

WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Continuity of Care for Our Mobile Patients with HIV/AIDS

4 November 2015

MODERATOR: Good afternoon. My name is Steve Luckabaugh And I'd like to welcome you to the Continuity of Care for Our Mobile Patients with HIV/AIDS webinar. This webinar is brought to you by the Partnerships for Care, HIV training Technical Assistance and Collaboration Center or HIV TAC.

Partnerships for Care project is a three-year multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act. The goals of the project are to one, expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV, two, to build sustainable partnerships between health centers and their state health department, and three, improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV Training Technical Assistance and Collaboration Center, HIV TAC.

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If you would like to ask a question for the presenter today, please type your question into the Question box and press Send. We will address your questions during the Q&A period. You can type your questions into this box at any time during the presentation. During the Q&A period, we will address as many questions as we can. If you have a question for me or any of the organizers today, you can type it in the chat box in the GoToWebinar toolbar.

Our speaker today will be Deliana Garcia. Deliana Garcia is the Director of International Projects, Research, and Development for the Migrant Clinicians Network, where she writes and presents on the health needs of migrants and the disparities in the provision of health care services they suffer. She has developed clinician training on infectious and chronic diseases and programs to assist migrants to remain in clinical care as they move for purposes of employment.

Ms. Garcia has been involved with migrant populations for 20 years. She has worked in the areas of reproductive health, access to primary care, and infectious diseases at the local, state, and national and international level through program and policy development and publications for more than 25 years. Her past experience includes direct patient education, legislative advocacy, and as a consultant to Federally Qualified Health Centers in the United States. Please join me in welcoming Deliana Garcia.

DELIANA GARCIA: Thank you so much for the opportunity to be with you this afternoon and speak to you a little bit about continuity of care. Continuity of care is really near and dear to my heart, because of all of the years that MCN has been working with migrant and mobile patients. And then because of my history in working with HIV, it is really a confluence of the things that are most important to me in my work life.

So let's go ahead and get started and look at some of the issues that I think we are concerned with as we look at HIV in migration and mobile patients. Anyone who is watching the news, who has picked up a magazine, who has looked at World AIDS Day information has been approached and has seen these messages, which is that we're now very close to finding a cure, or that we are so good at treating that now it's almost impossible to know that a person has HIV. And we have titles like the Fighting for an AIDS-Free Generation.

Now, we were supposed to have an AIDS-free generation by 2015. And I think what's important for us to remember is it to think about, how we stand in terms of defeating AIDS is really going to be stymied by how well we have been able to enter into communities of color and maintain the advancement that we've seen in other parts of the HIV/AIDS prevention education and treatment world. Despite what we see going on at a lot of different levels, I think in our communities, particularly communities of color, those advances have been difficult to experience or to maintain.

And if you've been involved in HIV care for very long at all, then certainly you've seen this continuum of care example. And what I think is important for us to be aware of is that when we talk about mobile and migrant and immigrant populations, we really are at the left hand side of this whole continuum of care, because we're working with a large population of individuals who are unaware of their status, either because they've never been tested or they didn't return for their result.

If you were a part of the webinar that we did earlier this year, looking at HIV in migrant and immigrant populations, then you say that we've seen more and more of an understanding and

an acceptance of HIV as an issue of concern, because of the kinds of patient education efforts we see going on particularly in immigrant and refugee settings. But if you'll recall, there is also a real reluctance to see HIV as a personal concern, where there's the possibility of the individual's infection with HIV and the needing to refer to it as an issue of concern for themselves and perhaps one where they need to look at their own behavior.

So when we think about continuity of care, particularly for migrant and immigrant populations, we really need to understand that a big part of our work may be in the very front part or the very initiation of this continuum, which is having those individuals come in for testing, return for their results, and then think about linking to HIV care. If we are able to get individuals into the care and retain them in care, then certainly we know that we drive down the effects of HIV and we really enhance life and extend life.

So is that whole element of bringing them into care that is very difficult for us. And then when we look at mobility, it's that movement between retention and care and perhaps needing to re-engage those people in care, because of the lapse in the medical access that can come as a result of migration. So in thinking about our groups then, I think what we want to focus on is retaining patients in care.

As I said, education is a huge piece. And more and more of it, there's familiarity with the issue. But now the education really needs to also include the benefits of medical care. I think improving the person's understanding of health and how they can have a role in preventing transmission is huge.

The education around the existence of HIV is certainly very solid. But I think many individuals are still coming to us from a position of believing that once you receive an HIV diagnosis there's really not much that can be done for you. And it can result then in a rejection of that individual's willingness to participate in health care.

So I think if we have good systems, where we can assist those individuals in getting into care right after they get their results and then look at those elements that are going to result in long-term retention and care or re-engaging those patients in care if they have to move away is going to be really critical. And it's the services that promote those linkages and the collaboration between all of the elements, particularly for a patient on the move, that I think is difficult to achieve but something that we can currently focused on.

