



Empowering communities to be healthy and free of TB and HIV

# Visualising facility based data to optimise linkage to care and retention in care

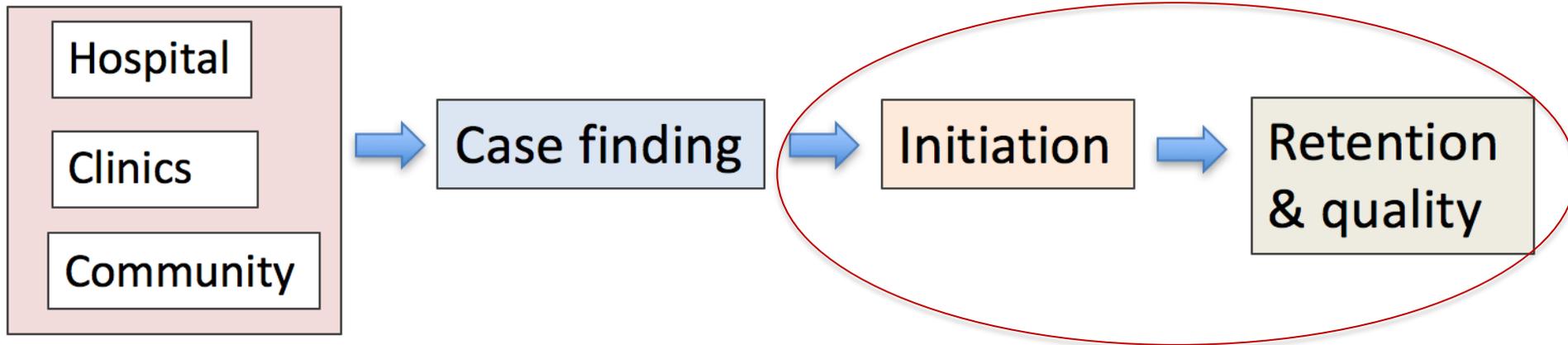
Prof Harry Hausler  
6 September 2017



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# The context

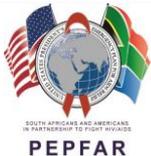
- TB HIV Care supports 128 facilities in Amathole District, Eastern Cape with TB and HIV care and treatment
- The intervention aimed to improve linkage to care (*initiation*), *retention* in care and *quality* of care



# The problem

There was no knowledge of:

- who had been diagnosed and not linked to care
- who was supposed to come back and when (because there was no appointment system)
- which care steps had been missed



# The intervention – 1. Adding human resources

DHIS data was used to identify *high volume sites* for placement of limited additional human resources:

- 39 Linkage Officers (LO) to link patients
  - *into care* for initiation
  - *back into care* for retention and quality of care
- 17 Data Capturers ensure capture of laboratory and clinical data in TIER.net including the TB module  
(The data capturers are supported by roving Systems Data Quality Mentors who support all 128 sites)



# The intervention - 2. Developing recall systems

## 2.1 Closing the 1<sup>o</sup> defaulter gap

### Recall Sheets for linking to initiation

#### a. TB Recall Sheet

LO reviews the *Case Identification Register* daily to identify GXP+ clients:

- Names are added to the *TB Recall List* and clients followed up to TB initiation

#### b. HIV Recall Sheet

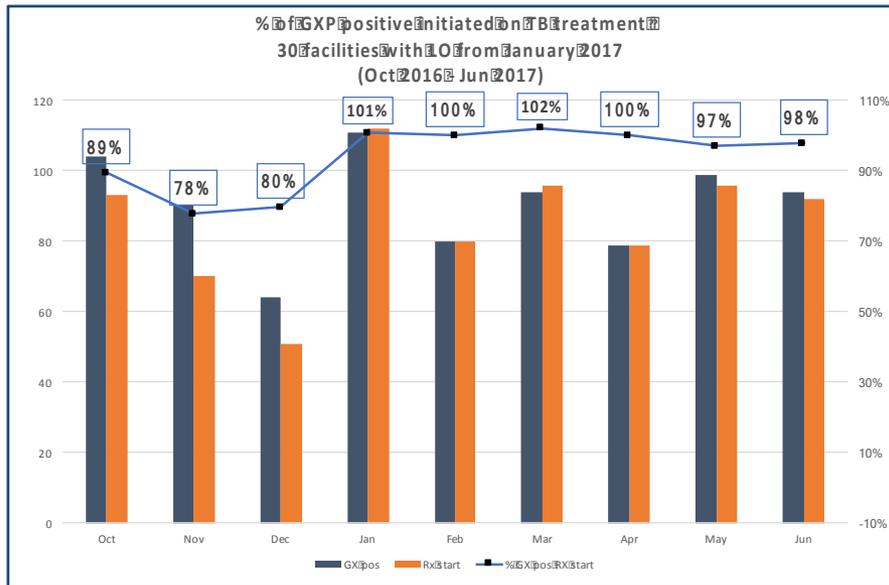
LO reviews the *HTS Register* daily to identify HIV-positive clients:

