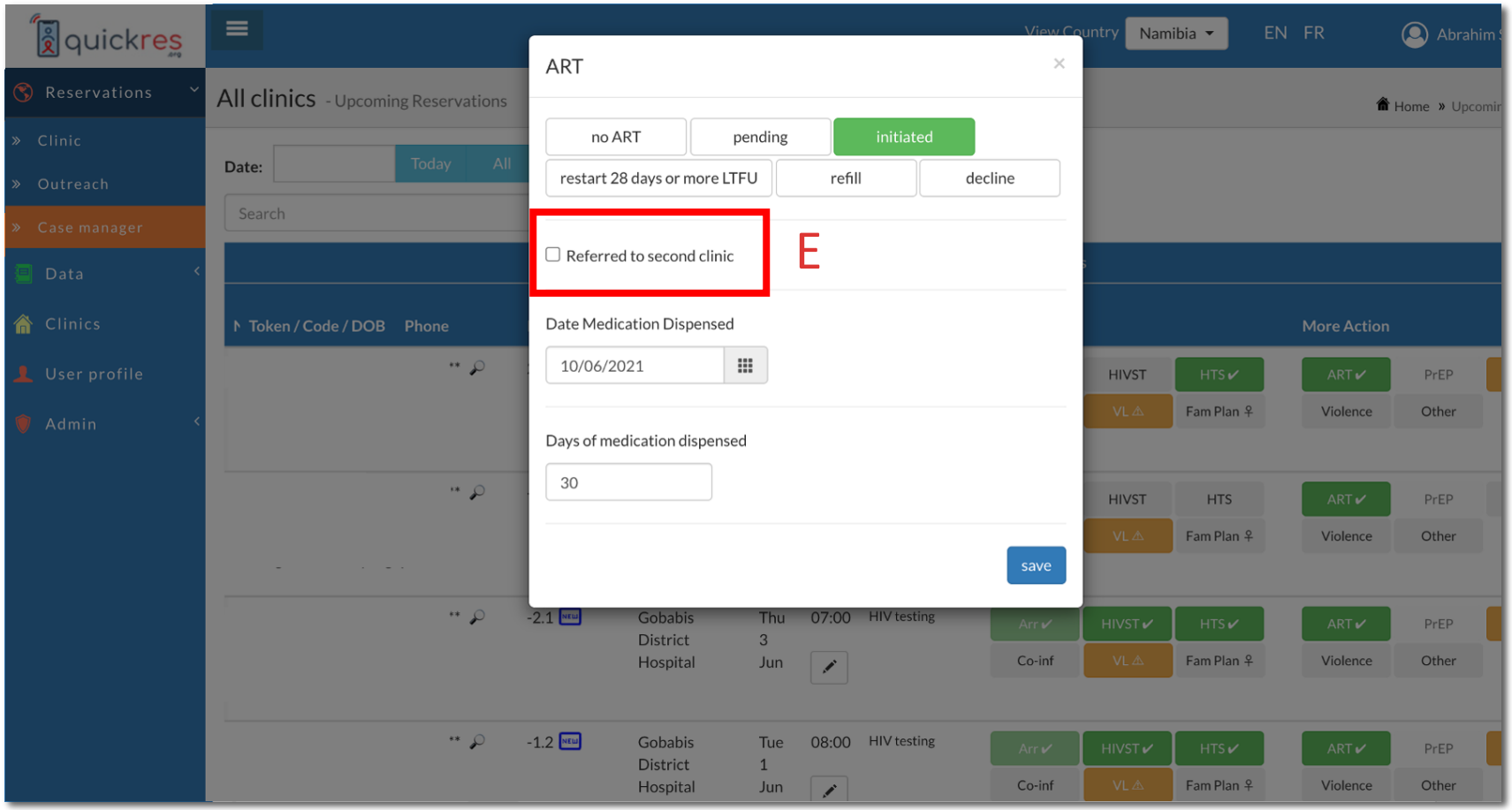
C. Service buttons can be edited by some CMs and clinic staff.

Case Management Functions on QuickRes



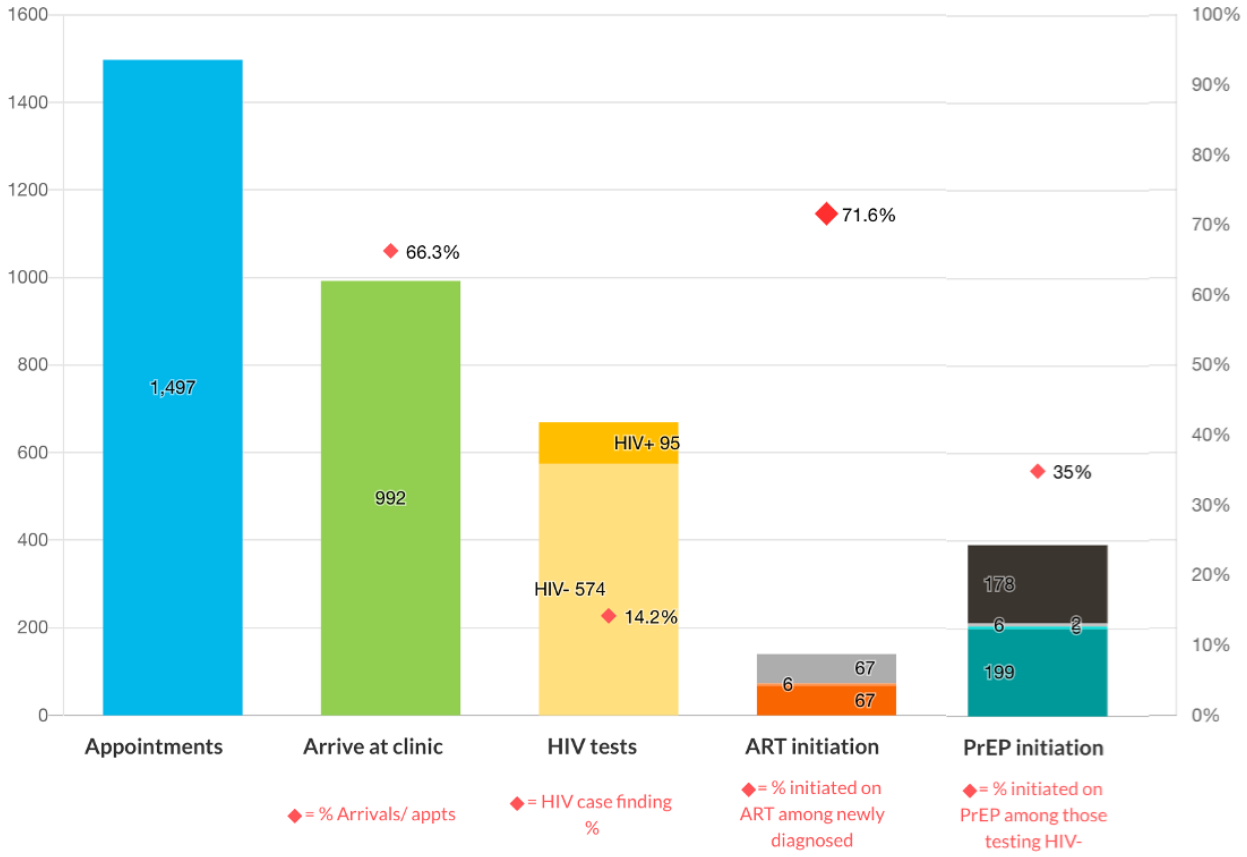
D. CMs can track refill status and last service access.

