Integrated Adherence Services for Chronic Treatment (HIV, TB and NCDs)

Adherence Guidelines Overview

AWACC Conference 2016

Presenter : Nokuthula Heath

Zoe –Life

Background

- Adherence to treatment is both a national and international priority
- Linkage to care, adherence, and retention in care interventions can be linked to key indicators to evaluate programmes performance
- The existing programme indicators and M & E System in particular National HIV/AIDS/STI program dashboard indicator report 2014/2015 reflect challenges and poor performance in our districts and facilities

Objectives of the National Adherence Strategy

- To strengthen access to appropriate services and interventions in order to improve clinical outcomes

- To assist service providers to ensure that people with chronic diseases are linked to care, retained in care and supported in adhering to treatment

- To address client and service-provider barriers

Adherence Strategy is for HIV, TB, NCDs like diabetes and hypertension

Questions

1. The following are minimum package of interventions except

a) Fast track Initiation counselling

b) Enhanced adherence counselling

c) Case finding

d) Spaced Fast Lane appointment

Questions

2. The following are part of the Repeat Prescription strategy except

a) Child and adolescent disclosure counselling

b) Adherence clubs

c) Decentralised medicine delivery

d) Spaced Fast Lane appointment

Questions

3. Tracing and Retention in care is applicable to all patients who miss their scheduled visit and unstable

a) True

b) False

Questions

4. Child and adolescent disclosure counselling is offered to the following

a) Children or adolescents

b) All children on chronic medication

c) The caregiver ,child and adolescent

d) The child

Questions

5. What tools are needed to implement EAC 2?

a) Minimum package SOP'S for enhanced adherence counselling.

b) Patient adherence plan sheet.

c) List of supporting organisations (CBOs , FBOs) to assist with referral

d) All of the above

Current challenges

SA is **ranked number 6** in the world for **burden of TB**
- **Global TB report 2013**

MDR-TB in *the world*

Estimated **450 000** people **in 2012**

Among 18 to 35 year olds, **20% have hypertension,**

12% have diabetes...

...and **will increase** to **30%** and **26%** respectively among 36 to 45 year olds

Although SA has the largest ART programme in the world, **retention in care rates** of ART clients are **declining** in South Africa

Reflection !

- Prevalence of NCD and co-morbidities continue to increase
- Our ART cohort is getting bigger—we moved to CD4 500 as eligibility criteria for ART initiation and option B+ for all pregnant women in January 2015
- Lost to follow up at six months after initiation is on the rise
- TB and HIV co-infected patients are initiated on ART irrespective of their CD4 count
- TB case holding is a challenge
- Drug resistance due to poor adherence is on the rise

WE NEED TO SCALE UP OUR LINKGAGE TO CARE, ADHERENCE AND RETENTION IN CARE STRATEGIES ACROSS THE CARE CASCADE

"We are already doing this"…

- We have been counselling our clients for years on the importance of adherence and returning for follow-up care
- We trace our clients who do not come back
- We counsel those who need more support
- We make sure our clients only come back to the clinic when they need to
- We have started integrating some of our services

Why do we need change?....

- Counselling for ART is **not standardized** across facilities.
  - Difficult to ensure that **all clients get best quality** without defining a **'gold standard'**
  - Also **difficult to measure (and therefore ensure) quality** without a **'gold standard'** against which to measure
- We lose many clients before they initiate treatment (**up to 6 weeks delays between eligibility and initiation**)
- **We do not routinely counsel our TB and NCD clients** the same way we do our ART clients
- We need to **focus on disclosure among HIV+ children**
- Counselling for non-adherence:
  - Not well structured
  - Not client focused.
- Reasons for non-adherence are not understood or dealt with
- We need to strengthen data capturing and records **'If it wasn't recorded then it wasn't done!"**

Session Objectives

- Provide a background to Adherence Guidelines
- Introduce the stepwise approach in strengthening adherence across care cascade
- Give an overview of key adherence strategies
- Define roles and responsibilities of clinicians and non-clinicians to support adherence guidelines

What is new with the Adherence Guidelines?

