ACTHIV® ChangeMakers: Empowering HIV Clinicians to Lead Improvements in Care

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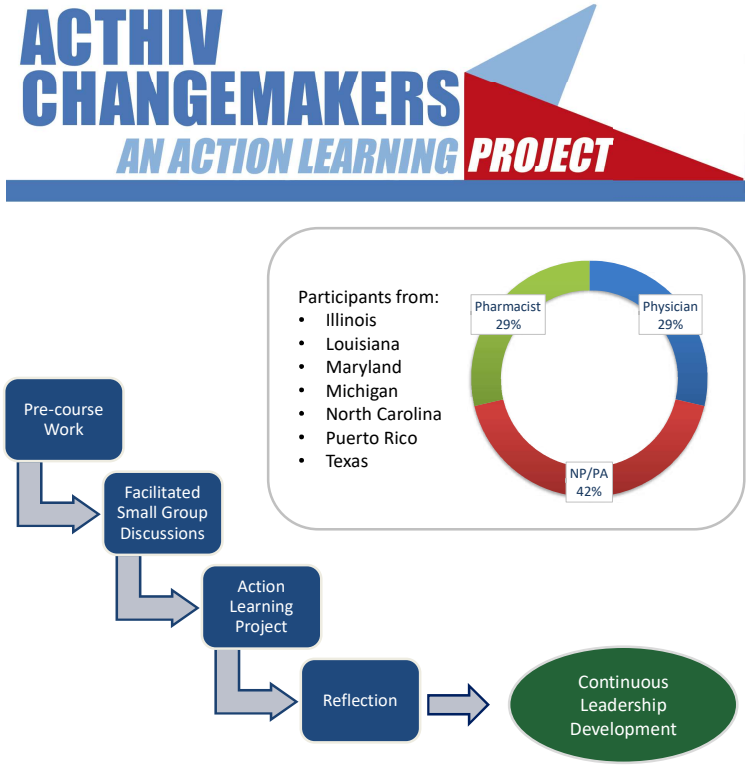
BACKGROUND

Team-based care is essential for delivering high-quality, patient-centered, and comprehensive care for people with HIV (PWH). However, HIV clinicians often face challenges in leading and managing their teams, especially in resource-limited settings. To improve team-based care, HIV clinicians need to develop and demonstrate leadership skills that can foster collaboration, communication, and innovation among team members. American Academy of CME Inc. and its ACTHIV® Institute worked in collaboration with Q Synthesis LLC to run a 9-month leadership program called ACTHIV® ChangeMakers. The goal of the program was to equip and enable HIV care team members to develop and demonstrate leadership in HIV care in their organizations by joining a learning collaborative and developing an action learning project designed to improve local care delivery.

METHODS

The 2023-24 ACTHIV® ChangeMakers learning collaborative was launched with 7 HIV clinicians from diverse practice settings. Through a series of facilitated meetings over six months, the group discussed key issues and challenges related to team-based care in HIV and learned about adaptive leadership principles and practices. The group discussed ways to apply the **adaptive leadership framework** to tackle complex challenges that require learning and change. Other leadership frameworks and models were incorporated into case discussions and interprofessional team scenarios.

Clinicians also reflected on their own leadership styles, strengths, and areas for improvement. As part of the learning collaborative, each clinician developed and implemented an "action learning project" that aimed to address a specific problem or opportunity related to team-based care in their clinical setting. The action learning projects allowed the clinicians to demonstrate project leadership and improve care delivery.



RESULTS

The action learning projects covered a range of topics, such as improving transitions in care, facilitating team-based care planning, improving the referral process, and addressing psychosocial needs. Clinicians reported that the action learning projects helped them to apply adaptive leadership skills, such as diagnosing the situation, mobilizing stakeholders, and experimenting with interventions. The clinicians shared their project results and lessons learned with the other members of the learning collaborative and received feedback and support.

Adaptive Leadership

Technical Challenges:	Adaptive Challenges:
The problem is clearly identified and defined	Difficult to define the problem
Proven technical or process-driven solutions are available	No clear solution may be available
Often solved by an expert or by an authority	Solution requires a collaborative effort by people throughout the department or organization
Implementing the solution is generally straightforward	Implementing a solution may require some experimentation

CONCLUSIONS

The 2023-24 ACTHIV® ChangeMakers learning collaborative demonstrated the value of equipping HIV clinicians with leadership skills and providing specific opportunities to improve care. By participating in the learning collaborative, clinicians improved team-based care and addressed complex problems related to HIV care delivery. The learning collaborative also created a community of practice among HIV clinicians who shared common goals, challenges, and experiences as they grew to develop and apply leadership skills. Learning collaboratives offer a valuable forum to build leadership capacity, share effective practices, and ultimately improve patient care.

