Integrating HIV in Primary Care

- 9:00am-10:00am: Integrating HIV in Primary Care: From Trends to Training
  Speakers: Brian Hujdich, HealthHIV & Stephen Perez, HealthHIV
- 10:00am-11:00am: Integrating HIV In Primary Care: The NHAS and HIV Care Team Model of Ryan White
  Speakers: Ronald D. Wilcox, MD, Delta Region AIDS Education & Training Center
- 11:00am-11:15am BREAK
- 11:15am-12:00pm: Panel Discussion: HIV Integration into Primary Care: Evolving toward a new reality
  Moderator: Brian Hujdich, HealthHIV, Executive Director
  Panelists: Tenya Fann, MD, MPH CO-Medical Director, Community Health Center of Buffalo, Stephen Perez, NP Clinical Specialist HealthHIV Nurse Practitioner, Inova Juniper Program, Kathy Brown, MD, FACP, AAHIVS HIV Medical Director, Country Doctor Community Health Center
HIV Integration into Primary Care: From Trends to Training
Learning Objectives

- Describe current trends and models in HIV integration into primary care
- Describe the need for HIV care models to incorporate strategies for capacity building and clinical training to facilitate HIV integration
- Describe barriers and facilitators for successful integration of HIV into primary care
- Describe efforts to align evaluation principles and program outcomes to address testing, engagement and linkage
THE HIV PRIMARY CARE LANDSCAPE
The HIV Landscape

• 1.2 million estimated to be living with HIV in the United States
  – 240,000 unaware of HIV infection
  – 50,000 new HIV infections annually

• HIV has become a manageable chronic disease

• HIV care delivery is shifting:

  Specialty Care  ➔  Primary Care
HIV Prevalence and Incidence
United States, 1980 - 2010

Stable incidence rates and increased survival rates have resulted in an increase in the number of people living with HIV

Hall HI et al. JAMA. 2008 Aug 6;300(5):520-9
National HIV/AIDS Strategy

• Reduce HIV incidence
• Increase access to care health outcomes
• Reducing HIV-related health disparities

• HIV has become a chronic manageable disease\(^1\)

• “Health care providers and public health officials will need to be increasingly flexible and willing to employ a variety of approaches to meet the needs of HIV-positive individuals, especially given the financial and capacity strains facing the health care system”\(^1\)

• Lines between primary care and HIV specialty care are blurring\(^2\)

• Some studies have shown that almost half of all HIV care is delivered by primary care providers\(^2\)

\(^1\) Institute of Medicine (2011). *HIV Screening and Access to Care* Series Summary Accessed October 31, 2012

State of HIV Primary Care

• Survey was designed to:
  – Assess the landscape of HIV care integration in a rapidly changing environment
  – Identify trends in the provision of HIV care among primary care providers and HIV Specialists
Methods

- 45 question survey (quantitative and qualitative)
- Distributed nationally by HealthHIV and Medscape online via Survey Monkey
- Respondents recruited through open invitations via targeted email lists, monthly newsletters, and website postings
- Data collected between July and October 2011
- Convenience sample
- Not incentivized
# Total Respondents & Analysis Focus

## Table 1. Total Respondents and Group of Focus

<table>
<thead>
<tr>
<th>Professional Designations Included</th>
<th>Number</th>
<th>Action for analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>DO, MD, NP, PA, PharmD, PhD, RN, RPh, MS/MPH, “Other”</td>
<td>n = 1806 (TOTAL RESPONDENTS)</td>
<td>Separate 440, MS/MPH, “Other”, Incomplete data</td>
</tr>
<tr>
<td>DO, MD, NP, PA, PharmD, PhD, RN, RPh</td>
<td>n = 1366</td>
<td>Separate 190 PharmD, PhD, RPh</td>
</tr>
<tr>
<td>DO, MD, NP, PA, RN</td>
<td>n = 1176</td>
<td>Separate 549 Registered Nurses (RNs)</td>
</tr>
<tr>
<td>DO, MD, Nurse Practitioners (NP), Physician Assistants (PAs) “Providers”</td>
<td>n = 627</td>
<td>Separate into categories of “provide HIV care” and “do not provide HIV care”</td>
</tr>
</tbody>
</table>
Profile of HIV Primary Care Providers by Percent of Respondents

- Ethnicity: Non-Hispanic: 83%
- Race: White: 68%
- Gender: Female: 58%
- Provider Type: MD: 58%
- Age: 50-59 years old: 40%
- Location: Lives in an urban community: 64%
- Speciality: Family Practice: 46%
- Region: The South: 39%
- Setting: Community Health Center: 36%

Source: 2nd Annual Health State of HIV Primary Care Survey, January 2012
### HealthHIV 2nd Annual
State of HIV in Primary Care Survey Readiness Report

