

Practice Transformation in HIV Primary Care: Perspectives of Coaches and Champions in the Southeast United States

Journal of Primary Care & Community Health
Volume 12: 1–8
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DOI: 10.1177/2150132720984429
journals.sagepub.com/home/jpc



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Abstract

Introduction/Objectives: Across the United States, and particularly in the South, there is an urgent need to improve health outcomes for people with HIV. In response, the Southeast AIDS Education & Training Center (AETC) conducted a 4-year Practice Transformation (PT) initiative (2015-2018) in 12 mostly primary care clinics across 4 states in the region. Drawing on the leadership of PT facilitators (“coaches”) from AETC partner sites throughout the region and specific clinic staff members (“champions”), clinics worked toward self-selected organizational goals to increase their HIV care capacity and improve HIV health outcomes. **Methods:** To explore coaches’ and champions’ experiences and perspectives of PT, we conducted 2 focus group sessions, 1 tailored for coaches (n=5) and another for champions (n=9). **Results:** Content analysis of qualitative data revealed 4 major themes around coaches’ and champions’ experiences and perspectives of PT. These themes include Challenges, Facilitators, Successes, and Suggestions for PT Improvement. **Conclusion:** Primary care and infectious diseases/HIV clinics can help improve HIV Care Continuum outcomes through increasing their capacity to serve the needs of their clients, as facilitated through coaches and clinic champions. Since no single clinic or clinic patient population is alike, it is important work within organizations to address specific needs and leverage unique skillsets. Future PT initiatives can learn from experiences of this PT program to optimize the effectiveness of their programs.

Keywords

Practice Transformation, organizational change, HIV Care Continuum, focus groups, Southeastern United States

Dates received: 24 September 2020; revised: 2 December 2020; accepted: 3 December 2020

There are 1.1 million people with HIV (PWH) in the United States (US), with an estimated 38 000 new infections occurring each year.¹ The Centers for Disease Control and Prevention (CDC) estimates that 40% of new HIV infections come from people who either do not know they are infected or who are aware of their positive HIV serostatus but not in care, illustrating the vital importance of HIV testing and treatment.² The HIV Care Continuum, a comprehensive population-level framework used to represent the series of steps involved in initiating and maintaining HIV medical care, demonstrates that the percentage of PWH drops at each step.³ Beginning with diagnosis and linkage to care, and followed by retention in care and, ultimately, viral suppression, the HIV Care Continuum is a useful framework for understanding how PWH move through the HIV

medical care system and can be used by providers and public health officials to identify areas for intervention to improve HIV prevention and treatment efforts. In fact, despite widespread public health efforts to increase HIV testing, 86% of PWH have been diagnosed with HIV and 14% remain unaware of their status. Of those diagnosed, just 64% and 49% are linked to and retained in HIV care, respectively.⁴ Moreover, just half of PWH (53%) are virally

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suppressed,⁴ which poses both personal and public health risks. Not only is lack of timely viral suppression associated with increased mortality,^{5,6} but it also increases risk of transmission.⁷ Considering that PWH who are virally suppressed cannot transmit the virus to others,⁸ these national statistics represent an urgent call to action.

Regionally, the US South experiences a higher HIV incidence and HIV-related mortality rate than any other area of the US.^{1,9} While HIV incidence has decreased in most areas of the US, new diagnoses in the South remained stable between 2012 and 2016. In 2017, half (52%) of the new HIV diagnoses were in the South, representing the region with the highest rate of new diagnoses.¹ By comparison, the West, which had the second-highest regional rate, comprised just 19% of new diagnoses.¹

In response to the disproportionate HIV burden in the South, the US Department of Health and Human Services (HHS) Health Resources and Services Administration (HRSA)'s Southeast AIDS Education and Training Center (SE AETC) launched a program in 2015 aimed at improving patient outcomes along the HIV Care Continuum. The SE AETC region includes Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee (SE AETC, 2020). The primary goal of this initiative was to partner with clinic sites across the Southeast to provide clinic-level training, capacity building, and technology assistance through Practice Transformation (PT), a process of organization-level change to increase and improve capacity to optimize patient health outcomes.¹⁰ SE AETC's PT program emphasized clinic-level goal setting to improve 1 or more steps of the HIV Care Continuum through leveraging SE AETC training/mentorship and the leadership of "coaches" from SE AETC partner sites and clinic "champions."