Case Management Functions on QuickRes



E. Referral sites can indicate uptake of PrEP and ART and other services.

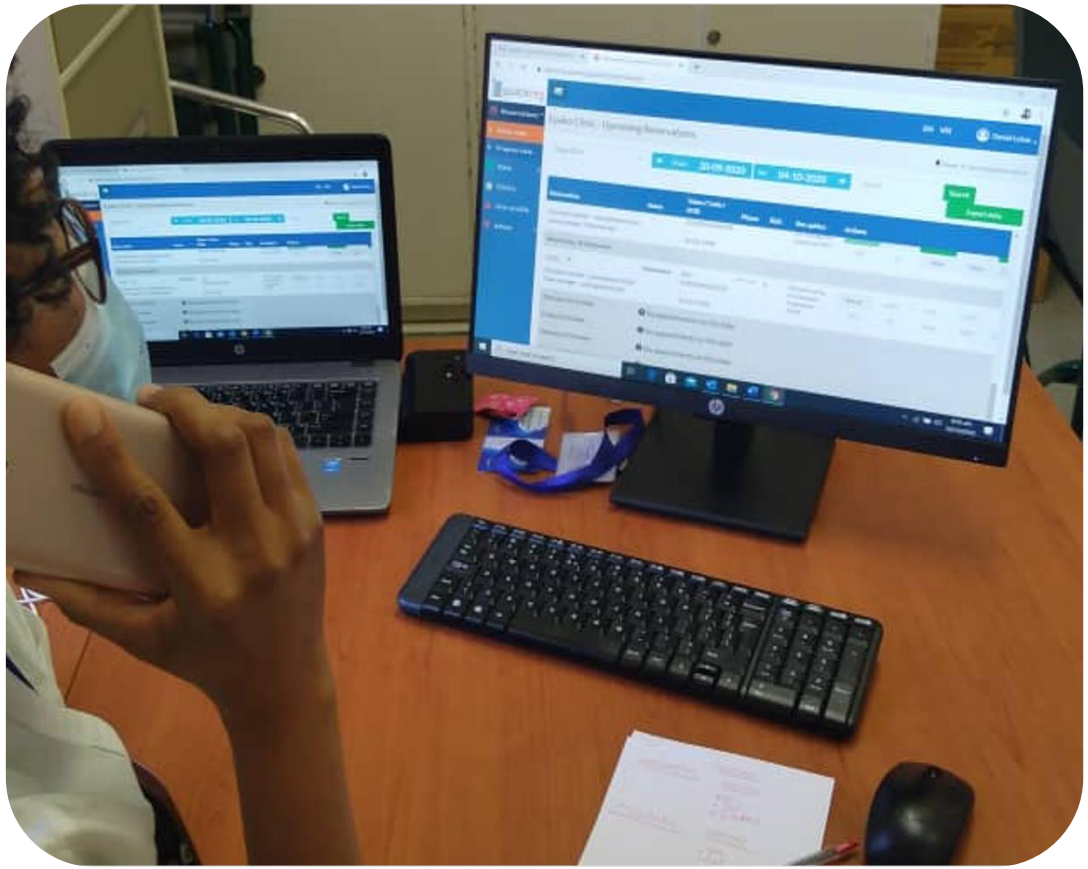
Results: Jan 1- Mar 31, 2021



- More than 50 clinics have been added across 10 districts.
- 37 Case managers have been trained to use QuickRes for VCM.

Lessons

- At the start of rollout, Case Managers need dedicated technical support.
- In Namibia, virtually all clinic and care settings have been able to leverage the platform to meet their needs.
- Having routine meetings with all QuickRes users help to quickly iron out issues with the system and prevent system wide errors.
- QuickRes is constantly upgrading, incorporating lessons from the field. Case Managers continue to improve the user experience with their sharing.
- We have learned new ways to protect clients as we engage them online, e.g., avoiding suggestive language in SMS and confirming client identities before sharing information.



Thank you

HIV Case Management in a Federally Qualified Health Center: Benefits & Challenges

Kristen Jarvis, RN, BSN, MS

Manager of Medical Adherence Nursing

Whitman-Walker Health

Barriers to Care & Medication Access During Covid

- Background: Whitman-Walker Health is an LGBTQ focused health center in downtown Washington DC that was founded in 1973 and began focusing on providing HIV care in the mid-1980's.
- March 2020: We shut down to in-person appointments and turned into a covid clinic almost overnight.
    - This created many challenges for our HIV+ patients who were used to coming in for labs and medical care every 3 months.
        - Challenging for all patients who needed to access medications (diabetes medications, insulin, hormones, etc)
    - This quick turnaround forced us to develop new ideas for innovative HIV care and medication-adherence moving forward.
    - Clients were unable to see providers in person, so had to switch to telehealth appointments (video or by phone call)

Ways our Nurse Care Managers (NCM's) Adapted

Prior to covid, many patients needed the nurses to assist them with their HIV regimens and pillboxes

- Used to come into the clinic daily, weekly or monthly to meet with an NCM

Our pharmacy stopped dispensing in-person and began delivering hundreds of meds per day to clients.

- Started bubble packs for those clients on the same, stable regimen
- Medicaid allowed pharmacy to send 3 months' worth at a time, instead of the usual 30-day allowance
- NCM's began going to their homes, meeting outside on benches or filling their pillboxes and delivering through FedEx

- Started doing telehealth video appointments for diabetic teaching, newly HIV-diagnosed patients, adherence check-ins for medications
  - MedAction Plan: Would develop a medication list for the patient with pictures of the pills & how many times a day to take them & mail this out with their medications
  - If patient was able, we would have client do a video chat to assist them with filling their pillbox by phone or video

HIV RW Case Management model at WWH

- To determine follow up for our Medical Adherence HIV patients, we use a 2-point acuity scale (high or low) to develop our case management program.
    - **Automatically Higher acuity:** New positives, youth, pregnant women, multiple chronic conditions, non-adherent patients
        - Follow up for adherence work is determined by the RN based on client's ability to manage healthcare and level of support needed
            - E.g. weekly phone calls, monthly check-ins, every 3 months
        - NCMs follow clients through "actions" –a to-do list kept in the medical record to help keep our tasks organized for that patient
    - **Automatically Lower acuity**: Stable HIV patients, long-term HIV patients
        - Only come in every 3-6 months
        - Other patients placed into acuity group based on assessment by RN with input from provider based on health goals.

