Acquired Immune Deficiency Syndrome and Community and Migrant Health Centers: A Preliminary Statement

Clinical Task Force
NACHC Health Policy Committee
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I. Introduction

Clinicians at Community and Migrant Health Centers (C/MHCs) note with rising concern the prevalence of Acquired Immune Deficiency Syndrome (AIDS) in the communities their centers serve. NACHC staff was asked in March to study the potential impact of AIDS on C/MHCs. The Clinical Task Force was assigned this responsibility. We offer this statement for review by the Association and for consideration by health centers.

II. Center Administration and Policies

A. The C/MHC Mission

AIDS clearly falls within the mission of Community and Migrant Health Centers, both as a disease and in light of its health impact on the population our centers were established to serve. C/MHCs exist to provide, directly and indirectly, effective, efficient and comprehensive primary care treatment for all diseases in our service population, and AIDS is a disease for which primary care can provide a substantial portion of the treatment required. Whether AIDS spreads widely into the general population or not, the numbers of cases of this fatal and debilitating disease will, according to expert sources, continue to increase substantially nationwide, for years to come. The low-income population in this country includes many of those clinically found to be at high risk for this disease. Moreover, social and educational disadvantages in this population increase the vulnerability of its members to the disease through lack of awareness of preventive measures, as the rest of the nation responds to this new threat. Centers are well positioned and well qualified to address both clinical vulnerability and the need for education.

B. Resources

Centers cannot meet this risk alone, however. Others in the health care delivery system of the nation have already been identified for receipt of massive infusions of funding for treatment needs posed by AIDS, as well as to address the research, education, and counseling needs it presents. Primary care treatment is a clinically acknowledged component of the overall treatment for AIDS, however, and one important to realizing overall savings for the nation as the number of cases and thus total cost for treatment increases.

NACHC staff and the Task Force have begun to obtain access to the networks through which this funding is flowing, to apprise them of the potential value of including C/MHCs in their funding plans and to clarify that provider agencies closest to the populations in need must be included in both externally-funded demonstrations of recommended service mix and in public health system treatment plans now under development.

The DHHS Public Health Service Task Force on AIDS, which currently provides $20 million for service demonstration and education projects, has included C/MHCs in the list of projects with which their grantees are instructed to coordinate. Several applicants for the education grants, which will operate regional centers, have proposed clinical advisory boards for their projects which include NACHC Clinical Task Force members.

The Centers for Disease Control recently announced a $7 million program for AIDS education in minority communities. NACHC will assist centers in obtaining access to this program. In addition, legislation is pending in Congress which would direct far more substantial funding to C/MHCs specifically, for AIDS-related services.

Other sources of funds and demonstration initiatives remain to be contacted, including foundations and state legislatures. Clinical and administrative staff at Centers, and State and Regional Associations, and NACHC, should develop formalized efforts to obtain new funding for AIDS services in the near future.

C. Legal Concerns

Strict confidentiality is a requirement in patient relations concerning AIDS due to its terminal nature, long incubation period, and high health care costs. Once a test proves positive, a person must face both the private emotional trauma of the

prospect of dying, and at the same time many arenas of social discrimination which can rapidly appear. Health centers, although already familiar with confidentiality procedures, must now develop procedures to assure that they are not responsible for the unauthorized release of information which could cost someone their job, their housing, or their health care coverage.

Recent and pending programs for AIDS treatment include strong safeguards for this confidentiality. Centers will have to provide them in order to receive funding and offer these needed treatment services.

Formal facility operations procedures must also be put in place where they do not already exist, for legal and clinical reasons. The CDC Clinical Guidelines "Recommendations for Prevention of HIV Tramsission in Health-Care Settings", first published as a Supplement to CDC's Morbidity and Mortality Weekly Report on August 21, 1987, are provided as an Appendix to this document, and should promptly be reviewed and adhered to by all Community and Migrant Health Centers.

These procedures are part of a complete set of local Center AIDS policies, including confidentiality, infection control, staff training, records handling and information release, and personnel policies. These measures should be developed, approved and implemented as early as possible, as more and more C/MHCs are seeing their first HIV positive patients.

III. Education and Training

A. Introduction

C/MHCs are uniquely qualified in the primary care system to address the profound community education needs triggered by the AIDS crisis. Additional resources are needed. Even limited increases in educational efforts by C/MHCs may not be possible presently, due to the severe funding constraints placed on non-clinical activities of Centers in recent years by Regional Offices.

