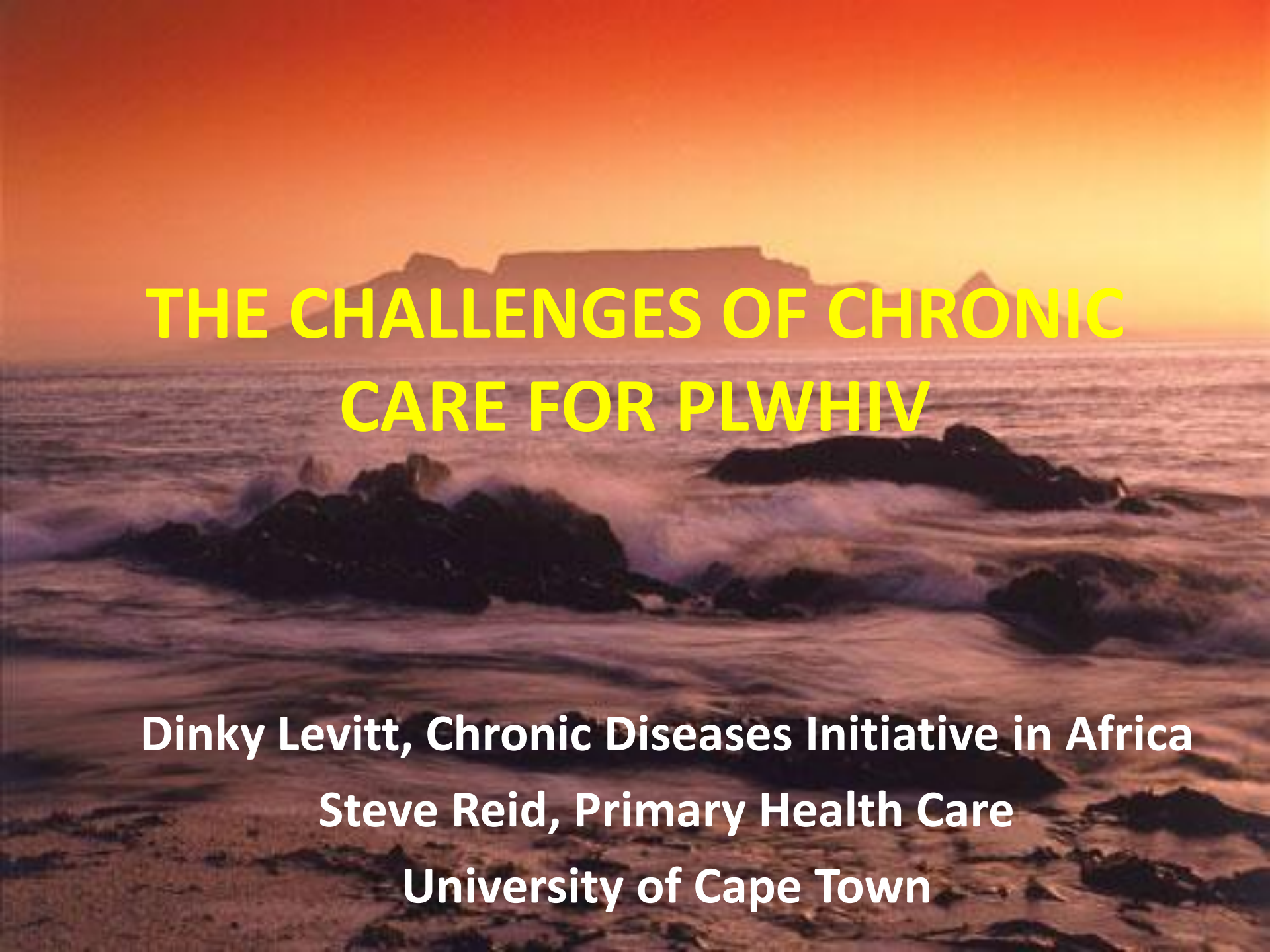


THE CHALLENGES OF CHRONIC CARE FOR PLWHIV

Dinky Levitt, Chronic Diseases Initiative in Africa
Steve Reid, Primary Health Care
University of Cape Town

Shifts in health care in SA

• HIV and AIDS	➪ Chronic disease
• Small numbers	➪ Huge numbers
• Individual patient	➪ Population-based planning
• Disease-based	➪ Comprehensive care
• Episodic care	➪ Continuity of care
• Referrals/discharges	➪ Coordinated care
• Passive patients	➪ Activated community
• One size fits all	➪ Risk categorization

Key issues in health systems for chronic disease management

1. Population-based planning
2. Comprehensive care
3. Continuity of care
4. Coordination of care
5. Risk stratification
6. Activated patients & communities
7. Outreach and support
8. Teaching, training and mentoring
9. Analyzing and using information
10. Quality improvement programme

CHRONIC CONDITIONS

- ***TRADITIONALLY NCDs***
  - Diabetes
  - Hypertension
  - Cancers
  - Cardiac disease
  - Lung disease eg asthma/COPD

