# Differentiated Care

## It’s time to *deliver* differently.

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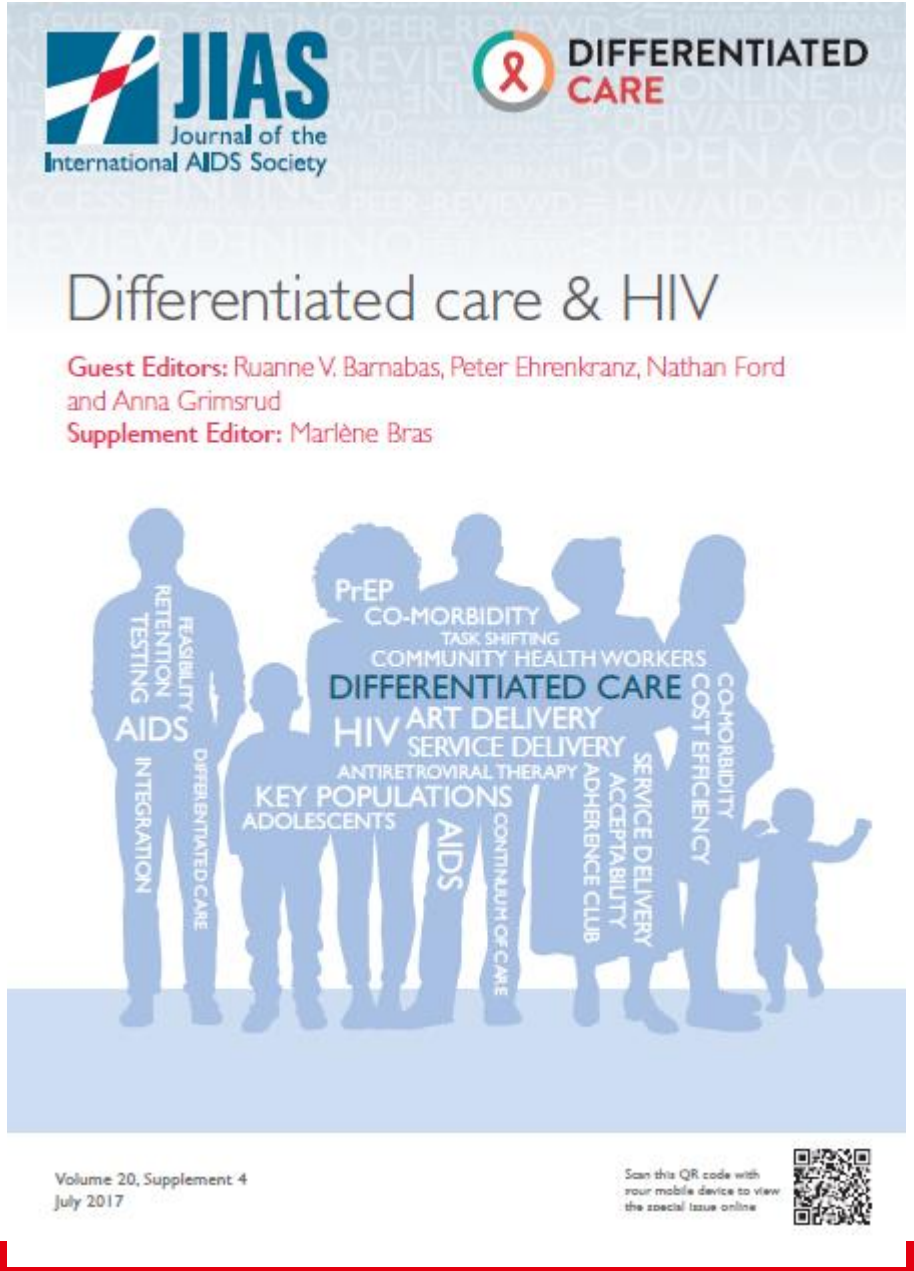
# Differentiated care

is a **client-centred** approach that simplifies and adapts HIV services **across the cascade** to reflect the preferences and expectations of various groups of people living with HIV (PLHIV) while **reducing unnecessary burdens on the health system**.

# Core principles of differentiated care

- Client-centred care
- Health system efficiency and adapt away from a “one-size-fits-all” approach

Differentiated care supports shifting resources to clients who are the most in need by supporting stable clients to have fewer and less intense interactions with the health system.



"It's not about everybody getting the same thing. It's about everybody getting what they need in order to improve the quality of their situation." Cynthia Silvia Parker, Interaction Institute for Social Change

