Analysis of HIV/AIDS Related Services in Community and Migrant Health Centers

Final Report Presentation

January 4, 1991

JSI

OVERVIEW OF STUDY OBJECTIVES AND METHODS

A. OBJECTIVES

* Assess the ability of C/MHCs to respond to HIV-related needs;

* Develop and test procedures for assessing needs/demand for HIV services;

* Develop and test an approach to evaluating the provision of HIV services in C/MHCs

B. METHODS

1. Site Visits to 11 C/MHCs (10 plus 1 pilot site).

   * 2-3 day visits

   * 3 person team - finance/management specialist, AIDS clinician, AIDS program specialist

   * Visits included: interviews with health center staff, interviews with others involved in the community's AIDS care network, review of C/MHC cost and utilization data, review of community data, review of medical records, observation of systems and procedures

2. Telephone conversations with 29 randomly selected C/MHCs

C. COMMENTS ON METHODOLOGY

* Combination of in-depth visits to experienced sites and interviews with a random selection of sites was very helpful.

* Use of multiple data collection methods on-site (records and data review, interviews, observation) was essential.

* Interviews with people outside C/MHC were very important.

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SITE VISIT RESULTS: HIV/AIDS NETWORKS

A. FINDINGS

* AIDS Network varies greatly between areas as does C/MHC role.

* C/MHCs can't provide all needed services.

* C/MHCs are most effective when an active part of a network.

* In rural areas, C/MHC may be the core of the network.

* Barriers (real and perceived) to appropriate participation in the network include: financial and other resource constraints, BHCDA productivity requirements, conflicting demands for other services, threat of being overwhelmed, fear and bias from board and staff.

B. RECOMMENDATIONS

* Recognize and support many different though appropriate roles for C/MHCs in AIDS care.

* Encourage active participation in the AIDS care network.

* Recognize and remove real and perceived barriers to AIDS care.

* Before awarding supplemental funds require a detailed description of the community AIDS care network.

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SITE VISIT RESULTS: NEEDS DEMAND ANALYSIS

A. FINDINGS

* Most current needs/demand assessments are descriptive with a minimum of quantitative data.

* Data used includes data provided by city/county/state surveillance units on incidence and in some cases seroprevalence. This data varies by geographic specificity and currency. Availability/accuracy of data on HIV positive or at risk populations is greatly variable.

* Proxy data (e.g. drug use and STD rates) are also used. These do not allow for comparison between C/MHCs.

* Most needs/demand assessments describe the AIDS care network and its gaps.

* Areas of highest HIV/AIDS incidence are not necessarily the areas of highest need for C/MHC services.

B. RECOMMENDATIONS

* C/MHC needs/demand assessments on HIV/AIDS must incorporate descriptive as well as quantitative information.

* Quantitative information that is provided (see attached recommendation) must be viewed with consideration of variation in completeness, accuracy and currency.

* Need of C/MHC service areas outside the high incidence AIDS areas should be recognized.

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RECOMMENDATIONS FOR AIDS NEEDS/DEMAND ASSESSMENT

A request for C/MHCs to provide information on HIV service needs in their areas could be organized according to the following parameters.

1. Provide data on the current and two year projected caseload of AIDS patients and HIV positive individuals for your service area, city or county by: (smallest area possible; list source)

   - total
   - transmission category
   - race/ethnic group
   - age/sex

2. Indicate the current and two year projected caseload of AIDS and HIV positive patients at the C/MHC by:

   - total
   - transmission category
   - race/ethnic group
   - age/sex

3. Estimate current and projected utilization of basic HIV services at the C/MHC and discuss the capacity of the C/MHC to meet these service needs:

   - annual demand for pre-test counseling
   - annual demand for post-test counseling
   - annual number of total HIV related medical encounters
   - annual number of HIV related medical encounters per FTE provider and as a % of all encounters
   - annual number of HIV related social service contacts
   - annual number of HIV related inpatient admissions followed by C/MHC medical staff

4. Describe the current HIV care network in the service area; indicate the specific organizations involved and health center linkages; and highlight gaps or unmet service needs for at least the following services:

   - education and prevention
   - HIV counseling and testing
   - primary care, including source of prophylactic/antiretroviral therapies
   - dental services
   - social services
   - mental health services
   - support groups
   - substance use counseling and treatment
   - experimental treatment protocols
   - inpatient care
   - hospice care
   - home care

5. Provide any additional information describing AIDS/HIV needs and demands such as: information on special populations (e.g. IVDU's, homeless, teens); information from community/user Knowledge, Attitude and Behavior (KAB) surveys; PWA surveys; area specific seroprevalence studies; rates and trends for other STDs; rates and trends of TB.

