PROMISING PROGRAM SERIES:

Prevention for Positives

Transitioning an HIV Primary Care Clinic into a Patient-Centered Medical Home through the Incorporation & Expansion of Partnership for Health

Developed by CBA CENTER High-Impact HIV Prevention Capacity Building Assistance for Healthcare Organizations

A CAI Center of Excellence

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Introduction

This resource describes the Prevention for Positives Program. A promising practice established by the Ruth M. Rothstein CORE Center in Illinois that uses elements of Partnership for Health (PfH) and the establishment of a Patient-Centered Medical Home model (PCMH) to improve upon the HIV primary care model. This resource discusses the importance of using a PCMH model, describes PfH intervention and explains how the Prevention for Positives Programs adapts the core values of PfH to a PCMH model.

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Background

HIV is now treated as a chronic disease. The CDC reports, "[t]hree decades after the first cases were reported in the United States, HIV infection is no longer inevitably fatal." [1] With the introduction of highly active antiretroviral therapy (HAART) in the mid-1990s, AIDS diagnoses and deaths declined from 1995 to 1997 and remained stable from 1999 to 2010. [2] As a result, the number of people living with HIV/AIDS (PLWHA) continues to rise, and people are living longer, healthier lives. [3]

It is now estimated that 11% of new HIV diagnoses are among people over the age of 50.[4] With the aging of PLWHA and new diagnoses among people over 50, the management of chronic diseases is even more important.

To maintain good health outcomes, the HIV Primary Care model must redesign itself and transform into a Patient-Centered Medical Home (PCMH), using the Chronic Care Model (CCM) as a foundation. PCMH has been proposed as a model for transforming primary care to improve efficiency and effectiveness in the healthcare system.

The PCMH model emphasizes the relationship between a patient and his or her care team along with holding this relationship accountable to ensure accessibility, continuity of care, comprehension of services, and care coordination.[5] The model bases its method of care delivery on the CCM, which includes attention to the community, the health system, self-management support, delivery system design, decision support, and clinical information systems.[6]

Accordingly, implementing the CCM helps practices transform care for patients with chronic illnesses from acute and reactive to proactive, planned and population based.[7] With alignment of the HIV Primary Care model to a PCMH, the following Prevention for Positives model was adapted and expanded to include not only HIV disease prevention but prevention of other co-morbidities such as hypertension, diabetes, and hepatitis C.

The Partnership for Health Intervention

Partnership for Health (PfH) is a Center for Disease Control and Prevention (CDC) High-Impact Prevention (HIP) Evidence-Based Intervention (EBI). PfH is a recommended behavioral EBI to target PLWHA by using "message framing, repetition, and reinforcement during patients' visits to increase HIV-positive patients' knowledge, skills, and motivations to practice safer sex." [8]

This EBI seeks to identify the patients' attitudes, beliefs, and personal values related to their transmission related behavior.[9]

Core Elements of PfH

Core elements are the parts of an intervention that should not be changed. In the development of interventions, researchers articulated what defines their intervention—those fundamental components that, if changed, would transform their intervention into something other than what they had deemed to be effective.[10]

The CDC PfH factsheet lists the following core elements of its intervention:

- Providers deliver the intervention to HIV-positive patients in HIV outpatient clinics
- The clinic adopts prevention as an essential component of patient care
- All clinic staff are trained to facilitate prevention counseling into standard practice
- Waiting room posters and brochures are used to reinforce prevention messages delivered by the provider
- Supportive relationships are built and maintained between the patient and the provider

- During routine visits, the provider initiates at least a 3- to 5-minute discussion with the patient on protection, partner protection, and disclosure
- The provider incorporates good communication techniques and uses consequences-framed messages for patients engaged in high risk sexual behavior
- Referrals are provided for needs that require more extensive counseling and services
- Prevention messages are integrated into clinic visits so that every patient is counseled at every visit" [11]

Key Messages of PfH

PfH focuses on three key messages, one of which a patient chooses to focus on and is discussed and reinforced at every visit. These messages include:

1. patient self-protection through safer sex
2. partner protection through safer sex
3. disclosure of status to sex partners[12]

PfH was the first CDC-supported prevention program designed to reduce high-risk sexual behaviors and increase disclosure of HIV status among PLWHA and which has evidence from a randomized, controlled trial study.

