

Linkages to Care and Treatment in Area I

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Children's Medical Services Pensacola has been providing Medical Sub-specialty care for children both exposed and infected with HIV since 1988. The Area I CMS Infectious Disease program is a part of a statewide network of pediatric HIV/AIDS services for infants, children, and young adults from birth to age 21 who are HIV at-risk, HIV-infected or AIDS diagnosed. Since 1994, CMS funded programs have been established at 16 areas of the state. Children enrolled in the CMS HIV program receive comprehensive medical, social and related services through a network of seven pediatric HIV referral centers and ten outreach clinics. CMS Pensacola and Panama City are outreach clinics.

Currently a pediatric infectious disease physician from the University of Florida travels to Pensacola once a month and to Panama City once a quarter to provide medical sub-specialty care for children assigned to the Infectious Disease (ID) caseload. The children are seen in the CMS clinic using a multi-disciplinary approach to care and follow up. CMS Pensacola/Panama City is the only provider for pediatric infectious disease in the western panhandle.

Necessity mandated that close relationships be created and developed between Children's Medical Services, STD, and HIV surveillance in Pensacola. Over ten years ago these relationships were created and continue to this day. Working together, follow up and linkages to care are verified between CMS, STD, and HIV surveillance. In Area I the surveillance liaison is Scott Mickley and the CMS liaison is myself or the ID nurse care coordinator in my absence.

The ultimate goal of all three programs is to create a network of linkages that ensure medical care and follow up is available to both women and children. Recently a "worst case" scenario occurred involving an infected mother with no prenatal care and an exposed infant who received no Protocol 076 treatment until two weeks after hospital discharge. Surveillance identified an exposed infant, CMS verified that the infant was unknown and not receiving treatment, STD found the family and brought them to CMS for treatment. Without the close professional relationships developed over time this infant could have been lost to care and not found until very ill. This case very graphically demonstrated that something was wrong with the system and stimulated a community meeting bringing major players together. The first meeting was well-attended and brought major stakeholders to the table which is a first for Area I.

CMS also works closely with Surveillance to ensure that reportable criteria are followed on all cases receiving care in our ID clinic. Sadly information is shared with Surveillance when children with AIDS expire.

I recommend that these types of relationships be developed if they do not exist. It is vitally important that each part of the linkage process understand what the other does and what each has to offer. CMS is not typically involved with STD and Surveillance. Many CMS areas do not group exposed and infected infants in a sub-specialty caseload. These cases can be spread out across multiple caseloads with multiple care coordinators. If the linkage process in your area is not fully developed approach the CMS Nurse Director in your area not in a negative fashion but with an interest in "what can we do together" to make this happen. I would suggest a meeting to bring

together CMS, STD, Surveillance, and any contract treating provider to fully discuss and learn what each has to offer.

The ultimate goal is the same for all these very different programs. We all want to provide the best care possible for the most people. We all believe that even one HIV infected child is one child too many. We have the opportunity to try to protect a child by preventing an infection that will bring pain and suffering as well as cost millions of scarce health care dollars.

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