- During covid, HIV clients were doing labs once every 6 months and then following up with their provider 1-2x for the year (by telehealth)
    - Unless another acute issue arose and then they would be seen sooner
- If the patient was stable and adherent to their regimen, the provider would send 6 refills to pharmacy to last until client had labs again
- Clients are slowly coming back in every 3 months, but the ones who did well are continuing on their 6-month appointment intervals

Social Services to Assist with Technology

- **Local & federal programs that were created during covid and increased patient access to telephonic and video technology**

1.) POWERON Cell phone program: During covid, our clinic partnered with POWERON, for a phone distribution program aimed at helping increase access to telehealth services for patients to see their doctors on video chat.

- 200 smart phones with video chat capabilities were donated for distribution to patients who didn't have access to the proper technology.
- This partnership helped us ensure our patients were able to still receive quality care through our health center's doctors without barriers of access to technology.

2.) May 2021 the FCC (Federal Communications Commission) began the **Emergency Broadband Benefit (EBB) program.**

- *Purpose:* To help our health center patients obtain the internet access they need to connect with virtual health care, jobs, and education.

- The US FCC set aside funding to help low-income residents subsidize their at-home internet service. The program will provide eligible District of Columbia residents with much-needed free or cheaper internet service.

The Realities of Technology in Healthcare

- **MANY of our patients fell out of care during covid**:
  - Unclear on how to use video for appointments
  - Did not make it to lab appointments
  - Had trouble ordering refills from the pharmacy so stopped taking meds
- **Difficulties with Telehealth**:
  - Challenging for our patients where English is their second language, ASL, elderly patients, patients who only had land-lines and no cell phone, no wifi, illiterate, no email address
  - Around the world, (but especially in the US) Covid highlighted the disparities in healthcare equality among minorities
    - Trouble navigating the healthcare system
    - Unable to access the technology
    - Lack of other social support services.

- We found that the patients in our RW Medical Adherence program had more controlled HIV numbers and were more engaged in care .
- This was due in part to the medication assistance they were given. The pillboxes filled for them, having bubble packs and other medications delivered to their house & working closely with an RN throughout the pandemic by phone.
- **After 1.5 years of covid, we've realized that telehealth IS here to stay**
  - Helpful for clients who did not live nearby the clinic
  - Had childcare issues
  - Had one or more jobs
  - Gives patients more freedom to come get labs

Using Different Tools to Support Patients on MMD and DDD

SIDHAS, Nigeria

Strengthening Integrated Delivery of HIV/AIDS Services
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Funded by the President's Emergency Plan for AIDS Relief through U.S. Agency for International Development

Using different tools to support patients on MMD and DDD

SIDHAS, Nigeria

Background

1. In Nigeria, the Strengthening Integrated Delivery of HIV/AIDS Services (SIDHAS) project is faced with several barriers and obstacles that affects clients access to ART. These barriers have the potential to affect the quality of care and services provided to PLWHA.

2. Challenges with Human Resource, increasing number of patients on antiretroviral therapy and advent of COVID-19 necessitated the need to provide longer medication refills (MMD) and alternative ARV Pickup points.

3. Alternative ARV Pickup points include non-supported health public/private facilities, private pharmacies, and community ART Clubs/Groups.

4. The models allows for the delivery and distribution of ART and other medications at points closer to clients and at low-volume areas of health facilities.

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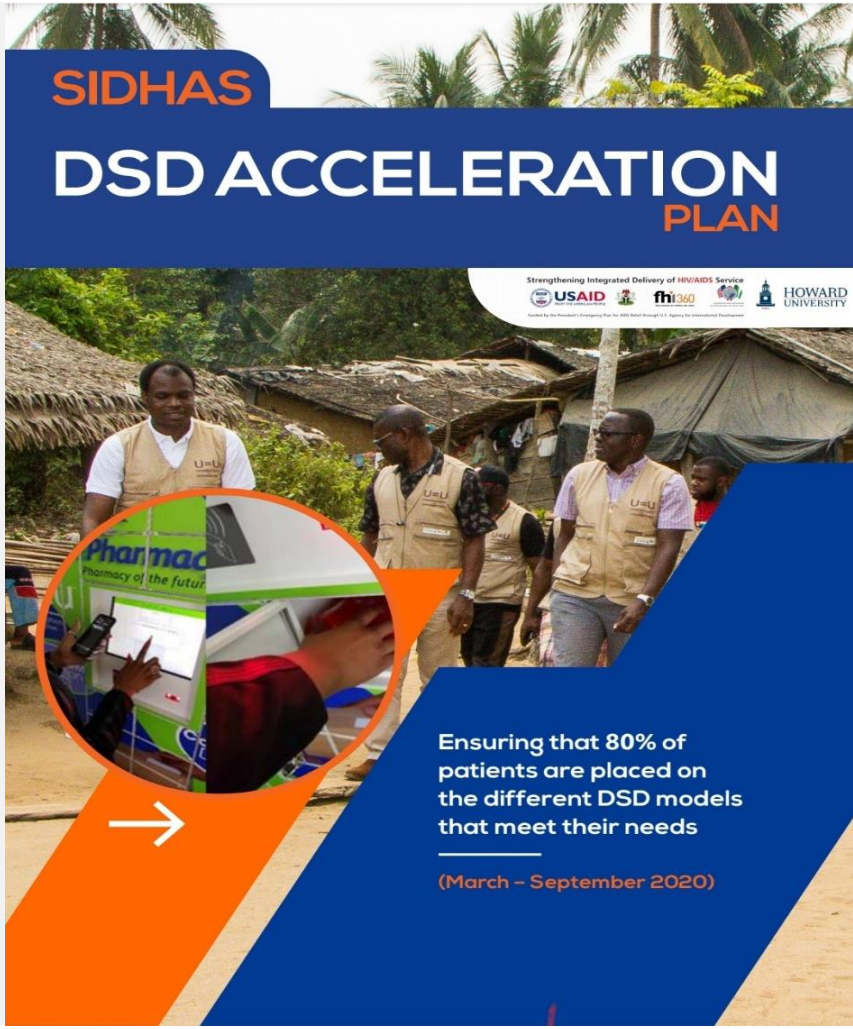
Using different tools to support patients on MMD and DDD

SIDHAS, Nigeria

In-Country Implementation

- DSD implementation in the SIDHAS project began in 2016 and very few models like CARC and CPARP were implemented. In 2018, MMD and Fast Track were also added to the above.
- These models alone could not meet the needs of all the patients necessitating the set up of other client centric models to expand the options available for clients.
- This led to the SIDHAS accelerated DSD plan where new models like Community ART Refill Groups (CARGs) for families (F-CARG) and members of a community (S-CARG), Decentralized ART Refill Facilities (DARF) were added, and older models scaled up.
- The SIDHAS technical team provided scale-up guidance with the DDD/DSD Acceleration Plan in March 2020.
- The Acceleration Plan provided clear guidance for the implementation of the various models also including processes and tools for documentation.



