Focused Strategies for Reimagining the HIV Workforce and Achieving the Goals of EHE

PACHA HIV Workforce Panel
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Ending the HIV Epidemic

The federal EHE initiative aims to end the HIV epidemic in the United States by 2030.

EHE relies on 4 key strategies to achieve the initiative’s aims:

- Diagnose
- Protect
- Treat
- Respond

A strengthened HIV workforce is needed to support implementation.
HIV Workforce Challenges: Scale, Reach, Effectiveness

**Workforce Challenge #1: Scale of comprehensive HIV care delivery**

- The number of people receiving HIV treatment is growing
- The cohort of PLWHIV on treatment is rapidly aging

**Workforce capacity for comprehensive HIV care at scale is needed**

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**Projected number of PLWHIV on ART (Baseline scenario)**

- N = 909,638 in 2030

**Projected number of PLWHIV on ART (If EHE goal of 75% infection reduction by 2025 is attained)**

- N = 718,347 in 2030

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Limitations in HIV Workforce Capacity

Studies on HIV Workforce Supply and Demand:

**HIV Specialist**

Supply and Demand Projections from 2010 to 2015

HIV workforce supply was forecasted to decrease by **10%**, while demand was forecasted to increase by **14%**

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Care capacity in the HIV workforce was estimated to increase by **65,000 patients by 2019**, while the number of people living with HIV in need of care was estimated to increase by **at least 100,000**.

Factors Limiting Workforce Capacity:

- Aging HIV workforce
- Insufficient trainees entering HIV specialties
- Strain on the ID workforce due to COVID-19

Source: Gilman et al. HIV Specialist, August 2016.; Weiser et al. CID. 2016;63(7):966-975.
HIV Workforce Challenges: Scale, Reach, Effectiveness

Workforce Challenge #2: **Reach** of HIV prevention and treatment

- Effective tools for HIV prevention/treatment exist, but new infections have remained relatively stable
- Accelerated decreases in annual HIV infections are needed to attain EHE goals

![Annual HIV Infections in the U.S., 2010-2019](chart)

Workforce Challenge #3: **Effectiveness** of HIV prevention and treatment delivery systems

- Gaps and failures in the systems for delivery of effective HIV prevention and treatment remain too frequent
- E.g., high transmission HIV clusters represent “breakdowns” of existing HIV prevention and treatment systems

The CDC reported the identification of

**136 high HIV transmission clusters**


**Molecular HIV Surveillance by Census Region, 2018-2019**

- **West** (n= 4 States)
- **South** (n=10 States)
- **Northeast** (n= 3 States)
- **Midwest** (n=2 States)

Priority clusters were defined as those with ≥5 diagnoses in the preceding 12 months.

COVID-19 has shaped the HIV care landscape in multiple ways

1. By Directly Impacting the HIV Workforce
2. By Exposing Chronic Inequities
3. Through Synergies that Exacerbate HIV Outcomes

Three Case Examples:

- The infectious disease specialty workforce represents the frontline of the COVID-19 response.
- Structural racism shaped the disproportionate impact of COVID-19 in communities historically impacted by the HIV epidemic.
- The COVID-19 pandemic has caused disruptions to traditional delivery models for HIV treatment and prevention services.
Approaches for Addressing HIV Workforce Challenges

Traditional Approach

I.e.: 
*Increased investment in primarily existing models* of HIV workforce development, prevention and care delivery

Reimagining the HIV Workforce

I.e.: 
*Adoption of new models for HIV workforce development* that are designed to address gaps in scale, reach, and effectiveness of prevention and care delivery
5 Strategies for Reimagining the HIV Workforce

- Broadening Definitions of the HIV Workforce
- Adopting Multidisciplinary Team-Based Models for HIV Prevention and Care
- Enabling Practice to the Highest Level of Training and Licensure
- Adopting Decentralized and Differentiated Models for Service Delivery
- Increasing Capacity to Mitigate the Social Determinants of Health
#1: Broadening Definitions of the HIV Workforce

**Traditional Model for Defining the HIV Workforce**

Singular focus on HIV specialty service providers

- Infectious Disease Physicians who provide HIV care
- Nurse Practitioners who provide HIV care
- Physician Assistants who provide HIV care
- Non-ID Physicians who provide HIV care

**Reimagined Model for Defining the HIV Workforce**

Non-HIV specialist practitioners involved in delivery of comprehensive health and social services to people at risk of and living with HIV

