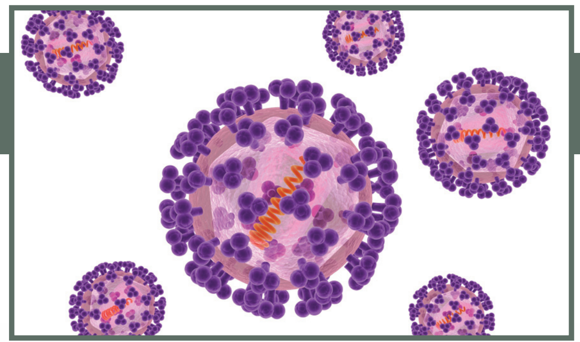
HIV / AIDS



Introduction

On June 5, 1981, the first cases of a new and fatal disease now known as acquired immunodeficiency syndrome (AIDS) were reported by the Center for Disease Control and Prevention (CDC). At that time the only treatment for HIV/AIDS was palliative care and tying to ward off opportunistic infections.

More than 30 years later, we have seen a dramatic decrease in HIV-related morbidity and mortality. This is due to extensive research and the development of combination antiretroviral therapy, also known as highly active antiretroviral therapy or HAART. A recent study indicates that these HIV/AIDS drugs saved three million years of life in the United States. Today, HIV/AIDS is no longer an acute illness but a chronic condition that must be monitored and managed in many of the same ways as other chronic illnesses.

For several factors, Care Coordination can be an effective strategy for improving the lives of people living with HIV. These factors include the many thousands of people who have been diagnosed with HIV/AIDS but are not in treatment, patients' struggles with medication and treatment adherence, the need to ensure equal access to care and treatment, and the demand for cost efficiencies. eQHealth's approach to HIV/AIDS Care Coordination addresses these factors by centering on three main goals:

1. Increase the quality and length of life for persons with HIV/AIDS
2. Empower individuals with HIV/AIDS to remain self sufficient for as long as possible
3. Reduce the transmission of HIV/AIDS to others

Care Coordinators serve as the day-to-day facilitator of an interdisciplinary team that assists the individual in navigating the health care system, sorting through medical data and assisting then with social barriers and stigmas that can contribute to poor health outcomes.

Program Objectives

- Participant achievement of optimal health through the administration of a health risk assessment (HRA) and disease specific assessments, self care education, coaching and behavior modification, wellness screenings, in person and telephonic on-going engagement and resolution of barriers to care.
- Improve each participant's ability to best navigate the health care system.
- Early identification of participants for intervention by Care Coordination staff.
- Promote a multidisciplinary approach to care of the high risk population.
- Linking participants to health care and support services.
- Create and strengthen the relationships between the participant, the physician and the Care Coordinator.
- Promote adhernce to the recommended drug therapy, HAART.
- Improve participant quality of life.
- Develop a network of community resources for patients to use to address socio-economic barriers.

HIV / AIDS (continued)

- Promote physician understanding and adherence to nationally recognized standards of care.
- Reduce variation in treatment by monitoring and evaluating phyisician prescribed treatment plans against national standards and provider peers.
- Demonstrate cost savings related to the integrated Care Coordination program.

Program Inclusion Criteria

- New Diagnosis of HIV/AIDS
- Current Diagnosis of HIV/AIDS AND at least one of the following:
  - No record of care within the last 6 months
  - Sporadic care
  - History of non-adherence to Anti-Retroviral Therapy (ART)
  - First time on an ART therapy or a recent change in ART therapy
  - ART therapy with treatment failure and/or drug resistance

Program Interventions

- Participant identification
- Participant stratification (based on internal data logic)
- In-person participant assessments (to identify participant issues)
- Ongoing participant follow up care (both in-person and telephonic)
- Care Transitions for hospitalized participants
- Development of an individualized, participant-centered plan of care
- Referrals to specialist or identified medical services when indicated
- Use of behavior change and motivational interview models of delivery
- Measurement of program outcomes