

The AMERICAN ACADEMY of HIV MEDICINE

February 2009
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HIV SPECIALIST

PATIENT CARE, PRACTICE MANAGEMENT & PROFESSIONAL
DEVELOPMENT INFORMATION for HIV CARE PROVIDERS

Who Will Care for Them?

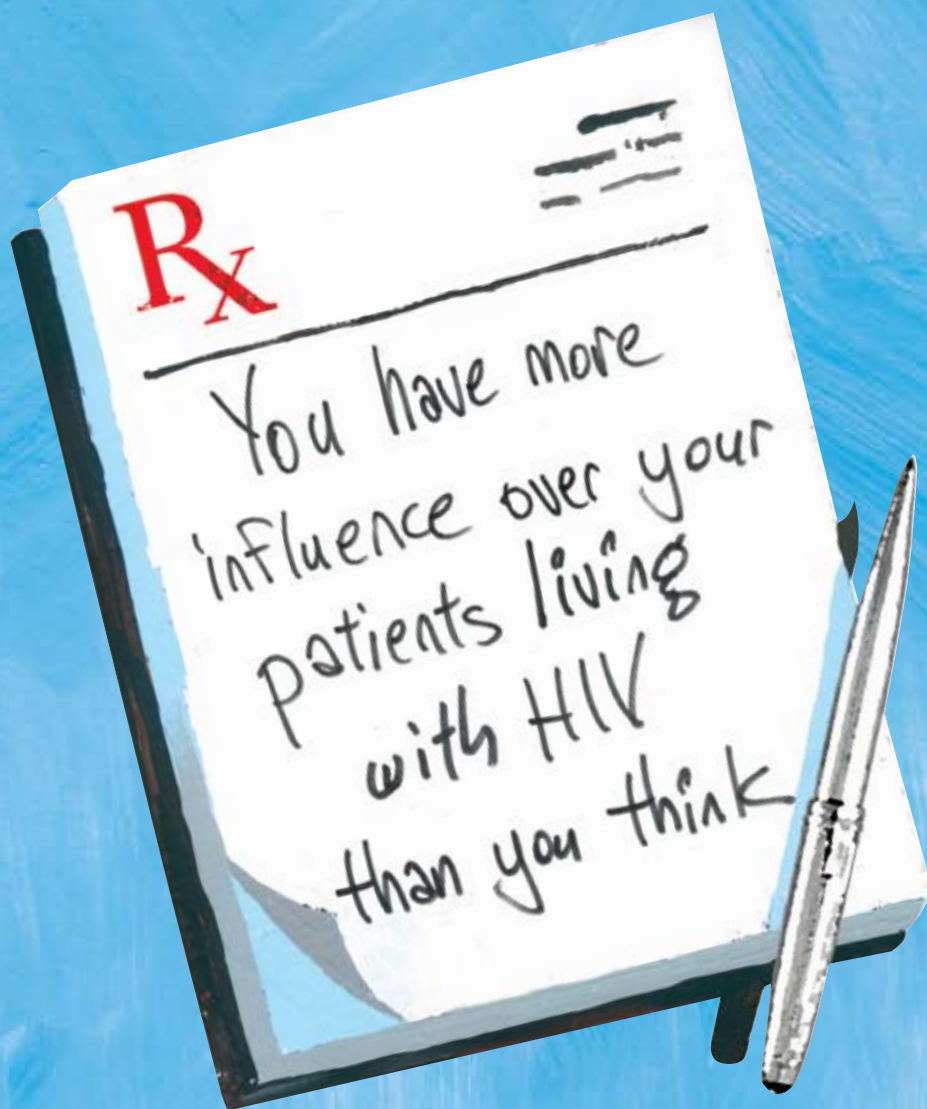
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DISCUSSING PREVENTION HELPS PROTECT YOUR PATIENTS AND THEIR PARTNERS

Although people living with HIV often adopt healthy behaviors upon initial diagnosis, many revert back to risky behavior after time. Risky behaviors can lead to acquiring an STD, which can jeopardize a patient's health, and untreated STDs increase the risk of transmitting HIV to partners. Research shows that integrating brief prevention transmission discussions into each patient visit helps reduce risky behaviors. The Centers for Disease Control and Prevention created the *Prevention IS Care* campaign and Web site to support providers who treat people living with HIV. **To receive FREE materials that translate scientific evidence into practical tools for providers and patients, visit www.cdc.gov/PreventionISCare or call 1-800-458-5231.**

PREVENTION IS CARE
Screen for risky behavior.
Prescribe healthy behavior.



Prevention IS Care

A New Call-to-Action for HIV Clinicians

DECEMBER 1, 2008, MARKED THE 20TH ANNIVERSARY OF THE FIRST WORLD AIDS DAY. As I reflected on its significance and what drew me to pursue a career caring for persons with HIV infection, I remembered the exciting challenges of confronting a mysterious, new disease for which we had few answers and little to no treatment.

Today, many (but not all) of the mysteries surrounding this disease have been resolved. With so many remarkable advances, what continues to challenge HIV clinicians like me? Why should we remain in this field and encourage young clinicians to pursue it?

At least part of the answer is that we still have a major role in caring for the lives of our patients and for public health at large by actively preventing the spread of this disease. We have a responsibility to make sure that HIV infection stops with our HIV-positive patients.

During the 1980s and early 1990s, the call to service was clear. We were asked to care for critically and often terminally ill patients. There was a keen sense of responding to a noble cause, fulfilling the reason why many of us became healthcare providers.

Today, many HIV clinicians report not feeling as needed as before. Many have left the practice of HIV medicine or have limited their number of HIV-positive patients. While part of the initial attraction to HIV medicine was saving the lives of seriously ill patients, another was the broader desire to combat and eventually defeat this devastating disease.

For those of us involved in clinical research, we know that our work has led to better treatments for HIV infection. So why should HIV clinicians in either non-research or research settings remain in this field of medicine? We must prevent further transmission of HIV.

Let's expand our sense of what challenges us—to include not only medical care, but also preventive care. We must not underestimate the influence of a "caring white coat" as a key factor in turning the tide in the HIV epidemic. Incorporating frank, non-judgmental brief discussions with our patients about their sexual and drug-related risk behaviors can continue our fight against the epidemic by effecting life-saving behavioral change.

By asking our patients about their sexual practices, condom use, frequency and number of sexual partners, we can discover fruitful areas for further discussion and education. These discussions help me assess my patients' knowledge of HIV transmission factors, safer sex, and drug use

practices. Many patients are often confused about the correlation between viral load and HIV transmission. Misconceptions regarding the safety of oral sex practices for both HIV and other STDs are commonly discovered. By initiating these discussions, we can help our patients adopt and maintain safer sex and drug use practices.

Clinicians can facilitate the use of partner notification programs, prevention counseling, and HIV serologic screening to help keep our patients' partners from becoming infected with HIV. We can get them into medical care quickly, and, where appropriate, refer our patients to mental and sexual health services, substance abuse treatment and other specific programs.

PREVENTION IS CARE
*Screen for risky behavior.
Prescribe healthy behavior.*

With almost 60,000 new cases of HIV infection each year in the United States through 2006 and evidence that STDs are increasing in both men and women with HIV, our work is far from done. We must remember that many of our patients as well as many younger healthcare providers have little memory of the horrific early years of the HIV epidemic. We now commonly care for a generation that has never had a "healthy fear" of HIV infection and its horrible consequences.

Our work as HIV healthcare providers is not over. We can still save lives on a grand scale by caring for our patients with education and reinforcing the HIV prevention message during every visit.

Are you up to this challenge?



About the Author: is Associate Professor of Medicine in Residence at David Geffen School of Medicine at UCLA and Director, Division of Infectious Disease and AIDS Program at Cedars-Sinai Medical Center in Los Angeles, California.

