



WestCAP WORDS

WESTERN COLORADO AIDS PROJECT

805 Main Street, Grand Junction, CO 81501

(970) 243-2437 or 1-800-765-8594

May-June 2010

“There are endless possibilities in every present moment...”

Important Numbers:

WestCAP:
(970) 243-2437
1-800-765-8594

website:
www.westcap.info

ADAP program:
1-866-499-2879

HIV/AIDS Treatment Information Service:
1-800-448-0440

CDC National Hotline:
800-342-2437 (English);
800-344-SIDA (en español);
800-243-7889 (for people who have a hearing impairment)

Western Colorado HIV Specialty Care Clinic:
Lucy Graham: 255-1735, or
toll-free @ 866/448-8383

Office Hours
are
Monday-Friday,
8:30 AM-5:00 PM.

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CAN WE DO BETTER.....?

WestCAP is undergoing a challenging process and asking ourselves if there is a better way to measure the quality of work that we provide to our clients. Between our Prevention Department and our Case Management Department, we continue to reach over 3,000 individuals annually, alleviating the stressors of living with HIV and reducing the transmission of HIV.

Each program has its own way of measuring effectiveness. The Prevention Department conducts focus groups and surveys and works with an outside agency to help create tools to evaluate this work. The Case Management Department conducts an annual Client Satisfaction Survey (which will be in mailboxes soon!), which provides feedback on the quality of care services. But is there more that we can do? This is the question we should always be asking and WestCAP is asking this now.

“Everything can be improved.” C.W. Barron.

This is the premise from which WestCAP is working and to “improve,” the first step will be to develop new ways for our clients to provide feedback. In order to improve what we do, we need to hear from our clients! WestCAP now has a group of consumers working with our agency to help! There is no one better who can see the strengths and the gaps of programs than those individuals receiving them. So, we need you! We need your input, thoughts, and insight so that we can continue to serve better. This group is open to individuals who currently receive services or who have received services in the past. What better way to make a difference?

There is some great discussion about creative ways to receive important client feedback and ways to improve what this agency can offer. I hope you can be a

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part of this effort! If you are interested in becoming a part of the consumer group, please call our office for more details! This is just the beginning!

—Mary Beth Luedtke, Executive Director

THE HEALTHCARE BILL AND YOU

As most of you know, landmark legislation was passed during the week of March 21st. Congress passed, and President Obama signed into law, the “Healthcare Reform Act.” Since that time, I have fielded several questions about the bill and what it means to our clients. Honestly, before writing this article I—like most Americans—didn’t know the key points, so I took it upon myself to research the bill and report back what I had found.

First, the bill is rather lengthy, over 2,000 pages. If you are interested in reading the document yourself, I invite you to look at http://docs.house.gov/rules/hr4872/111_hr3590_engrossed.pdf. The rest of this article will discuss the key points of the law. The following points were found at http://www.qctimes.com/article_30ba44a6-3492-11df-bdb8-001cc4c03286.html.

- **INSURANCE MANDATE:** As of 2014, almost everyone will be required to be insured or else pay a fine. There is an exemption for low-income people.
- **INSURANCE MARKET REFORMS:** Starting this year, insurers are forbidden from: placing lifetime dollar limits on policies, denying coverage to children because of pre-existing conditions, and canceling policies because someone gets sick. Additionally, parents would be able to place their children (up to age 26) on their coverage. A new high-risk pool would offer coverage to the uninsured with medical problems until 2014 (when there is coverage expansion). Insurers cannot deny coverage due to medical problems or charge more. Insurers cannot charge women more.
- **MEDICAID:** Expand the federal-state Medicaid insurance program for the poor to cover people with incomes up to 133 percent of the federal poverty level, \$14,404/year or \$1,200 a month for one person, or \$29,327/year or \$2,444 for a family of four. Childless adults would be covered starting in 2014. The federal government would pay 100 percent of costs for covering newly eligible individuals through 2016.
- **TAXES:** Taxes on high insurances would be delayed until 2018, and the thresholds at which it is imposed would be \$10,200 for individuals and \$27,500 for families. The bill applies an increased payroll tax to investment income as well as wages for individuals making more than \$200,000, or married couples above \$250,000. The tax on investment income would be 3.8 percent.
- **PRESCRIPTION DRUGS:** Gradually closes the “doughnut hole” coverage gap in the Medicare prescription drug benefit, once you have spent \$2,830. Those who hit the gap this year will receive a \$250 rebate. In 2011, those in the gap receive a discount on brand name drugs, initially 50 percent off. When the gap is completely eliminated in 2020, you will still be responsible for 25 percent of the cost of medications until Medicare’s catastrophic coverage kicks in.

