HIV TRAINING NEEDS REPORT FOR KANSAS

Midwest AIDS Training + Education Center,
University of Illinois at Chicago

Fall 2018

Introduction

This report provides the results of the needs assessment for the state of Kansas. The needs assessment workgroup conducted a series of activities between January and September of 2018. These activities involved data collection from primary and secondary data sources, data analysis, and reporting of regional as well as local (state-level) results.

The needs assessment results in this report are organized by workforce category (i.e. clinical versus non-clinical providers, low volume/novice providers, minority & minority-serving providers) as well as by topics that deserve special attention (i.e. PrEP, Hepatitis C, and the opioid epidemic). The clinics that each LP selected as potential candidates for Practice Transformation are shown at the end of the report.

Data sources used for the needs assessment include the following:

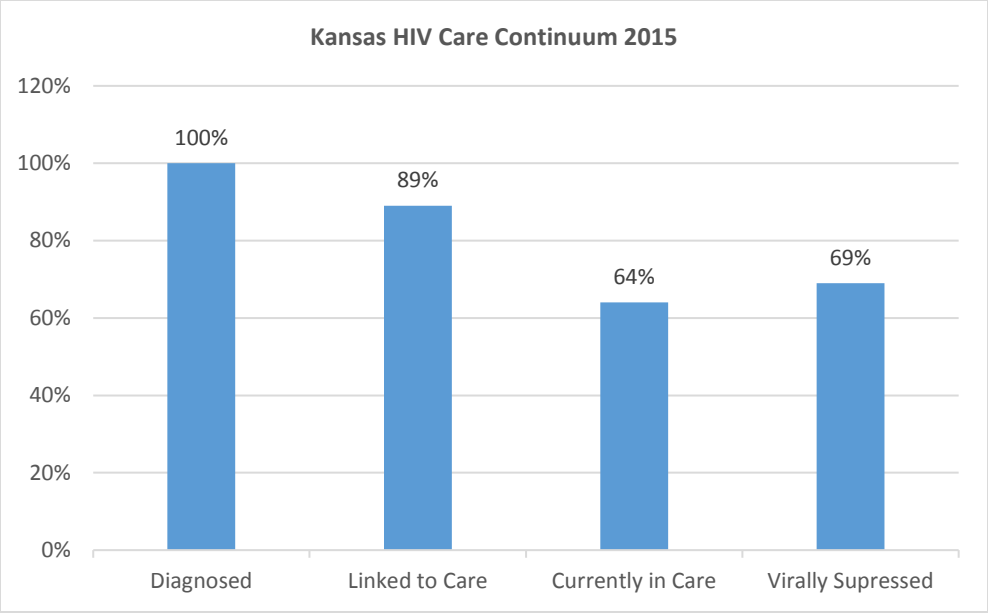
Primary Data Sources	Secondary Data Sources
• Policy Training Advisory Council (PTAC) • Key Informant Interviews with clinical leaders of each state • AETC Local Partner Program Directors	• HIV Integrated Prevention and Care Plans • HIV Surveillance reports from state health departments and CDC • AETC PIF, ER, and ACRE IP data from FY17-18 • CDC_Atlas Plus interactive database • amfAR Opioid and Health Indicators database • HRSA Data Warehouse • The Robert Graham Center workforce projections

Epidemiology

Kansas is considered a low incidence state in the Midwest region and accounts for only 2% of the region's prevalence rate as of 12/31/2015 and 3% of new HIV diagnoses in 2016 (Appendix 1, table 1).

Care Continuum

Kansas' HIV Care Continuum shows that 89% of newly diagnosed PLWH are linked to care in 2015. Of all diagnosed PWLH, 64% are currently in care and 69% are virally suppressed, which is higher than the national averages for these bars of the Care Continuum. Unlike most other states in the Midwest region, Kansas does not include those unaware of being HIV-infected in the denominator of the number of people diagnosed, which is why the percentage of diagnosed PLWH is shown as 100%. The percentage of people linked to care is based on those newly diagnosed in 2015, whereas the percentages for those who are currently in care and those who are virally suppressed are based on all people living with HIV.



The State of Kansas' HIV Workforce

Reviewing the Integrated Plan for HIV Prevention and Care and summarizing data obtained from key informant interviews and members of PTAC revealed the following information about the state of the HIV workforce in Kansas:

- The HIV workforce in Kansas is small, with only 5 or 6 providers who specialize in HIV care.
- There are no HIV providers in western and southeastern Kansas. Dr. Sweet's clinic does an outreach clinic in these areas every 6-8 weeks.
- There is a need for new providers who engage in outreach via local rural clinics. Too many providers do not consider this worth their time.
- Dr. Sweet's clinic is the only full service clinic in the state and is the pipeline for new providers. Most of these providers go to Kansas City after they are done with their training, but some go on to work in clinics in other parts of the state and become the HIV resource.
- MATEC can play a role in training providers in the rural parts of the state. Kansas' Part B works closely with Susan Tusher at MATEC. Once Part B identifies interested rural providers, they want to work with Susan on providing the training.
- MATEC should develop a database of existing and potential Ryan White medical and dental providers to track where additional education is needed.

Training Needs of Low Volume and Novice HIV Providers

The training needs of low volume and novice providers who attended training events in Kansas during FY2017-2018 were assessed by analyzing their responses to the needs assessment question on the ACRE-IP form. Figure 2 in the Appendix shows the results of this analysis. Low volume and novice providers indicated that they would like more training on Hepatitis C co-infection, mental health, pediatric management, ART, and PrEP. The discipline breakdown of the respondents helps clarify which professional disciplines were more likely to suggest each one of these training topics.