- **Defined Minimum package of interventions**
  - Standardised education counselling on Hypertension, Diabetes Mellitus, Tuberculosis and HIV including child and adolescent disclosure counselling
  - Alternate repeat prescription collection strategy options
  - Early tracing and retention in care
  - Integrated management of chronic conditions

Patient related barriers to linkage and retention into care

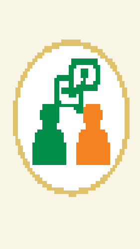
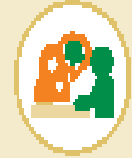
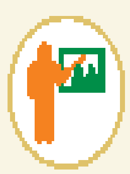
Table 1: Patient-related barriers to linkage, adherence and retention in care

Barrier	Description
Cognitive	Poor knowledge and understanding of results, disease and treatment options
Affective	Depression, anxiety, denial, lack of motivation, stigma and fear of violence
Behavioural	Forgetfulness, alcohol and drug consumption, missed appointments
Medical	Pill burden and regimen complexity, treatment adverse effects, medication toxicity, medication palatability
Family/ social support	Lack of social support, lack of community involvement and dependency on partner
Socio-demographic	Age, sex, socio-economic status, level of education, stigma, and non-disclosure of status

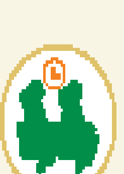
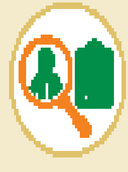
Provider –related and structural barriers to care, adherence and retention into care

Table 2: Provider-related and structural barriers to linkage to care, adherence and, adherence and retention in care

Provider-related

	Category	Barriers
	Communication	Poor client – provider communication, Inadequate health education, lack of assessment and understanding of the clients reasons for non-adherence, weakness in measuring adherence
	Behavioural	Attitude of health care providers towards clients, level of engagement and empathy towards the client
	Training	Inadequate training of staff in breaking bad news, educating and supporting clients in adhering to treatment, limited capacity to screen and identify mental illness

Structural

	Category	Barriers
	Organisational	• Distance to the clinic • Long waiting time • Lack of integration and coordination between services • Medicine shortages and stock-outs • Inflexible clinic hours
	Intervention quality	• Lack of tools to guide the health care workers on ways to support client's adherence • Lack of confidentiality • Inconvenient linkage to care • Delayed treatment initiation • Inadequate assessment of treatment adaption needed • Poor tracing system • Inadequate resources and laboratory services • Poor management and support of health care workers

Note: The categories are not mutually exclusive. They can also be shared across supply and demand. The classification above is only meant to provide guidance to identify strategies to improve retention in care.

Minimum Package of interventions to support linkage, adherence and RIC

8 Integrated care of patients with chronic conditions

Case finding for diagnosis

Eligible for treatment

1 Fast-track treatment initiation counselling

Stable and adherent

2 Enhanced adherence counselling

Unstable and non-adherent

3 Spaced fast-lane appointments

4 Adherence Clubs

5 Decentralised medicine delivery

If child or adolescent living with HIV

7 Child and adolescent disclosure counselling

Missed appointments

6 Tracing and retention in care

SMS

Patient adherence plan

- Assist patients to make **<u>their own</u>** commitment during counselling sessions
- Retrieved at every visit to review patient's commitment
- Used during counselling sessions
  - Fast Track Initiation Counselling
  - Enhanced Adherence counselling

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ANNEXURE I: PATIENT ADHERENCE PLAN

Name and Surname:

*It is important to note that not all patients will follow the steps sequentially

Session 1 after Chronic disease education session (date):
Adherence step 1: Education on HIV ☐ TB ☐ Hypertension ☐ Diabetes ☐ Other: ☐
Adherence step 2: Life goals My motivations to stay healthy are: 1) 2) 3) I will maintain a healthy lifestyle by: adopting healthy eating habits ☐ getting regular exercise ☐ managing stress ☐
Adherence Step 3 – Patient support system Agree for home visit: Yes ☐ No ☐ Who can support me in my treatment: Family ☐ Friends ☐ Work ☐ School ☐ Church ☐ Other: ☐
Adherence Step 4: Getting to appointments I will come to my appointments by: walk ☐ public transport ☐ own transport ☐ If I face a difficulty to come (money, transport, etc.), my alternative plan will be: to ask for assistance from: family ☐ friends ☐ neighbour ☐ other ☐ I will inform clinic I am unable to come to set appointment and request for an alternative appointment ☐
Adherence step 5: My readiness to start treatment I feel ready and will start treatment: Yes ☐ No ☐ I do not feel ready and would like to discuss more with: peer ☐ family member ☐ Community Health Worker ☐
Session 2 (date):
Adherence Step 6: Medication schedule The best time for me to take my treatment is: Morning ☐ Afternoon ☐ Evening ☐