B. Planning

Educational efforts on AIDS are needed for the general community and the Center's user population; by the groups at high risk for AIDS in the community, whether already users or not; by

other service agencies; and by board members, administrative employees, and clinical providers. Centers should begin to develop education and training plans to address each of these needs, and identify the resource requirements posed by each.

Centers are called upon to assess their role in the prevention of the spread of AIDS, by providing informed judgment to health planners on the true resource requirements indicated.

C. Community and Patient Education

Centers must be aware of the level of community knowledge of AIDS dangers, including risks associated with specific behavior and the need for concentrated efforts to modify behavior. Those groups in which high risk sexual and drug-related behaviors are found should be particularly targeted for educational efforts.

The original C/MHC concept held outreach as an important cornerstone of the ability of community-based centers to deliver acceptable and comprehensive care in a manner more effective than pre-existing delivery systems. AIDS is forcing a re-examination of the value of outreach. C/MHCs must be positioned to provide sensitive care in their communities, as ever, as this new disease emerges -- regardless of new government actions on AIDS which may affect the lives of their patients. To do this they will have to meet such new challenges with creativity and compassion.

This re-assessment of the need for increased outreach must be a part of the review of additional resource needs. It may also indicate the need for improved and revised relationships with related service providers, such as drug abuse and sexually-transmitted disease clinics.

D. Administration Training

Centers can be learning of and planning to use resources presently available for staff training on AIDS, including BHCDA, NACHC, Regional Office contractors, RCTC, CDC, local educational institutions, and others, so as to put in place as early as possible a training program that is:

1. <u>appropriate</u> - designed specifically for C/MHCs and incorporating staff assignment areas such as records, counseling, patient handling, infection control, referrals and patient education;

2. comprehensive - portrays the primary care role within the larger context of AIDS as a public health crisis, including detection, prevention, in- and outpatient care, and case followup;

3. periodic - regularly scheduled (for example, monthly) sessions, incorporating new knowledge and/or advisories, such that new employees are trained as early as practicable; and

4. formal - part of a complete, sound AIDS personnel protection policy.

E. Clinical Education

Primary care protocols for clinical treatment of AIDS are needed for C/MHCs, especially as part of a quality assurance plan utilizing standardized case management guidelines. The Clinical Task Force has begun to identify forums for the development of clinical protocols for outpatient care of the constellation of diseases and conditions which comprise AIDS and AIDS-Related Complex (ARC). Centers are urged to support this effort by developing/identifying such material and sharing it with NACHC. The Task Force can, through NACHC, assist in identifying and disseminating emerging findings, guidelines and other case management products which can be clinically useful. Affiliations with DHHS/PHS Regional AIDS Education Training Centers, with clinicians' associations, and through NACHC's national linkages will further these efforts in coming months.

IV. Center Operations

A. Counseling

In addition to education, direct services may be called for at levels not presently provided for, both for increases in patient load and for the amount and types of services needed. Counseling is foremost in this arena, due both to the demand posed by increasing availability of HIV testing programs, and because of its diminished availability at C/MHCs over the years. Center directors are urged to begin consideration of estimates of numbers of counselors indicated by projected testing activities affecting the user population, whether testing is through the Center or not, and consequent issues such as effect on total staff composition, recruitment strategies, training programs availability, facilities, and the like.

B. Facilities

Records handling and other facilities operations changes, including accommodating increased counselor capacity, increases in waiting room facilities, and records storage and staff increases, may also be studied by centers as part of planning ways of meeting needs, complying with new requirements, and preserving community acceptability.

V. Conclusion

C/MHCs can and must acknowledge their role in the AIDS crisis. Procedures for infectious disease control are not new in our clinical settings but the time is now for development of thoughtful and comprehensive policies in both clinical and personnel arenas regarding AIDS. Centers should focus on meeting staff and community educational needs that attend this epidemic. Clinicians should assume major educational responsibility and substantial board support should be enlisted to increase staff and community understanding and acceptance of what this epidemic entails in terms of realistic clinical risks for providers and the clinical needs of persons with AIDS. Health centers should take a strong public health advocacy position, acknowledging their communtiy-oriented role in the AIDS crisis and forging strong cooperative linkages with other provider organizations who share health care responsibility within their respective communities.