Building HIV Capacity in Primary Care and Integrating HIV Care within Federally Qualified Health Centers

Midwest AIDS Training and Education Center

San Ysidro Health Center

Costal Bend Wellness Foundation

FoundCare

Access Community Health Network

Moderator: Steve Bromer, MD

NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Building HIV Capacity in Primary Care and Integrating HIV Care within Federally Qualified Health Centers--Part 1:

Developing the HIV Workforce: The MATEC Clinician Scholars Program

Ricardo A. Rivero, MD, MPH
Midwest AIDS Training + Education Center (MATEC)

The AIDS Education and Training Program

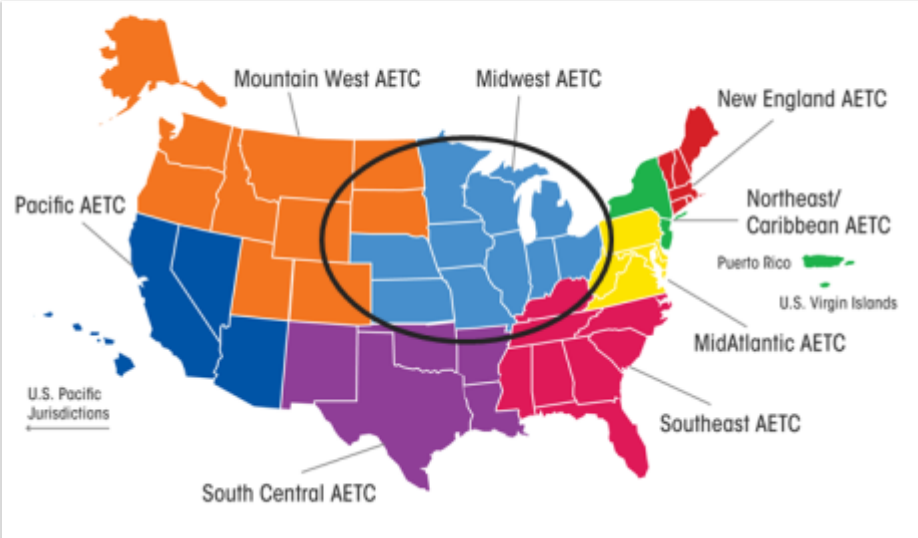
3 National Centers:

- National Coordinating Resource Center
- National Clinician Consultation Center
- National Evaluation Center

5 Health Professions Training Programs:

- SUNY Downstate PA Program
- Rutgers NP Program
- UCSF NP Program
- Duke NP Program
- John Hopkins NP Program

8 Regional Centers:



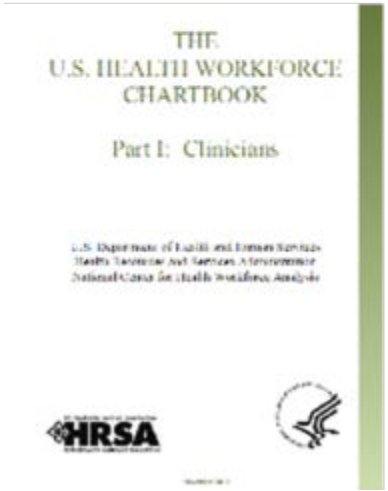
… The training arm of the Ryan White Program

In this session …

- Why a program to engage new clinical providers into the HIV workforce
- What the MATEC's HIV Clinician Scholars Program (CSP) is all about
- Does it work? … What do we know so far and future evaluation plans

Why a program to engage new clinical providers into the HIV workforce

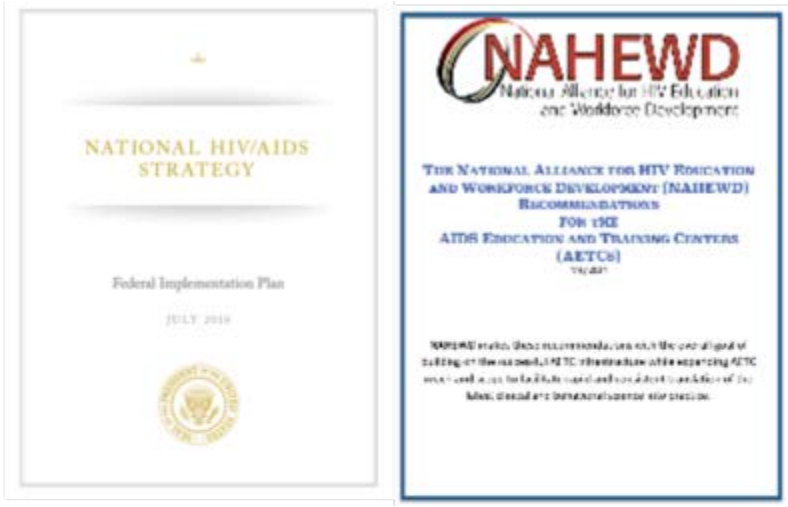
"18% of the health care workforce was over the age of 55"



"a third of respondents planned to retire by 2018"

"70% of Ryan White clinics were having a difficult time recruiting HIV care providers"

"increased training of health care providers to meet the needs of people living with HIV"



"ongoing development of the HIV workforce by providing "longitudinal capacity-building assistance tailored to individual HIV care settings"

HIV Clinician Scholars Program

… for minority or predominately minority-serving, front-line clinical care providers: Physicians, Nurse Practitioners, Physician Assistants, and Pharmacists.

