Integrating HIV Care - Case
Transforming HIV Care at the East Village Family Medicine Clinic[1]

Introduction

Dr. Reichen sat at her desk reflecting on the meeting she had just concluded with a group of clinicians and staff from the East Village Family Medicine Clinic (EVFMC). The meeting marked the launch of a broader transformation initiative in the Department of Family Medicine's (DFM) two ambulatory care units - EVFMC and the Metro Core Clinic System (MCCS).

The initiative planned to tackle the current staffing and care gaps, service line silos, and limited interprofessional collaboration within DFM's clinics. These issues were driving fragmented, sub-par care for patients, and poor use of clinician time to do tasks that could have been done as well or better by other staff members at a lower cost. Clinicians were extremely frustrated by the time it took for them to do tasks that they perceived to be outside of their responsibilities and that they recognized they could not do efficiently without specific time allocations and training. The transformation initiative sought to identify and address the care and coordination gaps, reduce service line silos and move toward a more integrated, interprofessional team based model of care.

Dr. Reichen had met with the EVFMC staff involved in HIV care to start identifying the gaps in HIV care and care coordination at EVFMC. The group included a nurse practitioner (NP), a physician, a pharmacist, the three RNs and four medical assistants who regularly floated to work in HIV care, as well as a clinical psychologist who provided some in-house counseling services to patients with HIV infection or AIDS.

Dr. Reichen had chosen the HIV service line at EVFMC to pilot her transformation initiative for several reasons. Most importantly, HIV care was inherently complex requiring the involvement of multiple professions and physician specialists and research had shown the positive impact of comprehensive, integrated care, built around interprofessional collaboration. Despite the barriers to comprehensive interprofessional HIV care at EVFMC most of the members of the HIV group were collaborative in nature. An added bonus, Dr. Sabba, the physician in the group was a passionate champion of interprofessional education and collaboration.

Joan Reichen, MD, MPH

Dr. Reichen, a practicing family physician for over thirty years, a faculty member in the DFM for over twenty years, had been appointed Department Chair four years prior. Dr. Reichen firmly believed this transformation was needed to address short term deficiencies in care outcomes, costs, and staff satisfaction at the DFM clinics. Longer term, Dr. Reichen saw the need to get ahead of the shifting reimbursement landscape,

[1] Case created by Frank Borgers, PhD, Health Policy and Administration, School of Public Health, University of Illinois at Chicago, in 2016. This case is a companion piece to, and should be taught in conjunction with the HIPEP curriculum module *"Integrating HIV Care - Foundation."*

which was inexorably moving away from physician based, fee-for-service care and toward value-based care, which punished and rewarded providers based on their ability to manage the health of their patient populations - a daunting challenge. In short, there was lot riding on making the EVFMC HIV pilot a success.
While enthusiastic about the initiative she had launched, Dr. Reichen was aware of the challenge she faced in winning the support and commitment of her faculty and clinic staff. The university and its academic medical center had seen high senior leadership turnover over the last few years, with each leadership change accompanied by new change efforts, none of which had delivered much concrete change. Faculty and clinic staff had, unsurprisingly, grown somewhat cynical about such change efforts.

Dr. Reichen hoped her long tenure at the university and leadership in the department would buy her enough trust and goodwill from her colleagues and clinic staff to convince them that this effort was different. In addition, Dr. Reichen had recently assumed the role of EVFMC's clinic Director and she hoped that this would give her the level of oversight and direct participation needed to make the project a success. Dr. Reichen also firmly believed that healthcare leaders had to "walk the walk" not just "talk the talk" in order to win the support and commitment of their care teams.

The HIV Care Group at the East Village Family Medicine Clinic

Ann Remnart, FNP, MPH: Ann Remnart had been engaged in HIV/AIDS care since she had started practicing as a registered nurse in 1987, not long after the start of the AIDS epidemic, and at the height of public attention and debate about the AIDS crisis in the US. Ann was proud to have contributed to the extraordinary progress in HIV care over her thirty years in practice. At the same time, the intensity, passion, and sense of battle amidst crisis, both medically and politically, has largely dissipated since the early days. In ways both good and bad, the life of an HIV clinician was now more tranquil but also less exciting than at the height of the crisis.

