

The HIV Workforce of the Future: Leveraging medical resident training to strategically address shortages in HIV workforce and improve health outcomes

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Disclosures

Jeannette L Aldous, MD has no financial interest to disclose.

Lisa Asmus, MPH has no financial interest to disclose.

Gordon Liu, MD has no financial interest to disclose.

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INTRODUCTION

- The U.S. is facing a severe HIV clinical workforce capacity shortage that will impact ability to provide care for the growing number of persons living with HIV/AIDS (PLWHA), especially as demand for primary care grows.
- HIV training through collaboration between community health centers and family medicine residency programs offers an innovative approach to bridge this gap, especially for underserved FQHC populations
- We describe experiences and lessons learned from three FQHCs that developed HIV curricula and implemented HIV training in collaborative residency partnerships.
- The three different program models were tailored to the existing infrastructure and strengths of each program, and the individual needs of the medical trainees and communities served.
- Together, these programs provide multiple strategies to address impending shortages in HIV services for highly-impacted, diverse populations.

Learning Objectives

At the conclusion of this activity, the participant will be able to:

1. Recognize existing workforce shortages and future needs for HIV medical care
2. List three strategies to incorporate HIV medical care training into the medicine resident training experience
3. Identify benefits and challenges of adding HIV primary care training to family medicine residency programs

HIV Workforce Shortage

Persons living with HIV/AIDS (PLWHA) are living longer, healthier lives and require a clinical workforce capable of meeting their evolving healthcare needs.

CDC estimates an **increase** of 30,000 patients/year requiring care in next five years (CDC, 2012, 2014)

It is estimated that while patient caseload and demand continues to increase, one-third of currently practicing, first-generation HIV care specialists will retire over the next 10 years. (Pettersen SM, et al., 2012)

By 2019, projected workforce net growth of 190 more fulltime equivalent HIV providers falls under the number needed to keep pace with increased patient care capacity (Weisner, et al., 2016)

HIV Training for US Primary Care Residents

AAFP Curriculum Guidelines list HIV core competencies as a training priority.
However:

- Only 25% of Family Medicine Residency Program Directors felt their programs had adequate HIV training
- 79% felt their program did not have faculty with enough HIV experience to train residents.
(Prasad et al. Fam Med 2014)
- AAHIVM lists only 10 Family Medicine Programs with HIV tracks
(<http://www.aahivm.org/trainingopportunities>)
(US has approx 477 FM programs)



**Closing the HIV workforce
gap in underserved
communities:
An HIV primary care rotation
for Family Medicine
Residents
(Strategy 1)**

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&**

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SYHealth SPNS Practice Transformation Project

Strengthen the HIV Care Team

1. Standardization of Team-Based Care Model:

- Increase **capacity**, and **maintain excellence**
- Increase engagement of HIV Care Teams in **clinical quality improvement** and **patient centered care**
- Electronic Health Record (**EHR**) integration

Increase Access to Services

2. System-Level Service Integration: “Project Connect”

- Increase **access** to non-HIV primary care services for HIV-positive patients through Patient Navigation, training, and outreach within SYHC. (**Opening up the “the silo”**)

Train HIV Providers

3. Workforce Capacity Building

- Expand HIV workforce capacity through **training providers** (residents and non-HIV providers) in HIV clinical care

Training Strategy

To expand the future HIV workforce, we developed an FQHC-based Community HIV Medicine Rotation for Family Medicine Residents

Goal: to increase resident knowledge, skills, and comfort with providing primary care to PLWHA in a community clinic setting

Setting

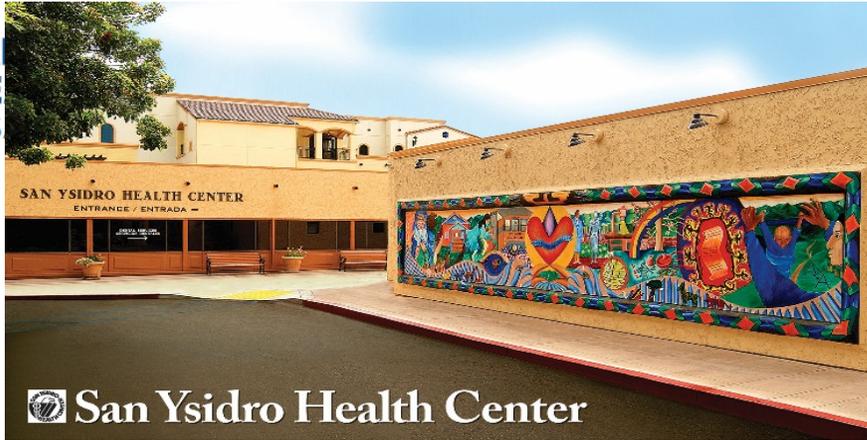
- **Large Federally Qualified Health Center (FQHC)**, multiple clinics serving Central/Southeast and Eastern Regions of San Diego County
- **94,225** Patients (2017): 37% 0-18yrs, 53% 19-64yrs, 10% 65yrs & over
- **83% Latino**, 7% Asian and Pacific Islander, 5% African American
- **92% at or below 200% of Federal Poverty Level** (70% below 100% FPL)
- **31% Uninsured**, 57% Medi-Cal, 8% Medicare, 4% Private
- ***Embedded Family Medicine Residency Program focused on Community Medicine***



**SAN YSIDRO
HEALTH**



SYHealth HIV Program



San Ysidro Health Center

SOUTH BAY:

650+ HIV+ patients
Border health, primarily Latino population



SAN YSIDRO
HEALTH
Our Place

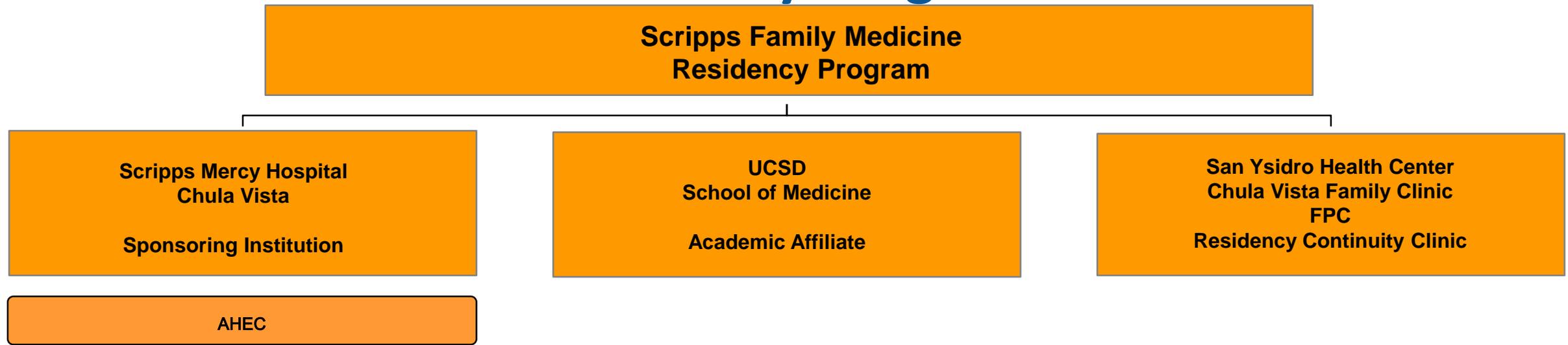
SOUTHEAST:

350+ HIV patients
Ethnically diverse, low-income population

SYHealth has provided HIV services for almost **25 years** and currently operates **two HIV social service sites** and **two Ryan White clinics** serving **1000+ patients**

Clinics provide integrated, comprehensive, primary care, HIV specialty care, health education, treatment adherence, and prevention services

Project Setting: Scripps Chula Vista Family Medicine Residency Program



Residency Program Goals:

- Train family physicians to provide care for the underserved
- Improve workforce diversity
- Focus on the US-Mexico Border

Resident Demographics :

- 50% Underrepresented Minorities
- 43% Latino, reflecting local culture
- Many have local roots in San Diego
- 60% of graduates work in underserved setting

HIV Curriculum

- The rotation formally launched July 2015 (pilot 2014)
- All 8 of the program's second year residents rotate through a six-week, hands-on HIV clinical rotation
- 3-4 AETC didactic sessions (previously in place)
- Self-directed learning via AETC modules and National HIV Curriculum

Evaluation Methods

- IRB approval, San Diego State University
- Second-year Family Medicine residents (n = 8 per year) recruited via email or in person by Evaluation Team – Starting August 2015
- Interested residents provided voluntary and informed consent for survey portion of study
- Pre-survey completed prior to initiating HIV curriculum
- Residents were re-contacted after the rotation for post-survey

Evaluation Measures

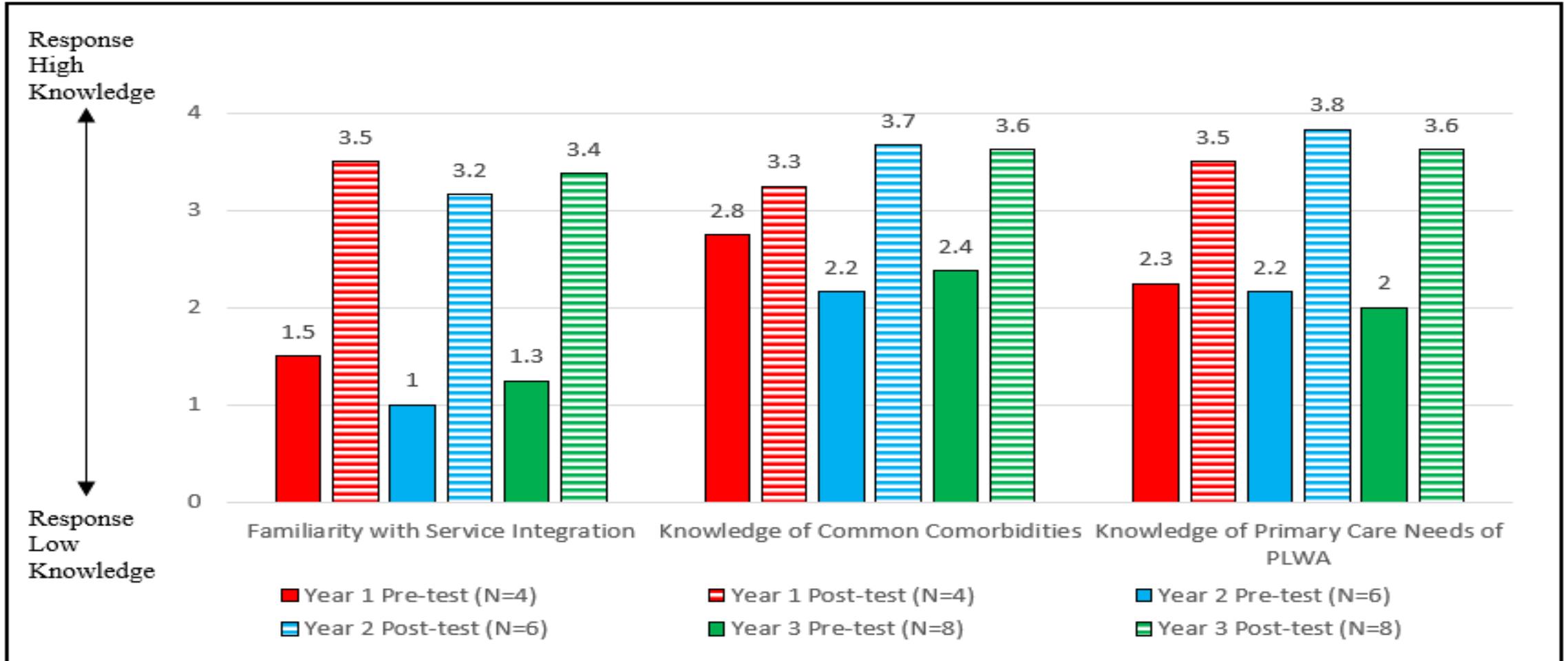
I. Structured, self-administered 18-item pre/post survey using likert scale format to measure:

- 1) Familiarity with service integration for PLWHA
- 2) Self-efficacy to care for PLWHA
- 3) Knowledge of common co-morbidities of HIV and routine primary care needs of PLWHA

e.g., “How familiar are you with service integration for PLWH, 1 (not much at all) to 5 (a great deal)?”