That study found that brief provider counseling in consequence framing can reduce HIV-transmission behaviors among HIV-positive patients who engage in high-risk sexual behaviors.[13] In the same study, HIV-positive patients who had two or more partners at baseline were significantly less likely to report unprotected vaginal or anal sex after the intervention than those in the comparison group.

Overall, PfH seeks to improve patient–provider communication about safer sex and HIV prevention while incorporating conversations about disclosure of HIV serostatus.

The Prevention for Positives Program

Adaptation of PfH Intervention for a PCMH Model:

The Prevention for Positives Program is the adaptation of the PfH intervention to a PCMH model. Like PfH, the Prevention for Positives Program is medical provider-driven and uses a multidisciplinary team including a Health Educator (HE), Peer Educator (PE), Care Coordinator, nurse, and medical provider. The Prevention for Positives Program, also features strong, consistent messaging with patients. This messaging model provides a distinctive advantage for all members of the PCMH team.

The first step of Prevention for Positives Program is the integration of the PfH-consistent messaging as a standard of practice throughout the multidisciplinary team. At every clinic visit, a patient is met by a PE who connects the patient with an HE. The HE discusses recent sex partners as well as provides safer sex options and preventive barriers as needed.

During this session, the HE promotes behavioral change based on the healthcare goals identified in conjunction with the patient. Patients that report having engaged in condomless sex, sex with multiple partners, or those who have current STIs are referred to CORE's onsite Partner Services. The objective is to reduce new HIV infections among sex partners along with HIV reinfections and coinfections with STIs.

To request training and technical assistance about how to increase your HIV testing efforts at your Health Care Organization, Visit the HIVCBACenter.org.

The second step of CORE's Prevention for Positives Program is the expansion of health education to include other comorbidities — conditions more prevalent in the aging HIV-positive population, such as diabetes, hypertension, and chronic renal disease.

It was identified early on during Prevention for Positives sessions that clients wanted to set goals beyond self-protection and partner protection and to focus more on living longer and healthier lives. These sessions expanded to include eating healthier, exercising, smoking cessation, and medication adherence using Motivational Interviewing techniques to promote health behavior change messages. In the past three years, 42% of all goals created by patients were focused on these additional health areas.

The Role of Health Educators (HE) in Prevention for Positives:

Job Duties: HEs are assigned to 16 four-hour HIV Primary Care clinics. Patients who are newly diagnosed or who have returned to care are automatically connected to a Prevention for Positives HE through the PE. In general, HEs provide risk-reduction counseling, safer sex education, and disclosure counseling. The following list outlines specific details of the ways in which the HEs implement the PfH intervention:

1. PEs refer a patient who reports engaging in risky transmission-related behaviors to the HE for an individual-level intervention (ILI).

2. During the ILI, the HE assesses the patient's behavioral risk factors associated with transmission-related (unprotected anal or vaginal sex) behaviors and identifies factors that may affect non-adherence to medical care while also dispelling erroneous beliefs about HIV disease. The ILI conversation is based on the PfH principles of self-protection, partner protection, and/or disclosure. Conversational role playing is used if needed to model examples of discussing safer sex or disclosure to partners.

3. The HE also assesses any other health concerns the patient may have. Discussions topics include HIV/STI 101, medication adherence, transmission, nutrition, hypertension, diabetes, cholesterol, smoking cessation, substance abuse, and establishing healthy relationships.

4. HEs help the patient create solutions by using consequences-framed messaging and reinforcing any protective behaviors. During this process, the patient and HE identify a SMART (Specific, Measurable, Achievable, Relevant, Time-phased) goal to help support positive behavior change.

5. HEs document the following in the patient's EMR: patient encounters, number of sex partners, adherence, condom use, risk behaviors, sexual identity, harm reduction plan, goals, action plan, and any discussion topics from the ILI session.

6. The HE follows the patient for a period of up to four sessions in which the HE assesses the SMART goal for behavior change progress and addresses achievements, challenges, and/or barriers. The time between the four sessions varies depending on the patient's schedule.

7. The HEs participate in pre-clinic meetings to discuss their patients and share information with the multidisciplinary team that helps develop patients' care plans. Ad hoc case staffing and weekly clinical supervision are conducted for improved coordination of care.

