

Russia HIV/AIDS Treatment, Care and Support Collaborative

Improving access to HIV/AIDS care and patient retention in four Russian cities

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Problem

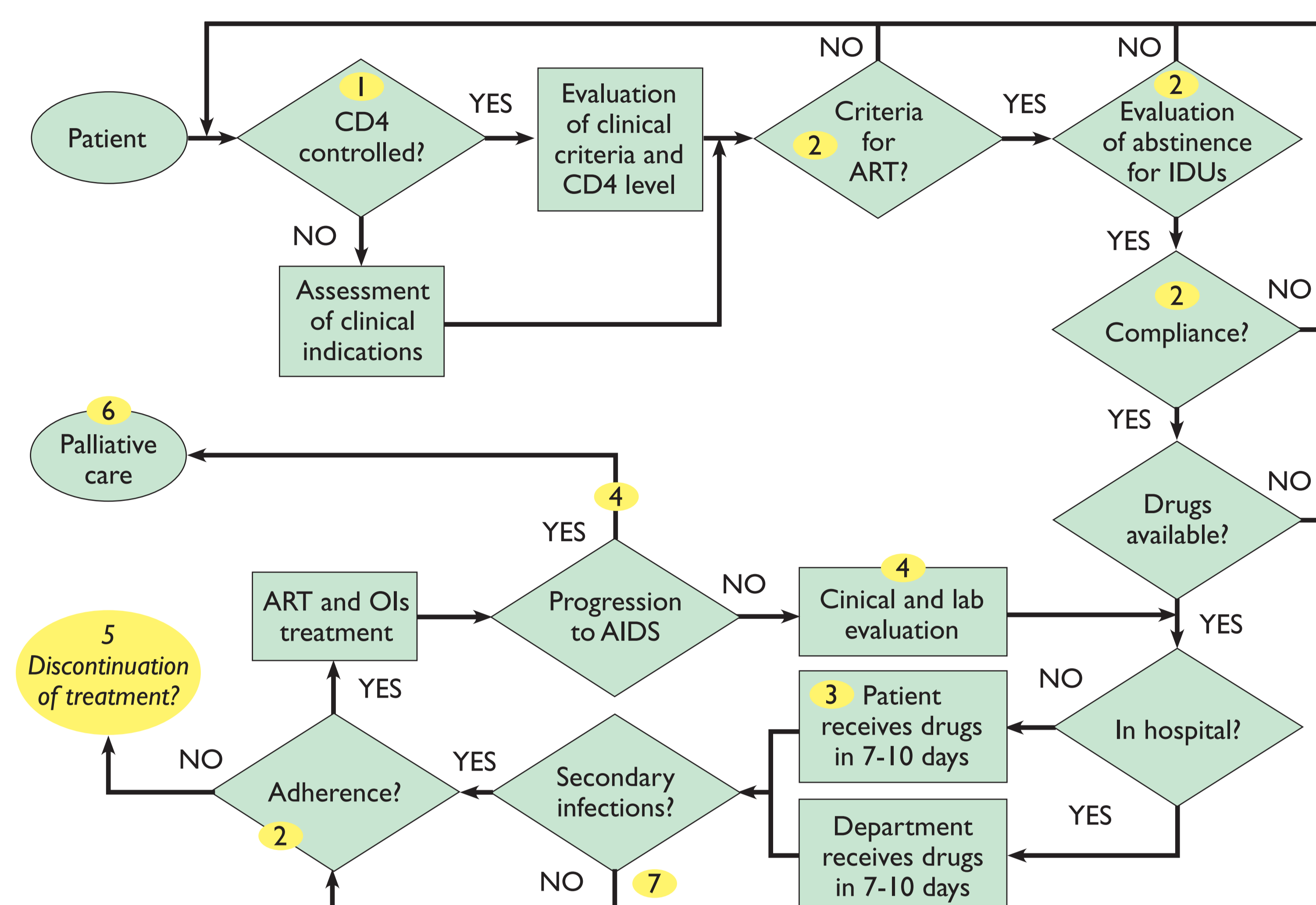
- Over 400,000 HIV-infected individuals are officially registered in Russia; almost 80% of them are substance users, and only half are in HIV care and treatment.

