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December 18, 2009

The President
The White House
Washington, DC 20500

Dear President Obama:

The American Academy of HIV Medicine would like to applaud your commitment to the development of a National HIV/AIDS Strategy. As you undertake the important work of crafting the strategy, we wish to offer our support for your efforts.

HIV care providers are on the front lines of the U.S. response to the disease, both domestically and internationally. Their input is vital to the development of a successful strategy, and their support will be key to its success. The American Academy of HIV Medicine (AAHIVM) is an independent organization of HIV Specialists, and other providers dedicated to promoting excellence in HIV/AIDS care and to ensuring better care for those living with AIDS and HIV disease. Our members provide direct care to more than two thirds of the patients in active treatment for HIV disease. The Academy has a diverse membership composed of Infectious Disease, Internal Medicine, Family Practice and General Practice providers as well as Nurse Practitioners, Physician Assistants, Dentists, and Pharmacists. Member distribution among these provider groups is proportionate to the specialty distribution of frontline providers nationwide. Nearly 50 percent of the Academy's members are employed in programs that receive Ryan White funding.

As the largest professional trade association for HIV care providers, we respectfully submit to you the following recommendations for the National HIV/AIDS Strategy.

Sincerely,

A handwritten signature in black ink that reads "Donna E. Sweetms".

Donna Sweet, MD, FACP, AAHIVS
Chair, National Board of Directors, American Academy of HIV Medicine

A handwritten signature in black ink that reads "James M. Friedman".

James M. Friedman
Executive Director, American Academy of HIV Medicine



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The Honorable Jeff Crowley
Director, Office of National AIDS Policy
The White House
Washington, DC 20502

Dear Director Crowley:

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I. Provider Representation on Governing Bodies

The American Academy of HIV Medicine (AAHIVM) and its members believe that all governing bodies responsible for HIV policy-making, such as the President's Advisory Counsel on HIV/AIDS (PACHA), should include HIV Specialist provider representation. It is our opinion that any conversation about HIV/AIDS in the United States must start with a conversation about appropriate medical care for the infected. The policy decisions around HIV, such as health care access, prevention, research, and health education, are inextricably intertwined with HIV medical care. Therefore, we also recommend that the Office of National AIDS Policy (ONAP) interagency working group seek input from HIV providers at every stage of development of the NHAS.

II. Workforce

The U.S. HIV care system is facing a crisis in care capacity. Data from a 2008 survey conducted by AAHIVM shows that more than 32 percent of today's HIV clinicians will stop providing care over the next 10 years, and there are inadequate numbers of new recruits to take their place. Shoring up the pipeline of qualified HIV medical providers is an extended process that requires years of targeted interventions. The NHAS Strategy should provide for assurance of a well-trained HIV workforce through the following steps:

Tuition Reimbursement / Student Loan Repayment - The Administration should seek to encourage medical (MD/DO), Physician Assistant (PA), and Nurse Practitioner (NP) students to practice HIV medicine through educational incentives. Opportunities for tuition reimbursement or student loan repayment should be expanded for medical students willing to enter HIV care. Additionally, the National Health Service Corps should designate all Ryan White-funded clinics as Federally Qualified Health Centers sites eligible for participation in student loan repayment programs.

Training Opportunities in HIV Care - The Administration should provide for expanded opportunities for medical (MD/DO), PA, and NP students to seek practice opportunities in HIV medicine as part of their training and to pursue clinical fellowships after their residency. This may help to draw some students into HIV care that would not otherwise focus on the field. Furthermore, HIV training should be encouraged for all providers in the course of their medical education. Rotations in HIV care and/or exposure to populations impacted by HIV should be expanded for all medical, PA and NP students, along with outpatient opportunities for internal medicine and family medicine residents. Additionally, clinical training opportunities, satellite learning and consultation through teleconferences and web-based programs should be expanded and encouraged for primary care providers already in the field. Finally, the mission of the AIDS Education and Training Centers (AETCs) should be re-focused to include attracting new clinicians, medical students, and residents into HIV care and treatment in addition to maintaining their current goals of educating providers.