CHRONIC CONDITIONS

- ***NOW EXTENDS TO***
  - **Persistent communicable diseases**
  - Mental Illnesses
  - Physical impairments & disabilities

WHAT WE FOCUS ON AS CLINICIANS especially in chronic disease settings

- ***Person in front of us***
  - Disease status and control
  - Level of functioning within self
    family and home
    community
    work environment

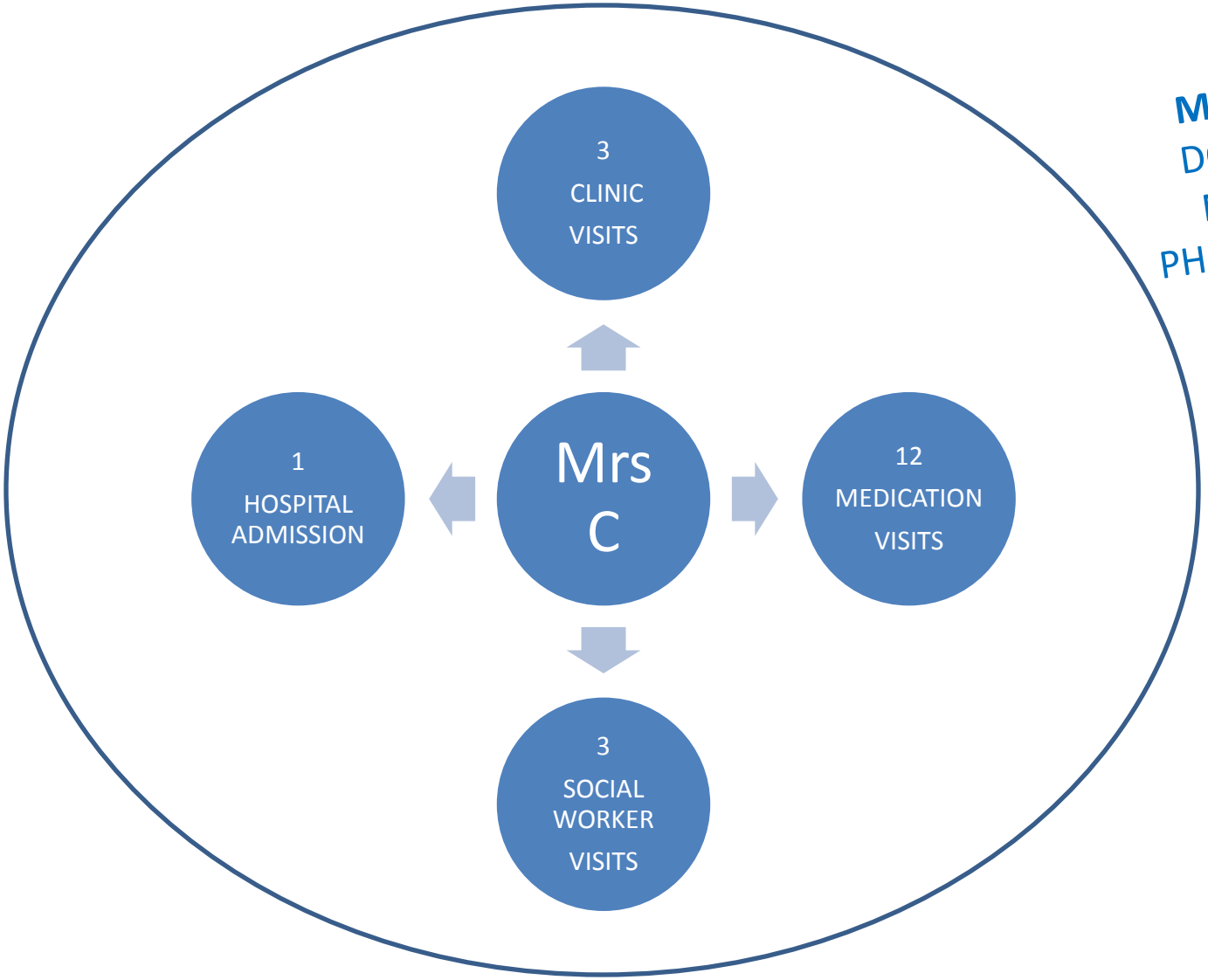
WHAT WE DO NOT FOCUS ON AS CLINICIANS

THE BIGGER PICTURE

THE “SOCIAL DETERMINANTS”

