Crossing the Know-Do Gap:
Continuing Education for Health Professionals Providing HIV/AIDS Care

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• Background/Introduction
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  – Limitations
• Implications/Future Directions
What do we know and need to know?

• Challenges in HIV care include
  – ensuring that new knowledge is translated into effective care
  – Ensuring that new providers are supported as they enter the HIV provide community
  – Supporting the existing HIV providers to remain in care, motivated and up-to-date

• Overcoming these challenges defines the goals of NEAETC
Why Should We Care?

- Shrinking funds – urgent need to understand impact of investments in the HIV workforce
- Growing gap in available providers due to lack of replacements in HIV workforce, aging workforce, movement to PCPs not warmly embraced.
- Need to understand how to successfully retain and sustain the HIV workforce
Why Should We Care?

• Urgency to develop PCPs as quality HIV providers is impacted by HIV complexity, aging populations, co-morbidities and increasing educational needs of providers.

• Need to understand the effectiveness of distance learning vs in-person education and mentorship.
  – Lack of clarity re impact of this shift to distance learning on HIV provider workforce and patient outcomes.
  – Can this modality adequately support Communities of Practice?
What do we know today

• Quantitative data that AETCs collect provide a great deal of important information on population served and knowledge gain

• Almost 60,000 trained in 2011-2012
  – Approx. 70% are providers of clinical care

• Training participants consistently indicate they gain knowledge from AETC trainings
NEAETC Training Participants 2010-2014, by Discipline and Year

- PA
- Other Dental Professional
- Dentist
- APN
- Clinical Pharmacist
- Nurse
- Physician

Year 2010-2011:
- 15% Other Dental Professional
- 7% Dentist
- 7% APN
- 4% Clinical Pharmacist
- 3% Nurse
- 1% Physician
- 1% Other

Year 2011-2012:
- 13% Other Dental Professional
- 11% Dentist
- 4% APN
- 3% Clinical Pharmacist
- 3% Nurse
- 1% Physician
- 1% Other

Year 2012-2013:
- 13% Other Dental Professional
- 7% Dentist
- 4% APN
- 2% Clinical Pharmacist
- 1% Nurse
- 1% Physician

Year 2013-2014:
- 15% Other Dental Professional
- 8% Dentist
- 5% APN
- 3% Clinical Pharmacist
- 2% Nurse
- 2% Physician

Average:
- 14% Other Dental Professional
- 8% Dentist
- 5% APN
- 3% Clinical Pharmacist
- 3% Nurse
- 3% Physician
- 1% Other
Why This Evaluation?

• After 28 years need to better understand the Value /Impact of what we are doing to continue to improve quality and effectiveness.

  – How is NEAETC helping providers translate knowledge into practice?
    • Experienced and novice
    • Crossing the Know-Do gap

  – How has NEAETC contributed to the retention and recruitment of providers into the HIV field?

• To do this we needed mixed-methods
Adult Learning

- Adult learning gives attention to situations and problems faced by learners
- Adult learning is a cooperative venture in non-authoritarian, informal learning
- Experience – and the analysis of experience – are the richest resources for adult learners
- In an adult class the student’s experience counts for as much as the teacher’s knowledge

A Learning Continuum for Communities of Practice:
Moving from Knowledge Transfer to Knowledge Translation

Communities of Practice

Novice

Information

Mentorship/Preceptorship

Confidence to Apply

Expert Empowered Teams

Bridging the Know-Do Gap

↔ Changes in information about virus/tx ↔

↔→ Information

↔→ Changes in information about virus/tx ↔

↔→ Changes in information about virus/tx ↔
Community of Practice

- Groups that share similar goals and interests. In order to achieve these goals they employ common practice, language and tools (skills).
- As a community they hold similar beliefs and value systems.
- The future of healthcare is the community practice model – “it takes a village”
Why a Community of Practice?