What MATEC's HIV Clinician Scholars Program is all about

Key Elements

- Longitudinal and multimodal approach
- Intensive mentoring
- Individualized approach
- Personal connections and relationships
- Localized context with regional support

Core Capabilities

Capability	Learning Objectives	Educational Activities
5. Manage treatment failure.	A. Use results of history, CD4 count and viral load to recognize HAART treatment failure and understand the factors that can contribute to HAART failure. B. Explain types and basics of interpreting HIV resistance tests and when to use these tests. C. Utilize HIV resistance tests to help formulate new treatment options for patients failing HAART.	○ Workshop: Clinician HIV Core ○ Discussion with Mentor: OSCE #4 ○ Clinical Observation
6. Address factors which may inhibit a patient's adherence to a prescribed treatment regimen.	A. Explain the importance of adherence to antiretroviral therapy. B. Identify factors that affect adherence to treatment regimens. C. Explain and apply patient-centered techniques to assist HIV patients to adhere to antiretroviral therapy.	○ Workshop: Clinician HIV Core ○ Clinical Observation
7. Institute appropriate opportunistic infections prophylaxis,	A. Cite the CD4 cell level and treatment options for the prophylaxis of Pneumocystis Pneumonia, TB and Mycobacterium Avium Intracellulare.	○ Workshop: Clinician HIV Core ○ Discussion with Mentor:

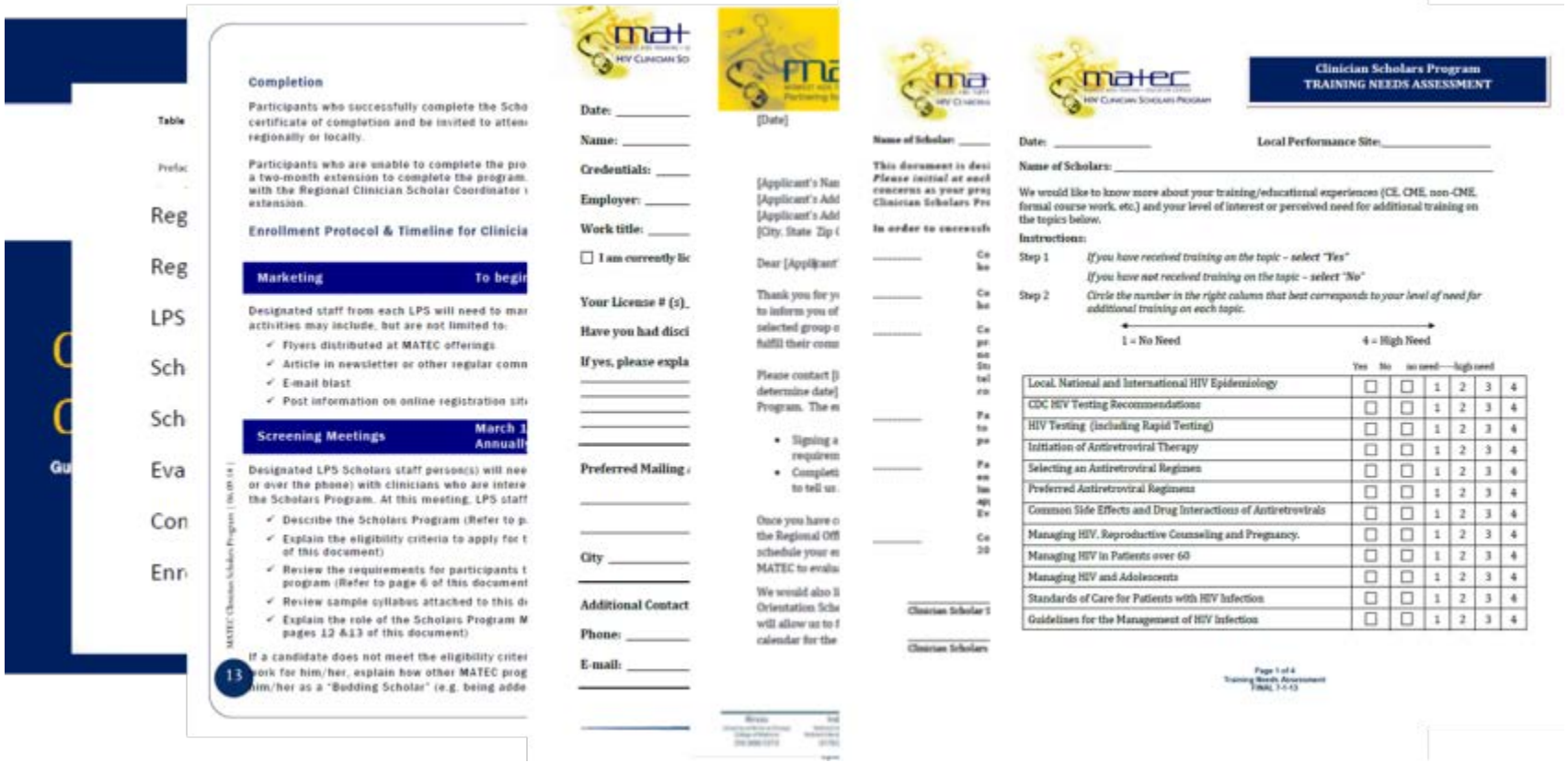
Entry Criteria

- Physicians, advanced practice nurses, physicians assistants or clinical pharmacists
- Minority or predominantly minority-serving clinicians (MD, APN, PA or PharmD)
- Planning to continue practice within the Midwest region
- **Serving medically underserved communities**
- **Prescribing ART for patients receiving assistance with cost for ART**

Completion Criteria

- Complete a minimum 12 hours of clinical practicum in HIV care
- Complete a minimum of 20 hours of training
- Participate in at least one Clinician Scholars Webinars by submitting a case to the Regional Clinician Scholars Coordinator prior to the webinar
- Participate in all evaluation activities

Implementation



Completion

Participants who successfully complete the Scho
certificate of completion and be invited to atten
regionally or locally.

Participants who are unable to complete the pro
a two-month extension to complete the program.
with the Regional Clinician Scholar Coordinator
extension.

