HRSA CARE A C T I O N



Rising Demand

A Template

Factors for Success

Special Role of Case Managers

INTERDISCIPLINARY CARE TEAMS: A LIFELINE FOR PEOPLE WITH HIV/AIDS

For Vernetta, a 52-year-old HIV-positive woman living in Philadelphia, access to the "one-stop shop" where she receives medical care and support services represents a true lifeline. "I get everything I need all in one place," she says.

What's more, the respect and understanding Vernetta receives from the clinic's staff make her feel like she's a part of a family. "Without this stability in my life, I would be a wreck," she explains. "There's not a day that I don't connect with somebody. It's a reason not to get high."

Vernetta started going to Philadelphia FIGHT, a comprehensive AIDS service organization (ASO) and community health center (CHC), shortly after her diagnosis in the mid-2000s. She visits the center about once a week, taking advantage of a range of services that has included HIV and primary medical care; health education on HIV disease, nutrition, and diabetes; a women's self-esteem group, and even a computer class. Over the years, she has also received referrals for dental and ocular care, as well as housing assistance. The fact that Vernetta feels she can rely on the staff at FIGHT to help her manage all aspects of her HIV disease has been invaluable. "Everyone helps me out, my case manager ... my social worker ... my therapist. They are always making calls for me or making it easier to get what I need."

This kind of comprehensive, integrated care is critically important for Vernetta, as well for countless other people living with HIV/AIDS

DID YOU KNOW?

- Team-based interdisciplinary models of care typically include varying combinations of professionals who provide primary and specialty medical care, behavioral health services, and support and outreach services.
- Interdisciplinary team members are dedicated to providing comprehensive and culturally competent care, as well as assistance in overcoming barriers to care.



U.S. Department of Health and Human Services Health Resources and Services Administration

DIRECTOR'S NOTES

HIV-positive people are living longer with the disease, increasing the need for expertise in managing age-related conditions. This fact, coupled with the complex nature of HIV disease and the challenges that patients commonly face, requires access to a diverse team of specialists. Rising caseloads and shortages of expert physicians also necessitate improved coordination.

Over the years, many interdisciplinary teams—supported by the Ryan White HIV/AIDS Program—have worked successfully to address patient needs and improve health outcomes. In this HRSA CAREAction newsletter, you'll find information about what has made those teams so successful. Interdisciplinary teams have, in many respects, become a prototype for the patient-centered medical home.

While it can be challenging to get teams working together seamlessly, we have more resources at our disposal now than ever. From electronic medical records that improve clinical care team communication to support services that improve patient retention, interdisciplinary care teams are a lifeline for countless Ryan White patients and, indeed, a hallmark of our programmatic approach.

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(PLWHA). Fully integrated care can promote retention in care and improve outcomes by enabling team members to address the multiple barriers and challenges to care that patients are facing. (For example, a physician discovers signs of intimate partner abuse during a physical exam and sends an alert to the patient's therapist or case manager.) It also facilitates the creation of integrated care plans that keep patients moving forward.

"There's so much complexity that comes along with providing HIV care," explains Sarah Smith, FIGHT's administrative director and a certified physician assistant. "Providing interdisciplinary care helps treat the patient as a whole, and obviously our hope is that the treatment will be more successful as a result."

Dr. Marwan Haddad, medical director at Community Health Center, Inc. in Middletown, CT, suggests that a lack of interdisciplinary care can compromise outcomes, particularly for high-need, multiply diagnosed PLWHA. "If we expect our patients to come to us for their HIV care, go somewhere else for their primary care, go to a gastroenterologist for their hepatitis C care, go to an addiction specialist for their opioid addiction, and then go somewhere else for their mental health care, we're setting them up to fail," he says.

The idea of interdisciplinary care is certainly not new. Comprehensive interdisciplinary HIV teams became a standard of care early in the epidemic because of the broad range of clinical and psychosocial needs exhibited by patients and the diversity of affected individuals and families.1

In fact, multiple studies have shown that access to interdisciplinary care improves engagement and retention in care.^{2,3,4} In one public hospital study, interdisciplinary teams were shown to improve enrollment and retention in care by 20 percent when patient needs for transportation, drug and mental health counseling, and case management were met.³ Another study looked at the effect of team composition on patients' adherence to antiretroviral therapy (ART). When PLWHA received care from an interdisciplinary team—compared with receiving care from a single HIV specialist—medication adherence improved by as much as 8.1 percent.⁵



Multiple studies have shown that access to interdisciplinary care improves engagement and retention in care.

