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Australasian Society for HIV Medicine Inc

**Models of Access and
Clinical Service Delivery
for HIV Positive People
Living in Australia**



**Models of access and clinical service delivery
for people with HIV used in Australia**

Background paper for models of access and clinical service
delivery project

**Prepared by
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Introduction

In Australia HIV clinical care is provided in a range of ways, by different service providers, under a variety of models. This paper will provide an outline of the models of clinical service delivery for HIV used in Australia. It will present the proposed or current frameworks for HIV service delivery that are available for each jurisdiction. Its aims is descriptive, to provide a background, rather than a comprehensive analysis. Service models have recently been reviewed in New South Wales (NSW), Victoria, Queensland, Western Australia and South Australia. There is no formal documentation of models used in the Northern Territory, the Australian Capital Territory or Tasmania.

Background to New South Wales

In 2005, NSW commissioned an HIV care and treatment needs assessment to inform its service orientation and delivery for the following 3 years (NSW Department of Health 2005). The following points are taken from the executive summary of the document.

Issues and Implications for service delivery

- **Shift from inpatient to ambulatory care.**

The data on the utilisation of inpatient services shows the dramatic decline in their use over the past five years, mainly as a result of effective treatment regimens that are available on a non inpatient basis.

- **Poor quality of data on the utilisation of non admitted services.**

There is a need to more accurately measure non admitted activity so that it is possible to ensure:

- service activity is able to be monitored and comparisons can be made between Areas
- resource allocation reflects the relative utilisation of admitted and non admitted care
- Areas are funded equitably.

- **Inadequate services in some Areas.**

Areas that have recently had an increase in the numbers of people diagnosed with HIV/AIDS such as SWSAHS, NRAHS, MNCAHS and other Areas which have staff recruitment and retention problems such as GMAHS and FWAHS, have difficulty providing basic HIV care and treatment services.

- **Patient complexity and the need for integrated services.**

The increased complexity of HIV patients was identified. This patient complexity refers largely to co-morbidities and other associated problems such as depression, cognitive impairment, dual diagnosis (HIV, hepatitis, STI, mental health and drug and alcohol) and behaviour, anxiety and adjustment disorders. In addition there are side effects of treatment and physical problems associated with ageing. The problems/co-morbidities of many PLWHA require that HIV services are well integrated with other services, especially mental health and drug and alcohol services.

- **Duplication of services, competitiveness, poor communication.**

Comments about service duplication, competition and poor communication between services, unclear referral pathways in high prevalence Areas were made in submissions from Area Health Services as well as non government organisations.

- **Access to some services such as allied health, dental, highly specialised drugs is an issue.**

Also some population groups – people from a CALD background, Aboriginal and Torres Strait Islander people, inmates of correctional facilities, people in rural Areas – have reduced access to services.

- **Supported accommodation.**

The respective roles of the NSW Department of Health, Department of Disability and Aged Care, Department of Housing in providing supported accommodation is not always clear. This is an issue that needs to be resolved as changes occur in the nature of the progression of HIV/AIDS so that it now resembles a chronic disease, resulting in an increase in the need for a range of supported accommodation services. This clarification of roles and responsibilities should include the other supported accommodation services providers, namely non government organisations.

- **Increasing prevalence of people with HIV with AIDS Dementia Complex and other neurological complications.**

People with AIDS Dementia Complex (ADC) are now living an average of 44 months after diagnosis; approximately four times longer than they were in pre-HAART times, when the average life expectancy was only six months after ADC diagnosis.

- **Distribution and number of GPs.**

The mal-distribution and lack of GPs with s100 prescribing rights for antiretroviral treatments was highlighted, especially outside South East Sydney Area Health Service (SESAHS).

- **Post Exposure Prophylaxis.**

Post exposure prophylaxis (PEP) with antiretroviral medications and counselling has been offered in NSW to persons at risk for HIV exposure through sexual activity or injecting drug use since 1999. The need to ensure that there are clear guidelines for clinicians regarding compliance with recommended prescribing and follow-up protocols and PEP policies and procedures need to be reinforced in Emergency Departments in hospitals was identified.

- **Low risk HIV antibody testing.**

A number of the submissions were concerned about the extent of low risk testing that occurs among surgical and obstetric patients. It is estimated that only about 1% of the total number of samples sent for an HIV test, are positive. Despite the decline in the number of newly infected cases, the number of HIV antibody tests continues to increase from 149,000 in 1996/97 to 253,000 in 2001/02. Thus, substantial savings could be made by targeting the request for testing to high risk individuals.

