

HIV TAC TEAM



Continuity of Care for Mobile Patients with HIV/AIDS

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4 November 2015

Disclaimer

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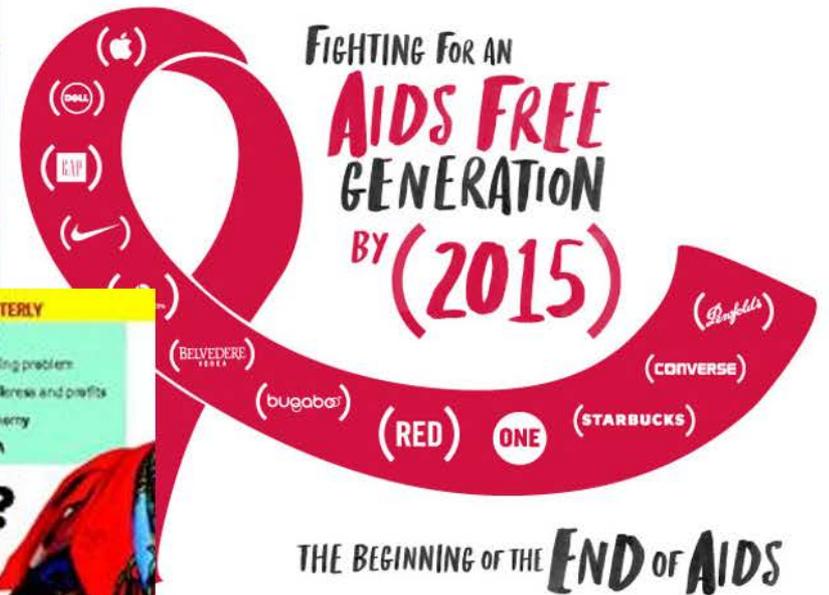
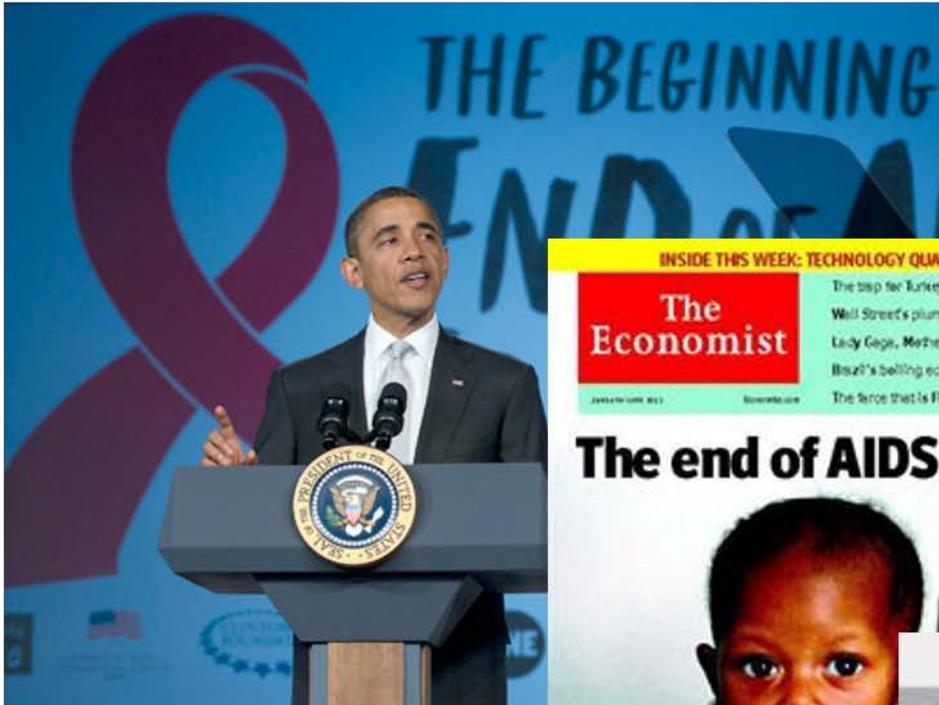


Continuity of Care for Mobile Patients with HIV/AIDS

Deliana Garcia, MA
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Media Campaigns