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Using different tools to support patients on MMD and DDD

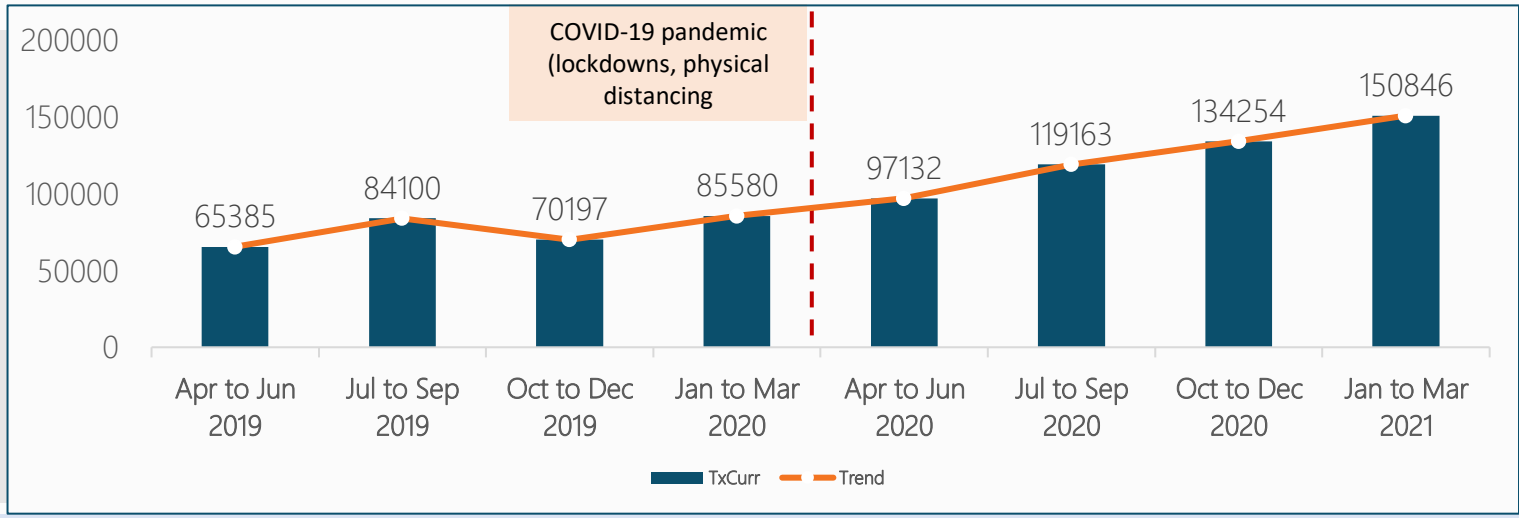
SIDHAS, Nigeria

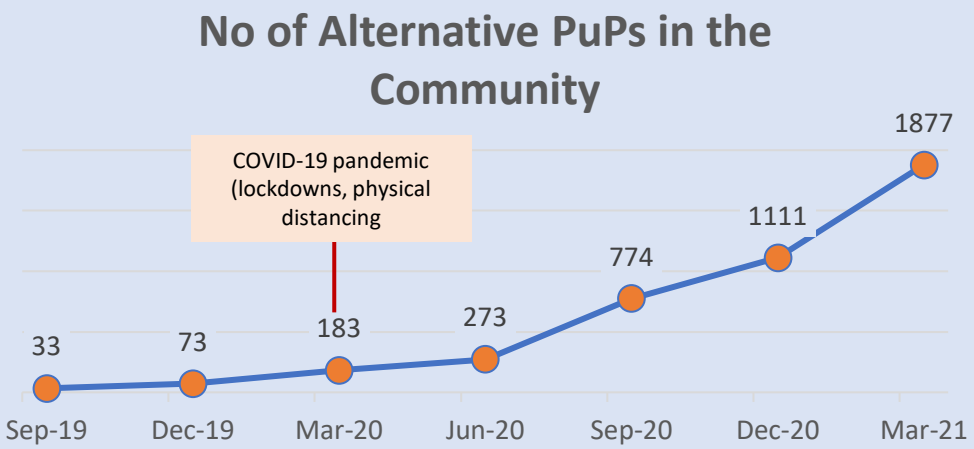
TARGETED MULTI DRUG REFILL APPROACH

ACHIEVED 99% OF ACTIVE CLIENTS ON MMD3/6

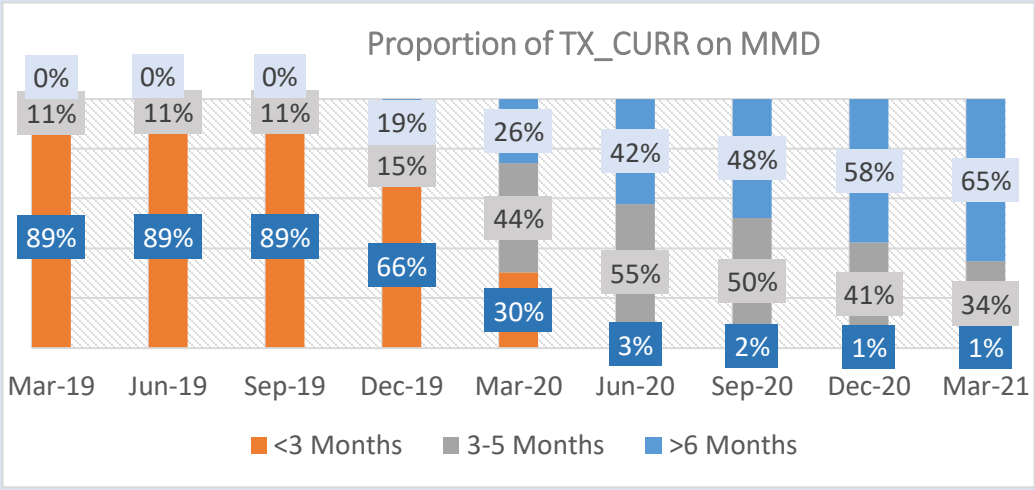
IMPROVED CONTINUUM OF CARE

- Increasing number of patients on antiretroviral therapy (ART)
- The COVID-19 pandemic required safer ways to provide services
- Need to sustain gains of epidemic control efforts
- MMD/DDD is an effective way to achieve scale
- Case Management (virtual or in-person) is key





As we grew the TX_CURR we created alternative PuPs and increased the spacing of clinical visits, prioritizing clients for MMD6 to improve their clinic experience