RISING DEMAND FOR INTERDISCIPLINARY CARE

Most PWLHA are living longer with HIV disease because of improved treatment efficacy, and as they age, they need expanded medical expertise to treat age-related conditions—such as heart disease, hypertension, kidney disease, non-HIV-associated cancers, and chronic neurologic disease.^{6,7,8,9}

Comprehensive medical services also are required to treat common comorbidities and coinfections. For example, people with HIV infection are disproportionately affected by viral hepatitis—about 25 percent of HIV-positive individuals in the United States are coinfected with hepatitis C virus (HCV) and about 10 percent are coinfected with hepatitis B virus (HBV).¹⁰ Mental illness and substance abuse disorders are common among PLWHA. Of the 212,000 Medicaid enrollees with HIV infection in 2007, 50 percent had a dual diagnosis with substance abuse disorders or mental illness.11 In addition, approximately one-third of PLWHA have difficult-to-treat oral lesions.12

Several groups of patients face unique obstacles to care, typically requiring extensive psychosocial support to remain engaged in care.¹³ These groups include:

- **Women.** In general, women with HIV are more likely to encounter challenges or barriers to getting the care they need than men are.14 Evidence suggests that supporting HIV-positive women with services such as childcare, disclosure counseling to prevent intimate partner violence, and transportation can be instrumental in terms of helping women enter and remain in care.15
- Minorities. Because racial and ethnic minority populations are disproportionately affected by HIV disease, many patients face cultural and linguistic barriers to care.¹⁶ Culturally competent staff members and access to translation services are critically important for engaging and retaining these patients in care.
- People living below the federal poverty level (FPL). According to one study, people living below the FPL were twice as likely to be HIV-infected

as people living above the FPL (within the same community).¹⁷ Poverty can severely limit access to HIV testing and care, and those who cannot afford the basics in life may end up in circumstances that increase their HIV risk.¹⁸ A lack of awareness of the availability of affordable services and how to access them is another barrier. As a result, interdisciplinary support services that help people living in poverty overcome these significant barriers are especially important.

Unstably housed individuals. As a group, PLWHA experience higher rates of homelessness or unstable housing—more than 5.5 times the rate in the general U.S. adult population—which presents significant barriers to remaining in care. 19,20 Thus, securing stable housing is vitally important.

PLWHA who experience unstable housing have particularly high needs for support services. The Health Resources and Services Administration's (HRSA's) HIV/AIDS Bureau (HAB) recently funded a Special Projects of National Significance (SPNS) initiative to assess the impact of providing interdisciplinary care within the context of a medical home for HIV-positive homeless or unstably housed individuals with mental health or substance abuse disorders. The initiative is ongoing and will measure the effect on participants of receiving interventions at nine demonstration sites.

Stigma surrounding HIV/AIDS is still a concern, as is discrimination against the racial, ethnic, and sexual minorities who suffer the highest HIV infection rates.²¹ As a consequence, education and support regarding disclosure is a persistent and significant need among PWLHA.

Rising caseloads also are causing providers to rely more on interdisciplinary teams, thus avoiding appointment delays and provider burnout. A 2009 survey of 363 publicly funded HIV clinics reported a mean increase in patient volume of 29 percent over the previous 3 years.²² In response, the National HIV/AIDS Strategy (NHAS) includes an objective to increase physician training and reimbursement by expanding AIDS Education and Training Centers (AETCs) activities.²³

A TEMPLATE FOR THE MODERN MEDICAL HOME

Over the years, the development and expansion of interdisciplinary models of care has been greatly facilitated by the Ryan White HIV/AIDS Program.¹³ In many respects, the HIV model of interdisciplinary care has created a template for the concept of a patient-centered medical home (PCMH).¹³ (See sidebar, **Becoming Recognized as a Patient-Centered Medical Home**.)

Team Structure

Interdisciplinary services typically are provided in one of three ways: 1) they are coordinated, with services delivered in different settings but facilitated by referrals and information sharing; 2) they are co-located, with a range of services delivered in one location with data sharing across disciplines; or 3) they are integrated, with services provided in one location and a system that removes administrative barriers that limit or delay patient access.²⁷

Philadelphia FIGHT has organized its care delivery to serve the needs of specific patient populations, a concept that is quite common among HIV care providers. Currently, it offers treatment teams for HCV patients, women, Latinos, and ex-offenders. The ex-offender team includes two medical providers, two case managers, the director of the institute for community justice, and two care outreach workers (who go to correctional settings and see clients while they are incarcerated). The HCV team also includes two medical providers and two case managers, as well as a mental health specialist, nutritionist, pharmacist, and nurse. "The treatment teams definitely look different depending on who they are working with," says FIGHT's administrative director, Sarah Smith.