 **TIME Healthland**
@TIMEHealthland

Newborn may be cured of HIV. Is the end of AIDS near? | ti.me/Ziv7V7



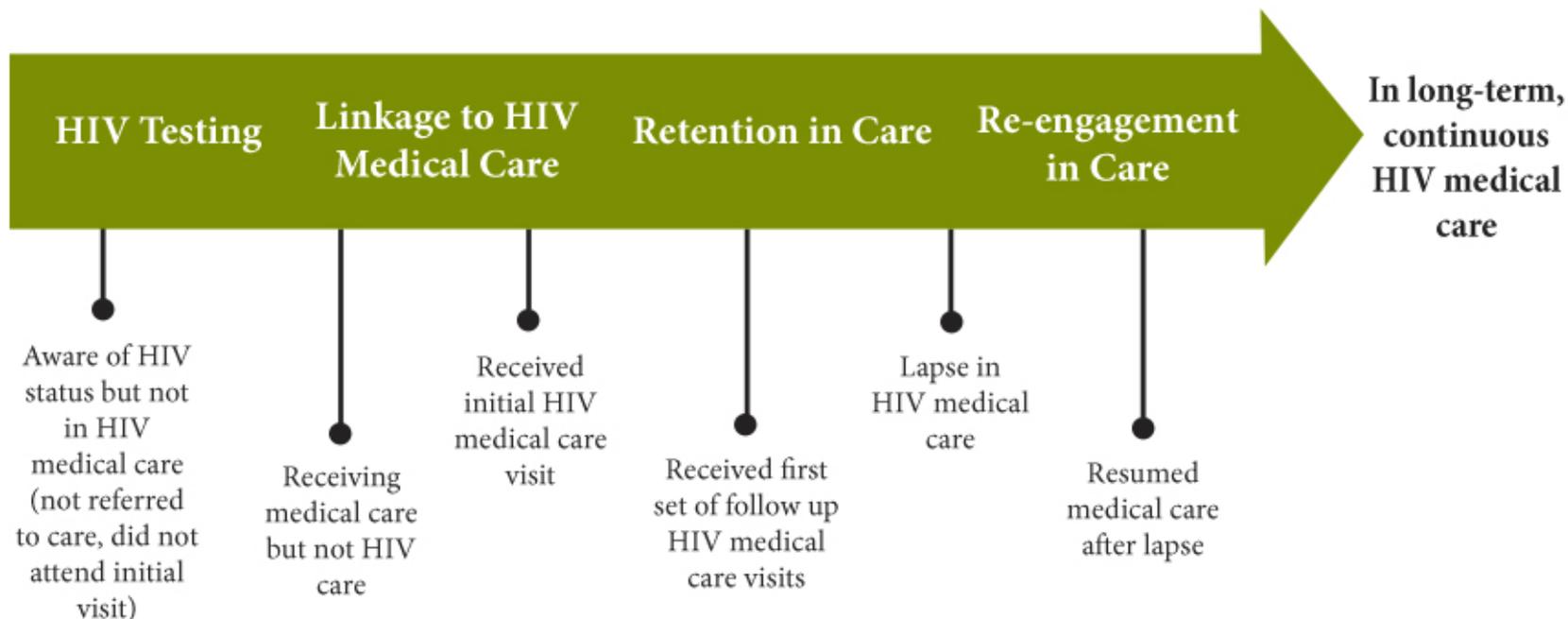
Despite all of
the advances
there is still a
long way to
go ...

Especially in
communities
of color



Continuum of care

Unaware of HIV Status
Not tested or never received results



Retaining Patients in Care

- Education at the time of diagnosis about the benefits of medical care for improving personal health and preventing HIV transmission.
- Establish the systems and services to:
 - Assist HIV+ patients to start medical care shortly after a positive test result,
 - Support long-term retention in medical care, and
 - Re-engage patients into medical care if they have dropped out of care.
- Offer services that promote linkage to and retention in care through collaborations among testing providers, community-based prevention providers, HIV care providers, case managers, and health departments.

