# OPERATION PHUTHUMA

# NERVE CENTRE SUPPORT HANDBOOK

**VERSION TWO**

**01 SEPTEMBER 2022**

health
Department:
Health
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THE AURUM INSTITUTE

Phila

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# ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| **ART** | Anti Retroviral Treatment |
| **CCMDD** | Central Chronic Medical Dispensing and Distribution |
| **DHIS** | District Health Information System |
| **DMOC** | Differentiated Models of Care |
| **HIV** | Human Immunodeficiency Virus |
| **HCT** | HIV Counseling and Testing |
| **HIV SS** | HIV Self Screening |
| **HM** | Huddle Meeting |
| **HTS** | HIV Testing Services |
| **LTF** | Loss To Follow |
| **NC** | Nerve Centre |
| **NDOH** | National Department of Health |
| **NIMART** | Nurse Initiated Management of ART |
| **OP** | Operation Phuthuma |
| **OM** | Operations Manager |
| **PDSA** | Plan Do Study Act |
| **PEP** | Post Exposure Prophylaxis |
| **PMTCT** | Prevention of Mother to Child Transmission |
| **PUP** | Pick Up Point |
| **RIP** | Rest In Peace |
| **SIMS** | Site Improvement Monitoring Systems |
| **SOP** | Standard Operating Procedures |
| **TEE** | Tenofovir Emtricitabine |
| **TFI** | Transfer In |
| **TFO** | Transfer Out |
| **TLD** | Tenofovir Lamivudine Dolutegravir |
| **TROA** | Total Remaining On Art |
| **VL** | Viral Load |
| **VLS** | Viral Load Suppressed |

# FOREWORD

In recognising the need for a centralised, more robust structure to manage and control interventions in the HIV program, the NDOH launched Operation Phuthuma in April 2019.

One of the primary objectives was to implement interventions that have immediate effect as well as long term sustainability. For this reason, Operation Phuthuma considers all interventions from a national perspective and plans are developed to address challenges in all facilities across all provinces.

Operation Phuthuma is run from a centralised project management office, called the Project Management Room (PMR), located at the National Department of Health offices in Pretoria central. It is important to note that Operation Phuthuma operates as a support structure to the NDOH HIV/AIDS and STI's cluster. Its function is to coordinate, facilitate and provide project management support. A project team has been appointed who oversee the management and coordination of all activities including:

- Target setting for facilities and districts.
- Project management of key interventions contributing to achieving 90-90-90 targets.
- Distribution of dashboards for interventions as soon as possible after the intervention is carried out.
- Monitoring of achievement against targets.
- Hosting of weekly teleconferences with provincial HAST managers.
- Hosting of weekly teleconferences with PEPFAR implementing partners.
- Management of facility support visits and improvement plans at prioritised facilities.
- Trouble shooting.

Operation Phuthuma has shown a significant improvement in coordination and active management of interventions right down to facility level. All provinces are actively participating in driving prioritised interventions across all facilities, with particular focus in high volume facilities identified by the Operation Phuthuma team.

PEPFAR, WHO, UNAIDS, Global Fund and The Bill and Melinda Gates Foundation, Clinton Health Access Initiative are participants within the project and have each contributed to its success in terms of technical as well as direct service delivery support.

We wish to specifically thank the Bill and Melinda Gates Foundation for funding the development and design of this Handbook.

I encourage all nerve centres to apply the Operation Phuthuma Nerve Centre approach in order to successfully and systematically address implementation challenges in all provinces, districts and facilities.

Dr Zukiswa Pinini
Chief Director: HIV/AIDS and STI's

# BACKGROUND

The South African National Department of Health (NDoH) has been applying a programmatic approach to improving the health system for more than a decade. The HIV/AIDS epidemic and the global focus on ending AIDS as a public health threat by 2030, created particular impetus on addressing the bottlenecks in our health system in order to improve programmatic outcomes.

The country launched projects like the **Accelerated PMTCT plan in 2008**, which introduced a project management approach to health system implementation, and a requirement to drive key interventions rapidly and robustly across the country. The HCT **Campaign introduced in 2010 saw the realisation of a need to have nerve centres**, connected through the data they report, act as the management and coordination structure of the campaign. The **3-feet approach led by UNICEF** in the Nelson Mandela Bay Metro introduced a granular focus on data at facility and sub-district levels that had previously limited data use to reporting. The 3-feet approach made the analysis of data necessary at the lowest level possible and this yielded good results in the program. The **District Implementation Planning process introduced by the Strategic Programs branch of the NDOH in 2015**, saw the prioritisation of key indicators, the monitoring of data and process via tools like cascades and dashboards, and a collective approach to problem solving across programs and platforms. Progress against targets were closely monitored through a set of cascades, tracer indicators, district and facility level targets and dashboards. The district and facility level targets were a disaggregation of the national level targets. This was modelled on the highly successful approach adopted by South Africa to achieve the Global Plan for eMTCT. The **Treatment and Retention Acceleration Plan (TRAP) SOP** focussed efforts at facility level, in alignment with the **DHMIS policy of the NDoH**. This SOP provided further guidance on how to review data at facility level, on a weekly basis, taking some of the primary requirements to understand and resolve challenges to the lowest levels possible with the staff that are actually involved in the processes themselves.

From a systems-perspective, various programs and strategies were introduced to support an improvement and standardisation in the services offered through our health system. These included the introduction of the **National Core Standards** for health facilities, the **Ideal Clinic Framework**, and more recently, the **Revitalised DHP framework**. These interventions escalated the importance of Quality Improvement, process modelling, and data for operational and strategic planning across the health system.

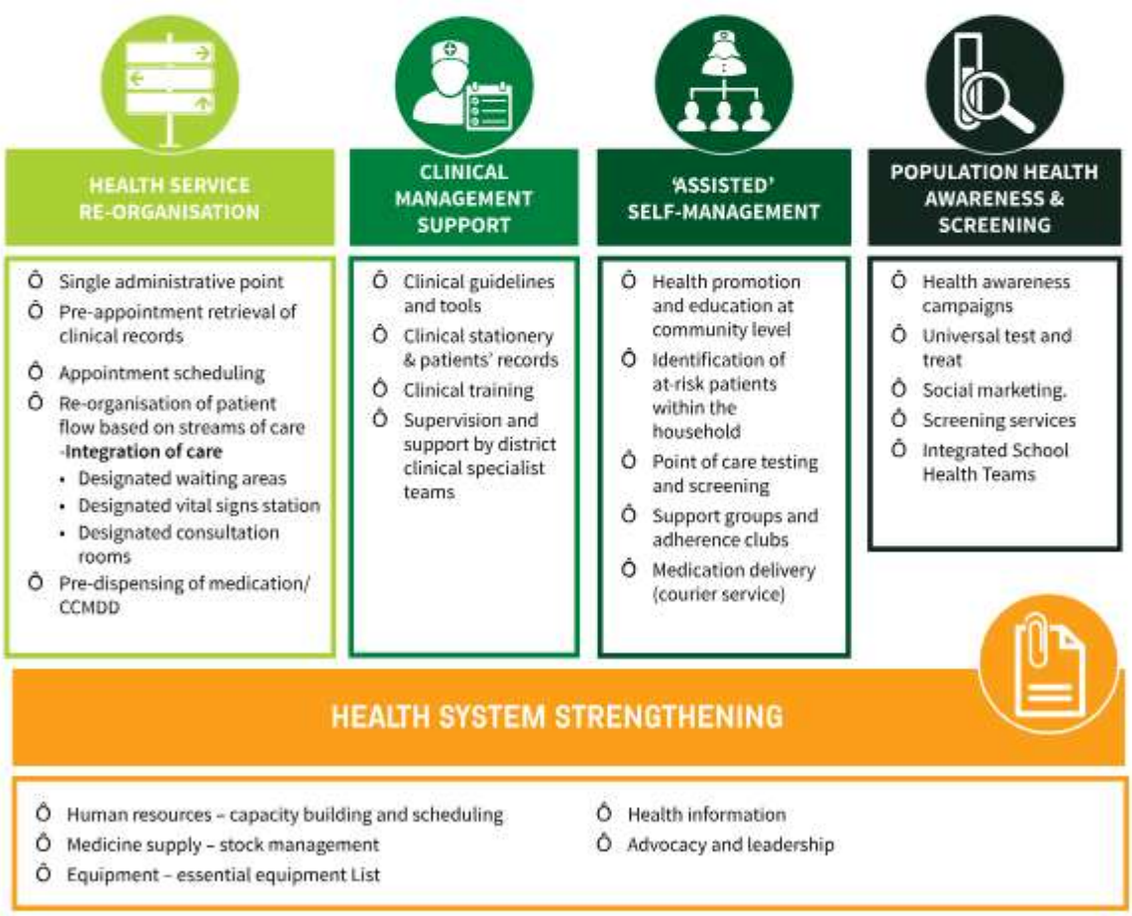
**In recognising the need for a centralised, more robust structure to manage and drive interventions in the HIV program, the NDoH launched Operation Phuthuma in April 2019.** Operation Phuthuma has shown a significant improvement in coordination and active management of interventions right down to facility level. It is necessary for a similar structure to be replicated at every level of the health system, and most importantly, that each level focus on the problems and challenges relevant to them and within their control to fix. For this reason, the flow of information upwards to escalate issues is critical as well as the feedback to lower levels for support and guidance. The requirement for Nerve Centres has been one of the focus areas for Operation Phuthuma since inception, and with each development, lessons and principles from pervious interventions are leveraged and built on.

We hope that this handbook will be both supportive and informative in bringing about the objective of nerve centres which is that of improvement. As we too are constantly trying to improve what we do and how we do it, we ask that you provide feedback as to how the material can be enhanced to better suit your needs.

**Operation Phuthuma Team**

# PURPOSE

The aim of Operation Phuthuma (OP) nerve centres are to enable OP teams to make informed, data driven improvements, using a multi-disciplinary approach, to understand and address problems. The handbook brings together learnings from DIP, TRAP, Ideal Clinic, ICRM, initial stages of OP implementation and other NDoH interventions, aligning these to existing DoH guidelines, policies, procedures and frameworks. In support of the TB/HIV information system, the THIS support portal contains all relevant documents/reference guides/training materials. It can be accessed at www.tbhivinfosys.org.za. Applying a quality improvement problem solving approach at all levels of health management, has prompted the development of the tools contained in the handbook. Working with Integrated Clinical Services Management, OP uses a health system strengthening approach and a patient-centric view to achieve operational efficiency. The revised OP handbook is designed to assist nerve centres at all levels, with a more effective structure, tools and processes needed to address and sustainably improve underperforming HIV indicators in a world with evermore increasing demands on staff and resources. Effective OP meetings, will assist with the realisation of Ideal Clinic components which focuses on the following:



The tools provided in the handbook will assist healthcare workers to analyse their data and processes of work, to better be able to understand why problems are occurring and therefore be better equipped, as teams, to address them in a timely manner. The handbook provides further guidance on how the data and information flows and contributes to the levels above and below. This supports management decisions at the appropriate level.

COVID-19 has reemphasised the need to work a lot smarter and not harder. The revised OP structure is laid out in this handbook and designed to assist teams achieve improvements in these complex times.

While the tools and templates are specifically focusing on the HIV programme priory indicators, all the principles taught in this handbook, can and should be applied to all indicators in any programme. Multi-disciplinary teams who are empowered and equipped to identify and address their own problems, within their own context, are destined for implementation success.

The tools and templates which have been provided in the handbook have all been tested within districts in SA and have found to be effective in developing improvement capacity. The following guidelines were used in developing all of the material within the handbook:

**1. 2019 ART Clinical guideline for the management of HIV in Adults, Pregnancy, Adolescents, Children and Neonates. Published 2019, Updated 2020**

- ART eligibility
- Defer ART
- TLD transition – eligibility criteria
- Viral load monitoring

**2. National HIV testing Services Policy, 2016, NDOH**

- HIV Testing, service points

**3. Integrated Adherence guidelines**

- Minimum package of intervention to support linkage, adherence and retention in care
- Patient tracing

**4. Integrated TB/HIV Data Management (Part I&II) SOP documents**

# STRUCTURE OF THE HANDBOOK

**The handbook has been organised into 3 main sections:**

The first two chapters are focused on OP nerve centres at health facilities. While good strides have been made at implementing OP nerve centre meetings at higher levels of health, **much greater emphasis must be placed at facility level. Where services are being delivered.**

**CHAPTER ONE** introduces nerve centres at health facility level, what their purpose is and how they should be structure for optimal results.

**CHAPTER TWO** is specifically focused on applying the OP nerve centre structure to the 7 OP priority indicators. In this chapter you will find all the necessary implementation steps, templates, tools and agendas needed to apply the OP improvement process to each priority indicator of the 7 priority indicators.

**CHAPTER THREE** concentrates on all above site level managers working at sub-district, district, provincial or national levels of health. A more in-depth understanding of factors causing challenges at facility level is essential to ensure that problems are addressed systematically. This chapter provides insights and tools for managers to remain focused on strengthening the health system and removing obstacles that are hindering improvement at facility level.

**The facility and above site management level sections, are further divided into 3 sections which highlight the OP meeting process:**

**A** **Pre-Meeting Preparation**

**B** **Conducting an OP Nerve Centre Meeting**

**C** **Post Meeting Activities**

# INTRODUCTION

Quality Improvement Management Framework
HIV Priority Indicators
Data Descriptions of Priority Indicators
Summary of Tools

# QUALITY IMPROVEMENT MANAGEMENT FRAMEWORK

In developing the handbook, we have used a Quality Improvement project management framework which we have found to be extremely useful in providing an overall, big picture improvement lens to the work of OP nerve centres. We would like to encourage you to use this model whenever you decide to do something about a problem. Remember, if we don't know what we have done, or how we have done it, how will we ever be able to do it again! This model is a simple way of looking at all our work to make sure it is more sustainable and effective. This framework suggests that all improvement work should follow the following 4 phases:

## 1 Assessment

Together assess the current situation, determine what the cause of the problem is, decide where you want to start. This can be done by:

- Situational Analysis using data (Family of measures, DHIS, TIER.Net, SIMS)
- Review registers, file audits etc
- Root cause analysis (Fishbone, process map, 5 whys)
- Develop an Improvement Plan with all relevant stakeholders.
- List all the changes you think may need to be made and start with 1.

## 2 Action

**a.** To get a different more sustainable result we must do something differently. Some interventions include:

**i.** Lack of knowledge (Training)

**ii.** Lack of skills (Mentoring)

**iii.** Workflow or systems issue: PDSA Testing cycles – What can we do differently? PDSA cycles are discussed in detail in the Ideal Clinic Manual and ICRM processes outlined by NDoH

**iv.** Lack of resources

**b.** Remember to think about and plan for your ANALYSE (What indicators will you use?) How often will you review the data?

## 3 Analyse

**a.** Determine the impact (Result) of the ACT. Was this change a success or not?

How do you know?

**b.** This must be data driven (process/outcome measures)

**c.** Remember to observe the situation; what is it telling you about the impact of your ACT?

**d.** Is there something you should rather do differently?

**e.** How can the findings be shared?

## 4 Anchoring

This is all about sustainability and maximising impact. Think through and plan to:

- Support staff/process so that it continues
- Sustain the ACT
- Endorse the ACT (SOPs, guidelines etc)
- Integrate the ACT into the system (should workplans be adjusted?)
- Report on the results of the ACT to all relevastakeholdersnt

# HIV PRIORITY INDICATORS

The handbook focuses on the HIV priority indicators listed below. It is important to note however, that all principles taught in this handbook, can and should be applied to all indicators in any programme. These are the HIV programme priority indicators:

**1**
**Total HIV tested**

**2**
**Total HIV positive**

**3**
**Total naive start ART**

**4**
**Total remaining on ART (TROA)**

**5**
**TLD Transition**

**6**
**ART Viral Load Suppressed**

**7**
**Differentiated Models of Care (DMOC)**

# DATA DESCRIPTIONS HIV PRIORITY INDICATORS

| Indicator | Description |
|---|---|
| **1. Total HIV Tested** | Number of individuals who received HIV Testing Services (HTS) and received their test results. This indicator includes ANC client's 1st test., Adult (males and females with age disaggregates and children with age disaggregates See https://dd.dhmis.org/ |
| **2. Total HIV Positive** | Number of individuals who tested HIV positive. This indicator includes ANC client's 1st test. Adult (males and females with age disaggregates and children with age disaggregates. See https://dd.dhmis.org/ |
| **3. Total naive Start ART** | Number of adults and children newly enrolled on antiretroviral therapy (ART). These clients have never been exposed to ART and PEP. It excludes experienced clients and transfer ins. |
| **4. Total remaining on ART (TROA)** | Total clients remaining on ART(TROA) are the sum of the following:<br>• Any client on treatment in the reporting month<br>• Any client with an outcome reported in the reporting month<br>• Clients remaining on ART equals [new starts (naive) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + loss to follow-up (LTF) + Transfer out (TFO)] |
| **5. TLD Transition** | Eligible patients on TEE switched to TLD<br>Eligible patients have 2 consecutive suppressed viral load. |
| **6. VL Suppressed** | ART viral load under 50 cps/mL (VLS) |
| **7. Differentiated Models of Care (DMOC)** | New registrations<br>Total active patients<br>Total patients Facility PuP<br>Total patients ExPUP<br>Dormant patients<br>Closed Patients |

# CALCULATING PRIORITY INDICATORS

| Indicator name | Description | Calculation | |
|---|---|---|---|
| | | Numerator | Denominator |
| Positivity rate (Yield) | Within a testing programme the percentage of positives found out of those who were tested and received their HIV results Yield can be used for general testing as well as targeted testing. | HIV positive total | HIV test done total |
| ART naive start rate | The percentage of people who test HIV positive and are linked into care and initiated on ART. | ART naive start ART Total | HIV positive total |
| Total remaining on ART (TROA) | The percentage of adults and children under 15 years old remaining on ART at the end of the period | ART remain in care - total | ART naive start total minus cumulative TFO |
| Viral Load Done rate (VLD) | Percentage of ART patients in care due for a viral load test within their cohort period. | ART viral load done | ART remain in care - total |
| Viral Load Suppression (VLS) rate | Percentage of patients with ART viral load done (VLD) who have a viral load result under 50 cps/ml | ART viral load suppressed - total | ART viral load done - total |

https://dd.dhmis.org/index.html

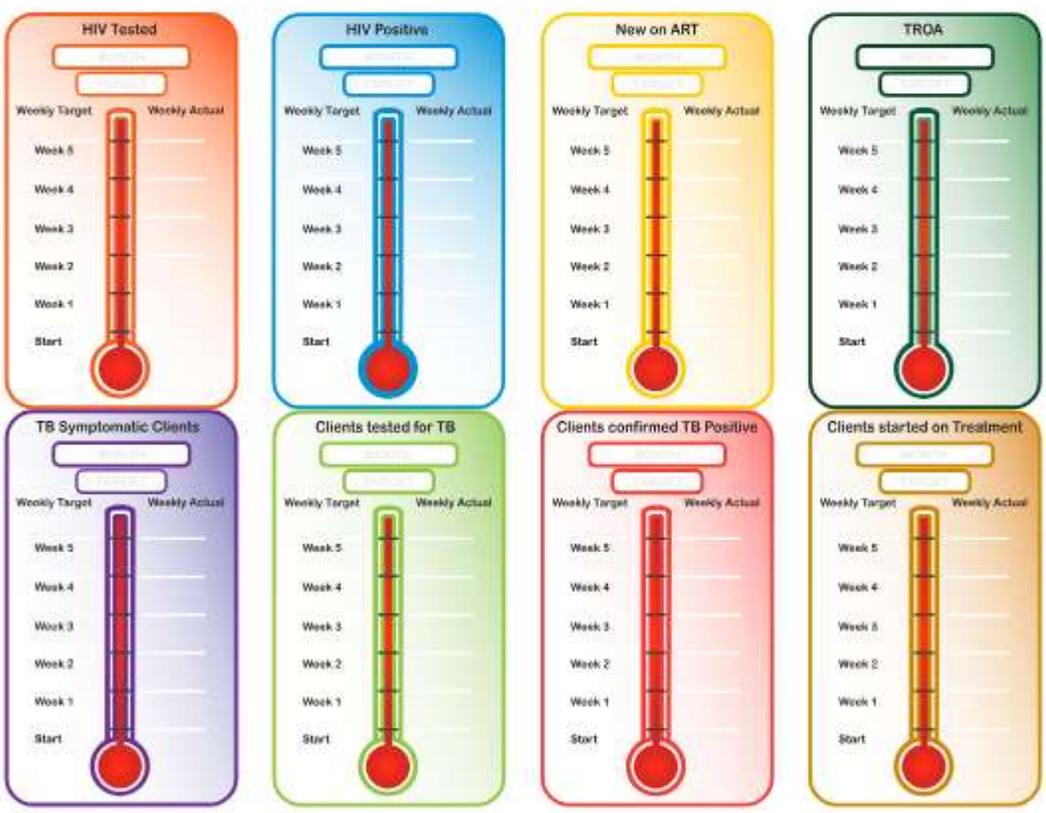
# SUMMARY OF TOOLS

In the OP nerve centre handbook, several tools and templates are introduced, which have been designed to improve the way nerve centre's function and more significantly align them to the goal of why nerve centres exist, which is to improve programme indicators.

**Here is a summary of each category of tool and its purpose:**

## a. Barometers

- Barometers display weekly data of priority HIV and TB indicators' performance against target.
- Barometers should be used and updated weekly by Indicator Teams in their huddle meetings (see Indicator Teams page 27).




- Targets for the following week or month, must be based on the previous periods' actual performance; the only target that therefore does not change is the annual one.
- To assist with completing barometers correctly, we have developed a brief poster to guide Indicator Teams (see annexure page 185)

## b. Indicator Summary Charts

- Provide a quick overview of all the data elements that contribute to a specific indicators' performance.
- Summary charts give OP Indicator Teams an opportunity to dig deeper into their data by giving a more detailed view of the elements impacting on an indicators performance.
- Indicator Teams can then make informed data-driven decisions when identifying problem areas and planning for improvement activities.

**Here is an example of an Indicator Summary Chart:**

- The data elements contributing to the overall performance of each specific indicator, form part of each summary chart
- Data must be recorded for each element every week of the month
- Each summary chart has a Data Analysis Guide that will assist Indicator Teams to analyse their weekly data and identify opportunities for improvement

**Total HIV Tested and Total HIV Positive (HTS Indicator Summary Chart)**

| Total HIV Tested | |
|---|---|
| MONTH: | |
| TARGET | |
| ACTUAL: | |

| Total HIV Positive | |
|---|---|
| MONTH: | |
| TARGET | |
| ACTUAL: | |

| 1 | Obtain the weekly facility headcount, excluding the known on ART |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 2 | Total Number of people tested for HIV this week = | | |
|---|---|---|---|
| | # tested at facility | # tested in community | # of index contacts tested |
| Week 1 | | | |
| Week 2 | | | |
| Week 3 | | | |
| Week 4 | | | |
| Week 5 | | | |
| Month | | | |

| 3 | Number Tested for HIV this week and recorded in the HTS register |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 4 | Number tested this week that were captured on TIER.Net |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 5 | % of Eligible headcount tested |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 6 | Total Number of people tested Positive for HIV this week = | | |
|---|---|---|---|
| | # tested at Facility | # tested in community | # of index contacts tested |
| Week 1 | | | |
| Week 2 | | | |
| Week 3 | | | |
| Week 4 | | | |
| Week 5 | | | |
| Month | | | |

| 7 | Number Tested for HIV Pos this week recorded in the HTS register |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 8 | Number tested Pos this week that were captured on TIER.Net |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 9 | HIV Pos Yield |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

**Data Analysis Guide**

- Tested at facility + Community + Index = Total tested
- Step 2 = Step 3 = Step 4
- Eligible Headcount = Number tested / Facility Headcount excluding the known on ART
- Tested Pos at Facility + Community + Index = Total tested Pos
- Step 6 = Step 7 = Step 8
- HIV Yield = Number tested Pos/ Number tested for HIV

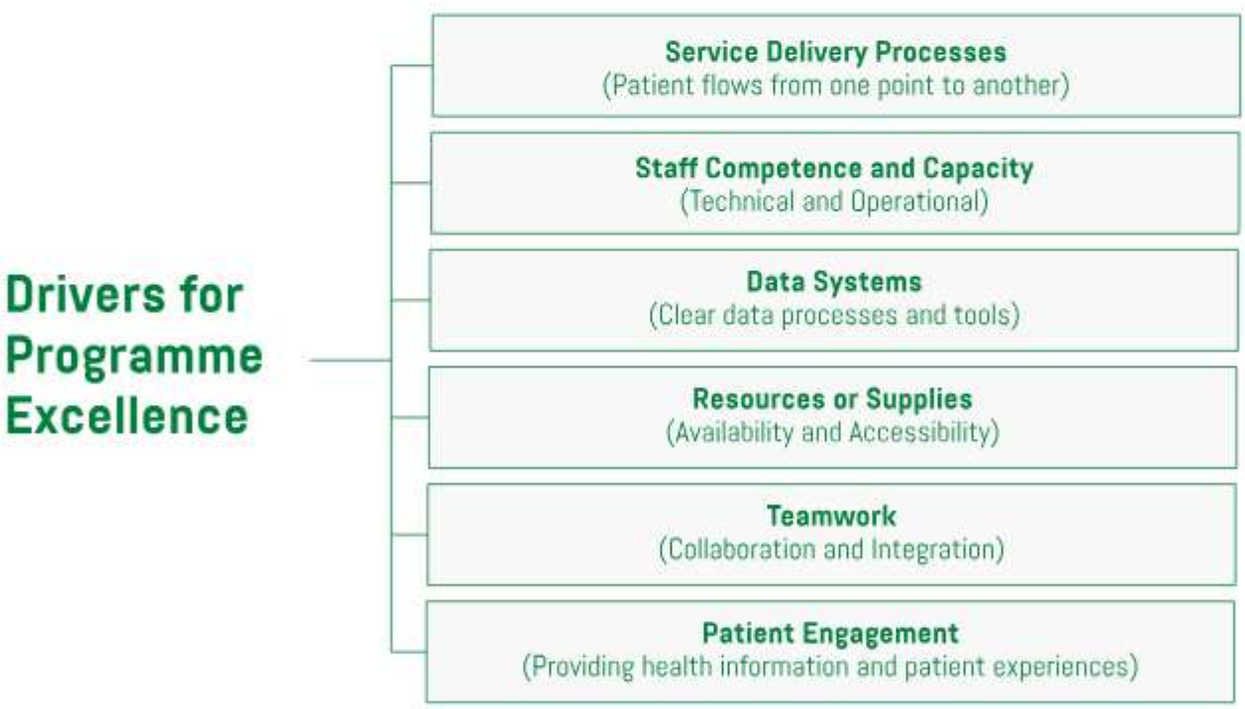
## c. Step-by-step Indicator Assessments

- The step-by-step assessments will assist OP Indicator Teams to identify specific gaps in their own system, process or workflows, and/or resources, that are inhibiting the achievement of the indicators target.
- Users need to follow each step in the assessment to identify the gaps
- The assessment is divided into sections; each section is colour coded and corresponds with the colours in the indicator summary chart
- Answers should be recorded under '**Data**'
- '**Source'** is the data source that should be used when collecting the data
- **Guiding Instructions** provides additional information to assist with the completion of the step/activity
- The purpose of the step or section is indicated under '**Assessment Objective**'
- Here is an example of a Step-by-step Indicator Assessment:

| Indicator: Total HIV tested (Adults incl. ANC & Children) & Total HIV Positive | | | | | |
|---|---|---|---|---|---|
| Elements: (Testing) : ANC client 1st test, HIV test around 18 months, HIV test 19-59 months, HIV test 5-14 years, HIV test female15- 24 (excluding ANC), HIV test male 15-24 years, HIV test 25-49 years, HIV test above 50 years | | | | | |
| Definitions (Positive) : ANC client 1st positive, HIV positive around 18 months, HIV positive 19-59 months, HIV positive male 5-14 years, HIV positive female 15- 24 (excluding ANC), HIV positive male 15-24 years, HIV positive 25-49 years, HIV positive above 50 years | | | | | |
| | **Assess the following:** | **Evidence** | **Source** | **Guiding Instructions** | **Assessment Objective** |
| **SERVICE DELIVERY APPROACHES & PROCESSES** | | | | | |
| **Step 1** | **HIV Screening process** | | Facility protocol | Draft descriptions of HIV screening process and demand generation approaches. Do pocess mapping | Determine if there is a routine screening process embedded in all service processes |
| | What is the HIV screening process to identify patients eligible for HIV testing at each relevant serivice entry point e.g. Acute, NCD Emergency room, Family planning, Dentistry etc. | | | | |
| **Step 2** | **Demand generation approaches used** | | Facility protocol | | Identify which demand generation strategies and innovations that are being utilised in the facility to make the HIV testing service accessible. |
| | Opt-in (patients made aware that there is availability of HIV testing, without explicitly offering them service) | | | | |
| | Active choice (Patients explicitly offered HIV testing, allowing them to actively choose the service) | | | | |
| | Opt-Out (Patients actively directed for HIV testing, but can decline it) | | | | |
| | PICT (Routine HIV testing recommendation to patient by the health care provider during consultation) | | | | |
| | Other (Describe) | | | | |
| | Community testing | | | | |

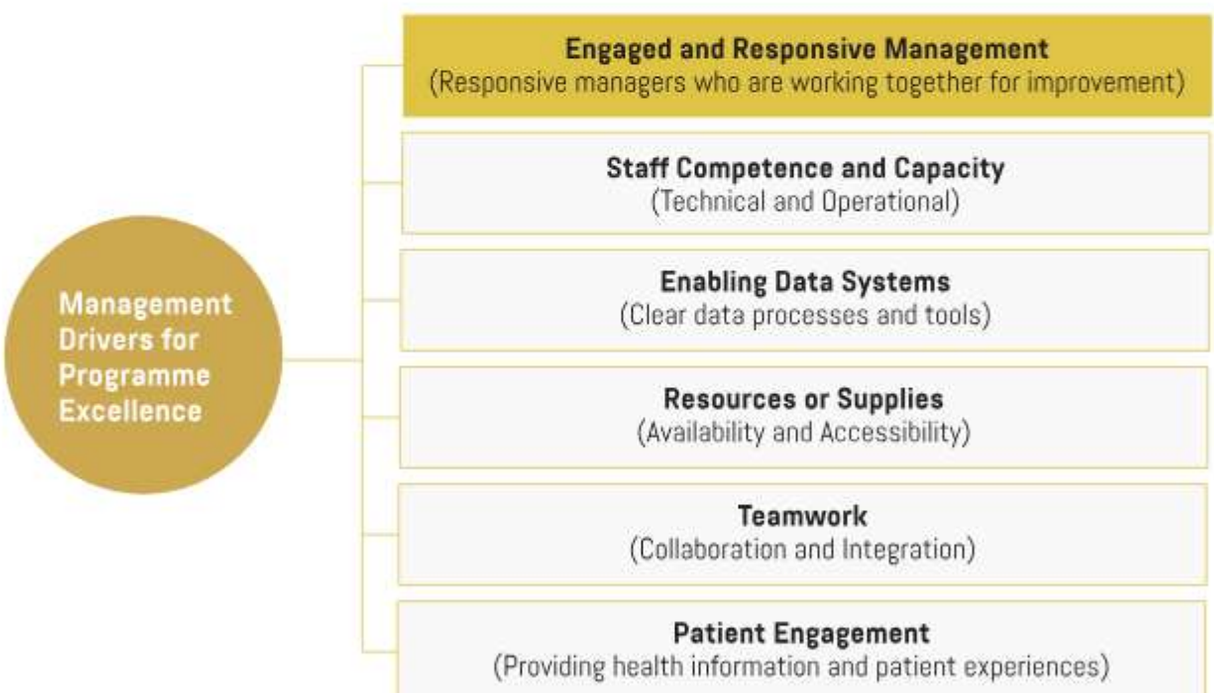
## d. Drivers for Programmatic Excellence for facilities

- **The way our programmes are designed and implemented can be the cause of the problems being experienced at facility level.** When identifying causes of a problem, an Indicator Team or manager, needs to work through the suggested 'Drivers for Programmatic Excellence' to ensure that the essential elements of the programme, have been considered and implemented. Gaps in a programme need to be identified, understood, and addressed for an indicators targets to be met
- Below is a **generic framework** for OP Indicator Teams as a guide to identity the essential elements that need to be considered when designing an implementation programme for each priority indicator
- Drivers for Programme Excellence have been developed for each priority indicator and can be found in Section 2 appendices of this handbook.



## e. Management Drivers for Programmatic Excellence

- These are suggested high-level 'drivers' that need to be considered when analysing the **performance of a programme designed to implement an indicator.**
- Each driver will need to be in place and addressed in order for the programme/indicator to be functioning correctly and effectively.
- The difference between drivers at facility level vs management level are that drivers at facility level are focused on the delivery of an indicator for a specific facility, whereas management level drivers address the design of the entire programme for all facilities in a set geographic area.
- A different driver is needed at management level which is 'Engaged and responsive leadership'; whereas at facility level, 'Delivery processes' is a higher priority. Engaged managers from all programme areas are essential to ensure that efforts and demands are not duplicated at facility level.



## f. Nerve Centre Meeting Agendas

- The aim of all nerve centre meetings is to create a multidisciplinary problem-solving approach within OP teams, that is dependent on data to make informed critical decisions toward improvement of indicators.
- At facility level, there are 2 different types of OP nerve centre meetings, (1) weekly Huddles and (2) Monthly Nerve Centre Meetings (see Facility Level section)
- Sample templates have been provided to encourage a standardised approach, structure, and flow to all nerve centre meetings.
- **Agenda points are largely focused on 2 items, current improvement project/s, and future improvement projects**
- This is an example of a Weekly Huddle Nerve Centre Meeting Agenda:

**Huddle Meeting Agenda**

| | | | | | |
|---|---|---|---|---|---|
| Date: | | | Week: | | |
| Priority Indicator: | | | | | |
| Indicator Champion: | | | | | |
| Indicator Team Members: | | | | | |
| **Time Allocation** | | **Agenda Point** | | **Responsibility** | |
| | | LAST WEEK'S PROGRESS | | | |
| | | 1. Did we do what we agreed to? | | All | |
| | | 2. Did it work? If not, why not? | | All | |
| | | 3. What were challenges faced? | | All | |
| | | 4. What support is required? | | All | |
| | | 5. What needs to be considered for sustainability? | | All | |
| *Indicator Champion completes Huddle meeting reporting template for the group | | | | | |
| | | CURRENT PROBLEM | | | |
| | | 1. Complete the Barometer | | All | |
| | | 2. Circle identified problems | | Champion | |
| | | 3. Discuss Drivers for Program excellence? | | | |
| | | 4. Prioritize the problem area to be worked on:<br>• What has the biggest effect on the indicator's performance?<br>• Can we do something to improve it now?<br>• Can the problem be solved at this facility? | | All | |
| | | 5. Develop an action/improvement plan | | All | |
| *Indicator Champion completes Huddle meeting reporting template for the group | | | | | |

## g. Nerve Centre Meeting Reporting Templates

- Templates have been provided for both:
  - huddle and
  - monthly nerve centre meetings
- It is important that improvement efforts, plans and data, flow from an Indictor Team to the Operational Manager and are then shared with all other levels of Health. Managers need a deeper understanding of what is causing problems at the facility level as well as insight as to what facilities are doing to address the gaps. This information found in the monthly OP report, will help managers specifically tailor their support.
- Indicator Teams, who are actively, involved in addressing a shortfall in their indicator's performance, will be meeting weekly, trying out many changes to see which one brings about an improvement
- Keeping track of all the activities is critical for learning and reporting
- For improvement purposes, data should be presented weekly to compare actual performance to the target. The reporting templates provide a snapshot of a month, broken down by the weekly actual performance.
- Below is an example of a weekly huddle meeting template:

**Huddle Meeting Reporting Template**

| **Month:** | Week 1 | Week 2 | Week 3 | Week 4 | Week 5 |
|---|---|---|---|---|---|
| **Duration:** | Start time:<br>End time: | Start time:<br>End time: | Start time:<br>End time: | Start time:<br>End time: | Start time:<br>End time: |
| **Name of Attendees:** | | | | | |
| **Last Week's Progress** | | | | | |
| Did you do what we agreed? | | | | | |
| Did it work? If not, why not? | | | | | |
| Should the change continue? If yes, what do we need to put in place for continuity? | | | | | |
| Challenges experienced | | | | | |
| Support needed | | | | | |
| **Current Problem** | | | | | |
| What is the problem area to focus on? Why did you choose this area as a priority? | | | | | |
| What is the intervention? | | | | | |
| What needs to be in place to start the intervention? | | | | | |
| **Checklist (Tick completion of the below stated tools for each week)** | | | | | |
| Barometer completed | | | | | |
| Summary Chart completed | | | | | |
| Weekly data compiled for weekly report | | | | | |
| Facility Manager signature | | | | | |

## h. Huddle Team Member Weekly Action Plan

- This template will help individual team members track and record their own improvements efforts for reporting at weekly Huddle meetings
- The individual efforts of each member will collectively contribute to the indicator improvement plan

**Huddle Team Member Weekly Action Plan**

| Name: | | | Position: | | |
|---|---|---|---|---|---|
| | Week 1 - Date: | Week 2 - Date: | Week 3 - Date: | Week 4 - Date: | Week 5 - Date: |
| 1. What must I do? | | | | | |
| 2. List how often or how much? | | | | | |
| 3. List each step of what needs to be done | | | | | |
| 4. Develop a measure for each step | | | | | |
| 5. Challenges | | | | | |
| 6. Suggestions/ what was learnt | | | | | |
| 7. Support Needed | | | | | |
| 8. Considerations for sustainability | | | | | |

## i. Supportive Supervision Visit Record

- When managers visit a facility, it should be with the aim of providing specific tailored support and not simply a compliance exercise.
- As an above site manager, it can be difficult to know exactly how to provide support for improvement at facility level; we have therefore developed a guide to be used when conducting a facility support visit. This guide will give structure to the visit and enable a manager to know what to do and ask, in order to drive improvement.
- The Supportive Supervision Guide can be used to generate improvement discussions with facility managers and Indicator Teams.
- Before leaving the facility, managers should identify the kind of support they need to provide, with timelines agreed as to when feedback will be given.

### Supportive Supervision Guide:

V3.0 01-07-2021

health
Department: Health
REPUBLIC OF SOUTH AFRICA

| | | | | |
|---|---|---|---|---|
| Name: | | Facility Name: | | |
| Facility Manager: | | Date: | | |
| Identify the Priority Indicator: | HTS Test | HTS Pos | Naive start on ART | Viral load |
| | TROA | Traced & return to care | Decanting | TLD Transitioning |
| **Nerve Centre's** | | **Comments** | | |
| Does the facility conduct weekly Nerve Centre huddles? Review minutes. | | | | |
| Does the facility conduct monthly Nerve Centre meetings? Review minutes. | | | | |
| Are Indicator teams functional and led by indicator champions? Teams for all problem indicators? | | | | |
| Are the Indicator Barometers updated and displayed? | | | | |
| Examine the Indicator Summary chart & determine if a proper assessment was conducted, and correct conclusions drawn. | | | | |
| Using the indicator summary chart, have the problems been prioritised correctly? | | | | |
| Is there evidence of step-by-step assessments been done by the indicator teams? | | | | |
| Is there evidence of root cause analysis been done by the indicator team? | | | | |
| Is there evidence of learning during testing? Review improvement plans and huddle minutes. | | | | |
| **Review QI interventions** | | | | |
| Have improvement plans been drawn up for all prioritised problems? | | | | |
| Does the intervention/change/QIP address the cause of the problem? | | | | |
| Review the data to analyse if the intervention is leading to an improvement. Review process measures. | | | | |
| **Supportive Interventions** | | | | |

# SECTION 1

# FACILITY LEVEL

## 1. Weekly Huddle Meeting
## 2. Monthly Nerve Centre Meetings

Facilities meet on a weekly basis in what is commonly known as a Phuthuma meeting or a Data Review Meeting. This often takes place on a Friday afternoon. Operational Managers gather the necessary data required to report on the OP priority indicators for that week.