SITE VISIT RESULTS: FINANCIAL ANALYSIS

A. FINDINGS

* HIV/AIDS patients averaged 16.2 visits/year vs. 3.2 for all health center users. (very sick parents)

* HIV/AIDS visits are longer, approximately 30 min. vs. 15 min. on average. (alot of time - 15' spent in paperwork, case management)

* HIV/AIDS patients use more ancillary services - in the study, 17.6 lab tests and 1.4 x-rays per year vs. 2.6 lab tests and 0.2 x-rays for the average patient.

* C/MHCs are not generally providing AZT or PCP prophylaxis directly.

* Utilization of other health services is not well documented.

* Pre-, post-test counseling averages 30 min. pre-test and 45 min. post-test for 12-14 patients per day.

* Cost per visit was essentially the same ($67 per HIV visit and $62 per other visit) but extended provider time and services/tests done outside the health center are not reflected.

* Reimbursement is generally better for HIV patients than other patients but only about 60% of costs are reimbursed. C/MHCs lose about $450 per year on HIV/AIDS patients vs. $145 per average patient.

* Other costs are incurred for training, waste disposal, supplies and renovations.

B. RECOMMENDATIONS

* C/MHCs should take greater advantage of other resources e.g. CDC testing programs, HRSA AIDS ETCs, clinical trials.

* Centers should be aggressive in accessing benefits from Medicaid and other state programs.

* Reduce real cost of providing AIDS care by directing time away from expensive medical staff.

* Supplemental funding initiatives should recognize the need to support traditionally non-reimburseable services.

* Further study, on a larger sample is needed to confirm/refute the cost and utilization estimates in this study.

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SITE VISIT RESULTS: EVALUATION OF HIV AIDS SERVICES

A. FINDINGS

* HIV/AIDS services at C/MHCs are affected by patient characteristics, health center characteristics, the local AIDS network and the progression of the epidemic.

* Evaluation of services must take individual differences into account.

* Rapidly evolving standards of care require frequent up-dating of any evaluation criteria.

B. RECOMMENDATIONS

* Use pre-defined criteria for evaluating HIV/AIDS services but only in conjunction with site specific reviews, preferably through site visits.

* Based on the site visits, several standards are recommended for use in evaluating HIV/AIDS services. These are attached.

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RECOMMENDED STANDARD HIV PREVENTION AND TREATMENT PRACTICES IN C/MHCs

1. HIV risk assessment will be performed on all patients, and recorded on the standard health history.

2. Patients determined to be at risk for HIV infection will receive information and counseling regarding HIV, including risk reduction guidelines and options for confidential and anonymous antibody testing; this process will be documented in their medical record.

3. Informed consent will be obtained and documented prior to HIV antibody testing. The center will monitor data concerning the frequency of testing, rates of seropositivity, and returns for results/post-test counseling.

4. All infants born to seropositive mothers will be tested for HIV antibody and, if positive, will undergo specialized testing (HIV culture or other viral marker such as PCR) between age 6 and 15 months.

5. Newly diagnosed HIV seropositive patients will be evaluated for immune function by performing T-cell subsets/flow cytometry within one month of learning their HIV status. This evaluation will also include a TB skin test (with controls for anergy) and syphilis serology.

6. HIV infected patients with M. tuberculosis infection will receive appropriate treatment, according to established PHS guidelines.

7. Patients with prior PCP or low CD4 lymphocyte counts (absolute number <200/mm3 or <20%) will receive prophylaxis against Pneumocystis carinii trimethoprim/sulfamethoxazole twice daily or aerosolized pentamidine once monthly.

8. To prevent cross-infection of patients or staff during treatments, active pulmonary TB will be ruled out before initiating nebulized pentamidine.

9. Antiretroviral therapy (zidovudine currently) will be promptly initiated for all HIV seropositive clients with CD4 lymphocyte counts <500, according to current FDA dose recommendations.

10. HIV infected patients will receive information concerning investigational treatments and be referred to available clinical trials upon request.

11. All clients with substance abuse problems will receive information, counseling and referral to treatment programs.

12. All seropositive women should have documented counseling on reproductive options/issues.

13. The center will increase the proportion of new HIV seropositive clients with CD4 counts > 500/mm3

Feb '89

GENERAL FINDINGS AND CONCLUSIONS

* Extensive variation was seen in the range and scope of HIV/AIDS services, number of HIV+ patients seen, the role of the health center and issues facing the centers (see attached chart).