The HIV Care Landscape



Structural Factors that Create Barriers to Retention in Care



Rural settings



Transportation



Food insecurity



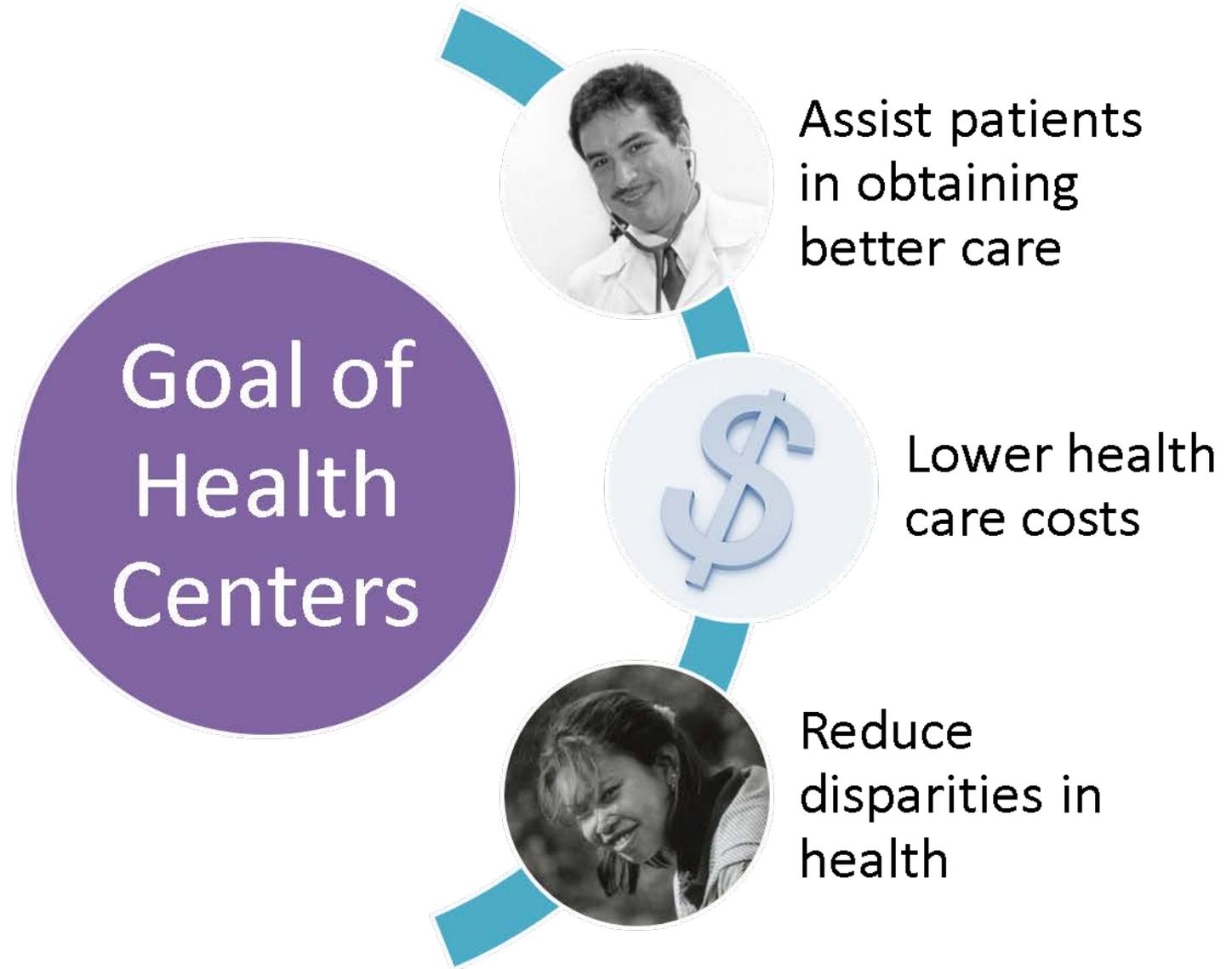
Work



Child-care responsibilities



Competing Forces



Operational Barriers



Challenges

- ✓ Providers can see up to 40 patients a day and
- ✓ Wait times can be 4-5 hours, but
- ✓ Face-to-face time between patients and clinicians can be as little as 2-3 minutes.
- ✓ Inevitable conflicts between patients seeking care and staff who are trying to maintain order have been reported.

HAART Initiation

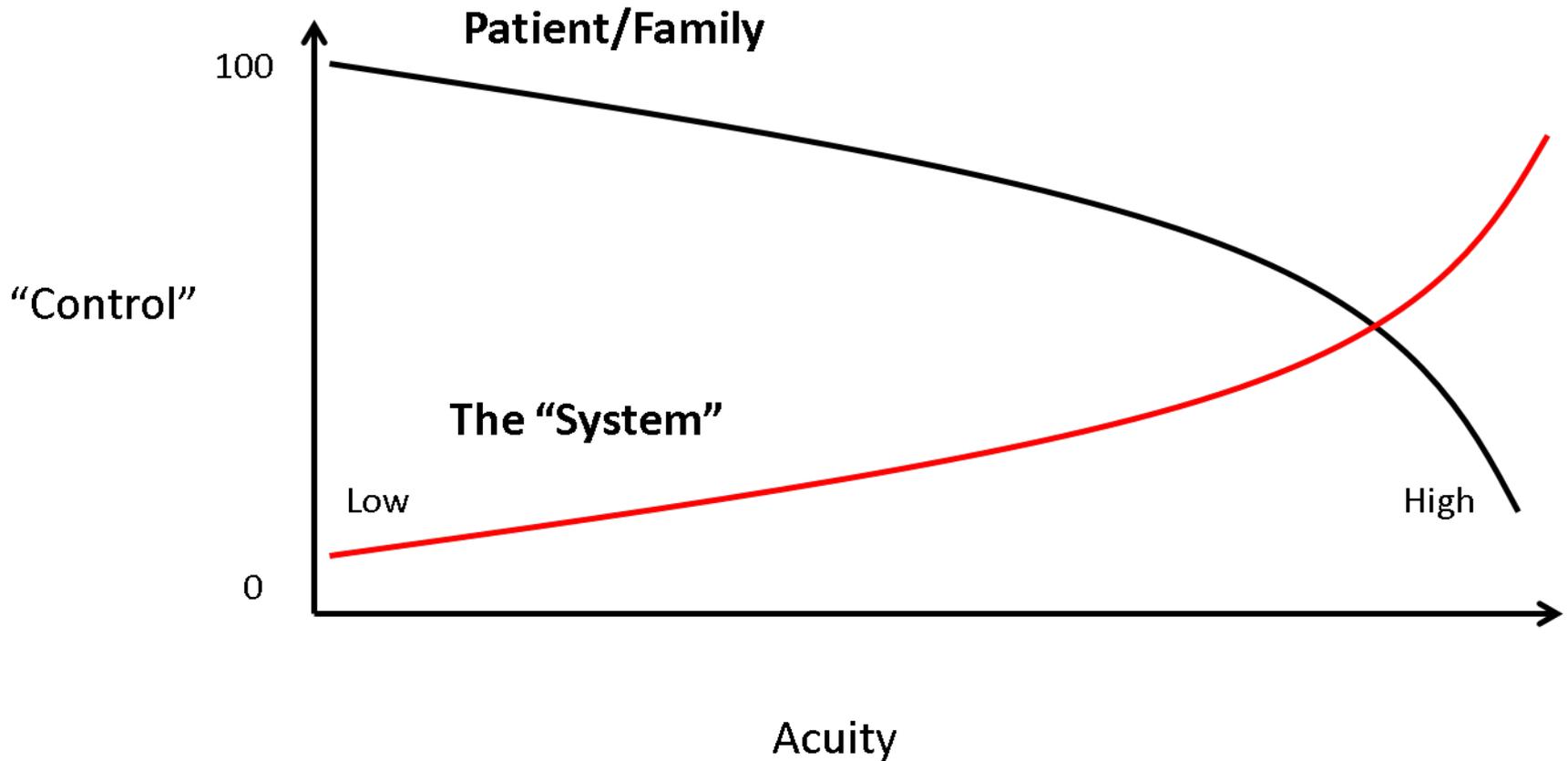
- ✓ I discuss it with all of my patients in the 1st visit to increase rapid uptake.
- ✓ I wait to discuss it until I feel we have a rapport, but then try to get them started independent of the CD4
- ✓ I would only discuss it if the patient's mental health is stable and substance abuse will not be a barrier to adherence.
- ✓ I only start it if the CD 4 is <500

Early Retention in Care



- ✓ The first year in care is a dynamic, formative and vulnerable time
- ✓ Poor early retention in care is associated with
 - Delayed/failed ART receipt
 - Delayed time to VL suppression and greater cumulative HIV burden
 - Increased sexual risk transmission behaviors
 - Increased risk of clinical events or mortality
 - Worse ART adherence, CD4 and VL response and increased mortality following ART start

CONTROL: WHO "DECIDES"?