Building on the success of the meetings, we are now proposing a more effective structure and purpose of the OP meetings to meet the ever-increasing demands on facility staff, resources, and managers.

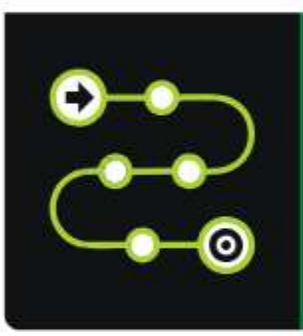
In this section, we will identify 2 types of OP meetings that should take place at all facilities.

# MEETINGS AS A PROCESS

FACILITY LEVEL

OP meetings are commonly viewed as a single event that convenes relevant stakeholders to discuss or share information on specific indicators and/or problems. While the practise of meeting with stakeholders is a great one and must continue, what has been lacking is the critical preparations for the meeting which gives participants a different understanding of problems and a more meaningful ability to contribute to improvement discussions at the meeting. **OP meetings need to have a greater emphasis on improvement and not just on reporting.**

**We therefore propose that OP nerve centre meetings are rather viewed as a process. The process should include 3 inherently linked phases:**



## PRE-MEETING PREPARATION:

An important contributor to a successful meeting is preparation. If not enough thought, planning, and information gathering is done in preparation of the meeting, then often, the meeting is spent exchanging opinions with very little evidence or data been used to validate the expressed thoughts and opinions. This preparatory work forms part of the ASSESS phase of our QI project management framework (See 4A model on page 10).

## MEETING

Using the information gathered in the preparatory phase provides meeting participants with opportunities for valuable discussions, consultations, insights and decisions that will add value to implementation plans and the process of improvement. These deliberations form part of the ANALYSE section of the QI project management framework (See 4A model on page 10).

## POST-MEETING

The final part of this meeting process is the post-meeting activities. Meetings are meant to produce action plans and decisions. It is therefore critical to ensure that those decisions are formalised and clearly communicated to all involved. Sustainability is therefore a key strategy to be discussed an OP meeting and therefore implemented post-meeting. This forms part of the ANCHOR section Of the QI Project Management Framework (See 4A model on page 10).

How programmes are implemented at facility level is complex. There are always many activities happening all at the same time, many of which are uncoordinated, lacking implementation details and therefore require implementers to constantly be adapting. This often results in nonstandard processes of delivery. This therefore requires consistent, deliberate, and focused efforts by a team, to address the process of implementation and challenges, for sustained improvement. We therefore recommend 2 types of OP Nerve Centre meetings at facility level:

1 Weekly Huddle Nerve Centre Meetings
(See page 32)

2 Monthly Nerve Centre Meetings
(See page 57)

# INDICATOR TEAMS

FACILITY LEVEL

Healthcare workers at facilities, have experience and important insight into why problems exist, and how to address them. This is not the sole responsibility of caps Operational Managers. Addressing problems as a team fosters a shared sense of responsibility and eases the workload of Operational Managers. **Tapping into the collective wisdom of all healthcare workers** will bring greater understanding of challenges, generate acceptable ideas for improvement, as well as validate and motivate staff who are central to the problem-solving process.

We therefore recommend the formation of specific **Indicator Teams** at facility level, who collectively, under the leadership and direction of the caps Operational Managers, lead and implement the problem solving and improvement process. Unlike the previous structure of OP meetings that focused on all indicators at once, these Indicator Teams will focus their time and attention on 1 or 2 specific indicators at a time, with the purpose of improving them.

## A Forming the OP Indicator teams

The Operational Manager is ultimately responsible for the performance of the facility; however, he/she is not able to do this alone. All staff members need to understand that everyone has a responsibility to the performance of indicators and achievement of targets. One way of driving ownership and engagement on performance, is to identify indicator teams and champions. It is the duty of the Operational Manager to select the Indicator Team and appoint an **Indicator champion.** Depending on the staff compliment and the volume at the facility, the champions can be rotated, but the decision remains the Operational Manager's to make in consultation with staff members.

## B Role of the OP Indicator Team/s

The OP Indicator Team takes on the responsibility for the improvement of a specific indicator. They will therefore need to comprehensively assess their OP priority indicator to learn why problems exist and where the gaps lie. The Assessment Tools provided in this handbook provide step by step guidance on how to complete this activity (see step by step assessment tool, page 38). The findings from the assessment will guide the improvement work carried out by the team. Teams are therefore expected to meet weekly in their Indicator Teams. Indicator Champions must also provide feedback to the Operational Manager during the weekly Clinic review meetings conducted by the Operational Manager. These 2 activities help to facilitate the Clinic review meeting processes previously tabled in the TRAP SOP and DHMIS Policy and SOP. A full report back is required monthly, in the bigger Monthly OP Nerve Centre Meeting. Completing and analysing the Indicator Summary Chart as a team (see Indicator Summary chart, page 16), will provide a more accurate picture of the factors/elements affecting the indicators performance and will therefore provide an opportunity to identify specific problem areas that the Indicator Team will need to address.

## C How many Indicator Teams should a facility have?

This is very dependent on available staff at facilities. It is important to have a specific focus on each prioritised indicator, so ideally you want a team for each indicator. Each team will specifically focus on the performance of their indicator. This may well mean that 1 person may belong to more than one indicator team or that 1 indicator team may want to focus on more than 1 priority indicator at a time e.g. you may want an HTS team that focuses on Total Tested and Total HIV Positive . Allow staff to work out what works best for them.

## D Who should be part of the Indicator Teams?

The participants of the OP Indicator Team are selected from the staff working in each facility. The idea is to have a **multi-disciplinary** group of healthcare workers, **who all play a role** in the indicator's performance, contributing to a deeper understanding of why problems exist and take responsibility for what needs to be done about the problem. Below is a table indicating all the people who should be involved in OP Nerve Centre Meetings. Each coloured line represents an indicator team and the suggested participants for that specific indicator team. The cadre of staff indicated by the red X, are the recommended indicator champions. **Each facility will need to decide on the composition of each team based on number of staff and the workload of staff.**

X The Indicator champion is indicated by the **red X**

| | Operational Manager | Professional Nurse | Data Capturer | Counsellor | Index Counsellor | OTL & Tracer | Clerks | Pharmacy | Community committee member |
|---|---|---|---|---|---|---|---|---|---|
| Total HIV Tested (HTS) | | x | x | X | x | | x | | |
| Total HIV Positive (HTS) | | x | x | X | x | | x | | |
| Total Naive Start ART | | X | x | x | x | | x | x | |
| Total Remaining on ART (TROA) | | x | x | | | X | x | | |
| TLD transition | | X | x | | | x | x | x | |
| ART Viral Load Suppressed | | X Phlebotomist/ Allocated PN | x | | | x | x | | |
| Differentiated Models of Care | | X Decanting Champion | x | | | x | x | x | |

## E Indicator Champion

Each specific Indicator Team needs a lead to steer and support the improvement work. The champion could be rotated and does not have to be the same person all the time. The selection of the indicator champions can be guided by the work done by the champion e.g. Counsellor could be selected for HIV testing. This will ensure that staffs' daily activities are integrated into the champions' responsibilities. Where there are more than one shift working at a facility, an indicator champion for each shift is advisable. The indicator champion should be responsible for the following:

**1. Overall accountability for the improvement process of the specific indicator**

**2. Facilitate the completion of the summary chart. This includes:**

**A**
Identifying the correct data sources for the completion of the indicator summary chart

**B**
Allocate team members to collect the data required

**C**
Ensuring that the step-by-step assessments are done before the relevant facility huddle and/or nerve centre meeting

**D**
Analysing the summary chart to identify the data elements that are contributing to the poor performance of the indicator

**E**
Recording any additional factors that could have had an influence on the indicators poor performance that is not being reflected in the data.

**3. Meet with and compile a weekly report for the Operational Manager on all improvement activities as well as any findings from root cause analysis assessments conducted by team members**

**4. Provide feedback to the Operational Manager on weekly progress during Clinic Review meetings, and a full report on progress at Monthly Nerve Centre meetings.**

## F Summary of Roles and responsibilities of Indicator Teams

### Weekly Huddle meeting

#### PREPARATION

**INDICATOR TEAM**

The individual members should prepare to share the following:

- Feedback on the previous week's activities
- Collect all the data required to complete the indicator summary chart.
- Complete the individual improvement plan template

**INDICATOR CHAMPION**

- Ensure each team member knows what data they are to collect
- Check in with team members to ensure they can gather the information and support them if there are any challenges.

#### MEETING

**INDICATOR TEAM**

- Report back using the improvement plan template
- Look for opportunities to share insights and ideas
- Be open to asking for or receiving assistance.
- Implement changes and conduct assessments as agreed to in meeting

**INDICATOR CHAMPION**

- Facilitate the meeting
- Ensure that all items on the agenda are covered
- Populate the summary chart
- Populate performance of indicator on OP barometer
- Complete the huddle meeting template to submit to OM

#### POST MEETING

**INDICATOR TEAM**

- Document the individual improvement plan template
- Monthly, summarize all previous weeks inputs for the monthly nerve centre meeting
- Collaborate with other team members to support the whole team's improvement plan

**INDICATOR CHAMPION**

- Submit a copy of the huddle meeting template to the OM
- File all reports and paperwork in a place that can be accessed by the team
- Meet OM to discuss drivers for indicator excellence as well as summary of all work being done by the team
- Monthly, consolidate all previous weeks inputs for presentation at the month nerve centre meeting
- Support the teams improvement efforts where necessary

### Monthly Nerve Centre meeting

#### PREPARATION

**INDICATOR TEAM**

Assist Indicator Champion to prepare the summary presentation to be presented in the monthly meeting:

- Barometers completed
- Interventions done are clearly documented with appropriate measures/data and learnings

**INDICATOR CHAMPION**

Indicator champion to prepare summary presentation focusing on:

a. Current problem

b. Planning for upcoming meetings

**OPERATIONAL MANAGER**

- Meet with Indicator Teams in their huddles where possible
- Weekly meeting with indicator champions

#### MEETING

**INDICATOR TEAM**

- The team to support the presentation by speaking to the details of interventions.
- To have an allocated member of the team documenting valuable contributions made by other staff etc.

**INDICATOR CHAMPION**

- Presents the summary presentation.

**OPERATIONAL MANAGER**

- Conduct the meeting
- Ensure completed barometer is presented and gaps identified
- Assign someone to take notes and minutes

#### POST MEETING

**INDICATOR TEAM**

Continue with huddle meetings.

**INDICATOR CHAMPION**

- Check in with Operational Manager to ensure they have all info for the facility monthly report
- Facilitate huddle meetings

**OPERATIONAL MANAGER**

- Ensure resolutions are implemented by Indicator Teams
- Meet with champions
- Submit report to line manager
- Escalate issues that need escalating

FACILITY LEVEL

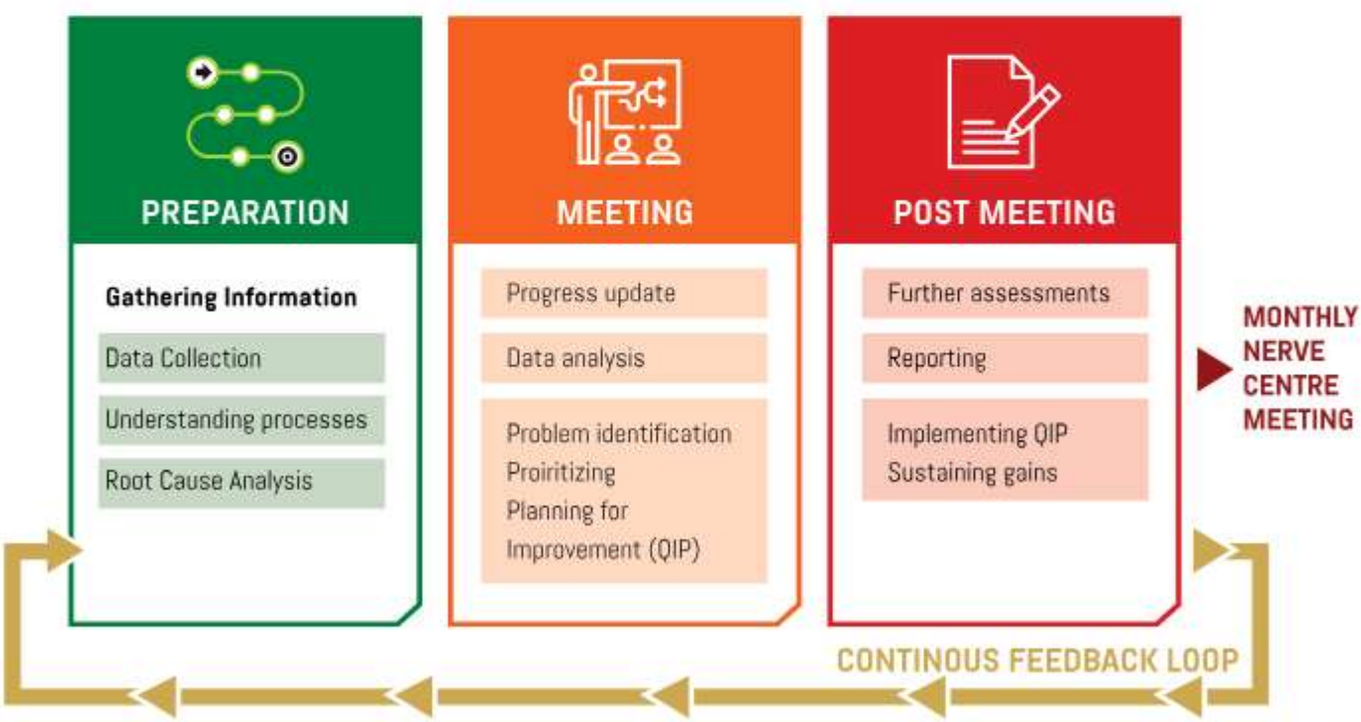
# WEEKLY HUDDLE MEETING

# WHAT IS A HUDDLE MEETING?

FACILITY LEVEL
WEEKLY HUDDLE MEETING

**A huddle meeting is a short, focused OP meeting conducted by the specific Indicator Team (see page 27). This replaces the previous OP or data review meetings.** The team meets weekly to focus on specific OP priority indicator/s. The team members convene to collaboratively problem-solve and develop solutions for identified gaps or challenges that directly affect the performance of the priority indicators. **While the team will collectively be focused on a specific problem, individual team members will all be required to do something differently each week that will contribute to the team's improvement efforts.** The huddle meeting therefore is an opportunity to coordinate and report on those individual efforts.

The **weekly** huddle meetings require good **preparation** by each team member for them to add value at the meeting. Indicator Teams collect the data to complete the indicator summary chart (see responsibilities of an Indicator Team on page 34). Meaningful discussions in the Huddles cannot take place without this data. Data gathered from the indicator summary chart and barometers, form the basis of discussions and are critical to the improvement process. Outcomes of the Huddle meeting inform what gets reported at the monthly nerve centre meetings and therefore make those meetings far more meaningful and concise.



# ROLES & RESPONSIBILITIES

FACILITY LEVEL
WEEKLY HUDDLE MEETING

As we view all OP Nerve Centre Meetings as a process, it is important to understand the purpose, expectations and expected outcomes for each phase of the Huddle meeting process as well as Huddle participants:

## PREPARATION

**INDICATOR TEAM**

The individual members should prepare to share

- Feedback on the previous week's activities
- Collect all the data required to complete the indicator summary chart.
- Complete the individual improvement plan template

**INDICATOR CHAMPION**

- Ensure each team member knows what data they are to collect
- Check in with team members to ensure they can gather the information and support them if there are any challenges.

## MEETING

**INDICATOR TEAM**

- Report back using the improvement plan template
- Look for opportunities to share insights and ideas
- Be open to asking for or receiving assistance.
- Implement changes and conduct assessments as agreed to in meeting

**INDICATOR CHAMPION**

- Facilitate the meeting
- Ensure that all items on the agenda are covered
- Populate the summary chart
- Populate performance of indicator on OP barometer
- Complete the huddle meeting template to submit to OM

## POST MEETING

**INDICATOR TEAM**

- Document the individual improvement plan template
- Monthly, summarize all previous weeks inputs for the monthly nerve centre meeting.
- Collaborate with other team members to support the whole team's improvement plan

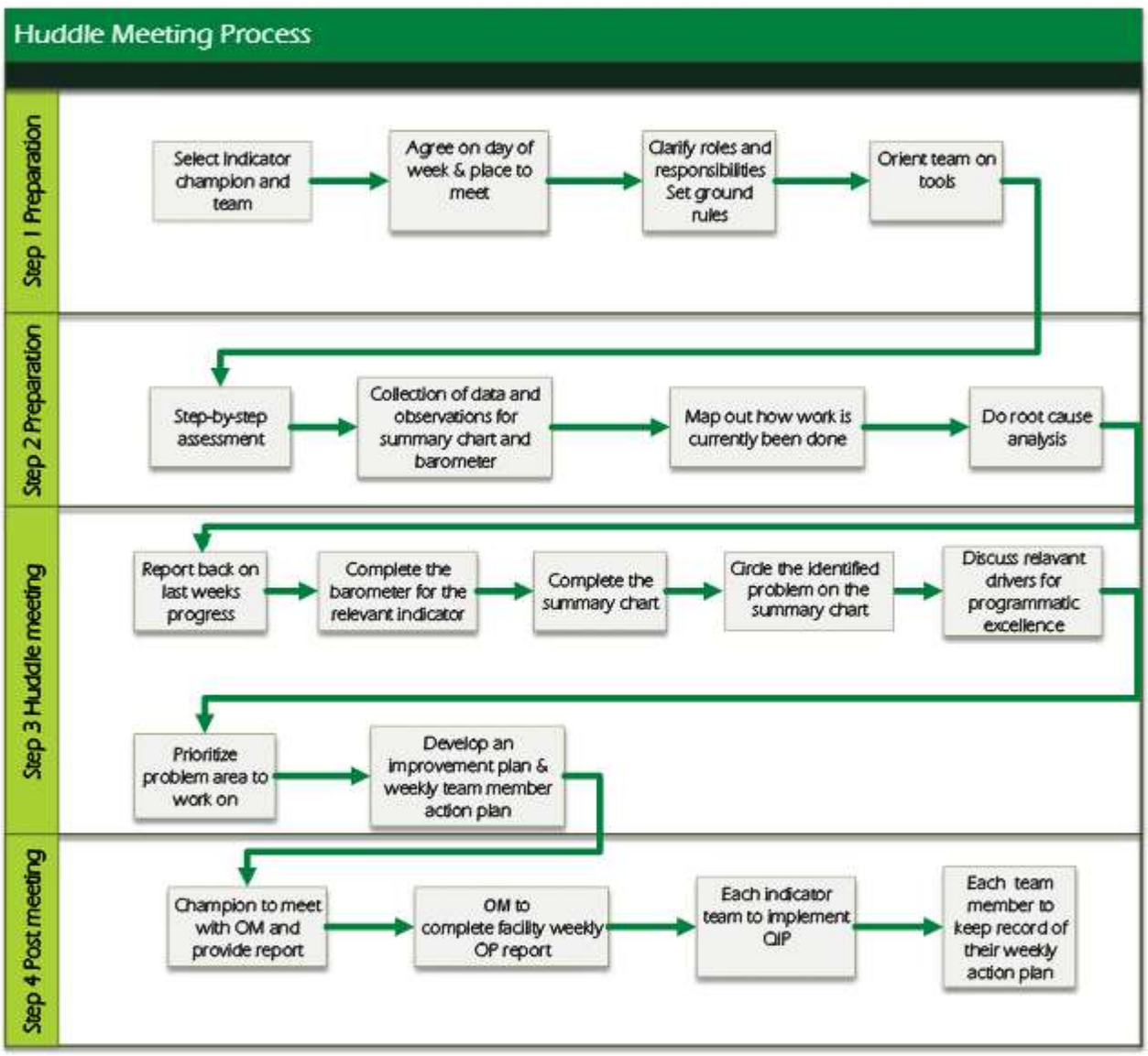
**INDICATOR CHAMPION**

- Submit a copy of the huddle meeting template to the OM
- File all reports and supporting documentation is in a place that can be accessed by the team
- Meet OM to discuss drivers for indicator excellence as well as summary of all work being done by the team
- Monthly, consolidate all previous weeks inputs for presentation at the month nerve centre meeting.

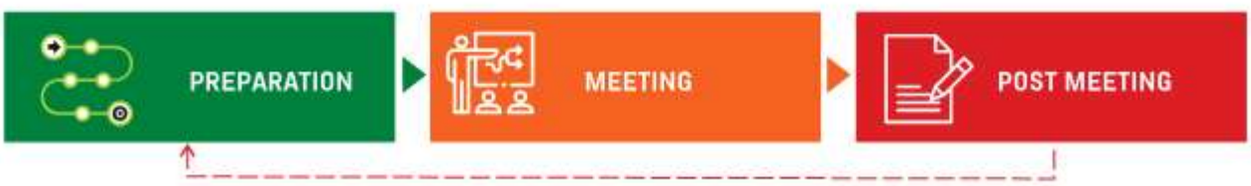
# HUDDLE MEETING PROCESS FLOW

FACILITY LEVEL
WEEKLY HUDDLE MEETING

This process flow shows how all the parts of the meeting process are linked and dependant on each other for success:




The remaining parts of this chapter will focus on the Huddle meeting process:



# A Preparation for a Huddle Meeting

# PREPARATION FOR A HUDDLE MEETING

Information gathering is the main objective for Indicator Teams at this point. This should include:

## A. DATA COLLECTION

Data collection from relevant data sources (e.g. registers, patient folders, DHIS, TIER.Net programme reports and other operational data sources etc.) to complete the barometer and the indicator summary charts at the huddle meeting.

## B. MAPPING HOW THE CURRENT PROCESS IS DONE

Listing each step in a process is a powerful way to understand the current way work is being done and how it is impacting of the performance of the indicator. You can list these steps from the perspective of the patient flow or that of data. Both give significant insights and opportunities for improvement.

- Below is a simple example of a **process map** which lists the steps the patient follows when visiting a facility to see a clinician.

- If your aim is to improve the number of people being tested for HIV, what do you think could be wrong with the way the work is currently being implemented?
- Once a patient leaves the consulting room, which is the reason they came to the facility, there are many opportunities for the patient to leave. The way you are currently implementing your work, could be affecting your outcomes
- Seeing how you are currently doing your work using process mapping, is therefore a critical step in the improvement process
- To learn more about how to develop and analyse a process map, download the Aurum Institute Quality Improvement HOW TO Guide **www.auruminstitute.org**

## C. CONDUCTING THE STEP-BY STEP INDICATOR ASSESSMENTS

Conducting the Step-by Step Indicator Assessments helps to identify steps that are missing, or not completed correctly, in your facilities process of work. It is important to understand the detail behind the performance of an indicator. Some of these steps may not be implemented correctly at present or even at all. We have developed Step-by-Step indicator assessment templates for all key HIV indicators (see page 67).

- Here is an example of a Step-by-Step Indicator Assessment Tool for New on ART
- Start at step 1 and work your way down to the last step

**Indicator: Total Naive Start ART**

Elements: ART adult naive start ART in month, ART child under 15 years naive start ART in month, ART adult male naive start, ART adult female naive start, ART child under 1 year naive started ART, ART child 1 to under 5 years naive started ART, ART child 5 to under 15 years naive started ART

| | Assess the following: | Evidence | Source | Assessment objective |
|---|---|---|---|---|
| HTS PERFORMANCE | | | | |
| Step 1 | Number HIV tested weekly | | | To determine if HTS performance and processes compromise the critical linkage to care step. |
| Step 1 | Number HIV positive weekly | | | |
| | HIV positivity rate (yield) | | | |
| LINKAGE TO CARE | | | | |
| Step 2 | **Same day initiation** | | TIER.Net | Determine if there is a management process of all eligible for ART patients who have not yet been initiated, due to various reasons, to ensure they are not missed or forgotten. |
| Step 2 | Number HIV positive same day initiation (within 7 days) | | | |
| | Verify if HIV positive index contacts are initiated on ART | | | |
| | Verify that PCR positives are initiated on ART | | | |
| Step 3 | **Waiting to start ART list** | Defer list/Diary | | |
| Step 3 | Does the clinician keep track of patients not started on ART the same day | | | |
| | Is there a monitoring tool for patients who deferred treatment | Waiting to start ART list | | |

The tool has been designed according to the following headings:

| Coloured Section heading | Steps | Assess the following | Evidence | Source | Assessment Objective/s |
|---|---|---|---|---|---|
| Key area of interest in the process | Sequence of the steps to follow and complete the tool | Information to collect, calculate or query to determine current situation | Space to record relevant numbers percentages or comments | Suggestion of possible source documents | The purpose of why you are collecting the data |

## D. ROOT CAUSE ANALYSIS TOOLS

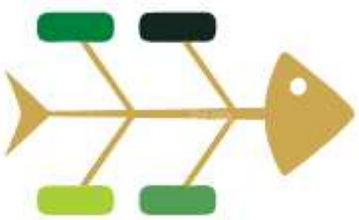
Quality improvement root cause analysis tools will assist the OP Indicator Team to collect additional root causes of a problem. For each prioritised gap, teams must complete root cause analysis. Root cause analysis is one of the primary tools of assessment introduced in the ICRM, DIP and DHP frameworks.

- Here is a summary of some of the root cause analysis tools that can be used. Copies of these tools can be found in the Annexures page 204

1

### FISHBONE

When there is more than one area contributing to the problem use the fishbone to orderly structure the cause and effect.



Careful topic selection can facilitate the identification of key root causes and some introspection

2

### 5 WHYs

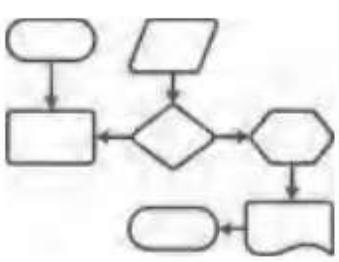
The method is remarkably simple: When a problem occurs you drill down to its root cause by asking WHY five times

A quick way of going deeper into a problem to try and find the underlying cause

3

### PROCESS MAPS

Allows easy understanding of the entire process through visual illustrations. It is used for determining the step by step flow of the process, its timing, handoffs, bottlenecks and identifying outputs that can be visualised, measured and studied.



Process maps can follow the journey of a person e.g. custer, patient as they pass through and experience the process. A process map is a series of sequential tasks known as 'steps" that together achieve a defined outcome.

**Once all Pre-Meeting Preparation has happened, discussion and decision-making can be effectively managed through the huddle meeting. The outcome of the huddle meeting should be an Improvement Plan.**

B

# Weekly **Huddle Meeting**

# WEEKLY HUDDLE MEETING AGENDA

FACILITY LEVEL
WEEKLY HUDDLE MEETING

The huddle meeting can be held on any day of the week that is convenient for the specific OP Indicator Team. **Decide on a day and stick to it!** The meeting should have a specific start and end time and should not take longer than **20 minutes.** Do not allow this to become a long-drawn-out meeting. Conducting the meeting with everyone standing up, gathered around the barometer for example, is a good way to keep it short. Each team member must be given a few minutes to share their findings from their pre-meeting preparation.

The weekly huddle meeting has two agenda points (See template for sample agenda on page 188):

**A. Last week's progress**

**B. Current Problem**

**Huddle Meeting Agenda**

| | | | |
|---|---|---|---|
| **Date:** | | **Week:** | |
| **Priority Indicator:** | | | |
| **Indicator Champion:** | | | |
| **Indicator Team Members:** | | | |

| Time Allocation | | Agenda Point | | Responsibility | |
|---|---|---|---|---|---|
| | | **LAST WEEKS PROGRESS** | | | |
| | | 1. Did we do what we agreed to? | | All | |
| | | 2. Did it work? If not, why not? | | All | |
| | | 3. What were challenges faced? | | All | |
| | | 4. What support is required? | | All | |
| | | 5. What needs to be considered for sustainability? | | All | |
| | | | | | |
| | | **Indicator Champion completes Huddle meeting reporting template for the group* | | | |
| | | | | | |
| | | **CURRENT PROBLEM** | | | |
| | | 1. Complete the Barometer | | All | |
| | | 2. Circle identified problems | | Champion | |
| | | 3. Discuss Drivers for Program excellence? | | | |
| | | 4. Prioritize the problem area to be worked on:<br>• What has the biggest effect on the indicator's<br>• performance?<br>• Can we do something to improve it now?<br>• Can the problem be solved at this facility? | | All | |
| | | 5. Develop an action/improvement plan | | All | |
| | | | | | |
| | | **Indicator Champion completes Huddle meeting reporting template for the group* | | | |

## A. Last week's progress update:

**1. Did we do what we agreed to?**

- Review all the improvement work agreed to in the previous weeks meeting. This includes any assessments, root cause analysis, process mapping or implementation of a quality improvement plan.
- Teams should use their Weekly Individual Improvement Plans to report back on what they did, learnt and recommend.

**2. Did it work? If not, Why not?**

ANALYSE the impact of your ACTION:

- You have to analyse if the action has led to better results and that its not simply something different to what you were doing before.
- Part of the analysis will come from using the process measures obtained from indicator team members
- Depending on the action that was taken to address the identified gap, be it training, mentoring, process improvement or resource allocation, we always need to check the following:
  - > Confirm if the action taken was done as it was planned
  - > Evaluate the impact of the action on the results/measure
  - > Was there anything that was observed or learnt during the action phase that impacted the result/measure?

**3. What were the challenges faced?**

The process of improvement is a learning process. Take time to share with teammates the things found to be:

- challenging about the 'action' and how you think they can be addressed
- interesting about how people responded or didn't respond
- helpful that could be applied toward addressing the current problem or contribute toward addressing another problem

**4. What support do you require?**

- Team members must request support for any hiccups experienced, either from their own team members or other stakeholders.
- If there is evidence of improvement in the data decide on how the results of the action will be communicated. This will take support from the operational manager and others

**5. What needs to be considered for sustainability?**

- Discuss and record the things the team feels need to be considered if a change needs to be sustainable
- These ideas must be taken to the Monthly Nerve Centre Meeting for discussion and actioning

## B. Current problem to work on:

**1.** Complete the barometer for the relevant Indicator (See how to complete a barometer page 185)

- Identify variance and adjust the following weeks' target.

**2.** Team members share the data they have collected to complete the indicator summary chart

| Total Naive Start ART Summary Chart | | | | | |
|---|---|---|---|---|---|
| MONTH: | | TARGET: | | ACTUAL: | |

| 1 | # tested HIV pos this week |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

+

| 2 | # Due to return for ART in this week from the Waiting to start ART list |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

=

| 3 | Total # Eligible to start New on ART this week |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 4 | Total New on ART started this week | |
|---|---|---|
| | Same day | Waiting to start ART |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 5 | Total captured on TIER.Net |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

**Data Analysis Guide**

- Number Eligible (3) = 1 +2
- 3 should = 4
- 4 should =5

**3.** Identify specific problems areas by circling them on the summary chart.

**Total Naive Start ART Summary Chart**

| MONTH: | | TARGET: | | ACTUAL: | |
|---|---|---|---|---|---|

| 1 | # tested HIV pos this week |
|---|---|
| Week 1 | 2 |
| Week 2 | 4 |
| Week 3 | 1 |
| Week 4 | 5 |
| Week 5 | 1 |
| Month | 13 |

+

| 2 | # Due to return for ART in this week from the # waiting for ART list |
|---|---|
| Week 1 | 1 |
| Week 2 | 1 |
| Week 3 | 2 |
| Week 4 | 2 |
| Week 5 | 1 |
| Month | 7 |

=

| 3 | Total # Eligible to start New on ART this week |
|---|---|
| Week 1 | 3 |
| Week 2 | 5 |
| Week 3 | 3 |
| Week 4 | 7 |
| Week 5 | 2 |
| Month | 20 |

**Data Analysis Guide**
- Number Eligible (3) = 1 +2
- 3 should = 4
- 4 should =5

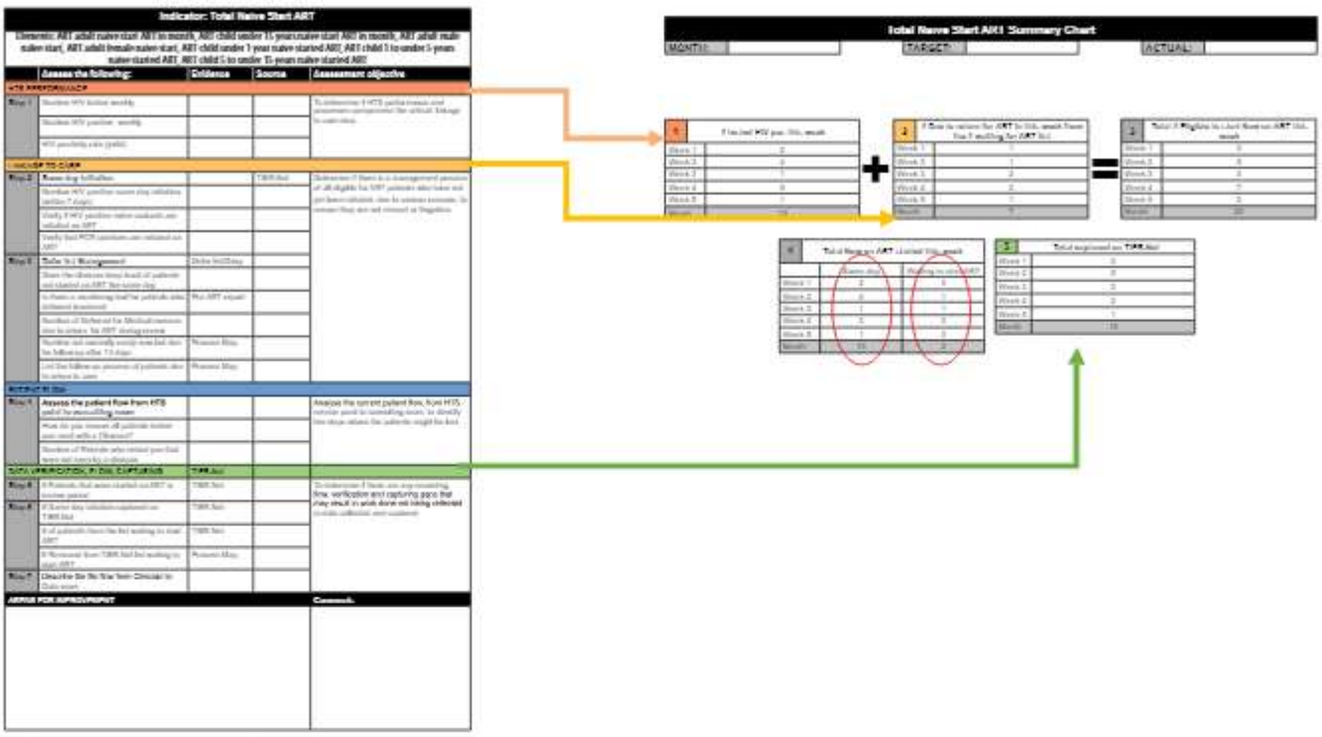
| 4 | Total New on ART started this week | |
|---|---|---|
| | Same day | Waiting to start ART |
| Week 1 | 2 | 0 |
| Week 2 | 4 | 1 |
| Week 3 | 1 | 1 |
| Week 4 | 2 | 0 |
| Week 5 | 1 | 0 |
| Month | 10 | 2 |

| 5 | Total captured on TIER.Net |
|---|---|
| Week 1 | 2 |
| Week 2 | 5 |
| Week 3 | 2 |
| Week 4 | 2 |
| Week 5 | 1 |
| Month | 12 |

**4.** This quick exercise will provide a systematic analysis of the data elements that are affecting the performance of the indicator. This will highlight where to focus the teams attention.

**5.** Each priority indicator has its own summary chart (**See Section 2 page 67**)

**6.** **NB! The indicator summary chart and the Step-by-Step indicator chart complement and support each other.** They are colour coded so teams can easily identify which parts of the tools support each other. If you find you have a problem with section 2, the green section in the indicator summary chart, then you should follow the steps in the green section of the step-by-step guide to help identify the steps in the process that need attention.




7. In developing your improvement plan, the team will need to prioritize what to do differently to address the problem (see **Notes to keep in mind when planning what to do differently** on page 50)

8. Develop an **improvement plan** which states who should do what when. Here are things to keep in mind when developing the improvement plan:
   - What is the problem you are trying to address?
   - What exactly must be done? Be very specific
   - How often should it be done or in what quantity
   - Who must do what?
   - How will you measure that each person did what they were meant to when they were meant to do it?

9. Remember that each team member will need to **feedback** at the following weeks meeting.

# TEAM MEMBERS WEEKLY REPORTING

As Indicator Teams meet weekly, the process of change will be rapid, requiring weekly actions from most team members. **While the team will collectively be focused on a specific problem, individual team members will be doing something differently each week to contribute to the teams overall effort.** it is therefore important for team members to track and monitor the things that they are specifically doing; this will help determine if change is an improvement and is also needed for reporting purposes. Weekly, team members should be recording the following:

## 1. What must I do?

Team members must be clear about what is expected of them, so the improvement process does not stop because a member was unsure or confused.

## 2. List each step of what you need to do differently

- Listing each step will clarify exactly what needs to be done
- Listing can either be done as a checklist, or develop a simple process map indicated below

## 3. Develop a measure for each step

- Keeping track of the implementation, requires a different kind of measurement called a process measure.
- Process measures measure if an activity was done and in what quantity.
- Process measures will help you to answer the question 'did I do what I said I would do'.
- See the Aurum Quality Improvement HOW TO GUIDE, Module 4, to learn more about what process measures are and how to develop them **www.auruminstitute.org**
- On the following page are examples of **changes with simple process measures:**

| INTERVENTION CATEGORY | ACTIVITY / CHANGE | PROCESS MEASURES |
|---|---|---|
| **Training** | Conduct a district level NIMART training | • You would want to know if the training was conducted<br>• The number of staff that are meant to attend<br>• The number that was actually trained<br>• Number from each facility<br>• Pre-test scores<br>• Post-test scores |
| **Mentoring** | Conduct a Subdistrict Mentorship program on TLD transitioning. | • You would want to know if the program was designed and rolled out.<br>• The number of professional nurses identified for the mentorship program<br>• Number of professional nurses who completed the mentorship program<br>• Number of professional nurses who were found competent in TLD transitioning after the mentorship program |
| **Additional resources** | Provide internet access to facilities identified with no internet connectivity | • Number of facilities identified with no internet access<br>• Number of facilities where internet connectivity was installed |
| **Process Improvement (PDSA)** | Improve the patient file flow from the consulting room to the data room at facility level<br><br>**Change:** The clinician places the completed ART file in the ART file container after consultation. Data capturer collects ART file from the consultation room at 11:00, 14:00 and 16:00 | • The number of ART files issued to consultation rooms per day<br>• Number of ART files collected at:<br>• 11:00<br>• 14:00<br>• 16:00<br>• Total number of ART files received in the Data room by the end of the day |

### 4. Challenges faced

- Record the challenges that you experienced. This is important for the learning process and can add insight into how the team will move forward
- Challenges are not usually measured with data; your thoughts and experience are important for the team to consider when addressing problems; jot them down and share them in a Huddle meeting

### 5. Support needed

- Identify how other team members or the OM needs to assist
- Raise this at the next huddle

### 6. Suggestions/what was learnt

- As indicated earlier, the improvement process is a learning process. No thought or observation is useless. Keep track of these and share them generously with the team
- Like challenges, thoughts and observations are generally not measured using data; jot them down and share them, you never know how your inputs will contribute to a better solution!

