

## Academy Board of Directors Meets with House Minority Leader Richard Gephardt

*Importance of Quality Care for HIV+ People; ADAP Shortfall Discussed*

During their visit to Washington, DC, the Academy Board of Directors had breakfast with House Minority Leader Richard Gephardt (D-Mo.). The objective of the meeting was to inform Representative Gephardt on issues facing the HIV community and to hear his concerns in the area of HIV.

The breakfast began with a discussion of the initiatives the Academy is addressing and the importance of assuring quality care for HIV+ people. Rep. Gephardt demonstrated an understanding of these issues and expressed his support for our efforts.

Board members explained and illustrated the current AIDS Drug Assistance Program (ADAP) shortfall—this discussion was greatly aided by information created and distributed by the ADAP Working Group, a national task force that assists and advocates for ADAP programs. Unfortunately, this meeting came shortly after the Senate had defeated the additional ADAP funding requests. But the representative voiced his support on the issue.

At the meeting they also discussed the rates of new HIV infections in various populations and the needed funding for realistic and effective prevention programs. Several Board members gave specific examples of some programs that have worked and several that have not.

Finally, the Board asked for guidance on where the Academy could aid in public policy issues. Rep. Gephardt explained the current mood of the House



AAHIVM Board of Directors meet with House Minority Leader Richard Gephardt (D-Mo.) during their visit to Washington, DC.

of Representatives and Congress as resistant to new funding initiatives due to the effects of September 11 and the budget deficit. He also gave us valuable information on how to communicate the Academy's issues to Congress and what

type of information they would need.

The breakfast meeting ended with a thank you from Rep. Gephardt for all that the Academy's members have done and will continue to do to provide quality care for our patients. 🏥

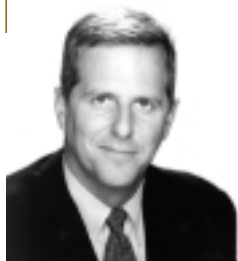
## Academy Board of Directors Meets for Strategic Planning

In June, the Academy's Board met in Washington, DC, to discuss strategy for the Academy. This meeting represents an important stage of growth for our organization. Although our full Board of Directors has met monthly by teleconference and twice a year in person, the

Washington meeting was our first dedicated exclusively to strategic planning.

The Board discussed credentialing, funding, and board organization during the meeting. But their first line of business was to complete the transition to our new

**...See Strategic Planning on page 3**



## The Medical Community Has Spoken: Nearly 1,000 Credential

### *Encouraging Results Seen in the Credentialing Process*

The Academy mailed the first HIV Specialist Credentialing Kits in December 2001. Since that time we have received nearly 1,100 applications and have credentialed nearly 1,000 HIV health care providers. That number is twice what we had planned — a strong statement in support of credentialing.

When our Board of Directors approved our credentialing process, we were making an educated yet hopeful guess that HIV health care providers would want and support credentialing. We collectively held our breath as the kits arrived in mailboxes across the country — and we are gratified by your response, which clearly voices your support for credentialing.

The credentialing process has two objectives:

1. To improve the quality of care for those living with HIV and AIDS

2. To expand the number of HIV health care providers

We believe that these objectives are not mutually exclusive, but that they need to be balanced so that we don't achieve one at the expense of the other. Based on most of the feedback we have received, our credentialing process created an opportunity

to improve the quality of care for patients and has begun to expand the number of HIV providers. One example is that many providers have earned additional CME credits to qualify, therefore increasing up-to-date knowledge in more practitioners.

We have heard stories from around the country about how the AAHIVM HIV Specialist credential has been used to improve care

for HIV patients. Members have told us that institutions are now requesting that their providers credential. We have heard several stories of patients requesting that their

provider credential, and several members have relayed stories of patients' positive comments upon seeing their provider's credential. Members have also shared with us that HMOs in California are now actively recruiting AAHIVM-credentialed HIV Specialists.

