Tri-County CHAIN Presentation to the Title I Steering Committee

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Topics

- How does CHAIN work… briefly
- “Products”
  - Population estimates
  - Strategic Plan Progress Indicators
  - Service Gaps & Utilization
  - Partner Notification
  - Selected Health Analyses
- Refreshing the cohort

Research Team

- Tri-County CHAIN Project, Columbia University
  - David Abramson, Study Director; Barbara Bennet, Field Director; Tasha Stehling, Data Manager; Rachel Ferat, Office Manager & Research Assistant; Sofia Luyando, Rose Rivera, Elizabeth Romero, Interviewers; Sandra Smartt; Dave Hunter, Data Editors
- Technical Review Team -- MHRA, NYC DOHMH, Office of AIDS Policy, HIV Planning Council, Westchester DOH
  - Mary Ann Chiasson, DrPH, MHRA (chair); Angela Aidala, PhD, Columbia; Ken Butler, PWA Advisory Group; Robert Cordero, HIV Planning Council; JoAnn Hilger, NYC DOHMH; Julie Lehane, PhD, Westchester County DOH; Peter Messeri, PhD, Columbia; Jennifer Nelson, MHRA
- WDOH: Tom Petro, Julie Lehane, Basil Reyes, Renee Recchia
- Provider Advisory Group
  - Claire Brazil, Liz Lacy, Rob Maher, Kay Scott, Amy Sucich, Scott Sullam, Pat Taddeo

Evaluation Objectives

- To recruit and maintain a representative cohort of HIV positive adults in the system of care in the Tri-County region
- To assess the system of HIV care – both health and social services – from the perspective of people living with HIV
- To report on unmet needs, service utilization trends, and outcomes to policy-makers, providers, consumers, and advocates

Matching CHAIN Data to Planning Questions

- Is there a compelling need for service?
- Is the service reaching special populations and areas?
- Is the service meeting Strategic Plan objectives?
- Does the service contribute to health outcomes?

CHAIN Data & Methodology

- Randomized sample recruitment of 398 participants at 32 sites among 28 agencies
- Representative of estimated 1,600 HIV+ in Tri-County care system
- At Wave 2 follow-up, 50 of 398 had died, moved, or were otherwise ineligible
- 315 of 348 eligible participants (91%) interviewed for Wave 2 follow-up

Cohort Representativeness

	People Living with AIDS, Tri-County† as of Dec. 31, 2001	CHAIN Cohort 2001 - 2002
n	2,186	398
MALE	1,476	204
Non-Hispanic White	32%	27%
Non-Hispanic Black	48%	43%
Hispanic	20%	29%
Other	1%	1%
FEMALE	710	194
Non-Hispanic White	20%	14%
Non-Hispanic Black	62%	57%
Hispanic	18%	26%
Other	1%	3%

† NYS DOH HIV/ AIDS Surveillance Program

Cohort Attrition

- Compare 315 interviewed with 33 who were eligible but not interviewed
  - Fewer 20-34 year olds interviewed
  - Fewer “doubled-up” interviewed
  - Fewer Rockland interviewed
- BUT… overall, distribution of groups in 315 looks much like original 398