ACTHIV Changemaker: Implementation of Interdisciplinary Team Case Discussions in an HIV Clinic

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1. Centro Ararat, Ponce, PR.; 2. Nova Southeastern University, Barry and Judy Silverman College of Pharmacy, San Juan, Puerto Rico

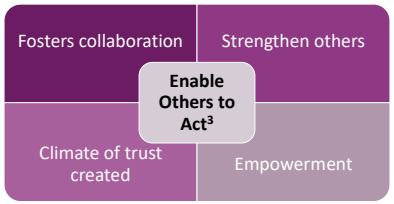
BACKGROUND

- Centro Ararat is a non-for-profit organization in Puerto Rico that manages over 1,200 people with HIV.
- Clinics are located at Ponce, San Juan, and Arecibo.
- Gaps in interdisciplinary communication were identified by clinic leaders since patient cases were discussed in an informal manner.
- A formalized case discussion with representation from all team members (physicians, pharmacists, nurses, case managers, nutritionists, psychologists, and quality personnel) was proposed.
- Studies exploring team case discussion focus on the management of patients with cancer. [1,2]
- These studies have demonstrated that a multidisciplinary team approach is important in decision-making and can lead to changes in patient management plans, although it did not cause an impact in cancer patient survival outcomes.[1-2]
- Gaps have been identified during these meetings such as case complexity, and availability of clinical information.[2]

Project Goals

- Improve team communication
- Build team trust
- Find possible patient-centered solutions for the problems presented
- Improve patient outcomes

Leadership Framework



METHODS

- A core leadership team was identified to coordinate and lead case discussions:

- Elements included in the case presentation template:

- Criteria for including patients in case discussion was developed
  - Inclusion criteria: new patients, patients who miss clinic appointments, patients with detectable viral load, or patients with special needs (e.g. complex socioeconomic status).
- Cases were pre-selected by the core leadership team for the first case discussion.
- Interdisciplinary team members were empowered to identify and propose patient cases for subsequent meetings.

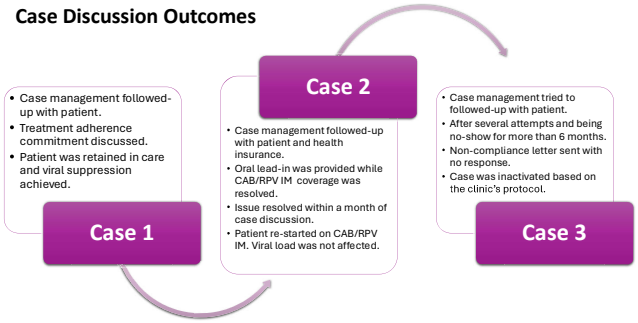
RESULTS

- The first formal patient case discussion was done in November 2023 led by the core leadership team.
- Great representation and strong participation from all interdisciplinary areas was observed in the first meeting.
- Staff were encouraged to introduce new ideas to challenging topics. For example, staff discussed ways to improve how clinics handled missed appointments by involving case managers and establishing commitment from patients.
- The total duration of the case discussion was about 2 hours.

- Staff reported feeling empowered to voice ideas and make recommendations.

RESULTS

Case Discussion Outcomes



Case Discussion Evaluation Results

- All respondents (100%) strongly agree that the formal case presentation was conducive to discussion amongst team members, strengthened interprofessional communication and collaboration, and helped to identify specific ways to improve patient outcomes.
- Seventy percent of respondents recommended that case discussion should be limited to 1 hour and that only 2 cases should be presented.
- Eighty six percent of respondents recommended that these meetings should be done every 3 months.

CONCLUSION

Team case discussions have yielded a positive impact amongst the interdisciplinary team as it enabled great participation of its members, increased communication, and lead to improving patient outcomes for most of the cases discussed. One of the main limitation in the implementation process of this formalized case discussions was scheduling conflicts. Our immediate goal is to establish this meetings every 3 months. Our future goal is to enable others to lead and continue this work by implementing it in other clinics or other service areas.

