Building an HIV Care Team: Breaking Out of Silos

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Learning Objectives
Upon completion of this presentation, learners should be better able to:

- Describe different members of a healthcare team caring for people living for HIV
- Discuss the healthcare team approach in management of people living with HIV
- Explain how Daily Huddles work and can improve care for people living with HIV

Faculty and Planning Committee Disclosure
- Please consult your program book or the Conference App.

Off-Label Disclosure
- There will be no off-label/investigational uses discussed in this presentation.
CASE #1

- 46 yo man presents to primary care clinic to discuss Lab results
- HIV Ag/Ab screen and HIV confirmatory test sent 3 days prior positive
- PMH significant for depression and hypertension. Currently not on meds
- An Infectious Diseases Consult is placed in chart and patient is called an hour later. Patient presents to the ID clinic on the same day

What is the best strategy for the first visit with the Infectious Diseases (ID) Clinic?

1. The patient meets with the provider and gets lab work done
2. The patient gets lab work done and schedules an appt in ID clinic within 4 weeks. A team member is assigned to call the patient in 1 week
3. The patient meets with the nurse, provider and case manager
4. The patient schedules an appointment within 4 weeks in ID clinic. A team member is assigned to call the patient in 2 weeks
The patient says he never felt sick before. How come HIV test came back positive and I feel just fine?

1. HIV can be asymptomatic. How come you were never tested before?
2. Some patients get opportunistic infections but that happens with advanced or late HIV
3. Good question. What do you know about the way people feel when they have HIV?
4. You may have gotten the flu like symptoms and forgot about it
Same-Day (Rapid) Start ART: Example Protocol

**Day 1**
- Upon notification, Confirm diagnosis and contact patient
- Patient meets with **provider** (initial education, symptom assessment/OI, risk behavior modification, med counseling, partner notification/PrEP and exam); nurse; and **social worker** (to assess imminent barriers to care, MH, SI/HI) +/- **PCMH**
- Lab work including RT/PI genotype, CD4 count, HIV VL, hepatitis serology, SCR, UA
- ART initiation: BIC/TAF/FTC; DTG + TAF/FTC; or Boosted DRV + TAF/FTC

**Day 14**
- Telephone visit with **PharmD** for med reconciliation, drug interaction, side effects and adherence education
- Lab work: SCR, UA, HIV VL
- **Social worker** call if follow up on any resources needed and identified during visit on Day 1 and to assess for any ongoing barriers to care

**Week 4-6**
- **Provider visit**: assess med adherence, side effects, drug interactions, risk behavior modification and psychosocial issues
- Lab work: CD4 count, HIV VL, CBC, CMP, UA
Clinic and Practice Setting: Type of Care

- HIV specialty care (no primary care provided)
- Primary care with HIV care integrated
- HIV specialty care with primary care integrated
- Other

Additional Services Provided

- Mental health services
- Dental services
- Case management
- Other

- In-house or somewhere else
Person-Centered Team Care

- Patient is a member of the healthcare team
- Integrated care or co-located services: Primary care, HIV and mental health
- Scheduled and acute care visits
- Clinic protocols
- Clinical reminders (vaccines, CA screening, Med reconciliation, other health assessments)
**Person-Centered Team Care**

- Effective communication strategies (EHR)
- Focus on quality

*Ojikutu B. AIDS Care 2014.*

**Whole Person Approach**

- Wellness
- “Whole person”
- Chronic disease management
- Preventive care
- Linkage and engagement to care

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**Healthcare Team: HIV Continuum of Care**

Missed clinic visits were independently associated with all-cause mortality (beyond HIV retention core indicators)

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Healthcare Team: HIV Continuum of Care

- Receptionist (scheduler), Case Manager, Social worker, Nurse, Peer navigator
- Phone calls, Secure messages, text messages

Pre-existing MH condition may influence appointment adherence

Table 2. Risk Ratios and 95% Confidence Intervals for the Association Between Having Recent Depressive Symptoms and the Risk of an Adverse Outcome Over Time Along the Human Immunodeficiency Virus Treatment Cascade

<table>
<thead>
<tr>
<th>Depressive Symptom Status</th>
<th>Detectable Viral Load</th>
<th>Missed Human Immunodeficiency Virus Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unadjusted RR (95% CI)</td>
<td>Adjusted* RR (95% CI)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No depressive symptoms (PHQ-9 &lt; 10)</td>
<td>1.00 (1.00, 1.00)</td>
<td>1.00 (1.00, 1.00)</td>
</tr>
<tr>
<td>Depressive symptoms (PHQ-9 ≥ 10)</td>
<td>1.37 (1.20, 1.56)</td>
<td>1.28 (1.07, 1.53)</td>
</tr>
</tbody>
</table>

Behavioral health specialist/mental health provider, Case Manager, Social worker, Nurse, Peer navigator

Clinic visits, support groups, Phone calls, Secure messages, text messages

Healthcare Team Plays a Central Role

- To empower patients
- To act as a facilitator for patients to engage and retain in care

“My nurse identifies my patients who are at risks of dropping out of care and calls them. My patients know that they can call my nurse all the time. I think it’s the team approach that really make people feel like they know how to navigate the system”.