Training Needs of Minority/Minority-Serving HIV

The training needs of minority and minority-serving providers who attended training events in Kansas during FY2017-2018 were assessed by analyzing their responses to the needs assessment question on the ACRE-IP form. Figure 3 in the Appendix shows the results of this analysis. Minority and minority-serving providers in Kansas indicated that they would like more training on drug resistance, Hepatitis C co-infection, PrEP, ART, and routine testing. The discipline breakdown of the respondents helps clarify which professional disciplines were more likely to suggest each one of these training topics.

Training Needs of the Clinical Workforce

The clinical HIV workforce includes physicians, nurse practitioners, pharmacists, physician assistants, and dentists. The following needs apply to the clinical workforce only. Needs that apply to both clinical and non-clinical providers are listed in a separate paragraph.

- Train primary care providers (family medicine doctors, NP's, and PA's) in the Hinterland on testing guidelines, prevention guidelines, and how to link people to care.
- Training should be hands-on and done one-on-one or in a small group by going into providers' offices to show them how to do a test, how to read results, what to do and whom to call.
- Stigma and discrimination need to be addressed as many rural providers are afraid to work with HIV patients.
- HIV care providers who are new need hands-on clinical training with someone who is going to oversee them.
- Rural providers in western Kansas need training in HIV care. Patients in this area now drive 2-3 hours for care.
- Dental health providers need training as there are only a few in the state and they are concentrated in the eastern part.
- Mini-clinics at drug stores and grocery stores that are doing HIV testing and offering PrEP need specific training on how to do this.

Training Needs of the Non-Clinical Workforce

The non-clinical HIV workforce includes nurses (RN), mental health professionals, substance abuse professionals, social workers, and case managers. The following needs apply specifically to the non-clinical workforce:

- Case managers need one-on-one hands-on training in linkage to care.
- There is a need for more case managers in non-clinical settings who are trained in medication adherence, cultural sensitivity, and insurance issues.
- Case managers need training in epidemiology and social determinants of health so they understand how to connect to patients to keep them adherent.
- Trauma-informed care is an important focus area.
- Educate case managers on PrEP to help spread the word.
- Substance abuse providers need targeted training on HIV testing, prevention, and harm reduction strategies.

Training Needs of All HIV Providers (Clinical and Non-Clinical)

The following training needs apply to both the clinical as well as non-clinical HIV workforce in Kansas:

- Due to the opioid epidemic and the large amount of meth and cocaine use in, all providers need to be trained in substance use, addiction, and risk reduction so they are prepared to deal with this population.
- Rural providers need education on housing and dental through one-on-one or small group visits.
- The need in Kansas is for MATEC to travel to the providers in the rural areas to do one-on-one training.
- Providers need to educate youth on STI's and HIV infection.

Training Needs around Prevention and PrEP

We asked key informants and members of PTAC specific questions about the needs in their state around PrEP and prevention. Based on the information they shared with us, we identified the following needs in Kansas:

- Educate primary care providers on PrEP to increase their knowledge and their comfort level. There is almost no uptake of PrEP in Kansas.
- The Health Department is hiring a rural outreach liaison who will work on identifying providers who are interested in doing PrEP. Training these providers is an opportunity for MATEC (Susan Tusher has already been approached by Part B).
- Consider a PrEP prescription model similar to TelePrEP (implemented in Iowa).
- Training needs to be in smaller groups, intensive, and in short amount of time. HIV is such a small part of providers' business in Kansas that they aren't going to commit an entire day to learning about PrEP.
- Increase training focus on opioid use and the increased risk of HIV infection as not much is being done in this area currently.

Needs of AI/AN Population

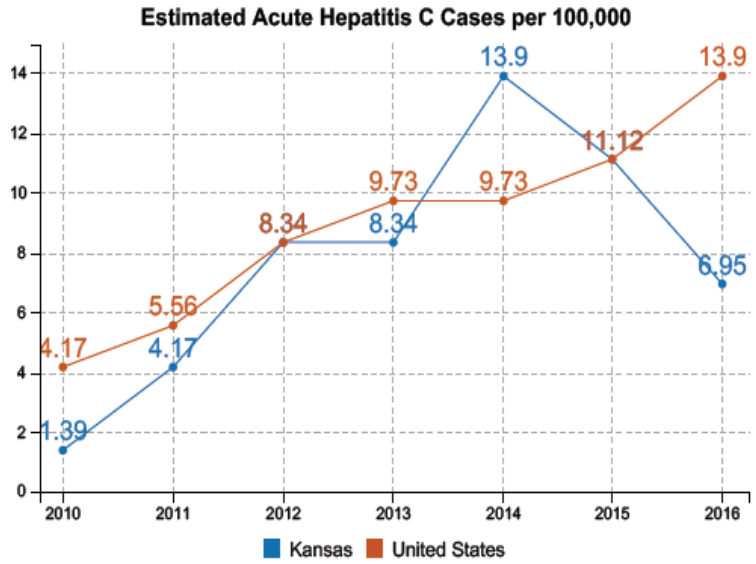
Kansas is home to 4 tribal communities who have unique challenges and needs with regard to HIV. Based on information obtained from clinical leaders and PTAC members, and results from a local needs assessment survey conducted by the LP in Kansas, the following needs were identified for Kansas' AI population:

- The needs in the AI community are along the early side of the HIV Care Continuum, i.e. screening, testing, and prevention.
- Training should include issues such as stigma, cultural competency, confidentiality, substance abuse, and mental health.
- Offer training on testing, PrEP, and general HIV knowledge.
- Providers need training in sexual risk assessment and drug/alcohol abuse risk assessment.
- Providers prefer face-to-face lectures with interactive discussions.
- Wherever possible, the four states that receive AI funding should share best practices for how to approach training in the AI communities.

