

## **WEBINAR VIDEO TRANSCRIPT**

### **SPNS / iHiP Webinar**

### **Workforce Capacity Building**

13 May 2019

ANGEL JOHNSON: Good afternoon, everyone. My name is Angel Johnson. And I'll be moderating today's webinar on Improving Health Outcomes, Moving Patients Along the HIV Care Continuum. This is the second webinar in our four part series brought to you by the HRSA Special Projects of National Significance Program.

So you see by today's agenda, I will provide a brief overview about the SPNS project of National Significance Program and the Integrating HIV Initiative Practices project or IHIP. You will then hear from our presenters, who will discuss their SPNS workforce initiative. Our first presenter today is Dr. Christian Ramers, with Family Health Centers of San Diego, with San Diego, California.

Dr. Ramers is the assistant medical director for research and special populations at the Family Health Centers of San Diego, a large federally qualified health centers system serving nearly 200,000 medically underserved individuals throughout San Diego County. In this role, Dr. Ramers serves as a primary care physician and a consultant for patients living with HIV, HBV, and HCV for those who are homeless or in residential drug and alcohol rehabilitation programs. Dr. Ramers is board certified in internal medicine, pediatrics, and infectious disease, is an American Academy of HIV medicine certified HIV specialist and is particularly interested in HIV, HBV, HCV, and service of medically underserved immigrant and refugee populations.

We will also hear from Darnelle Delva with Brightpoint Health in Bronx, New York. Darnelle Delva is an experienced clinical quality improvement coordinator and grants program evaluator at Brightpoint Health. In this role, she leads and facilitates the data driven development of workflow and quality improvement projects aimed at process improvement and documentation and quality of patient care. Darnelle oversees ongoing evaluation and quality assurance at Brightpoint Health, HIV/AIDS, linkage to care, prevention navigation, and care management grant funded programs.

Following these presentations, we will open up lines and take questions. The SPNS program is funded through part F of the Ryan White HIV/AIDS program and provides opportunities for poor developing, implementing, and assessing innovations designed to meet national goals to end the HIV epidemic and address the evolving nature of our health care delivery system. The SPNS program remains current by addressing emerging issues in HIV care and populations most affected by HIV.

Initially, the SPNS program was challenged by finding ways to effectively disseminate information about successful SPNS model of care and the lessons learned to help other providers replicate these innovations. However, through the IHIP Project, SPNS effectively promotes, markets, and disseminates strategies to support optimal implementation of these models. The IHIP strategies used to disseminate SPNS models include developing tools and resources, such as implementation manuals and interventions guide, and fact sheets to encourage replication, engage stakeholders to increase reach of these tools and provide capacity building assistance to support the replication of SPNS intervention model.

As I prepared to turn things over to Dr. Ramers, I want to provide you with some information on staying connected to SPNS and IHIP. If you have questions about any of the information shared in today's webinar or anything related to the replication of SPNS interventions, please send your inquiries to [SPNS@hrsa.gov](mailto:SPNS@hrsa.gov). For additional information on tools and resources, and to sign up for the IHIP list serve to receive the latest analysis about IHIP resources and webinar training, please visit the Target Center at [targetHIV.org/IHIP](http://targetHIV.org/IHIP).

And to learn more about HRSA and sign up for their newsletter, visit [HRSA.gov](http://HRSA.gov). And now without further delay, I'm going to turn things over to today's first presenter, Dr. Ramers with Family Health Centers of San Diego. Immediate following Dr. Ramers, you'll hear from Darnelle Delva from Brightpoint Health. Dr. Ramers.

CHRISTIAN RAMERS: Thank you so much, Angel. And thanks to her starting the HIV/AIDS bureau for the opportunity to present their work. And I'm presenting on behalf of my colleagues Verna Gant and Lisa Asmus regarding practice transformation in San Diego.