II. Semi-structured post-rotation survey elicited resident reflection on rotation experience and how integrate into future practice

Preliminary Results: Pre-Post Change



RED: Year 1 (2015-2016 cohort)

BLUE: Year 2 (2016-2017 cohort)

GREEN: Year 3 (2017-2018 cohort)

Resident HIV Rotation Qualitative Survey

Responses to seven qualitative questions were thematically analyzed and categorized into 3 overarching reflections:

- Experience in the rotation
- Self-efficacy with delivery of culturally competent care to PLWH
- Reflections about real-world, clinical application of their experience

Selected Qualitative Evaluation Questions: Resident Personal Experience

1.1: “What was it about your experience observing care delivery that helped you understand how caring for patient living with HIV may *differ* from caring for patients not living with HIV?”

- Screening/assessment practices
- Working in interdisciplinary team setting
- Considering variety of risk factors

1.2: “What was it about your experience observing care delivery that helped you understand how caring for patient living with HIV may be *the same* as caring for patients not living with HIV?”

- Screening practices are the same as any other patient (e.g. cancer, mental health, and chronic dz screening)
- Exposure led to less stigma
- Same health care needs as anybody else
- Specific procedures common to everyone

Preliminary findings

Selected Qualitative Evaluation Questions: Future Clinical Application

5.1

“What do you think that clinicians can do to help reduce HIV-related stigma among their patients living with HIV?”

- Use inclusive language
- Normalizing talk and screening of HIV
- Educate staff

7b

“What aspects of the training do you think you are most likely to apply in your primary care clinical work?”

- STI screening
- PreP tx
- HIV medication

Preliminary findings

Qualitative Survey Comments

“An integrated team...is important... This level of support, while it would be useful for the general patient, is crucial in the care of PLWHA.”

“Much of HIV care is primary care... I will be more cognizant of screening for HIV and STDs.”

“The LGBTQ community is very stigmatized by society, it’s extremely important to establish, support and make yourself an ally with patients so they are comfortable giving information. In the Latino community, this is even more stigmatized, we must be aware of this and act accordingly. In the non-LGBTQ/HIV Community, we need to be open and non-judging.”

Results

- Low pre-survey scores indicate opportunity for improvement across all indicators
- Pre-tests indicate residents begin rotation with:
 - low familiarity with service integration for PLWHA (ave 1.4, likert scale: 1 lowest, 5 highest),
 - low knowledge of common co-morbidities and ART side effects (average 2.6 and 1, respectively)
 - low knowledge of routine primary care needs of PLWHA (average 2.4).
- Post- tests showed improvements in all domains
- Qualitative questionnaires provided insightful revelations about rotation impact and influence on future care delivery

Discussion: Rewards and Challenges

Rewards: “unintended consequences”

- ↑ Primary Care expertise into the HIV clinic
- ↑ HIV/STI expertise into Primary Care clinic
- ↑ *Referral access for HIV+ patients to Family Medicine*

Challenges: Time!

- FQHC model does not include dedicated teaching time
- Limited funding for teaching in Community setting (reliance on volunteers)
- Utilize AETC and other local resources for curriculum support

Conclusions

- A core HIV clinical curriculum for Family Medicine residents is feasible
- Findings indicate that residents are interested in and willing to engage in the care of PLWHA
- Consistent pre/post improvement across survey items and qualitative survey responses indicate that the HIV block rotation is **meeting the goal of increasing resident confidence in caring for patients living with HIV through exposure to HIV care delivery in the community setting**
- Partnerships between RW clinics and Residency Programs may be an effective strategy to address current workforce capacity needs

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- Lucia Franco
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- Marianne McKennett, MD

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THANK YOU!



Scripps Family Medicine Residency Program

in partnership with



Expanding HIV Care: Adding HIV Primary Care to a Family Medicine Residency Program (2nd Strategy)

Lisa Asmus, MPH &

Principal Investigator / Research Scientist – Institute for Public Health, San Diego State
University, [Evaluator for Family Health Centers of San Diego]

Verna Gant, MA

Programs Manager - Family Health Centers of San Diego

Family Health Centers of San Diego



- Private 501(c)3 Federally Qualified Health Center
- Operates 21 clinic sites throughout San Diego County
- HIV Services since 1990's; largest provider of HIV services in SD County
- Serves approximately 1,300 persons living with HIV per year
- Patient population racially/ethnically diverse, un/underinsured
- Variety of services: HIV Pre-Exposure Prophylaxis (PrEP), transgender hormones, focused LGBTQ services (at certain clinics), medication-assisted treatment, mental health, healthcare for the homeless

HIV Care Shortage

Impending Challenges:

- Three full-time HIV Medical Specialists were leaving FHCSD
- HIV care and supportive services/case mgmt located at one central clinical site; siloed and not integrated into primary care

Goal:

Expand the capacity of FHCSD to provide specialty HIV care through system-level structural changes to better address the HIV needs of inner-city, urban communities

Overall Model

1. Training **support staff** at the additional clinical sites to provide HIV supportive services (sensitive to the needs of LGBTQ and other stigmatized groups) – 2 hrs per month 6 mo

Case Mgrs, Care Coordinators

Lab Staff

Front Desk Staff

MA, RN, LVN

Insurance Application Assistors

2. Training **existing** primary care providers and **family medicine residents** to provide HIV specialty medical care

MD, DO, NP, PA

FM Residents

Medical Resident / Provider Training

Model:

- Multi-modal and longitudinal training program culminating in American Academy of HIV Medicine (AAHIVM) specialty certification
 - **24 months** for medical residents
 - **6 months** for existing primary care medical providers
- Curricula developed by existing HIV Specialist Physician ('Physician Champion')

Medical Resident Training: Overview

1. Immersive clinical **preceptorship**: rotations of two ½ days per month progressing to preceptoring then empanelment (assigned own patients)
2. **Independent study**
 - HIV Webstudy/Question Bank (AETC) www.hiv.uw.edu
 - Telehealth recorded sessions (North West AETC)
 - Hepatitis Website (University of Washington) www.hepatitis.uw.edu
 - HIV Online Curriculum (University of Washington)
 - Telehealth (Pacific AETC HIV Learning Network); weekly HCV huddle
3. **Specialty consultation** (with physician champion via text, phone, electronic)

Medical Resident Training: Visual



Year 1



Year 2



AETC HIV LEARNING NETWORK
A TELEHEALTH PROGRAM OF THE PACIFIC AETC

Bridging the connection between primary care providers and HIV experts



National HIV Curriculum

Antiretroviral Medications > Course Modules > Question Bank > Clinical Challenges > Tools & Calculators >

National HIV Curriculum

A free educational web site from the University of Washington and the AETC National Coordinating Resource Center.