#### What the numbers tell us

Although the total number credentialed is important, there is also an important story in the breakdown of who has credentialed. First, many medical and government professionals assumed that only large providers, or providers whose majority of patients are HIV+, would credential. *But in fact, 61% of AAHIVM-credentialed HIV Specialists have fewer than 150 HIV+ patients, and only 14% have more than 300.* So, in reality, the average AAHIVM credentialed provider practices HIV medicine on a part-time basis.

That is an important observation, because there had been concern that the credentialing process might actually raise a barrier to HIV care by excluding smaller practices or part-time care providers. There was a belief that these practitioners would not participate in the process and

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 www.aahivm.org; info@aaahivm.org; The American Academy of HIV Medicine is an independent organization of HIV Specialists and others dedicated to promoting excellence in HIV/AIDS care. Through advocacy and education the Academy is committed to supporting health care providers in HIV medicine and to ensuring better care for those living with AIDS and HIV disease.

instead would exit HIV medicine. On the contrary, we have seen exactly the opposite, and the feedback we have received also tells us that the process has aided HIV practitioners in negotiating reimbursement and the selection of job candidates.

Second, a similar concern was raised about the location of providers — before we began the actual credentialing process, some had voiced concerns that rural areas would not have credentialed HIV Specialists because the requirements would exclude practitioners in areas with low HIV+ populations. Actually, credentialing has encouraged about a 15% increase in our membership from rural areas, and it has assisted us in forming our Mountain Plains Chapter. Our hope is that this trend will continue, and many of our Board members are working to recruit even more members from rural areas.

### **Concerns about the credentialing process**

We have heard concerns from individuals and institutions regarding the ease of our exam and the lack of a rigorous process because it is an open-book exam. In addressing these concerns, first, we want to be clear that we do not view our credentialing process as perfect. We were challenged to design a process that would increase quality of care, begin moving the area of HIV medicine toward a more formal specialty, while not limiting care or reducing the number of providers. That process will take years, but we believed that a good first step would be to assure patients that medical providers are up-to-date on their knowledge of HIV medicine. Our current credentialing process does just that by weighting our exam toward the 25 Recent Educational Objectives of our Core Curriculum. Second, we expect that our process will slowly evolve from input such as that we receive at our national meeting, and other meetings with key stakeholders.

Finally, and most important, we established our process by studying credentialing processes across several medical specialties in a variety of fields. We have worked hard to establish a process that is academically sound and also functions as a tool that raises knowledge and minimum standards of care, a very important factor in providing quality of care for the increasing number of HIV patients. Our HIV Medicine Credentialing Examination underwent a thorough psychometric analysis and overall

quality measurement evaluation by a nationally recognized firm with expertise in testing psychometrics. In testing terms, this evaluation included an analysis of the examination's reliability (the degree to which the results are free from errors of measurement) and discrimination (the degree to which it discriminates between practitioners who have the requisite knowledge and skills and those who do not). Both were determined to be acceptable by our Scoring Committee. Our intention is to expand care — not to limit it to a small number of highly trained specialists, but rather expand the number of educated, up-to-date HIV medical practitioners. We believe that we have accomplished these essential goals.

We are proud that we took the controversial stance of ranking NPs and PAs at the same membership level as our MD and DO members. They are equally important in their role on care teams and should be recognized as such.

### **We need to hear your experiences**

As we move forward in promoting our

educational initiatives, we would like to hear as much feedback as possible regarding the steps we are taking to improve the quality of HIV care and to support providers in their efforts to deliver that care. We need to know how the credentialing process is working for you, our members, and for your organizations — in practice, rather than in theory. We especially need information about how your institutions use and respond to your AAHIVM HIV Specialist credential. This will help us to continue to fine-tune our efforts as we advance the quality of care in HIV medicine.