Practice Transformation

PT is an improvement strategy designed to advance quality improvement and patient-centered care by promoting characteristics of high performing primary care.¹¹⁻¹³ It involves the systematic and continuous improvement of clinic services, culture, and outcomes, and requires engaged leadership; quality improvement; continuous and team-based healing relationships; organized, evidence-based care; patient-centered interactions; enhanced access; and care coordination (Safety Net Medical Home Initiative, 2013). PT is most commonly associated with primary care clinics striving to become Patient Centered Medical Homes (PCMH).¹⁴ For this award, HRSA adopted the term "Practice Transformation" to describe strategies for improving HIV-related care in primary care clinics.¹⁵

PT efforts typically focus on implementing technical improvements to transform the health care system. Examples include enhancements to electronic medical

records (EMR), data-driven outcome measures, targeted reminder systems, and provider skills development.¹⁶ However, consonant with the perspectives of Ruddy et al,¹⁷ PT is more than just transforming systems; it requires a transformation of people, habits, and customs. Based on best practices in PT, HRSA introduced 2 key personnel roles for implementing PT: Coaches and champions.

Coaches were AETC-funded coordinators with HIV knowledge who provided in-person trainings and technical support; SE AETC partner sites in the states identified at least 1 coach per PT clinic for organizational capacity building. Coaches worked with clinic champions to uncover knowledge gaps; generate clinic-level training plans; and identify resources and support, including an online PT curriculum for onboarding new staff members. Additionally, PT clinics identified at least 1 staff member to serve as a PT champion for their site. Champions represented a variety of roles in their clinics (eg, doctors, administrators, social workers) and worked with the PT coach to implement the PT program and encourage their fellow clinic staff members to participate in training. Previous research has suggested that coaching from an outside facilitator can enable clinics to undertake significant changes.¹⁸ Similarly, champions have been identified in the research literature for their important role in moving new innovations through the phases of initiation, development, and implementation.¹⁹ The purpose of this paper is to describe experiences and perspectives of PT from individuals who served as either a coach or champion during the 4-year award (2015-2018).

Methods

This study involved a qualitative inquiry of PT coaches and champions who were actively involved with 12 SE AETC PT clinics in Florida, North Carolina, Mississippi, and Tennessee. Nine PT sites were primary care clinics, while 3 were infectious diseases/HIV clinics. Qualitative methodology is an appropriate strategy for the study purpose, as it included the experiences and perspectives of individuals who provided direct support to clinics and clinic staff. This study adopted an inductive, exploratory design in which open-ended questions were asked focusing on experiences and perspectives of coaches and champions regarding PT. The sample included 14 adult (aged ≥ 18 years) participants ($n=9$ coaches; $n=5$ champions) who represented PT sites within the Southeast region.

Researchers conducted 2 focus group sessions using a semi-structured interview protocol, 1 tailored for coaches and another for champions. As an example, coaches were asked, "What challenges did you experience in acting as a liaison and communicating PT vision/expectations between SE AETC and your clinics?" while both coaches and champions were asked, "What were your clinics' successes in Practice Transformation?" The coaches' focus group occurred