In response to these areas of concern is a range of proposed strategic directions listed below.

1. Continue to endorse the planning principles outlined in the previous Review of HIV/AIDS Care and Treatment Services.
2. Recognise the changing treatment pattern of HIV/AIDS, in particular the shift from inpatient to ambulatory care.
3. Articulate models of HIV/AIDS service delivery in Areas with a high, moderate and low prevalence of PLWHA.
4. Develop mechanisms to enhance the integration and coordination of services.
5. Improve access to some services and for some population groups.
6. Develop and implement strategies that maximise people's access to PEP.
7. Develop a supported accommodation strategy.
8. Maintain funding for statewide services.
9. Address maldistribution and increase number of s100 accredited GPs.
10. Develop strategies to improve GPs knowledge of HIV medicine.
11. Foster partnerships between AHS and non government organisations.
12. Continue support for workforce development.
13. Evaluate some specific laboratory issues.
14. Enhance utilisation data and service monitoring.

Background to Victoria

In 2006, the Victorian Department of Human Services initiated a project to develop an integrated service model for HIV clinical services. This was based on the principle that 'that HIV care should be provided to people with HIV in Victoria in an integrated system that covers all parts of the health system, including acute care, non-acute health services, mental health services and home and community care' (RPR Consulting 2007).

The findings from this review are summarised below (RPR Consulting 2007). Common themes emerged to direct planning and service development and implementation for people with HIV in Victoria. These were:

- Patient centred, holistic and comprehensive approach to meeting the medical, nurse, psychosocial and emotional needs of people with HIV. Another area was for practical support, such as housing.
- Multidisciplinary care to assist people through the many aspects of their lives that are affected by chronic disease, not confined to clinical care.
- Access and availability, particularly for non-metropolitan dwellers.
- Provision of socioculturally appropriate services, and services that reach members of high risk or marginalised groups.
- Optimisation of self management.
- Strategic and coordinated approach to planning, that is evidence based and consultative (with PWHA and carers).
- Monitoring and evaluation of services so that they can change as required.

Other considerations for a model of HIV care were:

- Strengthening of ambulatory and long term care, particularly that is delivered in the community.
- Distributing hospital based, specialised HIV care more widely (through hospitals) to improve accessibility and choice.

- Provision of other specialist services related especially to mental health, drug and alcohol problems and socioeconomic issues.
- Planning for aged care services into which HIV care is integrated.
- Moving towards mainstream services..

Implementation issues that were considered included models that incorporated planning, coordination, high levels of communication and integration of other aspects of care with HIV management:

- Case coordination, a spectrum from intensive case management for those with complex needs and high dependency to supportive case management for those who are living reasonably independent and healthy lives.
- Clinical practice guidelines and clinical pathways, with the move away from specialist, hospital based care, the development of evidence-based clinical guidelines and clear service standards is essential to support the non specialist provider particularly.
- Patient information systems are another tool, and only one part of high quality clinical communication, to support coordinated, planned management and shared care.
- Strengthening the workforce at all levels so health providers may adopt their role and respond to the new care models.

The Victorian Department of Human Services published a response to the recommendations of the review (Victorian State Government 2008). The priority areas for action were:

- to pilot the effectiveness and appropriateness of the HARP model for HIV chronic and complex care during 2008/2009 (in response to recommendation 3; the establishment of a formal Intensive Care Coordination Program for people with HIV).
- the establishment of a community based statewide HIV counselling service. Such a service would provide accessible and responsive HIV counselling services from multiple sites; training and secondary consultation to existing counselling and mental health providers to increase their capacity to respond to the needs of people with HIV; and be involved in research and evaluation, with links and referral pathways to the Victorian HIV Mental Health Service (in response to recommendation 5).
- to engage in discussion with the Victorian HIV/AIDS Service and Victorian HIV Mental Health Service because of the need for a specialist service working with people with HIV with cognitive impairment, challenging behaviours and (broad) mental health issues (in response to recommendation 6 to immediately increase the capacity of the Victorian HIV Mental Health Service).
- to improve the communication between the department and positive Victorians by ensuring regular meeting between the three funded positive organisations (in response to recommendation 7).
- to pilot a nurse outreach program to support high caseload general practices (in response to recommendation 10).
- to establish an HIV Service Level Framework working group to investigate services, staffing and quality assurance for required to provide the different levels of HIV services in various hospital (in response to recommendation 11: to develop a Service Level Framework, and then to define which hospitals will provide Level 3 HIV care and how this will be resourced).