So hopefully, you're listening to this to become inspired to address workforce issues in the field of HIV, whether you're from a Ryan White funding clinic that's already doing HIV care and you want to expand or whether you're from a primary care environment and want to get into doing HIV care. Really what we want to do is share what we've experienced in terms of trying to address these issues and hopefully, inspire you to take action, but first a disclaimer. This work was funded by a grant from her son over four years, starting in about 2014 and finishing four years thereafter.

And this information and conclusions are really those of the authors and should not be construed as the official position or policy of the US government, HRSA, or HHS. But here's the outline of what we're going to talk about today. We'll start with an overview of the situation that we faced in San Diego and that many of you are facing in offering HIV care.

We'll talk about capacity and kind of what is needed to start to make change and to think about to change. And then we'll go through the implementation of our particular project with respect to medical providers, support staff, and then really talk about some adaptations we had to make along the way, some course corrections, and some successes. And then very importantly, we'll get into sustainability and share our lessons learned and recommendations in various areas.

And at the end, we'll have some resources. And then I'll turn it over to Darnelle. So a little bit of background in our environment, I work at family health centers in San Diego, which is a private 501(c)3 federally qualified Health Center in San Diego.

We operate 22 primary care clinics throughout the county. And we are the largest provider of HIV services in San Diego County, including clinical care as well as HIV case management and HIV testing and prevention services. In our main clinic, we care for approximately 1,300 people living with HIV per year. And our patient population is racially and ethnically diverse and largely low income.

Our goal with this project was to really expand the capacity of our organization to provide specialty care through system level structural changes. And the way we approach this was we felt we had to have a multipronged approach training primary care providers and family medicine residents to provide specialty care, but also due to more systemic changes to expand care from one to several additional clinic sites. And in order to do so, we had to train support staff at these additional clinic sites in HIV services.

I should mention that we were facing a situation as I'm sure many of you are across the country where our more experienced HIV providers of a generation before we're nearing retirement. And it's been said that necessity is the mother of invention. We had three providers that were leaving. And we had to fill this gap and train additional workforce to carry on HIV care in the future.

So what are the capacity requirements for success? This is a little bit of our lessons learned up in the front here. But I just wanted to share this with you early on. Really there's two main areas, the agency itself, looking at your own environment. You have to get buy-in from different levels of the agency, from the leadership, from the staff, from clinic directors, from supervisors, and of course from the providers.

You certainly need the raw materials in order to expand workforce. And the raw materials are really the clinics and the medical providers being willing to initiate HIV medical care. We felt it was really important to have a physician champion or somebody who can authoritatively train the staff or the use of an external HIV specialist as possible as well. And then within your organization, it's very important that staff champions from the nursing and phlebotomy and case management disciplines in order to train their colleagues.

Funding is obviously very important here. So funding is necessary to pay for people's time. Specifically the HIV physician champion or external specialist needs to have a dedicated time, which is supported financially in order to train.

The existing medical providers, if you are pulling them out of usual clinic hours, that needed to be back-filled in our situation with additional providers, such as per diem providers. In terms of support staff, if we're pulling them out from training, we need to do this outside of business hours and then compensate people for their time. And then finally, if you are going to be

bringing in external people or external agencies to train support staff, these needed to be compensated as well. So it's not all bad news.

There are a number of elements with respect to capacity that are actually free and available. And we would call these more resources. On the top here, you can see the AETCs, which spread out all across the country are available, and ready, and willing to help with training needs. There is now a national HIV curriculum which can be found at [www.hiv.uw.edu](http://www.hiv.uw.edu). That is a great source of material to use in training.

Something that we found useful is that although during the actual time of the grant, time was essential to be compensated for. But once you create a mentoring relationship people tend to work together off the clock so to speak. And so are HIV specialist champion is now able to continue mentoring after the training period is complete.

The American Academy of HIV medicine has many resources available for training. And then once you create a culture of learning and inspire people to share cases with each other, there's really internal education and case reviews that continues to occur, as well as other telehealth programs out there. And the one that we tend to use is called the Pacific AETC's HIV Learning Network.