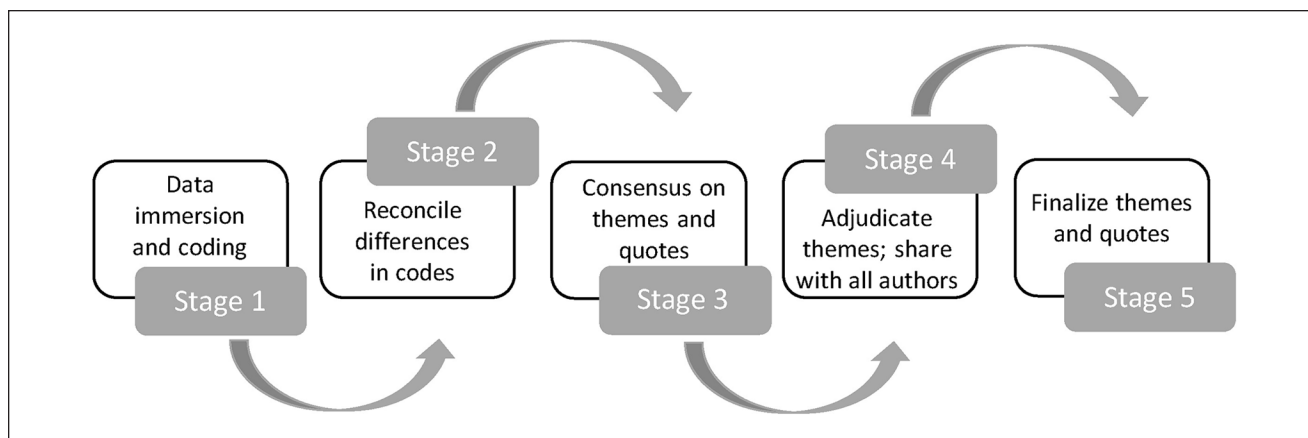


Figure 1. Data analysis.

in-person in May 2019 and coincided with the annual SE AETC meeting in Nashville, Tennessee; this focus group lasted approximately 2 hours. The champions' focus group occurred in June 2019 via Zoom© teleconferencing in order to accommodate a geographically dispersed group; it lasted approximately 1 hour. Both focus group sessions were conducted by a project Co-Investigator with qualitative research expertise, and a note-taker was present. Focus groups were audio recorded, and the resulting audio recordings were transcribed by a professional transcription company and subsequently analyzed.

Data Analysis

Four PT team researchers, 2 in social work and 2 in public health, engaged in content analysis for understanding the data and transposing it into themes. Content analysis is an analytical method that is used to organize and create meaning from data.²⁰ The full outline of the data analysis is in Figure 1. Authors 1, 2, and 9 initially became familiar with the data and open-coded transcripts independently from one another highlighting key words and phrases and identifying preliminary themes. Next, authors 1, 2, and 9 reviewed transcripts line-by-line with each other and resolved differences in coding through discussion and debate. The authors then reached consensus on themes and identified exemplar quotes for each theme. Subsequently, the authors reconciled differences through adjudication with author 3 and crafted a preliminary set of themes and quotes to share with the remaining authors. Once all input and feedback was received, authors 1, 2, 3, and 9 reconciled final instances of disagreement through further discussion and debate.

Approval and Consent

This research received IRB approval from University of Alabama at Birmingham. All participants provided

informed verbal and signed consent, and participants used pseudonyms of their choice during focus groups to maintain confidentiality.

Results

Four overall themes emerged from analysis of focus group transcripts: (a) Challenges; (b) Facilitators; (c) Successes; and (d) Suggestions for PT Improvement. For each theme, we provide exemplar quotes that best illustrate the concept. Themes and exemplar quotes represent consensus among authors.

Challenges

One prerequisite for clinic participation in PT was a “functional EMR system” to produce reports of patient demographics and clinic services as well as to track progress on PT site specific goals. This requirement, however, proved to be one of the greatest challenges identified by coaches and champions as true functionality of EMR systems was not tested prior to clinic selection for this PT initiative. Participants described their struggles with data tracking, information technology (IT), informatics, and EMRs:

I think we all experienced consistent challenges with EMRs that were not functional. Even though that was something the clinics had to sign a contract on saying that they had a functional EMR, the definition of functional is, apparently, very flexible, so we all struggled with that. (Coach 8)

Coaches and champions reported difficulties producing accurate reports as well as EMR systems that could not generate certain types of reports. Coaches further noted variability in the EMR systems that clinics used, which frequently led to discrepancies in data reporting.

