Introduction to the REACH Programme

A strategy to optimise long-term care for patients with HIV

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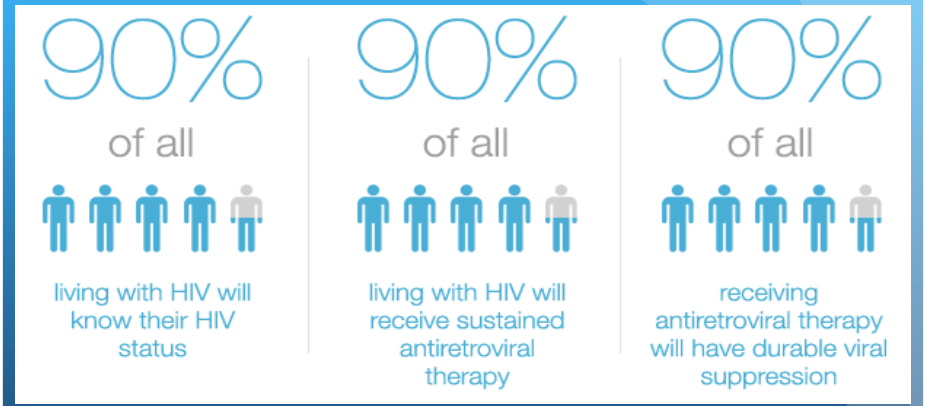
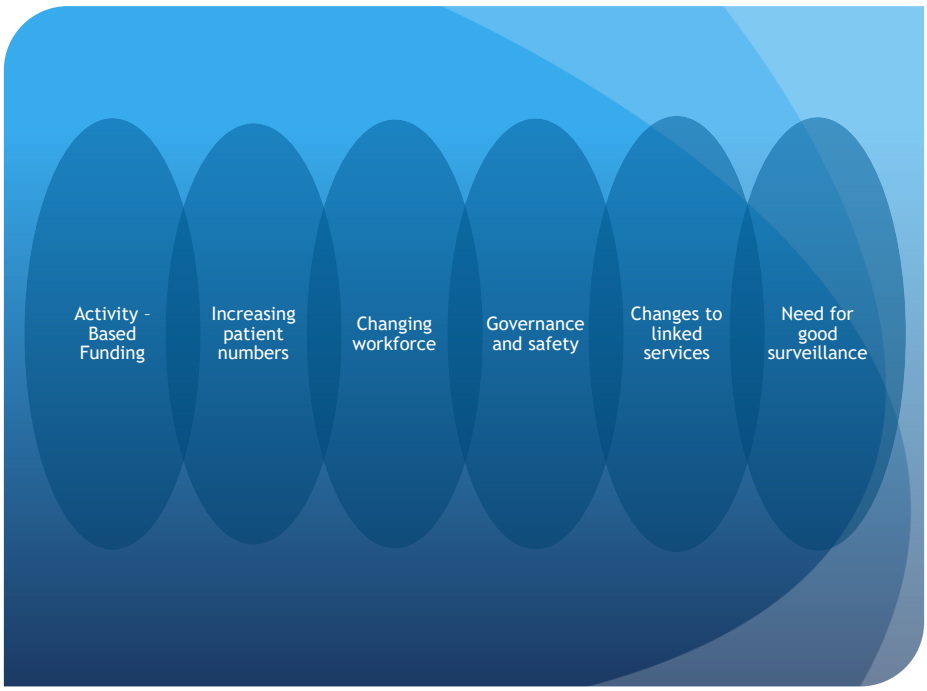
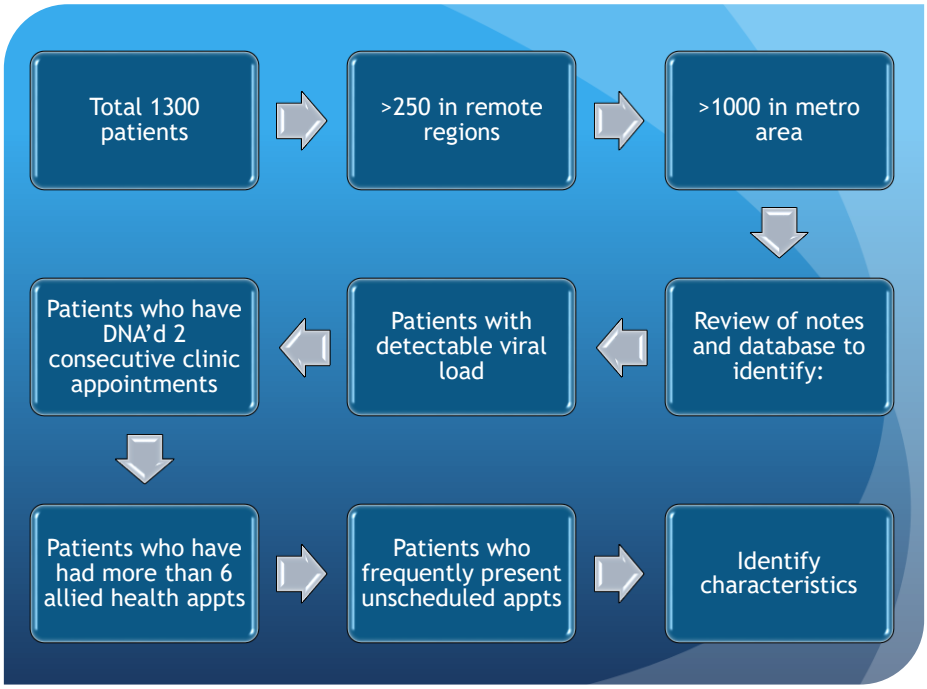