The Critical Goal of Healthcare is
Affecting Behavior Change By
Creating Continuous, Healing
Relationships Between the Patient
and her Family and the
Healthcare Team



Population mobility and HIV Vulnerability

various phases:

- ✓ during transit,
- ✓ in destination communities,
- ✓ in communities of departure and return

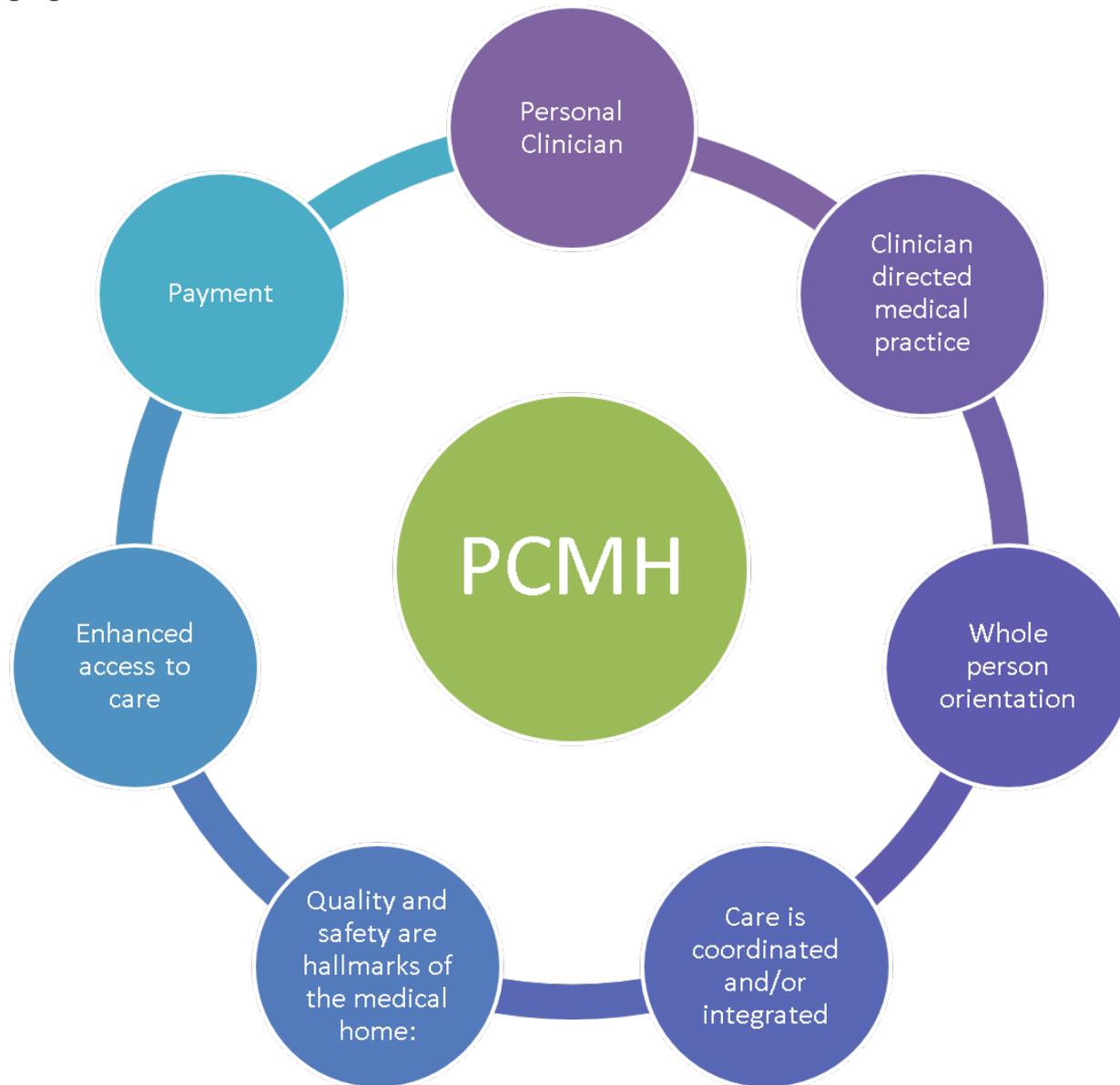


Strategies to Retain Mobile Patients in Care

Quote

“The patient-centered medical home is a model for care provided by primary care clinician practices that seeks to strengthen the clinician-patient relationship by replacing episodic care based on illnesses and patient complaints with coordinated care and a long-term healing relationship.” NCQA (www.ncqa.org)