### **National meeting – discussing changes to the process**

Our national membership meeting will be a great opportunity to provide feedback on credentialing and other issues of concern to HIV providers and patients (see back page for dates). Our credentialing process will be one of our main topics of discussion. I hope you will attend and add to your comments and experiences to the dialog. 🏥

## **Strategic Planning** (continued from page 1)

bylaws, which our membership approved in May by 98% of votes. These new bylaws, as many of you know, make small yet strategic changes in the structure of our leadership. A newly formed nomination committee accepted nominations for the officer posts of Board Chair, Vice Chair, Secretary, and Treasurer. We will announce the new leadership at our national membership meeting, which will be held at ICAAC in September.

Next, the Board considered the structure of our committees. After a good amount of discussion and debate, the Board decided to continue the Education, Practice Management, and Public Policy committees. A training committee will be created to aid educational and medical institutions in understanding and utilizing the AAHIVM HIV Specialist credentialing process and the AAHIVM Self-Directed HIV Medicine Education

Program. The Board also decided to add an exploratory task force on international issues, whose main goal will be to assess where the Academy can aid existing international education efforts. The Board also considered issues regarding the upcoming HIV Medicine Education Program's Self-Directed Study Guide and gave approval on marketing and distribution plans. Finally, they discussed increasing dialog with many organizations and government groups to increase awareness and understanding of the Academy's initiatives.

The Board is confident that these new bylaws, new committee structure, and other strategic plans made at the Washington, DC, meeting will help the Academy continue to serve our members and all health care providers in HIV medicine, to help ensure better care for those living with AIDS and HIV disease. 🏥

## Legal Issues Associated With Disclosure of Patient's HIV+ Status to Third Parties

*Thomas Bradley, JD; Helene Bradley, JD; Brian Boyle, MD, JD*

Academy member Dr. Brian Boyle has graciously offered to aid the Academy membership by writing a series of articles addressing several areas of law and HIV. Dr. Boyle is both a practicing HIV physician and an attorney, and initiated this project to offer current legal information that we hope Academy members will find enlightening and helpful.

The article that follows, addressing physician liability and informed consent, is the first of a series of four planned articles that will be published both in *The Nexus* and on our Website at [www.aahivm.org](http://www.aahivm.org). The other suggested topics are physician liability with AIDS drugs, legal issues with difficult patients, and employment issues in HIV practices. These topics could change if current issues suggest more timely topics, and your feedback on the series is welcome (send e-mail to [jerry@aahivm.org](mailto:jerry@aahivm.org))

**Jerry Calumn, AAHIVM Executive Director and *Nexus* Executive Editor**

Healthcare providers treating HIV+ patients have often been compelled to act despite some degree of uncertainty. One area of uncertainty that poses complex and sometimes conflicting ethical and legal issues involves disclosure of a patient's HIV status to a third party.

Most providers are aware that they have a clear ethical obligation to preserve the confidentiality of their patients' medical information. Patients' knowledge that the information they are providing will be kept confidential encourages their full disclosure, which allows physicians to provide more effective treatment.<sup>1</sup> This ethical obligation is not absolute, however, and the Council on Ethical and Judicial Affairs of the American Medical Association has advised physicians that if they are aware that an HIV+ patient is endangering a third party, they "should, within the constraints of the law: (1)

attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities; and (3) if the authorities take no action, notify the endangered third party."<sup>2</sup>

Maintaining physician-patient confidentiality is not just an ethical obligation, however, and a physician's breach of this confidentiality may give rise, under certain circumstances, to legal liability under a variety of common law and statutory perspectives.<sup>3</sup> One of the most heavily regulated areas of physician-patient confidentiality is the disclosure of a patient's HIV status to patient contacts who may be at risk for contracting HIV, and most states have statutes specifically addressing this issue. These statutes fall into three basic types:

1. Those that impose a mandatory duty on a physician to provide the name of the patient to a state health agency, which then notifies the contact<sup>4</sup>
2. Those that make such disclosure to a state agency optional
3. Those that give the physician the option of notifying the state health agency or directly notifying third-party contacts<sup>5,6</sup>