In terms of resources for the support staff, it's really important to survey your own resources and see which existing staff can lend their expertise to train their colleagues in terms of internal processes, patient flow, insurance issues, and HIV referrals. Again, there are many curricula out there already. We rely both on the Pacific AETC as well as the local AETC at the University of California San Diego, as well as an outside organization Coldspring Center, which has developed other trainings.

And finally, using our own staff champions, who are willing to train and inspire other staff was an important aspect. And now a little more into the detail of our model. We split our model into the medical provider training, as well as staff training. And our medical provider training, the curriculum was multi-modal and longitudinal.

And our goal really at the end was to culminate in AAHIVM specialty certification for all those who were going to undergo this training. In terms of the family medicine residents, we happen to have a family medicine residency of six residents per year at our site. Their training, we had to spread it out over two years. So our PGY two's or our second year residents and our third year residents will be involved. And then for existing primary care providers, we pulled them out only for about six months at a time to complete their training.

The methods here were a combination of immersive clinical preceptorship time with 1 to 2 1/2 days per month, progressing from just observing to more precepting to towards the end of people's time empanelment, where they actually took ownership of their own patients. There was also a fairly high level of independent study that was an expectation of this program. And then finally, because we have an ongoing mentoring relationship among our specialists and our

trainees, ongoing specialty consultation to provide that extra support once our primary care providers are out there doing HIV care.

In terms of the independent study that was expected, I mentioned some of the resources already. There is an online curriculum, which has been produced by the University of Washington. They also have a question bank tips for people to assess their learning.

The Pacific AETC HIV Learning Network provides telehealth sessions every two weeks, which is an opportunity to bounce cases off of experts and to review topics. They are recorded sessions that had been produced by the Northwest AETC, which is actually now called the Mountain West AETC, a little 15 to 20 minute topics from all different HIV topics, HIV areas. And there's additionally overlap with a lot of hepatitis C content.

And we relied on the University of Washington's hepatitis C curriculum as well. And we developed their own internal resources that we call hepatitis C huddle, which is an echo style program that runs inside of our clinics. For the clinical support staff, we took a slightly different approach.

We did a rolling curriculum of two hour sessions, both in-person and online, roughly once a month for a period of six months. And this was some of the topics you can see listed there below with a lot of assistance from the Pacific AETC to run some of these, as well as the Coldspring Center. Along the way we had to make a couple of adaptations just to maintain flexibility. Our provider curriculum, provider schedules are really very complicated and difficult to arrange. So we had to make some modifications.

Our existing providers, we originally planned on keeping them for a year. But it turned out that we could get most of what we needed accomplished in six months. And that also saved a little bit of money having to not back-fill their time with per diems. And then resonant curricula also was going to be a year originally. We likened this to two years again for scheduling reasons.

For our staff trainings, we offered repeated courses as a refresher, partially because misalignment of timing of training versus actually having HIV patients in their clinic and also partially because of staff turnover. We did have some successes along the way. We've trained 11 providers.

And they're all practicing at the end of 2018, seeing HIV patients. Among staff, we've trained 185 individuals. And our clinic sites have expanded from one centralized sites back in 2014 that we're seeing HIV patients out to seven of our clinics now offering HIV specialty care.

You can see some of our quantitative results here, just the number of unduplicated HIV patients being cared for in our primary care clinic nicely ramped up through the four years of the program to the point where we're close to 400 individual patients that are now receiving care outside of our centralized HIV specialty clinic. And on the bottom, you can see the number of actual encounters that this translates to to speak the language of clinic directors. Now,

sustainability is really important here. And I'm going to share with you the positive aspects of sustainability here.

And what you can see left out, I'll address at the end. Since we have a family medicine residency, we have a structure in place that will allow us to continue a track of training for family medicine residents coming in. And this is partially because once the curricula has been accomplished, the scheduling can really just be built into the existing residency program.