The nature of HIV care had shifted dramatically - from confronting a poorly understood, deadly epidemic, to helping patients live with a manageable albeit complex and chronic disease. In the mid-1990's, Ann had gone back to school to get a Master's degree in nursing to become a nurse practitioner and has been a licensed nurse practitioner since 2000. Today, Ann's biggest challenges often relate to managing her HIV patients' psychosocial issues and comorbidities. Her panel of twenty-five HIV patients consists largely of long-term patients who had been with her for years, most of whom have longstanding, consistent viral suppression. Most of Ann's patients visited her at EVFMC two to three times a year.

Ann had started at the DFM at UIC in 1993 and in her long and distinguished career she has served as DFM's Quality Manager and past EVFMC Clinic Director. Ann has developed national curricula for HIV/AIDS training for nurse practitioners within her College in collaboration with the Association of Nurses in AIDS Care (ANAC) and served on many of ANAC's regional and national committees.

Haroun Sabba, MD, MPH: Dr. Sabba joined the DFM faculty in 2005 and was promoted to Associate Professor in 2013. Dr. Sabba practiced both inpatient and outpatient family medicine with a particular interest in HIV and lesbian, gay, bisexual, and transgender health. As a gay male who came out in the mid to late 90s, Dr. Sabba saw the direct impact of life-saving emergent HIV treatment. Dr. Sabba felt a commitment to give back and be a provider for this community including being an advocate fighting against bias and discrimination.

Dr. Sabba had completed part of his residency at a west coast HIV Clinic, receiving mentorship from an interprofessional team of clinicians (a physician, a family nurse practitioner, and a physician assistant), and practicing as part of an interprofessional team that also included an on-site pharmacist, social worker, behavioral health specialist, and case manager. This experience cemented Dr. Sabba's commitment to both HIV care and to collaborative interprofessional, team based care.

Dr. Sabba started practicing in 2005 at a Metro Core Clinic System (MCCS) clinic in a predominantly low income, African-American community on the south side of the city. Dr. Sabba was explicit about generating his own panel of HIV patients through direct referrals from the other providers at the MCCS community outreach. When Dr. Sabba relocated his practice to EVFMC in 2008, much of his HIV patient panel followed him, despite the great distance from the south side. However Dr. Sabba did lose some of his HIV patients due to distance and transportation and insurance barriers. Dr. Sabba's panel of twenty HIV patients consists largely of his longer-term patients, most of whom have had longstanding, consistent viral suppression. Most of Dr. Sabba's patients visited him at EVFMC three times a year.

Like Ann Remnart, Dr. Sabba has been very engaged with the regional AIDS training and education center. As recognized by Dr. Reichen, much of Dr. Sabba's research and service work has focused on interprofessional collaboration and education and he has been a passionate advocate for ICP and IPE within the College of Medicine, the university, and his own profession.

Phil Segnarts, PharmD, BCBS, BCACP: Dr. Segnarts is a Dr. of Pharmacy, who started practicing at EVFMC in 2015. Dr. Segnarts is a faculty member of the College of Pharmacy. Dr. Segnarts completed residency training at the University of Michigan and has since practiced in urban academic medical centers providing care to primarily underserved and vulnerable populations. Dr. Segnarts provides several services in collaboration with EVCMCs providers and registered nurses related to chronic disease state management, HIV pre-exposure prophylaxis, and immunizations. His goal in practice as part of the EVFMC team is to ensure the provision of safe, effective, and rational medication therapy outcomes for all of EVFMC's patients. While not trained as an HIV specialist, Dr. Segnarts had developed a close working relationship with Ann Remnart and Dr. Sabba and had developed a keen interest and understanding of the complex pharmacology of HIV care.

Liv Streibner, Ph.D: Dr. Streibner, is a health psychologist, who started practicing at EVFMC in 2011. Dr. Streibner is the Director of Behavioral Science and an Assistant Professor of Clinical Family Medicine where she provides resident education in HIV related topics including sexual history taking, safer sex counseling, motivational Interviewing, giving HIV positive test results, and other behavioral medicine topics.

