

**Attachment D: Ryan White HIV/AIDS Program Models of Care -
Provider Interview Guide**

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0906-XXXX. Public reporting burden for this collection of information is estimated to average 120 minutes per interview. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, Maryland, 20857.

RW Models of Care Provider Site Interview

INTRODUCTION

Thank you for taking the time today to talk with us. Abt Associates is leading a project to explore different ways that care is delivered. We want to learn what effects the type of care delivery has on health and outcomes such as HIV viral load. The project will also look into the experiences that providers and clients may have with these different models of care delivery.

Abt Associates has been engaged by HRSA/HAB to conduct interviews with providers and staff in 50 different agencies/clinics. We aim to understand your experiences with different models of care. This interview may be done individually or as a group, as determined by leadership at your organization. We expect that the interview will take no more than 2 hours.

Date(s) of Interview	
Facility Name and Location	
Participants (full name & credentials)	Title and Role

1. **COMMUNITY CONTEXT.** We would like to learn about the community that your clinic serves.

1.1. Please describe some of the unique socio-economic and cultural characteristics of the community in which your clinic/facility operates and how these characteristics influence programming at your clinic/facility.

1.1.1. Probe: How would you describe the demographic characteristics of the community? Has it changed over time, and if so, how/why?

1.1.2. Probe: How widely available are medical and support services for people living with HIV within your community (including Ryan White Program and non-Ryan White Program funded services)? What are the gaps in medical/support services available to Ryan White HIV/AIDS Program (RWHAP) clients? [NOTE: **show list of services available at clinic**].

2. **CLINIC CONTEXT/History.** Let's now talk about your clinic and how its care for HIV positive clients has evolved over time.

2.1. How has the RWHAP clinic population changed over time in terms of:

- Demographics – how does this reflect the community at large?
 - Caseload – how many HIV positive clients does your clinic currently serve? (NOTE: **if provider does not know, how many HIV positive clients are on his/her panel?**) Has this changed over time (increased/decreased), and how/why?
 - Proportion of clients receiving RWHAP-funded services (NOTE: **confirm from site survey**) – how has this changed over time?
 - Health care coverage – What health care coverage types does your clinic currently accept? (NOTE: **confirm from site survey**) Medicaid? Health care exchange insurance? Private insurance? High risk insurance pools (if there are any currently operating in the state)? Clients without insurance?
- 2.2. Have RWHAP- funded services offered by your clinic changed over time, and why?
- 2.2.1. *Probe: Have there been expansion or reductions in RWHAP services offered at your clinic?*
- 2.3. Does your clinic partner with other community-based organizations to provide services? With which other community organizations does your clinic partner with most actively to provide services to clients? What role(s) do these partners play/provide? How has this changed over time?
- 2.4. Has the staff changed over time? How has the staff of the clinic changed over time in terms of: size, composition of provider types?
- 2.4.1. *Probe: What and how many staff currently serve at the clinic/facility? (NOTE: **Confirm from SMAT; and grant application**)*
3. **HIV MODELS OF CARE. Now let’s talk about your clinic’s model of care – how it delivers HIV services to RWHAP clients.**
- 3.1. First, how would you characterize or describe your clinic with regards to the dominant specialty or integration of specialties? (**Confirm from SMAT**) – Exclusively primary care; exclusively HIV specialty care; primary care-led co-managed or specialist-led co-managed?
- 3.1.1. *Probe: How is a RWHAP patient assigned to a physician in your clinic? – Exclusively primary care physicians; exclusively HIV specialist/ID physician; primary care-led co-managed or specialist-led co-managed?*
- 3.2. How is **care managed** for RWHAP patients among clinicians at your clinic?
- 3.2.1. *Probe: Which of these best describes your clinic?*
- **Physician¹-based care:** Comprehensive HIV care is delivered by physicians who primarily care for HIV-positive patients, regardless of their degree/training; the physicians manage most of their patient’s HIV, chronic disease, wellness, and acute care needs.
 - **Advanced practitioner-based care:** Nurse practitioners and physician assistants care primarily for HIV-positive patients and provide

¹ Kimmel et al 2016 – originally listed as “Specialty-based care”

comprehensive HIV and non-HIV care to HIV-positive patients, with support from HIV specialists as needed.

- **Team-based care:** Comprehensive, patient-centered management of HIV-positive patients by a multidisciplinary team that can include HIV specialists, primary care clinicians, advanced practitioners, case managers, behavioral health providers, social workers, and others. Teams are co-located.
- **Shared care:** ²Co-management of HIV care by HIV specialists, primary care clinicians and others; assumed that different team members are located in different settings.