- TB is a major co-infection; 30% of people with late stages of HIV present TB, yet only 10,000 people have been identified as TB-HIV co-infected.
- Although the availability of ART has expanded since 2005, the number of HIV patients on treatment remains low.

- Reliance on specialized AIDS centers has limited the Russian health system's ability to respond to the needs of a growing number of patients. Moreover, HIV, TB and substance abuse treatment services are weakly integrated and have little coordination with the general health care system.

Strategy for Change

- In 2004, the USAID-funded Quality Assurance Project (QAP) began to work in four Russian cities (St. Petersburg, Orenburg, Togliatti, and Engels) to implement an improvement collaborative that would develop a municipal model for delivery of treatment, care and support services to persons living with HIV/AIDS (PLWHA).
- QAP staff and participating providers analyzed the system of care for PLWHA. The analysis included collection of baseline data and diagramming patient flow through the care process, as seen in the figure at right. The results were presented to experts and key stakeholders at a planning meeting in 2005.
- Through the group process the following improvement objectives were set:
 - Develop provider counseling skills for HIV testing and integrate testing into practice
 - Reduce turn-around time for HIV test results
 - Increase coverage of HIV-positive patients with medical follow up through the involvement of primary health care providers



Numbers in yellow ellipses indicate problem areas: (1) Limited access to CD4 counts. (2) Poorly defined criteria for ART administration, evaluation of abstinence from drugs and estimation of adherence; adherence to ART usually evaluated only based on patients' verbal feedback. (3) Supply of drugs for ART is limited and irregular. (4) Procedures for clinical and lab evaluation of ART effectiveness differ across regions. (5) Unclear what happens to the patient if s/he discontinues treatment and "drops out" of follow-up. (6) Institutions to provide or coordinate hospice or home care do not exist. (7) Care to patients with secondary infectious differs between care providers depending on their knowledge, skills and preferences and therefore is not standardized.

- Develop patient referrals and improve communication between facilities of the general health care system, specialized health services and NGOs
- Develop a legal framework to support and institutionalize improvements

- Improvement teams were formed from representatives of AIDS centers, polyclinics, TB and narcological dispensaries, social service organizations, NGOs, and patient advocacy groups and included 12-15 people. The improvement collaborative methodology was applied to organize mutual learning and sharing of ideas among team members and teams. QAP staff provided coaching to teams through field visits and frequent communication.
- To ensure that the work of teams was authorized and constantly monitored, coordinating committees were formed in each city and were chaired by health authorities with active involvement of heads from participating institutions. Regional and interregional learning sessions were held by QAP with constant participation of national and international experts.