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ACTHIV Changemaker: Collaboration Across the Carceral Continuum

Author: Britt Gayle, MD/MPH

Background:

- Jail detainees typically serve jail sentences of under a year.
- Nearly 25% of jail detainees are released within two weeks
- Pre-trial detainees frequently have rapidly changing timelines with little advance notice of transfer, release etc.

Methods:

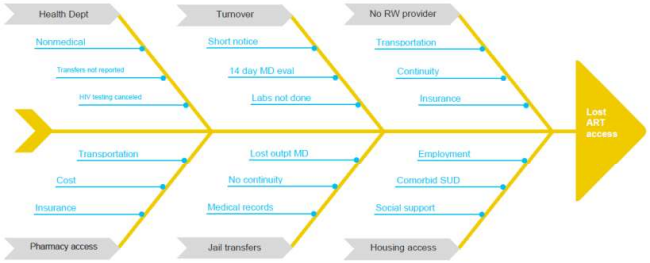
- The Adaptive Leadership model was used to solicit input from patients at Carroll County Detention Center
- Challenges highlighted by patients incorporated into discussion with Carroll County Health Department

Themes from Patient Responses

- Transfer across jails disruptive to continuity
- Lack of access to stable housing post release
- Relocation reduces access to ART prescription and medical services

Early coordination with Health Department is crucial

- *Independent of carceral system*
- *Provides time to coordinate*



Next Steps:

- Re-establish Health Department rapid HIV testing every 1-2 weeks
  - Opportunity to coordinate with medical team
  - Opportunity for case management
- Start consenting process for Health Department case management at intake and/or 14 day MD visit

ACTHIV ChangeMakers: Simplifying Antiretroviral Regimens Through Pharmacist-led Interventions

Authors: Ilona Guerra, PharmD, AAHIVP; Daniel Listiyo, PharmD Candidate 2024; Victoria Briggs, PharmD Candidate 2026; Glory Garcia, PharmD Candidate 2026

Background:

People with HIV often have several comorbid conditions resulting in increased pill burden. At Legacy Community Health, pharmacists have an opportunity to make interventions through a therapeutic interchange protocol with in-house providers. However, our process included several steps that needed to be refined and this presented a leadership opportunity for our pharmacists. Our aim was to streamline how patients may be switched to a simpler medication regimen that decreases pill burden and optimizes adherence.

Methods:

Using an adaptive leadership framework, the team identified a therapeutic interchange opportunity for patients who are taking Descovy + Prezcobix. These patients may benefit from switching to a single medication: Symtuza.

The phrase "Adaptive Leadership" is model coined by Ronald Heifetz and Marty Linsky. A key step in this model is differentiating technical problems from adaptive challenges and applying different approaches to create solutions. Adaptive challenges require people to challenge the status quo and adopt an experimental mindset.

By applying the adaptive leadership framework, we identified the technical and adaptive challenges around the therapeutic interchange process. The team found ways to standardize technical, engage stakeholders for their input, and train pharmacy interns to contact patients and explain the rationale for therapeutic interchange. We implemented the protocol, tracked metrics, and explored ways to make further improvements.

Technical Challenges:	Adaptive Challenges:
P&T committee must first approve the therapeutic interchange of Descovy + Prezcobix → Symtuza to add to the standing protocol	Patient has been out-of-care with no reliable transportation to return to the clinic
The new regimen must be updated and approved by the state ADAP program	Patient did not feel trust in the pharmacist and/or provider and felt this medication switch was being pushed by the manufacturer
Insurance requires a prior authorization for Symtuza	Patient experienced side effects when beginning with Descovy + Prezcobix and feels weary to make a switch now
A procedure must be written out to standardize the steps of the project	The entire team must be educated on the procedure and feel empowered to take appropriate steps to complete the therapeutic interchange as appropriate

- Designed to optimize patient care, therapeutic interchange involves addressing technical and adaptive challenges.
- As the most accessible healthcare professional, pharmacists in any role can expand their leadership skills while positively impacting patient care.

LEGACY COMMUNITY HEALTH

Results:

The team worked with the P&T committee to approve the therapeutic interchange of Descovy + Prezcobix to Symtuza. The team developed a standardized protocol for identifying eligible cases, outlined roles and responsibilities, and implemented the new process. Pharmacy interns were tasked with contacting patients, explaining the benefits of switching, and obtaining patient consent. Interns also learned about ways to establish trust and communicate effectively with patients.