Contributors

Funded by a grant from the Health Resources and Services Administration



Medical Residents Training: Logistics

Recruitment: The physician champion recruited providers (2 residents / year)

Timing: Precepting, telehealth and consultation was offered during clinical hours; independent study was outside of clinical hours

Attrition: First two trained medical providers left the agency; subsequent medical staff signed a 2-year commitment to remain at the agency after training

Financing:

- SPNS grant paid for per-diem providers for the clinic hours missed while existing medical providers were trained
- Physician Champion was paid by the grant – key but not sustainable
- Sustainable: Curricula integrated into the existing FM residency program

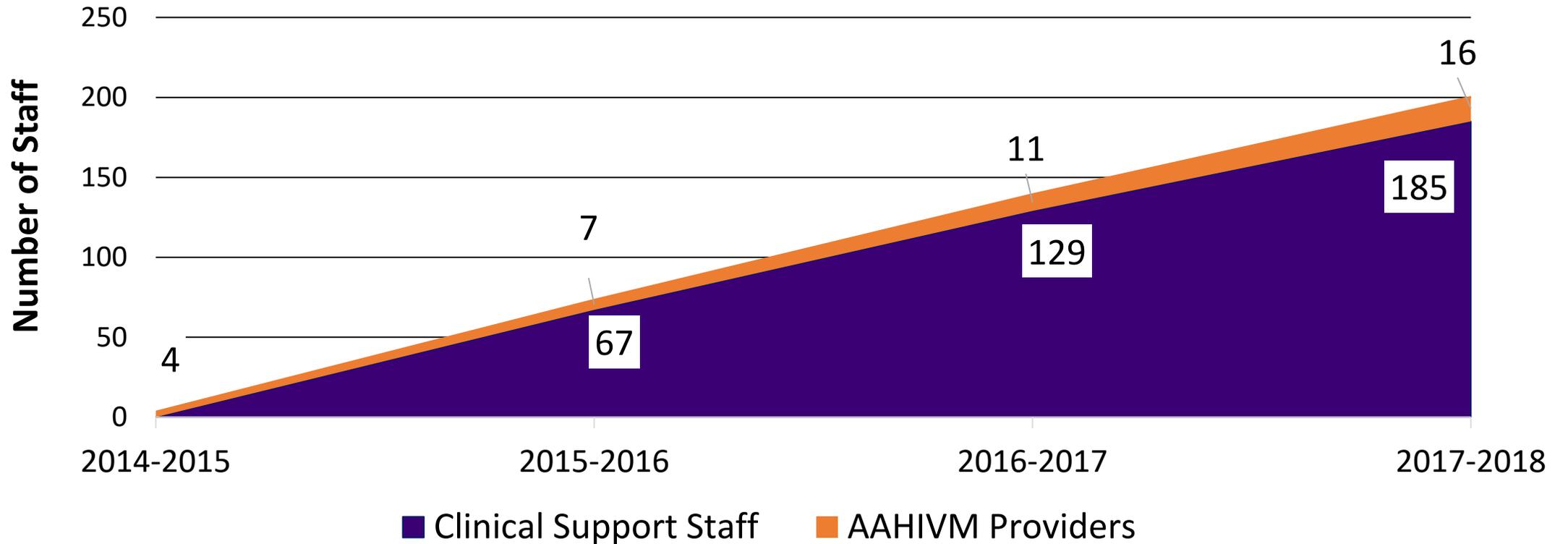
Results: Training Completion

Medical Providers

- **16** medical providers have been trained to provide HIV specialty care
 - 13 were AAHIVM-certified
 - 1 will focus on PrEP and not take the AAHIVM exam
 - 2 began training in July 2018
- **8** of these medical providers were/are Family Medicine Residents
 - **100%** of the four that graduate thus far were retained at FHCSD after residency

Results: Training Completion Visual

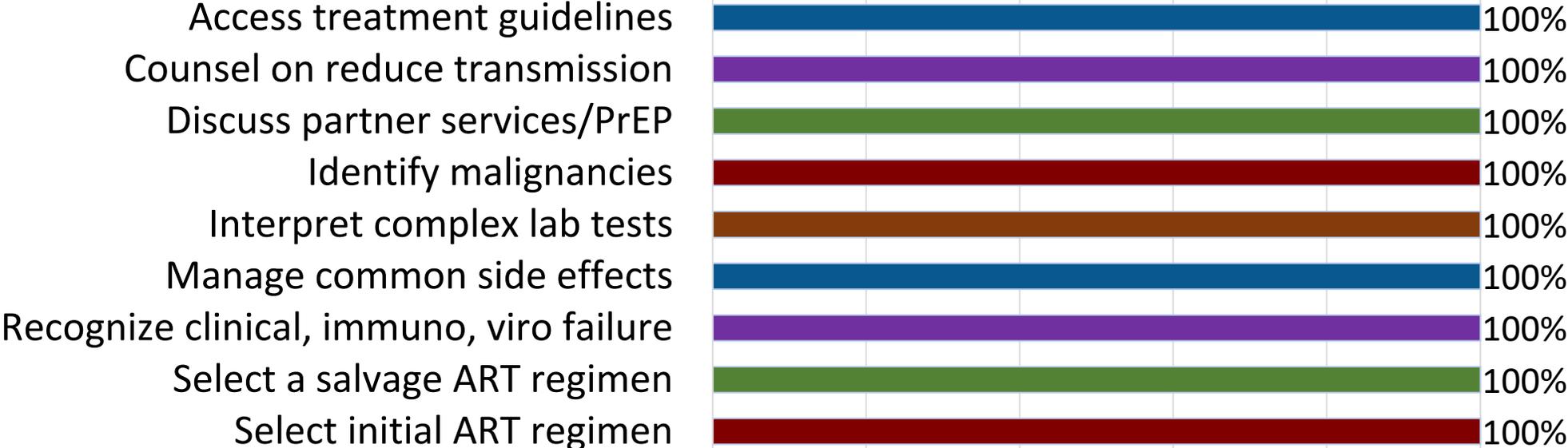
Cumulative Number of Staff Trained per Project Year



