WORKSHOP IIB : ADDRESSING THE WHOLE PATIENT

Facilitator: Julia Cohen
Room 914
1:30PM — 3:15PM

Pamela Guthrie *Harlem Hospital Center*	Fostering Health Literacy and Life Skills Development Necessary for Successful Transition to Adult Care
Nadine Akinyemi *Bridging Access to Care*	Leveraging Technology to Integrate Trauma Informed Care in Everyday Practice
Christopher Joseph **Vanessa Haney** **Elaine Ruscetta** *Mount Sinai/IAM – CC*	Personalizing Tobacco Cessation: Using Care Coordination to Augment Provider-Based Screening & Counseling
Vanessa Pizarro **Ramona Brown** *Institute for Family Health*	Women's Narratives: The Role of Group Health Promotion in Increasing Social Support among Women Living with HIV

Addressing the Whole Patient

Julia Cohen, Moderator
City Research Scientist, NYC DOHMH

The Power of QI Conference

November 9, 2016

1:30 – 3:15 pm

“It is far more important to know what person the disease has than what disease the person has.”

— Hippocrates

NATIONAL HIV/AIDS STRATEGY for the UNITED STATES: UPDATED TO 2020 - JULY 2015

GOAL 2: INCREASING ACCESS TO CARE AND IMPROVING HEALTH OUTCOMES FOR PEOPLE LIVING WITH HIV

Developing models of competent care that treat the whole person, as well as the virus, is crucial.

The World Health Organization defines mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community,” a definition that should inform all programs and policies targeting individuals living with HIV.

Walgreens at the corner of happy & healthy

Your Account
Sign In or Register

Prescription Refills | Health Info & Services | Contact Lenses | Shop Products | Photo

Store Locator | Weekly Ad & Coupons | Healthcare Clinic | Balance Rewards

Search by keyword or item #

Home › Pharmacy & Health › HIV-Specialized Pharmacy Services

Medications and Financial Assistance

- HIV-Specialized Pharmacy Services
- HIV-Specialized Network
- **Medications & Financial Assistance**
- Additional Services
- Well Beyond HIV™

Confidential HIV/AIDS Support

800-573-3602
8AM-10PM EST

Send us a message ›

It's important to care for the whole you

Our pharmacists can help identify ways to make medications more affordable.

HIV medications are expensive even with health insurance. Financial assistance is available, so take a look at some of these resources below and stay current with your treatment.

Today's Presentations

- *Fostering Health Literacy & Life Skills Development Necessary for Successful Transition to Adult Care* – *Harlem Hospital*
- *Leveraging Technology to Integrate Trauma Informed Care in Everyday Practice* – *Bridging Access to Care*
- Personalizing Tobacco Cessation: Using Care Coordination to Augment Provider-based Screening & Counseling – *Mount Sinai Institute for Advanced Medicine*
- *Women's Narratives: The role of group health promotion in increasing social support among women living with HIV* - *The Institute for Family Health*

Fostering Health Literacy & Life Skills Development Necessary for Successful Transition to Adult Care

Pamela Guthrie, Psy.D.

Clinical Director

FCC/HFC Mental Health Program

Harlem Hospital Center

Project Background

- The Family Care Center (FCC) serves a large number of perinatally infected youth who are in the process of transitioning to adult care.

- Many youth lack the life skills necessary to successfully navigate the health care system.

- In order to reduce the number of youth who become medically destabilized or lost to care upon transitioning, the FCC implemented a Transition Readiness Checklist (TRC) to identify and track gaps in knowledge and skills so that these deficits can be addressed.

The Family Care Center Model

- New York State Department of Health Designated AIDS Center
- Serves children, adolescents, adults and families living with HIV
- Offers nutrition, medical case management, health education, HIV testing, PrEP, linkage to care, mental health services
- Providing integrated mental health services since the mid 1990's for pediatrics, since 2001 for adults
- Mental Health services include individual, group, couples, & family therapy; psychopharmacology; assessment; navigation
- Care Coordination is built into program: All providers attend weekly to monthly meetings to discuss clients seen.
  - Pediatric CC: Monthly
  - Young Adult CC (ages 22+): Monthly
  - Adult CC: Weekly

Client Demographics

- Demographics (for mental health program, N=124)
  - Race/Ethnicity:
    - 81% Black (71% African American, 9% African; 2% African Caribbean); 11% Hispanic; 4% Multi-racial
  - Age:
    - 35% Under 24; 9% Ages 25-34; 11% Ages 35-44; 40% Ages 45+
  - Gender:
    - 56% Female; 44% Male; 2% Transgender
  - 18.5% Identify as MSM
  - 87% have Medicaid
  - HIV Exposure:
    - 34% Heterosexual; 33% Perinatal; 15% MSM; 4% IDU

How We Got Here:

- Young Adult Care Coordination Meetings: youth are being lost to care, aren't adherent, can't maintain health insurance, etc.
- Staff agreed that low levels of health literacy and insufficient life skills played a role.
- Team brainstormed how to stop this pattern with youth about to transition.
- Plan: Start developing transition skills earlier (at 14, not 18).
- Make a transition readiness checklist to track what skills clients need.
- Encourage youth independence (ex., have clients to come to appts without their parents).

Quality Improvement Assumptions

- Youth want to stay engaged in care.
- Pediatrics provides a lot of support that helps youth stay in care.
- Youth are capable of advocating for themselves if they have the skills to do so.
- Youth need health literacy and life skills to make a successful transition to adult care.
- Youth would benefit from skills that foster independence.
- Parents can, and will, step back if youth can step up.
- Fostering the development of health literacy and life skills will help youth remain engaged in HIV care and may help build self-efficacy and independence.

Quality Improvement Goals/Aims

1. To help youth develop health literacy and life skills, as measured by number of skills gained on the transition checklist.
    1. For 50% of youth to complete all items on checklist
    2. For 75% of youth to complete at least one item on checklist
2. To keep youth engaged in medical care and reduce the number of youth lost to care to zero.
3. To increase self-efficacy and a sense of independence (measured anecdotally, observationally, or by self-report to clinicians).

Quality Improvement Methods

Step 1: Identify Need: Youth Lost in Transition (Without Skills)

Step 2: Meet as a Team to Design QI Project

(Team Lead: Director of Adolescent Services)

Step 2: Design a Checklist Identifying Health Literacy/Life Skills Necessary to a Successful Transition

Step 3: Present Checklist to the Entire Team for Feedback

Step 4: Revise Checklist Accordingly (Add items, change language, etc.)

Step 5: Present Revised Checklist to Larger Team for Final Approval

Step 6: Launch Checklist and Analyze Data

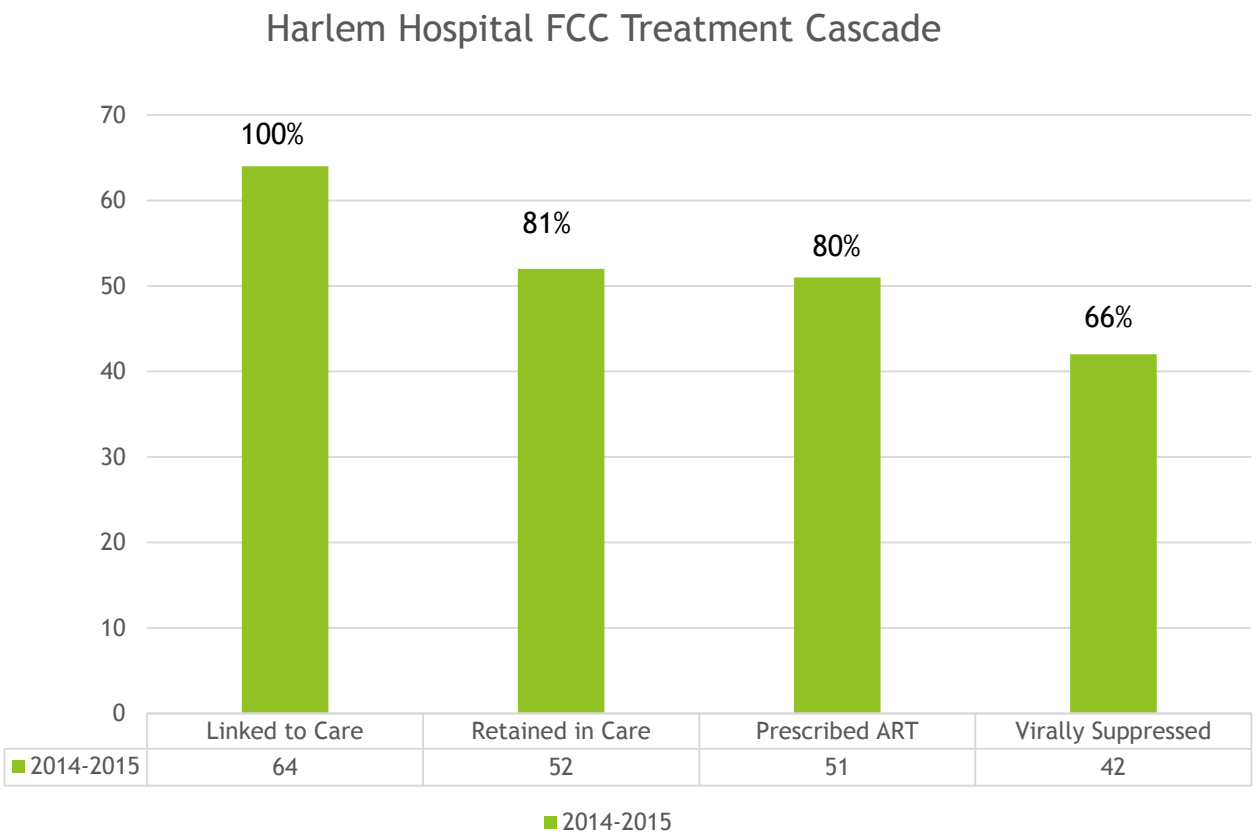
The Checklist

	Yes	No	Other
Knows how to contact the doctor			
Able to attend medical appointments independently			
Able to arrive on time for medical appointments			
Able to give medical history, including HIV status			
Able to identify the name of pharmacy			
Able to contact pharmacy			
Able to obtain refills from medical providers			
Able to make PCP appointments independently			
Able to make specialty medical provider appointments independently			
Able to identify closest ER to home			
Knows when to seek medical care for symptoms and emergencies			
Able to answer “What are T cells?”			
Able to verbalize last T cell count			
Able to answer “What is a viral load?”			
Able to verbalize last viral load			
Knows names & purposes of medications			
Able to adhere to medication regimens			
Has knowledge of modes of HIV transmission and prevention			
Has knowledge of contraception options, STI’s, STI prevention			

Checklist Implementation

1) Administer checklist every 6 months at pediatric CC meeting following medical appt.
2) Each item on the checklist is discussed – Can s/he do this?
3) Team discussion and debate. Example – Is calling your medical case manager the same as knowing how to schedule a medical appt?
4) Identify needs/gaps – everyone picks a goal to work on.
5) Enter checklist data in spreadsheet to monitor program effectiveness.
6) Checklist is filled in client binder and re-reviewed every six months.