THE HEALTH SYSTEM

THE PAST YEAR



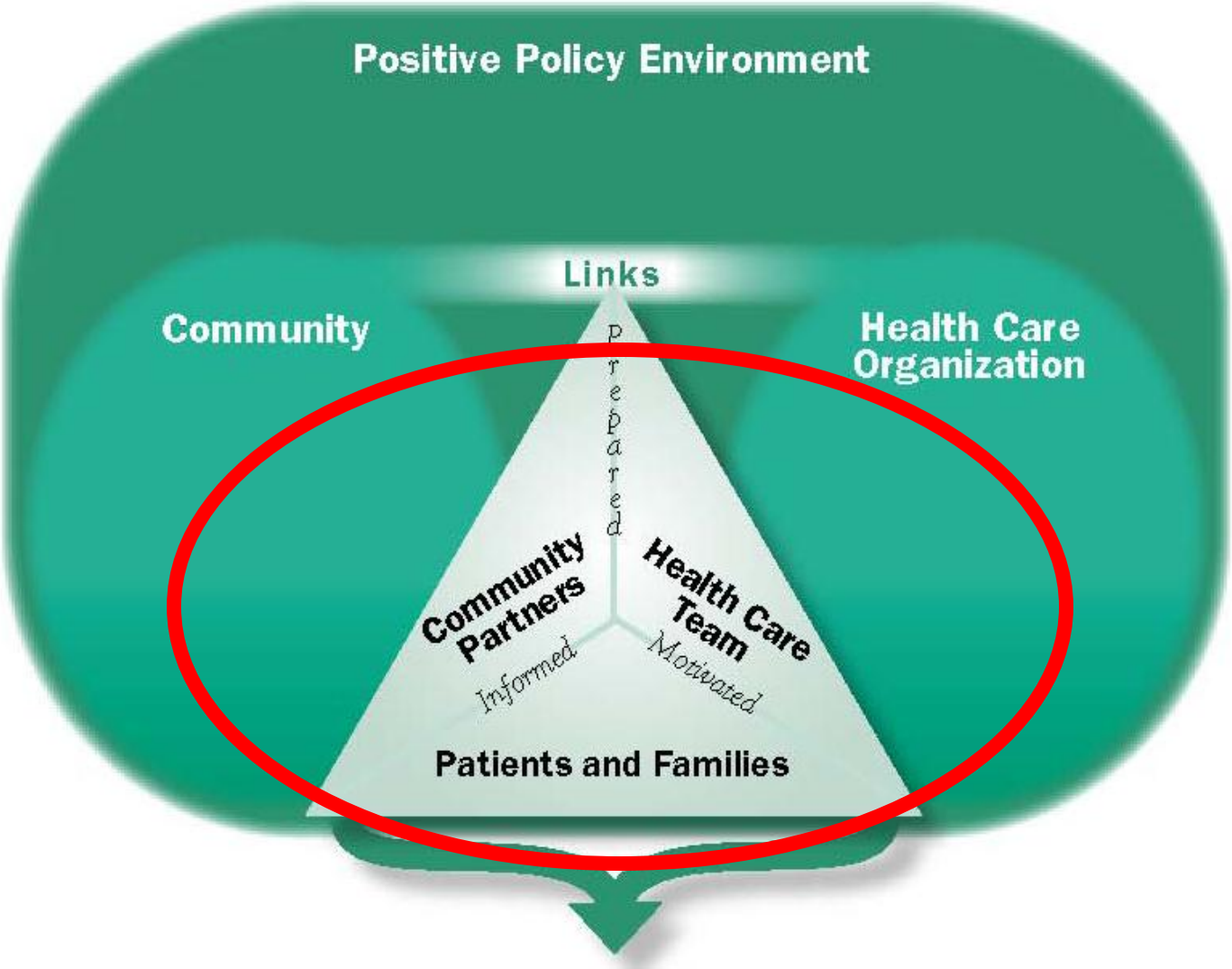
MULTIPLE
DOCTORS,
NURSES,
PHARMACISTS
SOCIAL
WORKERS
PHYSIOS

EXPERIENCE OF HEALTH SYSTEM BY FAMILY AND PATIENT

