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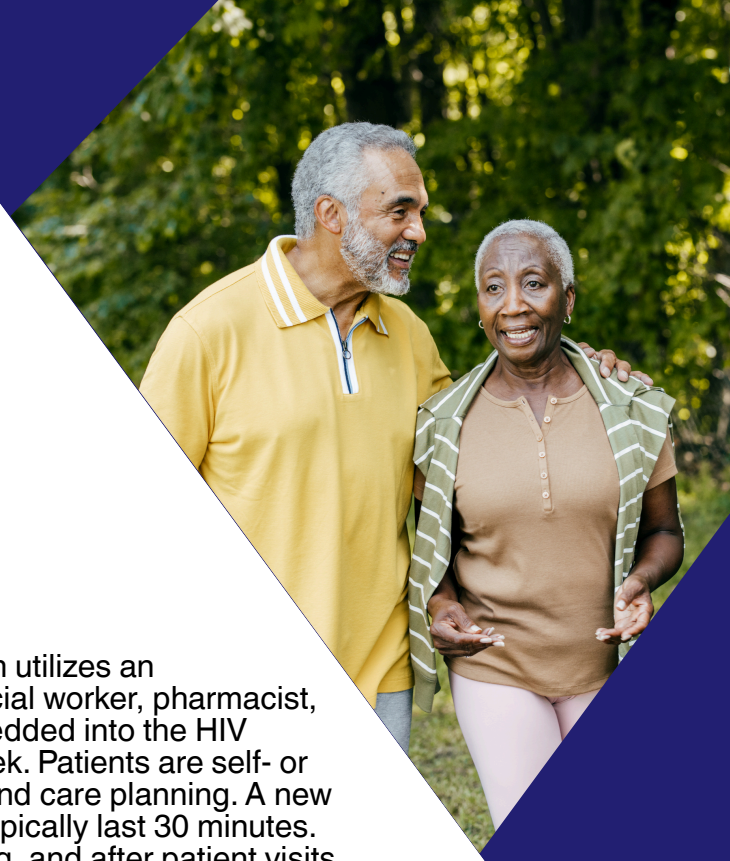

COMPREHENSIVE CARE FOR
Older Adults with HIV

POST-VISIT INTEGRATION OF CHW

The Comprehensive Care for Older Adults with HIV program utilizes an interdisciplinary team consisting of a geriatrician, nurse, social worker, pharmacist, and community health worker (CHW), all of whom are embedded into the HIV primary care service. The team sees patients one day a week. Patients are self- or provider-referred for comprehensive geriatric assessment and care planning. A new patient visit typically lasts 60 minutes, and follow-up visits typically last 30 minutes. The CHW serves a critical role in this program before, during, and after patient visits. Opportunities for CHW integration after the patient visit are described here.

Post-Visit Service Coordination by CHW

1. Provide care coordination based on the interdisciplinary team's (IDT) care plan 1-2 weeks after the visit via follow-up phone calls with patients and referral coordination with health teams, including:
    a. Assistance with scheduling referral appointments.
        i. If patient is identified during visit as needing assistance in scheduling appointments, CHW reaches out after office visit to assist. Referral needs are communicated to the CHW generally after the visit, during the geriatrician weekly check-in which for our team occurs the day after the clinical session.
        ii. If patient does not need assistance in scheduling appointments, CHW reviews chart 1-2 weeks after visit to ensure appointments have been scheduled. If they have not been scheduled, CHW reaches out to patient to assess barrier and assist in scheduling appointments.
    b. Assure transportation.
        i. If barrier to completing referrals is transportation, CHW will reach out to social worker via the electronic medical record. The social worker arranges next steps regarding transportation. This may mean the social worker coordinates with other staff such as patient navigator or care coordinator.
    c. Connect to community-based supportive services.
        i. If community resource need is identified at any point (i.e., office visit or telephone encounter), CHW will provide information as needed and discuss with social worker during their weekly meeting if additional resources are needed.
2. CHW supervision case conference with geriatrician and social worker
    a. Weekly geriatrician and CHW meeting to review care plans for patients
    b. Weekly social worker and CHW meeting to discuss patients' social/community needs

212-420-2620 mountsinai.org/care/GeriHIV AgingwithHIV@mssm.edu

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Community Health Care Worker Post-Visit Service Coordination

CHW outreach to patient based on IDT care plan from visit → Assist in scheduling referrals if needed → Assist in scheduling imaging tests if needed → Provide list of community-based services as needed

Geriatrics Clinical Post-Visit Follow-Up Diagram