Measures

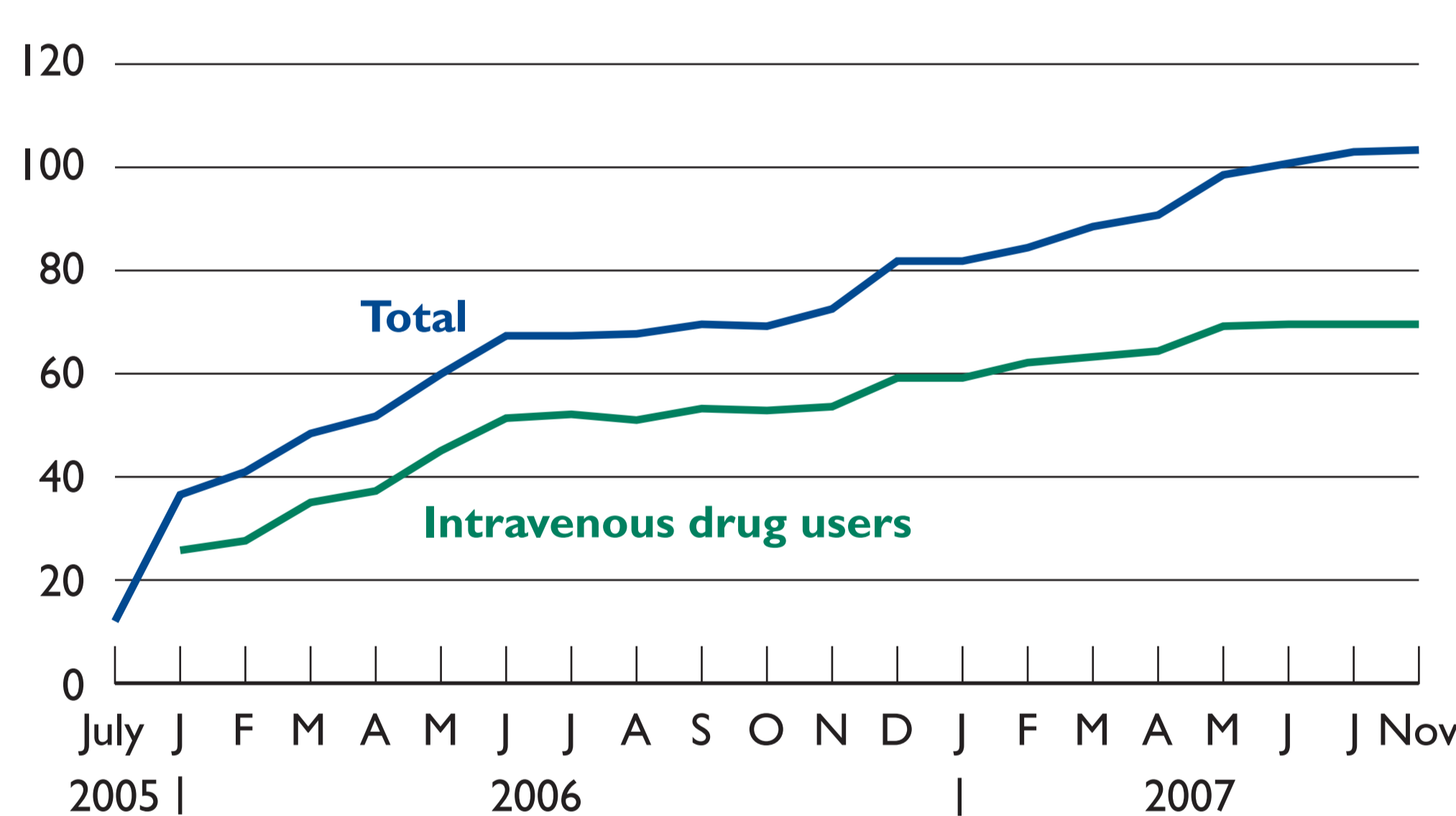
- Number of patients who received pre- and post-test counseling;
- Turn-around time for test results;

- Number of newly detected patients with HIV who are registered at the AIDS Center;
- Number of patients with HIV who returned for medical examinations;

- Number of patients enrolled on ART;
- Number of patients provided with social support services;
- Number of patients screened for TB; and
- Number of patients counseled on HIV-TB co-infection

