



The Network
 News
 December 2008
 Issue #105

OREGON HIV/AIDS CASE MANAGEMENT

Social Security Q & A

By Alan Edwards, Social Security Public Affairs Specialist in Oregon

SUPPLEMENTAL SECURITY INCOME

Question:

Is it true that a person can own a home and still be eligible for Supplemental Security Income (SSI) benefits?

Answer:

Yes, a person who owns a home and lives in that home can be eligible for SSI benefits. To be eligible for SSI a person must have no more than \$2,000 in countable resources (or \$3,000 for a married couple). But we usually don't count things like:
 The home you live in;
 Your personal effects and household goods;
 Some life insurance policies, depending on their value; and
 Your car.

To learn more about what kinds of resources do and don't count, see our publication, *Supplemental Security Income* online at <http://www.socialsecurity.gov/pubs/11000.html>. You can request that we mail you a copy by calling 1-800-772-1213 (TTY 1-800-325-0778), or stop by your local Social Security office to pick one up.

Question:

I'm in the hospital and my Supplemental Security Income (SSI) was reduced. I've been here for a month and the doctor says I'll be getting out in a few weeks. How can I pay my monthly bills without my SSI?

Answer:

In most cases, if you live in a medical institution where your needs are being met, you cannot receive your full SSI payment during those months. But in some cases, you can continue to receive your full SSI payment while you're in a hospital — and it sounds like you may be in one of those situations. You may be able to keep getting your full SSI amount during a temporary stay in a medical institution if a doctor certifies that your stay is expected to be three months or less, and you maintain and pay expenses -associated with permanent living expenses. We must have evidence of the above by the 90th day after you enter the institution or by the date of discharge, whichever is earlier. You should contact your local Social Security office or call us at 1-800-772-1213 (TTY 1-800-325-0778) to discuss this with a representative. For more information, take a look at our publication, *What You Need To Know When You Get Supplemental Security Income (SSI)* at www.socialsecurity.gov/pubs/11011.html, or call us and ask for a copy to be mailed to you.

Next

Case Management
 Network Meeting

January 13,2009

Heroin OD Prevention

**Jessica Guernsey
 Camargo, MPH**

**Multnomah County Health
 Department**

800 NE Oregon



This Column is provided as a public service by Attorney Sarah Patterson (www.sarahpattersonlaw.com), by e-mail: Sarah@sarahpattersonlaw.com, (503) 281-4766. Sarah is a lawyer in private practice and represents claimants with HIV and AIDS in Social Security and SSI disability cases and is not associated with the Social Security Administration

How to Prove Pain in Disability Claims

When we ask people what stops them from working, the most common reason is pain. As anyone who has experienced it knows, acute pain takes over every corner of your life, hindering physical ability, interfering with concentration and stamina, and causing fatigue. Many people with conditions as diverse as Multiple Sclerosis, Lupus, Fibromyalgia, migraines and lumbar disc disease are in this situation.

For Social Security disability and SSI claims, documenting and proving the severity and impact of pain is often the most critical element in winning a case.

As common as pain is as a symptom, it cannot be objectively measured. It can be very difficult to convince Social Security that a claimant is disabled on this basis alone. However, Social Security has a rule (Social Security Ruling 96-7p) which sets standards that decision-makers must follow when a claimant tells them that pain is a factor in disability.

The rule cautions that before any complaints of pain can be considered there must be an underlying condition -- medical signs and laboratory findings establishing that the person has a "medically determinable physical or mental impairment" which could be expected to cause some degree of the pain. Chronic pain of unknown origin simply cannot be the basis for a disability finding.

Assuming an underlying diagnosis can be established, the rule states that the decision maker must carefully consider all allegations of pain. The severity of the person's pain must be determined and the impact of the pain on ability to function must be assessed.

The rule also makes the important point that a person's level of pain may be greater than is suggested by the objective medical evidence alone, and that the person's statements about pain, even though subjective, must be carefully considered along with the medical information in the file. The patient's credibility is key.

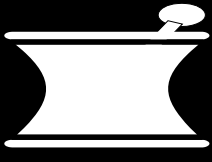
In deciding what to accept from the claimant's statements about pain, the decision-maker must determine if the testimony is consistent with the medical reports, treatment notes, and evidence of the claimant's activities.

Often there are psychological factors such as reactive depression or post-traumatic stress involved in pain cases. These can affect the claimant's pain tolerance. In some cases, the claimant may have a somatoform disorder, converting psychological problems into very genuine pain.

There are multiple factors at work in pain cases. In order for a claim to be successful, they all must be fully developed and documented. Contact us for help in developing this essential evidence.

Workshops on SSI/SSD Rules

We are available to conduct workshops or short training meetings, tailored to the needs of your office staff. There is no charge for this. Please call our office to make arrangements for inservice training, or talks to groups and organizations on any area of Social Security disability law.



Ask DEBBY:

What are some options for first line treatment?

In the past couple of years there have been several new medicines that have become available for those who are treatment experienced and in need of new treatment options. These new medications are either 'second generation' meds in existing classes of ARV or represent completely different mechanisms of fighting the HIV virus. Until recently, we did not have information available regarding use of these newer medicines as first line therapy for HIV. Below I summarize some newer data. At this point, only darunavir (Prezista) has been approved for use in treatment naïve.

