

LINKAGE TO MEDICAL CARE FOR HIV-POSITIVE PEOPLE

The development of effective antiviral treatment for HIV infection makes it possible to dramatically improve clinical outcomes for patients infected with HIV. Treatment also is an important tool for preventing the spread of HIV, since the reduction in viral load caused by treatment makes patients less infectious, and because a visit to a health-care provider for medication also provides opportunities for prevention-oriented behavioral counseling. Despite the compelling case for treatment we know that some HIV infected patients either do not initiate care or discontinue it. This issue of the *CD Summary* describes our attempts to quantify how many HIV-infected people in Oregon are not in care, and to describe the reasons for their not receiving care.

INITIATING CARE

One hundred and ninety-five Oregon clinicians were sent surveys about the health-care status of patients who had tested HIV-positive over a one-year period (Nov. 16, 1999–Nov. 15, 2000); 118 (61%) of those surveys were returned to us. Of those patients for whom health care status was known by the clinician (n=80), 6% were not receiving HIV medical care within three months of their diagnosis. This is likely to be an underestimate of the true number who are not in care because it is probable that those patients with an unknown care status (n=38) are more likely to be out of care than are those whose care status is known.

DISCONTINUING CARE

According to recent federal guidelines, measurement of plasma HIV RNA (viral load) is recommended every 3–4 months and measurement of CD4 t-cells is recommended every 3–6 months.¹ Given these standards, patients who had not received HIV medi-

cal care for longer than six months were considered to have discontinued their care. Data on discontinuing care were obtained from three independent sources: an examination of 1,125 Oregon Health Plan (Medicaid) claims records for HIV-positive patients in one 18-month period, a survey of 287 HIV-positive clients of Cascade AIDS Project, and telephone follow-up of 415 patients of Multnomah County's HIV Health Services Center. All three of these data sources agree that 3–5% of HIV-positive Oregonians discontinue their medical care.

REASONS FOR LACK OF MEDICAL CARE

Using qualitative methods, researchers interviewed 15 HIV-positive people who were not receiving medical care about the reasons they were not accessing care. All were low-income and two-thirds were uninsured. Respondents often cited multiple reasons for their lack of medical care, including: lack of health insurance; avoidance related to HIV status, HIV medications, or the possibility of additional health problems; health care system barriers such as poor provider relationships or inability to access the health care system; and social and legal barriers such as homelessness, active substance abuse, or undocumented immigration status.

SUMMARY AND IMPLICATIONS

Based on the studies described above, we estimate that at least 9–11% of HIV-positive Oregonians are not receiving appropriate care for their infection, either because they have not initiated care (3–5%) or because they have discontinued their care (at least 6%).

One of the most striking incidental findings of the Initiation of Care study described above is the large number of patients (38/118, 32%) for whom it was not known whether they sought care

after their diagnosis. One of the core functions of the public health system is to assure that the services and programs necessary to protect the public's health are in place and functioning.² The introduction this past October of name-to-code reporting of HIV infections in Oregon will give public health another tool with which they can help assure that HIV-infected patients are provided treatment for their infection. When a case is reported, public health staff contact the reporting clinician to help assure that the clinician's questions about treatment are answered, and to facilitate linkage of the patient with ongoing medical care and case management. If the patient is lost to follow-up because the clinician does not have an ongoing relationship with the patient, public health staff can help try to find the patient and assure that he or she has access to appropriate treatment and case management. In addition, public health staff can help with partner notification if desired.

Many of the barriers to care cited by those interviewed might have been reduced through the intervention of a case manager. Case managers typically provide information, coordination of clinical and support services, and patient advocacy. Case managers can work to ensure that co-morbid conditions (such as psychological problems or substance abuse) and social factors (such as homelessness) are addressed. In Oregon, access to case management services is provided through programs funded by the federal "Ryan White" CARE Act. Clinicians who want to help ensure that their patients are linked to case management services in the Portland metro area may contact the Partnership Project/Cascade AIDS Project Intake Team (503/517-3590); for other areas of the state, contact



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DHS Health Services' HIV Client Services Program (503/731-4029) or the local county health department.

Additional information about treatment for HIV-infected patients, access to health insurance for HIV-infected patients, access to HIV-related medications, or reporting of HIV infections can also be obtained from DHS Health Services' HIV/STD/TB Program at 503/731-4029.

REFERENCES

1. Department of Health and Human Services, Panel on Clinical Practices for Treatment of HIV Infection. Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents. August 13, 2001.
2. Institute of Medicine, Division of Health Care Services, Committee for the Study of the Future of Public Health. The future of public health. National Academy Press, Washington, DC, 1988.

Influenza Arrives

EIGHT CULTURE-CONFIRMED cases of influenza type A have been reported: 6 by the Oregon State Public Health Laboratory and 2 by the Providence Portland Medical Center Infectious Disease Laboratory. Cases were scattered across Oregon: one in Deschutes County, three in Jackson County, one in Multnomah County, two in Washington County, and one lacking a designated county. Ages ranged from 4 to 56 years with 4 (50%) aged 40 years or more. Dates of specimen collection ranged from 11/26/01 to 12/20/01. At this same time during the past season, we had received reports of 26 culture-confirmed influenza cases. Nationally, 97% of isolates tested this season by the Centers for Disease Control and Prevention were found to be

type A, of which 97% were A(H3N2) and the remainder A(H1N1). A and B isolates studied thus far were antigenically similar to the current vaccine strains.

For information on flu, including weekly postings of culture-confirmed cases by county, go to our web page at <http://www.oshd.org/acd/docs/influenza.htm>.

2001 CD Summary Topics (by issue)

1. Bioterrorism: could it happen here?
2. Whither polio; Measles reappears
3. Tobacco prevention: it's working on many levels; School exclusion deadline looms
4. Identifying and preventing youth's suicidal behavior
5. Recommended childhood immunization schedule; Meningococcal disease in Oregon
6. The other pox: varicella vaccine update; Shortage of Td
7. Death certificates and you (the certifying physician)
8. Keeping kids alive: what's killing kids in Oregon?
9. Colorectal cancer
10. Annual communicable disease review
11. Are we losing ground in HIV prevention?
12. Something in the air (and the water, and the food...)
13. Arthritis swelling among Oregonians ;Td vaccine shortage alert
14. Foodborne disease: an extra short primer for physicians
15. Proposed changes to disease reporting and other rules
16. Influenza vaccine education and prioritization plan 2001-2002
17. Happy and health-wise: measuring health-related quality of life
18. Too much of the good life—cardiovascular disease in Oregon
19. HIV reporting begins October 1, 2001; Flu surveillance opens
20. Abortion trends in Oregon
21. Preparations for blitz-katarrh; Shortage of Td and TT
22. Bioterrorism: priority agents
23. Boost 'em before you buckle 'em ; Oxycodone deaths in Oregon
24. Breast cancer in Oregon — update
25. Oregon's campaign to promote judicious use of antibiotics ; New vaccine guidelines
26. What about smallpox?
27. An on going tuberculosis outbreak in Oregon; Remicade (infliximab) alert stimulates a reminder