Dr. Streibner has had a long standing passion for HIV care stretching back to her role as a Student AIDS Educator while an undergraduate in psychology, through to her current research which focuses on the behavioral aspects of effective HIV care. Dr. Streibner's work in behavioral medicine allows her to work collaboratively with EVFMC's primary care providers on a number of health conditions, including obesity, diabetes, high blood pressure, substance use, disease prevention, HIV, and healthy behaviors. Dr. Streibner also sees patients for therapy for a number of conditions such as anxiety and depression, and has sub-specialties in sexuality and gender.

In the eight years that Dr. Streibner has been practicing as a health psychologist she has seen two major shifts in HIV care. Previously the focus in primary care was on identifying who should be tested whereas today everyone is tested and the focus has shifted to prevention. Previously the focus used to be more about existential issues, managing illness, and preparing for death. Today, care is more focused on adjustment and learning how to live with HIV, managing co-morbid physical and mental health conditions, and preventing infections. Stigma and communicating with family and partners remain big challenges.

Nurses: Three EVFMC nurses work primarily with the HIV providers:

> **Lisa Pulido, RN, MSN:** Lisa Pulido has been on staff at EVFMC since 2010. Graduating as an RN in 2000, she went onto get her MSN in 2006, specializing in HIV care. Lisa Pulido is a passionate HIV care advocate, serving in a city Chapter of the Association of Nurses in AIDS Care as both past president and program committee chair. She previously worked as a Nurse Epidemiologist and was then promoted to a Clinical Research Associate for the AIDS clinical trials unit of an academic medical center in another city. Lisa Pulido had taken the position at EVFMC when she relocated to the city because she needed the work and the clinic offered her the opportunity to engage in some hands-on HIV care. While Lisa Pulido loves working with the two HIV providers and their HIV patients, she feels that EVFMC's generalist focus and lack of a formal team-based HIV care model limit her to ability to fully apply her HIV care skills and passion.
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> **Chan Kee, RN**: Chan Kee has been on staff at EVFMC since 2008. She had been working with Dr. Sabba at the south-side MCCS clinic and took a position at EVFMC to continue to work with him. While not trained as an HIV specialist, Chan Kee had discovered a natural talent for dealing with the complex and challenging care needs

of the clinics HIV patients and developed a close working relationship with Dr. Sabba. While she continued to enjoy her HIV work and had subsequently developed a great working relationship with Ann Remnart, she also enjoyed the mix of patients

and lower intensity of the EVFMC care setting. While Chan can see the benefits of a focused team-based HIV care model, she is concerned that being a member of the HIV team may restrict her access to other types of patients.

Elena Castillo, RN: Elena Castillo is the most senior nurse at EVFMV, having been on staff at EVFMC since 2000, and getting promoted to the position of Administrative Nurse for the unit in 2010. She was trained as and sees herself as a family medicine nurse and defines this role as a generalist. Elena Castillo has limited interest in learning the complexities and nuances of HIV. While she has a great deal of empathy toward the HIV patients at EVMC her interests and passion lie in developing her leadership skills and advancing in clinic administration.

Medical Assistants: EVFMC is staffed by 10 Medical Assistants (MAs), who currently are assigned to one of the four care clusters, although they can float across clusters and providers. As a consequence, the MAs do not have a lot of specific HIV knowledge or skills and they have not been able to establish a personal relationship with the patients who have HIV infection or AIDS. In addition, there is not a sense of teamwork between the MAs and the clinical staff who make up the core HIV care team and given the challenges with the MA work culture (see below), the clinicians frequently end up managing patient flow and care processes themselves, which creates significant frustration and interferes with patient care.

East Village Family Medicine Clinic

Overview: East Village Family Medicine Clinic (EVFMC) is a medium size primary care clinic, that has around 35,000 patient visits per year, and it is affiliated with the DFM, in turn part of a large academic medical center located in a large mid-western city. EVFMC, along with the Metro Core Clinic System (MCCS) are part of DFM, staffed by DFM faculty, and provide both clinic rotations and residencies for DFM students. For an organizational chart of DFM, EVFMC, and MCCS see Appendix 1.

