hivma
hiv medicine association

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National Advisory Council on the National Health Service Corps (NACNHSC)
Bureau of Health Workforce
Health Resources and Services Administration
5600 Fishers Lane, Room 14N108
Rockville, Maryland 20857

Dear Advisory Council Members:

The HIV Medicine Association appreciates the opportunity to provide comments to the Advisory Council. HIVMA is an organization of more than 5,000 clinicians and researchers who are working on the front lines of the HIV epidemic. HIVMA's mission is to promote quality in HIV care by advocating policies and supporting programs that ensure a comprehensive and humane response to the HIV epidemic. Nested within the Infectious Diseases Society of America, HIVMA's work includes advocating for ensuring adequate HIV and Infectious Diseases medical and public health workforce capacity.

As the Advisory Council looks ahead to its work under a new Administration, we urge you to seek opportunities to revisit long stymied efforts to update the criteria and methodology that are utilized to determine eligibility for and allocation of HRSA's roughly $1.2 billion in resources for health professions education, training and recruitment among designated underserved populations and in underserved areas. The current rules have not been updated since the 1970s, and do not take into account our nation's changing demographics and important emerging public health challenges including the devastating impact of the opioid and injection drug use (IDU) epidemics in many underserved rural communities.[1] The IDU crisis has resulted in a burgeoning risk of HIV and hepatitis C (HCV) outbreaks as well as an urgent need for expanded overdose and substance use prevention and treatment services.

By way of background, from September, 2010 through October, 2011, HIVMA was represented among diverse stakeholders in a HRSA negotiated rulemaking process mandated by the Patient Protection and Affordable Care Act to devise an updated methodology and set of criterion for designation of Medically Underserved Areas (MUPs) and Health Professional Shortage Areas (HPSAs).

In the process, we urged that a new rule for medical underservice should recognize clinics and communities that are serving people with HIV, in order to improve access to quality HIV care and build HIV medical provider capacity with the rationale that people with HIV infection are a highly vulnerable group with nearly half living in households with incomes at or below the federal poverty level[2] and with many still experiencing significant stigma and discrimination. In addition, a large majority (75%) of people with HIV in care receive multi-disciplinary care in Ryan White-funded clinical settings. While an increasing number of Ryan White-funded clinical sites are affiliated with Federally Qualified Community Health Centers, many continue to either be free-standing community-based clinics or affiliated with an academic health center.

Data from a survey conducted in 2007 by HIVMA and the Forum for Collaborative HIV Research of Ryan White-funded clinics indicated that a majority of HIV clinics were experiencing significant increases in patient caseloads with the largest patient increases and longest appointment waiting times occurring in the Southeast.[3] Since then, a HRSA-sponsored study released in August, 2016 projected a deficit in the supply of HIV medical providers relative to demand for HIV care and treatment services, due to the combined trends of: 1) an increase in the number of newly diagnosed cases each year coupled with a low mortality rate among the currently diagnosed population; and 2) an insufficient number of clinicians entering the HIV workforce relative to the number of clinicians leaving the HIV workforce because of retirement and mortality.[4] The Centers for Disease Control and Prevention's (CDC) Medical Monitoring Project also published a study in 2016 projecting that within the next five years the numbers of new physicians trained in HIV care will fall significantly short of the numbers necessary to provide appropriate treatment to an estimated 30,000 additional patients each year.[5] The study also found that nearly half of HIV-trained physicians practice at facilities receiving Ryan White funding, providing care for nearly three quarters of all patients with HIV – highlighting the importance of bolstering the Ryan White medical workforce.

Neither the HRSA nor the CDC study took into account the decline in physicians pursuing infectious diseases training over the last several years. [6] While physicians trained in a diversity of specialties provide expert HIV care, infectious diseases is the largest specialty represented among the HIV workforce, and there are few training pathways for HIV medicine outside of infectious diseases. Steep declines in ID fellowship applicants from 2011 to 2016 suggest that the shortfall in the HIV workforce over the next several years could be more severe. In 2017, there was an increase in ID fellowship applicants, but it is not yet known if this will be the beginning of an upward trend. [7]

While the negotiated rulemaking Committee was not able to achieve consensus, in its final report it did approve a final proposal that specifically named safety-net clinics disproportionately providing primary care to special populations, such as HIV patients, as being eligible to receive NHSC recruits if they document insufficient provider capacity. The proposal also included a short cut for clinics that focus on HIV, LGBT and disability populations to be eligible to apply for community health center funding.

Unfortunately, HRSA never took action on the recommendations in the Committee's final report. We understand the challenges related to making any changes to the existing model for designating MUPs/HPSAs and the need to avoid disruptions in care delivery or provider capacity. However, we believe it is incumbent on HRSA to ensure that allocation of scarce safety net health care workforce resources is aligned with today's most pressing health care needs, including an adequate workforce of infectious disease/HIV clinicians and public health professionals to respond to the HIV and HCV epidemics.

Thank you for your consideration of our views, and please regard us as a resource in the important work of the Advisory Council. We can be reached through HIVMA Senior Policy Officer, Kimberly Miller at kmiller@hivma.org.

Sincerely,

Wendy Armstrong, MD, FIDSA
Chair, HIVMA Board of Directors

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[1] Jurisdictions Determined to be Experiencing or At-risk of Significant Increases in Hepatitis Infection or an HIV Outbreak Due to Injection Drug Use Following CDC Consultation, Centers for Disease Control and Prevention, https://www.cdc.gov/hiv/risk/ssps-jurisdictions.html (information current as of January 10, 2017).

[2] Blair, JM, et al. Behavioral and Clinical Characteristics of Persons Receiving Medical Care for HIV Infection — Medical Monitoring Project, United States, 2009. MMWR. June 20, 2014 / 63(ss05);1-22.

[3] Hauschild, B, et al. HIV Clinic Capacity and Medical Workforce Challenges: Results of a Survey of Ryan White Part C-funded Programs. Annals of the Forum for Collaborative HIV Research, Vol 13, No 1 (2011).

[4] The HIV Clinician Workforce in the United States: Supply and Demand Projections from 2010 to 2015, Boyd Gilman, Ph.D., Ellen Bouchery, M.S., Paul Hogan, M.S., Sebastian Negrusa, Ph.D., Sylvia Trent-Adams, Ph.D., and Laura Cheever, M.D., August, 2016.

[5] Qualifications, Demographics, Satisfaction, and Future Capacity of the HIV Care Provider Workforce in the United States, 2013-2014. John Weiser, Linda Beer, Brady T. West, Christopher C. Duke, Garrett W. Gremel, and Jacek Skarbinski. Clin Infect Dis. (2016) doi: 10.1093/cid/ciw442 First published online: June 29, 2016.

[6] National Resident Matching Program. Fellowship Matching Data. Available online at: http://www.nrmp.org/match-data/fellowship-match-data/.

[7] Infectious Diseases Society of America. ID Fellowship Match Results: Good News But Much Work Remains. 12/09/2016. Online at: http://www.idsociety.org/Press_Release_12_9_2016/.