- Names are added to the *HIV Recall Sheet* and clients are followed up to ART initiation

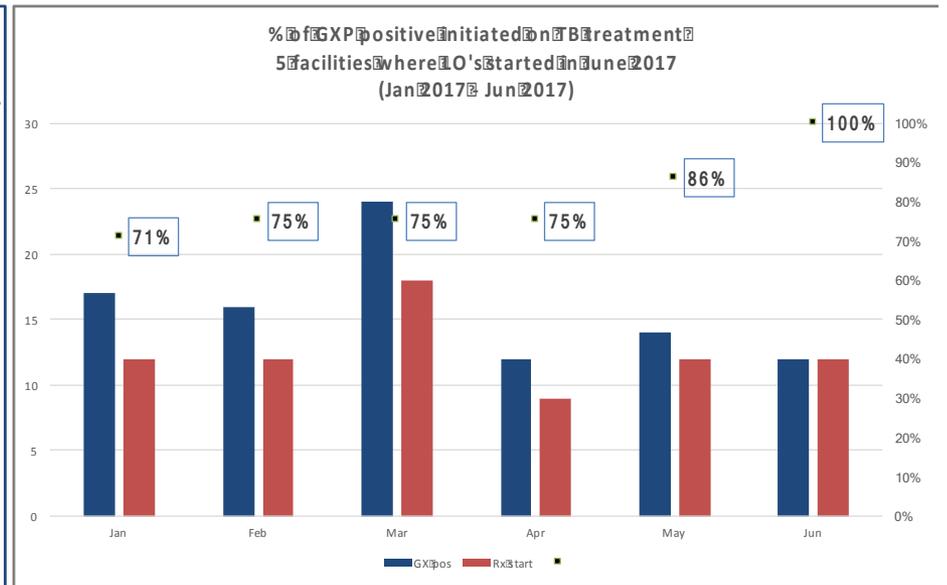


# Results: Closing the 1<sup>o</sup> defaulter gap for TB

The impact of the intervention is tracked using DHIS data



↑  
Linkage officers started



↑  
Linkage officers started



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# The intervention – 2. Developing recall systems

## 2.2 Managing missed appointments (Retention)

Appointment systems were introduced to know who is expected each day:

- i. TB Diaries were introduced
- ii. TIER.net appointment report are printed each day for the following day

Folders are drawn with admin staff the day before the appointment

Folders not used by the end of the day are ‘missed appointments’ for recall (a visual cue). Names are added to the Recall Sheets.

In addition

- i. TIER.net ‘Early’ and ‘Late Missed Appointment’ lists are printed weekly and monthly, respectively

Those with missed appointments are recalled to link them back into care



# The intervention – 2. Developing recall systems

## 2.3 Identifying care gaps (Quality)

### Cohort Tools designed to identify gaps in care

- i. TB Cohort Tool linked to the TB Register
- ii. ART TIER.net Cohort Tool

Cohort Tools applied monthly at the facilities to extract data from the TB register and various TIER.net reports to identify

- Current gaps in care
- Patients who have fallen through the gaps for recall



# The intervention – 2. Developing recall systems

## 2.4 Recalling patients

- Recalls are done in collaboration with Community Health Workers (CHWs) and ward based outreach teams (WBOTS), first by phone call (x 3) followed by a home visit, if necessary
- Cohort Tool and Recall Sheet data are collated at project level - comparison between sub-districts and facilities allow for focused support



# Using the data at project level

- At facility level data is used to identify and recall patients with missing care steps
- Cohort Tool and Recall Sheet data are then collated at project level ,sub-districts and facility performance compared to focus mentoring support.