Training: Prevention for Positives HEs are full-time employees at the Core Center with annual salaries starting at $32,000. Training is provided for HEs and training topics include HIV facts, HIV treatment, medication adherence, STI education, Motivational Interviewing, nutrition, smoking cessation, and cultural competency.

HEs stay up to date with advances in the HIV-treatment field by attending workshops sponsored by the Chicago Department of Public Health, the Midwest AIDS Training + Education Center, and the AIDS Foundation of Chicago. Prevention for Positives staff receives Partner

Services training through the Denver Department of Public Health and Environment. The Partner Services training provides a unique advantage to Prevention for Positives HEs in that they are able to conduct partner elicitation in the clinic and provide that information to the on-site Disease Intervention Specialist. They also receive training on the electronic medical record (EMR) charting and outcomes tracking

Supporting Outcomes

The outcomes below provide evidence of the model applied to 2,076 patients receiving HIV/AIDS care between 2012–2014. In the last three years, 80% of the 480 patients who completed four sessions with an HE have set goals and made changes toward them.

The most common goals set by patients were centered on medication and treatment adherence, nutrition, exercise, condom use, and smoking.

- **Adherence** - Improving and maintaining high levels of medication adherence among Prevention for Positives patients results in lower individual viral loads and increased protection for patients and their partners.[14] Of the CORE patients who set goals surrounding medication adherence, 89% partially or fully achieved their goal.

- **Condom Use** - Patients who set goals related to safer sex were interested in increasing condom use and reducing number of partners.

    - Out of the patients who identified increasing condom use as a goal, 85% partially or fully achieved their goal.

    - Out of all patients seen for Prevention for Positives, the mean number of partners reduced from 2.9 to 1.3.

- **Relationships** - Improving relationships and increasing disclosure is an essential part of improving patient health outcomes, improving support surrounding the diagnosis, and protecting partners.[15] Goals surrounding relationships involved improving relationships and disclosing to partners, friends, or family members: Almost three quarters (73%) of patients partially or fully achieved their goals surrounding relationships.

- **Viral Load** - Viral loads for patients are measured by lab results in three- and six-month intervals to track viral load suppression, an important biomarker that indicates disease progression and predicts health outcomes.[16] Using a cohort of 526 Prevention for Positives patients seen in 2012, the baseline viral load suppression was 49% at the first interaction with an HE; four sessions later, viral load suppression in this group reached 82%.

- **Retention** - Retention in HIV care is defined by the Health Resources Services Administration as two or more primary care visits at least three months apart within that year. Retention among Prevention for Positives CORE patients was 61% a year after starting the program and increased to 77% the following year.

- **Nutrition** - Improving nutrition was the second most frequent health prevention goal set. Four out of five (83%) patients who identified a nutrition goal (such as reducing caloric intake and reading food packaging labels) achieved their goal partially or fully.

- **Exercise** - In addition, many patients expressed an interest in exercise. 72% of all patients that identified an exercise-related goal partially or fully achieved their goal.

- **Smoking Cessation** - Goals related to smoking cessation were also popular. Of the patients that identified a smoking related goal, 86% were partially or fully successful in achieving their goal.

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Recommendations for Best Practices

Based on the successful implementation of the CORE Prevention for Positives Program, the following are recommended best practices for designing and incorporating PfH interventions within an HIV Primary Care Clinic:

- Incorporate Health Educators as part of the PCMH multidisciplinary team
- Provide consistent HIV-prevention messaging during each primary care visit
- Expand Health Educators' knowledge base to include other diseases such as diabetes, hypertension, and chronic renal disease
- Provide MI trainings to all clinic staff
- Ensure that Health Educators are trained well in outcomes tracking and the EMR system so that the patient outcomes are tracked accurately
- Develop and implement an electronic medical note which identifies patient's goals and level of accomplishment such as completely, partial or not met
- Consider PfH as an intervention in clinical settings to provide the initial framework that establishes a Prevention for Positives Program. This EBI can be adapted, as demonstrated by the CORE program, to maximize patient outcomes

Our trained staff can provide tailored training and TA to help your organization achieve your prevention with positive goals and work towards meeting the national HIV care standards.

Contact CAI to request free training and TA on the intervention Partnership for Health or other high impact prevention techniques.

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