For resources to help you integrate prevention messages into every patient visit, try the *CDC Prevention IS Care Provider Resource Kit*. The Resource Kit Includes provider intervention tools, patient education materials (in English and Spanish), an HIV risk screening tool, CME, and more. To order free copies, call 1-800-CDC-INFO, e-mail info@cdcnpin.org, or visit www.cdc.gov/hiv/topics/treatment/PIC/

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New AAHIVM Survey Warns of Looming Workforce Shortages in HIV Medicine

A critical shortage of practitioners who treat HIV/AIDS patients in the U.S. could be on the horizon, according to new research from AAHIVM.

BY BOB GATTY, EDITOR, *HIV SPECIALIST*

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HIV
SPECIALIST

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WHAT KALETRA MEANS TO ME

*I'M THINKING
OF MY FUTURE*

*Consuelo "Connie" Salazar
Office manager
and single mother*

KALETRA[®]
(lopinavir/ritonavir) **tablets**

The people depicted in the photo above are models and are being used for illustrative purposes only.
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 **Abbott**



Welcome Fellow Practitioners

A **S HIV CARE PROVIDERS, OUR COMMITMENTS ARE MANY AND OUR SCHEDULES ARE TIGHT.** Every day brings with it more and more information that requires our attention. Emails. Newsletters. Medical Journals. Letters. Announcements. We get them in the mail. We get them on our computers. We get them on our Blackberrys or our iPhones. Over and over again throughout the day, we must choose whether to open, read, peruse or delete.

But out of that avalanche of information, there are few—if any—publications that address the day-to-day professional life of the HIV-focused physician, physician assistant or nurse practitioner. Medical journals, online educational resources, national conferences and regional meetings help us keep current with treatment breakthroughs, epidemiological trends and clinical guidelines. But what publication synthesizes all of that information, along with information about HIV care workforce trends and public policy issues, into an easy-to-digest format that helps us in our daily practice?

We are delighted to present *HIV Specialist*, the new magazine of the **American Academy of HIV Medicine**, which includes patient care, practice management and professional development information for **HIV Care Providers**. This is a publication we know you will choose to make time for in your day. *HIV Specialist* is not an academic medical journal and not a tabloid. It is a practice management-focused magazine designed to address the unique issues we face as frontline HIV medical providers, and put them in a context applicable to our day-to-day patient treatment activities. *HIV Specialist* is by practitioners for practitioners, and we know you will find it interesting and informative.

In our inaugural issue, you'll see us start to take a closer look at what is happening to our **HIV-treating workforce**, as we present an overview of the findings of our recent survey of providers and medical students who have expressed an interest in pursuing HIV care. The news is both concerning and encouraging. We are all well aware of the looming crisis in all areas of primary care, and our survey confirms that we, too, have cause for concern. What is encouraging, however, is that we as providers have a great deal of job satisfaction, both from our ability to help people and make a difference, as well as to be intellectually challenged by the evolution of the treatment of the disease. And, since the students surveyed also feel job satisfaction from

helping others and intellectual challenge will be important to the direction they take in their medical career, we can confidently affirm for those students that if that's what they want, then that's what they'll get if they pursue HIV medicine.

Also in this issue we begin to look at the often daunting issue of moving from a paper to an **electronic medical record system**. We examine some of the current protocols for begin-

ning **ARV treatment**. You will discover why the CDC "**Prevention IS Care**" program is an important initiative to get us talking with patients about prevention, and you'll learn what the Academy sees as some of the **health policy issues HIV care providers should be thinking about** during the new Presidential administration.

I'd like to thank several Academy members without whom this inaugural publication could not have happened: **Dr. Jeffrey Kirchner** for his spirit of adventure in accepting the role of chair of



Donna E. Sweet

the magazine's Editorial Advisory Group (EAG) and the members of the EAG: **Drs. Joseph Cervia, Kay Kalousek and Richard Prokesch**, Nurse Practitioner **Tonia Poteat** and *Positively Aware* Editor **Jeff Berry**; AAHIVM Communications Director **Rob Banaszak** for his heavy lifting on the magazine project, and AAHIVM Executive Director **Jim Friedman** for his heavy pushing. And of course, our publishing team of editor **Robert Gatty**, publication designers **BonoTom Studio, Inc.**, and advertising sales representative **Jane Richardson** of the **Ad Marketing Group**.

Enjoy the first issue of *HIV Specialist*. And be sure to let us know what you think and how we can make it even better. **HIV**

Sincerely,

Donna E. Sweet, MD, MACP, AAHIVS
Chair, AAHIVM Board of Directors



Uncovering the Real Enemy, the Weapons for Victory

The early years of the HIV/AIDS pandemic found the hospital a fierce battleground as patients and caregivers engaged a fearsome, yet stealthy adversary. Antimicrobials were potent, but inadequate. Could patient and doctor become allies in the battle to unmask the enemy and uncover the only weapons that might bring victory?

OUTSIDE THE DOORWAY, the medical student began: "M.G. is a 37-year old man with AIDS and CMV retinitis. Ophthalmology confirms progressive disease on gancyclovir. He complains of weakness. Hemoglobin is down three grams over the last 48 hours. We'll have to transfuse three units. What else can we do?"

As I stepped inside, the patient greeted me, anxious and hostile. "Doc, get me out of this stinking rat hole."

"Good morning, Mr. Gray," I replied. "I'm Dr. Cervia, ward attending. How can I help you?"

"You can get me out of this lousy room and off of this damned medicine."

"You've become anemic on gancyclovir, and require blood transfusion," I conceded. "I agree, this medicine is not helping, and you aren't tolerating it. I recommend a different drug called foscarnet."

"Doc, you can take all of this medicine and shove it. Just get me out of here," my patient snapped.

"I'll do all I can. I'll come back later so we can talk some more," I said as I retreated into the hallway.

After rounds, I returned and listening, discovered that Merlyn Gray was an artist, and that he feared losing his sight even more than death. Sadly, realization of both fears did not appear remote.

"Gancyclovir made me anemic; what's this new medicine going to do?" Merlyn asked.

"It's uncertain that foscarnet would slow progression of visual loss, but it's also uncertain that you would suffer adverse effects," I said. "Nevertheless, foscarnet is associated with kidney failure."

"Well, that's just great Doc! First, you make me anemic; now you want to wipe out my kidneys! Just leave me alone, and let me die in peace," Merlyn fired.

"I don't believe we should give up without a fight. You aren't dying today. Why don't we try foscarnet?" I persisted.

"Just get out, Doc. You're making me angry. Please. Disappear."

I retreated from Merlyn's room, but returned the following

day and on each of the next seven. I was greeted by Merlyn's anger and his displeasure with his room, the hospital, food, nurses, house staff, and with me. On the seventh day, I told Merlyn that if he were so unhappy and unwilling to accept care, I would help arrange transfer to another institution of his choice.

But the following morning I was shocked when I was met with a warm smile and hug from Merlyn.

"Doc, thank you for putting up with me, for taking all the abuse, and never giving up," he said. "I want to live. I will give foscarnet a try." Rarely in my young career had I been filled with such joy.

Later, in the lobby I noticed a booth erected to honor the nascent World AIDS Day, and purchased a black button emblazoned in white lettering with the single word, "SURVIVE." I gave it to my brave comrade, pinning it to his hospital gown.

Two weeks later, we achieved a small victory. Merlyn's CMV retinitis appeared under control. Donning street garb for the first time in over a month, he prepared to go home. Then, Merlyn retrieved the black button from his knapsack, and with an embrace pinned it onto my white coat before disappearing into the elevator.