In all states, regardless of whether mandatory reporting is required, there is an obligation on the part of the provider to counsel the HIV+ patient to inform sexual and needle-sharing partners of his or her status. In some states, such as New York, doctors also must talk with HIV+ patients about their options for informing sexual and needle-sharing partners about their potential exposure to HIV, and must report to a state agency the names of any sexual and needle-sharing partners that *are known to the doctor*. However, the experience of most providers is that patients are often reluctant to report contacts or to notify partners. Some reasons for this reluctance may not justify a failure

to disclose, such as feelings of embarrassment or fear that a relationship will be jeopardized, but others may be justifiable reasons for nondisclosure, such as a legitimate fear of physical violence.

In New York and some other states, the notification of at-risk patient contacts is done by the health commissioner of the municipality where the infection occurred.<sup>7</sup> Thus, to some extent, providers in these states are relieved of the responsibility of making the difficult decisions about notifying patient contacts, because their state legislature has made that decision for them. Many states now permit a provider to directly contact a patient's partner if certain preconditions are met. The most common of these are where the provider has counseled the individual to refrain from sexual or drug activity likely to transmit the virus and knows the patient has not complied<sup>8</sup> or where the provider has requested that the patient notify a partner and knows the patient has not done so.<sup>9</sup>

In addition, many states, in an effort to protect the rights of the patient as well, require that providers warn the patient of their intention of notifying a partner before doing so.<sup>10</sup> State laws that allow a physician to contact partners also differ as to whether the physician may disclose their patient's identity when doing so. Some states expressly forbid such disclosure,<sup>11</sup> others permit it,<sup>12</sup> and still others are silent on this subject.<sup>13</sup> Importantly, these statutes typically also provide civil immunity from suit when a physician makes such a disclosure to a patient's contact, assuming there has been compliance with the statute. The statutes also typically provide immunity for those situations when a provider decides not to notify a contact.<sup>14</sup>

In addition to statutory regulation on this issue, providers should be aware that there may be a common law legal duty

imposed on them to protect third parties when their patients refuse to notify their contacts of their HIV+ status. Currently, no such duty has been firmly established by law. However, this possibility has its genesis in a 1976 California case, which ruled that a psychotherapist who determines (or should have determined) that a patient posed a serious danger of violence to a third party has a duty to protect that third party regardless of the patient's confidentiality rights.<sup>15</sup>

There have been several attempts to expand this analysis from psychotherapists to physicians treating HIV+ patients, in order to create a duty to protect endangered third parties. In two such cases, the courts declined to impose an affirmative duty on the part of the physician to notify a third party, both of whom sued alleging intentional infliction of emotional distress because of their fear of contracting AIDS.<sup>16</sup> The courts held in both cases that the existence of state confidentiality statutes would have prohibited disclosure of the information, and thus they declined to impose a duty on the physician.

Many states that have statutes that allow physicians to disclose their patients' HIV status to third parties also have confidentiality provisions in those statutes prohibiting disclosure except for this and other specific exceptions. However, the question arises as to what states may do that do not have specific confidentiality statutes. In those situations, there is at least the possibility that such a duty to protect third parties may be imposed in the future. In addition, aside from legal precedent, there is at least some support in the medical literature for the proposition that disclosure is warranted to protect third parties.

Because of the potential for civil liability regarding notification and compliance with the requirements of particular state statutes or common law, consider the following actions:

- Any provider involved in making a decision regarding whether or not to disclose a patient's HIV status should be conversant with all requirements for any such statute in their state.
- If disclosure is deemed appropriate, care should also be taken to document thoroughly, either in the patient's chart or in a written notification to the patient's contact, that all required preconditions have been met.

- If disclosure is not deemed appropriate, again, thorough documentation of the reasons behind that decision should be made.

Acting in this fashion will help to provide the provider with some protection from possible legal liability based upon statutory or common law.