### 7. Considerations for sustainability

- Thinking about how a change will be sustained at a facility is a very important question to think about. Sustainability of change must be thought about from the beginning of the process and not at the end.
- This is why each team member must think about things that may impact sustainability on a weekly basis
- You never want to implement something, even if it does feel like a good idea at the time, that cannot be sustained over a long period of time.
- The Indicator Team champion must summarise the team's sustainability thoughts and concerns and table it at the Monthly Nerve Centre Meeting

**Individual Team Members**

Each week, team members will be required to do something toward the indicators improvement. All the individual efforts need to be well coordinated to ensure that the team is working toward one improvement plan together.

This template will help team members keep track of their individual inputs. You may already have something that captures these inputs, feel free to use what you feel more comfortable using (annexure: see page 189).

**Huddle Team Member Weekly Action Plan**

| Name: | | | Position: | | |
|---|---|---|---|---|---|
| | Week 1 - Date: | Week 2 - Date: | Week 3 - Date: | Week 4 - Date: | Week 5 - Date: |
| 1. What must I do? | | | | | |
| 2. List how often or how much? | | | | | |
| 3. List each step of what needs to be done | | | | | |
| 4. Develop a measure for each step | | | | | |
| 5. Challenges | | | | | |
| 6. Suggestions/ what was learnt | | | | | |
| 7. Support Needed | | | | | |
| 8. Considerations for sustainability | | | | | |

# NOTES TO KEEP IN MIND WHEN PLANNING WHAT TO DO DIFFERENTLY



**For us to get a different result we must do something differently. Problems within our facilities mainly fall into 4 categories:**

- Lack of knowledge
- Lack of skill
- Lack of resources
- Poorly designed workflow and systems

Each category of intervention, requires a different response:

| PROBLEM | RESPONSE |
|---|---|
| **Lack of knowledge** | Training and or Mentoring |
| **Lack of skill** | Mentoring and or Training |
| **Poorly designed workflow and systems** | Testing methodology (PDSA cycles)<br>The areas for improvement identified from the assessments conducted are ideal opportunities to apply the PDSA cycle |
| **Lack of resources** | e.g. include:<br>Test kits, registers, human resources, medicine supply, clinical stationery etc |

Because our problems are often complex, we might need a combination of some or all interventions, however it is important for us to look at all 4 when trying to address a problem.

## NOTES TO KEEP IN MIND WHEN PLANNING WHAT TO DO DIFFERENTLY (CONTINUED)

**Training**

**Mentoring**

**Additional Resources**

**Process Improvements**

**(PDSA cycles)**

**Examples of how you could implement the different categories of interventions for each priority indicator**

| INDICATOR | TRAINING | MENTORING | RESOURCES | TESTING (PDSA) |
|---|---|---|---|---|
| **Total HIV Tested** | Training on a new test modality e.g. HIVSS | Mentoring of newly appointed Counsellors | Provide HTS testing kits | Develop and test a process to improve the HTS data flow from HTS service point to Capturing |
| **Total HIV Positive** | Post Counselling knowledge and skill | Mentoring of current skill of Counsellors | Confirmation test kits | To improve linkage to care: Design the Patient flow from HTS service point to Consulting room |
| **Total naive Start ART** | ART clinical guidelines | Clinical mentoring on changing treatment regime for patients | Medicine supply | Developing a Defer for ART return to care process |
| **Total remaining on ART (TROA)** | Understanding the in and outflow of TROA data | Advance adherence skills and method used | Medicine supply | Design a functional Booking system |
| **TLD Transition** | TLD drug | Mentoring the transitioning process and information provided to the patient | TLD stock availability | Develop a process to identify patients eligible for decanting |
| **VL Suppressed** | Using Lab Track to access results | Management of unsuppressed viral loads | Lab Track access | Develop a result management process |
| **Differentiated Models of Care (DMOC)** | Cohort management | Management of poor adherence | Medicine supply. Access to Synch | Develop a process to identify patients eligible for decanting |

For more detailed information on how to implement PDSA cycles to make the required process, workflow and systems changes, refer to the Aurum Quality Improvement HOW TO GUIDE, **www.auruminstitute.org**. A number of Quality improvement tools, including PDSA templates, have been included in the Annexures (See page 204)

# C Post Meeting Activities

# POST MEETING ACTIVITIES

This phase of the meeting process is all about action! It is now time to do something about the problems identified. This phase demands coordination, commitment, and accountability from all team members. If little or nothing is done post the meeting, then the continuous improvement cycle will not yield any progress and the weekly huddle meetings will become a waste of time.

## 1. Huddle Meeting Reporting Template

- Documenting the meeting and resolutions made is important for reporting purposes as well as the learning process. Below is a huddle reporting template that should be **submitted to the OM on a weekly basis.** If you have your own, please use that (see page 190).
- The champion should meet with the OM on a **weekly** basis to discuss the report and any drivers for programmatic excellence that need to be discussed and tabled at the monthly nerve centre meeting.

**Huddle Meeting Reporting Template**

| **Month:** | Week 1 | Week 2 | Week 3 | Week 4 | Week 5 |
|---|---|---|---|---|---|
| **Duration:** | Start time:<br>End time: | Start time:<br>End time: | Start time:<br>End time: | Start time:<br>End time: | Start time:<br>End time: |
| **Name of Attendees:** | | | | | |
| **Last Week's Progress** | | | | | |
| Did you do what we agreed? | | | | | |
| Did it work? If not, why not? | | | | | |
| Should the change continue? If yes, what do we need to put in place for continuity? | | | | | |
| Challenges experienced | | | | | |
| Support needed | | | | | |
| **Current Problem** | | | | | |
| What is the problem area to focus on? Why did you choose this area as a priority? | | | | | |
| What is the intervention? | | | | | |
| What needs to be in place to start the intervention? | | | | | |
| **Checklist (Tick completion of the below stated tools for each week)** | | | | | |
| Barometer completed | | | | | |
| Summary Chart completed | | | | | |
| Weekly data compiled for weekly report | | | | | |
| Facility Manager signature | | | | | |

## 2. Reporting to the OM on a Weekly Basis

The indicator champion should summarise all the inputs and reports from the individual team members and present them at a the weekly clinic review meeting with the OM to:

- Share the weekly data of the indicators performance
- Discuss identified problems and how they are being addressed
- Discuss plans for the coming week
- Receive guidance and direction from the OM

## 3. Facility weekly OP Report

- Each indicator champion submits a report to their OM on a weekly basis. The OM then summarises the information obtained and submits a facility report to their line manager.
- Below is a report to be used by indicator champions as well as the OM (see Annexure page 193)
- The report provides space for the data as well as improvement efforts; both are critical for the next level of health to have and understand.

**Facility Data Report**

| Month: | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Week 1 | | Week 2 | | Week 3 | | Week 4 | | Week 5 | | Month Totals | |
| Indicators: | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | | |
| HIV Tested (15 years and above) | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| HIV tested Positive (15 years and above) | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| Naive start on ART | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| Viral Load overdue 6 months | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| Viral Load overdue 12 months | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| TLD transition | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| Return to Care | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| TROA (Total Remaining On ART) | | | | | | | | | | | | |

Facility Improvement Reporting

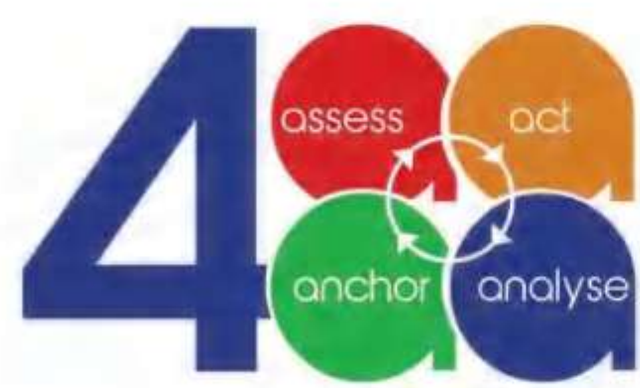
| Month: | | | | |
|---|---|---|---|---|
| Indicator: | Problem | Causes | Intervention | Status of the intervention |
| | | | | |
| | | | | |
| | | | | |

## 4. Huddle Team member action plan

As discussed in the meeting preparation section, each team member will be required to keep track of their own data and learnings so that it can be collectively captured toward the Indicator Teams' improvement efforts. This is captured in the Weekly Action Plan (See page 189)

## 5. Sustainability

- Once an intervention (best practice, idea, training etc.) has proven to work through improved data outcomes, structures and processes need to be put in place to ANCHOR (See QI Programme Management Framework page 10) the idea in place. **We must stop the practice of constantly reinventing the wheel; when things work, make them stick!**




- Sustainability is a collaborative effort and something that must be well-thought-out from **the time change is being considered.**

- **We need to consider the impact of all our activities, whether it is training, mentoring, resource allocation or process improvements.** Often measurement of impact or outcomes is only done when an official Quality Improvement plan is developed. Investigating the impact of all activities is a critical mind shift that needs to take place.

**a. When critically looking at interventions, you need to know:**

- if the change/activity was implemented as planned?
- did the right people get the change as planned?
- What the result of the change was?

**b. Considerations for sustainability**

When implementing any activity that you have determined adds value, the following factors need to be thought through and planned for:

- Support staff/process: what kind of support will people need going forward in order to ensure the best practice can continue.
- Sustain the 'ACT'; you do not want this to be a once off event. Careful thought needs to be given as to how we make something stick. The indicator and nerve centre teams will provide valuable input.
- Endorse the ACT: this endorsement is usually done through some sort of official communication or document i.e. SOPs, guidelines etc. Consider that many people feel more comfortable when things are officially communicated. Carefully plan how this SOP will be shared so that everyone knows about it and has an opportunity to ask clarity seeking questions.
- Integrate the ACT into the system (should workplans be adjusted?): you don't just want to think that because you said so, it will now be done; consider how workplans or job descriptions may need to be altered. We want to ensure that doing your work in a different way is clearly acceptable and expected.
- Report on the results of the ACT to all relevant stakeholders: make sure that all staff in the facility are aware of the results of your actions. Importantly though, consider who outside of our facility also needs to know; consideration should be given to managers, patients and funders.
- Importantly, the indicator must continue to be monitored to observe any changes in performance.

FACILITY LEVEL

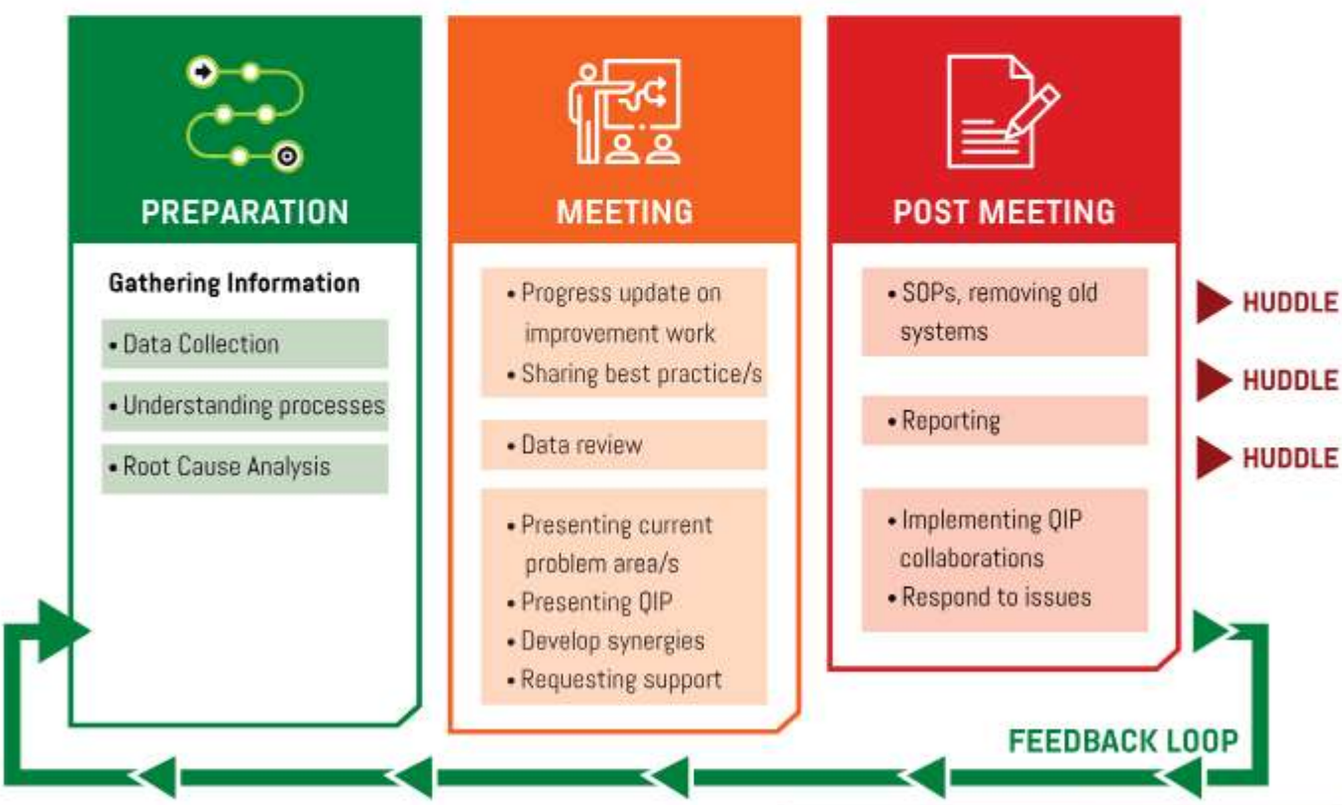
# MONTHLY NERVE CENTRE MEETING

# WHAT IS A MONTHLY NERVE CENTRE MEETING?

FACILITY LEVEL
NERVE CENTRE MEETING

The Monthly Nerve centre meeting is a comprehensive monthly meeting that involves all the OP Indicator Teams. The purpose of the monthly nerve centre meeting is to give each Indicator Team an opportunity to feedback to all other teams, about what they have done to understand and address challenges with their assigned Priority Indicator that month. It is also an opportunity for the teams to co-ordinate activities, solicit support as well as identify opportunities for synergies. Additionally, it is an opportunity to gain insights from other nerve centre members who may also have good ideas and perspectives that Indicator Teams may not have considered. Finally, it provides the OM with an opportunity to consult and instruct staff collectively, ensuring that efforts are aligned, well-coordinated and reported on. Staff need this time with the OM to not only gain their insights, but to also escalate issues that requires the OM to intervene in. Because of the robust and informed discussions taking place at the monthly nerve centre meeting, it is the ideal forum for sub-district managers to attend and support.

Data presented by each Indicator Team is central to discussions held in this meeting. A systems view of how each process and activity contributes to the facilities 90-90-90 achievement, is achieved through the union and collaboration of the Indicator Teams.



# SUGGESTED PARTICIPANTS

FACILITY LEVEL
NERVE CENTRE MEETING

The table below is a summary of all priority indicators and the cadre of people suggested to be part of the monthly nerve centre meeting. Remember, the monthly nerve centre meeting is made up of all the Indicator Teams.

X The Indicator champion is indicated by the **red X**

| | Operational Manager | Professional Nurse | Data Capturer | Counsellor | Index Counsellor | OTL & Tracer | Clerks | Pharmacy | Community committee member |
|---|---|---|---|---|---|---|---|---|---|
| Total HIV Tested (HTS) | x | x | x | X | x | | x | | x |
| Total HIV Positive (HTS) | x | x | x | X | x | | x | | x |
| Total Naive Start ART | x | X | x | x | x | | x | x | x |
| Total Remaining On ART (TROA) | x | x | x | | | X | x | x | x |
| TLD Transition | x | X | x | | | x | x | x | x |
| ART Viral Load Suppressed | x | X Phlebotomist/ Allocated PN | x | | | x | x | | x |
| Differentiated Models of Care | x | X Decanting Champion | x | | | x | x | x | x |

# SUMMARY OF RESPONSIBILITIES OF NERVE CENTRE TEAM MEMBERS

FACILITY LEVEL
NERVE CENTRE MEETING

## Monthly Nerve Centre Meeting

### PREPARATION

**INDICATOR TEAM**

Assist Indicator Champion to prepare the summary presentation to be presented in the monthly meeting:

- Barometers completed
- Interventions done are clearly documented with appropriate measures/data and learnings

**INDICATOR CHAMPION**

Indicator champion to prepare summary presentation focusing on:

a. Current problem

b. Planning for upcoming meetings

**OPERATIONAL MANAGER**

- Meet with Indicator Teams in their huddles where possible
- Weekly meeting with indicator champions

### MEETING

**INDICATOR TEAM**

- The team to support the presentation by speaking to the details of interventions.
- To have an allocated member of the team documenting valuable contributions made by other staff etc.

**INDICATOR CHAMPION**

- Presents the summary presentation.

**OPERATIONAL MANAGER**

- Conduct the meeting
- Ensure completed barometer is presented and gaps identified
- Assign someone to take notes and minutes

### POST MEETING

**INDICATOR TEAM**

Continue with huddle meetings.

**INDICATOR CHAMPION**

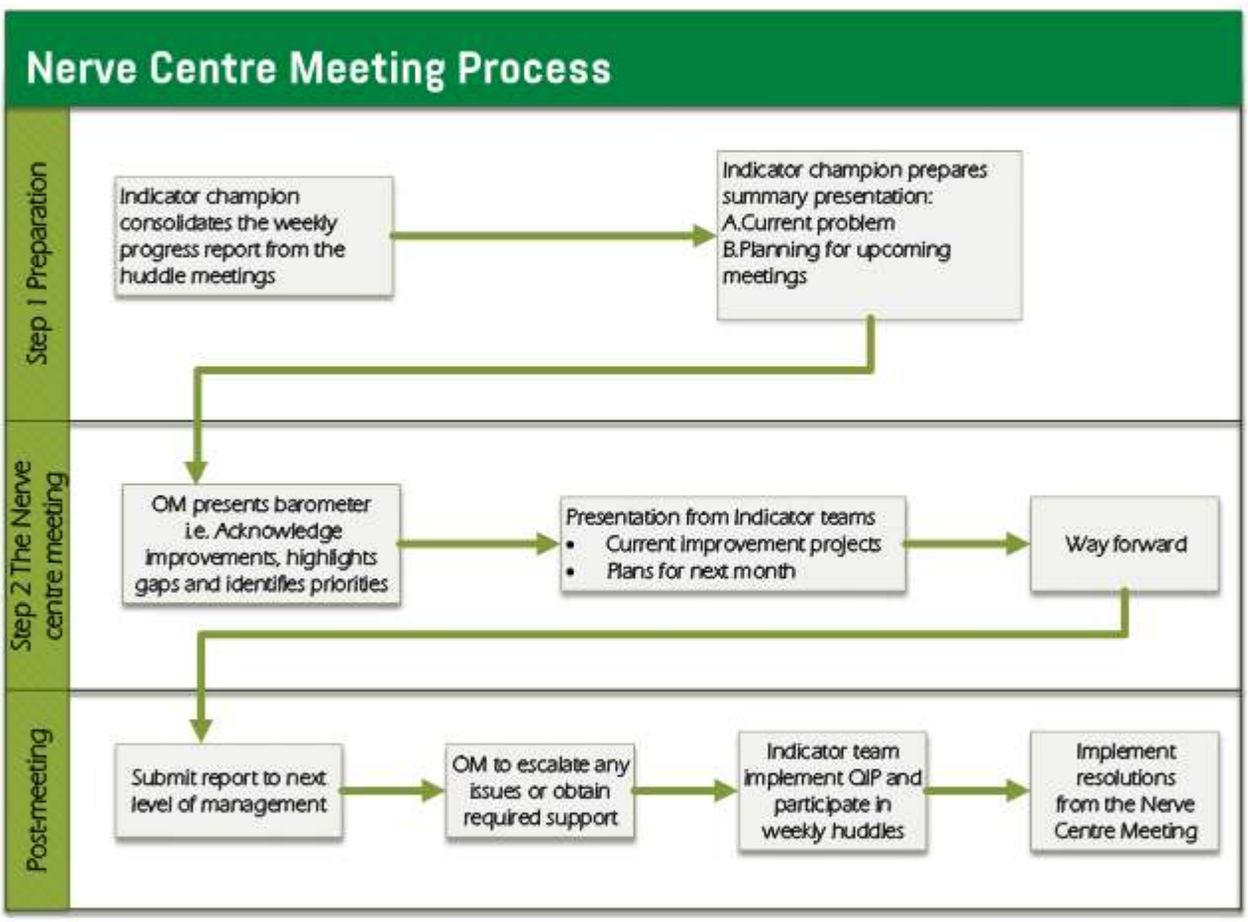
- Check in with Operational Manager to ensure they have all info for the facility monthly report
- Facilitate huddle meetings

**OPERATIONAL MANAGER**

- Ensure resolutions are implemented by Indicator Teams
- Meet with champions
- Submit report to line manager
- Escalate issues that need escalating

# PROCESS FLOW OF NERVE CENTRE MEETNG

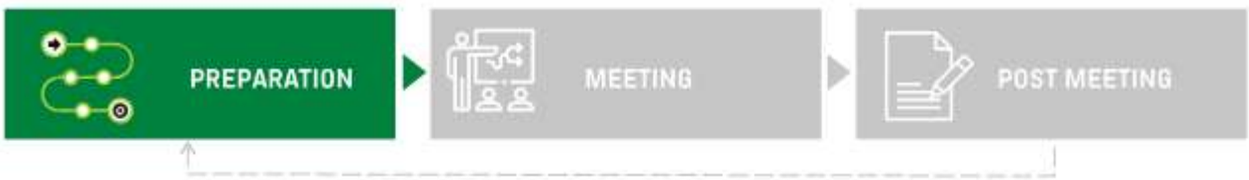
- Like the Huddle meeting, the Monthly Nerve Centre Meeting is also seen as a process.
- Here is a process flow to show how all the parts of the monthly nerve centre meeting process are linked and dependant on each other for success:




**The remaining parts of this chapter will focus on the monthly nerve centre meeting process:**

# PREPARATION FOR A MONTHLY NERVE CENTRE MEETING






**1.** The work done in the weekly Huddle meetings by the Indicator Teams, is the preparation work for the monthly nerve centre meeting. The following conducted by Indicator Teams will be used to prepare for the Huddle meeting:

| | |
|---|---|
| 1.1 | **Problem analysis done using the step-by-step assessments** |
| 1.2 | **Summary chart analysis** |
| 1.3 | **Improvement interventions (training, mentoring, resources, PDSA cycles)** |

The only piece of preparatory work to be done would be for the Indicator Champion to summarise the Weekly reports prepared for the OM and prepare the presentation for the monthly nerve centre meeting feedback.

# THE MONTHLY NERVE CENTRE MEETING

As most of the critical analysis and work will be done within the Huddles, the monthly meeting serves as a reporting back and collaboration platform.

## 1. MONTHLY NERVE CENTRE MEETING AGENDA

The monthly meeting has three important agenda items:

### a. Feedback on current improvement projects

Indicator champions will need to present on the following:

- Relevant target vs Current performance (Barometers and OP reports)
- Summary chart
- Problem area/s the current project is solving and the intervention
- What works well and what does not work?
- How to sustain what is working
- Areas of collaboration
- Required support

### b. Planning for upcoming weeks

Indicator champions will need:

- Problem area/s to focus on
- Intervention to be conducted
- Discussion to determine if further assessments are required

### c. Way forward

- The OM needs to ensure that action plans are well understood and recorded
- Next steps on challenges, support required and areas for collaborations
- Any other matters can also be raised at this point

## 2. SAMPLE AGENDA FOR THE MONTHLY NERVE CENTRE MEETING

**Monthly Nerve Centre Meeting Agenda**

| Date: | | Time: | |
|---|---|---|---|
| Chair: | | | |
| Time Allocation | | Agenda Point | Responsibility |
| | | **OPENING** | |
| | | 1. Matters Arising | |
| | | 2. Feedback on issues raised at previous meeting | |
| | | **FEEDBACK ON CURRENT IMPROVEMENT PROJECT** | |
| | | 1. Present relevant target vs Current performance (Barometers and OP reports) | Indicator Champions or team representative |
| | | 2. Present on summary chart | |
| | | 3. Problem area/s the current project is solving and the intervention. | |
| | | 4. What works well and what does not work? | |
| | | 5. How to sustain what is working | |
| | | 6. Areas of collaboration | |
| | | 7. Required support | |
| | | **PLANNING FOR THE UPCOMING WEEKS** | |
| | | 1. Problem area/s to focus on | Indicator Champions or team representative |
| | | 2. Interventions to be conducted | |
| | | 3. Discussion to determine if further assessments are required | |
| | | **WAY FORWARD** | |
| | | 1. Summary of improvement plan for each specific Indicator team | OPM |
| | | 2. Next steps on challenges, support required and areas for collaborations | OPM |
| | | 3. Any other business | All |

## 3. ROLES AND RESPONSIBILITIES OF NERVE CENTRE TEAM MEMBERS

In the meeting, all participants should try to offer input into each OP indicator teams presentations and plans. This cultivates a collective ownership of the problems, a deeper understanding of problems and may also contribute to the solutions.

Team members should try to gain an expanded viewpoint of how the facility operates and factors influencing indicators performance; this will add value to the work they will be doing in their huddles.

## 4. INCLUDING A REPRESENTATIVE FROM THE FACILITY COMMUNITY COMMITTEE

As the patient is the one who defines quality, it is important to create a formal platform where the patients view can be heard by all nerve centre members. It is not always easy to get this right, so this meeting offers an ideal opportunity to do this.

As all facilities are meant to have a Community Clinic Committee, a representative from this committee would be a good candidate to include at this meeting.

This meeting will increase the communities' engagement with staff members and provide an ideal opportunity to discuss challenges experienced with implementation. It also enables the community representation to raise priorities and concerns that have been gathered from the community and allows staff members to understand the communities needs and perspectives about factors that could be contributing to indicators performance. Importantly, the community representative, can play a valuable role in identifying ways to address challenges and implement improvement plans.

## 1. POST-MEETING ACTIVITIES

**There are really only 4 objectives post the monthly nerve centre meeting:**

### ACTIVITY ONE

OM to complete facility monthly report for submission

### ACTIVITY TWO

OM to escalate any issues that need escalating or obtain support required

### ACTIVITY THREE

Indicator teams to continue their improvement work and report back using Huddle meetings

### ACTIVITY FOUR

Implement resolutions from the Nerve Centre Meeting

SECTION 2

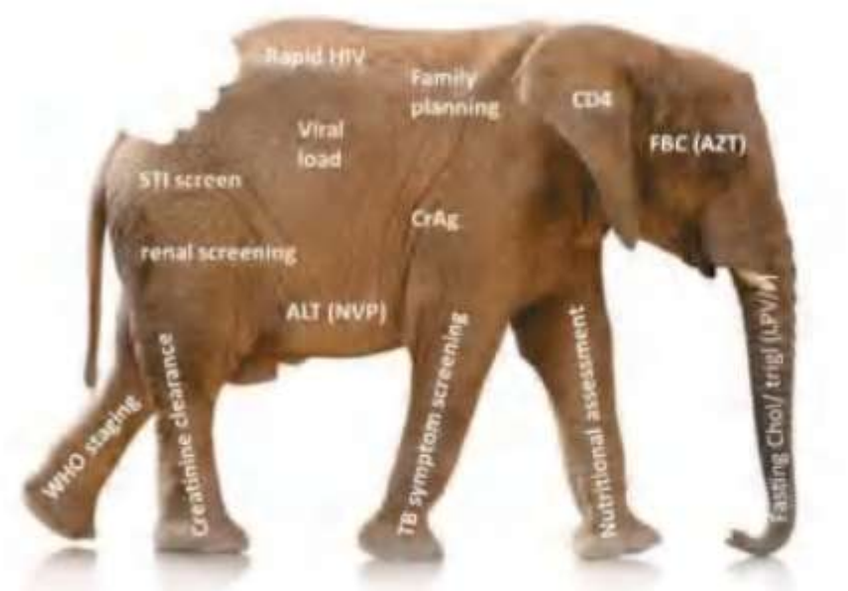
# APPLYING THE NERVE CENTRE MEETING PROCESS TO PRIORITY INDICATORS

National data management systems have progressed to ensure that facilities have access to the required data and data systems, to manage their own reporting and monitoring of achievement of targets. This has helped facilities to engage with their data at more frequent intervals.

As the focus of this OP Handbook is Improvement and not reporting, we will take you through a stepwise process to demonstrate exactly how all the tools, concepts and templates discussed in the previous sections, are applied to each HIV programme priority indicator, in order to achieve improvement.

After using the tools to identify gaps and problems, improvement plans will need to be developed for each gap or problem identified. Do not try to eat the elephant all at once; you can't address them all at once. Here are some questions the Indicator Team can use to assist in the **prioritisation process:**

- What has the **biggest effect** on the indicator's performance?
- Can we do something to improve it **now?**
- Are we able to solve this problem **at the facility?**




**HIV Programme Priority Indicators:**

**1.** Total HIV Tested | **2.** Total HIV Positive | **3.** Total Naive Start ART | **4.** Total Remaining On ART (TROA)

**5.** TLD Transition | **6.** ART Viral Load Suppressed | **7.** Differentiated Models of Care (DMOC)

# Total HIV Tested & Total HIV Positive } HTS

**Reporting indicators**

**HIV TEST:** Number of individuals who received HIV Testing Services (HTS) and received their test results.

**HIV POS:** Number of individuals who tested HIV positive.

| SOURCE | DATA | TIME |
|---|---|---|
| TIER.Net HTS module | Number tested for HIV and testing outcome | Can be obtained daily or weekly |
| HTS register | Number tested for HIV and testing outcome | Daily or weekly |
| Index register: Patient file: ART clinical stationary | Referral for Index counselling and number of Index contacts | Can be obtained daily or weekly |
| Index register | Index contact testing and outcome | Can be obtained daily or weekly |

X The Indicator champion is indicated by the **red X**

| | Operational Manager | Professional Nurse | Data Capturer | Counsellor | Index Counsellor | OTL & Tracer | Clerks | Pharmacy | Community committee member |
|---|---|---|---|---|---|---|---|---|---|
| Total HIV Tested (HTS) | | x | x | X | x | | x | | |
| Total HIV Positive (HTS) | | x | x | X | x | | x | | |

## 8 Responsibilities of the HTS Indicator Champion and Indicator Team

1. Complete the relevant barometers
2. Conduct or review the Step-by-Step Indicator Assessment to identify all the gaps
3. Collect the data and complete the indicator summary chart
4. Circle the identified problem on the summary chart
5. As a team, work through the Drivers for Program Excellence
6. Prioritize the problem area to be worked on
7. Decide what the team would like to focus on this week and develop a brief improvement plan
8. Report back

## The 8 Steps Explained:

**1.** Complete the relevant **Barometers** (See How to Complete a Barometer page 185)

a. Identify the variance.

b. Adjust the following weeks' target.

**2.** Conduct the **Step-by-Step Indicator Assessment** to identify all the gaps (see page 80)

a. The step-by-step assessment will identify all the gaps in your process that need to be addressed

b. Once the assessment has been conducted, and all gaps identified, there is no need to keep redoing the assessment week after week.

## 3. Collect the data and **complete the indicator summary chart** (see page 82)

a. Team members must come to the huddle with all the data needed to populate the summary chart

**Total HIV Tested and Total HIV Positive (HTS Indicator Summary Chart)**

| Total HIV Tested | |
|---|---|
| MONTH: | |
| TARGET | |
| ACTUAL: | |

| Total HIV Positive | |
|---|---|
| MONTH: | |
| TARGET | |
| ACTUAL: | |

| 1 | Obtain the weekly facility headcount, excluding the known on ART |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 2 | Total Number of people tested for HIV this week = | | |
|---|---|---|---|
| | # tested at facility | # tested in community | # of index contacts tested |
| Week 1 | | | |
| Week 2 | | | |
| Week 3 | | | |
| Week 4 | | | |
| Week 5 | | | |
| Month | | | |

| 3 | Number Tested for HIV this week and recorded in the HTS register |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 4 | Number tested this week that were captured on TIER.Net |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 5 | % of Eligible headcount tested |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 6 | Total Number of people tested Positive for HIV this week = | | |
|---|---|---|---|
| | # tested at Facility | # tested in community | # of index contacts tested |
| Week 1 | | | |
| Week 2 | | | |
| Week 3 | | | |
| Week 4 | | | |
| Week 5 | | | |
| Month | | | |

| 7 | Number Tested for HIV Pos this week recorded in the HTS register |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 8 | Number tested Pos this week that were captured on TIER.Net |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

## 4. Circle the identified problem on the summary chart

a. When circling the problems, the team is identifying the data elements that are affecting the non performance of the data indicator

b. The circled areas become a priority for improvement.

c. Use the summary chart and the indicator assessment together (See page 45). Identified problems in the indicator summary chart will point you the same colour coded section in the indicator assessment that will need to be addressed in order to address the problem

d. If you have not previously completed the indicator assessment, this would be a good time to start.

**Total HIV Tested and Total HIV Positive (HTS Indicator Summary Chart)**

| Total HIV Tested | |
|---|---|
| MONTH: | |
| TARGET | |
| ACTUAL: | |

| Total HIV Positive | |
|---|---|
| MONTH: | |
| TARGET | |
| ACTUAL: | |

| 1 | Obtain the weekly facility headcount,excluding the known on ART |
|---|---|
| Week 1 | 300 |
| Week 2 | 280 |
| Week 3 | 350 |
| Week 4 | 320 |
| Week 5 | 300 |
| Month | 1550 |

| 2 | Total Number of people tested for HIV this week = | | |
|---|---|---|---|
| | # tested at facility | # tested in community | # of index contacts tested |
| Week 1 | 85 | 25 | 1 |
| Week 2 | 70 | 0 | 0 |
| Week 3 | 50 | 15 | 2 |
| Week 4 | 75 | 0 | 1 |
| Week 5 | 37 | 45 | 0 |
| Month | 297 | 85 | 4 |

| 3 | Number Tested for HIV this week and recorded in the HTS register |
|---|---|
| Week 1 | 91 |
| Week 2 | 70 |
| Week 3 | 70 |
| Week 4 | 76 |
| Week 5 | 82 |
| Month | 389 |

| 4 | Number tested this week that were captured on TIER.Net |
|---|---|
| Week 1 | 89 |
| Week 2 | 68 |
| Week 3 | 63 |
| Week 4 | 70 |
| Week 5 | 75 |
| Month | 361 |

| 5 | % of Eligible headcount tested |
|---|---|
| Week 1 | 21% |
| Week 2 | 25% |
| Week 3 | 14% |
| Week 4 | 23% |
| Week 5 | 12% |
| Month | 19% |

| 6 | Total Number of people tested Positive for HIV this week = | | |
|---|---|---|---|
| | # tested at facility | # tested in community | # of index contacts tested |
| Week 1 | 1 | 0 | 1 |
| Week 2 | 3 | 1 | 0 |
| Week 3 | 1 | 0 | 0 |
| Week 4 | 2 | 3 | 0 |
| Week 5 | 1 | 0 | 0 |
| Month | 8 | 4 | 1 |

| 7 | Number Tested for HIV Pos this week recorded in the HTS register |
|---|---|
| Week 1 | 2 |
| Week 2 | 4 |
| Week 3 | 1 |
| Week 4 | 5 |
| Week 5 | 1 |
| Month | 13 |

| 8 | Number tested Pos this week that were captured on TIER.Net |
|---|---|
| Week 1 | 2 |
| Week 2 | 4 |
| Week 3 | 1 |
| Week 4 | 5 |
| Week 5 | 1 |
| Month | 13 |

| 9 | HIV Pos Yield |
|---|---|
| Week 1 | 3% |
| Week 2 | 5% |
| Week 3 | 2% |
| Week 4 | 7% |
| Week 5 | 1% |
| Month | 3% |

**Data Analysis Guide**

- Tested at facility + Community + Index = Total tested
- Step 2 = Step 3 = Step 4
- Eligible Headcount = Number tested / Facility Headcount excluding the known on ART
- Tested Pos at Facility + Community + Index = Total tested Pos
- Step 6 = Step 7 = Step 8
- HIV Yield = Number tested Pos/ Number tested for HIV

## 5. As a team, work through the Drivers for Program Excellence

**HTS**

**Services delivery processes**

Patient flow from HTS service point to consulting rooms

**Staff competency and capability**

Skilled and trained counsellors

**Data System**

Data quality processes i.e. Data recording, capturing, file flow, data verification and clean ups.

Targets being adjusted according to current performance.

**Resources and Supplies**

Sufficient HTS test kits

**Teamwork**

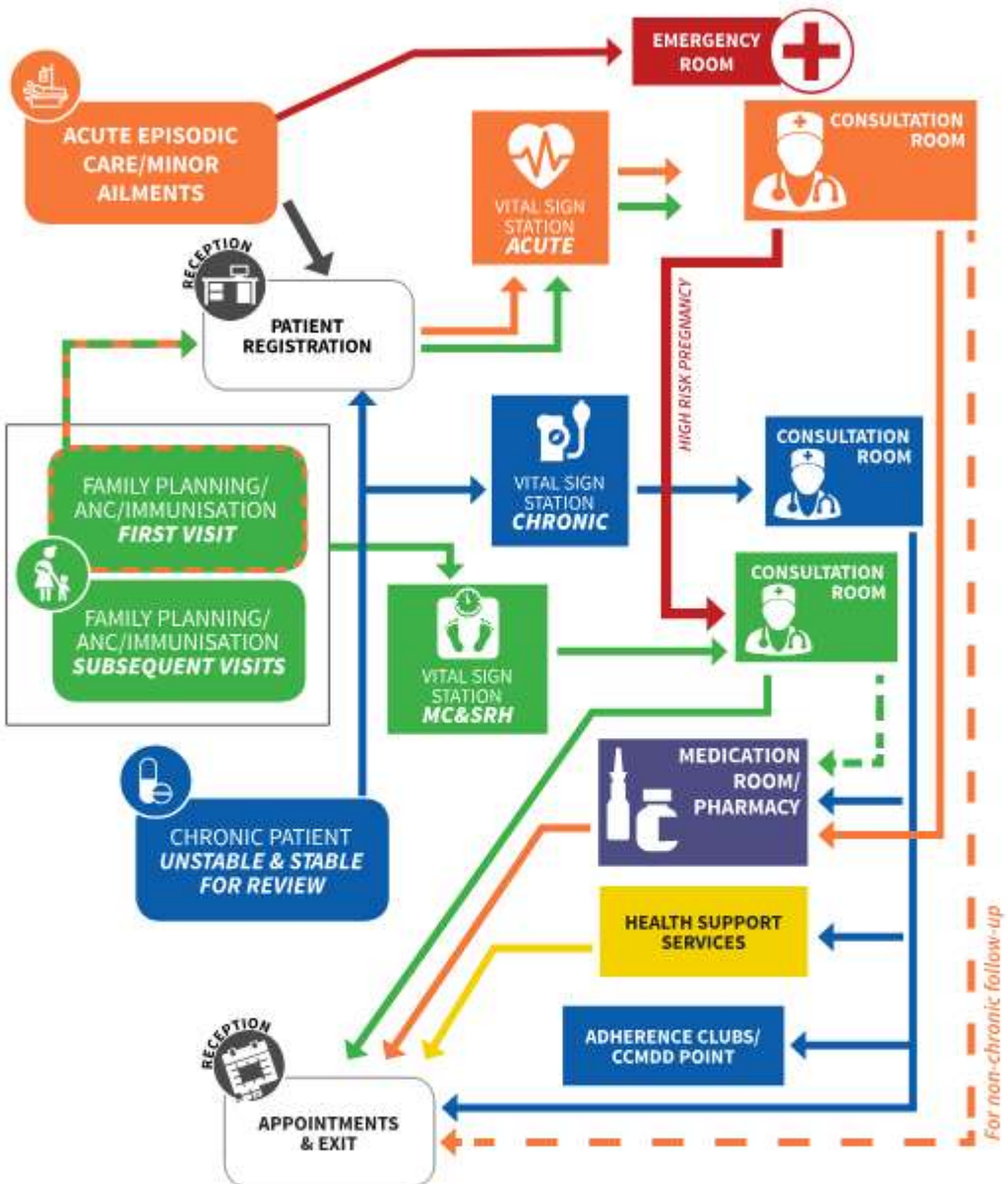
Multidisciplinary team collaboration

**Patient Engagement**

Pre-ART Counselling, Adherence Counselling. Demand creation strategy and its effectiveness.