Through the struggles of ensuing years, I have kept this badge of courage as a lasting reminder of the persistence and valor essential for victory. I finally understood that fear itself is the real enemy, stealthily camouflaged in anger, and that patience and kindness are our most powerful weapons in overcoming it. **HIV**



About the Author: Dr. Joseph S. Cervia is Clinical Professor of Medicine and Pediatrics, Albert Einstein College of Medicine. He is Attending Physician, The Center for AIDS Research and Treatment, The North Shore/Long Island Jewish Health System, and Medical Director and Senior Vice-President, Pall Medical, East Hills, NY 11548 **Contact:** cervia@lij.edu, joe_cervia@pall.com. The author has no conflicts. Patient names and identifying information have been altered to protect confidentiality.

Who Will Care for Them?

BY JEFFREY SCHOUTEN, MD, AAHIVS, ATTORNEY-AT-LAW;
& JAMES SOSMAN, MD, AAHIVS

BACKGROUND

WORKFORCE
SHORTAGE IN
PRIMARY CARE
SPILLS OVER TO
HIV MEDICINE

CLINICIANS WHO CARE FOR PEOPLE with HIV infection are concerned about a potential provider shortage in the United States as most entered the field early in the epidemic as they began their medical careers. Now, as many near retirement, a serious HIV workforce shortage could be looming.

This concern parallels the growing workforce supply crisis in primary care medicine, which shows signs of worsening unless action is taken. Many studies



show that fewer physicians are entering primary care medicine, a field that is common among HIV care providers.

Thus, there is real cause for concern.

According to an American College of Physicians (ACP) white paper “the lack of access to primary care doctors leads to worse health outcomes and higher costs. As the population ages and demands on health services increase,” the paper says, “Americans will find it more difficult to locate primary care physicians to help coordinate care in a fragmented system.”

The ACP observed that “notwithstanding a heightened interest and concern expressed by many physicians, policymakers and other stakeholders about the future of primary care, the United States has yet to implement comprehensive strategies to recognize, support, and enhance primary care to the degree necessary to reverse a worsening primary care shortage.”

The ACP has even proposed a new model of primary care medicine provision, the “advanced medical home” model, which advocates specialty medical practices that provide patient-centered care based on the principles of the Chronic Care Model.

According to a survey conducted by the Physicians’ Foundation between May and July 2008 with 11,950 respondents, 78 percent of physicians said there is an existing shortage of primary care doctors in the United States today. Almost half said that over the next three

years they plan to reduce the number of patients they see or stop practicing entirely.

Studies have shown that many factors influence the decision of health care providers to practice primary care medicine, including low reimbursement rates, complexity of management of people with chronic medical conditions, lack of mentors, life style factors, high educational debt load and fragmentation of care. In 1998, half of internal medicine residents chose primary care medicine, but today this rate has dropped to only 20 percent, according to ACP.

U.S. medical graduates with higher medical debt are less likely than those with no debt to choose a subspecialty career, according to a report in the *Annals of Internal Medicine*.

A recent survey of medical students showed that career interest in general internal medicine (IM) is particularly low. The items most frequently cited as attracting students toward IM careers were the intellectual challenge of IM, teaching on the IM rotation, the continuity of care in IM, the competence of IM residents and the responsibility for patient care during the core IM clerkship and sub-internship. However, the *Journal of the American Medical Association* reported that U.S. medical students have reservations about careers in IM because of patient complexity, the practice environment, and lifestyle compared with other specialties.

There is limited data on the impact of the primary care provider

crisis on HIV medical care. People with HIV are living much longer and there are an estimated 56,300 new cases of HIV infection annually in the United States, according to the Center for Disease Control (CDC). This concern is amplified by the expectation that CDC recommendations for routine HIV testing will identify and bring into care a significant percentage of the current estimated 25 percent of people who are HIV-infected, but unaware of their infection.

Likewise, HIV treatment is extremely complex, and reimbursement for HIV care is low. Many current HIV specialists have been caring for people with HIV for up to 25 years. As they retire will there be an adequate influx of new providers to replace them? **HIV**



About the Authors:

Dr. Jeffrey T. Schouten is the Director of The HIV/AIDS Network Coordination (HANC) project at the Fred Hutchinson Cancer Research Center in Seattle, WA. He is the immediate past chair of AAHIVM’s Board of Directors, and is a member of *HIV Specialist’s* Editorial Advisory Group.



Dr. James Sosman is Professor of Medicine at University of Wisconsin Medical School in Madison, WI, and is chair of the AAHIVM’s Great Lakes chapter.

AAHIVM Executive Director **James Friedman** contributed to this article and guided the development of the following article.

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Who
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Them?

COVER STORY

BY BOB GATTY, EDITOR, HIV SPECIALIST

New AAHIVM Survey LOOMING Workforce Shortage in HIV/AIDS Medicine

A **CRITICAL SHORTAGE OF PRACTITIONERS WHO TREAT HIV/AIDS PATIENTS** in the United States is on the horizon, according to new research by the American Academy of HIV Medicine (AAHIVM), which warns that more than 32 percent of today's HIV clinicians will stop providing that care over the next 10 years.

Even though most HIV physicians, certified physicians' assistants and nurse practitioners find their work challenging, interesting and gratifying as new scientific discoveries rapidly translate into clinical practice, nearly one-third of today's professional workforce will either retire or move on to other endeavors, leaving a potentially serious shortage unless new practitioners can be encouraged to replace them.

The research included two surveys distributed in November, one to 1,783 current practitioners that was aimed at providing insight into their job and career satisfaction and plans for the future, and a second to 205 student AAHIVM members to gauge the potential for new HIV/AIDS practitioners in the years ahead.

"The survey told me that most HIV practitioners entered the field because they liked the intellectual challenge of the specialty, the rapid translation of scientific discoveries into clinical practice, the opportunity to provide direct patient care, and the ability to impact outcomes for patients with life threatening diseases," said AAHIVM Chair Donna Elaine Sweet, MD, of the School of Medicine at the

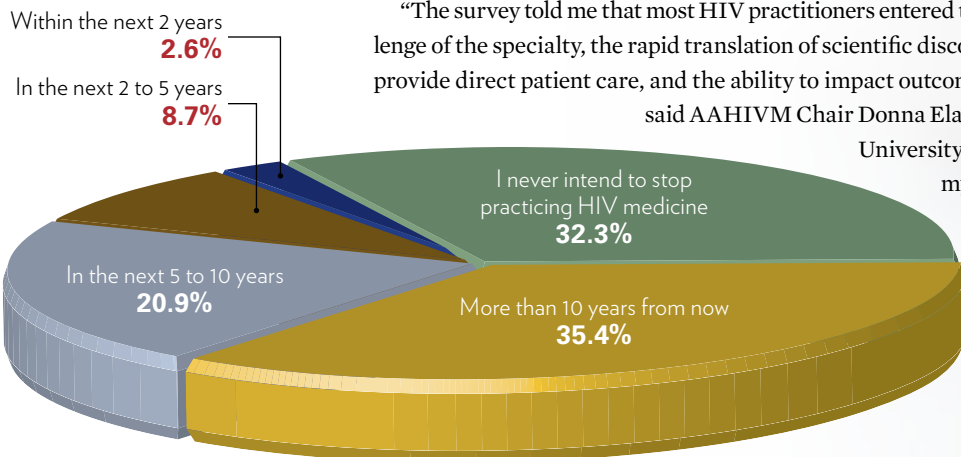
University of Kansas. "I was reassured since those were my reasons as well," she said. "Then I found that over 90 percent of the practitioners have been satisfied with their career, as I have been."

But the "shocker" for Dr. Sweet was the finding that nearly one-third of her colleagues intend to stop practicing over the next 10 years.

The student survey, she said, provides some reassurance since student respondents said they were interested in HIV medicine for the same reasons as today's providers, but

CLINICIANS

How soon are clinicians expecting to stop practicing HIV medicine?



A close-up photograph of a woman with dark hair pulled back, wearing a white hospital gown with a small blue floral pattern. She is looking upwards and to the left with a concerned expression. A doctor's hands, wearing a white coat and a metal watch, are gently holding her face from the sides. The background is blurred, showing a clinical setting.