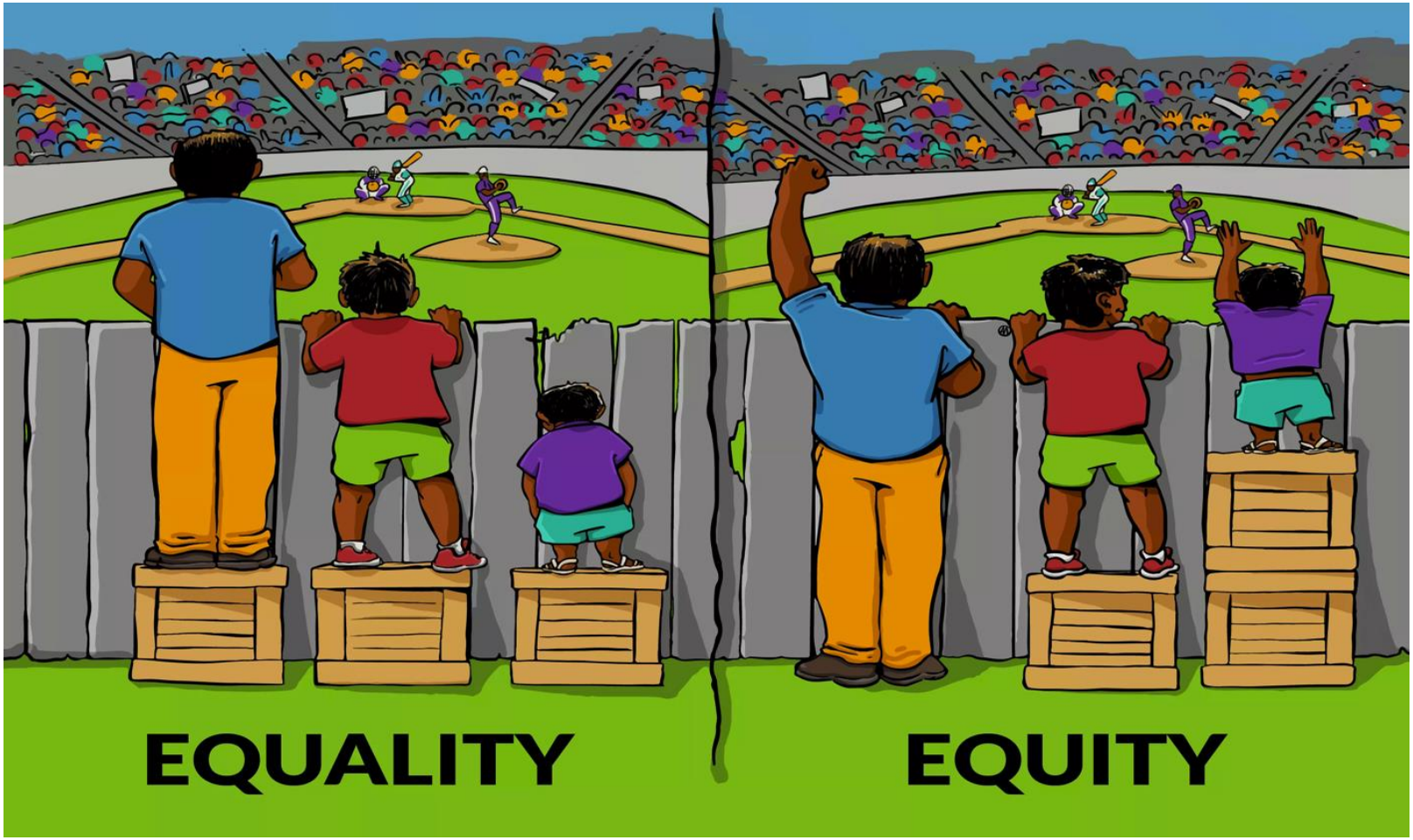
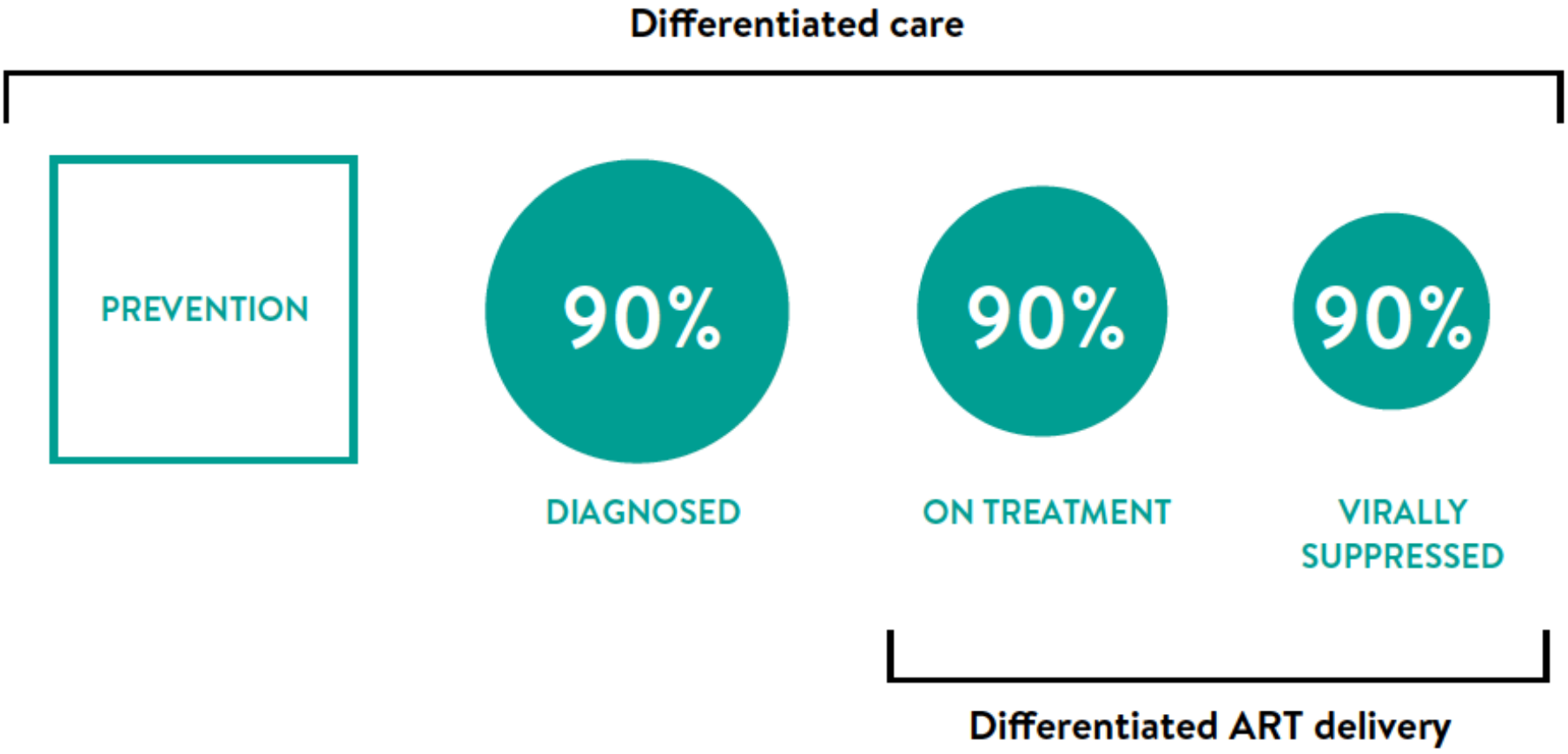
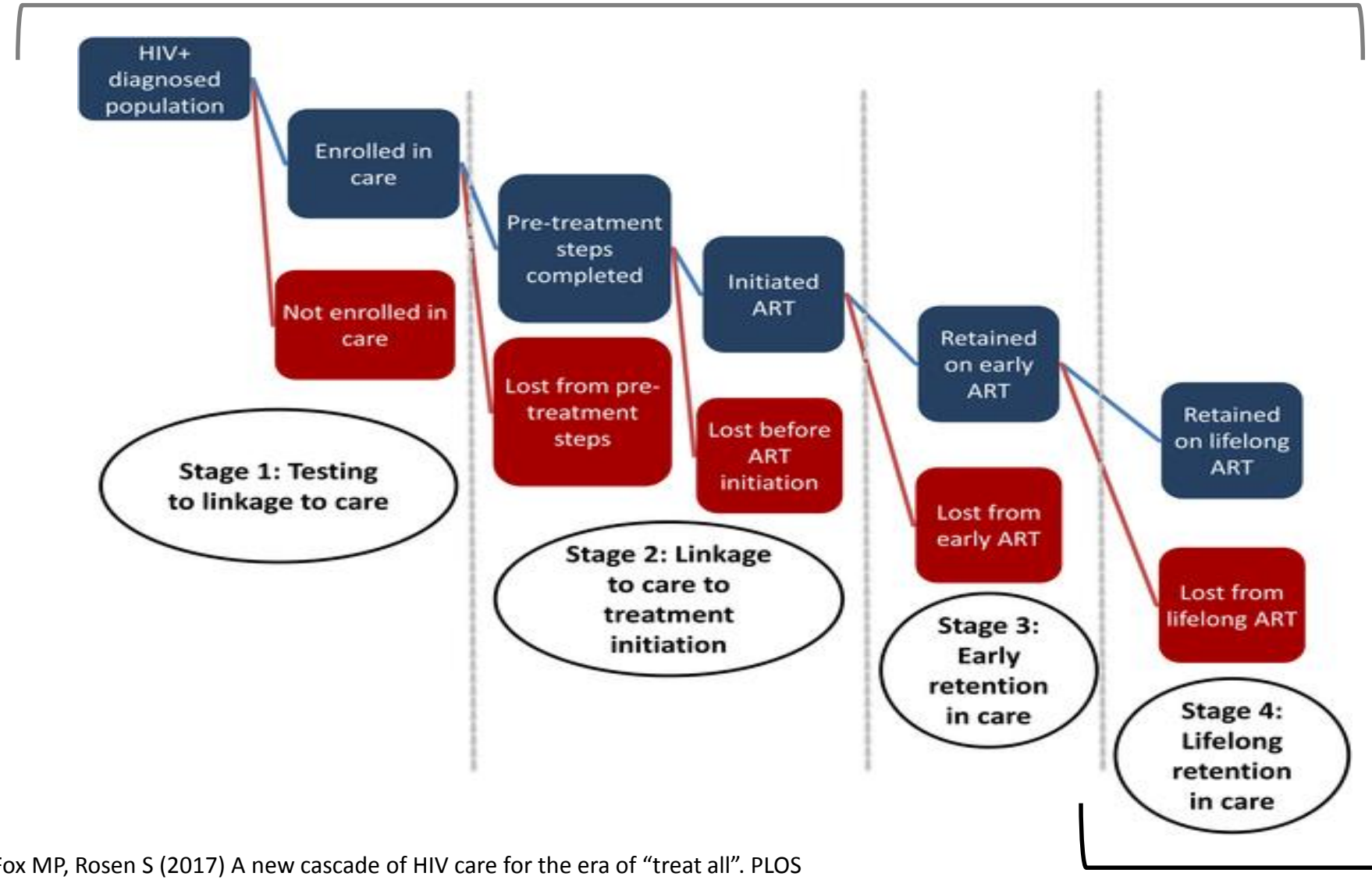



Image : "Interaction Institute for Social Change | Artist: Angus Maguire."

# Differentiated care is applicable across the HIV care continuum



# Differentiated care




Fox MP, Rosen S (2017) A new cascade of HIV care for the era of "treat all". PLOS Medicine 14(4): e1002268. https://doi.org/10.1371/journal.pmed.1002268
http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1002268

# Diversity of care needs for PLHIV

**PATIENTS PRESENTING WELL**

- Initiation of ART
- Adherence and retention support

**PATIENTS PRESENTING WITH ADVANCED DISEASE**

- Initiation of ART
- Clinical package to reduce morbidity and mortality
- Opportunistic infection screening and management. TB screening, diagnosis and treatment, co-trimoxazole prophylaxis and IPT[2]

