

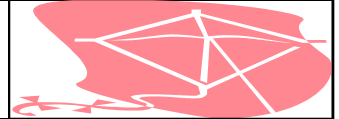


The Network News

February
2007
Issue # 82

OREGON HIV/AIDS CASE MANAGEMENT

Thanks for the update on the Resource Guides to Jennifer Snarski and to Alison Goldstein, LCSW and Jessica Guernsey, MPH for their informative presentation on Motivational Interviewing.



PLEASE NOTE

The network meeting on March 13th will be held at Metropolitan Community Church 2400 NE Broadway. A map can be found at www.mccportland.com/directions.htm

The remainder of the 2007 meetings will be back at the State Office Building 800 NE Oregon.

Next Meeting

March 13, 2007

Dealing with Psychotic Clients

**Metropolitan Community Church
2400 NE Broadway**

8:30 to 10:30 a.m.

PN STUDY SUPPORTS MEDICAL MARIJUANA *(AIDSmeds.com)*

A study conducted by veteran HIV researcher Donald Abrams, MD, and his colleagues at the University California, San Francisco (UCSF), suggests that smoking marijuana is safe and effective for the management of chronic pain associated with peripheral neuropathy in HIV-positive people. Based on these encouraging results, HIV/AIDS groups and other healthcare advocacy organizations have begun calling for congressional hearings to push for national legalization of cannabis for medical purposes.

From AIDSmed.com February 13, 2007 http://www.aidsmeds.com/articles/1667_11275.shtml

EDITORIALS, OPINION PIECES RESPOND TO IMPACT OF HIV/AIDS ON U.S. BLACKS

Access this story and related links online:
http://www.kaisernetwork.org/daily_reports/rep_index.cfm?DR_ID=42947

Newspapers recently have published editorials and opinion pieces on the impact of HIV/AIDS on blacks in the U.S. Feb. 7 marked the seventh annual National Black HIV/AIDS Awareness Day, which aimed to encourage blacks to get tested for HIV, become educated about the virus and receive treatment if necessary. According to CDC data from 33 states published in November 2005 in the Morbidity and Mortality Weekly Report, the rate of new HIV cases among blacks has decreased an average of 5% annually since 2001, declining from 88.7 cases per 100,000 people in 2001 to 76.3 cases per 100,000 in 2004. However, blacks in 2004 were 8.4 times more likely than whites to be newly diagnosed with HIV. Blacks -- who make up about 12.3% of the U.S. population in 2004 accounted for about 49% of the estimated number of reported AIDS cases nationwide. In addition, HIV/AIDS in 2002 was the leading cause of death for black women ages 25 to 34; was among the top three causes of death for black men ages 25 to 54; and was among the top four causes of death for black women ages 25 to 54. National Black HIV/AIDS Awareness Day is sponsored by the Community Capacity Building Coalition, a consortium of national minority-focused groups supported by CDC's Division of HIV/AIDS Prevention.

(Kaiser Daily HIV/AIDS Report 1/7)

We are planning in upcoming issues to highlight individuals who are working with HIV/AIDS in Title II areas. If you know of someone or a group that is making a difference in a part of the state outside the Portland EMA, please contact me with their information and story. Thank you.
Rick Stoller, 503-230-1202, stollerr@ohsu.edu



This Column is provide 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 representing claimants with HIV, and is not associated with the Social Security Administration.

NEW RULING ON “ACCEPTABLE MEDICAL EVIDENCE”

Late in 2006, Social Security issued a helpful new Ruling about “acceptable medical evidence,” **considerably broadening the scope of evidence allowed in a disability case claim.** This has always been a problematic area in Social Security law – particularly for the many patients who receive much of their care from nurse practitioners or physicians’ assistants.

In the past, treatment notes from licensed sources such as chiropractors, or even some therapists , were not given “substantial weight” in a disability determination. Only records from physicians, licensed psychologists or other certain “acceptable” medical sources having an “ongoing treatment relationship” with the claimant were considered valid.