We now have two of our six residents per year that continue on an HIV track. And the goal is still the same to attain HIV certification at the end of their two year track. The trainer or the physician champion is still available to continue mentoring. And now we have really a lot of HIV trained specialists that can also precept some of these residents.

Our support staff training will continue but has to be at a reduced capacity, which is OK, since many people are now trained in their worksite. This is partially because clinic directors were allowing staff hours during the trainings to occur. And they're allowing that still, but in a more limited area.

The expansion that we've had to the 11 current medical providers has been enduring. We like I said, have 11 people practicing and seeing HIV patients, which increased from three back at the beginning of this grant. And in general, clinic directors have been supportive of providers building their own HIV panels.

As I mentioned, we have close to 200 support staff that have been trained. And I feel like we've reached a point where we have a culture of HIV care now where it's just it's become part of what we do in terms of our normal clinic operations is to have HIV patients mixed in with primary care. We now have seven of our 22 sites that are offering HIV services up from a single centralized site at the start of this program.

So I'll finish this with some lessons learned. In terms of our agency lessons learned, it certainly requires time and effort to get buy-in and to gain support from new clinic sites. We all know in primary care everybody is very busy.

Everyone is sort of head down just nose to the grindstone doing what they want to do or what they're trying to do going. And add a whole new service line to those clinics doesn't always get the most enthusiastic response. So you really need to spend the time to build interest and to get buy-in from clinic directors and people from clinics that are not currently doing HIV care.

It's very important to synchronize your staff training to your medical provider training, because, of course, if the medical provider-- it's the clinic that they are going to be placed in that really needs to be the one ready to do HIV care. And we had a couple episodes of misalignment, where we had to do some refresher trainings to make the payment work. It overall is much more cost effective to integrate HIV training into a residency program, rather than pulling out already practicing providers just because of the costs that we took and lost revenue from

pulling those providers out from their usual practice and then having to back-fill a per diem support. And of course, the location of the practice really drives where the expansion should be.

In terms of support staff, we definitely need to incentivize training or support staff. A lot of people just want to finish their day and really get home as soon as possible. And in order to ask them to stay later, to get additional training, that needs to be incentivized.

It's important to take advantage of and to cultivate champions at your site-- so each staff type, meaning phlebotomist, and case managers, and front office staff, and nursing staff as well. We had to offer refresher trainings, because of staff turnover and because the timing didn't always work out ideally, and then very essential, provider and patient support as implementation is occurring. For medical providers, the physician champion really was a key element for success with adequate protected time to teach.

You can't really embark on this without putting adequate funding towards the providers time. We did have a couple of providers who were trained through the program and then left for other opportunities. So halfway through the program we added a commitment in terms of the training. So those that were going to be trained had to commit to stay at our agency for two years.

And again, relying on already existing resources such as the National HIV curriculum and the AETC are really great ways to utilize resources that already exist and not have to reinvent the wheel. And the support and mentoring for newly trained providers really has to go on beyond the training period. So it's not so easy for somebody to take on a new aspect of care and not have somebody to call for when they get stuck. So having that ongoing mentoring relationship is key.

Additionally, we felt like the AAHIVM exam was a really nice benchmark to reach for. It's a well-accepted standard in the industry of quality. And it allowed us a goal to train our providers towards.

We do have to organize schedules. And this was really one of the main pieces of work, especially around providers and residents schedules to allow the precepting sessions to occur, certainly, the budget time for that and make sure that the HIV patients were being scheduled as well in the right slot. Telehealth sessions are wonderful, a great way to collaboratively learn, but you need to budget time for them.

And if providers are busy seeing patients through lunch, then they won't be able to be trained using this tool. And then building a patient panel is a slow process, but when we have new providers that maybe at new clinic sites, it's important to really thoughtfully look at the geography of where your patients live and try to empanel those patients in a local clinic where they can receive care and their patients that are in medical homes.

So I'm just going to finish here with some resources that we relied on heavily. I mentioned the National HIV Curricula from the University of Washington. The HIV Learning Network is a really great bi-weekly telehealth noontime session that does case reviews, as well as didactic topics, as well as the other resources there.