HIV care landscape, when we think about what our patients are confronting, then I believe that we need to look just beyond the provision of care and think about those elements that make it hard for people even to approach it. When we talk about migrants and immigrants, then certainly we can think about the setting. If the individual is going to find themselves in a rural or less developed setting, then that could make access to care quite difficult.

And individuals who might be coming into the country, and at the low end of an economic ladder, will be looking at those industries that we might find in a less developed area, like

construction, where a rural setting, agricultural settings are now being changed to have more development in terms of housing or businesses. But they're still outside of a very easy access. So that, in that case, transportation and even in an urban setting, transportation can make it very difficult for an individual to get to care.

One of the things that we're hearing about more and more in all settings is food insecurity. And if the individual is having a difficult time even maintaining themselves, then the perspective that they can affect their health through maintenance of their care in a medical setting is a real challenge.

If they need to work and that work is unpredictable hours or they lack control as to when they need to show up and when they can be gone, then that can also be a real impediment to their ability to stay in care. And certainly, mostly for women, but we're seeing this for all members of family now, if they have child care responsibilities, children will certainly become a priority over their own health care and ability to maintain their health.

So when we think about what it is that the patients are up against, it's also important to think about the health care settings that they're entering into. And those health centers, for example, are also struggling with competing forces, because you have a health center with multiple goals. Certainly, they're trying to assist their patients stay in care and provide them with better care.

But they are also being required to look at cost. And when you think about what it might take to hold a mobile patient in care, that could be outreach, that could be making sure that you have extended hours or that you have open access. And all of those elements can be viewed as costing a health center quite a bit and making it difficult for them to hold their health care costs down.

And then you have populations coming to you with already great disparities of health in and of itself in terms of, say, diabetes or hypertension or any other thing, that may be going on for the individual. And then the overlay of HIV can make it very difficult in the effort that the clinic is trying to mount to reduce health disparities.

And then we have operational barriers, because if you're a health center, you have a lot of requirements. You're now being asked, for example, to assess your patient for their eligibility to a variety of funding sources, which means that you need for people to make an appointment, be there on time, not arrive late, be able to take the time to go through all of the eligibility and the intake process with you, very often in a language that's unfamiliar to them and in a system of care that they are not familiar with as well.

If you come from a part of the world where you just arrived first thing in the morning and you queue until they get to you, a whole system of appointments and arriving on time can be a difficult challenge. So our own operational requirements in how our health centers function can be a barrier for individuals who are coming in for HIV care.

And so we think about the fact that the way health centers are functioning, your providers may be asked to see a huge number of patients in a day and that the person coming in is going to be expected to be on time, so that they can go through the initial process. But then they may have wait times of several hours, only to have then a face-to-face session with the clinician that is very short by comparison to the time waited. And then inevitably, there can be that conflict between the patient that's trying to seek care and the staff that's trying to keep things in order.

Your medical assistants and your folks on sort of the back end and support side are trying to keep things flowing. And yet, you have patients with questions. And the time in the exam room may be the only period they believe they're going to get those questions answered. And so the challenge between maintaining flow so that as many people as possible can receive care versus someone who really does feel like their time in the room is their only opportunity can be very difficult.

And when we think about individuals coming into HIV care, then there's also the discussion of initiating a treatment. And one of the pieces that was very interesting to me was talking to different providers about when they talk to their patients and when they initiate treatment. And it was interesting that a number of the providers talk about the fact that they speak to their patients immediately, that as soon as they come through the door at their very first meeting with them, one of the things that they want to talk about is getting them into treatment so that they have rapid uptake.

But then there are others who feel like the issue of HIV, and advancement to AIDS, and depending on where the person is in their disease process may be such that they really do need to have a rapport before they can talk about that larger issue of treatment. And so they have to wait a while, independent of what the CD4 count might be to think about treatment.

Another piece that I think many people-- many clinicians struggle with is that, if we feel like the person's mental health is an issue and they are struggling perhaps with substance abuse, then an entire discussion of treatment could be moot, because the person is going to have a difficult time adhering to that treatment. And so it's making the assessment of whether or not the person's mental health will be a barrier to their ability to adhere to their treatment.

And then we have individual clinicians who look at it strictly from that functioning issue of a CD4 count, so that they're looking at 500 as a starting point. And at that point, then they're willing to engage with their patient in a whole discussion of treatment. So if only 60% of persons with HIV have been tested, and then they can have at least one care visit. However, 50% of those people are coming back into care.

So not as many people know their situation. And even half of those are coming into care. And then even fewer of those are being retained in care. And because of the fear that we won't be able to retain them in care, then many individuals are not having treatment initiated. And so then they are not able to achieve viral suppression.