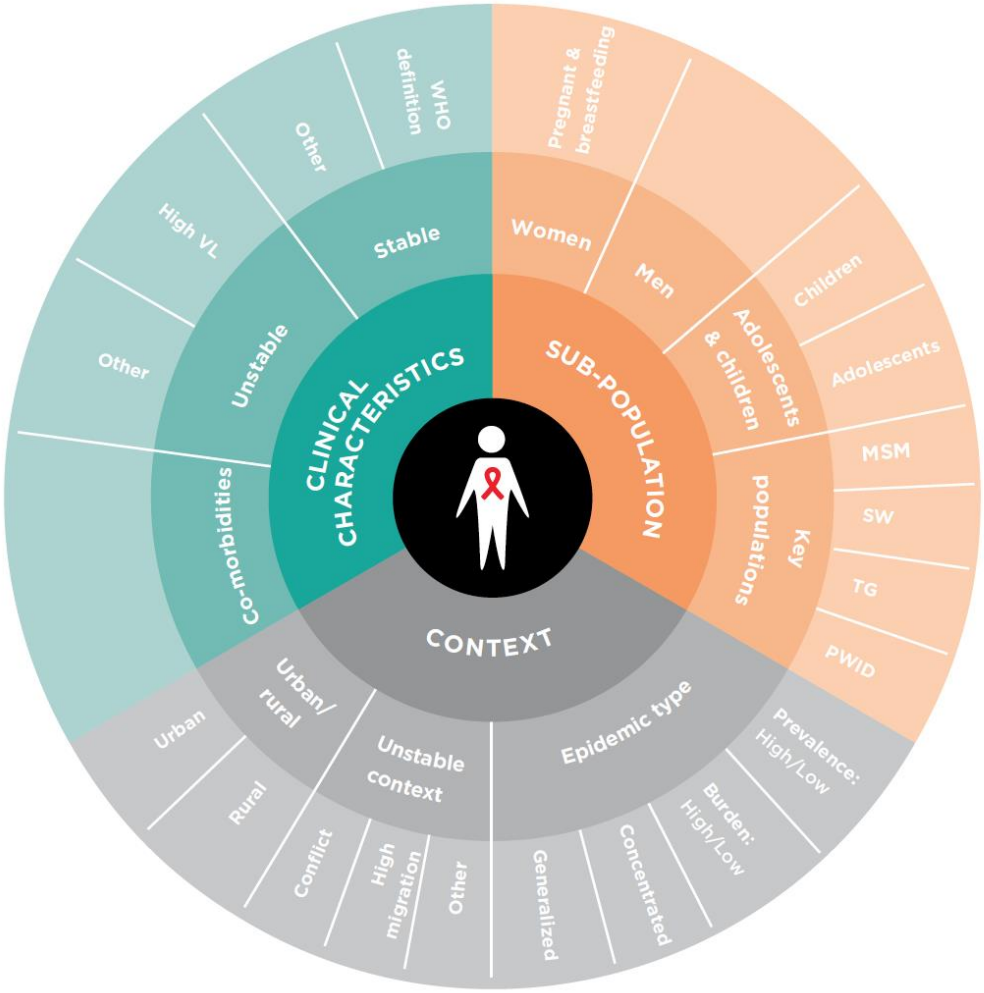
**STABLE PATIENTS**

- Differentiated care within the community (out of the facility)
- ARV delivery models

**UNSTABLE PATIENTS**

- Adherence and retention support
- Viral load testing
- Switch to second- or third-line ART if indicated
- HIV drug resistance testing
- Opportunistic infection screening and management. TB screening, diagnosis and treatment, co-trimoxazole prophylaxis and IPT[2]

# The three elements



# Myanmar Model

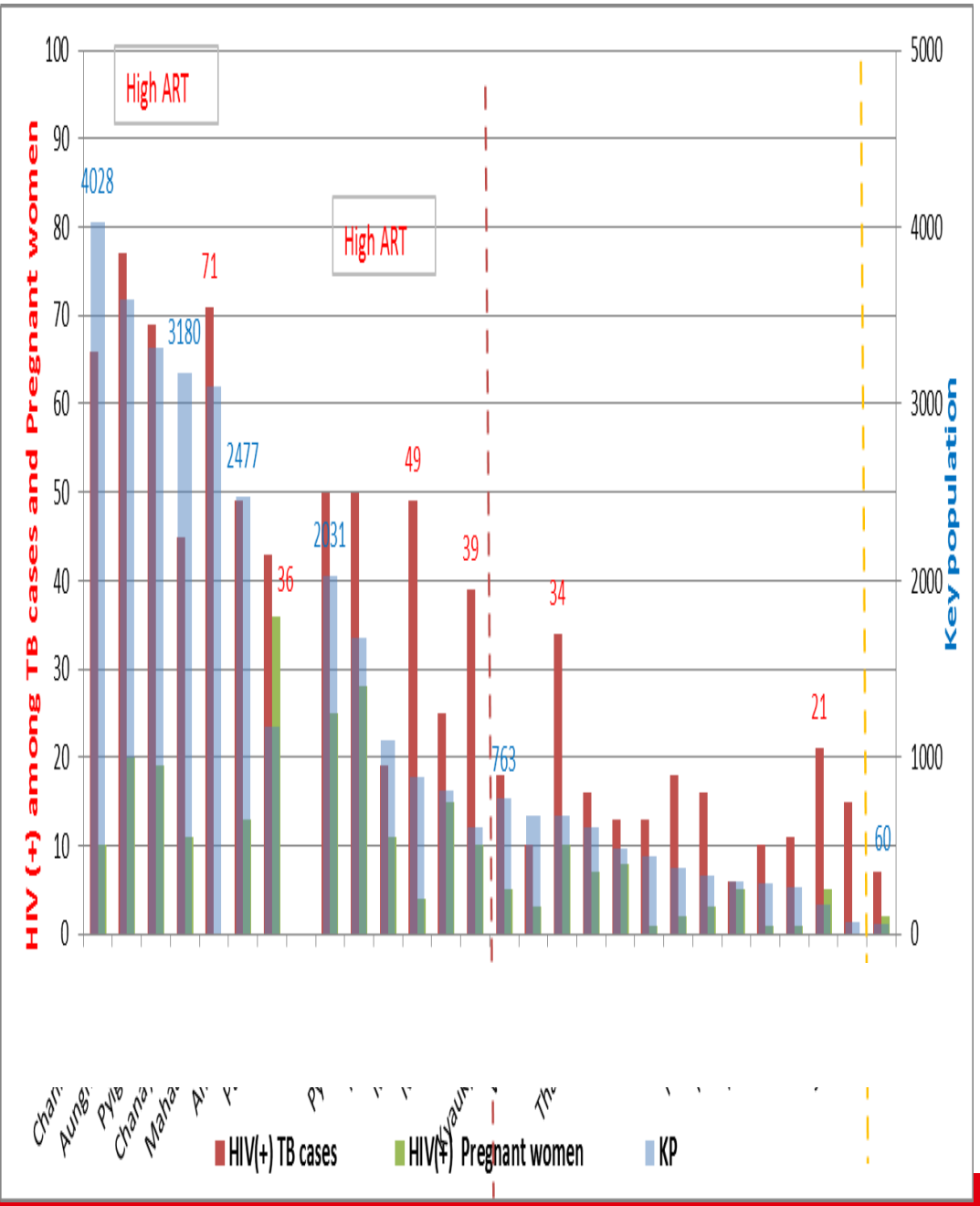
- For optimizing the response to HIV in Myanmar, an analysis of the geographical distribution of need and risk of new infections was carried out

- Townships were prioritized at central level through a process of triangulating population size estimates of priority populations, known HIV prevalence, reported data on HIV positive cases, number of people living with HIV on ART and reported data on the number of pregnant women living with HIV enrolled in PMTCT services.

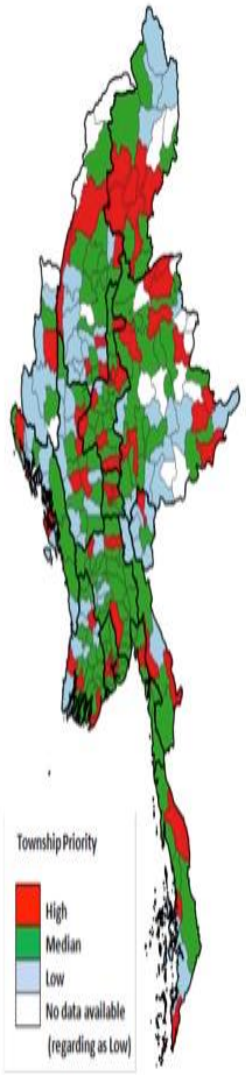
- Townships were categorized into three groups based upon HIV burden and risk of new infections: high, medium and low priority based

Table 5. Criteria used in township prioritization

| High Priority Risk/Burden | Medium Priority Risk/Burden | Low Priority Risk/Burden |
|---|---|---|
| Quantitative Criteria:<br><br>• Township having estimated key population above 1000 (or)<br><br>• Township having estimated key population in between 300 and 1000 and providing ART services for more than 200 PLHIV (or)<br><br>• Township having key population in between 300 and 1000, which has (>30) HIV-positive among TB patients or (>30) HIV-positive among pregnant women<br><br>Qualitative Criteria: border areas and mining areas having migrant population, large prison population and economic and trade zones | Quantitative Criteria:<br><br>• Estimated key population between 300 and 1000 (or)<br><br>• Estimated key population less than 300, which has ART centre (or)<br><br>• Estimated key population less than 300, which has >20 HIV-positive among TB patients or >20 HIV-positive among pregnant women<br><br>Qualitative Criteria: known areas with higher risk of HIV | Quantitative Criteria:<br><br>• Estimated key population less than 300, which has no ART centre (or) which has (<20) HIV-positive among TB patients or (<20 ) HIV-positive among pregnant women<br><br>• Inadequate information on key populations, HIV-positive among TB patients or pregnant women |




