HIV/AIDS – Siyenza – Facility Visit Assessment Tool

This tool is to be used to rapidly assess and understand challenges in relation to agreed priorities for February and March 2019.

These priorities have been discussed and agreed to at the meeting held with Provincial HAST Managers, Pepfar District Support Partners as well as representatives from USAID, CDC and PEPFAR on 13 February at Garden Court OR Tambo. The priorities include:

1. Data quality
2. Utilisation of HPRN as unique identifier
3. Improvement on PICT and Index testing
4. Linkage/Same Day Initiation
5. Retention
6. Tracking and Tracing
7. Minimum Requirements

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| --- | --- |
| **Facility Name** |  |
| **District** |  |
| **Province** |  |
| **Attendees** |  |
| **Date** |  |

*Paste in the site’s performance indicators from the weekly dashboard below:*

Data Quality

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| Question | Yes/ NO | If “NO” recommend | Decisions / Actions taken |
| Does the facility have any client files that have not yet been entered into tier.net? |  | If no, then 100% of client files must be entered correctly into tier.net. |  |
| Does the site run and print early and late missed lists and uLTFU weekly? |  | Ask the data capturer to print the early and late missed list. The goal should be to outcome 100% of the patients on these 3 lists. |  |
| Compare the early and late missed lists with the registers for CCMDD (i.e. decanted clients), adherence clubs/support groups, and fast lanes? |  | All patients that have been decanted need to be updated in Tier.net and taken off the early or late missed list. |  |
| Is the site using version v1.12.6 of Tier.net? |  | If not, the sub-district needs to be informed and the NDOH hotline at CDC needs to be alerted. |  |
| Are all patient files captured in Tier within 24 hours of the patient visit? |  | Back capture to ensure 100% capturing in Tier.net. |  |

Utilisation of HPRN

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| Question | Yes/ NO | If “NO” recommend | Decisions / Actions taken |
| Has the facility implemented HPRS? |  | If no, ask if they have a planned date for implementation and discuss further with District / Provincial managers on visit. If Yes continue to next question. |  |
| Is the HPRS number captured onto the clients’ records on Tier? |  | If no, recommend that they start capturing the number and communicate the benefits to doing so. |  |
| Is the HPRS number being used as the file number? |  | If no, recommend that they discuss the change in file numbers with their information units at district level in preparation for full HPRS implementation |  |

PITC/HIV Case Finding

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| Question | Yes/ NO | If “NO” recommend | Decisions / Actions taken |
| Is there a lay counselor targeting patients in the acute stream? |  | If not, the DSP needs to provide a lay counselor in the Acute stream. |  |
| Is the lay counselor asking about prior HIV + tests and on ART? |  | The lay counselors should determine if someone has previously tested for HIV and whether they are currently on ART. If not, then adult men and women should be offered HTS. |  |
| Does the facility have adequate stock of HIV test kits? |  | The DSP should try to borrow test kits from other facility. The DSP needs to alert the district immediately. The Site Lead needs to alert the NDOH hotline at CDC. |  |
| Are <100% of TB patients offered an HIV test? (Review presumptive TB register and the TB register for past 2 months: status of patients should be documented). Query if there is ‘unknown’ documented next to the patient name. |  | If HIV testing of TB patients is <100%, then the DSP should contact the TB patients to return to the facility for HIV testing. The DSP should also use its CHWs or community-based partners to test these individuals in the community. |  |
| Does the counselor/navigator escort the patient to the clinician for linkages to ART? |  | If not, a counselor/navigator should escort the individual to a NIMART trained nurse for ART initiation after the individual has seen a provider for the acute illness. If more appropriate, a counselor/navigator should direct a NIMART-trained nurse to the individual. |  |