Effects of Changes

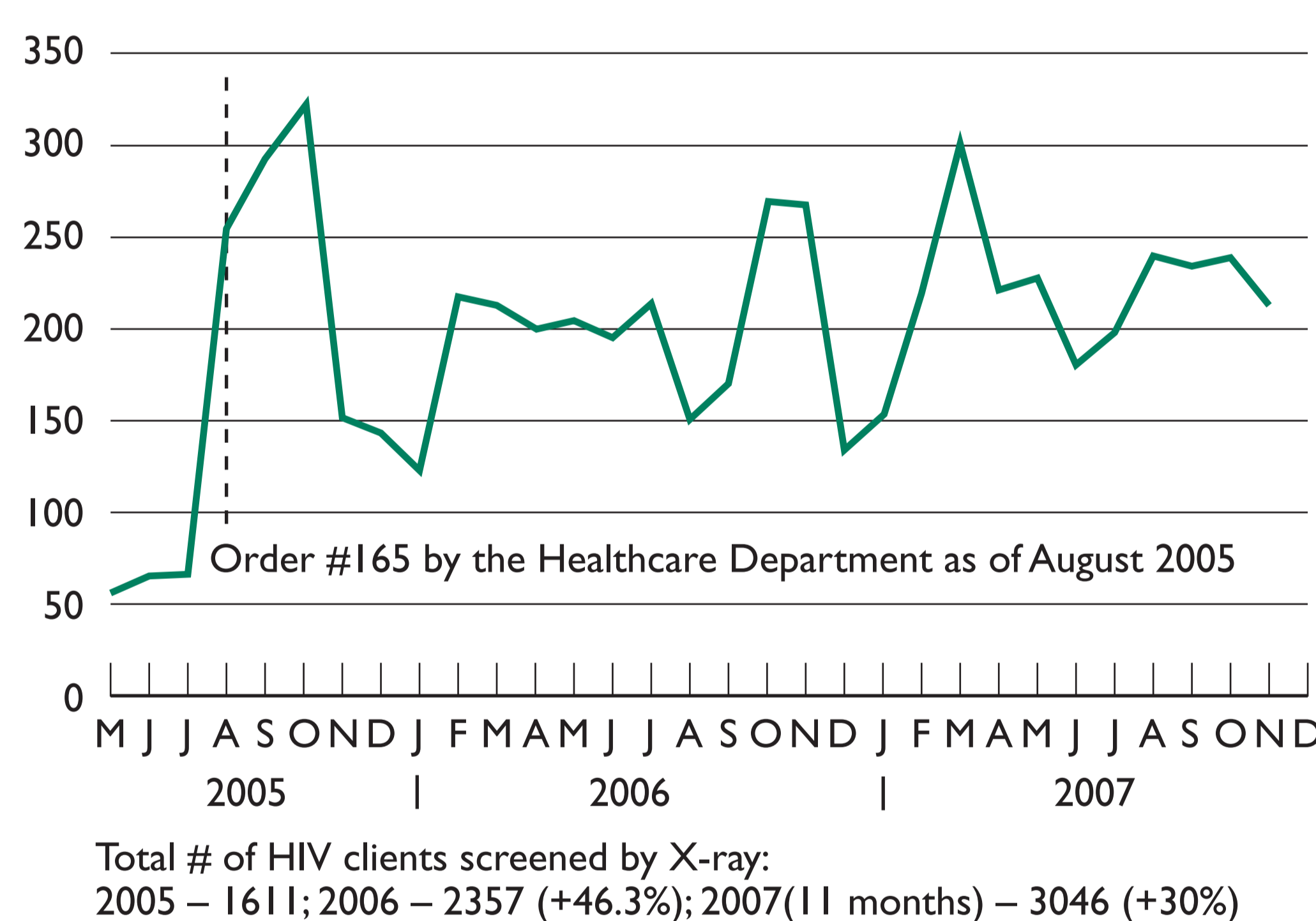
Number of HIV-positive Individuals Receiving ART in Krasnogvardeisky District of St. Petersburg 2005-2007



Changes introduced:

- Information stands on HIV/AIDS with information on expanded access to ART developed and installed at all health care facilities of Krasnogvardeisky District
- Care providers trained in VCT
- Algorithm for access to HAART developed and institutionalized
- Information exchange mechanisms established between care providers
- Follow-up of HIV clients at polyclinics organized
- Database on HIV patients verified between the AIDS Center and polyclinics