# Myanmar HIV Township Classification




| State/Region | High | Medium | Low | Total |
|---|---|---|---|---|
| Yangon | 20 | 22 | 3 | 45 |
| Mandalay | 13 | 14 | 1 | 28 |
| Sagaing | 7 | 13 | 17 | 37 |
| Kachin | 6 | 6 | 6 | 18 |
| Shan (N) | 6 | 11 | 7 | 24 |
| Naypyitaw | 5 | 3 | 0 | 8 |
| Ayarwaddy | 4 | 15 | 7 | 26 |
| Magway | 4 | 11 | 10 | 25 |
| Bago | 3 | 20 | 5 | 28 |
| Rakhine | 3 | 5 | 9 | 17 |
| Shan E | 3 | 3 | 4 | 10 |
| Thanintharyi | 3 | 5 | 2 | 10 |
| Shan (S) | 2 | 9 | 10 | 21 |
| Mon | 2 | 8 | | 10 |
| Kayin | 2 | 3 | 2 | 7 |
| Chin | 1 | 2 | 6 | 9 |
| Kayah | 1 | 1 | 5 | 7 |
| **Total** | **85** | **151** | **94** | **330** |

# Differentiated service delivery approaches based on township classification

| | High burden township | Medium burden | Low burden |
|---|---|---|---|
| Prevention | Enhanced outreach<br>KP Service Center<br>(By NGO & Public) | Outreach<br>(By Public &NGO) | Public facility-based<br>IEC |
| Testing | PITC for PW and TB<br>VCT at AIDS/STD team<br>VCT at township level<br>VCT at hospital ART site<br>Outreach HTS | PITC for PW and TB<br>VCT at township level<br>Outreach HTS | PITC for PW and TB<br>VCT at township level |
| Treatment | ART up to sub-township level<br>Integrated and collocated services for TB, MAT | ART at township level | Referral for ART |

# Public ART sites classification

## *Current*

**ART initiation**

ART initiation sites (ART centers)
- Specialist hospitals
- General hospitals
- District hospitals
- AIDS / STD team
- Some TSP hospitals *A *(not for all cases)*

**ART maintenance and PMTCT**

ART maintenance sites (DC sites)
- Township hospitals *B (having no capacity to initiate ART for all cases)
- Some AIDS/STD team (having no capacity to initiate ART for all cases)
- Some SHU, UHC and RHC

**PMTCT**

PMTCT –
- Some TSP hospitals (not having ART DC site) (Not in *A & *B)
- Some SHU, UHC and RHC

## *Proposed for 2017*

**ART initiation**

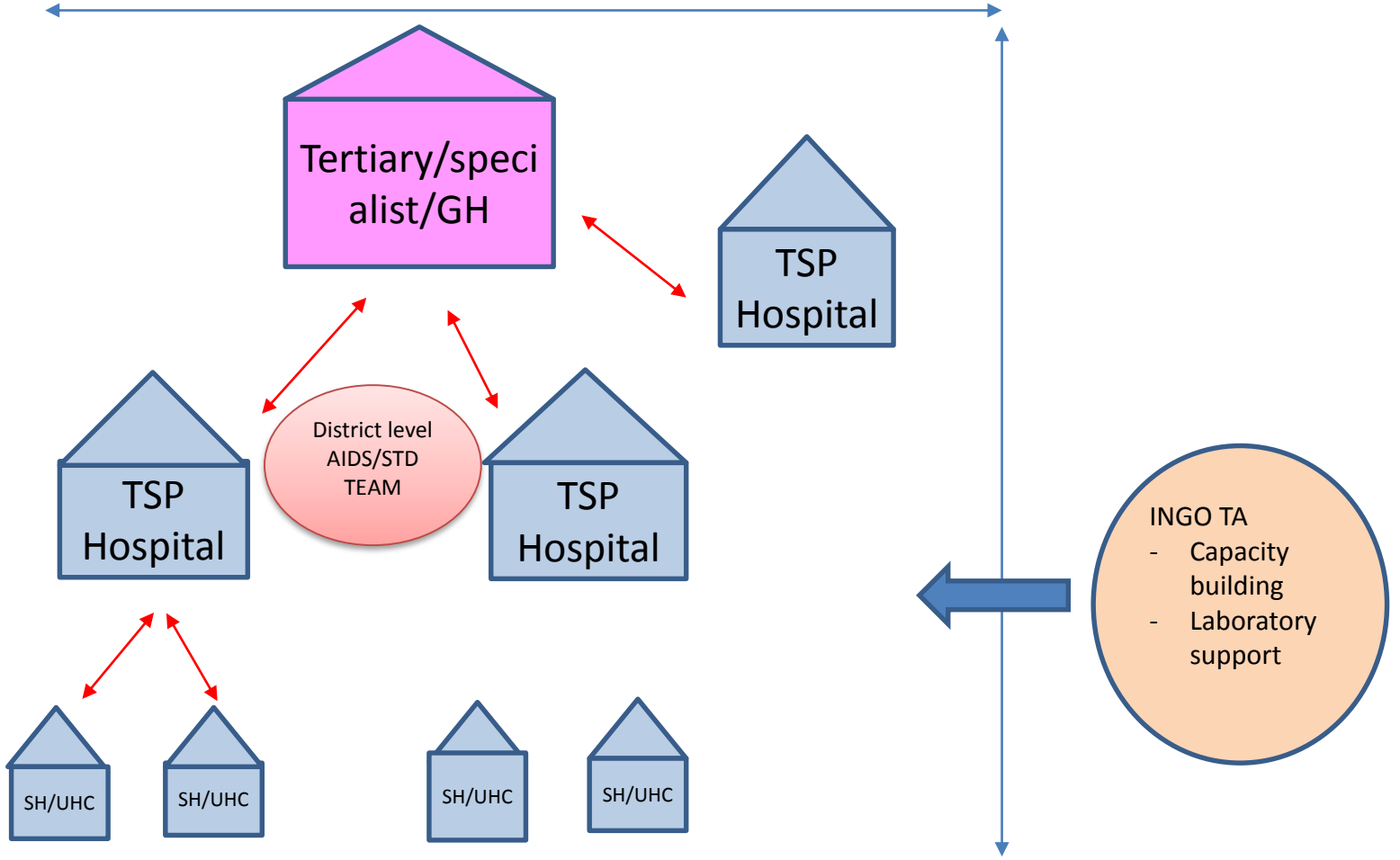
**ART maintenance**

| | |
|---|---|
| • ART initiation for **all cases** (adults & children)<br>• ART maintenance for all cases (adults & children) | • *Specialist Hospitals*<br>• *General Hospitals*<br>• *District hospitals* |
| • ART initiation focusing on **early disease and non complex cases** (adults)<br>• ART maintenance for all cases (adults) | • *AIDS/STD teams*<br>• *TSP hospitals [A]* |
| • ART initiation for **HIV+ TB cases (adults) and PW**<br>• ART maintenance for all cases (adults) | • *TSP Hospitals [B]*<br>• *UHC* |
| • ARV drugs to prevent MTCT<br>• ART maintenance for all cases (adults) | • *Sub-TSP facilities* (SHU, UHC, RHC) |
| • ARV drugs to prevent MTCT and link to ART facility | • *TSP Hospitals [C]*<br>• *Sub TSP facilities (SHU, UHC, RHC)* |