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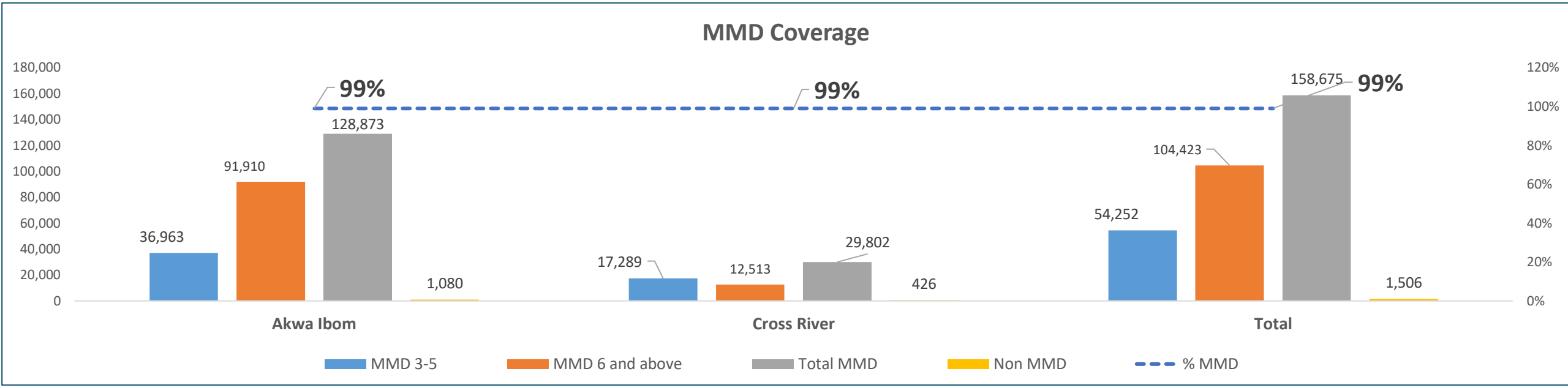
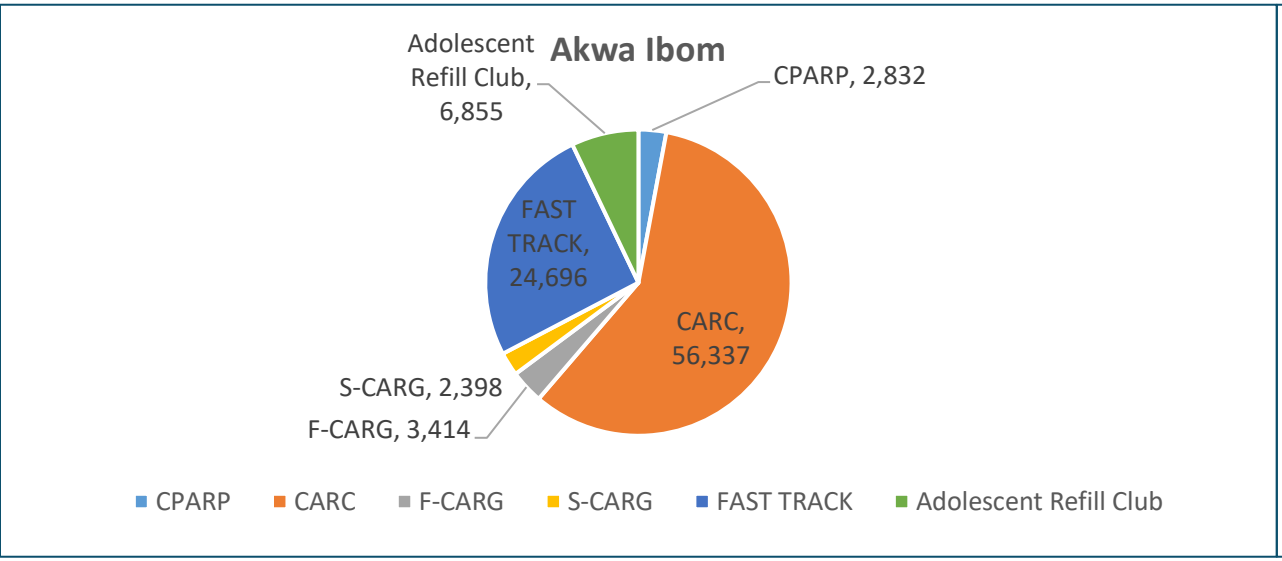
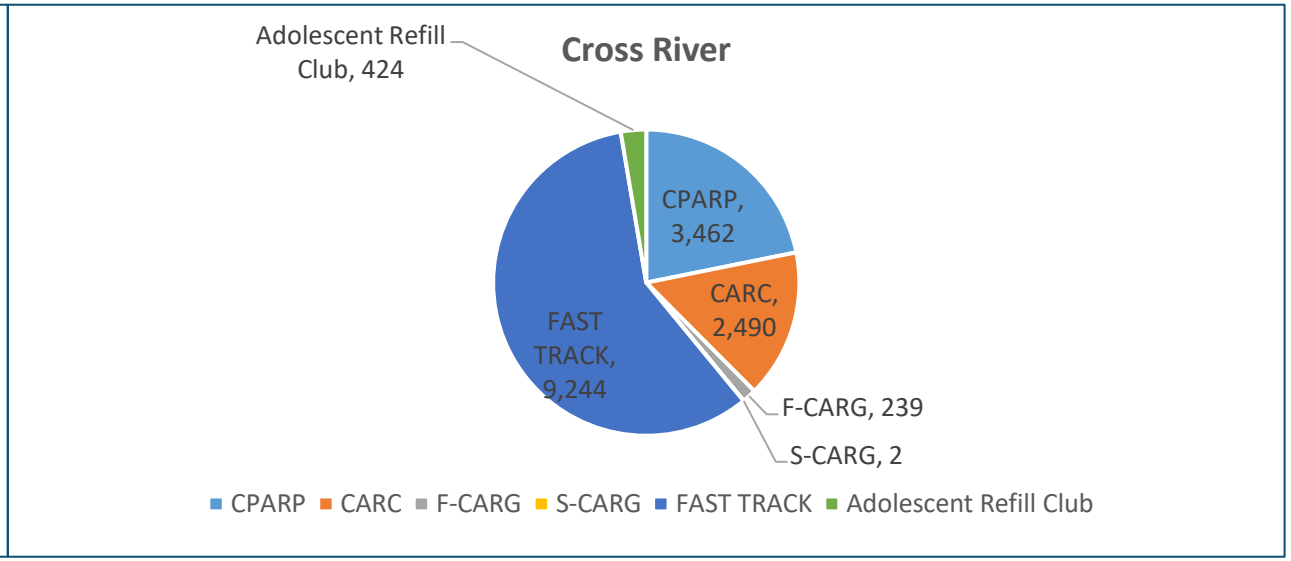


Distribution of DDD models by region

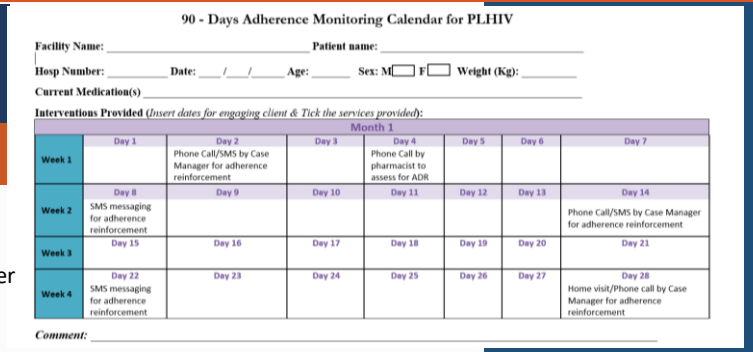




Using different tools to support patients on MMD and DDD

SIDHAS, Nigeria

Virtual adherence support for MMD patients
Call by pharmacist on Day 3 to screen for ADRs
Bi-weekly phone calls/SMS by ACM or adherence supporter