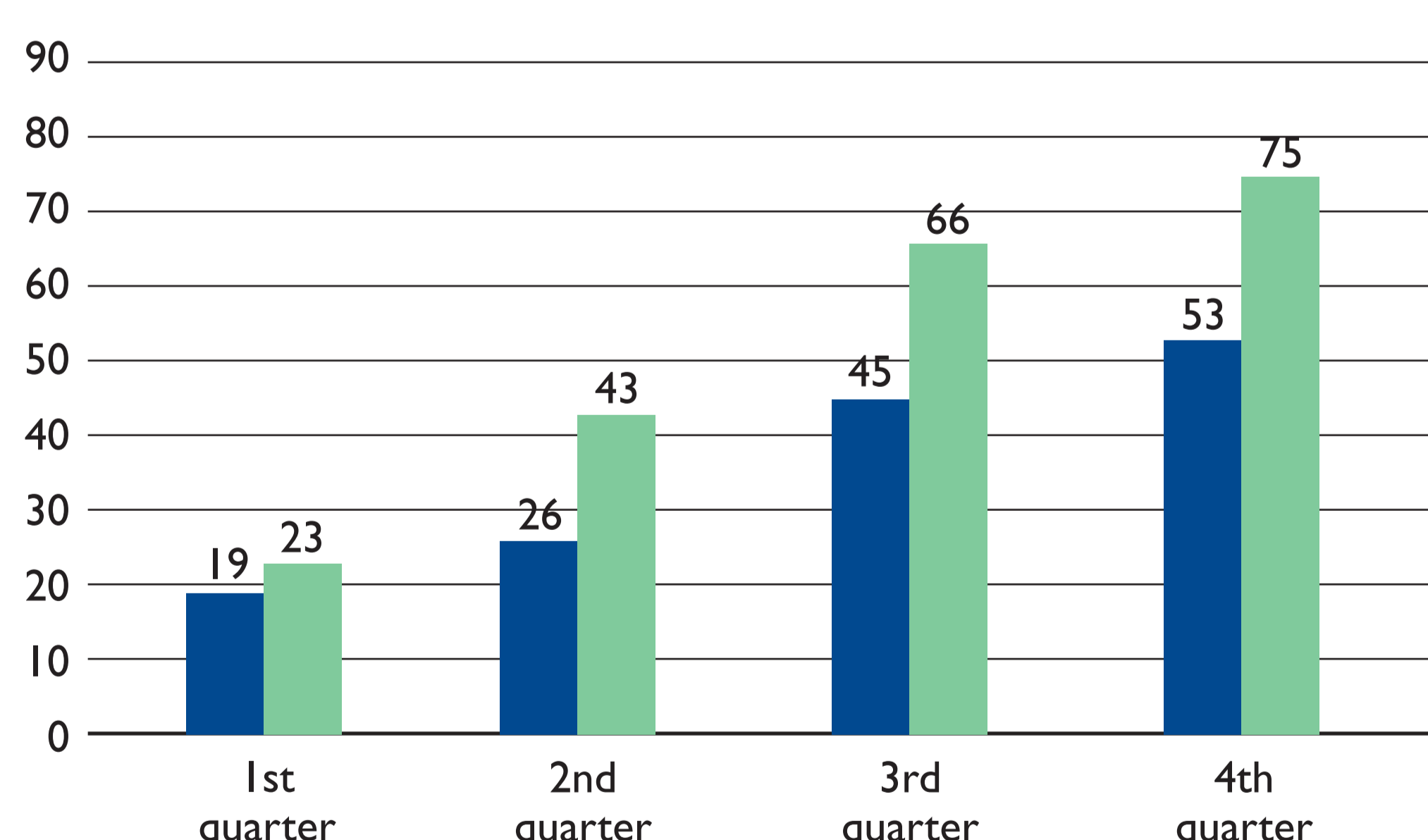
Number of HIV Patients Screened for TB by X-ray with the Results Submitted to the AIDS Center Togliatti, Samara Oblast, 2005-2007



Changes introduced:

- HIV-TB counseling upon registration and at any visit to the AIDS Center institutionalized
- Systematic X-ray screening of HIV patients at primary care settings and routine tuberculin testing at the AIDS Center
- Staff of TB facilities, AIDS Center and primary care settings trained in HIV, HIV-TB and VCT
- Counseling at TB facilities by AIDS Center specialists organized
- Information exchange established between primary care, TB services and AIDS Center
- Cooperation established with NGOs to refer patients for TB screening
- Outreach workers and hot-line staff trained in HIV-TB

