HealthHIV
HIV PRIMARY CARE SURVEY

# HealthHIV's Third Annual State of HIV Primary Care National Survey

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# Overview / Executive Summary

Analysis focused on 371 providers who work in primary care

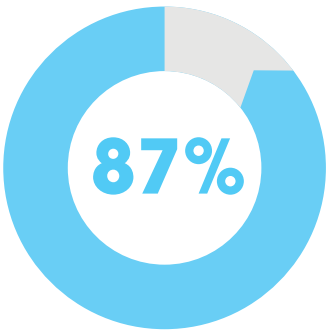
provide clinical HIV care (HIV PCP)

**51%**

**49%**

do not provide clinical HIV care (non-HIV PCP)

HIV specialists who worked in primary care




The HIV service delivery and broader public health systems are undergoing fundamental transformations that hold both promise and peril for patients as the Patient Protection and Affordable Care Act (PPACA) moves toward full implementation. At the epicenter of this changing environment is the integration of HIV care into primary care.

As people living with HIV (PLWH) are living longer and at times managing multiple chronic conditions, their healthcare is being increasingly delivered by primary care providers (PCPs) or by HIV specialists operating in primary care settings. The PPACA has accelerated this movement toward service integration by strengthening and streamlining the nation's primary care system. By raising Medicaid and Medicare reimbursement rates to PCPs, providing funding to establish medical homes, and testing innovative care delivery systems, the PPACA is establishing an integrated, collaborative, and patient-centered primary care service delivery model. In addition, the National HIV/AIDS Strategy (NHAS) and advances in biomedical interventions further prioritize the integration of HIV into primary care by increasing access and incorporating treatment as prevention strategies.

In order to assess HIV care integration into primary care in light of these changes, HealthHIV and Medscape, LLC. conducted the **Third Annual State of HIV in Primary Care Survey**. The survey collected demographic data on both the provider and the patient populations they serve, HIV workforce characteristics, gaps in clinical/non-clinical HIV services, funding streams, patient comorbidities, patient and provider barriers to care, perspectives on retention in care and ACA reforms, and provider education needs.

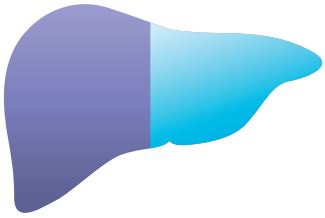
**Comparison groups used in analysis were:**

- Primary care providers who provide clinical HIV care (HIV PCPs)
- Primary care providers who do not provide clinical HIV care (non-HIV PCPs)

**Among the key survey findings:**

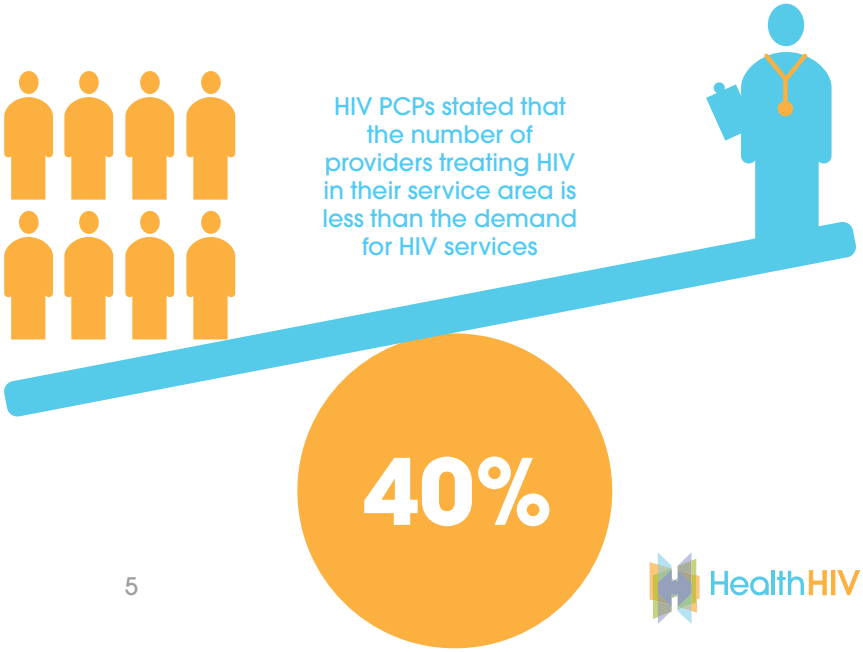
- HIV specialists are increasingly migrating into primary care settings.
- The HIV PCP workforce is aging, with a majority over 50 years old.
- The HIV PCP workforce is struggling to meet the demands of increasing caseloads for an increasingly comorbid population.
- The top five co-occurring conditions facing PLWH are: obesity, syphilis, cardiovascular disease, depression, and renal disease.

Top clinical HIV educational need identified by HIV PCPs



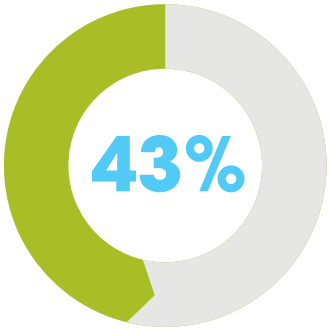
**40%**
Management of hepatitis C co-infection

- HIV PCPs who identified themselves as HIV specialists were significantly more likely to provide routine testing and HIV services than HIV PCPs who were not specialists.
- HIV PCPs (25%) saw an increase in the number of patients with HCV co-infection in the previous 12 months and are in need of education In the treatment of HCV co-infection.
- Retaining PLWH in care is the greatest challenge facing the HIV workforce, and building a strong patient-provider relationship was identified as the best strategy for retaining patients in care.
- Substance use and mental health issues among HIV patients are cited by providers as the two most significant barriers to seeking care, and are the most referred services.



## Overview / Executive Summary

PCPs who thought retention was the biggest challenge along the continuum




Moreover, results suggest challenges, confusion, and lack of readiness regarding the implementation of the PPACA. While a majority of HIV PCPs rely on public funding streams like the Ryan White CARE Act and ADAP to provide services, only one-quarter of respondents have a plan in place to transition patients from Ryan White to Medicaid and other insurance options available through the PPACA. Furthermore, 23% were unsure of, or not ready at all to accept newly insured HIV patients. Non-HIV PCPs were far less likely to work in organizations ready to care for the newly insured. While a majority of respondents thought access to care would increase with the PPACA, fewer believed that quality of care would increase.

HIV PCPs still face structural barriers to providing HIV care such as lack of time for clinic staff to take on new roles, transportation barriers, and lack of referral partners and reimbursement for HIV services. Non-HIV PCPs face the same structural barriers, as well as a lack of provider competency in the treatment of HIV.

**73%**

of HIV PCPs do not have a plan in place to transition patients from Ryan White to Medicaid and other forms of insurance

HIV PCPs are strained and face workforce challenges that will only exacerbate in the coming years as more HIV patients enter care. These findings indicate a need to recruit and educate PCPs on HIV – regardless of whether they currently treat it. They also demonstrate the need to leverage HIV specialists working in primary care as mentors for PCPs. Furthermore, results highlight the correlation between mental health and substance abuse and poor health outcomes for people living with HIV as well as the need to inform and engage patients in their care. As PPACA is implemented, providers must be educated on addressing these challenges in the HIV population. Finally, providers must be trained more thoroughly on PPACA, especially changes to service delivery and reimbursement.

# The Changing HIV and Primary Care Landscape

In the last several years, the HIV and primary care landscapes have changed dramatically with the passing and upholding of the PPACA, the release of the first comprehensive NHAS, and advances in biomedical interventions. With a greater emphasis on prevention and increasing access, there is even more of a need to understand the current landscape of HIV care in order to integrate it into primary care settings. This survey assesses the current state of integrating HIV care and treatment services into primary care in order to better understand the implications of this dynamic and rapidly changing landscape.

## Methodology

**HealthHIV** and Medscape, LLC developed the survey instrument. Questions were developed to define survey respondents, identify trends and further examine previous findings, and gather information on current prevention and treatment strategies. The survey instrument was developed with input from prescribing providers. The final survey instrument consisted of 56 questions (4 qualitative, 51 quantitative). The survey was distributed internationally online using Survey Monkey™. HealthHIV and Medscape, LLC recruited respondents through open invitations using targeted email lists, monthly newsletters, and website postings. Data were collected between March 7 and June 17, 2013. The survey was convenience sampled and no incentive was provided for participation.