Another ASO and CHC, Family and Medical Counseling Service, Inc. in Washington, D.C., is currently testing the concept of patient-centered teams—assigning a case manager's patient caseload to a standing team of

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BECOMING RECOGNIZED AS A PATIENT-CENTERED MEDICAL HOME

A patient-centered medical home (PCMH) is a model of care that emphasizes the relationship between clinicians and patients, replacing episodic care with coordinated care. According to the National Committee for Quality Assurance (NCQA), a medical home achieves these goals by providing a high level of accessibility and excellent communication among patients, clinicians, and staff, as well as by taking full advantage of the latest information technology to prescribe, communicate, track test results, obtain clinical support information, and monitor performance.²⁴

The PCMH approach increasingly is being promoted as a way to improve health care delivery. For example, the Affordable Care Act uses the PCMH model as a basis for regulations in a number of areas.²⁵ And the 2010 National HIV/AIDS Strategy specifically cites the PCMH model, comparing it directly to the Ryan White approach.²³

Because of this growing influence, the Health Resources and Services Administration's (HRSA's) HIV/ AIDS Bureau (HAB) funded a cooperative agreement to establish the HIV Medical Homes Resource Center, available at https://careacttarget.org/mhrc. In addition, eligible providers can now seek PCMH accreditation or certification.²⁶ Multiple organizations, such as the National Committee for Quality Assurance (NCQA), The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), and URAC (formerly the Utilization Review Accreditation Commission) offer accreditation and certification. Visit the following Web pages for more information:

- NCQA: http://www.ncqa.org/Programs/Recognition/ PatientCenteredMedicalHomePCMH.aspx
- ► The Joint Commission: http://jointcommission.org/ accreditation/pchi.aspx
- ▶ AAAHC: http://aaahc.org/accreditation/primary-care-medical-home/
- URAC: https://www.urac.org/accreditation-andmeasurement/accreditation-programs/all-programs/ patient-centered-medical-home-achievement/

clinical and other service providers. "It wouldn't replace the larger team meetings that we do," says Chief Operations Officer Angela Wood, "but we hope that it will result in more consistent daily face-to-face communications."

Depending on sites' staffing models and the skills and experience level of individual staffers, clinics have varying ways of assigning tasks among team members. For example, some clinics will ask a case coordinator to schedule routine meetings with clinic staff instead of having a case manager perform that function.

Regardless of specific titles and tasks, however, the most effective interdisciplinary teams work to address myriad patient needs, increase engagement in care, and make patients feel as though they have compassionate advocates on their side. The most important requirement

is that members function well as a team. Systems must be created that promote communication, specific tasks need to be identified and assigned, and training with follow-up is essential.

FACTORS FOR SUCCESS

Over the years, Ryan White HIV/AIDS Program sites have discovered many best practices for interdisciplinary models of care. These best practices include the following:

Patient-centered "one-stop shop" approaches with integrated or co-located services. This model allows for the collaboration necessary for managing complicated patients and minimizes patient travel time and cost.



TABLE 1: COMMON TASKS FOR INTERDISCIPLINARY TEAM MEMBERS TO ENCOURAGE PATIENT ENGAGEMENT

Prior to clinic visits:

- ▶ Remind every patient of appointments via phone call or mail.
- ▶ Review charts to list items to address during the visit.

During clinic visits:

- ▶ Verify patients' current contact information and current insurance status.
- Orient new patients.
- Assist with insurance gaps.
- Assess other barriers to care and psychosocial needs.
- Assess medication adherence.
- ▶ Teach and provide behavior-change counseling about medications and self-care.
- Assess ongoing transmission behaviors.
- ▶ Teach and provide behavior-change counseling about transmission behaviors.
- Make referrals/appointments for psychosocial services.
- Make referrals/appointments for clinical specialty services.

Following clinic visits:

- Make follow-up calls regarding new medication regimens or referrals.
- Call or mail correspondence to patients who missed their visits.
- ▶ Help patients overcome barriers to clinic attendance.
- Extract patient data and enter it into the information system (not necessary with electronic medical records).