- Virtual or in-person
- Facilitates peer-to-peer learning and sharing of best practices, support and goals
- Together can help articulate the needs of the communities they serve
- Common in medical care communities
  - How do we further develop a Community of Practice Model in diverse settings such as CHC’s and rural areas that will support all levels of providers in delivery of quality effective care?
Methods

A qualitative study using semi-structured interviews with 30 HIV providers in Massachusetts
Interview Guide

- Describe your HIV/AIDS work.
- What has kept you motivated to stay in this field over time?
- Describe some of the NEAETC HIV/AIDS trainings you have attended.
- Why do you keep coming back?
- How (if at all) have NEAETC trainings contributed to your ability to provide quality HIV/AIDS care over time?
- What (if any) are some strengths of the NEAETC offerings from your perspective?
- What (if any) suggestions do you have for improvement?
- What (if any) other sources of HIV/AIDS trainings do you use?
## Sample Codes & Definitions

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>Examples</th>
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<tbody>
<tr>
<td>Attribute</td>
<td>Aspects of location, timing, topics or modalities that support respondents’ participation</td>
<td>It's really helpful to have a variety of courses or updates or conferences that are available to the different perspectives that I have on my staff</td>
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<tr>
<td>Impact</td>
<td>Examples of times or incidents when respondent was grateful for NEAETC training or otherwise describes training impact</td>
<td>When you have multiple people from the same office hearing the same message at the same time, it's easier to go back and train others and change policies or practices or procedures because they have all heard the same message together</td>
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<tr>
<td>Suggestions</td>
<td>Suggestions for improvements, speakers, new training topics, etc</td>
<td>Things that cross boundaries between HIV and other stuff that we do, for example, HIV and renal disease or cardiac risk factor or HIV and its relation to cancer screening, ... the bottom line in terms of what I need to do for my patients and screening. That would be a nice talk to have.</td>
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Descriptive Characteristics of Evaluation Study Sample (N=30)
By “Big 6” Discipline

- Physician, 13
- Nurse, 6
- APN/NP, 6
- PA, 1
- Dentist, 2
- Other Dental Professional, 1
- Other, 1
Descriptive Characteristics of Evaluation Study Sample (N=30)
By Years as HIV Provider

- 10-19 years: 27%
- <10 years: 23%
- >30 years: 17%
Insight – Tailor topics & modalities

“Not every topic is valuable at every site. Tailoring speakers and topics to the site is right on.”

“Some dental programs are available through live web conferencing so that people in other states who don't want to travel can watch the program live, call in, and have their questions answered.”

• Engage learners and organizations in determining training topics and modalities and tailoring training to needs of individuals and sites.
Insight – Experts & Mentorship

“Having people come in here and talk is a lot more intimate and it's more of a conversation.”

“Trainings where the faculty member presents cases is really helpful. It really sticks.”

“I am little bit isolated as there are no other infectious disease or HIV doctors where I practice. The trainings help me learn more about HIV and keep up to date.”

• Bring experts who can impart best evidence and translate it to practice, and provide mentorship that ultimately expands the resource network
“The range of topics is diverse. They are valuable for the beginning person who wants to learn about HIV and how to provide care and be empathetic to HIV patients and their family. They are also tailored to advanced individuals, so I find that very valuable.”

• Approach HIV care comprehensively, so providers can treat the whole person
Insight – Empowerment Means Better Quality of Care

“It's a very big disconnect between seeing a PowerPoint slide of a major study on the screen and then going and changing practice for the patient, which is a very high risk when you have people’s lives on the line. The [NEAETC] clinical training is empowering and gives you the confidence to make changes.”

- Training that empowers providers to make changes results in better quality of care
“All types of staff, from medical providers to case managers to receptionists attend the trainings at my site. This helps the team to develop shared knowledge and helps people at all levels to feel that they are part of the team.”

“When the trainings are inside the health center, it’s a lot easier to get the whole team to go.”

• Reach individuals and teams, by diffusing information that helps to strengthen Communities of Practice
Training Suggestions – from Respondents

• Maintain the ability to tailor programs to providers and settings. Offer a menu of different opportunities (topics, modalities)

• Continue to bring HIV to the attention of the public and providers to prevent complacency
Suggestion – Incorporate Primary Care Outcomes into Quality Measures

“We have a quality improvement program and we are following HIV-related outcomes, and those have been very solid and good, but we haven’t yet found a way to incorporate primary care-type measures into our HIV quality measures.”

