Career Guide
Physician jobs from the New England Journal of Medicine • July 2021

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The latest physician jobs brought to you by the NEJM CareerCenter

In Demand Specialties
Dear Physician:

As a primary care, psychiatry, or neurology physician about to enter the workforce or in your first few years of practice, you may be assessing what kind of practice will ultimately be best for you. The *New England Journal of Medicine* (NEJM.org) is the leading source of information for job openings for physicians in the United States. To further aid in your career advancement we’ve also included a couple of recent selections from our Career Resources section. The NEJM CareerCenter website (NEJMCareerCenter.org) continues to receive positive feedback from physicians. Because the site was designed based on advice from your colleagues, many physicians are comfortable using it for their job searches and welcome the confidentiality safeguards that keep personal information and job searches private.

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A career in medicine is challenging, and current practice leaves little time for keeping up with new information. While the *New England Journal of Medicine*’s commitment to delivering top-quality research and clinical content remains unchanged, we are continually developing new features and enhancements to bring you the best, most relevant information each week in a practical and clinically useful format.

A reprint of the Clinical Practice article, “HIV Infection — Screening, Diagnosis, and Treatment,” is also included in this booklet. Our popular Clinical Practice articles offer evidence-based reviews of topics relevant to practicing physicians. We also have audio versions of Clinical Practice articles. These are available free at our website, NEJM.org, or at the iTunes store and save you time, because you can listen to the full article while at your desk, driving, or working out. Another popular feature, Videos in Clinical Medicine, enables you to watch common clinical procedures — including information about preparation and equipment — right on your desktop or mobile device. You can learn more about these features at NEJM.org.

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On behalf of the entire *New England Journal of Medicine* staff, please accept my wishes for a rewarding career.

Sincerely,

Eric J. Rubin, MD, PhD
Telemedicine: It's here to stay

A recent study by the COVID-19 Healthcare Coalition Impact Study Work Group, in which Dr. Kvedar participated, found that telehealth claims increased 50 to 100 times in several US states between July 2019 and July 2020, and grew significantly in all states. A companion survey of 1,594 physicians and health professionals last summer found that 83.6 percent had engaged in interactive video patient visits in 2020 and that nearly 40 percent averaged more than 20 virtual visits a week.

In Dr. Kvedar’s view, the issue now is not whether physicians will practice telemedicine but what their practice will look like. “We’re at the point now where it’s a question of how physicians will use it and how they’ll determine which clinical cases should be in office and which might be virtual,” he said. “I think we’ll see physicians joining practices where they’ll have 60 percent in-person and 40 percent telehealth visits. We’ll also see physicians who do 100 percent virtual practice with four or five companies — they’ll be the Uber drivers of health care.”

The model’s appeal is obvious for physicians seeking flexibility in their lives, to care for young children or aging parents, for example. Still others will seek part-time, limited telehealth opportunities to increase their income and pay off education debt more quickly. Some might choose the model out of pure preference, after trying it out and finding it a good fit.

That’s the case for Kurt Gilbert, MD, an internist in Cookeville, Tennessee. He was practicing as a hospitalist but then started seeing patients virtually when the pandemic hit. “I’ve always had an interest in telemedicine, and once I tried it, I really liked it. So, I’m now practicing telemedicine full time, from home,” said Dr. Gilbert, who works with Doctor On Demand, the company cofounded by the TV personality Dr. Phil. “The big difference for me now is that when my shift is over, I’m done. And when I want to see my 17-month-old on my lunch break, I can. For me, it’s a dream job, and the patients love it because they can choose the visit time.”

Dr. Gilbert sees patients in the numerous states where he is licensed. His care ranges from acute and urgent-care issues and chronic condition management to regular follow-up care for patients with whom he has established relationships. When a situation requires emergent medical attention, Doctor on Demand’s emergency support team steps in.

For Krista Grow, MD, a Kansas emergency medicine physician, telemedicine provided has proved an ideal solution to an intermediate-term family need. Her husband is doing his fellowship at the Cleveland Clinic, so the family moved to Ohio to stay together. Dr. Grow started doing some telehealth practice, about 12 hours a month, through Sycamore Independent Physicians of Alabama, and she also commutes to Kansas for ER shifts several days a month. “The [virtual-visit] care model is sort of slow-paced for me, but I find the work fulfilling. I’m often taking care of patients who can’t see their physician or who have lost their job and their benefits,” she said. “It’s rewarding to be able to help people when they need it.”