**Illustration of where HTS service points can be added**

**Reference:** Integrated Clinical Services Management (Page 36)




**6. Prioritize the problem area to be worked on by using the prioritization questions provided:**

a. What has the biggest effect on the indicator's performance?

b. Can we do something to improve it now?

c. Are we able to solve this problem at the facility?

## 7. Decide what the team would like to focus on this week and develop a brief improvement plan

(See template 'Huddle Team Member Weekly Action Plan' (see page 189) to assist team members with recording and monitoring their own weekly inputs):

**a. What?**

- Decide exactly what needs to be done differently based on the step-by-step assessment and indicator summary chart?
- Be very specific. Visualise exactly what needs to be done so that members describe and understand exactly what needs to be done
- A simple process map will assist you to know exactly what needs to be done (see Annexure page 210)

**b. Who?**

- Assign a team member to each step in the process

**c. How much or how often?**

- Make sure each team members know how often or how much to do
- i.e. are they to do it everyday for the next 6 days with every patient, or are you only doing it in the mornings etc. Assumptions must be clarified

**d. Where?**

- Where will the change take place?

**e. How will team members know that the change was implemented as planned?**

- This will require the use of simple process measures (see page 47)
- It is important that we use data to measure the implementation of the new change and not rely on team members to have to remember
- Team members must keep track of these measures
- Below is an example of a change and **process measures** to help measure the change

| Example of Changes | Process Measures |
|---|---|
| 1 Counsellor allocated at the Dentist area every Tuesday and Thursday from 08:00 – 13:00 to test 80% of the eligible headcount for HIV. | • Headcount for the day<br>• Counsellor allocated<br>• # Eligible for HIV testing<br>• # Tested<br>• Measures are to be repeated for each day, Tuesday, Wednesday and Thursday |
| Pre-retrieve files 1 week prior to appointment. Sort files according to the day of appointment. Allocate 1 person to a specific day: review the file and identify eligibility for HIV testing – place a sticky note on the file. On the day of the visit: Refer all files with sticky note to HTS service point directly from reception. | • # Files Pre-retrieved for the day<br>• Person allocated to a day<br>• # patients identified as eligible for HTS per day by placing a sticky note on the file<br>• # Patients referred to HTS service point on the day of the visit.<br>• # HTS tests done |

f. **Challenges** faced

- Keep track of the challenges that were faced while trying to implement the change
- This will add valuable insight into deciding if the change is an improvement

g. **Suggestions/**what you learnt

- Observations are very important as not everything can be captured using data

h. Considerations for **sustainability**

We do not want to waste time and effort; thinking about sustainability of the change from the beginning is critical

**8. Report back** to the team to determine the way forward

# Appendix of tools

## Total HIV Tested and Total HIV Positive

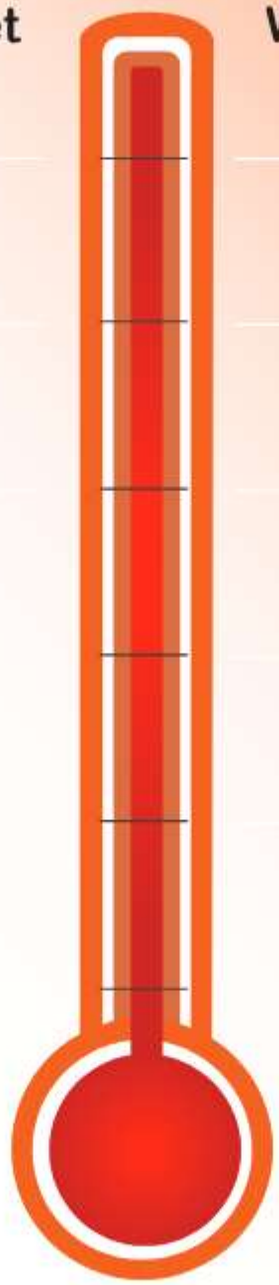
1. HIV Tested Barometer
2. HIV Tested Positive Barometer
3. Step-by-step Indicator Assessment Tool
4. Indicator Summary Chart
5. Drivers of Programme Excellence

# HIV Tested

MONTH

TARGET

| Weekly Target | Weekly Actual |
|---|---|
| Week 5 | |
| Week 4 | |
| Week 3 | |
| Week 2 | |
| Week 1 | |
| Start | |



# HIV Tested Positive

MONTH

TARGET

| Weekly Target | Weekly Actual |
|---|---|
| Week 5 | |
| Week 4 | |
| Week 3 | |
| Week 2 | |
| Week 1 | |
| Start | |

| Indicator: Total HIV tested (Adults incl. ANC & Children) & Total HIV Positive | | | | | |
|---|---|---|---|---|---|
| Elements: (Testing) : ANC client 1st test, HIV test around 18 months, HIV test 19-59 months, HIV test 5-14 years, HIV test female15- 24 (excluding ANC), HIV test male 15-24 years, HIV test 25-49 years, HIV test above 50 years | | | | | |
| Definitions (Positive) : ANC client 1st positive, HIV positive around 18 months, HIV positive 19-59 months, HIV positive male 5-14 years, HIV positive female 15- 24 (excluding ANC), HIV positive male 15-24 years, HIV positive 25-49 years, HIV positive above 50 years | | | | | |
| | **Assess the following:** | **Evidence** | **Source** | **Guiding Instructions** | **Assessment Objective** |
| **SERVICE DELIVERY APPROACHES & PROCESSES** | | | | | |
| Step 1 | **HIV Screening process** | | Facility protocol | Draft descriptions of HIV screening process and demand generation approaches. Do pocess mapping | Determine if there is a routine screening process embedded in all service processes |
| | What is the HIV screening process to identify patients eligible for HIV testing at each relevant serivice entry point e.g. Acute, NCD Emergency room, Family planning, Dentistry etc. | | | | |
| Step 2 | **Demand generation approaches used** | | Facility protocol | | Identify which demand generation strategies and innovations that are being utilised in the facility to make the HIV testing service accessible. |
| | Opt-in (patients made aware that there is availability of HIV testing, without explicitly offering them service) | | | | |
| | Active choice (Patients explicitly offered HIV testing, allowing them to actively choose the service) | | | | |
| | Opt-Out (Patients actively directed for HIV testing, but can decline it) | | | | |
| | PICT (Routine HIV testing recommendation to patient by the health care provider during consultation) | | | | |
| | Other (Describe) | | | | |
| | Community testing | | | | |
| Step 3 | **Testing methods or innovations** | | Facility protocol | | |
| | Index testing | | | | |
| | Self testing | | | | |
| | Other (Describe) | | | | |
| **HTS PERFORMANCE Assessment is best done with a weekly viewpoint. An allowance of 4 weeks data can provide a more comprehensive understanding.** | | | | | |
| Step 4 | **HTS performance: Weekly actuals vs targets** | | Barometers, Weekly reports, Index registers | | |
| | The weekly HIV testing target | | | | Determine the facilities weekly outcome performance |
| | The weekly HIV Positive target | | | | |
| | HIV positivity rate (yield) | | | | |
| | Number of people tested weekly | | | | |
| | Number of people tested HIV positive weekly | | | | |
| | Number of elicited index contacts | | | | |
| | Number of index contacts tested for HIV | | | | |
| | Number of index contacts tested HIV positive | | | | |
| | Number of HIV tested in CHTS (Community/Mobile clinic etc) | | | | |
| Step 5 | **HTS performance: Eligibility and coverage** | | | | |
| | What is the average daily headcount | | | | Determine facility's potiential for HIV testing and reveal missed opportunities |
| | Calculate the % of eligible headcount | | | Number eligible divided by the daily Headcount 80% of the Total | |
| | Current % of HTS coverage of eligible headcount | | | | |

| | | | | | |
|---|---|---|---|---|---|
| Step 6 | **HTS performance: Counsellor performance** | | HTS registers | | |
| | What is the Daily target per counsellor | | | | |
| | Total # of Counsellors | | | | Determine if counsellor-target ratio is feasible and if counsellor capacity is efficiently utilised to reach targets. |
| | Counsellor 1 | | | Total number tested per counsellor per day to compare against daily target: take into consideration absentism from work. | |
| | Counsellor 2 | | | | |
| | Counsellor 3 | | | | |
| | Counsellor 4 | | | | |
| | Counsellor 5 | | | | |
| | Total number tested | | | | |
| Step 7 | **HTS service point performance** | | | | |
| | Acute: Headcount | | | | Assess if all service points offer HIV testing and Identify the areas where HIV testing can be optimised. |
| | • Coverage | | | Divide total number tested by total headcount per stream | |
| | Chronic: Headcount | | | | |
| | • Coverage | | | Divide total number tested by total headcount per stream | |
| | Mother & Child: Headcount | | | | |
| | • Coverage | | | Divide total number tested by total headcount per stream | |
| | Dental & Oral Health: Headcount | | | | |
| | • Coverage | | | Divide total number tested by total headcount per stream | |
| | Mental Health: Headcount | | | | |
| | • Coverage | | | Divide total number tested by total headcount per stream | |
| | Rehabilitation: Headcount | | | | |
| | • Coverage | | | Divide total number tested by total headcount per stream | |
| **DATA MANAGEMENT** | | | | | |
| Step 8 | **Data collection and flow** | | HTS registers, facility protocol | | |
| | Number tested recorded in the HTS register | | | | To determine if there are any recording, flow, verification and capturing gaps that may result in work done but not being refelected in data collected and captured |
| | What is the data flow between HTS rooms to data capturing points | | | | |
| Step 9 | **Data verification and capturing** | | TIER.Net SOPs, Facility protocol | | |
| | What is the data verification process | | | | |
| | Number captured on TIER.Net | | | | |
| **AREAS FOR IMPROVEMENT** | | | | | **COMMENTS** |
| | | | | | |

## Total HIV Tested and Total HIV Positive (HTS Indicator Summary Chart)

| Total HIV Tested | |
|---|---|
| MONTH: | |
| TARGET | |
| ACTUAL: | |

| Total HIV Positive | |
|---|---|
| MONTH: | |
| TARGET | |
| ACTUAL: | |

| 1 | Obtain the weekly facility headcount, excluding the known on ART |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 2 | Total Number of people tested for HIV this week = | | |
|---|---|---|---|
| | # tested at facility | # tested in community | # of Index contacts tested |
| Week 1 | | | |
| Week 2 | | | |
| Week 3 | | | |
| Week 4 | | | |
| Week 5 | | | |
| Month | | | |

| 3 | Number Tested for HIV this week and recorded in the HTS register |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 4 | Number tested this week that were captured on TIERNet |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 5 | % of Eligible headcount tested |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 6 | Total Number of people tested Positive for HIV this week = | | |
|---|---|---|---|
| | # tested at Facility | # tested in community | # of Index contacts tested |
| Week 1 | | | |
| Week 2 | | | |
| Week 3 | | | |
| Week 4 | | | |
| Week 5 | | | |
| Month | | | |

| 7 | Number Tested for HIV Pos this week recorded in the HTS register |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 8 | Number tested Pos this week that were captured on TIERNet |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 9 | HIV Pos Yield |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

### Data Analysis Guide

- Tested at facility + Community + Index = Total tested
- Step 2 = Step 3 = Step 4
- Eligible Headcount = Number tested / Facility Headcount excluding the known on ART
- Tested Pos at Facility + Community + Index = Total tested Pos
- Step 6 = Step 7 = Step 8
- HIV Yield = Number tested Pos/ Number tested for HIV

HTS

**Services delivery processes**

Patient flow from HTS service point to consulting rooms

**Staff competency and capability**

Skilled and trained counsellors

**Data System**

Data quality processes i.e. Data recording, capturing, file flow, data verification and clean ups.

Targets being adjusted according to current performance.

**Resources and Supplies**

Sufficient HTS test kits

**Teamwork**

Multidisciplinary team collaboration

**Patient Engagement**

Pre-ART Counselling, Adherence Counselling. Demand creation strategy and its effectiveness.

# Total Naive Start ART

3

**Reporting indicators**

**Naive started on ART:** Number of adults and children newly enrolled on antiretroviral therapy (ART)

| SOURCE | DATA | TIME |
|---|---|---|
| TIER.Net HTS module<br>HTS register | Number of patients who tested HIV pos | Can be done daily or weekly |
| Defer ART list | Number of patients due to return for the day/week that were deferred for ART due to a medical reason or who were not yet ready to start ART | Can be obtained for the week |
| TIER.Net | Number of patients who started new on ART | Can be done weekly |

X The Indicator champion is indicated by the **red X**

| | Operational Manager | Professional Nurse | Data Capturer | Counsellor | Index Counsellor | OTL & Tracer | Clerks | Pharmacy | Community committee member |
|---|---|---|---|---|---|---|---|---|---|
| Total Naive Start ART | | X | x | x | x | | x | x | |

## 8 Responsibilities of the Indicator Champion and Indicator Team

1. Complete the relevant barometer
2. Conduct or review the Step-by-Step Indicator Assessment to identify all the gaps
3. Collect the data and complete the indicator summary chart
4. Circle the identified problem on the summary chart
5. As a team, work through the Drivers for Program Excellence
6. Prioritize the problem area to be worked on
7. Decide what the team would like to focus on this week and develop a brief improvement plan
8. Report back

## The 8 Steps Explained :

**1.** Complete the relevant **Barometer** (See How to Complete a Barometer page 185)

**a.** Identify the variance.

**b.** Adjust the following weeks' target.

**2.** Conduct the **Step-by-Step Indicator Assessment** to identify all the gaps (see page 93)

**a.** The step-by-step assessment will identify all the gaps in your process that need to be addressed

**b.** Once the assessment has been conducted, and all gaps identified, there is no need to keep redoing the assessment week after week.

## 3. Collect the data and **complete the indicator summary chart** (see page 94)

**a.** Team members must come to the huddle with all the data needed to populate the summary chart

**Total Naive Start ART Summary Chart**

| MONTH: | | TARGET: | | ACTUAL: | |
|---|---|---|---|---|---|

| 1 | # tested HIV pos this week |
|---|---|
| Week 1 | 2 |
| Week 2 | 4 |
| Week 3 | 1 |
| Week 4 | 5 |
| Week 5 | 1 |
| Month | 13 |

+

| 2 | # Due to return for ART in this week from the # waiting for ART list |
|---|---|
| Week 1 | 1 |
| Week 2 | 1 |
| Week 3 | 2 |
| Week 4 | 2 |
| Week 5 | 1 |
| Month | 7 |

=

| 3 | Total # Eligible to start New on ART this week |
|---|---|
| Week 1 | 3 |
| Week 2 | 5 |
| Week 3 | 3 |
| Week 4 | 7 |
| Week 5 | 2 |
| Month | 20 |

| 4 | Total New on ART started this week | |
|---|---|---|
| | Same day | Waiting to start ART |
| Week 1 | 2 | 0 |
| Week 2 | 4 | 1 |
| Week 3 | 1 | 1 |
| Week 4 | 2 | 0 |
| Week 5 | 1 | 0 |
| Month | 10 | 2 |

| 5 | Total captured on TIER.Net |
|---|---|
| Week 1 | 2 |
| Week 2 | 5 |
| Week 3 | 2 |
| Week 4 | 2 |
| Week 5 | 1 |
| Month | 12 |

**Data Analysis Guide**

- Number Eligible (3) = 1 +2
- 3 should = 4
- 4 should =5

## 4. Circle the identified problem on the summary chart

**a.** When circling the problems, the team is identifying the data elements that are affecting the non performance of the data indicator

**b.** The circled areas become a priority for improvement.

**c.** Use the summary chart and the indicator assessment together (See page 45). Identified problems in the indicator summary chart will point you the same colour coded section in the indicator assessment that will need to be addressed in order to address the problem

**d.** If you have not previously completed the indicator assessment, this would be a good time to start.

**Total Naive Start ART Summary Chart**

| MONTH: | | TARGET: | | ACTUAL: | |
|---|---|---|---|---|---|

| 1 | # tested HIV pos this week |
|---|---|
| Week 1 | 2 |
| Week 2 | 4 |
| Week 3 | 1 |
| Week 4 | 5 |
| Week 5 | 1 |
| Month | 13 |

+

| 2 | # Due to return for ART in this week from the # waiting for ART list |
|---|---|
| Week 1 | 1 |
| Week 2 | 1 |
| Week 3 | 2 |
| Week 4 | 2 |
| Week 5 | 1 |
| Month | 7 |

=

| 3 | Total # Eligible to start New on ART this week |
|---|---|
| Week 1 | 3 |
| Week 2 | 5 |
| Week 3 | 3 |
| Week 4 | 7 |
| Week 5 | 2 |
| Month | 20 |

| 4 | Total New on ART started this week | |
|---|---|---|
| | Same day | Waiting to start ART |
| Week 1 | 2 | 0 |
| Week 2 | 4 | 1 |
| Week 3 | 1 | 1 |
| Week 4 | 2 | 0 |
| Week 5 | 1 | 0 |
| Month | 10 | 2 |

| 6 | Total captured on TIER.Net |
|---|---|
| Week 1 | 2 |
| Week 2 | 5 |
| Week 3 | 2 |
| Week 4 | 2 |
| Week 5 | 1 |
| Month | 12 |

**Data Analysis Guide**
- Number Eligible (3) = 1 +2
- 3 should = 4
- 4 should =5

**5.** As a team, work through the **Drivers for Programme Excellence**: Identify possible gaps for improvement.

**Naive start on ART**

**Services delivery processes:**
Defined process for HIV positive client linked to same day ART initiation i.e. patient flow from HIV service point to consultation room. Tracking patients that have deferred ART due to clinical or psychospcial reasons

**Staff competency and capability:**
Skilled and trained counsellors

**Data System:**
Monitored file flow process i.e. from consultation room to data capturing room
Timeous data capturing processes

**Resources and Supplies:**
Sufficient HTS test kits

**Resources and Supplies:**
Available ART supply in consultation rooms

**Teamwork:** Clear allocation of roles and responsibilities i.e Allocated nurse for initiated etc.
Agreed coordination of functions to facilitate linkage and initiation to ART

**Patient Engagement:**
Quality Pre-ART and Adherence Counselling
Efficient blood results management process

**6. Prioritize the problem area to be worked on by using the prioritization questions provided:**

**a.** What has the biggest effect on the indicator's performance?

**b.** Can we do something to improve it now?

**c.** Are we able to solve this problem at the facility?

**7. Decide what the team would like to focus on this week and develop a brief improvement plan**

(See template 'Huddle Team Member Weekly Action Plan' (see page 189) to assist team members with recording and monitoring their own weekly inputs):

**a. What?**

- Decide exactly what needs to be done differently based on the step-by-step assessment and indicator summary chart?
- Be very specific. Visualise exactly what needs to be done so that members describe and understand exactly what needs to be done
- A simple process map will assist you to know exactly what needs to be done (see Annexures page 210)

**b. Who?**

- Assign a team member to each step in the process

**c. How much or how often?**

- Make sure each team members know how often or how much to do
- i.e. are they to do it everyday for the next 6 days with every patient, or are you only doing it in the mornings etc. Assumptions must be clarified

**d. Where?**

- Where will the change take place?

**e. How will team members know that the change was implemented as planned?**

- This will require the use of simple process measures (see page 47)
- It is important that we use data to measure the implementation of the new change and not rely on team members to have to remember
- Team members must keep track of these measures
- Below is an example of a change and **process measures** to help measure the change

| Example of Changes | Process Measures |
|---|---|
| Five clinicians to be NIMART trained in May 2021. | • # of NIMART trained clinicians in May 2021 |
| Counsellors to escort patients tested HIV pos to clinicians for ART initiation | • # of HIV pos patients<br>• # of HIV pos patients escorted to the clinicians<br>• # of patients initiated on ART |

**f. Challenges** faced

- Keep track of the challenges that were faced while trying to implement the change
- This will add valuable insight into deciding if the change is an improvement

**g. Suggestions**/what you learnt

- Observations are very important as not everything can be captured using data

**h.** Considerations for **sustainability**

- We do not want to waste time and effort; thinking about sustainability of the change from the beginning is critical

## 8. Report back to the team to determine the way forward

# Appendix of tools

## Total Naive Start ART

1. Total Naive Start ART Barometer
2. Step-by-step Indicator Assessment Tool
3. Indicator Summary Chart
4. Drivers of Programme Excellence

Total Naive Start ART
MONTH
TARGET
Weekly Target
Weekly Actual
Week 5
Week 4
Week 3
Week 2
Week 1
Start

| Indicator: Total Naive Start ART | | | | |
|---|---|---|---|---|
| Elements: ART adult naive start ART in month, ART child under 15 years naive start ART in month, ART adult male naive start, ART adult female naive start, ART child under 1 year naive started ART, ART child 1 to under 5 years naive started ART, ART child 5 to under 15 years naive started ART | | | | |
| | **Assess the following:** | **Evidence** | **Source** | **Assessment objective** |
| **HTS PERFORMANCE** | | | | |
| **Step 1** | Number HIV tested weekly | | | To determine if HTS performance and processes compromise the critical linkage to care step. |
| | Number HIV positive weekly | | | |
| | HIV positivity rate (yield) | | | |
| **LINKAGE TO CARE** | | | | |
| **Step 2** | **Same day initiation** | | TIER.Net | Determine if there is a management process of all eligible for ART patients who have not yet been initiated, due to various reasons, to ensure they are not missed or forgotten. |
| | Number HIV positive same day initiation (within 7 days) | | | |
| | Verify if HIV positive index contacts are initiated on ART | | | |
| | Verify that PCR positives are initiated on ART | | | |
| **Step 3** | **Waiting to start ART list** | Defer list/Diary | | |
| | Does the clinician keep track of patients not started on ART the same day | | | |
| | Is there a monitoring tool for patients who deferred treatment | Waiting to start ART list | | |
| | Number of Deferred for Medical reasons due to return for ART during review | | | |
| | Number not currently ready now but due for follow up after 14 days | Process Map | | |
| | List the follow-up process of patients due to return to care | Process Map | | |
| **PATIENT FLOW** | | | | |
| **Step 4** | **Assess the patient flow from HTS point to consulting room** | | | Analyse the current patient flow, from HTS service point to consulting room, to identify the steps where the patients might be lost. |
| | How do you ensure all patients tested pos meet with a Clinician? | | | |
| | Number of Patients who tested pos that were not seen by a clinician | | | |
| **DATA VERIFICATION, FLOW, CAPTURING** | | **TIER.Net** | | |
| **Step 5** | # Patients that were started on ART in review period | TIER.Net | | To determine if there are any recording, flow, verification and capturing gaps that may result in work done not being reflected in data collected and captured. |
| **Step 6** | # Same day initiation captured on TIER. Net | TIER.Net | | |
| | # of patient's from the defer list that were started on ART and captured | TIER.Net | | |
| | # Removed from TIER.Net Waiting to start ART list | Process Map | | |
| **Step 7** | Describe the file flow from Clinician to Data room | | | |
| **AREAS FOR IMPROVEMENT** | | | | **Comments** |
| | | | | |

## Total Naive Start ART Summary Chart

| MONTH: | | TARGET: | | ACTUAL: | |
|---|---|---|---|---|---|

| 1 | # tested HIV pos this week |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

+

| 2 | # Due to return for ART in this week from the # waiting for ART list |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

=

| 3 | Total # Eligible to start New on ART this week |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 4 | Total New on ART started this week | |
|---|---|---|
| | Same day | Waiting to start ART |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 5 | Total captured on TIER.Net |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

### Data Analysis Guide

- Number Eligible (3) = 1 +2
- 3 should = 4
- 4 should =5

**Naive start on ART**

**Services delivery processes:**

Defined process for HIV positive client linked to same day ART initiation i.e. patient flow from HIV service point to consultation room. Tracking patients that have deferred ART due to clinical or psychospcial reasons

**Staff competency and capability:**

Skilled and trained counsellors

**Data System:**

Monitored file flow process i.e. from consultation room to data capturing room

Timeous data capturing processes

**Resources and Supplies:**

Sufficient HTS test kits

**Resources and Supplies:**

Available ART supply in consultation rooms

**Teamwork:**

Clear allocation of roles and responsibilities i.e Allocated nurse for initiated etc.

Agreed coordination of functions to facilitate linkage and initiation to ART

**Patient Engagement:**

Quality Pre-ART and Adherence Counselling

Efficient blood results management process

# Total Remaining On ART (TROA)

4

**Reporting indicators**

**TROA:** Total clients remaining on ART (TROA) are the sum of the following:

- Any client on treatment in the reporting month
- Any client with an outcome reported in the reporting month
- Clients remaining on ART equal [new starts (naive) + Experienced (Exp) + Transfer in (TFI) + Restart] minus [Died (RIP) + loss to follow-up (LTF) + Transfer out (TFO)]

| SOURCE | DATA | TIME |
|---|---|---|
| Facility and Home Tracing Register<br>TIER.Net<br>Patient file: Clinical ART stationery | Track weekly updated tracing outcome. | Weekly |
| TIER.Net | Appointment list to check the patients who missed their appointments | Appointment list can be printed daily |
| TIER.Net | Newly initiated on ART | Can be obtained weekly |
| Lab Track | Daily or weekly check on patients who already tested HIV pos to be re-initiated on ART | Can be obtained during patient visit |

X The Indicator champion is indicated by the **red X**

| | Operational Manager | Professional Nurse | Data Capturer | Counsellor | Index Counsellor | OTL & Tracer | Clerks | Pharmacy | Community committee member |
|---|---|---|---|---|---|---|---|---|---|
| Total Remaining on ART (TROA) | | X | X | | | X | X | | |

## 8 Responsibilities of the Indicator Champion and Indicator Team

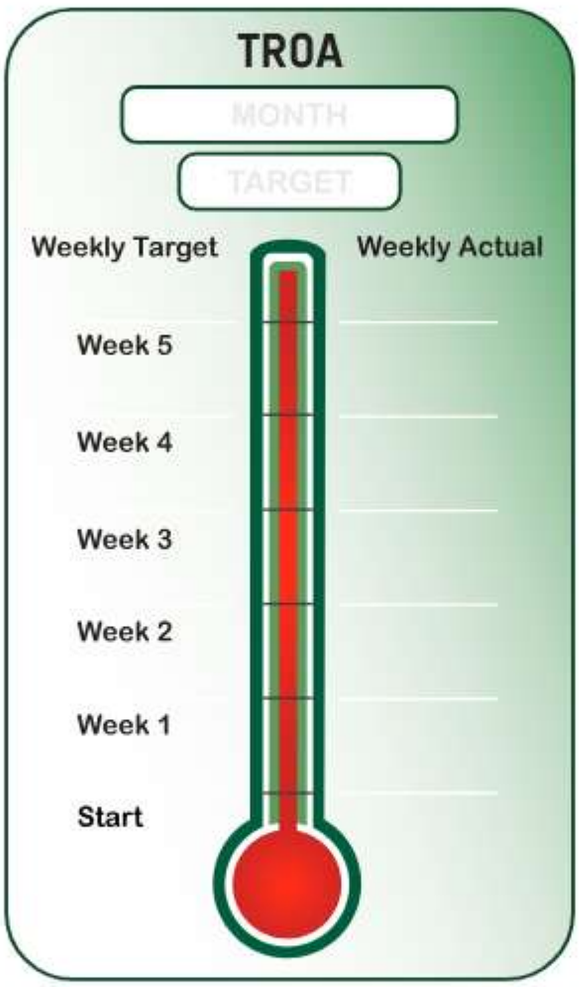
1. Complete the relevant barometer
2. Conduct or review the Step-by-Step Indicator Assessment to identify all the gaps
3. Collect the data and complete the indicator summary chart
4. Circle the identified problem on the summary chart
5. As a team, work through the Drivers for Program Excellence
6. Prioritize the problem area to be worked on
7. Decide what the team would like to focus on this week and develop a brief improvement plan
8. Report back

## The 8 Steps Explained:

**1.** Complete the relevant **Barometer** (See How to Complete a Barometer page 185)

a. Identify the variance.

b. Adjust the following weeks' target.




**2.** Conduct the **Step-by-Step Indicator Assessment** to identify all the gaps (see page 106).

a. The step-by-step assessment will identify all the gaps in your process that need to be addressed

b. Once the assessment has been conducted, and all gaps identified, there is no need to keep redoing the assessment week after week.

**3.** Collect the data and **complete the indicator summary chart** (see page 107 & 108)

a. Team members must come to the huddle with all the data needed to populate the summary chart (see page 16)

b. TROA in care is a complex indicator to monitor and improve on as patients will constantly move in and out of TROA for various reasons

c. As there are many factors that impact on TROAs performance, we have identified the need for two summary charts

d. The first needs to be completed on a weekly basis and focuses on the tracing and returned to care process

**Total Remaining on ART Weekly Summary Chart**

| WEEK: | | MONTH: | | TARGET: | | ACTUAL: | |
|---|---|---|---|---|---|---|---|

**1-7 Days**

| 1 | | | 2 | | |
|---|---|---|---|---|---|
| Same day missed appointments per week | Week 1 | 4 | # Missed appointments traced in 24 hours | Week 1 | 0 |
| | Week 2 | 7 | | Week 2 | 0 |
| | Week 3 | 2 | | Week 3 | 0 |
| | Week 4 | 1 | | Week 4 | 0 |
| | Week 5 | 1 | | Week 5 | 0 |
| | Month | 15 | | Month | 0 |

| 3 | | | 4 | | |
|---|---|---|---|---|---|
| # of same day missed appointments not returned within 7 days | Week 1 | 1 | # Referred for Tele or Home tracing | Week 1 | 0 |
| | Week 2 | 2 | | Week 2 | 0 |
| | Week 3 | 1 | | Week 3 | 0 |
| | Week 4 | 1 | | Week 4 | 0 |
| | Week 5 | 1 | | Week 5 | 0 |
| | Month | 6 | | Month | 0 |

Data Analycic Guide:
- Step 1 + Step 2
- Step 3 + Step 4

**Total Remaining on ART Monthly Summary Chart**

| QUARTER: | | ACTUAL: | | Total remaining in care at end of the quarter | |
|---|---|---|---|---|---|

| Lost in Care | | | | |
|---|---|---|---|---|
| | 1 | 2 | 3 | 4 |
| | Died | LTF | Transfer out | Total lost in care |
| Month 1 | | | | |
| Month 2 | | | | |
| Month 3 | | | | |
| Total | | | | |

| Gained in Care | | | | |
|---|---|---|---|---|
| | 5 | 6 | 7 | 8 |
| | New on ART | Re-initiated | Transfer in | Total gained in-care |
| Month 1 | | | | |
| Month 2 | | | | |
| Month 3 | | | | |
| Total | | | | |

## 4. Circle the identified problem on the summary chart

a. When circling the problems, the team is identifying the data elements that are affecting the non performance of the data indicator

b. The circled areas become a priority for improvement.

c. Use the summary chart and the indicator assessment together (See page 45). Identified problems in the indicator summary chart will point you the same colour coded section in the indicator assessment that will need to be addressed in order to address the problem

d. If you have not previously completed the indicator assessment, this would be a good time to start

e. The second needs be completed on a monthly basis to give a team greater insight into how TROA as a outcome measure is responding

f. The huddle team must ensure that the monthly summary chart is completed and analysed on a monthly basis

**Total Remaining on ART Weekly Summary Chart**

| WEEK: | | MONTH: | | TARGET: | | ACTUAL: | |
|---|---|---|---|---|---|---|---|

**1-7 Days**

| 1 | | | 2 | | |
|---|---|---|---|---|---|
| Same day missed appointments per week | Week 1 | 4 | # Missed appointments traced in 24 hours | Week 1 | 0 |
| | Week 2 | 7 | | Week 2 | 0 |
| | Week 3 | 2 | | Week 3 | 0 |
| | Week 4 | 1 | | Week 4 | 0 |
| | Week 5 | 1 | | Week 5 | 0 |
| | Month | 15 | | Month | 0 |

| 3 | | | 4 | | |
|---|---|---|---|---|---|
| # of same day missed appointments not returned within 7 days | Week 1 | 1 | # Referred for Tele or Home tracing | Week 1 | 0 |
| | Week 2 | 2 | | Week 2 | 0 |
| | Week 3 | 1 | | Week 3 | 0 |
| | Week 4 | 1 | | Week 4 | 0 |
| | Week 5 | 1 | | Week 5 | 0 |
| | Month | 6 | | Month | 0 |

Data Analysis Guide:
- Step 1 = Step 2
- Step 3 = Step 4

**Total Remaining on ART Monthly Summary Chart**

| QUARTER: | | ACTUAL: | | Total remaining in care at end of the quarter | |
|---|---|---|---|---|---|

| Lost in Care | | | | |
|---|---|---|---|---|
| | 1 | 2 | 3 | 4 |
| | Died | LTF | Transfer out | Total lost in care |
| Month 1 | 0 | 40 | 8 | 48 |
| Month 2 | 1 | 25 | 4 | 30 |
| Month 3 | 2 | 30 | 7 | 39 |
| Total | 3 | 95 | 19 | 117 |

| Gained in Care | | | | |
|---|---|---|---|---|
| | 5 | 6 | 7 | 8 |
| | New on ART | Re-initiated | Transfer in | Total gained in care |
| Month 1 | 2 | 1 | 2 | 5 |
| Month 2 | 4 | 0 | 2 | 6 |
| Month 3 | 1 | 0 | 1 | 2 |
| Total | 7 | 1 | 5 | 13 |

**5.** As a team, work through the **Drivers for Programme Excellence**: Identify possible gaps for improvement.

**TROA**

**Services delivery processes:**
Functional appointment booking and reminder system for patients
Defined Tele-tracing and Home tracing processes
Defined Return to care process and patient flow
Defined patient flow process of the Transfer In and Transfer out patients

**Staff competency and capability**
Trained and skilled in implementing the adherence guidelines
Skilled tracers/community health workers

**Data System:**
Updating the tracing outcomes
Monitored file flow process from different service points to data capturing point
Manage the missed appointment list
Data verification & cleaning activities

**Resources and Supplies:**
Sufficient available Tracers and Community health workers covering relevant demographic areas
Available ART medication to ensure patient has medication in hand

**Teamwork:**
Integrated tele-tracing and home tracing processes
Collaboration of the multi-diciplinary team
Integration of DMOC processes

**Patient Engagement:**
Routine provision of health education
Confirming and updating patient contact details at each visit

**6. Prioritize the problem area to be worked on by using the prioritization questions provided:**

a. What has the biggest effect on the indicator's performance?

b. Can we do something to improve it now?

c. Are we able to solve this problem at the facility?