FCC Youth Treatment Cascade



Of the 12 patients not retained in care, 5 were incarcerated or moved and transferred care. Excluding these 5 patients would increase the retention rate to 88%, prescribed ART to 86%, and virally suppressed to 71%.

Results: As of October 31, 2016

	#/n	%
Knows how to contact the doctor	28/48	58%
Able to attend medical appointments independently	41/48	85%
Able to arrive on time for medical appointments	33/48	69%
Able to give medical history, including HIV status	42/48	88%
Able to identify the name of pharmacy	40/47	85%
Able to contact pharmacy	20/47	43%
Able to obtain refills from medical providers	24/47	51%
Knows how to maintain active health insurance	16/48	33%
Able to make PCP appointments independently	31/48	65%
Able to make specialty medical provider appointments independently	15/48	31%
Able to identify closest ER to home	41/48	85%
Knows when to seek medical care for symptoms and emergencies	38/48	79%
Able to answer "What are T cells?"	44/48	92%
Able to verbalize last T cell count	15/48	31%
Able to answer "What is a viral load?"	44/48	92%
Able to verbalize last viral load	28/48	58%
Knows names & purposes of medications	43/48	90%
Able to adhere to medication regimens	25/47	53%
Has knowledge of modes of HIV transmission and prevention	43/48	90%
Has knowledge of contraception options, STI's, and STI prevention	37/48	77%

Changes Just this Year: From January – October 2016

- Able to Arrive on Time for Medical Appts: From 64% - 69%
- Able to Contact Pharmacy: From 37% - 43%
- Able to Identify Closest ER to Home: From 79% - 85%
- Able to Verbalize Last Viral Load: From 55% - 58%
- Has Knowledge of Modes of HIV Transmission and Prevention: From 87% - 90%

Result Highlights

- Health education on HIV is successful:
  - 90% of youth can describe transmission and prevention
  - 92% can describe what T-cells are
  - 92% can describe what viral load means
  - 90% know the names and purposes of medications
- Health Literacy is increasing:
  - 88% can give medical history, including HIV status
  - 85% know the closest ER to their home
  - 79% know when to seek care for symptoms and emergencies
- Youth are becoming more independent:
  - 85% can attend appts independently

There is Still Work to Be Done

- Knowledge doesn't necessarily translate to behavior
  - While 85% know the name of their pharmacy, only 43% know how to contact their pharmacy, and only 51% know how to ask a provider for refills
- Independence in health care behaviors seems limited to the pediatric ID clinic.
  - Only 31% can schedule a specialty medical appt (dentist, etc.)
  - Only 33% know how to maintain active health insurance
- Health Literacy gains are inconsistent
  - Only 31% know their last T-cell count, 58% know last viral load

Lessons Learned and Next Steps

- Good news: We were able to reach our goal of over 75% on a whopping 10 TRC items! We can now set the bar higher.
- Gains are not evenly distributed – We did not meet our goal of 50% for all youth completing all items on the TRC. Some youth need additional support.
- Health literacy and life skill gains need to be spread to other clinics, departments, and organizations, ***particularly pharmacy access***.
- Maintaining active health insurance is key to health care access – this process needs to be made clearer to youth.
- Knowledge isn't translating to adherence – only 53% can adhere to ART.

Questions?

Leveraging Technology to Integrate Trauma Informed Care in Everyday Practice

BRIDGING ACCESS *to* CARE *Inc.*

Nadine Akinyemi, MHA

BRIDGING ACCESS to CARE Inc.

www.bac-ny.org

Background

- BAC's Services & Harm Reduction Program
  - Trauma Identified as a barrier to care
    - Sociocultural Perspective
    - Organizational Culture Perspective

BRIDGING ACCESS to CARE Inc.

www.bac-ny.org

Our Aspirations

Impose an organizational culture change that transforms the agency into a trauma-informed, value based, data-driven entity that integrates trauma-informed approaches into everyday activities and tracks trauma outcomes to improve quality of care in all programs.

BRIDGING ACCESS to CARE Inc.

www.bac-ny.org

Project Goal

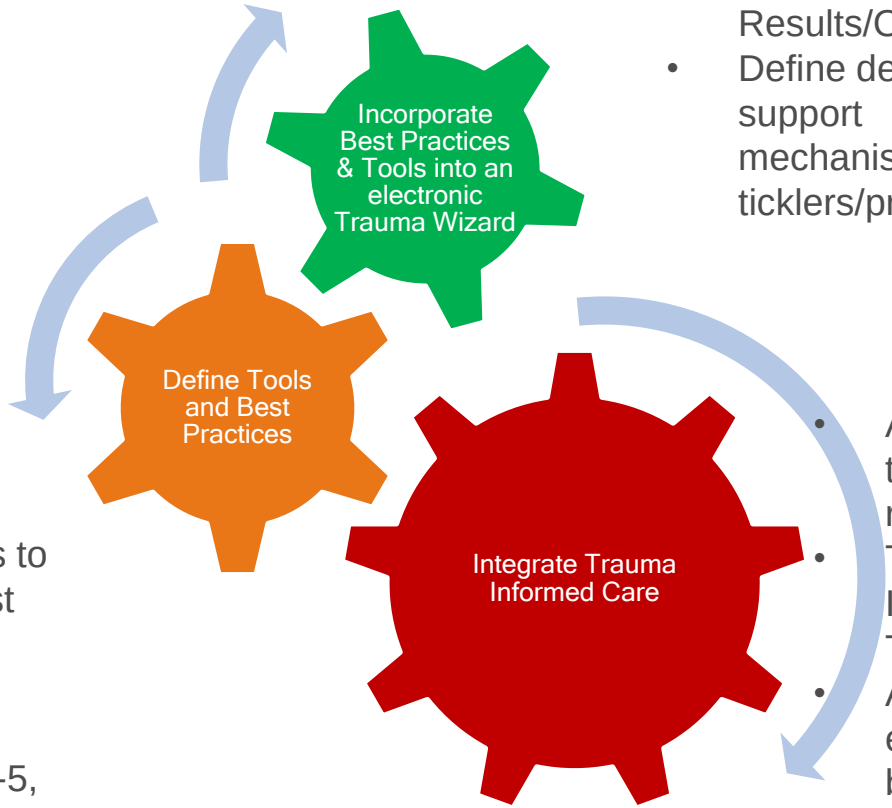
- The goal was to screen 100% of HRR clients for trauma, increase the number of HRR clients receiving Seeking Safety to 85%, increase the number of HRR clients referred to mental health services to 50%, increase the number of HRR clients linked to mental health services to 50%, and assess the impact of trauma on functionality.

BRIDGING ACCESS to CARE Inc.

www.bac-ny.org

BAC's Strategies

- Determine matrix for Decision Tree Assessments
- Trend Trauma Results/Outcomes
- Define decision support mechanisms—ticklers/prompts



- Research Trauma Screening Tools
- Select user-friendly tools to promote best practices
  - PCLS, PCL5, CAPS-5, DLA-20

- Assess agency trauma readiness
- Trauma Informed Training
- Adjust physical environment to become trauma sensitive