So I think a major point for migrant and immigrant and refugee groups is the same as it has been for any individual who has HIV disease and is coming into care. The very first year is huge. It's very dynamic for them. I think, anything, any systems, and personal behavior changes that we can put in place in that first year are going to be of utmost important, because it's a really vulnerable time. And because what it can do then is help us retain those individuals in care.

So every effort we make for that individual as soon as they walk through the door for us really does mean then that we can get the person into treatment. We reduce the possibility that they'll fail in that treatment. We can really accelerate, or at least match, the time when they are going to have some viral load suppression. And so the HIV burden and advancing disease is really reduced.

And there's always the effort also to protect others by the fact that you decrease the risk of sexual transmission. But I think also, individuals who enter into care late and are not retained in care then also have an increased risk of other clinical events and mortality and worsening adherents or worsening effectiveness and increased possibility of dead, even after they've started ART, because they waited so long, and they haven't been brought into care and retained in care well.

And this is the whole issue then I think that we get into with our patients-- are standing community patients as well as our migrant and immigrant patients-- is the whole issue of control. And we have those within the "system", quote unquote, who understand that if they step into it and they really are able to talk to people about what is required, they have an acute understanding of what needs to occur. And so the system is really trying to employ the best strategy for the patient.

But the patient and their family are not as familiar. And so they're struggling to hold onto the control of their health care, and of their family's functioning, and any of those forces that might affect their ability to function well as they see themselves. And so we're looking for that place where the lines intersect, where the system and the health care system is able to really say, we're working with the patient. We're able to have our flux and flow work so that we can get the patients into care and give them what they need.

We're looking at what needs to happen to them, so there's no interruption. And it matches with the patient's understanding of what's going on, acceptance of how the system works, and experiencing it not so much as a loss of control but a willingness to engage in shared control. And I think this is what we're trying to achieve, is that it doesn't become a tug of war. It's not a challenge to see who's going to dominate in the decision-making process, but rather that the patient, their family, and the health care system are really working in partnership with one another.

And so that's why the goal then is that we look at behavior change in a way that does create that continuous and healing and healthy relationship between the patient, the family, and the

health care team. And we want to really reinforce the notion that it isn't just the patient with the health care team.

What we're talking about in terms of migrant patients is that they are coming to us very often from cultures where decision-making is not so independent. It really is a family process or a group process. And so we want to understand that the relationship by and large includes not only the patient but whoever the patient considers their family or their support group.

If you were on our last webinar, we talked about the fact that as someone is moving with HIV, their vulnerability is affected by where they are in the phases of their movement. If they are transiting from one point to the next, or they're entering into a new destination community, or they're returning to the community from which they departed, then that shift in the landscape for them really does increase their vulnerability. And they have to go back in very often and establish the relationship that we were just talking about with a new health care system. And so their ability to maintain their treatment, to maintain their focus, to maintain their willingness to engage is challenged at each step in their mobility.

And so as you receive someone, then it is important to consider that it's not just the person directly in front of you, but it's the preceding experience of where they are coming to you from and then being mindful of the fact that they may be leaving you and moving on elsewhere. And what will be their effectiveness in maintaining their health, their adherence to treatment, if they are going on to a new system? And what is it that you can do to prepare them for that?

And so then that really asks us to look at those strategies for maintaining the mobile patient in care. And we know that we're asking you to do this even as you are having to look at your own internal systems and at the demands of your funding sources as to how you structure your health care setting.

And I think one of the points that we try and make is that as health centers are looking at the patient-centered medical home that they look at not just as a certifying requirement, let's say, but they look at that model for a mechanism for really providing a way for a clinical practice to strengthen that clinic-patient relationship. Because the whole point of the efforts that we put in place with patient-centered medical home are to get rid of episodic care and really look at coordination and then long-term relationships.

And what's really true is that health centers that are engaged in trying to look at their processes so that they can qualify as a patient-centered medical home, can do all of this work without even considering their mobile patients. And as a matter of fact, they may decide that it's even easier to go through that certification process if they don't focus on their mobile patients.

But I think if you look at all of the elements of patient-centered medical home, which is that the person has a clinician that they turn to, that the clinician-directed medical practice is done in combination with an understanding that it is the whole person in front of you and all of their experiences that needs to drive how we put our care together, and that it should be

coordinated and integrated not only with just our own setting but perhaps with those services, that will enhance the person's quality of life, and so that we really are having a safe place.

And by safe, we don't mean just medically or physically, but where they feel like they can come for support without fear of harm. And that may mean that we have to enhance their access to that care. All of these elements are part of patient-centered medical home.