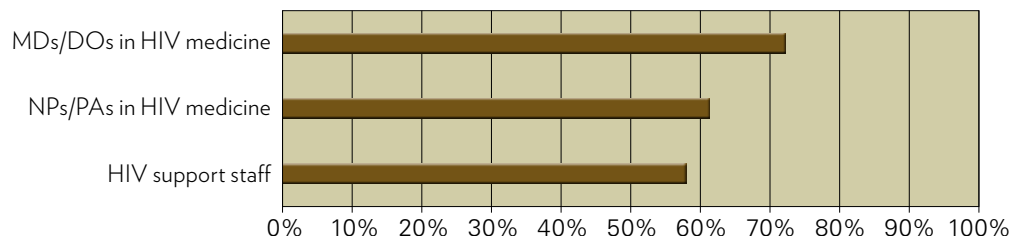
Warns of **G** tages

LOOMING Workforce Shortages in HIV/AIDS Medicine

The survey showed that a majority of practitioners with their medical careers as a function of time spent practicing and that satisfaction increases with the percentage of clinical time

CLINICIANS Clinician perceptions regarding meeting the demand for HIV treaters

I am concerned about a future shortage of:



STUDENTS General perceptions of students interested in practicing HIV medicine

- 1 in 3 are planning to pursue a career in HIV medicine
- 8 in 10 report that a government loan repayment program would influence their decision to pursue a career in HIV medicine
- 1 in 5 plan on practicing medicine in a rural area
- 2 in 3 report their expected level of education-related debt at the time of graduation to be greater than \$75,000; 1 in 4 expect a debt level higher than \$200,000

many are still undecided.

"It is our job, those of us who are in the field and are worried about the adequacy of our future workforce, to let those students know (and potentially thousands more who haven't thought about a career in HIV medicine) that they are likely to get what they want if they choose HIV medicine," Dr. Sweet said.

"At a time when AIDS is no lon-

ger a death sentence and our patients can live productive lives, we are concerned about this potential shortage of practitioners who care for one of the most vulnerable segments of our population," said AAHIVM Executive Director James Friedman. "If there is a growing shortage of primary care physicians, there will soon be a similar shortage of providers who serve those infected with HIV/

AIDS. The potential consequences in terms of patient access and the quality of care could be severe."

Key Findings—Today's Practitioners

The survey indicates that for 51.3 percent of respondents, patient relationships are the greatest source of professional satisfaction, while 38.7 percent identified the intellectual challenge of their work. Nearly

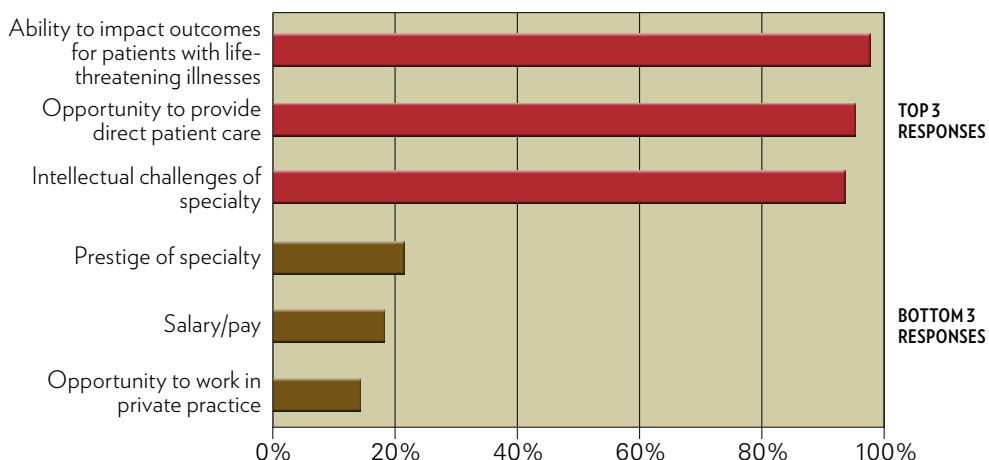
are satisfied HIV medicine, spent on HIV.

80 percent said they were satisfied that their practice provided the opportunity to build trusting relations with patients, as well as to teach students and trainees.

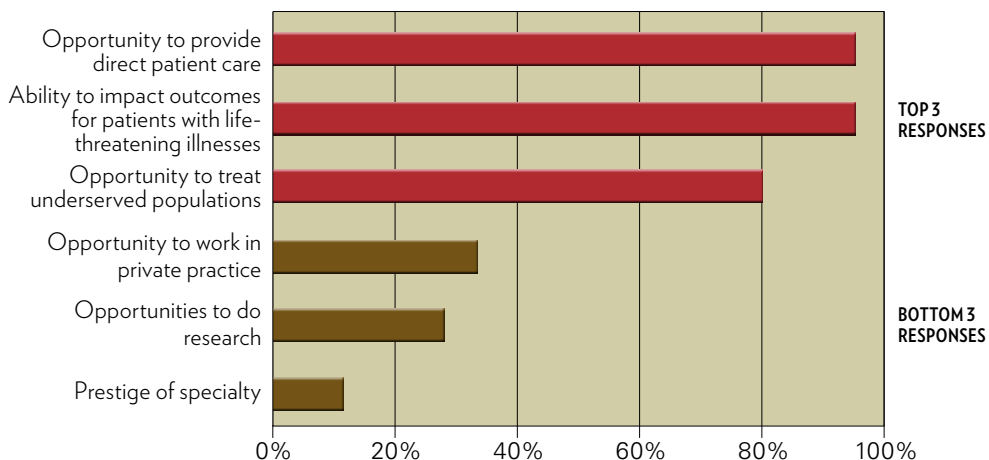
Those conclusions were also the primary reasons why many decided to work in HIV medicine when they entered the field, along with their ability to impact outcomes for patients with life-threatening disease. They were also the top reasons given by most of today's students for being interested in HIV medicine, although 80 percent also want an opportunity to treat underserved populations.

The survey showed that a majority of practitioners are satisfied with their medical careers as a function of time spent practicing HIV medicine, and that satisfaction increases with the percentage of clinical time spent on HIV. For example, while 84.8 percent of those who spend up to 25 percent of their clinical time on HIV said they are satisfied, 94.3 percent of practitioners who spend more than 75 percent of their time on HIV were satisfied. In short, the more time HIV practitio-

CLINICIANS What are the most and least important factors in deciding to pursue a career in HIV medicine?

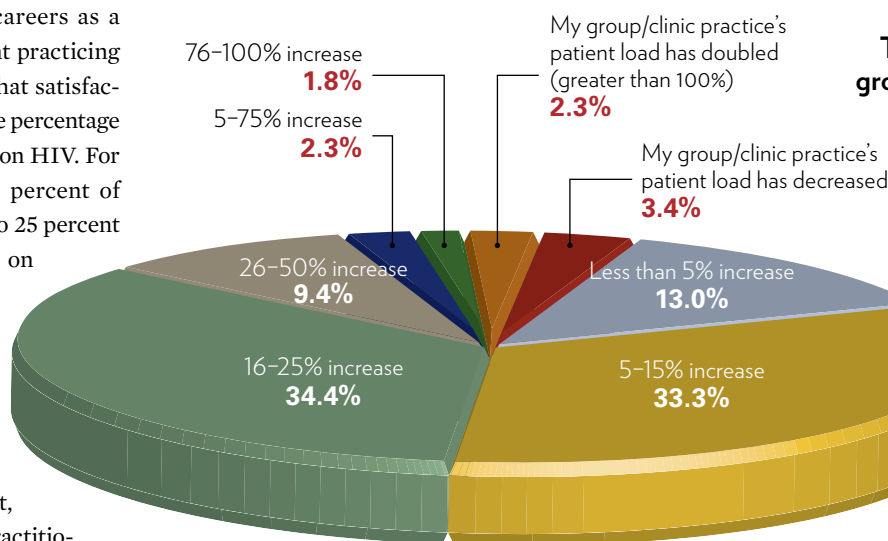


STUDENTS



CLINICIANS

To what degree has your group/clinic practice's HIV patient load changed over the last 2 years?