<table>
<thead>
<tr>
<th>Readiness Indicator</th>
<th>HIV Specialist</th>
<th>HIV Primary Care Provider</th>
<th>Primary Care Provider Not Treating HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demand for Services</td>
<td>Increasing (☑)</td>
<td>Increasing (☑)</td>
<td>Increasing (☑)</td>
</tr>
<tr>
<td></td>
<td>Decreasing (☐)</td>
<td>Decreasing (☐)</td>
<td>Decreasing (☐)</td>
</tr>
<tr>
<td>Confident in Ability to Treat HIV</td>
<td>Highly Confident (☑)</td>
<td>Confident (☐)</td>
<td>Lacks Confidence (☐)</td>
</tr>
<tr>
<td></td>
<td>Confident (☐)</td>
<td>Confident (☐)</td>
<td>Confident (☐)</td>
</tr>
<tr>
<td></td>
<td>Lacks Confidence (☐)</td>
<td>Lacks Confidence (☐)</td>
<td>Lacks Confidence (☑)</td>
</tr>
<tr>
<td>Level of HIV Education</td>
<td>High (☑)</td>
<td>Needs Improvement (☐)</td>
<td>Needs Improvement (☐)</td>
</tr>
<tr>
<td></td>
<td>Low (☐)</td>
<td>Low (☐)</td>
<td>Low (☑)</td>
</tr>
<tr>
<td>Staff Capacity</td>
<td>Decreasing</td>
<td>Decreasing</td>
<td>Decreasing</td>
</tr>
<tr>
<td></td>
<td>Specialists Retiring</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest in Treating HIV</td>
<td>Highly interested &amp; self sufficient (☐)</td>
<td>Highly interested but need support (☐)</td>
<td>Interested but disengaged from resources (☐)</td>
</tr>
<tr>
<td>HIV Testing</td>
<td>Always</td>
<td>Inconsistently</td>
<td>No</td>
</tr>
</tbody>
</table>

HealthHIV Putting Health First
Barriers to Providing HIV Care

- Top five barriers cited by PCPs
  - Lack of provider competency on HIV disease treatment (63%)
  - Lack of clinical staff time to take on new roles and procedures (50%)
  - Lack of competency on hepatitis treatment (32%)
  - Lack of support staff time to take on new roles and procedures (29%)
  - Lack of HIV education in medical and professional schools (26%)
Co-Occurring Conditions

• Providers of HIV Care reported increasing numbers of HIV patients with co-occurring conditions like:
  – Cardiovascular disease (50%)
  – Renal disease (49%)
  – Mental health conditions (48%)
  – Substance abuse (38%)
  – Hepatitis C (36%)

• 58% of Providers of HIV Care are seeing increasing number of HIV patients with sexually transmitted infections
HIV Caseloads

- HIV Providers indicate that the size of their current caseload make it difficult to see additional patients
  - 66% say they have already seen an increased HIV case-load in the past 12 months
  - 45% say a lack of clinical staff time to take on new roles and procedures is a barrier
  - 36% say a lack of support staff time to take on new roles and procedures is a barrier
Time Spent: HIV vs. Primary Care

- HIV Providers say they focus as much on co-occurring conditions as on treating HIV
  - 36% spend most of their time treating HIV
  - 26% spend most of their time treating co-occurring conditions
  - 38% spend equal amounts of time on both
Survey Implications

- Increase HIV-related education for PCPs
- Support and maintain coordinated national efforts to:
  - build infrastructure,
  - increase access points, and
  - enhance provider confidence to help ensure patients get quality HIV care
- Emphasize acute need to address HIV within minority communities
Institute of Medicine

- Institute of Medicine
  - Commissioned by ONAP:
    - evaluate the extent to which federal, state, and private health insurance policies and practices pose barriers to expanding HIV testing and treatment
    - examine the current capacity of the health care system to administer more HIV tests and accommodate new HIV diagnoses

- IOM committee issued three reports:
  - HIV Screening and Access to Care: Exploring Barriers and Facilitators to Expanded HIV Testing (2010)
  - HIV Screening and Access to Care: Health Care System Capacity for Increased HIV Testing and Provision of Care (2011)
Many among the “first generation” of HIV providers are reducing their practices or retiring, and relatively few new health professionals are choosing to specialize in HIV care. 

Lines between primary care and HIV specialty care

Some studies have shown that almost half of all HIV care is delivered by primary care providers.

Nurses and APRNs receive little formal training in managing HIV-positive patients (especially in the outpatient setting).

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Provider Workforce Shortage

- In 2008, HRSA projected shortage across entire workforce
- 63,000 fewer physicians than needed by 2015
- Projected shortage of providers by 2020
  - 45,400 PCPs
  - 46,100 medical specialists
- Physician shortages to worsen without increases in residency training
Projected Supply and Demand, Physicians, 2008–2020

- Demand—All Specialties
  - Supply—All Specialties
  - Shortage=91,500
HIV Workforce Trends

• Approximately 4,500 HIV providers (MD, DO, NP, PA) in US
• The current HIV workforce composed of first generation providers who entered the field over 20 years ago.
  —50% of current HIV provider workforce retiring in next 5 to 10 years
• Ryan White Part C-funded clinics report difficulty recruiting HIV clinicians
Trends in Care Settings

• By 2013, less than 1/3 of physicians will be in private practice
  – Movement to larger health systems

• Shift related to:
  – Burden of administrative responsibilities
  – Stability of health systems
  – Manageable hours
  – Job security
  – Increased pay
A Shifting Landscape

- Rising HIV caseloads
- Overworked specialists
- Shrinking HIV workforce
- Insufficient reimbursement for HIV services
- Dynamic health care environment driven by reform
Increasing Caseloads and Decreasing Providers Create a Fractured Delivery Landscape

Patients Accessing Care & HIV Caseloads Increasing

HIV Patients
500,000 - 600,000 will be newly insured in 2014*

HIV Caseloads
Consistent “increase in HIV caseloads” among HIV PCPs since 2010

HIV Care Provider Workforce Decreasing

HIV Specialists
Roughly one-third of HIV Specialists are planning to retire in the next 10 years. (1)

Primary Care Providers
Projected shortage of Primary Care Providers by 2020. (2)

HIV PCPs “able to provide care to newly diagnosed HIV positive patients”

* HealthHIV calculation based on 2009 CDC estimates of 45% of people living with HIV that are uninsured.

