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
- Small numbers
- Individual patient
- Disease-based
- Episodic care
- Referrals/discharges
- Passive patients
- One size fits all

- Chronic disease
- Huge numbers
- Population-based planning
- Comprehensive care
- Continuity of care
- Coordinated care
- Activated community
- 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

1 HOSPITAL ADMISSION

3 CLINIC VISITS

Mrs C

3 SOCIAL WORKER VISITS

12 MEDICATION VISITS

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

Positive Policy Environment

Links

Community Partners
Community

Health Care Team
Health Care Organization

Patients and Families

Prepared

Informed

Motivated
Innovative Care for Chronic Conditions Framework

Positive Policy Environment
- Strengthen partnerships
- Support legislative frameworks
- Integrate policies
- Provide leadership and advocacy
- Promote consistent financing
- Develop and allocate human resources

Community
- Raise awareness and reduce stigma
- Encourage better outcomes through leadership and support
- Mobilize and coordinate resources
- Provide complementary services

Health Care Organization
- Promote continuity and coordination
- Encourage quality through leadership and incentives
- Organize and equip health care teams
- Use information systems
- Support self-management and prevention

Links
- Community Partners
- Informed
- Community
- Health Care Team
- Motivated
- Health Care Organization
- Patients and Families

Better Outcomes for Chronic Conditions
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

Positive Policy Environment
- Strengthen partnerships
- Support legislative frameworks
- Integrate policies
- Provide leadership and advocacy
- Promote consistent financing
- Develop and allocate human resources

Links
- Community
- Health Care Organization

Links
- Patient and Partners
- Health Care Team

Better Outcomes for Chronic Conditions
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

Community
- Resources and Policies
- Self-Management Support

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

Improved Outcomes
- Informed, Activated Patient
- Prepared, Proactive Practice Team
- Productive Interactions

Developed by The MacColl Institute
© ACP-ASIM Journals and Books
What Characterises an “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” Healthcare 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

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
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 unreachable
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

- **At risk**
  - “Healthy” population
  - **PRIMARY PREVENTION & HEALTH PROMOTION**

- **Uncomplicated chronic disease or disability**
  - **SECONDARY PREVENTION**

- **Complicated or multiple disease**
  - **TERTIARY PREVENTION**

- **Hosp & ICU**
  - **CASE MANAGEMENT**
Score your system

<table>
<thead>
<tr>
<th>Principle</th>
<th>Your score</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population-based planning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continuity of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk stratification</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activated patients &amp; communities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outreach and support</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teaching, training and mentoring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Analyzing and using information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality improvement programme</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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