# Demographic & Geographic Analysis of Provider Survey Respondents

**2,531** respondents from all 50 states, 4 US territories, and 28 countries participated in the survey. Individuals who were not licensed to prescribe medication, practiced outside of the United States, and did not work within the scope of primary care were excluded from analysis. Accordingly, analysis focused on 371 prescribing providers who worked within the scope of primary care. Providers answered questions based on whether or not they provided clinical HIV care. Providers also indicated whether or not they worked in the scope of primary care.

For the purposes of this survey:

- Providing HIV clinical care is defined as providing HIV care and treatment including, but not limited to, administration of antiretrovirals and drug therapies, prophylaxis and treatment of opportunistic infections, and management of co-occurring conditions.
- Primary care is defined by the American Academy of Family Physicians (AAFP) as care provided by physicians specifically trained for, and skilled in, comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the "undifferentiated" patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis. Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis, and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care, day care, etc.). Primary care is performed and managed by a personal physician often collaborating with other health professionals, and utilizing consultation or referral as appropriate.

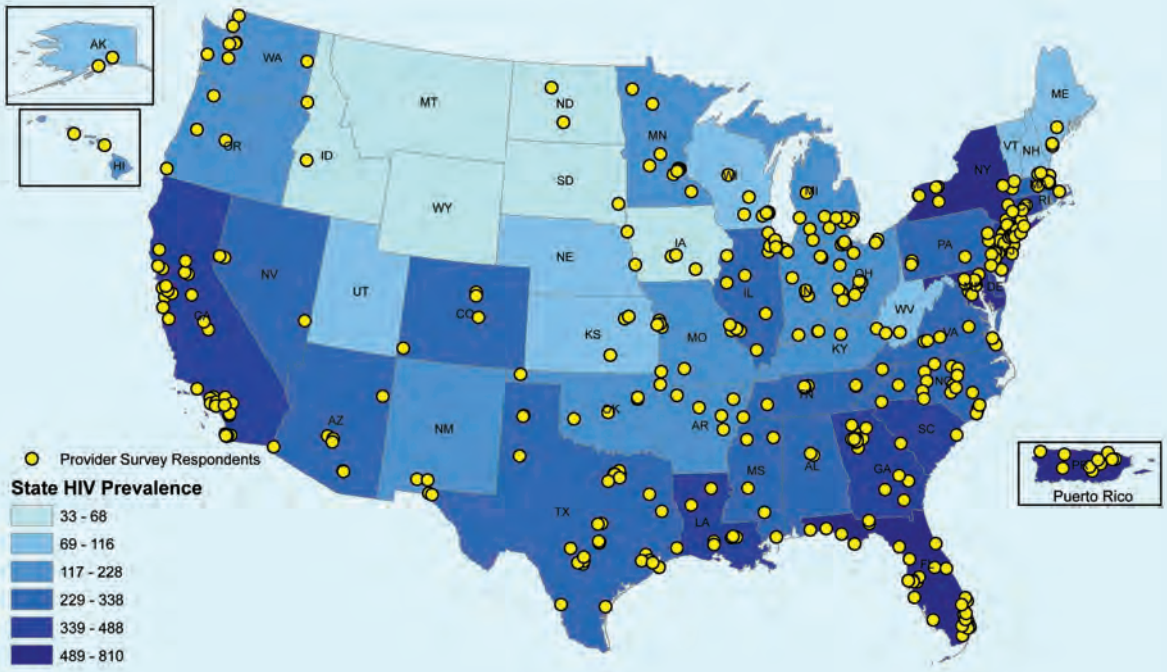
Comparison groups used in analysis were:

- Primary care providers who provide clinical HIV care (HIV PCPs)
- Primary care providers who do not provide clinical HIV care (non-HIV PCPs)

In total, 43% of HIV PCPs identified themselves as credentialed HIV specialists and 87% of HIV specialist respondents worked in primary care.

## THIRD ANNUAL STATE OF HIV PRIMARY CARE PROVIDER SURVEY RESPONDENTS AND 2011 STATE HIV PREVALENCE RATES

HealthHIV
Putting Health First




Map shows the location of provider respondents to HealthHIV's Third Annual State of HIV Primary Care Survey. HIV Prevelance Data was adapted from the Centers for Disease Control and the Prevention's 2011 HIV Surveilance Report. Prevelance rates are calculated per 100,000 people.

September 4, 2012

**2,531**
**RESPONDENTS**

Prescribing Providers (MD, DO, NP, PA), Pharmacists, Dentists, Researchers, Health Administrators, Social Workers/Case Managers, Consumers

50 US States,
4 US territories,
28 Countries

**2,494**
**RESPONDENTS**

Prescribing Providers (MD, DO, NP, PA), Pharmacists, Dentists, Researchers, Health Administrators, Social Workers/Case Managers, Consumers

50 US States
and
Puerto Rico

**464**
**RESPONDENTS**

Prescribing Providers (MD, DO, NP, PA)

45 US States
and
Puerto Rico

**371**
**RESPONDENTS**

Prescribing Providers (MD, DO, NP, PA) who are working in the scope of primary care

45 US States
and
Puerto Rico

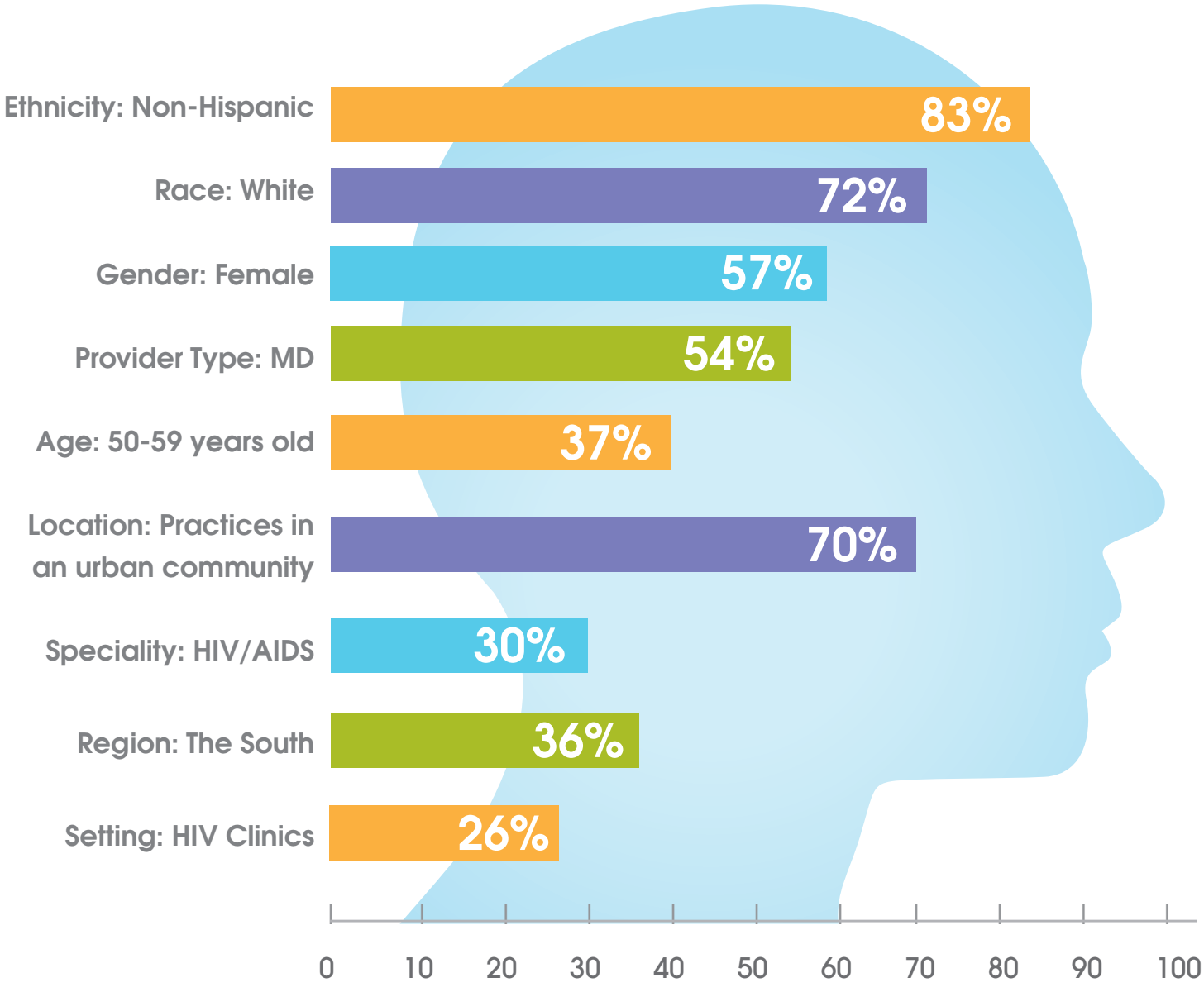
## Demographic Comparison between HIV PCPs and Non-HIV PCPs