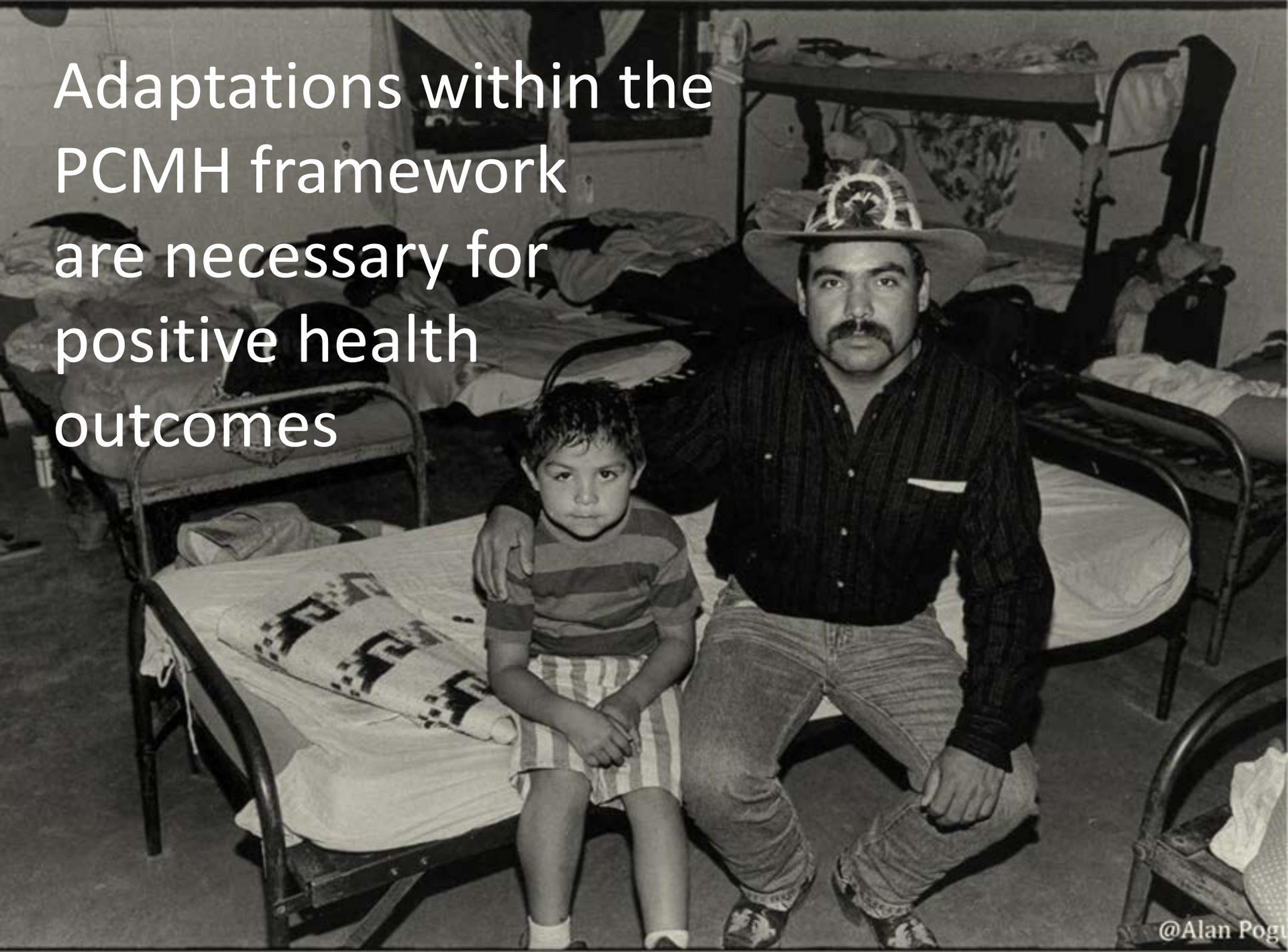
PCMH



Include Patients

Promote medical home transformation designed to **include** patients who experience barriers to health care due to mobility, poverty, language and culture.

Adaptations within the
PCMH framework
are necessary for
positive health
outcomes



Adapted Mobile Medical Home

An adapted mobile medical home includes...

- Integrative approach between disciplines and across sites of care
- Increased capacity for health information technology to be transmitted
- Intensive primary care both in-center and out in the community

Tools

What tools do you need to build a mobile medical home on your site?



Examples



Standard One, Must Pass Element

Access During Office Hours

Open Access Checklist for Migrants

- ✓ **Orient** all patients to the scheduling protocols, recognizing that patients may be unfamiliar with scheduling practices or US healthcare systems.
- ✓ **Document** the numbers of migrant workers in the region by month, the typical work hours and the transportation available to them.
- ✓ Open Access scheduling permits an influx of migrant patients to be seen as **seasonal variance** is experienced.
- ✓ Open Access scheduling **accommodates** the work hours, transportation issues and geographic **barriers** experienced by migrant workers.