Results: Residency/Provider Training 1

Medical Providers Reporting Increased Confidence in their Ability to Manage HIV/AIDS Patients (n=12 with baseline and post measures)

HIV/AIDS CARE ELEMENT
(AETC ECHO SURVEY)

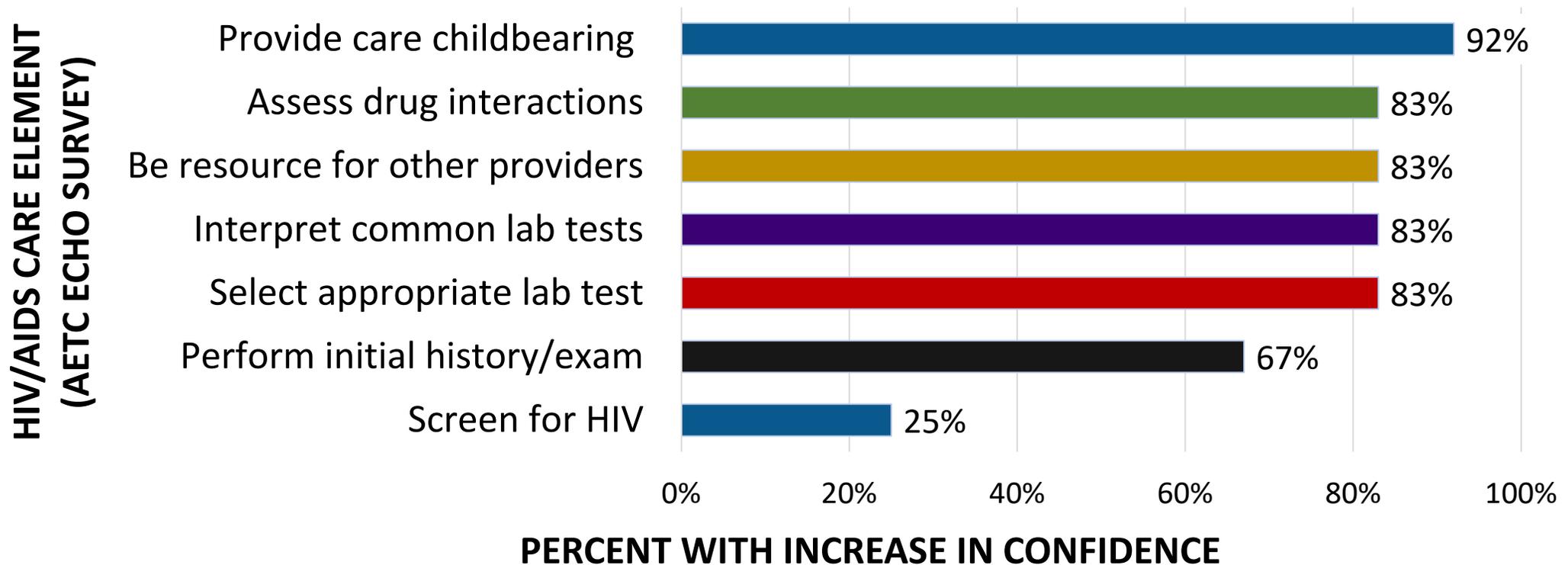


0% 20% 40% 60% 80% 100%

PERCENT WITH INCREASE IN CONFIDENCE

Results: Residency/Provider Training 2

Medical Providers Reporting Increased Confidence in their Ability to Manage HIV/AIDS Patients (n=12 with baseline and post measures)



Results: Residency/Provider Training 3

HIV-Practice Level

No Experience
Beginning Level



Intermediate

(100%, n=9 who rated themselves)

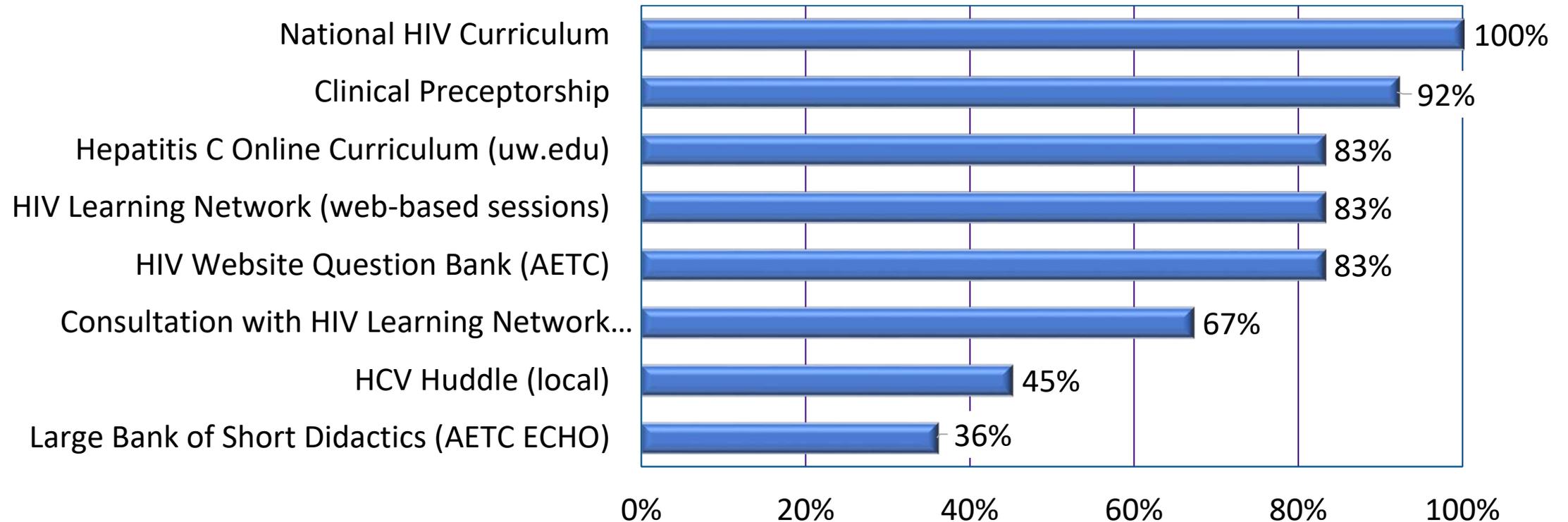
Self-Rated Knowledge Gain (n=12)