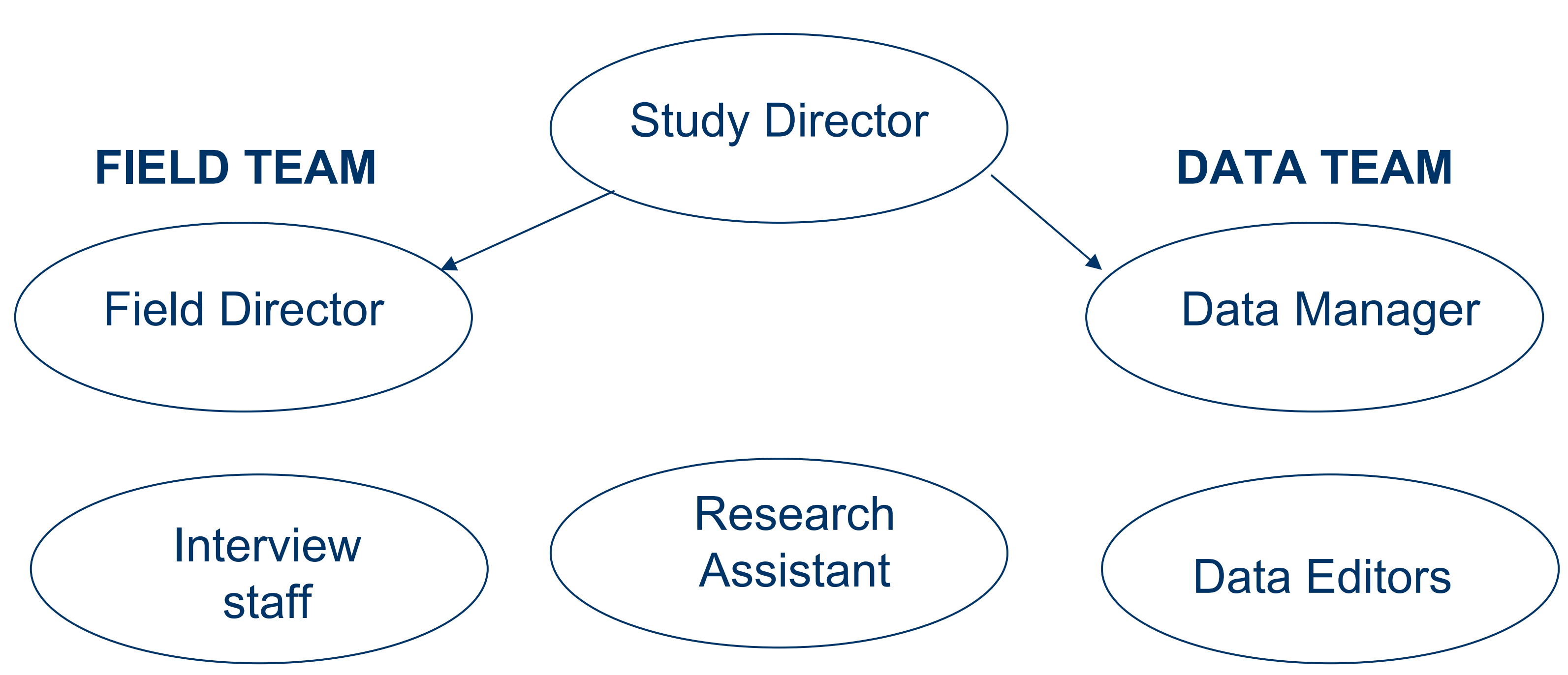
Topics Covered

- Current health status
- Family, housing, work, resources
- Outlook on life
- Risk behaviors – sex & drugs
- History and use of medical services
- History and use of social services
- Needs, satisfaction, barriers

Collecting Data

- Respondents interviewed annually
- Most often in their homes
- Community-based interviewing team
- $25 incentive for every interview + referral resource

Staffing the research enterprise



Case-finding Effort

- In Wave 2 follow-up, CHAIN interviewed 315 people
- The first 285 cases required 13 hrs per case
- The last 30 cases required 86.3 hrs per case
- … the last 10% of cases required 40% of the effort