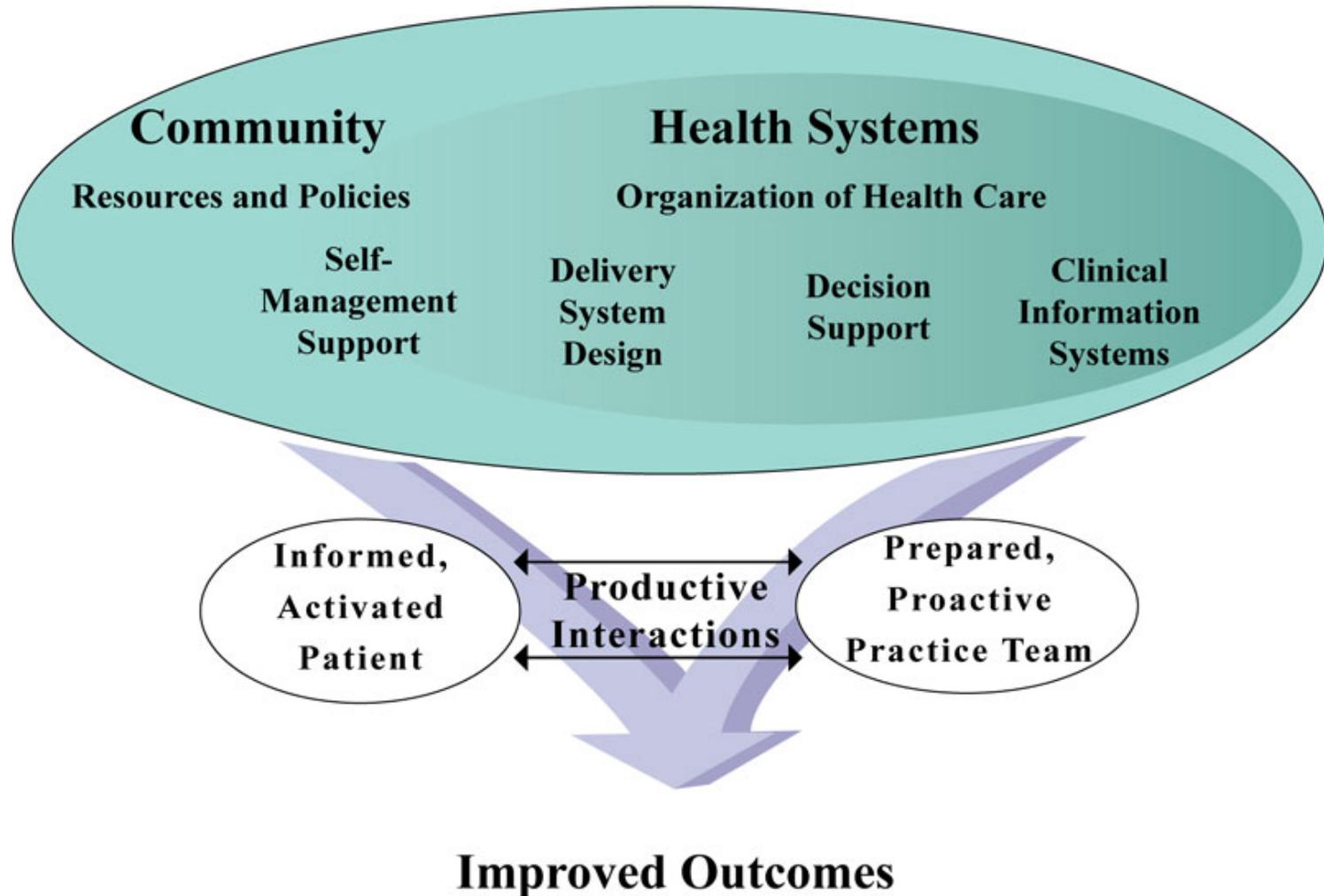
Data Tool for Population Management

Center measures (examples):

- ✓ # migrant workers and dependents with subcategories of children, retired, disabled and adult in retrievable EHR entries
- ✓ Occupational and environmental health conditions associated with crop work in center region
- ✓ Core measures by migrant status
- ✓ Access to specialty services for migrant population
- ✓ ED use and hospitalization of migrant population

Chronic Care Model

The Chronic Care Model



What
about
mobile
patients?



Case Study:
Pregnant, HIV+
migrant woman





Case Study: HIV and Tuberculosis

Self-Management Support

- ✓ Emphasize the patient's central role in managing their illness
- ✓ Use effective self-management strategies that include assessment, goal-setting, action planning, problem-solving and follow-up.
- ✓ Organize internal and community resources to provide ongoing self-management support to patients.



What is self-management?

“The individual’s ability to manage the symptoms, treatment, physical and social consequences and lifestyle changes inherent in living with a chronic condition.”

Self-Management

Patient Education

- Information and skills are taught
- Usually disease-specific
- Assumes that knowledge creates behavior change
- Goal is compliance
- Health care professionals are the teachers

Self-Management Support

- Skills to solve pt. Identified problems are taught
- Skills are generalizable
- Assumes that confidence yields better outcomes
- Goal is increased self-efficacy
- Teachers can be professionals or peers

Self-Management Tasks in Chronic Illness

- ✓ To take care of the illness
- ✓ To carry out normal activities
- ✓ To manage emotional changes



