



# **TRAIN. RETAIN. SUSTAIN.**

Addressing the HIV Workforce Gap



## BACKGROUND

The HIV healthcare workforce, grounded in the use of interdisciplinary teams, includes clinical and supportive non-clinical team members working to provide status-neutral HIV care across the United States and its territories (U.S.). This care includes the prevention of new HIV infections through post-exposure prophylaxis (PEP), pre-exposure prophylaxis (PrEP), substance use and sexual practice harm reduction, and perinatal transmission prevention interventions. For people with HIV (PWH), clinicians and teams strive to provide tolerable, individualized antiretroviral therapy (ART), address comorbidity prevention and management, and provide support to address detrimental social determinants including unsafe or unstable housing, food instability, stigma, discrimination, no or limited health insurance, poor health literacy, and poverty. As our understanding of HIV treatment and prevention has improved and newer treatment options have been made available, treatment of HIV has become less complicated. PWH are living fuller life expectancies. However, with an incidence of more than 30,000 new infections per year<sup>1</sup> and fewer HIV-related deaths per year, HIV prevalence in the U.S. is increasing.<sup>2</sup> With improved health outcomes of PWH receiving care, the U.S. population of PWH has also been aging which brings additional demands to HIV care teams as they address comorbidities and health conditions of an aging population. **Yet, since 2010, the U.S. HIV workforce has been declining.**<sup>3</sup>



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Recognizing the shift in HIV care delivery and the strained HIV workforce, the **U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA)** has focused its efforts on strategies that address the ongoing needs of PWH and the clinicians who care for them. In 2010, HRSA funded a national study to determine the number of clinicians providing HIV care in the U.S. and project future supply and demand of the HIV clinician workforce. The study identified several factors leading to an HIV workforce shortage, including the aging of HIV care clinicians and fewer clinicians entering the field of HIV as compared to other specialties.<sup>3</sup>



## CURRENT SURVEY

# 1,004

Total sample of eligible, completed surveys

Sampled Gender Identity



FEMALE

**58%**



MALE

**40%**



NON-BINARY

**1%**

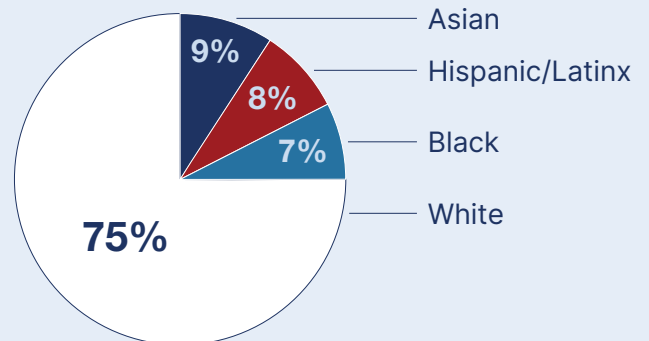


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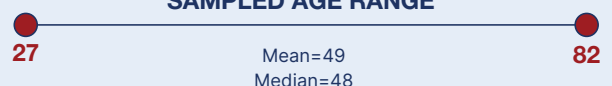
**1%**

In 2019, HRSA charged The AIDS Education and Training Center (AETC) National Coordinating Resource Center (NCRC) with reevaluating the current and future HIV clinician workforce needs in the U.S. From 2021 – 2022, the AETC NCRC conducted a study in which a 32-question, one-time, self-administered survey was developed and disseminated nationally to licensed healthcare clinicians in the U.S. who prescribe HIV antiretroviral medications to project the numbers of clinicians who will continue to provide HIV-related care over the next 5 years.<sup>4</sup>

### SAMPLED RACE/ETHNICITY



### SAMPLED AGE RANGE



Of the 1,004 survey respondents, 492 (49.2%) of respondents reported expectations of increasing the number of patients with HIV they care for over the next 5 years, and 330 (33.0%) reported expecting to serve the same number of patients with HIV.<sup>4</sup>

## 5 YEAR PREDICTIONS\*

The number of PWH I care for will increase:	49.2%
The number of PWH I care for will remain the same:	33.0%
The number of PWH I care for will decrease:	7.3%
I will stop providing care to PWH altogether:	10.5%

\* Predictions made in 2022 reflecting changes in 2027



### Predictors of continuing to provide HIV care beyond 5 years included:

- » **Profession** – Advanced practice registered nurses (APRNs) inclusive of nurse practitioners (NPs)
- » **Specialty** – Family Medicine physicians
- » **Race** – Black or African American identifying
- » **Age** – Less than 45 years old



### Top reasons given for leaving or decreasing HIV care practice included:

- » **Retiring** from medical practice or reducing number of hours worked in medical care
- » Too much time spent on documentation and other **administrative work**
- » General **burnout**
- » **Inadequate support services** to assist with the care of patients with HIV
- » **Other** – including the federal End the HIV Epidemic (EHE) initiative



### Interesting Findings

- No statistically significant differences between Ryan White HIV/AIDS Program (RWHAP) funded and non-RWHAP funded clinicians
- No statistically significant differences between metropolitan and non-metropolitan (rural, non-metropolitan urban) clinicians
- No statistical significance found in working with more team members