| Professional Characteristics | HIV PCP | Non-HIV PCP |
|---|---|---|
| **Profession** | | |
| **Physician (MD, DO)** | **54%** | 32% |
| Advanced Practice Nurse (NP, CNS) | 31% | 52% |
| Physician Assistant (PA) | 11% | 16% |
| Pharmacist (PharmD, RPh) | 3% | 1% |
| Dentist (DDS, DMD) | 2% | -- |
| **Organization** | | |
| **HIV clinic** | **26%** | -- |
| Hospital | 25% | 18% |
| Academic health center | 23% | 9% |
| Community health center | 15% | 12% |
| Clinic (urgent care clinic, private clinic, etc.) | 12% | 25% |
| Federally Qualified Health Center | 10% | 6% |
| Private practice | 9% | 22% |
| AIDS service organization (ASO) | 8% | -- |
| Infectious disease clinic | 7% | -- |
| **Practice Setting** | | |
| **Urban/Metropolitan** | **70%** | 37% |
| Suburban | 16% | 37% |
| Rural | 14% | 26% |
| **Specialty** | | |
| Internal Medicine | 15% | 12% |
| Infectious Diseases | 17% | 1% |
| Family Medicine | 20% | 48% |
| **HIV/AIDS** | **30%** | -- |
| Ob/Gyn & Women's Health | 4% | 15% |
| **Population Served** | | |
| **Women** | **91%** | 84% |
| Racial or ethnic minorities | 90% | 76% |
| Lesbian, Gay, Bisexual & Transgender (LGBT) populations | 88% | 63% |
| Substance abuse/mental health populations | 83% | 55% |
| People with limited English proficiency (LEP) | 75% | 57% |
| Youth | 57% | 64% |
| Homeless populations | 75% | 36% |
| Immigrants | 63% | 40% |
| Recently incarcerated/prison populations | 64% | 29% |
| Migrant workers | 39% | 27% |

## Demographic Comparison between HIV PCPs and Non-HIV PCPs

| Demographic Characteristics | HIV PCP | Non-HIV PCP |
|---|---|---|
| **Region** | | |
| Northeast | 30% | 16% |
| Midwest | 18% | 23% |
| **South** | **36%** | 42% |
| West | 17% | 18% |
| **Gender** | | |
| **Female** | **57%** | 71% |
| Male | 41% | 29% |
| Transgender | 2% | -- |
| **Hispanic/Latino** | | |
| Yes | 17% | 7% |
| **No** | **83%** | 93% |
| **Race** | | |
| **White or Caucasian** | **72%** | 83% |
| Black or African American | 19% | 10% |
| Asian | 9% | 6% |
| American Indian or Alaska Native | 3% | 2% |
| Native Hawaiian or Other Pacific Islander | 1% | -- |
| **Age** | | |
| 20-29 | 3% | 5% |
| 30-39 | 19% | 18% |
| 40-49 | 24% | 27% |
| **50-59** | **37%** | 34% |
| 60-69 | 17% | 15% |
| 70 or older | 1% | 1% |

# Profile of HIV Primary Care Providers

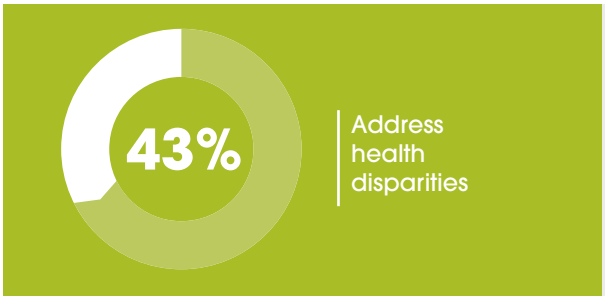


# HIV Primary Care Workforce Characteristics

## Personal and Professional Factors for Treating HIV

HIV PCPs were asked what professional and personal factors influenced their decisions to provide HIV care.

**Top Personal Factors for Treating HIV:**




**39%** Mentor or role model involved in the HIV field

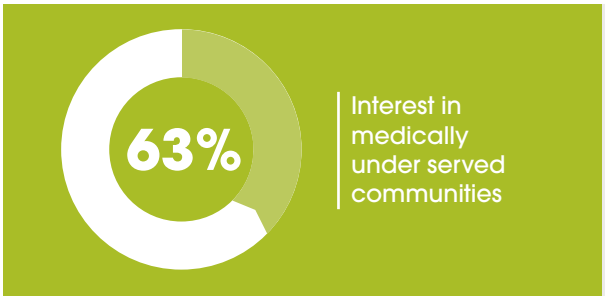
**39%** Social justice

**29%** Advance health equity

**29%** Part of a community highly impacted by HIV

**20%** Family or friend with HIV/AIDS

**Top Professional Factors for Treating HIV:**



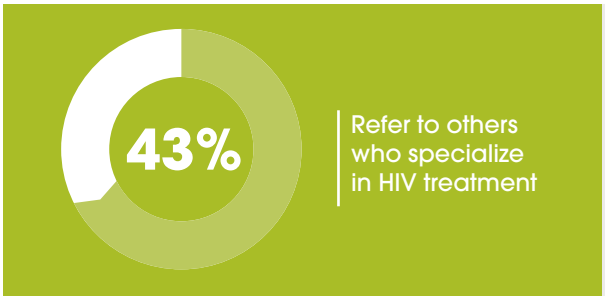

**44%** High HIV prevalence and HIV primary care demand in my area

**41%** Impact of HIV training or education

**33%** Job opportunity

**31%** Exposure to or interest in international/ population health

**Non-HIV PCPs were asked the reason why they do not provide HIV care. Main reasons identified were:**




**28%** None of their patients are living with HIV

**22%** HIV care is not relevant to their setting or specialty

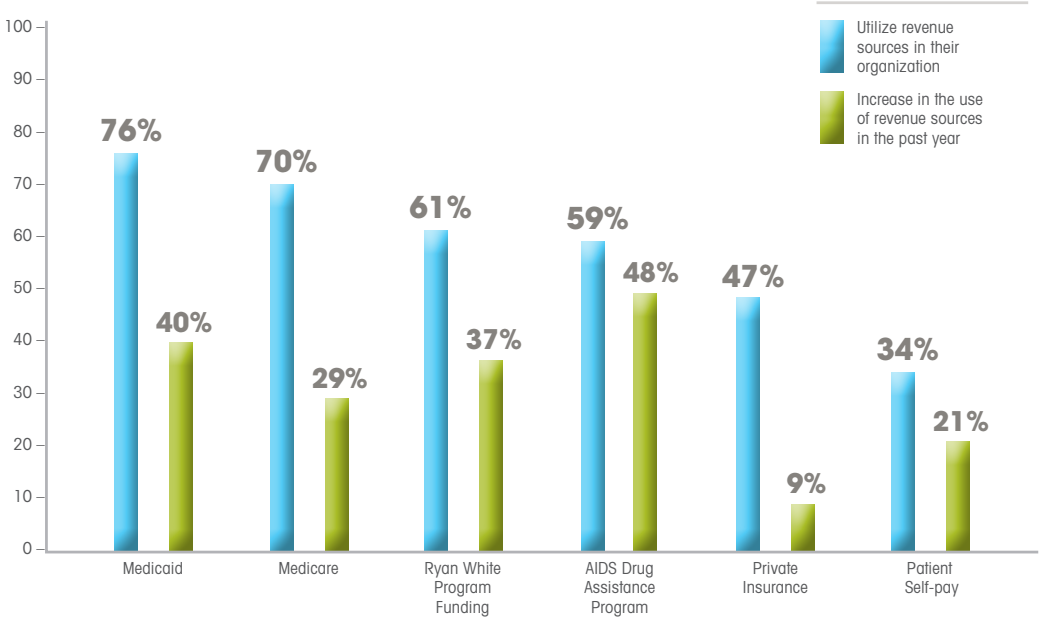
## Public Funding Driving HIV Services

Over three quarters of HIV PCPs **(76%)** stated that Medicaid supports HIV services in their practice setting. Nearly as many **(70%)** indicated that Medicare supported services. Other common funding includes:

- Ryan White program funding **(61%)**
- AIDS Drug Assistance Program **(59%)**
- Private Insurance **(47%)**

In addition, HIV PCPs saw an increase in the usage of these main funding sources during the past year.

### HIV Revenue Source Data




While a majority of HIV PCPs utilize Ryan White funding (including ADAP), they also indicate that they are not ready to transition patients from Ryan White to Medicaid and other forms of insurance. Only **27%** of HIV PCPs have a plan in place to transition patients, while **33%** were unsure of their organization's plan to transition patients. These findings indicate confusion regarding the PPACA and the future of the Ryan White CARE Act moving forward.

