Continuity of Care for Mobile Patients with HIV/AIDS

Presenters: Deliana Garcia, MA
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Deliana Garcia, MA
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Media Campaigns

Fighting for an AIDS Free Generation by (2015)

The Beginning of the End of AIDS

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

HIV Testing
- Aware of HIV status but not in HIV medical care (not referred to care, did not attend initial visit)

Linkage to HIV Medical Care
- Receiving medical care but not HIV care

Retention in Care
- Received initial HIV medical care visit
- Received first set of follow up HIV medical care visits

Re-engagement in Care
- Lapse in HIV medical care
- Resumed medical care after lapse

In long-term, continuous HIV medical care
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

"Le SIDA disparaîtra un jour...
En attendant nous avons l'opportunité d'apprendre et de grandir....
Et nous devons le faire!"

-Pon Farha
(1958-1993)
Fondateur, Fondation Farha

Credit: Gabriel Girard, University of Montreal
Structural Factors that Create Barriers to Retention in Care

- Rural settings
- Transportation
- Food insecurity
- Work
- Child-care responsibilities
Competing Forces

Goal of Health Centers

- Assist patients in obtaining better care
- Lower health care costs
- Reduce disparities in health
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”? 

- **Patient/Family** 
  - High 
  - Low 

- **The “System”** 
  - Low 
  - High 

**Acuity**
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
“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

- Personal Clinician
- Clinician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety are hallmarks of the medical home:
- Enhanced access to care
- Payment
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?

- Referral tracking and follow-up
- Support Self-Care services that are in reach
- Easy access to care
- Care management that is “mobile-friendly”
- Measure special population needs
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

Community
- Resources and Policies
  - Self-Management Support

Health Systems
- Organization of Health Care
  - Delivery System Design
  - Decision Support
  - Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

Developed by The MacColl Institute
© ACP-ASIM Journals and Books
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.”

Barlow et al, Patient Educ Couns 2002;48:177
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

Based on work by Corbin and Straus
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.”

Funnell & Anderson  JAMA 2000;284:1709
It is not...
Self-Management in CCM

**ASSESS**
Beliefs, Behavior, Knowledge

**ARRANGE**
Specify plan for follow-up (e.g. Visits, phone calls, mailed reminders)

**ADVISE**
Provide specific information about health risks and benefits of change

**ASSIST**
Identify personal barriers, strategies, problem-solving techniques, and social/environmental support

**AGREE**
Collaboratively set goals based on patient’s interest and confidence in their ability to change the behavior

**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 then 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**

- Try a wide variety of methods, which ever 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

Source: Lorig et al, 2001
Health Network
Ensuring continuity of care through bridge case management
Bridge Case Management

- Ongoing communication
- Patient care coordination services
- Easy enrollment
- Health education provided to mobile patients
- Store & transfer medical records
- Expert bilingual & culturally competent staff
- Toll free access
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 on the basis of immigration status and will not share personal patient information without patient permission.
Tools for Maintaining a Patient in Care

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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