Hepatitis C

In the United States, 25% of PLWH are co-infected with Hepatitis C (HCV). About 80% of PLWH who inject drugs also have HCV. HIV/HCV co-infection more than triples the risk for liver disease, liver failure, and liver-related death. Liver disease, most of it related to HCV and HBV, has become the leading cause of non-AIDS-related deaths among the HIV population. African Americans are twice as likely to have HCV as whites.[1]

The incidence rate of HCV in Kansas has dropped significantly since it peaked at 13.9 in 2014 and is well below the national rate in 2016. ***However, as a result of the worsening opioid epidemic, providers need to be aware of the risk of HCV infection among injection drug users and should be trained in screening, testing, and harm reduction.***

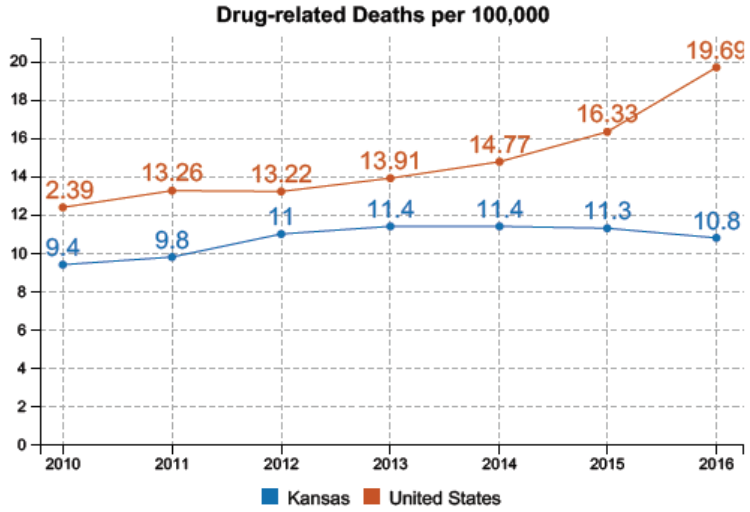


Source: http://opioid.amfar.org

Opioid Epidemic

Many of the Midwestern states have seen a sharp rise in the number of opioid-related overdose deaths since 2013. As the number of injection drug users continues to rise, the risk increases for the spread of infectious diseases such as HIV and HCV as a result of needle sharing. Several states in the country, including some in the Midwest, are seeing an increase in new HIV infections among white injection drug users.

Kansas' drug-related death rate is fairly stable between 2010 and 2016 with 10.8 cases per 100,000 reported in 2016. This number is well below the national average, but ***providers need to be aware of the confluence of the opioid epidemic and rising rates of HIV and HCV infection among injection drug users.***

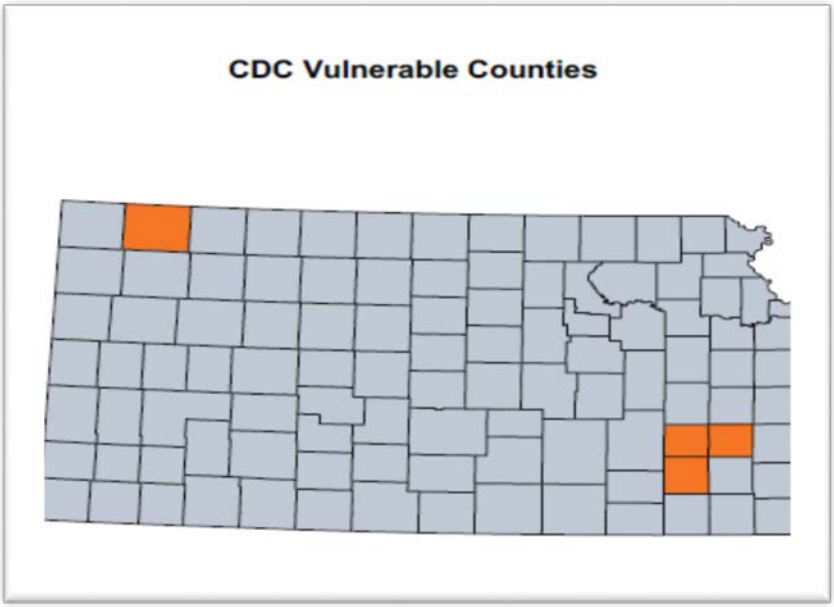


Source: http://opioid.amfar.org

[1] https://www.cdc.gov/hiv/pdf/library_factsheets_HIV_and_viral_Hepatitis.pdf

Rural Counties at High Risk for HIV and HCV Outbreaks

The CDC has identified 220 counties at risk of HIV and/or HCV outbreaks as a result of the opioid epidemic. Kansas is home to 4 vulnerable counties, which include Woodson, Allen, Wilson, and Rawlins County. There are no syringe exchange programs in Kansas. Forty-two facilities located throughout the state provide some medication assisted treatment. ***Providers in the CDC-labeled vulnerable counties and other similar rural counties need to be trained in awareness of the increased risk for HIV and HCV infection among injection drug users, including screening, testing, prevention, and harm reduction***



Source: http://opioid.amfar.org

Potential Practice Transformation Clinics

We asked our LP's to identify clinics in their state that could be potential candidates for Practice Transformation during the next grant cycle. While identifying these clinics, we asked the LP's to select clinics that would meet the strict criteria from the 2015 AETC guidance (existing criteria) as well as clinics that did not meet the existing criteria but would be excellent candidates if the criteria are loosened during the next grant cycle. Kansas identified the following clinics as potential candidates for Practice Transformation.