Larson Hicks, CEO of Sycamore Independent Physicians, reports a definite uptick in physicians seeking practice arrangements like Dr. Grow’s, either out of personal interest or because of declining patient volumes in the wake of the pandemic. “We have some independent physicians who practice telemedicine because they want to diversify their practice portfolio or gain a new revenue stream. Others like the platforms because they can build their own panel of patients or fill in a hole in their schedule,” said Mr. Hicks. His company, whose primary business is in emergency medicine locum tenens services, has placed 150 physicians in telemedicine positions in 2020. While many work in locums-type models, others are moving into more structured, permanent arrangements.

Whatever telemedicine model physicians are interested in, they’ll find opportunities, said Ateev Mehrotra, MD, MPH, a Harvard health care policy researcher and hospitalist at Beth Israel Deaconess Medical Center in Boston. “If physicians want to be free spirits, they can do 100 percent telemedicine,” he said. At companies like Blue Sky Neurology, physicians do virtual consults on stroke or neurological disorders. In radiology, an early telemedicine entrant, the market for all-remote positions has expanded dramatically, and psychiatry has seen major growth in all-virtual and hybrid models. “We’re seeing psychiatrists whose schedules include in-person clinic one or two days a week and tele-psychiatry visits at home in the evenings, for example,” he said. “Moving forward, physicians across all specialties will be engaging in more remote patient monitoring, especially for patients with chronic conditions. The innovations we’re seeing will give physicians a lot more flexibility than they’ve had before.”

Even hospitalist medicine is moving into remote care. Sound Physicians, a long-established hospitalist company, now offers tele-hospitalist positions
in which home-stationed hospitalists work collaboratively with onsite hospital nurses and physicians to triage patients and create care plans. “Our tele-hospitalists might be supporting five to eight hospitals on a shift, and they have more control over how they manage the requests and alerts in their queue than they might in the hospital,” said Brian Carpenter, MD, the company’s national medical director. Sound Physicians is also moving into tele-SNF (skilled nursing facility) and virtual transitional care for discharged patients, providing a new range of telemedicine physician practice opportunities.

What telemedicine organizations look for

All sources interviewed for this article agreed that practicing telemedicine requires a change of mindset and that physicians who want to do virtual practice need a few years of post-training practice experience before making the shift. Moving from in-office visits to virtual ones is a definite adjustment because video visits obviously don’t allow for a traditional physical exam. Physicians who need to listen to the heart and lungs, check a patient’s ears, or examine a rash must use technology. They’ll also have to be extra diligent in obtaining a history in new patients and adept at establishing rapport quickly. “Not everyone can communicate effectively virtually, so that’s one of the qualities we screen for, in addition to solid experience,” Dr. Carpenter said. His company seeks hospitalists with at least three years of onsite practice experience, for example, as well as a strong critical care comfort level.

“Beyond practice experience, telemedicine organizations are looking for is physicians who are personable, adaptable, and willing to learn something new,” Mr. Hicks said. It also helps when physicians have licenses in multiple states. That’s become easier with the advent of the Interstate Medical Licensure Compact, which expedites licensing among its 30 participating states.

Tony Yuan, MD, medical director at Doctor On Demand, which employs 600 physicians and has seen a dramatic spike in demand in 2020, boils it down to what he calls good “webside” manner. “Anyone can learn the skills and pick up the technology, but we’re looking for physicians who present themselves well, who are compassionate and approachable,” Dr. Yuan said, “and who can adapt to the volume.” Most video visits are scheduled for 15 minutes, with a short buffer between visits. Doctor on Demand physicians may take as much time as they need or extend a visit when necessary, but the basic expectation is that they’ll see four patients an hour. The company provides extensive training, a robust support system, and an integrated electronic health record.

Doctor on Demand has two primary models, a 32-hour work week and a 40-hour schedule, with some flexibility to break up visit “blocks” to suit personal or family needs. The company looks for a minimum commitment of 60 hours a month. Compensation, Dr. Yuan said, is “on par” with the income physicians would receive in a traditional care model. The virtual practice model, he added, is ideal for primary care physicians, emergency medicine physicians, pediatricians, and psychiatrists. “We can’t hire people fast enough, and we’re hearing from physicians who tell us that they didn’t even know these options existed,” Dr. Yuan said.

Tyler Covey, CPA, who is CEO of the national firm MDstaffers in Rancho Cordova, California, echoes that demand-versus-supply dilemma. His company filled 900 telemedicine positions (for physicians and advance practice clinicians) in a single month and has seen the demand for behavioral health professionals and primary care clinicians “pretty much explode.” The physicians that MDstaffers has placed practice in a variety of settings, from dedicated virtual clinics to call centers to their own homes.

