INTEGRATING HIV SPECIALTY CARE INTO A PRIMARY CARE SETTING

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Family Practice and Counseling Network-Health Annex
“The United States will become a place where new HIV infections are rare and when they do occur, every person, regardless of age, gender, race/ethnicity, sexual orientation, gender identity or socio-economic circumstance, will have unfettered access to high quality, life-extending care, free from stigma and discrimination”

Vision for the National HIV/AIDS Strategy, 2010
There is an increasing shortage in Infectious Disease specialists and an increasing number of People Living with HIV/AIDS (PLWHA).

Infectious Disease specialists tend to be concentrated in particular geographic areas—especially downtown urban settings.

Primary care can address multiple chronic illnesses, possibly more easily than in a specialist office. Many people with HIV are not living simply with HIV, but also with diabetes, hypertension, asthma, and/or Hepatitis C, among other issues.

“The high rates of care and treatment adherence required for ongoing suppression of HIV are best supported within... integrated service delivery environments, such as Ryan White–funded clinics and the VA. This is particularly true for patients with 2 or more co-occurring conditions.”

Newly diagnosed people are more likely to enter care sooner if they are tested in an integrated care model.

“The NHAS estimates that 35% of patients newly diagnosed with HIV are not linked to HIV care within 3 months of diagnosis, which is recommended by the Centers for Disease Control and Prevention. However, higher levels of linkage are found in integrated care systems.”

Better access to a care team, including support services, is a benefit to patients, both in access to services and in improving HIV care outcomes.

“...patients who visited HIV clinics with more integrated specialty services were more likely to achieve viral suppression. In particular, patients visiting clinics which offered hepatitis, psychiatric, psychological and social services in addition to primary care and HIV specialty services were three times more likely to achieve viral suppression than patients visiting clinics which offered only primary care and HIV specialty services. .”

“...our finding that frequency of visits was a strong predictor for viral suppression, we suggest not only that resources should be allocated to integrate subspecialty services into HIV primary care clinics but also that providers should channel patients toward these clinics and retain them in care. “

Health Annex

• Federally Qualified Health Center – Accepts everyone regardless of insurance status, uninsured are seen on sliding fee scale. Grant funding allows for no charge for HIV patients.

• One of four practices that are part of the Family Practice and Counseling Network

• Nurse-managed primary care clinic located in well-used shopping center in SW Philadelphia

• 5219 patients in 2011

• 60+ HIV patients
OUR MODEL:

SERVICES AVAILABLE

- Primary Care
- Dental
- Behavioral Health
- Prenatal
- Behavioral Health Consultants
- Social Workers
- Pharmacy Dispensary
- Outreach
- Nutritionist/Diabetic Educator
- Certified Peer Specialists
- Specialists on site at least monthly: Cardiologist, Optometrist, GLBT specialists, Podiatrist
**OUR MODEL**

**HIV SERVICES FUNDING**

- Routine and walk in rapid HIV testing
  - city funding for ongoing testing
  - grant funding to implement routine testing

- Ambulatory Medical Care
  - city-funded through Ryan White Part A
  - Part of Carelink, a network of FQHCs that provide ambulatory HIV care
OUR MODEL - HIV SERVICES OVERVIEW

• HIV specialist Family Practice Nurse Practitioner sees people living with HIV/AIDS in family practice setting with significant support from Care Coordinator.

• Belief that good quality care could not be done without this team approach

• Constantly working to align provider agenda with patients' agendas
OUR MODEL- STAFF

• Nurse Practitioner – Board certified Family Practice nurse practitioners with years of HIV care experience in specialty care settings, other socials service backgrounds.
  -In addition to seeing patients, performs QI, case conferences, and in-house consultant to other primary care providers

• Outreach Worker--community-based individual who finds people lost to care
OUR MODEL - STAFF

- Care Coordinator - Social Worker

- Helps with access to the clinic, transportation, food access, housing, appointments with other specialists, access to medication

- Counseling -- adherence, risk reduction

- Quality improvement, data collection, flowsheets
**HIV FLOWSHEET**

<table>
<thead>
<tr>
<th>LABS</th>
<th>DUE</th>
<th>COMPLETED</th>
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<tbody>
<tr>
<td>CD4 with CBC and CMP</td>
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<tr>
<td>Viral Load</td>
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<tr>
<td>Lipid Panel</td>
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<tr>
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<tbody>
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<tr>
<td>Change in meds</td>
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<tr>
<td>PCP Prophylaxis</td>
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<tr>
<td>MAC Prophylaxis</td>
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<td>RPR</td>
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<tr>
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<td>Hep B S Ab</td>
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<tr>
<td>Hep C</td>
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<tr>
<td>Pap</td>
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<td>Did they get a colposcopy?</td>
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<tr>
<td>When was last dental appt?</td>
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<td>Dentist:</td>
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<tr>
<td>Risk reduction</td>
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<tr>
<td>Substance Abuse</td>
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<td>Depression</td>
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<tbody>
<tr>
<td>Influenza</td>
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<tr>
<td>Hepatitis B</td>
<td>☑</td>
<td>☐ Contra ☐ Refused</td>
</tr>
<tr>
<td>Pneumovax</td>
<td></td>
<td>☐ Contra ☐ Refused</td>
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**FOLLOWUP NEEDED BY CARE COORDINATOR:**
**NEW PATIENT**

**HIV FLOWSHEET**

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<tr>
<th>LABS</th>
<th>DUE</th>
<th>COMPLETED</th>
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<tbody>
<tr>
<td>Confirmatory test</td>
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| ASSESSMENT                    |     |           |
| Lowest CD4/VL                 |     |           |
| Mode of transmission          |     |           |
| Adherence                     |     |           |
| Risk reduction                |     |           |

| CARE COORDINATOR:             |     |           |
| Substance Abuse Screening     |     |           |
| Mental Health Screening       |     |           |
| Release for records from prior clinic | |       |
| Care Outreach consent/ meet Care Outreach | |   |
Supportive administration/Colleagues
- Initiated by Primary Care Coordinator who oversaw all three primary care practices.
- Grants sought and obtained

