



PARTNERSHIP PROJECT

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OREGON HIV / AIDS CASE MANAGEMENT

Special Column from Portland Minority AIDS Initiative Program of Partnership Project

My name is Catherine Azouyangui, Partnership Project MAI case manager that works with Africans/ African Americans. I am originally from Central Africa Republic. I have lived in the USA since 2003 and was granted political asylum in 2004. I provide medical case management for African American and African immigrant clients living with HIV that have needs that impact their ability to connect or maintain connection to healthcare. I want to thank Lutheran Community Services NW and Partnership Project for giving me the opportunity to serve in our community. Most of the clients I work with are African Immigrants and refugees. Some are from rural areas. They have no experience working with a health worker and their traditional beliefs can cause conflicts. What they have witnessed in the refugee camps lead to Post Traumatic Stress Disorder. There are different approaches based on culture and country of origin. HIV and mental health remains taboo. They come from different backgrounds: Teachers, nurses, doctors, lawyers, community leaders, etc... Because of war, political unrest or many other reasons they end up in this beautiful country, facing a different diet and having to learn a new language with little social support. I relate to them in so many ways. I became homeless in my own country due to political unrest. I was separated from most of my family members for many months and had very little contact with them. I lost my friends, my job, and did not have any money, nothing to eat or clean water to drink. I witnessed crimes and other injustices, fighting everyday for my life, because I belonged to a particular tribe that was not in power politically. I really understand what refugees go through; because I lived it. HIV is the second most devastating challenge they're facing. My goal is to help them and their families cope with emotional and life challenges. I also help them to try and live a normal life.

When I meet with a client for the first time, we usually don't talk about HIV. I always tell them who I am and what I do for living. I listen attentively. Prior to the first visit, I think about a funny story, anything to get the clients attention. Most of the time we laugh so much and I end up learning a lot about my client in one day than I could ever imagine. It creates a relationship and builds trust. The client will be the first to ask me "when will I see you again?" Social support contributes hugely to health. Refugees feel isolated and don't have experience in telling people what is going on with their lives.

Here is one example of my work:

HIV was a myth according to a client I am working with. She had refused to take ARV for the past couple of years. She denied being HIV positive and stated her doctor is trying to have her try some medicine for a clinical trial. I explained to her why ARV is important. She got very upset. She had other needs that seem to be more important than her health. I got the news that she had been very ill, I called and she agreed I could come to visit. When she walked out of her room I barely recognized her. She appeared very sick. She was complaining about everything (providers, nurses) and she had developed lots of opportunistic infections. After over an hour discussion, she finally understood that something needed to be done as soon as possible. She realized that she made a mistake by not seeking care. She also realized that her children are more important than her own self pity and she would do anything for them. I could not let the client spend another day without taking ARV, she agreed to start. She then refused to go by taxi. She suggested taking the bus. It took us a whole day to go by bus to her clinic and come back. The client didn't have food to eat prior taking her meds. I drove to the store and bought some food for her and her kids. The client is feeling much better and has gained her weight back. She has told me that she would be dead by now if I didn't come to get her out of her house and help her to understand that she was making a mistake by not listening to her providers.

Each of our clients is special and unique. It had been a blessing working with them and I look forward to more referrals. It touches my heart to I think about a client who depended on welfare to provide for their family and is now working and paying their own bills; that a client who did not know they could ever disclose their status to their partner but has now; that a client who was working prostitution, but has now stopped and is focusing on her health and believing in her future; that a client who was so lonely and now has someone to call; that a client experiencing domestic violence who has finally spoken up; that a client who had never worn a condom and has testified he is now wearing one to protect himself and others; that the many that I did not list, to those who I have not yet connected no matter how much I have tried I will not quit.

Catherine Azouyangui, MAI CM

Next

Case Management
Network Meeting
800 NE Oregon

June meeting is cancelled

July meeting will be
on July 14th



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

When is Kidney Disease Disabling?

Kidney disease may cause **severe impairment of renal function and functional capacity**. The question of disability turns on the severity of symptoms.

Many people go on **working with moderate symptoms for years**. The disorders caused by kidney disease may **eventually result in limitations** that affect a person's ability to **work on a full-time basis**, and that is when the disability benefit application should be considered.

Chronic kidney disease has **many causes**, among which are **high blood pressure** and **diabetes**. It is hereditary, and some ethnic groups are more prone to be affected. It can trigger **edema, pain, neuropathy and weight fluctuation**. Kidney disease is typically controlled by medication, but tends to worsen as years go by. The illness is considered as a "genitourinary impairment" under the regulations. The disability **must have lasted, or be expected to last for a continuous 12 months**.

If a patient is under **dialysis treatment**, or had or needs a **kidney transplant**, a **claim should be granted quickly** at the application level. The new **Compassionate Allowance** policies for some kidney cancers also **allow rapid favorable decisions**. We can help you be sure **everything is lined up to facilitate this**.

Social Security considers a patient **disabled for 12 months after transplant surgery because of immunosuppression** and the danger of rejection. On a more subtle level, renal disease can be the basis of **severe neuropathies** that can qualify a claimant for benefits.

To decide whether an individual is disabled from kidney disease, **SSA considers symptoms, physical finding signs and laboratory results**. Medications for this constellation of illnesses have notable **side effects**, including **high blood pressure**, profound **fatigue, nausea, diarrhea** and **weight loss**. Steroids have their own set of daily side effects, and can cause long-term bone loss.

There are other common **genitourinary impairments that are considered severe** enough to qualify for benefits. If the illness does not exactly meet this regulation's criteria, Social Security must also consider whether the impairment fits into a "**combination of impairments**" that are disabling.