## Partnerships

In addition to reliance on public funding, a majority of HIV PCPs partner with public/nonprofit organizations to coordinate and deliver HIV care and treatment services. The most common partnerships occur with:

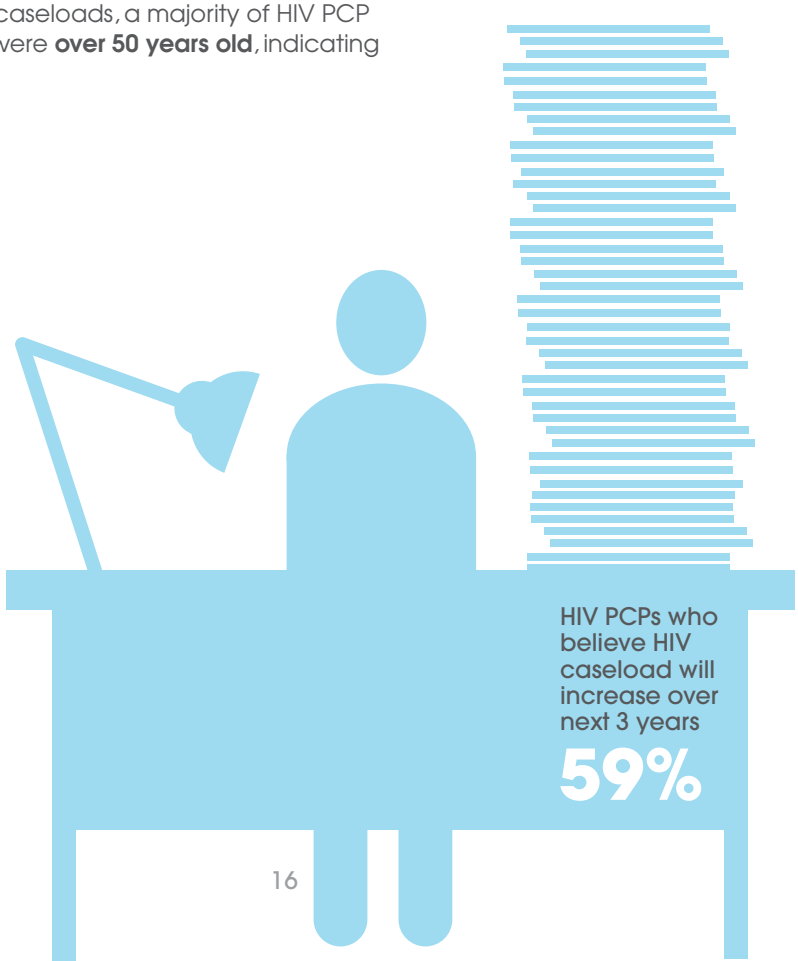
- Local/State Health Departments **(62%)**
- AIDS Service Organizations **(53%)**
- Community-Based Organizations **(48%)**
- Social Service Providers **(42%)**

## Increasing Caseloads for HIV PCPs

Survey respondents identified challenges in the HIV workforce:

- **50%** of HIV PCPs see over 100 HIV clients and nearly half **(49%)** have seen an increase in their HIV caseloads in the past 12 months
- More HIV PCPs **(59%)** have seen an increase in their total patient caseloads than their non-HIV PCP counterparts **(46%)**
- **Over half (59%)** of HIV PCPs believe their HIV caseload will increase over the next three years. The most frequently cited reasons identified were:
  - Increased number of HIV patients seeking care in my practice setting **(90%)**
  - Staff turnover leading to increase in HIV patient caseload **(28%)**
  - Practice improvements allow me to see more HIV patients **(25%)**
- Fewer HIV PCPs **(17%)** indicated that health exchanges will require their practice to provide HIV care
- **4 in 10** respondents **(40%)** stated that the number of providers treating HIV in their service area is less than the demand for HIV services

In addition to rising caseloads, a majority of HIV PCP respondents **(55%)** were **over 50 years old**, indicating an aging workforce.



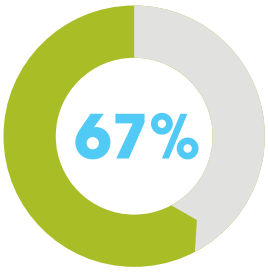
# Clinical HIV Testing and Treatment Services

## HIV Testing Services

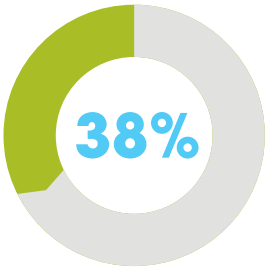
Survey respondents identified their process for conducting HIV testing. HIV PCPs were more likely to provide routine HIV testing than non-HIV PCPs (**67%** for HIV PCPs and **38%** for non-HIV PCPs).

Because nearly **9 in 10** credentialed HIV specialists surveyed worked in primary care, testing data results were compared between HIV PCPs who identified as HIV specialists with those that did not. Findings show that HIV PCPs who identified as HIV specialists were significantly (P=<.005) more likely to conduct routine testing than HIV PCPs who were not HIV specialists. HIV PCPs who were not HIV specialists were significantly more likely to test based on identified risk factors as opposed to testing routinely.

### Offer Routine Testing

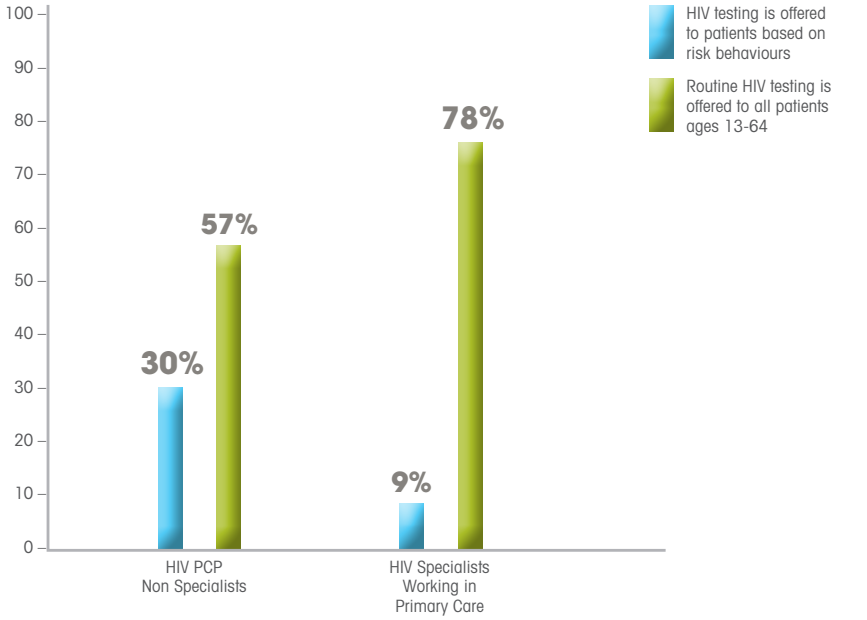



HIV PCPs




Non-HIV PCPs

### HIV Specialists More Likely to Routinely Test for HIV




## HIV Treatment Services

HIV PCPs were asked to identify which HIV clinical services they offered and which they referred out.

**Most commonly referred HIV services**

**36%** Management of hepatitis C co-infection

**31%** HIV rapid testing

**30%** HIV medical case management

**29%** Pre-exposure prophylaxis – PrEP

**23%** Post-exposure prophylaxis – nPEP

**HIV PCPs refer the following specialized services**

**64%** Oral health care

**60%** Substance abuse treatment

**44%** Reproductive health services

**44%** Mental health care

### HIV Services Provided vs. Referred by HIV PCPs

| HIV Services | Service Provided | Service Referred | Neither Provide Nor Refer |
|---|---|---|---|
| **Low Complexity Services** | | | |
| **HIV treatment education** | **89%** | 10% | 1% |
| Adherence counseling | 88% | 9% | 3% |
| HIV prevention counseling | 86% | 10% | 4% |
| Sexual health behavioral assessment | 81% | 11% | 8% |
| Routine testing | 79% | 13% | 8% |
| HIV testing (conventional serum or oral fluid) | 78% | 17% | 5% |
| Linkage to care | 73% | 21% | 6% |
| HIV medical case management | 66% | 30% | 4% |
| **HIV rapid testing** | 59% | **31%** | **10%** |
| **Moderately Complex Services** | | | |
| **Sexually transmitted infection (STI) testing** | **90%** | 7% | 3% |
| **Sexually transmitted infection (STI) treatment** | **90%** | 5% | 4% |
| Immunizations (Hepatitis A/B) for PLWHA | 89% | 8% | 3% |
| Hepatitis C virus (HCV) screening | 89% | 8% | 3% |
| CD4 count monitoring | 88% | 10% | 2% |
| Prophylaxis for opportunistic infections | 88% | 8% | 4% |
| Viral load testing | 87% | 10% | 2% |
| Resistance testing | 81% | 16% | 2% |
| **Post-HIV exposure prophylaxis (nPEP)** | 70% | 23% | **7%** |
| Mental health care | 53% | 44% | 3% |
| Reproductive health services | 51% | 44% | 5% |
| **Oral health care** | 34% | **64%** | 2% |
| **Highly Complex Services** | | | |
| **Diagnosis and treatment for opportunistic infections** | **91%** | 7% | 2% |
| Antiretroviral therapy (ART) - initial | 86% | 11% | 3% |
| Antiretroviral therapy (ART) - 2nd or 3rd line | 81% | 16% | 3% |
| Retention in care | 80% | 16% | 5% |
| Management of hepatitis C co-infection | 59% | 36% | 5% |
| **Pre-HIV exposure prophylaxis (PrEP)** | 49% | 29% | **22%** |
| **Substance abuse treatment** | 35% | **60%** | 5% |