Potential clinics that meet existing PT criteria	Potential clinics that do not meet existing PT criteria
1. Genesis Family Health in Garden City	1. University of Kansas Medical Center in Kansas City 2. Haskell Health Center (Lawrence) in Lawrence City 3. Potawatomi Nation Health & Wellness Center in Mayetta 4. White Cloud Health Station in White Cloud

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APPENDIX

Table 1: HIV Incidence and Prevalence for 10 states in Midwest AETC Region, 2016						
	Population as of 12/31/2015		HIV Prevalence as of 12/31/2015		HIV Incidence in 2016	
State	Total population in numbers	Total Population as % of Midwest Region	HIV prevalence in numbers as of 12/31/15	HIV prevalence as % of Midwest Region as of 12/31/15	HIV incidence in numbers in 2016	HIV incidence as % of Midwest Region in 2016
IL	12,835,726	19%	35,441	31%	1,391	28%
IN	6,634,007	10%	10,741	9%	484	10%
IA	3,130,869	5%	2,427	2%	137	3%
KS	2,907,731	4%	2,830	2%	142	3%
MI	9,933,445	15%	14,615	13%	748	15%
MN	5,525,050	8%	7,803	7%	289	6%
MO	6,091,176	9%	11,887	10%	518	10%
NE	1,907,603	3%	2,040	2%	76	2%
OH	11,622,554	18%	20,709	18%	973	20%
WI	5,772,917	9%	5,916	5%	224	4%
Midwest	66,361,078	100%	114,409	100%	4,982	100%

Source: https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2016-vol-28.pdf

Table 2: People Living with HIV by State, Compared by Racial Population Percentages, as of 12/31/2015									
State	Total population in millions in 2015	White		AA, Black		Latino		Multiple Races	
		Number of People Living with HIV	Rate per 100,000	Number of People Living with HIV	Rate per 100,000	Number of People Living with HIV	Rate per 100,000	Number of People Living with HIV	Rate per 100,000
IA	3.12	1565	68.2	458	574	224	180.6	118	423.9
IL	12.86	9963	144.6	16508	1101.9	6629	405.7	1849	1527.8
IN	6.61	5410	120.5	3817	780.6	960	306.6	380	564.2
KS	2.91	1441	76.6	704	519.5	487	205.8	152	346.3
MI	9.92	4869	75.3	8294	736.4	811	230.6	500	378.2
MN	5.48	3812	100.3	2710	1141.7	778	392.4	248	362.3
MO	6.07	5615	135.7	5202	913.8	636	361.9	341	456.6
NE	1.89	1059	82.8	569	836.7	306	223.7	51	269.8
OH	11.61	9357	118.0	9072	783.1	1255	422.0	801	584.1
WI	5.76	2648	64.9	2177	772	817	304.6	163	305.4
US	321.22	298,373	174.2	404,375	1238.3	213,428	496.8	37810	890.0

Source: https://gis.cdc.gov/grasp/nchhstpatlas/tables.html

Table 3: Number of HIV Diagnoses by State, Absolute Numbers and Rates per 100,000, (2016)								
State	White		AA, Black		Latino		Multiple Races	
	Number of HIV diagnosis	Rate per 100000	Number of HIV diagnosis	Rate per 100000	Number with HIV diagnosis	Rate per 100000	Number with HIV diagnosis	Rate per 100000
IA	72	3.1	43	51.9	10	7.8	4	13.7
IL	284	4.2	741	49.6	291	17.5	28	22.4
IN	190	4.2	217	43.9	55	17.0	7	10
KS	77	4.1	32	23.6	23	9.5	5	11
MI	234	3.6	430	38.2	46	12.7	19	13.9
MN	116	3.0	129	52.3	23	11.1	6	8.4
MO	207	5.0	248	43.3	40	22.0	11	14.2
NE	38	3.0	15	21.7	16	11.3	2	10.1
OH	380	4.8	499	42.8	52	16.9	29	20.4
WI	78	1.9	109	38.4	24	8.7	8	14.4
US	10329	6.0	17450	52.9	9750	22.2	871	19.8

Source: https://gis.cdc.gov/grasp/nchhstpatlas/tables.html

Table 4: HIV/AIDS Prevalence, Number of Ryan White Providers, Number of Community Health Centers (CHCs) providing HIV Care, and Number of Unique Facilities/Providers reporting CD4 and Viral Load in 10 Midwestern States (2015)				
State	# of PLWHA as of December 31, 2015[2]	# of Ryan White providers as of December 31, 2015[3]	# of CHCs providing clinical HIV care as of December 31, 2015[2]	# of unique facilities or providers reporting CD4 and viral load in 2015[4]
Illinois	35,441	121	37	318 facilities
Indiana	10,741	21	20	N/A
Iowa	2,427	10	11	80 facilities
Kansas	2,830	11	13	88 facilities
Michigan	14,615	36	33	N/A
Minnesota	7,803	20	15	85 facilities
Missouri	11,887	27	19	352 providers
Nebraska	2,040	17	6	121 providers
Ohio	20,709	38	36	267 providers
Wisconsin	5,916	22	13	581 providers
Total 10 states	114,409	323	203	571 facilities 1,321 providers

