LETTER TO THE EDITOR

To the Editor:—The article by Landon et al. offers evidence that the care rendered by general internists, committed to the care of HIV-infected patients, compares favorably with that given by infectious disease physicians, based on an assessment of HIV care knowledge.¹ The accompanying editorial by Paul Volberding reminds us of the impact of the HIV epidemic.² Its ongoing morbidity and mortality place enormous strain on our health-care delivery system. Consequently, there is a need for creative models of care. Our own experience in Denver corroborates the viability of a novel community clinic-based program.

Our program, HIV Early Intervention Services (EIS), was created in 1990 with funding from Ryan White Title III to increase access to HIV care in heavily impacted neighborhoods in Denver through decentralized community health centers. Denver Health, the only safety-net public hospital in Denver, operates a Community Health Service of primary care clinics located throughout medically underserved areas.

The HIV-EIS program is built upon a core team, which includes two RNs, a psychiatric RN, a nutritionist, a social worker, and an outreach worker. This team, which travels to the clinic sites, supports four community-based general internists, who provide specialized HIV medical care during the EIS designated clinic sessions. There are a total of seven half-day sessions at the four internal medicine clinic sites. Currently, there are 414 active patients enrolled, for which there were 1,781 primary care visits in 2001. Our four physicians have gained their expertise by providing care to a large number of patients during the last decade. They are committed to keeping current of new treatment modalities and standards of care. This is accomplished by attending local weekly HIV conferences and national HIV conferences, and by focusing on this area of the

medical literature. All of the physicians have voluntarily opted to also pursue this unique specialized niche within general internal medicine while maintaining a generalist's approach to their patients.

Patients (including 160 enrolled for more than 5 years) attest to the success of this approach by continuing to access ongoing care in EIS when other options are available to them. Each patient has individual reasons for her/his choice. These include: continuity of care, access in a familiar neighborhood clinic rather than a designated HIV clinic, and better integration of HIV care with other primary care issues. Moreover, these non-HIV-related preventive health issues, which are an integral part of general internal medicine, are gaining new import as patient life expectancy increases in this population.

This program offers specialized care by general internists in a diversity of settings to meet the needs of patients with HIV disease. There are increasing amounts of data that confirm the importance of HIV experience in physicians' effectiveness in deftly managing these complex patients.³ General internists, such as those in our model of care, with substantial ongoing HIV expertise, have been found to provide quality HIV care for their patients.⁴—**DAVID W. LEHMAN, MD, PhD, JOEL WITTER, MD, MARTINA SCHULTE, MD, JOSH BLUM, MD, TERENCE SHEA, RN, PHILIP S. MEHLER, MD**, *The University of Colorado Health Sciences Center and Denver Health, Denver, Colo.*

REFERENCES

1. Landon BE, Wilson IB, Wenger NS, et al. Specialty training and specialization among physicians who treat HIV/AIDS in the United States. *J Gen Intern Med.* 2002;17:12–22.
2. Volberding P. Who cares for AIDS? *J Gen Intern Med.* 2002;17:82–3.
3. Stone VE, Mansourati FF, Poses RM, Mayer KH. Relation of physician specialty and HIV/AIDS experience to choice of guideline-recommended antiretroviral therapy. *J Gen Intern Med.* 2001;16:360–8.
4. Brosgart CL, Mitchell TF, Coleman RL, Dyner T, Stephenson KE, Abrams DI. Clinical experience and choice of drug therapy for human immunodeficiency viral disease. *Clin Infect Dis.* 1999;28:14–22.

JGIM welcomes your letters and comments. Letters may contain brief commentaries on articles published in the Journal, illustrative case reports, general suggestions for improving the Journal, or other information of interest to readers. Letters to the Editor should not exceed 450 words in length and should be sent to the Editor via e-mail at jgim@jhmi.edu.