Percent 'Agree' or 'Strongly Agree'

1. I learned how to prescribe and monitor ART – **100%**
2. I learned about cultural competency/sensitivity (HIV/sexual orientation) – **100%**
3. I learned how to help patients overcome barriers to treatment adherence – **100%**
4. This program adequately prepared me to provider HIV medical care – **92%**
5. I learned how to use and apply the current HIV/AIDS treatment guidelines – **92%**

Results: Residency/Provider Training 4

Percent of Medical Providers who Rated the Various Training Modules as 'Very Useful' or 'Extremely Useful' (n=12)



Results: Suggestions for Improvement

“Ensure that participating residents are actually getting one HIV clinical scheduled per month”

“Allow more sessions with patients”

“Have some kind of check-in...to ensure residents are doing what they should (online learning etc.) and getting what they need (adequate clinics, etc.)”

Tell residents about the AAHIVM exam requirements at the beginning
“focus on CME activities, save the certificates, etc.”

“Would appreciate periodic (i.e. monthly) ‘huddles’ for HIV”

“...spend more time with each patient ...”

Results: Positive Feedback

“Online/self-paced trainings were most important for basic understanding. Preceptorship and provider-provider direct consultations have been most relevant to real world practice.”

“The clinical preceptorship, flexibility of study and ongoing specialty support were most relevant to my work.”

“The clinical preceptorship was most relevant.”

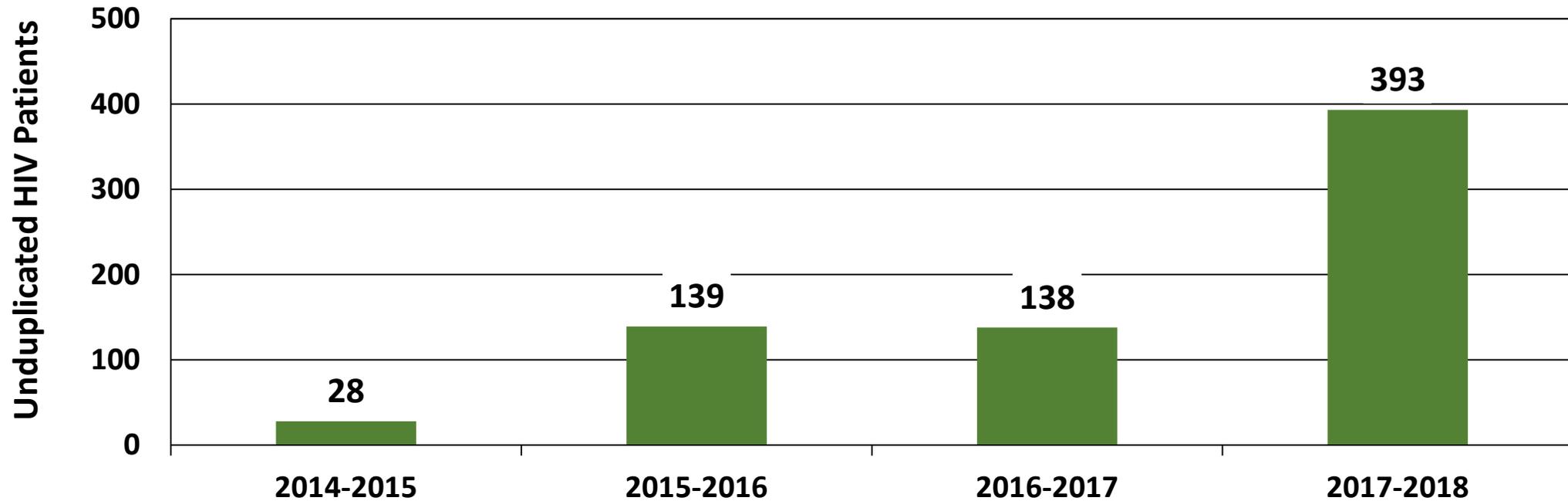
Outcomes: New HIV Clinic Sites

Significant Expansion:

- ★ 6 ★ FHCS D clinics began providing HIV medical care and supportive services [total of 7 clinic sites]
- **11** trained family medicine providers who also provide HIV specialty care
- **Increase** in persons living with HIV served at these new sites by newly trained medical providers