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- **EMPLOYER RESPONSIBILITY:** Businesses are not required to offer coverage. Instead, employers are hit with a fee if the government subsidizes their workers' coverage. The \$2,000-per-employee fee would be assessed on the company's entire work force, minus an allowance. Companies with 50 or fewer workers are exempt from the requirement.
- **SUBSIDIES:** Tax credits for purchasing insurance. The aid is available on a sliding scale for households making up to four times the federal poverty level, \$43,320/year or \$3,610/month for one person or \$88,200/year or \$7,350 for a family of four. Premiums for a family of four making \$44,000 would be capped at around 6 percent of income.
- **HOW YOU CHOOSE YOUR HEALTH INSURANCE:** Small businesses, the self-employed, and the uninsured could pick a plan offered through new state-based purchasing pools called exchanges, opening for business in 2014. The exchanges would offer the same kind of purchasing power that employees of big companies benefit from. People working for medium-to-large firms would not see major changes. But if they lose their jobs or strike out on their own, they may be eligible for subsidized coverage through the exchange.
- **GOVERNMENT-RUN PLAN:** No government-run insurance plan. People purchasing coverage through the new insurance exchanges would have the option of signing up for national plans overseen by the federal office that manages the health plans available to members of Congress. Those plans would be private, but one would have to be nonprofit.
- **ABORTION:** No health plan would be required to offer coverage for abortion. In plans that do cover abortion, policyholders would have to pay for it separately, and that money would have to be kept in a separate account from taxpayer money. States could ban abortion coverage in plans offered through the exchange. Exceptions would be made for cases of rape, incest, and danger to the life of the mother.

So what does this all mean? First, you must have medical coverage (unless you are in the "low income" bracket). You cannot be denied coverage due to a "pre-existing" condition, and you cannot pay more than other people. Some taxes will increase, but overall there is an expected cost savings for America. Most of the changes will not start going into effect until 2014, so we have time to get used to the changes. On a final note, several states, including Colorado, have decided to question the Constitutionality of the Healthcare Bill. So in the end, the article gives a good outline of what is to come but there is still a lot we just have to wait and see what happens. If you would like to know more about the legislation, then please go to <http://edlabor.house.gov/blog/2010/03/affordable-health-care-for-ame.shtml>, and research. As Paul Harris once said, "Individuals and nations owe it to themselves and the world to become informed."

—Crystal Luce, Client Services Advisor

CLIENT SERVICES

CASE MANAGEMENT TIDBITS

ADAP CHANGES

- Pharmacy Change: The AIDS Drug Assistance Program for Colorado has recently changed pharmacies. For many years, The Apothecary Pharmacy in Boulder has been providing HIV medications to people enrolled in ADAP. As of April 1 of this year, the pharmacy at The Rose Clinic will be providing ADAP medications both at that location and by mail order.
- Formulary Change: There have been some changes to the formulary of medications that are covered by ADAP. For a list of ADAP medications provided, go to: www.cdphe.state.co.us/dc/hivandstd/RyanWhite/adap.html or speak with your case manager or clinic staff. There may be other options available for assistance with medications that are not on the formulary. A great resource for “Patient Assistance Programs” for non-HIV medications is: www.needymeds.org

RETREATS: Shadowcliff retreat is coming up. They are accepting registrations. Talk with your case manager for more information or to request assistance.

“Be who you are and say what you feel, because those who mind don’t matter and those who matter don’t mind..”
—Dr. Seuss

ARE YOU STAYING ADHERENT? I INVITE YOU TO TAKE THIS QUIZ TO CHECK...

1. Should you take your meds. every day at the same time?
2. Should every HIV-positive person be on HIV meds.?
3. If you miss a dose, should you take an extra dose the next day?
4. If you have a glass of wine with dinner, should you still take your meds.?
5. Should a person who is HIV-positive start and stop and stop HIV meds.?

Answers

1. Yes, you should take your meds. every day at the same time.
2. No, it depends on their DC4 count and viral load.
3. No, do not take an extra dose.
4. Yes, take your meds. even if you have a drink, but don’t drink so much you forget to take your meds.
5. No, once a person starts taking meds., it is a lifetime commitment.

—Jenny Vargas, Client Services Advisor

PREVENTION

The first public health term for the HIV epidemic (in 1981) was GRID, Gay-Related Immunodeficiency Disease. In July of that year, the New York Times reported an outbreak of “gay cancer” among men in New York and California. A CDC (Centers for Disease Control) report quoted in the newspaper article stated, “There is no apparent danger to non-homosexuals from contagion. The best evidence against contagion is that no cases have been reported to date outside the homosexual community or in women.” However, in 1983 the CDC reported, “The cause of AIDS is unknown, but it seems most likely to be caused by an agent transmitted by intimate sexual contact, through contaminated needles, or, less commonly, by percutaneous inoculation of infectious blood or blood products.” By 1985, HIV (Human Immuno-Deficiency Virus) had been diagnosed as the cause of AIDS and 33 countries confirmed cases of the virus that was once limited to New York and California, specifically gay men in those states.