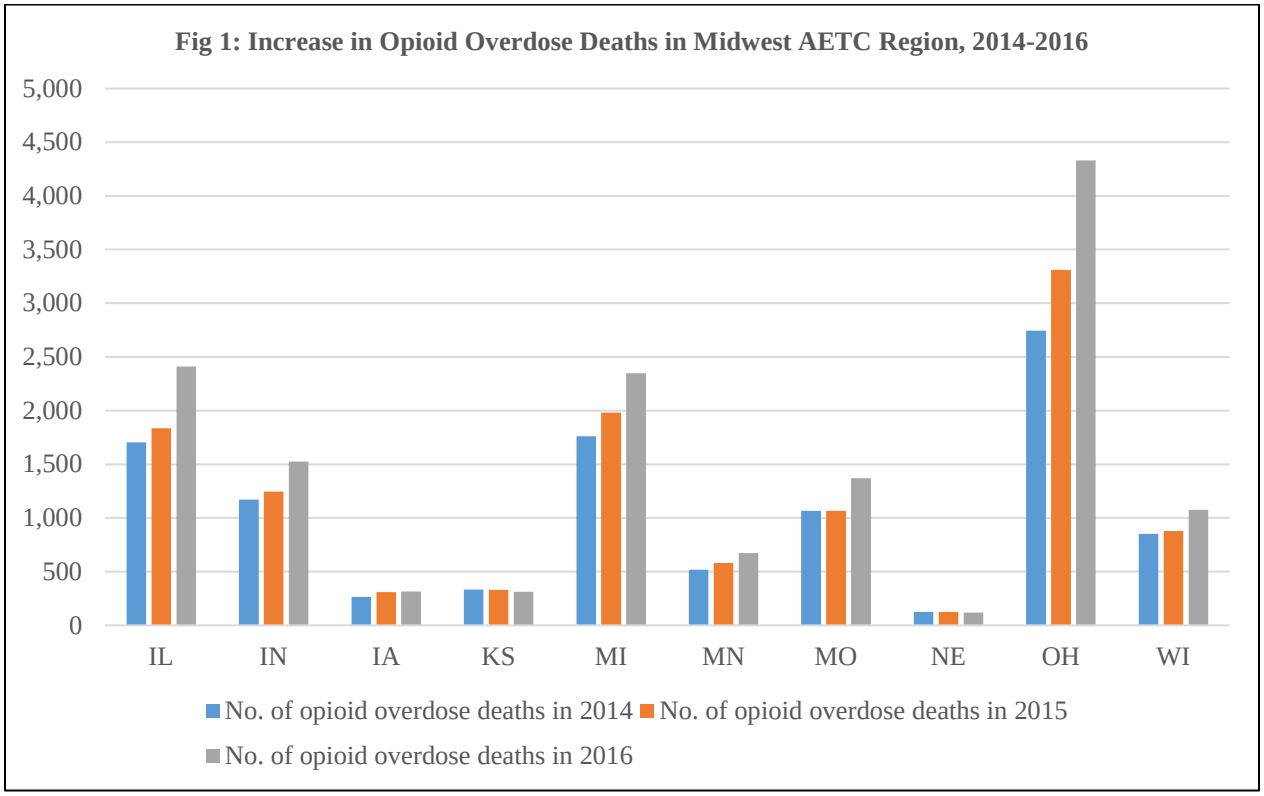
[2] Centers for Disease Control and Prevention, HIV Surveillance Report, Volume 28. Diagnoses of HIV Infection in the United States and Dependent Areas, 2016. https://www.cdc.gov/hiv/pdf/library/reports/surveillance/cdc-hiv-surveillance-report-2016-vol-28.pdf

[3] Health Resources and Services Administration, Data Warehouse. Accessed 4/9/2018. https://datawarehouse.hrsa.gov

[4] Data provided by State Health Departments upon MATEC's request.

Table 5: Drug-related deaths, HCV incidence, HIV incidence, and HIV prevalence rates in 10 Midwestern States and the United states, 2015-2016				
States	Drug-related deaths per 100,000 in 2016	Acute HCV cases per 100,000 in 2015	New HIV diagnoses per 100,000 in 2016	HIV prevalence per 100,000 as of 2015
IA	10.0	N/A	5.1	93.5
IL	18.8	2.8	12.9	330.1
IN	23.0	30.6	8.8	195.7
KS	10.8	7.0	5.9	118.6
MI	23.6	15.3	8.9	174.6
MN	12.2	12.5	6.2	171.3
MO	22.5	5.6	10.0	234.0
NE	6.3	1.4	4.9	131.6
OH	37.3	22.2	9.9	212.5
WI	18.6	25.0	4.6	122.0
US	19.7	13.9	14.7	362.3

