NATIONAL 2016 RYAN WHITE CONFERENCE ON HIV CARE & TREATMENT

# Integrating HIV Care into Primary Care Settings: Two paths to improving the HIV continuum

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*Lawrence, MA*

# Goals and Objectives

- Describe current HIV care continuum and how primary care integration of HIV care can fill the gaps

-Describe two different models for primary care integration of HIV services

- Describe challenges to ensuring on-going high quality care and tools to resolve these challenges.

# Goals and Objectives (2)

-Give the historical context of how HIV care has been delivered at GLFHC

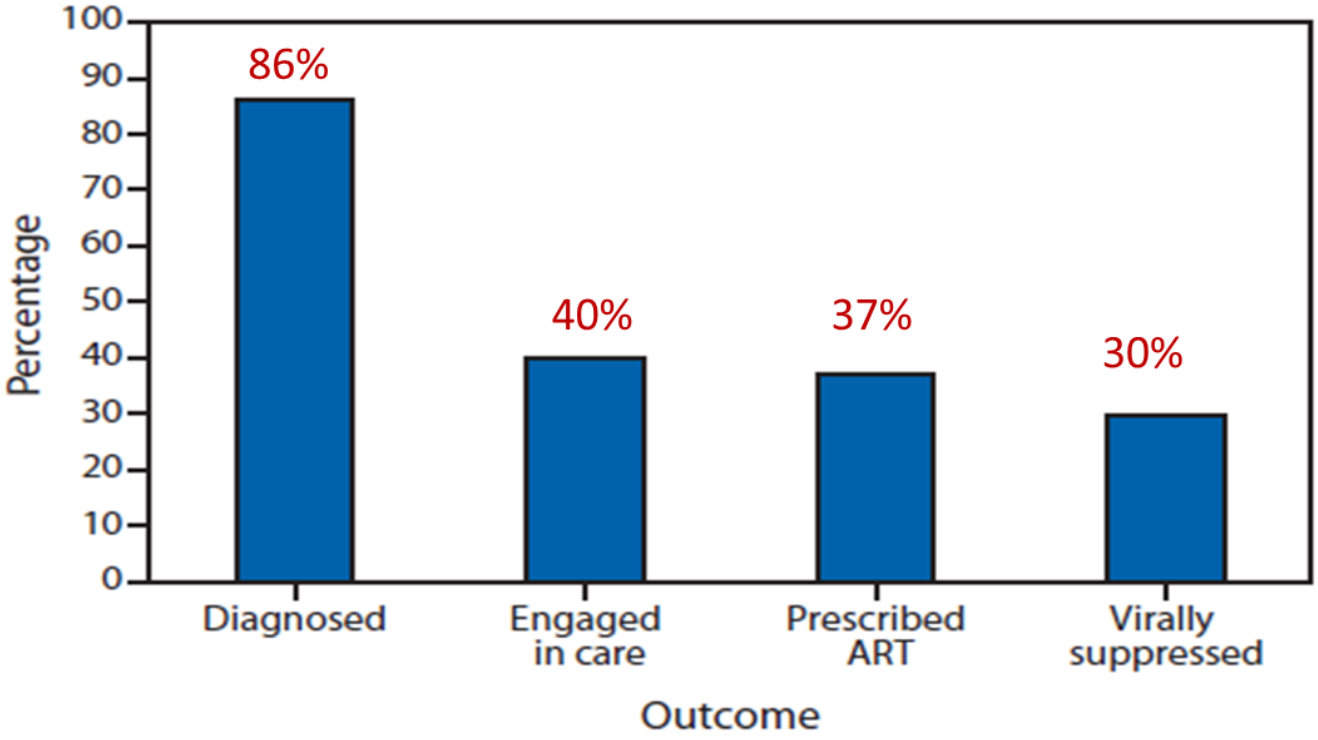
-Describe key aspects of the current model of HIV care at GLFHC ("Path 2")

-Discuss successes and challenges

-Review the current GLFHC continuum

# The HIV Care Continuum - USA

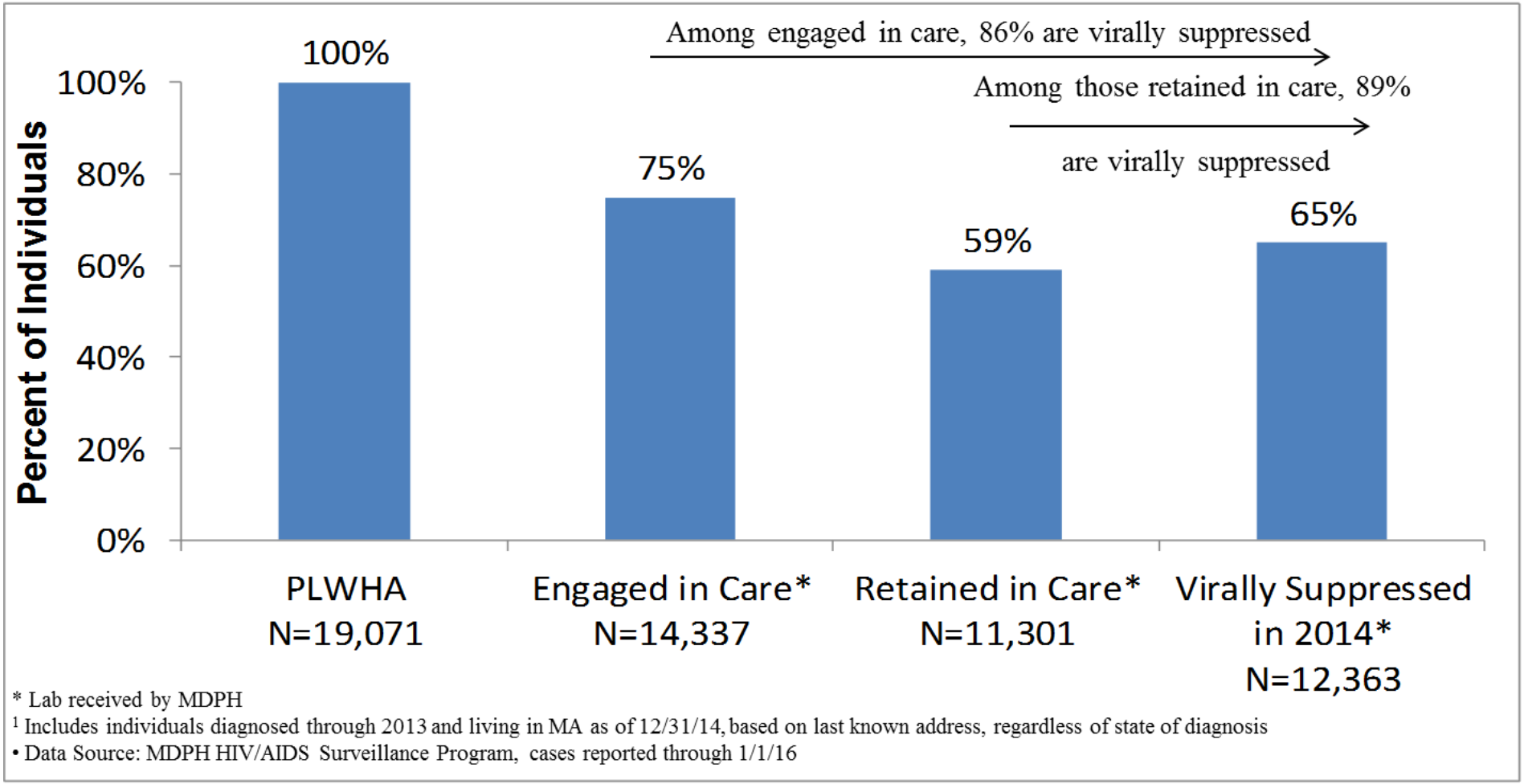
**FIGURE 1. Estimated percentage of persons living with HIV infection,* by outcome along the HIV care continuum — United States, 2011**




**Abbreviations:** HIV = human immunodeficiency virus; ART = antiretroviral therapy.
* N = 1,201,100.

MMWR Morb Mortal Wkly Rep. 2014 Nov 28;63(47):1113-7.

# Care Among People Living with HIV/AIDS in Massachusetts[1]




* Lab received by MDPH

[1] Includes individuals diagnosed through 2013 and living in MA as of 12/31/14, based on last known address, regardless of state of diagnosis

• Data Source: MDPH HIV/AIDS Surveillance Program, cases reported through 1/1/16



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# Overview of GLFHC

- **Established in 1980**
- **Over 600 employees** serving nearly 60,000 patients (250,000+ visits) annually
- **Six primary care sites**, 2 school based health centers, 14  Healthcare for the Homeless sites
- **Home to the Lawrence Family Medicine Residency,** the nation's first community health center based residency program

# GLFHC Patient Population

- The city's **72,043 residents** live within its **seven square miles**, making it one of the most densely populated urban communities in the country (2000 U.S. Census).