90 - Days Adherence Monitoring Calendar for PLHIV

Facility Name: _____ Patient name: _____

Hosp Number: _____ Date: ___/___/___ Age: _____ Sex: M☐ F☐ Weight (Kg): _____

Current Medication(s) _____

Interventions Provided (*Insert dates for engaging client & Tick the services provided*):

	Month 1						
Week 1	Day 1	Day 2 Phone Call/SMS by Case Manager for adherence reinforcement	Day 3	Day 4 Phone Call by pharmacist to assess for ADR	Day 5	Day 6	Day 7
Week 2	Day 8 SMS messaging for adherence reinforcement	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14 Phone Call/SMS by Case Manager for adherence reinforcement
Week 3	Day 15	Day 16	Day 17	Day 18	Day 19	Day 20	Day 21
Week 4	Day 22 SMS messaging for adherence reinforcement	Day 23	Day 24	Day 25	Day 26	Day 27	Day 28 Home visit/Phone call by Case Manager for adherence reinforcement

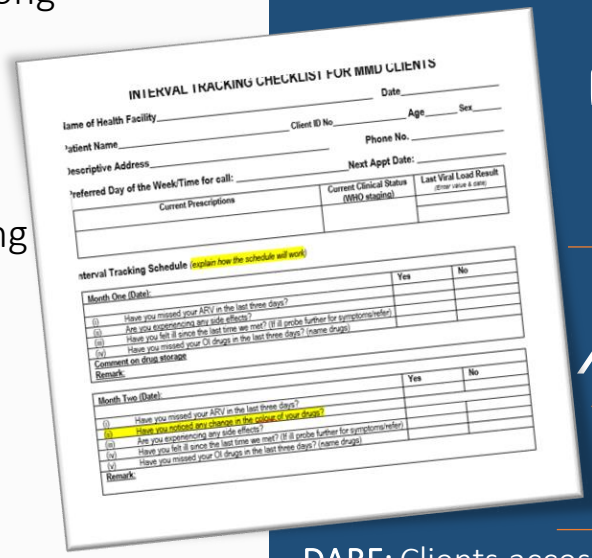
Comment: _____

90-day adherence calendar sustain adherence and improve retention while averting ADRs among clients newly initiated on MMD3.

Client Interval checklist

Sustain adherence and improve retention while averting ADRs among clients on MMD3 and MMD6 refills.

Community ART Refill



INTERVAL TRACKING CHECKLIST FOR MMD CLIENTS

lame of Health Facility _____ Date _____

atient Name _____ Client ID No. _____ Age _____ Sex _____

escriptive Address _____ Phone No. _____

referred Day of the Week/Time for call: _____ Next Appt Date: _____

Current Prescriptions	Current Clinical Status (WHO staging)	Last Viral Load Result (Enter value & date)

nterval Tracking Schedule (*explain how the schedule will work*)

Month One (Date):	Yes	No
(i) Have you missed your ARV in the last three days?		
(ii) Are you experiencing any side effects?		
(iii) Have you felt ill since the last time we met? (If ill probe further for symptoms/refer)		
(iv) Have you missed your OI drugs in the last three days? (name drugs)		
Comment on drug storage		
Remark:		

Month Two (Date):	Yes	No
(i) Have you missed your ARV in the last three days?		
(ii) Have you noticed any changes in the colour of your drugs?		
(iii) Are you experiencing any side effects?		
(iv) Have you felt ill since the last time we met? (If ill probe further for symptoms/refer)		
(v) Have you missed your OI drugs in the last three days? (name drugs)		
Remark:		

Supporting patients on DDD/MMD to remain adherent to ART

Flexi refill

This involves ensuring clients can pick up wherever they are, not just in their facility of registration, similar to what happens in the banking sector.

Remodeled fast track

This involves remodeling our fast-track services for Tier 1 sites, to serve eligible clients within five minutes of arrival to health facility.

Decentralized Drug Delivery (DDD) systems

Increase access to fast-track refill, Time-specific refill appointment, intra and inter state dispensing model, inter IP dispensing model, scale-up of CPARP (fee paying), CPARP+ (non-fee paying).

Community Scale Up CARC & CARG

CARCs, CARGs (family centered and self-forming refill groups) with involvement of CSOs involvement

Contactless Refill system through CSO Networks and Angel clients providing courier services to remote locations.

DARF: Clients access ART services from activated SIDHAS non-supported facilities Willingness of client to be devolved and sign the informed consent form. Priority population are clients who receive home refills, from high burden facilities, clients' resident in hard-to-reach areas proximal to DARF sites. Maintains routine connection with Hub site for clinical/viral load services.

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Using different tools to support patients on MMD and DDD

SIDHAS, Nigeria

STRATEGIES TO A SUSTAINABLE DECENTRALIZED CARE

01 Regular adherence monitoring and follow up

02 Client Feedback System set up at Drug pick up points

03 Scheduling appointments in batches to leverage on household members ART refills and Viral Load sample collection

04 Educating the Client on Self Care Management processes to bridge gaps and improve well being

05 Regular training for case mangers and focal persons involved in decentralized care.

CASE MANAGEMENT PROCESSES FOR CLIENTS ON MMD/DDD

01 Client Identification and Initiation

02 Client Eligibility for decentralized care assessment

03 Client-centered care plan developed

04 Linkage and service provision in-person and virtually

05 Monitoring implementation and adherence/Routine assessment of clients in care

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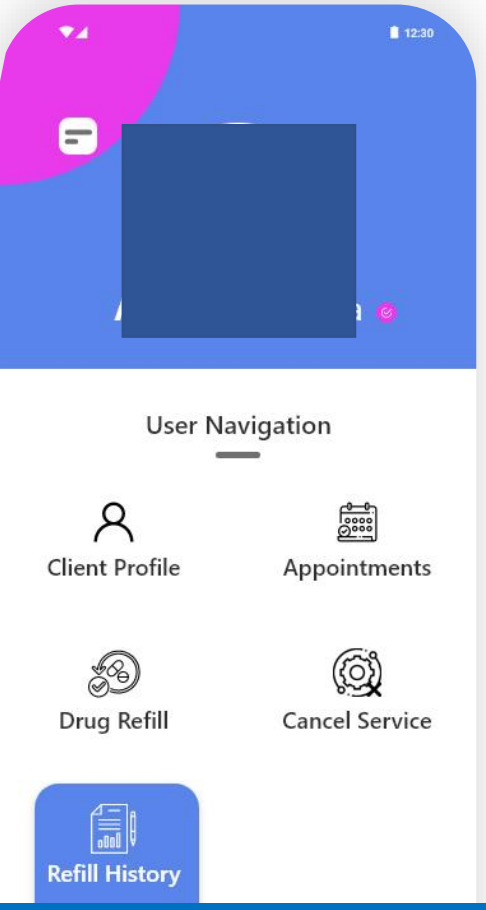
SIDHAS, Nigeria

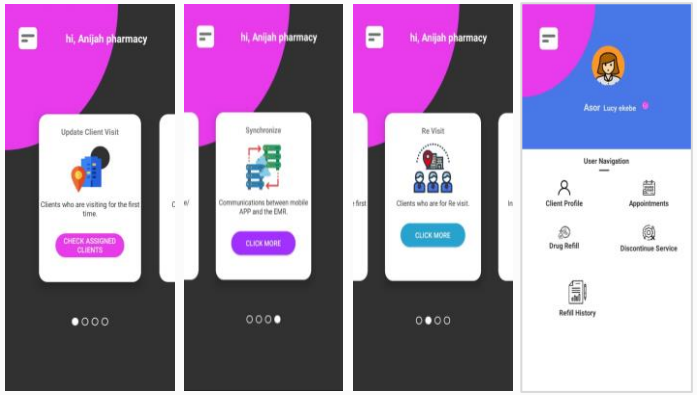
Supporting patients on MMD to remain adherent to ART?