## HIV Treatment Services

**Findings show that HIV PCPs who identified as HIV specialists were significantly more likely to provide services than HIV PCPs who were not specialists.**

| Services Provided | HIV Specialists Working in Primary Care | HIV PCP: Non-Specialists |
|---|---|---|
| **Low Complexity Services** | | |
| **HIV treatment education** | **99%** | **81%** |
| **Adherence counseling** | 96% | **81%** |
| HIV prevention counseling | 95% | 79% |
| Sexual health behavioral assessment | 90% | 74% |
| Routine testing | 82% | 76% |
| Linkage to care | 81% | 66% |
| HIV testing (conventional serum or oral fluid) | 79% | 76% |
| HIV medical case management | 76% | 58% |
| HIV rapid testing | 64% | 54% |
| **Moderately Complex Services** | | |
| **Prophylaxis for opportunistic infections** | **99%** | 79% |
| **Sexually transmitted infection (STI) testing** | 95% | **87%** |
| **Sexually transmitted infection (STI) treatment** | 95% | **87%** |
| Immunizations (Hepatitis A/B) for PLWHA | 95% | 84% |
| CD4 count monitoring | 94% | 83% |
| Viral load testing | 94% | 82% |
| Hepatitis C virus (HCV) screening | 94% | 84% |
| Resistance testing | 92% | 72% |
| Post-HIV exposure prophylaxis (nPEP) | 78% | 63% |
| Mental health care | 64% | 44% |
| Reproductive health services | 54% | 48% |
| Oral health care | 37% | 30% |
| **Highly Complex Services** | | |
| **Antiretroviral therapy (ART) - initial** | **99%** | 75% |
| Antiretroviral therapy (ART) - 2nd or 3rd line | 99% | 66% |
| **Diagnosis and treatment for opportunistic infections** | 97% | **85%** |
| Retention in care | 88% | 72% |
| Management of hepatitis C co-infection | 68% | 52% |
| Pre-HIV exposure prophylaxis (PrEP) | 56% | 43% |
| Substance abuse treatment | 40% | 31% |

## HIV Treatment Services

While nearly half of HIV PCPs indicated they provide PrEP services **(49%)**, only **35%** have actually implemented PrEP with a patient.

**Main reasons cited for providing PrEP were:**

- Working with high-risk or targeted patient populations **(28%)**
- Blood-born pathogen exposure or post-exposure prophylaxis **(21%)**
- Used with serodiscordant couples **(17%)**

**Main reasons cited for not implementing PrEP were**

**26%** Patients do not fit profile

**21%** Cost

**20%** All of their patients are living with HIV

**14%** No interest from patients

## Gaps in Hepatitis C Care Capacity

Nearly all **(89%)** HIV PCPs provide hepatitis C (HCV) screening and **97%** indicated that they provide HCV screening either to all patients born between 1945 and 1965, or based on identified risk factors, both of which are consistent with current HCV screening guidelines. While vast majorities of HIV PCPs provided HCV screening services, fewer are providing treatment for hepatitis C co-infection. More than a quarter **(27%)** of HIV PCPs saw an increase in HCV co-infection in the previous 12 months. Only slightly more than half **(59%)** manage HCV co-infection and **40%** stated that they are in need of education in the management of HCV co-infection.

**40%**
of HIV PCPs said highest educational need:
**HCV co-infection**

**27%**
**of HIV PCPs saw an increase in the number of patients with HCV co-infection in the previous 12 months**

## Co-Occurring Conditions

HIV PCPs were asked to indicate any changes in the incidence of co-occurring conditions in their HIV-positive patients in the past twelve months. The largest increases in co-occurring conditions were seen in:

**49%**
Obesity

**45%** Syphillis

**43%** Cardio-vascular Disease

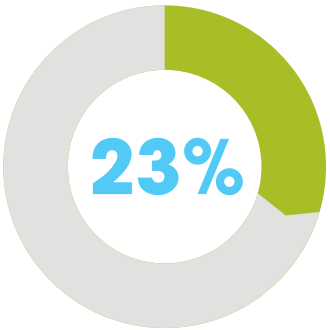
**42%** Depression

**40%** Renal Disease

## Changes in the Incidence of Co-Occurring Conditions

| Co-Occurring Conditions | Increase | No Change | Decrease |
|---|---|---|---|
| **Obesity** | **49%** | 44% | 2% |
| Syphilis | 45% | 43% | 7% |
| Cardiovascular disease | 43% | 52% | -- |
| Depression | 42% | 54% | 1% |
| Renal disease | 40% | 50% | 4% |
| Diabetes | 38% | 57% | -- |
| Hypertension | 37% | 58% | 1% |
| Cognitive impairment | 35% | 56% | 4% |
| Anxiety | 35% | 58% | 3% |
| Gonorrhea/Chlamydia | 32% | 59% | 4% |
| Substance use | 30% | 62% | 5% |
| Hepatitis C | 27% | 67% | 2% |
| Peripheral neuropathy | 24% | 59% | 12% |
| Liver disease (not related to viral hepatitis) | 24% | 67% | 1% |
| **Opportunistic infections** | 17% | 55% | **23%** |
| Tuberculosis | 12% | 64% | 18% |
| Hepatitis B | 11% | 79% | 5% |

**The largest decrease in co-occurring conditions was:**




Opportunistic Infections

# Provider and Patient Barriers to HIV Care

**37%**
Lack of support staff time

## PCP Barriers to Providing HIV Care

Survey respondents were asked to identify the most significant barriers they face in providing HIV care.

HIV PCPs identified structural barriers to providing HIV care that include:

- Lack of support staff time to take on new roles/ new procedures **(37%)**
- Transportation barriers **(32%)**
- Lack of clinical staff time to take on new roles/ new procedures **(28%)**
- Clinical hours of operation **(24%)**
- Lack of referral partners for services not offered in our organization **(21%)**
- No or minimal reimbursement for services **(17%)**

Non-HIV PCPs identified knowledge gaps as well as structural barriers that include:

- Lack of provider competency on HIV disease treatment **(23%)**
- Lack of clinical staff time to take on new roles/ new procedures **(22%)**
- Lack of support staff time to take on new roles/ new procedures **(20%)**
- Not the primary reason a patient is being seen **(17%)**
- Lack of available providers proficient in HIV **(14%)**

## PCPs Perceived Patient Barriers to Seeking HIV Care

Survey respondents were asked their perceptions on the most significant barriers people living with HIV encounter when seeking care.