89 patients were on the combination regimen and 31 agreed to switch. Among those who did not switch, the following reasons were identified:

- 21 were out of care
- 17 did not have insurance coverage for the new medication
- 9 declined to switch
- 8 were unreachable
- 3 had an outside prescriber

Further analysis revealed that patients require a better understanding of treatment-related side effects, need access to reliable transportation, and need to trust their providers. These results provided additional insights on ways to further improve the process.

Conclusion:

Pharmacist-led interventions can simplify medication regimens for patients and help them adhere to their regimen. This project represents how pharmacists can expand their leadership skills while positively impacting patient care.

ACTHIV ChangeMakers: Early Intervention Specialist (EIS) Referral Process Utilizing a Standardized Referral Form For Newly Diagnosed or Lost to Follow-Up HIV Patients.

WAYNE STATE
School of Medicine

Authors: Tammie McClendon MSN, ANP, Gretchen Snoeyenbos Newman MD., Lauren Touleyrou MD, Armani Ford-Webb EIS, Ronald Doe-Patient Advocate, EIS

Background

Tolan Park Clinic is the largest HIV clinic in the city of Detroit, caring for over 1,800 patients a year. However, referrals into the clinic from hospital-based providers (attendings, fellows, advanced practice providers) were inconsistent with multiple inappropriate referrals to EIS, i.e., HIV negative, in care patients, and STI treatment. A lack of consistent process limited tracking of referrals and follow-up of patients who did not attend their appointment. Additionally, there was a lack of knowledge around enhanced services available to patients and requirements for those services.

Methods

Included analyzing the technical and adaptive challenges around referrals and identifying steps to address those barriers. We used an adaptive leadership framework to improve the referral process. This included analyzing the technical and adaptive challenges around referrals and identifying steps to address those barriers. On a technical level, the referral form was updated with questions designed to filter out inappropriate referrals. The new form was presented to EIS and provider stakeholders. Then an education effort was made through presentations to providers and EIS to ensure form completion and adherence to the new workflow. The reported information was adjusted as more cycles were conducted based on the needs of the participants.

Figure 1. Technical problems vs. Adaptive Challenges

Figure 2. Technical problems vs. Adaptive Challenges

Goals

- Tolan Park staff, fellows, and colleagues know who to contact for loss to follow-up patients.
- Improvement in completeness of reports received from clinicians and use of referral forms.
- Increased appropriate referrals received.
- Increase uptake of linkage to care for patient's loss of care.
- Improved awareness among staff and providers of Tolan Park ID specialty programs.

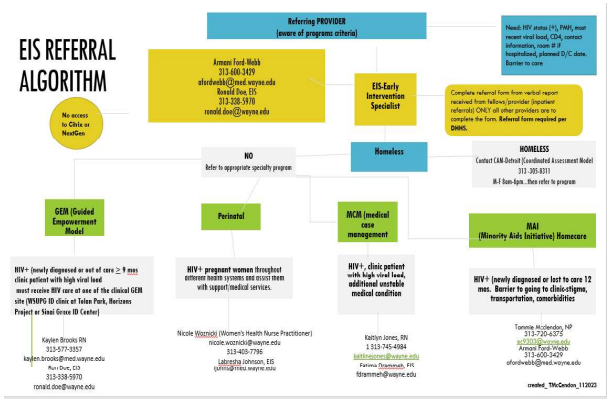


Figure 3. EIS Referral Algorithm

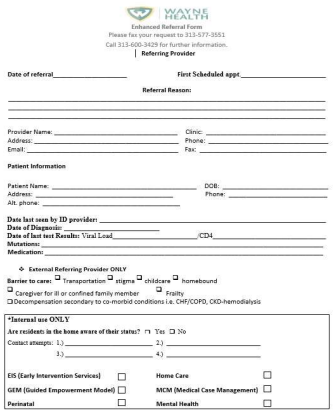


Figure 4. Enhanced Referral Form

Results

- A total of sixteen EIS referrals were received from 11/7/23-1/19/24.
- Four of those 16 patients attended their initial appointments.
- Ten patients did not attend and were not able to be rescheduled.
- One patient was hospitalized.
- One patient was in care with the Home Care program.

