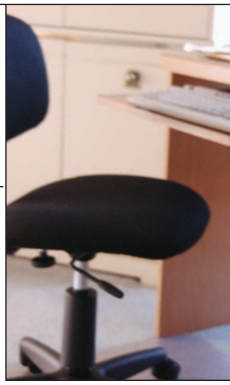
HIV CARE COORDINATOR 17

The HIV Care Coordinator is an individual level intervention designed to maintain a coordinated care plan for all persons living with HIV who are clients of the medical center. The key characteristics of the HIV Care Coordinator are: the ability to maintain and coordinate communication between the person living with HIV and the clinical treatment team; and the HIV+ person's on-going, easy access to the HIV Care Coordinator for crisis services and routine assistance in addressing HIV related medical care needs.

CURRENT ACTIVITY SETTING

Veterans Affairs Medical Center
Infectious Disease Clinic

- ✔ **Directly links the client to medical care**
- **Gets the client in a conversation about starting medical care**
- **Brings the agency closer to where HIV+ people are so that the conversation can begin**



I. Description

OBJECTIVES

- To provide and sustain comprehensive and extensive care to the HIV+ patient
- To coordinate the health care for the HIV+ patient between sections/units of the hospital and between the disciplines of professional staff

TARGET AUDIENCE

- HIV+ male or female veterans who are receiving HIV specific medical care
- Male or female veterans recently diagnosed with HIV

ACTIVITY DESCRIPTION

The HIV care coordinator is responsible for managing the HIV+ patient's primary and HIV related medical care plan, offering the possibility for the client to have the best, most consistent, and non-fragmented medical care possible within the hospital care system. The HIV care coordinator also plays an important role with the general hospital staff by helping to educate them about HIV infection and helping to understand their important role in an HIV+ patient's global health care. The HIV care coordinator is the "central figure" for the HIV+ patient.

QUICK NOTES:

"The target population for our service is also the rest of the staff at the hospital. Having a coordinated staff can influence the care of a patient."

— NURSE PRACTITIONER, WEST PALM BEACH, FLORIDA

How a person first contacts the HIV care coordinator:

- Every day, the HIV care coordinator runs a report from the database of all the positive HIV test results given within all departments of the medical center.
- When a positive result is spotted, the coordinator contacts the staff person within the center who ran the HIV test.
- The post-test counselor is contacted within 24 hours from the respective department to ensure that the patient knows their test results, and then a call is made to the infectious disease clinic to convey the results.
- During the post-test counseling session, the counselor asks permission from the patient to make an appointment that same day to see the HIV care coordinator in the infectious disease clinic. (The coordinator always leaves "open time" in his or her daily agenda for possible "walk in" cases.)
- If the patient arranges to see the HIV care coordinator, the coordinator performs a half-hour prescreening: history of risk activities and former diagnosis of HIV, demographic information, and vital statistics. All the data about the patient are housed in a computer program located in the HIV care coordinator's office.
- The HIV nurse practitioner then sees the patient and completes all parts of the formal intake process. The formal intake process consists of doing a full sexual history, a full drug history, a test for Hepatitis A, B, and C, and an explanation of viral load and CD_4 cell counts, and an explanation of the basic concepts of antiretroviral treatment.
- The HIV care coordinator does the basic blood work and schedules a follow-up appointment to see the patient in 3 to 4 weeks after the initial appointment.
- The patient is given a print out of the appointment date, the phone number of the coordinator, and other support service numbers.
- A letter is sent out from the coordinator to the patient two weeks before the appointment. A telephone call reminder is also placed 48 hours before the appointment.
- During this follow-up appointment, the coordinator reinforces the educational information and goes over the therapy regimen, if required.
- For the follow-up, or second appointment, the HIV nurse takes the patient's vital signs and asks what observations the patient may have about his or her health.
- The patient then spends time with the HIV clinician to discuss, among other issues, the potential need to begin an antiretroviral regimen.
- If the patient needs to begin antiretroviral medication, they are asked to come back in 3 weeks for a follow-up visit. The HIV care coordinator begins to be available to answer questions, schedule the patient's appointments, send reminder letters, and coordinate with any other hospital service necessary according to the needs of the individual patient.
- The HIV care coordinator runs "lost follow-up" reports every month to track patients who are "lost" in their follow-up schedules. The clinic has a tracking system which allows the coordinator to know when 3 and 6 months have gone by without seeing a particular patient.
- The HIV care coordinator will be actively involved in the person's HIV related healthcare as long as they are clients of the hospital.

PROMOTION OF ACTIVITY

- For patients, this is promoted through the education department's materials of the hospital.
- For health professionals, promotion and education about this activity is given during the employee orientation at the time of hiring, or during the "annual update" session on the hospital's programs and services.

II. Logistics

STAFF REQUIRED

- HIV care coordinator (a registered nurse)
- HIV nurse practitioner
- Social Worker
- Case Manager
- Clinician

TRAINING & SKILLS

The staff needs to have experience working with HIV and HIV specialized medical training.

PLACE OF ACTIVITY

- Private office or exam room (There is not always a closed door, since some veterans cannot be in small closed places.)

FREQUENCY OF ACTIVITY

The frequency could range from every 2 weeks to every 3 months depending on the patient's health care needs.

OUTSIDE CONSULTANTS

None

SUPPORT SERVICES

- Transportation services
- Translation services

CONDITIONS NECESSARY FOR IMPLEMENTATION

- A caring staff
- The coordinator has to demonstrate commitment and responsibility to go beyond what is written in the job description.

III. Strengths and Difficulties

STRENGTHS

- A commitment to the patient
- Kindness towards the patient
- Consistent and non-fragmented health care
- Good relationships among staff (The office is closed from 12 to 1 for staff to eat lunch together.)

WEAKNESSES

A lack of support groups for the patients

DIFFICULTIES FOR CLIENTS

There is sometimes an inability on the patient's part to follow through on their care because of the emotional impact the HIV diagnosis has had on their life.

DIFFICULTIES FOR STAFF

The patient's reluctance to follow through on their health care

OBSTACLES FOR IMPLEMENTATION

Lack of coordination within the greater community's health network for other HIV related services

NON-APPROPRIATE CLIENTS

None

IV. Outcomes

EVIDENCE OF SUCCESS

There is a 90% success rate of completion of scheduled appointments. Before the HIV care coordinator position was created, only 65 to 70% of patients followed through on their appointment schedules.

UNANTICIPATED BENEFITS

- The activity promotes overall well-being because the coordination of the care program manages both primary and HIV related healthcare.
- The activity incorporates comprehensive care; clients are monitored for diabetes, high blood pressure, and other diseases, if applicable.
- It creates a very caring environment for both patients and staff.

"CONNECTING TO CARE" ELEMENT OF ACTIVITY

A key part of activity is minimizing the number of steps necessary to achieve the quality of care for the HIV+ patient. There is a strong belief in the non-fragmentation of health care.

EVALUATION

- Weekly, sometimes bi-weekly, staff meetings
- Quality assurance reports
- Monthly meeting discussing the current reports

KEEP IN MIND...

- Put your activity plan on paper.
- Set up a timeline of how you expect the patient's care to "flow" over a course of time.
- Educate patients on what they can expect from the clinic in the coordination of their care.
- Try to create a very relaxed atmosphere for the patient's first visit, no "rushing and bustling;" try to offer calm and peace.

CONNECT TO:
- WEST PALM BEACH AT A GLANCE: P. 43
- OTHER INDIVIDUAL ACTIVITIES: PP. 49, 85, 97, 103, 115, 121, 127, 139

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