There's Coldspring Training Center, the HIV Webstudy Question Bank, the recording sessions that we relied on from Mountain West AETC, and then hepatitis resources as well. I will finish just with our contact information. If anyone has additional further questions that are not answered at the end of this hour, we're happy to be in touch. And thank you to my collaborators. So with that, I'm going to pass it over to Darnelle Delva.

DARNELLE DELVA: Hi, good afternoon. This is Darnelle. I want to thank Dr. Ramers for passing on and thank HRSA the opportunity to speak today. And I will be sharing the successes and sustainability of the Practice Transformation Model that was implemented here at Brightpoint.

This project was funded by HRSA SPNS at \$300,000 annually over five years with no portion financed by non-governmental sources. The information that I'm going to present has no reflection on HRSA, HSF, or the US government, its policy's, endorsements, or official position. I have no other disclaimers to provide.

For this presentation, we have outlined an overview of our organization and the PTM, our Practice Transformation Model, the capacity that we use for implementation, how we went about implementing our practice transformation model, our sustainability model, as well as lessons learned and recommendations. So a little bit about us, Brightpoint health has a long history of providing service and care for New Yorkers. It was first established as a nursing home in the Bronx that responded to the early epidemic of HIV and substance abuse.

We have since grown to 23 operational sites in all five boroughs, where we have seven PCMH recognized primary care clinics and collectively our FQHC services, all populations, including homeless, low income families, people affected with mental illness, and the formerly incarcerated. At the end of 2017, Brightpoint help provided care and services to nearly 34,000 patients. It's almost a little more than 14,000 of which were people living with HIV/AIDS.

Our care centers offer many services, including primary care, behavioral health, maternal health, outpatient substance abuse services, health home medical case management, and grant funded services among others. And I just want to mention that in December, at the end of last year, the organization merged with Hudson River Health Care, a larger organization. And now as a combined entity, we have a reach of 125,000 people throughout Hudson Valley, New York, and Long Island.

So for our Practice Transformation Model, despite having a great number of services to address the needs of our patients, we recognize a need to further transform our practices and embody the model of a patient-centered medical home. Our Practice Transformation Model was aimed around improving care coordination between our primary care and behavioral health services



and also to empower our HIV positive patients, who are not virally suppressed may be dealing with multiple chronic illnesses and are also at risk of falling out of care.

This model we implemented it at our Bronx Inwood Health Care Center, primarily because it served the largest population of patients and HIV positive patients, about 4,500 respectively. And it also housed many of the services that I mentioned previously. For our Practice Transformation Model, we had four key components. They included standardizing systems for identifying and engaging high risk HIV positive patients, formalizing communication between and amongst our primary care and behavioral health providers, as well as enhancing the infrastructure of our electronic health information systems and providing self-management programs for our HIV positive patients.

To carry out or PTM, we established a practice transformation team, which consisted of a program director. And she was largely responsible for supervising and monitoring the team and the program's activities, as well as ensuring that trainings and trainings were timely and appropriate and collaborating with our quality management to develop QI activities or Quality Improvement activities. We also had a QI coordinator.

She was responsible for developing a plan for the implementation and facilitating its evaluation, as well as engaging appropriate staff in quality assurance and quality improvement activities, such as PDSA. Also, part of the team was the patient navigator. And his responsibility was to collaborate between the practice transformation team and the clinic staff, to coordinate services for HIV positive patients, as well as providing the patients with education on harm reduction, healthy living, and self-management. And when appropriate, they also provided outreach to the clients that are at risk of falling out of care.

The peer educator, this team member is really a linking factor for the team between the care team and the patient. They serve as a positive role model for the patients on adherence to treatment and care. And they would also provide outreach and escorting to appointments, as well as facilitating the self-management groups. In addition to the PT team, our successes around implementation were facilitated by establishing buy-in amongst the staff and providers in the clinic.