**7. Decide what the team would like to focus on this week and develop a brief improvement plan**

(See template 'Huddle Team Member Weekly Action Plan' (see page 189) to assist team members with recording and monitoring their own weekly inputs):

a. **What?**

- Decide exactly what needs to be done differently based on the step-by-step assessment and indicator summary chart?
- Be very specific. Visualise exactly what needs to be done so that members describe and understand exactly what needs to be done
- A simple process map will assist you to know exactly what needs to be done (see Annexure page 210)

b. **Who?**

- Assign a team member to each step in the process

c. **How much or how often?**

- Make sure each team members know how often or how much to do
- i.e. are they to do it everyday for the next 6 days with every patient, or are you only doing it in the mornings etc. Assumptions must be clarified

d. **Where?**

- Where will the change take place?

e. **How will team members know that the change was implemented as planned?**

- This will require the use of simple process measures (see page 47)
- It is important that we use data to measure the implementation of the new change and not rely on team members to have to remember
- Team members must keep track of these measures
- Below is an example of a change and **process measures** to help measure the change

| Example of Changes | Process Measures |
|---|---|
| Dedicated Clinician to record outcomes in the file of all patients transferred in and out of the facility every Friday. | • # of patients transferred in<br>• # of patients transferred out.<br>• # of patients outcome in the file. |
| CHW's to give outcomes from home tracing to OTL every Friday. OTL update Transferred out files with outcome. Take files to Data room. Data Capturer update transferred out outcomes on TIER.Net | • # Patients traced by CHW's<br>• # Tracing outcomes provided to OTL<br>• # Found as Transferred out<br>• # Transferred out updated on the Patient files<br>• # Files taken to Data room.<br>• # Transferred out outcomes updated on TIER.Net |

f. **Challenges** faced

- Keep track of the challenges that were faced while trying to implement the change
- This will add valuable insight into deciding if the change is an improvement

g. **Suggestions**/what you learnt

- Observations are very important as not everything can be captured using data

h. Considerations for **sustainability**

- We do not want to waste time and effort; thinking about sustainability of the change from the beginning is critical

**8. Report back to the team to determine the way forward**

# Appendix of tools

## Total Remaining On ART (TROA)

1. Total Remaining on ART Barometer
2. Step-by-step Indicator Assessment Tool
3. Weekly Indicator Summary Chart
4. Monthly Indicator Summary Chart
5. Drivers of Programme Excellence

TROA
QUARTER
TARGET
Monthly Target
Monthly Actual
Month 3
Month 2
Month 1
Start

## Total Remaining on ART (TROA)

| | Assess the following: | Evidence | Source | Assessment objective |
|---|---|---|---|---|
| **MISSED APPOINTMENT MANAGEMENT** | | | | |
| Step 1 | Describe the process you have in place to identify the patients who missed their appointments on the scheduled appointment date | | Process Map | Determine if missed appointments are identified the same day and traced to return within 7 days. Assess if all patients not traced in 7 days are handed over for Tele-tracing |
| Step 2 | Are files pre-retrieved 24-72 hours prior to appointments | | | |
| Step 3 | Is there a dedicated space to keep pre-retrieved files | | | |
| Step 4 | Who is responsible to trace the patient within 24 hours | | | |
| Step 5 | Identify the source where the tracing outcome gets recorded. Who is responsible for updating tracing outcomes in the patient file. | | | |
| Step 6 | How do you monitor the return of these patients within 7 days? | | | |
| Step 7 | Describe the process of handing over patients who were not traced within the 7 Days for Tele-tracing | | | |
| **PREPARATION FOR TRACING** | | | | |
| Step 8 | Describe the process of verifying if missed appointments returned to care, updated and captured appropriately so that they do not appear on the missed appointment list | | | Determine the verification process to ensure a correct list of missed appointments. This will ensure that patients that did attend their visit, are not called. |
| **TELE TRACING** | | | | |
| Step 9 | Does the facility make use of tele-tracing | | | Determine the efficiency of the agreed tele-tracing process and its effectiveness. |
| Step 10 | Who is responsible for tele-tracing | | | |
| Step 11 | Identify the source for recording tele-tracing outcomes | | | |
| Step 12 | What is the agreed tele-tracing protocol (Number of times to call and what action to take for voicemails, wrong numbers etc.) | | | |
| Step 13 | How do you ensure that files are updated with the Tele-tracing outcome | | | |
| Step 14 | Describe the file flow from updating the file by a clinician to capturing on TIER.Net | | | |
| Step 15 | What process is in place to handover the patients not tele-traced to Home tracing | | | |
| **HOME TRACING** | | | | |
| Step 16 | Map out the Home tracing Process | | | Assess the effective collaboration between tele-tracing and home tracing. |
| Step 17 | Identify the documents used to record Home tracing outcomes | | | |
| Step 18 | Describe the process of updating the Home tracing outcome on the patient file | | | |
| Step 19 | How do you ensure that all Home tracing outcomes are captured on TIER.Net | | | |
| **PATIENT REASON FOR MISSED APPOINTMENT** | | | | |
| Step 20 | What process is in place to collect the reasons why patients miss their appointments? | | | Assess if there is consideration and understanding of patient needs in the delivery of the ART service. |
| Step 21 | Identify the most common reasons why patients miss their appointments. | | | |
| **AREAS FOR IMPROVEMENT** | | | | **COMMENTS** |
| | | | | |

## Total Remaining on ART Weekly Summary Chart

| WEEK: | | MONTH: | | TARGET: | | ACTUAL: | |
|---|---|---|---|---|---|---|---|

### 1-7 Days

| 1 | | |
|---|---|---|
| Same day missed appointments per week | Week 1 | |
| | Week 2 | |
| | Week 3 | |
| | Week 4 | |
| | Week 5 | |
| | Month | |

| 2 | | |
|---|---|---|
| # Missed appointments traced in 24 hours | Week 1 | |
| | Week 2 | |
| | Week 3 | |
| | Week 4 | |
| | Week 5 | |
| | Month | |

**Data Analysis Guide:**
- Step 1 = Step 2
- Step 3 = Step 4

| 3 | | |
|---|---|---|
| # of same day missed appointments not returned within 7 days | Week 1 | |
| | Week 2 | |
| | Week 3 | |
| | Week 4 | |
| | Week 5 | |
| | Month | |

| 4 | | |
|---|---|---|
| # Referred for Tele or Home tracing | Week 1 | |
| | Week 2 | |
| | Week 3 | |
| | Week 4 | |
| | Week 5 | |
| | Month | |

| Total Remaining on ART Monthly Summary Chart | | | | | |
|---|---|---|---|---|---|
| QUARTER: | | ACTUAL: | | Total remaining in care at end of the quarter | |

| Lost in Care | | | | |
|---|---|---|---|---|
| | 1 | 2 | 3 | 4 |
| | Died | LTF | Transfer out | Total lost in care |
| Month 1 | | | | |
| Month 2 | | | | |
| Month 3 | | | | |
| Total | | | | |

| Gained in Care | | | | | |
|---|---|---|---|---|---|
| | 5 | 6 | 7 | 8 | 9 |
| | Current on ART | Newon ART | Re-initiated | Transfer in | Total gained in care |
| Month 1 | | | | | |
| Month 2 | | | | | |
| Month 3 | | | | | |
| Total | | | | | |

**Data Analysis Guide:**

- Current TRO A = Step 9 - Step 4
- Lost in care (Step 4) = Step 1 + Step 2 + Step 3
- Gained in Care (Step 9) = Step 5 + Step 6 + Step 7 + Step 8

TROA

**Services delivery processes:**

Functional appointment booking and reminder system for patients
Defined Tele-tracing and Home tracing processes
Defined Return to care process and patient flow
Defined patient flow process of the Transfer In and Transfer out patients

**Staff competency and capability:**

Trained and skilled in implementing the adherence guidelines
Skilled tracers/community health workers

**Data System:**

Updating the tracing outcomes
Monitored file flow process from different service points to data capturing point
Manage the missed appointment list
Data verification & cleaning activities

**Resources and Supplies:**

Sufficient available Tracers and Community health workers covering relevant demographic areas
Available ART medication to ensure patient has medication in hand

**Teamwork:**

Integrated tele-tracing and home tracing processes
Collaboration of the multi-diciplinary team
Integration of DMOC processes

**Patient Engagement:**

Routine provision of health education
Confirming and updating patient contact details at each visit

# TLD Transition

5

**Reporting indicators**

**TLD Transition:** Process for switching stable adult patients on ART from first line regimen TEE (Tenofovir + Emtricitabine + Efavirenz) to TLD (Tenofovir + Lamivudine + Dolutegravir) and the process for registration of new patients to TLD.

**Data Sources to consider when collecting the data**

Viral load results
Patient file
TIER.Net

| SOURCE | DATA | TIME |
|---|---|---|
| Lab Track/Hard copy of results/Patient file: ART stationery | Viral load results to check Viral load suppression for eligibility for TLD Transition | 72 hours – 7 days after the viral load was done |
| Patient file | Recording of transitioning to TLD in clinical stationary or on Prescription chart | Can be obtained after patient visit |
| Rx Solution/other electronic pharmacy system | TLD stock level availability | Can be obtained weekly |

X The Indicator champion is indicated by the **red X**

| | Operational Manager | Professional Nurse | Data Capturer | Counsellor | Index Counsellor | OTL & Tracer | Clerks | Pharmacy | Community committee member |
|---|---|---|---|---|---|---|---|---|---|
| TLD transition | | X | x | | | x | x | x | |

## 8 Responsibilities of the Indicator Champion and Indicator Team

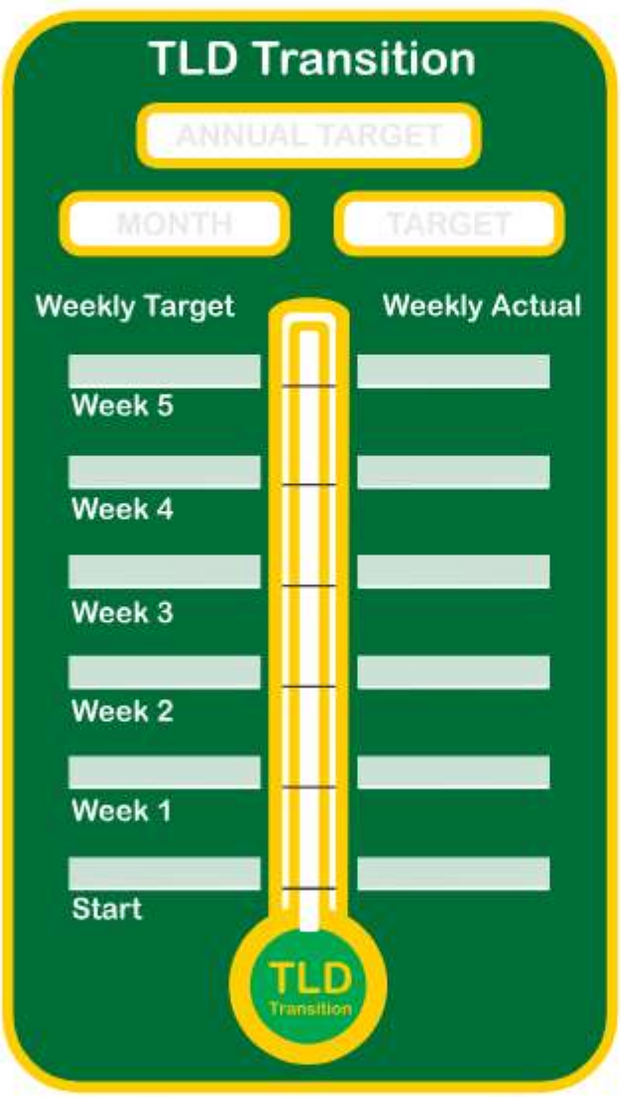
1. Complete the relevant barometer
2. Conduct or review the Step-by-Step Indicator Assessment to identify all the gaps
3. Collect the data and complete the indicator summary chart
4. Circle the identified problem on the summary chart
5. As a team, work through the Drivers for Program Excellence
6. Prioritize the problem area to be worked on
7. Decide what the team would like to focus on this week and develop a brief improvement plan
8. Report back

## The 8 Steps Explained:

**1.** Complete the relevant **Barometer** (See How to Complete a Barometer page 185)

**a.** Identify the variance

**b.** Adjust the following weeks' target




**ADVANTAGES OF TLD**

Side effects are mild and uncommon

Adherence results in rapid viral suppression

High genetic barrier to resistance

No interaction with hormonal contraceptives

Dolutegravir has a low risk of neural tube defects when used around the time of conception and in the first 6 weeks of pregnancy.

By the end of 6 weeks, the neural tube closes and there is no longer a risk of neural tube defects.

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**2.** Conduct the **Step-by-Step Indicator Assessment** to identify all the gaps (see page 120)

**a.** The step-by-step assessment will identify all the gaps in your process that need to be addressed

**b.** Once the assessment has been conducted, and all gaps identified, there is no need to keep redoing the assessment week after week.

**3.** Collect the data and **complete the indicator summary chart** (see page 121)

**a.** Team members must come to the huddle with all the data needed to populate the summary chart

**TLD Transition Summary Chart**

| MONTH: | | TARGET: | | ACTUAL: | |
|---|---|---|---|---|---|

| Viral Load Completion | | | Identify eligibility for TLD Transitioning | | | |
|---|---|---|---|---|---|---|
| 1 | | | 2 | | | |
| | Due | Done | | 6 Month VL <50c/ml | 2 Consecutive VL 50-100c/ml within 3 months | VL Suppressed with co-morbidities on NCD medication with no known drug interaction |
| Week 1 | | | Week 1 | | | |
| Week 2 | | | Week 2 | | | |
| Week 3 | | | Week 3 | | | |
| Week 4 | | | Week 4 | | | |
| Week 5 | | | Week 5 | | | |
| Month | | | Month | | | |

| Total number transitioned to TLD | | Data Management | | | |
|---|---|---|---|---|---|
| 3 | | 4 | | | |
| Week 1 | | | Patient file | TIER.Net | DHIS |
| Week 2 | | Week 1 | | | |
| Week 3 | | Week 2 | | | |
| Week 4 | | Week 3 | | | |
| Week 5 | | Week 4 | | | |
| Month | | Week 5 | | | |
| | | Month | | | |

**Data Analyisis Guide:**
- Step 1 determine the number of Eligible
- Step 2 should equal step 3
- Step 3 should equal step 4

## 4. Circle the identified problem on the summary chart

**a.** When circling the problems, the team is identifying the data elements that are affecting the non performance of the data indicator

**b.** The circled areas become a priority for improvement.

**c.** Use the summary chart and the indicator assessment together (See page 45). Identified problems in the indicator summary chart will point you the same colour coded section in the indicator assessment that will need to be addressed in order to address the problem

**d.** If you have not previously completed the indicator assessment, this would be a good time to start.

**TLD Transition Summary Chart**

| MONTH: | | TARGET: | | ACTUAL: | |
|---|---|---|---|---|---|

| Viral Load Completion | | | Identify eligibility for TLD Transitioning | | | |
|---|---|---|---|---|---|---|
| 1 | | | 2 | | | |
| | Due | Done | | 6 Month VL <50c/ml | 2 Consecutive VL 50-100c/ml within 3 months | VL Suppressed with co-morbidities on NCD medication with no known drug interaction |
| Week 1 | 9 | 9 | Week 1 | 1 | 1 | 2 |
| Week 2 | 20 | 20 | Week 2 | 5 | 3 | 2 |
| Week 3 | 9 | 9 | Week 3 | 4 | 1 | 0 |
| Week 4 | 15 | 15 | Week 4 | 5 | 1 | 1 |
| Week 5 | 12 | 12 | Week 5 | 5 | 1 | 0 |
| Month | 65 | 65 | Month | 20 | 7 | 5 |
| | | | Total | 32 | | |

| Total number transitioned to TLD | | Data Management | | | |
|---|---|---|---|---|---|
| 3 | | 4 | | | |
| Week 1 | 2 | | Patient file | TIER.Net | DHIS |
| Week 2 | 8 | Week 1 | 1 | 1 | 1 |
| Week 3 | 3 | Week 2 | 3 | 3 | 3 |
| Week 4 | 4 | Week 3 | 0 | 0 | 0 |
| Week 5 | 4 | Week 4 | 4 | 2 | 2 |
| Month | 21 | Week 5 | 2 | 2 | 2 |
| | 60% | Month | 10 | 8 | 8 |

**Data Analyisis Guide:**

- Step 1 determine the number of Eligible
- Step 2 should equal step 3
- Step 3 should equal step 4

**5.** As a team, work through the **Drivers for Programme Excellence**: Identify possible gaps for improvement.

## TLD Transition

**Services delivery processes:**

Monitoring system forecasting patients eligible for TLD and decanting

Clearly defined process to identify patients eligible for TLD

Efficient viral load result management process

Coordinated appointment system aligned with cohort

**Staff competency and capability:**

Clinical staff updated with TLD guidelines

Confidence and competency in TLD Transition

**Data System:**

Record transition in patient file

Manage file flow processes from service area points to data capturing points

**Resources and Supplies:**

Sufficient TLD stock level

**Teamwork:**

Collaboration between clinical staff and Pharmacy

**Patient Engagement:**

Patient education on TLD as an option

**6. Prioritize the problem area to be worked on by using the prioritization questions provided:**

**a.** What has the biggest effect on the indicator's performance?

**b.** Can we do something to improve it now?

**c.** Are we able to solve this problem at the facility?

**7. Decide what the team would like to focus on this week and develop a brief improvement plan**

(See template 'Huddle Team Member Weekly Action Plan' (see page 189) to assist team members with recording and monitoring their own weekly inputs):

**a. What?**

- Decide exactly what needs to be done differently based on the step-by-step assessment and indicator summary chart?
- Be very specific. Visualise exactly what needs to be done so that members describe and understand exactly what needs to be done
- A simple process map will assist you to know exactly what needs to be done (see Annexure page 210)

**b. Who?**

- Assign a team member to each step in the process

**c. How much or how often?**

- Make sure each team member knows how often or how much to do
- i.e. are they to do it everyday for the next 6 days with every patient, or are you only doing it in the mornings etc. Assumptions must be clarified

**d. Where?**

- Where will the change take place?

**e. How will team members know that the change was implemented as planned?**

- This will require the use of simple process measures (see page 47)
- It is important that we use data to measure the implementation of the new change and not rely on team members to remember
- Team members must keep track of these measures
- Below is an example of a change and **process measures** to help measure the change

| Example of Changes | Process Measures |
| --- | --- |
| PN allocated to receive Viral load results, identifies the patients with a VL that meets the TLD eligibility criteria and marks the file with a blue sticky note | • # Viral load results received<br>• # Identified as eligible for TLD Transition<br>• # Eligible files marked with blue sticky note |

**f. Challenges** faced

- Keep track of the challenges that were faced while trying to implement the change
- This will add valuable insight into deciding if the change is an improvement

**g. Suggestions**/what you learnt

- Observations are very important as not everything can be captured using data

**h.** Considerations for **sustainability**

- We do not want to waste time and effort; thinking about sustainability of the change from the beginning is critical

## 8. Report back to the team to determine the way forward

# Appendix of tools

## TLD Transition

1. TLD Transition Barometer
2. Step-by-step Indicator Assessment Tool
3. Indicator Summary Chart
4. Drivers of Programme Excellence

# TLD Transition

ANNUAL TARGET

MONTH | TARGET

| Weekly Target | Weekly Actual |
|---|---|
| Week 5 | |
| Week 4 | |
| Week 3 | |
| Week 2 | |
| Week 1 | |
| Start | |

TLD Transition

## ADVANTAGES OF TLD

Side effects are mild and uncommon

Adherence results in rapid viral suppression

High genetic barrier to resistance

No interaction with hormonal contraceptives

Dolutegravir has a low risk of neural tube defects when used around the time of conception and in the first 6 weeks of pregnancy.

By the end of 6 weeks, the neural tube closes and there is no longer a risk of neural tube defects.

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## TLD Transition

| | Assess the following: | Evidence | Source | Assessment Objective |
|---|---|---|---|---|
| **TLD PERFORMANCE** | | | | |
| Step 1 | Weekly Target | | Patient file<br>VL Results | Understand the Current Performance of the facility using the data to identify the problem. |
| | What are the TLD target/s | | | |
| | **Weekly performance** | | | |
| | Total number eligible for TLD transition in the review period | | | |
| | Actual number eligible switched to TLD in the review period | | | |
| | **Eligibility criteria** | | | |
| | 1.New eligible for TLD switch<br>Eligible: On ART VL within the last 6 months <50 | | | |
| | 2. Eligible: VL within the last 6 months <50 with co-morbidity and NCD medication with no contra-indication | | | |
| | 3. Existing CCMD patients<br>Eligible: last VL <50 | | | |
| | 4. Eligible: 2 consecutive VL between 50 - 999 within the 3 months, referred for Advance adherence counselling, ABCDE assessment done. If co-morbidities present the patients must be NCD medication with no contra-indications | | | |
| **VIRAL LOAD MANAGEMENT** | | | | |
| Step 2 | Viral load due previous week | | TIER.Net VL Report | Assess the efficiency of the viral load management process. |
| Step 3 | Retrieve files on VL Due report | | | |
| Step 4 | # Files not found on VL report | | | |
| Step 5 | Do you find evidence of Viral load done | | Patient file | |
| Step 6 | # of Viral load results recorded and available in patient file | | Clinical stationary/ Lab Form | |
| Step 7 | Identify the number of patients eligible for TLD switch | | VL results (use guideline criteria) | |
| Step 8 | What was the actual number that was switched to TLD | | Count/TIER.Net | |
| Step 9 | # Not switched to TLD: obtain the reasons for not switched | | Patient file | |
| **DATA MANAGEMENT** | | | | |
| Step 10 | Weekly review<br># Transitioned to TLD # recorded in Clinical stationary | | Patient file (from Audit) | Assess if data quality processes are in place to ensure TLD performance is collected, captured and reporting to reflect actual work done. |
| Step 11 | # Transitioned to TLD # captured on TIER.Net | | TIER.Net | |
| | Describe the file flow process from Transitioning to the Data room | | Process Map | |
| **TLD STOCK AVAILABILITY** | | | | |
| Step 12 | Determine the number of months of TLD supply issued to patients at a time | | Patient file, Synch | Assess if proper stock control and management process are in place to ensure supply of TLD is consistent. |
| Step 13 | Assess the ordering process of TLD from consulting rooms | | Order register | |
| Step 14 | # on TLD due for pick up of supply<br># Eligible for TLD Switch<br>TLD stock available | | TIER.Net, Pharmacy: Rx Solution, stock cards | |
| Step 15 | Communication Process: Stock out communicated to Clinicians | | Memo's/ Meetings | |
| | Change in Month supply communicated to Pharmacy | | | |
| **PROCESS** | | | | |
| Step 16 | Describe the process from identifying TLD eligibility to TLD initiation | | Process Map | Asses the process from point of Identifying the patients as eligible for TLD transitioning to the point of switching the patient to TLD |
| | When is the patient identified as Eligible for TLD | | | |
| | When is the patient transitioned to TLD | | | |
| Step 17 | Describe the process of Tracing those Eligible to return to care for transitioning to TLD | | Process Map | |
| Step 17 | Describe the VL management process | | Process Map | |
| **PATIENT ENGAGEMENT** | | | | |
| Step 18 | How does the facility ensure ongoing education on TLD initiation and transitioning. | | | Assess the patients knowledge about TLD |
| Step 19 | Are patients offered TLD on initiation and offered the option of transitioning when already on ART | | | |
| **AREAS FOR IMPROVEMENT** | | | | **COMMENTS** |
| | | | | |

## TLD Transition Summary Chart

| MONTH: | | TARGET: | | ACTUAL: | |
|---|---|---|---|---|---|

| Viral Load Completion | | | Identify eligibility for TLD Transitioning | | | |
|---|---|---|---|---|---|---|
| 1 | | | 2 | | | |
| | Due | Done | | 6 Month VL <50c/ml | 2 Consecutive VL 50-100c/ml within 3 months | VL Suppressed with co-morbidities on NCD medication with no known drug interaction |
| Week 1 | | | Week 1 | | | |
| Week 2 | | | Week 2 | | | |
| Week 3 | | | Week 3 | | | |
| Week 4 | | | Week 4 | | | |
| Week 5 | | | Week 5 | | | |
| Month | | | Month | | | |

| Total number transitioned to TLD | | Data Management | | | |
|---|---|---|---|---|---|
| 3 | | 4 | | | |
| Week 1 | | | Patient file | TIER.Net | DHIS |
| Week 2 | | Week 1 | | | |
| Week 3 | | Week 2 | | | |
| Week 4 | | Week 3 | | | |
| Week 5 | | Week 4 | | | |
| Month | | Week 5 | | | |
| | | Month | | | |

**Data Analyisis Guide:**

- Step 1 determine the number of Eligible
- Step 2 should equal step 3
- Step 3 should equal step 4

## TLD Transition

**Services delivery processes:**

Monitoring system forecasting patients eligible for TLD and decanting

Clearly defined process to identify patients eligible for TLD

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**Staff competency and capability:**

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**Data System:**

Record transition in patient file

Manage file flow processes from service are points to data capturing points

**Resources and Supplies:**

Sufficient TLD stock level

**Teamwork:**

Collaboration between clinical staff and Pharmacy

**Patient Engagement:**

Patient education on TLD as an option

# ART Viral Load Suppressed

6

**Reporting indicators**

**Number Traced :** Number of people living with HIV in the reported period with suppressed viral loads (<50copies/mL)

**Data Sources to consider:**

| SOURCE | DATA | TIME |
|---|---|---|
| TIER.Net | Viral load due list | Weekly/monthly |
| Lab Track | Viral load results | 72 hours – 7days after Viral load was done |
| TIER.Net | Number of outstanding Viral load results list | Weekly |
| Patient file: ART clinical stationary | Viral load that was done recorded or Barcode pasted Viral load results recorded | After patient visit or weekly |

X The Indicator champion is indicated by the **red X**

| | Operational Manager | Professional Nurse | Data Capturer | Counsellor | Index Counsellor | OTL & Tracer | Clerks | Pharmacy | Community committee member |
|---|---|---|---|---|---|---|---|---|---|
| ART Viral Load Suppressed | | X Phlebotomist/ Allocated PN | x | | | x | x | | |

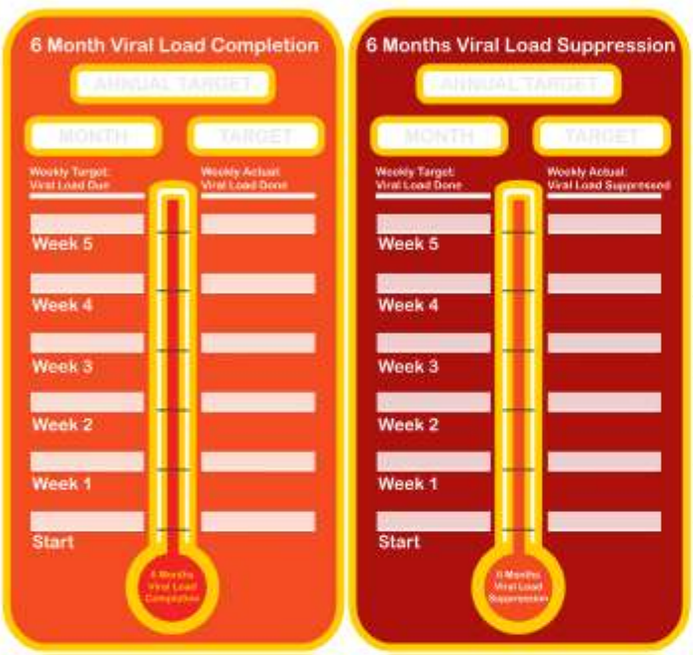
## 8 Responsibilities of the Indicator Champion and Indicator Team

1. Complete the relevant barometers
2. Conduct or review the Step-by-Step Indicator Assessment to identify all the gaps
3. Collect the data and complete the indicator summary chart
4. Circle the identified problem on the summary chart
5. As a team, work through the Drivers for Program Excellence
6. Prioritize the problem area to be worked on
7. Decide what the team would like to focus on this week and develop a brief improvement plan
8. Report back

## The 8 Steps Explained:

**1.** Complete the relevant **Barometers** (See How to Complete a Barometer page 185)

- **a.** Identify the variance
- **b.** Adjust the following weeks' target




### 6-month VL Completion

- Fill in the Annual target as well as the current months target
- Calculate the monthly target: Monthly target = Monthly target plus (+) or minus (-) variance from the previous months target
  - + Appointments rescheduled for defaulters
  - + Appointments rescheduled for out of Cohort clients
- Calculate the Weekly target Weekly target = (from Viral load due report) + or – variance from previous weeks target
  - – out of cohort appointments
- Record the weekly target on the left column under Weekly Target
- Record the actual number of viral loads done on the right column under Weekly Actual

### 6-month VL Suppression

- Fill in the Annual target as well as the current months target
- Calculate the Monthly target:
  - Monthly target = Viral loads done + or – variance from previous + Unsuppressed Viral loads actioned and repeat
- Calculate the weekly target:
  - Weekly target = Number of Viral loads done + or – variance from previous week
- Record the weekly target on the left column under Weekly Target
- Record the actual number of viral loads suppressed on the right column under Weekly Actual

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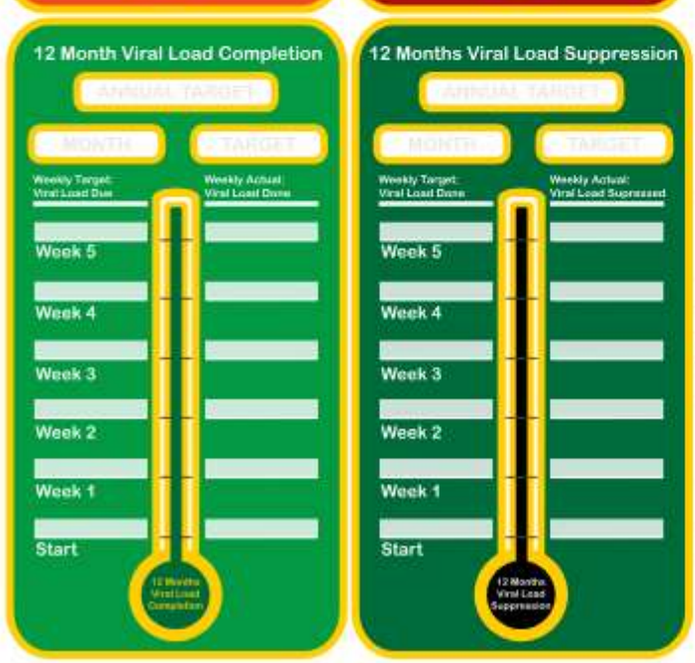



### 12-month VL Completion

- Fill in the Annual target as well as the current months target
- Calculate the monthly target:
  - Monthly target Monthly target + or – variance from the previous months target
  - + Appointments rescheduled for Defaulters
  - + Appointments rescheduled for out of Cohort clients
- Calculate the Weekly target
  - Weekly target = (from Viral load due report) + or – variance from previous weeks target
  - – out of cohort appointments
- Record the weekly target on the left column under Weekly Target
- Record the actual number of viral loads done on the right column under Weekly Actual

### 12-month VL Suppression

- Fill in the Annual target as well as the current months target
- Calculate the Monthly target:
  - Monthly target = Viral loads done + or – variance from previous + Unsuppressed Viral loads actioned and repeat
- Calculate the weekly target
  - Weekly target = Weekly target + Number of Viral loads done + or – variance from previous
- Record the weekly target to the left column under weekly target
- Record the number of suppressed viral loads on the right column under weekly actual

health

**2.** Conduct the **Step-by-Step Indicator Assessment** to identify all the gaps (see page 136)

**a.** The step-by-step assessment will identify all the gaps in your process that need to be addressed

**b.** Once the assessment has been conducted, and all gaps identified, there is no need to keep redoing the assessment week after week.

**3.** Collect the data and **complete the indicator summary chart** (see page 137)

**a.** Team members must come to the huddle with all the data needed to populate the summary chart (see page 16)

**ART Viral Load Suppressed Summary Chart**

MONTH: | TARGET: | ACTUAL:

**Viral Load Completion**

| 1 | # Viral load due on VL report | |
|---|---|---|
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| | # Viral load from VL due report | |
|---|---|---|
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 2 | From the Pre-retrieved files identify the number of: | | |
|---|---|---|---|
| | # Active files | # of Defaulters | # Out of Cohort |
| Week 1 | | | |
| Week 2 | | | |
| Week 3 | | | |
| Week 4 | | | |
| Week 5 | | | |
| Month | | | |

| 3 | Action on Viral load due files | | |
|---|---|---|---|
| | Viral Loads done | # Traced and Promised to come | # Appointments rescheduled in correct Cohort |
| Week 1 | | | |
| Week 2 | | | |
| Week 3 | | | |
| Week 4 | | | |
| Week 5 | | | |
| Month | | | |

**Viral Load Results Management**

| 4 | Viral load results received |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 5 | From the VLs done, how many were: | |
|---|---|---|
| | # Suppressed | # Unsuppressed |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 6 | From the VLs done, how many were: | |
|---|---|---|
| | # Suppressed referred for Decanting | # Unsuppressed contacted to return to clinic |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 7 | From the VLs done, how many were: | |
|---|---|---|
| | # Decanted | # Started on New regimant |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

**Data Management**

| 8 | Viral load Done captured | |
|---|---|---|
| | Patient file | TIER.Net |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 9 | Viral Load Results updated | |
|---|---|---|
| | Patient file | TIER.Net |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

## 4. Circle the identified problem on the summary chart

**a.** When circling the problems, the team is identifying the data elements that are affecting the non performance of the data indicator

**b.** The circled areas become a priority for improvement.

**c.** Use the summary chart and the indicator assessment together (See page 45). Identified problems in the indicator summary chart will point you the same colour coded section in the indicator assessment that will need to be addressed in order to address the problem

**d.** If you have not previously completed the indicator assessment, this would be a good time to start.

### ART Viral Load Suppressed Summary Chart

MONTH: | TARGET: | ACTUAL:

**Viral Load Completion**

| 1 | # Viral load due on VL report |
|---|---|
| Week 1 | 10 |
| Week 2 | 25 |
| Week 3 | 12 |
| Week 4 | 20 |
| Week 5 | 20 |
| Month | 87 |
| | # Viral load from VL overdue report |
| Week 1 | 10 |
| Week 2 | 25 |
| Week 3 | 12 |
| Week 4 | 20 |
| Week 5 | 20 |
| Month | 87 |

| 2 | From the Pre-retrieved files identify the number of: | | |
|---|---|---|---|
| | # Active files | # of Defaulters | # Out of Cohort |
| Week 1 | 9 | 1 | 0 |
| Week 2 | 20 | 0 | 5 |
| Week 3 | 9 | 0 | 3 |
| Week 4 | 15 | 1 | 4 |
| Week 5 | 12 | 2 | 6 |
| Month | 65 | 4 | 18 |

| 3 | Action on Viral load due files | | |
|---|---|---|---|
| | Viral Loads done | # Traced and Promised to come | # Appointments rescheduled in correct Cohort |
| Week 1 | 9 | 1 | 0 |
| Week 2 | 20 | 0 | 0 |
| Week 3 | 9 | 0 | 0 |
| Week 4 | 15 | 0 | 0 |
| Week 5 | 12 | 2 | 6 |
| Month | 65 | 3 | 6 |

**Viral Load Results Management**

| 4 | Viral load results received |
|---|---|
| Week 1 | 3 |
| Week 2 | 10 |
| Week 3 | 6 |
| Week 4 | 12 |
| Week 5 | 9 |
| Month | 40 |
| % done | 62% |

| 5 | From the VLs done, how many were: | |
|---|---|---|
| | # Suppressed | # Unsuppressed |
| Week 1 | 2 | 1 |
| Week 2 | 8 | 2 |
| Week 3 | 6 | 0 |
| Week 4 | 10 | 2 |
| Week 5 | 8 | 1 |
| Month | 34 | 6 |

| 6 | From the VLs done, how many were: | |
|---|---|---|
| | # Suppressed referred for Decanting | # Unsuppressed contacted to return to clinic |
| Week 1 | 0 | 1 |
| Week 2 | 3 | 2 |
| Week 3 | 3 | 0 |
| Week 4 | 5 | 2 |
| Week 5 | 4 | 1 |
| Month | 15 | 6 |

| 7 | From the VLs done, how many were: | |
|---|---|---|
| | # Decanted | # Started on New regiment |
| Week 1 | 0 | 0 |
| Week 2 | 3 | 1 |
| Week 3 | 3 | 0 |
| Week 4 | 5 | 1 |
| Week 5 | 4 | 1 |
| Month | 15 | 3 |

**Data Management**

| 8 | Viral load Done captured | |
|---|---|---|
| | Patient file | TIER.Net |
| Week 1 | 9 | 9 |
| Week 2 | 20 | 20 |
| Week 3 | 9 | 9 |
| Week 4 | 15 | 15 |
| Week 5 | 12 | 12 |
| Month | 65 | 65 |

| 9 | Viral Load Results updated | |
|---|---|---|
| | Patient file | TIER.Net |
| Week 1 | 3 | 3 |
| Week 2 | 10 | 10 |
| Week 3 | 6 | 6 |
| Week 4 | 12 | 12 |
| Week 5 | 9 | 9 |
| Month | 40 | 40 |

**5.** As a team, work through the **Drivers for Programme Excellence**: Identify possible gaps for improvement.

## ART Viral Load Suppressed

**Services delivery processes:**

Functional Booking system

Effective processes to highlight patients due for VL

Effective blood result management process and actioning of abnormal results

Managing missed viral load appointments

Planned patient flow (Bloods prior consultation)

**Staff competency and capability:**

All clinicians to be trained on interpreting blood results

All clinicians cognisant of processes to support viral load management

NIMART trained nurses to adapt ART treatment due to abnormal results

**Data System:**

Print VL due reports to identify patients expected within the month

Print the VL outstanding results report to follow-up on expected blood results

Clinician to record results in patient files

Manage file flow processes between consultation rooms and data capturing point.

**Resources and Supplies:**

Lab materials

Access to Lab track

**Teamwork:**

Effective communication between facility and laboratory

Intergration and coordination of the multi-disciplinary team supporting viral load management processes

**Patient Engagement:**

Routine provision of health education

Patient reminders for viral load appointments

**6. Prioritize the problem area to be worked on by using the prioritization questions provided:**

a. What has the biggest effect on the indicator's performance?

b. Can we do something to improve it now?

c. Are we able to solve this problem at the facility?

