Supporting education and training for the HIV workforce

PACHA HIV Workforce Panel

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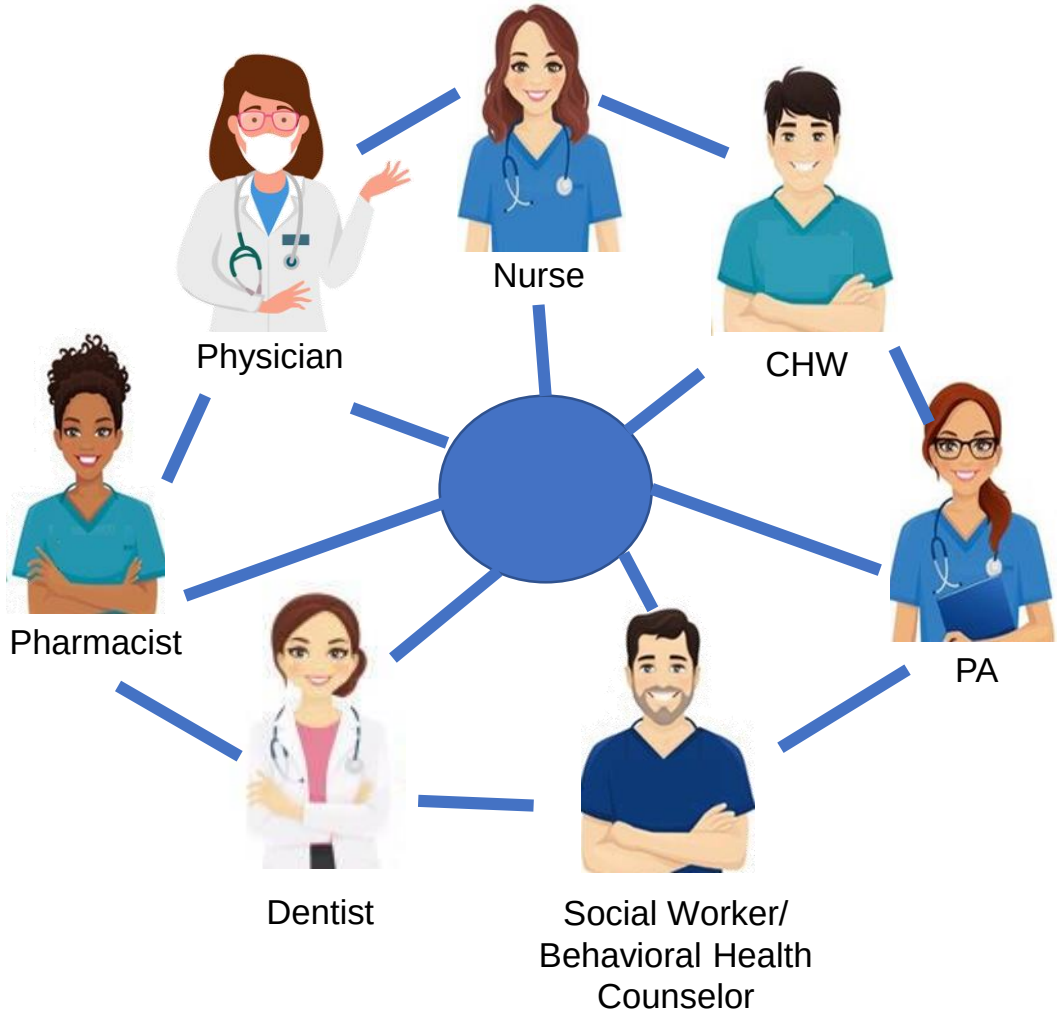
#2: Adopting Multidisciplinary Team-Based Models for HIV Services

- This **IS** optimal care for PWH or at risk for HIV – and what we should strive to accomplish
- This approach is critical to the success of RW programs
- Deploying this model in all areas of need will be challenging in the short run.