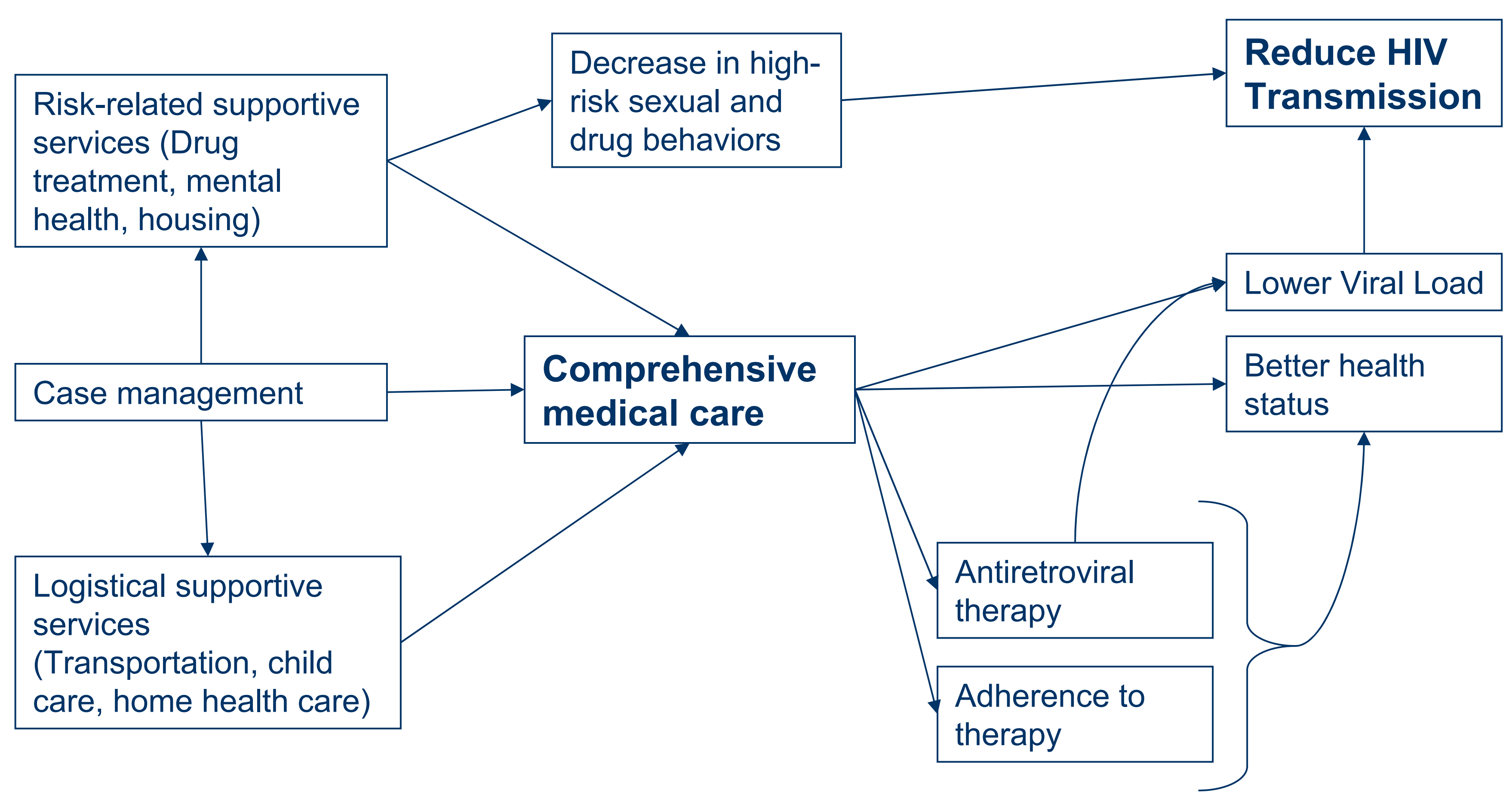


Fig. 1 Model of an HIV Care System (*David Abramson, Columbia University CHAIN Project, Apr 2004*)

