



# **Data Day 3: Using CHAIN Data**

**Presentation to the HIV  
Planning Council**

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## 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?

## Matching CHAIN Data to Planning Questions

- Is there a compelling need for service?
  - **Estimating Needs & Service Gaps**
- Is the service reaching special populations and areas?
  - **Estimating Needs & Service Gaps**
- Is the service meeting Strategic Plan Objectives?
  - **Strategic Plan Update**
- Does the service contribute to health outcomes?
  - **Ryan White Impact Study**



# Estimating Service Need

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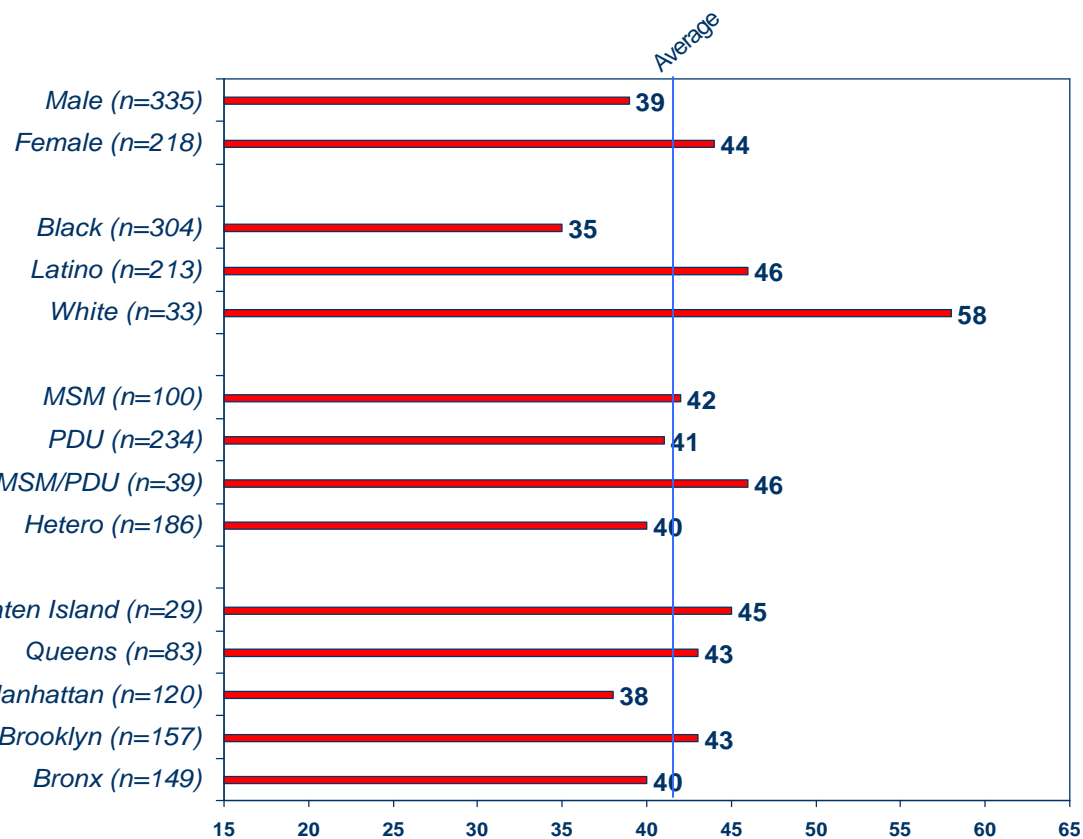
An illustration from the  
CHAIN Service Gaps report

## Definition of Mental Health Needs & Services

Need	Service Gap
(1) Very low mental health score on standardized scale (Medical Outcomes Study SF-36 “mcs” scale), OR (2) Reported that needed help with emotional or psychological problems	Respondent did not report professional (psychiatrist, psychologist, therapist) or supportive (support group, peer counselor, clergy) mental health service in past 6 months

# Estimating Mental Health Needs

## GENDER



Percent reporting need

\*\* significant ( $p < 0.01$ )



# Mapping Work Group Objectives

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An illustration from the  
CHAIN Strategic Plan Update report

# Health Work Group Objectives

Objective	Progress Indicator	% of Original CHAIN with Positive Indicator	% of New CHAIN 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”	48%	51%	1. Whites 2. Latinos 3. Problem drug users 4. CD4<500
PLWHA will have improved survival and health outcomes	Self-reported CD4 count is greater than 500 cells/mm <sup>3</sup>	34%	34%	
Persons who receive health services will adhere to treatment	Self-reported adherence to HIV medications	67%	72%	1. Women 2. Blacks 3. Whites