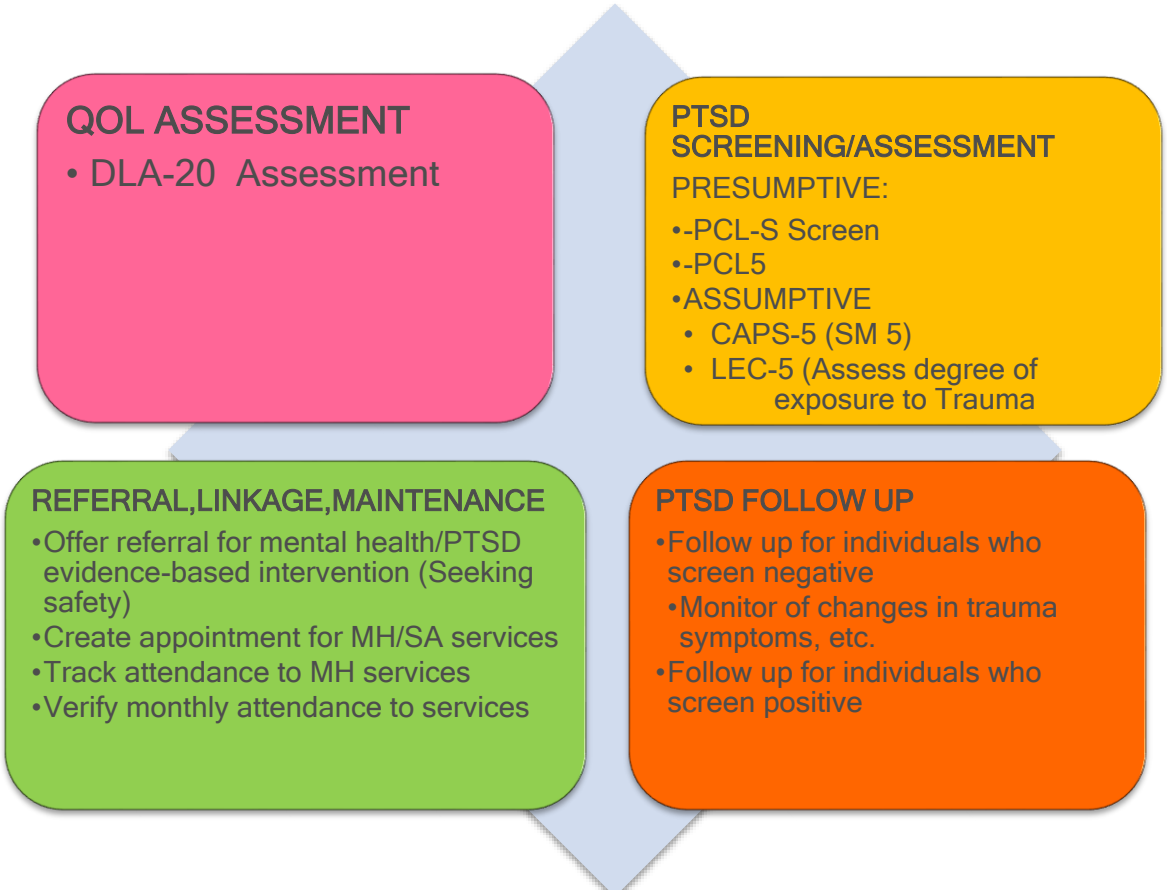
Implementation

Method

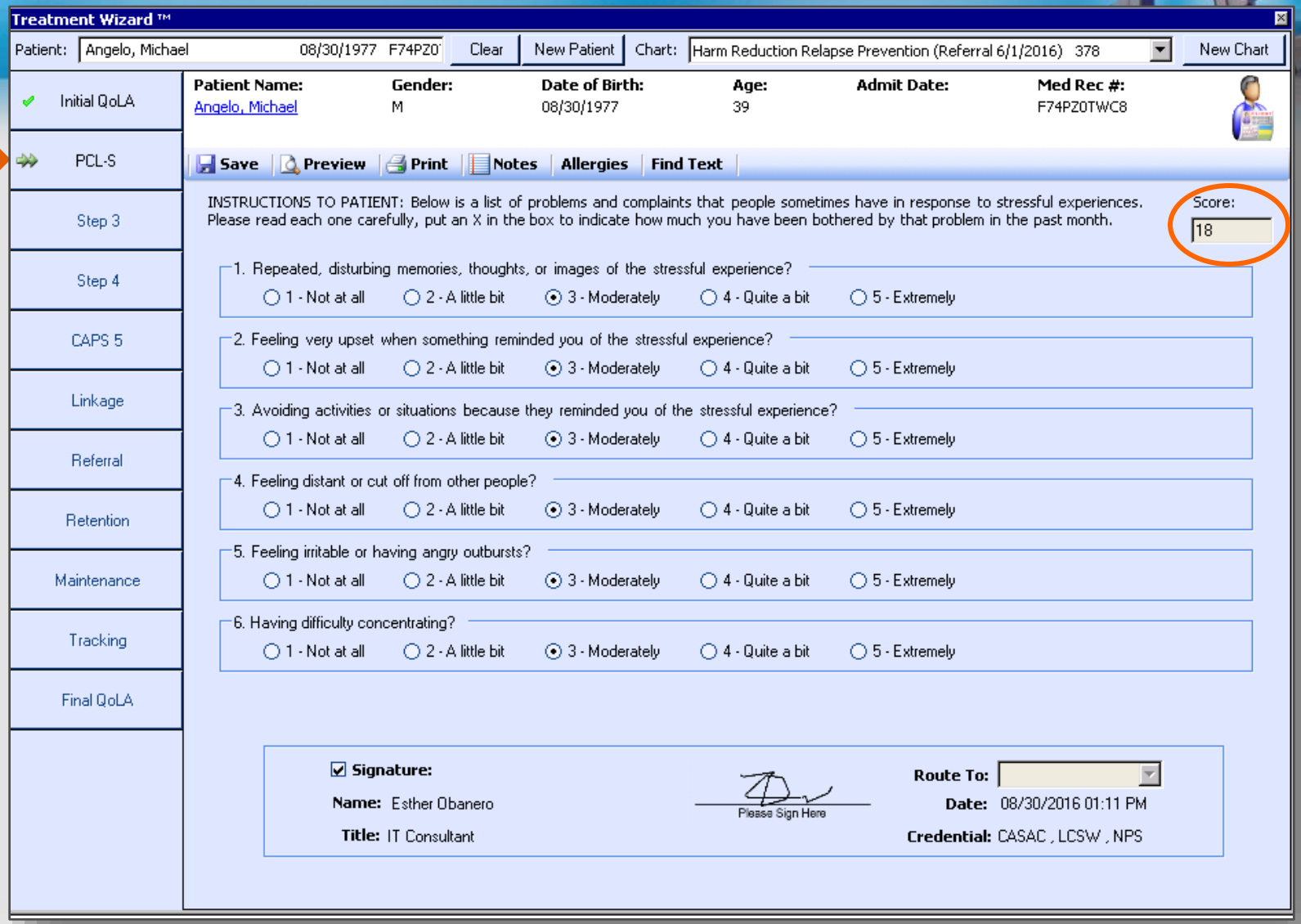
Method

- Identify Barriers
  - Chart Reviews
  - Staff Interviews
  - Literature Review
- Analyze data from EHR Trauma Wizard
  - Pre/post Trauma Wizard Implementation
  - Trend client trauma outcomes, severity of trauma, and level of functioning

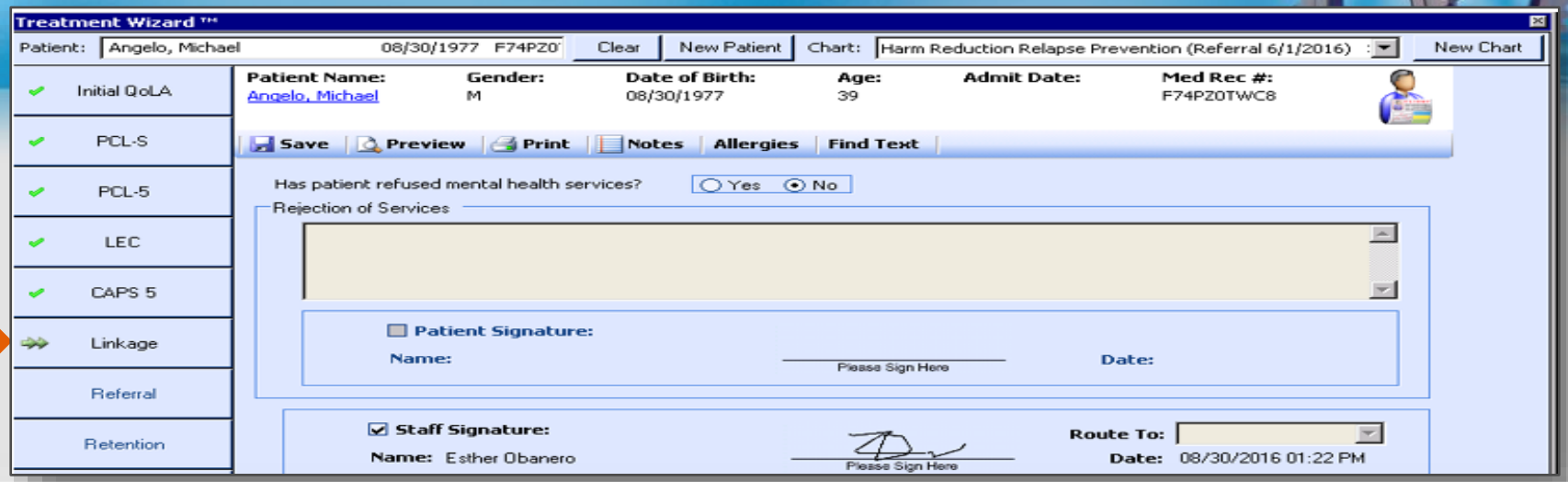
Work Flow

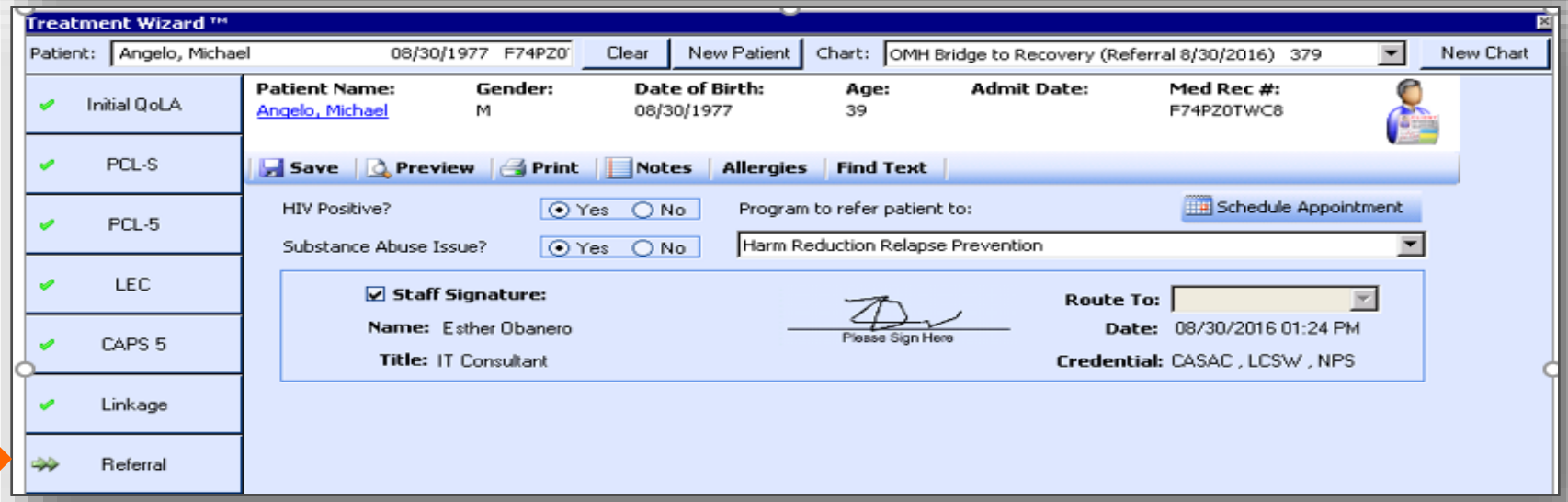

QOL ASSESSMENT
• DLA-20 Assessment
PTSD SCREENING/ASSESSMENT
PRESUMPTIVE:
•-PCL-S Screen
•-PCL5
•ASSUMPTIVE
• CAPS-5 (SM 5)
• LEC-5 (Assess degree of exposure to Trauma
REFERRAL,LINKAGE,MAINTENANCE
•Offer referral for mental health/PTSD evidence-based intervention (Seeking safety)
•Create appointment for MH/SA services
•Track attendance to MH services
•Verify monthly attendance to services
PTSD FOLLOW UP
•Follow up for individuals who screen negative
•Monitor of changes in trauma symptoms, etc.
•Follow up for individuals who screen positive