3 - HealthHIV, 2nd Annual State of HIV in Primary Care Survey.
WHY INTEGRATION?
HIV Integration in the Literature

- Journal of Urban Health: Bulletin of the New York Academy of Medicine
- Discussed the need for new models in HIV Care delivery
- Includes discussion of need for new primary care models
- Transition to chronic disease management, health disparities, and workforce shortages are driving the need for new models

A Changing Epidemic
Another Kind of AIDS Crisis

A striking number of HIV patients are living longer but getting older faster—showing early signs of dementia and bone weakness usually seen in the elderly.

By David France  Published Nov 1, 2009

Left: Russell Steinke. Age: 56 / HIV: 23 years / Has suffered from: memory loss, nerve damage in feet, lipodystrophy, fatigue.

Right: Enrico McLane. Age: 52 / HIV: 17 years / Has suffered from: short-term memory loss, two hip replacements.

(Photo: Marco Grob)
Stages of Engagement in HIV Care

Engagement in HIV care:
- HIV-infected: 1,178,350
- HIV-diagnosed: 941,950
- Linked to HIV care: 725,302
- Retained in HIV care: 480,395
- On ART: 426,590
- Suppressed viral load (≤200 copies/mL): 328,475
Engagement in HIV Care

- HIV-infected: 1,178,350
- HIV-diagnosed: 941,950
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MMWR (60) 2011
In 2006, the CDC expanded screening recommendations to all persons aged 13-64.\(^1\)

USPSTF recently submitted draft recommendations for all adolescents and adults ages 15-65.\(^2\)

More funding for testing and more diagnoses made (many times in high volume settings i.e. emergency departments)

Patients with HIV are also moving from urban to rural areas where specialty care access may be limited

Trained HIV specialists (MD, PCPs, ID, Midlevel Providers) are not readily available in many areas (what is a “specialist”?)


Patients are **presenting with high complexity** given longer survival times, medical co-morbidities, and late diagnosis

**Now a chronic care issue** Specialists are confronted with complex co-morbidities and PCPs are confronted with specialty ID issues

HIV-positive patients often need other **specialty involvement** (i.e. GI, Surgery, Endocrine, Pulmonary, Colo-rectal etc...)
Factors Supporting HIV Integration in CHCs

• External Factors
  – HIV prevalence
  – Need for more Providers
  – Funding
  – Federal, State & Local prioritization
  – Mentorship and technical assistance support

• Internal Factors
  – Motivated Leadership (Board & CEO)
  – Motivated Clinicians
  – HIV experienced Clinicians
  – Desire to provide comprehensive HIV Care
Factors Restricting HIV Integration in CHCs

• Restricting
  – Lack of Providers
  – Geography
  – Competition between sites
  – Lack of funding
  – Inadequate access to mentorship and technical assistance
MAKING INTEGRATION HAPPEN:
EXPLORING EXISTING MODELS FOR HIV CARE DELIVERY
Essential Components of HIV Care

Chronic Care Model

The Chronic Care Model

Community
Resources and Policies
Self-Management Support

Health Systems
Organization of Health Care
Delivery System Design
Decision Support
Clinical Information Systems

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes
Patient Centered Medical Home

[Diagram showing the layers of a medical home including Whole Person Orientation, Safety & Quality, Care Coordination & Integration, Personal Provider, Enhanced Access, Continuity of Care, and Capacity & Accountability.]
Model for Integration

- Model for care delivery
  - PCMH
  - RW Care
  - Chronic Care Model

- Strategies for Integration (need multiple strategies)
  - Capacity Building
  - Performance Improvement
  - Clinical training
  - Level setting
1. Recruiting and targeting health centers in high need areas

2. Providing Organization-Wide Training
   – Performance Improvement
   – HIV Clinical Training and Mentoring

3. Engaging continuously through distance learning
   – HealthHIV’s HIV Primary Care Training Platform
Targeting & Recruitment

• Micro targeting based on Data
  – HIV% in minority populations, unmet need, poverty, % minority pop, educational attainment

• Assessing the environment
  – Ryan White engagement in areas of need
  – State Primary Care Association support
  – State and local initiatives supporting integration
  – Funding opportunities supporting integration
Goal of CBA to CHCs:
Increase access to comprehensive HIV care for ethnic and racial minority communities severely impacted by HIV by developing the organizational capacity of health centers that are not directly funded through the Ryan White Program
HealthHIV Capacity Building Locations for HIV Primary Care Integration

State shading based on percent of people living with HIV that are racial or ethnic minorities calculated using 2011 CDC surveillance data.

March 8, 2013
Clinical Stages of HIV Care

**Introductory Stage**
- Sporadic or no HIV testing, with little testing infrastructure and no HIV care available onsite

**Foundation Stage**
- Provide HIV Testing (routine or targeted) but no medical management for patients with positive test results

**Stage 1**
- Onsite management of stable HIV-positive patients who are ARV naive or on 1st line ARV therapy, and management of common complaints.

**Stage 2**
- Onsite management of HIV-positive patients on 2nd line therapy and/or those with opportunistic infections or advanced HIV disease.