“There’s a lot of variation, but for physicians, I think the important thing is ensuring the organization is well equipped to support virtual care,” Mr. Covey said. Ideally, that means having dedicated support personnel, top-notch technology, a system for ensuring patients are prepared for the visit, and a platform in which the electronic health record (EHR) is integrated. “Not all telemedicine jobs are created equally,” he said.

Kurt Schussler, a managing partner of Medical Advantage Recruiters in Addison, Texas, whose company is seeing skyrocketing demand for telemedicine physicians, urges physicians to thoroughly research both the position and the organization offering it. “It’s important to know how the organization is structured, how much support they’ll receive, and whether the entity is financially solid,” Mr. Schussler said. That due diligence includes obtaining credit reports and speaking to physicians who work for the organization to ensure that compensation is equitable, as advertised, and paid timely.
Kaiser: the ‘gold standard’ keeps innovating

Organizations that want to do virtual care right might look to Kaiser Permanente for expert instruction. Kaiser has been delivering telemedicine services and virtual care for more than 15 years, in a highly organized, orchestrated, and integrated manner. All physicians who practice with The Permanente Medical Group — with 9,000 physicians, TPMG is the country's largest — are equipped with video cameras, state-of-the-art information technology, dedicated smartphones, and a system that enables physicians to quickly “accelerate” care when specialists are needed. Even with those components in place, Kaiser had to adjust to accommodate the new environment after the coronavirus hit, said Richard S. Isaacs, MD, TPMG’s CEO and executive director.

“When the shelter-in-place mandate came, we had to move to a video-care-first strategy almost overnight and we quickly converted to conducting 90 percent of all exams on video,” Dr. Isaacs said. “What we’re seeing is that patients really love video visits, both the convenience and the personalization.” By August 2020, Kaiser was conducting nearly 25,000 video visits daily in its Northern California region alone and provided four million in the first three quarters of 2020 across all eight Permanente Medical Groups.

Although Kaiser had long been using virtual visits for preventive care and some follow-up care, behavioral health, and dermatology, the pandemic spurred innovations in other clinical areas. A Kaiser pilot in tele-critical care, for example, has become part of a sophisticated hybrid-care model going forward, in which specialists perform remote monitoring and proceduralists provide direct patient care in the ICUs. “Our physicians are really enjoying this — it’s as if they're part of a team like the Navy SEALs,” Dr. Isaacs said.

A more recent innovation involves virtual cancer care. Kaiser oncologists recently began using primarily video visits for oncology patients, who, because of their compromised immune systems, may be especially vulnerable to COVID-19 infection and poor outcomes. Tatjana Kolevska, MD, chair of the Kaiser Permanente Northern California Oncology and Hematology Chiefs Group, spearheaded the effort to move almost all oncology care to phone or video appointments, in very short order. “We moved from 15 percent before the pandemic to 98 percent [virtual visits] within a week, and it’s been very successful,” she said. “We've discovered that physicians find it easier to act on issues that patients are experiencing. And the video visits make it easier for caregivers to participate.”

Dr. Kolevska said that somewhat surprisingly, the majority of Kaiser oncology patients, based on survey findings, have proved amenable to having even sensitive issues such as a new diagnosis or a treatment failure discussed using virtual visits. “We've seen a significant increase in patient satisfaction overall with the video visits,” said Dr. Kolevska. Kaiser is also convening multidisciplinary patient conferences and tumor boards completely virtually now, enabling oncologists and other specialists from across the organization to review and guide care.

In Dr. Kvedar's vision of the future, virtual care and telehealth will play an increasingly larger role in most physicians’ lives, with mostly beneficial results, especially when physicians manage patients who can’t readily get to care facilities. But telemedicine won't supplant face-to-face visits, he said, or obviate onsite physical exams. “Most of us chose this career path because we want to help people and form that bond, which might be harder in a virtual setting,” he said. “At the same time, I see telemedicine and its flexible work environment as extremely liberating for physicians.”

Considering a Telemedicine Job? Ask the Important Questions

There’s so much going on in telemedicine today that it can be daunting to physicians trying to explore the fast-evolving marketplace and compare different practice opportunities that are wholly or predominately virtual. Because there are so many new players in the market and organizations offering positions differ widely, it’s a bit of a Wild West out there. For that reason, it’s very important for physicians considering telemedicine practice to obtain as much information as possible before making a commitment.