**HIV PCPs identified barriers consistent with underserved populations that include:**

**62%** Substance abuse

**62%** Mental illness

**56%** Ability to pay

**50%** HIV stigma in community

**44%** Homelessness

**34%** Lack of transportation/ HIV treatment center too far

**In contrast, 31% of non-HIV PCPs said they were unsure of the barriers encountered by patients seeking care. Ability to pay (39%) was identified as the most common perceived barrier. Other common responses include:**

**26%** HIV stigma in community

**24%** Substance abuse

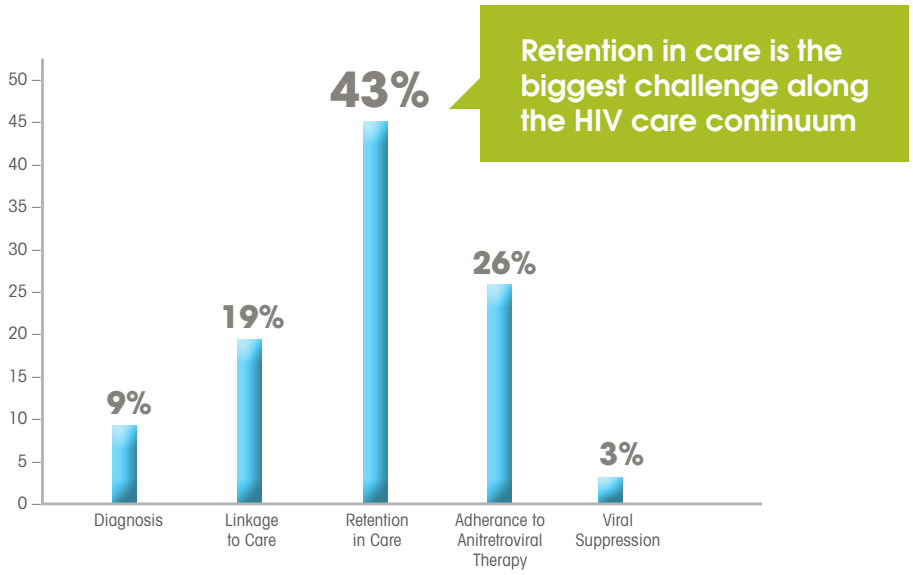
**18%** Mental illness

**18%** Lack of HIV health care providers in the community

# Provider Perspectives on Retention in Care

HealthHIV HIV PRIMARY CARE SURVEY

### Retention in Care a Key Challenge to the HIV Care Continuum




PCPs were asked to identify the most effective way to retain patients in care. HIV PCPs were asked specific to their HIV patients, while Non-HIV PCPs were asked more generally since they do not treat HIV patients.

For HIV PCPs, building relationships and improving access to support services are seen as the most effective ways to retain HIV patients, each cited by a third of respondents in open-ended format:

- Build a strong patient-provider relationship **(31%)**
- Help patients access support services and resources **(30%)**

The other frequently mentioned suggestions for retaining HIV patients in care are:

- Offer comprehensive services **(22%)**
- Follow up with patients **(20%)**
- Provide excellent care **(10%)**

Non-HIV PCPs also identified building a strong patient-provider relationship **(33%)** as one of the most effective practices to retain patients in care.

The other practices identified were:

- Provide excellent care **(33%)**
- Listen to and communicate with patients **(13%)**
- Provide good customer service **(11%)**
- Educate patients and answer their questions **(8%)**

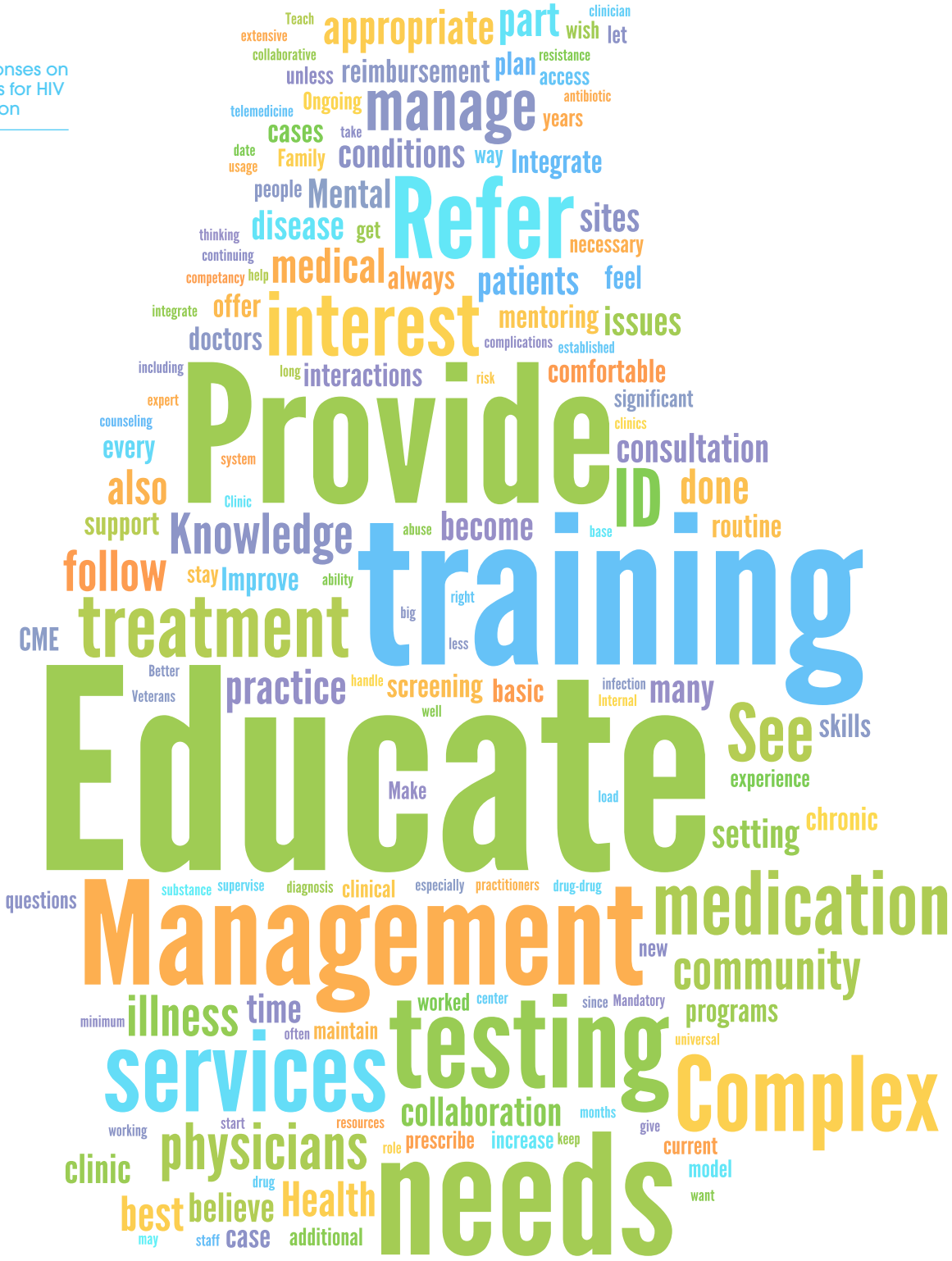
**31%**
of HIV PCPs dentified a strong patient-provider relationship as key to retaining HIV patients



HealthHIV

# Provider Perspectives on HIV Integration into Primary Care

Provider responses on best strategies for HIV care integration



## "Primary Care Providers should be targeted and educated about HIV testing, diagnosis, and treatment. If a provider is not comfortable in treating a complex condition then the patient will suffer."

PCPs as a whole were asked to describe in open-ended format the best strategies to integrate HIV into primary care. Strategies identified by respondents were:

- Provide more clinical training and education for HIV **(48%)**
- Define a clear and limited role for PCPs **(29%)**
- Have specialists and PCPs collaborate or work side-by-side **(16%)**


## "Patients with HIV are best served by collaboration between the PCP, specialists (including but not limited to HIV specialists), social workers and community services."

While one of the main strategies identified was to define a clear and limited role for PCPs, opinions were split about the role they should play in offering HIV services.