66 | Annexure I: Patient Adherence Plan

Patient Treatment Adherence Pamphlet

- Adapted in **11** languages
- **Provides** patients with reference material after counselling on treatment adherence
- **Informs patients of:**
  - Importance of treatment adherence
  - Dealing with side effects
  - Benefits of disclosure
  - Healthy life style
  - Contacts details for more information

TREATMENT ADHERENCE

A KEY TO A LONG AND HEALTHY LIFE

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Adherence education flip file

- **Guides and assists** health care service providers during counselling sessions to provide **standardised adherence education**
  - TB, HIV, hypertension, diabetes, healthy living and mental health.

- Can be used by:
  - Health care workers
  - Enrolled nursing assistants
  - Health promoters
  - Lay counsellors
  - Home based carers
  - Community health workers
  - WBOT leaders
  - Support group facilitators

ADHERENCE GUIDELINES: Education on Illness and Treatment

MENTAL HEALTH
HYPERTENSION
TUBERCULOSIS
NUTRITION
DIABETES
HIV
HEALTHY LIFESTYLE
LINKAGE TO CARE, ADHERENCE AND RETENTION IN CARE

Adherence Guidelines: Education on Illness and Treatment / Page 1

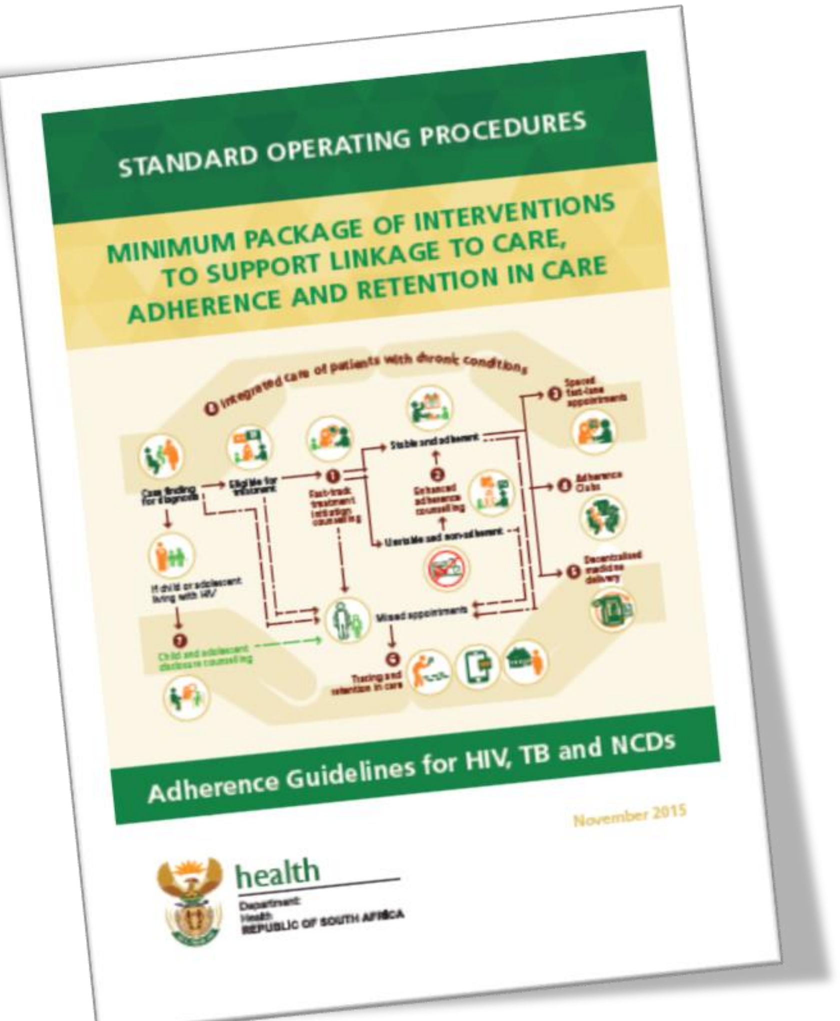
Adherence Talk Tool

- **Guides and assists** health care service providers during counselling sessions to provide **standardised adherence education**
  - TB, HIV, healthy living and emotional status.

- Can be used by:
  - Health care workers
  - Enrolled nursing assistants
  - Health promoters
  - Lay counsellors
  - Home based carers
  - Community health workers
  - WBOT leaders
  - Support group facilitators

Standard Operating Procedures (SOPs) for minimum package interventions

- SOPs for 7 minimum package interventions.
- Each SOP details
  - Purpose
  - Person's affected
  - Criteria
  - Guiding principles and
  - Procedure on how to implement
- Tracing and retention in care cuts across in all SOPs



Training manual and mentorship guide

- Introduces AGLs in public sector health facilities and communities.
- Participant guide provides reorientation and skills especially for **non clinicians** to support AGLs implementation.
- A mentorship guide supports non-clinicians during implementation.

LINKAGE TO CARE, ADHERENCE AND RETENTION IN CARE SERVICES FOR CHRONIC CONDITIONS (HIV, TB AND NCDS)

A TRAINING CURRICULUM

PARTICIPANT GUIDE