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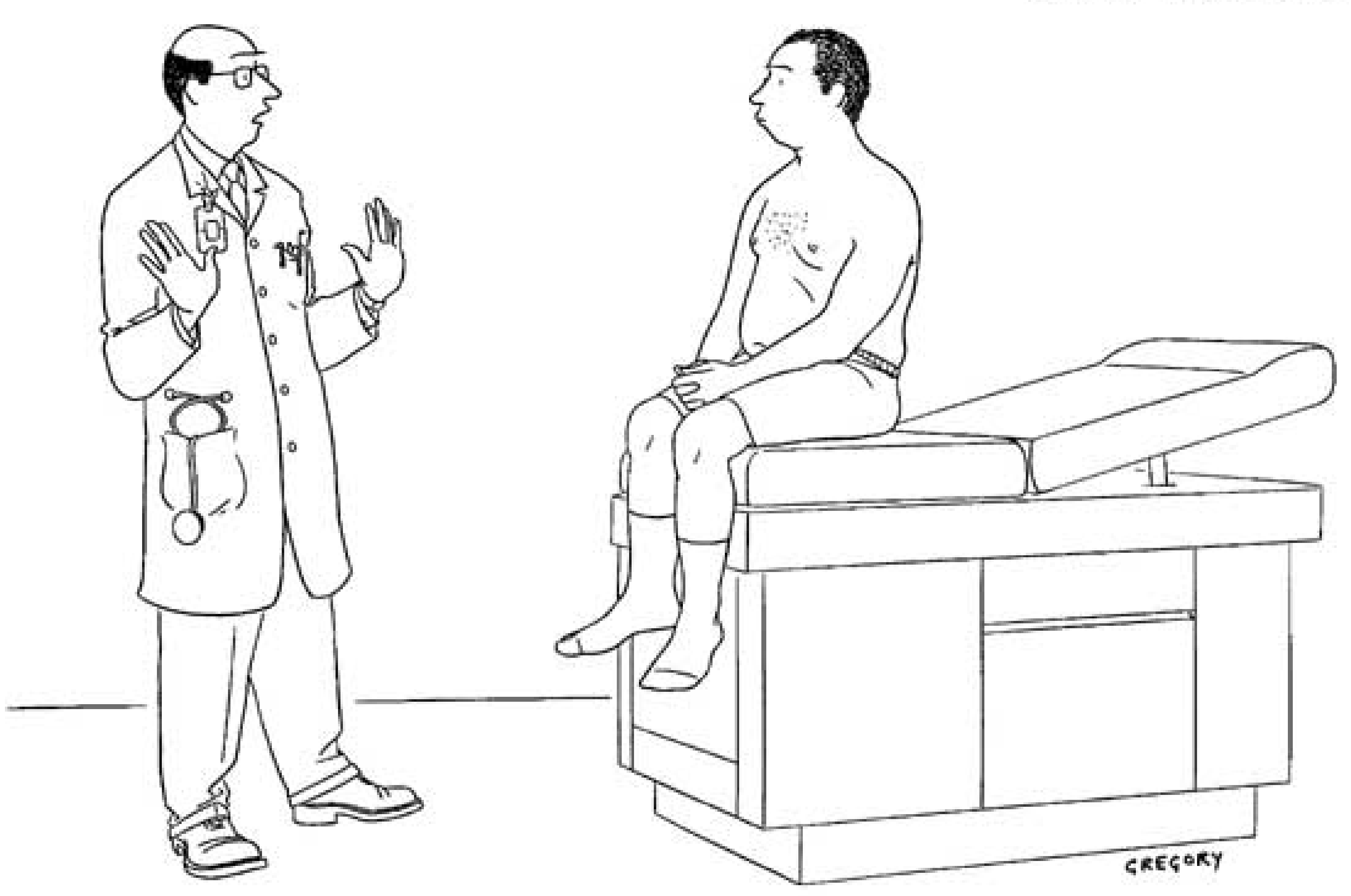

"Whoa—way too much information."

Estimates of HIV+, In Care and Not in Care

(Tri-County CHAIN Report 2003_5)

Estimates of HIV+ in Tri-County

System of Care	Living with HIV	Living with AIDS	TOTAL
Public system	**627**	**1,022**	**1,649**
Private MD	652	1,063	1,715
Not in care	621	100	721
TOTAL:	**1,900**	**2,185**	**4,085**

Strategic Plan Progress Indicators

(Tri-County CHAIN Report 2003_7)

Health Objectives

Objective	Progress Indicator	% of Baseline CHAIN with Positive Indicator	% of Follow-Up (W2) with Positive Indicator	Groups with statistically lower progress
PLWHA will have improved survival and health outcomes	Self-reported health status score is at or above national average for "good health"	**45%**	**41%**	1. Problem drug users 2. MSM/PDU

Mental Health Objectives

Objective	Progress Indicator	% of Baseline CHAIN with Positive Indicator	% of Follow-up (W2) with Positive Indicator	Groups with statistically lower progress
PLWHA engaged in mental health care will have improved quality of life	Among those with an objective need for mental health services, % reporting good physical health	**31%**	**25%***	1. Problem drug users