Linkage/Same Day Initiation

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| Question | Yes/ NO | If “NO” recommend | Decisions / Actions taken |
| Review the 10-10 dashboard and see if ≥80% of new initiations are the same day as the positive test? |  | If <80%, review the 7 and 14 day reports in tier.net, and if these reports are <90%, then root causes need to be determined why same day initiation is not happening. |  |
| Is the facility implementing NDoH policies on Universal Test and Treat (UTT) and Same-Day ART initiation? |  | The NDOH hotline should be informed if <80% of PLHIV are not initiated the same day. |  |
| If <80% same day initiation, discuss the counseling script with a counselor (do a role play). Does the counselor mention the importance of same day initiation? |  | Site leads should assess barriers to same-day ART and reassure providers about safety.  Discuss the counseling messages that are provided and ensure that they are supportive, clear, and aligned with the NDOH policy on UTT. |  |
| Are the majority of NDOH nurses at this site NIMART trained and doing ART initiations? (vs. referring all initiations to the partner). |  | Review site-level data to see whether the partner or NDOH clinicians are initiating patients on ART. |  |
| Are there any linkage officers/patient navigators for patients that are referred from HIV testing to ART within their visit? |  | If not, the partner needs to provide linkage officers/patient navigators at the site. |  |
| Are the HTS/pre-ART module in use at this site? |  | Ensure there is a tracking tool to ensure follow-up of patients who are not started on ART the day of diagnosis (**See Annex 1**). |  |
| Is there someone responsible for following-up with patients who do not start ART on the day of diagnosis? |  | Recommend that the facility assign the patient(s) to a linkage officer who will follow-up with them to ensure (s)he initiates ART when ready. |  |
| Are there tools to document the tracing of these patients until a final outcome of ART initiation is achieved? |  | Site leads should review the performance of this patient tracking tool during their site visits. |  |
| Is there anyone responsible for greeting and supporting patients referred to the facility from the community? |  | Identify someone in the facility to serve in this role. |  |