And the payment piece, that is an additional element, is one of the places where we have to work very hard particularly with our migrant and immigrant patients, because their eligibility for all of these services is really variable. If they have a refugee status, that's very different than if they're an undocumented immigrant. And so we can work very hard to put all of these elements of patient-centered medical home in place. And then the payment part can really cause us to fumble.

So as we look at systems that are going to be good at providing HIV care to migrants, to immigrants, to other mobile individuals, then I think if we can look at all of these system pieces that make up sound patient-centered medical home, we are really creating an environment where mobile patients can be well cared for, and their HIV can be dealt with appropriately.

So when health centers can promote that patient-centered medical home transformation work, the improvement of their systems, and really look to include the patients that are mobile and poor or have cultural issues or language differences, rather than trying to create the environment where they can meet the certification needs but exclude those patients, they really are doing a great job. And if they can look at all of this processes with these difficult-to-manage and difficult-to-reach patients at the center of their work, then they really are putting together a system that will be responsive to all their patients. And I'll do a great job with mobile patients and HIV care.

So I think that it's really adapting all of that framework, particularly for these difficult-to-reach patients, that will give you the best health outcomes for everything, including HIV and AIDS. So if you're adapting a medical home, then I think the elements that you need to consider are integrated approaches across disciplines and across sites. If you are in an area where housing services are going to be one place and access to food services are going to be somewhere else, then making sure that you have a good cross discipline system for integration is important.

And it's also looking at your internal information technologies as strong allies, as opposed to fighting with our systems for data collection and then data extraction. But really seeing that if we have a sound system that we know how it functions and that we really call on to give us data and usable data, then we can make that an important element in how we structure our work.

Because if we are able to look at things like the health care system within our health center and what is that we provide out in the community and what services we are providing are being driven by the information that we get from our technology, then it also helps us look at, are

there other partners that we need to integrate into our approach across the various sites. And so it moves both from left to right in understanding that we have to have these elements in place. And then it also moves from right to left in understanding that each of the decisions can be addressed and can be informed by what's going on out in the community, in our data collection, and inside our health care setting.

So when you think about your site, what is it that you're going to need in terms of tools to make your medical home better for mobile patients? And I think that's a little bit of what we wanted to talk about today, because when you have a good system in place for mobile patients, then you really are going to be very effective in your efforts to provide continuity of care.

So you have to have easy access to care. And for mobile patients, that can be really quite difficult, particularly if you're running on a schedule of appointments. Then we need to make sure that our data looks at the special needs population, because what is it that you're standing population needs versus those that are coming to you with a different set of needs. And everyone certainly needs care management.

But when you have someone who's on the move, then what are the additional elements that need to be put in place so that it is effective for them? And that means that if you're looking at self-care services and the person is going to be on the move, then what kind of systems can you put underneath them essentially even virtually that make them effective in doing that?

And then there really needs to be the piece of your work that allows you to refer that patient forward, that you're not just sending them off into the ethers-- after you've done all of the hard work, bringing them into care, trying to make it easier for them to arrive, looking at what might be special needs, and thinking about how to make your services mobile friendly, so that they can go on and really be engaged in self-care, and then you lose them to follow-up.

And at some point, you know that your health center is going to be asked to respond. For any patient that you engage, what was the outcome, essentially. Even though with HIV there is really no endpoint in treatment, you might need to be able to speak to what the outcome was for that patient that you've brought into care.

So a system that actually allows you to do sound referral and then gives you information about what has transpired for that patient, so that it feeds back into your system and allows you to evaluate if the elements that you put in place actually do create a system that is supportive for mobile patients in the same way we described earlier is an important element. So you want to be able to get good feedback to make sure that what your employing is really providing your patients with what you're hoping it will.

And so we're going to give you a couple of examples. I'm going to do some case studies as we go further into the presentation. I want to talk to you about an HIV-positive pregnant woman, because when you have the combination of HIV and prenatal care, that's one set of issues.

And I'd like to do a case study of a young man who has TB and HIV, because very often your understanding of the person's HIV status becomes clear to you because they presented with another illness that requires immediate action because of its infectious and contagious nature, like TB. So we'll give you some examples as we move further along that try and look at all of those elements that we've talked about in terms of how do you make your care system receptive and supportive of mobile patients, as you're trying to provide HIV care in a complex setting, where they may have many other problems and health care issues of concern.

And when we look at the standard elements of patient-centered medical home and you think about the patients that we're talking about, then I think it's great for us to start with the must pass element of the standard one. And that's access during office hours. And so very often it may mean that you have to have open access.

And so while you do certainly want to talk to your patients about scheduling and what it means, as I was saying earlier, you may be having patients who are unfamiliar with the US health care system and they really don't understand scheduling practices-- meaning, their whole experience has been just showing up and waiting till they get to you. And so the amount of time that you can put in at the front end may seem excessive. But if you help that person really gain footing in understanding how the system functions, then they will be more responsible and more receptive to what's being said to them and the actions that they're being required to take.