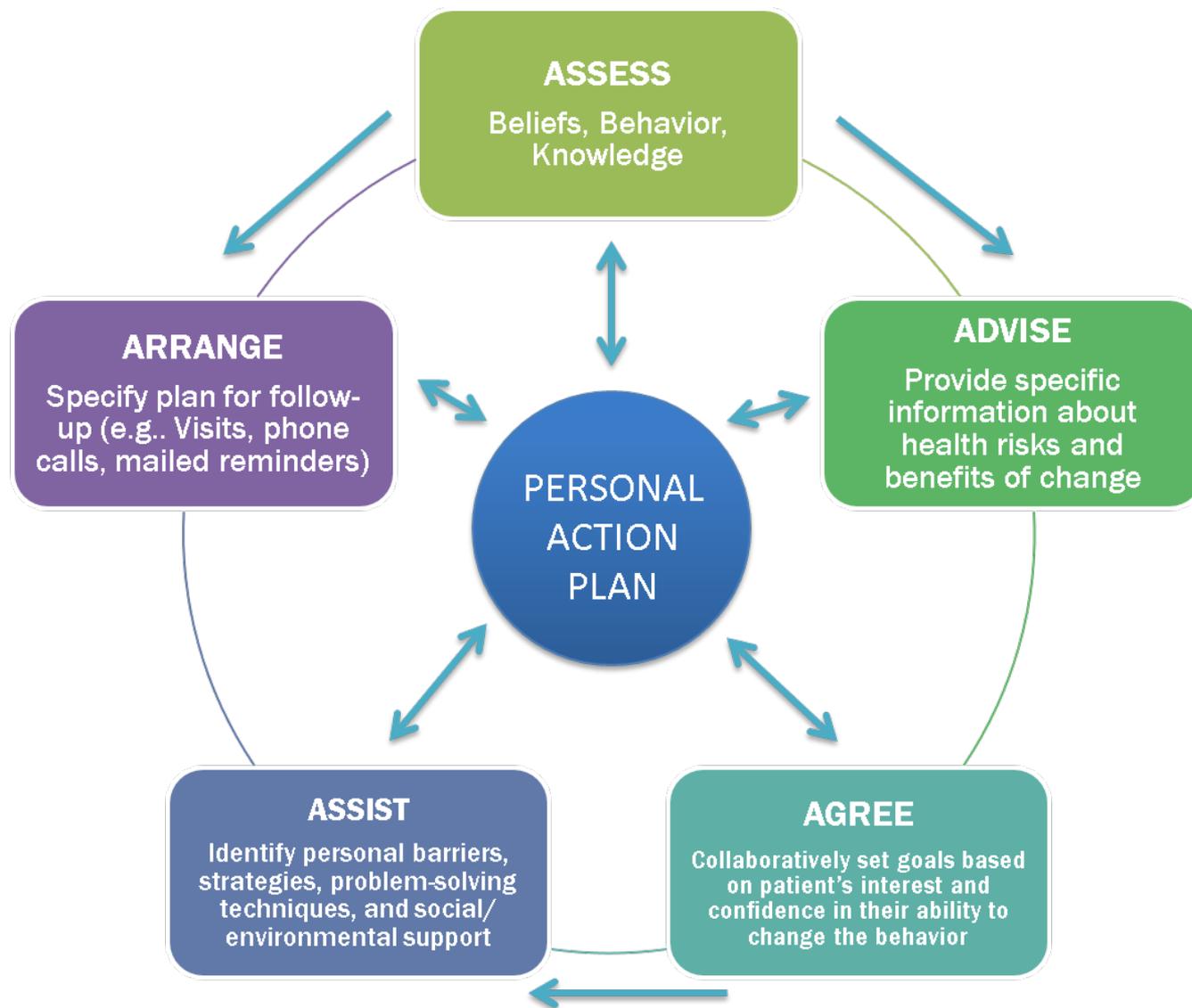
Collaborative care

“If physicians view themselves as experts whose job is to get patients to behave in ways that reflect that expertise, both will continue to be frustrated...Once physicians recognize patients as experts on their own lives, they can add their medical expertise to what patients know about themselves to create a plan that will help patients achieve their goals.”

It is not...



Self-Management in CCM



PERSONAL ACTION PLAN

1. List specific goals in behavioral terms
2. List barriers and strategies to address barriers
3. Specify Follow-up Plan
4. Share plan with practice team and patient's social support

Using the **Five A's**



ASSESS

Risk factors, Beliefs,
Behavior and
Knowledge

Tips on assessing



- ✓ Ask questions about them....get to “know” them
- ✓ Provide feedback to team when appropriate
- ✓ Assess their view of progress and how easy/difficult it is to get things done.



ADVISE

Provide specific information about the benefits of practice change

Tips on providing advice



- ✓ Make the source of advice clear
(medical knowledge or best practice)
- ✓ Personalize advice to the Health care environment
- ✓ Listen more than you talk
- ✓ Have a key message for each idea you present
- ✓ Don't overwhelm them with information



AGREE

Foster collaboration in
selecting ideas for
change.

Tips to create agreement

- ✓ Base goals and measures and patient's priorities
- ✓ Let them start where they want
- ✓ Do not judge ideas for change
- ✓ Do not make them agree with you
- ✓ Consensus on testing ideas is not critical unless there is obvious opposition or discomfort





ASSIST

Using behavior change techniques (problem solving, counseling) to aid the person in acquiring skills, confidence to test ideas quickly.

Tips on assisting patients



- ✓ Use other cases as examples
- ✓ Address helplessness
- ✓ Learn and use a problem-solving approach
- ✓ Link to the assessment of barriers and environment
- ✓ Avoid telling them what to do
- ✓ Avoid speeches
- ✓ Avoid cheerleading

Problem Solving

1. Identify the problem.
2. List all possible solutions.
3. Pick one.
4. Try it in the next testing cycle.
5. If it does not work, try another.
6. If that does not work, find a resource for ideas.
7. If that does not work, accept that the problem may not be solvable now.

Thoughts on Team QI Literacy

- ✓ People can read and function above their cognitive level on topics that interest them
- ✓ People are very sensitive about being talked down to.
- ✓ Be cognizant of power inequities





ARRANGE

Schedule follow-up contacts to provide ongoing assistance and support as needed.

Tips for follow-up



Helpful
Tips

- ✓ Try a wide variety of methods, whichever the patient prefers (in person, phone, email)
- ✓ Make sure follow-up happens, trust can be destroyed by missed follow-up
- ✓ Determine follow-up based on patient's preference