Source: http://opioid.amfar.org



Source: https://www.cdc.gov/drugoverdose/data/statedeaths.htm

Table 6: Syringe Exchange Programs and Facilities Providing Some Medication Assisted Treatment (MAT) in 10 Midwestern States in 2018		
States	Syringe Exchange Programs in 2018	Facilities providing MAT (2018)
IA	1	29
IL	9	178
IN	7	108
KS	0	42
MI	4	121
MN	10	89
MO	2	107
NE	0	19
OH	7	215
WI	15	101

Source: http://opioid.amfar.org

Table 7: Additional PCPs needed in 10 Midwestern States by 2030			
State	Additional PCPs required by 2030	% increase compared to state's current PCP workforce	Current population to PCP ratio
Illinois	1,063	12%	1462:1
Indiana	817	20%	1659:1
Iowa	119	5%	1507:1
Kansas	247	13%	1561:1
Michigan	862	12%	1400:1
Minnesota	1,187	28%	1258:1
Missouri	687	18%	1564:1
Nebraska	133	11%	1489:1
Ohio	681	8%	1482:1
Wisconsin	942	22%	1364:1

https://www.graham-center.org/rgc/publications-reports/browse-by-topic/workforce.html

Table 8: Number of Health Professional Shortage Areas (HPSAs), Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs) in 10 Midwestern States, HHS Regions V and VII, and the United States in 2018

Region/ State	Population Estimate as of 1/7/2017[1]	Number of HPSAs for Primary Care (as of 4/4/2018)	Number of MUAs (as of 4/4/2018)	Number of MUPs (as of 4/4/2018)
United States	325.7 million	7,176	3586	426
HHS V and VII	66.6 million	1,831	935	96
Illinois	12.8 million	234	147	17
Indiana	6.7 million	159	45	22
Iowa	3.1 million	132	87	1
Kansas	2.9 million	169	90	14
Michigan	10.0 million	361	89	11
Minnesota	5.6 million	128	97	10
Missouri	6.1 million	250	115	5
Nebraska	1.9 million	111	81	1
Ohio	11.7 million	150	114	13
Wisconsin	5.8 million	137	70	4

[1] United States Census Bureau, Annual Estimates of the Resident Population for the United States, Regions, States, and Puerto Rico: April 1, 2010 to July 1, 2017. https://www.census.gov/data/tables/2017/demo/popest/state-total.html

Fig 2: Training Needs of Low Volume and Novice Providers in Kansas during FY 2017-18

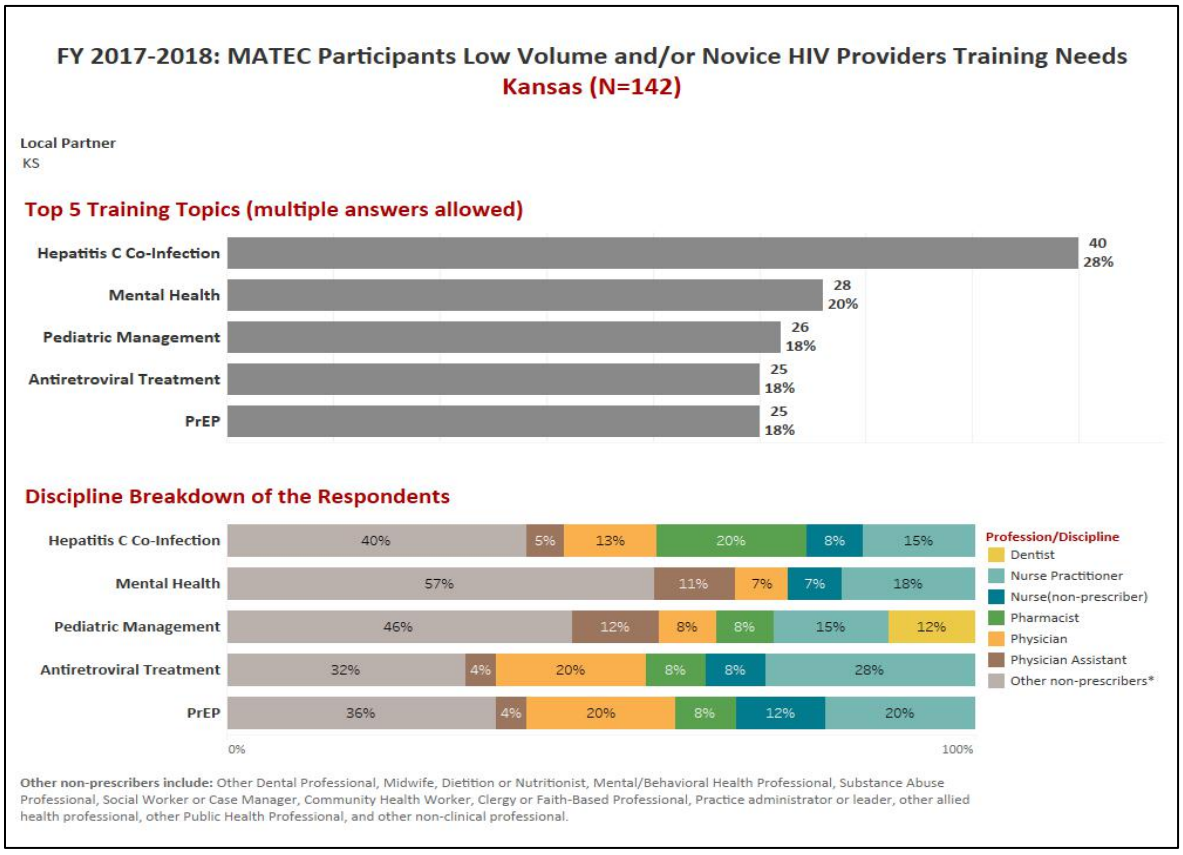


Fig 3: Training Needs of Minority and/or Minority Serving Providers in Kansas during FY 2017-18