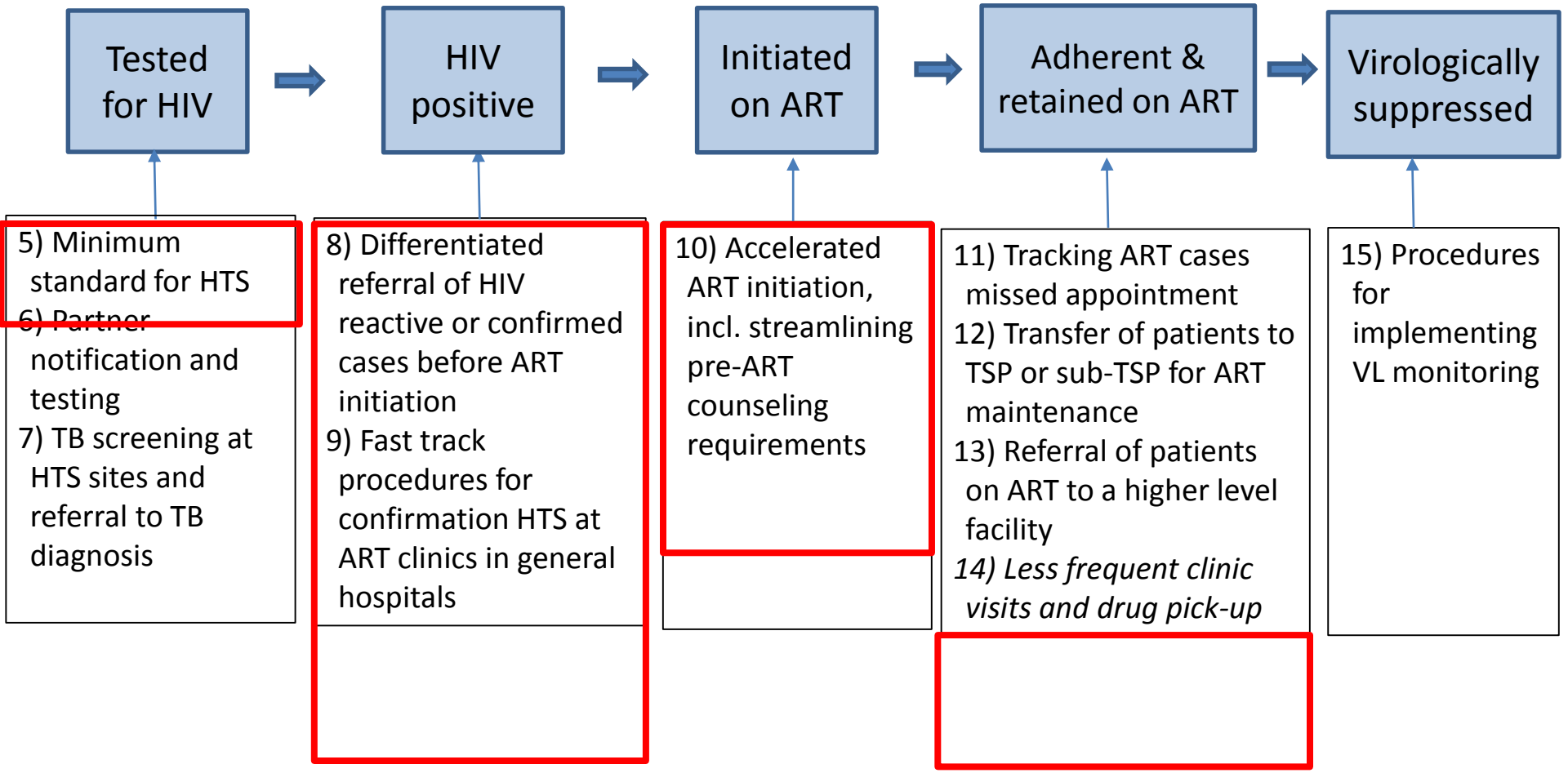
# Local networking among public facilities in each district

Networking : to establish “formal” linkages between facilities to support lower level facilities (TSP/sub TSP), and foster access to comprehensive services for PLHIV

- Referral
- Mentoring and on the job training
- Laboratory (according to context)



# Overview of the Operational Guidance along the Care Continuum




1) Classification of HTS sites and public ART sites based on differentiated care concept
2) HIV focal point at facility level to coordinate activities
3) Local networking among public facilities in each district for ART maintenance
4) Role of peers at facility level - Case management along the continuum for PLHIV from KP

Mesic A et al. *Journal of the International AIDS Society* 2017, **20(Suppl 4)**:21644
http://www.jiasociety.org/index.php/jias/article/view/21644 | http://dx.doi.org/10.7448/IAS.20.5.21644

Research article

# Implications of differentiated care for successful ART scale-up in a concentrated HIV epidemic in Yangon, Myanmar

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**Abstract**

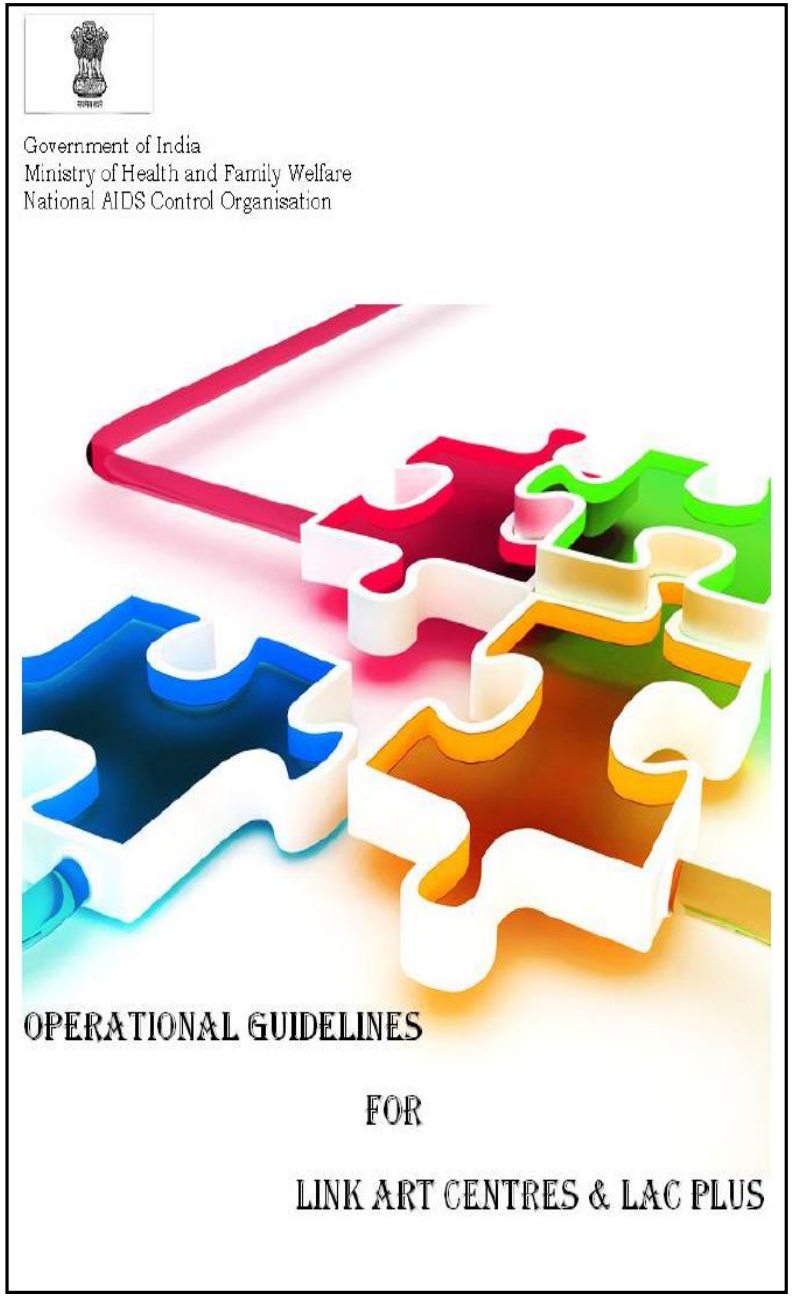
**Results**: On 31 December 2014, our programme counted 16, 272 adult patients enrolled in HIV care, of whom 80.34% were stable. The model allowed for an increase in the average number of patients one medical team could care for – from 745 patients in 2011 to 1, 627 in 2014 – and, thus, a reduction in the number of teams needed. An assessment of stable patients enrolled on ART one year after the implementation of the new model revealed excellent outcomes, aggregated for stable patients as 98.7% remaining in care, 0.4% dead, 0.8% lost to follow-up, 0.8% clinical treatment failure and 5.8% with immunological treatment failure.

**Conclusions**: Implementation of a differentiated model reduced the number of visits between stable clients and physicians, reduced the medical resources required for treatment and enabled integrated treatment of the main co-morbidities. We hope that these findings will encourage other stakeholders to implement innovative models of HIV care in Myanmar, further expediting the scale up of ART services, the decentralization of treatment and the integration of care for the main HIV co-morbidities in this context.

# Differentiated care in India

- Since 2008
- LAC concept
- Decentralization

But was a step towards towards differentiated care



# LAC

## 3. Objectives of Link ART centres/LAC plus Scheme:

1. To reduce the travel cost and travel time in accessing ART services
2. To increase the access to HIV care for the PLHIV.
3. To improve the drug adherence of patients on ART
4. To bridge the gap between counseling & testing services and Care, Support & Treatment services
5. To integrate HIV Care, Support & Treatment services with the Primary / Secondary Health Care system (NRHM).
6. To build the capacity of the health care providers at the Primary/secondary Health Care Level for Care, Support and Treatment services for sustainability of services. (Integration with NRHM)

# LAC

### 7.1.1 Referral of Patient from Nodal ART Centre to Link ART Centre

*Eligibility Criteria for "link out" of "on ART" patients from Nodal ART Centre to LAC/LAC plus:*

Patients satisfying all of the following conditions shall be linked out to Link ART centres:

1. PLHIV on ART for minimum 6 months at the Nodal ART Centre.
2. Those who have exhibited increase in CD4 count and clinical improvement after 6 months of initiating ART.
3. Do not have any active OI.
4. The patient is a resident of an area closer to the LAC than to the Nodal ART Centre
5. Those who are willing to be linked out and collect their ARV drugs from the LAC, once the above conditions are fulfilled.