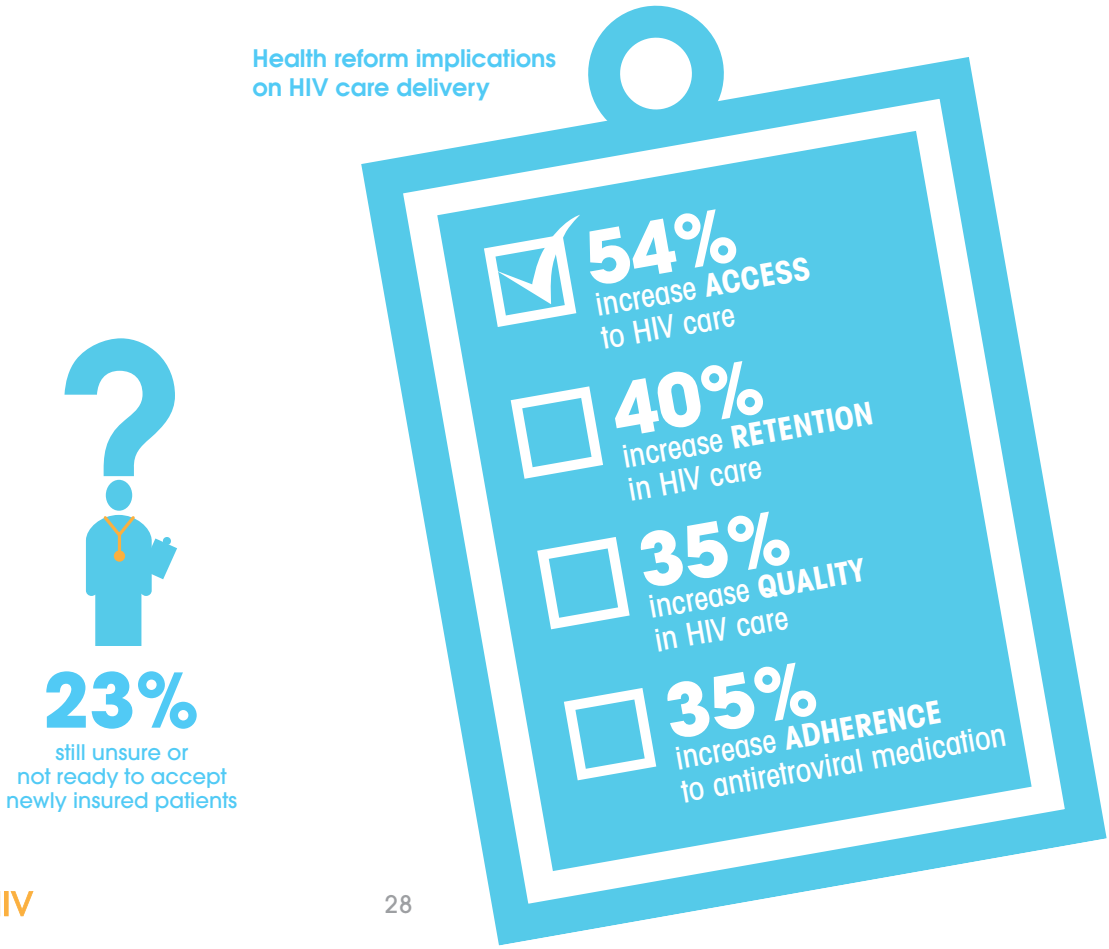
- **41%** believe that primary care providers should provide at least basic management of HIV and refer complex cases.
- **20%** believe that only clinical specialists should provide HIV care and another **19%** thought primary care providers should only test for HIV and refer out for care.
- **11%** believe that primary care providers should administer the full spectrum of HIV care.

# Provider Perspectives on Health Reform Initiatives and Implications

HIV PCPs were more likely than non-HIV PCPs to think that the PPACA will increase access to care, testing, diagnosis, linkage to care, and patient satisfaction for HIV-positive patients. However, fewer HIV PCPs thought that retention in care, quality of HIV care, and adherence would increase.

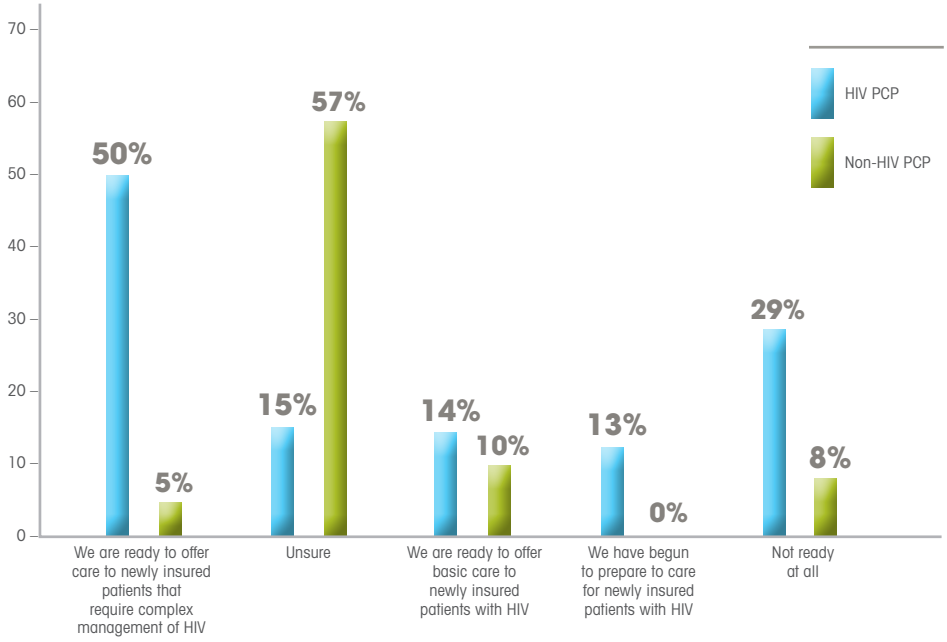
| Percent foreseeing an increase in: | HIV PCP | Non-HIV PCP |
|---|---|---|
| **Access to HIV care** | **54%** | **40%** |
| **Diagnosis of HIV infection** | 51% | **40%** |
| Testing for HIV | 51% | 39% |
| Linkage to HIV care | 52% | 36% |
| Patient Satisfaction | 45% | 30% |
| Retention in HIV care | 40% | 31% |
| Quality of HIV care | 35% | 32% |
| Adherence to antiretroviral medication | 31% | 29% |

While a majority of HIV PCPs **(57%)** believed the Ryan White Care Act would change as a result of the PPACA, one-third **(35%)** were still unsure if Ryan White would be affected.



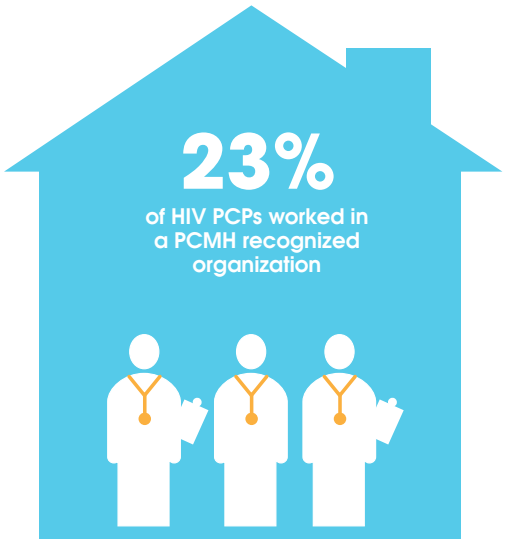
## Readiness to Provide HIV Care to Newly Insured

When asked how ready their organizations were to provide HIV clinical care to newly insured patients, a majority **(64%)** of respondents stated that their organizations were ready to provide basic HIV care or complex HIV care to the newly insured. However, **23%** were still unsure or not ready to accept newly insured HIV patients. Non-HIV PCPs were far less likely to work in organizations ready to care for the newly insured.




## Patient Centered Medical Home

Only **23%** of HIV PCPs worked in an organization that was PCMH recognized. A majority of HIV PCPs had a greater awareness of PCMH and it's 7 principles compared to non-HIV PCPs. A majority **(54%)** of non-HIV PCPs were unsure of the benefits to obtaining PCMH recognition.




| Benefits of PCMH Recognition | HIV PCP | Non-HIV PCP |
|---|---|---|
| **Enhanced patient access to care** | **53%** | 31% |
| Improved health outcomes | 49% | 34% |
| Enhanced communication between providers and patients | 49% | 34% |
| Improved quality of care | 51% | 32% |
| Increased retention in care | 47% | 26% |
| Enhanced reimbursement from Medicare and Medicaid | 41% | 23% |
| **Unsure** | 28% | **54%** |


HIV Infection and AIDS
Increasing in Women
• In 1992, 14% of AIDS patients were women[1]
• In 2007, 23% of AIDS patients were women[2]
• In 2007, women were estimated to make up 26% of new HIV infections[3]
[1]CDC. HIV/AIDS Surveillance Report 1998; 10 (No 2): 1—43
[2]CDC. HIV Surveillance Report 2007; 19( No. 1): 1-43
[3]CDC HIV/AIDS Surveillance Supplemental Report - Volume 14, Number 2