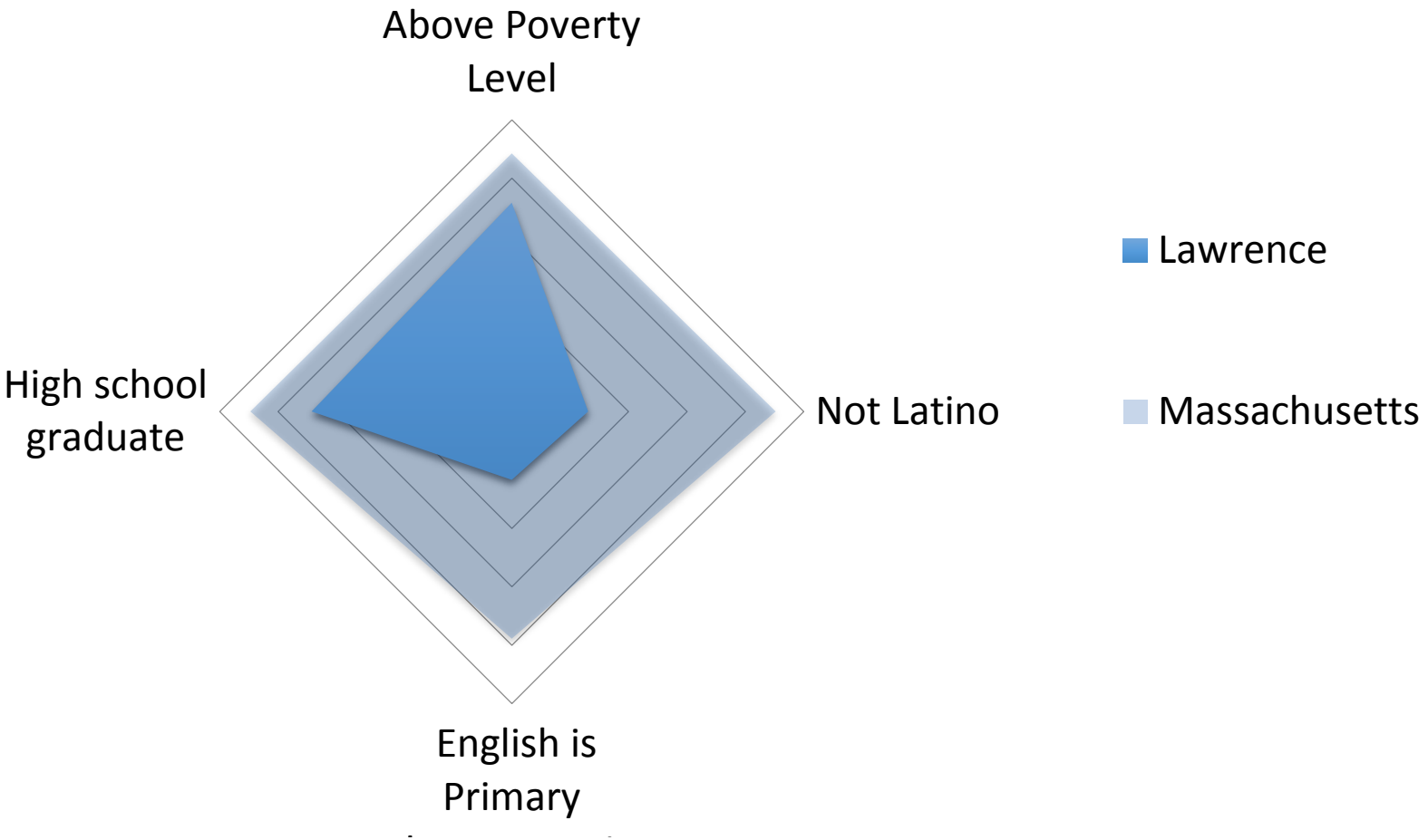
-More than **51 percent** of Lawrence residents live **below the federal poverty level**

**-Lowest per capita and per household income in MA**

-Nearly **76 percent** of the population is **Latino** – the city has the largest proportion of Hispanics of any Massachusetts community