- to develop a Workforce Development Strategy which will identify HIV workforce needs and to continue working with the Victorian General Practice Network and the Australasian Society for HIV Medicine to ensure adequate professional training and support (in response to recommendation 16: to build the numbers and capacity of medical and nursing professionals to provide HIV care).

Recommendation 9 for the articulation of a framework for the organisation of medical care for people with HIV in Victoria, incorporating clear pathways and referral protocols across three levels of medical care was supported.

The Department partially supported a central HIV support service for diagnosing doctors (recommendation 1) and the provision of comprehensive assessment of every person who is newly diagnosed with HIV by an experienced clinician (recommendation 2).

Recommendation 8, to improve the response to individuals with HIV from culturally and linguistically diverse backgrounds, was supported in principle, as was recommendation 15, a commitment to evidence-based and collaborative planning and decision making.

Other recommendations related to service planning, partnerships, funding for an expanded Victorian HIV Consultancy and Departmental leadership were noted.

The findings from a recent Victorian report on Gay, Lesbian, Bisexual and Transgender people in aged care services HIV (Barrett 2008) are relevant to the discussion on clinical care for older people with, since there has been no work done on aged care service provision and HIV in Australia. Barrett found that discrimination, or fear of discrimination about sexuality (and HIV) resulted in concerns by seniors about their confidentiality and disclosure (sexuality and HIV status), ability for sexual and cultural expression, about safety and standards of care. Additionally, older people who developed dementia and their partners required more support and understanding from staff (Barrett 2008).

The Western Australia Model of Care for HIV

The following is a summary of the points from the HIV Model of Care for WA:

1. Decide upon and manage change of clinical service centres.
 - Ensure service providers are aware of the potential impact that the pending closure or change of services at RPH and Fremantle Hospital and the transfer of HIV services to SCGH and/or the Fiona Stanley Hospital at Murdoch might have upon both staff and patients.
2. Maximise the role of GPs in HIV management.
 - “Up-skill” GPs in HIV troubleshooting (rather than have them become experienced s100 prescribers – develop the capacity to understand or anticipate problems with treatment and refer).
 - Supported by Medicare chronic disease management items/systems.
 - Provide training GPs (and nurses) for shared care with an HIV clinician (either a specialist or s100 GP prescriber). In consultation and partnership with WA General Practice Network.

- Recognise and support the roles of HIV specialist nurses in many areas of chronic HIV management.
3. Enhance services in rural and remote areas – based on a number of regional HIV-trained nurses, supported by local “GPs with an interest” and further supported by specialist clinician and other allied health professionals based in the metropolitan area applying a shared care model.¹

This Model also proposes that rural and remote services are enhanced and supported by the provision of adequate funding for an expanded Royal Perth Hospital (RPH) based system, reviewing its coordination and ensuring that the workforce capacity is maintained in “regions with special needs”.

4. Use information and communication technology to improve service delivery – so that services are patient focused; that there are secure and confidential databases to assist with patient care; that Telehealth can be used for rural and remote staff with metropolitan specialists.
5. Reorient services for the management of asymptomatic or uncomplicated HIV disease, that is chronic disease self management - recognise the need for “wellness maintenance”, support health enhancing services and preventive/protective behaviours to promote healthy lifestyles and continuation of or integration into an independent lifestyle.
6. Undertake regular clinical audits - Clinical audits should be undertaken on a regular basis to ensure that appropriate HIV clinical management strategies are being implemented by clinical services.
7. Use or integrate HIV care into other services .
 - Strengthen the links between HIV, other blood borne viruses and sexual health services.
 - Enhance mainstream services for people with HIV.
 - Prioritise auxiliary specialist services to meet the needs of people with HIV over the next 10 years.
 - Aged care services.
 - Dental health.
 - Mental health services.
 - Dementia care services.
 - BBV co-morbidities.

¹ In summary: develop and implement a regional model of shared care for the care and management of regionally based PLWHA develop and implement referral pathways as well as communication protocols and shared care documentation; tailor training and shared care mechanisms for individual GPs; provide general support for rural and remote services to meet the needs of PLWHA including maintaining the workforce capacity of the regional public health unit teams; use information and communication technology to improve service delivery

8. Involvement in research.

Workforce development is, of course, a recurring theme that must underpin and change to the HIV model of care; it will be addressed in more detail in a later paper. Briefly, important areas that are highlighted include:

- Train and support GPs to provide HIV shared care rural/remote areas of WA.
- Continue to update and disseminate best care providers involved with the management of STIs including HIV/AIDS.
- Support appropriate specialist training to meet the changing needs of an ageing HIV-positive.
- Enhance current training for specialists in clinical immunology and infectious diseases.
- Provide WA-based training program needs of HIV specialist nurses.
- Enhance awareness about cultural sensitivity in training programs for health care providers and other staff.

