A Good Start: Weaving HIV Services and Reproductive Health Care in a Public Health Setting

INTRODUCTION

Perinatal transmission of HIV disease still occurs in urban centers that have access to counseling, testing and treatment. Creative measures need to be explored to gain full understanding of this phenomenon.

A ‘Good Start’ is a collaborative project to help coordinate existing but disconnected services and to reduce perinatal transmission among HIV positive women in a public health setting.
KEY PARTNERS

The mission of CityMatCH was to bring together these key partners working in perinatal HIV transmission:

- Division of Early Childhood, Youth & Women’s Health, PDPH
- AIDS Activities Coordinating Office, PDPH
- Ambulatory Health Services, PDPH (including HIV specialists and staff at Health Care Center 6)
- The Circle of Care, Title IV Grantee
- PA mid-Atlantic Education Training Center

The PDPH played a major role in coordinating this “best practice.”

GOAL

The goal of this project is to provide an integrated array of services to women and families with, or at risk for HIV. These include: HIV primary care, family planning, gynecology, prenatal and pediatric care, and nutritional services.
PRIORITIES

- Provide HIV testing/counseling for all women attending prenatal clinics, family planning clinics, and GYN clinics.
- Provide timely, comprehensive, on-site HIV care to newly diagnosed HIV-positive women seen in family planning, and prenatal clinic.
- Provide on-site HIV management for diagnosed HIV-positive women, including consultation with GYN and family planning as needed.
- Ensure that HIV-positive women receive regular GYN care and family planning services.
- Provide pediatric care to newborns with perinatal HIV exposure.

OBJECTIVES

- To improve the rates of HIV counseling and testing within City Health Centers.
- To coordinate HIV services for women of reproductive age within City Health Centers.
- To prevent the loss of clients within the system due to the fragmentation of services.
- To provide coordinated care to prenatal patients diagnosed with HIV within City Health Centers rather than referring out to other providers.
METHODS

- Recognized and framed the problem.
- Identified elements/administrative support needed to address problem at upper management level.
- Chose most appropriate area based on incidence of AIDS cases identified by zip codes to pilot the project.
- Identified services currently available at targeted location.
- Identified elements of services needed to have to make a continuum of care of HIV services within the Health Center.

METHODS

- Met with appropriate Health Center staff to discuss problem and proposed plan
- Discussed how services could be integrated
- Discussed days services were currently available to identify at least one day services could be made available in a one stop manner for patients.
  - Available days identified at Health Center # 6 were Wednesday and Thursday
METHODS

- Identified gaps in current services:
  - Need for case management support for existing social worker
  - Need for educational services
  - Need for nutritional services

- Implemented solutions for identified service gaps:
  - HIV case manager was identified to support the social worker in the clinic
  - Bilingual peer education services were made available to the patients
  - Nutritional counseling and meal planning services were made available. Meals were also provided to clinic participants during clinic hours.

METHODS

- Organized a training plan for staff employed at the clinic.

- Developed an evaluation/quality assurance plan for clinic services. A three-month evaluation of clinic services will include:
  - number of people counseled/tested
  - number of appointments missed/kept
  - chart audits to determine adherence to treatment
  - attrition rate
  - client satisfaction survey (peer administered)
ANTICIPATED OUTCOMES

- Integration of services: Expansion of "one-stop" shop model of Circle of Care into the city health centers.
- Improved convenience of medical care and overall health status of HIV-positive women attending city health centers.
- Improved rate of kept appointments in HIV and pediatric clinics.
- Improved adherence to treatment regimens.
- Improved pap/breast exam rates for HIV-positive women attending city health centers.
- Increased rates of HIV testing.

RESULTS

1. Collaboration of multiple partners working toward a common goal.

2. Creation of an easily replicated model using existing resources.

3. Coordination of services for HIV-positive women within a public health setting.
SECRETS TO SUCCESS

1. Identify and frame a “need.”

2. Bring key players to the table early in the process to get buy-in.

3. Utilize existing resources as much as possible.

   If the right people are involved, most barriers can be overcome.

BARRIERS TO IMPLEMENTATION

1. Prenatal providers are accustomed to referring HIV-positive women out. They may resist maintaining them in city health centers.

2. Health center staff may lack experience in counseling women about HIV testing.
HOW TO OVERCOME BARRIERS

1. Arrange educational sessions for health center staff to improve their clinical knowledge of care for HIV-positive women.

2. Conduct needs assessments to identify gaps.

3. Assign a case manager to the prenatal clinic to facilitate comprehensive care for HIV-positive women.

4. Have peer counselors available to HIV-positive women for support.