**-Many new immigrants with 38.3% born outside of US**

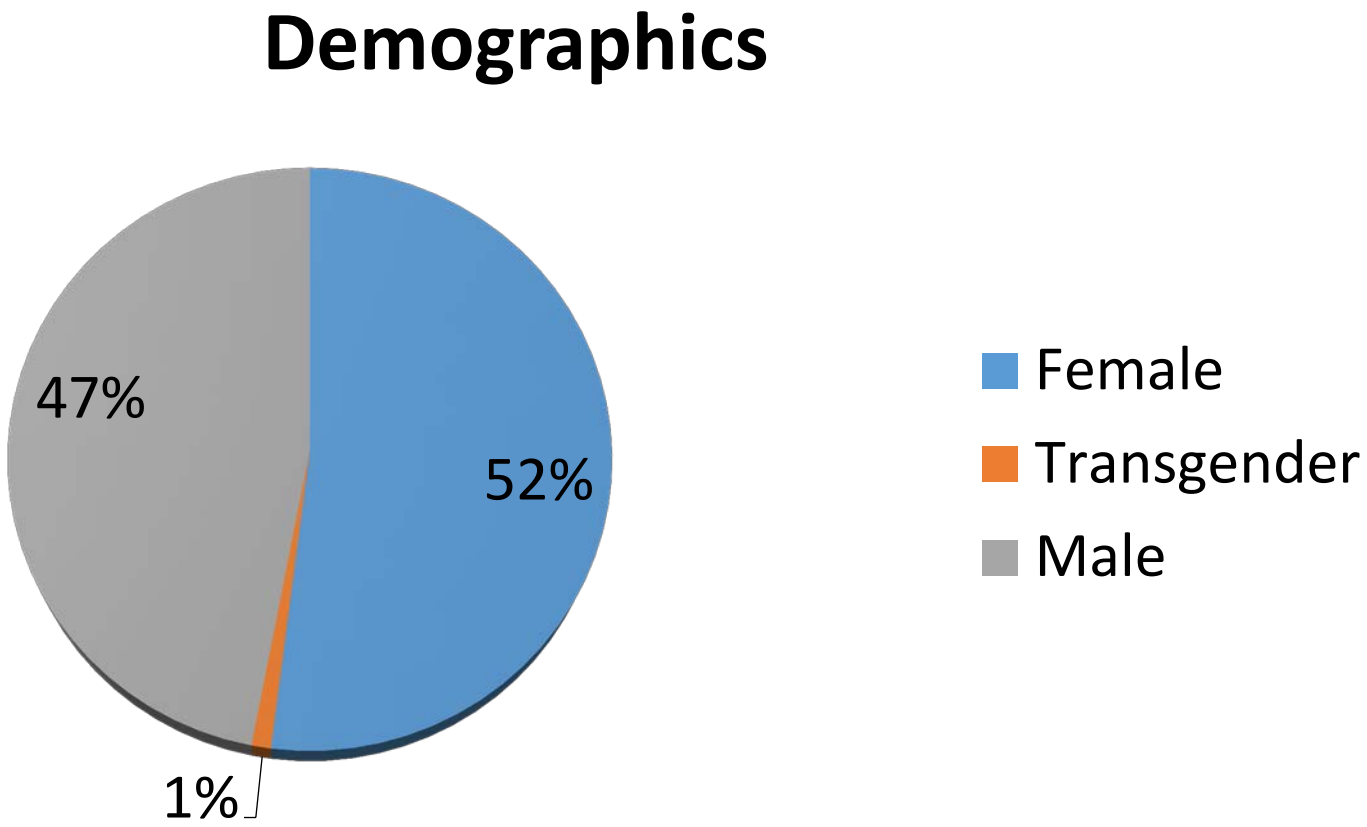
# Lawrence population



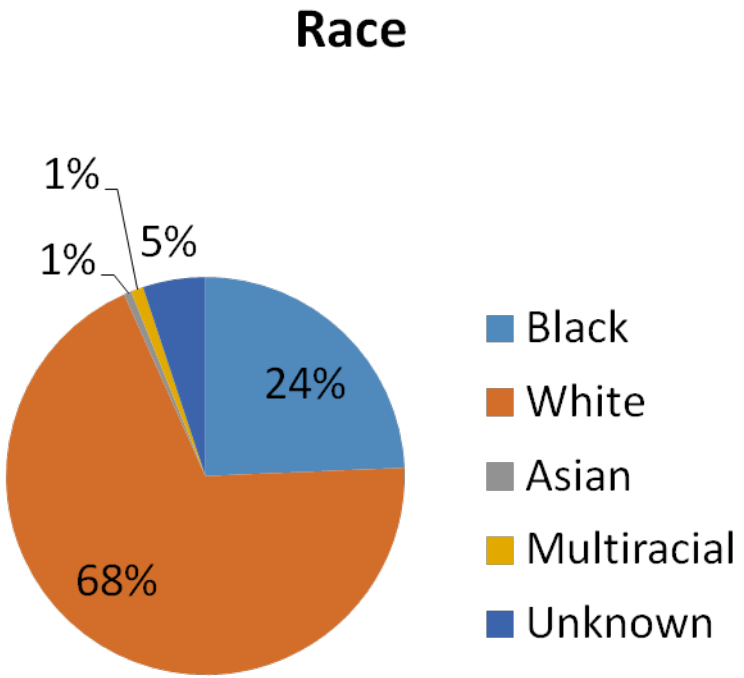
# GLFHC HIV program

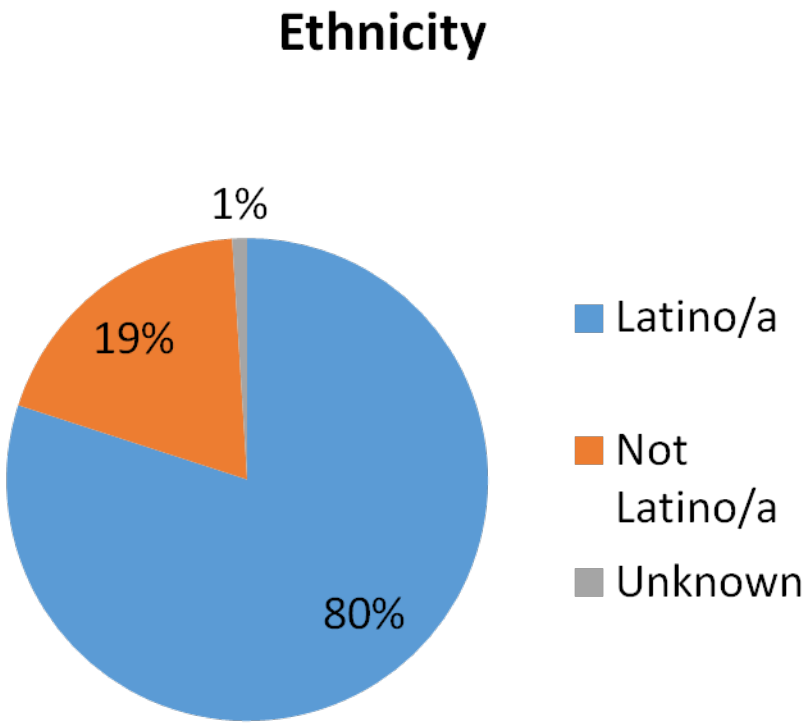
- **Established in 1990 utilizing Ryan White Part C funding**
  - Supports primary care, CQI
  - Supports Lowell Community Health Center as sub-recipient
- **Expanded in 1994 with Ryan White Part A funding**
  - Medical Case Management, Peer Support & Transportation
- **MDPH funded Part D -** 1992 – 2016
- **MDPH funded PICSR**
  - HIV, STI screening, counseling and referral
  - Overdose prevention education, Narcan Enrollment
- **301 patients engaged in primary care and HIV specialty care**
- **30 patients receive MCM but HIV care from outside specialists**

# HIV patient population 1

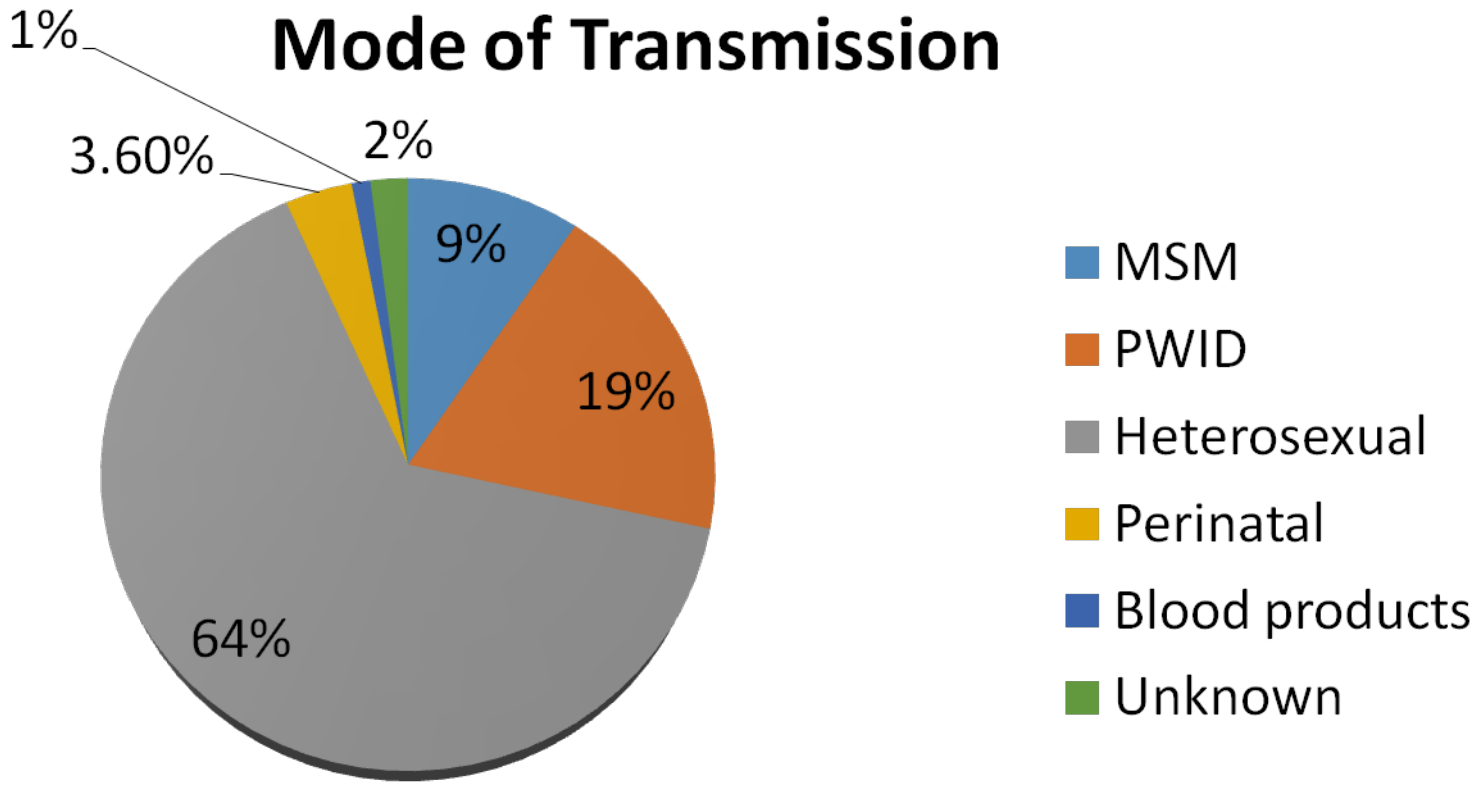


# HIV patient population 2



# HIV patient population 3



# GLFHC model of HIV care - history

-Integrated primary care model

-Most patients with non-HIV specialist PCPs

-2-3 FM HIV specialists providing support to PCPs

-Monthly case conferences to discuss challenging cases and give feedback/advice to PCPs

- -Multidisciplinary
- -Outside subspecialty support through Tufts ID (Dr. Christine Wanke)

# Why integrated primary care model?

-Barriers to the traditional specialist/referral model for HIV care:

  -Insurance barriers

  -Transportation barriers

  -Cultural/linguistic barriers

-Community health centers historically built to address barriers to care

  -Extensive experience with/support for addressing social determinants of health

# Why integrated primary care model? (Continued)

-Shifting realities of HIV medical care

  -Fewer HIV-related complications

  -More primary care-related complications

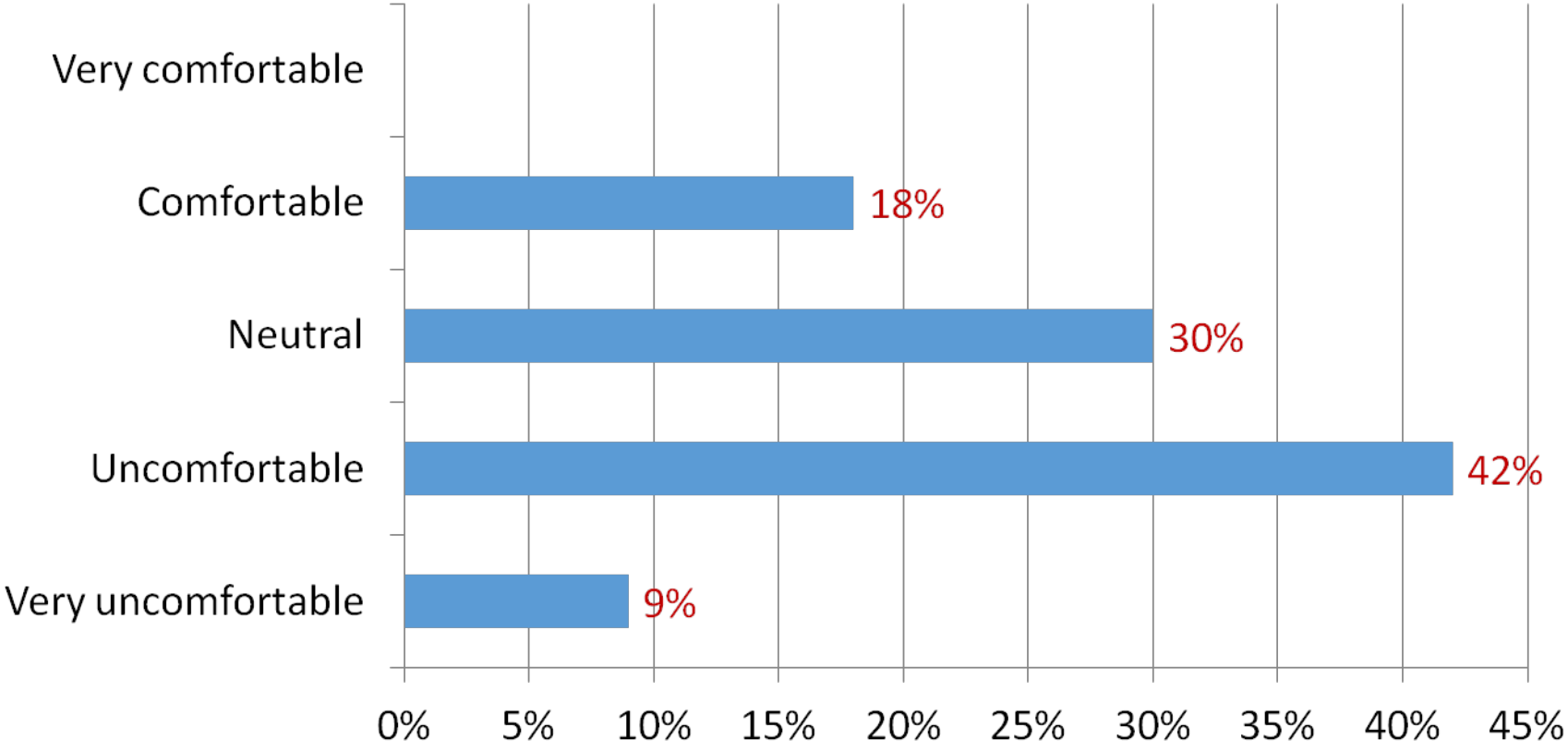
-Data

  -“Generalists with appropriate with appropriate experience and expertise in HIV care can provide high-quality care to patients with this complex chronic illness” (*Arch Intern Med.* 2005;165:1133-1139)

# Stimulus for change

-Stressors to the model
  -Staff turnover
  -EMR changes
-Leadership change
-Provider and patient feedback

# Provider comfort identifying ART side effects/toxicities (2012)



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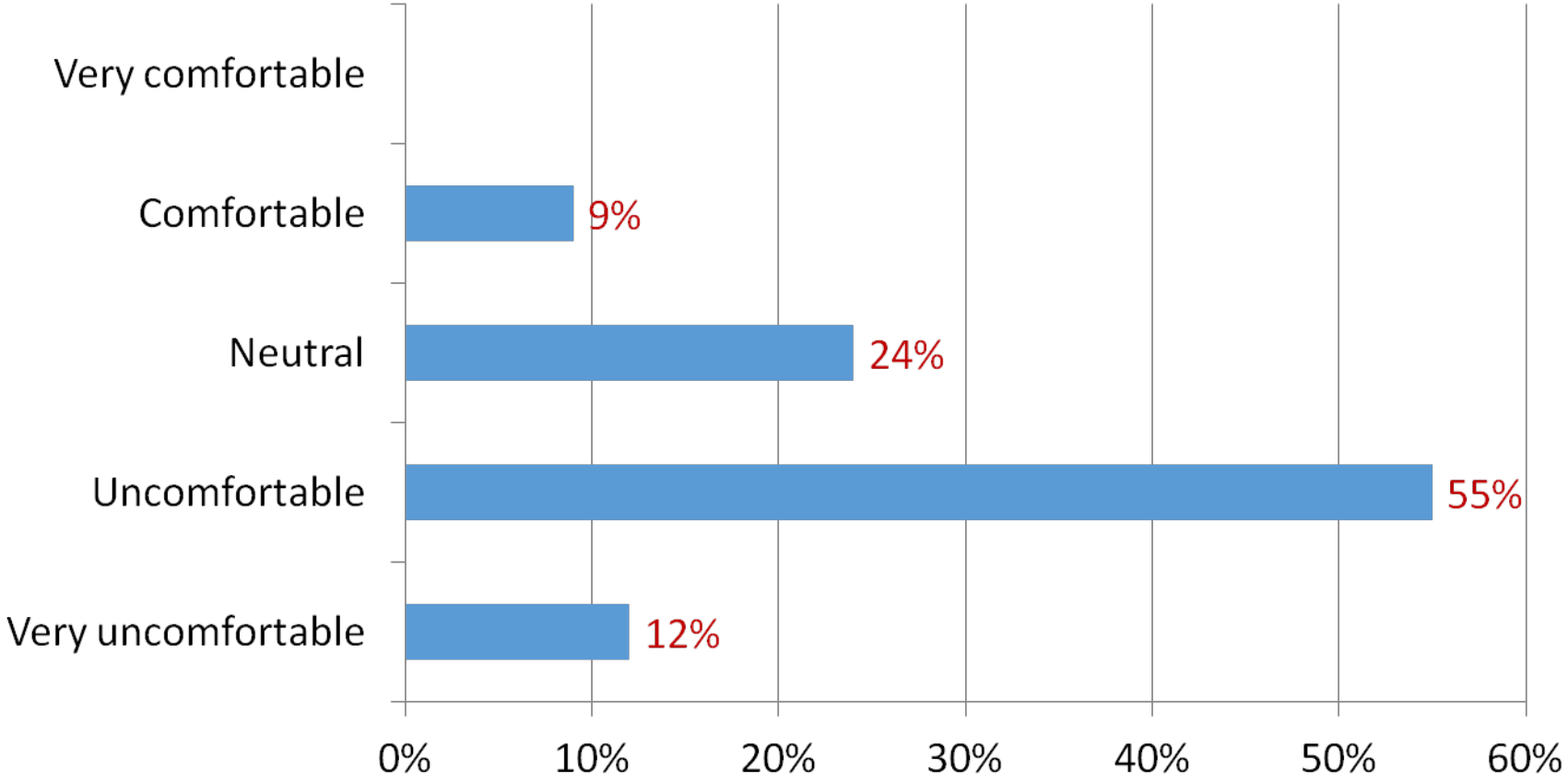