III. Access to Care

Though current political attempts are underway to reform U.S. health care through legislative policy-making, there are some basic principles that we believe should apply to HIV care regardless of what form the U.S. health care system takes. The NHAS strategy should seek to incorporate the following principles of access to care:

Access to Care For All People Living With HIV/AIDS (PLWHA) – It is our belief that one goal of the NHAS should be to promote policies that increase access to medical care for all HIV/AIDS patients. One way to accomplish this goal is the Early Treatment for HIV Act (ETHA), and other policies which would

create a pathway to link a diagnosis of HIV to immediate enrollment in coverage and access to medical care and treatment. Additionally, any health care system must still provide an adequate safety net and payer of last resort programs for PLWHA. Due to the financial and social demands of the disease, access to care will always be an issue for uninsured/under-insured, marginalized, and underserved populations with HIV. We must also work to provide access to care for the aging HIV population, who may face realities of fixed incomes and barriers to finding providers equipped or willing to take on their care. We should constantly emphasize that untreated HIV disease places heavy burdens on families as well as government and public health budgets.

AIDS Drug Assistance Programs (ADAPs) – Many ADAP formularies that were created, in some cases, almost twenty years ago, have become inadequate for the HIV treatment standards of today. ADAP formularies need to be reviewed and updated to reflect new treatment paradigms and medications. AAHIVM also urges NHAS efforts to include – at a minimum – full federal funding of ADAPs for antiretroviral and other HIV disease-specific medications, with an option for states to expand the program as able to cover medications commonly used to treat co-morbid conditions such as hepatitis B and C, diabetes, hypertension, and mental illness.

Reduction of Healthcare Disparities – In terms of medical care, a priority of the NHAS should be to encourage all providers to access the most current medical interventions. Education in current standards of care and cultural competency training for underserved populations should be readily available for all HIV providers.

For patient populations, one goal of the NHAS should be to close the differential in access to antiretroviral medications for communities of color, which have less access to medical interventions, less favorable outcomes, and increased rates of HIV transmission. Communities of color should also be provided with better access to behavioral and mental health services.

We also encourage the Administration to cultivate greater minority representation among qualified HIV providers. A laudable goal for the NHAS would be to increase the number of minority providers to more closely reflect the patient population they serve. We support full funding of the Health Professions Title VII and VIII programs. We also encourage the Administration to promote opportunities for minority medical students.

IV. Reimbursement

Reimbursement Rates that Support the Cost of Care – We believe reimbursement rates should, at a minimum, allow both clinics and providers the ability to maintain the standard of care. Reimbursement from all payers should reflect the true cost of medical procedures, labs, and treatments. Reimbursement for evaluation and management service (E&M) should be balanced appropriately in comparison to reimbursement for procedure-based specialties. Because HIV care is just as complex and demanding as other medical specialties, certified HIV specialists should be reimbursed at rates comparable to other medical specialists. This issue is closely related to successful recruitment of medical providers into the field of HIV medicine.

Coordination of Medicaid/Medicare Reimbursement – We urge the Administration to prepare for the transition of HIV/AIDS patients into Medicare systems as the HIV population ages. Reimbursement and provision of care in each system must be aligned to ensure smooth transition of patients between the programs. Medicare providers may need further incentive to accept HIV patients. The NHAS must ensure that low/fixed income elderly don't lose access to care, medication, or case management services as they age and transition to Medicare programs.

V. Coordination of care

Interdisciplinary/ Multidisciplinary Care - We encourage the Administration to promote the “medical home” model and other multidisciplinary approaches to care through the NHAS. HIV patient care would benefit from better coordination with other medical specialties, including dental care and mental health services. As such, HIV providers should be encouraged to coordinate patient care with other medical specialties and to look for opportunities to create comprehensive programs for care. Concurrently, all medical specialists should be encouraged to provide care for HIV patients.

Aging HIV Population - The coming influx of a generation of older HIV patients means that HIV care will need coordination with a new set of medical specialties geared toward the conditions of aging. HIV care will need to be coordinated with geriatric, cardiac, rheumatologic, dental, pain management, and endocrinologic specialties, among others. A new medical awareness should also be cultivated of treating HIV “throughout the life span” as opposed to focusing on short term survival or urgent care, as PLWHA now have life spans measured in decades rather than years.