Presumptive PTSD Screen



Referral & Linkage to Care



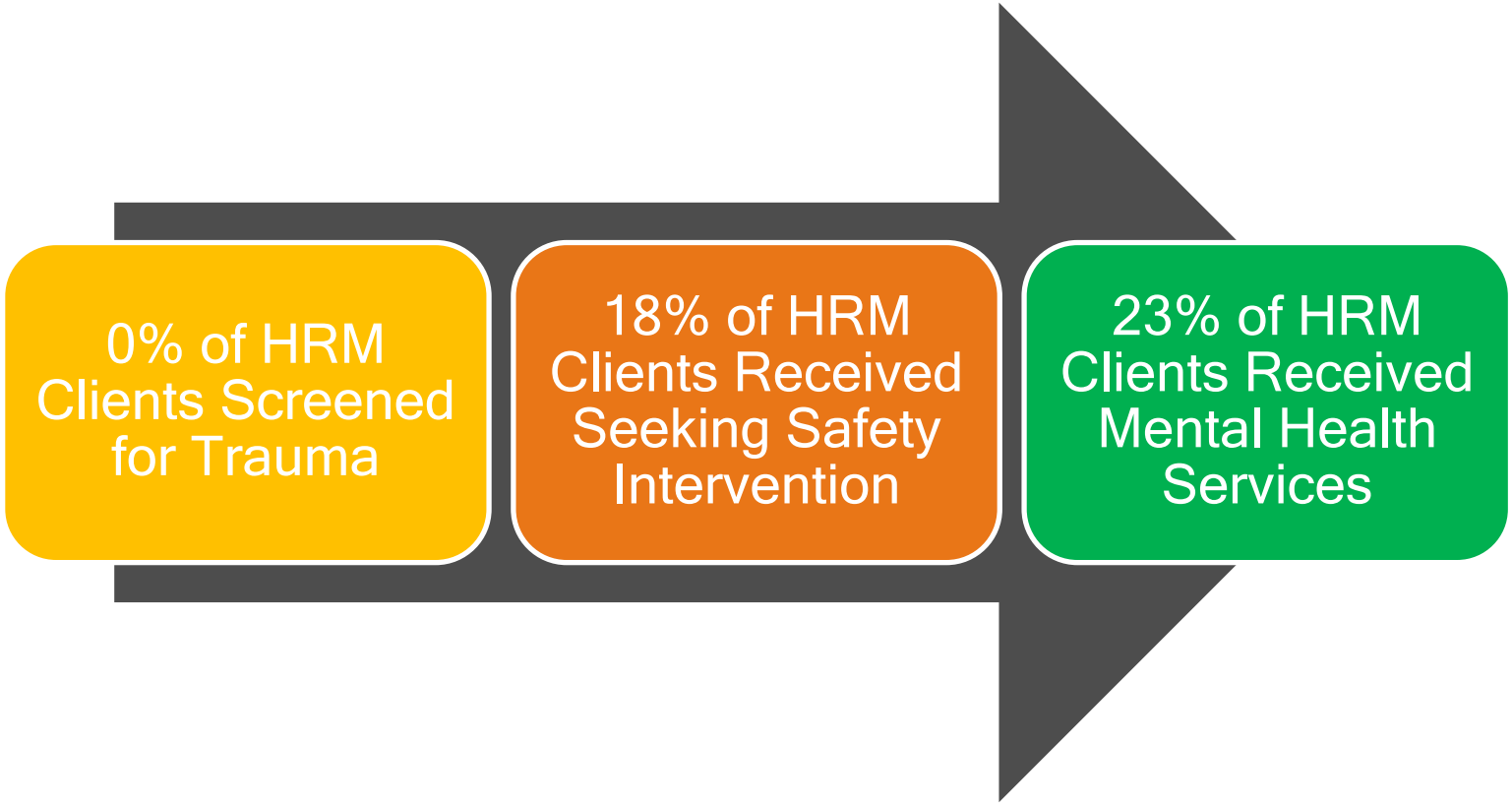


Project Evaluation

Results

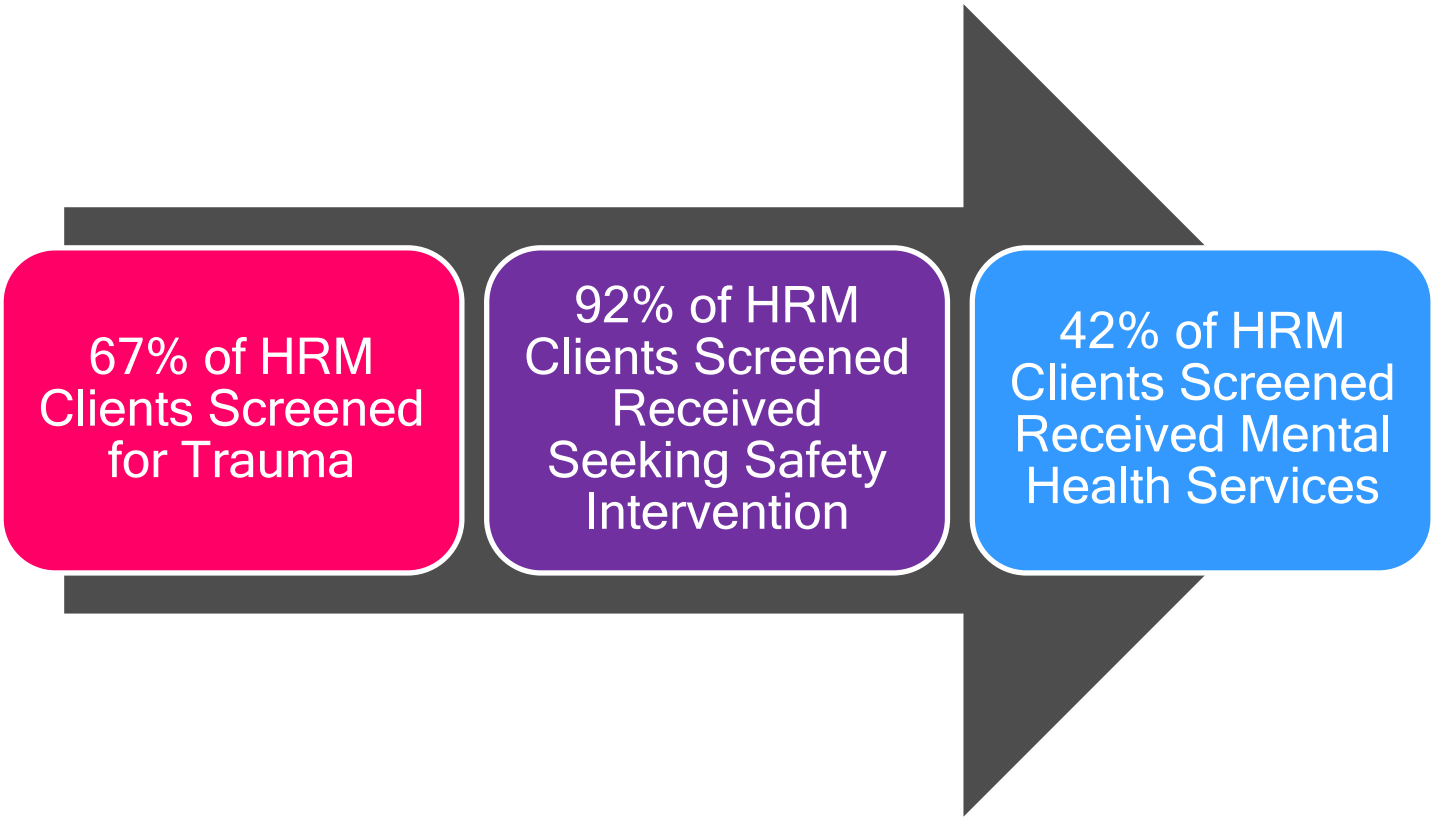
Pre Trauma Informed Care Implementation (Baseline)

Clients Screened for Trauma and referred to SS and MH Services
March 2015 to February 2016