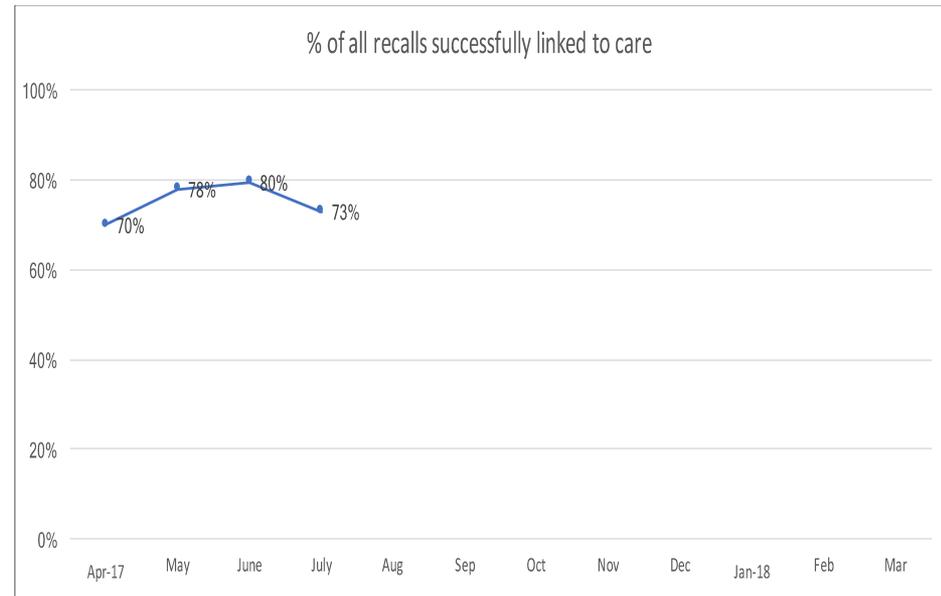
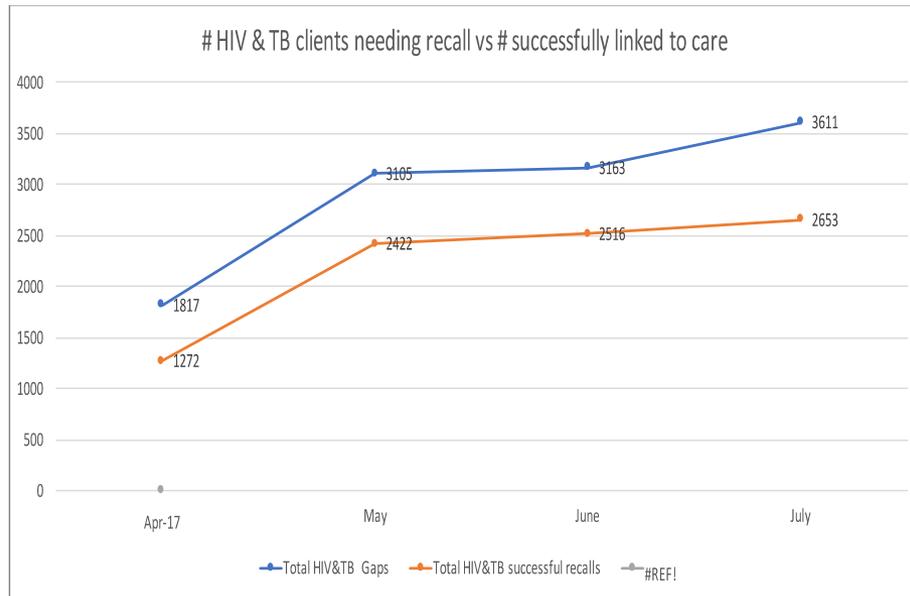


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# Using the data: Tracking progress

## Total number of TB and HIV gaps (combined) and % successful recalls



The increase in gaps identified month on month reflects the increased effort put in to finding patients with missed care steps