# What we have In India

- Decentralized delivery at LAC
- 2 month dispensing
- But these are all facility based

# What is Planned

- Community delivery at Care and support centres and TI sites in the NSP 2017-21

# What we need to think over

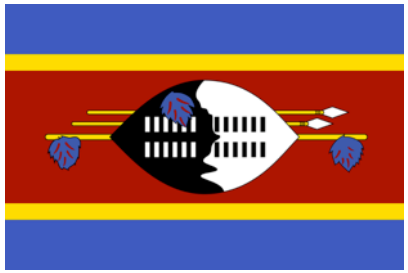
- Task shifting
- Nurse provider, pharmacy refills
- Differentiated timings-After office hours and holiday opening time

# What we need to be careful

- Adherence counselling
- Pill count
- Regularity of CD/VL
- Serious OIs
- Timely referral back
- Supply Chain issues
- SIMS

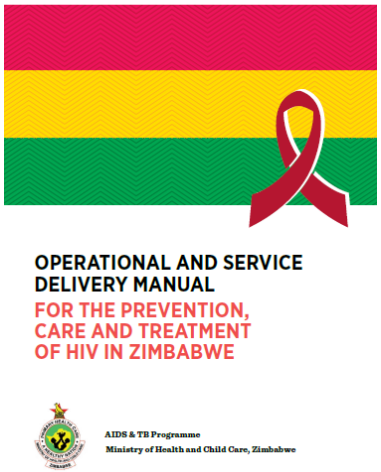
# What we need to discuss Other Models of Differentiated care

- **Client-managed groups** (known as community adherence groups or CAGs)-Mozambique
- **Healthcare worker-managed groups** (known as adherence clubs)-South Africa
- **Facility-based individual models** (known as the six monthly appointment or SMA programme)-Malawi
- **Out-of-facility individual models** (known as points de distribution communautaires or PODIs)-DRC Uganda etc



- **Zimbabwe**
- **South Africa**
- **Swaziland**
- **Kenya**

# Zimbabwe





- Integrates HIV management with service delivery models
- Differentiated across the continuum of care from HIV testing to ART delivery
- Covers all populations
- Supported by job aides

# Stable client ART delivery models

## Options for differentiated ART delivery for stable adults

**What is the challenge for the health care system?**
**What is the challenge for the clients?**
**What intervention will address these challenges?**

**Is the maximum ART refill being prescribed?**
**Are patients booked across the week?**
**Are extended pharmacy opening hours feasible?**
**Are additional options for differentiated ART delivery needed?**

| **"Fast track"** – facility- based individual refill from pharmacy | **"Club refill"** – facility-based health care worker-led group refill | **"Outreach"** – community-based individual ART delivery through mobile outreach | **"CARG"** – community-based client-led group refill | **Family member refill** |
|---|---|---|---|---|

**Whenever a patient presents with a high viral load or other indication of challenges to adherence (late appointments , mental health issues), ensure referral for enhanced adherence and clinical follow up**

# Combined building blocks + SOP

## "CARG"– Community-based, client led group refill

See page 62 OSDM

**WHEN?**

Every 3 months at agreed time in community and appointed date at facility

**WHERE?**

Community meeting is held at group members house or chosen community venue. Medication dispensed at facility or at a mobile outreach site and distributed in community

**WHO?**

Group Leader completes community form

Chosen group representative collects medication and distributes

Nurse sees group representative

**WHAT?**

ART and CTX refill only

Peer support

**Clinical review is done as a group. Annual if VL available; Twice yearly if VL not available.**

**STEP 1**

- The day before their refill date or early morning on the refill date, the community group members meet at chosen house/community venue.
- The group leader completes the CARG refill form together with the group members.
- The group chooses a representative to attend the clinic to collect the ART; if a member has a clinical problem, this member is selected. The group representative takes the completed community ART refill form from the previous visit and the one completed for this refill to the clinic.

**STEP 2**

- At the facility, use the EPMS or patient appointment diary to pull the patient care and treatment books for clients booked for CARG refill; care and treament booklets should be filed according to their group membership.
- The CARG representative is seen by the clinic nurse.

**STEP 3**

- The nurse reviews signatures from the previous refill form to ensure all clients have received their medication (this form is filed in a "CARG refill folder").
- Prescription of ART is given and documentation of any results is made on today's refill form.
- Today's community group refill form is given back to the CARG representative.
- Patient care and treatment book is filled according to the refill SOP (Page 65 and 66 of Job Aide).

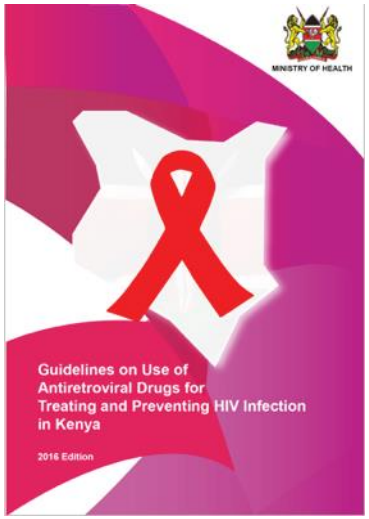
**STEP 4**

- Patient care and treatment book is sent to data clerks for entry into EPMS.
- Next refill date for the group is documented in the appointment book (can document group number rather than individual names).
- If any group representative does not collect medication as per their appointment, the standard defaulter tracing system should be triggered (Page 59 of Job Aide).

**STEP 5**

- Group representative returns to the community and distributes the ART to their group members.
- Each member signs that they have received their refill.

# Kenya

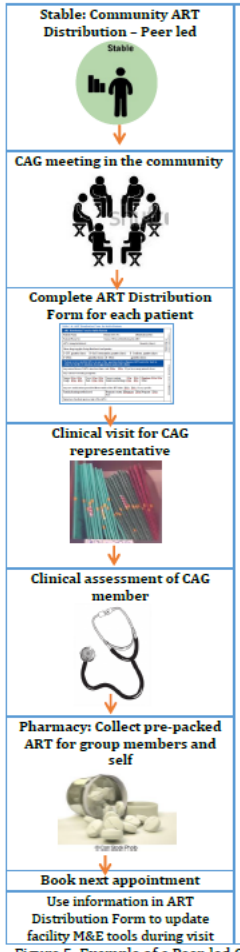




- Integrates HIV management guidelines and differentiated service delivery
- Follows WHO approach by differentiating at ART initiation (well or advanced HIV) & once on treatment (stable or unstable)
- Prescriptive ito building blocks but not service delivery models
- Accompanied operational guide
- Model SOPs including in operational guide

# Stable client building blocks

| Stable Patients | |
|---|---|
| Stable Patients (have achieved **all** of the following):<br>• On their current ART regimen for ≥ 12 months<br>• No active OIs (including TB) in the previous 6 months<br>• Adherent to scheduled clinic visits for the previous 6 months<br>• Most recent VL < 1,000 copies/ml<br>• Has completed 6 months of IPT<br>• Non-pregnant/not breastfeeding<br>• BMI ≥ 18.5<br>• Age ≥ 20 years<br>• Healthcare team does not have concerns about providing longer follow-up intervals for the patient*<br><br>**Note: some patients may not meet all eligibility criteria but could benefit from specific aspects of the stable patient package of care, such as community-based ART delivery (e.g. patients with disabilities), or less frequent follow-up (e.g. children at boarding school)** | |
| Package of Care | • Standard Package of Care (Section 4 of the 2016 ARV Guidelines)<br>• Viral load monitoring (and any other routine investigations) timed to coincide with patient appointments (e.g. the annual VL can be drawn 2-4 weeks before the patient's clinical follow-up visit so that the results are ready for discussion and decision-making during the visit)<br>• Re-assessment of criteria as a stable patient at every visit (and move to "unstable" category if any criteria not met) |
| Location of Services | • Clinical review and ART prescription from any ART service delivery point; all facility levels<br>• Fast track distribution of ART between clinical appointments, which can be facility-based or community-based |
| Focus of Counselling | • Encourage patient to continue with what is working; they are doing well<br>• Reminders that any significant life event or major change in daily routine could interfere with adherence |
| Frequency of Follow-up | • Maximum of 6 month intervals between facility-based clinical review<br>• ART can be distributed for up to 3 months (through fast track pick-up at facility or through community-based distribution) between clinical review appointments<br>• Patients on injectable contraception should be provided FP through a fast-tracked process between clinical follow-up visits; oral contraceptives and condoms should be distributed with ART<br>• Additional visits as required to address any medical or psychosocial concerns<br>• Closer follow-up based on patient preference |
| *The healthcare team can consider other criteria such as mental illness, alcohol or substance abuse, unstable comorbid conditions, inadequate support systems, etc., if they feel the patient requires closer follow-up, despite meeting the other criteria listed | |