Sources interviewed for this article offered tips for navigating the telemedicine market and making informed decisions:

• “It’s important to ask how patients will be prepared for virtual visits, whether there's a dedicated virtual exam room, and whether they'll have a well-trained assistant to help support them. Physicians practicing telemedicine will have the highest satisfaction if all these components are in place.” — Lou Ann Gonzales, Advanced Physician Recruitment
“Physicians need to know the types of patients they’ll see, what the volume expectations are, and what’s required in terms of schedule and call to reach the stated compensation levels.” — Kurt Schussler, Medical Advantage Recruiters

“Ask whether the EHR is fully integrated with the virtual-care platform, where you’re permitted to work from, and what the payment models are: is it hourly, salaried, per consult, or productivity based?” — Joseph Kvedar, MD, American Telemedicine Association

“Make sure any organization you consider has an acceptable standard of care and that they’re compliant with CMS [Centers for Medicare and Medicaid Services] rules and state regulations.” — Tyler Covey, MD, Staffmark

### Knowing Your Worth in the Physician Job Market

By Nisha Mehta, MD, a physician leader whose work focuses on physician empowerment, community building, and career longevity in medicine

One thing physicians seldom do in the training setting is talk about money. Between daily clinical responsibilities and call, a never-ending amount of information to learn, and doing your best to keep up with the other aspects of your life, most of us would agree we’re in survival mode for most of our residency and fellowship. Learning the business and financial aspects of a life in medicine doesn’t usually make it to the priority list.

Consequently, as the end of training approaches, most physicians find themselves overwhelmed with the prospect of finding a job, and underprepared for negotiations. Many just feel grateful to have come to the conclusion of a long journey. After years of being paid a very low hourly rate and (on average) holding substantial six-figure debt, it’s tempting to just be happy with the positive cash flow.

Not doing the requisite research before talking about numbers will almost always work against you. I routinely find myself encouraging physicians to know their worth — not just because I think physicians have the expertise to warrant earnings that reflect it, but because career longevity and job satisfaction are closely intertwined with feeling valued. When I counsel early-career physicians who are dissatisfied, this is often the reason they end up seeking other opportunities within the first five years out of practice.

As salary transparency is not commonplace in medicine, trainees (and their older counterparts as well, for that matter) often don’t know how to evaluate offers or know what reasonable expectations are. This is a significant disadvantage at the negotiating table, and why physicians must put the research into figuring out their market value.

Many mistakenly assume that knowing your worth means simply looking at widely cited compensation databases such as Medical Group Management Association (MGMA) and Association of American Medical Colleges (AAMC). These are available for purchase or may be available from your hospital libraries or your contract attorney. Although a great place to start, it’s important to take this data into context. Compare not only the salary numbers, but the actual compensation per RVU. Know that this can range widely even within the same region of the United States depending on exact location, type of practice, stage of practice, how competitive the job market is, and
a host of other factors. You should dig deeper. If the job is at an institution where compensation data is published, such as state and government organizations, look up the salaries of other physicians there. Ask your medical school classmates, mentors, training program alumni, and other physicians in your network who may have knowledge of or connections within the pertinent market.

Importantly, realize there is a lot of work that you do that may not be reflected in RVUs. This may take the form of call responsibilities, teaching or research expectations, or administrative duties. These are all things that contribute to your worth to an employer, and should be factored in when calculating your market value.

Next, it’s important to do your research on the employer. Do you have a particular skill they are in need of? Some skills that may strengthen your bargaining position include fluency in a foreign language, procedural skills, the potential to attract certain patient populations, or the ability to develop a niche that the practice does not currently offer.

Finally, utilize a contract attorney, ideally one that is experienced with physician contracts. Many trainees are hesitant to spend the money, but having the objective feedback on how your deal compares to others is well worth it. Oftentimes, they will be able to point out areas where you should ask for more, give feedback on things like partnership and bonus structures, and protect you from expensive mistakes. After all that you’ve spent to get to this point, it’s a worthwhile investment to make sure your contract is fair and in your best interest.

In every negotiation, both sides will understandably try their hardest to get the best deal for themselves. This is a business transaction, and should be approached as such. There will be give and take on both sides, but having a solid understanding of your worth will empower you to advocate for it. And remember...if you don’t ask, you won’t get.
not receive a diagnosis until they present with advanced disease, when treatments may be less effective and the risk of death is highest.7

In 2019, the United States initiated the “End the HIV Epidemic” plan with a goal of reducing the number of new infections by 75% by 2025 and by 90% by 2030.8 The plan includes four components to identify all persons with HIV infection, preferably early; to successfully initiate therapy; and to respond quickly to outbreaks as they occur. The foundation for the first two components includes minimization of gaps in diagnoses, improvement in linkage to care, rapid initiation of therapy for HIV infection, and maintenance of viral suppression through successful retention in care.