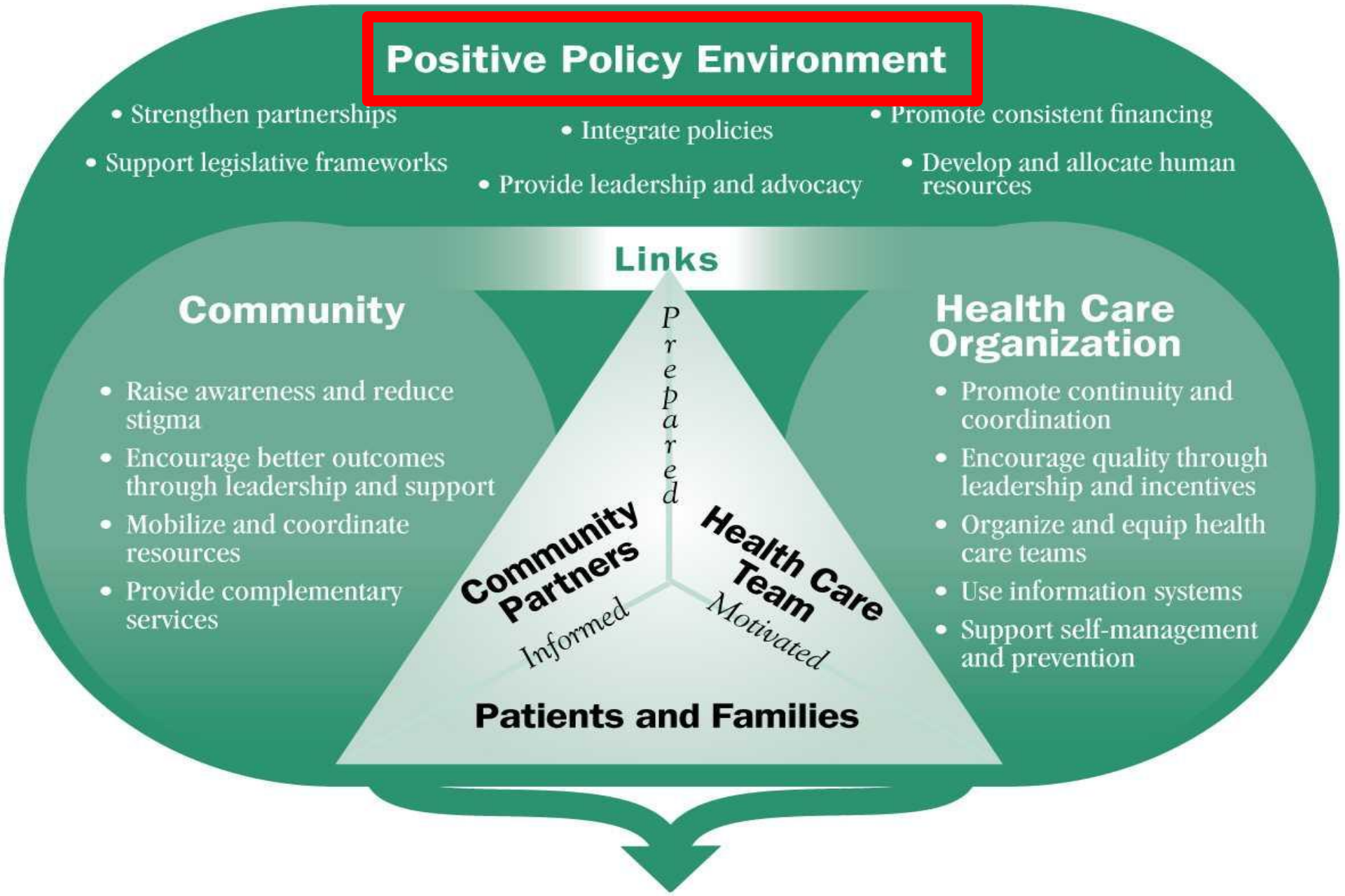
- Fragmented
- Discontinuous
- Difficult to access
- Inefficient
- Uncaring staff

WHAT OF THE ICCC MODEL FOR LONG TERM CARE FOR PLWHIV ON ART ?