Coaches and champions also described lack of ongoing clinic-level administrative support as a challenge of PT,

including both limited buy-in from clinic leadership and more general buy-in across clinics given the multiple duties providers and staff had to balance. While clinics had to meet certain criteria to participate in this 4-year project, they did so voluntarily to enhance their capacity to offer HIV prevention, testing, and treatment services. Clinics received no direct financial incentive for participation. PT trainings and other activities associated with PT did not replace existing services. Rather, they were *in addition to* day-to-day clinic operations. According to coaches and champions, the high levels of enthusiasm and support they experienced at the beginning of the project waned over time:

I think in the grand scheme of things buy-in sometimes is our largest challenge just because business as usual does need to continue. Here we are trying to make changes and brainstorm creative ideas, and that's not always the priority in the moment. (Champion 2)

The administrative burden clinics experienced increased over the life of the program. As Coach 8 explained, the leadership was asked to complete yearly surveys, while staff were asked to complete multiple trainings:

There was definitely fatigue as we went along. Yeah. You could see the excitement wane as we were asking for more and more things and asking for a survey every year and asking for them to attend more trainings and put in more time and give us more data. It was hard for them to continue to do that for four years.

Coaches and champions identified a number of issues that may have contributed to the lack of organizational buy-in including the voluntary nature of clinic participation, competing organizational priorities, understaffing, staff turnover, financial restrictions, and fear of change. Despite the benefits of PT and initial enthusiasm of being selected as a participating site, coaches and champions described challenges that were pervasive across the SE AETC region. As illustrated by exemplar quotes, inadequate or dysfunctional EMR systems and lack of ongoing administrative support were topics that best expressed the theme of Challenges.

Facilitators

In contrast to clinics that experienced a lack of organizational buy-in, some PT sites received strong support from their organizational leaders, which coaches and champions described as a facilitator of PT:

I will say that having a supportive administration, a supportive administrative arm in whichever clinic you were at is critical in things going right. Just having that full support from CEO, Board of Directors if it's applicable, that they can help champion their care provider teams into motion to attend the trainings, to attend activities, to just encourage them to be engaged and

working towards those Practice Transformation goals. In order for all of that to align, you needed to have the backbone—the bosses needed to fully support that endeavor. (Coach 4)

Coaches and champions suggested that an unwavering commitment from clinic leaders encouraged clinic staff to challenge the status quo throughout the 4-year project.

Similarly, organizational support fostered creativity among coaches and champions to meet the needs of clinic staff in innovative ways. Coach 2 described how creativity served as a facilitator of PT:

We had to kind of think outside of the box. We had to come up with different ways to meet their needs. What we started doing—we got creative. We would come in late afternoon and meet with the staff at that time. . . We did conferences that they were invited to. We had to think outside of the box and continue to think outside of the box. We also did a mini-residency specifically for the providers of the PT clinics where they would come in for two weeks and shadow our provider. It was just a continuous effort to meet them where they were.

There was consensus among coaches and champions that PT provided the structure for clinic improvement, but it was incumbent upon them to find creative ways to address a clinic's unique culture and expressed needs. For example, Champion 7 used creativity to organize a visit to an HIV clinic in a neighboring state:

I need(ed) to grow them as a unit, not necessarily as individuals. I have to grow them as a family so that they can grow the practice together. That's exactly what we did and that was amazing. The culture of the little team we were growing started changing as soon as we got back. Did it fix everything? No, but did it help the team see how they were supposed to function, the mechanics of working together, what does it look like when each new client comes through, the time, the organization, the communication? All of that started working.