EVFMC is housed in a new commercial development located on the east perimeter of the university's urban campus, which is spread over a large mixed use urban area. The clinic consists of two floors, with four care clusters centered around four nursing stations, one on the first floor, and three on the second floor. EVFMC has an on-site pharmacy, located on the second floor. For a floor plan of EVFMC see Appendix 2.

Staffing:

Clinical Staff

- Attending physicians: 19; All Board Certified in Family Medicine. Three chronic disease management specialists and 2 are adolescent medicine specialists.

- Family Medicine Residents: 17
- Family Nurse practitioners: 3 – one specialist in chronic disease management
- PharmDs: 3
- Clinical Psychologist: 1 (part-time)
- Registered Nurses - 3

Other Staff -
Medical Assistants (MA): Ten, four of whom were Spanish bilingual, currently assigned to the four care clusters but who are floated to different clusters and providers based on day-to-day needs and staffing.
Front desk staff: 3
Pharmacy technicians - 3 for on-site pharmacy.

The RNs, MAs, front desk staff all belong to unions. The RNs have their own union and the MAs and front desk staff all belong to another union.

Patient Population: EVFMCs patient population includes the university students who are covered by the student HMO in additional to people from the community, university employees and others who chosen EVFMC as their primary care site. The primary service area (PSA) for EVFMC and the academic medical center consists of five zip codes that encompass sixteen of the forty-eight community areas that comprise the city. The sixteen community areas are just southwest and northwest of the city center and have some of the greatest health needs in the city.

While gentrification, including by the university itself, has reduced racial segregation to some extent, fourteen of the community areas have a minority population greater than 75% (minority includes Hispanic, Black and Asian populations). Thirteen of the community areas have a median household income lower than that of the city, with three areas having a median household income under half the city's median. Many of the communities in the PSA also have lower levels of educational attainment and higher rates of unemployment compared to the overall average for the city.

A significant number of community members within the PSA do not have health insurance (24% overall, 30% of Hispanics, 23% of Blacks, and 16% of Whites). With further implementation of the Affordable Care Act, the university anticipates a lower proportion of community residents to remain uninsured. However, many residents in the PSA may not be eligible for Medicaid or the commercial insurance due to immigration status. A community needs survey revealed that many residents indicate additional barriers to accessing care:

- When they needed medical care, 15% of all respondents reported that they could not get it. The most common barrier was the cost of care (24% of Blacks, 11% of Hispanics, and 10% of Whites).
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- The ability to afford prescriptions was a barrier for 22% of all respondents (27% of Blacks, 21% of Hispanics, and 14% of Whites).
- 37% of all respondents reported that they did not visit the dentist in the past year (41% of Blacks, 34% of Hispanics, and 32% of Whites),
- Participants cited additional barriers to accessing care, including the limited number of mental health facilities, lack of a regular source of transportation, and limited education and awareness around the type of care needed.

The community needs survey revealed that three of the ten top health conditions found in the PSA were mental health conditions. Diagnoses of depression, anxiety, and attention deficit hyperactivity disorder (ADHD) were found in each racial/ethnic category. A significant number of community members within the PSA suffer from depression (19% overall, 30% of Hispanics, 19% of Blacks, and 18% of Whites).

As described by one clinical staff member: *"Mental health is a big need. There is such a strong interaction between mental and physical health, which encompasses anxiety, depression, self-medication, overeating, and smoking. Many of these are comfort behaviors that happen as a result of other factors. There is a need to better integrate physical and mental health into one primary care network."*

The prevalence of violence in the communities within the PSA, and the trauma that often results from experience with violence, can also have a detrimental effect on mental health. For example, violent events can trigger posttraumatic stress disorder (PTSD). The data on homicide rates presented below suggest that the need for mental health services is likely to be disproportionately high in our PSA. Half of the communities in the PSA have homicide rates higher than the city rate and some have homicide rates that are more than three times the average for the city.

While many of EVFMCs HIV patients are long-time patients of the two HIV providers and come from all over the greater Chicago area, the clinic also has new HIV patients from the surrounding community, including the UIC student body, who are referred after initial diagnosis. EVFMC does not see patients without some form of insurance coverage, and does not receive Ryan White funding.