STRATEGIES AND EVIDENCE

HIV SCREENING

U.S. guidelines recommend that all sexually active persons be tested at least once for HIV9 and that those who have an ongoing high risk of infection be tested at least annually.9 Persons with high risk are defined as those with an incident sexually transmitted infection; sexual partners of persons with sexually transmitted infections; persons who have had more than one sexual partner (or whose sexual partners have had more than one partner) since their most recent HIV test; injection-drug users; and persons who exchange sex for money or drugs. Testing is also recommended after the diagnosis of incident sexually transmitted infections and during pregnancy.

According to data from the National HIV Surveillance System of the Centers for Disease Control and Prevention (CDC), more than 75% of persons in high-risk categories who had seen a primary care provider within the previous year were not offered an HIV test,10 and many patients with undiagnosed HIV infection had multiple health care visits before receiving an HIV test.11 This lack of testing is a failure of the health care system, because each encounter is an opportunity to reduce the incidence of HIV transmission. Up to 38% of new HIV infections are transmitted by persons who are unaware of their HIV status.12 Moreover, once HIV infection is identified and appropriately treated to maintain HIV RNA levels below 200 copies per milliliter, patients can have a near-normal life span and virtually eliminate transmission of HIV to others.13

Several studies have shown that in health care settings (including emergency departments and sexually transmitted disease and primary care clinics), more HIV infections could be referred for ART with the use of routine “opt-out” testing (i.e., all adult patients are informed that an HIV test could be performed, but they can opt out if they wish).14,15 Up to 38% of new HIV infections are transmitted by patients who have been offered an HIV test but did not take it;16,17 than with physician-directed testing. Recommendations for opt-out testing have been in place since 2006.18 Routine testing in the emergency department has been shown to be cost-effective.19

DIAGNOSTIC TESTS

Many tests are available to accurately diagnose HIV infection. The choice of the most appropriate test depends on an understanding of the natural history of HIV infection (i.e., which marker is present at a given point after infection) (Fig. 1), the volume of the specimen, and the test-performance specifications.8 During the “window” period, before establishment of viremia at day 5, infection cannot be detected. By days 6 to 8, virus can be detected by a nucleic acid amplification test (NAAT). Viral proteins (p24 antigen) can be detected between days 13 and 20. Antibodies, initially in the form of IgM, are detectable by day 20, and IgG is detectable by day 30. Most patients present long after the initial infection, when tests for antibodies and nucleic acid are both positive.

Owing to the high cost of NAAT, combination antigen–antibody tests, which use p24 antigen to identify patients in early stages of infection, are now the standard tests in hospital and commercial laboratories. Most of these tests can detect HIV-1 and HIV-2 infections. The CDC algorithm for testing is shown in Figure 2.

Several available point-of-care rapid tests use one of two techniques: lateral flow or flow-through. Once antibodies bind to antigens, they are detected by an indicator. Rapid tests can use either whole blood (10 to 50 μl) or plasma, because fingerstick or an oral swab as specimens; these tests are convenient and easy to administer. Although the sensitivity and specificity of these tests are generally greater than 99%, laboratory-based tests are more accurate, especially in early infection, and they are required to confirm any diagnosis made on the basis of a point-of-care rapid test.

LINKAGE TO CARE

All persons who receive a diagnosis of HIV infection (i.e., which marker is present at a given point after infection) and day 0 indicates the establishment of infection. Most infections occur years after primary infection. The sooner that an initial clinic visit is scheduled after diagnosis, the more likely it is that the patient will show up for the visit.23 One trial in sub-Saharan Africa showed that “immediate” initiation of ART at the time of a positive home-based test increased follow-up with care.24 Similar findings related to immediate initiation of therapy at the point of testing have been reported in resource-rich countries, although structural barriers often block implementation of immediate therapy, especially in hemic emergency departments.25 In the United States, “rapid” initiation of ART, within 1 week after diagnosis, is the recommended practice.26 Establishing an
active relationship with the patient, providing assistance in setting up the first appointment, maintaining contact with the patient until the first visit, and addressing any barriers to keeping the first appointment (e.g., transportation) are associated with an increased incidence of linkage to treatment.26

**BASELINE ASSESSMENT AND INITIATION OF ART**

A comprehensive intake evaluation should be performed at the initial visit. The items to be covered in the first visit are provided in Table 1. The history taking should focus on the risk to other persons associated with exposure to the patient as well as the patient's sexual health, ongoing use of substances (including alcohol), and mental health disorders. A physical examination should be performed to evaluate for signs of advanced HIV infection such as thrush, vaginal candidiasis, herpes simplex virus infection, Kaposi's sarcoma, lymphadenopathy, retinopathy, mental status alterations, and wasting. Counseling should address the implications of an HIV diagnosis, the importance of disclosure of the patient's HIV status to a few trusted friends or relatives (for emotional support) and established sexual partners, and potential barriers to keeping future appointments (e.g., lack of transportation, food insecurity and lack of housing which may cause a person to prioritize day-to-day survival over medical visits), and interpersonal violence. Specific topics of discussion regarding prevention of transmission to others should include the routine use of condoms during sexual activity and avoidance of sharing needles or other equipment during intravenous drug use.