**Stage 3**
- Onsite management of complex HIV-positive patients on 3rd line or salvage therapy and/or with complex opportunistic infections, and/or the need for PMTCT
Integration Models

Introductory HIV Care:
No onsite HIV testing or sporadic (not routine or targeted) testing available, but no medical management for HIV-positive patients

External HIV Care
HIV testing, (routine or targeted), but no medical management for HIV-positive patients

Collaborative HIV Care
HIV Care within primary care with extensive collaboration and consultation from clinical mentor

Supported HIV Care
HIV care within primary care supported by consultation with clinical mentor as needed

Comprehensive HIV Care Management
HIV and primary care fully integrated for management of complex co-morbid conditions, PMTCT, and complex OIs. Access consultation from clinical experts as needed
**External HIV Care**
- **Foundation**
- Provide HIV testing (routine or targeted) but no medical management for patients with positive test results

**Collaborative HIV Care**
- **Stage 1**
- Onsite HIV care integrated with primary care through extensive consultation from clinical mentor for initiation of ARV regimen and for management of more complex patients

**Supported HIV Care**
- **Stage 2**
- Onsite HIV care integrated with primary care, supported by consultation with clinical mentor as needed for management of treatment failure and/or co-morbid conditions complicated by HIV disease and/or treatment

**Comprehensive HIV Care Management**
- **Stage 3**
- Onsite integrated HIV care with primary care, including management of complex co-morbid conditions, PMTCT, and complex OI’s with access to consultation from clinical mentors as needed

**Introductory HIV Care**

**HIV Primary Care**
**HealthHIV STEP Model**

**Staged External HIV Care**
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**Introductory HIV Care**

**HIV Primary Care**
What is the HealthHIV STEP Model?

- It is a framework for Integration of HIV Care into primary care
- It is a classification model for CHC’s based on two systems, Clinical Stages of HIV Care and Integration Models
- It allows sites progress from one step (where they entered the project) to the next step (where they could be after clinical training and practice transformation efforts)
- It provides a stepwise approach to developing capacity building around HIV care
HealthHIV HIV STEP Model

- Reflects where CHCs and clinicians fall in HIV Care delivery spectrum
- Establishes a framework for graduated, progressive integration
- Advances training and HIV care delivery through an interdisciplinary, whole-site approach to care
- Creates benchmarks supporting evaluations and measurement
- Enhances and builds upon the CHCs existing internal capacity for providing HIV care
HIV-positive patients will benefit from receiving care in patient centered environments (primary care or specialty care)

Whole-site assessment and implementation is key

Ryan White Care highlights similar strategies for patient centered care and a holistic approach

PCMH is a patient centered model of care with applicability to HIV

Chronic Care Model values the system and patient empowerment

HealthHIV STEP Model provides a framework for HIV integration into primary care
CAPACITY BUILDING AND CLINICAL TRAINING TO FACILITATE INTEGRATION
CBA Implementation

- Needs Assessment
- Level-Setting
- Clinical Training Plan and PI Workplan Development
- Participate in Training Materials
- Evaluation
## Comprehensive Organization-Wide Capacity Building

| Assessing & Staging | • Assessment of organizational systems, processes and attitudes  
|                     | • Whole-site HIV Training Needs Assessment  
|                     | • Individualized Self-Assessments for providers in multiple disciplines. |
| Laying the Foundation for Integration | • PDSA: Process for Improvement  
|                                        | • Maximizing Revenue  
|                                        | • HIV Training Package  
|                                        | • Group & Individual Training Plans |
| Supporting HIV Integration | • QI: PDSA HIV Testing/Core Clinical Indicators  
|                            | • ACCESS: Cultural Competency & Confidentiality  
|                            | • Patient Recruitment & Retention  
|                            | • Clinical Training Plan Monitoring & Evaluation  
|                            | • Distance & Onsite Training  
|                            | • Mentoring |
| Sustaining HIV Care in Primary Care | • Building Collaborations for Sustainability  
|                                     | • Population Management  
|                                     | • Expanded Appointment Access  
|                                     | • Continued Clinical Training & Education |
Assessment

- Needs Assessment
- Level-Setting
- Clinical Training Plan and PI Workplan Development
- Participate in Training Materials
- Evaluation
Instructions for completing and returning the HIV in Primary Care Learning Community Assessment:

This assessment is in two sections, one focused on clinical services and one focused on performance improvement. Please have your Clinical Learning Leader complete the clinical section and your Performance Improvement Learning Leader complete the performance improvement section. We realize there may be questions that either learning leader cannot respond to immediately, but we ask that the assessment tool be as complete as possible before you return it to us. We will discuss any unanswered questions during the assessment interview to be scheduled in the next few weeks.
# Self Assessment Tool

Review the following proficiencies and:
- Assess your current competency in each, using the scale
- Select the proficiencies you would like to include in your training plan