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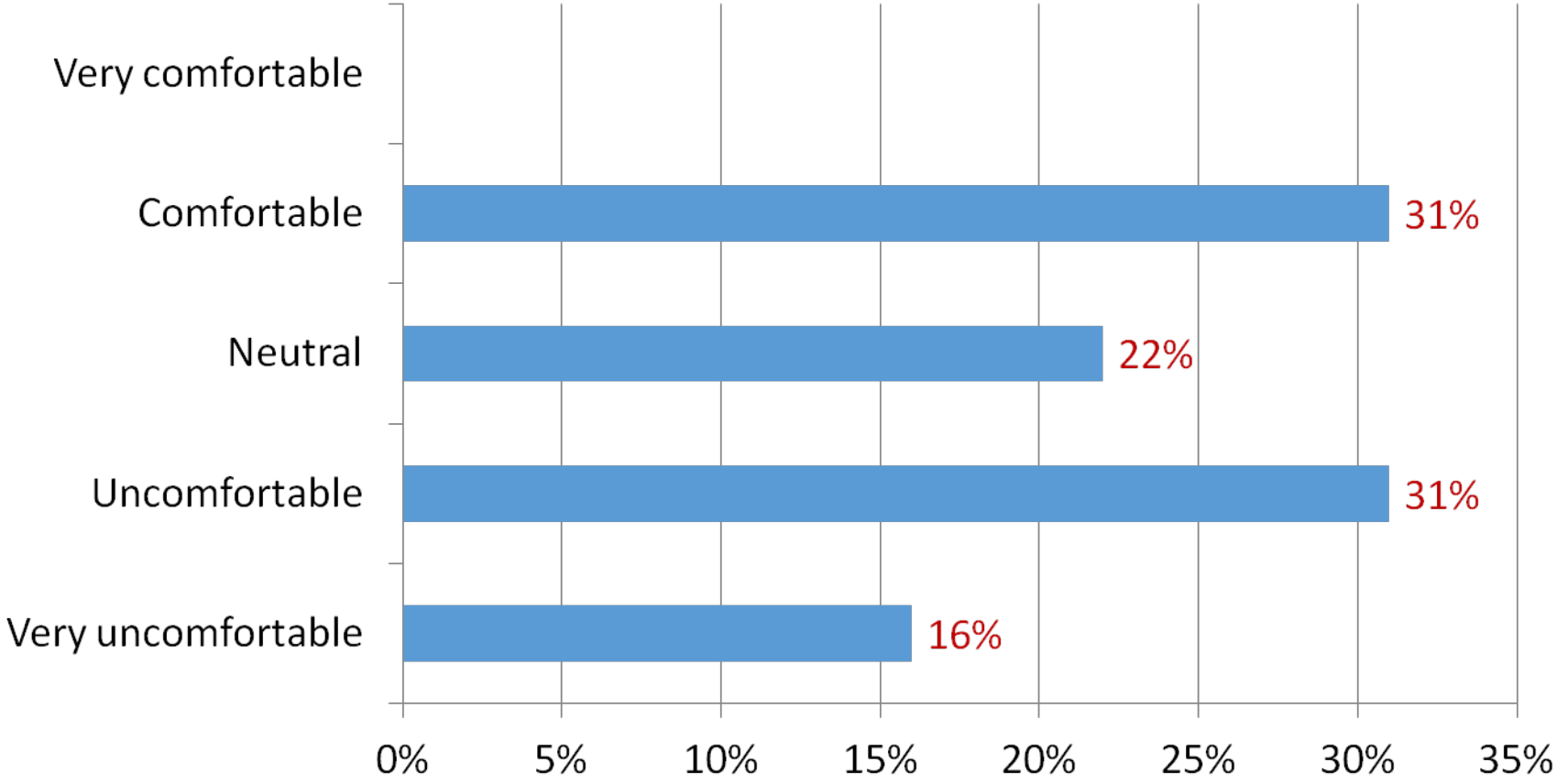
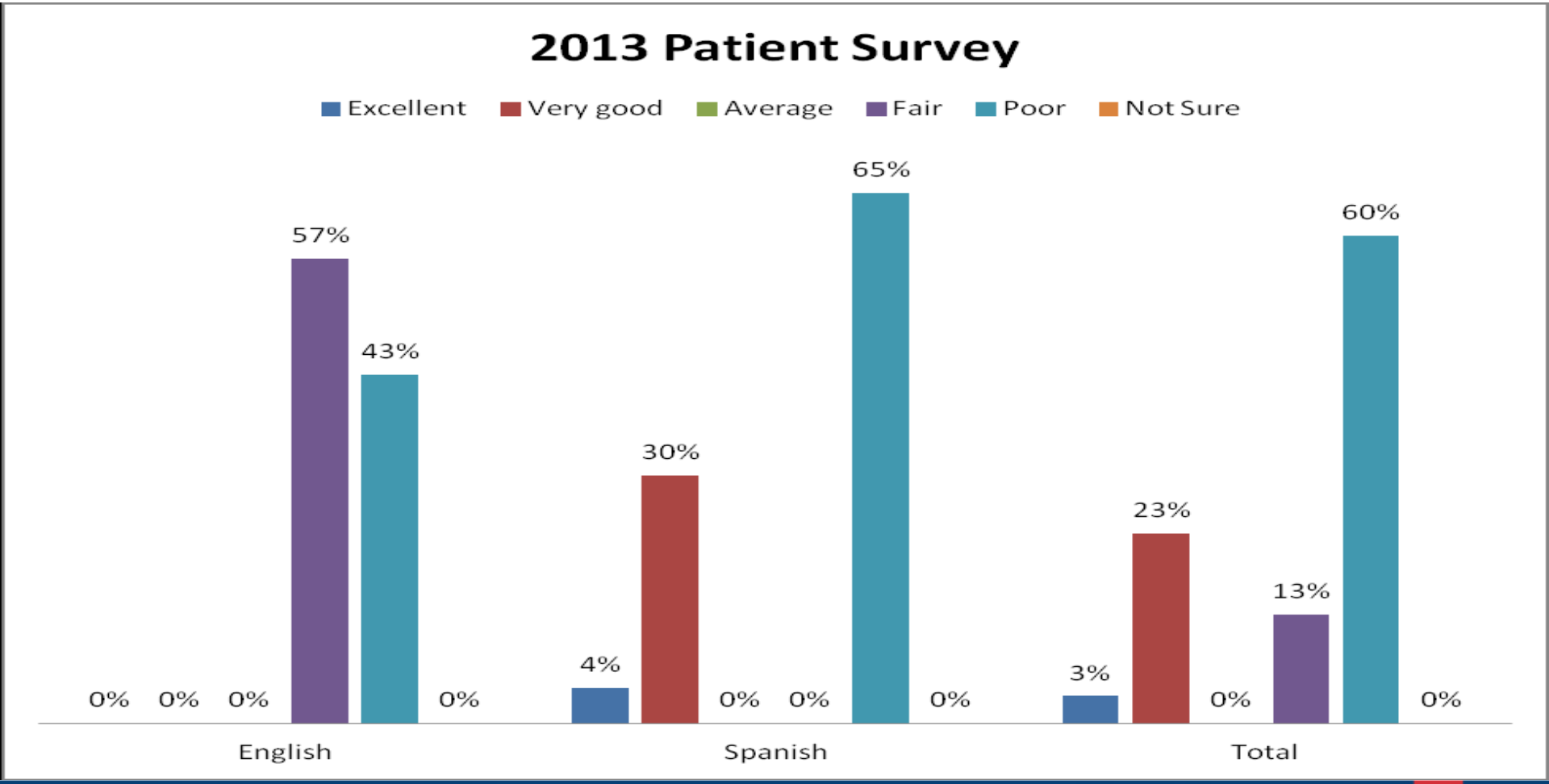


# Patient ratings of provider's understanding of newest developments in HIV, 2013



# Stimulus for change (cont.)

-Yet:

- -Desire to maintain integrated primary care model
  - -Most patients had longstanding relationships with their PCPs
  - -Belief that care is usually best provided within the patient's medical home

# The model

-“Comprehensive Care Clinic”

- Takes place within the patient’s medical home

-Multi-disciplinary, nurse-led clinic

  -HIV nurse, HIV Specialist, MCM, Peer, Nutritionist, Clinical Pharmacist, (behavioral health), resident physicians

-Patient anecdote: EP

-All HIV patients come to CCC at least yearly; more often if:

  -Starting or changing ART

  -Identified treatment failure

  -Other challenging cases

    -“Salvage” regimens

    -Complex OIs/co-morbidities

# The model (cont.)

-Central to the model:

- -Pre-clinic patient discussions
  - -All team members provide input
    - -Nurse: “big picture” view, care direction
    - -Case management: insurance, housing, other issues
    - -Clinical pharmacy: refill histories, DDIs with newly prescribed meds
    - -Nutrition: food insecurity
    - -(Behavioral health)
  - -Opportunity to identify when patients need additional services/care completion
  - -Team members present to provide this when needed

-

# What did not change

-Most patients still cared for by non-HIV specialist PCPs

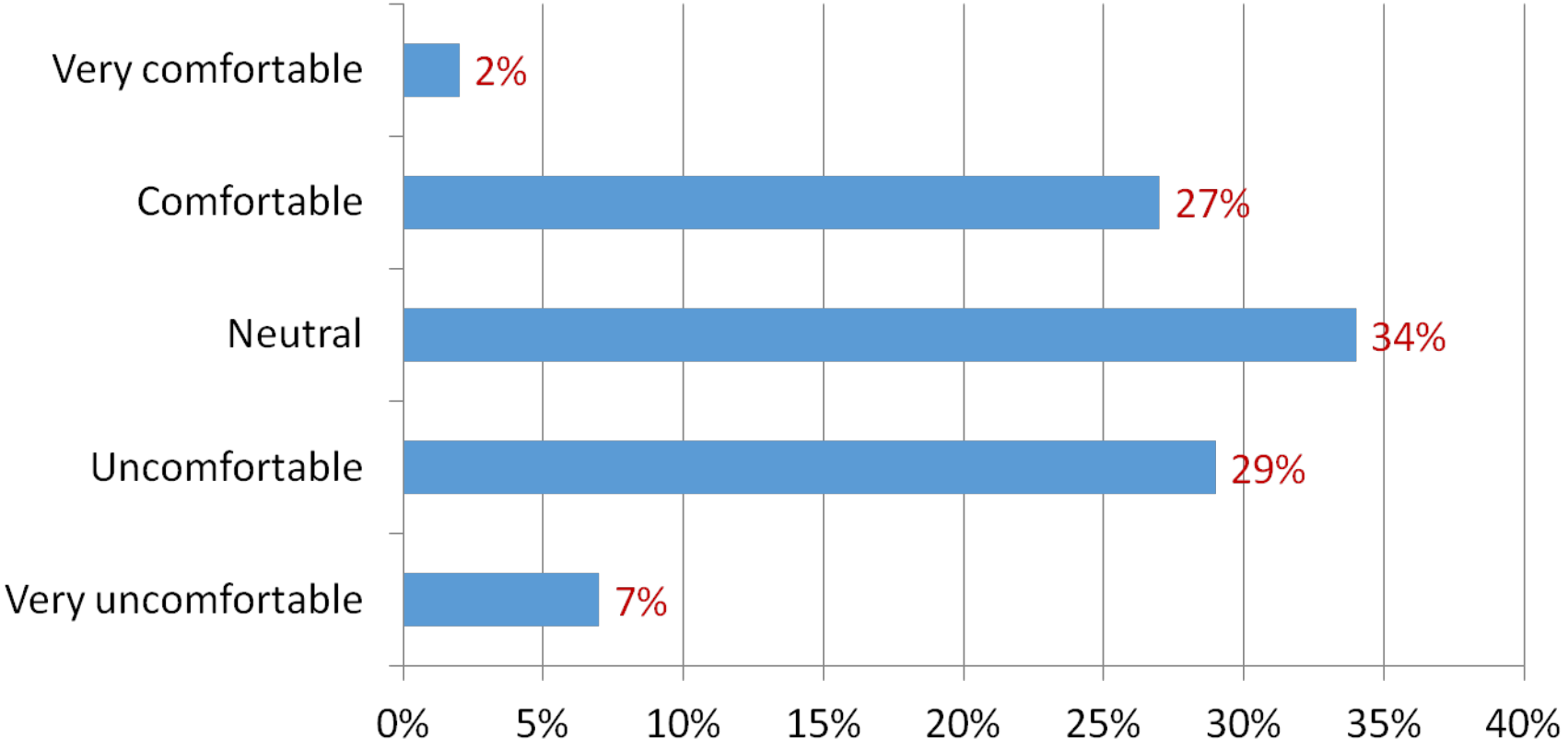
-Still have monthly multidisciplinary case conferences