This Participant Guide has been designed to assist facility- and community-based non-clinicians to develop skills to provide linkage to care, adherence and retention in care services for chronic conditions.

Adherence Guidelines for HIV, TB and NCDs

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What tools are needed to implement FTIC 1 model?

- Standard Operating Procedures booklet
- Patient Adherence Plan sheet.
- Adherence education flip file.
- Mental Health assessment tool.
- Adherence treatment pamphlet.
- Talk Tool
- List of supporting organisations (CBOs, FBOs) to assist with referral to psychosocial

- I support

Fast Track Initiation counselling (FTIC 1) model

- Provides p**re- and post**-initiation support to newly diagnosed patients with particular focus on **adherence support**
- Provides education and support to patients **without delaying initiation** of treatment.
- Provides standardized education and counselling using **Adherence Counselling flip file for HIV, TB, Hypertension and Diabetes**.
- Assist the patient to develop **an individualized adherence plan** and **set clear treatment milestones.**
- Assist patient with **problem solving around the most common barriers** to adherence including the need for support, alcohol and substance use issues and clearing misperceptions about adherence.

What patients qualify for fast track initiation counselling (FTIC 1) model?

- Newly diagnosed HIV, hypertension and Diabetes patients **(first session)**
- All newly diagnosed patients who are pre-treatment and treatment patients
- Patients co-infected with TB who need to initiate ART shortly after TB treatment.
- Pregnant women who initiate on the same day as HCT.
- Caregiver of children with HIV,TB or NCDs under 12 years

FTIC 1 sessions

Four sessions in the adherence plan:

- Day of linkage to care - start an adherence plan
- Day of initiation – continue with adherence plan
- First refill (1 month of treatment) – finalise the last steps of adherence plan.
- Second refill 2 months on treatment) – set treatment goals.

FTIC 1 sessions

PATIENT ADHERENCE PLAN

Name and Surname: Nokuthula Heath

It is important to note that not all patients will follow the steps sequentially

Session 1 after Chronic disease education session *(date)*: 05/10/2016

Adherence step 1: education on HIV (circled) TB Hypertension Diabetes Other ....