Patients should be reassured that they can expect a near-normal life span27 and no risk of transmission to others once viral suppression is achieved and maintained with ART.12 From 2011 to 2017, among patients receiving standard ART regimens, the incidence of death at 5 years after diagnosis differed by only 2.7 percentage points from that of age-matched controls.28

With rare exception, ART should be initiated at the first clinic visit. The primary reason for not initiating treatment is that the patient is identified as an “echo chamber” (i.e., a person who has no detectable HIV RNA on presentation) or is not ready to begin treatment for personal reasons. Retention in care is improved when ART is prescribed at the initial visit and not delayed.11,12

**FOLLOW-UP AND RETENTION IN CARE**

Follow-up visits should occur 4 to 6 weeks during the visit and, if warranted, the regimen should be switched. Laboratory tests (Table 1) and any adverse effects is essential. Any difficulties with the regimen should be addressed during the visit and, if warranted, the regimen should be switched. Laboratory tests (Table 1) should be performed, and the patient should be evaluated for sexually transmitted infections, ongoing use of substances (including alcohol), mental health disorders, and barriers to maintaining health (including housing issues, food insecurity, domestic violence, and other social determinants of care). Medication changes or adjustments in dosages may be warranted if new renal, hepatic, or hematologic abnormalities are detected on laboratory tests.
Table 1. Evaluation and Screening in Persons with HIV Infection.*

<table>
<thead>
<tr>
<th>Test or Screening Procedure</th>
<th>At Diagnosis</th>
<th>At First Clinic Visit</th>
<th>At Subsequent Visits</th>
<th>With Regimen Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical evaluation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical history taking</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Physical examination</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Screening test for HIV antibody and antigen</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measurement of HIV RNA (viral load)</td>
<td>Yes, if ART initiated at time and place of diagnosis or if acute HIV seroconversion suspected</td>
<td>Yes, but not needed if ART initiated at time and place of diagnosis</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CD4 count</td>
<td>Yes, if ART initiated at time and place of diagnosis or if acute HIV seroconversion suspected</td>
<td>Yes, but not needed if ART initiated at time and place of diagnosis</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Assessment of HIV resistance genotype</td>
<td>Yes, if ART initiated at time and place of diagnosis, HIV RNA obtained if acute HIV seroconversion suspected</td>
<td>Yes, but not needed if ART initiated at time and place of diagnosis</td>
<td>No</td>
<td>Yes, at time of confirmed virologic failure (detectable viremia)</td>
</tr>
<tr>
<td>Assessment of resistance to INSTIs</td>
<td>No</td>
<td>Yes, if known sexual partner is receiving an INSTI</td>
<td>No</td>
<td>Yes, at time of confirmed virologic failure (detectable viremia)</td>
</tr>
<tr>
<td>Liver and kidney profile</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Serum lipid profile</td>
<td>No</td>
<td>Yes</td>
<td>Yes, only once per yr</td>
<td>No</td>
</tr>
<tr>
<td>Complete blood count with differential</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>No</td>
<td>Yes</td>
<td>Yes, only once per yr</td>
<td>No</td>
</tr>
<tr>
<td>HBV serologic test</td>
<td>No</td>
<td>Yes</td>
<td>Yes, only once per yr</td>
<td>No</td>
</tr>
<tr>
<td>HCV serologic test</td>
<td>No</td>
<td>Yes</td>
<td>Yes, if known sexual partner is receiving an INSTI</td>
<td>No</td>
</tr>
<tr>
<td>Pregnancy test</td>
<td>No</td>
<td>Yes, women of childbearing potential</td>
<td>Yes, in women of childbearing potential; evaluate as indicated</td>
<td>No</td>
</tr>
<tr>
<td>Initiation of prophylaxis against Pneumocystis jiroveci pneumonia</td>
<td>Yes, if ART initiated at time of diagnosis or if P. jiroveci pneumonia clinically suspected (lymphopenia, wasting, oral candidiasis)</td>
<td>Yes, according to guidelines when CD4 count &lt;200 cells/mm³</td>
<td>No</td>
<td>Yes, in patients with virologic failure</td>
</tr>
<tr>
<td>Cryptococcal antigen screening</td>
<td>No</td>
<td>Yes, in all patients with CD4 counts &lt;100 cells/mm³ at diagnosis or first clinic visit</td>
<td>No</td>
<td>Yes, only once per yr</td>
</tr>
<tr>
<td>Urine test for histoplasmosis</td>
<td>No</td>
<td>Yes, in patients with CD4 count &gt;100 cells/mm³ in areas where histoplasmosis endemic</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Screening for sexually-transmitted infection</td>
<td>Yes, if ART initiated at time of diagnosis, screen at time of diagnosis or first clinic visit and routinely thereafter (frequency of testing depends on level of at-risk sexual activity)</td>
<td>Yes</td>
<td>Yes, screen routinely (frequency of testing depends on level of at-risk sexual activity)</td>
<td>No</td>
</tr>
<tr>
<td>Evaluation for cervical cancer</td>
<td>No</td>
<td>No</td>
<td>Yes, annually (anal Pap smears, if available, digital rectal examination at a minimum)</td>
<td>No</td>
</tr>
<tr>
<td>Evaluation for anal cancer</td>
<td>No</td>
<td>No</td>
<td>Yes, annually (anal Pap smears, if available, digital rectal examination at a minimum)</td>
<td>No</td>
</tr>
<tr>
<td>Testing for HLA-B*5701</td>
<td>No</td>
<td>Yes, perform before prescribing abacavir</td>
<td>No</td>
<td>Yes, perform before prescribing abacavir</td>
</tr>
<tr>
<td>Tropism assay (CCR5)</td>
<td>No</td>
<td>Yes, perform before prescribing maraviroc</td>
<td>No</td>
<td>Yes, perform before prescribing maraviroc</td>
</tr>
<tr>
<td><strong>General screening to assess psycho-social factors</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication adherence</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Substance use</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Depression, anxiety, or both</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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</tbody>
</table>
in the same care facility, should be available if the patient has a new or recurring mental health disorder.