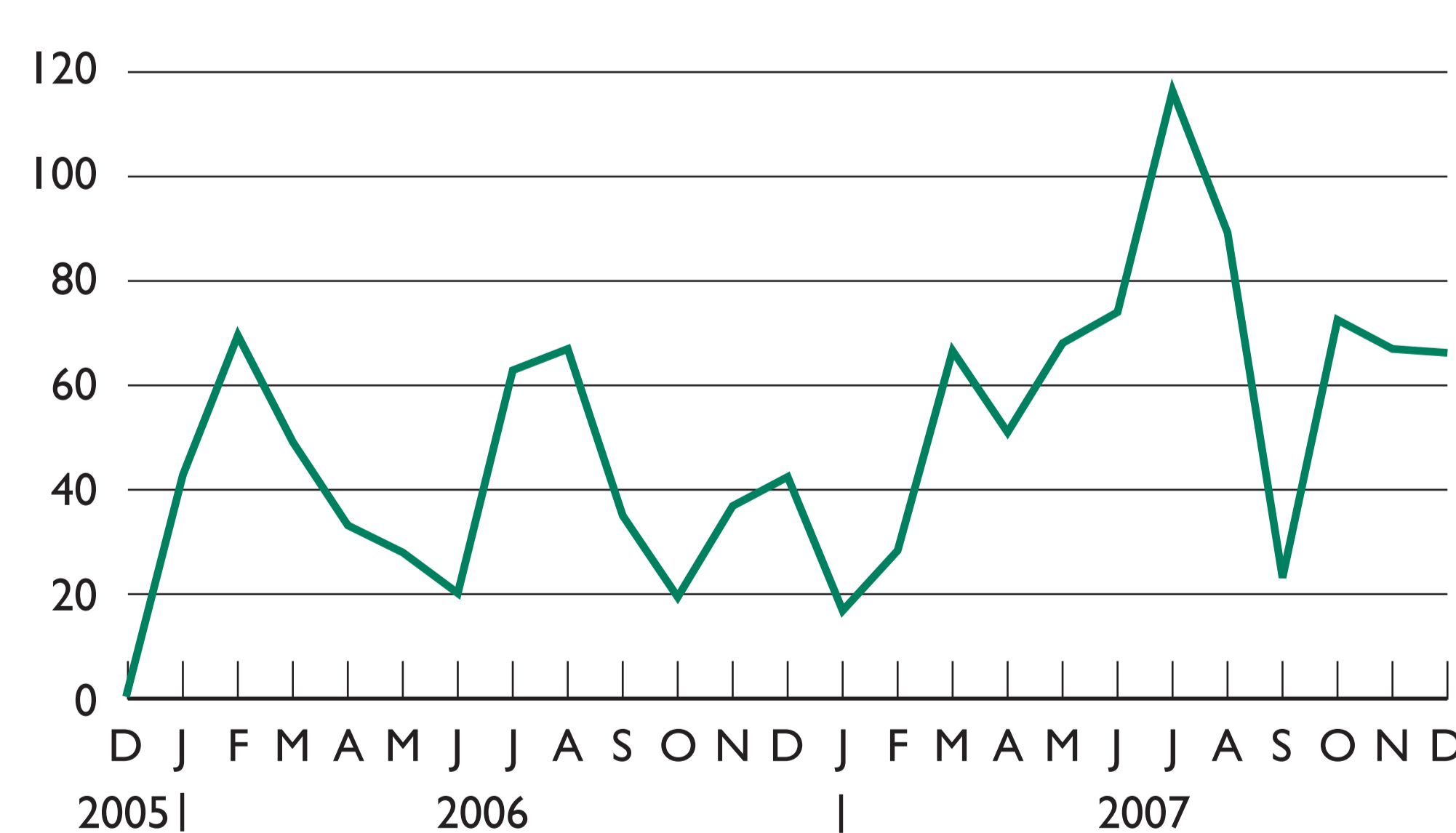
Number of HIV-positive Individuals Followed-up at Polyclinics, Nevsky District of St. Petersburg, 2007



Changes introduced:

- Database on HIV patients verified between the AIDS Center and polyclinics
- Primary care infectious disease specialists asked to actively encourage patients who have not been in the health care system to visit the polyclinic for a check-up
- Primary care providers trained in VCT
- Improved communication between primary care settings, AIDS Center and specialty facilities
- Re-organized system of referrals

Number of HIV Clients Seen by the AIDS Center Social Workers in Orenburg Oblast AIDS Center, 2006-2007



Changes introduced:

- Social worker position created at the AIDS Center
- Social worker trained in case management
- Referral mechanisms developed
- Cooperation established with NGOs and peer support groups
- Communication established between specialty services, primary care settings and social services

Lessons Learnt

- The collaborative facilitates building a shared vision among providers, generates commitment for improvement and ownership for successes, thus ensuring long-term sustainability of new practices
- Interdisciplinary teams need to be constantly supported to keep them focused on their improvement objectives, encourage regular meetings, and assist them with using data for analysis of improvements during action periods. We found that it was important to have team members assigned by leadership of their institutions to be constant members of the teams and to have time allocated during their work schedules to participate in team meetings.

- Communication of results by team members to other staff of their institutions and to the leadership was very important to maintain the momentum of improvements. Our project facilitated this by providing phone cards, facilities to conduct conference calls, and access to the internet.
- Key Message: *Where HIV/AIDS services are fragmented and systems are vertical, improvement efforts need to foster interdisciplinary collaboration between various sectors such as health, social services, education, and nongovernmental sectors. Having health authorities on board and bringing different types of providers together to work out operational issues in care integration yields solutions which then can be rapidly taken to scale.*

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