

TRAINING PHYSICIANS TO PROVIDE HIV MEDICAL CARE ALONG THE TEXAS-MEXICO BORDER

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Problem

- Reliance on primarily one (1) full-time physician to be the sole provider for a growing caseload of HIV patients distributed across the Lower Rio Grande Valley of South Texas
- Lack of HIV expertise among physicians in area community health centers (CHCs)

Challenges Posed by the HIV Epidemic to the US-Texas-Mexico Border Primary Care Physician Workforce

- Small but steadily growing number of HIV/AIDS patients
- Small number of physicians [most in the public sector] willing to care for HIV patients
- Geography prohibits referral to a tertiary care center

Cumulative AIDS Cases Urban and Border Areas	
URBAN Harris County - Houston Dallas County - Dallas Bexar County - San Antonio Travis County - Ft Worth Tarrant County - Ft Worth	43,886
BORDER Cameron/Hidalgo Counties - Harlingen and Brownsville El Paso - El Paso Webb County - Laredo	2,367
Source: Texas Dept of Health Texas HIV/STD Surveillance Report, September 30, 2002	

HRSA HAB HIV SPNS

Border Initiative

- Major aims of the initiative
 - Improve and/or increase access to HIV Primary Care along the United States-Mexico Border
 - Focus on partnership with HRSA-BPHC supported CHCs to provide HIV primary Care
 - Describe the HIV epidemic along the United States Mexico Border
- 5 US-Mexico border projects funded in 2000
 - Valley AIDS Council (Harlingen) – Texas
 - Centro de Salud Familiar Health Center (El Paso) – Texas
 - San Isidro Community Health Center – California
 - El Rio Health Center – Arizona
 - Camino de Vida Health Center – New Mexico

HRSA = Health Resources and Services Administration

HAB = HIV/AIDS Bureau SPNS = Special Projects of National Significance

BPHC = Bureau of Primary Health Care CHCs = Community Health Centers

Proyecto Juntos

- **The Valley AIDS Council's (VAC) Proyecto Juntos is one of five grantees** funded by the Health Resource Services Administration's (HRSA) HIV/AIDS Bureau (HAB) to improve the HIV Primary Care delivery system for HIV positive Latino's living along the United States-Texas-Mexico border region.
- The project is a collaborative between VAC in Harlingen and Community Health Centers in Brownsville, Pharr/McAllen and Eagle Pass, Texas. The Division of Community Pediatrics at the UTHSCSA oversees evaluation of the project.

South Texas HIV Primary Care Training Sites

- 3 Lower Rio Grande Valley Clinics
 - Brownsville Community Health Center (CHC) – Brownsville
 - Nuestra Clinica del Valle (CHC) – McAllen/Pharr
 - Valley AIDS Council HIV Clinic - Harlingen
- 1 Clinic in Eagle Pass
 - United Medical Centers (CHC)

Barriers Created by Traditional Physician Education and Training

- Primary care residency programs do not adequately prepare physicians to manage the outpatient aspects of HIV care
 - Why not? Comments from border physicians:

“ I have nothing against HIV patients, I just don’t know how to care for them”

“Learning HIV would be like doing a whole new internship and residency”

Border CHC Physician explaining why they cannot provide HIV care.

“The Bible” - Characteristics of Post-Graduate Medical Education Model (Internship/Residency)

- Didactics (with constant interruptions)
- Emphasis on links to reliable and routinely updated resources as a basis for self education
- Emphasis on “continuous mentored patient care” (CMPC) with gradually increasing independence on the part of the physician trainee

Barriers to Physician Education Posed by Texas-Mexico Border Community Health Center “Environments”

- Huge demand for CHC primary care services
- Small number of CHC physicians and nurses
- Time constraints prevent CHC physicians and nurses from attending training programs to increase skills in management of HIV (or other chronic diseases for that matter)
- Fears about HIV

A Model to Address CHC Setting Constraints

- **Setting “realities” recognized by the border training model**
 - **CHC physicians unable to leave their practice site to attend a new residency or training program**
 - **The “residency” must be brought to them over time**
 - **Physicians must have quick access to expert HIV consultation once they begin managing HIV patients**

Training Model Components

- Didactics
- Access to resources and literature
- On-site/off-site “precepting”
 - Preceptor visits to clinical site
 - Preceptor availability for consults