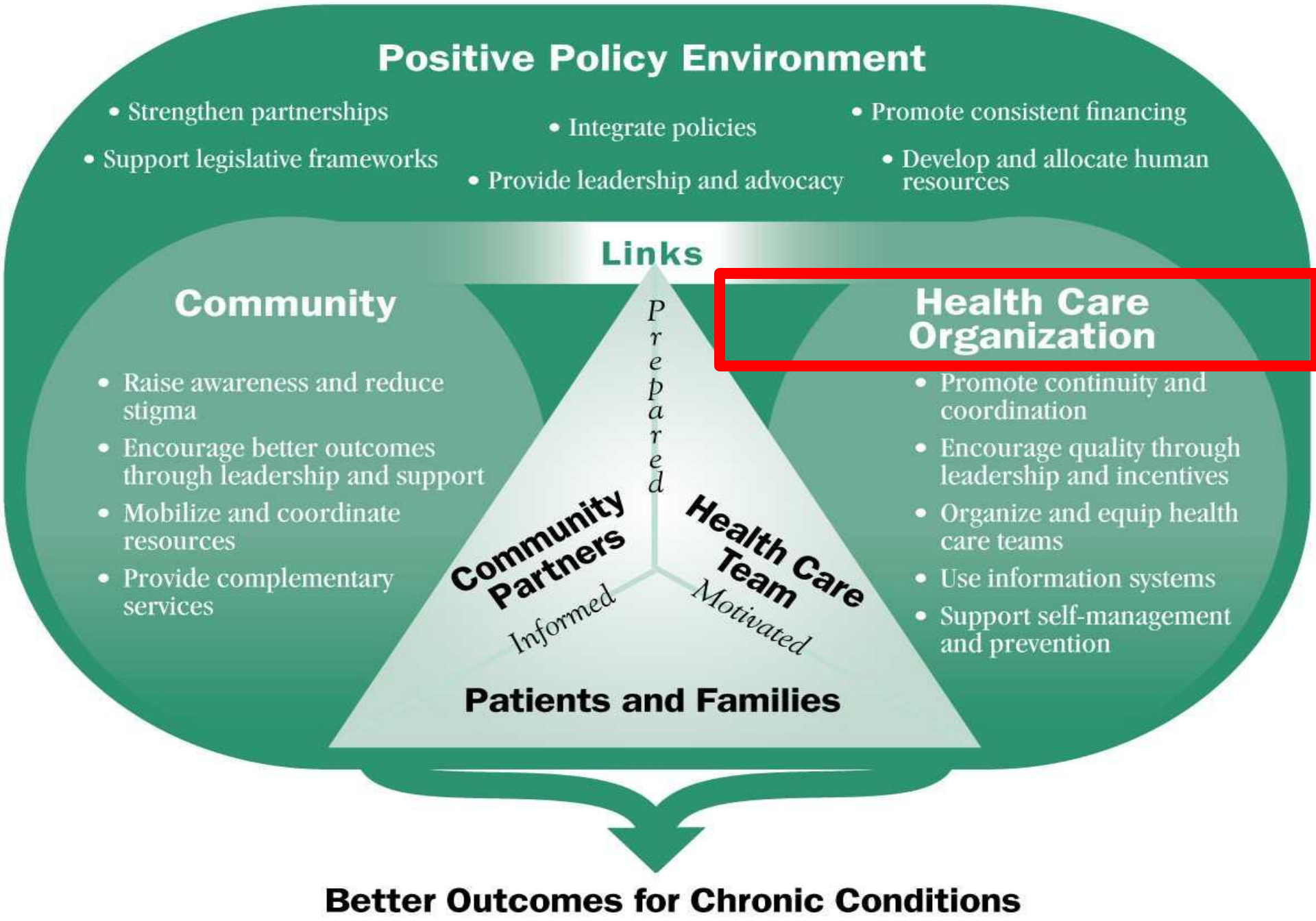
INNOVATIVE CARE FOR CHRONIC DISEASES MODEL



Innovative Care for Chronic Conditions Framework



Innovative Care for Chronic Conditions Framework

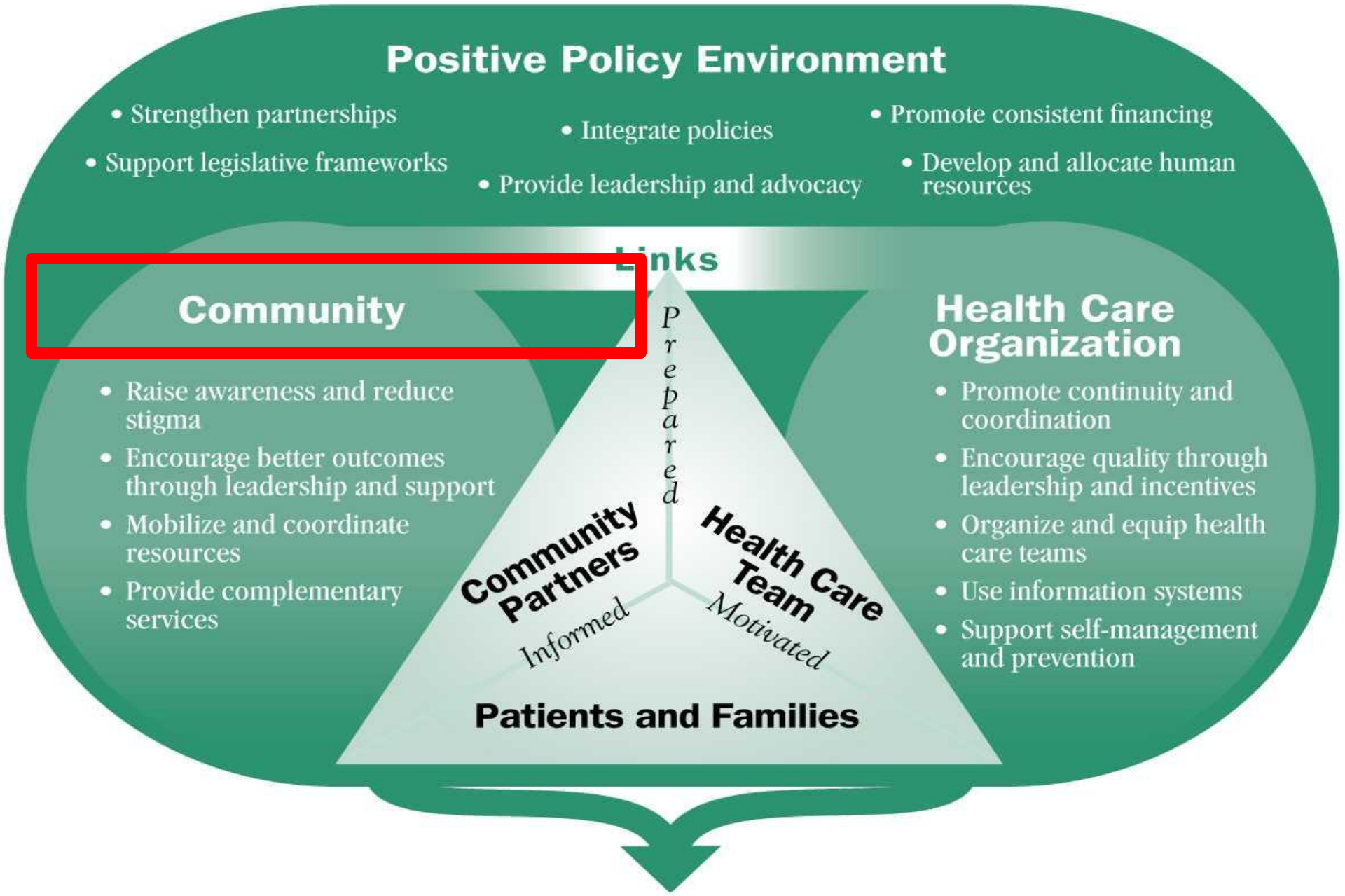