Reimagined Model for Team-Based HIV Service Delivery

Comprehensive and team-based model of whole-person care that relies on complementary skills



HIV WORKFORCE:

Prescribing clinicians

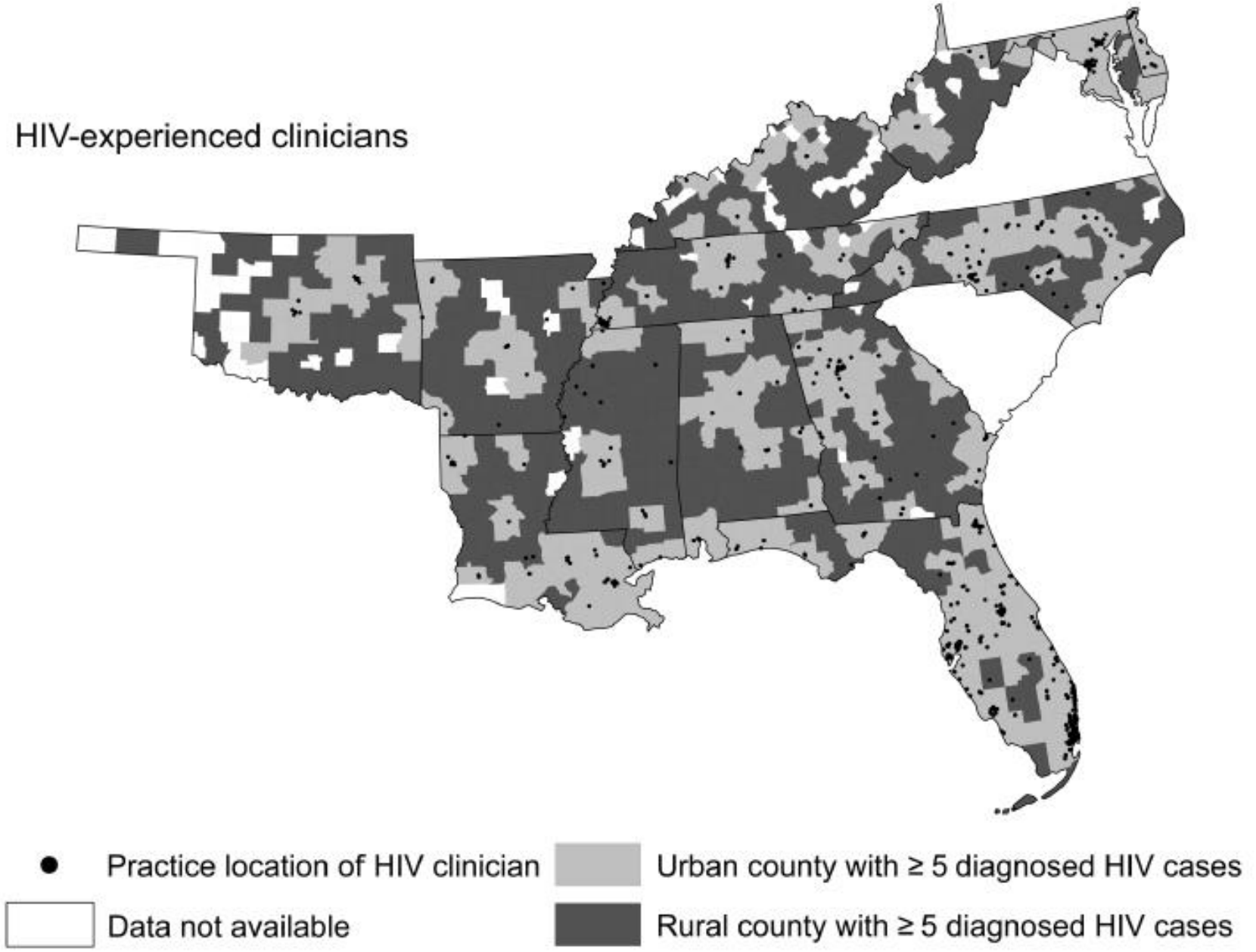


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Table 2. Number of Counties and Median County-level Human Immunodeficiency Virus (HIV) Clinician-to-Population Ratios (Clinicians per 1000 Diagnosed HIV Cases)