The Initial HIV Care Transformation Meeting

The initial HIV care transformation meeting had focused on identifying the gaps in HIV care and care coordination at EVFMC. Dr. Reichen had set this up as an open brainstorming session to get initial ideas on the table and she had emphasized that she needed to hear equally from everyone present and that she saw all voices as equal. All staff were invited to the meeting however not everyone attended due to not being scheduled to work at the time the meeting was held.

Based both on Dr. Reichen's knowledge of the DFM and EVFMC and the results of the brainstorming exercise, she had identified a series of challenges and opportunities for

integrating interprofessional team-based HIV care at EVFMC. Unfortunately, the list of challenges outweighed the opportunities. Dr. Reichen had grouped the challenges under two broad categories:

1. ***The lack of a comprehensive, integrated HIV care team staff:*** While EVFMC did have the potential for a comprehensive and integrated staff, there were currently significant gaps and barriers:

a. *Availability of Dr. Stegnars:* While Dr. Stegnars, the pharmacist, was a tremendous resource in the clinic, there were significant barriers to his availability:

- The entire EVFMC typically shared two to three on-site Pharm.D's, including Dr. Stegnars. While the HIV clinicians and prescribers did not always need Dr. Stegnar's input, there were frequently questions that came up during HIV patient visits, for example regarding potential drug interactions among the complex array of medications many HIV patients were taking, drug adherence, drug access including prior authorizations with insurers and sometimes the AIDS Drug Assistance Program (ADAP) applications.
- The pharmacy was located on the second floor while patient visits were primarily located on the first floor. Dr. Stegnars had to cover all the clinics that were in session, not just the HIV care clinic and so there were times when he was unable to provide consultation at the time of an HIV patient visit. In addition, he had many other responsibilities, including supervising PharmD students and residents, teaching and research, it was not uncommon for him to be unavailable when one of the physicians or nurse practitioners needed his input on a prescription. This often meant that these issues had to be resolved at another time, and when the patient was not in clinic, which requires more time and effort, and created important lags in information flow and posed a challenge to creating a seamless team environment, where all the HIV team members and patient could interact simultaneously.
- Dr. Reichen knew this issue was a significant challenge as PharmDs are high cost providers and were considered a luxury in primary care practice. Likewise, Dr. Reichen understood that she did not have control over Dr. Stegnar's teaching and research responsibilities. Dr. Reichen also knew that she was at a competitive disadvantage as Ryan White funded clinics pretty typically had dedicated HIV specialized pharmacists.

b. *Lack of a Robust Mental Health Clinical Staff:* While EVFMC had a clinical psychologist, Dr. Streibner, on staff, she was only on-site three times per week and her practice was extremely full. As a result, there was minimal to no real on-site mental health services for therapy and counseling. Compounding the challenges of availability of Dr. Segnars, the pharmacist, EVFMC had neither a psychiatrist nor Psychiatric-Mental Health Nurse Practitioner on staff for medication management.

c. *EVFMC's Lack of Social Work/Counseling Capacity:* A major staffing gap was that there was no on-site social worker or case manager at EVFMC to help with social issues and who could be leveraged to do adherence and substance use counseling and follow up. While there was an on-call social work number, none of the on-call social workers were dedicated to EVFMV and none were knowledgeable specific to HIV. Most significantly, the fact that they were off-site and not in any real sense part of the EVFMC staff meant that they would not be able to play a role in an integrated IPC HIV team.

d. *An Emergent HIV Nursing Gap:* Much to Dr. Reichen's dismay, during the brain-storming exercise Lisa Pulido had revealed her intention to leave EVFMC for a position with the regional AIDS training and education center that both Ann Remnart and Dr. Sabba are involved with. Lisa Pulido would be leaving within a month. Her pending departure meant that the nursing care for HIV patients would diminish substantially. Unless EVFMC dealt with this challenge Ann Remnart and Dr. Sabba were both concerned that they would end up trying to cover as much of the specialized HIV nursing work as they could.

