Meeting Minutes
Needs Assessment Committee
Jennifer Irwin, Co-Chair

Tuesday, February 26, 2008
9:00 am – 11:00 pm
GMHC, 119 West 24th Street, Room 720

Members Present: Angela Aidala, G. Garcia-Goldwyn, JoAnn Hilger, Jennifer Irwin, Rebecca Kim, Juana Leandry-Torres, Rosemary Lopez, Jan Carl Park, Glen Philip, Roberta Scheinmann (for Mary Ann Chiasson), Howard Schwartz, Ricardo Vanegas-Plata, DDS

DOHMH Staff Present: Daniel Weglein, MD, Mary Irvine, Dr.P.H., A. Santella, M.P.H., Ph.D., Clarissa Silva, J. Hilger, David Klotz, Rafael Molina

I. Welcome/Introductions/Minutes: The meeting opened with a round of introductions. The minutes from the Committee's January 15th meeting were reviewed and were accepted with no changes.

II. Public Health Practice Unit/Treatment Adherence Program

Dr. Weglein discussed the role of the DOHMH HIV Bureau's Public Health Practice Unit and its treatment adherence pilot initiative. PHP is an implementation and evaluation focused unit. Dr. Santella will direct a policy and planning unit. PHP's role is to make sure that programs that have been implemented are effective and promote best public health practices and improve health outcomes.

The treatment adherence pilot initiative began as a directive from DOHMH Commissioner Frieden to help especially under-funded public hospitals with their program design and implementation in this area. The program is designed to demonstrate the model and concept, and is not necessarily based on need. Generally, our treatment adherence programs do not have lengthy protocols and are often social service-based/education & counseling models. None have been rigorously evaluated, using viral load or CD4 count as measures. We saw a model in Boston that was also used in Haiti, and we liked and decided to replicate it. It involves intensive case management integrated with treatment adherence, and includes health promotion/education and skills building. It requires high intensity contact with the patients (at least once per week in the patient's home), helping them to develop healthier behaviors, particularly taking medication, but also other health behaviors (e.g., substance use, etc.). There is also a daily directly observed therapy component with patients for whom health promotion was not enough. Many non-adherent patients are not interested in DOT, and so lower intensity services (i.e., weekly health

promotion) were initially needed, with the hope that they would move to DOT. Those who were enrolled in DOT had great success with adherence. We began the pilot program in NYC in October 2007. We make weekly site visits. They have received 40 referrals and has enrolled 23, all into the weekly intervention. Everyone is switched to a single pharmacy and pill box so that we can track them. Three patients were fast tracked to DOT (they had severe mental illness), followed by two others later. The program submits data on pill taking and self-reported adherence to DOHMH via a secure channel, rather than through the URS, which is a big innovation. When there is a problem with the data we can get back to the program within a day or two, rather than weeks. It's too early to say if the program is a success, although preliminary data is promising. It has been a challenge to enroll patients at the rate that we wanted. We will keep this committee abreast of developments with the program.

There followed discussion about aspects of the program, including the data transfer, the difficulty of reaching home-based clients, the use of peers, and the possibility of linking the program with maintenance in care programs.

III. Questions for Outreach Programs

Dr. Weglein and Ms. Hilger reported that in FY 2009, the HOPWA is assuming Ryan White funding for rental assistance, and transferring to Ryan White funding HOPWA funds for outreach programs that target homeless street youth and SRO residents to engage them in care and link them to care. We need to know what questions the PSRA and Council need to answer in order to reallocate these funds to serve those target populations.

Dr. Aidala reported that CHAIN has data on the unconnected to care, including that many are SRO residents who also report high risk behaviors. Columbia School of Public Health also has data on both positive and homeless street youth that could be mined for planning (e.g., where they can be found, what interventions are better to connect them to care). CHAIN also has data on delayed entry into care and its link to unstable housing, as well as the efficacy of various outreach strategies on access to and maintenance in care.

Ms. Irwin suggested looking at the Ryan White portfolio to see what services are being targeted to these populations now. There are several programs currently working in SROs, which PSRA will examine. Ms. Lopez reported that a new harm reduction program in Long Island City is seeing many homeless youth (many of them transgendered) who are unconnected to care and social services. Ms. Irwin confirmed the great unmet needs of transgendered youth (health, housing, educational, legal, etc.). Dr. Weglein said that HOWPA also has data from their existing programs that can be extracted.

III. CHAIN Discussion

Dr. Irvine presented ideas recently discussed at the CHAIN Technical Review Team meeting for possible reports and changes in the survey instrument that may help the priority setting process, particularly with input for the consumer priority variable in the priority setting tool and unmet need. The DOHMH HIV Bureau Research and Evaluation Unit also met with the Consumer

Committee to discuss ways of getting data on consumer priorities (e.g., a survey of clients recently returned to care, focus groups, etc.).

Open-ended questions in the CHAIN survey were recommended to enhance data on barriers, history of social services, health services utilization, and those not in care, as well as questions on perceived efficacy of services. The CHAIN survey instrument will be distributed to the Committee to get input on questions that would help quantify and rank consumer priorities.

Discussion in the Committee centered around how the questions can be structured to provide accurate information, particularly with self-reporting of efficacy and satisfaction of service. Clients are often dissatisfied with services because of incorrect expectations of the services provided (e.g., expecting medical care in a case management program). Data is needed on why clients select the providers that they do (e.g., location, etc.), and what is keeping people in care.

There was also discussion on possible CHAIN questions to get data on the effect of insurance on service utilization, and a comparison of multiple service types on the degree to which receipt of those services promotes engagement in primary care.

At the next meeting, NAC will discuss a CHAIN report on "Housing Need, Housing Assistance, and Connection to HIV Medical Care". Other TRT suggestions for future CHAIN projects were: examine predictors of preserved immune function (e.g., race/ethnicity, drug use, Medical provider type), and determine which combination of housing and case management/supportive services (e.g., supportive housing vs. separate housing services and case management services) has the greatest positive impact on outcomes such as engagement in care and clinical health status. Committee members were urged to think about other possible CHAIN topics for consideration at the next meeting (e.g., concerns about managed care, impact of mental health services on maintenance in care). The TRT suggestions will be circulated to the committee before the next meeting. Report topics that have already been done will be shared with the Committee (most are on the Planning Council website, www.nyhiv.org – go to the "Data" pull-down menu). Dr. Aidala offered to prepare a brief summary of recent reports, with methods and definitions that will be distributed before the next meeting.

The next meeting will be held on Tues., April 1st, 9:30-11:30am.