I think if you can really document the number of migrant workers in your region, the hours that they work, what transportation is available to them, then it'll also make it easier for you to understand how to have those must pass elements available. And if you've been in the health care system for a while, you know that migrant is the word that's generally employed when talking about agricultural workers. And certainly, that is a funding element that you need to keep in mind.

But I would ask you right here to think about migrant workers as those members of the labor force in your community that can move around, because of the labor that they're engaged in, that could then upend or change significantly the demand for services in your site and the ease with which you can work with individuals-- so for example, if you have a high number of construction workers in your area, because there's a particular building going up. But then once that building is complete those workers will move on with their construction team to another location, they are essentially migrant workers. And they will create a flux in the demand and utilization your health care services.

So we talk a lot about open access and think about the seasonal variance. Certainly things like agriculture and construction, the service industry are very seasonal for summer months, unless you're in a winter location and you have skiing, whatever. So understand what are the industries in your area and what might create a seasonal variance in the demand and consider open access that looks at that.

And then be willing to look at some accommodations. That could be hours. It may mean that you need to have a couple of stay late or open early. If the geographic barriers are a great deal, perhaps it will encourage you then to look at your outreach, so that it goes on site to provide a little patient support and some services at the location of their employment, as opposed to requiring that the patients come to you. So as you're looking at the standards that you need to meet for patient-centered medical home, then access during office hours is one of the areas that we think we need to look at very strongly, particularly for migrant patients.

And I think I mentioned earlier, but I think data is so critical. And how it is that we obtain that data, and manage it, and then extract it, and then utilize it is really quite important. And so numbers-- numbers of workers, particularly with the subcategories, if you're able to tease it out and have it in an EHR system that is still retrievable is one of the places where we've seen health centers truly struggle.

They had to convert from their old practices into the new EHR. Some site are still in that process. And even afterwards, they're starting to see that their EHR is not constructed in such a way that they can tease out these subcategories and retrieve that information. And as I was saying, sort of the occupational and environmental conditions that you see going on-- crop work is one of the places that we focus a great deal, because that is an industry where we see a lot of migrant workers, but as I said, it could be other occupations as well-- knowing what's going on in your community is really important.

Core measures for migrant status-- and here the use of migrant really is according to the HRSA definition, which is the migrant agricultural worker-- there are going to be some core measures that are specific to them. And so if you are engaging those patient in HIV care and looking at continuity of care, it's going to be important to remember that there are going to be some core measures specific for them, perhaps outside of HIV. I don't think they've been decided on yet. And so they'll need to be incorporated into your entire data management effort.

One of the pieces that's also important is, what is your need for specialty care? And so as you look at your data in terms of what the occupations are, what the seasonal variance is, and you see them coming in for HIV care, then what is going to be the specialty access that you are able to provide your patients? And as they move around, then how is it that you're going to maintain that? Is it even available where you are?

And then I know that there is a huge demand for a reduction in the use of emergency departments and preventable hospitalization of migrants. And certainly when we're talking about HIV and AIDS, then these individuals are usually at a much higher level of need than is what we hope for for an individual with HIV and AIDS. We would like for them to be in better control.

But if you're able to look at your emergency room data and see what's going on, then it'll give you a perspective on the kinds of services that are really required. And they may be more support services. You may need to have community health workers that are there and able to

engage migrant populations in your area earlier, so that they understand that the health center is there, the health system is open to them and giving them some insights about how it works, bringing them into care for testing and treatment.

If you've worked in a health center setting for any length of time, then certainly you've looked at the chronic care model. It was discussed a great deal over the last 10 years when we were talking about diabetes and hypertension. But I think it's an important model for us to keep in mind, and something that we're already familiar with. And so then we can employ it again when we're talking about our HIV patients.

If they are able to see HIV as a chronic illness, one that requires that they participate in self-management with support from the system, they can be informed and actively engaged with the team, so that they have good interactions about what's required, then in the same way that we have seen and had always hoped to see in terms of things like diabetes and hypertension, you can have improved outcomes. And that improved outcome for migrant and immigrants with HIV would be that they were in treatment, that there was strong treatment adherence, that they would have a real reduction in viral load, and that they would have a real advancement and improvement in their quality of life.

And so I think if you've been engaged in the health care setting, where the chronic care model has been used a great deal, then a lot of those processes and tools and methods of interaction that you've had in terms of support of patients and support of clinicians can be used again around a discussion of HIV.

But, as always, what we mean here is we're talking about the mobile patient. So in addition to what you have going on within your health care setting, and the kinds of conversations that you're having about systems, and the efforts that you're trying to make in terms of improved data collection and management and use, there also needs to be a clear recollection of what your patients are up against because they are moving around, generally for survival, generally because employment is essential. And so they're needing to move to follow the work or to access work.