### Notes and References

1. AMA, Counsel on Ethical and Judicial Affairs, Code of Medical Ethics: Current Opinions with Annotations: 1998-1999 Edition §5.05, §7.02 (1998).
2. *Ibid.*, §2.23.
3. Common law theories of liability include defamation and invasion of privacy. A number of courts have held that HIV-infected patients have a constitutional right to privacy, the violation of which will give rise to civil liability. See, e.g., *Doe v. Southeastern Pa. Transp. Auth.*, 72 F.3d 1133 (3rd Cir. 1995) cert. denied, 117 U.S. 51 (1996); *Doe v. City of New York*, 15 F.3d 264 (2nd Cir. 1994). In addition, many states (e.g., Pennsylvania) have confidentiality statutes expressly regulating the release of a patient's HIV+ status and that create a civil cause of action if the statute is violated. See 35 P.S. §7610.
4. See, e.g., Cal. Health & Safety Code §121015(a); Ga. Code Ann. §24-9-47(h)(1)(3); W.Va. Code §16-3c-3(a).
5. Cal. Health & Safety Code §131015(a).
6. See N.Y. Pub. Health Law §2130(1); Mich. Comp. Laws §333.5131(5)(b); Texas Health & Safety Code Ann. §81.051(g)(2).
7. N.Y. Pub. Health Law §2131.
8. Fla. Stat. ch. 455.674(1)(b)(1999), amended by 1999 Fla. Laws ch. 99-8 §220.
9. 410 Ill. Comp. Stat. 305/9(a) (1999).
10. Cal. Health & Safety Code §121015(b); Conn. Gen. Stat. §19a-584(b); Iowa Code §141.6(3)(c)(2); 35 Pa.C.S. §7609(a).
11. Conn. Gen. Stat. §19a-584(b); 35 Pa. C.S. §7609(b); W.Va. Code §16-3c-3(d).
12. Iowa Code §141.6(3)(c)(2); Wash. Rev. Code §16-3c-3(d).
13. Fla. Stat. ch. 455.674, amended by, 1999 Fla. Laws ch. 99-8 §220; 410 Ill. Comp. Stat. 305/9; Kan. Stat. Ann. §65-6004, amended by 1999 Kan. Sess. Laws 109 §4.
14. Kan. Stat. Ann. §65-6004(d), amended by 1999 Kan. Sess. Laws 109 §4; Ala. Code §22-11A-38(f); 35 Pa. C.S. §7609(c)-(d).
15. *Tarasoff v. Regents of University of California*, 17 Cal. 3d 425, 131 Cal. Rptr. 114, 551 P.2d 334 (1976).
16. *Garcia v. Santa Rosa Health Care Corporation*, 41 Tex. Sup. J. 535 (1998) and *N.O.L. v. District of Columbia*, 67 A.2d 498 (1995).

## Local Academy Update

# Board Members Elected in Three Regions

The Arizona, Mid-Atlantic, and Southeast chapters of the American Academy of HIV Medicine have elected new board members:

### Arizona Board

Douglas Cunningham, Phoenix, AZ  
 Sam Downing, Prescott, AZ  
 Dean Martin, Phoenix, AZ  
 Andy Myers, Phoenix, AZ  
 John Post, Phoenix, AZ  
 Thanos Vanig, Scottsdale, AZ  
 Carol Williams, Scottsdale, AZ

### Mid Atlantic Board

Jean Anderson, Baltimore, MD  
 Gary DeSimone, Washington, DC  
 Richard Elion, Washington, DC  
 Kelly Gebo, Baltimore MD  
 Mulhammed Niaz, Newark, DE  
 William Ruby, Baltimore, MD

### Southeast Board

David Butcher, Washington, NC  
 Patricia Jennings, Lexington, KY  
 Earl Joyner, Griffin, GA  
 Dennis Melton, Atlanta, GA  
 Stephen Raffanti, Nashville, TN  
 Polly Ross, Asheville, NC  
 Rafael Torres, Dunn, NC

## Reimbursement Hotline

Do you need assistance with reimbursement issues related to providing HIV health care?