# Provider Educational Needs

HealthHIV HIV PRIMARY CARE SURVEY

**Clinical HIV educational needs most identified by HIV PCPs were:**

**40%** Management of hepatitis C co-infection

**36%** Retention in care

**34%** Antiretroviral therapy – 2nd or 3rd line

**32%** HIV treatment education

**32%** Mental health care

**28%** PrEP

**Clinical HIV educational needs most identified by non-HIV PCPs were:**

**36%** HIV prevention counseling

**36%** HIV treatment education

**33%** HIV rapid testing

**33%** HIV routine testing

**31%** Sexual health behavioral assessment

**30%** Diagnosis and treatment for opportunistic infections

| Educational Topic Areas | HIV PCP | Non-HIV PCP |
|---|---|---|
| **Low Complexity Services** | | |
| **HIV treatment education** | **32%** | **36%** |
| Sexual health behavioral assessment | 26% | 31% |
| HIV medical case management | 25% | 23% |
| Linkage to care | 25% | 14% |
| Adherence counseling | 25% | 17% |
| **HIV prevention counseling** | 24% | **36%** |
| HIV rapid testing | 20% | 33% |
| HIV routine testing | 16% | 33% |
| Conventional HIV testing | 12% | 24% |
| **Moderately Complex Services** | | |
| **Mental health care** | **31%** | 24% |
| Resistance testing | 26% | 11% |
| Post-HIV exposure prophylaxis (nPEP) | 19% | 28% |
| Reproductive health services | 17% | 16% |
| Oral health care | 17% | 14% |
| **Treatment for sexually transmitted infections** | 15% | **27%** |
| Prophylaxis for opportunistic infections | 14% | 22% |
| CD4 count monitoring | 13% | 23% |
| Screening for sexually transmitted infections | 12% | 24% |
| Hepatitis C virus (HCV) screening | 12% | 23% |
| Viral load testing | 11% | 19% |
| Immunizations (Hepatitis A/B) for PLWHA | 11% | 16% |
| **Highly Complex Services** | | |
| **Management of hepatitis C co-infection** | **40%** | 23% |
| Retention in care | 36% | 10% |
| Antiretroviral therapy - 2nd or 3rd line | 32% | 17% |
| Pre-HIV exposure prophylaxis (PrEP) | 28% | 18% |
| Substance abuse treatment | 24% | 19% |
| **Diagnosis and treatment for opportunistic infections** | 20% | **30%** |
| Antiretroviral therapy - initial | 19% | 22% |

# Trending Analysis

Trending analysis was conducted to identify similarities and differences between past surveys and the third annual survey. Results identified trends in the HIV PCP profile, co-occurring conditions, and barriers to providing and seeking HIV care. HealthHIV's Second Annual State of HIV Primary Care Survey identified a profile of the typical HIV PCP based on respondent demographics.

The profile of survey respondents for the third annual survey closely mirrors the profile identified in the previous survey, with the exception of practice types and specialties. Similarities were also seen in the percentage of respondents who saw an increase in certain co-occurring conditions, including sexually transmitted infections, mental health conditions, cardiovascular disease, and renal disease. However, obesity was added to the list of co-occurring conditions for the third survey and was the most identified condition.

Barriers to providing care and perceived barriers to seeking care were identical from the second to third survey. Educational needs most identified in each year indicate the need for more training on the management of hepatitis C co-infection and mono-infection.

| HIV PCP Profile | 2nd Annual Survey | 3rd Annual Survey |
|---|---|---|
| Ethnicity: Non-Hispanic | 83% | 83% |
| Race: White | 68% | 72% |
| Gender: Female | 58% | 57% |
| Age: 50-59 | 40% | 37% |
| Setting: Urban | 64% | 70% |
| **Main Specialty** | **Family Practice 46%** | **HIV/AIDS 30%** |
| Region: South | 39% | 36% |
| **Main Practice Type** | **CHCs 36%** | **HIV Clinics 26%** |
| **Common Co-Occurring Conditions** | **2nd Annual Survey** | **3rd Annual Survey** |
| | Sexually transmitted infections **58%** | Obesity **49%** |
| | Cardiovascular disease **50%** | Syphillis **45%** |
| | Renal disease **49%** | Cardiovascular disease **43%** |
| | Mental health issues **48%** | Depression **42%** |
| | Substance use **88%** | Renal disease **40%** |
| | Hepatitis C **36%** | -- |
| **Barriers to Providing Care** | **2nd Annual Survey** | **3rd Annual Survey** |
| | Lack of clinical staff time to take on new roles and procedures **45%** | Lack of support staff time to take on new roles and procedures **37%** |
| | Patient transportation barriers **42%** | Transportation barriers **32%** |
| | Lack of referral partners for services not offered **41%** | Lack of clinical staff time to take on new roles/new procedures **28%** |
| | Lack of reimbursement for services **37%** | Clinical hours of operation **24%** |
| | Lack of support staff time to take on new roles and procedures **36%** | Lack of referral partners for services not offered in our organization **21%** |
| | -- | No or minimal reimbursement for services **17%** |
| **Perceived Barriers to Patients Seeking Care** | **2nd Annual Survey** | **3rd Annual Survey** |
| | Mental illness **67%** | Substance abuse **62%** |
| | Substance abuse **63%** | Mental illness **62%** |
| | Ability to pay **57%** | Ability to pay **56%** |
| | Stigma **52%** | HIV stigma in community **50%** |
| | Homelessness **45%** | Homelessness **44%** |
| | English proficiency **28%** | Lack of transportation/ HIV treatment center too far **34%** |

# Implications

HealthHIV is reviewing the survey results and will distribute a full analysis. Initial implications:

- PCPs need HIV clinical education regardless of whether they currently treat HIV.
- There is greater need to leverage HIV specialists as mentors for PCPs to address workforce shortages.
- HIV PCPs are strained and face workforce challenges that will only increase in the coming years as more HIV-positive people enter care.
- An increase in resources in underserved communities and communication among provider types will help identify best practices for retention in care.
- A strong correlation exists between mental health and substance abuse and poor health outcomes for people living with HIV. As health reform is implemented, providers should receive training on addressing these challenges in the HIV community.
- Providers should be trained more thoroughly on health reform, especially changes to service delivery and reimbursement.

# Roadmap to HIV Primary Care Integration

HealthHIV
HIV PRIMARY CARE SURVEY

## Recruit HIV Workforce

**55%** of HIV PCPs are over 50 years old

**49%** experienced increased HIV caseloads

**4 in 10** think the supply of HIV services is less than demand

## Educate PCPs on HIV

**48%** need clinical training to integrate HIV into primary care

**23%** of non-HIV PCPs cited lack of provider competency in HIV

**1/3rd** of HIV PCPs need training on retention, treatment education, and HCV co-infection

## Treat the Whole Patient

**36%** of HIV PCPs refer out for HCV co-infection

**49%** saw increase in obesity among HIV patients

**42%** saw increase in depression among HIV Patients

## Collaborate with Colleagues & Consumers

**87%** of HIV specialists work in primary care

Only **23%** work in PCMH recognized organizations

**Strong patient-provider relationship** cited as best practice for retention in care

## ACT on the PPACA

**61%** of HIV PCPs rely on Ryan White funding

**35%** unsure of ACA impact on Ryan White

**73%** do not have a plan to transition from Ryan White to other payment methods



HealthHIV

# HealthHIV Programs

## National Center for Healthcare Capacity Building

### Capacity Building for Health Departments
Scales-up high-impact HIV prevention programs, and strengthens HIV infrastructure

### Capacity Building for Community Health Centers (CHCs)
Increases access to comprehensive HIV care (prevention and treatment) for ethnic and racial minority communities severely impacted by HIV

### HIV Workforce Capacity Building Initiative
Provides HIV expert mentoring to clinicians through one-on-one expert coaching, education, and training

### Remaining Relevant in the New Reality
Emphasizes accountability and focuses on high-impact, scalable prevention strategies within the ever-changing healthcare landscape

## Research & Evaluation

### HIV Primary Care Survey
Assesses the current state of integrating HIV care and treatment services into primary care in light of the rapidly changing healthcare landscape in the dynamic health care environment by syncing systems, programs, models, and policies

### HealthHIV Research and Evaluation
Conducts original research using data collection and mapping to guide and enhance HealthHIV's work across its capabilities, conduct continuous quality improvement in programming, and disseminate findings

# Education & Training

### HIV Primary Care Training and Certificate Program
A web-based continuing medical education (CME) program approved for AMA PRA Category 1 Credits™

### Fiscal Health
Ensures the fiscal sustainability of Ryan White funded grantees by building organizational fiscal management capacity

### HIV Primary Care Plus
Performance Improvement CME designed to support clinicians delivering primary care to patients with HIV by integrating mentoring and performance-measure based education into clinics

### SYNChronicity
Annual meeting to prepare individuals and organizations to succeed in the dynamic health care environment by syncing systems, programs, models, and policies

# Advocacy

### Advocacy
Engages leaders at all levels of government to address improving health disparities, treating the medically underserved, understanding the changing primary care setting, advancing chronic disease management and the medical homes movement, and redefining how HIV fits into the broader healthcare environment

### Pozitively Healthy Coalition
A national advocacy coalition composed of people living with HIV (PLWH) and their allies advancing equitable access to HIV competent healthcare and evidence-based treatment

### HealthHCV
Advances hepatitis C (HCV) advocacy and education by providing key advocacy messages to providers and consumers and presenting HCV data and information in compelling, contextual visuals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