HIV for PCAs Office Hours Series
Office Hours 3: Care Coordination for HIV+ Patients (January 8, 2015)

Faculty
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Key Points
- **Health centers do not need to receive Ryan White funding to effectively serve their HIV+ patients.** Health centers can implement systems to coordinate the care for their HIV+ patients without becoming a Ryan White-funded entity through effective community partnerships. For example, Piedmont Health Services’ model allows the health center to care for the primary care and HIV needs of a segment of its stable HIV+ patients through a partnership (including payment for lab costs) with a Ryan White-funded infectious disease provider group at an academic institution.

- **Early treatment is one of the best methods of the prevention of the transmission of HIV.** A comprehensive screening and care coordination program at the health center can mean a quickly-controlled viral load and stabilized CD4 count for a newly diagnosed patient. In turn, the patient’s health is improved and the risk of transmission to partners is significantly decreased.

- **Critical components of a successful care coordination system** include a well-trained provider staff and care team, care management by a designated care manager, partnerships with infectious disease providers, and partnerships with a network of organizations serving patients' various psychosocial needs.

Takeaways
- **Receiving HIV care in the primary care setting helps to reduce barriers to care and supports coordination.** When patients can receive the majority of their care in the community health center setting that is familiar to them, they avoid some of the barriers that make it difficult to seek and achieve care in other settings. These barriers can include securing transportation to distant infectious disease clinics; the stigma of visiting an infectious disease provider (primarily provides HIV care) as opposed to a measure of discretion allowed from visiting a health center (provides a variety of care and other services); and a missed opportunity to engage with the trusted and familiar health center care team. The care management and care coordination offered by a health center can further prevent patient disengagement.

- **Engaged providers and care teams support patient care.** In Family First Health’s model, providers who work with HIV+ patients are expected to have at least 20 HIV+ patients in their panel in order to remain attuned to the needs of this population. At Piedmont Health Services, the primary care team determines patient stability and the need for an HIV+ patient’s referral to an infectious disease provider or other specialist or resource. Additionally, Karen McCraw noted that her staff develop their HIV care skills through free trainings and resources, some of which are listed below.

Additional Resources
- Staff training, patient education materials, and other resources from local, state, and regional AIDS Education and Training Centers (AETCs).
- **Partnerships for Engaging in the Development of Community-Based Systems of Care**, NACHC.
- HIVClinician.org, a new resource from HIVMA (HIV Medicine Association) including guidelines, billing and coding resources, and partnership resources.
- **HIV Care Continuum** published December 2014), CDC.
- **HIV Care Saves Lives** (published November 2014), CDC.

Questions? For more information, contact Ashley Barrington at abarrington@nachc.com