* Range of services offered was more correlated to interest of staff and availability of funding than need.

* Most of the centers do not keep specific information on the number of HIV/AIDS patients. Where actual counts are not available, estimates are used. Two sites had seen less than 10 patients, one, 15 patients and one, 500. Most are seeing 100-200 patients.

* Centers which are active participants in their network are able to offer more comprehensive services. Some centers are "late-comers" to AIDS care and must work to establish credibility

* In some areas, particularly rural areas C/MHCS may be the only provider of care. This can seriously strain resources.

* C/MHCs must have strong arrangements with a hospital experienced with AIDS care. This may mean forming new linkages.

* Greater emphasis must be placed on training C/MHC staff and boards. Care is best when supported on an institution-wide basis, is difficult when burden is assumed by a few. HRSA AIDS ETCs and other federally supported training resources (CDC, Family Planning, NIMH) have been underutilized.

* Health centers which see a significant number of HIV+ patients can expect a significant, negative financial impact. The proportion of patients may be as influential as the absolute numbers.

* Other services may be detrimentally affected by the provision of significant HIV services, even when sufficient funding is available. BHCDA must be accepting of different responses to the epidemic.

* All health centers should be involved in the prevention, diagnosis and treatment of HIV and BHCDA should raise its expectations in this regard. Some, but not all will require supplemental funding to meet needs.

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SUMMARY OF SERVICES AT HIV STUDY SITES

	1	2	3	4	5	6	7	8	9	10	11
PREVENTION & EDUCATION											
patient ed materials	YES	YES	YES	YES	YES	YES	YES	YES	FEW	NO	YES
group sessions	NO	YES	YES	YES	NO	NO	IN CAMPS	YES	NO	YES	YES
community education	YES	YES	YES	YES	YES	YES	YES	YES	NO	NO	YES
patient risk assessment	HI RISK	ALL	HI RISK	ALL	ALL	HI RISK	HI RISK	HI RISK	HI RISK	SELECT	ALL
COUNSELING AND TESTING	ATS	CONFID	PERINATAL	CONFID	CONFID	CONFID	PLANNED	A CONFID	LO RISK	SELECT	CON
Partner Notification	NO	YES	NO	NO	HD	NO	HD	YES	NO	NO	NO
CLINICAL SERVICES											
initial eval	YES	YES	NO	YES	YES	YES	YES	YES	YES	YES	YES
primary care for HIV+	YES	YES	EMER	YES	YES	YES	YES	YES	YES	YES	YES
order T-cells	YES	@ hosp?	NO	YES	STARTING	YES	YES	YES	YES	YES	YES
clinical case mgmt	INFORMAL	YES	NO	TEAM	YES	YES	NO	YES	YES	NO	YES
AZT Mgmt	YES	YES	NO	YES	NO	YES	NO	YES	YES	YES	YES
AZT Dispensing	NO	NO	NO	AFFILIATE	NO	NO	NO	LIMITED	NO	YES	NO
AP onsite	YES	NO	NO	YES	NO	YES	NO	SPECIALTY	NO	NO	NO
CRI involvement	YES	YES	NO	NO	NO	NO	NO	YES	NO	NO	NO
follow inpatient	NO	YES	TRACK	YES	TRACK	NO	NO	YES	YES	YES	YES
dental	YES	YES	YES	YES	YES	NO	YES	YES	NO	YES	YES
substance use	NO	AFFILIATE	NO	YES	YES	NO	YES	NO	NO	YES	AFF
SUPPORT SERVICES											
Mental Health	YES	NO	NO	YES	NO	NO	NO	NO	YES	YES	YES
support groups	STAFF	YES	NO	YES	PLANNED	NO	NO	NO	STAFF	NO	NO
social service case mgmt	INFORMAL	YES	NO	YES	PLANNED	YES	NO	CONTRACT	NO	NO	INF
home care	NO	NO	NO	NO	NO	YES	NO	CONTRACT	NO	YES	NO
assist w/ entitlements	INFORMAL	YES	YES	YES	NO	YES	YES	YES	NO	YES	YES

RESULTS OF TELEPHONE CONVERSATIONS

* Characteristics of C/MHCS participating in telephone conversations were diverse (see attached chart).

* There was an extensive range in the number of AIDS patients seen and the volume of AIDS related services provided (see attached chart).

* Most health centers are conducting targeted risk assessment; however, a few are not assessing client risk at all. Even in low incidence areas, centers should be encouraged to conduct risk assessment.