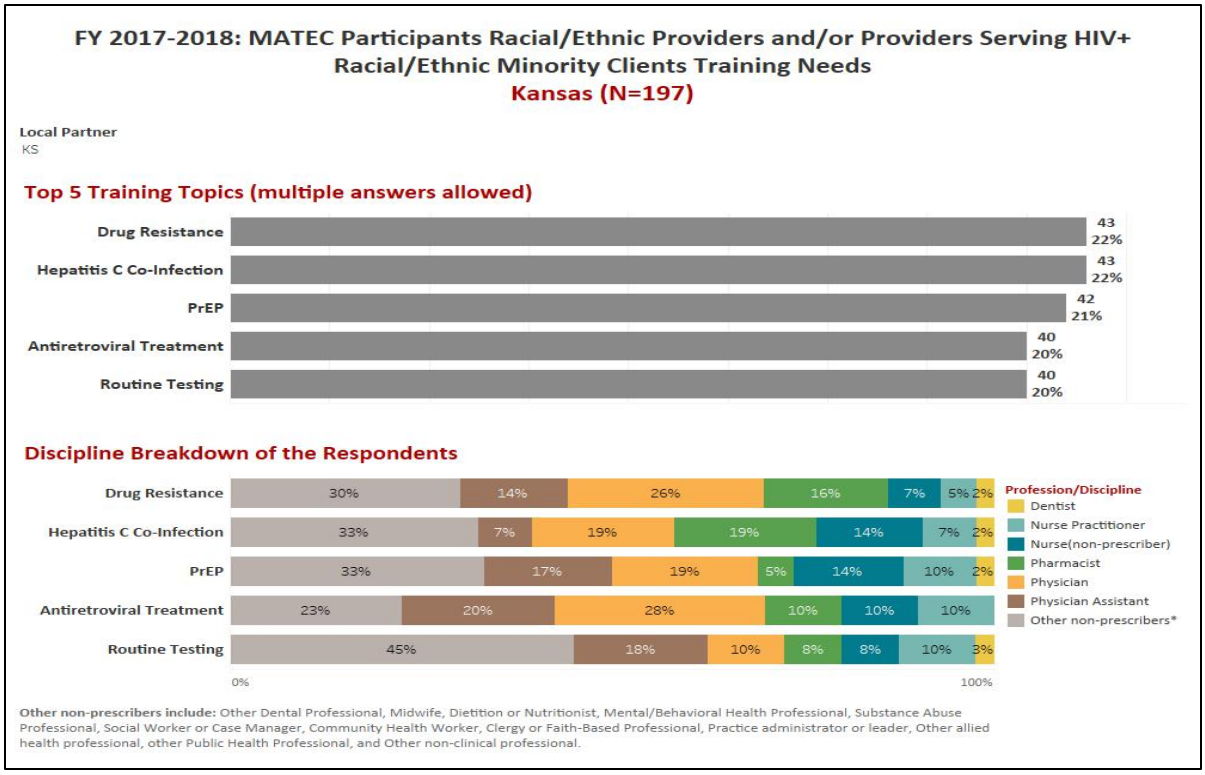


Fig 4: CORE and MAI Participants by Discipline in Kansas and Midwest Region during FY 2017-18

