

INTEGRATING HIV-PREVENTION STRATEGIES INTO CLINICAL PRACTICE

OIL AND WATER, Republican and Democrat, HIV prevention and HIV patient care delivery. Separate and incompatible? How can a busy clinician ever hope to integrate prevention for this complex and complicated disease into the context of primary or urgency/ER care? With the remarkable improvement in HIV/AIDS prognosis and many people with HIV living longer, it is imperative that prevention strategies keep pace. Currently, most HIV prevention programs are available through local county health departments or HIV-focused community-based organizations. In contrast, most HIV-positive people in Oregon receive their medical care from private practice clinics, and the linkages between prevention services and clinical care may not occur.

Like the immune system, effective prevention efforts require a multi-layered and overlapping set of strategies for diverse populations. These include sound policies promoting HIV risk reduction, access to health and social services, condom use, availability of sterile needles and syringes, interventions shown to motivate behavioral change including abstinence, HIV prevention by organizations capable of reaching people at risk, facilitating adherence to complicated medication schedules, and the diffusion of technologies to interrupt viral spread.¹ Integration of prevention into primary care is an outgrowth of the evolving "biopsychosocial" model of comprehensive health care.² With vaccines only a distant hope, prevention strategies must still focus on behavior-based approaches. The U.S. Public Health Service has set as a goal that 75% of primary care and mental health providers offer age-appropriate counseling on preventing HIV and other sexually transmitted diseases.

The four main barriers to HIV prevention in clinical care are: 1) narrow concepts of medical care and the role of the physician, 2) physicians' discomfort with issues raised by HIV and attitudes toward

patients, 3) practical constraints of time and resources, and 4) ambiguities inherent in HIV prevention messages.

Some clinicians see their role exclusively in disease management and would leave the HIV prevention role to "someone else." Historically, the rewards and incentives in health care have been weighted in favor of delivering acute, problem-oriented care. Managed care is changing these priorities, but the millennium is not yet here. The economic incentives of prevention alone are compelling; each infection that doesn't occur saves ~\$10,000 per person-year in medical care costs. Particularly in managed care settings, support for HIV prevention could be modeled after successful smoking cessation campaigns.

In a recent survey,* many clinicians reported a lack of enthusiasm for asking patients about their sexual practices, perhaps out of concern about offending them. In another study—a real one—physician reported asking 75% of their patients screening questions about general health risks, but only 11% about risks for HIV infection and other STDs.³ Yet perhaps it is the doctors who are the squeamish ones; when patients were surveyed, fewer than 5% actually objected to discussing HIV or STD prevention in this setting. Care providers are human, and as such many bring personal biases against certain behaviors into the exam room. Discomfort with or outright prejudice against gay men, persons using injection drugs, or women with multiple sex partners can be addressed through continuing provider education, referrals, skill building in culturally informed interactions, and, if necessary, electroshock therapy.

If you hadn't noticed, a busy clinic schedule is not conducive to extensive patient counseling and education. Education messages need not be all or none. Identifying realistic objectives to reduce if not eliminate risk may be the best one can

do for many patients.⁴ For patients with challenging risk prevention problems, the use of prevention case managers and focused, client-centered behavioral change counseling is effective.⁵

A final barrier is uncertainty about the actual or relative risk of various "risk behaviors" and the effectiveness of prevention strategies. There is always a need for better data, but we are no longer operating in a vacuum about everything. Some components of current public health campaigns have been evaluated in multiple settings, such as the identification, screening and treatment of sexually active patients for STDs, and the referral of injection drug users to needle exchange programs. Other areas are less well studied: the impact of antiviral therapy on the rate of HIV transmission, for example. Persons with low or undetectable viral loads may be less likely to transmit HIV, but they may also be tempted to resume risky sexual practices.

Primary prevention means reducing the number of new HIV infections. Programs that focus on identified risk behaviors have been successful, and support for risk reduction for HIV-positive persons is an increasingly important part of those programs. Secondary prevention focuses on reducing the risk of the complications that cause morbidity and mortality in people who are HIV-positive. Both primary and secondary prevention can have a dramatic impact in terms of reduced costs. Were only 30% of the estimated 300 new infections in Oregon each year prevented, the cost savings would be at over \$1,000,000 annually.