CLINIC INFORMATION SYSTEM

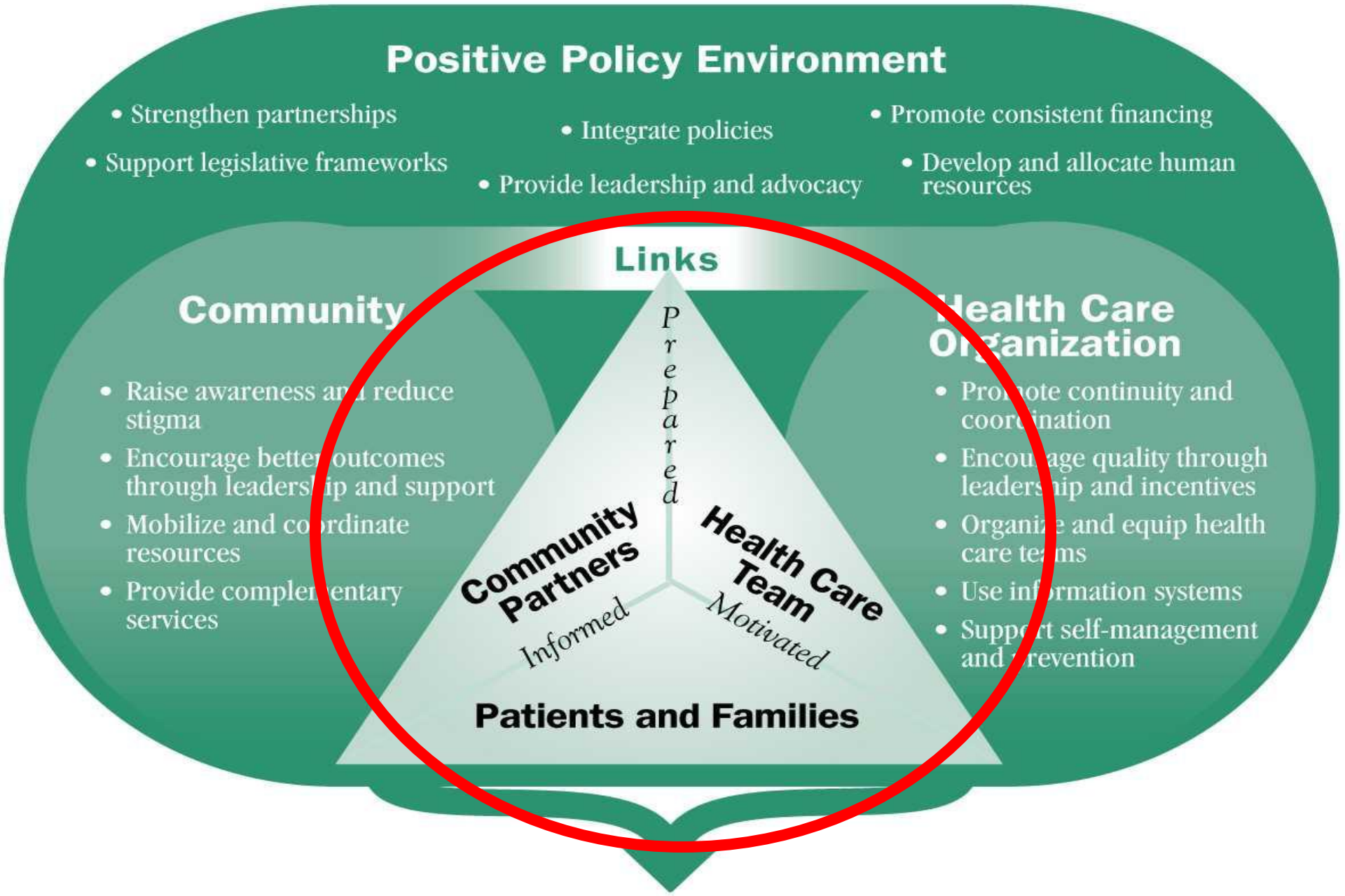
Type of registration and recall

- Registers
  - Book based
  - Electronic
- Reminders
  - Appt cards
  - Mobile phone
  - Home visits
- Recalls
  - Mobile phone
  - Home visits