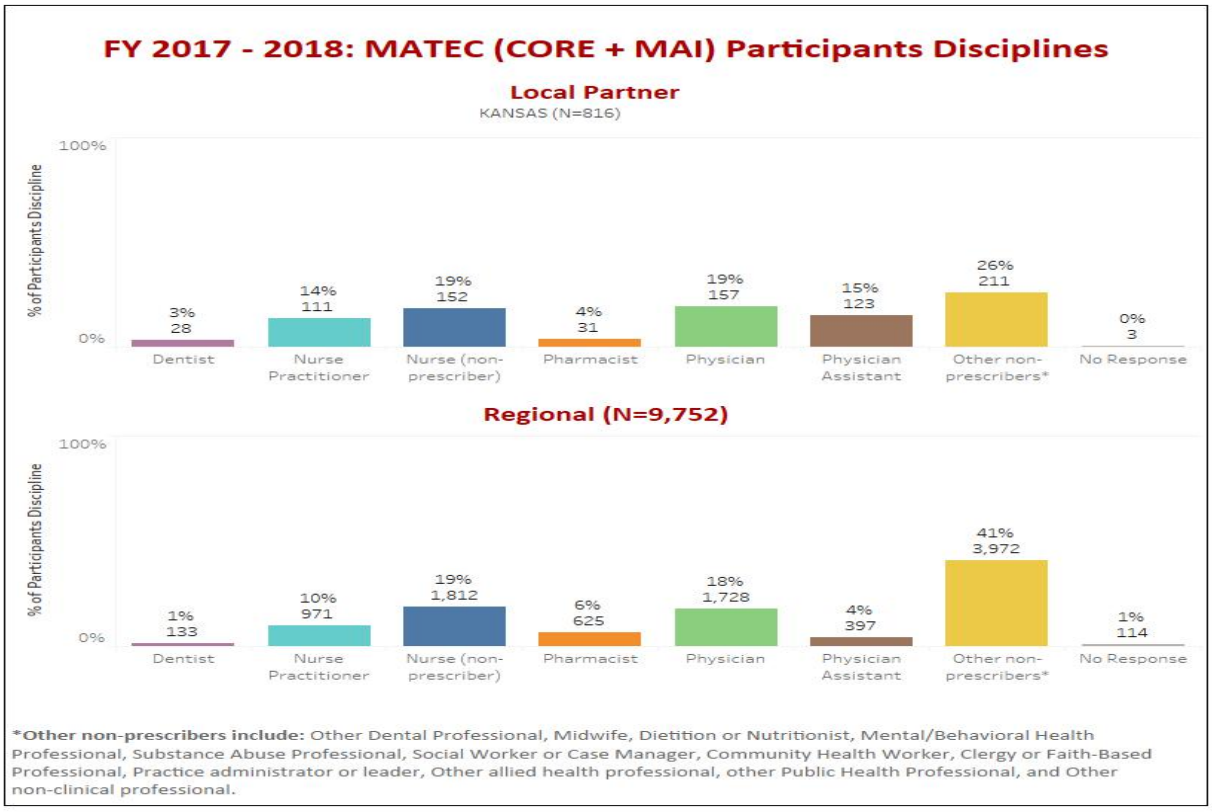


Fig 5: CORE + MAI Participants by Race and Ethnicity in Kansas and Midwest Region during FY 2017-18

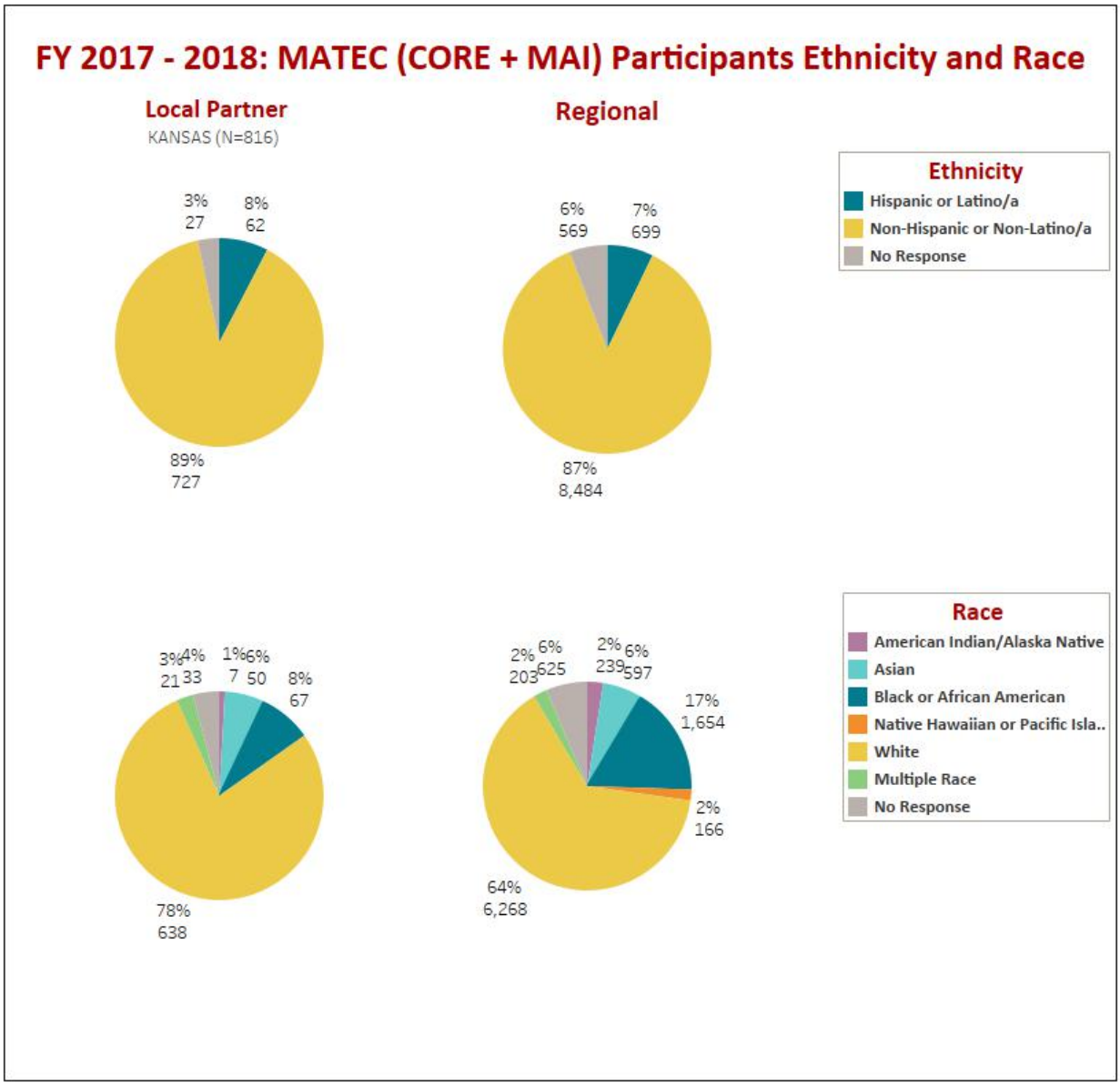


Fig 6: Map of employment zip codes of MATEC trainings who are working in Kansas