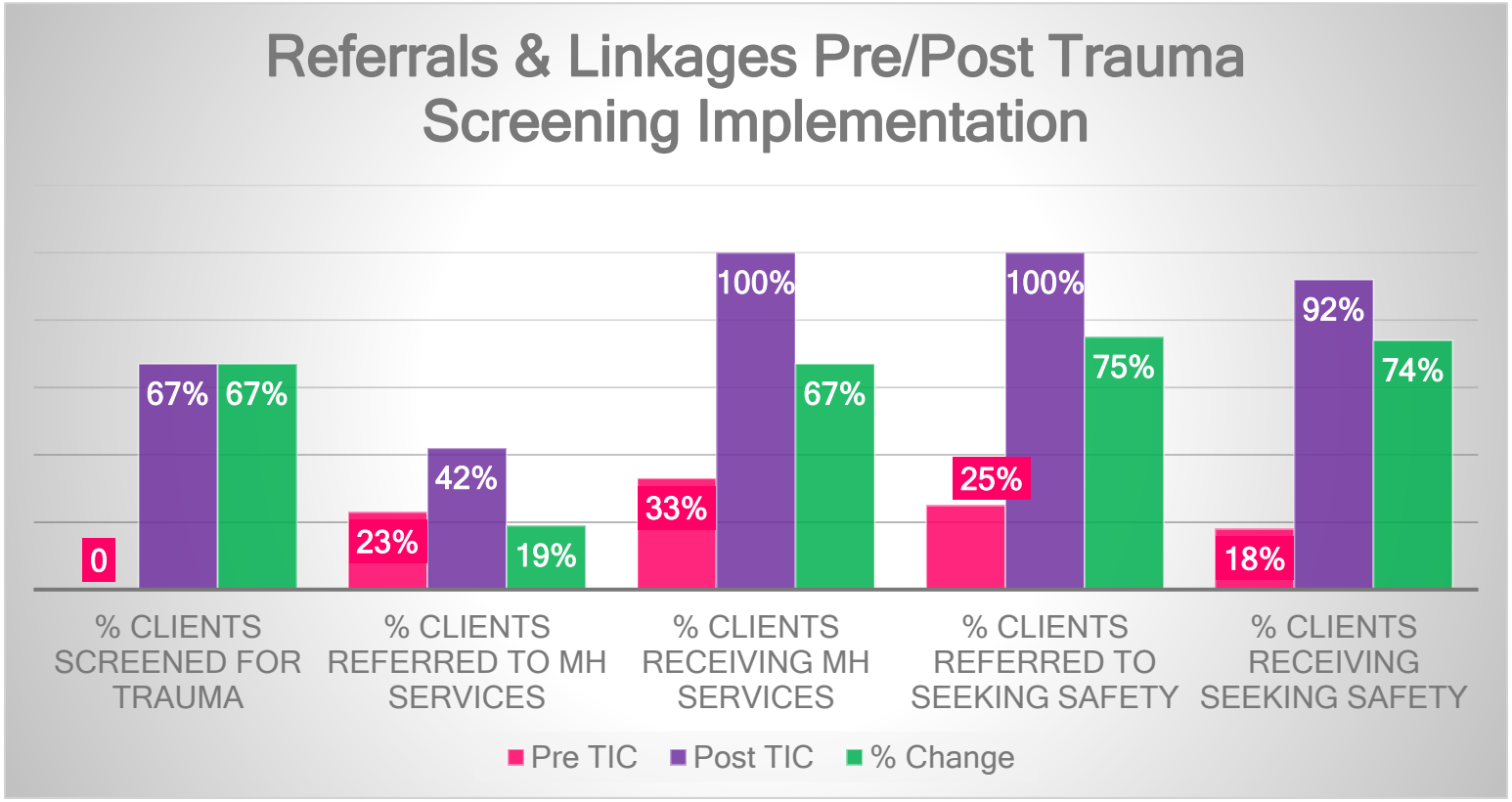


Post Trauma Informed Care Implementation

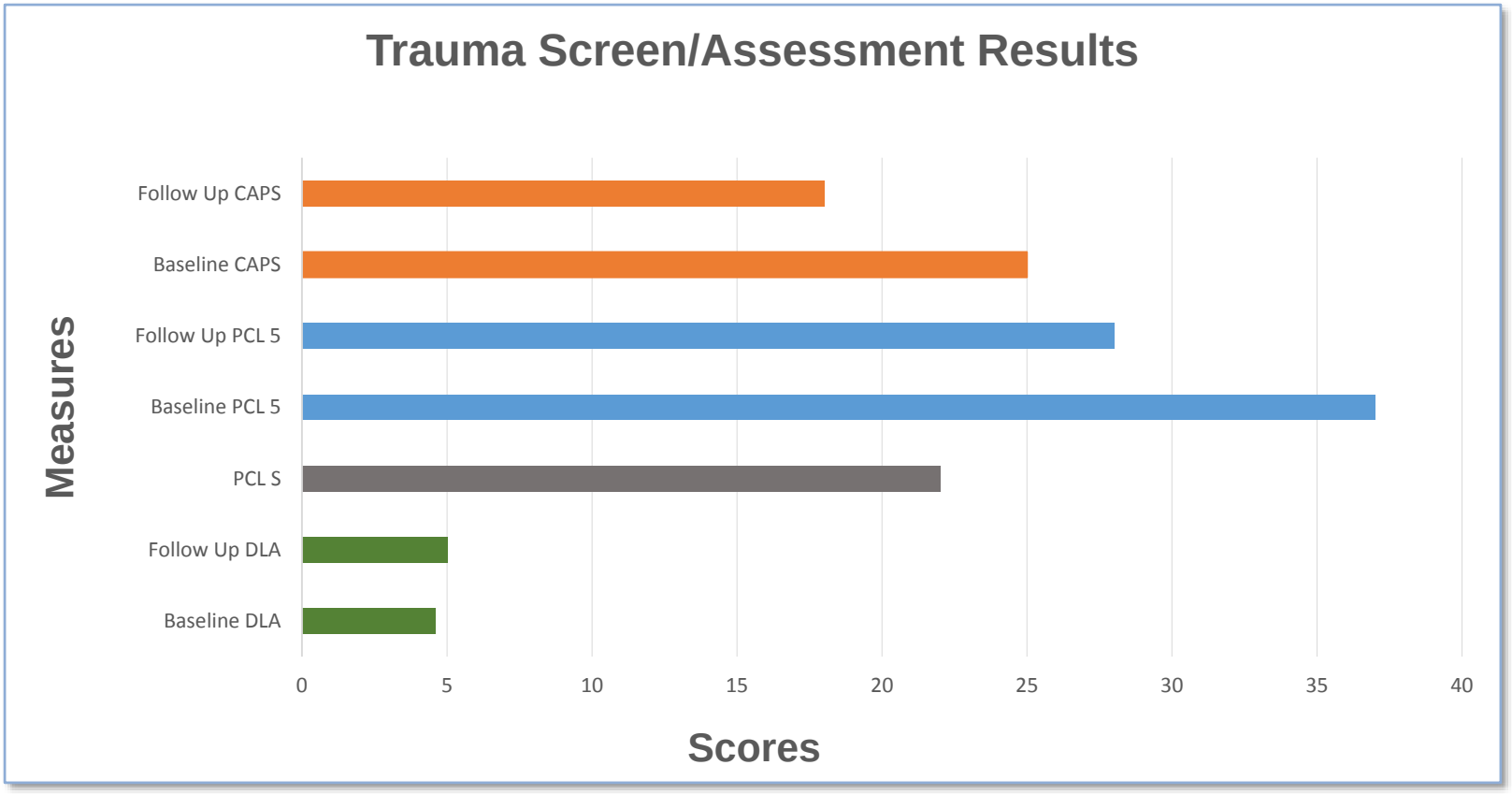
 # Clients Screened for Trauma and referred to SS and MH Services
March 2016 to July 2016