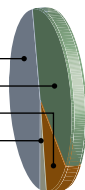
LOOMING Workforce Shortages in HIV/AIDS Medicine

“I find that I enjoy the relationships
one survey respondent commented.
hurt less and feel like living

CLINICIANS Satisfaction with career overall as a function of time spent practicing HIV medicine:

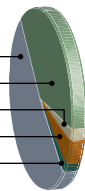
1% - 25% of clinical time

1. Very satisfied—**45.8%**
2. **39.0%**
3. **3.4%**
4. **11.9%**
5. Very dissatisfied—**.0%**



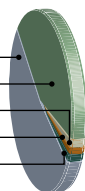
26% - 50% of clinical time

1. Very satisfied—**52.1%**
2. **38.5%**
3. **2.1%**
4. **5.2%**
5. Very dissatisfied—**2.1%**



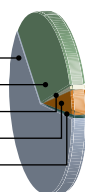
51% - 75% of clinical time

1. Very satisfied—**53.0%**
2. **42.4%**
3. **1.5%**
4. **1.5%**
5. Very dissatisfied—**1.5%**



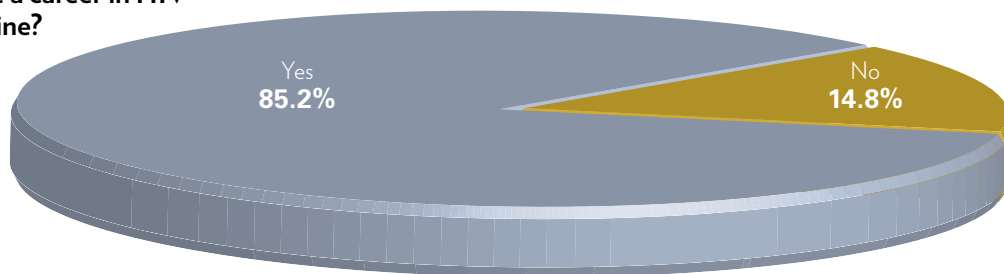
76% - 100% of clinical time

1. Very satisfied—**61.8%**
2. **32.5%**
3. **.6%**
4. **4.5%**
5. Very dissatisfied—**.6%**



STUDENTS

Would a government loan repayment program influence your decision to pursue a career in HIV medicine?



ners spend with their patients, the more satisfied they are with their work.

“I find that I enjoy the relationships with patients most,” one survey respondent commented. “I feel I am helping my patients hurt less and feel like living again,” said another.

Other key findings of the practitioners’ survey highlight some of their primary concerns:

About two thirds of providers practice in an institution that receives funding from the Ryan White CARE Act, which has suffered from federal budget reductions.

Increasing personal patient load is forcing many providers to work longer hours and cutting the time they can spend with patients.

Only one in 10 report that average face-to-face time per patient is much higher than two years ago.

The average patient’s wait time for an appointment is much higher than it was two years ago, and for new patients the wait now averages 10 business days.

Thus, while there is considerable job satisfaction resulting from providers’ ability to help vulnerable patients and save lives, there is frustration with the lack of funding and support for HIV medicine. For example, some 80 percent are dissatisfied with the extent of staffing resources available and patient load was identified as a concern by about 66 percent of respondents. Most HIV/AIDS professionals would like to spend more time with each patient.

Key Findings—Students

Even as remarkable advances in drug treatment and outcomes have been made in recent years, the disease continues and while patients are living longer, they must continue to have high quality care.

Some of the key student findings included:

Of those students that decided to become members of AAHIVM, about one in three plan to pursue a career in HIV medicine. Two of three students expect

with patients most,”
“I feel I am helping my patients
again,” said another.

their education related debt to exceed \$75,000 when they graduate, and one in four anticipate a debt of more than \$200,000.

Almost 90 percent of those who are unsure about their career choice said a government loan repayment program would encourage them to enter HIV medicine

Many of the most satisfying elements of HIV patient care reported by today's providers parallel the objectives expressed by many of the students who responded to their survey.

For example, intellectual stimulation was reported to be a source of great satisfaction by almost 90 percent of HIV professionals, and was an important reason given by nearly 92 percent of medical students for choosing HIV care. Those students also want to provide direct patient care, with more than 96 percent giving this as an important factor in their decision.

Likewise, the ability to impact health for patients with life-threatening illnesses is important to nearly 97 percent of student respondents for entering HIV care, and a similar number of clinicians indicated that as extremely important to them.

More than 60 percent of students said “prestige of the specialty” was not important, although 71 percent said salary/pay is at least somewhat important—as is the amount of education-related debt they expect to roll up.

Today's Reality

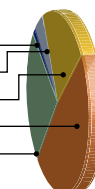
For many HIV practitioners, today's reality means working longer hours and serving more patients with fewer resources. For example, 49.5 percent of respondents said the supply of health care providers in clinical HIV infection services in their community is less than current demand, and 71.8 percent said their patient load has increased by from 5 to 50 percent over the past two years.

As one HIV doctor commented, “In 16 months that my practice has been open, I have inherited patients from 13 providers, both MDs and mid-levels, whose practices closed due to the harsh economic environment meeting the generally poor business skills of MD-owner/managers. Most of these providers were HIV specialists. We are creating a practice that is in-

CLINICIANS What is the potential of each of the following for meeting a future increase in demand for care in HIV care services without compromising the quality of care provided?

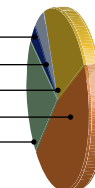
Train more HIV clinical staff

1. Much lower—**1.6%**
2. **5.0%**
3. No change—**21.5%**
4. **47.9%**
5. Much higher—**24.1%**



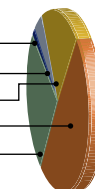
Increase in use of NPs/PAs

1. Much lower—**3.9%**
2. **5.8%**
3. No change—**23.2%**
4. **46.3%**
5. Much higher—**20.8%**



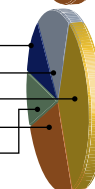
Increase in use of social workers, counselors, and patient educators

1. Much lower—**1.8%**
2. **4.7%**
3. No change—**18.9%**
4. **48.8%**
5. Much higher—**25.7%**



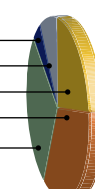
Increased use of hospitalists

1. Much lower—**11.6%**
2. **16.8%**
3. No change—**36.6%**
4. **25.5%**
5. Much higher—**9.5%**



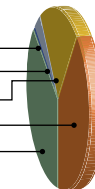
Reduction of paperwork and regulations

1. Much lower—**4.5%**
2. **9.2%**
3. No change—**23.4%**
4. **34.4%**
5. Much higher—**28.6%**



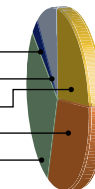
Improved information technology such as electronic medical records

1. Much lower—**.8%**
2. **3.7%**
3. No change—**20.0%**
4. **39.7%**
5. Much higher—**35.8%**



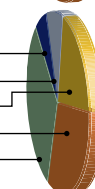
Create incentives for currently practicing HIV clinical staff to delay retirement

1. Much lower—**3.7%**
2. **10.8%**
3. No change—**24.1%**
4. **31.5%**
5. Much higher—**29.9%**



Government loan forgiveness programs

1. Much lower—**6.6%**
2. **3.7%**
3. No change—**20.0%**
4. **39.7%**
5. Much higher—**35.8%**



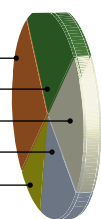
LOOMING Workforce Shortages in HIV/AIDS Medicine

Students gave many reasons for choosing
For some, it's because the disease has affected
the previous generation. For others, it's the intellectual

STUDENTS Please rate the importance of each of the following factors in your decision whether or not to pursue a career in HIV medicine?