So what I want to do now is a couple of case studies that combine all of these elements. So I want to talk about first a migrant woman, who's pregnant but HIV-positive. And so what we've seen very often with women who are HIV-positive and pregnant is a real discussion about the kind of treatment that needs to go on so that we reduce transmission from mother to child.

And what I've seen happen in a number of cases is that that message has become so important in what was being said to the woman by the health care provider that there was a real loss of perspective of the woman herself, so that what was communicated to her was that the most important thing is for you not to transmit your HIV to your child. Rather than looking at the woman, who at this point may be feeling well and is pregnant.

And so this is a natural part in her estimation of her moving forward as a woman. And so she does not see herself as sick, because of the pregnancy. And yet the clinicians are looking at her pregnancy as a real challenge, particularly because of its effect on her HIV state. So their focus is on not transmitting it to the child and on the negative impact of the pregnancy onto her HIV state.

And what is essential perhaps for the woman is for everyone to understand that she perceives pregnancy to be a natural state for her, that it is not indicative of illness, but rather just of a continuation of life, that she has a need to support herself and survive. And it may mean that she needs to migrate, so that she can be engaged in work.

And the message then, what she is hoping to receive perhaps, is a message that says, we can help you stay in care, as you need to move. We want you to have a healthy pregnancy. And we want you to have a good outcome.

And indeed, with good management, we can make sure that the HIV is not transmitted from you to your child. And so we will then put in place important steps so that you can stay well. And it's just a variation in perspective.

And then we can have the case of a young man, who came into a health department, because he had an active and productive cough. And they realized that he had tuberculosis. And then upon further testing, they realized that he also had HIV, and the whole discussion about when you engage, when you initiate treatment for one of the other.

And there are really good guidelines out there. I think the fact that the tuberculosis needs to be brought under control, so that it does not have the ability to infect others, is an important consideration. But it doesn't trump looking at the young man's HIV status.

And so the issue here is that not one more important than the other, but the two pieces together, so that you can engage in treatment for the cure of one while you engage in treatment for the management of the other, and that the young man in his need to move and to remain employed is viewed as a whole.

And so that gets into the whole discussion of self-management support and really emphasizing the fact that the person is the one who needs to be managing their illness and that there are good strategies for figuring out how to set goals and put plans to the place, but that it really does mean there have to be not only good internal processes, but then there have to be resources out in the community that help the individual.

And so really, what are we talking about then is the person's ability to manage their symptoms. Because if they are having good symptom management, then they're going to be feeling better. They're going to be able to go out pay greater attention to their treatment. Socially and physically, the consequences are going to be much better. And they may be in a better state

then to make lifestyle changes that we think are important when you're talking about a chronic disease, which is how we're looking at HIV.

So this means then that in your work with patients, you want to look at your education. You want to make sure that there's good communication of information, but also in skills. It certainly can be disease-specific, but some of them can have a cross to other things.

But more than anything else is we know that they can create the change that they need, that the goal that we really have for them is that they comply with whatever is needed so that they are able to achieve a level of function despite HIV, and that professionals, health care professionals, can be seen as really important teachers, but not to the exclusion of understanding that they play the strongest role.

And so they need to really have the skills to do problem-solving, that some of those skills are really generalizable. But more than anything else, it's the confidence that they can make this decision and have good outcomes. And so what we're doing is then increasing that person's sense that they're going to be able to care for themselves.

So we want good patient education. And we want good self-management support. And clinicians can be great teachers in that as well as peers.

So we want the individual to take control of what's going on for them. But we want them to be able to carry on with the normal activities and an understanding, as with any illness, that there can be emotional changes. And they need to be able to manage those and not take them out on whomever is around them.

And so that whole issue then that we got to before in terms of collaboration, it's the strength in the system, being able to see that while there are certain steps that we want our patients to take because we want the best for them in terms of their health care, they are trying to hold on to control in their life. And so it has to be evenly weighed. So we want patients to behave, and it can create frustration when they don't. But it really, I think, has greater effectiveness if we have a target in place, if we can explain it as an important personal health goal, if we can get the buy-in of the patient, and then we can work collaboratively to achieve that goal.

But I think what is important to recall is that it's not sort of this didactic interaction, where we're being the sage and wagging our finger, sort of lecturing, or really feeling like that when the patient has received enough information, then they will ask us to help them. And that's really not what we're looking for. What we're looking for is helping people put in place a personal action plan.

And so we have a system that we'd like for you to look at, which we call the five A's. And we'll look at each one of these in turn. But if we can help the individual then put in place their whole action plan, then they can have their own goals in terms of perhaps behavior change, and in

addressing some barriers, and looking at specific practices, and being able to see the health care team as partners in what's going on.