**7. Decide what the team would like to focus on this week and develop a brief improvement plan**

(See template 'Huddle Team Member Weekly Action Plan' (see page 189) to assist team members with recording and monitoring their own weekly inputs):

a. **What?**

- Decide exactly what needs to be done differently based on the step-by-step assessment and indicator summary chart?
- Be very specific. Visualise exactly what needs to be done so that members describe and understand exactly what needs to be done
- A simple process map will assist you to know exactly what needs to be done (see Annexure page 210)

b. **Who?**

- Assign a team member to each step in the process

c. **How much or how often?**

- Make sure each team member knows how often or how much to do
- i.e. are they to do it everyday for the next 6 days with every patient, or are you only doing it in the mornings etc. Assumptions must be clarified

d. **Where?**

- Where will the change take place?

e. **How will team members know that the change was implemented as planned?**

- This will require the use of simple process measures (see page 47)
- It is important that we use data to measure the implementation of the new change and not rely on team members to remember
- Team members must keep track of these measures
- Below is an example of a change and **process measures** to help measure the change

| Example of Changes | Process Measures |
|---|---|
| **Reminder calls for Viral load due appointment:** Professional nurse does reminder calls every Tuesday for the VL due appointments of the following week. | • # Viral due for the week<br>• # Patients reached and promised to come<br>• # Patients came for the bloods<br>• # Bloods done |
| Professional Nurse to use Lab track every Friday to access Viral load results and update the results in the ART clinical stationary | • Lab track accessed every Friday<br>• # VL Done<br>• of the VL that were done<br>• # Results available on Lab track<br>• # Files updated with the VL results |

f. **Challenges** faced

- Keep track of the challenges that were faced while trying to implement the change
- This will add valuable insight into deciding if the change is an improvement

g. **Suggestions**/what you learnt

- Observations are very important as not everything can be captured using data

h. Considerations for **sustainability**

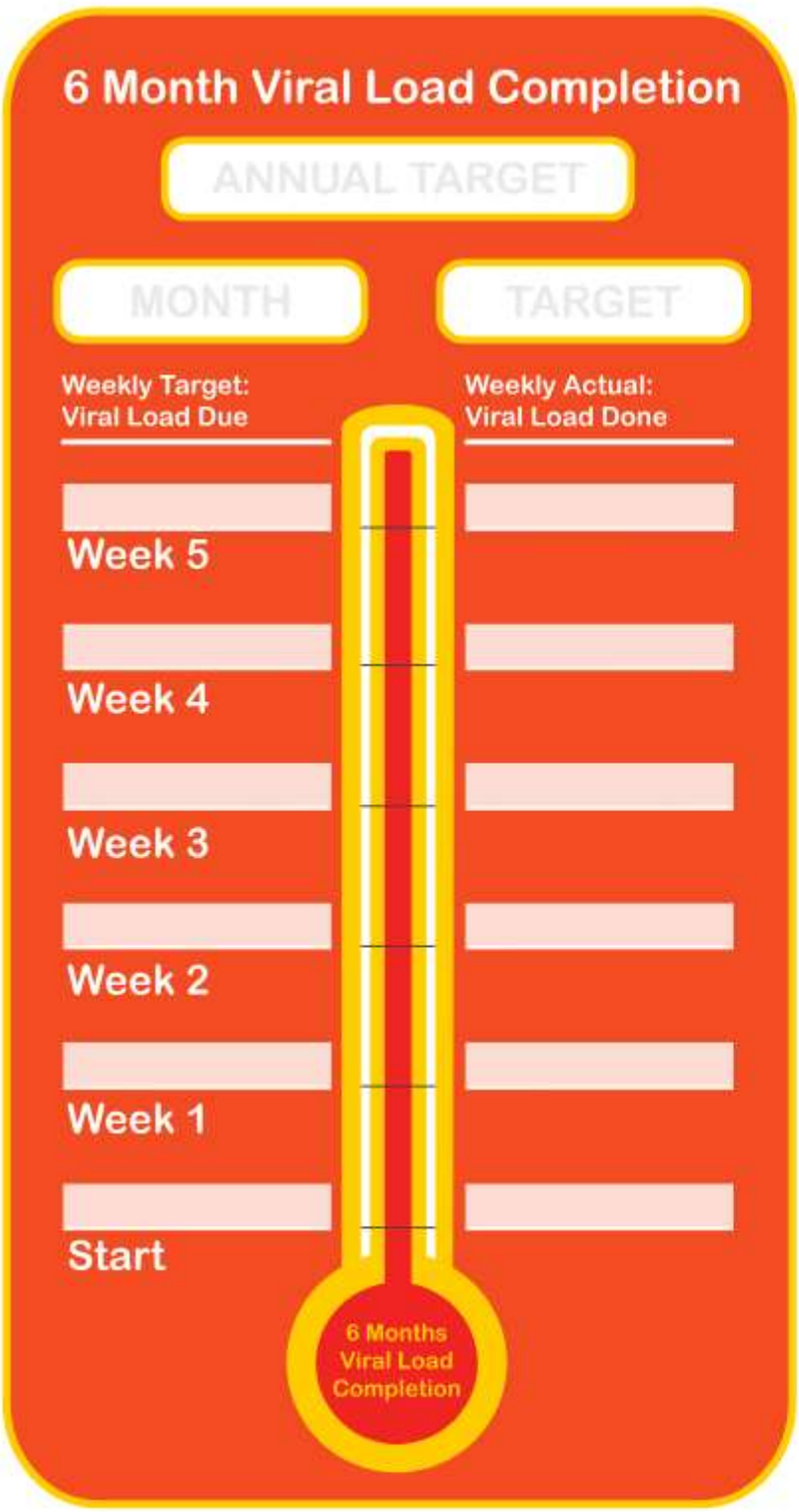
- We do not want to waste time and effort; thinking about sustainability of the change from the beginning is critical

**8. Report back to the team to determine the way forward**

# Appendix of tools

## ART Viral Load Suppressed

1. 6 Months Viral Load Completion Barometer
2. 6 Months Viral Load Suppression Barometer
3. 12 Months Viral Load Completion Barometer
4. 12 Months Viral Load Suppression Barometer
5. Step-by-step Indicator Assessment Tool
6. Indicator Summary Chart
7. Drivers of Programme Excellence



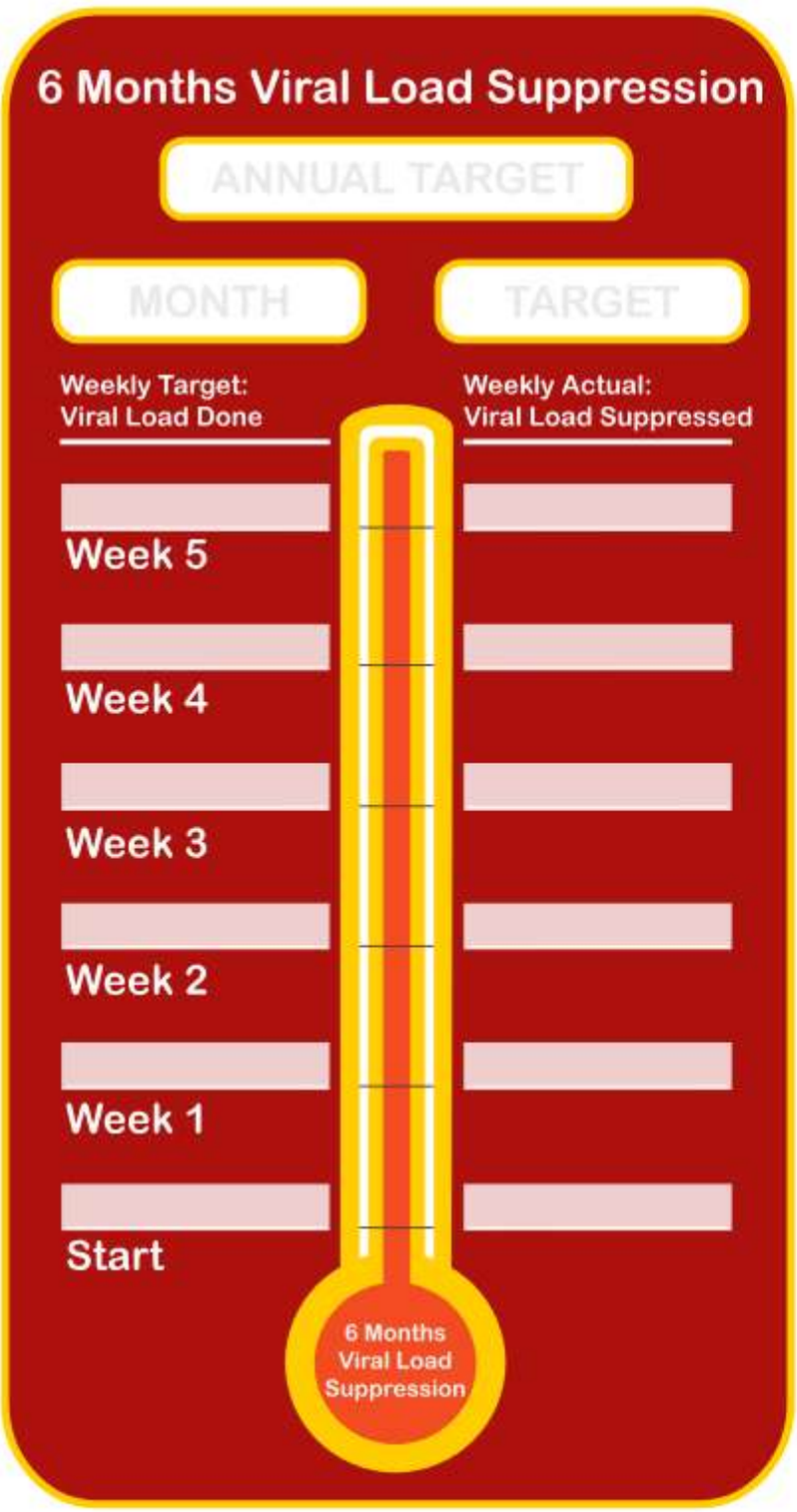

## 6-month VL Completion

- Fill in the Annual target as well as the current months target
- Calculate the monthly target:
  Monthly target = Monthly target plus (+) or minus (–) variance from the previous months target
  - + Appointments rescheduled for defaulters
  - + Appointments rescheduled for out of Cohort clients
- Calculate the Weekly target
  Weekly target = (from Viral load due report) + or – variance from previous weeks target
  - – out of cohort appointments
- Record the weekly target on the left column under Weekly Target
- Record the actual number of viral loads done on the right column under Weekly Actual

## 6-month VL Suppression

- Fill in the Annual target as well as the current months target
- Calculate the Monthly target:
  - Monthly target = Viral loads done + or – variance from previous + Unsuppressed Viral loads actioned and repeat
- Calculate the weekly target:
  - Weekly target = Number of Viral loads done + or – variance from previous week
- Record the weekly target on the left column under Weekly Target
- Record the actual number of viral loads suppressed on the right column under Weekly Actual

health
Department:
Health
REPUBLIC OF SOUTH AFRICA




## 6-month VL Completion

- Fill in the Annual target as well as the current months target
- Calculate the monthly target:
  Monthly target = Monthly target plus (+) or minus (–) variance from the previous months target
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  - + Appointments rescheduled for out of Cohort clients
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  - – out of cohort appointments
- Record the weekly target on the left column under Weekly Target
- Record the actual number of viral loads done on the right column under Weekly Actual

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- Fill in the Annual target as well as the current months target
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health
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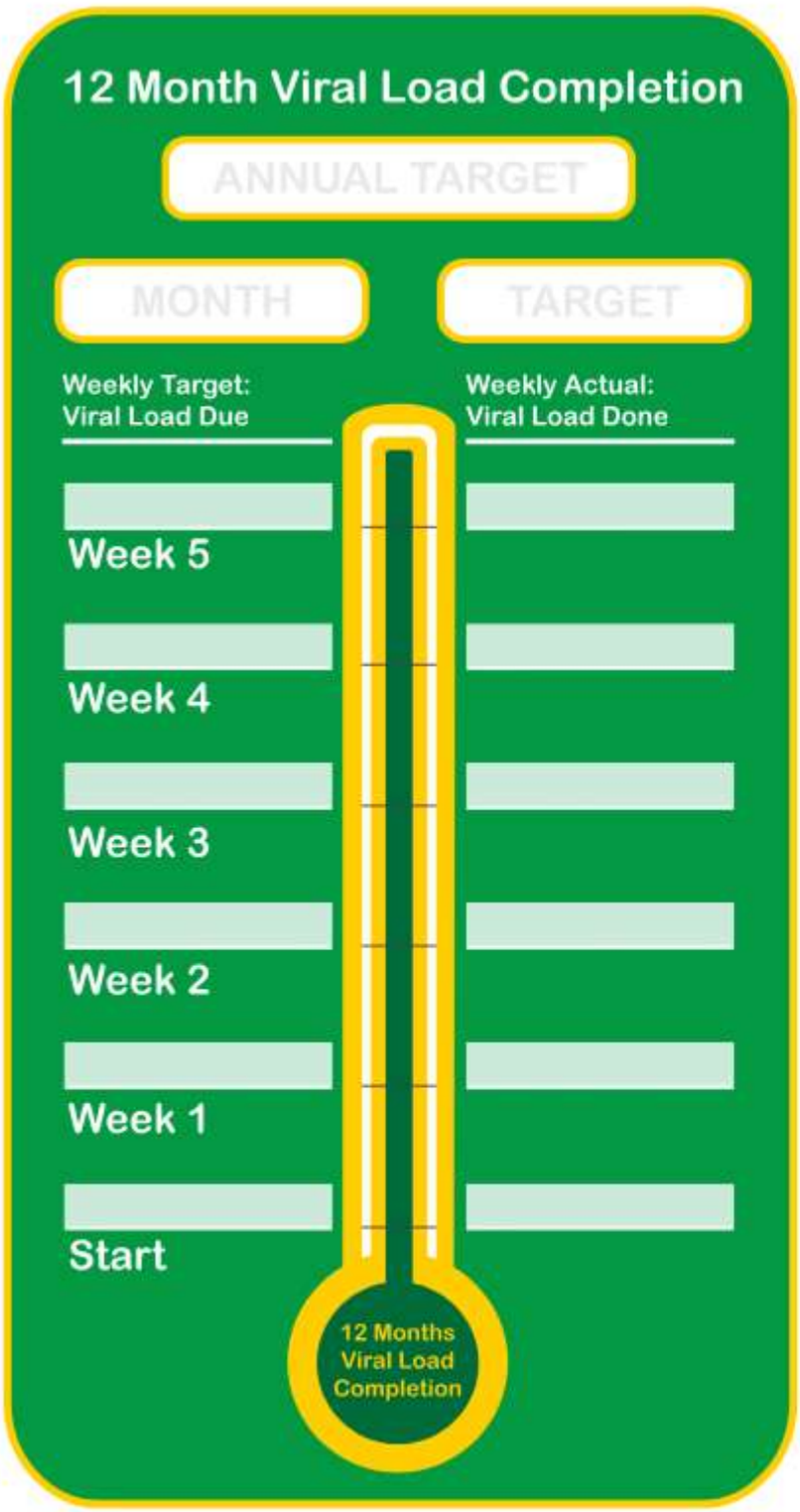
REPUBLIC OF SOUTH AFRICA



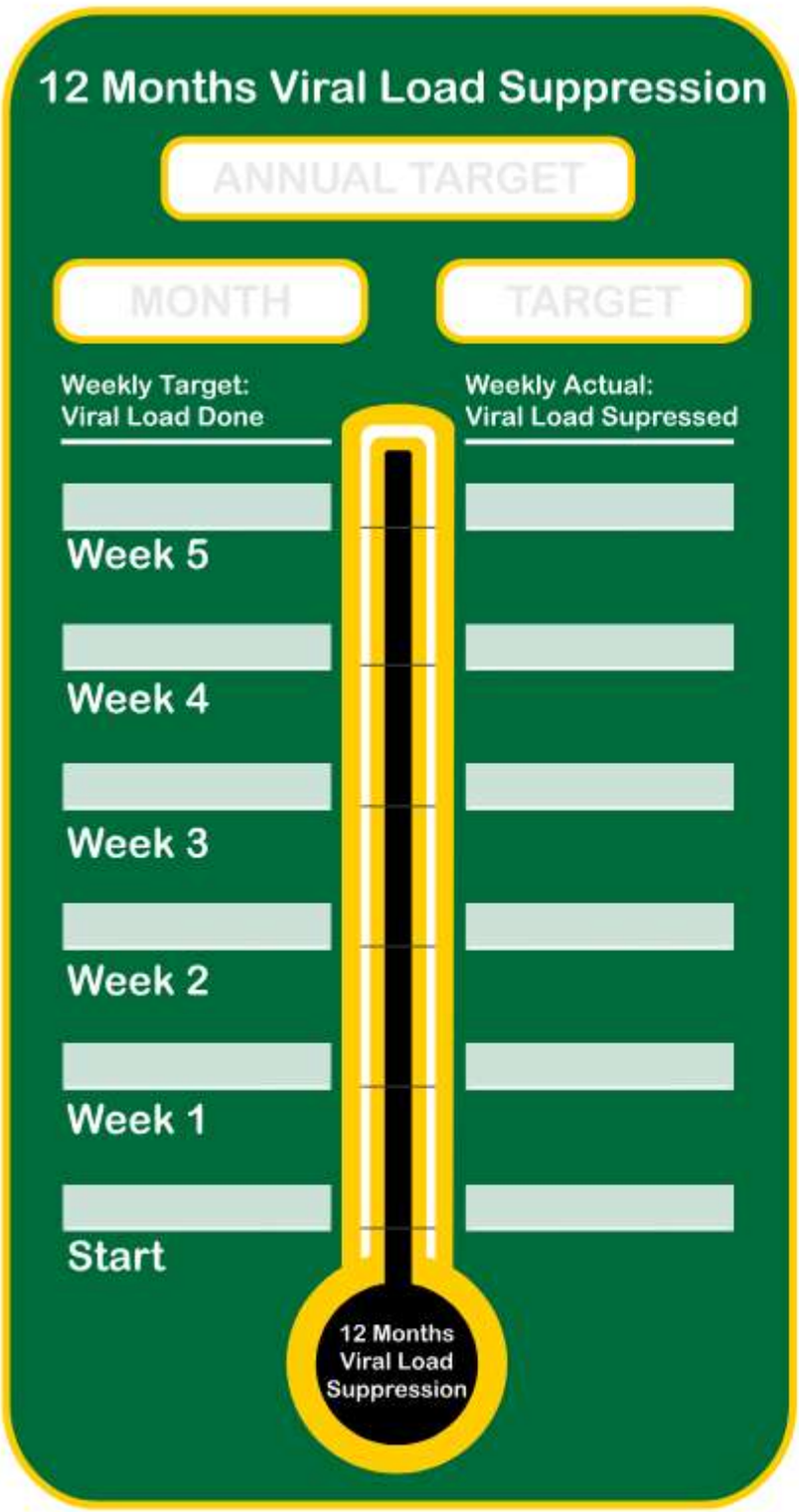

## 12-month VL Completion

- Fill in the Annual target as well as the current months target
- Calculate the monthly target:
  - Monthly target Monthly target + or – variance from the previous months target
  - + Appointments rescheduled for Defaulters
  - + Appointments rescheduled for out of Cohort clients
- Calculate the Weekly target
  - Weekly target = (from Viral load due report) + or – variance from previous weeks target
  - – out of cohort appointments
- Record the weekly target on the left column under Weekly Target
- Record the actual number of viral loads done on the right column under Weekly Actual

## 12-month VL Suppression

- Fill in the Annual target as well as the current months target
- Calculate the Monthly target:
  - Monthly target = Viral loads done + or – variance from previous + Unsuppressed Viral loads actioned and repeat
- Calculate the weekly target
  - Weekly target = Weekly target = Number of Viral loads done + or – variance from previous
- Record the weekly target to the left column under weekly target
- Record the number of suppressed viral loads on the right column under weekly actual

health
Department:
Health
REPUBLIC OF SOUTH AFRICA




## 12-month VL Completion

- Fill in the Annual target as well as the current months target
- Calculate the monthly target:
  - Monthly target Monthly target + or – variance from the previous months target
  - + Appointments rescheduled for Defaulters
  - + Appointments rescheduled for out of Cohort clients
- Calculate the Weekly target
  - Weekly target = (from Viral load due report) + or – variance from previous weeks target
  - – out of cohort appointments
- Record the weekly target on the left column under Weekly Target
- Record the actual number of viral loads done on the right column under Weekly Actual

## 12-month VL Suppression

- Fill in the Annual target as well as the current months target
- Calculate the Monthly target:
  - Monthly target = Viral loads done + or – variance from previous + Unsuppressed Viral loads actioned and repeat
- Calculate the weekly target
  - Weekly target = Weekly target = Number of Viral loads done + or – variance from previous
- Record the weekly target to the left column under weekly target
- Record the number of suppressed viral loads on the right column under weekly actual

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

| Indicator: ART Viral Load Suppressed | | | | |
|---|---|---|---|---|
| Elements: Viral load done (Disaggregated by age and months - 6 and 12 months) | | | | |
| | **Assess the following:** | **Evidence** | **Source** | **Assessment Objective** |
| **VIRAL LOAD DUE AND DONE** | | | | |
| Step 1 | **Planning for Patients due for VL at 6 and 12 months** | | TIER.Net, Booking list | Determine if there is a process to support the adherence of clinical monitoring of viral loads and to ensure no eligible patient is missed. |
| | Planning for Patients due for VL at 6 and 12 months | | | |
| | The source used to obtain list of patients due for viral load appointments at 6 and 12 months | | | |
| | Does the facility pre-retrieve files for VLs due prior appointments | | | |
| | What is the pre-retrieval period to appointment date | | | |
| | Describe the process of sorting the Viral load due files<br>• Active files<br>• Viral load Defaulters<br>• Out of cohort appointments | | | |
| | Is there a process in place to remind the patient of the appointment | | | |
| Step 2 | **Managing VL defaulter patients** | | | Determine if there is a process to ensure missed appointments and defaulters are realigned to their cohort. |
| | Describe the process of tracing VL defaulters | | | |
| | How do you schedule and track the return to care appointments | | | |
| | How do you reschedule appointments within cohort of VL that was due out of cohort | | | |
| **RESULTS MANAGEMENT PROCESS FOR VIRAL LOAD DONE** | | | | |
| Step 3 | **Result Access** | | LabTrack, Shipping list, TIER.Net | Determine if there is a timely and proactive results management process that will efficiently enable responsive clinical action |
| | What method is used to access VL results: SMS Printer, Lab Track, Hard Copies | | | |
| | What is the turn around time for VL results | | | |
| | Who is allocated to receive the results and update patient's files | | | |
| | Describe the process for following up on Outstanding results | | | |
| Step 4 | **Actioning results** | | | |
| | Describe the clinical actioning process of unsuppressed viral load results | | | |
| **DATA MANAGEMENT OF RECEIVED VIRAL LOAD DONE** | | | | |
| Step 5 | **Viral load result documentation** | | Patient file and TIER.Net | Determine if fundamental data quality processes are in place to ensure data is collected and reflecting work done. |
| | Identify the document used to record Viral load results | | | |
| | Describe the process for receiving results, documenting results and capturing result on TIER.Net | | | |
| Step 6 | **Viral load file flow and capturing** | | Patient file and TIER.Net | |
| | Describe the file flow from file update to capturing on TIER.Net | | | |
| | Obtain the estimated time it takes for the viral load result to be captured on TIER.Net | | | |
| **AREAS FOR IMPROVEMENT** | | | | **COMMENTS** |
| | | | | |

# ART Viral Load Suppressed Summary Chart

| MONTH: | | TARGET: | | ACTUAL: | |
|---|---|---|---|---|---|

## Viral Load Completion

| 1 | # Viral load due on VL report | |
|---|---|---|
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| | # Viral load from VL due report | |
|---|---|---|
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 2 | From the Pre-retrieved files identify the number of: | | |
|---|---|---|---|
| | # Active files | # of Defaulters | # Out of Cohort |
| Week 1 | | | |
| Week 2 | | | |
| Week 3 | | | |
| Week 4 | | | |
| Week 5 | | | |
| Month | | | |

| 3 | Action on Viral load due files | | |
|---|---|---|---|
| | Viral Loads done | # Traced and Promised to come | # Appointments rescheduled in correct Cohort |
| Week 1 | | | |
| Week 2 | | | |
| Week 3 | | | |
| Week 4 | | | |
| Week 5 | | | |
| Month | | | |

## Viral Load Results Management

| 4 | Viral load results received |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| 5 | From the VLs done, how many were: | |
|---|---|---|
| | # Suppressed | # Unsuppressed |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 6 | From the VLs done, how many were: | |
|---|---|---|
| | # Suppressed referred for Decanting | # Unsuppressed contacted to return to clinic |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 7 | From the VLs done, how many were: | |
|---|---|---|
| | # Decanted | # Started on New regiment |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

## Data Management

| 8 | Viral load Done captured | |
|---|---|---|
| | Patient file | TIER.Net |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 9 | Viral Load Results updated | |
|---|---|---|
| | Patient file | TIER.Net |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

## ART Viral Load Suppressed

**Services delivery processes:**

Functional Booking system

Effective processes to highlight patients due for VL

Effective blood result management process and actioning of abnormal results

Managing missed viral load appointments

Planned patient flow (Bloods prior consultation)

**Staff competency and capability:**

All clinicians to be trained on interpreting blood results

All clinicians cognisant of processes to support viral load management

NIMART trained nurses to adapt ART treatment due to abnormal results

**Data System:**

Print VL due reports to identify patients expected within the month

Print the VL outstanding results report to follow-up on expected blood results

Clinician to record results in patient files

Manage file flow processes between consultation rooms and data capturing point.

**Resources and Supplies:**

Lab materials

Access to Lab track

**Teamwork:**

Effective communication between facility and laboratory

Intergration and coordination of the multi-disciplinary team supporting viral load management processes

**Patient Engagement:**

Routine provision of health education

Patient reminders for viral load appointments

# Differentiated Models Of Care (DMOC)

7

**Reporting indicators**

**Decanting to DMOC and CCMDD:** "Central Chronic Medicine Dispensing and Distribution" programme, which distributes and dispenses medicine from a central point for patients with chronic conditions who are stable on their medication.

**Data Sources to consider when collecting the data**

| SOURCE | DATA | TIME |
|---|---|---|
| TIER.Net | Appointment list: For pre-retrieval of files to identify eligibility for Decanting | Can be done 24 hours to a week prior to the booked appointment. Recommended to at least 48 -72 hours to allow sufficient time for the review of pre-retrieved files |
| Lab track / Hard copy of results / Patient file: Clinical stationery | Viral load results: To check Viral load suppression for decanting eligibility | Recommended to check 72 hours – 7days after Viral load was done to use the opportunity to decant within the same cohort month |
| Synch | The number of patients enrolled for Decanting | Can be done daily or weekly |

X The Indicator champion is indicated by the **red X**

| | Operational Manager | Professional Nurse | Data Capturer | Counsellor | Index Counsellor | OTL & Tracer | Clerks | Pharmacy | Community committee member |
|---|---|---|---|---|---|---|---|---|---|
| **Differentiated Models of Care** | | X Decanting Champion | X | | | X | X | X | |

## 7 Responsibilities of the Indicator Champion and Indicator Team

1. Conduct or review the Step-by-Step Indicator Assessment to identify all the gaps
2. Collect the data and complete the indicator summary chart
3. Circle the identified problem on the summary chart
4. As a team, work through the Drivers for Program Excellence
5. Prioritize the problem area to be worked on
6. Decide what the team would like to focus on
7. Report back

## 7 Steps Explained:

**1.** Conduct the **Step-by-Step Indicator Assessment** to identify all the gaps (see page 147)

- **a.** The step-by-step assessment will identify all the gaps in your process that need to be addressed
- **b.** Once the assessment has been conducted, and all gaps identified, there is no need to keep redoing the assessment week after week.

**2.** Collect the data and **complete the indicator summary chart** (see page 148)

- **a.** Team members must come to the huddle with all the data needed to populate the summary chart

**Differentiated Models of Care Summary Chart**

| MONTH: | | TARGET: | | ACTUAL: | |
|---|---|---|---|---|---|

**Identify patients eligible for Decanting**

| 1 | Viral Load <50 | # Reviewed for decanting |
|---|---|---|
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 2 | 2 Consecutive VL 50-999 | # Referred for decanting |
|---|---|---|
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 3 | Pre-retrieved Patient files | # Referred for decanting |
|---|---|---|
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 4 | During Consultation | # Referred for decanting |
|---|---|---|
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

**Scheduling appointments for Decanting**

| 5 | Total Found eligible for Decanting | |
|---|---|---|
| | # In Cohort | # Out of Cohort |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| 6 | # Contacted to return for decanting within Cohort month | # Decanted in next Cohort month |
|---|---|---|
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

**Data Management**

| 7 | Total Number Decanted |
|---|---|
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

**Total Number Captured**

| 8 | Registered on Synch | Captured on TIER.Net | Captured on DHIS |
|---|---|---|---|
| Week 1 | | | |
| Week 2 | | | |
| Week 3 | | | |
| Week 4 | | | |
| Week 5 | | | |
| Month | | | |

**Data Analysis Guide:**

- Step 7 = Step 1 + 2 + 3 + 4 + 5
- Step 8 = step 10
- Step 11 = step 8

## 3. Circle the identified problem on the summary chart

**a.** When circling the problems, the team is identifying the data elements that are affecting the non performance of the data indicator

**b.** The circled areas become a priority for improvement.

**c.** Use the summary chart and the indicator assessment together (See page 45). Identified problems in the indicator summary chart will point you to the same colour coded section in the indicator assessment that will need to be addressed in order to address the problem

**d.** If you have not previously completed the indicator assessment, this would be a good time to start.

### Differentiated Models of Care Summary Chart

MONTH: | TARGET: | ACTUAL:

**Identify patients eligible for Decanting**

| 1 | Viral Load <50 | # Reviewed for decanting |
|---|---|---|
| Week 1 | 2 | 2 |
| Week 2 | 8 | 8 |
| Week 3 | 6 | 6 |
| Week 4 | 10 | 10 |
| Week 5 | 8 | 8 |
| Month | 34 | 34 |

| 2 | 2 Consecutive VL 50-999 | # Referred for decanting |
|---|---|---|
| Week 1 | 2 | 2 |
| Week 2 | 4 | 4 |
| Week 3 | 1 | 1 |
| Week 4 | 3 | 3 |
| Week 5 | 4 | 4 |
| Month | 14 | 14 |

| 3 | Pre-retrieved Patient files | # Referred for decanting |
|---|---|---|
| Week 1 | 0 | 0 |
| Week 2 | 0 | 0 |
| Week 3 | 0 | 0 |
| Week 4 | 0 | 0 |
| Week 5 | 0 | 0 |
| Month | 0 | 0 |

| 4 | During Consultation | # Referred for decanting |
|---|---|---|
| Week 1 | 2 | 2 |
| Week 2 | 1 | 1 |
| Week 3 | 3 | 3 |
| Week 4 | 2 | 2 |
| Week 5 | 3 | 3 |
| Month | 11 | 11 |

**Scheduling appointments for Decanting**

| 5 | Total Found eligible for Decanting | |
|---|---|---|
| | # In Cohort | # Out of Cohort |
| Week 1 | 8 | 0 |
| Week 2 | 11 | 2 |
| Week 3 | 10 | 0 |
| Week 4 | 12 | 3 |
| Week 5 | 13 | 2 |
| Month | 52 | 7 |
| Total Eligible | | 59 |

| 6 | # Contacted to return for decanting within Cohort month | # Decanted in next Cohort month |
|---|---|---|
| Week 1 | 0 | 0 |
| Week 2 | 2 | 0 |
| Week 3 | 0 | 0 |
| Week 4 | 3 | 0 |
| Week 5 | 2 | 0 |
| Month | 7 | 0 |

**Data Management**

| 7 | Total Number Decanted |
|---|---|
| Week 1 | 8 |
| Week 2 | 9 |
| Week 3 | 10 |
| Week 4 | 8 |
| Week 5 | 10 |
| Month | 43 |
| % Decanted | 73% |

**Total Number Captured**

| 8 | Registered on Synch | Captured on TIER.Net | Captured on DHIS |
|---|---|---|---|
| Week 1 | 4 | 8 | 8 |
| Week 2 | 8 | 9 | 9 |
| Week 3 | 8 | 10 | 10 |
| Week 4 | 7 | 8 | 8 |
| Week 5 | 7 | 10 | 10 |
| Month | 32 | 43 | 43 |

**Data Analysis Guide:**

- Step 7 = Step 1 + 2 + 3 + 4 + 5
- Step 8 = Step 10
- Step 11 = Step 8

**4.** As a team, work through the **Drivers for Programme Excellence**: Identify possible gaps for improvement.

## Differentiated Models Of Care (DMOC)

**Services delivery processes:**

Process to identify Eligibility for DMOC

Viral load result management

Coordinated appointment system

Dispensing processes to maintain cohort alignment

Planned patient flow (Bloods prior consultation)

**Staff competency and capability:**

Clinicians trained and skilled on DMOC

Staff trained on SYNC system

**Data System:**

Functional SYNC system

Verification processes between SYNC and TIER.Net

Update decanting report on TIER.Net

Manage the file flow from decanting service points to data capturing point

**Resources and Supplies:**

ART Treatment supply

Functional pick-up points

Access to Registration system (Synch)

**Teamwork:**

Coordination of staff to support Facility pick up and external pick up points

**Patient Engagement:**

Routine patient education and information session

Offering of DMOC service when patient is eligible

Monitor patients adherence at each ART pick up and scheduled consultations

**5. Prioritize the problem area to be worked on by using the prioritization questions provided:**

**a.** What has the biggest effect on the indicator's performance?

**b.** Can we do something to improve it now?

**c.** Are we able to solve this problem at the facility?

**6. Decide what the team would like to focus on this week and develop a brief improvement plan**

(See template 'Huddle Team Member Weekly Action Plan' [see page 189] to assist team members with recording and monitoring their own weekly inputs):

**a. What?**

- Decide exactly what needs to be done differently based on the step-by-step assessment and indicator summary chart?
- Be very specific. Visualise exactly what needs to be done so that members describe and understand exactly what needs to be done
- A simple process map will assist you to know exactly what needs to be done (see Annexure page 210)

**b. Who?**

- Assign a team member to each step in the process

**c. How much or how often?**

- Make sure each team member knows how often or how much to do
- i.e. are they to do it everyday for the next 6 days with every patient, or are you only doing it in the mornings etc. Assumptions must be clarified

**d. Where?**

- Where will the change take place?

**e. How will team members know that the change was implemented as planned?**

- This will require the use of simple process measures (see page 47)
- It is important that we use data to measure the implementation of the new change and not rely on team members to remember
- Team members must keep track of these measures
- Below is an example of a change and **process measures** to help measure the change

| Example of Changes | Process Measures |
|---|---|
| Pre-retrieve files 1-week prior to appointments. Allocate 2 clerks to identify files eligible for decanting. Take files to clinician for Eligibility confirmation. Mark eligible files with Yellow Sticky note. On the day of the visit direct eligible patients to Decanting room | • Pre-retrieval done 1 week prior to appointment<br>• Clerks allocated<br>• # Pre-retrieved files<br>• # Identified as Eligible<br>• # Confirmed as Eligible by clinician with yellow sticky note<br>• # Patients directed to Decanting room<br>• # Decanted |

f. **Challenges** faced

- Keep track of the challenges that were faced while trying to implement the change
- This will add valuable insight into deciding if the change is an improvement

g. **Suggestions**/what you learnt

- Observations are very important as not everything can be captured using data

h. Considerations for **sustainability**

- We do not want to waste time and effort; thinking about sustainability of the change from the beginning is critical

**7. Report back to the team to determine the way forward**

# Appendix of tools

## Differentiated Models of Care (DMOC)

1. Step-by-step Indicator Assessment Tool
2. Indicator Summary Chart
3. Drivers of Programme Excellence

## Differentiated Models of Care

Elements: New registration, Total active patients, Total patients facility pick up points, Total patients external pick up points, Dormant patients, Closed patients

| | Assess the following: | Evidence | Source | Assessment Objective |
|---|---|---|---|---|
| **IDENTIFING PATIENTS ELIGIBLE FOR DECANTING** | | | | |
| Step 1 | **Pre-Retrieval of Files** | | Pre-retrieved Patient File | Determine the eligibility identification process |
| | Are files pre-retrieved prior to patient appointments | | | |
| | How many days prior to appointment are files pre-retrieved | | Appointment list | |
| | Who is responsible to identify the files eligible for decanting | | Process Map | |
| | Map out the process followed to identify the files of potentially eligible patients | | | |
| Step 2 | **Viral Load Results** | | | |
| | Identify staff responsible to interpret Viral load results and describe the process for actioning Suppressed Viral loads | | Process Map | Assess the early identification of suppressed VL results in order to begin assessment and referral for decanting Eligibility |
| | After being identified as potentially eligible for decanting (Viral Suppressed) what is the next steps to the review all criteria for decanting to confirm eligibility | | | |
| Step 3 | **On the day of appointment: Consulting room** | | | |
| | Do all clinicians decant eligible patients or do they refer to Decanting staff? | | | Determine if there is an allocation of clinicians to attend to decanting and if competence of clinicians in decanting |
| | Map Patient flow from the Consulting room to Decanting room | Process Map | | Assess if the current decanting process is efficient |
| | Do we lose patients in the referral process? | | | |
| | Identify the source for documenting reasons for decanting criteria not met. | | | |
| **APPOINTMENT SCHEDULING** | | | | |
| Step 4 | **Enrolment appointment** | | | |
| | Are patients who are found eligible prior to the next scheduled appointment, rescheduled for return for decanting within the current Cohort month? | | Appointment list | Assess if enrolment appointments are scheduled within the cohort month and synchronised with other relevant appointments |
| | Map out the patient flow for the eligible patient on the day of enrollment - From reception to consulting room | | Process Map | Assess the patient flow on the day of enrolment |
| Step 5 | **Retention in Care** | | | |
| | Describe the Management of Missed appointments | | Tracing outcomes | Determine is there is a functional and efficient tracing process of missed appointments. |
| | What is the reason why patients missed their appointments? | | Patient Survey | Assess if patient experiences are considered to design responsive processes. |
| Step 6 | **Patient Education** | | | |
| | Does the patient understand what Decanting means and the way forward for their treatment | | | Assess if there is active engagement with patients to inform them about the available decanting option. |
| | Describe how and when patient education for those eligible for decanting happens prior to enrolment | | Health Education register/Patient file | |
| | How is the patient educated about remaining in care | | | |
| | What activity is in place to educate patients on presenting their ID documents | | | |
| **DATA MANAGEMENT** | | | | |
| Step 7 | **Are all clinicians trained to use Synch** | | Registered users | Assess if there is processes in place to ensure quality data is collected, captured and reported to reflect actual work done and outcomes |
| | Describe the process to verify data captured on Synch with TIER.Net | | Data verification | |
| | Describe the file flow from the Decanting services to Point of capturing | | Process Map | |
| **AREAS FOR IMPROVEMENT** | | | | **COMMENTS** |
| | | | | |

# Differentiated Models of Care Summary Chart

| MONTH: | | TARGET: | | ACTUAL: | |
|---|---|---|---|---|---|

| Identify patients eligible for Decanting | | |
|---|---|---|
| **1** | | |
| | Viral Load <50 | # Reviewed for decanting |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |
| **2** | | |
| | 2 Consecutive VL 50-999 | # Referred for decanting |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |
| **3** | | |
| | Pre-retrieved Patient files | # Referred for decanting |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |
| **4** | | |
| | During Consultation | # Referred for decanting |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| Scheduling appointments for Decanting | | |
|---|---|---|
| **5** | | |
| | Total Found eligible for Decanting | |
| | # In Cohort | # Out of Cohort |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |
| **6** | | |
| | # Contacted to return for decanting within Cohort month | # Decanted in next Cohort month |
| Week 1 | | |
| Week 2 | | |
| Week 3 | | |
| Week 4 | | |
| Week 5 | | |
| Month | | |

| Data Management | |
|---|---|
| **7** | |
| | Total Number Decanted |
| Week 1 | |
| Week 2 | |
| Week 3 | |
| Week 4 | |
| Week 5 | |
| Month | |

| Total Number Captured | | | |
|---|---|---|---|
| **8** | | | |
| | Registered on Synch | Captured on TIER.Net | Captured on DHIS |
| Week 1 | | | |
| Week 2 | | | |
| Week 3 | | | |
| Week 4 | | | |
| Week 5 | | | |
| Month | | | |

**Data Analysis Guide:**

- Step 7 = Step 1 + 2 + 3 + 4 + 5
- Step 8 = step 10
- Step 11 = step 8

# Differentiated Models Of Care (DMOC)

**Services delivery processes:**

Process to identify Eligibility for DMOC

Viral load result management

Coordinated appointment system

Dispensing processes to maintain cohort alignment

Planned patient flow (Bloods prior consultation)

**Staff competency and capability:**

Clinicians trained and skilled on DMOC

Staff trained on SYNC system

**Data System:**

Functional SYNC system

Verification processes between SYNC and TIER.Net

Update decanting report on TIER.Net

Manage the file flow from decanting service points to data capturing point

**Resources and Supplies:**

ART Treatment supply

Functional pick-up points

Access to Registration system (Synch)

**Teamwork:**

Coordination of staff to support Facility pick up and external pick up points

**Patient Engagement:**

Routine patient education and information session

Offering of DMOC service when patient is eligible

Monitor patients adherence at each ART pick up and scheduled consultations

# SECTION 3

# ABOVE SITE MANAGEMENT LEVEL NERVE CENTRES

# ABOVE SITE MANAGEMENT LEVEL NERVE CENTRES



Trying to improve health indicators, requires a unified and well-coordinated effort from all levels of health. While healthcare facilities are predominately the only patient facing structures whose data is used to determine the success of the HIV programme, management at all levels of health, play a pivotal role in enabling, supporting, managing and improving the health system which provides the patient care.

This section of the OP handbook is pitched at managers at all levels of health. While the scope of work and responsibilities of managers may differ, the foundational principles provided in this OP handbook, apply to all. Our **health system is made up of interrelated and interconnected parts, all impacting on each other and affecting the way services are rendered**. Anyone who has been involved in improvement activity over the past 10 or 15 years will be familiar with the **phrase 'every system is perfectly designed to achieve the results it gets'**, the idea being that both the intended and unintended consequences are designed into our systems. This is a critical realisation for managers to make, **intended and unintended consequences or outcomes are DESIGNED INTO OUR SYSTEMS**. Dr Edward Deming, who is largely considered as the founder of improvement science, stated that "The performance of anybody, almost anybody, is governed almost totally by the system he works in... In actual life it may be that **90-95% of performance comes from the system**. Most of what we observe comes from the system... their output is governed by the system (www.deming.org)".

The **role of management therefore must be to CHANGE THE SYSTEM rather than focusing on individuals as the source and solution of the problem.**

All inputs in this chapter are therefore based on the understanding that **managers need to understand and manage the design of the health system in order ensure programme success.**

The structure and design of nerve centres are based on sound project management principles that require all people involved with a problem to come together to collectively understand and address it. This is not a once off event or an instant solution, but rather a continual way of working that relies on collective wisdom from providers, patients, and data to constantly **make calculated changes to the health system**, to meet patients' needs and achieve targets.

As managers supporting the HIV programme, **nerve centre meetings must be used as a vehicle to effect system-wide change**. Therefore, management level nerve centre meetings should be structured as strategic improvement meetings with a central focus on utilising data to understand outcomes and plan for quality programme delivery. This management section will focus on 3 parts:

1. **Providing supportive supervision to facilities**
2. **Addressing Drivers for Programme Excellence**
3. **Nerve Centre Meeting Process**

# 1

# Providing supportive supervision to facilities

# PROVIDING SUPPORTIVE SUPERVISION TO FACILITIES

Facility visits should not be seen as a 'meet and greet' session, but rather an opportunity to **provide support** to facility level staff, **gain** important **insights** into how the health system functions, **understand** why **challenges** are being experienced and determine how **support** can be **tailored** to **facilitate the improvement process**. Tools and checklists have been previously provided through the PHC Supervisors checklist which also support this process.