To secure buy-in, it's been important to involve leadership in the entire process, especially from the beginning. So at Inwood, we included our regional medical director early on in the process, as well as we had our vice president of nursing and chief operating officer to participate in the workflow development. We provided presentations during staff meetings. And for this project, we included leadership during any site visits that we had from our ETAC and HRSA.

Additionally, buy-in was established through staff training and the use of external resources. So during morning meetings staff received trainings either from our AETC or leadership that were skilled in a range of topics, including best practices and brainstorming innovative ways of conducting case conferencing and huddle, as well as motivational interviewing and health coaching. We also participated in collaborative. We participated in an IHI collaborative.

And through this participation, we were able to develop methods to better assess clients experience within the clinic and also to assess their engagement in self-management work. Throughout our PTM, we documented and tracked the proposed interventions as well as any successes and challenges. We made use of tools like Gantt charts to maintain accountability amongst the team and to guide internal discussions.

We shared with the clinic team these successes and challenges that we are facing in our practice transformation model. And by demonstrating the value of the practice transformation to the staff, it really helped to routinely share these successes to the larger team, especially when we're trying to establish buy-in and implement these practice transformations. Within our clinic what we also had is a standing electronic health record that was used by all team members for the Inwood health clinic.

It's co-located with clinic services, behavioral health services, and a number of wraparound services. So this was also to our benefit in implementing our practice transformation model. We also had a physical space to hold those self-management groups that are a part of our intervention.

So as I mentioned, there are four parts to our practice transformation model, the first being standardizing systems for identifying and emerging-- engaging, sorry, high-risk HIV positive patients. We successfully developed a patient registry that identified clients with upcoming behavior health and primary care appointments, who had three consecutive months of being unsuppressed. And also, the registry identified those patients, who were medically uncontrolled in their other co-morbidities.

So the registries allowed the PT team to flag charts within our EMR on their upcoming appointment dates. And this allowed the providers to see these flags and in turn refer them to the PT team for further engagement and tension. So we really use them to facilitate warm-hand offs to the practice transformation team, especially for those clients who are at risk for falling out of care.

The transformation model was really on formalizing communication between our primary care and behavioral health providers. In establishing these processes, we use PDSAs plan to study act cycles to test and adapt workflows for huddles and case conferences between and amongst the team. Based on these tests of change, we found that retrospective huddles worked at least within our Inwood clinic best for conducting previous planning.

One of the reasons why is that we do have high no show rate within the clinic. So often it's better to plan for the next visit after we have seen the client. Additionally, we found it's best when we operationalize any of these workflows. And once we've identified something that works that we carve out the time within the providers schedule.

As mentioned, we do have an existing EMR. And we sought out to enhance it. We sought out by first contacting the EMR provider. We use these clinical works. And there was an enhancement

that would facilitate creating care plans between our primary care and behavioral health providers.

However, for this intervention, we were unable to establish that enhancement, but we developed great workarounds that we continue to sustain. And these include the use of sticky notes and telephone encounters, as well as uploading the care plans that were created by any PT team member. So whoever has access to the EMR is able to see and communicate through these modalities.

The fourth part of our practice transformation was really to engage the patients through self-management group. We train staff in two models of self-management group. And these were facilitated over the course of the grant.

And the groups themselves or the cycles themselves were 10, 10 sessions of two to three hours. We made use of pre and post-assessments to establish a baseline and to see improvements in the participants with regards to their general health confidence in doing things related to their health as well as their cognitive system management and the use of their medical care. The peer groups were effective in the HIV treatment cascade as they promote self-efficacy, health literacy, and motivation.

And the peers definitely played an important role in facilitating these groups, as well as providing a shared experience for the participants. The groups we're really used to educate and empower patients to make active roles in managing their health and mitigating any barriers to their treatment and adherence. Now just briefly to talk about how we learn to sustain our practice transformation and integrate it really into our overall practice and workflows.