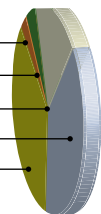
Opportunities to do research

1. Not important—**27.4%**
2. **22.6%**
3. Somewhat important—**22.6%**
4. **17.7%**
5. Very important—**9.7%**



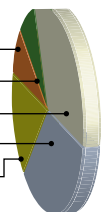
Intellectual challenges of specialty

1. Not important—**27.4%**
2. **22.6%**
3. Somewhat important—**22.6%**
4. **17.7%**
5. Very important—**9.7%**



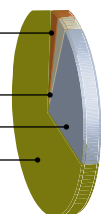
Rapid transition of scientific discovery into therapies

1. Not important—**8.1%**
2. **8.1%**
3. Somewhat important—**33.9%**
4. **33.9%**
5. Very important—**16.1%**



Ability to impact health for patients with life-threatening illnesses

1. Not important—**3.2%**
2. **0%**
3. Somewhat important—**3.2%**
4. **22.6%**
5. Very important—**71.0%**



tended to allow new HIV providers to join us without having to handle the hassles of management that lead to financial losses (from the lack of business training among MDs) and burnout.”

More than 70 percent of practitioners surveyed expressed worry about a future shortage of MDs/DOs, as did some 60 percent regarding NPs and PAs and HIV care support staff. Likewise, 60 percent said it is difficult to recruit MD/DOs as well as NP/PAs.

The practitioners survey asked respondents for specific reasons why they decided to enter HIV/AIDS care. One respondent, a former AIDS activist who lost numerous friends to the disease in its early days, credited the enormity of those losses with influencing his decision even though he knew there would be poor pay and plenty of paperwork. It was the same motivation for many others who entered HIV care at the onset of the disease. But there are many other reasons as well.

HIV, one respondent said, is an “important field of healthcare with stigma attached. I felt I could make a difference and help people prevent spread of this infection. Also, it's great to help people cele-

brate living rather than certain and imminent death as in the old days.”

“When I started, only AZT and DDI and ddC were available,” wrote another. “I enjoyed supporting complex patients through difficult times as a fellow. I have thoroughly enjoyed seeing the wonderful progress made in therapeutics and the impact on the lives of my patients. Intellectually, this is an incredibly fulfilling field. Income wise – No.”

Students gave many reasons for choosing HIV medicine as a career. For some, it's because the disease has affected them in a direct way, just as it did many of those in the previous generation. For others, it's the intellectual challenge or the chance to make a difference.

“This is a field in which the opportunity to make one's life better through interpersonal relationships is huge. This is why I like it,” one student explained.

Another said the ability “to combine a public health model for medicine with medical practice,” is important—as is the opportunity to treat diverse populations.”

Yet another student's career decision is being driven by “learn-

HIV medicine as a career.

them in a direct way, just as it did many of those in challenge or the chance to make a difference.

ing more about HIV/AIDS and being able to be a part of helping change the future of how this disease is treated and even cured, and it's impact on patients' lives."

As the survey results show, perhaps students should listen to the men and women now in HIV care, providers who are experiencing the job satisfaction that they, the students, now seek:

"I started in HIV medicine early in the epidemic," one survey respondent commented. "In addition to being an intellectually challenging field with a disease that affects every or-

gan system, it was where physicians were needed. So it was a no-brainer."

Said another: "I would do 100% HIV if I could. It is by far the most enjoyable part of my practice."

"During my residency and fellowship, which were in the 1980s, HIV care was a new frontier and not too many physicians at that time were willing to take the challenge. However, I remember my greatest mentors were in the fields of ID (infectious disease) and HIV, and they inspired me to go into the field," one physician wrote.

Then, there is the story of the 80-year-old practitioner who won't quit. "I am actually retired and volunteer in the clinic I helped develop for uninsured HIV-infected persons 20 years ago," he wrote. "I continue as I love to see patients, enjoy the challenge of HIV work and work in a very congenial setting. I... hope to continue indefinitely." **HIV**

About the Author: Editor of *HIV Specialist*, **Bob Gatty** is a Washington, DC-area health policy writer and publications professional. He is founder of G-Net Strategic Communications and can be reached at bob@gattyedits.com

Survey Methodology:

Two surveys were developed to elicit opinions of AAHIVM members (both clinicians and students) regarding workforce issues including satisfaction with their careers in HIV medicine, workload issues, factors affecting their decision to pursue careers in HIV medicine and outlook for the future of HIV medicine. Surveys were distributed by email to 1,723 AAHIVM clinician members and 205 medical, nursing and physician assistant students during November 2008. Responses were collected from 393 AAHIVM clinicians (response rate of 23%) and 62 students (response rate of 30%).

Frequencies, percentages, and 95% exact confidence intervals for binomial proportions were calculated. All analyses were conducted at the .05 level of significance using SPSS V.15.0 (SPSS, Inc. Chicago, IL). This survey was conducted in collaboration with Outcomes Inc.

Survey Sponsor:

AAHIVM wishes to thank Abbott Laboratories for its support in the development of the workforce survey.

Challenges of Service

PROVIDERS ENTER HIV/AIDS MEDICINE;
OTHERS LEAVE.
WHAT ABOUT THE PATIENTS?

Dr. Jeffrey King on a tsunami relief mission in Sri Lanka in 2004

THERE ARE MANY DEDICATED YOUNG MEN AND WOMEN who choose careers in HIV/AIDS medicine because they want to make a difference for patients who desperately need help. They know it will be challenging and difficult. They know they could earn more money in other specialties. Yet, they make their choice.

At the same time, talented and dedicated specialists are often forced to leave HIV/AIDS care and move on to other careers. A key factor, of course, is funding. If grants dry up, so do positions, and often patients are caught in the middle.

For Dr. Jeffrey King, a Spring 2008 Hitt Scholar, being a doctor was a lifelong ambition. His father was a psychiatrist who frequently was nominated by his patients for awards recognizing the difference he had made in their lives.

"Some of my earliest memories are reading those citations, and I aspired to make a difference in people's lives like he did," King recalled.

Today, that's exactly what Dr. King is doing. In addition to operating a family practice with Dr. Uldine Castel, also a Hitt Scholar, in Ventura, CA, he treats HIV

patients at a local immunology clinic and, with his wife, frequently travels abroad to what he calls "resource challenged" areas of the world to provide care.

"I was fortunate enough to train at the Ventura County Family Practice Residency, which gave a lot of exposure to ICU, Peds, OB and surgery," he said. "This has given me a lot of flexibility as a 'jack of all trades', but I feel the desire at this point to tackle a smaller area of medicine to master."

Dr. King chuckled when he was asked why he uses his personal time to go overseas and offer his services as a medical care provider and how he navigates all of the challenges of family, practice, clinic, volunteer-community work, and now HIV training.

"Ask me in six months when I'm done with the HIV fellowship," he said. "My wife and I are inspired and driven by our faith. We feel that we have received so much, and that we have a responsibility to share what we have with anyone who is interested. We want to be people who are aware of the immense suffering that exists in the world, and to take the opportunities that we have to mitigate that suffering where we can."

But for the Kings, it's not all about giving. "There is an element of sacrifice there for us, but the 'mission'...gives us meaning and the drive to continue."

Meanwhile, certified physician assistant Beck Royer, who had more than 16 years experience working with HIV/AIDS patients, found herself in 2006 looking for a new job. The reason: Ryan White funding at Harborview Medical Center in Seattle, WA, was slashed and seven physician assistants and nurse practitioners were let go.

"It was very sad to take those 16 years that I spent in HIV care and trash them," recalled Royer. "To find a job in HIV in Seattle was impossible because there was no funding."