The new ruling still requires that the **underlying diagnosis be provided by a physician** – the existence of the impairment must be certified in this way. But the **severity and ongoing functional limitations may now be demonstrated by treatment notes and letters from other medical personnel.** Before this ruling, Social Security could disregard anything but physician evidence. Sometimes that meant that the only evidence in the file might be an consultative examination provided by Social Security.

The new ruling recognizes that these non-physician treating sources have “increasingly assumed a greater percentage of the treatment and evaluation functions previously handled by physicians and psychologists.” These highly trained professionals are providing most of the treatment and care for Americans. Social Security has finally recognized this fact. This regulatory change may open doors long-closed to our clients who receive health care in clinic settings, where treatment by a physician can be rare.

The “other sources” which are now acceptable for providing legitimate and binding evidence are nurse practitioners, physicians’ assistants, psychiatric social workers and some therapists. Next in evidentiary importance are teachers, counselors or social welfare agency staff–non-medical people acting in their professional capacities. Of lesser importance, but still valued, would be information from lay witnesses such as spouses, clergy, friends and employers. Any opinion evidence provided is judged by its consistency with other evidence, length of relationship, and degree to which the opinion is supported by other medical records.

All information submitted has a cumulative effect. If, for example, there are numerous letters from friends and neighbors observing a person’s daily actions reflecting a psychiatric problem, it adds detail that may be missing from the paper record. The medical record still must provide an impairment diagnosis, but these details are like brush strokes that allow the decision-maker to paint a picture of the real, whole person. Now all of these sources are seen as “very valuable sources of evidence for assessing impairment severity and functioning.”



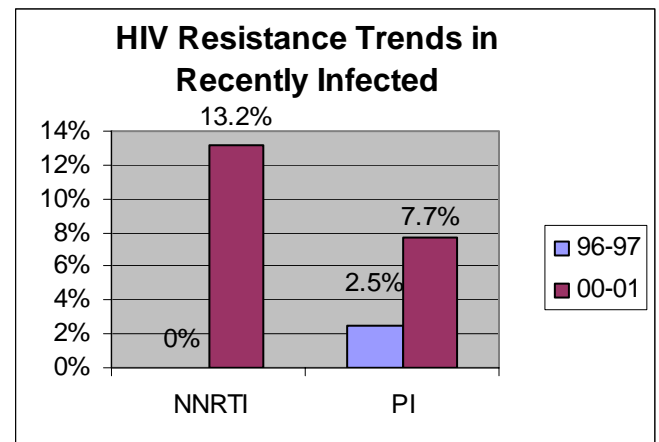
ASK DEBBY:

My doctor has recommended I start HIV meds, How are the medications to use as initial therapy chosen?

IS IT POSSIBLE TO TRANSMIT RESISTANCE TO HIV MEDICATIONS ?

There is increasing evidence that resistant HIV can be transmitted to newly infected individuals, a phenomenon known as primary drug resistance. The HIV treatment guidelines from the US Dept of Health and Human Services recommends conducting drug resistance testing prior starting treatment, preferably as close to diagnosis as possible. Because over time the initial drug resistant HIV can be obscured by the overgrowth of a non-resistant viral strain (called wild-type).

The presence of resistance to HIV meds at baseline can result in suboptimal virologic response to initial antiretroviral therapy and influence the time to viral suppression during therapy. Trends in HIV resistance were reported from 225 patients referred to a San Francisco, CA hospital with recent HIV infection, from June 1996 through June 2001. Mutations associated with resistance to non-nucleoside reverse transcriptase inhibitors (NNRTIs) rose steadily from the 1996-1997 period to 2000-2001 (**See graph**). Protease inhibitor resistance in 1996-1997 was 2.5% and 7.7% in 2000-2001. Resistance to nucleoside reverse transcriptase inhibitors (NRTIs) initially decreased and then returned to prior levels. Resistance to 2 or more classes of drugs increased from 2.5% to 13.2%. This demonstrates that the frequency of primary resistance to NNRTIs is increasing, although resistance to all available classes (MDR = multi-drug resistance) of antiretroviral therapy remains rare (*Grant et al. JAMA.2002; 288: 181-188*).