We are incorporating additional groups for patients with co-morbidities within the clinic. So in addition to HIV, we know that many of our patients also have HCV. And we are incorporating groups to address those conditions as well, or in regards to HIV, we have established a capacity to provide direct observational therapy for those patients who we needed to facilitate their adherence.

We continue to integrate this model to address social determinants of health. The PT teams are really leading that to engage clients in identifying any or addressing any of the barriers that they have. And we continue to engage staff in their morning meetings and any meetings that they have to really create an agency wide culture on ending the AIDS epidemic.

And this was a grant funded project. And we continue to expand our capacity by looking for additional funds to promote or transformation. Some lessons learned and recommendations that we can make for those who are interested in replicating or using bits of this in their practice is that early communication with ancillary staff is important, especially when you're trying to implement a new patient flow.

Staff training for our practice it really helps to facilitate efficient communication between clinic staff and patients at the time of their visit and again, using those PDSAs is important in establishing buy-ins. As I mentioned, retrospective huddles, especially when you have a large no-show rate can be really helpful in conducting pre-visit planning. Furthermore, for patients living with HIV, the peers are especially important in establishing a positive role model, the shared experience, and the help to communicate those experiences to the care team.

And additionally, providing the self-management groups were well-received amongst our patients. There are aspects of those groups that we plan to continue, which include action planning. And I mentioned earlier that the group were two to three hours long.

However, within our clinic setting, it's not so feasible to keep clients engaged for such a long period of time. So we have developed workshops that are shorter periods of time, about an hour and hour and a half. Additionally, a comprehensive group materials help to facilitate both what we're teaching the clients within those self-management groups, such as problem-solving, making use of system cycle, and appropriate decision-making, as well as understanding the purpose and use of their medication.

And if you do have any questions regards to our Practice Transformation model, you can reach out to myself or Mary Corea. And our information is here on the screen. Thank you.

ANGEL JOHNSON: Thank you, Darnelle. And thank you, Dr. Ramers, for sharing your initiative. Dr. Ramers, I have a question I would like to-- if you could address. Can you talk about any of the barriers and challenges that you may have encountered while implementing the training model to medical providers?

CHRISTIAN RAMERS: Sure. Thanks for the question. As I mentioned, some of it is just logistical. With residents, their schedule is really up to us to tell them where to be on their assigned rotations. And with actual providers, especially those that are full time clinical providers.

In order to provide them with precepting experiences, they really had to block their clinics. And so that really was the main one, not too popular with clinic directors to have us come in and just say, oh, we're going to take your provider for four hours a month. And they're not going to be very productive during that time. It's just going to be all training.

So that was really the root of some of our barriers with existing medical providers. And as I mentioned, residents were much easier, because of the scheduling. The other thing I'll mention is that some people are sort of set in their ways and don't really feel like they need to add anything to their practice. I would say this is a little more common with older medical providers that just don't feel like they don't really want to learn a new area.

Maybe they're nearing retirement. And I would say with younger providers it's a little easier to-- since they're still fresh out of training and they're so used to just jumping into things that

they're not all that experienced with. There's much more willingness from the younger providers to want to learn something new.

ANGEL JOHNSON: Thank you for that. And is there a way to ensure that the training provided are committed to remaining after they're trained?

CHRISTIAN RAMERS: Yes. Thanks for that follow-up. As I mentioned, we did have a couple that went through the entire training and got certified and then the last shortly after, which was a little disappointing. So we actually implemented a contractual obligation that if somebody was going to commit to the training and we were going to invest the time and resources to train them that they would promise to stay with the organization for at least two years.

And this actually worked quite well, because I think people that if they're here for two years, they develop a panel by that point. And then you've kind of got them comfortable with what their practice might look like incorporating HIV. And so since we implemented that, we have not lost anybody else.

ANGEL JOHNSON: Thank you for that. We have a question from Andrea, I think it says, Norberg. Thank you.

This question is for, Darnelle. Thank you for your presentation today. Darnelle, can you share more details related to the workaround for the EHR enhancement?