So let's look at the five A's. The first is assess. And it's not only just their health state, but also their beliefs, their knowledge of HIV and of their own capacity to affect their health. And so what does that mean in terms of the behavior that they currently employ and their ability to change that behavior?

So your assessment needs to not just be their HIV state, but of the whole individual. So asking them questions-- you know, the whole getting to know. And again, I know the challenge to clinician is the amount of time.

But if you take the time to learn more about the patient and then give that feedback to the other team members so that they benefit from the time that was invested, then they can see the view of how easy or difficult it's going to be to get the patient to move forward in what we think is the best strategy for their own health. So assess means that one person can engage and certainly then provide that information to the others who are trying to engage as a part of the team on the patient's behalf.

And then advise, and advise rather than educate. Because while education is important and we're trying for people to understand, more than anything else, if we're working as a partner, then we're just providing information to the individual that they get to then incorporate and determine how it'll work best for them.

So what we're talking about then is providing advice that's clear and with the statement that it comes from your professional knowledge, because you have tried to study it, that you know what's going on in the environment where they're trying to get care, but that also by your [INAUDIBLE] that you're willing to listen as much as you are to talk, if not more so, so that you are giving the person the advice about how they move. But more than anything else, you get that you're providing sort of ideas for them that don't overwhelm them, that'll allow them to take that information in, see that it is coming to them from you from a place of experience and expertise, but also a desire to help them achieve the best possible.

And then the next A would be to agree. And what we see is people take this lesson in and they understand that when the patient says something the answer needs to be yes. But what we see often is, yes, but-- Yes, that's a good idea, but I want you to do this.

And I think that what is very important and has been valuable in a lot things is to be able to go, yes, and, rather than but. They've given you an idea of what it is that they feel like they can do. We don't think it's quite as strong or as effective a strategy as they could use. But we're going to go with it.

And rather than saying, but I think you need to do the other, say yes, and you may want to try this other. And so you can set up some goals, get their priorities, understand that they want to

change, don't judge it, if you can agree with them. And then if you need to have them consider something else, have them say, well, we'll try that. And then we'll try something other, rather than it be in opposition, but just an additional piece of information and suggestion.

Problem-solving is one of those things that is a difficult talent and a difficult skill. But if we can really assist our patients in getting there, it increases their confidence. And that is what makes it possible for them to be successful.

What is really very helpful is if you can have them see themselves as similar to someone else who's been successful, because then it beats back that sense of being helpless. They can really look at what's going on in their environment and what might be blocking for them. And then they can really see that you're not trying to tell them what to do, you're not just engaged in a monologue, and that you're not really just being a cheerleader, yay, you're doing a great thing, but that you are there in partnership and assisting them in developing their own ideas and solutions for their health.

So really what we're talking about then is a good problem-solving strategy, helping them figure out what it is that they're trying to confront, what they believe is within their capacity to do and apply as a solution. And then not to just see it as the shotgun-- we're going to try everything-- but to pick one at a time and to really try and be effective with it.

And if it doesn't work, not a problem. We can try another one, because you're there and you're going to be willing to help them look for other resources and ideas. And it may not be solvable now, but it doesn't mean that you just ignore it all along. And so this also means that you work internally with your team, because the whole inside of your health center system, the people that are engaged there are also going to be able to support the work that you do with the individual patient.

And so in the same way that you don't want to talk down to your patient, we don't want to talk down to the folks who are there supporting this within the team, like our outreach workers or community health workers, and understanding that if they are seen as a powerful component in the health care team, then they can engage with the individual and reinforce the messages that are being given. So the work that you do with your patients is also work that we probably need to do internally with our own colleagues, so that we're all working effectively to the same end.

And then arrange, very often I think what trips up many of the patients with whom we work is that they just don't know how to access the services. And so whatever sort of scheduling support that we can provide them is really important. And so you may have to do a number of methods.

We are now starting to see that many of the individuals with whom we work want us to text them, because they're not able to get on the phone during the day while they're working. But they don't want the relationship to be fractured, because they're going to miss something

important. And so the texting really then is the patient's preference. And it really does allow us to see what's going to be the best way to provide follow-up.

This is just a little outline of how you can help someone structure their personal action plan. It's really what is it that they want to do, really being specific as to the how, what, when, where, the frequency. What are they up against? What are their plans for overcoming that?

And then letting them rate for themselves-- how successful do you think they're going to be-- because it allows you to come back. When they've been somewhat successful, you can say, you might have rated it lower. And you actually wound up doing better. Or it didn't go as well, and you were fearful that that might be the case, but let's go ahead and try it again.

In the last few minutes available to us, I'm going to whip through these slides, because what I want you to see is a source for continuity of care is Health Network, which is a service provided by the Migrant Clinicians Network. And it's really a Bridge Case Management program that allows us to bring a patient into care and move them along to other sources of care as they migrate for whatever reason.

