

# The Role of Community Based Organizations for Partner Services

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# Howard Brown

## Background

- Founded in 1974 by Northwestern University medical school students for STD testing and treatment for gay and bisexual men
- Currently the Midwest's largest provider of LGBT health
  - 190 FTEs
  - Budget of \$14 million

# Howard Brown Services

## FQHC, "One Stop Shop" Model

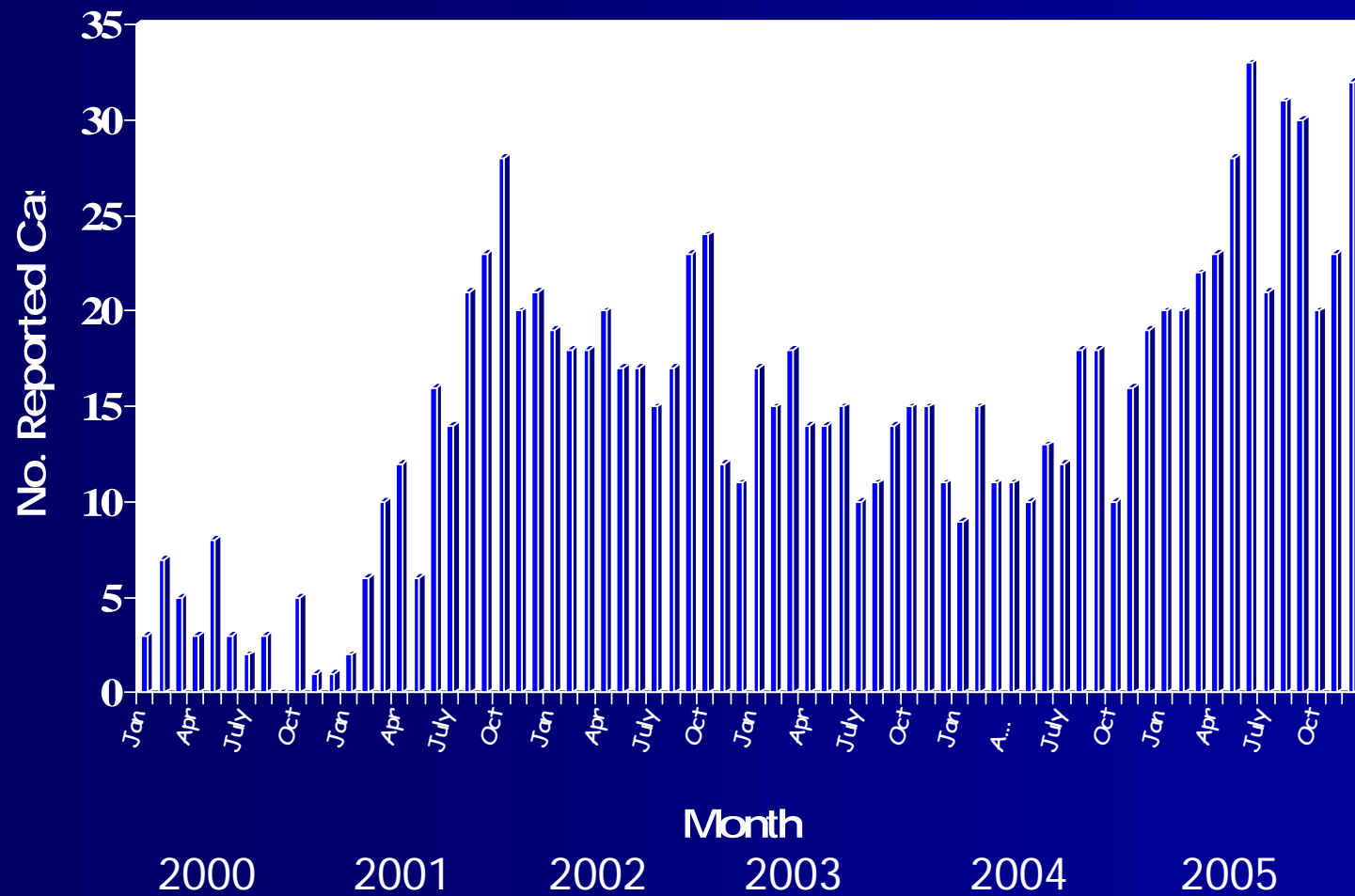
- Range of services include
  - Primary medical care
  - Behavioral health
  - HIV/STD Prevention
  - Case Management
  - Research
  - Youth Center
- Serve over 10,000 clients/year in primary medical care, and provide over 30,000 units of service

# Syphilis in Chicago

## Initial MSM Outbreak

- Significant shift in syphilis diagnoses from heterosexuals to MSM in 2001
  - Increase to 177 P&S cases from 44 in 2000
  - CDC deployed Rapid Response Team to assess situation
  - Over 50% of MSM previously diagnosed with HIV
- Health Department encountered difficulty providing partner services to MSM, particularly those diagnosed at private providers