Enrollment Protocol & Timeline for Clinicia

Marketing — To begi

Designated staff from each LPS will need to mar
activities may include, but are not limited to:

- Flyers distributed at MATEC offerings
- Article in newsletter or other regular comm
- E-mail blast
- Post information on online registration sit

Screening Meetings — March 1 Annuall

Designated LPS Scholars staff person(s) will nee
or over the phone) with clinicians who are intere
the Scholars Program. At this meeting, LPS staff

- Describe the Scholars Program (Refer to p.
- Explain the eligibility criteria to apply for t
of this document)
- Review the requirements for participants t
program (Refer to page 6 of this document
- Review sample syllabus attached to this d
- Explain the role of the Scholars Program M
pages 12 &13 of this document)

If a candidate does not meet the eligibility crite
work for him/her, explain how other MATEC prog
him/her as a "Budding Scholar" (e.g. being adde

13

Date: _____

Name: _____

Credentials: _____

Employer: _____

Work title: _____

☐ I am currently lic

Your License # (s)_

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Additional Contact

Phone: _____

E-mail: _____

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Clinician Scholar

Clinician Scholars

Clinician Scholars Program
TRAINING NEEDS ASSESSMENT

Date: _____ Local Performance Site:_____

Name of Scholars: _____

We would like to know more about your training/educational experiences (CE, CME, non-CME, formal course work, etc.) and your level of interest or perceived need for additional training on the topics below.

Instructions:

Step 1 *If you have received training on the topic – select "Yes"*
If you have not received training on the topic – select "No"

Step 2 *Circle the number in the right column that best corresponds to your level of need for additional training on each topic.*

1 = No Need — 4 = High Need

	Yes	No	no need			high need
Local, National and International HIV Epidemiology	☐	☐	1	2	3	4
CDC HIV Testing Recommendations	☐	☐	1	2	3	4
HIV Testing (including Rapid Testing)	☐	☐	1	2	3	4
Initiation of Antiretroviral Therapy	☐	☐	1	2	3	4
Selecting an Antiretroviral Regimen	☐	☐	1	2	3	4
Preferred Antiretroviral Regimens	☐	☐	1	2	3	4
Common Side Effects and Drug Interactions of Antiretrovirals	☐	☐	1	2	3	4
Managing HIV, Reproductive Counseling and Pregnancy.	☐	☐	1	2	3	4
Managing HIV in Patients over 60	☐	☐	1	2	3	4
Managing HIV and Adolescents	☐	☐	1	2	3	4
Standards of Care for Patients with HIV Infection	☐	☐	1	2	3	4
Guidelines for the Management of HIV Infection	☐	☐	1	2	3	4

Implementation













Does it work?: Evaluation Methodology

I. Baseline and Endpoint Self-Assessments

II. Mentor 6-month and 12-month assessments

III. Entrance and Exit Interviews

IV. Ongoing transcript of program activities

V. Post-program evaluations for each learning activity

Evaluation Results: Descriptive Analysis

- 74 clinicians enrolled to-date
- 80% female; 20% are African American
- Age range: 25-63
- 80% has < 2 years HIV experience
- Discipline: 54% APNs, 25% MDs, 16% pharmacists

Evaluation Results: Descriptive Analysis

- Work place: 35% CHCs, 20% HIV clinics, 10% academic health centers
- 7% from rural areas
- Average monthly HIV patient load:
  - 40% have 20-49 patients
  - 20% have 50+ patients
  - 20% have 1-9 patients
  - 12% have 10-19 HIV patients
  - 8% have 0 patients

Evaluation Results: Transcript Analysis

- Over 60 hours completed (N = 25)
- 32 hours spent in skill-building workshops
- 20 hours spent in preceptorships

Evaluation Results Assessments

- Baseline and Endpoint Self-Assessments (N = 20)

  Mean difference between baseline and endpoint showed statistically significant increase in competency for all 11 core capabilities ($p < .05$)

- Mentor Assessments (*N* between 19 and 22 depending on capability)

  Statistically significant increase between midpoint and endpoint mentor assessments in 8 out of 11 capabilities ($p < .05$)

Evaluation Results Exit Interviews

- Increased clinical knowledge and skills
- Commitment of Mentor and Monitor
- Networking opportunities
- Tailored Approach
- Increased career opportunities
- Scholars with a clear vision reported greater satisfaction

Summary

- Engaging minority and minority-serving clinicians in a one-year program is achievable.
- A multi-modal approach of the program offers the opportunity to improve HIV clinical skills.
- Significant improvement is shown in eleven core capabilities as measure by individual self-assessments and mentor reviews.
- Participants gain connections to a network of colleagues within the field to help ensure a high level of comfort and satisfaction while participating in the program.

NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Building HIV Capacity in Primary Care and Integrating HIV Care within Federally Qualified Health Centers--Part 2:

Workforce of the Future: Educating Primary Care Residents through an FQHC-based Community HIV Medicine Rotation

Jeannette Aldous, MD
San Ysidro Health Center

María Luisa Zúñiga, PhD
San Diego State University

Study Authors

San Ysidro Health Center

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- Katie Panella

Manager, HIV Clinical Services

Scripps Chula Vista Family Medicine Residency

- *Marianne McKennett, MD*

  Residency Program Director

  Professor of Family Medicine

San Diego State University

- María Luisa "Mari" Zúñiga, PhD

  Professor

  Director, Joint Doctoral Program in Interdisciplinary Research on Substance Use

- David Howard

  Research Coordinator

Funding Support: Health Resources and Services Administration # 1 H97HA274210100

HIV Workforce Trends

- 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)
- 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)
- *Increased workforce capability and HIV competency of Primary Care workforce will be needed to address future healthcare needs of PLWHA*

HIV training for U.S. Primary Care Residents

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

- ***only 25% of Family Medicine Program Directors felt their residency had adequate HIV training.[1]***
- ***79% felt their program did not have faculty with enough HIV experience to train residents.[1]***
- ***AAHIVM lists only 10 Family Medicine Programs with HIV tracks[2]*** (US has approx. 477 FM programs)

1. Prasad et al. Fam Med 2014)
2. http://www.aahivm.org/trainingopportunities)

SYHC SPNS Project:
"System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Healthcare Settings"