# Response to the change

-Providers

-Patients

# Provider comfort identifying ART side effects/toxicities (2014)



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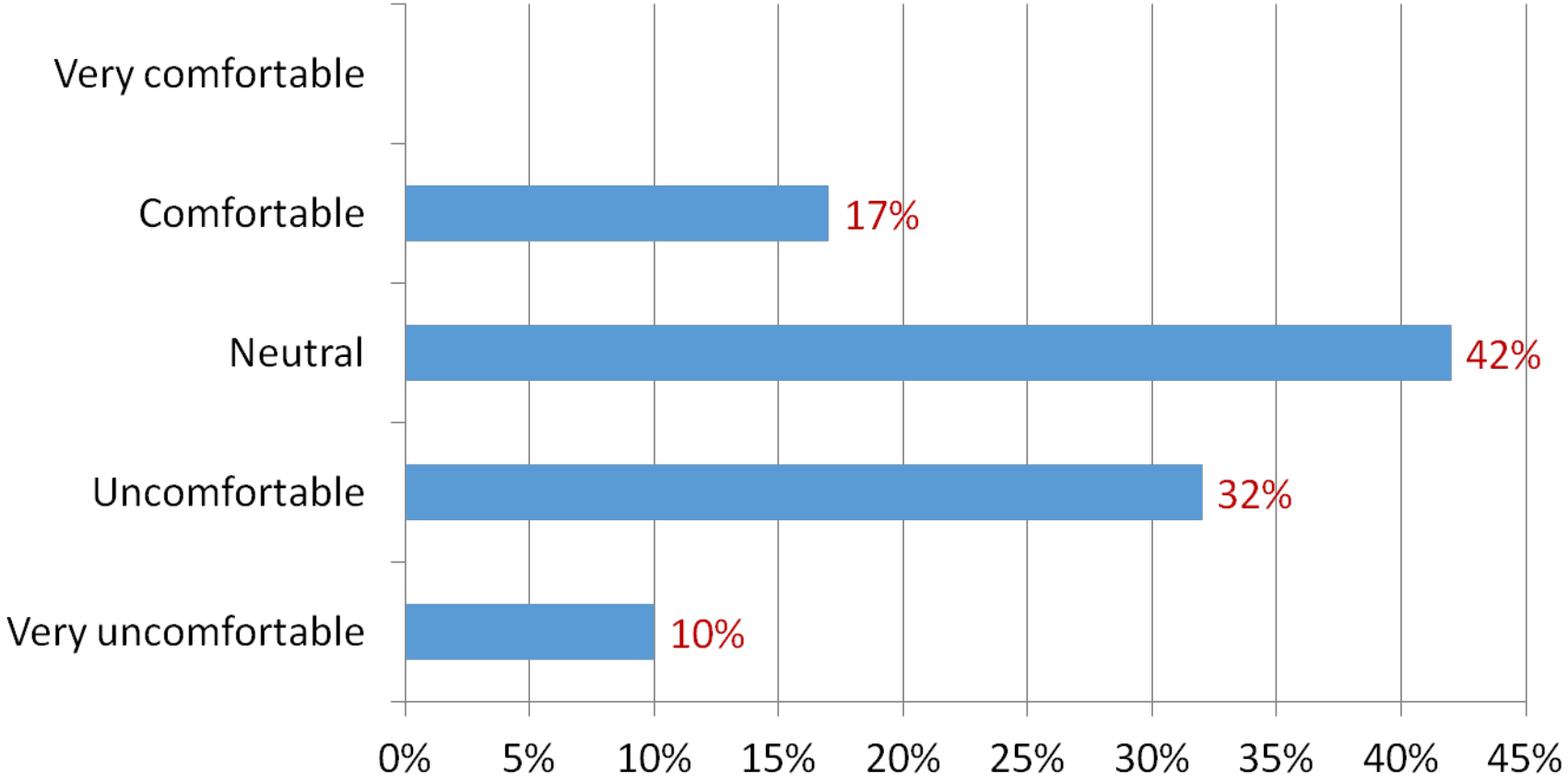

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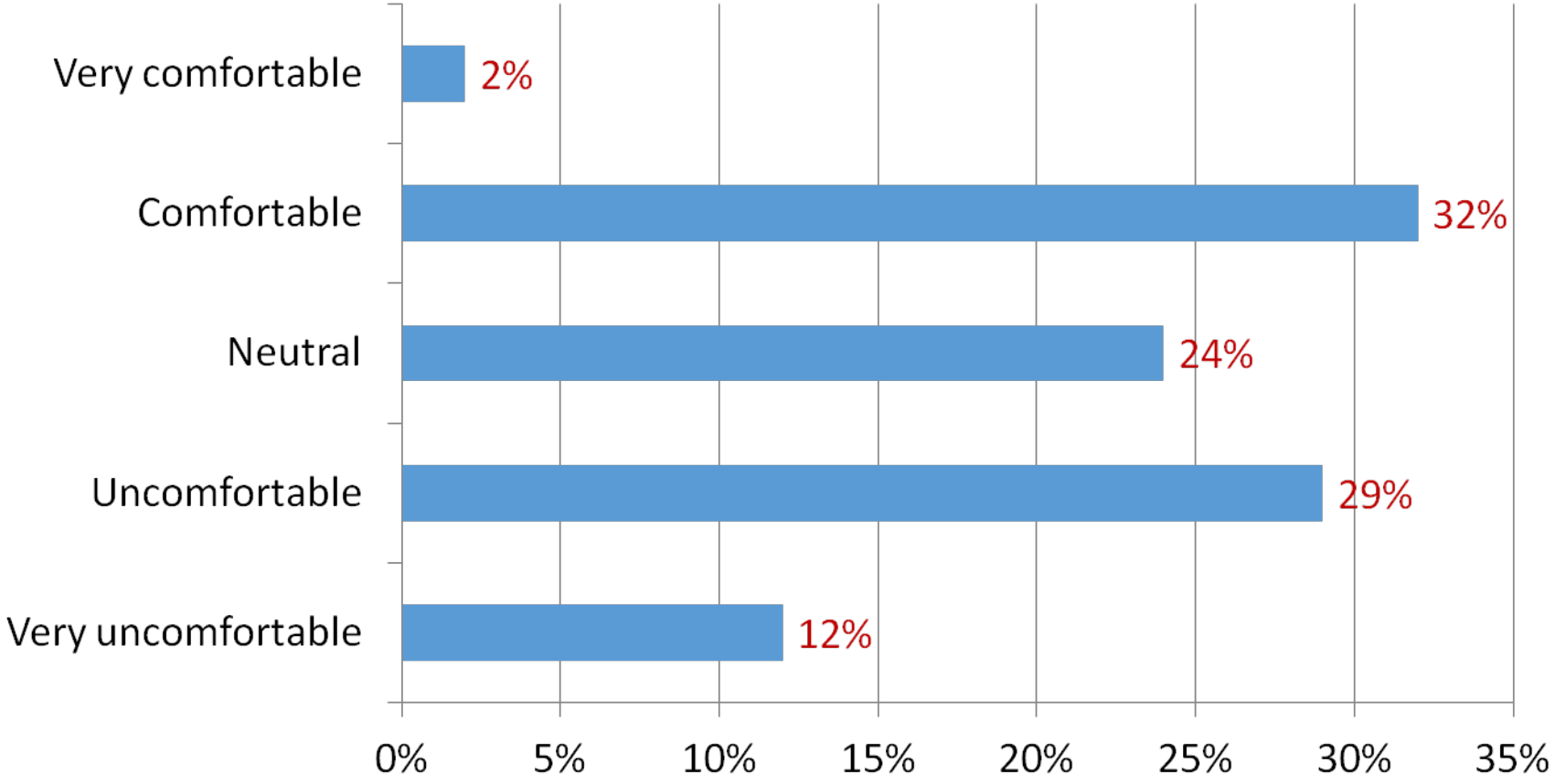