Referral & Linkage to Care



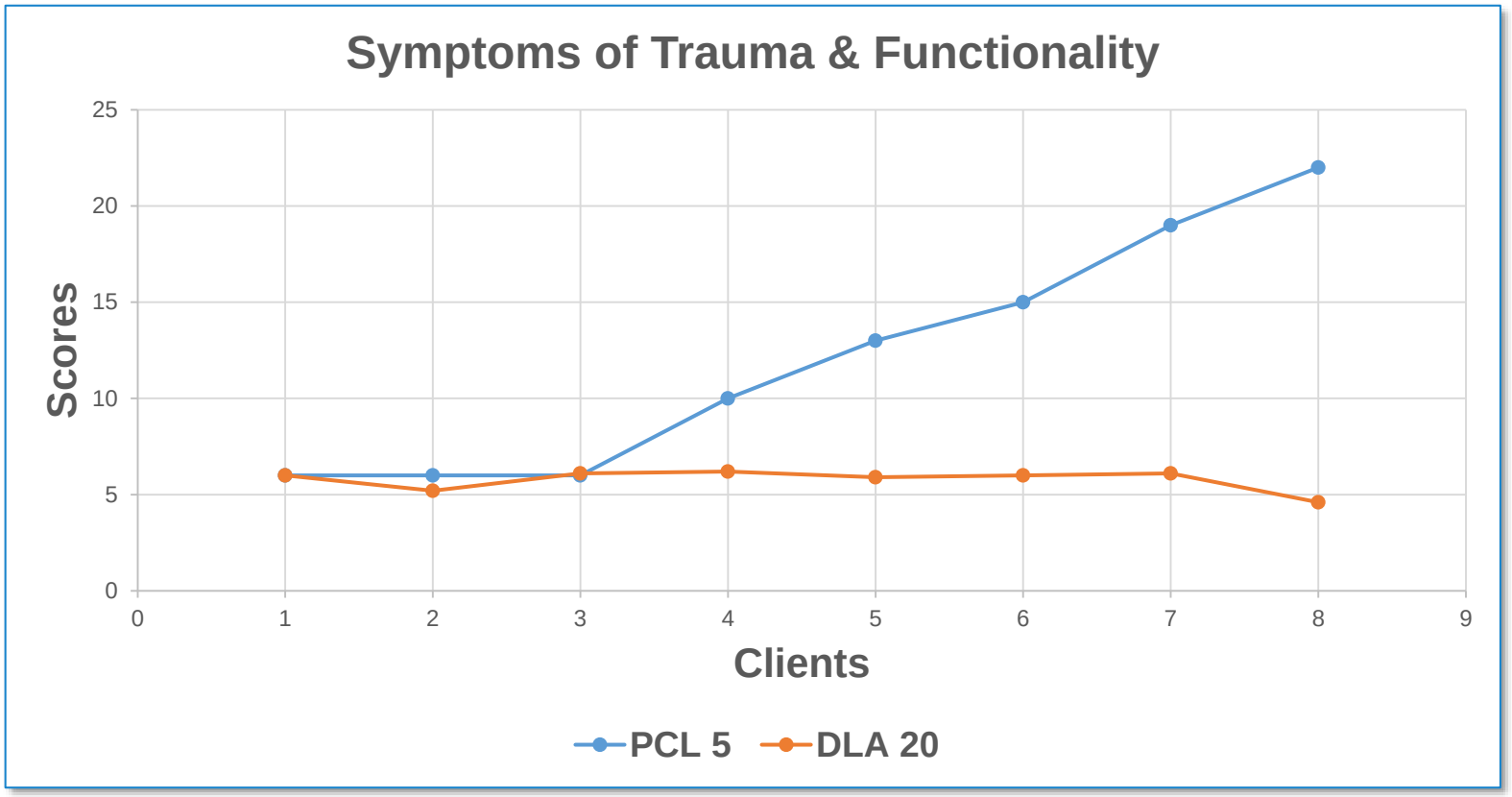
Trauma & Functionality Measures



Example of a client who completed baseline and follow up Screening/Assessments

Symptoms vs. Functionality

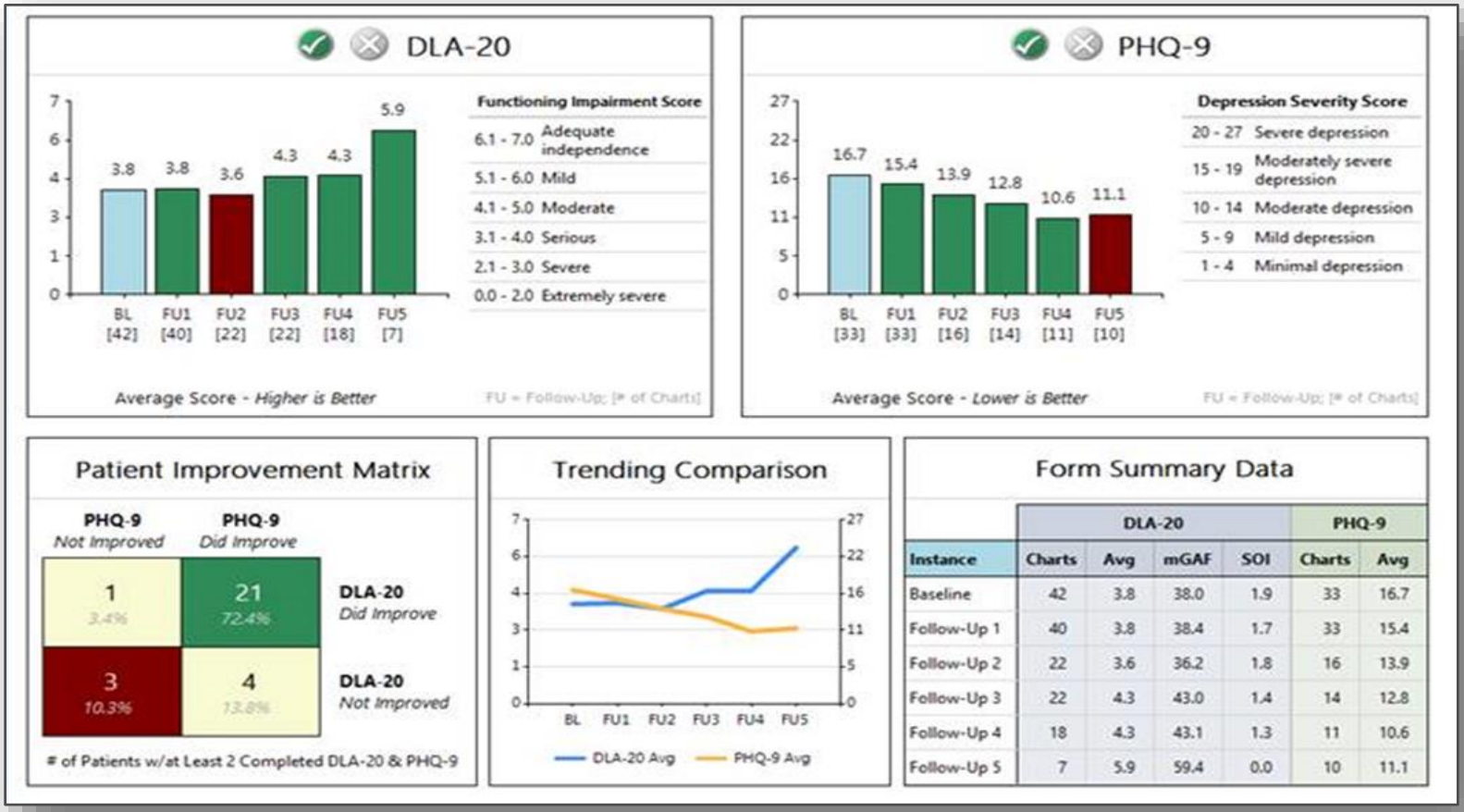
37% of HRR Clients Screen Positive for Trauma



Mar 2016 – Aug 2016

BRIDGING ACCESS to CARE Inc.

Data Analytics



	DLA-20				PHQ-9	
Instance	Charts	Avg	mGAF	SOI	Charts	Avg
Baseline	42	3.8	38.0	1.9	33	16.7
Follow-Up 1	40	3.8	38.4	1.7	33	15.4
Follow-Up 2	22	3.6	36.2	1.8	16	13.9
Follow-Up 3	22	4.3	43.0	1.4	14	12.8
Follow-Up 4	18	4.3	43.1	1.3	11	10.6
Follow-Up 5	7	5.9	59.4	0.0	10	11.1

Example of Dashboard Detailing Patient Improvement Matrix

Lessons Learned

INTEGRATING TRAUMA INFORMED CARE

BRIDGING ACCESS to CARE Inc.

www.bac-ny.org

Lessons Learned

- Trauma is a barrier to accessing care and can influence health outcomes
- When trauma symptoms decreased, functionality increased
- Clients who had significant decreases in trauma symptoms were actively engaged in mental health services and evidence-based interventions
- Systematizing trauma informed care can improve consumer health outcomes
- Delivering care using a trauma-sensitive approach can be augmented by an electronic health record system
- Developing a trauma sensitive plan of care can facilitate the delivery of trauma informed care

Next Steps

Where do we want to go?

BRIDGING ACCESS to CARE Inc.

www.bac-ny.org

Next Steps

- Routinize Trauma Screen agency-wide
- Ongoing data analysis to determine if any change occurred using the trauma wizard to measure progress
- Implement a Trauma Specific Plan of Care (POC)
- Create a client dashboard that provides a global view of consumer progress that can be shared with appropriate personnel
- Identify areas of improvement to address additional trauma specific issues needing interventions
- Enhance the value of care to the consumer
- Decision support mechanisms to assist in decision-making
- Enhance person-centered approach

Questions and Comments

BRIDGING ACCESS to CARE Inc.

www.bac-ny.org

Contact Information

Nadine Akinyemi, MHA

347-505-5115

nakinyemi@bac-ny.org

Mount Sinai

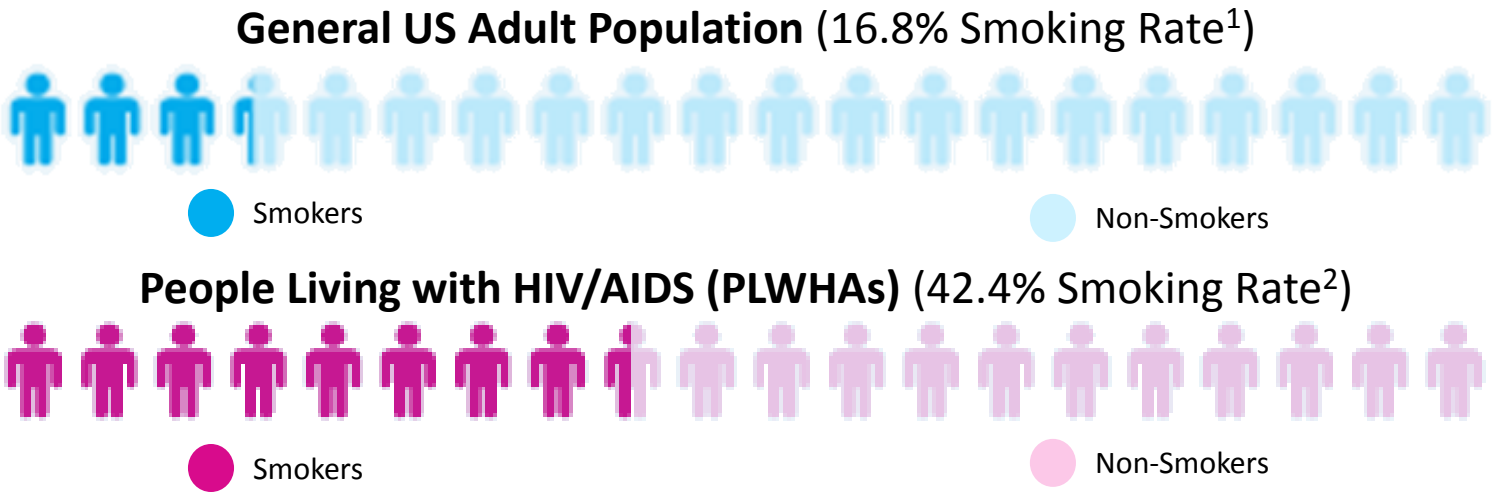
Personalizing Tobacco Cessation:

Using Care Coordination to Augment Provider-based Screening & Counseling

The Power of Quality Improvement Conference
November 9, 2016
Vanessa Haney, Christopher Joseph, Elaine Ruscetta

Institute for Advanced Medicine
Ryan White Part A Care Coordination Programs at
Mount Sinai Beth Israel * Mount Sinai Hospital * Mount Sinai St Luke's * Mount Sinai West