>10 Medicaid PLH

State	Counties With at Least 5 Diagnosed HIV Cases (Frequency)			All HIV Clinicians, Median (IQR)			*P* Value[a]	HIV-Experienced Clinicians, Median (IQR)			*P* Value[a]
	All	Rural	Urban	All Counties	Rural Counties	Urban Counties		All Counties	Rural Counties	Urban Counties	
All 14 states	926	531	395	13.3 (38.0)	7.4 (43.5)	16.0 (32.3)	.13	0.0 (0.0)	0.0 (0.0)	0.0 (4.9)	< .01
Alabama	67	38	29	11.0 (27.8)	17.0 (38.5)	4.3 (14.4)	.05	0.0 (0.0)	0.0 (0.0)	0.0 (3.2)	< .01
Arkansas	71	51	20	0.0 (45.5)	0.0 (52.6)	15.9 (24.8)	.47	0.0 (0.0)	0.0 (0.0)	0.0 (5.6)	< .01
DC	1	0	1	6.2 (–)	…	6.2 (–)		2.8 (–)	…	2.8 (–)	
Delaware	3	0	3	34.5 (14.5)	…	34.5 (14.5)		8.6 (2.2)	…	8.6 (2.2)	
Florida	67	23	44	19.3 (20.5)	27.3 (32.3)	19.0 (14.6)	.69	4.0 (6.7)	0.0 (6.8)	5.0 (6.7)	.04
Georgia	156	83	73	7.6 (28.4)	0.0 (30.3)	10.7 (23.7)	.63	0.0 (0.0)	0.0 (0.0)	0.0 (1.8)	< .01
Kentucky	99	67	32	0.0 (53.4)	0.0 (76.9)	4.4 (37.9)	.62	0.0 (0.0)	0.0 (0.0)	0.0 (0.0)	< .01
Louisiana	62	28	34	13.5 (28.6)	11.7 (32.8)	14.5 (21.4)	.71	0.0 (0.0)	0.0 (0.0)	0.0 (5.2)	< .01
Maryland	24	5	19	6.9 (12.0)	0.0 (16.7)	7.1 (9.4)	.48	0.0 (0.4)	0.0 (0.0)	0.0 (1.0)	.16
Mississippi	80	63	17	29.2 (48.0)	27.3 (56.3)	33.9 (31.1)	.39	0.0 (0.0)	0.0 (0.0)	0.0 (3.5)	< .01
North Carolina	98	52	46	20.0 (41.7)	17.1 (39.1)	24.4 (32.5)	.28	0.0 (4.1)	0.0 (0.0)	0.0 (9.3)	< .01
Oklahoma	61	44	17	26.3 (47.1)	26.3 (59.7)	27.4 (22.4)	.91	0.0 (0.0)	0.0 (0.0)	0.0 (0.0)	< .01
Tennessee	89	48	41	27.0 (56.3)	30.4 (64.6)	24.4 (51.3)	.69	0.0 (0.0)	0.0 (0.0)	0.0 (0.0)	< .01
West Virginia	48	29	19	0.0 (48.0)	0.0 (0.0)	32.3 (83.3)	< .01	0.0 (0.0)	0.0 (0.0)	0.0 (14.9)	< .01

We need to increase the number of prescribing clinicians whose primary interest is HIV care

- ART regimen decision-making can still be complex
- Increased co-morbidities that are not managed identically to persons without HIV
  - Bone health, cardiovascular risk, DM, weight gain, frailty, cancer screening….
- Providers must have comfort with addressing sexual health
- Commitment to holistic care (with a team) and addressing SDOH is necessary

Training for expertise: Exposure matters

Specialized Training Tracks:

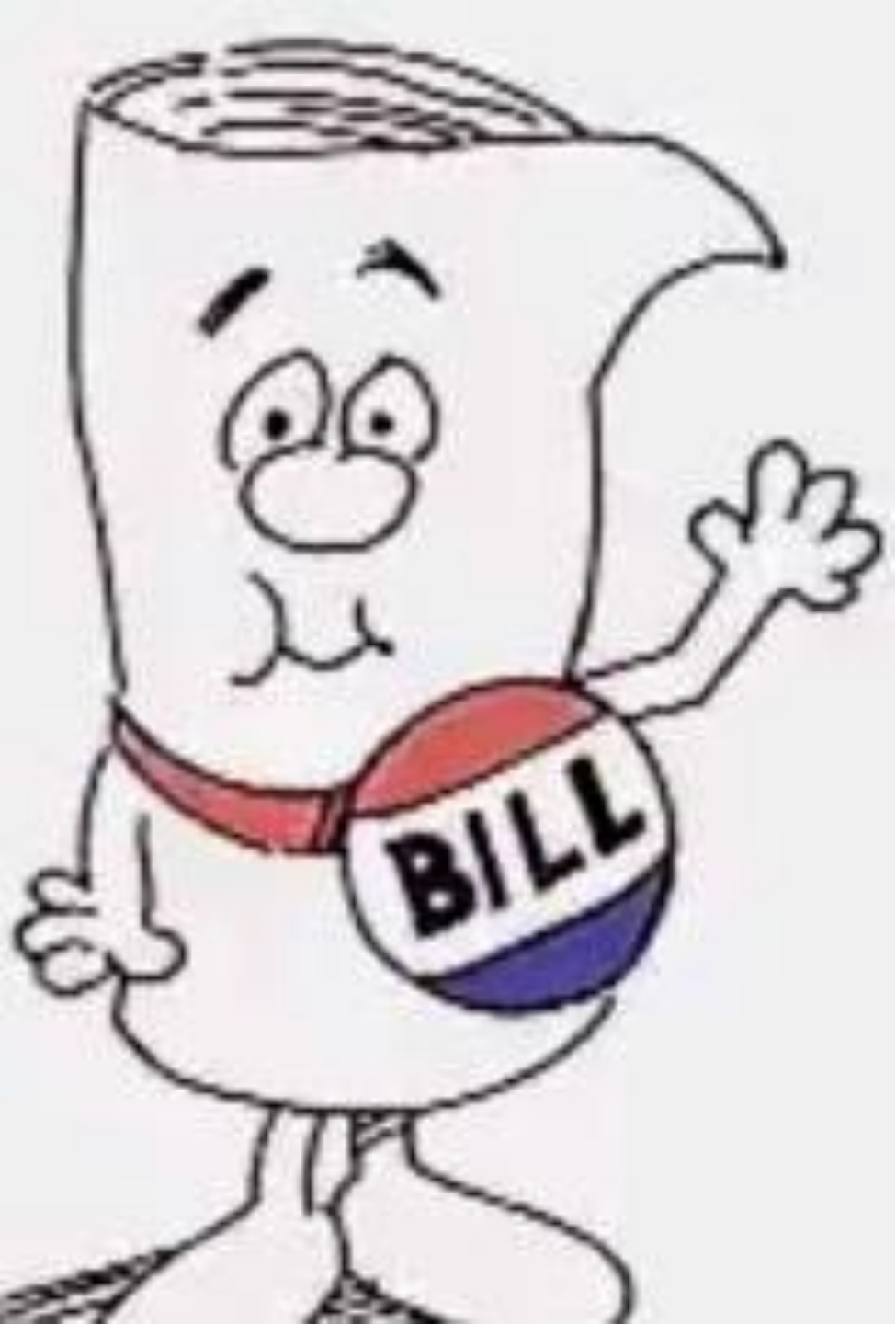
*Pathways in residency programs for Int Med and Fam Med trainees (HIV tracks)

*HIV Clinical Fellowships

*Residencies in HIV medicine for APPs

*Residencies with HIV experiences for dentists

* (and more trainees choosing Infectious Disease)



Bolstering Infectious Outbreaks (BIO) Pandemic Workforce Act

- Student loan repayment opportunity for physicians, pharmacists, physician assistants, advanced practice registered nurses, dentists
- Work in a medically underserved community, for a medically underserved population, for an FQHC or rural health clinic, in Ryan-White funded clinics, in health professional shortage area most of the time
- Encourage your representatives to support this!