TRAINING PROGRAM OVERVIEW

DIDACTICS	REFERENCES & RESOURCES	CONTINUOUS MENTORED PATIENT CARE (CMPC)
<p>Approximately 6 hours of didactics at project outset focused on:</p> <ul style="list-style-type: none">✓ Recognizing and Diagnosing HIV across the Spectrum✓ Initial Therapy with Antiretroviral Agents✓ Prophylaxis and Treatment of Opportunistic Infections✓ Resistance Testing and Rescue Therapy✓ Putting it All Together: Case Studies	<p>Provision of commonly used reference sources:</p> <ul style="list-style-type: none">✓ CDC Website (Guidelines for Management of Opportunistic Infections)✓ DHHS (Guidelines for Use of Antiretroviral Agents HIV Infected in Adults and Adolescents)✓ Stanford HIV Database✓ Epocrates.com✓ Clinical Infectious Diseases *✓ JAIDS✓ AIDS	<ul style="list-style-type: none">✓ CHC physicians “precept” with an experienced HIV provider who practices along the Texas-Mexico border✓ HIV expert from academic medical center provides onsite support for CHC physicians when they see their first HIV patients✓ Quarterly precepting visits from HIV expert for first two years of project✓ Distance consultation by phone, fax, and email provided 24-7 for as long as needed

Educational Activities Timeline (2 Years)

Time Frame	Activity
October 2000	Initial Didactic Training All MDs
October 2000	Initial Precepting with border MDs
January 2001	Initial precepting Eagle Pass MD
January 2001 January 2003	On-going distance consultation with border MDs begins (phone, fax, e-mail)
February 2001 January 2003	Quarterly precepting visits begin

Utilization of the Consultation Services

Two Year Training Post Training Periods

January 2001 – January 2003

	Routine	Urgent/ Emergent	Total
VAC Physician	22	1	23
CHC Physicians	36	16	52
Total	58	17	75
Post Training (February 2003 – May 2004)			23

UNANTICIPATED BARRIERS

FEAR

STRUCTURAL [Related to the environment in which care is delivered]

Fear of Contracting HIV

CHC dental staff highly concerned about airborne transmission

Resolution:

Training
Physician examination of first HIV patient using double gloves and stethoscope bell wrapped with glove

Resolution:

Demonstration of appropriate level of contact precautions by HIV Preceptor

TIME Constraints for project physicians/nurses

Expected to see 25-30 patients per day

Chronic CHC understaffing leads to loss of protected time negotiated for provision of HIV care (e.g.,

1 hour initial HIV visit scheduled, but time available if there is only one physician in clinic and emergencies arise)

Physician Compensation

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).

Complaints of bonus denials due to reduced performance

CHC Administrator Support

Incorporation of HIV care "disrupts" regular clinical operations

Physician time devoted to "special HIV program" detracts from management of other chronic diseases (diabetes, HTN, etc)

"Special rules for HIV patients" (no co-pays, longer visits with doctors, special formulary) seen as unfair to other patients

Access to Technology by Project Physicians Limited

Physicians Reported Limited Ability to Access to computers and Web-Based Resources

Physician Turnover

Physician at one CHC turned over twice during the first 6 months requiring almost continuous training/retraining; another left after two years -- no replacement identified.

Patients Enrolled into Care

SITE	May 2004 Client Caseload	Patient Caseload			
		Fall 2000	Fall 2001	Sum 2003	May 2004
VAC - Harlingen	606	411	460	501	514
NCDV - Pharr/McAllen	NA	0	4	22	26
BCHC - Brownsville ¹	NA	0	11	0	0
VAC - Brownsville ²	NA	0	0	0	66
UMCEP - Eagle Pass ³	52	0	7	22	20