Retention

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| Question | Yes/ NO | If “NO” recommend | Decisions / Actions taken |
| Do lay counselors intensify interpersonal interaction and counselling to improve treatment literacy, client information, and demand for services? |  | Work with the DSP to understand whether the main counseling messages communicated during counseling sessions are helpful, accurate, and encourage clients to initiate/remain on treatment. |  |
| Do DSPs assign lay counselors to serve as case managers to each newly identified HIV positive client (up to 80 HIV positive patients/month)? |  | Review case manager SOP and work with DSP to identify staff to begin serving in this capacity (including hiring when needed |  |
| Does lay counselors complete the client locator form to confirm locating information? |  | Counselors need to ensure that they have correct and clear locating information for phone and home-based tracking. Calling clients while they are present on the mobile number they provide is one way to verify the information provided. |  |
| Are lay counselors responsible for routinely calling clients to remind them of their appointment? |  | Each Siyenza facility should have a mobile phone that can be used to call clients for reminders, etc. |  |
| Review the number of patients on the Early, Late Missed, and uLTFU for the week. How does this compare to TROA? Is it <5% in total? |  | If no, improving tracking and tracing should be a priority activity. |  |
| Is there sufficient resource to conduct telephonic tracing?   * Are there enough staff members making phone calls to call everyone on their Early and Late Missed appointment, and Waiting on ART lists each week? * Do they have sufficient phone access/airtime to do this? |  | Discuss staffing with managers. Explore whether partner is able to support additional staffing, if required, as an interim measure.  At a minimum, ensure there are enough persons available *at the site* to call all Early, Late Missed and Waiting on ART clients each week.  Partners should provide cell phones/airtime if needed to support this process. |  |
| Do lay counselors follow up on all missed appointments within 24 hours, and document the outcome of these calls on the provided tracking/tracing register? |  | Instead of waiting for early/late missed lists, counselors should follow up on all missed appointments within 24 hours. Outcomes of all calls should be documented and when clients are reached, the reason for their missed appointment should be included as well. |  |
| When the phone/SMS contact does not result in a return visit within 5-7 days, does the CHW conduct a home visit? |  | Initial home visits should be completed within 7 days of a missed appointment, when DSP CHWs are present. National guidelines stipulate that CHWs follow-up after 2 weeks, but when willing WBPHCOTS should be encouraged to begin their follow-up sooner. Results of these visits should be documented on the cohort tracking and tracing register kept at the site. |  |
| Is the cohort tracking and tracing register being utilized and completed correctly by all involved staff? |  | The DSP must have a system in place to track the outcomes of phone calls, and home visits, that includes reason for missed appointment and documentation of final outcome. On each site visit, review the results of these registers to ensure adherence to all SOPs and algorithms. |  |
| Are site staff (DSP and NDOH) ensuring a “welcome-back” campaign is instituted to acknowledge clients returning for previously missed appointments? |  | All retaining clients should be warmly welcomed back to facilities, rather than chastised for missing previous appointments, as this is a known reason why clients do not come to facilities after a missed appointments. When possible, clients traced and returned to care should be greeted directly by their case manager and supported through their follow-up visit. |  |
| Do lay counselor (case managers) receive an incentive for achieving 95% of ART clients retained in care after 3 months? |  | If not, review the DSP’s retention data. If not ≥95%, then ask whether incentives could be initiated for lay counselors. |  |
| Is there a clear lead at the site coordinating activities across all community partners/health workers (including WBPHCOTs, DSP CHWs, FBOs, CBOs) and that communication between the facility and community workers is bidirectional? |  | Review site level data to ensure that facilities are being linked to PLHIV who are tested by community-based organizations. Ensure that community partners are receiving feedback on their efforts and the final outcome of patients tracked and traced is documented at the facility level. |  |
| Are 100% of all eligible ART clients offered differentiated care of their choice (i.e including access to external pick-up points, adherence clubs, fast lane, multi-month dispensing, and support groups)? |  | If not, work with partner to ensure all differentiated care options are available, and flag for additional partner/DOH follow-up when needed. |  |
| Does the facility have functioning adherence clubs for stable clients? |  | These can be on- or off-site. |  |
| Does the facility have functioning support groups for new (<6 months) ART clients, patients with unsuppressed viral load, and other high risk populations (i.e. adolescents)? |  | These groups should be offered for clients not eligible for adherence clubs. |  |
| Does the facility open at 5am Monday – Friday and stay open until 7pm (where safe), open for the full day on Saturday, and offer the full complement of HIV services? |  | All facilities should offer HIV services during the weekend and extended hours, unless it is unsafe to do so. Review the daily data to ensure that case finding, initiation, and drug pick-ups are taking place during these times/days. |  |

Challenges and Opportunities – *Summarize key issues for action below*

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| Category (Data quality, PITC, linkage, retention, etc.):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Issue | Root Cause | Next Steps | Person Responsible |
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| Follow up *(on issue above)*: | *Describe any progress on this issue for the person visiting the site next week.* | | |
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|  |  |  |  |
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**Example:**

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| LINKAGE/SAME DAY START/COMMUNITY SERVICE STAFF | | | |
| Issue | Root Cause | Next Steps | Person Responsible |
| EXAMPLE: Same Day Start: 70% | Staffing – DOH nurses only initiate newly diagnosed HIV+ clients from ANC, not any other entry points | 1. Increasing # days DSP nurses are at the facility 2. Understand why DOH nurses are not initiating (i.e. skills audit, task shifting issue, etc.) | Training Program Manager (DSP) – Name/mobile  Clinical Advisor (DSP) – Name/mobile  Operational Manager - Name  QI Person (DSP) – Name/mobile |
| Follow up *(on issue above)*: | DSP assigned 1 more NIMART trained nurse to this facility. DOH nurses were retrained on NIMART (nurse initiated and managed ART), and now initiate newly diagnosed clients even when DSP nurses are not present. The majority of clients put on the pre-ART register are reported to be “diagnosed late.” Retrain nurses on advanced disease. | | |