How do we optimize care for those who don't have access to an HIV expert/ program?

Low volume providers
(most primary care clinicians)

Current state: Low comfort level

- Enhance basic knowledge
- Provide easy access to experts

Enhancing basic knowledge

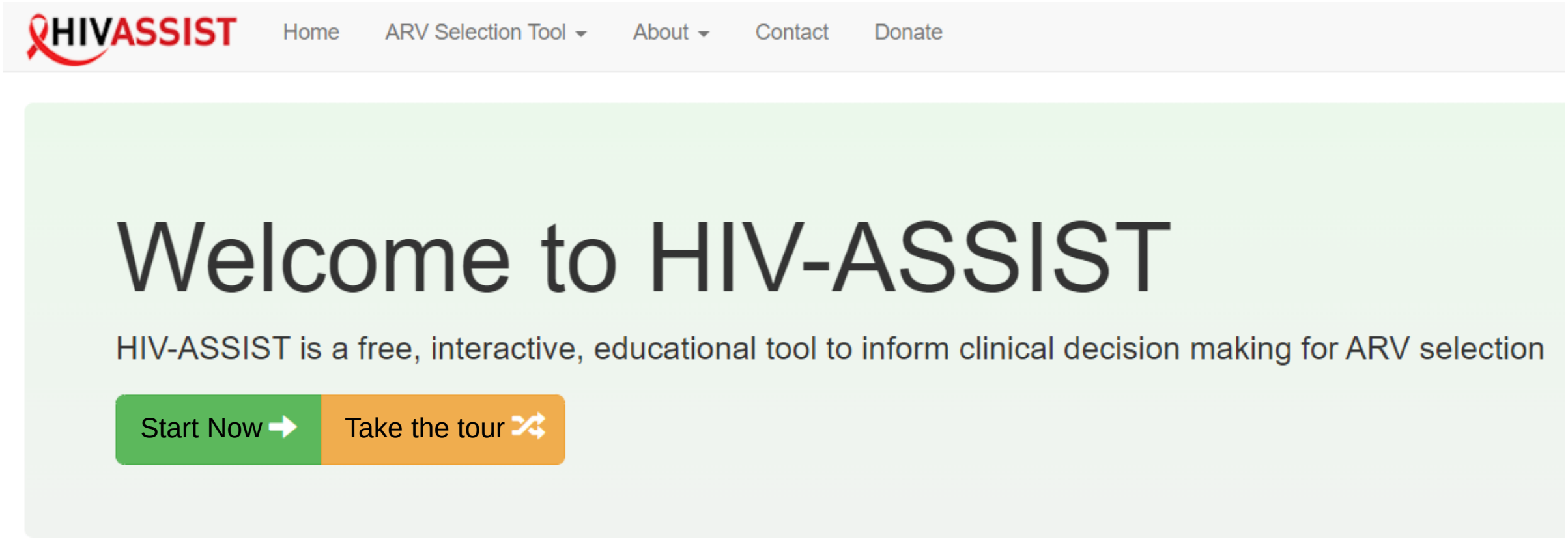
Multiple studies highlight knowledge gaps and low comfort level prescribing PrEP, much less HIV medications.

- **Basic curricula** in HIV care and in HIV prevention need to be **required** for training programs – MDs and APPs
  - Testing
  - Stigma-free sexual health evaluation
  - PrEP
  - Initial ART regimens

Providing EASY access to experts

- Regional experts that provide an opportunity for relationship – building
- Low barrier access (email or other 24/7 web-based system)
- Well-advertised
- Ultimately, some mechanism of compensation