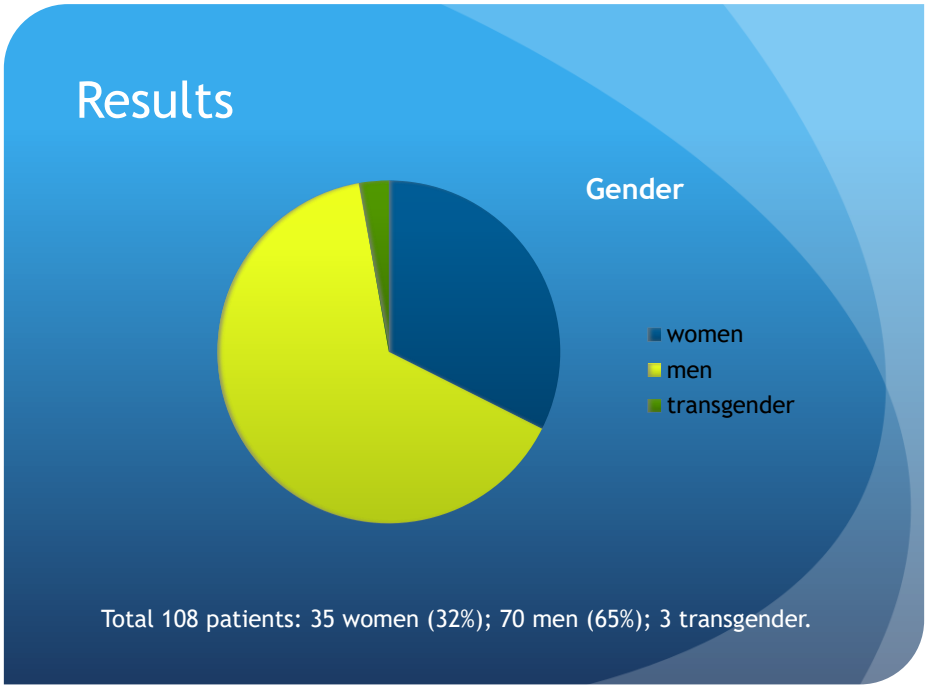
What about the other 10% ?

A systematic process to:

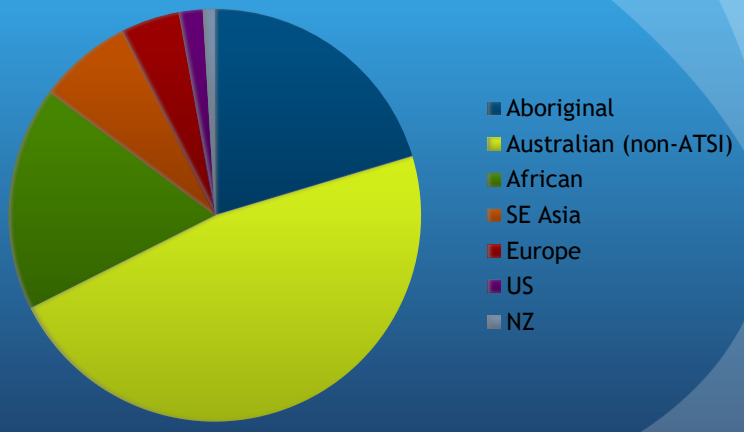
- Identify patients who have become disengaged with clinic services or are at risk of becoming disengaged.
- Identifying the patients who are engaged in service only through sustained effort of team.
- Develop pathways to promote medication adherence
- Developing systems to minimise risk of clients being lost to follow up.
- Promote links with services inside and outside the hospital




Total 1300 patients
>250 in remote regions
>1000 in metro area
Review of notes and database to identify:
Patients with detectable viral load
Patients who have DNA'd 2 consecutive clinic appointments
Patients who have had more than 6 allied health appts
Patients who frequently present unscheduled appts
Identify characteristics

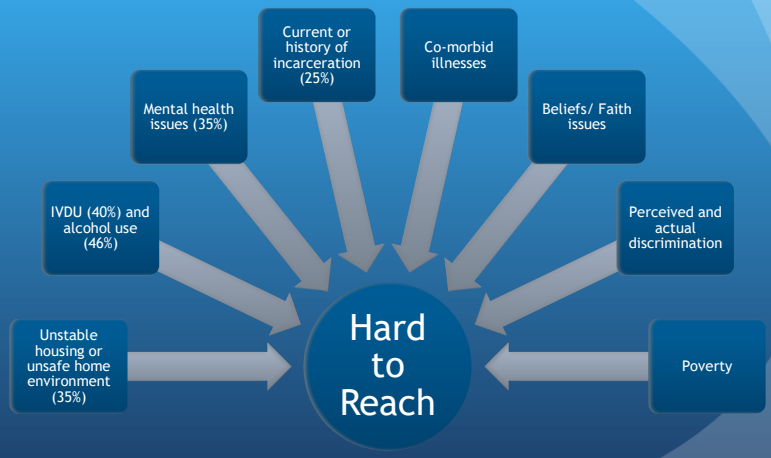

Results
Gender
women
men
transgender
Total 108 patients: 35 women (32%); 70 men (65%); 3 transgender.

Country of Origin



Non-ATSI Australian 47%; ATSI 20%; African 18%; SE Asia 7%; European 5%; US 2%

Identifying the hard to reach



Total 108 patients

Use of other services

- 74% patients have made more than 6 nursing/allied health visits in the last year. (Some >50)
- 43% don't have a GP
- Nearly half of the patients had presented to the Emergency Department for non-HIV related issues in the last year.
- 17 current SHAPE clients
- 12 patients under the Case Management Programme

FOCUS

Flexible service provision

- Seeing patients outside of clinic hours or in an alternative setting
- 'Drop-in' service, and being opportunistic
- Effective collaboration with other services
- Focus on the patients presenting issue, often HIV is not the priority.
- REACH patients flagged as 'priority' with reception and new nursing staff

Medication Assistance

- Closer support during initiation of ART
- Dosette boxes / Webster packing
- Keeping medication in the department for daily or weekly collection
- Management of treatment for other conditions, including opiates for chronic pain
- Direct liaison with community pharmacy
- Documentation and drug storage that reflects best practice and hospital policy

The Virtual Clinic

- Weekly meeting between nursing and social work staff to promote communication.
- 6-8 patients who have been identified as 'REACH clients' are discussed in the group
- Most recent blood results, most recent medication collection, any current concerns, whether they have attended other services or ED. Patient contacted to discuss.
- Fulfills ABF requirements, reduces clinic DNA's
- Care plan initiated including safety concerns.

Improved communication with outside services

- SHAPE Programme
- Case Management team
- Emergency Department
- TB Service
- Drug and alcohol services
- Street Doctor / Homeless services
- Meeting with Corrective Services Nursing Team

Does it make any difference?

- Non-attenders are not discharged
- Notification of patients attending ED
- Direct entry into drug rehabilitation programmes
- Connections between Case Management teams and community services
- Better planning for incarcerated patients release
- DNA's have dropped dramatically

Acknowledgements

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