Information Technology for HIV Medicine - Although the Department of Health and Human Services has worked strenuously to encourage adoption of medical technology innovations, we perceive that the HIV medical field has yet to benefit from some of the incentives to adopt these technologies. Medical information technology has the potential to improve comprehensive management of medical care and information for PLWHA. The NHAS strategy should recommend that the Office of the National Coordinator (ONC) incentivize the adoption of medical technologies in the HIV field and tailor medical technologies and the exchange of medical information to this mobile patient population. Specifically, there are three areas of medical technology which hold great promise for HIV care: electronic medical records, personal health records, and telemedicine.

Electronic medical records are especially useful for the detailed and complex record keeping associated with managing HIV, provided that they contain the ability for providers to make extensive notes, and record finely tuned medical treatments and regimens. However, access to electronic medical record systems can be unattainable for smaller provider offices not connected with a large medical network or hospital. The NHAS should encourage availability of health information technology (HIT) for these circumstances.

Portable personal electronic health records are another approach for HIV patients. The ability to transport the detailed record of medical history, drug regimens, and other treatments are invaluable for a patient with HIV facing relocation, travel, medical emergency, and incarceration. Likewise, electronic health information exchanges are especially helpful for mobile or incarcerated patients, who move from clinic to clinic or state to state.

Another technological advancement which holds great promise for HIV care and treatment is telemedicine. The NHAS should include efforts to promote telemedical technology which allows for the provision of HIV or other specialty care for populations who may otherwise not have access, such as those who reside in rural areas and correctional settings.

VI. HIV Testing

Adoption of Centers for Disease Control and Prevention (CDC) Guidelines - The NHAS should continue efforts to promote the 2006 CDC Revised Recommendations on HIV Testing. Anecdotal evidence from many HIV providers indicates that the CDC message of universal testing for all adults ages 13-64 is not getting through to non-HIV specialties. Despite advancements in the area of prenatal

screenings, adolescents and many other patient groups are still not being tested. Further education on universal testing guidelines for physicians in non-HIV specialties is desperately needed. Additionally, many states still have laws which are not fully compatible with CDC recommendations in the areas of counseling and consent, which may impede testing efforts. We encourage the NHAS to work with state AIDS officials in these states to further promote CDC testing efforts.

Linkage to Care – One downfall of community testing efforts across the nation is the failure to reliably link individuals diagnosed with HIV to experienced HIV care providers and other critical HIV-related services. Prevention efforts under the NHAS should work to build a robust infrastructure to link HIV testing to both medical and behavioral health care following a diagnosis. This would further promote appropriate testing and reduce HIV transmission.

VII. Research

A strong research agenda will be, undoubtedly, a core component of the NHAS Strategy. We urge the Administration to encourage and support innovative research not only into diagnosis, treatment and prevention, but also into the social and epidemiological factors of the disease that weave the complex tapestry that is HIV/AIDS in the U.S. in the twenty-first century.

Research in Medicine - Research into the co-morbid conditions associated with living a long life with HIV is a topic of great interest to our providers. A few specific subjects of medical research that they feel would benefit this understanding are: co-morbidities for HIV and aging, malignancy, cardiovascular disease, renal disease, hyperlipidemia, diabetes, osteoporosis, cancer, and hepatitis B and C co-infection. Our providers also have a desire to see research into drug interactions antiretrovirals and other medications commonly used in to treat heart conditions, cholesterol, lipid metabolism, dementia, and psychiatric conditions. However, in all research forums, we see a need for stronger representation by non-white, non-male participants to accurately reflect the changing face of HIV in the U.S.

Research in Demographics and Human Behavior - We would like to recommend new studies based on emerging locations and populations affected by HIV. The disease has migrated into new populations and locations over the past decade though studies have not kept pace with this changing epidemiology. While studies are abundant on urban Caucasian gay men, research is sparse on HIV-infected populations of women, the indigent, and migrant populations, and also on HIV in the rural South and central portions of United States. We encourage the Administration to promote further examination of the disease in these populations and locations, and to support a research platform that more fully reflects the changing identity of the epidemic

Thank you for your consideration of our requests for the National HIV/AIDS Strategy. We look forward to working with you to ensure the best possible strategy is advanced to contain the nation's HIV/AIDS epidemic and care for those already infected.