Sources:

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HRSA, HAB. *The Utilization and Role of Peers in HIV Interdisciplinary Teams*. October 2009. Available at: https://careacttarget.org/sites/default/files/file-upload/resources/peersmeetingsummary.pdf.

- Diverse teams of clinical and ancillary service providers. As described previously, teams may include primary care physicians or infectious disease specialists, nurses, nurse practitioners or physician assistants, case managers, medical assistants, phlebotomists, mental and behavioral health specialists, substance abuse counselors, pharmacists, and community outreach workers. A few sites might have dentists and nutritionists, though funding limitations have decreased the availability of these service providers.
- A site culture that promotes a team approach and a safe and stigma-reducing environment for clients. Cultural competency has been indentified as important, as well as an interdisciplinary model in which staff members feel that their contributions are valued.
- The availability of a comprehensive array of medical, behavioral health, and ancillary services. Consensus exists that mental health and counseling and treatment for substance use disorders should be colocated. Treatment for HCV co-infection, pharmacy services, dental care, and specialty services (e.g., gynecology, proctology, dermatology, and so on) are also considered important. Ancillary services such as HIV education, peer support, support groups, and individual psychosocial supports are important as well.
- Effective communication strategies. Weekly or biweekly team meetings to discuss patient issues are common and led by team members or skilled facilitators. Some sites hold daily "huddles" to discuss all of the patients to be seen that day.
- A focus on quality. Most sites report collecting and using quality measures recommended by HRSA. The most common are viral load suppression, retention in care, and among female patients, receipt of Papanicolaou (Pap) smear. Performance measures related to health issues (such as substance abuse and HCV) and patient satisfaction are routinely measured at some sites.

Ongoing Communication: The Most Critical Success Factor

Ongoing communication—for both internal and external interdisciplinary teams—is extremely important for coordination of care and to promote treatment

adherence and retention in care. As Angela Wood says, "When team members are communicating well, it allows you to engage all the resources in the organization to help a patient."

For example, one patient at Wood's clinic was taking a medication that was suddenly recalled. Because of a routine staff meeting, the team was able to spot the problem, identify an appropriate replacement, and engage one of the care coordinators to go to the patient's home to alert the patient and give him the new prescription—all within a few hours.

Many interdisciplinary care teams rely on formal communication, holding weekly or biweekly meetings to discuss quality improvement issues or manage integrated care plans for specific patients. "Our core team meets every other week on Mondays to talk about everything and anything that has to do with our programs," says Dr. Haddad of Community Health Center, Inc. in Connecticut. "We also hold clinical team meetings every 2 weeks where we discuss patients who need a bit more help, so we can coordinate that a bit more intensely."

Some teams hold more frequent meetings to review barriers/challenges related to care for specific patients—such as the regular afternoon meetings that Wood's care teams hold. Those meetings may occur during daily "huddles" or through more informal, organic communication. (See sidebar, **Huddles: What They Are and How They Work**.)

When patients are linked to external care, clinic staff typically follow up to facilitate that care and track results. Accompanying PLWHA to those external appointments often is the best way to ensure that the patients remain engaged in care and that effective communication is maintained. Case managers or coordinators frequently perform this role; however, just as often peers are engaged to support patients in this way. (See section on **Integrating Peers**).

Another way that HIV care providers facilitate communication with external care providers is by asking to meet with them face to face whenever the providers are treating their patients. For example, Family and Medical Counseling Service, Inc. received a local government grant to support comprehensive treatment. Part of that funding goes toward enabling staffers from several subcontractors who provide HIV testing to attend monthly and weekly integrated treatment meetings. "This is an important part of the creation of an



HUDDLES: WHAT THEY ARE AND HOW THEY WORK

Many interdisciplinary care teams hold daily "huddles," extremely brief meetings to discuss the needs of patients who will be seen that day or the following day. "We have huddles at the beginning of each session to review a report of who is coming in," says Pegi Fina, manager of the Harborview Madison Clinic in Seattle, WA. "So we know if they're a star patient; we know if they're a difficult patient; we know if there's a special care plan that's in place; we know if they need to connect with a social worker. We also have reports run around quality metrics, so the nursing staff is aware on a daily basis if somebody needs lab work or something else addressed on that day's visit."