“We make team rounds every week and discuss issues as they come up. We try to help patients navigate the pharmacy world which could be confusing”.

Gelaude MA. J Assoc Nurses AIDS Care 2017.

Education Starts at the Team level: Be Ready

- To address fears
- To change attitudes
- To offer support

Childcare, adoption, foster care, transportation, insurance,... in addition to physical, mental health and substance use
Healthcare Team: HIV Care

- Physician assistant
- Nurse practitioner
- Physician/ Infectious Disease Specialist
- Nurse (RN and/or LPN)
- Medical assistant
- Peer navigator/advocate
- Case manager
- Pharmacist
- Behavioral health specialist/ mental health provider
- Receptionist
- Dentist
- Health educator
- Dietitian or nutritionist
- Social worker
- Community health worker

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AHRQ, October, 2016
Healthcare Team

- Scheduling and appointment reminders (calls, texts)
- Labs
- Vital signs, BG
- Medical and psychosocial history
- Med reconciliation
- ART and other med education
- Immunizations
- Screening for depression
- Individualized healthcare plan
- Discharge planning
- Acute care calls and visits
- Follow up calls: labs, radiology

Effort Team

Healthcare Team: Identifying Barriers to Care

HIV CARE CONTINUUM:
The series of steps a person with HIV takes from initial diagnosis through their successful treatment with HIV medication

- Diagnosed with HIV
- Engaged or retained in care
- Linked to care
- Prescribed antiretroviral therapy
- Achieved viral suppression
Team Approach to Barriers to Care

- Structural barriers such as Transportation in PLWH → Telehealth services, case manager and community health worker
- Social barrier such as Housing → case manager, social worker and peer navigator
- Structural barriers such as Working Long Hours → offer extended hours, acute care visits options (provider, RN, receptionist)

Yehia BR. BMC Infect Dis 2015.
Dandachi D. J Investig Med 2019

Healthcare Team: Clear Roles
Healthcare Team: Roles and Responsibilities

- **Communication** is the process through which team roles are expressed and team goals are achieved (including to patients, families and other staff)

- Use the full scope of knowledge, skills, and abilities of available staff

- Engage in continuous professional development to enhance team performance

Kreps GL. Int Arch Nurs Health Care 2016.

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CASE #2

- 45 yo man living with HIV since 1994 and is on TAF/FTC, ETR bid, and RAL bid presents for follow up with you
- He has been on multiple regimens including d4T/3TC + IDV; 3TC/TDF + IDV; TDF/FTC + EFV; AZT/DDI + ATV/R; TDF/FTC + ENF bid + RAL bid
- Previous genotypes revealed M41L, D67N, M184V and K103N in RT gene, and M46I, V82T, and L90M in PI gene. No mutations in envelope gene
- He recently refused to take ritonavir due to diarrhea but is willing to try again and stopped ENF due to local site reaction
What should you recommend at this time?

A. BIC/TAF/FTC
B. DRV/C + TAF/FTC + DTG bid
C. DRV/C + TAF/FTC + DTG daily
D. DRV/C + TAF/FTC
E. DTG/RPV
F. DRV/C + TAF/FTC + DOR

You switched the patient to BIC/TAF/FTC

- 4 weeks later, HIV VL is checked and is 25,000
FDA- Approved HIV Drugs in 2018

- BIC/TAF/FTC: February 7, 2018
- Ibalizumab: March 6, 2018
- DRV/C/FTC/TAF: July 12, 2018
- Doravirine (or DRV/3TC/TDF): August 30/2018

What should you recommend at this time?

- The patient is very treatment experienced
- There is N155 in integrase gene \( \rightarrow \) Not sure what would happen with BIC
- Would rather use DTG BID + DRV/C + TAF/FTC

Team members need to know newly approved ART, indications and side effects (providers and pharmacists)
CASE #2- FOLLOW UP

- HIV viral load done after 4 weeks is 52 copies/ml
- Patients is not experiencing side effects
- Case manager is following up with the patient

Healthcare Team: Professional Development

- Continuous and for all team members
- Conferences, meetings, webcasts, journals
- Patients care coordination meetings

Improved Patient Care and Satisfaction
Interprofessional Team Communication: Meetings

- Standing
- Daily/weekly/monthly
- Meeting remotely via conference call, Skype, or video can make it easier to accommodate all team members
- Each team member: committed and actively preparing and participating
- Patient care meetings, Daily Team huddles, core team meetings
Interprofessional Team Communication

- Learn how to interact effectively within a team (different professional backgrounds)
- Be a good listener: Practice careful, receptive, and analytical listening
- Shared decision making: Main goal is to enhance patient’s experience, increase engagement in care and improve quality of care
- Achieve team goals by following evidence-based treatment options

Kreps GL. Int Arch Nurs Health Care 2016.