- Primary Care Providers, RNs, LPNs, Pharmacists, Dentists, Social Workers, Behavioral/Mental Health Professionals, Community Health Workers, etc.
Making the Case for Expansion of the Traditional HIV Workforce

Relative Sizes of the Traditional HIV Workforce vs. the Available, Qualified Workforce

Physicians (ID and other) providing HIV care (~3,900)

Nurse Practitioners and Physician Assistants providing HIV care (~500)

~4,400

Data:
- HIV Specialists: 2015 estimates, HRSA, HIV Specialist

Notes:
- Primary Care MDs are comprised of General Internal Medicine Physicians and Family Medicine Physicians
- Social Workers are comprised of Healthcare, Mental Health, and Substance Abuse Social Workers
- Counselors are comprised of Substance Abuse, Behavioral Disorder, and Mental Health Counselors
#2: Adopting Multidisciplinary Team-Based Models for HIV Services

**Traditional Model of Physician-Driven HIV Service Delivery**

Physician-centered model focused on delivery of clinical prevention and treatment services

**Reimagined Model for Team-Based HIV Service Delivery**

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

- Nurse
- CHW
- Physician
- Pharmacist
- Dentist
- Social Worker/Behavioral Health Counselor
- PA
Reliance on coordinated, multidisciplinary care teams for comprehensive HIV services represents a key characteristic of Ryan White funded care settings.


Viral Suppression among People Living With Diagnosed HIV, United States

- **Ryan White Patients (2020)**: 89.4%
- **National Average (2019)**: 65.5%
#3: Enabling Practice to the Highest Level of Training and Licensure

Traditional Model

State-level regulatory restrictions preventing practice to the highest level of training/licensure for key members of the HIV care team

E.g.:

- Nurse Practitioners
- Physician Assistants
- Pharmacists

Reimagined Model

Consistency for practice to the highest level of training/licensure for all members of the HIV care team across the U.S.

Sources: Campaign for Action; American Academy of Physician Assistants; National Alliance of State Pharmacy Associations
Making the Case for Removal of Practice Restrictions

**Nurse Practitioners**

If full NP SOP were adopted nationally, the number of U.S. residents living in a county with primary care shortages would decrease by **70%**.

Nurse-delivered primary care results in **comparable patient outcomes** relative to physician-delivered care, including for HIV treatment.

**Physician Assistants (PAs)**

The quality of primary care delivered by PAs, including patient service use and referral, is **comparable** to physicians and NPs.

APRNs/PAs are **~50%** more likely to prescribe PrEP than physicians.

**Pharmacists**

Advancement in pharmacist **education, certification, and training** has vastly expanded prevention and treatment services delivered by pharmacists.

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#4: Adopting Decentralized and Differentiated Models for HIV Service Delivery

**Traditional Model for HIV Service Delivery**
Delivery of one-size-fits-all HIV services across the status-neutral care continuum within traditional, centralized clinical settings

**Reimagined Model for HIV Service Delivery**
Differentiated and decentralized models that tailor HIV service delivery across the status-neutral care continuum to the needs of patients
Making the Case for Decentralized and Differentiated HIV Services

Optimal Adherence to Guidelines ≠ Optimal Care Outcomes

“The relationship between retention in care and viral suppression is not linear and characteristics of those who are virally suppressed are different based on retention status.” (Pellegrino et al., 2019)

“Improved retention did not lead to improved viral suppression” (Griffith et al., 2019)

Tailored Differentiated Models of Care are Warranted

#5: Increasing Workforce Capacity to Mitigate the Mechanisms of Social Determinants of Health (SDOH)

Traditional Model for Addressing SDOH in HIV Care

Focus on **screening** for patient vulnerability and **referral** to health and psychosocial support services to address SDOH impact

Reimagined Model for Addressing SDOH in HIV Care

Focus on identification and understanding of specific mechanisms of SDOH impact for **targeted mitigation**

**Understanding mechanisms as opportunities for targeted intervention**

**Focus on Resilience**

Factors that enable individuals, institutions, or communities to thrive despite adversity

# Recommendations for Supporting a Reimagined HIV Workforce

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

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

3. **Support a shift** toward education and training for the future health workforce that emphasizes **key competencies** of team-based, whole-person HIV care and increase **funding for specialized HIV training programs** (e.g., via GME, GNE, etc.).

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

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

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Please send any questions to:

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