App Functions: Remote dispensing, refill appointment scheduling, inventory management, requisition and reports



How it works – DDD App

1. From facility all clients devolved and documented in register are entered in LAMIS, with the DDD model selected correctly.
2. This data is upload to the central server (cloud) when the facility does the daily upload
3. Users will then click on the synchronization button in the DDD App and all clients devolved will download and reflect in the patient grid.
4. User fills all forms in the App after dispensing drugs to clients and upload to Server daily by clicking on synchronization module. They can download available clients devolved to them at the same time of uploading to server.
5. After uploading to server, facility LAMIS desktop also have option to download all data uploaded to server from CPs



53 Health Facilities

11 Community Pharmacies

15,867 Patients enrolled

DDD Models: CARC, S-CARG, F-CARG, CPARP, Home Delivery, DARF (Decentralized ART Refill Facility), Fast Track, ARC –Adolescent Refill Club

Online and offline platform using a smartphone, tablet or laptop
Enabled interactive bi-directional communication
Secure sharing of patient information
Capacity for automated reminders and reports
Dashboards
Inventory management- From Hub or Central store

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Using different tools to support patients on MMD and DDD

SIDHAS, Nigeria

Virtual/Tele Case Management support is critical to achieving programmatic & individual client outcomes

How it works

INTERVAL TRACKING CHECKLIST FOR MMD CLIENTS

Name of Health Facility_____ Date_____

Patient Name_____ Client ID No_____ Age_____ Sex_____

Descriptive Address_____ Phone No._____

Preferred Day of the Week/Time for call: _____Next Appt Date: _____

Current Prescriptions	Current Clinical Status (WHO staging)	Last Viral Load Result (Enter value & date)

Interval Tracking Schedule *(explain how the schedule will work)*

Month One (Date):		Yes	No
(i)	Have you missed your ARV in the last three days?		
(ii)	Are you experiencing any side effects?		
(iii)	Have you felt ill since the last time we met? (If ill probe further for symptoms/refer)		
(iv)	Have you missed your OI drugs in the last three days? (name drugs)		
Comment on drug storage Remark:			

Month Two (Date):		Yes	No
(i)	Have you missed your ARV in the last three days?		
(ii)	Have you noticed any change in the colour of your drugs?		
(iii)	Are you experiencing any side effects?		
(iv)	Have you felt ill since the last time we met? (If ill probe further for symptoms/refer)		
(v)	Have you missed your OI drugs in the last three days? (name drugs)		
Remark:			

1/2

MMD 3/6 patients are placed in tracking pool for regular contact
Use of the monthly phone discussion checklist assessing for adherence to ART/OI prophylaxis and ADRs.

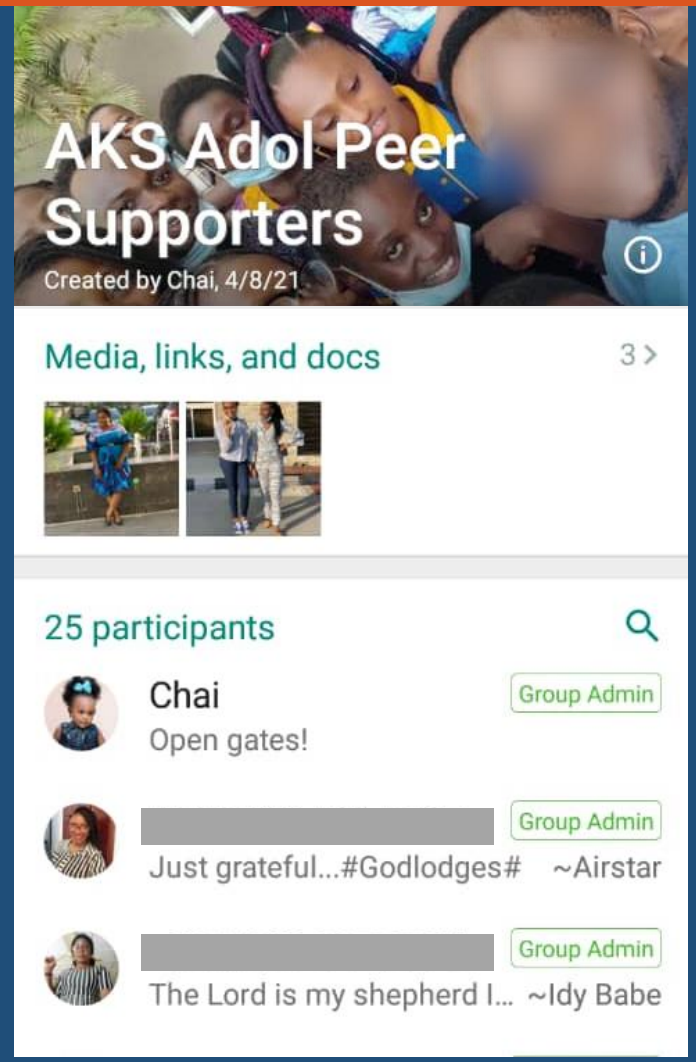
3/4

Phone calls are made monthly in the 3- or 6-months refill period by Doctor/Nurse/pharmacist
Appointment reminder at least one week prior to the 3 or 6-month clinic visit by the ACM.

5/6

At least two (for MMD3) or three (for MMD 6) completed checklists within a 3 or 6 months MMD cycle.
Home visits by the ACM is promptly conducted for clients that are unreachable via the monthly phone calls.
Patients who cannot or whose assigned treatment supporter cannot be reached will become ineligible for MMD 3 or 6 during subsequent follow up clinic assessment visits.

24-hour service centers:
WhatsApp platform
V-DOTS
Tele-EAC



Online adherence groups were created to provide peer support to clients who tend to forget taking their medication. With the reminder coming from fellow clients, it also served as an additional motivation to continue on treatment.