Careful analysis is required to evaluate whether the **limitations from kidney disease will result in an award of benefits**. We would be glad to consult with you on any of your patients or clients who are experiencing these conditions.

Special Column from Portland Minority AIDS Initiative Program of Cascade AIDS Project

My work with the Minority AIDS Initiative program at Cascade AIDS Project

My name is Pedro Ortega and I am the Cascade AIDS Project MAI case manager. I provide support to HIV case managers that are working with Latinos clients that are in need of intensive medical case management. I am able to provide in-home, flexible, intensive case management services to those clients who need this extra support to maintain adequate medical care.

I have worked with over 20 clients since the RW MAI case management program was implemented. My assistance has helped clients stabilize their care and improve their general well being. Clients that are more engaged in their medical case management services are more likely to improve their overall situation. I spend a great deal of time linking clients to services including providing transportation to medical and other HIV related appointments and assisting them with interpretation at these service locations.

Below there are 2 summaries from 2 experiences that I hope will describe some of the work I do in my role as a MAI case manager. Client names have been changed to protect confidentiality

Case 1: Jose Manuel was chronically homeless and seriously ill when his Partnership Project case manager contacted CAP for an emergency medical voucher. I came to work with Jose Manuel through an internal CAP referral. I arranged for ongoing emergency shelter in a motel while long-term housing options were explored. I was also able to connect Jose Manuel with mental health services through a joint project between CAP and Cascadia. "Jose Manuel's" mental illness played a significant role in his difficulty engaging fully in medical care and maintaining housing. When Jose Manuel expressed his dissatisfaction with the mental health care provider I helped him schedule assessments with two other mental health care providers. Today, Jose Manuel is living in long-term housing and receives mental health care services from a provider of his choice. With this support he has been able to fully engage in HIV medical care.

Case 2: When Marco was first referred to CAP MAI, he had recently broken his leg. I met Marco during a home visit. He was living in a metal tool shed, the only amenity a mattress on the floor. Temperatures had been over 90 degrees for three days. It was even warmer inside the tool shed. Marcelino remained inside because his injury made it difficult to move about. I helped Marco into my air-conditioned car and drove around until the temperatures dropped to a bearable level. The next day, Saturday, I arranged a motel voucher for him I accompanied him to numerous medical appointments until a second surgery was performed. I showed Marco how to use Tri-met to get to medical appointments, CAP offices, the HIV Day Center and to look for an apartment. Within three months Marco was able to secure a Shelter Plus Care housing voucher and found a comfortable apartment. He was able to stabilize his health including being able to walk again, unfortunately, 8 months later he ended up incarcerated due to involvement in a stabbing incident.

As the above case scenarios illustrate, some of the challenges that case managers find when they are working with Latinos in addition to HIV include coming from a different culture (less likely to express weakness, cure placed in faith, family priority) language barriers, discrimination, stigma, isolation, homelessness to some clients just not wanting to engage in services and to some of them struggling with erratic behavior. Other very difficult challenges are that most clients lack legal status, most are unemployed or have very unstable employment. All of these barriers are influencing how they are able to adhere to medications and remain connected to medical care and case management.

Overall, my work with MAI has been instrumental in assisting the current case management system to meet the needs of this community. When I see the joy when I ask them about how their medical appointments went, I see that my work is having a positive impact. When they are prepared to ask the doctor their questions, they seemed pleased and are happier, especially if they communicate their needs to the doctor without the need for an interpreter. I think that being able to communicate with their medical providers improves their self-confidence therefore improving their overall health.



Comings and Goings....

We wish all the Social Work interns, Rachel, Victor and Jennifer, in the HIV community the best of luck in their new career

IN TIMES LIKE THESE, EVERY DOLLAR COUNTS

By Alan Edwards, Social Security Public Affairs Specialist

Fathers are often known for their good advice, whether it's how to catch a ball, ace a job interview, grill the perfect burger or get the best deal on a new car.

But if your father is struggling with the high cost of prescription drugs, maybe it's time for you to give him a few words of advice. This Father's Day, you may be able to help your dad save an average of \$3,900 a year on his prescription drug costs. Here's how.

If your father, or any father figure you know, is covered by Medicare and has limited income and resources, he may qualify for extra help - available through Social Security - to pay part of his monthly premiums, annual deductibles and prescription co-payments. The extra help is worth an average of \$3,900 per year.

To figure out whether your father is eligible, Social Security needs to know his income and the value of his savings, investments and real estate (other than the home he lives in). To qualify for the extra help, he must be receiving Medicare and also have:

* Income limited to \$16,245 for an individual or \$21,855 for a married couple living together. Even if his annual income is higher, he still may be able to get some help with monthly premiums, annual deductibles and prescription co-payments. Some examples where income may be higher include if he or his wife:

- Support other family members who live with them;
- Have earnings from work; or
- Live in Alaska or Hawaii; and

* Resources limited to \$12,510 for an individual or \$25,010 for a married couple living together. Resources include such things as bank accounts, stocks and bonds. We do not count his house or car as resources.

Social Security has an easy-to-use online application that you can help complete. You can find it at www.socialsecurity.gov/prescriptionhelp.

To apply by phone or have an application mailed to you, call Social Security at 1-800-772-1213 (TTY 1-800-325-0778) and ask for the Application for Help with Medicare Prescription Drug Plan Costs (SSA-1020). Or go to the nearest Social Security office.

To learn more about the Medicare prescription drug plans and special enrollment periods, visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048).

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