Smoking Prevalence & HIV

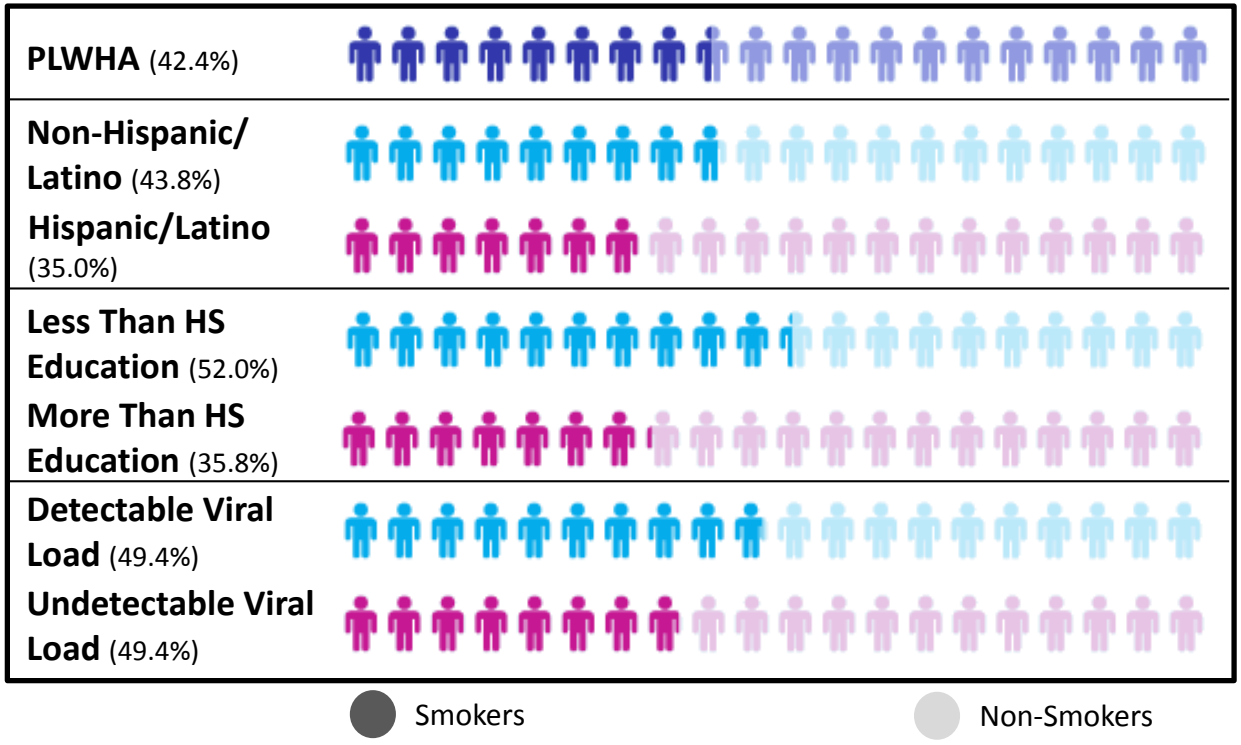


- PLWHA are more than **2.5 times more likely to smoke** than the general US adult population.[2]
- For PLWHA, cigarette smoking is associated with **a decreased response to antiretroviral therapy (ART)** and the development of thrush, pneumonia, cardiovascular & pulmonary diseases, and various cancers.[3]

Mount Sinai *Institute for Advanced Medicine*

Smoking Prevalence & Special Populations

- Smoking prevalence is also significantly higher among various subgroups of PLWHA, notably: non-Hispanic white or non-Hispanic black race, and those with less education. [4,5]



- Poverty, homelessness, incarceration, substance use, binge alcohol use, depression, and **having a detectable viral load** are also contributors to higher smoking rates for PLHWA. [4,5]

Mount Sinai *Institute for Advanced Medicine*

Provider-based Interventions

- Medical providers have a unique opportunity to prescribe and promote Nicotine Replacement Therapies (NRT) and pharmacotherapy to support tobacco cessation (i.e. Chantix) during medical visits.

- Research has shown that **as few as 3 minutes of counseling** provided by physicians has an impact on smoking cessation rates.[6]

IAM-wide Tobacco QI Initiative

- MSHS Institute for Advanced Medicine (IAM) primary care providers (PCPs) screen patients for tobacco use and offer counseling at least annually.
- Tobacco Screening/Counseling Rates are included in performance measures across IAM.
- While tobacco screening rates remain high across IAM, providers are currently trying to improve counseling rates as part of an IAM-wide QI Initiative.

RW Care Coordination QI Methods

- IAM's RWCC Tobacco Cessation QI Project has a three-pronged approach:
  1. Targeted screening of CC patients' tobacco use
  2. Personalized health education/promotion
  3. Multidisciplinary tobacco-use counseling

- Front-line CC Staff from across IAM's 3 RW Care Coordination Programs met as a QI Committee to develop this project.

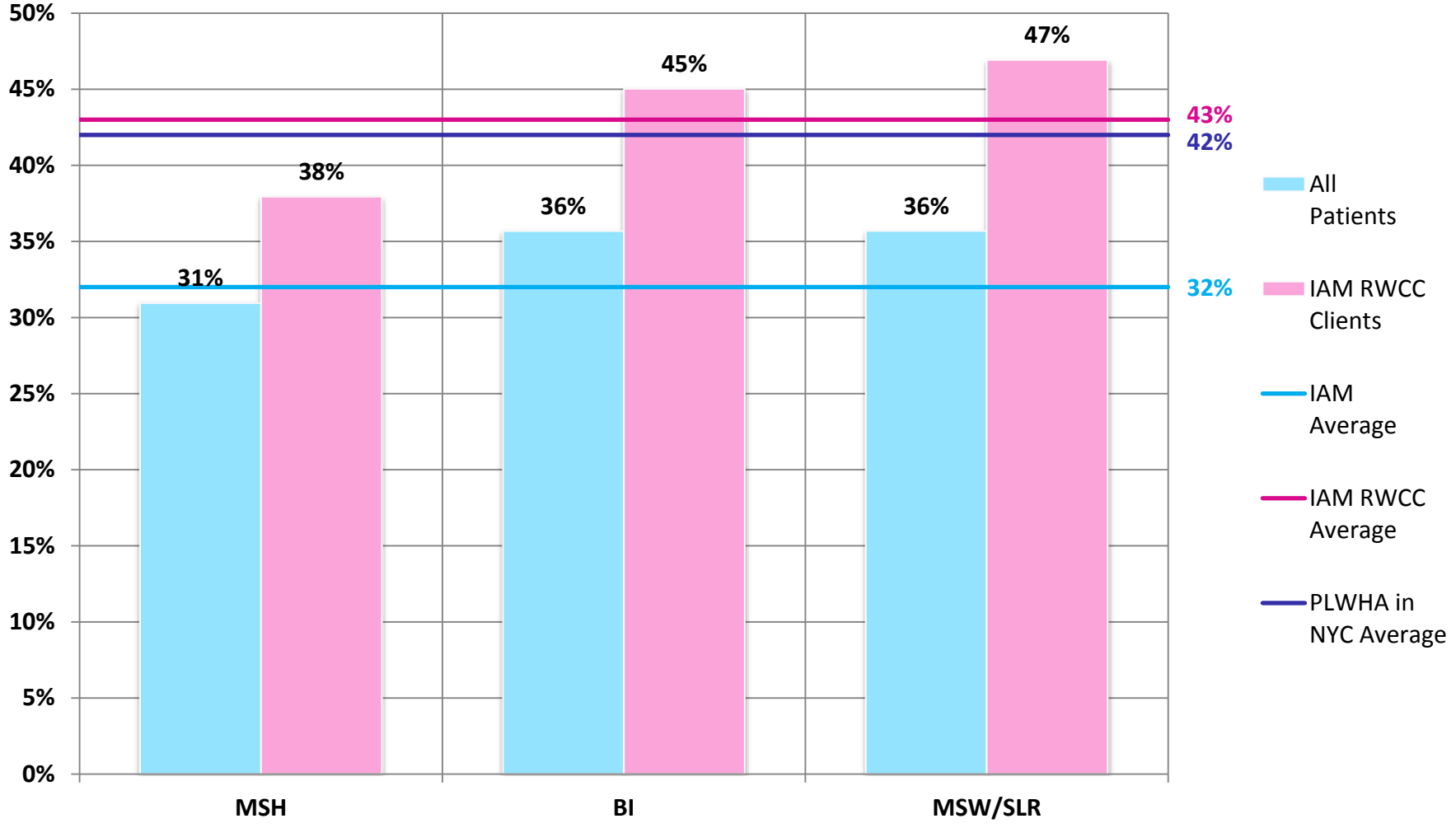
EMR Data and Patient Eligibility

- Data was pulled from the “Social History” and “Rooming” sections of Epic, the MSHS EMR. These should be updated by PCPs at each visit.

- NRT Prescriptions were also pulled by therapeutic class of medication.

- Data given to CC teams included each RWCC enrollee’s:
  - Last date screened for tobacco use
  - Current smoking status
  - Quit date (if applicable)
  - Last date counseled by PCP regarding tobacco use
  - NRT prescriptions (current and past)

IAM/RWCC Smoking Prevalence at Baseline



Mount Sinai *Institute for Advanced Medicine*

Use of Front-Line CC Staff

- Patient Navigators are uniquely aligned to screen/counsel patients about their tobacco use and assist in their plan to quit or reduce:
  - Frequent face-to-face visits (weekly or monthly)
  - Special training in Harm Reduction and Motivational Interviewing
  - Tobacco-related SMART Goals added to Care Plans

Targeted Health Education

- QI Committee tailored the pre-existing Harm Reduction health promotion module from NYCDOHMH to address tobacco/nicotine specifically.
- The module can be used for individual or group education sessions.

New Patient Questionnaire

- QI Committee developed a 2-part Patient Questionnaire:
  - Measures current & historical tobacco use
  - Assesses patients' "Readiness to Change" based on principles from Motivational Interviewing and Stages of Change Theory.

Part I: Behavioral Assessment

History of Tobacco Cessation

- What types of toba
- How many times have you tried to quit tobacco?