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Using different tools to support patients on MMD and DDD

SIDHAS, Nigeria

Tools for monitoring MMD/DDD patients

SIDHAS

Development Register

- Documentation of all devolvement to DSD and DDDs
- Patient's consent form

1

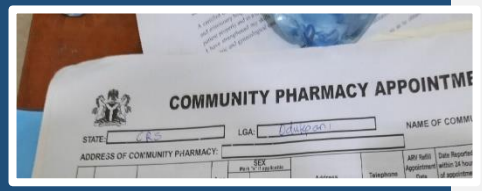
Fast-Track Access Card

- One-way ticket to access fast-track services

ADR Monitoring tool

- Documenting ADRs and interventions carried out

2



CPARP Appointment Diary

- Scheduling and tracking appointments of clients devolved to community pharmacies

3

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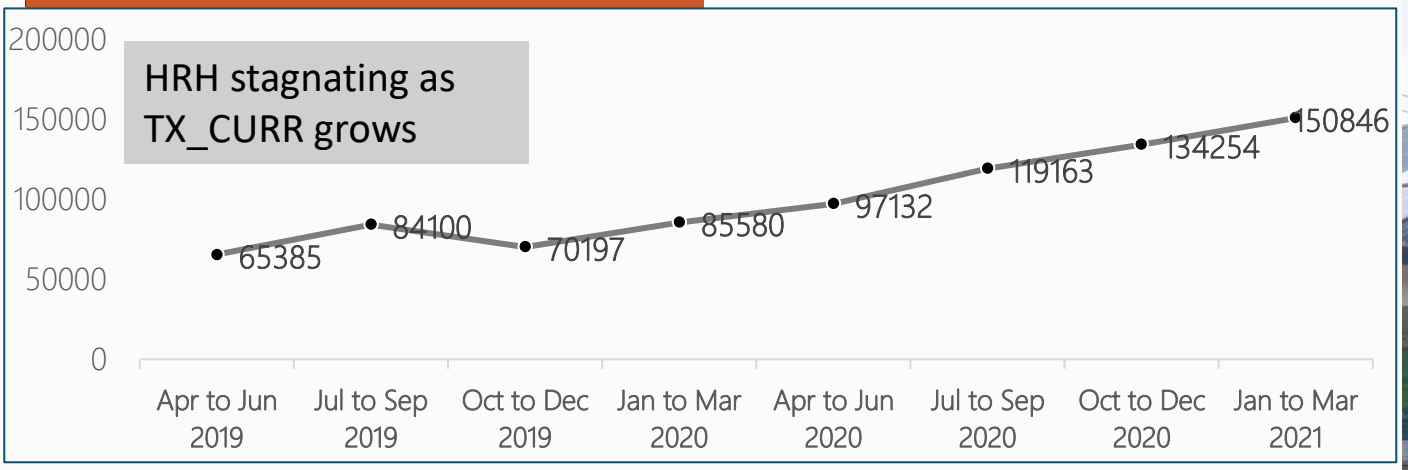
Impact/potential of DDD/MMD to alleviate HRH challenges at health facilities



What Difference Does DDD/MMD make?

The Problem	The Result
1/2 Regular Hospital Visits Long queues and extended waiting times	**7/8** Fewer Clinic Visits Faster/Convenient services at alternative pick-up points
3/4 Far distance from ARV Clinics Patients aren't allowed to have someone collect their medications	**9/10** Medication refills closer to home Group pick-ups with CARGs
5/6 Unavailability of adequate HR to attend to patients COVID-19	**11/12** Reduced stress impact on HRH Decongestion of clinics in compliance with COVID-19 Guidelines

PHC Enwang has **12,526** clients on treatment but is rarely overcrowded

A typical clinic day at PHC Enwang

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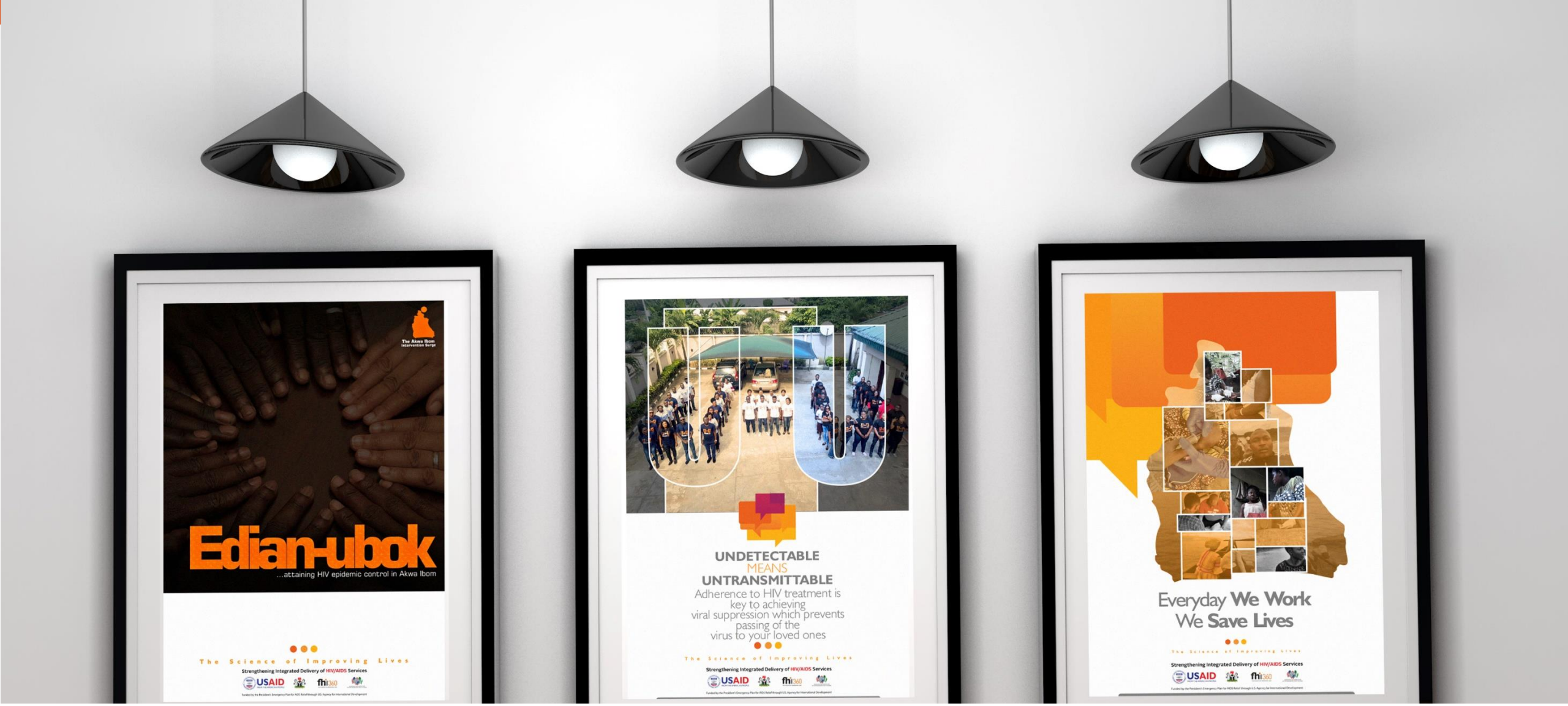

THANK YOU

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Q&A

Upcoming Session

Progress made but still a lot more to do– understanding the nuances and final hurdles of Decentralized Drug Distribution (DDD)

Thursday, July 15, 2021

7:00 AM-8:30 AM ETD | 13:00-14:30 EAT

Register here: https://bit.ly/3cJF6RU