Coaches and champions also identified PT training and access to nationally and internationally recognized experts in HIV care and treatment as facilitators of PT. For instance, Champion 5 expressed appreciation for the PT leadership team that was reliably available to guide clinics as they experienced organizational change:

That was the thing that I really enjoyed at the Practice Transformation, they were always there for me to call. Still to this day I could pick up the phone and call anybody from the [site] team or AETC and ask for any help, and they're right there on the other end. It was just that point of havin' that access to help us understand that we're not left out there by ourselves, and we don't know what we're doing.

Moreover, Coach 6 suggested that in-depth training sessions over time allowed PT sites to truly invest in staff

members so that transformation could occur at all levels of the organization:

I do think the quality time that we got to spend in training some of these clinics allowed us to train, not just the prescriptive providers, but the front desk staff as well, which are, potentially, equally as important in continuum of care. I don't know that, if we didn't have as much contact as we did with said clinic, that front desk staff might not have realized their role in this and how critical it is for them to be just open, receptive, engaged, care. Just the difference of the attitude.

There was agreement among coaches and champions that supportive leadership, creativity, and access to PT training and experts facilitated PT. These facilitators exemplify the importance of dependable leadership to provide structure and guidance as well as the value in clinics remaining flexible and open to innovative solutions when needed.

Successes of PT

A principle success of PT centered on clinics' increased capacity to engage community members and, in some cases, extend community reach into some populations for the first time. As Champion 5 shared:

...we do a lotta community outreach now. I've been able to tap into targeted populations that we weren't able to tap into before such as the LGBTQIA population. ...Just the outreach department alone is providing almost over 3000 HIV tests a year just so we can find new positives and educate people about HIV and PrEP [pre-exposure prophylaxis] as far as finding new clients out there and working with other agencies.

In addition to experiencing increased community outreach, participants noted that some of the challenges inherent to PT—in particular, facing vacillating administrative support over the life of the program—only made the successes that much more rewarding. After experiencing “the ups and downs, the dives, the leaps, sometimes the deflation that we feel in doing this coaching work,” Coach 7 experienced an unforeseen success after launching an HIV prevention program at a rural mental health facility:

Our outreach from this one little clinic amazed me to no end where they were able to speak to these individuals where there was just this great dialog about sexual health. Talking about important, tough topics right there in a way that I had never seen happen. At that moment, my balloon filled up and I said, “You know what? We don't always get the impact where we think,” but the impact in that spot of prevention, of dialog, of people knowing—they were signing up. I wanna be tested. When's your van coming?

Another success of PT, echoed by both coaches and champions, arose from clinics' improved EMR systems,

which represented both a challenge and, ultimately, a success of PT. Champion 3 noted, “For us that—[the EMR system]—was our biggest challenge, but it was our biggest accomplishment.” Updated EMR systems offered clinics an increased capacity to identify patients with unsuppressed viral loads and prioritize case management efforts:

...before where this virally unsuppressed group of patients who are kind of on the radar before were not really well identified. I think now they're—we have a language that we can use. ... These people are now kind of known to us, so if someone comes in and has a provider appointment we know who they are. We can reach out to them, and we can talk to them about what resources we have or just ask them what would help you. (Champion 4)

Similarly, improved EMR systems allowed clinics to track the impact of the changes associated with the PT program: “I feel over the last year and a half or so, two years, we've actually come a very long way and actually being able to measure and track patient care and actually seein' if we're makin' an impact” (Champion 1). As a result of the trainings and technical assistance offered by the PT program, coaches and champions reported both increased community outreach and improved EMR capacity to identify patients at risk of falling out of care and to track patient outcomes over time.