Disseminate decision support tools



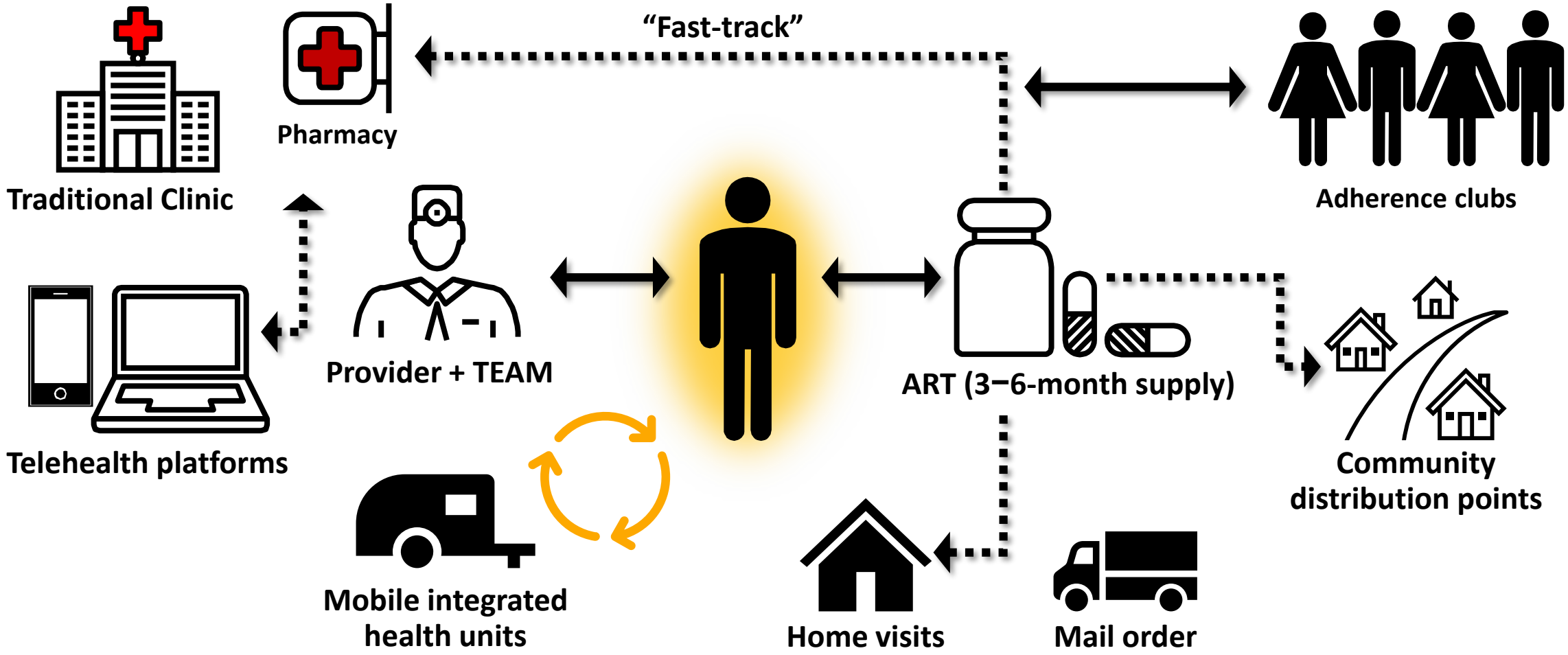
Biden Administration Seeks to Expand Telehealth in Rural America

New funding will allow more medical appointments to take place via video in rural communities, where some of the nation's oldest and sickest patients live.

September 19, 2021

The New York Times

Differentiated Service Delivery



Collins et al, *AIDS* 2020

Recommendations for Supporting a Reimagined HIV Workforce

1. **Remove regulatory barriers that place restrictions on practice at the highest level of training and licensure**

2. **Ensure CMS offers reimbursement for decentralized, differentiated, and team-based whole-person HIV prevention and care services**

3. **Support a shift toward education and training for the future health workforce that emphasizes key competencies of team-based, whole-person HIV care as well as training for those not pursuing full time HIV work and increase funding for specialized HIV training programs (e.g., via GME, GNE, etc.)**

4. **Invest in infrastructure development for delivery of decentralized, differentiated HIV prevention and care (e.g., telehealth, community-based delivery of services, etc.) and develop infrastructure to support non-expert workforce**

5. **Allocate funding to HIV-specific demonstration projects designed to mitigate the specific mechanisms of SDOH and foster multilevel resilience (e.g., via Medicaid Section 1115)**