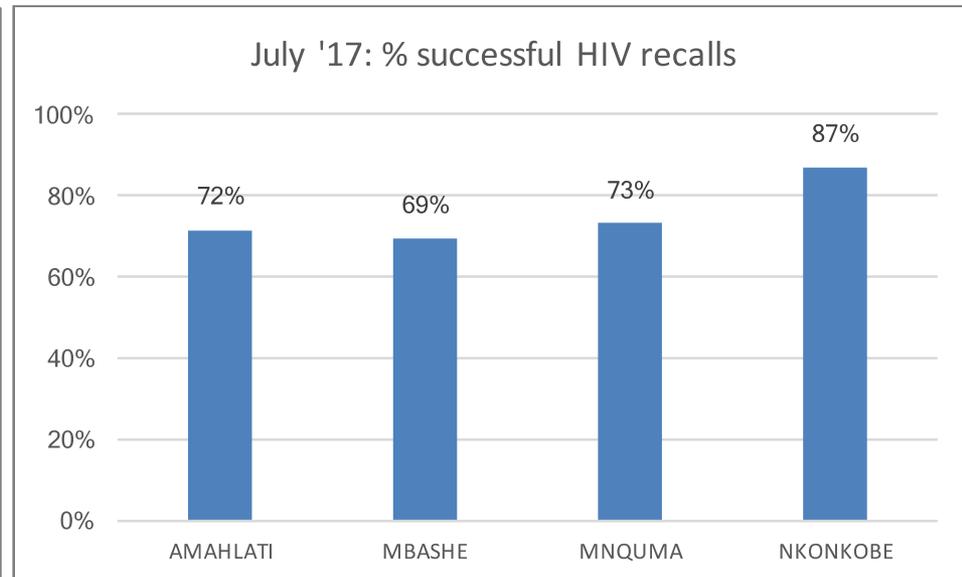
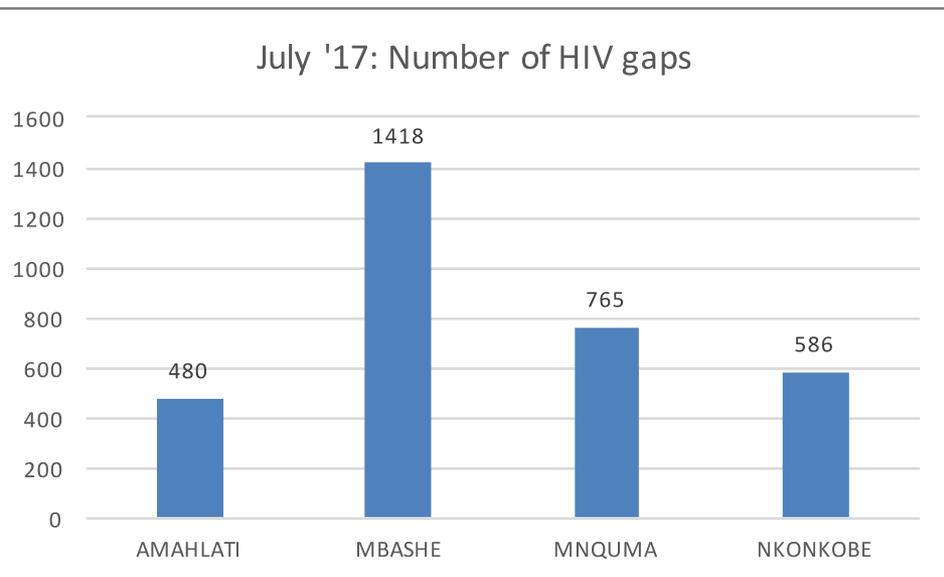


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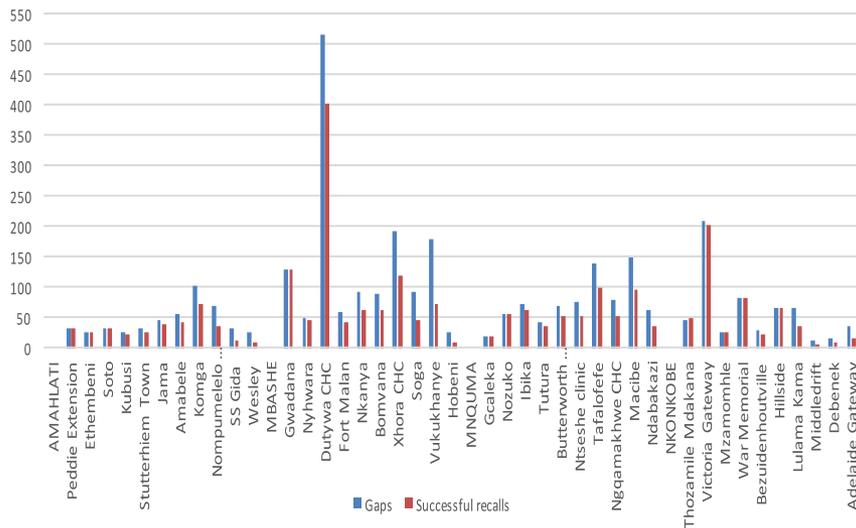
# Using the data for management: Comparing sub-district performance: Number of HIV gaps and % successful recalls