Suggestions for PT Improvement

Upon reflection of their experiences with PT, coaches and champions identified information and resources that would have strengthened the PT program and better supported them in their respective roles. Champions, in particular, suggested that more guidance at the beginning of the project about PT and strategies for preparing clinics for PT would have been beneficial in year 1 of the program:

I prob'ly coulda used a little bit more orientation or education on what PT really is. ...I don't think I really ever appreciated what the true meaning of PT, Practice Transformation, was. I don't know whether it woulda been like a book or a video or maybe a consultant or someone that could've given me more guidance on that. (Champion 3).

Coaches and champions further noted that there was confusion about the term “Practice Transformation” since it is traditionally applied to primary care clinics striving to achieve PCMH status and not all clinics identified this as one of their goals of the PT program. According to Coach 8, shifting priorities by HRSA and the flexible use of the term PT over the life of the project were at the heart of this confusion:

Obviously, the goal from HRSA was increase capacity to provide HIV care. That was the main goal, and then, initially,

they wanted patient-centered medical home but they kind of backed out of that in the last couple years, realizing it was a tough thing. To increase HIV care capacity, that was definitely the ultimate goal, but all the pieces that the clinic needed to do that were many goals to get to that goal.

To address concerns regarding the lack of understanding of PT as well as consistency of language, Champion 4 proposed a simple yet elegant solution, a glossary:

...there're a lot of terms that we use that it's almost like we need a glossary. I think it would be helpful with just there are so many acronyms and terms to be able to flip through and be like, oh, that's right, that was that thing or champion or steering committee.

Coaches and champions also expressed a desire for clearer expectations from the SE AETC PT leadership regarding steps toward transformation. Despite differences in clinic populations, services, and staffing, site participants seemed to want a more prescriptive approach for clinic improvement:

I think there was a kind of a passive approach with this round where, let's look at the surveys that the clinics completed and then, ask the clinics to pick the goals that they wanted to focus on. I think doing it the other way and saying, "Okay. Here's how this project's gonna work and here's the goals that you will be focusing on," and starting at the beginning with just—with HIV testing and working our way all the way through to providing complicated HIV care is a better way to go. (Coaches 8)

Ultimately, Champion 3 raised a question that coaches and champions struggled with: How will we know if we are successful?

At the end of the day I do think we transformed as a practice, but maybe it would be helpful to have someone more objectively tell us whether we did or not. . .Maybe there needs to be like a final audit at the end of the—I hate the word audit, but like an evaluation to tell us what we did that people saw as successful transformation and what didn't work.

Coaches and champions recommended that future PT projects, especially those focused on the HIV Continuum of Care, would benefit from an orientation to PT and what it involves, defined terms, clearer expectations from the sponsoring organization regarding transformation, and a more precise measure of success.

Discussion

Under SE AETC's 4-year (2015-2018) PT initiative, a group of mostly primary care clinics across the Southeast had the opportunity to receive expert training and mentorship in 1 or more self-selected organizational domains to

improve patient outcomes along the HIV Care Continuum. As coaches and champions described during their focus groups, this ongoing exposure to professional training opportunities, in concert with the expertise and support provided by the coaches and champions, presented PT sites with the unique opportunity to enact organizational change. The PT program provided essential structure while still supporting clinics' efforts to approach change in innovative and creative ways. In addition to these facilitators of PT, coaches and champions also discussed PT successes, challenges, and suggestions for improvement.

While the involvement of all PT team leaders and clinic staff was central to the streamlined operation of the PT program, coaches and champions were the lynchpins of the initiative. As external facilitators with valuable "outsider" perspective, coaches were indispensable in guiding clinics toward their individualized PT goals, which site leaders set with their coaches upon onboarding with this PT initiative. Coaches shared a sense of pride in this role and noted that the accomplishments of their respective clinics felt like real victories, especially when they encountered seemingly intractable challenges along the way. Within clinics, champions were essential to the success of PT and expressed pride in their clinics' accomplishments during the PT program. In particular, coaches and champions considered their updated EMR systems a major accomplishment, especially given that this increased clinics' ability to identify and track patients with poor clinical outcomes. This enhanced data functionality is in line with the CDC's Data to Care (D2C) public health strategy, which promotes utilizing HIV surveillance data to identify patients at risk of suboptimal outcomes at 1 or more steps of the HIV Care Continuum.²¹ D2C has been shown to be effective in relinking PWH who have fallen out of care, as well as increasing viral suppression.^{22,23} Thus, improved EMR functionality represents a major success of SE AETC's PT program.