Alcohol or Drug Treatment Objectives

Objective	Progress Indicator	% of Baseline CHAIN with Positive Indicator	% of Follow-up (W2) with Positive Indicator	Groups with statistically lower progress
Providers will understand AOD culture and provide culturally appropriate and sensitive treatment	Among current or past drug users, % who delayed or didn't get medical or social services because of barriers	**26%**	**44%**	

Social Services Objectives

Objective	Progress Indicator	% of Baseline CHAIN with Positive Indicator	% of Follow-up (W2) with Positive Indicator	Groups with statistically lower progress
PLWHA will have access to a broad range of support, advocacy and basic needs programs within their geographic area	Among those who reported needing help with legal matters, child care, or food/ groceries/ meals, % with no change, no progress, or problems worsened	**47%**	**32%**	1. Rockland

Housing Work Group Objectives

Objective	Progress Indicator	% of Baseline CHAIN with Positive Indicator	% of Follow-up (W2) with Positive Indicator	Groups with statistically lower progress
Housing placement assistance services will be available for PLWHA who need them	Among those who reported any unstable housing, % who received housing subsidy, lived in specialized AIDS housing, or received housing services	**21%**	**15%***	

Tri-County Specific Objectives

Objective	Progress Indicator	% of Baseline CHAIN with Positive Indicator	% of Follow-up (W2) with Positive Indicator	Groups with statistically lower progress
Clients and providers will know how to access services	% who reported they knew how to find help for HIV or who know how to find services	**63%**	**53%***	1. Latinos 2. Rockland

Multiple Factors Analysis

Factors most significantly associated with...				
Reporting a lower physical health score	Being adherent to HIV medications	Reporting comprehensive medical care	Knowing how to access services	Experiencing barriers to medical or social services
➢Less than High School education ➢T-cell < 500 ➢Low MH score	➢Reporting comprehensive medical care ➢Not reporting barriers to care ➢Not having low MH score ➢No problem drug use ➢Being over age 50	➢Not having low MH score ➢Having a case manager	➢Not having low MH score ➢Living in Urban Westchester ➢Ever used drugs ➢Diagnosed between 1990-1995 ➢Attending AA/NA or self help	➢Having a low MH score ➢Unstable housing ➢Not attending AA/NA or self help

Service Gaps & Utilization

(Tri-County CHAIN Report 2003_1)

Defining Health Care Needs & Service Gaps

Area	Need	Service Gap
Patient/Provider communication	HIV seropositivity	Patient doesn’t know t-cell or viral load or says current doctor “could do a better job explaining my treatment options to me

Health Needs & Gaps

	New York City, n=622 (2002-2003)		Tri-County, n=398 (2001-2002)	
Area	**% with need**	**% with service gap**	**% with need**	**% with service gap**
Patient / Provider Communication	100%	**38%**	100%	**47%**

Defining Case Mgmt Needs & Service Gaps

CM Model	Need	Service Gap
Comp-rehensive care model	(1) Current drug user, OR (2) very low mental health, OR (3) recent unstable housing, OR (4) experienced barrier to med or soc service because didn't know where to go, couldn't get child care or transportation, or couldn't afford care, OR (5) not enough money in household for rent, utilities, food, or clothing	No CM developed a care plan, assisted in getting or referring clients to social services, or helped fill out forms for benefits or entitlements in past 6 months

Case Mgmt Needs & Gaps

	New York City, n=622 (2002-2003)		Tri-County, n=398 (2001-2002)	
Area	**% with need**	**% with service gap**	**% with need**	**% with service gap**
Comprehensive Case Management	75%	**40%**	77%	**45%**

Defining Mental Health Needs & Service Gaps

Area	Need	Service Gap
Supportive mental health	Scored above very low MH score AND (1) reported a need for help with emotional or psychological problems, OR (2) felt counseling regarding sexuality and sexual issues was considerably or extremely important, OR (3) strongly disagreed with statement, “Most of the time I am in firm control of my feelings and behavior”	Client did not report receipt of supportive MH service (support group, case manager, clery, peer worker) in past 6 months

