Working Toward 21st Century Interprofessional Workforce Training and Leadership in HIV Care

Joachim G. Voss, PhD, RN, ACRN, FAAN*
James (Les) L. Harmon, DNP, RN, ANP-BC, AAHIVS

Key words: *global, HIV, leadership, nursing, training, workforce development*

More than 3 decades into the epidemic, enormous progress has been made in the diagnosis, care, and treatment of those with HIV infection (Killian & Levy, 2011). They are living longer, healthier lives, remaining in the workforce and their social environments, and, when diagnosed and treated early in infection, can expect to live a normal lifespan. We have highly effective and well-tolerated single-pill combinations of antiretroviral agents that improve immune function and suppress the virus, and our best form of prevention is preexposure prophylaxis, with efficacy rates far exceeding behavioral interventions (Grant et al., 2010; Tseng, Seet, & Phillips, 2015). This progress is due to the tireless efforts of scientists and clinicians who have assured the efficacy, quality, and safety of each of these measures. This special issue of the *Journal of the Association of Nurses in AIDS Care (JANAC)* is the first of its kind to focus on the current national and global efforts that are underway to train the next generation of nurses, nurse practitioners (NP), physicians, physician assistants, and other providers to assume responsibility to care for people living with HIV (PLWH), at every stage of infection, who have life expectancies that can extend well into their 70s and 80s.

At the same time that clinicians, scientists, and policymakers are working nationally and globally toward the goal of an AIDS-free generation (Delva & Karim, 2014; Montaner, 2013) and increasing numbers of PLWH experience less mortality due to optimized treatment options, a retirement wave of graying baby-boomer HIV providers who began working in the 1980s (Boehler et al., 2015) is creating demands to mentor and train a new and larger interdisciplinary HIV workforce that can plan and implement sustainable models of care and support policy efforts to improve access. The landmark legislation of the Patient Protection and Affordable Care Act has allowed many uninsured PLWH to enter the health care system (Donohue et al., 2015; "Treatment. Researchers predict ACA", 2014), creating an influx of patients without a corresponding increase in HIV care providers. Due to the ease of prescribing single-pill HIV treatment regimens, insurers and legislators now expect that HIV care will soon be moved out of the hands of specialty care and into the hands of primary care providers who are not well prepared to handle the complex needs of PLWH (Johnston et al., 2015;

*Joachim G. Voss, PhD, RN, ACRN, FAAN, is Professor and the Director of the Sarah Cole Hirsh Institute for Evidence-Based Practice, Frances Payne Bolton School of Nursing, Case Western Reserve University, Cleveland, Ohio, USA. (*Correspondence to: joachim.voss@case.edu). James (Les) L. Harmon, DNP, RN, ANP-BC, AAHIVS, is an Associate Professor, lead faculty for the Adult Gerontology Nurse Practitioner Program, and Director of the HIV/AIDS Concentration, Duke University, School of Nursing, Durham, North Carolina, USA.*

JOURNAL OF THE ASSOCIATION OF NURSES IN AIDS CARE, Vol. 27, No. 3, May/June 2016, 199-202
http://dx.doi.org/10.1016/j.jana.2016.02.013

Relf & Harmon, 2015). While PLWH face some of the same chronic illnesses as their age-matched healthy peers, such as diabetes, obesity, and metabolic syndrome, they are also prone to experience higher incidences of cancer, bone loss, lipid changes, and accelerated aging processes. In order for the workforce to manage HIV in addition to multimorbidities, our HIV-specific training and mentoring efforts nationally and globally need to reflect these demands.

The provider community in the United States faces different challenges than their colleagues in sub-Saharan Africa. In the United States, we are experiencing an aging HIV cohort, 75% of whom are men, and the majority of those are men who have sex with men and injection drug users (Scott & Klausner, 2016). More than half of the HIV epidemic in the United States occurs in African American communities, many of which struggle with poverty, lack of jobs, limited access to medical care, and high rates of violence and incarceration (Dale et al., 2015). And, while the HIV workforce is shrinking, nursing and medical education programs in the United States provide no, or only very rudimentary, training in HIV. How can we expect to hand over HIV care to the primary care arena when providers do not receive adequate training for such a complex disease? Is primary care, indeed, the best and most cost-effective place for PLWH to receive care and long-term management? Will specialty care continue to have its place in the complex management of patients with HIV infection? The outcomes of this impending shift remain to be seen.

The situation in sub-Saharan Africa, where the epidemic affects as many women as it does men, and where HIV infection affects up to 20% or more of the population in a single country, is vastly different. The cultural differences between ethnic groups and the lack of women's rights in many parts of Africa, combined with pervasive stigma against PLWH, contribute to the lack of disclosure and the avoidance of antiretroviral treatment, resulting in the continuous spread of the virus. Almost every provider in Sub-Saharan Africa is an HIV provider by default. Burnout and brain drain have left the provision of rural HIV care mainly in the hands of nurses, and task-shifting has become the new norm (Crowley & Mayers, 2015; Kredo, Adeniyi, Bateganya, & Pienaar, 2014; Rustagi et al., 2015). Large-scale funders have demanded task shifting and task sharing without ensuring that countries follow suit in their scope of practice laws, which has created a large void in the legal coverage of nursing professionals. These are important issues that need to be addressed for the workforce of the future.

For this special edition of *JANAC*, we have searched for positive examples of how researchers, educators, policy experts, and clinicians are addressing the many challenges facing the domestic and global workforce. We invited those currently engaged in workforce development to share the best examples of their work with us, speak about their experiences, and document their successes and challenges.

In the United States we invited four Schools of Nursing (Duke, University of California San Francisco, Johns Hopkins, and Rutgers) that have received funding from the Health Resources and Services Administration to develop HIV NP training programs to introduce their work. We invited the Northwest AIDS Education and Training Center to highlight the development of the new national HIV curriculum for primary care physicians, physician assistants, and NPs. Other workforce development projects featured in this special issue include the Midwest AIDS Training and Education Center's 1-year competency-based clinical scholars program for minority service providers, and the University of San Francisco's model for training Family NPs in sexual health care and HIV and sexually transmitted disease prevention. From our Canadian colleagues we present an innovative implementation process of community-based nurse mentorship intervention in HIV care.

On the global scale, the HIV workforce is in dire need of more regulation of nursing scope of practice to reflect the 10-year practice of task shifting and task sharing. Better salaries are needed for HIV clinicians to remain in their countries of origin, and better leadership training is needed to enable scale-up and implementation efforts, particularly in Sub-Saharan Africa. Of the many organizations that were invited to showcase their work, contributors to this special *JANAC* issue include representatives from the U.S. Centers for Disease Control and Prevention, the Afya Bora Consortium, the International Training & Education Center for Health, the Clinton Access