• Could the AETCs help quality measurement move in this direction?
<table>
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<th>Outcomes – Respondent Perspectives</th>
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<tr>
<td>• Earlier diagnosis</td>
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<tr>
<td>• Keeping partners negative</td>
</tr>
<tr>
<td>• Patient-centered care</td>
</tr>
<tr>
<td>[whole person, not just HIV</td>
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<tr>
<td>patient]</td>
</tr>
<tr>
<td>• Care provided by cohesive,</td>
</tr>
<tr>
<td>multi-disciplinary team</td>
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<tr>
<td>• Better patient-provider</td>
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<tr>
<td>relationships</td>
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<tr>
<td>• Catching issues early [e.g.</td>
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<tr>
<td>kidney disease]</td>
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<tr>
<td>• Improved care for all patients</td>
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<tr>
<td>with similar co-morbidities</td>
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<tr>
<td>• Referrals to specialists</td>
</tr>
<tr>
<td>• Better medication management</td>
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<tr>
<td>• Better viral suppression</td>
</tr>
<tr>
<td>• Improved quality of life</td>
</tr>
<tr>
<td>• Increased hope</td>
</tr>
<tr>
<td>• Improved awareness of new</td>
</tr>
<tr>
<td>evidence, e.g. HIV in brain</td>
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In sum, respondents told us that NEAETC programs...

- Are accessible
- Have contributed to the building of Community Practice
- Are tailored to the needs of providers in their settings
- Have bridged the Know-Do gap between knowledge and translation to practice (bench to bedside)
- Should maintain what works in training and advocacy, and seek to refine quality measurement to better match care model
“We have all become knowledgeable about HIV, and it’s really an area of expertise for us as primary care clinicians. There is value to the patient to have this cohesive team, this multi-disciplinary team, because the patients are so complicated, and we have actually got pretty good results. About 80% of our patients are virally suppressed.”
Limitations of the Study

• A random sample of providers was invited to respond, but participation was self-motivated. Respondents wanted their voices heard – both positive and negative. However, providers with more negative experiences with NEAETC training may have been missed.

• The data gathered are self-reported. Memories can be faulty. A given day or time, or even just talking by phone instead of in person can influence the information shared.

• Primarily an urban/suburban sample.
Implications/Future Directions

• Continue with what works:
  – Provide a range of topics and training modalities that will allow providers to choose the best fit
  – Continue to tailor programs to meet the needs of local and regional audiences and urban/rural
  – Use a Community Practice lens to provide programs that meet the needs of the Big 6 along with all team members
  – Use a mixed methods approach to measure the outcomes of NEAETC practice.
Implications/Directions cont’d

Suggestions for improvement:

– Consider new learners, e.g. long-term care, geriatric, school providers

– Facilitate interactions between isolated providers and HIV experts throughout the region to strengthen Communities of Practice

– Expand mental health topics to help provider teams address the comprehensive HIV patient needs and to imbed strategies that impact behavioral health
Implications/Directions cont’d

Suggestions for improvement:

– Continue the success of peer-to-peer modalities that enhance Communities of Practice

– Use evaluation methods (mixed methods) that track and illuminate program impact on individual, population health and primary care practice
Ongoing Challenges

• How best to support the HIV healthcare team given shrinking dollars to invest in them and in their education and training?

• How to maintain a balance between the needs of learners, the healthcare system, and policymakers?
  - Seeking input from all three moving forward will be vital to maintaining successes to date.

• How understand and more successfully measure the impact of what we do, and use that as the basis for quality improvement?
  - Continuation of funding for HIV-related programming, education, tx, and research is vitally important
Fear is a primal emotion in medicine. The fear of making a mistake and causing harm never goes away, even with decades of experience.


You need to walk a mile in their shoes.

– Unknown
Q & A
Acknowledgments - Thanks

- Providers who responded
- The NEAETC Teams in Boston and Worcester
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