PREVENTION INTERVENTIONS

Primary care prevention can be done as health education rather than a psychological intervention. In a relatively small period of time, the provider can effectively: 1) help the patient assess their risk, 2) refer patients for more extensive counseling, 3) reinforce good prevention practices, and 4) determine the patient's interest in changing behavior. Having a standard set of scripted questions regarding risk behaviors is very

* To be submitted to JAMA for expedited publication.

helpful during the review of systems. You can ask your patient; "Are you currently sexually active?" and if the answer is yes, ask "do you have sex with men, women, or both?*" A question about the number of past sexual partners, their potential HIV risk, and the use of injection drugs can round out a basic but effective 90-second HIV/STD risk assessment.

When clinicians and counselors encourage or discuss prevention strategies rather than give lectures, patients are more likely to demonstrate reduced HIV and STD risk. Ask your patient what level of risk-reduction behavior change is achievable, and what the time frame could be. Then formalize the agreement by writing a "prescription" for the prevention activity. Examples might be, "I will use condoms with all sexual intercourse," or a harm reduction message like, "I will use only clean needles." The prescription might also include a referral to the local county health department for more in-depth prevention counseling. Pamphlets and educational materials demonstrating the correct use of condoms and how to secure sterile injections equipment or clean rigs before reuse are available from local county health departments or the HIV/STD/TB program. Referrals to mental health providers who offer individual counseling directed at sustained behavior change for those who are most challenged is appropriate for selected clients. Finally, clinicians play a major role in reinforcing high level adherence to antiviral medication regimens. With this prevention "Rx," a clinic or ER

* Now if the answer to *that* one is "yes," you may want to modify your approach.

visit is an important added opportunity to reduce the spread of HIV and other STDs.

REFERENCES

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Breaking Measles Outbreak; Details on Web Site

IT'S BACK. First one, then two, and now four cases of measles have been lab-confirmed in the past few days in the Portland area. An additional six suspicious cases—some of them epidemiologically linked to the confirmed cases—have serology results pending. These are the first cases in Oregon since 1996, when 14 were diagnosed.

Every single one of these individuals has a history of wandering in and out of a variety of medical offices, clinics, or emergency rooms during the days before and after rash onset (i.e., during the communicable phase of their infection)—not to mention the occasional school, mall, church, etc. The incubation period from exposure to rash onset is typically about 14 days, although patients are shedding virus for several days before (and after) rash onset. IgM's become positive within 3-4 days of rash onset.

Clinicians are urged to watch for signs and symptoms of measles in patients who present with history of fever and rash,

with or without the classic triad of cough, coryza, and conjunctivitis. Patients with possible measles should be immediately isolated, and you must notify your local health department directly. Do not wait for serological confirmation!

Space limitations preclude a complete review of measles and its implications for our readers in this issue. Our web site (<http://www.ohd.hr.state.or.us/cdpe/acd/welcome.htm>) will feature special information for health care professionals on this evolving outbreak, including recommendations for immunizations, targeting high risk contacts for immune globulin administration, up-to-date outbreak body counts, and more. If you don't have internet/web access, call. Or better yet, get it.

Northwest AIDS Education and Training Centers

THE HEALTH DIVISION has teamed up with Multnomah County's HIV Clinical Services and the University of Washington to offer primary care providers state-of-the-art HIV/AIDS training. In a one-day, clinic-based experience, primary care clinicians can sharpen their skills in HIV diagnosis and management under the watchful eye of an experienced mentor. The objectives are to improve skills in combination anti-viral management, diagnosing early stages of HIV disease, and learning the values of care coordination and HIV case management. In addition, practical approaches to patient risk assessment, adherence and prevention will be discussed. If you are interested in participating, please call Mark Loveless, MD or Jan Johnston at 503/731-4029. CME credits and travel reimbursements are available.