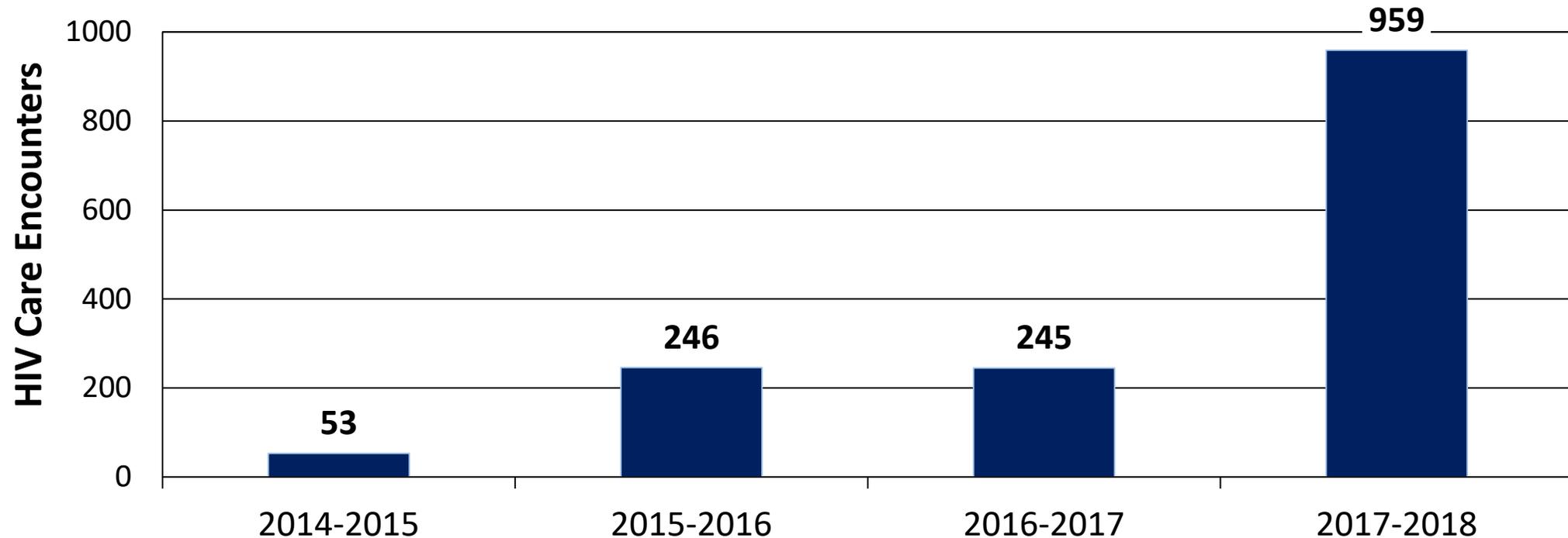
Outcomes: New Provider Empanelment

Newly Trained HIV Medical Providers: Number of Patients Living with HIV/AIDS



Outcomes: New Provider Encounters

Newly Trained HIV Medical Providers: Number of Medical Encounters with Patients Living with HIV/AIDS



Discussion: Implementation Challenges

1. Clinic buy in

2. Logistical residency challenges

- Resident schedules required complex coordination
- Preceptorship: once monthly clinic ideal, but sometimes less frequently
- Building resident patient panels takes time and effort
- Limited availability to attend telehealth sessions when offsite
- Preceptor's schedule impacted available clinic learning times
 - HCV or elastography
 - Language: Spanish Speaking

Try your best to fit everything into everyone's schedules; staff time needed to coordinate; need enough patients

Discussion: Sustainability

Residency 'HIV Track'

- Limited resident costs
- Precepting costs covered in residency training budget

Existing medical provider training

- Not sustainable

Conclusion

1. **Possible (excellent idea)** to fold 'HIV Track' into Family Medicine Residency Programs
2. **Physician Champion** (faculty trainer) is key
3. National HIV and University of Washington **online curricula** as well as the AETC's **HIV Learning Network** are enduring resources
4. Essential that **support staff** are also trained; training needs will continue over time

Thank you Again!



FAMILY HEALTH CENTERS
OF SAN DIEGO





UPMC Primary Care HIV Track Addressing Workforce Capacity in HIV (Strategy 3)

Gordon Liu MD, AAHIVS

Deborah McMahon, MD

UPMC McKeesport Family Medicine Residency Program

Latterman Family Health Center

- Comprehensive primary care services
- 14 exam rooms, including a surgical/procedure room, OB room with ultrasound and fetal non-stress test, educational exam room (self evaluation for residents and medical students)
- Multiple board specialists available
- Behavioral specialist on-site
- Ties to community agencies and hospital
- Patient-Centered Medical Home since 2012, with interprofessional care delivery model



UPMC HIV Primary Care Track

HIV Primary Care Track in Family Medicine

MISSION STATEMENT

Train future family medicine physicians with an interest in HIV medicine to provide comprehensive and high quality care to persons living with HIV and their families.

Selected residents provide continuity care for a cohort of at least 25 persons living with HIV and receive enhanced training in:

- HIV/AIDS, STDs, Hepatitis C, TB
- Care of marginalized populations including racial, ethnic, and sexual minorities

Current Enrollment: 4 residents (includes 1 from UPMC St. Margaret's Family Medicine Program)

HIV Primary Care Tracks in Family Medicine

- There are 453 Family Medicine (FM) residency programs in the USA
- 1 of 10 primary care HIV tracks in the country (**5 are Part C Sites**)
- 2 year track integrated into residency training;
 - **partnered with RW Part C site**
- Started in 2013 and one of the 1st FM HIV tracks in the country
- 170 HIV specialists in the country that are FM-trained

Identification of HIV Primary Care Track Trainees

- PGY-1 FM residents from any UPMC FM Residency Programs (McKeesport, Shadyside, St. Margaret) are eligible to apply
- Applicants must:
 - Provide a one-page statement of their career goals
 - Outline reasons for entering the track
 - Describe relevant past experiences
 - Interview with the track director and current track residents
 - Submit a letter of support from the Program Director
- 1 or 2 residents selected per year, based on capacity

HIV Primary Care Track

Training Sites:

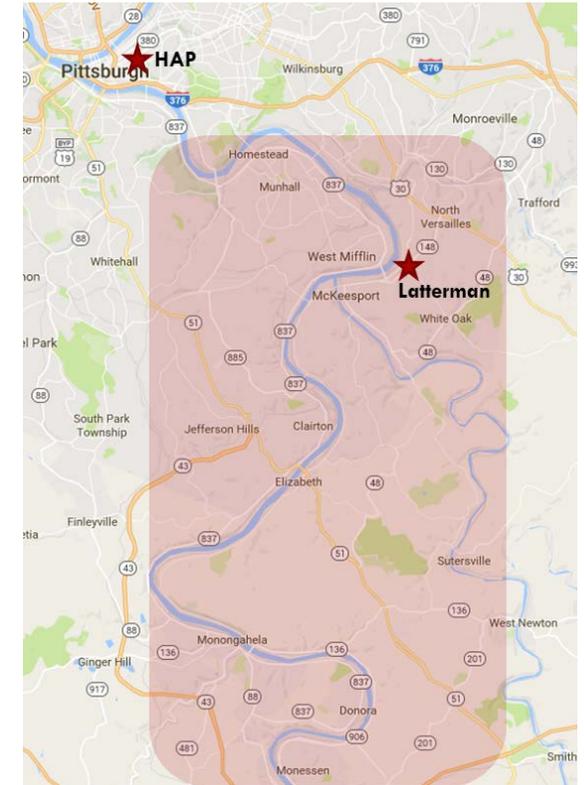
Pittsburgh AIDS Center for Treatment (PACT), UPMC, Pittsburgh, PA