July 2017 HIV Cohort Tool Recalls

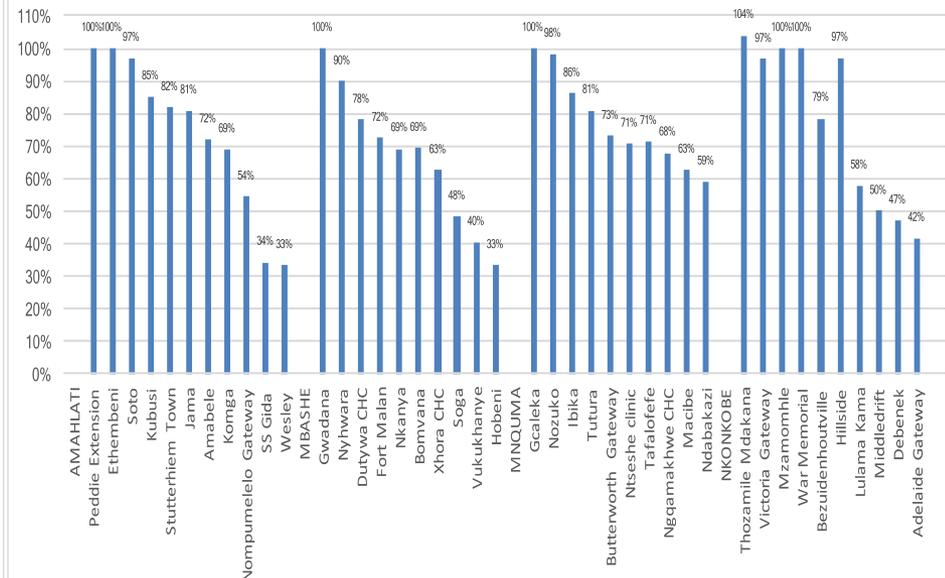


# Using the data for management: Comparing facility performance: Numbers and % successful recalls (Facilities are grouped by sub-district)