<table>
<thead>
<tr>
<th>Proficiency:</th>
<th>I am able to perform this proficiency:</th>
<th>Include in my training plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the Natural History of HIV Disease to Patients and Families (HIV 101)</td>
<td>☐ Yes, with direct HIV expert guidance ☐ Yes, in consultation with an HIV expert ☐ Yes, without guidance</td>
<td>☐</td>
</tr>
<tr>
<td>2. Define Current Trends in the Epidemiology of HIV Infection in the United States</td>
<td>☐ Yes, with direct HIV expert guidance ☐ Yes, in consultation with an HIV expert ☐ Yes, without guidance</td>
<td>☐</td>
</tr>
<tr>
<td>3. Integrate HIV Quality Improvement Measures into Patient Monitoring and Care</td>
<td>☐ Yes, with direct HIV expert guidance ☐ Yes, in consultation with an HIV expert ☐ Yes, without guidance</td>
<td>☐</td>
</tr>
<tr>
<td>4. Optimize Clinic Management to Address Health Needs of HIV-positive Patients</td>
<td>☐ Yes, with direct HIV expert guidance ☐ Yes, in consultation with an HIV expert ☐ Yes, without guidance</td>
<td>☐</td>
</tr>
<tr>
<td>5. Provide Culturally Appropriate Patient Education and Care to HIV-positive Patients</td>
<td>☐ Yes, with direct HIV expert guidance ☐ Yes, in consultation with an HIV expert ☐ Yes, without guidance</td>
<td>☐</td>
</tr>
<tr>
<td>6. Provide a Supportive Care Environment for HIV-positive Patients</td>
<td>☐ Yes, with direct HIV expert guidance ☐ Yes, in consultation with an HIV expert ☐ Yes, without guidance</td>
<td>☐</td>
</tr>
<tr>
<td>7. Provide Comprehensive “Prevention with Positives” Education</td>
<td>☐ Yes, with direct HIV expert guidance ☐ Yes, in consultation with an HIV expert ☐ Yes, without guidance</td>
<td>☐</td>
</tr>
<tr>
<td>8. Provide HIV Testing in Accordance with CDC Recommendations and State/Local Regulations</td>
<td>☐ Yes, with direct HIV expert guidance ☐ Yes, in consultation with an HIV expert ☐ Yes, without guidance</td>
<td>☐</td>
</tr>
<tr>
<td>9. Adhere to Principles of Confidentiality and HIPAA Regulations Specific to HIV-positive patients</td>
<td>☐ Yes, with direct HIV expert guidance ☐ Yes, in consultation with an HIV expert ☐ Yes, without guidance</td>
<td>☐</td>
</tr>
</tbody>
</table>

10. Recognize and Address Common Stigma-Associated Disclosures Associated with HIV-positive Patients | ☐ Yes, with direct HIV expert guidance ☐ Yes, in consultation with an HIV expert ☐ Yes, without guidance | ☐                           |
Level-Setting

- Needs Assessment
- Level-Setting
- Clinical Training Plan and PI Workplan Development
- Participate in Training Materials
- Evaluation
Clinical Stages of HIV Care

Introductory Stage
• Sporadic or no HIV testing, with little testing infrastructure and no HIV care available onsite.

Foundation Stage
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Stage 1
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**Integration Models**

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**HealthHIV STEP Model**

**Staged**

**External HIV Care**
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**Providers**

**Introductory HIV Care**

**HIV Primary Care**

**For Engaging**

**Training**
Plan Development

- Needs Assessment
- Level-Setting
- Clinical Training Plan and PI Workplan Development
- Participate in Training Materials
- Evaluation
Group Training Plans

- Initiated with on-site intensive training session (approx. 4 hours) for providers and nurses
- Multidisciplinary and Interdisciplinary sessions
  - Approx. 1 hour a month
- Available for:
  - Foundations
  - LVN/LPN/MA
  - RN
  - Providers (MDs, DOs, NPs, PAs)
- Covers a specific number of learning proficiencies
  - Those proficiencies not covered in group training should be covered by individual learning
Self-Assessment Analysis

**PROVIDER STAGE 1 SELF ASSESSMENT ANALYSIS**

**Site:** South Dakota Urban Indian Health, Inc.  **Date of Analysis:** 04/10/2012

**Clinical Learning Leader:** Tami Hogle-Lorenzen

**Total Provider Level Care Team Members:** 4
**Provider Self-Assessment Forms Received/Analyzed:** 4

**Number of Respondents by Professional Designations:**
- Medical Doctor (MD): 0
- Doctor of Osteopathy (DO): 0
- Physician Assistant (PA): 1
- Nurse Practitioner (NP): 3
- Other Prescribing Clinician: 0

**Competency:**
1. I am unable to perform this proficiency
2. I am able to perform this proficiency with direct HIV expert guidance
3. I am able to perform this proficiency in consultation with an HIV expert
4. I am able to perform this proficiency independently

**Proficiencies For Foundation Stage**

<table>
<thead>
<tr>
<th>Proficiencies For Foundation Stage</th>
<th>Average Competency Reported</th>
<th>Respondents who Want Proficiency Included in Training Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Explain the Natural History of HIV Disease to Patients and Families (HIV 101).</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
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<td>4</td>
<td>3</td>
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<tr>
<td>3. Integrate HIV Quality Improvement Measures into Patient Monitoring and Care.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4. Optimize Clinic Management to Address Health Needs of HIV-positive Patients.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>5. Provide Culturally Appropriate Patient Education and Care to HIV-positive Patients.</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>6. Provide a Supportive Care Environment for HIV-positive Patients.</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>
# Group Training Plan

## Curriculum Menu: Foundation

**Training Start Date (Month/Year):** TBD

**Group Training Plan frequency (Weekly, Twice a month, Monthly):**

<table>
<thead>
<tr>
<th>Session 0 (Introduction to NCHCMC and HIV Training)</th>
<th>Session 1</th>
<th>Session 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date:</strong> 5/25/2012</td>
<td><strong>TBD</strong></td>
<td><strong>TBD</strong></td>
</tr>
</tbody>
</table>

