Welcome to the first edition of our new series

In-depth perspectives of project implementation

This new series will feature in-depth perspectives of SA SURE Plus implementation experiences and good practice models gaining ground in the field, as our teams strive to achieve PEPFAR targets for HIV treatment. The Phakama Digest will be shared with key external stakeholders as a knowledge-sharing resource when appropriate.

Ramping up our responses from frenzy to momentum – the Siyenza drive

Since embarking in February 2019 on intensified efforts to improve HIV service performance in our focus clinics, HST has demonstrated substantial advances in programme-shifting and direct service delivery. Two key factors driving this achievement were stringent data-cleaning, and full engagement with the interventions by the Department of Health (DoH) staff with whom we partner.

Ownership of the innovations and performance focus has been particularly evident among the DoH Area Managers, who are eagerly committed to achievement of the targets.

As the ‘February Frenzy’ propelled into momentum, Lima Mashamba, SA SURE Regional M&E Co-ordinator, noted: “We are ensuring that what we implemented during the 28 days of February is integrated into our service delivery moving forward, so that we show consistent improvement in retaining patients on treatment.”

PEPFAR’s three-phase plan of action is named Siyenza (‘We do’). Phase 1 ran from March until 9 May 2019, with a robust focus on retaining patients on treatment, and tracing those lost to follow-up to relink them to care.

During Phase 1, the mantra was ‘Stop – Listen – Fix!', which mandated us to repair any leaks in the cascade from diagnosis to antiretroviral therapy (ART) initiation in our focus clinics, and to develop retention interventions based on the lessons learnt during the Frenzy period.

Because women are the most affected by South Africa’s HIV epidemic and HIV transmission occurs most among youth and older men, linkage to and retention on treatment is crucial. Our work in the field shows that ART enrolment of older men is rising, but younger men who know their status are less inclined to take up treatment.

PEPFAR’s Phase 1 action plan contained a suite of interventions, including alignment of our staff cadres with the most critical retention gaps which were determined by close analysis of clinic data.

Across PEPFAR’s 27 focus districts 250 000 patients were lost to follow-up during the first quarter of FY18/19, warranting targeted interventions that focus on men and all clients aged 15 to 24 years.
Noting feedback from the field indicating that people were wary of accessing HIV services, HST’s SA SURE Plus Project partnered with the Department of Health (DoH) in adopting a compassionate approach to bringing patients back into care, and deployed Campaign Agents to support treatment adherence.

The PEPFAR Country Operational Plan (COP) review meeting held in March 2019 highlighted two good practices towards this end, innovated by HST’s uMgungundlovu District team. One of these is the Case Management Model (CMM).

Ignited by a ‘change idea’ for quality improvement to serve the Siyenza drive, the uMgungundlovu project team developed and implemented a case management initiative which markedly boosted the retention rate in the district’s focus clinics.

Based on these results, PEPFAR recommended that all partners include this model in their districts, and all CDC partners requested benchmark visits to observe application of the CMM in uMgungundlovu. The Health Minister instructed all DoH facilities to case-manage newly diagnosed HIV-positive patients for the first year of treatment.

An HIV-positive patient encounters many milestones in the treatment journey, and should be assisted in following a comprehensive plan that incorporates both psychological and clinical care, to holistically address the individual’s life circumstances.

Case management is a targeted and person-centred model, recognising that antiretroviral therapy alone cannot resolve patient-level management issues such as stigma, pain, fatigue, depression, transport, nutrition, sleep disturbances, finances and family context.

Case Managers (Campaign Agents and Lay Counsellors) guide patients through these issues, supporting their participation in their own care planning, and referring them to specialist attention as needed.

HST’s uMgungundlovu District Co-ordinator, Nomvula Radebe – who has a strong background in case management – explains that consistently tracking patients tightens service delivery for the HIV cascade, thus reducing the need to trace them at a later stage:

“Case management entails closer and more regular communication with patients – proactively managing their condition before they withdraw or disappear from clinic engagement.

This begins the minute after diagnosis, so that there is no delay in linkage to care. The key actions are clustering, documenting and reminding – all the while carrying the patient through a supportive care plan.”

Case management is defined as:

“A collaborative process of assessment, planning, facilitation, care co-ordination, evaluation and advocacy for options and services to meet an individual’s and family’s comprehensive health needs through communication and available resources to promote patient safety, quality of care, and cost-effective outcomes.”