e. *EVFMC's MA Work Culture:* While no one raised the issue, Dr. Reichen was very aware of and believed that issues around EVFMC's MA work culture were a central challenge to her transformation project. EVFMC was currently staffed by 10 Medical Assistants (MA) who were assigned to one of the four care clusters, although the MAs floated across clusters and providers. The MAs, who were unionized, had contractually defined job responsibilities that were well below the full scope of practice of certified medical assistants. It was not uncommon, even on EVFMCs busiest days, to see MAs who were idle with no work to do while the rest of the staff scrambled to get patient care completed. While some of the MAs would have preferred to pitch in to meet patient care needs, they were limited in being able to do so by their contract and by peer pressure from other MAs who for various reasons believed that it would be a mistake to not follow the contract. In addition, because there were no opportunities for advancement for MAs in the union contract, the majority of the MAs had no interest in professional development or clinical specialization in areas such as HIV. The more senior MAs, a number of whom were active in the MA union, had a great deal of influence on the work culture. While many of the junior MAs did not necessarily approve of this culture, they felt powerless to change it as they were afraid to challenge the authority of the more senior MAs. Likewise, as a consequence of the MA culture, Ann Remnart and Dr. Sabba did not feel that the Medical Assistants (MA) knew enough about HIV to do much in the clinic and did not have a relationship with the HIV patients. Ann and Dr. Sabba frequently felt they had to fill in the gaps in the patient flow and care processes themselves, taking time they needed for providing HIV care. One of the core goals of Dr. Reichen's transformation effort was to broaden MAs' job duties to their full scope, to change the MA work culture toward professional and clinical development, and to inculcate a team-based value system among the MAs. Dr.

Reichen's goal of creating integrated collaborative interprofessional team based care required that such a transformation be successful. While a central challenge, Dr. Reichen had hoped no one would raise the issue because, a) she wasn't sure how best to tackle the issue at this juncture, b) she didn't think raising this issue at this meeting would have been productive, and, c) she didn't think raising the issue without all the other MAs present would have been appropriate.

2. ***The EVFMC Payment Model:*** While Dr. Reichen, like many healthcare leaders, wanted to get ahead of the shifting reimbursement landscape toward value based care, the reality was that EVFMC was still firmly rooted in a physician based fee-for-service payment model. Both research and Dr. Reichen's own experience made it clear that physician based fee-for-service payment model was a serious barrier for integrated practice and interprofessional, team based care. Dr. Sabba had raised this issue at the meeting with an illustrative example based on one of his HIV patients who was covered under an ACA health plan. This patient was not on her medications due to substance abuse issues, and to address the adherence issue, really needed help from an addiction specialist to address her heavy non-injection opioid use and methadone abuse. But EVFMC did not have addiction specialists on staff and the addiction specialist Dr. Sabba normally referred his patients to was out of network under the patient's health plan.

On the opportunities side of the ledger Dr. Reichen was exploring making better use of EVFMC's MAs by assigning them to specific teams and providers and expanding their duties closer to the full scope of their practice. Her thought was that the MAs, because they floated across teams and providers, were unable to establish the depth of connections with patients and practitioners needed to really utilize the full scale of their scope of practice. Dr. Reichen hoped that the medical assistants would enjoy more interaction with EVFMCs patients while also fulfilling a broader range of support tasks, in turn giving the providers more time to address patient needs rather than spending much of their time gathering data.

The list of expanded MA tasks Dr. Reichen had in mind focused on increased pre-consultation data gathering including:

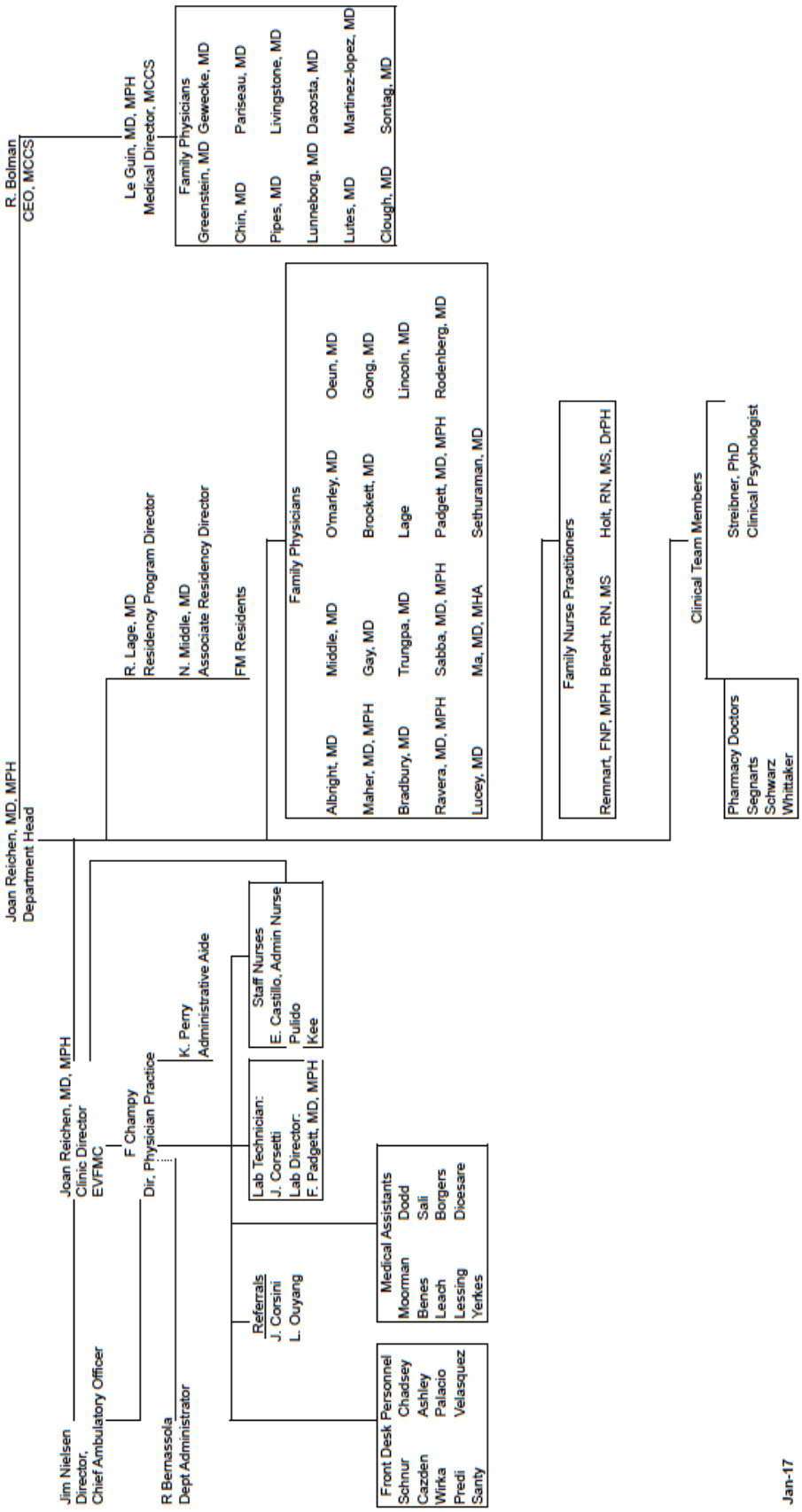
1. Escorting patients to treatment rooms.
2. Completing Data collection tasks such as allergy information, home medication history, history of medical procedures, family history, social history, past medical history

While the HIV clinical staff supported Dr. Reichen's broad proposal they had had pushed back a little by pointing out that much of the time medical assistants were assigned to 2 physicians and in those situations it was unlikely that they would have time for these additional tasks. Dr. Reichen acknowledged that this would be a challenge and one that she would have to try and address in her draft strategic plan.