Goal 1: Provide seamless continuity of a full spectrum of care for PLWHA

HIV Team PCMH Transformation

Increasing access/utilization of health center services through patient Navigation and education for non-HIV departments

Improved EHR Utilization

Goal 2: Develop a sustainable clinical workforce pipeline that secures medical resident and non-HIV provider capacity to serve HIV-positive patients

Train Medical Residents

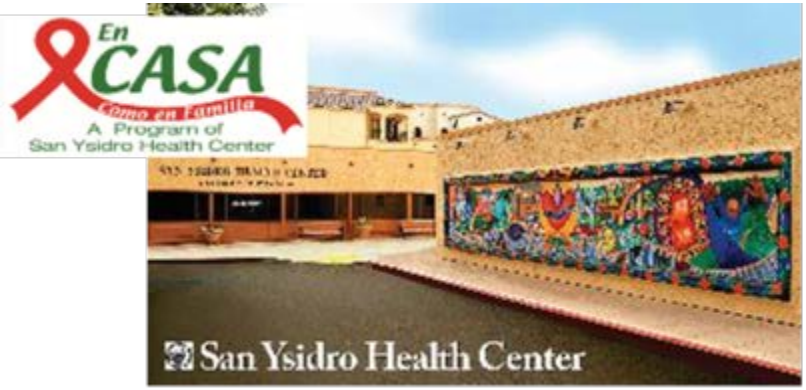
Train Primary care providers

Project Setting:
San Ysidro Health Center

- Large FQHC, Est 1969
- Eleven clinical sites in Southern San Diego
- Approx. 90,000 patients
- Dual funded: HRSA 330 Community Health Cluster and Ryan White Part C
- *Embedded Family Medicine Residency Program focused on Community Medicine*

SYHC HIV Clinics

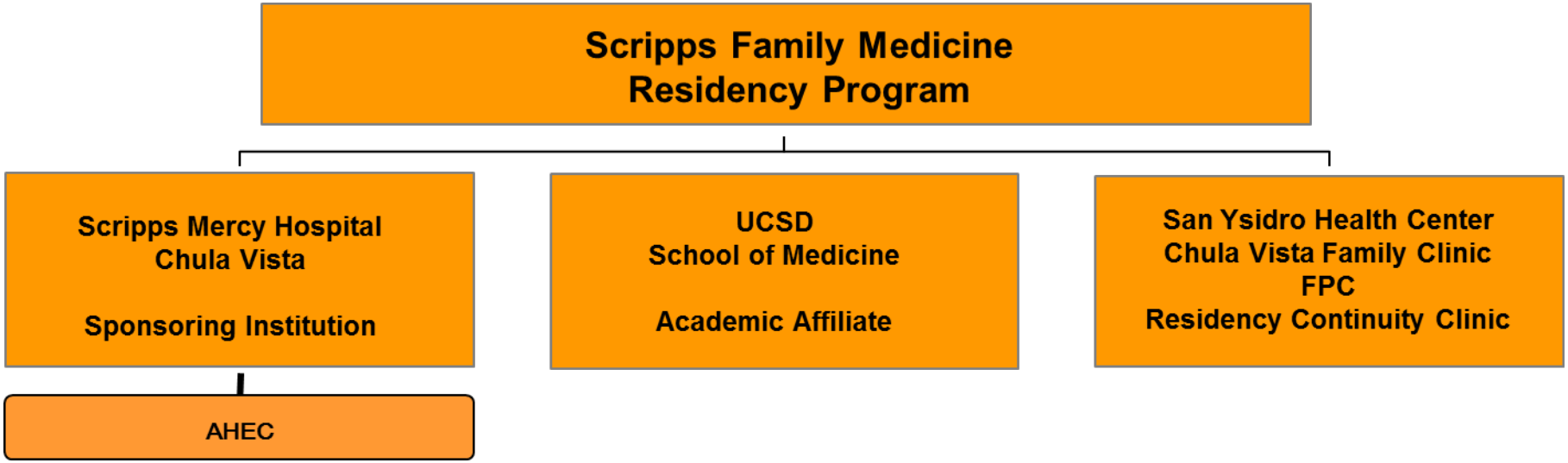
Integrated, comprehensive, primary care, HIV specialty care, health education, treatment adherence, and prevention services



SOUTH BAY:
650+ HIV+ patients
Border health, primarily Latino population

SOUTHEAST:
350+ HIV patients
Ethnically diverse, low-income population

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 (demo 2014)
- 8 Second Year residents rotate each year through a six-week, hands-on HIV clinical rotation.
- 3-4 AETC didactic sessions (previously in place)
- Self-directed learning (AETC modules)
- Evaluation through a structured, self-administered pre/post survey.

Evaluation Methods

18-item self-administered clinician survey assessed resident:

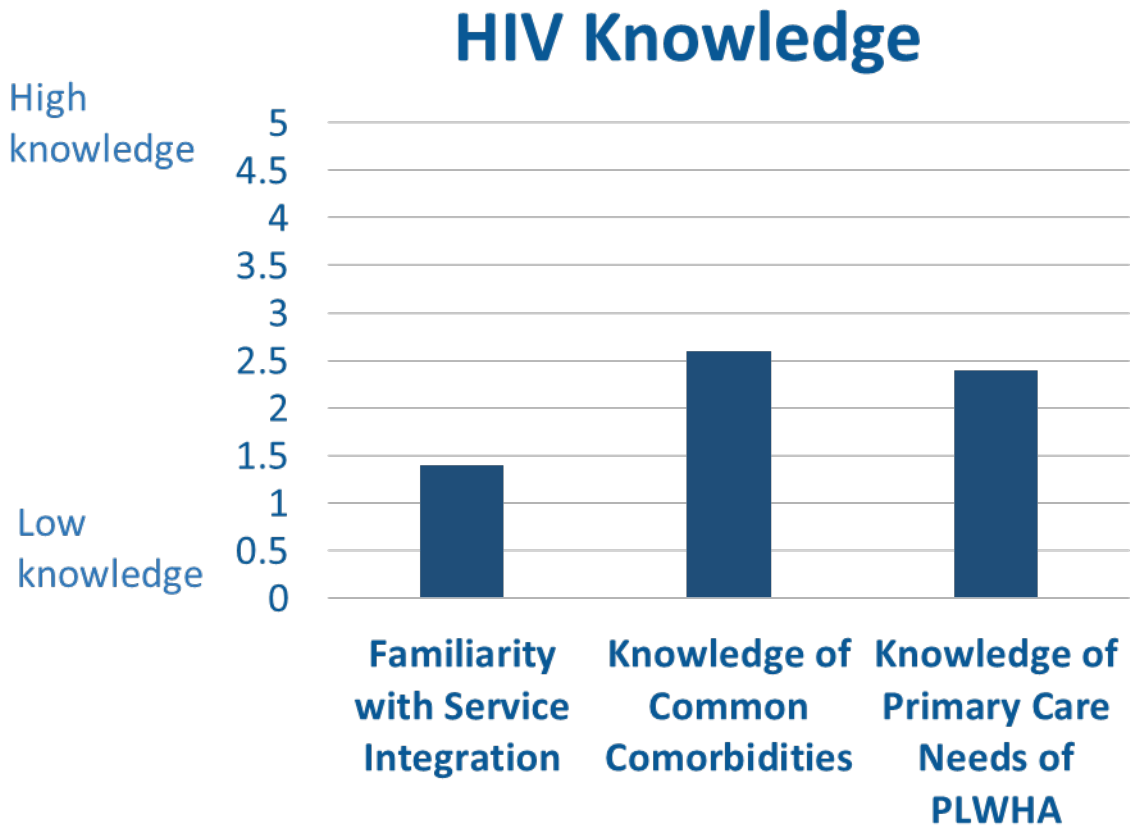
1) Familiarity with service integration for PLWHA
2) Knowledge of common co-morbidities of HIV
3) Knowledge of routine primary care needs of PLWHA

Evaluation Methods, cont.

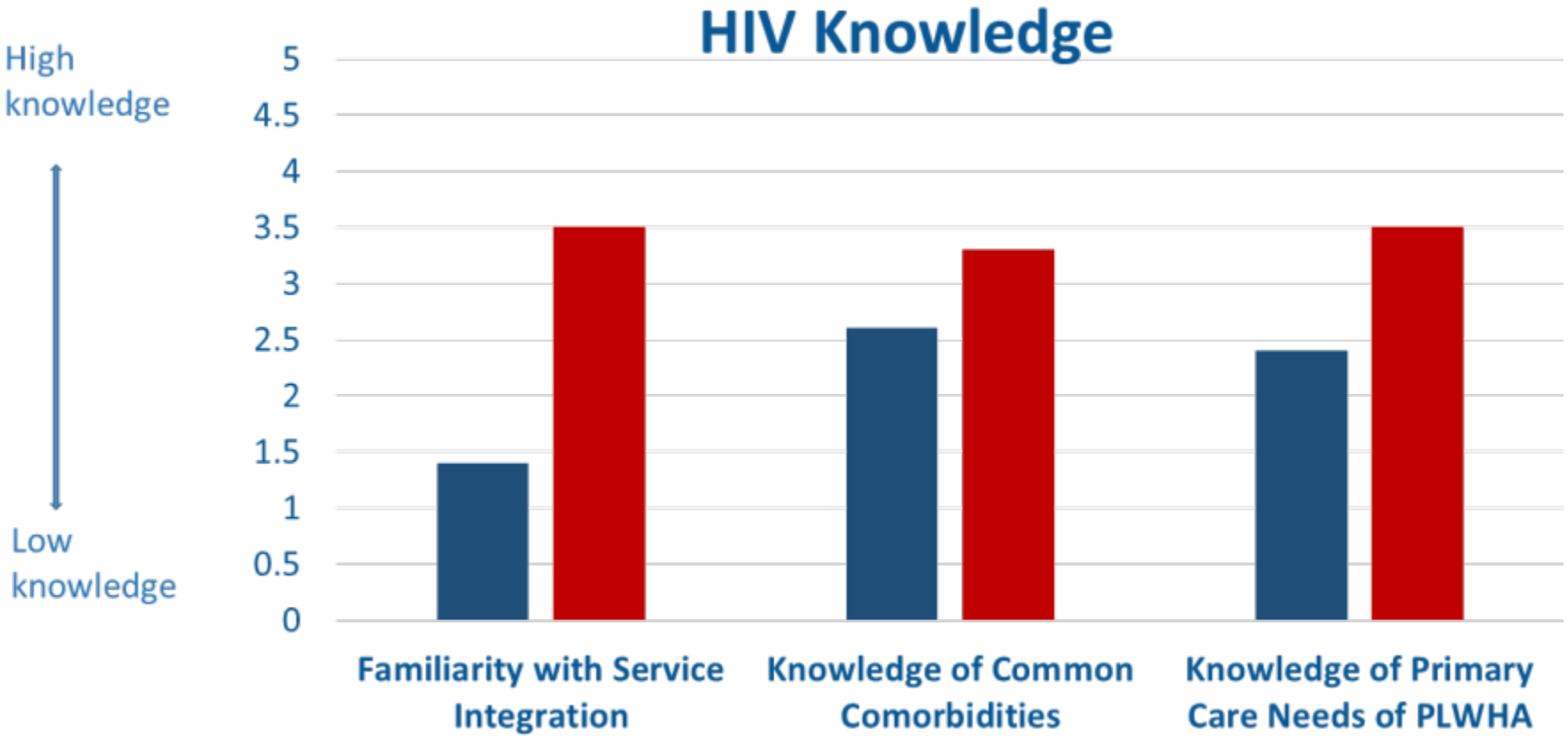
- Second-year Family Medicine residents (n = 8 per year) recruited via email from Evaluation Team – August 2015
- Provided voluntary and informed consent for survey portion of study
- Pre-survey completed prior to initiating HIV curriculum
- Residents were re-contacted and post-survey completed at conclusion of HIV-related training – May 2016
- Survey: Residents self-assess level of knowledge and confidence in training areas -- e.g., “How familiar are you with service integration for PLWH, 1 (not much at all) to 5 (a great deal)? 1 2 3 4 5 (likert scale format)

Results: Pre-Survey (n = 5)

- 5 of 8 residents completed consent and pre-survey
- 3 female & 2 male
- Avg. age = 31 yrs. (Range: 29-34 yrs.)