### Proficiency:
- P/A

### Session Objectives:
- Discuss the NCHCMC project and your CHCs role in HIV clinical training
- Demonstrate how to access the HIV Training Package (HTP) through the Virtual Learning Lab (VLL) and how to use the HTP manual
- Provide an introduction to the HTP Learning Resources and Tools
- The draft HIV training worksheet you have developed, and revise/adapt if required

### Group Activity:
- Case Discussion/Presentation: Overview of HIV Training Process
  - Led by: Dr. Lisa Fink
- Self-Study: Review HIV training PPT
- Corresponding Mentorship/Clinical Consultation: TBD
  - Topic: TBD

### Session Objectives:
- Define current trends in epidemiology of HIV
- Provide comprehensive Prevention for HIV Positive Pts
- Provide HIV Testing

### Session Objectives (continued):
- Describe the Epidemiology of HIV-infection in the United States, including current trends in racial and ethnic minority populations.
- Define CDC HIV Testing Guidelines and Recommendations
- Explain current HIV Testing Strategies
- Conduct assessments of high risk behaviors in people living with HIV and provide “prevention with positives” messaging.

### Group Activity:
- NCHCMC Webinar #11: HIV 101 Part Two (TBD) or Live Presentation by Stephen Perez
  - Led by: Dr. Lisa Fink
- Self-Study: See Proficiency in curriculum menu
- Corresponding Mentorship/Clinical Consultation: TBD
  - Topic: TBD

### Session Objectives (continued):
- Identify key structural components of HIV and the T-lymphocyte cell.
- Describe the replication cycle of HIV and its implications for treatment
- Describe the signs and symptoms of Primary HIV Infection
- Explain the Natural History of HIV-infection
Individual Training Plan

• Supplements group training activities
• Self-directed
• Self-Paced
• Utilizes information gleaned from Self-Assessments
• Allows the provider/clinician to target their learning based off perceived needs and prior training or knowledge
1) Universal HIV Screening  Please circle and rank in order of priority:  1  2  3  4  N/A

**Goal:** By December 31, 2012 Health Center X staff will have plan in place to conduct universal HIV screening for all clients ages 13-64.

<table>
<thead>
<tr>
<th>Outcome Objective</th>
<th>Complete</th>
<th>Will complete by 12/31/12</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health center is aware of current HIV screening compliance as compared to state and CDC guidelines</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Health center staff are aware of best practices for universal screening</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Health center has determined ideal testing method (i.e. rapid, traditional, both)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Health center has CLIA waiver in place/application for waiver submitted if health center wishes to conduct onsite rapid testing</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Health center has universal screening protocol in place for all primary care patients ages 13-64</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Health center has protocol in place for managing reactive/confirmed positive results</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Performance Improvement Activities

- HIV reporting
- HIV testing
- HIV quality improvement
- HIV-related stigma among non-clinician staff and
- HIV revenue maximization
HIV Primary Care Training Platform

• Offers stage-based, manageable, self-contained learning proficiencies, which correspond to particular clinical topics in HIV prevention, care and treatment.

• Developed by HealthHIV clinical staff and delivers distance-based, learning content to prescribing providers and nursing disciplines (including unlicensed assistive personnel).
Overview of HIV Primary Care Training Platform

- The HIV Primary Care Training Platform includes the following:
  - Self-Assessments
  - Curriculum Menus

  - Core and supplemental learning resources for each level of care team and each stage of HIV integration
  - These resources are grouped into specific “HIV Learning Proficiencies”
  - Learning proficiencies correspond specific topics around HIV Care
Login

Username: [textField]
Password: [textField]

If you do not have a login, please email info@healthhiv.org.

Forgot Your Password? Login
Current Available Curriculum Menus Include:

- Foundation Stage
- Providers (MD, DO, PA, NP, APRN)
  - Stage 1: Part 1 & 2
  - Stage 2
  - Stage 3
- RN Part 1 & 2
- LPN/LVN/MA
Proficiency 1: Diagnose and Manage Acute Retroviral Syndrome

CORE RESOURCES:


DHHS Guidelines: Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents 2011.

SUPPLEMENTAL RESOURCES:

CME/CE Resources


Point of Care Resources: (Job Aids, Pocket Guides, Mobile Applications, etc.)


Curriculum Development

- Designed by practicing HIV-providers
- Uses select existing materials relevant to all levels of learner (providers new to HIV and more experienced clinicians)
- Vetted through providers across the country
- Based on distance education and adult learning needs, specific to medical education
- Structured to facilitate ongoing updates
Accessing Training Materials

- Accessible through online learning platform
- Password Protected
- Available to providers 24 hours a day, 7 days a week
- Technical assistance around user experience and accessibility is provided
- Content is accessible to all users across the spectrum of providers
# Case 1: Acute (Primary) HIV Infection

**Author:** David H. Spach, MD  
**Learning Objectives**

A 27-year-old previously healthy man presents to an urgent care center with fever, sore throat, lymphadenopathy, severe fatigue, and a diffuse erythematous rash. His symptoms have been present for approximately 48 hours and his history reveals unprotected receptive anal intercourse with another man 12 days prior to the onset of his symptoms. He had a negative HIV antibody test approximately 6 months ago. His physical examination shows a temperature of 38.0°C, non-exudative pharyngitis, cervical and axillary lymphadenopathy, and a generalized morbilliform rash (Figure 1). All laboratory tests are pending. The diagnosis of acute (primary) HIV infection is suspected.