**Call Toll-Free  
 (877) REIM-HOT  
 877-734-6468**

## Peter J. Piliero, MD

*An Albany, NY-based physician helps ensure that inmates receive quality HIV care*

Peter J. Piliero, M.D., describes himself as a man who wears many hats – which is often the case with Academy members who work in smaller population centers. The Albany, NY-based physician is a clinician, a researcher, and a policy shaper who cares for patients, works on numerous clinical trials, and helps ensure that inmates at correctional facilities in Upstate New York receive care that's on par with the services provided "on the outside."

He's also an associate professor of medicine at Albany Medical College, medical director of the Clinical Pharmacology Studies Unit there, and director of research for its Division of HIV Medicine. His major areas of interest are characterization of antiretroviral therapy pharmacokinetics, including drug-drug interactions and investigating novel treatments for rescue treatments for multi-drug-resistant HIV. Since 1995, he's been principal investigator on many Phase I through Phase IV studies, most of them involving HIV antiretroviral agents or antimicrobial agents. He's also CME course director for *HIV Inside*, a quarterly newsletter for correctional professionals.

Piliero received his M.D. from the State University of New York at Stony Brook, holds a B.S. in biomedical education from the City College of New York, and is board certified in internal medicine and infectious diseases. His internship and residency in internal medicine were at Columbia-Presbyterian Medical Center in New York; he also served as an infectious diseases and AIDS fellow at



Peter J. Piliero, MD

Harvard Medical School in Boston. And he has obtained the HIV Specialist designation.

His interest in HIV medicine, he tells *The Nexus*, started with good mentoring. "Initially," he says, "like many people, I was a little intimidated by the disease because of how little we knew and how sick people were. But strong mentors

led me to an infectious diseases fellowship, and that led to an HIV fellowship as part of it. That's when I truly fell in love with this field – and with the people I was taking care of." As treatment options have advanced, Piliero adds, his role has changed from providing comfort to dying patients to providing care for patients with long lives ahead of them. "As therapies become available," he comments, "we're more and more able to take care of people for the long haul.

At the end of every day, there's a sense that you really made a difference for someone. That's what keeps me in HIV medicine."

He's in it in a way that not many of his colleagues can claim to be, in fact. Piliero and other members of the Albany Medical College's Division of HIV Medicine report regularly to a regional correctional medical unit in Coxsackie, New York, a dozen or so times a month for half-day shifts, providing consultative care for HIV-infected inmates. All told, he notes, there are approximately 2,000

inmates in their catchment area.

And, he points out, "I'm the only non-correctional member of the New York State Department of Corrections HIV primary care guidelines committee and hepatitis C treatment guidelines committee. As such, I advise the committees on standards of care that exist in the community and help write and revise, on a regular basis, the guidelines we use in New York State correctional facilities." As part of that effort, Piliero reports, the Department of Corrections committees "decided there should be a special designation for HIV care providers in the system, that they should become credentialed as HIV Specialists." That, he adds, presented an opportunity to leverage the Academy's credentialing standards into the real world in a very real way.

The department, he continues, had created its own definition of an HIV Specialist which largely reflected that of the New York State AIDS Institute. And

part of that involved providers – nurse practitioners, physician assistants, and physicians – who wanted to be credentialed by taking an exam that he adapted from one that already existed in New York. When the Corrections Committee decided recently to update the exam, Piliero suggested

using the Academy's "already-recognized credentialing process." He "brought the exam back to the committee and said, 'Why don't we have our New York State providers certified via the Academy?'"


**"At the end of every day there's a sense that you really made a difference for someone.**

**That's what keeps me in HIV medicine."**

The Corrections committee liked the idea. "We're very close to incorporating the Academy's process," he says. "It will be the new way our providers get credentialed." That, he emphasizes, "provides not just our own local measure of credentialing, but a national organization's process with an established test and a process that makes what we're doing more formal." At press time, he notes, meetings were taking place to formalize adoption of the Academy's credentialing process for New York State Department of Corrections HIV care providers.