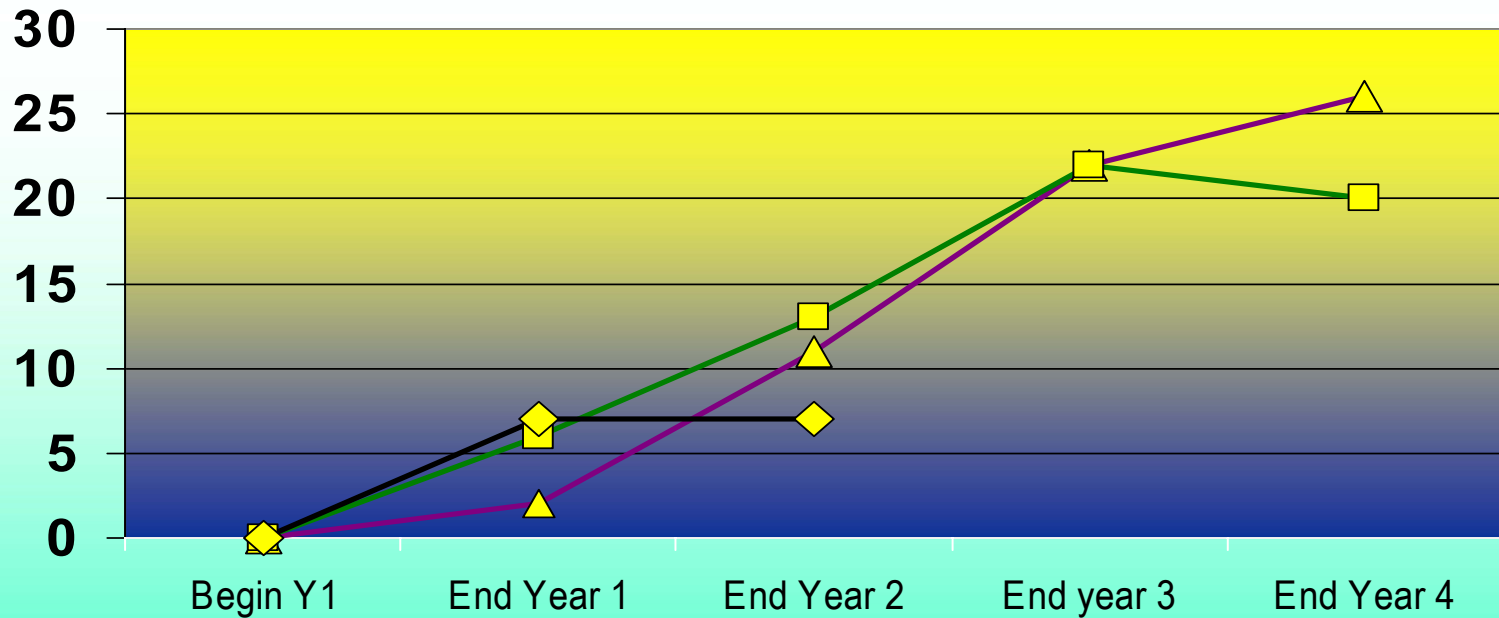
1 Brownsville CHC withdrew from project in Summer 2002

2 VAC clinician began providing care in Brownsville January 2004

3 Eagle Pass Population had been receiving HIV care in San Antonio prior to project.

Patients Enrolled into Local HIV Care

Changes in Patient Utilization of CHCs Over Project Period



- ▲— Nuestra Clinica del Valle Pharr (N=26)
- United Medical Center Eagle Pass (N=22)
- ◆— *Brownsville Community Center (N=7)

*Terminated Project Participation Summer 2002

Provider Satisfaction with Proyecto Juntos Model

[Interviews with Project Staff]

Staff Type	1. Satisfaction with Model	2. Satisfaction with Consultation	3. Linkage to HIV Specialist before Project	4. Satisfaction with training and Education	5. Comfort Level Providing HIV Care	6. Attitude Change in providing Care	7. High and Low Points Associated with Project Participation
Physicians (Baseline)	Satisfied with the program model concept Issues: <ul style="list-style-type: none"> • Time Protection • Referral to other Specialty Care 	Satisfied with consultation provided by Dallas AETC	No linkage prior to Project	Physicians satisfied with training provided (frequency/content) Consistently express need for more knowledge	Low Comfort Level	Lack Confidence	+ Education and Training received - Lack of knowledge to provide basic HIV care; fear of hurting patients
Physicians (Follow-up)	All but 1 continued satisfied with the model Issues: <ul style="list-style-type: none"> • Time Protection • Referral to other Specialty Care • Hospital Admissions • No Backup • Request for more nurse training to assist physicians with management of cases 	Satisfaction with consultation model continues <ul style="list-style-type: none"> • Would also like access to HIV ID • A clarified consultation process would be helpful 	Linkage to AETC ID Physician identified as crucial to the quality of care provided to patients	Satisfaction with training continued In year 3, begin to express need for continued fidelity to the precepting model (systematic scheduled training)	Increased Comfort Level	Increased Confidence	+ Expansion of care at CHCs; and seeing patients get better (“coming back from the dead”) - Lack of experience in providing care for complex HIV patients; knowing when to refer out
Nurses (Baseline)	Satisfied with the model Identified need for nurse specific training on HIV	Model did not account for nurse consultations	N/A	Model did not account for nurse educational needs Expressed as a need in year 1	Low Comfort Level	Lack Confidence	+ Education and Training - Lack of knowledge to provide basic HIV care and support physicians
Nurses (Follow-up)	Continue satisfied with model Desire to participate in physician precepting	Model did not account for nurse consultations	Recent problems with timely response on questions from AETC	Satisfied with the 2 training provided by project Continue to request to participate in the physician Identify specific training needs to support physicians (reading lab results & medication interactions)	Increased Comfort Level	Increased Confidence	+ Expansion of care at CHC's and increased patient comfort with receiving care at the CHC -Lack of knowledge to provide care for complex HIV patients

Lessons Learned

- With training and support, CHC physicians are capable of providing HIV care
 - Physicians require an intensive, residency-like educational program to learn to manage a new chronic disease.
- A residency like training program can be incorporated into border physician practices, but requires time and support from administration.
- System capacity and access can be increased; but tax the limited resources of CHC along the border.
- Sustaining the capacity is hampered by physician turnover.