Today, Royer works in breast cancer oncology at Seattle Cancer Care Alliance, and she likes her work.

“Yes, I had to learn something new, that was fine,” she said. “But I did provide continuity of care to my patients, and I did develop expertise. When I started in HIV care in 1992, you had to jump in and learn, and I cherished that work. I really feel that HIV providers have to be in it completely and keep up on all the changes that are taking place. But that re-



Beck Royer

quires time and commitment.”

The loss of her position at Harborview Medical Center was devastating, she recalled. “It’s one thing if you leave because you want to, but it’s another to leave because somebody feels it’s no longer worth funding this work. I had committed myself to this work. I had decided that it was what I wanted to do with my career.”

At first, she said, working in HIV/AIDS was difficult “because of the multiple deaths.” But she is pleased that so many advances have been made. “Over time, I have seen improvements. I worked with one of the first protease inhibitors, and saw the results. It was neat to be on the cutting edge of things.”

Patient Impact

Royer was concerned about her patients when she had to leave her position. “Sure, they got passed on to someone else, but there was no continuity of care. People are seeing different providers all of the time. They don’t like seeing somebody different all the time. I’d love to get back into that field, but there is just no funding.”

Indeed, when HIV/AIDS caregivers – whether it’s physicians, PAs, or NPs – move on, the impact on the patients they served can be traumatic and difficult.

“HIV-positive individuals lose their providers for all sorts of reasons, but the end result can be devastating,” said Jeff Berry, an HIV treatment advocate and editor of *Positively Aware* magazine. “Until they are able to locate a new provider, they may not have access to care or their medication. This can lead to an interruption in therapy, and they may end up getting sicker or developing resistance to the drug as a result.”



Jeff Berry

Joel Gallant, a leading HIV physician from Johns Hopkins University, points out that people just assume when private doctors who used to care for HIV-patients go out of business that hospital-based clinics, academic centers

and community-based clinics will just pick up the slack, but they’re under the same financial pressures.

“The other concern is that we’re seeing more and more people come into the system,” said Gallant, “especially if we begin to

are often stuck between a rock and a hard place. “They usually must learn very quickly how to become advocates for their own health care, and seeking support and information from a local community-based organization is often a good place to start,” he said.

HITT SCHOLARSHIPS

The Hitt Scholarship was created by the American Academy of HIV Medicine (AAHIVM) to encourage clinicians in post-residency training programs to enter the field of HIV medicine.

The program, operated by the AAHIVM Foundation, aims to increase access to qualified medical care for HIV positive persons and was named in honor of the late Dr. Scott R. Hitt, MD, AAHIVS, founder of AAHIVM.

Scholarships are awarded twice yearly by competitive selection to internal medicine/family practice/pediatric/OB/GYN residents, nurse practitioners, physician assistants and clinicians. Award recipients receive an honorarium ranging from \$5,000 to \$10,000 and the awardee’s associated training institution receives between \$4,000 and \$9,000 to defray indirect costs of providing an in-depth HIV related clinical training experience.

For more information about the AAHIVM Hitt Scholarship Program, please visit www.aahivm.org.

follow the CDC guidelines for routine testing, we will certainly see an increased number of patients.”

Some have suggested a move towards having people with HIV visit a primary care physician regularly in addition to seeing an HIV specialist once or twice a year, with ongoing consultation between the two. “As we move forward with a dwindling number of HIV experts and a growing number of patients, we’re just going to have to accept the fact that HIV docs are not going to be able to provide primary care for all of their patients,” Gallant said.

For now, says Berry, those who need to find a new provider because their doctor retired, has closed the practice, or moved on to a more lucrative job in industry,

Fortunately for some patients, there are HIV specialists who simply refuse to quit, even in the face of poor pay and difficult circumstances.

“What initially drew me to pursuing additional training in HIV medicine is the thought of this virus, in some parts of the world, decimating an entire generation, leaving orphans and widows in its wake,” Dr. King said. “What’s exciting now is that we are seeing people live with the infection controlled, that we have the means to offer hope and life. Think back to the pre-antiretroviral era, and the contrast is mindblowing. Now the challenge is to continue to expand that. I would love to be a part of doing that.” **HIV**



BY JEFFREY T. KIRCHNER, D.O., AAHIVS

FOREFRONT

Should We Re-define the Optimal Time to Start Anti-Retroviral Therapy?

IT APPEARS THAT THE OVERUSED but perhaps appropriate “swinging pendulum” metaphor regarding initiation of antiviral therapy is indeed moving back to where it was in the mid- to- late 1990s, which ushered in the era of highly active antiretroviral therapy (HAART).

The “hit early and hit hard” 1995 mantra was replaced in 2001 by a less aggressive approach towards antiviral therapy. Data from Jonathan Kaplan and others showed that if HAART was started with a CD4+ above 200 cells/mm³ the risk of death over two years was only about 2%. At higher quartiles of CD4+

counts up to 350 cells/mm³, this risk did not significantly change. At the same time, we began seeing the toxicity (neuropathy, diabetes, lipodystrophy) move to the forefront along with drug resistance.

Then arose concerns of what combination of drugs we would use after the first regimen failed. However just over one year ago, the DHHS guidelines started swinging the pendulum back, noting that a CD4+ of < 350 was the time to start HAART—and that we probably were waiting too long for many patients.

A key issue regarding the “when to start” debate is whether one would make this decision based on observational studies or only accept the gold standard of a randomized controlled trial, the latter requiring a very large number of patients followed prospectively for five to ten years or perhaps longer.

Mari Kitahata and colleagues at ICAAC/IAS presented new data this past October from the North American AIDS Cohort Collaboration on Research and Design (NA-ACCORD). The study included 8,374 persons from 22 centers in the United States and Canada.

Kitahata looked specifically at patients with a CD4+ count between 351-500 cells/mm³ who were in active care between

1996 and 2006, free of clinical AIDS, and treatment naïve (n=5,901). The study divided the patients into two groups—those who deferred or never started therapy (n=4,005) and those who started medications within 18 months of their CD4 count being 351-500 (n=2,473). The primary endpoint was the relative hazard (HR) of death between the two groups of patients.

During the follow up period there were 206 deaths among patients who started ARV therapy at 351-500 cells/mm³ and 387 deaths among those who deferred or never started treatment. When the data was analyzed by cohort and calendar year, deferring ARV therapy was associated with a 74% (HR = 1.74) relative risk of death. This increased risk was not associated with hepatitis C co-infection or intravenous drug use (as has been noted in other observational studies). ***The authors believe these data strongly support initiation of HAART at a CD4+ count of 351-500 cells/mm³.***

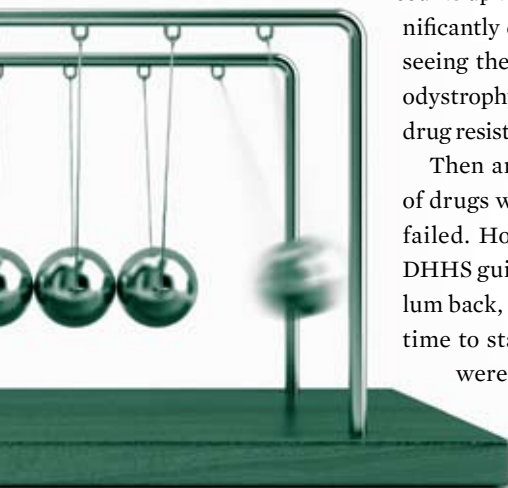
Whether the results of this study are robust enough to change the DHHS or IAS guidelines for starting therapy remains to be seen. They certainly may have a more immediate impact on clinical practice – especially if patients are requesting to be placed on antiviral at higher CD4+ counts.