Results: Pre-Post Change



Discussion

- Pre-tests indicate residents begin rotation with:
  - low familiarity with service integration for PLWHA (avg. 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
- Low pre-survey scores indicate opportunity for improvement across all indicators
- Additional sample size over next two years may allow for more nuanced analysis

Discussion: Qualitative Analysis

- Qualitative analysis is ongoing to evaluate Resident's perception of the training experience. Examples:

- Re: increased comfort treating HIV+ patients
  "Much of HIV care is primary care, especially when patient's viral loads are undetectable and they are well controlled on their medication. I will be more cognizant of screening for HIV and STDs [in future primary care clinical work]."

- Re: depth and integration of the care team at SYHC
  "An integrated team including a nurse, health educator, social worker, and MA is important. . . . This level of support, while it would be useful for the general patient, is crucial in the care of PLWH."

Discussion: Qualitative Analysis, con't

- Re: opportunity to improve understanding of HIV primary care

  "I had opportunity to see patients on my own first then precept with Dr. Aldous or see patients together with her. There was a wide variety of pathology including AIDS, molluscum, h/o cocci meningitis, uncontrolled diabetes, hypertension, CKD on dialysis, prostatitis, Bells Palsy. I saw both well controlled patients with undetectable HIV viral loads on therapy and uncontrolled patients who were quite sick."

Discussion: rewards and challenges

Rewards: "unintended consequences"

- Primary Care expertise into the HIV clinic
- HIV/STI expertise into Primary Care clinic
- R*eferral 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

- Partnerships between RW clinics and Residency Programs may increase access to HIV training.
- A curriculum targeting Family Medicine residents is feasible
- Further focus on training in FQHC settings is a strategy to address current workforce capacity needs
- Ongoing efforts are needed to evaluate the short and longer-term efficacy of HIV training for Family Medicine residents

Thank You

THANK YOU!!

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

SAN DIEGO STATE UNIVERSITY

Scripps Family Medicine Residency Program

in partnership with

Scripps Mercy Hospital Chula Vista

THE UNIVERSITY OF CALIFORNIA 1868

SAN YSIDRO HEALTH CENTER

CALIFORNIA AHEC

NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

Building HIV Capacity in Primary Care and Integrating HIV Care within Federally Qualified Health Centers--Part 3:

Ryan White Programs and Federally Qualified Health Centers: Shared Visions and Common Challenges

Moderator: Steve Bromer, MD

Panelists:

- **Jeannette Aldous**, Clinical Director of Infectious Disease: San Ysidro Health Center, San Diego, CA
- **Bill Hoelscher**, CEO, Coastal Bend Wellness Foundation, Corpus Christi, TX
- **Brian Bragg**, Director, Health and Community Integration at Access Community Health Network, Chicago, IL
- **Zack Sharp**, Director of Improvement and Planning, FoundCare, West Palm Beach, FL

Intro Question:

Tell us about how your agency integrated HIV care within the context of a Community Health Center and a little about how your program is structured.

San Ysidro Health Center, San Diego, CA

- Large FQHC, Est 1969
- Eleven clinical sites in Southern San Diego
- Approx. 90,000 patients
- Dual funded: HRSA 330 Community Health Cluster and Ryan White Part C

Coastal Bend Wellness Foundation, Corpus Christi, TX

- **Founded in 1986 as an AIDS Service Organization; FQHC status since August 2016**

  Additional on-site services include RW, Part B case management services; HIV, STI, & Hepatitis C testing; Substance abuse outpatient treatment; Mental health counseling.
- **Number of HIV Clients Served**

  486 receive RW, Part B case management services; 412 seen in on-site clinic.
- **Demographics of HIV Clients**

  64% Hispanic; 59% equal to or below FPL; 43% uninsured; 27% Medicaid; 36% in temporary housing; 49% CDC-defined AIDS.