(Source: http://www.cmsa.org/who-we-are/what-is-a-case-manager/)

HIV case management

The most important intervention for reducing new HIV infections is enabling people to receive and stay on treatment so that they become and remain virally suppressed.
Leading the way in HIV case management

Prior to a patient being assessed for eligibility to enrol in differentiated care via the Central Chronic Medicine Dispensing and Distribution programme (CCMDD) – whether through registration for Spaced Fast-lane access in the clinic, external/community pick-up points, or adherence clubs – case management lays strong foundations for those beginning their treatment, and for those brought back into care after defaulting on ART.

Through mechanisms such as pre-retrieval of patient files and reminder records – as determined by the Caseload Sheet – the CMM closes breaches in the care process, e.g. blood results not being viewed, actioned, explained to the client or filed. Active case management strengthens health system efficiency – in particular, Integrated Clinical Service Management (ICSM) – by streamlining clinic flow, and decongesting the Chronic Stream area.

Graduation to the CCMDD programme for differentiated care options is explained to patients once they have completed 12 months on treatment and are clinically stable and virally suppressed. The case management process is complete once the patient is registered for one of these options.

Initiating the Case Management Model

The team began piloting the CMM by identifying and retrospectively clustering patients who had been on treatment for a year, while introducing case management to all newly diagnosed patients as part of the normative treatment process.

To catch up on outstanding interventions, the patients were cohorted within each Case Manager’s cluster according to the interventions required for the patients’ needs.

The team had noted that the standard method of sending patients reminders about their clinic appointment just before the date was too loose to be effective, and that a more tactical approach was needed. A reminder support system was developed to strengthen real-time monitoring of patients’ adherence.

“The human touch is very important in this process,” says Nomvula.

“It develops a bond between the Case Manager and the client through ongoing, non-judgemental conversation which assures the patient that her needs are validated and understood.

The patient receives all communication from an individually named Case Manager – one person who co-ordinates all clinical navigation for the client. This personal connection enables recording of accurate patient contact details, needed for efficient and sustained engagement for ongoing adherence support.”

While a clinician might issue the patient with a return date without negotiating his/her ability to honour the next appointment, the Case Manager discusses with the patient all possibilities that will keep the client in care without disrupting his or her life.

Case Manager
Nonjabulo Hlengwa
Engaging with clients for HIV case management

Bulk SMS reminders to come to the clinic are sent to identified patients already on ART, and an SMS ‘Welcome note’ is issued to new patients.

Clients are advised that they can also send a ‘Please Call Me’ or WhatsApp message to their Case Manager. Enabling two-way communication allows patients to participate in their own care. Each message explains that treatment support will be provided by an individually named patient navigator who will receive and refer the patient to a clinician for required services.

If clients send a reply text, the Case Manager calls them back to converse in person rather than texting a response. Reminders are sent seven days and two days prior to the scheduled appointment.

Tracking is done during a few hours every morning; this entails examining the previous year’s history of traced patients, noting gaps and discrepancies in tests, results and appointments in the patients’ folders.

Case Managers can take a break in the afternoon to rest, and then conduct telephonic and physical tracing between 16h00 and 18h00, and on weekends, when most patients are likely to be at home.

The allocation of caseloads to individual Case Managers is determined at each site. The caseload per agent can vary from 80 to 150, spread over one month. As a daily average, the Case Manager might see six clients, and call six more.

The Case Management spreadsheet tool covers 24 months of activity, and uses colour coding to indicate the progress of new client enrolment, the ART start-date and appointment dates, routine reminders, viral load tests (due and done), tracing, transporting and various status tags, as well as actions and outcomes.

The ‘Outcome’ field offers prompts for details of patients who are transferred out of the facility. By plotting notifications for reminders, follow-up and outcomes, smooth clinic flow is ensured, with files being pulled to check for indicators and uncaptured data.

Colour-coded ticks on the tool denote which milestones the patient has reached at each visit date. A ‘CCMDD’ sticker is placed on the file to indicate readiness for differentiated care, pending the attending clinician’s decision.

A facility-held cell-phone is loaded with data bundles and standard reminder messages, and TIER.Net is the central data system into which the patient management updates are fed.

Flexi-time enables Case Managers to be on duty when they can make the most difference.

Case Managers also capture details of clients with presumptive TB on the TB Calendar, plotting appointments at their treatment start-dates.

Each Case Manager maintains a personal diary or appointment book to organise timeframes and actions, and uses a desktop calendar for month-at-a-glance views of bookings.

The case management tool-box

The Case Management spreadsheet tool covers 24 months of activity, and uses colour coding to indicate the progress of new client enrolment, the ART start-date and appointment dates, routine reminders, viral load tests (due and done), tracing, transporting and various status tags, as well as actions and outcomes.

The ‘Outcome’ field offers prompts for details of patients who are transferred out of the facility. By plotting notifications for reminders, follow-up and outcomes, smooth clinic flow is ensured, with files being pulled to check for indicators and uncaptured data.