Adherence step 2: Life goals:
My motivations to stay healthy are: (1) Travell (2) Study (3)..............................
I will maintain a healthy lifestyle by adopting healthy eating habits getting regular exercise (circled) managing stress

Adherence Step 3 - Patient Support system Agree for home visit: Yes No (circled)
Who can support me in my treatment: Family (circled) Friends Work School Church other: Husband

Adherence Step 4 - Getting to appointments
I will come to my appointments by : walk (circled) public transport own transport
If I face a difficulty to come (money, transport, etc.), my alternative plan will be: to ask for assistance from:
family friends neighbour (circled) other
I will inform clinic I am unable to come to set appointment and request for an alternative appointment

Adherence step 5: My readiness to start treatment
I feel ready and will start treatment Yes (circled) No
I do not feel ready and would like to discuss more with: peer family member Community Health Worker other

Session 2 *(date)*: 20/10/2016

Adherence Step 6 - Medication schedule
The best time for me to take my treatment is: Morning Afternoon Evening (circled)

Adherence step 7: Managing missed doses
If I miss a dose, my plan is : to take treatment as soon as I remember

FTIC 1 sessions

Adherence Step 8 - Reminder strategies

To remind me to take medication, I will use: (watch) cell phone alarm pill box (buddy) other:..............................

Adherence Step 9 - Storing medication and extra doses

I will store my medication in: Safe place: In my Room Far from reach of children

I will carry extra supply and keep it in: bag (pill box) other:............ I will keep it in my: (handbag) pocket other:......

Adherence Step 10 – Dealing with side-effects

If I experience side effects, I will: Refer to treatment adherence pamphlet

Inform clinic if side effects do not go away or are too worrying

Session 3 *(date)*: 01 / 11 / 2016

Adherence Step 11 - Planning for trips

***If I have some trips planned, before going away I will*:** inform health facility before travelling to receive referral letter and treatment Get enough supply of treatment for trip

In case I cannot come to the facility before going away:

I will go to the nearest health facility in the travel access as soon as I arrive to get access to treatment

Carry evidence of my condition and evidence of the treatment I am taking

Adherence Step 12 - Dealing with substance use

My plan to make sure I take my medication if I used alcohol or drugs is:

To make sure I take treatment before starting to use drug or alcohol

Arrange for someone to remind me to take treatment in case I am intoxicated

Session 4 *(date)*: 10 / 11 / 2016

Education on follow up: Viral load Sputum HbA1c Other: ....

Patient's signature........NHeath.......... Date..10/11/2016

TREATMENT GOALS:

ARV goal: My first Viral Load will be suppressed! And thereafter remain below 400 copies/mL

TB goal: I have completed 6 months TB treatment and I am cured of TB

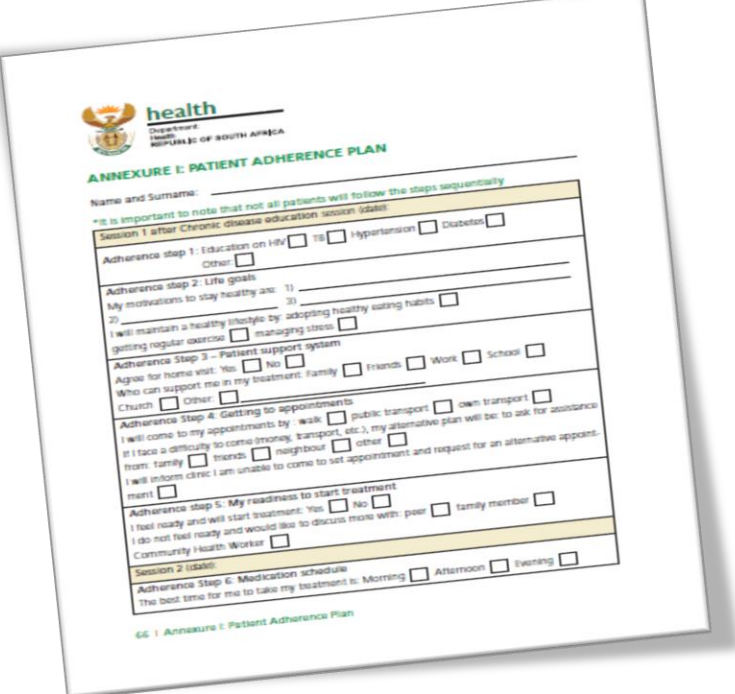
Hypertension goal: My Blood Pressure is less than 140/90

Diabetes goal: I monitor and keep my blood glucose within (FPG) 4-7 mmol/L

Adherence Plan treatment goals

Important to remind patient of treatment goals

- **Hypertension goal**: My Blood Pressure is less than 140/90.
- **Diabetes goal:** I monitor and keep my blood glucose within (FPG) 4-7 mmol/L.
- **ARV goal:** My first Viral Load will be suppressed! And thereafter remain below 400 copies/mL.
- **TB goal:** I have completed 6 months TB treatment and I am cured of TB!