3.2.2. *Probe:* How would you describe the care team for a RWHAP client? Describe the composition of staff and function of each role) (**confirm the SMAT**)

4. **CHRONIC DISEASE MODELS OF CARE. Now let's talk about your clinic's model of care used in caring for patients with chronic illnesses.**

4.1. Is the model of care for patients with chronic illnesses different than the model of care for patients with HIV? If it is, describe how?

4.1.1. What about for RWHAP clients that have a chronic illness – how is the model of care different from the HIV model of care if at all? Does the model of care change if it is a RWHAP client? If it does, explain how the model of care differs?

5. **CARE COORDINATION. Now let's talk about how your clinic integrates or coordinates HIV and non-HIV services for RWHAP clients.**

5.1. How would you describe the coordination of HIV and non-HIV services at your clinic?

5.1.1. *Probe:* How do your RWHAP clients with other clinical comorbidities receive care for their non-HIV conditions (e.g., hypertension, diabetes, renal disease, tuberculosis, and viral hepatitis)?

5.1.2. *Probe:* Which, if any (reference table from survey), services are integrated and how?

- Location of services - on site in this location; co-located; on site in another medical area; off-site
- Communication between providers
 - o Specialist provides telephone consultation, but has no direct patient care
 - o Interdisciplinary team meetings by phone or in-person? How often?
 - o Routine discharge or referral letters
- Formal contractual agreements used between providers, clinics, or practices sharing RWHAP patients
- Patient information sharing
 - o Shared decision-making about treatment and care
 - o Single treatment plan

² Also referred to as “collaborative care”

- o Shared information exchange system – e.g., clinical dashboard to integrate information from multiple sources into electronic health record (EHR) system
 - *What systems do you use? How do other providers systems interface with your system if at all? How do you collect and report RWHAP data?*
- 5.2. Does a care team’s composition and roles/functions differ for RWHAP patients who have other clinical comorbidities? If so, how?
- 5.3. How are routine screenings and other preventative care services provided to RWHAP patients? (e.g., routine vaccinations, routine colon cancer screening, smoking cessation)? **(confirm with the SMAT)**
- 5.4. How are screenings and treatment for mental health and substance use administered in your model of care?
 - 5.4.1. *Probe:* At what point in care process, by whom, using a validated screener; self-report only; based on clinical information, routine screen, etc.?
 - 5.4.2. *Probe:* Treatment integrated on site, off-site through referral to local providers, some services provided by care team?
- 5.5. Has the model of care at your clinic changed over time? If yes, then how? What factors have contributed to these changes? Or what factors contributed to not making any changes?
- 5.6. Facilitators/Barriers to INTERNAL CARE COORDINATION: Thinking about coordination of care within your clinic:
 - 5.6.1. What, if anything, makes care coordination difficult or challenging? (e.g. organizational culture, organizational structure, setting space/structural, staffing: roles, types, and HIV caseload; billing processes, network integration, pharmacy location, coordination processes, etc.)
 - 5.6.2. What, if anything, facilitates or enables care coordination? (e.g. organizational culture, organizational structure, setting space/structural, staffing: roles, types, and HIV caseload; billing processes, network integration, pharmacy location, coordination processes, etc.)
- 5.7. Facilitators/Barriers to EXTERNAL CARE COORDINATION: Thinking about care coordination within the context of your larger community and any other external factors that influence care coordination:
 - 5.7.1. What, if anything, makes care coordination difficult or challenging? (e.g. urban, rural, economic, availability of services, pharmacy, other service providers, health care coverage availability, different EHR systems, etc.)
 - 5.7.2. What, if anything, facilitates or enables care coordination? (e.g. urban, rural, economic, availability of services, pharmacy, other service providers, health care coverage availability, different EHR systems, etc.)

6. **Model of Care Impact.** Let's talk about what impact the model of care has on various elements and receipt of care. Remember that the three models of care that we are considering are: exclusively primary care physicians; exclusively HIV specialist/ID physician; primary care-led co-managed or specialist-led co-managed.

6.1. What impact do you think the model has on a RWHAP client's ability to achieve viral suppression? Other health outcomes?

6.2. What impact do you think the model of care has on RWHAP client's choice of clinic?

6.2.1. *Probes:*

- Do you think that your client's have a choice in which model of care they utilize/receive? If yes, how do you think clients choose their model of care?
- What model of care do you think they prefer?
- Why do you think your clients come to this clinic?
- What model of care do you think clients would prefer? How do you think they would prefer to receive their care?

6.3. What impact do you think the model of care has on a provider's (your) ability to provide care to RWHAP clients?

6.3.1. *Probe:* How is the model of care a barrier or facilitator to care for RWHAP clients?

6.4. What impact do you think the model of care has on addressing issues of stigma and cultural competency in your clinic?

6.4.1. *Probe:* Conversely, how much have issues of stigma and cultural competency impacted the design of your clinic's model of care?