Colour-coded ticks on the tool denote which milestones the patient has reached at each visit date. A ‘CCMDD’ sticker is placed on the file to indicate readiness for differentiated care, pending the attending clinician’s decision.

A facility-held cell-phone is loaded with data bundles and standard reminder messages, and TIER.Net is the central data system into which the patient management updates are fed.
The Case Manager’s role

The Case Manager’s role is central to guiding the Professional Nurse through a patient’s case, while motivating the client through sustained interpersonal communication, as well as liaising with other facility staff to maintain momentum along the care pathway and ensure that all data are accurate, complete and up to date.

The client’s contact numbers and address are confirmed by the Linkage Officer at every visit, and by the Case Manager who checks the cell-phone’s message delivery report (which shows whether the client is either not responding or has not received the reminder).

The ART files deposited in each consulting room every day are documented by the Case Manager, who also collects the files once consultations are completed, so as to verify that the patients kept their appointments and that the files reflect new ‘next appointment’ dates.

The Case Manager works closely with the Data Capturer to collate each day’s visit details.

Training and mentoring of Case Managers is essential to ensure that the incumbents can respond creatively to each patient’s unique needs and experiences.

This requires a knowledge base of clinical aspects and the ability to provide psychosocial support.

“The standardised colour-code system enables all clinicians in the facility to scan the Caseload Sheet for updated information on the patient’s whereabouts and progress,” says Nomvula.

“The Chronic Stream Nurse monitors the notations, and observes adherence behaviour patterns for each Case Manager’s caseload and adherence trends among all patients in managed care.

This makes it easier to profile patients who miss appointments, analyse why this occurs, and plan targeted interventions.

Once she has recorded these on the caseload clinical stationery, the Case Manager follows up accordingly.”

Rolling out the CMM implementation

A caseload presentation meeting is held every week to review the case-sheets as a team and address any bottlenecks that may affect the whole facility. A similar presentation is conducted in monthly Nerve Centre meetings so that HST can formally brief the DoH on the CMM implementation. Daily morning sessions are held in the clinics so that the facility staff are kept abreast of progress, and decisions can be made on caseload allocation.

To clear the clustered backlog of cases, the clients are grouped into different categories:

- those adhering to treatment,
- those who should be tested,
- those not adhering to treatment.

This is led by the Chronic Stream Nurse with input from the Case Manager, who follows up with actions agreed in-facility to address them, and ‘surging’ appropriate activities for as many clusters as possible.

In rolling out this model, patient tracing should be processed via the Operational Manager for delegation to the Outreach Team Leader and Community Caregivers. Consistent testing of index patients’ contacts is very important, and should be pursued until all off-shoots are tested and initiated on the care pathway.

Once firm bonds between the clients and their Case Manager are formed, these index patients are more likely to share information about their partners and children, and about life changes such as relationship break-ups, the death of a partner, or pregnancy planning.

Case management monitoring entails amassing and analysing data on: reminders issued; the number of clients who keep scheduled appointment dates, and of those who come to the clinic within one to seven days after their appointment date; missed appointments; percentages of viral load testing uptake, and viral load suppression rates.
The journey of HIV case management

The Case Manager’s key aim is to encourage positive adherence behaviour among all patients in managed care and when graduated to CCMD, with special attention to those with poor viral load results and a history of defaulting on ART.

After 12 months of committed tracking and interaction, patients who remain clinically unstable will be managed through higher levels of clinical and psychosocial interventions. Roll-out of the CMM is also being geared to identify and case-manage children younger than 18 in various age cohorts, as they need specialised care approaches and treatment adherence support. An article focused on this aspect of case management will be featured in a forthcoming edition of the Phakama Digest.

HST’s Siyenza case management momentum

Project teams from other HST-supported districts have visited the uMgungundlovu focus clinics for on-site exposure to the CMM process.

A key advantage in HST’s implementation of this model is that the project’s Campaign Agents have local knowledge of the patients and their contextual circumstances.

A concept paper on the practice, as well as related standard operating procedures and a training programme, are being developed to share along with the Case Management spreadsheet tool.

Benchmarking standards have been set around which to measure achievement of targets and levels of success.

The advantage of implementing the CMM during the Siyenza drive lies in clearing the backlog of historically untraced and untracked patients.

A year from now, we should be case-managing only ‘new-on-ART’ patients. Those who will have reached intermediate stages of treatment enrolment will be case-managed towards eligibility for differentiated care.

For further information on the CMM, please contact:
Lindokuhle (Howard) Colvell
Sub-district Co-ordinator, CMM Project Manager and Trainer
084 801 5381
Howard.Colvell@hst.org.za