Mental Health Needs & Gaps

	New York City, n=622 (2002-2003)		Tri-County, n=398 (2001-2002)	
Area	**% with need**	**% with service gap**	**% with need**	**% with service gap**
Supportive mental health	14%	**34%**	18%	**64%**

Definition of Drug Tx Needs & Services

Need	Service Gap
(1) Current drug or heavy alcohol use, OR (2) Client said that treatment or further treatment is “considerably” or “extremely” important	No reported therapeutic or self-help AOD treatment in prior 6 months

Drug treatment Needs & Gaps

	New York City, n=622 (2002-2003)		Tri-County, n=398 (2001-2002)	
Area	**% with need**	**% with service gap**	**% with need**	**% with service gap**
Alcohol or drug treatment	71%	**70%**	63%	**76%**

Definition of Transport Needs & Services

Need	Service Gap
(1) Delayed or didn't get medical or social service because couldn't get transportation, OR (2) Reported that s/he needed help or assistance with transportation	No transportation received in prior 6 months

Transportation Needs & Gaps

	New York City, n=622 (2002-2003)		Tri-County, n=398 (2001-2002)	
Area	**% with need**	**% with service gap**	**% with need**	**% with service gap**
Transportation services	21%	**77%**	32%	**67%**

What groups have significantly greater need?

- **Women**: Comprehensive care CM, Counseling CM, Financial & Permanent Housing, Transportation services
- **Problem drug users**: Comprehensive care CM, Counseling CM
- **Latinos**: Counseling CM, Professional MH, Drug treatment
- **Men**: Supportive mental health

What groups report significantly greater gaps?

- **Urban Westchester & Rockland**: Professional mental health, Drug treatment
- **Women**: Patient / Provider communication
- **Whites & Latinos**: Comprehensive medical care
- **Men**: Comprehensive case management

Partner Notification

(Tri-County CHAIN Report 2003_4)

Partner Notification

- As of June 2000, physicians and labs in NYS must report HIV and t-cells below 500, including for previously diagnosed, and physicians should probe for sexual and drug contacts
- CHAIN asked respondents if physician asked about contacts and requested names

Partner Notification - Findings

- Among 398 respondents, 18% (71) said their MD asked about sex/drug partners
- Of those 71, 99% (70) said the MD asked about sex partners… 27% (16) said the MD asked about drug partners
- Of those 71, 35% (25) provided MD with a contact name

Among those who did not report a name…

- 25 had no sex or drug partners
- 6 concerned about confidentiality
- 5 did not want to
- 3 said MD didn’t ask for specific name
- 2 said not MD’s business
- 2 couldn’t remember names
- 1 contact already knows status
- 0 concerned about domestic violence or relationship

Selected Health Analyses

Knowledge of T-Cells

Area	**NYC II**	**Tri-County Wave 1**	**Tri-County Wave 2**
Dates	**2002-2004**	**2001-2002**	**2003**
n	622	398	315
Number who don't know their t-cell count	24	46	52
Proportion who don't know t-cell count	**4%**	**12%**	**17%**

Key Factors Associated with Not Knowing T-Cell Count

- Less than a high school education
- Respondent believes that MD does not spend enough time with him/her

Proportion on HAART

	NYC II	Urban Westchester	Suburban West/Put	Rockland
n	619	115	63	31
Proportion on HAART	**54%**	**50%**	**48%**	**71%**

Note: Analysis restricted to individuals diagnosed prior to 1998 and who had EVER had an AIDS diagnosis

Factors Associated with HAART

- In Tri-County, white respondents were twice as likely as black respondents to be on HAART
- Unstably housed respondents in Tri-County were less likely to be on HAART

Major Findings

- Patient – Provider issues
  - Increase t-cell awareness
  - Can providers spend more time?
  - Consider integrated team approach
- Persistent racial/ethnic disparities
- Persistent need for…
  - Supportive mental health
  - Financial housing support
  - Transportation

Need to Refresh CHAIN Cohort

- Wave 3 has begun, anticipate drop to 270
- Need to bring cohort to 400 strength
- NYC refreshed in 4th year of larger cohort
- Requires additional…
  - Interviewer manpower, min. .5 FTE
  - Agency & client incentives
  - Transportation budget