Innovative Care for Chronic Conditions Framework



Innovative Care for Chronic Conditions Framework



PREPARED, INFORMED AND MOTIVATED PATIENTS AND FAMILIES

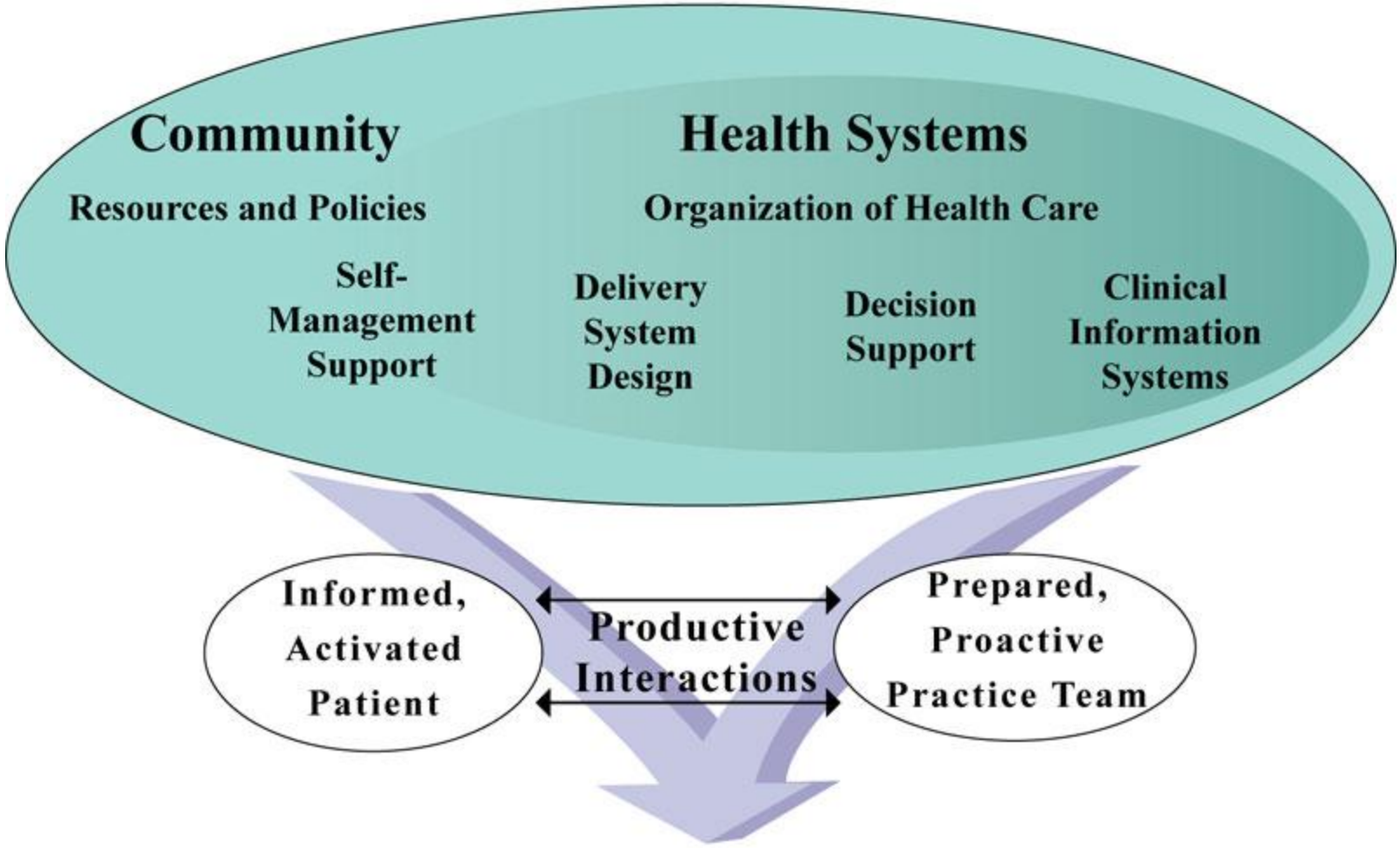
Need three fundamentals to manage and prevent chronic conditions.

- ***To be informed about their chronic conditions*,**
  - **the expected course and complications**
  - **effective strategies to prevent complications and manage symptoms.**

- ***Motivation to change and maintain daily health behaviours, adhere to long-term therapies, and self-manage their conditions.***

- ***To be prepared with behavioural skills to manage their conditions at home.***
  - **includes having the necessary medications and medical equipment, self-monitoring tools, and self-management skills**

The Chronic Care Model



Improved Outcomes

What Characterises an "Informed, Activated" Patient?

Informed, Activated Patient

- Patient understands the disease process
- Patient realizes his/her role as the daily self manager.
- Patient uses knowledge to engage with providers in care options.
- Patient regards provider as a guide, not a sage
- Family and caregivers are involved in the patient's self-management.

What Characterizes a "Prepared" Heathcare Team?