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ANNEXURE I: PATIENT ADHERENCE PLAN

Name and Surname: ____________________

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Session 1 after Chronic disease education session (date):

Adherence step 1: Education on HIV ☐ TB ☐ Hypertension ☐ Diabetes ☐ Other: ☐ ____________________

Adherence step 2: Life goals
My motivations to stay healthy are: 1) ____________________ 2) ____________________ 3) ____________________
I will maintain a healthy lifestyle by: adopting healthy eating habits ☐ getting regular exercise ☐ managing stress ☐

Adherence Step 3 – Patient support system
Agree for home visit: Yes ☐ No ☐
Who can support me in my treatment: Family ☐ Friends ☐ Work ☐ School ☐ Church ☐ Other: ☐ ____________________

Adherence Step 4: Getting to appointments
I will come to my appointments by : walk ☐ public transport ☐ own transport ☐
If I face a difficulty to come (money, transport, etc.), my alternative plan will be: to ask for assistance from: family ☐ friends ☐ neighbour ☐ other ☐
I will inform clinic I am unable to come to set appointment and request for an alternative appointment ☐

Adherence step 5: My readiness to start treatment
I feel ready and will start treatment: Yes ☐ No ☐
I do not feel ready and would like to discuss more with: peer ☐ family member ☐ Community Health Worker ☐

Session 2 (date):

Adherence Step 6: Medication schedule
The best time for me to take my treatment is: Morning ☐ Afternoon ☐ Evening ☐

66 | Annexure I: Patient Adherence Plan

Roles and Responsibilities for FTIC 1 model

Clinician's role	• **Screen and provide treatment based on the clinical guidelines** • **Screen for mental health and substance use disorders** • **Provide next appointment as recommended per guidelines**
Non-clinician's role	• Education and counselling on illness • Assist patient complete adherence plan • Continuation of adherence plan at every visit • Inform patient about tracing and RIC
Patient's role	• Understand importance of starting treatment • Complete adherence plan with counsellor • Agree on treatment goals with health providers • Return for appointments as scheduled

Child and Adolescent Disclosure model - 7

- Focus is on providing **step by step**, **incremental** and **standardised approach** to **HIV** disclosure counselling in **children** and **adolescents**.

- Caregivers and all children **from 3 years old** should start being prepared for partial disclosure.

- **Disclosure criteria is as follows:**
  - **Non- Disclosure (2 yrs. and below)**
  - **Partial Disclosure (3 -9 yrs)**
  - **Full disclosure (10 yrs. and above)**

How is CADC 7 model implemented?

It is important to ensure that the **caregiver** is the **primary caregiver** who **lives** with the child or adolescent.

There are two sessions mainly:

- **session 1: Partial disclosure**
- **session 2: Full disclosure.**

- For each session, the caregiver is **prepared separately** to support the child during disclosure session.

- **Images or drawings** must be used to help children and adolescents understand the explanations during counselling sessions.

(use of the disclosure talk tool)

Education on illness

Education on Illnesses

11

Education on illness

Education on illnesses

Enhanced adherence counselling (EAC 2)

- Unstable patients can be counselled by clinicians or experienced non-clinicians.
  - mainly done by clinicians.
  - non-clinicians with experience nominated by facility manager

- **Enhanced adherence** counselling model **focus** on providing:
  - enhanced adherence monitoring,
  - adherence counselling
  - targeted interventions for unstable patients and
  - referring patients for support as soon as possible.

What patients qualify for the Enhanced Adherence Counselling (EAC 2) model?