DARNELLE DELVA: Yes, sure. Thank you for the question. So in terms of our workaround, we really use the telephone encounters. So within the EMR, there is a way for the staff to communicate within the EMR.

So they have these telephone encounters, where they can write notes. We also have the use of sticky notes, where these pop-up when a provider opens up the client charts. And they can see notes related to where the client is or any emerging or high priority items that need to be addressed.

Additionally, I mentioned that we wanted to have a joint care plan within the primary care of behavioral health, as well as the care team. And addressing that we actually have a paper care plan, where, at least, for the PT team. So they fill out a care plan, and then they upload that within their EMR.

Those were the workarounds that we developed. And we're still using them now. Now, that we've actually merged with the Hudson River, I think they might have other enhancements or EHR enhancements that we're looking forward to making you some too.

ANGEL JOHNSON: Thank you. I hope that was helpful, Andrea. Darnelle, can you tell us a little about what encompasses the client self-management program.

DARNELLE DELVA: Sure. So for our program, we were trained in two different programs, one which was more towards addressing HIV and the symptoms and barriers to adhering to the medications. And that was probably the self-management program. And this was developed by Stanford. And then another self-management program that we were trained in was called WHAM. And this was a Whole Health Action Management program.

This one deals with addressing your disease and managing that disease, but not directly focusing on HIV. And then both programs were long sessions, almost three hours. And here the peer and the patient navigator, they would facilitate these groups. And they were really both didactic.

And also, there is a chance for the client to establish goals. And then when they came back from the next sessions, they would report out on their goals. And the goals were largely around what was discussed during the session of that day. And they can range from anything from sidings to take your medication at a certain time, or if they had to deal with being healthier, maybe adding a new or healthier meal to your day, or drinking more water, and it's entirely on the participants to decide what goal they wanted to establish and address.

ANGEL JOHNSON: Thank you, Darnelle. And how did you choose which staff to complete training, and was it voluntary?

DARNELLE DELVA: So for the grant, we really have the PT team to be trained in the group, in facilitating group. I think they have more time. At least for the grants were the staff that were selected to be trained.

We do have other grant programs. And we've trained other staff within these grant programs to also be trained in the WHAM groups. And we're using them at other clinics and other-- well, for other groups of patients as well.

So it's really those who have time. We do think that it's valuable for people who are health coaches or case managers to be trained in programs like these to facilitate them as well. And especially when you have a peer to facilitate, I think that's valuable as well.

ANGEL JOHNSON: Thank you, Darnelle. Dr. Ramers, were there any incentives used for supporting staff training in your program?

CHRISTIAN RAMERS: Yeah, thanks for the question. Remember that we split our trainings into sort of the medical provider side of things and the staff. For medical providers, we kind of made it an application-based program.

So we tried to hype it up a little bit and make it something that people would want to do to distinguish themselves from their colleagues. And so in and of itself, that provided some incentive. And for staff, it was really about just paying them for their time. So we did offer payment, regular payment, extra hours, essentially, for those trainings that were conducted.

ANGEL JOHNSON: Thank you. Thank you, both. And do you we any other questions from our audience?

OK. So if we don't have any other questions from the audience, I will ask if either of our presenters have any final word they like to say regarding their program.

CHRISTIAN RAMERS: Sure. I can jump in and just say that this is a lot of work to twist the arms of people that may or may not want to do HIV care, but it's really, really needed in the community. As I mentioned at the top, a lot of HIV providers are retiring. We need a good workforce to take care of the patients that currently have HIV.

DARNELLE DELVA: That's very true.

ANGEL JOHNSON: Thank you all so very much for your participation. And thank you to our attendees. If you have additional questions for today's webinar or any of the webinars in this series, please don't hesitate to contact SPNs at [HRSA.gov](http://HRSA.gov).

And if there are no other questions, then this concludes our SPNS webinar session for today. Thank you, Dr. Ramers. Thank you, Darnelle, very much for your time.

DARNELLE DELVA: Thank you.

CHRISTIAN RAMERS: Thank you very much.