Maraviroc: The MERIT trial compared Combivir plus either Sustiva (efavirenz) or Selzentry (maraviroc) as first line therapy. The previously published data has been reanalyzed. Prior to using maraviroc, a special test is required to determine which co-receptor the virus uses for cell entry, only in those with R5 tropic virus should Maraviroc be used. The test originally used in conjunction with this study was not very sensitive, meaning that there could be presence of R4 virus that was not detected. A test that is much more sensitive is now available, an enhanced Trofile assay (Monogram Biosciences). Rerunning baseline tests led to a reclassification of 15% of those previously classed as virologic failures, they were found to have mixture of R5 and R4 prior to starting. With the reanalysis, using the enhanced assay, both groups had the same results, 68% vs. 68% with undetectable viral load. More patients discontinued drug on the basis of adverse drug reactions in the efavirenz group (14%) compared with of maraviroc recipients (4%).

Darunavir: The ARTEMIS study is a comparison of Truvada given with Kaletra (800/200 mg total daily dose) to Prezista (800/100 mg of darunavir/ritonavir once a day) in treatment naïve. The 96-week data results showed 79% in the Prezista group had a VL<50 compared to 71% in the Kaletra group. Both were well tolerated, with 4 percent of darunavir recipients and 9% of lopinavir recipients discontinuing for adverse drug reactions. As a result of this data, Prezista 400mg tablets were approved for use in treatment naïve, given as two 400mg tablets boosted with 100mg ritonavir. The dose for treatment experienced remains 600mg twice daily with ritonavir.

Raltegravir: There are a couple trials published looking at using raltegravir in treatment naïve, comparing it to efavirenz, both showing similar results. One smaller study by investigator Martin Markowitz evaluated the efficacy, safety, and tolerability of multiple doses of raltegravir, versus [efavirenz \(Sustiva\)](#), both combined with [tenofovir \(Viread\)](#) plus [lamivudine \(EpiVir\)](#). Patients received doses of 100, 200, 400, or 600 mg raltegravir twice a day for the first 48 weeks in the dose-ranging portion of the study. All participants were switched to 400 mg twice a day after week 48 for continuation of the trial. At the 96 week point, 83% of the patients receiving raltegravir and 84% of the patients receiving efavirenz maintained HIV RNA levels of lower than 50.

A larger trial called STARTMRK was presented at this year's ICAAC/IDSA Annual Meeting. Treatment-naïve patients were screened for resistance, then enrolled to take either raltegravir (400 mg twice daily) or efavirenz (600 mg every day at bedtime) in addition to tenofovir and emtricitabine. Using an intent-to-treat analysis, where dropouts for any reason were counted as failures, 86% of the raltegravir and 82% of the efavirenz groups achieved a viral load of less than 50. This small difference is not statistically significant.

*Ask Debby is graciously provided by Debby Parrish, Rph, MPA:HA
A pharmacist who specializes in HIV*



Comings and Goings

Beginning in January 2009, CAP's internal structure will look a bit different. CAP is reorganizing to be more efficient and cost effective and will go from having three departments to only two departments. CAP will now have a Department of Prevention and Education and a Department of Housing and Support Services.

As a result of this reorganization, Gloria Willis will no longer hold the position of Supportive Housing and Care Services Team Lead. Gloria has been an asset to CAP providing clinical supervision of the Housing Case Managers and ongoing support and leadership during the implementation of the Oregon Housing and Behavioral Health Initiative (OHBHI) and the Latino - Minority AIDS Initiative grants

Fuzeon Information Group ending

After 4 years of offering the Fuzeon Information, the leaders of the group have decided that the need for this group has changed and we are in the process of developing a education/support group for all Persons Living with HIV/AIDS who take any type of self injection medication-Fuzeon, Interferon, Insulin, Testosterone, etc.

The group will be held on the 4th Tuesdays of the month at 1-2:30 p.m. starting January 27th, 2009.

Space has graciously been donated by Our House, 2727 SE Alder St

A special thank you to Toni Kempner, RN and Fred Schaich for being part of the development and implementation of this group as well as Marilee Smith and Marty Crittendon of Kaiser for their work on this group. A continued thank you to Julee Graven, RN and Mary Clark, RN for their energy and expertise that they bring to this group.

Thank you especially to all those who attended and shared your incredible stories. You were all the best teachers for me.

Julia Lager- Mesulam, LCSW
Partnership Project Director

This newsletter is published by OHSU/ Partnership Project. Our thanks to Kim Lewis and Myrna Walking Eagle for their patient proofreading Jan Johnston for assembling and mailing, Barbara Danel for website posting and to the Department of Human Services, Health Services for providing the printing and postage. The editor is Julia Lager-Mesulam.

Comments / questions about this publication should be directed to:

Julia Lager-Mesulam at lagermes@ohsu.edu, or call (503) 230-1202, FAX (503) 230-1213, 5525 SE Milwaukie Ave. Portland, OR 97202

This issue, and issues from Feb 2002 on, can be found electronically at <http://egov.oregon.gov/DHS/ph/hiv/vices/.shtml>