Part IIB: "Stage of Change" Assessment

Note: *The following questions are OPTIONAL and you do not need to ask them all. These questions can help you better understand your patients' strengths and barriers to tobacco use/cessation, as well identify opportunities for intervention.*

Pre-Contemplation (Score 0-3)

Consider asking the Following Question(s):

- What benefits do you get from using tobacco? (Perceived Benefits)
- What harm or negative effects has tobacco-use caused you? (Perceived Negative Consequences)
- Would you like more information about how smoking impacts your health?
- Would you like more information about how smoking impacts your HIV care?
- I understand you aren't ready to talk about quitting smoking, and that's OK. I would like to ask you about it again in 3 months. Is that OK?

Contemplation (Score 4-7)

Consider asking the Following Question(s):

- What benefits do you get from using tobacco? (Perceived Benefits)
- What harm or negative effects has tobacco-use caused you? (Perceived Negative Consequences)
- What are some steps you think you could take to start cutting down on how much you smoke?
- Why do you want to change your tobacco use? What would you gain by changing?
- What would be hard about changing your tobacco use? What concerns do you have?

Preparation/Action (Score 8-10)

Consider asking the Following Questions(s):

- What would change look like for you?
- Let's identify the steps necessary to help you stop smoking. What would be your first step?
- Who's been supportive of you before? How can he or she help you to quit smoking?
- Would you like to add Smoking Cessation as a goal on your Care Coordination Care Plan? We will revisit this topic a few times in the next 3-6 months.

Not at all Confident | Unsure | Very Confident

Multi-disciplinary Case Conference

- Results of Questionnaire are collected and shared via EMR with patient's PCP

- CC Staff also meet with PCP to discuss the findings in more detail, with the aim of ensuring future patient-provider tobacco counseling is appropriate to patients' readiness to change

CQI Goals

- Between 8/1/16 and 1/31/17, ≥75% of RWCC patients who currently use tobacco (a total of at least 186 patients across three programs) will:
  1. Complete our new Questionnaire,
  2. Receive at least 1 tobacco-related Health Promotion,
  3. Have a tobacco-specific Case Conference between RWCC Staff and their PCP, ideally including the patient as well.

QI Limitations

- Because this is a brief intervention, we are unable to draw conclusions about behavior change (i.e. quit rates, reduction in smoking).

- While CC Staff can inform and educate patients on nicotine replacement therapies, these decisions are ultimately made by Medical Providers and patients.

Lessons Learned & Future Implications

- Targeted tobacco-use counseling and smoking cessation are ongoing needs for >40% of patients within IAM's RWCC Programs.
- Collaborative QI Projects that utilize/build-upon staff strengths are most successful
- We may track "readiness to change" scores over time to see if health education and/or provider counseling move people toward "Action"
- Integration of Tobacco Questionnaire into EMR

Acknowledgements

Many thanks to our partners –

- Providers and colleagues within the Mount Sinai IAM for their continuous support and collaboration.
- Partners at NYCDOHMH, Public Health Solutions, NYS AIDS Institute & National Quality Center for their guidance and leadership.
- IAM Ryan White Care Coordination Program Staff & QI Team, especially Shruti Ramachandran, Vince Mojica & Rebecca Lindner.
- CC colleagues at other agencies, with whom we exchange best practices.
- Last but not least, thanks to our collaborating clients, from whom we learn every day.

Mount Sinai *Institute for Advanced Medicine*

Thank you!

Questions?

Resources

1. Centers for Disease Control and Prevention. ”Smoking and HIV.” [last updated 2015 September 1; accessed 2016, August 22.]

2. Mdodo, R.; Frazier, E.; Dube, S.R.; Mattson, C.; Sutton, M.; Brooks, J.; Skarbinski, J. (2015) “Cigarette Smoking Prevalence Among Adults With HIV Compared With the General Adult Population in the United States: Cross-sectional Surveys.” *Ann Intern Med.*, 162(5): 335-344.

3. Kwong, J., & Bouchard, K. (2010). “Smoking cessation for persons living with HIV: A review of currently available interventions.” *Journal of the Association of Nurses in AIDS Care*, 21(1): 3-10.

4. Centers for Disease Control and Prevention. (2012). “Current cigarette smoking among adults—United States, 2011.” *MMWR Morb Mortal Wkly Rep*., 61: 889-94.

5. Krueger, P. & Chang, V. (2008). “Being poor and coping with stress: health behaviors and the risk of death.” *Am J Public Health*, 98: 889-96.

6. Fiore, M.; Jaen, C.; Baker, T.; Bailey, W.; Benowitz, N.; Curry, S.; . . .Wewers, M. (2008 Sept 1). “Treating tobacco use and dependence: 2008 Update.” *Respiratory Care*, 53(9): 1217-1222.

Women's Narratives

The role of group health promotion in increasing social support among women living with HIV

Addressing the Needs of the Whole Patient in the Care Coordination Program

Vanessa Pizarro, LMSW
Associate Program Director
The Institute for Family Health

THE INSTITUTE FOR FAMILY HEALTH

The Institute for Family Health

- Federally Qualified Health Center
- Network of 27 full and part-time clinics in Manhattan, the Bronx and the Mid-Hudson region, serving over 90,000 patients annually
- Joint Commission accredited, Level 3 Patient Centered Medical Home
- Primary care, mental health, dental care, case/care management, community programs and more
- HIV specific services at 3 locations: Family Health Center of Harlem, Urban Horizons (Bronx), Sidney Hillman/Phillips Clinic (Union Square)
- Ryan White Part A, C and AIDS Institute supplemental funding.
- Serving approx. 1000 patients with HIV/AIDS annually

THE INSTITUTE FOR FAMILY HEALTH

BACKGROUND

- Expanded scope of Health Promotion from individual to group-based in May 2015
- The benefits of support group interventions for people living with HIV/AIDS are well established
- Curiosity about supports outside of CBO setting
- Curiosity about Women's Groups

THE INSTITUTE FOR FAMILY HEALTH

HYPOTHESIS

“Can women come together and feel comfortable talking openly about HIV and HIV disclosure, and impact social supports”

THE INSTITUTE FOR FAMILY HEALTH

AIM

This project set out to explore the effectiveness of group based health promotion as a form of social support among women living with HIV receiving primary care and supportive services at an FQHC in Harlem

THE INSTITUTE FOR FAMILY HEALTH

METHODS

- Monthly groups
- HIV Positive and women-identified
- Typically Tues or Thurs afternoons (flex time)
- 90 mins (1 hour of discussion)
- Participant led, organic/flexible flow of conversation
- Snacks provided – group decided

THE INSTITUTE FOR FAMILY HEALTH

METHODS cont.

- Group developed norms, days/times
- “What we want…” – Individual
- “What we expect…” – Rules for all
- Diagnosis year/risk was encouraged to be shared
- Often emotional reactions
- Group reminders provided (flyer, phone)

THE INSTITUTE FOR FAMILY HEALTH

COMPASS Women's Group

Oct 14th and 28th

Fridays

230-4pm
Family Health
Center of Harlem
1824 Madison
2nd Floor Conf.
Room, SIDE B

Vanessa Pizarro,
LMSW
212-423-4500
Ext 4573

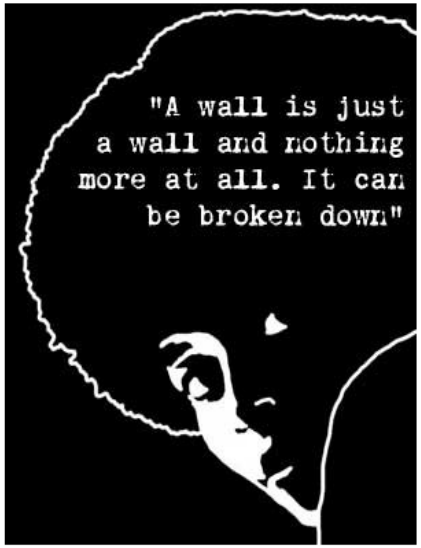
COMPASS Women's Group

Nov 10 & 29th

Thurs & Tues

330-5pm
Family Health
Center of Harlem
1824 Madison
2nd Floor Conf.
Room, SIDE B

Vanessa Pizarro, LMSW
212-423-4500
Ext 4573



~Assata Shakur~

THE INSTITUTE FOR FAMILY HEALTH

INTERVIEWS

- How was group different from your individual meetings with other people like therapists or doctors or family or friends?
- How did it feel in group when talking about your experiences living with HIV and people learning about your status?
- How was group a **positive** or a **negative** experience for you?
- Why do you believe you keep coming to group?
- What do you want to see **more of** or **less of** in future groups?
- Are you comfortable coming to group?
- What is different about this group from other groups you've been to?
- What if the group included negative women as well?

THE INSTITUTE FOR FAMILY HEALTH

CHART REVIEWS

What was I looking for?

Connections to VLS, retention in care, adherence, disclosure comfort/discussion, appointment attendance, engagement in mental health

THE INSTITUTE FOR FAMILY HEALTH

RESULTS

- Overwhelmingly positive interview responses
- “I feel happy meeting new people”
- “I like the women in the group”
- “We all have the same situation”
- “We get to the bottom of things”
- ¾ women were against/ambivalent about adding negative women
- Endorsement of shared experiences related to disclosure

THE INSTITUTE FOR FAMILY HEALTH

CONCLUSION

- Group conversations were much richer and far more animated than in individual settings
- Many expressed a universal women-hood experience
- Participants expressed a desire for normalcy, and a want to no longer be “othered”

- Stigma, fear and past neg. experience > want for sameness/inclusion

THE INSTITUTE FOR FAMILY HEALTH

Participant Experience

THE INSTITUTE FOR FAMILY HEALTH

QUESTIONS

THE INSTITUTE FOR FAMILY HEALTH

Resources

- Liamputtong, Pranee, Niphattra Haritavorn, and Niyada Kiatying-Angsulee. "HIV and AIDS, Stigma and AIDS Support Groups: Perspectives from Women Living with HIV and AIDS in Central Thailand." *Social Science & Medicine* 69.6 (2009): 862-68. Web

THE INSTITUTE FOR FAMILY HEALTH

Last Session
Rosenthal, 10th Floor at 3:15PM
Closing Remarks
&
Poster Awards