Which one of the following statement is TRUE regarding acute HIV infection?

- Less than 5% of persons who acquire HIV develop an acute clinical illness.  
- More than 80% of patients with acute HIV present with aseptic meningitis.  
- Patients recently infected with HIV typically have plasma HIV RNA levels greater than 50,000 copies/ml within 4 weeks of acquiring HIV.  
- An HIV RNA level of 120,000 copies/ml combined with a positive HIV antibody test would be diagnostic of acute HIV infection.
Evaluating Engagement in Training

- Self-assessments from individual providers
- Monitoring and tracking learner engagement in online training activities
- Evaluations of live “intensive training” sessions
- Completion of CME activities
- Self-reassessment after training is completed
Betty Jean Kerr People’s Health Center
• Increases the number of providers and sites with the capacity to provide quality HIV care

• Focuses on areas of highest unmet need

• Identifies and implements mentoring models

• Disseminates and communicates approach (best practices, models) to guide workforce efforts
HIV Workforce Capacity Building Initiative

- National mentoring initiative pairing HIV experts with providers interested in expanding their HIV care
- Guided by National Steering Committee of HIV experts
- Focused in areas of greatest need utilizing GeoMapping
- Includes a residency program
- Utilizes multiple mentoring models
Salary growth lagging for U.S. primary care doctors: study

Nov 28 (Reuters) - Primary care doctors in the United States don't seem to be reaping the rewards of rising health care costs where it counts - in their paychecks, according to a study.

The findings, which appeared in the Journal of the American Medical Association, could have implications for what some predictions say will be a primary care shortage in some parts of the United States in the coming years.

Researchers found that since the late 1980s, the average doctor's earnings have grown more slowly than the salaries of other health professionals, such as pharmacists, dentists and registered nurses.

"It is possible that there are some specialties that have done extremely well in the past 10 or 15 years," said health policy researcher Amitabh Chandra from Harvard University, who worked on the study.

"In terms of the experience of the median doctor, the median doctor is not at the heart of all the cost growth we're seeing in America," he added.

"Median" doctors were the ones in the middle of the salary range.

For their study, Chandra and his colleagues analyzed data from a nationally-representative survey of American's occupations and earnings.
52,000 more primary care doctors needed by 2025, researchers say

By Mary MacVean
November 13, 2012 | 12:49 p.m.

The United States will need an additional 52,000 primary care doctors to cope with population growth, newly insured people and an aging population, a group of researchers has forecast.

The researchers — from several institutions including Georgetown University and the Robert Graham Center, Policy Studies in Family Medicine and Primary Care,
Testifying at a Senate hearing, physicians call for payment reforms as well as additional support from teaching hospitals and the AMA-convened RUC.

By JENNIFER LUBELL amednews staff — Posted Feb. 11, 2013

WASHINGTON To adequately prepare for 30 million people who will gain insurance under the Affordable Care Act, primary care needs an overhaul that puts those physicians on more equal ground with specialists, witnesses told a Senate panel on Jan. 29.

The law authorizes the expansion of Medicaid and the creation of marketplaces to buy affordable private insurance. But many primary care physicians say this will not be enough.

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Healthcare crisis: not enough specialists for the poor

With months-long waits for Medi-Cal patients to see specialists, some turn to emergency rooms — exactly what healthcare reform is banking on avoiding.

By Anna Gorman, Los Angeles Times
Latimes.com, November 2012

http://www.latimes.com/health/la-me-clinic-specialists-20121216,0,5635001.story
Are Primary Care Doctors a Vanishing Breed?
By Kathleen Doheny
WebMD Health News Reviewed by Louise Chang, MD

Dec. 4, 2012 -- Doctors who practice general internal medicine, known as internists, may be a vanishing breed, according to a new study.

In the new research, few medical residents in general internal medicine programs say they plan to pursue that career path. Instead, they plan to become specialists.


Salary growth lagging for primary care doctors
By Genevra Pittman
NEW YORK | Tue Nov 27, 2012 4:12pm EST

(Reuters Health) - Despite rising spending on health care in the United States, primary care doctors don't seem to be reaping the rewards on their paychecks, a new study suggests.

The findings could have implications for what some predictions say will be a primary care shortage in some parts of the country in the coming years.

<table>
<thead>
<tr>
<th>Model Name</th>
<th>Description</th>
<th>CHC Applicable?</th>
<th>Residency Applicable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyadic Personal Mentoring Program</td>
<td>Pairs a junior faculty member with a senior faculty mentor in a one-to-one mentoring relationship for 2 years</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>The Mentor's Model</td>
<td>Intended to develop independence, initiative, improved thinking, skills, and self-reflection over fifteen 1-hour meetings.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Collaborative Mentoring Program</td>
<td>A collaborative or peer-group faculty medical school mentoring program comprising of an 80-hour program spanning eight months.</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Community Care Continuum</td>
<td>Model for integration of HIV care into the primary care setting for community health centers (CHCs) by providing capacity building services through an HIV training package and practice transformation supported by clinical training.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Co-Management Model</td>
<td>A physician from the AETC visits an HIV clinic to discuss difficult or complicated cases with the new HIV provider and using hands-on training in order to improve quality of care given to HIV+ patients.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>E Mentoring</td>
<td>A computer mediated, mutually beneficial relationship between a mentor and a protégé that is often boundary less, egalitarian, and qualitatively different than face-to-face mentoring.</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Community Health Center Mentoring Model</td>
<td>Enhances the mentee and their CHC's existing capacity for providing HIV care via progression of the CHC through HealthHIV's model for integration of HIV care into the primary care</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
Mentoring in Action