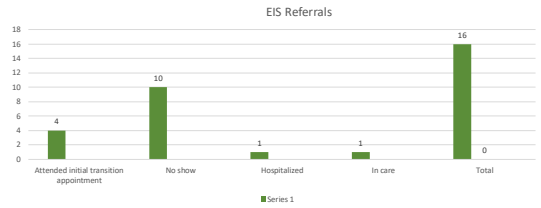


Chart 1. EIS referral results

Conclusion

Improving the referral process from the hospital to the clinic resulted in better communication and more appropriate referrals. The form was easy to adopt and acceptable to the stakeholders. The use of scripts and ongoing education increased uptake of this system and the quality of communication. Getting clients into care, even for the first visit, remains an adaptive challenge and will be the focus of future efforts.

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WAYNE HEALTH

ACTHIV Changemaker: Incorporation of Integrated Behavioral Health to Meet Psychosocial Needs of People with HIV Living in Eastern North Carolina

David J. Surovchak, PA-C, AAHIVS. *Carolina Family Health Centers, Inc.*

BACKGROUND

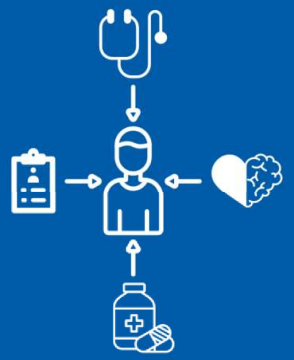
- The Southeastern United States has the highest rates of HIV in the country with some of the greatest psychosocial needs unmet.
- Carolina Family Health Centers, Inc. (CFHC) is a federally qualified health center, migrant health center, and Ryan White grantee in Eastern North Carolina.
- Social determinants of health (SDOH) are conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.
- CFHC's service area is negatively impacted by SDOH such as low income, housing instability, and food insecurity, to name a few.

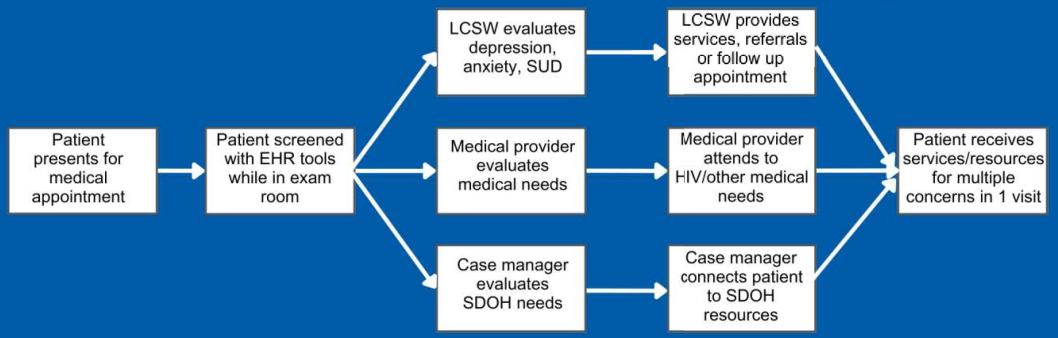
PURPOSE

- In 2023, CFHC used SDOH to screen 94% of Ryan White patients (541 out of 573) during their annual assessments. SDOH identifies psychosocial barriers focusing on housing, food, transportation, and other barriers. Any areas identified to be "At Risk" are addressed through an appropriate referral.
- **CFHC aimed to improve processes that need to occur when patients have psychosocial needs.**

A **patient-centered**, **multi-disciplinary** approach to clinical encounters with PLWH:

- *Improves* health outcomes,
- *Increases* access to care; and,
- *Addresses* underlying factors creating barriers to healthy lifestyles.





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METHODS

- Adaptive Leadership is a practical framework that helps individuals and organizations adapt and succeed in challenging environments.[1]
- The Adaptive Leadership Framework for Chronic Illness offers specific adaptive leadership strategies to improve patient-provider interactions.[2]

Step 1 – Identify the technical and adaptive challenges around screening and referrals.
Step 2 – Utilize tools in electronic health records system to screen for SDOH, depression, anxiety and SUD.
Step 3 – Link patients to members of care team who provide resources for screening results.

RESULTS

Established Integrated Behavioral Health by having a Licensed Clinical Social Worker (LCSW) stationed in the clinical work area during HIV clinic days for referrals from positive screenings. Results are over 1 year.

	Before	After	% Change
Patients Seen by LCSW	97	129	↑33%
Patients Enrolled in MAT	6	11	↑83%
PLWH MAT Visits	12	71	↑492%