Treatment Navigator Model

SPOTLIGHT ON RETENTION

Tshwane I Stanza Bopape CHC and Soshanguve Block X Clinic
Combined average monthly headcount : 14675

IMPROVEMENT AREA & AIM

In FY20, Tshwane District program data showed high linkage-to-care rates (90% among newly diagnosed HIV positive patients), but low retention-in-care rates at six months. In line with these findings, in March 2020 Stanza Bopape Community Health Centre (CHC) and Soshanguve Block X Clinic reported a six-month retention-in-care rate of 52%.

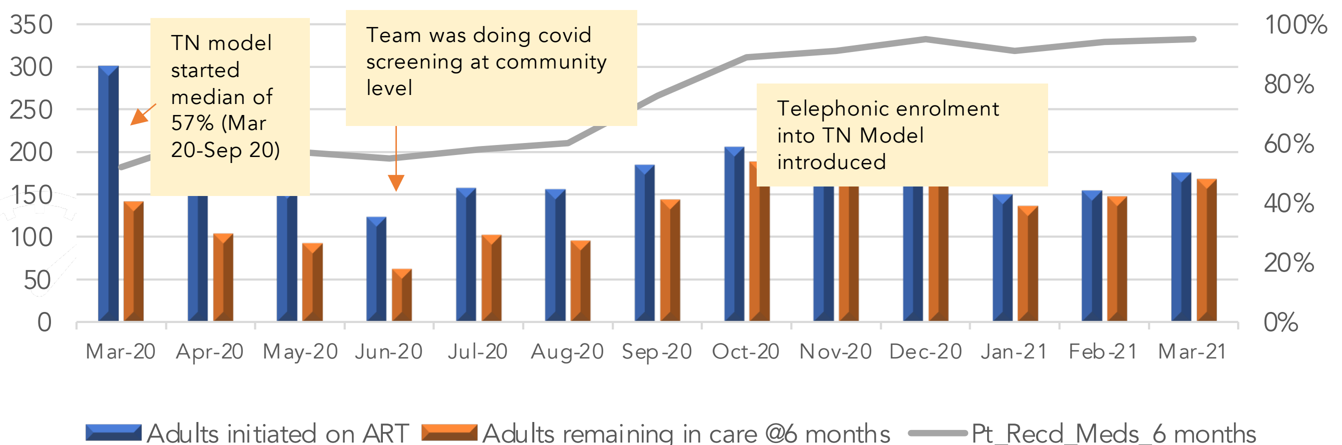
Through the Treatment Navigator (TN) Model, **we aimed** to improve retention-in-care rates at six months among new ART enrolees from 52% in March 2020 to 90% in March 2021.

DESCRIPTION

Treatment navigators (TN) are a lay cadre of staff who act as “buddies” to newly initiated ART patients. Enrolment is voluntary and each TN is allocated no more than XXX number of patients. The TN journeys with the patient through their ART experience up to 6 months, establishing rapport, providing adherence support, telephonically reminding patients of appointments, and facilitating linkage for routine follow-up or blood . After 6 months, patients who are virally suppressed graduate from the TN program and are offered the option to enroll into a Differentiated Model of Care (DMOC), whilst those unsuppressed are referred to psychosocial services.

OUTCOMES

After one year of implementing the TN model, retention-at-six-months rates among new ART enrolees improved from 52% in March 2020 to 95% in March 2021. Initially, enrolment was low (57%) due to COVID-19 travel restrictions, resulting in only modest improvements from April to September 2020 (ranging from 55% to 76%). Telephonic enrolment into the TN was introduced in October 2020 resulting in improvements reaching 95% in March 2021. The bar graph below shows the interval between patients initiated on ART (the blue bar) and the patient remaining in care at 6 months (the orange bar) narrows over time resulting in an increase in patients retained in care (the grey line).



STEPS TO IMPLEMENT

PRE-IMPLEMENTATION

- Recruit lay cadre as TNs.
- Newly recruited TNs are trained by facility project managers on the TN Model which includes basic HIV testing, adherence counselling & LIVES training.
- TN allocated cellphones with airtime to contact patients throughout the 6 months period.
- TN deployed to the priority facilities- one per facility.

IMPLEMENTATION

- Newly initiated adult ART patient are referred to a TN for orientation on the model.
- ART patient voluntarily enrols onto the TN model.
- TN journeys with patient for six months, serving as a patient "buddy" – provides adherence support, telephonically reminds patient of clinic visits and addresses all questions patient might have regarding ART.
- TN introduces the concept of differentiated models of care (DMOC) to patients.
- TN navigates patient through the facility during clinic visits for either routine follow up or blood draws including 6 months VL.
- At 6 months, TN graduates VL suppressed patients from TN programme to either DMOC or mainstream care.
- TN refers VL unsuppressed patients to psychosocial services.

FACILITATORS

- Standard Operation Procedure for Treatment Navigators
- Designated TN for each facility
- Facility management buy-in
- Monitoring of implementation TN model through monthly reporting

CHALLENGES & ADAPTATIONS

- Some patients did not have phones → request next of kin contact details
- Not all patients signed up for the TN model → provide more information
- COVID-19 related travel restrictions, facility closures and facility decongestion efforts limited number of clinic visits → telephonic enrolment was introduced
- Retrenchment of some TNs due to partner budget cuts → work with facility management to integrate this role into lay cadres in the government staff establishment

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ABBREVIATIONS

- ✓ TN- Treatment Navigator
- ✓ LIVES-Listen, Validate , Enhance Safety and Support
- ✓ VL-Viral Load
- ✓ DMOC-Differentiated models of care
- ✓ PSS-Psychosocial services
- ✓ THIS –TB/HIV integrated system
- ✓ SOP-Standard operation procedure

RESOURCES

- ✓ TN registers
- ✓ Cellphones with airtime
- ✓ THIS

LESSONS LEARNED

- ✓ Patients linked with one TN for 6 months strengthened retention of newly initiated patients in care
- ✓ Testing of patients contact details during 1st contact with patients enhanced the ability to reach more patients for appointment pre-reminders and tacking and tracing
- ✓ Pre-reminder system and regular updating of patient contact details has proven to be effective in increasing attendance rates hence improves retention to HIV care.