- Patients with abnormal results on treatment:
  - **Hypertension**: persistent high BP (> 140/90).
  - **Diabetes**: high blood sugar level (FPG > 4.0- 7.0 mmol/L).
  - **TB**: positive smear on treatment for 2 months.
  - **HIV**: high HIV viral load on HAART VL> 400mmoll/mL
- Patients with adherence problems to prescribed chronic medication.

What tools are needed to implement EAC 2 model?

- Standard Operating Procedures booklet
- Patient Adherence Plan sheet.
- Mental Health assessment tool.
- List of supporting organisations (CBOs, FBOs) to assist with referral to psychosocial support

Guiding Principle

- Prioritise patients with less than optimal outcomes
- Provide information to patients on their latest health facility assessment
- Assess and address the barriers to adherence and to discuss effective strategies to overcome barriers to adherence
- Assist patients to set new objectives according to the next treatment steps

Guiding Principle

- Provide additional, individual support in case of switching to another regimen or treatment
- Refer patients for appropriate additional care and support services
- *Where possible, the facility manager shall identify lay counsellors with experience in counselling unstable patients on adherence issues.

Before every session

- Ensure you have all the tools you need:
- Health facility register
- Patient Adherence Plan sheet
- Adherence treatment pamphlet
- List of supporting organisations (CBOs, FBOs) to assist with psychosocial support.
- Pen

During each session :

- Build rapport with patient: Introduce yourself and ensure patient is comfortable.
- Show your appreciation to the patient for coming back to health facility
- Confirm contact details for patient tracing and cover issues of shared confidentiality
- Give the patient time to consider the abnormal results and help patient cope with emotions arising
- Encourage and provide time for the patient to ask questions and discuss his/her concerns

Procedure

- Discuss immediate concerns and help patient decide who in their social network may be available to provide immediate support
- Make an active referral for a specific time and date to community structures for psychosocial and other care and support

At the end of the visit

- Discuss any further questions or concerns that the patient may have.
- Schedule follow up visit, including confirming time and date to ensure that the patient is available
- Write the date of the follow-up visit in your diary/appointment card

Procedure

- Inform the patient they will be traced if they miss appointments and obtain consent for patient to be visited at home, if necessary
- Leave IEC materials with the patient after making sure that the patient understands information in IEC material in their language
- Provide hope and encouragement to the patient
- Update health facility register/(records)

EAC 2

Two sessions

- **Session 1:**
  - – Initial enhanced adherence counselling for unstable patients.
- **Session 2:**
  - – Enhanced adherence counselling for **persistent unstable** patient.

EAC 2

Two sessions

- **Session 1: (initial counselling for unstable patients)**
  - Initial enhanced adherence counselling for unstable patients.

1. Explain the purpose of your session, define terms
2. Education on the result
3. Flexibility on treatment
4. Patients experiences
5. Identify strategies to ensure good adherence

Session 2:

- Enhanced adherence counselling for **persistent unstable** patient.
- Patients are called for session 2, if they continue to have abnormal results after EAC session 1

Roles and Responsibilities for EAC 2 model

Clinician's role	• **Screen and provide treatment based on the clinical guidelines** • **Explain abnormal result to the patient** • **Assess and manage side effects** • **Consider switching to alternate regimen as per treatment guidelines**
Non-clinician's role	• Education on abnormal result and common causes to treatment failure • Assess and address barriers to adherence • Review adherence plan and set new treatment goals • Encourage adherence to influence next result • Inform patient about tracing and RIC
Patient's role	• Express barriers to adherence and potential reason for treatment failure • Review and adapt adherence plan with counsellor • Set new objectives • Come for next appointment and inform staff of any changes to contact or address if travelling

In Conclusion……………

- **Linkage to care, adherence and retention in care**
  - is key for better clinical outcomes hence the proposed innovative adherence guidelines interventions.

- **Linkage, adherence and RIC is everyone's responsibility:**

  - Patients
  - Clinicians
  - Non-clinicians
  - Communities
  - Traditional authorities
  - Implementing partners
  - Civil Society Organizations

- **Standardization of adherence interventions** should be done consistently to ensure that we deliver the right things, in the right places to the right people along the care cascade.