Ryan White (Parts B, C, D) clinic, medical home model

- Provides primary HIV care for over 1700 persons living with HIV
- Infectious Diseases physician-led clinical setting
- On-site sub-specialty care (anal dysplasia, GYNE, MH, HCV, PT, Addiction, Pain)
- Major training site for ID fellows, primary care residents, medical students
- Affiliated w/HRSA-funded MidAtlantic AIDS Education and Training Center

Latterman Family Health Center, UPMC, McKeesport, PA

- Level 3 Patient-Centered Medical Home serving over 12,500 patients



HIV Primary Care Track Program Residents

- Provide continuity care for 150+ patients living with HIV
- Receive enhanced training in HIV/AIDs, STDs, Hepatitis C, TB
- Fulfill FM training requirements
- Develop capacity to serve as a HIV physician champion, mentor
- Meet requirements to sit for:
 - American Board of Family Medicine (ABFM)
 - HIV Specialty Certification examination offered by American Academy of HIV Medicine (AAHIVM)

HIV Primary Care Track

- Ryan White Part C site serves as a secondary continuity clinic site for HIV Primary Care Track residents during their 2nd and 3rd year of residency training
- Residents:
 - 1) Participate in a comprehensive HIV primary care curriculum
 - 2) Complete the National HIV curriculum (University of Washington)
 - 3) May also participate in Global Health Track
 - Sites in Philippines, Mozambique, South Africa
 - Gain experience in providing care to persons living with HIV in resource-limited settings

HIV Track Curriculum

PGY 2

- 4 wk HIV primary care PACT rotation
- Weekly HIV Continuity Clinic (½ d/wk)
- Scholarly project related to HIV primary care (QI)
- Maintain own panel of HIV patients at Latterman Family Health Center
- Global Health rotation in area with high prevalence of HIV infection (encouraged)

PGY 3

- Weekly Continuity Clinic (½ d/wk)
- Maintain own panel of HIV patients at Latterman Family Health Center
- Participate in case conferences, core didactics
- Earn 45 HIV-specific CME credits
- Present at least 1 HIV-related journal club article, 1 HIV care M&M, 1 senior presentation on HIV-related topic
- Global Health rotation (encouraged)
- One month away elective at another academic institution (encouraged)

HIV Primary Care Track Evaluation

- Meet all core FM residency requirements as detailed by the residency program
- Meet HIV Track curriculum objectives
- Maintain a weekly longitudinal HIV clinic for at least 2 years
 - Provide high quality and comprehensive HIV primary care for their patient panel (monitored by QI indicators)
- Meet AAHIVM credentialing exam requirements, including HIV-related CME and patient volume expectations
- Present scholarly project to UPMC HIV Program leadership

HIV Primary Care Track Faculty

- Dr. Gordon Liu
 - Board Certified FM Physician and an HIV/AIDS Specialist
 - Assistant Professor in the Department of Family Medicine at UPMC McKeesport Family Medicine Residency Program
 - Assistant Professor in the Department of Infectious Diseases at UPMC
- Dr. Peter Veldkamp
 - Professor of Medicine, U of Pittsburgh (Infectious Diseases)
- Dr. Deborah McMahon
 - Professor of Medicine, U of Pittsburgh (Infectious Diseases)

HIV Primary Care Track Challenges

- Integrating an HIV Primary Care Track into a 3 year FM residency program or 5 year FM/Psychiatry residency program
- Meeting Continuity of Care expectations (1650 outpatient encounters by graduation; staffed by Family Medicine MDs)
- Maintaining support from other (busy) FM faculty
- Obtaining staff buy-in at LFHC
- Enlisting support from Division of Infectious Diseases, Department of Medicine

HIV Primary Care Track Outcomes

HIV Physician Champions

Graduates	Current Position
Gordon Liu MD, AAHIVS	Assistant Professor Department of Family Medicine, U of Pittsburgh HIV panel: 250+ patients; mentoring FM and IM residents
Britt Gayle MD, AAHIVS	Assistant Professor of Clinical Family Medicine at Georgetown University – Medstar Franklin Square HIV panel: 200+ patients; mentoring FM residents
Hadrian Holder MD, AAHIVS	HIV Fellow – University of Pittsburgh HIV panel at LFHC: 40+ patients
Michelle Caster MD, AAHIVS	Family Medicine Faculty, University Hospitals Cleveland Medical Center HIV panel: 100+ patients; mentoring FM residents

Current HIV Primary Care Track Residents

Current residents	Residency Program
Roshni Kanji, MD – PGY 3	UPMC McKeesport
Yui Sugiura MD – PGY 3	UPMC McKeesport
Allison Vogl, MD – PGY 2	UPMC St. Margaret's
Daniel Salahuddin, MD – PGY 2	UPMC McKeesport FM/Psych Program

HIV Training for Non-HIV Track Family Medicine Residents

- Staff (Office Staff, MA's, Nurses) receive training from the MidAtlantic AETC
- Monthly HIV-related didactics for LFHC faculty and residents
- On-site mentoring from HIV physician champion
- Partnered with a Ryan White Part C site through common EHR
- Monthly HIV case conferences at LFHC



Summary

- 1) HIV Primary Care Tracks within FM Residency Programs can help address the HIV workforce capacity shortfall
- 2) RW Part C sites can be leveraged to serve as training sites for FM physicians
- 3) FM physicians are well-positioned to serve as HIV care providers due to increased life expectancy, need for life-long primary care by persons with HIV
- 4) FM trainees are interested in incorporating HIV care into their practice
- 5) Professional societies can play a key role (ie, Society of Teachers in Family Medicine) in facilitating HIV training curriculum and standards

In Conclusion: Summary

The U.S. is facing a severe HIV clinical workforce capacity shortage that will impact ability to provide care for the growing number of persons living with HIV/AIDS

HIV training through collaboration between community health centers and family medicine residency programs offers an innovative approach to bridge this gap, especially for underserved community health center populations

We described to you three strategies to incorporate HIV medical care training into medical residency programs:

- HIV primary care rotation in an FQHC for family medicine residents
- HIV primary/specialty care track in a family medicine residency program
 - At an FQHC led by FQHC staff
 - At a community health center run by a university and led by university staff