The implications for bringing more HIV-infected persons into care and the cost of additional medication would be substantial. In a press conference that followed the presentation of this study, Dr. Kitahata noted that if guidelines were changed, “several hundred thousand” additional persons with HIV would be eligible for treatment. An analysis of patients from NA-ACCORD who started therapy at a CD4 count of > 500 cells/mm³ is underway and will be presented at a future conference. **HIV**



About the Author: Dr. Jeffrey Kirchner is Medical Director–Comprehensive Care Center for HIV at Lancaster (PA) General Hospital. He is on AAHIVM’s Board of Directors and is chair of *HIV Specialist’s* Editorial Advisory Group.

Photo: Ali Ender Biler / Stock





Best

BY RICHARD PROKESCH, MD, AAHIVS

PRACTICES

FIRST IN A SERIES

EMR and the HIV Practice

THERE RECENTLY HAS BEEN A GROWING migration towards technology in medical practice. Whereas an electronic medical record (EMR) has been available for many years, multiple factors have resulted both in a rising use of such records and an increasing public awareness of the technology. An EMR applies to all genres of medicine, but also has unique advantages and disadvantages for the HIV practice. This is the introduction to a series in *HIV Specialist* that will address many aspects of EMR. It is not our intention to explore specific EMR systems as there are many sources available which address this and there is vast individual practice variation in specific system needs and requirements.

WHY GO ELECTRONIC?

Five years ago our practice learned that the computer system we had employed upon opening in 1981 had become overloaded and outmoded. That system was only capable of billing and compiling related business reports.

Upon investigation we found that for approximately the same dollars we could purchase a new system that would perform all of the billing and business office functions, but also was a full EMR system as well.

After considerable discussion among the physicians in the practice and other clinical personnel, front office and business office employees, we decided to embark on the journey (and it truly is a journey) to purchase and implement an EMR.

In this series we will cover aspects, including various components, of an EMR and what each can potentially add to your practice, the challenges in implementation and advice on how to overcome them, the pros and cons of making the conversion to an EMR, governmental rewards on the horizon that most likely will quickly evolve into a punitive system, and more specifically how an EMR can be used to benefit an HIV practice and potentially a Ryan White clinic.

EVERYBODY NEEDS A CHAMPION

It cannot be overemphasized that for an office to switch over to an EMR there must be at least one champion to drive the conversion. It helps—and is nearly imperative—that the champion is a physician, although it is also extremely useful if there is an additional proponent from the nonclinical side of the practice.

The switch from a traditional paper practice to an EMR system is far from simple. There are not only financial considerations, but logistical obstacles at every phase that can undermine and even halt the implementation. This undertaking is probably not for every office, although the future may require universal adaptation per government and/or third party payer pressures.

THE POT OF GOLD

However there is a definite “pot of gold” at the end of the difficult process.

A full-functioning EMR will result in a more efficient office with greatly enhanced communication, leading to improved quality in patient care, improved justification of charges and collection efficiency. There will be a seamless interface between the back office and the front office/ the billing office, the physicians and nurses/medical assistants, the laboratory and the clinical staff and even potentially between the office and patients.

We will delve into many of these issues in future articles in this series. **HIV**



About the Author: Dr. Richard Prokesch is in private practice in Riverdale, GA. He is chair of AAHIVM's Atlanta, GA chapter, and is on AAHIVM's Board of Directors.



At the **BY BRUCE PACKETT, ROB BANASZAK & HOLLY KILNESS, AAHIVM**

ACADEMY

As an AAHIVM member, you are part of a dedicated group of physicians, physician assistants, nurse practitioners and other health care professionals committed to promoting excellence in HIV/AIDS care through advocacy, education, and its professional credentialing program. For more information or to join, visit www.aahivm.org, email membership@aaahivm.org, or call 202-659-0699, ext. 11.

Advocacy & Action AAHIVM Policy Priorities

THE TRANSITION to a new administration has bolstered the hope of domestic HIV advocates, treaters and patients that their voices will be heard about HIV/AIDS, but it must be tempered with some challenging realities.

The United States government is facing a world-wide economic recession. Meanwhile the national HIV epidemic continues to expand its grip on our nation's community—especially those who are affected most by economic turmoil. Moreover, HIV care providers face static or declining fiscal and staffing resources that strangle their ability to deliver quality care.

In 2008, Congressional health legislation primarily focused on the States Children Health Insurance Program (SCHIP), mental health parity, food and import safety, and expansion of AIDS and infectious disease efforts overseas. While Congress spent considerable time addressing those issues, a consensus grew within the community around the need for a US national plan to address HIV/AIDS.

Last year, Congress was unable to agree on any of the eight FY09 appropriations bills, resorting to flat funding most federal programs with continuing resolutions. Thus, there is a substantial appropriations burden on the new 111th Congress and President Obama.

The devastated economy inherited by the new administration means tough decisions are on the horizon for entitlement programs like Medicaid and Medicare used by many HIV patients to access care. Fortunately, there seems to be mounting support for “health care reform,” although there are complex and uncertain details inherent in such a proposition.

Congressional Leadership has indicated health care reform will be a top priority, though it has yet to outline which federal health programs will be included, or how they will be funded. At a briefing held on Capitol Hill last December, Connie Gardner, legislative staffer to Senate Health, Education, Labor and Pensions (HELP) Committee Chairman Senator Edward M. Kennedy (D-MA), indicated there is discussion underway of what role Ryan White funding should take in the broader health care reform issue.

The federal Ryan White Program has always been the crown jewel of HIV care advocates in Washington. AAHIVM aggressively represented the interests of providers in the last reauthorization, scoring wins for prioritizing medical care and increased authorization funding levels. After negotiations and compromises within the community and on the Hill, many difficult decisions were deferred to the next reauthorization. To ensure that these difficulties were fully addressed, lawmakers agreed to ‘sunset’ the bill after September 2009.

With this deadline looming and the threshold for beginning the legislative process for rewriting the bill now seemingly passed, there is broad consensus among HIV advocacy groups and the bill's principal authors on the Hill that an extension of the current Ryan White law may be the best way to deal with the September 2009 sunset.

AAHIVM has joined its partners in the community to support such an extension, along with a handful of “technical” fixes that allow the program to continue to fund important HIV care and treatment services. Big political battles within the bill, including core medical services definitions, funding formulas, and other substantial changes, would once again be deferred to a full reauthorization of Ryan White in a more stable political and economic environment.

Another issue that AAHIVM hopes to see addressed this year is an increased focus on the looming HIV care workforce shortage. We hope to pursue appropriations language redirecting the National Health Service Corps towards HIV/AIDS provider settings that meet HMSA definitions.

AAHIVM has always been a bottom-up, grassroots organization that relies on its membership to advocate for the interests of HIV providers. It is crucial that AAHIVM's members lend their voices to advocate for sound HIV public policy. We hope to utilize the Ryan White Advocacy Network to help achieve important public policy objectives by reaching out to key decision makers.

This organizational philosophy and membership structure will gain in importance, and AAHIVM and its members must continue to participate in this important debate as it unfolds. **HIV**

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Minorities & HIV

HIV/AIDS continues to disproportionately affect minorities with at least 58 percent of the cases of reported AIDS cases involving racial and ethnic minorities since the epidemic began in 1981. According to the federal government, AIDS is the leading cause of death among African-American men ages 25-44. In 1998, President Clinton declared HIV/AIDS to be a severe and on-going health crisis in racial and ethnic minority communities, and the federal government launched an initiative to Eliminate Racial and Ethnic Disparities in Health by the year 2010. What has been the progress? What challenges remain? We will discuss those issues and more as we address this important topic.

Credentialing

Credentialing of health care practitioners is an extremely important undertaking. AAHIVM is the only organization in the United States offering a credentialing program for three provider types, including physicians (MDs and DOs), nurse practitioners and physician assistants. The Academy's credentialing program begins in the spring with the application period and concludes in late summer with the exam cycle. We will cover the issues related to the professional credentialing process.

Your Comments are Welcome!

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