"We want to make sure that care in corrections is on par with care in the real world," Piliro comments. "Having Academy-credentialed providers do it helps this be accomplished." That's a special challenge in the Empire State's correctional system, he adds, because its 7,000 or so HIV-positive inmates – most of whom are minority intravenous drug users, much like an urban clinic's population might be – are spread across approximately 70 facilities, mostly in rural Upstate

New York. As a result, he explains, "it's often hard to find providers who are going to want to work in corrections and who also have an interest in HIV."

Although he can't do much to increase the numbers of providers willing to work with inmates, he points out, he can make sure that those who do are as educated as possible in current HIV treatment. The Academy, he adds, assists in that endeavor by "maintaining an accepted standard for credentialing. That helps validate that correctional providers who provide HIV care are specialists. It gives them the recognition they deserve and helps validate the quality of care that we provide to inmates." He emphasizes that "key administrators in the Department of Corrections are very much interested in having credentialed providers." Specifically, he lauds Lester Wright, M.D., M.P.H., deputy commissioner and chief medical officer for the New York State Department of Corrections, for championing efforts to credential HIV care providers in the correctional system. 

**The Academy is supported by unrestricted grants from our sustaining donors:**



## Academy Question and Answer

# Credentialing, Certification, & Specialities

**Q: Do you need to be board certified in another specialty in order to be credentialed by the AAHIVM?**

A: No. However, you must have a currently valid license to practice from your state.

Many physicians are in practice without being board certified. This means that they completed a residency in their specialty but did not take or pass their board exam or recertification exam. Some employers, hospitals, or institutions require board certification, but many do not. The Academy believes that the California regulations will encourage managed care programs to identify and recruit HIV practitioners who are keeping up-to-date. Adding mandatory board certification to the requirements would place an unnecessary barrier to achieving an adequate number of HIV Specialists, especially in undeserved areas.


**Q: How is the Academy's credentialing process different from the ABMS certification program?**

A: The AAHIVM program is meant to encourage focused education on the recent changes in the full range of HIV medicine and to measure that in a standardized way.

The Academy's credentialing program is neither the same as, nor meant to replace, the certification program run by the ABMS, which might require fellowship programs to be in place for a specified length of time, a high fee, and a lengthy proctored exam (usually every 10 years), and which excludes NPs, PAs, and non-board-certified physicians. If and when the ABMS creates a subspecialty in HIV medicine, it may be seen as creating a significant entry barrier to recruiting practitioners into the field of HIV medicine. We are currently exploring a subspecialty with the ABMS that will not create barriers.

**Q: Will there be different credentialing criteria for different specialties? For example, will infectious diseases specialists have different criteria than a immunologists?**

A: No. Although board certification does represent a knowledge base in a particular specialty, none of the specialties encompasses the full spectrum of knowledge needed by an HIV Specialist.

HIV medicine includes knowledge from the specialties of immunology, infectious diseases, endocrinology and metabolic disorders, hematology, oncology, gastroenterology, and cardiology. HIV patients have many noninfectious complications from their disease and from the medicines used to treat the virus. The Academy's position is that regardless of providers' backgrounds, they should all be held to the same standard to be called an HIV Specialist. For example, an immunologist should have to meet the same requirements as an infectious diseases physician or general internist. 



# THE NEXUS™

Newsletter of the American Academy of HIV Medicine

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### Current Events & Information



## 2nd Annual AAHIVM Membership Meeting

at the  
**42nd Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC)**

*Thursday, September 26, 2002  
6:00 p.m. to 8:00 p.m.  
San Diego Marriott Hotel & Marina  
333 West Harbor Drive  
San Diego, California*

### Make plans to join us!

Interactive discussion will include:

- Revising the AAHIVM credentialing criteria, the Self-Directed Study Guide, and future initiatives.
- Also remember to stop by our booth and see a sample of the 2003 Self-Directed Study Guide.