**Categorization and Entry into the CAG**

1. Clinician uses the patient categorization checklist (Annex 6) to identify stable patients during their routine clinic visit
2. Stable patient is sensitized about ART refill system and agrees to join a CAG; patient is referred to the CAG focal person for registration and entry into a CAG
3. Appointment date is set for the next clinical review appointment within 6 months, and recorded in the Clinic Appointment Diary (all CAG members' clinic appointments are staggered over a six-month period, so that each member attends clinic once in six months, and there is at least one member coming to clinic each month)

**CAG Meetings**

4. Members meet every month at a pre-determined venue in the community
5. The group's leader facilitates a standing agenda, including completion of the second part of the ART Distribution Form, which includes a review for "danger signs"
6. ART (which was picked up from the facility by a CAG member) is distributed to each member upon completion and signing of the ART Distribution Form
7. Any member with danger signs on the ART Distribution Form or who would like to be seen at the health facility for any reason is referred to the health facility
8. A member is assigned to return the ART Distribution Forms to the facility within 7 days (including forms and drugs for any member who did not attend the CAG meeting as expected)

**Updating Tools at the Facility**

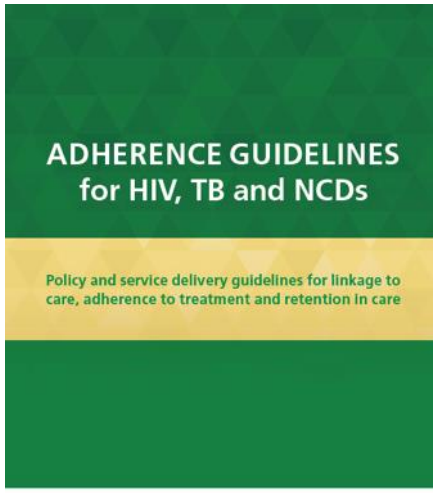
9. The ART Distribution Forms that are returned to the facility are used to update the Appointment Diary for ART Refills, ART Refill Register, and the Pharmacy Dispensing Tool, and then are placed in the patient file (or entered into the facility EMR for electronic sites)
10. Any patients who did not attend the CAG meeting and pick up their ART refill as expected is entered into the facility's missed appointment/defaulter register for tracing (Figure 5.3 of the 2016 ARV Guidelines)

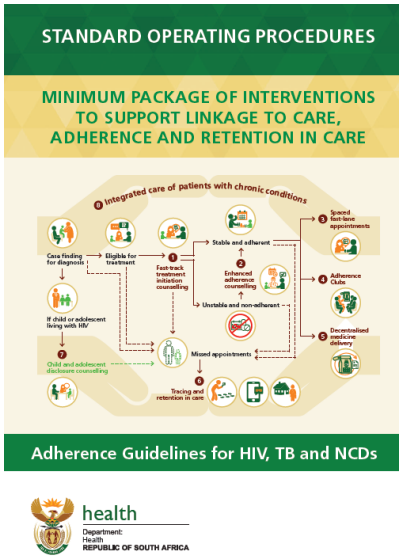
**Clinical Review Visit**

11. The group member scheduled for the bi-annual clinical review attends a regular clinic visit at the health facility. The Standard Package of Care is offered, and patient is assessed to see if they still meet stable criteria
12. During the facility visit, the member picks up a one-month supply of ART for themselves and the other group members (pre-packed and named, with corresponding ART Distribution Forms that have the first section already completed and signed)

Figure 5: Example of a Peer-led Community ART Group for ART Refills

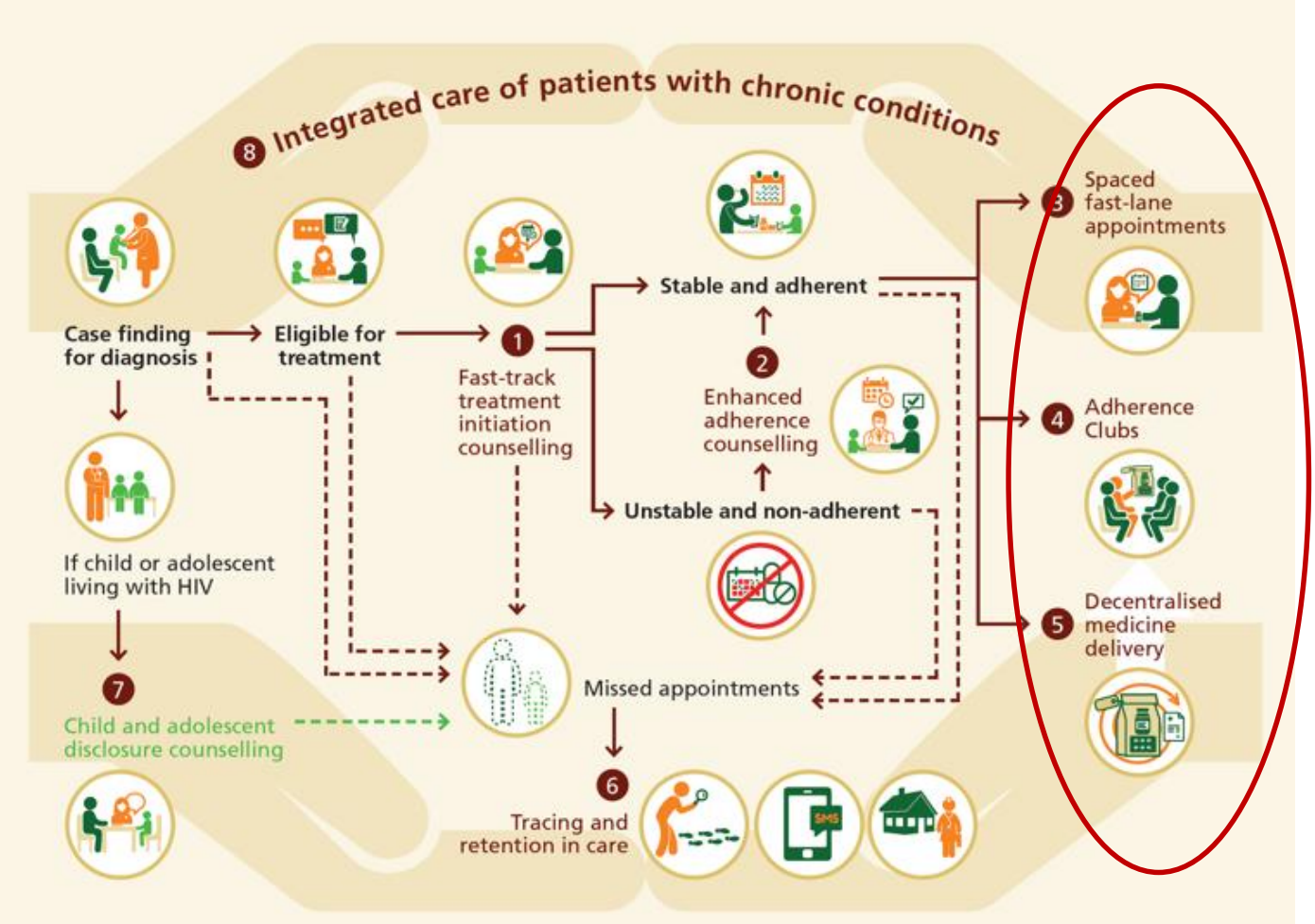
# South Africa



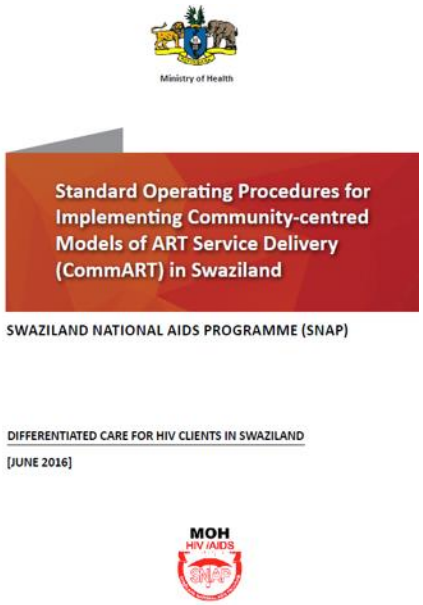




- Not limited to HIV
- Accompanies HIV management guidelines
- Across the continuum but focused on ART delivery models for stable clients
- Mostly adult with some reference to other populations
- Accompanied by SOPS

# Stable client ART delivery models



# Swaziland


- Separate from HIV management guidelines
- Focuses on differentiated ART delivery models
- Covers adult and adolescent populations
- Accompanied by SOPS