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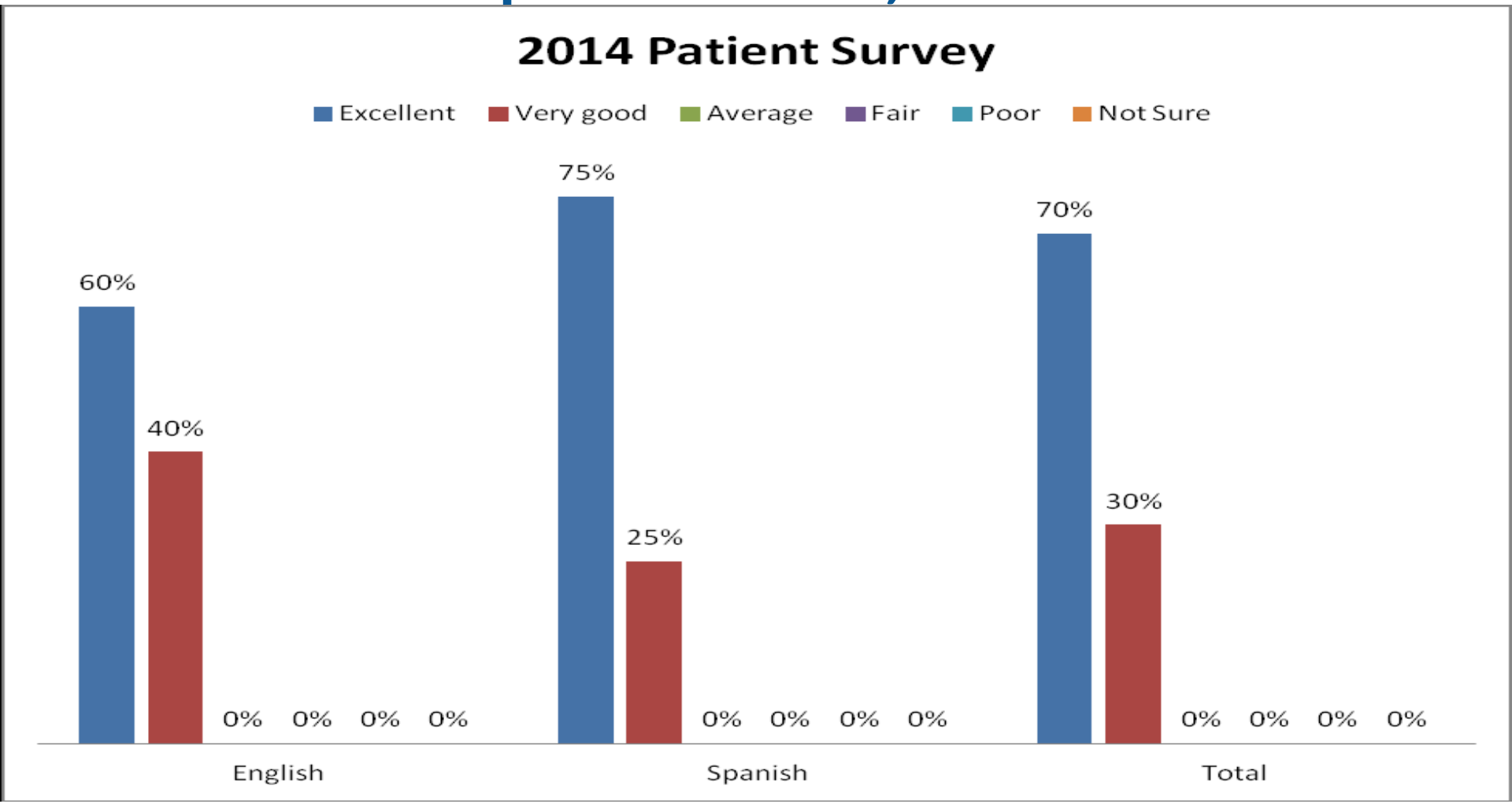


# Successes

-Aforementioned patient/provider satisfaction

-Caveats

-Cannot do direct comparison- respondents not matched/the same

-Not research, not statistically powered to detect true differences

-Provider comments about the CCC:

-“Fantastic clinic, has made a huge difference for several of my patients, and made a huge impact on me. I do not think I am exaggerating when I say that the CCC saved one of my patient's life. I have learned a ton from reading clinic notes, and these have helped me greatly in taking care of my patients in the CCC as well as HIV+ patients not involved with CCC. It is an excellent model for patient care and for the osmosis effect it has had on my practice. I wish we had more clinics like it.

- “I would not feel comfortable managing these patients without the CCC. Very responsive and can breathe easier knowing we have good comprehensive support! Thanks for providing this resource!”

-“Thank you for your awesome, comprehensive, patient-centered care for our patients”

# Successes Continued

-Patients like it

  -Comprehensive, one-stop services

  -Medical and psychosocial needs can be addressed

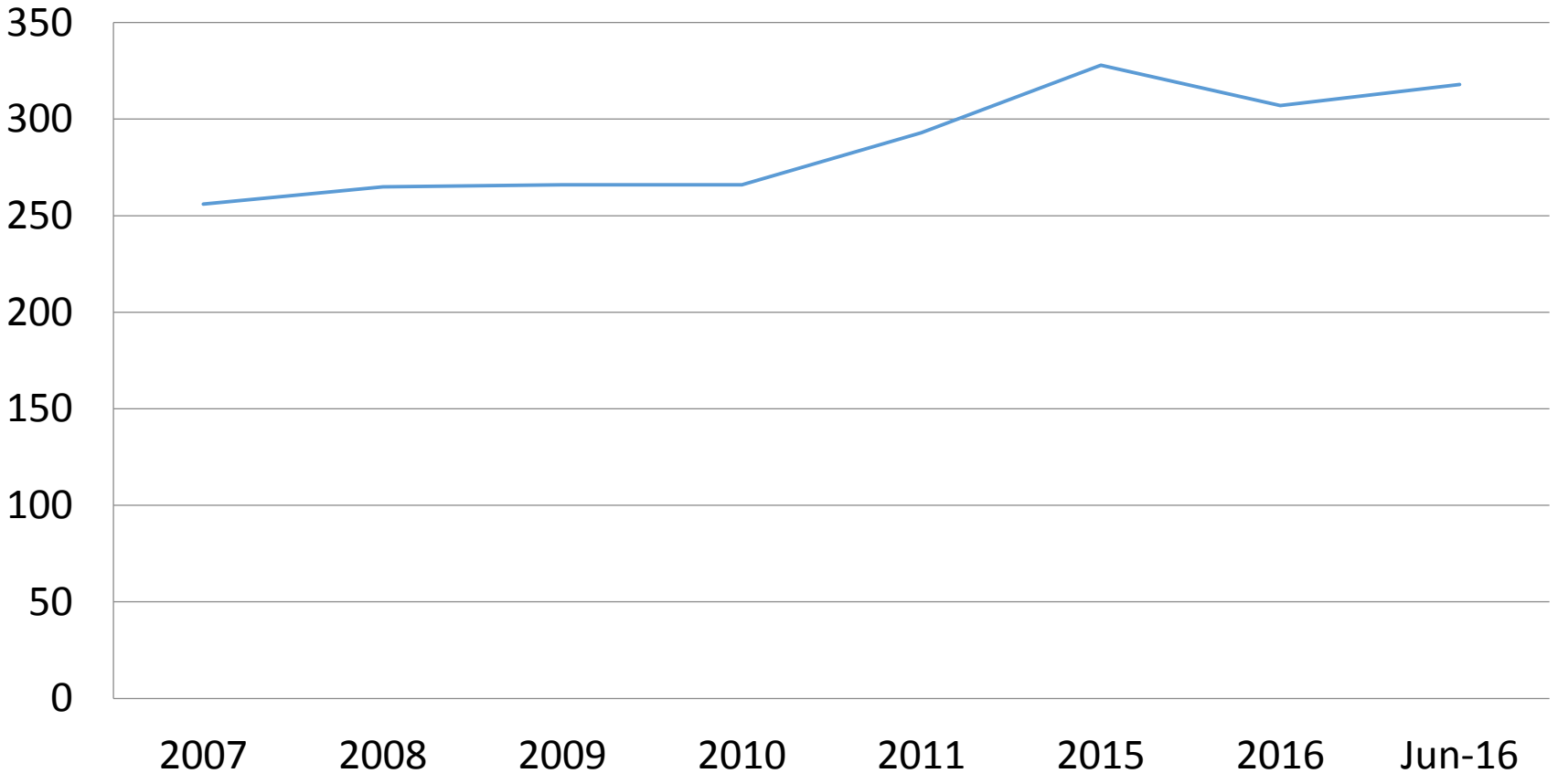
-From the HIV specialist point of view

  -Gives a more complete, well-rounded picture of what's happening with the patients