Mentoring a Latina Provider in an urban Latino community

Mentoring African-American Providers in an African-American urban setting
Insights to Mentor Motivation

Professional Satisfaction –
• “Working with persons living with HIV most interpersonally and intellectually satisfying... Sharing experience with colleagues is source of great joy.”
• “Chance to share my hard earned expertise in HIV medicine”

Expanding Skills and Career –
• “...expertise in adolescent and pediatric HIV. As my patient population ages out of the pediatric clinic... looking for additional ways to utilize my expertise”
• “My job security and maintaining my HIV career focus”

Building Capacity of PCPs –
• “in community medicine... ability to share my enthusiasm with those who might want to delve in the field but who might otherwise be intimidated.”
• “Help others become experienced HIV healthcare providers”
Expanding Access to Quality Care –

• “Work within a larger community of practice to share the expertise…and commitment to caring for persons with HIV.
• “Improve access to high quality in rural and low prevalence settings, where access to high volume HIV specialty clinics is limited.”
• “…with more providers treating HIV patients, we can decrease transmission, and more patients will be in care.”
• “Opportunity to be champion for local integration of HIV care into primary care”
• “..make HIV/AIDS care part of routine primary care management”
Insights to Mentee Motivation

Expanded Access and Workforce
• “Ability to provide service to the local community”
• “Develop HIV treatment program at St Catherine's Hospital”

Increased Clinical Skills and Confidence
• “Gain new insights in HIV diagnosis and treatment”
• “Gain confidence in treating HIV”
• “Increase knowledge on current treatment options”
• “Understand and address complications with co-morbidities in PCP care setting”
• “Develop expertise in managing complicated patients”

Enhancing Skills and Knowledge
• “Reinforce and refresh my core knowledge”
Expanding the HIV Workforce
• “Becoming a local HIV provider”
• “Already being a PCP provider in a FQHC”
• “Serving as a resource person to NP if ID doc unavailable”
• “Introducing Family docs to the program”

Increasing Diversity
• “Bringing cultural diversity to the workforce – more providers of color”

Ongoing Interest in HIV
• “Eagerness to expand on knowledge of HIV”
Expanding the HIV Workforce: Trends and Innovative Approaches

This CME certified webinar (0.75 AMA PRA Category 1 Credit(s)™) was presented as a Learning Lab Session at IDWeek 2012, in San Diego CA.

Playlist: Uploaded videos (23 videos)

Release date: January 17, 2013
Expiration date: January 31, 2014
Estimated time to complete activity: 0.75 hours

A PC or MAC with access to the internet or an intent enabled mobile device is required to access this CME certified webinar.

Watch the video here (or click on the video link above) and download the presentation here.

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Evaluation

- Needs Assessment
- Level-Setting
- Advancing into the curriculum
- Participate in Training Materials
- Evaluation
Stages of Engagement in HIV Care

- HIV-infected: 1,178,350
- HIV-diagnosed: 941,950
- Linked to HIV care: 725,302
- Retained in HIV care: 480,395
- On ART: 426,590
- Suppressed viral load (≤200 copies/mL): 328,475

Engagement in HIV care

Tiered Indicators

Tier One: TESTING AND LINKAGE TO CARE

- # individuals at CHC eligible for HIV test using CDC criteria
- #/% eligible individuals offered HIV test
- #/% individuals who test HIV positive and receive test result
- #/% of newly diagnosed HIV positive patients who were linked to care within 3 months of diagnosis
Stages of Engagement in HIV Care

# individuals at CHC eligible for HIV test using CDC criteria

#/% eligible individuals offered HIV test

#/% individuals who test HIV positive and receive test result

# of tests performed in reporting period
Stages of Engagement in HIV Care

- 1,178,350 newly HIV-infected patients
- 941,950 newly diagnosed HIV patients
- 725,302 linked to HIV care
- 480,395 retained in HIV care
- 426,590 on ART
- 328,475 suppressed viral load (≤200 copies/mL)

*% of newly diagnosed HIV positive patients who were linked to care within 3 months of diagnosis.
Tiered Indicators

Tier 2: Retention in Care

A) #/% unduplicated HIV-positive patients currently enrolled in your CHC

B) #/% of unduplicated HIV-Positive patients with one or more HIV-related medical visit in the reporting period

C) #/% of ALL HIV patients who receive one or more CD4 T cell counts in the reporting period

D) #/% of ALL HIV patients receive one or more VL tests in measurement year

E) #/% patients with HIV on ART and have VL below level of detection according to assay used (VL= 50-200)
Stages of Engagement in HIV Care

- Medical visits, virologic testing, CD4 count monitoring
- Viral suppression

Engagement in HIV care:
- HIV-infected
- HIV-diagnosed
- Linked to HIV care
- Retained in HIV care
- On ART
- Suppressed viral load (≤200 copies/mL)

MMWR December 2, 2011 / 60(47);1618-1623
QUESTIONS?