



★ HIV Research Has Women to Thank

Twenty years, thousands of women, and hundreds of scientific papers after it began, the largest and longest-running study to investigate the impact of human immunodeficiency virus (HIV) on women in the U.S. is celebrating its platinum anniversary.

Every 6 months since 1993, researchers for the Women's Interagency HIV Study (WIHS) have made study visits to Chicago; Los Angeles; New York City; San Francisco; Washington, DC; and other sites to interview women about their health and behavior and conduct clinical and laboratory tests. The study has resulted in more than 550 scientific papers detailing the clinical, biological, neurocognitive, and behavioral assessments; comparisons of women infected with and women not infected with HIV; and other data.

During those 2 decades, WIHS has helped redefine treatment for women with HIV. Among other things, study findings have shed light on how genetic, metabolic, behavioral, and other factors influence HIV disease progression; the health effects of other viruses, such as herpes, human papillomavirus, and hepatitis C; and how such coinfections affect the course not only of HIV disease, but also of cardiovascular, liver, and kidney diseases; cervical cancer; lipodystrophy; diabetes; and neurocognitive disorders.

Although > 1,100 volunteers have died of acquired immunodeficiency syndrome (AIDS) or other causes and 917 women have dropped out of the study, > 2,000 women are still participating in the study. About 70% have HIV infection; nearly 90% of those have taken anti-retroviral drugs.

The study has always reflected

the truth of the HIV epidemic: The women affected are mostly minority and low income. Nearly half the participants live in poverty; 58% are black. The study has shown, though, according to an August 30, 2013, press release from the National Institutes of Health, "that economically and socially disadvantaged women will volunteer to participate in intensive, long-term clinical studies and make important contributions to medical research."

At the U.S. Conference on AIDS 2013, organized by the National Minority AIDS Council, speakers shared plans for furthering the goals of President Obama's National HIV/AIDS Strategy and discussed how the Affordable Care Act (ACA) will affect HIV/AIDS care.

Conference participants covered a variety of topics, including the implications for expanded coverage of HIV and hepatitis C testing. The U.S. Preventive Services Task Force recently released a new recommendation statement on screening for HIV, giving a grade A recommendation for routine HIV screening for all people aged 15 to 65 years, as well as younger adolescents and older adults who are at increased risk for HIV infection. (The grade A recommendation means there is strong evidence that the test has large potential benefits and few potential harms.) The task force also gave an A recommendation for HIV screening for all pregnant women, including those in labor whose HIV status is unknown. The ACA requires most private health insurance plans to cover preventive services, especially HIV testing and behavioral counseling.

Phill Wilson, president and chief executive officer of the Black AIDS Institute, said, "We now have the tools to end the AIDS epidemic—better

diagnostic tools, better surveillance tools, better prevention tools, and now with the implementation of the Affordable Care Act, better health care financing tools."

★ What the Affordable Care Act Means for the IHS

With the opening of the Affordable Care Act (ACA) Health Insurance Marketplace, American Indians and Alaska Natives (AI/ANs) get more options for health care—and the Indian Health Service (IHS) gets some business competition. At the recent Indian Health Partnerships Conference, the Acting Director of the IHS, Yvette Roubideaux, MD, MPH, provided an update on changes and improvements in the IHS, particularly in the context of the ACA.

One of the most important changes from the ACA is that AI/ANs—even if they already get their health care through the IHS—will have more options for additional coverage. Approximately 30% of IHS patients have no health coverage other than IHS. They may benefit most from the ACA, Dr. Roubideaux suggests. For one, more patients than the 38% now on Medicaid may become eligible for Medicaid. She notes that there are special provisions for AI/ANs who are members of tribes. If their income is below a certain level, they won't have copays or deductibles if they go to IHS (or anywhere). They also have the option of enrolling on a monthly basis, not just once a year.

The definition of Indian will have an impact on certain benefits, but IHS eligibility is not affected. Current ACA law defines Indian more narrowly than the IHS does, restricting it to only members of tribes. By contrast, the IHS also includes descendants. Moreover, all AI/ANs who are

eligible for IHS will be exempt from the penalty for not having insurance coverage. Previously, that exemption applied only to tribal members.