## Mental Health Work Group Objectives

Objective	Progress Indicator	% of Original CHAIN with Positive Indicator	% of New CHAIN with Positive Indicator	Groups with statistically lower progress
PLWHA engaged in mental health care will adhere to treatment	Among those with an objective need for mental health services, % who reported being fully adherent to HIV meds	<b>61%</b>	<b>66%</b>	1. Women 2. Blacks 3. Whites
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	<b>28%</b>	<b>48%*</b>	1. Whites

## AOD Work Group Objectives

Objective	Progress Indicator	% of Original CHAIN with Positive Indicator	% of New CHAIN 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	<b>18%</b>	<b>17%</b>	1.Heterosexual HIV risk
Health care, mental health, and other services will be more available and accessible to AOD users	Among current or past drug users with a need for MH services, % who received prof'l or supp MH services	<b>50%</b>	<b>60%</b>	

## Social Services Work Group Objectives

Objective	Progress Indicator	% of Original CHAIN with Positive Indicator	% of New CHAIN 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	<b>53%</b>	<b>58%</b>	1. 20-34 year olds
PLWHA will have access to necessary transportation services	Among those who reported needing transportation, or who said it was a barrier, % receiving transport services	<b>45%</b>	<b>38%</b>	

## Housing Work Group Objectives

Objective	Progress Indicator	% of Original CHAIN with Positive Indicator	% of New CHAIN with Positive Indicator	Groups with statistically lower progress
Transitional housing will be available to PLWHA who need it	% who reported being unstably housed in past 6 months	18%	28%*	1. Men
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	33%	47%*	

# Multiple Factors Analysis

## *Factors most significantly associated with...*

Reporting a lower physical health score	Being adherent to HIV medications	Reporting comprehensive medical care	Unstable housing in the past 6 months	Experiencing barriers to medical or social services
<ul style="list-style-type: none"> <li>➤ Original cohort</li> <li>➤ Problem drug users</li> <li>➤ T-cell &lt; 500</li> <li>➤ Age 50+</li> <li>➤ Low MH</li> <li>➤ Experienced barriers</li> </ul>	<ul style="list-style-type: none"> <li>➤ Men</li> <li>➤ Latinos</li> <li>➤ Reporting comprehensive medical care</li> <li>➤ Not reporting barriers to health or social service care</li> </ul>	<ul style="list-style-type: none"> <li>➤ Living in Brooklyn</li> <li>➤ Continuous medical care</li> <li>➤ Being white or Latino</li> <li>➤ Not having low mental health score</li> <li>➤ Not reporting barriers to health or social service care</li> </ul>	<ul style="list-style-type: none"> <li>➤ New cohort</li> <li>➤ Men</li> <li>➤ Problem drug users</li> <li>➤ Living in Manhattan</li> <li>➤ Age 20-34</li> <li>➤ Current or former drug user</li> </ul>	<ul style="list-style-type: none"> <li>➤ Being white</li> <li>➤ Not reporting comprehensive medical care</li> <li>➤ Having a low physical health score</li> </ul>



# Correlating Service & Health Outcome



An illustration from the  
CHAIN Ryan White Impact Study

## Odds of receiving appropriate medical care if you receive Ryan White-funded..

	<u>Adj. OR</u>	<u>(95% CI)</u>
– Primary Medical Care Provider	<b>1.7***</b>	(1.3, 2.3)
– Health Services	<b>1.8***</b>	(1.3, 2.4)
– Housing Services	0.7	(0.4, 1.2)
– AOD Services	1.1	(0.6, 2.2)
– Professional MH Services	1.1	(0.4, 1.8)
– Supportive MH Services	1.1	(0.6, 2.2)
– Case Management/Client Advocacy	<b>1.8**</b>	(1.3, 2.7)
– Food and Nutrition Services	1.2	(0.6, 2.2)
– Dental Services	0.8	(0.4, 1.5)

\*p<.05

\*\*p<.01

\*\*\*p<.001

Source: CHAIN Update report #35, Impact of Ryan White CARE Act

## Odds of being on any ARV if you receive Ryan White-funded...

	<u>Adj. OR</u>	<u>(95% CI)</u>
– Primary Medical Care Provider	0.8	(0.5, 1.3)
– Housing Services	1.7	(0.9, 3.4)
– Health Services	1.0	(0.6, 1.5)
– AOD Services	1.4	(0.6, 3.2)
– Professional MH Services	1.2	(0.4, 3.1)
– Supportive MH Services	0.9	(0.3, 2.4)
– Case Management/Client Advocacy	<b>1.7*</b>	(1.0, 2.8)
– Food and Nutrition Services	1.7	(0.7, 4.2)
– Dental Services	1.2	(0.5, 2.9)

\*p<.05

\*\*p<.01

\*\*\*p<.001

Source: CHAIN Update report #35, Impact of Ryan White CARE Act