Personal Action Plan

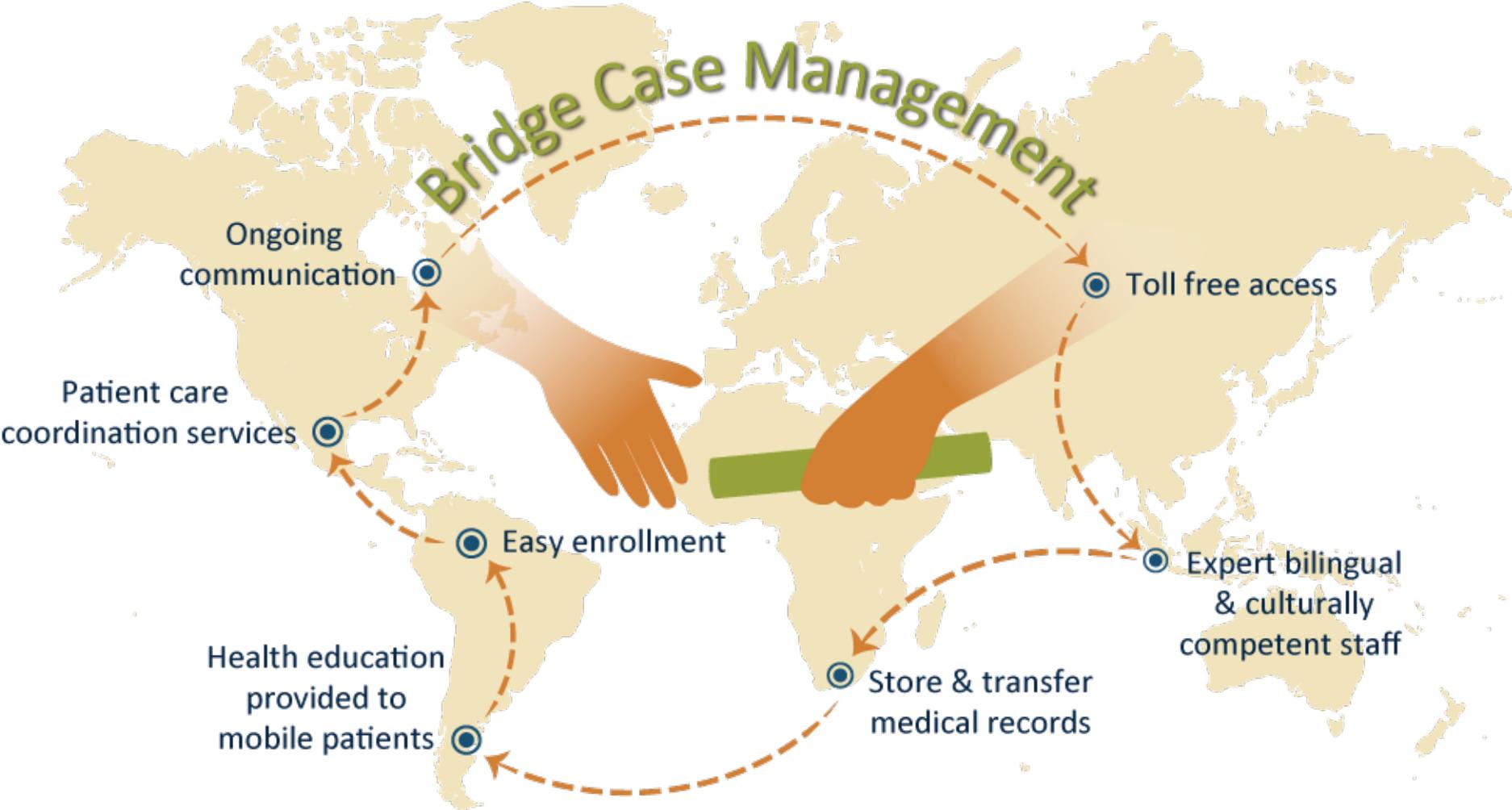
1. Something you WANT to do
2. Describe
 - How Where
 - What Frequency
 - When
3. Barriers
4. Plans to overcome barriers
5. Confidence rating (1-10)
6. Follow-Up plan

Health Network

Ensuring continuity of care through bridge case management



Bridge Case Management



Ask Yourself...

- Who will follow these patients if the results come back positive?
- How can these patients remain adherent while moving to a different state / country?
- How can I get completion results for patients that have started treatment?

Health Network IMPACT

- Bridge between patients and their providers
- Fewer patients lost to follow up
- Higher % of patients completing treatment
- Treatment completion reports
- Improved patient participation

Health Network Enrollment Criteria

1

Patient is:

- Already mobile OR
- Likely to move

2

Patient has:

- Active or latent tuberculosis
- Diabetes or pre-diabetes
- Been tested for or is at risk for breast, cervical or colon cancer
- Is pregnant and needing prenatal care
- In need of a clinic for follow-up of Chronic condition



MCN's Health Network does not discriminate...

MCN's Health Network does not discriminate on the basis of immigration status and will not share personal patient information without patient permission

Tools for Maintaining a Patient in Care

<p>ATTENTION PROVIDERS: This client is a user of the MCN Health Network. MCN can help you access:</p> <p>ATENCIÓN PROVEEDORES: Este paciente es usuario de la Red de Salud MCN. MCN les puede ayudar a encontrar:</p> <hr/> <p>This patient's medical record • <i>El expediente médico de este paciente</i> This patient's lab results • <i>Los resultados de laboratorio de este paciente</i> Financial assistance for his/her health care • <i>Ayuda económica para el cuidado de su salud</i></p> <p>This is a free service. • <i>El servicio es gratis.</i></p> <p>Call 1-800-825-8205 De México 01-800-681-9508</p>	<p>MCN Health Network</p> <hr/> <p>Medical Records and Care Coordination Card <i>Tarjeta de Expedientes Médicos y Coordinación de Salud</i></p> <p>1-800-825-8205 De México 01-800-681-9508 www.migrantcliniclan.org</p> <p>THIS IS NOT A MEDICAL INSURANCE CARD. <i>Esta no es una tarjeta de seguro médico.</i></p>
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Make sure patients have the HN toll free number:

800-825-8205

or

+01-800-681-9508 if calling from Mexico

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