A more recent publication presented data from 103 people diagnosed in 2005 with newly acquired HIV showed 12% had a mutation associated with resistance to the NNRTI class and 2% had a evidence of resistance to the PI class. Overall, resistance mutations were present in 25% of the cases. This compares to 8-20% in previous studies. (*Smith et al; CID Feb 1, 2007*)

Last month, King County Public Health was in the news, reporting cases of multi-drug resistance HIV virus in the Seattle area. Seattle/King County has been conducting resistance surveillance since mid-2003. 16 or 3% of cases have been found to be multi-drug resistant viruses. Four of them seem to be very similar viruses; authorities are investigating further because this is a very significant finding. Overall, high level resistance to one or more ARV is running about 11%.

The State of Oregon does not have a resistance surveillance system. Public Health officials are investigating to determine if there are any similar MDR viruses found in Oregon.

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

Comings and Goings

CAP welcomes John Motter as their Public Policy Coordinator.

BENEFITS

* New data from the Centers for Medicare & Medicaid Services (CMS) find that generic use is especially high among those in the new Medicare drug benefit, with generics accounting for nearly 60 percent (59.6 percent) of the drugs dispensed to people in Medicare Prescription Drug Plans (PDP's) and Medicare Advantage (MA) plans through the third quarter of 2006. www.CMS.HHS.gov (2/8/07)

* The Centers for Medicare & Medicaid Services (CMS) will waive the penalty for late Part D enrollment for people eligible for the Extra Help program in 2007. The late enrollment penalty is assessed if a person eligible for the Part D benefit does not enroll within a specified period of time and does not have other coverage that is as good as the Part D benefit. The late penalty is set at 1 percent of the average national premium for every month enrollment was delayed. Without the waiver, individuals with the full low-income subsidy would have had to pay 20 percent of that amount.

http://www.rcilinc.org/index.php?option=com_content&task=view&id=24&Itemid=2

* Medicare Advantage Plans are health plan options that are part of the Medicare program. These Medicare plans are offered by private insurance companies and pay for the same health care services as Original Medicare. But they might also pay for additional services that aren't covered by Original Medicare. Some plans cover prescription drugs. In some Medicare Advantage plans (like a Health Maintenance Organization), you may only be able to see certain doctors or go to certain hospitals to get covered services. You can join or switch Medicare Advantage Plans from January 1st to March 31, each year, but you cannot add or drop Medicare prescription drug coverage during this time. For example, if you are currently enrolled in a Medicare Advantage Plan with prescription drug coverage, you can switch to Original Medicare, but you'd also have to join a Medicare Prescription Drug Plan. To compare Medicare Advantage Plans and Medicare Prescription Drug Plans that are available in your area, visit www.medicare.gov <http://www.medicare.gov> or call Medicare at 1-800-633-4227. Once you have decided on a plan, contact the plan to find out more information and to enroll. Once you enroll, the plan will let you know when your new coverage begins.

* This month's "Frequently Asked Question"

Q: If a person who has Medicare has a private insurance policy and thus opted out of Medicare B, will the person be penalized if they need Part B in the future? Will the letter showing that they had uninterrupted creditable coverage, keep them from being penalized?

A: The only way of avoiding a penalty for not enrolling in Part B is if they or their spouse, are still working and have coverage equivalent to Part B through their current insurance. Your Medicare Part B premium may go up 10 percent for each 12 month period that you could have had Medicare Part B, but did not take it. For example, in 2005, the Medicare Part B premium is \$78.20 per month. If you delayed enrolling in Medicare Part B for 24 months from the time you first could have had Medicare Part B, your premium in 2005 would be \$93.84 per month. January 1—March 31 of each year is the General Enrollment Period. If you enroll in Part B during a General Enrollment Period, it will be effective July 1 of the year in which you apply. A client can enroll in Part B by calling the Social Security Office at 1800-772-1213 from 7am - 7pm.

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Comments and questions about this publication should be directed to: Rick Stoller at stollerr@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/services/news.shtml>