Not all patients reach "undetectable" levels of virus; some have a consistently maintained level of virus between 50 and 100 copies per milliliter owing to a large reservoir of latently infected cells. In such patients, new replication is stopped with ART and no further adjustment in treatment is necessary. In contrast, if a viral load is measured at more than 50 copies per milliliter after previous viral suppression to 50 copies per milliliter or less, the measurement should be quickly repeated, and medication adherence and the side-effect profile should be assessed. A confirmed HIV RNA level above 200 copies per milliliter should prompt assessment of viral resistance, including evaluation of INSTI resistance if the patient is receiving an INSTI-based ART regimen.

More than 85% of patients who consistently receive care have sustained virologic suppression indefinitely. After a year of stable viral suppression, clinical care typically transitions to primary care, and HIV becomes secondary in focus during routine visits. Patients can receive care from both an HIV clinic and a primary care provider, or primary care can be provided in the HIV clinic. Weight gain is common, especially among patients who begin to receive an INSTI-based regimen combined with TAF, although the mechanism of weight gain remains incompletely understood. Patients should be followed for coexisting conditions, including obesity, diabetes mellitus and other metabolic disorders, cancer, and cardiovascular, renal, and hepatic disease. These disorders occur more frequently and at a younger age in patients with successfully treated HIV infection than in age-matched controls.

**Areas of Uncertainty**

More than 42% of new HIV infections are transmitted by persons who are known to be infected with HIV but who are no longer receiving care; this fact underscores the need for effective strategies for retention in care. Best practices to achieve this goal are still being developed. Centralized care, the use of bilingual, bicultural teams, clinical-based buprenorphine treatment for patients with concomitant opioid use disorders, specialized services for the transition from jail to

<table>
<thead>
<tr>
<th>Table 2. Current Recommended Initial Oral ART for Most Persons with HIV Infection</th>
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<tbody>
<tr>
<td><strong>Regimen and Dose</strong></td>
</tr>
<tr>
<td><strong>No. 1</strong></td>
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<tr>
<td><strong>No. 2</strong></td>
</tr>
<tr>
<td><strong>No. 3</strong></td>
</tr>
</tbody>
</table>
The diagnosis through routine opt-out screening in the emergency department underscores the benefit of this approach, because otherwise this diagnosis would probably have been made much later. An appointment at an HIV clinic should be scheduled within 1 week after diagnosis for a baseline evaluation (a detailed social history taking and laboratory testing, including testing for other sexually transmitted infections, and assessment of the CD4 count and viral load) and prompt initiation of ART, and she should be referred for management of substance abuse. She should be counseled regarding disclosure of her HIV status to trusted persons and sexual partners, the importance of using condoms and avoiding needle sharing to reduce disease transmission, the need to continue to receive ART as prescribed and to return for follow-up, and the expectation of a near normal life span if viral suppression is achieved and maintained. In subsequent appointments, adherence to and any adverse effects of ART, as well as substance use and other social factors that might interfere with adherence to ongoing treatment, should be routinely assessed.