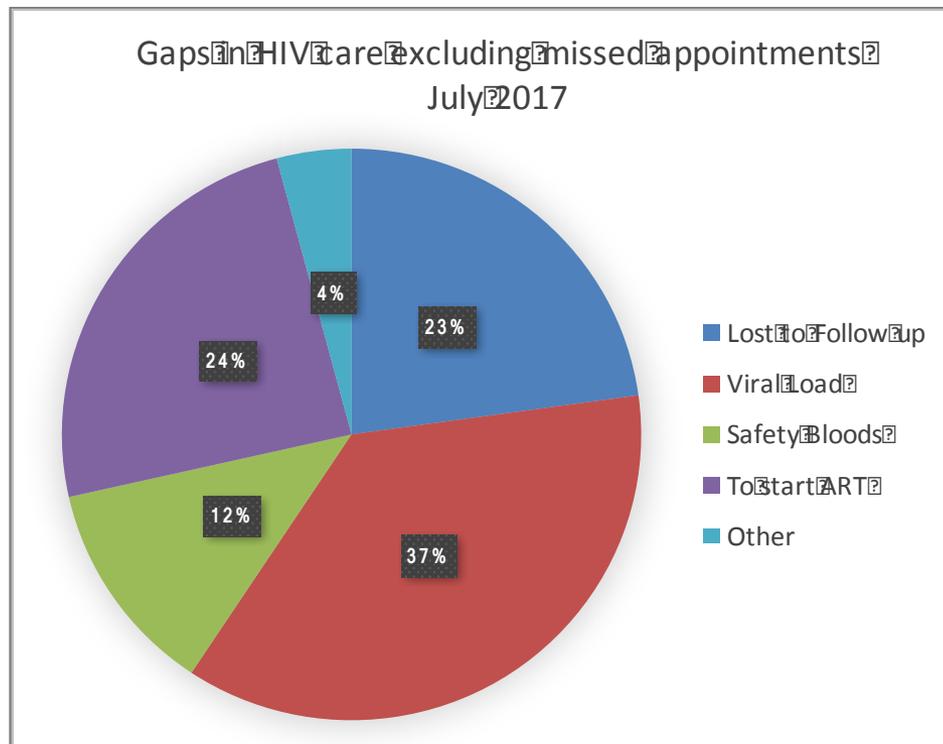
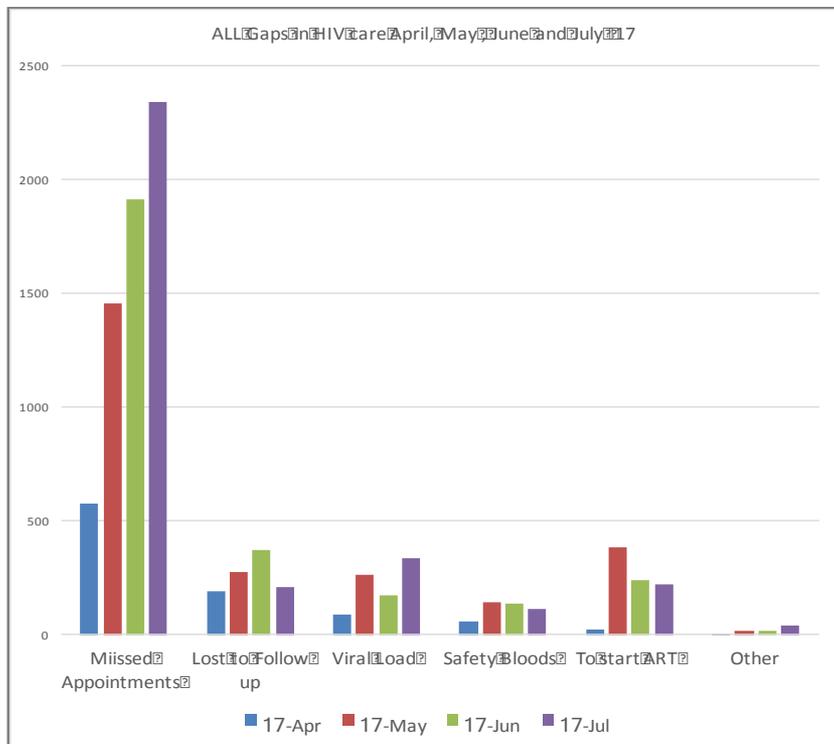
JULY 17: # HIV gaps vs # successfully recalled in facilities  
(HIV Cohort Recall Sheets)



JULY 17: HIV % Recall success



# Results: Identifying specific care gaps



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# Results: Impact on TB and HIV care

To monitor the impact of the interventions we will use:

A. Non routine data for:

i. Gene Xpert positive vs TB initiations (1<sup>0</sup> defaulters)

B. Routine ETR and TIER.net data for:

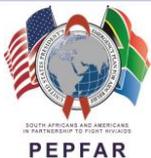
i. # patients started on ART/m

ii. Retention in HIV care (6m and 12m)

iii. Viral done (6m and 12m)

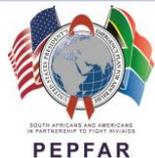
iv. Viral suppression (6m and 12m)

v. TB treatment success rate



# Next steps

- Provide Linkage Officers with household registration forms and individual adult health records so that the information will be collated into the WBOT reports and DOH will also see the impact of these home visits



# Conclusion

- The key to closing the care gaps is having a dedicated staff member (LO) to identify patients needing to be *linked into*, or *back into care*
- Structured interventions needed for all three stages of linkage
  - i. Linking to initiation
  - ii. Managing missed appointments
  - iii. Identifying specific care gaps (e.g. sputum, HTS, VL ,etc)
- Tools maximised existing facility registers and reports
  - i. TB and HIV Recall Sheets
  - ii. TB Cohort Tool and ART TIER.net Cohort Tool
- Once the gaps are closed it should reflect in the routine data



# TB/HIV Care Consortium



Southern African Catholic Bishops' Conference



SFH

Partners for a healthier nation



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# Thanks!

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