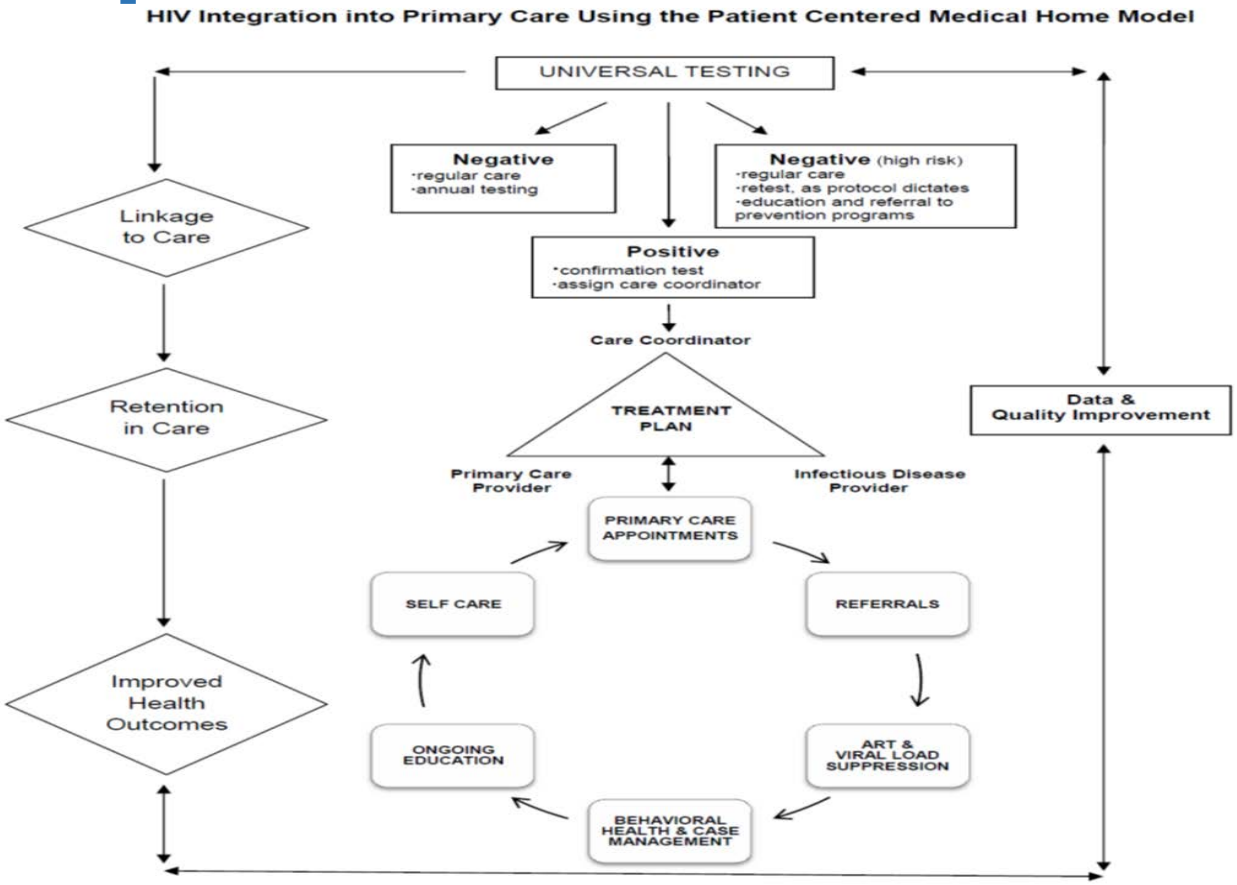
Access Community Health Network, Chicago, IL

- MISSION: to provide outstanding preventive and primary health care, accessible to all in their own communities.
- FQHC Network
- Serve 175,000 patients each year – target population is low-income, medically isolated, underserved, predominantly minority residents
- Majority Medicaid, uninsured
- 75% African-American and/or Latino
- 900 staff including more than 200 physicians
- Primary care provided at 35 sites throughout area. Currently embedding PCMH model of care

ACCESS HIV Service Locations

ACCESS HIV HUB Health Centers	Geographic Area Served	ID Specialist Hours/Month
ACCESS Evanston-Rogers Park Family Health Center	Chicago – North Side	25 hours/month
ACCESS Grand Boulevard Health and Specialty Center	Chicago – South Side	64 hours/month
ACCESS Madison Family Health Center	Chicago – West Side	6 hours/month
ACCESS Family Health Society	South Suburban Cook County	3 hours/month
ACCESS Martin T. Russo Family Health Center	DuPage County	4 hours/month

Description of Overall PTM



FoundCare, West Palm Beach, FL

- History as ASO founded in 1985; FQHC in 2013
- West Palm Beach, Florida
- 120 total staff; 1 FTE clinician in HIV; 30+ Ryan White case managers; 15 outreach/ prevention workers
- Clients served: HIV+: 2,891 social services; 270 medical services
- Primarily Black/Hispanic heterosexuals, at or below 200% FPL
- Good linkage to single provider; only serving 10% of available population with medical care

Question

- What have been some of the advantages and some of the the challenges of having both Health Center and Ryan White programs in your agency?

San Ysidro: Challenges and Opportunities

Limitations in HIV Practice Model

- HIV Department functions “in a “bubble”
- Patients do not routinely access FQHC services outside the HIV Department
- *Need for better HIV clinical competency for non-HIV providers and staff*

San Ysidro SPNS Project:
"System-level Workforce Capacity Building for Integrating HIV Primary Care in Community Healthcare Settings"

Goal 1: ***Provide seamless continuity of a full spectrum of care for PLWHA***

a) HIV Team PCMH Transformation

b) Increasing access/utilization of health center services through patient Navigation and education for non-HIV departments

c) Improved EHR Utilization

Goal 2: *Develop a sustainable clinical workforce pipeline that secures medical resident and non-HIV provider capacity to serve HIV-positive patients*

a) Train Medical Resident trainees

b) Train Primary care providers

San Ysidro: Challenges and Opportunities

Challenges

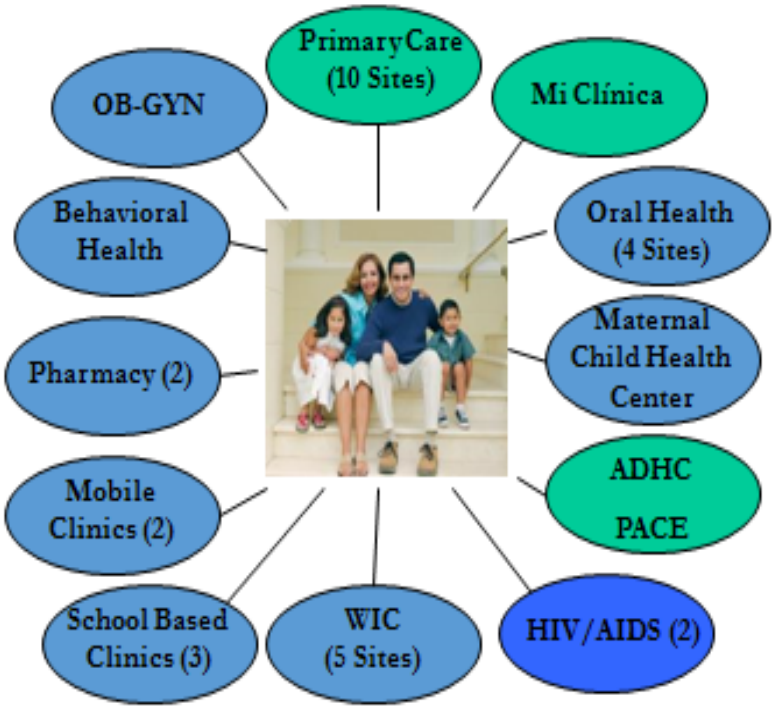
- Complex Stakeholder Engagement

Opportunities

- Leveraging FQHC Services
- Shared mission to meet needs of underserved populations