Background to South Australia

The majority of HIV care is provided through the major centres with very few high caseload GPs undertaking full HIV management or shared care. Discussions with departmental officers and review of the South Australian HIV Action Plan (South Australian HIV Policy and Programs 2009) resulted in these brief preliminary comments.

The principles guiding the South Australian service delivery model are for coordinated, comprehensive, integrated, accessible, inclusive and empowering responses to HIV. Preventative and therapeutic actions target priority groups. The emphasis for HIV service delivery is to improve service coordination through the development of a centralised care coordination model as well as a chronic care model for people with HIV, to improve access to HIV and mainstream health services and antiretroviral therapy and to support workforce development so that health providers can improve health outcomes for people with HIV.

Background to Queensland

The *Queensland HIV Models of Care 2008: A report to stakeholders* (Queensland Health 2009) addressed the domains of HIV workforce, traditional HIV clinical issues and non-traditional HIV clinical issues. Their key recommendations are presented below:

1. A GP Liaison pilot program with the following features:
 - Linking with University of Queensland HIV medical programs, GPs, sexual health services and Divisions of General Practice to profile HIV care with GPs.
 - Establishing a Network of Enhanced HIV Care with HIV specialists and GPs.
 - Working with non-GP high HIV case load clinics to develop evidence-based guidelines for the management of non-traditional HIV medical issues.
 - A pilot proof of concept project that could initially occur in a high caseload area to assist GPs in an Enhanced Primary Care Program that allows GPs to access additional payments from Medicare, therefore providing an option for GPs to bulk-bill HIV positive clients.

2. A planning and auditing strategy for all Queensland Health HIV services sets out the following actions.
 - The purpose is to strengthen the HIV sector in terms of its negotiating strength with the District Health Services.
 - The clinic providing HIV services to allocate specific time and resources for planning and monitoring of services.
 - There should be a focus on the outcomes of the PHICSS project in terms of the tool's ability to assist with the monitoring and evaluation of performance of the individual clinician and the performance of the clinic.
 - The establishment of an HIV clinicians' meeting. This meeting will include hospital ID specialists, GPs and other clinicians working in the area of HIV/AIDS care. This will be the appropriate forum to establish performance indicators and benchmarks for QLD HIV/AIDS services. This meeting should be funded by Queensland Health and be attached to, but separate from, the sexual health clinicians meeting.
3. A feasibility study into the establishment of key specialists networks in the emerging co-morbidity specialities:
 - The networks would develop management algorithms and referral pathways within their specialty and disseminate information throughout their clinical network.
 - The networks can assist in facilitating educational updates, case conferencing with GPs and the HIV specialists.
 - The benefits, logistics and feasibility of the network have not been adequately explored.
4. A Queensland HIV smoking cessation program.

The program needs to target HIV infected smokers using evidence based strategies. Relative merits of nicotine replacement and counselling techniques should be reviewed. Collaboration between QPP and HIV clinicians in the development of this program is recommended. The formation of a working party and the creation of a proposal for a Statewide HIV smoking cessation program should be the first outcome of the working party.

Conclusion

Across Australia there are common issues and common responses to the emerging shift in care needs for people with HIV. As a consequence of improved treatment, improved life expectancy, development of co-morbidities and side effects from treatment their care needs will, become more complex. Responses range from the strengthening and development of systems to support HIV service delivery at the primary health care level, with an emphasis on workforce training and support, models of shared care and GP liaison and models of chronic care which are integrated with mainstream services to the maintenance and strengthening of specialist HIV services. Additionally, the importance of the provision of accessible mental health and social services is identified.

Similarly it is recognised that to succeed these changing models of care must be supported by new(er) and different patient information management systems and communication systems. Other organisational and infrastructural supports (policy, legislation, partnerships etc) are necessary. Although it may be implicit, it appears that some of the challenging areas that relate to providing care for high risk or marginalised individuals, those people who don't or can't

access or “fit” the system (and who absorb disproportionately high amounts of providers time and energy when they do) may be underdeveloped, this includes service delivery to remote areas. Another area that requires more consideration is the impact on the system of the ageing individual with HIV; are chronic disease models suitable, what more should be factored into the response.

In all jurisdictions difficulties with attracting, retaining and training sufficient numbers of suitable clinicians is documented or reported anecdotally. Most jurisdictions have developed targeted, staged responses to this; a coordinated national response would be of interest and benefit, as would evaluations of local interventions.

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