

# **Increasing Physician Participation in the Care of HIV Patients in the Lower Rio Grande Valley**

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# Project Juntos Goals

- **To increase access to locally delivered primary health care for persons living with HIV in the LRGV of the U.S./Texas Mexico border**
- To organize health care networks with the capacity to provide a comprehensive array of health and enabling services to persons living with HIV along the U.S. Texas Mexico border

# Purpose of this Presentation

- To discuss the anticipated barriers to achieving the goals of the system level intervention in terms of physician training and education
- To discuss the unanticipated barriers to achieving the goals of the system level intervention in terms of physician training and education

# Barriers to Physician Education and Training

Primary care residency programs do not adequately prepare physicians to manage the outpatient aspects of HIV

- In a baseline survey of the Project Physicians (all of whom are board certified Internal Medicine specialists who completed their training within 5 years), at least 50% reported lack of comfort in dealing with basic issues of HIV management

# **Barriers to Physician Education and Training (cont'd)**

**Continuing medical education resources (IDSA, CROI, ICAAC, journals, web based resources) are not aimed at the rural primary care provider**

- Aimed at the HIV experienced physician
- Designed to update physicians on new developments and do not provide “HIV 101” type information
- Developed with the aid of pharmaceutical support and therefore emphasize subtle differences between viable treatment options

# **Barriers to Physician Education and Training (cont'd)**

**The AETC model of physician education was developed in response to a largely urban epidemic**

- AETC “mini fellowships” are often based in academic medical centers. Rural physicians cannot afford time away from their clinics
- AETC “mini fellowships” have not capitalized on their potential to serve as a starting point for ongoing “joint” or “mentored” patient care

# Barriers to Physician Education and Training (cont'd)

**The AETC model of physician education was developed in response to a largely urban epidemic ...**

- One Project Physician was offered the AETC co-sponsored Galveston Texas Course for prison providers and reported the following:

*“I felt out of the loop...all of the other physicians had worked with HIV for many years...much of the course was specific to the prison environment.....I did not find it useful.”*

# Project Strategies to Address Barriers

## Characteristics of the IDEAL educational program for the CHC Physician:

- Compact, highly practical, and stress the essentials (minimal time devoted to training)
- Stress links to reliable routinely updated resources as a basis for self education (CDC, DHHS, epocrates.com)
- Involve continuous “mentored patient care” with gradual increasing independence on the part of the trainee

See TOAETC Binders

# Overview of the Training Program

- 5-6 hours of didactic instruction
- Preceptorship with two experienced physicians utilizing one of the experienced physician's own clinic for 1.5 days
- Follow up visit by experienced physician when trainee begins to see HIV patients for first time
- Quarterly follow up visits by experienced physician over the course of two years
- Ongoing HIV specialty consultation by phone, fax, and email (response within 24 hours)

# HIV Specialty Consultation

## System/Provider Capacity Building IN ACTION:

- Example of a series of consultations regarding a single patient from the Lower Rio Grande Valley
- Example of a standardized and comprehensive method for specialty consultation via e-mail and/or fax

# Unanticipated Barriers

**Two major types of Unanticipated Barriers were encountered:**

- FEAR
- STRUCTURAL - IE., complex issues related to the environment in which physicians deliver care

# FEAR

## **Fear of HIV transmission to healthcare workers**

- Dentists and dental hygienists were concerned about airborne transmission
  - Resolution: arranged impromptu teleconference with dentist from the largest HIV dental clinic in Dallas
- One Project participant examined his first patient double gloved and wrapped a glove around the bell of his stethoscope
  - Resolution: Precepting demonstrated appropriate level of contact precautions

# STRUCTURAL

## **CHC physicians report TIME as major barrier**

- 25-30 patients per day regardless of hospital call
- Chronic understaffing leads to loss of protected time with HIV patients (HIV patients were scheduled one hour, but this becomes meaningless if there is only one physician in clinic and emergencies arise)
- Bonuses and evaluation are linked to “quotas” (4200-5000 encounters per year with no allowance for increased time for education or actual HIV patient care). One Project Physician feels he was denied annual bonus on this basis

# Possible Solutions to STRUCTURAL Barriers

## **CHC's MUST protect physician time for provision of HIV care: Recommendations from the Field**

- Hire additional physicians to insure double physician coverage during HIV protected time
- Decrease quotas commensurate with time spent in educational activities (1 day=25 patients)
- “Weigh” HIV patients to recognize increased time demands (IE., one HIV patient counts as four non-HIV)
- Establish review process to evaluate situations in which time may not adequately be protected

# Key Lessons Learned

- CHC physicians require a curriculum tailored to their unique needs
- The training model must incorporate “continuous mentored patient care “ with gradually increasing independence on part of the trainee
- Physician time **MUST** be protected