# P&S Syphilis, MSM, 2000-2005



# Role of Howard Brown

Howard Brown diagnoses and treats a significant proportion of syphilis in Chicago and suburban Cook County

- In 2003, 43/267 (16%) of Chicago P&S cases were from Howard Brown
- In 2005, HB diagnosed 189 total new cases, of which 91 were staged as P&S

# DIS Program at HB

## Program History

- In June 2002, CDPH funded Howard Brown to hire a full-time DIS to provide case management for all HB cases
- Our DIS program now employs three full-time staff to provide partner services
- All staff go through required CDC training (Module Training, ISTD, ASTDI)

# Benefits of the program

## Howard Brown

- DIS model was fully integrated into clinic; interview is now seen as part of standard of care
- Clinicians more invested in encouraging clients to fully disclose sexual history
- Enhanced overall provision of syphilis services: walk-in treatment clinic, training to staff

## CDPH

- Reduced burden of cases for CDPH DIS
- Strong collaboration between HB and CDPH DIS
- Provision of internet notification for CDPH cases
- Ensure accuracy of surveillance/reporting

# But does it actually work?

## Two data sets to evaluate program

- Comparison of CDPH/HBHC

- Presented at ISSTDR and NSTDC
- Compared three years of early syphilis
- This represented first 1.5 yrs of HB program

- Post-comparison data

- Pulled as routine data collection
- Extends data above for two years
- Enables us to look at program maturity

# Methods

## Retrospective case audit

- All early cases diagnosed at HB from January 2000-December 2003
  - CDPH investigated cases Jan 2000-May 2002
  - HB investigated cases June 2002-Dec 2003

## On-going case audit

- All early cases diagnosed at HB from January 2004-December 2005—all HB investigated

## Used 73.54 form for data collection

- Recorded interviewer number, diagnosis, demographic info, behavioral info, and partner dispositions for analysis

# Study population

232 early syphilis cases were included in the analysis

- CDPH investigated 108 (46.6%) cases
- HB investigated 124 (53.4%) cases
  - No significant differences in total cases, demographics, or stage of disease

# Results

Lost to follow-up (coded as 999)

- CDPH: 43/108 cases (39.8%)
- HB: 6/124 cases (4.8%)
  - $p < 0.01$

Time from treatment to interview for cases not lost to follow-up, in median number of days

- CDPH: 26 days
- HB: 1 day

# Partner Elicitation Results

Cases with at least one partner elicited

- CDPH: 29/108 (26.9%)
- HB: 63/124 (50.8%)
  - $p < 0.01$

Total partners elicited = 191

- CDPH: 50 (26.2%)
- HB: 141 (73.8%)
  - $p < 0.01$

Partner index (elicited partners/cases assigned)

- CDPH: 0.463
- HB: 1.14

# Case Finding Results

Partners identified as a new case of syphilis = 13

- CDPH: 2 (15.4%)
- HB: 11 (84.6%)

Partners preventively treated during incubation period = 63

- CDPH: 9 (14.3%)
- HB: 54 (85.7%)

# 2004-2005 Data

Total number of early cases = 266

Lost to follow-up (999) = 18

Time from Tx to Ix = Median 0 Days

## Partner elicitation

Cases with at least one partner elicited

$137/266 = 51.5\%$

Total number of partners elicited = 334

Partner index

$334/266 = 1.26$

## Case Finding

Partners preventively treated = 105

New cases identified = 29

# Results Overview

	CDPH	HB 02-03	HB 04-05	HB Total
Total early cases	108	124	266	390
# partners treated	9	54	105	155
# partners previously treated	12	19	48	67
# infected partners	2	11	29	40
Contacts per index case	0.463 50/108	1.14 141/124	1.29 344/266	1.24 485/390
Cases found (inc. E) per index	0.13 14/108	0.24 30/124	0.29 77/266	0.27 107/390
Cases found (exc. E) per index	0.02 2/108	0.09 11/124	0.11 29/266	0.10 40/390

# Howard Brown Model

“Interrogation” style interviewing less effective than interview that *feels* client-centered

DIS more invested in work because of link with community (job satisfaction)

Method of evaluation for HD DIS may lead to burn-out and apathy; DIS also not motivated to work *with* client

HB DIS specialized; this is primary job of DIS, not also running clinic and other STDs

# Reasons for success

- Time from Tx/Ix
- Cultural Competency
- Use of internet for PN
- Integration of DIS into clinical model
- Broader community knowledge of syphilis epidemic, as reported in press
- Distance ourselves from “HD” while still performing same function; main goal is to not burn bridge with client (repeats)

# Discussion

Should this model be applied elsewhere?

- Legality
- Training and infrastructure
- Funding (both in overall program dollars and as competition for DPH)
- Large number of cases
- Other programs in the country

# Next steps

Need evaluation data to measure differences in contact methods

Are there priority cases?....by diagnosis, repeat status, partners elicited at first interview, etc.

Expand program into HIV PCRS—Could be used as national model to engage HIV prevention agencies

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# For more information:

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