The IHS is also working on initiatives to enhance the quality of care, Dr. Roubideaux says. One of those is the Improving Patient Care (IPC) program: a patient-centered medical home initiative. Currently, it exists at 127 sites; IHS plans to expand IPC throughout the entire IHS system, in part because IPC sites have been remarkably successful: They've drastically cut waiting times, reduced no-shows, and streamlined care by making it possible for patients to see the same providers each time they come to the clinic. Implementing IPC concepts, for example, has helped the IHS Fort Yuma Health Center cut no-show rates from 20% to 9%, and its patient-centered task teams have improved patient outcomes, such as lowering AIC levels. The IHS Claremore Indian Hospital has reduced appointment-availability delays from an average of 140 days to 1.5 days and reduced no-show rates from 30% to 10%.

Another IHS initiative, the Special Diabetes Program for Indians (SDPI), may already have had a tremendous impact. Between 1995 and 2006, the incident rate of end-stage renal disease in AI/ANs with diabetes fell by 28%—a greater decline than for any other racial or ethnic group. While the cause-and-effect connection isn't definite, Dr. Roubideaux says, the drop happened after SDPI was implemented.

Reforms are "ongoing," Roubideaux says, such as addressing the shortage of physicians and health professionals in the IHS with scholarships, loan repayment programs, and other incentives, and recruiting more providers through the National Health Service Corps. The efforts are paying off: There are now more than 300 full-time providers at IHS health pro-

gram sites, up from 260 in 2012, but not at the expense of traditional healers. Dr. Roubideaux emphasizes, "Providing culturally competent services is also a way to make our care patient-centered."

To help patients understand the new changes in health care coverage, the IHS has been bumping up training for staff and tribes, with resources such as enrollment assistance training, webinar training, and fact sheets. The National Indian Outreach and Education initiative, which includes partners from all IHS areas, has conducted several hundred training sessions so far on the ACA and has developed helpful materials, including a website (<http://tribalhealthcare.org>) and an informational public service announcement for waiting rooms and offices. The IHS website (<http://www.ihs.gov>) has also been redesigned to make it easier to find health care information faster.

★ Making It Easier to Get the Right Health Care

Veterans will have expanded access to health care through a new initiative called Patient-Centered Community Care (PCCC), the VA announced in a September 19, 2013, press release. Under PCCC, when geographic inaccessibility or limited capacity prevents VA medical centers (VAMCs) from providing needed care, the VAMCs will be able to buy non-VA medical care through contracted medical providers.

Part of the overall Non-VA Medical Care Program, PCCC will provide all VA facilities with options when required veteran care services are unavailable within the VAMC (eg, when a specialist is not available or wait times are long) or when the veteran benefits from receiving the care nearer to home. Eligible veterans will have access to inpatient specialty care, outpatient specialty care, mental

health care, limited emergency care, and limited newborn care for enrolled women.

The VA has awarded contracts to Health Net Federal Services, LLC, and TriWest Healthcare Alliance Corp, which will set up networks in 6 regions throughout the country. The VA expects to have the regional contract networks available to its medical centers by spring 2014.

VA's Under Secretary for Health Robert Petzel says PCCC will help in the VA's "continued efforts to ensure timely and accessible services."

★ Job Training for Veterans With Disabilities

Fabrication of Assistive Technology (FATe), a joint research program between the VA Pittsburgh Healthcare System and the University of Pittsburgh School of Health and Rehabilitation Sciences, both in Pennsylvania, which studies wheelchairs and related technology, is now accepting applications from veterans with disabilities for job training.

The program is designed to help active-duty wounded warriors and veterans in rehabilitation. Over 12 weeks, students learn basic machine principles and practices, including carpentry, welding, prototyping, and electronics. At the end of training, participants can independently design, develop, and evaluate their own product (prototype) using established design principles. They will also be prepared to sit for the National Institute for Metalworking Skills Machining Level I certification.

The FATe program offers scholarships and paid on-the-job training experience. Participants who complete the program will have a variety of pathways to pursue, including full-time employment in the manufacturing and technology sector, segue to technology degree programs, and enrollment in the college transition program. ●