To deliver the best possible, patient-centered care, the team must have:

- Patient information readily available
- Efficient care strategy tailored for that patient
- Right people to see the patient
- Correct equipment
- Sufficient (not too much) time

Key issues in health systems for chronic disease management

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Population-based planning

- District population = 1 million
- 10% HIV prevalence = 100 000 HIV+
- 25% CD4<200 = 25 000 require ARVs
- 15 000 pts enrolled in Rx = 10 000 unreached

Barbara Starfield: The Three C's that make a difference in primary care

- Comprehensiveness
- Continuity
- Coordination

AN EXAMPLE FROM TANZANIA

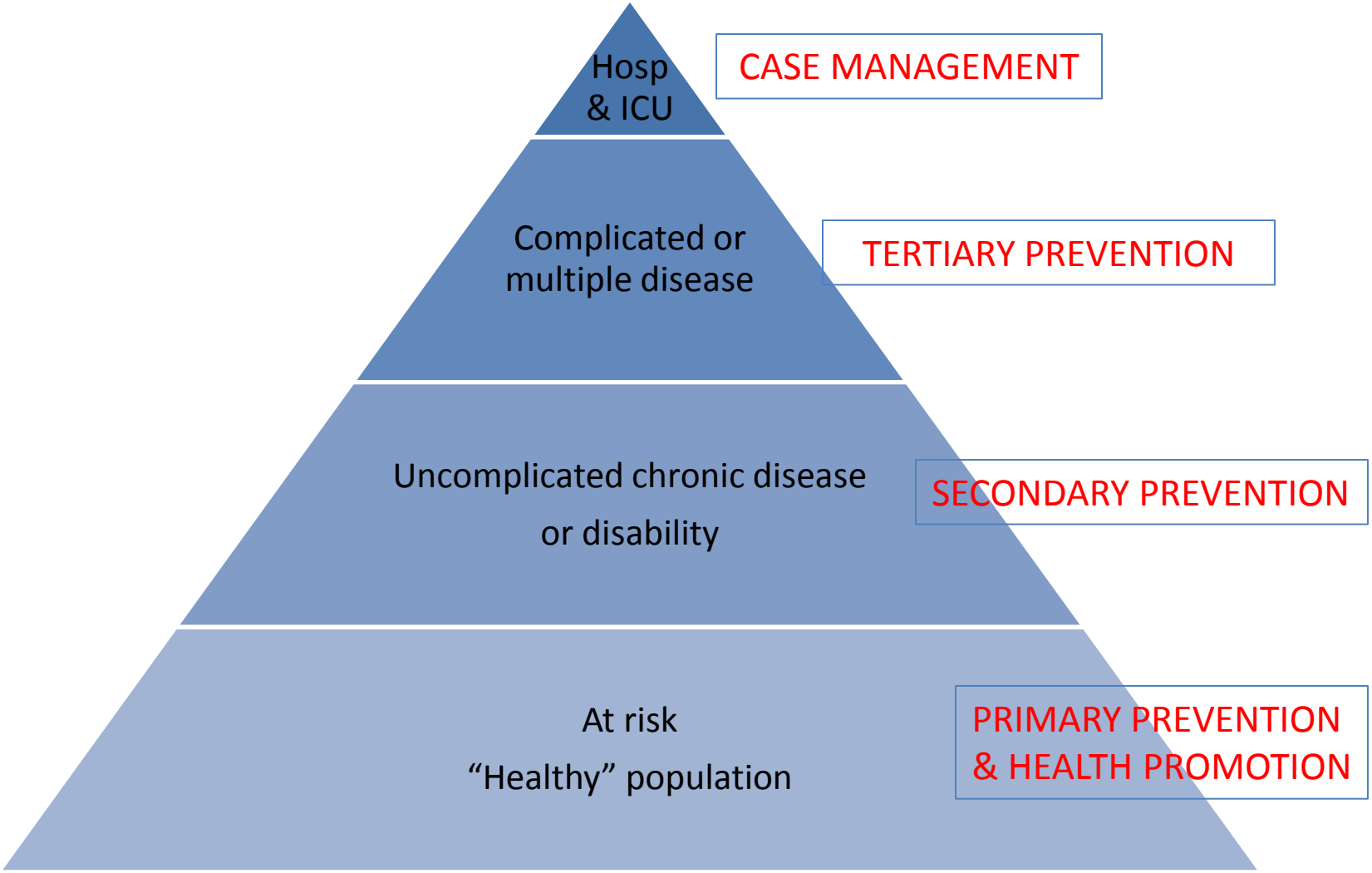
ROUTINE CARE CLINIC

HIV CLINIC

Barbara Starfield: The Three C's that make a difference in primary care

- Comprehensiveness
- Continuity
- Coordination

Risk stratification



Score your system

Principle	Your score -2 -1 0 +1 +2	Actions
Population-based planning		
Comprehensive care		
Continuity of care		
Coordination		
Risk stratification		
Activated patients & communities		
Outreach and support		
Teaching, training and mentoring		
Analyzing and using information		
Quality improvement programme		

MAJOR QUESTION FOR CHRONIC HEALTH CARE FOR THE FUTURE

- Are the current systems ideal and or sustainable?
  - Vertical programme for PLWHIV
  - Vertical programme for TB
  - Or combined programme for PLWHIV and TB
  - Separate programme for NCDs and the acute conditions at primary level

CAN WE AFFORD NOT TO INTEGRATE?

INTEGRATED PROGRAMME FOR CHRONIC DISEASES

- Needs of people with chronic diseases - PLWHIV and NCDS similar
- Health care organisational factors have similar requirements
- Increasing risks of NCD co-morbidity in PLWHIV
- Development of common tools with specific elements where needed
- Government is interested in this approach


THANK YOU