To be able to provide this personalised support, managers need to know how nerve centres are meant to function at facility level as well as be very familiar with the current indicator performance data. Knowing these facts will assist managers to provide well-structured and helpful supervisory support visits. The **'Supportive Supervision Checklist'** previously provided by OP, has been updated to be far more focused on the functioning and outcomes of facility nerve centres. The checklist or guide, therefore provides guidance as to what a manager should look for as they structure the visit according to the facility's specific needs.

In the facility section of this handbook (see page 24), we outline the importance of **seeing nerve centre meetings as a process** (page 170) that requires 3 phases: preparation, meeting as a nerve centre and post-meeting action.

To achieve the sustained outcomes required, indicator teams (page 27), led by an indicator champion (page 30) must meet weekly to focus on OP priority indicators. Indicator teams convene in **huddles** (page 32 ) to collaboratively problem-solve and develop solutions for identified gaps or challenges that directly affect the performance of the priority indicator they are assigned to. Monthly, all the indicator teams come together under the direction of the facility manager, to collaborate, share ideas, seek assistance, and obtain guidance in the monthly nerve centre meeting (page 57). In this way, problems are addressed rapidly by a multidisciplinary team that has significant insight into the causes of the problems being experienced as well as practical ideas to tackle them.

**No one person working at a health facility can adequately resolve the poor performance of an indicator/s by themselves**, this requires the collective and consistent efforts of all facility staff as well as management at all levels of health as it will require the redesign of the how they system is currently being implemented.

X The Indicator champion is indicated by the **red X**.

| | Operational Manager | Professional Nurse | Data Capturer | Counsellor | Index Counsellor | OTL & Tracer | Clerks | Pharmacy | Community committee member |
|---|---|---|---|---|---|---|---|---|---|
| Total HIV Tested (HTS) | x | x | x | X | x | | x | | x |
| Total HIV Positive (HTS) | x | x | x | X | x | | x | | x |
| Total Naive Start ART | x | X | x | x | x | | x | x | x |
| Total Remaining On ART (TROA) | x | x | x | | | X | x | x | x |
| TLD Transition | x | X | x | | | x | x | x | x |
| ART Viral Load Suppressed | x | X Phlebotomist/ Allocated PN | x | | | x | x | | x |
| Differentiated Models of Care | x | X Decanting Champion | x | | | x | x | x | x |

The indicator teams have been provided with several tools (summary of tools page 15) to assist them on the continual everyday improvement journey. These tools will assist users to see the design of their system and the processes and help them identify the issues with the design that are probably causing the shortfall. As a **manger, your role will be to support, strengthen and encourage functional indicator teams for all priority indicators, who need to consistently make changes to the design of their processes of work**. Additionally, managers will need to **inspire the use of OP tools** and ensure that they are being used correctly so that the insights gained from the improvement process are correctly addressed and channelled. **Unpacking the process of service delivery** with indicator teams, will reveal significant opportunities for management support and action. Unpacking the process is as simple as listing each step in a process to reveal the design of the particular process i.e.

When doing improvement work, it will be important as a manager to know that each step in the process was done, as skipping one or two of the identified steps, could be the cause of the problem. Keeping track of the implementation, requires a different kind of measurement called a **process measure**. Process measures help to answer the question 'did I do what I said I would do'.

- See the Aurum Quality Improvement HOW TO GUIDE, Module 4, to learn more about what process measures are and how to develop them **www.auruminstitute.org**
- Below are examples of changes with simple **process measures:**

| Category of Intervention | Activity/ Change | Process Measures |
|---|---|---|
| **Training** | Conduct a district level NIMART training | • You would want to know if the training was conducted<br>• the number of staff that are meant to attend<br>• the number that actually trained<br>• # from each facility<br>• pre-test scores<br>• post-test scores |
| **Mentoring** | Conduct a Subdistrict Mentorship program on TLD transitioning. | • You would want to know if the program was designed and rolled out.<br>• The number of professional nurses identified for the mentorship program<br>• Number of professional nurses who completed the mentorship program<br>• Number of professional nurses who were found competent in TLD transitioning after the mentorship program |
| **Additional Resources** | Provide internet access to facilities identified with no internet connectivity | • Number of facilities identified with no internet access<br>• Number of facilities where internet connectivity was installed |
| **Process Improvement (PDSA)** | Improve the patient file flow from the consulting room to the data room at facility level<br>**Change:**<br>The clinician place the completed ART file in the ART file container after consultation. Data capturer collect ART file from the consultation room at 11:00, 14:00 and 16:00 | • The number of ART files issued to consultation rooms per day<br>• Number of ART files collected at:<br>  • 11:00<br>  • 14:00<br>  • 16:00<br>• Total number of ART files received in the Data room by the end of the day |

## 1. SUPPORTIVE SUPERVISION GUIDE

**The guide is divided into 3 main sections:**

**1.1** Nerve Centres | **1.2** Review QI interventions | **1.3** Supportive Interventions

### Supportive Supervision Guide:

V3.0 01-07-2021

health

| | | | | |
|---|---|---|---|---|
| Name: | | Facility Name: | | |
| Facility Manager: | | Date: | | |
| Identify the Priority Indicator: | HIV Tested | HIV Tested Pos | Naive Start ART | TROA |
| | TLD Transition | VL Suppressed | DMOC | |

| | Nerve Centre's | Comments |
|---|---|---|
| 1.1 | Does the facility conduct weekly Nerve Centre huddle meetings? Review minutes. | |
| | Does the facility conduct monthly Nerve Centre meetings? Review minutes. | |
| | Are Indicator teams functional and led by indicator champions? Are there teams for all problem indicators? | |
| | Are the Indicator Barometers updated and displayed? | |
| | Is there evidence that step-by-step assessments have been done and problem areas identified for further analysis? | |
| | Examine the Indicator Summary chart & determine if a proper assessment was conducted, and correct conclusions drawn. | |
| | Review the drivers for programme excellence to identify the systems requirements for indicator excellence. | |
| | Have the problems been prioritised correctly? | |
| 1.2 | **Review QI interventions** | |
| | Have improvement plans been drawn up for all prioritised problems? | |
| | Review the data to analyse if the intervention is leading to an improvement. Review process measures. | |
| 1.3 | **Supportive Interventions** | |
| | What management drivers for programmatic excellence do you need to focus on to support this facility? | |
| | Identify best practices for spread to other facilities. | |
| | List the Interventions you will implement to support the facility:<br>1.<br>2.<br>3. | |

**Date of next support visit:** **Facility Manager Signature:**

### 1.1 Nerve Centres

**a.** The purpose of this part of the support visit is to determine that problems are rapidly being addressed by indicator teams in weekly huddles and monthly nerve centre meetings.

**b.** Managers need to be familiar with and review indicator summary charts (see page 16) to gain insights into the data elements impacting indicators performance. Reviewing outcome data from DHIS or TIER.Net will not provide enough context for why challenges are being experienced.

**c.** Step-by-step indicator assessments (see page 17) are a powerful tool to assess the process of implementation. How a service is being provided directly impacts outcomes. Discussing the steps and the learnings gained from the assessments, will facilitate a rich understanding of the complexities of implementation and opportunities for management support and direction.

**d.** Analysing root causes, will ensure that problems are not being addressed superficially. Managers will need to probe into the analysis conducted to ensure that root causes have indeed been identified.

### 1.2. Review QI Interventions

**a.** Reviewing the QI work being conducted, will establish the productivity of indicator teams and their decision-making processes. Guidance can be provided around prioritisation of activities and the interpretation of data.

**b.** The use of both process (see pages 46 - 47 on process measures) and outcome data is critical at this stage as improvements will only be realised if the process of how a service is being provided is understood and addressed.

### 1.3. Supportive Interventions

**a.** This section speaks to the forthcoming support a manager will provide the facility as a result of what was learnt and observed.

**b.** Consider the drivers for programmatic excellence (see page 18) and determine what needs to be prioritised and addressed. At times, some of the challenges being experienced at facilities is as a result of systems and process that have not been addressed by management levels.

**c.** Managers need to commit to the support they intend on providing and ensure a follow-up process is put in place. This will foster trust and a collective sense of responsibility.

# 2

# Addressing Drivers for Programme Excellence

# ADDRESSING DRIVERS FOR PROGRAMME EXCELLENCE

There are several factors such as resources, structures, processes, data systems, staff competence or availability etc. that are not measured using routine data systems. They are however critical to the success of our programmes as they inform the design of our health system. These factors address how a programme is being implemented and are often referred to as **Drivers, as they drive the success of a programme.** If they are not implemented or not implemented well, they will impact on a facilities ability to meet indicator targets. Managers therefore have a critical responsibility to ensure that **drivers for programmatic excellence are being addressed and appropriately considered in the design of the health system.**

When problems are being experienced at facilities, it is at times because the drivers have not been addressed by managers at the higher levels of health. When conducting a proper root cause analysis, facility indicator teams may discover issues contributing to a problem that is out of their control; this will need to be addressed by higher levels of management. **Conducting supportive supervisory visits will assist in understanding how these drivers are impacting programme implementation and will provide good insights into know how the drivers can be addressed.**

The drivers below, that have been adapted from the WHO Building Blocks, are overarching general categories that need to be used by managers when evaluating an issue or problem; this will help to demonstrate a way forward to achieve the desired outcomes. These overarching general categories can be used by any programme to drive success.

**Management Drivers for Programme Excellence**

- **Engaged and Responsive Management**
- **Staff Competence and Capacity**
  (Technical and Operational)
- **Enabling Data Systems**
  (Clear data processes and tools)
- **Resources or Supplies**
  (Availability and Accessibility)
- **Teamwork**
  (Collaboration and Integration)
- **Patient Engagement**
  (Providing health information and patient experiences)

## 1. MANAGEMENT DRIVERS FOR PROGRAMME EXCELLENCE

### a. Leadership and governance:

In order to simplify and standardise service delivery, engaged managers need to understand the complexities of implementation and therefore provide support through practical guidelines and standard operating procedures. These are not set in stone and should change as managers learn and understand more about the health system and as context changes. Managers therefore need to be seen at facilities to provide guidance and to reassure staff that they are seen, heard and matter. Managers need to provide oversight, accountability, build alliances among stake-holders and motivate staff.

### b. Staff capability and competence:

Staff need to be knowledgeable about their area of expertise and have the confidence to effectively provide responsive and fair services to patients. As managers, training and mentoring programmes need to be provided and standardised to ensure a similar level of skill across all facilities. Assessing the levels of knowledge and skill of all and not just new staff, is therefore an important management role.

### c. Data Systems:

Providing the correct and sufficient data tools is an important consideration for managers. Too often facilities run out of critical stationary or registers with little explanation of an expected delivery date or a strategy of how to manage data in the interim. Outdated versions or registers are at times still found; managers should ensure that these are removed, and that the new way of working is standardised. Supporting data flow and capturing processes and policies is a high priority as this determines accurate and timely data. Data quality concerns are very often cited as causes for not meeting targets, therefore this driver should be a high priority for managers.

### d. Resources and supplies:

There are essential resources and supplies needed to deliver on programme outcomes. These could include human, internet access, registers, medication, test kits, lab equipment, computers etc. Without these, implementation becomes impossible or is severely compromised. Ensuring that resources are available and utilised in a cost-effective manner is an important consideration for managers.

**e. Teamwork:**

Working in a complex health system requires not only facility staff to work together, but also managers at all levels of health. As programme success is our aim, people need a clear practical vision that they can work towards. If managers and facilities are pulling in different directions, meeting targets will almost be impossible. Even though managers may be accountable for different indicators or programmes, they are all realised within heath facilities. It is therefore expected that managers should work together to simplify and harmonise expectations for facilities. Managers should therefore advocate for and provide a collaborative way of working.

**f. Patient engagement:**

Managers must consider how patients voices are being heard and addressed. Quality is defined by the patient, so therefore the patient must be provided with a safe platform to define and contribute to quality.

## 2. PRIORITY INDICATOR DRIVERS FOR PROGRAMME EXCELLENCE

To assist with understanding how each driver should be considered for all priority indicators, we have provided examples for each. We encourage you to think of different activities in your context, to include when addressing each driver. What is provided, is simply a starting point. **As a management level nerve centre, engaging with, understanding, and addressing drivers through programme design or redesign, is critical for implementation success.**

### Management Drivers:
### HTS:
### Total HIV Tested

**HTS: Total HIV Tested**

**Leadership & governance**
> Provide and amend HTS and adherence guidelines and SOPs
> Identify and endorse HTS best practices
> Communicate HTS targets
> Support workplan and provide catch up plans after review periods
> Address escalated operational matters
> Provide support visits

**Staff competence and capability**
> Continuous in-service training of the HTS programme
> Training of HTS guidelines and updates for frontline staff

**Data systems**
> Relevant & functional TIER.Net (HTS Module)
> Provide efficient monitoring and evaluation tools
> Provide data support teams and data clean up activities

**Resources and Supply**
> Supply of HTS test kit facilities
> Routine audit of counsellor and client ratios per facility
> Provide resources for innovations and campaigns

**Teams**
> Collaboration with Community Health Workers, Workplace programmes, General Practitioners, School programs etc

**Patient engagement**
> Public relations strategy to create demand for HTS services
> Support the facilitation of community clinic commitees
> Provide structures for customer satisfaction feedback

## Management Drivers:
## HTS:
## Total HIV Positive

**HTS: TOTAL HIV POSITIVE**

**Leadership & governance**
- Provide and amend HTS and adherence guidelines and SOPs
- Identify and endorse HTS best practices
- Communicate HTS targets
- Support workplan and provide catch up plans after review periods
- Address escalated operational matters
- Provide support visits

**Staff competence and capability**
- Continuous in-service training of the HTS programme
- Training of HTS guidelines and updates for frontline staff

**Data systems**
- Relevant & functional TIER.Net (HTS Module)
- Provide efficient monitoring and evaluation tools
- Provide data support teams and data clean up activities

**Resources and Supply**
- Supply of HTS test kit facilities
- Routine audit of counsellor and client ratios per facility
- Provide resources for innovations and campaigns

**Teams**
- Collaboration with Community Health Workers, Workplace programmes, General Practitioners, School programs etc

**Patient engagement**
- Public relations strategy to create demand for HTS services
- Support the facilitation of community clinic committees
- Provide structures for customer satisfaction feedback

## Management Drivers: Total Naive Start ART

**Total Naive Start ART**

**Leadership & governance**
> Provide and amend ART guidelines and SOPs
> Support adherence to ICSM and pharmacy processes
> Communicate targets
> Support workplans and develop catch up plans after review period
> Identify and endorse linkage to care best practices
> Address escalated operational matters
> Provide support visits

**Frontline capability and capacity**
> Available and trained NIMART nurses
> Routine NIMART nurse and patient ratio
> Provide in-service trainings of guidelines and updates of ART initiation

**Data systems**
> Provide trained data support staff to manage data processes and flow
> TIER.Net and DHIS available and accessible at all facilities
> Provide data reporting structures and tools to support ART initiation

**Resources and Supply**
> Available ART treatment supply
> Internet connectivity for data systems functionality

**Teams**
> Collaboration between interdependant departments: e.g.
> Community ART programme

**Patient engagement**
> Public relation strategy to communicate the early start on ART and its benefits
> Support the facilitation of community clinic committees
> Provide structures for customer satisfaction feedback

## Management Drivers:
## Total Remaining On ART (TROA)

**Total Remaining On ART (TROA)**

**Leadership & governance**
- Provide and amend TROA guidelines and SOPs
- Provide quality assurance support to ensure adherence to ICSM processes
- Identify and endorse retention in care best practices
- Provide and communicate targets
- Support workplans and develop catch up plans after review process
- Address escalated operational matters

**Staff competency and capability**
- Availability of updated Program guidelines
- Provide in-service training on guideline/program changes
- Available skilled tracers and Community Health workers

**Data systems**
- TIER.Netand DHIS available and accessible at all facilities
- Defined reporting lines and structure
- Effective communication and training on changes of NIDS

**Resources and Supply**
- ART Treatment supply
- ART services available and accessible after hours and over weekends
- Internet connectivity for data system functionality

**Teamwork**
- Collaboration between interdependant departments/programs: i.e. Clinical and Community Health Care programs

**Patient engagement**
- Public relations strategy to communicate the importance of ART treatment adherence
- Support the facilitation of Community Clinic Committees
- Provide a structure for patient satisfaction feedback

## Management Drivers:
## ART Viral Load Suppressed

**ART Viral Load Suppressed**

**Leadership & governance**
- Provide and amend Viral load management guidelines and SOPs
- Support adherence to ICSM processes
- Defined workflow processes between NHLS and facilities
- Provide and communicate targets
- Support workplans and develop catch up plans after review periods
- Identify and endorse Retention in care best practices
- Address escalated operational matters

**Staff competency and capability**
- Availability of updated Program guidelines and SOP's
- Provide in service training on guideline/program changes

**Data systems**
- Provide trained data support staff to manage data processes and flow
- TIER.Net and DHIS available and accessible at all facilities
- Lab track available and accessible at facilities
- Provide data reporting structures and tools to support Viral load completion and Viral load result capturing

**Resources and Supply**
- Establish defined integration with courier services and NHLS that will ensure availability of lab material for Viral load management and timeous transportation of blood specimens and delivery of blood results

**Teamwork**
- Collaboration between interdependant departments/programs i.e. Clinical programs, NHLS,

**Patient engagement**
- Public relations strategy to communicate the importance of Viral load results and actioning of abnormal results. Emphasising the importance of honouring the booked appointment at facilities
- Support the facilitation of community clinic committees
- Establish a structure for patient satisfaction feedback

## Management Drivers:
## Differentiated Models of Care (DMOC)

**(DMOC) Differentiated Models of Care**

**Leadership & governance**
- Provide and amend DMOC program guidelines and SOPs
- Defined supply chain processes
- Communicate targets
- Endorse best practices that improve DMOC
- Address escalated operational matters

**Staff competency and capability**
- Allocate trained staff to facilitate decanting.
- In-sevice training on guideline/program changes
- Provide training on Synch

**Data systems**
- Provide trained data support staff to manage data processes and flow
- TIER.Net and SYNC optimization
- Provide data reporting structures and tools for CCMDD/DMOC capturing

**Resources and Supply**
- Sufficient ART treatment supply
- Internet connectivity to ensure functional data systems
- Establish accessible external medication pick-up points

**Teamwork**
- Collaboration between interdependant departments/programs

**Patient engagement**
- Public relations strategy to introduce the DMOC opportunities and the benefits
- Support the facilitation of Community Clinic Committees
- Establish a structure for patient satisfaction feedback

## Management Drivers:
## TLD Transition

**TLD Transition**

**Leadership & governance**
> Provide and amend TLD program guidelines and SOPs
> Endorse best practices of TLD Transitioning
> Provide quality assurance support to ensure adherence to TLD guidelines
> Address escalated operational matters
> Communicate TLD Transitioning targets and adjust based on relevant performance

**Staff competency and capability**
> Availability of updated Program guidelines
> Provide in service training on guideline/program changes
> TLD in-services training programs to ensure competency in transitioning patients to TLD

**Data systems**
> Provide trained data support staff to manage data processes and flow
> TIER.Net and DHIS available and accessible at all facilities
> Provide data reporting structures and tools for the capturing of TLD Transitioning

**Resources and Supply**
> Available TLD stock and calculation of stock levels
> Internet connectivity to allow functional Data systems

**Teamwork**
> Collaboration between viral load management and DMOC

**Patient engagement**
> Inform the public about TLD eligibility and its benefits
> Establish a structure for patient satisfaction feedback

# 3

# Nerve Centre Meeting Process

# NERVE CENTRE MEETING PROCESS

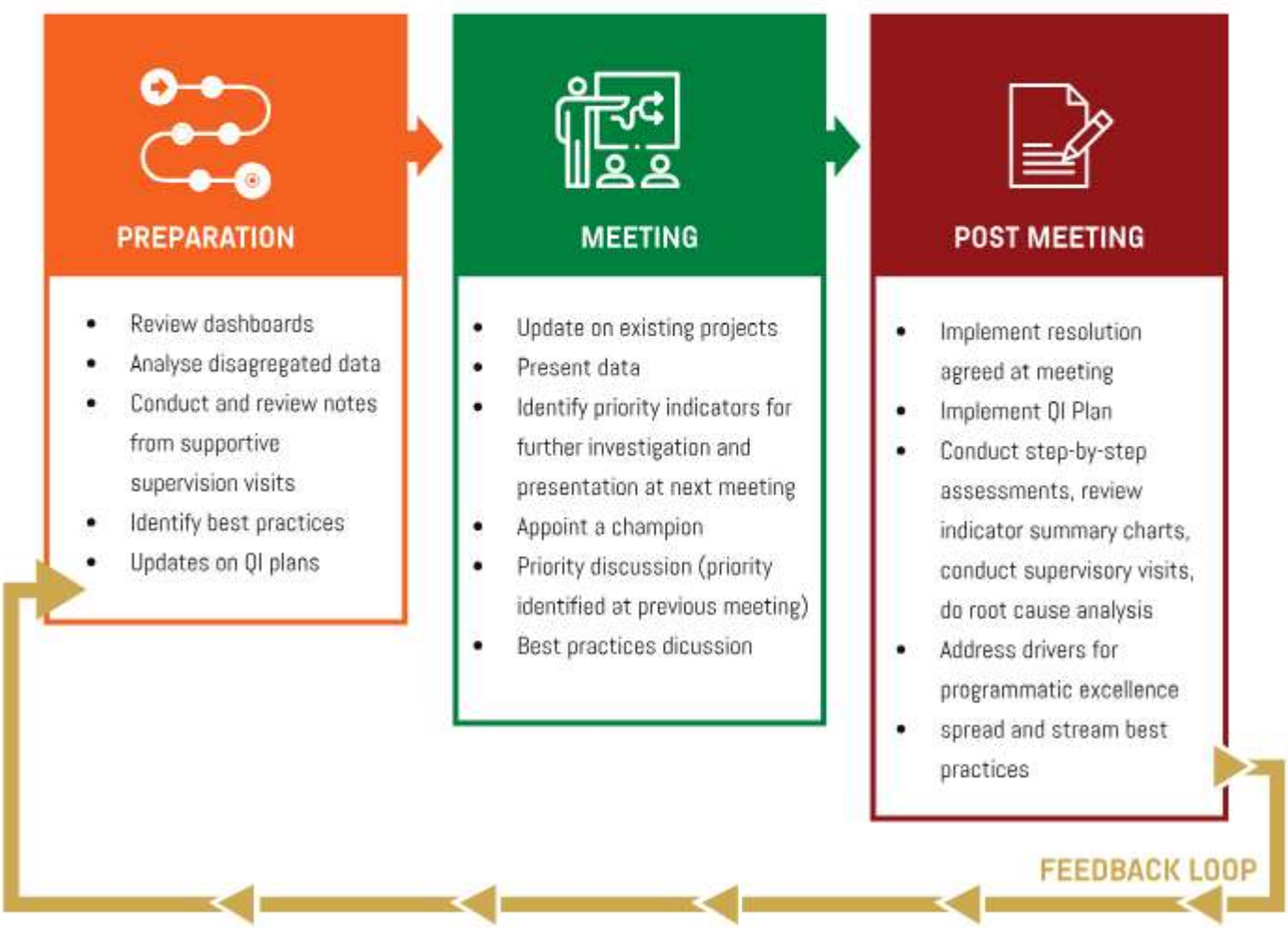
ABOVE SITE MANAGEMENT LEVEL NERVE CENTRES

The purpose of nerve centre meetings at management level, is to convene all relevant managers to collectively:

- review and analyse priority indicators performance
- contribute to a more in-depth understanding of why they are performing as they are
- identify and discuss key drivers that require intervention and
- develop a supportive, targeted improvement plan

The nerve centre meeting, no matter the level it is being conducted at, sub-district, district or provincial, should draw from the preceding level of health as their source of information and area of focus. Additionally, they must consider lessons learnt while conducting supportive supervision visits to add to the richness of the discussions.

A meeting is commonly viewed as an event that convenes relevant stakeholders to discuss or share information on specific matters. In the context of OP, it is proposed that the nerve centre meetings be viewed as a process. **The process should include 3 fundamental phases:**



# Nerve Centre Meeting **Preparation**

# NERVE CENTRE MEETING PREPARATION

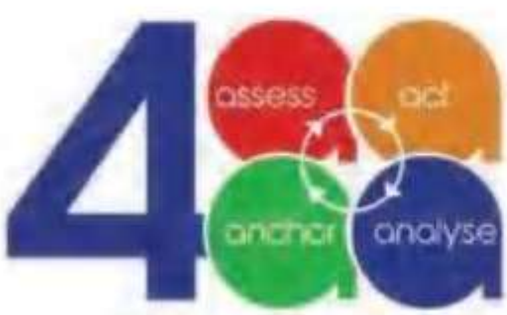
An important factor of what makes a meeting successful, is the preparation. By preparation, we do not mean well designed PowerPoint presentations, but rather, **extensive information and data gathering** to be presented to nerve centre team members with the aim of contributing to a deeper understanding of factors causing poor performance. This will facilitate richer conversations about how problems need to be addressed collectively, without bombarding facilities with conflicting priorities.

**Supportive Supervisory visits forms a very important part of the meeting preparation.** Use the Guide to record your findings. Looking for common challenges from all supervisory visits conducted, will assist in understanding some of the issues a sub/district is experiencing which is affecting the performance of targets. Additionally, managers will **identify best practices** while on supervisory visits. Consideration should be given as to whether these should be spread to the rest of the sub/district and how.

**Gathering updates about the progress and impact of improvement projects** will be another important task in preparation for the meeting. The champion for each particular QI project will need to come to the meeting ready to present an update:

- summary of the project including problem and changes tested
- review of the performance indicator data
- discussion on what worked and what did not
- a spread and sustainability plan for discussion

If not enough thought, planning, and information gathering is done in the preparation phase, then very often the meeting will boil down to a report back session. Possible improvement plans focussed on addressing drivers for programmatic excellence, will therefore have little to no consideration in a meeting focused on reporting back.



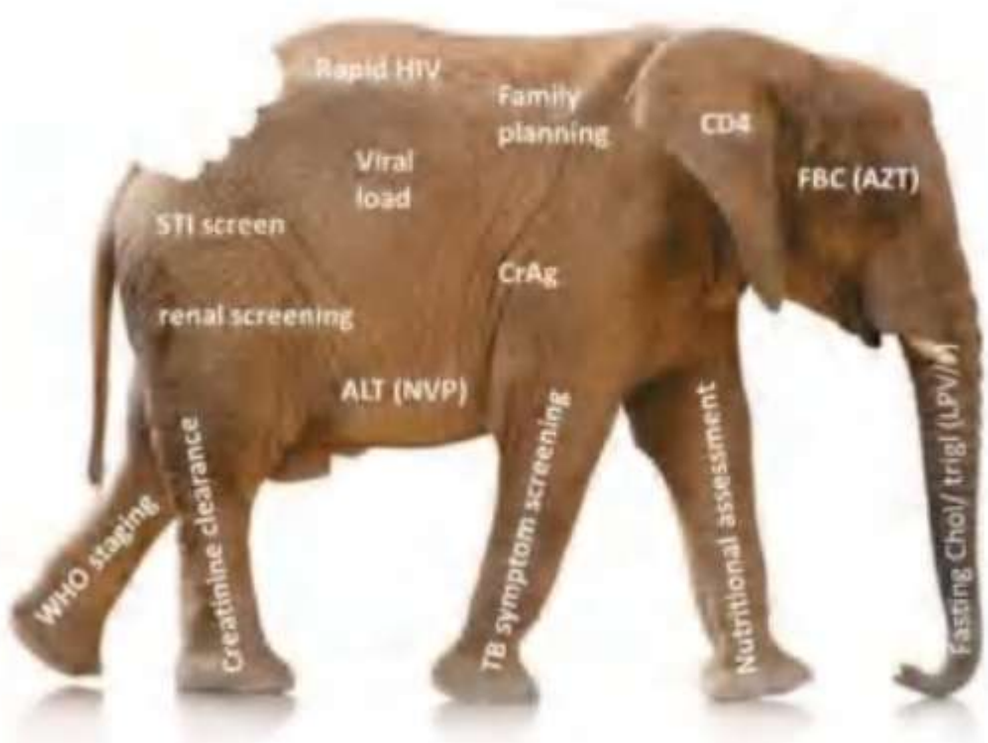

This critical preparatory work forms part of the ASSESS section of our QI project management framework (See 4A model page 10).

# Nerve Centre **Meeting**

Although the meeting may vary due to level of health and area of focus, the most important aspect is that the purpose of the meeting is clearly understood by the participants, which is to collectively redesign the health system to better be able to meet the needs of patients.

The meeting is therefore informed by the information and insights gathered in preparation for the meeting. The meeting should be structured as a strategic think tank that develops scalable improvement plans and focuses managers attention on key priorities. Focusing on the aim of the meeting is crucial as it will dictate who presents, what is presented, and the kind of deliberations allowed. Its easier to simply allow everyone to report back, however simply reporting back does not facilitate moving forward.

Managers should not be tempted to 'eat the elephant all at once'. There are many complex challenges in our health system, and they cannot all be addressed at once. Systematically and collectively working through problems, step-by-step, while addressing the drivers for programme excellence, will produce sustainable solutions. This process builds will, understanding, capabilities and expertise.



## 1. STRUCTURE OF NERVE CENTRE MEETING

The management level nerve centre meeting has six agenda points (See template for sample agenda on page 197):

- I. Opening
- ii. Feedback on current Improvement project/s
- iii. OP Data Presentation
- iv. Priority Area/s Discussion
- v. Best Practices
- vi. Way Forward

**Monthly Management Level Nerve Centre Meeting Agenda**

| | | | |
|---|---|---|---|
| Date: | | Time: | |
| Chair: | | Sub/District: | |

| Time Allocation | Agenda Point | Responsibility |
|---|---|---|
| | **OPENING** | **Chairperson** |
| | Matters arising from D/P-PMR (preceding level of health) | |
| | Feedback on action items from previous meeting | |
| | **Feedback on current Improvement project/s** | Identified leads |
| | Summary of project including problem and change being tested | |
| | Review performance indicator data | |
| | Discuss what is working and what is not | |
| | Discuss a spread and sustainability plan | |
| | **OP Data presentation** | HAST Manager |
| | Compare indicators to relevant target (weekly, monthly, quarterly, ar | |
| | Identify the gap to target. | |
| | Identify the poor performing indicators | |
| | Identify the facilities/sub/districts contributing most to poor perform | |
| | Identify the priority and focus area/s for the **following** meeting | |
| | **Priority Area/s Discussion** | Prog Mng |
| | Present disaggregated data to determine burden | |
| | Discuss findings from facility supervisory visits and other insights | |
| | Present the drivers for programme excellence and discuss gaps and ir | |
| | Identify possible need for further assessments and assign accordingly | |
| | Develop an improvement plan (who is going to do what, when, where, how and for how long) | |
| | **Best Practises** | Chairperson |
| | Identify any best practises | |
| | Develop a standardisation and spread plan | |
| | **Way Forward** | Chairperson |
| | Recap of resolutions | |
| | Other matters arising | |

### i. Opening

- Matters arising from D/P-PMR (preceding level of health). It is important that information and challenges are effectively communicated and addressed at the next level of health. This will ensure focus and unified support around similar challenges
- Feedback on action items from previous meeting to ensure accountability and progression

### ii. Feedback on current Improvement project/s

These are the problems previously identified as a priority and an improvement plan developed to address them

The champion for that specific project should go prepared to the meeting to present an update:

- summary of the project including problem and changes tested
- review of the performance indicator data
- discussion on what worked and what did not
- a spread and sustainability plan for discussion

### iii. OP Data Presentation

All indicators should be presented and:

- Compare indicators to relevant target (weekly, monthly, quarterly, annually)
- Identify the gap to target
- Identify the poor performing indicators
- Identify the facilities/sub/districts contributing most to the poor performance
- Based on the data presented, **identify the priority and focus area/s for the following months meeting.** Participants will not be able to have an in-depth discussion at this point as additional assessments and investigations will need to be done in order to identify what is contributing to the poor performance. **A champion should be assigned at the meeting to lead the assessment and improvement process.** The decision will be based on the focus area/priority indicator, workload, preferences, need etc.

### iv. Priority Area/s Discussion

In the previous months meeting, priority area/s were identified. Participants would agree to conduct further investigations to understand why this is a problem

Prioritize the problem area to be worked on by using the simple prioritisation questions:

- What has the biggest effect on the indicator's performance?
- Can we do something to improve it now?
- Are we able to solve this problem at the facility?

The improvement champion will lead a discussion on the findings which should include:

- Present disaggregated data to determine burden
- Discuss findings from facility supervisory visits and other insights
- Present an analysis of the drivers for programme excellence and discuss the gaps and possible interventions
- Identify possible need for further assessments and assign accordingly
- Develop an improvement plan (who is going to do what, when, where, how and for how long)

### v. Best Practices

A number of opportunities arise where best practises are identified. Nerve centre members will need to decide if these need to be adopted on a larger scale in the sub/district.

Standardisation is a key outcome in any health system. Variations in care to meet patients needs is expected, but patients should not think that our health system is a lottery service where you are lucky to get a service.

Participants should therefore come prepared to share the identified best practises as well as determine how they can be scaled up and sustained

### iv. Way forward

Recap on all resolutions discussed during the meeting as well as who is to carry them out by when.
Members should be given an opportunity to raise any other matters arising at this point

## 2. SUGGESTED PARTICIPANTS

The suggested participants are selected from a multi-disciplinary group of managers. A multidisciplinary health team will contribute to a more thorough and comprehensive assessment of the sub/districts performance and provide varied perspectives as to why it is performing that way it is. The managers work collaboratively with other technical managers and implementing partners. Below is a list of suggested participants for the different levels of health:

| Management Level | Sub-district | District | Province |
|---|---|---|---|
| Facility Manager | X | | |
| Sub-district Manager | X | | |
| Nursing Managers | X | | |
| HAST Manager | X | X | X |
| PHC Managers | | | X |
| Information Officers | X | | |
| Data Managers | X | X | X |
| District Managers | | X | X |
| Programme Managers | | X | X |
| WBPHCOT Manager | | X | X |
| Hospital Representatives | | X | X |
| Pharmacy Representatives | | X | X |
| Implementing Partners | | X | X |
| Provincial Managers | | X | X |

# Nerve Centre **Post-Meeting** Activities

# POST MEETING ACTIVITIES

The post-meeting phase is all about action. Participants are required to implement all the resolutions made and to focus on understanding why the identified priority area is a challenge. In the meeting, OP dashboards were used to identify poor performing indicators for that reporting period; this helped prioritise a problem for the team to focus on for the following month. **However, dashboards alone will not provide enough information about why problems exist and how they are impacting on service delivery.**

Managers must use this outcome data to direct the need for further analysis, root cause investigations and step-by-step assessments (see page 17). These cannot successfully be done from an office and require managers to go to many facilities to experience service delivery and observe how the design of the overall programme is impacting outcomes. OP facility level nerve centre tools such as the step-by-step assessments, summary charts, huddle meeting templates, weekly improvement plans (see summary of tools page 15) all contribute to a broader understanding of problems.

The **supportive supervision tool will lead managers through a systematic assessment process at facilities** which will add critical insights into understanding why problems exist. **Addressing drivers for programmatic excellence** may not need to be done at facility level but will require significant attention from managers during this period to understand how to sustainability address these drivers.

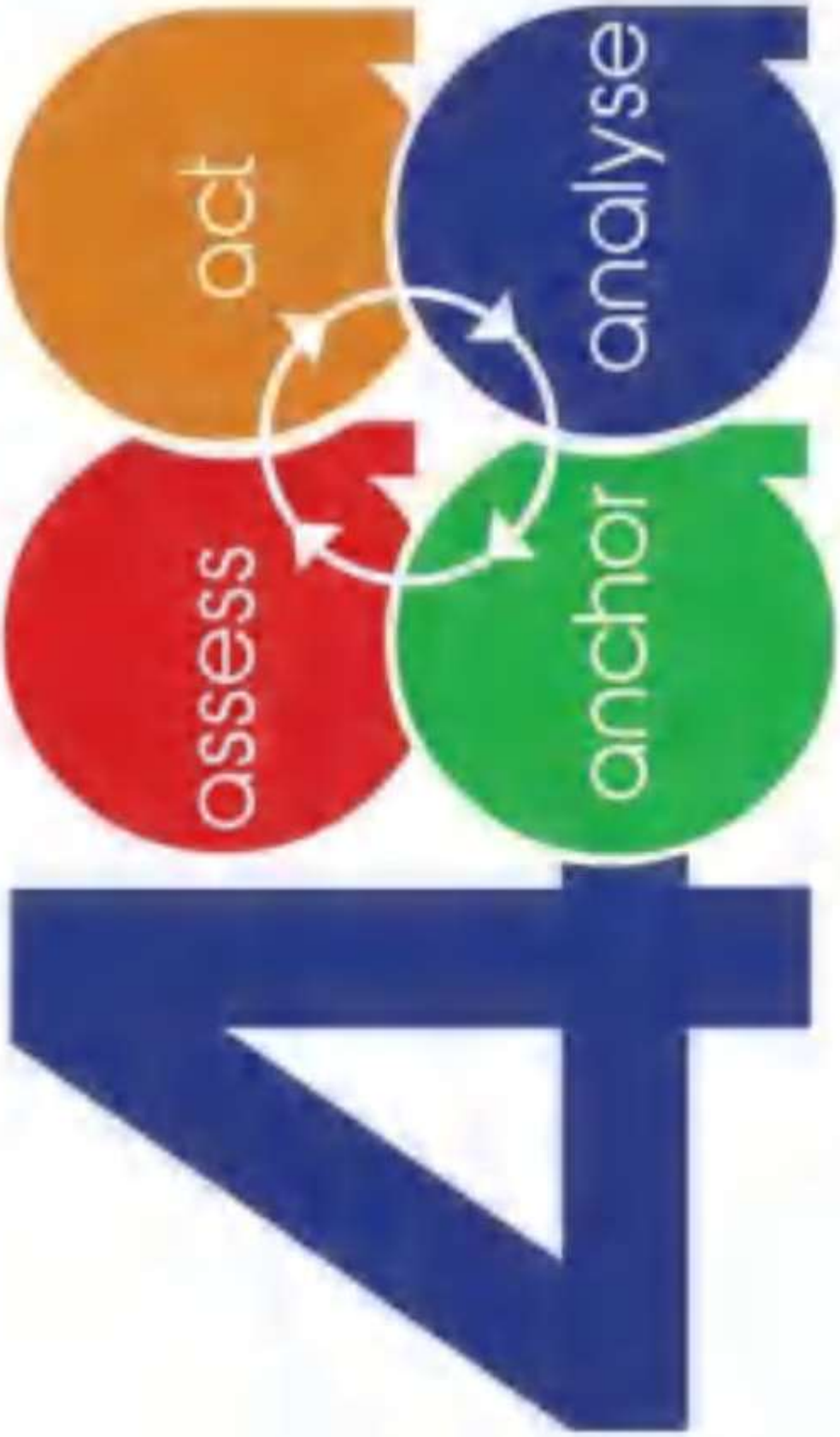
Endorsing and spreading best practices to all facilities is an essential activity at the post meeting phase. This can be done through developing standard operating procedures, removing systems that are no longer relevant, engaging with relevant stakeholders to approve or recommend a suggested change and assisting facilities to implement the change.