## Illustrations from survey respondents included the following:

- “As a physician, medical management of HIV has become quite simple. **Addressing mental health** and **social determinants of health** with ancillary providers (i.e., social workers, mental health practitioners) is becoming **more important than ever** in reaching those who need it most.”
- “Consider **expanding Ryan White Part A funding beyond typical metropolitan areas**, to ASOs [AIDS Service Organizations] that provide care to communities/HSDAs [Health Service Delivery Areas] with over 1 million population.”
- “**Revise the national health care system.** Enhance support for all parts of primary care and provide more training exposure for student residents in a functional practice.”
- “Providing the highest quality comprehensive HIV care requires a **commitment to ongoing education, knowing who to consult with** for the more challenging cases that do come up...”
- “Currently, in addition to insufficient [numbers of] physicians, **lack of nursing [staff]** and [the] **ability to refer internally for mental health care** are serious **impediments** to providing the best care I can to my patients.”
- “A major struggle is **balancing providing primary care and HIV care** for an aging population with an increasingly complex comorbidity burden and geriatric care needs. I think **more personnel support** for ID [infectious disease]-trained HIV providers in these areas would be helpful.”
- “**Severe shortages** threaten the success of full-service HIV clinics. Open positions with grant funds for social work, nursing, and providers have no applications. The shortages result in further burnout and turnover. Our patients are challenging, and **we need people dedicated to the cause, who work for more than the money.**”



## RECOMMENDATIONS

The **AETC Program**, the training arm of the **Ryan White HIV/AIDS Program (RWHAAP)**, is a national network of leading HIV experts who provide locally based, tailored education, clinical consultation, and technical assistance to healthcare professionals and healthcare organizations working with people with or vulnerable to acquisition of HIV. With more than **35 years** of program experience, the AETC Program is uniquely positioned to address many of the identified needs. To leverage the work of the AETC Program, the following strategies are recommended:

- » Allocate **funding** toward the development and stabilization of programs that focus on **HIV education** for **pre-license students** across health profession programs and expand the scope of the AETCs to address these needs. It is highly recommended that the utilization and integration of the **AETC National HIV Curriculum** be used and expanded in this strategy.
- » Factors that influenced students to provide HIV care included clinical **preceptorship experiences** directly working with PWH.<sup>4</sup> HRSA HAB has funded medical residency, nurse practitioner, and physician assistant programs to increase the number of clinicians prepared to provide HIV-related care. Despite being successful, several of these entities were **not able to sustain programs** once funding ceased. Tied to this is an opportunity to expand interprofessional education (IPE) and training programs. **IPE programs** provide learning opportunities for pre- and post-license students from various disciplines to collaborate, communicate, and provide **team-based care** that can lead to improved quality of care of patients.

- » **Expand** HIV, sexually transmitted infections (STIs), and viral hepatitis preceptorships, fellowships, and residencies for physicians and nurse practitioners in family medicine, primary care, internal medicine, and others. As an example, a **model HIV fellowship** was initiated by the New England AETC local partner UMass Chan Medical School in 2014. The fellowship included physicians and nurse practitioners. Based on a qualitative study conducted, fellowship graduates reported that they **developed** the **skills needed** to address **HIV comorbidities**, improved healthcare outcomes of their patients, improved their communication skills, and developed leadership skills.<sup>6,11</sup>
- » **Expand practice transformation** and training in **primary care** settings to promote the integration of **status neutral** HIV care continuum services (testing, prevention, and treatment). Practice transformation funding for a variety of clinics and clinical settings (e.g., rural, emergency department and urgent care settings) are needed in addition to the ongoing primary care clinical site supported.
- » Support role shifting to include the provision of laboratory testing, PEP and PrEP administration, and STI treatment by **pharmacists**.
- » Provide **funding** for comprehensive, patient-centered healthcare and the inclusion of **oral health** professionals, **pharmacists**, **mental** health clinicians, **nutritionists**, **physical** and **occupational** therapists, **community** health workers, navigators, public health **disease intervention** specialists, and case managers in addition to medical and **nursing** professionals. Participants in the HIV Workforce Study indicated that healthcare students would be more inclined to provide HIV care if they worked in a team-oriented clinical setting.
- » Address **confusion** about **EHE** efforts to ensure that clinicians and the public are aware that the goal is to reduce newly diagnosed HIV infections to less than 3,000 per year, and not completely eradicate HIV by 2030. Healthcare professional students must understand that there will still be a significant need for clinicians to provide ongoing HIV care to PWH after 2030.
- » Recognize and support **changes** that enhance needed **data collection** and clinical encounter documentation while reducing administrative burdens experienced by the healthcare team. Offer support to healthcare organizations to **reduce** clinician **administrative burden** and burnout including educating about and improving coding and billing systems to enhance reimbursement for needed comprehensive care (i.e., time spent with established patients with comorbidities and addressing social determinants).
- » Ensure the availability of **clinician resiliency training** and interventions to mitigate the premature exodus from clinical care.<sup>12</sup>

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