# Stable client ART delivery models

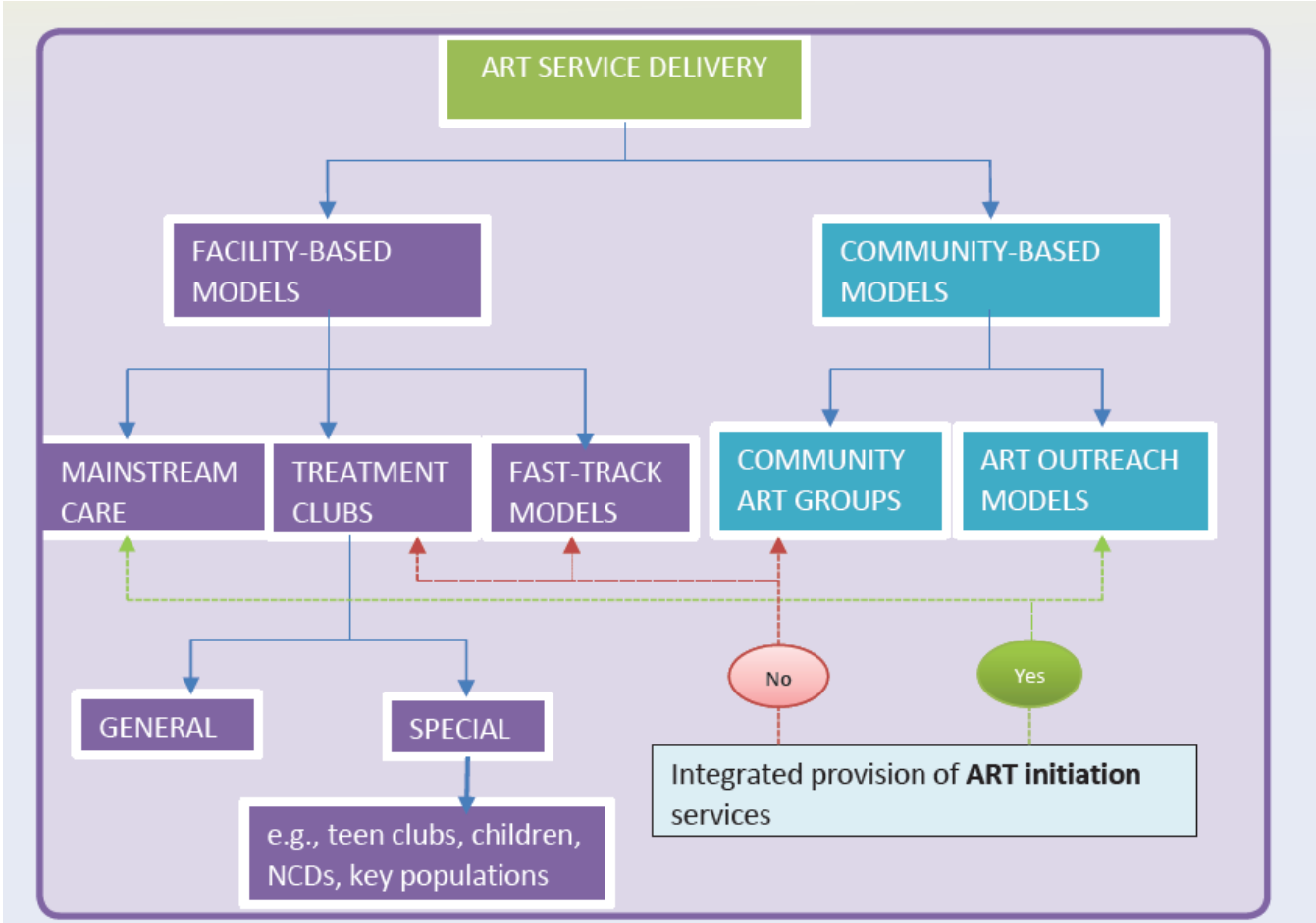
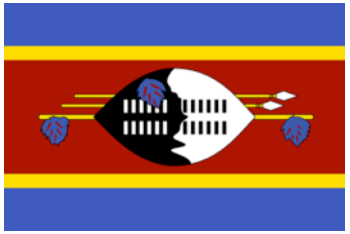



Figure 7: Summary of ART delivery models

# Eligibility for each model



**6.1 SUMMARY OF INCLUSION CRITERIA BY MODEL OF ART DELIVERY[7]**

| | MODEL OF ART DELIVERY | | | | |
|---|---|---|---|---|---|
| **CRITERIA** | **Fast track** | **Treatment Club** | **Teen Club*** | **CAG** | **Outreach** |
| Adult (18+years) | X | X | N/A | X | X |
| Adolescent (10-19 years) | N/A | N/A | X | N/A | X |
| 12 months on ART | X | X | X | X | N/A |
| **Undetectable** viral load (two consecutive viral load measurements are undetectable with the latest one taken within the last 6 months of eligibility date) OR CD4 above 350 OR Evidence of rising CD4 | X | X | X | X | N/A |
| No current TB | X | X | X | X | X |
| Not currently pregnant or breastfeeding± | X | X | X | X | X |
| No other medical condition requiring intensified clinical consultations | X | X | X | X | X |
| At least two ART visits at the facility | X | X | X | X | X |

# Models of Differentiated care

- **Client-managed groups** (known as community adherence groups or CAGs)-Mozambique
- **Healthcare worker-managed groups** (known as adherence clubs)-South Africa
- **Facility-based individual models** (known as the six monthly appointment or SMA programme)-Malawi
- **Out-of-facility individual models** (known as points de distribution communautaires or PODIs)-DRC Uganda etc

Health care worker-managed group

Client-managed group

Facility-based individual

Out-of-facility individual

# Health care worker-managed groups

Stable clients put into groups where they receive their ART refills

Groups meet inside or outside of the primary health system

# Client-managed group models

Clients receive ART within a group managed by a client

Can happen within or outside of a health care facility

- *Community ART Groups, Community Client-Led ART Delivery, community adherence groups*

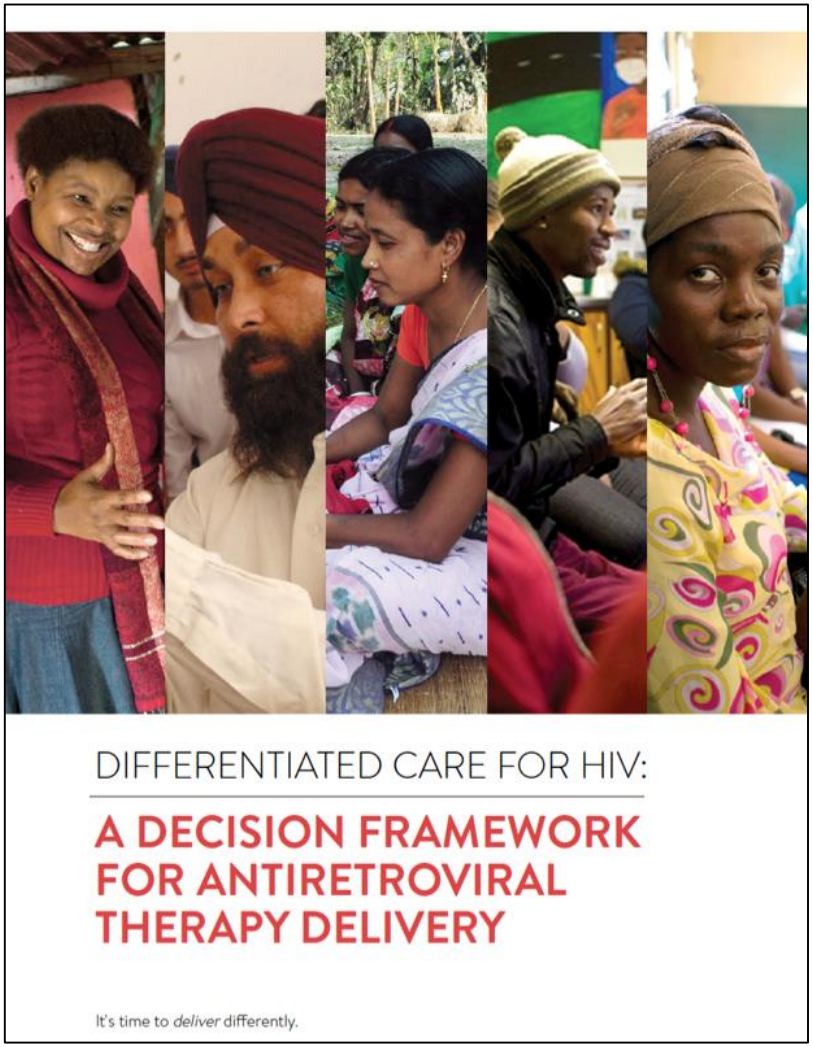
# Facility-based individual models

ART refill visits are separated from clinical consultations. On ART refill visits, clients are “fast-tracked” directly to the pharmacy

- *Fast track, appointment spacing, multi-month prescription, quick pick up*

# Out-of-facility individual models

Clients receive ART outside of a health care facility

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