Development of The Johns Hopkins University School of Nursing Adult/ Geriatric Primary Care Nurse Practitioner Program in HIV Prevention, Treatment, and Care

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In response to the call to create an AIDS Education and Training Center for Nurse Practitioner Education by the Health Resources and Services Administration, The Johns Hopkins University School of Nursing embarked on a transformative curriculum overhaul to integrate HIV prevention, treatment, and care into the Adult/Geriatric Nurse Practitioner Program. A six-step process outlined in the Curriculum Development for Medical Education was followed. A pilot cohort of Adult/Geriatric Nurse Practitioner students were enrolled, including 50% primary care setting and 50% HIV-focused primary care through a 12-month HIV continuity clinic experience. Through this pilot, substantive changes to the program were adopted. Programmatic outcomes were not compromised with the modification in clinical hours. The model of a 12-month HIV continuity clinical experience reduced the number of required preceptors. This model has important implications for the HIV workforce by demonstrating successful integration of HIV and primary care training for nurse practitioners.

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Persons living with HIV (PLWH) deserve quality, patient-centered, and life-affirming care that is rooted in evidence. Poor access to such care may result in stigma, late diagnosis, opportunistic illnesses, and immunologic decline, including the potential development of AIDS. New infections continue to disproportionately impact underserved and marginalized populations, such as communities of color, persons with lower socioeconomic status, and persons engaged in substance use, as well as men who have sex with men and transgender women (Centers for Disease Control and Prevention [CDC], 2013, 2015). The National HIV/AIDS Strategy for the United States provides a roadmap to reduce new HIV infections, increase access to care, improve health outcomes, increase provider diversity, and reduce HIV-related disparities and health inequities. Notably, the plan calls for "developing models of competent care that treat the whole person, as well as the virus" (Office of National AIDS Policy, 2015. p. 5).

Baltimore, Maryland, and the District of Columbia in the United States are among the 12 metropolitan statistical areas most affected by HIV (Centers for Disease Control and Prevention, 2015). HIV care specialists and primary care clinicians are widely available in the urban areas of this region. However, the HIV specialist often becomes the default provider for primary care services due to overlapping needs for prevention and chronic disease management, and a lack of HIV expertise among primary care providers.

Nurse practitioners (NPs) are highly trained primary care providers with evidence demonstrating that health outcomes for PLWH under their care are comparable to those of physicians (Ding et al., 2008). A recent national HIV provider survey demonstrated that NPs, more than any other clinical group, reported greater attention to adherence and retention in care (Weiser et al., 2015). Patient satisfaction is often highly rated by patients who receive care from NPs (Swan, Ferguson, Chang, Larson, & Smaldone, 2015), and fewer health inequities have been demonstrated by providers with greater cultural competence (Saha et al., 2013). Despite these findings, training programs designed to integrate HIV clinical care competencies into primary care are lacking for the NP.

In response to the call to create an AIDS Education and Training Center for Nurse Practitioner Education by the Health Resources and Services Administration, The Johns Hopkins University School of Nursing (JHUSON) embarked on a transformative curriculum overhaul to integrate HIV prevention, treatment, and care into the Adult/Geriatric Nurse Practitioner (AGNP) Program. We will review the process of curriculum development, pilot implementation, and modification of the AGNP HIV-Primary Care Certificate (HIV-PCC) program, which was designed to enhance the development of the primary care workforce in caring for persons at risk for or living with HIV.

Methods

A six-step process outlined by Kern, Thomas, and Hughes (2009) was followed to facilitate an iterative curriculum design process that was grounded in the needs of the community as well as trainees within the institution (Figure 1). The evaluation proceeded in three phases using a continuous quality-improvement process that included: Phase I (developmental); Phase II (pilot); and Phase III (implementation).

In Phase I, a steering committee of five faculty and a senior AIDS Certified Registered Nurse with subject matter expertise was formed. The committee chose to encompass HIV care and HIV treatment as distinct entities in the program design. HIV care refers to the health system and clinical infrastructure that support client engagement, adherence, and retention, while HIV treatment focused on the use of antiretroviral therapy, management of opportunistic infections and co-infections, and the associated clinical aspects.

Step 1: Problem Identification and General Needs Assessment

The steering committee began by conducting an extensive literature review identifying the current epidemiologic profile within the greater Baltimore area and the State of Maryland, as well as national