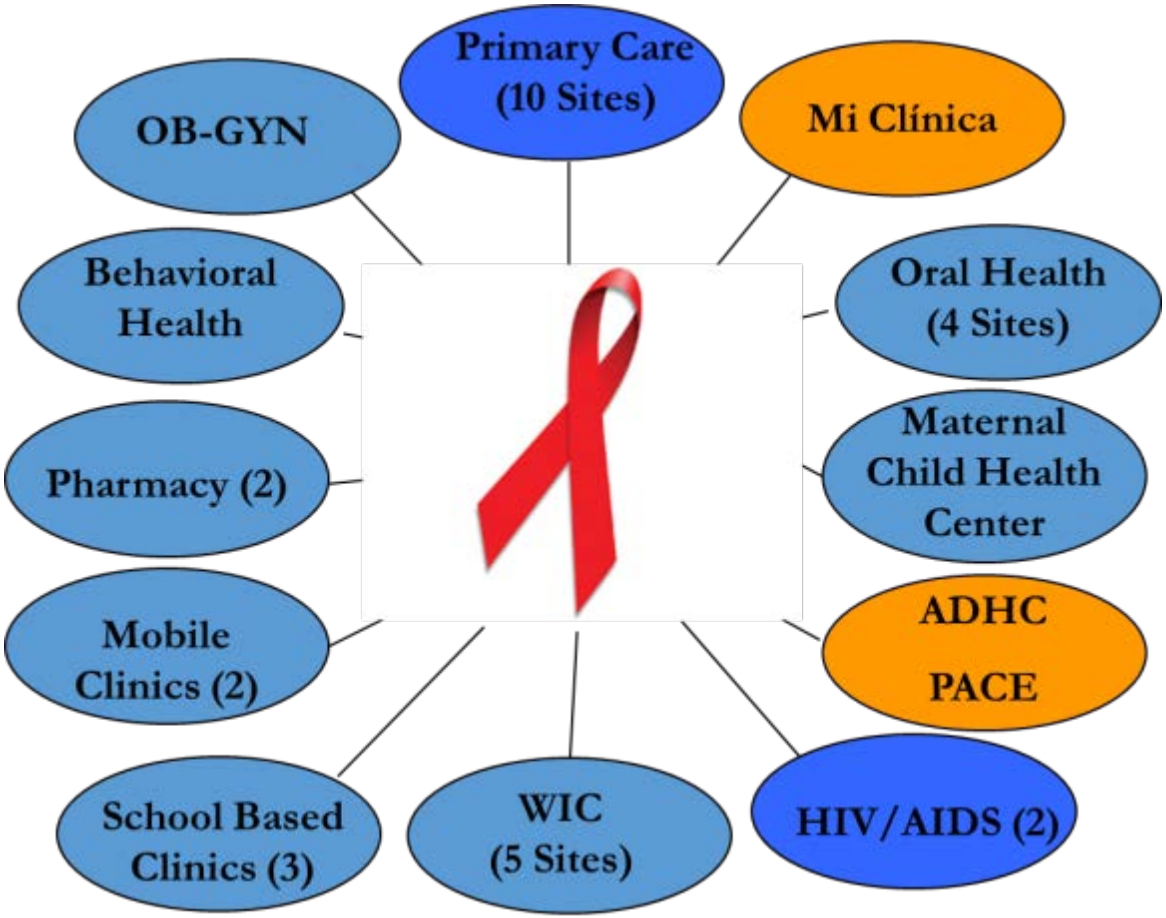
San Ysidro: Integration: Complex Stakeholder Engagement

FQHC Clinical Services and Departments



Multiple Stakeholders, Complex Structure

San Ysidro Integration Opportunities:
Leveraging Services



San Ysidor -- Integration Opportunities: *Shared Vision*

"San Ysidro Health Center is dedicated to improving the health and well-being of our community's traditionally underserved and culturally diverse people."

Mission of the HIV Department is to provide a continuum of culturally sensitive medical, social and supportive services free of charge that enhance the health and enrich the quality of life of people living with HIV/AIDS and their families

Coastal Bend Wellness Foundation, Corpus Christi, TX

- **Challenges**

  Rapid increase in clinic patient load; Loss of Infectious Disease Specialist; Difficulty finding providers willing to treat HIV.

- **Successes**

  Two new providers hired and trained in HIV treatment; HIV and primary care provided consecutively; Services expanded to include Prep & Hepatitis C treatment; Psychiatry integrated into clinical services.

Shared Vision of PTM

Whole Team Model/PCMH

Eliminate Silos

Expand System Capacity and Workforce

Patient empanelment to a Primary Care Provider (PCP)

RN Care Coordinator

Provider and site staff training and support

Focus on primary care needs and HIV care

Implementation of Universal HIV Testing

Implementation Challenges of PTM

- Eliminating Silos
  - “My Patients”; Trusting the Care Team
- Expand System Capacity and Workforce
  - Patient empanelment to a Primary Care Provider (PCP) – having capacity at the health center level
  - RN Care Coordinator – defined role for care team, complement to Ryan White case management team
  - Provider and site staff training and support - cultural competency; comfort disussing sensitive topics

Focus on primary care needs and HIV care

Question

Some of you were FQHCs before adding RWHAP grants and some were RWHAP grantees who became FQHCs. What do you wish you had known before making this transition?