At the Harborview Madison Clinic, participants in the 5-minute daily huddle include the attending physician—the "doc of the day"—front desk staff, social work, nursing, pharmacy, and management. "It's all about members of the interdisciplinary team coming together to gain a sense of what the day's going to look like and

what the specific needs are of the patients who will be coming in," says Fina.

Washington, D.C.-based Family and Medical Counseling Service, Inc. is currently testing holding twice-daily huddles. "During the morning huddle, we review the list of scheduled patients to look at what their needs are, who may be best in the organization to meet those needs, and where they are in the meeting of their treatment goals," explains Chief Operations Officer Angela Wood. "The afternoon huddle is a time to prepare for patients who are coming in the next day."

A Webinar—"Pre-Clinic Huddles: Supporting Effective Care Teams in the Patient-Centered Medical Home"—is available on the TARGET Center Web site at https:// careacttarget.org/library/pre-clinic-huddles-supportingeffective-care-teams-patient-centered-medical-home-0. Some of the issues discussed include gaining buy-in, defining roles, addressing scheduling conflicts, and setting an agenda.

extended patient-centered medical home that encompasses more than just one provider," explains Wood.

Electronic health records (EHRs) can serve as a vital supplemental tool to support the work many organizations do to facilitate face-to-face communication between team members. "A provider may not be available in the moment, so a case manager can access information immediately in the electronic medical chart. Of course, they could theoretically walk into the chart room and pull the paper chart, but it goes without saying that when it's right in front of them on their computer, it's just a lot easier and way more likely to happen," says FIGHT's Sarah Smith.

Many data programs have unique features that facilitate communication. As Dr. Haddad explains, "We can send an immediate 'telephone' message directly to a team member through our electronic system that says I need X, Y, or Z done for a particular patient." Data programs also can send automatic messages that alert team

members when specific patients are due for key screenings or tests.

The ease of communication that EHRs provide helps reduce the complexity of providing HIV care—for example, reducing the potential for drug-drug interactions—and assist providers in identifying barriers to adherence and recognizing client needs. The emerging ideal is fully integrated EHRs that allow interdisciplinary providers to coordinate care easily, even when they are not co-located.

SPECIAL ROLE OF CASE MANAGERS

HIV case managers have always played a special role on interdisciplinary teams because they assist patients in accessing a range of services and entitlements that can help them succeed in treatment. Depending on the clinic's staffing model, this may include helping patients apply for insurance; access support groups; access supplemental food, housing, homemaker and

💓 The premise behind using peers to help engage and retain other PLWHAs in care is based on the idea that peers are uniquely situated to motivate attitudinal and behavioral change.

other concrete services; and access mental health and substance abuse services.27

Enrollment in case management has been shown to improve engagement in care. According to one study, 78 percent of patients enrolled in case management visited an HIV clinician at least once within 6 months, compared with 60 percent of those not enrolled; 64 percent of those enrolled in case management visited an HIV clinician at least twice within 12 months, compared with 49 percent of those not enrolled.²⁸ Another study showed that as few as two case management visits could significantly improve linkage to and retention in care for newly diagnosed patients.²⁸

Case managers' participation in the provision of HIV care took on even greater importance with the passage of the 2006 Ryan White HIV/AIDS Treatment Modernization Act. That law identified "medical" case management as a core service and allowed other models of case management to be funded under support services.²⁹ To qualify as medical case management under the law, activities must be tied to "providing, facilitating, and keeping a client retained in primary medical care."30 As such, medical case managers are more clearly identified as part of the clinical care team.

In both medical and nonmedical case management situations, coordination between clinic staff and case workers is important for avoiding duplication of efforts and services; of course, patients will need to provide written consent so that their information may be shared among the team members providing their care.28

INTEGRATING PEERS INTO INTERDISCIPLINARY TEAMS

For some HIV care providers, peers are an essential part of a team of experts. The premise behind using peers to help engage and retain other PLWHAs in care is based on the idea that peers are uniquely situated to motivate attitudinal and behavioral change.

Several of HRSA's recent SPNS initiatives have examined the impact of peer support and integration into the care team. For example, a SPNS intervention launched in 2005 trained more than 850 HIV-positive individuals from 21 States to serve as peers supporting HIV care and treatment. Several best practices emerged and many of the participating providers were successful in establishing ongoing peer programs.31 An earlier SPNS initiative involved recruiting peers and training them as health coaches to serve the communities in which they lived. Follow-up data on clients showed reductions in structural, financial, and personal barriers to HIV care, as well as increased utilization of case management services.32 These kinds of peer educator training sites (PETS) programs were undertaken to disseminate replicable models for HIV care providers across the county. See http://peer.hdwg.org/lessons/ for more information.