Clinic manager with previous experience in HIV-integrated model in another FQHC
- Allowing for the extra
time/attention/different rules given to HIV patients

Other Family Practice NPs (in the practice) who accepted and supported the program
- Will see HIV patients as needed, often with input from care coordinator and in consultation with HIV NP
- Availability of preceptor to train new providers-two have currently gone through program
OUR MODEL - CHANGES OVER TIME

Modifications to model necessary due to changes in staffing over time

• Consultant model with hospital ID practice
• Fulltime NP with informal ID relationship
• Fulltime NP with ID case consultation
• Consultant model with HIV-experienced primary care providers
• Using preceptor to support interested NPs in training
Ease of access

- Usually closer to home and located in community
- Knowledge of patient's community and availability of resources
- Eliminates barriers to specialty care - Referrals, copay, extra travel time
- Fewer appointments in fewer places – less overwhelming
Reducing stigma

• “Normalizing” the HIV part of their health by addressing it in the context of their overall health

• Less concern of confidentiality breach by bumping into people you know in lobby who will know why you’re at appointment
**WHY HIV-INTEGRATED PRIMARY CARE IS IMPORTANT - FLEXIBILITY**

**Flexibility**

- Flexibility for patients -- particularly important for those difficult to reach, need more supports, who are easily lost to care

- “Backdoor” access to care - for expedited appointments, discussing medication access, medical questions - preschedule appointments one day to one week in advance

- No long waits on phone, not put on hold, quick callback. Treated very individually, Care coordinator knows person’s issues from their patients as well as medical establishment perspective.
Flexibility

- Cooperation of other staff so that Care Coordinator knows if patient requests to be seen or NP needs patient to come in.
- Outreach services – Outreach person is not associated specifically with HIV care.
- Catching patients when they come in for other issues/appointments.
- Recognition of complicated lives of patients and ability of Care Coordinator to advocate for patients in busy clinic context
Addressing Social Issues

WHY
HIV-INTEGRATED
PRIMARY
CARE IS
IMPORTANT-

ADDRESSING
SOCIAL
ISSUES

• Working with patients to find underlying causes and find initial and longer term solutions.
• Social supports
• Case management
• D&A
• Food, clothing
• Assessing housing needs
• Access to onsite short or long term behavioral health care
• Appropriate referrals to other longer term BH care in community
Family-Friendly Care

- Can preschedule family members appointments along with the patient or catch patient at other family members appointments.
  ex: "While we're giving your kids these shots, let's do your bloodwork and get you scheduled for an appointment."

- Helping individuals reveal their HIV status to partners and family members who can be supportive

- Easy to offer testing for partners. Promotes discussion of secondary transmission.
Addressing Other Medical Needs

WHY HIV-INTEGRATED PRIMARY CARE IS IMPORTANT

ADDRESSING OTHER MEDICAL NEEDS

• Other medical needs can be addressed in same appointment--this allows for prioritization of patient's agenda of priority goals vs. provider's agenda of quality of care

• "Come in every 3 months for Depo, we'll do your bloodwork while you're here."

• Breast exams, pap smear, colonoscopy
Developed in 2010 under Obama’s directive to have a coordinated response to HIV/AIDS epidemic instead of “silos” responses between HIV research, prevention, care.

Three primary goals:

• Reducing HIV incidence
• Increasing access to care and optimizing health outcomes
• Reducing HIV-related health disparities

www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf
Increasing Access to Care and Improving Health Outcomes for People Living with HIV

- Establish a seamless system to immediately link people to continuous and coordinated quality care when they learn they are infected with HIV.
  - Test positive, link straight into care/support services at a location and among people they already know. No transitions, outreach support available.

- Support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing.
  - Able to address co-occurring health conditions in primary care, along with connecting to basic resources available in community for social conditions.

- Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV.
  - Allowing for the support for other providers to manage PLWHA who are more stable medically, provide ability to attend preceptor/comanage patients.
The medical home model holds promise as a way to improve health care in America by transforming how primary care is organized and delivered.”

Agency for Healthcare Research and Quality

pcmh.ahrq.gov/portal/server.pt/community/pcmh_home/1483/PCMH_Defining%20the%20PCMH_v2
“The HIV care model that incorporates the best aspects of the medical home model and contributes to our remarkable success in treating HIV disease should be promoted and enhanced with national health care reform.”

• Comprehensive Care

• Patient Centered

• Coordinated Care

• Accessible Services

• Quality and Safety
Comprehensive Care
- Looking at HIV as chronic care condition, as part of a one stop shop with family planning, behavioral health, HIV and PCP in one place.

- The more support available to a medical provider, the more this frees them up to be able to manage more complex patients

Patient Centered
- Multiple visits and an ongoing relationship with one main provider ideally allows for the patient to have a stronger relationship with provider. This will help with patient feeling confident in setting own goals and expressing concerns to provider

Coordinated Care
- Eliminating extra steps of referrals, travel time, tracking down consult notes

If HIV can be integrated under this model, then other medical issues could be integrated using same principles. This would further steps towards becoming a Patient Centered Medical Home.
RESOURCES

The National HIV Telephone Consultation Service
800-933-3413

National Perinatal HIV Consultation and Referral Service
1-888-448-8765

HHS Clinical Guidelines Portal
aidsinfo.nih.gov/Guidelines/

HRSA Guide for HIV/AIDS Clinical Care

AIDS Education and Training Centers
http://www.aidsetc.org/