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I thank Donna Zarrazi for technical assistance and Donna Jacobson for editorial assistance with an earlier draft of the manuscript.

GUIDELINES

Professional guidelines regarding screening,11,15 the selection of an ART regimen for individual patients,16 and primary care for patients with HIV infection17 are available. The recommendations presented here are concordant with these guidelines.

REFERENCES

10. Saag MS, Gandhi RT, Hoy JL, et al. Antiretroviral drugs for treatment and clinical,16 behavioral interventions,18 and enhanced patient contact through navigator programs18 have been successful. Calling patients on the telephone if they do not show up for scheduled appointments is one of the most effective means of retaining patients in care.19,20 An intervention that involved brochures, posters, and short verbal messages conveying the importance of continued health care visits was associated with a higher incidence of return for subsequent appointments than no such intervention.19,20

With the success of ART over the past 2.5 decades, the population of persons with HIV infection is aging. In the United States, more than 50% of the patients receiving care for HIV infection are older than 50 years of age; 18% are older than 60 years, and older persons with HIV infection are at higher risk for poor health outcomes than persons of similar age without HIV infection.21 Incident cardiovascular, kidney, neurocognitive, and mental health disorders occur at younger ages in persons with HIV infection than in age-matched controls. Older patients with HIV infection tend to have worse outcomes than younger patients because of the increased likelihood of polypharmacy,22 frailty,23 social isolation,24 and stigma.25 More data are needed to guide the care of patients as they age.

"complex-disease-view-full.
surveillance-supplemental-report-vol25-

"pdf).
47. Bakai DK, Gosling LE, Luz PM, et al. Obesity following ART initiation is common and influenced by both traditional and HIV-ART-specific risk factors. J Anti-

"301.
51. Lucas GM, Chaouthy A, Hue J, et al. Clinic-based treatment of opioid-depen-
dent HIV-infected patients versus referral to an opioid treatment program: a ran-
domized trial. Ann Intern Med 2015;162:

"74-81.
55. Eaton EE, Xue S, Magugu M. Engage-
gment in human immunodeficiency virus care: linkage, retention, and antire-

49. Groyon SR, Horowitz LI, Covinsky KE, Gordon E, Old ME, Justice AC. Does so-
50. Lam A, Moy HE, Scott S, Breslin JB, Fellows LR. HIV-related stigma af-
fec
t
t
t
t
51. Brown SR, Kennedy C. AAPF recom-
mends universal screening for HIV infec-
52. Quesen A, Snow V, Sheppel D, Hop-
kins B, de Vries GK. Screening for HIV in emer-
gency health care settings: a guidance state-
ment from the American College of Physi-
53. U.S. Preventive Services Task Force. Human immunodeficiency virus (HIV) in-
uspstestreviewsupporttaskforce.org/usp-
st-recommendation/human-immunode-
fective-virus-hiv-infection-screening).
54. Thompson MA, Hoiberg MA, Apgar AL, et al. Primary care guidance for peo-
ple with human immunodeficiency virus: 2020 update by the HIV Medicine Associa-
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December 10, 2007 — 7 words
A — 1 word
Duluth, MN 55812 — 3 words

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Send CV — 2 words
October 10, 2007 — 7 words
A — 1 word
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The physician chosen will work part-time (1/2 day per week, 1 day every 2 weeks) as Transplant Nephrologist under the umbrella of the Nephrology Section in the Medicine Service Line. S/he will provide comprehensive nephrology transplant care services including history taking, physical examination, ordering laboratories and diagnostic studies and diagnosing and formulating treatment plans for acute and chronic conditions within the scope of Medicine, Nephrology and Transplant Nephrology practice.

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Interested candidates should submit their curriculum vitae via The Federal Government’s Official Jobs Site at
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 referencing Number: 91570182-15049-2021-05-14.

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- Board eligible or board certified in Internal Medicine.
- Experience in HIV care.
- Experience in treating complex cases of HIV/AIDS.

**Salary:**

Salary will be determined based on experience.

**Email:**

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- **Conduct research and publication in the area of HIV/AIDS.**
- **Conduct research in the area of HIV/AIDS and related conditions.**

**Salary:**

Salary will be determined based on experience.

**Email:**

Email all questions to the attention of Lauren Broome, Provider Recruitment Coordinator, at Lauren.Broome@cha.org.

The University of Maryland School of Medicine is seeking two additional full-time academic palliative medicine physicians to join our expanding program. Successful candidates will be board certified/highly skilled in Internal Medicine and also trained in Palliative Medicine. Teaching and research or quality improvement experience is preferred.

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