* Most C/MHCs' HIV/AIDS activities have focused on education and prevention. Only 9 of 29 had seen more than 5 HIV infected people.

* Most centers (with the notable exception of Puerto Rico) have access to AZT and PCP prophalaxis.

* Most do not provide aerosolized pentamidine on site.

* Access to clinical trials is extremely limited.

* Most centers seeing HIV+ patients describe their role as primary care. Most have access to speciality care though some significant gaps exist.

* In most places, case management is being assumed by physicians.

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Table 1. Characteristics of Community and Migrant Health Centers Providing Telephone Information--July 1990

	Urban Site (N=10)	Rural/Migrant Site (N=19)
Users CY 1989	12,180*	11,995
range	(4,000-26,000)	(800-64,600)
Encounters CY 1989	39,870	46,442
range	(10,900-84,000)	(2,000-355,000)
Patient race/ethnicity:		
Black	49%	16%
Hispanic	23%	30%
White	28%	53%
Other	5%	2%
Income below 200% poverty	86%	70%
Receiving Medicaid	31%	21%
No third party coverage	52%	47%
Staffing:		
Physician FTE (mean)	5.2	4.5
range	(1.5-10.0)	(0-20.0)
Mid-level FTE (mean)	1.3	1.5
range	(0-3)	(0-7)

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* Group mean values

Table 2. Measures of HIV Prevention and Treatment in Community and Migrant Health Centers--July 1990

	Urban Centers (N=10)	Rural/Migrant (N=19)
	mean, median	mean, median
Patients with HIV:		
Current AIDS	5.5, 0.5	2.4, 0
range	(0-26)	(0-26)
Former AIDS	3.7, 0.5	3.8, 0
range	(0-20)	(0-25)
HIV without AIDS	6.6, 2.5	12.0, 0.5
range	(0-31)	(0-100)
Total HIV-infected	15.8, 5	18.2, 1.5 *
range	(0-65)	(0-140)
% Users with HIV	0.13, 0.04	0.12, 0.01
range	(0-0.61)	(0-1.09)
HIV Antibody Testing:		
Total CY 1989	258.2, 80	103.2, 20
range	(0-1,000)	(0-600)
HIV-positive	5.9, 2.5	4.2, 0
range	(0-30)	(0-50)
% users tested	2.79, 0.80	0.74, 0.28
range	(0-10.55)	(0-5.13)
Medical Visits:		
Total HIV CY 1989	154.3, 10 +	38.5, 1
range	(0-1,000)	(0-250)
% visits HIV-related	0.60, 0.06	0.08, 0.01
range	(0-4.00)	(0-0.87)

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* N=18; data unavailable for one site.
\+ N=7; data unavailable for three sites.

Recd 12/10/90 Migrant

HUMAN SERVICES

Public Health Service

RESOURCES AND SERVICES ADMINISTRATION
BUREAU OF HEALTH CARE DELIVERY AND ASSISTANCE

Memorandum

Date DEC 6 1990

Dave — Make sure we cover this session — let others in the Division know about it Thanks DCh

From Director
Division of Special Populations Program Development

Subject Briefing Meeting on "Analysis of HIV/AIDS Related Services in Community and Migrant Health Centers" on January 4, 1991

To Addressees Below

The Division of Special Populations Program Development (DSPPD) is pleased to extend a special invitation for you to attend a briefing to present results of the evaluation study "Analysis of HIV/AIDS Related Services in Community and Migrant Health Centers." This briefing will be held on January 4, 1991, from 1:30-4:00 p.m., in the "Maryland Room," Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857.

This project was undertaken by John Snow, Inc., for the DSPPD, Bureau of Health Care Delivery and Assistance (BHCDA). The goal was to enhance BHCDA's understanding of HIV/AIDS services in community and migrant health centers as a basis for development of Bureau strategies, policies, and evaluation approaches.

If for some reason you are unable to attend, please consider designating a representative. We look forward to seeing you on January 4, 1991. If you have any questions, please call Joseph O'Neill, M.D., M.P.H., Chief, Program Development Branch, DSPPD, at FTS 443-8113.

Joan Holloway

Dr. Marilyn Gaston
Dr. Steven Bowen
Division Directors, BHCDA
Beth Roy
Anabel Crane
Dr. George Counts, NIH
Gary West, CDC
Dr. Merle McPherson, MCH
Dr. Lydia Soto-Torres, BHPr
Dr. Janet Arrowsmith, AHCPR