EMR systems also presented challenges, however. While sites were eventually able to ameliorate IT issues through the support provided through the PT program, this took some time and, in some cases, represented a year or more of troubleshooting. An additional challenge experienced by some sites was insufficient or inconsistent administrative support at their clinics. This primarily arose from differences in prioritization of PT goals: While coaches and champions were focused on implementing organizational transformation, clinic directors and medical staff were often more attentive to managing the day-to-day needs of their clinics, especially once the novelty of the PT program had worn off. Future research should explore PT sustainability in HIV care settings to ensure that organizational goals, once achieved, do not lose priority among clinic personnel.

Based on their experiences in the PT program, coaches and champions shared some suggestions for improvement. Both participant groups expressed frustration with the lack

of pre-specified goals at the beginning of the program which, while helpful for fostering creativity and flexibility in achieving goals, also served to obfuscate clear direction. Coaches and champions discussed possible corrective measures for future PT initiatives, such as providing a more in-depth orientation, glossary of terms, and evaluation framework at the start of the program. The PT literature suggests that applying a guiding theoretical framework²⁴ or implementation science framework²⁵ may be helpful in orienting clinics through the process of organizational change, and may also guide the evaluation process. This framework may also increase participant buy-in by specifying the extent and duration of the project and clarifying roles and responsibilities.

While this qualitative study provides useful contextual data on PT in HIV care settings from the perspectives of coaches and clinic champions who participated in a 4-year PT program, it is not without limitations. We conducted just 2 focus groups (1 for coaches and 1 for champions) comprising 14 adults in total, who were all located at clinics in the Southeast US. Moreover, while all 12 SE AETC PT sites were available to participate in the coaches' focus group, just 4 of the clinics were available to participate in the champions' focus group; therefore, not all of the champions' experiences were represented. This PT initiative was implemented in the Southeast due to the region's disproportionate HIV incidence and HIV mortality rates; yet, clinics in other areas of the US may have chosen different PT goals and had different kinds of experiences. In addition, this study did not capture the perspectives of patients or other clinic staff, which represents a logical next step for future research, as it is important to ensure that clinic changes align with patient need.

Conclusion

Based on feedback from coaches and champions indicating that more prescriptive direction was desired, PT leadership implemented some changes in its current, second cycle of the PT program that provide clinics with clearer expectations and more delineated, stepwise goals toward achieving practice transformation. The PT program is now divided into 6 "levels," beginning with HIV testing and ending with developing an HIV medical home model. Clinics complete each level together, thereby providing more of a cohort experience that offers clinics the chance to learn from each other's successes and challenges.

While the HIV Care Continuum offers a general framework for achieving and maintaining HIV health, national surveillance data shows that PWH are not meeting these key health metrics. Primary care and infectious diseases/HIV clinics can help improve these Continuum outcomes through increasing their capacity to serve the needs of their clients, as facilitated through coaches and clinic champions, who can

provide expertise "on the ground." Since no single clinic or clinic patient population is alike, it is important work within organizations to address specific needs and leverage unique skillsets. Some clinics may need assistance in improving their EMR systems and capturing patient data, for example, while other clinics may benefit from more administrative support in order to enact organizational changes. Future PT initiatives can learn from the successes and challenges of our PT program in order to optimize the effectiveness of their programs and improve patient health outcomes.


Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This project is supported by the Health Resources and Services Administration of the U.S. Department of Health and Human Services (HHS) under grant number U1OHA30535, AIDS Education and Training Centers Program. This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS, or the U.S. Government.

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