Decades later, there is evidence to suggest that HIV is once again being labeled “a gay man’s disease.” From 2001 through 2006, according to the CDC, male-to-male sexual transmission was the largest HIV transmission category in the United States. Further, in 2006 (the latest full year for which this CDC data is available), MSM (men who have sex with men) was the only risk category for which HIV/AIDS cases was increasing. In addition, according to a 2010 CDC study, the rate of new HIV diagnoses among MSM is more than 44 times that of other men and more than 40 times that of women. (There is more about this in the article on the next page.)

However, HIV demographic trends have changed since the early 1980s and the virus currently affects communities of color in the U.S. like never before. According to the CDC, blacks represent almost 12 percent of the U.S. population but 48 percent of all new HIV cases in the nation. In addition, HIV/AIDS related illnesses are the leading cause of death for black women aged 35-44.

In a POZ magazine article, Phil Wilson, the founder and CEO of the Black AIDS Institute, stated, “The vast majority of the leadership in the AIDS movement in the mid-’80s was white, gay men, and their anger and intensity was also born out of a sense of entitlement. The fact the country didn’t care they were dying was a shock to them because they grew up with privilege based on race and gender. For black people who grew up in a world where you’re reminded every day that the norm is that folks don’t care about you, it is difficult to have that same kind of rage and urgency.” Distrust of the system and lack of access to resources may increase the sense of isolation and shame that black gay men may already feel because of cultural, social, and community norms.

Based on surveillance data, black MSM are at increased risk. A study conducted by the DC HIV/AIDS Administration in 2008 and released in March 2010 indicates that black MSM account for more than 60 percent of the city’s HIV/AIDS cases while white MSM comprise 35 percent. Avert.org reports that HIV rates among young black MSM in major cities approach 50 percent, a rate more than twice that of white MSM (21 percent). In addition, CDC-sanctioned surveys in six U.S. cities show that black gay/bisexual men are eight times more likely than white men to be unaware of their HIV status.

The HIV prevention message is clear, regardless of the ethnicity or race of MSM at risk. “There is no single or simple solution for reducing HIV ... rates among gay and bisexual men,” said Kevin Fenton, MD, director of the CDC’s National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. “Solutions for young gay and bisexual men are especially critical, so that HIV does not inadvertently become a rite of passage for each new generation of gay men.”

—Rabeeha Ghaffar, Prevention Program Director

PREVENTION



Grand Valley ManREACH
RURAL EDUCATION IN ACTION
FOR COMMUNITY HEALTH

Grand Valley ManREACH fosters a sense of community among gay, bisexual, and questioning men in a safe, healthy environment free of alcohol and drugs.

We host social events every month and informational workshops every three months.

For a calendar of events, visit www.manreach.org and click on WestCAP or call Scott at 970-243-2437.

Upcoming Events

Saturday, April 17th
Glenwood Caverns Trip
51000 2 Rivers Plaza Road
in Glenwood Springs - 11:00am
Carpool from WestCAP at 9:00am
Call Scott to RSVP at 970-243-2437.

Saturday, April 24th
Conversational Dinner
Before Mesa State GSA Drag Show
Time and Location TBD
More information will be sent out to everyone on the GV MR e-mail list.
Please contact Scott with questions.

Saturday, May 8th
River Rafting
Rimrock Adventures
927 17 Road in Fruita
Time TBD
More information will be sent out to everyone on the GV MR e-mail list.

CDC ANALYSIS PROVIDES NEW LOOK AT DISPROPORTIONATE IMPACT OF HIV AND SYPHILIS AMONG U.S. GAY AND BISEXUAL MEN

A data analysis released [3/10/10] by the Centers for Disease Control and Prevention [CDC] underscores the disproportionate impact of HIV and syphilis among gay and bisexual men in the United States.

The data, presented at CDC's 2010 National STD Prevention Conference, finds that the rate of new HIV diagnoses among men who have sex with men (MSM) is more than 44 times that of other men and more than 40 times that of women.

The range was 522-989 cases of new HIV diagnoses per 100,000 MSM vs. 12 per 100,000 other men and 13 per 100,000 women.

The rate of primary and secondary syphilis among MSM is more than 46 times that of other men and more than 71 times that of women, the analysis says. The range was 91-173 cases per 100,000 MSM vs. 2 per 100,000 other men and 1 per 100,000 women.

While CDC data have shown for several years that gay and bisexual men make up the majority of new HIV and new syphilis infections, CDC has estimated the rates of these diseases for the first time based on new estimates of the size of the U.S. population of MSM. Because disease rates account for differences in the size of populations being compared, rates provide a reliable method for assessing health disparities between populations.

"While the heavy toll of HIV and syphilis among gay and bisexual men has been long recognized, this analysis shows just how stark the health disparities are between this and other populations," said Kevin Fenton, M.D., director of CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. "It is clear that we will not be able to stop the U.S. HIV epidemic until every affected community, along with health officials nationwide, prioritize the needs of gay and bisexual men with HIV prevention efforts."

—from the CDC's 3/10/10 Press Release