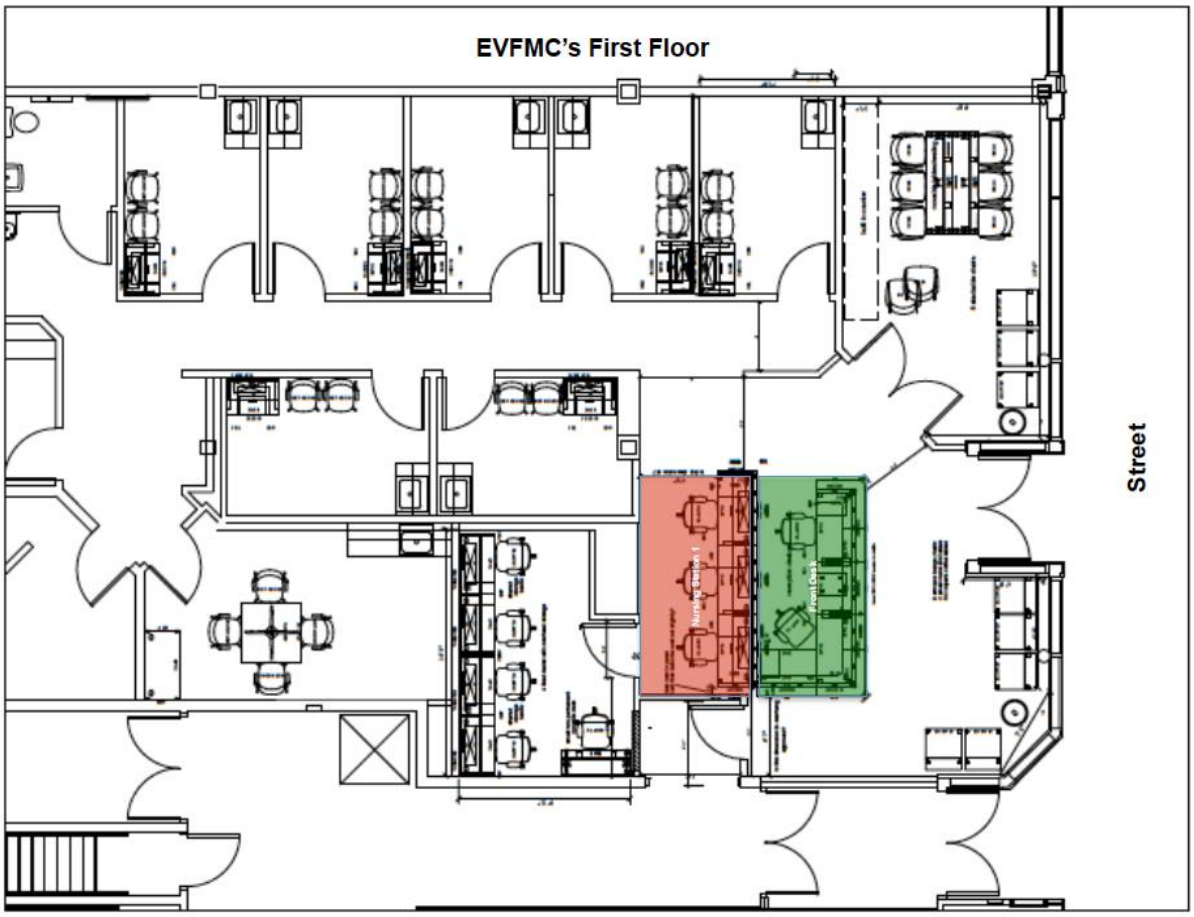
Next Steps

As Dr. Reichen reflected on the meeting she decided her next step was to put together a draft strategic plan for launching the pilot transformation project. Her goal was to bring the plan back to the HIV the full staff at EVFMC at their next meeting, a month from now, in order to get feedback and input. She knew that the plan would have to address the initial concerns and challenges raised by the group, although she knew she would never have the resources to address all the gaps in care. The plan would not only need to win the support and commitment of her HIV clinic staff, but, ideally, it would need to convert them into passionate champions of the transformation project.

APPENDIX 1: EVFMC's Organizational Structure



APPENDIX 2: EVFMC's Floor Plan




EVFMC's Second Floor
NORTH
0674
02
201
2295.97
0674
02
203
9865.34
1476.0
Pharmacy
Front Desk
Nursing Station 3
Nursing Station 2
Nursing Station 4
Pharm.D Office