And so it's free of charge to the patient, free of charge to the provider. It's toll free. We have bilingual, bi-cultural for Spanish and Latino staff. But we also use translators services.

We store medical records. We do ongoing patient education. It's a very easy process that allows us to coordinate services for patients that are on the move, and we remain engaged with them through the entire time.

Because I think what's important is that you are concerned about how you're going to get results back, when the person moves along, how are you going to know what the outcome was for them. And so I really want you to see Health Network as a resource, because it can really be a bridge between you and your patients. We can reduce their loss to follow-up. We can make sure that they stay in care, that you get a report on how they're doing, and that they really see that there is a system in place, even as they move that wants them to be successful.

So if they're already moving or if they're likely to move and they need support and treatment, and we're looking at HIV as it is a chronic condition, then we hope you'll see Health Network as an important resource for you and your patients. There's no discrimination on the basis of immigration status. We never share the personal information without their consent.

We have tools at the toll free number and a card that you can give your patient, so that they can access us no matter where they go. And if you had a patient that you enrolled in your site and they left, but we knew about them and we were already engaged with them, and we could contact them and help them get into care into their next site, we can call you back and say, you know, your patient X who you enrolled wound up in this new location. And we've been able to continue the good care that you started for them.

So I'm sorry I didn't give us much time for questions. But you will have my contact information, I believe, with the handout. And certainly, Migrant Clinicians Network is available via the internet. And in there, there's a Contact Us. And you can certainly call with any continuing questions. Thank you so much.

MODERATOR: Thank you, Ms. Garcia. If anybody has any questions, we have a few minutes here. We can ask a couple of questions.

DELIANA GARCIA: Steve, as you all decide, certainly you can make my email available to anyone. If there was something that I said that was not particularly clear or they would like for me to elaborate, I'm more than happy to communicate with whomever.

MODERATOR: OK. We do have a question here. What is the biggest factor in retention?

DELIANA GARCIA: The biggest factor in retention is really core preparation of the patient at the time that you first engage them, so that they have a complete understanding of what they're up against and that they have some appreciation for the resources that are available to them, so that they walk away with a sense of, yes, this is an illness, it can be chronic, but I have the capacity to engage.

And so it's that investment of time and energy, when the patient first comes in to you. It may be at the time of testing, or it may be at a time when they return and they were tested previously and they're re-engaging. But it's that first few moments of time, where you really engage them, talk about being a partner, and really enter into a collaboration.

MODERATOR: OK, and another person asked, what insurance issues-- about insurance issues for this population.

DELIANA GARCIA: Right. And that's always the case, because so much of HIV care is state by state. For example, treatment is very often controlled by access to those medications on a state-by-state basis. So as they move from one place to the other, that's why a system like Health Network is so important.

The health center may have a payment requirement per visit, even on a sliding fee scale. That's a problem for some folks. And it may be in partnership with Ryan White monies, which will pay for their HIV care. But it's still coupled with that payment that comes per visit at a health center. If they are undocumented, then they don't have access to insurance.

And they can't even go into the Marketplace. And that is really a problem. So the health centers becomes a system of great importance to migrants, because we can do a hand-off because, they should not be turned away for their ability to pay or not. Because by and large, they are really tied into Ryan White funds and other sources of state-based payments. So insurance is really an issue. And it's knowing what's out there to pay for services for both documented and undocumented immigrants and migrants that's so important for health care providers.

MODERATOR: OK. Anyone else have any questions before we wrap things up here? OK, it doesn't look like it. We can certainly take questions via email as well. So at this point, I'd like to thank everyone for participating in today's webinar. We hope that you were able to find the information provided useful, as you continue your P4C project.

And I ask that you take a few moments to complete the feedback survey that you will receive when you close out of this webinar. You will also receive it via email. Today's webinar was recorded. And audio and video versions of the entire webinar will be available on the P4C website within the next few weeks.

Ms. Garcia's previous webinar on the topic, along with copies of all of our P4C webinars, are currently available on the website on the P4C Resource Materials page at p4chivtac.com. You'll need to log in to access the materials. If you need logging credentials, send an email to p4chivtac@mayatech.com.

Thank you again for participating in today's webinar. And thank you, Ms. Garcia, for that excellent presentation. And if you have any additional questions for the P4C project or for Ms. Garcia, please email us at p4chivtac@mayatech.com, and we'll take care of that. Any closing thoughts?

DELIANA GARCIA: No, wonderful. Thank you so much. And good fortune to you all. I know that work in HIV for any population can be difficult. And so I want to be supportive to you. And if I can help any way, please let me know.

MODERATOR: OK, thanks a lot. And take care, everybody. We'll see you next time.