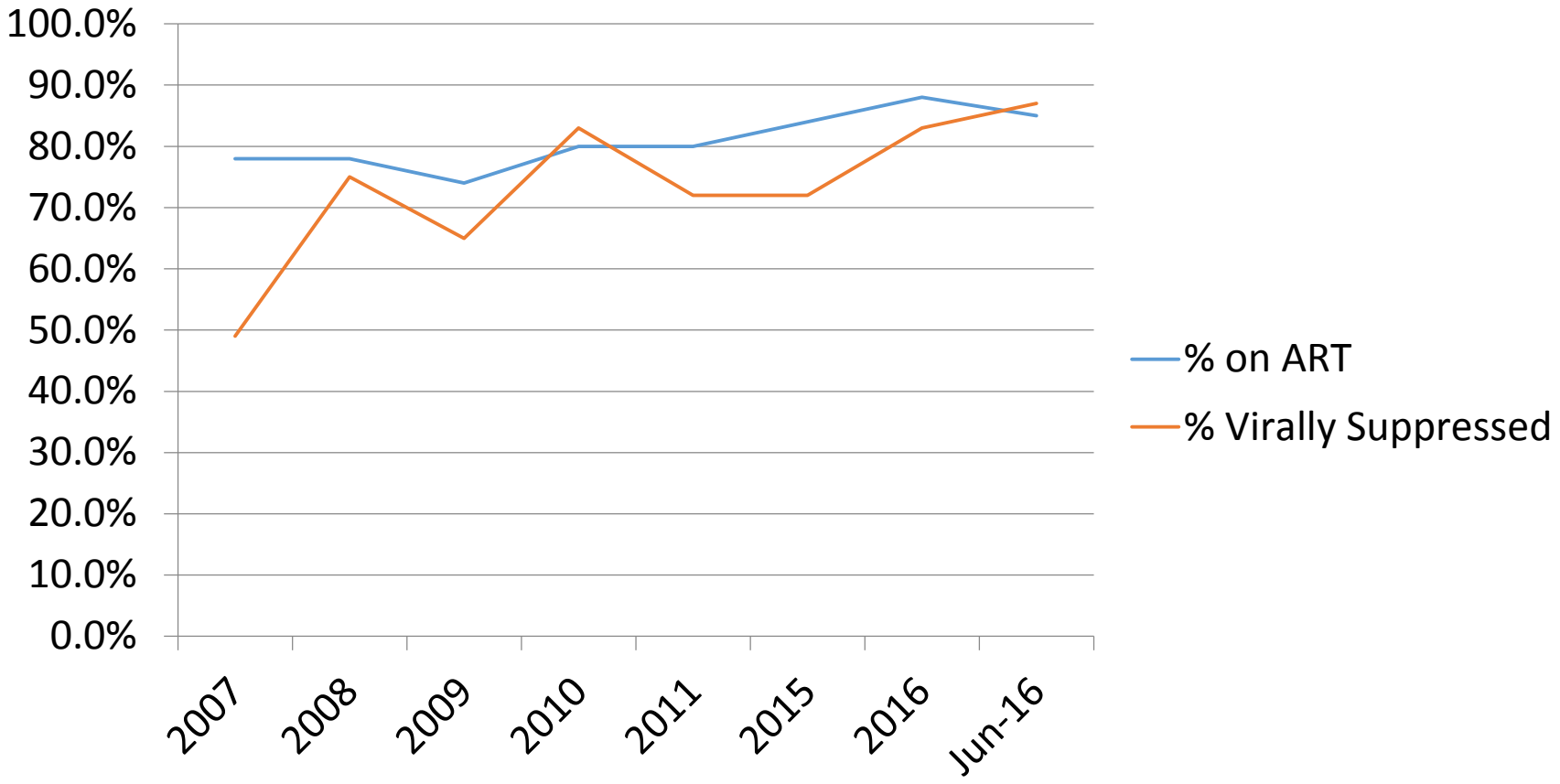
-Patient outcomes have steadily improved over time

  -Association v correlation?

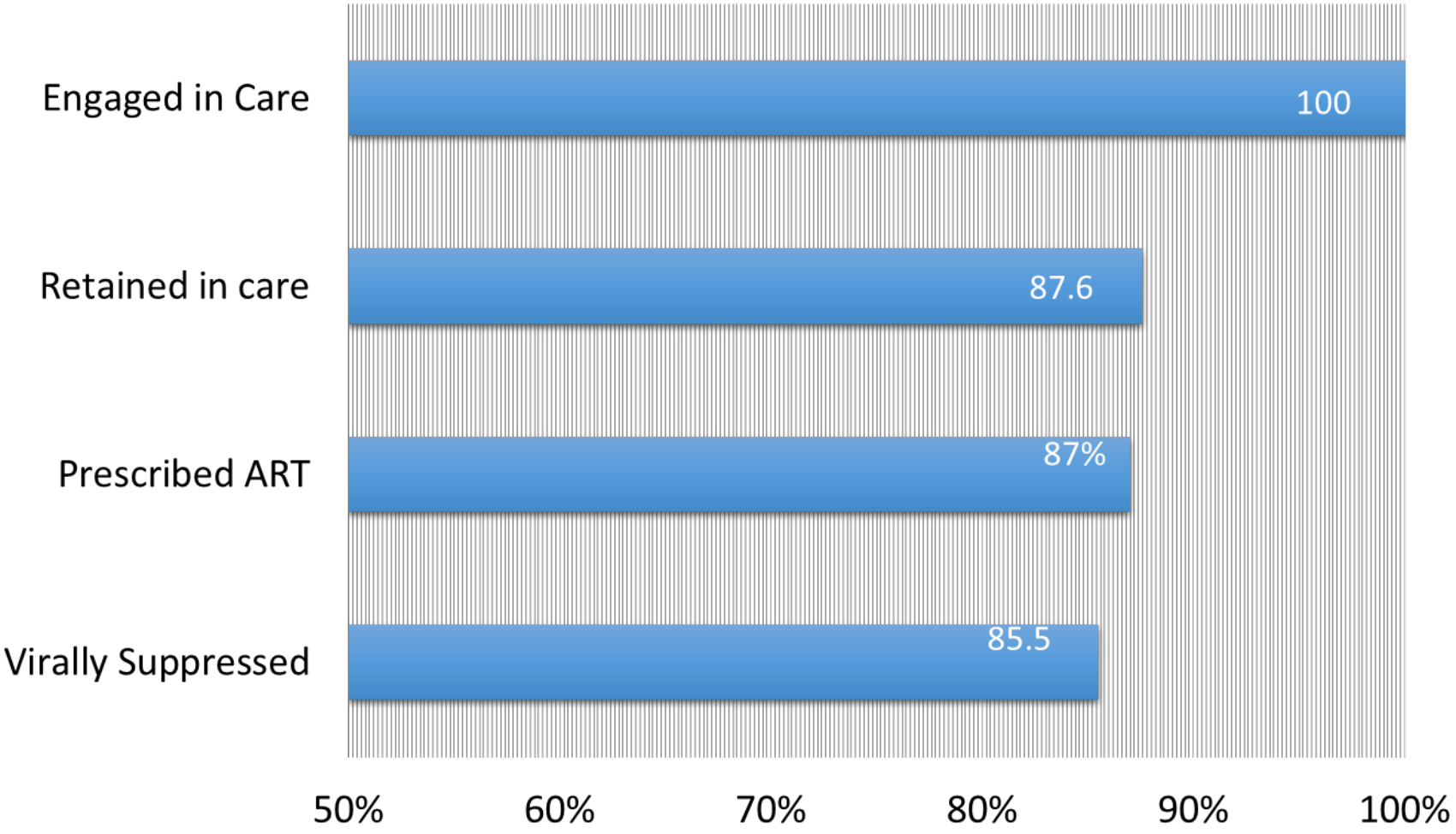
# Patient outcomes - census



# Patient outcomes – viral suppression



# GLFHC care continuum - 2015



# Challenges

-Big team
  -Space
  -Time
-Providing care within the PCMH
  -Not all sites have enough patients to justify going on a regular basis
  -Time of patient's own PCMH-based CCC often not convenient
-Scheduling
-Not all patients like it
  -Too many people
  -Takes too much time
  -Concerns about confidentiality

# Challenges Continued

-Not all PCPs like it
  -Concern that it creates too many visits for patients
  -Concern that it interferes with PCP-patient relationship
-Large amount of staff commitment required
  -And not always an efficient use of their time
-Financial repercussions for providers
  -Cannot schedule as many patients – opportunity cost in terms of our incentive payment
-Behavioral health
  -Only consistently present at 1 site currently, and only at beginning of clinic

# Way forward

-Improve integration of behavioral health

-Improve scheduling/develop a prioritization system

-Identify ways to improve staff efficiency during CCC time

-Identify ways to “tailor” clinic to individual patient desires/needs

# Summary

-"Comprehensive Care Clinic (CCC)" model:

-Provides integrated, multidisciplinary team based care in the patient's medical home

-Has enabled us to retain our commitment to the integrated primary care model of HIV care, while expanding patient access to HIV specialist care

-Has been well-received by patients and providers alike

-Has been associated with improved patient outcomes over time

-Improved integration of behavioral health a vital next step given the complex psychosocial needs of our patients