# ANNEXURES

4A Model

Barometers (WHO one pager)

Completing Barometers


4
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Department: Health
REPUBLIC OF SOUTH AFRICA

# Barometer

PEPFAR

World Health Organization

## HIV Tested

MONTH

TARGET

Weekly Target | Weekly Actual

Week 5

Week 4

Week 3

Week 2

Week 1

Start

## HIV Positive

MONTH

TARGET

Weekly Target | Weekly Actual

Week 5

Week 4

Week 3

Week 2

Week 1

Start

## New on ART

MONTH

TARGET

Weekly Target | Weekly Actual

Week 5

Week 4

Week 3

Week 2

Week 1

Start

## TROA

MONTH

TARGET

Weekly Target | Weekly Actual

Week 5

Week 4

Week 3

Week 2

Week 1

Start

## TB Symptomatic Clients

MONTH

TARGET

Weekly Target | Weekly Actual

Week 5

Week 4

Week 3

Week 2

Week 1

Start

## Clients tested for TB

MONTH

TARGET

Weekly Target | Weekly Actual

Week 5

Week 4

Week 3

Week 2

Week 1

Start

## Clients confirmed TB Positive

MONTH

TARGET

Weekly Target | Weekly Actual

Week 5

Week 4

Week 3

Week 2

Week 1

Start

## Clients started on Treatment

MONTH

TARGET

Weekly Target | Weekly Actual

Week 5

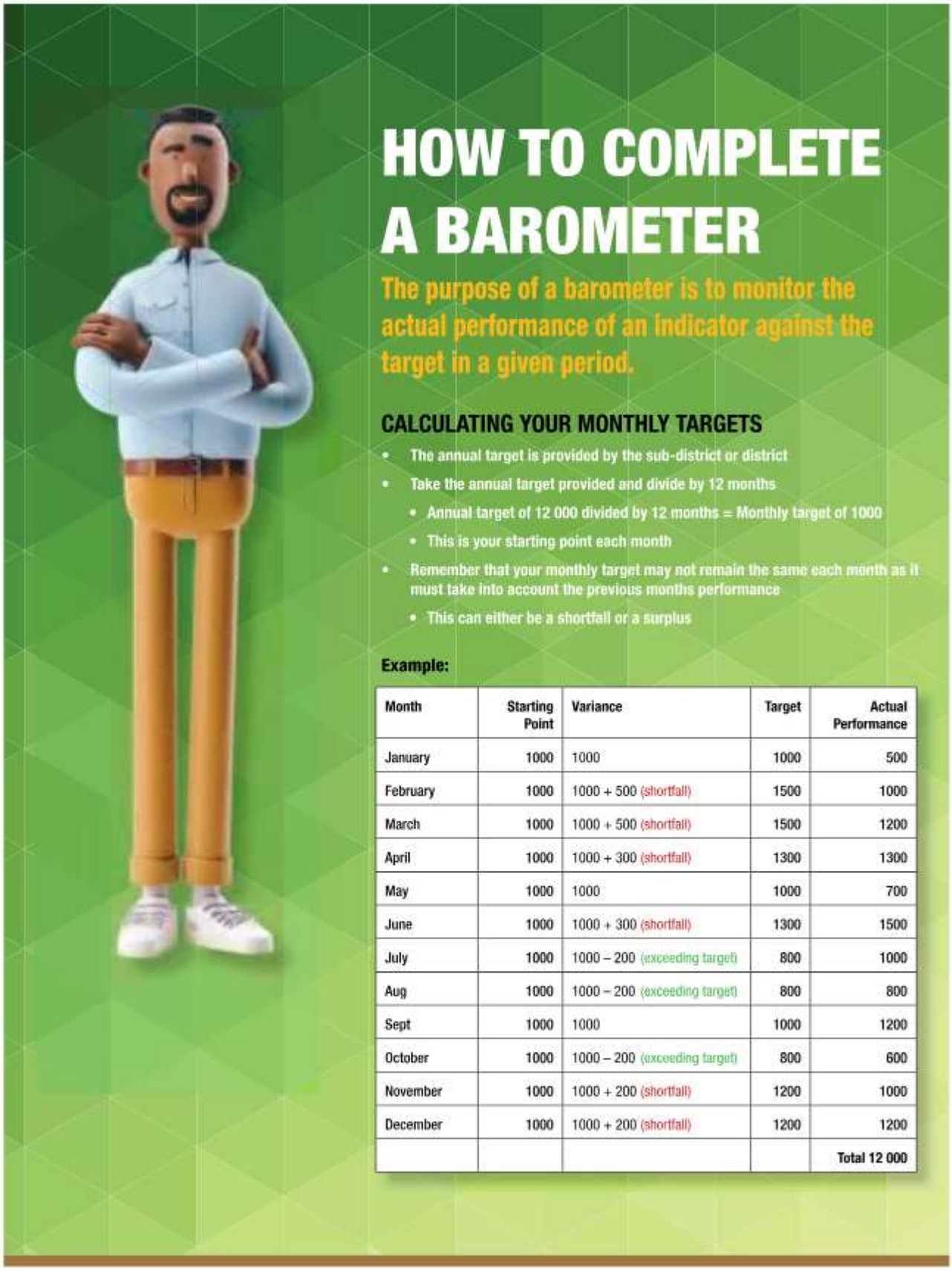
Week 4

Week 3

Week 2

Week 1

Start



# HOW TO COMPLETE A BAROMETER

**The purpose of a barometer is to monitor the actual performance of an indicator against the target in a given period.**

## CALCULATING YOUR MONTHLY TARGETS

- The annual target is provided by the sub-district or district
- Take the annual target provided and divide by 12 months
  - Annual target of 12 000 divided by 12 months = Monthly target of 1000
  - This is your starting point each month
- Remember that your monthly target may not remain the same each month as it must take into account the previous months performance
  - This can either be a shortfall or a surplus

**Example:**

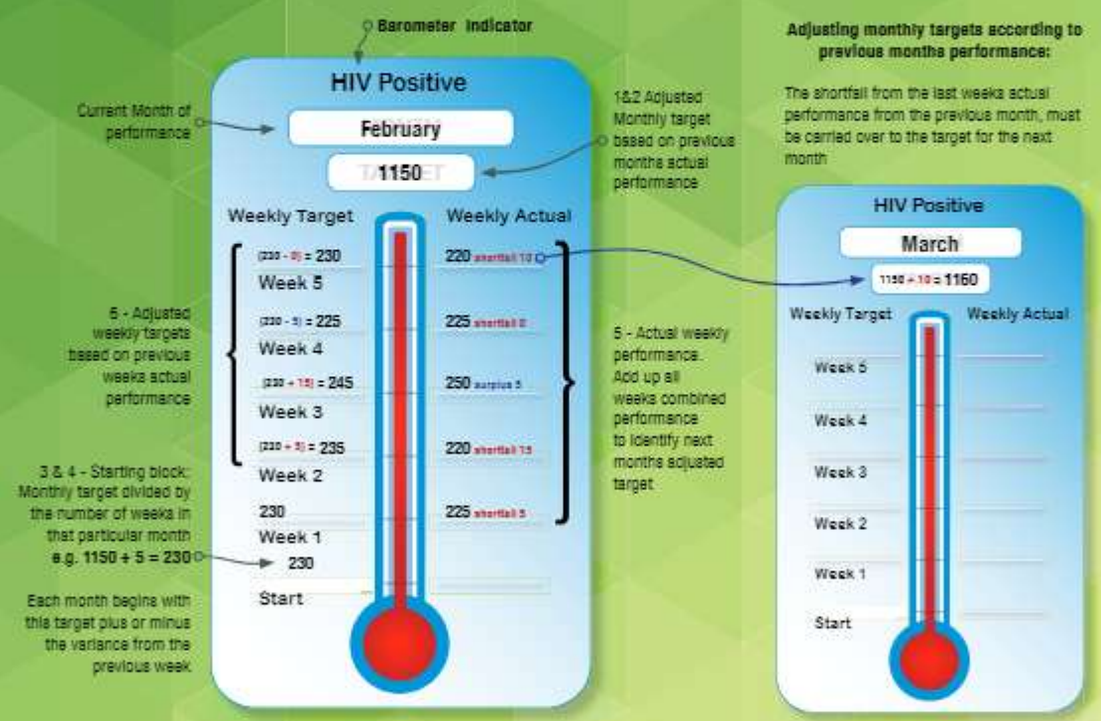
| Month | Starting Point | Variance | Target | Actual Performance |
|---|---|---|---|---|
| January | 1000 | 1000 | 1000 | 500 |
| February | 1000 | 1000 + 500 (shortfall) | 1500 | 1000 |
| March | 1000 | 1000 + 500 (shortfall) | 1500 | 1200 |
| April | 1000 | 1000 + 300 (shortfall) | 1300 | 1300 |
| May | 1000 | 1000 | 1000 | 700 |
| June | 1000 | 1000 + 300 (shortfall) | 1300 | 1500 |
| July | 1000 | 1000 – 200 (exceeding target) | 800 | 1000 |
| Aug | 1000 | 1000 – 200 (exceeding target) | 800 | 800 |
| Sept | 1000 | 1000 | 1000 | 1200 |
| October | 1000 | 1000 – 200 (exceeding target) | 800 | 600 |
| November | 1000 | 1000 + 200 (shortfall) | 1200 | 1000 |
| December | 1000 | 1000 + 200 (shortfall) | 1200 | 1200 |
| | | | | Total 12 000 |

health
Department
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

# COMPLETING A MONTHLY BAROMETER

1. Insert monthly starting target according to what was calculated from yearly target.
   - 12 000 ÷ 12 = 1000
2. Add or minus the previous months shortfall/ surplus
   - Monthly target = 1000
   - Actual performance = 850
   - Variance Shortfall = 150
   - This months target = 1000 + 150 = 1150
3. Calculate the weekly target
   - 1150 ÷ divided by number of weeks (5) = 230
4. Write the weekly target on the starting line
   - Week 1 is the same number as the starting line
5. Record the actual performance for the week
   - Record actual performance for each week
6. Calculate the next weeks target
   - Week 2 to 5 targets will need to be adjusted according to the variance of actual performance from the previous week



# ANNEXURES

## Huddle Meeting Templates

**Huddle Meeting Agenda**

**Huddle Team Member Weekly Action Plan**

**Huddle Meeting Facility Reporting Template**

## Huddle Meeting Agenda

| Date: | | Week: | |
|---|---|---|---|
| Priority Indicator: | | | |
| Indicator Champion: | | | |
| Indicator Team Members: | | | |

| Time Allocation | | Agenda Point | | Responsibility | |
|---|---|---|---|---|---|
| | | **LAST WEEKS PROGRESS** | | | |
| | | 1. Did we do what we agreed to? | | All | |
| | | 2. Did it work? If not, why not? | | All | |
| | | 3. What were challenges faced? | | All | |
| | | 4. What support is required? | | All | |
| | | 5. What needs to be considered for sustainability? | | All | |

**Indicator Champion completes Huddle meeting reporting template for the group*

| | | | | |
|---|---|---|---|---|
| | | **CURRENT PROBLEM** | | |
| | | 1. Complete the Barometer | All | |
| | | 2. Circle identified problems | Champion | |
| | | 3. Discuss Drivers for Program excellence? | | |
| | | 4. Prioritize the problem area to be worked on:<br>• What has the biggest effect on the indicator's performance?<br>• Can we do something to improve it now?<br>• Can the problem be solved at this facility? | All | |
| | | 5. Develop an action/improvement plan | All | |

**Indicator Champion completes Huddle meeting reporting template for the group*

## Huddle Team Member Weekly Action Plan

| Name: | | | Position: | | |
|---|---|---|---|---|---|
| | Week 1 - Date: | Week 2 - Date: | Week 3 - Date: | Week 4 - Date: | Week 5 - Date: |
| 1. What must I do? | | | | | |
| 2. List how often or how much? | | | | | |
| 3. List each step of what needs to be done | | | | | |
| 4. Develop a measure for each step | | | | | |
| 5. Challenges | | | | | |
| 6. Suggestions/ what was learnt | | | | | |
| 7. Support Needed | | | | | |
| 8. Considerations for sustainability | | | | | |

## Huddle Meeting Reporting Template

| **Month:** | Week 1 | Week 2 | Week 3 | Week 4 | Week 5 |
|---|---|---|---|---|---|
| **Duration:** | Start time:<br>End time: | Start time:<br>End time: | Start time:<br>End time: | Start time:<br>End time: | Start time:<br>End time: |
| **Name of Attendees:** | | | | | |
| **Last Week's Progress** | | | | | |
| Did you do what we agreed? | | | | | |
| Did it work? If not, why not? | | | | | |
| Should the change continue? If yes, what do we need to put in place for continuity? | | | | | |
| Challenges experienced | | | | | |
| Support needed | | | | | |
| **Current Problem** | | | | | |
| What is the problem area to focus on? Why did you choose this area as a priority? | | | | | |
| What is the intervention? | | | | | |
| What needs to be in place to start the intervention? | | | | | |
| **Checklist (Tick completion of the below stated tools for each week)** | | | | | |
| Barometer completed | | | | | |
| Summary Chart completed | | | | | |
| Weekly data compiled for weekly report | | | | | |
| Facility Manager signature | | | | | |

# ANNEXURES

## Monthly Nerve Centre Meeting Templates

**Monthly Nerve Centre Meeting Agenda**

**Monthly Facility Data Reporting Template**

**Monthly Facility Improvement Reporting Template**

## Monthly Nerve Centre Meeting Agenda

| Date: | | | Time: | |
|---|---|---|---|---|
| Chair: | | | | |
| Time Allocation | | Agenda Point | | Responsibility |
| | | **OPENING** | | |
| | | 1. Matters Arising | | |
| | | 2. Feedback on issues raised at previous meeting | | OM |
| | | 3. Barometer discussion | | |
| | | **FEEDBACK ON CURRENT IMPROVEMENT PROJECT** | | |
| | | 1. Present on summary chart | | |
| | | 2. Problem area/s the current project is solving and the intervention | | |
| | | 3. What works well and what does not work? | | |
| | | 4. How to sustain what is working | | |
| | | 5. Areas of collaboration | | |
| | | 6. Required support | | |
| | | **PLANNING FOR THE UPCOMING WEEKS** | | |
| | | 1. Problem area/s to focus on | | Indicator Champions or team representative |
| | | 2. Interventions to be conducted | | |
| | | 3. Discussion to determine if further assessments are required | | |
| | | **WAY FORWARD** | | |
| | | 1. Summary of improvement plan for each specific Indicator team | | OPM |
| | | 2. Next steps on challenges, support required and areas for collaborations | | OPM |
| | | 3. Any other business | | All |

## Facility Data Report

| Month: | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Week 1 | | Week 2 | | Week 3 | | Week 4 | | Week 5 | | Month Totals | |
| Indicators: | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | | |
| HIV Tested (15 years and above) | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| HIV tested Positive (15 years and above) | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| Naive start on ART | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| Viral Load overdue 6 months | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| Viral Load overdue 12 months | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| TLD transition | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| Return to Care | | | | | | | | | | | Target | |
| | | | | | | | | | | | Actual | |
| TROA (Total Remaining On ART) | | | | | | | | | | | | |

## Facility Improvement Reporting

| Month: | | | | |
|---|---|---|---|---|
| Indicator: | Problem | Causes | Intervention | Status of the Intervention |
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# ANNEXURES

## Above Site Level Management Templates

Supportive Supervision Guide

Monthly Management Level Nerve Centre Meeting Agenda

Cluster Improvement Reporting Template

Cluster Level Weekly Report

Sub-District Improvement Reporting Template

Sub-District OP Report

District Improvement Reporting Template

District OP Report

# Supportive Supervision Guide:

V3.0 01-07-2021

health

| Name: | | | Facility Name: | |
|---|---|---|---|---|
| Facility Manager: | | | Date: | |
| Identify the Priority Indicator: | HIV Tested | HIV Tested Pos | Naive Start ART | TROA |
| | TLD Transition | VL Suppressed | DMOC | |

| Nerve Centre's | Comments |
|---|---|
| Does the facility conduct weekly Nerve Centre huddle meetings? Review minutes. | |
| Does the facility conduct monthly Nerve Centre meetings? Review minutes. | |
| Are Indicator teams functional and led by indicator champions? Are there teams for all problem indicators? | |
| Are the Indicator Barometers updated and displayed? | |
| Is there evidence that step-by-step assessments have been done and problem areas identified for further analysis? | |
| Examine the Indicator Summary chart & determine if a proper assessment was conducted, and correct conclusions drawn. | |
| Review the drivers for programme excellence to identify the systems requirements for indicator excellence. | |
| Have the problems been prioritised correctly? | |
| **Review QI interventions** | |
| Have improvement plans been drawn up for all prioritised problems? | |
| Review the data to analyse if the intervention is leading to an improvement. Review process measures. | |
| **Supportive Interventions** | |
| What management drivers for programmatic excellence do you need to focus on to support this facility? | |
| Identify best practices for spread to other facilities. | |

List the Interventions you will implement to support the facility:

1.

2.

3.

**Date of next support visit:** **Facility Manager Signature:**

## Monthly Management Level Nerve Centre Meeting Agenda

| | | | |
|---|---|---|---|
| Date: | | Time: | |
| Chair: | | Sub/District: | |

| Time | Agenda Point | Responsibility |
|---|---|---|
| | **OPENING** | **Chairperson** |
| | Matters arising from D/P-PMR (preceding level of health) | |
| | Feedback on action items from previous meeting | |
| | **Feedback on current Improvement project/s** | **Identified leads** |
| | Summary of project including problem and change being tested | |
| | Review performance indicator data | |
| | Discuss what is working and what is not | |
| | Discuss a spread and sustainability plan | |
| | **OP Data presentation** | **HAST Manager** |
| | Compare indicators to relevant target (weekly, monthly, quarterly, annually) | |
| | Identify the gap to target | |
| | Identify the poor performing indicators | |
| | Identify facilities/sub/districts contributing most to poor performance | |
| | Identify the priority and focus area/s for the **following** meeting | |
| | **Priority Area/s Discussion** | **Prog Mng** |
| | Present disaggregated data to determine burden | |
| | Discuss findings from facility supervisory visits and other insights | |
| | Present the drivers for programme excellence and discuss gaps and interventions | |
| | Identify possible need for further assessments and assign accordingly | |
| | Develop an improvement plan (who is going to do what, when, where, how and for how long) | |
| | **Best Practises** | **Chairperson** |
| | Identify any best practises | |
| | Develop a standardisation and spread plan | |
| | **Way Forward** | **Chairperson** |
| | Recap of resolutions | |
| | Other matters arising | |

## Improvement Reporting Template

| **Month:** | | | |
|---|---|---|---|
| **Underperforming Indicator** | Problem and causes | Key drivers for change | Intervention |
| Facility 1 | | | |
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| Facility 2 | | | |
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| Facility 3 | | | |
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| Facility 8 | | | |
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## Cluster Level Weekly Report

| Week Date: | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | F1: | | F2: | | F3: | | F4: | | F5: | | F6: | | F7: | | F8: | |
| | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual | Target | Actual |
| HIV Tested (15 years and above) | | | | | | | | | | | | | | | | |
| HIV tested Positive (15 years and above) | | | | | | | | | | | | | | | | |
| Naiive start on ART | | | | | | | | | | | | | | | | |
| Viral Load overdue 6 months | | | | | | | | | | | | | | | | |
| Viral Load overdue 12 months | | | | | | | | | | | | | | | | |
| TLD transition | | | | | | | | | | | | | | | | |
| Return to Care | | | | | | | | | | | | | | | | |

## Sub-District Improvement Reporting Template

| Month: | | | |
|---|---|---|---|
| Underperforming Indicator | Problem and causes | Key drivers for change | Intervention |
| Cluster 1: | | | |
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| Cluster 2: | | | |
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| Cluster 3: | | | |
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| Cluster 7: | | | |
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| Cluster 8: | | | |
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# Sub-district Report

## Quarter 1 and 2

| INDICATORS | Month | | Month | | Month | | Q1 | | Month | | Month | | Month | | Q2 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HIV Tested (15 years and above) | Target | Actual | Target | Actual | Target | Actual | Target | | Target | Actual | Target | Actual | Target | Actual | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| HIV tested Positive (15 years and above) | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Naive start on ART | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Viral Load overdue 6 months | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Viral Load overdue 12 months | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| TLD transition | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Return to Care | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| TROA (Total Remaining On ART) | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |

## Quarter 3 and 4

| INDICATORS | Month | | Month | | Month | | Q3 | | Month | | Month | | Month | | Q4 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HIV Tested (15 years and above) | Target | Actual | Target | Actual | Target | Actual | Target | | Target | Actual | Target | Actual | Target | Actual | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| HIV tested Positive (15 years and above) | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Naiive start on ART | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Viral Load overdue 6 months | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Viral Load overdue 12 months | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| TLD transition | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Return to Care | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| TROA (Total Remaining On ART) | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |

## District Improvement Reporting Template

| Month: | | | |
|---|---|---|---|
| Underperforming Indicator | Problem and causes | Key drivers for change | Intervention |
| SD 1: | | | |
| | | | |
| | | | |
| | | | |
| SD 2: | | | |
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| SD 3: | | | |
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| SD 4: | | | |
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| SD 5: | | | |
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| SD 6: | | | |
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| SD 7: | | | |
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| | | | |
| | | | |
| SD 8: | | | |
| | | | |
| | | | |
| | | | |

# District OP Report

## Quarter 1 and 2

| INDICATORS | Month | | Month | | Month | | Q1 | | Month | | Month | | Month | | Q2 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HIV Tested (15 years and above) | Target | Actual | Target | Actual | Target | Actual | Target | | Target | Actual | Target | Actual | Target | Actual | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| HIV tested Positive (15 years and above) | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Naiive start on ART | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Viral Load overdue 6 months | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Viral Load overdue 12 months | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| TLD transition | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Return to Care | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| TROA (Total Remaining On ART) | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |

## Quarter 3 and 4

| INDICATORS | Month | | Month | | Month | | Q3 | | Month | | Month | | Month | | Q4 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| HIV Tested (15 years and above) | Target | Actual | Target | Actual | Target | Actual | Target | | Target | Actual | Target | Actual | Target | Actual | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| HIV tested Positive (15 years and above) | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Naiive start on ART | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Viral Load overdue 6 months | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Viral Load overdue 12 months | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| TLD transition | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| Return to Care | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |
| TROA (Total Remaining On ART) | | | | | | | Target | | | | | | | | Target | |
| | | | | | | | Actual | | | | | | | | Actual | |

# ANNEXURES

## Quality Improvement Tools

**5 Whys Template**

**Aim statement**

**Driver Diagram Template**

**Fishbone Template**

**PDSA Template**

**Process Map Template**

**QI team form**

**QI meeting agenda**

# 5 WHYs

# AIM STATEMENT

**At** .....

**clinic/department we aim to improve**

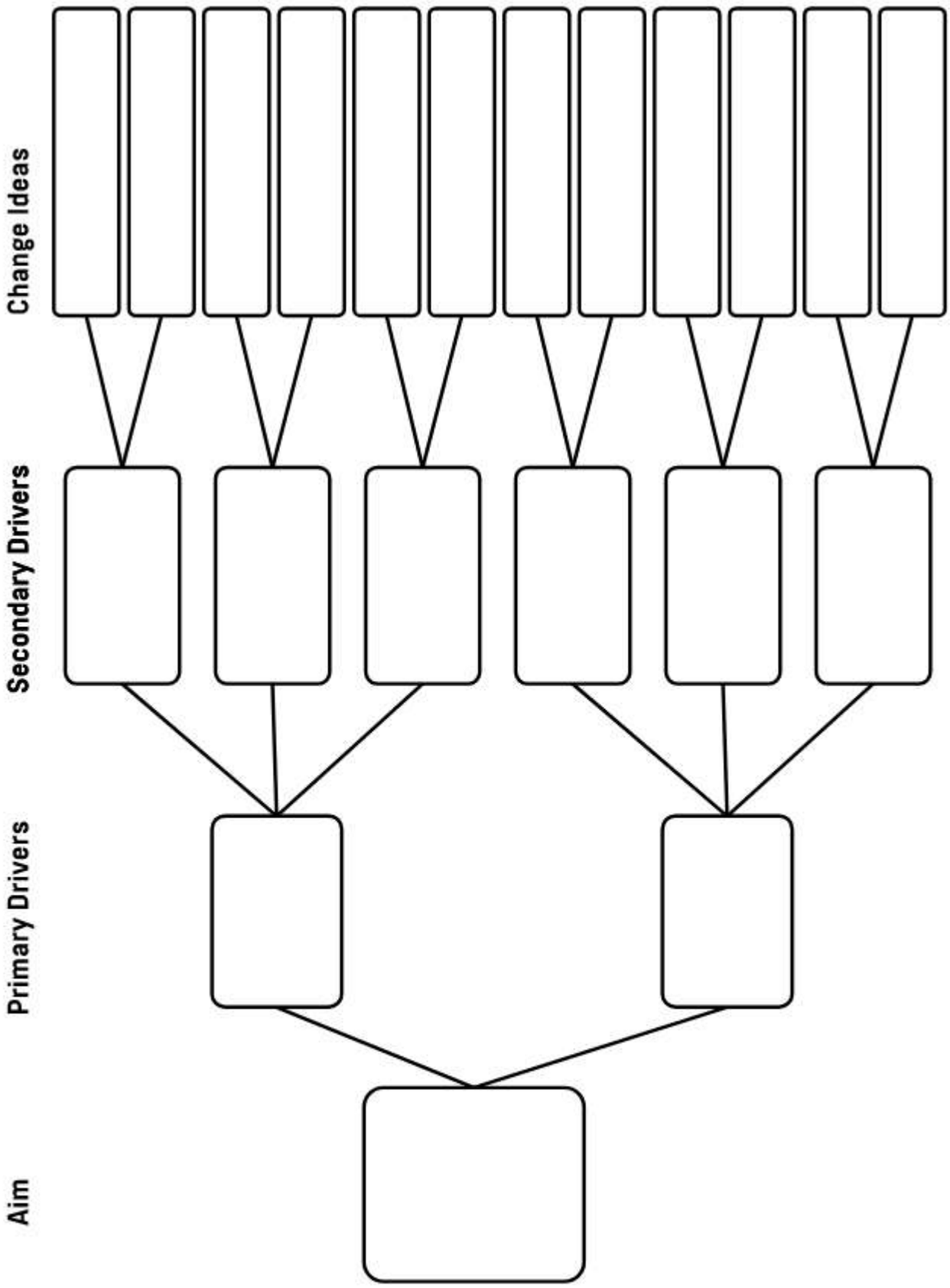
.....

**from** (baseline & date) .....

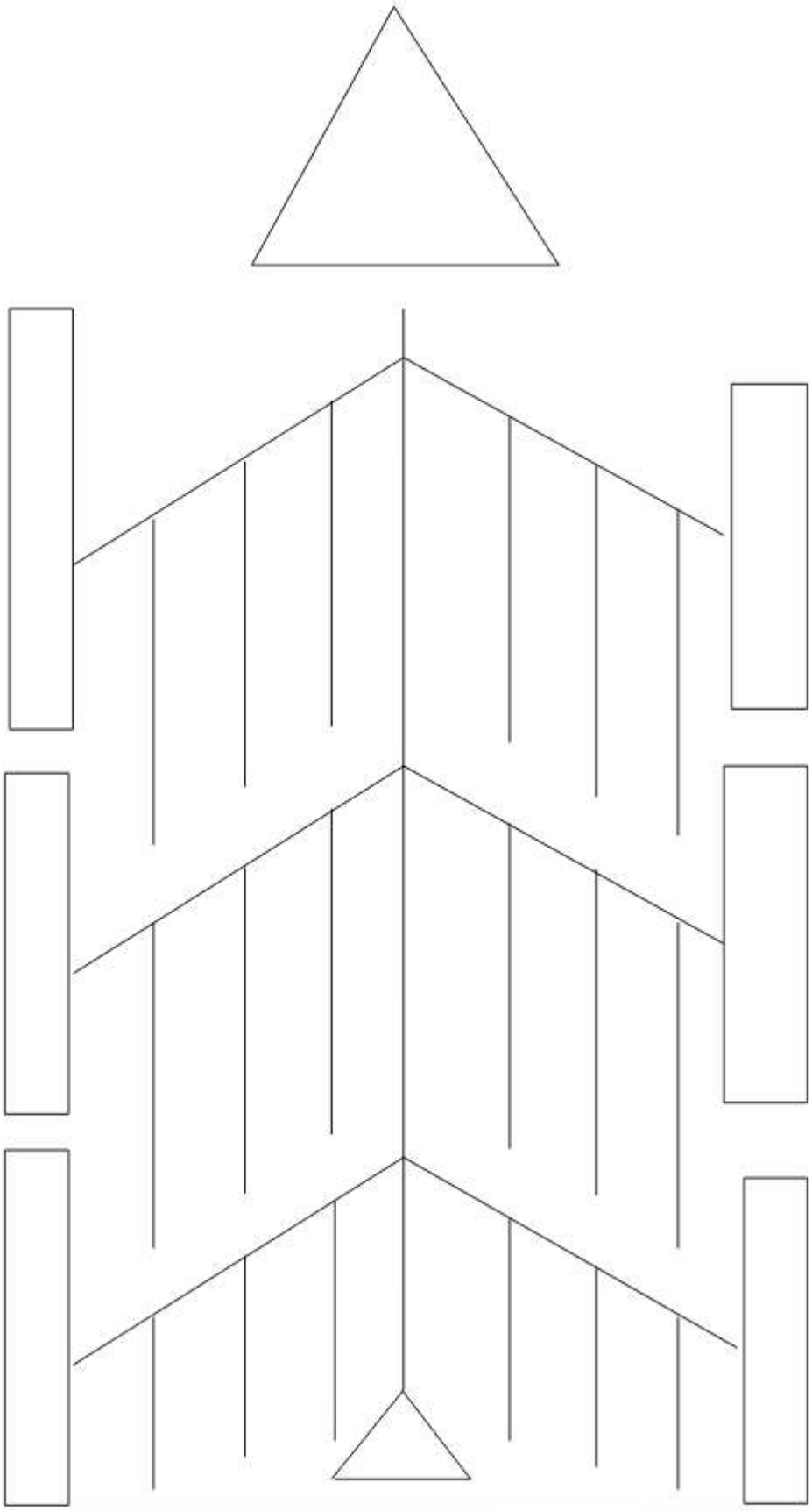
**to** .....

**by** .....

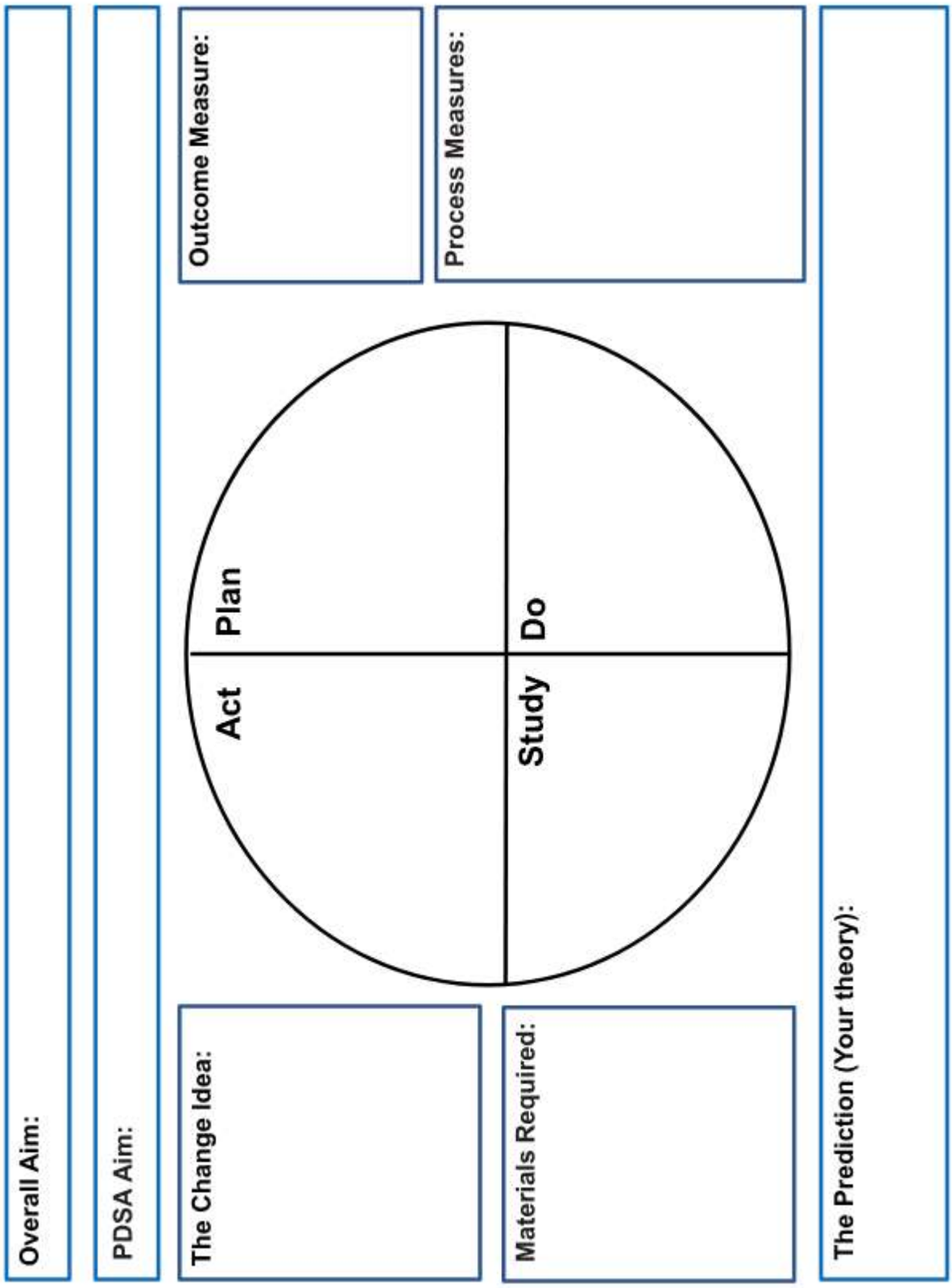
# DRIVER DIAGRAM



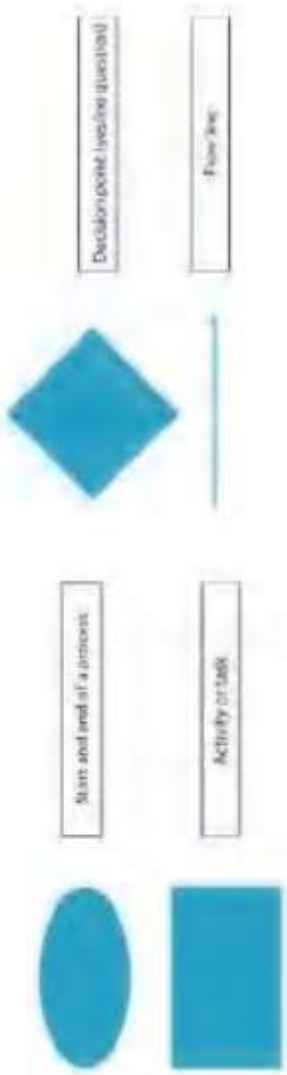
# FISH BONE

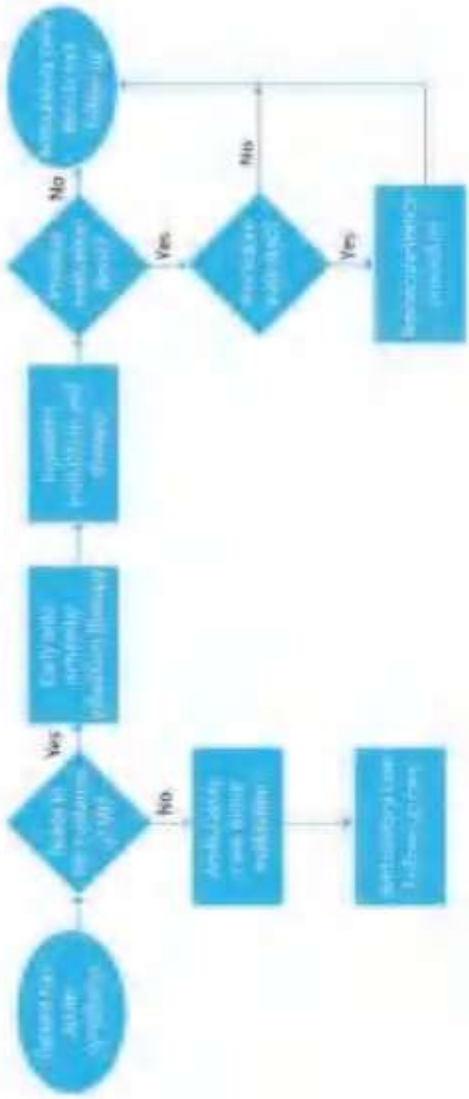


# P D S A


Overall Aim:
PDSA Aim:
The Change Idea:
Materials Required:
Act
Plan
Study
Do
Outcome Measure:
Process Measures:
The Prediction (Your theory):

# PROCESS MAP




1. Get the "right" people in the room — those who know the process best.

2. Start by defining the first and the last step in the process — so that everyone has a shared understanding of where the process you're working on begins and ends.

3. Using the shapes below, fill in all the steps in the process from first to last. Show the process as it actually works (not as it should work).
   - Tip: Use sticky notes (one for each step) to create a flowchart. This allows you to add steps and move steps around as you depict the process.
   - Tip: Note that some steps are parallel — that is, they happen at the same time.

4. Review the flowchart to check for accuracy and completeness.

5. Assign action items to team members to fill in unfamiliar steps and verify accuracy.

6. When the flowchart is complete and accurate, analyze it, use it, revisit it, and keep it up to date.

# QI Team

**Clinic/Organisation/Team:**_____

**Project:**_____

| **Members** | **Meetings** |
|---|---|
| **1.** _____ | Date_____ |
| **2.** _____ | Date_____ |
| **3.** _____ | Date_____ |
| **4.** _____ | Date_____ |
| **5.** _____ | Date_____ |
| **6.** _____ | Date_____ |
| **7.** _____ | Date_____ |
| **8.** _____ | Date_____ |
| **9.** _____ | Date_____ |
| **10.** _____ | Date_____ |

Signed by OM: _____

# QI MEETING AGENDA

## Sample agenda for improvement meeting

*(Directions to facilitator in italics)*

**Date:**

**Time:**

**1. Duration of meeting**

*Establish how much time you have*

**2. Reminder of aims**

**3. Update on change ideas**

*Recap on the change idea(s) they've been testing*

**4. Update on PDSA(s)**

Recap on the PDSA(s) the team was working on or planning. This information should have been recorded in the notes you made of their last meeting and their own minutes/notes. Get an update on progress if you haven't been involved in the test. If they havenît started to test, check their plan and encourage them to agree a start date

**5. Review your data**

You are looking for evidence of improvement. If they have completed a PDSA cycle, review the data collected during the test. If the test covers a whole month, some of this data may have been routinely collected and collated. Check whether any decision has been made under this "Act" section of the PDSA and if the data supports this decision. If no decision was made, encourage the team to make one. Check if there are plans to modify the change before it is tested again based on the learning from the previous PDSA

**6. Plan the next test of change**

If the previous idea was abandoned, identify a new change idea using appropriate improvement tools. Otherwise, plan the next test based on the decision made under "Act"

**7. Review the run charts**

You are interested in run charts relating to aims they`ve previously been working on and their current improvement topics. Help them plot new data points if necessary. Check if successful changes are still being implemented in old topics where performance improvements have not been sustained

**8. Action plan**

Be clear you and the team members have recorded important decisions and actions from the meeting

**9. Date and time of next meeting**