CASE #2

- 65 yo man living with HIV since 2004. HLA B5701 positive
- PMH significant for depression and Hypertension. Lives alone
- Treated with AZT, 3TC, Nelfinavir, lopinavir, and ritonavir in the past. Currently on TDF/FTC/EFV. HIV VL undetectable
- HBV negative
- History of severe diarrhea with lopinavir/ritonavir; headaches with AZT
- Seen in your clinic for routine follow up and is complaining of R hip pain
CASE #2

- SCR 2.7 (baseline 1.2)
- UA: 3+ protein
- You discuss with him getting off tenofovir

Which regimen would you recommend now?

A. BIC/TAF/FTC
B. DTG + TAF/FTC
C. DTG/ABC/3TC
D. DTG/RPV
E. DTG + 3TC
F. DRV/C + DTG
G. DRV/C + TAF/FTC
Are 2-Drug Regimens The Present?

- Not quite
- Guidelines have recommendations on 2-drug regimes that may be used in treatment-naïve or switch
- Need to take into account baseline genotypes/resistance information and medication adherence among other factors

Two-Drug Regimens for Patients on ART

- DTG/RPV (SWORD 1 & 2)
- DRV/R + 3TC (Dual-Gesida)
- DRV/R + DTG (DUALIS)
- DTG + 3TC (LAMIDOL and ASPIRE)
- Cabotegravir IM + RPV (long acting) (LATTE-2, FLAIR Week-48, and ATLAS)

Two-Drug Regimens for Naïve Adults

- DTG + 3TC in ART-naïve adults with baselines HIV VL <500,000 c/ml when ABC, TDF, or TAF cannot be used or are not optimal (GEMINI 1 & 2; ACTG A5353)

- DRV/R + 3TC can be considered (ANDES trial)

- DRV/R + RAL can be considered only in patients with HIV RNA <100,000 c/ml and CD4 count >200c/mm and only in patients who cannot take ABC, TDF, or TAF (NEAT001/ANRS143)

- DRV/C + RPV (PREZENT)


It Takes a Team

- Patient
- Provider (physician, PA, NP)
- Pharmacist
- Nurse

- Evidence Based treatment
- Baseline labs
- Follow labs in few weeks
- Monitor side effects

- Social support
- Transportation
- Mental health support
Team Communication

- Clear: use standard terminology and information that is plainly understood when talking to patients
- Timely
- Brief
- Relevant and complete

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Team Communication

- Clear
- Timely
- Brief: be concise
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Daily Morning Huddle

- Standing up
- Keep it short: 15 minutes or so
- Leader
- Same place, same time
- Discuss tasks and roles, emerging events and critical issues, assign resources, and express concerns
- Can develop elements such as: metrics review, clinical volume review, daily readiness assessment
- Erasable whiteboards

CASE #3

- 32 yo man living with HIV presents to clinic for follow up
- He is complaining of RUQ pain and nausea for 2 weeks
- On ART with undetectable viral load for the past year
- PMH: HCV, treated with Harvoni with SVR
- Exam: jaundice, RUQ tenderness
- Labs: AST 385, ALT 522, TB 4.2
CASE #3

- The patient states that he has a new male partner for the past 6 months. Partner also living with HIV and is on ART
- The patient is having oral, insertive, and anal insertive sex. He does not use condoms because he feels that he does not “feel much” with the condom on
- HCV ultraquant and anal GC TMA are positive. The patient states that he heard “you cannot get Hepatitis twice”

What is the best strategy to address the patient knowledge and practices?

1. The peer navigator should meet the patient and offer him resources such as helpful brochures
2. The RN should give the patient IM ceftriaxone and order PO azithromycin or doxycycline
3. The case manager or provider should use motivational interviewing to discuss with the patient a plan to maintain his sexual health
4. A liver US should be ordered
Healthcare Team and Data

- Electronic Medical Record (EMR)
- Clinical reminders
- Templates (notes, telephone calls, letters)
- Chart reviews (internal)
- Data-driven quality improvement process to integrate evidence into practice procedures
  - develop an inter-professional QI team that meets regularly (clinical, non-clinical, even patients)
  - Adopt a consistent QI approach and use QI tools to make changes (use charts, workflow maps, patient and family feedbacks)
  - Select internal QI measures, collect data, compare with goals and benchmarks, and act on data regularly
  - Engage healthcare team to support implementation of new evidence

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Healthcare Team in Outpatient setting: Team work Matters

- Better continuity of care
- Higher patient satisfaction
- Better health outcomes

E.g. patient navigators, as part of the healthcare team, improve health outcomes by improving retention in care and viral load suppression especially in patients with behavioral health comorbidities

Acknowledgements

- Patients
- My team
- The internet