

OREGON PUBLIC HEALTH DIVISION • DEPARTMENT OF HUMAN SERVICES

GETTING HIV PATIENTS INTO CARE AND KEEPING THEM THERE

Medical care for HIV not only helps the individual patient, but also helps others; since Highly Active Antiretroviral Therapy (HAART) reduces infectiousness, it also helps reduce the spread of HIV. But while treatment for HIV can be lifesaving, its benefits can't be realized if patients don't access care, don't do so regularly, or don't stay on their prescribed medications. What can health care providers do to help get HIV infected patients into care, and help them stay with it? This issue of the *CD Summary* summarizes what we know about this problem, and describes some tools providers can use to address it.

HOW BIG IS THE PROBLEM?

The Centers for Disease Control and Prevention (CDC) estimates that approximately one third of people living with HIV in the U.S. who know their HIV status do not receive any HIV medical care.¹ In addition, of those who have engaged in care, CDC estimates that 17%-40% cycle in and out of care and therefore receive less than the recommended number of HIV primary care visits, emergency department visits that do not lead to hospitalization, or do not receive HAART when clinically indicated.^{2,3}

In a recent multi-site national study, Oregonians and participants from nine other states with HIV who received suboptimal HIV primary care were demographically very similar to those who were not at all engaged in care. Patients who receive suboptimal or no primary care for HIV are more likely to come from population groups in which the HIV epidemic is spreading most rapidly: they are more likely to be people of color, low income, uninsured or on Medicaid, women, people with mental health or substance abuse disorders, homeless or unstably housed individuals, and adolescents.^{2,3,4,5,6}

For example, Blacks/African Americans account for 2% and Hispan-

ics 10% of Oregon's population yet the two groups combined accounted for 19% of all new diagnoses during 2005, with Blacks/African Americans at 9% and Hispanics at 11%.

WHY AREN'T THEY IN CARE?

Why aren't people in care when HIV care is more widely available in the United States than in other parts of the world? The barriers are the same in Oregon as they are around the US. Racial and ethnic disparities in access to health care services are well documented, and these disparities are further compounded by age, gender, and a host of barriers to care. These barriers can be grouped into three groups: structural (e.g., unavailable or inconveniently located services, long appointment waiting times, inconvenient appointment times, speaking a different language than your provider, and competing subsistence needs such as food, housing, and transportation), financial (e.g., lack of insurance, underinsurance, or cost of obtaining

services), and personal/cultural (e.g., knowledge, attitudes, beliefs, racism, language, sexism, and homophobia).

ENGAGING THE UNENGAGED

The Health Resources and Services Administration has identified outreach as an important service delivery strategy to engage underserved individuals in HIV care. For example, in a recent five-year, multi-site study, each of the 10 sites employed professionally trained peers or near-peers to do outreach to HIV-infected patients. These "care coordinators" or "health navigators" worked in medical or community-based settings and used patient-centered approaches such as education, goal planning behavior change counseling, and service coordination to identify and link out-of-care patients with HIV primary care. These approaches included working with patients to set their own health care goals as well as helping them navigate the often overwhelming system of care.

Table 1. Changes over time in service utilization and health outcome measures, n = 105 participants

Outcome	Assessment	Sample size	% with outcome	Adjusted ¹ OR (95% CI)
≥ 2 medical visits in past 6 months	Baseline	92	62%	1
	6-month follow-up	99	85%	3.39 [1.84 – 6.25]
	12-month follow-up	84	73%	1.64 [0.93 – 2.90]
CD4 or VL test done in past 6 months	Baseline	94	74%	1
	6-month follow-up	96	90%	2.96 [1.27 - 6.91]
	12-month follow-up	83	82%	1.56 [0.75 - 3.22]
CD4 ≥ 200	Baseline	66	68%	1
	6-month follow-up	84	75%	1.45 [0.94 – 2.23]
	12-month follow-up	67	80%	1.89 [1.23 – 2.88]
Undetectable VL	Baseline	67	23%	1
	6-month follow-up	84	36%	1.92 [1.00 – 3.70]
	12-month follow-up	67	42%	2.49 [1.20 – 5.13]

VL, viral load; OR, odds ratio; CI, confident interval

¹ORs and 95% CIs based on generalized linear mixed models; and adjusted for gender, being Latino, age, education, income, being an injection drug user, being incarcerated, time since HIV positive, and study withdrawal.

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Data from the CareLink program, an outreach project implemented by Cascade AIDS Project in the Portland metropolitan area, provides compelling evidence to suggest that outreach interventions to HIV-infected people who are not fully engaged in care improve both service utilization and health outcomes. For patients who participated in the program, the odds of having at least two medical visits and of having a CD4 and viral load (VL) test performed were almost three times higher at the 6 month follow-up than baseline. Patients who received this intervention also had significantly higher odds of having a CD4 count of at least 200 and an undetectable VL.

WHAT CAN PROVIDERS DO?

In many counties across Oregon, HIV case managers are available through county health departments or other contracted agencies to help health care providers engage and retain patients in HIV care. To find out how the HIV case management system works in your area, contact the Oregon AIDS Hotline at 1-800-777-2437 or visit www.oregonaidshotline.com. In the Portland metropolitan area, HIV care providers can access additional resources to help connect and retain their patients in HIV primary care through the CareLink program by contacting Gloria Willis at Cascade AIDS Project (503-223-5907 or gwillis@cascadeaids.org).

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2007–08 Influenza Season Update

Oregon's first case of influenza was identified during this season's first week (September 30–October 6). However, since then, only 12 more cases have been confirmed by PCR or culture; 8 were influenza A, and four were influenza B.

CDC has characterized 30 influenza A viruses this season. Nineteen were A/Solomon Islands/3/2006, the H1 component of the 2007–08 vaccine. Eleven were influenza A (H3) viruses; four were A/Wisconsin/67/2005-like, the H3 component of the 2007–08 vaccine, and seven were A/Brisbane/10/2007-like, a recent antigenic variant of the Wisconsin virus.

Nationally, three influenza B viruses (including one from Oregon) have been characterized, and all are of the B/Yamagata lineage. The influenza B component in 2007–08 influenza vaccine is B/Malaysia/2506/2004-like, belonging to the B/Victoria lineage.

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