One current SPNS initiative that addresses the impact of peers on minority populations found that providing extra support for peers is essential for integrating them into the workforce successfully.33 The demonstration sites in this ongoing initiative have reported that it is helpful to develop job descriptions for peer workers and identify what their roles are in relation to case management. Supervisors also must carefully consider the impact of full-time employment on the peers' personal well-being and access to benefits.

Even if a provider doesn't hire peers to work as staff members, they can still gain the benefits of peer support for patients through linkages to community ASOs. "We typically provide referrals to MSM, Latino, and women's groups through our case managers or HIV educator," says Dr. Shireesha Dhanireddy, assistant medical director at the Harborview Madison Clinic.

In addition, a few providers have turned to peers to participate in advisory boards with the idea that they can contribute valuable insight into clinic operations. "Our Consumer Advisory Board meets once a month; we present our quality management projects and ask for feedback on where we might make changes or how we might make improvements," says Harborview Madison Clinic Manager Pegi Fina.

▼ VIRTUAL INTERDISCIPLINARY TEAMS

Across the country, some HIV specialists are using virtual technology to provide consultative support and ongoing mentoring for providers who may not have access to a team of interdisciplinary professionals.

The "telehealth" concept is based on an innovative clinical consultation model—Project ECHO, which stands for Extension for Community Healthcare Outcomes—originally developed by Sanjeev Arora in New Mexico. To promote adoption of this approach, the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) has provided grant funding through the AIDS Education and Training Centers (AETC) Telehealth Training Center Program (TTCP). The goal of this program is to expand access to telehealth technology for hard-to-reach HIVpositive people residing in historically underserved communities.

The Northwest AETC ECHO program, one of the TTCP grantees, began a telehealth program almost 2 years ago. To participate, providers can submit patient cases for discussion during the weekly real-time, interactive video conferences; alternatively, they can just listen in to gain experience and knowledge related to HIV care. The typical session lasts about an hour and a half and attracts about 30 to 40 participants.

"The idea is to connect community-based rural clinicians with a panel of specialists—and to each other," says Dr. Brian Wood, medical director for the Northwest AETC and an assistant professor at the University of Washington. This network of support is a way to build capacity so that community clinicians can provide better HIV/AIDS care.

The core team of interdisciplinary experts includes three infectious disease physicians, as well as a psychiatrist, nurse, pharmacist, and social worker. "But if there is a particularly complex case, we can pull in additional specialists," explains Dr. Wood.

One notable case involved an HIV-positive woman who was struggling with medication adherence—as well as with other complications such as latent tuberculosis and syphilis—early in a pregnancy. Her rural provider presented the case to the ECHO panel about 7 or 8 times over the course of the pregnancy. By the time the baby was born, the mother's viral load was at its lowest level ever and the baby was born HIV free. Another interesting case involved a provider who was struggling to help an undocumented immigrant obtain HIV medications. Through ECHO, participants were able to share local resources and several organizations even offered to specifically help that patient.

For more information about TTCP and to obtain a list of all grantees, go to the AETC National Resource Center Web site at www.aids-ed.org. For more information about Northwest AETC ECHO, go to http://depts. washington.edu/nwaetc/echo/index.html.

Another AETC virtual team resource is the National HIV/AIDS Clinicians' Consultation Center (NCCC), operated by the University of California, San Francisco, Department of Family and Community Medicine at San Francisco General Hospital. Providers can call 1 of 3 phone lines to receive expert clinical advice on caring for HIV patients (800-933-3413), workers who have been exposed to HIV and the hepatitis virus (888-448-4911), and HIV-infected pregnant women (888-448-8765). See www.nccc.ucsf.edu for more information.

IT TAKES COMMITMENT TO REAP THE REWARDS

While the benefits of implementing interdisciplinary care are clear for both patients and providers, challenges and barriers will occur. "It's always a struggle to get people to 'play well together in the sandbox," acknowledges Angela Wood of Family and Medical Counseling Service,

Inc. "Just the fact that [some team members] are on a different floor is a structural barrier that can compromise communication."

The effort, however, is well worth it. "If you start small with some level of an integrated approach, it will continue to evolve," Wood advises. "Just keep at it, and eventually you'll look up and say, 'Wow. It's working."



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